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Center for Health Care Purchasing Improvement (CHCPI) Annual Report

January - December 2011

Minnesota Department of Health

Report to the Minnesota Legislature 2012

July 2012

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Center for Health Care Purchasing Improvement (CHCPI)
Annual Report
January - December 2011

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Center for Health Care Purchasing Improvement (CHCPI) Annual Report

January – December 2011

SUMMARY

Overview

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January to December 2011 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63.

CHCPI is part of the Health Policy Division of the Minnesota Department of Health (MDH). Its primary mission is to support "the state in its efforts to be a more prudent and efficient purchaser of quality health care services" and in achieving other related health care system improvement goals. In particular, CHCPI is authorized to help reduce the costs and burdens associated with the exchange of routine health care business (administrative) transactions. This is important because health care is a transaction-intensive enterprise, with millions of billings, payments, and other common business-related exchanges in Minnesota each year. Achieving even small efficiency improvements across this large volume of administrative activity can result in substantial savings. In addition, improving the flow and accuracy of health care business transactions is foundational to achieving other health reform goals, including tracking health care costs and quality.

In mid-2007 CHCPI was selected to manage the implementation of first-in-the-nation state requirements to automate and simplify exchanges of routine, high volume health care business data. The rules became effective in 2009 and were subsequently updated in 2010 and 2011 to comply with recent federal regulations. The state's regulations are projected to reduce overall health care administrative costs in Minnesota's health care system by $40 million to $60 million,[i] allowing more of every health care dollar to be spent on patient care and health improvements. The regulations apply to over 60,000 health care providers in Minnesota and to more than 2,000 insurance carriers and other health care payers nationwide.

CHCPI works closely in partnership with the health care industry and stakeholders, particularly the Minnesota Administrative Uniformity Committee (AUC), a large, voluntary organization of health care providers, payers, health care associations, and state agencies working together to reduce health care administrative costs and burdens. Because of its substantial contributions and active partnership with the state, Governor Dayton proclaimed February 21, 2012 as "AUC Day" in Minnesota.

However, CHCPI's scope and purpose also increasingly reflect broader efforts to bring about greater administrative streamlining and automation at the national level. In particular, CHCPI is leading efforts to harmonize Minnesota's requirements with recent federal regulations, including

a series of rules to be adopted during the period 2011-2016 pursuant to the 2010 federal Patient Protection and Affordable Care Act (ACA). In addition, CHCPI is working with the AUC to inform the development and implementation of the federal regulations, and serves as a liaison and participant with other national standards setting organizations.

CHCPI key activities and accomplishments in 2011

During 2011 CHCPI served as project manager for the state's health care administrative simplification and streamlining initiative. In this capacity it:

- Facilitated an open, public rulemaking process to advance the state's health care administrative cost reduction initiative, including staffing and facilitating over 60 open, public meetings, leading to the promulgation/adoption of 10 sets of rules to help standardize and automate routine health care administrative transactions;
- Responded to over 400 requests from providers, payers, and others for information, clarification, or technical assistance.
- Completed research and discussions on two legislatively required reports on the current state of the art and related issues in health care administrative simplification; and
- Facilitated the AUC in providing comments and recommendations regarding federal rules and the work of national standards setting groups.

Center for Health Care Purchasing Improvement (CHCPI) Annual Report

January – December 2011

INTRODUCTION

Annual Report

This CHCPI annual report encompasses the period from January to December 2011, in fulfillment of requirements of Minnesota Statutes, section 62J.63, subdivision 3, that

> "The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health Web site and must be available to the public…."

Background

Minnesota's health care environment and challenges

It is a significant understatement to note that Minnesota's health care system, like the nation's generally, is large, complex, and expensive. In 2010, the most recent year for which data is available, total expenditures in Minnesota's health care sector were $37.7 billion.[ii] This level of spending represented 13.9 percent of the state's gross domestic product (GDP)[iii]—more than the value of Minnesota's agriculture and tourism industries combined.[iv] In 2011 the State of Minnesota alone purchased health care services on behalf of an estimated 985,000 Minnesotans at projected costs of nearly $6.0 billion,[v] and health care costs are one of the most rapidly growing components of the state budget.

Despite its broad scope and significant costs, a number of studies have characterized the health care system overall as disjointed and fragmented, plagued by variable or poor quality, and directed by skewed payment incentives that do not align for optimum value and performance.[vi] Moreover, other analyses have reported high levels of administrative expense and that even common, routine health care business activities—such as determining patient eligibility for insurance coverage and benefits, submitting bills to payers for reimbursement, and providing remittances to providers—are often unnecessarily burdensome or expensive.[vii]

CHCPI purpose and current focus

CHCPI was authorized and created in 2006 to help address systemic problems contributing to health care system underperformance. Pursuant to statute, CHCPI serves to "support the state in its efforts to be a more prudent and efficient purchaser of quality health care services." A key CHCPI objective is to promote common strategies and approaches across diverse stakeholders to improve health care outcomes and to increase the value of every dollar spent on health care.

CHCPI is also authorized to participate in other related health care improvement activities, including reducing the costs and burdens of health care administration. In mid-2007 it was selected to manage the development and implementation of first-in-the-nation rules to automate and simplify several high volume, routine health care administrative transactions, effective in 2009. As noted in the preceding summary, CHCPI consults in the development of the rules with a large, broad-based multi-stakeholder advisory organization, the Minnesota Administrative Uniformity Committee (AUC).

As required by statute, the state's rules comply with and build upon federal administrative simplification regulations adopted under the Health Insurance Portability and Accountability Act (HIPAA). Both HIPAA and the state's requirements are designed to accelerate the use of standard, automated, electronic data interchange (EDI), also known as computer to computer interchange, for the exchange of common health care business data. Further information regarding the rationale for and importance of these rules is summarized in Appendix 1.

KEY ACTIVITIES AND ACCOMPLISHMENTS IN 2011

In 2011 CHCPI advanced health care administrative simplification in the four key areas below, as described in more detail in the following sections:

- Implementing state and federal regulations;
- Technical assistance;
- Contributions to national administrative simplification; and
- Legislatively required studies.

Implementing state and federal regulations

CHCPI's focus for 2011 and its corresponding collaborations with the Minnesota AUC were largely directed by state and federal regulations, including: federal adoption of new versions of national EDI standards; administrative simplification provisions of the ACA; and additional follow up and implementation of 2010 amendments to Minnesota Statutes, section 62J.536. Each of these efforts is briefly summarized below.

Compliance with new versions of federally adopted EDI standards

In 2009, the federal Centers for Medicare & Medicaid Services (CMS) adopted new, improved versions of the standards named by HIPAA for the electronic exchange of common health care administrative data. The new versions, known as "5010" and "D.0," were required for use no later than January 1, 2012.

CHCPI collaborated extensively with the AUC in 2009 and 2010 to develop and refine Minnesota's rules to be compliant with the federal regulations for versions 5010 and D.0. This

task was completed during 2011 with additional state rulemaking and updates after CMS adopted further clarifications and corrections of the 5010 standard.

Administrative simplification required under the ACA

Section 1104 of the ACA enacted some of the most sweeping federal health care administrative simplification in a decade. It requires the Secretary of the U.S. Department of Health and Human Services (HHS) to adopt and implement over a five year period:

- Nine sets of "operating rules" and three related transactions standards. The rules and standards are intended to complement HIPAA transactions and code sets regulations with additional specificity, and to reduce administrative costs by promoting greater standardization and automation of common business communications;
- New HIPAA transactions standards; and
- Related compliance certification and enforcement.

