

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HIPAA READINESS:
ADMINISTRATIVE SIMPLIFICATION
FOR MEDICAID STATE AGENCIES**



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EXECUTIVE SUMMARY

OBJECTIVE

To determine if state Medicaid agencies expect to comply with the electronic data transaction standards and code sets under the Health Insurance Portability and Accountability Act (HIPAA) by October 2003.

BACKGROUND

The purpose of Title II of HIPAA is to improve the efficiency of the health care system by establishing standards to facilitate the electronic transmission of data between providers and payers. Electronic data interchange (EDI) can eliminate the inefficiencies associated with handling paper documents. It can reduce administrative costs and improves overall data quality for transactions, such as health care payments and coordination of benefits.¹

In accordance with the provisions of Title II of HIPAA, the Secretary of Health and Human Services has promulgated regulations mandating the use of specific standards for eight different types of electronic transactions and medical code sets. According to the regulations, state Medicaid agencies and other covered entities that filed an extension must implement the standards by October 16, 2003.

FINDINGS

We conducted telephone interviews with officials from the 51 state Medicaid agencies (50 states and the District of Columbia). While few similarities exist in the planning and strategies among the 51 Medicaid agencies, 42 programs (approximately 80 percent) anticipate that they will be in compliance by October 2003. Of the remaining nine programs, eight are developing contingency plans to allow them to conduct business with compliant and noncompliant trading partners, and the ninth is expected to be minimally compliant by the deadline, with expectations that a new compliant system will be on line by March 2004.

¹65 F.R. 50312 (August 17, 2000).

Approximately 80 percent of the state Medicaid programs will be in compliance with the HIPAA standards by October 2003

Forty-two state Medicaid agencies expect to be fully compliant by October 16, 2003. Nine states will not meet the October 2003, target. The nine states are developing strategies that they expect will enable them to continue paying claims. Furthermore, twenty-nine of the 51 states currently have contingency plans in the event they are unable to implement the transaction standards by October 16, 2003.

Few similarities exist in the planning and strategies among the 51 state Medicaid programs

Twenty-nine states will use an electronic data interchange translator to handle the new electronic standards. In addition to these 29, 15 states have new systems or plan to install new systems over the next several years, and 7 states will use a clearinghouse or other interim measures to meet the implementation date. Respondents from 40 states indicated that they plan to sequence implementation of the transactions.

Lack of financial resources and technical support are barriers to meeting the October 2003 compliance date

Twenty-one states report that lack of financial resources and of technical support are barriers. In addition, 21 state officials cited regulatory delays, changing federal regulations, and inconsistent rule interpretations as barriers. Moving low volume and rural providers to compliance is perceived as a barrier in 21 states. In 24 states, code set conversion is a major barrier to compliance.

CONCLUSION

Overall, states are making progress in meeting the October 2003, deadline for implementing the HIPAA electronic transaction standards and code sets. All 51 states expect to be ready to implement the transactions, which will enable them to pay claims for Medicaid beneficiaries. The nine states that anticipate not being fully compliant on October 16, 2003, expect to continue to transact business using compliant and noncompliant electronic data until their systems are ready.

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INTRODUCTION

OBJECTIVE

To determine if state Medicaid agencies expect to comply with the electronic data transaction standards and code sets under the Health Insurance Portability and Accountability Act (HIPAA) by October 2003.

BACKGROUND

Congress instituted significant reforms to the health care industry with the passage of HIPAA. Title I of HIPAA ensures the availability and portability of health care insurance coverage, while Title II creates a regulatory framework focused on improving the efficiency of the health care system by establishing standards to facilitate the electronic transmission of data between providers and payers. The goal is to create a seamless transfer of data with limited manual intervention.

Administrative Simplification

Under Title II, Subtitle F (Administrative Simplification), the Secretary of Health and Human Services has the authority to: (1) mandate the use of standards for the electronic exchange of health care data; (2) specify what medical and administrative code sets should be used, (3) require the use of national identification systems, and (4) specify the types of measures required to protect the security and privacy of personally identified health care information.

Electronic Transactions and Code Sets

Electronic data interchange (EDI) is the electronic transfer of information in a standard format between trading partners. The EDI substantially reduces the handling and processing time compared to paper transactions. The EDI can eliminate the inefficiencies of handling paper documents by reducing the administrative burden, lowering operating costs, and improving overall data quality.²

Transactions are the exchange of information between two parties to carry out financial or administrative activities related to health care. The standards for electronic transmission

²65 F.R. 50312 (August 17, 2000).

of each of the transactions are codified in the Code of Federal Regulations (45 CFR Parts 160 and 162). The rule provides standards for eight types of electronic transactions:

- ▶ health care claims or equivalent encounter information,
- ▶ health care payments and remittance advice,
- ▶ coordination of benefits,
- ▶ health care claim status,
- ▶ enrollment and disenrollment in a health plan,
- ▶ eligibility for a health plan,
- ▶ health plan premium payments, and
- ▶ referral certification and authorization.

