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Center for Health Care Purchasing Improvement (CHCPI) Annual Report

January - December 2012

Minnesota Department of Health
Report to the Minnesota Legislature
June 2013

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Protecting, maintaining and improving the health of all Minnesotans

June 27, 2013

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 2012 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 2012 as well as preliminary planning considerations for 2013.

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 Minnesota'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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Center for Health Care Purchasing Improvement (CHCPI) Annual Report, January – December 2012

Executive Summary

Introduction and overview

CHCPI coordinates a statutory, statewide initiative to reduce the costs and burdens associated with exchanges of common health care business (administrative) transactions such as billings and remittances. The initiative is an important, integral part of broader health care reforms because the health care system is transaction-intensive and increasingly data driven. Achieving even modest efficiency gains through greater use of "e-billing" and "e-commerce" across a large volume of routine business activity will result in an estimated annual savings to the state's health care system of $40 million to $60 million.[i] Moreover, the accurate, efficient exchange of health care business data is foundational for achieving other health reform goals, including improving patient care and outcomes.

CHCPI works closely with the health care industry, and in particular, a voluntary stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC), in developing and administering rules to promote more standard, automated, efficient exchanges of health care business data. It is responsible for providing technical assistance to help comply with the rules, enforcement, and coordination with other state agencies on related issues. CHCPI also serves as a participant in and liaison to federal and national health care administrative simplification efforts.

2012 activities and accomplishments

As described in more detail in the body of the report, in 2012 CHCPI:

- Revised and updated seven sets of state rules in consultation with the AUC, to ensure conformance with complementary federal requirements and use of best practices. As part of the rulemaking process, CHCPI planned, staffed, and conducted more than 50 open public meetings and reviewed comments from public comment periods;
- Provided technical assistance in responding to more than 250 inquiries and questions. In addition, CHCPI collaborated with the AUC and industry stakeholders in developing best practices and medical coding clarifications for use throughout the industry;
- Undertook joint administrative simplification compliance reviews and follow-up with the Minnesota Department of Labor and Industry (DLI) regarding workers compensation medical claims and other business data that was not being exchanged electronically per state statute; and
- Coordinated AUC responses to proposed applicable federal rules and national standards. CHCPI also served as a member of a small, select national committee charged with recommending an appropriate governance structure for an industry-wide health care standard-setting organization known as the Committee on Operating Rules for Information Exchange (CORE).

Because of its substantial contributions and active partnership with the state, Governor Dayton proclaimed February 21, 2012, as "AUC Day" in Minnesota.

Plans and next steps for 2013

In 2012 CHCPI also began developing a series of AUC strategic planning sessions to be conducted in 2013 to: capitalize on progress and successes to date; address ongoing needs; and adapt to rapid, dramatic changes and demands on the health care industry. The planning will address:

- Continuing administration, updates, and refinements of existing rules for standard, electronic exchange of routine health care business transactions;
- Meeting needs for technical assistance and assuring compliance, with particular attention to identifying the largest achievement and performance gaps, and conducting "root cause analysis" to help understand reasons for the gaps and to take steps to address them;
- Broader sharing with other states and nationally of lessons learned, best practices, and ongoing, common challenges;
- Setting priorities to meet administrative simplification goals during a time of rapid, often unprecedented changes and competing demands on the health care industry, including:
    - Transition to a complex, much more detailed, more robust new version of an international medical diagnoses coding system known as "ICD-10." By way of comparison, some industry analysts have reported that the information technology (IT) preparations needed for ICD-10 will require a level of effort similar to what was needed to address Y2K computer issues in 2000;
    - Implementing new administrative simplification transactions standards and federal operating rules mandated by the federal Patient Protection and Accountable Care Act (ACA) that supplement existing federal transaction standards and code set rules adopted pursuant to the Health Insurance Portability and Accountability Act (HIPPA);
    - Adopting and demonstrating meaningful use of electronic health records (EHRs) in order to receive federal financial incentives and to avoid payment reductions;
    - Learning about and implementing a new national Health Plan Identifier (HPID) for exchanges of electronic business data in which a health plan must be identified;
    - Planning for and adapting to health coverage expansions under the ACA;
    - Transitioning to a new market structure with the implementation of health insurance exchanges; and
    - Implementing new integrated health care delivery and financing models such as "Accountable Care Organizations (ACOs)" and "health care homes."
- Additional new projects and responsibilities, including fulfilling requirements in Minnesota Statutes, 62J.497 by January 1, 2014, for the development of a guide to aid the implementation of an emerging new national standard to automate prior authorization (PA) requests for prescription drugs.

