05.15.2017

HIPAA and ACA Timeline
Change Healthcare Quarterly Updates

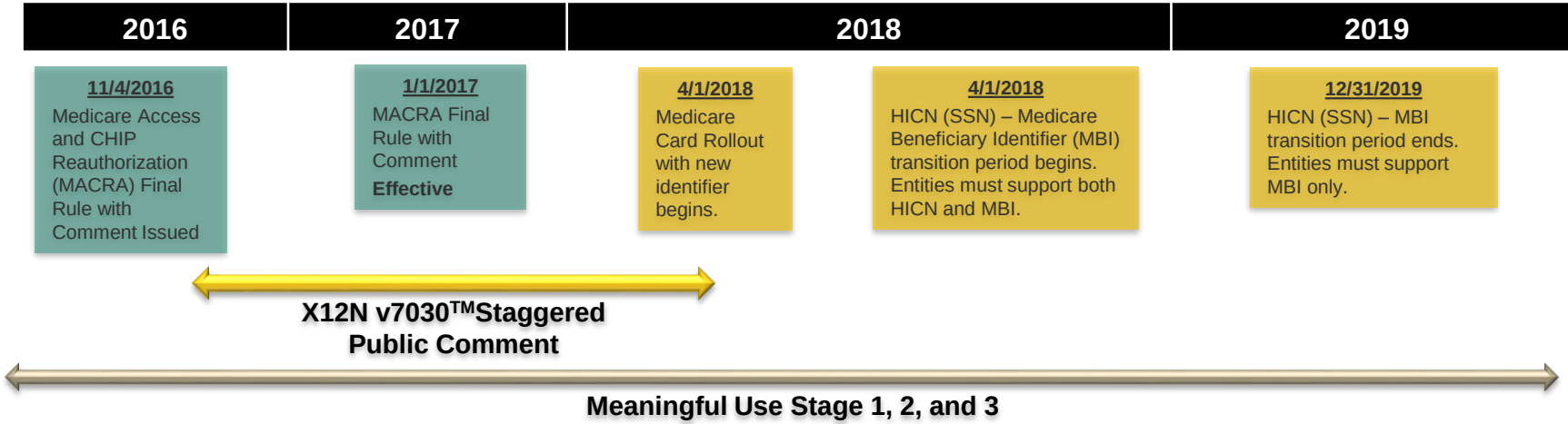
Q2 2017 Update Published: May 15, 2017

Q3 2017 Update Available: No later than August 15, 2017

CHANGE HEALTHCARE™

Table of Contents

HIPAA and ACA 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
Health Plans must register for HPID
Compliance

Enforcement Delay
Small Health Plans must register for HPID
Compliance

Enforcement Delay
Health Plan ID use in Transactions
Compliance

TBD
Health Plan Eligibility, Claim Status, EFT, ERA
Certification

TBD
Health Plan Eligibility, Claim Status, EFT, ERA
Penalty Fees

TBD
Health Plan Claims, Enrollment, Attachments, Premium Payment, Referral
Certification

TBD
Claims, Enrollment, Authorizations Premium Payment, Operating Rules
Effective

TBD
Claims, Enrollment, Authorizations Premium Payment, Operating Rules
Compliance

TBD
Attachments Standard and Operating Rules
Effective

TBD
Attachments Standard and Operating Rules
Compliance

X12N Version 7030™

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 those 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 TR3's together when the public comment cycles have been completed and all comments considered.

ASC X12N Version 7030 – Public Comment

X12N v7030™ Staggered Public Comment

Review Cycles – Completed/Closed

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)

ASC X12N Version 7030 – Public Comment

X12N v7030™ Staggered Public Comment

Review Cycles – In Progress/Future

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 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.

ASC X12N Version 7030 – Public Comment

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

Change Healthcare Encourages Your Participation

Change Healthcare is actively participating in the v7030TM Public Review and Comment process and we encourage all entities to participate.

