Center for Health Care Purchasing Improvement (CHCPI)

ANNUAL REPORT, JANUARY – DECEMBER 2015

Minnesota Department of Health

Center for Health Care Purchasing Improvement (CHCPI)

Annual Report, January – December 2015

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MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

October 31, 2016

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

Dear Governor Dayton and Legislators:

We are pleased to submit this 2015 annual report of the Center for Health Care Purchasing Improvement (CHCPI) as required by Minnesota Statutes, section 62J.63. The report summarizes CHCPI's operations, activities, and impacts in calendar year 2015 as well as the Center's preliminary plans and goals for 2016.

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 (administrative) data for billing, payment, and other purposes. This administrative simplification initiative is helping not only reduce overall administrative costs and burdens throughout the state's health care system, but also helps assure the efficient, accurate exchange of vital data needed for health system planning and health improvement.

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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Executive Summary

Overview

The Minnesota Department of Health (MDH) Center for Health Care Purchasing Improvement (CHCPI) contributes to Minnesota health reforms for achieving the health care "triple aim" of reduced costs, better health, and better health care experiences through its leadership of a statewide initiative to reduce health care administrative expenses. By some estimates, these administrative costs account for 25% of every health care dollar spent.[i] At the same time, CHCPI's administrative simplification efforts are also streamlining and accelerating the flow of health care financial and business data needed for a variety of purposes, including the implementation of new "Accountable Care Organization" (ACO) forms of health care delivery and financing designed to improve patient care and outcomes.

Much of health care's administrative spending is unnecessary and results in part from extraordinary numbers – more than 500 per second[ii] -- of ceaseless, often paper-based exchanges of routine business data for billing and payment. Other industries have successfully managed ever-increasing volumes of business transactions by automating them with computer-to-computer electronic data interchange. However, not only does much of the health care industry lag behind in its use of electronic business transactions, but it frequently relays its business information via manual, person-to-person phone calls, faxes, and letters that can be nearly 60 times more expensive than their automated counterparts.[iii] MDH has estimated that fully automating several key health care business transactions via electronic data interchange could save the state's health care system $40 - $60 million overall.[iv]

CHCPI's roles, recent accomplishments, and goals

CHCPI and the industry have worked closely for several years to improve the adoption and use of more rapid, efficient, accurate electronic data interchange for routine health care business transactions. As a result, Minnesota has achieved higher rates of several key electronic health care administrative transactions than the national average, saving the state health care system millions of dollars and improving the flow of business data to help achieve the triple aim. As described below and in more detail in the body of this report, CHCPI contributed to these savings and system-wide improvements in 2015 by leading and coordinating rulemaking, networking, and technical assistance.

Rulemaking

CHCPI is responsible for implementing and administering a state law, Minnesota Statutes, section 62J.536, requiring the adoption of standard, electronic health care business transactions. The law is intended to accelerate the adoption and use of more automated, efficient electronic data interchange for high volume, routine health care business communications and data exchanges. It also authorizes MDH to make rules for the data

content and format specifications needed to ensure that the data being exchanged electronically is machine–readable.

CHCPI works closely with the industry, especially through a large, voluntary, multi-stakeholder organization, the Minnesota Administrative Uniformity Committee (AUC), to adopt, implement, and maintain rules with the relevant data specifications needed for successful health care electronic data interchange.

- In 2015 CHCPI updated seven sets of electronic data exchange specification rules to ensure that they remained current and reflected best practices and industry needs. As part of this activity, CHCPI coordinated and facilitated more than 50 open public meetings with stakeholders to gather information and recommendations, and to develop related best practices and tools to aid in implementing the rules.

Networking and liaison role

The transition to electronic data interchange is often complex and strongly influenced by federal laws and national data exchange practices and requirements. As a result, CHCPI serves as a liaison with the AUC and other national groups to coordinate efforts and to aid the resolution of questions and issues.

- CHCPI coordinated the submission of a number of responses in 2015 to requests for information and testimony on behalf of the AUC to national health care standards-setting bodies and advisory groups.

