Center for Health Care Purchasing Improvement (CHCPI)

Annual Report

(January 2009 - December 2009)

Report to the Minnesota Legislature 2010

Minnesota Department of Health

April, 2010

MINNESOTA MDH DEPARTMENT OF HEALTH

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As required by Minnesota Statute 3.197: This report cost approximately $1000 to prepare, including staff time, printing and mailing expenses.

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Annual Report

(January 2009 – December 2009)

Summary

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January – December 2009 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63.

The State of Minnesota currently purchases health care services on behalf of over 868,000 Minnesotans at projected costs of more than $5.4 billion annually[i], and health care costs are one of the most rapidly growing components of the state budget. The CHCPI was established in late July, 2006 following enactment of Minnesota Statutes, section 43A.312 during the 2006 legislative session. The Center serves to "support the state in its efforts to be a more prudent and efficient purchaser of quality health care services" and is authorized to participate in other related health care improvement activities, including simplification and streamlining of health care administration. It is funded through an annual base appropriation of $130,000.

A variety of studies have characterized the current health care delivery and financing system as disjoint and fragmented, with variable or often poor quality, and burdened by skewed payment incentives that do not align for optimum value and performance.[ii] At the same time, even routine health care business transactions, such as submitting claims for payment, are often non-standard and overly burdensome or expensive. Greater alignment of appropriate incentives and practices are needed to improve not only the delivery and outcomes of health care services, but to decrease administrative costs and burdens as well

During the period covered by this report, the Center primarily oversaw further development, adoption, and administration of first-in-the-nation rules to streamline and standardize high volume, routine health care transactions. The rules require that these transactions be exchanged electronically, using a single, uniform data content and format. They apply to more than 60,000 health care providers statewide as well as more than 2000 "group purchasers" (payers) licensed or doing business in Minnesota. The rulemaking process is complex, is being undertaken in consultation with a large, voluntary group of stakeholders known as the Minnesota Administrative Uniformity Committee (AUC) and other industry representatives, and is being completed to meet very tight statutory deadlines. **When fully implemented, the rules will reduce overall health care administrative costs throughout the system by more than $60 million annually[iii], allowing more of every health care dollar to be spent on patient care and health improvements.**

We are pleased to report that **12 sets of rules for standard, electronic health care administrative transactions were successfully updated, revised, or adopted in 2009, on time and on budget. CHCPI** consulted actively with the AUC on the rules, and **staffed, facilitated, and resourced an estimated 160 AUC-related meetings or teleconferences in the process.** The Center also initiated a statutorily required project to reduce administrative costs associated with a type of common prior authorization request between providers and payers, and completed a development of a tool to standardize another common similar transaction. CHCPI further provided a wide range of outreach and technical assistance in the form of press releases, targeted mailings, meetings, and **responses to over 1500 individual inquiries**. The remainder of this report describes in greater detail the Center's primary rulemaking responsibilities and accomplishments, and other efforts and activities of the Center during 2009.

Center for Health Care Purchasing Improvement (CHCPI)
Annual Report

(January 2009 – December 2009)

I. Introduction

A. Annual Report

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) encompasses the period from January – December, 2009. This report is being submitted to fulfill the requirements of Minnesota Statutes, section 62J.63, subd. 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. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement."*

B. CHCPI Background

The State of Minnesota currently purchases health care services on behalf of over 868,000 Minnesotans at projected costs of more than $5.4 billion annually,[iv] and health care costs are one of the most rapidly growing components of the state budget. The Center for Health Care Purchasing Improvement (CHCPI) was established by the 2006 Legislature with the enactment of Minnesota Statutes, section §43A.312, to "*support the state in its efforts to be a more prudent and efficient purchaser of quality health care services."*

The Center's enabling statute further provides that the Center may undertake a variety of activities with "the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies." These activities include for example:

- "support the Administrative Uniformity Committee under section 62J.50 and other relevant groups or activities to advance agreement on health care administrative process streamlining";
- "initiate projects to develop plan designs for state health care purchasing";
- "contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance".

The CHCPI was initially established and administered as a unit of the Department of Employee Relations (DOER). However, in January, 2007 Governor Pawlenty announced that DOER would be merged with other state agencies. Legislation enacted in 2007 clarified that the "duties relating to health care purchasing improvement under Minnesota Statutes, section 43A.312, are transferred on or before June 1, 2008, to the commissioner of health."[v] The transfer of the Center to the Minnesota Department of Health (MDH) occurred on July 29, 2007, and CHCPI now operates as a section within the MDH Health Policy Division.

