Health Record and Payment Integration Program Advisory Committee

Meeting Agenda

August 21, 2018 | 2:00pm-4:00pm EDT

4160 Patterson Ave
Baltimore, Maryland, 21215

I. INTRODUCTIONS

II. OVERVIEW OF LAST MEETING

III. THE LIFE CYCLE OF A MEDICAL CLAIM – AN OVERVIEW OF ROLES AND PERSPECTIVES ABOUT CLAIMS PROCESSING FROM A PAYER AND CLEARINGHOUSE

Ken Sullivan – CareFirst BlueCross BlueShield

John Evans – Change Healthcare

Mike Denison – Change Healthcare

Deanne Kasim – McKesson

IV. DISCUSSION ITEMS

a. Explain approach (version 2)

b. Review discussion items/information gathering grids

V. NEXT STEPS

a. Action items

b. Next meeting (September 18, 2018; 2:00 - 4:00pm at MHCC)

c. Remote participation

d. Other

CLAIMS PROCESSING AT CAREFIRST, INC.

High level overview

AUGUST 2018

Proprietary and Confidential

Claims Processing at CareFirst

- **Claims Data and Statistics**
- **Claims Processing and Efficiency**
- **Analytics and Submitted Claims**

Claims Data and Statistics

Claim Types

- Medical (institutional and professional)
- COBC (Medicare)
- Dental
- Pharmacy
- Mental Health
- Interplan Teleprocessing System (ITS)
  - Governs how claims are processed & paid throughout the Blue Cross Blue Shield Association

Claim Formats

- Paper
- Electronic
  - Electronic Data Interchange (EDI)
  - EDI Transactions –
    - 837 (Claim)
    - 835 (Payment Remittance)
    - 276 (Claim Status Request)
    - 277 (Claim Status Response)
    - 999 (Acknowledgement)
  - Claim versions:
    - Professional – '005010X222A1
    - Institutional – '005010X223A2'
    - Dental- '005010X224A2'

Claims Data and Statistics

- Claims Volumes:
  - Institutional, Professional, Dental 2017 — 41.3 M
  - Pharmacy 2017 — 15 M

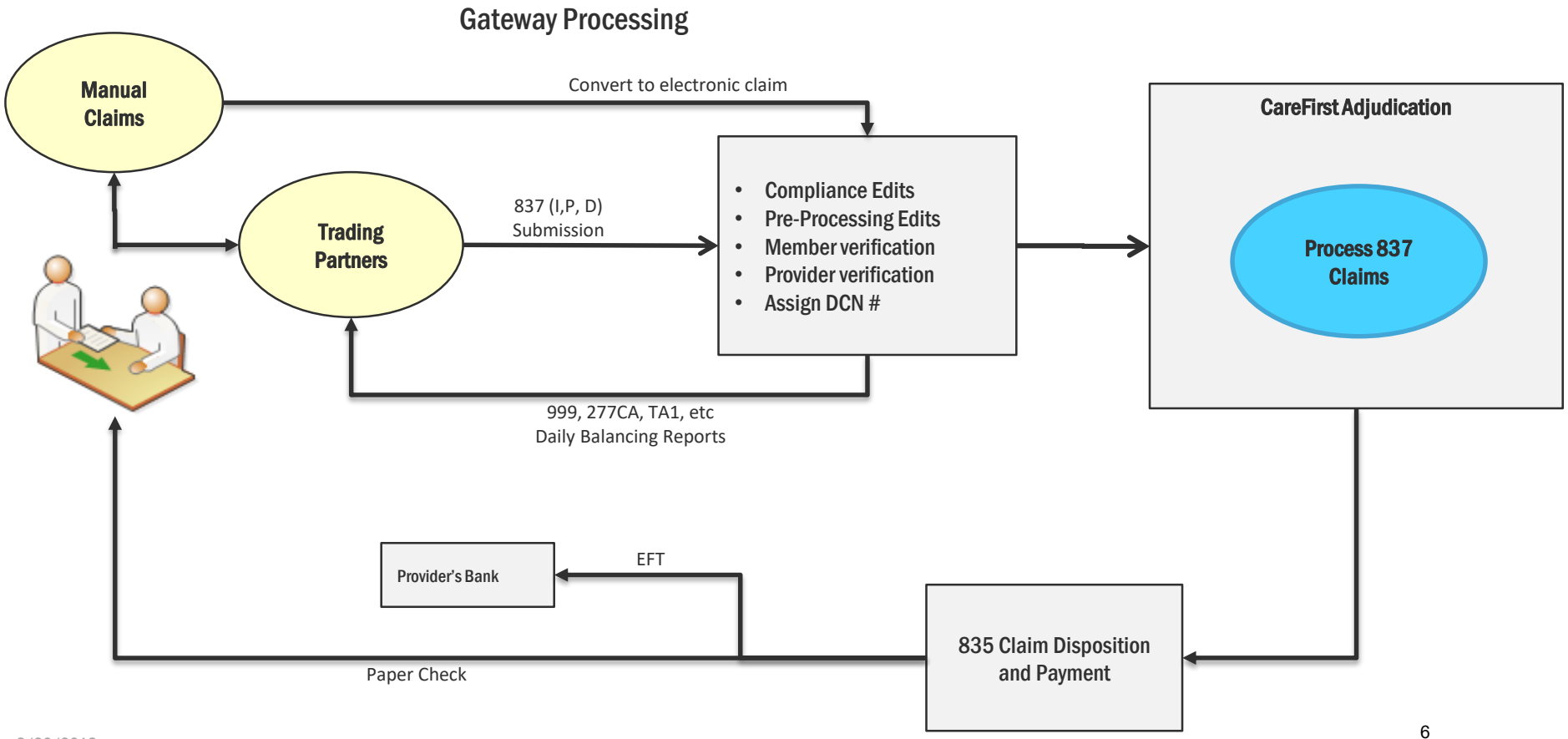
- *Claims Turnaround Times* –
  - 96% within 14 days
  - 100% within 30 days

