

BHG UPDATE

No State-wide Extension Plan for EDI Compliance Delay

The last issue of *BHG Update* (January 2002) announced that compliance with the HIPAA transactions (EDI) and code set requirements could be delayed for one year to October, 2003 for any covered entity that submits a plan to the HHS Secretary outlining how the entity will come into compliance by that date. It was also suggested that the State might make application for the extension on behalf of boards and providers using the MACSIS system. Bad news! At the April 2002 meeting of the MACSIS project operations team, it was announced that the State will not be developing an extension application for boards and providers. The responsibility for making application for the extension will rest with individual providers and boards.

The law (Administrative Simplification Compliance Act) that provides for the extension of the compliance date also required that the Department of Health and Human Services develop and publish a model compliance form for the plan that covered entities would submit prior to October 16, 2002. A "Standard Model Compliance Form" was published prior to the March 31, 2002 deadline and is now available at the following website: <http://www.cms.gov/hipaa>. There are also instructions related to submitting

the form electronically.

The compliance form requests summary information about the entity's plan for compliance and dates for completion of key components of the plan, not the whole plan. For example, the entity must complete a check list of reasons why compliance cannot be accomplished by October 2002; provide an estimate of the cost to comply with the transactions and code set requirements; and, provide start and completion dates implementation activities at the entity such as awareness/ education, operational assessment and development and testing of the technology required for compliance.

For a number of reasons, it has been recommended that every provider and board complete the extension request form and submit it to HHS prior to October 16, 2002. Vendor compliance delays for software, lack of approved standard Mental Health code sets and the expectation that MACIS will not be compliant until 2003 are three good reasons why filing the extension makes sense.

Interestingly, there is no approval process for the extension. A covered entity need only submit the model compliance form to receive the extension. Why not?

State Conversion To New EDI Standards July 1, 2003

The MACSIS operations group announced in April that conversion to the standard transactions and code sets will occur July 1, 2003. It was also announced that claims submitted using the HCFA 1500 format will not be accepted after the June 30, 2003. In fact, this decision means that agencies sub-

mitting claims to MACSIS will have to be compliant with EDI and code sets prior to the extension date of October 16, 2003. The details of the transition from the 1500 to the 837 have yet to be determined. Stay tuned!

Behavioral Health Generations

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Special points of interest:

- *No Statewide Plan for EDI Compliance Delay*
- *State to Conversion to EDI and Standard Codes July 1, 2003*
- *QRS Publishes CQRT Report*
- *HIPAA Privacy Rule Changes*

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QRS Publishes CQRT Survey Results

In the first quarter of calendar year 2002, Quality Review Services, Inc. released the results of consumer quality review team (CQRT) surveys conducted over the period 2000-2001. The results were published in a clever, light-hearted format called "*Recipes for Recovery*". According to Kandy Witte, QRS's Executive Director, "Though the tone (of the report) is light, the content is based on real facts... and the data are comparable to the five years of data collected during the life of the CQRT project." Witte's hope is that the CQRT data will be taken seriously enough to foster change in a system with variable levels of quality and performance, "consumers deserve to have a quality system of care available to them, the kind of care we would all want for ourselves and our families."

The QRS report identified the following key findings:

- Recovery is supported by case management; medication; psychotherapy; daily structure; financial and social support and spirituality. Recovery is hindered by medication side effects; poor financial status; the fluctuating course of the illness; social isolation and loss of friends.
- Peer support is **extremely important**. Whether the support was through organized peer group activities or one-on-one, many consumers, family members and friends cited the positive impact of having someone who truly understands and empathizes, as well as supports.
- Accessibility to service was a problem cited by consumers, significant others, and providers. Accessibility issues included: unable to get the service; poor transportation to services; long waiting lists for medication and counseling services; large caseloads for case managers; physical access problems for the disabled client and lack of accommodation for special needs.

