AUC Operations –

As noted in our email earlier this week (below), we trying something a little different for Tuesday's Ops meeting.

- First, the meeting will be Webex/dial-in only.
- Second, in lieu of reviewing much of the "usual" AUC activities and accomplishments at Tuesday's meeting, we are providing the attached brief written summary. We encourage you to read it in advance of the meeting, to contact us if you have questions or suggestions, and to follow-up with others in your organization or elsewhere as may be needed for any additional information or discussion about AUC Technical Advisory Group (TAG) and AUC activities and products.
- Third, the focus of the meeting will be to provide very brief introductions to the topics below, and to use the topics as starting points for broader discussions and planning with the AUC. The topics represent a number of recent developments and/or possible models that we thought might be of interest and that may help with thinking about next steps for Minnesota's health care administrative simplification initiative and the work of the AUC. For each of the topics we have also provided some example "discussion starter" questions for possible use at the meeting. Please review the links in the table below and or related attachments, as well as the related suggested discussion questions, prior to the meeting.

Meeting Topics

1. **CMS's Administrative Simplification Enforcement and Testing Tool (see the two links below)**

   https://asett.cms.gov/ASETT_HomePage

   https://asett.cms.gov/ASETT_ST_ABOUT

   Recently, CMS has publicized the availability of a new online tool – ASETT -- for testing transactions for HIPAA compliance. In concept, the tool may be useful in a variety of ways for the state's administrative simplification efforts. On the other hand, the tool is relatively new and may be relatively unfamiliar to the AUC. Please check out the information at the link above and consider the related questions for discussion on Tuesday.

   - Is anyone familiar with the tool? (Has anyone used it?)
   - What possible benefit do you see in the tool? Could it be helpful in resolving questions about varying uses or interpretations of the HIPAA transactions? Could it be helpful about learning to use the transactions correctly and/or most effectively? Might be helpful as part of developing companion guides, best practices, etc.?
   - Are there other possible applications of the tool as part of the AUC's work and MN's administrative simplification initiative?
   - What additional information would be helpful?
   - Do you see any potential downsides to the tool? What cautions, questions, or concerns do you have?
   - Other?

2. **Recent WEDI White Paper to provide education on the importance of the 835 PLB segment, as well as its challenges (and overcoming them) – <u>see PLB paper attached</u>**

   The national Work Group for Electronic Data Interchange (WEDI) recently published the attached white paper, "Provider Adjustments (PLB) in the Electronics Remittance Advice (835)." The paper was also recently provided to and discussed with the AUC EOB/Remit TAG.

   The paper is an excellent example of WEDI's work, while at the same time suggesting some possible questions for the AUC to consider (a few are listed in the column to the right).

   - What do you think of the general approach taken in the paper (ie, providing a foundation of base-level information that will be built upon with succeeding appendices exploring particular use cases/examples/challenges)?
   - Is the paper a possible model for AUC educational materials?
   - Could the AUC possibly collaborate with/contribute to WEDI or other white papers?

3. **Follow-up to last year's AUC survey and subsequent TAG discussions about administrative simplification "pain points" and priorities. <u>[a brief summary will be provided at the meeting]</u>**

   The AUC and TAGs have spent considerable time and energy over the last year identifying possible pain points and priorities to be addressed. The conversations and data gathering has resulted in a range of possibilities, including the following broad categories:

   - Improving the use rates and most effective use of existing Minnesota-mandated electronic transactions;
   - Learning about and adopting additional transactions that are not mandated in Minnesota;
   - New levels of ongoing dialogue and problems solving, coordination, and collaboration; and,
   - Addressing key industry-wide challenges (eg, claims attachments, prior authorizations).

   It is important to build from the AUC's previous data collection and brainstorming to more clearly identify goals and plan accordingly. Please note the questions to the right, and be thinking about them for Tuesday's meeting.

   - Are there specific things you would like to see the AUC focus on in the short and long term?
   - Are there topics related to proposed or existing mandates that you would like more on and could the AUC coordinate those discussions?
   - Are there other ways the AUC can help coordinate discussions or planning in our payer/provider community around reducing administrative burden?

4. **Recent federal requests for comment in response to proposed rulemaking and requests for information (RFIs) [for the most recent example, see attached CMS RFI re. "Reducing Administrative Burden to put Patients over Paperwork" -- see especially the sections highlighted in yellow as possibly most relevant to the AUC.]**

   This year has seen a number of important federal requests for comments, on topics ranging from proposed new rules to improve the interoperability of electronic health information (https://www.hhs.gov/about/news/2019/02/11/hhs-proposes-new-rules-improve-interoperability-electronic-health-information.html) to announcements just this week (June 5, 2019) of CMS's RFI regarding "Patients over Paperwork."

   Please review the most recent RFI example (with a few sections highlighted in yellow), attached, and consider the questions to the right.

   - Are you and your organization aware of the rules and RFIs and are you responding?
   - Much of the emphasis of recent federal comment solicitation has been in the context of interoperability of health data exchange, particularly for clinical data. Are there connections between the interoperability focus and administrative simplification? If so…
     - What do you see as the connections? How do larger interoperability concepts relate to the exchange of "administrative transactions"? Are there specific aspects of interoperability-related proposed rules that overlap with or relate more closely to the exchange of administrative transactions? Is the interoperability-related focus relevant to the AUC – and how?
     - How should the AUC track, discuss, and respond to opportunities to comment?
       - Should it be working with others? (Who, and how?)
       - Should the AUC be more proactive on federal/national initiatives (in what ways, for what purposes, how?)

We look forward to your participation at Tuesday's Ops meeting and to important discussions on the topics above. Our time will be brief but we will seek to have the fullest conversations possible. We will reserve the very last part of the meeting for review and next steps, especially if seems that additional discussion and planning are desired and would be helpful.

Please contact us if you have questions or suggestions.

Thank you for your involvement and contributions with the AUC.

Best regards,

Dave Haugen

David K. Haugen
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DEPARTMENT OF HEALTH

memo

DATE: June 7, 2019

TO: Minnesota Administrative Uniformity Committee (AUC) Operations Committee

FROM: David K. Haugen

SUBJECT: Brief update of AUC activities and accomplishments since December 2018

Background:

The Minnesota Administrative Uniformity Committee (AUC) has a long and productive collaborative working relationship with the Minnesota Department of Health (MDH) to standardize and streamline health care business (administrative) transactions and processes to reduce health care costs and improve health.