- Average days of receipt from claim DOS
  - Professional — 23.9 days
  - Institutional — 34.0 days
  - Dental — 16.3 days

- Claim Rejection Rate
  - Electronic — 1.6%
  - Paper — 4.4%

Claims Processing and Efficiency

Claims arrive throughout the day and are adjudicated on **the day they are received**. In addition to claims, there are thousands of real time claims status and eligibility ***inquiry*** transactions (270, 271, 276, 277) received and processed.



Claims Processing and Efficiency

Two levels of edits are performed upon receipt of the claims: Compliance and Pre-processing (PPE). In both edit types the claims are REJECTED and returned to the Trading Partner:

Compliance Edits is verification and rules surrounding the X12 EDI standard format. Compliance errors relate to EDI uniform data requirements. Examples:

- Element N401 (D.E. 19) at col. 4 is missing, though marked "Must Be Used"
- Element NM103 (D.E. 1035) at col. 10 is missing, though marked "Must Be Used"

Pre-Processing (PPE) Edits is the validation of the *contents* on the inbound claim record that CareFirst requires to process according to our business rules. Examples:

- *NPI not on file*
- *SubscriberID Not Found*
- *Invalid NDC[##########] for HCPCS[J###] code*
- *Principal Diagnosis Code ['H2001']. Must be entered, must be a valid code for date.*
- *Procedure Code ['NS']. Must be a valid 5 position CPT-4 or HCPCS code.*
- *Valid Tooth number(s) are not present ['', ''] when Procedure Code ['D5226'] Level equals T*

Claims Processing and Efficiency

- Confirm member eligibility
- Confirm provider is in/out of network
- Timely Filing - varies
  - *Account specific*
  - *365 days*
  - *180 days*
  - *NASCO: 365 days, OR end of the following year after the service date (Ex: Service date 08/17/2018 , filing limit by 12/31/2019)*
- PENDS
  - *Clinical editing*
  - *Duplicate claims editing/Claims History check*
  - *Utilization Management*
  - *Service Rules (Deductibles, Limits and Penalties)*
- Pricing
- Accumulators

