Panel 2: Health Plan Eligibility, Benefits Inquiry & Response NCVHS Subcommittee on Standards, Review Committee

June 16, 2015

Robert M. Tennant
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Medical Group Management Association

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About MGMA

- MGMA is the premier association for professional administrators and leaders of medical group practices
- Since 1926, the association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals
- Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties.

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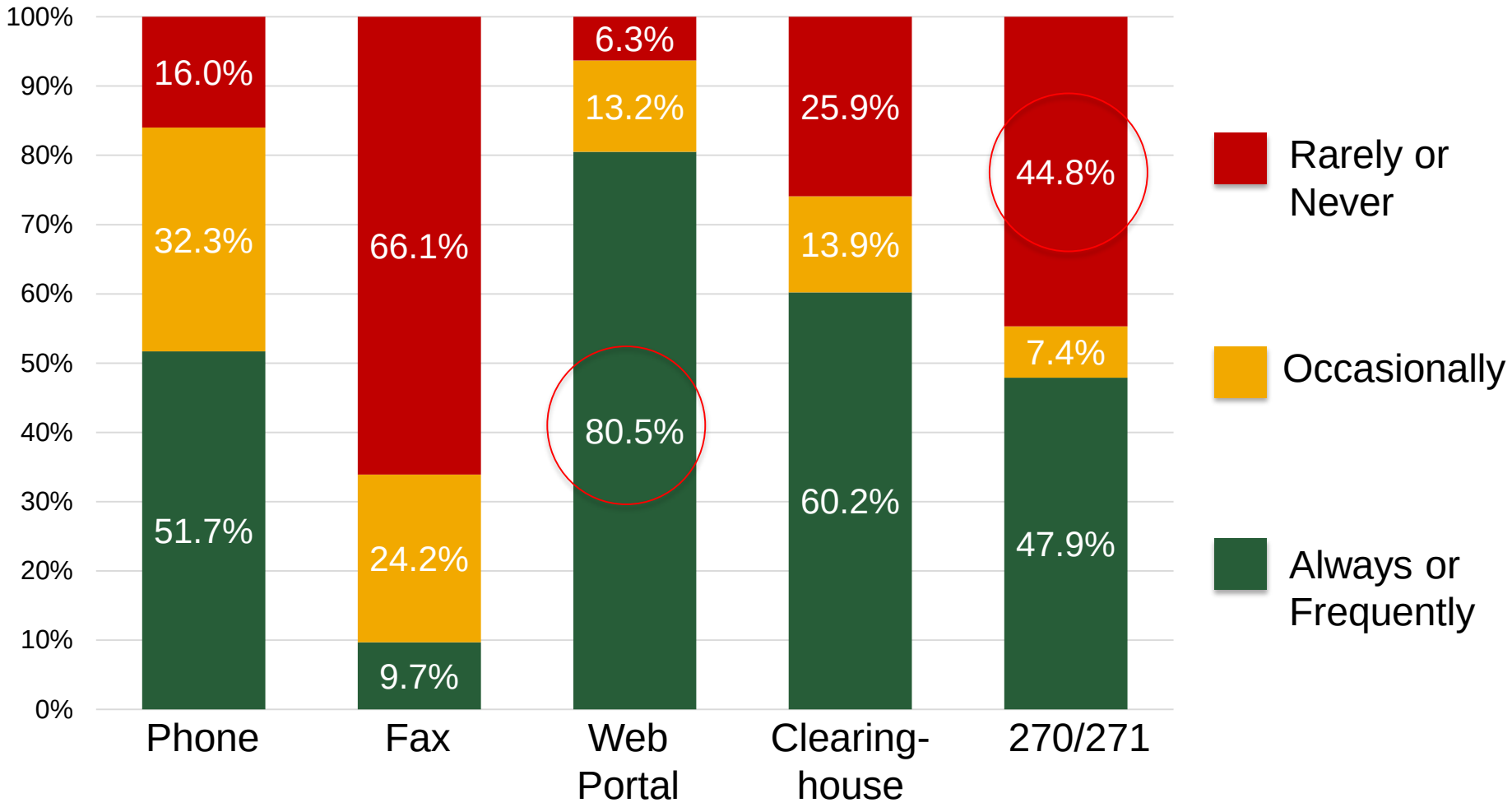
Survey Data

1. Joint survey with the American Dental Association, American Medical Association and MGMA
   - April-May 2015
   - 1151 respondents
2. MGMA member survey
   - June 2015
   - 547 respondents

How often does your practice use the following methods to verify patient insurance eligibility?



What are the reasons your practice does not always use the HIPAA 270/271 electronic transaction to check patient eligibility? Please check all that apply.

Answer Options	Response
The eligibility response returned by our health plans typically lacks all of the patient financial responsibility information we need	**41.3 %**
The eligibility response lacks explicit information regarding eligibility of specific medical services	33.5%
Our practice management system does not have the capability to conduct the 270/271 transactions	21.9%
The eligibility response is typically not returned by our health plans within the required 20 second window	12.9%
The fees charged by our clearinghouse for the 270/271 transaction are excessive	10.5%

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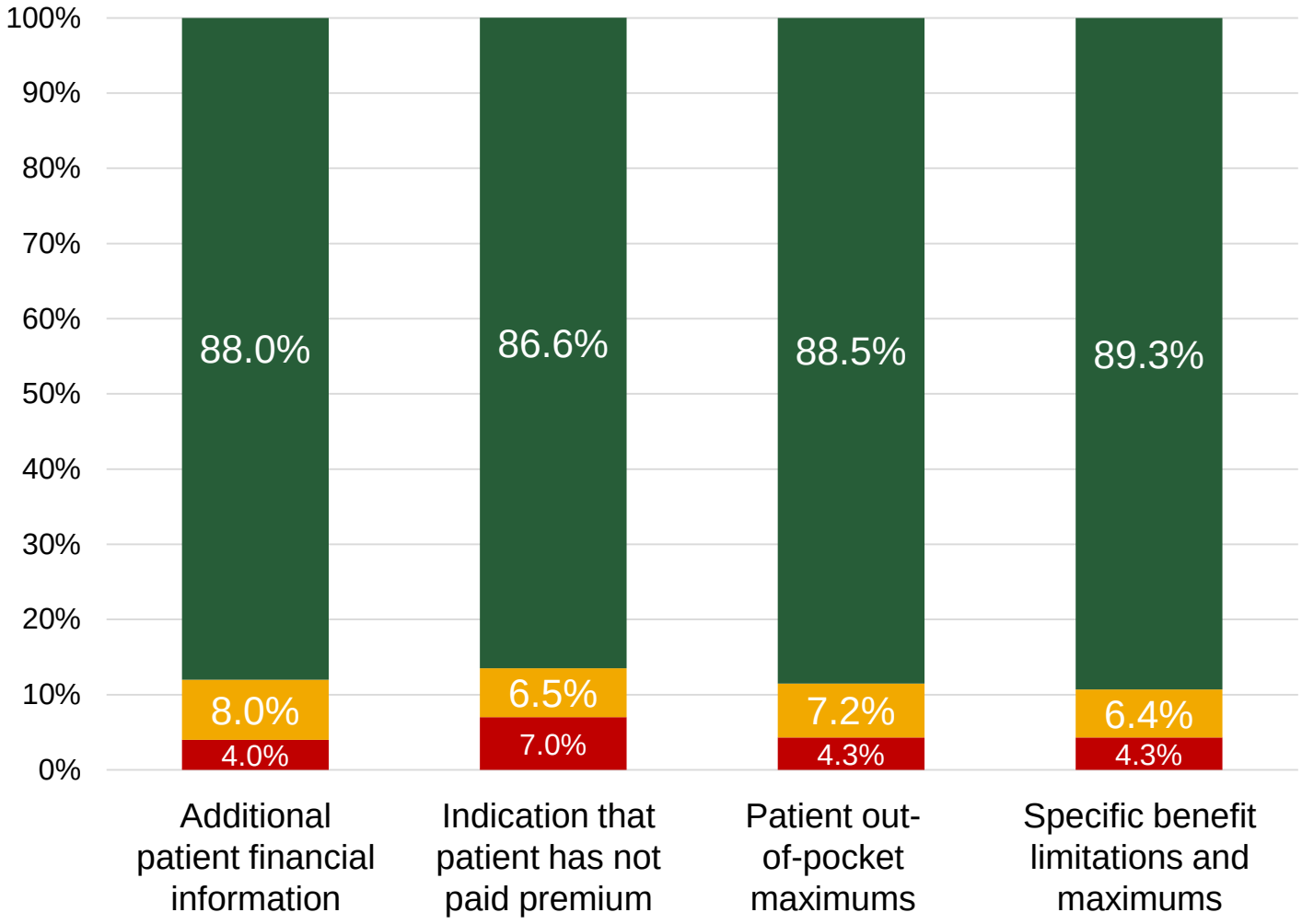
Rate how valuable your practice would find the following if they were included in the 270/271



