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Medicaid Caucus Welcomed by X12

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At the X12 Working Group Meeting in Denver this month, we held our inaugural Medicaid Caucus meetings. We found it beneficial to meet the night before the conference began and then every day after the wrap-up of the X12 sessions, to document action items, compare notes and discuss strategies for meetings the next day. Lisa Doyle, NASMD representative to X12, chaired the caucus. We had representatives from the State Agencies of Mississippi, Wisconsin, Montana, Minnesota, North Carolina and Colorado, as well as fiscal agents without State Agency counterparts from California (EDS), and New York (CSC). Also, First Health and Consultec as well as some Medicaid consultants, made wise corporate decisions to send representatives, so they will better meet the needs of their clients, and they joined our group.

Many X12 Work Group chairs and the veteran X12 members approached me personally to express appreciation for the increased Medicaid presence. Although our small group could not fully represent the interests of all Medicaid programs on the spot, the Medicaid attendees graciously offered to go back and gather required information from all States through the S-TAG and/or the National Medicaid HIPAA EDI Workgroup and report back to X12.

Our group was very impressed by the friendly and helpful nature of the discussions they had with the veterans. We found that many of X12 members have experience converting from proprietary systems to standard transactions. They agreed that it seems daunting at first, but Medicaid now can benefit from their experience. They were willing and able to sit down with us at this and future X12 meetings to discuss, one by one, specific mapping issues that we have and show us how many of our data transfer issues have been accommodated by the standards. For those information transfers that are not currently doable, they will walk us through the change request process. Now that the lines of communication are open, the group agreed that continuity of presence at X12 meetings is critical to the efficient and successful implementation of HIPAA standards in each state.¤

The Impact of HIPAA

Aside from the retooling that will be required to implement the standards for the first time, the biggest impact may be the following:

Currently, when a State legislature passes a law and/or HCFA grants a waiver or makes a program change that requires, for implementation, a change in the data collected from Medicaid providers or "enrollers," the agencies gather their systems people together to define and implement the changes. If reporting requirements are modified, the State Agency notifies their business partners of the changes and sets a date for compliance.

Under HIPAA, an additional, possibly time-consuming, process is added. There will be federally mandated standards defining the list of data elements that may be collected electronically, what code sets may be used, and what format these records take when transmitted electronically. To restate --- **all** of the data elements defined by HIPAA and **only** the data elements defined by HIPAA for a particular HIPAA covered situation will be allowed to flow from provider to plan to payer (State Agency or Fiscal Agent). Therefore, as the health care business evolves, it is incumbent on the State Agencies to be involved in the standards development process, so that

1) Anticipated State Medicaid data requirements can be built into the new versions of the HIPAA implementation specifications. The standards may be modified once the standard has been effective for a least one year or earlier if it is determined the modification is necessary to permit compliance. It is anticipated that standards will routinely be updated once a year.
2) Medicaid will have a say in the changes brought forward by other health care providers and payers (commercial and Medicare) to minimize their impact on the annual changes that Medicaid Agencies will have to implement. ?

Ask the HIPAA Wizard

Q. Our MCOs are required to submit provider subcapitated arrangements, i.e., subcapitated codes, on each encounter submitted. These codes indicate how the MCO processed the claim based on provider agreements (fully capitated, partially capitated, organ transplant only services, etc.) and service (HCPCS or Revenue). In X12N Loop 2300, instead of the Pricing Methodology (HCP), the Contract Information (CN1) appears to be the best fit. However, the data set in CN1 is much too limited for our data needs. Would we need to contact each subcommittee (X096, X097, X098, and NCPDP) on our CN1 data needs?

A. The Accredited Standards Committee (ASC) X12 is divided into subcommittees. X12N is the subcommittee responsible for insurance transaction standards. X12N is divided into task groups (TGs). TG2 is Health Insurance. Each task group is further subdivided into work groups (WGs). TG2 has nine work groups. Standards and Implementation Guides are developed and modified by consensus within these work groups. TG2, WG2 is responsible for all three claims implementation guides (X096-institutional, X098-professional, and X097-dental). You would only have to discuss your request for modification to the CN1 code set with one task group, and make a motion to change all three implementation guides at once.

Until the final transaction rule is published and a formal change request process is defined, you should write up your request, explaining your business case in detail, for the required modification and send it to the X12N/TG2/WG2 Chairs. The Chairs' names and mailing addresses can be found on the X12.org web site. You should also make sure a representative familiar with your issue is present to answer any questions the committee may have at the meeting where they discuss it. (This can be someone from the Medicaid HIPAA EDI workgroup. Better yet, your agency should join X12 and represent its own interests!) Once the WG responsible for the segment has approved the

change, they will help you to get concurrence from any other WGs who use that segment in one of their transactions and send the request forward for vote by the TG and full subcommittee.

Q. My state agency sent comments to the proposed rules, but to date, the Department of Health and Human Services (DHHS) has not sent me any answers. Don't they care about what I wrote?

