STATEMENT

of the

Medical Group Management Association

to the

Special Committee on Aging

U.S. Senate

HIPAA Medical Privacy and Transaction Rules: Overkill or Overdue?

Cathy Treadway, FACMPE
The Woman's Clinic
Boise, Idaho

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Good morning. I am Cathy Treadway, FACMPE, the administrator of The Woman's Clinic, a nine-physician, 65 employee single-specialty obstetrics/gynecology practice in Boise, Idaho. Our clinic is the oldest specialty clinic in Idaho and was established in 1946 by Harold Dedman and Verne Reynolds, pioneers in the formation of the American College of Obstetricians and Gynecologists (ACOG). We currently deliver approximately 1,700 babies a year and provide care for thousands of women throughout their lifetime.

I am a member of the Medical Group Management Association (MGMA) and a fellow of the American College of Medical Practice Executives. MGMA is the nation's oldest and largest medical group practice organization representing more than 19,000 members who manage and lead 11,000 organizations in which approximately 220,000 physicians practice. MGMA's membership reflects the full diversity of physician organizational structures today.

MGMA's individual members, who include practice managers, clinic administrators, and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices run efficiently allowing physician time and resources to be focused on patient care. MGMA members are uniquely qualified to assess the direct impact of the Health Insurance Portability and Accountability Act (HIPAA) on providers and the delivery of quality care to beneficiaries.

I have held many positions in the Idaho MGMA, including President and Scholarship Chair. In my current position, I represent medical practice administrators and physicians on the Idaho HIPAA Coordinating Council (IHCC). The IHCC, a state affiliate of the Workgroup for Electronic Data Interchange (named in HIPAA as an advisor to HHS), represents those who are impacted by HIPAA. IHCC members include representatives of health care providers, insurance carriers, third-party billing agents, and state, county and city governmental entities. The IHCC provides the means to create a collaborative healthcare industry-wide process to bring about a statewide coordination effort that is necessary to achieve successful HIPAA compliance. IHCC has conducted a series of seminars to educate Idaho providers, hospitals, and other entities covered by the HIPAA regulations.

On behalf of MGMA, I would like to thank Chairman Craig and the committee for convening today's hearing on HIPAA implementation. While I will be commenting on aspects of the HIPAA privacy rule, due to the looming October 16 deadline, I will focus particular attention on electronic transactions and code sets (TCS).

As a group practice administrator, my tasks include: financial management, recruitment and orientation of physicians, patient advocacy, employee supervision, regulatory compliance, marketing, facilities management, and contract negotiation. The physicians in our practice rely on my expertise to guide them through innumerable and continually changing federal rules and regulations, including HIPAA, coding, documentation, billing, physician referral rules, local Medicare review policies, physician credentialing, and assignment and reassignment of patient and physician billing rights. As most physician time is consumed by providing and documenting patient care, they depend upon my business acumen to maintain the smooth daily operations of the practice.

Over the past 2 ½ years, I have dedicated considerable energy to increasing my knowledge of the HIPAA regulations, striving to bring our practice into compliance, and helping educate providers throughout Idaho. Like practices throughout the country, we struggle with limited resources to deal with the magnitude, complexity and costs of HIPAA implementation.

HIPAA Standard for Protecting the Privacy of Health Information

For many years, physicians have placed the highest priority on protecting the privacy of patients' health information. The HIPAA privacy rule serves as an important tool to ensure that each patient's privacy is sufficiently protected by every sector of the health care community. The requirement to educate each staff member on a patient's right to privacy has increased the overall level of awareness in our industry regarding the importance of maintaining privacy.

While I found, and continue to find, aspects of the HIPAA privacy compliance process challenging, my task would have been even more difficult without the positive changes made to the original consent requirement by the current Administration. The rule's current approach allows us to continue to provide care to our patients with minimal delays. Adding a consent form to the already unmanageable paperwork burden practices face would not enhance patient privacy. Conversely, the original consent provision would have interfered with the routine administration of health care, delayed patient care, and created confusion among patients and physicians alike.

