

September 6, 2011

The Honorable Kathleen Sebelius
Secretary
U. S. Department of Health and Human Services
200 Independence Avenue, SW
Room 445-G
Hubert H. Humphrey Building
Washington, DC 20201

Re.: Submission of Minnesota Administrative Uniformity Committee (AUC) comments to the Centers for Medicare & Medicaid Services (CMS) regarding the interim final rule, “Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC)”

Dear Secretary Sebelius:

We are pleased to submit comments on behalf of the Minnesota AUC regarding “Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC)”. We appreciate the opportunity to respond to the IFC, as well as the significant efforts of CMS, the Council for Affordable Quality Health Care (CAQH) Committee for Operating Rules for Information Exchange (CORE), and others in developing and adopting the rule to promote greater health care administrative simplification.

We are providing a description of the AUC as well as our comments in a series of attachments to this letter. We would like to note in particular:

Minnesota Administrative Uniformity Committee Members

Aetna ◇ Aging Services of Minnesota ◇ Allina Hospitals & Clinics ◇ American Association of Healthcare Administrative Management ◇ Blue Cross Blue Shield of Minnesota ◇ Care Providers of Minnesota ◇ CentraCare Health System ◇ Children’s Hospitals and Clinics of Minnesota ◇ CVS Pharmacy ◇ Delta Dental of Minnesota ◇ Essentia Health ◇ Fairview Health Services ◇ HealthEast ◇ HealthEZ ◇ HealthPartners–Health Plan ◇ HealthPartners–Medical Group and Regions Hospital ◇ Hennepin County Medical Center ◇ Hennepin Faculty Associates ◇ Mayo Clinic ◇ Medica ◇ Metropolitan Health Plan ◇ Minnesota Chiropractic Association ◇ Minnesota Council of Health Plans ◇ Minnesota Dental Association ◇ Minnesota Department of Health ◇ Minnesota Department of Human Services ◇ Minnesota Department of Labor and Industry ◇ Minnesota HomeCare Association ◇ Minnesota Hospital Association ◇ Minnesota Medical Association ◇ Minnesota Medical Group Management Association ◇ Minnesota Pharmacists Association ◇ Noridian Administrative Services LLC ◇ Olmsted Medical Center ◇ Park Nicollet Health Services ◇ PreferredOne ◇ PrimeWest Health ◇ Sanford Health ◇ Sanford Health Plan ◇ Silverscript ◇ St. Luke’s ◇ UCare ◇ UnitedHealth Group ◇ University of Minnesota Physicians ◇ WPS Health Insurance

www.health.state.mn.us/auc

- Attachment A: AUC Comments Regarding CMS-0032-IFC Operating Rules for the Eligibility Transaction

The AUC supports the CORE Eligibility for a Health Plan operating rules and offers recommendations to take fullest advantage of the transaction's capabilities, and to improve the readability and application of the operating rules in practice. The AUC as a group has greater experience with data content issues than with connectivity and infrastructure issues; as a result, our comments in Attachment A are focused primarily on the data content aspects of the eligibility operating rule.

- Attachment B: AUC Comments Regarding Maintenance and Modifications to Standards and Operating Rules

In correspondence to CMS and testimony earlier this year to the National Committee on Vital and Health Statistics (NCVHS), the AUC communicated several concerns and recommendations regarding maintenance and modifications to transaction standards and operating rules. With the recent adoption of the first of several anticipated sets of operating rules, we feel that these concerns and recommendations are especially timely, and we are forwarding them as Attachment B.

In particular, we are concerned that:

- many independent parties play a variety of roles in the maintenance and modifications of transaction standards and operating rules;
- it is often difficult for some stakeholders and end-users to participate in the maintenance/modification process; and,
- the process is not as efficient or timely as it could and should be.

We recommend that a single, overarching umbrella organization manage standards and operating rule maintenance/modifications. This concept is suggested to facilitate greater coordination of the process, to reduce the time spent by industry requestors of changes and maintenance, and to reduce overall administrative costs. The umbrella entity could serve as both the coordinator of changes, as well as a communicator/facilitator for their implementation by the industry.

- Attachment C: AUC Comments Regarding Acknowledgments

The AUC has substantive experience with acknowledgment transactions and supports their usage. In particular, the State of Minnesota has adopted requirements for the exchange of acknowledgements (including the 277CA) as well as single, uniform companion guides for acknowledgment transactions, developed in consultation with the AUC. Our experience indicates that acknowledgements, especially the 277CA, are important, much-desired transactions. We feel that the recently adopted CMS-0032-IFC should include requirements for the exchange of acknowledgments, especially the

277CA, and that, based on our first-hand experience, such requirements are practical and achievable within the timeframe for implementing the eligibility and claim status operating rules. In Attachment C, we summarize these points and also include a copy of the AUC's testimony regarding acknowledgments that was submitted earlier this year to NCVHS.

The AUC as a group has not previously addressed the Health Care Claim Status Request and Response (276/277) transaction, so it is not forwarding comments at this time regarding the CORE operating rules for the transaction.

- Attachment D: Summary Overview of the Minnesota Administrative Uniformity Committee (AUC)

In this attachment, we present a brief summary of the purpose, structure, and activities of the AUC, which has served as a large, voluntary, multi-stakeholder advisory group to help advance health care administration for almost 20 years in the State of Minnesota.

Thank you for this opportunity to provide comments. We are happy to provide any additional information or to respond to questions.

Sincerely,

Paige Hinz
Co-chair, Minnesota AUC

Laurie Darst
Co-chair, Minnesota AUC

Elizabeth Stanley
Co-chair, Minnesota AUC

Attachment A was submitted by the Minnesota AUC with its letter of comments regarding the interim final rule, “Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC).”

Attachment A: AUC Comments Regarding CMS-0032-IFC Operating Rules for the Eligibility Transaction

The Minnesota AUC has divided its comments regarding the eligibility-related provisions of CMS-0032-IFC (IFC) into two sections. The first section provides high-level comments regarding the IFC. The second section provides more detailed, specific comments regarding the Committee for Operating Rules for Information Exchange (CORE) eligibility-related operating rules that have been adopted, and is organized as a series of tables showing: the CORE rule or section of the rule being addressed; concerns or issues identified; and AUC recommendations.

Section I. AUC Comments Regarding the IFC

The AUC commends the Centers for Medicare & Medicaid Services (CMS), the Council for Affordable Quality Health Care (CAQH) Committee for Operating Rules for Information Exchange (CORE), and others for their efforts in advancing health care administrative simplification pursuant to section 1104 of the Affordable Care Act. The adoption of CMS-0032-IFC is testimony to a significant level of work and accomplishment in a short timeframe.

