Review Committee Findings and Recommendations from the June 16 and 17, 2015 NCVHS Hearing on Adopted Standards, Code Sets, Identifiers, and Operating Rules.

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I. Executive Summary

Background

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (DHHS or referred to in this paper as HHS).

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS advises the Secretary on the adoption of standards, implementation specifications, code sets and identifiers for the HIPAA-named transactions. The Patient Protection and Affordable Care Act (ACA) {sec. 1104) (i) enacted on March 23, 2010, authorizes the Secretary to establish a Review Committee responsible for conducting hearings to evaluate and review the adopted standards and operating rules. Specifically, the Review Committee is to: 1) Conduct hearings not less than biennially to evaluate and review the adopted standards and operating rules. 2) Provide recommendations to the Secretary not less than biennially for updating and improving such standards and operating rules. 3) Recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards. 4) Ensure coordination, as appropriate in developing recommendations, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology. NCVHS was designated in 2014 by the Secretary to act as the Review Committee.

Studies support that administrative costs continue to represent an important component of the overall cost of health care and that these costs can be reduced through greater standardization. In fact, the overarching goal of the administrative simplification provisions of HIPAA and ACA is to improve the efficiency and effectiveness of the health care system through the establishment of uniform standards and requirements for the electronic transmission of certain health information to reduce the clerical burden on patients, health care providers, and health plans. Simplification occurs through adoption of standards via the federal rule making process, followed by implementation of the adopted standards by those entities subject to the regulations and engaged in each of the transactions.

Inaugural Review Committee Hearing

NCVHS held its first Review Committee on June 2015 NCVHS Review Committee hearing. The purpose of the June 2015 hearing was to gather feedback from the industry regarding the state of implementation of all the HIPAA named transactions which included: 1) health plan enrollment and disenrollment; premium payment; (2) claims status; 3) health plan eligibility, benefits inquiry and response; 4) prior authorization; 5) health care claim or equivalent

encounter information; 6) electronic fund transfer and electronic remittance advice; and 7) coordination of benefits.

Over the two-day hearing, NCVHS listened to seventy-seven oral testimonies and reviewed over 100 additional written testimonies from the health care industry. In this report, we summarize the findings and provide recommendations directed to the health care industry, Standard Development Organizations (SDOs), Operating Rules Authoring Entity (ORAE) and the Department of Health and Human Services (DHHS). NCVHS developed a separate letter that was submitted to the Secretary of HHS on February 29, 2016, including observations, themes, issues, and NCVHS recommendations for HHS[1]. The content of the letter to the Secretary is included in this report.

To ensure that stakeholders had an opportunity to provide feedback to NCVHS, health care industry organizations and associations were contacted requesting their participation as testifiers at the hearing. Additional organizations and associations that contacted NCVHS requesting to participate at the hearing were either added to the agenda or were requested to submit written testimony that were included in this report. Consequently, testimony was presented or submitted for health care providers, health plans, vendors, clearinghouses, professional and trade organizations and associations, public programs (Medicare, Medicaid), federal agencies, standard development organizations, operating rules authoring entity and consultants. A list of panelists at the June 2015 hearing can be found in Section 7.2 of this report.

Testifiers were asked to address a set of specific predefined questions concerning:

- The current status of implementation of all HIPAA-named transactions and their corresponding standards and operating rules.
- The degree to which current standards, code sets, identifiers, and operating rules continue to fulfill the business needs of the health care industry.
- The degree to which the use of the standard or operating rule results in discrepancies, ineffectiveness or inefficiencies in the implementation of a transaction, which causes conflicting or unanticipated negative impact to transaction implementers and the industry as a whole.
- Any inability or limitation of the standard or operating rule to meet new and emerging business needs of the industry.
- Whether changes in current standards and operating rules for any particular transaction are needed.

The Designated Standards Maintenance Organizations (DSMO), SDOs, and ORAE were invited to testify and address these questions for each of the existing named HIPAA transactions. Representatives from various segments of the health care industry (i.e., providers, payers,

[1] February 29, 2016 letter to Secretary Sylvia M. Burwell, Review Committee Findings from the Administrative Simplification Hearing.

clearinghouses, public programs, vendors, and others) were also invited to testify. The health care industry at large was invited to submit written testimony. All testifiers were requested to provide objective data to support their testimony. This may include analytical data, market research, cost-benefit analysis and other forms of objective analysis. Specific questions asked of panelists at the June 2015 hearing can be found in Section 7.1 of this report.

NCVHS reviewed testimony and formulated its recommendations utilizing the criteria that formed the basis of the questions testifiers were asked to address in their testimony. The criteria, centered on identifying if the adopted standards (including code sets and identifiers) and operating rules (where adopted):

- Meet the industry's business need/use/problem resolution;
- Decrease cost and/or administrative processes;
- Are flexible/agile to meet changes in technology and/or healthcare delivery systems;
- Can be operationalized; and
- Can be enforced

In addition to these criteria, NCVHS looked at other factors to evaluate the degree to which the adopted standards and operating rules were meeting the overall goal of administrative simplification of *completeness, efficiency*, lack of c*omplexity*, f*lexibility*, c*onsistency*, *effectiveness*, and lack of a*mbiguity.*

General Findings and Recommendations

Many stakeholders reported their belief that the adoption and implementation of all HIPAA-named transaction standards and operating rules across the industry is viewed as a significant step forward towards achieving greater administrative efficiencies. However, further work is needed to refine and continuously update the adopted transaction standards and operating rules and increase their level of implementation and the consistency in the way they are implemented and used.

The health care industry representatives indicated that not all adopted transaction standards and operating rules show consistent and sustained adoption for a number of reasons including advances in information technology, changes in health care delivery models, changes in reimbursement models, and availability of simpler or less costly alternatives. These however, do not negate the progress and the ongoing need for administrative simplification. The health care industry has made significant progress in identifying ways to continue to improve administrative processes and functions. The process is dynamic and the ability to achieve greater administrative simplification needs to adjust and evolve, if lower administrative costs are to be attained through standardization. There are strategic opportunities to achieve greater administrative simplification at lower costs, and this report highlights many of them. Some transactions such as health care claims, eligibility and claim status are likely to remain useful while other transactions may not as the health care industry continues to evolve around population health management, chronic and rare disease management, increased integration

and coordination across delivery systems, shared risk payment models, and high value provider/payer network arrangements.

One of the most significant findings from the June 2015 hearing was the variation in the *level* of implementation of various transaction standards and operating rules. While five transactions (eligibility, claim, claim status, remittance advice and coordination of benefits) are being widely implemented, others (electronic funds transfer, benefit enrollment/disenrollment, premium payment, and prior authorization) are not yet widely implemented. Industry representatives believed that for greatest impact at this time, primary focus should be on enhancing the quality, consistency and reliability of the five transactions that are most widely implemented, and their adopted standards and operating rules, to expand and strengthen demonstrated benefits. Testifiers indicated that the health care industry deems the EFT transaction as the transaction to move forward and de-emphasis the other HIPAA – named transactions at the current time.

Another significant and related finding was the degree of *inconsistency* that still exists within the industry in the way transaction standards and operating rules are being implemented. Even when the transactions are implemented electronically using the adopted standards and operating rules, inconsistencies in the implementation rules that define the data content, coding, and processing are creating barriers that require workarounds or manual interventions to achieve the expected efficiencies and effectiveness.

In this report, NCVHS describes benefits, issues and barriers to full implementation of the HIPAA-related transactions, as identified by health care industry experts and reported in written and oral testimony at the Review Committee's June 2015 hearing. NCVHS provides recommendations to further support adoption and implementation of standards, code sets, identifiers, and operating rules.

To address concerns raised by the testifiers at the June 2015 hearing, NCVHS provides recommendations for issues identified as common to all transactions while others are unique to specific transactions. Some of the recommendations have been addressed in the February 29, 2016 letter to the Secretary included in the appendix. Recommendations are directed to HHS, Standard Development Organizations (SDOs), and Operating Rule Authoring Entity (ORAE), healthcare industry or a combination of these. General recommendations include:

1. Explore the feasibility of expanding the definition of HIPAA covered entities.
2. Broaden education.
3. Ensure consistency.
4. Enforce compliance.
5. Adopt the acknowledgment transaction.
6. Provide predictability in the adoption of standards, code sets, identifiers, and operating rules.
7. Ensure responsiveness to evolving changes in health care.

Specific Transactions

Because issues identified by testifiers differed depending on the specific transaction, each of the adopted HIPAA transactions are addressed separately identifying issues that are barriers to implementation and NCVHS recommendations to address these issues. As noted in the General Recommendations section above, recommendations are directed to the HHS, SDOs, ORAE, the industry or combinations of these. Additionally, recommendations in the General Section above apply to the specific transactions below as well. Key issues and recommendations for each of the adopted transactions are summarized below.

Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

The healthcare industry representatives indicated that there has been low implementation of the Health Plan Enrollment/Disenrollment transaction (known as the X12 834) and the health plan premium payment transaction (known as the X12 820), citing various reasons including the fact that employers (one of the end-points of these transactions), are not designated as a covered entity under HIPAA and therefore are not required to implement the standard. Recommendations addressed concerns regarding the need:

(1) For the X12 834 used by the insurance marketplace, the Center for Consumer Information and Insurance Oversight (CCIOO) Companion Guides, and the X12 834.
(2) To examine approaches to increase implementation of the X12 834 and 820.
(3) To examine the necessity for the X12 834 and 820.

Health Plan Eligibility, Benefits Inquiry and Response

Utilization of the adopted standard and operating rules for the Health Plan Eligibility, Benefits Inquiry and Response transaction is variable. While the benefits of the transaction and its ability to meet the healthcare industry's business needs had been noted by some testifiers, others indicated that the standard could be enhanced. Recommendations addressed concerns regarding the need to:

(1) Evaluate the adopted standard and operating rules to determine if business needs are being met and the degree to which it allows for reporting complex benefit structures.
(2) Ensure data elements are comparable to data elements on the website
(3) Ensure all required information is required in the standard.
(4) Ensure reporting of tiered benefits, granularity, and consider service type differences.
(5) Confirm next version of the standard removes barriers.
(6) Consider real time information of patient liability.

Prior Authorization

The complexity of the prior authorization transaction standard (X12 278) is reported as not helping the health care industry achieve its intended purpose and benefits. Variation in medical and pharmacy benefits results in different prior-authorization rules that are cumbersome, result in inconsistent workflow processes, and require additional requested information through manual processes. Additionally, health plans' web portals have become

predominant venues for providing greater level of functionality and information exchange to achieve prior-authorizations. Recommendations are on the need to:

(1) Name the NCPDP Script Standard Version 2013101 as the adopted standard for prior authorization for the pharmacy.
(2) Evaluate the value of the current prior authorization standard including the use of web portals and changes required to future versions.
(3) Determine if the standard's low utilization is due to the issues identified by stakeholders.
(4) Ensure effective communication of the transaction status beyond "contact us or pending."
(5) Determine if the standard meets business needs.
(6) Determine why prior authorization standard is seen as too complex.
(7) Ensure that providers' systems vendors support the X12 278.
(8) Have health plans provide more than basic responses to requests received.

Health Care Claim or Equivalent Encounter Information

Testifiers reported that the healthcare claim or equivalent encounter information (X12 837) is being submitted electronically and are meeting the business needs of the healthcare industry. Recommendations are on the need to:

(1) Research the variations in requirements to determine needed data and proper placement of the data to submit a clean claim and have it processed correctly.
(2) Address the issues identified by stakeholders.
(3) Expand or revisit Medicaid specific codes that are different than commercial codes.

Coordination of Benefits

Testifiers indicated the coordination of benefits (COB) transaction is minimally used by midsized and smaller payers. Every clearinghouse has the ability to send COB information. It is the quality and amount of the payment/rejection data that is key to success. Value is achieved when coordination of benefits is performed electronically and payment information on the remittance advice is accurate and accepted by the secondary payer resulting in variable use of the coordination of benefits transaction. Recommendations are on the need to:

(1) Evaluate the standard and operating rules for applicability in various health care settings.
(2) Consider the most effective way for providers to receive information on individuals with multiple health insurance coverage.
(3) Operating rules on how information is communicated should be developed.

Health Care Claims Status

There is a varying degree of utilization of claims status and eligibility inquiry transactions (X12 276 provider inquiry and the X12 277 response) across providers and third party vendors.

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However, stakeholders have indicated the effectiveness of the Health Care Claim Status transaction. Recommendations are on the need to:

(1) Consider adopting the X12 277 Health Care Claim Pending status information transaction.
(2) Consider implementing operating rules for content of the claims status response with defined code combinations which would address questions on valid code use.
(3) Determine if real-time health care claim status meets a business need.
(4) Include all adjudication information in the claims response.
(5) Evaluate and modify current standard and operating rules to address identified issues.

Health Care Payment, Remittance Advice and Electronic Fund Transfer

As with the other transactions, there is variability in use of the Electronic Fund Transfer (EFT) and Electronic remittance Advice (ERA) transactions. Several providers noted that approximately 90 percent of payments are posted electronically using the X12 835 (Remittance Advice). Sufficiently detailed Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) codes are being used more consistently. Recommendations are on the need to:

(1) Address problems with reconciling an ERA to the related EFT.
(2) Address the overpayment and recovery process within the X12 835.
(3) Coordinate activities to maintain code sets.
(4) Evaluate data requirements.

In conclusion, the healthcare industry's adoption and implementation of administrative simplification standards and operating rules has presented many challenges. The first Review Committee hearing provided an opportunity for NCVHS to learn about the successes as well as the barriers to successful implementation. NCVHS remains available to answer any questions and will continue to support the efforts of the healthcare industry, Standard Development Organizations, Operating Rule Authoring Entity and DHHS in the promotion and expansion of administrative simplification.

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II. Background

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (DHHS or referred to in this paper as HHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS advises the Secretary on the adoption of standards, implementation specifications, code sets and identifiers for the HIPAA-named transactions.

The Patient Protection and Affordable Care Act (ACA) {sec. 1104) (b) enacted on March 23, 2010, called for NCVHS to further assist in the achievement of administrative simplification to "reduce the clerical burden on patients, health care providers, and health plans." ACA also requires the Secretary to adopt standard operating rules for the implementation of each of the HIPAA-named transactions, as recommended by NCVHS. In addition, Section 1104(i) of (ACA) authorizes the Secretary to establish a Review Committee responsible for conducting hearings to evaluate and review the adopted standards and operating rules. NCVHS was designated in 2014 by the Secretary to act as the Review Committee.

Health care costs continue to rise. Studies support that administrative costs continue to represent an important component of the overall cost of health care and that these costs can be reduced through greater standardization. In fact, the overarching goal of the administrative simplification provisions of HIPAA and ACA is to improve the efficiency and effectiveness of the health care system through the establishment of uniform standards and requirements for the electronic transmission of certain health information to reduce the clerical burden on patients, health care providers, and health plans. Simplification occurs through adoption of standards via the federal rule making process, followed by implementation of the adopted standards by those entities subject to the regulations and engaged in each of the transactions.

Testifiers at various NCVHS hearing in the past, including the June 2015 NCVHS Review Committee hearing, have acknowledged evidence of savings achieved through the adoption and implementation of standards for all the HIPAA named transactions. However, achieving the potential savings has been limited by a number of factors, including variability in the level of implementation and inconsistency in the method of implementation of both the transaction standards and operating rules.

A. Administrative Simplification Legislation

The Administrative Simplification provisions of HIPAA (signed into law in 1996) require the Secretary of HHS to adopt a series of standards to support the electronic exchange of specific administrative and financial healthcare transactions. HIPAA called for NCVHS to advise the Secretary on the adoption and implementation of standards in:

- Health care financial and administrative transactions and code sets;
- Unique health identifiers for employers, providers, health plans and individuals;

- Health information privacy and security standards; and
- Medical record information data standards.

Enactment of the American Recovery and Reinvestment Act, (ARRA, Public Law 111-5) and in particular Title XIII, the Health Information Technology for Electronic and Clinical Health (HITECH) Act and the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act, expanded NCVHS' responsibilities to advise the Secretary on the adoption and implementation of standards as cited above and in addition:

- Establishment of the Review Committee
- Adoption of a set of standard Operating Rules for each of the HIPAA named transactions
- Recommendations on additional administrative and financial areas where standardization would provide cost and efficiency benefits (the 10109 section)

B. Review Committee Legislation

Section 1104(i) of the Affordable Care Act stipulates that the Secretary establish a Review Committee to: 1) Conduct hearings not less than biennially to evaluate and review the adopted standards and operating rules. 2) Provide recommendations to the Secretary not less than biennially for updating and improving such standards and operating rules. 3) Recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards. 4) Ensure coordination, as appropriate in developing recommendations, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

NCVHS has been designated as the Review Committee by the Secretary of HHS. NCVHS is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the HHS Secretary. The NCVHS has delegated the responsibility of the Review Committee to the NCVHS Standards Sub-Committee.

C. Review Committee Structure and Process

Consistent with Section 1104(i) of the Affordable Care Act (ACA), the purpose of the Review Committee is to review all of the HIPAA named health care administrative transactions for which standards, code sets, identifiers, (heretofore collectively referred as "standards") or operating rules have been adopted in regulations and are currently in use. For these HIPAA named health care administrative transactions the Review Committee review process will determine if each adopted standards or operating rules) 1) continues to meet current industry business needs and therefore no change is necessary; 2) does not meet current industry business needs and therefore there is a need to move to a new version of the standard or operating rule; or 3) does not meet current industry business needs and therefore there is a need to adopt a different standard or operating rule for the transaction.

All members of the NCVHS Standards Sub-Committee are considered members of the Review Committee. The co-chairs of the Standards Sub-Committee act as Review Committee co- chairs. The lead staff of the Standards Sub-Committee acts as lead staff for the Review Committee. Any other members of the full NCVHS can also participate in the Review Committee by joining the Standards Sub-committee. When additional expertise is needed, content experts may be invited by the Review Committee co-chairs to address specific issues. Additional expertise would be accomplished either through limited participation at Review Committee meetings or in the formation of time-limited, purpose-focused Review Committee task groups, at the discretion of the Review Committee co- chairs. Technical support is provided by the Standard Sub-Committee lead staff and other existing Standards Sub-Committee staff and resources.

III. Inaugural Review Committee Hearing

NCVHS, acting as the Review Committee, held its first hearing on June 16 and 17, 2015. Over the two-day hearing, NCVHS listened to seventy-seven oral testimonies and reviewed over 100 additional written testimonies from the health care industry. In this report, we summarize the findings and provide recommendations directed to the health care industry, Standard Development Organizations (SDOs), Operating Rules Authoring Entity (ORAE) and the Department of Health and Human Services (DHHS). NCVHS developed a separate letter that was submitted to the Secretary of HHS on February 29, 2016, including observations, themes, issues, and NCVHS recommendations for HHS[2]. The content of the letter to the Secretary is included in this report.

A. Intent

The purpose of the June 2015 hearing was to gather feedback from the industry regarding the state of implementation of all the HIPAA named transactions which included: 1) health plan enrollment and disenrollment; premium payment; (2) claims status; 3) health plan eligibility, benefits inquiry and response; 4) prior authorization; 5) health care claim or equivalent encounter information; 6) electronic fund transfer and electronic remittance advice; and 7) coordination of benefits.