During 2011 CHCPI outlined key provisions of Section 1104 with the AUC, began planning for next steps to ensure compliance with the Section, and assisted the AUC in responding to requests for comments and input regarding the federal requirements. A summary of Section 1104 and its relationship with Minnesota's health care administrative simplification initiative is included in Appendix 2.

Follow-up to amendments to Minnesota Statutes, section 62J.536 adopted in 2010

In 2009, CHCPI assisted in the development of an MDH legislative proposal to address concerns raised about the role of health care clearinghouses in the communication of health care administrative transactions. Clearinghouses serve as intermediaries between providers and payers to facilitate exchanges of data from one point to another. MDH's proposal expanded provisions of Minnesota Statute, section 62J.536, to include these intermediaries, and required that providers, payers, and clearinghouses exchange a version of an electronic receipt ("acknowledgment") when sending or receiving health care claims or remittances.

The proposal, the first of its kind in the nation, was enacted into law in April 2010, and required that MDH adopt rules for the automated exchange of electronic acknowledgments by the end of the year. CHCPI worked closely with the AUC to quickly and successfully promulgate and adopt the required rules on time. It continued to work with the AUC's Acknowledgement Technical Advisory Group (TAG) in 2011 to develop a detailed best practice with instructions for which types of acknowledgements to exchange under a variety of scenarios. The best practice will be completed and publicized in 2012 to encourage its use.

Technical assistance

Minnesota Statutes, section 62J.536, describes a process by which complaints of noncompliance with the state's administrative simplification rules can be submitted to MDH for investigation and follow-up. While the statute authorizes the collection of civil monetary fines for noncompliance in certain situations, it emphasizes working with affected parties to achieve

voluntary compliance and informal resolution of complaints. In addition, the statute authorizes MDH to provide technical assistance to help implement the rules and to foster compliance.

In 2011, CHCPI responded to over 400 requests from health care providers, payers, and others for information, clarification, or other technical assistance in understanding, implementing, and complying with the state's administrative simplification rules. The requests were often from smaller providers, vendors, and others, and ranged from general questions about Minnesota's rules and rulemaking process, to more detailed, complex medical billing and coding issues. In addition to serving as a resource for individual questions, CHCPI frequently updates and enhances two websites to provide current, detailed information in response to the inquiries and information requests it receives. The websites can be accessed at: www.health.state.mn.us/asa and www.health.state.mn.us/auc, and provide a wide range of information regarding the state's rules, industry best practices, frequently asked questions, and calendar and meeting-related activities of the AUC.

CHCPI also investigated and followed up on a variety of communications it received regarding possible noncompliance with the administrative simplification rules. All were resolved through informal resolution to bring about voluntary compliance pursuant to the stated objectives in state statute.

Contributions to national administrative simplification

The AUC actively contributes to national rules and standards for health care EDI. In 2011, CHCPI continued to facilitate and staff the AUC in an open, public process for commenting and responding to national regulations and administrative simplification standards. The goal of the process was to present Minnesota's perspective and experience, and to contribute to national dialogues and planning for health care administrative simplification. These efforts resulted in several letters and testimony to the federal Centers for Medicare & Medicaid Services (CMS) and the National Committee on Vital and Health Statistics (NCVHS)[1] Subcommittee on Standards, as briefly summarized in Appendix 3. The comments have often resulted in greater awareness of issues, and broader discussion and debate on important direction and precedent for administrative simplification.

Legislatively required studies

CHCPI completed research and discussions on two legislatively required study projects in 2011 as briefly summarized below, and plans to issue the study reports in the second half of 2012. The projects were undertaken during a period of significant change and shifting priorities as a result of national health reform debates and passage of the ACA, state and federal administrative simplification regulations, market changes, and a sustained, significant economic downturn. They frequently overlapped with other competing objectives and priorities, and the study

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[1] The NCVHS is a statutorily chartered advisory committee to the Secretary of the U.S. Department of Health and Human Services (HHS), created to "…assist and advise the Department in the implementation of the Administrative Simplification provisions of [HIPAA] … ." Source: Charter: National Committee on Vital and Health Statistics. Accessed at: http://www.ncvhs.hhs.gov/charter10.pdf.

participants were often also members of the AUC or involved in planning and implementing large scale changes for other national health reforms and administrative simplification efforts.

In some cases, the interplay between the studies and other complementary activities and goals produced rapid, positive results. For example, some preliminary findings and suggestions from the studies were incorporated as part of broader, ongoing AUC-influenced development of best practices and the state's administrative simplification rules that was also occurring at the time.

In other cases, however, the studies spotlighted emerging new challenges, differences of views, and rapidly changing expectations and priorities. Even when consensus on the underlying problem or solution set was not always possible, the studies served to educate stakeholders and broaden awareness of health care administrative simplification efforts, issues, opportunities, and resources.

Study of a "Uniform Claims Review Process"

The first of the two studies that CHCPI led was tasked with exploring a "uniform claims review process." The study requirement was enacted in response to concerns raised by health care providers regarding the costs and burdens associated with processing of health care claims (bills). Its two principal charges, undertaken in two phases of the study project, were to examine: "…the potential for reducing claims adjudication costs of health care providers and health plan companies … ." and the "…potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers… ."

The first phase of the study, which examined the potential for reducing claims adjudication costs, took an expanded view of the problem by reviewing the entire "health care revenue cycle" of administrative steps and transactions prior to, during, and after claims submission and adjudication. The cycle is described in more detail in Appendix 1 and includes steps such as verifying patient insurance eligibility and benefits, obtaining authorizations for services, correct billing and coding, checking claims status, and payment.

This broad view of claims processing is important because incomplete or erroneous data at any point in the process may result in a cascade of interrelated problems at subsequent stages, leading to costly, time-consuming delays and rework to correct. For example, if patient insurance eligibility is not verified, or if the eligibility information is not up to date and complete, it may lead to incorrect billings, improperly adjudicated claims, claims denials, and appeals that take time and effort to address and rectify.

As noted above, the study project and other ongoing health care administrative simplification activities were often interrelated, and exchanged findings and suggestions. For example, many AUC members also participated actively in the study process. During the course of the study the AUC recommended information to be included in the eligibility transaction to ensure that the transaction was accurate, complete, and current. The recommendations were subsequently incorporated as part of the state's rules and compliance with the federal adoption of v5010 EDI standards.

The study process also led to additional findings and suggestions for both short and longer term improvements of revenue cycle transactions. The recommendations ranged from simplifying the submission of "claims attachments" (x-rays, detailed operative reports, and other supplemental information that must often be submitted to as part of the billing process), to assuring more common coding and billing of services, and are presented in more detail in the forthcoming final report.

The second phase of the study explored "the potential impact of establishing uniform prices" based on a concept developed as part of a 2008 state health reform task force report, in which:

> "…all providers should establish and make publicly available a single price for each service billed on a fee for service basis or offered under a 'basket of care'…. That price would be offered to consumers and would be accepted as payment in full by the provider from all private payers (and by public programs such as Medicare and Medicaid to the extent possible) for the service provided. Providers will no longer negotiate prices with numerous third party payers, and payment rates for a service to a particular provider will no longer vary based on the type of insurance a person has."[viii]

As noted in the task force report, the concept was "intended to promote greater competition by providers, as well as reduce health plan and provider administrative costs."