Center for Health Care Purchasing Improvement (CHCPI)

Annual Report
January – December 2012

Introduction and Overview

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January to December 2012 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63.

CHCPI is part of the Health Policy Division of the Minnesota Department of Health (MDH), and is authorized in statute to coordinate state efforts to reduce the costs and burdens associated with the exchange of routine health care business (administrative) transactions. This health reform goal – known as "administrative simplification" – is important because health care is a highly transaction-intensive enterprise, with millions of billings, payments, and other common business-related exchanges in Minnesota each year. For example, Minnesota's health plans reported processing over 52 million billings (claims) in 2012 alone,[ii] a number that is projected to increase with a growing and aging population using more medical services. Despite the considerable volume of routine business exchanges and its expense, many transactions are often still manual, paper-based, and unnecessarily costly. In addition, improving the flow and accuracy of health care business data is integral to not only reducing health care administrative costs, but to also achieving other health reform goals, including improvements in care delivery and quality.

Minnesota Statutes, section 62J.536 was enacted in 2007 to accelerate the transition of health care business transactions to less costly, more automated, computer-to-computer electronic data interchange (EDI). The law requires that specified high-volume business communications must be exchanged electronically using a standard data content and format adopted into state rules by MDH. Achieving even small efficiency improvements from greater use of EDI-based "e-billing" and "e-commerce" is projected to save $40 to $60 million dollars annually across the state's health care system, permitting more of every health care dollar to be spent on patient care and health improvements.

CHCPI was selected in mid-2007 to manage the ongoing adoption and oversight of the administrative simplification rules, which apply to more than 60,000 health care providers in Minnesota and more than 2,000 insurance carriers and other health care payers and intermediaries nationwide. Minnesota's efforts operate in tandem with, and are complementary to, federal health care administrative simplification requirements and standards. These include federal transactions and code sets regulations adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), as well as more recent provisions of the federal Patient Protection and Accountable Care Act (ACA) designed to accelerate the adoption and use of EDI in health care business processes. As applicable federal regulations and national

standards are adopted or changed, Minnesota's rules must also be reviewed and revised to ensure conformance with federal law and industry best practices.

CHCPI continues to lead and coordinate the state's health care administrative simplification initiative, including: development and administration of rules to standardize and automate health care business data; providing technical assistance to help health care providers, payers, and others implement the rules; assuring compliance with and enforcement of regulations; responding to and participating with policymakers and the policy process on health care administrative simplification issues; and serving as a participant, liaison, and contributor to national and federal administrative simplification efforts.

CHCPI works closely in partnership with the health care industry and stakeholders, particularly the Minnesota Administrative Uniformity Committee (AUC), a large, voluntary organization of health care providers, payers, health care associations, and state agencies working together to reduce health care administrative costs and burdens. CHCPI coordinates and staffs the AUC committee of the whole as well as several AUC workgroups known as "Technical Advisory Groups" (TAGs) that bring together subject matter experts with interests and expertise in particular business transactions and topics. This division of labor is important to rulemaking to ensure that relevant experts and interested parties are aware of and involved in the process. It is also important to help identify and address any problems or questions in implementing and complying with the rules. Because of its substantial contributions and active partnership with the state, Governor Dayton proclaimed February 21, 2012, as "AUC Day" in Minnesota.

Appendix A provides additional background and detail regarding Minnesota's health care administrative simplification initiative. Appendix B lists the AUC member organizations.

CHCPI Key Activities and Accomplishments in 2012

In 2012 CHCPI actively led and coordinated a variety of ongoing activities as summarized below, including:

- Rulemaking;
- Technical assistance;
- Enforcement;
- Participation in national level health care administrative simplification; and
- Planning for next steps and phases.

