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AUC Update

July 30, 2014

The AUC Update is published monthly and provides news and updates regarding the Minnesota Administrative Uniformity Committee (AUC) and Minnesota's health care administrative simplification initiative pursuant to Minnesota Statutes, section 62J.536 and related federal and state regulations. The Minnesota Department of Health (MDH) administers MS §62J.536 and publishes this newsletter in association with the AUC.

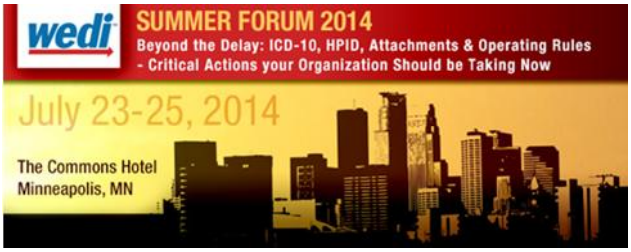
More information about the AUC is available at: AUC home page.

Inside this issue:

WEDI National Summer Forum Held in Minneapolis July 23-25

Weather was mild, but topics were hot

Participants from around the country at last week's Workgroup on Electronic Data Exchange (WEDI) Summer Forum, held in Minneapolis, were treated to unusually mild weather and balmy evenings. Inside however, as suggested by the title of the event, "Beyond the Delay: ICD-10, HPID, Attachments & Operating Rules - Critical Actions your Organization Should be Taking Now," there was often an urgency and concern among those watching the administrative simplification horizon.



As a result, the Forum's topics were hot ones and the discussion – like a late afternoon shower to clear the air on a muggy day -- was sometimes a little stormy.

The Forum included several listening sessions, to capture discussion on a range of topics, and to identify and better understand differences of opinion. Below is a brief sampler of some of the conversations and issues examined during the three days of the Forum's active learning and discussions.

Attachments: Structured vs. Unstructured

The Forum devoted a full day to learning about and discussing the development and adoption of a standard and operating rules for attachments as required by the Accountable Care Act (ACA). In particular, one of many areas of debate and questions focused on the development and use of "structured attachments" vs. "unstructured attachments."

As suggested by the name, structured attachments contain information that is structured to be machine readable. Unstructured attachments allow the exchange of unstructured documents such as scanned images (.pdf, .tiff, jpeg, etc.), Word documents, and others that ultimately require human viewing and interpretation.

As a listening session, there was plenty of feedback from the industry that emphasized two competing points of view. Those advocating for structured attachments pointed out that they were more consistent with goals to automate health care business transactions using computer-computer electronic data interchange (EDI). Others questioned the ability to implement structured attachments by the January 1, 2016 deadline set by the ACA, and whether they could fully replace the unstructured data often being exchanged in attachments at this time.

While the issues were not resolved last week, the Forum provided an opportunity to better understand and work through concerns in creating the attachments operating rules. Similarly, the Forum also encouraged further conversations on a number of other attachments-related issues, ranging from adherence to HIPAA data privacy provisions requiring the exchange of only "minimum necessary" data, to the integration of complementary X12 and HL7 data standards for the greatest flexibility and range of information sharing as part of attachments.

"ICD-10 is not an IT project, it is a business project"

While perhaps not as heated an issue as attachments, it was evident at the Forum that the winds of change were also blowing through the most recent stages of ICD-10 preparation and implementation. In particular, presenters at several sessions pointed out that after many ICD-10 implementation efforts and several corresponding delays in the effective date for ICD-10, it is important to look at other ways of advancing ICD-10.

These new outlooks especially embraced the concept that – as several presenters emphasized in a variety of forms -- "ICD-10 is not an IT project, it is a business project." As a number of presenters noted, in order to reposition ICD-10 as part of a larger, ongoing business objective, it is important to change the focus from coding per se to "clinical documentation improvement (CDI)." Participants at the Forum pointed out that CDI was vital to capturing not only the detailed clinical information to meet the more granular reporting needs of ICD-10 coding, but to also aid in meeting a range of quality improvement and reimbursement challenges. Others noted that focusing on CDI created a new vocabulary and energy for change that was important following recent federal delays and resulting loss of momentum in ICD-10 implementation.

In addition to making the case for CDI, presenters also compared notes on different approaches to testing to assure ICD-10 readiness. While some advocated end-to-end testing, several agreed that it is expensive and time consuming, and may not provide the education needed to transition most efficiently to the use of ICD-10 in practice.

