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# MEDICAID HIPAA PLUS

## Why do we need Administrative Simplification?

*by Cathy Sheppard, EDI Consultant*

Just imagine how much harder life would be if we had to keep track of our transactions using rules like these:

- The grocery store on the corner only accepts checks and cash. But the checks must be blue and you must use black ink and include your library card number on the memo line. To use cash you must be able to recite the specific customer number they have assigned to you.
- The grocery store two miles further down the road accepts any color of check, but requires blue ink. The check cannot contain any information on the memo line. In addition, since they don't really care about the date you write the check you have to include your driver's license number on the date line instead.
- The owner of the dry cleaners doesn't take checks at all, and only accepts coins for payment but you must include a slip of paper with your name and the customer number they assigned you in pencil before you can pick up your cleaning.
- The movie rental place accepts only credit cards and you must submit a copy of an envelope with a postage date within the last month showing your current address so that they can attach it to your credit card slip in their files.
- The gas station takes any form of payment, but you have to pay them by the first of the month for any gas you want to purchase during the month. You also have to call for permission to fill your car at least 24 hours before you arrive at the station.

So in order to run your errands, you have to carry a list of the rules, two checkbooks, a bag of coins, a credit card, some cash, a list of all your assigned customer numbers, a few copies of envelopes you have received, at least two pens and a pencil, and blank paper. In addition you

must get permission to fill your car up at least a day before you actually need gas.

Congress passes a new law and each of these trading partners is required to accept any color check and ink, accept the same data on each check, accept coins or bills, and can't require specific customer numbers or advance notice of purchase.

At first the trading partners are very upset with the new rules because they think they only benefit the consumers. Then the gas station notices that the 10 people who took the calls requesting permission to gas up their cars can now spend their time on more productive tasks. The grocery store doesn't have to maintain their customer number files and can reduce their support staff. After a while the business partners can't imagine why they ever did business any other way.

This sounds a little ridiculous doesn't it? But many providers are frustrated by the rules and data required by the payers they do business with. The HIPAA Administrative Simplification requirements will reduce the number of specific rules the providers have to work with and introduce consistency in the collection and submission of data. Eventually, it will be better for both sides of the industry.

# Local Procedure Code Analysis Due July 31st

Those States that have been involved in the National Medicaid EDI HIPAA Workgroup know that it has undertaken the huge task of coordinating the assignment of national procedure codes to a large number of Medicaid local codes. First the committee developed a matrix of categories for all States to use to organize their codes. Then they created an Excel template for States to use to submit their local code lists to Mario Tedesco and Mark Malone of New York State Medicaid. (Three cheers to New York Medicaid for donating the resources to consolidate the lists for all the States who participate!) The group then met with the Kaye Riley, chair of the national HCPCS code maintenance committee to develop a procedure for presenting the consolidated list to the HCPCS committee in such a manner that new national codes can most easily be assigned the local codes needed by Medicaid.

The guidelines for research prior to submitting State local code templates to New York State for inclusion into the NMEH database are:

a) Find all local codes. To accomplish this, look beyond the range per coding section and look at the deleted codes to see if some were retained beyond the HCPCS deletion date.
b) Determine if there is an existing national code that would meet your business needs.
c) Eliminate any codes from the list that were not billed in calendar years 1999 and 2000.

To be included in the national local code database and initiative, all States must have their templates to New York State Medicaid by July 31, 2000. While this will not solve all procedure code problems for all States, members feel it will put them well along the path to HIPPA compliance. For more information, contact the NMEH Workgroup.

## Local Code Categories

The local code categories identified by the group are:

1) Alcohol & Other Drug Abuse (AODA) Treatment NOC
2) Anesthesia
3) Audiology
4) Case Management NOC
5) Children's Rehab Services
6) Chiropractic Services

7) Community Based Services (non-waiver)
8) Day Treatment, Community Service Program, Crisis Intervention
9) Dental
10) Dialysis
11) Drugs
12) Durable Medical Equipment
13) Durable Medical Supplies
14) EPSDT
15) Family Planning
16) FQHC & Rural Health Center/Clinic Services
17) Hearing Aids
18) Home Health, Personal Care & Respiratory Care Services
19) Hospice
20) Hospital
21) Lab
22) Managed Care Program (i.e., capitation payments)
23) Medical Services NOC
24) Mental Health NOC
25) Nursing Home
26) Nursing Services NOC
27) Physical, Occupational and Speech Therapy
28) Podiatry
29) Radiology
30) School Based Services
31) Special Prenatal Care Coordination & Child Care Coordination Services
32) Telemedicine
33) Transportation
34) Vaccines & Immunizations
35) Vision
36) Waiver Programs NOC
37) Miscellaneous – Use this section only if one of the previous 36 categories does not 'fit' your local procedure code.

