Meeting Information:	**AUC Operations Committee Meeting** ***Teleconference and WebEx Only*** **January 22, 2013** **9:00 A.M. – 11:00 A.M.**
Dial-in Number:	**1-605-475-5950** (Callers are responsible for their long distance charges to this number.)
Participant Access Code:	**337213**
WebEx Access Instructions:	1. Click or copy the link in your browser: https://health-state-mn-ustraining.webex.com. 2. Under "Attend a Session", click **Live Sessions** (if page is not displayed). 3. Click on the session **AUC Operations Committee Webinar** 4. Click **Join Now**. 5. Enter the Password **Ops2010!** (The password is case sensitive and the exclamation point is part of the password.)

What's coming down the pike?

Background and information to aid AUC planning

An introductory informational webinar

January 22, 2013

Overview

- This is the first of two sessions to aid AUC planning
  - January 22, 2013 webinar
    - Provide common information, education
      - What's coming down the pike?
      - Other interests, needs, priorities?
  - February 19, 2013 AUC Operations meeting
    - Develop work plan and priorities for 2013
      - Focus, priorities
      - Timeline and deadlines, organization and delegation

Today's session (Jan. 22)

- Housekeeping -- Requests, suggestions to aid this webinar format
  - Please participate -- You will have opportunities along the way to ask questions and provide comments
    - Send us questions or comments
  - As a courtesy to others, please mute your phone unless you are deliberately speaking to the group
    - Press *6 on your phone to mute and unmute the line
    - **Please do not put your phone on hold**
  - The photo of a gearshift knob on some slides indicates a shift in the presentation to a new focus or topic.

Today's session (Jan. 22)

- Overview
- Purpose
  - Set the stage for February 19 AUC work planning
    - Common background, education, information
      - What's coming down the pike
        - » Federal and national
        - » State and local
        - » Near term and longer term
    - Other needs, priorities, interests
  - <u>This outline is a draft based on preliminary discussion with the AUC Exec Committee. We want to hear from you.</u>

What's coming down the pike

- Affordable Care Act (ACA) and other related federal laws/rules
  - Supreme Court decision, national elections over
    - Implementation underway and in many cases now accelerating
    - Direct and indirect impacts on administrative simplification
- State-specific reforms and activity
- Current and ongoing AUC activities
- Other?

ACA and related rules

- Section 1104 – Administrative Simplification
  - Most visible, direct impact for AUC
    - Adoption of operating rules for HIPAA standard transactions
    - Adoption of additional rules for:
      - Health Plan Identifier
      - Standard for Electronic Funds Transfer (EFT)
      - Claims Attachments
    - Requirements for health plan certification of compliance and provisions for fines and penalties for noncompliance

Some Implications of §1104 for AUC

- Need/opportunity/desire for AUC to contribute to/shape national decisions
- Possible impacts on MN Uniform Companion Guides (MUCGs) and their implementation, compliance/enforcement
- Demands on available bandwidth, resources
- Other?

