Coordinating Healthcare Operating Rules: Financial Services & Healthcare

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Agenda

- Background
- Challenges with Acceptance
- Operating Rules Changes
  - Healthcare EFTs
  - Payment and Remittance Information Timeliness
  - Claim Payment Advices (835s)
  - Standardization of EFT Enrollment Information
  - Standardization of CARCs and RARCs
  - Acceptance of NOC's by HHS
  - NACHA Healthcare RFC

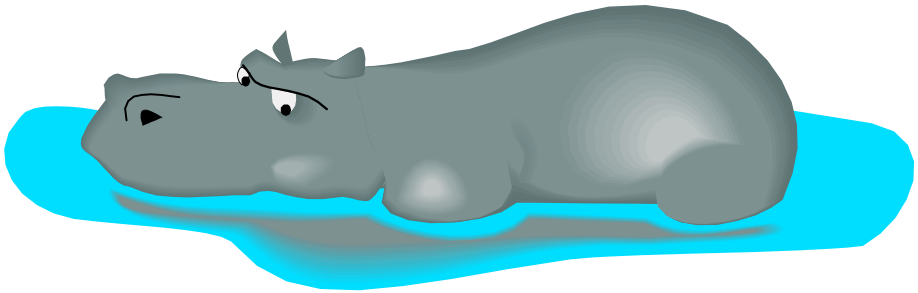
Background

1996 2004 2009 2010 2012 2014

You are here

Health Insurance Portability and Accountability Act (HIPAA)

- Transaction and Code Set Standards
  - Nine defined transactions
- Privacy Standards
- Security Standards



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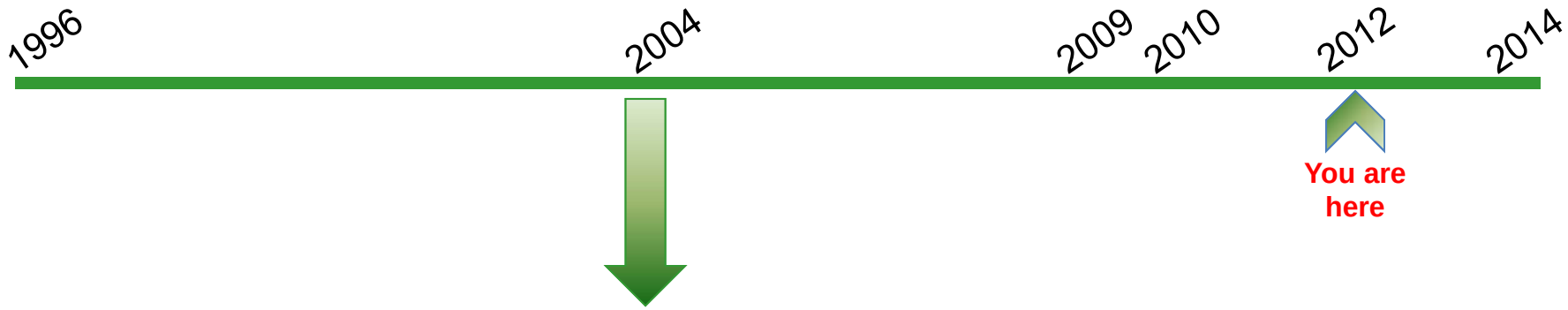
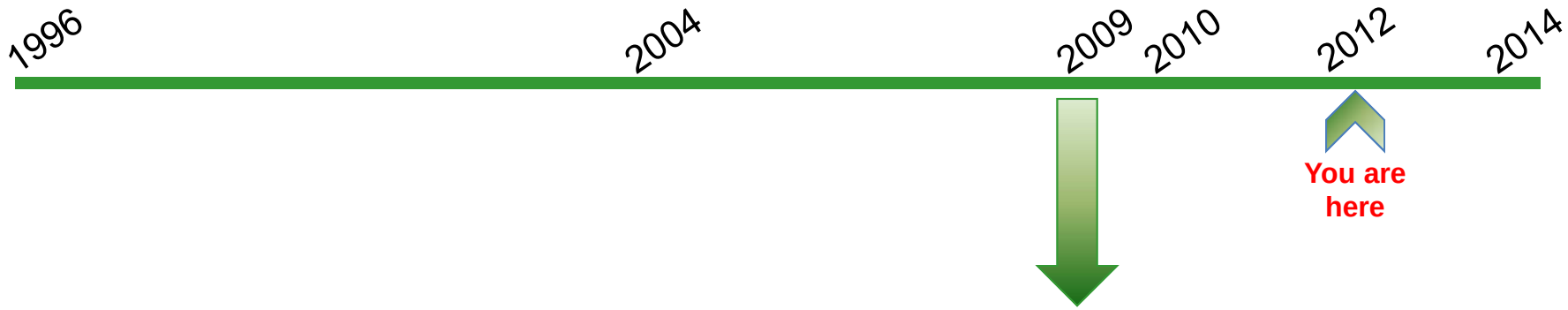