NOC (Not Otherwise Classified)

– Use this category only if there is not a more specific category that the services fit into. For example: Nursing services provided in the home are considered home health services and would be reported under category 18. Nursing services provided in a physician's office (if separately identifiable/billable in your State) would be reported under category 26-Nursing Services NOC.


# PRESS RELEASE

## *HCFA Awards Contract*

The Department of Health and Human Services, Health Care Financing Administration, is pleased to announce the award of a technical services contract to AverStar and Fox Systems, (collectively referred to as the "A-Team,") to provide assistance to States and HCFA to achieve compliance of Medicaid systems with the Administrative Simplification Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The contract is managed by the HCFA Center for Medicaid and State Operations (CMSO).

The A-Team's first order of business will be to develop a national conceptual model of State Medicaid Management Information Systems (MMIS) with a focus on HIPAA compliance. Referred to as the Medicaid HIPAA-Compliant Concept Model (MHCCM), the product will serve as a roadmap for States to achieve HIPAA compliance. The primary objective of this project is to assist States in planning and implementing their compliance solutions.

Achieving HIPAA compliance is a major undertaking for States and their data exchange partners, outstripping Y2K efforts in terms of complexity and resource demands. This contract is a vehicle to provide assistance to all States at any step along their route to compliance. The MHCCM will provide States with models and data mapping tools, and guidance in their application. Use of the tools will allow States to assess their level of effort, select appropriate strategies, and develop budgets. The CMSO and the A-Team will draw upon State and Regional Office (RO) experience as the model evolves and will field-test the MHCCM at three host States with the intention of continuously improving the tools.

The project also supports CMSO and the ROs in their HIPAA leadership and awareness

campaign to achieve a common, national understanding of the importance and value of implementing standards, as well as an appreciation for the significant efforts required. Other year one tasks include presenting the MHCCM at the MMIS annual conference; hosting of a second, HIPAA-specific Medicaid conference; producing white papers to address common problems confronting States; disseminating useful information through the HCFA web site and publications; and identifying other opportunities to get the message out.

# Ask the HIPAA Wizard

**Q.** There's a statement that I don't understand in the last Medicaid HIPAA Plus. It reads, "You must transmit **all** the data elements and **only** the data elements for a situation as defined in a standard." The "all" part of the statement is the part I just don't understand. From my brief participation in ANSI X12 standard-setting workgroup, my understanding is that a transaction (say 837 for claims) is developed with certain mandatory data fields. All data format is standardized. But then a whole host of business users from Medicaid agencies, to private insurers, to workman's comp (WC) processors come to the table to be sure their individual business needs are addressed in some the fields defined in the 837. So, in the end, Medicaid may get a data field adopted for their needs (for example, one related to EPSDT) and WC may get another one adopted to meet their needs that has no applicability to Medicaid. These fields would be optional fields on the 837 transmission, and Medicaid wouldn't have to mandate the submission of a non-needed WC field, and vice versa.

**A.** The operative word here is "situation." Unlike the X12 *Standard* itself (which uses the term "optional"), all fields are described in the *HIPAA Implementation Guides* as mandatory, situational, or not used, and the *HIPAA Implementation Guides* clearly define the situations under which each field would or would not be included. It might say, "Include this field when required by State law" or " . . . required when the condition being reported is accident or employment related." You are correct that Medicaid would usually not have to fill in the field in the second case. But there are a lot of required fields that States do not currently use, so the agencies must do a careful analysis to determine how to create and/or store the extra data in their systems.

**Q.** When will there be publication of an NPRM for 'First Report of Injury'? The Transaction and Code set NPRM indicated that it would be in a separate NPRM. Is there any movement on this?

**A.** There is no date proposed for a First Report of Injury Standard at this time. Since there was no industry-wide standard for First Report of Injury at the time of publication of the NPRM for Transactions and Codes, none was included. When a standard is developed, the Department will consider it as a possible standard to be adopted under HIPAA.