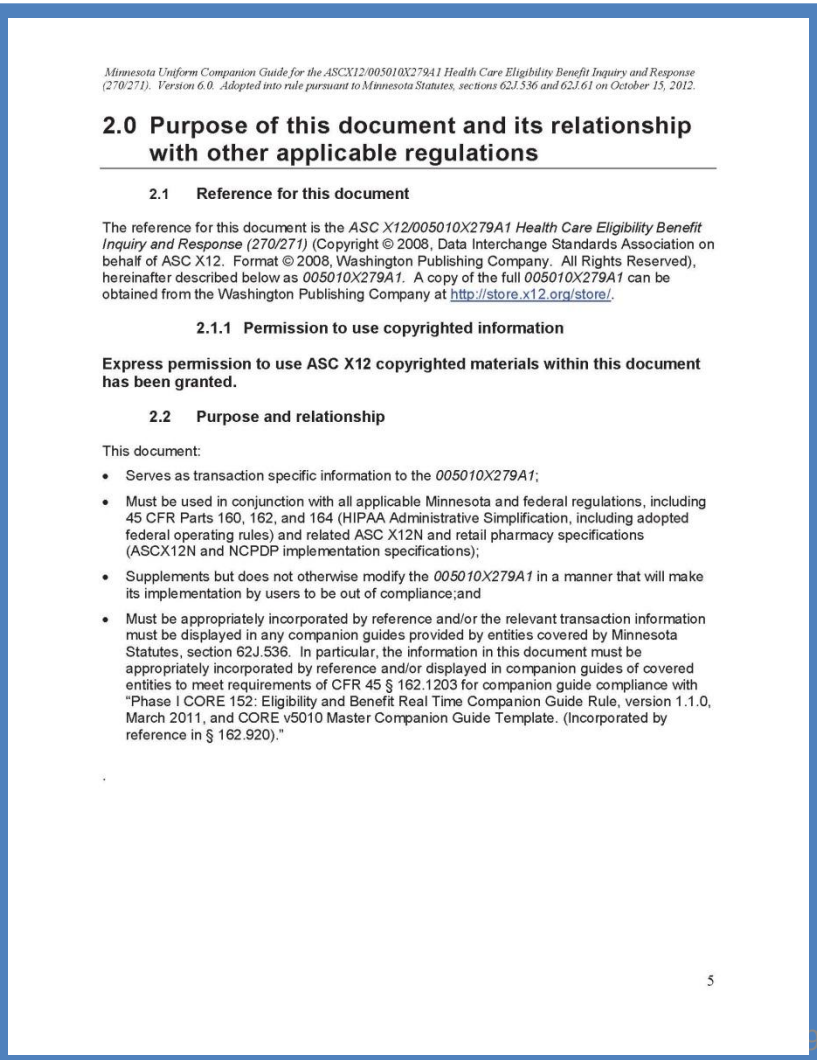
Operating rules timeline

HIPAA Standard Transaction	Rule to be Adopted By	Health Plan Certification Date http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/ComplianceCertificationandPenalties.html
Eligibility*	July 1, 2011	December 31, 2013
Claims Status	July 1, 2011	December 31, 2013
EFT *(new standard)*	July 1, 2012	December 31, 2013
ERA*	July 1, 2012	December 31, 2013
Health care claim attachment *(new standard)*	January 1, 2014	December 31, 2015
Claims/encounter information*	July 1, 2014	December 31, 2015
Health plan enrollment/disenrollment	July 1, 2014	December 31, 2015
Health plan premium payment	July 1, 2014	December 31, 2015
Referral certification and authorization	July 1, 2014	December 31, 2015

* -- Indicates transaction is required by Minn. Statutes, section 62J.536

General MUCG Approach to Operating Rules

- **MUCGs state that if companion guides are produced, they must be consistent with applicable state and federal requirements**
  - **Use common companion guide template if applicable**
  - **Incorporate directly or by reference the relevant MUCG information in other companion guides**



Minnesota Uniform Companion Guide for the ASCX12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271). Version 6.0. Adopted into rule pursuant to Minnesota Statutes, sections 62J.536 and 62J.61 on October 15, 2012.

2.0 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document is the *ASC X12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, Washington Publishing Company. All Rights Reserved), hereinafter described below as *005010X279A1*. A copy of the full *005010X279A1* can be obtained from the Washington Publishing Company at http://store.x12.org/store/.

2.1.1 Permission to use copyrighted information

Express permission to use ASC X12 copyrighted materials within this document has been granted.

2.2 Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X279A1*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements but does not otherwise modify the *005010X279A1* in a manner that will make its implementation by users to be out of compliance;and
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities covered by Minnesota Statutes, section 62J.536. In particular, the information in this document must be appropriately incorporated by reference and/or displayed in companion guides of covered entities to meet requirements of CFR 45 § 162.1203 for companion guide compliance with "Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide Rule, version 1.1.0, March 2011, and CORE v5010 Master Companion Guide Template. (Incorporated by reference in § 162.920)."

