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HIPAA and ACA Timeline

Change Healthcare Quarterly Updates

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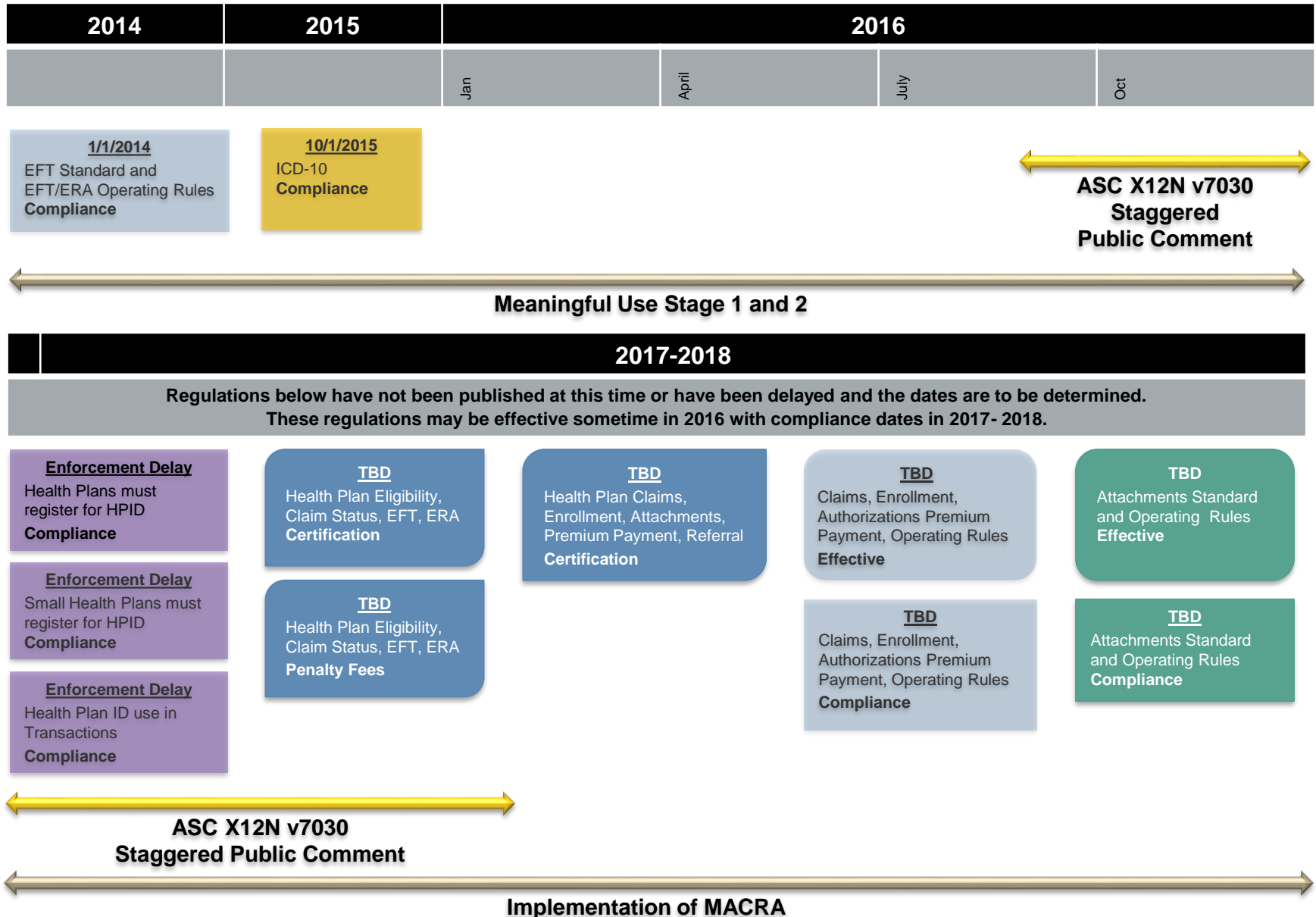
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HIPAA and ACA Timeline





ASC X12N Version 7030

ASC X12N Version 7030 – Public Comment



The public review and comment cycles for version 7030™ of the ASC X12N Type 3 Technical Reports (TR3s) have begun. These public review and comment periods allow the health care industry the opportunity to review the proposed changes and provide feedback on the next published version of the healthcare administrative transactions.

