

August 18, 2021 – Administrative Simplification Enforcement Webinar Transcript

Introduction

This transcript is from the August 18, 2021, Administrative Simplification Enforcement Webinar.

Transcript

Moderator: Hello, and welcome to the Centers for Medicare & Medicaid Services (CMS) National Standards Group (NSG) webinar on Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Enforcement. Our speaker today is Paul Anderson, health insurance specialist at CMS. Paul will begin the presentation by discussing HIPAA Administrative Simplification, what it covers, and how it is enforced. Specifically, we'll be taking about the non-privacy/security portions of the rule. Then, we'll go over CMS's efforts related to enforcement and the tools we offer to help the health care industry be compliant. Finally, we will have a question-and-answer portion at the end of the presentation. To ask a question, please use the questions box in the webinar interface. Questions not answered during the webinar will be answered and posted with the other webinar materials on the Administrative Simplification website in the next 2 weeks. Now I would like to introduce Paul Anderson. Paul, you may begin.

Paul Anderson: Thank you, Tim. Hello, everyone. Welcome to the webinar today. Let's begin with an overview of Administrative Simplification rules. We can go to the next slide.

Administrative Simplification basics. More than 20 years ago, Congress passed the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA. One of HIPAA's 5 provisions, Administrative Simplification, mandated that the Department of Health and Human Services adopt standards to streamline communications between health care providers and health plans. HIPAA includes a set of Administrative Simplification provisions that can be divided into 2 main sets of requirements: privacy and security, and transaction standards, code sets, unique identifiers, and operating rules. The goals of transaction standards, code sets, unique identifiers, and operating rules are to save time and money by streamlining communication around billing and insurance-related tasks. Next slide, please.

So, who's covered? HIPAA-covered entities must comply with Administrative Simplification. That includes health care providers, health plans, and clearinghouses. Covered entities that engage business associates to carry out activities must also have an arrangement in place that establishes exactly what the business associates are engaged to do and requires the business associates to comply with HIPAA. An example of a business associate is a third-party administrator that assists health plans with claims processing. Next slide, please.

HIPAA enforcement clarification. We'd like to provide some clarification about the distinction between the privacy and security provisions of HIPAA, which are overseen by the Office of Civil Rights, and the non-privacy and security provisions, which are overseen by the National Standards Group here at CMS. Not all potential violations fall under NSG's purview. NSG only handles potential violations related to electronic transactions, operating rules, code sets, and unique identifiers. If the potential HIPAA violation is related to health information privacy rights or the Privacy, Security, or Breach Notification Rules, it falls under the purview of the Office of Civil Rights. Next slide, please.

The Office of Civil Rights oversees enforcement of HIPAA security/privacy rules. Examples of security/privacy violations: unauthorized access to protected health information, unauthorized transmission of protected health information, and impermissible use of disclosure – or disclosure of protected health information. Next slide, please.

NSG, on the other hand, enforces non-security/privacy portions of Administrative Simplification. Examples of non-security/privacy violations would be use of nonstandard transactions, incorrect use of unique identifiers, inappropriate use of the name or ID in a transaction, improperly structured information, incorrect use of code sets, or failure to conduct a standard transaction. In general, NSG focuses on making sure the business rules of Administrative Simplification are enforced. Next slide, please.

Now that we've clarified the purview of OCR and NSG in regard to Administrative Simplification, we're going to focus on the non-privacy/security portion that NSG oversees. These portions of Administrative Simplification include rules for code sets, unique identifiers, operating rules, and transactions. Moving forward, when we refer to Administrative Simplification, we're referring to the portion of the rule. Next slide, please.

Administrative Simplification establishes national standards for electronic transactions to improve the efficiency and effectiveness of the nation's health care system. This includes code sets, unique identifiers, and transactions, as well as supplemental operating rules. Code sets include: ICD-10, or the International Classification of Diseases for inpatient hospital procedures; CPT, or Current Procedure Terminology for outpatient services and procedures; HCPCS, which you may know as Healthcare Common Procedure Coding System; CDT, which is the Current Dental Terminology; or NDC, which is maintained by the FDA and is also known as National Drug Codes. For unique identifiers, there are 2 standard identifiers that are used: the NPI, or the National Provider Identifier, or the EIN, which is the Employer Identification Number. Standards exist for several transactions, which we will discuss in the next slide. Operating rules, however, are business rules or guidelines that aren't standards per se. For example, operating rules include real-time response requirements for health plans that receive inquiries from providers. Currently, operating rules are in place for eligibility, claim status, and electronic fund transfer (or EFT)/ERA remittance advice transactions. Next slide, please.

