HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

The First National HIPPA Summit

HIPAA for Financial Officers

Preconference Session

October 15, 2000

Trinita C. Robinson, MA, Technical Director, HFMA
John St. George, FHFMA, President, St. George Consulting

HFMA

Presentation Objectives

- Discuss the challenges that will impact an organizations' bottom line
- Provide reasons on why the HIPAA regulation was instituted
- Discuss what the legislative and regulatory requirements are for implementation
- Discuss what the advantages/disadvantages are and what the impact will be for financial managers, payers, employers, clearinghouses, TPAs, and providers

Legislative Approach (Legal Counsel, Risk Managers, and Compliance Officers)

- Under subtitle F of Title II of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Congress added under the Social Security Act (Title XI), a new part C (sections 1171 through 1179), which requires that specific administrative provisions be carried out by health plans, healthcare clearinghouses, and healthcare providers that process information electronically

Brief Synopsis of Sections 1171 through 1179

- 1171 of the Social Security Act establishes definitions for the following terms: healthcare clearinghouse, code set, healthcare provider, health plan, standard, individually identifiable health information, and standard setting organization (SSO)

- 1172 ensures that any standard that is adopted under part C is applicable to each of the terms listed in section 1171

Section Definitions Con't

- Section 1172 addresses standard setting by specific organizations that are accredited by the American National Standards Institute (ANSI), under consultation with the National Uniform Billing Committee (NUBC), the National Uniform Claim Committee (NUCC), the Workgroup for Electronic Data Interchange (WEDI), and the American Dental Association (ADA)

Section Definitions Con't

- Section 1173 also states that a standard may be adopted other than the one established by a standard setting organization if it will reduce the amount of money that healthcare providers, healthcare clearinghouses, and health plan have spend to be in sync with the regulation

Section Definitions con't

- Section 1173(a) adopts standards for financial and administrative transactions

- Transaction standards are required for the following: health plan enrollment and disenrollment, healthcare claims or equivalent, health plan payment and remittance advice, health plan premium payments, first report of injury, healthcare claim status, and referral certification and authorization

Section Definitions con't

- Section 1173(a)(1)(B) applies to standards that need to be developed for any other financial and administrative transactions
- Paragraph 1173(b) requires the adoption of health identifiers and the intended use for each individual, employer, health plan, and healthcare provider
- Paragraph 1173(c) through (f) requires the adoption of standard code sets for each data element for every healthcare transaction listed in paragraph 1173(b), and for security standards that protect the flow of healthcare information, for electronic signature, and standards for the transmission of data elements

The Following Sections Have Direct Financial Implications for Health Plans and Other Organizations

(Board of Directors, CEOs, CFOs, and Other Financial Managers)

- Section 1174—Requires HHS to establish standards for all transactions and data elements that enable information to be exchanged except for claims transactions. This is to be accomplished within 18 months

Financial Implications con't

- Section 1175—Prohibits health plans from refusing to process or delay in the processing of transactions that have been presented in the standard format. It requires health plans to establish a compliance plan that is to be followed by each person who is responsible for the exchange of standard information

Financial Implications con't

- Section 1176—Establishes civil monetary penalties for violation of the provisions in part C of title XI of the Act. Penalties may not be more than $100 per person per violation, and not more than $25,000 per person per violation of a single standard for a calendar year
- Section 1177—Establishes penalties for anyone who knowingly uses a unique health identifier or obtains or discloses individually identifiable health information

Financial Implications con't

- The penalties for such action include a fine of not more than $50,000 and/or imprisonment of not more than one year. If the offense is done under false pretenses, then a fine of $100,000 and/or imprisonment of not more than five years may be imposed

HFMA

Financial Implications con't

- If the intent is to sell, transfer, or use individually identifiable medical information for commercial, personal, or financial gain, a fine of not more than $250,000 and/or imprisonment of not more than 10 years may be imposed

Financial Implications con't

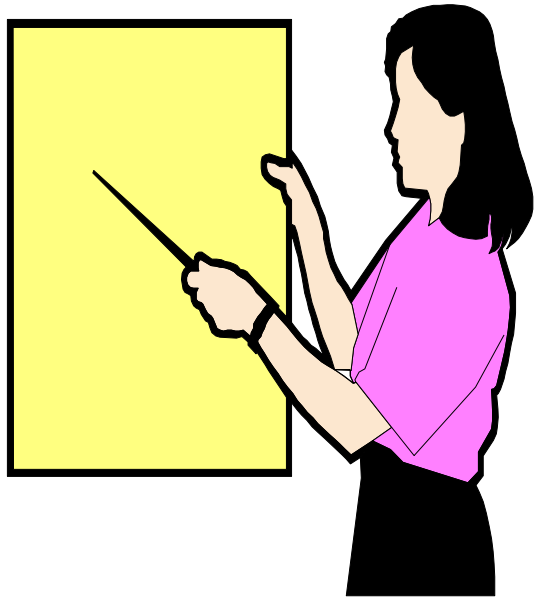
- Section 1178—Part C preempts state law except in the following circumstances: 1) When state law is determined by the Secretary of HHS to be necessary for certain purposes as established by the instituted statute; 2) If the state law addresses controlled substances; and 3) If the state laws relating to the privacy of individually identifiable health information are contrary to or are more stringent than the federal requirements

