HHS Releases White Paper on Unique Health Identifier

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On July 6, 1998, the Department of Health and Human Services (HHS) published a white paper on unique health identifiers for individuals. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HHS Secretary Donna Shalala is required to adopt standards that support the electronic exchange of administrative and financial transactions.

Prior to publishing a notice of proposed rule making on the requirements for a unique health identifier for individuals, HHS published the white paper to solicit comments from the industry. The National Committee on Vital and Health Statistics (NCVHS) held a hearing July 20-21 in Chicago and will hold an additional hearing September 14 in Washington, DC. Another hearing also will be scheduled later this fall.

Discussing the need for a unique identifier for individuals, privacy issues, approved uses of an identifier for individuals, criteria for evaluation of candidate identifiers, costs, and implementation issues, the white paper has sparked concern regarding privacy and confidentiality. Varying opinions on the unique identifier for individuals have also emanated from the paper. The proposed identifiers are as follows:

- social security number
- CPRI proposal—an identifier based on social security number with a check digit
- computed healthcare identifier
- ASTM sample unique health identifier
- biometric identifiers
- personal immutable properties
- civil registration system
- master patient index

HHS plans to publish a notice of intent in the *Federal Register* to discuss the identifier options under consideration and to request public comment. There will be a 60-day comment period. After comments are analyzed, HHS will decide whether to publish a notice of proposed rule making or take other action. During this time, the NCVHS will complete public hearings and issue its recommendation to the Secretary of HHS.

For a copy of the white paper, go to http://aspe.os.dhhs.gov/admnsimp.

HCFA Publishes Interim Final Rule Establishing Medicare+Choice Program

On June 26, the Health Care Financing Administration (HCFA) published an interim final rule outlining the provisions for the Medicare+Choice Program. The interim final rule became effective July 27, and comments on the regulation are due September 24, 1998.

The Balanced Budget Act of 1997 established the Medicare+Choice Program to significantly expand healthcare options available to Medicare beneficiaries. The primary goal of the Medicare+Choice program is to provide Medicare beneficiaries with a wider range of health plan choices to complement the original Medicare program. Alternatives available to beneficiaries under the Medicare+Choice program include both the traditional managed care plans (such as HMOs) that have participated in Medicare on a capitated payment basis and a broader range of plans comparable to those now available through private insurance. Specifically, section 1851 (a)(2) of the Social Security Act provides for three types of Medicare+Choice plans, effective January 1, 1999:

- Medicare+Choice coordinated care plans, including HMO plans (with or without point of service options), provider-sponsored organizations (PSO) plans, and preferred provider organization (PPO) plans

- Medicare+Choice medical savings account (MSA) plans (combination of a high deductible Medicare+ Choice health insurance plan and a contribution to a Medicare+Choice MSA).
- Medicare+Choice private fee-for-service plans

In addition to expanding the types of available health plans, the Medicare+Choice program introduces several other fundamental changes to the private health plan sector of the Medicare program. These changes include:

- Establishing an expanded array of quality assurance standards and other consumer protection requirements
- Introducing an annual coordinated election period
- Revising the way HCFA calculates payment rates to the plans that will narrow the amount of payment variation across the country and increasing incentives for plans to operate in diverse geographic areas
- Establishing requirements concerning participation procedures for physicians and other healthcare professionals in Medicare+Choice plans, including prohibitions on interference with advice to enrollees

The regulations in the interim final rule are codified in 42 CFR Part 422, Medicare+Choice Program. There are 14 subparts dealing with major subjects. Subpart C outlines the requirements concerning benefits, POS options, disclosure of information, access to services, confidentiality of enrollee records, advance directives, and beneficiary protection against liability. Subpart D outlines the requirements concerning quality assurance standards, external review, and accreditation of organizations.

Section 422.118, Confidentiality and Accuracy of Enrollee Records, requires Medicare+Choice organizations to safeguard the confidentiality and accuracy of enrollee records that identify a particular enrollee, including medical documents and enrollment information. A Medicare+Choice organization may circulate this information within the organization to coordinate care for a Medicare enrollee. The Medicare+Choice organization may not, however, circulate this information outside the organization without specific authorization from the Medicare enrollee. Medicare+Choice organizations are prohibited from selling (or circulating outside the organization) names and addresses of enrollees for any purpose, including scientific study.

Additionally, the Medicare+Choice organization must maintain records in an accurate and timely manner and ensure timely access to enrollees who wish to examine their records. Moreover, the Medicare+Choice organization must abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and enrollee information.

Section 422.128, Information on Advance Directives, requires Medicare+Choice organizations to document advance directives in a prominent part of the Medicare beneficiary's medical record. Section 422.152, Quality Assessment and Performance Improvement Requirements, requires that an organization's quality assurance program meet the following requirements with respect to each plan that it offers:

- Stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that HCFA recognizes) that will permit measurement of outcomes and other quality indices
- Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions
- Evaluate the continuity and coordination of the care that enrollees receive
- Be evaluated on an ongoing basis as to its effectiveness
- Include measures of customer satisfaction
- Provide HCFA access to the information it needs to monitor and ensure the quality of care provided
- Provide for physicians and other healthcare professionals to review the process followed in providing healthcare services
- Establish written protocols for utilization review, based on current standards of medical practice
- Have mechanisms to detect both underutilization and overutilization of services
- Establish or alter practice parameters when areas needing improvement are identified
- Take action to improve quality and assess the effectiveness of that action through systematic follow up
- Make available to HCFA information on quality and outcomes measures to facilitate beneficiary comparisons and choice of healthcare options (in such form and on such quality and outcomes measures as HCFA determines is appropriate)

Section 422.152(f) requires all health plans to maintain a health information system that collects, analyzes, integrates, and reports data. Although an encounter data system may often be the most efficient means of meeting the requirements of these standards, the plan may use any methods or procedures for the collection of quality data, so long as it can demonstrate that its system achieves the objectives of the requirement.