Ongoing Challenges and Costs

Preparing for the April 14, 2003 compliance date was a most trying time for most practices, as it took several hundred hours of dedicated effort. Some uncertainty regarding particular aspects of the rule remains. It is important to note that we have not encountered any significant problems from patients. Rather, the continuing challenges stem from provider misunderstanding, misinterpretation and uncertainty in complying with the rule's requirements.

Patient Consent

The privacy rule permits practices to disclose health information without a patient's consent for purposes of treatment, payment, and health care operations. Unfortunately, some practices are refusing to release information for these purposes without a patient's consent. For example, a common scenario involves patient referrals to physician specialists, where the disclosure pertains to treatment and thus the patient's consent clearly is not required. Much of this confusion seems to originate from the rule's initial consent requirement. Practices fear that they will improperly release information without a patient's consent and be assessed penalties as a result. This confusion creates unwarranted delays in providing needed care to patients.

Notice of Privacy Practices

Physician groups must provide a "notice of privacy practices" to every patient and make a good faith effort to obtain a written acknowledgment that the patient received the notice. The notice describes a group's privacy policies and procedures, a patient's rights, and to whom health information may be disclosed. There appears to be some uncertainty regarding how to satisfy the aforementioned requirements. Some groups are providing patients a hard copy of the notice, while other groups are choosing to laminate copies of the notice for patients to read in the waiting room.

Preemption

In addition to the time and effort required to understand the HIPAA privacy rule, practices must also examine state medical privacy laws (including regulations, case law, etc.). Because the privacy rule only preempts less stringent state laws, practices must compare both the HIPAA privacy rule and state law as part of their compliance efforts. As you can imagine, this is a daunting task for our small Idaho practices. In addition, due to the complexity of a preemption analysis, there is a concern that practices will reach different conclusions regarding which requirements to follow - federal or state.

Costs

Examining just our small practice, the privacy implementation costs total in excess of $10,000. I must emphasize that these are just the initial privacy implementation costs. There are significant ongoing costs for each practice, including continuing education, training of staff and physicians, printing, and facility modifications. These expenses must be considered in conjunction with the many unfunded mandates group practices face, projections of decreasing physician reimbursement, and skyrocketing medical liability premiums. It is imperative that the Congress and Administration not examine the effect of any one regulation in a vacuum, but consider the cumulative effect that government decisions have on patient access to quality care.

MGMA Privacy Recommendations

Develop Additional Guidance - The Office for Civil Rights (OCR) has made great strides in its outreach efforts to assist practices and all covered entities in complying with the privacy rule. MGMA urges OCR to continue to develop additional guidance to clarify the ongoing issues which affected parties identify.

Develop a Preemption Analysis - MGMA urges OCR to develop and maintain a preemption analysis that can be utilized by physician practices. OCR guidance in this area would ensure a uniform application of the HIPAA privacy rule and state privacy laws. The Congress should allocate necessary funds to enable the agency to conduct a preemption analysis and continue other important compliance outreach activities.

HIPAA Standards for Electronic Transactions and Code Sets

While the HIPAA standards for electronic transactions and code sets (TCS) are a long overdue re-engineering of the business side of the health care system, the migration to this new system has proven to be particularly demanding for physician practices. Successful deployment of HIPAA's electronic data interchange (EDI) standards has depended heavily on coordination between critical trading partners - providers, vendors, clearinghouses, and health plans. However, developing these partnerships and coordinating implementation strategies has been somewhat elusive in an industry often known for acrimony.

While MGMA is fully committed to advancing the widespread adoption of electronic data interchange, we are also concerned about the financial relationship between providers and health plans. For practices, failure to implement these standards could mean more than experiencing government enforcement action - timely reimbursement from health plans, the financial lifeblood of every provider organization, could be severely impacted.

Industry Readiness

With less than one month until the October 16 compliance date, MGMA has great concern regarding the readiness level of each sector of the health care industry. Surveys indicate that significant numbers of covered entities and vendors are either non-compliant or have yet to begin the testing of claims. In addition, there is great concern regarding the readiness level of both government-sponsored and private health plans.