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

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

Operating Rules

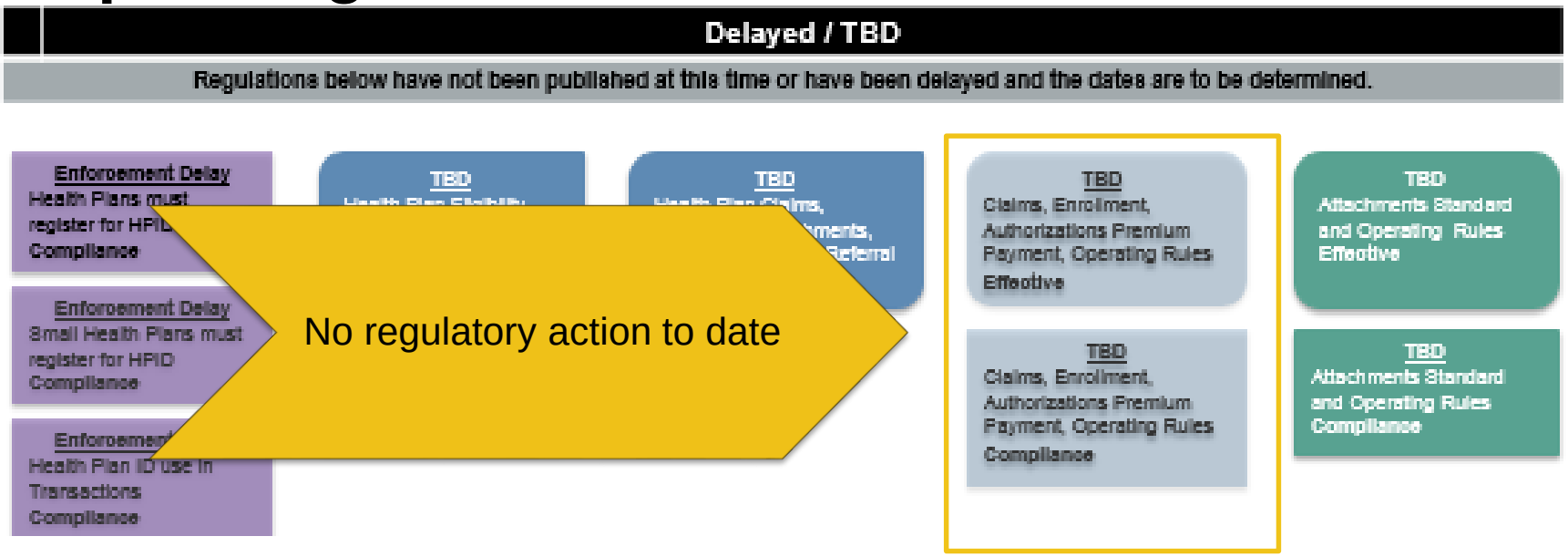
Change Healthcare Operating Rules Readiness

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.HIPAASimplified.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.