Most X12 standards are written by very small groups of volunteers. If any States are particularly interested in seeing such a standard defined along their business needs, and participate in the X12 workgroup responsible for the transaction, it will probably evolve faster. This is true of all transactions.

# NOTICE—LAST ISSUE OF MEDICAID HIPAA PLUS…

…that will be sent to you unless you subscribe to our LISTSERV. To receive future issues, subscribe to the Medicaid HIPAA Administrative Simplification listserv. This listserv is maintained by HCFA's Data and Systems Group with a goal of keeping subscribers abreast of the latest HIPAA Administrative Simplification policy developments as related to Medicaid IT systems. Subscribers may also post information to the listserv. To subscribe, send mail to LISTSERV@LIST.NIH.GOV with the command: SUBSCRIBE HIPAAadminsimpl.

# HIPAA Implementation Should Start Immediately

WEDI advised its membership in a letter dated March 13, 2000, that the final rule for Transactions and Codes relates to the implementation guides for the following X12 transactions:

Health claims or equivalent encounter information.
*Health Care Claim (837)

Enrollment and disenrollment in a health plan.
*Benefit Enrollment and Maintenance (834)

Eligibility for a health plan.
*Health Care Eligibility/Benefit Inquiry (270)
*Health Care Eligibility/Benefit Information (271)

Claim payment
*Health Care Claim Payment/Advice (835)

Health claim status.
*Health Care Claim Status request (276)
*Health Care Claim Status Notification (277)

Referral certification and authorization.
*Health Care Service Review Information (278)

It went on to say that it is important to keep in mind is that there are no further technical changes that will take place with the Implementation Guides prior to the final rule being released. There is no reason to delay the recommended action steps for implementation of these transactions;

- Commence an assessment of the gaps and impacts to implement the transactions.
- Identify any translator requirements, if appropriate, and commence the selection process.
- Involve your vendors, clearinghouses, and other entities to determine their plans and any assistance that may be available.
- Determine specific plans for implementation of the transactions from both an IS and business perspective.
- Determine testing criteria and identify your trading partners.
- Develop "Chain of Trust" language to provide to vendors and others, as appropriate.
- Utilize any third party testing tools to determine HIPAA compliance with the Implementation Guides.

In a separate letter to the work group LISTSERV, Dave Feinberg, Co-Chair, X12 HIPAA Implementation Work Group, Insurance Subcommittee wrote:

HIPAA Transaction Standards Implementation Guides can be voluntarily adopted at any time by organizations that believe such adoption makes good business/economic sense. The Federal Rules will 'only' mandate adoption; absence of Federal Rules does not preclude adoption. Early Implementation Guide adoption should not be materially impacted when the final Federal Rules are issued.

It is suggested that organizations commence their planning now rather than waiting until final rules to be published. Two years is not a very long time in MMIS terms, so every day of advanced

planning will put us father along the road to compliance.

## Transmittals to Provide for Quick Release of Official Medicaid HIPAA Information

HCFA's Division of State Systems (DSS) has striven to improve communication with Medicaid State Agencies in the past year. Medicaid HIPAA Plus is just one manifestation of this effort. Now DSS has begun using Action Transmittals and Information Transmittals to quickly release information to the States. The first transmittal, which is an Action Transmittal (requires action by the States) was issued on July 6th and gives States vital new information about the creation and funding of statewide Immunization Registries. The transmittal is signed by Tim Westmoreland, Director of the Center of Medicaid and State Operations, and was attached to a State Medicaid Director (SMD) letter.

DSS will soon to release an SMD letter on HIPAA which will have a paragraph describing the transmittals. From there on, the transmittals may be stand-alone documents. In order to track the transmittals issued by the Division, the transmittals will be numbered sequentially.

The SMD letter and all attachments regarding the Immunization Registry are on HCFA's website at http://www.hcfa.gov/medicaid/smd70600.pdf. Transmittals regarding HIPAA will be placed in the soon-to-be-established Medicaid HIPAA web page along with Medicaid HIPAA Plus.