The Center is funded through a base appropriation of $130,000. As prescribed in statute, the CHCPI is staffed by a Director, who was appointed in late July, 2006. For a period in 2006 to early 2007, it housed two additional staff. At present, the Center includes the Director and one additional staff member to assist in coordinating and staffing health care administrative simplification efforts described later in this report, and one-third FTE administrative support staff. Personnel, consulting, and other costs in excess of the base appropriation have been funded using additional budget sources.

II. CHCPI OPERATIONS, ACTIVITIES, AND IMPACTS

As described below, the Center's operations, activities, and accomplishments in 2009 were focused in three primary areas:

A. Health Care Administrative Simplification and Savings -- Implementation and Administration of Minnesota Statutes, Section 62J.536 and Related Rules

B. Statutorily required studies and projects

C. Additional health reform and administrative simplification

A. Health Care Administrative Simplification and Savings -- Implementation and Administration of Minnesota Statutes, Section 62J.536 and Related Rules

1. Overview

The Center's primary responsibility in 2009, as in 2008, was to serve as project manager overseeing the adoption, implementation, and administration of first-in-the-nation requirements pursuant to Minnesota Statutes, section 62J.536, for the standard, electronic exchange of health care administrative (business) transactions.

The statute and related rules apply to more than 60,000 health care providers statewide as well as more than 2000 "group purchasers" (payers) licensed or doing business in Minnesota. When fully implemented, the rules will reduce overall health care administrative costs throughout the system by more than $60 million annually[vi], allowing more of every health care dollar to be spent on patient care and health improvements.

The state's policy framework for health care administrative simplification complies with, builds upon, and supplements federal administrative simplification regulations adopted under the Health Insurance Portability and Accountability Act (HIPAA). Minnesota's framework addresses three key challenges in particular that currently contribute to unnecessary health care administrative burdens and costs, as follows.

Three key challenges addressed by Minnesota's health care administrative simplification policy framework:

1) 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 three high volume, important health care business transactions – eligibility verification; claims; payment remittance advices -- be exchanged electronically.*

2) A proliferation of "companion guides" to federal HIPAA transaction standards has resulted in variable, non-standard, more costly transactions.
Current Federal 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 requires a single, uniform companion guide to be used by all providers and all payers (except Medicare) for the exchange of eligibility verification, claims, and payment remittance advices. The three transactions chosen for the single companion guides and electronic exchange represent:*
>
> - *Key transactions within the health care business cycle;*
> - *Common, high volume, high value transactions;*
> - *Potential for savings, especially with improved eligibility information;*
> - *Recognition of industry and federal direction – for example, claims were being widely exchanged electronically and would be important to include.*

3. Many payers are not covered by federal HIPAA data exchange requirements.
Federal HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. As a result, these payers have not been required to follow federal HIPAA rules for the electronic exchange of business transactions. 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.*

A detailed discussion of the rationale for Minnesota's administrative simplification efforts, and a description of the rulemaking process and timelines pursuant to Minnesota Statutes § 62J.536, have been presented in previous annual reports and is provided as Appendix 1 in this report. However, to understand better understand the Center's activities and accomplishments in 2009, it is important to summarize several key requirements and relationships that are presented in more detail in the Appendix, as follow:

- Consultation with the Minnesota Administrative Uniformity Committee (AUC)

  Pursuant to statute, MDH consults in the development of rules for the standard, electronic exchange of health care business data with a large, voluntary stakeholder organization known as the Minnesota Administrative Uniformity Committee (AUC). The pace and scope of the rulemaking is perhaps unprecedented, requiring significant technical input of affected stakeholders, as well as substantial outreach and communication to inform health care providers, payers, and others of the legislation and rules, within a very short timeframe. The rulemaking process has leveraged hundreds of hours of non-state, in-kind expertise across several dozen health care provider, payer, and other technical subject matter experts affiliated with the AUC and interested parties.

- Updates, revisions, and administration of administrative simplification rules

  CHCPI and the AUC developed an additional process to provide for a review of the rules six months after their adoption, but six months before they take the effect of law, for any possible clarifications, technical updates, or changes that may be indicated with preliminary experience and testing of the rules. The Center and the AUC also planned for annual in-depth reviews and maintenance of the rules, as well as any revisions that needed to conform with changes to federal HIPAA transactions and code set regulations.