5

Additional §1104 rules

Health Plan Identifier (HPID)

Provision	Date
Health plans other than small health plans must obtain HPID	Nov. 5, 2014
Small health plans must obtain HPID	Nov. 5, 2015
All covered entities are required to use HPIDs in the standard transaction	**Nov. 7, 2016**

Special Focus – Health Plan Identifier (HPID)

- Summary overview of HPID from CMS presentation
  - CMS information and presentation available at:
    - http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html
  - AUC previously held special meeting to review HPID and submit comments

What is the Purpose of the HPID?

- Required to be used in the standard transactions to identify a health plan that has an HPID
- Allowed to be used for any other lawful purpose

Who is Required to Get the HPID?

- Health plans as defined by 45 CFR 160.103
- Controlling health plan (CHP) vs. Subhealth plan (SHP)

Entity	Enumeration Requirements	Enumerations Options
CHPs	Must get an HPID for itself	• May get an HPID(s) for its SHP(s) • May direct its SHP(s) to get HPID(s)
SHPs	Not required to get an HPID	• May get an HPID at the direction of its CHP • May get an HPID of its own initiative

Definitions

- Controlling health plan (CHP)
  - A health plan (as defined at 45 CFR 160.103) that—
    - (1) controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan
    - (2) and if it has a subhealth plan(s) (SHPs), exercises sufficient control over the subhealth plan(s) to direct its/their business activities, actions, or policies.

From: HPID Final Rule, at: http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf

Definitions

- Subhealth plan (SHP)
  - A SHP would mean a health plan (as defined in 45 CFR 160.103) whose business activities, actions, or policies are directed by a CHP.

From: HPID Final Rule, at: http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf

What is the Timeline for Compliance with the Regulation?

Entity Type	Compliance Date for Obtaining HPID	Full Implementation Date for Using HPID in Standard Transactions
Health Plans, excluding small health plans	November 5, 2014	November 7, 2016
Small Health Plans	November 5, 2015	November 7, 2016
Covered Healthcare Providers	N/A	November 7, 2016
Healthcare Clearinghouses	N/A	November 7, 2016

What is the Other Entity Identifier

- Voluntary Identifier
- Must meet following requirements:
  - Needs to be identified in the standard transactions
  - Is NOT eligible to obtain an NPI
  - Is NOT eligible to obtain an HPID
  - Is NOT an individual

What does this final rule NOT require?

- Does not require that health plans now be identified in the standard transactions if they were not identified before this rule
  - For instance, TPA is not now required to identify a self-insured health plan in the standards transactions if the TPA did not identify it prior to this rule

Example

- ASC X12 Version 5010 health care eligibility benefit inquiry and response (the 271)
- Segment is the NM1 – Information Source Name in the 2100 A loop – Information Source
- "The information source is the entity that has the answer to the questions being asked in a 270 Eligibility or Benefit request transaction. The information source is typically the insurer or payer….Regardless of the information source's actual role in the health care system, they are the entity who maintains the information regarding the patient's coverage."
- The information source could be a health plan or it could be a third party administrator (TPA).

Example Cont.

- If covered entity is currently identifying a health plan as the information source, the covered entity will be required to use an HPID to identify that health plan as the information source by November 7, 2016.

- If a covered entity is currently identifying a TPA as the information source, the covered entity can continue to identify that TPA as the information source using whatever identifier the TPA uses (or an OEID) after the adoption of the HPID.

