



FIFTH THIRD BANK



Preparing for Healthcare Reform and Administrative Simplification: Key Strategies and Benefits for Providers

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Disclaimer

The authors of this white paper have based their projections on how APA administrative simplification might evolve and the potential impacts of that process on the industry. One author, Steve Lazarus, has been a consultant to CAQH CORE since 2005 and has been involved with the WEDI Health Plan ID card Implementation Guide Workgroup at times as a volunteer. He also has extensive industry experience with providers and health plans and served on the WEDI Board of Directors for 17 years. The views expressed here are not those of CAQH CORE or WEDI. The views are based on an independent analysis conducted and the discussions that took place in these workgroups over the past several years. All of these discussions were open to the members of the respective organizations who chose to participate in the discussion. This paper does not contain legal advice and is to be used for educational purposes only.



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Introduction

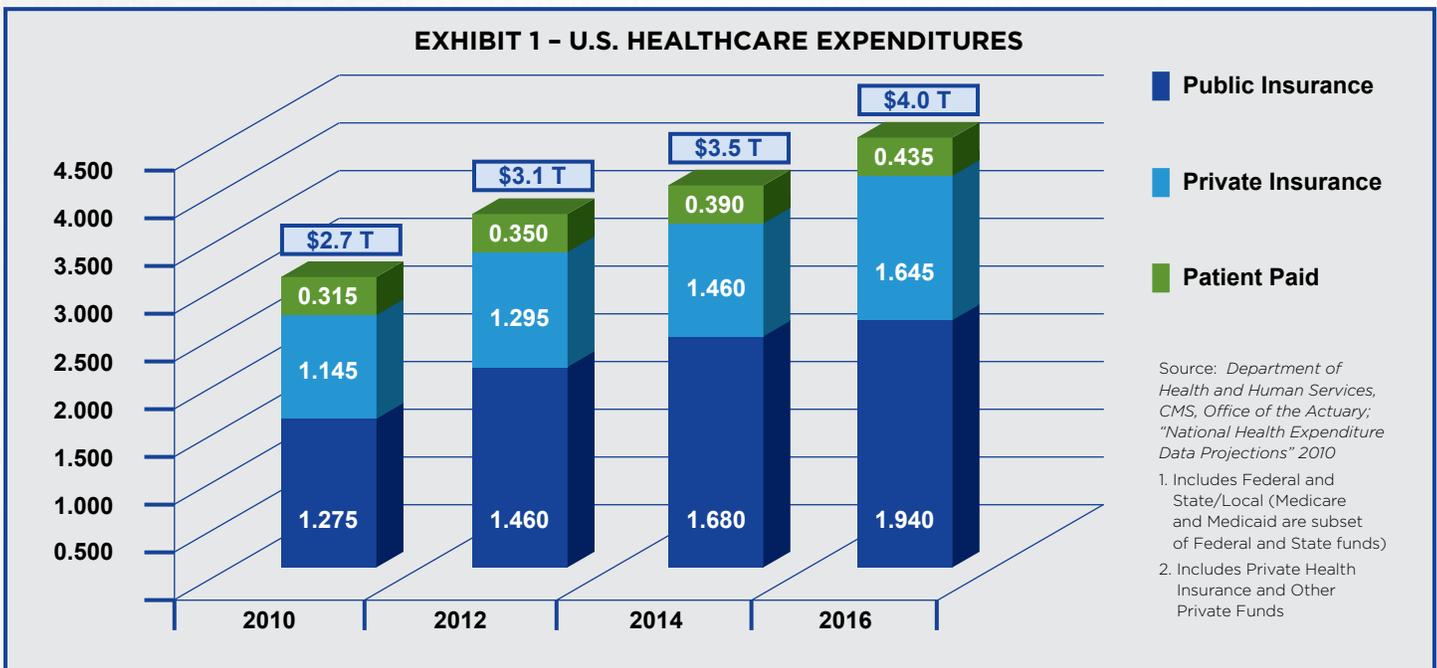
As a result of sweeping healthcare industry reforms passed under the Patient Protection and Affordable Care Act of 2010 (PPACA or commonly referred to as “Healthcare Reform”), providers will be required to radically alter the way they handle basic administrative processes with the goal of reducing administrative costs in the nation’s healthcare system.

Pending Administrative Simplification rules will target inefficiencies around the medical claim payments process, which has been identified as a potential source for significant cost savings. The existing claims process, which is predominantly paper-based and requires manual manipulation, is rife with inefficiencies and presents both challenges and opportunities for the industry. The combination of Administrative Simplification mandates, industry efforts, and advances in technology solutions are ushering in a transition from paper to electronic processes—delivering critical savings for the healthcare industry and facilitating compliance to coming mandates.

The intent of this white paper is to provide current information on this evolving topic and to encourage a dialogue around Administrative Simplification, helping providers gain a more thorough understanding of the potential implications of new rules on their business operations.

1. Industry Context

Healthcare is a \$2.7 trillion industry in the United States¹ (see Exhibit 1 below), representing approximately 17 percent of U.S. gross domestic product (GDP), and expected to grow annually and exceed \$4.0 trillion in the next decade. Currently, the industry is experiencing unprecedented change. The combination of recent legislation, industry efforts, technology innovations, and overall economic conditions have presented an evolutionary mandate and a significant opportunity for seismic change in the healthcare industry. However, due to the enormous scale of the industry and the highly regulated nature of administrative processes and patient care, the challenges are considerable.



¹ Source: Department of Health and Human Services, CMS, Office of the Actuary; National Health Expenditure Data Projections, 2010



Starting with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the U.S. Government has increasingly focused attention on the administrative waste in the U.S. healthcare system. HIPAA introduced initial data standards and practices designed to begin creating processing efficiencies in the healthcare claim payment cycle.

In 2009, the American Recovery and Reinvestment Act (ARRA) was passed into law, which included passage of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009. This legislation furthered the HIPAA standards with mandated adoption of updated versions (v5010 and ICD-10), and added government incentives for industry adoption of electronic medical record (EMR) capabilities to improve overall efficiency and accuracy. The recently passed Patient Protection and Affordable Care Act (PPACA) of 2010, also known more commonly as “Healthcare Reform,” expands upon former efforts to foster what is called Administrative Simplification.

During the past several years, the healthcare reform debate has focused significant attention on the administrative costs of healthcare. According to some estimates, just over 30 cents of every dollar spent on healthcare in the U.S. is consumed by administrative costs². As a leading focus of Administrative Simplification, reducing the inefficiencies in the medical claim payments process has been targeted as an area that could result in significant cost savings.

The challenges posed by inefficiencies in the medical payments process are substantial. The healthcare payment cycle is far less efficient and much more complicated than payment processes for any other industry. The claims process is costly and prone to error with a sizeable number of claims requiring resubmission by healthcare providers seeking payment. Furthermore, payments and the related remittance data are predominantly paper-based (90 percent of all payments are via check³) and often travel different paths, arriving at different times.

Solving these challenges will allow the industry to realize enormous improvements in efficiency. According to a 2009 UnitedHealth working paper, there are approximately \$161 billion in savings opportunities possible through full adoption of integrated electronic payments and remittance advices⁴. This will not be easy to achieve and will require close analysis, tough decisions, technology investments, process changes, and the sincere commitment of numerous industry participants. Candid dialogue and leadership will be required to cultivate efficient solutions that deliver tangible benefits to all industry participants.

2. Document Purpose

In furtherance of the Administrative Simplification goals mentioned above, specific sections of recent legislation expand upon HIPAA transactions and code sets in ways that are designed to promote efficiency and support the transition from ICD-9 to ICD-10. There are also provisions regarding changes in reimbursement levels for Medicare. This paper is focused on a relatively narrow portion of the legislation which addresses changes in the way provider organizations and healthcare insurance companies exchange information and have business relationships with one another. In general, these changes include potential improvements to the revenue cycle process resulting in significant productivity and cost saving opportunities.