Financial Implications con't

- Section 1179—Allows the cited provisions to be inapplicable to financial entities or anyone acting on behalf of a financial institution when "authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments for a financial institution"
- Lastly, federal rules would pre-empt the existing state laws that protect the health information found in a patient's medical record

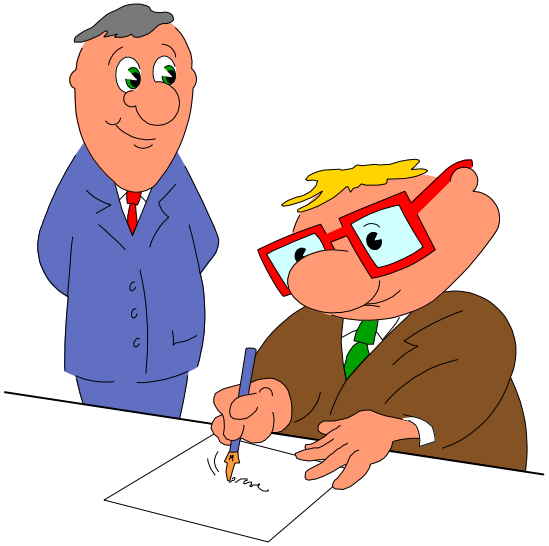
Policies and Procedures for Assessing Your Organizations' Readiness

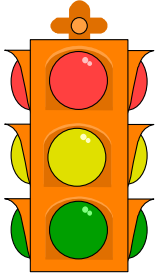
- Where do you begin?
- Risk/Needs Assessment
- How is one conducted?
- What do you look for?



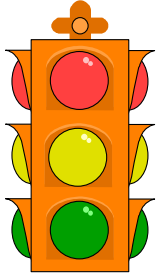
Where do you begin?

- How important is it to have a checklist of items that are a must to do?
- Who should be involved in this process?





Stop Here



Give out Risk/Needs Assessment Tool

Transaction Standards

Healthcare Claim or Encounter (ASC X12N 837)

- Leads to administrative simplification and cost savings
- Allows for the addition of business functions
- Medicaid agencies

Claim Payment and Remittance Advice (ASC X12N 835)

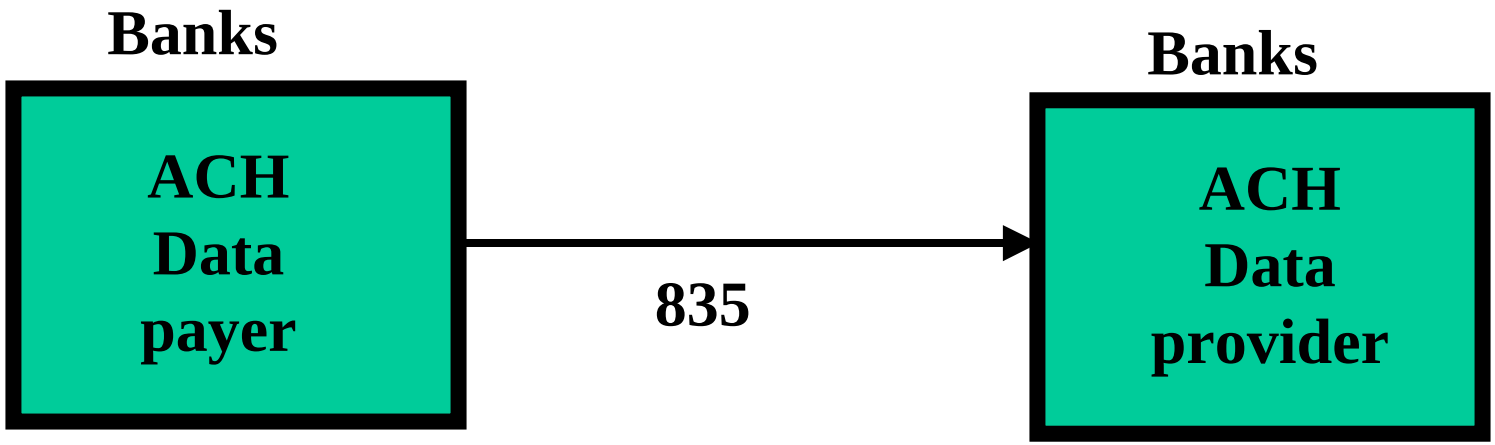
- Notifies provider of amount being paid
- Allows for explanation
- Does not offer information on coverage policies

Claim Payment and Remittance Advice (ASC X12N 835) con't

- Accepts the automated clearinghouse (ACH) transaction
- Electronic transfer of funds
- Can be sent from a health plan to healthcare provider/healthcare clearinghouse
- Appeal rights