In lieu of recounting recent AUC activities and activities as part of the June 11, 2019 AUC Operations Committee meeting, we are providing this brief written summary of recent accomplishments and work being undertaken since the last Operations meeting in December 2018. As noted below, the AUC has been busy and productive. On behalf of MDH, we gratefully acknowledge the AUC's ongoing efforts and accomplishments.

Minnesota Uniform Companion Guides

A primary focus of the AUC is to advise MDH on the development, implementation, and ongoing maintenance/updating of rules known as Minnesota Uniform Companion Guides (MUCG), pursuant to Minnesota Statutes, section 62J.536.

- Since December 2018, the AUC has collaborated with MDH in recommending proposed changes to the MUCG for the electronic remittance advice (835) transaction. The changes were primarily for brevity and clarity, to reduce the length of the guide by deleting material no longer felt to be relevant and needed, and to ensure that the document reads as clearly as possible. In addition, a new example for use of the 835 with tertiary billing was added in one of the appendices, and a number of formatting changes were made to ensure that the guide met accessibility standards for material to be posted on MDH's website. The proposed changes were reviewed and approved by the AUC's EOB/Remit Technical Advisory Group (TAG). They were subsequently again reviewed and approved as a recommendation to MDH by the Operations Committee. MDH published a notice of the proposed changes in the State Register as well as a notice of a 30-day public comment period on March 18, 2019. No comments were received during the comment period. The proposed revised version of the guide is under final review by MDH prior to being published in the near future as an adopted rule.

- The Medical Code TAG is currently reviewing lengthy, detailed coding appendices in the 837I and 837P MUCG for potential changes or revisions that may be needed as part of "annual maintenance" and updating of the guides. In particular, volunteers from the TAG are comparing sections of the appendices with relevant chapters of the online Medicare Claims Processing Manual, to identify and help address possible areas of inconsistency or lack of clarity in the MUCG compared with the Medicare Manual. This work will be ongoing over the summer, with additional development and review of any possible changes to the 837 MUCG to be completed this fall.

Best practices

The AUC publishes a number of best practices that are not rules with the force of law as the MUCG are, but provide important information and examples to help clarify and assure more uniform, consistent, "best use" of health care administrative transactions.

- The Eligibility TAG recently developed and approved the "Provider Eligibility Verification" best practice, which was also subsequently reviewed and approved by the Operations Committee. The best practice includes recommendations for providers to facilitate verifying a patient's eligibility for health coverage and benefits with a health plan, including:
    - when and how to verify;
    - preferred methods of eligibility inquiry; and,
    - sharing eligibility information.
- The Eligibility TAG also surveyed its members to identify additional topics for best practices, and has started a draft new best practice for review and discussion at the next TAG meeting.

Technical Advisory Groups (TAGs)

The majority of the research, discussions, brainstorming, problem solving, development, and fine-tuning of AUC work products occurs in work groups known as Technical Advisory Groups (TAGs). Below are brief highlights of TAG activity and accomplishments since the last Operations meeting in December 2018. Additional TAG information, including their respective charges, co-chairs, and regularly scheduled meetings, is available on the AUC TAG webpage.

TAG	Most recent activities and accomplishments (since December 2018)
Eligibility	• Participated in education and discussion of "Service Type Codes" • Completed an annual review of a limited, statutorily authorized exemption of payers not subject to federal HIPAA transactions and standards requirements from state requirement for the electronic exchange of the 270-271 eligibility transaction. ○ The TAG recommended continuation of the limited exception above, and also recommended 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. The AUC Operations Committee reviewed and also approved the recommendation, which was then forwarded to MDH. MDH approved and published the exception through 2019, to be reviewed annually with the AUC. • See above discussion re. development and AUC Operations approval of "Provider Eligibility Verification" best practice (now in the process of being posted to the AUC website). • Developed and completed a brief survey of TAG members regarding key areas of interest and possible areas of focus for the remainder of 2019 Next regularly scheduled meeting: 6/26/19 (Plan at this time: review results of survey above, discuss possible best practices)
EOB/Remit	• Identified and discussed of challenges ("pain points") regarding the 835 transaction • See above for the TAG's contributions in recommending proposed revisions to the 835 MUCG • In response to an X12 solicitation of public comments on a proposed 7030 version of X12's 835 Implementation Guide, the TAG reviewed the proposed 7030 version and developed and approved comments. The comments were further reviewed and approved by the AUC, and submitted to X12 by MDH on behalf of the AUC. • Discussed a national Work Group for Electronic Data Interchange (WEDI) White Paper, "*Provider Adjustments (PLB) in the Electronic Remittance Advice (835),*" to better understand challenges and opportunities of the PLB, and as a possible model for educational material to be developed by the TAG. The TAG also similarly discussed creating possibly more detailed "educational" versions of examples in the 835 MUCG appendices. Next regularly scheduled meeting: 6/17/19 (Plan at this time: consider possibly more detailed, "educational" versions of examples in 835 MUCG appendices, other educational efforts and products.)

Medical Code	• Reviewed and discussed coding for programs and services administered by the Minnesota Department of Human Services (DHS – the state Medicaid agency), including:
	  ○ Housing Stabilization
	  ○ Withdrawal Management-residential
	  ○ Community First Services and Supports (CFSS)

	• See above regarding the TAG's comparison of coding appendices in 837I and 837P MUCG with Medicare Claims Processing Manual Next regularly scheduled meeting: 6/25/19 (Plan at this time: review and discussion of comparison of 837 MUCG with Medicare Claims Processing Manual)
Claims Data Definition (DD)	• Reviewed, discussed CAQH-CORE "Value Based Payments Advisory Group" ○ The Value Based Payments Advisory Group was formed as part of a CAQH-CORE 18-month study to examine value-based payment operational processes and to identify opportunity areas that, if improved, would streamline implementation of value-based payment. The CORE study report identified five opportunity areas and made nine recommendations that were reviewed and discussed by the TAG. Next regularly scheduled meeting: 8/7/19 (Plan at this time: Review and consider possible changes to existing best practice; review 837 MUCG for any possible revisions/updates as part of "annual maintenance of the MUCG"

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06/07/2019

Provider Adjustments (PLB) in the Electronic Remittance Advice (835)

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I. Change Log

This paper will be published in a series of iterations, with updated information being provided in additional appendices. This will allow the WEDI Remittance Advice and Payments Subworkgroup (SWG) to provide information in a timely manner, while keeping all the related information in one paper (not requiring the reader to access multiple papers to gain the full set of information).