B. Structure

The June 2015 Review Committee hearing consisted of seven panels – Health Plan Enrollment/Disenrollment and Health Plan Premium Payment; Health Plan Eligibility, Benefits Inquiry and Response; Prior Authorization; Health Care Claim or Equivalent Encounter Information; Coordination of Benefits; Health Care Claim Status; and, Health Care Payment, Remittance Advice and Electronic Fund Transfer. Each of the testifiers was allocated five minutes to present highlights of their testimony with details provided in written testimony. After each panel of testimony, questions were asked by NCVHS committee members followed

[2] February 29, 2016 letter to Secretary Sylvia M. Burwell, Review Committee Findings from the Administrative Simplification Hearing.

by discussion among testifiers and NCVHS members. At the conclusion of each panel, the public was invited to provide commentary. The public was also invited to submit written testimony. Over 100 written testimonies were submitted by panelists and the public.

The hearing was conducted in accordance with FACA policies and NCVHS practices, including: (1) issuing early public announcement, (2) developing an agenda and topics to be covered, (3) establishing a set of questions to be addressed by testifiers, (4) identifying and inviting industry representatives to provide oral testimony, (5) inviting the health care industry and the public at large to provide written testimony, and (6) allowing for public input during the hearing. The hearing was public, and was accessible remotely through webcast.

Consistent with the ACA Statute, the Review Committee subsequent to the hearing, provided to the HHS Secretary a summary of findings and a set of recommendations for HHS on the need to update specific standards, code sets, identifiers or operating rules for specific transactions. This report incorporates the recommendations in the February 2016 letter to the HHS Secretary as well as recommendations directed to the health care industry, Standards, Development Organizations (SDOs) and Operating Rule Authoring Entity (ORAE).

C. Questions

Testifiers were asked to address a set of specific predefined questions concerning:

- The current status of implementation of all HIPAA-named transactions and their corresponding standards and operating rules.
- The degree to which current standards, code sets, identifiers, and operating rules continue to fulfill the business needs of the health care industry.
- The degree to which the use of the standard or operating rule results in discrepancies, ineffectiveness or inefficiencies in the implementation of a transaction, which causes conflicting or unanticipated negative impact to transaction implementers and the industry as a whole.
- Any inability or limitation of the standard or operating rule to meet new and emerging business needs of the industry.
- Whether changes in current standards and operating rules for any particular transaction are needed.

The Designated Standards Maintenance Organizations (DSMO), SDOs, and ORAE were invited to testify and address these questions for each of the existing named HIPAA transactions. In addition, the groups were asked to review key maintenance changes made to existing standards or operating rules including a description of the business case and technical solution/approach used. Representatives from various segments of the health care industry (i.e., providers, payers, clearinghouses, public programs, vendors, and others) were also invited to testify.

The health care industry at large was invited to submit written testimony. All testifiers were requested to provide objective data to support their testimony. This may include analytical data, market research, cost-benefit analysis and other forms of objective analysis. Specific questions asked of panelists at the June 2015 hearing can be found in Section 7.1 of this report.

D. Panelists

To ensure that stakeholders had an opportunity to provide feedback to NCVHS, health care industry organizations and associations were contacted requesting their participation as testifiers at the hearing. Additional organizations and associations that contacted NCVHS requesting to participate at the hearing were either added to the agenda or were requested to submit written testimony. Consequently, testimony was presented or submitted for health care providers, health plans, vendors, clearinghouses, professional and trade organizations and associations, public programs (Medicare, Medicaid), federal agencies, standard development organizations, operating rules authoring entity and consultants. A list of panelists at the June 2015 hearing can be found in Section 7.2 of this report.

IV. Evaluation Criteria

NCVHS reviewed testimony and formulated its recommendations utilizing the criteria that formed the basis of the questions testifiers were asked to address in their testimony. The criteria, centered on identifying if the adopted standards (including code sets and identifiers) and operating rules (where adopted):

- Meet the industry's business need/use/problem resolution;
- Decrease cost and/or administrative processes;
- Are flexible/agile to meet changes in technology and/or healthcare delivery systems;
- Can be operationalized; and
- Can be enforced

In addition to these criteria, NCVHS looked at other factors to evaluate the degree to which the adopted standards and operating rules were meeting the overall goal of administrative simplification. These included:

- *Completeness:* Does the standard or operating rule provide the complete information necessary to execute the transaction and achieve the business purpose?
- *Efficiency*: Does the standard or operating rule decrease resource utilization and the time to perform the transaction function?
- *Complexity*: Do the standard or operating rule requirements exceed the healthcare industry's cost and resource capacity resulting in limited or non-implementation?
- *Flexibility*: Does the standard or operating rule allow for interim updates and can it adapt to changes in technology and health delivery models?
- *Consistency*: Is the standard or operating rule able to be implemented in the same manner across all healthcare entities?
- *Effectiveness*: Does the standard and operating rule solve the business need?
- *Ambiguity*: Does the standard or operating rule result in differences in interpretation and in implementation?

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V. General Findings and Recommendations

Many stakeholders reported that the adoption and implementation of all HIPAA-named transaction standards and operating rules across the industry is a significant step forward towards achieving greater administrative efficiencies. The health care industry, SDOs, ORAE and HHS have led the way in moving the entire ecosystem towards administrative simplification. However, further work is needed to refine and continuously update the adopted transaction standards and operating rules and increase their level of implementation and the consistency in the way they are implemented and used.

The health care industry representatives indicated not all adopted transaction standards and operating rules show consistent and sustained adoption for a number of reasons including advances in information technology, changes in health care delivery models, changes in reimbursement models, and availability of simpler or less costly alternatives. These do not negate the progress made and the ongoing need for administrative simplification. The health care industry has made significant progress in identifying ways to continue to improve administrative processes and functions. However, the process is dynamic and the ability to achieve greater administrative simplification needs to adjust and evolve if lower administrative costs are to be attained through standardization. There are strategic opportunities to achieve greater administrative simplification at lower costs, and this report highlights many of them. Some transactions such as health care claims, eligibility and claim status are likely to remain useful while other transactions may not as the health care industry continues to evolve around population health management, chronic and rare disease management, increased integration and coordination across delivery systems, shared risk payment models, and high value provider/payer network arrangements. Additionally, many health care industry entities are not HIPAA covered entities, resulting in increased costs attributed to customization and maintenance associated with using proprietary specific methods to capture necessary data and information. Specifically, testifiers indicated that non-covered entities have not adopted the standards to any significant degree, and thus providers and their vendors are obligated to support duel systems, eroding the savings potential.

One of the most significant findings from the June 2015 hearing was the variation in the *level* of implementation of various transaction standards and operating rules. While five transactions (eligibility, claim, claim status, remittance advice and coordination of benefits) are being widely implemented, others (electronic funds transfer, benefit enrollment/disenrollment, premium payment, and prior authorization) are not yet widely implemented. Industry representatives believed that for greatest impact at this time, primary focus should be on enhancing the quality, consistency and reliability of the five transactions that are most widely implemented, and their adopted standards and operating rules, to expand and strengthen demonstrated benefits. Testifiers indicated that the health care industry deems the EFT transaction as the transaction to move forward and de-emphasis the other HIPAA – named transactions at the current time.

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Another significant and related finding was the degree of *inconsistency* that still exists within the industry in the way transaction standards and operating rules are being implemented. Even when the transactions are implemented electronically using the adopted standards and operating rules, inconsistencies in the implementation rules that define the data content, coding, and processing are creating barriers that require workarounds or manual interventions to achieve the expected efficiencies and effectiveness. Such is the case, as noted by testifiers, with some of the submissions and responses of each of the five widely implemented transactions (eligibility, claims, claims status, remittance advice, and coordination of benefits). Reasons for these two issues identified by testifiers included:

- Level of complexity of the adopted standards.
- Concerns that adopted standards are not meeting business needs.
- Use of alternative technologies to conduct the transactions in a more efficient and effective manner.
- Not all entities engaged in conducting the HIPAA-named transactions are deemed as covered entities under HIPAA and therefore are not subject to complying with standards and operating rules.

A substantial amount of effort has been put forth across the country to foster administrative simplification. However, there is still much to be done to enhance the transactions to expand their adoption and increase consistency in the way they are implemented and used. Implementation efforts have been impacted by multiple priorities and resource constraints including the lack of clear lifecycle for managing national standardization to achieve reductions in administrative burden.

At the same time, rapid advances in health information technology (HIT) and the transformative changes in health care delivery and payment models currently underway are creating the need for new business requirements that are not part of the current standards for how administrative and billing processes in health care will be done in the future. NCVHS views these challenges as strategic opportunities to refine and align the goal of administrative simplification with the changes in technology and healthcare delivery models.

In this report, NCVHS describes benefits, issues and barriers to full implementation of the HIPAA-related transactions, as identified by health care industry experts and reported in written and oral testimony at the Review Committee's June 2015 hearing. NCVHS also provides recommendations to the SDOs, ORAE, health care industry and HHS, to further support adoption and implementation of standards, code sets, identifiers, and operating rules. The term Standards Development Organizations (SDO) is used inclusively to refer to both Standards Setting Organizations (SSO) and Designated Standards Maintenance Organizations (DSMO).

The following recommendations address concerns raised by the testifiers at the June 2015 hearing. Some of the issues identified and the subsequent recommendations are common to all transactions while others are unique to specific transactions. Transaction specific recommendations are discussed in their respective areas further in this report. Some of the

recommendations, indicated by a * have been addressed in the February 29, 2016 letter to the Secretary included in the appendix.

A. Definition of HIPAA Covered Entities

Recommendation 1: ***Explore the Feasibility of Expanding the Definition of HIPAA Covered Entities.***

Consistent and broad implementation of the adopted standards and operating rules is at times challenged by the current definition of a HIPAA Covered Entity. Various organizations that are currently not included in the definition of a HIPAA Covered Entity are actively engaged in exchanging administrative and financial data. They include employers, worker's compensation plans, property and casualty industry, and other health care related organizations. This results in a lack of use of electronic transaction standards and increased costs attributed to customization and maintenance associated with using proprietary methods to capture necessary data and information. For example, Health Plans, as HIPAA covered entities, are required to be capable of conducting the enrollment/disenrollment and premium payment transactions electronically. However, employers, who are the other end of these two transactions, are not covered under HIPAA, thus, are not required to conduct these transactions electronically using the adopted standards. Similarly, in the workers' compensation area, providers that are HIPAA covered entities submit claims to workers' compensation plans, but cannot always use the same electronic claim transaction standards adopted for all other health care claims, because the workers' compensation plans are not covered entities, and they can and often do use a different standard to receive and process these types of claims.

Recommendation 1.1: *HHS* should*:

1.1.1 Explore the feasibility of requesting that Congress amend the definition of a covered entity to include all entities that performs HIPAA-named transactions. As covered entities, they would then be required to comply with the adopted standards and operating rules. This would include but not be limited to employers, worker's compensation, property and casualty industry, practice management systems (PMS), and other vendors of relevant solutions.

1.1.2 In the absence of a statutory amendment to the definition of a covered entity, HHS should explore other regulatory and non-regulatory mechanisms (including federal procurement and contractual requirements) to require that any entity that performs a HIPAA-named transaction specified in §1104(h)(B)(3) of ACA and, comply with the standards (including code sets, identifiers) and operating rules adopted for these transactions.

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B. Education

Recommendation 2: ***Broaden Education***

The lack of consistent and reliable industry-wide knowledge and understanding of the use of transaction standards, code sets, identifiers and operating rules was attributed to the variability in implementation of the transaction. All testifiers agreed that increased education and knowledge on the use of standards and operating rules is needed. The success of the ICD-10 transition has been attributed to industry wide education efforts. As this is an industry-wide, multi-stakeholder need, NCVHS recommends a broad education effort.

Recommendation 2.1: The *Healthcare industry, Standard Development Organizations, and Operating Rules Authoring Entity and HHS* should work together to ensure that:

2.1.1 Stakeholders have access to and are educated on the purpose, value, implementation and use of standards and operating rules. This would include intended benefits and other considerations to support greater implementation and standardization of use.*

2.1.2 Instructional materials are prepared with multi-stakeholder involvement, address currently adopted standards (including code sets and identifiers) and operating rule requirements, and are clear, concise, consistent and relevant.*

2.1.3 Stakeholders are educated on the already demonstrated benefits of administrative simplification transactions, such as:*

2.1.3.1 Front-end edits by clearinghouses and payers have quickly identified and reported back to providers claim errors or deficiencies so they can be promptly addressed and the claim submitted correctly improving processing timeliness.

2.1.3.2 Automated edits helped speed development and review of claims as fewer claims must be manually inspected and checked.

2.1.3.3 Providers' ability to capture upfront, more information needed for payment.

2.1.3.4 Ability to send secondary and tertiary claims electronically.

2.1.3.5 Reduced claim adjudication issues and denials.

2.1.3.6 Accelerated turnaround times resulting in better use of staff and resources.

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2.1.4 Ensure that due to the inherent complexity of standards and operating rules, education should be geared towards the specific receiver.

2.1.4.1 Non-technical education for the institutional decision makers who make the business decisions to implement the standards and operating rules.

2.1.4.2 Technical and more comprehensive education should be targeted for those who will be implementing the standards and operating rules.

C. Consistency

Recommendation 3: ***Ensure Consistency***

Testifiers discussed the multiplicity of requirements and instructions addressed in the standards, operating rules, and proprietary policies. Some testifiers indicated that the standards and their accompanying operating rules are developed in isolation rather than as a system of standards, with a number of processes or workflows that need to be integrated. As this is an industry-wide issue, NCVHS sees the need to promote consistency as an industry-wide endeavor. Consequently, the *Healthcare industry, Standards Development Organizations, Operating Rule Authoring Entity and HHS* should work together to ensure that standards, code sets, identifiers and operating rules are simplified, unambiguous, able to be operationalized, and adaptable to current and future needs. Specifically,

Recommendation 3.1: *HHS* should:

3.1.1 Consider requiring operating rules (e.g. connectivity) be consolidated across transactions including combining all phases in a single document, to alleviate the need for the industry to support different versions of a similar rule for different transactions.*

3.1.2 Respond to the X12 request to validate the use of the X12 TR3 Schema thus mitigating inconsistent XML based solutions.*

3.1.3 Work with the *Standards Development Organizations and the healthcare industry* to measure the degree to which each of the transaction standards and operating rules are being implemented in an inconsistent manner, the reasons for the inconsistent implementation, and explore requirements to reduce or eliminate the causes of these inconsistencies.*

3.1.4 Consider that additional efficiencies can be realized through common understanding of the healthcare industry to ensure consistent implementation and cohesion between adopted standards and operating rules.

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Recommendation 3.2: *Standard Development Organizations and Operating Rules Authoring Entity* should:

3.2.1 Ensure that all data requirements are transparent, clearly delineated, uniform and applicable across all entities.

3.2.2 Ensure that all of the data requirements, coding, and data structures contained in the standards are fulfilled completely and accurately, and in accordance with the guidelines of the standard.

3.2.3 Consider the aggregate healthcare data sets generated from claims such as statewide hospital discharge databases and emerging All-Payer Claims Databases, and analytic initiatives as standards and operating rules are developed and/or modified.

3.2.4 Ensure that data content and information available is consistent with the data and information provided by proprietary web portals and automated voice response systems.

3.2.5 Ensure that key terms are defined to mitigate misinterpretation, misuse and confusion.

Recommendation 3.3: The *Operating Rules Authoring Entity* should require the same connectivity and security requirements across all transactions.

D. Enforcement

Recommendation 4: ***Enforce Compliance***

As noted earlier, a common theme by testifiers was the inconsistent level of implementation and compliance with the adopted standards and operating rules. Testifiers indicated the need for enforcement in addition to the complaint-driven enforcement approach being used. Testifiers also noted that there is reluctance by the industry to report lack of compliance by other covered entities.

The level of and inconsistency in the implementation of adopted standards and operating rules are for the most part transaction-specific issues and generally associated with two factors:

- Whether the two ends of the transaction (that is between provider and payer) are required to conduct the transaction electronically using the adopted standards and operating rules.

- The complexity of the adopted standards and/or operating rules for the transaction.

Testifiers affirmed that enforcement would serve as an incentive for compliance especially with the possibility of being assessed a considerable penalty fee. However, because of the range of inconsistencies identified, NCVHS recommends the following:

Recommendation 4.1: *HHS* should:

4.1.1 Sequence enforcement efforts initially focusing on the five widely implemented transaction standards and operating rules (eligibility, claim, claim status, remittance advice and coordination of benefits).*

4.1.2 Educate the industry on compliance and penalties, including communicating compliance, audit, and enforcement requirements to ensure that there is consistency in compliance with all the transaction requirements.*

4.1.3 Consider publicizing best practices and educational resource tools to support compliance efforts.*

4.1.4 Initiate development of a tool that could be used by stakeholders and by HHS to assess compliance, and that can evaluate and measure compliance with each standard and operating rule.*

4.1.5 Review existing mechanisms designed to enforce compliance with adopted standards and operating rules including the assessment of penalties and fines for non-compliance.*

4.1.6 Consider enforcing compliance with the adopted standards and operating rules with the same level of engagement seen in the OCR HIPAA Privacy and Security Compliance Program.*

4.1.7 Consider publicizing enforcement details to include but not limited to:*

4.1.7.1 Number of complaints that were penalized
4.1.7.2 Consequences of non-compliance
4.1.7.3 Enforcement process
4.1.7.4 How to file complaints while mitigating damage with the payer relationships

4.1.8 Work with the industry to consider establishing automated testing tools that practice management systems and other vendors can use to validate a transaction's conformance to the adopted standards and of operating rules.

Recommendation 4.2: *The healthcare industry* should:

4.2.1 Ensure that covered entities and their trading partners, vendors and business associates comply with the requirements in the adopted standards and operating rules. This may include specifying this need in contractual content, eliminating

proprietary specific forms, policies and requirements if they impede with business needs; transmitting all information by intermediaries and vendors; and providing benefit information, authorization requirements and referral requirements.

4.2.2 Encourage Practice Management Systems to comply with adopted standards and operating rules.

4.2.3 Require more vendor transparency of which standards and operating rules it supports and how well they perform on conformance testing tools described in recommendation 4.1.8.

4.2.4 Consider the effectiveness of establishing vendor responsibility for compliance with transaction standards and operating rules through validation described in section 4.1.8 or other mechanism.

E. Acknowledgment Transaction

Recommendation 5: ***Adopt the Acknowledgment Transaction****

Presenters indicated that one transaction that is not currently mandated or used consistently by the healthcare industry yet has great value is Acknowledgments.

The acknowledgment transaction is widely seen by the industry as a critical element in the end-to-end healthcare administrative transactions lifecycle. The transaction, which is used to quickly return valuable information about the receipt of an inbound transaction (for example, a claim submitted by a provider to a health plan), helps inform the submitter of the inbound transaction (the provider, in the example) about the need to correct certain elements of the submitted transaction before it can begin to be processed, or confirm that the transaction was appropriately received and no corrections are needed before processing begins.

