

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE DEPARTMENT OF HEALTH

In the Matter of the Proposed Expedited  
Rules Relating to Minnesota Health Care  
Claims Reporting System,  
Minnesota Rules, Chapter 4653

**ORDER ON REVIEW  
OF RULES UNDER  
MINN. STAT. § 14.389  
AND MINN. R. 1400.2410**

On May 22, 2009, the Minnesota Department of Health (Department or MDH) filed documents with the Office of Administrative Hearings (OAH) seeking review and approval of the above-entitled rules under Minn. Stat. § 14.389 and Minn. R. 1400.2410.

Based upon a review of the written submissions by the Department, and for the reasons set out in the Memorandum which follows below,

**IT IS HEREBY ORDERED THAT:**

1. The proposed rules were adopted in compliance with the procedural requirements of Minnesota Statutes, chapter 14, and Minnesota Rules, chapter 1400.
2. According to Minn. Stat. § 62U.06, subd. 3, the Department has the statutory authority to adopt these proposed rules using the expedited rulemaking process.
3. The following rule part is **DISAPPROVED** as not meeting the requirements of Minnesota Rules, part 1400.2100, item D:
  - (A) Minn. R. 4653.0400; and,
  - (B) Minn. R. 4653.0600 to the extent it seeks to enforce the coding practice on data elements "MC 032 – Service Provider Specialty" "MC 038 – Claim Status" and "MC 063B – Allowed Amount."
4. All other proposed rule parts are approved.

Dated: June 5, 2009

/s Eric L. Lipman

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ERIC L. LIPMAN  
Administrative Law Judge

## NOTICE

Minn. Rule 1400.2410, subp. 8, provides that an agency may ask the Chief Administrative Law Judge to review a rule that has been disapproved by a Judge. The request must be made within five working days of receiving the Judge's decision. The Chief Administrative Judge must then review the agency's filing, and approve or disapprove the rule within 14 days of receiving it.

## MEMORANDUM

The Department requests approval of proposed expedited rules governing the Minnesota Health Care Claims Reporting System. In 2008, the legislature directed the Department to create a provider peer grouping system to make publicly available comparative information on health care cost and quality. Specifically, under Minn. Stat. § 62U.04, the Department is to create the provider peer grouping system by collecting and interpreting encounter, pricing and quality data.

The language at Minn. Stat. § 62U.04, subd. 4 requires, as follows:

Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

- (1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;
- (2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and
- (3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

To accomplish this directive, the Department has developed the Minnesota Health Care Claims Reporting System (MHCCRS).

The legislature has authorized the Department to use the expedited rulemaking process to adopt these rules. The Department published a *Notice of Intent to Adopt Expedited Rules* in the *State Register* on March 23, 2009, and submitted the proposed rules to the OAH for review as to their legality on May 22, 2009.

**I. Standards of Review**

In expedited rulemaking, the legal review of the proposed rules is conducted according to the standards of Minn. R. 1400.2100, items A and C to H.<sup>1</sup> These standards state:

A rule must be disapproved by the judge or chief judge if the rule:

- A. was not adopted in compliance with procedural requirements of this chapter, Minnesota Statutes, chapter 14, or other law or rule, unless the judge decides that the error must be disregarded under Minnesota Statutes, section 14.15, subdivision 5, or 14.26, subdivision 3, paragraph (d);
- ...
- C. is substantially different than the proposed rule, and the agency did not follow the procedures of part 1400.2110;
- D. exceeds, conflicts with, does not comply with, or grants the agency discretion beyond what is allowed by its enabling statute or other applicable law;
- E. is unconstitutional or illegal;
- F. improperly delegates the agency's powers to another agency, person or group;
- G. is not a "rule" as defined in Minnesota Statutes, section 14.02, subdivision 4, or by its own terms cannot have the force and effect of law; or
- H. is subject to Minnesota Statutes, section 14.25, subdivision 2, and the notice that hearing requests have been withdrawn and written responses to it show that the withdrawal is not consistent with Minnesota Statutes, section 14.001, clauses (2), (4), and (5).

**II. Compliance with Procedural Requirements**

The Department complied with all of the procedural requirements of Minnesota Statutes, chapter 14, and Minnesota Rules, chapter 1400.

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<sup>1</sup> See, Minn. R. 1400.2410, subp. 3 (2007).