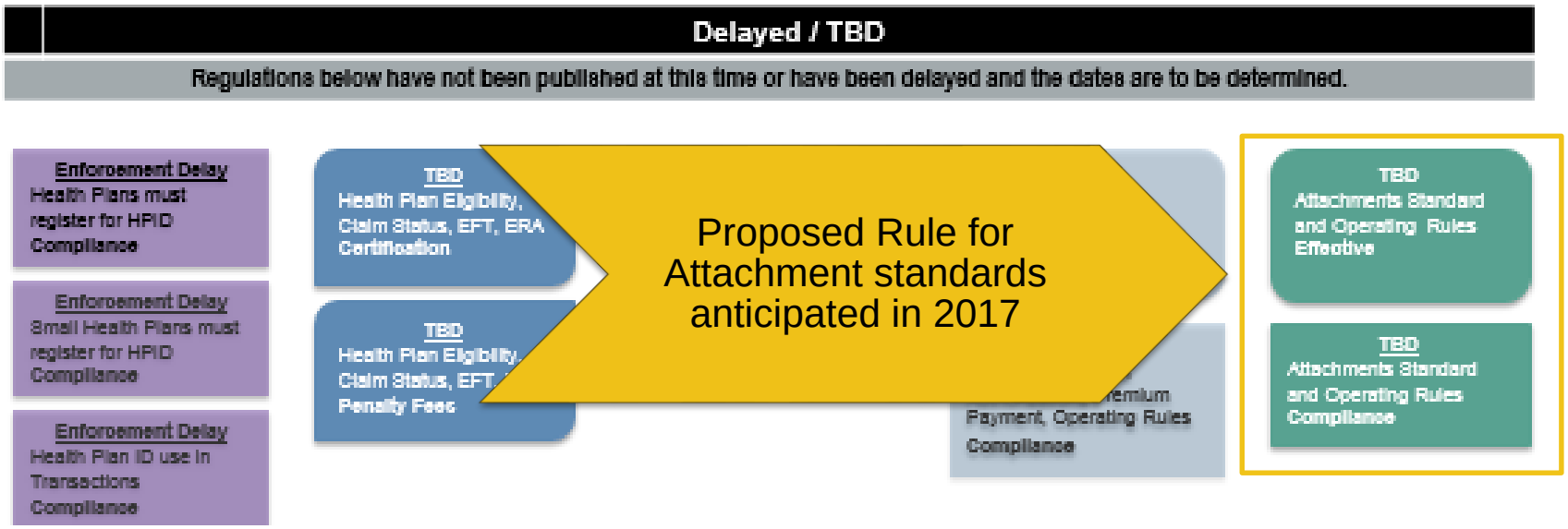
Regulatory Roadmap – Phase IV Operating Rules

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



- 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 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.
- X12, HL7, and WEDI are developing a “How To” white paper to help implementers understand how the 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 Q2 2017.
- 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.

Implementation of MACRA

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

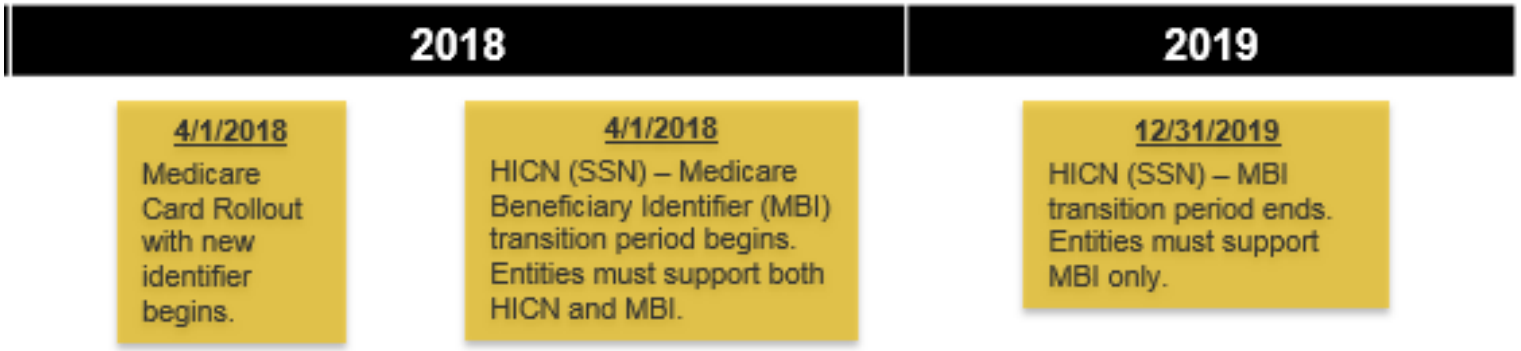
Implementation of MACRA

- 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),
    - Registration is open until 6/30/17 for MIPS participants planning to report as a group.
    - 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.
    - Organizations wishing to apply for the ACO Track 1 program in 2018 need to submit a Notice of Intent to Apply by May 31, 2017.