The AUC supports the operating rule concept and offers recommendations below to improve the readability and application of the eligibility operating rules in practice. The AUC as a group has greater experience with “data content” and “situationality” issues than with connectivity and infrastructure issues; as a result, our comments in Attachment A are focused primarily on the data content-related aspects of the operating rule. The AUC also has more experience with the data content of the eligibility transaction than with the health care claim status transaction, and so the focus of our comments in this attachment is on the eligibility transaction. In addition, the AUC is submitting two additional attachments, one with comments regarding acknowledgments transactions, and the other regarding the overall process used for standards and operating rule maintenance and modifications.

At a slightly more detailed level, we offer the three observations and recommendations in this section, which are also incorporated as part of our more detailed response in Section II:

A. Use of the term “health plan” as an example of “ambiguous or conditional requirements in the standard”

Page 40460 of CMS-0032-IFC states that “Operating rules augment the standards in ... three important ways...” including that “They address ambiguous or conditional requirements in the standard ...”. The example that follows to illustrate a case of ambiguity or conditionality being clarified is that of the use of the term “health plan”.

We believe that the ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 (TR3) implementation guide (hereafter v5010 270/271) is clear and unambiguous about the use of the term “health plan” as found in the description of the EB05 (Plan Coverage Description) data element. The usage instructions

for this data element clearly indicate when a “specific product name or special program name for an insurance plan” should be used. Similarly, v5010 270/271 is clear and unambiguous in the instructions for the “NM1 – Information Source Name” segment to “identify the eligibility or benefit information source,” and the NM101 (Entity Identifier Code) data element code value of PR for “payer”. It is unclear then what ambiguity is being addressed in linking operating rules with the use of the term “health plan”.

Recommendation: In order to promote administrative simplification and reduce ambiguity and confusion, operating rules should not be imposed where the standard is already clear. Operating rules should recognize and be consistent with the terminology that is used in the standards, particularly with the terms and definitions that are used in conjunction with “health plan,” and, “information source”.

[See also comment #1 under table A. CAQH CORE Phase I and II Operating Rules: General comments, and comment #1 under table B3. CORE 154.]

B. Explicit inquiries

We are concerned that CMS did not offer any rationale for mandating explicit service inquiries as part of the eligibility transaction in CMS-0032-IFC. The v5010 270/271 does not include standards for explicit inquiries; therefore, the rationale for creating explicit inquiry operating rules is unclear. Configuring systems to enable explicit inquiries is a significant undertaking; it is difficult to justify the resources needed for this additional programming when the rationale is unapparent.

Recommendation: It is important that the industry understand the rationale for the explicit inquiry requirements. In addition, it is not clear what information must be provided by way of a response. If explicit inquiries are going to be required, then more clarification is needed on the essential elements of the response that will be required.

[See also comment #2 under table A. CAQH CORE Phase I and II Operating Rules: General comments, comment #4 under table B3. CORE 154, and comment #1 under table C4. CORE 260.]

C. Reformat and republish the CORE rules to be easier to understand and to implement

We appreciate that CMS references the CORE operating rules in total as they were published by CORE. However, this is often problematic for at least two reasons:

- 1) The distinction between CORE “Phase I” and “Phase II” data content rules (Phase I CORE 154 and Phase II CORE 260) is not meaningful to the industry and instead, causes confusion. It should not be necessary to have to consider and reconcile the provisions of separate Phase I and Phase II documents in order to understand and implement the IFC.
- 2) The operating rules published by CORE include requirements for certification as a CORE-certified health plan. We understand that CMS has not adopted the CORE

certification policies in CMS-0032-IFC. Nonetheless, the appearance of CORE certification policies as part of the operating rules referenced by the IFC is often distracting and/or confusing.

Recommendation: Combine, edit, streamline, and simplify the presentation of the CORE Phase I and II operating rules so that there is just one reference document for the eligibility transaction operating rules, and one reference document for the claim status transaction operating rules. Remove references to CORE certification. The IFC should then be revised and republished to reference a specific website where these two separate documents can be found.

We appreciate that implementing these recommendations will require some time and effort, and that any delays in moving forward to implement the IFC may be of concern. However, we feel that the additional time and effort in making the rules more readable and useable in advance of implementation efforts will more than be offset by easier, quicker, more efficient implementation.

[See also comment #1 under table C5. CORE 270.]

Attachment A was submitted by the Minnesota AUC with its letter of comments regarding the interim final rule, “Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC).”

Section II. CAQH CORE Phase I and II Operating Rules

A. CAQH CORE Phase I and II Operating Rules: General comments

Ref. No.	Item	Concerns	Suggestions
1	Usage of the terminology, “health plan (or information source)”	Throughout the operating rules, it is unclear what is being referred to with the terms “health plan” and “information source.”	Make CORE operating rule terminology consistent with v5010 270/271 terminology. [See also comment A under Section I. AUC Comments Regarding the IFC and comment #4 under table B3. CORE 154.]
2	Explicit inquiries	If explicit inquiries are going to be required, then more clarification is needed on the essential elements that will be required.	[See also comment B under Section I. AUC Comments Regarding the IFC, comment #4 under table B3. CORE 154, and comment #1 under table C4. CORE 260.]

B. Comments regarding specific sections of CAQH CORE Phase I Operating Rules

B1. CORE 152

Ref. No.	Item	Concerns	Suggestions
1	Phase I CORE 152 is entitled “Eligibility and Benefit Real Time Companion Guide.”	The title of this rule only references real time, but we think consideration should also be given to batch.	Modify the title of the operating rule to include real time and batch, or simply retitle CORE 152 as the, “Eligibility and Benefit Companion Guide Rule.”

B2. CORE 153

Ref. No.	Item	Concerns	Suggestions
1		The AUC did not address this CORE rule.	

B3. CORE 154

Ref. No.	Item	Concerns	Suggestions
1	Subsection 1.1: Health Plan Name	For EB05-1204, the ASC X12N/005010X279A1 states: <ul style="list-style-type: none"> <i>This element is to be used only to convey the specific product name or special program name for an insurance plan.</i> 	Make CORE operating rule terminology consistent with v5010 270/271 terminology. [See comment A under Section I. AUC Comments Regarding the IFC, and comment #1 under table A. CAQH CORE Phase I and II Operating Rules: General comments.]
2	Subsection 1.2.1: To specify the co-insurance responsibility Subsection 1.2.2: To specify the co-payment responsibility Subsection 1.2.3: To specify the deductible responsibility	These subsections allow for health plans to exercise discretion to not return patient financial responsibility; however, Minnesota payers and providers expect known patient financial responsibility to be reported whenever possible.	Known patient financial responsibility should be reported whenever possible and that there not be exclusions from requirements to report known patient financial responsibility. [See also comment #4 under table C4. CORE 260]
3	Subsection 1.3: Eligibility Dates	We are concerned that the 12-month time period allotted below is insufficient. <ul style="list-style-type: none"> <i>The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code "62" Date of Service Not Within Allowable</i> 	Information sources must support a benefit coverage date 12 months in the past, or a length of time equal to their timely claim filing window if greater than 12 months.

