Center for Health Care Purchasing Improvement

January 2016 – June 2017
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Center for Health Care Purchasing Improvement, Report pursuant to MS §62J.63, January 2016 – June 2017

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 11, 2018

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

Dear Governor Dayton and Legislators:

We are pleased to submit this report of the Center for Health Care Purchasing Improvement (CHCPI) as required by Minnesota Statutes, section 62J.63. It summarizes CHCPI's operations, activities, and impacts during calendar year 2016 and the period January – June 2017.

CHCPI's primary focus has been to reduce health care administrative costs and burdens by accelerating the adoption and use of more standard, automated, efficient exchanges of health care business (administrative) data for billing, payment, and other purposes. As described in this report, in July 2017 the administrative simplification functions and staff of CHCPI were merged with and are continuing as part of the MDH Office of Health Information Technology (OHIT). The result is a single, broader policy and implementation resource for Minnesota Health Information Technology and e-Health, building on and bridging the specialized experience and knowledge of each of the previous units to establish more coordinated, integrated approach to meeting 21st century health care data needs and challenges. Because of this change, future updates on CHCPI activities will be included in the annual e-Health legislative submitted as required by Minnesota Statutes, section 62J.495.

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

Sincerely,

Jan K. Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Executive Summary

Key responsibilities for reducing health care administrative costs

The US health care system has among the highest administrative costs in the world, in part because of a staggering volume of routine business processes and communications needed for billing and payment. A significant portion of these transactions are conducted manually, via phone, paper, and fax, which can be up to 100 times more expensive than if they were automated and exchanged electronically through computer to computer connections.[i]

The Center for Health Care Purchasing Improvement (CHCPI) coordinated and led the state's health care reform initiative to reduce health care administrative costs by accelerating the adoption and use of standard, more automated electronic exchanges of common health care business data. The data are also essential for monitoring, planning, and evaluating the health care system, and the initiative is improving data flows for these purposes as well.

CHCPI was established under 2006 Minnesota Session Laws, Chapter 282. In 2007, Minnesota Statutes, section 62J.536 was enacted, requiring health care providers, payers, and intermediaries to exchange several key billing and payment-related transactions electronically. More specifically, the law:

- Requires that health care providers, payers, and intermediaries exchange certain common, high volume types of routine business data electronically.
- Authorizes MDH rulemaking to create and maintain well-established, clear, detailed data content and format standards and specifications needed for automated, computer-to-computer exchanges of common business transactions (also known as Electronic Data Interchange, or EDI);
- Requires MDH to consult with a large, voluntary, multi-stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC) in the rulemaking and related matters;
- Requires universal adoption and use of the standards and specifications by all virtually all health care providers, insurers (payers), and data exchange intermediaries (clearinghouses); and;
- Authorizes MDH to provide technical assistance and enforcement of the law, with an emphasis on achieving voluntary compliance, to bring about broad EDI adoption.

CHCPI was authorized under its enabling legislation to support the AUC and related groups or activities, and was designated the lead MDH section responsible for implementing and administering the law in mid-2007.

Overall accomplishments

CHCPI and the industry have worked closely for several years to improve the adoption and use of more rapid, efficient, accurate EDI for routine health care business transactions. As a result, Minnesota has achieved higher rates of several key electronic health care administrative transactions than the national average, saving the state health care system an estimated $40-60 million dollars.[ii] These reform efforts are ongoing, with continuing efforts to further streamline administrative processes and transactions and to reduce costs.

Administrative simplification activities and impacts during 2016-2017

During 2016-2017 CHCPI:

- Played a key leadership and organizing role in examining the role of electronic data exchange in addressing the current epidemic of opioid abuse and misuse, and in rapidly developing initial recommendations requested by Governor Dayton to best use and build upon the state's health e-data capabilities to address the epidemic;
- Planned, coordinated, helped organize, and facilitated 77 open public stakeholder meetings to: obtain input and recommendations for rules and best practices; provide information, updates, and technical assistance; coordinate a statewide review of and response to proposed national EDI standards; and plan and implement subsequent phases and steps of the state's health care administrative simplification initiative;
- Coordinated and led state rulemaking for seven sets of adopted rules to ensure that health care providers, payers, and others have the single, common "rules of the road" needed to most effectively automate large volumes of business transactions and exchange them as rapidly, accurately, and efficiently as possible; and,
- Actively participated in a year-long strategic planning effort examining new working relationships between the state's two health care electronic data initiatives. As described in this report, CHCPI led one initiative to reduce administrative costs by streamlining and accelerating the exchange of common health care business data. The other is led by MDH's Office of Health Information Technology, which has parallel responsibilities for accelerating the adoption and use of e-health technology such as Electronic Health Records (EHRs) and electronic prescribing (e-prescribing). The planning effort resulted in a mutual decision to incorporate CHCPI's staff and functions within the larger OHIT umbrella for greater, broader impact and operational efficiencies.

