HIPAA Administrative Simplification Opportunities (and Challenges) for Physician Practices

National HIPAA Summit
Washington, DC
Sept. 16, 2016

Robert M. Tennant
Director, HIT Policy
MGMA
202.293.3450
rtennant@mgma.org
Todays Agenda

• Automation opportunities/challenges
  – Eligibility
  – Electronic payments

• What’s on the horizon
  – Patient relationship codes
  – SSNRI
  – UDI
  – Admin simp standards

• Summary
Benefits of Automation

• Reduction in manual data entry and processing
• Elimination of cost and delays of postal service
• Improved data comparability
• Elimination of disparate forms and codes
• Improved cash flow
• Improved accuracy of information
• Fewer billing errors
• Fewer claims rejections
• Cost savings (including reduced labor costs)
Background: HIPAA and ACA Section 1104

- HIPAA (1996) and ACA (2010) identified a number of key administrative transactions that needed to be standardized, including:
  - Insurance eligibility verification (standards/ORs)
  - Electronic payments (standards/ORs)
- CAQH CORE created voluntary “operating rules”
- ACA moved ORs from voluntary to mandatory
Automating Insurance Eligibility Verification
How often does your practice use the following methods to verify patient insurance eligibility?

- **Phone**: 16.0% Rarely or Never, 32.3% Occasionally, 51.7% Always or Frequently
- **Fax**: 9.7% Rarely or Never, 24.2% Occasionally, 66.1% Always or Frequently
- **Web Portal**: 6.3% Rarely or Never, 13.2% Occasionally, 80.5% Always or Frequently
- **Clearing-house**: 13.9% Rarely or Never, 25.9% Occasionally, 60.2% Always or Frequently
- **270/271**: 7.4% Rarely or Never, 44.8% Occasionally, 47.9% Always or Frequently

Note: The percentages may not sum to 100% due to rounding.
Eligibility Verification

- Critical to identify patient financials before the visit or at time of service (even more important with high deductible plans)
- Operating rules now mandated on payers and Clearinghouses
- ORs require payers to respond…in 20 seconds or next day for batch
- Even more important now-HDHPs
  - CAQH Index: provider savings estimate-$3.07 per transaction
HIPAA 270/271 ORs

• Requires health plan to support explicit 270 eligibility inquiry for 39 service type codes
• Response must include all patient financial liability
• Base contract deductible AND remaining deductible
  • Co-pay
  • Co-insurance
  • In/out of network amounts if different
  • Whether or not benefit is covered for out-of-network
• Related dates of eligibility
Challenges to Wide Adoption

- Some providers lack the required robust practice management system software
  - We as an industry have not sufficiently established the ROI
- Many health plans aggressively promoting use of their web portal above use of the 270/271
- CHs/third party vendors charging for the transactions
- Some health plans simply don’t support the 270/271 and ORs
- Lack of enforcement for non-compliance
The Electronic Payment Environment
Electronic Payments: The Good News

- We have national standards for EFT, ERA and supporting ORs
- Health plan must offer EFT if provider requests (and supporting ERA)
- “Trace Numbers” allow for reassociation (saving $)
- Streamlined enrollment process
- CAQH created “EnrollHub”
- No better definition in HC of “low hanging fruit”
- Potential savings: $3 per ERA transaction / $7.21 EFT/ERA (2015 CAQH Index)
The Bad News

- Industry adoption: 58% - EFT 47% - ERA
- Some health plans actually CHARGE for EFT (25% of EFT payments, according a WEDI survey)
- Rise of the infamous “Virtual” Credit Card, with MGMA finding:
  - 86% have seen increased payments via VCCs
  - 87% received VCC payments without prior consent/notification
  - 70% reported payers provided no instruction on how to switch to EFT
- EnrollHub active, but only 35 plans participate (13 Anthems)
- No government oversight
- However…an industry set of “guiding principles” was recently released…
New Industry ePayments Guidance

- Guiding Principles developed by WEDI Taskforce
- MGMA co-chaired the Taskforce (along with Aetna)
- Hope is that CMS will adopt via sub-regulatory guidance (FAQs)
New Industry ePayments Principles

Key principles:

1. A health plan, clearinghouse or payment-related vendor should complete the ACH EFT enrollment process within 30 days of receipt of provider enrollment information.

2. No delay of ongoing payments when a provider elects to begin receiving any form of electronic payment.

3. Providers notified (a) regarding fees associated with this payment method; (b) to check with any of their contracted vendors (i.e., their credit card merchant processor) regarding any additional administrative fees; and (c) about the availability of an ACH EFT payment option.
New Industry ePayments Principles

4. Before a provider may be paid via an epayment method other than ACH EFT, the provider should give explicit agreement (“opt-in”).

5. When a health plan or any of their clearinghouses or payment-related vendors offers an ACH EFT payment option, it should offer an ACH EFT option with no origination fees.

6. There should be transparency from health plans, clearinghouses and payment-related vendors regarding any required transition from paper-based payments to electronic payments, and providers should be given a minimum 90-day notice before the effective date of the electronic payment mandate and must opt-in to any nonstandard electronic payment method scheduled to replace a paper-based payment.

7. Providers must give explicit authorization prior to use of the ACH EFT debit transaction for recoupment purposes.
On the Horizon...
Patient Relationship Codes

• Problem, current patient “attribution” approach inherently flawed
• MACRA requires CMS to develop new approach
• Just issued RFI-MGMA provided comments
• Expected that these new codes will be required to be included on claims as of Jan. 2018
• Concerns:
  – Ability of PM systems/coders to insert appropriate codes
  – Workflow changes
  – Codes for “team-based” care approach
SSNRI

- MACRA requires removal of SSNs from Medicare ID cards, consideration of a new #
- CMS has announced they will be issuing all beneficiaries, alive or dead (160 million) a new MBI (to replace HICN on the cards)
- Numbers to be issued starting Jan. 2018
- Transition period Apr 2018-Dec 2019 where both numbers can be used on Medicare claims
- Claims with HICNs rejected starting Jan 2020
- No proposed rule
UDI

- Unique Device Identifier mandated on the manufacturers
- CMS, health plans now pushing for UDI to be captured on the claim (by providers) and tracked by payers **Theory**-it will be used for post-surgery surveillance and tracking of recalled devices

**Reality:**
- Plan cannot effectively track patients who no longer customers
- Payers want this data for utilization purposes

- Expected to be included in the next version of the HIPAA transactions
- Better approaches available (i.e., UDI included in 2015 CEHRT)
Forthcoming Standards?

- Electronic attachments
- Electronic acknowledgements
- New version of the HIPAA standards (moving from “5010” to “7030”)
- New operating rules for prior authorization
- Payer certification requirements (leading to enforcement actions?)
Summary

• Providers:
  – Identify IT for RCM automation
  – Utilize simple, standardized approaches to administrative transactions
  – Recognize proven ROI
  – Work with your vendors to ID opportunities
  – Know your rights

• Payers/vendors: look for admin simp opportunities and not portals

• Industry: look ahead to new standards and requirements (new Administration = new priorities)
Thank you!

Robert Tennant
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