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Center for Health Care Purchasing Improvement (CHCPI)

Annual Report

January - December 2014

Minnesota Department of Health

Report to the Minnesota Legislature

April 2015

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Protecting, maintaining and improving the health of all Minnesotans

April 6, 2015

Office of the Governor
130 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Governor Dayton and Legislators:

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January to December 2014 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63. The report summarizes CHCPI's operations, activities, and impacts in 2014 as well as preliminary planning considerations for 2015.

CHCPI works closely with the health care industry, and in particular, a voluntary stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC) to bring about more standard, automated, efficient exchanges of health care business data such as claims (billings) and other common transactions. This administrative simplification initiative is vital to many health reforms and to reducing overall administrative costs and burdens throughout the state's health care system.

Thank you for the opportunity to provide this update. For additional information, please contact the CHCPI Director, David K. Haugen, at 651-201-3573 or at david.haugen@state.mn.us.

Sincerely,

Edward P. Ehlinger, MD, MSPH
Commissioner
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St. Paul, MN 55164-0975

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Executive Summary

Minnesota is undertaking a variety of health care reforms to meet the "Triple Aim" of improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.[i] One often-overlooked area with great potential to decrease costs and increase efficiency within the health care system is the electronic exchange of certain administrative transactions – such as claims and payment information - between health care providers and payers. According to a recent estimate by the Council for Affordable Quality Healthcare (CAQH), the U.S. healthcare system could save as much as $8 billion annually if six categories of administrative transactions were consistently exchanged electronically[ii]; in Minnesota, the estimate is $40 - $60 million annually.[iii] .

Minnesota has established first-in-the-nation requirements for electronic exchange of eligibility, claims, payment/advice and acknowledgements transactions between health care providers and payers. MDH's Center for Health Care Purchasing Improvement (CHCPI) leads the work of implementing these requirements to assure that the millions of routine health care billing and payment transactions that take place each year between health care providers and payers are exchanged as efficiently as possible, following state requirements for electronic exchange. Electronic billing and payment transactions will support more rapid, accurate exchanges of data that are foundational to other reform goals of improving the patient experience and improving health outcomes.

Key CHCPI activities and accomplishments in 2014

CHCPI works closely with the health care industry, and in particular, a broad-based, voluntary stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC), as well as national health care standards-setting and advisory bodies to accomplish the goals above. In particular, in 2014 CHCPI:

- **Led the administration and enforcement of MS §62J.536,** which requires that routine health care business data be exchanged electronically, based on a single set of technical specifications adopted by MDH into rule. CHCPI led and coordinated rulemaking to update five sets of state rules, held roughly 40 open public meetings, and led enforcement and compliance efforts.
- **Planned and hosted an industry-wide symposium on workers' compensation issues (with the Department of Labor and Industry)** to identify, discuss, and address industry-wide challenges to the use of health care e-transactions for workers' compensation, and presented the symposium's findings at state and national events.
- **Participated in national administrative simplification discussions and reviews**, including a presentation to the Workgroup for Electronic Data Interchange (WEDI) annual national conference. WEDI is a statutorily designated advisor to the Secretary of the federal Department of Health and Human Services on health care EDI issues.
- **Submitted formal comments on behalf of the AUC to the federal Department of Health and Human Services (HHS)** regarding the Department's notice of proposed rulemaking, "Administrative Simplification: Certification of Compliance for Health Plans."
- **Presented to the annual statewide "e-Health Summit"** regarding the important interplay between the state's initiative to assure the secure, efficient exchange of health care clinical data

such as reports of lab tests and discharge summaries, and the state's health care administrative simplification initiative.

- **Provided technical assistance in responding to more than 150 inquiries and questions**, and developed best practices and clarifications to supplement and enhance state rules.
- **Coordinated with the AUC and the Minnesota ICD-10 Collaborative** to develop tools to aid the industry in implementing a federally mandated new national diagnosis coding system known as the International Classification of Disease tenth revision (ICD-10).
- **Helped organize and facilitate a new AUC technical advisory group (TAG)** to research, understand, and respond to federal requirements for the industry-wide adoption and use of a new Health Plan Identifier (HPID) for the identification and enumeration of health plans.