### **III. Substantial Difference Analysis**

The Department received a significant number of comments from interested parties in response to the Notice published in the *State Register*. In response to those comments, the Department made significant changes to the proposed rules. The Administrative Law Judge finds that none of the changes to the proposed rules make the rules substantially different than originally published in the *State Register*.

### **IV. Compliance with Enabling Statute and Other Applicable Laws**

Commentators identified four key areas in which they asserted that one or another provision of the proposed rules was beyond the lawful authority of the Department to promulgate. The claims are addressed in turn below.

#### **A. Part 4653.0100, Subpart 4 – Information on Covered Individuals**

In Part 4653.0100, subpart 4, the Department proposes a broad definition of “covered individual;” a definition that, because of the careful drafting of specific exclusions, includes those Minnesota residents who hold coverage under a policy “issued as a supplement to Medicare, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, *et seq.*, as amended.”<sup>2</sup>

The Minnesota Council of Health Plans and Blue Cross and Blue Shield of Minnesota assert that the Department is not permitted to collect health care encounter data from individuals who are covered by Medicare supplemental insurance plans. The commentators advance two different arguments in support of this view.

First, the Minnesota Council of Health Plans argues that because Medicare supplemental plan is not a “health plan” that is otherwise subject to state regulation under Chapter 62A, it is likewise beyond the reach of state data collection efforts under Chapter 62U. The Administrative Law Judge disagrees. The State of Minnesota could not, as it does with respect to private insurance companies operating in Minnesota, regulate the offerings of a federally-established health insurance program in Chapter 62A. The exclusion of the federal program from the reach of that Chapter is both reasonable and natural. Likewise, the Legislature’s forbearance from attempting to set minimum terms for a federal insurance plan is not an indication that the Legislature may not – or does not wish to – assemble data about the utilization of the federal program, when this data is in the hands of Minnesota’s health care providers. Collecting data on the local use of Medicare insurance programs is a different regulatory purpose than setting the minimum terms for these programs.

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<sup>2</sup> Compare, Proposed Rule 4653.0100 (4) with Minn. Stat. § 62A.011 (3)(10) (2008).

Second, Blue Cross and Blue Shield asserts that because the rules seek to collect health encounter and claim data relating to the Medicare Advantage (MA) program, the regulatory goal is preempted by 42 U.S.C. § 1395w-26 (b) (3). In this law, Congress states:

The standards established under this part supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to the [Medicare Advantage] plans that are offered by [Medicare Advantage] organizations under this part.

When adopting a later conforming set of regulations, the U.S. Department of Human Services' Centers for Medicare and Medicaid Services (CMS) spoke to Congress' intent to occupy the regulatory field as to the operation of the Medicare Advantage program. CMS writes:

The [Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA")] amended section 1856(b)(3) of the Act and significantly broadened the scope of Federal preemption of State law. We proposed to revise § 422.402 to clearly state that MA standards supersede State law and regulation with the exception of licensing laws and laws relating to plan solvency. In other words, with those exceptions, State laws do not apply to MA plans offered by MA organizations. We believe that the Conference Report was clear that the Congress intended to broaden the scope of preemption in the MMA. We accordingly believe that the exception for State laws that relate to "State licensing" must be limited to State requirements for becoming State licensed, and would not extend to any requirement that the State might impose on licensed health plans that absent Federal preemption must be met as a condition for keeping a State license.

....

We note that the Conference Report makes it clear that the Congress intended to broaden the scope of Federal preemption with the intention of ensuring that the MA program as a Federal program will operate under Federal rules. We have also clarified (in the preamble to the interim regulation) and we restate here that we believe that State licensing laws under Federal preemption are limited to State requirements for becoming State licensed, and cannot be extended to other requirements that the State might impose on licensed health plans that absent Federal preemption must be met as a condition for keeping a State license. We believe that under current Federal preemption authority States are limited in applying only those requirements that are directly related to becoming State licensed. For example, State-licensing requirements may include requirements such as filing articles of incorporation with the appropriate State agency, or satisfying State governance requirements. However, under Federal preemption, State

licensing laws may not be extended to include rules that apply to State licensed health plans which we believe would include network adequacy requirements for MA plans.

See, 70 Fed. Reg. 4663-64 (January 28, 2005) (emphasis added).