In contrast, the Forum included a demonstration of "content based testing." In this form of testing, over 300 clinical care scenarios were created and made publicly available on a website. Those interested in testing their assumptions and knowledge about ICD-10 coding can review the scenarios and indicate the ICD-10 codes that they believed apply. After submitting their results they automatically received feedback showing how their

code choices compared with the choices made by others. While lacking the robustness of end to end testing, the demonstration illustrated a useful, relatively low-tech educational tool to help in understanding and using ICD-10.

To HPID or not to HPID …. That is the question …

The final day of the Forum was convened under occasional clouds of preoccupation and uncertainty regarding ACA requirements that large health plans must obtain a Health Plan ID (HPID) by November 5 this year, small health plans (under $5 Million revenue) must enumerate by November 5, 2015, and the uses of the HPID.

Health plans, providers, and vendors at the Forum attributed the overcast conditions to several factors including:

- HPID was intended in the original HIPAA administrative simplification mandates of 1996 to help with routing of electronic business transactions. However, this function has since been superseded by a different model based on self-administered payer IDs that has gradually emerged over the past nearly 20 years, and that has become the de facto routing process used by the industry.

  In comparing health plans' preparations for obtaining HPIDs with the current payer ID structure, it is clear that there is often no one-one match between the two. Several Forum participants noted that not only would a reliance on HPIDs for routing standard transactions be disruptive and costly, it would increase the risks of sending confidential patient information to incorrect recipients, in violation of HIPAA and the federal HITECH Act.

  Finally, in addition, the Centers for Medicare and Medicaid Services (CMS) has clarified that its primary interest in HPID at this time is not for routing of transactions, but rather to answer questions about the number of health plans that meet the HPID enumeration requirements.

- Self-insured health plans must also enumerate by obtaining HPIDs. Concerns have been widely raised that the self-insured plans are still largely unware of the requirements, and are unprepared to meet the enumeration deadlines.

- Final federal rules are being developed for health plan certification of conformance with operating rules. While enumeration of health plans under HPID and certification will be linked, it is uncertain at this time how each may influence the other, and their implications together.

Given this general backdrop, the audience was reminded that WEDI has testified at the National Committee for Vital and Health Statistics (NCVHS) and with the Centers for Medicare and Medicaid Services (CMS) regarding the concerns above, and that it had made the following recommendations:

- That CMS continue to require enumeration of health plans, but modify the HPID rule to make HPIDs "Not Used" in transactions;

- That CMS conduct educational outreach for self- insured (group) health plans on the HPID and HPID enumeration process; and

- That self-insured (group) health plans be permitted but not required to obtain an HPID.

In the meantime, while the recommendations above are in play, health plans at the Forum indicated a mostly cautious approach in enumerating, to obtain the minimum number of HPIDs that the rule requires. WEDI also plans to continue to make the case for its recommendations to CMS and for greater clarity and certainty for HPID going forward.

AUC Member Participation at the WEDI Forum

Several AUC members actively participated at the WEDI Forum as presenters and panelists, including:

- Shelagh Kalland of Blue Cross and Blue Shield of Minnesota and current AUC co-chair, who presented at sessions entitled "ICD-10 Test Results from a Payer, Provider and Clearinghouse Perspective" and "Enumeration Panel; Plan Considerations and ASOs."
- Laurie Darst of Mayo, immediate past AUC co-chair, presented at two sessions, "Interactive Discussion Between Providers and Payers on Proposed Changes to Attachments" and "Interactive Discussion on Impacts of HPID in Transactions."
- Laurie Burckhardt, WPS Health Insurance, and past Claims DD TAG chair, presented on "HIPD Enumeration Schemas."

Update: 2014 companion guide maintenance

As described in the June AUC update, each year MDH consults with the AUC on changes to the Minnesota Uniform Companion Guides that may be needed to ensure that the Guides remain clear, current, and correct.

Below is a calendar showing the approximate deadlines for this year's companion guide maintenance. Items shaded in light grey are AUC Technical Advisory Group (TAG) deadlines; items shaded in darker grey are AUC Operations Committee deadlines.