		<i>Inquiry Period in the AAA03-901 Reject Reason Code data element.</i>	
4	Subsection 1.4: Support for CORE Required Service Types	<p>We have concerns with respect to the requirements for explicit inquiries.</p> <ul style="list-style-type: none"> <i>The health plan (or information source) must support an explicit request for each of the CORE required service types. The CORE required service type codes are: “1”, “33”, “35”, “47”, “48”, “50”, “86”, “88”, “98”, “AL”, “MH”, “UC” submitted in the v5010 270 EQ01 by providing the content identified in subsections 1.1 through 1.3 above for the submitted service type(s).</i> <i>The required response to an inquiry when the individual is located in the health plan’s system under the following conditions:</i> <ol style="list-style-type: none"> <i>A generic v5010 270 inquiry</i> <i>A specific inquiry for a Service Type not supported by the health plan</i> <i>A specific inquiry for one of the CORE required service types</i> <p>The rule requires payers to support explicit inquiries for the mandated Service Types which is a requirement beyond v5010 270/271. Furthermore, there is no mention of this requirement in the IFC. The IFC references other “additional” requirements such as patient responsibility amounts, plan name, and connectivity, but there is no mention of explicit inquiries.</p>	<p>If explicit inquiries are required, then there needs to be more guidance or instructions that specify the requirements on what has to be returned for an explicit inquiry.</p> <p>[See also comment B under Section I. AUC Comments regarding the IFC, comment #2 under table A. CAQH CORE Phase I and II Operating Rules: General comments, and comment #1 in table C4. CORE 260.]</p>

B4. CORE 155

Ref. No.	Item	Concerns	Suggestions
1		The AUC did not address this CORE rule.	

B5. CORE 156

Ref. No.	Item	Concerns	Suggestions
1		The AUC did not address this CORE rule.	

B6. CORE 157

Ref. No.	Item	Concerns	Suggestions
1		The AUC did not address this CORE rule.	

C. Comments regarding specific sections of CAQH CORE Phase II Operating Rules

C1. CORE 250

Ref. No.	Item	Concerns	Comments/Suggestions
1		The AUC did not address this CORE rule.	

C2. CORE 258

Ref. No.	Item	Concerns	Comments/Suggestions
1	3.6 Outside the Scope of this Rule	The operating rules do not specify any search criteria that could be used to identify a patient.	<p>Minnesota requires the application of a particular search logic.</p> <p>The AUC has defined a search scenario algorithm to be used, which is considered extremely valuable by the provider community and which eliminates many otherwise unnecessary phone calls.</p> <p>Minnesota requires payers to support six unique search scenarios that may occur based on what data is submitted by the provider (“Information Receiver”). The search</p>

			<p>scenarios are based on different combinations of the following Subscriber/Dependent data: last name, first name, DOB and Member ID. The search scenarios are designed so that an Information Source continues to look for the Subscriber/Dependent even if some of the data elements submitted do not match the Information Source's system. The scenarios do not require providers to continually resend the 270 transaction to fit the different scenarios. This allows providers to gain benefit information when cards are not available, unclear or outdated. This will be a significant loss if payers are no longer required to support the requirement. If needed information cannot be obtained via an electronic transaction, a phone call to the insurance company is required, leading to more manual efforts and administrative costs for both providers and payers. Without this algorithm, providers lose the important, cascading aspect of only having to send <u>one</u> request and have the payer cascade through the data to try and find a matching record.</p> <p>This is the same search algorithm process that many health information exchanges are using as they develop ways to exchange electronic health records.</p> <p>ASC X12 has formally asked Minnesota's permission to examine and consider the application of this algorithm and we were more than happy to share it—as this information is public, anyone may use it.</p>
2	<p>3.7 Approved Basic Character Set</p> <p>3.8 Use of Extended Character Set</p>	<p>Sections 3.7 and 3.8 are addressed in v5010 270/271 under "B.1.1.2.2 Basic Character Set" and "B.1.1.2.3 Extended Character Set" respectively.</p>	<p>Reduce redundancy by deleting the information in sections 3.7 and 3.8 of CORE 258 as it is already in v5010 270/271.</p>

C3. CORE 259

Ref. No.	Item	Concerns	Comments/Suggestions
1	3.3 What the Rule	The operating rules do not specify any search criteria	[See also comment #1 under table C2. Core 258.]

	Does Not Require	and match criteria or logic that could be used to identify a patient.	
2	4.5 Error Reporting Codes & Requirements Table	<p>It appears as though the table is missing information and some information is inaccurate.</p> <ul style="list-style-type: none"> • Many scenarios are not listed • Missing “Dependent” on many <ul style="list-style-type: none"> ○ AAA64 missing Dependent ○ AAA68 missing Dependent • #8 on page 11 should be 73 • Under column headings “Data Element Returned in 271 response”-- What does “Note 1” refer to? • 75 does not have any “X’s” __needs example <p>Furthermore, Section 4.5 states that these are the only scenarios and codes available for use.</p> <ul style="list-style-type: none"> • <i>The Error Reporting Codes and Requirements Table below describes each error condition and the corresponding AAA03 error code that must be used to identify the error in the v5010 271.</i> 	We suggest that the table be enhanced to be inclusive of all relevant scenarios and codes, or to clearly state that other scenarios and codes can be used.

C4. CORE 260

Ref. No.	Item	Concerns	Comments/Suggestions
1	4.1.1.1, Requirements for a Response to an Explicit Inquiry for a CORE Required Service Type	<p>We are concerned about the requirements for “explicit inquiries” as shown in 4.1.1.1, which states:</p> <p>“A CORE-certified health plan (or information source) must support an explicit v5010 270 for each of the CORE service types specified in Table 4.1.1.1 by returning a v5010 271 as specified in §4.1.2 through §4.1.5.”</p> <p>In particular, we are concerned that:</p> <ul style="list-style-type: none"> • If a potentially large number of service types are submitted in one explicit inquiry, the large number 	<p>We suggest that a limit be imposed on how many service type codes can be submitted for an explicit inquiry. As noted above, the rationale for the explicit inquiry requirement is not clear. Configuring systems to enable explicit inquiries is a significant undertaking, and it is difficult to justify the resource expenditure needed for this additional programming when the rationale is not apparent.</p> <p>If explicit inquiries are required, then there needs to be more guidance or instructions to specify what has to be</p>