Practice Concerns

- Significant variability in the use of eligibility transactions and operating rules
- Verification even more critical in the era of high deductible plan products
- Requires practices to understand each payer requirement
- Payers driving providers to web portals to check eligibility
- Required information not always supplied to the providers
- Required information not always supplied within the 20 second window (or next day for batch)
- PM vendors do not always support use of the 270/271

Select Member Comments

- “Some are in conflict with copays/coinsurance on an effective card or even on the payer’s own website”
- “Fees and offerings by our PM vendor prohibit our interest”
- “Numerous small plans do not support the 271”
- “The 271 does not indicate if a HCX patient is in the grace period”
- “No one should be allowed to offer new insurance options before their 271s are ready to support it”
- “The information is not reliably accurate or up-to-date”
- “Our software vendor’s clearinghouse fees are excessive”
- “Often find patient is not eligible, then when I call plan, I find the patient IS eligible. Frustrating!”

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Use and Potential Savings

- According to the *2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2013*
- Fully Electronic 270/271 (HIPAA standardized) Transaction Adoption Rates, Health Plans Reporting 2013 Data = 65.3%
- Potential provider savings: $3.07 per eligibility verification transaction

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MGMA Recommendations

- Practices want a simple, automated electronic approach to eligibility verification
- Must be low cost if to be widely used
- Should be encouragement to use the 270/271 and not payer portals
- 270/271 should be better integrated within provider workflow
- More complete patient eligibility and financial responsibility “picture” should be available (and in real-time)

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MGMA General Recommendations

- Short-term
  - CMS should significantly increase provider education on the 270/271
  - CMS should endorse/support the EHNAC/WEDI PMSAP
- Longer term
  - Additional collaboration between provider organizations and SDOs (go where the providers are)
  - CMS should proactively audit HPs for 270/271 compliance
  - Provider should not be responsible when 271 comes back green
  - CMS should consider incentives to move industry toward wide-scale adoption (similar to meaningful use)

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Panel 3: Prior Authorization

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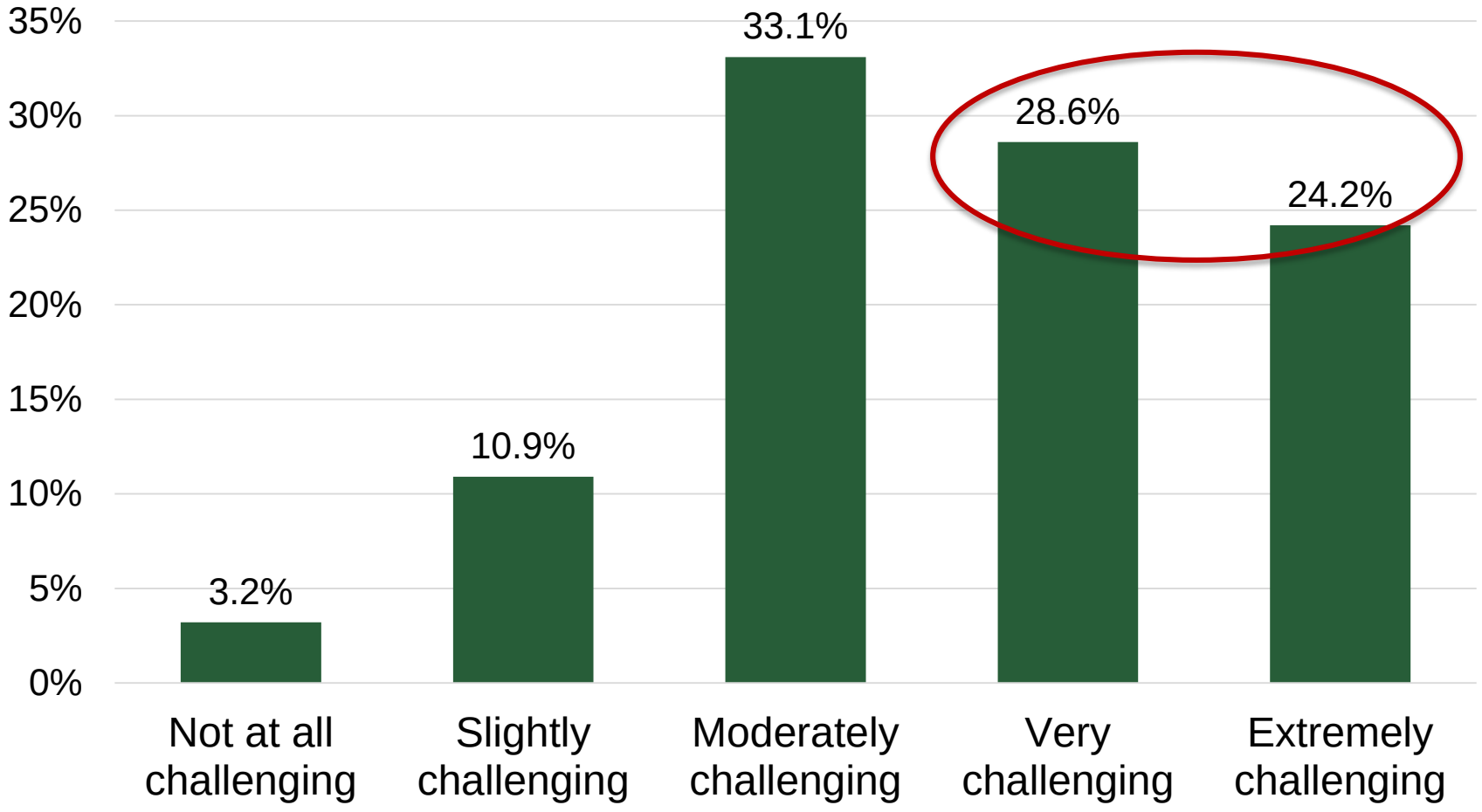
Overall, how would you rate the current prior authorization process?