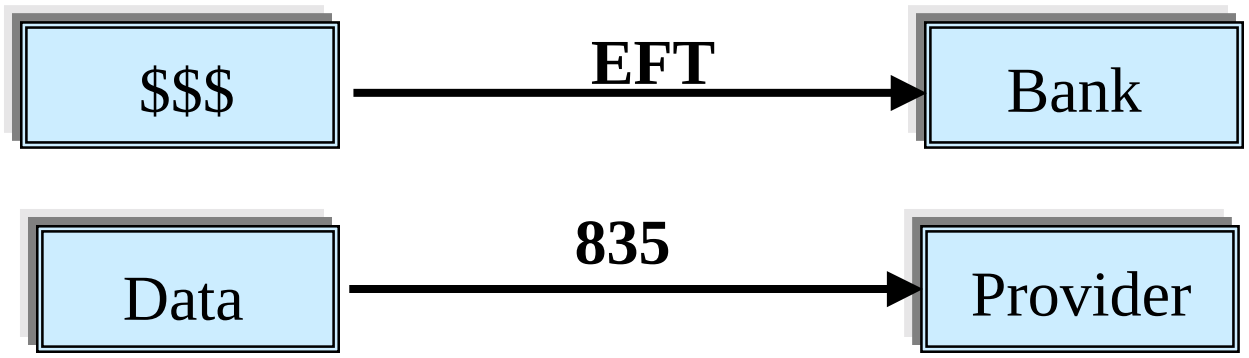
Claims Payment

Scenario 1 - Dollars and data sent together through the banking system



Claims Payment

Scenario 2 - Dollars and data are sent separately



Premium Payments (ASC X12N 820)

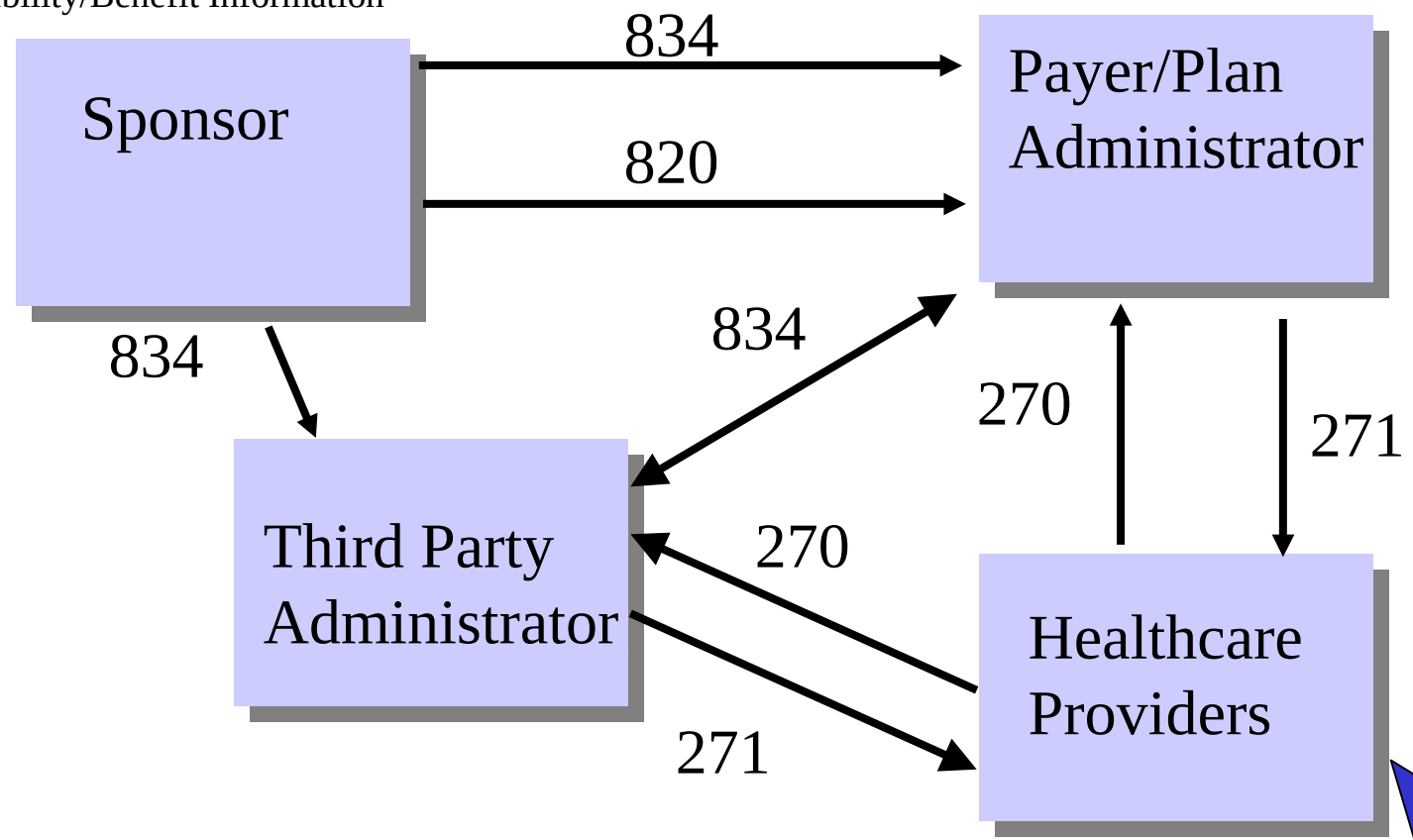
- Health plan premiums
- Payroll deductions and other group premium payments

Healthcare Claim and Status Request and Response (ASC X12N 276-277)

- Unsolicited Claims Status (ASC X12N 277) is not part of the HIPAA transactions
- Standard for healthcare claims
- Required for transmitting a transaction to a health plan
- Health plans must accept the standard transaction

