MARYLAND HEALTH CARE COMMISSION

Spotlight on Maryland EDI

2003 EDI-HIPAA Progress Report: Market Expansion Creates Growth Opportunities

The Maryland Health Care Commission (MHCC, or Commission) operates certification and education programs to promote increased use of EDI within Maryland. The certification program is a cornerstone of the initiative and uses national standards and industry "best practices" for certifying electronic health networks (EHNs, or networks) doing business in the state. EHNs must obtain certification from MHCC in order to send transactions to payers that operate in the Maryland market. In 2003, ten EHNs are MHCC-certified and six others are in candidacy status.[1] The number of fully certified networks increased by two from 2002 and the number of new networks in candidacy status increased by four. Maryland law requires payers to accept electronic health care transactions only from MHCC-certified EHNs.[2] To gauge the success of our initiatives, MHCC requests that payers submit an annual EDI Progress Report, which describes how providers submit claims and other health care transactions. This information is compared against prior year reports to measure annual growth. Information contained in the EDI Progress Report is also used to guide MHCC in developing new EDI/HIPAA related initiatives. MHCC received information from approximately 30 payers doing business in the state. In 2003, the Commission expanded its evaluation to analyze more fully the impact of EDI in Maryland by separately reporting on the performance of Maryland large and small private payers along with Medicare and Medicaid.[3] Large private payers included in this year's report are CareFirst of Maryland (and its affiliates), Cigna Healthcare, Aetna (and its affiliates), Kaiser Permanente, and MAMSI (and its affiliates).[4] These payers insure over 90 percent of the privately insured population statewide. The remaining payers consist of large insurers with small market shares and niche insurers that limit offerings to one segment of the market such as the individual market. MHCC uses EDI Progress Reports submitted by private payers to produce this analysis and to identify EDI growth barriers in the EDI promotion activities.

MHCC's Electronic Health Network Certification Program Gains Momentum

Networks view the Maryland market as a stable market with strong potential for growth. Recent enactment of HIPAA's transaction standards expanded networks' opportunities for growth. MHCC estimates that the number of available electronic claim transactions in Maryland can generate roughly $7.3 million in revenue for networks. The revenue generating impact for networks and the associated savings for providers and payers on the other nine electronic transactions are more difficult to estimate because these transactions are not widely used. A number of networks that have not established a presence in Maryland are considering entering the market. Over the last year, MHCC received certification applications from Mutual of Omaha's Medicare Crossover Clearinghouse, PassPort Health Communications, Inc., HDM Corporation, Eyefinity, and Electronic Network Services.

MHCC recognized the need to expand its EHN certification program to networks with less than $1 million in revenue. In the past, only large networks that usually do business nationwide had the resources to obtain MHCC certification. Existing law mandates all payers to use certified EHNs; MHCC developed its certification program to allow smaller networks to compete in Maryland. MHCC's effort to certify small networks has been moderately successful. In recent months, several small networks have expressed interest in participating in the MHCC small network program. MHCC provides consultative support to small EHNs in developing their site review documentation. The Commission uses a candidate's site review report and staff recommendations for determining MHCC certification. MHCC expects to see continued interest in certification from other large and small networks.

HIPAA Compliance – A Challenge for Some Providers

Administrative simplification provisions of the federal Health Insurance Portability and Accountability Act of 1996 were intended to improve the efficiency and effectiveness of the health care system by standardizing the electronic transmission of certain administrative transactions and protecting the security and privacy of patient identifiable information. Regulations developed under the Act apply to health care providers, health plans, and claims clearinghouses (covered entities). All medical records and other individually identifiable health information held or disclosed by a covered entity, in

any form, whether communicated electronically, on paper, or orally, are protected under the regulation. The effective date for the privacy standard was April 14, 2003 and for the transaction standard was October 16, 2003. Compliance with these standards varies by practitioners and health care facilities. Some health care practitioners have had difficulty complying with the privacy standard due to a lack of resources needed to develop and implement the required policies and procedures. Health care facilities have reported less trouble implementing the privacy standards due to their ability to dedicate internal resources to making changes required by the standard. Many experts contend that meeting the transactions standards will be even more challenging. On November 16, 2001, Congress passed a law (HR 3323) that allowed these groups to take an additional year to comply with the requirements by completing an extension request and submitting it to the Centers for Medicare and Medicaid Services (CMS). HIPAA does not require practitioners and health care facilities to send claims electronically. On the other hand, payers and claims clearinghouses are required to support electronic claims and the other transactions. Presently, most payers are not yet able to accept electronic claim attachments. The majority of practitioners and health care facilities submit claims on paper when supporting documentation is required.