A transaction is an electronic exchange of information between 2 parties to carry out financial or administrative activity related to health care. For example, a health care provider will send a

claim to a health plan to request payment for medical services. When electronic health care transactions are used effectively, they increase efficiencies in operations, improve the quality and accuracy of information, and reduce the overall cost to the health care system. Standards are in place for common health care transactions that cover the following services or activities: payment and remittance advice, claim status, eligibility, coordination of benefits, claims and encounter information, enrollment and disenrollment, referrals and authorizations, or premium payment. Details about each of these transactions that you see on the screen are on the CMS website. Next slide, please.

So, how is it enforced? CMS enforces the Administrative Simplification standards for transactions, code sets, unique identifiers, and operating rules. This enforcement is essential to ensuring the health care community reaps the benefits of standardized transactions and reduced administrative costs. NSG enforces these standards by responding to complaints about noncompliance. In the past, CMS took a reactive, complaint-based approach to compliance. That is, CMS investigated when someone filed a complaint against a business trading partner for not complying with standards or operating rules. In 2019, CMS expanded that approach to conduct proactive compliance reviews of health plans and clearinghouses while continuing to respond to complaints. CMS took this expanded approach in response to requests from the health care community, with groups representing providers, health plans, and clearinghouses all advocating for action to improve compliance. The goal of these enforcement activities is to increase compliance across the industry with streamlined billing that reduces administrative burden. Next slide, please.

The first way CMS enforces HIPAA Administrative Simplification standards is by reviewing complaints from the health care industry that allege a HIPAA-covered entity is not compliant with the standards. You do not have to be a HIPAA-covered entity – i.e., a health plan, clearinghouse, or provider – to file a complaint against the entity you believe to be in violation of HIPAA Administrative Simplification standards. To check on the status of a complaint, you can use ASETT or the HIPAA mailbox at hipaacomplaint@cms.hhs.gov. Anyone who believes a HIPAA-covered entity is not compliant with the rule may file a complaint. You can file this complaint at asett.cms.gov. NSG keeps the identities of those filing complaints confidential upon request. Next slide, please.

The ASETT tool, or the Administrative Simplification Enforcement and Testing Tool, is a web-based application that allows you to test your transactions, test your trading partner's transactions, file complaints, or track your complaint status. The Quick Start User Guide is a brief reference for using ASETT. It notably includes a walk-through for registering your account. There is also an ASETT User Manual that contains more detailed resources on how to file complaints, test transactions, and check the status of complaints, upload supporting documents, close or retract complaints, and more. Next slide, please.

The CMS process for HIPAA Administrative Simplification complaints contains 6 phases. This graphic represents those 6 phases. In the first step, the complainant submits the complaint to CMS, which documents and reviews the complaint. During this step, CMS will post the de-

identified complaint in the Enforcement Report. Next, CMS contacts the complainant and the filed-against entity (FAE) and investigates the validity of the complaint. A complaint may be deemed invalid when we do not receive a valid complaint and FAE contact information. Communication is key when validating and investigating a complaint. If we are unable to communicate with the complainant or the filed-against entity because contact information is not provided, is incomplete or bogus, this triggers a complaint closure. The FAE will then either demonstrate compliance or submit a corrective action plan, also known as a CAP, to CMS for review. If the filed-against entity submits a CAP and CMS approves it, the FAE will be responsible for executing this plan. CMS will monitor that plan and update the complainant. Once the filed-against entity demonstrates compliance, CMS and the complainant will both review and confirm the filed-against entity is now compliant. Upon approval, which would be phase 6, CMS will notify the filed-against entity and complainant, and it will update the public enforcement report to reflect the FAE's new compliance status. You can also find this graphic on the CMS Administrative Simplification website. Again, the easiest way to file a complaint is to utilize the Administrative Simplification Enforcement and Testing Tool, or the ASETT tool. Next slide, please.