Acknowledgments are currently voluntarily being used by many in the healthcare industry. For example, Medicare uses claim acknowledgment X12 277CA transaction to report acceptance or rejection of claims, which many payers have followed. However, others continue to generate proprietary reports which are dynamic and require constant support to maintain the integrity of the data extracted and lack details to show that a payer has moved the submitted claims into its adjudication system. Acknowledgments also provide a way to the submitter, a receipt of a transaction, thus avoiding costly and lengthy details to validate receipt of transactions.

There are four types of X12 acknowledgments currently voluntarily in use.

- The X12 999 Implementation Acknowledgment for all batch transactions (rejects only for real-time) which functions like a postal return receipt and provides consistent messaging when there are syntactical errors with the transaction so they can be corrected and resubmitted.

- X12 TA1– Interchange Acknowledgment used for EDI envelope containing external addressing information that lets the submitter know if its envelope was received and if there were any errors.

- The X12 277 Health Care Claim Acknowledgment acknowledges each individual claim and when there are business errors a standardized set of error codes describe what the error was so the provider can correct and resubmit. Historically every health plan and clearinghouse had their own proprietary acknowledgment for claims requiring providers to interpret each payer and clearinghouse claim reports. The X12 277 would replace all reports with a single transaction.

- The X12 824 Application Reporting for Insurance provides same functionality as the X12 277 for all other transactions than the X12 837 healthcare claims.

Testifiers have indicated that there is wide industry consensus in support of adopting this transaction. NCVHS has in the past recommended that HHS adopt a national standard for the Acknowledgement transaction[3]. NCVHS stands by this previous recommendation. In addition:

Recommendation 5.1: *HHS should:*

As previously recommended by NCVHS, *HHS* should pursue adoption of the standards and operating rules for the acknowledgment transaction, and specify which acknowledgments are to be used in conjunction with each transaction.

F. Predictability

Recommendation 6: ***Provide Predictability in Adoption of Standards, Code Sets, Identifiers, and Operating Rules.***

Industry representatives expressed concerns regarding the lack of predictability in the adoption life cycle of standards, code sets, identifiers and operating rule and the associated implementation timetables and processes. This applies to initial adoption and version updates. Further, timetables appear to be set without consideration of the range of mandated requirements; availability and adoption of standards; implementation process for standards, code sets, identifiers, and operating rules; the lag time between standard versions; and the adoption of standards and operating rules that often coincide with the need to implement other mandated requirements. NCVHS recognizes that recommendations to resolve these issues require a **long term approach** that would not be achieved within the next year.

Recommendation 6.1: *HHS* working with the *Standard Development Organizations, Operating Rule Authoring Entity and the healthcare ind*ustry should consider developing in 2016:

[3] September 22, 2011, September 21, 2012 and September 20, 2013 letters to Kathleen Sebelius, Secretary, Department of Health and Human Services, from the National Committee on Vital and Health Statistics (NCVHS)

6.1.1. A long term roadmap for the adoption and implementation of the next version of standards and operating rules, including a more predictable and efficient cycle from industry recommendation to upgrade of standards and operating rules, to the regulatory levers to mandate scope and timing of the upgrade. There should be an opportunity for broad industry review and comment on the roadmap. The roadmap development may include the need for coordination among applicable HHS agencies around a consolidated strategic plan, interoperability of the roadmap, and the approach to achieving enhanced processes for the implementation of revised and/or new mandated standard transactions and operating rules to ensure an orchestrated glide path for adoption and implementation while reducing the current state of competing priorities. The roadmap and enhanced processes should also be flexible to accommodate the need to adopt standards in between cycles, if required for healthcare industry business needs.*

6.1.1.1. The developed roadmap could be used by HHS agencies to pre-identify emerging business requirements for standards development to accommodate emerging innovations in delivery systems (e.g. accountable care organizations, comprehensive primary care programs, and other prototypes being developed by CMS.

6.1.2 A proposed mechanism for monitoring progress in the implementation of transaction standards and operating rules. This could entail working with other organizations on standardized metrics and data sets to monitor industry usage of the HIPAA required transactions and their respective adopted standards and operating rules.*

G. Evolving Health Care

Recommendation 7: Ensure Responsiveness to Evolving Changes in Health Care

To ensure that the standards and operating rules maintenance process is responsive to evolving changes in the healthcare industry's business needs, *Standard Development Organizations and Operating Rules Authoring Entity* should reassess and determine the degree to which their standards and operating rules meet current business needs.

Recommendation 7.1: The *Standard Development Organizations and Operating Rules Authoring Entity* should:

7.1.1 Consider the steps taken by NCPDP to maintain developed standards and determine its applicability to their standards and operating rules.

7.1.2 Undertake research to confirm that modifications to standards and operating rules remove identified barriers and have the potential for return on investment for covered entities before recommending adoption.

7.1.3 Determine if new transaction features provide business value before recommending adoption to ensure that adopted standard and operating rule requirements are clear, concise, consistent and relevant.

7.1.4 Ensure that Pilot testing of standards occur before adoption and before final implementation.

7.1.5 Evaluate the cost of implementation is critical to determining true impact and benefit of adopting future transactions and should be considered in the development of and modification of standards and operating rules.

7.1.6 Review the adopted standards and operating rules to simplify them where the complexity is beyond the industry's capacity resulting in non-adoption.

7.1.7 Should work with HHS and the healthcare industry to ensure that any modifications made can be implemented in a cost-effective manner.

Recommendation 7.2: The *Operating Rule Authoring Entity* should review and development of operating rules should allow for sun setting, consolidation, flexibility and revision of the current rules and should include a regular development cycle of review and maintenance of currently adopted ORs.

VI. HIPAA Transaction-Specific Findings and Recommendations

As noted earlier in this report, testifiers indicated that there are multiple reasons for the varying degrees of implementation of specific HIPAA-named transactions. Examples of barriers to implementation and specific recommendations to resolve the issues were provided. This section addresses transaction specific barriers.

To ensure consistency in terminology, in this report we use the term "transaction" for the HIPAA – named transactions (e.g. Health Claim Status Transaction); and "standard" for the current version 5010. Implementation guides for the numbered specifications in v5010 standard are indicated simply as the number in the guide (e.g. "276" for the provider inquiry). Finally, the term "payer" is used interchangeably with health plans.

A. Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

The healthcare industry representatives indicated that there has been low implementation of the health plan enrollment/disenrollment transaction (known as the X12 834) and the health plan premium payment transaction (known as the X12 820), citing various reasons including the fact that employers (one of the end-points of these transactions), are not designated as a covered entity under HIPAA and therefore are not required to implement the standard. This significant barrier creates a significant degree of variability in data provided because adopted transactions are not used by all trading partners. Testifiers agreed that utilization would increase if there was a statutory requirement that the transaction be implemented for all healthcare enrollment and premium payment uses. In addition, Health Plans participating in the health insurance marketplaces (HIX) are having to work with the X12 834, adopted for HIPAA covered entities, the X12 834 HIX standard, and the Center for Consumer Information and Insurance Oversight (CIIO) Companion Guides for use in the enrollment of individuals participating in the insurance marketplaces.

Business and data requirements for exchange transactions differ from enrollment for commercial and other lines of business. Other regulatory requirements require the issuer and the market exchange to track and reconcile membership and financial data differently than commercial and other lines of business. State-based marketplaces (SBMs) are not required to implement the same enrollment and payment processes as the Federally Funded Marketplaces (FFM), resulting in wide variability and is major challenge for issuers requiring additional information technology (IT) builds and operational processes for each State in which issuers offer exchange coverage. Each SBM determines which components of the X12 834 it will use including which data elements will be sent and what available codes will be used. Business needs of the HIPAA transaction and the HIX transactions that are not currently accommodated, are anticipated to be addressed in later versions.

Other barriers cited by testifiers include:

- Costs associated with implementing the transaction are required due to the need to purchase TR3s, understand the transactions and X12 EDI, and create programs and coding to meet requirements.

- A lack of response transaction to allow the payer to respond about the processing of enrollment or premium payment sent.

- Lack of adoption of the acknowledgement standard which validates against the TR3 leading to payers to sending a custom report to the employer group or field member's status questions.

- Employers have their own formats for creating employee lists to send to payers for inclusion in a health plan group benefit and there is no HIPAA rules for this business usage. In addition, the sending entity is not a covered entity.

Recommendation 8: Based on the testimony provided, NCVHS provides the following recommendations for the Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

Recommendation 8.1: *HHS should:**

Explore ways to bring to full convergence the X12 834 HIX (used by the insurance marketplaces), the CCIIO Companion Guides, and the current X12 834 used by HIPAA covered entities for all other enrollment transactions, so they become one and the same. This would simplify and reduce administrative burden on health plans.

Recommendation 8.2: The *Healthcare Industry and HHS* should:*

Examine the approaches that would increase Implementation of the X12 834 and 820, avoiding maintenance of multiple channels of data input that results in increased customization of vendor tools increasing costs and labor, into enrollment systems.

Recommendation 8.3: The *Standard Development Organizations* should:

Develop a response transaction – different from an acknowledgment transaction- to allow the payer to respond to the processing of enrollment and/or premium payment sent and the status of the processing.

Recommendation 8.4: The *Healthcare industry, Standard Development Organizations and Operating Rules Authoring Entity* should*:*

8.4.1 Evaluate the necessity of the transaction standards to determine if the X12 834 and the X12 820 are meeting current business needs and either modify the existing standard and/or proposed operating rule or recommend to NCVHS the need to eliminate the requirement to implement them.

8.4.2 Research the value of the 834 HIX created by X12 to determine if it aligns better with the use case rather than using the X12 834 with the Center for Consumer Information and Insurance Oversight (CCIIOO) companion guide.

B. Health Plan Eligibility, Benefits Inquiry and Response

Utilization of the adopted standard and operating rules for the Health Plan Eligibility, Benefits Inquiry and Response transaction is variable. While the benefits of the transaction and its ability to meet the healthcare industry's business needs had been noted by some testifiers, others indicated that the standard could be enhanced. Testifiers cited benefits of the transaction as:

- Improved productivity.

- Labor cost savings.
- Patient satisfaction.
- Bad debt reduction with improved collection.
- Enhanced revenue cycle management.
- Ability to track transactions flow among trading partners.
- Common documentation requirements.
- Direct connection.

Additionally, the transaction could give a provider the necessary information about a patient's health insurer prior to rendering care including:

- Clear identification of entities involved in the claims payment process.
- Available coverage.
- Required documentation.
- Prior authorization.
- Requirements to help the provider file claims and get paid.

Testifiers indicated that providers do not always use the eligibility request and response standard (X12 270/271) because the returned eligibility response by health plans typically lacks sufficiently meaningful patient financial responsibility information needed, and lacks explicit information regarding eligibility of specific medical services. With the growing trend of high deductible Health Plans and alternative payment models for reimbursement, eligibility verification at the point of service is critical to establish patient financial responsibility and to mitigate bad debt. Healthcare providers specified that the information needed as listed below is often not provided with current transaction:

- Entity with primary responsibility to pay claim.
- Entity responsible for administering claim.
- Entity that has direct contact with provider.
- Specific fee schedule applicable to the claim.
- Specific plan/product type.
- Location where the claim is to be sent.
- Secondary or tertiary payers.

Various surveys have been conducted by stakeholders that demonstrate variability in use of the transaction. The Operating Rule Authoring Entity noted over 60 percent of survey respondents reported benefits by reducing staff time on telephone inquiries and in collections from the value of updating processes through real-time access. 2014 CAQH Index[4] shows an average of 82 percent adoption rate conducted electronically with projected cost savings from full

[4] CAQH Index report tracks how standards are used, areas for improvement in efficiency and effectiveness of the business process, and areas for additional savings. The CAQH Index has projected $8 billion could be saved if the transition standards were routinely utilized. The Index provides information about utilization of each transaction standard, including rates of adoption, estimated monetary measure of what can be achieved with greater adoption.

adoption are $4 billion for the industry ($3.52 or 88 percent for providers). A Practice Management Systems (PMS) survey indicated that their members predominately (80.5 percent)

use web portals to verify patient insurance eligibility followed by clearinghouse [5](60.2 percent); 47.9 percent surveyed use the X12 270/271; and the majority surveyed felt that these transactions are valuable or very valuable (85 - 89.3 percent).

For the eligibility, benefits inquiry and response, pharmacies use the National Council for Prescription Drug Programs (NCPDPs) Version *D.O* eligibility transaction (E1) and the X12 Standards for Electronic Data Interchange Technical Report (TR3) – Health Care Eligibility Benefit Inquiry and Response X12N 270/271). However, there is low usage of the 270/271 in electronic prescribing to obtain the formulary, medication history, group and cardholder information, formulary ID, alternate list ID, coverage ID and co-pay ID, BIN, PCN.

Testifiers indicated that for the most part, NCPDP Version *D.O*. E1 transaction and X12 270/271 meet pharmacy business needs for basic eligibility and benefit information. Workarounds have been developed to support business requirements not currently met. The pharmacy industry uses Direct Data Entry (DDE) via web portals and interactive voice response as alternatives to electronic transactions. To address changing needs and to demonstrate flexibility to meet ongoing business needs, NCPDP has been addressing these needs without moving to a new version of the standard and time to adopt a new version of the standard, changes were made using the change request process called DERF enabling stakeholders to request changes to standards.

- Developed an Emergency ECL Value Exception process.
- Significant changes were made to Version D.0 to support Medicare Part D eligibility requests.
- Requested additional service type codes be added to the X12N 270/271 to support additional types of pharmacies (long term care and specialty) – workaround in the current version.
- Developed external code list process due to workarounds.

The X12 271 does not reflect the different healthcare models as it does not support reporting of service tiers nor the Accountable Care Organizations (ACO) and Third Party Administrators (TPA) information. Smaller providers use payer websites or portals for claim status & eligibility since their practice management systems do not support all HIPAA transactions. Practices supplement practice management system gaps by phone calls to payers or through payer tools offered on their websites. Increased web utilization means payers have to monitor website closely to ensure the tool is able to handle the volume.

[5] Result from the 2nd survey. Responses from 177 organizations (68 HPs, 12 Medicare/Medicaid plans, 17 clearinghouses, 21 software vendors & 17 clearinghouse software vendors)

Conversely, the Veterans Administration (VA) found that requiring their trading partners and business associates to be compliant with the X12 270/271 resulted in increased volumes of use of the electronic transaction. One of greatest benefits is amount of time in which can verify insurance as opposed to spending significant time on the phone or going through websites. The VA did find that compliance and payer discretionary issues are their greatest challenge as well as challenges in the need to teach payers the law and asking them to implement it.

Testifiers provided insight into the issues and barriers that inhibit greater use of the transaction. These are summarized as follows:

- Expected benefits of the standard has not been attained by providers. Providers continue to check payer's website directly or phone to verify patient eligibility.

- Some health plans use the National Provider Identification (NPI) and taxonomy code to determine eligibility type response to return to provider.

- Medicaid payers can provide a single estimated value for patient responsibility information and Medicaid systems will unlikely be able to determine all patient responsibility given only information in an X12 270 eligibility request. Modifying the X12 271 response transaction to allow for ranges of responsibility amounts and qualifier values indicating estimated versus explicit amounts would allow for more accurate reporting. Several States reported their web-based portal was more useful to providers because available information was not constrained by operating rules and therefore were more robust. Behavioral health when included in managed care grouping have different standards which may have more stringent rules for compliance.

- Transaction standard requirements such as multiple service type codes are not required by some covered entities (e.g. State Medicaid).

- Many group health plans are not covered entities and therefore are not required to comply with the HIPAA standards. Employers, which are not HIPAA defined covered entities have their own formats for creating employee lists that are sent to payers and do not utilize the standard transaction.

- High use of proprietary portals to verify eligibility often contain better information than the standard transaction response and are labor intensive for users.

- Providers do not always use the X12 270/271 because the returned eligibility response by health plans typically lacks all patient financial responsibility information needed, and lacks explicit information regarding eligibility of specific medical services. There is also a lack of consistency in the provision of required eligibility information. Not all payers populate the required minimum level of information in eligibility response. Some intermediaries and vendors are not transmitting all information to providers resulting in need to revert to other mechanisms (portals or phone) for more information.

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Consequently, there is a need for more granularity to provide specific information such as identification of the entity with primary responsibility to pay the claim, applicable fee schedule, secondary or tertiary payer.

- Lack of agility to adapt to changing healthcare payment models with differing and complex benefit structures such as tiered benefits. The X12 271 does not permit sufficient reporting of complex benefit structures as tiered benefits or specialty networks resulting in time consuming expensive phone calls to obtain information. The operating rules do not support an agile response to emerging industry needs (e.g. no requirements to follow guidance on how to report information for patients in HIX premium grace period).

- Provider's network status is not sufficiently granular nor is it patient or product-line specific (e.g. indicate patient eligible for physical therapy but not indicate how many sessions).

- Procedure-specific requests result in general responses (e.g. health plan respond with no indication of particular radiotherapy requires prior authorization or if there are restrictions).

- Proprietary (therefore inconsistent) XML based solutions are being built because of uncertainty of whether the X12 TR3 Schemas are permissible and authoritative.

- Coverage verified at the first of the month may not be accurate later resulting in the need for re-verification.

- Eligibility response is typically not returned by health plans within the required 20 second window.

- Currently, providers need to understand each payer transaction requirements.

Recommendation 9: Based on the testimony provided, NCVHS makes the following recommendations for the *Health Plan Eligibility, Benefits Inquiry and Response* transaction:

Recommendation 9.1: *HHS* should*:

9.1.1 Significantly increase provider education on the X12 270/271.

9.1.2 Proactively audit Health Plans for X12 270/271 compliance.

Recommendation 9.2: The *Standard Development Organizations and Operating Rules Authoring Entity, in conjunction with the Healthcare industry* where applicable, should:

9.2.1 Evaluate the adopted standard and operating rules to determine how they can be modified to fulfill the business needs of complex health plans and multi-tiered benefit plans and provide data on member financial responsibility.

9.2.2 Consider the:

- Need to provide all accumulators and maximums (e.g. visit maximums).
- Degree to which the X12 271 allows for reporting of complex benefit structures.

9.2.3 Ensure that all eligibility data elements are comparable to the data elements on the website, and include information such as beneficiary co-payments, coinsurance, deductible and out-of-pocket amounts.

Recommendation 9.3: The *Standard Development Organizations* should:

9.3.1 Evaluate the standard to ensure all information that providers need is required in the transaction standard. Information requirements should include but not be limited to entity with primary responsibility to pay claim; entity responsible for administering claim; entity that has direct contact with provider; specific fee schedule applicable to the claim; specific plan/product type; and location where claim to be sent and secondary or tertiary payers.

9.3.2 Ensure:

9.3.2.1 The next version supports reporting of tiered benefits and other enhancements.

9.3.2.2 The provider network status should be sufficiently granular and patient or product-line specific (e.g. indicate patient eligible for physical therapy but not indicate how many sessions).

9.3.2.3 Differences in service types and related benefit information are considered (for example, the needs of long term care and mental health).