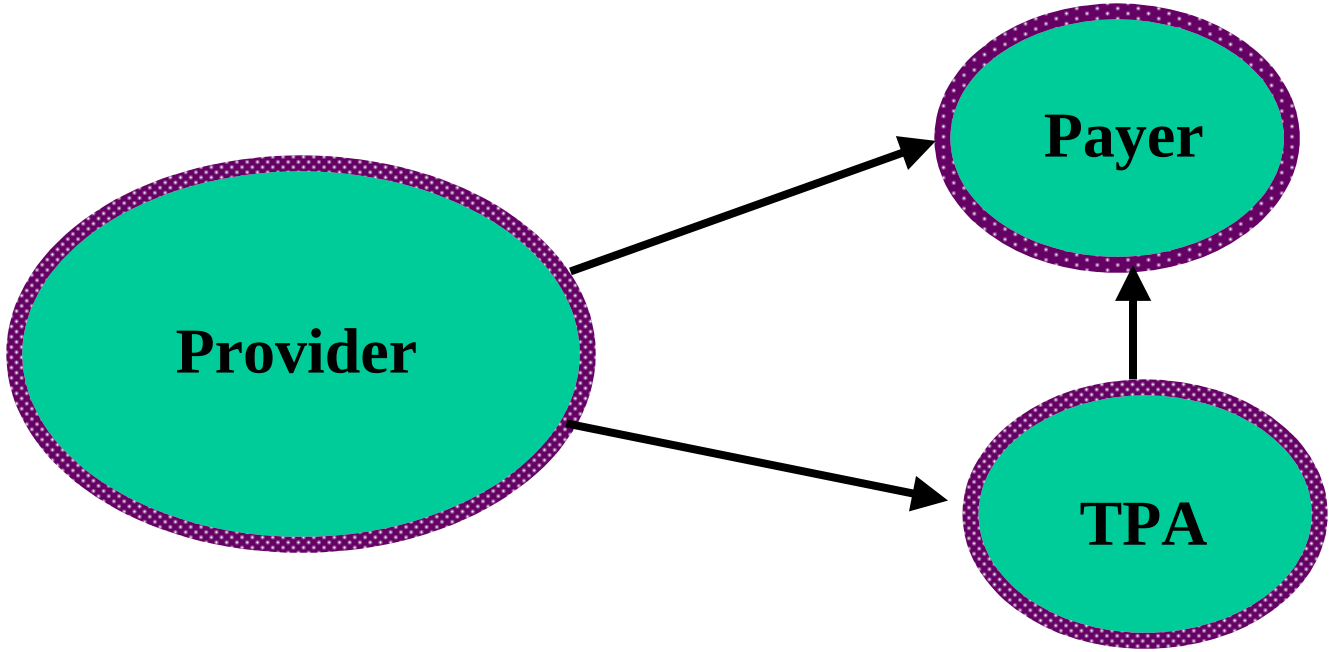
Eligibility Information Flows

834: Benefit Enrollment and maintenance
820: Premium Payments
270: Eligibility/Benefit Inquiry
271: Eligibility/Benefit Information



Claims/Encounter Submission

837: Claim/Encounter Submission



Enrollment and Disenrollment in a Health Plan (ASC X12N 834)

- Includes demographic data
- Not available to research entities
- State agency use and monthly capitation claims from a MCO

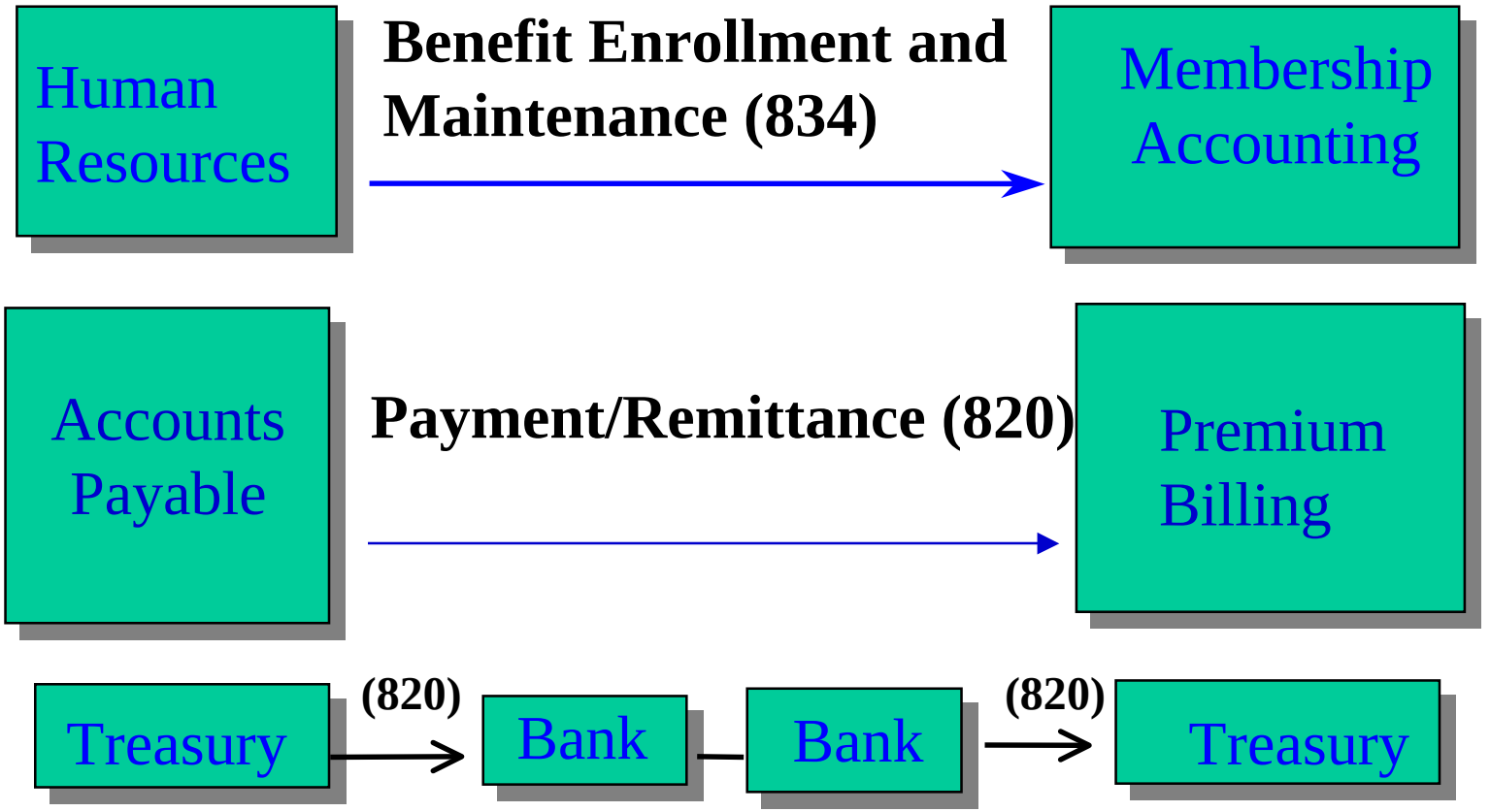
Healthcare Eligibility/Benefit Inquiry/Response (ASC X12N 270-271)

