Medicaid HIPAA Plus

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Inside this Issue

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Introduction

With this publication, HCFA's Data and Systems Group within the Center for Medicaid and State Operations is launching a new effort to keep you abreast of the latest HIPAA Administrative Simplification policy developments. This document will delve into the fields of information technology and data utilization as these relate to the effective and efficient administration of the Medicaid program. A broad spectrum of topics falls within the Data and Systems Group's responsibilities, and we hope that you will find our across-the-board approach useful and interesting. New information will be published monthly. Please provide us with your feedback as noted on page 3.

Preparing for HIPAA

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of l996 direct the Secretary of Health and Human Services to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans and providers. HIPAA seeks to simplify and encourage the electronic transfer of data by replacing the many nonstandard formats currently used nationally, with a single set of electronic standards that would be used throughout the health care industry.

These standard transaction format requirements are not limited to Medicaid. These requirements apply to virtually all private, commercial, State and Federal entities (referred to as health plans) in the United States that pay health care bills as well as to the providers and clearinghouses that exchange electronic payment information with each other for secondary payment purposes, among others. Coordination of benefit payers that currently exchange claim and payment data with other payers, either electronically, in paper form, or in another mode, also need to begin to prepare for the implementation of HIPAA.

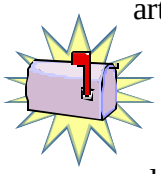
The proposed rule for the transactions and code sets, other than attachments and first report of injury, was published in the **Federal Register** on May 7, 1998. Following processing of thousands of comments, the final rule for those standard transactions is expected to be published by the end of this year. Medicaid State

Agencies, their fiscal agents, their processing centers, and the providers and clearinghouses that interact with them electronically will need to upgrade their health care transactions software. The upgrade will take place at some to-be-determined point in the 2000-2002 time frame to meet the new transaction standard requirements. This time frame is subject to change according to the actual publication date. Future newsletters will address the standard requirements.

More definitive information will be shared with Medicaid Agencies and providers following publication of the final rule. Due to the magnitude of the coming changes, providers must be kept apprised of changes on a regular basis. There have been numerous provider association and national media articles on Administrative Simplification in the past two years, but many providers are still confused as to whether or how these changes may apply to their own operations.

More intensive provider education outreach efforts are expected to be needed in 2000 and 2001 following publication of the final rule.

Be on the lookout for a HCFA article that Medicaid State Agencies may forward to providers as a means of education. ¤



Implementor's Corner

Elimination of the Type of Service Code

The lack of a Type of Service code in the HIPAA 837 Professional Claim (which will replace the HCFA-1500 form) may be of interest to some states. Under HIPAA, HCPCS modifiers will be the standard way to impart the information currently contained in the Type of Service code. Evidently, Medicare switched to the HCPCS modifiers a while ago, and discontinued use of the Type of Service code. States should be able to crosswalk to the place of service intelligence required by their systems to HCPCS. ¤

Early Notice

Please assume that HIPAA standards will require annual updating of code sets such as ICD and HCPCs. Be prepared!

Batch Enumeration or Not?

Under HIPAA rules each provider, no matter what their line of business (Medicare, Medicaid, or Commercial) will be assigned one unique national provider identifier. When the National Provider System is ready to assign identifiers next year, state agencies and plans will most likely have the option of sending in batch requests for multiple provider number assignments. Of course, each of their providers may apply for its number on its own. During the comment process many Medicaid Agencies noted that they do not have all the required enumeration data elements in their databases and, therefore, would prefer not to send in batch requests for all their providers. HCFA is interested in hearing from those states that think they would take advantage of the batch submission option. Please e-mail Sheila Frank at SFrank1@HCFA.gov. This is not a commitment. The enumerator is just trying to get a feel for the workload. Note: By the time state agencies or their providers submit requests, all Medicare

providers will already have been assigned numbers. ¤

X12 Wants YOU!

