

The Administrative Simplification Provisions of Health Care Reform

Summary of Section 1104 of the Patient Protection and Affordable Care Act

Stanley Nachimson

Principal

Nachimson Advisors, LLC

www.nachimsonadvisors.com

The Patient Protection and Affordable Care Act (the Health Care Reform Bill) contained significant changes to the HIPAA requirements for transactions and code sets. These were specified in Section 1104 of the Act. They are a further attempt by Congress to legislate administrative standards in health care, strengthen the standardization of transactions, and increase the requirements and penalties for health plans for not following the standards. There are also some additional responsibilities for the vendors of health plans.

The provisions introduce the concept of operating rules, call for regular updating of the standards on a two year cycle, and also require the adoption of several new standards, most of which were already required by HIPAA but were not yet implemented by HHS.

A summary of each of the requirements is presented.

New Concept of Operating Rules

The Act introduced a new concept to the Administrative Simplification process – operating rules. These are defined as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.”. The concept of operating rules has been championed by the CORE organization as a necessary addition to the X12 implementation specifications, adding further guidance in the use of certain responses, constraining code sets, and providing greater specificity to the situational rules. The CORE operating rules also include items such as system availability and response time, things that have generally been outside the

X12 arena. Note that the Act did not require the adoption of the CORE operating rules, just operating rules in general.

Requirements for standards and operation rules:

The Act also included some additional functional requirements for standards and operating rules. The Act requires that standards and operating rules:

“to the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care;”

and

“provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals)”

This appears to further dictate that the standards be able to support real time (or near real time) eligibility benefit determinations, and financial calculations of deductible status and coinsurance status. This has been a focus of providers for a long time. There has been some move by health plans to provide estimated deductible and coinsurance information at the point of care, but the Act appears to push this further.

Acknowledgments are now recognized as a critical part of the claims processes. Acknowledgements have not been required as part of the HIPAA standards to date. X12 has a complete suite of acknowledgement transactions that can serve the purposes required, and some entities have already adopted them. It now appears that they will be required.

Adoption of Operating Rules

The Act sets out a detailed process for the creation and adoption of these new operating rules.

“The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.”

First, the operating rules are to be developed by a non-profit entity. This entity must meet several qualifications:

“(A) The entity focuses its mission on administrative simplification.

(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations

(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

(E) The entity allows for public review and updates of the operating rules.”

Secondly, the National Committee on Vital and Health Statistics (NCVHS) must:

“(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

(B) review the operating rules developed and recommended by such nonprofit entity;

(C) determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

Then, the Secretary, based on the recommendations, and having ensured consultation with providers, can adopt the operating rules via Interim Final Rule.

The Act set out specific timelines for the adoption of the first sets of operating rules. For eligibility and claim status transactions, the operating rules are to be adopted (via regulation) by July 2011 and effective by Jan 1, 2013. The Act suggested that the rules allow for the use of a machine readable identification care.

Operating rules for remittance advice and electronic funds transfer (EFT) must be adopted by July 2012 and effective by January 1, 2014. These rules are to allow for automated reconciliation of the electronic payment with the remittance advice.

The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions are to be adopted not later than July 1, 2014, and effective not later than January 1, 2016.

Use of Interim Final Rules for Adoption

Until now, the HIPAA standards were adopted through the use of proposed rules allowing for public comment, followed by final rules based on the public comment. This has been a long and drawn out process and has been severely criticized as duplicative of the public comment process of the standards organizations. The Act now allows the Secretary to promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics. The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication. Interim final rules are considered to be final on their effective date, which means that the standards are to be considered adopted. There is an opportunity for public comment, but no requirement for the rule to be changed based on that public comment.

Periodic Revision of Standards and Operating Rules

The Act set up a process for the periodic review and revision of HIPAA standards and operating rules. It requires that the Secretary establish a review committee (which may be NCVHS or another appropriate committee) by January 1, 2014. Then, beginning April 1, 2014 and not less than every two years after that, the review committee will conduct hearings to evaluate and review the adopted standards and operating rules.

Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report. The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule shall be 25 months following the close of the 60 day comment period of the rule, basically 27 months after regulatory publication.

For any new or revised transaction standards from the review committee, the Secretary will have to adopt a single set of operating rules.

Standards and Operating Rules for Unique Health Plan Identifier, EFT, and Attachments

Three new standards are required to be adopted by HHS, two of which were already required under HIPAA but never adopted. **A unique health plan identifier**, to be effective not later than Oct 1, 2012; **an EFT standard**, to be adopted no later than Jan 1, 2012 and effective not later than Jan 1, 2014, and a **claims attachment standard and set of operating rules**, to be adopted no later than Jan 1, 2014 and effective not later than Jan 1, 2016. Each of the adopting rules can be issued on an interim final basis.

This adds to the list of required standards, all at the same time the industry is coping with the transition to 5010 and the implementation of the ICD-10 code set.

Compliance

The Act has set up a new process to assure compliance by health plans. This process requires plans to file certification statements that the plans are in compliance with standards and operating rules.

By 12/30/2013, health plans must file a statement to the Secretary that their systems are in compliance with standards and operating rules for EFT, eligibility, claims status, and payment and remittance advice.

By 12/30/2015, health plans must file a statement to the Secretary that their systems are in compliance with standards and operating rules for claims, enrollment and disenrollment, premium payments, claims attachments, and referral certification/authorization.

The health plan must also provide documentation of such compliance. This documentation must be such that it:

“(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

“(B) provides documentation showing that the **plan has completed end-to-end testing** for such transactions with their partners, such as hospitals and physicians.

Health plans are required to document their compliance showing that they conduct the transactions in compliance with the regulations, and that they have completed end-to-end testing for transactions with their partners

A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection. This means that clearinghouses that serve health plans will have to produce documentation of their compliance.

The Secretary may designate independent, outside entities to certify that a health plan has complied with these the compliance requirements.

For any revised standards or new standards, health plans must file certification statements by the effective date of the new requirements.

The Secretary is to do audits of health plans to ensure their compliance.

Penalties

The noncompliance penalties for health plans have been significantly increased for those that fail to meet the certification and documentation requirements. The increase penalties will begin on April 1, 2014 and can be assessed annually. Amount of the penalty is \$1 per covered life for each day the plan is not in compliance with the certification and documentation requirements. The penalty fee doubles if plan knowingly provides inaccurate or incomplete information in their certification statement or documentation.

Maximum penalty, per year, is \$20 per covered life, or \$40 per covered life if inaccurate or incomplete information has been provided.