

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HIPAA READINESS:
ADMINISTRATIVE SIMPLIFICATION
FOR TERRITORIES WITH MEDICAID PROGRAMS**



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March 2003
OEI-09-02-00423

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

OBJECTIVE

To determine if United States territories with Medicaid programs 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, 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 five territories with Medicaid programs. Four of the five territories report that they will not be fully compliant with the electronic transaction standards and code sets, and they will not meet the October 2003, implementation date. The most significant barriers for the territories are the lack of financial and technical resources. Since the territories' federal Medicaid funds are capped, they were ineligible for additional federal financial participation funds to implement the electronic transaction standards.

Territories have not developed compliance strategies

None of the territories has developed a compliance strategy. Territories have considered

¹65 F.R. 50312 (August 17, 2000).

alternatives but have not moved forward with implementation plans, due to the lack of funding to convert to the electronic transaction standards and code sets.

Because they lack the funds, territories have not developed sequence planning and testing protocols

Neither the federal government nor the territorial governments have allocated funds for compliance. Therefore, the territories lack the funding to acquire the technical resources needed to develop their implementation strategies.

CONCLUSION

One territory may be in compliance if its legislature allocates funds designated to implement the HIPAA transaction standards and code sets. According to territory officials, limited funding and the lack of technical resources will prevent the remaining four territories from meeting any of the transaction standards by October 2003.

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INTRODUCTION

OBJECTIVE

To determine if United States territories with Medicaid programs 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 assures 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.² 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.³

²Trading partners are external entities, such as hospitals, physicians, dentists, nursing homes, and other Medicaid providers with whom the Medicaid agency does business.

³65 F.R. 50312 (August 17, 2000).

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 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.⁴ 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. 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, all five territories with Medicaid programs have filed extensions. Therefore, October 2003, is the effective compliance date for the territories. Because the implementation date is several months away, standards have not yet been developed to measure compliance.

⁴45 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 Medicaid directors for the five territories, HIPAA coordinators, and/or their staff between October 1 and October 31, 2002.

We questioned the officials about the level of readiness 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 five territories with Medicaid programs. Four of the five territories report that they will not be in compliance with the electronic transaction standards and code sets, and they will not meet the October 2003, implementation date. The most significant barriers for the territories are the lack of financial and technical resources. Since the territories' federal Medicaid funds are capped, they were ineligible for additional federal financial participation funds to implement the electronic transaction standards.

Territories have not developed compliance strategies

None of the five territories have developed a compliance strategy. One territory is considering a contract with a clearinghouse until it can make major conversions in its territorial data processing system. Another territory is considering a translator or a clearinghouse, depending on the availability of funds. One territorial official stated that the territories could easily implement the transaction standards and code sets using a personal computer program, if CMS would develop it. Only one of the territories anticipates that it will be able to coordinate payments with a compliant Medicare system for crossover beneficiaries by the October 2003, deadline.

Because they lack the funds, territories have not developed sequence planning and testing protocols

Neither the Federal Government nor the territorial governments have allocated funds for compliance. Four of the five territories entire Medicaid budget is less than \$15 million and the federal match is capped for each of them. Therefore, the territories lack the funding to acquire the technical resources needed to develop their implementation strategies. One territorial official has considered a basic sequencing strategy that would start with the easiest transaction, coordination of benefits. However, none of the territories has developed any type of sequencing plan. Furthermore, none of the territories has developed testing plans or contingency plans, since they do not have resources to guide the implementation process. One territorial official said the contingency plan was "to continue doing business as usual with compliant and noncompliant trading partners."

CONCLUSION

One territory may be in compliance if its legislature allocates funds designated to implement the HIPAA transaction standards and code sets. According to territory officials, limited funding and the lack of technical resources will prevent the remaining four territories from meeting any of the transaction standards by October 2003.

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.

Medicaid State 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.

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul A. Gottlober, Regional Inspector General for Evaluation and Inspections, and Deborah Harvey, Assistant Regional Inspector General for Evaluation and Inspections in San Francisco. Other principal Office of Evaluation and Inspections staff who contributed include:

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