- Health plans must accept a complete ASC X12N 270
- Must respond with the ASC X12N 271
- Good for trading partners

Employer/ Plan Sponsor

Flow Chart

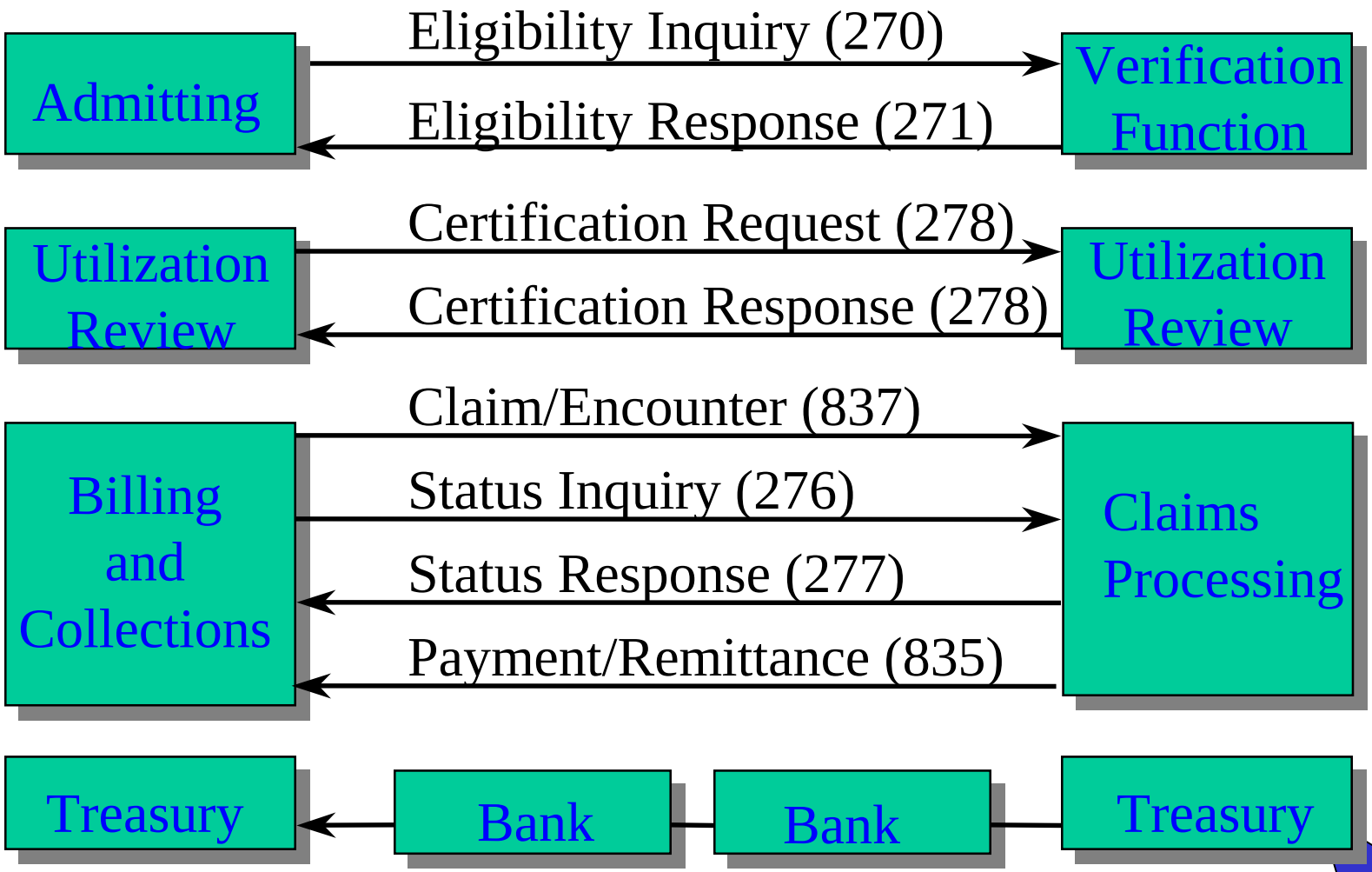
Health Plan



Provider

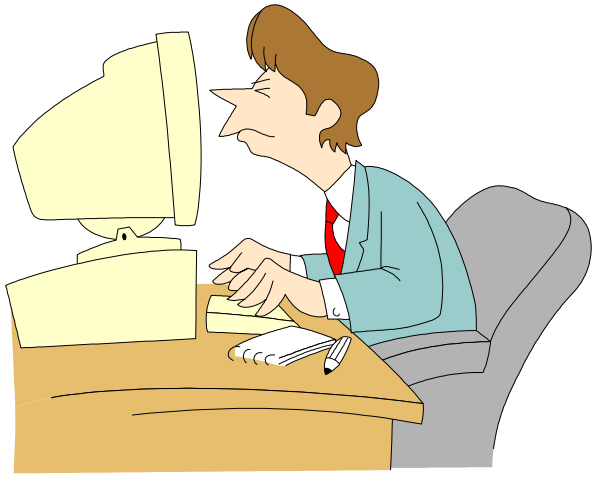
Payer

Flow Chart



Referral Certification and Authorization (ASC X12N 278)

- Electronically request and receive approval from a health plan
- Should lower the cost for use by smaller health plans
- Eliminates Duplicate proprietary formats

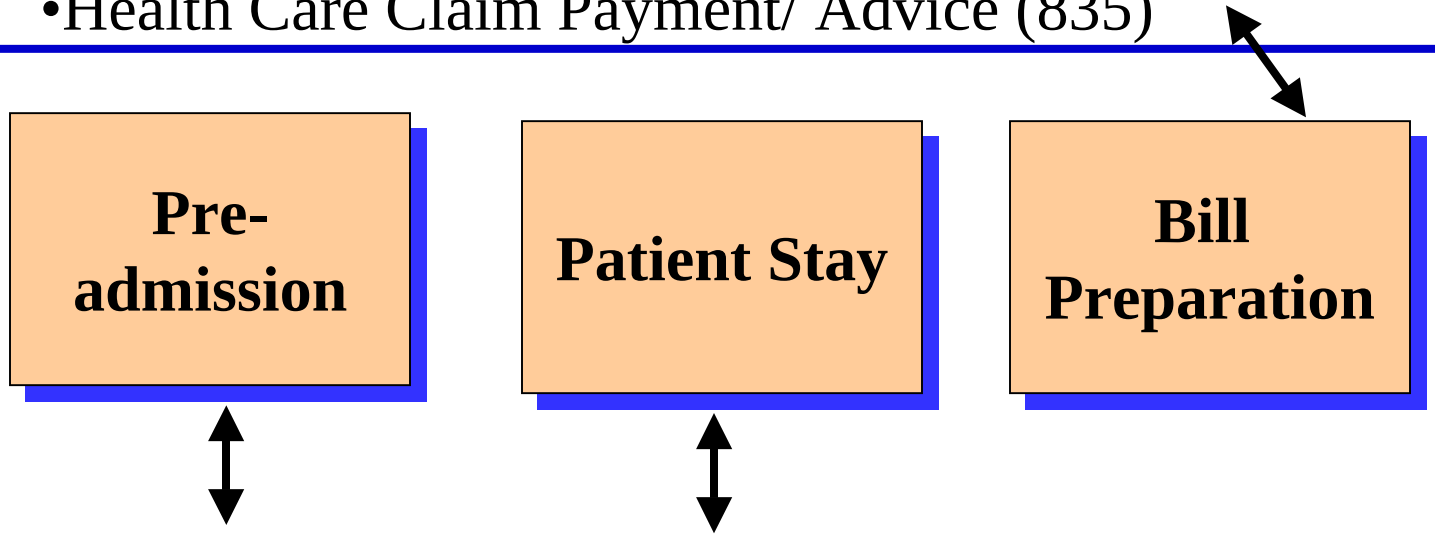


HFMA

Later…

- Healthcare Claim Attachment (275) -- John will discuss later
- First Report of Injury (148)

•Health Care Claim(837)
•Health Care Claim Status Inquiry/Response (276/277)
•Health Care Claim Payment/ Advice (835)



•Eligibility, Coverage or Benefit Inquiry/Response(270/271)

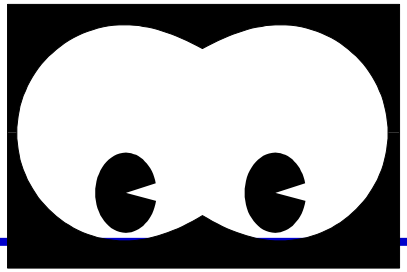
•Health Care Service Review Information (278)

•Report of Injury, Illness or Accident (148)

Privacy and Security Proposed Rules

- Overall goal and purpose of the rules
  - Protection of individually identifiable health information
- Privacy and Security: Different Purposes

Privacy Purpose



The purpose of our proposal is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by others. We are proposing to make the use and exchange of protected health information relatively easy for healthcare purposes, and more difficult for purposes other than healthcare.

Security Purpose

That covered entities have in place safeguards to insure "that health care information and individually identifiable health care information be protected to ensure privacy and confidentiality when health information is electronically stored, maintained, or transmitted.”