## What is WEDI?

(Adapted from the WEDI web site, www.wedi.org)

**WEDI** stands for Workgroup for Electronic Data Interchange. WEDI's mission is to foster widespread support for the adoption of electronic commerce within health care. To meet their mission they:

- Provide a forum for the definition of standards, the resolution of implementation issues, the development and delivery of education and training programs, and the development of strategies and tactics for the continued expansion of electronic commerce in health care;

- Assist health care leaders to define, prioritize, and reach consensus on the critical technical and business issues which affect the implementation and value of electronic commerce;

- Ensure that electronic commerce standards, policies, and regulations for health care are thoughtfully developed and implemented;

- Serve as the primary catalyst for the identification, communication, and resolution of obstacles that impede the growth of electronic commerce within health care; and

- Inform and educate WEDI members and other health care stakeholders about the benefits and strategies for successfully implementing electronic commerce.

WEDI was named in HIPAA (Sec. 1172, c) 3) B) iii)) as one of the industry groups that both the standard setting organizations, and the Secretary of DHHS must consult, to be in compliance with the law, when setting standards.

WEDI makes recommendations to the Secretary as to which transactions should be mandated in the next wave of Administrative Simplification standards. As voting members of WEDI, some State Agencies already have a voice in what HIPPA mandates come next, and can take the opportunity to help define those standards before a

proposed rule freezes the formats. WEDI is where it is happening!

The WEDI web site is filled with useful information. For those still trying to understand the alphabet soup of HIPAA terms and organizations, a wonderful HIPAA Glossary, prepared by Richard Zon Owen of Hawaii Medical Service Association, can be found there (http://www.wedi.org/htdocs/resource/index.htm). The Strategic National Implementation Process (SNIP) described in the last issue of Medicaid HIPAA Plus, is sponsored by WEDI, so one can find presentations, papers, online conferencing, and a chat site for SNIP at the WEDI.org web site. Additionally, check the WEDI SNIP education page as it evolves into a comprehensive resource pointing to hundreds of informational and educational materials about HIPAA Administrative Simplification.

## TESTIMONY BEFORE THE NATIONAL COMMITTEE ON VITAL HEALTH STATISTICS

The National Committee on Vital and Health Statistics (NCVHS) subcommittee on standards and security held a hearing regarding local codes issues and early implementers of HIPAA transactions on Thursday, July 13 and Friday, July 14, 2000. The hearing addressed two areas:

- Delineating the problem of local codes (Medicaid was represented by Stan Rosenstein of California Medicaid and Dr. Jerry Zelinger of HCFA); and
- Explanation of tools and processes that could lead to a solution (Medicaid was represented by Lisa Doyle, Chair of the National Medicaid EDI HIPAA workgroup)

Following are excerpted notes from Dr. Zelinger's and Lisa Doyle's testimony. Stan Rosenstein's notes may be viewed at http://www.ncvhs.hhs.gov/.

### DELINEATING THE PROBLEM OF LOCAL CODES

Excerpted from speech by Dr. Jerry Zelinger

#### Overview of the Medicaid Program

The Medicaid program, which operates as a joint Federal-State entitlement program, is the third largest source of health insurance in the U.S. after employer-based coverage and the Medicare program. The Medicaid program pays for a broad range of services for certain groups of low-income persons. These groups are disabled children and adults, the elderly, pregnant women and single parents. Total (Federal and State) expenditures in 1999 were $190 billion with the Federal government contributing about 57% and States 42% of the total. There are approximately 41 million beneficiaries in the program including 41% of all children now born in this country and more than half of Americans with AIDS. Managed care has become the major delivery/payment system in the Medicaid program. In 1998 53% of Medicaid beneficiaries were enrolled in a managed care plan, five times more than in 1991.

States are given considerable discretion and control to run their Medicaid program within broad Federal guidelines. States are given a great deal of flexibility in developing their program eligibility criteria, in designing their benefit packages and in determining how much to pay for covered services. Therefore, across the country the Medicaid program consists of 50 unique programs with considerable state-to-state variation.

#### Medicaid Procedure Coding Requirements

The fact is that there has been little **Federal** guidance on the procedure codes that Medicaid providers should use on claim forms to enable the State Medicaid agency to process and pay claims for services provided to Medicaid patients. Neither the Medicaid statute (Title 19 of the Social Security Act) nor Federal

Medicaid regulations specify what procedure codes are to be used. It has been longstanding Federal policy that States are to use the HCFA Common Procedure Coding System (HCPCS) codes for these transactions and updates of the codes are sent annually to the States. But Level III of the HCPCS coding system allows for the use of local codes and we, at the Federal level, have allowed and, at times, encouraged States to create local codes to meet their own unique needs.

