Minnesota Department of Health
121 East Seventh Place
P.O. Box 64975
St. Paul, MN 55164-0975

December 12, 1995

Ms. Maryanne V. Hruby, Executive Director
Legislative Commission to Review Administrative Rules
55 State Office Building
100 Constitution Avenue
St. Paul, Minnesota 55155

Re: In the Matter of Proposed Rule Amendments of the State Department of Health Relating To Aggregate Health Care Financial and Statistical Data From Providers, Minnesota Rules, Chapter 4651

Dear Ms. Hruby:

The Minnesota Department of Health intends to adopt rule amendments relating to aggregate health care financial and statistical data from health care providers, Minnesota Rules, chapter 4651. We plan to publish a Notice Of Intent To Adopt Rules in the December 18, 1995 State Register.

As required by Minnesota Statutes, sections 14.131 and 14.23, the Department has prepared a Statement of Need and Reasonableness which is now available to the public. Also as required, a copy of this Statement is enclosed with this letter.

For your information, we are also enclosing a copy of the proposed Rules and a copy of the Notice Of Intent To Adopt Rules in this matter.

If you have any questions about these rules, please contact me at 282-6310.

Yours very truly,

Dave Orren
Rule Writer

Enclosures: Statement of Need and Reasonableness
Rules
Notice Of Intent To Adopt Rules

STATE OF MINNESOTA
DEPARTMENT OF HEALTH

In The Matter Of Proposed Rule Amendments Relating To Aggregate Data From Providers - Chapter 4651

STATEMENT OF NEED AND REASONABLENESS

General Statement of Need and Reasonableness.

The purpose of this rulemaking is to amend rules that set out reporting requirements for health care provider financial and statistical data. The rules state who is required to report the data and list the data elements which must be annually reported. The rules specifically define the data elements to ensure that uniform and accurate data are reported. The rules also include provisions for reporting dates, extensions, and review of reports.

The rules were first adopted as emergency (temporary) rules, governing the 1994 collection of 1993 data. The rules were then adopted as permanent rules in late 1994. Under the permanent rules, the Department has collected one year's worth of data, namely, the 1995 collection of 1994 data. The Department has learned a great deal from the 1994 data and from the comments made to us by the persons and organizations who provided the data. These rules are being amended to respond to the suggestions received and the problems identified during the collection of 1994 data.

Proposed rule amendments that will apply to the collection of 1995 data, as discussed in this SONAR, are:

- clarification of some definitions;
- reduction in the number of providers who must complete the long report;
- addition of a question on system ownership;
- addition of a question regarding Medicare program participation by providers;
- refinement and clarification of some data categories such as source of insurance payments, clarification of patient out-of-pocket payments, and clarification that revenue data is necessarily estimated;
- elimination of a requirement to report employees by site and type, and elimination of reporting of physician specialty;
- addition of a question tracking trends related to capitated reimbursement;
- addition of a category in which to report payments that cannot reasonably be allocated or attributed elsewhere;
- elimination of a requirement to estimate the cost of complying with government reporting; and
- clarification that systems which include clinics may submit an aggregate report.

Legislative History- Health Care Reform- MinnesotaCare Act- Data Collection Objectives

Minnesota's health care reform initiative encompasses a wide range of activities. The primary goal is to provide universal coverage for health care while maintaining the quality of the care and reducing the rate of growth in current health care expenditures. Cost containment was clearly a part of the 1992 MinnesotaCare law, previously known as the HealthRight Act, and is the vehicle to achieve savings that could be used to expand coverage to the currently uninsured. The 1992 legislation provided a framework for the overall approach to cost containment: the rate of growth in health care spending must be reduced by 10 percent each year beginning in 1993 and the Commissioner of Health was required to establish enforceable statewide and regional limits on the rate of growth of health care spending for Minnesota residents. The 1992 legislation established a 25-member commission (the Minnesota Health Care Commission) of providers, payers, and consumers to develop a cost containment strategy and report back to the Legislature in 1993. The Minnesota Health Care Commission met bimonthly for a period of six months to develop and report its cost containment strategy to the Legislature. The Commission's basic proposal, with some modification of the details, was passed by the Legislature as part of the 1993 health care reform legislation. The Legislature has amended this health care reform legislation in 1994 and 1995.

The framework underlying the strategy of cost containment chosen by the state of Minnesota requires that one be able to quantify state health care expenditures and monitor the expenditures and their trends over time. There is currently limited data available on health care spending at the state level. The federal Health Care Financing Administration (HCFA) infrequently publishes estimates on health care spending by state; once in 1982 and more recently in 1993. However, the method used by HCFA actuaries does not provide the detailed information needed to effectively establish information on health care spending and trend at the state level. In addition, much of the work done in estimating state-level spending is developed by manually pulling together a diverse set of information from various data sources and this time-consuming compilation of disparate data sources must be re-enacted every year to keep the numbers up to date.

Minnesota's objective was to develop its own method and state infrastructure for collecting information on health care spending for the purposes of quantifying and monitoring health care expenditures over time. State-level data would be more accurate and more timely. In addition the data could be used to inform policy makers on the impact of health care reform and to document the state's progress toward meeting statewide cost containment goals.

The Health Care Commission recommended using a two stage strategy for data collection that included: (1) a short-term initiative to provide immediate information from payers on a significant, but not complete, picture of health care spending that will be used to establish a growth trend for 1991; and (2) a more comprehensive data collection plan to provide more detailed data based on aggregate surveys of providers and payers and encounter-level data that can be used to monitor spending and growth patterns over time. The framework for defining the elements to include in health care spending is based on the framework used by HCFA National Health Expenditure accounts to estimate national expenditures.

The short-term data collection strategy used to establish the 1991 baseline of health care expenditures clearly did not capture all health care expenditures of interest. The data did not represent all payers nor all types of health care expenditures. Other expenditures of interest that were not reviewed as part of the short-term strategy include out-of-pocket expenditures, charity care and bad debt, technology, research and education, and capital expenses. Several provider groups felt strongly that by relying on payer-level data to set expenditure limits, the Department would miss several important components, namely bad debt, charity care and out-of-pocket costs. In response, a physician-clinic report was developed to supplement hospital financial information as part of the long-term data collection strategy.

The goal of the long-term data collection strategy was to collect aggregate data on health care revenues and expenditures by payer type and service category for all public and private payers. The state has several data sources that, while not all-inclusive, are helpful in building the process for data collection for other payers and providers. Minnesota has long-standing data collection requirements for aggregate financial data from hospitals and HMOs and detailed information on state public programs. The largest gaps include the lack of information on services by medical doctors and services by other health care providers.

The data collection strategy involves collecting: 1) aggregate data on health care revenues and expenditures by payer type and service category for both public and private programs, and 2) disaggregated claims paid and encounter level data provided by payers. This data will be used to track total health care expenditures and revenues in the State of Minnesota. Attention will be given to the data collection and aggregation process to avoid any double counting. The two levels of data will be used to document revenues and expenditures and to cross check the data provided through each method. More detailed information will be needed for both the provider and payer groups including but not limited to the identification of Minnesota and non-Minnesota residents and the county of residence to be able to establish statewide cost containment goals.

Aggregate data from HMOs (and eventually ISNs) and hospitals are based on modified versions of existing annual financial reporting forms. New reporting forms were developed for the 1995 collection of 1994 data from commercial insurers, Blue Cross/Blue Shield, self-insured plans, and physician clinics. The Provider Financial and Statistical Report form covering physician clinics is being revised pursuant to this rulemaking.

In order to estimate and monitor health care spending in the State of Minnesota, more precise state-level data is needed. A primary objective has been to collect uniform and consistent state-level data in a routine and efficient manner on an ongoing basis. The Health Care Commission's report to the Legislature outlined the key assumptions for data collection. These include the following. 1) Health care revenue and spending data will be routinely collected from both payers and providers of health care services. 2) Data will be collected annually based on consistent guidelines and data definitions. 3) The data set will include as a base, expenditures and revenues for health care services contained in the set of basic benefits generally included in health coverage programs. 4) The expenditure data base will be limited in the initial years but will evolve as additional sources of data are developed and submitted. 5) Data definitions and data collection techniques will be refined over time to ensure the collection of uniform and

accurate data on health care spending and to assess the balance between the need for accurate data and the costs associated with collecting the data.

Statutory Sections Requiring Providers To Submit Data

Providers are required to collect and provide financial and statistical data to the Commissioner by Minnesota Statutes, section 62J.41, which states:

"62J.41 DATA FROM PROVIDERS.

Subdivision 1. **Cost containment data to be collected from providers.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

(1) the total number of patients served;

(2) the total number of patients served by state of residence and Minnesota county;

(3) the site or sites where the health care provider provides services;

(4) the number of individuals employed, by type of employee, by the health care provider;

(5) the services and their costs for which no payment was received;

(6) total revenue by type of payer or by groups of payers, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, integrated service networks, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

(9) revenue from out-of-pocket payments by patients;

(10) revenue from donations; and

(11) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs. The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

Subd. 2. **Annual monitoring and estimates.** The commissioner shall require health care providers to submit the required data for the period July 1, 1993 to December 31, 1993, by April 1, 1994. Health care providers shall submit data for the 1994 calendar year by April 1, 1995, and each April 1 thereafter shall submit data for the preceding calendar year. The commissioner of revenue may collect health care service revenue data from health care providers, if the commissioner of revenue and the commissioner agree that this is the most efficient method of collecting the data. The commissioners of health and revenue shall have the authority to share data collected pursuant to this section."

(Includes updates from the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 5, sections 13 and 14.)

Other Statutory Sections Relating To The Collection Of Data From Providers

Under Minnesota Statutes, section 62J.04, subdivision 1a, paragraph (a), the Commissioner of Health is required to "report to the legislature by February 15 of each year on the implementation of the growth limits. This annual report shall describe the differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy." (Includes updates from the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 3, section 2.) To do the report required under this section, it is necessary for the Commissioner to collect data from providers on actual expenditures. All payers and providers are included in the State's efforts to reach its cost containment goals, and the Commissioner will use both sources of data.

Minnesota Statutes, sections 62J.301 and 62J.311, give the Commissioner directives regarding the collection and analysis of data from providers. Sections 62J.301 and 62J.311 state in pertinent part:

> **"62J.301 RESEARCH AND DATA INITIATIVES.**
>
> . . . .
>
> Subd. 3. **General duties.** The commissioner shall:
>
> (1) collect and maintain data which enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;
>
> (2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;
>
> (3) collect and maintain data for the purposes of setting limits under section 62J.04, and measuring growth limit compliance;
>
> (4) conduct applied research using existing and new data and promote applications based on existing research;
>
> (5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;
>
> (6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and
>
> . . . .
>
> **62J.311 ANALYSIS AND USE OF DATA.**
>
> **Subdivision 1. Data analysis.** The commissioner shall analyze the data collected to:
>
> (1) assist the state in developing and refining its health policy in the areas of access, utilization, quality, and cost;
>
> (2) assist the state in promoting efficiency and effectiveness in the financing and delivery of health services;
>
> (3) monitor and track accessibility, utilization, quality, and cost of health care services within the state;
>
> (4) evaluate the impact of health care reform activities;
>
> . . . .

(6) evaluate and determine the most appropriate methods for ongoing data collection.

Subd. 2. **Criteria for data and research initiatives.** (a) Data and research initiatives by the commissioner, pursuant to sections 62J.301 to 62J.42, must:

. . . .

(5) be structured to minimize the administrative burden on health plan companies, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

. . . ."

(Sections 62J.301 and 62J.311 were first enacted in the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 5, sections 6 and 7.)

Statutory Section Governing Privacy Of Data Collected From Providers

Minnesota Statutes, section 62J.321, subdivision 5, paragraph (a), governs the classification of data collected from providers. It states:

"Subd. 5. **Data classification.** (a) Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter." (Section 62J.321 was first enacted in the 1995 MinnesotaCare Act, Minnesota Laws 1995, chapter 234, article 5, section 8. Data classification provisions were formerly in section 62J.35, subdivision 3, which was repealed by Minnesota Laws 1995, chapter 234, article 5, section 24.)

Uses Of Health Care Provider Data

The provider data collected pursuant to these rules will assist analysts with public policy decisions and also will assist providers in comparing their expenditures to aggregated data from all providers. Ultimately the data collection should provide the information needed to monitor cost savings in the health care system. The financial and statistical data collected by the Department will serve the following purposes:

1) The aggregate provider data will contribute to the development of estimates of total health care spending for the state of Minnesota. Minnesota Statutes, section 62J.301, subdivision 3, clause (2).

The information collected as part of the data requirements for providers will be used to help establish detailed information on health care expenditures, and to track expenditures and trends over time. Spending on physician services represents 26% of total personal health care spending, according to the Minnesota Department of Health's preliminary analysis of 1993 data. Physician spending is the third largest category, following hospital

and long term care spending. If the Department were to fail to capture physician spending, we would miss an important component of health care costs.

Before the Provider Financial and Statistical Report was required, estimates of medical services spending were typically made by using national (e.g. HCFA) figures and adjusting them to Minnesota. The Provider Financial and Statistical Report has shown, however, that there are unexpected differences between the broad picture from national sources and Minnesota. For instance, according to analysis from the 1993 and 1994 reports required by these rules, there are differences in the sources of payment between metropolitan area providers and non-metropolitan (rural) providers. One of the most striking differences is the rural areas' dependence on Medicare and other public program reimbursement. The detailed analysis allowed by the report will help show policy makers not only what effect changes in reimbursement may have, but demonstrates that national data adjusted downward to the state level do not accurately portray the situation in Minnesota.

Overall, the aggregate Provider Financial and Statistical Report information will provide baseline information on health care spending by type of provider and will allow the state to monitor those trends over time. Compiled with other health care spending data, these data will provide information for policy analysts and key decision makers on the total picture of health care spending. Some of the questions that will be addressed include the following:

a) What proportion of health care spending is attributed to physician services, and what proportion is attributed to hospital services?
b) How does this distribution of health care spending track with national trends for the same set of services?
c) How have the trends in health care spending changed over time?
d) How have the trends in health care spending changed as MinnesotaCare reforms such as ISNs and CISNs become operational?
e) What are the differences in health care spending in certain parts of the state? What impact will changes in federal programs such as Medicare and Medicaid have on providers, and thus on access and cost to consumers in those areas?

2) The data collected will provide unique information that is not a part of other data collection requirements, and will assist in developing policy in relation to cost, quality, and access per Minnesota Statutes, section 62J.311, subdivision 1, clause (1).

Collecting information directly from providers on health care revenues and costs will provide additional information that is not a part of the aggregate information submitted by payers. Payers are required to submit aggregate data on health care spending by type of provider. However, the information submitted is based on claims paid and will not include any expenditures that are not covered by third-party payers. This includes out-of-pocket payments made directly by the patient and care that is provided without remuneration. In addition, the state does not have the authority to require self-insured plans to submit aggregate data. Collecting data directly from the providers will provide this additional piece of data. Also, this data collection provides information on areas

unique to physician clinics that may contribute to health care spending and costs. Such issues include use of non-physician providers, medical malpractice costs, and research costs.

The data collected will allow providers to demonstrate to policy analysts and key decision makers particular areas of their costs that are possibly out of their control. There are costs directly related to the provision of health care services that will not be collected from any other source of data collection. Providers represented on the Health Care Commission recommended that data collection provide an opportunity for providers to submit data to the Department of Health to highlight some of the costs associated with the provision of care. These costs include such items as labor costs, malpractice insurance, billing and collection costs, research and education costs, and costs related to uncompensated care and charity care.

3) Aggregate data will demonstrate the impact of health care reform and the cost containment strategies proposed under MinnesotaCare, as well as the impact of potential reductions in federal programs. Minnesota Statutes, section 62J.311, subdivision 1, clause (4).

The state of Minnesota has initiated major health care system reform relying on the competitive marketplace and managed care as the major vehicle for service delivery. One of the reasons for collecting comprehensive data on health care spending is to track the impact of major system reform and its ability to contain the growth in health care spending. The information collected through the aggregate reports from providers and payers will be used to monitor trends in health care spending and report back to the legislature, the Commissioner, the Governor, the Health Care Commission, and Minnesotans on whether the reforms have had any effect on limiting the rate of growth of health care spending. Changes in health care quality, as measured by other departments and agencies, such as the Minnesota Health Data Institute, may be tied back to the baseline and trend data collected here.

4) Aggregate data will assist health care providers in identifying trends and variances in costs and can be used to promote efficiencies in the marketplace. Minnesota Statutes, section 62J.311, subdivision 1, clause (2).

The financial data on health care provider costs will be useful to health care providers in determining how individual health care provider clinic's or group's costs compare to average health care costs in Minnesota. The data may illustrate variances in the different aspects of health care costs. For example, a clinic may spend a certain amount on billing and collection, and the aggregate data may indicate that similar clinics spend more or less. This information would be useful to health care providers and health care administrators.

5) Certain data elements will help to provide information about likely Legislative issues, that will assist the State in developing its health policy in areas of access, quality, and cost. Health care reform is an iterative process and new questions emerge each year as

the system continues to evolve. Minnesota Statutes, section 62J.311, subdivision 1, clause (1).

Certain issues will probably be examined by the Legislature in the upcoming session. These include medical education costs, research costs, and malpractice costs. The Provider Financial and Statistical Report requests information regarding these costs to individual provider groups and will provide information that would not be available through study of larger institutions.

A trend occurring both locally and nationally, which is likely to affect most providers, is an impetus toward "managed care" in both private and public spending for health care services. In private spending, several large employers locally have announced intentions to begin contracting directly with providers for health care services, rather than purchasing services through an intermediary, such as a health plan. In the public sector, Congress is currently considering substantial Medicare growth reductions over seven years and anticipates much of the reduction to be achieved by increasing enrollment into managed care. Likewise, Medicaid enrollment in managed care may increase as Congress reduces growth in this sector and/or provides funding to the states in the form of block grants.

Statutory Rulemaking Authority

The Commissioner's statutory authority for amending these rules is found in Minnesota Statutes, section 62J.321, subdivision 6, which states: "The commissioner may adopt rules to implement sections 62J.301 to 62J.452."

These rules were originally adopted under the authority of Minnesota Statutes, section 62J.35, which was repealed in the 1995 MinnesotaCare Act (Minnesota Laws 1995, section 234, article 5, section 24). Section 62J.321 was enacted in the 1995 MinnesotaCare Act to replace section 62J.35. As a transition from the former to the present statutory rulemaking authority, the 1995 MinnesotaCare Act contains the provision: "Notwithstanding Minnesota Statutes, section 14.05, subdivision 1, Minnesota Rules, chapters 4650, 4651, and 4652, shall continue in effect under the authority granted in Minnesota Statutes, section 62J.321, subdivision 6." (Minnesota Laws 1995, section 234, article 5, section 22).

Solicitation of Outside Opinions; Input Into The Rule Amendments; Work Group

On May 15, 1995 the Department published in the State Register a Notice Of Solicitation Of Outside Information Or Opinions notifying the public of the Department's plans to amend these rules. On July 31, 1995, the Department published on Amended Solicitation to comply with new Solicitation requirements as set out in Minnesota Statutes, section 14.101. The Solicitations invited all interested persons to contact the Department. The Solicitations were also mailed to persons on the Department's rulemaking mailing list, to persons who had commented when these rules were adopted as emergency rules and as permanent rules, and to other persons identified by the Department as likely to be interested in the permanent rules.

As stated in the May 15, 1995, Solicitation, the Department formed a work group to advise on the development of amendments to these rules. The Department was able to accommodate all persons who wanted to participate on the work group. The first work group meeting was June 5, 1995. The work group met eight times from June 1995 through November 1995. Many of the work group's suggestions were incorporated in the revised rules and report form. Letters regarding the process are in the appendix to this SONAR.

The health care provider data collection rules work group included accountants from clinic organizations, health care providers, clinic managers, and financial officers. There were representatives from large and small health care organizations, specialty clinics, and various types of provider groups including medicine, dentistry, and chiropractic.

Many of the work group members completed the initial health care provider report for 1993 and 1994. Because they had first-hand experience with the report, they had constructive suggestions and ideas about areas for clarification and improvement.

Persons from the following organizations participated in provider work group meetings:

Allina Health System
Aspen Medical Group
Delta Dental Plan of Minnesota
Fairview Hospital & Healthcare Services
HealthEast
Kelley Dental Clinic
Mayo Foundation
Metropolitan Orthotics
The Minneapolis Clinic of Neurology
Minnesota Chiropractic Association
Minnesota Dental Association
Minnesota Department of Health
Minnesota Department of Human Services
Minnesota Department of Revenue
Minnesota Medical Association
Minnesota Medical Group Managers Association
Minnesota Nurses Association
Minnesota Otolaryngology
Pike Lake Dental Health Center
Professional Management Midwest
University of Minnesota Rural Health Research Center
University of Minnesota School of Nursing

Persons who attended work group meetings are listed in the minutes to the meetings. Minutes from the work group meetings are in the appendix to this SONAR.

Small Business Considerations.

Minnesota Statutes, section 14.115, requires the Department of Health to consider the effect on small businesses when it adopts rules. For purposes of this section, "small business" means "a business entity, including farming and other agricultural operations and its affiliates, that (a) is independently owned and operated; (b) is not dominant in its field; and (c) employs fewer than 50 full-time employees or has gross annual sales of less than $4,000,000."