		<p>of inquiries will make it more difficult to send a timely response;</p> <ul style="list-style-type: none"> • The submission of a large set of service types will require a corresponding large response, which will have implications for web portals and the ability to display the information; • Programming to comply with this rule will be a significant undertaking, requiring a disproportionate amount of work for the times that the explicit inquiries would be used and the value they would provide in practice; and • Requirements for the explicit inquiries are not part of the ASC X12N/005010X279A1, and it is not clear from the CORE operating rule what specific information must be returned in response to an explicit inquiry. 	<p>returned for an explicit inquiry.</p> <p>For example, does plan level patient financial responsibility (deductible) need to be returned in addition to service level deductible?</p> <p>Using 270 Inquiry with EQ*78 (chemotherapy) as an example, all of the following <u>could</u> be returned, but what <u>must</u> be returned?</p> <ul style="list-style-type: none"> • Plan level deductible <ul style="list-style-type: none"> ○ Base ○ Remaining • Service type co-insurance and co-pay • Plan level coverage dates • Service type benefit date if different from the plan level <p>We suggest that a limit be imposed on how many service type codes can be submitted for an explicit inquiry. As noted above, the rationale for the explicit inquiry requirement is not clear. Configuring systems to enable explicit inquiries is a significant undertaking, and it is difficult to justify the resource expenditure needed for this additional programming when the rationale is not apparent.</p> <p>[See also comment B under Section I. AUC Comments Regarding the IFC, comment #2 under table A. CAQH CORE Phase I and II Operating Rules: General comments, and comment #4 under table B3. CORE 154.]</p>
2	Table 4.1.1.1	The introduction to Table 4.1.1.1 states that the table specifies “48 service type codes...”. However, 51 codes are actually listed in the table.	Determine how many codes are to be listed in Table 4.1.1.1 and provide the correct number in the introduction to the table.
3	4.1.3 Patient Financial Responsibility	We have concerns about the usage and number of service type codes including service type code 30. Additionally, the total number of service type codes is unclear:	We suggest that the rule be reorganized to specifically state what is required when responding to service type code 30 health plan coverage and specifically, what is required when responding to an explicit service type

		<ul style="list-style-type: none"> • The “Background Summary” (section 1) references 51 codes • 4.1.1.1, “Requirements for a Response to an Explicit Inquiry for a CORE Required Service Type” states that 48 codes are provided in Table 4.1.1.1, but the table lists 51 codes. • The table in 6.1, “Appendix 1: Phase II CORE Service Type Codes”, includes code 30, for a total of 52 codes 	<p>request.</p> <p>We also suggest that the number of service type codes be clarified and the operating rule be modified accordingly.</p>
4	4.1.3 Patient Financial Responsibility	The subsections within 4.1.3 allow for health plans to exercise discretion to not return patient financial responsibility; however, there should not be an opt-out option because providers need this important information. Additionally, even with an opt-out option, it is likely that providers will invest time and resources to obtain this information. Therefore, providing an opt-out option will likely result in providers using inefficient processes to obtain needed information which ultimately undermines the intent of administrative simplification.	Known patient financial responsibility should be reported whenever possible. Exclusions from requirements to report known patient financial responsibility should not be allowed.
5	4.1.3.1 Specifying Deductible Amounts	It is unclear what is required for reporting the deductible for plan coverage level versus service type level.	<p>It would be helpful, and consistent with our previous comments above, to revise section 4.1.3.1 by modifying the existing sentence, and by adding the sentence that is now below Table 4.1.3.1.1, to section 4.1.3.1.1. With these suggested revisions, section 4.1.3.1 would now read:</p> <p><i>An information source must return the dollar amount of the base and remaining deductible. When a service type does not have a base deductible separate and distinct from the Health Plan base deductible, the Health Plan base deductible must not be returned on any EB segment where EB03≠30 – Health Benefit Plan Coverage.</i></p> <p><i>The deductible amount must be returned in U.S. dollars only.</i></p>

6	4.1.3.1.1 Specifying the Health Plan Base Deductible and throughout operating rule	We are concerned that “EB12 = N or Y as applicable” is not comprehensive.	We suggest that all references to EB12 also include code W.
7	4.2 Basic Requirements for Submitters (Providers, Provider Vendors and Information Receivers)	We are concerned that the title of section 4.2 is incorrect as the content is applicable to information receivers.	Change the title to “Basic Requirements for Information Receivers”
8	6.1 Appendix 1: Phase II CORE Service Type Codes	Service Type Codes lack comprehensiveness.	Section 1.4.7.2 of v5010 270/271 categorizes the Service Type Code components and CORE should consider adopting similar categories.

C5. CORE 270

Ref. No.	Item	Concerns	Comments/Suggestions
1	Entire rule	References in this CORE rule, such as the statement “ <i>CORE-certified entities are required to comply with all CORE Rules and thus a CORE-certified entity must support a CORE-compliant connectivity method</i> ” (from Section 4.1 of CORE 270) are confusing given other statements in the rule. For example, the rule also indicates that trading partners do not need to discontinue existing connections, and neither must they require use of a CORE-compliant communication method for new connections (see also section 4.1). In addition, as noted previously, CMS also did not adopt the CORE certification policies.	<p>We suggest that all references to "certified" or "certification" be removed from the operating rule because certification policies and requirements have not been adopted.</p> <p>We also suggest clarification on whether or not the connectivity “safe harbor” is required or not given certification policies and requirements have not been adopted.</p> <p>[See also comment C under Section I. AUC Comments Regarding the IFC.]</p>

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Attachment B: AUC Comments Regarding Maintenance and Modifications to Standards and Operating Rules

In correspondence to the Centers for Medicare & Medicaid Services (CMS) and testimony earlier this year to the National Committee on Vital and Health Statistics (NCVHS), the Minnesota AUC communicated several concerns and recommendations regarding maintenance and modifications to standards and operating rules. With the recent adoption of the first of several anticipated sets of operating rules, we feel that these concerns and recommendations are especially timely, and we are forwarding them as this Attachment B.

In particular, we are concerned that:

- many independent parties play a variety of roles in the maintenance and modifications of standards and operating rules;
- it is often difficult for some stakeholders and end-users to participate in the maintenance/modification process; and,
- the process is not as efficient or timely as it could and should be.

We recommend that a single, overarching umbrella organization manage standards and operating rule maintenance/modifications. This concept is suggested to facilitate greater coordination of the process, to reduce the time spent by industry requestors of changes and maintenance, and to reduce overall administrative costs. The umbrella entity could serve as both the coordinator of changes, as well as a communicator/facilitator for their implementation by the industry.

This Attachment B includes two parts: a transcript of testimony provided by Laurie Darst, AUC Co-chair, and an accompanying slide presentation that Ms. Darst referenced during her testimony.