Action by the Centers for Medicare and Medicaid Services established a quasi-transition period for the transaction standards. Covered entities were allowed to accept non-standard transactions as long as they could document progress in moving toward compliance. Prior to October 16, 2003, Medicare, Maryland Medicaid, and most private payers implemented contingency plans that allowed providers to continue to submit non-standard transactions through the end of 2003 if they could not submit a claim in the standard format. CareFirst of Maryland relies on WebMD, their designated EHN, to convert all non-standard claims to the standard 837 electronic claim format required by HIPAA. On the other hand, Aetna said they will accept the non-standard and standard 837 electronic claim format for the time being and will reassess their position in early 2004. Most health care facilities have been able to make changes in their information technology systems or purchase hardware and software necessary to bring their systems into compliance for the transaction standards. Practitioners, however, have had to rely on their practice management software vendor for achieving compliance. Some software vendors are using claims clearinghouses to convert non-standard information into the required format. Most practitioners express uncertainty as to the ability of their practice management software to comply with the transaction standards. HIPAA's transaction standards require covered entities to send and receive electronic transactions in the HIPAA compliant format as of October 16, 2002.

GENERAL FINDINGS

Government & Private Payers Report Steady Claims Growth

Government and private payers reported an increase in their total claim volume by about three percent, or roughly 2.6 million claims, in 2002 compared to 2001. Private payers experienced a modest claim volume increase of about five percent. Medicare increased by nearly five percent and claim volume under Medicaid grew by four percent. Changes in claims volume can occur for a variety of reasons. Obvious causes include changes in enrollment and jumps in utilization per enrollee. Administrative factors can also play a role. In 2002, many payers reported an increase in claims volume due to provider efforts to resolve outstanding accounts receivables in preparation for HIPAA. Some increases for private payers and Medicare are attributable to declining enrollment in HMOs and reduced reliance on capitation as a form of payment. Medicaid increases are primarily a result of administrative efforts to reduce claim backlogs and continuing enrollment increases in the S-CHIP program.

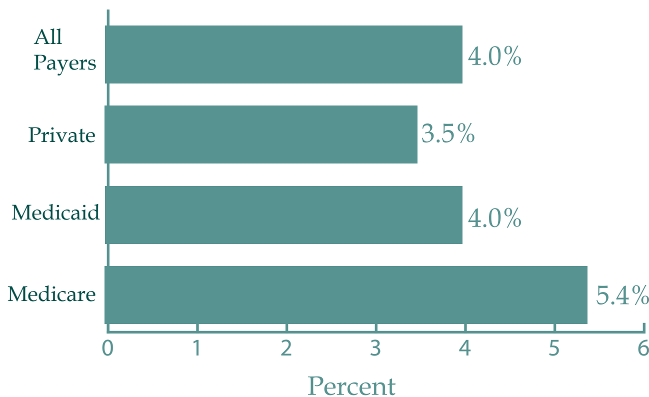
Growth in Electronic Claims Slows as Industry Responds to HIPAA

In an effort to comply with the transaction standards, most payers dedicated the lion's share of their information technology resources to re-tooling for HIPAA. By and large, preparing for the transaction standards slowed EDI growth among government and private payers. Medicare continues to lead the industry in its EDI acceptance rate. Over the last year, Medicare's electronic claim share remained nearly the same at about 87 percent. By comparison, Medicaid reported an electronic claim share of roughly 65 percent, a decline of about four percent from the prior year. Medicaid's reporting systems are not able to separately track EDI between Medicaid claims and Maryland Health Partners claims.[5] Manual adjustments made to Medicaid's EDI numbers to account for Maryland Health Partners claims is the primary factor driving the change in Medicaid's EDI activity from the prior year. Non-government payers reported an electronic claim share at about 48 percent. The increase in electronic claim share among private payers is notable; however, private payers have the most room for growth.