Committee on Operating Rules for Information Exchange (CORE)

- Initially sponsored by CAQH to develop "industry-wide operating rules, built on existing standards, to streamline administrative transactions"
  - Rule writing
  - Certification and testing
  - Education and outreach

CORE®
Committee on Operating Rules for Information Exchange

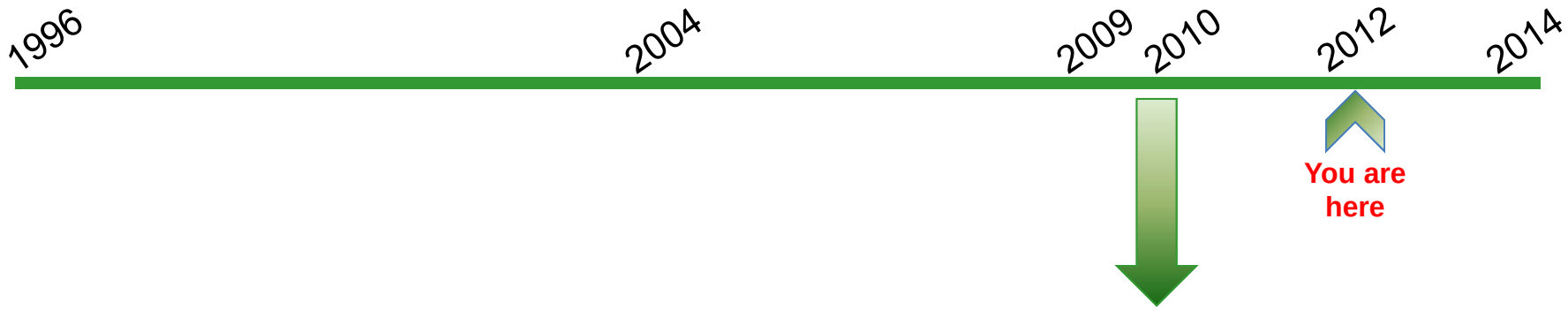
Background



Health Information Technology for Economic and Clinical Health (HITECH) Act

- Part of the American Recovery and Reinvestment Act (ARRA)
- Mandates security breach notification for HIPAA covered entities and their business associates
- Makes many obligations of business associates that formerly were only contractual now direct regulatory obligations as well.
- Enhances penalties for non-compliance with HIPAA and broadens enforcement.