As a result, today most State Medicaid programs use their own State developed codes to identify many of the services for which they pay. We have heard estimates that 40-50% of all State Medicaid "fee-for-service" transactions use local procedure codes and we know that there is enormous state-to-state variation with some States using local codes only and others using very few local codes. We also know that Medicaid managed care plans have not been submitting the kinds of encounter data that are often required under their contracts with State Medicaid agencies. The reasons for this are not totally known and probably vary by health plan, but the impact of HIPAA and the elimination of local codes on Medicaid managed care plans is likely to be significant.

**Are Special/Unique Procedure Codes Needed by the Medicaid Program?**

With HIPAA on the horizon, we know that State Medicaid programs as well as other public and private insurers will be required to eliminate the local codes they have developed. The question, or one important question, is whether and the extent to which special, unique codes will be needed by State Medicaid agencies to run their programs or will the standard sets of codes used by other insurers be sufficient? In other words, how different and unique are the services covered by the Medicaid program compared to the services covered by other insurers? I know that some of these issues will be discussed by others following me on this panel and on the next panel discussing the resolution of the problem. I would like to briefly and simply describe the issue and landscape from a Federal Medicaid perspective.

Local codes used by States now can be classified into one of three categories. One category reflects local codes that are, in fact, basically the same as existing national codes that adequately describe services that are commonly provided and covered by other payers. States frequently use these kinds of codes and they can be "safely" eliminated under HIPAA. There is another category of local codes that reflects services covered by Medicaid and other payers but where no national code currently exists to describe the service. For example, services provided via telemedicine (now covered by 17 State Medicaid programs and by Medicare) and new and emerging procedures and technologies covered by State Medicaid programs and others but where a national code has not yet been developed. There remains a third category consisting of a substantial number of local codes used to describe special and unique services covered by the State Medicaid program but **not** generally covered by any other health insurers. For example, there are currently 250 Medicaid Home and Community-Based Waiver programs operating in every State but one at a cost of $10 billion annually. These programs provide coverage for an extensive array of non-medical type services such as air conditioners, home and vehicle modifications, companion and attendant care for the elderly, disabled, mentally retarded and developmentally disabled individuals included in these programs. Such services are not generally covered by other public or private health insurers. Medicaid Home and Community-Based programs are expected to increase dramatically following the recent Supreme Court decision in **Olmstead**. Other examples include the school-based health services provided to disabled children under the Individuals with Disabilities Education Act to enable these children to receive a free, appropriate public education. Almost all State Medicaid programs cover these services for Medicaid children at a cost of

over $2 billion annually while the local, State and Federal Education Agencies pick up the rest of the cost for these services when provided to non-Medicaid children. Other services commonly covered by State Medicaid programs but not other health insurers include transportation to health care providers, case management services and services that are part of Medicaid enhanced pregnancy related services such as health education and counseling. Procedure codes to describe these special and unique services not generally covered by other health insurers are needed to enable State Medicaid agencies to run their programs.

## Local Codes Issues - Tools and Processes that could Lead to a Solution

Excerpted from speech by Lisa Doyle, Medicaid Information Specialist, Wisconsin Department of Health and Family Services and Chair, NASMD, National Medicaid EDI HIPAA Workgroup

### State Efforts

In November 1999, the National Medicaid EDI HIPAA (NMEH) Workgroup was formed by NASMD to give States a forum to assess the impact of HIPAA Administrative Simplification on Medicaid systems. Today, approximately 40 States actively participate in the workgroup. The New York State Medicaid agency leads the local code subgroup and receives local code templates from the NMEH participants. The criteria for local code research prior to submission is as follows:

a) Find all local codes. To accomplish this, look beyond the range per coding section and look at the deleted codes to see if some were retained beyond the HCPCS deletion date.
b) Determine if there is an existing national code that would meet your business needs.
c) Eliminate any codes from the list that were not billed in calendar years 1999 and 2000.

These submissions will form the basis of a national local code database. In order to be included, states must submit this information by July 31, 2000.