After successfully meeting extremely tight statutory deadlines for the promulgation of rules in 2008, the Center began administering the rules in 2009, including outreach and technical assistance efforts, and planning and undertaking appropriate compliance and enforcement of the regulations. At the same time, CHCPI successfully completed a series of planned technical updates to the rules, as well as major rule revisions to comply with new federal HIPAA regulations announced in January 2009.

The federal rules require that new versions of standards for the electronic exchange of health care business transactions, known as versions "5010" and "D.0", must be used nationwide no later than January 1, 2012. The Center worked with the AUC in an aggressive rule development process to ensure that Minnesota's final uniform companion guide rules for the new versions of the HIPAA standard will be adopted no later than mid-2010. The timing of Minnesota's rulemaking ensures that statutory and rulemaking requirements are met, and that the industry has sufficient lead time for any system changes and transaction testing that may be need to meet the January 1, 2012 federal compliance date.

A brief summary of the Center's key activities and accomplishments in 2009 for the implementation and administration of Minnesota Statutes, section 62J.536 and related rulemaking is presented below.

2. CHCPI key activities and accomplishments related to implementation and administration of Minnesota Statutes, section 62J.536 and related rulemaking during 2009

The Center's key activities and accomplishments included:

a. In consultation with the AUC, developed/adopted of 12 sets of rules for the standard, electronic exchange of common health care business transactions

- CHCPI coordinated and facilitated the development, review, public comments, and adoption of planned technical changes and updates (rules) for current Claims (837I, 837P, 837D, Pharmacy, Pharmacy Reversal) and Payment Remittance Advice v4010 Minnesota Uniform Companion Guides;
- The Center also coordinated the development, review, and adoption of proposed new version 5010 and D.0 Minnesota Uniform Companion Guides (rules) needed to comply with new federal regulations for Eligibility and Claims (Professional, Institutional, Dental) transactions. It also coordinated development and AUC reviews of proposed version D.0 Pharmacy, Pharmacy Reversal, and version 5010 Payment Remittance Advice Guides (rules). Final adoption of all the version 5010/D.0 rules is scheduled for mid-2010 following a public comment period and a review of any comments.

b. Organized, coordinated, staffed, and facilitated, more than 160 open, public meetings/teleconferences across a wide range of issues and topics

- CHCPI provided coordination, planning, staffing, technical assistance, resources, communications and other support to the AUC and several Technical Advisory Groups (TAGs) and workgroups working simultaneously on updates and major revisions to rules and best practices as part of statewide health care administrative simplification efforts.

c. In consultation with the AUC, developed/adopted 19 additional community-consensus best practices and medical coding clarifications for use by the health care industry

- Best practices do not have the force of rule, but represent community agreement regarding preferred approaches to medical billing, coding, and other administrative issues. CHCPI publishes and maintains the best practices on a website administered on behalf of the AUC. As the best practices become increasingly accepted over time, they may be incorporated in later revisions or updates to the Minnesota Uniform Companion Guide rules.

d. Implemented mandates for seven v4010 Minnesota Uniform Companion Guides (seven sets of rules), including technical assistance, outreach, compliance and enforcement

- CHCPI is responsible for administration and enforcement of uniform companion guide rules pursuant to Minnesota Statutes, section 62J.536. As part of its administration and enforcement efforts in 2009, the Center provided a range of **outreach and technical assistance** to a number of audiences, including:

i. Responses to more than 1500 individual email or telephone inquiries and contacts from health care providers, payers, vendors, state and national organizations, states, and others, to provide information, answer questions, problem solve, and build and maintain relationships;

ii. A survey and follow-up of more than 600 licensed insurance carriers and other health care payers nationally to obtain and post information on an MDH website to facilitate health care providers in making electronic connections with payers and vendors;

iii. Maintenance and regular communications using a gov.delivery list (listserve) of over 2000 subscribers;

iv. Development and wide dissemination of a series of four "Implementation and Compliance Updates" to provide information and clarification regarding Minnesota Statutes, section 62J.536 and related laws, and MDH policies and practices for administering and enforcing the statute;

v. Publication and dissemination of press releases; interviews with the trade and general news media; materials for newsletters and other publications.

vi. Development and maintenance of two websites. One website is focused on AUC activities, updates, and communications (www.health.state.mn.us/auc) while the other provides additional information regarding Minnesota's administrative simplification statue and rules, compliance and enforcement, and other related information (www.health.state.mn.us/asa).

vii. Development and implementation of a standard, consistent approach, document templates, website information, and record keeping for administration, complaint investigation, and enforcement of Minnesota Uniform Companion Guide rules.