This phase of the study in particular identified a number of differing perspectives and open issues regarding the uniform pricing concept. It was noted for example that a number of complex, unresolved operational questions need to be addressed to implement and administer the concept in practice, including: appropriately defining services or bundles of services to be priced; coordinating uniform pricing across commercial, state, and federal health care programs now working under differing mandates and legal frameworks; and, to bring about the fullest level of informed consumerism, ensuring that consumers have adequate data on health care outcomes and quality as well as costs.

In addition, several key analytic questions about the potential costs and impacts of adopting and implementing the uniform pricing concept were identified but were beyond the scope and resources of the study. For example, the description of the uniform pricing concept states that the current practice of volume discounts ("prices negotiated individually by providers with separate payers") would be "replaced." It remained uncertain however, what the impacts of the loss of discounting would be, and whether theoretical improvements in price transparency and price competition as result of uniform pricing would more than offset the costs of instituting the uniform pricing concept and the loss of current discounts.

As noted above, during the extended study period the underlying health care administrative simplification and health reform environment was rapidly changing. Perhaps the most significant environmental change with a direct bearing on the underlying study concerns was the transition to new "total cost of care (TCOC)" health care delivery and financing arrangements. Under these arrangements, providers agreed to deliver a comprehensive set of patient care services and to be accountable for the total cost of care of the services in exchange for a single payment agreed to in advance. In many instances, providers were also accountable for quality

outcomes, and shared in any overall savings or additional costs if the total cost of care differed from their agreed upon payments.

The TCOC concept was also fostered during the study timeframe by ACA provisions that created incentives for organizations to act as "Accountable Care Organizations (ACOs)", accountable for the total costs of patient care under the federal Medicare program.[ix] In addition, legislation was enacted in Minnesota in 2010 that created similar TCOC/ACO-like opportunities for enrollees of the state's Medical Assistance (Medicaid) and other publicly financed programs, through the state Department of Human Services (DHS) "Health Care Delivery System (HCDS) Demonstration Project"[x] and other related initiatives.

Participants in the study noted that the TCOC models have dramatically altered the health care delivery and financing landscape since the study requirement was enacted, especially in changing the relevant unit of analysis from comparisons of per-unit prices (the focus of the second part of the study) to comparisons of aggregate, total costs of care. As a result, the study report will recommend that further exploration of health care unit pricing should also consider the TCOC/ACO concept and its potential contributions to broader health care reform goals of administrative cost reductions, cost and quality transparency, and promoting optimal quality patient care.

Study of "technology standards and tools" to meet rapidly changing business needs

In 2011, CHCPI also completed data collection and analysis as part of a required study of technologies to meet business needs in a rapidly shifting health care delivery and financing environment. In particular, the study was enacted largely in response to provider concerns for adequate business tools to manage new billing responsibilities for increasing numbers of self-pay, uninsured patients and patients with high deductible health plans.

In the study, CHCPI conducted an environmental assessment regarding possible "technology standards and tools" to meet providers' business challenges. CHCPI found that an EDI system to help address concerns raised by providers largely already exists as a result of state and federal administrative simplification regulations.[xi] However, the study found that some providers were not fully aware of or using the system's current capabilities, and that some were also not fully aware of or planning to use enhancements and expansions of the system resulting from the 5010/D.0 mandates or provisions of the ACA.

In addition, the project also found that the industry is devoting the majority of its available health information technology (HIT) resources to comply with requirements to implement 5010/D.0 and a mandated new diagnosis coding system known as ICD-10. These transitions have been likened to the planning and computer upgrades necessitated by "Y2K" in the late 1990s,[xii] often leaving little, if any, reserve capacity for other technology-specific pursuits during the foreseeable future.[2] As a result, the study's draft recommendations include achieving greater

[2] The American Recovery and Reinvestment Act (ARRA) enacted in 2009, includes the Health Information Technology for Economic and Clinical Health (HITECH) Act with incentives for providers to implement and demonstrate "meaningful use" of electronic health records (EHRs) from 2011 to 2015. In addition, Minnesota enacted requirements in 2008 for the deployment and use of EHRs by 2015. Efforts to improve the exchange and

familiarity with and use of the existing EDI system for administrative transactions, while continuing to make the successful transitions to 5010/D.0 and ICD-10 a high priority.

CONCLUSION AND LOOKING AHEAD

Impacts and results

During 2011, CHCPI led a first-in-the-nation rulemaking initiative for reducing costs and burdens associated with the exchange of health care business transactions throughout Minnesota's health care system. It provided significant staffing and other support to a large, voluntary, multi-stakeholder advisory group, the Minnesota AUC, resulting in the promulgation or adoption of 10 sets of rules for greater uniformity and automation of administrative transactions, as well as recommendations to NCVHS, CMS, and other national standards setting organizations regarding administrative simplification rules and standards.

As a result of these activities, and as also presented and documented in previous annual reports:

- Minnesota continues to demonstrate progress toward automating and streamlining common health care business transactions, and to reducing health care administrative costs system-wide by $40 million - $60 million;
- The state is garnering national recognition for its efforts through participation in and communications with relevant national groups and other states; and,
- Minnesota is well-positioned to constructively contribute to and benefit from federal administrative simplification as part of federal health reform and other federal regulations.

Looking ahead – 2012

During 2012, CHCPI will continue to work closely with the AUC to advance Minnesota's standardization and automation of health care administrative transactions. In particular, it plans to assist the AUC in reviewing and addressing federal operating rules as they are proposed and adopted, and in making any corresponding modifications or updates to the state's rules and administration of the rules. As part of this process, CHCPI is planning the first of an anticipated series of annual comprehensive reviews and updates of all the state's health care administrative simplification rules. The annual reviews are designed to ensure that the rules remain current to best reflect industry needs and changes, reflect new and emerging federal regulations, and incorporate lessons learned over time. In addition, CHCPI will also serve as a liaison and resource for additional administrative simplification at the national level, and as a potential resource for other Minnesota health care reforms.

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use of patient clinical data in response to these measures will likely have to compete for similar health information technology (HIT) resources and expertise needed for administrative simplification, exacerbating the challenges of complying with 5010/D.0 and ICD-10. In response to national concerns regarding the significant demands of current federal health care EDI mandates and incentives, CMS announced delays totaling six months in its enforcement of 5010/D.0 requirements, and in 2012 proposed a one-year delay in the implementation of ICD-10.