Claims Processing and Efficiency

- CareFirst Electronic Claims rate equals 99.0% (including conversion of Paper Claims to Electronic Claims)
  - CAQH reports 95.0% based on Industry survey

- First Pass Rates – efficiency measure of our claims processing, along 2 measures
  - Operational - ~85% of claims require no manual intervention due to business rules before automated adjudication
  - System - ~92% claims require no manual intervention stemming from systemic rules before flowing into specific lines of business

- Adjustment Rates –
  - The scope of this metric is limited to adjustments within the claims area (does not include system errors): 2.5-3.5% depending on business unit

Claims Processing and Efficiency

- **Format and Processing**
  - Claim forms/claim submission format must adhere to uniform standards set by federal and state law; must have a process to reject claims that do not meet "clean claim" standards (15-1003 through 15-1005)
    - Need to maintain a manual or other document that sets explains claims filing standards (15-1004(d))
    - Need to maintain a phone number where providers can call with questions and concerns related to claims filing (15-1004(d))
    - Claims processing must be compliant with HIPAA standard transactions, privacy, and security rules, as well as complementary state laws

Claims Processing and Efficiency

- **Utilization Review:**
  - Must be certified to do utilization review or contract with a private review agent (15-1001)
    - May need to implement process to handle pre-authorization requests and/or provide advance notice of eligibility/coverage upon request (not sure whether this is applicable?)
  - Must ensure that utilization review of mental health and substance abuse claims satisfies state and federal mental health parity laws
  - Must have a mechanism to request additional medical records when medical necessity is in question
    - If requesting additional information delays processing of the claim, interest may be due (15-1004)
  - Must have an internal process to allow members to appeal adverse benefit determinations, including an emergency process for urgent cases (15-10A-02)
    - This process is strictly regulated and includes requirements related to timing and communication content. In general, emergency cases must be responded to in 24 hours and other cases within 30-45 days
  - Must have a process to engage with HEAU/MIA (as applicable) on adverse benefit determination appeals that proceed to external review, including potentially to a formal administrative hearing
  - Must be prepared to litigate adverse benefit determinations that advance to formal legal action

Claims Processing and Efficiency

- **Prompt Pay:**
  - Must give providers 180 days from date of service to submit a claim (15-1005)
  - In general, claims must be processed within 30 days of receipt of a claim (15-1005)
    - Claim must be paid; OR
    - Must transmit notice of what charges are being denied, along with the reason for the denial; if additional documentation is required, the notice must contain this information
  - Must give providers a minimum of 90 business days from date of a claims denial to appeal (15-1005)
    - If a claim was denied erroneously, must give providers a minimum of 1 year to notify the payer and request reprocessing (15-1005)
  - Payments made by EFT (electronic funds transfer) must meet all relevant federal and state banking laws and other industry standards (i.e., NACHA, etc.)
  - Need a process to identify other sources of insurance coverage and coordinate benefits between multiple policies
  - Payers serving individual market consumers need to have a process to suspend claims payments and notify providers when consumers receiving federal APTC fall into arrears for late premiums and are in months two and three of their federally-required grace period (15-1005)

Claims Processing and Efficiency

- **Recoupment:**
  - Need a process to reconcile and recoup erroneous claims payments
  - Maryland allows for recoupments within 6 months of payment—
    - this can be especially challenging when employers do not communicate employee plan terminations on a timely basis.
  - Must send the provider a communication explain the recoupment
  - Need a compliance program to investigate and report provider billing fraud

- **Privacy**
  - We have self funded accounts where we are prohibited by Federal Law from sharing that data
  - Consent – who gives consent for the data to go to the intermediary
  - Part 2/Mental Health data
    - Is this a legally required submission of data (even then we can't provide ASO groups)? If not, what covered entity is accountable (e.g. who is CRISP a BAA to in this model)?