Complaint enforcement statistics. CMS compiles data on the complaints it receives and summarizes it in reports published every quarter. Above you'll see an example of the report covering the first quarter of 2021. In the first quarter of 2021, 85% of the complaints NSG received were not enforceable by HIPAA Administrative Simplification rules. Within the reports there are several categories. Categories include invalid complaints, code sets, operating rules, and transactions. Reasonings for closure include the filed-against entity executing a corrective action plan, CMS finding the FAE to be compliant with Administrative Simplification rules, the complainant withdrawing the complaint, and the complainant and the FAE resolving the issue through remediation. When a complaint is invalid or not enforceable by HIPAA Admin Simp rules, CMS works with complainants to locate the appropriate agency or mediates to achieve a resolution. In addition to 85% of the complaints being not enforceable, most valid complaints concern transactions that we received in the first quarter of 2021, and NSG executed a corrective action plan on 39% of the complaints that were closed in the first quarter. Next slide, please.

The Compliance Review Program. The Compliance Review Program conducts periodic reviews with randomly selected entities to assess HIPAA-covered entities' compliance with Administrative Simplification rules. Again, standards reviewed include transaction formats, code sets, and unique identifiers. All health plans and clearinghouses defined as covered entities are eligible for random selection. The following reasons may exclude a covered entity from being selected: the covered entity has a pending complaint against it, the covered entity is inactive or no longer in business, the covered entity was a participant in a compliance review within the past calendar year. Each organization will be contacted by telephone or email to identify the appropriate point of contact for HIPAA compliance review. The contact will then receive an introductory email with further instructions and resources for assistance, such as a dedicated mailbox and one-on-one training. There is no standard amount of time for completion of compliance review. It may take 4 to 6 months to complete depending on any

findings and/or corrective actions. This includes our compliance review team reviewing transactions as well as any steps needed by the covered entity to achieve compliance. Compliance reviews are ongoing. When one entity's compliance review is completed, HHS will randomly select another entity for review. If your organization isn't compliant, HHS will provide guidance to you to resolve any issues. Corrective action plans are commonly used to address noncompliance. Next slide, please.

This graphic illustrates CMS's process for HIPAA Administrative Simplification compliance or compliance reviews. It consists of 5 phases: selection and contact, submission, review, corrective, and validation. When CMS selects an entity for review, it contacts that entity, which is responsible for identifying points of contact who will be responsible for the compliance review. CMS will then provide these contacts instructions and resources for submitting transaction files and required artifacts. These contacts are expected to provide this information within 30 days. CMS will review this information within 30 days of receipt and conduct transaction testing. If corrective action is necessary, the entity will be responsible for executing it. Once the corrective action is complete and CMS has approved it, or if CMS determines no corrective action is necessary, CMS will notify the entity and close the review. You can also find this graphic on CMS Administrative Simplification website. Next slide, please.

How to prepare for a compliance review. Testing your transactions for compliance using ASETT is one of the best ways to prepare for a potential compliance review. You can also visit the enforcement section of Administrative Simplification website to find resources about the Compliance Review Program, such as our Prep Steps and Q&As. In addition, verify compliance with operating rules for eligibility claim status, EFT/ERA, or electronic remittance advice. Next slide, please.

This concludes our review of the Administrative Simplification enforcement. We will share some resources that we've created and then open up for questions. So, our recap. To recap, NSG only handles alleged HIPAA violations related to electronic transactions, operating rules, code sets, and unique identifiers. NSG's enforcement process consists of 2 programs: Compliance Review, which is proactive, and complaints, which is reactive. Visit asetts.cms.gov to test your transactions, test your trading partner's transactions, file complaints, and track your complaint status. Okay. We're open to the Q&A portion of it, and I believe we can begin there.

Moderator: Thank you, Paul. We will now begin the question-and-answer portion of the webinar. As a reminder, you can submit a question using the questions box. Questions not answered during the webinar will be answered and posted with the other webinar materials on the Administrative Simplification website following the webinar. You can see the link to the website on the page currently viewed. Please use the questions-and-answers box to submit any questions.