PUBLIC COMMENT PERIOD – KEY FACTS

- Public comment periods for the TR3s are being held in 8 staggered cycles.
- Public comment periods will be held for all 7030 TR3s, including those transactions not mandated under HIPAA.
- Staggered approach allows for more focused reviews and hopefully, increased participation from the industry.
- The intent of ASC X12N is to publish all TR3's together when the public comment cycles have been completed and all comments considered.

ASC X12N Version 7030 – Public Comment

← ASC X12N v7030 Staggered Public Comment →

Review Cycles Q4 2016 through Q1 2017

Cycle 1 – September 1 through October 31

Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
Health Insurance Exchange Related Payments (820)
Benefit Enrollment and Maintenance (834)
Health Insurance Exchange: Enrollment (834)

Cycle 2 - November 1 through November 30

Health Care Claim Status Request and Response (276/277)
Health Care Claim Acknowledgment (277CA)
Health Care Claim Pending Status Information (277P)
Implementation Acknowledgment for Health Care Insurance (999)

Cycle 3 – November 1 through December 31

Health Care Claim Payment/Advice (835)

Cycle 4 - December 1 through March 1, 2017

Health Care Claim: Professional (837P)
Health Care Claim: Institutional (837I)
Health Care Claim: Dental (837D)
Health Care Service: Data Reporting (837R)

ASC X12N Version 7030 – Public Comment



ASC X12N v7030 Staggered Public Comment

The full schedule of all review cycles is available here:

<http://www.x12.org/announcements/asc-x12n-announcement-public-comment-period-timeline-for-7030-tr3s.cfm>.

Change Healthcare Encourages Your Participation

Change Healthcare is actively participating in the v7030™ Public Review and Comment process and we encourage all entities to participate.

See the Change Healthcare Version 7030 Customer Communication and Version 7030™ FAQs on www.hipaasimplified.com.

To review and comment on the TR3s, go to forums.x12.org.



Operating Rules

Change Healthcare Operating Rules Readiness

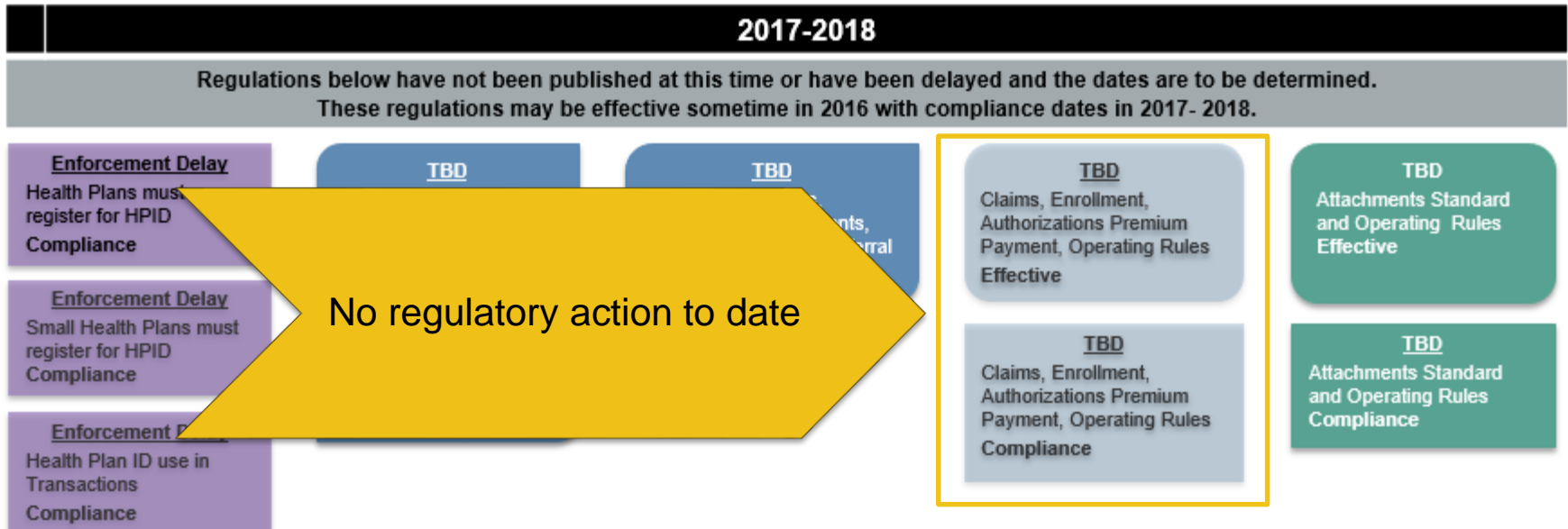


Change Healthcare is **CORE Phase III Certified** which is one of the two options proposed in the Health Plan Certification NPRM. To become CORE Phase III certified entities must be CORE-certified on the earlier phases. Our CORE Phase III certification serves as Change Healthcare's exhibit of readiness.

