# CHANGE HEALTHCARE REGULATORY AND STANDARDS UPDATE

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CHANGE HEALTHCARE

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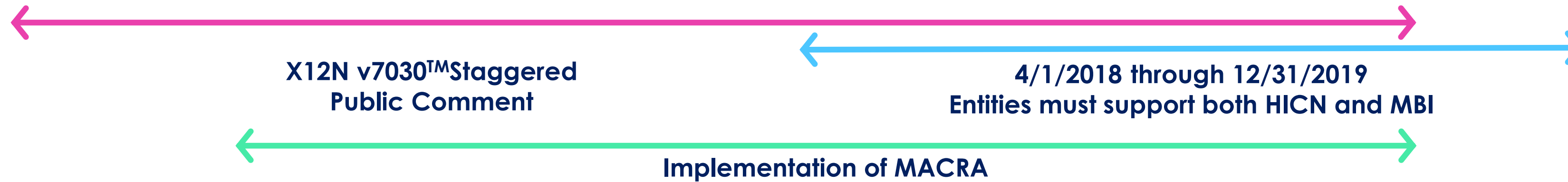
# Timeline

| 2016 | 2017 | 2018 | | 2019 |
|---|---|---|---|---|
| **9/1/2016**<br>X12N v7030™ public comment cycles begin<br><br>**12/13/2016**<br>Public law 21st Century Cures Act enacted. | **1/1/2017**<br>MACRA Final Rule with Comment Effective | **4/1/2018**<br>New Medicare Card Rollout begins, Transition period HICN to MBI begins | **Q4/2018**<br>Attachments Regulation with 6020 278 and Acknow-ledgments expected Q4 2018 | **12/31/2019**<br>HICN (SSN) – MBI transition period ends. Entities must support MBI only. |




## Withdrawn / Delayed / TBD

**Regulations below have been withdrawn, published at this time or have been delayed and the dates are to be determined.**

| **Enforcement Delay-Health Plan Identifier (HPID)**<br>HPID Enumeration; Use of HPID in transactions. Rescission expected Q4 2018. | **Withdrawn-Certification Regulation**<br>Health Plan Eligibility, Claim Status, EFT, ERA, Health Plan Claims, Enrollment, Attachments, Premium Payment, Referral; Penalty fees | **TBD**<br>Claims, Enrollment, Authorizations Premium Payment, Operating Rules | **TBD**<br>Attachments Operating Rules |
|---|---|---|---|

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Section 1

# CMS NEW MEDICARE CARD PROJECT

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# CMS New Medicare Card Project – the transition is here

- Issuance of new Medicare cards is well underway. All new cards will be issued by **April 1, 2019**. See the CMS Card Rollout Strategy.
- The CMS transition from HICN to MBI in electronic transactions and on print claim forms began **April 1**.
- The transition period extends through **December 31, 2019**, after which Medicare will accept MBI only (with some exceptions).

Change Healthcare is successfully receiving, processing, and routing transactions containing MBI.
See www.hipaasimplified.com for additional information.

## Important Dates

- **June 1, 2018** – CMS MBI Lookup tool became available to providers via their MAC (see CMS letter to providers). Patient MBIs can be obtained using the patient's Social Security number, first and last names, and date of birth.
- **October 1, 2018** – CMS began returning the MBI on the Claim Payment/Advice (835) as a Corrected Identifier, when a HICN has been submitted on the claim.