**AUC Testimony Presented at the NCVHS Subcommittee on Standards Hearing on
“Administrative Simplification under the Patient Protection and Affordable Care Act: The
Acknowledgment Transaction Standard and Maintenance and Modifications to Standards and
Operating Rules (the present and the future)”, April 27, 2011**

Thank you to the co-chairs, members, and staff of the Subcommittee for the opportunity to present today. I am Laurie Darst, Revenue Cycle Regulatory Advisor at Mayo Clinic. I am also one of the co-chairs for the MN Administrative Uniformity Committee (AUC) and will be presenting today on behalf of the MN AUC.

You have received a brief written testimony sent on behalf of the MN AUC which will supplement our oral testimony. Our testimony reiterates several of the concerns and recommendations made by the MN AUC previously submitted to CMS in letters dated February 2010 and again in March 2011.

You’ve heard about the make up of the MN AUC in previous testimony today, but I want to reiterate a couple of important points that we feel attributes to our success in Minnesota. We feel some of these attributes may be valuable to consider replicating at a national level as they promote participation, adoption, and balance. First, we have an equal representation balance of payers and providers. Voting is done requiring a quorum of payers and providers, guaranteeing a balanced vote. Second, our meetings are open to the public and meeting information and documents (such as our companion guides) are available to anyone free of charge on the MN AUC website. Third, administrative support is funded by appropriations, thereby making participation free to anyone who wants to participate.

Slide 2

We’d now like to turn our focus to the current state of the maintenance and modifications update process. Our comments are intended to address the medical transaction process only. (not pharmacy or dental – although I will mention them briefly on a slide). What the MN AUC would like to go over are three points: 1) the current process is not as efficient as it should be 2) we’d like to present an alternative approach to the current system 3) and finally talk about the benefits of change.

Slide 3

Let’s start by looking at the current process: Based on ever-changing billing requirements and new emerging payment models, the industry may need to request new administrative data for billing purposes. This may be in the form of actual data or maybe a new billing “indicator”. To best illustrate the process, we’d like to use a hypothetical example. In our example here, let’s say we need to be able to bill for “package billing or bundled services” for both chronic and acute conditions. Other examples of new administrative data might include billing data for medical homes or data needed to support the implementation of the HPID.

- We first go to X12 to get an indicator/data element for a number of different electronic transactions. We might first seek a data field in the eligibility transaction that would specify what type of “package billing coverage” that a patient has coverage for. (For example, the patient may have a package billing coverage for a chronic condition, such as diabetes which

is for a year duration, or it may be for a shorter time-period such as a knee replacement package.) An indicator would also likely be needed in the professional & institutional claim which would alert the payer the services or particular service lines submitted should be “bundled” into a package when payment is made. The same type of indicator would likely need to be requested in the remit and potentially other transactions.

- A next step might be to go to the Remit Code Committees to request a number of Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Although this meeting is held at the same time as the X12 meeting, these are separate committees on different timelines.
- We should also take into consideration the paper billing process since some of the smaller providers will continue to bill via paper. If an indicator or field is needed on the professional and/or institutional paper claim, we would need to address this with the NUCC and NUBC respectively.
- If a taxonomy code is needed, we would need to seek this from NUCC.
- Value codes, Condition Codes, Occurrence Codes would need to be requested from the NUBC.
- Perhaps a solution might involve seeking new procedure codes from the AMA, the ADA or ICD 10 codes from CMS. We recognize these are medical code requests and outside of the scope of the DSMO process, but yet another potential request the industry would need to pursue none- the - less.
- If the package billing requires an attachment, we might need to seek a specific attachment data field with Health Level Seven (HL7).
- We’ve included the Dental Content Committee and NCPDP on this example only because there may be an *occasion* where we’d need to consult with them (i.e. oral surgery package or children with asthma package).
- Finally, we now have new “operating rules” added to the process and need to consult with the entity or entities who will oversee the operating rule process for each of these transactions.

The MN AUC feels the time and energy that stakeholders need to invest to get everything done is costly and time consuming. It also assumes that each of these separate entities would agree to the same solution and make efforts to provide a coordinated response – a coordinated, *timely* response. If entities don’t move forward in unison or an entity or two don’t agree with the request, this causes solutions to be out-of-synch and can derail the overall request.

(DSMO Highlights)

- We recognize there is currently a DSMO process in place which includes six of the organizations highlighted in yellow. But the MN AUC feels there is significant opportunity

to facilitate better solution coordination **between** entities. Our intent is not to criticize any of these individual organizations – they all do a good job independently. It’s the overall need for coordination we feel needs to be addressed. Now, with the addition of mandated operating rules, this just adds another “cog/spoke” to the wheel. *

Slide 4 (Wheel) --- Speaking of wheels - we feel the wheel needs to be fixed.

- We can view this analogy another way - - as a vehicle going to a destination, with each organization representing a different sized wheel on the vehicle - each moving at it’s own speed - arriving at the destination at different times – some may even have a breakdown along the way. The MN AUC feels it’s time for an upgrade, for a new vehicle.”

Slide 5 (Timeline)

This slide reflects stakeholder time commitment and costs. In order for stakeholders to have a voice in the administrative simplification process or addressing challenges and new requirements, it requires time and money. This timeline provides a glimpse of some of the meeting schedules and the time required to participate. There are cost associated with travel, meeting fees, membership dues, and document fees for most of these organizations. The ability to vote on particular issues varies by organization. Some are open voting based on dues paid, others only allow designated members to vote.

- It is difficult for industry stakeholders to stay abreast of all the different activities with all the different organizations – and all the different timelines.

Slide 6

- Another concern expressed by the MN AUC is with the timing in which each organization releases updates. The most stringent timelines are those named in legislation, which take additional legislation to adopt to a new version. There is too much time lapsed between updates for these organizations due to this requirement. Other entities have their own schedules. We feel this disjointed update schedule stands in the way of moving forward with administrative simplification. In our “package billing example”, we may not even be able to implement our billing solution if different entities can not make the necessary changes along with their other counterparts.

Slide 7

We need a new approach ~ ~

Slide 8

So we come to the MN AUC recommendation: an umbrella organization to manage the process. This concept would facilitate the coordination process, reduce the time spent by industry requestors, and reduce overall costs. This entity could be both coordinator of the changes and communicator to the industry.

Business Needs Identified (looking to the left side of umbrella)

We envision this umbrella organization would receive the new business requests and would provide a coordination point between the standards organizations; the non-medical code set committees and the operating rule entities. The MN AUC feels it’s important that the umbrella organization oversight committee would include balanced stakeholder representation, to ensure

all points of view were taken into account when forwarding the request to the different entities. The umbrella organization should be tasked to establish clear expectations and timelines for the different organizations under the umbrella. They would also be a tasked to providing timely responses back to the requester on the status of the request. This is illustrated by the two way directional arrow below the umbrella.