Use and Potential Savings

- According to the *2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2013*
- Fully Electronic PA (HIPAA standardized) Transaction Adoption Rates, Health Plans Reporting 2013 Data = 6.7%
- Potential provider savings: $8.93 per PA

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Practice Concerns

- Requires practices to understand each payer requirement (significant variation)
- Every health plan has its own format, criteria and forms
- Practices forced to use payer web portals for “online” access
- PA growing is payer use
- Most common PA-imaging services and brand name drugs
- Some payers are requiring PA for everything—even generic drugs
- Significant workflow burdens
- PA process in general slows treatment for patients, adds frustration for patients and providers
- The 278 standard is difficult and frustrating for all stakeholders to use, often confusing for providers to interpret
- Rarely is the complete required information supplied to the providers

MGMA Recommendations

- Practices want a simple, automated electronic approach to PA
- Must be low cost if to be widely used (especially in primary care)
- One that applies to all transactions (i.e., drug and imaging) and operates in real-time while the patient is in the office
- HIPAA 278 response has too much variability – tighter controls on what is returned is critical

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MGMA General Recommendations

- Short-term
  - CMS should significantly increase provider education on the 278
  - CMS should endorse/support the EHNAC/WEDI PMSAP
  - Release the Claims Attachment regulation
- Longer term
  - Additional collaboration between provider organizations and SDOs (go where the providers are)
  - CMS should proactively audit HPs for 278 compliance
  - CMS should consider financial incentives to move industry toward wide-scale adoption (similar to meaningful use)
  - Development of a single formulary

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Panel 4: Healthcare Claim or Equivalent Encounter Information

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Rate how often your practice uses the following methods to submit claims

Answer Options	Always	Frequently	Occasionally	Rarely	Never
5010 submitted directly to health plan	12.7%	13.7%	11.2%	16.1%	**46.3%**
5010 HIPAA 837 submitted to clearinghouse	**66.3%**	29.5%	1.5%	0.8%	1.9%
4010 HIPAA 837 submitted directly to health plan	1.9%	4.4%	8.8%	13.8%	**71.3%**
4010 HIPAA 837 submitted directly to clearinghouse	9.2%	9.2%	6.7%	12.3%	**62.6%**
"NSF" or older version submitted directly to health plan	2.4%	1.2%	2.4%	12.2%	**81.7%**
Paper claim submitted to health plan	0.8%	8.1%	**45.7%**	39.7%	5.7%
Paper claim submitted to clearinghouse	2.9%	3.4%	15.7%	22.1%	**55.9%**

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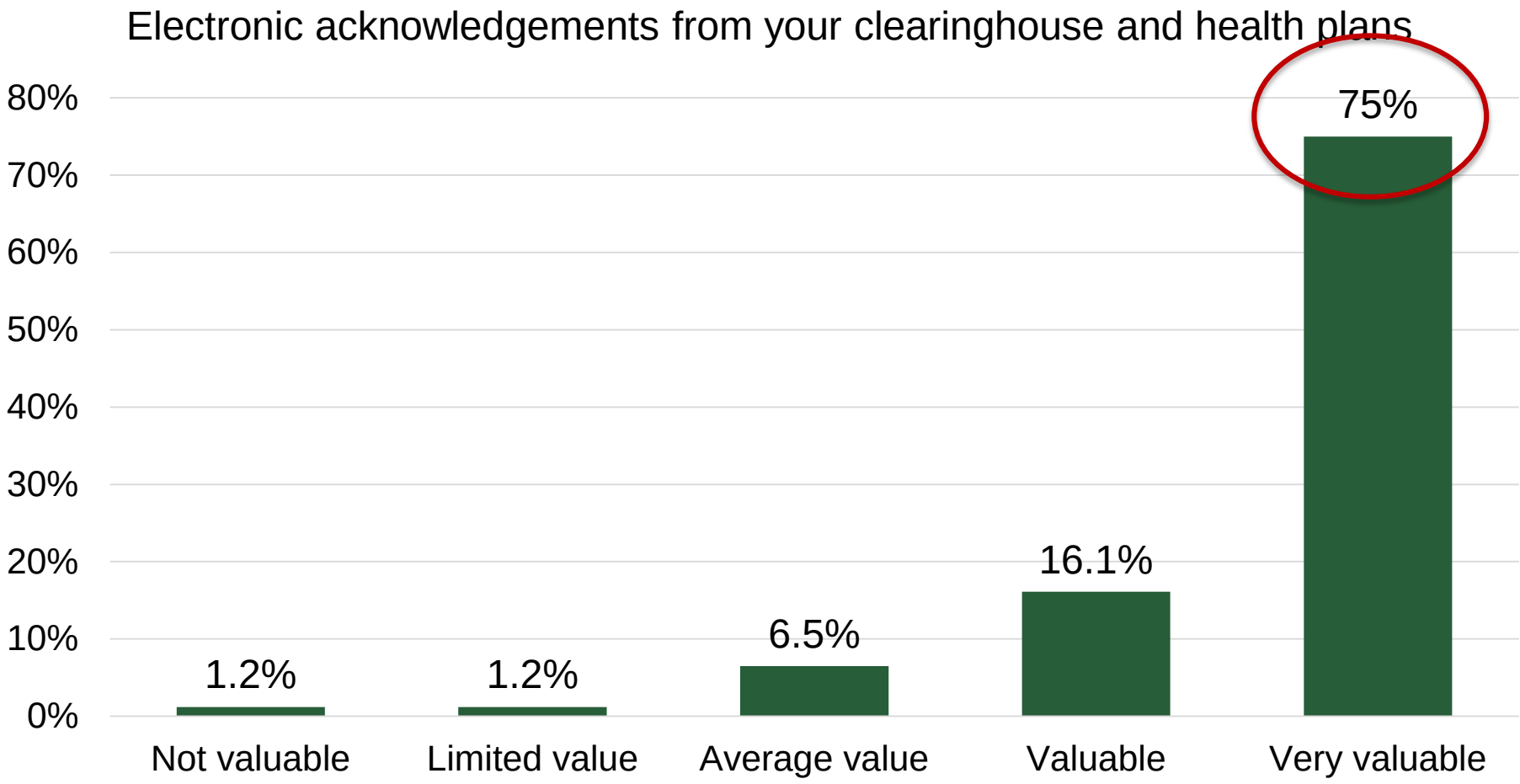
Rate how valuable your practice would find the following if included in the 837



Practice Concerns

- Significant variability in payer acceptance of electronic claims
- We have not quite reached standardization- practices still required to understand each payer's unique requirements
- PM vendors do not always support use of 5010 837
- When there is a submission problem, much finger pointing (vendor, CH, payer)
- No acknowledgments = reduced transparency

Select Member Comments

- “Certain payers cannot accept electronic claims”
- “Work comp require paper”
- “Some of the smaller payers do not accept e-claims through our clearinghouse”
- “Some local plans don’t accept electronic claims”
- “Carrier does not accept electronic filing”
- “Sometimes insurance plans have the wrong logic built into their claim system and it needs to be circumvented by manual review”

Use and Potential Savings

- According to the *2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2013*
- Fully Electronic 837 (HIPAA standardized) Transaction Adoption Rates, Health Plans Reporting 2013 Data = 91.8%* (2/3rds via CH)
- Potential provider savings: $2.23 per claim transaction

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MGMA Recommendations

- Short-term
  - CMS should significantly increase provider education on use of the 5010 837
  - Critical to tie use of the 4010 to ICD-10 codes
  - Mandate acknowledgement transactions
  - CMS should endorse/support the EHNAC/WEDI PMSAP
- Longer term
  - Additional collaboration between provider organizations and SDOs (go where the providers are)
  - Require workers comp to accept 837
  - CMS should proactively audit HPs for 837 compliance
  - CMS should consider financial incentives to move industry toward wide-scale adoption (similar to meaningful use)

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Panel 5: Coordination of Benefits

