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New HIPAA Certification Requirement & Other New Health Plan “To Do” Tasks under HIPAA Standard Transaction Rules

Deadlines to Remember:

11/5/14 Health plans must register for Health Plan Identifier Number (HPID)*

**1/1/15
– 12/31/15** Health plans must obtain outside HIPAA Certification of Compliance with Standard Transactions for: (1) Eligibility, (2) Health Claim Status, and (3) EFT Remittance Advice*

12/31/15 Health plans must file attestation of Certification with HHS*

*(*Small health plans generally have delayed effective date of one year)*

The Department of Health and Human Services (HHS) recently issued the latest in an ongoing set of rules that apply to health plans that are covered entities under the HIPAA privacy and security rules. Under the original HIPAA administrative simplification statute, which included privacy and security requirements, covered entities were required to conduct certain transactions electronically using standards and code sets designated by the Secretary of HHS (or Transaction Rules - see below for additional background).

The Affordable Care Act (ACA) added new requirements to these Transaction Rules, including more detailed operating rules and a new electronic transaction requirement for electronic funds transfer (EFT). The ACA also required HHS to issue rules for a national Health Plan Identifier number and a new requirement for health plans to certify compliance with all of these Transaction Rules.

For the most part, health plans typically look to their business associates to handle these “standard transactions” responsibilities for them. In fact, many TPA agreements and business associate agreements expressly require the business associate to conduct any applicable transactions as standard transactions. Alternatively, if a health plan does conduct transactions of its own, it usually hires a clearinghouse to convert the required information into “standard” format.

Some of these new rules, however, place responsibilities directly on the health plan, even if it normally looks to a third party to conduct its standard transactions. For example, the health plan must register for its own Health Plan Identifier number to be used in standard transactions. And most recently, under proposed rules issued by HHS in January, the health plan must obtain a certification that its standard transactions are being conducted under the required Transaction Rules - even for transactions conducted by its business associates. 79 Fed. Reg. 298 (January 2, 2014). Under the proposed rules, by December 31, 2015, health plans will be required to obtain the certification from an outside organization and then file an attestation with HHS that it has obtained the necessary certification. Plans may be penalized \$1 per covered life per day (up to a maximum cap) for failure to file the required certification.

Below we provide background of the Transaction Rules and the new requirements mandated by the ACA.

Background of HIPAA Standard Transaction Rules

On August 17, 2000, HHS published final regulations adopting the original HIPAA standard transactions, which, after a delay, were effective for most plans as of October 16, 2003. 65 Fed. Reg. 50312 (August 17, 2000).

The Transaction Rules require that if a health plan covered entity, as defined under the HIPAA privacy rules, conducts certain "standard transactions" with another covered entity using electronic media, the two covered entities must use standards and code sets designated by Secretary. These standards and code sets establish which data must be provided and fields that must be used when transmitting electronic information. In addition, the Transaction Rules provide that if any entity requests a health plan covered entity to conduct one of the listed transactions as a standard transaction, the health plan must do so and may not delay or reject the transaction because it is standard transaction.

Groom Observation: Not all transmissions of electronic information are subject to the Transaction Rules. The rules only are required where information is transmitted between two covered entities under one of the listed transactions below (and then only when the information is transferred electronically). For example, where a health care provider files an electronic claim with the health plan, the transmission would be between two covered entities and must be a standard transaction. But if an individual files a claim with a health plan, the transmission would not be between two covered entities, so would not have to be conducted as a standard transaction.

The list of transactions to which these rules apply are:

- *Claims & Encounter Information* – Request from provider to plan to obtain payment or information.
- *Eligibility* – Transmission from provider to plan, or plan to plan – and their responses – related to eligibility, coverage, or benefits under the plan.
- *Authorization & Referrals* – Request for authorization for health care or to refer to another provider – and response.
- *Claim Status* – Inquiry about status.
- *Enrollment & Disenrollment* – Transfer of subscriber information to plan to establish or terminate coverage.