Plans for 2015

CHCPI works to assure that the state's electronic data exchange rules are consistent with related existing and pending federal administrative simplification regulations and national EDI standards., and bring examples and lessons forward from Minnesota's experience to help inform and shape national efforts.

The AUC Executive Committee has identified a number of key needs and objectives for the coming year, including:

- Meeting CHCPI and the AUC's primary continuing responsibilities for the development, administration, and updating of rules for the standard, electronic exchange of routine health care business transactions as needed;
- Additional follow-up to address issues and challenges to workers' compensation e-transactions identified at the November 2014 symposium, including collaborations with relevant national organizations;
- Promoting preparedness and successful implementation of ICD-10 by a revised federal deadline of October 1, 2015;
- Monitoring HPID developments and taking any next steps for further preparation and implementation as needed;
- Creating a framework for the review and discussion of the administrative implications of new forms of health care delivery and financing, such as bundled payment, Accountable Care Organizations (ACOs), and pay for performance. Part of this framework will seek to ensure that information needed to continuously improve ACO performance ("data analytics") is collected and exchanged as efficiently as possible through standard, automated processes to the extent practicable;
- Continuing engagement with the AUC and with national organizations in the development and implementation of administrative simplification transactions standards and federal operating rules mandated by the federal Affordable Care Act (ACA).

Introduction

The problem: Staggering numbers of routine health care business transactions add costs

The costs of administering the US health care system, including health care billing and payment, are staggering. The New England Journal of Medicine for example reported that the national Institutes of Medicine (IOM) found that "the United States spends $361 billion annually on health care administration — more than twice our total spending on heart disease and three times our spending on cancer" and that "fully half of these expenditures are unnecessary."[iv]

These high administrative costs are due in part to the fact that the U. S. health care system is a complex, transaction-intensive industry, with an estimated more than 18 billion routine business (administrative) data exchanges annually. This is more than 500 transactions every second, to meet needs such as verifying insurance coverage, billing, checking on the status of claims, and making payments.[v]

Minnesota easily contributes its share to the total. The state's health plans reported processing nearly 68 million medical claims alone in 2014, of which more than 66.3 million (97.3%) were submitted electronically.[vi] In addition, the Minnesota Department of Human Services (DHS), which oversees the state's Medical Assistance (Medicaid) program, reported processing nearly 32 million fee-for-service claims in 2013, the most recent year for which data was available, with 99% of non-pharmacy claims submitted electronically.[vii] Both claim totals are likely to increase with a growing and aging population using more medical services and a greater share of the population with health coverage as a result of the federal Affordable Care Act (ACA).

The sheer volume of ordinary, ongoing health care administrative data exchanges to support primarily billing and payment is costly under even the best of circumstances. However, the problem is exacerbated because these data are often communicated using outmoded, often manual 20th century practices and technology rather than 21st century capabilities, adding dramatically to overall costs without enhancing value.

Minnesota's solution: Reduce paper-based, manual administrative transactions

Minnesota's solution to excessive health care transactions costs was to enact Minnesota Statutes, section 62J.536 in 2007, with first-in-the-nation requirements for the standard, electronic exchange of administrative data. The law reduces wasteful friction and delays in common, recurring health care business processes by accelerating the adoption and best use of streamlined, more automated electronic data interchange (EDI) to replace what have often to this point been manual, paper-based transactions.