B. Statutorily required studies and projects

CHCPI was also responsible for carrying out several studies, development projects, and reports in 2009 as required by statute and as briefly summarized below.

1. Electronic drug prior authorization standardization and transmission, pursuant to Minnesota Statutes, section 62J.497, Subd. 5

The above statute was enacted during the 2009 legislative session in response to concerns regarding administrative burdens and costs associated with the current prescription drug prior authorization (PA) process. The Center organized, coordinated, and completed development of a direct data website portal concept to facilitate drug prior authorization requests per statute. The work was undertaken in consultation with the AUC, the Minnesota e-Health Advisory Committee, and a stakeholder/interested parties advisory group, including representatives of national pharmacy payers and the national pharmacy transactions standard setting body, the National Council for Prescription Drug Plans (NCPDP).

Prescription drug prior authorizations are required of prescribers, and in some cases pharmacies, by group purchasers (payers) in order that patients may receive particular prescription drugs. While prescription drugs requiring prior authorization make up only a small fraction of all prescribed medications,[vii] PA is a "widely adopted method of drug utilization management"[viii] and the majority of prescribers submit PA requests.[ix] Both the number of drugs requiring prior authorization and the number of PAs have grown rapidly in recent years.[x] Despite its growing visibility and importance, the drug prior authorization process is often manual and nonstandard, creating administrative burdens and costs to health care providers and payers.[xi] It also may result in patients experiencing delays in getting prescriptions filled, or foregoing medications, leading to potentially adverse health impacts as well.[xii]

The Center also contracted with an outside consultant to assist the development process, and a final project report was prepared and to submitted to the Legislature to meet a February 15, 2010 deadline. The project report describes limitations of current available PA transactions and provides specifications for a standard prescription drug PA website or online fillable form to facilitate more standard exchanges of PA requests. Both the Uniform Formulary Exception Form described below and the PA request form have much in common, and plans are underway to merge the two as a single, combined form.

2. Uniform Formulary Exception Form (UFEF), pursuant to Minnesota Statutes, section 62J.497, Subd. 4

   CHCPI organized, coordinated, and completed development of the UFEF per statute, in consultation with the AUC and other state and national stakeholders. Requests for exceptions from group purchaser formularies are requests to make nonformulary prescription drugs available to a patient. The Minnesota Uniform Formulary Exception Form is required to be made available pursuant to Minnesota Statutes, section 62J.497, subd. and is the single form to be used by health care providers to request exceptions from group purchaser (payer) formularies. The UFEF is available at http://www.health.state.mn.us/asa/form.html.

3. Uniform Claims Review Process, pursuant to Chapter 358, Article 4, Section 13, 2008 Minnesota Laws

The Center organized, coordinated, and completed large portion of a study of a uniform health care claims review process pursuant to Chapter 358, Article 4, Section 13, of 2008 Minnesota Laws. The study charge was to "make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers."

The study was undertaken in consultation with the AUC, the Minnesota Medical Association, and the Minnesota Hospital Association pursuant to the statute. A final report is being prepared for the Commissioner of Health pursuant to the study charge.

4. Study of the feasibility of and barriers to simplifying health care administrative transactions through electronic data interchange, pursuant to Chapter 155, Section 1, 2009 Minnesota Laws

   CHCPI is consulting with the AUC and the Department of Human Services in a study project to make "recommendations regarding the feasibility of and barriers to establishing a single, standardized system for all group purchasers for health care administrative transactions and notification, preauthorization, or service notification, and retroactive denial through electronic data interchange, identifying a range of potential technologies to accomplish this purpose." In addition, the study is to consider relationships and priorities of any potential technologies with other specified administrative simplification and health care information technology (HIT) initiatives and requirements.

   The Center has undertaken initial planning and information collection, with more focused study activity scheduled for later in 2010. A completion date for the study was not specified in statute.

5. Biennial review of rulemaking procedures and rules, pursuant to Minnesota Statutes, section 62J.61, Subd. 5

   CHCPI organized, coordinated, and completed the biennial study of rulemaking procedures under Minnesota Statutes, section 62J.61. The study required a public meeting and the opportunity to submit public comments. The AUC unanimously approved a resolution expressing its support for and the importance of, the biennial rulemaking procedures and rules pursuant to Minnesota Statutes, section 62J.61; no other comments were received. The study report with the resolution was delivered to the AUC on January 12, 2010 pursuant to statutory requirements.