In addition, the CHCPI director was named in 2016 to a two-year term as the only government representative to the Board of Directors of the national Workgroup for Electronic Data Interchange (WEDI), a congressionally chartered national stakeholder advisory committee to the Secretary of the federal Department of Health and Human Services (HHS) on EDI issues. The director participated on several WEDI workgroups and has presented on Minnesota's initiative, lessons learned, and recommendations at WEDI board meetings and at national WEDI conferences. He also served as a liaison between Minnesota stakeholders and national health care administrative simplification goal setting and policy discussions.

Introduction

A costly, complex health care system with costly, complex administration

In describing CHCPI's functions and recent accomplishments it is important to consider how large and complex the US health care system is, and how complex and costly it is to administer. Total US health care spending topped $3.2 trillion[iii] in 2016 -- nearly $10,000 per US resident, or nearly twice Canada's entire gross domestic product (GDP).[iv] These expenditures are financed through a complex array of private and public insurance and individual out-of-pocket spending. Insurance coverage as well as monthly premium and point of service costs can vary widely and change quickly depending a variety of factors. Similarly, the costs and payments for medical procedures, services, and products vary by differing providers and payers, and by varying legal requirements and contractual arrangements.

It is perhaps no surprise then that a complex system of routine business communications has evolved between the various parties to administer the health care billing and payment system. They are used for example to convey 68,000 available diagnosis codes, thousands of medical procedure codes, and other detailed billing information, as well as insurance status and benefit levels, adjustments to or denials of bills, payments, and a variety of other data. A number of related transactions are used to: satisfy prior authorization requirements; appeal payment decisions; check the status of pending bills; enroll and dis-enroll patients from insurance; and provide receipts or acknowledgements of the transactions from their respective receivers to the senders originating them.

The results are significant – it is estimated that the US health care system generates nearly ten billion health care business ("administrative") transactions each year, or more than 300 per second, 24/7, 365 days a year.[v] In Minnesota, the state's Department of Human Services administers publicly funded health care programs and it alone processes an estimated 27 million fee for service health care provider billings (claims) annually, the vast majority of them electronically.[vi]

The method by which health care business transactions are communicated, accessed, used, and sometimes repeatedly re-routed or re-communicated, has a tremendous bearing on the overall costs, accuracy, and quality of the underlying data, with implications for the entire health care system. While the system is continually improving, far too many routine business processes and communications are still conducted via paper or time-consuming telephone conversations. Studies have found that these outmoded communications can be up to 100 times more expensive than if the same transactions were automated and conducted using standard, electronic computer-computer electronic data interchange (EDI).

These transactions and their follow-up contribute to the highest health care administrative cost levels in the world. Researchers have estimated that administrative costs account for up to 25% of total US health care expenditures, a level that is twice the country's spending on heart disease and three times its spending on cancer.[vii] A recent well-recognized national study estimated that using EDI and fully automating the exchange of just seven key health care business transactions would save the US health care system $9.4 billion annually.[viii]

Both Minnesota and the nation have been working to close the gap between current levels of costly manual business transactions and desired levels of their automated, electronic counterparts. The gap has been narrowed more rapidly in some areas than others. For example, based on the national study above and surveys of Minnesota health care payers, billings (claims) from health care providers to insurers (payers) are now being exchanged about 95% of the time electronically, both nationally and in Minnesota.

However, gaps remain in other important transactions, representing additional savings opportunities for the state and the nation. By way of illustration, the national study noted above estimated the cost differential – and potential savings - to the industry as a whole between manual remittance advices (RA - a transaction from payers informing providers about adjustments or other actions on their bills) and comparable electronic versions. The differential was estimated at over $5.00 each, multiplied by millions of transactions annually. A recent survey of clinics in Minnesota indicated that over 80% of RAs were electronic,[ix] which compares with the national average of 55% electronic.[x] While Minnesota is making important progress, especially compared against the national average, achieving further closure of the manual-electronic gap for this and other transactions will be important to additional administrative cost reductions.

2016-2017 Activities and Accomplishments

Rulemaking and technical assistance

In 2016-2017 CHCPI worked closely with the AUC, the industry, and other state agencies to update and maintain rules with the detailed specifications needed to ensure that common business data exchanges flowed as quickly, reliably, and efficiently as possible. As summarized below, it also worked extensively and closely with the same groups to raise awareness of the rules and new developments affecting them, to provide a range of explanatory and other information, participate in education and problem solving, and provide a variety of other technical assistance.

