AUC Executive Committee Meeting
Agenda – December 5, 2016

Teleconference line: 1-712-832-8300	Participant passcode: 337213
https://health-state-mn-ustraining.webex.com	Password: Exec2010!

Agenda Item	
A.	**Meeting to order – Tony Rinkenberger**
B.	**Anti-trust statement**
C.	**Approve November 7, 2016 meeting notes**
D.	**Updates/Old business**
	1. Update – Companion guides maintenance – 837D 2. Update – Publication of continued exemption of 270/271 for non-HIPAA entities 3. TAG and SBAR update 4. AUC website 5. Ops December agenda 6. Provider co-chair
E.	**New Business** 1. Brief report on Nov. 2016 WEDI conference 2. AHIP letter re. administrative simplification
F.	**Other business**
Next meeting: **(Note new location)** 8:30 am – 10:30 am January 9, 2016 MN Department of Health – Rm 226, Golden Rule Building, downtown St. Paul	

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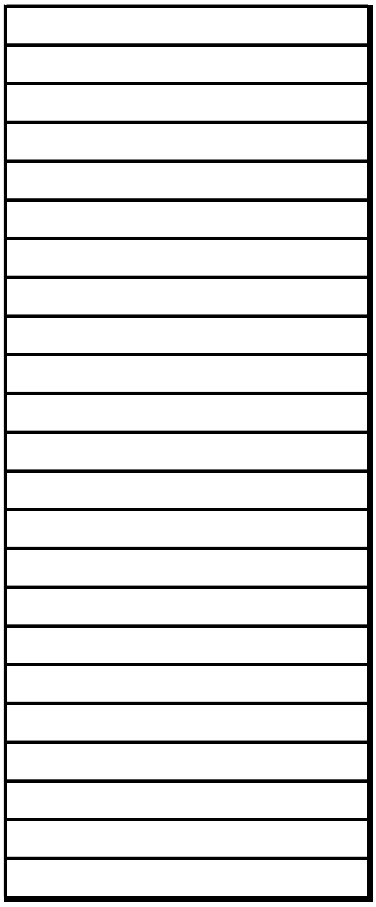


12/5/16 Exec Committee: TAG/SBAR update

- Key emerging interests and issues – telehealth/telemedicine (Claims DD and Medical Code TAG)
- X12 revised its v7030 review schedule, which affects most TAG planning and priorities
- Note for upcoming Ops meeting – add follow-up to previous discussion of revamping 837 guides to reference DHS-specific programs/services via a link to DHS website, rather than by describing the services/programs in the guides

Acknowledgment TAG	Last met on 10/27/16; completed comments to x12 re. v7030 277CA; comments submitted to meet Nov. 30 deadline.
Claim DD TAG	Nov. 2 and Dec. 1 meetings canceled. Meeting scheduled for Dec. 7. Plan to discuss SBAR seeking clarification of POS for telehealth. Also examining coding for accident date for workers comp-related claims.
Eligibility TAG	Met Nov. 23, scheduled to next meet on Dec. 28. Developing best practice for reporting "Restricted Recipient Program Information"
EOB/Remit TAG	Met Nov. 21 to review the v7030 835 for possible comments. The TAG next meets on Dec. 19 to continue its review.
Medical Code TAG	Met Dec. 1. Discussed changes to 837 claims guides to reference DHS-specific coding instructions rather than including the instructions in the guide. Reviewed educational materials regarding telehealth and telemedicine. Note: plan follow-up on 837 guide change issue with Ops
Operations Committee	Meeting at TIES conference center, Dec. 13. Meeting agenda being discussed at Exec.

Exec developed the following agenda for the Operations Committee December meeting:

a. Reminder re responsibility for member organizations, i.e., assigning primary/secondary representatives; attendance; and TAG representation
b. Year-end recap of AUC accomplishments
c. MDH's Record retention schedule and how that impacts the AUC website
d. AUC Website archives and updates (including proposed changes and redesign)
e. Recruit provider AUC co-chair for 2017
f. AUC presentations
g. TAG updates
h. Dave Haugen to report what's on the horizon for 2017
i. Discuss workers comp attachment mandate effective January 1, 2017