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

Medicare Social Security Number Removal Initiative (SSNRI)

Social Security Number Removal Initiative (SSNRI) / Medicare Beneficiary Identifier (MBI)



- The Medicare Access and CHIP Reauthorization Act (MACRA) mandates the removal of the Health Insurance Claim Number (HICN) from Medicare cards.
- As a result, the Centers for Medicare & Medicare Services (CMS) has initiated the Social Security Number Removal Initiative (SSNRI).
- The primary goal of the SSNRI is to decrease Medicare beneficiaries' vulnerability to identify theft by removing the Social Security number from all Medicare ID cards.
- The SSN will be replaced with a CMS-enumerated Medicare Beneficiary Identifier (MBI).
- CMS will conduct a phased card issuance of new, redesigned ID cards with the MBI to existing beneficiaries from April 2018 to April 2019. Additionally, new beneficiaries will be issued an MBI.

About the MBI

- Will be 11 characters in length, excluding two dashes.
- Will be visibly distinguishable from the HICN.
- Occupy the same field as the HICN on transactions.
- Be unique to each beneficiary.
- Must be treated as Personal Health Information (PHI).
- Contains numeric and upper-case alphabetic characters.
- Easily readable: limits the possibility of letters being interpreted as numbers by excluding S, L, O, I, B, and Z.
- Does not contain any intelligence or special characters.
- An individual's MBI will not be change unless the MBI is compromised or for other considerations.

Regulatory Roadmap – Transition to MBI

- CMS will issue replacement and new ID cards, which will replace the HICN with the MBI, starting in April, 2018 through April, 2019.
- **All systems, applications, and operational processes must be able to accept, send, and receive 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.

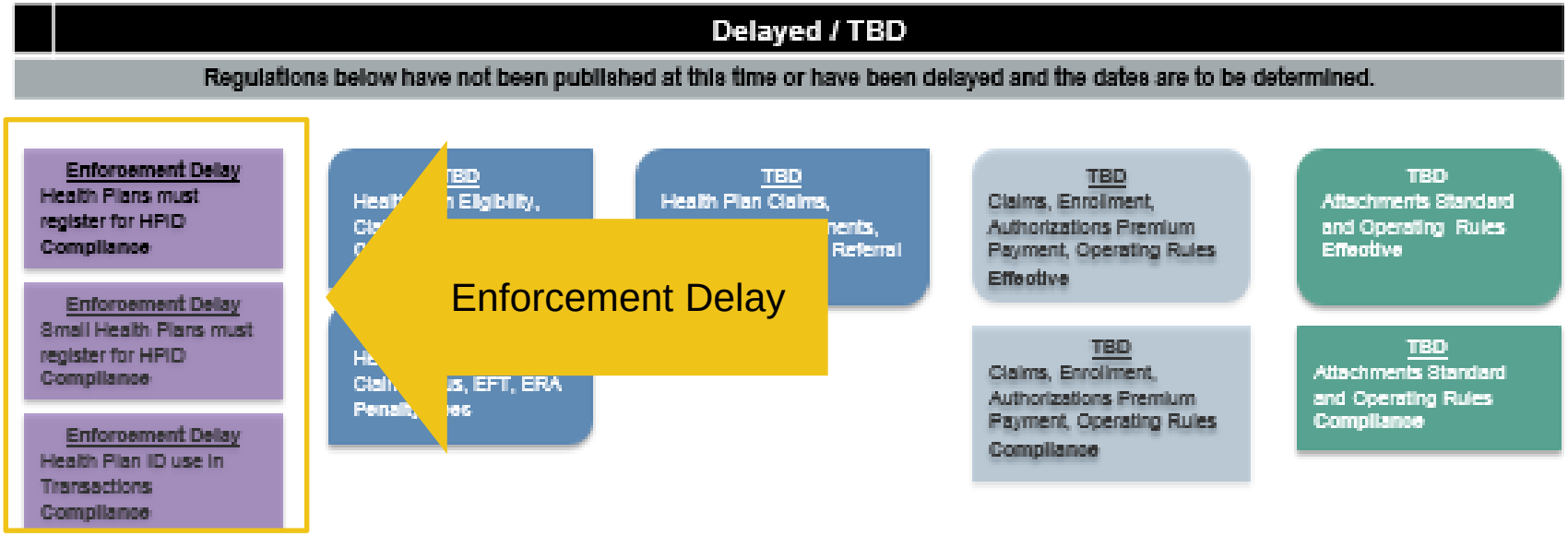
Additional Information

- 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: www.cms.gov/medicare/ssnri/index.html.