The statute applies to an estimated 60,000 health care providers in the state, as well as to hundreds of health insurers and other business intermediaries, and is an important, integral part of broader state health care reforms. Achieving even modest efficiency gains through greater use of e-billing and e-commerce for millions of health care administrative exchanges in Minnesota each year will

result in estimated savings to the state's health care system of $40 million to $60 million annually.[viii] Reducing administrative burdens and speeding the payment process means that "clinicians can spend more time seeing patients and less time filling out forms and calling health plans."[ix] Patients also further benefit when their routine insurance verifications, billing, and payment are automated, so that they receive needed services as timely as possible, are charged correctly, and deal with minimal paperwork. Moreover, the accurate, efficient exchange of health care business data with information about health care diagnoses, utilization, and costs is foundational for achieving other health reform goals, including the effective use of health information technology to continually improve health care delivery, patient outcomes, and population health.

CHCPI's role

Since 2007, the Center for Health Care Purchasing Improvement (CHCPI) has implemented and administered MS §62J.536 and related rules. Per statute, CHCPI actively coordinates with the Minnesota Administrative Uniformity Committee (AUC), a large, voluntary organization of health care providers, payers, health care associations, and state agencies, as well as other stakeholders, in implementing the law.

CHCPI serves in a number of roles, including:

- developing and administering rules with single, common specifications for electronic data exchange;
- providing technical assistance, communications, and outreach to ensure compliance with regulations;
- providing technical support, and development and implementation assistance for related legislative initiatives;
- acting as a resource within the Department of Health and the State, particularly regarding the interplay between health care administrative data and other health care reforms; and
- coordinating with other state agencies, including the Minnesota Department of Human Services (DHS) and the Department of Labor and Industry, as well as other state agencies, other states, and national organizations on state and national administrative simplification efforts.

The latter role above is often one of CHCPI's most important and most challenging. The state's reforms to reduce health care administrative costs operate in tandem with and are complementary to related federal health care administrative simplification requirements and standards. At the same time, both state and federal initiatives are often based on EDI specifications and conventions developed by independent national standard setting and advisory bodies.

CHCPI bridges these complex relationships to inform Minnesota stakeholders regarding national trends and developments, while also informing and participating in national level discussions of the state's recommendations and needs. In this capacity, CHCPI is a member of a several national advisory and standards setting organizations, contributes to the ongoing work of the organizations, and has presented at national meetings. Similarly, it works closely with the AUC and others to create awareness of national administrative simplification issues and opportunities for advancing common goals.

2014 Activities and Accomplishments

CHCPI's primary work falls into four general categories summarized below:

- rulemaking;
- technical assistance;
- compliance and enforcement; and
- participation in broader health care administrative simplification and reforms.

Rulemaking

CHCPI collaborates extensively with the health care industry and the AUC as part of an ongoing process to create and maintain "rules of the road" needed for the secure, efficient exchange of health care business transactions. The rules help assure that key business transactions crucial to all aspects of the health care billing and payment "revenue cycle" are exchanged electronically, according to a single set of well-defined, uniform, detailed standards for greatest efficiency, accuracy, and reliability. The state's rules are intentionally aligned with and are intended to serve as "companions" to federal regulations and national standards, and are therefore known as "Minnesota Uniform Companion Guides (MUCGs)."

In recent years, federal and national administrative simplification efforts have accelerated as a result of provisions of the ACA, additional federal requirements, and other national developments and market pressures. As a consequence, the MUCGs must be periodically reviewed and updated as needed to conform with and appropriately supplement federal rules and national standards. In 2014 CHCPI led and coordinated an open, public rulemaking process to revise and update the MUCGs to assure that they remained accurate, relevant, and in conformance with federal requirements and changes at the state and national levels.

As shown in table 1 below, CHCPI consulted with the AUC in overseeing the development and adoption of five sets of revised MUCG rules in 2014, pursuant to the process described in MS §62J.61. As part of the process, CHCPI provided staff, logistics, planning, research, outreach, communications, and facilitation support for nearly 40 open public meetings of the AUC and relevant AUC work groups, known as Technical Advisory Groups (TAGs). The most recent versions of the MUCGs adopted into rule are available at http://www.health.state.mn.us/auc/guides.htm and http://www.health.state.mn.us/asa/rules.html.