https://www.onehealthport.com/adminsimp-overview

https://www.onehealthport.com/best-practice-recommendations

WEDI-Con 2016

A brief sampler of selected sessions

Juxtaposition of old and new

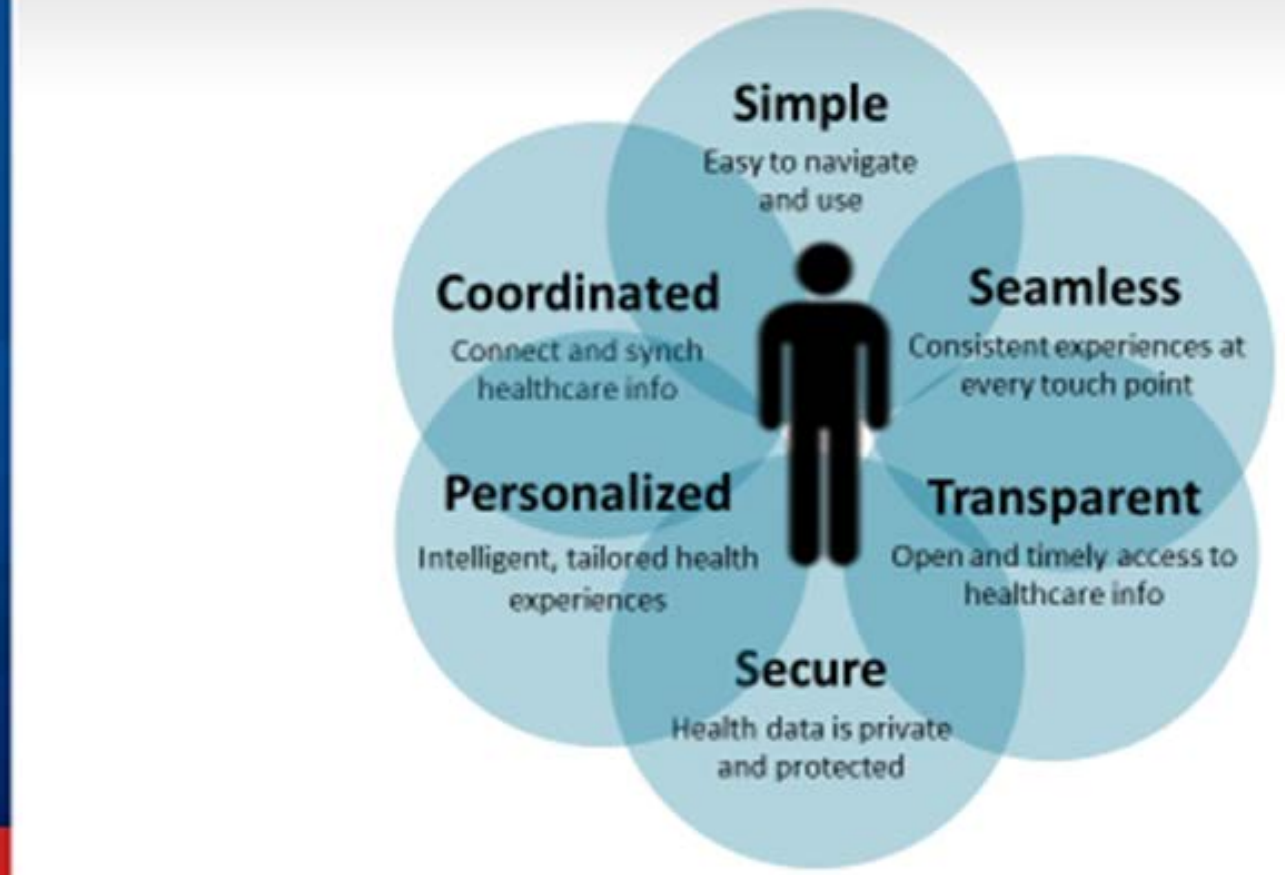
- Rapid growth of telehealth/telemedicine/internet of things
- Why aren’t existing transactions being used/providing benefits – opportunities/future possible alternatives
- Cybersecurity – especially ransomware

New -- Consumer valuation of health care changing

- Technical competence assumed, so consumers looking for other value added
- Analogue: air travel. Consumers expect to take off on time, land safely. Value added for consumers is other features – comfort, convenience, amenities
- Health care consumers increasingly assume technical competence. Value added is personalization, comfort, convenience, etc.
- Technology will play an important role (because is less expensive and more deployable than people)