The rule also contains requirements concerning the use of standardized code sets, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes used to encode data elements in the transaction. The code set includes the codes and the descriptors of the codes.³ The following code sets have been adopted:

- ▶ International Classification of Diseases-9-Clinical Modifications (ICD-9-CM), volumes 1, 2, and 3,
- ▶ Combination of Health Care Financing Administration Common Procedure Coding System (HCPCS) and Current Procedural Terminology-4 (CPT- 4), for physicians and other health services,
- ▶ HCPCS for all other items,
- ▶ National Drug Codes (NDC) or HCPCS for prescription drugs, and
- ▶ Common Treatment for Dentists-2 (CTD-2) for dental services.

Covered entities, defined as providers, clearinghouses, and health plans that use the electronic exchange of health information as part of their business, will be required to adopt these standards. State Medicaid agencies are defined as health plans under Title II. The compliance date for this rule (45 CFR Parts 160 and 162) was originally October 16, 2002. The Administrative Simplification Compliance Act, signed into law on December 27, 2001, extends the compliance date by one year to October 16, 2003. The extension applies only to those covered entities that filed an extension with the Centers for Medicare & Medicaid Services (CMS) by October 16, 2002. According to CMS officials, states have all filed extensions. Therefore, October 2003, is the effective compliance date for state Medicaid agencies. Because the implementation date is several months away, standards have not yet been developed to measure compliance.

³45 CFR §160.1002

METHODOLOGY

This is one of several inspections that the OIG is conducting to determine the expected level of readiness for compliance by October 2003. After receiving input from CMS officials in the Centers for Medicaid and State Operations (CMSO), we developed a standardized telephone questionnaire to gather information from the Medicaid program officials responsible for implementing HIPAA electronic transactions and code sets.

We conducted telephone surveys of the 51 Medicaid agency directors, HIPAA coordinators, and/or their staff between October 1 and October 31, 2002. The 51 states included the 50 states and the District of Columbia.

We questioned the HIPAA officials about the level of readiness, as of October 2002, in four broad areas:

- ✓ assessment and awareness activities, for example, which programs and functions are being affected by the regulations;
- ✓ barriers that have impeded or are current obstacles to achieving compliance,
- ✓ compliance strategies, such as sequencing and testing plans that are being used for implementation in the Medicaid program; and
- ✓ contingency planning.

The inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

We conducted telephone interviews with officials from the 51 state Medicaid agencies (50 states and the District of Columbia). While few similarities exist in the planning and strategies among the 51 Medicaid agencies, 42 programs (approximately 80 percent) anticipate that they will be in compliance by October 2003. Of the remaining nine programs, eight are developing contingency plans to allow them to conduct business with compliant and noncompliant trading partners,⁴ and the ninth expects to be minimally compliant by the deadline, with expectations that a new compliant system will be on line by March 2004.

Approximately 80 percent of the state Medicaid agencies reported they will be in compliance with the HIPAA standards by October 2003

Forty-two of 51 state Medicaid agencies reported that they will be fully compliant with the new electronic transaction standards, while nine reported that they probably will not be compliant by October 2003. Thirty-six of the 42 believe that they have adequate financial and technical resources to implement the standards. The remaining six states expect some funding cuts or budget and staff adjustments in their HIPAA plan.

Six of the nine potentially noncompliant states expect to have enough technical and financial resources to become compliant at a later date. However, three of the noncompliant states indicate that they need additional technical staff and financial resources to become compliant.

Twenty-nine of the 51 states reported that they have developed specific contingency plans to continue services if their systems are not fully compatible with their trading partners, as of October 16, 2003. This includes eight of the nine states expected to be noncompliant, whose contingency plans will allow them to handle critical compliant and noncompliant transactions, such as paying provider claims. The remaining 22 states have no formal specific contingency plan.

⁴Trading partners are external entities, such as managed care organizations, physicians, dentists, home-maker services, nursing homes, and other Medicaid providers with whom the state agency does business.

Planning and strategies vary widely among the 51 state Medicaid agencies

State Medicaid program staff adopt compliance strategies and sequencing plans to meet their specific program needs

The 51 states have electronic data interchange (EDI) systems that range from 30-years-old to new systems that currently are being installed. The HIPAA teams in each state conducted gap analyses to determine what changes in their current EDI systems would be most appropriate to implement the new transaction standards. Twenty-nine states will use their existing EDI software along with an EDI translator to handle the new standard transactions. Fifteen states have new EDI systems or plan to install new systems during the next several years. Seven states are using clearinghouses or making minimal modifications in their current EDI systems to meet the new standards, anticipating major system and regulatory changes beyond 2003.

More than 75 percent (40) of the states are using a sequencing strategy, which is the process for logically implementing each of the eight transactions according to state specific needs. Fifteen of these states are prioritizing transactions related to provider payments. The remaining 25 states have developed sequencing plans, based on system design, ease of making the electronic conversion, or volume of business in each transaction. Eleven states have no sequencing strategy.