During the 18 months summarized in this report, CHCPI:

- Organized and facilitated 77 open public meetings of the AUC and its various standing workgroups ("Technical Advisory Groups" or TAGs) and related ad-hoc meetings. This extensive, ongoing contact was important to develop and maintain rules that must be periodically updated to remain current with changes in industry practices, federal and national requirements, and other developments. This close working relationship was also essential for awareness raising, education, planning, and technical assistance in implementing and benefitting from the state's requirements;
- Led the rulemaking process through the adoption of seven sets of revised rules, for transactions used for billing, reimbursement information and reconciliation, and special acknowledgments that transactions had been received and their status;
- Developed and presented a special, detailed primer on billing and payment requirements across Medicare, Minnesota Medicaid, and Minnesota commercial insurers for the rapidly emerging, rapidly evolving field of telemedicine/telehealth;

- Published a monthly newsletter distributed to over 3,000 subscribers across the state and nationally. The newsletter included a digest of AUC and state activities and recent developments, as well as reviews of pertinent national news and developments, how-to tips, and other resources and information;
- Organized and led a review with the AUC and other stakeholders to respond to an approximately once-per-decade opportunity to review and comment on a proposed set of national business transaction EDI standards that are slated to be adopted by federal rulemaking in the future to replace current national standards. CHCPI used its resources to contract with an outside consultant to help review and summarize the proposed detailed EDI technical specifications for broader discussion with Minnesota stakeholders, and to lead a series of review sessions with the AUC to develop and submit a timely response with detailed comments, questions, and recommendations.
- Actively facilitated and supported several AUC TAGs comprised of industry and state agency subject matter experts who meet regularly to explore issues and to assist the development of related rules, recommendations, educational materials, and other products;
- Maintained two websites, including one on behalf of the AUC and widely used by the Minnesota health care industry, with a wide variety of information, links and other resources;
- Served as an information clearinghouse for wide variety of inquiries and referrals from stakeholders and the public;
- Collaborated closely with the AUC to develop a variety of other tools and resources to assist in implementing and benefitting from the state's requirements, including best practices and medical services coding recommendations; and
- Coordinated the development of presentations on additional applications of EDI not currently required under Minnesota law but which offer significant potential benefits for further reducing excess administrative cost and burdens.

Networking and Liaison

Minnesota's efforts are part of an interrelated, broader administrative simplification and health reform environment comprised of the federal government, national data standards-setting organizations, advisory organizations, and other states and groups. In addition, CHCPI works closely with several state agencies in their roles as health care purchasers and regulators, including the Departments of Human Services (DHS), Labor and Industry (DLI), and Commerce. This broad set of working relationships enabled CHCPI and the AUC to contribute to broader policy and standards-setting discussions, while also gaining valuable insights and information about new or emerging changes and practices.

Minnesota's rules and rulemaking considerations are also part of this broader environment. Per state law, the state's administrative simplification rules must be based on and complement national standards adopted under federal rules for use as baseline or foundational standards more generally. CHCPI was a member of several of the national organizations responsible for developing and maintaining the federally adopted standards, and routinely monitored and participated in a variety of related educational, review, and standards development forums and activities. For example, in 2016, CHCPI coordinated with the AUC and DHS to obtain a formal clarification from a national standards

setting organization regarding the exchange information for a particular new type of payment methodology that DHS was implementing. The response that was developed for Minnesota's inquiry was also published and made available nationally as well.

In addition, in 2016 the CHCPI director was elected to a two-year term as the only government representative to the Board of Directors of the Workgroup for Electronic Data Interchange (WEDI), where he also serves on several sub-committees. WEDI is a large stakeholder advisory organization named in federal HIPAA law as the health care EDI advisor to the Secretary of the federal department of Health and Human Services (HHS). While on the Board, the director has:

- Presented a WEDI-sponsored webinar to a national audience on the telemedicine-telehealth primer developed for the AUC as noted above;
- Presented at a national WEDI conference in the summer of 2017 with a public-sector representative from Utah about the states' respective health care administrative simplification roles and accomplishments. The presentation led to further conversations between the Minnesota and Utah directors, and the initiation of a broader coalition-building effort to draw together and engage other similar state directors for ongoing information sharing and coordination and collaborations;
- Served as co-chair of WEDI's peer review committee to review and comment on WEDI national white papers and other products;
- Accepted an invitation to present at a WEDI national conference on the current epidemic of opioid abuse and overdose, and Minnesota's development of recommendations to leverage electronic health data to help address the epidemic.

Strategic planning

The Minnesota Department of Health (MDH) is responsible for two statewide, statutory electronic health care data initiatives. One is the subject of this report, with a focus on health care administrative data; the other, led by the MDH Office of Health Information Technology (OHIT), is working to accelerate the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) to improve individual and population health. Following industry-wide historical patterns, the initiatives emerged somewhat separately and have operated in parallel for some time.