² Source: PNC Bank; *PNC Healthcare Industry Study*, 2007

³ Source: U.S. Healthcare Efficiency Advisory Council, *National Report on Healthcare Efficiency*, 2010

⁴ Source: UnitedHealth Center for Health Reform and Modernization; *Working Paper 2 – Healthcare Cost Containment – How Technology Can Cut Red Tape and Simplify Healthcare Administration*, July 2009

The following topics are included in this white paper:

- Operating rules to improve the functionality and efficiency from using the HIPAA standard transactions, code sets, and identifiers
- ICD-9 to ICD-10 crosswalk

The following topics are excluded from the focus of this white paper:

- New provisions for healthcare insurance
- Changes in the Medicare reimbursement levels
- Health insurance tax incentives for employers
- All workforce requirements included in the legislation
- Health Savings Account (HSA) changes, including the exclusion of over-the-counter items as being eligible for tax exempt payments

The purpose of this paper is to understand how other aspects of Healthcare Reform, mostly in the areas of administrative simplification, affect the business operations of providers with regard to electronic administrative transactions. This discussion is intended to afford providers an understanding of how they can prepare to take advantage of increased interoperability, real-time access to health plan information, and other performance criteria in order to operate more efficiently and be more productive in their revenue cycle management.

The legislation spells out specific timeframes for the publication of regulations, which will specify requirements for the administrative simplification, as well as the dates when they will become effective. This is a multi-stage approach, allowing time for development and deployment of these changes over several years.

There is very little descriptive detail included in the legislation, such as specifics on the operating rules and other aspects of administrative simplification. The Administration's first indication of how the Operating Rules will be implemented occurred on September 30, 2010 when the National Committee on Vital and Health Statistics (NCVHS) issued a letter to the Secretary of HHS recommending the designation of CAQH CORE (www.caqh.org) as the Operating Rules development entity for a medical component of the industry for the eligibility and claims status transactions, and NCPDP for the retail pharmacy component of the industry for eligibility and claims status. CMS, the agency within HHS that will publish the final rules on operating rules, worked very closely with NCVHS in reaching this recommendation.

This paper will discuss reasonable expectations of what may happen over the next few years as regulations are issued and implemented with detailed specifications. This information is provided as background to assist provider organizations (and their system vendors and business associates) to prepare strategically and operationally for these changes, with the understanding that some of the expected specifications may not materialize in the precise form described herein.

The specific sections of the legislation that are addressed in this white paper include the following:

- 1104 – Administrative Simplification
- 10109 – Development of standards for financial and administrative transactions

3. Administrative Simplification

Section 1104 of Healthcare Reform, Administrative Simplification builds upon existing HIPAA transactions and code set standards that require the use of “operating rules” which are defined in the legislation as the “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.” The purpose of these operating rules is to reduce the clerical burden for patients and providers.

The legislation goes on to describe a process for the development and adoption of operating rules and their effective dates. The discussion that follows in this section is developed based on the specific dates in the legislation for implementation and compliance, as well as the subject matter of the operating rules. As is normally the case, the legislation does not specify the details of the operating rules, but does name the topics or types of rules that will be developed. The process for establishing these operating rules and the health plan identifier were initiated on July 19-21, 2010 when the National Committee on Vital and Health Statistics (NCVHS) held public hearings as the first step of providing input to HHS CMS as it develops the regulations to promulgate these rules. This committee also held public hearings on another set of operating rules on December 3, 2010. The testimony and documents from these hearings can be found at www.ncvhs.hhs.gov.

Exhibit 2 below lists the Operating Rules and their timeframe specified in the Affordable Care Act, with adoption dates ranging from July 1, 2011 through July 1, 2014, and effective dates ranging from January 1, 2013 through January 1, 2016.

EXHIBIT 2 - OPERATING RULES AND THEIR SPECIFIED TIMELINES IN THE AFFORDABLE CARE ACT		
Operating Rule	Adoption Date	Effective Date
Eligibility (270/271)	July 1, 2011	January 1, 2013
Claims Status (276)	July 1, 2011	January 1, 2013
EFT	July 1, 2012	January 1, 2014*
Payment and Remittance Advice (835)	July 1, 2012	January 1, 2014*
Health Plan Identifier	July 1, 2012	January 1, 2014
Health Claims and Attachments	January 1, 2014	January 1, 2016**
ICD-9 to ICD-10 Crosswalk (Section 10109)	No date specified	No date specified***

Notes:

- * Health plan certification of compliance required by Dec. 31, 2013
- ** Health plan certification of compliance required by Dec. 31, 2015
- *** Review process by Jan. 1, 2011 and ICD-10 required by Oct. 1, 2013

Most of these operating rules are required by the legislation. However, ICD-10 compliance use is mandated by October 1, 2013 under the ICD-10 HIPAA regulation. HHS may also choose to include operating rules for a Machine Readable ID Card and health plan enrollment. For ICD-9 to ICD-10 crosswalk, a review process is required by January 1, 2011.

In addition, health plans must certify compliance before the effective date for several operating rules. This health plan certification is a new (HIPAA) requirement. Its form is not specified in the legislation. It may take a form similar to the covered entity certification for transactions and code sets that was required under the Administrative Simplification Compliance Act (ASCA) in 2002 where an officer of the covered entity completed a form and submitted it to CMS, attesting to the fact that the organization had a plan in place to become compliant with the HIPAA transactions and code sets by the regulatory compliance date. In this case, the attestation by an officer would be to document that the health plan was in compliance with the operating rule specification prior to the compliance date.

These deadlines are extremely aggressive and there already is discussion in the healthcare industry about whether or not these dates will be allowed to slip, especially based on the relatively drawn out adoption of similar mandates in HIPAA which extended from when the legislation was passed in 1996 to initial adoption in 2003. The current administration, however, appears to be acting aggressively in implementing Administrative Simplification and other provisions of Healthcare Reform.

Although the legislation was passed in only April 2010, hearings were quickly scheduled by CMS for NCVHS to receive input from the industry on the operating rules and health plan identifiers on July 19-21, 2010. A second public hearing was held on December 3, 2010 to gather input on operating rules for EFT and ERA. Based on this early start and the action of NCVHS in September 2010 to recommend operating rule development organizations (NCPDP for retail pharmacy and Council for Affordable Quality Healthcare for all other medical operating rules), it is likely that the 2011 deadlines for these provisions in the legislation will be met for adopting regulations. CAQH CORE has developed voluntary operating rules for five years, some of which are the basis for the operating rule components of the Healthcare Reform legislation.

In addition, NCVHS is expected to make recommendations on EFT and ERA in the first quarter of 2011, which should provide time for adoption of these operating rules by July 1, 2012. CAQH CORE seems well positioned to become the recommended entity for the second set of operating rules. There is, of course, always a chance that priorities may change and issues can be raised during the process, which might present challenges requiring resolution prior to adopting a regulation.

3.1. Introduction to Operating Rules as Addressed in the Affordable Care Act

The first sets of regulations under Administrative Simplification are scheduled to be adopted by July 1, 2011. Various regulations (as described below), are planned for adoption through July 1, 2014, with effective dates for compliance ranging from January 1, 2013 to January 1, 2016. In some cases there are no dates specified for adoption or effective compliance. Instead, a study or review is required by a specified date. Adoption refers to the publication of a final rule (regulation) and effective compliance refers to the compliance date included in the regulation, at which time every affected party must be in compliance with the regulation. While not specified in the legislation, the background behind the rationale for including operating rules in this legislation is based on expected cost savings for health plans, providers, and patients/employers through the use of more efficient communication of standard electronic information between providers and health plans to support interoperability, including the use of electronic information within trading partner systems to make business decisions. The legislation does not specify the organization that will manage the operating rules process; however, many of the operating rules identified for early adoption are the same ones that the Council for Affordable Quality Healthcare (CAQH) has already developed under its Committee on Operating Rules for Information Exchange (CORE) initiative in the 2005-2010 timeframe. In September 2010, NCVHS recommended to the Secretary of HHS that CAQH CORE be the operating rule development entity for eligibility and benefits (for non-retail pharmacy transactions), and claims status operating rules⁵.