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- *Payment* – Payment or information about fund transfer from plan to provider’s financial institution; or EOB or remittance advice from plan to provider. [Note that, as a practical matter, this transaction is now part of the new EFT / Remittance Advice transaction – see below.]
- *Premium Payments* – Information about payment, fund transfer, remittance, or payment processing from entity arranging provision of care.
- *Coordination of Benefits* – Transfer of claims or payment information to plan for purpose of determining relative payment responsibility.

Groom Observation: For many health plans, it is their business associate that is conducting any standard transactions. For example, a TPA generally is the party that is transmitting information about claims or sending payment, so the TPA would be the party that most likely is complying with the Transaction Rules on behalf of the health plan. Having said that, the plan should verify that their business associates are conducting standard transactions, where required, since the obligation technically falls on the health plan itself.

New ACA Requirement: New EFT / Remittance Advice Transaction

The ACA mandated that the Secretary adopt a new transaction to add to the list above for electronic funds transfers (EFTs). HHS issued a final rule adopting the EFT transaction on January 10, 2012. 77 Fed. Reg. 1556.

The new EFT / Remittance Advice transaction replaces the Payment transaction in the list above and is defined as:

- *Electronic Funds Transactions* – Transmission of any of the following from a health plan to a health care provider: payment, information about the transfer of funds, and payment-processing information.
- *Remittance Advice* – Transmission of any of the following from a health plan to a health care provider: an explanation of benefits or a remittance advice.

Covered entities were required to comply with the new EFT / Remittance Advice transaction by January 1, 2014.

Groom Observation: For the most part, a health plan’s TPA will be conducting any payment transaction with a covered entity health care provider, so it is the TPA that must comply with the new EFT / Remittance Advice transaction. However, if a health plan is self-administered or sends payment directly to a provider, it should review whether and how the EFT / Remittance Advice rules may apply. A health plan that simply pays an individual plan participant will not have to conduct the payment as an EFT / Remittance Advice transaction, since the payment is not between two covered entities. For example, if a health plan sends a check directly to an individual claimant, the EFT / Remittance Advice rules would not apply. While the health plan may be a covered entity, the individual is not. On the other hand, if the health plan sends a check directly to the health care provider, then the transmission is between two covered entities, and the EFT / Remittance Advice rules may apply.

New ACA Requirement: Health Plan Identifier (HPID)

The original HIPAA administrative simplification statute, enacted in 1996, required the Secretary to adopt an identifier system for employers, health care providers, health plans, and individuals. The intent was to have the same identifiers on a national basis so that all electronic transmissions of health information would be uniform. HHS has adopted rules for the employer and health care provider identifier programs, but had not adopted the health plan identifier or individual identifier. The ACA again mandated that the Secretary issue rules adopting the health plan identifier. (The individual identifier has been very controversial due to privacy reasons, so it is unclear whether it will ever be adopted.)

HHS issued final regulations on September 5, 2012, which require health plans to obtain a Health Plan Identifier (HPID) by November 5, 2014. 77 Fed. Reg. 54664. Small health plans, defined as health plans with annual receipts of \$5 million or less, have until November 5, 2015 to register for an HPID.

The HPID rules introduce two new terms for defining health plans, which also are used in the new certification rules.

- *Controlling Health Plan (CHP)* means a health plan that controls its own business activities, actions, or policies.
- *Subhealth Plan (SHP)* means a health plan whose business activities, actions, or policies are directed by a Controlling Health Plan.

Each covered entity health plan must obtain an HPID. The regulations provide that a Controlling Health Plan must obtain its own HPID, but can also apply on behalf of any Subhealth Plans. Alternatively, these Subhealth Plans may obtain their own numbers.

Groom Observation: Where an employer has a “wrap” welfare plan that includes more than one health benefit option, these rules appear to allow the wrap plan to apply for one HPID on behalf of all of the Subhealth Plans or to allow each health plan option (i.e., each Subhealth Plan) to obtain its own HPID. This structure is similar to the plan number required on the Form 5500. Plans may file separate 5500s with separate plan numbers for each health benefit option, or may combine into one 5500 with one plan number.