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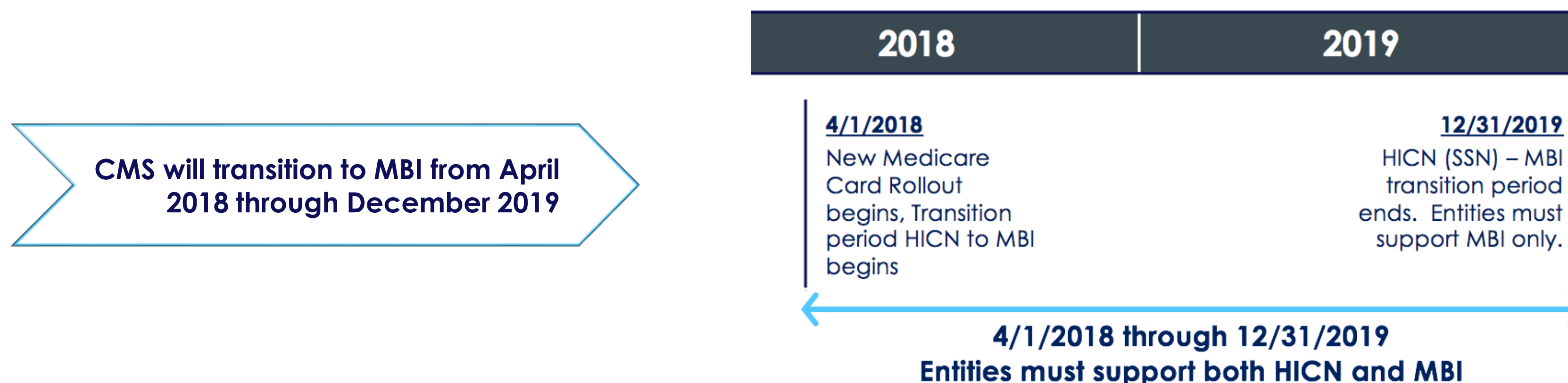
# CMS New Medicare Card Project – HICN to MBI




- The Medicare Access and CHIP Reauthorization Act (MACRA) mandates the removal of the Social Security number-based Health Insurance Claim Number (HICN) from Medicare cards.
- As a result, the Centers for Medicare & Medicare Services (CMS) has initiated their New Medicaid Card Project wherein all beneficiary Medicare cards will be reissued with the new Medicare Beneficiary Identifier (MBI), and all Medicare systems will be remediated to accept and process the new identifier.
- The primary goal of the New Medicare Card Project is to decrease Medicare beneficiaries' vulnerability to identify theft and fraud by removing the HICN from all Medicare ID cards and systems and replacing it with a randomly-generated MBI.

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# Regulatory roadmap – transition to MBI

- CMS is conducting a phased issuance of new ID cards which will include the MBI.
- **All systems, applications, and operational processes must be able to accept, process, and transmit both the HCIN and MBI from April 1, 2018 through December 31, 2019.**

MAILING NOW
New Medicare cards with new numbers.
Are you ready?
#NewCardNewNumber
LEARN MORE

- During the transition period:
  - CMS will accept, use for processing, and return to stakeholders either the MBI or HICN. CMS will return the same beneficiary number submitted on the incoming transaction.
  - CMS will return a message segment (MSG) in the eligibility transaction when the beneficiary has been mailed their MBI card. Providers may also ask patients if they have received their new card with their assigned MBI.
  - For claims submitted using the HCIN identifier, CMS will return the MBI on the remittance advice starting October 2018.
  - CMS recommends that providers use the beneficiary's MBI in transactions once the beneficiary has received their new card.
- All systems and processes must use only the MBI beginning January 1, 2020. There may be limited exceptions for use of the HICN after transition, such as appeals, adjustments, and other scenarios.

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# Technical and operational readiness

- Change Healthcare has completed our internal remediation and operational readiness program in preparation for the issuance and support of new Medicare numbers (MBIs).
- All Change Healthcare systems and solutions now accept, process, and transmit either the old Medicare number (HICN) or the new Medicare number (MBI) within applicable health care transactions.
- As directed by CMS, the MBI will utilize the same data elements as the current CMS HICN.
- Change Healthcare trading partners that support transaction workflows involving Medicare, Medicaid, or Medicare supplemental plans should research and identify needed technical or operational remediation within their applications and organizations.

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# Additional information

- CMS is working with state Medicaid agencies who display the HICN on their Medicaid cards as well as the Railroad Retirement Board who issues their own cards.
- All new cards will be issued by **April 1, 2019**.
- CMS is conducting intensive education and outreach to beneficiaries and their agents, providers, advocacy groups, caregivers, states and territories, key stakeholders, vendors, and other partners.
- CMS will monitor impact to providers and other industry stakeholders throughout the transition.
- More information is available at https://www.cms.gov/medicare/new-medicare-card/nmc-home.html.
- For Change Healthcare's HIPAA Simplified overview, click here.