Table 1. Summary of CHCPI recent rulemaking for standard health care administrative transactions

Health care transaction	Description/purpose	Most recent rule updates/revisions
Claims (Professional, Institutional, Dental)	Claims are bills submitted by health care providers to third party payers (insurers) for health care services and products. Separate, slightly different versions of the claim transaction are sent for professional (e.g., physician/clinic), institutional (e.g., hospital), and dental billings.	Revised, updated rules for Professional, Institutional, and Dental claims transactions were proposed in December 2014 and scheduled for adoption in March 2015.

Health care transaction	Description/purpose	Most recent rule updates/revisions
Eligibility Inquiry and Responses	This transaction is used by health care providers to inquire of third party payers regarding a patient's insurance coverage and benefits, in order to properly bill the third party payer and the patient. The response is used by the payer to respond to the eligibility inquiry.	Updated rules for the Eligibility Inquiry and Response transaction were proposed in November 2014 and scheduled for adoption in March 2015.
Remittance Advices	Remittance advice transactions, known formally within the industry as "Health Care Claim Payment/Advice" transactions, are sent by the payer to the health care provider to explain the disposition of a claim, including any adjustments to what is being paid and payment amounts.	Revised rules for the Health Care Claim Payment/Advice transaction were November 2014 and scheduled for adoption in March 2015.

Technical assistance

The state's rules provide an important legal and regulatory framework for health care administrative simplification and cost savings. However, additional information and technical assistance is often needed to comply with the rules and to realize the greatest benefits from administrative simplification. In 2014 CHCPI also played a key role in providing and coordinating technical assistance, education, information sharing, and communications to help health care providers, payers, and others understand the rules and to modernize and streamline health care business transactions.

CHCPI assists the industry and coordinates activities with other state agencies through a combination of AUC staffing and engagement, special projects or meetings, and responses to individual questions or requests for assistance. In this role, CHCPI also supports the AUC in developing and maintaining industry consensus best practices, medical coding clarifications, and other information and tools that do not have the force of law but are used voluntarily by the industry to bring about more efficient, standard exchanges of health care business data.

In 2014 CHCPI:

- **Responded to over 150 individual requests from providers, payers, and others for information, clarification, referrals to other agencies or organizations, or other technical assistance**. The assistance ranged from answering complex questions regarding the applicability of state law and rules, to providing directions for finding and using common forms, processes, website information, and other available resources;
- **Staffed and facilitated AUC TAGs on the development and maintenance of best practices and related resources.** These resources are used to clarify business transactions and/or to recommend billing and coding solutions for new and emerging medical services. As part of this ongoing effort, CHCPI coordinated and participated in the adoption of important new best practices for meeting federal regulations regarding termination of health coverage for persons enrolled through health insurance exchanges such as MNSure and who are receiving "advance payments of premium tax credits (APTC)." Pursuant to the federal regulations, health plans must allow APTC enrollees a three month grace period before terminating coverage due to

nonpayment of premiums. Health plans must also notify providers when APTC enrollees have lapsed in their payment of premiums and the three month grace period applies. The AUC's best practices are based on a national model, and provide instructions for using standard electronic health care transactions to communicate the three month grace period to providers in fulfillment of the federal regulations.

- Coordinated with the AUC and another stakeholder advisory organization, the Minnesota ICD-10 Collaborative, in March 2014 to **jointly produce and host a webinar with information to help stakeholders meet federal requirements for adoption of more robust, much more detailed disease classification coding system known as the International Classification of Disease tenth revision (ICD-10)** by a deadline (at the time) of October 1, 2014.

CHCPI will continue refining and implementing its communications and technical assistance plans with the AUC and others in 2015.

