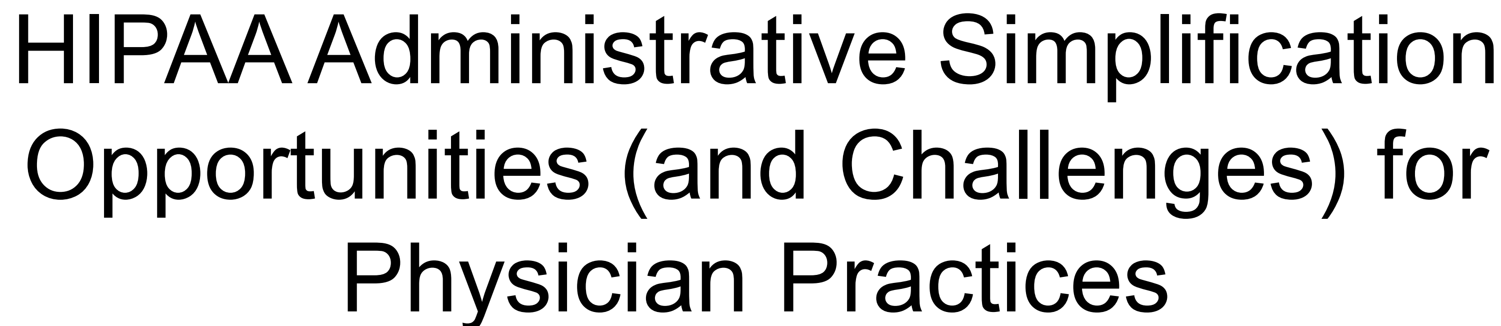

National HIPAA Summit
Washington, DC
Sept. 16, 2016

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Advancing Leaders. Advancing Practices.™

- Automation opportunities/challenges
  - Eligibility
  - Electronic payments
- What’s on the horizon
  - Patient relationship codes
  - SSNRI
  - UDI
  - Admin simp standards
- Summary

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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)

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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, including:
  - Insurance eligibility verification (standards/ORs)
  - Electronic payments (standards/ORs)
- CAQH CORE created voluntary "operating rules"
- ACA moved ORs from voluntary to mandatory

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Automating Insurance Eligibility Verification

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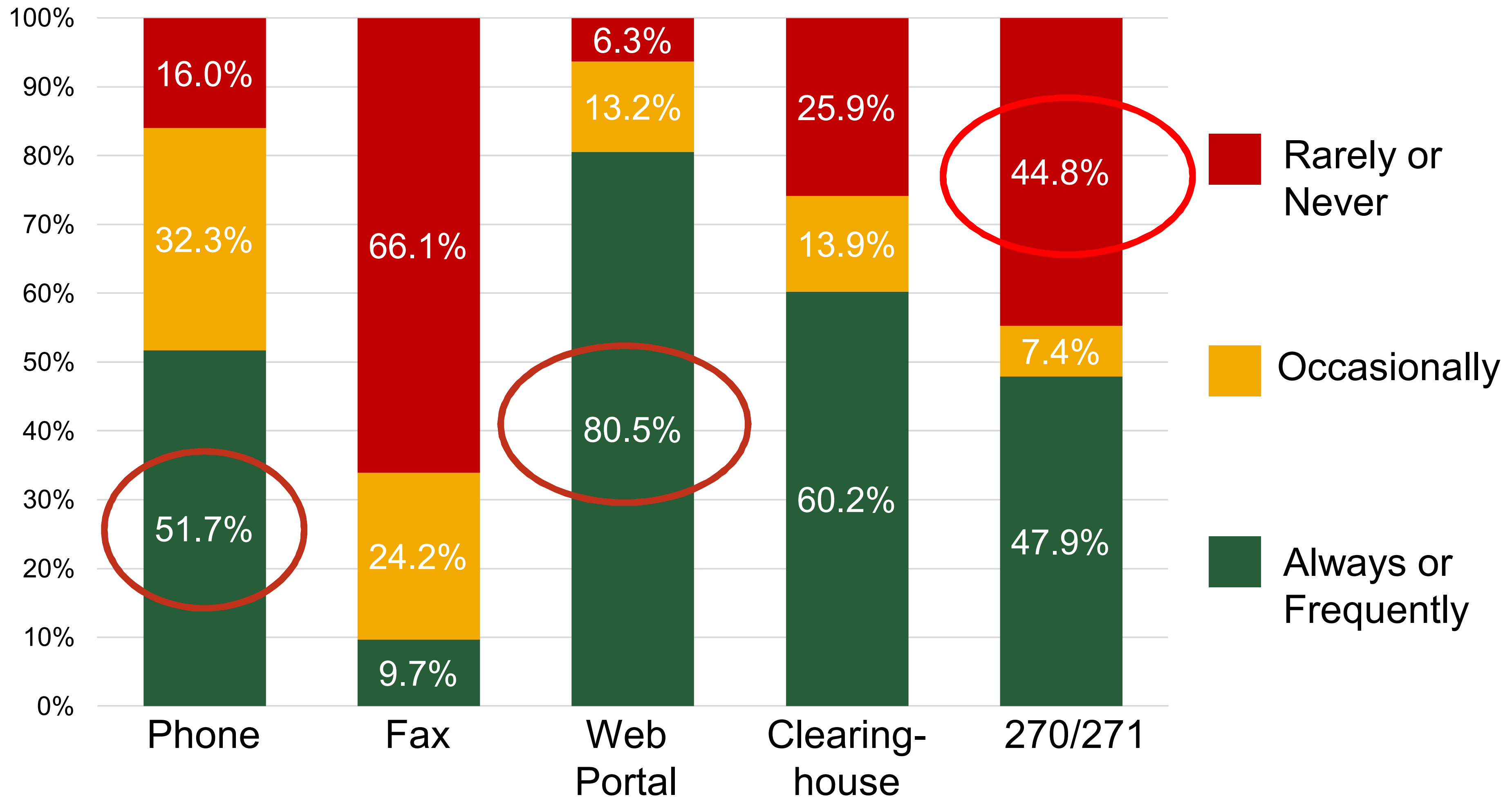
How often does your practice use the following methods to verify patient insurance eligibility?