Technical assistance

CHCPI provides a variety of ongoing technical assistance through webinars, newsletters, and other means to aid the transition to standard, electronic health care transactions, and to help assure that participants benefit from the transition as fully as possible.

- In 2015 CHCPI also worked closely with the AUC and another industry stakeholder group, the Minnesota ICD-10 Collaborative, to increase awareness of and to help implement a new federally mandated disease classification system known as “ICD-10.” As an indication of its scope and complexity, the transition to ICD-10 was sometimes described as “the Y2K of health care.”
- In addition, CHCPI coordinated the AUC’s response to a request from the Minnesota Department of Human Services (DHS) to advise Minnesota health care providers and payers on standard file formats and data content for exchanging enrollee membership files needed to establish and manage newly emerging ACO forms of health care delivery and financing.

Goals for 2016

Despite the efforts above and successes to date, more work is needed to continue to improve the rates of electronic data interchange use and to adapt to continuing changes in federal laws,

market developments, and technology. CHCPI plans to address these challenges in 2016 by collaborating with the AUC and others to:

- identify and address root causes of sometimes variable, inconsistent adoption and use of standard, electronic health care administrative transactions;
- expand education and outreach efforts;
- engage fully at a number of levels in national and federal health care administrative simplification policy and program development; and
- continue to help stakeholders adapt to a rapidly changing health care delivery and financing environment.

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Introduction

The problem

The US health care system is the most expensive in the world,[v] in part because of high administrative costs related to the inefficient creation and exchange of astonishing amounts of routine business data for billing and payment. Every day, millions of ordinary business transactions cycle repeatedly between health care providers, insurers, and intermediaries for health insurance verification, billings (claims), authorizations, payments, and other administrative purposes.

The finance, travel, and other sectors of the economy have synchronized and accelerated many routine business-to-business processes through automated, computer-to-computer electronic data interchange. However, despite improvements over a number of years, health care often lags behind other sectors in the adoption of more efficient, automated, electronic business communications. As a result, many routine health care business transactions are conducted via inefficient paper correspondence, phone conversations, or exchanges of faxes. This is time-consuming, inefficient, and often less accurate, reliable, and secure than electronic data interchange. It is also much more costly.

For example, a large study compared the costs of manual, paper-based health care business transactions and those conducted via electronic data interchange. It found that for six common transactions combined, health plans spent on average $2.30 each for the manual exchanges of information, but only $0.04 when electronic data interchange was used -- a nearly 60-fold difference in cost.[vi] Obtaining even small efficiencies across the health care system's high volume of common, recurring business transactions can result in significant savings, less burden for all parties, and timely, more reliable data to plan and manage valuable health care resources while improving population health and outcomes.

The solution

CHCPI's goals are to reduce unnecessary, wasteful health care administrative costs, while improving the flow of valuable data needed for planning, patient care, and population health. These efforts also contribute to broader Minnesota reforms designed to achieve the "triple aim"[vii] of reduced overall health care costs, improved health, and better health care experiences.

As part of this effort, CHCPI is responsible for implementing and administering a state law, Minnesota Statutes, section 62J.536, requiring the adoption and use of several key electronic health care business transactions. The law promotes successful implementation of electronic data interchange by:

- Authorizing MDH rulemaking to create and maintain well-established, clear, detailed data content and format standards and specifications needed for automated, computer-to-computer exchanges of common business transactions;
- Requiring universal adoption and use of the standards and specifications by all virtually all health care providers, insurers (payers), and data exchange intermediaries (clearinghouses); and
- Authorizing MDH to provide technical assistance and enforcement, with an emphasis on achieving voluntary compliance, to bring about broad electronic data interchange adoption.

CHCPI works closely with the industry, especially through a large, voluntary, multi-stakeholder advisory organization, the Minnesota Administrative Uniformity Committee (AUC), to fulfill the statutory provisions above and to meet other related needs. As described in more detail later in this report, the rate of electronic exchanges of several high volume health care administrative transactions is higher in Minnesota than the national average. This more automated flow of business data saves the state health care system millions of dollars while improving the flow of data to help achieve the triple aim. At the same time, Minnesota is well positioned for further automation of health care administrative data exchanges and additional future savings.