Compliance and enforcement

CHCPI is responsible for compliance and enforcement of MS §62J.536 and related rules requiring the standard, electronic exchange of health care administrative transactions. The law applies broadly to health care providers, group purchasers (payers), and to intermediaries facilitating the electronic exchange of transactions known as "clearinghouses." It further specifies that MDH:

- seeks voluntary compliance to the extent practicable;
- investigates complaints of noncompliance;
- attempts to arrive at informal resolution of complaints;
- may impose civil monetary penalties of up $100 for each violation, not to exceed $25,000 for identical violations during a calendar year if the violation cannot be addressed by informal means; and,
- may consider may consider certain aggravating or mitigating factors in imposing fines.

Workers compensation transactions

In 2014 CHCPI's primary and most visible compliance and enforcement efforts were undertaken jointly with the Minnesota Department of Labor and Industry (DLI), which oversees the state's workers' compensation system, to explore and address concerns regarding compliance with the state's e-billing requirements for workers' compensation-related medical claims. The collaboration is important because MS §62J.536 applies to the exchange of billings and other transactions for medical care under the workers' compensation system. In addition, Minnesota Statutes, section 176.135 also specifically references that workers' compensation medical claims must comply with MS §62J.536.

The two agencies worked together to assess and improve compliance with the statutes by:

- conducting surveys and individual meetings with parties subject to the laws, to learn about compliance rates and challenges;
- undertaking investigations of possible noncompliance; and in some cases,
- issuing and monitoring corrective action plans to individual organizations to improve their compliance with the state's e-billing regulations.

Industry-wide symposium for improving compliance, problem solving

In an effort to better understand and address challenges to workers' compensation health care e-transactions, MDH (CHCPI) and DLI jointly hosted an industry-wide symposium in November 2014 to bring the stakeholders together for facilitated discussions and interaction with one another to identify issues and to begin considering possible solutions. The day-long symposium was attended by 100 participants, including many from other states and representatives of national organizations. A number of key issues and challenges were identified for further review and work in 2015, including:

- **Submission of required medical documentation or attachments** to substantiate a health care bill to be paid under workers' compensation. The attachments can take a variety of forms, from scanned images to faxed documents, to paper files sent by conventional mail. Attachments are frequently lost or mishandled enroute to an insurer (payer), and/or are not received on a timely basis, and/or must be manually processed at additional cost. Because of these difficulties and challenges, the parties involved may resort to noncompliant paper medical billing rather the required electronic billing.
- **Lack of readily accessible, reliable information needed for correct routing of bills** or other business transactions across often complex pathways.
- **Difficulties tracking bills and attachments to ensure that they are reaching the proper destinations and are being processed as needed**. Existing electronic "receipts" or acknowledgments that could be used to help inform parties of the status of their transactions are often not used, or are not used fully and correctly.
- **Difficulties obtaining and correctly using numbers needed to correctly identify the medical bill with a particular injured worker "casefile."** In order for bills for services provided to an injured worker covered under workers' compensation to be correctly submitted and processed, the provider must include a special casefile number from the workers' compensation insurer on the bill. There are often miscommunications and other challenges in obtaining and entering the casefile number correctly on the bill.

Almost immediately following the symposium above, CHCPI and DLI began working with other well-recognized national standards-setting and advisory groups to share the symposium findings and to broaden collaborative efforts to address them. In late November and early December CHCPI and DLI presented to the national Workgroup for Electronic Data Interchange (WEDI) Property and Casualty Sub Work Group; the Cooperative Exchange, a national trade association for health care clearinghouses; and the Healthcare Administrative Technology Association (HATA), the national trade association for practice management systems. The symposium, as well as the follow-up, was successful in creating support and momentum for ongoing industry efforts to address the issues above, which will be a key priority for 2015.