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APPENDIX 1: MINNESOTA'S HEALTH CARE ADMINISTRATIVE SIMPLIFICATION INITIATIVE

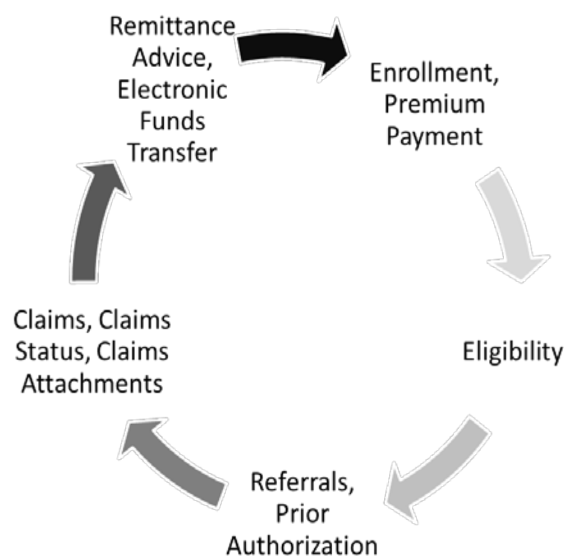
As described below, the Minnesota Department of Health's Center for Health Care Purchasing Improvement (CHCPI) serves as project manager in implementing requirements that health care administrative transactions be exchanged electronically, using a standard data content and format. The initiative is projected to reduce overall administrative costs in Minnesota's health care system by an estimated $40 million to $60 million.[xiii] In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to meeting other goals for the accurate, efficient flow of data for health care performance measurement and improved patient care.

Background

A complex business model with large volumes of routine administrative transactions

American health care is a transaction intensive enterprise that is sometimes represented by a revenue cycle similar to the one illustrated below. The illustration summarizes in a simplified diagram several, but not all, of the key steps and transactions in the health care billing and payment process. The process starts below with enrollment in an insurance plan, and continues through successive steps of: determining patient eligibility for health insurance coverage and benefits prior to or at the point of health care services; obtaining any necessary prior authorizations and referrals necessary for patient care; submission of claims (billings) to insurers for care and services provided, as well as inquiries regarding the status of claims; through to payment and delivery of the corresponding remittance advice to the provider.

Illustrative health care billing and revenue/payment cycle



The volume of transactions exchanged throughout the revenue cycle is staggering. Nationally, health care payers process more than five billion medical claims (billings) annually.[xiv] In Minnesota alone, the state's health plans processed more than 59 million health care claims in 2010.[xv] Moreover, providers, payers, and venders exchange millions of other business communications, including eligibility inquiries and responses, authorizations, payments, and acknowledgments.

Unnecessary costs and burdens

Despite the large volume of these common administrative transactions, the health industry care has often lagged far behind the financial, transportation, and other sectors of the economy in its use of standard, automated electronic data interchange (EDI) to conduct routine business.[xvi] The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient. Because of the high volume of these transactions, even small inefficiencies add up significantly and quickly as unnecessary costs and burdens across the health care system.

For example, a national actuarial firm found that it cost health care providers on average $3.73 more per claim to submit their bills on paper than to submit them electronically.[xvii] The same actuarial firm found that insurers and other payers likewise pay more—in this case, an average of sixty cents more to receive a paper claim than when the same claim is sent electronically.[xviii] Moreover, when paper and nonstandard data exchanges are incomplete, inaccurate, or less timely, costs and delays are often compounded. A 2006 report estimated the costs for just follow-up telephone calls between Minnesota health care providers and payers to resolve questions related to patient eligibility for insurance coverage, benefits, and health care claims at between $15.5 and $21.8 million annually.[xix] Not only are unnecessary transaction costs not adding value, but they also displace valuable resources better used for patient care and improved health care outcomes.

Federal HIPAA administrative simplification

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and related rules are intended in part to address the problems above by accelerating health care's adoption of more efficient EDI for business purposes. For example, HIPAA required that health care payers accept certain electronic transactions from providers, and that the transactions adhere to standards and code sets developed by several specified national organizations. In addition, the federal Administrative Simplification Compliance Act (ASCA) requires most health care providers to submit their initial bills to Medicare electronically.

These regulations provided an important framework for quicker, less burdensome, more accurate communications of large amounts of industry business data. However, the HIPAA regulations were often not as specific and detailed as needed, resulting in variability and ambiguity in how data were to be exchanged. In response, and to the extent allowed by law, health care payers often published their own additional data exchange specifications, known as "companion guides." These guides are used in conjunction with national data rules and standards, and together provide the detailed instructions needed to electronically exchange data. While the proliferation of many individual, idiosyncratic companion guides was permitted under HIPAA, it

eroded the regulations' effectiveness as a single, common standard for effectively and efficiently automating data flows.

Minnesota's Three-Pronged Approach to Health Care Administrative Simplification

Minnesota Statutes, section 62J.536, was enacted in 2007 to address the problem of "nonstandard standards" created by the proliferation of individual companion guides, as well as other barriers to administrative simplification. The statute effectively addresses three root causes of unnecessary health care administrative costs and burdens as described below.

1. Problem: Many health care business transactions are still exchanged on paper

   Many health care transactions are still exchanged on paper, which national studies have shown to be about twice as expensive to process as electronic transactions.

   Solution: Minnesota requires that four high volume health care business transactions be exchanged electronically via a single, standard form of HIPAA-compatible EDI including:

   - Eligibility verification – submitted by a provider to a payer to confirm a patient's medical insurance coverage and benefits to facilitate proper billing;
   - Claims – bills submitted by providers for payment for care and services;
   - Payment remittance advices – submitted by payers to providers to explain any adjustments to bills and corresponding payments; and,
   - Acknowledgments – receipts indicating that one party has received an exchange submitted by another party.

2. Problem: A proliferation of "companion guides" to federal HIPAA transaction standards has resulted in variable, non-standard, more costly transactions

   HIPAA standards for the electronic exchange of health care business transactions are often not sufficiently detailed to be used independently of other instructions or specifications known as "companion guides." Many payers have issued their own companion guides with requirements for data exchange that supplement the HIPAA standards. Requiring many different ways of sending the same business transaction (e.g., billings or "claims") to different recipients (payers) creates unnecessary administrative burdens and costs.

   Solution: Minnesota required the adoption into rule of a single uniform companion guide for each of the transactions to be exchanged electronically. The guides comply with HIPAA and provide additional data content specificity where needed. They must be used by health care providers providing services for a fee in Minnesota, by all payers licensed or doing business in the state, and by clearinghouses when exchanging acknowledgments for claims and remittance transactions and in order to ensure compliant transactions on the part of their customers.

3. Problem: HIPAA data exchange requirements do not apply to many payers

HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. Consequently, many transactions with these payers are often now conducted on paper or using nonstandard exchanges that are less efficient and more costly.

Solution: Minnesota's requirements for the standard, electronic exchange of claims and payment remittances apply to non-HIPAA covered payers.

In mid-2007 CHCPI was selected to manage an extensive, multi-year rulemaking process for the development and implementation of single, uniform companion guides required under MS § 62J.536. CHCPI is also responsible for administration and enforcement of the law and subsequent changes or refinements of the rules. Pursuant to statute, CHCPI partners closely in the development of the regulations with a large, voluntary stakeholder organization known as the Minnesota Administrative Uniformity Committee (AUC), which has provided in-kind contributions of thousands of hours of expertise by many different subject matter experts.

More recent federal and state health care administrative simplification initiatives

Minnesota's rulemaking has been undertaken against a backdrop of the most sweeping national health care administrative simplification in over a decade. In 2009 the federal Department of Health and Human Services (HHS) adopted rules requiring new versions of the transaction standards adopted under HIPAA. In addition, section 1104 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary of HHS to adopt a series of rules and standards over a five year period to further standardize and automate a number of high volume health care business transactions.