According to 1994 MinnesotaCare tax information, 5,816 of the 6,301 non-hospital, non-pharmacy providers who paid the MinnesotaCare tax in 1994 had revenues under $1 million. Clearly, most of the businesses affected by these rules are small businesses.

Section 14.115, subdivision 2. states in part:

"When an agency proposes a new rule. or an amendment to an existing rule, which may affect small businesses .... the agency shall consider each of the following methods for reducing the impact of the rule on small businesses:

(a) the establishment of less stringent compliance or reporting requirements for small businesses;

(b) the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

(c) the consolidation or simplification of compliance or reporting requirements for small businesses;

(d) the establishment of performance standards for small businesses to replace design or operational standards required in the rule; and

(e) the exemption of small businesses from any or all requirements of the rule."

In addition, Section 14.115, subdivision 3 states the following:

"The agency shall incorporate into the proposed rule or amendment any of the methods specified under subdivision 2 that it finds to be feasible, unless doing so would be contrary to the statutory objectives that are the basis of the proposed rulemaking."

The Department considered the feasibility of implementing the five suggested methods in order to lessen the impact of these rules not only on small businesses, but on all businesses, while considering the statutory objective. The statutory objective of the rules is to collect specific financial and statistical information from health care providers in order to monitor health care spending and trend in the aggregate for all health care in Minnesota. One of the important methods used to reduce the impact of the rules on small businesses is to exempt certain small businesses from itemizing certain cost categories. The rules give a threshold of $1,000,000 in annual total revenues for this exemption rather than the $4,000,000 threshold contained in the definition of small business. The higher threshold was not used because too much data would have been lost and the aggregate numbers would not have been as accurate, which would have been contrary to the statutory objective.

The impact of the rules has been reduced in the following ways:

a. Less stringent requirements. In order to lessen the impact of the rules on the smallest of the businesses that are affected, the rules continue to permit providers whose total revenues are less than $1,000,000 to complete a shortened form. The short or simplified form requests the same information as the long form for demographic description, number of encounters and patient residency status, staffing, revenues, charity care and bad debt, physician list, and cost and effort of reporting. It requires much less detail on expenses.

Additionally, the Department modified some of the categories defined in statute in order to reflect the practice in health care provider businesses. For example, the statute requires the patient's county of residence. According to information from the work

group, this information is not currently captured by health care providers, and it would be extremely difficult to capture and report this information even if given several years lead time to modify billing and reporting systems. Therefore, the proposed rules do not require this information. Note that although Minnesota Statutes, section 62J.41, subdivision 1, requires county, this subdivision also allows modification of categories to reduce the burden of compliance, as long as the Department can meet its statutory data collection responsibilities. As a practical matter, this will not affect data collection because the data is not available and could not be collected even if required.

b. Less stringent schedules. The Department considered lessening the impact of the proposed rules by implementing less stringent schedules. The emergency rules and original law required the health care provider financial and statistical report to be submitted to the Department by February 1 with information from the previous calendar year. The original health care provider report respondents indicated that the deadline needed to be extended in order to complete the report with calendar year data. Therefore, the Department went to the legislature in 1994 and requested and received a change in the reporting deadline to April 1. We are also assessing whether we could extend this deadline in order to avoid conflict with providers' federal tax return due date of April 15.

Additionally, the proposed rules provide that a health care provider with reasonable cause may obtain an extension to file the report. This is another method of lessening the scheduling demands imposed by the reporting requirements.

It was suggested in the work group that providers be allowed to report based on their fiscal year, as hospitals do for the Health Care Cost Information (HCCIS) report. The Department is including a question on the Provider Financial and Statistical Report to determine which fiscal years are used by providers, in order to determine whether using a fiscal year for the report would be feasible in the future.

c. Consolidation or simplification of requirements. Minnesota Statutes require health care providers to report financial and statistical data. However, it would be unduly burdensome to have each individual provider submit separate financial and statistical data. Instead, the 1994 rules provided that health care providers who practice in groups or in a clinic may jointly submit one set of data. This simplifies the reporting requirements for the health care providers, because they do not have to individually complete separate reports. This is still consistent with the statutory objectives of collecting financial data. The health care provider data will be aggregated so that it is not necessary to receive data separately from individual providers.

Another way in which the Department consolidated or simplified requirements was to use data available from another source to replace one of the data elements previously collected. For 1994 data, providers were requested to list health care providers by site of practice. This data could be used to demonstrate where providers of various types and specialties are available, which answers some policy questions of access to services and trend in access to services. However, similar data are collected by the Department's Office of Rural Health and Primary Care (in conjunction with the provider licensing

boards for nine types of providers) and these data are readily available to the Department. Therefore, the requirement to supply a breakdown of types of providers by each clinic location was removed.

Further, the Department simplified reporting requirements, by permitting clinics with multiple sites to submit one report along with general information regarding each site. The Department has begun to evaluate how clinics who are associated with another health care entity (such as a hospital or health plan) might report all units together in a combined report. The plan for the consolidated report will lessen the burden to complete all reports, while retaining compliance with the statutory objective of collecting aggregate financial and statistical data. This plan is being worked out as part of the rule amendment process for the rules governing the HCCIS Report, namely, Minnesota Rules, chapter 4650.

Pursuant to statute, the Department will be obtaining data from all providers who are subject to the MinnesotaCare 2% tax. These providers will submit data as part of their MinnesotaCare 2% tax return. Consolidation of requirements is accomplished in that the data items to be submitted are ones already used by the providers in calculating their tax amount.

The Department has offered to accept the report or parts of the report in computer disc format. The parts of the report most readily amenable to submitting in computer format are lists of the satellite addresses and provider names. Since many clinics, large and small, maintain these lists on personal computers, submitting them on discs will reduce the time required to complete the report.

d. Performance standards. The proposed rules do not include any performance standards, so there is no consideration for using performance standards as a method of reducing the impact on small businesses.

e. Exemption. The Department exempted certain health care providers from the health care reporting requirements. Health care provider is defined broadly in statute and includes a variety of professions involved in providing health care services. The current rules require only medical doctors, doctors of osteopathy, chiropractors, and dentists to complete the Health Care Provider Financial and Statistical Report. Other providers are not routinely required to complete the Provider Financial and Statistical Report, although these other providers will be required to report several data items with their MinnesotaCare 2% tax return. The proposed rule amendments will require only medical doctors and doctors of osteopathy to complete the Provider Financial and Statistical Report; chiropractors and dentists will no longer routinely have to complete the Provider Financial and Statistical Report. The rationale for this is discussed in the scope section of this SONAR.

In clinics which include non-physician health care providers such as psychologists, nurse practitioners, or therapists, the Department is not requiring the clinic to separate those

providers' revenues from physician revenues. This, for all but a few large clinics, would not be feasible.

Departmental Charges Imposed By The Rules

Minnesota Statutes, section 16A.1285, does not apply because the rules do not establish or adjust charges for goods and services, licenses, or regulation.

Fiscal Impact

Minnesota Statutes, section 14.11, subdivision 1, does not apply because adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption of the rules.

Agricultural Land Impact

Minnesota Statutes, section 14.11, subdivision 2, does not apply because adoption of these rules will not have an impact on agricultural land.

Other Specific Statutory Requirements

Minnesota Statutes, section 62J.07, subdivision 3, requires the Commissioners of Health, Commerce and Human Services to provide periodic reports to the Legislative Commission on Health Care Access on the progress of rulemaking that is authorized or required under the MinnesotaCare law and to notify members of the Commission when the draft of proposed rules has been completed and scheduled for publication in the State Register. This will be done concurrently with submitting the rules and the Notice of Intent to Adopt to the State Register for publication.

Other Statutory Requirements

Minnesota Statutes, sections 115.43, subdivision 1, and 116.07, subdivision 6, regarding pollution control and Minnesota Statutes, section 144A.29, subdivision 4, regarding nursing homes are not applicable to these rules.

Witnesses

If these rules go to a public hearing, the witnesses listed below may testify on behalf of the Department in support of the need for and reasonableness of the rules. The witnesses will be available to answer questions about the development and the content of the rules.

- Barbara Nerness, Assistant Commissioner of Health
- David Giese, Acting Director, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- Lynn Blewett, Director, Health Economics Program, Health Care Delivery Systems Policy Division, Minnesota Department of Health

- Stella Koutroumanes, Health Economics Program, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- Kathleen Kuha, Principal State Planner, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- Dave Orren, Rule Writer, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- any other Department staff that may have expertise in the subjects within the scope of the rules.

Rule-by-Rule Analysis

4651.0100 DEFINITIONS.

Subpart 1. Scope. Part 4651.0100 gives specific meanings for terms which are used to report financial and statistical data. Most of these terms are familiar to health care providers or the clinic managers and financial staff. However, the specific interpretation of some terms may vary slightly from provider to provider. Work group members stressed that there should be clear definitions for reporting.

It is important to define these data elements to ensure consistent and accurate data from health care providers. Clear and complete definitions will also assist health care providers or clinic managers who are completing the report and reporting to the department. Without comprehensive definitions, there may be confusion about where to report a specific cost or revenue.

The definitions are reasonable as they were compiled by using the definitions in the existing rules and revising them based upon the recommendations of work group members who are accountants, clinic managers, and health care providers. As stated above, these are terms which are familiar to health care providers or health care administrators; they are defined to ensure consistency and to provide clarity.

Subpart 2. Bad debt. This term is defined because it is a category in the report. The 1995 rule modification is to add "for which a collection attempt has been made" because a debt is not classified as bad until at least one collection attempt has been made. A collection attempt would consist of more than the sending of a bill, and would include such activities as telephone calls, follow-up letters, or reporting to collection agencies. The change makes the report more consistent with the tax code.

The phrase "or supervising." The term "billing and collection costs" is defined in subpart 3 because this is a data element to be completed in the report. The 1995 rule modification is to add the phrase "or supervising" in the sentence "costs of personnel performing or supervising these functions." Some providers consider that their supervisory personnel are entirely supervisory, and that they do not perform the functions of billing and collection. The addition clarifies that these supervisory costs should be allocated to the relevant cost category. The work group agreed that this change would help ensure consistency in reporting.

For the same reasons as given in the discussion of the phrase "or supervising" in the definition in subpart 3, billing and collection costs, the phrase "or supervising" was added to the definitions in: subpart 9, education-degree program costs; subpart 10, education-other costs; subpart 12, financial, accounting, and reporting costs; subpart 18, patient registration, scheduling, and admissions costs; subpart 19, patient and public health education costs; subpart 20, promotion and marketing costs; subpart 21, research costs; and subpart 23, utilization review and quality assurance costs. The addition will not be noted separately in this SONAR in the discussion of these subparts.

Subpart 4. Charity care. This definition is necessary because charity care and bad debt costs are specifically reported. The 1995 rule modification is deletion of the word "partially" in the sentence "the total amount of dollars ~~partially~~ written off." The word 'partially' may imply that some part of the charges must be paid, and the other part written off, before the total charges may be considered charity care. In many actual charity care cases, the entire patient care charge is written off. The word does not add to the clarity of the sentence; the sentence reads better without it. The work group agreed with this clarification.

Subpart 11. Encounter. The previous definition of encounter was "any visit or procedure provided as a service to a patient and for which the provider has a billing code." In the 1995 collection of 1994 data, during the spring of 1995, the Department noticed that providers were interpreting this definition in various ways. Some providers counted their "visits" from their appointment books and added a note near the item on the form (e.g. "appointments"). The words "any procedure" led others to count their total CPT codes. A few providers noted this on the form (e.g. "all my CPT codes").

The inconsistencies in reporting encounters made it difficult and problematic to use the 1994 encounter data. To get valid, reliable, and usable data, it is necessary to amend the definition.

Most providers made no note of what the definition meant to them, and thus the Department has no means of determining whether the number submitted is actually a count of visits or total CPT codes. There is a significant numerical and technical difference between a visit and a CPT code.

An "encounter" intuitively means a visit to the physician or other provider in which the patient and the provider interact regarding the patient's health. For most providers, these encounters are tracked in an appointment book or system, which may enable a simple count of the number of visits. The Department will allow any reasonable means of estimating, such as sampling several weeks of a year and multiplying.

A "procedure" tends to mean an individual CPT coded-activity. A visit may include several CPT-coded activities, for example a physician visit, which also includes a cholesterol test and hemoglobin measurement. This visit would have three CPT codes. Allowing the provider to choose whether to count the one visit or the three CPT codes results in the inconsistency noted above.

The 1995 rule modification is a redefinition of "encounter." The new definition for "encounter" is "a contact between a patient and a health care provider during which a service is rendered.

Encounter also means an instance of the professional component of laboratory and radiology services. Patients may have more than one encounter per day. An encounter does not include failed appointments, telephone contacts, or the technical component of radiology or laboratory services."

This revised definition of "encounter" follows the intuitive definition. It is similar to the federal Health Care Financing Administration (HCFA) definition of an encounter which is "a face-to-face encounter between the patient and a licensed health care provider during which a CPT-coded service is rendered. Encounters with more than one professional and multiple encounters which take place on a single day and at a single location constitute a single encounter except for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment." [Source: federal Rural Health Clinic Manual.]

There was extensive discussion of this item. Several of the work group favored keeping the definition of encounter to include the word "procedure." The arguments for retaining the count of procedures were:

- it is significantly easier to count total CPT codes when using a computerized accounting system. Most software programs can produce a total count of CPT codes.
- it can be difficult to decide what constitutes an encounter. The HCFA and intuitive definitions require face-to-face contact, which would seem to exclude laboratory and radiologic visits. By counting total CPT codes, providers would be able to avoid having to decide which codes constitute an encounter, or which codes to not count. Using this count could reduce inconsistency, but only if everyone reported total CPT codes.

However, the counting of CPT codes, even if every provider used the same method in counting them, is far from the apparent intent of the Legislature in Minnesota Statutes, section 62J.41, subdivision 1, governing data to be collected from providers, which states in part: "The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on: (1) the total number of patients served . . . ."

The revised definition enables the Department to count utilization of services. It has uniformity in that providers may not submit a raw count of CPT codes. It specifically includes more than one encounter per day (as opposed to the HCFA definition) because multiple encounters on the same day are an increase in utilization.

This definition specifically includes encounters which may not be face-to-face because they are a part of utilization, but only includes the professional component of those encounters. For services which have both a technical component and a professional component (e.g. an X-ray), the professional component (the reading) is counted where the technical component (the taking of the picture) is not, because this reduces double counting. The definition also excludes failed appointments and telephone contacts because these items are counted on some computer systems, but do not contribute an actual "encounter" to utilization.

A question brought up at the final work group meeting was whether the second sentence in the definition would lead a provider to double-count encounters which consisted of an office visit with a simple lab visit and discussion of the results. The words "also means an instance of the professional component of laboratory and radiology services" could be taken to mean that the provider who performs cognitive (professional) services during the office visit, when laboratory or radiology is also involved, should count the cognitive service as an encounter as well as the office visit. However, it seems simpler to correct this misperception by explaining this particular section with an example in the form directions, rather than by adding a phrase such as "when the provider provides only the professional component of laboratory and radiology services" to the definition.

Other than the above specific inclusions and exclusions, the rules leave open exactly how the provider is to count encounters. Many providers will continue to count or estimate encounters using their appointment book. In the work group, some larger clinic providers mentioned that they would be evaluating their CPT codes to determine which of them would be an encounter (e.g. their evaluation and management codes, plus surgical codes, etc.) and letting their computers do the work of counting those codes. Either method is more likely to produce an accurate count of utilization without the uncertainty inherent in the previous definition.

Old subpart 13. Health care professional costs. New subpart 16a. Patient care personnel costs. The 1995 rule modification to this definition is to use the phrase "patient care personnel" instead of "health care professional." Members of the work group pointed out that the word "professional" has a connotation of licensed or registered person, such as a licensed physician or registered nurse, and seems to exclude other patient care personnel such as assistants or aides. These personnel probably have been reported as "other," a category which is intended for non-patient-care personnel. The definition probably led to under-reporting of non-licensed patient care personnel and over-reporting of "other" personnel for 1993 and 1994. The new phrase was re-alphabetized into subpart 16a. The substitution is reasonable because it makes the report easier to complete.

Subpart 16. Other patient care costs. In the rules, the term "health care professional costs" is replaced by the term "patient care personnel costs." The reference to the first term is changed accordingly in subpart 16. The addition of the phrase "professional services purchased from other providers" is a clarification that goes hand-in-hand with the last two paragraphs of the discussion in this SONAR regarding part 4651.0120, item H. Some providers will send patients to other providers for certain services. The first provider will bill the patient's insurer and pay the other provider for the services. This clarifies that such payments are patient care costs.

Subpart 17. Patient pay. This term is defined in the existing rules. The 1995 rule modification is deletion of the definition. Another section in the rules, part 4651.0120, item H, subitem (8), specifies the category into which patient pay revenues are to be placed. It reads "patient pay, including deductibles, copayments, self-filed insurance, and services not covered by insurance" which adequately describes the items to be included in this category. The definition in subpart 17 is redundant.

Subpart 20a. Provider identifier. This definition is added to clarify the provider identifier which is to be used in the future. The unique provider identification number (UPIN), one of the two identifiers requested on the provider list, is to be phased out in the next year by HCFA. It will be replaced by a National Provider Identifier (NPI). For those providers who do not have a UPIN, the state or other jurisdiction license number is requested as the identifier.

The identifier is needed on the provider list in order to differentiate providers who may have the same or similar names. The identifier is more specific and unique to the person because some names are not unique, and an individual may have several ways to write the same name.

4651.0110 HEALTH CARE PROVIDER REPORTING.

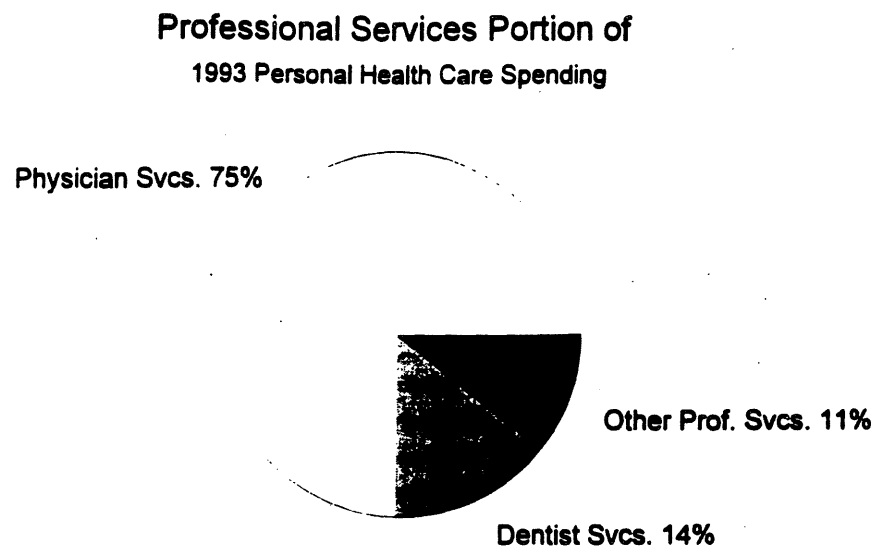
The requirements for who has to complete the provider financial and statistical report are being changed. The existing rules require medical doctors, doctors of osteopathy, chiropractors, and dentists to complete the report. The rules are being revised to require medical doctors and doctors of osteopathy to complete the report. Chiropractors and dentists will only have to complete the report if the commissioner determines that it is important for statutory data collection purposes. Further, surveying of chiropractors and dentists will only take place using a statistically valid sample of these providers. In making these changes, subpart 1 was deleted, subpart 2 was made to cover only medical doctors and doctors of osteopathy, and subpart 2a was added to cover chiropractors and dentists.

Minnesota Statutes, section 62J.03, subdivision 8, defines health care provider to include any person or organization, other than a nursing home, who can provide health care services for a fee. Many allied health professionals such as speech pathologists, podiatrists, and physical therapists are included in this definition. The department is not seeking financial and statistical data from all health care providers included in this definition at this time. The requirement to complete a report must be balanced with the need and value of the report information. The financial and statistical information is most valuable from those health care providers who account for a majority of health care expenditures. Therefore, the department is narrowing the definition of health care provider for the purpose of these rules.

For the past report, three groups of health care providers were required to submit the report information: 1) doctors of medicine or osteopathy, 2) doctors of chiropractic, and 3) doctors of dentistry. These health care providers were chosen because according to 1991 data from the U.S. Department of Commerce, medical doctors, including doctors of osteopathy, dentists, and chiropractors comprise the three highest health service categories in annual receipts for noninstitutional health care.

Data from the Department's preliminary analysis of 1993 personal health care spending indicate that the professional services portion of health care service spending, (which excludes hospital and long-term care), is allocated as follows:
- physicians $3.6 billion (about 1,000 physicians and physician groups)
- dentists $699 million (about 2,000 dentists and dental groups)
- other health care providers including chiropractors $524 million (which includes, among others, about 1,200 actively practicing chiropractors). Breakout of spending on chiropractic

services alone is not available. Totals are rounded. All others includes licensed providers such as ambulance, audiologist, licensed social worker, occupational, physical, or speech therapist, optometrist, optician, podiatrist, and psychologist.