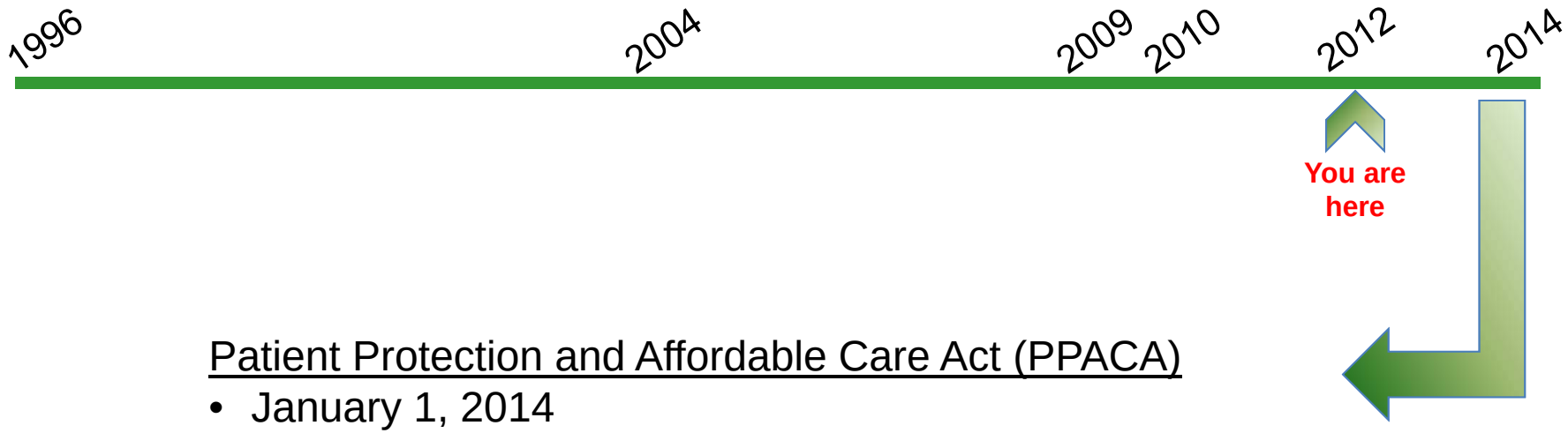
Background



Patient Protection and Affordable Care Act (PPACA)

- Part of the American Recovery and Reinvestment Act (ARRA)
- Section 1104 – Administrative Simplification
  - Mandates electronic payments by Medicare beginning Jan.1, 2014
  - Authorizes the creation of operating rules developed by a not-for-profit entity to be named by the Secretary of Health and Human Services

Background



Patient Protection and Affordable Care Act (PPACA)

- January 1, 2014
  - Medicare makes all payments electronically
  - Operating rules for healthcare payments go into effect

Background (continued)…

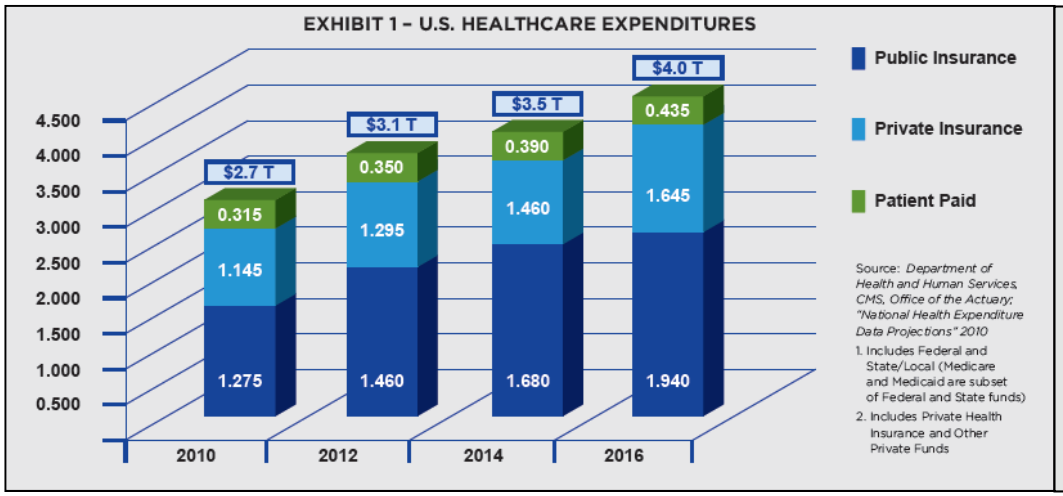
- Common Goals of Healthcare Legislation
  - Improve quality and accessibility of care
  - Provide protection for private patient information
  - Drive improved efficiency of the industry

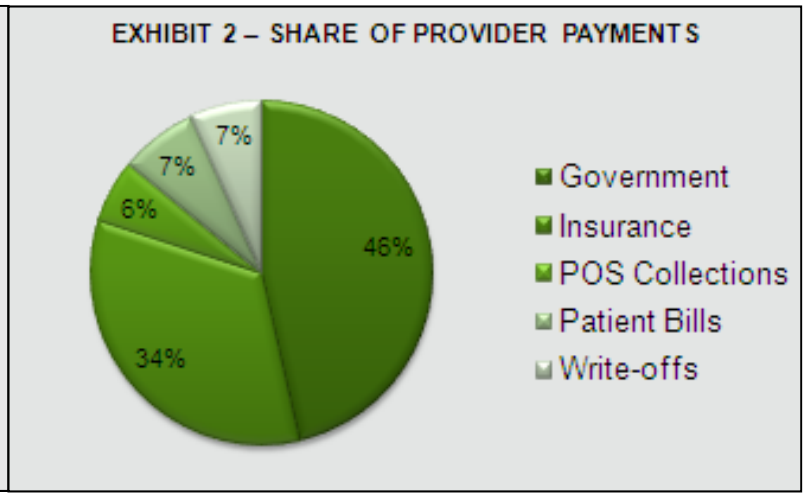
Highlights of PPACA / Administrative Simplification