Date	2014 Companion Guide Deadlines, Milestones
Aug 28	TAGs have completed their reviews and votes on any recommended changes - all TAG-approved changes should be submitted to MDH by September 3. (Note: if TAGs can complete their work in advance of August 28 that would be great.)
Sept 3	MDH sends underline-strikeout versions of all revised companion guides to AUC Operations. Ops will vote on the proposed revised guides at the September 16 meeting.
Sept 16	Regular quarterly Ops meeting -- AUC Ops vote on proposed revised companion guides.
Sept 16 – Oct. 6	MDH reviews AUC recommendations, prepares State Register notice of proposed revised companion guides. Notice submitted by Oct 6 for publication Oct 13.
Oct 13	State Register announcement of proposed revised companion guides for public comment, start of 30-day public comment period
Oct 13 – Nov. 13	30 day public comment period
Nov. 17 – Dec. 1	TAG/MDH review of public comments and development of any further companion guide revisions; completion of any TAG reviews and votes on further revisions by December 1.
Dec. 2	Revised companion guides that are to be adopted are sent to AUC Ops in advance of AUC Ops meeting December 9.
Dec. 9	Regular AUC Ops quarterly meeting – Ops vote on final revised companion guides to be adopted.
Dec. 10 – Dec. 29	MDH reviews AUC recommendations, prepares State Register notice of adopted revised companion guides. Notice submitted by December 29 for publication January 5, 2015.
Jan 5, 2015	State Register announcement of adoption of revised companion guides.

AUC Technical Advisory Group (TAG) Updates

Information about AUC committees and TAGs and their activities can be accessed from the AUC TAG page and by clicking on the TAG or committee name in the following article.

With the exception of the Medical Code TAG, all TAG meetings are generally conducted via teleconference rather than in-person. All AUC meetings are open, public meetings. Meeting agendas and other materials are posted on the AUC website in advance of meetings. TAG meeting schedules and information are also available on the AUC calendar page. (http://www.health.state.mn.us/auc/calendar.htm).

Executive Committee

The Executive Committee met July 7 to address ongoing needs (e.g., a number of AUC policies are out of date and MDH will draft updated versions for review) as well as a changing landscape for health care administrative simplification.

In particular, the Committee discussed the Committee on Operating Rules for Information Exchange (CORE) development of operating rules for attachments, and plans for remaining informed of and contributing to emerging new health care delivery and reimbursement models. It was agreed to seek the Claims DD TAG's assistance in monitoring and engaging with the attachments operating rules development, and for MDH staff to help maintain connections with the state's health care delivery reforms, including implementation of health care homes and reforms being undertaken as part of Minnesota's State Innovation Model (SIM) grant.

Medical Code TAG

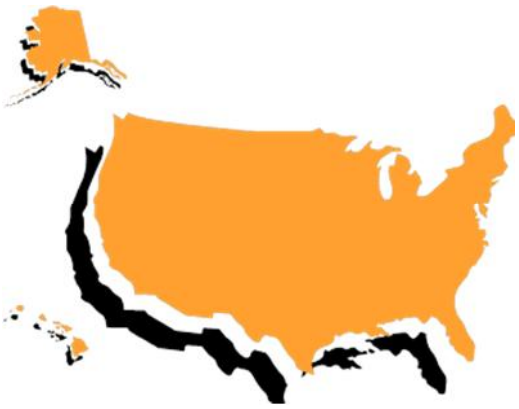
The Medical Code TAG met July 22 and completed its review of the coding appendix for the Minnesota Uniform Companion Guides (MUCGs) for professional and institutional claims (837P, 837I). The TAG also reviewed a new index of previously addressed coding questions and continued its review of several coding questions that had been recently submitted.

Upcoming TAG meetings, August 2014

(For additional information, see the AUC Calendar)

August 4, 2014	**Executive Committee**
August 6, 2014	**Claims DD TAG**
August 14, 2014	**Medical Code TAG**
August 14, 2014	**HPID/OEID TAG**
August 18, 2014	**EOB/Remit TAG**
August 27, 2014	**Eligibility TAG**

National Industry News



NCVHS Report to Congress on HIPAA Implementation

The National Committee on Vital and Health Statistics (NCVHS) is the federal statutorily chartered group created to advise the Secretary of the federal department of Health and Human Services (HHS) on implementation of the administrative simplification provisions of HIPAA. NCVHS submits a report every two years to Congress regarding the status and prospects of HIPAA implementation. In June 2014, NCVHS posted its eleventh biennial report to Congress, describing

advances in 2012 and 2013, as well as recent successes in public health informatics standards and community health data initiatives.