Claims Processing and Efficiency

- **Member Communications Related to Claims:**
  - Insurers must provide consumers with notice of claims processing/claims denials via HIPAA-compliant Explanation of Benefits (EOB) forms (15-1006)
  - Insurers must provide consumers with an annual (12 month) summary of all claims submitted by providers and the balance owed by the consumer for each claim filed (15-1007)
  - Need a process to handle member-submitted claims and payments owed directly to the member for out of network care
  - Need a process to respond to member complaints filed with the MIA
    - Note: Complaints are different from adverse benefit determination appeals. Complaints can cover a broad range of other issues ranging from poor customer service to major operational/technical problems impacting claims payment.

Analytics and Submitted Claims

- Submitted claims are not generally used in CareFIrst clinical processes or administrative reporting
  - Claims adjudication may result in the rejection or denial of a submitted claims
  - For claims that are accepted, they are often edited based upon CMS rules and CareFirst Medical Policy
    - 74% of Professional Claims are edited, bundled, etc
    - Frequency Validation - Allowed once per date of service, clinically possible/reasonable to perform a given procedure on a single date of service, across all anatomic sites.
      - **Claim Billed:** Appendectomy (44950) , DOS 8/1/2018 , frequency of 2
        Result: 1 unit allowed, second unit denied
    - Frequency Validation - Allowed multiple times per date of service, clinically possible/ reasonable to perform a given procedure on a single date of service, across all anatomic sites.
      - **Claim Billed:** Application of short arm splint (29125), DOS 8/1/2018 , frequency of 3
        Result: 2 units allowed, third unit denied

Submitted Claims

- Incidental Procedures - Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
  - **Claim Billed:** Laparoscopy abdomen (49320) & Laproscopy with biopsy (49325), DOS 8/1/2018
    Result: 49320 is considered incidental to 49325 and therefore denied, and 49325 is allowed
- Submitted claims may pend and be held for review which may depend upon collection of Medical Records
- Submitted claims can be adjusted based upon appeals
- Submitted and finalized claims are subject to further review for fraud, waste and abuse

THANK YOU

For more information, contact

KEN SULLIVAN

OVERVIEW, DISCUSSION

MD SB.896 legislation, Maryland Health Care Commission

08.21.2018

CHANGE HEALTHCARE

Change Healthcare Team

- **Mike Denison,** Senior Director, Regulatory and Standards Compliance
- **John Evans,** Director of Content Intelligence, Product Management, Revenue Cycle Management
- **Deanne Kasim**, Senior Director, Health Policy Strategy

Questions

- At what point does a clearinghouse insert itself in the claims process?
- What is the value of clearinghouses to providers?
- What type of value add services are offered to providers?
- Other?

Clearinghouse Defined

- Rule (§160.103) public or private entity – can include the following:
  - billing service
  - repricing company
  - community health management information system
- Value- added services, "switches" for:
  - processing information received in nonstandard format (or containing nonstandard data content) into standard data elements (or a standard transaction)
  - Receiving standard transaction from another entity and processing information into nonstandard format or nonstandard data content for the receiving entity

Value of Clearinghouse Functions

- Process all HIPAA covered transactions
- Mapping to multiple EHR/PMS systems output (not all transactions are the same)
- Connectivity to multiple payers
- Connectivity to multiple vendors
- Claims editing to increase 1st pass rate
- Certification (EHNAC/Others)
- File Error monitoring
- Claim Rejection monitoring & resubmission
- Remit delivery, timing, follow up, code mapping
- State / Federal Regulatory change updates

The Intelligent Healthcare Network™

- Connects providers, payers, and technology partners with the nation's largest health information networks for eligibility and benefits verification, claims submission and processing, remittance, and payments
  - Connects to more than 800,000 providers and 2,100 payers
  - Direct connections to nearly all government and commercial payers

The Intelligent Healthcare Network ™

- Improves first pass rates with behind-the-scenes edits and customizations
  - Features an extensive repositories of rules and logic to appropriately clean claims before sending
- Transmits electronic claims and remittance advice securely through compliance infrastructure – meeting or exceeding industry data standards
  - Includes broadest and widely-accepted accepted standards (ANSI standards, 835/837)
  - Supports nearly all file formats, including .pdf, .jpg,.tif, and .gif

