HIPAA requires sweeping changes in health care billing and payment processes

TOPIC
Effects of the Health Insurance Portability and Accountability Act (HIPAA) on health care billing and payment processes.

PURPOSE
To inform counties of DHS compliance activities to meet HIPAA’s electronic data interchange (EDI) provisions by October of 2002.

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INTRODUCTION AND BACKGROUND
The federal Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. HIPAA responds to concerns from citizens, the health care industry and government agencies for enhanced security and privacy of individual health information. In passing HIPAA, Congress intended to:

- **Improve the portability and continuity of health insurance coverage for consumers;**
  This section of HIPAA law (referred to as the portability provisions) intends to protect consumer health care coverage in the event of job loss or change, and essentially expands the Consolidated Omnibus Budget Reconciliation Act, or COBRA. These provisions took effect in 1997.

- **Combat waste, fraud and abuse in health insurance and health care delivery;**
  HIPAA is an industry-wide effort to improve health care administration, simplify billing and payment processes and protect personal health information.

- **Standardize electronic data interchanges between health care organizations;**
  This refers to the first of HIPAA’s administrative simplification provisions to standardize electronic data interchange, or EDI. These regulations define more uniform methods to electronically bill and share health information between providers, payers and other organizations in both the private and public sectors. (This Bulletin provides some general HIPAA information but focuses on these EDI regulations, which take effect in October of 2002.)

- **Protect the security, privacy and availability of individual health information.**
  This refers to other parts of HIPAA’s administrative simplification provisions: privacy and security. HIPAA privacy regulations will change how health care providers, payers and employers use and release health information, allowing for enhanced security and consumer control of personal health information. The privacy regulations also direct health care providers and payers to appoint an internal privacy officer. (Please refer to DHS Bulletin #01-29-02 dated June 25, 2001 for more specific HIPAA privacy information.)

  Proposed HIPAA security standards will set security measures that every organization must follow to maintain, store and process health care information. HIPAA security standards will ensure that appropriate protections are in place to safeguard health data and health-related information, and will become effective 26 months after they are published in the Federal Register. We anticipate the final regulation on HIPAA security to be published in the next year.

Although Minnesota has existing data privacy and administrative uniformity laws, HIPAA will significantly impact the health care industry here and throughout the country. HIPAA’s administrative simplification provisions impact every health care provider that shares health information with other public and private health care organizations (e.g., payers, plans, and other providers).
HIPAA AND HUMAN SERVICES IN MINNESOTA
As covered entities, Minnesota’s social services agencies and many public health agencies (both public and private) must comply with HIPAA’s administrative simplification provisions.

Minnesota Department of Human Services (DHS)
DHS is a covered entity under HIPAA law as both a payer and provider of health care services, and must comply with the administrative simplification provisions of HIPAA. The Department’s Health Care Operations (HCO) and Health Care Systems (HCS) divisions are responsible for maintaining the Medicaid Management Information System (MMIS), the computer system that processes claims for DHS-administered Minnesota Health Care Programs. Like all health payment systems, Minnesota’s MMIS uses proprietary and other transaction formats and code sets that will not meet HIPAA EDI provisions. HCO and HCS must upgrade and revise the MMIS over the next fifteen months to meet HIPAA compliance standards for MMIS. Other areas of DHS are in the process of determining the impacts of HIPAA on other DHS programs and services.

Counties and Tribal Governments
Some functions within Minnesota’s tribal governments, local social services and public health agencies make them covered entities under HIPAA. (Please refer to Appendix A: HIPAA Definitions/Concepts.) Consequently, county and tribal agencies must also develop and implement HIPAA solutions within their own organizations.

SIGNIFICANCE OF HIPAA’S EDI PROVISIONS
As part of the administrative simplification provisions, HIPAA’s electronic data interchange standards revolve around the following concepts:

Health Care Standardization and Uniformity
Currently, there are few national health care administrative standards in place. This lack of standardization has forced providers to determine patient eligibility and bill for services differently for each individual payer and plan. Specifically, different computer formats and code sets make the current health care billing and claims process inefficient, confusing, and expensive for both providers and payers. HIPAA will reduce costs by requiring standardization. With HIPAA, the health care industry will eliminate more than 400 variations on administrative and financial transmissions, ultimately providing significant savings and operational efficiencies for health care providers and payers.

