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Minnesota's Health Care Administrative Simplification Initiative

Overview

As described below, the Minnesota Department of Health (MDH) is responsible for developing, implementing, and administering state requirementsi to reduce the costs and burdens of exchanging common, high-volume health care business (administrative) transactions. The initiative is projected to reduce overall administrative costs in Minnesota's health care system by an estimated $40 million to $60 million.ii In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to meeting other goals for the accurate, efficient flow of data for health care performance measurement and improved patient care.

Background

Large volumes of routine administrative transactions

Health care delivery and payment is a transaction-intensive enterprise that is sometimes represented by a revenue cycle similar to the one illustrated on the right. The illustration summarizes in a simplified diagram several, but not all, of the key steps and transactions in the health care billing and payment process.

As illustrated, the process starts with enrollment in an insurance plan, and continues through successive steps of:

- determining patient eligibility for health insurance coverage and benefits prior to or at the point of health care service;
- obtaining any necessary prior authorizations and referrals necessary for patient care;
- submission of claims (billings) to insurers for care and services provided, as well as inquiries regarding the status of claims; and
- payment and delivery of the corresponding remittance advice to the provider.

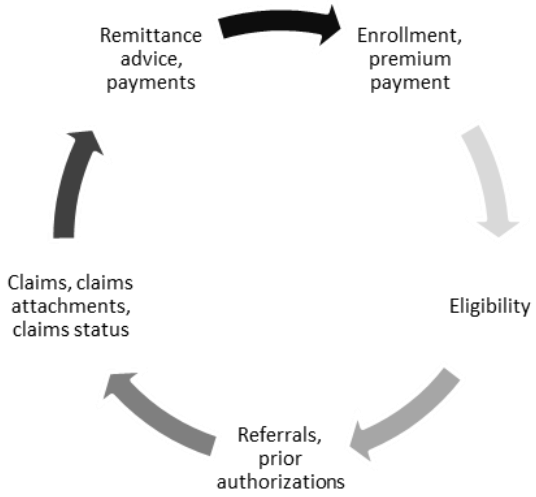

Figure 1 - Example health care revenue cycle

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

Unnecessary costs and burdens

Despite the large volume of these common administrative transactions, the health care industry has often lagged behind other sectors of the economy in its use of standard, automated electronic data interchange (EDI) to conduct routine business.[v] The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient. Because of the high volume of

these transactions, even small inefficiencies add up significantly and quickly as unnecessary costs and burdens across the health care system.

Federal HIPAA administrative simplification

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

These regulations provided an important framework for quicker, less burdensome, more accurate communications of large amounts of industry business data. However, the HIPAA regulations were often not as specific and detailed as needed, resulting in variability and ambiguity in how data were to be exchanged.

In response, and to the extent allowed by law, health care payers often published their own additional data exchange specifications, known as "companion guides." These guides are used in conjunction with national data rules and standards, and together provide the detailed instructions needed to electronically exchange data. While the proliferation of many individual, idiosyncratic companion guides was permitted under HIPAA, it eroded the regulations' effectiveness as a single, common standard for effectively and efficiently automating data flows.

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

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

Problem: *Many routine, high volume health care business transactions are still exchanged on paper.*

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

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

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

Problem: *A proliferation of "companion guides" to federal HIPAA transaction standards has resulted in variable, unnecessarily costly transactions.*

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

Solution: Minnesota required the adoption into rule of a single uniform companion guide for each of the transactions above that must be exchanged electronically. The guides comply with HIPAA and

provide additional data content specificity where needed. They must be used by health care providers providing services for a fee in Minnesota, by all payers licensed or doing business in the state, and by clearinghouses when exchanging acknowledgments for claims and remittance transactions and in order to ensure compliant transactions on the part of their customers.

In addition, as part of the overall standardization emphasis, Minnesota requires the exchange of standard, electronic acknowledgments, which are not yet required by HIPAA. Acknowledgments are important to determining whether transactions reached their destinations, and to identify errors or problems so that they can be addressed most effectively and efficiently.