**Watch Change Healthcare's HIPAA Simplified site for updates.**

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Section 2

# ASC X12N VERSION 7030™ PUBLIC REVIEW AND COMMENT PERIOD

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# X12N version 7030™ – public review and comment

The public review and comment cycles for version 7030™ of the X12N Type 3 Technical Reports (TR3s) began in the fall of 2016. 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.

- Cycle 6, for the Health Care Eligibility Benefits Inquiry and Response (270/271), will be completed on November 16, 2018, after a 120 day public review and comment period. Released for review with this TR3 was a new companion TR2 document **Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response**, which instructs on proper usage of external code sets.
- Five additional initial review cycles, comprising 17 TR3s (both HIPAA-adopted and non-mandated), have also been completed.
- Based on industry comments received during initial reviews, some TR3s will undergo a second public review and commenting period.

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# X12N version 7030™ – key facts

The public review and comment cycles for version 7030™ of the X12N Type 3 Technical Reports (TR3s) began in late 2016.

- Public comment periods for the TR3s are being held in staggered cycles.
- Public comment periods will be held for all 7030 TR3s, including transactions not mandated under HIPAA.
- A staggered approach allows for more focused reviews and hopefully, increased participation from the industry.

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# X12N version 7030TM – timeline

X12N v7030TMStaggered
Public Comment

## Initial Review Cycles - Upcoming

Cycle 7 **TBA**

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

## Second Public Comment and Reviews

*Review of changes stemming from first public review*

**Closed: April 1 through May 15, 2018**

- Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- Health Insurance Exchange Related Payment (820)

**Upcoming (TBA)**

- Health Care Claim Status Request and Response (276/277)
- Health Care Claim Acknowledgment (277CA)
- Health Care Claim Payment/Advice (835)
- Health Care Claims (837P/I/D)

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# X12N version 7030™ – timeline

## Initial Review Cycles - Complete

**Cycle 1**

**September 1 through October 31, 2016**

- 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**

**October 1 through November 30, 2016**

- 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, 2016 through January 30, 2017**

- Health Care Claim Payment/Advice (835)

**Cycle 4**

**February 1 through June 1, 2017**

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

**Cycle 5**

**September 1 through January 31, 2018**

- Health Care Services Request for Review and Response (278RR)
- Health Care Services Review Inquiry and Response (278IR)
- Health Care Services Review – Notification and Acknowledgment (278NA)

**Cycle 6**

**July 16 through November 16, 2018**

- Health Care Eligibility Benefits Inquiry and Response (270/271)
- Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response (TR2)

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# X12N version 7030™ – participation

For updates to the public comment period timeline, watch: www.x12.org.

**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 view and comment on the TR3s, go to forums.x12.org.

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Section 3

# ATTACHMENTS NPRM

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# Attachments – Timeline

- The Administrative Simplification provisions under the ACA include adoption of transaction standards and operating rules for Attachments.
- Electronic Attachments are electronic transactions that support healthcare transactions such as:
  - Health Care Claims/Encounters (837)
  - Health Care Services Review-Request for Review and Response (278)
- **A proposed rule establishing Attachment Standards and Operating Rules is expected in December 2018, per the Current Unified Agenda of Regulatory and Deregulatory Actions** (RIN 0938-AT38).

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# Attachments – Publications

- HL7 Publications:
  - HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 Standard for Trial Use
  - HL7 CDA ® Release 2 Implementation Guide: Exchange of C-CDA Based Documents; Periodontal Attachment, Release 1
  - HL7 CDA® R2 Implementation Guide: Orthodontic Attachment, Release 1 – US Realm (draft)
- X12, HL7, and the Workgroup for Electronic Data Interchange (WEDI) White Paper:
  - Guidance on Implementation of Standard Electronic Attachments for Healthcare Transactions, provides guidance on the implementation of standard electronic attachments for healthcare transactions.

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# 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 "Attachment", 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, click here.

