CHANGE HEALTHCARE

REGULATORY AND STANDARDS UPDATE

Q3 2017 Update Published: August 15, 2017

Q4 2017 Update Available: No later than November 7, 2017

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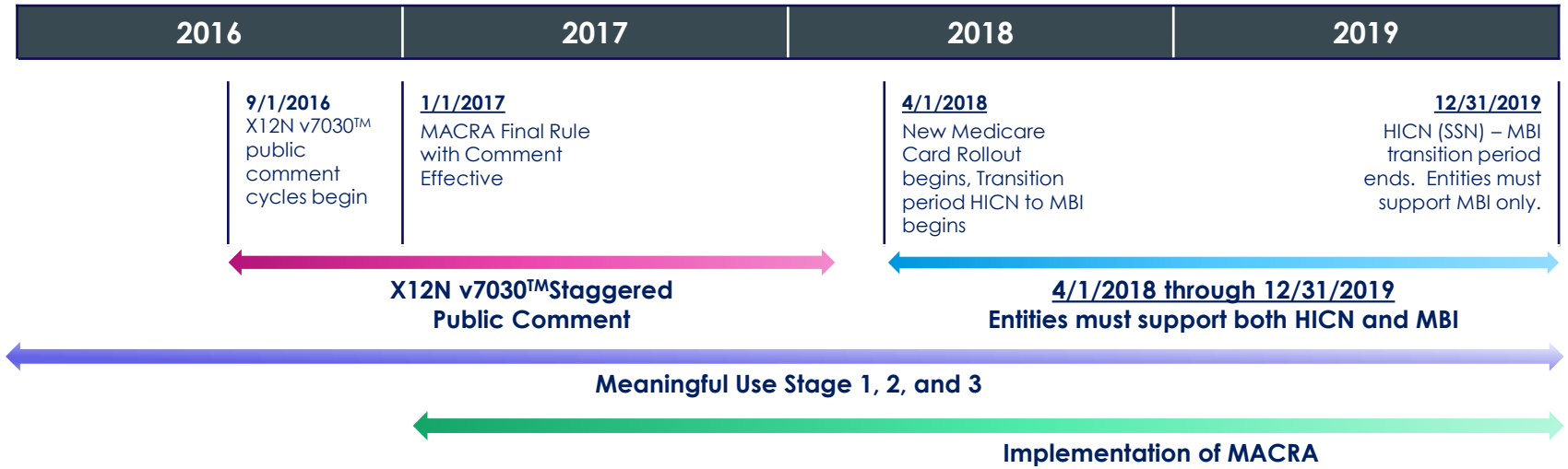
Timeline



Delayed / TBD

Regulations below have not been published at this time or have been delayed and the dates are to be determined.

Enforcement Delay-Compliance Health Plans must register for Health Plan ID(HPID)	**TBD-Certification** Health Plan Eligibility, Claim Status, EFT, ERA	**TBD-Effective** Claims, Enrollment, Authorizations Premium Payment, Operating Rules	**TBD-Effective** Attachments Standard and Operating Rules
Enforcement Delay-Compliance Small Health Plans must register for HPID	**TBD-Certification** Health Plan Claims, Enrollment, Attachments, Premium Payment, Referral	**TBD-Compliance** Claims, Enrollment, Authorizations Premium Payment, Operating Rules	**TBD-Compliance** Attachments Standard and Operating Rules
Enforcement Delay HPID use in transactions	**TBD-Penalty Fees** Health Plan Eligibility, Claim Status, EFT, ERA		

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Section 1

X12N Version 7030™

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X12N Version 7030™ – Public Comment

The public review and comment cycles for version 7030™ of the 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 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.
- The intent of X12N is to publish all TR3s together when the public comment cycles have been completed and all comments considered.

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X12N Version 7030™ – Timeline

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)

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X12N Version 7030™ – Timeline

Review Cycles - Upcoming

Cycle 5

September 1 through November 30, 2017
Health Care Eligibility/Benefit Inquiry and Information Response (270/271)

Cycle 6

September 1 through November 30, 2017
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 7

Postponed (not yet rescheduled)
Application Reporting for Insurance (824)
Health Care Claim 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)

Cycle 8

Canceled
Version 7030™ of the Health Care Fee Schedule (832) has been withdrawn.

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

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Section 2

Operating Rules

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Change Healthcare Operating Rules Readiness

Change Healthcare is **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.

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.HIPAASimplified.com.