9.3.3 Consider:

9.3.3.1 Standardizing the reporting of the HIX grace period information through new operating rules requiring compliance with the related X12 request for Information.

9.3.3.2 Including participating and non-participating copayments, coinsurance, deductible, out-of-pocket maximum information and indication if the patient met these amounts, as required data elements.

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9.3.3.3 The impact of the inability to get complete information from the adopted standard and operating rules that require access to insurers' and payers' web portal to get complete information instead of using the X12 270.

9.3.3.4 State needs. Multiple service type codes on the eligibility response are problematic for States that have no need to use some of the codes. Some States have seen increased call center volume as providers question the meaning of the new data. Some data elements are confusing or not specific enough because the State doesn't have Plan information. Several States reported their web-based portal was more useful to providers because available information was not constrained by operating rules and, therefore were more robust.

9.3.4 Expand the use of repetition separators permitted in the EB03 data element for additional data elements to provide additional opportunities for streamlining transaction. Important to include appropriate repetition qualifiers to indicate to the provider how the separator is being used.

9.3.5 Provide further research to confirm that next version will remove identified barriers and ensure ROI before adopting.

9.3.6 Support all service type codes beyond Health Benefit Plan Coverage (service type code 30) needed for providers to better predict patient coverage and estimated patient financial responsibility.

9.3.7 Include in the standard:

9.3.7.1 Plan product types, names/descriptions, and provider networks in the X12 271.

9.3.7.2 Referral required information to reduce denials and phone calls after the office visit.

9.3.7.3 Whether Prior Authorization is required per service type code to reduce denials related to benefit coverage, pre-certification and pre-authorization calls.

9.3.8 Return the primary care provider (PCP) NPI in the 2100C Loop in the EBL segment to allow providers to better coordinate across specialties.

9.3.9 Accept inquiries for HCPCS codes in the EQO2 data element to determine coverage and patient financial.

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Recommendation 9.4: The *Operating Rule Authoring Entity* should:

9.4.1 Evaluate if the 20 second window for eligibility response is necessary to meet the healthcare industry needs.

9.4.2 Increase the minimum requirement functionality for the eligibility and benefit response operating rules to require procedure-specific responses.

9.4.3 Consider requiring complete eligibility and financial responsibility response availability in real-time.

Recommendation 9.5: The *Healthcare Industry should:*

9.5.1 Encourage payers to respond to HCPCS/CPT eligibility requests; provide benefit information, authorization requirements and referral requirements.

9.5.2 Provide more transparency about vendor capability and performance. Consider establishing vendor responsibility for compliance with transaction standards and operating rules through accreditation or other mechanism.

9.5.3 Require Practice Management Systems to provide the capability to send and receive eligibility transactions and automate the use of this information within the workflow.

9.5.4 Consider developing and maintaining an X12 270/271 eligibility databases that are always in sync with other eligibility data bases, files or direct website eligibility services.

C. Prior Authorization

The complexity of the prior authorization transaction standard (X12 278) is reported as not helping the industry achieve its intended purpose and benefits. Variation in medical and pharmacy benefits, results in different prior-authorization rules that are cumbersome, inconsistent workflow processes, and require additional requested information through manual processes. Additionally, health plans' web portals have become predominant venues for providing greater level of functionality and information exchange to achieve prior-authorizations. Some testifiers indicated there is little use of prior authorization transaction by providers, pharmacies, long term care and clinical laboratories. Pharmacies predominantly use the NCPDP SCRIPT Electronic Prior Authorization (ePA) transaction for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

Medicare, on the other hand, uses the transaction to decrease utilization and unnecessary services.

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Several associations conducted surveys of their membership to determine the utilization of the transaction. A Health Plan survey found that 33 percent of the respondents indicated the transaction did not meet their business needs; 25 percent noted the need for multi-stakeholder adherence to be beneficial; 25 percent said the current standard was not specific enough and needed operating rules. Respondents noted that the standard did not allow for communications among users resulting in use of other sources or receiving response of "contact us."

Clearinghouses cited low usage of the transaction with expected value not realized resulting in 76 percent of respondents using web portals rather than the electronic transaction. WEDI's findings were comparable.

Additional barriers to implementing the transaction are summarized as follows:

- Industry failure to ensure that all necessary electronic transaction components are in place to support end-to-end automation. Two major process gaps exist - the need for procedure specific prior authorization requirements in the eligibility response and a mandated electronic attachments standard must be addressed.

- Provider internal workflow require manual processes.

- Providers continue to use alternative processes to obtain information. For example, providers find exchange through web portal more convenient.

- Only basic responses to requests health plans receive from providers as few providers use the transaction.

- Some inquiries require responses that are not able to be processed for approval in an automated real-time fashion due to the need for medical review.

- Many inquiries result in a pending status initially and are later determined after manual review.

- Attachments documenting medical necessity are often required. Because there is no mandate for the use of electronic attachments, necessary information is not always accepted electronically.

- No response to NCVHS' recommendation (in NCVHS May 15, 2014 letter to the Secretary) that HHS should name the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transactions as the adopted standard for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

- Limited vendor support for the transaction.

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- Comprehensive end-to-end testing for all types of requests is resource intensive and presents significant challenges to implementers because of the high number of options and opportunities within the transaction.

- Lack of accurate, granular pharmacy formulary data at point of prescribing limits value of these transactions. Physicians cannot ascertain prior authorization requirements at the time of prescribing due to electronic health record (EHR) formulary data quality and completeness deficiencies.

- Use of the transaction by many insurers is intended to decrease utilization and unnecessary services and to make sure proper payment is made prior to rendering services. In Medicare fee-for-service prior authorization is a process in which provisional affirmation of coverage is submitted for review before a service is furnished and before a claim is submitted for payment.

- Every health plan has its own format, criteria and forms.

Recommendation 10: Based on the testimony received, NCVHS recommends for the Prior Authorization transaction that:

Recommendation 10.1: *HHS* should*:

Respond to the NCPDP's request and NCVHS recommendation (in NCVHS May 15, 2014 letter to the Secretary) that HHS should name the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transaction as the adopted standard for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

Recommendation 10.2: The *Standard Development Organization, Operating rules Authoring Entity*, *healthcare* industry *and HHS* should:*

10.2.1 Evaluate the value of the current prior authorization transaction and the adopted standard. This includes:

10.2.1.1 Identifying why web portals and other HIPAA-compliant alternative technology data exchange means are more effective and provide all the necessary and useful information, compared to the adopted transaction standard.

10.2.1.2 Considering the appropriate changes to future versions of the standard, including potentially leveraging the attachments transaction standards and operating rules to enhance the usefulness and effectiveness of the X12 278 transaction.

Recommendation 10.3: *Standard Development Organizations* should evaluate the adopted standard to:

10.3.1 Determine if prior authorization's low utilization is due to issues identified by stakeholders as:

- Need to understand each payer requirement.
- Every Health Plan has its own format, criteria and forms.
- Stakeholders are forced to use payer web portals.
- Process slows treatment.
- Standard is difficult to use and confusing to interpret.
- Rarely is complete required information supplied.

10.3.2 Consider providing flexibility to use newer business technologies to exchange information that would accommodate the need for more iterative authorization process due to the need for ongoing exchange between clinical staff and the health plan.

10.3.3 Determine:

10.3.3.1 When and why the standard does not meet business needs.

10.3.3.2 Why the industry believes prior authorization is a very complex transaction and develop remedies to ensure the ease of its use.

10.3.3.3 Laboratories' needs. The laboratory industry indicates that adopting HIPAA transaction standards and operating rules do not meet laboratory needs. The process is extremely inefficient, subject to significant variation among payers, and often hampered by ambiguous payer policy requirements.

10.3.3.4 States' needs. States have seen little uptake (< 5 percent) as the X12 278 does not meet business needs for clinical authorization and the X12 278 is very difficult to conduct.

10.3.4 Modify the adopted standard to ensure that the X12 278 and proposed Operating Rules contain data content requirements beyond "pending."

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10.3.5 Investigate the feasibility of converging eligibility and prior authorization transactions and modify the standards and operating rules to support this.

10.3.6 Require that the X12 278 standard indicate if prior authorization:

- Is not needed.
- Is approved or denied.
- Requires additional information for a prior authorization decision.
- Provide a final answer to prior authorization requests

Recommendation 10.4: The *healthcare Industry and HHS* should ensure that the industry does not use the web portal solely for the purpose of circumventing the transaction.

Recommendation 10.5: The *healthcare industry* should:

10.5.1 Ensure that all necessary electronic transaction components are in place to support end-to-end automation; other process gaps as the need for procedure specific PA requirements in the eligibility response and a mandated electronic attachments standard are addressed; and vendors support for the X12 278.

10.5.2 Ensure that provider systems vendors support of the X12 278.

10.5.3 Convene a multi-stakeholder workgroup to analyze and resolve issues impeding the adoption of the X12 278.

10.5.4 Implement and support the X12 275 and 277 to mitigate the amount of manual work to get precertification and referral authorization.

Recommendation 10.6: The *pharmacy* industry should:

10.6.1 Ensure that there is accurate, granular formulary data from Health Plans at point of prescribing.

10.6.2 Urge swift action on development and piloting of a real-time pharmacy benefit inquiry transaction.

Recommendation 10.7: *Health Plans* should:

10.7.1 Provide more than basic responses to requests they receive, consistent with HIPAA Privacy minimum necessary provisions.

10.7.2 Ensure:

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10.7.2.1 Payer portals, call centers, and HSR systems are updated simultaneously to maintain standardization across all systems to ensure consistent information is being disseminated.

10.7.2.2 Allows for communications among users and negates the need to use other sources or get response of "contact us."

10.7.2.3 Provider portals are not more useful to stakeholders than the standard.

10.7.2.4 Payers' required support or return authorization and benefit information at the CPT/HCPCS code level to reduce the need for provider calls to payers and avoid unnecessary requests.

Recommendation 10.8: The *Operating Rule Authoring Entity* should enhance eligibility operating rules to require provision of procedure-specific responses with any PA requirements.

D. Health Care Claim or Equivalent Encounter Information

Healthcare claim or equivalent encounter information (X12 837) is being submitted electronically and are meeting the business needs of the healthcare industry. Benefits are seen in accelerating turnaround time to report errors in submitted claims; reducing claim adjudication issues and denials; some realignment and better use of staff and resources***;*** front-end edits by clearinghouses and payers enabling more prompt claim submissions; automated edits help speed development and review of claims as fewer claims must be manually inspected and checked; and allows providers to capture more information needed for payment.

Most significant administrative burden for clean claim submission requires capturing accurate eligibility information, determining non-standard payer requirements, setting up practice management or billing systems to account for variation, and accurate coding. Testifiers cited examples of issues such as:

- The need for additional information that must be exchanged with electronic claims;
- Many payers do not accept electronic attachments;
- The X12 837 includes instructions for sending data to use in linking attachments that have been faxed with claims that have been submitted electronically but the instructions may not be followed or are difficult to comply with resulting in lost attachments and denied claims;
- Variations in rules and requirements are contrary to goals of consistency and uniformity for electronic data exchange;
- Individual states especially State Medicaid programs have unique rules and requirements contrary to goals; and
- Payers may vary significantly in their acceptance of cancelled and replacement claims.

Medicare uses claim acknowledgment X12 277CA to report acceptance or rejection of claims. Many payers have followed this but others continue to generate proprietary reports which are dynamic and require constant support to maintain the integrity of the data extracted and do not provide details required to prove a payer has moved the submitted claims into its adjudication system.

Some sectors of insurance industry (Property and Casualty) are not HIPAA covered entities leading to inconsistency in implementing the X12 837. Web portals, direct data entry (DDE) systems and paper forms are known to be implemented instead of or in addition to the adopted transaction.

However, there are HIPAA covered entities who have reported that the claims transaction did not apply to them. The situation involves Long Term Care (LTC) insurance companies and providers that do not use the EDI process. LTC providers usually bill the care recipient or responsible individual directly and very rarely submit electronic claims to LTC insurers, receive claims from providers, pay providers directly, send providers ERAs or receive claim status inquiries. Further, the X12 270/271 requirements mandate the return of specific information related to patients' financial responsibility as co-insurance, deductible and co-payment amounts, it does not translate to the LTC benefit model. LTC insurance benefit provides a cap on benefits as daily benefit amount or satisfaction of some prior co-insurance responsibility and these limitations do not fit into X12 271 definitions resulting with, in most responses, returning zeroes or null values. The LTC testifier indicated that CMS FAQ 8127 which asks if HIPAA transactions and operating rules apply to transactions between a health plan and its policy holders with the response that they generally apply to electronic transactions between HIPAA covered entities who transmit any health information in electronic form in connection with HIPAA transactions.

Multiple surveys were done by the industry. One association survey of its members comprised of coders, billers, medical auditors, compliance professionals and practice managers indicated that 98 percent of its members reported submitting electronic health claims 90 – 100 percent of the time. The majority of respondents noted transmission of claims is more efficient but requires properly setup systems to account for different payer requirements. The burden is knowing the correct data elements needed to comply with various payer requirements. Variations require research to determine needed data and proper placement of the data to submit a clean claim and have it processed correctly. CAQH's "Efficiency Index" reported a national average rate of electronic claims of 92 percent in 2013.

The association for clearinghouses testified that the greatest variance in use of the transaction occurred with dental claims. They also reported different formats for institutional, professional and dental providers. Responders reported:

- 61 percent of providers, 93 percent of payers and 92 percent of transaction volume use 5010 standards for professional claims;
- 77 percent of providers, 93 percent of payers and 92 percent of transaction volume use 5010 for institutional claims; and,

- 83 percent of providers, 98 percent of payers and 97 percent of transaction volume use 5010 for dental claims.

Practice Management Systems' survey identified that:

- 46.3 percent of respondents never do 5010 submissions directly to health plans;
- 66.3 percent always submit to clearinghouses;
- 9.9 percent always submit 4010 to clearinghouses;
- 75 percent would consider electronic acknowledgments added to 837 from clearinghouses and health plans valuable.

According to the 2014 CAQH Index 91.8 percent of health plans have fully adopted the 837 with a potential provider savings of $2.23 per claim transaction

Testifiers cited barriers to increased utilization as variability in the denial remark codes among payers, inconsistent application of the CPT code set, need for adoption of the standard attachment, lack of knowledge, lack of compliance, variability in provider formats, variability in payer acceptance of electronic claims, and inconsistent support by practice management vendors. Additional barriers discussed are summarized below:

- Some payers require one-line item with modifier 50 and one unit of service; others require 2 - line items with modifier RT and LT with one unit reported for each line.

- When HCPCS codes report the same service as an existing CPT code, billing and coding staff need to determine if the HCPCS code or CPT code is required.

- Each denial or rejection requires determining the reason and the steps to be taken or fixes in the system to be put in place.

- Denial remark codes vary among payers requiring manual review or phone call averaging 20-40 minutes per call.

- Three to four hours per week is needed by providers to research non-standard payer requirements.

- Instances of having to utilize workarounds to meet business needs include the need to report a diagnosis present on admission, report repackaged and original NDC numbers, and dental readiness classification codes.

- Lack of adopted and mandated claims attachment. Additional information is often needed and must be exchanged in addition to or with electronic claims. The X12 837 includes instructions for sending data to use in linking attachments that have been faxed with claims that have been submitted electronically but the instructions may not be followed or are difficult to comply with resulting in lost attachments and denied claims.

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- Individual States especially State Medicaid programs have unique rules and requirements.

- Lack of knowledge of the X12 837 and other EDI formats and terminology creates communication gap between providers and payers, resulting in providers and payers speaking different languages, variability of use with the transactions, and requiring additional support from clearinghouses.

- Providers continue to submit a myriad of formats to clearinghouses looking to them to provide standard transaction for the payer.

- Significant cost is associated with each new transaction or major change in a transaction for development, implementation and training of customers.

Many enhancements to functionality are anticipated in subsequent versions and include: RARC reporting at a claim service line level, support for predetermination of benefit submissions, and additional functionality for Worker's Compensation and other Property and Casualty claims.

Recommendation 11: NCVHS makes the following recommendations for the *Health Care Claim or Equivalent Encounter Information transaction*:

Recommendation 11.1: *HHS* should*:

11.1.1 Consider requesting some sectors of insurance industry (Property and Casualty), which are not covered entities, be designated as covered entities by submitting a request to Congress for the statutory change. Non-covered entities lead to inconsistency in implementing the X12 837. In the interim, the industry and stakeholders should encourage non-covered entities to comply with the adopted standard. Discussed in general recommendation 1.

11.1.2 Increase compliance enforcement to include addressing variability between health plans in claim core data and coding requirements. Discussed in general recommendation section D.

11.1.3 Adopt the:

11.1.3.1 Use of the Interchange Acknowledgment (TA1) which provides immediate awareness of the file status in the file exchange process.

11.1.3.2 Acknowledgment (X12 999) for all batch transactions.

11.1.3.3 Health Care Claim Acknowledgment (X12 277CA) as the claim status format.

Recommendation 11.2: The *healthcare industry* should educate stakeholders on the:

11.2.1 Purpose of the Health Care Claim standard is uniformity and consistency. This means that differences in payer requirements and formats may impede the

ability to have correct data elements, requires time and labor to research payer variability, and adjust systems to account for the differences. Providers and payers indicate that they do not have resources to establish and maintain connectivity with large numbers that they send and receive numerous transactions.

11.2.2 Ability to add reporting requirements for additional data potentially unrelated to claim processing could increase burden and increase risk of processing error.

11.2.3 Correct application of CPT and HCPCS code sets.

Recommendation 11.3: *Standard Development Organizations and Operating Rules Authoring Entity* in partnership with *Health Plans* should research the variations in requirements to determine needed data and proper placement of the data to submit a clean claim and have it processed correctly.

Recommendation 11.4: As discussed in general recommendation two, the *healthcare industry and HHS* should educate stakeholders on the benefits of electronic claims experienced by stakeholders, which have accelerated turnaround times resulting in some realignment and better use of staff and resources including:*

11.4.1 Front-end edits by clearinghouses and payers to be quickly identified and reported back to providers claim errors or deficiencies so they can be promptly addressed and the claim submitted correctly.

11.4.2 Automate edits to help speed development and review of claims as fewer claims would be manually inspected and checked.

11.4.3 Allow providers to capture more information needed for payment.

11.4.4 Provide the ability to send secondary and tertiary claims electronically.

Recommendation 11.5: *Standard Development Organizations* should:

11.5.1 Consider developing workarounds for atypical providers (e.g. transportation) and another standard for encounters.

11.5.2 Address the concern that the X12 TR3s not meeting Medicare's business needs, particularly locum tenens and subrogation situations.

Recommendation 11.6: The *Standard Development Organizations, Operating Rules Authoring Entity and the healthcare industry* should address

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issues raised by the healthcare industry and provide modifications in a timely manner.

Recommendation 11.7: The *Standard Development Organizations and Operating Rules Authoring Entity* should consider expanding and/or revising Medicaid specific codes for the services Medicaid pays that are different from commercial insurance.