The American National Standards Institute (ANSI) has worked with health care industry representatives (including staff from DHS) to develop national standards for health care EDI. These HIPAA-compliant standards for health care information transmission will be required in October of 2002.
Transactions and Code Sets

According to the EDI regulations, all health care providers and payers must ensure they can send and receive private health information:

- Using standard, HIPAA-compliant code sets (refer to Appendix A: HIPAA Definitions);
- Using standard, HIPAA-compliant transaction sets (see below);
- Eliminating all proprietary (organization-based) and/or local codes for waivered services; and
- Accommodating unique identifiers for providers, health plans and employers (see below).

The following nine specific transaction sets are outlined in HIPAA EDI regulations:

1. Health claims or equivalent encounter information
2. Health claims attachments
3. Enrollment and disenrollment in a health plan
4. Eligibility for a health plan
5. Health care payment and remittance advice
6. Health plan premium payments
7. First report of injury
8. Health claim status
9. Referral certification and authorization

DHS and other health care providers and payers must modify their existing computer systems to send and receive these HIPAA-compliant standard transaction and code sets by October of 2002.

Unique Identifiers

Currently, health plans assign proprietary identification numbers to health care providers, resulting in providers having multiple identification numbers. Under a proposed HIPAA standard related to the EDI standards, National Provider Identifications (NPIs, or unique identification numbers) would be assigned to all providers and used by all plans (public and private). NPIs must be used in connection with the electronic transactions identified in HIPAA. As this proposed federal standard is announced in the Final Rule in the Federal Register, NPIs will be used by health plans, clearinghouses, and providers that conduct HIPAA-specified electronic transactions.

HIPAA’S IMPACT ON MINNESOTA’S MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

Minnesota’s MMIS processes health claims according to complex pricing and audit rules. Health Care Operations must make significant changes to MMIS over the next fifteen months to enable MMIS to conduct EDI business more efficiently, and to store and share health information in compliance with HIPAA’s privacy and security regulations (which go into effect after the EDI regulations). HCO has formed an internal HIPAA Project Office to coordinate DHS health care systems changes.

Background and Compliance Options

The HCO HIPAA Project considered numerous technical scenarios to make MMIS compliant for HIPAA, such as:
Purchasing a new MMIS to adapt to the new HIPAA environment. Although HIPAA’s impact on the existing DHS claims and prior authorization subsystems will be substantial, the rest of the MMIS is relatively unaffected by the new EDI regulations. Furthermore, HIPAA EDI standards go into effect on October 16th, 2002, so implementing a new MMIS would almost certainly mean that Minnesota would not be able to comply by that date. Finally, the staggering cost estimates (between $25 and $100 million for other states) required HCO to explore other options.

Attaching a computer system onto MMIS to accommodate HIPAA transactions. This proposed “front-end” system would contain most of the modified claims processing functions. Since MMIS has a tight integration of various DHS health care subsystems and a rigid architecture, this approach attempted to minimize the HIPAA-related changes necessary to the core MMIS system. HCO went in this direction initially, but discovered that several key HIPAA requirements could not be built into a front-end system and would cause major modifications to the existing MMIS. These requirements included; the capability to process a claim with 999 line items; the identification of the service authorization at the line level; and the future use of data that could not readily be incorporated into the MMIS. As a result, HCO had to determine how to incorporate these HIPAA requirements into a DHS HIPAA solution.