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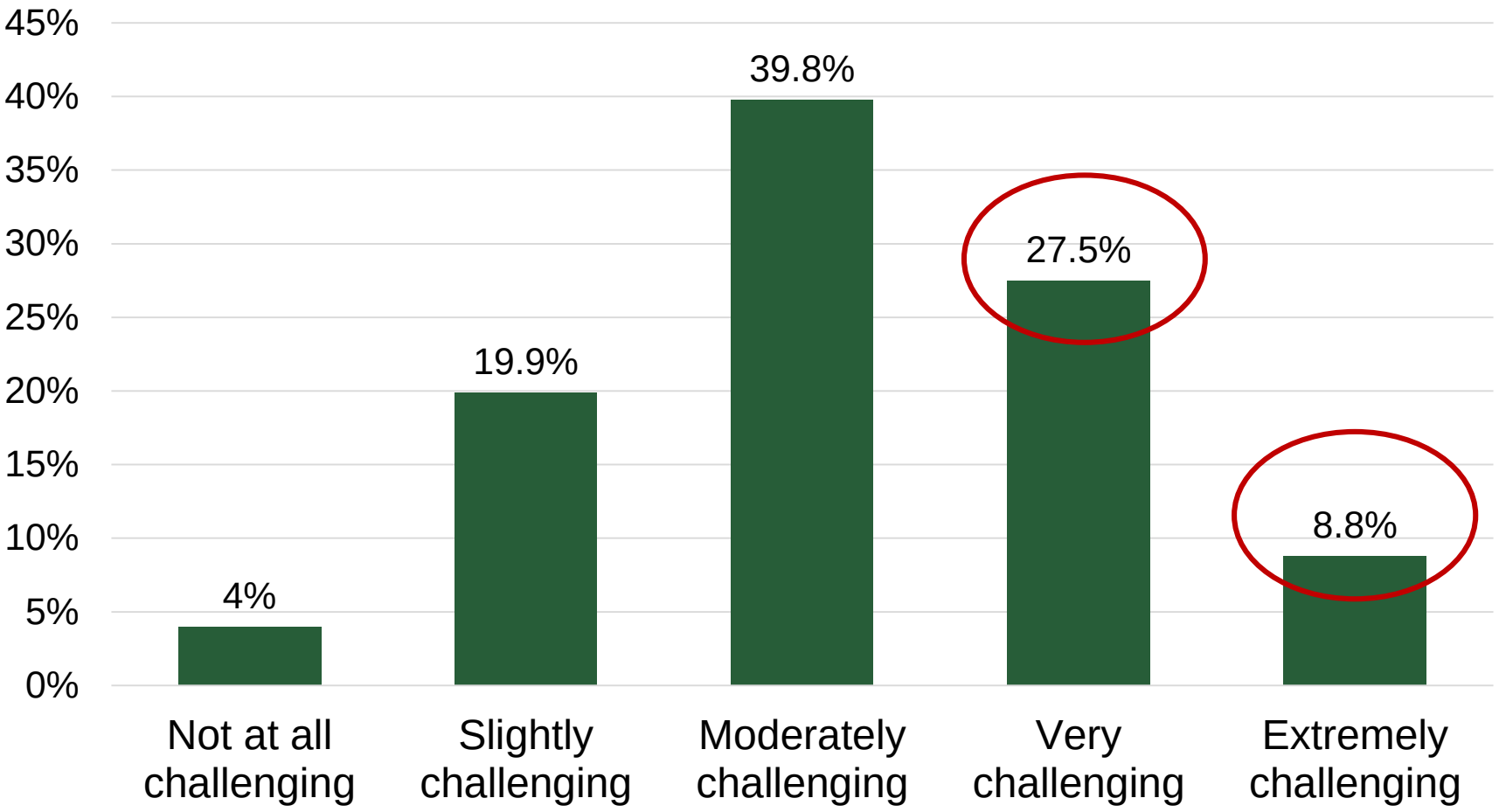
Overall, how would you rate the current coordination of benefits process?



Practice Concerns

- CAQH estimates that current COB processes burdens the U.S. healthcare system with more than $800 million in unnecessary administrative expense per year
- More insurance coverage under the ACA may equate to more COB challenges
- Most sources of insurance coverage equates to manual processes and a protracted and error-prone RC
- We have not reached standardization-practices still required to understand each payer's requirements
- Inadequate communication between various payer types (i.e., commercial vs government-sponsored vs workers comp)

Select Member Comments

- Some secondaries are paper if COB is not enabled”
- Some insurance require that if they are secondary payer that it be in paper”
- “Secondary claims are sometimes submitted on paper if the payer is requesting a copy of the primary EOB”
- “Paper claims are commonly submitted to secondary payers or corrected claims due to payer restrictions on electronic claims”

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MGMA General Recommendations

- Short-term
  - CMS should significantly increase provider education on use of the automated COB
  - Critical to identify an electronic and fully automated COB process
  - Require workers comp to accept HIPAA transactions
  - CMS should endorse/support the EHNAC/WEDI PMSAP
  - CMS and all payers should support CAQH “COB Smart”
- Longer term
  - Additional collaboration between provider organizations and SDOs (go where the providers are)
  - CMS should consider financial incentives to move industry

Panel 6: Healthcare Claim Status

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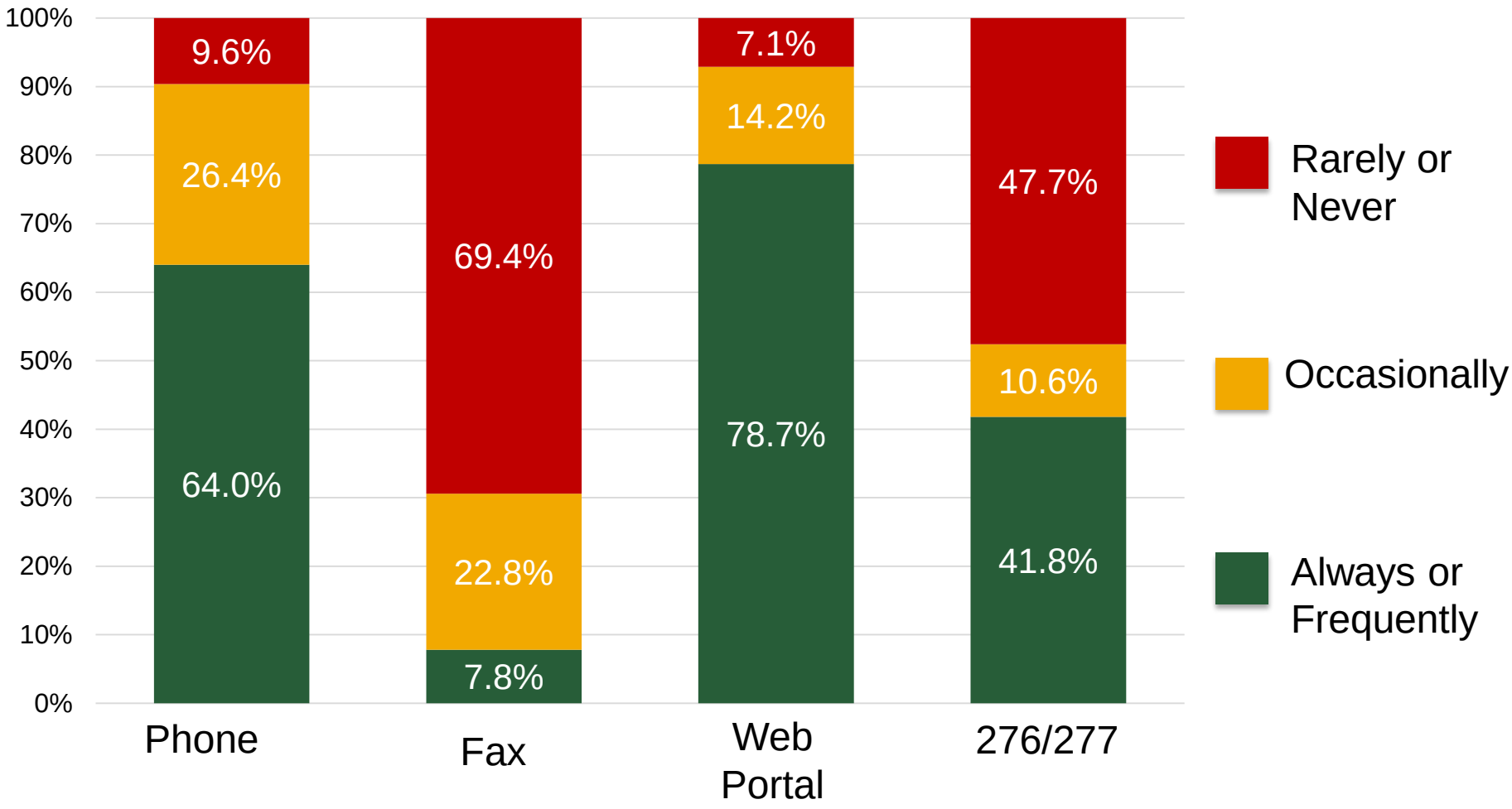
Rate how often your practice uses the following methods to check claim status