6. Annual report and update on maximum charges for patient records, pursuant to Minnesota Statutes section 144.292, Subd. 6

   Minnesota Statutes section 144.292, Subd. 6 requires MDH to publish maximum charges that providers can charge for providing copies of patient records. The

maximum charges are to be set each year, based on changes in the consumer price index for all urban consumers, Minneapolis-St. Paul (CPI-U), published by the U.S. Department of Labor. The Center calculates, publishes, and disseminates the annual changes to maximum charges for patient records in March.

C. Additional health reform and administrative simplification

CHCPI contributed to a variety of other health reform activities in 2009, including:

1. Development of MDH legislative policy proposal to bring about greater regulatory oversight of health care clearinghouses.

   Health care providers and payers often use vendors and intermediaries known as "clearinghouses" to help them translate and/or exchange the electronic health crae administrative transactions required under Minnesota Statues 62J.536 and described previously in this report. Most clearinghouses comply with industry best practices, but recent experience exposed clearinghouse practices that are barriers to the timely, efficient exchange of routine administrative transactions. CHCPI assisted in the development of an MDH legislative proposal to ensure that health care clearinghouses comply with industry best practices and meet the same requirements as health care providers and payers when exchanging administrative transactions. (The proposal was subsequently enacted as 2010 Laws of Minnesota, Chapter 243--S.F.No. 2852.)

2. In consultation with the AUC, provided recommended interim coding for five levels of patient complexity to be used as part of "medical home" payment and assisted in requests for new permanent national codes for five levels of patient complexity.

   Minnesota Statutes, section 256B.0751 requires development of certification and payment of "health care homes", also called "medical homes". The health care home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. CHCPI coordinated a workgroup process and contributed to recommendations for interim coding for medical home billing and reimbursement purposes. It also participated in follow-up requests for permanent national coding changes to meet Minnesota's requirements.

3. Participated with the AUC in advising MDH on billing and coding for "baskets of care".

   Minnesota Statutes, section 62U.05 authorizes pricing for bundled medical services known as "baskets of care". The concept of baskets of care seeks to bundle payments for a set of health care services together in ways that will create incentives for health care providers to cooperate and develop innovative ways to improve health care quality and reduce costs. A "basket" or "baskets of care" is defined as a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient. Each basket of care will be a "product" that consumers will be

able to purchase. This product will need to balance uniformity for purposes of consistency and comparability with the ability of providers and payers to be innovative in providing effective, high quality and lower-cost care. The Center participated with AUC members in advising MDH and a related advisory group and consultants on issues regarding common billing and coding for baskets of care.

4. Presentation at a national conference for the pharmacy industry in Dallas, Texas regarding Minnesota's administrative simplification and other health reform initiatives.

   CHCPI presented at a national conference organized by the recognized standards setting organization for the electronic exchange of pharmacy data, the National Council for Prescription Drug Programs (NCPDP), regarding Minnesota's administrative simplification efforts and other state health care reforms.

5. Providing information and updates regarding Minnesota's administrative simplification efforts to other state government representatives from Oregon and Georgia, as well as other health care provider, payer, electronic transactions standards setting, and other organizations.

   The Center has responded to several requests from other states and national organizations for information, updates, and additional background regarding Minnesota's administrative simplification efforts and activities. The Center is continuing to develop relationships with these groups and sharing of information and ideas.

6. Providing information and suggestions to Minnesota congressional delegation staff regarding the state's administrative simplification efforts in response to requests for information made by congressional staff researching issues during the 2009 national health reform debate.

   CHCPI was contacted by Minnesota congressional delegation staff during 2009 national health reform debates regarding the state's health care administrative simplification efforts. The Center provided background and updates regarding Minnesota's efforts and accomplishments.

III. Anticipated Center Activities and Priorities for 2010

At this time, it is anticipated that the Center will likely be undertaking the following for 2010:

1. Continued development and completion of projects identified above, including adoption of final rules for new version 5010 and D.0 rules for administrative simplification, statutorily required studies, and other projects;

2. Reviewing, analyzing, and responding to possible federal health reforms;

Note: President Obama signed the Patient Protection and Affordable Care Act in March, 2010. The Act includes a section on Administrative Simplification, with requirements and timelines for the Secretary of the federal department of Health and Human Services to adopt "operating rules" and other standards for the electronic exchange of several common, important health care business transactions in intervals over the period 2011 – 2016. The potential scope and content of the federal rules is uncertain at this time, but will have potentially significant implications for Minnesota's administrative simplification efforts. The Center will continue to serve as a key state resource in planning, coordinating, and assisting Minnesota's response and integration with the federal administrative simplification initiative in 2010, as well as provide additional review and response to other aspects of the federal health care legislation.