Once a health plan has an HPID, any covered entity that identifies the health plan in a standard transaction must use the appropriate HPID number, rather than another identifier. In addition, covered entities must require business associates to use the appropriate HPID number when they conduct standard transactions on behalf of a covered entity.

HHS has established a website where health plans can register and obtain their HPID. There are a series of screens the plan must walk through to provide information about the plan sponsor and plan. See <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html>.

New ACA Requirement: Certification of Compliance with Standard Transactions Rules

Rounding out all of the above requirements, the ACA mandates that health plans must file two one-time certifications with the Secretary attesting that the plan is in compliance with the applicable standard transaction requirements. The ACA imposes a penalty on noncompliant plans of \$1 per covered life per day until certification is complete with a maximum penalty of \$20 per covered life. The ACA also imposes a penalty of up to \$40 per covered life if the plan knowingly provides inaccurate or incomplete information.

The ACA breaks down the certification into two parts:

- *First Certification* - The ACA required the First Certification by December 31, 2013, but new proposed rules issued in January 2014 (see below) delay the requirement until December 31, 2015. This certification requires health plans to file an attestation with HHS to demonstrate compliance with the following standard transactions:
 - Eligibility,
 - Claim status, and
 - EFT & Remittance Advice.
- *Second Certification* – Under the ACA, the Second Certification also is due 12/31/15, but no regulations have been issued yet, so this certification may be delayed. This certification requires health plans to file an attestation with HHS to demonstrate compliance with the following standard transactions:
 - Claims & Encounter Information,
 - Enrollment and Disenrollment,
 - Premium Payments,
 - Claims Attachments, and
 - Authorization & Referrals.

New Proposed Rules on First Certification Requirement

On January 2, 2014, HHS issued proposed rules explaining how a health plan would be required to meet the First Certification requirement above. 79 Fed. Reg. 298. As discussed in more detail below, the health plan must obtain certification from an outside vendor that shows that the plan performs the required standard transactions and has tested these transactions with a minimum number of third parties. There are two forms of certification – one that involves self-reporting of the required testing to obtain certification and one that requires testing with a “dummy” service to demonstrate compliance. After obtaining certification, the health plan must file an attestation with HHS by December 31, 2015 that represents that the plan has obtained the required certification and otherwise complies with the privacy and security rules. This attestation must be signed by a senior level executive. The attestation filing also must include information about the number of covered lives under the plan so that HHS can be able to assess a penalty on covered lives if it finds noncompliance.

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Groom Observation: While the attestation deadline is not until December 31, 2015, it may take some time for plans to obtain the required certification. Until final rules are issued, we do not know exactly what the certification will entail, but we do know that it will involve testing of a minimum number of transactions, so may be lengthy. In addition, where plans have business associates that conduct standard transactions for them, they will need to arrange for their business associates to perform this testing so that the plan can be certified. Once final rules are issued, plans will need to budget plenty of time to reach out to business associates and ensure testing can be completed so that the plan can obtain the required certification and perform the attestation filing by 12/31/15.

Below we include Q&As on the highlights of the new certification rule.

- **Which health plans must be certified and file the attestation?**

All health plans that are covered entities under the HIPAA privacy rules must file the attestation that they have been certified. The Controlling Health Plan must file on behalf of any Subhealth Plans (see the definitions under the HPID rule section). The certification/attestation requirement applies to insured and self-funded plans.

- **When do Controlling Health Plans have to file the attestation?**

Generally, plans must file their attestation with HHS by December 31, 2015. This means that they must go through the testing and certification process before this date. Small health plans will have until December 31, 2016 to file. HHS says this timeframe gives plans at least a year following the HPID deadline to complete the certification and filing.

- **How does a health plan obtain certification?**

The health plan must obtain certification from an outside third party, the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE). There are two types of certification: (1) the HIPAA Credential; and (2) the Phase III Core Seal. The health plan can choose which one it would like to seek. Both require that the health plan, or its business associates where applicable, actually test the standard transactions that are part of the First Certification. The HIPAA Credential relies more on self-reporting that testing was performed, while the Phase III Core Seal requires affirmative external testing with a third party. Health plans must obtain certification for each of the three standard transactions that are part of the First Certification.