What are the reasons your practice does not always use the HIPAA 276/277 electronic transaction to check claim status? Please check all that apply.

Answer Options	Response
Our practice management system software does not generate electronic claims status transactions	22.6%
Our health plan(s) do not support the electronic claim status transaction	20.1%
The claim status inquiry is typically not returned by our health plans within the required 20 second window	22.6%

Practice Concerns

- 276 does not always provide a clear picture of where the claim is
- 276 is often used as a replacement for an electronic acknowledgement
- Sent immediately after submission of claim
- Claim status codes not always being used consistently across payers. This lack of consistency requires providers to refer to different tables of codes in their systems for their different payers

Use and Potential Savings

- According to the *2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2013*
- Fully Electronic 276 (HIPAA standardized) Transaction Adoption Rates, Health Plans Reporting 2013 Data = 49.6%
- Potential provider savings: $1.23 per claim status transaction

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MGMA Recommendations

- Practices want a simple, automated electronic approach to verifying the status of a claim
- Must be low cost if to be widely used
- There should be encouragement to use the 276 and not drive providers to payer portals
- 276 should be better integrated within provider workflow

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MGMA Recommendations

- Short-term
  - CMS should significantly increase provider education on use of the 5010 276
  - CMS should mandate acknowledgements
  - CMS should endorse/support the EHNAC/WEDI PMSAP
- Longer term
  - Additional collaboration between provider organizations and SDOs (go where the providers are)
  - CMS should proactively audit HPs for 276 compliance
  - CMS should consider financial incentives to move industry toward wide-scale adoption (similar to meaningful use)

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Panel 7: Healthcare Payment, Remittance Advice and EFT

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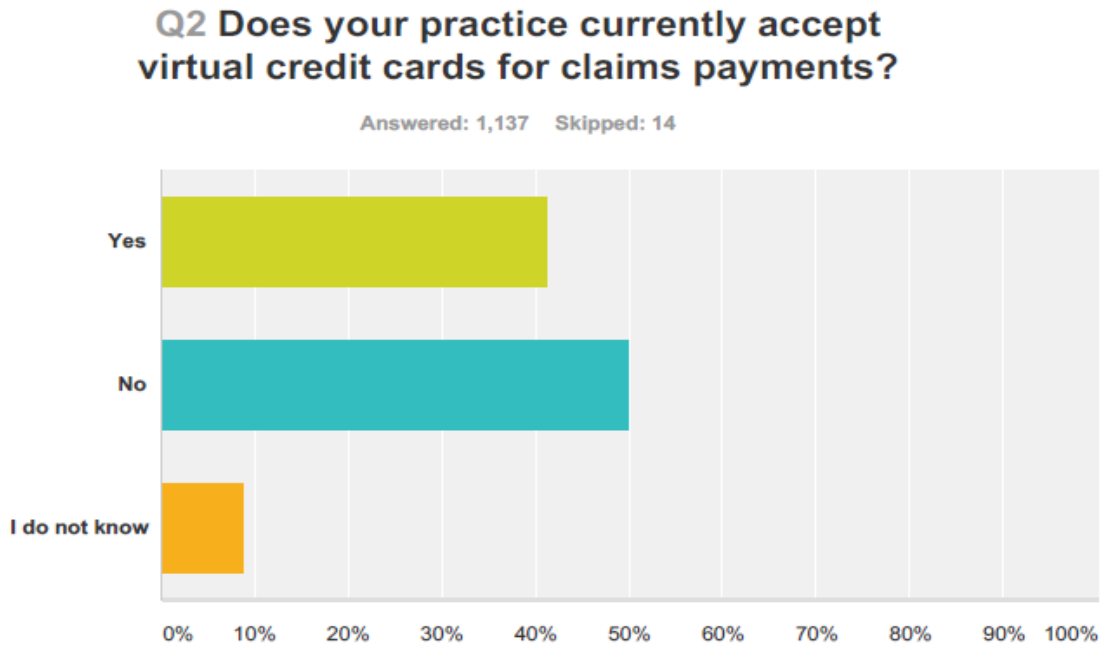
Use of VCCs (ADA/AMA/MGMA Data)



Answer Choices	Responses	
Yes	41.34%	470
No	49.96%	568
I do not know	8.71%	99
Total		1,137