Government & Private EDI Activity

Payer	Electronic Claim Share 2001	2002
Medicare	87.7%	87.3%
Medicaid	71.4%	65.3%
Private	45.2%	47.6%

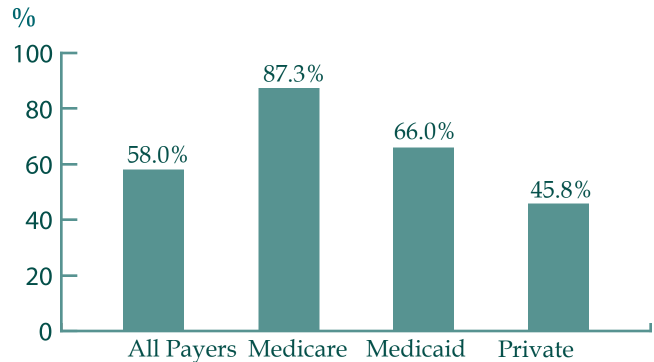
Change in Practitioner, Hospital and Dental Claims Volumes



Government Payers' EDI Continues To Outpace Private Payers

Overall, government payers continue to lead private payers in accepting electronic claims with an EDI increase of about one percent from 2002 to 2003. Providers frequently report ease in submitting electronic claims to Medicare and Medicaid and this level of comfort may contribute to the fairly large variation between government and private payer electronic claim share. A more obvious observation is that often times a government payer is a provider's largest payer making good business sense to optimize efficiency with the largest partner first. Approximately 58 percent of practitioner, hospital, and dental claims were submitted electronically to payers. Private payers accepted about 46 percent of electronic practitioner, hospital, and dental claims. The gap between government and private payer electronic claim share is likely to narrow as private payers implement the transaction standards requirements. Providers cite that variations in attachment rules among private payer are often the leading reason they opt for paper submissions. While a few private payers offer the option to send claims electronically and mail or fax supporting documentation, the overall success of increasing electronic claim share among private payers remains contingent upon their ability to resolve long-standing barriers regarding claim attachments. Medicare continues to set the standard in electronic submissions by offering providers cost-effective and user-friendly electronic claim submission software.

Electronic Claim Share, 2002

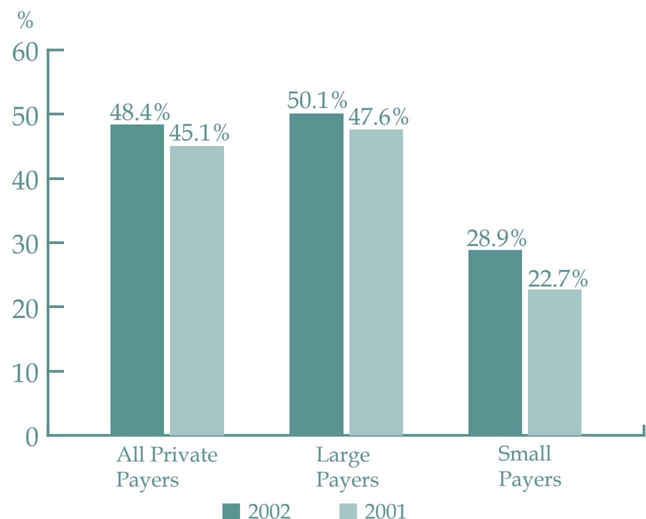


PRIVATE SECTOR ANALYSIS

Five Large Payers Dominate the Market

CareFirst of Maryland, Cigna Healthcare, Aetna, Kaiser Permanente, and MAMSI insure the majority of individuals with private health insurance and account for over 90 percent of private payer enrollees and nearly 94 percent of total claims volume. Private payers report a wide variation in their EDI strategies and information technology resources. Collectively, the five largest non-government payers reported an EDI share of about 50 percent while all small payers' electronic claim share was reported at about 29 percent.[6] Over the last year, small payers improved their EDI claim share by roughly six percent as compared to a modest three percent for large payers. Differences in electronic claim share among private payers are often a result of the success of EDI business plans and the partnerships that small payers establish with EHNs.