Source: extract from Minnesota Department of Health, Issue Brief 95-03

Subpart 1. Scope. This subpart was deleted, as stated above. Subparts 2 and 2a have their own scope statements which make subpart 1 unnecessary.

Subpart 2. Medical doctor and doctor of osteopathy reporting. This subpart defines the data collection scope for physicians and osteopaths. (For clarification purposes, doctors of osteopathy are listed separately from medical doctors. However, these two groups are treated as one. Both doctors of osteopathy and doctors of medicine are licensed to practice medicine; both are licensed and regulated by the Board of Medical Examiners; both may take the same board examinations. The distinction between the two relates to where they received their medical school training.)

The 1995 rule modifications are:

- Substitution of "medical doctors and doctors of osteopathy" for the generic "health care providers." This clarifies that certain types of providers may have different reporting requirements.
- Addition of language to provide that the Commissioner may use a sample of smaller medical providers instead of requiring the report from every provider. Completing the report is a burden on many small providers, and the Department would like to mitigate this burden, as long as this does not compromise the Department's requirements in Minnesota Statutes, sections 62J.301 and 62J.311, to collect enough information to

estimate total spending, and monitoring and trending of access, utilization, quality, and
- cost of health care services in Minnesota.

If a sample is drawn, the sample of medical providers will be from those providers whose total revenues are less than $1 million per year; larger medical clinics will complete the full report as before. The small-clinic sample will be administered to include a statistically significant number of providers of all sizes under the $1 million threshold. Medical providers who are not selected to be in the sample will not be required to complete a report for that year.

Subpart 2a. Chiropractor and dentist reporting. There was much discussion in the work group and from providers about how dentists and chiropractors should report. Many of the arguments in the following are applicable to both types of providers. The Commissioner's decisions in this area were governed by making the best use of limited resources (for both providers and the Department), and by the total proportion of the market which can be attributed to each provider group. The two provider groups will be discussed in turn.

Dentists: Many members of the dental community and the Minnesota Dental Association have expressed a wish not to be included in the Provider Financial and Statistical Report in the future. Their reasons are that data collection and reporting by the dental community causes a significant burden on dentists, without providing much useful information to the Department. In addition, they note that the survey instrument is not well adapted to dental clinics, and that much of the information needed (e.g., geographic distribution of dentists, total size of the dental market) is provided by other data sources. The Department received hundreds of telephone calls and many letters and attachments to reports from dentists protesting the reporting requirement, which bear out the Minnesota Dental Association's reasoning. Their letter, with additional comments regarding use of the data, is in an appendix to this SONAR.

The Department's position on not requiring dentists to complete the report is that the 1994 data, in addition to the 1994 MinnesotaCare tax revenue data, are sufficient to describe the dental market relative to the physician market, and the report should not be required from dentists every year. The Department would be open to conducting a sample of the dental community if there were indications that dental costs are rising rapidly or if there was other evidence that market forces were not controlling costs for this segment of health care.

A preliminary analysis of the 1994 Provider Financial and Statistical Report dental data shows that the portion of care paid for directly by patients out of pocket is much higher in dentistry than in medical clinics. Patients who pay for their care directly are more likely to shop for a cost-effective provider, and to limit their consumption of services to what is reasonable to them. Thus, price competition is more likely among dentists than among medical providers, and the market would tend to be more stable.

In the future, the Department may wish to do a followup to the 1994 baseline data if aggregate revenue trends indicate substantial growth or evidence of increasing costs in the dental market. The Commissioner retains the authority to collect data by sample in the future if necessary. The 1994 data collected in 1995 will provide a snapshot of revenue sources and some information on expense allocations (most dentists have less than $1 million in revenues and thus did not have to

complete the expenses page). While the 1994 data are not yet completely analyzed, conclusions about dental access and cost, as well as revenues and expenses, may be drawn from what the Department currently has, and from other data sources such as the MinnesotaCare 2% tax data and the dental licensure board.

The reasons considered for including a sample of dentists (e.g., the large clinics over $1 million and a sample of smaller clinics) in the reporting process are:

1) To analyze trends in the dental market, to keep policy makers informed. The dental market is reportedly more stable than the medical market (fewer mergers and acquisitions, for instance) and a sample should be sufficient when the Department needs to look at certain trends.
2) To keep the data up to date. If policy makers are to be adequately informed with factual data about the state of and trends in the dental market, then the data should be kept current. A sample of providers should be adequate to point out changes.
3) So that all providers are treated by the Department in the same fashion. The Minnesota Medical Association brought up in the work group that requiring all medical providers, including small clinics, to complete the report when dental clinics are excused from it, may seem discriminatory. It may seem contradictory to require time and effort from small medical clinics, while not requiring it from large dental clinics who could more easily provide data.
4) To encourage providers to maintain and improve their ability to report data for the future. There is a "learning curve" which applies to the second year of any data collection. Completing the report for the second time is not nearly as difficult or intimidating as the first time, and the data are likely to be more reliable.

The Department proposes that the option be left open to sample the dentists, and a sample be conducted only if evidence is received that indicates a need to do so. Based on anecdotal evidence, the MinnesotaCare 2% tax data, and preliminary analysis of the 1994 Provider Financial and Statistical Report data, it appears that:

- there is a wide spread in geographic distribution of practices, which suggests that lack of geographic access to dental services is not a problem, and does not need to be tracked every year.
- there are a very large number of dental practices (about 2,000), compared to the number of medical practices (about 1,000), and therefore a large number of persons who would be completing the report, each on a very small part of the total volume. There is more burden on the dental community than on the medical community when completing the report. Also, the number of reports which would have to be sent, returned and coded by the Department is very high if dentists are to be included in the reporting process. Given the other reasons, and that dentists are a relatively small part of health care costs, this does not seem to be a wise use of the Department's resources.
- price competition and therefore control of costs by market forces seems more likely, given that out-of-pocket payment by patients seems to be very common in dentistry.

Therefore, it seems most reasonable to require at most a sampling of dentists. The default written into the rules is *not* to sample this provider group unless there is a compelling need based

on aggregate data collected from other sources (for example, the MinnesotaCare 2% tax data or payer data).

Chiropractors: The same arguments apply to the chiropractic community. However, the position of the Minnesota Chiropractic Association (MCA) is for chiropractors to be included in the report in the future. Their reasons are that the Department has a legislative mandate to collect data to develop a tracking tool for consumer access, utilization, and quality assurance and chiropractic should not be excluded from the data collection. The MCA also noted that repeating the data collection will produce greater ease of compliance and greater accuracy of the data. Their letter, with additional comments regarding use of the data, is in an appendix to this SONAR.

The Department's position on not requiring the Provider Financial and Statistical Report from chiropractors is consistent with that of not requiring the report from dentists. If there is evidence of deviations from the market such as rapidly increasing prices among these providers, the Department may complete a statistically significant sampling. Further, in the case of chiropractors, preliminary data indicate that chiropractic is a small part of the market, and to require reports from a small segment of the market does not seem a wise use of those providers' resources or of the Department's resources.

Minnesota Statutes, section 62J.41, subdivision 1, states in pertinent part: "The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on: [the statute then gives ten specific data categories and one general data category] for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs." The Commissioner will meet the stated purposes of this statute by using the Provider Financial and Statistical Report to collect data from medical doctors and doctors of osteopathy annually and by using the Provider Financial and Statistical Report to collect data from chiropractors and dentists only when there is a need to do so. This reduction in the number and types of providers who must fill out the Provider Financial and Statistical Report will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

Subparts 2 and 2a. Date for filing; reporting period. Subparts 2 and 2a clarify that reports required under these subparts must be filed on specific forms on or before April 1 with data from the previous calendar year.

There was discussion in the work group about using a fiscal year versus a calendar year or changing the dates. Minnesota Statutes, section 62J.41, subdivision 2, clearly specifies that the information is due by April 1, and that the information is from the preceding calendar year. The Department agreed to evaluate the feasibility of allowing providers to report on a fiscal year, recognizing that to do so would ease the reporting process and possibly result in more accurate data. The question to gather these data is optional and is contained on the report page with other demographic items such as accounting method used.

Subpart 4. Aggregate reporting. The 1995 rule modifications are to include the phrase "and number of encounters for" each clinic within the entity that completes the report, and to delete the requirement for full-time equivalent employees by employee type. The changes are explained fully in part 4651.0120, item E, and part 4651.0120. item C, respectively.

Subpart 5. Small business providers. As before, small providers, namely those with revenues under $1,000,000, will complete a shorter version of the Provider Financial and Statistical Report than large providers. Essentially, the small providers would not be required to submit detailed expense information.

The suggestion has been made to eliminate even the simplified version of the Provider Financial and Statistical Report for small providers, in favor of using only the MinnesotaCare 2% tax return data. The MinnesotaCare tax data file is the most efficient method of collecting data from all providers, as permitted by Minnesota Statutes, section 62J.41, subdivision 2. However, the amount of detail which can practically be collected by the Department of Revenue is quite limited. Telephone collection of data, the most efficient method, does not allow a thorough cleaning and inspection of data anomalies, because there are no hard copies available. This data collection does not adequately replace the Provider Financial and Statistical Report, both in terms of detail and for accuracy of the data collected, and does not by itself enable the Department to carry out its statutory responsibility of monitoring and trending access, utilization, quality, and cost of health care services in Minnesota.

The revenue and demographic portions of the Provider Financial and Statistical Report are relatively easy to complete because the information required is typically accounted for by the health care provider or clinic. However, the data elements related to expenses are not typically tracked by health care providers. Many of these expense items need to be calculated based upon allocations of costs from various accounting categories. These allocations may be made by making estimates based upon personnel, square footage, etc.

The clinic will have to devote personnel time to calculating these allocations when filling out the report. Typically, health care providers practicing in a small clinic do not have the specialized financial staff or the sophisticated financial and record keeping ability available in larger clinics. According to 1992 report data from the Medical Group Management Association, the average medical doctor from a multispecialty group employs .96 administrative and business office staff. Based upon this data, a clinic of three or fewer health care providers would employ two or fewer of such employees. Clinics with few administrative or business staff may not have the time or sophistication to calculate the expense allocations accurately. The work group also emphasized that when there are only one or two persons doing a variety of business and patient care tasks, allocation of their time into the categories on the form would be little better than guessing. It is reasonable to permit small clinics or health care provider groups to complete an easier version of the form.

The shorter version of the report is redefined in the 1995 rules for Subpart 5 to include the clinics' demographic description, number of encounters and patient residency status, staffing, revenues, charity care and bad debt, physician list, and cost and effort of reporting.

In the expense categories, the short form requires only malpractice costs, research costs, medical education degree costs, MinnesotaCare tax, and total expenses. The first three items are included as an addition to the rules because they may be used to inform policy makers on the issues of malpractice reform, and medical education and research funding. This is an easy requirement to meet for smaller providers because malpractice costs are usually equal to the provider's malpractice insurance premium, which is a single concrete number. Further, most small providers are likely to have no expenses in education or research, so they can quickly complete the category with a zero.

MinnesotaCare tax amount is included as it was last year, because it is an easy number for even small providers to generate, and because the work group indicated that providers may wish to demonstrate the impact of this tax. The final item, total expenses, is the same requirement as last year.

There are also changes to this subpart that are intended to make the subpart easier to read without changing the substantive requirements of the subpart. There are also changes to internal references within the rules based on renumbering of these references.

4651.0120 REPORTING REQUIREMENTS.

This subpart details the financial and statistical data elements to be reported to the Commissioner. The data elements are labeled in the same manner as they are labeled in the report form which will be sent to providers.

Because of the addition and deletion of several items in part 4651.0120, it was necessary to renumber some items and to change internal references accordingly. These technical changes will not be discussed other than this note to say they have been done.

Item A. Demographic data. *(Form section 1.1, details for each site on Attachment A.)* This item requires statistical and demographic data including the facility/organization name, county, and the federal tax identification number or employer identification number, the system ownership if applicable, and the participating or non-participating status for the Medicare program. The last two items were added in the current rulemaking process.

System ownership is required because there are some clinic systems that may provide several reports, because their clinics operate under separate financial systems or for other internal bookkeeping reasons. In some cases, the clinics have different names from each other or the parent corporation. System ownership is useful to the Department to identify entities which belong to systems. The current trend in growth in medical service systems (clinics plus hospitals and/or health plans) is of interest to policy makers.

Medicare participating or non-participating status was added because a clinic's status has a bearing on whether the clinic writes off charges over the Medicare allowable amount (participating) or requires the patient to pay charges over the Medicare allowable amount (non-participating); this is a greatly simplified version of the Medicare rules. The relative proportion of "patient pay" to total revenues is affected by the participation status of the clinic. The

requirement is reasonable because, in view of possible Medicare reform, clinics in Minnesota may in future choose to change their participation status, which affects consumers.

Item B. Provider's name and unique identifier. *(Form Attachment B.)* This item requires basic identifying information about the health care provider: the name of the health care provider and the provider identifier (NPI, UPIN or license number). This item is necessary first for establishing a database with uniform identifying information about health care providers, and, second, to enforce the statutory and rule requirements to report data.

Clearly, health care provider financial and statistical data collection must begin with basic identifying information about the health care providers. The name is the primary identifier. However, because names are not always unique to individuals, a secondary form of identification is necessary. In addition to the name of the health care provider, the rules require a provider identifier number.

The 1995 rule modification is to change the identifier required. In the past, HCFA has assigned UPINs to physicians and a few other health care providers who receive Medicare reimbursement. These numbers are now being replaced under a plan to provide a more comprehensive numbering system to be used in billing. The NPI numbering system will begin with medical doctors who now have UPINs and then will expand to include all health care providers. The 1994 MinnesotaCare Act specifies that after January 1, 1996, all group purchasers in Minnesota shall use the UPIN as the uniform identifier for health care providers for the "purpose of submitting and receiving claims, and in conjunction with other data collection and reporting functions." (Minnesota Laws 1994, chapter 625, article 9, section 5, subdivision 2.) The date for implementation was changed in the 1995 MinnesotaCare bill to January 1, 1998, and the statute is in the process of being updated to reflect the change from UPIN to NPI. The substitution is reasonable because the UPIN will be phased out. Health care providers who do not have NPIs will use their license number for the Provider Financial and Statistical Report until assigned an NPI.

Secondly, in order to enforce the reporting requirements of the data collection rules, the commissioner will have to check the names of health care providers submitted in the Provider Financial and Statistical Report against a complete list of licensed and active providers. The identifiers, as well as the names, of health care providers are essential for monitoring health care provider compliance with these reporting requirements.

Item C. Employees. *(Form section 1.2)* This item requires the total number of full-time equivalent employees for the health care provider by type of employee. The first 1995 rule modification to this item is to delete the requirement for providers to report the FTEs of each of their employees "by clinic site."

According to numerous telephone conversations with providers who were completing the report during the spring of 1995, the allocation of each employee's time by site was very time-consuming. An inspection of the returned reports showed that there appeared to be varied understanding of this request, with some reports showing providers at "home offices" and others with provider time allocated.

The Department of Health's Office of Rural and Primary Care (ORHPC) collects data on nine types of providers (Physicians, Dentists, Physician Assistants, Dental Hygienists, Registered Nurses (includes nurse practitioners), Dental Assistants, Licensed Practical Nurses, Respiratory Care Practitioners, and Physical Therapists). More types of providers will be added to the databases in the near future. The purpose of the ORHPC databases is to determine access to all types of providers; the data contain unique identifiers and other information including provider specialty. These data can be used to show access to providers throughout the state.

Collecting these providers' FTEs by clinic site is redundant to the ORHPC data. For those employees whose data is not collected by ORHPC, (e.g. administrators and clinic managers) the work group agreed that their geographic distribution was not as important.

Another modification to this item is to replace the phrase "nurse practitioners [and] nurse-midwives" with the more inclusive term "advanced practice nurses." There are a number of advanced practice nurse specialties in addition to nurse practitioners and nurse midwives, and the broader term allows providers to more easily categorize their staff. Additional data about the location of advanced practice nurses, with their specific certifications, is available from the ORHPC database. The work group agreed that these nurses, along with licensed practical nurses and other nurses, were as well enumerated in the ORHPC data, and that it is not necessary to require providers to categorize them on this report.

The phrase "other allied health providers" was deleted in favor of "other patient care personnel" because it is a broader term. "Allied health providers" has a connotation of licensed or certified providers, which left the clinics with some trouble fitting their unlicensed patient care personnel into a category. A category of personnel who do not provide patient care (e.g. administrators, managers, clerical staff) was added to allow providers to categorize all of their staff. The work group did not find that this category needed more precise subcategorization, so it includes all personnel whose functions do not include patient care.

These changes are reasonable because they reduce the burden of reporting but do not interfere with the statutory duty to collect data, since the needed data can be found elsewhere.

Item D. Encounters. *(Form sections 1.3 and 1.4)* Minnesota Statutes, section 62J.41, subdivision 1, requires health care providers to provide information on total number of patients served by state of residence and county. The 1995 rule modifications are to delete the phrase "or patients" and to add the phrase "Minnesota or non-Minnesota."

The first 1995 rule modification is to delete the choice of a count of patients OR a count of encounters. In the 1994 data, providers chose which of the two to report. "Patient" was defined as an individual who receives care from a provider, each individual being counted once per year regardless of whether they visited the provider once or many times during a year. The definition of encounter as described in part 4651.0100, subpart 11, includes each visit and is a better descriptor of utilization than the number of patients.

Some members of the work group have preferred to report patients rather than encounters, and have their systems set up to report this way. In a preliminary review of 1994 data, 66% of

medical providers chose to report encounters, against 27% who reported patients (7% gave no answer). Some providers will have to change their systems. The Department was in contact with several software vendors who will be able to produce software changes for their clients to report the item as required.

The change is reasonable because the data, some of which was reported on an encounter basis and some of which was reported on a patient basis, did not allow analysis on a consistent basis. In order to develop good data analysis, one or the other definition must be used.

The proposed rules do not require patient information by county. Currently, health care providers do not ask patients for their county of residence as part of the patient registration process. If the Department required county information, clinics would have significant expense and trouble to change their patient registration forms and processes. Therefore, it is not reasonable to request this information.

The second 1995 rule modification is to clarify that "residency status" means either Minnesota or non-Minnesota. The purpose of this data collection is to analyze health care spending, revenues, and utilization in Minnesota and for Minnesotans. To require a breakdown of residency status that was more detailed than "Minnesota or Non-Minnesota" would serve no purpose.

This category of encounter, broken down by Minnesota or non-Minnesota residency status, does not match exactly with Minnesota Statutes, section 62J.41, subdivision 1, clause (2), which is "the total number of patients served by state of residence and Minnesota county." The change in this category is, however, consistent with the last sentence of subdivision 1 which allows the Commissioner to "by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts." This change will reduce the burden on providers by not requiring them to submit data they do not have, namely data on patients' counties of residence. The Department feels that this will not have a significant negative effect on necessary data collection efforts.

Item E. Encounters by clinic site. *(Form Attachment A.)* This modification is a requirement to provide encounters by clinic site. For 1993 data, the providers were requested to provide all information by clinic site. For 1994 data, the requirement was dropped, so no comparison or trend analysis was possible.

Minnesota Statutes, section 62J.311, subdivision 1, clause (3), requires the Commissioner of Health to "monitor and track accessibility, utilization, quality, and cost of health care services within the state." Because there has been a trend for the past two to three years for large systems (which may include clinics, hospitals, and/or health plans) to purchase physician practices, the Department is gradually losing the ability to measure physician service utilization in several areas of the state.

For instance, in the Twin Cities area, one large system now owns more than 40 clinics, and another more than 20 in a geographic spread covering fourteen counties. If each of these many clinics were to report encounters only as part of a mass system, no utilization measure would be

made for a significant area. Likewise, in other parts of the state, physician services are dominated by a large system in six counties in southwestern Minnesota, and another system encompassing seven counties in northwestern Minnesota. If these groups reported encounters only as an entire system, there would be little measurement of utilization detail in some parts of the state.

Encounters by site is a reasonable measure because clinics keep some kind of measure of daily patient volume at each of their sites, in order to staff at an appropriate level. This measure by the clinics may not be encounters as previously defined, but the data collection must be consistent to be successful.

Item G. Name of report preparer. *(Form section 1.1)* This item requires the signature and telephone number of the person completing the report, and certification that the contents of the report are true. The requirement is needed to ensure the accuracy of the data by holding someone accountable to its accuracy.

The 1995 rule modification is to add the phrase "if a person who is not an employee of the clinic is used to assist in the preparation of the report, the name, address and telephone number of the person." One of these two persons will serve as a contact person if there are any follow-up questions regarding the report; during the collection of 1994 data the Department often found that the clinic's phone number was listed, with an outside accountant's name as the person who completed the report. This was not only confusing, but caused some difficulty in getting authorization (which should only come from within the clinic) to discuss the data. Adding a space to allow the outside preparer of the form to include his or her name simplifies the followup process when it is needed.

Item H. Net patient receipts by type of payer. *(Form section 2.1)* This item is necessary because it is a specific requirement in Minnesota Statutes, section 62J.41, subdivision 1. The statute specifies that patient receipts be itemized by type of payer. This information will inform health care policy planners of shifts in the payer mix over time. Policy analysts will watch to see what reliance there is on public programs and/or patient out-of-pocket payments and if they change over time.