Initial Version	5/6/19
Appendix C – Interest and Prompt Pay Discounts	5/6/19
Appendix D – Overpayment Recovery	TBD
Appendix E – Capitation	TBD
Appendix F - Federal / Regulatory PLBs, including Medicare-specific	TBD
Appendix G – Periodic Interim Payments	TBD
Appendix H – Other Adjustments	TBD
Appendix I - 7030 updates to the PLB and processes to request a new Provider Adjustment code	TBD

II. Purpose

The purpose of this paper is to provide guidance and information on the functionality and usage of the Provider Adjustment Segment (PLB) within the electronic remittance advice (ASC X12N 835 transaction) for specific business use cases, as described in the appendices. This paper is not intended to be a primer on the 835 itself, but instead focuses on this specific function within the 835, and assumes some knowledge of the transaction for the reader.

The PLB segment has historically been problematic for both payers and providers. Payers often do not provide all the necessary information in the 835 (for example, the Reference Identifier), and providers often are not able to correctly interpret the information provided.

In this paper, the SWG has looked at the different business use cases of the PLB, issues that commonly appear for those use cases, and provided some best practices to remediate challenges that both payers and providers experience. The initial sections of the document provide some level-setting information about the PLB and its usage, and then each appendix outlines a specific use case, along with challenges and best practices for that use case.

III. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for electronic transactions for electronic remittance advice and electronic funds transfer[1], which includes the ASC X12N 005010x221 Health Care Claim Payment/ Advice (835). The HIPAA regulation also includes a requirement that providers cannot be dis-incentivized from using the standard transactions, for example by providing more information on a paper remittance advice or web portal than is available within the standard transaction.

The ASC X12N 005010x221 835 transaction (required by HIPAA) includes adjudication information for health care claims, including payments, adjustments and denials.

Within the X12N 835 transaction, the Summary level contains the Provider Adjustment Segment (PLB), which provides information related to adjustments to the payment amount not specific to the claim and service level. These adjustments can either increase or decrease the total actual payment. The PLB segment provides for reporting increases or reductions to the total payment amount in conjunction with reference numbers for further identification.

[1] 45 CFR Part 162, "Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFTs) and Remittance Advice Transactions; Final Rule"

IV. Scope

This paper provides guidance and information on the functionality and usage of the PLB segment within the electronic remittance advice (X12N 835 transaction) for specific business use cases, as described in the appendices.

Usage of provider adjustments on a paper remittance advice or web portal is not included.

V. Structure of the Provider Adjustment Segment (PLB)

The PLB segment includes the following elements:

PLB01 – Provider Identifier. This identifies the provider receiving the payment that is being adjusted in this segment

PLB02 – Fiscal Period Date. This is the last date of the provider's fiscal year.

PLB03 – This is a composite element made up of the reason and identifiers for the amount being adjusted.

PLB03-01 – The first element of the composite is the Adjustment Reason Code. This code outlines the reason for the adjustment being made, and is a standard code specific to the PLB segment identified in the X12N 835 TR3.

PLB03-02 – The second element of the composite is the Reference Identifier (ID). This critical element provides information to the provider about what account or transaction is related to the adjustment. This element should contain a transaction trace number, claim Internal Control number, or patient account number to direct the provider to the specific information related to the adjustment. The information contained in the Reference ID will vary depending on the business use case (as defined in the appendices).

PLB04 – Provider Adjustment Amount. This is the amount being adjusted from the total payment amount. This amount can be positive or negative. A positive adjustment amount REDUCES the payment, and a negative amount INCREASES the payment.

The element pairs of Adjustment Reason Code / Reference Identifier and Provider Adjustment Amount can be repeated up to 5 additional times, so that a total of 6 combinations of Adjustment Reason Codes and Amounts can be reported in a single PLB segment. If more than 6 adjustments need to be reported, then an additional PLB segment is used.

VI. Use of the Provider Adjustment Segment (PLB)

The PLB segment should be used to report increases or reductions to the total payment amount within the 835. The amounts in the PLB segment are generally not related to specific claim balances in this 835; they apply to general ledger information – for instance, in the case of overpayment recovery for claims not paid in this 835. The amounts are posted to the general ledger and not to the individual patient accounts. The amounts in the segment must be reported in conjunction with reference numbers that identify the transaction or other relevant identifiers in order for the amounts to be posted appropriately. Even when individual claim identifiers are reported as the reference identifier, the PLB amounts are posted to the general ledger and not to the individual patient accounts.

The PLB segment is used to convey information for multiple business scenarios, including Interest and Prompt Pay Discounts, Overpayment Recovery and Balance Forwards, Capitation, Federal/Regulatory, Periodic Interim Payments (PIP) and Other Adjustments. See the appendices of this document for specific use cases for the PLB.

VII. Transaction Balancing, Including the PLB Adjustments

Adjustment amounts within the 835 in either the CAS or PLB segments can be positive or negative. A positive adjustment amount REDUCES the payment, and a negative amount INCREASES the payment.

For example, if the total provider payment amount would be $500 and there is a PLB adjustment for $-50, then the total payment amount for the 835 would be $500 – ($-50) or $550. If the PLB adjustment amount was $50, then the total payment amount for the 835 would be $500 - $50 or $450.

To balance the 835 transaction, the sum of all claim payments (CLP04) minus all Provider Level Adjustments (PLB04, PLB06, PLB08, PLB10, PLB12, PLB14) must equal the Total Actual Provider Payment Amount (BPR02).

i.e.