Private Payer Electronic Claim Share



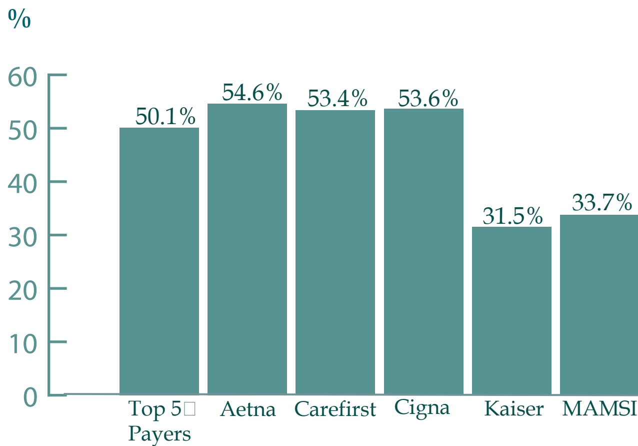
Percent Change in EDI Share -- Private Payers

Private Payer	Percent Change
Large	2.5%
Small	6.1%
Total	3.3%

EDI Among Private Payers

Private payers continue to report increases in electronic claim share with most large payers reporting electronic claim shares exceeding roughly 50 percent. The electronic claim share for most payers is expected to increase over the next year as information technology investments made to support the transaction standards are brought on line and accepted by providers. Aetna and Cigna Healthcare exceeded the 50 percent electronic claim share and reported the largest gain in electronic claim share due, perhaps, to statewide EDI initiatives. Large payers reporting an electronic claim share below the combined average experienced varied growth rates in their electronic claim share. Rationalizing conflicting IT technologies has been a significant challenge for CareFirst of Maryland since it went through a wave of acquisitions and mergers around 2000. MAMSI continued to focus on offering providers multiple approaches to submitting claims electronically. Offering providers multiple approaches appears to be a sound strategy because it recognizes that the needs of small and large providers vary. Although Kaiser Permanente reported the smallest electronic claim share of all payers, their implementation of an EDI provider recruitment program yielded them the largest percent change in EDI share. Most small payers reported a slight increase in their EDI expansion drives as a result of converting to the HIPAA standards.

Electronic Claim Share Large Payers



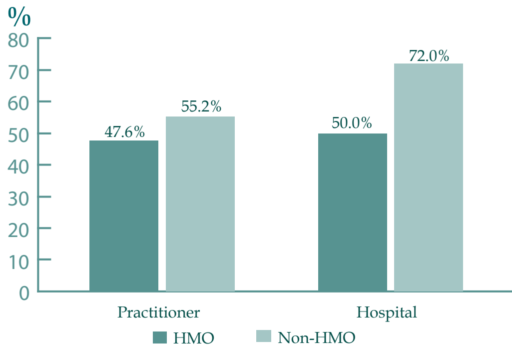
Percent Change in EDI Share

Large Payer	Percent Change
Total Top Five	2.5%
Aetna	6.0%
CareFirst of Maryland	1.0%
Cigna Healthcare	4.3%
Kaiser Permanent	20.8%
MAMSI	4.2%

Dramatic Gains for HMOs Narrow EDI Gap - Changes in Payer EDI Submission Requirements Spur Growth

Collectively, EDI among private payers improved by roughly three percent. Practitioners reported an increase of about two percent, and hospitals reported an increase of about six percent. HMOs made considerable progress in accepting electronic claims. Over the last year, HMOs increased their electronic claim share by about eleven percent. The percentage of electronic practitioner claims increased from approximately 36 percent to 48 percent. HMOs posted a similar gain in their share of electronic hospital claims as they increased from approximately 42 percent to 55 percent. Non-HMO shares of electronic practitioner claims remained about the same as the prior year at 50 percent, while hospitals increased from 63 percent to 72 percent. Last year, non-HMOs reported about 52 percent share of electronic claims while HMOs reported about a 49 percent share of electronic claims. For the most part, electronic claim share for non-HMOs remained unchanged from the prior year, while HMOs reported a sizable increase. Practitioner and hospital electronic claim share is expected to increase as payers continue to expand their EDI systems to comply with HIPAA. Several HMOs altered their requirements on claim attachments and supporting documentation, which, in the past, discouraged electronic claims. Aetna is an example of a payer that allows providers to submit claims electronically and fax supporting documentation. Kaiser Permanente enables providers to use the Internet for completing referral and authorization forms online.