The 1995 rule modifications are:

- To delete the requirement that providers indicate whether their revenue data were estimated or actual. The 1994 data form did not include a method for providers to indicate this, and providers found this irritating. According to the work group, "actual" figures are few and far between after adjustments for payer categories and calendar vs. fiscal year. They felt that most, if not all, figures generated for the report are estimates, and the requirement to label a figure as an estimate is redundant and not useful.

- To add CISNs (community integrated service networks) and ISNs (integrated service networks) to the health maintenance organizations (HMOs) category. These types of entities are contemplated under the current statutory scheme. These types of entities are similar to HMOs and it is appropriate to include them in this category.

- To add a category of workers' compensation and automobile personal injury. These types of payment come from insurance systems which are outside the scope of health insurance and which are administered under separate laws and licensure. National data to which these data may be compared do not include workers' compensation and automobile insurance. Payers who write these lines of business are licensed separately, have separate payment systems, and often have separate claims offices for these lines. The providers who treat many patients under these systems are aware of the differences because the billing procedures are different (e.g. in workers' compensation, the bill must include a copy of the medical record) and litigation is relatively common in both. The work group providers who bill these two types of insurance as a large proportion of their business reported that it would not be difficult for them to separate these payers; to do so will also make the Minnesota data more consistent with other data sets. Note, however, that some providers who bill only a small proportion of these types of insurance may have some difficulty separating these two types of insurance from other revenue sources.

- To clarify the meaning of the phrase "patient pay" as "including deductibles, copayments, self-filed insurance, and services not covered by insurance." The previous line was "out-of-pocket and self-filed insurance." The new phrase uses the language from the patient pay definition in part 4651.0100, subpart 17. Note that now this language is in subitem (7), subpart 17 is no longer needed and has been deleted.

- To add a category (8) for patient revenues which cannot reasonably be allocated into the previous categories. An example of this is payments to a clinic and/or individual provider for a service contract such as services to institutionalized patients or a medical directorship which includes actual patient care. The addition is reasonable because it makes the form easier to complete; providers do not have to attempt to allocate these patient revenues to a category.

There was a long discussion of the implications of "pass-through" payments at the final work group meeting. A "pass-through" payment for purchased services is where (for example) a radiology clinic sells services to a primary care clinic. For the patient's convenience, the radiology clinic bills the primary care clinic for the services. Thus, a clinic which sells services to other clinics may have a large volume of services which to them appear to be revenues for providing patient services, but which are paid by another entity which is in turn billing the insurer.

If these revenues are placed in with other types of patient revenues, they are being counted twice: once on the Provider Financial and Statistical Report of the selling clinic, and once on the Provider Financial and Statistical Report of the purchaser of the services. Therefore, the work group recommended that the directions for the Provider Financial and Statistical Report include instruction for clinics which sell services to place them in "other operating revenues" and include a footnote indicating part of this category includes revenues for selling services to other clinics.

Item I. Net patient receipts by type of payment arrangement. *(Form section 2.2)* This item is an addition to the rules, of a method of identifying a type of total patient revenue. The total

revenues are to be itemized in item H by the source of revenues. In item I, providers are asked to identify the amount of revenue from capitated payments. The addition is necessary in order to monitor whether there is a shift between fee-for-service medicine and capitation payment. This information is critical to understanding market trends and changing reimbursement policies.

Both popular press and industry publications indicate that fee-for-service payment for physicians may be becoming less common, and capitated basis payment may be becoming more common. Capitation is one of the cost-control methods included in the much-used term "managed care."

Background: 'Fee-for-service' means that the provider is paid for each service (each office visit, each surgery, each x-ray) rendered. Providers may increase income by increasing the volume of services, and thus fee-for-service payment is criticized as allowing health care costs to increase.

'Capitated' means that the provider is paid a negotiated lump sum (for example per year, per member of a plan, per course of patient treatment, etc.) without charging for each service rendered. Efficient providers may treat the patient for less cost than is paid to them in the lump sum, thus having an incentive to control costs. Capitated contracting may also reduce the need for certain managed care techniques such as precertification or utilization review, sometimes called the "hassle factor." Critics of capitated payment note that lump-sum payments increase the temptation for providers to undertreat patients and may damage quality of care.

Little or no data is available on which health care plans and providers in Minnesota engage in capitated contracting. Most of the capitated contracting appears to be in the Twin Cities metro area, between HMOs and large primary care clinics, and this data is available through the Minnesota Department of Health's Occupational and Systems Compliance Division (OSC). Information is not readily available on where, or whether, capitation occurs outside the metro area, if it occurs in non-HMO health plans, or with which, if any, specialty clinics.

One assumption in MinnesotaCare is that ISNs and CISNs will wish to use capitated contracting with their providers in order to gain the cost-control benefits with minimum hassle. Another likely increase in managed care and capitation is in Medical Assistance and Medicare, both of which are facing a decrease in federal funding.

In the summer of 1995, some large employer groups announced that they plan to move toward "direct contracting" with providers, some of which may be on a capitated basis. Direct contracting means that the self-insured employer develops contracts for services directly with providers, rather than going through a health plan.

Since no baseline now exists on the geographic, specialty clinic, or dollar extent of capitated payment, and this trend appears to be moving forward, the Department wishes to collect a simple version of what portion of the provider's revenues is collected under capitated contracts. This measure may eventually show that capitation is increasing or spreading under health care reforms and ISNs, or it may show that capitation is rejected by providers in some geographic or specialty areas.

The difficulty of collecting this information is that there are many variations on "capitated." Providers may be paid by:

- a negotiated lump sum (clinic will provide all services for the health of XXX persons for a total of $xxx.xx per year). The lump sum may be paid out to the provider on a fee-for-service basis until it is all gone or, if it is not used up, the rest will be paid at the end of the year. Other variations on lump sums exist, including extra payment for agreed-upon services such as primary care case management.
- a per-member per-month fee (clinic will be paid $xxx.xx per member of Health Plan A per month)
- a per-member treated fee (instead of or in addition to the above payment, clinic will receive $xxx.xx for each Plan A member who arrives at the clinic)
- a per-diagnosis fee (clinic will be paid $xxx.xx for every diagnosis XXX.X that they treat, similar to Diagnosis-Related Groups or Ambulatory Patient Groups)

There is also a payment arrangement called "withhold" in which part of a fee-for-service payment is withheld by the payer until the end of the year, a form of partial capitation which is less risky to the provider because some fee will always be paid for services. At the end of the year, the payment may be refunded or negotiations may take place. Whether the withhold is refunded may depend on whether the health plan achieves its goals. This grey area, and new variations on partial-risk contracting, should be studied further.

Fee-for-service contracts include standard Medicare and Medicare supplement payments, non-HMO public programs, most commercial insurers and PPOs, automobile personal injury, and workers' compensation. The great majority of payments to small providers can be expected to be fee-for-service.

The proposed category, item I, will require providers to report the dollar amount of services which are paid on a per-member per-month basis. This narrow definition of capitation is the most risky type to the provider. Per-member per-month capitation allows the provider to assume the financial risk associated with the group of patients and their health service needs. If the group of patients were to require a large amount of services, the provider's financial status could be threatened, possibly leading to a loss of access to medical services if the provider went out of business.

The data collection request for patient receipts by capitated per-member per-month is a minimal burden on providers, because those providers who have capitated contracts are likely to be large clinics and are likely to watch those contracts very closely. That is, the contracts are negotiated, and the provider who is inefficient in providing services may be penalized by receiving less per patient than the services cost per patient (lose money on the contract). Clinics large enough to consider a 'shared-risk' contract will have sophisticated data systems and will keep close track of both costs for providing services and the receipts from them in order to negotiate an appropriate contract next time. Clinics who do not have per-member per-month capitated contracts will simply put a zero in that item.

The work group considered the Department's initial proposal to require clinics to split their revenues into three categories: capitated, fee-for-service, and gray area (everything not clearly

identified as capitated or fee-for-service). At the final work group meeting, the work group recommended limiting the question to the "pure" capitation method of per-member per-month. This will provide data on where and with whom the most risky form of provider payment is presently occurring, and may in time show whether this form of capitation is increasing or decreasing.

The work group considered whether the data might be available from payers instead and the payer data collection work group was asked for their opinion. While the payers are capable of providing an overall amount of capitated vs. fee-for-service dollars, the payers can't readily provide this data either by geographic area or by specialty clinics. To do so they would have to provide clinic-by-clinic breakdowns of payments, or code each clinic by geographic and specialty clinic indices and produce a report. Clinic-by-clinic data is not aggregate, and providing a geographic and specialty clinic breakdown from the payers would be a greater burden than for each clinic to report its capitated dollars, using this narrow definition, in the Provider Financial and Statistical Report.

The work group was asked to consider breaking out each of the insurance categories into capitated and non-capitated, and rejected this as too difficult. A simpler, more aggregate measure would be preferable. The work group emphasized that the data from this question is likely to be variable because of the number of variations on payment and the difficulty of categorizing each of their contracts. However, beginning to collect the data may result in a clearer delineation in time.

As in the item H division of total revenues into payer categories, the item I report of per-member per-month capitation amounts is to be estimated, and the provider is not required to go back through records and sort information.

Item J. Other operating revenue. *(Form section 2.3)* The 1995 rule modification is to add the word "operating" in the first reference to other revenues. The remainder of the subpart is about operating revenue other than patient revenue, and the addition clarifies that revenues which are not from operating the provider facility and not from providing patient services should not be included in the report.

Item N. Expenses. *(Form section 3)* This item requires a detailed statement of expenses for the health care provider; the detailed listing is used only for providers who are not small businesses as set out in part 4651.0110, subpart 5. The purpose of the expense portion of the report is to identify and measure key functional categories of health care provider costs. This item was the focus of much of the work group discussion last year, and little modification seemed necessary or appropriate this year.

The first 1995 rule modification is to replace the term "health care professional costs" with the term "patient care personnel costs," because the second term is more inclusive. The word "professional" has a connotation of licensed or registered personnel. The new term makes the reporting requirement more clear, in that it includes patient care personnel who may not be licensed.

The second 1995 rule modification is to delete the line "if individuals dedicate their time or a portion of their time to performing these functions." This line is redundant to part 4651.0100, subpart 23, the definition of utilization review and quality assurance, which also contains this phrase.

Old item N. Cost of government reporting requirements. *(Form section 4)* This item requires the report respondent to estimate the cost to comply with all government reporting requirements. The 1995 rule modification is to delete the requirement.

In numerous telephone calls received by the Department during the data collection, providers reported that this question was too vague. While they would be interested in quantifying and reporting the amount that government reporting costs them, to do so would require a defined methodology. The work group, when consulted, did not feel that the question was important enough to define a method, then require providers to spend time and effort to follow the method and quantify the time and cost associated. Therefore, the requirement is deleted.

4651.0150 VARIANCES.

Subpart 1. Data from other sources. Under this subpart, the Commissioner of Health will determine whether to use data from other sources if these data duplicate data collected under the rules. This determination would be triggered either by a request from a provider or on the Commissioner's own initiative. To make this determination, the Commissioner would have to consider whether the data are duplicative, the data are available at reasonable cost, the Department has the resources available to use the data, and the data will meet all statutory data collection, analysis, and privacy requirements. The Department is aware of data that are similar, and possibly duplicative, to data required under the rules. This subpart gives the Department the flexibility to reduce the reporting burden on providers if these data are in fact duplicative or if a data source is developed in the future which duplicates data required under the rules. The Department's interest is in obtaining these data for analysis, not in making all providers give the data directly to the Department. The criteria for the Commissioner to consider ensure that the Department's data collection efforts will not be compromised by using data from other sources.

Subpart 2. Aggregate reporting for systems. This subpart will allow an organization operating a provider clinic which is part of a system of clinics, hospitals, or group purchasers to report all components of the system as an aggregate. This subpart was included in an attempt to give the Department the flexibility to deal with health care systems in whatever form they may take in the future. Driven in part by health care reform and in part by forces in the health care marketplace, health care will be delivered in some cases by systems consisting of health care providers, hospitals, and group purchasers. The Department cannot predict exactly what forms these systems will take, but wants to leave open the possibility in the rules of collecting data at the system level. While allowing system level reporting, the Department will still have to comply with statutory requirements so it is reasonable that this subpart only allows system-level reporting if statutory requirements are met. This subpart contemplates that a system and the Commissioner would have to meet and work out the details of the data submission so that the Department can use the data to meet all statutory requirements.

Conclusion

Based on the foregoing, the Department's proposed rules are both necessary and reasonable.

12-1-95
Date

Anne M. Barry, Commissioner
Department of Health

Appendix

Items in the Appendix are included as part of the official rulemaking record. Copies of Appendix items are available upon request from Kathleen Kuha, Minnesota Department of Health, Health Care Delivery Systems Policy Division, P.O. Box 64975, 171 East Seventh Place, Suite 400, St. Paul, Minnesota 55164-0975, 612/282-3822. TDD users may call the Minnesota Department of Health at 612/623-5522.

A. Proposed form developed for future Provider Financial and Statistical Report data collection, as modified for work group in 1995

B. Letters from work group members and associations regarding work group activities

C. Minutes of work group meetings. Note that minutes are included for the purpose of documenting the work group's input, and do not necessarily represent the Department's position.

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Completion and submission of this report is required by Minnesota Statutes, section 62J.41. Health care providers organized as a clinic or group may choose to file jointly one report for the clinic or group or may choose to file individual reports for each provider.

Section 1.1 Statistical and Demographic Data; Contact Person

Clinic / Reporting Organization Name: _____

Name of System, if owned by a system: _____
("System" means a group of clinics who may not all have the same name, or who are part of a hospital-clinic system, or are owned by or part of a larger corporate entity.)

Administration Address: _____

_____

_____

County: _____

Federal Tax Identification Number: _____

Contact Person at Clinic: _____

Title: _____ Telephone: _____

Contact Person at Outside Accounting or Billing Firm (if applicable): _____

Title: _____ Telephone: _____

Type of Accounting Method Used: ❑ Cash ❑ Accrued ❑ Modified Cash

Participating in Medicare program: ❑ Yes ❑ No

Billing and collection system is: ❑ Computerized ❑ Manual

To the best of my knowledge this report has been prepared in accordance with applicable instructions, except as noted.

_____ _____ _____

Name Title Date

All data received on this form are private or non-public as applicable, except to the extent given a different classification by Minnesota Statute 62J
For help completing this form, call (612) 282-3822. Return form to: Minnesota Department of Health, Health Care Delivery Policy (HEP), P.O. Box 64975, St. Paul MN 55164-0975

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Clinic Name: _____

Section 1.2: Staffing Data

Please list Full Time Equivalents (FTEs) for your entire reporting organization for each category:

(Round to two decimal places. See page __ for definitions. Please complete all categories; enter a zero if you do not have any FTES in a category.)

	Sum of FTEs:
Line 1.2.1 Medical Doctors and Osteopaths (M.D., D.O.)	
Line 1.2.2 Chiropractors (D.C.)	
Line 1.2.3 Dentists (D.D.S., D.M.D.)	
Line 1.2.4 Physician Assistants (P.A.,C.)	
Line 1.2.5 Advanced Practice Nurses (A.N.P., C.N.M., C.R.N.A., etc)	
Line 1.2.6 Registered Nurses (R.N.)	
Line 1.2.7 Other patient care personnel (see page ___)	
Line 1.2.8 Provider services under contract (see page ___)	
Line 1.2.9 Non-patient care personnel: Administration, Billing, Collection, Financial, Maintenance, Reception and Other Personnel (see page ___)	

Section 1.3: Total Number of Encounters

Please list the following count: (Round to the nearest whole number.)

Total Encounters (see page __ for definition)	**Count =**

"Encounter" means a contact between a patient and a health care provider during which a service is rendered. Encounter also means an instance of the professional component of laboratory and radiology services. Patients may have more than one encounter per day. An encounter does not include failed appointments, telephone contacts or the technical component of radiology or laboratory services.

Providers may estimate encounters by any reasonable method. See page ___.

Section 1.4: Residency Status

The number in Section 1.3 consists of _____ Minnesota residents and _____ non-Minnesota residents.

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Clinic Name: _____

Section 2.1: Revenues/ Receipts

Line 2.1 Patient Revenues, Calendar Year 1995:

(Revenues are net of contractual discounts, charity care and bad debt.) $_____

Please allocate Patient Revenues above to each of the following revenue sources:

(See page ___ for definitions. Please complete all categories: enter a zero if you do not have any revenues in a category.)

Line 2.1.1	Medicare (see page ___)	$
Line 2.1.2	Medical Assistance, General Assistance Medical Care, MinnesotaCare (see page ___)	$
Line 2.1.3	Other Public Payers (see page ___)	$
Line 2.1.4	Commercial Insurers, BCBS, PPOs; Delta and other dental plans (see page ___)	$
Line 2.1.5	HMOs / CISNs/ ISNs (see page ___)	$
Line 2.1.6	Worker's Compensation and Auto (see page ___)	$
Line 2.1.7	Patient payments, including self-filed insurance and out-of-pocket (see page ___)	$
Line 2.1. 8	Contracted patient revenues which cannot be allocated to above categories. Do not include reveunes from other clinics for purchased services. (see page ___)	$

Section 2.2: Revenues/ Receipts by Payment Method

Please report the amount of Patient Revenues above that are paid to you on a capitated, per-member per-mont basis:

(See page ___ for definitions. Please complete all categories: enter a zero if you do not have any revenues in a category.)

Line 2.2	Capitated payments (see page ___)	$

All data received on this form are private or non-public as applicable, except to the extent given a different classification by Minnesota Statute 62J. For help completing this form, call (612) 282-3822. Return form to: Minnesota Department of Health, Health Care Delivery Policy (HEP), P.O. Box 64975, St. Paul MN 55164-0975

Clinic Name: _____

Section 2.3: Other Operating Revenues/ Receipts

Line 2.3	**Total of Other Operating Revenues, Calendar Year 1995:** $_____	
	Please allocate Other Operating Revenues above to each of the following revenue sources: (See page ___ for definitions. Please complete all categories: enter a zero if you do not have any revenues in a category.)	
Line 2.3.1	Research Revenues (see page __ for definition)	$
Line 2.3.2	Education revenues (see page __)	$
Line 2.3.3	Donations, grants and subsidies (see page __)	$
Line 2.3.4	Other operating revenues (see page __). Include revenues paid to you by other providers for purchased services. If these revenues are included in this category, please check here : ☐	$

Section 2.4: Add Section 2.1 (Patient Revenues) and Section 2.3 (Other Operating Revenues):

Line 2.4 Total of Patient and Other Operating Revenues, Calendar Year 1995:

$_____

(See page ___ for definition. Round to nearest whole dollar.)

Section 2.5: Charity Care, Bad Debt and Contractual Discounts.

(See page ___ for definitions. Round to nearest whole dollar. Please complete all categories; enter a zero if you do not have any of a category.)

Line 2.5.1 Charity care and bad debt (see page __ for definition). This category is optional for clinics with less than $1,000,000 in Section 2.4.	$

Line 2.5.2 Discounts, contractual adjustments, disallowed charges (see page __ for definition). This category is optional for all clinics.	$

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Clinic Name: _____

Section 3: Expenses

Line 3.0 Total Expenses, Calendar Year 1995:

$ _____

Please allocate Expenses above to each of the following expense categories:

(See page ___ for definition. Round to nearest whole dollar. Please complete all categories: enter a zero if you do not have any costs in a category.)

Line 3.0.1	Patient Care Personnel Costs (see page ___)	$
Line 3.0.2	Other Patient Care Costs (see page ___)	$
Line 3.0.3	Malpractice Costs (see page ___)	$
Line 3.0.4	Billing and Collection Costs (see page ___)	$
Line 3.0.5	Patient Registration, Scheduling & Admissions Costs (see page ___)	$
Line 3.0.6	Financial, Accounting, & Reporting Costs (see page ___)	$
Line 3.0.7	Quality Assurance & Utilization Review Costs (see page ___)	$
Line 3.0.8	Research Costs (see page ___)	$
Line 3.0.9	Education - Degree Program Costs (see page ___)	$
Line 3.0.10	Education - Patient and Public Health Education Costs (see page ___)	$
Line 3.0.11	Education - Other Costs (see page ___)	$
Line 3.0.12	Promotion and Marketing Costs (see page ___)	$
Line 3.0.13	MinnesotaCare Tax (see page ___)	$
Line 3.0.14	**Other Costs** which cannot be allocated to above categories (see page ___) (**Include personnel** costs which cannot be attributed and allocated into above categories, such as general administration or human resources personnel)	$

Clinic Name: _____

Section 4: Cost and Effort of Reporting:

Line 4.1) Did you receive outside assistance in completing this report (e.g. consultants, accountants, etc)?

❑ Yes ❑ No

Line 4.2) Please include an estimate of the time spent to compile information for and completing this report:

_____ hours and _____ minutes.

Line 4.3) The Minnesota Department of Health is trying to make this form as easy for providers to complete as possible, within the requirements of the data collection legislation. *One idea that was suggested is to allow providers to report on their own fiscal year rather than a calendar year.* To help us determine how many reporting organizations would be affected by this, please tell us which accounting year you normally use, and the start and end of your accounting year.

Accounting Year Used: ❑ Calendar
❑ Fiscal Start date: _____ End date: _____

Line 4.4) Please attach your comments regarding this report.