3. Reviewing and responding to possible state legislation, including any studies or development projects, as well as to any action on a legislative proposal to include health care clearinghouses under the Administrative Simplification Act, and other health reforms;

   Note: Minnesota Session Laws 2010, Chapter 243 – SF No. 2852, was enacted in April, 2010. The law extends requirements of the Administrative Simplification Act (Minnesota Statutes, sections 62J.50-61), including implementation and compliance, to intermediaries in the exchange of standard, electronic health care business transactions, known as "clearinghouses". The law requires that providers, payers, and clearinghouses must exchange standard "acknowledgements" beginning in 2012. (Acknowledgements are analogous to receipts. This provision of the law will ensure that transactions arrive at their intended destination and are not lost.) The law also clarifies fees that clearinghouses may charge, and requires that clearinghouses track electronic transactions. In addition, clearinghouses must report certain types of information when requested, and must be willing to connect electronically to other clearinghouses to assure that business transactions can be effectively and efficiently be relayed and processed.

   CHCPI will be working with the AUC to coordinate the development of single, uniform companion guide rules for each of four acknowledgement types required by law. The rules must be developed, formally proposed, receive public review and comment, revised as necessary following public comment, and formally adopted, no later than December 31, 2010.

   The Center will also be communicating with clearinghouses in Minnesota and nationally regarding the new requirements and will continue to be responsible for administrating the law, including compliance and enforcement.

4. Assisting the AUC in responding to anticipated federal rules regarding standards for electronic health records and related capabilities for exchanging administrative transactions;

Note: The U.S. Department of Health and Human Services issued proposed and interim rules in January, 2010 regarding standards for electronic health records to qualify for "meaningful use" payments to health care providers. CHCPI assisted the AUC in reviewing and responding to the rules during a formal public comment period. The Center will assist the AUC in responding to other opportunities for public review and comment should additional relevant federal rules be announced in 2010.

5. Developing and providing additional outreach, communications, and technical assistance to aid awareness and compliance with the rules for standard, electronic health care transactions;

6. Continued development and refinement of "best practices" to help reduce administrative burdens and costs;

7. Continued integration and coordination with other health care reform efforts;

   The CHCPI will continue to work with other MDH units and the AUC to coordinate the rulemaking for standard, electronic health care transactions with other health care reform efforts, including e-health initiatives and other improvements in health care cost and quality. In particular, these efforts will be targeted to address key operational and implementation questions about billing and coding of new types of services, harmonization of standards, and other related questions.

8. Continued outreach and communications at the local, regional, and national levels regarding health care administrative simplification, health care purchasing, and health care reform.

   CHCPI will continue to provide communications, outreach, and exchange of best practices and experiences regarding health care reforms and innovations.

Appendix 1
Summary Overview of Minnesota Health Care Administrative Simplification Pursuant to Minnesota Statutes, section 62J.536

Overview and rationale

Health care has lagged far behind the financial, transportation, and other sectors of the economy in its use of efficient, effective, standard electronic exchanges of routine business transactions. The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient, much more burdensome, and much more costly to the health care system.

Studies have shown that exchanging common health care administrative transactions on paper, or in nonstandard formats, is more expensive than standard, electronic data exchanges and can result in problems of incomplete or incorrect information that cause delays and further expense. One recent national study estimated that the costs of processing paper health care claims (billings) at $1.58 per claim, or nearly double the cost of electronic billings, at 85 cents per claim.[xiii] A 2006 report estimated that between $15.5 and $21.8 million is spent annually in Minnesota for follow-up telephone calls between health care providers and payers to resolve questions related to patient eligibility for insurance coverage and benefits and health care claims.[xiv]

Because routine administrative transactions such as checking patient eligibility for benefits, submitting bills for services, or making payments to providers occur every minute, every day, millions of times each year, even small inefficiencies add up to be significant costs and drags on health system productivity. As described below, the CHCPI is playing an important role in implementing requirements that administrative transactions be exchanged electronically, using a standard data content and format, to reduce overall administrative costs in Minnesota's health care system by more than $60 million per year by 2013.[xv] In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to achieving other goals for health care performance measurement and improved patient care.