E. Coordination of Benefits

The coordination of benefits (COB) transaction is minimally used by midsized and smaller payers. Every clearinghouse has the ability to send COB information. It is the quality and amount of the payment/rejection data that is key to success. Value is achieved when coordination of benefits is performed electronically and payment information on the remittance advice is accurate and accepted by the secondary payer resulting in variable use of the coordination of benefits transaction. Traditional information collection methods (i.e. patient registration forms, member canvassing, data mining) yield incomplete, stale and sometimes incorrect results. Health plans have varying policies about the supply of coordination of benefits information in the X12 271 eligibility and benefits responses. Critical information frequently missed include subscriber's name, member's ID number, start and end coverage date, and detailed description of type of coverage.

Information CAQH makes available via the X12 271 eligibility and benefits response are information about the:

- Other payer including full payer name.
- Subscriber of the other coverage.
- Dependents on the other coverage.
- Dates for each of the coverage, and the period of overlap.
- Primacy and that the data was sourced from CAQH.

CAQH noted that coordinating benefits for those with coverage by more than one health plan creates significant cost burden largely due to processes for correcting COB incorrectly paid claims. Based on 2011 research CAQH estimates that COB inefficiencies cost the industry as much as $840 annually with $490 (60%) borne by providers and $350 (40%) borne by payers. In response, CAQH developed the COB Smart ™ to address the cause of the inefficiencies and to enable consistently correct paid claims. COB Smart ™: covers more than 120 million individuals and enables plans to collaborate to find individuals with multiple forms of coverage and make that information available to primary and secondary payers and the provider submitting the claims.

Lack of consistent usage of the X12 837 claims submission format to submit properly formed secondary claims cause significant manual verification and adjudicating processing of claims as they are received. Processing is improving through increased industry collaboration and new

technology solutions that augment the impact of existing industry solutions and enable further progress towards achieving efficient cost effective coordination of benefits by:

- Enhancing operating rules for how COB information is communicated via standard eligibility and benefits responses
- Use of standard electronic claims formats to submit clean secondary claims

Testifiers indicated the lack of universal use by dentists of the 837D (dental claim & encounter) and the 835 (RA) are due to:

- COB is one of the most confusing aspects of dental benefit program.
- Dentists are not using X12 837(Dv5010) transaction set to support intended use of automated payer to payer coordination.
- The need for 3rd party payers to provide primary and secondary coverage would adopt a unified standardized formula for determining coverage.
- Dentists and their office staff often are not aware of COB rules that affect reimbursement.
- Dental carriers coordinate benefits inconsistently.
- Secondary carrier requires explanation of benefits (EOB) statement from the primary to process claim and payment.

Testifiers indicated the COB process subject to provisions of State insurance law vary from State to State with most following a model adopted by the National Association of Insurance Commissioners (NAIC) and, apply when the medical or dental plan is a State regulated carrier but not to employer self-funded and collectively bargained medical and dental plans operating under the federal Employee Retirement Income Security Act (ERISA). There is little use of the transaction by State Medicaid who indicated that enforced use of CARC/RARC combinations and a national payer identifier would make COB easier.

With the exception of using the transaction (that is X12N 837), pharmacies have little need for the transaction. There is no aggregator of COB data in the commercial oriented space (including Marketplace Plans) so availability of data is solely based on member providing valid and timely information. Pharmacies use version D.O claim and service transaction and X12 TR3 – Health Care Claim: Professional (X12 837), to bill medications and supplies covered under Medicare Part B program and for professional pharmacy services covered under a medical plan. It also supports COB. NCPDP is working on solutions for a mechanism to identify payment/payer types and streamlining the COB data elements and segments and they have made changes to Version *D.O*. claim/encounter transaction to support COB that includes:

- Added guidance and example for tertiary billing
- Modified Prescription and Service Pricing Formulae with emphasis on COB.
- Added guidance regarding non-zero/zeroes and Patient Pay Amount.
- Modified Other Coverage Code situations and code definitions.
- Clarified Other Payer Coverage Type situation.

Testifiers identified additional barriers summarized as follows:

- Health Plans do not consistently following instructions in the X12 835 TR3 related to reporting adjustment information often reporting it incorrectly.

- Health Plans
  - Are not processing or are rejecting COB transactions.
  - Many still require the payers' EOB as payment validation and do not adjudicate from the paid amounts in the COB section of the claim.
  - Do not have other payer information on the subscriber so payers stop processing to validate secondary payer.
  - Do not know how to handle zero dollar payments.
  - In provider to payer, there is often a need to submit attachments which are often submitted on paper.

- Lack of:
  - Standardization of use of COB in all settings.
  - Consistent usage of the standard X12 837 claims submission format to submit properly formed secondary claims cause significant manual verification and adjudicating processing of claims as they are received.
  - Accuracy of payment information from the remittance advice creates barriers for creating a compliant secondary claim – the key to coordination of benefits is the accurate and actionable payment info on the remittance advice and clear standard definitions to reduce the margin of error.

- Critical information is frequently missing such as subscriber's name, member's ID number, start and end coverage date, and detailed description of type of coverage.

- Use of Web portals, direct data entry (DDE) systems, and paper as alternatives to the transaction.

- Complexity and detailed contracts increase challenge for payers to provide accurate payment information.

- All information on electronic information must be transparent and programmable.

Recommendation 12: As a result of the testimony, NCVHS recommends for the *Coordination of Benefits* transaction:

Recommendation 12.1: The *Healthcare industry* should:

12.1.1 Educate stakeholders on the:
- Need for Health Plans not having varying policies about the COB information in the X12 271 eligibility and benefits responses.
- Use of coordination of benefits to mitigate Health Plans and providers from continuing to submit COB claims on paper.

12.1.2 Consider the most effective way for providers to receive information for individuals with multiple health coverage as there is no aggregator of COB data in the commercial environment.

Recommendation 12.2: The *Standard Development Organizations and Operating Rules Authoring Entity* should:

12.2.1 Evaluate the standard and operating rule for applicability in various settings such as pharmacies, dental and Long Term Care (LTC) as testifiers indicated there is very little use of the X12 837.

12.2.2 Consider utilizing comparable methods used by NCPDP to include but not limited to:

- Guidance and example for tertiary billing.
- Guidance regarding non-zero/zeroes and Patient Pay Amount.
- Modifying Other Coverage Code situations and code definitions.
- Clarify Other Payer Coverage Type situation.
- Solutions for a mechanism to identify payment/payer types and streamlining the COB data elements and segments.

Recommendation 12.3: The *Operating Rules Authoring Entity* should develop operating rules on how COB information is communicated via standard eligibility and benefit responses.

F. *Health Care Claims Status*

There is a varying degree of utilization of claims status and eligibility inquiry transactions (X12 276 provider inquiry and the X12 277 response) across providers and third party vendors. However, stakeholders have indicated the effectiveness of the Health Care Claim Status transaction. For example, one stakeholder found there was an increase in transactional service growth with no corresponding increase in resource utilization. Other testifiers noted that the transaction provides consistent responses across all methods of inquiry, reduces administrative maintenance requirements, reduces the need for users to use multiple routes of inquiry, reduces the need to request assistance to resolve differences in status results, provides timely flow of HIPAA transactions, and provides the ability to track transactions flow among trading partners.

One commenter found the transaction to have high value to Health Plans by providing a means to determine whether a claim has been received and not necessarily the status. Others believed that while claim submission transaction has widespread adoption and brought benefits, there are significant additional savings to be realized through better use, particularly the remittance standard that outlines the information provider receive back from a payer when

a claim is paid. Industry can realize greater promise for business needs if improvements are made to information reported within each of the other standards. Of all the transactions only the claim status has reached more than 90% utilization – all others, except the claim fall significantly short of this level.

All claims status responses regardless if web based or other non-electronic sources utilize the claim status transaction's category and group codes. This provides consistent responses across all methods of inquiry, reduces administrative maintenance requirements, reduces the need for users to use multiple routes of inquiry and reduces the need to request assistance to resolve differences in status results. However, one testifier noted a surprisingly low volume use of the transaction but explained that by the increase in volume in electronic remittance advice (ERA) transactions with a response to the claim in a timely fashion, there is no need to perform a claim status inquiry unless the entity is not receiving payment.

Some covered entities acknowledged that the claims status transaction was not used. LTC providers do not use the X12 277 yet are required to do so. For Medicaid the X12 277 response is often seen as insufficiently robust to help providers understand the status of the claim and operating rules not helpful and doesn't provide enough information on end results. Many report that direct data entry of claims or a claim status portal was the preferred method for providers to learn claim status.

A WEDI survey found varying degree of use of the transaction and concluded that it could deliver greater benefits through more automated processes and alignment and operating rules may need to be developed. The survey found a high use of the transaction with 83 percent surveyed report claim status transaction meets industry needs.

A CAQH Survey found that nearly half of respondents reported productivity improvements. Between 2012 (prior to ACA mandate) and 2013 (first year of operating rule mandate), there was an approximate 18 percent increase in claim status inquiry (all means including HIPAA transactions, portals, fax and telephone). In 2014, the CAQH index shows a 72 percent adoption rate of electronic claim status (*an increase of 80 percent in four years*) and provider adoption rate of 54 percent. The Index projected cost savings (based on direct costs only) of $830 million for the industry; $450 million of the $830 million for providers (54 percent saving), and a potential savings of $1.23 per claim status transaction.

The Harvard Pilgrim Health Plan, has used the 276 for 15 years, with 2.2 million claim status transactions annually, explained that they found value in the use of the claims status code sets. While the increase use of the X12 276 was entirely driven by the volume increase of transactions, portal, paper, phone and fax volume remain constant. All claims status responses regardless if web based or use of other sources, utilize the claim status transaction standard's category and group codes. Harvard Pilgrim Health Plan found the X12 276 provides consistent responses across all methods of inquiry, reduces administrative maintenance requirements, reduces the need for users to use multiple routes of inquiry and reduces the need to request assistance to resolve differences in status results. They also found tangible benefit of the operating rule implementation in the efficiencies gained in on-boarding trading partners to

conduct eligibility and claims status transactions. Specifically, prior to the transaction's implementation, connectivity with trading partners was largely through point-to-point, virtual private networks and on-boarding which averaged 50 business days. With the transaction, on-boarding took 15 business days and on an on-going basis have sustained an on-boarding time at below half of the plan's historical time of 50 business days.

While use of the Health Care Claim status transaction is high, specific issues and problems with the transaction were cited by the testifiers. These are summarized as follows:

- Stakeholders use and interpret claims status responses differently especially in real-time. Providers look to the claim status response transaction to post claim adjudication items communicated in the X12 835 ERA. Specifically they receive requests for items communicated in the provider level adjustment (PLB) segment which are not components of the claims status response.

- There are differences in the adjudication reason results reported in the claims status transaction compared to the ERA. Difference in code sets causes confusion in accounts receivable groups when different codes describe the same issue across different standard transactions (X12 276 vs. X12 835).

- Lack of patient financial responsibilities are not included in the claim status response.

- Providers or third party entities fail to fully utilize claim receipt acknowledgment information whether given in a proprietary format or X12 277 claim acknowledgment. Specifically, claim acknowledgment information from payer does not always reach the provider when an intermediary is used resulting in providers submitting a second claim status inquiry related to claims for which a response with a rejection status and the reason for the rejection has already been communicated. There would be a more effective process if payer acknowledgment is fully shared with and acknowledged by the provider.

- The transaction does not indicate to providers when the claim will be paid if in pended status resulting in the need to make calls to obtain the claims' status.

- Claim status codes are not being used consistently across payers resulting in providers referring to different code tables for each payer causing confusion in accounts receivable groups when different codes describe the same issue across different standard transactions.

- Misperceptions exist regarding what information is communicated in the claims status response. Providers look to the claim status response transaction to post claim adjudication items communicated in the X12 835 remittance advice. Specifically, providers receive requests for items communicated in the provider level adjustment (PLB) segment which are not components of the claims status response resulting in

frequent questions as to why patient responsibilities are not included in the claim status response.

- As discussed in general recommendation 1, covered entity versus non-covered entity mismatch in responsibility creates challenges for providers as vendor products may not be able to handle all of the information in a standard and employers may not provide all of the needed data.

- Health plans search/filtering processes can result in a large number of improper "claim not found" responses.

- The current mechanisms result in physician receiving inaccurate and useless responses. Some payers have not mapped their claim status rejection/pending proprietary codes to most detailed standard codes are not providing detail info to assist provider to identifying current claim status.

- Health plans often direct practices to portals for claim status information which, offer more accurate claim status information than response.

- Quality of claim status response is not granular enough to stop calls or resubmitting claims.

- Many smaller providers believe the transaction is not cost effective as using website or phone verification is free.

- Lack of transaction audit trail results in delay or duplicate communication between payer and provider.

- Vendors require contractual provider upgrade to include the new functionality.

- Claim status inquiry is not returned by health plans within the required 20 seconds.

- Information provided are not user friendly requiring additional edit logic for the information to have meaning for processing.

- From the onset of claim EDI, providers have adopted the unsolicited claim and application of X12 277CA Health Care Claim Acknowledgment reports to obtain file status reporting from their clearinghouses, vendors and many PMS. These daily delivered reports facilitate workflow automation, eliminate the need to request claim status and provide an electronic audit trail reducing phone calls and duplicate claims submission.

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- Anecdotal evidence suggests PMS vendors (non-covered entity) and HIPAA covered entities may not make infrastructure changes available on a timely basis because vendors are waiting for provider demand.

Recommendation 13: As a result of testimony presented, NCVHS offers the following recommendations for the *Health Care Claim Status* transaction:

Recommendation 13.1: *HHS* should consider adopting the X12 277 Health Care Claim Pending status information transaction which would reduce administrative costs through timely notification to providers of pended claims while reducing paper management costs of printing, mailing and fling.

Recommendation 13.2: The *Healthcare industry* should:

13.2.1 Educate:

13.2.1.1 The industry on the effectiveness identified by stakeholders using the X12 276.

13.2.1.2 Stakeholders that it is possible that a response to the claim in a timely fashion could result in no need to perform a claim status inquiry except when payment has not been received.

13.2.1.3 The industry including Practice Management Systems vendors, on the need to make infrastructure changes available on a timely basis.

13.2.1.4 Providers on the availability of real-time claims status.

13.2.2 Implement operating rules for content of the claims status response with defined code combinations for the claim status transaction would result in similar benefits and would address business user questions on valid code use in the claim status transaction.

13.2.3 Increase business understanding of the claim status inquiry and response standards, their purpose and role.

13.2.4 Focus efforts on other critical activities in the service and claim cycle to ensure they are functioning efficiently before focusing on claim status (e.g. effective use of eligibility inquiry reduces pending or rejected claims volume, moving referral, authorization and notification services from paper to automated transactions will reduce claim adjudication issues).

13.2.5 Determine if real-time health care claim status meets a business need.

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Recommendation 13.3: *Health Plans* should:

13.3.1 Provide clear, actionable explanations of the error responses they send in claim status response files.

13.3.2 Include all adjudications of a specific claim in the claim response for a full claim history.

13.3.3 Include adjudication dates and check numbers in their response files to ensure accuracy of payment information that is accurately matched with the appropriate claim adjudication.

Recommendation 13.4: *Standard Development Organizations and Operating Rules Authoring Entity* should evaluate:

13.4.1 And modify in a timely manner, current standards and operating rules to address the current process that some testifiers indicate results in physician receiving inaccurate and useless responses and, Health Plans often directing practices to portals for claim status information which offer more accurate claim status information than response.

13.4.2 The standard and operating rules to address issues raised in a timely manner.

13.4.3 Consider the need for a transaction audit trail between payer and provider.

13.4.4 Conduct further research to confirm that the next version of standards and operating rules will remove barriers and support business needs before adoption.

Recommendation13.5: *Operating Rules Authoring Entity* should amend previously adopted operating rules to permit batch as an option rather than force real-time claim status responses.

G. Health Care Payment, Remittance Advice and Electronic Fund Transfer

As with the other transactions, there is variability in use of the Electronic Fund Transfer (EFT) and Electronic remittance Advice (ERA) transactions. Several providers noted that approximately 90 percent of payments are posted electronically using the X12 835 (Remittance Advice). Sufficiently detailed Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) codes are being used more consistently. One provider reported staffing reduction of its cash posting team by 2 full time equivalents (FTEs) over 5 to 6 years and anticipates a further 1 FTE reduction.

Other benefits of the use of the EFT and ERA transaction described by testifiers included:

- Improved cash flow – EFT via Automated Clearinghouse (ACH) payments are received faster from health plans than checks and allow providers to bill and collect remaining patient payment responsibility sooner.
- Improved automated claim payment re-association between EFT and ERA using Trace Number (TRN) Re-association.
- Reduced manual posting errors with automated re-association and posting of transactions.
- Reduced administrative work & claims days in accounts receivable.
- Improved staff efficiency.
- Reduced cost and processing time.
- Labor cost savings including reduced staff time spent on manual follow-up.
- Bad debt reduction due to improved collections.
- Increased ability to conduct targeted payment issue follow-up with plans.
- More accurate and efficient payment of claims.
- Streamlined enrollment.
- Access to inexpensive electronic payment options.
- Denial follow-ups are more efficient because CARCs, and RARCs can be related to eligibility, registration, and other issues that can be addressed proactively.

The EFT operating rules requires uniform and maintained CARCs and RARCs combinations to give a consistent approach to reporting and interpreting the claim denials and adjustments and ensures delivery of EFT (X12 837) and ERA re-association can occur by requiring the critical data elements for re-associating the payment and remittance advice.

It was reported that most providers receive ACH EFT from at least some health plans. ACH EFT provider benefits include:

- Reduced time on manual processes.
- Reduced risk of fraud.
- Faster payments.
- Elimination of lost checks/check stubs.
- Enhanced reconciliation potential.

Industry surveys demonstrate comparable finds. The CAQH Index showed 51 percent use of ERA and 58 percent EFT transactions in 2014. CAQH CORE's survey respondents reported over 50 percent of respondents indicated productivity improvements, over 20 percent achieved direct cost savings and over 40 percent indicated CARCs and RARCs code combinations have made ERAs easier. Projected cost saving are based on direct costs only of $2.28 billion for industry if full adoption of EFT and ERA; providers could realize $1.2 billion. One clearinghouse survey indicated 75 percent of providers and 86 percent of payers use the X12 format with an increase in the number of ERAs and EFTs being exchanged in recent years due to standardization and requirement to support EFTs. However, the value of ERA is still not fully realized due to gaps in business processes, data content, and compliance issues. WEDI's survey demonstrated that the EFT transactions and operating rules are delivering high value and are achieving the intended benefits, but the ERAs still need improvement. Thirty-eight percent of

Health plans reporting significant usage of EFT and ERA transaction. EFT transactions are reported to meet industry needs by 94 percent of respondents.

Testifiers indicated variable usage by entity type. Dentists report that by using the X12 835v5010, they are able to allocate reimbursements sent separately to patient accounts where monies are due. While EFT is encouraged but not required under Minnesota's e-transaction statute, the X12 835 is meeting current and near-term industry needs and benefits with Minnesota companion guide helped.