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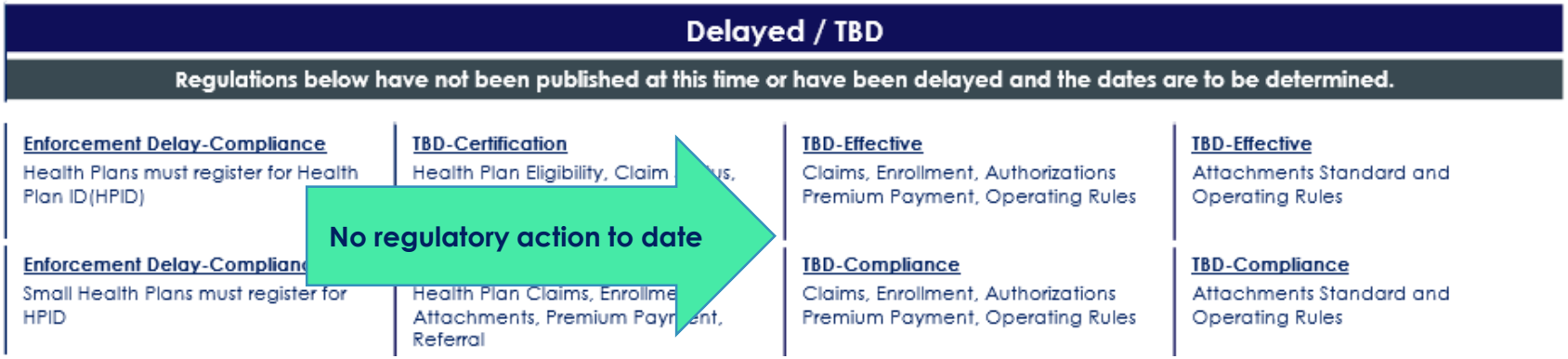
Operating Rules – Timeline



- 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 have not yet been established.

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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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Section 3

Attachments

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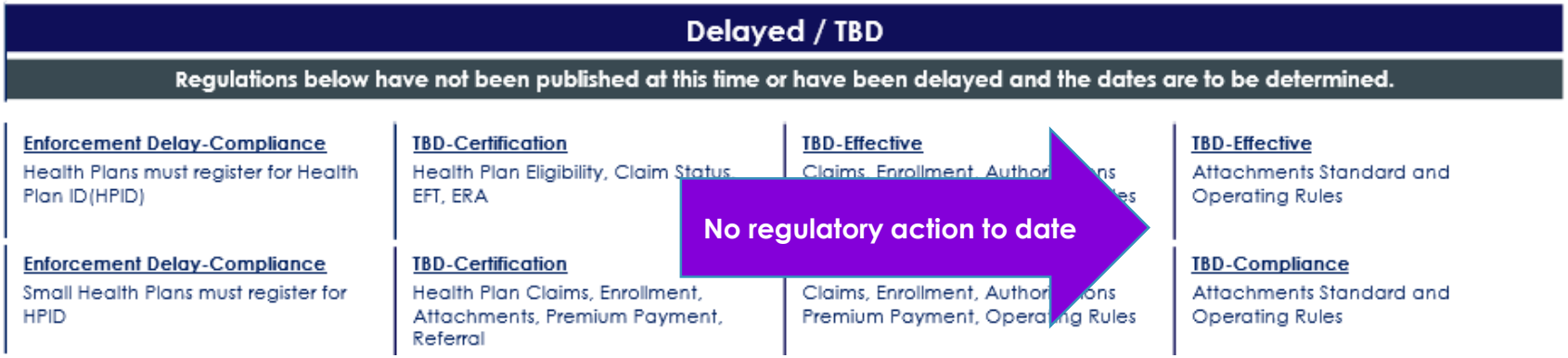
Attachments – Timeline



- The Administrative Simplification provisions under the ACA include adoption of transaction standards and operating rules for Attachments.
- Electronic Attachments are electronic transactions that support 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.

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Attachments – Current Activities

- Two Standards Development Organizations, Health Level 7 (HL7) and X12, have been collaborating on the development of Attachments standards.
- HL7 has finalized the Implementation Guide for Attachments and is in the publication phase. This guide describes the use of the HL7 Consolidated CDA R2.1 document type specification for Health Claim Attachments.
- X12, HL7, and the Workgroup for Electronic Data Interchange (WEDI) are developing a "How To" white paper to help implementers understand how the X12 and HL7 Attachment standards work together. The white paper is in the final approval phase and will be published on the WEDI website
- The HL7 Attachment Workgroup developed a C-CDA for periodontal charting in collaboration with the ADA. This document was published at the end of July 2017.

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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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Attachments – Regulatory Roadmap

- NCVHS hearing was held on February 16, 2016.
- Conformance Version of the Supplemental Specifications for Attachments balloted by HL7 in May 2016.
- NCVHS Letter of Recommendation sent to HHS on July 5, 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.

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Section 4

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

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About 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),
    - MIPS Participation Fact Sheet
    - CMS Provider Eligibility Lookup Tool
  - Advanced Alternative Payment Models (APMs)
    - Advancing Care Coordination through Episode Payment Models rule published.