In late 2006 the CHCPI responded to interests on the part of Governor Pawlenty's Health Cabinet to explore opportunities for rapidly aligning efforts to streamline and simplify routine health care administrative transactions. In December 2006, the Center planned and staffed a site visit to a promising example of alignment for health care administrative simplification in Utah, known as the Utah Health Information Network (UHIN). Minnesota's site visit delegation included nearly twenty state and private sector representatives, which met with a similar large contingent from UHIN for two days of discussion and information exchange.

The site visit led to broader discussions and momentum for changes in Minnesota to accelerate health care administrative simplification and standardization efforts. That interest culminated in the 2007 legislative session with passage of Minnesota Statutes, section 62J. 536 -- first-in-the-nation legislation requiring that all health care providers

and group purchasers (payers) exchange three types of common health care business transactions electronically, using a single, uniform data content and format, by 2009. The statute effectively addresses three root causes of unnecessary health care administrative costs and burdens as presented below.

Three key challenges addressed by Minnesota's health care administrative simplification policy framework:

1. 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 three high volume, important health care business transactions – eligibility verification; claims; payment remittance advices -- be exchanged electronically.*

2. A proliferation of "companion guides" to federal HIPAA transaction standards has resulted in variable, non-standard, more costly transactions.
Current Federal 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 requires a single, uniform companion guide to be used by all providers and all payers (except Medicare) for the exchange of eligibility verification, claims, and payment remittance advices. The three transactions chosen for the single companion guides and electronic exchange represent:*
  - *Key transactions within the health care business cycle;*
  - *Common, high volume, high value transactions;*
  - *Potential for savings, especially with improved eligibility information;*
  - *Recognition of industry and federal direction – for example, claims were being widely exchanged electronically and would be important to include.*

3. Many payers are not covered by federal HIPAA data exchange requirements.
Federal HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. As a result, these payers have not been required to follow federal HIPAA rules for the electronic exchange of business transactions. 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.*

Minnesota Statutes, section 62J.536 rulemaking timelines and process

a) Rules Timeline

Minnesota Statutes, section 62J.536 further requires that the Minnesota Department of Health (MDH) adopt rules for the data content and format standards to be used in the exchange of the administrative transactions. The rules are to be promulgated at least one year in advance of the dates that they take the effect of law, as shown in the table below.

Health care transaction	Rule Promulgation Deadline	Rule Implementation (Rule has the force of law)
Eligibility Inquiry and Response	January 15, 2008	January 15, 2009
Claims	July 15, 2008	July 15, 2009
Payment remittance advice	December 15, 2008	December 15, 2009

b) Rules are based on federal HIPAA regulations and Medicare, in consultation with large stakeholder group, the Minnesota Administrative Uniformity Committee (AUC)

The statute further specifies that the rules be based on federal Health Insurance Portability and Accountability Act (HIPAA)[xvi] transactions and code sets requirements and the Medicare program, with modifications the Commissioner of Health finds appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC). The AUC is a broad-based, voluntary group representing Minnesota's public and private health care payers, hospitals, health care providers and state agencies. It has served since 1992 to develop agreement among payers and providers on standardized administrative processes. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. It meets as a large committee of the whole, as well as through numerous work groups and Technical Advisory Groups (TAGs). The work groups and TAGs reflect particular areas of expertise and divisions of labor with respect to different types of health care administrative transactions and processes.

c) Rule development and administration provides for systematic rule updates

In addition to the statutory rule development and implementation deadlines above, CHCPI and the AUC developed an additional process to provide for a review of the rules six months after their adoption, but six months before they take the effect of law, for any possible clarifications, technical updates, or changes that may be indicated with

preliminary experience and testing of the rules. The Center and the AUC also planned for annual in-depth reviews and maintenance of the rules, as well as any revisions that may be needed to conform with changes to federal HIPAA transactions and code set regulations.

Endnotes

[i] Sources:
Personal communications, Minnesota Department of Human Services (DHS) and Minnesota Department of Management and Budget (MMB), 2010. DHS reported projected FY2010 average enrollment in Medical Assistance Basic Care and MinnesotaCare at 750,000, with total payments of $4.8 billion. MMB reported enrollment of 118,000 and over $.6 billion annual costs for the health insurance component of the State Employee Group Insurance Program (SEGIP).