The Intelligent Healthcare Network ™

- Provides the platform for transmission of electronic claim attachments - providers can submit via ASC X12 275 transactions or through the secure online portal
- Payers can receive batch image and ASC X12 275 index files, and request, receive, and manage using the online portal
- FUTURE - Blockchain

Questions, Discussion, Follow-Up

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Health Record and Payment Integration Program
Advisory Committee

DISCUSSION ITEMS/GRIDS

The Maryland Health Care Commission (MHCC) is tasked with convening an Advisory Committee to conduct a health information technology policy study that assesses the benefits and feasibility of creating a health record and payment integration program (or program) that, among other things, could incorporate administrative health care claim transactions into the State–Designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP).* Discussion items listed below are required in law (Chapter 452) and intended to guide Advisory Committee deliberations and the development of recommendations. Discussion items have been simplified to focus on the specific components of the law and are organized using grids that will be used for information gathering purposes. Terms used in the grids have the following meaning:

Benefit:	Value derived from producing or consuming a service
Barrier:	A circumstance or obstacle (e.g. operational, economic, political, budgetary, etc.) that hinders or prevents progress
Challenge:	A difficult task or complex situation that must be overcome in order to implement a solution
Solution:	An idea aimed at solving a problem or managing a difficult or complex situation

* Required by Senate Bill 896, *Health Record and Payment Integration Program Advisory Committee*, passed during the 2018 legislative session (Chapter 452). More information is available at: mgaleg.maryland.gov/2018RS/chapters_noln/Ch_452_sb0896E.pdf.

1. Feasibility of incorporating administrative health care claim transactions into the State–Designated HIE

a. Requiring MHCC Certified Electronic Health Networks (clearinghouses) to send claims information to CRISP	

BENEFITS
 	
• Expand access to and integrate claims data into care delivery to improve clinical decision making
• Fill in missing gaps of ambulatory encounter information
  ○ Procedures types and diagnoses
  ○ Place of service
  ○ Point of contact
• Continuity pre- and post-hospitalization
• Improve monitoring and coordination of care, especially for patients with chronic conditions
• Large majority of claims are processed electronically
• Complement efforts to improve quality, patient-centered care
• Enhance population health/public health
• Facilitate reporting of quality metrics (e.g., help providers determine if patients have received select services outside their practice)
• Decrease redundant or unnecessary services and tests
	BARRIERS
	
	• Claims data not always clinically rich and may be influenced by reimbursement policies
	• Provider consent to participate in making their claims data available to CRISP
	• EHNs may be reluctant without compensation or incentive
	• Payers may view data as proprietary and a competitive advantage
	• Coordination of data transfer procedures from a large number of EHNs (37 certified by MHCC as of August 2018)
	• Development and execution of data sharing agreements and protocols
	• Timeliness of data (payers timely filing limits for claims)
	• Privacy concerns relating to behavioral health data
	• Increased exposure and vulnerability of electronic patient information

SOLUTIONS • Mandate reporting of claims information to CRISP • Voluntary reporting of claims information to CRISP • Offer reporting incentives • Require claims information to be reported and refreshed within a specified time period • Provide HIE users with read-only access, not download and storage	**CHALLENGES** • Behavioral health providers tend to have a lower EHR adoption rate • Requires legislation and regulations • Funding source(s) • Patient control/consent • Inaccurate claims information, especially pre-adjudication (e.g., processing errors, fraud, etc.) • Patient matching

b. Enhancing the CRISP infrastructure to support electronic claims transactions	

BENEFITS
 	
• CRISP already integrated with all acute care hospitals in the State
• A pathway to centralize available claims data
• Small pilot demonstrated CRISP can support electronic claims transactions
• Value add in helping CRISP monitor appropriate user access
• Expand access to and integrate claims data into care delivery to improve clinical decision making
• Fill in missing gaps of ambulatory encounter information
  ○ Procedures types and diagnoses
  ○ Place of service
  ○ Point of contact
• Continuity pre and post hospitalization
• Improve monitoring and coordination of care, especially for patients with chronic conditions
• Large majority of claims are processed electronically
• Complement efforts to improve quality, patient-centered care
• Enhance population health/public health
• Facilitate reporting of quality metrics (e.g., help providers determine if patients have received select services outside their practice)
• Decrease redundant or unnecessary services and tests
	BARRIERS
	