      The Episode Payment Model start date has been delayed from July 1, 2017 to October 1, 2017 and may be delayed until January 1, 2018, pending further communication from CMS.
- On June 20, 2017, CMS issued a proposed rule that would make changes in the second year of the Quality Payment Program. To view the CMS fact sheet on the proposed rule, click here.
- More information on the Quality Payment Program can be found at QualityPaymentProgram.cms.gov and Quality Payment Program Educational Resources

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Section 5

CMS New Medicare Card Project

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CMS New Medicare Card Project – HICN to MBI

CMS will transition to MBI from April 2018 through December 2019

- 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 will conduct a phased issuance from April 2018 to April 2019 to existing Medicare beneficiaries 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.**
- 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 initiated 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 will accept, process, and transmit either the old Medicare number (HICN) or the new Medicare number (MBI) within applicable health care transactions on and after April 1, 2018. 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 will work with state Medicaid agencies who display the HICN on their Medicaid cards as well as the Railroad Retirement Board who issues their own cards.
- The gender and signature lines will also be removed from the new cards.
- CMS will conduct intensive education and outreach to beneficiaries and their agents, providers, advocacy groups, caregivers, states and territories, key stakeholders, vendors, and other partners.
- More information is available at https://www.cms.gov/medicare/new-medicare-card/nmc-home.html.

Watch Change Healthcare's HIPAA Simplified site for updates.

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Section 6

Health Plan Identifier (HPID)

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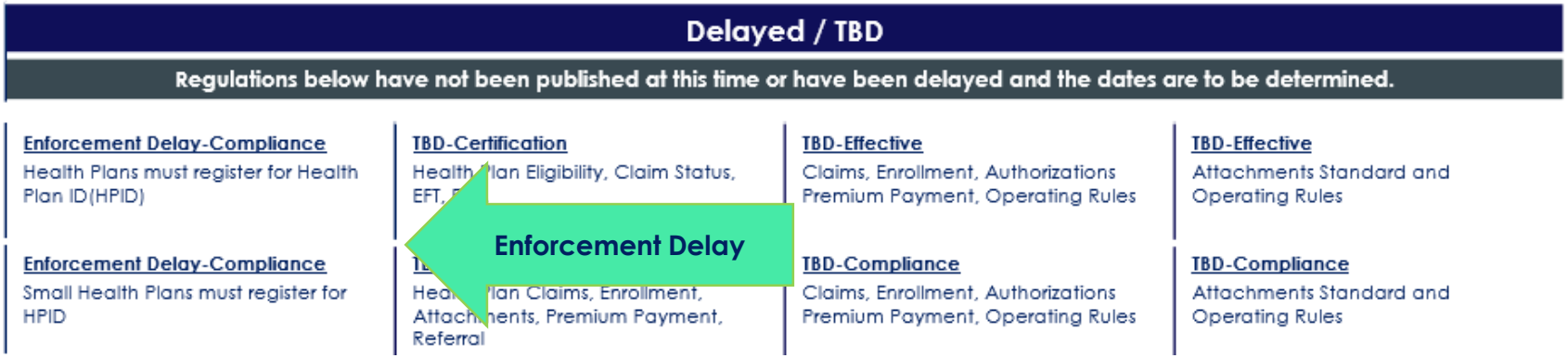
Health Plan Identifier – Timeline



- 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.
- HHS to consider the recommendations outlined by NCVHS.

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Section 7

Health Plan Certification

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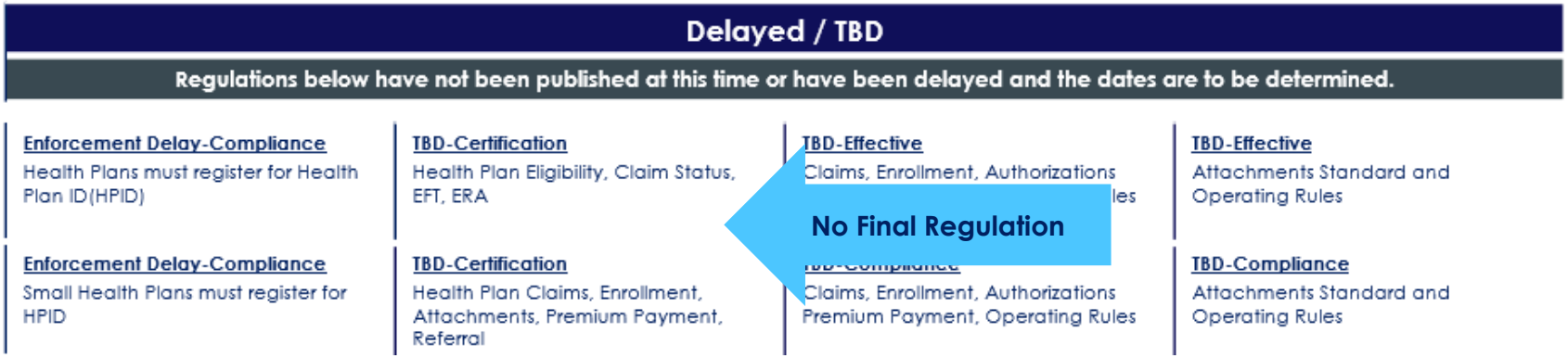
Health Plan Certification – Timeline



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

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