A. The Department received over ten thousand comments. Comments on proposed rules are not responded to individually; the comments are addressed in the preamble to the final rule when it is published in the Federal Register. No word from DHHS does not mean that your concerns were not addressed. The publication of the final rule will provide the answers.?

HIPAA WEB SITES

www.wpc-edi.com (X12N version 4010 transacton implementation guides)

aspe.hhs.gov/admnsimp (Text of Administrative Simplification law and regulations publishing dates)

aspe.hhs.gov/datacncl (HHSData Council)

www.ncvhs.hhs.gov (National Committee on Vital and Health Statistics)

disa.org –select the Insurance, X12N, subcommittee file (X12N meeting)

hmrha.hirs.osd.mil/registry/index1.html (Data Registry; searchable database containing all data elements defined in HIPAA implementation guides)

www.hcfa.gov/medicare/edi/edi.htm (Medicare Electronic Data Interchange)

www.hcfa.gov/medicare/edi/hipaadoc.htm (Map of Medicare National Standard Format to X12 837 Professional Claim Transaction, Version 4010-HIPAA Standard)

www.hcfa.gov/medicaid/hipaapls.htm (Previous and current issue of "Medicaid HIPAA Plus")

What Are the Real Regulation Publication Dates???

HIPAA Plus has decided not to publish "Unofficial" publication dates for HIPAA Regulations. Previously published dates are proving to be no more reliable than the official dates that can be found on the HHS Department web site at www.aspe.hhs.gov/adminsimp.

The Department web site documents the regulation development process (aspe.hhs.gov/admnsimp/8steps.htm). It has become clear to the editors that attempting to predict the delays that can befall a regulation on its way through the approval process is not a useful exercise. From time to time, as a regulation moves from one step to the next, HIPAA Plus may comment on where it is, so you can judge for yourself as to when publication may be imminent.

In the meantime, let us look upon the delays as an opportunity. State Agencies are going to be hard pressed to implement HIPAA in the required 60-day plus two-year period. Although the final rules are not known, there is much we do know about the transactions and code sets. It is important to start planning for HIPAA implementation by doing a detailed analysis of current practices against X12 version 4010 Implementation Guides, and mapping local state code sets and identifier characteristics to those defined and named in the proposed rules.

This activity will provide two benefits. First, when the final rules are published, an update can be done in much less time than a full analysis, thereby buying time during the legislated

implementation period. Second, it will afford Medicaid the time and knowledge to bring Medicaid requirements into the standards development process, which can be quite lengthy. ?

HIPAA Provider Education

The following article may be adapted by Medicaid Agencies to educate their provider community about HIPAA Administrative Simplification.

Provider Education Document

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) contain a number of requirements that will improve and simplify the administrative demands on providers of health care. Although use of electronic health care transactions has grown significantly, especially for Medicaid, providers have complained that different health plans have different format requirements for transactions. Even when the same format is accepted by multiple plans, those plans usually have different coding or other completion requirements for the formats. This forces providers to respond to the separate requirements of each plan if the providers want to be able to interact electronically with those plans for billing, payment, eligibility, claim status query, and a number of other health care transactions. This is inefficient, expensive, and confusing.

HIPAA will remedy those complaints. The benefits of HIPAA will be experienced on electronic health care transactions within the next few years. As this may have significant impact on provider operations and planning for billing/practice management systems, Medicaid plans a series of educational efforts to furnish providers the information needed to make informed choices. In addition, information will also be shared with professional associations, their publications, and national media to publicize the impact of these changes.

HIPAA Administrative Simplification Summary Background

HIPAA requires that the Secretary of the Department of Health and Human Services adopt standards for electronic transactions and data elements for those transactions, standard code sets to be used in the transactions, unique health identifiers, and security standards and safeguards for electronic information systems involved in those transactions. This article is limited to information on the HIPAA transaction standards. Unique health identifiers, standard code set, and security issues will be addressed in later updates.

The following health care transaction standards are specified:

- Health claims or equivalent encounter information;
- Enrollment and dis-enrollment in a health plan;
- Eligibility for a health plan;
- Health care payment and remittance advice;
- Health plan premium payments;
- Health claim status;
- Referral certification and authorization;
- First report of injury;
- Coordination of benefits; and
- Attachments.

A proposed rule was published in the Federal Register on May 7, 1998. It proposed the adoption of version 4010 of the X12N standards for each of the transactions as well s the National Council for Prescription Drug Program (NCPDP) standards for retail pharmacy transactions.

Those X12N standards are the 837 (claims, encounters, and coordination of benefits), 834 (enrollment and dis-enrollment), 270/271 (eligibility, query and

response), 835 (payment and remittance advice), 820 (premium payments), 276/277 (claim status inquiry and response), and 278 (referral certification and authorization). Publication of the final rule for those transactions is expected later this year. The attachments transaction proposed rule is also expected to be published later this year. A first report of injury transaction proposed rule will be published when an industry consensus standard emerges.
Although the NCPDP standards are for real time and batch transactions, Medicaid is not required to support other real time health care transactions at this time. Medicaid Agencies are not precluded from offering real time and direct data entry (DDE) after implementation of the Administrative Simplification transaction standards, as long as the real time transactions meet the format and content requirements of the Administrative Simplification standards.