CHCPI continues to work closely with the AUC and stakeholders to implement and administer Minnesota's health care administrative requirements in tandem with the federal regulations. It collaborates in particular with the AUC at this time to: help facilitate single, state-wide responses to proposed federal requirements; update and harmonize Minnesota rules with federal regulations; and to share the state's lessons learned and experience in administrative simplification as part of other national standards setting activities.

APPENDIX 2: SECTION 1104 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) AND RELATED HEALTH REFORMS

Minnesota Statutes, section 62J.536 requires the standard, electronic exchange of several high volume, common health care business transactions to reduce health care administrative costs and to improve the accuracy and timeliness of business data. The statute builds upon and also requires compliance with federal health care administrative simplification regulations.

As the federal regulations are adopted or modified, Minnesota's requirements must be reviewed and updated as necessary. At the same time, it is important to work with the Minnesota industry to create broader awareness and understanding of the changes, and to communicate lessons and Minnesota perspectives as part of national level policy making.

This state-federal relationship has become more visible and important recently with the 2010 enactment of section 1104 of the ACA. The law requires the Secretary of the U.S. Department of Health and Human Services (HHS) to develop and implement a variety of "operating rules" and data exchange standards over five years to simplify and automate a number of frequently exchanged health care business transactions. Operating rules are intended to supplement transactions standards and specifications adopted under federal Health Insurance Portability and Accountability Act (HIPAA) regulations, and are defined as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."[xx]

The tables and chart below show the timelines for completing the ACA rules and other related ACA milestones. In addition, they also summarize other important state and federal health care electronic data interchange (EDI) initiatives, including efforts to accelerate the flow of standard, electronic patient clinical data through adoption of incentives for "meaningful use" of Electronic Health Records (EHRs). These incentives were part of federal legislation and rules enacted in 2009-2010 under the Health Information Technology for Economic and Clinical Health (HITECH) Act, and part of the broader American Recovery and Reinvestment Act (ARRA). Efforts to benefit from these incentives and to improve the exchange and use of patient clinical data will likely have to compete for similar, limited health information technology (HIT) resources and expertise that will be needed to meet the state's administrative simplification goals and requirements. CHCPI is monitoring and coordinating with the state's patient clinical data exchange activity as part of its planning and oversight for administrative simplification. A summary chart below includes the ACA and HITECH milestones, as well also additional Minnesota-specific requirements for implementation of e-prescribing and interoperable EHRs to be considered as part of overall planning and work plan development.

CHCPI anticipates maintaining much of its current focus on administrative simplification in 2012 and playing an important role in collaboration with the Minnesota Administrative Uniformity Committee (AUC) in aiding Minnesota's responses to, implementation of, and compliance with the ACA. This harmonization with the ACA and other federal regulations will take two forms:

- a direct approach, in which the primary goal is to integrate applicable Minnesota rules and the ACA regulations, as well as to provide any broad-based review and comments or recommendations regarding the federal regulations; and
- an indirect approach, which includes reviewing and communicating additional administrative simplification provisions of the ACA so as to most effectively comment or offer recommendations on them, as well as to benefit as much as possible from greater administrative simplification as the provisions are implemented.

Table 1 below lists common health care business transactions that will become more uniform and more efficient under the ACA's operating rule requirements. It also lists the dates by which certain federal rulemaking milestones must be reached, including dates by which health plans must ertify that they are compliant with the operating rules. The asterisked items indicate transactions for which Minnesota also has established standard data content rules pursuant to MS § 62J.536, to be reviewed and harmonized in the context of the ACA requirements.

Table 1. Operating rule adoption and compliance dates for covered transactions

<table>
<tr><th rowspan="2">Transaction
(An asterisk indicates that Minnesota requirements also apply)</th><th colspan="2">Federal Operating Rules</th></tr>
<tr><th>Rule Adoption Date</th><th>Certification Date
(Health Plans must be certified as in compliance)</th></tr>
<tr><td>Eligibility*
Description: Transmits inquiries and responses regarding the applicable insurance coverage and benefits of a benefit plan enrollee to aid correct billing.</td><td rowspan="2">July 1, 2011</td><td rowspan="4">December 31, 2013</td></tr>
<tr><td>Claim status
Description: Transmits inquires and response regarding the status of a health care claim (billing)</td></tr>
<tr><td>Electronic funds transfer
Description: Transmits the electronic exchange of funds to pay medical claims</td><td rowspan="2">July 1, 2012</td></tr>
<tr><td>Payment/advice*
Description: Transmits payment and payment processing information and explanations of amounts paid</td></tr>
<tr><td>Claims attachments
Description: Transmits supplemental health information needed to support a specific health care claim</td><td>January 1, 2014</td><td>TBD</td></tr>
<tr><td>Claims*</td><td></td><td>December 31, 2015</td></tr>
</table>

Transaction (An asterisk indicates that Minnesota requirements also apply)	Federal Operating Rules	
	Rule Adoption Date	Certification Date (Health Plans must be certified as in compliance)
Description: Transmits a request to obtain payment, or transmission of encounter information for the purpose of reporting health care.	July 1, 2014	
Enrollment/disenrollment in a health plan *Description*: Transmits subscriber enrollment information to a health plan to establish or terminate insurance coverage		
Health plan premium payments *Description*: Transmits health insurance premium payment and payment information		
Referral certification/authorization *Description*: Transmits requests for an authorization and/or referral for health care		

Source: Publ. L. No. 111-148.

Table 2 summarizes implementation deadlines for new HIPAA transaction standards. At this time both HIPAA standards and complementary operating rules are needed to achieve the greatest standardization and automation of health care business activity. The standards and operating rules had not been adopted for the following three transactions at the time of this publication: electronic funds transfer (EFT); claims attachments; and health plan identifier. For this reason, these three transactions appear in both Tables 1 and 2.

Table 2. Summary timelines for new HIPAA standards under the ACA

Transaction	Rule Adoption Date	Certification Date
Electronic funds transfer Transmits the electronic exchange of funds to pay medical claims	January 1, 2012	December 31, 2013
Claims Attachments Transmits supplemental health information needed to support a specific health care claim	January 1, 2014	December 31, 2015
Health plan identifier Transmits an identification number to identify a health plan	(Proposed April 17, 2012, adoption pending)	A compliance date of October 1, 2014 has been proposed. (For small health plans, the proposed compliance date is October 1, 2015).

Source: Publ. L. No. 111-148.

Table 3 shows additional important health information technology (HIT) deadlines in federal and Minnesota regulations, including deadlines for: adoption of new versions of existing HIPAA transactions standards ("5010"); adoption of a new disease classification system ("ICD-10"); and incentives to bring about "meaningful use" of electronic health records (EHRs) for the exchange of patient clinical data. CHCPI does not have a direct role in clinical data exchange at this time, but the clinical data exchange requirements will likely compete for many of the same HIT resources as administrative data exchange, and should be considered for planning purposes. In addition, it is anticipated that clinical and administrative data exchange activities may often converge in the future.