Innovation (looking to the right side of umbrella)

The umbrella organization should also facilitate new innovations and new billing needs, such as future payment models, P4P, ACOs, medical home, and outcome based payment models. These new innovations also need to be coordinated between organizations to move forward efficiently and timely.

Slide 9

This next slide just summarizes some of the characteristics of the “Umbrella” that we discuss on the previous slide. We need a single, one-stop shop to go to for administrative simplification updates. This umbrella entity needs to include a feedback loop on response and updates. The umbrella entity would allow for common prioritization and a coordinated solution. The MN AUC feels it is essential to have balanced representation and voting on this type of umbrella committee. This would also provide a more nimble process for innovation and facilitates meeting future opportunities and challenges

Slide 10

This slide illustrates the benefits of a coordinated & balanced process. The MN AUC feels the umbrella organization model would streamline the process for the industry, thereby making this a less costly process. There would be greater transparency and accountability so industry representatives would be aware of the status of the requests and plan accordingly.

With balanced representation at the umbrella level, we feel it would be a more equitable and representative process.

Finally, we feel this concept provides the tools to achieve the levels of Administrative Simplification really desired by the industry.

Slide 11

In summary – the MN AUC feels now is the time to implement change to the process. We need this change to meet current and future challenges and opportunities. We recognize there are considerable details that need to be worked out with this concept, but change is possible, manageable, and desirable. Administrative Simplification is the ultimate goal – not only with implementing administrative billing changes, but we also need changes to the update process. The MN AUC feels the update process itself also needs an “administrative simplification” review.

Again, I would like to thank the Committee for the opportunity to testify on behalf of the MN Administrative Uniformity Committee.



MN Administrative Uniformity Committee (AUC) Testimony to NCVHS on DSMO Process

April 27, 2011



Overview

- Current process is not efficient
- Present an alternative approach
- Benefits of change



Operating Rule Entity (ies)

Operating rules: privacy; security; connectivity; data content

Work groups

Eligibility

Claims

Remittances

PA/Referral

Claims Status

NCPDP

Pharmacy, drugs

X12

Data element-content/code choice

New Data Element Needed
{e.g. Billing for Package ("bundled") Services}

Code

CARC

DeCC

Field in form

Code

RARC

Claims attachments

Field in form

NUCC

HL7

ICD-9
(ICD-10)

CMS

CDT

ADA

CPT

AMA

Value Code,
Condition Code,
Occurrence code

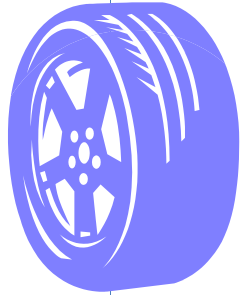
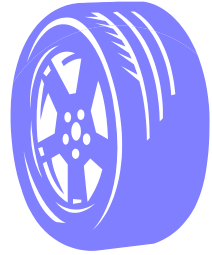
NUBC

Taxonomy

NUCC

Field in form

NUBC



Operating Rule Entity (ies)

Operating rules: privacy; security; connectivity; data content

Work groups

- Eligibility
- Claims
- Remittances
- PA/Referral
- Claims Status

NCPDP

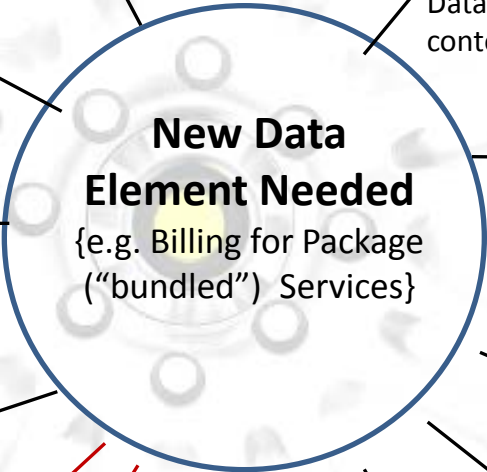
Pharmacy, drugs

X12

Data element-content/code choice

DeCC

Field in form



Code → **CARC**

Code → **RARC**

Field in form → **NUCC**

HL7

Claims attachments

ICD-9 (ICD-10) → **CMS**

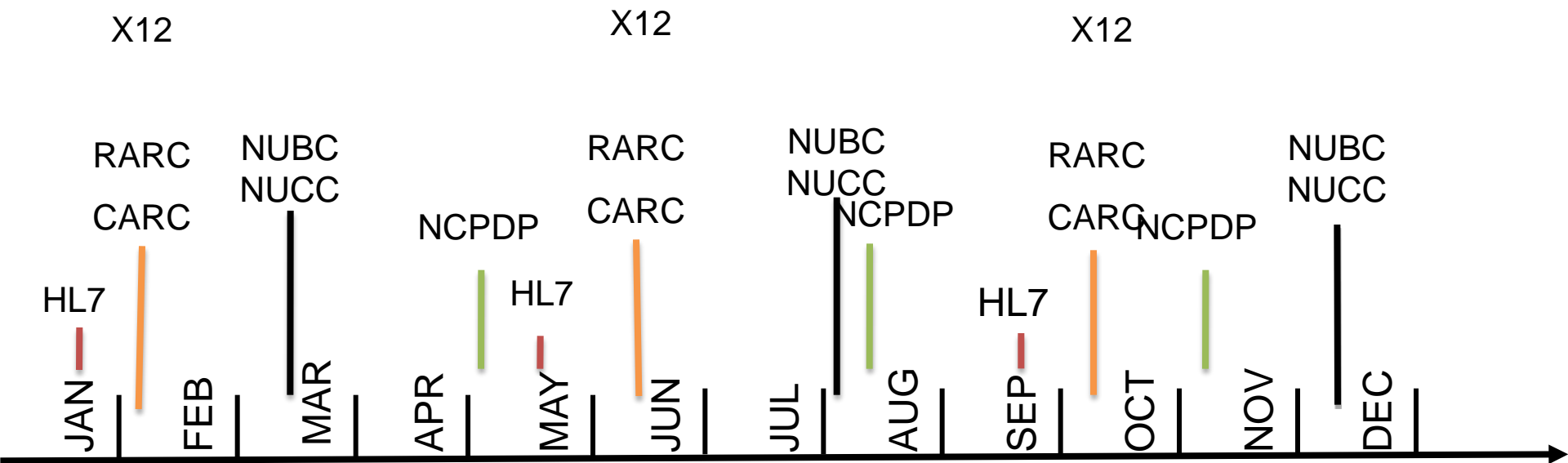
CDT → **ADA**

CPT → **AMA**

Value Code, Condition Code, Occurrence Code → **NUBC**

Taxonomy → **NUCC**

Field in form → **NUBC**



- In-Person meetings occur most months
- Travel time and costs for in person meetings may limit who can participate
- Membership dues costs
- Cost of Documents
- Voice in the process – ability to vote
- Difficult to stay abreast of all the different activities with all the different organizations