Health Plan Identifier (HPID)

Health Plan ID – HIPAA and ACA Timeline



- 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 3, 2017, NCVHS held a hearing to seek further input from the health care industry for disposition and next steps for the HPID following its three year enforcement discretion period.
- Change Healthcare provided oral testimony at the the hearing.
- HHS has not yet communicated further regulatory action based on the feedback.

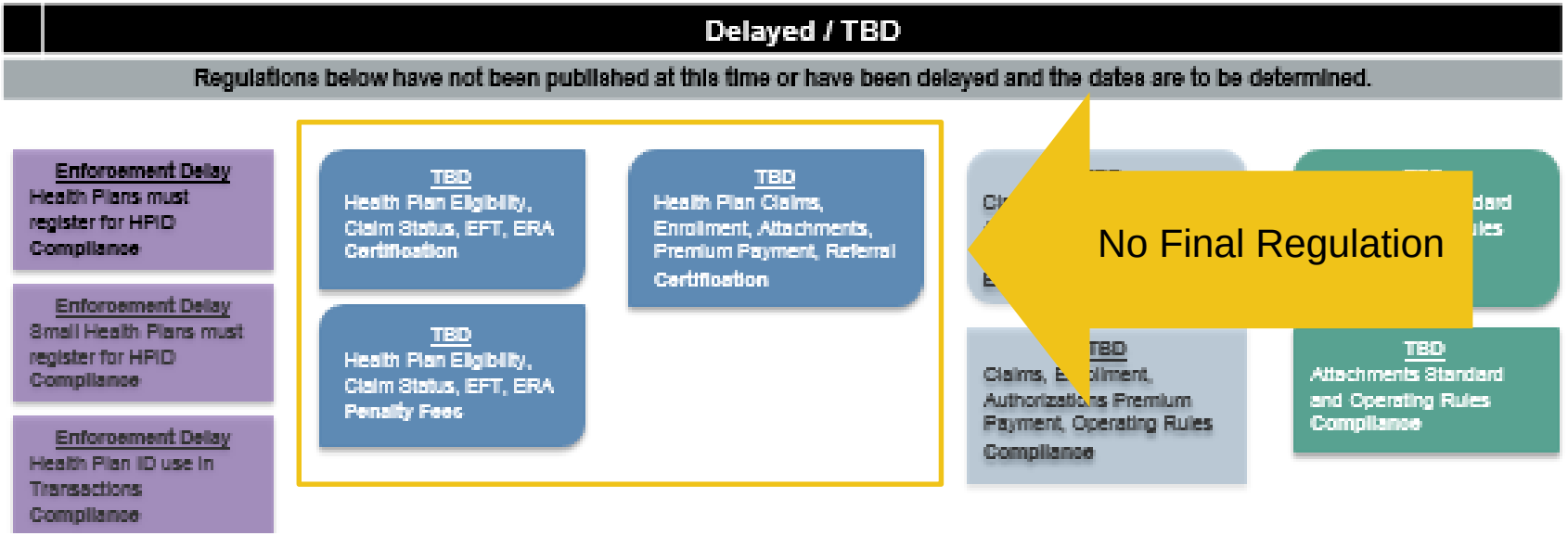
Due to the HPID enforcement discretion delay until further notice, covered entities are NOT required to use HPID to identify health plans in transactions effective November 7, 2016.

Related Materials

- X12 updated errata in HIPAA transactions
- WEDI Issue Brief clarifying Payer vs. Health Plan

Health Plan Certification

Health Plan Certification – HIPAA and ACA 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 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.