2015 Accomplishments

As the lead MDH unit responsible for the implementation and administration of MS §62J.536 and related health care administrative simplification efforts, CHCPI serves several roles in guiding and coordinating the key activities below.

Rulemaking

One of CHCPI's primary roles is to lead and coordinate the rulemaking needed to define clear electronic data specifications that serve as uniform "rules of the road," and to assure that all parties are on the "same page" for successful electronic administrative transactions. In addition, CHCPI oversees ongoing regular maintenance of the rules to ensure that they reflect changes in applicable state and federal laws and best meet end-user needs.

In 2015, CHCPI led rulemaking to:

- Adopt rule updates initiated in late 2014, for rules governing automated, electronic transactions used to verify insurance eligibility and benefits, and for remittance advices;
- Develop and adopt updated rules for transactions used to submit electronic claims for professional (physician), inpatient (hospital), and dental services;

- Develop revisions of electronic data interchange specifications for three types of acknowledgments, which serve as receipts to indicate whether transactions were received by the intended recipient or rejected, and why.

As part of the 2015 rulemaking process, CHCPI organized and facilitated 50 open public meetings with the AUC, its workgroups (Technical Advisory Groups – TAGs), and other stakeholders to help develop the rules, to review and address related public comments, and to refine and update the rules as needed. The meetings and associated follow-up also served as forums for the development of corresponding tools, tips, and instructions for more consistent, uniform use of standard, electronic health care administrative transactions in practice.

Technical assistance

CHCPI actively teams with the AUC and others to help inform the industry of not only what is required, but also how to meet the requirements and how to obtain the greatest benefit from transitioning to automated, more efficient electronic data interchange. As health care delivery and financing changes, CHCPI collaborates with the AUC and other groups to ensure that billing and payment mechanisms keep pace with rapidly evolving health services, public health concerns, and emerging new payment models.

During 2015 CHCPI:

- Actively facilitated and supported several AUC TAGs comprised of industry and state agency subject matter experts who meet regularly to explore issues and to develop rules, recommendations, educational materials, and related products;
- Published a monthly newsletter distributed to over 3,200 subscribers, to keep the AUC and others current on AUC activities, industry developments, and other relevant news;
- Maintained two websites, including one on behalf of the AUC and widely used by the Minnesota health care industry, with a wide variety of information, links and other resources;
- Served as an information clearinghouse for wide variety of inquiries and referrals;
- Organized, planned, and participated in several statewide instructional webinars and other educational and outreach events;
- Aided the development and dissemination of AUC-reviewed and agreed-upon best practices and clarifications to supplement and enhance the state rules described above;
- Actively raised awareness of and helped the industry prepare for the federally mandated adoption of a new national health care diagnosis and procedure coding system known as “International Classification of Disease tenth revision (ICD-10),” which had become known as the “Y2K” of health care.” As part of these efforts, CHCPI:
  - Proposed, organized and coordinated a 2-day, multi-venue ICD-10 workshop and provided other ICD-10 resources at the state’s annual rural health conference attended by over 500 people in July 2015;
  - Secured resources of the federal Centers for Medicare and Medicaid Services (CMS) for a Minnesota-focused ICD-10 instructional webinar. More than 350 health care

billers, coders, and other administrative, IT, and management staff statewide attended the webinar; and

- Proposed and submitted two articles regarding the state's administrative simplification initiative that were published in "Minnesota Medicine," a medical business journal with a monthly circulation of 17,000 that is mailed to all licensed physicians residing in Minnesota and to hospital and clinic administrators.