While CMS does place very broad data disclosure requirements into its Medicare Advantage contracts – insisting upon access to “all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services,” including “information on health outcomes”<sup>3</sup> – Blue Cross and Blue Shield does not indicate which federal standards are interrupted, frustrated or derailed by the proposed state rules. The bare claim that if federal authorities wish to see a record, no Minnesota official may demand the same data is overly broad and untrue. A more direct clash with CMS regulations is required before a preclusive effect is warranted – and such a conflict is not apparent on this record.

#### **B. Part 4653.0100, Subpart 19 and Part 4653.0600 – Establishment of Submission Thresholds**

In Part 4653.0100, subpart 19, and the accompanying Appendices that are incorporated by reference in Part 4653.0600, the Department proposes to establish a series of data submission standards – denominated “thresholds” – by which the completeness of submitted data will be assessed.

The Minnesota Council of Health Plans asserts that the Department does not have authority to establish such standards for completeness. The Administrative Law Judge disagrees. Subject to the three limitations in Minn. Stat. §§ 62U.04, subdivision 4,<sup>4</sup> the Legislature conferred upon the Commissioner of Health the power to specify the “form and manner” of the submissions of health care encounter data. Because the standards for completeness do not violate the statute’s strictures on de-identification of identifiable information, identifying health care homes and requesting data covered by section 62J.536, they are properly within the Legislature’s delegation of rulemaking authority to the Department.

#### **C. Part 4653.0400 – Variance Provisions**

The Minnesota Council of Health Plans, HealthPartners and Medica assert that the provisions of Part 4653.0400 (General Variances to Data Elements, Submission Specifications, and Data Element Characteristics), are beyond the delegation of rulemaking authority made by the Legislature. In this part, the Department proposes a process through which the Commissioner of Health could modify the number,

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<sup>3</sup> See, 42 C.F.R. § 422.504 (f)(2) (2008).

<sup>4</sup> See, page 2, *supra*.

characteristics and specifications of data elements submitted under the MHCCRS without undertaking formal rulemaking.

The Department asserts that the Commissioner's power to designate the "form and manner" of the data submissions (under Minn. Stat. § 62U.04, subd. 4 (a)) likewise includes the power to later modify data elements, data element characteristics, submission specifications and standards for the completeness of data elements. According to the Department, modifications will be necessary to fine-tune the rules and to keep pace with changes in federal Health Insurance Portability and Accountability Act (HIPAA) regulations and analogous state regulations.

Part 4653.0400 appears to propose a variance process, similar to the process now used by regulated parties under Minn. Stat. § 14.055, for the Department's own use. The Commissioner proposes to cabin exercises of this variance power by limiting future revisions to the range of required data to instances where: (1) the changes are necessary to comply with a state or federal law, or will improve the quality of, or directly enhance, the use of the data being collected; and (2) the data is readily available and will not create a material additional burden on those submitting the data. Additionally, in all cases except the changing of a submission specification, the proposed rule provides that the Commissioner will provide notice and an opportunity to comment to interested persons before modifying an existing rule.

While such regulatory flexibility may be well-intentioned, and desirable, the Administrative Law Judge does not agree that the Commissioner has been delegated the power to modify these regimens outside of formal rulemaking. A plain reading of Minn. Stat. § 62U.06, subdivision 3 makes clear that the Legislature has granted the Department two options for regulatory change – ordinary rulemaking or expedited rulemaking.<sup>5</sup> The provisions of Chapter 62U do not authorize processes, outside of those in Chapter 14, for making revisions to the data disclosure rules; and a separate, less formal process is not lightly inferred.

The instances when the Minnesota Legislature has carved out specific exceptions to the rulemaking – such as where (1) notice and comment by stakeholders on the procedures of a government agency is inappropriate;<sup>6</sup> (2) the regulatory environment in a given area is so fact-specific that the process for developing a general rule is not useful;<sup>7</sup> or (3) the regulatory environment as to a particular subject is so dynamic and unstable that any general rule is quickly outmoded<sup>8</sup> – are rare and explicitly stated in the statute books.

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<sup>5</sup> See, Minn. Stat. § 62U.06 (3) (2008) ("For purposes of this chapter, the commissioner may use the expedited rulemaking process under section 14.389").

