



March 27, 2019

2:00 pm – 4:00 pm

Teleconference/WebEx ONLY – see instructions on meeting email

AUC Eligibility TAG

AGENDA

1. **Meeting to Order**
2. **Welcome & Introductions** – Please e-mail your attendance to Theresa.noponen@centracare.com
 - Introduce the new Co-Chairs of the Eligibility TAG – Tim Lopez and Susan Brousseau from BCBS. Thank you, thank you both for volunteering!
3. **Anti-trust Statement** – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>
4. **Approve Previous Meeting Minutes**
5. **Decision regarding Best Practice for Eligibility Frequency** – Review, update and vote. Please review draft prior to meeting and please bring your comments, suggestions to the meeting for discussion.
 - **Meeting Goal:** If Best Practice draft is still useful for the industry, make modifications and finalize.
 - **Discussion:** First we have discussed in a past meeting, as providers we are told by the payors that it is our responsibility (the provider/organization) to determine or know the patient's coverage. Patients will present with old cards, they don't know their insurance, don't have a current card with them or a patient will state that they want X insurance billed as primary and Y as secondary, but when we review, it should be flipped. Medicare requires an MSPQ to be completed and this is where we get a lot of push back from patients regarding Veterans coverage. As a provider we are already at a disadvantage, we are told that we cannot phish or search for active coverage, where do we start? Yes it would be difficult without a member id or group #, but we do have patient name, date of birth, social security number is iffy, not typically used, are there data elements that we could use to effectively send out a 270 to payors? What payors do we query, terminated coverages the patient had on their account in the past, any payor that we have a connection with??
 - **Second:** To back up the Eligibility Frequency is checking our self-pay patients coverage with at least MN-ITS or Medicare based on age. I feel this one is similar to the beginning of the month point in the current draft BP. Patient comes in today, doesn't have coverage but states they are working on it. We send out statements to them, no word, no payment, we are now at the point of sending to collections. Our policy is to send through MN-ITS on self-pay accounts before sending to collections, Medical Assistance returned is ok with a year for claims, but if we get a response that the patient is on a PMAP plan, we might be writing off for timely filing due to shorter filing limits. We would like to send files more often, but this is where the searching more than just at times of service comes in.

6. Brainstorm ways to get more Providers involved in the 270/271 Eligibility TAG

7. Provider Concerns/Survey feedback Goal: Discuss and identify next steps.

- Static benefit and Accumulation requirement or Best Practice for out of pocket and limitations (Visits, Dollar Max, # of visits, Days, Hours, etc...)?
- Prior Auth requirement or Best Practice for EB11 specific to Service Type Level until Procedure/Diagnosis response is mandated?
- Self-insured vs Fully insured MSG requirement or Best Practice?

8. Training and Education Goal: Identify group needs and preferences for education and outreach to increase adoption of transactions and meaningful use.

- Service Type/Prior Auth
- Error Messages
- Other?
- Presentation during meeting or white paper or other?

9. Non-HIPAA payors - Volunteers to work with Co-Chairs to do outreach for implementing 270/271

10. Topics for upcoming meetings

- Are existing mandates and Best Practices still current?

11. Other Business

12. Meeting Summary & Next Steps

13. Next Meeting – Teleconference/WebEx ONLY

April 24th, 2019 (2-4pm)

2019 Calendar, please mark your calendars accordingly.

Wednesday, April 24, 2019 (2-4pm)

Wednesday, May 22, 2019 (2-4pm)

Wednesday, June 26, 2019 (2-4pm)

Wednesday, July 24, 2019 (2-4pm)

Wednesday, August 28, 2019 (2-4pm)

Wednesday, September 25, 2019 (2-4pm)

Wednesday, October 23, 2019 (2-4pm)

Wednesday, November 27, 2019 (2-4pm)

Wednesday, December 18, 2019 (2-4pm)



January 23, 2019

2:00 pm – 4:00 pm

Teleconference/WebEx ONLY - ([Participant Instructions](#))