Participation in broader health care administrative simplification and reforms

As briefly summarized below, CHCPI monitors and participates in broader health care administrative simplification and reforms in order to: be informed of potential changes affecting Minnesota's efforts; share information regarding the state's efforts and experience with the broadest range of stakeholders and experts; and contribute to national discussions, problem solving, and innovations. In 2014, CHCPI:

- **Presented to the Workgroup for Electronic Data Interchange (WEDI) annual national conference in Los Angeles, California, May 2014**. WEDI is a statutorily designated advisor to the Secretary of the federal Department of Health and Human Services on health care EDI issues. The WEDI national conference provided an important opportunity to showcase Minnesota's initiative nationally, and stimulated interest and discussion of future health care e-billing and e-health goals and needs.
- **Submitted formal comments on behalf of the AUC to the federal Department of Health and Human Services (HHS) regarding the Department's notice of proposed rulemaking**, "Administrative Simplification: Certification of Compliance for Health Plans." The AUC's comments identified key concerns and offered suggestions and recommendations. (HHS received a large volume of comments and it has not yet published a final rule.)
- **Presented to the tenth annual statewide "e-Health Summit" regarding the important interplay between secure, efficient exchange of health care clinical data and the state's health care administrative simplification initiative**. CHCPI presented on the rapid changes taking place in health care that are creating greater needs – and opportunities – for unifying exchanges of health care clinical and financial (administrative) data to create a more streamlined, responsive, and effective health care system.
- **Analyzed capabilities of administrative data to help stratify health care quality measures by socio-economic variables, including race, ethnicity, language, and disability**. Because most health care administrative transactions were developed for very narrow, predetermined business purposes, they were generally limited in providing socio-demographic data.

Emerging Issues

International Classification of Diseases (ICD-10) and Health Plan Identification (HPID)

Federal rules require the industry-wide adoption of an updated method of coding for medical diagnoses and inpatient procedures known as the International Classification of Diseases, tenth revision or ICD-10. The current classification system is ICD-9, which has been in place over 30 years, and is now considered inadequate to meet the needs of the current health care system. ICD-10 codes are also considered by many to be integral to correct billing and payment, and will provide for greater specificity in disease tracking and for improvements in health care delivery.

Federal requirements for industry-wide adoption of ICD-10 and HPID were controversial, due to concerns about the costs and benefits of the transition from the current system to the new one. As a result of ongoing disputes, the federally mandated implementation date for ICD-10 has been delayed three times. The most recent delay occurred by an act of Congress in April 2014, shortly after CHCPI and the AUC developed and hosted an ICD-10 webinar to help a range of stakeholders prepare for the conversion to ICD-10. That delay postponed the implementation of ICD-10 from a previously announced date of October 1, 2014 to at least a year later. A subsequent revised implementation date of October 1, 2015 was not announced until nearly August, 2014.

Similarly, requirements in the ACA for development and adoption of a universal health plan identifier (HPID) to uniquely identify health plans (payers) for transaction routing and

accountability purposes were also controversial. In 2014 CMS announced that a previous HPID compliance date would not be enforced at this time, effectively leading to suspension of national efforts that had been underway to complete the development and adoption of the identifier.

These controversies and postponements, as well as a number of other competing mandates and priorities discussed elsewhere, created considerable uncertainty in the industry and often diverted attention and resources from reducing health care transactions costs. CHCPI, the AUC, and other stakeholders will likely face significant challenges in overcoming some lost momentum in 2014, in continuing ICD-10 implementation efforts, and in realizing the goals of the HPID. Nonetheless, it will be important to make progress toward an ICD-10 implementation date of October 1, 2015, while also participating as part of any efforts that may emerge to review and restart discussions of the HPID concept.

Accountable care and administrative processes

At the same time that the industry and federal government have struggled with ICD-10 for a number of years, other landmark changes and demonstration projects are being quickly launched and implemented. For example, Minnesota is working under a special "State Innovation Model" grant from CMS to rapidly transform health care delivery and financing to be much more integrated and accountable for results.[x] Accountable Care Organizations (ACOs), in addition to promoting new combinations of services across a broader range of providers, is resulting in new types of results-based financial incentives and reimbursement. Many of the conventional administrative processes and data exchanges now in place may not be adequate for these emerging delivery and financing arrangements, and adaptations and innovations will likely be needed quickly.