Example of use of HPID

Reference Description	Name	Code	Definition	Content of Field before HPID	Content of Field after HPID
NM101	Entity Identifier Code	2B 36 GP P5 PR	Third Party Administrator Employer Gateway Provider Plan Sponsor Payer	If health plan is identified as information source, then "PR"	If health plan is identified as information source, then "PR"
NM108	Identification Code Qualifier	24 46 FI NI PI XV XX	Employer Identification (EIN) Electronic Transmitter Identification (ETIN) Federal Taxpayer's Identification Number NAIC number Payer Identification CMS Plan ID CMS Provider Identifier	If a health plan is to be identified as the information source, 24, 46, FI, NI, or PI can be use.	If a health plan is to be identified as the information source, ONLY XV can be used.
NM109	Identification Code			Depending on the qualifier this could be the EIN, ETIN, TaxID, NAIC, or proprietary ID	HPID ONLY (if a health plan is to be identified as the information source)

Register for a New Account

HIOS Sign in: https://insuranceoversight.hhs.gov/

Accessing HPOES

Login Page


Health Insurance Oversight System
Friday, September 21, 2012
Sign-In
* Indicates required fields.
*User Name:
*Password:
Forgot Password?
Register for New Account
Type the letters you see in the image into the Word Verification field below. If you are unable to read the image pictured below, please select the Play Audio Code link for audio verification
*Word Verification: Please enter the letters you see in the image. If you use the Audio Verification, type the pronounced numbers and the first letter of each word.
SSQTC
Can't read it?
Generate New Image
Play Audio Code
Log In
Accessibility | Rules of Behavior | Web Policies | File Formats and Plug-Ins
U.S. Department of Health & Human Services - 200 Independence Avenue, S.W. - Washington, D.C. 20201

HIOS Portal Home Page

Questions and Issues re. HPID

- Relationship to X12 transactions?
  - Qualifier needed?
- Other?

Other ACA provisions

- Payment methodologies
  - Accountable Care Organizations (ACOs)
  - Medical Home
  - Bundled payments
- Coverage and access
  - Health insurance exchanges, subsidies, Medicaid expansion
- Other

ACOs

- Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
  - **Implementation**: January 1, 2012

From: Kaiser Family Foundation, http://healthreform.kff.org/timeline.aspx

Medical Home

- New Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home
  - Provides states taking up the option with 90% federal matching payments for two years for health home-related services.
  - **Implementation:** January 1, 2011

From: Kaiser Family Foundation, http://healthreform.kff.org/timeline.aspx

Bundled Payments

- From KFF
  - Medicaid Payment Demonstration Projects -- Creates new demonstration projects in Medicaid for up to eight states to pay bundled payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in cost-savings.
    - **Implementation:** January 1, 2012 through December 31, 2016
  - Medicare Bundled Payment Pilot Program -- Establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.
    - **Implementation:** January 1, 2013

From: Kaiser Family Foundation, http://healthreform.kff.org/timeline.aspx

Possible Implications for AUC

- Possible new codes for services, education/information regarding coding
- Need/opportunity/desire for AUC to contribute to/shape national decisions
- Possible impacts on MN Uniform Companion Guides (MUCGs) and their implementation, compliance/enforcement
- Demands on available bandwidth, resources
- Other?

ACA Coverage and Access

- Implications for AUC?

ICD-10

- All “covered entities”—as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—are required to adopt ICD-10 codes for use in all HIPAA transactions with dates of service on or after the [**October 1, 2014**] compliance date

From: CMS, at: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10LargePracticeHandbook.pdf (updated for revised compliance date)

What is ICD-10?

- The World Health Organization (WHO) publishes the International Classification of Diseases (ICD) code set, which defines diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.

- In 1990, the WHO updated its international version of the ICD-10 (Tenth Edition, Clinical Modification) code set for mortality reporting. Other countries began adopting ICD-10 in 1994, but the United States only partially adopted ICD-10 in 1999 for mortality reporting.

From: CMS, at: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10LargePracticeHandbook.pdf

What is ICD-9?

- Currently, the United States uses the ICD code set, Ninth Edition (ICD-9), originally published in 1977, in the following forms:
  - ICD-9-CM (Clinical Modification), used in all health care settings
  - ICD-9-PCS (Procedure Coding System), used only in inpatient hospital settings

From: CMS, at: http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10LargePracticeHandbook.pdf

Why the switch from ICD-9 to ICD-10?

