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COMPLIANCE PERSPECTIVES

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Administrative Simplification Requires Interoperability, New Financial Management Platforms

Administrative simplification has an aggressive timetable, with far-reaching consequences for laboratories, providers, and payers and new demands for information exchange and technology infrastructures.

The administrative simplification provision under Section 1104 of the Patient Protection and Affordable Care Act requires new operating rules that improve the exchange and standardization of electronic data transactions governed by the Health Insurance Portability and Accountability Act (HIPAA). The goal of the provision is to specify how HIPAA standards should be implemented across the health care system to reduce administrative costs, create uniformity in transaction processing, and improve efficiency by reducing the clerical burden on patients, providers, and payers.

The Department of Health and Human Services (HHS) estimates that 12 percent of every dollar received from patients goes to "cover the cost of excessive administrative complexity" and that the new operating rules have the potential to save providers and health plans $13 billion to $15 billion over the next 10 years.

The operating rules supplement existing HIPAA transactions and guidelines (ASC X12 version 5010) and govern compliance by covered entities such as payers, health care clearinghouses, and certain health care providers conducting electronic administrative transactions. The new operating rules are intended to further improve interoperability, including real-time, Internet-based transactions for eligibility verification and claim status, as well as changes to electronic funds transfers (EFTs), and electronic remittance advices (ERAs).

HHS selected the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) to develop several sets of operating rules. The rules define responsibilities, transaction formats, and other requirements for electronic information exchange between payers and providers. The rules were released in separate "Phase" documents. Phase I focuses on the patient

eligibility transaction, and Phase II adds rules for the claims status transaction plus additional rules regarding patient matching, infrastructure requirements, and connectivity for both eligibility and claims status. Phase III introduces new rules regarding the use of CARCs (claim adjustment reason codes) and RARCs (remittance advice remark codes). Phase III also addresses EFT and ERA issues, such as requiring the electronic enrollment of EFT and ERA, and enhancing bank reconciliation.

The timetable required for health care administrative simplification is aggressive. The final operating rules will be phased in from 2012 through 2016 as follows:

Jan. 1, 2013: Point-of-care eligibility and claims status operating rules (Phases I and II)

Jan. 1, 2014: Electronic funds transfer and electronic remittance advice (Phase III)

Oct. 1, 2014: Implementation of ICD-10 coding set

Jan. 1, 2016: Claims and encounters, enrollment/disenrollment, premium payments, referral certification/authorization, and claim attachments

Point-of-Care Eligibility and Claims Status

Many health insurers are already compliant with the CAQH/CORE Phase I and II operating rule requirements regarding the information received from an electronic eligibility request and are electronically confirming patient benefit coverage, copays, coinsurance, and base deductibles at the point of care. This information helps estimate patient costs up front before the patient is treated and empowers providers with key information to discuss treatment options with patients. Eligibility also allows providers to collect patient deductibles and coinsurance immediately at the point of service.

The widespread, real-time availability of patient eligibility information reduces both the time and costs associated with administrative tasks. More importantly, real-time eligibility information enables more informed decisionmaking by providers. The key to this empowerment is timely access to data contained within the payers' systems.

With the effective date for Phases I and II already past, HHS is in position to impose penalties for noncompliance. However, CMS announced a 90-day period of enforcement discretion. This does not change the effective date; it only delays the penalties. Additionally, payers are required to file a statement with HHS certifying that their data and information systems are in compliance with all new standards and operating rules by Dec. 31, 2013. The certification date carries a separate penalty for noncompliance. Providers are strongly encouraged to reach out to payers, system software vendors, and clearinghouses to determine compliance with new operating rules.

Standards for Electronic Funds Transfer and Remittance Advice Transactions

Payers, providers, health care clearinghouses, and technology vendors use EFTs and ERAs to process and manage claims payments and claims remittance advice with the Automated Clearing House (ACH) network carrying the electronic payment information between providers and payers.

A significant challenge for health care providers is reconciling their bank statements with the payers' remittance advice. At issue is that the payment information from the bank may have to be processed manually because the EFT is not yet a mandated format. Even when an EFT is available, it is transmitted separately (over the ACH network) to the bank, while the ERA that explains the detail of services that have been paid is sent to the provider through electronic data interchange channels.

Another significant obstacle is that an ERA and an EFT may be separated from each other and from the payment effective remittance date by up to a day. Additionally, if either of the other transaction files is not received due to an error, it can take days to replace the missing file. This lack of synchronization in electronic information flow and reconciliation negatively impacts providers' financials as they try to manually reconcile the vast combination of manual checks, electronic funds transfers, explanations of benefits (EOBs) and ERAs in order to apply and book their cash receipts accurately and in compliance with Generally Accepted Accounting Principles.