- Education is needed for consumers and significant others. Specifically, respondents want to know what services are available; what is the function of each service; how to access the service; what do various diagnoses mean; what are the side effects of medications; how can families cope with a loved one's mental illness; and, how can friends help in the recovery process?
- Consumer satisfaction is strongly linked to the sense of being cared about, being valued by providers.
- There is a shortage of qualified staff across the public mental health system in the State of Ohio.

The message in this report—the more things change, the more they stay the same! The findings of the CQRT surveys are amazingly consistent, year after year. Our collective response is consistent as well. The results don't apply to my organization because there is no link of responses to my agency or my board. Service limitations, lack of transportation, waiting lists, limited employment opportunities, inadequate housing and other consumer concerns are problems in the next county, the big cities or the other side of the State, not here. We all complain about consumer complaints about "survey overload". The complaints might go away if we aggressively acted on them and made some substantive improvements in these areas of consumer concern.

The number and dispersion (rural, urban, north/south, east/west, male, female) of participants in the CQRT project during the past five years is certainly adequate to support the findings of the surveys as a barometer of system function anywhere in Ohio. It's time to act. QRS has set aside a limited pool of money to help support BHG Board and agency projects to address some of the findings of the CQRT report. Contact Larry Bosserman at BHG 513-759-6345 or Kandy Witte at QRS 513-860-2130 with your improvement idea and request for support.

BHG Spring Conference Scheduled for June 14

BHG has scheduled a Spring Conference for member boards and provider agencies. A similar meeting last June seemed to be a good way to share plans and activities for the coming fiscal year. This year's Conference is scheduled for Friday, June 14, 2002 at the meeting facilities of Edison Community College in Piqua, OH. Although the agenda has not been finalized, a number of topics have been suggested for the meeting including an update on MH

code sets; an update on the transition from the HCFA 1500 to the new ANSI 837; and, a tutorial on the MACSIS data warehouse. If you have any special topic interests, contact Larry Bosserman at BHG prior to May 15. Phone: 513-759-6345. E-mail: bosserman@bhg.org. Fax: 513-759-6326.

HHS Announces Privacy Rule Changes

On March 21, 2002, HHS Secretary Thompson proposed changes to the HIPAA privacy regulations needed to fix problems with the previously published rule that otherwise could make it more difficult for patients to get quality care quickly and easily. The proposed changes were issued in response to the thousands of comments from hospitals, physicians and other healthcare providers that identified unintended barriers to the timely provision of care. For example, under the rule as promulgated, a sick patient would be forced to visit a pharmacy in person to pick up a prescription—she could not send a family member or friend instead. Similarly, a healthcare provider such as a hospital or specialist would be unable to use health information from a referral source until the first face-to-face encounter with the patient at which consent to use the information would be obtained. The changes proposed by the Secretary and published in the March 28, 2002 *Federal Register* are intended to address the possible adverse effects of the final privacy standards on an individual's access to, or the quality of, health care. The modifications touch on five key policy areas including consent, notice of privacy practices, business associates, research and marketing.

Perhaps the most controversial proposed change is elimination of the requirement for written consent to use or disclose protected health information (PHI) for treatment, payment and healthcare operations. Apparently, the consent requirement posed many difficulties for access and operations essential to quality care, especially in relation to sharing information among providers in the continuum of care. The consent requirement also created costly administrative burdens such as tracking the status and revocation of consents that were not foreseen. Although the proposed rule eliminates the requirement for written consent, covered entities may obtain such consent if they choose.

In spite of the elimination of the consent requirement, HHS proposes to preserve the opportunity for an entity with a direct treatment relationship with an individual to engage in a meaningful communication about the provider's privacy practices and the individual's rights by strengthening the notice requirements. Under the Privacy Rule, a provider is required to distribute to individuals their Notice of Privacy Practices no later than the date of the first service delivery after the compliance date (April, 2003). The change would not affect the distribution requirement, but would add a new documentation requirement. The provider will be required to make a good faith effort to obtain the individual's acknowledgment of receipt of the notice provided at first service delivery. The form of acknowledgment

is not prescribed, but left up to the provider. If the good faith effort fails, documentation of the attempt would be required.

