HIPAA Administrative Simplification Compliance Certification

What it means for Blue Plans

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Topics

Affordable Care Act Requirements

What are we Certifying? Background

Proposed Compliance Certification Rule

Issues with Proposed Rule

Affordable Care Act Requirements

ACA Certification of Compliance

Certify by 12/31/2013 with respect to:

- Eligibility for a health plan **(ASC X12N 270/271)**;
- Claims status; **(ASC X12N 276/277)**
- Remittance advice (including EFT transactions) **(ASC X12N 835)**

Certifies that health plan:

- Fully complies with Transactions Standards & Operating Rules
- Has completed end-to-end testing with trading partners

ACA Certification of Compliance

Certify by 12/31/2015 with respect to:

- Health care claims **(ASC X12N 837)**
- Enrollment/disenrollment in health plan **(ASC X12N 834)**
- Health plan premium payments **(ASC X12N 820)**
- Referral certification/authorization **(ASC X12N 278)**
- Claims attachments **(???)**

ACA Certification of Compliance

Adequate documentation of compliance

- Demonstrates conduct of compliant transactions
- Completed “end-to-end” testing with trading partners

Business Associates: health plan must:

- Ensure compliance
- Supply adequate documentation

ACA Certification of Compliance

Re-certify compliance:

- Upon change to transaction standards
- Upon change to Operating Rules
- By effective date of change

Certify compliance with

- New transaction standard
- By effective date of standard

ACA Certification of Compliance

Enforcement

- HHS ***may*** use outside entity for certification
- HHS ***must*** conduct periodic audits

Severe penalties for non-compliance

- Failure to file: $1/covered life/day **(maximum $20/covered life)**
- Fine doubles for inaccurate or incomplete certification

What Are We Certifying? Background

Background

HIPAA Administrative Simplification

Transactions Rule

- 9 transactions
- Applies only when conducted electronically
- Must use standardized format
- Health plans must conduct upon request

Background

Standard = Implementation Guide

- *e.g.*, ASC X12N 837 (claims—696 pages—3 versions)
- *e.g.*, ASC X12N 270/271 (eligibility—546 pages)

Identifiers and Codes Sets

- National Provider ID, Health Plan ID, EIN
- Diagnosis and procedures codes:
  - ICD-9 (10), HCPCS, Dental

SEGMENT DETAIL

EB - SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION

X12 Segment Name: Eligibility or Benefit Information

X12 Purpose: To supply eligibility or benefit information

X12 Syntax: 1. **P0910**
If either EB09 or EB10 is present, then the other is required.

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION Loop Repeat: >1**

Segment Repeat: **1**

Usage: **SITUATIONAL**

Situational Rule: **Required when the subscriber is the person whose eligibility or benefits are being described and the transaction is not rejected (see Section 1.4.10) or if the transaction needs to be rejected in this loop. If not required by this implementation guide, do not send.**

Background

ASC X12N 270/**271** Transaction (Version 5010)

ST*271*4321*005010X279~BHT*0022*11*10001234*20100513*1319~HL*1**20*1~
NM1*PR*2*BCBS Geography*****PI*842610001~ HL*2*1*21*1~NM1*1P*2*BONE
AND JOINT CLINIC*****SV*2000035~HL*3*2*22*0~TRN*2*93175-
012547*9877281234~NM1*IL*1***SMITH*JOHN****MI*123456789~ N3*15197
BROADWAY AVENUE*APT 215~N4*KANSAS
CITY*MO*64108~DMG*D8*19630519*M~DTP*346*D8*20100101~EB*1**30**GOL
D PLAN~EB*L~LS*2120~
NM1*P3*1*JONES*MARCUS****SV*0202034~LE*2120~**EB*1****1^33^35^47^86^88^
98^AL^MH^UC~**EB*B****1^33^35^47^86^88^98^AL^MH^UC*HM*GOLD
PLAN*27*10*****Y~ **EB*B****1^33^35^47^86^88^98^AL^MH^UC*HM*GOLD
PLAN*27*30*****N~SE*22*4321~

