EFT and Other Transactions: What Transactions are Under-Utilized, and What's Coming Next

HIPAA Summit
March 23, 2016

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Advancing Leaders. Advancing Practices.™

About MGMA

- MGMA is the premier association for professional administrators and leaders of medical group practices
- Since 1926, the association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals
- Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties.

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Background: HIPAA and ACA Section 1104

- HIPAA (1996) and ACA (2010) Identified a number of key administrative transactions that needed to be standardized
- EFT/ERA, PA, Attachments
- ACA moved “operating rules” from voluntary to mandatory
- EFT/ERA standards/ORs in effect Jan. 2014
- PA standard in effect, waiting on ORs
- Attachments?

ePayments

EFT/ERA Standards

- EFT: the healthcare electronic funds transfer standard is the NACHA CCD+Addenda
  - Similar to consumer “direct deposit”
- ERA: the healthcare Electronic Remittance Advice is the X12 835 transaction
  - The 835 is the e-message from the payer to practice advising whether a bill has been paid or denied, by what method, how much, and reasons on a line-by-line basis for paid/denied
  - The 835 is designed to allow automatic posting into the PMS or Clearinghouse, provided the practice has been enabled with the capability to import
- Plan must offer EFT if provider requests (and support ERA)
- Industry adoption: 58% - EFT 47% - ERA with a $3 per transaction savings potential w/EFT, $7.21 EFT/ERA (2015 CAQH Index)

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EFT/ERA Operating Rules

- Requires payers to release the EFT and ERA within a reasonable timeframe (3 days or less) if the provider has enrolled for both transactions
- Standardizes enrollment data and requires payers to offer online enrollment
- Standard use of code combinations (CARCS, RARCS, and Group Codes) across different payers
- Practices now receive the identification data element (“trace number”) in the two transactions necessary for successful reassociation

Charging to Deliver the Healthcare EFT Standard

- Good news: CMS issued FAQ 9778 on March 28, 2014
  - *If a provider requests that a health plan conduct the electronic funds transfer (EFT) and remittance advice transaction in standard format (by using the ACH network), then the health plan must comply with the HIPAA standard for this transaction…The health plan also cannot incentivize a provider to use an alternate payment method other than the adopted standard or adversely affect the provider for using the standard transaction **(i.e. charging excessive fees**).*
- Bad news…they removed it!
- Some plans and vendors now charging 1-5% for EFT

❖ *MGMA now co-chairing industry workgroup developing ePayments "best practices"*

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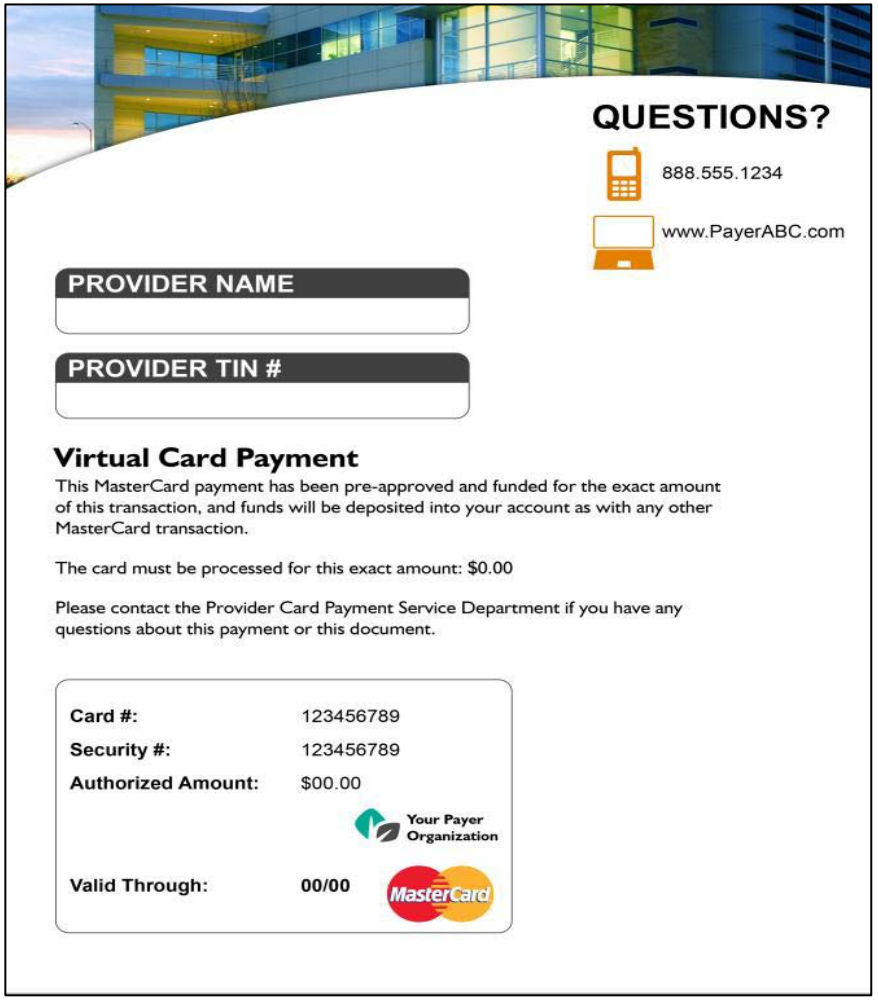
Virtual Card Payments for Claim Reimbursement