**MMIS HIPAA Solution**

HCO weighed the options above, and determined that DHS needed to both modify the existing MMIS and attach a front-end “translator” to meet HIPAA compliance for EDI. This approach allows HCO to make the necessary changes to the core MMIS and use the front-end system mentioned above to correctly interpret HIPAA-compliant information sent from other provider-based computer systems. Modifying the existing MMIS and attaching a front-end “translator” is most beneficial for DHS because it:

- Maintains the core system integrity of MMIS;
- Expands the life of the existing MMIS and avoids rebuilding the system;
- Leverages past investments in DHS information technology;
- Eases maintenance and increases flexibility of the current claims system within MMIS; and
- Improves DHS services to providers and local agencies.

This HIPAA solution for MMIS allows DHS to replace the existing proprietary electronic formats in MMIS with HIPAA-compliant ANSI standards for transaction and codes sets. HIPAA compliance will make Minnesota’s MMIS more efficient and user-friendly. MMIS upgrades will improve the department’s ability to pay health claims securely and also enhance existing electronic transmission of data with counties, tribes and other business partners.

**Changes to the Information Transfer System (ITS)**

Since 1994, DHS has sent the Information Transfer System software to providers, tribes and counties to bill DHS for services. ITS is free, proprietary software from DHS – other payers distribute similar billing and claims software to health care providers. HCO is replacing ITS with
a new, HIPAA-compliant billing system called **ITS-Direct** in 2002 to comply with the new HIPAA EDI regulations. Counties, tribes and other health care providers will access ITS-Direct securely through a web browser to build, process and submit Minnesota Health Care Programs claims to MMIS immediately (in “real time”). Additional features of the new ITS-Direct system will include:

- Standardized, electronic Remittance Advices (RAs)
- Online status inquiries for claims throughout adjudication
- Enhanced security and privacy for transactions.

**Changes to the MMIS Batch Processing System**

HCO will modify the existing MMIS system architecture from a batch and online system to one that provides the option of adjudicating claims using an online transaction processing (OLTP) model. (This new OLTP engine will enable MMIS to process claims transactions online as opposed to the batch model used in the current system.) The OLTP engine will treat all claims the same, regardless of origin, resulting in more efficient claims processing between counties/providers and DHS, and immediate feedback on claims that are in error and/or require resubmission. MMIS batch processing will utilize ANSI X12 standards in compliance with HIPAA regulations.

**HIPAA AND DHS**

DHS is preparing for HIPAA’s impacts on our programs, systems and business partners. HCO is collaborating with other DHS business units, like Information & Technology Strategies, Appeals & Regulations and Health Care Customer Services. HCO is synchronizing MMIS technical upgrades with any changes in DHS programs and policies and will continue to inform tribes, counties and providers about HIPAA impacts on the department’s health care practices and administration.

HIPAA provides a unique opportunity for DHS to streamline and standardize MMIS billing and payment functions, expand functionality via the web, and improve electronic claims services. DHS will provide more specific details on HIPAA compliance activities of our health care systems as these details become available. DHS is committed to providing information and technical assistance as appropriate to counties and tribes in their own HIPAA assessment and compliance efforts. DHS encourages local agencies to research HIPAA issues and make the necessary changes to local systems and policies to ensure HIPAA compliance for EDI regulations by October of next year.
ADDITIONAL HIPAA INFORMATION
The Federal Register publishes the text of HIPAA regulations:

Office of the Federal Register (NF)
National Archives and Records Administration
700 Pennsylvania Ave NW
Washington DC 20408-0001
(E-mail address) fedreg.info@nara.gov

The following web sites provide additional information about HIPAA:
- Minnesota DHS HIPAA Page (www.dhs.state.mn.us/hipaa)
- DHHS HIPAA Public Law 104.191 (http://aspe.hhs.gov/admnsimp/pl104191.htm)
- HCFA’s HIPAA Page (www.hcfa.gov/hipaa/hipaahm.htm)
- Medicaid/MMIS Private Sector Technology Group (www.ps-tag.org/)
- American Hospital Association HIPAA Page (www.aha.org/hipaa/links.asp)

HIPAA EDI CONTACTS AT EACH COUNTY/TRIBAL GOVERNMENT
In the next few weeks, we will be requesting that county and tribal human services directors designate a contact person for both HIPAA EDI and HIPAA privacy to help with information flow and compliance activities. Directors will receive a separate DHS memo about this request.