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# Additional Regulatory Action in Attachments NPRM

- The upcoming Attachments Regulation, anticipated in December 2018, per the **Current Unified Agenda of Regulatory and Deregulatory Actions** (RIN 0938-AT38), is expected to propose the following:
  - X12 Version 6020 of the Health Care Services Request for Review and Response (278), replacing the 005010X217 TR3 currently under adoption.
  - Acknowledgments transaction standards for the health care claim status, enrollment and disenrollment in a health plan, health plan premium payments, coordination of benefits, referral certification and authorization, and health care attachments transactions
  - Operating Rules requiring use of acknowledgments for eligibility and benefits (270/271), health care claim status (276/277), and health care electronic funds transfers (EFT) and remittance advice transactions (835).

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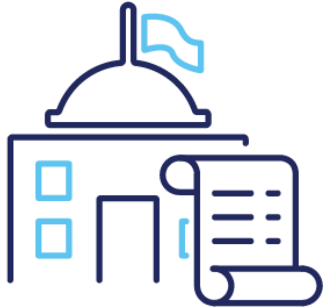
# Attachments – Regulatory Roadmap



- NCVHS hearing was held on February 16, 2016.
- NCVHS Letter of Recommendation sent to HHS on July 5, 2016.
- Unified Agenda (RIN 0938-AT38) indicates that a proposed rule is expected in December 2018, with Public Comment Period.
- Proposed Rule to include adoption of X12 Version 6020 Health Care Services Request for Review and Response (278) *as well as* X12 Health Care Acknowledgments.
- Final Rule to follow with an implementation period and compliance date of up to two years following final rule publication.

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Section 4

# NCVHS DRAFT RECOMMENDATIONS PREDICTABILITY ROADMAP

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# History

- The Patient Protection and Affordable Care Act (ACA) of 2010 authorized the Secretary of the Department of Health and Human Services (HHS) to establish a Review Committee responsible for evaluating the adopted transaction standards and operating rules. The Secretary designated the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, to act as the Review Committee.
- June 2015 testimony gathered from industry stakeholders – including the Standards Development Organizations (SDOs) and the Operating Rules Authoring Entity (ORAE) – indicated that that HIPAA named transaction standards and operating rules are significant steps towards achieving greater administrative efficiencies.
- However, concerns expressed resulted in a letter to HHS with a set of recommendations including the need to*:
  - **Explore the feasibility of expanding the definition of HIPAA covered entities.**
  - **Broaden education.**
  - **Ensure consistency.**
  - **Enforce compliance.**
  - **Adopt the acknowledgment transaction.**
  - **Provide predictability in the adoption of standards, code sets, identifiers and operating rules.**
  - **Ensure responsiveness to evolving changes in health care.**
- After further information gathering, the Standards Subcommittee of the NCVHS developed the **Draft Recommendations for the Predictability Roadmap,** presented to the full committee on September 14, 2018.

*See Roadmap Narrative

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# Next steps

- **October-November 2018:** Industry stakeholders review the **Draft Recommendations for the Predictability Roadmap**.
- **December 13-14, 2018:** The NCVHS Standards Subcommittee will conduct a hearing to hear testimony on these recommendations.
  - Written testimony will also be accepted at NCVHSmail@cdc.gov, with the subject line **Predictability Roadmap** (see Draft Recommendations for full details).
- **December 2018 through January 2019:** The Standards Subcommittee will incorporate feedback from comments and testimony.
- **February 6-7, 2019:** The full NCVHS will consider the revised draft recommendations.
- **Q1 2019:** NCVHS will release letter of recommendation to HHS based on review and final Committee vote.

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# Resources

Draft Recommendations for the Predictability Roadmap, October 2018

Improving Health Care System Efficiency by Accelerating the Update, Adoption, and Use of Administrative Standards and Operating Rules: A Brief History and Draft Recommendations (Roadmap Narrative), September, 2018

NCVHS Hearing December 12-13, 2018

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Section 5

# MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

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# About 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). See CMS New Medicare Card Project (SSNRI).
- Required 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),
        - MIPS Overview
    - Advanced Alternative Payment Models (APMs)
        - APMs Overview
    - Quality Payment Program Participation Status Tool
        - QPP Participation Status
- **On November 1, 2018, CMS released a Final Rule for the 2019 Quality Payment Program –** Executive Summary; Fact Sheet
- Provide feedback and comments on the MACRA program to CMS.
- More information on the Quality Payment Program can be found in the Quality Payment Program Resource Library