Care and compassion

What qualities empower people today will inform the services of tomorrow



Source: FJORD Era of Living Services 2015

Healthcare will become more virtual

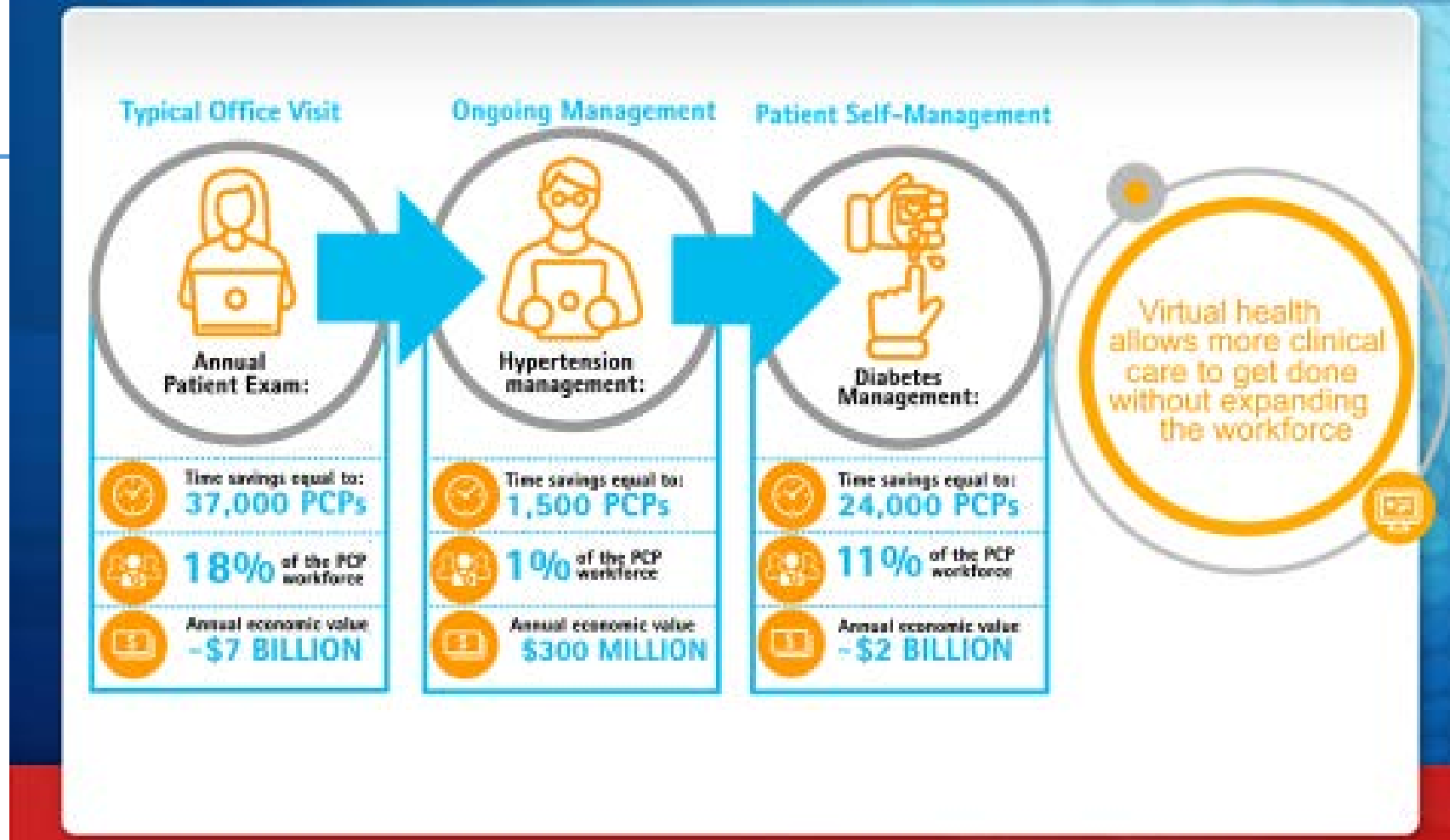
Virtual health benefits the already served, not just the underserved

- Matching supply to demand
- One to many
- Asynchronous
- Augmented experience
- Digital Therapy