Eight of the nine potentially noncompliant state agencies have planned major systems' renovations which include using translators and clearinghouses and/or replacing hardware and software. Only one of the noncompliant states plans a "bare bones" or minimal approach to compliance in 2003, anticipating a new compliant system in 2004. All nine of the states anticipate that they will be compliant in 2004.

States have begun testing transaction standards

As of November 2002, five states have implemented at least one of the eight new transaction standards and have begun testing with their trading partners. Thirty-nine states have or are in the process of completing the development of their testing plans. Additionally, 36 states anticipate conducting systems' testing with their Medicare partners by April 2003. Although it was not one of the eight listed transactions, an additional four states are implementing the National Council for Prescription Drug Programs standard (NCPDP 5.1) for high volume drug dispenser transactions, which are specified under the HIPAA transaction standard for health care claims or equivalent encounters.

Lack of financial resources and technical support are barriers to meeting the compliance deadline

State Medicaid officials identified challenges with code set conversions, state funding, on-going standards' modifications, and provider concerns as barriers to compliance

For 24 states (3 of which expected to be noncompliant), the local code conversion effort is a major barrier to compliance. States have as few as 75 to more than 10,000 local codes to convert, crosswalk, delete, or refine. The conversion is particularly difficult because many state codes that are used for Medicaid services are beyond the scope of traditional medical services. For example, no code existed in the HCPCS or CPT-4 codes for homemaker services. Also, state officials expressed concerns over the long delays in getting timely responses for new code designations. The delays affect implementation costs, schedules, and their ability to integrate the new codes into their systems in a timely manner.

In 21 states, implementation plans may have to be altered during the next 12 months, due to budget cuts and state deficits. This includes six of the nine potentially noncompliant states where implementation costs and state budget problems are barriers to meeting the October 2003, target.

In 21 states, including four of the expected noncompliant state programs, officials said the federal regulatory environment is a barrier to compliance. They cited regulation delays, rule changes, and modifications to the standards that continued during planning, and the lack of consistent rule interpretations from staff among the regional CMS offices as causes for delays in planning system conversions. They believe these barriers have added to the cost of implementation.

Small and/or rural providers create some unique challenges for state Medicaid program compliance. In 18 states, smaller providers may revert to paper claims rather than incur the expense of converting to the HIPAA electronic transaction standards. Small states are having difficulty reaching rural providers in remote communities to inform them of the HIPAA transaction standards. Also, most providers were aware of the HIPAA "privacy regulation," but not the transaction standards.

CONCLUSION

Overall, states are making progress in meeting the October 2003, deadline for implementing the HIPAA electronic transaction standards and code sets. All 51 states expect to be ready to implement the transactions, which will enable them to pay claims for Medicaid beneficiaries. The nine states that anticipate not being fully compliant on October 16, 2003, will continue to transact business using compliant and noncompliant electronic data until their systems are ready.

We will provide additional technical information, as appropriate, to CMS.

Glossary of Electronic Transaction Standards Terminology

Administrative Simplification: the use of mandated standards for the electronic exchange of health care data and specific measures to protect the security and privacy of personally identifiable health care information.

Business Associate: a person or organization that performs certain business functions on behalf of a covered entity.

Clearinghouse: an entity that processes information received from one entity in a nonstandard format into a standard transaction, or receives a standard transaction and converts it to a nonstandard format for a receiving entity.

Code Set: the tables of terms, medical concepts, diagnostic codes, or procedure codes and descriptions used to encode information in a transaction.

Contingency Plan: a plan developed by covered entities to provide an alternative for submitting or receiving HIPAA electronic transactions after October 2003, in the event that the covered entity's system conversion fails or is incomplete.

Covered Entity: any health plan, health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by the HIPAA standards.

EDI Translator: a software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI file into an EDI format for transmission.

Electronic Data Interchange (EDI): any electronic exchange of formatted data.

Gap Analysis: an evaluation of a covered entity's system to define the changes to be made, how the data will be managed, and what procedures will be implemented to enter and to verify information.

Local Codes: a generic term for code values that are defined for a state or other political subdivision or specific payer.

State Medicaid Agency: the state agency responsible for overseeing the state's Medicaid program, defined as a covered entity under HIPAA.

Small Health Plan: under HIPAA, a health plan with annual receipts of \$5 million or less.

Sequencing: a process plan developed by a covered entity to implement each of the transaction standards in a logical sequence.

Standard Transactions: the exchange of information between two parties that complies with the requirements established under HIPAA.

Trading Partner: an external entity, such as a customer, with whom the covered entity does business. A trading partner can be so designated for some purposes and considered a business associate for other purposes.

Translator: See EDI translator.

Vendor: software and/or hardware entities that provide HIPAA compliant services, consulting, and/or products to covered entities. Vendors may be business associates or trading partners.

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