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Clinic Name: _____

Attachment A: Site List

List all clinic sites. Please copy this form as needed for additional sites.

Please note: You may submit this list in another format rather than rewriting onto this page: *use the same field names in the same order.* Or you may submit by computer disc; please see back of this page for instructions.

Primary location name: (if different from reporting organization name)	Total encounters at this site: (See page ___)
Street Address:	
Building Name / Suite Number:	
City:	
State:	
Zip: County:	

Additional location name: (if different from reporting organization name)	Total encounters at this site: (See page ___)
Street Address:	
Building Name / Suite Number:	
City:	
State:	
Zip: County:	

Additional location name: (if different from reporting organization name)	Total encounters at this site: (See page ___)
Street Address:	
Building Name / **Suite Number**:	
City:	
State:	
Zip: County:	

Please see instructions for reporting addresses and encounters at "outreach" program sites.

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Clinic Name: _____

Attachment B: Provider List

Please list **physicians, dentists and chiropractors** whose billings appear on page 3. Revenues. Do not list other health care personnel. Please copy this form as needed for additional providers.

If there are providers at your facility *for whom you do not bill* for services that they provide (for example, outreach program physicians or contractors), do not list those providers on this report.

If you have this list already available in another format you may submit that list, rather than rewriting onto this page; *use the same field names in the same order*. Or you may submit by computer disc: please see back of this page for instructions.

Provider's First name	Middle name or initial	Last name	Suffix (for example, Jr., Sr., III)	Licensure Degree (e.g. M.D., D.O., D.D.S., D.M.D., D.C.) Please list only one degree.	Identifier (NPI, UPIN or state license number)

All data received on this form are private or non-public as applicable, except to the extent given a different classification by Minnesota Statute 62J

For help completing this form, call (612) 282-3822. Return form to: Minnesota Department of Health, Health Care Delivery Policy (HEP), P O Box 64975, St. Paul MN 55164-0975

Minnesota Department of Health

Health Care Provider Financial and Statistical Report - Data for Calendar Year 1995

Clinic Name: _____

Section 3: Expenses - CLINICS WITH LESS THAN $1 MILLION IN SECTION 2.4

Line 3.0 Total Expenses, Calendar Year 1995:

$_____

Please allocate Expenses above to each of the following expense categories:

(See page ___ for definition. Round to nearest whole dollar. Please complete all categories: enter a zero if you do not have any costs in a category.)

Line 3.0.1	Patient Care Personnel Costs (see page __)	$
Line 3.0.2	Malpractice Costs (see page ___)	$
Line 3.0.3	Research Costs (see page ___)	$
Line 3.0.4	Education - Degree Program Costs (see page ___)	$
Line 3.0.5	MinnesotaCare Tax (see page ___)	$
Line 3.0.6	All other costs: Include • Patient Care Costs other than personnel costs • Billing and Collection Costs (see page ___) • Patient Registration, Scheduling & Admissions Costs (see page ___) • Financial, Accounting, & Reporting Costs (see page ___) • Quality Assurance & Utilization Review Costs (see page ___) • Education - Patient and Public Health Education Costs (see page ___) • Education - Continuing Education and Other Costs (see page ___) • Promotion and Marketing Costs (see page ___)	$

October 4, 1995

Ms. Kathleen Kuha
Planner Principal
Health Care Delivery Systems Division
PO Box 64975
MN Department of Health
St. Paul, MN 55164-0975

Dear Ms. Kuha:

It is with some apprehension that the Minnesota Chiropractic Association requests that chiropractic doctors remain within the scope of the data collections mandate. Our request hinges upon data comparisons and applications that may arise from the data collected.

The MCA's apprehension centers around the seemingly arbitrary fashion that the data is being collected and the lack of information as to how this data will actually be used. The Department seems vague about the type of information it wishes to collect as well as divided about how best to collect the data and use it.

It is our understanding that the edict of the Department is to collect and analyze data to forecast rates of growth in health care spending and to set limits (MN Statutes 62J.35). The Department, under this mandate, also has the obligation of developing a tracking tool for consumer access, utilization and quality assurance. Surely the chiropractic profession does not wish to be excluded from this process; however, it is the Department's responsibility to ensure that the data collected is relevant to this mandate, appropriate in scope and adequate to answer the responsibility of the law.

This being said, the MCA would call to question any recommendation in which only a sampling is used to determine issues for the entire provider group as well as any information that is requested but not justified for its utilization. We share with other work group members the same trepidation of how the collected data will ultimately be used. In this same vein, we are concerned with the use of the 1994 collected data, since there seems to be significant limitations with this data. We urge the Department to cautiously provide this data with complete disclaimers to its reliability.

(over)

1700 W. Hwy. 36, Ste. 130
Roseville, MN 55113-4057
612/639-0863 · FAX 612/639-1951

There also seems to be questions regarding collaboration with the Department of Revenue for the use of 2 percent provider tax information. Perhaps the modem(s) of information sharing needs further discussion by the work group since tax data addresses only income issues without regard to actual costs.

As with most required forms, repetition of completion will afford greater ease of compliance and greater accuracy of the data. When there exists a comfort level with the reliability of the data, at some future time, there may be consideration of using samples to track the necessary components of this legislative decree. Until that time, consistent components of the data collection form will help to improve reliability. However, until substance exists proving that the data is accurate, the MCA urges that the Department require entities that request this information to include an explanation of the limitations of this data.

The MCA appreciates the opportunity to comment. We look forward to working with you to develop a reliable data collection tool.

Sincerely,

Loren Stockton, DC
President

Kendra Calhoun
Executive Director

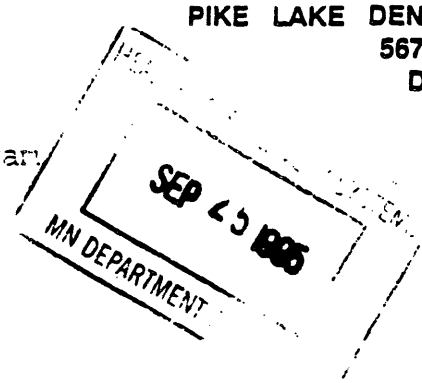
Zachary Kimble, DC
Work Group Advisory Member

Cc: MCA Board of Directors
MCA Legislative Committee

CARTER F. JOHNSON, D.D.S., F.A.G.D.

PIKE LAKE DENTAL HEALTH CENTE
5670 MILLER TRUNK HW
DULUTH, MN 55811-12
(218) 729-72

September 20, 1995



Dr. Lynn A. Blewett
Director, Health Economics Program
Minnesota Department of Health
Metro Square Building
121 E. 7th Place, Suite 700
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Dr. Blewett,

I have been a member of the Provider Data Work Group for the last three months. I feel that the issue, which data should be collected and from whom, is a critical one. It is the basis for the initiation of the survey, but in all the time and energy spent on this matter, I feel that we are not any closer to discovering the purpose of the information and its use.

I feel that the amount of tax money that has been spent on this survey was wasted. The time and energy that the doctors are being asked to spend providing information is also wasteful. Finally, no issues have been resolved because they have not been well defined. I am certain that others in the work group share my frustration.

Dr. Doug Reim's points about the surveys of dental offices are well taken. Most dental practices are small. Dentistry represents a small and very efficient part of the total health care dollars spent in Minnesota. Burdening dentists, who are usually the people who have to gather the data and submit the requested reports, is unreasonable. They do not have the staff, time, equipment or income personally to complete these surveys.

A lot, if not all of the data that you seem to be requesting is already available from the Department of Revenue and from the license surveys that accompany the Board of Dentistry's renewal form. In the interests of holding costs down both for dentists and taxpayers, couldn't a cooperative effort be initiated to gather the data that is already held by the state, and utilize it for your information purposes?

The form, as it has been laboriously redesigned by Ms. Kuha and Mr. Orren, really does not lend itself well to dental practices. It is better designed for use by large medical clinics.

Revenue sources for dental offices are not typically tracked in the categories you are requesting. In small dental offices, the requirement to begin tracking this information is onerous and unreasonable. The expense categories are also difficult to allocate because your categories do not exactly ask for information in the way that most offices categorize it. That means that the dentist has to sort through all this information, reorganize it and try to make it fit in the pigeonholes that have been designed by you for this report. Responders will be

creative in selecting categories that have been designed by non-dentists. This results in statistical chaos, where the data is meaningless.

If the interests of the Health Dept and the legislature were really to hold down health care costs, limiting the duplication of reports to government agencies would be a very good place to begin.

Very truly yours,

Cheryl L. Larson, Manager
Pike Lake Dental Health Center

Minnesota Dental Association
2236 Marshall Avenue, Saint Paul, Minnesota 55104 612-646-7454

October 12, 1995

Dr. Lynn A. Blewett
Director, Health Economics Department
Minnesota Department of Health
Metro Square Building
121 E. 7th Place
Suite 700
PO Box 64975
St. Paul, MN 55164-0975

OCT 16 1995

Dear Dr. Blewett:

As the Provider Data Work Group that is advising the Department of Health brings its business to a close, I wish to make clear the position of the Minnesota Dental Association regarding the use of a survey instrument.

The MDA believes that having dentists complete any version of the survey form under consideration will not provide useful additional data and will not be cost effective. Dentists already submit information to the Minnesota Department of Revenue with their provider tax forms. Additionally, the Department of Health's Office of Rural Health receives survey information annually when dentists renew their licenses with the Board of Dentistry. This information fulfills the statutory requirement.

The survey instrument being reviewed by DOH and the work group would not significantly enhance the information already available about the practice of dentistry in Minnesota--the survey is designed to gather information from medical (not dental) providers and it does not establish data categories that are meaningful to dentists or captured by them in their computer systems. As result, it would be particularly burdensome for most dentists to complete.

If dentists must respond to the survey, the data provided on the forms will mostly duplicate the information already provided from the other sources. Furthermore, it will not provide greater expenditure data since the categories on the form reflect medical rather than dental practices. This would not be a cost effective activity for the state to require of dentists.

Similarly, the idea of having larger dental offices complete either the long or the short form, perhaps on a periodic basis, is not any more justified than having all dentists prepare a long form or a short form. There are few dental offices above the $1 million threshhold (much less a higher threshhold, if one is considered), and these offices comprise a small portion of dental expenditures in the state, unlike the medical situation where large clinics comprise a large protion of total expenditures. Therefore, little additional useful information would be gathered. And, since the forms reflect medical

expenditure categroies more than dental, the long form would not really be any more descriptive of dental expenditures than the short form.

In conclusion, we see little value in requiring addtional forms to be filled out by all or by a few dentists, especially since the information that the State would collect is already being provided by other means. The Minnesota Dental Association therefore requests that dental providers be exempted from completing the Department of Health provider survey.

Sincerely,

Edward Kishel, Jr., DDS
President, Minnesota Dental Association

Minnesota Dental Association
2236 Marshall Avenue, Saint Paul, Minnesota 55104 (612) 646-7454

August 31, 1995

Dr. Lynn A. Blewett
Director, Health Economics Program
Minnesota Department of Health
Metro Square Building
121 E 7th Pl, Suite 700
PO Box 64975
St. Paul, MN 55164-0975

Dear Dr. Blewett:

An important issue that remains for this year's Provider Data Work Group is determining which data should be collected and from whom. Please consider the following points that I recommend to you regarding survey data from dental offices.

Most dental practices are relatively small. Dental services comprise a very small portion of the data that the Department of Health is attempting to collect. The data survey is designed to collect data from medial clinics and physicians and is, therefore, not well suited for the collection of data from dental practices. In either the long form or the short form, the survey requires considerable expenditure of time and resources in dental offices which are not set up with administrative staff or computer systems that can readily provide this information. Most of the dental data being sought by the DOH is already being collected by the Department of Revenue and the Office of Rural Health (from licensure surveys collected by the Board of Dentistry). Therefore, it is my belief that the minimal incremental benefit provided by either the long form or the short form of the survey does not justify the cost and effort involved in collecting the data. I recommend that data already being collected be used by the Department of Health and that the collection of additional and duplicative data in a provider sur[illegible]e discontinued.

A more detailed discussion follows.

The Department could gather most or all of the required data from the Minnesota tax return and from the ORH/Board of Dentistry surveys returned annually by dental license applicants.

Nearly all dentists qualified for last year's short form. This information is available from two existing sources. The Minnesota Tax Return already provides information on revenues.

Demographic information is available from a survey returned each year by applicants for dental licensure. It covers licensees' status (active, retired, etc.), practice location, type of practice, activity by category, specialty information, number of patients served. With respect to access, it is more detailed than the current data form.

Both the present and proposed long forms do not lend themselves to dental practices.

Because of the differences between medicine and dentistry, the long form is particularly difficult for dental practices. The long form is designed for large medical clinics. From a cost standpoint, these clinics provide most health care. Dental offices--even large group practices--do not and cannot easily break down revenue sources or expense categories as required by either the current or proposed long form. Even the demographic data presents a problem because it is tracked differently in medical practices than dental offices. For example, it appears that medical clinics find it easier to track patient encounters rather than number of patients. For dentists the reverse is true.

Many calls received by the Minnesota Dental Association regarding the 1994 form involved the inability to provide accurate data for the specific items.

Looking at the larger picture, dental expenses as a share of total health expenses have remained around 5% over the past five years. Dentistry is a small portion of the health care dollar. It is unlikely that the inclusion of additional survey data from dentists would have any effect on total data results.

In summary, the Minnesota Dental Association urges the Department to use the Minnesota tax return and the Minnesota Board of Dentistry license renewal survey as the data collection mechanisms for dentistry. Making the data collection process as simple and straightforward as possible would result in the highest compliance and most accurate data.

If you or anyone from the Department would like more specifics on our concerns, please feel free to contact me at 631-2944, or Mr. Richard Diercks at the Minnesota Dental Association, 646-7454.

Yours Truly,

Douglas K. Keim, D.D.S.

Douglas K. Keim, D.D.S.

August 21, 1995

VIA FACSIMILE: 282-5628

Ms. Kathleen Kuha
Minnesota Department of Health
Health Care Delivery Policy Division
121 East Seventh Place
Suite 400
St. Paul, MN 55164-0975

Dear Ms. Kuha:

As returning members on the provider financial and statistical report work group, we feel compelled to express our concerns with the work group process. In particular, we are concerned with the process by which changes to the reporting form have been proposed, and the process by which resolution of issues has been attempted.

The work group was developed to provide the department with technical assistance and expertise on issues related to the refinement of the financial and statistical report. Numerous individuals and organizations are contributing valuable time to this process in an attempt to improve the report and to garner consensus from the various representatives. The department, in proposing to expand the report beyond the specific statutory requirements, is obligated to show that the changes are reasonable, not arbitrary and capricious.

During the entire process, the department has been very indecisive and vague about the type of information it would like to collect. This is creating frustration for work group members. It is not, and should not be, the responsibility of the work group to justify the inclusion or exclusion of new data elements; rather, the work group has the responsibility to provide feedback to the department on the practical ability to provide the information and to develop suitable definitions to achieve the greatest level of compliance for the information requested. Unfortunately, we do not believe this has been the process employed. Numerous changes to the report have been proposed and suggested. Some of these changes are technical in nature, but others represent significant changes. The department, in our opinion, has not been forthright in explaining or justifying the rationale for these changes.

The department also appears to be in the position of supporting changes to the reporting form based on recommendations from various researchers. At no time, however, have any of these individuals attended a committee meeting to clarify or justify their request. This has resulted in the work group trying to guess the motivations and rationale for such requests, and the department attempting to support the requests. Without direct discussion and feedback, the process breaks down and work group members are left to speculate on the reasons for these "mystery" requests. The department has an obligation to ensure that individuals wanting to change the reporting form attend work group meetings to discuss the proposal. We are not opposed to the consideration of new ideas; however, we are opposed to discussing changes to the form which neither the department nor any one else can or will define or justify.

Many issues have been discussed at length by the work group and appear to be resolved, but the same issues emerge at subsequent meetings for further discussion. This speaks, again, to the department's

- apparent inability to define a specific, global agenda for the work group. For example, at an early meeting the department indicated its interest in collecting revenue received under capitated arrangements. The department's rationale for collecting this information was to monitor trends in capitation and to anticipate a legislative request. The work group spent a great deal of time discussing this issue -- attempting to decipher the department's intent in collecting the data, and attempting to clarify and define what such data would yield. The general consensus of the group was that such information would be very difficult to define and its value to policy makers was not apparent. Nevertheless, this item remains on the reporting form, without subsequent discussion or resolution.

The purpose of the data collection process can not be forgotten. The purpose of the financial and statistical report is to forecast rates of growth in health care spending and to set limits (MN Statutes 62J.35). Statutory authority can be modified only if changes help to further develop spending estimates, set spending limits, monitor actual spending, and monitor costs (MN Statutes 62J.41, subdivision 1). Work group members urge the department to consider changes to the document within this scope of authority.

For the most part, we were pleased with the report developed last year. Although there is certainly room for improvement and refinement, we are not convinced that numerous phone calls to the department justify a full-scale overhaul of the report. Rather, we believe that a thorough review of definitions is the best way to mitigate confusion, minimize questions and improve the validity of the data. The physical appearance of the form should be of secondary importance to the accuracy of data requested.

Also, please understand the concerns outlined above are directly related to our apprehension about how the data obtained from this report will ultimately be used. Although we understand the demands placed on the department, and the department's desire to present Minnesota-specific data to policy makers, we remind the department that there are significant limitations with all data collection efforts. Such limitations should be adequately identified on any documents utilizing the data, particularly data from the 1993 and 1994 reports. As this process continues, the reliability of some of the data is certain to improve as long as there is consistency in data elements collected. Until then, however, limitation footnotes are essential to avoid the development of policy based on inadequate or inaccurate data.

We appreciate the opportunity to comment. It is our intent to resolve as many outstanding issues as possible within the confines of the work group process. It is in both our interest and in the department's interest to avoid an administrative hearing. We look forward to working with you to resolve our concerns.

Sincerely,

Janet Silversmith, MMA
Kerry Durkin, Fairview
Tim Geisler, Mayo
Doug Keim, MN Dental Association
Jim Tierney, MMGMA
Kevin Walsh, Allina
Chuck Munster, MN Otolaryngology

JOHN W. LARSEN M.D., ISABEL FEINSTEIN M.D., MARK H. MONTGOMERY M.D., JOHN W. MECCL
SPECIALIZING IN SURGERY OF THE HEAD & NECK. DISEASE OF THE EAR, NOSE &
MINNESOTA OTOLARYNGOLOGY PA
AUDIOLOGY CYNTHIA L. RAVER, MA, SHARON L. PETERSON, MS, MARLENE A. JOHNS

August 17, 1995

Lynn Blewett
DHD/HCDP
121 E. 7th,Place #400
St. Paul MN 55101

Dear Lynn,

In 1992 Kenneth E. Thorpe wrote an article regarding the Black Box of Administrative Costs. He proposed an alternative to the cost accounting methods and wanted a functional accounting method of evaluating the costs of delivering medical care. His proposals included a desire to reduce administrative costs. He also supported the single payer system of health care. He wanted to get to the costs of billing and collection as he felt these costs could be saved if there were a single payer system.

Now we have adopted the Functional Accounting method of evaluating costs in the medical practices. By doing this we have imposed extraordinary costs on the medical community and at the same time have reports with data that is virtually unusable. The accuracy and consistence of gathering and evaluating information under this system is completely subjective and can only result in Highly questionable data. I know all too well that making good decisions from bad data is virtually impossible except in cases of blind luck. You can make people fill out the forms and you can give them some guidelines, but there is such a variety in medical practices, it seems impractical to make instructions comprehensive enough to have people complete the reports with consistency. I'll wager that if you went to every CPA firm (costs) and asked how they completed the forms, you would get a different answer each time. To me all this says is that the Functional Accounting method does not work and we are continuing to try to find ways to keep it going. Someone, sometime, somewhere is going to have to decide to find a better method.

It is a major shame that you have missed a number of meetings where we have discussed the problems that we face. The attempt to lump all the medical services into one size fits all has been graphically exposed as a major problem. Kathleen and Dave have heard and tried to synthesize some of our ideas. But, you are only getting the tail end of the discussions. You cannot appreciate the intensity of the ideas or the flavor of the presentations. So if you hear-- it can't be done-- or --it's going to be costly--know that they are telling the truth and not just dodging the issue.

Yours Truly,

Charles Munster

PMM Professional Management Midwest, Inc.

4640 W. 77 Street, Suite 340 • Minneapolis, MN 55435 • 612-831-2407

August 1, 1995

Kathleen Kuha
Minnesota Department of Health
Health Care Delivery Policy
121 East 7th Place, Suite 400
St. Paul, MN 55101

Dear Kathleen:

You asked us to report if it was possible for us to obtain the number of patients seen per year at a clinic. Many of our clients use the Medic computer system. It is possible with the Medic system to have the computer generate a report showing the number of patients seen per year. This would be available for the number of patients or the total visits of those patients per year. In other words, if one patient was seen six times, they would be counted once for the number of patients, or they would be counted six times for patient visits.

Unfortunately, I will not be able to attend the two sessions in the month of August that are scheduled for the 9th and the 23rd. I will be out-of-town both days.

If there is any other information that you would like or my input into any other issues, please feel free to give me a call or to send me a letter.