Source: Silvercloud

Virtual health tools unlocks productivity

Three uses of virtual health among primary care physicians

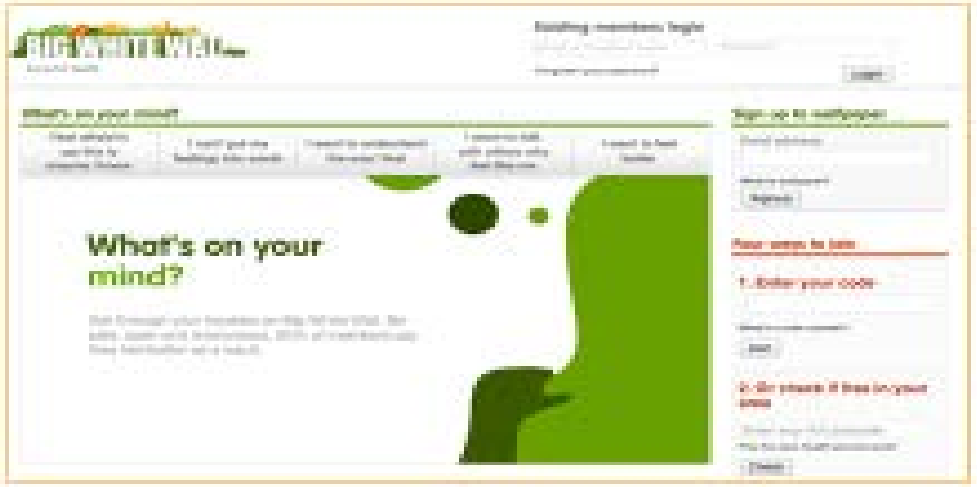


Source: Accenture, "Virtual Health: Untapped Opportunity to get the most out of Healthcare," 2015

Social Software

Delivers healthcare while increasing self-care and self-service

- Business-class social networks
- Self-service platform
- Community created content
- Gaming



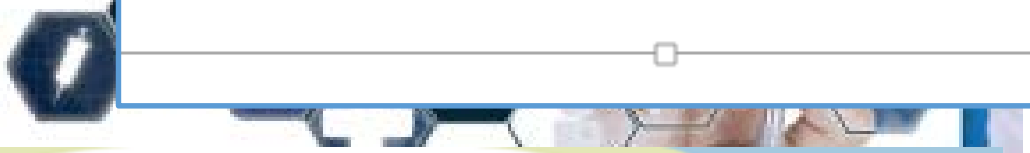
Source: www.bigwhitewall.com; Wicks, P. et al. Nature biotechnology May 2011

Internet of Things

- Sense-interpret-respond
- Platforms over products
- Systems over devices
- Productivity and effectiveness

Petabyte storage cost 2010=$80,000 2020=$4. I suspect that the electricity to run it will cost more. #CMLS2015

4G … 1400-fold faster
5G … 100X faster than 4G (Download movies in second vs minutes) by 2020



Internet of Things

- 6.4b connected things in use in 2016 – up 30% from 2015 (Gartner)
- IoT will grow from 2 billion “things” to 200 billion by 2020 (Intel)
- 10-15 devices per hospital bed

Old -- But we are still having trouble implementing the 20th century

WEDI-Con Session title:

- “Why hasn’t the increase in Eligibility & Benefits transactions resulted in a reduction in phone calls?

NCVHS Testimony

Value

The eligibility transaction is a key to the success of the claim payment cycle. The survey results showed that the expected benefits have not been realized by stakeholders.

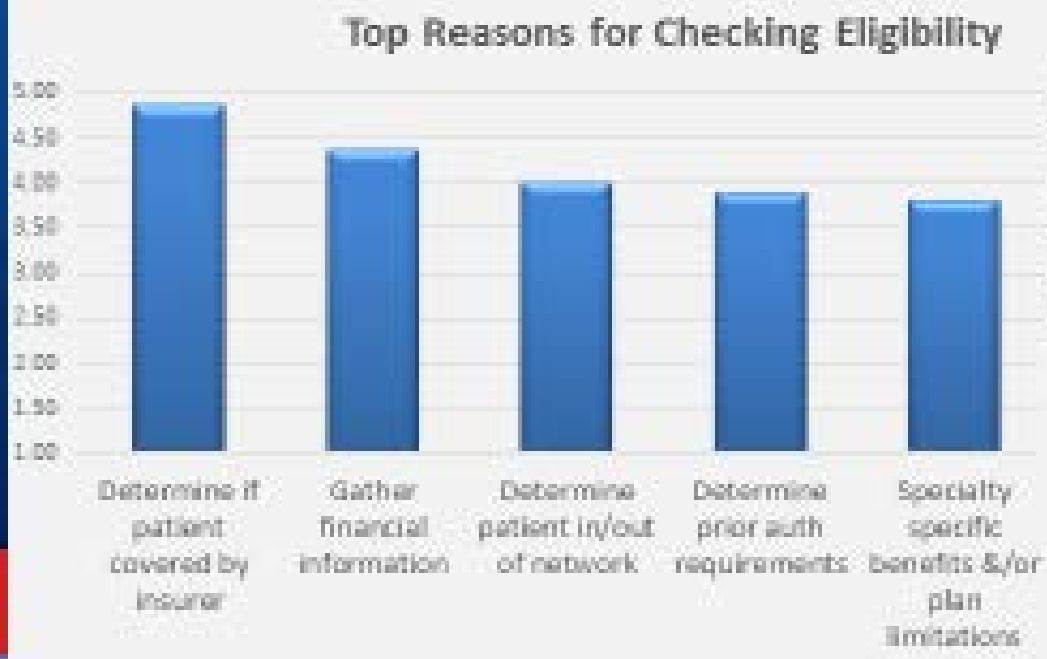
- The current transaction does not support the information needed for automating the eligibility process.
- Results in providers using web portal or phone applications to obtain more detail eligibility information.