Laboratories noted they were able to match 90 percent of payments to the X12 835s received. For those unmatched automatically, payers may not send the X12 835 if the money reported within the transaction is out of balance forcing utilization of the paper remittance or payer's website to obtain the required details to properly apply the received payment to patients' accounts. The operating rule requiring payers to identify and isolate claims that do not balance and allow the remaining information to be sent electronically.

The X12N 835 is created by the processor and sent to the pharmacy to indicate final payment and non-claim adjustments. For the most part, the X12N 835 and payment meet the pharmacy business needs. Only 21.43 percent slightly use CARCs and RARCs. To effect greater use of the transaction, NCPDP developed specific implementation guidance assistance for the pharmacy industry:

- Claim Paid But No Financial Transaction Reporting Transaction – for reporting pharmacy claims paid at point of sale (POS) but because of an agreement there is no financial transactions exchanged using the X12N 835 to their long term care business partners.

- NCPDP Pharmacy Reference Guide to X12/005010X221 Health Care Claim Payment/advice (835) – meant to supplement the provider manuals built by payers.

- White Paper – guidance to the pharmacy industry to prepare for implementation of X12N 835.

- Mapping Document – provides for consistent use of CARC, CAGC & NCPDP Reject Codes in the X12N 835.

- Payer Audit reporting Transaction – guidance to pharmacy for reporting outcome of a payer initiated post payment audit and adjustment of pharmacy claims using the X12N 835.

- Low Income Subsidy (LIS) Reporting Transaction – guidance for reporting the outcome of a payer initiated retroactive LIS adjustment of pharmacy claims using the X12N 835 to their LTC business partners.

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- Central Pay Transaction – convey a consistent solution for recovering overpayments from a Central Pay Prescription Service Administrative Organization (PSAO) and/or financial intermediary via the X12N 835.

It was reported that most State Medicaid had EFT and X12 835s in place before the adoption of the EFT and ERA operating rules. Most had a streamlined process for EFT enrollment. Implementing EFT/ERA enrollment requirements means investing in an unneeded layer of complexity to be form or format complaint. Collecting unused data confuses enrollment and increases call center volume. Operating rules for EFT enrollment may work when relationship is between the provider and a payer of a health plan. Some States have never needed to segregate the provider population in their vendor tables as required in the operating rule.

The remittance advice standard, operating rules, code sets and identifiers are used in Medicare transactions and meet business needs. Seventy percent of remittance advice transactions are being conducted electronically.

For 2014, The Veterans Administration (VA), EFTs received represented 79.1 percent of revenue. The VA accepts only CCD+EFT payment. The VA has developed the ePayments system to replace paper checks and remittances and in 2003 began receiving ERAs and EFTs. They have experienced great success with ERAs but until the operating rules were published, struggled with EFTs. However, operating rules continue to allow too much payer and clearinghouse discretion with some of these creating further work for the provider.

One testifier presented case studies using the EFT and ERA transaction that demonstrated improved efficiency and cost savings. The case studies included a micro pediatrics practice, a mid-size physician's group for Women's healthcare and a large hospital group.

- The pediatric practice had 95 percent adoption of EFT and ERA resulting in improved posting accuracy; faster processing and receipt of claim payments; and improved patient and secondary billing frameworks thus improving patient collections.

- Women's healthcare achieved 90 percent adoption of EFT and ERA with reduced days of claims in accounts receivable from 25 to 13 days; increased number of claims processed per employee; practice increased with increased billing with no additional staff; improved posting accuracy with fewer posting errors and less verification needed; and EFT payments received and processed more quickly.

- The hospital group experienced reduced processing costs by 70 percent; eliminated posting error; achieved 83 percent match of posting and reconciliation on day zero; 97 percent match by day one and 98 percent by day 2.

Alternatively, LTC insurers do not use the EFT and ERA. LTC insurers enter policy contracts with consumers, not healthcare providers and benefits are paid to the individual and direct consumer payments are not addressed under HIPAA.

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Associations and organizations provided testimony on the effect of the EFT and ERA transactions on their members. A State Consortium members' experienced improvement with remittance transactions since the adoption of the operating rule provides guidance on how to use the claim adjustment reason codes and the RA remark codes. The association representing physicians indicated the ERA and EFT transactions reduce manual processes, speeds payment and frees up resources for patient care. An association of clearinghouses indicated that the EFT standard is meeting business needs. Providers accepting EFT and ERA for claim payments reduce their receivable costs by $7.21 per payment (according to the 2014 CAQH Index) with benefits.

As with the other transactions, barriers and concerns were also discussed. These are summarized as follows:

- Most common issue is the number of remittances and payments that providers receive with expectation that within the remittance and the associated payment is that the NPI of the payee will match that of the billing provider on the submitted claim unless explicit notification has been made to the payer from the provider identifying the payee and related billing NPI.
    - Both NPI and Tax ID are used for payments resulting in need for multiple processes and procedures and increased costs.
    - There is no mixture of making payment based on the NPI or Tax ID. Providers may need to divide payments differently depending on how the payment is reported. It may be necessary for a provider to use manual workarounds to split payments
- With the adoption of version 5010 standard remittance advice, the ability to report pending claims was removed because the pended claim would be reported in a separate transaction. Reporting of pending transactions is not included in the Health Care Claim Payment/Advice transaction, and 277 Pending Status transaction is not mandated so providers cannot count on receiving this information. Existence of a code used to communicate the final adjudication of the claim in the remittance still refers to "pending" leads to confusion.
- Code lists for RA are maintained by multiple committees; Claim Adjustment Group Codes by X12 and Claim Adjustment Reason Codes and Remittance Advise remark Codes by CQH CORE[6]. Variations in how plans interpret and apply codes to the adjudication

[6] CARCs & RARCs code combinations operating rules ongoing maintenance that are performed 3 times per year. One includes market based review that seeks public comments by submitting code combination adjustments demonstrating that the proposed adjustment follows specific evaluation criteria & has a strong business case supported by real word usage data. Before the operating rules there were possibly 200,000 potential CARC/RARC code combinations. Maintenance has reduced them to 1,600 code combinations that address business scenarios driving claim issues.

results of a claim has caused confusion and hindered opportunity for automated work flows

- Anecdotal information suggests that PMS vendors may not make EFT/ERA data or infrastructure changes available on a timely basis because vendors are waiting for demand. Out-of-date PMS software does not allow providers to receive the most recent payment remittance detail.

- Overpayment and recovery process within the 835 is very cumbersome for providers to track and reconcile.

- Payers must meet many different State regulations regarding notification of a recovery.

- CARCs & RARC improvements have also helped with coordination of benefits although challenges remain:

    - Require adjudication on the paper RA from a managed care organization often doesn't translate to standard CARCs & RARCs.

    - Providers used to proprietary RAs are unable to interpret codes on the X12 835.

    - More explanation is needed when primary insurance is making negative payments or negative CARC codes so secondary and tertiary payers can determine liability.

    - There are 360 CARC/RARC combinations which lack clarity to give providers a meaningful explanation of benefit/adjudication decisions.

    - With 5010 the X12 837 does not allow service line linkage between CARC and RARC codes. Newer versions of the X12 837 have been modified with a new segment – Reason Adjustment (RAS) which allows direct linkage of the CARC and RARC codes at the claim level and the service line level. The X12 835 does not link CARCs to RARCs. If there are multiple CARCs and RARCs for a single service line, there are a number of CARCs multiplied by the number of RARCs combinations which may or may not be valid combinations. Payers may be paying for multiple lines of business making it difficult to know when to institute contractual adjustments versus patient responsibility.

    - Challenge with use of multiple CARC 237 codes on a single claim within a single CAS adjustment segment. However, using more than one occurrence of the same CARC in a CAS segment causes errors and rejections.

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- Lack of consistency in payer use of CARC RARC codes.
- Need for additional guidance on correct interpretation of existing CARC/RARC codes combinations related to LTC insurance adjudication, particularly CARC 246.
- Lack clarity to give providers a meaningful explanation of benefit/adjudication decisions.
- The lack of requirement that the words associated with CARCs and RARCs be used verbatim on an EOB or explanation of payment (EOP) document. This absence is a gap that hinders full achievement of administrative simplification goals.

- Difficult to determine the degree to which 835 transaction is meeting workers' compensation needs or the exchange of desired information due to low compliance.
- Variance in payer use of reason and adjustment codes and contractual adjustments continue to erode standard transaction use from provider.
- Payers sometimes continue to send paper when sending ERA resulting in providers receiving duplicate remittances making it difficult to track payments with claims. Payers always require enrollment; sometimes testing also.
- EFT enrollment remains challenging requiring separate enrollment processes for different TINs. Once a provider submits enrollment forms for a payer all TINs that payer utilizes for payment should be automatically enrolled for EFTs. Burdensome enrollment processes.
  - Current operating rules do not standardize enrollment information. Providers must enroll separately with each health plan. Some health plans require physicians to enroll individually. Some health plans' vendors have separate provider enrollment forms.
  - Current operating rules fail to establish a timetable for health plan EFT enrollment processing – time can range from 1 to 5 weeks.
  - ERA enrollment is a plan-by-plan process.
- Health plans often do not follow the TR3 (implementation guide) instructions related to the processing of corrections and reversals resulting in inconsistent information and miscommunication between trading partners.

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- Not all EFT and ERA operating rule content is consistently being offered including enrollment data sets, re-association data elements, CARC/RARCs code combinations and business scenarios.

- Updates are often required out-of-cycle with regularly scheduled releases.

- Much of the information is not user friendly and requires additional edit logic for the information to have meaning for computer processing (e.g. remittance standard guides the payer's report back to a provider once a claim has been approved for payment has the ability to convey information about the adjudication of the claim and the type of adjustments that were applied). An RA that balances is the one that accounts for all the adjustments made to the billed amount along with the payment made.

- Many health plans fail to submit a RA that balances or they use a default code to force the balance. Failure to balance the RA requires the provider to undertake additional work by phone. Although balancing instructions are included in the mandated TR3, specific processes or system constraints within a health plan or vendor system may result in out-of-balance 835 transaction.

- Paper EOB provided more relevant detailed adjudication information than the limited information provided in the data content.

- The reconciliation process between ERAs and EFTs are still in use for many providers due to non-compliant activity such as multiple ERAs for a single EFT or failure to supply required re-association data in the files. ERA and EFT are designed to work synergistically to maximize payment automation and reconciliation. Standard EFT payments are made using the CCD+ addenda format which contains necessary information for pairing EFT with ERA. Many practices report significant problems with reconciling an ERA to the related EFT due to lack of vendor support for automated reconciliation and banks' truncation of re-association trace number.

    - Payers systems may create payment and/or ERA files group differently than needed by provider (e.g. TIN vs NPI) resulting in providers' inability to reconcile and direct payment or remittance to the appropriate system for posting.

    - Non-balanced ERA transactions, provider does not know what adjustments or other info is missing and can't use an electronic file. This requires use of manual processes to reconcile. Providers remain or revert to paper transactions rather than attempting to resolve these issues with payers thus reducing or eliminating cost savings because of the need to create alternative manual processes outside of their typical workflow.

- Compliance Issues:
    - Failure to send one ERA for one EFT.

- Health plan portals provide more complete/accurate remittance information.

- Health plan compliance issues reduce physician adoption. 44% of providers reported not enrolling because it was not offered by a particular health plan; 11% pay percentage-based fees for standard EFT with 29% indicating they were only offered a fee-based option when enrolling. Reports of health plans requiring use of certain banks for enrollment.

- Providers have a challenge posting the X12 835 because they can't determine if it is an inpatient, outpatient, dental or professional claim or the method the claim was submitted.

- Payers using the X12 835 to recoup payments on aged claims without submitting further explanatory information making it difficult to understand the basis for recoupment and top reconcile accounts.

There are alternatives to achieve similar or greater efficiency and effectiveness between trading partners at lower administrative cost. These include educational material published in X12N Technical Report Type 2 documents and CARC/RARC Encyclopedia. The healthcare industry also uses alternatives to EFT and ERA to obtain the requisite information to complete the transaction. These include web portals and paper instead of or in addition to Claim Payment Advice transactions. Others use virtual cards as an alternative to EFT or check payment.

Enhancements in subsequent standard versions are expected to resolve barriers and limitations include association of CARC and RARC, virtual card payments, conversion of PLB adjustment reason code list to external code set, reporting dental payments, and inclusion of an indicator to allow providers to easily determine the type of claim or the method the claim was submitted.

***Recommendation* 14**: NCVHS makes the following recommendations for the *Health Care Payment, Remittance Advice and Electronic Fund Transfer transaction*:

Recommendation 14.1: The *Operating Rules Authoring Entity* should:

14.1.1 Evaluate and modify the 360 CARC/RARC combinations to address the issues stated by testifiers.

14.1.2 Provide additional guidance on correct interpretation of existing CARC/RARC codes combinations related to LTC insurance adjudication, particularly CARC 246.

14.1.3 Consider naming the code value usage in health care claim payments and subsequent claims as a source for those scenarios that fall outside of current CAQH CORE Rule 360 as a guideline to assist payers in applying appropriate

actionable reason and remark codes that promote a consistent automated workflow.

14.1.4 Address:

14.1.4.1 Problems with reconciling an ERA to the related EFT.

14.1.4.2 The burdensome enrollment processes.

14.1.4.3 The transactions necessary to the business flow that are not mandated for example, reporting of pending transactions is not included in the Health Care Claim Payment/Advice transaction; the X12 277 Pending Status transaction is not mandated so providers cannot count on receiving this information.

14.1.4.4 Payments in the claim level payment (CLP) loop should always equal the sum of the payment of the Service level (SVC) loops, that is, the total check payment in the Financial Information (BRP) segment should equal to the sum of the CLP and provider adjustment (PLB) loops;

- Payers should not use a negative contractual adjustment to increase the balance transferred to the patient;
- Claim level patient responsibility (in CLP05) should equal the sum of the PR claim adjustment reason codes in the claim adjustment (CAS) segments;
- Additional payments outside of the claim's adjudication should be in the PLB segment and transparently defined with identifying information to indicate what the payment is for and if it relates to a provided service and the specific payment number;
- TRN should indicate the specific payment number for EFT;
- A single check number or EFT trace number should correspond to a single ERA – the BRP segment should indicate the payment type (e.g. ACH for EFT).

14.1.5 Consider:

14.1.5.1 An improved method of reporting information currently contained in Claim Adjustment Reason and Remark Code.

14.1.5.2 Assigning reasons and remarks for adjustment/denials to most specific actionable code to remove costs associated w/manual provider review.

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14.1.5.3 Providing stronger language and additional guidance on balancing.

14.1.5.4 Addressing the overpayment and recovery process within the X12 835. Testifiers have reported that it is very cumbersome for providers to track and reconcile. Operating Rules could improve the process as payers must meet many different State regulations regarding notification of a recovery. Another possibility is to create a separate transaction to allow for overpayment and recovery information to be reported

14.1.5.5 Developing a standard and an operating rule implementation guidance assistance comparable to the one developed by NCPDP.

14.1.5.6 Improving the level of information communicated on the X12 835.

14.1.5.7 Aligning the EFT and RA so as not to require using the payer's website.

14.1.5.8 Assigning reasons and remarks for adjustment/denials to most specific actionable code and programmable to remove costs associated with manual provider review.

14.1.5.9 Modifying the re-association Trace Number (TRN) to indicate the specific payment number.

14.2 Address concerns that payers do not know how to handle zero dollar payments and providers receive remittance advice transactions that do not balance.

Recommendation 14.2: The *Standard Development Organizations, Operating Rules Authoring Entity and healthcare industry* should:

14.2.1 Adopt a more comprehensive CARC and RARC resource containing CAQH CORE Rule 360 and X12 TR2 including instructions explaining how to use both resources in combination to obtain the most actionable mapping that will promote automation and reduce manual effort for provider and payer.

14.2.2 Coordinate activities to maintain code sets. Currently code lists for RA are maintained by multiple committees - Claim Adjustment Group Codes by X12; Claim Adjustment Reason Codes and Remittance Advise Remark Codes by others; some combinations of those codes are governed by CAQH CORE Phase III. Additionally, Operating Rules variations in how plans interpreted and applied codes to the adjudication results of a claim has caused confusion and

hindered opportunity for automated work flows. Externalization of codes would be of value.

14.2.3 Evaluate data requirements. For example, testifiers reported that most States had EFT and X12 835s in place before adoption of operating rules. Implementing EFT/ERA enrollment requirements by the States requires investing in an unneeded layer of complexity to be form or format compliant. Collecting unused data confuses enrollment and increases call center volume. Some States have never needed to segregate the provider population in their vendor tables as required in the operating rule.

Recommendation 14.3: The *Operating Rule Authoring Entity* should:

14.3.1 Address the cumbersome process for providers to track and reconcile for overpayment and recovery process within the X12 835 transaction. The process could be improved by operating rules as payers must meet many different State regulations regarding notification of a recovery or create a separate transaction to allow for overpayment and recovery information to be reported.

14.3.2 Create additional ERA operating rules to include:

14.3.2.1 Requirement of Alert CARC for specific scenarios (e.g. reversal claims)

14.3.2.2 Prohibit "dummy" codes to force ERA balancing

14.3.2.3 Require payers to indicate when they are serving as primary and secondary payer on a claim and notify that there will be 2 separate processes using the "crossover" notification

14.3.2.4 Require health plans to regenerate ERAs upon provider request

14.3.2.5 Provide "roll up" capability by provider choice so large facilities are not forced to receive separate ERAs for each patient or physician

14.3.2.6 Expand CARC/RARC compliance to include use of valid codes and conveyance of an accurate message, and

14.3.2.7 Require compliance with X12 RFIs regarding standard reporting of HIX grace period information in the ERA

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14.3.3 Create additional operating rules to improve provider enrollment experience to include:

14.3.3.1 Standardization of required enrollment information,
14.3.3.2 Maximum time for EFT enrollment processing
14.3.3.3 Prohibition of multiple enrollment processes if health plans use vendors

VII. Conclusion

In conclusion, the healthcare industry's adoption and implementation of administrative simplification standards and operating rules has presented many challenges. The first Review Committee hearing provided an opportunity for NCVHS to learn about the successes as well as the barriers to successful implementation. NCVHS remains available to answer any questions and will continue to support the efforts of the healthcare industry, Standard Development Organizations, Operating Rule Authoring Entity and DHHS in the promotion and expansion of administrative simplification.