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Section 6

# $21^{st}$ CENTURY CURES ACT

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# About the 21st Century Cures Act

- On December 13, 2016, the 21st Century Cures Act was enacted into public law "to accelerate the discovery, development, and delivery of 21st century cures, and for other purposes."
- The legislation includes 18 sections under 3 divisions:
  - DIVISION A—21ST CENTURY CURES
    - TITLE I—INNOVATION PROJECTS AND STATE RESPONSES TO OPIOID ABUSE; TITLE II—DISCOVERY; TITLE III—DEVELOPMENT; TITLE IV—DELIVERY; TITLE V—SAVINGS
  - DIVISION B—HELPING FAMILIES IN MENTAL HEALTH CRISIS
    - TITLE VI—STRENGTHENING LEADERSHIP AND ACCOUNTABILITY; TITLE VII—ENSURING MENTAL AND SUBSTANCE USE DISORDERS PREVENTION, TREATMENT, AND RECOVERY PROGRAMS KEEP PACE WITH SCIENCE AND TECHNOLOGY; TITLE VIII—SUPPORTING STATE PREVENTION ACTIVITIES AND RESPONSES TO MENTAL HEALTH AND SUBSTANCE USE DISORDER NEEDS; TITLE IX—PROMOTING ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE; TITLE X—STRENGTHENING MENTAL AND SUBSTANCE USE DISORDER CARE FOR CHILDREN AND ADOLESCENTS; TITLE XI—COMPASSIONATE COMMUNICATION ON HIPAA; TITLE XII—MEDICAID MENTAL HEALTH COVERAGE; TITLE XIII—MENTAL HEALTH PARITY; TITLE XIV—MENTAL HEALTH AND SAFE COMMUNITIES
  - DIVISION C—INCREASING CHOICE, ACCESS, AND QUALITY IN HEALTH CARE FOR AMERICANS
    - TITLE XV—PROVISIONS RELATING TO MEDICARE PART A; TITLE XVI—PROVISIONS RELATING TO MEDICARE PART B; TITLE XVII—OTHER MEDICARE PROVISIONS; TITLE XVIII—OTHER PROVISIONS

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# 21st Century Cures Act – Title IV-Delivery (focused breakdown)

- **Sec. 4001. Assisting doctors and hospitals in improving quality of care for patients**
- **Sec. 4002. Transparent reporting on usability, security, and functionality**
- **Sec. 4003. Interoperability**
- **Sec. 4004. Information blocking**
- **Sec. 4005. Leveraging electronic health records to improve patient care**
- **Sec. 4006. Empowering patients and improving patient access to their electronic health information**
- Sec. 4007. GAO study on patient matching
- Sec. 4008. GAO study on patient access to health information
- Sec. 4009. Improving Medicare local coverage determinations
- Sec. 4010. Medicare pharmaceutical and technology ombudsman
- Sec. 4011. Medicare site-of-service price transparency
- Sec. 4012. Telehealth services in Medicare

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# Title IV-Delivery - Section 4001

## Assisting doctors and hospitals in improving quality of care for patients

- 4001(a) Amends the HITECH Act to require HHS to establish a goal, develop a strategy, and make recommendations to reduce regulatory or administrative burdens relating to the use of EHRs
- 4001(b) ONC must encourage, keep, or recognize the voluntary certification of health IT for use in medical specialties. HHS must solicit stakeholder input and make criteria recommendations, adopt certification criteria, and support voluntary certification to support health IT for pediatric health providers
- 4001(c) HHS must publish attestation statistics for the Medicare and Medicaid EHR Incentive Programs to assist in informing standards adoption and related practices

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# Title IV-Delivery - Section 4002

## Transparent reporting on usability, security, and functionality

- 4002(a) Requires HHS, through notice and comment rulemaking, to require as a condition and maintenance of certification, that the HIT developer or entity "does not take any action that constitutes information blocking" (as defined in Section 3022(a) of the Public Health Service Act, as amended), or "any other action that may inhibit the appropriate exchange, access, and use of electronic health information"
- 4002(b) A health care provider whose adopted health IT is decertified is exempted from the application of a payment adjustment
- 4002(c) HHS must support the convening of stakeholders to develop reporting criteria