- **ICD-9-CM limits operations, reporting, and analytics processes because it:**
  - Follows a 1970s outdated medical coding system
  - Lacks clinical specificity to process claims and reimbursement accurately
  - Fails to capture detailed health care data analytics
  - Limits the characters available (3-5) to account for complexity and severity

From: http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD10SmallandMediumPractices508.pdf

Advantages of ICD-10

- **ICD-10 codes refine and improve operational capabilities and processing, including:**
  - Detailed health reporting and analytics: cost, utilization, and outcomes;
  - Detailed information on condition, severity, comorbidities, complications, and location;
  - Expanded coding flexibility by increasing code length to seven characters; and
  - Improved operational processes across health care industry by classifying detail within codes to accurately process payments and reimbursements.

From: http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD10SmallandMediumPractices508.pdf

CMS FAQs re. ICD-10

1. What does ICD-10 compliance mean?

- *ICD-10 compliance means that everyone covered by HIPAA is able to successfully conduct health care transactions using ICD-10 codes.*

2. Will ICD-10 replace Current Procedural Terminology (CPT) procedure coding?

- *No. The switch to ICD-10 does not affect CPT coding for outpatient procedures. Like ICD-9 procedure codes, ICD-10- PCS codes are for hospital inpatient procedures only.*

3. Who is affected by the transition to ICD-10? If I don't deal with Medicare claims, will I have to transition?

- *Everyone covered by HIPAA must transition to ICD-10. This includes providers and payers who do not deal with Medicare claims.*

From: CMS, http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10FAQs.pdf

CMS FAQs re. ICD-10

4. Do state Medicaid programs need to transition to ICD-10?

- *Yes. Like everyone else covered by HIPAA, state Medicaid programs must comply with ICD-10.*

5. What happens if I don't switch to ICD-10?

- *Claims for all services and hospital inpatient procedures performed on or after the compliance deadline must use ICD- 10 diagnosis and inpatient procedure codes. (This does not apply to CPT coding for outpatient procedures.) Claims that do not use ICD-10 diagnosis and inpatient procedure codes cannot be processed. It is important to note, however, that claims for services and inpatient procedures provided before the compliance date must use ICD-9 codes.*

From: CMS, http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10FAQs.pdf

More CMS FAQs

6. If I transition early to ICD-10, will CMS be able to process my claims?

- *No. CMS and other payers will not be able to process claims using ICD-10 until the compliance date. However, providers should expect ICD-10 testing to take up to 19 months.*

7. Codes change every year, so why is the transition to ICD-10 any different from the annual code changes?

- *ICD-10 codes are different from ICD-9 codes and have a completely different structure. Currently, ICD-9 codes are mostly numeric and have 3 to 5 digits. ICD-10 codes are alphanumeric and contain 3 to 7 characters. ICD-10 is more robust and descriptive with "one-to-many" matches in some instances.*
- *Like ICD-9 codes, ICD-10 codes will be updated every year.*