Background

Operating Rules

- Business rules & guidelines for transactions
- Previously established in companion guides

Examples

- Eligibility response: remaining deductible, co-pay
- EFT “enrollment” form
- Uniform use of claim adjustment reason codes

Background

Operating Rules:

- Eligibility: 10 rules, 133 pages
- Claim status: 2 rules, 83 pages
- Remittance Advice (EFT): 6 rules, 137 pages

CAQH/CORE

- Council for Affordable Quality Health Care
- Committee on Operating Rules for Info. Exchange

Background

Health Plan Identifier

- Apply and obtain by Nov. 5, **2014**
- Use in transactions by Nov. 7, **2016**

Controlling health plan

- Plan that controls own business activities, actions, policies or
- Is controlled by an entity that is not a health plan

Background

*Sub*health plan

- Controlling health plan controls business activities, actions, policies

Examples:

- Blue Plan and wholly-owned subsidiary (i.e., HMO)
- ASO account's self-funded plan (***not*** the Blue Plan/TPA)

Proposed Compliance Certification Rule

Certification Process

As of 12/31/2013 . . .

- No Rule;
- No proposed rule;
- No guidance on how to certify compliance

Notice of Proposed Rulemaking

- Published 1/2/2014
- Proposed deadline for certification now 12/31/2015

Proposed Certification Process

Outsource process to CAQH-CORE

- Established operating rules adopted by HHS
- Nonprofit alliance of health plans, clearinghouses, trade assocs
- Blue Plan membership

Reporting based on *Health Plan Identifier*

- Controlling health plan must report on own compliance
- CHP must report on compliance for any subhealth plan

Proposed Certification Process

Must submit to HHS 1/1 - 12/31/2015

1. Covered lives (major medical policies)

- Members (subscribers and dependents)
- Commercial, Medicare, Medicaid
- Including subhealth plans, but
- Not ASO *(different controlling health plan)*

Proposed Certification Process

Must submit to HHS 1/1 - 12/31/2015

2. Meet attestation & testing by:

- Achieving CORE Certification Seals (Phases I – III) or
- Obtaining CORE "HIPAA Credential"

Certification Options

Option 1: CORE Certification Seals

- Conduct gap analysis to ensure compliance with all CORE (including non-HIPAA) operating rules
- CORE Pledge (attestation of compliance)
- Complete testing by CORE-authorized vendor
- Submit final application to CORE (with applicable fee)
  - *$18,000 fee*
  - *$12,000 for smaller plans (net revenue of < $75 million)*

Certification Options

Option 2: HIPAA Credential

- Process & content not completed
- CORE Pledge (attestation of compliance)
- Testing attestation

Testing attestation to include:

- Successful testing for 30% of transactions (with subhealth plans)
- Provide list of trading partners (with name and contact information)

Certification Options

Option 2: HIPAA Credential Cost:

- HHS estimate
- $4,000 +

Health plan's certification applies to:

- Subhealth plans
- Business associates

Issues with Proposed Compliance Certification Rule

Getting Ready

Early to do list:

- Gap assessment:
  - How/where does company conduct transactions? (Subsidiaries? Business associates? Multiple platforms?)
  - Who are trading partners? For which type of transactions? How many?
  - Compliance with standards? Operating Rules? Level of confidence?
- Project plan—eliminate gaps
  - Priorities, timelines, budget

Getting Ready

Other considerations

- Conversion to ICD-10
- Health Plan identifier compliance
  - Identify subhealth plans
  - Obtain HPIDs by 11/5/2014
- New transaction (claims attachments)
- Operating rules
  - Claims (837) and 4 other transactions by 12/31/2015
- Ongoing ACA (and other) issues (Exchanges, etc.)

Concerns About Proposal

Sole outside source for verification

- Ability to timely process certifications?
- Conflict of interest?
- Cost?
- No self-certification option?

30% testing requirement

- Threshold too high
- Trading partner contact information

Concerns About Proposal

Controlling health plan issues

- Application to ASO accounts
- Wellness programs/FSAs

Scope of attestation

- Privacy & security in attestation

Compliance Certification

Questions?

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