HIPAA requires that the adopted standards be implemented by virtually all health plans in the United States (including, but not only, Medicare and Medicaid), and health care clearinghouses. This includes any plan that performs the business function related to each standard transaction regardless if that function is performed electronically, in paper form, by telephone or in another mode, and by providers of health care that transmit any of these transactions electronically.

Providers that exchange any of these transactions electronically with health plans must either transfer transactions that comply with the implementation guides adopted in the final rule or contract with a clearinghouse to translate their transactions into or from the standard formats. If a provider chooses to contract with a clearinghouse for these translation services, the provider is responsible for the clearinghouse charges and the accuracy of the translations performed by that clearinghouse. Likewise, health plans that conduct these transactions electronically must be able to receive and send standard transactions that comply with the requirements in the published implementation guides. Effective with implementation of these standard transaction formats, a plan may not require an exchange of electronic transactions of these types in any other format. Nor may a provider or a plan use a trading partner agreement to override, substitute or otherwise change any requirement or condition of use of any part of an implementation guide for standard transactions.

A health plan that is unable to directly exchange electronic transactions in a standard format can contract with a clearinghouse to translate incoming and outgoing transactions to comply with the standard format requirements. If a health plan chooses this option, it cannot charge providers or other clearinghouses that choose to use the standards for those translation costs. Nor may a plan delay or disadvantage processing of transactions that are submitted or issued in a standard format.

HIPAA does not require that providers submit claims or receive remittance advice electronically. Nor does HIPAA require that providers submit electronic queries and receive electronic responses for claim status and eligibility. Providers may continue to make mail and telephone inquiries if they prefer unless they have trading partner agreements that require otherwise. HIPAA does make it easier and more cost-effective to use electronic transactions with the expectation that these improvements will result in greater use of electronic data interchange (EDI). Medicaid may continue to issue free billing software that can be used by providers to electronically bill Medicaid. HIPAA requires that the transaction standards be implemented by most health plans and “electronic” providers within two years of the effective date of publication of the final rule in the Federal Register. Certain “small” health plans will be allowed three years for implementation.

What This Means for Providers

Once the transaction standards are implemented nationally, a provider will be able to submit the same transaction in the same format to any health plan. Likewise, an “electronic”

provider will receive transactions of these types from any plan in the same format. This will make it more cost-effective for most health care providers to use software to automatically produce standard transactions to send to plans, and to automatically post data directly to accounts receivable. HIPAA will reduce the need for manual processing in the day-to-day processing of patient account information.

Many providers and plans may need to make significant changes to realize the benefits of HIPAA. Once the HIPAA transaction standards are fully implemented, Medicaid will no longer be able to accept flat-file electronic proprietary Medicaid, UB-92 or National Standard Format (NSF) transactions for claims. Nor will Medicaid be permitted to issue any electronic remittance advice in non-HIPAA format, or exchange any electronic transactions of the type specified by HIPAA, such as eligibility queries/responses, in any version not adopted as a national standard in the transaction and code set final rule.

Providers who currently use a health care clearinghouse to translate outgoing or incoming electronic transactions, may continue to use a health care clearinghouse to translate nonstandard transactions into the HIPAA standard transactions or to translate standard transactions into nonstandard transactions. If a clearinghouse is not used, a choice must be made as to whether to install software that can send and receive in the HIPAA transaction standard or contract with a clearinghouse for this service.

Providers that do not currently transmit by electronic means some or any of the transactions affected by HIPAA should re-examine the cost-effectiveness of beginning to use or expanding their use of EDI. EDI staff at their local Medicaid office can provide information about the advantages of EDI, requirements for EDI, vendors that may be able to help providers become EDI capable, and on the impact of the HIPAA transaction standards.

How to Get More Information

Medicaid will issue additional information to providers regarding the HIPAA transaction standards as the final rules are published. Providers that would like to obtain more information about EDI under Medicaid and HIPAA may also want to consult the following Web sites:

Map of Medicare National Standard Format to X12 837 Professional Claim Transaction, Version 4010-HIPAA Standard
http://www.hcfa.gov/medicare/edi/hipaadoc.htm

X12N version 4010 transaction implementation guides - www.wpc-edi.com

Text of Administrative Simplification law and regulations- www.aspe.hhs.gov/admnsimp

X12N meeting and workgroup meeting information and minutes—www.disa.org (select the Insurance, X12N, Subcommittee)

Providers who would like to test X12 EDI transactions should contact _____ (Note to State Agency: insert State Agency contact person here).?

Please send comments or questions regarding this issue of Medicaid HIPAA Plus to Sheila Frank at Sfrank1@HCFA.gov or to Karen Leshko at Kleshko@HCFA.gov.

Note: This document is located on the Web at HTTP://WWW.HCFA.GOV/MEDICAID/NEWS0200.PDF