Medical practices had anticipated and in many cases been assured that their practice management system software vendors would provide "HIPAA-compliant" solutions. In some cases, practice management system vendors will not offer their medical practice customers HIPAA-compliant connectivity between the practice and health plans by the October deadline. These delays have occurred for a variety of reasons. Certain vendors have made the appropriate software modifications, but have not found time to test them. Other vendors may not be able to complete all the required software revisions until well after the deadline. In other cases, vendors have not offered any HIPAA solutions to their customers.

Exacerbating the problem, certain vendors have already decided not to offer their medical practice customers direct connectivity with payers. Instead, they have required their customers to use a proprietary clearinghouse to submit electronic claims resulting in additional expenses to a practice. Concern also exists with the readiness level of health plans. With many health plans focused specifically on the October compliance date for their own systems, few have aggressively tested with their practice clients.

One of the reasons for the inability of health plans to initiate testing of provider claims in a timely manner was the delay in the Centers for Medicare & Medicaid Services (CMS) publication of the Addenda to the Implementation Guide - the first round of modifications to the TCS standard. This Addenda was not published until February 20, 2003, well after the original TCS compliance date of October 16, 2002. Most health

plan, clearinghouse, and provider software vendors waited for these changes before finalizing their products. This resulted in many health plans using virtually all the time available before the deadline to prepare their own organization for compliance. Although practices typically require at least three months to conduct such testing, in many cases they are only now beginning to start this process. Indications are that many practices will not have the opportunity to complete testing until well after the mandated compliance deadline.

In addition, there is great concern that many state Medicaid agencies will not meet the compliance deadline. Community health centers are typical of the organizations that rely heavily on Medicaid funds to sustain their operation. These entities are also the most financially vulnerable and can least afford to experience an interruption in their cash flow.

The Idaho Experience

According to an informal survey that I conducted throughout Idaho, a vast majority of practices do not feel that they will be ready to submit HIPAA compliant claims by October 16. Although they have been working to implement these standards, they have met many roadblocks. Many health plans are just beginning to test claims with their provider customers.

Most Idaho physicians currently submit claims electronically through Blue Cross of Idaho Clearinghouse or Regence Blue Shields Clearinghouse at no charge per claim. However, some software vendors are requiring providers to process their claims through a proprietary commercial clearinghouse, thus incurring a per transaction charge. The result is yet another unanticipated cost for providers.

In my own practice, we have experienced significant claims testing challenges. During our first sixty days of testing, rejected claims returned to us contained no specific error information. Thus, we had no idea if the error was with our own software, our clearinghouse, or potentially non-compliance on the part of our health plan. As of September 19, our vendor-designated clearinghouse has yet to schedule testing with some of the largest health plans in the state including Blue Cross of Idaho, Regence Blue Shield, and Idaho Medicaid. How can we even hope to be paid by our payers after October 16 when we cannot even test our claims? Fears of payment delays are exacerbated by the fact that in states without prompt payment laws, such as Idaho, there is no incentive for health plans to pay claims expeditiously.

Claim Format Errors versus Data Content Errors

Providers are aware that they must submit electronic forms using the HIPAA mandated ASC X12N format. However, the X12N Implementation Guide includes both “required” and “situational” information. Who decides when the “situation” calls for additional data? The health plans themselves. Providers and their software vendors have relied on health plans to announce how they have interpreted the Implementation Guides in what are termed “Companion Guides”. Some health plans, however, have either not yet finalized their Companion Guides or have just recently released them. This led to delays

in software development, provider outreach, claims testing, and potentially the disruption of payment.

We continue to hear reports of health plans that believe they should require a much higher standard of perfection in claims submissions under the transactions rule than had previously existed. We are concerned that isolated mistakes will be considered violations of TCS standards and lead to the rejection of claims that would have been successfully adjudicated prior to October 16.