Very truly yours,

PROFESSIONAL MANAGEMENT MIDWEST, INC.

Dale R. Seubert, CPBC
Field Manager

DRS/jfr

Kelley Dental Clinic
2534 East Seventh Avenue
North St. Paul, Minnesota 55109
Telephone: (612) 777-6454

Kathleen Kuka,
Minnesota Department of Health
July 27, 1995

Dear Kathleen,

Due to a prior schedule I am unable to attend the August 9th Meeting. On page three of the Gram. Dept I would like the or left in, the ~~total~~ patient = individuals (not unique) and encounter Meaning a face to face service or evaluation. If the Dentist do not fill out this form I realize it doesn't matter. I would recommend we only fill out the Mn. Care Tax Form.

THE MINNEAPOLIS CLINIC OF NEUROLOGY, LTD.

Administration
Golden Valley Office
4225 Golden Valley Road
Golden Valley, MN 55422-4287
Telephone: (612) 588-0661

FAX: (612) 287-2303

FACSIMILE TRANSMISSION COVER SHEET

Date: 7/20/95 Time: 5:00 pm Pages (including cover) 2

To: Kathleen Kuka Fax Phone Number 282-5655

Company Name: Minn Dept of Health

Department Health Care Delivery Systems

From Lyle Spella, Health Care Provider Work Group

Regarding Suggested definition of "Other Operating Revenue" line as discussed at our 7/12 meeting

Comments: This is my thoughts on how best to define this category.

Hope it helps.

IF YOU DO NOT RECEIVE ALL OF THE PAGES OR EXPERIENCE OTHER PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL THE PERSON FROM OUR OFFICE NAMED ABOVE AT (612) 588-0661.

After faxing, material to be: [ ] Destroyed [ ] Returned

MCN:jh 8/94

POSSIBLE DEFINITION OF OTHER OPERATING REVENUE:

This includes all revenues or receipts which do not involve direct patient care. It includes but is not limited to: independent medical exams, expert witness testimony, DOT/FAA physicals, copying medical records, parking fees, cafeteria revenues, vending commissions, etc. Do not include investment or financing revenues like interest or dividend income, sale of assets/equipment, etc. These are considered to be non-operating revenues to be reported on line _____.

50 East McAndrews Road • Burnsville, MN 55337
Phone 612-892-5050

July 11, 1995

Ms. Kathleen Kuha
Minnesota Department of Health Fax No. 282-5628

RE: Rules 4651 Work Group Data Collection

Dear Ms. Kuha:

Thank you for keeping me up to date on the progress of the work group. I am sorry that I have been unable to attend the meetings in person. May I submit the following comments:

1. Depending on who you talk to, there are differing opinions as to whether or not dentistry should indeed be part of Managed Care in this State. I have noticed from the minutes there are three representative parts of dentistry participating within the "4651" Group.

The Providers Themselves
The Minnesota Dental Association
The Delta Dental Plan of Minnesota

Because each of these "players" have their very own special interests regarding the outcome of this report, the group should understand how their "special interests" affect their interpretation of the collected data. Even though dental care represents only a small percentage of the total health care dollar spent, dentistry must receive special considerations from medical care, if it is to continue to provide the quality care it has achieved by dedicated practitioners over the past quarter century.

2. Most often there are several different treatment options available to the dental patient (and dentist) as to how to restore a tooth. Each obviously costs a different amount to do. For example, materials used [gold, silver, or porcelain] as well as whether or not to extract the tooth in question. It is very definitely cheaper to pull a tooth than to place a gold crown on it. In a capitation plan where the provider is at financial risk, a dentist may extract the tooth because it is less costly to him or her. Certainly when a tooth is removed it should be replaced, but it is doubtful a capitation patient will be given a prosthesis to replace the tooth, because this would cost the provider even more.

3. The "DRAFT" of patient revenue for dentists needs reorganization. Whether it is long or short is not as important as if it realistic for the profession. For example, most dental offices make a lot less than $1,000,000 per year. They cannot generally differentiate the income received from the hundreds of different insurers they deal with. Dental offices can, however, easily differentiate the following income sources:

a. Medicare
b. Medical Assistance
c. Minnesota Care
d. PPO's
e. HMO's (Capitation)
f. Service Corporations (Delta & BCBS)
g. Commercial Insurers
h. All Others

I hope this information is helpful to you, and I apologize for getting it to you so late.

Sincerely yours,

Dr. Lloyd A. Wallin, D.D.S.

Minutes from Rules 4651 Work Group (Health Care Providers) for Monday, June 5, 1995

The work group began at appx. 10:00 a.m.

Members signed in were:
Liz Backe - MN Dept of Human Services
Pat Belland - Allina Health System
Carol Collier - John M. Collier D.D.S.
Kerry Durkin - Fairview Health System
Lou Fuller - MN Department of Health
Tim Geisler - Mayo Foundation
Tom Hogan - MN Department of Revenue
Debbie Jacobs - Metropolitan Orthotics
Dr. Douglas Keim, D.D.S. - MN Dental Association
Barbara Kelley - Kelley Dental Clinic
Dr. Zachary Kimble, D.C.
Dianne Knight D.D.S. - MN Dental Association
Chari Konerza - MN Department of Health
Anne Morse - Divine, Sherzer & Brody
Charles Munster - MN Otolayngology
Dawn Renner - Management Accounting Group
Trisha Schirmers - Allina Health System
Dale Seubert CPBC - Professional Management Midwest, Inc.
Tom Truax - Delta Dental Plan of MN
Kevin Walsh - Allina Health System
Debra Welle/Mary Dehmer - Healtheast
Yamei Wang - Mayo Foundation

Members not signed in:
Bernadine Feldman - U of MN, School of Nursing
Michelle Casey - U of MN, School of Public Health
Dick DeFalco - Delta Dental Plan of MN
Tedd Hauser - Medica/Allina Health System
Christine Heine - U of MN, School of Nursing
Rich Johnson, D.D.S.
Kathy Koehn - MN Nurses Association
Cheryl Larson - Pike Dental Health Center
Ann Reite - U of MN, Dept of Phys Med & Rehab
Tim Schmidt - Lurie, Besikof, Lapidus & Co.
Janet Silversmith - MN Medical Association
Leota Spalla - The Minneapolis Clinic of Neurology
Jim Tierney - MN Medical Group Managers Association
Dr. Lloyd Wallin, D.D.S. - Crestridge Dental

Members absent will continue to receive meeting minutes unless they indicate otherwise; please contact Laura Millsap at (612) 282-3847

This was the first and only joint meeting of all work groups connected with MN Rules 4650, 4651, and 4652. The general meeting began with Dave Orren, J.D., of the MN Department of Health (MDH) explaining the work group and rulemaking process. He was followed by Mary Kennedy, Director of the MDH Health Care Delivery Policy Division, who reviewed some of the data initiatives which will provide the Legislature information to measure the progress of and modify MN's health care reform.

The work group for Rules 4651 meeting began with a brief review of issues from providers who had contacted MDH in the last four months. A review of legislative requirements for this data collection and and a time frame for its completion were also given.

Discussion then centered on the process of modifying the Rules 4651 and what type of input will be required from the work group. The work group then moved on to the issues of data collection by MDH. The topics which were discussed were:

- What are the intended results of this data collection?

- Data collection process and progress
- Validity of data
- Timing of Report deadline for provider compliance
- Redesign of Provider Financial and Statistical Report
- Definition of Encounter & clarification of that term within the Report
- Tracking of costs incurred with Medicaid and MinnesotaCare services.
- Shortening of Report form through use of data from other sources.

The work group asked the MDH facilitator to go back and look at what major issues are to be addressed through the collection of this data and provide an overview for them to review at the next meeting on Wednesday, June 21.

After setting the next meeting for Wednesday, June 21, 1995 10a.m. - noon. at Professional Management Midwest, Inc., 4640 West 77th Street, Suite 340, Edina, MN 55435, the group adjourned at 11:45 a.m.

The MDH wishes to thank Dale Seubert of PMM for offering to host the next meeting.

Fax Memo

MINNESOTA DEPARTMENT OF HEALT
HEALTH CARE DELIVERY POLICY
121 East 7th Place, Suite 400
St. Paul, Minnesota 55101
Fax: 612/282-5628

June 21, 1995

To: Members and Interested Parties: Work Group On Health Care Provider Data Collection - Chapter 4651

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Joseph Witwicke	JBW Management Corporation	(612) 481-0497

From: Kathleen Kuha, Minnesota Department of Health
Phone: (612) 282-3822 Fax: 282-5628

Re: Minutes from Rules 4651 Work Group (Health Care Providers) for Wednesday, June 21, 1995

The work group began at 10:05 a.m.

Members signed in were:
Liz Backe, DHS
Pat Belland, Allina Health System #13502
Dick Diercks, Minnesota Dental Association
Kerry Durkin, Fairview Hospital & Healthcare Services
Bernadine Feldman, School of Nursing, U of M
Tom Hogan, Dept of Revenue
Zachary Kimble, Kimble Chiropractic
Dianne Knight, Minnesota Dental Association
Christine Heine, Minnesota Nurses Association
Debby Jacobs, Metropolitan Orthotics
Douglas Keim, Minnesota Dental Association
Kathy Koehn, Minnesota Nurses Association
Cheryl Larson, Pike Lake Dental Health Center
Charles Munster, Minnesota Otolaryngology
Dale Seubert, Professional Management Midwest, Inc.
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Minneapolis Clinic of Neurology
Jim Tierney, MN Medical Group Managers Associa
Tom Truax, Delta Dental Plan of Minnesota
Yamei Wang, Mayo Foundation
Kevin Walsh, Allina Health System, #13502
Debra Welle, HealthEast

Members and interested parties will receive all handout material and minutes. The agenda and directions for the next meeting will be faxed the week before the meeting. If you do not wish to receive materials and meeting notices, please contact Denine Casserly at (612) 282-5651.

The work group for Rules 4651 meeting began with a presentation by Lynn Blewett, PhD, Director of the Health Economics Program at the Minnesota Department of Health. Ms. Blewett discussed the data collection activities for all three sectors of the health care market, and provided preliminary results from the Provider SFR 1993.

The work group then reviewed a set of initial changes to Rules 4651 as received by the MDH during the survey process, and a first-draft process for which providers will get the "short form" next year in their MinnesotaCare 2% tax form, and which providers will get the "long form". A number of additional points were brought up by work group members.

Before the next meeting, members are requested to make comments on the initial Rules changes, suggest other changes, and prioritize the changes. Please mail or fax your comments by Friday

July 7 at 3 p.m., to Kathleen Kuha at Minnesota Dept of Health, Health Economics, 121 East 7th Place, St. Paul MN 55101; fax number (612) 282-5628.

Materials to be provided by MDH at the next meeting on Wednesday, July 12 are
1) a list and "priority votes" of changes for Rules 4651 from the work group members, as received by the previous Friday at noon.
2) a first mock-up of the 1996 format "long form" for the provider data collection.
3) copies of the executive summary of the National Provider Identifier from HCFA
4) preliminary data from the Revenue file on how many providers (medical, dental, chiropractic) would get the "short form" and how many the "long form" under the suggested data collection plan.

After setting the next meeting for Wednesday, July 12, 1995 2 p.m. - 4 p.m. at the offices of the Minnesota Medical Association, the meeting concluded at 11:50 a.m.

The Minnesota Medical Association's address is 3433 Broadway St NE, Ste 300, Minneapolis. Directions will be sent out with the agenda the week before the meeting.

The MDH wishes to thank Dale Seubert of PMM for hosting this meeting, and Janet Silversmith of the MMA for offering to host the remainder.

Minnesota Department of Health
Aggregate Data from Providers - Chapter 4651
Meeting Summary for July 12, 1995

Provider Rules Work Group Members and Interested Persons signed in:

Liz Backe, Department of Human Services
Lorraine Berger, Aspen Medical Group
Kerry Durkin, Fairview Hosp & HC Services
Bernadine Feldman, School of Nursing, U of M
Douglas Keim, Minnesota Dental Association
Zachary Kimble, Kimble Chiropractic
Chari Konerza, Minnesota Department of Health
Charles Munster, Minnesota Otolaryngology
Kathleen Kuha, Minnesota Department of Health
Cheryl Larson, Pike Lake Dental Health Center
Dave Orren, Minnesota Department of Health
Dale Seubert, Professional Mgmt. Midwest, Inc.
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Mpls. Clinic of Neurology
Kevin Walsh, Allina Health System
Yamei Wang, Mayo Foundation
Debra Welle, HealthEast

The meeting began at 2:08 with a presentation from the MDH Office of Rural Health and Primary Care.

The work group agreed that it is easier for them to work from the draft of the form rather than the Rules draft. However, the Rules must match the form exactly at the end of the work group process.

The issues discussed were:

- Whether the Provider Financial and Statistical report form could be more closely tied to the MinnesotaCare tax form. The group decided that due to differences in accounting and fiscal years, the revenues page of the PFS report could not be made to match the MinnesotaCare tax exactly.
- A replacement for the phrase "net patient receipts" which confused many providers. Work group members will come up with new words.
- Where PPOs should be placed (in Commercial or HMO category). It was decided to keep them in Commercial.
- Whether discounts and charity care/bad debt should be moved elsewhere on the form or redefined. They were left as is.
- Independent Medical Examinations, DOT and FAA physicals - are they patient care or other operating revenue? It was decided that these revenues should go in other operating revenue.
- Whether non-operating revenue (interest income, return on investment, etc.) should be reported and if so where. It was decided that it need not be reported, and a list of examples was generated. There was discussion of whether offering a list was useful to providers, or whether listing the items that should be reported and stating not to report all else was better. Unresolved.
- A long discussion of how to report capitated payments. Some group members questioned the need to report this trend. The group rejected itemizing each revenue category by capitated vs. fee-for-service: a simple measure of dollar totals or percent of revenue is more feasible. A definition of capitated is needed, or instructions on how to allocate revenues this way.
- The $1,000,000 cutoff for the "short form" or the long form. The work group looked at preliminary numbers which showed 6,301 providers altogether, out of which 485 would get the long form as well as

the MinnesotaCare tax form. Further analysis of the numbers is needed. (Note: the percentile values on the worksheet in the meeting materials are incorrect.)

The meeting concluded at 4:10. The next meeting is to be in two weeks. Wednesday July 26, 1995 at 2:00 in the same location (MMA, 3433 Broadway Ave Suite 300 NE, Mpls. (612) 378-1865)). Materials and new drafts will be mailed to members and interested parties on Thursday July 20.

The MDH wishes to thank Janet Silversmith and the MMA for providing the meeting space.

Minnesota Department of Health
Aggregate Data from Providers - Chapter 4651
Meeting Summary for July 26, 1995
at the Minnesota Medical Association, Mpls.

Provider Rules Work Group Members and Interested Persons signed in:

Lorraine Berger, Aspen Medical Group
Michelle Casey, Rural Health Research Center
Dick Diercks, Minnesota Dental Association
Kerry Durkin, Fairview Hosp & HC Services
Bernadine Feldman, School of Nursing, U of M
Tim Geisler, Mayo Foundation
Brenda Holden, Minnesota Department of Health
Debby Jacobs, Metropolitan Orthotics
Douglas Keim, Minnesota Dental Association
Barbara Kelley, Kelley Dental Clinic
Zachary Kimble, Kimble Chiropractic
Stella Koutroumanes, MN Department of Health
Kathleen Kuha, Minnesota Department of Health
Cheryl Larson, Pike Lake Dental Health Center
Charles Munster, Minnesota Otolaryngology
Dave Orren, Minnesota Department of Health
Dale Seubert, Professional Mgmt. Midwest, Inc.
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Mpls. Clinic of Neurology
Jim Tierney, MN Medical Group Mgrs Assn
Kevin Walsh, Allina Health System
Debra Welle, HealthEast

The meeting began at 2:05.

The subjects discussed were:

1) The feasibility and utility of reporting how many patients and how many encounters, using modified HCFA definitions. (See green draft form. "Patient" means individual; "encounter" means appointment, but only one appointment is counted if more than one occur in a day.) Some agreement was reached:
- "patients" would be extremely difficult for small clinics to collect, if they have unsophisticated or no software. Most would have to use the "chart shelf" method, sampling part of their chart room. This would probably produce unreliable data.
- "appointments" should be feasible for small clinics to collect, since they probably have paper appointment books and could sample a number of weeks in a year and then multiply.
- "patients" may be possible for larger clinics with more sophisticated software. Kathleen Kuha will contact some software firms (DISC, PACE) to see whether their databases are capable of extracting unique individuals.
- "encounters" would be very difficult for larger and multispecialty clinics to collect. These clinics often have patients who see multiple doctors and departments in a single day, and to reduce these to one-per-day encounters would be onerous. The larger clinics could probably produce a count of charge tickets or visit slips (whatever the local name for this) which would approximately equal "appointments." Alternatively, a method of counting significant (E &M, surgery, etc) codes might work.
MDH would like to note that both numbers are valuable, and if feasible, would like to collect both. Work group members are asked to prepare to discuss the relative effort of providing patients or appointments or both at the next meeting.

2) What the Legislature meant by "the total number of patients served". Is it to track patient volume by the literal HCFA definition, or is the object to be able to track utilization? If so, a measure that included not only how many people went to the doctor but how many appointments were kept would be more descriptive.

3) Which clinic staff should be listed on the FTEs page. In 1993, almost a third of the staff were in catego "Other", and preliminary 1994 data have even more in "Other." It would be desirable to get all patient-care staff out of "Other." Retitling the category may solve the problem. Also, whether we need to continue to have clinics separate four types of nurses, when similar data are available from ORHPC.

4) Whether it is feasible to continue to collect the employee FTEs by clinic site. MDH has been told that this was the most time-consuming part of reporting (through multiple provider telephone calls to MDH, 1995). Since there is considerable turnover in staff, rotation of staff, and centralization of administrative functions, assigning these FTEs may have been a guess at best for many clinics. The work group felt that discontinuing this would be an improvement. Whether valuable data would be lost was undecided.

5) Whether it is feasible to collect financial and utilization information at each site, specifically revenues, encounters (appointments), and expenses. The work group rejected expenses immediately; expenses are a centralized function. Appointments may be feasible. Revenues is not as feasible as gross charges, because patients may be seen at multiple sites and payments may come in aggregated for those appointments. Gross charges will not be the same values as revenues, but would indicate the growth or decline from year to year at a site.

6) Whether it is useful to provide "outreach" program information. While outreach programs increase access to specialty care, the variability of the programs may mean that the data would be quickly out of date. The burden of providing an outreach site list would be quite low.

7) The need and effort required to provide physician specialties on the provider list Attachment B. Some clinics use different specialty codes than the HCFA/ ORHPC codes listed and they would need to re-code. Since MDH has access to physician (MD and DO) lists from health plans and ORHPC, it may be unnecessary to collect this item. However, collecting it would be a minimal effort because clinics supply this list to health plans often. It is usual to identify the physician specialty on such a list and it would be somewhat odd without it; also, the clinics would be supplying correct and current information.

8) The need to collect other kinds of providers on the provider list, other than physicians, dentists and chiropractors. While MDH understands that some professions are very willing to participate in enumeration, collecting additional types of providers (who outnumber physicians, dentists and chiropractors by a wide margin) would introduce a large burden on both the clinics and MDH. Currently the provider list is primarily a tool for checking compliance, and as yet only the three listed providers are required to comply, so collection of only these three types is enough.

9) Another plan for who will get the "full form". We had previously discussed limiting the full form to clinics over $1 million annual revenue, at which level we would survey 485 out of 6,300 clinics, and capture 83% of the dollar volume. The rest of the clinics would report 1995 data only through their MinnesotaCare tax return, which would allow limited analysis. Because small clinics are the ones of greatest interest in rural areas, and because impending federal funding cuts may affect small clinics more than larger clinics, the loss of data would be very significant. Therefore one option would be to continue to collect the full form (minus the expenses page as before for small clinics) from all medical clinics, and discontinue or scale back reporting from the other providers.

The chiropractic association expressed an informal and preliminary opinion that they would wish to continue reporting. They cited, in particular, the learning curve, and that it would be a pity to lose the second year's data which is probably going to be much better than this first year. The dental association had no opinion at this

time. but has expressed a willingness to be sampled. Some intermediate position may be worked out. for instance requiring a report from these two provider types once in five years. getting 20% of the chiropractic and dental providers each year. (The 20% is an example for illustration only.)

If using the formula "all medical clinics. plus no other providers" MDH would collect about 1081 clinics and about 63% of the total dollar volume. If using the formula. "all medical clinics. plus 20% of the chiropractic and dentist market by clinic count", MDH would collect about 1650 clinics and an estimated 68% of the total dollar volume. (Source: MinnesotaCare tax information. Dept of Revenue. July 1995)

10) Whether there is enough need for the "cost of government reporting" question to write a definition and method for it. Without a standard way to estimate. providers indicated (telephone calls) that they were very frustrated by this question. The work group did not seem so attached to it as to want to write a standard format for how to estimate this number.

MDH wishes to thank Janet Silversmith and MMA for providing the meeting space.

The meeting concluded at 4:20.

Minnesota Department of Health
Aggregate Data from Providers - Chapter 4651
Meeting Summary for August 9, 1995
at the Brennan Education Center, Fairview Riverside Hospital, Minneapolis.