	• Up-front investment and ongoing costs
	• Infrastructure modifications to support a high volume of claims data
	• Claims data not as clinically rich and may be influenced by reimbursement policies
	• Outreach and education to providers
	• Provider consent to participate in making their claims data available to CRISP
	• EHNs may be reluctant without compensation or incentive
	• Payers may view data as proprietary and a competitive advantage
	• Coordination of data transfer procedures from a large number of EHNs (37 certified by MHCC as of August 2018)
	• Development and execution of data sharing agreements and protocols
	• Timeliness of data (payers timely filing limits for claims)
	• Privacy concerns relating to behavioral health data
	• Increased exposure and vulnerability of electronic patient information

SOLUTIONS • User fees to supplement development and maintenance costs • State funding (short and long term) to supplement development and maintenance costs • CRISP as an ad hoc second destination (while data is in motion) and not for adjudication of claims • Federated model, where participants maintain control over their data • Mandate reporting of claims information to CRISP • Voluntary reporting of claims information to CRISP • Offer reporting incentives • Require claims information to be reported and refreshed within a specified time period • Provide HIE users with read-only access, not download and storage	**CHALLENGES** • Sustainability • Value proposition for EHNs • Ensuring CRISP has bandwidth and can continue to meet other State mandates • Requires legislation and regulations • Funding source(s) • Patient control/consent • Inaccurate claims information, especially pre-adjudication (e.g., processing errors, fraud, etc.) • Patient matching

2. Feasibility of establishing a free and secure web–based portal for providers, regardless of payment method being used for health care services to:
    a. create and maintain health records
    b. file for payment for health care services provided

a. Making available a web-based electronic health record solution at no cost to providers	
BENEFITS • Resource/support to non-adopters (selection, implementation, maintance, cost, etc.) • Data standardization and centralization • Increased accessiblity to clinical data • Improve value of data available in CRISP • Value add to CRISP HIE services • Improve care delivery and coordination • Secure exchange of electronic patient information • Enhance population health/public health • Efficiencies gained • Support providers under alternative payment models (technology requirements, quality reporting, etc.)	**BARRIERS** • Technical support/training for providers • Provider technical capabilities (e.g., internet speed, etc.) • Integration with external software (e.g. billing, scheduling) • Opposition from competing EHR vendors • Process to evaluate and select a solution • Ensuring appropriate access/use • Privacy concerns relating to behavioral health data
SOLUTIONS • Cloud-based solution • Open-source solution • User fees to supplement development and maintanance costs • State funding (short and long term) to supplement development and maintenance costs • Voluntary	**CHALLENGES** • Value proprosition – EHR adoption widespread (acute care hospitals 100%, physicians 71%) • Up-front investment and ongoing costs • Funding source(s) • Patient matching • Interoperability

b. Developing a web-based portal for submitting claims to third party payers at no cost to providers	
BENEFITS • Value add to CRISP HIE services • Efficiencies gained • Resource/support for providers that still submit paper claims	**BARRIERS** • Resistance to electronic billing by a small percentage of providers • User friendly, provider workflows • Opposition from competing EHNs
SOLUTIONS • User fees to supplement development and maintanance costs • State funding (short and long term) to supplement development and maintenance costs • Voluntary	**CHALLENGES** • Value proprosition/desirabililty since a large majority of providers already submit electronic claims • Up-front investment and ongoing costs • Funding source(s)

3. Approaches for accelerating the adjudication of clean claims*

Revising prompt payment requirements – Insurance Article, §15-1005(c)	
BENEFITS	**BARRIERS**
SOLUTIONS	**CHALLENGES**

4. Estimated cost to the State to support the program*

Funding source	
BENEFITS	**BARRIERS**
SOLUTIONS	**CHALLENGES**

5. Using multiple vendors integrated with the State-Designated HIE

Integrating multiple vendors with CRISP	
BENEFITS	**BARRIERS**
SOLUTIONS	**CHALLENGES**