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VIII. Appendix

A. QUESTIONS FOR PANELISTS

Panelist Questions from the June 2015 Review Committee Hearing:

GENERAL QUESTIONS TO ALL PANELISTS APPLICABLE TO ALL PANELS

- VALUE - Overall, does the currently adopted **transactions** meet the current (and near-term) business needs of the industry? Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints
- VALUE - Overall, do the **standards, code sets, and identifiers** adopted for each transaction meet the current (and near-term) business needs of the industry? Is the industry achieving the intended benefits from the transactions and their corresponding standards, code sets and identifiers? Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints
- VALUE - Have there been any studies, measurement or analysis done that documents the extent to which the transactions and their corresponding standards, code sets and identifiers, as adopted and in use, have improved the efficiency and effectiveness of the business processes? Please provide, as much as possible, information for specific transactions.
- VOLUME - What is the current volume / percentage / proportion of business transactions being conducted electronically (each transaction) using the adopted standard?
- BARRIERS – Are there any known barriers (business, technical, policy, or otherwise) to using the transactions, standards, or operating rules?
- BARRIERS – Is there any perceived or qualified degrees of variability in stakeholders' usage of adopted transactions and operating rules?
- BARRIERS – What is the qualified or quantified degree of difficulty in adopting and expanding the usage of the transactions and operating rules

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- ALTERNATIVES – Are there any known perceived or qualified availability and acceptance of other methods / approaches in achieving the same goal which the adopted transactions and operating rules intend to deliver
- OPPORTUNITIES – Are there any identified areas for improvement of currently adopted transactions and their corresponding standards, code sets and identifiers?
- OPPORTUNITIES – What, if any alternatives exist for improving efficiency and effectiveness of the business process for each of the transactions adopted and in use?
- OPPORTUNITIES – Are there additional efficiency improvement opportunities for administrative and/or clinical processes of these transactions and strategies to measure impact? Would they be addressable via new or different standards?
- OPPORTUNITIES – What alternatives exist to achieve similar or greater efficiency and effectiveness between trading partners at lower administrative cost?
- CHANGES – Are there any changes that should be made to the current transaction standards, or the mandate to use them?

QUESTIONS ON OPERATING RULES APPLICABLE TO PANEL 2 (ELIGIBILITY), PANEL 6 (CLAIM STATUS) AND PANEL 7 (ERA/EFT)

- [CAQH CORE] Outline the current mandated Operating Rules (Claims / Eligibility Status, EFT / ERA) and their intended benefits
- [ALL] Overall, do the currently adopted operating rules meet the current (and near-term) business needs of the industry? Is the industry achieving the intended benefits from the operating rules? Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints
- [ALL] Have there been any studies, measurement or analysis done that documents the extent to which the operating rules, as adopted and in use, have improved the efficiency and effectiveness of the business processes?
- [ALL] Explain the perceived or actual adoption trend of each set of operating rules (by transaction, by industry sector – i.e., providers, health plans). Describe challenges and opportunities for broader adoption of these ORs by industry stakeholders
- [ALL] Are there any identified areas for improvement of currently adopted operating rules?
- [CAQH CORE] What will be the process for updating and publishing operating rules?
- [ALL] What, if any alternatives exist for improving efficiency and effectiveness of the business process for each of the transactions for which operating rules have been adopted?
- [ALL] Are there additional efficiency improvement opportunities for administrative and/or clinical processes of these transactions that can/should be addressed via operating rules, and strategies to measure impact?
- [ALL] What alternatives exist to achieve greater efficiency and effectiveness between trading partners?
- [ALL] Are there any changes that should be made to the current ORs or the mandate?
- [CAQH CORE] What lessons learned from the adopted operating rules has or will be applied to the next set of proposed operating rules?

ADDITIONAL QUESTION FOR PANEL 1 – HEALTH PLAN ENROLLMENT/DISENROLLMENT AND HEALTH PLAN PREMIUM PAYMENT

- What is the usage of enrollment/disenrollment and premium payment transaction standard in health insurance exchanges?

ADDITIONAL QUESTION FOR PANEL 2 – HEALTH PLAN ELIGIBILITY, BENEFITS INQUIRY & RESPONSE (PART 1)

- What is the degree of usage of non-batch transactions (i.e., web portals) for eligibility?

ADDITIONAL QUESTIONS FOR PANEL 3 – PRIOR AUTHORIZATION

- What are the main reasons for non- or limited-usage of transaction?
- What is the degree of usage of non-batch transactions (i.e., web portals) for prior authorization?

ADDITIONAL QUESTION FOR PANEL 4 – HEALTH CARE CLAIM OR EQUIVALENT ENCOUNTER INFORMATION

- What is the degree to which clean claims are being achieved?

ADDITIONAL QUESTION FOR PANEL 5 – COORDINATION OF BENEFITS

- What is the status of coordination of benefits processes, opportunities for process improvement via operating rules?

ADDITIONAL QUESTION FOR PANEL 7 – HEALTH CARE PAYMENT, REMITTANCE ADVICE AND ELECTRONIC FUND TRANSFER

- What is the status of use of CARC/RARC code sets?

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B. Testifiers

Panel 1 – Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

Employer (Xerox)	Debra Strickland
Health Plan (BCBSA)	Gail Kocher
Health Plan (BCBS, Tennessee)	Don Petry
Pharmacy (NCPDP)	Annette Gabel
X12	Stacey Barber

Panel 2 – Health Plan Eligibility, Benefits Inquiry and Response

Billing (HBMA)	Dave Nicholson
Clearinghouse (Cooperative Exchange)	Sherry Wilson
Health Plan (AETNA/AHIP)	Merri-Lee Stine
Health Plan (BCBSA)	Gail Kocher
Long Term Care (AHIP)	Stephanie Eades
Medicaid (MPHI)	Melissa Moorehead
Medicare	Rich Cuchna
Mental Health (UC Denver)	Benjamin Miller
Operating Rule Authoring Entity (CAQH CORE)	Gwen Lohse
Pharmacy (NCPDP)	Annette Gabel
Provider (AHA)	George Arges
Provider (MGMA)	Robert Tennant
Practice Management Vendors (HATA)	Chris Bruns
Veterans Administration	Ruth-Ann Phelps
WEDI	Laurie Darst
X12	Stacey Barber

Panel 3 – Prior Authorization

Clearinghouse (Cooperative Exchange)	Sherry Wilson
Health Plan (BCBSA)	Gail Kocher
Health Plan (AHIP)	Rhonda Starkey
Mental Health (UC Denver)	Benjamin Miller
Medicaid (MPHI)	Melissa Moorehead
Medicare	Connie Leonard
Pharmacy (NCPDP)	Margaret Weiker
Provider (AHA)	George Arges
Provider (AMA)	Heather McComas
Provider (MGMA)	Robert Tennant

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Practice Management Vendors (HATA)	Chris Bruns
WEDI	Sam Rubenstein
X12	Stacey Barber

Panel 4 – Health Care Claim or Equivalent Encounter Information

Clearinghouse (Cooperative Exchange)	Sherry Wilson
Coders (AAPC)	Raemarie Jimenez
Dental (ADA)	David Preble
Health Plan (BCBSA)	Gail Kocher
Medicaid (MPHI)	Melissa Moorehead
Medicare	John Evangelist
Mental Health (UC Denver)	Benjamin Miller
Pharmacy (NCPDP)	Margaret Weiker
Practice Management Vendors (HATA)	Chris Bruns
Provider (AHA)	George Arges
Provider (MGMA)	Robert Tennant
X12	Stacey Barber

Panel 5 – Coordination of Benefits

Clearinghouse (Cooperative Exchange)	Sherry Wilson
Medicaid (MPHI)	Melissa Moorehead
Medicare Supplemental Carrier (AHIP)	Gary Beatty
Operating Rule Authoring Entity (CAQH CORE)	Atul Pathiyal
Practice Management Vendors (HATA)	Chris Bruns
Provider (AHA)	George Arges
Provider (MGMA)	Robert Tennant
X12	Stacey Barber

Panel 6 – Health Care Claim Status

Clearinghouse (Cooperative Exchange)	Sherry Wilson
Health Plan (BCBSA)	Gail Kocher
Health Plan (AHIP)	Rhonda Starkey
Medicare	John Evangelist
Operating Rule Authoring Entity (CAQH CORE)	Gwen Lohse
Provider (AHA)	George Arges
Provider (MGMA)	Robert Tennant
WEDI	Jean Narcisi

Panel 7 – Health Care Payment, Remittance Advice and Electronic Fund Transfer

Clearinghouse (Cooperative Exchange)	Sherry Wilson

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Dental	David Preble
Health Plan (AETNA/AHIP)	Merri-Lee Stine
Health Plan (BCBSA)	Gail Kocher
Long Term Care (AHIP)	Stephanie Eades
Medicaid (MPHI)	Melissa Moorehead
Medicare	John Evangelist
NACHA	Priscilla Holland
Operating Rule Authoring Entity (CAQH CORE)	Gwen Lohse
Pharmacy (NCPDP)	Annette Gabel
Provider (AHA)	George Arges
Provider (AMA)	Heather McComas
Provider (MGMA)	Robert Tennant
Veterans Administration	Ruth-Ann Phelps
WEDI	Jean Narcisi
X12	Stacey Barber

C. Written Testimony Contributors

Panel 1 – Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

Employer (Xerox)	Debra Strickland
Health Plan (BCBSA)	Gail Kocher
Health Plan (BCBS, Tennessee)	Don Petry
Pharmacy (NCPDP)	Annette Gabel
X12	Stacey Barber

Panel 2 – Health Plan Eligibility, Benefits Inquiry and Response

Billing (HBMA)	Dave Nicholson
Clearinghouse (Cooperative Exchange)	Sherry Wilson
Health Plan (AETNA/AHIP)	Merri-Lee Stine
Health Plan (BCBSA)	Gail Kocher
Long Term Care (AHIP)	Stephanie Eades
Mental Health (UC Denver)	Benjamin Miller
Operating Rule Authoring Entity (CAQH CORE)	Gwen Lohse
Pharmacy (NCPDP)	Margaret Weiker
Provider (AHA)	George Arges
Provider (MGMA)	Robert Tennant
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WEDI	Sam Rubenstein
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Panel 7 – Health Care Payment, Remittance Advice and Electronic Fund Transfer

Clearinghouse (Cooperative Exchange)	Sherry Wilson
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Provider (AMA)	Heather McComas
Provider (MGMA)	Robert Tennant
WEDI	Jean Narcisi
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D. Public Contributors

American Clinical Laboratory association
Administrative Uniformity Committee
LabCorp
NCHICA

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E. February 2016 Review Committee Letter to the Secretary

NCVHS
National Committee on Vital and Health Statistics

February 29, 2016

Honorable Sylvia M. Burwell
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Findings from Administrative Simplification Hearing

Dear Madam Secretary,

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS advises the Secretary on the adoption of standards, implementation specifications, code sets and identifiers for the HIPAA-named transactions.

In this letter, we are providing recommendations for action by HHS to address a significant opportunity to advance Administrative Simplification by focusing on the need for increased coordination, education and enforcement. In summary, we recommend that the Department consider the following actions. Background and detailed descriptions of the following recommendations are provided in this letter:

- Expanding the definition of covered entities under HIPAA
- Broadening HIPAA-related education activities
- Ensuring consistency in the interpretation and implementation of administrative transactions, code sets, identifiers and operating rules requirements
- Enforcing compliance

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- Adopting standards for the Acknowledgment transaction
- Defining a roadmap to provide predictability in adoption of standards, code sets, identifiers and operating rules
- Increasing utilization of the Enrollment/Disenrollment and Premium Payment standards
- Evaluating the use of the prior authorization transaction.

NCVHS will also be developing a separate report that will include observations, themes, issues and NCVHS recommendations for the entire health care industry.

BACKGROUND

Health care costs continue to rise. Studies support that administrative costs contribute to the cost of health care and that these costs can be reduced through greater standardization. In fact, the overarching goal of the administrative simplification provisions of HIPAA is to improve the efficiency and effectiveness of the health care system through the establishment of uniform standards and requirements for the electronic transmission of certain health information to reduce the clerical burden on patients, health care providers, and health plans. Simplification occurs through adoption of standards via the federal rule making process, followed by implementation of the adopted standards by those entities participating in each of the transactions. Testifiers at the Review Committee hearing acknowledged that there is evidence of savings through the adoption and implementation of standards for the HIPAA named transactions, however, achieving the potential savings have been limited by a number of factors, including variability in the level of implementation and inconsistency in the method of implementation of the transaction standards and operating rules.

In addition to the statutory requirements under HIPAA, the Patient Protection and Affordable Care Act (ACA) Sec. 1104 (b) enacted on March 23, 2010, also calls for NCVHS to further assist in the achievement of administrative simplification to "reduce the clerical burden on patients, health care providers, and health plans." ACA also requires the Secretary to adopt standard operating rules for the implementation of each of the HIPAA-named transactions. Section 1104(i) of ACA authorizes the Secretary to establish a Review Committee responsible for conducting hearings to evaluate and review the adopted standards and operating rules. The Secretary last year designated NCVHS as the Review Committee.

NCVHS, acting as the Review Committee, held its first Review Committee hearing on June 16 and 17, 2015. The purpose of this hearing was to address all HIPAA-named transactions and their corresponding adopted standards (including code sets and identifiers) and operating rules (referred to in this letter as "standards and operating rules") currently being implemented by the healthcare industry. The HIPAA-named transactions covered during the hearing included: 1) health plan enrollment and disenrollment; 2) premium payment; 3) health plan eligibility benefits inquiry and response; 4) prior authorization; 5) health care claim or equivalent encounter information; 6) electronic fund transfer and electronic remittance advice; and 7)

coordination of benefits. Over the two-day hearing, NCVHS received seventy-seven oral testimonies and reviewed over 100 additional written testimonies from the health care industry representing providers, health plans, vendors, clearinghouses, associations, public programs (Medicare, Medicaid), federal agencies, standard development organizations, operating rules authoring entity and consultants.

General Findings and Recommendations

Consistent and comprehensive adoption and implementation of the HIPAA-named transaction standards and operating rules across the industry is viewed by many stakeholders as a significant step forward towards achieving administrative efficiencies. The health care industry, Standards Development Organizations, Operating Rule Authoring Entity and DHHS have led the way in moving the entire ecosystem towards administrative simplification. However, further work is needed to continuously improve the adopted transaction standards and operating rules and increase their level of implementation and the consistency in the way they are implemented and used.

One of the most significant findings from the hearing was the variation in the *level* of implementation of various transaction standards and operating rules. While six transactions (eligibility, claim, claim status, electronic funds transfer, remittance advice and coordination of benefits) have been widely implemented, others (benefit enrollment/disenrollment, premium payment, and prior authorization) are not yet widely implemented. Industry representatives agree that for greatest impact at this time, focus should be on the five adopted standard transactions and operating rules that are most widely implemented. Future focus should be on adopted transaction standards and operating rules that have low implementation.

Another significant and related finding was the degree of *inconsistency* that still exists within the industry in the way transaction standards and operating rules are being implemented. Even when the transactions are implemented electronically using the adopted standards and operating rules, inconsistencies in the data content, coding, and processing are creating barriers to achieving the expected efficiencies and effectiveness. Such is the case, as noted by testifiers, with some of the submissions and responses of each of the five widely implemented transactions (eligibility, claims, claims status, remittance advice, and coordination of benefits). Reasons for these two issues identified by testifiers included:

- Level of complexity of the adopted standards
- Concerns that adopted standards are not meeting the business needs
- Use of HIPAA-compliant alternative technologies to conduct the transactions in a more efficient and effective manner
- Not all entities engaged in conducting the HIPAA-named transactions are subject to HIPAA as covered entities.

At the same time, rapid advances in health information technology (HIT) and the transformative changes in health care delivery and payment models currently underway are creating the need

for transitioning existing models into new paradigms for how administrative and billing processes in health care will be done in the future. NCVHS views these challenges as strategic opportunities to refine and align the goal of administrative simplification with the changes in technology and healthcare delivery models.

NCVHS reviewed testimony and formulated its recommendations utilizing the criteria that formed the basis of the questions testifiers were asked to address in their testimony. The criteria, centered on identifying if the adopted standards (including code sets and identifiers) and operating rules (where adopted):

- meet the industry's business need/use/problem resolution
- decrease cost and/or administrative processes
- are flexible/agile to meet changes in technology and/or healthcare delivery systems
- can be operationalized
- can be enforced.

In addition to these criteria, NCVHS looked at other factors to evaluate the degree to which the adopted standards and operating rules were meeting the overall goal of administrative simplification. These included:

- Completeness: Does the standard or operating rule provide the complete information necessary to execute the transaction and achieve the business purpose?
- Efficiency: Does the standard or operating rule decrease resource utilization and the time to perform the transaction function?
- Complexity: Do the standard or operating rule requirements exceed the healthcare industry's cost and resource capacity resulting in limited or non-implementation?
- Flexibility: Does the standard or operating rule allow for interim updates and can it adapt to changes in technology and health delivery models?
- Consistency: Is the standard or operating rule able to be implemented in the same manner across all healthcare entities?
- Effectiveness: Does the standard and operating rule solve the business need?
- Ambiguity: Does the standard or operating rule result in differences in interpretation and in implementation?

The following recommendations provide specific ways in which DHHS can further advance administrative simplification. Some of the issues identified and the subsequent recommendations are common to all transactions while others are unique to specific transactions.

Recommendation # 1: ***Expanding the definition of covered entities under HIPAA.***

Consistent and broad implementation is at times challenged by the current definition of HIPAA covered entity. Various organizations actively engaged in exchanging administrative and financial data such as employers, workers' compensation plans, property and casualty industry,

and other health care related organizations are not HIPAA **covered entities**. This results in a lack of use of electronic transaction standards and increased costs attributed to customization and maintenance associated with using proprietary methods to capture necessary data and information.

For example, health plans, as covered entities, are required to be capable of conducting the enrollment/disenrollment and premium payment transactions electronically. However, employers, who are the other end of these two transactions, are not covered under HIPAA, thus, are not required to conduct these transactions electronically using the adopted standards. Similarly, in the workers' compensation area, providers that submit claims to workers' compensation plans cannot always use the same electronic claim transaction standards adopted for all other health care claims because the workers' compensation plans are not covered entities, and they can and often use a different standard to receive and process these types of claims. *HHS* should:

1.1 Explore the feasibility of requesting that Congress amend the definition of a covered entity to include all entities that perform HIPAA-named transactions. As covered entities, they would then be required to comply with the adopted standards and operating rules. This would include but not be limited to employers, workers' compensation, property and casualty industry, practice management systems (PMS), and other vendors of relevant solutions.

1.2 In the absence of a statutory amendment to the definition of a covered entity, explore other regulatory and non-regulatory mechanisms (including federal procurement and contractual requirements) to require that any entity that performs a HIPAA-named transaction specified in §1104(h)(B)(3) of ACA comply with the standards (including code sets, identifiers) and operating rules adopted for these transactions.

Recommendation # 2: ***Broadening education.***

All testifiers agreed that increased education and knowledge on the use of standards (including code sets and identifiers) and operating rules is needed. As this is an industry-wide, multi-stakeholder need, NCVHS recommends a broad **education** effort. The *healthcare industry, Standards Development Organizations, and Operating Rules Authoring Entity and HHS* should work together to ensure that:

2.1 Stakeholders have access to and are educated on the standards and operating rules. This would include intended benefits and other considerations to support greater implementation and standardization of use.

2.2 Instructional materials are prepared with multi-stakeholder involvement, address currently adopted standards (including code sets and identifiers) and operating rule requirements, and are clear, concise, consistent and relevant.