Sum of ALL CLP04s – Sum of All PLB Amounts = BPR02

Example (not all segments are included):

```
ST*835*1234~
BPR*I*149996.5*C*ACH*CCP*01*88899977*DA*24681012*193566554**01*111333555*DA*144444*20180316~
TRN*1*12345*1512345678~
DTM*405*20180316~
N1*PR*INSURANCE COMPANY OF TIMBUCKTU*XV*1234567890~
N1*PE*REGIONAL HOPE HOSPITAL*XX*6543210903~
LX*110212~
CLP*666123*1*211366.97*138018.4**MA*1999999444444*11*1~
CAS*CO*45*73348.57~
LX*130212~
CLP*777777*1*15000*11980.33**MB*1999999444445*13*1~
CAS*CO*45*3019.67~
PLB*6543210903*20181231*CV:12345*-1.27*CR:234567*3.5~
SE*20*1234~
```

TRANSACTION BALANCING:

138018.40+11980.33-(-1.27)-3.50=149996.50

Transaction Balancing:

CLP04	+	CLP04	-	PLB04	-	PLB06	=	BPR02
138018.4	+	11980.33	-	(-1.27)	-	3.5	=	149996.50

VIII. PLB Only Remit

The 835 transaction supports delivery of detailed payment information relative to the health care claim(s) and information describing why the total original charges have not been paid in full (if applicable). The 835 also supports delivery of remittance information that is not specific to a claim in the Provider Level Adjustment segment. The 835 can contain the detailed claim payment information only, both claim payment and provider level adjustments, or only provider level adjustments.

For example, capitation payments may be made in an 835 that does not include any other fee-for-service payments, so a PLB would be included to reflect the capitation payments, but no claim payment detail would be included. PIP payments may be treated the same way. A health plan acknowledging receipt of a check could be done in a PLB-only remit, if needed (see Appendix D.)

As in any situation where a net negative amount is created, BPR02 (total provider payment amount) cannot be negative. So if a PLB-only remit would create a net negative payment amount, the Balance Forward process must be used (See Appendix D).

IX. Provider Usage of the PLB Adjustment Information

The PLB includes identifying information for adjustments made to the total provider payment amount. The PLB03-1 Adjustment Reason Code and the PLB03-2 Reference Identification are the primary data elements that allow providers to understand and auto post the amounts in the PLB.

If all the pertinent information to track and reference adjustments is included in the PLB, provider systems should be able to accurately auto post 835s to the general ledger system. NOTE: For providers to track adjustments directly to specific claims, manual processing may be required. The current implementation guide intends for amounts to be posted at a general ledger level.

Practice Management Systems vary from provider to provider. Some systems may allow more flexibility in posting PLB data, while others may require manual intervention.

Providers use the Reference Identifier to track the amounts that are included in the PLB and reconcile amounts that carry forward from one 835 to another (see appendix D on Overpayment Recovery and Balance Forward). Providers must monitor the amounts that are being recouped to ensure that the amounts are accurate and often may have to use a spreadsheet or other manual method to track that information. Because of the tracking required, providers depend upon the Reference Identifier being the same from one 835 to the next to ensure that they are able to follow the amounts as they are recouped.

States may have a waiting period which require the amount to be recouped at a later time, requiring providers to track the amount. Payers need to use the same Reference ID to facilitate tracking.

X. Common Issues with the PLB Adjustment Segment

- Provider staff may be unable to determine what the PLB adjustment is for or what original claim the adjustment is related to
- Provider staff may not be trained on PLB interpretation
- Practice Management Systems may not track or map PLB data appropriately
- Practice Management Systems may not have the ability to associate PLB data to debit or credit
- Positive and negative offsets in the PLB can be complicated; for instance, amounts the provider has refunded by check to the payer (refer to Appendix D on acknowledging checks)
- Reference ID usage may not be correct. For instance, for partial recoveries, predecessor and current reference ID must be present. If both aren't, the amounts may be difficult to post

- The physical address where mail is received / processed is likely not the same location where posting of the 835 occurs. Information sent via mail will probably not be seen by the people posting the 835, so information related to a PLB adjustment that is sent via paper may not be accessible to those resources. The Reference Identifier included on both the letter and 835 should be related to information available to the provider (like transaction trace number or patient account number) and not a separate identifier.

The Reference Identifier Within the PLB Segment

The Reference ID should be an identifier that allows the provider to associate the adjustment with a prior claim or transaction on their Practice Management System. The Reference ID should not be only a payer-assigned number like the payer's internal control number (ICN), as that does not allow the provider to identify the information on their system. The payer's ICN is useful if the provider needs to contact the payer about the adjustment (see the next section, "What to do if there are issues with the PLB" for further information on contacting the payer), but does not provide information needed for posting.

As described above, information sent on paper will likely not be accessible to the resources posting the remittance information. As a result, using a reference ID in the PLB that refers to a paper letter will not be meaningful and may cause delays. The provider will have to call the payer to get information on the reason for the PLB adjustment and the information on the claim or transaction related to the adjustment.

Depending on the business use case, the reference ID may need to refer to the transaction as a whole, or a specific patient account number. Refer to the appendices below for information on reference IDs for each business use case.

X12's Request for Interpretation (RFI) portal (See Appendix B, Resources) includes three different RFIs that describe usage of a Reference ID that relates to a specific claim. RFIs 1976, 1956 and 1386 all include instructions for using a claim-level identifier for situations related to overpayment recovery (See Appendix D).

When the PLB is not used correctly:
Impact to the Payer

- Time/resources required to handle calls from provider and/or patient
- Audit issues due to incorrect information
- Additional handling of resubmitted claims due to confusion by the provider

Impact to the Provider

- Amounts are not applied to provider accounts correctly.
  - May be applied to individual patient accounts instead of the general ledger, causing incorrect patient balances
- Provider must call payers to get correct information about debits or credits.
- Provider may have to expend resources to track information manually

Impact to the Patient

When the PLB amounts are not applied to the provider accounts correctly or applied to the individual patient accounts instead of the general ledger, then this impacts the patient balances owed and will result in incorrect billing statements being sent to the patient. This, then, results in increased dissatisfaction on the part of the patient and increased calls to the provider to correct the issue (with corresponding increase in time required by the provider to research and remediate the issue).

There may even be situations where the patient does not realize that they have been billed an incorrect amount and they may pay the incorrect amount. This has an even larger impact on the patient by having a financial burden on them.

Impact:

- **Extra time and resources required**
- **Audit issues**
- **Patients billed incorrectly**

XI. What To Do If There are Issues with the PLB

When there are issues or there is a lack of clarity with the information in the PLB, the provider will need to contact the payer to get additional information. It is imperative that the provider has the correct information for contacting the payer to avoid additional delays.