Some of the key characteristics of the key CORE Operating Rules are the following:

- Consensus based
- Developed based on existing standards, not in conflict with standards
- Utilize standards from a variety of sources based on the business need, including ANSI X12 and others

⁵ Source: <http://www.ncvhs.hhs.gov/100930lt2.pdf>

- Supportive of the business process and exchange of information between providers and health plans
- Vendor neutral
- Sensitive to existing propriety approaches and standards in use
- Include consideration of cost and value

To date, the CORE Rules tend to fall into one of two categories:

1. Infrastructure rules which promote interoperability and exchange of information to support business processes. Examples of infrastructure CORE Rules include:
 - Real-time transactions for eligibility and claims status inquiry, with an average response time of under 20 seconds
 - Specified response times for batch transactions
 - A requirement that all health plans that are CORE certified support real-time eligibility and claims status inquiry and response (they may also support batch, but they must support real-time)
 - A floor of health plan systems availability to respond to real-time and eligibility and claims status transactions of at least 86 percent up time per week
 - A connectivity rule which provides for a choice of two options for interoperable connectivity including security
 - Required use of standard acknowledgements
2. Enhanced data content to the information exchange, usually building beyond the requirements of the HIPAA X12 standards by requiring the use of specific data elements that are specified as “situational” in the standard. Examples include:
 - Reporting of remaining deductible in the 271 eligibility response
 - Report of eligibility and benefit coverage for specific service categories in the 271 eligibility response
 - Health plan response reporting specific periods of eligibility coverage in the 271 eligibility response
 - Required use of specific error codes in acknowledgements

Since 2005, as the CORE Operating Rules have been developed, the use of the rules has been voluntary. Health plans, vendors, clearinghouses, and providers publicly demonstrate their commitment to the CORE Operating Rules by going through a formal certification process, which includes partial testing by an independent third party. Those entities that are currently certified for Phase I and/or Phase II rules are found at www.caqh.org/core_organizations.php.

The Colorado Insurance Commissioner issued a regulation (4-2-32) that went into effect October 1, 2010 for all health plans and providers in the State of Colorado, requiring that they implement and comply with the CORE Phase I and Phase II Operating Rules. This is the first state to require compliance with these rules. The compliance date is September 1, 2012. That is four months sooner than the effective date for the eligibility and claims status operating rules under the Affordable Care Act. That means that all of the national health plans and the regional plans that do business in Colorado will have to be in compliance with this requirement under state law four months sooner than the national legislative expected effective date.

3.2. Eligibility Operating Rules (Effective January 1, 2013)

PPACA provides for eligibility operating rules, without specifying their scope. CORE Operating Rules Phases I and II that have been developed since 2005 include the following for eligibility: (Additional operating rules are under consideration for Phase III (2009-2010). The operating rules recognized and adopted under the Affordable Care Act will likely be based on these eligibility operating rules.)

1. Eligibility data content rule specifying that particular service coverage codes be returned in the eligibility response if requested in the eligibility inquiry transaction. The CORE Phase II data content rule requires reporting the remaining deductible amount, plus static co-insurance information in the response, as well as the mandatory use of additional service type codes (a total of 46 service type codes). Some of these service type codes are required in the 5010 version of the eligibility and benefits transactions, which are required in 2012 (under HIPAA), so they will not need to be addressed by the operating rules after January 1, 2012.
2. Batch response time requiring that eligibility inquiries submitted by 9:00 pm Eastern Time must be returned by 7:00 am Eastern Time the following business day.
3. Real-time mode response time requirement stipulates that from the time of submission of an eligibility inquiry, a reply must be made in 20 seconds or less, including eligibility and benefit response transactions and acknowledgements.
4. System availability requirement that primarily health plan systems must be available no less than 86 percent per calendar week for both real-time and batch processing modes.
5. Connectivity Rule: CORE certified entities must be able to implement HITTP/S Version 1.1 over the public Internet as a transport method for eligibility inquiry and response transactions. An XML specification and a Web services definition language (WSDL) specification are included.
6. Companion Guide Operating Rule: All CORE certified entities' Companion Guides covering 270/271 eligibility inquiry response transactions must follow the format/flow as defined in the CORE 270/271 Companion Guide Template for HIPAA Transactions.
7. Use of specific batch acknowledgement transactions as specified.
8. Use of real-time acknowledgements as specified.

CAQH CORE commissioned an independent study by IBM of industry-wide savings projections from the use of the CAQH CORE Phase I Operating Rules, which address infrastructure and eligibility and benefit verification. The participants included six national and regional health plans, representing 33 million commercial members and 1.2 million providers. Together they accounted for 22 million eligibility verifications per month and approximately 30 million claims per month. Five clearinghouses and vendors, and six providers, including hospitals, physician groups, and surgical centers participated.

The key results from the IBM study were that individual health plans had an average savings of \$2,666,800 as a result of shifting telephone to electronic transactions with providers incurring initial one-time implementation costs averaging \$542,800. Total electronic eligibility was up 33 percent in one year for participating health plans.

Provider benefits realized included the following:

- Decrease in claim eligibility denials ranged from 10 to 12 percent
- Increased patients verified by 24 percent
- Riders saved an average of seven minutes per electronic verification versus telephone, with an estimated savings of \$2.60 per verification
- Verifying and collecting the patient liability at time of service for every visit reduces bad debt and collection costs
- Direct connect to health plans reduces clearinghouse fees

Based on an estimated 1.3 billion eligibility verifications per year in the United States, and a savings of \$4.60 per transaction, based on a ramp-up over the next three years of percentage of visits verified with CORE Phase I eligibility, an estimated annual savings of \$1.86 billion dollars per year is expected.

Key Anticipated Benefits for Providers

By requiring all health plans (currently voluntary, but eventually required under PPACA) to meet the infrastructure operating rules of real-time eligibility transactions, high level of available access across the 24-hour by seven day work week, and a data rich eligibility response with remaining deductible, specific benefits, and detailed information on the date range of eligibility, providers will be able to rely on a consistent process for integrating real-time transactions for eligibility and benefits verification into the work processes of registration through collection. For providers, the benefits include:

- Eliminate need for costly phone based eligibility checks
- Reduce claim denials / rejections
- Better estimate patient responsibility at the time care is delivered
- Improve working capital
- Increase patient collections at the time of service
- Lower collections costs
- Lower bad debt due to accelerated patient collections
- Reduce patient frustration around the uncertainty of their benefits and amount owed

3.3. Claims Status Operating Rules (Effective January 1, 2013)

The CORE claim status rule is included in CORE Phase II. It is designed to support electronic claims status inquiries and responses to provide for:

- Less staff time spent on phone calls and websites to track outstanding claims that have been submitted
- Increased availability to conduct targeted follow-up on claims in process
- More accurate and efficient processing and payment of claims

The 276/277 claims status inquiry and response transactions are designed to do more than let a provider know if a claim has been received or not by the health plan to which it was submitted. However, the ASC X12 277 claims status response standard for Versions 4010 and 5010 do not require the robust response needed by providers to determine what actions to take on outstanding claims. Specifically, information such as pre-adjudication acceptance or rejection by the health plan, and incorrect or incomplete claim is pending, or the claim is suspended and additional information is being requested, are useful status reports to assist providers in knowing what specific actions to take to manage claims that are not proceeding directly to adjudication.

Because claims status inquiry response is designed to be a real-time transaction to support business office operations in hospitals and physician practices, the claim status CORE operating rule includes the infrastructure components of real-time, systems availability, and standard use of acknowledgements as the infrastructure characteristics of the eligibility inquiry and response operating rules, described in Section 3.2. In part, the CORE claims status rule is designed to eliminate the “black hole” where claims are submitted to a health plan, but the health plan cannot find them and the information available is insufficient to easily track down whether the problem resides with the process of the provider sending the claim and the health plan receiving it, or whether the problem lies within the internal operations of the health plan.