Liaison with other state agencies, national organizations, and the federal government

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

In 2015 CHCPI:

- Met at least monthly with DHS and the AUC to address questions of medical coding for DHS programs and services, and to ensure that the rulemaking process described above reflected changes in DHS programs and services as needed.
- Submitted formal comments and recommendations on behalf of the AUC to:
  - The federal Department of Health and Human Services (HHS) regarding the Department's request for information regarding a proposed "national health plan identifier (NPI)" to uniquely identify health plans as part of business communications and for other purposes;
  - A national health care advisory committee chartered by Congress, the National Committee on Vital and Health Statistics (NCVHS), regarding the relative impacts and utility of federal health care administrative regulations as well as any changes and improvements that may be needed;
  - The nationally designated author of federal administrative simplification "operating rules," CAQH-CORE, regarding suggested additions and expansions to federal administrative simplification rules maintained by CORE;
  - A national health care standards-setting organization, the Accredited Standards Committee X12 (ASC X12), in response to concerns that particular EDI coding conventions and capabilities needed in Minnesota to report health care taxes might be discontinued. X12 subsequently approved a continuation of the coding provision of interest, ensuring that the future national EDI requirements will reflect Minnesota's data reporting needs.

Applying administrative simplification concepts more broadly

In 2015, DHS requested AUC assistance to advise a joint DHS-MDH project that is part of a federal "State Innovation Model (SIM)" grant that the two agencies jointly administer. The grant is intended to help develop and promote a new form of health care delivery and financing, known as Accountable Care Organizations (ACOs).[viii] ACOs require a variety of data from payers, including membership and enrollment data, to manage the health of a population for which they are financially accountable. For provider organizations that participate in more than one ACO or similar arrangement with multiple payers, the inconsistency in these data streams in terms of timing, file naming conventions, file layout and standards, creates an administrative burden.

In response to these concerns, CHCPI helped organize and facilitate a new AUC TAG at a series of meetings in late 2015 and early 2016 to recommend a standard data file content and record layout for the transfer of ACO member data from payers to providers. The TAG completed its work in early 2016 and submitted a series of recommendations that were reviewed and approved by the AUC in March 2016. The recommended file specifications will be rolled out by payers in 2016, for use with providers that participate in ACOs or similar arrangements.

Progress to Date

Minnesota health plans report they are now receiving nearly all billings (claims) electronically

Health care claims are one of the most visible and well-monitored health care business transactions. CHCPI reviews summary data each year from health plans licensed in the state regarding the total number of health care claims received, and the proportion of claims received electronically, to track this fundamental business activity.

Results

When MS §62J.536 was enacted in 2007, Minnesota's health plans reported receiving 83 percent of health care claims electronically. In the most recent data available (2014), they reported receiving over 97 percent of claims electronically.[ix] During this seven-year period, both the volume of all health care claims and the percent received electronically increased annually. One large national study estimated that the overall difference in costs between paper, manual claims and electronic claims at nearly $1.53 each.[x] The savings for each electronic billing, multiplied by the millions of additional electronically submitted claims in Minnesota between 2007 and 2014, quickly accrue in the form of millions of dollars of administrative savings across the state's health care system. While the total savings from the state's health care administrative simplification initiative depend on many factors and assumptions, CHCPI estimates that Minnesota's health care system will save at least $40-$60

million overall from the additional use of e-claims and other electronic versions of common transactions such as insurance eligibility and benefits verifications, remittance advices, and acknowledgments.[xi]

Minnesota ambulatory clinics also report high rates of e-claims and other transactions

In 2015 CHCPI collaborated in a joint survey with the MDH Office of Health Information Technology (OHIT) to obtain preliminary summary level information regarding the use of four types of standard, electronic health care administrative transactions by 1,181 ambulatory clinics statewide.[xii]

Survey findings

The table below summarizes the survey results and shows the percent of clinics reporting that they routinely sent/received a business transaction electronically for at least 80% of their patients (or in some cases, depending on the transaction, the question was asked in terms of at least 80% of health care claims). A reference column in the table compares Minnesota's survey data with the most readily available national data, from 2014.

RESULTS OF A 2015 SURVEY OF 1181 MINNESOTA AMBULATORY CLINICS*[xiii]

	For 80%-100% of patients	National Comparison[xiv]
Question #1: Does your clinic routinely file claims electronically for patients, either using the Electronic Health Record (EHR) or another electronic method?	94%**	94% adoption of electronic claims
Question #2: Does your clinic routinely check insurance eligibility electronically, either using the EHR or another electronic method?	77%	71% adoption of eligibility inquiries/ responses
Question #3: Does your clinic receive electronic remittance advices (ERA)?	77%	50% adoption of ERA
Question #4: Does your clinic receive electronic acknowledgements of their claims submissions?	81%	N/A (no data available)

*Note: Results may not total 100% due to rounding.