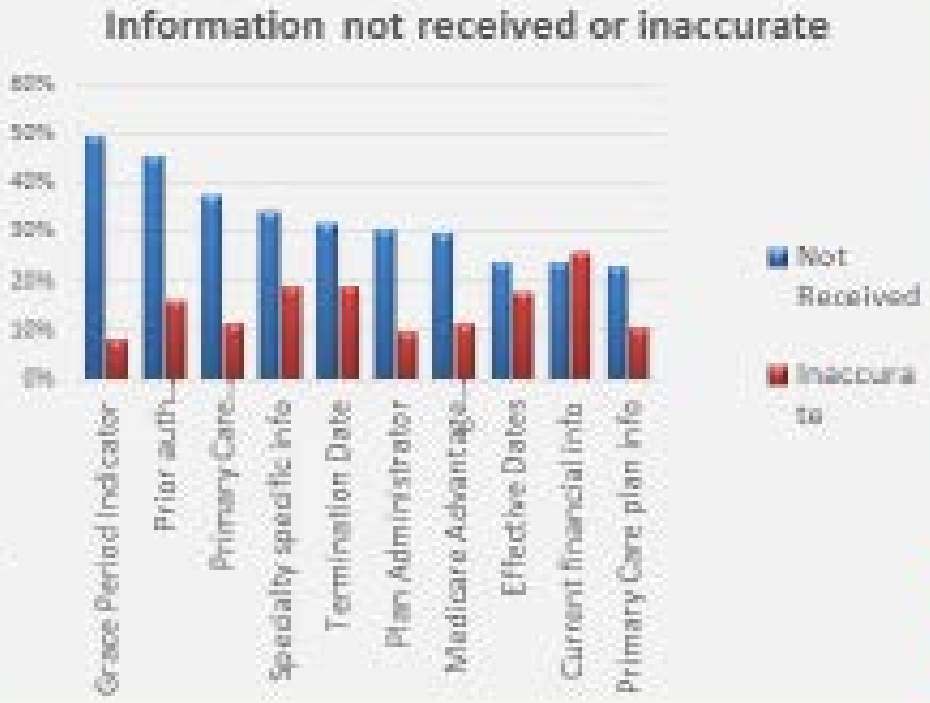
Findings:

27% of respondents continue to struggle getting accurate information through electronic eligibility checks through their Practice Management system

87% still find the need to occasionally, frequently or always utilize secondary methods to gather more detailed, accurate or current information.

To identify the areas we want to focus on for improvement, we'll take a look back at the reasons practices check eligibility compared to what's missing or inaccurate:





Barriers

- Lack of real time response and/or detailed responses due to payer disparate systems
- Does not meet business need, requiring providers to leave their workflow to make costly phone calls and access web portals.
- Payers do not provide CPT/HCPCS code level benefit detail.
- CPT/HCPCS code level benefit detail requests allow payers to provide upfront authorization or referral information.
- Complex benefits such as tiered benefits/narrow networks are not always supported.
- PMS may not provide capability or integrated user interface to automate workflow.

With more exposure, increased concerns whether data is current, accurate

Due to high cost of procedures/services and higher POS cost sharing at point of service, providers double and triple check – Is this patient covered? What is his/her out of pocket cost?