Please note: Because of the technical nature of HIPAA’s EDI standards, your organization’s HIPAA EDI contact person may need technical skills and/or health care program knowledge which may differ from the skills needed for the HIPAA privacy contact to be assigned from your agency.

SPECIAL NEEDS
Upon request, this information will be made available in an alternative format, such as Braille, large print or audiotape.

For TTY, contact the Minnesota Relay Service at (800) 627-3529.
APPENDIX A: HIPAA DEFINITIONS/CONCEPTS

The following list of HIPAA-related terms has been reproduced from the original text of the Health Insurance Portability and Accountability Act, Public Law 104-191.

**Code Set**

Any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

**Health Care Clearinghouse**

A public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

**Health Care Provider**

A provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

**Health Information**

Any information, whether oral or recorded in any form or medium, that:

a. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

b. Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

**Health Plan**

An individual or group plan that provides, or pays the cost of, medical care (as such term is defined in section 2791 of the Public Health Service Act). Such term includes the following, and any combination thereof:

A. A group health plan (as defined in section 2791(a) of the Public Health Service Act), but only if the plan (i) has 50 or more participants (as defined in section 3(7) of the Employee Retirement Income Security Act of 1974); or (ii) is administered by an entity other than the employer who established and maintains the plan.

B. A health insurance issuer (as defined in section 2791(b) of the Public Health Service Act).
C. A health maintenance organization (as defined in section 2791(b) of the Public Health Service Act).

D. Part A or part B of the Medicare program under title XVIII.

E. The Medicaid program under title XIX.

F. A Medicare supplemental policy (as defined in section 1882(g)(1)).

G. A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

H. An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

I. The health care program for active military personnel under title 10, United States Code.

J. The veterans health care program under chapter 17 of title 38, United States Code.

K. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1072(4) of title 10, United States Code.

L. The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.)


**Individually Identifiable Health Information**

Any information, including demographic information collected from an individual, that (A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and:

i. Identifies the individual; or

ii. With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Individual health information includes information stored or transmitted electronically, on paper, or even orally transmitted (in conversation).
APPENDIX B: BENEFITS OF EDI*

Tactical Benefits: Reduce direct and overhead costs
- Reduce the accounts receivable cycle
- Improve accuracy
- Reduce data entry time
- Reduce/eliminate rework
- Avoid/reduce manual data entry
- Reduce operational costs (office supplies, postal costs, telephone charges)

Strategic Benefits: Improvements that directly impact healthcare stakeholders
- Improved patient, provider and payer support
- More efficient information delivery
- Improved quality
- Increased “good will” with patients
- Closer working relationship between organizations

Cultural Benefits: Creating a competitive advantage
- Increasing responsiveness between healthcare stakeholders
- Penetrating new markets
- Becoming easier to do business with
- Improving relations with other organizations

Real Value to Providers:

Imagine a world automated by these electronic transactions:
1. Eligibility available from all payers at patient check-in
2. Referrals handled without paper-tracking and waiting on the phone for authorization numbers
3. Electronic claims understood in a consistent manner for all payers
4. A clear and automated process for claims attachments
5. Automated claims status checking, enabling exception-based monitoring
6. Fully-automated insurance receipt posting

This type of automation will offer the provider increased access to information such as:
- Clinical outcomes
- Practice guidelines
- Comparative data
- Other keys to the decision-making process

HIPAA will ultimately benefit the patient because it will result in higher efficiency, cost effectiveness and quality care.

*source: www.per-se.com
APPENDIX C: DHS HIPAA CONTACTS

Please contact the following individuals for more specific information about HIPAA:

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<tr>
<th>HIPAA Focus</th>
<th>DHS Contact</th>
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<tbody>
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<td>Electronic data interchange (EDI)</td>
<td>Matthew Woods</td>
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<td>(651) 296-4769</td>
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<td>Mary Evenhouse</td>
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