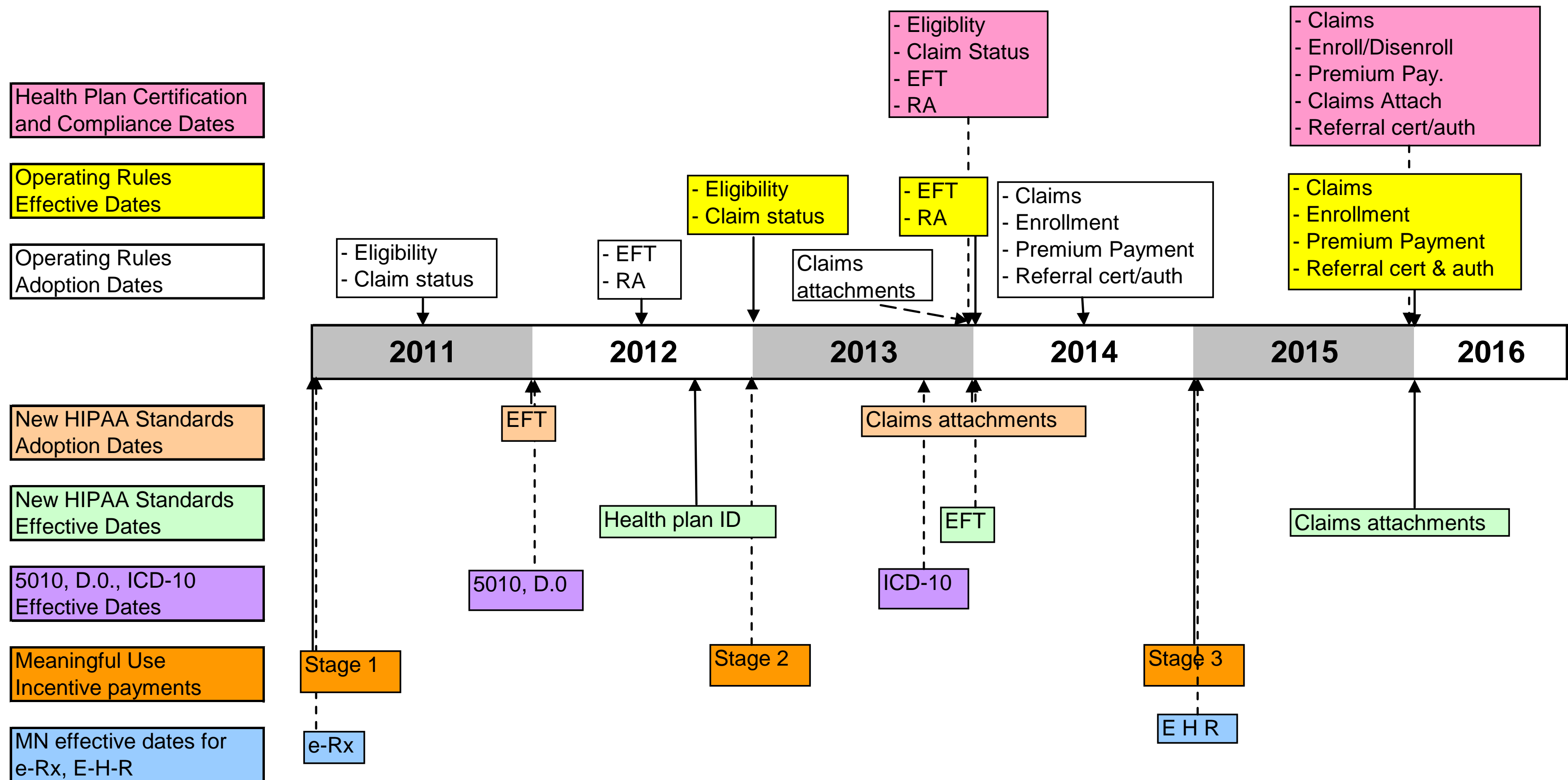
Table 3. Summary of selected additional federal and state HIT regulation deadlines

Category/transaction	Effective dates
Version 5010 of current HIPAA transaction and code set rules	January 1, 2012
ICD-10 (International Classification of Diseases, 10th revision)	October 1, 2013[3]
Incentives for Meaningful Use of Electronic Health Records (Incentives are planned in three stages as shown in the column to the right)	Stage 1: 2011 Stage 2: 2013 Stage 3: 2014
Minnesota requirements:	
Electronic prescribing (e-perscribing)	January 1, 2011
Adoption of interoperable EHRs	January 1, 2015

Chart 1 below shows the timelines for Tables 1-3 in a single illustration**.**

[3] Note: In 2012, HHS proposed delaying the required ICD-10 implementation date by one year, to October 1, 2014.

Chart 1. Patient Protection and Affordable Care Act (PPACA) Section 1104 Administrative Simplification and other selected federal/state health care data exchange initiatives[xxi]



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APPENDIX 3: CONTRIBUTIONS TO FEDERAL RULES AND NATIONAL STANDARDS SETTING ACTIVITIES

The Minnesota AUC contributes to national rules and standards for health care EDI. In 2011, CHCPI facilitated and staffed the AUC in an open, public process for commenting and responding to national rules and administrative simplification standards. The goal of the process was to present Minnesota's perspective and experience, and to contribute to national dialogues and planning for health care administrative simplification. These efforts resulted in several letters and testimony to the federal Centers for Medicare & Medicaid Services (CMS) and the National Committee on Vital and Health Statistics (NCVHS)[4] Subcommittee on Standards, as briefly summarized in the table below.   The comments have often resulted in greater awareness of issues, and broader discussion and debate on important direction and precedent for administrative simplification.

Topic	Summary of AUC response/comment
Development and maintenance of EDI standards and Operating Rules *AUC letter to NCVHS, March 23, 2011*	The AUC communicated concerns to CMS and NCVHS that: • many independent parties play a variety of roles in the maintenance and modifications of health care administrative simplification standards and operating rules; • it is often difficult for some stakeholders and end-users to participate in the maintenance/modification process; and, • the process is not as efficient or timely as it could and should be. The AUC recommended that a single, overarching umbrella organization manage standards and operating rule maintenance and modifications. The umbrella entity could serve as both the coordinator of changes, as well as a communicator/facilitator for their implementation by the industry. The concept was suggested to facilitate greater coordination of the process, to reduce the time spent by industry requestors of changes and maintenance, and to reduce overall administrative costs.

[4] The NCVHS is a statutorily chartered advisory committee to the Secretary of the U.S. Department of Health and Human Services (HHS), created to "…assist and advise the Department in the implementation of the Administrative Simplification provisions of [HIPAA] … ." Source: Charter: National Committee on Vital and Health Statistics. Accessed at: http://www.ncvhs.hhs.gov/charter10.pdf.

Topic	Summary of AUC response/comment
The need for acknowledgements (receipts) of health care business transactions *Statement by AUC provided as testimony to NCVHS, April 27, 2011*	The AUC provided testimony to NCVHS on the importance of exchanging the acknowledgement transaction, which permits submitters of a transaction to know whether it reached its intended destination and other information about any possible errors in the transaction. The AUC also submitted provider, payer and general industry perspectives and experience with acknowledgements, as well as Minnesota's experience in implementing requirements for acknowledgements at the state level. It further recommended that the industry pilot acknowledgement transactions before CMS requires them under a HIPAA mandate, and that two strong candidates for the pilot are Medicare and Minnesota.
Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions *AUC letter to HHS, September 6, 2011*	In September 2011, the AUC submitted comments to HHS regarding a federal interim final rule, "Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC)". In its comments, the AUC: • Offered its support for the Eligibility for a Health Plan operating rules and provided recommendations to take fullest advantage of the transaction's capabilities; • Communicated several concerns and recommendations regarding maintenance and modifications to transaction standards and operating rules; and, • Supported the adoption of acknowledgment transactions requirements.
Topics addressed as part of NCVHS hearing November 2011 *AUC letter to NCVHS, November 15, 2011* Enrollment of health care providers by health plans	Health plans obtain information from providers needed to establish EDI exchanges, for payment, and for other purposes through a provider enrollment process. NCVHS sought comments about the concept of national provider enrollment standards for a more uniform, efficient provider enrollment process. The AUC responded that significant discussion and agreement is needed regarding the provider enrollment data that should be collected and verified by health plans, and how it will be used, before the technical specifications can be refined for an overarching national enrollment system that best meets the need.