Security Proposed Rule

- Administrative procedures
- Physical safeguards
- Technical security services
- Technical security mechanisms
- Scalability of requirements

Security Components

TECHNICAL SECURITY SERVICES TO GUARD DATA INTEGRITY, CONFIDENTIALITY, AND AVAILABILITY

Requirement	Implementation
Access control (The following implementation feature must be implemented: Procedure for emergency access. In addition, at least one of the following three implementation features must be implemented: Context-based access, Role-based access, User-based access. The use of Encryption is optional).	Context-based access. Encryption. Procedure for emergency access. Role-based access. User-based access.
Audit controls	
Authorization control (At least one of the listed implementation features must be implemented).	Role-based access. User-based access.
Data Authentication	
Entity authentication (The following implementation features must be implemented: Automatic logoff, Unique user identification. In addition, at least one of the other listed implementation features must be implemented).	Automatic logoff. Biometric. Password. PIN. Telephone callback. Token. Unique user identification.

Privacy Proposed Rule

- No formal consent for treatment and normal business purposes
- Contracts and verification of business partner use of data
- Access without written authorization for national and public health needs
- Individual's right of access
- Scalable

Final Rule Process

- Process
- Anticipated publication date
- Possible changes

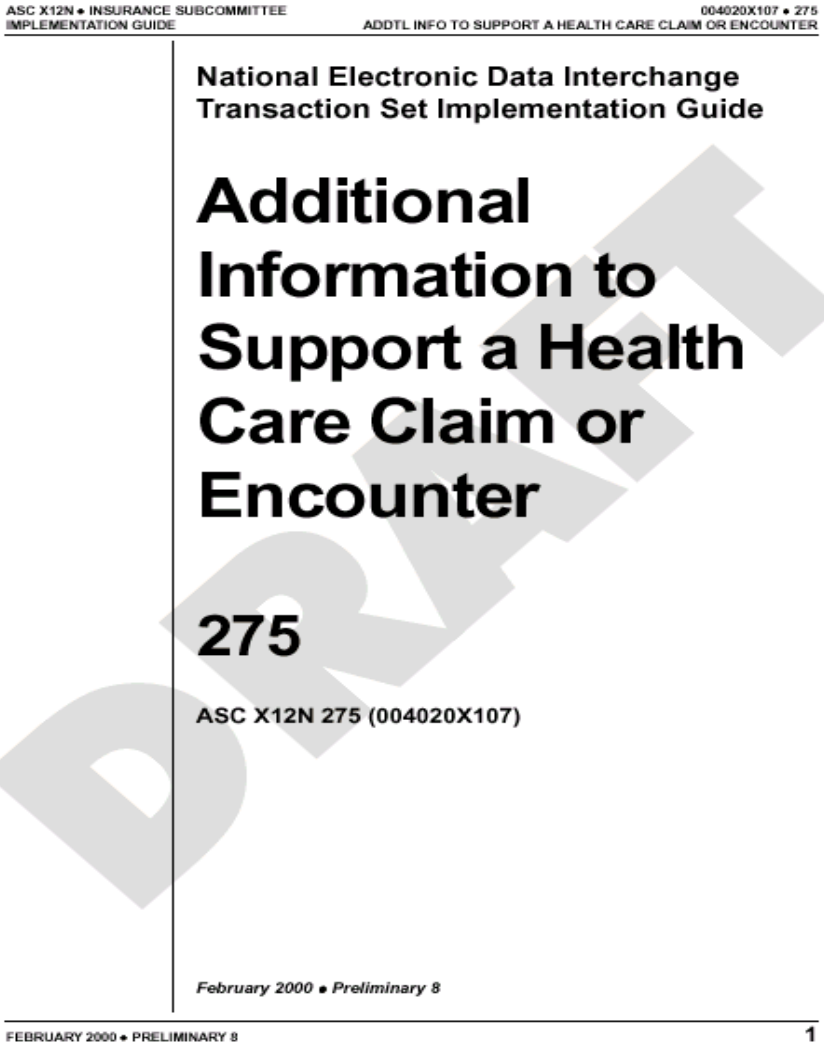
Attachments Proposed Rule

- What is an attachment
  - Supports claims
  - Not needed on every claim
- Expected NPRM

Attachments

- Ambulance
- Emergency department
- Rehabilitation services
- Medications
- Laboratory report
- Clinical notes