Below are highlights of both types of certifications. Note that the HIPAA Credential has not yet been established, so this information is what HHS expects to be included, as described in the Preamble to the proposed rule.

	HIPAA Credential	Phase III CORE Seal
Who administers the certification?	CAQH CORE	CAQH CORE
What tests must be performed?	Controlling Health Plans would be required to certify that they have successfully tested each of the three transactions with at least three trading partners that collectively conduct at least 30% of the total number	Controlling Health Plans must externally test the required transactions with a CORE-authorized Testing Vendor using CORE Certification Master Test Suites.

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	HIPAA Credential	Phase III CORE Seal
	<p>of transactions conducted with providers. However, if the number of transactions conducted with three trading partners does not account for at least 30%, the Controlling Health Plan may confirm that it has successfully tested with up to 25 trading partners.</p> <p>The Controlling Health Plan would be required to provide a list of the names of the trading partners and their contact information.</p>	
What steps do plans have to take to apply for and obtain the certification?	<ol style="list-style-type: none"> 1. Submit two attestation forms <ol style="list-style-type: none"> a. CAQH CORE HIPAA Attestation Form (described below) b. Testing Attestation - attesting that it has successfully tested the standard transactions for the three transactions (Eligibility, Claim Status, and EFT/Remittance Advice) with required number of trading partners. 2. Application Form – Submit an application form verifying that all forms have been submitted and indicating that HHS may view the application and associated forms, if such is request is made to CAQH CORE. 	<p>Health plans must complete four steps to obtain a CORE Seal:</p> <ol style="list-style-type: none"> 1. Conduct a gap analysis of necessary system upgrades; 2. Sign and submit the CAQH CORE Pledge to make a commitment to become a CORE-certified entity within 180 days; 3. Conduct testing through a CORE-authorized testing vendor; and 4. Apply for a Phase III CORE Seal by submitting the proper documentation and fee to CAQH CORE for consideration, including, among other documents, the CAQH CORE HIPAA Attestation Form (described below).
What does the CAQH CORE HIPAA Attestation Form require?	An attestation from a senior-level executive indicating that, to the best of the applicant's knowledge, the entity is compliant with the applicable HIPAA transaction provisions and the HIPAA privacy and security provisions.	An attestation from a senior-level executive indicating that, to the best of the applicant's knowledge, the entity is compliant with the applicable HIPAA transaction provisions and the HIPAA privacy and security provisions.
Do plans need to engage a third-party testing entity?	No. The HIPAA Credential requires external testing; however, it does not require a specific approach to external testing.	Yes. Testing must be conducted by a CORE-authorized Testing Vendor using CORE Certification Master Test Suites, which are operating rules and documentation requirements necessary to demonstrate compliance with each operating rule

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	HIPAA Credential	Phase III CORE Seal
		requirement.
Who can obtain the certification?	The HIPAA Credential only will be available to health plans.	Any health care entity that conducts standard transactions may voluntarily undergo certification testing with an independent CORE-authorized testing vendor and submit the appropriate documentation to be awarded a CORE Seal.
What are the fees associated with the filing?	<p>CAQH CORE charges fees on a sliding scale according to net annual revenue. The fees <i>expected</i> to be charged for the HIPAA Credential are outlined below.</p> <ul style="list-style-type: none"> Federal and State Government Health Plans - \$100 CAQH Member Plans – No Charge Health Plans below \$5 million in net annual revenue - \$100 Health Plans with net annual revenue above \$5 million to below \$25 million - \$1,000 Health Plans with net annual revenue of \$25 million to below \$50 million - \$2,000 Health Plans with net annual revenue of \$50 million to below \$75 million - \$4,000 Health Plans with net revenue above \$75 million – according to HHS, the anticipated fee is unclear 	<p>CAQH CORE charges fees on a sliding scale according to net annual revenue. The fees are outlined below. The fees to obtain the CORE Seal do not include the cost for certification testing with a CORE-authorized testing vendor.</p> <ul style="list-style-type: none"> Federal and State Government Health Plans – No Charge. CAQH Member Plans – No Charge Health plans below \$5 million in net annual revenue - \$12,000 (\$4,000 for each of the three CAQH CORE Operating Rule Phases). Health Plans with more than \$5 million net annual revenue - \$18,000 (\$6,000 for each of the three CAQH CORE Operating Rule Phases).
What is required of business associates?	The proposed rules do not require anything specific to business associates, but as a practical matter, health plans likely will need to have business associates test the transactions for them.	If a health plan is dependent on a business associate to meet one of the operating rule requirements for which it is seeking certification, it must have that business associate achieve CORE certification.