The “black hole” claims submission problem was significant across the healthcare industry when it implemented Version 4010 of the claims transaction (837) in 2003. There were numerous articles citing “lost” claims, and in most cases the audit trails were insufficient to readily track what had happened to them. In some cases, it is likely that the problem was associated with the significant changes that most health plans made to implement 4010 in their information systems and front-end transaction receiving applications. When substantial changes of a large project scope comparable to implementing 4010 or 5010 are being made throughout an industry, it is likely that some of them will have problems. The healthcare industry may face the same issue again during the end of 2011 when the 5010 version of the HIPAA transactions and code sets are implemented. In addition, this problem continues to persist at some level, and the only tool that providers have to manage the claims submission process from their perspective is to utilize the claim status inquiry transaction and response to identify whether or not a claim has been received by a health plan and what its status is in the adjudication process.

The only two alternatives to utilizing the 276/277 electronic transactions to manage this process from a provider perspective are to:

- Wait until the claim adjudication information is received, even if it is past due
- Call health plans on the phone and have them do the research to determine what the status is on claims that are outstanding beyond normal adjudication cycle patterns

Neither of these options promote efficient operations for providers, and the second contributes to health plan inefficiency by having to respond to telephone calls and do research on problems, both of which take human and other resources to accomplish.

The CORE Claims Status Operating Rules are designed to empower providers with the tools to manage the process of tracking and resolving problems associated with claims that are not adjudicated in a timely fashion by the health plans.

Key Anticipated Benefits for Providers

By adopting the CORE operating rules for Claims Status transactions, this will force more meaningful responses from health plan providers. These operating rules include the requirement of a standardized infrastructure for support of real-time and batch processing, as well as system availability requirements, and improving accessibility of responses. In addition, response transactions will become more informative, including the reporting of receipt and claims errors submitted.

Further enhancements of the claim status inquiry and response may be considered in developing the first or subsequent versions of the operating rules, including an expanded set of standard codes to describe the types of errors and provide more specificity to the status level of claims that have been received and accepted.

The information provided on a timely basis under the CORE Claims Status Rule provides a uniform infrastructure that enables providers to manage their outstanding claims without telephone calls. “Black hole” problems can be identified early and acted upon with claims being resubmitted or contacting the health plan directly to work through the problem.

3.4. Machine Readable ID Card Operating Rules (Effective January 1, 2013)

Even though mandated, the legislation provides no specific details about machine-readable ID operating rules. However, the Colorado Insurance Commissioner, in implementing Colorado Senate Bill 135 in 2010, and CAQH CORE as part of its Phase III Operating Rules in 2010, addressed certain aspects of operating rules for machine readable health plan ID cards. Standardized Electronic Identification and Communication Systems Guidelines for Health Benefit Plans, Colorado Regulation 4-2-32, went into effect on October 1, 2010. It initially provides for the requirement of all health plans doing business in the State of Colorado under the purview of the Insurance Commission to be able to support real-time data exchange for eligibility and benefits, following all CORE guidelines for data formats and system requirements. Furthermore, CORE Phase I certified health plans are required to become CORE Phase II certified within one year of completing the certification for CORE Phase I. This latter requirement will likely be overridden by the federal operating rule requirement for both Phase I and Phase II Operating Rule components for eligibility and claims status to be implemented by January 1, 2013, except in those cases where the health plan is certified for CORE Phase I prior to January 1, 2012, in which case an earlier date is required for Colorado.

In its HPID enumeration scan (Appendix A to the NCVHS letter to the Secretary of HHS on September 30, 2010), NCVHS noted that MGMA estimated an annual savings of \$1 billion dollars through the use of a standard health identifier card (page 13). The NCVHS report did not include the assumptions or details behind the estimate. One of the benefits referenced in MGMA press releases is that having a standardized machine readable ID card reduces input errors in the physician’s office and hospital, which translated into a 50 percent reduction in denied transactions.

Since 2005, there has been an interest in having standard health plan ID cards used throughout the industry. The Workgroup for Electronic Data Interchange (WEDI) responded to this business need by creating a health plan ID card implementation guide in 2007. Use of the guide is voluntary. The guide incorporates both print and machine readable versions of the card and provides for cards that are health plan only; health plan and prescription drug plan; health plan and dental plan and other combinations of plans on the sample card. In addition, it permits the use of individual cards for each benefit.

Some health plans have followed the WEDI Implementation Guide for issuing their ID cards, whereas others have followed parts of the guide, and still others follow proprietary formats inconsistent with the guide. Having a standard print format on health plan ID cards makes it easier for provider office staff to find the information they are looking for because it will always be in the same place on the card. In addition, all cards that follow the guide will include in the print format all of the required data elements. One of the shortcomings of the print version of the card is its limited real estate, so potentially there won't be enough room to accommodate long names, multiple long names for the subscriber and each dependent, and/or multiple insurance plans (medical, dental, drug, vision, behavioral health, etc.).

Because there are physical space limitations on the human readable version of health plan ID cards and limited space on the machine readable version of these cards, most healthcare stakeholders who have studied this issue recognize that the solution to obtaining detailed information on a timely basis about an individual's eligibility and benefits, as well as information needed to file a claim, is best obtained by utilizing the eligibility inquiry and response transaction. The routing of the eligibility, claim and other transactions based on the card issuer identifier or the health plan identifier, together with other information, is an infrastructure issue, which may also be addressed by the Affordable Care Act operating rules. Based on that assumption, one of the important aspects of the health plan ID card is to be an access key for use in conducting the eligibility and benefit inquiry and response transaction. That is, the health plan ID card has to have enough information on it to enable the provider to successfully conduct a 270 eligibility inquiry transaction in order to receive back a detailed 271 eligibility and benefit response (with PPACA operating rules establishing the minimum data requirements to provide all of the information that is needed to file a claim and determine eligibility and benefits).

The NCVHS discussed this issue in its July 2010 hearings. NCVHS recommendation 8.1 in its letter to the Secretary of HHS on September 30, 2010, "encourages the use of the HPID in health plan identification cards."⁶

Machine readable cards are thought to have the advantage of transferring data from the card to the provider's billing system computers without data entry, thereby increasing productivity and reducing data entry errors associated with this process. The machine readable plastic cards following the same ISO standards as the one used by bank cards, has space on the magnetic stripe for health plan ID and subscriber information, but the space is limited. The ISO standard provides for four required data elements:

1. Card issuer identifier (may or may not be the health plan)
2. Subscriber first name
3. Subscriber last name
4. Subscriber identifier

In addition, optional data elements are permitted including date of birth. As the CAQH CORE workgroup investigated machine readable ID cards and operating rules to use them in 2009-2010, the subgroup identified several limitations which needed to be addressed in order for operating rules to be developed and used. The following are among the issues that are likely to be considered under the healthcare reform legislation implementation of machine readable ID card's operating rules:

1. The card issuer identifier may need to conform to ISO specifications (if the card is to follow the standards for bank cards), which may not be the health plan identifier. (The Affordable Care Act provides for a health plan identifier operating rule, see Section 3.7.)