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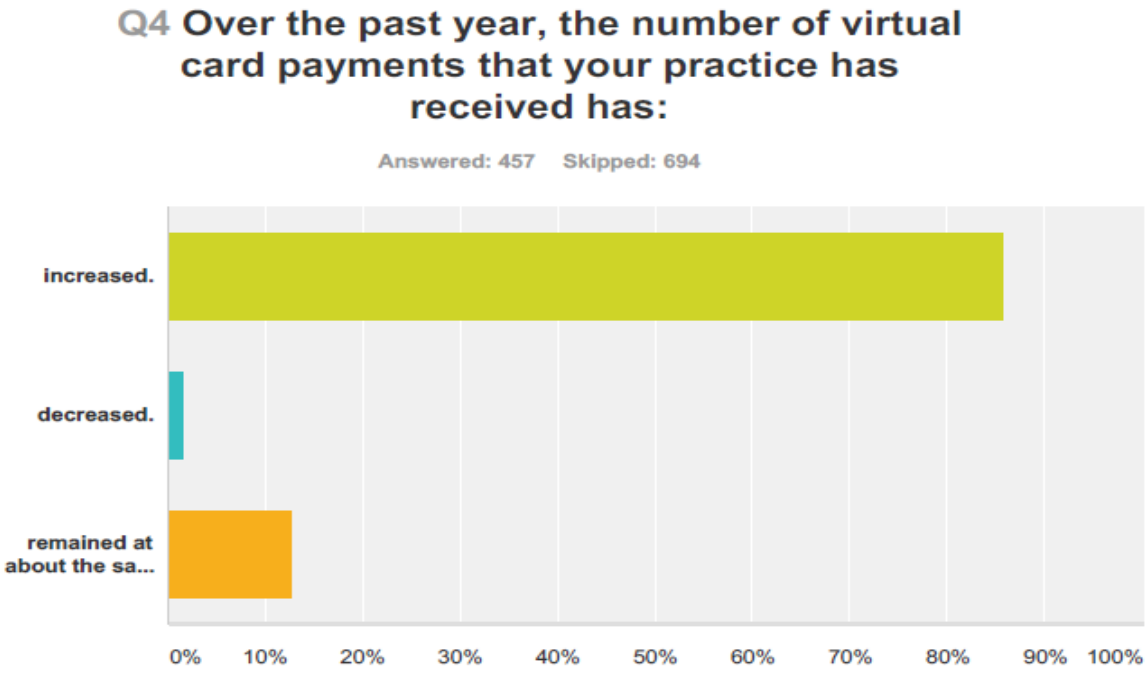
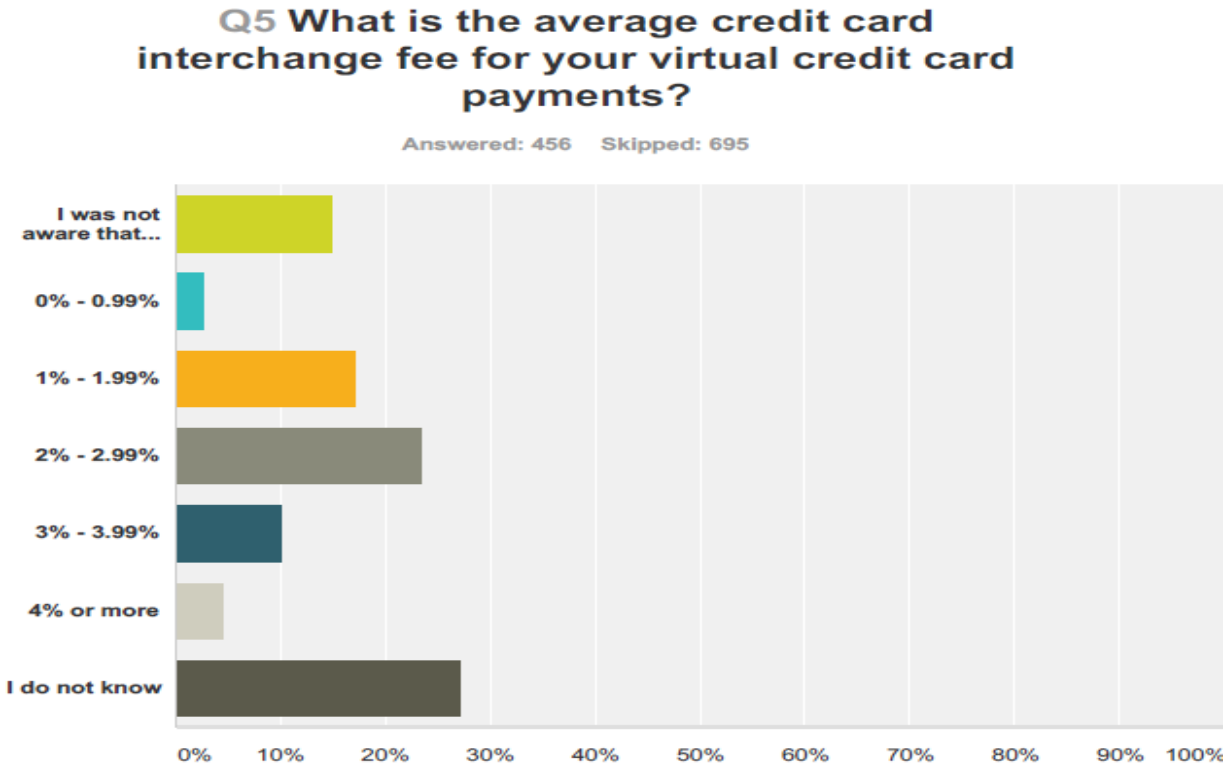
Increased use of VCCs (ADA/AMA/MGMA Data)

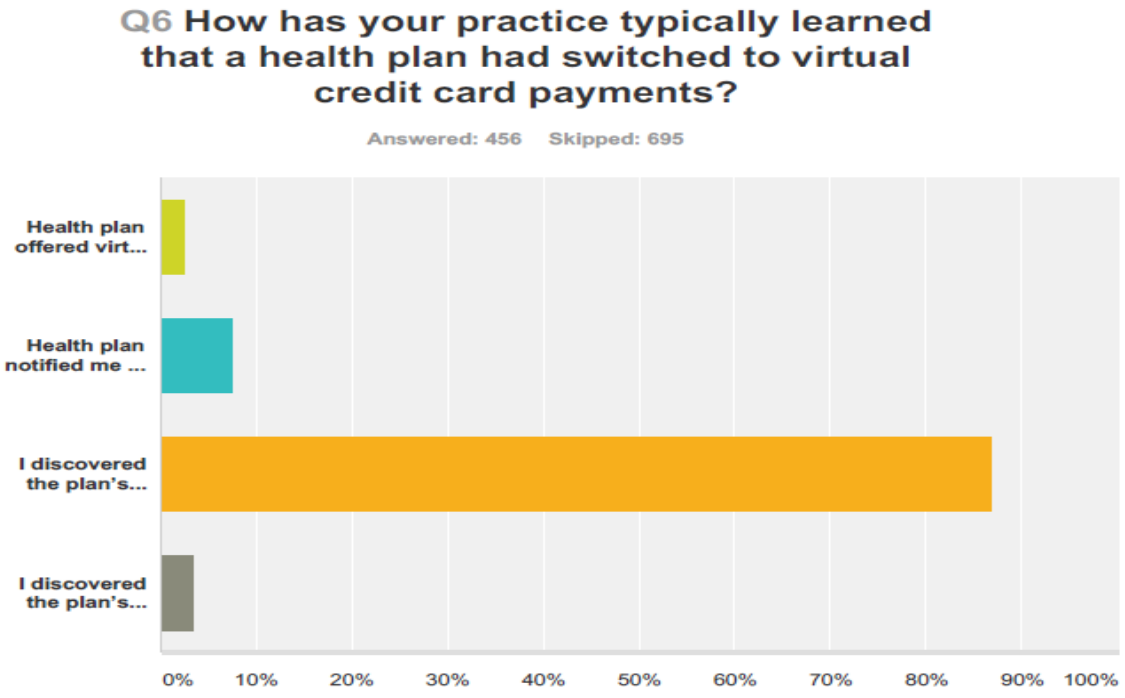


Answer Choices	Responses	
increased.	85.78%	392
decreased.	1.53%	7
remained at about the same level.	12.69%	58
Total		457

VCC Fees (ADA/AMA/MGMA Data)



VCC Communication (ADA/AMA/MGMA Data)



Answer Choices	Responses	
Health plan offered virtual payment option, and I signed up to receive	2.41%	11
Health plan notified me in advance of the date on which I would be automatically transitioned to virtual credit cards	7.46%	34
I discovered the plan's usage of virtual credit cards when receiving my first payment	86.84%	396
I discovered the plan's usage of virtual credit cards when I saw an increase in fees on my credit card statement	3.29%	15
Total		456