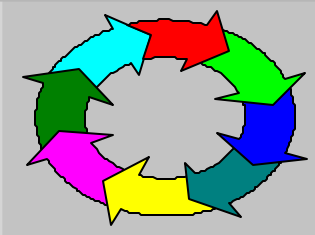
At the recent X12 Standards development meeting, seventeen people showed up for an informal meeting to talk about Medicaid concerns. Two attendees were from HCFA Central Office; one was from a Medicaid fiscal agent and the rest were software vendors supporting the provider sector and other payers who do business with Medicaid. Most were dismayed that the X12 workgroups were discussing issues and proposed changes to the standards that are critical to the business needs of Medicaid Agencies, yet there was no coordinated strategy to speak up for Medicaid's interests.

The Claim Adjustment Reason and Claim Status Code Committee meets three times a year to vote on proposed code changes. These meetings are held in conjunction with X12 on the Sunday preceding the official X12 meeting. All year, discussions are held on line at http://www.wpc-edi.com/AdjustmentStatusCodes/Index.html. Sign on to the web site and propose changes, or make comments on other proposals.

There is a vacant position on this committee for a representative from Medicaid. Since Medicaid Agencies often find that standard code sets don't meet their needs, active participation by Medicaid Agencies would help ensure that code sets required for use under HIPAA contain the breadth required to meet Medicaid business needs. ¤

TRAINING CONTRACT AWARDED

On September 30, HCFA signed a contract with Leads Corporation to provide HIPAA training at all the HCFA Regional Offices. Each Medicaid State Agency will be able to designate an average of five people to attend. There will be no charge for the course itself. It will have a "train the trainer" format, so that attendees should be prepared to inform additional staff upon their return. The agenda will cover issues from an executive overview to how to read an X12 Implementation Guide. Scheduling and detailed course outlines will be conducted after publication of the final transaction rules. ¤



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.

HIPAA WEB SITES

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

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

www.aspe.os.dhhs.gov/datacncl (HHS Data Council)

www.aspe.os.dhhs.gov/ncvhs (National Committee on Vital and Health Statistics

www.disa.org –select the Insurance, X12N, subcommittee file (X12N meeting and workgroup meeting information and minutes)

HTTP://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

Schedule for Publication of HIPAA Administrative Simplification

The following estimated publication dates for HIPAA rules and proposed rules were announced at the ASCX12 meeting in Orlando on October 3, 1999:

NPRMs Already Published

Standard	NPRM Published	Expected Final Rule
Transactions and Coding	05/07/98	12/99
National Provider Identifier	05/07/98	01/00
National Employer Identifier	06/16/98	12/99
Security	08/12/98	02/00
Privacy	11/03/99	02/00

NPRMs in Development

National Health Plan Identifier	12/99	05/01
Claims Attachments	01/00	09/00

National Individual Identifier (On hold pending privacy)

Data Sharing under HIPAA

HIPAA implementation will require some significant systems reengineering. This will give states a great

opportunity to build enhancements that will facilitate the sharing of data with public health departments to the benefit of both Medicaid and public health programs. Historically, there have been impediments to the exchange of data between Medicaid

Management Information Systems (MMIS) and Public Health Data Repositories such as immunization and cancer registries. In addition, each HCFA regional office separately authorizes MMIS enhancements, and grants waivers for initiatives on a case by case basis. Except for a model Memorandum of Understanding (MOU) that entities can use to facilitate data sharing, there is no uniform national policy or guidance for these activities. There is inconsistency in the way HCFA administers and encourages (or does not encourage) data sharing. HCFA's Central Office Data and Systems Group is currently developing a guide outlining a national policy on data sharing between Medicaid and Public Health Agencies addressing the following:

1. Why exchange data – benefits to be gained

2. Legal and policy obstacles to data exchange and solutions

3. Cost allocation/ matching rate determination

4. Incentives – Under what conditions development would be funded

5. Data exchange boundaries and how to set them – who owns which data

6. Use of standards for data system communicability; HIPAA claims attachments, HL7 Immunization transaction, Government Computerized Patient Record (GCPR)

7. Best practices-creative ways to match and use data effectively ¤

MMIS Reform

As state systems are reorganized for the implementation of HIPAA, an opportunity will be afforded to take advantage of Medicaid Management Information Systems (MMIS) Reform.