⁶ Source: <http://www.NCVHS.hhs.gov/100937lt1.pdf>

2. Without a routing directory matching card issuer identifiers to Internet routing addresses, the machine readable ID card by itself cannot be used to route eligibility and benefit inquiry, and other transactions. This routing function is one that is desired by many provider organizations in order to simplify the process of determining where to send eligibility and benefit transactions, as well as claims and other transactions. The NCVHS letter to the Secretary of HHS asked that CMS should establish an HPID enumeration system and process supported by a robust online directory database (recommendation 4.1). Furthermore, recommendation 4.4. says that HHS should make available appropriate information from the HPID directory database to support the efficient and accurate exchange of information. While the recommendation does not specify how routing would be done, it does imply that NCVHS understands that the HPID database needs to be robust to support a number of business functions, which may include routing.
3. Today, some health plans require that their eligibility and benefit transactions, and/or claims must be routed to an organization independent of the card issuer or health plan associated with the subscriber. For instance, all Blue Cross Blue Shield plans require that eligibility transactions and claims be routed to the local Blue Cross Blue Shield plan for the provider, independent of the plan associated with the subscriber (beneficiary).
4. The magnetic stripe is not long enough to accommodate “long” names, particularly hyphenated names, because of storage space limitations on the magnetic stripe.
5. There is no universal agreement on whether or not all health plans should be required to issue cards with magnetic stripes.
6. Having an operating rule associated with machine readable ID cards implies that there are one or more specific business uses of the cards, such as routing electronic transactions to the correct health plan. There is no industry consensus today as to what these business uses are for the provider or for the patient.
7. Health plans use a number of different strategies with regard to whether or not, as well as how, dependents are listed on health plan ID cards.

Various strategies include the following:

- Individual cards are issued for each family member and their unique beneficiary identifiers and therefore each one is referred to as subscriber (per ANSI ASC X12 5010 version definitions)
- The subscriber and all dependents are listed on the card with the subscriber being the only one with a unique number
- Cards are issued with the subscriber name and identifying number, together with the words, “all dependents” without identifying the individual dependents that are included in the coverage

Because of these inconsistencies across the industry, the CAQH CORE Phase III subgroup on health plan ID cards reached limited agreement on operating rules for the ID card until further clarification and consensus could be reached regarding some of the issues that were identified. Therefore, future operating rule considerations for machine readable ID cards may fall in the following categories:

1. Machine readable ID cards will support a routing structure to be defined and supported in order to facilitate routing of eligibility and benefit transactions (and others) between providers and health plans.

2. Addressing how dependents will be handled in a consistent way by all health plans, or if multiple strategies are allowed, provide for a consistent interpretation and use of the information that is received in the electronic response transaction from the health plan.
3. A requirement for all health plans to issue cards to every subscriber or every individual with coverage.
4. Address the machine readable technology options for health plan ID cards to support the other operating rules, including the options of magnetic stripe, PDF, cell phone technology (similar to airline boarding passes) or other forms of machine readable technology.
5. Reduce potential fraud because it is harder to produce a false machine readable card than it is to create a false paper card.

The most important principles that are likely to be considered in developing operating rules include overall costs to providers and health plans, provider productivity gain, data error reduction, beneficiary access to technology (not everyone has a cell phone), and health plans generally do not issue cards to every individual in the family, which means that unless the policy changes, some beneficiaries will not have access to machine readable technology when they present themselves at the provider's office or hospital. Human readable cards will continue to be used because patients cannot read machine readable cards and they often need to provide insurance information over the phone. Further discussions toward developing an industry consensus are likely before operating rules for machine readable ID cards are adopted.

Given the lack of consensus across the healthcare industry expressed during CORE Phase III activities on machine readable ID cards, it is unlikely that an operating rule can be created with sufficient industry support to meet the adoption date of July 1, 2011. Note that the Affordable Care Act legislation considers this operating rule as something that may be included. It is possible that some of the business operation issues identified can be addressed by July 1, 2011, to add more consistency in how the industry processes and utilizes information on health plan ID cards. Business needs for the new State health exchanges (and/or the expanded Medicaid program under Healthcare Reform) may influence a priority for resolving some of these issues in the near term.

3.5. Electronic Funds Transfer (EFT) and Payment and Remittance Advice Operating Rules (Effective January 1, 2014)

According to some estimates, a little more than 30 cents of every dollar spent on healthcare in the U.S. is consumed by administrative costs⁷. While some adoption of electronic payment and remittance transactions has occurred, a significant opportunity exists to both increase adoption and truly realize the available efficiency gain through full standardization. This begs the need to adopt industry-wide Operating Rules and dramatically reduce the need for variable use of the messaging standards.

Specific to this set of operating rules, according to a 2009 UnitedHealth Working Paper, there are approximately \$161 billion in healthcare industry savings opportunities possible through full adoption of integrated electronic payments and remittance advices⁸. Based on this estimate, this is perhaps the most impactful set of operating rules to be developed in furtherance of achieving Administrative Simplification.

Section 1104 of the Affordable Care Act recognizes the efficiency opportunity and specifically stipulates required adoption of the following, no later than July 1, 2012 for an effective date no later than January 1, 2014:

⁷ Source: PNC Bank; PNC Healthcare Industry Study, 2007

⁸ Source: UnitedHealth Center for Health Reform and Modernization; *Working Paper 2—Healthcare Cost Containment—How Technology Can Cut Red Tape and Simplify Healthcare Administration*, July 2009

“Electronic funds transfers and health care payment and remittance advice—The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall allow for automated reconciliation of the electronic payment with the remittance advice...”

The key inefficiencies of the existing payment process can be broken into the following four key challenges, each of which has hindered realizing the obvious efficiency opportunities:

- 1. Complexity and Cost of Re-Association**—As with most electronic payments today, funds travel through the banking system (ACH) and EOBs flow in either electronic form (via ERA or website download) or paper documents into bank lockboxes or directly to providers. Only in the case of fully paper-based transactions, with checks sent with hardcopy EOBs, does the remittance information pass together with the funds. In virtually no electronic instances does the remittance data flow together with the payment. This requires the manual matching, or re-association, of the payment and the remittance information.
- 2. Need for Provider Bank Account “Registry”**—Paper payments and remittances continue to be dominant due in large part to the challenge of each payer needing to obtain and maintain banking information for tens or hundreds of thousands of providers. This is a Herculean task for each payer entity requiring significant investment in technology, as well as staff to manage the enrollment and maintenance of this banking information for each provider they pay.
- 3. Variability in Implementation of EDI 835 Standards**—Following implementation of HIPAA data standards, most payers invested significantly in compliance with the EDI 835 (Claim Payment Remittance Advice transaction) data standards, which included significant conditional and optional data elements. Due to these variable elements, the implementation of this standard resulted in different forms of EDI 835's from almost each payer, which consequently requires providers to somehow normalize these transactions into a form that their system can ingest.

Providers desiring to post payments electronically have been forced to interpret each payer's 835 transactions using the payer's EDI 835 “Companion Guide” in order to convert each version of the standard messages into a truly standard data stream. Many providers leverage the services of an outside entity to provide this normalization service. Banks and claims clearinghouses are two of the primary service providers offering these “normalization” services today.

The lack of Operating Rules for the EDI 835 facilitating more standard usage of the EDI 835 data standards is squarely in the focus of this committee. Progress to define, implement, and continue to refine these operating rules will likely be an ongoing effort. However, an opportunity for significant process gains should be achievable in a first phase.

- 4. Alignment of Stakeholder Interests**—Despite the positive intentions of each stakeholder group, there remains a general lack of coordination between healthcare insurers, healthcare providers, the financial industry and technology providers to identify and implement interoperable end-to-end electronic processing capabilities.

The first challenge is the obvious crux of the problem behind this component of Healthcare reform. This issue should be addressed through the requirement that CMS / HHS establish the operating rules for EFT and ERA (electronic remittance advice) transactions. It is the challenge of this section of Healthcare Reform for the industry to dramatically broaden the standards initiated under HIPAA through the adoption of operating rules that allow for true transaction normalization that doesn't require complex companion guides from each originating entity. These operating rules must deliver efficiency to all participants in order to achieve lasting success. The choice of organizations with the appropriate constituency and capability is critical to achieving this success in the development of operating rules that are embraced and adhered to by all key industry participants.

The second challenge can be addressed through the creation and maintenance of a centrally controlled payment-routing database and payee registry, which can potentially be provided by the operators of the ACH infrastructure (The Clearing House and The Federal Reserve) or through possible extension of the CAQH-supported Universal Provider Data Source, which could be a resource for the provider enumeration component of payee registry creation.