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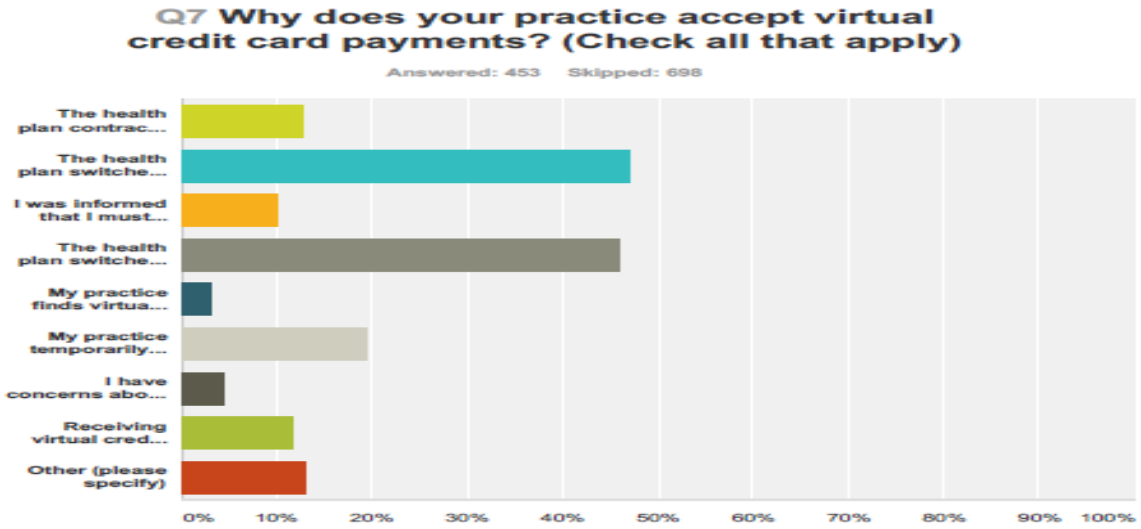
Why Accept VCCs? (ADA/AMA/MGMA Data)



Answer Choices	Responses	
The health plan contract requires that I accept virtual card payments.	12.80%	58
The health plan switched to this payment method, and I have not actively tried to change to another form of payment.	47.24%	214
I was informed that I must accept virtual credit card claims payment because I accept credit cards from patients.	10.15%	46
The health plan switched to this payment method, and I was not aware that I could switch to another form of payment.	46.14%	209
My practice finds virtual cards to be more efficient than paper checks and ACH-EFT payments.	3.09%	14
My practice temporarily accepts virtual credit cards and is currently trying to transition to another payment method.	19.43%	88
I have concerns about providing bank account information to health plans in order to receive ACH-EFT payments	4.64%	21
Receiving virtual credit cards from health plans with which we do not have a contract is less burdensome than enrollment and receipt of ACH-EFT from those plans.	11.70%	53
Other (please specify)	13.02%	59
Total Respondents: 453		

#	Other (please specify)	Date

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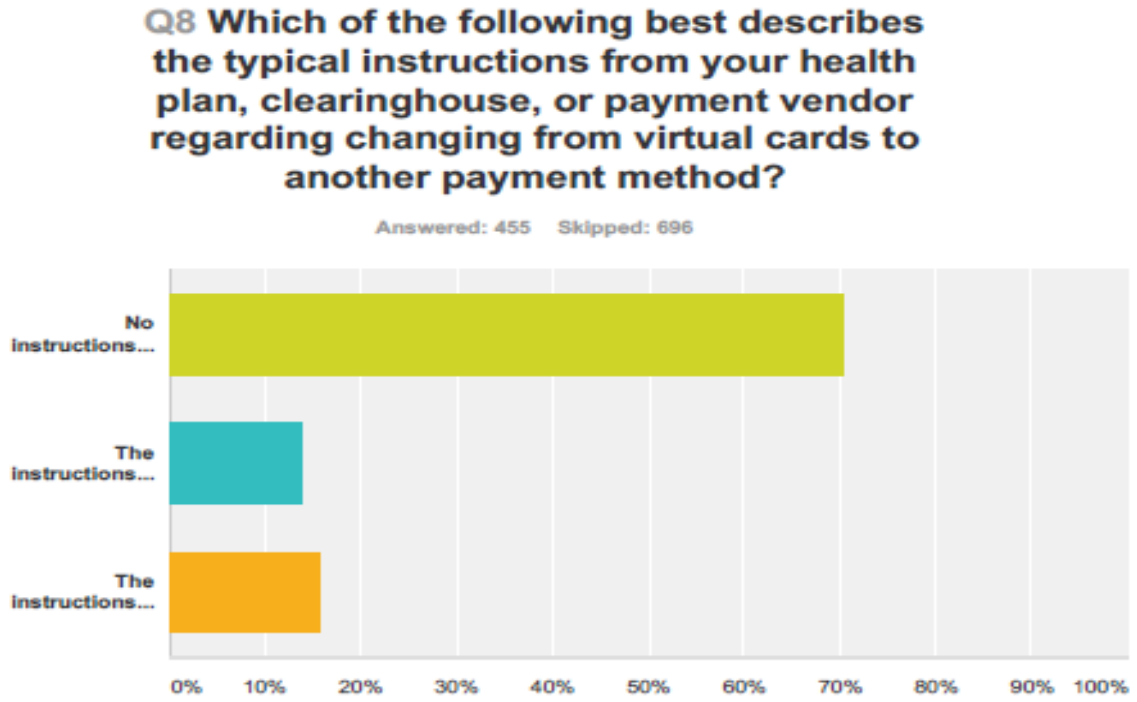
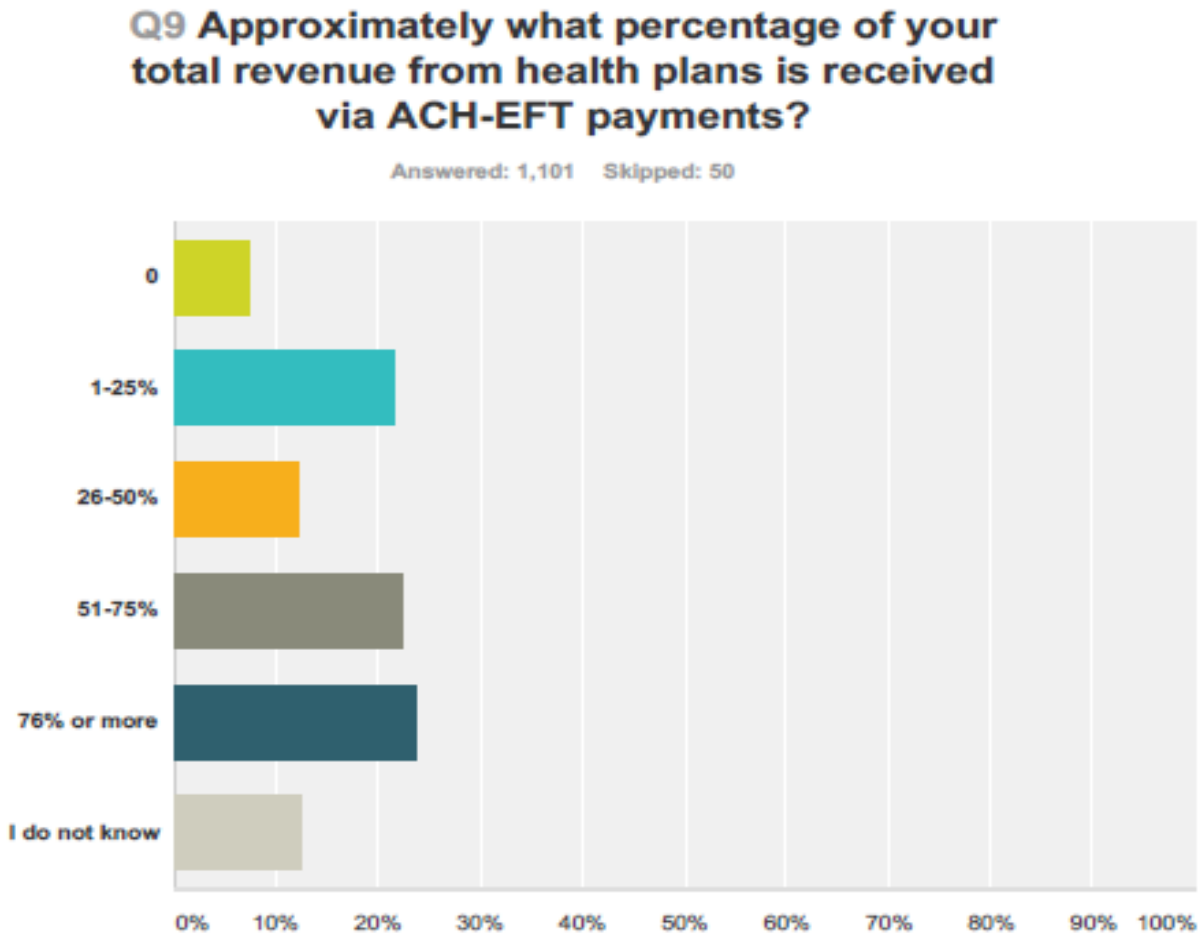
Instructions on Changing (ADA/AMA/MGMA Data)