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" to assure that key business transactions crucial to all aspects of health care financial management and data reporting are exchanged electronically, according to well-defined, detailed standards for greatest efficiency, accuracy, and reliability. These state rules are intentionally designed to be aligned with complementary federal

regulations and national standards. 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.

CHCPI led and coordinated an open, public rulemaking process throughout 2012 to revise and update the state's rules to assure that they remained accurate, relevant, and in conformance with federal requirements and changes at the national level. As part of the process, CHCPI provided staff support, logistics, planning, research, outreach, communications, and facilitation for over 50 open public meetings of the AUC and relevant TAGs. As shown in table 1 below, six sets of revised rules were developed and proposed in 2012. One set of rules was also adopted in 2012 following a required public comment period, with the remaining proposed rules scheduled for public comment periods, review of the comments, and adoption of final rules in 2013. The rule revisions addressed state conformance with federal operating rules mandated by the ACA and reflected other national and state changes in medical service coding used in billing. In addition, the rules were also reformatted and reorganized to be shorter and easier to understand.

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

Health care transaction	Description/purpose	Most recent rule updates/revisions
Claims	Claims are bills submitted by health care providers for health care services and products to third party payers (insurers). 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 late 2012, for adoption in early 2013.
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 August 2012 and adopted in October 2012.
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 proposed in late 2012, for adoption in 2013.
Acknowl-edgments	Acknowledgments serve as receipts showing whether a transaction was received at a destination point, and, depending on the type of acknowledgment, provide additional information that may be needed to identify and correct errors or mistakes in the transaction.	Rule revisions and updates for a type of acknowledgment known formally as the "Health Care Claim Acknowledgment (277)" were developed and proposed in 2012, for adoption in 2013.

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 2012 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 2012 CHCPI:

- Responded to over 250 individual requests from providers, payers, and others for information, clarification, referrals to other agencies or organizations, or other technical assistance;
- Researched, staffed, and facilitated special topics meetings for the AUC and the industry more generally, including a review and discussion of the federal Centers for Medicare & Medicaid Services (CMS) proposed rule for a single, national health plan identifier (HPID), and subsequent AUC response to CMS regarding the HPID rule;
- Staffed and facilitated AUC TAGs on the development and maintenance of best practices, including:
  - The Medical Code TAG's "coding clarification grid" with information and best practice recommendations for new, complex, and controversial medical coding issues. For example, the grid will provide instructions for medical billing codes to be used for several types of health care services, including: a recent demonstration project to provide community-based alternatives for persons of all ages and disability groups who reside in Medical Assistance (Medicaid)-funded institutional settings; dental services performed in the operating room; and services provided by recently established "community paramedics;"
  - Development of a detailed, illustrated interactive tutorial and best practice with the Acknowledgement TAG that explains the types of acknowledgements to be used in a variety of scenarios. This resource will help ensure that when transactions such as billings or remittances are exchanged that the receiving parties respond with an appropriate acknowledgment indicating whether the transactions were received and other information. This permits transactions to be tracked, and facilitates more rapid identification of and responses to any data exchange problems;
  - Ongoing joint collaborations between the AUC, the Minnesota Department of Human Services (DHS), which is responsible for administering the state Medical Assistance (MA

- Medicaid) program, and CHCPI, to address medical coding and billing issues for a number of new services to be covered by MA. For example, coding recommendations were developed for special programs to provide more preventive care and case management for frequent users of hospital emergency rooms, and to help those transitioning from institutional care settings to other settings.

Compliance and enforcement

CHCPI is responsible for compliance and enforcement of Minnesota Statutes, section 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." The law specifies that MDH:

- Will seek voluntary compliance to the extent practicable;
- Is authorized to investigate complaints of noncompliance;
- Will attempt 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.

In 2012 CHCPI's primary compliance and enforcement efforts were undertaken jointly with the Minnesota Department of Labor and Industry (DLI), which administers the state's workers' compensation system. The collaboration arose 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.[1]

In mid-2012 DLI responded to concerns and complaints regarding health care providers who were not submitting workers' compensation claims to payers electronically as required by Minnesota law, and brought the issue to the attention of MDH. CHCPI and DLI then collaborated in compliance reviews with several health care provider organizations, including face to face meetings with the organizations, and additional investigation and fact finding pursuant to guidelines in MS §62J.536. Pursuant to statute, CHCPI and DLI issued joint corrective action plans to several organizations in the fall of 2012 to take remedial action to become compliant and to informally resolve any violations.