Once the local procedure code and procedure code modifiers have been received, they will be prioritized by volume per category. We will then submit, in priority order, all procedure and procedure code modifiers to HCFA for inclusion in the appropriate national coding structure.

### State Concerns with Current HCPCS Process

As it was discussed on the previous panel, State Medicaid agencies rely heavily on local codes to meet our unique business needs. Since its inception in the mid-1980s, the HCFA Common Procedure Coding System (HCPCS) has been reflective of the services and products available under the Medicare program. If all of the Medicaid procedures currently being supported by local codes must be included in the level II HCPCS the demand on the HCFA HCPCS workgroup will be immense. We question whether the existing quarterly review process and HCFA resources will be adequate to meet this demand. We are concerned that unless there is adequate staffing for the review each quarter, states will have no alternative but to use local codes beyond the date that HIPAA compliance is mandatory.

In addition, the process of adding new procedure codes has not been developed to accommodate the numerous, rapid turn-around requests that States will have. Currently, any requests for new codes are accepted once a year. The HCFA HCPCS workgroup then meets quarterly to review these requests and sends their recommendations on to the Alpha-Numeric Editorial Panel for final decision. This means that State Medicaid agencies will not be able to implement any expansion of services within a short timeframe simply because the necessary procedure codes may not be available. This is unacceptable for a program that is continually evolving in its efforts to provide a myriad of services to vulnerable populations.

**Recommendations**

Local codes are integral to the business of Medicaid and reflective of the unique products and services we offer. Many of them support "closed-loop transactions" for which Medicaid is the only source of payment for specialized services. While the goal of standardization is logical in today's electronic world, it may not make sense in all situations. We believe there is little value in imposing national standards on the closed-loop businesses of Medicaid. However, in the absence of any final rules, assuming that all local codes are eliminated, we offer several recommendations. These are based on the premise that Medicaid will create the greatest demand both initially and on-going for new Level II HCPCS codes.

1. In light of the fact that the business needs of Medicaid differ from those of commercial insurers and Medicare, it is critical that we become part of the process. The National Association of State Medicaid Directors should be offered a direct voice on NCVHS and the HCPCS Alpha-Numeric Editorial Panel. Both of these decision-making bodies already include representatives from the commercial insurance sector.

2. Timing is critical and establishment of procedure codes and related nomenclature should never be allowed to drive effective dates of policy. State legislation and approval dates for Federal waivers drive effective dates for policy which in turn create the need for local codes today, Level II codes in the future. The Alpha-Numeric Editorial Panel that advises HCFA meets three times a year. This will not accommodate the needs of States. Consumers should not have to wait for a service nor should providers be asked to wait for payment for a service authorized as payable, simply because the bureaucracy has not yet created a procedure code. A more rapid response process must be implemented in order for standardization to succeed.

3. In the interim, HCFA may want to consider a policy of allowing States to create and use temporary Level II codes while awaiting action by the HCPCS workgroup. This policy could include an understanding that upon establishment of a permanent Level II code, if that code differs from the temporary code, the States will agree to adopt the permanent code and perform history conversions to accommodate Federal reporting.

The elimination of local codes under HIPAA presents a challenge of huge proportions. It will take a great deal of collaboration between not only HCFA and the State Medicaid programs but also with the entire health care industry. We look forward to being an active player as Administrative Simplification moves forward.

## Utah to Host National Computer System Conference this Fall

The Utah Department of Health will host the 2000 National Medicaid Management Information System (MMIS) Conference September 26 – 28th. Several hundred State and Federal employees who provide MMIS technical support are expected to attend the event, which will be held at the Cavanaughs Olympus Hotel in Salt Lake City. Conference sessions will focus on three exciting tracks: l. HIPAA Administrative Simplification, 2. New Worlds of Data Sharing, and 3. New Technology Applications. This conference is an excellent forum to meet your colleagues compare notes and establish important contacts. For more information contact Gayle Coombs, Conference Coordinator, 1-800-538-6406 or gcoombs@doh.state.ut.us.