AUC Eligibility TAG

Meeting Minutes

1. Meeting to Order

2. Welcome & Introductions – Please e-mail your attendance to Theresa.noponen@centracare.com

| | |
|----------------|----------------|
| Andrew Dito | Barb Vonasek |
| Bob Johnson | Dave Haugen |
| Clark Fenske | Doug Curtis |
| Jacki Rathke | Quinn Thomas |
| Rigzin Dolma | Tim Lopez |
| Joy Nollenberg | Kathy Wrazidlo |
| Loni Wegman | |

3. Anti-trust Statement – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>

4. Approve Previous Meeting Minutes

5. Service Type Codes Presentation by MDH consultant, Doreen Espinoza

Presentation PowerPoint was sent out, any comments? Nothing new to discuss.

Announcement re: Doreen Espinoza, she was voted in as the next X12 President, please send your congratulations to her.

6. Continued exception from 270-271 exchange requirements for entities not subject to HIPAA

A unanimous approval for the exception, which this group did recommend for another year. However, (and noted on the ballot) *the TAG also recommended strongly that the AUC engage with the exempted payers and others during the coming year to help find a solution for more standard, automated exchanges of eligibility information between the parties.*

Per the notes from our last meeting we asked a few different questions for follow up:

- Approve with the caveat that work be done throughout the next year to identify data elements, usage of 270/271? Work with X12, CMS and other national organizations.
 - Dave is a member of WEDI, has great working relationships with other organizations. Would take to X12 with Doreen being the president. Can they join our next meeting?
 - AUC community, DOL, Department of Commerce?
 - End users of the transaction, who might we be able to tap into? TPL, MVA or WC payors and why are they not able to use? Talked with Chip Evelsizer a few years ago.

Corvel or Jopari contacts? Not sure if Sherry Wilson is still with Jopari (sherry.wilson@jopari.com).

- Federal HIPAA identified exempt entities are not required to use the 270/271, typically these are TPL, MVA, and WC payors, should we continue to allow this exemption? Do not want to and will work on throughout the year to discontinue as much as possible.
- Why do we continue to allow this exemption? Dave provided some history as to why this came about and slide presentation (separate attachment). We will need to fully vet the transaction and hopefully engage payors to work with us on coming to an agreement on the various data elements, what we can we do, what works or not.
- We should ask these exempted entities to provide reasons for not being able to use 270/271?
- Have they done any research, development to become compliant?
- MN has been including these payors with other transactions, we might have traction in getting them onboard with 270/271, at least open the conversation.
- Document attached from prior discussion with MVA in 2016, good place to start.

7. Other Business

- **Introduction of Bob Johnson** – Has worked in the HIM and EMR line of business, whereas Dave has been focused on Administrative Simplification. Bob will be partnering with Dave; their offices have come together OHIT (Office of Health Information Technology). Welcome Bob!
- **Other business that Eligibility TAG could work on?** In attached presentation from Dave, there are a couple of slides from survey with opportunities for education and work.
 - **The Eligibility Transaction didn't have the same consistent usage as the other transactions. Out of 26 responses, only 11 said they are at 95% electronic usage, 5 in 80-95% range and 10 below 80% or not known.**
 - **Survey responses stated 270/271 was incomplete, inaccurate, insufficient. Providers felt they received better information on the website or via phone specifically noting the 270/271 transaction. What are we missing?**
 - Accumulations of out of pocket, # of visits
 - Query about prior-auth – is 270/271 adequate? A lot of effort would need to be put into this and there are so many options, by CPT, Dx, too many variables. Do we have opportunities to start small? Service Types? Probably too generic.
 - Self-insured vs insured plan
 - **Eligibility Frequency** – Complete the update to our Best Practice
 - **More web documentation available** – electronic changes can take time; do we have interim options for any of our ideas?

8. Meeting Summary & Next Steps

- **Any word on the 278 Work Group?** Dave is not aware.