**Note on how to read the table: This example shows that 94% of clinics reported that they routinely submitted electronic claims on behalf of 80%-100% of their patients.

- As shown in the table above, the vast majority of clinics - 94% - reported routinely filing "e-claims" for more than 80% their patients.
- Minnesota's rates of electronic insurance eligibility verification and remittance advices (ERAs) appear higher than the national average. However, a more detailed comparison of electronic data interchange use rates and corresponding administrative savings requires recent, more comparable data.
- The survey results were also sorted by the following clinic types: primary, specialty, urban, and rural. However, the differences among the categories were generally small and so this additional level of detail was not included with this summary.

The survey yielded a number of important findings and baseline measures for future comparisons, as well as raised a number of questions. For example:

- What are appropriate, useful benchmarks and comparisons to evaluate progress and make course corrections?
- Why are some clinics submitting claims electronically for less than the majority of their patients?
- What savings and return on investment has the effort produced for providers so far?
- What is needed to increase rates of electronic transactions, particularly for those transactions such as eligibility inquiries/responses, remittance advices, and acknowledgments that are not being used as widely and consistently as electronic claims?

As noted in the final section of this report, CHCPI will address these and other questions with the AUC and other partners as part of its work plan for 2016.

Looking Ahead

New opportunities for administrative simplification and electronic data interchange

In a recent letter to the Secretary of the federal Department of Health and Human Services, NCVHS reported that an "entire ecosystem" is moving towards administrative simplification with "evidence of savings through the adoption and implementation of [national and federal electronic transactions standards]." However, the letter also noted that "achieving the potential savings have been limited by a number of factors," including "variability in the level of implementation and inconsistency in the method of implementation of the transaction standards and operating rules."[xv] Moreover, NCVHS also pointed out that the future holds particular challenges as well, especially with

> "Rapid advances in health information technology (HIT) and the transformative changes in health care delivery and payment models currently underway [that] are creating the need

for … new paradigms for how administrative and billing processes in health care will be done in the future."[xvi]

The NCVHS's glass half-full perspective above is also relevant to Minnesota's administrative simplification efforts and to CHCPI's focus and goals in 2016. As noted above, Minnesota has achieved high rates of standard, electronic medical billings, and higher than national average adoption rates of electronic data interchange for other important transactions. The state has a long history of provider-payer and private-public collaboration on health care transaction automation through the AUC and other partnerships, and its electronic data interchange requirements are among the most comprehensive in the nation.

However, while Minnesota is well positioned for further health care administrative simplification, as described below there is still a great deal to be done, especially to accelerate the use of electronic data interchange beyond exchanges of claims, to bring about further system-wide improvements and administrative savings.

Plans and goals for 2016

CHCPI will be working with the AUC and others over the coming year to:

- **Identify and address the root causes of what the NCVHS termed "variability" and "inconsistency of implementation"** in the transactions that have not yet been adopted as widely as electronic claims, to increase their adoption and use;
- **Explore new ways to provide information and useful examples to help move more quickly and effectively to electronic data interchange-based business**. As part of this effort, CHCPI plans to experiment with a variety of new communication and outreach tools, ranging from short videos and recorded webinars, to adding additional technical tips and pointers in the AUC monthly newsletter, to finding and organizing resources that can respond quickly to specific industry "pain points" and obstacles;
- **Engage as fully as possible in a range of national and federal administrative simplification issues and opportunities** by sharing experiences and lessons, and networking with others to help design and implement common solutions and innovations. In particular, CHCPI plans to coordinate community responses to new national health care administrative standards slated for review during 2016, as well as ongoing discussions regarding standards for supplemental information to accompany claims ("claims attachments"); and
- **Help stakeholders adapt to a rapidly innovating and changing health care delivery and financing environment**. In particular, Minnesota is actively undertaking a wide range of reforms, including a federally funded three-year, joint MDH-DHS State Innovation Model grant, designed to plan for and accelerate advances in health information technology, as well as in health care payment and reform. With these transformations will come changes in health care business practices, billing and payment concepts and methods, and other challenges for the exchange of new types of health care business data in

potentially new ways. CHCPI and the AUC will be exploring new opportunities and relationships to contribute as fully as possible to these changes, while also guiding and advancing the business and operational needs of the current system.