# HIPAA WEB SITES

www.wpc-edi.com (X12N version 4010 transacton implementation guides)
http://aspe.hhs.gov/adminsimp (Text of Administrative Simplification law and regulations publishing dates)
http://aspe.hhs.gov/datacncl (HHS Data Council)
http://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/hpaadoc.htm (Map of Medicare National Standard Format to X12837 Professional Claim Transaction, Version 4010-HIPAA Standard)
www.hcfa.gov/medicaid/hipaapls.htm (Previous and current issues of "Medicaid HIPAA Plus")
http://www.hl7.org (Health Level 7)
http://www.ncpdp.org (National Council for Prescription Drug Programs)
http://www.wedi.org/ (Workgroup for Electronic Data Interchange)

**NOTE:** This document is located on the Web at www.HCFA.gov/medicaid/news0700.pdf

# Results of Survey of States

The Division of State Systems (DSS) recently conducted a survey of HIPAA baseline activities in the States and 40 responses were received by the end of May. The following results are summarized categories with the number of states that responded with an answer that closely matches the category.

**Question 1**

Have you performed any assessment of how and where the proposed HIPAA Administrative Simplification regulations will impact current Medicaid processes?

28 States have assessment in progress
9 States have done no assessment.
3 States have completed assessment.

*Additional responses of interest:*

6 States have reprocurement to consider
1 State is developing a HIPAA planning APD
1 State is proposing joint assessment effort with other neighboring States
1 State would like HCFA to initiate a contracting effort with fiscal agents that serve multiple States

**Question 2**

Does a formal project management structure currently exist to support HIPAA Administrative Simplification? If yes, list specific activities, tasks, and goals that are being undertaken.

6 States answered No
14 States answered Yes, but using current structure
20 States answered Yes, dedicating specific individual/group to specific HIPAA work

*Additional responses of interest:*

1 State is putting together a multi-State conference to discuss implementation alternatives
1 State has a two-tier project management for HIPAA; in-house and fiscal agent
1 State established comprehensive project team and assigned specific tasks

**Question 3**

What are some of the key issues and barriers for your State? What steps are planned to address these issues/barriers?

28 States answered, Eliminating Local Codes
8 States answered, NPI systems changes and conversions
8 States answered, Funding/Cost
7 States answered, Timeframes for implementation/timing
5 States answered, Reimbursement modification

caused by changes in provider file
4 States answered, Eliminating Type of Service, Category of Service, Place of Service Codes
4 States answered, Lack resources
3 States answered, History conversion (claims, SURS…)
3 States answered, NPI Taxonomy (lack Medicaid provider types)
3 States answered, How will NPI be assigned/who will enumerate?
3 States answered, Implementing Security and Privacy Rules
2 States answered, Lack of intelligence in NPI
1 State answered, NCPDP Version 3.2 vs. 5.0
1 State answered, Difficult to ask Legislature to fund project with so many unknowns
1 State answered, General lack of consideration for Medicaid in development of States answered, National Standards
1 State answered, May require providers to bill hardcopy if Level 3 HCPCS are not nationally assigned
New Mexico answered, State strongly supports standardization so they don't see any huge barriers

*Question 3--Addressing Issues*

3 States are participating in National Medicaid EDI HIPAA Workgroup
2 States are addressing HIPAA during MMIS reprocurement
2 States are exploring options: translators, clearinghouses, reprogramming, combination of both
1 State is raising awareness with HCFA and SDOs
1 State is not beginning any effort until Final Rules
1 State is participating and supporting at X12, HL7, and WEDI; reviewing current standards and developing new policy where needed
1 State has begun outreach programs to educate provider community about HIPAA requirement
1 State is exploring methods for assisting the provider in EDI compliance

**Question 4**

Describe any plans you have to submit APD(s).

22 States have not submitted, but plan to
9 States have not submitted
3 States included HIPAA in APD for MMIS reprocurement
2 States have submitted HIPAA planning APDs
3 States plan to include HIPAA in APD for MMIS reprocurement
3 States are waiting for completion of assessment, decision on approach, and cost estimates
3 States will combine regulations and develop APDs accordingly
3 States are drafting a consortium approach for HIPAA planning, APDs, implementation
1 State has an APD for HIPAA requirements analysis
1 State submitted APD in 1996 for EDI implementation and will submit APD for NPI
1 State is waiting on 90% FFP decision
1 State is looking for Enhanced FFP
1 State understands States may not apply for Enhanced FFP
1 State cites HIPAA as primary unmet need for justifying MMIS replacement
1 State notes issue of APDs is discussed at the National Medicaid EDI HIPAA Workgroup

**Question 5**

Does your State currently participate in any standards development activities with any of the national organizations (X12, WEDI, NUCC, NUBC, etc?)? Is your State currently participating in the National Medicaid EDI HIPAA Workgroup sponsored by the S-TAG and led by Lisa Doyle of Wisconsin?