From: CMS, http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10FAQs.pdf

Implications for AUC

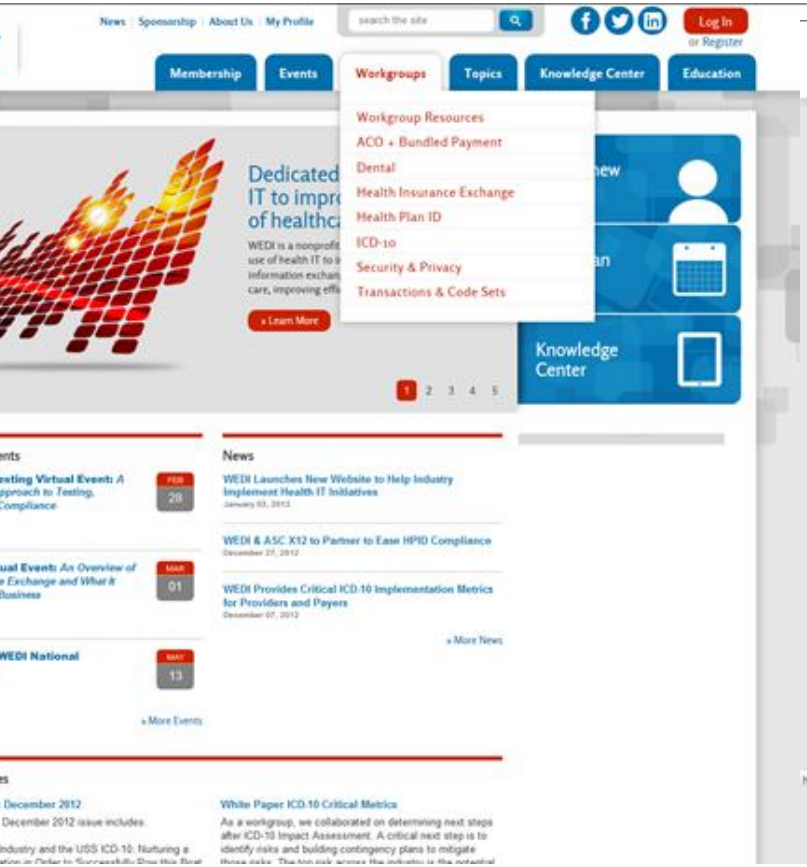
- ??
- Bandwidth – resources

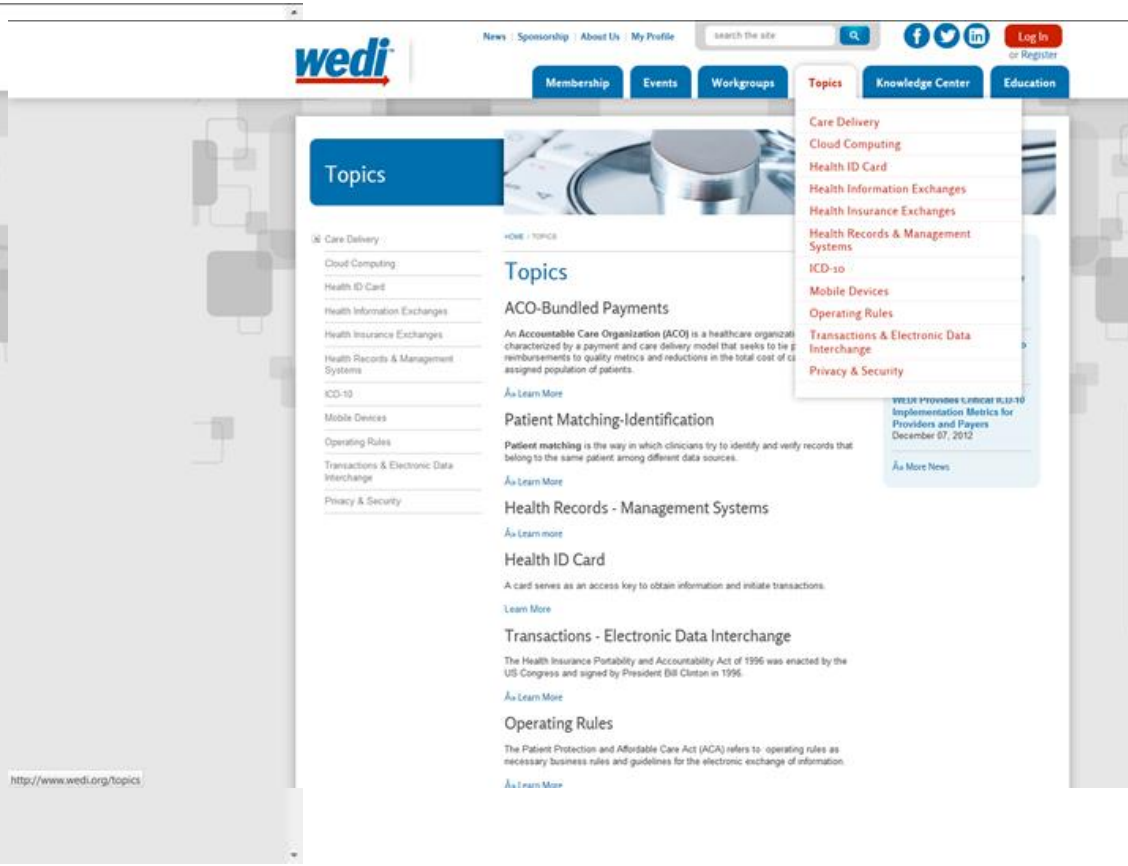
National Actors and Activity to Keep In Mind