The PER Segment in the 835

The PER segment within the 835 contains information for who to contact in case of issues. Two types of PER segments can be supplied: a business contact from the Claims Office (qualifier CX) and a technical contact from the technical department (qualifier BL).

It is critical that this information includes a valid phone number or email address and that the contact included in this PER segment fully understands the 835 file segments and requirements and be able to respond to the provider's inquiry. The phone number included should be as direct as possible (avoid complicated voice response systems) and should direct the provider to a contact that has the information and expertise necessary to respond to issues. The payer resources should also have access to the information included in the 835 – often providers are told that what is on the 835 is not what they have in their system. They then refer the provider to their paper remittance advice, which is not beneficial to the provider.

When the provider cannot determine from the 835 the intent or source of the PLB adjustment and cannot get clarification from the payer, they are unable to post the information. The providers have growing lists of PLBs that are not posted because there is not enough information to know what the payer is intending.

Handing Compliance Issues in the 835

When a trading partner is out of compliance, the first step should always be to approach and work with that trading partner directly to resolve the issue. In the situation where compliance issues cannot be resolved, however, CMS does offer a mechanism for bringing visibility to the issue and working through a corrective action plan to resolve the issue.

The CMS Administrative Simplification Enforcement and Testing Tool (ASETT) is available for reporting issues that need assistance in creating or working through a corrective action plan. This tool is not intended as a mechanism for imposing fines or penalties, but rather as a way to engage CMS in working through compliance issues and implementing plans to remediate these issues. Issues can be reported through this tool anonymously and provide CMS a way to gain visibility into the issues that are occurring in the industry that may require additional education, guidance, or regulation[2].

[2] https://asett.cms.gov/ASETT_HomePage

XII. Summary

This paper seeks to identify and explain the complexities of the Provider Adjustment Segment (PLB). The PLB segment is necessary to convey specific information related to adjustments to the total provider payment amount, but is often used incorrectly or misunderstood. The payer's technical team and the business teams must work together to identify the data to be reported and how to include the data in the 835 to clearly identify to the provider how to use the information. It is critical that the payer pay close attention to instructions in the X12 835 TR3 when implementing the PLB in order to correctly convey the information to the provider.

This paper outlines specific business use cases for the PLB and how information should flow from the payer to the provider. It is important that the provider's practice management system manage the PLB segments correctly in order to get the information posted correctly without unnecessary manual intervention by the provider.

XIII. Acknowledgements

The following individuals have contributed to the leadership in the development of this white paper:

WEDI Remittance Advice and Payment SWG Co-Chairs

a. Pam Grosze, PNC Bank
b. Deb Strickland, Individual Member
c. Margaret Richardson, Centene
d. Mary Lynam, DST

The co-chairs wish to express their sincerest thanks and appreciation to the members of the WEDI Remittance Advice and Payment Subworkgroup who participated in the creation of this document.

APPENDIX A – Abbreviations, Acronyms and Definitions

ANSI – American National Standards Institute is the organization that accredits U.S. Standards Development Organizations, ensuring that their methods for creating standards are open and follow due process.

ASC – Accredited Standards Committee

CAQH CORE – Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) is a national multi-stakeholder initiative that streamlines electronic health care administrative data exchange and improves health plan-provider interoperability through the development of industrywide operating rules. CAQH CORE has been designated by the Department of Health and Human Services (HHS) as the operating rule authoring entity for federal mandates related to health care standards under ACA Section 1104.

ERA – The Electronic Remittance Advice is an EDI transaction describing the payer, payee, payment amount and other identifying information about the payment. It also includes other information that resulted from the adjudication process, including denial information and adjustment reasons and amounts.

ICN – Internal Control Number. This is a number assigned by the payer to claims that are received into their processing system.

Operating Rules – The Patient Protection and Affordable Care Act defines operating rules as "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

PIP – Periodic Interim Payments

PLB – Provider Level Adjustment segment

PMS – Practice Management System

RFI – Request for Interpretation. X12's Request for Interpretation portal provides access to information related to the meaning, use and interpretation of ASC X12 Standards, Guidelines and Technical Reports – including Technical Report Type 3 (TR3) implementation guidelines. The information is available in the form of responses to questions submitted by implementers of the ASC X12 products.

TR3 – Technical Report Type 3 are implementation guides developed by X12N.

X12 – ANSI accredited standards development organization and one of the six Designated Standards Maintenance Organizations (DSMO) tasked to develop, update and maintain the administrative and financial transactions standards.

X12N – Insurance Subcommittee within X12 responsible for developing standards and related technical reports for the insurance industry.

X12N 835/ERA – The X12N 835 is the X12N transaction for the Health Care Claim Payment/Advice and is the HIPAA-required transaction set to use for health care claim payments, using the ASC X12N/005010x221 Health Care Claim Payment/Advice (835) TR3.

APPENDIX B – Resources

The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835) is available at www.wpc-edi.com.

The X12 Request for Interpretation Portal is available at http://rfi.x12.org/.

CAQH CORE Phase III EFT and ERA Operating Rules and associated FAQs are available at www.caqh.org.

Additional papers on the 835 and EFT transactions published by the WEDI Remittance Advice and Payments SWG are available at www.wedi.org.

The CMS Administrative Simplification Enforcement and Testing Tool (ASETT) - https://asett.cms.gov/ASETT_HomePage

APPENDIX C – Interest and Prompt Pay Discount

Interest and prompt pay discounts are adjustments in payment between the provider and payer and are not specific to the patient's accounts receivable. The additional or reduced payment amounts are not included as part of the claim or service line balancing but must balance at the payment level. These adjustments are handled in the PLB – provider level balancing section of the transaction set.

The addition or removal of interest and/or a prompt pay discount will adjust the payment to the provider but will not adjust the billed charges or payment due on the individual member claim. The actual claim billed charges and adjustments are kept whole but the provider payment is adjusted.

If a payment includes interest amounts, all interest should be consolidated into one amount in the PLB adjustment using the '**L6**' (Interest Owed) qualifier. The same consolidation of adjustment occurs with a prompt pay discount amount using one PLB adjustment with a '90' (Early Payment Allowance) qualifier.