- Administrative Simplification Section 1104 of PPACA – real teeth to driving cost savings – in a number of areas; in fact, this piece of legislation has very aggressive goals both in terms of automation as well as timeline
  - » Drives aggressive adoption of new EDI and procedure code data standards
  - » Specifically, PPACA also mandates rapid adoption of new operating rules to correct gaps that emerged as the industry adopted HIPAA over past 10 years. These operating rules are being established quickly and should dramatically increase availability of electronic healthcare claim payment & remittance transactions

Healthcare Payments

- Public and private insurance expenditures makeup more than 90% of all domestic U.S. expenditures (see exhibit 1)
- Over 1 trillion payments are originated by payers, providers and patients
  - 80% of all healthcare related payments are originated by the U.S. Government and commercial insurance carriers (see exhibit 2)





HR 3590 Patient Protection and Affordable Care Act: Section 1104

The concept of operating rules was addressed in the health reform bill in section 1104, which focuses on administrative simplification. Requires the Secretary to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purposes of financial and administrative transactions.

Source: NACHA-EPCOR Payments Conference 2011

Challenges with Acceptance

understood ↑

- Information on EOBs better than 835s
- No re-association needed when dollars and data arrive together in the mail
- Limited budget for investments in payments technology, particularly at smaller practices
- Non-standard authorization terms
- Non-standard ERA implementations / Companion guide overload
- Data collection & maintenance overload (for enrollment)

Healthcare EFTs

- EFT payments are incorporated into HIPAA
  - Not originally part of the nine approved transactions
- CCD+ is the approved standard
  - CTX is referenced, but not officially endorsed
- Addenda data must incorporate the v5010 835 TRN segment
- Addenda data must be provided by the financial institution upon request

Interim Final Rule issued
Jan. 10, 2012
Federal Register, Vol. 77,
No. 6, pages 1556 - 1590

Implications

- Plans will be required to offer an EFT option (although Plans will still control the terms of the enrollment).
- CCD+ means re-association will still be needed. With CTX, re-association would not have been required.
- Addenda information on request creates business opportunities.

Healthcare Operating Rules

- Payment and Remittance Information Timeliness
- Claim Payment Advices (835s)
- Standardization of EFT Enrollment Information
- Standardization of CARCs and RARCs

CORE
Committee on Operating Rules for Information Exchange
Phase III Rules

These rules are part of a larger rules set that has been drafted by CORE. We expect a response from HHS in July/August 2012.

How many of you are either providing remittance information (835s) now or are interested in doing so in the future?

Payment and Remittance Information Timeliness

- Plans must release for transmission to Providers the v5010 835 corresponding to the CCD+
  - No sooner than three business days prior to the CCD+ Effective Entry Date, and
  - No later than three business days after the CCD+ Effective Entry Date
- The CCD+ must have a valid Effective Entry Date that corresponds to the v5010 835 BPR16

Implications

- Timing of remittance information relative to payment simplifies re-association but may have some adverse consequences for providers.
- Possible product opportunity to monitor payment receipt.
- Even if you aren't re-associating the information, you need to understand the rules if you are an ODFI or RDFI.

Claim Payment Advices (835s)

- Acknowledgements (v5010 999) are required; optional today
- Dual delivery (paper and electronic) must be available for at least 31 calendar days
  - Must encompass at least three payments
  - May be extended by mutual agreement; may be shortened by provider
- Companion Guides will still be allowed but must follow CORE guidelines

Implications

- *Most relevant to banks that process remittance information (835s)*
- More reliable service; potential product enhancement to intervene when 999s are not received timely.
- May ease concerns about conversions to electronic. Today, many payers will allow only one method for information delivery.
- Standardized Companion Guides will be easier to interpret.