- **X12**
- **CORE**
- **NCVHS**
- **WEDI**
- **CMS**
- **NCPDP**
- **Others**

National Actors and Activity

- Note new WEDI website and activity





National Actors and Activity

- **Collaboration, cross-fertilization example**

WEDI & ASC X12 to Partner to Ease HPID Compliance
December 27, 2012

"The Workgroup for Electronic Data Interchange (WEDI) and ASC X12 announced today they are working together to prepare the industry for a smooth Health Plan ID (HPID) implementation. …

WEDI has formed a Health Plan ID workgroup whose goals include identifying the activities, risks, solutions and educational opportunities to support implementation of HPID for all industry stakeholders.

ASC X12N's Entity Workgroup is evaluating whether the HPID mandate impacts the ASC X12 version 005010 Technical Report Type 3 (TR3) implementation guides. …

From: http://www.wedi.org/news/press-releases/2012/12/27/wedi-asc-x12-to-partner-to-ease-hpid-compliance

National Actors and Activity

- **Collaboration, cross-fertilization example (cont.)**

WEDI & ASC X12 to Partner to Ease HPID Compliance
December 27, 2012

"…WEDI and ASC X12 will host a joint webinar addressing industry questions about the impact of HPID on the HIPAA adopted ASC X12 TR3s. Watch for more details soon.

In addition, WEDI is planning a number of educational offerings to help industry prepare for HPID implementation, including a virtual event in June 2013.

If you are interested in participating in the ASC X12 Entity Workgroup, please send an email to info@disa.org with the subject "X12N Entity Workgroup" and participation information will be provided. "

From: http://www.wedi.org/news/press-releases/2012/12/27/wedi-asc-x12-to-partner-to-ease-hpid-compliance

Possible Implications for AUC

- Need/opportunity/desire for AUC to contribute to/shape national decisions
- Demands on available bandwidth, resources
- Other?

State and Local

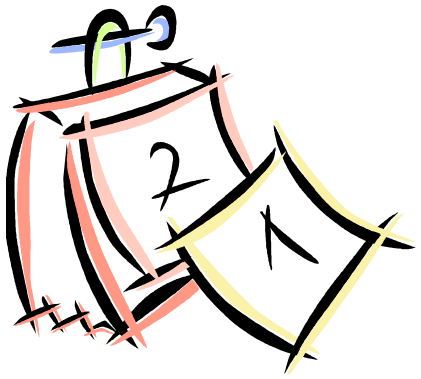
- As discussed -- maintenance, administration, and enforcement of MUCGs
- Response to state legislation
- Other?

Ongoing AUC activities and process

- MUCG “annual maintenance” and updates
  - SBARs and work requests
  - Best practices and coding clarifications
- Discussions and forums
  - Comments and requests to X12, NCVHS, CMS, NUBC, NUCC, etc.
- Response to state legislation and rules
- Other?

Current AUC Organization and Schedule

- AUC Operations
  - Meets quarterly and as needed
- AUC Executive Committee
  - Meets monthly
- TAGs
  - Meet monthly
- Other, ad hoc
  - As needed



Possible implications for AUC

- Priorities
- Process
- Bandwidth and resources
- Other?

Questions, suggestions

Thank you. See you February 19.

- Part 2 of planning exercise -- AUC Operations meeting on February 19, 2013.
- Purpose:
  - Develop priorities and work plan for 2013 (and beyond)