Transactions, Codes & Other Update Timelines

X12 – Based on HIPAA regulatory compliance dates

HL7 – (Attachment Transaction) -Based on HIPAA regulatory compliance dates

CARC - Can be three times a year

RARC - Can be three times a year

NUCC – Varies based on update type:

Instruction Manual * Form * Taxonomy codes

NUBC – Varies based on update:

Instruction Manual * Form * Non-Medical codes

Operating Rule Entity (ies) – Schedule TBD



We Need a New Approach One that Promotes:

Coordination & Timeliness Across all Organizations

Communication

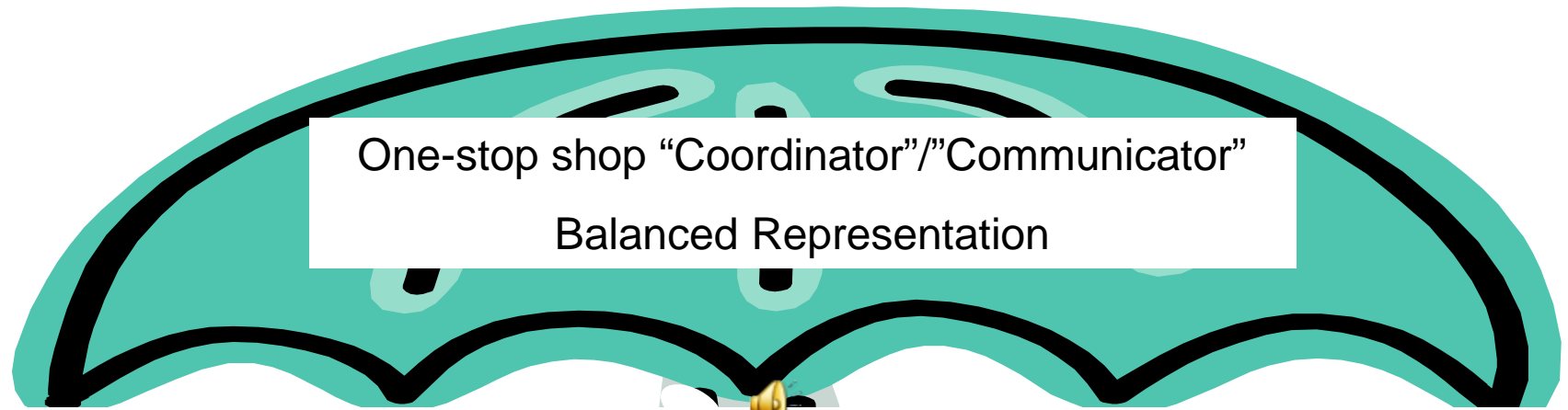
Balanced Representation

Affordable Costs



Business needs – e.g., data content, response times, etc.

Innovations – e.g., future payment models (P4P, ACOs medical home) and real time claims



One-stop shop “Coordinator”/”Communicator”
Balanced Representation

STANDARD SETTING ORGANIZATIONS

e.g. X12, HL7, NUCC, NUBC, etc.

NON MEDICAL CODE SETS

CARC, RARC, add new service type, etc

OPERATING RULES



Characteristics of the “Umbrella”

- Single one-stop shop for administrative simplification
 - Accountable: Includes feedback loop and response/updates
- Common prioritization of work
- A coordinated solution
- Balanced representation
- More nimble process for innovation, meeting future opportunities and challenges



Benefits of “Umbrella”

- Easier and less complicated process
- Fewer costs
- Greater transparency and accountability
- Equitable and more representative process
- Encourages greater participation and action at all levels
- Provides the levels of Administrative Simplification really desired by the industry



Summary

- Need process improvement now
- Need improvement to meet future challenges
- Many details to be further discussed, but change is possible, manageable, and desirable

- Ultimate goal is Administrative Simplification

Attachment C was submitted by the Minnesota AUC with its letter of comments regarding the interim final rule, "Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC)."

Attachment C: AUC Comments Regarding Acknowledgments

The Minnesota AUC's experience affirms that acknowledgements, and in particular, the ASC X12N/005010X214E2 Health Care Claim Acknowledgment (277) (hereafter, 277CA), are important, much-desired transactions. For example, the State of Minnesota has adopted requirements for the exchange of acknowledgements, including the 277CA. Further standardization of the 277CA data content requirements were addressed with the state's adoption of single uniform companion guides for the transaction, developed in consultation with the AUC.

We feel that the recently adopted CMS-0032-IFC should include requirements for the exchange of acknowledgments, especially the 277CA, and that, based on our first-hand experience, such requirements are practical and achievable within the timeframe for implementing the Eligibility and Claim Status Operating Rule.

The points above were presented by Shelagh Kalland, AUC Acknowledgment Technical Advisory Group Co-chair, earlier this year to the National Committee on Vital and Health Statistics (NCVHS) and are being resubmitted at this time.

**AUC Statement to the NCVHS Subcommittee on Standards Hearing on
“Administrative Simplification under the Patient Protection and Affordable Care Act: The
Acknowledgment Transaction Standard and Maintenance and Modifications to Standards and
Operating Rules (the present and the future)”, April 27, 2011**

Presented By: Shelagh Kalland
Minnesota Administrative Uniformity Committee
Acknowledgment Technical Advisory Group Co-Chair

Co-chairs and members of the Subcommittee, I am Shelagh Kalland, speaking on behalf of the Minnesota Administrative Uniformity Committee (AUC) and as co-chair of its Acknowledgment Technical Advisory Group (TAG). I would like to thank you for the opportunity to present testimony today concerning the provider, payer and general industry perspectives of acknowledgements.

The Minnesota Administrative Uniformity Committee (AUC)

The AUC is a voluntary, stakeholder advisory organization with balanced representation between payers and providers. It has served for nearly twenty years to achieve consensus between payers and providers in Minnesota on standardizing health care administrative processes to reduce administrative costs and burdens. The AUC is comprised of health care providers, payers (medical, workers comp, property casualty and auto), state agencies, and health care associations. Our membership includes the Minnesota Department of Labor and Industry as a representative of non-HIPAA covered entities. The AUC receives staffing and logistical support from the Minnesota Department of Health (MDH) and has no dues or membership fees. All AUC meetings and activities are well publicized in advance and are open to anyone wishing to attend. Remote access through dial-in and webinar capabilities is provided. The AUC actively pursues input from other organizations including clearinghouses and vendors in developing our solutions.