CHCPI and DLI continue to monitor progress on the corrective action plans and to provide technical assistance to assure compliance. These efforts will also apply to other parties as necessary to ensure that enforcement is applied equally and fairly. While the joint enforcement

[1] While workers' compensation medical claims account for a small proportion of the total volume of medical billings in the health care system, medical claims are a major cost in the workers' compensation system, and a significant focus of injured workers, health care providers, insurers, and DLI. DLI participates as a member of the AUC and in advancing "e-billing" of workers' compensation medical claims to ensure that the submission and payment of the claims is accurate and efficient.

initially focused on health care providers, the investigations showed that providers were sometimes noncompliant as a result of their trading partners who were not providing information or taking actions needed to establish electronic connections, or who were themselves possibly not yet in compliance with the law. As a result, we will be undertaking any additional compliance reviews and follow-up with payers and other parties as needed.

Participation in national-level health care administrative simplification

CHCPI monitors and participates in national-level health care administrative simplification in order to: be informed of potential changes affecting Minnesota's efforts; share information regarding Minnesota's efforts and experience with the broadest range of stakeholders and experts; and contribute to national discussions, problem solving, and innovations. CHCPI remains engaged nationally through: membership and participation in a number of well-recognized standards setting and advisory groups; partnerships with the AUC and state agencies to submit comments regarding federal rules, national standards, and other requests for comments and testimony; networking and contacts with other state and national groups; and outreach and communications through a large list-serve, website postings, and other communications.

More specifically, in 2012 CHCPI:

- Served as a representative of other state governments on a select 13-member transition committee to the national Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH-CORE). CORE is the national organization responsible for recommending federal operating rules that are mandated by the ACA and are intended to provide additional specificity and direction to existing HIPAA transactions and code sets regulations. The transition committee recommended a new governance model consistent with CORE's responsibilities and to ensure that CORE activities and processes are appropriately representative and inclusive of stakeholders and interested parties. The new governance model will be adopted and implemented in 2013.
- Staffed and facilitated the AUC in submitting comments solicited by the Accredited Standards Committee (ASC) X12, a federally designated national health care standards setting organization, regarding a proposed new version of the current HIPAA designated standards for health care business transactions.
- Staffed the AUC in responding to CMS's notice of proposed rulemaking for creation of a national Health Plan Identifier (HPID) that must be used in all HIPAA health care business transactions no later than 2016. The goal of the HPID is to meet a fundamental requirement for the electronic exchange of health care business transactions with a single, standard method to identify the health plan (payer). The AUC's response to CMS noted a number of key issues and questions to be addressed. CMS subsequently adopted a final HPID rule in September 2012, but many questions about implementing it in practice remain unresolved. The AUC will be developing plans for reviewing the HPID rule and its implementation in more detail as part of its 2013 work plan.
- Served as a member of and participant in several other national health care administrative transaction standards setting and/or advisory groups including: ASC X12; National Council for Prescription Drug Programs (NCPDP); and the Workgroup for Electronic Data

Interchange (WEDI). CHCPI shares developments at the national level with the AUC and other stakeholders; contributes information, updates, and perspectives to the national process; and remains informed of and engaged in national and federal regulations and standard setting affecting Minnesota.

- Regularly communicated via an email distribution list with over 2,900 interested parties nationwide, as well as through other more targeted communications.

Planning for next steps

In 2012 CHCPI also began developing a series of AUC strategic planning sessions to be conducted in early 2013 to: capitalize on progress and successes to date; address ongoing needs; and adapt to rapid, dramatic changes and demands on the health care industry. In particular, CHCPI and its partners will need to consider:

- Current responsibilities for maintaining and administering existing rules;
- Responding to and leading new initiatives or responsibilities arising from state legislation and executive branch direction;
- Setting priorities, especially given a number of industry objectives and requirements that will compete for similar, limited resources also needed to advance administrative simplification;
- Identifying and closing gaps between larger, better resourced early adopters of health care e-commerce and others who lag behind; and
- Continuing to integrate and expand Minnesota's efforts with other states, national organizations, and federal initiatives.