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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***

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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*

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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

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The Electronic Payment Environment

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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)

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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…*

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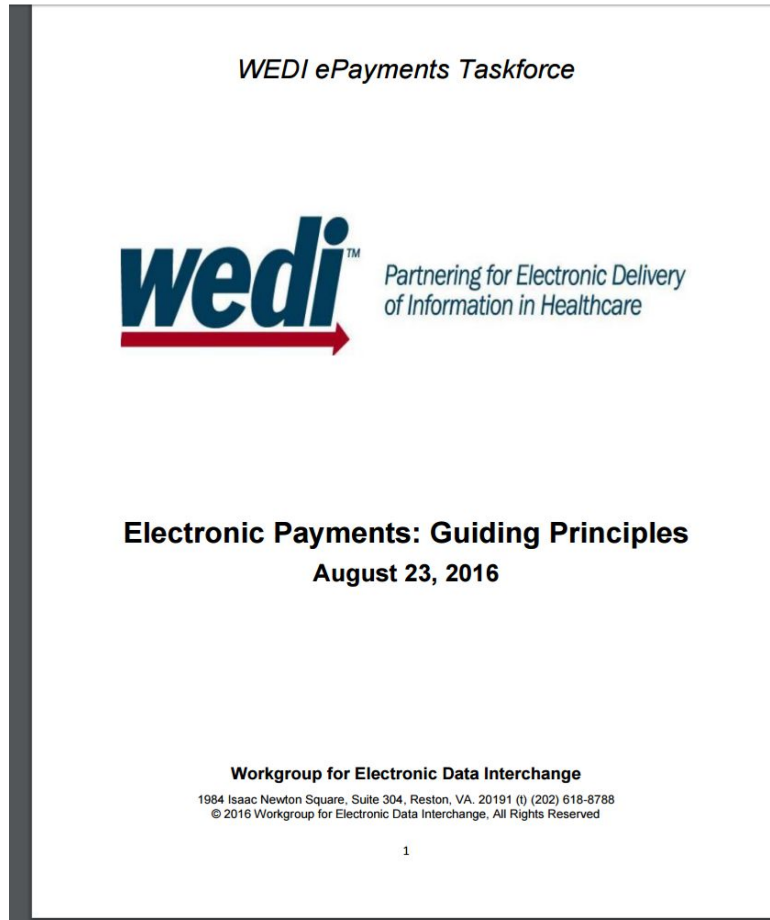
New Industry ePayments Guidance



WEDI ePayments Taskforce

wedi™ Partnering for Electronic Delivery of Information in Healthcare

Electronic Payments: Guiding Principles

August 23, 2016

Workgroup for Electronic Data Interchange

1984 Isaac Newton Square, Suite 304, Reston, VA. 20191 (t) (202) 618-8788

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1

- 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)

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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 processer) regarding any additional administrative fees; and (c) about the availability of an ACH EFT payment option.

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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.

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On the Horizon…

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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

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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

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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)

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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?)

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- 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)

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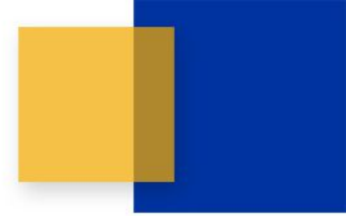

Thank you!

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