The AUC has developed and implemented statewide companion guides for several of the HIPAA transactions including eligibility (270/271), claims (837P, 837I, 837D, and NCPDP D.0), and remittances (835). In addition, the AUC developed single, uniform companion guides for three types of health care acknowledgments (TA1, 999, and 277CA) pursuant to recent amendments of Minnesota Statutes, section 62J.536.

An overarching principle of the work of the AUC is the fact that all parties affected by the statute may be required to make changes to procedures, policies and/or systems in some way, as a result of the work of the AUC, resulting in lowering or slowing the rise in administrative costs for the system as a whole.

Minnesota Acknowledgments

Minnesota 2010 Session Laws, Chapter 243, S.F. No. 2852, required the AUC to develop Minnesota Uniform Companion Guides for acknowledgment transactions. This law requires all health care providers, health care clearinghouses, and group purchasers to provide an

appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction. The acknowledgment provided must be based on one or more of the following American National Standards Institute, Accredited Standards Committee X12 standard transactions (TA1, 997, 999, 277CA). The effective date of the mandate is 1/1/2012 to coincide with the implementation date for version 5010 of the HIPAA transactions.

The AUC has completed, vetted and published the companion guides for the TA1, 999 and 277CA. As with our other mandated transactions, the AUC reviewed the Medicare guidelines and modified them only where the community believed necessary to achieve maximum administrative benefits. The AUC further proposed that the MDH not adopt the Functional Acknowledgment (005010X230 Functional Acknowledgment For Health Care Insurance) 997 based on formal Interpretations that were conducted by ASC X12. The interpretation states that for a healthcare TR3 implementation, the 999 transaction must be used.

Further, the AUC Acknowledgment TAG is completing a best practice which includes process flow diagrams suggesting how the set of acknowledgment transactions are used together to provide clear responses to the sender of transactions. A sample of the process flow diagram is attached to this presentation in its written form. I will address some of the key components later in this testimony.

Variations in CMS Interpretation and AUC Recommendations

The AUC Acknowledgment TAG has identified three differences in the way we have proposed implementing the acknowledgment transactions in comparison to the CMS interpretation.

The first difference is that the AUC recommends that a TA1 be sent only in the event of failure of the Interchange. Although the transaction envelope allows for the sender to indicate that they wish to receive a TA1, we recognize that receipt of multiple acknowledgments becomes an administrative burden. As a result, it is our recommendation that the TA1 not be requested specifically by the sender but that it is sent only in the event of an interchange error.

The second difference in our recommendation relates to the use of the Implementation Acknowledgment (999). CMS has indicated in their presentations that providers will receive a 999 Accepted with Errors. The AUC recommends that the 999 be used to indicate that the transaction set has been accepted or rejected in its entirety for further processing. The AUC further recommends that the 277CA be sent to provide transaction level information related to acceptance or rejection. Sending the 999 indicating that the transaction set is being accepted with errors implies that the provider must do something about the 'errors' but does not provide enough business information for action. The 277CA will provide specific information related to the rejection such that the provider can take action to correct and resubmit the claim.

The final difference is related to the work that the AUC completed to define and map claim status and claim category codes to standardize the results that will be received by the providers across payers. It appears that not all Claim Status and Claim Category Codes were intended for use in the Claim Acknowledgment 277CA, and those not intended for use were removed from

the Minnesota Uniform Companion Guide list of allowed category codes. Further, through the use of a mapping table, we have developed a solution that provides consistency of use within the national standard that enables providers to take appropriate action to correct errors and resubmit transactions for adjudication. Inconsistency in the use of Claim Status and Claim Category Codes requires providers to alter posting programs for each payer's 277CA file. Non-standard use of the Claim Status and Claim Category Codes invokes phone calls to the payers driving up resource costs and wasting provider and payer staff time.

AUC Recommendation

The AUC recommends that the industry pilot these transactions before CMS requires them under a HIPAA mandate. Over the years, WEDI and other testifiers have stated that mandating transactions that are not tested and proven does not result in adoption or in reduced administrative costs or burden.

- a) We offer that two of the pilots could be the Medicare implementation and the Minnesota implementation (along with any other established community pilot deemed ready by January 1, 2012).
- b) The pilots will provide feedback to NCVHS and to the operating rule standards committee chosen to develop national operating rules for acknowledgements. The pilots should have members benchmark their current processes and costs so that savings and reduced burden can be measured. In addition the pilot participants should report on specifics of each acknowledgement transaction including data content and technology issues such as connectivity, or response times or transaction flow.

Conclusion

The AUC strongly supports standard acknowledgements as an important part of administrative simplification, and we will be happy to report on our experience.

I'd like to thank you again for the opportunity to testify today.

Attachment D was submitted by the Minnesota AUC with its letter of comments regarding the interim final rule, "Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions (CMS-0032-IFC)."

Attachment D: Summary Overview of the Minnesota Administrative Uniformity Committee (AUC)

Purpose and membership

The Minnesota AUC is a large, voluntary, multi-stakeholder advisory organization that has served for nearly 20 years to achieve consensus between payers and providers in standardizing health care administrative processes to reduce administrative costs and burdens. The AUC is comprised of health care providers, payers, state agencies, and health care associations. A list of AUC members can be accessed at: <http://www.health.state.mn.us/auc/memborg.htm>.

Advisor to the Minnesota Department of Health (MDH) on Minnesota Uniform Companion Guides

As required under Minnesota statutes, section 62J.536, the AUC is the primary advisor to MDH in the development of first-in-the-nation rules requiring the adoption and use of single, uniform companion guides to the ASC X12 and NCPDP implementation guides for the following transactions: acknowledgments, health care claim payment/advice, health care claims, and health care eligibility benefit inquiry and response.

The Minnesota Uniform Companion Guides became effective with the force of law in 2009. They are required for use by over 60,000 health care providers in Minnesota, as well as an estimated more than 2,000 health plans, insurance carriers, and other payers nationwide that are licensed or doing business in the state.

AUC Process

The AUC receives staffing and logistical support from MDH and has no dues or membership fees. All AUC meetings and activities are well-publicized in advance and are open to anyone wishing to attend. Remote access is provided through dial-in and webinar capabilities.

The Minnesota Uniform Companion Guides were developed in open, public meetings, including meetings of AUC Technical Advisory Groups specific to each transaction. The AUC Operations Committee (committee of the whole) then voted on each guide as a recommendation to MDH. MDH announced the availability of the AUC-recommended draft guides as part of an open public comment period. The AUC reviewed technical public comments and further advised and consulted with MDH regarding the comments. Following this process, MDH published a notice of formal adoption of the guides as rules. The AUC continues to advise MDH regarding technical updates and maintenance of the guides on a scheduled and as-needed basis.