The backdrop for this planning is generally positive, if somewhat uneven. For example, since the passage of MS §62J.536 in 2007 and adoption of related rules, Minnesota has taken significant strides in automating health care claims. The Minnesota Council of Health Plans, an association of licensed, regional nonprofit health care organizations, reported that approximately 83% of medical claims were received electronically by Minnesota health plans in 2007, and that in 2012 the *percentage of electronic claims had increased to 98.5%*.[iii]

While the overall success in electronic claims is noteworthy, it obscures several continuing challenges. Our enforcement activity described above showed that claims to workers' compensation payers are often still submitted on paper, requiring manual, time-intensive preparing and processing. In addition, based on our experience, the small fraction of paper claims still being exchanged with the state's health plans are likely being submitted disproportionately by smaller providers and vendors with fewer resources and less familiarity with automated business data exchanges.

At the same time, while electronic claims are generally becoming nearly universal, rates of other important electronic transactions such as insurance eligibility and benefits verifications and acknowledgments have also improved but still remain less widely used. These exchanges are important for patient care, proper billing and payment, and to prevent costly delays and rework that may be needed to resolve errors or correct problems. In the same way that it is important to

better understand and address the needs of those who are not exchanging claims electronically, it will also be important to continue to better understand and address the factors contributing to lower rates of other electronic business transactions.

Planning must also take into account the competing demands for limited health information technology (IT) resources and available expertise and capabilities -- often referred to by the industry as competition for available "bandwidth." In the next one to three years, the health care industry will be planning and responding to a series of simultaneous state and federal requirements and complex, far-reaching policy goals, including:

- Transition to a complex, much more detailed, more robust new version of an international medical diagnoses coding system known as "ICD-10" that will be required under federal regulations by October 2014. This new version of the diagnoses coding system will be used by medical coders and billers nationwide to report health care diagnoses and hospital inpatient procedures. While the current version of diagnoses coding, ICD-9, employs nearly 18,000 codes, ICD-10 will have over eight times as many, with over 155,000.[iv] Some industry analysts have likened the resource demands and potential impacts of ICD-10 as being similar in scope to the IT planning and preparations to address Y2K computer issues in 2000; [v]
- Implementing several new administrative simplification transactions standards and federal operating rules mandated by the ACA that supplement and provide additional specificity to existing HIPAA standards and code set rules;
- Adopting and demonstrating meaningful use of electronic health records (EHRs) in order to receive financial incentives and to avoid payment reductions;
- Learning about and implementing a new national Health Plan Identifier (HPID) for exchanges of electronic business data in which a health plan must be identified;
- Planning for and adapting to health coverage expansions under the ACA;
- Transitioning to a new market structure with the implementation of health insurance exchanges; and
- Implementing new integrated health care delivery and financing models such as "Accountable Care Organizations (ACOs)" and "health care homes."

While these developments have the potential to dramatically transform health care delivery and financing, their convergence at this time creates unparalleled changes and challenges for the industry. As a result, many of the same resources and attention needed for administrative streamlining will face competition from other important priorities. Several of these key reform objectives, including implementation timelines, are also summarized in more detail in Appendix C.

Not only will these changes result in greater competition for limited resources to accomplish e-billing and e-commerce objectives, but there will be more direct immediate impacts for administrative simplification as well. For example, diagnosis coding is important for correct billing and payment of medical services and supplies. Any faltering in the transition to ICD-10 could potentially ripple through a number of often time-consuming, expensive business processes and their corresponding transactions. At the same time, there are often few coding and billing precedents for new ACO-like delivery and reimbursement mechanisms and the codes and

billing conventions must be developed and implemented quickly and widely. Similarly, while the adoption and meaningful use of EHRs is primarily focused on the exchange of patient clinical data, many EHR systems incorporate modules for administrative transactions as well. Successfully integrating the administrative exchange components as part of EHRs will require collaborative efforts to share knowledge, expertise, and problem solving across vendors, providers, and payers.