Provider Rules Work Group Members and Interested Persons signed in:

Liz Backe, Department of Human Services
Dick Diercks, Minnesota Dental Association
Kerry Durkin, Fairview Hosp & HC Services
Beth Feckter, Department of Revenue
Bernadine Feldman, School of Nursing, U of M
Tim Geisler, Mayo Foundation
Debby Jacobs, Metropolitan Orthotics
Douglas Keim, Minnesota Dental Association
Zachary Kimble, Kimble Chiropractic
Kathleen Kuha, Minnesota Department of Health
Charles Munster, Minnesota Otolaryngology
Dave Orren, Minnesota Department of Health
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Mpls. Clinic of Neurology
Kevin Walsh, Allina Health System

General comments:

The work group expressed several reservations about the limits of all data collected, and especially about interpretations of the data which may not be properly supported. For instance, it may be of interest to produce an "average revenue per encounter" value, by dividing total revenues by total encounters. The number so produced from these data would describe essentially nothing, because there is no such thing as an "average encounter." The broad definition of encounter used in this data set encompasses every patient contact from a tooth-cleaning to major surgery, and attempting to describe Minnesota's clinics with such a number would be worse than nonsense. The cost of the thousands of component services in total revenues is so variable that an average could not begin to describe them. Therefore the work group expressed that in some cases, no data are better than poor data.

Another problem expressed by the work group is that they felt they were being asked to produce opinions and judgements of the feasibility of various data items without a clear picture of why the data element was requested, and what actions might be taken based upon the results. Some data elements, notably the encounters and dollars by site, were requested by research groups who have not attended many of the work group meetings nor experienced much of the discussion, and have not been available to provide in-depth information on how the requested data would be used. Thus the balance between need and feasibility has been obscure, and the work group felt that the emphasis was sometimes shifted to them to show why they *couldn't* produce data when the emphasis should be for MDH to show the need and reasonableness of the data requested.

The following are a detailed discussion of the topic which took the most time at the meeting (namely, encounters and charges by site), and shorter discussions of the remaining topics of the meeting.

Encounters and charges by site:

General comments: The work group expressed frustration over the request to provide statistics on encounters and charges by site. They felt that the explanation of why the data are needed was less than comprehensive, that the encounters and charges values collected may not provide an accurate picture of the financial health of a clinic site, and that the burden of collecting these data would be high.

Need for data: MDH requests these encounters and charges per site in order to demonstrate trends in utilization, especially at rural clinics, which may indicate the financial health of the clinic. Changes in encounters may show that a clinic is losing or gaining patient volume. Changes in charges, without concurrent changes in encounters, may show price

increases. Either value may demonstrate not only how much access to physicians is available, but how much is actually used on a trend basis, comparing from year to year in the same clinic or region. The information would be valuable to researchers in access to care in rural areas and to rural legislators. Note that access to physician services might also be obtained from 1) FTEs of provider groups by site, or 2) the ORHPC databases of nine licensed occupations.

Background: Clinics may be associated as a system, perhaps spanning a large geographic area. The system's aggregate values for encounters and charges may not be sufficient to show increases or decreases in utilization in smaller areas, such as a county. Therefore, values by site are preferable.

Charges vs. Revenues: In all other areas of the report, revenues are requested. For this instance, charges are requested because it appears that revenues per site would be very difficult to obtain. "Revenues" may be defined as "charges" less discounts and bad debt. That is, the amount charged for a patient's visit is generally reduced by the payer in the form of a discount or according to a fee schedule. The patient sees the doctor, a charge is generated, and the bill is sent to the payer. The payer reduces the amount to pay, and remits the reduced amount to the provider's billing office. (Also, the patient may pay a part of the bill, or have secondary insurance, or capitation, or there may be other confounding issues involved.) A patient may visit more than one site or more than one provider, and the visits may eventually be combined into one reimbursement. Therefore, the revenues from the original charge may be very difficult to assign to a single clinic site.

The original clinic visit, however, almost always takes place at a specific site and clinic systems enter charges by site into their computer systems, as a logical tracking method and because certain reimbursement programs require site of service on the bill (e.g. Medicare). Charges by site will *not* be the same number as revenues by site, but charges should be feasible to collect. Thus charges are requested as a proxy for revenues.

As noted by a work group member, introducing a new term "charges" when previous pages used only revenues may be confusing to clinics. MDH is aware that charges will not equal revenues. The "charges" values would only show the trend from year to year at a particular clinic site or region.

Reasonableness of request: The request for encounters is reasonable because the clinics report encounters as a system, and those encounters are "booked" at particular sites. The system only needs to disaggregate them. The request for charges is a compromise for a request for revenues by site; charges are directly associated with encounters (encounters generate charges). These are direct measures of utilization at a site, and differ from each other. Encounters measures patient volume, while charges measure both price and volume.

Burden of reporting: The values are being requested on the PFS report because to do so would decrease need to do additional surveys by other MDH entities who would use these data, which would lessen the clinics' burden of reporting. It would also reduce the cost to the taxpayer of collecting substantially similar data in two or more efforts.

An argument against requesting encounters and charges by site is that the burden of reporting the data on a per-site basis would be significant for large clinic systems. The benefit, if any, would be to small clinics and rural systems. Requiring all clinics to report by site, when the data would be used to describe few clinics, puts an unnecessary burden on many. Additional surveys which are closely targeted to the population of interest would be more cost-effective.

Work group response to reasonableness of request: The work group questioned whether the data requested were adequate for the requested purpose, that is, to describe trend in utilization to study the financial health of clinics. They pointed out that changes in encounters at a clinic site may be a result of an outbreak of illness, aging of the local population, arrival of a new doctor, service, or specialty, or some other factor. Similarly, increases in charges are attributable to many causes. Thus, the data collected may not satisfy a primary validity test. Encounters and charges, while they may show utilization trends, do not provide an answer to the question of financial health of a clinic site.

Work group members suggested that FTEs per site would be a measure of the financial status of a clinic site; that is more employees suggest positive changes in volume and/or price, while decreases in FTEs would indicate less volume. However, MDH suggests that this would be an even less direct measure of financial status, and would be subject to the

same or more variability than encounters and charges.

The work group questioned the statutory authority to collect unaggregated data on single clinics and to use the data to monitor trends at single clinics. Some members of the work group also expressed concerns that such data might be used at some later date by MDH to micro-manage clinics.

The authority to collect this data is contained in Minnesota Statutes, section 62J.41, subdivision 1, which states in pertinent part: "The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on: [ten specific categories are listed]; and (11) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs."

The guidelines on the use and dissemination of this data are contained in Minnesota Statutes, section 62J.321, subdivision 5, paragraph (a), which states: "Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter."

Clearly, the statute does allow collection of unaggregated data, which might be analyzed in an unaggregated fashion in order to draw conclusions which must then be aggregated before release. That is, these data might be used to demonstrate something like: "Between year 199x and 199y, 30 clinics in Region Z increased encounter volume, 20 decreased encounter volume, and 80 clinics stayed the same."

MDH conclusion: MDH management will be advised of work group discussion and concerns.

Definition of Patient, Encounter

Two definitions of "patient" and "encounter" were reviewed.

HCFA uses and has a definition for the term "encounter." MDH suggested that giving the term "encounter" a different definition for purposes of the Provider Financial And Statistical Report would be confusing to providers. MDH suggested using "appointment" or some equivalent. Work group members stated that encounter already has a number of definitions attached to it and that providers would not be confused by one more. Therefore, "encounter" is to be used.

The HCFA definition of 'encounter' is "a face-to-face encounter between the patient and a licensed health care provider during which a CPT-coded service is rendered. Encounters with more than one professional and multiple encounters which take place on a single day and at a single location constitute a single encounter. If the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment, an additional encounter may occur."

Agreement was reached that the HCFA definition of encounter was unworkable, because it may require clinics to reduce multiple face-to-face visit per day by the same patient to one per day, an almost impossible task even on a sophisticated computer system. Further, multiple physician visits in a day constitute more use of the medical system than a single visit, and should be counted as multiple encounters if MDH wants to use this as a measure of patient volume.

"Encounter" was therefore loosely defined as a provider contact at which a medical, dental, or chiropractic service is rendered. The work group is invited to send in their definitions which may be combined into the final product.

For some clinics, encounters normally occur face-to-face, one per day, and are readily counted through an appointment book or computer (e.g. chiropractic, general dentistry). For others, the following rules apply:
- global visit charges should be counted as multiple services even though there is a single charge for the code (e.g. prenatal visits, orthodontics), because they increase volume demand upon the system.

- some services are never face-to-face (e.g. pathology, radiology), but should be counted as encounters because they are demand upon the system. The count would reflect one encounter with the films or specimen, not one count per film or specimen.
- services which involve two physicians of different specialties (surgeon + anesthesiologist, telemedicine of FP + specialist) should count as two encounters.
- services rendered independently by non-physician providers such as nurse practitioners or dental hygienists count as encounters.
- some services consist of a professional component and a technical component, and the technical component may be significant (e.g. the technical component of an MRI may be $1,000). To avoid double counting, the group agreed that the technical component should not be counted, even if the clinic only provides the technical component or it is a high-dollar service. Every technical component has a professional component which will be counted.

The work group recommended that MDH not prescribe how each clinic is to come up with its count. Rather, each clinic may count, sample or calculate as needed to fit its business systems. However, the form directions (not the Rules 4651) might include suggested methods, if the work group will contribute methods.

Patients may be defined as "the number of unique individuals evaluated or treated during the year." An individual may be seen one or multiple times for one or several illnesses or injuries, but will always count as one patient. "Patients" is difficult to count without a computerized system, and may not be feasible for small clinics to provide. Rough estimation methods, such as estimating the percentage of charts with a 1994 tag, were criticized by the work group.

The options for computerized counting of patients and encounters were researched through DISC, PACE and Medic software vendors. The vendors all reported that they could produce a count of unique individuals, and could produce a count of encounters either through defined CPT codes or, more readily, a count of charge slips. Some controls would have to be included to subtract the no-shows. PACE and DISC felt that making a report based on patient accounting rather than the scheduling module would be easier and more universal, since clinics do not always buy computerized scheduling.

MDH has requested both encounters and patients on the report. The reasons for this are that number of patients shows how many persons are using the medical system. Encounters shows volume of visits. Values are expected to change as insurance coverage changes, as prices change, as new systems of care emerge, and through demographic changes such as an aging or more-ill population. The request will be further discussed at the next meeting.

Expense allocations and accounting categories

A work group member suggested that it would be useful to clinics to provide a guide to allocation from the usual accounting categories, to the functional categories used in the report. MDH will try to index the two categories together. If the relationship is one-to-many it may be feasible, but it is also possible the index would be even more confusing to providers. MDH will try it and the work group may give their opinion.

Other Expense discussion:

"Other" now includes all items which cannot be allocated to the functional categories. One of these items is administrators' salaries and benefits. The work group reported that these costs are not readily allocable because administrators' work does not fit the categories. (The work of human resources personnel also does not fit into the categories.) The work group stated that they would place these costs in "Other." MDH asked whether this would not make the "Other" category a euphemism for administrator costs and make it a target for those who believe administration costs are high in health care. The work group did not agree.

MDH prefers that identifiable items which are common in many clinics be given a home so that all clinics report consistently. Administrator costs will be placed in "Other," and the instructions will include a direction to clinics to complete the item in this fashion.

"Utilization review and quality assurance" has a definition which clearly identifies these costs as those for *internal* clinic review. However, many health plans use the term "utilization review" to mean preauthorization, precertification, or prior approval processes. Some clinics have personnel whose jobs are to respond to prior approval requests, and may have placed costs for these personnel in the utilization review and quality assurance category. (These costs belong in the patient care categories.) A simple retitling of the category to "Quality assurance and utilization review" may make it less confusing.

A work group member also asked why the category was necessary. Only a few clinics in Minnesota are large enough to dedicate significant amounts of time and personnel to internal review. If the category is small, why have it? [Note: the category was included in last year's report so that these costs would not skew other categories at these few large clinics. It was felt that having the category would not be a burden for the other clinics because they could easily know that their costs for this category would be zero.] If necessary, this subject will be discussed at the next meeting.

Outreach sites:

The encounters by site discussion touched on the definition of a "site." Which of their sites should providers list on Attachment A?

It seemed reasonably clear to define what a site is NOT: it is not a temporary and contractual arrangement such as an outreach site. A site could be defined as a location where the provider sees patients regularly, where the provider has some ownership or rental agreement for space, may keep a telephone, equipment, or records, and probably has a sign on the building.

The list of sites is needed by MDH to keep its mailings correct as we do not want to send report copies to all the sites of a system. The burden of providing a site list is low because clinics frequently supply this to health plans and use such a list for marketing purposes.

Whether MDH could make use of an *outreach* site list is unknown. The list could be used to show access to various specialties. However, because outreach programs tend to change as patient demand changes, the information would be out of date quickly. The list would require information on which specialty provider went where, with some indication of how many hours and how often, to be useful. The detail would likely be a burden.

Wording and form changes:

~~Health care professional costs~~ should be changed to patient care personnel costs. "Professional" has a connotation of 'licensed' or certified in some way, and the category is meant to include all those whose jobs exist to provide patient care.

Remove "estimated" checkbox from expenses. Expense allocations are assumed to be estimated.

The name of the category ~~Patient and Public Health Education Costs~~ should be changed to Costs - Patient and Public Health Education to be consistent with the other education categories.

Whether the provider list Attachment B needs to have a provider "licensure degree" field (M.D., D.O., D.D.S., etc). MDH needs this field to separate the providers, as neither license nor UPIN number series can distinguish the three types. The next field, "additional degrees", was included as a courtesy, as providers may wish to include their additional degrees. MDH does not need a specialty designation on this list.

Note regarding minutes from 7/26/95 meeting:

The minutes for the 7/26/95 meeting did not contain MMA's position regarding MDH's idea to send the Report Form only to medical doctors. Assuming medical doctors will continue to be monitored, MMA is opposed to MDH sending the Report Form only to medical doctors. MMA's reasons are:

- The legislative intent is to survey all health care providers. Under the current rules which governed the collection of 1994 data, the Report Form is already limited to medical doctors, chiropractors, and dentists. To further limit the scope of the data collection would go against the legislative intent to look at all health care providers.
- MMA is concerned about the inequity of the burden on medical doctors who would have to report, while other health care providers would not.
- MMA is also concerned about data loss. MMA agrees that the bulk of health care spending in Minnesota is related to medical doctors. However, the other types of health care providers certainly have an impact on state health care expenditures.

Please note that which providers would be completing the report for 1995 was NOT discussed at this meeting.

The meeting concluded at 4:18. The next meeting will be Wednesday, August 23, 2:00 - 4:00 p.m. at MMA. *If* an additional meeting is needed it would be Wednesday, August 30, 2:00 - 4:00 p.m. at MMA.

MDH wishes to thank Kerry Durkin and Fairview for providing the meeting space.

Minnesota Department of Health
Aggregate Data from Providers - Chapter 4651
Meeting Summary for August 23, 1995
at the Minnesota Medical Association, Minneapolis

Provider Rules Work Group Members and Interested Persons signed in:

Lorraine Berger, Aspen Medical Group
Lynn Blewett, Minnesota Department of Health
Dick Diercks, Minnesota Dental Association
Kerry Durkin, Fairview Hosp & HC Services
Beth Feckter, Department of Revenue
Bernadine Feldman, School of Nursing, U of M
Tim Geisler, Mayo Foundation
Christine Heine, School of Nursing
Douglas Keim, Minnesota Dental Association
Barbara Kelley, Kelley Dental Clinic
Zachary Kimble, Kimble Chiropractic
Kathleen Kuha, Minnesota Department of Health
Charles Munster, Minnesota Otolaryngology
Dave Orren, Minnesota Department of Health
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Mpls. Clinic of Neurology
Kevin Walsh, Allina Health System
Yamei Wang, Mayo Foundation

The meeting began at 2:05.

Dave Orren announced the continuation of the work group meetings for two more dates, September 6 and 20, 1995. The rules are being extended mainly because the hospital rules have been extended, and we hope to be able to better coordinate the data between the two reports. MDH is trying to develop a single report for "systems" (which range from a rural hospital affiliating with the local clinic, to large health systems of multiple hospitals, clinics and health plans). The single system report will reduce the burden of reporting. It must be developed carefully to avoid loss of detail. Common data items and definitions are key to successful integration of the reports; extending the PSFR work group will help.

Persons from this work group who would like to participate in the hospital work group are requested to call Denine Casserly at (612) 282-5651 to be added to the mailing list for "Rules 4650". You may also send a message by e-mail: Denine.Casserly@health.state.mn.us.

The timeline is affected by extending the work group's meetings. Previously, MDH estimated that these rules would be complete, with a hearing, by the end of 1995. Now it appears that the rules will be completed by the end of January or mid-February 1996. If we can avoid a rules hearing, the rules would be complete two months earlier.

The site-specific information requested on the PFSR is similar to the important utilization data elements requested on the Health Care Information System (HCCIS) hospital report.

The comments on the meeting summary from last meeting led into the agenda for this meeting. There was a question on the authority to collect information by site. Dave Orren and Lynn Blewett explained that data may not be *released* in a form which identifies any participant, but that authority to *collect* unaggregated data is clear. There was also a comment on justification of "reasonable" by the relative 'easyness' of the provider getting a piece of data. A balance exists between need and the amount of work required to get a data elemen. Data that is difficult to get requires a stronger justification than data which is easy to obtain.

The following data elements were discussed:

Encounter:

The definition of "encounter" appearing in the rules draft dated 8/23/95 is adequate. Additional guidelines on how to count encounters will appear in the report directions (see notes from 8/9/95), but not a specific method. Some providers will use an appointment book method, others will count significant CPT codes, and others will take a sample. However, the estimate will be improved over 1994 and will provide the Legislature an estimate of total utilization of clinics.

Patients:

A "patient" is understood to be an individual human being who visits a clinic, but is counted once for the whole year regardless of how many visits during the year. An analogy may be the 'customer base' of a retailer: a customer base of thousands is different from a customer base of a hundred, even if the two groups purchase the same total dollar amount of goods in a year.

Unique patients is extremely difficult for small clinics to count. Three software vendors report that a count of patients could be added as a standard data report. However, there are lots of vendors and it may be expensive for all to modify software. Non-computerized clinics would have difficulty complying with the request.

The work group also reported that there would be a significant amount of double counting of patients. In a non-staff-model situation one person is likely to go to more than one *clinic* and be counted more than once. In a staff model or multispecialty clinic the same amount of medical care is likely to be rendered within the clinic, and be counted once. This inconsistency would make the data suspect.

Encounters and/or patients

MDH is interested in both 'customer base' and utilization, that is, both encounters and patients. The work group recommends requesting encounters, but not patients, as data elements.

For 1994 data, the clinics were given a choice between encounters and patients, which resulted in a less usable data set. A preliminary analysis of the 1995 data shows that clinics prefer to count encounters, but the choice varies by provider type. The work group will discuss the implications of requiring clinics to count encounters.

Percent of clinics choosing to count:	1994 Patients	1994 Encounters	No answer
Medical Clinics	27%	66%	7%
Dental Clinics	52%	43%	5%
Chiropractic Clinics	38%	55%	7%

Revenue by site

Revenue by site was requested because researchers and rural legislators are very interested in keeping clinics open, or what factors keep clinics open, and it was thought that revenue would be a major factor. It affects policy because if clinics are closing, the Legislature is capable of providing grants or encouraging programs such as the University's Primary Care training program in areas where clinics are in trouble. (Recently, six rural Minnesota hospitals have received grants through the Financial Assistance Grant Program to preserve health care access in rural areas of the state.)

The work group reported that a) revenue by site is almost impossible to get, and would be an allocated estimate, and b) revenue may not be the most important factor in whether the clinic site is to stay open. As with hospitals, revenue from a variety of sources may be transferred into a clinic site in order to keep it open, depending on the strategic need for the clinic site. Systems prefer to count revenue as a whole system, and the revenue flow cannot readily be described as belonging to one part or another. While the work group recognizes the value of having information that affects policy, they felt that this report would be poorly targeted toward gathering that data.

Charges by site:

Charges by site was suggested as a proxy for revenue by site, as it might give some picture of the finances of a clinic. The work group reported that their systems do not customarily count charges by site but they may be able to come up with this raw data. However, the relationship of charges to actual revenue is highly variable by payer and by provider, depending on the fee schedule and contractual relationships. Charges by site will be discussed again in the work group.

Encounters by site:

Encounters by site will apparently be feasible to count. Of the data elements available, encounters by site seems the most valid element in answering questions of utilization in regions (rural vs. urban), or types of clinics (e.g. is utilization at community clinics with sliding scale/free care increasing?).

There are many factors involved in changes in utilization, including changes in the population or disease patterns, which must be described at any time the data is released. MDH requested the help of the work group members in developing these caveats, and will include them in future publications.

There was a very brief discussion of other site-related data elements, such as payment source by site. Payment source by site, while probably valuable and available, may be onerous to provide.

FTEs by site remain up for discussion. The work group did not seem to object to providing this item, but it was a source of a lot of phone calls and objections from providers during the 1995 reporting period. Information on FTE time spent in each clinic is available from the ORHPC databases for licensed providers.