<sup>6</sup> See, e.g., Minn. Stat. § 14.03 (a)(1), (a)(3) and (b)(1); Minn. Stat. § 84.027 (16) (2008).

<sup>7</sup> See, e.g., Minn. Stat. § 14.03 (b)(2) and (b)(3) (2008).

<sup>8</sup> See, e.g., Minn. Stat. § 14.03 (a)(2), (a)(4), (b)(4), (b)(5), (b)(6), (b)(7) and (b)(8); Minn. Stat. § 97C.005 (2008).

To correct the defect in the proposed rules, the language of part 4653.0400 must be deleted in its entirety. Deletion of the proposed language at part 4653.0400 is needed and reasonable, and will not make the proposed rules substantially different than originally proposed.

**D. Part 4653.0600 – Requests for Data that is Not Otherwise Included in a Health Care Claim or Equivalent Encounter Information**

The Minnesota Council of Health Plans, Blue Cross and Blue Shield of Minnesota and HealthPartners assert that some of the data element characteristics included in the MHCCRS Appendices exceed the data collection and transmission practice set forth in Minn. Stat. § 62J.536. With one exception, that is not applicable here, the Department may not oblige health plan companies and third-party administrators to transmit “information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.”

The difficulty in assessing the commentators’ challenge is two-fold. First, the permissible and current practice for coding health care data under Minn. Stat. § 62J.536 is established by the Department after consultations with the “Minnesota Administrative Uniformity Committee.” Together, these entities are charged with developing “uniform companion guides” that are to be used in health care transactions. Yet, the current companion guides are not part of this rulemaking record.

Second, the legal review of expedited rules under Minn. Stat. § 14.389, subdivision 4, is a binary process – either the rule is approved for legality or it is disapproved.

Thus, where commentators attack the legal authority to promulgate a rule during the comment process (as beyond the terms of the companion guides, and thus the authorizing statutes), there is no reply from the Department on this point, and the record does not include sufficient materials for an independent assessment of the commentator’s claim to be made, it must be that the legal authority for the proposed rule is not established. Accordingly, to the extent that the Department seeks to enforce the coding practice on data elements “MC 032 – Service Provider Specialty” “MC 038 – Claim Status” and “MC 063B – Allowed Amount,” these portions of the rule are not approved.

With that said, if the Department is of the view that these features of MHCCRS Appendices are, in fact, consistent with practice set forth in the companion guides, the agency may ask the Chief Administrative Law Judge to consider this matter during a later review. Under Minnesota Rule 1400.2410, subpart 8, such requests for review must be made within five working days of receiving the Administrative Law Judge’s decision.

## **V. Delegation of Authority to Outside Source**

The data processing required by the proposed rules will be carried out by the Maine Health Information Center (MHIC) under contract with the Department. Because Minn. Stat. § 62U.04, subds. 4 and 5 direct the Commissioner of Health to designate a private entity to analyze the health data, the proposed rules do not improperly delegate the agency's powers to another source.

## **VI. Compliance with Definition of a "Rule"**

Minn. Stat. § 14.02, subd. 4, defines a "rule" as "every agency statement of general applicability and future effect, . . . adopted to implement or make specific the law enforced or administered by the agency or to govern its organization or procedure." The proposed rules, with the exception of part 4653.0400, clearly implement and make specific the requirements of Minn. Stat. § 62U.04 regarding the creation of a provider peer grouping system.

## **VII. Withdrawal of Hearing Requests**

Under the expedited rulemaking process, a hearing is required only if the statutory authority permitting the use of the expedited process refers to Minn. Stat. § 14.389, subd. 5. The Department's authority to use the expedited process, Minn. Stat. § 62U.06, subd. 3, makes no such reference. Accordingly, the hearing request withdrawal procedures of Minn. Stat. § 14.25, subd. 2, do not apply here.

## **VIII. Recommended Technical Corrections**

The Administrative Law Judge recommends one technical correction to the rules. The recommendation is not a defect in the rules, but is merely a recommendation for corrections to the rules that the agency may adopt if it chooses to do so.

The Administrative Law Judge suggests that the Department amend this part as follows: "Minnesota Health Care Claims Reporting System: Appendices to Minnesota Administrative Rules, Chapter 4653 . . ." Such a change would correct an error in the title of the document and would not make the rules substantially different.

**E. L. L.**