As the pace of change quickens it will become increasingly essential -- and challenging -- to monitor and contribute to developments at a number of levels. It will be critical to continue to address a myriad of details and technical issues, while also keeping focused on larger goals and broader opportunities for collaboration. The challenges and changes confronting Minnesota's health care system are not unique to the state, but are common across a variety of other states and nationally. While Minnesota's administrative simplification requirements remain nation-leading, it will be important to be similarly effective in integrating with other state and federal efforts.

Given the environment described above, CHCPI's 2013 planning and key involvement will address:

- Ongoing administration, updates, and refinements of existing rules for standard, electronic exchange of routine health care business transactions;
- Setting priorities to meet administrative simplification goals during a time of rapid, often unprecedented changes and demands on the health care industry;
- Meeting needs for technical assistance and assuring compliance, with particular attention to identifying the largest achievement and performance gaps, and conducting "root cause analysis" to help understand reasons for the gaps and to take steps to address them;
- Broader sharing of lessons learned, best practices, and ongoing, common challenges with other states and nationally; and
- Additional new projects/responsibilities.
    - Minnesota Statutes, 62J.497 requires that a guide be created by January 1, 2014 to help implement an emerging new national standard to automate prior authorization (PA) requests for prescription drugs. Most prescribers (doctors) must request prior authorizations from payers for at least some patients for some drugs in order for the medications to be covered by the patient's health coverage. At present, prescribers typically use a variety of forms and methods to request the prior authorizations from each payer. A new national standard for electronic PA is intended to help automate and streamline the PA process, and Minnesota's guide is intended to assist those implementing the new standard. CHCPI will serve as project manager, facilitator, and coordinator in meeting the statutory requirements. It plans to work with an outside contractor with special expertise in the area, as well as the AUC, in developing the guide.

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Appendix A: Minnesota's Health Care Administrative Simplification Initiative

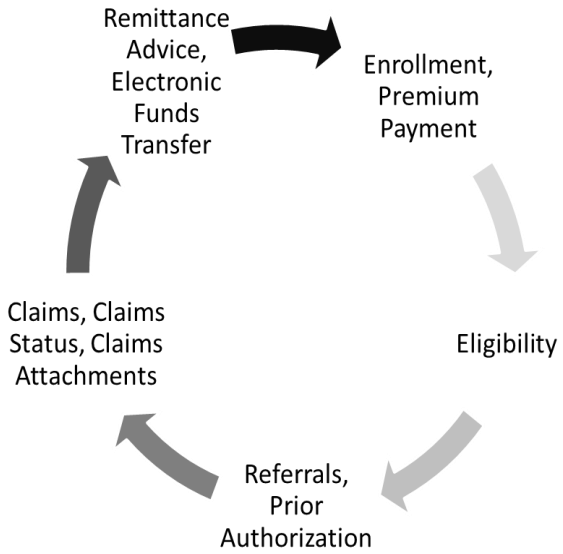
As described below, the Minnesota Department of Health's Center for Health Care Purchasing Improvement (CHCPI) serves as project manager in developing and implementing state requirements that health care administrative transactions must be exchanged electronically, using a standard data content and format.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

Background

A complex business model with large volumes of routine administrative transactions

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

Illustrative health care billing and revenue/payment cycle



The volume of transactions exchanged throughout the revenue cycle is staggering. Nationally, health care payers process more than five billion medical claims (billings) annually.[vii] In Minnesota alone, the state's health plans processed over 52 million health care claims in 2012.[viii] Moreover, providers, payers, and venders exchange millions of other business communications, including eligibility inquiries and responses, authorizations, payments, and acknowledgments (receipts).

Unnecessary costs and burdens

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

For example, a national actuarial firm found that it cost health care providers on average $3.73 more per claim to submit their bills on paper than to submit them electronically.[x] The same actuarial firm found that insurers and other payers likewise pay more—in this case, an average of sixty cents more to receive a paper claim than when the same claim is sent electronically.[xi] Moreover, when paper and nonstandard data exchanges are incomplete, inaccurate, or less timely, costs and delays are often compounded, and significant efforts and expense may be needed to resolve problems. A 2006 report commissioned by key stakeholders estimated the costs for just follow-up telephone calls alone between Minnesota health care providers and payers to resolve questions related to patient eligibility for insurance coverage, benefits, and health care claims at between $15.5 and $21.8 million annually.[xii]

Federal HIPAA administrative simplification

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

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

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

Minnesota's three-pronged approach to health care administrative simplification

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

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

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

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

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

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

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

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

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

   HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. Consequently, many transactions with these payers are

often now conducted on paper or using nonstandard exchanges that are less efficient and more costly.