The third challenge around the variability in payers' EDI 835 transactions is more an issue of implementation and not a failure of the underlying message standards. The pending upgrade from version 4010 to version 5010 will undoubtedly address much of this variability by mandating use of some of the prior "optional" data elements. However, a layer of operating rules should further help to dramatically reduce the variability and ambiguity in payers' file formats.

The last challenge requires coordination across the three key healthcare payment flow stakeholders (payers, providers and financial institutions). This can most appropriately be addressed by assembling a multi-stakeholder cooperative forum with mandated authority, such as potentially through the combined initiative proposed by CAQH CORE and NACHA for participants to come together and develop mutually beneficial payment and remittance solutions.

Solving these challenges will allow the industry to realize significant improvements in efficiency. According to a UnitedHealth Working Paper, there are approximately \$161 billion in savings opportunities through full adoption of integrated electronic payments and remittance advices⁹. This will not be easy to achieve and will require close analysis, tough decisions, collaboration, technology investments, process changes, and the sincere commitment of numerous industry stakeholders and individual participants. Candid dialogue and leadership will be required to cultivate efficient solutions that deliver tangible benefits to all industry participants.

In December 2010, NCVHS held a day-long public hearing to discuss proposals for organizations to become the authoring body of Operating Rules for Electronic Funds Transfer (EFT) and Payment and Remittance Advice transactions and the associated reconciliation. Two primary proposals emerged, with some hybrids also discussed. However, there seemed to be strong cross-industry support for a joint proposal from CAQH / CORE and NACHA (National Automated Clearing House Association)—the operating rule making body for ACH transactions.

CAQH and NACHA have worked together for the last five years, with NACHA offering rule making guidance to CAQH during its initial development phase of the CORE operating rules. This partnership is well positioned to collaborate with healthcare industry leaders in the development of effective operating rules for electronic healthcare payments. A solid foundation based on operating rules that enforce standards will play an instrumental role in the migration to electronic healthcare payments by driving compliance and increased efficiencies throughout the healthcare industry.

The initial recommendation for CORE on the first round of operating rules in conjunction with the strong reputation of NACHA from a banking industry perspective is a strong indicator that this joint proposal will be thoroughly evaluated by the committee. Whether this proposal will ultimately be selected is difficult to predict, but the cooperative multi-stakeholder model and experience in both healthcare and financial transaction standards and operating rules should provide a solid basis for the subcommittee's recommendation.

⁹ Source: UnitedHealth Center for Health Reform and Modernization; *Working Paper 2—Healthcare Cost Containment—How Technology Can Cut Red Tape and Simplify Healthcare Administration*, July 2009

Regardless of the rule-making body ultimately recommended for the operating rule responsibility, it seems highly likely that a consensus will emerge that addresses the four key challenges previously mentioned:

1. Complexity and Cost of Re-Association
2. Need for Provider Bank Account “Registry”
3. Variability in Implementation of EDI 835 Standards
4. Alignment of Stakeholder Interests

The implementation of these operating rules, once finalized, will begin in July 2012 and become effective by January 1, 2014. While the deadlines remain far off, the system and technology investments being made today need to incorporate the IT concepts and capabilities that will be required to deal with and integrate these payment and remittance transactions.

Recommendation for Providers

Now is the time for providers to make strategic back-office technology investments while they are evaluating practice management or patient accounting systems to comply with Electronic Health Record (EHR) or other business requirements. In addition, leading providers are not only incorporating these needs into their systems architecture, but also their operational models.

Key Anticipated Benefits for Providers

Providers and Payers alike should achieve significant benefits from implementing industry-wide operating rules for EFT and ERA. Maximum cost savings benefits from Administrative Simplification will only be achieved once nearly all medical claim payments are made in a fully electronic, straight-through processing environment. Following are the key benefits available to providers:

1. Improved working capital through faster receipt and posting of commercial claim payments, as well as downstream billing.
2. Efficient reconciliation of ERA and EFT, along with reduced errors and standardized delivery timing of both.
3. Ability to re-allocate back office responsibilities from manual processes to more value-added activities.
4. Error reduction, as well as associated reduction in patient refund processing costs.
5. Reduced rate or claim resubmission through the use of standardized, meaningful adjudication codes beyond the current ones utilized in the 835 (ERA).

In addition to the benefits mentioned above for providers, health insurers will also reap significant savings from full adoption of EFT and ERA based payments, through the elimination of printing and mailing costs associated with paper checks and remittance documents.

3.6. Provider Enrollment in Health Plan, Enhanced Transparency and Consistency of Methodologies Used to Establish Claim Edits Used by Health Plans and Other Items for Initial Consideration (Study on potential benefits to be completed by January 1, 2012)

Section 10109 Development of Standards for Financial Administrative Transactions requires that the Secretary of Health and Human Services shall, by January 1, 2012, seek input on whether the provider application process, including the use of a uniform application form, for enrollment of healthcare

providers by health plans could be made electronic and standardized (section 10109)d(1). There is no adoption or effective dates associated with health plan enrollment, as actions to be taken would be dependent on the outcome of the study.

Providers have complained for a long time that the process of being credentialed by multiple health plans is burdensome. This process has been streamlined on a voluntary basis through the use of the Universal Provider Data Source (UPD) supported by CAQH (www.caqh.org/usd.php). More than 800,000 physicians and other health professionals are included in the UPD, which is used by more than 550 participating health plans, hospitals and healthcare organizations. This service is provided at no charge to the physicians and other health professionals who choose to participate. All of the participating health plans, hospitals, and healthcare organizations have agreed that once physicians and other health professionals submit their data to UPD and maintain it on a quarterly basis, they will not require any additional information for credentialing purposes.

The legislation speaks to the “application process,” which could include the UPD or a similar concept.

In the same Affordable Care Act section, the legislation directs the Secretary of HHS to seek input on activities on the following areas by no later than January 1, 2012:

1. Whether standards and operating rules described in Section 1173 of the Social Security Act should apply to the healthcare transactions of automobile insurance, worker’s compensation, and other programs or persons not described in Section 1772(a) of the Social Security Act. Note that worker’s compensation was specifically excluded from the transactions and code sets in the 1996 Health Insurance Portability and Accountability Act.
2. Whether standardized forms could apply to financial audits required by health plans for federal and state agencies.
3. Whether there could be greater transparency and consistency of methodology processes used to establish claim edits used by health plans.
4. Whether health plans should be required to publish their timeliness of payment rules.

While Congress did not include a requirement to develop and implement operating rules in each of these areas, there clearly is interest in potentially adopting operating rules for some or all of these areas to further support administrative simplification and reduce costs for the administrative aspects of healthcare delivery.

Key Anticipated Benefits for Providers

These additional areas for potential further operating rules will afford providers added opportunities for efficiencies:

1. Ability to build workflow and work process tools to support a more transparent, reliable, and consistent approach to each of the following areas across all health plans:
 - Provider enrollment
 - Processing of claims edits
 - Set reliable expectations with payer payment timelines
 - Overall improved transparency dealing with payers
2. Standardized forms for financial audits for all federal and state agencies, instead of each agency creating its own reporting mechanism, could reduce overall costs.

In addition to these provider benefits, Federal and state agencies can save money when conducting financial audits if electronic forms for financial reporting are consistent across all government entities, allowing for the creation and use of standard data analysis tools to be used by all government agencies.

3.7. Health Plan Identifier Operating Rules (Effective January 1, 2014)

There has been limited work to date on health plan identifier operating rules, with the exception of the CAQH CORE Phase III work on health plan ID cards (refer to section 3.4). During 2009-2010, as part of its work on health plan ID cards, CORE considered the use of the health plan ID to enable access to eligibility and other benefit information. Note that the health plan identifier operating rule in the Affordable Care Act would likely consider both machine readable and non-machine readable health plan identification cards, if the implementation of the operating rule for machine readable ID cards is implemented later than the operating rule for the health plan identifier or if the machine readable health plan ID card operating rule permits the use of non-machine readable health plan ID cards under some circumstances.