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- **Once a health plan is certified, what will the attestation involve?**

Once the health plan is certified under either the HIPAA Credential or Phase III Core Seal, the plan must file an attestation with HHS. The attestation must include (1) documentation that demonstrates the health plan's compliance with either the HIPAA Credential or Phase III Core Seal for the three required transactions; and (2) information on the number of covered lives of the Controlling Health Plan on the date of the documentation – called a “snap shot” date.

- **How does the health plan calculate the number of covered lives for the attestation?**

The proposed regulation defines “covered lives” to mean individuals covered by or enrolled in “major medical policies” of a Controlling Health Plan and any Subhealth Plans, including the subscriber and any dependents covered by the plan. The proposed rules define “major medical policy” to mean “an insurance policy that covers accident and sickness and provides outpatient, hospital, medical, and surgical expense coverage.” Any penalty related to the First Certification process will be based on the number of covered lives reported in the attestation.

Groom Observation: The definition of “covered lives” in the proposed rule only refers to individuals enrolled in “major medical policies,” which are defined to be insurance policies that cover certain benefits. This language seems to suggest that self-funded plans or plans that perhaps do not provide significant medical coverage must still certify and file the attestation, but cannot be penalized. This will be a provision to watch in final rules.

- **How do plans submit the First Certification?**

The proposed rules do not get into the mechanics of how the certification will be filed. However, HHS indicated that the filing likely will be electronic. This will be an area to watch in the final rules.

- **After a health plan provides the attestation, is there an obligation to update the information or a requirement to file on an annual basis?**

No. HHS indicates that the submission requirement in the proposed rule is a “snap shot” of a Controlling Health Plan's compliance with the required standard transactions. Once the information has been submitted, there is not an obligation to update it or resubmit it on a regular basis.

Groom Observation: HHS says it will compare the list of HPIDs to the list of plans that have submitted an attestation to determine when a plan has not complied with the certification rule for purposes of imposing penalties. In the Preamble to the rules, HHS says that lack of knowledge or confusion will not be defenses to a failure to obtain certification or to file the attestation.

Health Plan “To Do” Tasks:

- ☐ Health plans should register to obtain an HPID by November 5, 2014. In doing so, health plans will need to decide which plan options are Controlling Health Plans and Subhealth Plans and whether to request an HPID for each or request one HPID for all of the health plan options that fall under the Controlling Health Plan. In addition, since most health plans have business associates that conduct standard transactions for them, these health plans will need to communicate their HPIDs to their business associates.

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- ❑ Health plans should review their Services Agreements or Business Associate Agreements with third parties that conduct standard transactions on their behalf to ensure that business associates are contractually required to comply with the existing rules (and consider adding this language if it is not already included). Plans also may want to update these representations to require the business associate to provide any necessary information or to perform any necessary testing in order for the health plan to meet the certification requirements.
- ❑ Health plans should watch for final rules on the certification process and attestation and be ready to act. In the meantime, health plans can be identifying which business associates conduct the three standard transactions that are part of the First Certification and reach out so that all parties are ready to hit the ground running when final rules are issued. Health plans also should keep in mind December 31, 2015 as the final date to file an attestation of compliance with the First Certification.

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