



HOSPITAL HIGHLIGHTS

Prepared for AHA members whenever there is important HIPAA-related news.

CMS ISSUES GUIDANCE ON HIPAA TRANSACTIONS COMPLIANCE

July 25, 2003

At an “Open Door Forum” held July 24, 2003, the Centers for Medicare & Medicaid Services (CMS) released guidelines for complying with the Health Insurance Portability and Accountability Act’s (HIPAA) transactions standards, “Guidance on Compliance with HIPAA Transactions and Code Sets After the October 16, 2003 Implementation Deadline.” In the guidance and at the forum, CMS said that (1) it will focus on voluntary compliance and utilize flexibility in enforcing compliance; (2) it will not impose penalties on entities that deploy contingencies if reasonable and diligent efforts toward compliance have been made; (3) significant testing and outreach by covered entities, including Medicare fiscal intermediaries and carriers, still must occur; and (4) it will make more decisions regarding additional contingency planning before October 16. The guidance is available on the CMS Web site at www.cms.hhs.gov/hipaa/hipaa2/guidance-final.pdf.

The AHA is encouraged by the guidance and CMS’s discussion at the forum, which recognizes that hospitals and other providers must continue to receive payment from payors, and that potential harm to patients could result if payments are threatened or delayed. CMS has taken a first step in endorsing the AHA’s contingency payment recommendation by indicating that penalties will not be imposed on covered entities that “deploy contingencies” under certain circumstances, and said that payors that can demonstrate active outreach and testing efforts *may* continue processing payments to providers. CMS encourages payors and providers to implement contingency plans, which may include use of parallel systems to ensure that claims are paid. Finally, CMS urges all covered entities to conduct outreach with their trading partners, engage in testing, and document their efforts toward compliance.

However, CMS failed to establish in the guidance a real safety net for providers by adopting the AHA’s recommendations on payment of Medicare claims to providers after October 16. The AHA has been urging CMS to recognize the barriers to full compliance with the HIPAA transactions and code sets regulations, and provide guidance to covered entities regarding contingency plans to ensure that hospitals will continue to receive payments after October 16. CMS is still undecided, however, as to whether a claim that is missing data elements but

complies with the HIPAA format and code sets requirements is compliant. They've also failed to state that Medicare will continue to pay providers who submit these transactions. This means that CMS still needs to provide specific information to covered entities regarding its contingency plan for Medicare.

Enforcement

In the guidance and the forum, CMS repeated that it will “focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA’s electronic transactions and code set provisions.” If CMS receives a complaint about a covered entity’s compliance with the Transactions Rule, CMS will notify the entity and allow the entity to demonstrate compliance, document its good faith efforts to comply, and/or submit a corrective action plan. CMS said that evidence of good faith may include increased external testing with trading partners; a lack of availability of, or refusal by, the trading partner(s) to test the transaction with the covered entity whose compliance is at issue; and concerted efforts by a health plan to conduct outreach and make testing opportunities available to the provider community. Sustained actions and demonstrable progress toward compliance will be key factors in CMS’s determination of whether an entity has made a good faith effort.

CMS recognizes that, under the HIPAA statute, it has flexibility in determining whether to impose a civil money penalty for violation of the Transactions Rule “where the failure to comply is based on a reasonable cause and is not due to willful neglect.” In addition, CMS may extend the period within which an entity must cure the noncompliance, “based on the nature and extent of the failure to comply.”

The agency also acknowledges that both parties to the transaction must comply and that, if one party is not compliant or not cooperating, it can put the other in a difficult position. Thus, CMS said that it intends to examine both parties’ efforts in the case of a non-compliant transaction. The AHA is encouraged that, if payors have refused to test with hospitals or are not working cooperatively to conduct a compliant transaction, hospitals may not be held responsible *so long as they have made good faith efforts to comply*.

While they said this flexible approach toward enforcement will not end at some future date, CMS also said that the agency is less likely to be lenient about enforcement the further away from October 16 the noncompliance occurs.

Contingency Plans

The AHA urged CMS to institute a national contingency plan that would ensure payment of claims in the event that full compliance is not obtained by the deadline. As already noted, some uncertainty regarding payment remains. However, the AHA is pleased that CMS stated it wants payors to pay claims, and will not impose penalties on covered entities that use contingencies in order to ensure the smooth flow of payments, so long as they have made “reasonable and diligent efforts to become compliant.” CMS is clear that health plans are expected “to facilitate the compliance of their trading partners.” If health plans can demonstrate that they have made outreach and testing efforts, they may continue processing payments to providers who submit

noncompliant transactions. As the AHA requested, CMS has repeatedly said, both in its guidance and during the forum, that it is critical that health plans conduct outreach and engage in testing with their trading partners, as well as “help its noncompliant providers come into compliance.”

The AHA is pleased that CMS recognizes the need for payments to continue, despite the failure to achieve full compliance, and appears to place some responsibility on health plans for ensuring that their trading partners are compliant. We’re still concerned, however, that some health plans may withhold payments if claims are not submitted in full compliance particularly if the health plans have failed to provide for necessary testing with hospitals. CMS said it may make additional decisions regarding contingency plans, depending upon how Medicare testing progresses.

According to CMS, the flexibility offered should “permit health plans to mitigate unintended adverse effects on covered entities’ cash flow and business operations during the transition to the standards, as well as on the availability and quality of patient care.” Although CMS recognizes the AHA’s warnings about the potential impact on hospitals’ cash flow and, thus, the quality of patient care if health plans are unable to process or pay claims that do not fully comply with the Transactions Rule, CMS still has failed to provide specific contingencies, as proposed by the AHA, to guarantee that hospitals will continue to receive commensurate levels of payment after October 16. Nevertheless, CMS states that “as long as a health plan can demonstrate to CMS its active outreach/testing efforts, it can continue processing payments to providers” which could be interpreted to mean that payors who have made good faith efforts may use legacy systems to process and pay claims after the deadline.

Documentation

CMS suggests that entities should document Transactions Rule compliance efforts, in case a complaint is filed against the entity. Documentation of an entity’s good faith efforts to achieve compliance will help CMS justify why a civil money penalty is not warranted in a particular case. Thus, the AHA urges all hospitals to document their compliance efforts, any obstacles to compliance, communications from payors and clearinghouses regarding testing, and their testing efforts.

Additional Guidance

During the forum, CMS staff said that the agency is still deciding whether, after October 16, it will accept legacy formats and imperfect claims, including those that are missing data elements but otherwise meet the HIPAA requirements for format and code sets. CMS will make its decision as testing by its intermediaries and carriers progresses, to determine whether a sufficient number of providers have been able to successfully test transactions with Medicare. The AHA still firmly believes CMS needs to issue guidance stating that claims using HIPAA-mandated formats and code sets but not necessarily containing full data content are HIPAA-compliant and should be paid.