For business associates, the modifications do not change the standards for contracts or the implementation specifications with respect to the covered entity's responsibilities for managing them. However, as part of the proposal, HHS included model business associate contract language in response to requests, particularly from small health care providers. The proposal also gives entities additional time to review their existing business associate contracts and to conform written contracts to the privacy standards. Under the proposal, a covered entity's written business associate contracts, existing at the time the modifications become effective, would be deemed to comply with the privacy standards until such time as the contracts are renewed or modified or until April 14, 2004, whichever is earlier. This provision eliminates the necessity to rewrite all contracts prior to the April, 2003 compliance deadline.

The Privacy Rule included extensive criteria which an Institutional Review Board (IRB) or Privacy Board would have to review to approve a waiver of individual authorization for use/disclosure of PHI for research purposes. The proposed modification would simplify and reduce the number of criteria required for an IRB or Privacy Board to approve a waiver of authorization. The net effect of the modifications would be to reduce the time necessary to review and act on waiver request.

According to the Privacy Rule, certain health related communications are subject to special conditions on marketing communications, if they also serve to promote the use or sale of a product or service. These marketing conditions require that particular disclosures be made as part of the marketing materials sent to individuals. Absent these disclosures, PHI can only be used or disclosed in connection with these marketing communications with the individual's authorization. The conditions for health related communications create a potential burden on covered entities to make difficult assessments regarding many of their communications. The proposed modifications to the marketing provisions would relieve the burden on covered entities by making most marketing subject to an authorization requirement and eliminating the statutory conditions on marketing communications.

"Privacy Rule changes will lower costs of implementation and enhanced implementation and compliance with the Privacy Rule without compromising the protection of individually identifiable health information or access to quality health care."

Behavioral Health Generations

Promoting Improved Performance and Outcomes Through Collective Voice and Action

Member Boards:

Brown County ADAMH, Georgetown, OH
Hancock County ADAMH, Findaly, OH
Logan Champaign Counties MHDAS, West Liberty, OH
Seneca Sandusky Wyandot Counties MH & RS, Tiffin, OH
Union County MH & R, Marysville, OH
Warren Clinton Counties RS, Lebanon, OH

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BHG Main	513-759-6326
MACSIS Enrollment	513-759-6329 or 888-780-0242
Web Address:	www.bhg.org

**Visit the BHG Web Site at
www.bhg.org and link to
member Boards.**

Web Site Utilization Update

The web sites for BHG member Boards and the computers provided to selected provider agencies have been in operation now for about 10 months. The web sites and computers were the centerpiece of a joint project of BHG and Quality Review Services, Inc. funded by the Ohio Department of Mental Health designed to improve the scope of information available to clients and family members in topic areas such as mental illness, substance abuse, diagnosis, treatment, medications, family assistance, housing, employment and others. The web sites also provide a vehicle for up-to-date communication about local happenings through a Board Calendar of Events, a Board News page, a provider resource link and a page for current issues.

Each month, the web host provides utilization data for each of six board web sites and the BHG site. The data is tracked at BHG and reported to member Boards, providers and the ODMH Office of Consumer Affairs. Between June 1, 2001 and March 31, 2002 there were 21,962 visits to the combined sites of BHG and its members. This number includes both first time and repeat visitors. For the 10-month period, the breakdown of visitors and length of visit by web site was as follows:

• Brown County	2076	2.85 min
• Hancock	2984	3.79 min
• Logan Champaign	1864	2.81 min
• Seneca Sandusky Wyandot	1798	3.75 min
• Union	1937	3.54 min
• Warren Clinton	1338	3.21 min
• BHG	9965	1.74 min

The difference in session length for member Boards compared to BHG may be encouraging. BHG site visitors apparently satisfy their curiosity quickly and move on as compared to Board site visitors that spend nearly twice as long at the local sites. It is hoped that the additional time at the Board site reflects interest in local news and activities and some exploration for links to other sites that provide the critical information that consumers and their significant others seek about critical issues related to recovery.