More recently however, there are increasing indications of a growing convergence and blurring of the distinctions between the two. For example:

- Both OHIT and CHCPI have substantial interests, experiences, and resources in standards setting and use of the standards to advance the exchange of electronic health data. There are potential synergies and benefits from sharing information and learning from one another.
- New health care payment and delivery models such as Accountable Care Organizations (ACOs) rely on combined financial and clinical data to assess and demonstrate their accountability for quality and to be paid and rewarded. Increasingly, ACOs will need new forms of integrated, comprehensive data for planning and innovating to be successful.
- The health care system needs the power of seamless financial, clinical, and other "big data" to meet modern challenges, whether they are sudden public health emergencies or fulfilling the

goals of the federal 21st Century Cures Act. As with the ACO example above, an important first step to assuring that critical data needs are met is to assure that previously siloed data exchange activities are coordinated and working closely together.

As these factors and their impacts or potential have become more visible, CHCPI and OHIT began exploring options in 2016 for sharing experience and ideas, learning from one another, and working more closely together. The ensuing discussions and research identified not only benefits from cross-fertilization and gaining broader new outlooks between the two units, but also potential operational efficiencies and new synergies. In July 2017, the smaller administrative simplification functions and staff of CHCPI merged with the larger OHIT. The expanded OHIT will continue to plan and lead the state's electronic health care data initiatives while at the same time offering new combined experiences, skills, and resources to better meet 21st century health care data needs and challenges.

Summary and plans for continued impact

As noted above, CHCPI worked extensively with the state and national health care industries to reduce health care administrative costs related to the exchange of common, recurring business transactions. These efforts will continue and will likely broaden and address new challenges following the recent incorporation of the state's administrative simplification initiative as part of our broader ehealth and clinical health information exchange portfolio.

MDH is putting into place plans for continued education and problem solving with the AUC and the industry to further accelerate the adoption and use of electronic transactions mandated under Minnesota Statutes, section 62J.536. At the same time, we are planning to provide education and assistance for voluntary adoption and effective use of additional electronic transactions with significant potential for reducing health care administrative costs and burdens.

In 2018, we will continue our work to adapt and apply the processes and stakeholder engagement that have been effective in streamlining administrative transactions to promote more standard, efficient exchanges of other types of health care clinical data. This work will be important to ensure not only the efficient exchange of the data, but also to help provide new tools and resources needed for: new health care delivery and financing options; meeting the challenges of a rapidly aging population with increasing health care needs; and responding quickly to emerging public health concerns, whether in the form of the current opioid epidemic or responding to natural disasters such as the 2017 hurricanes and wildfires.

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

The Minnesota Department of Health (MDH) works closely with a large, voluntary multi-stakeholder 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 46 AUC member organizations follows below.

AUC member organizations:

- Aetna
- Aging Services of Minnesota
- Allina Hospitals and Clinics
- American Association of Healthcare Administrative Management (AAHAM)
- Blue Cross Blue Shield of Minnesota
- Care Providers of Minnesota
- CentraCare Health
- Children's Hospitals and Clinics of Minnesota
- CVS Pharmacy
- Delta Dental Plan of Minnesota
- Essentia Health
- Fairview Health Services
- Grand Itasca Clinic and Hospital
- HealthEast
- HealthEZ
- HealthPartners
- Hennepin County Medical Center
- Mayo Clinic
- Medica
- 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 HomeCare Association
- Minnesota Hospital Association
- Minnesota Medical Association
- Minnesota Medical Group Management Association
- Minnesota Pharmacist Association
- Olmsted Medical Center

- Park Nicollet Health Services
- PrairieCare
- PreferredOne
- PrimeWest Health
- Ridgeview Medical Center
- Sanford Health
- Sanford Health Plan
- Silverscript
- South Country Health Alliance
- St. Luke's
- UCare Minnesota
- UnitedHealth Group
- University of Minnesota Physicians
- WPS Health Insurance Corporation

References

[i] 2016 CAQH INDEX: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. Page 26. Accessed at https://www.caqh.org/sites/default/files/explorations/index/report/2016-caqh-index-report.pdf.

[ii] 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.

[iii] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[iv] https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?view=map

[v] 2016 CAQH INDEX: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. Page 27. Accessed at https://www.caqh.org/sites/default/files/explorations/index/report/2016-caqh-index-report.pdf.

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[vii] Reducing Administrative Costs and Improving the Health Care System. David Cutler, Ph.D., Elizabeth Wikler, B.A., and Peter Basch, M.D. N Engl J Med 2012; 367:1875-1878 November 15, 2012 DOI: 10.1056/NEJMp1209711. Accessed at: http://www.nejm.org/doi/full/10.1056/NEJMp1209711#t=article.

[viii] 2016 CAQH INDEX: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. Page 27. Accessed at https://www.caqh.org/sites/default/files/explorations/index/report/2016-caqh-index-report.pdf.

[ix] Minnesota e-Health Profile, MDH Office of Health IT, 2017.

[x] 2016 CAQH INDEX. Page 19.