NCVHS -Opportunities/Recommendations

- Many barriers today are addressed in the next iteration of the ASC X12 270/271 transaction
- Provide transparency leading to automation, including what role each organization plays in the patients healthcare
  - The entity with primary financial responsibility for paying the claim
  - The entity responsible for administrating the claim
  - The entity that has the direct contact with the healthcare provider
  - The specific fee schedule that applies to the claim
  - The specific plan/product type
  - The location where the claim is to be sent and any secondary/tertiary payers

Opportunities/Recommendations

- Encourage payers to respond to HCPCS/CPT eligibility requests and provide benefit information, authorization requirements and referral requirements.
- Encourage PMS systems to become HIPAA covered entities and subject to the HIPAA TCS rule. Require capability to send/receive eligibility transactions and automate the use of this information within the workflow.
- WEDI facilitate an industry forum for stakeholders to address identified barriers and strategies for remediation
- Further research to be completed to confirm the next HIPAA version will remove the industry identified barriers and ensure ROI before adopting.

Other examples of implementing 20th century

- Electronic attachments via v6020 275
  - NGS pilot for Medicare part B
  - Currently supports unsolicited attachments for surgical procedures with modifier 22 (“work required to provide a service is substantially greater than typically required”) or modifier 62 (“Two surgeons are required to perform a specific procedure”)
- 278 for prior authorization (Humana-athenahealth pilot)

Old being updated – SSN replaced by Medicare Beneficiary Identifier (MBI)

SSN removal:

- all Medicare cards with the new Medicare Beneficiary Identifier (MBI) by April 2019
- Assign 150 million MBI's in the initial enumeration (60 million active and 90 million decease/archived) and generate a unique MBI for each new Medicare beneficiary

Medicare Beneficiary Identifier (MBI)

- New Non-Intelligent Unique Identifier
- 11 bytes
- Key positions 2, 5, 8, and 9 will always be alphabetic

Key	Example
SSA HICN	123-45-6789-A1
MBI	1EG4-TE5-MK73

Questions to Consider

Current Operational Processes

- When do you ask for the Medicare card and what do you use Medicare card and HICN for?
- How have you handled mass patient identification changes with other insurers?
- How do you currently handle Health Insurance Claim Number (HICN) and name changes?
- Who do you exchange the HICN with?
- What transactions do you use the HICN on?
- Where do you store the HICN?

Patient Interactions

- How often does a patient not have their Medicare card OR does not know their HICN?
- What do you do when the patient does not have their Medicare card OR does not know their HICN?
- Do your patients usually bring their health insurance cards with them (Medicare or other patients)?
- Without a HICN, what is the percentage of beneficiaries who are denied services?

- **IN THE FUTURE:**
- If the patient is unable to provide you with a MBI, what will you do to ensure they can get the services they need at that visit?
- What is the impact on the patient who needs service immediately and for whom you don't have an MBI?
- What would you do if a patient has their MBI from a prior visit but not for the current visit?
- What is the percentage of beneficiaries that will be denied services if you cannot obtain their MBI?

Questions to Consider

Implementation

- What systems and business process impacts do you expect given the change from HICN to MBI?
- How much time do you need to implement these changes?
- What other systems issues/implementation are also occurring during the same timeframe?
- How do we need to communicate information to you?
- What are some critical success factors or readiness factors for you?
- What performance metrics will reflect a successful SSNRI implementation?
- What outreach and training will you need to perform to be ready?

Patient Communication

- How do you think this change will affect your patients?
- How do you suggest we communicate with patients about the new card and the associated changes?

New -- Setting the world on FHIR?

A possible alternative –

- Demonstration of FHIR® – Fast Healthcare Interoperability Resources for claims attachments
  - FHIR is a “next generation standards framework created by HL7,” and “is designed to enable information exchange to support the provision of healthcare in a wide variety of settings.”

Old, with a new twist -- Technology may be great but …

Emerging Risks- Technological

Cybersecurity (Cyber Attacks)