2.3 Stakeholders are educated on the already demonstrated benefits of administrative simplification transactions, such as:

- front-end edits by clearinghouses and payers have quickly identified and reported back to providers claim errors or deficiencies so they can be promptly addressed and the claim submitted correctly improving processing timeliness
- automated edits helped speed development and review of claims as fewer claims must be manually inspected and checked
- allowed providers to capture more information needed for payment
- provided the ability to send secondary and tertiary claims electronically
- helped reduce claim adjudication issues and denials
- accelerated turnaround times resulting in better use of staff and resources.

Recommendation # 3: ***Ensure consistency.***

Testifiers discussed the multiplicity of requirements and instructions addressed in the standards, operating rules, and proprietary policies. Some testifiers indicated that the standards and their accompanying operating rules are developed in isolation rather than as a system with a number of processes or workflows that need to be **integrated**. As this is an industry-wide issue, NCVHS sees the need to promote consistency as an industry-wide endeavor. The *healthcare industry, Standards Development Organizations, Operating Rule Authoring Entity and HHS* should work together to ensure that standards, code sets, identifiers and operating rules are simplified, unambiguous, able to be operationalized, and adaptable to current and future needs. Specifically, HHS should:

3.1 Respond to the X12 request to validate the use of the X12 TR3 Schema thus mitigating inconsistent XML based solutions.

3.2 Consider requiring operating rules (e.g., acknowledgement, response time) be consolidated across transactions including combining all phases in a single document to alleviate the need for the industry to support different versions of a similar rule for different transactions.

3.3 Begin discussions with the *Standards Development Organizations and the healthcare industry* to measure the degree to which each of the transaction standards and operating rules are being implemented in an inconsistent manner, the reasons for the inconsistent implementation, and explore requirements to reduce or eliminate the causes of these inconsistencies.

Recommendation # 4: ***Enforce compliance.***

A common theme by testifiers was the inconsistent level of implementation and compliance with the adopted standards and operating rules and the lack of **enforcement** by HHS. The level

and inconsistency in the implementation are for the most part transaction-specific issues and generally associated with two factors:

- Whether the two ends of the transaction are required to conduct the transaction electronically using the adopted standards and operating rules. This is the case for transactions such as enrollment/disenrollment and premium payment, and the issue is covered under Recommendation 1.
- The complexity of the adopted standards and/or operating rules for the transaction. This issue is covered under Recommendation 3 and the "Specific Transaction Recommendations" section below.

Testifiers affirmed that enforcement would serve as an incentive for compliance especially with the possibility of being assessed a considerable penalty fee. However, because of the range of inconsistencies identified, NCVHS recommends that *HHS* should:

4.1 Sequence enforcement initially focusing on the five widely implemented transaction standards and operating rules (eligibility, claim, claim status, remittance advice and coordination of benefits).

4.2 Educate the industry on compliance and penalties, including communicating compliance, audit, and enforcement requirements to ensure that there is consistency in compliance with all the transaction requirements.

4.3 Consider publicizing best practices and educational resource tools to support compliance efforts, consistent with Recommendation 2.

4.4 Initiate development of a tool that could be used by stakeholders and by HHS for use in assessing compliance that can evaluate and measure compliance with each standard and operating rule.

4.5 Review existing mechanisms designed to enforce compliance with adopted standards and operating rules including the assessment of penalties and fines for non-compliance.

4.6 Consider enforcing compliance with the adopted standards and operating rules with the same level of engagement seen in the OCR HIPAA Privacy and Security Compliance Program.

4.7 Consider publicizing enforcement details to include but not be limited to:

- Number of complaints that were penalized
- Consequences of non-compliance
- Enforcement process
- How to file complaints while mitigating damage with the payer relationships.

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4.8 Working with the industry to consider establishing a certification process for practice management systems and other vendors that can validate adherence to the adopted standards and of operating rules.

Recommendation # 5: ***Adopt acknowledgment transaction.***

One transaction that is not currently mandated or used consistently by the healthcare industry yet has great potential value is **Acknowledgments.**

The acknowledgment transaction is widely seen by the industry as a critical element in the end-to-end health care administrative transactions lifecycle. The transaction, which is used to quickly return valuable information about the receipt of an inbound transaction (for example, a claim submitted by a provider to a health plan), helps inform the submitter of the inbound transaction (the provider, in the example) about the need to correct certain elements of the submitted transaction before it can begin to be processed, or confirm that the transaction was appropriately received and no corrections are needed before processing begins.

Acknowledgments are currently voluntarily being used by many in the healthcare industry. For example, Medicare uses claim acknowledgment 277CA transaction to report acceptance or rejection of claims, which many payers have followed. However, others continue to generate proprietary reports which are dynamic and require constant support to maintain the integrity of the data extracted and lack details to show that a payer has moved the submitted claims into its adjudication system. Acknowledgments also provide a way to the submitter, a receipt of a transaction, thus avoiding costly and lengthy details to validate receipt of transactions.

NCVHS has in the past recommended that HHS adopt a national standard for the Acknowledgement transaction[7]. Testifiers have indicated that there is wide industry consensus in support of adopting this transaction.

5.0 As previously recommended by NCVHS, *HHS* should pursue adoption of the standards and operating rules for the acknowledgment transaction, and specify which acknowledgments are to be used in conjunction with which transaction.

Recommendation # 6: ***Provide predictability in adoption of standards, code sets, identifiers and operating rules.***

Industry representatives expressed concerns regarding the lack of predictability in the adoption of standards, code sets, identifiers and operating rules and the associated implementation timetables and processes. This applies to initial adoption and version updates. Further,

[7] September 22, 2011, September 21, 2012 and September 20, 2013, letters to Kathleen Sebelius, Secretary, Department of Health and Human Services, from the National Committee on Vital and Health Statistics (NCVHS).

timetables appear to be set without consideration of the range of mandated requirements. The availability and adoption of standards; implementation process for standards, code sets, identifiers, and operating rules; the lag time between standard versions; and the adoption of standards and operating rules often coincide with the need to implement other mandated requirements. NCVHS recognizes that recommendations to resolve these issues require a **long term approach** that would not be achieved within the next year. *HHS* working with the *Standards Development Organizations, Operating Rule Authoring Entity and the healthcare industry* should consider developing in 2016:

6.1 A roadmap for the adoption and implementation of the next version of standards and operating rules, including a more predictable and efficient cycle from industry recommendation to upgrade of standards and operating rules, to the regulatory levers to mandate scope and timing of the upgrade. This helps ensure an orchestrated glide path for adoption and implementation while reducing the current state of competing priorities. There should be an opportunity for broad industry review and comment on the roadmap. The roadmap development will greatly benefit from coordination among applicable HHS agencies around a consolidated strategic plan, interoperability of the roadmap, and the approach to achieving enhanced processes for the implementation of revised and/or new mandated standard transactions and operating rules. The roadmap and enhanced processes should also be flexible to accommodate the need to adopt standards in between cycles, if required for healthcare industry business needs.

6.2 A proposed mechanism for monitoring progress in the implementation of transaction standards and operating rules. This could entail working with other organizations on standardized metrics and data sets to monitor industry usage of the HIPAA required transactions and their respective adopted standards and operating rules.

Transaction-Specific Findings and Recommendations

As noted earlier in this letter, testifiers indicated that there are varying degrees of implementation of specific HIPAA-named transactions due to multiple reasons. Testifiers provided examples of barriers to implementation and specific recommendations to resolve the issues. Some of these barriers have been addressed in the General Recommendations above. NCVHS also found that most of the concerns, barriers and recommendations for specific transactions pertained to the Standards Development Organizations, Operating Rule Authoring Entity and the industry. However, there were two transactions that NCVHS felt important to highlight in this letter with recommendations.

Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

Recommendation # 7: ***Increase utilization of the Enrollment/Disenrollment and Premium Payment standards.***

Testifiers indicated that there has been low implementation of the health plan enrollment/disenrollment transaction standard (known as the 834 transaction) and the health plan premium payment transaction standard (known as the 820 transaction) citing various reasons including the fact that employers (one of the end-points of these transactions) are not designated as a covered entity under HIPAA and therefore are not required to implement the standard. In addition, Health Plans participating in the insurance marketplaces (HIX) are having to accept both the 834 standard adopted for HIPAA covered entities, and the 834 HIX standard, mandated for use in the enrollment of individuals participating in the insurance marketplaces.

Therefore, NCVHS recommends that:

7.1 The *healthcare industry and HHS* examine approaches that would increase implementation of the 834 and the 820 standards, avoiding maintenance of multiple channels of data input that results in increased customization of vendor tools increasing costs and labor, into enrollment systems.

7.2 HHS explore ways to bring to full convergence the 834 HIX (used by the insurance marketplaces) and the current 834 used by HIPAA-covered entities for all other enrollment transactions, so they become one and the same. This would simplify and reduce administrative burden on health plans.

Prior Authorization

Recommendation #8: ***Evaluate the use of the prior authorization transaction.***

The complexity of the prior authorization transaction standard (known as the 278 transaction) is reported as not helping the industry achieve its intended purpose and benefits. Testifiers indicated that because of the variation in medical and pharmacy benefits, there are different prior-authorization rules that result in cumbersome and inconsistent workflow processes and the need to provide additional requested information through manual processes. Additionally, health plans' web portals have become predominant venues for providing greater level of functionality and information exchange to achieve prior-authorizations. Therefore, NCVHS recommends that:

8.1 The *Standards Development Organization, Operating Rules Authoring Entity*, *healthcare* industry *and HHS* should evaluate the value of the current prior authorization transaction and the adopted standard. This includes (1) identifying why web portals and other HIPAA-compliant alternative technology data exchange means are more effective and provide all the necessary and useful information, compared to the adopted transaction standard, and, (2) consider appropriate changes to future versions of the standard, including potentially leveraging the attachments transaction standards and operating rules to enhance the usefulness and effectiveness of the 278 transaction.

8.2 *HHS* respond to the NCPDP's request and NCVHS recommendation (in NCVHS May 15, 2014 letter to the Secretary) that HHS should name the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transaction as the adopted standard for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

In summary, the healthcare industry's adoption and implementation of administrative simplification standards and operating rules has presented many challenges. The first Review Committee hearing provided an opportunity for NCVHS to learn about the successes as well as the barriers to successful implementation. Thank you for consideration of the recommendations in this letter. NCVHS remains available to answer any questions and will continue to support your efforts in the promotion and expansion of administrative simplification.

Sincerely,

Walter G. Suarez, M.D., M.P.H., Chairperson,
National Committee on Vital and Health Statistics

Cc: HHS Data Council Co-Chairs

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RECOMMENDATIONS	HHS	Industry	SDO	ORAE	Pharm	HPs
General Recommendations						
A. Expand Definition of Covered Entities						
o Congressional Request	X					
o Regulatory/Non-Regulatory Mechanism	X					
B. Broaden Stakeholder Education						
o On Standards and Operating Rules	X	X	X	X		
o Stakeholder Involvement in Material Development	X	X	X	X		
o On Benefits Of Administrative Simplification	X	X	X	X		
o Geared for Audience	X	X	X	X		
C. Ensure Consistency						
o Require Consolidation of Operating Rules	X					
o Respond to X12 Schema Request	X					
o Measure Degree of Transaction Implementation	X	X	X			
o Understanding of Healthcare Industry	X					
o Ensure Consistent Data Requirements			X	X		
o Consider Data Sets in Developing/Modifying Standards and Operating Rules			X	X		
o With Information On Web Portals and AVR Systems			X	X		
o Define Key Terms			X	X		
D. Enforce Compliance						
o Sequence Enforcement Efforts	X					
o Educate Stakeholders on Compliance and Penalties	X					
o Publicize Best Practices and Resource Tools	X					
o Initiate Tool Development	X					
o Review Existing Enforcement Mechanisms	X					
o Consider OCR's Compliance Efforts	X					
o Publicize Enforcement Details	X					
o Consider Establishing Automated Testing Tools	X	X				
o All Business Entities Comply With Requirements		X				
o Encourage PMS Compliance		X				
o Require Vendor Transparency		X				
o Consider Vendor Validation		X				
E. Adopt Acknowledgment Transaction	X					
F. Provide Predictability in Adoption						
o Consider Developing a Long-term Roadmap	X	X	X	X		
o Identify Emerging Business Requirements	X					
o Consider Developing a Mechanism to Monitor Implementation of Transactions	X					

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Recommendations	HHS	Industry	SDO	ORAE	Pharm	Payer
G. Responsiveness to Evolving Changes in Health Care						
○ Research effectiveness of standards and operating rules before adoption			X	X		
○ Determine business value before recommending adoption			X	X		
○ Ensure pilot testing before adoption and implementation			X	X		
○ Evaluate cost of implementation			X	X		
○ Review adopted standards and operating rules to simplify them			X	X		
○ Work together to ensure modifications can be implemented	X	X	X	X		
○ Review of current operating rules				X		
Transaction Specific Recommendations						
A. HP Enrollment/Disenrollment/Premium Payment						
○ Convergence of 834 HIX, CCIIO Companion Guides & 834 for all enrollment transactions	X					
○ Increase implementation of 834 & 820 standards	X	X				
○ Develop a response transaction			X			
○ Determine if 834 & 820 are meeting business needs		X	X	X		
○ Research value of 834 HIX alignment with use case		X	X	X		
B. Eligibility, benefits inquiry & response						
○ Provider education on 270/271	X					
○ Mandate acknowledgments	X					
○ Audit HPs for 270/271 compliance	X					
○ Evaluate adopted standard and operating rule		X	X	X		
○ Ensure comparability of eligibility data elements with website elements			X	X		
○ Ensure all information required is in the standard			X			
○ Ensure next version supports enhancements			X			
○ Ensure granularity of provider network status			X			
○ Consider service types & benefit information			X			

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Recommendation	HHS	Industry	SDO	ORAE	Pharm	Payer
○ Consider standardizing reporting of HIX grace period			X			
○ Consider including patient financial liability amounts			X			
○ Consider impact of insufficient information			X			
○ Consider State needs			X			
○ Expand use of repetition separators			X			
○ Ensure next version removes barriers			X			
○ Support all service type codes			X			
○ Include plan product information			X			
○ Include referral required information			X			
○ Include need for prior authorization by service type			X			
○ Return PCP NPI in the 2100C loop			X			
○ Accept inquiries for HCPCS codes in the EQ02			X			
○ Evaluate necessity of 20 second eligibility response				X		
○ Require procedure-specific responses				X		
○ Consider requiring real-time eligibility & financial responsibility response				X		
○ Encourage payers to respond to HCPCS/CPT eligibility requests		X				
○ Provide transparency of vendor capability & performance		X				
○ Require PMS to provide capability to send & receive eligibility transactions		X				
○ Consider developing & maintaining 270/271 eligibility database		X				
C. Prior Authorization						
○ Respond to NCPDP Script request	X					
○ Identify why alternative technology data exchanges are more effective	X	X	X			
○ Enhance usefulness & effectiveness of the 278	X	X	X			
○ Evaluate the transaction as it relates to low utilization			X			
○ Consider flexibility to use newer technology			X			
○ Determine if the standard does not meet business needs			X			
○ Determine why the standard is too complex			X			
○ Determine States' needs			X			
○ Determine laboratory needs			X			

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Recommendation	HHS	Industry	SDO	ORAE	Pharm	Payer
○ Modify the standard to require response beyond "pending"			X			
○ Investigate feasibility of converging eligibility & prior authorization			X			
○ Require the 278 to indicate needs			x			
○ Ensure industry use of portals is not to circumvent the transaction	X	X				
○ Ensure technologies are updated simultaneously		X				
○ Ensure communication among users		X				
○ Ensure systems support end-to-end automation		X				
○ Ensure payers return authorization & benefit information at the CPT/HCPCS level		X				
○ Ensure providers' system vendors support the 278		X				
○ Convene multi-stakeholder workgroup to resolve issues impeding adoption of the 278		X				
○ Implement the 275 & 277		X				
○ Ensure formulary data at point of prescribing					X	
○ Develop real-time pharmacy benefit inquiry					X	
○ Provide specific responses						X
D. Health Care Claim or Equivalent Encounter Info						
○ Adopt the use of the TAI	X					
○ Adopt the 999 for all batch transactions	X					
○ Adopt the 277CA as claims status format	X					
○ Educate on the purpose of the Health Care Claim Status		X				
○ Educate on the problem of adding reporting requirements		X				
○ Educate on correct application of CPT & HCPCs code sets		X				
○ Research needed data & placement			X	X		X
○ Educate on benefits of electronic claims	X	X				
○ Consider developing workarounds for atypical providers			X			
○ Address TR3s not meeting Medicare's business needs			X			
○ Address issues raised by the industry		X	X	X		

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Recommendations	HHS	Industry	SDO	ORAE	Pharm	Payer
○ Consider expanding and/or revising Medicaid specific codes			X	X		
E. Coordination of Benefits						
○ Educate on need for non-varying policies		X				
○ Educate on the use of COB		X				
○ Multiple health coverage information		X				
○ Evaluate standards & operating rules for applicability in various settings			X	X		
○ Address zero dollar payments & unbalanced RA			X	X		
○ Consider NCPDP methods			X	X		
○ Develop operating rules on communication of COB information				X		
F. Health Care Claims Status						
○ Consider adopting the 277	X					
○ Educate on effectiveness of the 276		X				
○ Educate on timely claim response		X				
○ Educate on timely infrastructure changes		X				
○ Educate on availability of real-time claim status		X				
○ Implement operating rules		X				
○ Increase business understanding of claim status inquiry & response		X				
○ Focus efforts on critical activities		X				
○ Determine if real-time status meets a business need		X				
○ Provide explanations of error responses						X
○ Include all adjudications in the claim response						X
○ Include adjudication dates and check number in response files						X
○ Evaluate & modify current standards & operating rules			X	X		
○ Address raised issues			X	X		
○ Consider the need for a transaction audit trail between payer & provider			X	X		
○ Determine if next versions will remove barriers & support business needs			X	X		
○ Consider permitting batch status response				X		
G. Health Care Payment, Remittance Advice & Electronic Fund Transfer						

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Recommendation	HHS	Industry	SDO	ORAE	Pharm	Payer
○ Evaluate & modify the CARC/RARC combinations to address issues				X		
○ Provide additional guidance of CARC/RARC combinations for LTC insurance adjudication				X		
○ Consider naming code value usage as a source for outliers				X		
○ Consider improved method of reporting information in the CARCs & RARCs				X		
○ Address issues with tracking & reconciling overpayment & recovery						
○ Create additional ERA operating rules				X		
○ Create additional operating rules to improve provider enrollment						
○ Address reconciliation problems			X			
○ Address enrollment problem			X			
○ Consider including necessary non-mandated transactions			X			
○ Total payment in the BRP segment should equal the sum in the PLB loops			X			
○ Consider assigning reasons & remarks for adjustment/denials to most specific code			X			
○ Consider providing stronger language & guidance on balancing			X			
○ Consider addressing overpayment & recovery in the 835			X			
○ Consider improving level of communication in the 835			X			
○ Align EFT & ERA			X			
○ Modify TRN to indicate the specific payment number			X			
○ Consider developing a standard and operating rule implementation guide			X	X		
○ Adopt a more comprehensive CARC/RARC resource		X	X	X		
○ Coordinate activities to maintain code sets		X	X	X		
○ Evaluate data requirements		X	X	X		

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