[ii] See for example reports and studies such as Crossing the Quality Chasm: A New Health System for the 21st Century , Institute of Medicine, 2001 at http://www.nap.edu/openbook.php?isbn=0309072808; Report of the Minnesota Citizens Forum on Health Care Costs, February 2004 at: http://www.minnesotahealthinfo.org/other/citizensforum.pdf and resource material provided as part of the Governor's Health Care Transformation Task Force at: http://www.health.state.mn.us/divs/hpsc/hep/transform.

[iii] Preliminary estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), January, 2008.

[iv] Sources: See endnote i above.

[v] Minnesota Session Laws, 2007 Regular Session, Chapter 148, Article 2, Sec. 80.

[vi] Preliminary estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), January, 2008.

[vii] National Committee on Vital and Health Statistics (NCVHS) letter to Tommy Thompson, Secretary, US Department of Health and Human Services, Sept. 2, 2004. Accessed at: http://www.ncvhs.hhs.gov/040902lt2.htm.
The letter reported that "It is estimated that 2 percent of prescriptions now require prior authorization."

[viii] Wegner, et. al. A Physician-Friendly Alternative to Prior Authorization for Prescription Drugs. American Journal of Managed Care. 2009;15(12):e115-e122). Accessed at http://www.ajmc.com/articles/managed-care/2009/2009-12-vol15-n12/AJMC_decWegnerWbX_e115finl.

[ix] Source: Current State of E-Prescribing Standards: Electronic Prior Authorization (ePA). February 5, 2008. Tony Schueth, Task Group Leader, NCPDPD (Multi-SDO) Prior Authorization Workflow-to-Transactions Task Group, CEO & Managing Partner, Point-of-Care Partners, LLC and Jon White, M.D., Director of Health Information Technology, AHRQ Center for Primary Care, Prevention, and Clinical Partnerships. (Presentation slides, accessed at: http://healthit.ahrq.gov/images/erx_meeting_20080218/attachment4/attachment4_files/textonly/slide9.html. Slide 9 states that: "Findings from 2004 PDR online survey (n=3,529):63% of prescribers write some Rxs that require PA")

[x] Source: Current State of E-Prescribing Standards: Electronic Prior Authorization (ePA). February 5, 2008. (Presentation slides, accessed at http://healthit.ahrq.gov/images/erx_meeting_20080218/attachment4/attachment4_files/textonly/slide8.html. See slide 8.)

[xi] See for example: Current State of E-Prescribing Standards: Electronic Prior Authorization (ePA) (cited above, see slides 9-12). See also: Balkrishnan, R., et al. Prior Authorization of Newer Insomnia Medications in Managed Care: Is It Cost Saving?".J Clin Sleep Med. 2007 June 15; 3(4) 393-398. Accessed at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1978307/. See also Wegner, SE, et. al. A Physician-Friendly Alternative to Prior Authorization for Prescription Drugs. The American Journal of

Managed Care. Volume 15, Number 12, December 2009. e115-3-121. Accessed online 1/29/10 at: http://www.ajmc.com/articles/managed-care/2009/2009-12-vol15-n12/AJMC_decWegnerWbX_e115finl

[xii] Wegner, SE, et. al. A Physician-Friendly Alternative to Prior Authorization for Prescription Drugs. The American Journal of Managed Care. Volume 15, Number 12, December 2009. e115-3-121. Accessed online 1/29/10 at: http://www.ajmc.com/articles/managed-care/2009/2009-12-vol15-n12/AJMC_decWegnerWbX_e115finl. See also
Balkrishnan, R., et al. Prior Authorization of Newer Insomnia Medications in Managed Care: Is It Cost Saving?". J Clin Sleep Med. 2007 June 15; 3(4) 393-398.

[xiii] Source: An Updated Survey of Health Care Claims Receipt and Processing Times, May, 2006. AHIP Center for Policy and Research at http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

[xiv] "2006 Administrative Simplification Project – Project Documentation. Nov. 10, 2006".

[xv] Preliminary estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), January, 2008.

[xvi] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for: maintenance of health insurance coverage after leaving an employer; and standards for health-care-related electronic transactions. While HIPAA provided important standardization of electronic health care transactions, it did not address all standardization issues. Requirements of Minnesota Statues, section 62J.536 further harmonize and clarify HIPAA standards, for group purchasers and health care providers to exchange health care administrative transactions electronically.