9. Next Meeting – Teleconference/WebEx ONLY

February 27th, 2019 (2-4pm)

2019 Calendar, please mark your calendars accordingly.

Wednesday, January 23, 2019 (2-4pm)

Wednesday, February 27, 2019 (2-4pm)

Wednesday, March 27, 2019 (2-4pm)

Wednesday, April 24, 2019 (2-4pm)

Wednesday, May 22, 2019 (2-4pm)

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1. Provider Eligibility Verification Best Practice

2. How to Do the Best Practice:

Below are recommendations for providers to facilitate verifying a patient’s eligibility with a health plan. The practices cover four areas:

- When and How to Verify
- Preferred Methods of Eligibility Inquiry
- Sharing Eligibility Information
- Data Elements That Should Be Used To Update Information Systems

| When and How Eligibility Should Be Checked | |
|--|---|
| Because eligibility changes typically happen at the beginning of the month, eligibility should be checked once per calendar month and not every 30 days. These practices should be used for all health plans including Medicare. | |
| Planned Visit | Unplanned Visit |
| Clinic: 3 business days prior to appt via daily batches if not already done within that calendar month. Hospital: at time of pre-registration or registration via real-time transaction*, or you may also send requests via batch* process for patients who cannot be reached by telephone. *(See Methods of Eligibility to be Used) | Clinic: at time of encounter via real-time transaction* Hospital: at time of registration via real-time transaction* *(See Methods of Eligibility to be Used) |
| Re-verify eligibility when account value reaches provider determined dollar threshold | |
| Re-verify eligibility periodically for SNF to check for potential benefit changes (ex: nursing home qualifying stays) | |
| Re-verify eligibility outside normal schedule if patient states something has changed | |
| Re-verification of data via an alternative method (web, IVR, phone) may be used when specific benefit information is not available with traditional response | |
| Re-verify eligibility at beginning of each calendar month for patients not discharged at the end of the prior month. | |

| Preferred Methods of Eligibility Inquiry in Order of Priority | |
|--|---|
| Electronically Use the HIPAA based MN Standard 270/271 Eligibility Inquiry and Response – this method is preferred since it removes the chance for errors by having to re-key information. | <ul style="list-style-type: none"> • Real-time transaction is preferred when interacting with the patient • Batch transaction is preferred for checking eligibility prior to collections, planned clinic visits, monthly re-checks or when accounts reach a certain dollar threshold. • Clearinghouse vendors should not submit 270 transactions unless it is requested by the provider. |
| Web Portal | <ul style="list-style-type: none"> • Real-time check is preferred when interacting with the patient. • Use when 270/271 is not available |
| IVR | <ul style="list-style-type: none"> • Use when 270/271 or web is not available |
| Phone call | <ul style="list-style-type: none"> • Call health plan customer service number as a last resort or if level of detail needed cannot be obtained via the other 3 methods. |

| Recommendations for Sharing Eligibility Data Across Care System |
|--|
| Care systems should develop a repository for patient eligibility information. |
| Care systems should give appropriate access to different information systems within the care system in order to access eligibility information |
| Physical information sharing between departments |
| Recommend centralize sharing of information across clinics first, then hospitals |

| Data Elements That Should Be Used To Update Information Systems | |
|--|---|
| In the health plan's eligibility response you will see information about the patient/member that may or may not match what you have in your information system. This explains what data you should automatically update to your information system and which data you should confirm with the patient. | |
| Data Element | Recommended Action |
| Subscriber ID number | Automatically update information system with information provided by health plan – no discussion with patient required. |
| Patient ID number | |
| Group number | |
| Patient last name | <ol style="list-style-type: none"> 1) Discuss discrepancy with patient. 2) If patient states health plan data is incorrect, instruct patient to contact employer or health plan to get information corrected at |
| Patient first name | |
| Patient date of birth | |

| | |
|--|---|
| | <p>the health plan. The claim may not process at the health plan until these data fields match. Therefore, in order to get the claim to process, one of the following options is recommended:</p> <ul style="list-style-type: none">▪ Option #1: Update health plan record only in Information System to match the health plan information.▪ Option #2: Change data on the claim only and document what was changed and why. <p>3) If patient states health plan data is correct, manually update your information system.</p> |
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3. Approval date:

October 5, 2007

4. Last reviewed date:

October 5, 2007