Patient Pay and Medicare:

Discussion returned to the "patient pay" category. A potential problem with payment sources is changes in definitions. Payment source can appear to be shifting, when the source of the apparent changes may be definition changes in the report.

For 1993 data, providers were NOT requested to separate patient payments from Medicare payments. Medicare payments consisted of all Medicare-covered services, regardless of the source of payments for those services.

For 1994 data, providers were instructed to separate patient pay from Medicare payments, and do the same for other categories. The Medicare category should have consisted of payment received directly from Medicare. Patient co-pays, deductibles and Medicare supplement payments were placed in their respective categories.

For providers who do not participate with Medicare, the 1994 method may significantly overstate patient payments, since most of the revenues received for Medicare-covered services do not come directly from Medicare. [Comments from Mayo Clinic.]

Patient Pay and MinnesotaCare tax

Providers are required to include patient payments from Medicare-covered services in the Medicare category for the MinnesotaCare tax. They are exempt from tax on the amount received from Medicare or patients and/or Medicare supplements for Medicare-covered services. However, some providers find that separating the Medicare patient pay (which they can subtract as an exemption), from the rest of the patient pay is more difficult than overpaying the tax.

MDH recognizes that it would be desirable for clinics to be able to use the same number, for the Medicare category at least, on both the PFSR and the MinnesotaCare tax statement. However, taxes are computed on a *cash/calendar* basis. Providers using accrued, modified cash, and/or a fiscal year will not match the MinnesotaCare tax number in any case.

Therefore MDH is in favor of using a method that is consistent from year to year within the PFSR. It will be noted on the instructions that the MinnesotaCare tax is computed on cash/calendar, and may not match the PFSR number for Medicare.

Patient Pay and burden of reporting

MDH wishes to have an accurate picture of how much patients pay for health care out-of-pocket, and what the trend is in out-of-pocket pay, as a policy issue. The patient pay category consists of copays, deductibles, non-covered services, and self-filed insurances. It is not an exact source of patient out-of-pocket payments. The alternate resource for out-of-pocket payments is payer data. Payers calculate 'patient responsibility' for the explanation of benefits (EOB). However, how much of the patient responsibility is paid and how much ends up as bad debt is an open question. Another complicating factor is drugs and supplies paid for out of the clinic which are not claimed through insurance.

To get an accurate value for patient pay for clinic services, MDH will have to require providers to separate patient pay from each category, placing it all in the patient pay category as was requested for 1994. This will be inconsistent with the MinnesotaCare tax.

Whether providers were able to separate patient payments from third-party payments in 1994 is uncertain. In general, we believe that small providers do not have the systems to allocate revenues exactly to the patient or Medicare or third-party payer. In less sophisticated accounting systems, all revenue for a patient who is coded "Medicare" or "Commercial" will be allocated to that category. In other systems, every patient payment may be recorded as "private pay" without indicating the original insurance coding of the patient. There is considerable variation among accounting systems, and a given provider may be using either or both methods in their insurance categorization.

An idea suggested in this work group was to allow providers who *cannot* separate patient pay from third-party pay within insurance categories to report this way on the 1995 PFSR. They would also check off that the category includes some amount of patient pay as well as third-party revenues. Providers who *can* separate patient pay would continue to do so as in 1994.

MDH would NOT be able to determine how much patient revenue is included in a category, but would be able to distinguish "those who can" from "those who can't", and modify analysis based on this. This compromise reduces the burden of reporting on providers, but results in a mixed data set.

Please note that it is possible that the 1994 data set is mixed, even though providers were requested to separate patient pay.

The work group recommends maintaining consistency in the definitions, and requiring providers to begin to separate patient pay into the patient pay category. The work group emphasized that if the providers are required to begin modifying systems, then data will become more consistent in future. This is desirable. MDH will consider the balance between accurate data and the work required of small providers.

Miscellaneous topics:

There was short discussion of why R.N.s would be counted separately from non-nurse allied health providers. It was decided to leave the section as it appeared after the 8/9/95 meeting.

There was a discussion of whether "outreach" sites should be counted as sites when encounters, etc. are to be reported by site. Apparently some providers have as many as 60 outreach sites, and it seems onerous to request full information on each of them. A compromise may be to have full information for "owned" clinics sites plus a single total for "all outreach sites".

The meeting ended at 4:00.

Next meeting:

There will be two additional meetings of the Rules 4651 work group.

Wednesday, September 6, 1995 2:00 - 4:00 p.m. at the offices of the Minnesota Chiropractic Association, 1700 West Highway 36, Suite 130, Roseville MN. Rosedale Towers is the big white building across from, and south of Rosedale. Phone: (612) 639-0663.

From Minneapolis: take Highway 35W north to Highway 36 east. Take the Fairview exit south, turn left on the south frontage road by Frank's Nursery.

From St. Paul: take Highway 35W north to Highway 36 WEST. Take the Fairview exit south, turn left on the south frontage road by Frank's Nursery.

Wednesday September 20, 1995 2:00 - 4:00 p.m. at the offices of the Minnesota Medical Association, Broadway Place East, 3433 Broadway St NE, Suite 300, Minneapolis. This is the glass building with maroon pillars at the intersection of Broadway Ave. and Industrial Blvd. Phone (612) 378-1865.

The topics remaining to be discussed are:

- Which providers will get the long form?
- Which providers will get a reduced version of the long form? (for 1994, clinics with less than $1 million did not complete the expenses page)
- Which providers will report only through the MinnesotaCare tax form?

- The value, difficulty, reliability and definitions for the "capitated vs. fee for service" question.
- Complete the discussions on FTEs by site, encounters and/or charges by site, and requiring patient pay to be separated from third party payments.

Minnesota Department of Health
Aggregate Data from Providers - Chapter 4651
Meeting Summary for September 6, 1995
at the Minnesota Chiropractic Association, Minneapolis

Provider Rules Work Group Members and Interested Persons signed in:

Lynn Blewett, Minnesota Department of Health
Debra Welle, HealthEast
Dick Diercks, Minnesota Dental Association
Kerry Durkin, Fairview Hosp & HC Services
Jim Golden, Minnesota Department of Health
Christine Heine, School of Nursing
Debby Jacobs, Metropolitan Orthotics
Douglas Keim, Minnesota Dental Association
Barbara Kelley, Kelley Dental Clinic
Zachary Kimble, Kimble Chiropractic
Kathleen Kuha, Minnesota Department of Health
Dave Orren, Minnesota Department of Health
Dale Seubert, Professional Mgmt Midwest
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Mpls. Clinic of Neurology

The meeting began at 2:05.

Dave Orren reviewed the rules adoption process and where we will go next. As we finish this developmental phase of the rules, we will continue to work on the Statement of Need and Reasonableness. After final decisions are made on which data elements are needed and reasonable, the rules as written will go to the Revisor, who will review them for syntax and correctness (not for content). The next step is publication, followed by a 30-day public comment period. A hearing may be requested during this time.

Repeat announcement: Persons from this work group who would like to participate in the systems/ hospital work group are requested to call Denine Casserly at (612) 282-5651 to be added to the mailing list for "Rules 4650". You may also send a message by e-mail: Denine.Casserly@health.state.mn.us.

The meeting summary from August 23 did not reach most of the members in time for review before this meeting. After a brief reading, one comment was noted: payment source by site (pg 3) is probably NOT available.

A copy of Minnesota Statutes 62J.301, 62J.311, 62J.321 and 62J.41 was reviewed briefly. This section of statute defines the Commissioner of Health's requirements to collect and analyze data to: "(1) assist the state in developing and refining its health policy in the areas of access, utilization, quality, and cost; (2) assist the state in promoting efficiency and effectiveness in the financing and delivery of health services; (3) monitor and track accessibility, utilization, quality, and cost of health care services within the state; 4) evaluate the impact of health care reform activities".

The following issues and data elements were discussed:

Charges by site:

Although revenue by site is the information most needed by MDH, charges by site was suggested as a proxy revenue by site. As clinics are becoming part of systems, MDH is losing the ability to measure geographic distributions of health care spending.

As the work group discussed, there seems to be a significant difference between small clinics and the large

clinic systems (Allina, Fairview, HealthEast) in the validity and reliability of charges by site. Small clinics would be able to produce reasonably meaningful numbers for each of their few sites' charges. In the large systems, charges by site has less meaning because the system shifts resources as needed for business or strategic purposes. MDH and the large clinic systems agreed to study this problem further at a later date in order to find some meaningful method of gathering data that will help MDH maintain its data collection. Charges by site will remain in the rules and on the form; the joint system-MDH study will help to evaluate its meaning.

FTEs by site were clarified. The question here is whether to continue to collect these data by site instead of for clinics as a whole. The disadvantages are that information on time spent in each clinic is available from the ORHPC databases for licensed providers, that in 1995 providers apparently gave "home office" sites (not site FTEs) for many providers, and that this page took a long time for many providers to complete. The advantage is that this page describes how many jobs (including administrative and other) are supplied by the medical, dental, and chiropractic professions in many small cities. The decision was to stop collecting FTEs by site.

Patient Pay

MDH wishes to have an accurate picture of how much patients pay for health care out-of-pocket, and what the trend is in out-of-pocket pay, as a policy issue. The patient pay category should consists of copays, deductibles, non-covered services, and self-filed insurances. To get an accurate value for patient pay for clinic services, MDH will have to require providers to separate patient pay from each category, placing it all in the patient pay category as was requested for 1994.

Whether providers were able to separate patient payments from third-party payments in 1994 is uncertain. In general, we believe that some or many providers do not have the systems to allocate revenues exactly to the patient or Medicare or third-party payer. In some accounting systems, all revenue for a patient whose primary insurance code is "Medicare" or "Commercial" will be allocated to that category. In other accounting systems, every patient payment may be recorded as "private pay" without indicating the original insurance coding of the patient. There is considerable variation among accounting systems, and a given provider may be using either or both methods in their insurance categorization.

The idea to allow providers who *cannot* separate patient pay from third-party pay within insurance categories to report this way and indicatethat the category includes some amount of patient pay as well as third-party revenues was eliminated. Providers will be required to separate patient pay in all categories. The goal of this is to improve consistency in the data, although it will require providers to begin modifying systems.

Payment Methods: Capitation, Fee-For-Service, and other variations

Section 2.5 of the pink draft form was discussed again. MDH wishes to begin baseline collection of how providers are paid, because the issue of providers accepting risk for health care contracting is likely to become important soon. For instance, the Buyers' Health Care Action Group is planning to begin direct risk contracting with providers. In order to begin to answer questions like who is accepting risk, how the risks are negotiated, and whether risk is moving to a level which is untenable for providers, a baseline value is needed.

The difficulty with this question is that capitation and risk-sharing have both many variations and multiple levels. Jim Golden reported that the question had been previously evaluated in another group. The working definition used there had three "bands":

- Straight capitated by per-member per-month, with no relationship between number of services provided and payment, only a negotiated sum.

- Straight fee-for-service, where a fee is charged and paid. Discounted fee for service as in BCBS, Medicare or a PPO is included in this band.
- Other variations on partial risk, as in "withholds", or part fee-for-service and part lump sum payment.

The "other" variations band contains a lot of grey areas, but beginning to collect the data will help to better define the question.

Multiple levels of capitation, such as subcapitation to a specialty provider, were briefly discussed. Whether these payments are captured as an expense or as a deduction from revenue is not clear.

MDH will draft a format in the form and definitions in the rules for the three bands. Any suggestion for a better descriptive word than "bands" will be gratefully received.

Who will complete which form:

Which providers will complete the "full form", which will get a reduced version of the Expenses page, and which will report only through the MinnesotaCare tax form was discussed.

MDH's position on this is that in order to maximize data collection while minimizing expense and provider burden, the following reporting will be required:

- All providers will complete the MinnesotaCare tax form as required by Minnesota statute.
- All medical clinics over $1 million in total revenues (section 2.5) will complete the full form as attached.
- A sample of medical clinics under $1 million in total revenues (section 2.5) will complete the form w. the reduced expenses page (attached) as page 5, instead of the full form page 5. The size of the subgroup and the variability of the data in the subgroup will determine the sample size.
- Chiropractic and dental clinics over $1 million in total revenues (section 2.5) will complete the full form
- A **sample** of chiropractic and dental clinics under $1 million in total revenues (section 2.5) will complete the form with the reduced expenses page (attached) as page 5, instead of the full form page 5. The size of the subgroup and the variability of the data in the subgroup will determine the sample size.

Form	Who gets
MinnesotaCare tax form	All providers
Full form	Medical, dental, chiropractic clinics over $1 million
Form with reduced expenses page	A sample of medical, dental, chiropractic clinics under $1 million

The advantage of using this method (large clinics report all data; small clinics are sampled, and report a reduced number of data elements) is that data collection remains excellent for the largest part of the market in dollars, and the sampling allows checking of 1994 baseline data for smaller clinics. Also, this method means all professions are treated alike.

Reduced Expenses Page

There was a discussion of what would constitute a reasonable "reduced" expenses page. Last year small providers did not complete the expenses page except for total expenses. Because many providers did not seem to have read the definition of total expenses, odd numbers (like $5,000) showed up in the category, and it seems

likely that we will not use a lot of the data.

There are several items on the expenses page which are of interest in the coming legislative session: malpractice, medical education (degree program costs), and research. It would be worthwhile for the provider community to be able to highlight these items. Malpractice costs tend to be a simple number. Degree program education and research, if present, should not be very difficult for providers to quantify, and for most providers these can be expected to be "easy zeros".

Whether providers would be able to separate expenses into patient care and non-patient-care is a more difficult question. MDH had suggested requesting the above items, plus combining Lines 1 and 2 into one category of patient care, and lumping all the rest into general expenses (Version A of page 5). On review, it seemed to the work group that if Line 2 (Other Patient Care Costs) had to be split out from general expenses, then the provider might just as well keep on separating them into the original full-form categories.

A member suggested that Line 1 was easily separated into its own category, then Line 2 could be lumped into general expenses. This provides some additional data, more than lumping all expenses, but may pose some privacy concerns. In a one-provider office, the personnel costs would be that provider's salary and benefits. The work group could not state whether the privacy concern would be significant because there were no representatives of very small offices present.

Revised Version "A" (as sent out 9/15)	Version "B"
Patient care personnel costs	
General expenses	General expenses (includes Patient Care Personnel Costs)
Malpractice	Malpractice
Degree program education	Degree program education
Research	Research

Miscellaneous topics:

Outreach sites: There was a clarification of whether "outreach" sites should be counted as sites when encounters, etc. are to be reported by site. The compromise reached last meeting was to have full information for "owned" clinics sites plus a single total for "all outreach sites". Instructions for this would be included in the report. Leota Spalla will review those instructions, along with other clinics who have large outreach programs.

Employer Reimbursement: Employers may reimburse patients directly for services. Which category this would belong in was questioned. MDH believes that if the reimbursement was because the employer was self-insured for group health, then the reimbursement would probably look to the provider like commercial insurance as it would probably come in through a TPA. If the reimbursement was of a employer cafeteria-plan reimbursement for a deductible, then the reimbursement would look to the provider like patient pay.

Fiscal Year: Whether providers might in future begin to report based upon their own fiscal year, rather than the currently required calendar year, was briefly discussed. Hospitals report on HCCIS by their fiscal year: they are

required to have the report in by the following quarter. While it would be much easier and more accurate providers to work from a year-end report, the logistics of getting the report out and back is a concern for MDH.

The potential problems with fiscal year reporting are getting the report to the providers at the appropriate time, getting it back promptly, and the transition year. Transition between calendar and fiscal would require completing an entire interim report to separate the overlapping data. There are also a great many more providers than hospitals (more than 1,000 vs. 156), and providers go in and out of business much more readily than hospitals.

MDH agrees that the fiscal report would be a lot easier on the providers, and is willing to consider the question for a later issue of the report. For 1995 data, we will add a survey question to determine how many providers use a fiscal year and what the common year boundaries are. If judged practical from this question, MDH will develop a plan for the transition after 1995 data are in.

The meeting ended at 4:10.

MDH would like to thank Zack Kimble and the Minnesota Chiropractic Association for the meeting space and treats.

Next meeting:

Please note that the Provider Rules work group meeting scheduled for September 20, 1995, IS CANCELLED.

An additional meeting was suggested to review the final drafts of the rules and form. The suggested date is October 4, 1995, from 2:00 to 4:00 p.m. **IF there is enough interest in this additional meeting, after your review of these drafts, it will be held as below.** If the meeting does not seem necessary, it will not take place. In either event, we will send notice on September 27 of whether the meeting will be held on October 4.

Please call Dave Orren at (612) 282-6310 if you feel it would be worthwhile to have this final meeting.

If there is a meeting, it will be Wednesday October 4, 1995, 2:00 - 4:00 p.m. at the offices of the Minnesota Medical Association, Broadway Place East, 3433 Broadway St NE, Suite 300, Minneapolis. This is the glass building with maroon pillars at the intersection of Broadway Ave. and Industrial Blvd. Phone (612) 378-1865.

Thank you!

Minnesota Department of Health
Aggregate Data from Providers - Chapter 4651
Meeting Summary for November 13, 1995
at the Minnesota Medical Association, Minneapolis

Provider Rules Work Group Members and Interested Persons signed in:

Lynn Blewett, Minnesota Department of Health
Mary Dehmer, HealthEast
Dick Diercks, Minnesota Dental Association
Kerry Durkin, Fairview Hosp & HC Services
Douglas Keim, Minnesota Dental Association
Zachary Kimble, Kimble Chiropractic
Stella Koutroumanes, Minnesota Department of Health
Kathleen Kuha, Minnesota Department of Health
Chuck Munster, Minnesota Otolaryngology
Dave Orren, Minnesota Department of Health
Dale Seubert, Professional Mgmt Midwest
Janet Silversmith, Minnesota Medical Association
Leota Spalla, The Mpls. Clinic of Neurology
Yamei Wang, Mayo Foundation

The meeting began at 2:05.

Dave Orren reviewed the time line for adoption of the provider rules. The highlights of this are:

- The proposed rules and a Notice of Intent to Adopt will be published in the State Register on December 11, 1995, or shortly thereafter.
- A 30-day public comment period follows publication. During this time, you and other interested persons can submit comments regarding the rules and suggestions for changes to the rules. Also, during this time, you can request a hearing on the rules before an administrative law judge. If there are 25 requests for a hearing, a hearing must be held.
- If there is no hearing, the rules would be adopted in mid-January 1996 and would become effective sometime around the end of February 1996.
- If there is a hearing, the rules would be adopted in mid-March 1996 and would become effective sometime around the beginning of April 1996.

The rules, SONAR, and report form drafts mailed to you before the meeting are in almost-final form. The Department might still make changes to these documents based upon persuasive comments received or as part of the final internal Department review and approval process.

Discussion regarding the almost-final drafts of the rules, SONAR, and report form followed. Members of the work group reiterated some concerns over certain data elements. The "out-of-pocket" category is overstated because it contains an unknown amount of self-filed insurance, which is not really a patient out-of-pocket expense. However, there is no pratical way for the provider to know when a payment from a patient is a self-filed insurance payment, or an actual out-of-pocket. MDH will "caveat" this on public materials.

Another concern was potential double counting of services which are sold by one clinic to another. See page 30 of the revised SONAR; the work group discussed this point at length but was not able to come to a conclusion due to lack of the member whose clinic sells a large

part of their services. He was contacted after the meeting. The decision was to request clinics who sell services to place them in "other operating revenue" and for clinics who purchase services to include them as a patient care expense.

Othe possible confusion arises when a patient has a claim processor different from the eventual payer of the services, e.g. a Medica or UCare "PMAP" (pre-paid Medical Assistance project) client. Does this revenue belong in Medical Assistance or HMO? The group agreed that it would be in HMO because the provider cannot be expected to track the difference among patients' plans. MDH has another data source, from DHS, to check this element.

The group discussed the question of allocating revenues between the three categories of capitated, fee-for-service, and partially capitated / withhold (everything else). The group agreed that simplifying the question to the dollar amount of per-member per-month capitation may provide almost as much information as the more complex question, but would be significantly easier for providers to complete.

Additional smaller points were covered. One was the term "employed by or own the clinic" at the top of the provider list. A more inclusive phrase "all the providers whose services you bill" would be better. The phrase "on a request by a provider" in 4651.0150 subpart 1 might lead one to think that a provider may discontinue the reporting process in favor of other data sources, but a closer reading shows that the Commissioner of Health shall determine this.

4651.0110 subpart 5 needed to be rewritten so that it does not conflict with subpart 2; subpart 5 might have been read to require a short report form, whether or not the provider had been included in the sample described in subpart 2.

Which providers will complete the form (be included in samples) was briefly discussed. Starting in 1996 for 1995 data, dental and chiropractic providers will be excused from the reporting process unless cause is determined by the Commissioner to include them. Medical organizations whose revenues exceed $1 million will report as in previous years. The small medical providers sample, which is intended to reduce the number of providers under $1 million who must report, would begin in the January 1996 mailing for 1995 data. Exactly which and how many of the small medical providers would report remains open, and MDH requested MMA's assistance in constructing the sampling frame.

The meeting ended at 3:55.

MDH would like to thank all work group members for their time, effort, and dedication. The rules and report form will be better tools for the collection and analysis of data and will be less burdensome on providers because of your involvement in the process.

MDH would like to thank Janet Silversmith and the Minnesota Medical Association for the meeting space and treats.