Someone asked, "Are we able to view the video using that link?" Yes. The webinar materials will be posted on the Administrative Simplification website following the webinar in the coming

weeks. And you will be able to follow the links in the PowerPoint presentation to those videos. And they are also available on the CMS Administrative Simplification website.

Moderator: Our first question is, “What is the average length of time entities are taking to correct deficiencies?”

CMS: That time can vary depending upon what the issue is. It can vary anywhere from a few weeks to a few months. It’s just dependent upon what the issue is and what the solution is to fix that issue.

Moderator: Thank you, Paul. Our next question is, “Even though the unique patient identifier does not have a standard, is it still a mandate that EDI trading partners must use one?”

CMS: It’s not an adopted standard, so it’s not required. We’ve never adopted patient or individual identifier at this time.

Moderator: Thank you, Gladys. Our next question is, “Does CMS analyze recurrent themes and ASETT complaints to identify areas that may warrant additional guidance enforcement? For example, numerous providers have filed complaints regarding assessment of percentage-based fees.”

CMS: Hi, this is Gladys. As part of our policy, we monitor all the complaints and violations, and when we see that there is a recurring issue, typically we use that as a topic to publish some regulatory guidance in the way of an FAQ or a guidance letter or informational bulletin to clarify the subject because it seems that when we indicate that a number of people are experiencing that same violation. The issue regarding the fees, well, we probably would not publish guidance related to that because it has not been determined as of yet whether or not there is a violation. It’s a topic that’s currently being evaluated at CMS and investigated.

Moderator: As a reminder, you can submit your questions through the questions box in the webinar interface. Our next question is, “Are entities required to submit an annual attestation of compliance?”

CMS: No, they are not. They are not required to submit any kind of certification or attestation that they are compliant.

Moderator: Thank you, Gladys. Our next question is, “When there is a disagreement on the interpretation of a TR3 requirement, how does that get handled?”

CMS: The TR3 reports are owned by the X12. So, normally when there is a discrepancy about an area in the TR3 that may not be clear or may be interpreted differently by the entities, we defer to X12. We write to X12. It is their guide, and we ask them for the interpretation or the intention of a particular segment or data element. And we always go through – we work through whatever their determination is.

Moderator: Thank you, Gladys. Coming back to the question we asked earlier, “If a health plan only provides member eligibility on their portal and not via a 270 transaction, are they considered noncompliant?”

CMS: According to regulation, if a provider requests that a health plan conduct the standard transaction, which is the 270, the health plan is not in compliance if they do not conduct the transaction, the 270.

Moderator: Thank you, Gladys. In a follow up to that question about interpretations, “Are the interpretations posted on CMS sites anywhere if complaints then result in the need to go to X12?”

CMS: They aren’t posted on the CMS website, but if we do go for an interpretation from X12, because they are the author of the guides, we communicate that with the complaint entity, such as the filed-against entity and the complainant, and it is posted and stored in our ASETT system with that particular complaint. But currently we’re not posting, you know, any RFIs, or requests for information that we submit to X12.

Moderator: Thank you. Our next question is, “Are trading partners considered covered entities, and if so, do the requirements apply to them as well?”

CMS: If the trading partner meets the definition of a business associate, they are required to comply with the HIPAA requirements.

Moderator: Thank you, Gladys. Our next question is, “Is CMS able to comment on the timing for guidance for future rules?”

CMS: This is Chris Gerhardt speaking. With respect to the public information about future rules, you need to consult the Unified Agenda, the Federal Unified Agenda for the Federal Register. And that will announce the scheduled publication for future rule making. Other than that, we don’t have other public postings of schedules for rule making.

Moderator: Thank you, Chris. Thank you, everybody, for joining today. That was the final question of the Q&A portion of the webinar. For more information about Administrative Simplification, please visit the CMS Administrative Simplification website at [go.cms.gov/adminsimp](https://www.cms.gov/adminsimp). You can see it on the slide available on the screen now. You can also email questions, comments, and feedback to administrativesimplification@cms.gov. Any questions not answered during the webinar will be answered and posted with the other webinar materials, including the transcripts and slide deck on the Administrative Simplification website in the 2 weeks following the webinar. Thank you for joining.