Topic	Summary of AUC response/comment
Standardized claim coding (claims edits**)**	Claims edits are edits (screens) used by payers to identify duplicate or incorrect combinations of medical procedure codes on provider billings; the edits may reflect specific payment policies. The AUC reported to NCVHS that the term "claims edit" is not well defined. It recommended focusing instead on an alternative concept of "standardized medical claim coding", with agreed-upon "upfront" medical coding conventions that are applied to a claim before it is submitted, rather than attempting to standardize payers' edits applied to claims after they are submitted. The AUC indicated that the standardized claim coding model was more feasible and practical at this time than standardizing other claims edits that reflect payment issues and payment policies.
Claims attachments	Claims attachments are additional documentation provided in conjunction with a claim to substantiate or clarify services, products, and care that is being billed. Payers may require notes, records, x-rays, and similar documentation in order to adjudicate and pay claims. The AUC expressed its support for a type of claims attachment furnished by the provider in advance of any specific request from the payer, known as "unsolicited claims attachment". The AUC further identified concerns if unsolicited attachments are not allowed, in which case providers must: submit claims without the attachments; have the claim rejected due to lack of information (information that is subsequently requested by a payer via an attachment); and then must resend the claims with the necessary solicited attachment, which is often an iterative process with several submissions of different attachments that were requested. This is not only administratively burdensome and expensive, but often creates undue financial hardship for patients who have to pay their share of the bill until insurance coverage issues are resolved.

Topic	Summary of AUC response/comment
Applicability of standards to insurers currently not mandated to use EDI under HIPAA	At present, certain types of insurers -- workers compensation, property-casualty, and auto insurers – are exempt from requirements from federal HIPAA administrative simplification. Minnesota Statutes, section 62J.536 requires that all health care providers, group purchasers (payers), and clearinghouses exchange certain administrative transactions electronically, according to a single, uniform companion guide. The requirement applies to non-HIPAA covered entities, including workers compensation, property-casualty, and auto insurers unless certain statutory exception criteria are met.[xxii] The AUC noted that "A goal of health care administrative simplification and standardization is that common standards and rules should apply as broadly as possible to minimize the potential for "one-off" customization of administrative transactions with particular subsets of the industry. This goal cannot be met if the common standards and rules do not apply to an important sector of the industry such as workers compensation, auto, and property-casualty insurers."
The need for a single overarching umbrella organization to manage standards and operating rule maintenance/ modification	The AUC reiterated previous comments regarding the need for greater openness, inclusivity, transparency, and coordination of national standards setting and advisory groups in the development and maintenance of transaction standards and operating rules. It also emphasized the importance of a single a single, overarching umbrella organization to manage EDI standards and operating rule maintenance/modifications nationally.

In addition to its facilitation role with the AUC on the responses above, CHCPI serves as a representative on special 13-member transition committee to the national Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH-CORE). CORE is a the national organization responsible for recommending federal operating rules; the transition committee is recommending governance and financing models consistent with CORE's responsibilities, and to ensure that CORE activities and processes are appropriately representative and inclusive.[5]

CHCPI is also a member of and participant in several other national health care administrative transaction standards setting and/or advisory groups including: American Standards Committee X12 (ASC X12); National Council for Prescription Drug Programs (NCPDP); and the Workgroup for Electronic Data Interchange (WEDI). CHCPI participates with these and other groups to advance health care administrative simplification in the context of Minnesota's related regulations and initiatives

[5] Additional information regarding the CORE transition committee can be accessed at: http://www.caqh.org/CORE_Transition_Committee.php.

ENDNOTES

[i] Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI). (February 2011). *Preliminary unpublished estimate of potential Minnesota health care administrative cost reductions with implementation of requirements for the standard, electronic exchange of health care administrative transactions.*

Note: The unpublished estimate above was developed by reviewing preliminary data and assumptions for Minnesota's rates of standard, electronic health care transactions. Potential cost savings were then estimated based on the findings and projections of other state and national studies of the potential savings as a result of greater use of standard, electronic health care business transactions. Source data included:

Milliman Technology and Operations Solutions. (2006). *Electronic Transaction Savings Opportunities for Physician Practices.* Retrieved from website: http://www.emdeon.com/resourcepdfs/MillimanEDIBenefits.pdf.

American Medical Association Practice Management Center. (June 22, 2009). *Standardization of the Claims Process: Administrative Simplification White Paper.* Retrieved from website: http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-wp.pdf

American Medical Association Practice Management Center. (2008). Follow That Claim: Claim Submission, Processing, Adjudication, and Payment. Retrieved from website: http://www.ama-assn.org/ama1/pub/upload/mm/368/follow-that-claim.pdf

Office for Oregon Health Policy and Research. (June 2010). *Oregon Administrative Simplification Strategy and Recommendations: Final Report of the Administrative Simplification Work Group.* Page 17. Retrieved from website: http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/AdminSimplification/Docs/FinalReport_AdminSimp_6.3.10.pdf?ga=t

[ii] Minnesota Department of Health. Health Economics Program. (June 2012). *Minnesota Health Care Spending and Projections, 20010.* Retrieved from website: http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2012.pdf .

[iii] Federal Reserve Bank of St. Louis. Economic Research. (2012). *Total Gross Domestic Product by State for Minnesota (MNRGSP).* Retrieved from website: http://research.stlouisfed.org/fred2/graph/?id=MNNGSP (download data in graph, Minnesota 2009 total GDP = $258,499 million).

[iv] Sources:

United States Department of Agriculture. Economic Research Service. *Data Sets, State Fact Sheets: Minnesota (2012). Farm Financial Indicators: Farm Income and Value Added Data. Final Minnesota agricultural sector output for 2009 equaled $15.7 billion.* Retrieved from website: http://www.ers.usda.gov/StateFacts/MN.htm

State of Minnesota. Explore Minnesota. (2011). *Tourism and Minnesota's Economic Recovery.* Retrieved from website: http://industry.exploreminnesota.com/wp-content/uploads/2011/01/Tourism_and_Economy_2011_edition_2-7-11.pdf .
("Travel/tourism in Minnesota generates $11.0 billion in leisure and hospitality gross sales" and "Tourism is comparable to agriculture in its contributions to the gross state product.")

[v] Minnesota Department of Human Services (DHS) and Minnesota Department of Management and Budget (MMB). 2011. *Personal communications.*

DHS reported projected FY2012 average enrollment in Medical Assistance Basic Care and MinnesotaCare at 864,000, with total payments of $5.4 billion. MMB reported calendar 2011 enrollment of 121,000 and over $.58 billion annual costs for the health insurance component of the State Employee Group Insurance Program (SEGIP).

[vi] See for example several reports and studies including:

Institute of Medicine. Committee on Health Care in America. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Retrieved from website: http://www.nap.edu/openbook.php?isbn=0309072808.