When adopting the National Provider Identifier (NPI) standard, HHS adopted a strategy that the identifier would be unique with no intelligence. As a result of that decision, there were implementation problems because the legacy health plan issued provider identifiers containing intelligence for specific health plan use. Two good examples of the business rules that had to be addressed when the intelligence was taken away are: location (sometimes providers practice in more than one location and the reimbursement level they receive is dependent on the location), and taxonomy codes, which were created to identify providers by type of specialty, which can also impact reimbursement levels under certain circumstances. Because of these problems with the National Provider Identifier, it is likely that an operating rule research and development process will study whether there needs to be unique identifiers without intelligence, or if some intelligence could be used, for example, in support of routing the transactions or knowing the type of health plan (HMO, PPO, High Deductible, etc.). CORE's work in the health plan identifier associated with a machine readable ID card determined that some in the industry supported a routing mechanism for transactions using the standard identifier. Others disagreed and recommended using a unique number system which has no intelligence. There was no industry consensus on this issue, but it is likely to be seriously considered again as the standard health plan identifier is developed.

Another consideration is that the National Plans and Provider Enumeration System (NPPES) implemented by CMS to support enumeration of unique provider identifiers, was also designed to support the unique enumeration of national health plan identifiers. Adding intelligence to the national health plan identifier might add additional costs and delays for CMS to issue the numbers, but that is likely to be taken into account along with the business needs of the industry.

Other issues that may be considered are whether health plans (insurance companies) should have one unique national health plan identifier for all lines of business, should have separate national health plan identifiers for each different contract (benefit structure) or multiple numbers should be either required or may be permitted based on other criteria determined in developing the operating rule. There has been limited discussion on this issue, but there have been enough discussions to assure that it will be considered in the future. Changes from present health plan identifying structures may result in significant costs for health plans to make changes in internal operating procedures, which will be considered in developing the operating rules. The resulting operating rule could be one directive for all health plans under all circumstances. Options could range from choosing whatever you want to each health plan organization having one national plan identifier for all lines of business.

Health plans could be given some discretion such as provided for in the National Provider Identifier for provider organizations, where each organization has to have at least one National Provider Identifier, but can have more than one if the business need warrants. NCVHS heard testimony on these issues at its July 2010 hearings. The NCVHS letter to the Secretary on September 30, 2010, advises the Secretary to: enumerate unique health plan identifiers, study a number of issues relating to how the enumeration should take place in terms of granularity, develop a HPID enumeration system and process supported by a robust online directory database, and consider that the effective date of October 1, 2012 be interpreted as the date to begin registering for an HPID. In addition, full implementation would be completed by October 1, 2013. The NCVHS letter to the Secretary also emphasized the importance of considering many stakeholders in the industry in order to gain input on how this process should occur and the level of enumeration required, as well as reviewing the HIPAA definition of health plan.

3.8. Health Claims and Attachments Operating Rules (Effective January 1, 2016)

The HIPAA legislation in 1996 included provision for health claims and attachments. However, CMS has not issued a final regulation on claims attachments. The technology and business environment of healthcare has changed considerably since 1996 in the following significant ways:

1. Secure Internet transactions can be used to move information electronically between providers and health plans.
2. Electronic Health Records are being implemented by providers, which contain the electronic data that would be included in the attachments (the future expectation is that most providers will store the attachment data electronically in an Electronic Health Record instead of on paper, enabling a business process that is based on electronic, standardized data to support the need that previously had been addressed through scanned or photocopied attachments).
3. Medical data standards and clinical data transactions are commonly supported by HL7 standards, without having to be inserted within an ANSI ASC X12 administrative transaction.
4. Through the growing implementation of Health Information Exchange Organizations (HIEOs) and the Nationwide Health Information Exchange (NHIN), there soon may be technology and policy in place to permit health plan access to electronic provider clinical data in a manner which is more efficient than the use of a claims attachment as envisioned in 1996.

These changes, as well as the original intent and business model for the HIPAA claims attachments strategy, will be considered as an operating rule is developed for health claims and attachments to be effective in January 2016. The resulting operating rules are likely to be dependent on the level of Meaningful Use of Electronic Health Records in use by providers not later than 2015, the end of the Medicare and Medicaid Meaningful Use Incentive Program, and the deployment and use of the NHIN and regional HIEOs as an alternative infrastructure for exchanging clinical information.

3.9. Health Claims or Equivalent Encounter Information Operating Rules (Effective January 1, 2016)

Several State Medicaid programs and other health plans have required equivalent encounter information to be reported in those cases where claims are not filed, in order to conduct utilization and quality of care studies on care delivery. This requirement most commonly occurs in an HMO environment where capitated payments are made monthly based on enrollment to the health plan or to the provider. The new reimbursement and care management arrangements, such as "Accountable Care Organizations" are evolving. In order to collect information on all patient encounters, both encounter data and claims data will be utilized in the future. The provisions of this section of the legislation call for the development of operating rules to

support the standardization of the encounter information to be equivalent to that collected on claims, where practical. The following are likely to be considered in developing this operating rule:

1. Standard data definitions and a minimum data set required by all reporting entities (individual reporting agencies will no longer be able to create their own data sets or definitions, or at least a floor will be created of a minimum data set and definitions for the elements contained in that set).
2. Identification of which level of an organization is responsible for reporting the information (e.g., individual providers, Accountable Care Organizations, HMOs, state Medicaid agencies contracting with HMOs and Accountable Care Organizations, etc.) will be the standard transaction that will be used to report the equivalent encounter information.
3. The timeliness of reporting the equivalent encounter information can expect to be evaluated (with claims, there is usually a maximum timely filing requirement for reimbursement and providers are incentivized to submit claims sooner rather than later in order to get paid in a timely fashion). There may not be similar incentives in place today for submitting equivalent encounter information on a timely basis because the timing of the payment is not directly tied to the submission of the encounter data. However, some rules along this line are likely to be considered in order to enable the conduct of utilization review and quality of care studies based on both claims and encounter data on a predictable time basis.

3.10. Referral Certification Authorization Operating Rules (Effective January 1, 2016)

The ASC X12 standard transaction for referral authorization exists and is one of the HIPAA administrative simplification transactions. This electronic transaction is not widely utilized. Business rules that would be considered are likely to include:

- The data content of the referral authorization request and the response (including the capability of electronic health records to populate granular data efficiently)
- The timeliness of responding to referral authorization request
- Business rules to determine when a referral authorization request is needed

There has not been much use of this standard transaction, nor has there been significant discussion about what operating rules are needed to enhance its use. It is likely that there will be studies conducted over the next few years to develop business models that incorporate referral certification authorization within the framework of electronic health records and other factors that can be supported in the changing healthcare electronic environment.

Key Anticipated Benefits for Providers

With operating rules to enhance the use of referral certification authorization transactions, providers can rely on a uniform process with health plans to conduct electronic referral authorization requests and receive a response in a timely fashion. This infrastructure will offer providers an opportunity to save valuable time and improve care for patients by implementing a timely response process that eliminates the time wasted on the phone with health plan call centers and delayed fax responses commonly used today instead of electronic transactions.

Health plans stand to benefit by reducing clinically trained and other personnel in the process of responding to referral requests. And providers stand to gain in personnel costs by reducing telephone wait time and being able to communicate in a timely fashion with patients who are awaiting their referral approval.

3.11. ICD-9 to ICD-10 Crosswalk

Section 10109(c) ICD Coding Crosswalks requires convening of a meeting, no later than January 1, 2011, to receive input from appropriate stakeholders regarding the crosswalk between the ninth and tenth revisions of the ICD-9 and ICD-10 that is posted on the website of Centers for Medicare and Medicaid Services to make recommendations about appropriate revisions to such crosswalk. There are many uses being discussed for crosswalks in general between ICD-9 and ICD-10 as the transition of changing the diagnosis coding system for all health plans and providers on claims and other transactions goes into effect on October 1, 2013. The task of this transition is huge, in part because for a substantial percentage of the diagnosis codes, there is not a one-to-one match, making it difficult to map from ICD-9 into ICD-10. As it stands, current ICD-9 codes have many possible codes in ICD-10. Therefore, the use of crosswalks for payment on specific claims after October 1, 2013, has been questioned by many in the industry.