- Single use 16-digit credit card number
- Health plans fax, email or mail the payment information to the Provider or their Lockbox facility
- Provider will manually process the claims payment through their CC terminal
- Provider is charged standard interchange fee for commercial purchasing card not present (av 3%) plus a transaction fee
- Some plans dropping paper checks-some have moved to a VCC “opt out” approach



Virtual Credit Card: Environment

- 86% have seen increased payments via virtual credit cards
- 87% received virtual credit card payments without prior consent/notification (opt-out model)
- 70% reported payers provided no instruction on how to switch to EFT

❖***/ADA/AMA/MGMA Survey*** *1151 respondents (May/June 2015)*

ePayments Concerns

- EFT/ERA issues:
  - Some plans defaulting to VCCs and only reluctantly agree to send EFT
  - CAQH offers “EnrollHub” but not all plans use
  - Reassociation requires either (CH action) or robust PM
- VCC problems
  - 2-4+% per transaction using credit card reader
  - Additional costs-staff time
  - Lost value of reassociation with ERA
  - Plans sharing “profit” with CC companies?

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Under-Utilized Standard: Prior Authorization

Prior Authorization

- "Prior Auth" or "Pre Auth" transaction now a standard part of the provider RC
- Two types: (1) medications (2) services
- Indications are that plan PA requirements increasing (i.e., generic drugs)
- Only 7% PA conducted using X12 278 (2015 CAQH Index)
- Most via fax, phone, web
- Directly impacts patient—can delay treatment by days or even weeks

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Prior Authorization

- Plans argue PA is a cost-savings feature that helps to ensure the safe and appropriate use of selected prescription drugs and medical procedures
- Theory is that criteria is based on clinical guidelines and medical literature
- Reality is that criteria vary by payer, as do request forms and formats
- PA costs physicians billions yearly

Workflow Challenges

- Physician often not aware that prescribed drug or service requires PA
- Plan criteria not residing within EHR or visible to physician
- Little automation for the PA process
- Paper forms and portals require manual reentry of data that may already reside electronically within an EHR
- Multiple routes to obtain PA depending on health plan, drug, pharmacy, and patient combination

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Operating Rules Can Improve the X12 278

- Industry further ahead with medications PA (NCPDP standards, SureScripts functionality)
- For services, only a “bare minimum” approach to 278 implementation
- Plans often simply just “acknowledge” receipt of the request
- Providers are instructed to call the plan or are referred to plan portals to complete the PA process
- New operating rules could encourage adoption by requiring the 278 response to:
  - Indicate if PA is not needed
  - Real-time approve or deny if no additional information is required
  - Identify additional information needed for PA processing
  - Communicate final PA determination

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Future Standard: Attachments

Current Attachments Environment

- MGMA survey results: 51% answered “always” or “often” that payers request attachments for claims, 78.4% for WC
- Nearly 100% for some specialties (i.e., orthopedics)
- Payer requests sent by paper
  - Often lost or sent to incorrect address
  - Difficult to determine what is being requested by payer
- Paper claim attachments are a significant cause of claim denials, payment delays, write-offs
- Providers concerned that CAs simply used to delay payment
- MGMA survey-avg. provider cost per request is $21.34
- Mandated in 1996…REmandated in ACA…NPRM this yr?

Opportunities for Attachments

We need attachments to work in the real world of HC

- 1st step is unstructured documents sent electronically in a secure manner
- 2nd step focus on structured data with narrative text
- 3rd step support structured, codified data

- Claims and PA
- Beyond claims…
  - Care coordination / Transitions of care
  - Quality reporting (MIPS)
  - Support for alternative payment models
    - Patient-centered medical homes
    - Accountable care organizations

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Standards

- MGMA supports the following attachment standards:
  - **Request for additional information**
    - ASC X12 278 Services Review Response (prior authorization)
    - ASC X12 277 Request for Additional Information (claim)
  - **Envelope**
    - ASC X12 275 Additional Information to Support a Health Care Claim (claim)
    - ASC X12 275 Additional Information to Support a Health Care Services Review (prior authorization)
  - **Clinical Content**
    - HL7 C-CDA R2 Consolidated Clinical Document Architecture Release 2

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Summary-Moving Forward to Admin Simp

- Standards and technology are transforming HC administration
- Practices can't take advantage of ACA 1104 without support from their PMS/billing/EHR vendors
- MGMA encouraging PM vendors to be EHNAC /WEDi accredited
- ePayments = 1 step forward…1 step backwards
- CMS guidance could discourage epayments "bad actors"
- Prior auth-significant challenge in need of automation
- Attachments rule now 20 years late…huge efficiency opportunity for industry
- Absent government action, industry can and should move forward

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Thank you

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