Insufficient CMS Guidance

On June 30, 2003, MGMA and almost 40 other provider organizations called upon the government to issue a definitive statement to the industry regarding enforcement of the transactions and code sets standard. On July 24, 2003, HHS responded with guidance ("Guidance on Compliance with HIPAA Transactions and Code Sets") regarding the enforcement of the HIPAA transactions and code set standards after October 16. The guidance clarified that plans which make a good faith effort to comply with HIPAA transaction and code set standards may continue to process legacy claims and permit claim data flexibility.

The HIPAA statute requires covered entities to comply with the standards for electronic healthcare transactions and code sets by October 16, 2003. By restating that fact, while also outlining some conditions under which CMS will not impose penalties, the agency sent health plans conflicting messages in the July 24 guidance. Consequently, some health plans believe that they are legally compelled to reject non-complaint transactions. This quandary is particularly problematic for those health plans that will not become compliant until shortly before the deadline; and therefore, are not in a position to engage in testing outreach efforts to providers until that point. However, the guidance did send a signal to health plans that they should make every effort to continue the cash flow for their provider customers.

CMS bolstered this enforcement flexibility position with the publication of a set of FAQs on September 8. In them, CMS states that a contingency plan for a payer could include not only the acceptance of legacy claims, but also flexibility in terms of data content and the offering of interim payments to their provider clients. While MGMA was pleased to see these pronouncements, we believe CMS must explicitly tell health plans that failure to develop appropriate contingency plans to prevent cash flow disruptions is unacceptable and is grounds for enforcement action.

MGMA Transaction and Code Sets Recommendations

Payment of Medicare Legacy Claims - We encourage CMS to instruct its intermediaries to continue processing non-compliant "legacy" claims after the October 16 deadline. Such instructions should indicate a specified period sufficient to allow all medical practices to complete testing. In addition, CMS should reiterate that all Medicaid and commercial health plans can continue accepting legacy claims.

Claim Data Flexibility - CMS should clarify that all public and private health plans are permitted to accept, process, and pay HIPAA-compliant claims with fewer data elements than specified in the maximum data set after the October 16 deadline. This clarification would dispel the notion that to comply with the law, health plans must reject claims with minor errors that would normally not impact the processing of the claim. In addition, CMS should clarify that claims with errors are still HIPAA standard transactions and cannot be rejected outright. Such clarification should indicate that minor errors that are not material to the processing of claims should not result in rejection of the claim, nor should entire batches be rejected because some individual claims in the batch contain errors or are not fully compliant with TCS standards.

Contingency Plan Publication - Medicare, Medicaid and all commercial health plans should announce publicly their contingency plans to allow providers sufficient time to implement business plans that ensure continued cash flow.

Delay Provider Enforcement - CMS should delay any enforcement action against providers until the provider community assures the agency that appropriate testing with health plans is completed.

Health Plans Must Report Missing Data to Providers - Health plans should return claims to providers with an explanation of any data content deficiencies in a timely manner. This will permit the entry of missing data and prompt resubmission of claims.

Medicaid Interim Payments to Providers - State Medicaid plans that will not be compliant by October 16 should offer providers an interim payment to avoid cash flow disruptions. This payment should be based on a calculation of the previous year's payments.

Health Plans to Prepare for Additional Paper Claims - CMS should encourage health plans to develop contingency plans to adjudicate a greater number of anticipated paper claims.

Conclusion

The burden of complying with both HIPAA privacy and TCS implementation has certainly strained our practice's staff and budget. Practices do not have the resources to survive significant payment delays, while continuing to provide care for all patients. Some practices have been pro-active - establishing lines of credit, delaying capital expenditures, setting aside cash reserves - hoping to weather delays in claims payment, meet payroll, and continue treating patients. It is clear, however, that resources may not be available to handle payment delays that extend more than several weeks.

While MGMA is confident that complete HIPAA implementation will eventually ease some administrative burdens and facilitate improved data interchange within the health care community, significant roadblocks continue to exist. MGMA, along with IMGMA and IHCC, believe our recommendations will help providers manage this difficult transition. We urge Congress to play an active role in ensuring that the Administration takes the necessary steps to avoid potential interruptions in the delivery of care. I

appreciate the Committee's interest in this important topic and thank the Committee for inviting me to present my views on this issue.