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

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

AUC member organizations:

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

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

References

[i] Himmelstein, D., et. al. A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far. Health Affairs, 33, no. 9 (2014):1586-1594. Accessed at: http://content.healthaffairs.org/content/33/9/1586.full.pdf+html

[ii] 2015 CAQH Index.™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2014. Accessed at http://www.caqh.org/sites/default/files/explorations/index/report/2015-caqh-index-report.pdf. The report noted that "an estimated 16 billion health care administrative transactions flowed between commercial health plans and healthcare providers in 2014." The 16 billion health care administrative transactions was divided by the number of seconds in a year (approximately 31,500,000) to arrive at the figure cited in this report of "more than 500 [administrative transactions] per second."

[iii] Ibid. The 2015 CAQH Index reported that health plans' average unit cost across six key business transactions was $2.30 for manual transactions, and $.04 for the electronic versions of the transactions, making the average unit cost of the manual versions nearly 60 times more expensive than the electronic versions.

[iv] 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.

[v] Based on: US per capita health care spending of $9,086 vs. average per capital spending of $3,661 for other developed (OECD) nations, and health care spending as a percent of GDP at 17.1% for the US, vs. an average of 8.9% for OECD countries.

Data from: Squires, D. and Anderson, C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries. The Commonwealth Fund Issue Brief, October 2015. Accessed at: http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective and OECD Health Statistics 2015. Focus on Health Spending. July 2015. Accessed at http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf.

[vi] 2015 CAQH Index. Accessed at http://www.caqh.org/sites/default/files/explorations/index/report/2015-caqh-index-report.pdf. See also note iii above.

[vii] Donald M. Berwick, Thomas W. Nolan and John Whittington. The Triple Aim: Care, Health, And Cost. Health Affairs, 27, no.3 (2008):759-769. Accessed at http://content.healthaffairs.org/content/27/3/759.full.

[viii] In February 2013 the Center for Medicare and Medicaid Innovation (CMMI) awarded Minnesota a State Innovation Model (SIM) testing grant of over $45 million to use across a three-year period ending October 2016. Minnesota will use the grant money to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. The goal of this model is to improve health in communities, provide better care, and lower health care costs. More information is available at the Health Reform Minnesota website, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home.

[ix] Minnesota Council of Health Plans. (2015). Personal communication.

[x] 2015 CAQH Index. Accessed at http://www.caqh.org/sites/default/files/explorations/index/report/2015-caqh-index-report.pdf.

[xi] 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.

[xii] OHIT conducts an annual survey of ambulatory clinics in the state to measure their use of electronic health record (EHR) systems and other health information technology (HIT). In the most recent survey, conducted in the spring of 2015, OHIT also asked questions regarding clinics' use of and/or receipt of the following four key electronic transactions: claims, insurance eligibility inquiries/responses; remittance advices; and acknowledgments.

[xiii] Source: Unpublished data, 2015 Minnesota Health Information Technology (HIT) Ambulatory Clinics Survey. Minnesota Department of Health, Office of Health Information Technology. Personal communication, January 2016.

[xiv] 2015 CAQH Index. Accessed at http://www.caqh.org/sites/default/files/explorations/index/report/2015-caqh-index-report.pdf.

[xv] National Committee on Vital and Health Statistics (NCVHS). Letter to HHS Secretary, Sylvia Burwell, dated February 29, 2016. Accessed at http://www.ncvhs.hhs.gov/wp-content/uploads/2013/12/2016-Ltr-to-Burwell-Findings-of-RC-Adm-Simp-June-2015-Hearing-Word.pdf.

[xvi] Ibid.