CAQH certifies and awards CORE Certification Seals to entities that create, transmit or use the administrative transactions addressed by applicable Operating Rules. CORE Certification means an entity has demonstrated that its IT system or product is operating in conformance with a specific phase(s) of the Operating Rules.

- Change Healthcare is CORE Phase I, Phase II, and Phase III certified, as evidenced by our Phase III seal.
- Link to [Change Healthcare's CORE Phase III Seal](#).
- Link to our [CORE Voluntary Certification](#) (Clearinghouses tab).
- Link to the [Change Healthcare Press Release](#) announcing our certification.
- Additional information regarding the Change Healthcare Operating Rules program can be found on www.HIPAAimplified.com.

Operating Rules – HIPAA and ACA Timeline



- In September 2015, CAQH CORE via their voting process, approved the Phase IV Operating Rules for voluntary certification.
- The Phase IV rules define infrastructure, connectivity, and companion guide requirements for Health Care Claims (837), Health Care Services Review – Request for Review and Response (278), Benefit Enrollment and Maintenance (834), and Premium Payment (820) transactions.
- Phase IV rules did not address Health Claim Attachments, as prescribed under the ACA, because attachment transaction standards have not yet been established.

Regulatory Roadmap – Phase IV Operating Rules

On July 6, 2016, NCVHS sent a letter to the HHS secretary that recommended the Phase IV Operating Rules not be adopted under regulatory mandate and instead supported voluntary industry adoption.

- Recommendations also included; addressing inconsistencies in authentication and connectivity requirements, regulatory adoption of the acknowledgement standard as HIPAA-mandated, and transaction-specific findings and recommendations.
- To see the NCVHS Letter to the Secretary – Recommendations for the Proposed Phase IV Operating Rules, go to www.ncvhs.hhs.gov.



Attachments

Attachments – HIPAA and ACA Timeline

2017-2018

Regulations below have not been published at this time or have been delayed and the dates are to be determined. These regulations may be effective sometime in 2016 with compliance dates in 2017- 2018.



- The Administrative Simplification provisions under the ACA include adoption of transaction standards and operating rules for Attachments.
- Electronic Attachments are electronic transactions that support the following:
 - Health Care Claims/Encounters (837)
 - Health Care Services Review-Request for Review and Response (278)
 - Health Care Services Review Notification and Acknowledgment (278).
- A proposed rule establishing Attachment standards is anticipated in 2017.

Attachments – Current Activities

- Two Standards Development Organizations, Health Level 7 (HL7) and ASC X12, have been collaborating on the development of Attachments standards.
- HL7 is finalizing the Implementation Guide for Attachments, which describes the use of the HL7 Consolidated CDA R2.1 document type specification for Health Claim Attachments.
- ASC X12, HL7, and WEDI are developing a “How To” white paper to help implementers understand how the ASC X12 and HL7 Attachment standards work together.
- HL7 Attachment Workgroup is developing a C-CDA for periodontal charting in collaboration with the ADA.

Attachments – Recommendations

On February 16, 2016, the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, conducted hearings on the Attachment standards. The following summary recommendations were made by NCVHS to the Secretary of Health and Human Services in a letter dated July 5, 2016:

- Adopt one standard definition of the “Attachment” transaction, and establish the scope of the transaction.
- Adopt a set of mature, implementable electronic standards for the health care industry to execute the Attachments transaction.
- Define a series of transaction process requirements, including consistency with adopted privacy laws and regulations.
- Take an incremental, flexible implementation approach in no less than five years inclusive of rulemaking.
- Broaden the testing, education, outreach and compliance efforts.
- Ensure alignment of the Attachment standard’s regulatory requirements with those adopted for use with Electronic Health Records under the Office of the National Coordinator (ONC) for Health Information Technology’s 2015 Edition Certification of Health Information Technology program (i.e., Meaningful Use) and the Medicare Access CHIP Reauthorization Act of 2015 (MACRA)/Merit-Based Incentive Payment System (MIPS).