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

More recent federal and state health care administrative simplification initiatives

Minnesota's rulemaking has been undertaken against a backdrop of the most sweeping national health care administrative simplification in over a decade. In 2009 the federal Department of Health and Human Services (HHS) adopted rules requiring new versions of the transaction standards adopted under HIPAA, effective January 1, 2012. In addition, section 1104 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary of HHS to adopt a series of rules and standards over a five year period to further standardize and automate a number of high volume health care business transactions. Additional information regarding these and other sweeping health care changes are summarized in Appendix C.

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

Appendix B: 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

- Sanford Health
- Sanford Health Plan
- Silverscript
- St. Luke's
- UCare Minnesota
- UnitedHealth Group
- University of Minnesota Physicians
- Wisconsin Physicians Service Insurance Corporation

Appendix C: Section 1104 of the Federal Patient Protection and Affordable Care Act (ACA) and Related Health Reforms

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

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

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

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

Table 1 below lists common health care business transactions that will become more uniform and more efficient under the ACA's operating rule requirements. It also lists the dates by which health plans must certify that they are compliant with the operating rules. Because of the lead times needed to implement and test computer system changes, efforts to meet the required compliance deadlines must be undertaken well in advance of the certification date. The asterisked items indicate transactions for which Minnesota also has established standard data

content rules pursuant to MS § 62J.536, which will need to be reviewed and harmonized with the ACA operating rule requirements.

Table 1. Standards and operating rule compliance dates for covered transactions

Transaction (An asterisk indicates that Minnesota requirements also apply)	**Federal Operating Rules/Standard Certification Date** (Health Plans must be certified as in compliance)
Eligibility* Transmits inquiries and responses regarding the applicable insurance coverage and benefits of a benefit plan enrollee to aid correct billing	December 31, 2013
Claim status Transmits inquires and response regarding the status of a health care claim (billing)	
Electronic funds transfer Transmits the electronic exchange of funds to pay medical claims	
Payment/advice* Transmits payment and payment processing information and explanations of amounts paid	
Claims* Transmits a request to obtain payment, or transmission of encounter information for the purpose of reporting health care	December 31, 2015
Enrollment/disenrollment in a health plan Transmits subscriber enrollment information to a health plan to establish or terminate insurance coverage	
Health plan premium payments Transmits health insurance premium payment and payment information	
Referral certification/authorization Transmits requests for an authorization and/or referral for health care	
Claims attachments Transmits supplemental health information needed to support a specific health care claim	
Health plan identifier Transmits an identification number to identify a health plan	November 7, 2016

Sources: Centers for Medicare & Medicaid Services websites for "Operating Rules for HIPAA Transactions" (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/OperatingRulesforHIPAATransactions.html) and "Health Plan Identifier" (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html)

Table 2 shows additional important health information technology (HIT) deadlines in federal and Minnesota regulations, including deadlines for the adoption of a new disease classification

system ("ICD-10"), and incentives to bring about the "meaningful use" of electronic health records (EHRs).