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# Title IV-Delivery - Section 4003

## Interoperability

- 4003(a) Defines Interoperability:
- The term 'interoperability', with respect to health information technology, means such health information technology that:
  A. Enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user
  B. Allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law
  C. Does not constitute information blocking as defined in section 3022(a) of the Public Health Service Act (PHSA) as amended

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# Title IV-Delivery - Section 4003

## **Interoperability** (continued)

- Section 4003(b) directs the National Coordinator to convene appropriate public and private stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement (TEFCA) for exchange between health information networks.
  - A User's Guide to Understanding the Trusted Exchange Framework (ONC HealthIT.gov)
  - Timeline:

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# Title IV-Delivery - Section 4003

**Interoperability** (continued)

- 4003(c) requires that HHS establish an index of digital contact information for health professionals, health facilities, and others to encourage the exchange of health information
  - The Center for Program Integrity (CPI) in CMS will be responsible for implementing the provision. CPI is working with ONC on implementation of the provision.
- 4003(e) replaces the Health IT Policy Committee and the Health IT Standards Committee with the Health IT Advisory Committee (HITAC)
  - The ONC must periodically convene the HITAC to report on priority uses of health IT and standards and implementation specifications that support the implementation of a health information technology infrastructure that advances the electronic access, exchange, and use of health information.

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# Title IV-Delivery - Section 4004

## Information blocking

- Section 4004(a) defines information blocking as a practice that:
  A. ''except as required by law or specified by the Secretary pursuant to rulemaking under paragraph (3), is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.''
  B. "(i) if conducted by a health information technology developer, exchange, or network, such developer, exchange, or network knows, or should know, that such practice is likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information; or (ii) if conducted by a health care provider, such provider knows that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.''



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# Title IV-Delivery - Section 4004

## **Information blocking** (continued)

- Section 4004(b) The Inspector General of HHS is authorized to investigate claims of information blocking
  - A health information technology developer or other entity offering certified health information technology, or a health information exchange or network, may be penalized for engaging in information blocking, up to $1M per violation.
  - Providers determined by the Inspector General to have committed information blocking shall be referred to the appropriate agency to be subject to appropriate disincentives using authorities under applicable Federal law, as the Secretary sets forth through notice and comment rulemaking.
- Section 4004(d) The National Coordinator must implement a standardized process for the public to submit reports on claims of information blocking

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# Title IV-Delivery - Sections 4005 & 4006

## Leveraging electronic health records to improve patient care

- 4005(a) To be certified, electronic health records must be capable of transmitting to, and where applicable, receiving and accepting data from, registries certified by the ONC
- 4005(c) HHS must report on best practices and current trends provided by patient safety organizations to improve the integration of health IT into clinical practice

## Empowering patients and improving patient access to their electronic health information

- 4006(a) instructs HHS to:
  - Encourage partnerships between health information exchanges and health care providers, health plans, and others with the goal of offering patients access to their electronic health information
  - Issue guidance to health information exchanges on best practices
  - Educate providers on leveraging health information exchanges
  - Promote policies to facilitate patient communication with providers and others, given patient consent
  - Update education on accessing and exchanging personal health information
  - Develop and prioritize standards, implementation specifications, and certification criteria required to support patient access to electronic health information and usability

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Section 7

# OPERATING RULES

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# Change Healthcare Operating Rules Readiness

Change Healthcare clearinghouse services **CORE Phase III Certified.** 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 Operating Rule readiness.

The CAQH Committee on Operating Rules for Information Exchange (CAQH CORE®) 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.HIPAASimplified.com.

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# Operating Rules – 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 had not yet been established at the time of rule development.

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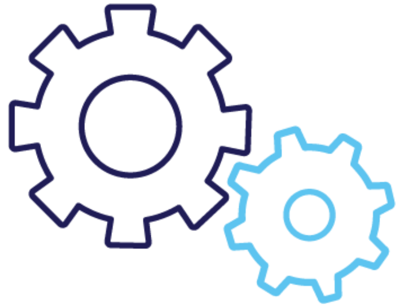
# Phase IV Operating Rules – regulatory roadmap



- On July 6, 2016, NCVHS sent a letter to the HHS secretary recommending that the Phase IV Operating Rules not be adopted under regulatory mandate and supporting 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, click here.