HMO and Non-HMO
Practitioner and Hospital Electronic Claim Share



HMO and Non-HMO EDI Share

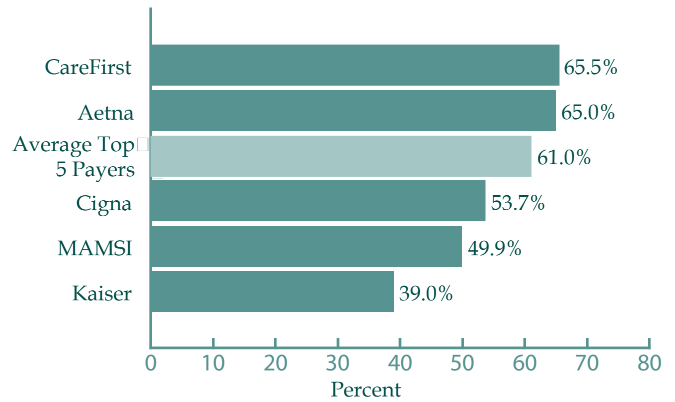
Payer Share	Percent Change in EDI 2002	2001
HMO	11.2%	4.3%
Non-HMO	0.8%	3.1%

SECTOR SPECIFIC RESULTS

Payer Changes Improve Hospital EDI Activity

Hospitals, including other health care facilities, continue to strengthen their use of EDI as roughly 61 percent of hospital claims were received electronically. The use of EDI among hospitals continues to expand as payers reported an increase of about six percent from prior year. Payers' adjudication rules requiring claim attachments often discourages EDI as most hospitals submit paper claims when attachments are required. Several payers reported using the Internet for posting authorizations that, in the past, caused hospitals to submit on paper.[7] A number of hospitals reported that a lessening of the attachment requirements, in general, is a factor in submitting more claims electronically. Nearly all payers reported having programs aimed at expanding the use of hospital EDI. CareFirst of Maryland and Aetna are examples of two payers that developed EDI programs targeting hospitals that submit the bulk of their claims on paper. Kaiser Permanente reported sizable growth in electronic hospital claims as a result of an aggressive provider recruitment program. EDI submission rates improve when electronic government claims are included in the analysis. Collectively, government and private payers reported receiving approximately 75 percent of hospital claims electronically. Over the last year, the percentage of electronic hospital claims received by government and private payers increased by about three percent. EDI use among hospitals is expected to increase as a result of the transaction standards.

Hospital Electronic Claim Share



Percent Change in Hospital EDI Share

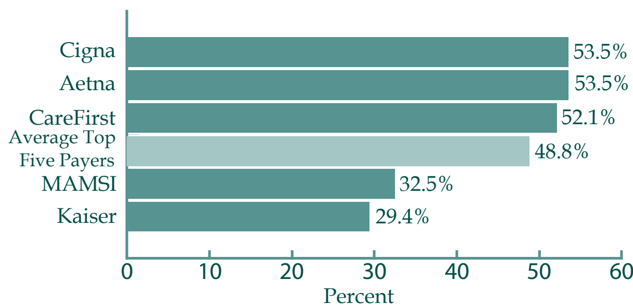
Payer	Hospital Percent Change
Kaiser Permanente	22.7%
MAMSI	16.4%
AETNA	6.3%
Cigna Healthcare	5.2%
CareFirst of Maryland	2.6%
Average Top Five	**5.8%**

Claim Submission Requirements Continue to Slow Practitioner EDI

Practitioners, including physician and non-physician health care providers, submitted about 49 percent of claims electronically to private payers. This is an increase of about three percent from the prior year. Practitioner EDI increased to approximately 60 percent when including government payers in the mix. Payers with the largest share of electronic claims posted only a slight increase. Practitioner EDI is impacted not only by payer electronic claims submission requirements but also by practitioner choice. CareFirst of Maryland and Aetna report that a large number of paper submitters preferred to submit on paper rather than adopt EDI. Some payers provide options to practitioners that want to submit electronic claims, such as submitting the claim electronically and forwarding support documentation via fax or by mail. Providing practitioners with options for submitting electronic claims has been moderately successful for some payers in boosting EDI activity. For the most part, practitioners view splitting claims and attachments as burdensome and tend to bill on paper rather than electronically.[8] Somewhat new to the EDI market is Kaiser Permanente. Over the last year, they implemented

an aggressive practitioner recruitment program which has been very successful in its early stages. Payer adjudication rules tend to be the leading factor influencing practitioner EDI activity. EDI growth among practitioners is likely to continue as payers begin to accept claim attachments electronically as a result of the transaction standards.