Minnesota Citizens Forum on Health Care Costs. (2004). *Report of the Minnesota Citizens Forum on Health Care Costs*. Retrieved from website: http://www.minnesotahealthinfo.org/other/citizensforum.pdf.

Health Care Transformation Task Force. (2008). *Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature*. Retrieved from website: http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf.

National Research Council. (2010). *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. Retrieved from website: http://www.nap.edu/catalog.php?record_id=12750#toc.

National Research Council. (2011). *Informing the Future: Critical Issues in Health, Sixth Edition*. Retrieved from website: http://www.nap.edu/catalog.php?record_id=13180#description.

Squires DA. *The U.S. health system in perspective: a comparison of twelve industrialized nations*. Issue Brief (Commonw Fund). (2011). Jul;16:1-14. Retrieved from website: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Jul/1532_Squires_US_hlt_sys_comparison_12_nations_intl_brief_v2.pdf.

David C. Radley, Ph.D., M.P.H., Sabrina K. H. How, M.P.A., Ashley-Kay Fryer, Douglas McCarthy, M.B.A., and Cathy Schoen, M.S. *Results from a Scorecard on Local Health System Performance, 2012. Prepared for the Commonwealth Fund Commission on a High Performance Health System.* (March 14, 2012). Retrieved from website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Mar/Local%20Scorecard/1578_Commission_rising_to_challenge_local_scorecard_2012_FINALv2.pdf.

[vii] For example, see several studies and reports, including:

U.S. Healthcare Efficiency Index: National Progress Report on Healthcare Efficiency 2010. Retrieved from website: http://www.ushealthcareindex.org/.

American Medical Association Practice Management Center (PMC). (December 23, 2008). *Administrative Simplification White Paper*. Retrieved from website at: http://www.ama-assn.org/resources/doc/psa/admin-simp-whitepaper.pdf.

Oregon Health Authority, Office for Oregon Health Policy and Research. (2010). *Oregon Administrative Simplification Strategy and Recommendations: Final Report of the Administrative Simplification Work Group. June 2010*. Retrieved from website at: http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/AdminSimplification/Docs/FinalReport_AdminSimp_6.3.10.pdf.

Milliman Technology and Operations Solutions. (2006). *Electronic Transaction Savings Opportunities for Physician Practices*. Retrieved from website: http://www.emdeon.com/resourcepdfs/MillimanEDIBenefits.pdf.

National Research Council. (2010). *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. Retrieved from website: http://www.nap.edu/catalog.php?record_id=12750#toc. (See especially chapter four, "Excess Administrative Costs").

[viii] Health Care Transformation Task Force. January 2008. *Recommendations Submitted To: Governor Tim Pawlenty and the Minnesota State Legislature*. Retrieved from website: http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf.

[ix] According to CMS, ACOs *"are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program." (Source:* Centers for Medicare and Medicaid Services (CMS). *Accountable Care Organizations (ACO): Overview.* Retrieved from website: https://www.cms.gov/ACO/.)

CMS announced on December 19, 2011, that 32 organizations nationally had been selected to participate in a particular ACO model known as "Pioneer", including the following three Minnesota health care delivery systems: Allina Hospitals and Clinics; Fairview Health Systems; and Park Nicollet Health Services. (Source: Centers for Medicare and Medicaid Services (CMS). (December 19, 2011). *Pioneer Accountable Care Organization Model: General Fact Sheet*. Retrieved from website: http://innovations.cms.gov/documents/pdf/PioneerACO-General_Fact_Sheet_2_Compliant_2.pdf.)

[x] State of Minnesota. Office of the Revisor of Statutes. (2011). *Minnesota Statutes, section 256B.0755*. Retrieved from website: https://www.revisor.mn.gov/statutes/?id=256B.0755.

[xi] The concept of a "single system of EDI" is noted in a variety of applicable federal regulations. These regulations often use similar language to note that "*Congress addressed the need for a consistent framework for electronic health care transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), (P.L. 104-191), enacted on August 21, 1996*" and other ensuing regulations. For an example from 2011 pertinent to this report, see "*Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions*", Federal Register Volume 76, Issue 131 (July 8, 2011), page 40458.

[xii] Sources:

Robert E. Nolan Company. (October 2003). *Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS: Challenges, Estimated Costs, and Potential Benefits*. Retrieved from website: http://www.renolan.com/healthcare/icd10study_1003.pdf .

Minich-Pourshadi, K. (November 11, 2011). *Hospital Margins in Jeopardy as 5010, ICD-10 Deadlines Loom.* HealthLeadersMedia, November (2011). Retrieved from website: http://www.healthleadersmedia.com/content/MAG-272013/Margins-in-Jeopardy-as-5010-ICD10-Deadlines-Loom.

[xiii] Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI). (February 2011). *Preliminary unpublished estimate of potential Minnesota health care administrative cost reductions with implementation of requirements for the standard, electronic exchange of health care administrative transactions*. (See also endnote i above.)

[xiv] Centers for Medicare and Medicaid Services (CMS). *HCPCS – General Information: Overview, HCPCS Background Information*. Retrieved from website: http://www.cms.gov/MedHCPCSGenInfo/

[xv] Minnesota Council of Health Plans. (2010). *Personal communication.*

[xvi] John L. Phelan, Ph.D.. *Electronic Transactions Between Payors and Providers: Pathways to Administrative Cost Reductions in Health Insurance.* Milliman Client Report. (May 6, 2010). Retrieved from website: http://www.navinet.net/files/navinet/Milliman_report.pdf .

[xvii] Milliman Technology and Operations Solutions. (2006). *Electronic Transaction Savings Opportunities for Physician Practices.* Retrieved from website: http://www.emdeon.com/resourcepdfs/MillimanEDIBenefits.pdf.

[xviii] Ibid.

[xix] Minnesota Administrative Simplification Work Group. (2006). *2006 Administrative Simplification Project – Project Documentation.* (working paper).

[xx] Department of Health and Human Services. *Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions*. Federal Register Volume 76, Issue 131 (July 8, 2011). Retrieved from website: http://www.gpo.gov/fdsys/pkg/FR-2011-07-08/pdf/2011-16834.pdf .

[xxi] Minnesota Department of Health. Division of Health Policy, Center for Health Care Purchasing Improvement (CHCPI). (2011). Chart 1 was prepared by CHCPI and first presented at the regular monthly meeting of the Minnesota Administrative Uniformity Committee, April 12, 2010.

[xxii] One or more of the following criteria must be met to obtain an exception to Minnesota's rules for the standard, electronic exchange of health care administrative transactions: (i) a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or (ii) another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction. (See Minnesota Statutes, section 62J.536, Subd. 2a (1), at: https://www.revisor.mn.gov/statutes/?id=62J.536.) To date, the Minnesota Department of Health (MDH), which administers Minnesota Statutes, §62J.536, has exempted non-HIPAA entities from only the requirement to exchange eligibility inquiries and responses, on the basis that this transaction was found to satisfy criterion (i) above. Additional information regarding MDH's decision is available at http://www.health.state.mn.us/asa/inpcompupdt021811.pdf. It is important to note that Minnesota's regulations for the standard, electronic exchange of claims, remittance advices, and acknowledgments still apply to workers' compensation, auto, and property-casualty carriers covered by the state's rules.