The environment in which state Medicaid agencies operate has changed greatly since 1980, when the first generation of MMIS development and implementation took place.

- The **business functions** of the agencies have become much more complex, and involve coordination with the operations of many public agencies and private vendors. In addition, states have become sophisticated users of management information as they have changed their orientation from regulator to purchaser.

- **Technologically**, systems are more powerful, faster, "smarter", and, importantly, can be developed and modified in modular fashion. In addition, proprietary systems architecture has been replaced with new open systems architecture.

- The general **rate of change** in the business and technological environments has accelerated dramatically. Change is now understood to be a constant for state Medicaid agencies.

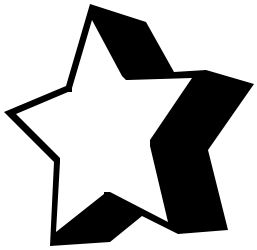
While the environment has changed, the process by which states are directed by HCFA to design and procure information systems has remained fairly constant since the inception of the MMIS. The recognition of the need to reform how HCFA and state Medicaid agencies work together to strategically plan for, and acquire, information technology led to a focused retreat in July 1998. This retreat was co-sponsored by HCFA and the National Association of State Medicaid Directors (NASMD). Participants analyzed and clarified anticipated future business needs of both HCFA and the states, as well as objectives for the Federal-State relationship relative to information technology procurement.

Reform participants conceived of an alternative to the detailed sub-system approach to system design. They envisioned a system design approach that would be based upon *core business functions*. These core business functions would become the basis for a revamped definition of what constitutes an MMIS. The effect would be to change the focus of defining an MMIS from "how does an MMIS perform specific functions?" to "what functions can the MMIS perform?"

After reaching agreement on the concepts, underlying templates and architectural principles, participants developed a more detailed discussion of the specifics of a template approach. They focused upon how best to structure templates to describe core business functions.

In developing the template concept, reform team members recognized that state and HCFA systems staff not only need to change their fundamental design questions from "how" to "what", but they also need to think about systems design in dynamic, rather than static terms. That is, the design process must ask not only *"how do you start*?" but of equal importance, *"how do you change*?"

This has led to the conclusion that future MMIS design should consist of not only a series of template definitions, but also a set of technical parameters describing system attributes of *flexibility*, *interoperability*, and *modularity* to apply to each template. Flexibility, interoperability, and modularity are attributes that support the ability of an MMIS to change over time, and to do so incrementally and with ease. ¤



HIPAA EDI Team

The S-TAG announced at the October 6 meeting that the EDI workgroup would reconvene to cover HIPAA issues. Lisa Doyle, a Medicaid Systems Specialist with Wisconsin Medicaid has kindly agreed to lead this critical effort. The main goal of this workgroup is to leverage Medicaid's considerable resources. Since HIPAA regs will start flying fast and furious soon, now is the time to put heads together to 'break the code' on how to implement the various portions of HIPAA. We hope enough volunteers will step forward to allow in-depth analysis of all the HIPAA transactions and code sets in detail. As needed, the group will prepare formal transaction and code set modification proposals to be sent to the HIPAA designated Standards Development and Data Content Committees. That effort will allow future versions of the standards to meet the unique business requirements of Medicaid Systems.

The workgroup will convene via conference calls. APHSA has generously offered to sponsor these calls. The first conference call is scheduled for the week of November 8. Calls will probably be held every other week until the end of this calendar year. The group will collectively decide how they should be scheduled into 2000. Contact Lisa at doylelj@dhfs.state.wi.us or (608) 266-6960, right away to get involved in this effort.¤