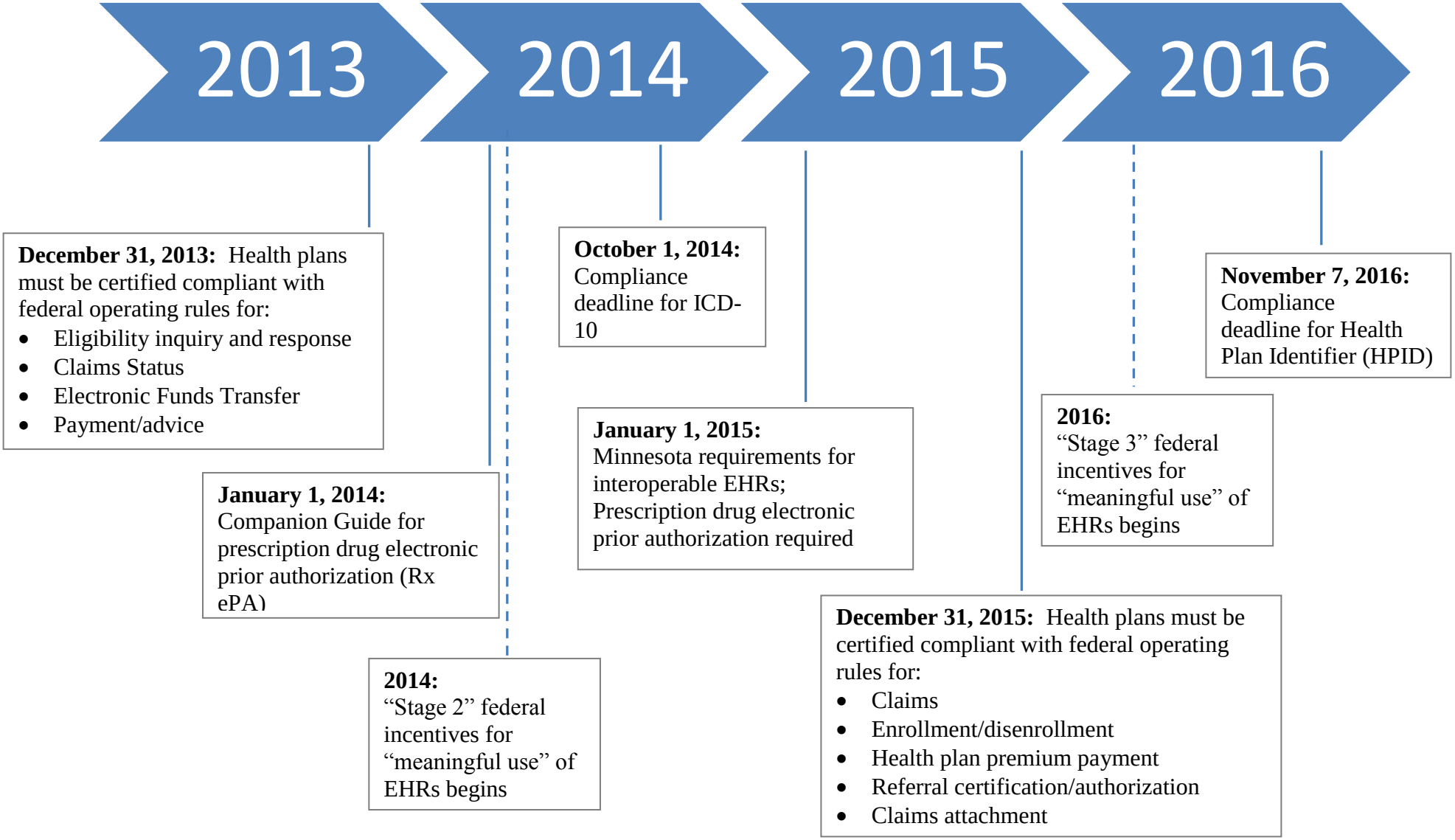
Table 2. Summary of selected additional federal and state HIT regulation deadlines

Category/transaction	Effective dates
ICD-10 (International Classification of Diseases, 10th revision)	October 1, 2014
Incentives for Meaningful Use of Electronic Health Records (Incentives are planned in three stages. Stage 1 began in 2011. Incentives for Stages 2 and 3, requiring more advanced types of meaningful use, start in 2014 and 2016)	Stage 2: 2014 Stage 3: 2016
Minnesota requirements: *Adoption of interoperable EHRs*	January 1, 2015

Sources: HealthIT.gov websites on "Meaningful Use" (http://www.healthit.gov/policy-researchers-implementers/meaningful-use); CMS websites on ICD-10 (http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10); Minnesota Statutes, section 62J.495 Electronic Health Record Technology (https://www.revisor.mn.gov/statutes/?id=62J.495)

Chart 1 below shows the timelines for Tables 1-2 in a single illustration.

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



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Endnotes

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

[ii] Minnesota Council of Health Plans. (2013). *Personal communication*.

[iii] Ibid.

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

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