Nonetheless, the industry is faced with several longitudinal uses of diagnosis and treatment data on patients over time, which may be addressed through crosswalks. For example, providers treating patients after October 1, 2013, may want to refer to previous diagnoses for the same patient (in a paper or electronic health record) and view the entire patient record from an ICD-10 diagnosis perspective. In the case of medical research and aggregate data studies on populations with specific diseases, crosswalk is probably the most practical approach to studying these patient populations over time. The crosswalk posted by Medicare on the CMS website is the one planned for use by CMS. This review process will give others in the industry an opportunity to comment on the published CMS crosswalk and provides a process for revising it, if appropriate. This has potential ramifications beyond Medicare. Some have argued that there is benefit for the industry to use a standard crosswalk for longitudinal patient data analysis and for patient population disease research and related studies. The CMS published crosswalk is the most likely candidate for this purpose. While there may not be 100 percent agreement among all stakeholders as to what the crosswalk should be, at least if there was one standard reference crosswalk used by everyone, there would be consistency among different users as to how they are used and everyone would be aware of the strengths and weaknesses associated with the published crosswalk.

By identifying the CMS published ICD-9 to ICD-10 revised crosswalk as a “code set” for which a standard has been adopted by the secretary, it would become a standard which would have to be used in all applications where the use of a standard code set is specific in federal law or regulation. (Reference Section 10109(c).

Experts advise hospitals, physician practices, and other providers to be prepared to conduct reimbursement audits for several months prior to and after the October 1, 2013 implementation date for ICD-10. If some payers decide to implement ICD-10 by crosswalking from ICD-9 to ICD-10 or reverse crosswalking diagnosis data on claims submitted in ICD-10 back to ICD-9, errors in reimbursement may occur. For the most part, this would most likely impact benefit coverage more so than the amount reimbursed. In most cases, physician practices and outpatient hospital facilities’ reimbursement levels are determined by procedure codes, not diagnosis codes. For termination of benefit coverage, request for additional information before processing claims, and other similar nuances, a diagnosis code is typically used in the determination. Hospitals are advised to be vigilant on reimbursements based on procedures performed in the hospital that are coded with ICD-10 procedure codes, as these translations may not work well either. For those anticipating that the October 1, 2013 date for ICD-10 compliance will be delayed, it is not likely to happen because the consequences are rather significant on other Healthcare Reform and Stimulus Bill activities. For example, the Meaningful Use criteria and the certification of electronic health records by 2013 are likely to be based on ICD-10. In this timeframe, physician practices and hospitals will be reporting data (specifications to be determined) to CMS in order to be considered Stage II and Stage III incentive payments of electronic health records. Obviously, monitoring of developments over the next three years is part of the best strategy in the event timeframes do change, but there is good reason to believe that they might not.

4. Timeline for New Requirements

There are several deadlines to be met in developing, publishing, and implementing the Operating Rules specified in the Affordable Care Act legislation. The dates range from July 1, 2011, to January 1, 2016. Two of the three early deadlines, eligibility and claims status operating rules, can likely be met by utilizing the CORE Phase I and Phase II Operating Rules for eligibility and claims status, with minor modifications to the existing rules, as well as to modifying them for 5010 implementation (an activity that is already under way). In order to meet the deadlines for the other operating rules, research and consensus building will have to commence very soon. This is necessary so that the extensive analysis and preparation work required to develop good quality operating rules within the timeframe specified can be achieved. All of this will be going on while the industry is implementing the 5010 and D.O administrative transactions versions under HIPAA, implementing ICD-10 under HIPAA and implementing electronic health records including achieving Meaningful Use under the Stimulus Bill incentive programs. The challenges for the industry and the government to meet these deadlines are significant. There will have to be an increase of resources applied in both developing the rules (not only from a facilitations/staff perspective, but from an industry input resource perspective), as well as an increase in the level of resources committed to the changes needed from an IT and workflow perspective in order to implement the operating rules. NCVHS has already recommended CAQH CORE for the medical operating rules and NCPDP for the retail pharmacy operating rules. It would be most efficient for the health care industry if NCVHS continues to recommend these two organizations for operating rules development going forward. Otherwise, industry stakeholders will have to attend meetings and participate in processes across multiple organizations involved in the development of operating rules, as well as manage the consistency of terminology, definitions, and approach. This will add overhead and expense for everyone in the process. It is likely that NCVHS will take this into account in its further determination on recommending the designation of operating rule entities.

However, since the operating rules are designed to save money, some of the participants are incented to put forward significant investments early on in order to achieve the savings. One health plan, in testifying before NCVHS in July, 2010, stated that it was going to cost them \$8 million to implement CORE Phase I and CORE Phase II Operating Rules, but the resulting savings would totally pay back that investment within the first year. With the new health plan medical loss ratio requirements as part of the Affordable Care Act, health plans will be further incentivized to seek ways of saving administrative costs. Furthermore, health plans are required to certify that they are compliant with these operating rules before the effective dates. Providers also have an opportunity to benefit from operating rule implementation, but they are not required to certify to the government that they are compliant by the effective date, nor are they required to effectively utilize the operating rules to gain efficiency and improve patient satisfaction. One of the challenges in meeting the timeline, as well as seeing results of administrative savings, is for the industry to figure out how to implement these operating rules and share that information among themselves and their vendors so that the products and services supporting business operations can be changed in time to meet the deadlines, together with a change in workflow and business processes to leverage the new capabilities provided by these operating rules.

5. Conclusions

As the specific rules and regulations associated with healthcare reform and the new policies around Administrative Simplification emerge over the coming months and years, providers will be keenly interested in the potential for improved efficiency and lower administrative costs. Top of mind for health plans will be concerns about the medical loss ratio requirements under the Affordable Care Act. Non-profit hospitals face concerns about satisfying IRS requirements for charity care (versus bad debt) in order to remain tax exempt. At the same time, non-profits remain focused on the need to do a better job of collecting bad debt in lieu of writing it off as charity care.

Overall, one of the biggest concerns for the healthcare industry is whether it has the capacity to both participate in developing the operating rules and making all of the necessary changes needed in time to meet critical deadlines, given other regulatory obligations.

Moving forward, providers should consider the following five strategic recommendations, in order to better prepare themselves for the impacts of reform:

- 1. Lead your peer group**—First and foremost, as with all transformational changes towards industry-wide efficiency gains, the most savvy industry leaders will be rewarded amongst their peers by providing an opportunity for competitive advantage. We recommend this as an opportunity to act quickly, empowering provider organizations to achieve competitive advantage in their segment with respect to these important legislative changes.
- 2. Focus on core competencies**—It is critical for providers to work with selected business advisors / partners to gain a broader perspective on the coming changes and efficiency opportunities available.
- 3. Free up capital**—As the many changes mandated by reform come into force, it is important for providers to begin freeing up capital—both working and human—to be prepared to meet the varying demands. Working capital will be needed to invest in strategic business decisions—both operational as well as technical. And allocating the right human capital resources will be required to focus on analysis, strategy, selection, and execution of appropriate strategies and solutions.
- 4. Ensure all future needs are factored into strategic investment decisions**—It is important to keep an eye toward future needs when it comes to strategic investments. Considerations should include Electronic Health Record (EHR), healthcare coding (ICD-10), claims processing, patient billing, payments, and remittance posting.
- 5. Consolidate back-office systems**—Wherever possible, providers should be looking to consolidate their back-office systems, including the potential integration of subordinate business units onto a single technology platform for improved efficiency.

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