To see the NCVHS Letter to the Secretary – Recommendations for the Electronic Health Care Attachment Standard, go to www.ncvhs.hhs.gov.

Attachments – Regulatory Roadmap

- NCVHS hearing was held on February 16, 2016.
- Conformance Version of the Supplemental Specifications for Attachments balloted by HL7 in early May 2016.
- NCVHS Letter of Recommendation sent to HHS on July 5, 2016.
- The HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 to be published in Q3 2016.
- Proposed rule expected in 2017.
- Final Rule to follow with an implementation period and compliance date of up to two years following final rule publication.



Health Plan Identifier (HPID)

Health Plan ID – HIPAA and ACA Timeline

2017-2018

Regulations below have not been published at this time or have been delayed and the dates are to be determined.
These regulations may be effective sometime in 2016 with compliance dates in 2017- 2018.



- On 10/31/14 CMS announced an HPID enforcement discretion delay until further notice.
- With clarification that **HPID does not replace PayerID**, the impact of implementing HPID has been significantly reduced.
- Industry dialog continues with regard to **removing HPID/OEID in health care transactions.**

Regulatory Roadmap – Health Plan ID

- Since the HPID final rule was issued in 2012, there have been growing industry concerns surrounding the regulation, including (1) lack of clarity of the purpose and function of the HPID, (2) the requirement to use the HPID in HIPAA transactions, and (3) the definition of health plan versus payer.
- Additionally, the National Committee on Vital and Health Statistics (NCVHS), a governmental advisory body to the Department of Health and Human Services (HHS), [recommended](#) that the HPID not be used in HIPAA transactions.
- On May 29, 2015, HHS issued [a Request for Information](#) soliciting public comments on the requirements set forth in the HPID final rule.
- The public comment period ended July 28, 2015.
- Change Healthcare participated and submitted comments in response to the RFI.
- HHS has not yet communicated further regulatory action based on the feedback.

Due to the HPID enforcement discretion delay until further notice, covered entities are NOT required to use HPID to identify health plans in transactions effective November 7, 2016.

Related Materials

- ASC X12 [updated errata](#) in HIPAA transactions
- WEDI [Issue Brief](#) clarifying Payer vs. Health Plan



Health Plan Certification

Health Plan Certification – HIPAA and ACA Timeline

2017-2018

Regulations below have not been published at this time or have been delayed and the dates are to be determined. These regulations may be effective sometime in 2016 with compliance dates in 2017- 2018.



- Would require Health Plans to certify data and information systems are in compliance with applicable standards and operating rules.
- Dependent on Health Plan ID regulatory clarifications and revisions.

Regulatory Roadmap – Health Plan Certification

Proposed Rule

- Outlines Health Plan definitions and requirements for Controlling Health Plans (CHPs) and Sub Health Plans (SHPs).
- Outlines applicable penalties and fees based on covered lives.
- Controlling Health Plans are required to certify compliance.



Implementation of MACRA

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)



Implementation of MACRA

- On April 16, 2015, the [Medicare Access and CHIP Reauthorization Act](#) (MACRA) was enacted into public law. The [MACRA](#) amends the Social Security Act making changes to how Medicare pays those who provide care to Medicare beneficiaries and extends the CHIP program.
- Includes provisions for CMS to remove Social Security numbers (SSNs) from Health Care Insurance Numbers (HICNs) and Medicare Claims Numbers (MCNs).
- Requires that CMS establish a classification code set for physician-patient relationships.
- On November 4, 2016, the [MACRA Final Rule with Comment](#) was published in the Federal Register. The rule establishes a unified framework called the CMS Quality Payment Program that rewards the quality and value of care in one of two ways:
 - Merit-based Payment System (MIPS), and
 - Advanced Alternative Payment Models (APMs)

More information on the Quality Payment Program can be found at QualityPaymentProgram.cms.gov.

HHS is accepting comments on the rule through 5pm on December 19, 2016.

The provisions of the final rule with comment period are effective on January 1, 2017. Calendar year 2017 will be a “transition year” and the first performance period of the program, with the first payment period occurring in calendar year 2019.