Practitioner Electronic Claim Share



Percent Change in Practitioner EDI Share

Payer	Practitioner Percent Change
Kaiser Permanente	20.6%
Aetna	7.4%
Cigna Healthcare	5.0%
MAMSI	3.8%
CareFirst of Maryland	0.5%
Average Top Five	**2.2%**

Payers Provide Limited EDI Support for Dentists

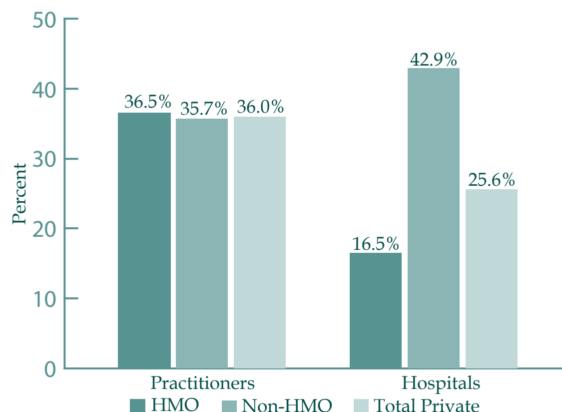
The lack of EDI among dentists continues to be a concern for the Commission. Only about ten percent of all dental claims are received by payers electronically. The change in electronic claim share over the last year has been minimal at roughly 1 percent. A number of factors influence the low rate of EDI among dentists. The most compelling reason is that payers dedicated little information technology resources to supporting electronic dental claims. Payer adjudication rules are often viewed as a barrier by dentists to submitting electronic claims. For the most part, many payers require that the dental record and the X-ray accompany the claim. Dental administrative staffs tend to be very small and are required to routinely multi-task. According to the Maryland Academy of General Dentistry, even when payers offer EDI, dentists tend to bill on paper, as their administrative staff is usually not able to keep up with variations in payer EDI rules. Keeping up with the wide range of payer and technology system requirements is often the leading reason cited by dentists for generating paper claims. Dentists view the start up and maintenance costs associated with electronic billing as burdensome. Dental contracts usually account for a small percentage of covered lives insured by most private payers. Metropolitan Life is the only payer that reported accepting dental claims electronically. In the past, many payers expressed a reluctance to modify existing information technology systems to support dental EDI for a small segment of their business. Some payers had simply decided to wait to make changes to support dental EDI simultaneous with implementing HIPAA.

INNOVATIVE & NEW DIRECTIONS

Electronic Processing Gains Momentum

Most payers report that receiving and processing claims electronically significantly reduces administrative costs. In general, claims received electronically required manual intervention to adjudicate. Payers' ability to receive and process claims electronically varies somewhat by HMOs and non-HMOs. For example, HMOs reported processing electronically approximately 37 percent of practitioner claims and about 16 percent of hospital claims. Non-HMOs processed nearly 36 percent of practitioner claims and roughly 43 percent of hospital claims electronically. The most notable improvement in electronic claims processing occurred by HMOs in their ability to adjudicate almost 34 percent of hospital claims electronically. Overall, electronic claims processing grew by nearly nine percent. Generally speaking, the decision to process electronic claims without manual intervention is driven by the payer's business rules. In some instances, payers will accept electronic claims, but print the claim on paper to adjudicate. Processing claims electronically reduces the turnaround time from when the claim is received to when it's paid. Most payers report that electronic claims are processed within approximately 14 days of receipt. Conversely, paper claims require about 28 days for processing. A few payers reported adjudicating electronic claims within roughly five days of receipt.