To identify which claim(s) is owed interest, a Claim Supplemental Information Segment, (**AMT**) is added with qualifier 'I' in AMT01 to indicate there is interest owed on that claim. The amount is not included in balancing calculations but is informational. In the case of a prompt pay discount that the payer has permitted, the claim will be identified using the AMT segment with a 'D8' qualifier.

If a claim is reversed or corrected that had interest or a prompt pay discount originally applied, that amount needs to be negated in the AMT segment of the impacted reversal claim.

Example: (not all segments included in example)
BPR*I*102*C
CLP*PATIENTX*1*200*45*5*12
CAS*PR*5
SVC*HC:12345*200*45
CAS*CO*45*150
AMT*I*5
CLP*PATIENTY*1*100*50*12
SVC*HC:23455*100*50
CAS*CO*45*50
AMT*I*2
PLB*1234567893*20181231***L6***-7

Key Concept:

All interest amounts are added into one L6 adjustment amount for the PLB, and each claim that is included in that amount has an AMT segment to indicate the interest amount that applies to that claim.

Recommended Reference ID to include / Best Practices

Because all of the interest amounts are consolidated into a single PLB amount, interest amounts for this remittance advice do not need to include a reference identifier. If there is an interest amount related to a previous remittance advice, then the reference identifier should be the TRN02 (EFT Trace Number/ Check Number) from that previous remittance advice so that the provider can refer back to that previous payment.

Common issues seen with Interest and Prompt Pay Discount reporting

- Interest may be reported in a CAS segment at the claim level, rather than following the documented procedures for aggregating the interest amount and reporting as one amount in the PLB. When this occurs, the interest amount is then applied to the patient's account and can impact the balance on the account (either positively or negatively) and cause the provider to bill the patient for an incorrect amount. Interest amounts should be noted on the claim in the AMT segment, but not in the CAS so that the amount will not impact the patient's balance.
- Rather than being aggregated into one single amount in the PLB segment, payers may report each individual interest payment as a separate PLB adjustment amount, listing the claim patient account number as the reference ID. This does not follow the procedures outlined in the X12 835 TR3 and can cause additional work for the provider to post each individual interest amount separately to the general ledger. Because the AMT segment is available at the claim level to identify which claims are included in the PLB interest amount, it is not necessary to have an individual PLB adjustment to identify the specific claims.
- Providers may not be reconciling the claims identified as having an interest amount with the interest amount reported in the PLB and then ensuring that the correct interest amount is posted to their general ledger account. When this reconciliation does not occur in a timely manner, additional work is required by the payer to correct any issues that occur.
- The payer may include the interest or prompt pay discount amount in the EFT or check payment, but not include the information in the corresponding 835. This will cause the payment amount reported in the 835 to not match the payment amount of the check or EFT and will result in a call to the payer to determine the reason for the out of balance situation.

APPENDIX D – Overpayment Recovery

APPENDIX E – Capitation

APPENDIX F – Federal / Regulatory PLBS, Including Medicare-Specific

APPENDIX G – Periodic Interim Payments

APPENDIX H – Other Adjustments

APPENDIX I – 7030 Updates to the PLB, Processes to Request a New Provider Adjustment Code

This document is scheduled to be published in the Federal Register on 06/11/2019 and available online at **https://federalregister.gov/d/2019-12215**, and on **govinfo.gov**

[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Ch. IV

[CMS-6082-NC]

RIN 0938-ZB54

Request for Information; Reducing Administrative Burden to put Patients over Paperwork

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS; Department of the Treasury

ACTION: Request for information.

SUMMARY: CMS is committed to transforming the health care delivery system--and the Medicare and Medicaid programs--by putting additional focus on patient-centered care, innovation, and outcomes. As part of our continuing Patients over Paperwork initiative, we have actively solicited feedback from the medical community through Requests for Information (RFIs), listening sessions, and clinical onsite engagements with front-line clinicians and staff to learn how our administrative requirements and processes affect their daily work and ability to innovate in care delivery. This RFI solicits additional public comment on ideas for regulatory, subregulatory, policy, practice, and procedural changes that reduce unnecessary administrative burdens for clinicians, providers, patients and their families. Through these efforts, we aim to increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple, and accessible.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[**Insert date 60 days after date of publication in the **Federal Register].**

ADDRESSES: In commenting, refer to file code CMS-6082-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in **one** of the following three ways (please choose only **one** of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-6082-NC,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address

ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-6082-NC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the

"SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Morgan Taylor, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-3458.

Mary G. Greene, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-1244.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

I. Background

CMS is committed to transforming the health care delivery system--and the Medicare and Medicaid programs--by putting additional focus on patient-centered care, innovation, and outcomes. Our top priority is putting patients first and empowering them to make the best decisions for themselves and their families. Our continued goal is to eliminate overly burdensome and unnecessary regulations and subregulatory guidance in order to allow clinicians and providers to spend less time on paperwork and more time on their primary mission – improving their patients' health. We are also modernizing or eliminating outdated regulations to remove barriers to innovation. By reducing unnecessary paperwork, we are unleashing the most powerful force in our healthcare system for improving health outcomes: the clinician-patient relationship.

We launched our Patients over Paperwork initiative in 2017 to focus all of CMS on finding opportunities to modernize or eliminate rules and requirements that are outdated, duplicative, or getting in the way of good patient care. Public input has been critical to CMS achieving more flexibilities and efficiencies. As part of the Patients over Paperwork initiative, we actively solicited feedback from the medical community through requests for information (RFI), listening

sessions, and clinical onsite engagements with front-line clinicians and staff to learn how our administrative requirements and processes affect their daily work and ability to innovate in care delivery. Through the RFI process alone, we received over 3,000 responses that outlined current burden and recommendations, which resulted in 1,146 distinct burden topics to address. Topics included, but were not limited to: Audits and Claims; Documentation Requirements; Health Information Technology; Interoperability; Provider Participation Requirements; Quality Measures and Reporting; Payment Policy and Coverage Determinations; the Physician Self-Referral Law; and Telehealth.

Over 2,000 clinicians, administrative staff and leaders, and beneficiaries have participated in our listening sessions and onsite engagements and we continue to send teams out into the field to learn more. This fieldwork helped elucidate how our rules affect workflow and decision-making, and potentially impede innovation. As of February 8, 2019, after reviewing and adjudicating all 1,146 burden topics with executive leadership across the agency, we have resolved or are actively addressing over 80 percent of the actionable RFI burden topics through changes to our regulations, subregulatory guidance, operations, or direct education and outreach to providers and beneficiaries. Please see the Appendix for a sample of what we have accomplished so far.