Several administrative simplification provisions of the ACA are also scheduled to become effective during 2015 and 2016 to further standardize and streamline health care business transactions for greater automation and efficiency. These provisions will require further coordinated management and adaptations by the industry in a relatively short amount of time.

Plans and Next Steps for 2015

CHCPI met with the AUC Executive Committee in December 2014 to briefly review the challenges and opportunities for improving health care administration at this time and to discuss and make preliminary plans for 2015. The planning process identified a number of key needs and objectives for the coming year, including:

- Meeting CHCPI and the AUC's primary ongoing responsibilities for the development, administration, and refinement of rules for the standard, electronic exchange of routine health care business transactions;
- Additional follow-up to address issues and challenges to workers' compensation e-transactions identified at the November 2014 symposium, including collaborations with relevant national organizations to address attachments-related issues and to improve overall transparency and accountability for routing of transactions;
- Promoting preparedness and successful implementation of ICD-10 by the most recent deadline of October 1, 2015;

- Monitoring HPID developments and taking any next steps for further preparation and implementation as needed;
- Creating a framework for the review and discussion of the administrative implications of rapidly emerging new forms of health care delivery and financing, such as payment for bundled services, Accountable Care Organizations (ACOs), pay for performance, and others. Part of this framework will seek to ensure that information needed to continuously improve ACO performance ("data analytics") is collected and exchanged as efficiently as possible through standard, automated processes to the extent practicable;
- Continuing engagement with the AUC and with national organizations in the development and implementation of administrative simplification transactions standards and federal operating rules mandated by the ACA.

Appendix A: Minnesota Administrative Uniformity Committee (AUC) Member Organizations

The Minnesota Department of Health (MDH) works closely with a large, voluntary stakeholder organization, the Minnesota Administrative Uniformity Committee (AUC), in the development and administration of state requirements for the standard, electronic exchange of health care administrative transactions. A list of AUC member organizations is provided below.

AUC member organizations:

- Aetna
- Aging Services of Minnesota
- Allina Health System
- American Association of Healthcare Administrative Management (AAHAM)
- Blue Cross Blue Shield of Minnesota
- Care Providers of Minnesota
- CentraCare Health System
- Children's Hospitals and Clinics
- CVS Pharmacy
- Delta Dental Plan of MN
- Essentia Health
- Fairview Health Services
- HealthEast
- HealthEZ
- HealthPartners
- HealthPartners Medical Group and Regions Hospital
- Hennepin County Medical Center Hennepin Faculty Associates
- Mayo Clinic
- Medica Health Plan
- Metropolitan Health Plan
- Minnesota Chiropractic Association
- Minnesota Council of Health Plans
- Minnesota Dental Association
- Minnesota Department of Health
- Minnesota Department of Human Services
- Minnesota Department of Labor and Industry
- Minnesota Hospital Association
- Minnesota Medical Association
- Minnesota Medical Group Management Association
- Minnesota Pharmacist Association
- Noridian - Medicare Part A
- Olmsted Medical Center
- Park Nicollet Health Services
- PreferredOne
- PrimeWest Health
- Ridgeview Medical Center
- Sanford Health
- Sanford Health Plan
- Silverscript
- St. Luke's
- UCare Minnesota
- UnitedHealth Group
- University of Minnesota Physicians
- Wisconsin Physicians Service Insurance Corporation

Endnotes

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[vii] Minnesota Department of Human Services. Medicaid Management Information System — MMIS. DHS-4996-ENG 02-14. Accessed at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4996-ENG.

[viii] Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI). (February 2011). See note ii above.

[ix] Centers for Medicare and Medicaid Services. Fact Sheet: Introduction to Administrative Simplification. (September, 2014). Accessed at: http://www.cms.gov/eHealth/downloads/eHealthU_IntroAdminSimp.pdf April 2, 2015.

[x] More information regarding Minnesota's State Innovation Model (SIM) grant is available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home