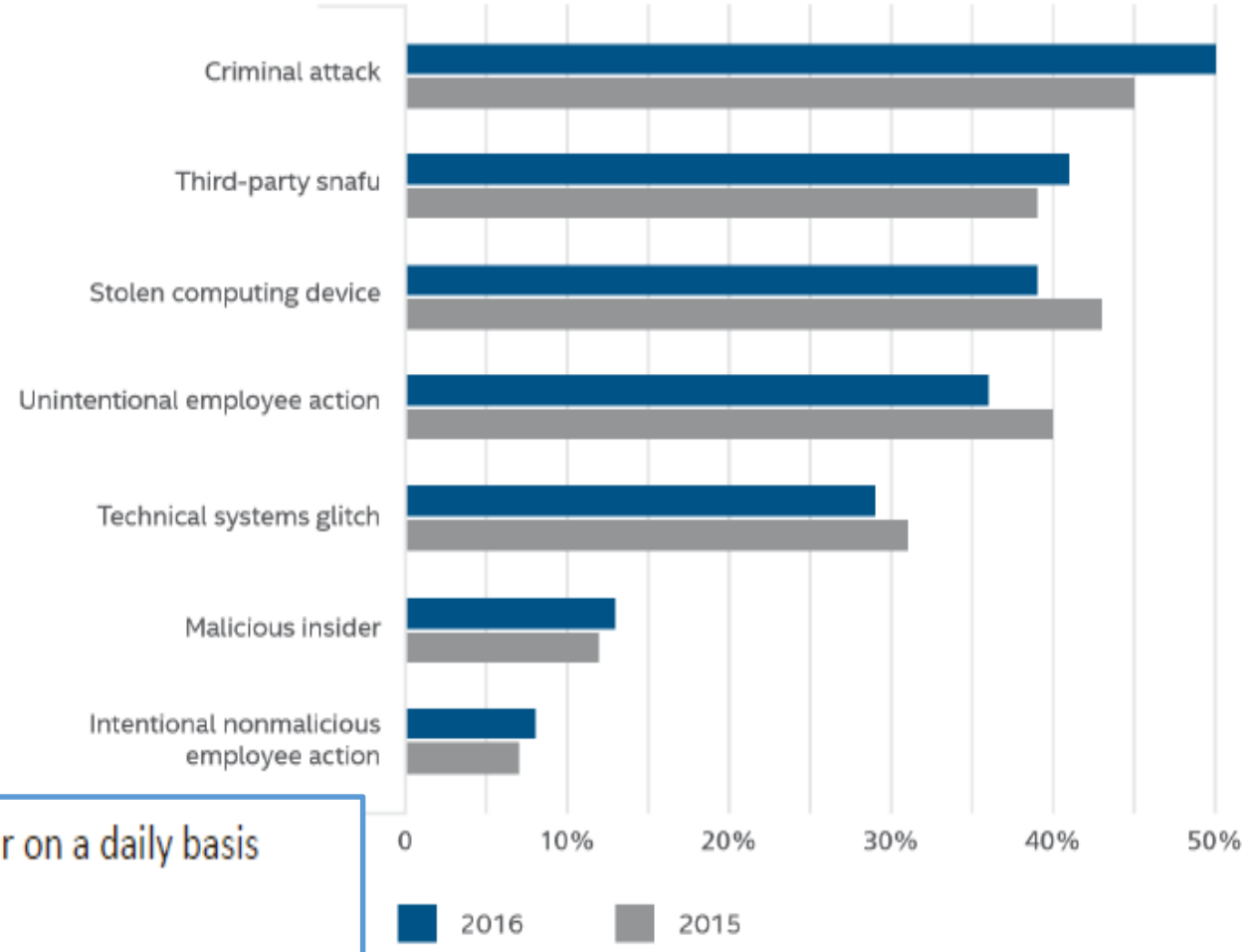
Some of the risks that entities face in this realm include:

- Legal liability
- Computer security breaches
- Privacy breaches
- Cyber theft
- Cyber espionage and cyber spying
- Cyber extortion
- Cyber terrorism
- Loss of revenue
- Recovery of costs
- Reputational damage
- Business continuity/supply chain disruptions
- Cyber threats to infrastructure

Emerging Risks- Healthcare Sector

Source: Experian 2016 Data Breach Industry Forecast

Top Causes of Breaches in Healthcare



Benchmark Study on Privacy & Security of Healthcare Data, May 2016, Ponemon Institute.