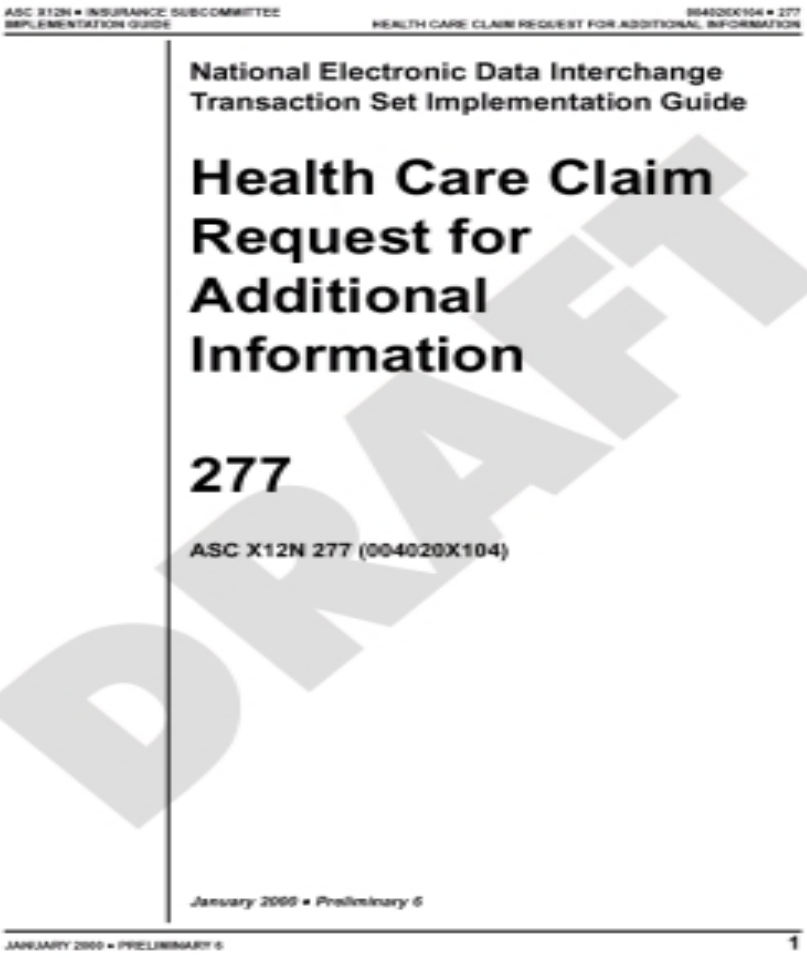
The Attachment Transaction



X12N Implementation Guide

- 275 Additional Information to Support a Healthcare Claim or Encounter
- Imbedded HL7 message

Request for attachments



ASC X12N • INSURANCE SUBCOMMITTEE
IMPLEMENTATION GUIDE

004020X104 • 277
HEALTH CARE CLAIM REQUEST FOR ADDITIONAL INFORMATION

National Electronic Data Interchange
Transaction Set Implementation Guide

Health Care Claim Request for Additional Information

277

ASC X12N 277 (004020X104)

January 2000 • Preliminary 6

Draft Implementation Guides

- Available for review
  - public comment accepted
  - comments can be submitted to X12N
- Source: www.wpc-edi.com

Expected NPRM

- Publicaton
  - By the end of this year
- NPRM Process

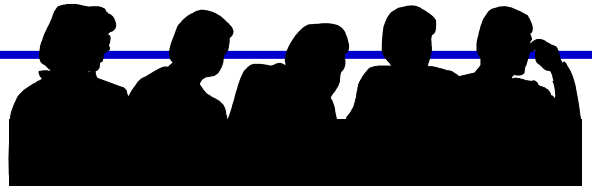
Implementation Considerations

- Transactions
  - What business functions are now occurring
  - What functions now occur electronically
- Code Sets
  - What code sets are now being used
  - Relationship to national code sets

More Considerations

- Redesign of business process
- Work flow to be automated
- Staffing changes needed
- Changing work patterns
- Related functions

Organizing for Implementation

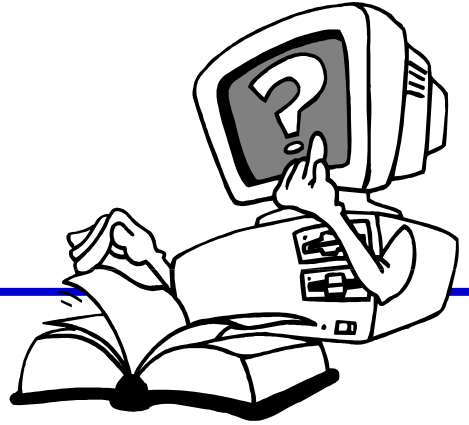


- Operational staff
- Information systems staff
- Health Information management staff
- Legal staff
- Contracting staff
- Human resources staff
- Financial planning and budgeting staff
- Compliance staff

Financial Implications of Transactions Final Rule

- Internal translator vs. clearinghouse
- Modifications to application software
- Cost savings

Using Translators



- Standard syntax and code sets included
- Audit and internal controls
- Updates usually part of package
- Cost
- Use for other electronic data exchanges
- Communication requirements including security

Using Clearinghouses

- Handle contact to many entities
- Convert to internal existing formats
- How to handle required data not in current application
- Pricing
- No internal software maintenance with standards updates
- Security requirements

Contract Considerations

- Provider option to use paper
- Turnaround time for mandated transactions
- Communications protocols
- Sharing cost savings

Privacy/Confidentiality

- First steps
- Establish and document detailed policies and procedures
- Designate a privacy official
- Provide privacy training to workplace
- Implement safeguards against intentional or accidental misuse of data
- Establish a complaint mechanism
- Develop sanctions for workforce and business partners

Security

- First Steps
  - Assign responsibility for bringing your organization up to this standard
  - Identify relevant policies and procedures for current employees and system practices
  - Identify and evaluate all immediate risks, such as email and exchange of data with outside parties
  - Analyze business relationships and negotiate “Chain of Trust Agreements” with parties that are not “covered entities” under HIPAA

Security con't

- Practices
  - Security and Confidentiality Policies
  - Security Audits
  - Information Security Officers

Next Steps

- Purchase software to do EDI translations
- Develop links to employers
- Reduce time period for eligibility guarantees when negotiating contracts
- Establish trading partners with HMOs, clients and providers

Closing

?

?

QUESTIONS

?

?

?

?

?