20 States are actively participating in National Medicaid EDI HIPAA Workgroup
13 States are not participating in SDOs or national groups
6 States' fiscal agent has representation at X12
5 States keep abreast of National Medicaid EDI HIPAA Workgroup activities
4 States are members of WEDI
4 States may participate in X12 as voting member
2 States are members of X12
2 States are members of NUCC and NUBC ( 1 Represents NASMD)
2 States are members of NCPDP

2 States attend X12 on infrequent basis

**Question 6**

Have you implemented any of the transactions proposed under HIPAA Administrative Simplification? If so, which transactions, and which versions?

6 using NCPDP Version 3.2
1 using NCPDP Version 3.3c
1 using NCPDP Version 5.0
1 using 270/271 for eligibility verification
1 using 837 v.3051 in use for encounters
1 using 835 in pilot for 2 years, 837 v.4010 in testing
1 working on implementing 835 v.4010
1 contracted with Recipient Eligibility Vendor (REV) as front-end for X12 transactions
1 moving from HCFA-1500 to 837 v.3050 by end of 2000
1 looking to vendor as Intermediary for 270/271
1 using 837 v.3032 and 835 v.3030 in use for FFS
1 using 834 v.3031 and 837 v.3032 (Institutional)/v.4010 (Professional) in use for MC

**Question 7**

Have you published any outreach/training materials on the subject of HIPAA Administrative Simplification to increase awareness for both external partners and internal staff and management?

5 States are circulating HIPAA information obtained from Internet and other sources to internal staff
5 States are communicating via newsletters, internet, and presentations to the provider community and other external partners
5 States plan to use HCFA-provided materials
5 States are sending staff to HIPAA training (provided by fiscal agent, HCFA, in-house…)
3 States are conducted meetings with internal staff/external partners
2 States are waiting for Final Rules
1 State hopes HCFA will take the lead
1 State would appreciate outreach materials provided by HCFA
1 State held regional conference
1 State is using State's Health Information Network

**Question 8**

Have you received any technical assistance (in any part of the Medicaid "enterprise") on HIPAA Administrative Simplification? Are you seeking technical assistance from sources external to your organization?

8 States are receiving Technical Assistance from fiscal agents
6 States are seeking Technical Assistance from vendors
5 States have attended/will attend HCFA sponsored training
3 States are interested in Technical Assistance, if provided
3 States are relying on fiscal agent or fiscal agent may provide
2 States are receiving Technical Assistance from consultant
2 States are working with State IT services
2 States are relying on Internet sources
2 States may need separate Technical Assistance just for Security and Privacy
1 State is unclear if "Technical Assistance" means IT or policy
1 State is attending conferences

The survey results are over a month old as of this edition of Medicaid HIPAA Plus. Many States may have started or have completed work on HIPAA such as assessments, training, and outreach since the survey. Although responses may change over a short period of time, it is clear from the baseline responses that States will need every bit of the 24-month timeframe for implementation of the standards. What DSS will have to do from this point on is to monitor assessment activities, collect assessment information, and let States know that their success is in the best interest of all that are involved in health care. CMSO will continue to develop more outreach and training materials, continue initiatives to provide guidance by developing a technical assistance strategy, and facilitate effective communication between the States and HCFA. States can also actively initiate HIPPA-specific activities as well. Some suggested activities for the States to engage in are as follows:

* Communicate issues and barriers to HCFA, Central Office.

* Communicate APD activity to HCFA Regional Offices and Central Office.

* Participate in efforts such as the Strategic National Implementation Planning (SNIP) that is sponsored by WEDI and AFEHCT.

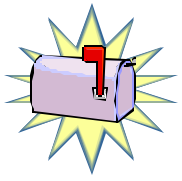
* Participate in the National Medicaid EDI HIPAA Workgroup.

* Participate in content committees such as the NUCC and the NUBC.

* Participate in X12, WEDI, and HL7.

* Learn from States that have implemented, or will implement the standard transactions.

If you have questions or comments about the results of the survey, please contact Henry Chao at 410-786-7811 or e-mail at hchao@hcfa.gov



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