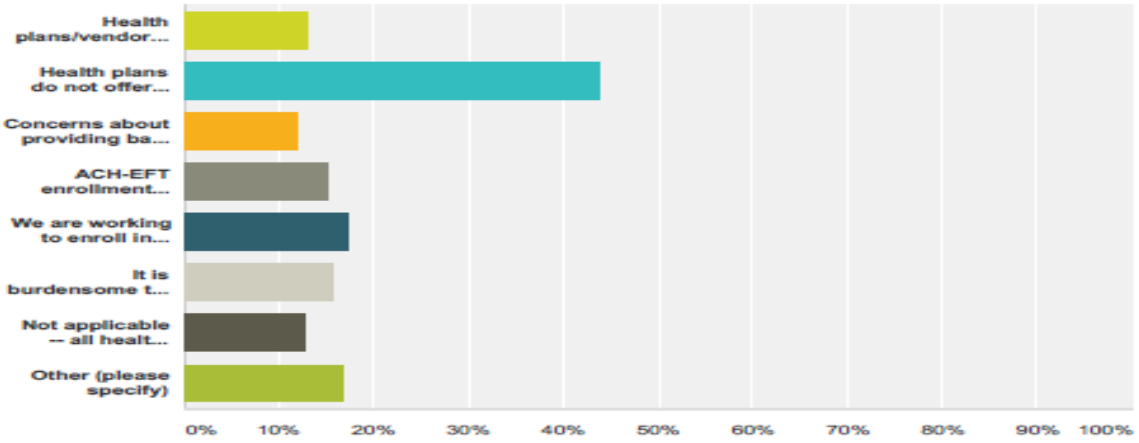
Answer Choices	Responses	
No instructions were given	70.33%	320
The instructions were unclear	14.07%	64
The instructions were clear	15.60%	71
Total		455

Revenue from EFT (ADA/AMA/MGMA Data)



Q10 For what reasons does your practice either not receive any payment using ACH-EFT or not receive ACH-EFT from certain vendors? (check all that apply)

Answered: 799 Skipped: 352



Answer Choices	Responses	
Health plans/vendors are charging ACH-EFT payment fees	13.02%	104
Health plans do not offer payments via ACH-EFT	43.93%	351
Concerns about providing bank account information to health plans in order to receive ACH-EFT	11.89%	95
ACH-EFT enrollment process is too burdensome	15.14%	121
We are working to enroll in ACH-EFT payments, but the process is not complete	17.27%	138
It is burdensome to enroll in ACH-EFT for health plans with which we do not have a contract.	15.64%	125
Not applicable -- all health plan payments are received via ACH-EFT	12.64%	101
Other (please specify)	16.65%	133

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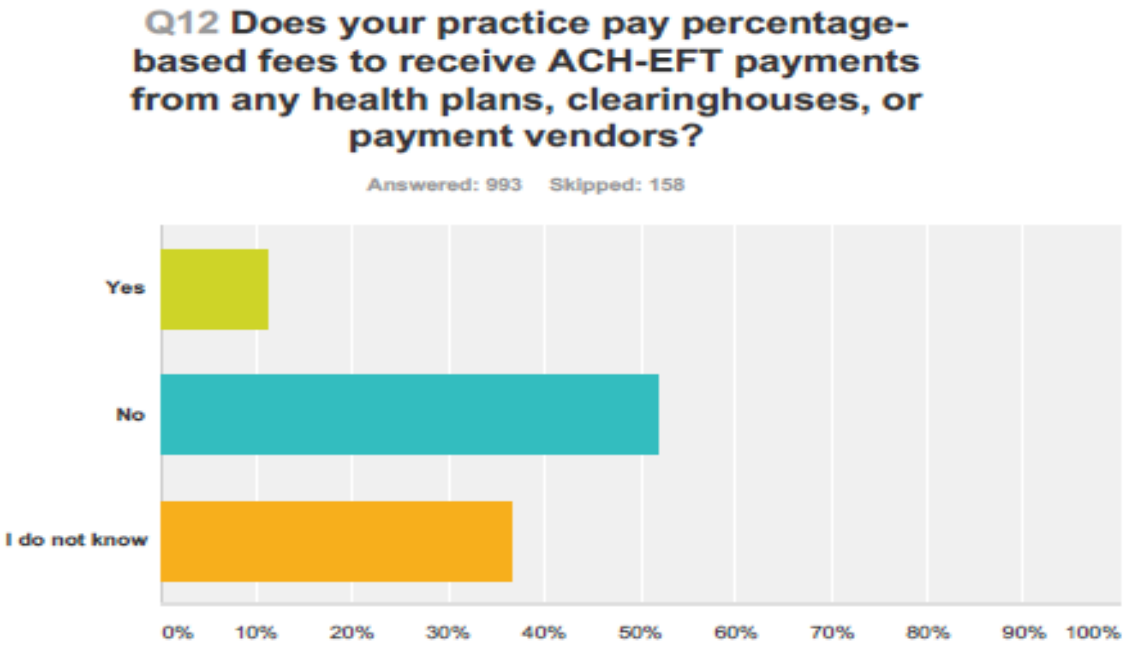
EFT Fees? (ADA/AMA/MGMA Data)



Answer Choices	Responses	
Yes	11.28%	112
No	52.06%	517
I do not know	36.66%	364
Total		993

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VCCs and EFT Concerns

- 2-4+% per transaction when card number entered in a credit card reader by practice
- The fees are not always transparent
- Payment is less than the negotiated price for services.
- Opt “in” versus opt “out”
- Additional costs-staff time
- Could health plans require these in contract?
- Are health plans sharing “profit” with CC companies?

Use and Potential Savings

- According to the *2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2013*
- Fully Electronic payment - Transaction Adoption Rates, Health Plans Reporting 2013 Data = 57.1%
- Potential provider savings: $3.04 per claim payment transaction

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MGMA Recommendations

- CMS should consider:
  - Expanding provider education on EFT/ERA standards and operating rules
  - Not permitting virtual cards to be EFT
  - Encouraging the development of a single sign-up for all e-transactions (i.e., CAQH EFT EnrollHub)
  - Just 30 payers involved
  - Limiting “excessive fees” for EFT
  - Better guidance to industry could discourage “bad actors”

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MGMA General Recommendations

- Short-term
  - CMS should significantly increase provider education on use of EFT
  - CMS should identify EFT “best practices” guidance
  - CMS should endorse/support the EHNAC/WEDI PMSAP
- Longer term
  - CMS should proactively audit HPs for EFT compliance
  - CMS should consider incentives to move industry toward wide-scale adoption (similar to meaningful use)

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