Standardized EFT Enrollment

- Eight Data Element Groups; 24 Individual Data Elements; 47 Sub-Elements
  - Maximum allowable data; plans can use less
- Element Names and definitions may not be modified
- Electronic enrollment must be offered
- Instructions for completion must be provided
- Does not standardize enrollment terms and conditions

Implications

- Important first step toward a shared enrollment utility
  - Several groups interested in providing that utility, including CORE and TCH
  - Opportunity for UPIC?
- Concerns remain about adverse terms in some enrollment agreements

Standardization of CARCs and RARCs

- Four business scenarios identified
  - Add'l Information Required – Missing/invalid/Incomplete Documentation
  - Add'l Information Required – Missing/Invalid/Incomplete Claim Data
  - Billed Service Not Covered by Health Plan
  - Benefit for Billed Service Not Separately Payable
- CARCs/RARCs/CAGCs defined for each business scenario

Implications

- *Most relevant to banks that process remittance information (835s)*
- Could come into play if CTX is used
  - NACHA wants to try a CTX pilot, but the healthcare community has some reservations

CARC/RARC/CAGC

CARC – Claim Adjustment Reason Code

294 CARCs approved for use[1]

80% of claims covered by nine or fewer codes (although not the same nine – varies by payer)[2]

RARC – Remittance Advice Remark Code

824 RARCs approved for use[3]

80% of remittances use 12 or fewer codes (although not the same 12 – varies by payer)[2]

CAGC – Claim Adjustment Group Code

- PR – Patient Responsibility
- CO – Contractual Obligation
- PI – Payer Initiated Reduction
- OA – Other Adjustments

Maintained by ASC X12 to group CARCs based on financial responsibility

[1] See http://www.wpc-edi.com/content/view/695/1 for a complete list
[2] See Metrics 12, 13, and 14 on the AMA's National Healthcare Insurer Report Card at http://www.ama-assn.org/ama1/pub/upload/mm/368/2010-nhirc-results.pdf
[3] See http://www.wpc-edi.com/content/view/739/1 for a complete list

Standardization of CARCs and RARCs

- Four business scenarios identified
  - Add'l Information Required – Missing/invalid/Incomplete Documentation
  - Add'l Information Required – Missing/Invalid/Incomplete Claim Data
  - Billed Service Not Covered by Health Plan
  - Benefit for Billed Service Not Separately Payable
- CARCs/RARCs/CAGCs defined for each business scenario
- Text describing the business scenario and any CARC/RARC/CACG must be available to the end user

Implications

- *Most relevant to banks that provide remittance information (835s)*
- Easier identification and interpretation of adjustments
- Better adoption of ERAs (835s)
- More consistency in adjustment coding from payers

Acceptance of NOCs by HHS[4]

- NOCs will be accepted when issued by financial institutions as a result of other account renumbering situations (e.g., acquisition, divestiture, etc.)
- Re-enrollment will be required when account numbers are changed as a result of actions initiated by the provider

[4]NOC Rules changes were issued by HHS on November 23, 2011 (TDL-12048).

Implications

- How will HHS know if an NOC is the result of a bank-initiated action versus customer-initiated? Will NACHA have to modify the Rules?
- Addresses a big problem for banks, many of which have implemented special procedures to insulate providers during mergers and divestitures.
- Reduces the risk of a Medicare payment interruption to providers.

NACHA Healthcare RFC

- RDFI must report "CORE-required Minimum CCD+ Reassociation Data Elements" to Receivers
  - Proactive, electronic delivery within 2 banking days of settlement
  - Electronic delivery within 2 banking days, upon request
  - Proactive delivery within 2 banking days, no manner of delivery req.

Implications

- Proactive – can you set up a client in two days or less, regardless of output method?
- Upon Request – will branch and call center personnel know how to handle a request for "CORE-required Minimum CCD+ Reassociation Data Elements"?

NACHA Healthcare RFC

- Identification of a healthcare payment – alternatives:
  - Entry Description ("HCCLAIMPMT") in the Type 5 record
  - Discretionary Data Field ("HX") in the Type 6 record
  - New Originator Status Codes in the Type 5 record
    - Will any one suffice or do you need two to be certain?
    - What edits or activities might be triggered by a healthcare pymt?
      - EFT data delivery?
      - Addenda edits?

Implications

- NACHA was concerned about adding a new Standard Entry Class code. Do these options make it easier?
- Have you considered what you would do differently if you could differentiate a healthcare payment from other payments?

NACHA Healthcare RFC

- Inconsistencies between X12 standards and NACHA standards
  - ASC X12 allows a variety of delimiters; NACHA requires a "*" between fields and a "\" at the end (see 2012 NACHA Rules, page OG270)

Implications

- This is technical issue that needs to be resolved. The X12 standard allows more delimiters than NACHA, including "<", ">","^", and "~". A transaction using one of these delimiters would be in compliance with X12 but not in compliance with NACHA Rules.

Wrap – up / Questions?

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