The strategy of relying on performance measurement and performance standards to assess and improve quality is heavily dependent on the validity of data collected and reported by plans. Therefore, section 422.152(f)(1)(ii) requires that an organization ensure that the information received from its providers is reliable and complete. If the organization receives individual encounter data directly from providers, it must have a system for comparing reported data to a sample of medical records to verify the accuracy and timeliness of reporting or transmission. The objective is to assure that, to the extent feasible, there is a one-to-one correspondence between items included in an organization's summary data and specific services entered in medical records or equivalent source documents.

Republican Task Force Agrees on Health Quality Plan

After several months of contentious deliberations, the House Working Group on Health Care Quality released an outline of its healthcare quality proposal on June 24, 1998. The 15-member Republican group, led by Congressman J. Dennis Hastert (R-IL), agreed to "a broad outline of initiatives...to increase accessibility, affordability and accountability to healthcare..." It is expected that staff will complete a draft of legislative language in the near future. Floor consideration has not been scheduled.

The Senate task force, led by Sen. Don Nickles (R-OK), is also developing a healthcare quality proposal. The Senate legislation is evolving from S 1712, the Health Care Quality, Education, Security, and Trust (QUEST) Act (see "Capital Currents," *Journal of AHIMA*, July/August 1998), which was introduced by Sens. James Jeffords (R-VT) and Joseph I. Lieberman (D-CT). Legislative language is expected in the coming days. Senate Majority Leader Trent Lott (R-MS) has indicated that floor consideration may take place within the next several weeks if a scheduling agreement can be reached with the Democrats.

Accountability: The House bill's accountability goals address several issues, including the confidentiality of health information. According to the plan's outline, the accountability requirements will specifically call for:

- Safeguarding confidential information to protect personal and sensitive healthcare data from abuse
- Expediting internal review to hold plans accountable by providing patients access to immediate decisions about what is covered for routine and emergency services
- Providing independent medical expertise in external appeals to provide patient protection by guaranteeing that an independent doctor decides if a requested service is medically necessary, if originally turned down by internal review
- Disclosing plan information to make it easier for patients to learn more about what their health plan coverage includes
- Lifting the "gag rule" to allow free and open communications between patients and doctors in order to make fully informed decisions about the best course of treatment

The health information confidentiality provisions are being drafted by Rep. William M. Thomas (R-CA), chair of the House Ways and Means Health Subcommittee. Thomas is using the draft of Sen. Robert Bennett's (R-UT) Medical Information Protection Act as his guiding document to develop legislative language. Deliberations are still ongoing as to how comprehensive the Thomas confidentiality language will be. AHIMA has met with Thomas' staff to inform its members of the need to pass federal preemptive legislation to establish uniform national guidelines for the use and disclosure of individually identifiable health information.

The accountability section addressed another controversial issue by not including provisions to make managed care plans liable for medical decisions. Instead the plan expands the Employee Retirement Income Security Act (ERISA) which will fine managed care plans for each day the plan delays required coverage. These plans also will be charged for attorney's fees and court costs.

Accessibility: The plan outline released by Hastert also explains how the task force bill will address accessibility issues.

- Ensuring emergency room/prudent layperson standards to allow all patients to have ready access to emergency care by prohibiting plans from arbitrarily refusing to pay for covered emergency benefits
- Ensuring point of service to allow patients new avenues to healthcare coverage where quality and choice are unavailable

- Providing direct access to pediatricians to guarantee families peace of mind that their child's pediatrician is the primary care physician
- Providing direct access for OB/GYN to allow women the opportunity to bypass the health plan's bureaucracy and go directly to their providers

The prudent layperson standard, in one form or another, has been consistently included in the health quality bills introduced in Congress. For example, the Health Care Quest Act defines emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part." Other variations of this definition do exist, some dropping the reference to "severe pain."

Affordability: The task force's outline also includes those items that will address the affordability of healthcare.

- Creating association health plans to provide avenues so small businesses can pool together for their employees to enjoy the kinds of coverage afforded in big business
- Creating health marts to increase consumer choice by serving as a cooperative group marketplace so working families can choose from a menu of benefit options
- Creating community health center networks to promote expansion of health coverage to all patients within their communities
- Expanding medical savings accounts to increase patient access to healthcare services and to have greater control over their healthcare dollars
- Reforming medical malpractice to hold down healthcare costs by ensuring that doctors are free to practice medicine responsibly without the fear of lawsuits, excessive legal damages or trial lawyers

Passage of healthcare quality legislation is anything but sure. Not only do the Republicans have to deal with uneasiness in their own party over this legislation, but any Republican legislation ultimately considered will have to contend with a concerted effort to replace it with the Democrats' Patients' Bill of Rights (S 1890-Daschle, HR 3605-Dingell). Several Republicans, including Rep. Greg Ganske (R-IA), a plastic surgeon, support the Democrats' legislation. AHIMA will continue to watch this issue very closely and make you aware of the latest developments from Capitol Hill.

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