Claims Processed without Manual Intervention



Share of Claims Processed Without Manual Intervention

Provider Type	2002	2001	Percent Change
Practitioner	36.0%	26.9%	9.1%
Hospital	25.6%	20.6%	5.0%
Total	34.8%	26.2%	8.6%

Other HIPAA Electronic Transactions on the Horizon

The transaction standards identify approximately ten transactions, with the possibility for the Secretary of Health and Human Services to add others in the future.[9] Electronic transactions are required to meet certain content, code, and format criteria. HIPAA's transaction standards require payers to accept electronic transactions that meet the established criteria. Most payers and claims clearinghouses presently only support the electronic claim transaction. Generally speaking, payers expect to implement the other transactions at various times throughout the next year. A gradual implementation approach has been adopted by nearly all payers as the result of CMS implementing their transaction standards contingency plan. The CMS contingency plan opened the doorway for other payers to implement a similar approach for accepting the new standards as well as continuing to support the old format. Practitioners and health care facilities will be able to take advantage of the other transaction standards in the upcoming months. The ability to send and receive the remaining electronic transactions largely depends upon the capabilities of practice management/facility based software. Vendors continue to make staggered changes in software products to support the transactions. Costs associated with software upgrades vary by product and these costs may impact a practitioner or health care facility's decision to implement the other transaction standards.

EDI - Administrative Efficiencies Possible

Payers and providers continue to express concern over administrative health care costs. EDI has the potential to generate a number of efficiencies for practitioners and health care facilities related to billing activities. The turnaround time on electronic claims is about a third as long as paper claims. Other transactions offer even more impressive savings. Electronic eligibility inquiry takes seconds as compared to the wait time involved with telephoning a customer service representative. Following up on the status of a claim electronically requires only a few minutes as compared to the somewhat arduous task of tracking down the status using the telephone. EDI creates an electronic trail for monitoring internal administrative activities as well as an external audit trail. A leading challenge for providers is to implement EDI in a way that creates value by reducing the time it takes to complete routine tasks. Performing administrative tasks more efficiently enables providers to control spending or to dedicate staff resources to other functions. However, adding EDI capabilities to a practice without in-house IT staff is a complex endeavor. Until the implementation of HIPAA, the lack of standards was a major bottleneck; however, it was not the only challenge. Health care professionals have been slow to adopt EDI because they lack the technical expertise to evaluate alternatives that may pose significant financial risk to the practice. Layering EDI on existing administrative functions does not necessarily create efficiencies. Often practitioners and smaller health care facilities need guidance and assistance in evaluating their administrative operations and assessing technical alternatives. The MHCC and its EDI/HIPAA Workgroup have helped fill this void.

AN INDUSTRY VALUE

MHCC's EDI Programs Expected to Increase EDI Use

The Commission has an ambitious EDI/HIPAA agenda for the upcoming year. Regional provider conferences on administrative cost savings associated with EDI and HIPAA awareness are planned. The Commission intends to work more closely with payers in an effort to explore program opportunities to boost practitioner and health facility use of EDI. The activities of the EDI/HIPAA Workgroup are increasing and the Commission's EDI and HIPAA-related tools continue to grow in popularity among providers.

MHCC presented on HIPAA at most medical and non-medical health care association conferences. Generally speaking, many practitioners and health care facilities have relied on MHCC as a leading source of HIPAA information. A number of regional Medical Group Manager Associations and allied health associations invited MHCC to overview the HIPAA requirements. MHCC's EDI/HIPAA Workgroup completed the, *"Professional Claims Required Data Element Users Guide,"* the *"Institutional Claims Required Data Element Users Guide,"* the *"User Education Guide To The Pharmacy Telecommunication Standards,"* and its *"HIPAA Transaction Contingency Development Guide."*

Footnotes

[1] Under most circumstances, EHNs have one year from initial application to complete accreditation and certification processes.

[2] Health General §4-302 mandates require payers doing business in Maryland to use only an MHCC-certified EHN.

[3] Five payers and their affiliates represent the largest payers in terms of premium according to the Maryland Insurance Administration.

[4] Affiliates for CareFirst of Maryland include Capital Care, Delmarva Health Plan and FreeState Health Plan. Affiliates for MAMSI include MD-IPA and Optimum Choice. Affiliates for Aetna include Aetna Health Inc. of Maryland, DC, and Virginia.

[5] Information reported to the Maryland Medical Assistance Program, September 2003.

[6] Small payers are defined as those with more than $1 million but less than $276 million in 2001 premium, as reported to MHCC.

[7] Information reported to the Commission by various hospitals in the Baltimore Metropolitan Area, October 2003.

[8] Information reported to the Commission by the state's Medical Society, MedChi, October 2003.

[9] Department of Health and Human Services, Office of the Secretary, 45 CFR Part 162, Electronic Transaction and Code Set Standards.

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