Per state statute, MDH consults with the Minnesota Administrative Uniformity Committee (AUC) on the Minnesota Uniform Companion Guide rules. The AUC is a large, voluntary stakeholder advisory group comprised of health care provider, payer, and association organizations, as well as several state agencies. MDH also consults with the AUC in developing and publishing best practices, coding recommendations, responses to questions, and other information and recommendation. While these materials are not adopted into rule with the force of law, their use is highly encouraged as a further means of promoting the exchange of standard health care business data.

In recognition of the AUC's efforts and accomplishments, Minnesota Governor Mark Dayton declared February 21, 2012 as "Administrative Uniformity Committee Day" throughout the state.

Problem: *HIPAA data exchange requirements do not apply to all health care payers and providers.*

HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. Consequently, many transactions with these payers are often now conducted on paper or using nonstandard exchanges that are less efficient and more costly. Similarly, while the federal ASCA requires that most initial claims for reimbursement under Medicare be submitted electronically, there are exceptions for small providers.

Solution: Minnesota's requirements for the standard, electronic exchange of claims, remittance advices, and acknowledgments apply to payers not subject to HIPAA. In addition, Minnesota's regulations apply to all health care providers as defined in state statute.

More recent federal and state health care administrative simplification initiatives

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

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

Example initial impacts

Under Minnesota's health care administrative simplification initiative:

- The percent of health care claims submitted electronically to Minnesota health plans increased from 83% (2007) to 98.5% (2012).[vii] This is important because one national actuarial firm estimates that paper claims cost an average $3.73 more per claim than electronic claims.[viii]

- Automation and standardization of eligibility and billing is reducing the need for phone-based follow-up and questions between providers and payers, helping reduce an estimated $15.5 million - $22 million annual expense statewide for the calls.[ix]
- The Minnesota Department of Human Services (DHS) administers the state's publicly funded health care programs such as Medical Assistance (Medicaid) and pays more than one million fee-for-service health care claims annually. DHS reported in 2010 that:
  - It is receiving more electronic, automated claims and fewer needing manual review;
  - As a result of greater automation and streamlining, it was able to reduce its staff for claims processing from 41 to 16 persons, and to reallocate the 25 staff that previously worked in claims to new, higher priorities. In addition, greater claims processing automation allowed DHS to discontinue a software maintenance contract and a post office box for paper claims, and reduced other overhead costs.
- Other providers and payers have also reported that reductions in health care administrative burdens costs will permit reallocation of critical information technology and operational resources to other high priority uses, including improving the flow of clinical health care data, where even greater savings and improvements in patient care are anticipated long term.

Endnotes

[i] Minnesota Statutes, section 62J.536 and related rules.

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

[iii] Centers for Medicare and Medicaid Services (CMS). HCPCS – General Information: Overview, HCPCS Background Information. Retrieved from CMS HCPCS Information website: http://www.cms.gov/MedHCPCSGenInfo/.

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

[v] John L. Phelan, Ph.D.. Electronic Transactions Between Payors and Providers: Pathways to Administrative Cost Reductions in Health Insurance. Milliman Client Report. (May 6, 2010). Retrieved from Report website: http://www.navinet.net/files/navinet/Milliman_report.pdf.

[vi] Milliman Technology and Operations Solutions. (2006). Electronic Transaction Savings Opportunities for Physician Practices. Retrieved from Emdeon website: http://www.emdeon.com/resourcepdfs/MillimanEDIBenefits.pdf.

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

[viii] John L. Phelan, Ph.D.. Electronic Transactions Between Payors and Providers: Pathways to Administrative Cost Reductions in Health Insurance. Milliman Client Report. (May 6, 2010). Retrieved from Report website: http://www.navinet.net/files/navinet/Milliman_report.pdf.

[ix] 2006 Administrative Simplification Project Project Documentation. (Working document.) 2006.

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