HHS aims to streamline this process by requiring that a single electronic file format known as CCD+ be used by all health plans and that the CCD+ and ERA be transmitted within three business days of the payment effective entry date.

New CCD+ Format Required

The CCD+ format was adopted as the HIPAA standard format required to transmit an EFT transaction. The CCD+ format is a National Automated Clearing House Association ACH payment standard with a place specifically for the reassociation trace number from the ERA. For health care claims, the CCD+ provides a vast improvement over paper claims because the transaction reassociation trace number can now be linked to the EFT by the provider's accounts receivable (A/R) system.

Private-sector payers are required to use the CCD+ format with health care providers by Jan. 1, 2014, and are allowed to request that providers be able to accept ACH payments instead of paper checks. All Medicare payments are also required to eliminate paper check processing and move to using only ACH electronic payment by Jan. 1, 2014. Payers who do not comply with requests by providers to conduct EFT using the ACH network may be subject to fines.

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New Financial Technology Frameworks Needed

To be effective, administrative simplification will require the end-to-end electronic processing of financial management functions, and many providers will have to make upgrades or changes to their A/R and financial management technology infrastructure to compete in the marketplace. The operating rules allow providers to work with any vendor of choice.

There is no question that today's labor-intensive revenue cycle management (RCM) workflow needs to be streamlined and automated. For example, in many instances, a provider's clinical information and financial information is housed in two different information systems, requiring billing staff to compile data from disparate systems to process claims.

Traditional RCM systems that are accessible only by the billing department of the laboratory will be inadequate. Diagnostic service providers cannot effectively implement the operating rules or remain competitive if the data needed in their financial system is only accessible by a limited number of people, during 9-to-5 business hours. The RCM system must be accessible and interoperable in real time with other departmental systems in the health care setting. While traditional RCM systems have achieved some degree of interoperability, they often rely on batch updates at regular intervals (as opposed to real time), leading to lags in data accuracy between systems. Additionally, since most RCM systems are bill generators rather than financial accounting packages and thus lack financial controls and referential integrity, the quality of the data can also be questionable. Legacy system infrastructures cannot communicate in real time or be easily altered to integrate new information-sharing systems required of the new operating rules.

A more cost-effective approach is to implement next-generation financial management systems that can automatically query and exchange billing information with other systems in real time to optimize claims processing and A/R management. Using standard Internet interoperability and health care security protocols, next-generation financial management platforms enable information exchanges between disparate, distributed systems through use of cloud-based Web services. This interoperability enables a two-way conversation between systems regardless of source, operating system, or programming language.

This framework reduces workload on clerical and billing staff by reducing duplicate data entry and allowing access to up-to-date data in real-time as well as enabling self-service functionality.

Providers who invest in new financial system frameworks by 2014 will benefit tremendously from the accuracy, timeliness, and breadth of data available via real-time sources, eliminating significant back-office costs and streamlining workflow efficiency for improved net revenue.

IT Options

The A/R and financial management systems landscape has evolved significantly over the years. Traditional, off-the-shelf purchased software where the provider owns and maintains the software, rules, and data used by their internal billing staff continues to be an option, albeit one that is impossible to maintain at the level necessary to keep up with technology in our rapidly changing environment. Another option is a completely outsourced model whereby the provider contracts with a vendor to provide the billing staff; own and maintain the software, rules, and data; process claims on their behalf; and buffer the technology gap with manual labor.

Cloud-based, "Software-as-a-Service" is the model of the future that offers the best of both worlds, where the vendor retains management and continual development of

the system, and the provider's staff access it remotely via the Internet. This hosted model has a superior total cost of ownership requiring no up-front costs, capital expense, equipment or licenses, IT personnel costs, data centers, or maintenance, while still allowing internal staff daily, hands-on interaction. The management of electronic files is significantly reduced. Additionally, the software is always at the latest version with the most recent payer rules, settings, and regulatory configurations.

Implementation of administrative simplification will be challenging for all stakeholders.

The demands and competing administrative projects impacting the industry over the next several years—the transition to the new operating rules, including managing to the new HIPAA 5010 standards, migrating to new ICD-10 code sets, and complying with numerous regulatory mandates—will significantly impact both IT resources and billing staff. Providers will require extensive investments in training and financial management technology to ensure the compliance and interoperability needed for effective information exchange to be successful. Payers, too, will be required to invest in technology to enable the information exchange mandated by the operating rules.

Those that rethink the role offered by interoperable financial management systems that stay ahead of technology requirements will be poised to succeed in the health care system of tomorrow including active participation in high-quality data interchange, improved responsiveness to ongoing regulatory changes, and measurable financial gains.

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