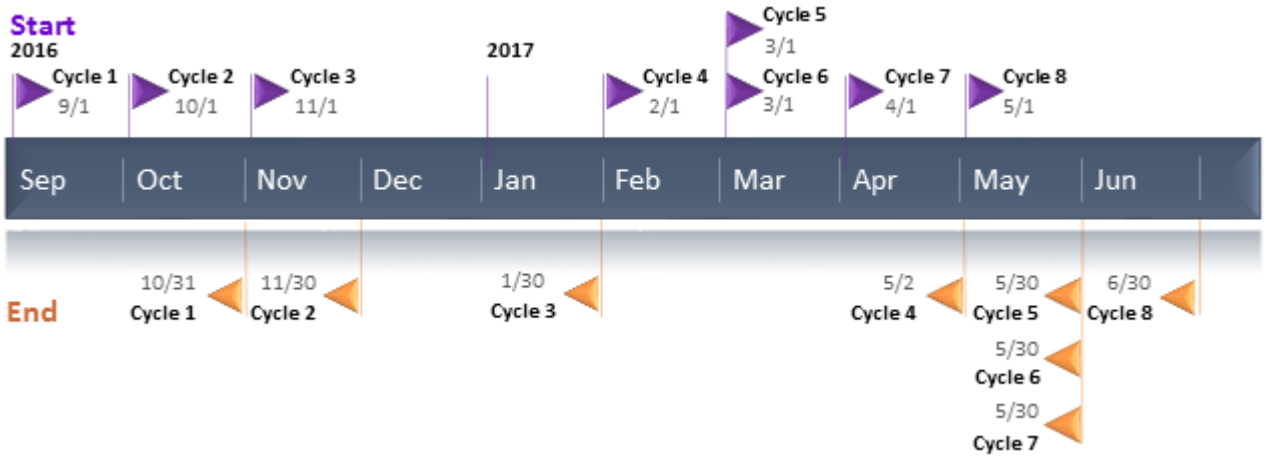
- In 2016, as of June, there are 4,000 ransomware attacks that occur on a daily basis *(Symantec Security Response)*
  - A 300% increase from 2015; 2015 had 1,000 attacks per day
  - Targets home users, businesses, and government networks

- IoT will bring added challenges to protecting patient information on top of an already challenge environment:
  - New avenues for hackers to attack
  - Connecting to devices for which security updates are no longer being made
  - More medical devices which is attacked could increase chances of patient harm

What's New

Revised X12 Public Comment Period Timeline for X12N 7030™ Technical Reports

X12's Insurance Subcommittee (X12N) has revised the schedule for public review and comment periods related to the 007030 counterparts to the HIPAA-adopted transactions and related Type 3 Technical Reports (TR3s) as follows:



The TR3s associated with HIPAA covered transactions are denoted with an asterisk.

- Cycle 3's review period has been extended through January 30, 2017, providing 30 additional days for review and comment
- Cycle 4 now begins February 1, 2017, rather than December 1, 2016 and will run for 90 days, closing May 2, 2017
- Cycles 5 and 6 will now run simultaneously, starting March 1, 2017 and will run for 90 days, closing May 30, 2017
- Cycles 7 and 8 are unchanged, with Cycle 7 starting April 1, 2017, closing May 30, 2017 and Cycle 8 starting May 1, 2017, closing June 30, 2017

Cycle 1: September 1 through October 31, 2016

- 007030X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)*
- 007030X345 Health Insurance Exchange Related Payments (820)
- 007030X333 Benefit Enrollment and Maintenance (834)*
- 007030X346 Health Insurance Exchange: Enrollment (834)

Cycle 2: October 1 through November 30, 2016

- 007030X329 Health Care Claim Status Request and Response (276/277)*
- 007030X330 Health Care Claim Acknowledgment (277CA)
- 007030X331 Health Care Claim Pending Status Information (277P)
- 007030X335 Implementation Acknowledgment for Health Care Insurance (999)

Cycle 3: November 1, 2016 through January 30, 2017

- 007030X322 Health Care Claim Payment/Advice (835)*

Cycle 4: February 1 through May 2, 2017

- 007030X323 Health Care Claim: Professional (837P)*
- 007030X324 Health Care Claim: Institutional (837I)*
- 007030X325 Health Care Claim: Dental (837D)*
- 007030X326 Health Care Service: Data Reporting (837R)

Cycle 5: March 1 through May 30, 2017

- 007030X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)*

Cycle 6: March 1 through May 30, 2017

- 007030X327 Health Care Services Review Inquiry and Response (278)
- 007030X328 Health Care Services Review - Notification and Acknowledgment (278)
- 007030X342 Health Care Services Request for Review and Response (278)*

Cycle 7: April 1 through May 30, 2017

- 007030X321 Application Reporting for Insurance (824)
- 007030X340 Health Care Claim Request for Additional Information (277RFI)
- 007030X341 Additional Information to Support a Health Care Claim or Encounter (275)
- 007030X343 Additional Information to Support a Health Care Services Review (275)

Cycle 8: May 1 through June 30, 2017

- 007030X339 Health Care Fee Schedule (832)

Questions may be directed to info@x12.org.