Report notes accelerating changes, success in public health, overall challenges and opportunities

NCVHS's report to Congress describes "recurrent themes" from stakeholders, including the challenges of maintaining momentum for administrative simplification in the midst of accelerated health care changes and increased complexity. Despite these challenges, the report also notes that "Significant advances occurred in the adoption of Administrative Simplification transaction standards, code sets, identifiers and operating rules in 2012 and 2013." In addition, NCVHS points out that "While not an explicit component of HIPAA, public health agencies and health care organizations have leveraged the same standards used in administrative transactions to collect and exchange health information for various purposes."

But it is the future that seems to energize the report. The report notes that "Health care today and in the future holds promises that exceed anything envisioned when the Administrative Simplification provisions of HIPAA were initially implemented in early 2000..." Similarly, it points out that "Health care in the United States is undergoing major transformative changes that are re-shaping the nature and exchange of data and information used for personal, clinical, community, business, and scientific purposes…. These changes will revise the way consumers, patients, providers, health plans, employers, government, researchers, and others interact. Transformation of how health care is organized, delivered, and paid for, is also creating an unprecedented opportunity to redefine the way health information is captured, exchanged, and used to improve access, value, quality, safety, equity, efficiency and the public's health and wellness."

For a copy of the report, see the NCVHS website at http://www.ncvhs.hhs.gov/.

Operating Rules – What's Next?

Note: In April we started a new feature to provide regular information and updates regarding a group of federal operating rules that are to be developed and required for use beginning January 1, 2016. Please see the first page article regarding the WEDI Summer Forum 2014 for updates and discussion of key operating rules being developed.

Test Your AdminSimp IQ

In April we started a new feature entitled: "Test Your AdminSimp IQ." This month we use the feature to profile the Eligibility Code TAG, an important community coding resource. We plan to profile other AUC TAGs in the future.

Spread the Word – AUC Eligibility TAG Facts

The AUC Eligibility Technical Advisory Group (TAG) is a group of technical experts whose focus is reducing administrative costs for Minnesota payers, providers, and employers through development and maintenance of rules and best practices for the Eligibility Inquiry and Response Electronic Transactions (ANSI ASC X12 270/271).

The Eligibility TAG developed the first Minnesota Uniform Companion Guide (CG), Eligibility Inquiry and Response Electronic Transactions (270/271). The 270.271 CG was adopted as rule December 10, 2007, with an implementation date of January 15, 2009.

The Eligibility TAG developed 10 best practices showing providers and payers how to report 270/271 transactions. Most have been incorporated into the 270/271 Minnesota Uniform Companion Guide and are now rule of law. Two of the original best practices currently posted on the AUC website instruct payers and providers how to:

- *Report health care home benefits*
- *Report Minnesota Department of Human Services two-digit major program code for prepaid medical assistance plans*

The Eligibility TAG work was accomplished initially through its four workgroups: 1) Enrollment Investigation (WG1); 2) Best practices (WG2); 3) Companion Guide (WG3); 4) and Implementation Tracking (WG4). Each one of the Work Groups was phased out and their work taken on by the Eligibility TAG.

Eligibility TAG created an Administrative Simplification tracking tool, the Implementation Tracking Grid, that allowed Providers and Payers to track ROI for implementing the 270/271 transaction.

The Eligibility TAG developed its mission statement July 29, 2009.

The Eligibility TAG surveyed providers to discern possible impacts of the 5010 Implementation Guide's definition of subscriber, patient, insured and dependent have on its primary payer.

Ed Stroot holds the record as the longest serving co-chair for the Eligibility TAG, having held this post since November 19, 2008.

The Eligibility TAG completed its first 5010 270/271 CG December 16, 2009. It was approved by the AUC in January 2010.

Need help in reporting the appropriate loops/segments and data elements or usage of situational data elements in the eligibility inquiry and response transactions?

Have any administrative simplification issues you would like the AUC address regarding uniformity and standardization with the 270/271 electronic transactions?

Follow these simple steps to get help from the AUC Eligibility TAG:

1. Click on this link to access the Forms page (http://www.health.state.mn.us/auc/forms.htm) on the AUC website.
2. Download and complete the AUC SBAR form.
3. Submit the completed forms to the AUC inbox at auc.health@state.mn.us.

AUC Newsletter Subscription

Interested in signing up to receive this newsletter and other AUC updates and information? Please sign up using the Subscribe feature on the right hand side of the AUC homepage under the "Most Viewed" navigation frame at: (http://www.health.state.mn.us/auc/index.html).

Comments or questions about this newsletter? Please contact us at: health.auc@state.mn.us.

Administrative Uniformity Committee