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# Phase V Operating Rules – new rule development

- CAQH CORE is actively developing new rules for the Prior Authorization transaction (005010X217 278 Health Care Request for Review and Response), which is a HIPAA adopted transaction.
- Drafting of new rules by the Prior Authorization Subgroup began 5/17/2018.
- Rules address data content requirements for the 278 as well as proprietary web portal prior authorization form standardization.
- Draft rules under review and vote by the Rules Workgroup.
- Drafting of Certification Testing requirements to begin Q1 2019, with final full CAQH CORE vote on Phase V by mid-2019.
- Operating Rules for Attachments are slated for development after issuance of the Attachments regulation.

**Contact CAQH CORE at core@caqh.org for additional information.**

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Section 8

# HEALTH PLAN IDENTIFIER (HPID)

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# Health Plan Identifier – timeline

- On 10/31/14 CMS announced an HPID enforcement discretion delay until further notice.
- On 6/21/17 NCVHS sent a letter to the HHS secretary with three recommendations all focused on rescinding the current final rule and educating the industry on next steps.
  - HHS should rescind its September 5, 2012 HPID Final Rule which required health plans to obtain and use the HPID.
  - HHS should communicate its intent to rescind the HPID Final Rule to all affected industry stakeholders as soon as a decision is made. HHS should provide the applicable guidance on the effect a rescission may have on all parties involved.
  - HHS should continue with the 2014 HPID Enforcement Discretion until publication of the regulation rescinding the September 5, 2012 HPID Final Rule.
- **Rescission of the HPID regulations appears on the Current Unified Agenda of Regulatory and Deregulatory Actions for Fall 2018 (RIN 0938-AT42).**

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Section 9

# HEALTH PLAN CERTIFICATION

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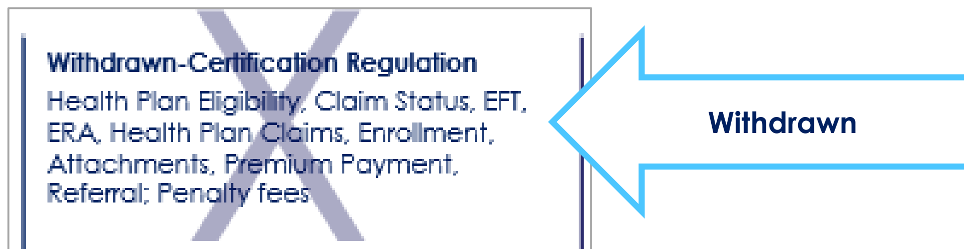
# Health Plan Certification – timeline




- The Department of Health and Human Services (HHS) posted a proposed rule in the Federal Register on October 4, 2017 to withdraw the January 2, 2014 final rule entitled *Administrative Simplification: Certification of Compliance for Health Plans*, which would have required controlling health plans (CHPs) to submit certain information and documentation that demonstrated compliance with the Standards and Operating Rules adopted under HIPAA.
- he 2014 Health Plan Certification rule was dependent on the 2012 Health Plan Identifier (HPID) rule, which is in enforcement delay and on the HHS Unified Agenda for withdrawal in 2018 (see Health Plan Identifier).

Section 10

# CHANGE HEALTHCARE ACCREDITATIONS & CERTIFICATIONS

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# HHS Optimization Program Certification

- On October 4, 2018, The U.S. Department of Health and Human Services (HHS), Division of National Standards (DNS) within the Centers for Medicare & Medicaid Services (CMS), recognized Change Healthcare for successfully completing the HHS Optimization Program Pilot of Administrative Simplification transaction standards, code sets, unique identifiers, and operating rules.
- Visit the Change Healthcare Viewpoints blog post for additional information.
- Certificate of Completion

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# Change Healthcare Accreditations & Certifications

To demonstrate our continued commitment to assure that applicable Change Healthcare products and services meet industry and regulatory requirements and expectations, we maintain several industry recognized and trusted accreditations and certifications.

Click HERE for more information.

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