Commentary

Contingency Planning for a Possible HIPAA Claims Crisis

The worst-case scenario for HIPAA transactions occurs if providers fall back to paper claims. Some healthcare organizations are preparing for that possibility.

Background

In “HIPAA COMPARE Level Five: A Worst-Case Scenario Ahead,” Gartner describes insufficient progress in meeting the U.S. Health Insurance Portability and Accountability Act’s (HIPAA’s) transaction and code sets (TCS) regulation’s deadline. Based on the results of the seventh iteration of our COMpliance Progress And Readiness (COMPARE) survey of HIPAA, we describe the very real potential for a worst-case scenario in which providers drop back to paper claims in large numbers, health plans are not able to keep up with the paper flow and the resulting payment delays wreak havoc on healthcare provider organizations.

Here, we describe the actions that some health plans are taking to deal with the potential crisis. We also give advice to healthcare providers on how to take control of their HIPAA transaction implementation.

Avoiding the Worst Case

Allowing a significant disruption in healthcare is not good business for U.S. health plans or good politics for the Bush administration or Congress. Something must be done soon to create an orderly transition to the new standards. On 15 April 2003, the Workgroup on Electronic Data Interchange (WEDI) sent a letter to the Secretary of the U.S. Department of Health and Human Services (DHHS) recommending two contingency approaches:

- Allowing health plans that are able to accept the standard format to continue to accept the old format for a limited time
- Allowing health plans to accept the new format without the new data elements for a limited time, as long as the health plan does not need the new elements to adjudicate claims. (Many health plans will not need the new data elements.)

Allowing health plans that can comply to continue to accept the old format is consistent with the provisions of the HIPAA law. The TCS regulation is much more stringent than the law in this regard.
DHHS Has Limited Flexibility

Congress was explicit in the U.S. Administrative Simplification Compliance Act (ASCA). DHHS does not have the legal authority to extend the deadlines. At best, it can use an enforcement process that supports those covered entities that have taken the right steps to become compliant, but are dealing with trading partners that are not, or do not have the bandwidth to bring everyone on board in time.

In addition to the limitations of ASCA and the regulatory process, DHHS must deal with the perception of some government officials that industries always whine about new regulations.

Within these limitations, DHHS should do whatever it can to signal health plans that TCS enforcement will first emphasize health plans that are not able to accept compliant claims. This will make it easier for health plans that have successfully tested the new format with some trading partners to make their tough business decisions.

What Some Health Plans Are Doing

Because there are many fewer health plans than providers, and because health plans are the source of the money, they really drive the process. Many large health plans have confided to Gartner that they will be ready for the new format, but they will unilaterally follow at least the first of the recommendations that WEDI made to DHHS. They will continue to accept old-format electronic claims after the deadline for a limited time, even if this puts them in violation of the TCS regulation. Their intent is to aggressively test with trading partners in the new standard and, when most of their trading partners are using the new format, make an economic decision to stop accepting old-format transactions from the laggards.

This approach is a difficult business decision that involves assessing legal risk. There is at least the possibility that someone will file a complaint with DHHS, and DHHS will assess civil monetary penalties. Under this unlikely scenario, they do not know what the maximum annual civil monetary penalty would be, although it would probably be between $250,000 and $2.5 million. For a large health plan, however, the cost of having providers drop back to paper would be much higher than the penalty. It would be far easier for health plans to decide on this approach if DHHS were able to state, or at least imply, that its initial enforcement priorities will go lightly on health plans that are accepting the new format, but continue to accept the old format beyond the deadline.

These approaches will not be effective unless providers know about them. The health plans we have talked to are working to find ways to communicate their plans to their providers without giving the appearance of flaunting federal regulations.

Health plans that are not willing to follow this approach should be contracting with vendors such as Affiliated Computer Systems, Perot Systems, Computer Science Corp., IBM, Unisys or off-shore suppliers for additional optical character recognition (OCR) bandwidth to deal with paper claims. They should also be assessing the effect of payment delays on their contracts and compliance with state regulations.

What Providers Should Be Doing

Those providers that have upgraded their billing systems should identify the health plans with which they have large volumes and be aggressive in dealing with their vendors and the health plans to schedule testing time. They should not accept blandishments; they should get specific dates and requirements and ensure that the implementation of their vendors’ products support collecting the additional data elements.
Providers that have not completed internal testing and begun testing with their high-volume health plans and trading partners must recognize that their vendors and their health plans will be flooded with providers trying to make the deadline. Most providers that are not already in external testing must assume that they will not be able to complete trading-partner testing by the deadline. Therefore, they should be talking to their high-volume health plans to understand their policies concerning the WEDI suggestions.

Providers that are not already testing and cannot get a clear picture of the approach of their high-volume health plans should make business plans for a disruption in cash flow when they revert to paper. This includes, but is not limited to, securing a line of credit. Providers should not wait to take decisive action. It will become increasingly difficult to secure the credit line as the October deadline draws near.

What Everyone Should Be Doing

This is a time that requires tough decisions by everyone, including the regulators in DHHS. Covered entities can support DHHS by writing Secretary Tommy Thompson and their congressional delegations to alert them of the continued need for flexibility.

**Bottom Line:** It is possible to avoid the "train wreck" of many providers dropping back to paper claims. But this can only happen if payer organizations make the tough business decision to follow one of the Workgroup on Electronic Data Interchange recommendations and communicate clearly to providers their approach and their estimates of the time frame in which they will continue to support the old formats. The U.S. Department of Health and Human Services must find a way to support such payers. Providers that take such announcements as excuses to continue to accept blandishments from their software vendors or clearinghouses will learn a hard lesson, which will come when enough of their peers have converted to the new format and payers cut them off. Implementation and testing takes time and coordination with outside entities. It cannot be put off to the last minute.