As we continue to work to maintain flexibility and efficiency throughout the Medicare and Medicaid programs, we would like to continue our national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, providers, and patients and their families. Through these efforts, we aim to increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple, and accessible. For these reasons, we are seeking comments on additional opportunities for improvement through this RFI.

II. Solicitation of Public Comments

We invite the public to submit ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals. Specifically, we are soliciting new ideas not conveyed during our first RFI on this matter and innovative ideas that may help broaden perspectives about potential solutions. Ideas may include, but are not limited to:

- Modification or streamlining of reporting requirements, documentation requirements, or processes to monitor compliance to CMS rules and regulations;
- Aligning of Medicare, Medicaid and other payer coding, payment and documentation requirements, and processes;
- Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance patient care, support the clinician-patient relationship, and facilitate individual preferences; and
- New recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, and providers.

We are particularly interested in recommendations on how CMS could:

- Improve the accessibility and presentation of CMS requirements for quality reporting, coverage, documentation, or prior-authorization;
- Address specific policies or requirements that are overly burdensome, not achievable, or cause unintended consequences in a rural setting;
- Clarify or simplify regulations or operations that pose challenges for beneficiaries dually enrolled in both Medicare and Medicaid and those who care for such beneficiaries; and
- Simplify beneficiary enrollment and eligibility determination across programs.

We are requesting respondents provide complete, clear, and concise comments that include, where practicable, data and specific examples.

III. Collection of Information Requirements

Please note, this is a request for information (RFI) only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

We note that this is a RFI only. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This RFI does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. We note that not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this RFI.

We will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. We may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this RFI. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for

program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. In addition, we may publically post the public comments received, or a summary of those public comments.

CMS-6082-NC

Dated: April 22, 2019.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: June 3, 2019.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.

Appendix: Patients over Paperwork Sample Accomplishments

The following is a sample of CMS accomplishments reducing unnecessary administrative burden in response to input from clinicians, providers, beneficiaries, and other stakeholders. For more Patients over Paperwork highlights, visit https://www.cms.gov/About-CMS/story-page/patientsover-paperwork.html.

Reducing Regulatory Burden

- Removed data elements from the Outcomes and Assessment Information Set (OASIS) assessment instrument.
- Removed the inpatient admission order documentation requirement in an effort to reduce duplicative documentation requirements at the time of admission.
- Removed the requirement that certification/recertification statements detail where in the medical record the required information can be found.
- Established the innovative new classification system, the Patient Driven Payment Model (PDPM), that ties skilled nursing facility payments to patients' conditions and care needs rather than volume of services provided, and simplifies complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden.
- Eliminated the requirement that certifying physicians estimate how much longer skilled services are required when recertifying the need for continued home health care.
- Proposed giving facilities the flexibility to review their emergency program every 2 years, or more often at their own discretion, in order to best address their individual needs.
- Proposed allowing multi-hospital systems to have unified and integrated Quality Assessment and Performance Improvement (QAPI) and unified infection control programs for all of its member hospitals.
- Published a proposed rule to streamline Medicaid & CHIP managed care regulation.

- Issued Medicare Advantage (MA) and the prescription drug benefit program (Part D) final rule that promotes innovation, empowers patients and providers to make healthcare decisions, and includes burden-reducing provisions.

Simplifying Documentation Requirements

- Changed policy to allow a teaching physician to rely on medical student documentation and verify it rather than re-documenting the evaluation and management (E&M) service, and explained that the physician's signature and date is acceptable verification of the medical student's documentation.
- Provided an exception so that physicians acting as suppliers do not need to write orders to themselves.
- Simplified the requirements for preliminary/verbal Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) orders: Suppliers may dispense most items of DMEPOS based on a verbal order or preliminary written order from the treating physician.
- Clarified DMEPOS written order prior to delivery date requirements: If the written order is dated the day of or prior to delivery, there is no need for affirmative documentation of it being "received".
- Clarified that a supplier can use the discharge date as the date of service if mailing 1 or 2 days before discharge.
- Released a newly revised Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) with concise instructions and no longer using the 5 denial letters and Notice of Exclusion from Medicare Benefits – SNF.

Focusing on Meaningful Measures

- Our Meaningful Measures initiative is centered on holding providers accountable for patient health outcomes, safe and efficient care, and making sure the measure sets providers are asked to report on are meaningful to patients and clinicians alike.

- Reduced the burden of reporting quality measures in MIPS with a focus on reporting through electronic means and incentivizing the use of clinical registries.

Improving Operational Efficiencies and Interoperability

- In implementing the Quality Payment Program (QPP), established a consolidated data submission experience for the different performance categories of the Merit-based Incentive Payment System (MIPS) so that clinicians no longer need to submit data in multiple systems as under the legacy programs (the Physician Quality Reporting System (PQRS) and the Medicare Electronic Health Record (EHR) Incentive Program).
- Refocused the Medicare EHR Incentive Program (now called the Promoting Interoperability Program) on interoperability, emphasizing exchange of health information between patients and providers.
- Implemented changes resulting in faster processing of state requests to make program or benefit changes to their Medicaid program through the state plan amendment (SPA) and section 1915 waiver review process.

Enhancing Transparency and Consistency

Made significant changes to the Medicare Program Integrity Manual Chapter 13 to improve transparency in the Local Coverage Determination process. The manual includes instructions, policies and procedures for Medicare Administrative Contractors (MAC) that administer the Medicare program in different regions of the country, as well as guidance for stakeholder engagement in the process.

Offering Burden-Reducing Flexibilities in Payment Model Demonstrations

- In the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model, CMS issued the Post-Discharge Home Visit Payment Policy waiver which allows for certain services to be delivered in the eligible model beneficiary's home by auxiliary personnel under the general supervision of a participating practitioner.

- In the Next Generation Accountable Care Organization (Next Gen ACO) model, CMS issued the Telehealth Expansion waiver which allows for eligible model beneficiaries to receive

Telehealth services in their home.

[FR Doc. 2019-12215 Filed: 6/6/2019 11:15 am; Publication Date: 6/11/2019]

AUC Quarterly Operations Committee Meeting

June 11, 2018

DEPARTMENT OF HEALTH

Today's Agenda

- Review and discussion
  - CMS Administrative Simplification Enforcement and Testing Tool (ASETT) tool
  - WEDI White Paper -- Provider Adjustments (PLB) in the Electronics Remittance Advice (835)
  - Follow-up to last year's AUC survey and subsequent TAG discussions about administrative simplification "pain points" and priorities
  - Recent federal requests for comment in response to proposed rulemaking and requests for information (RFIs)
- Meeting Summary & Next Steps
- Next Meeting – September 10, 2019

CMS Administrative Simplification Enforcement and Testing Tool (ASETT) tool

- Test transactions for HIPAA compliance
- File complaints
- https://asett.cms.gov/ASETT_HomePage

CMS Administrative Simplification Enforcement and Testing Tool (ASETT) tool

- Is anyone familiar with the tool? (Has anyone used it?)
- What possible benefit do you see in the tool? Could it be helpful in resolving questions about varying uses or interpretations of the HIPAA transactions? Could it be helpful about learning to use the transactions correctly and/or most effectively? Might be helpful as part of developing companion guides, best practices, etc.?
- Are there other possible applications of the tool as part of the AUC's work and MN's administrative simplification initiative?
- What additional information would be helpful?
- Do you see any potential downsides to the tool? What cautions, questions, or concerns do you have?
- Other?

WEDI White Paper -- Provider Adjustments (PLB) in the Electronics Remittance Advice (835)

- WEDI White Paper
- What do you think of the general approach taken in the paper (ie, providing a foundation of base-level information that will be built upon with succeeding appendices exploring particular use cases/examples/challenges)?
- Is the paper a possible model for AUC educational materials?
- Could the AUC possibly collaborate with/contribute to WEDI or other white papers?

Follow-up to last year's AUC survey and subsequent TAG discussions about administrative simplification "pain points" and priorities

- AUC
  - Active since early 1990s
  - Consulting with MDH per state statute on single, standard companion guides and related issues since 2007
- How are we doing?
  - What are problems ("pain points")?
  - What are opportunities and needs?
  - What should the AUC be focusing on?
- Let's find out
  - Survey of AUC members
  - Interviews with TAG co-chairs
  - Discussions

III A. Rates of electronic MN required transactions

Rates of electronic claims, eligibility inquiries and responses, remittance advices, and acknowledgements

- 23 - 26 responses for each transaction, depending on transaction

Transaction	More than 95% electronic	80-95%	60-80%	Less than 60%	Do not know/ not applicable
Health care claims (837I, 837P, 837D) [25 responses]	18	5			2
Eligibility (270-271 and corresponding CORE operating rule) [23 responses]	11	5	3	3	4
Remittance advice (835) [26 responses]	14	8	2		2
Acknowledgments (TA1, 999, 277CA) [26 responses]	15	6	1		4

III B. Use of additional HIPAA-required transactions

HIPAA-required transactions (not listed in MN Law)	Use extensively/ frequently	Use somewhat/ occasionally	Rarely or never use	Do not know
Referrals and authorization (278)	8	10	5	3
Claim status (276/277 and corresponding CORE operating rules)	14	8	1	2
Enrollment/disenrollment in a health plan (834)	5	5	10	4
Electronic funds transfer (NACHA and CORE operating rules)	17	1	2	6
Health plan premium payments (820)	4	5	8	9
Coordination of benefits (837P, 837I, 837D)	18	4	2	3
Medicaid pharmacy subrogation (NCPDP Batch Standard Medicaid Subrogation Implementation Guide, (Version 3.0))	3	4	5	14

IV A. (cont) – Main categories of pain points

Category	High level summary
Standardization	The goal of standardization has not been achieved. There are still differences across the industry in requirements for information that must be exchanged and how it is to be exchanged, variations in practices among trading partners and clearinghouses, continued use of proprietary codes and formats, and continued issues regarding NPI, payer ID, etc.
270-271	Information being exchanged on the 270-271 is incomplete, inaccurate, insufficient.
Attachments	Lack of a HPPA-adopted standard is delaying implementation of electronic attachment. Increasing numbers of attachments – are they necessary/useful?

Follow-up to last year's AUC survey and subsequent TAG discussions about administrative simplification "pain points" and priorities

- Are there specific things you would like to see the AUC focus on in the short and long term?
- Are there topics related to proposed or existing mandates that you would like more on and could the AUC coordinate those discussions?
- Are there other ways the AUC can help coordinate discussions or planning in our payer/provider community around reducing administrative burden?

Recent federal requests for comment in response to proposed rulemaking and requests for information (RFIs)

- February 11, 2019 -- HHS announced two proposed rules to support the seamless and secure access, exchange, and use of electronic health information
  - ….increase choice and competition while fostering innovation that promotes patient access to and control over their health information.
- The proposed ONC rule would require that patient electronic access to this electronic health information (EHI) be made available at no cost.
  - Also – exceptions not considered "information blocking"
- CMS proposed requirements that Medicaid, the Children's Health Insurance Program, Medicare Advantage plans and Qualified Health Plans in the Federally-facilitated Exchanges must provide enrollees with immediate electronic access to medical claims and other health information electronically by 2020

Recent federal requests for comment in response to proposed rulemaking and requests for information (RFIs)

- Most recently -- CMS Request for Information (RFI) re. "Reducing Administrative Burden to put Patients over Paperwork"

Recent federal requests for comment in response to proposed rulemaking and requests for information (RFIs)

- Are you and your organization aware of the rules and RFIs and are you responding?
- Much of the emphasis of recent federal comment solicitation has been in the context of interoperability of health data exchange, particularly for clinical data. Are there connections between the interoperability focus and administrative simplification? If so…
  - What do you see as the connections? How do larger interoperability concepts relate to the exchange of "administrative transactions"? Are there specific aspects of interoperability-related proposed rules that overlap with or relate more closely to the exchange of administrative transactions? Is the interoperability-related focus relevant to the AUC – and how?
  - How should the AUC track, discuss, and respond to opportunities to comment?
    - Should it be working with others? (Who, and how?)
- Should the AUC be more proactive on federal/national initiatives (in what ways, for what purposes, how?)

Meeting Summary & Next Steps