**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Mr. Keck | 3-23-12 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 10-377 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>_____<br>cc: Singleton, Deps, CMS file ✓ | [ ] Prepare reply for appropriate signature<br>DATE DUE _____<br>[ ] FOIA<br>DATE DUE _____<br>[ ] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services



DATE: March 21, 2012

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: Section 1104 of the Affordable Care Act

This bulletin is one of a series intended to provide guidance on the implementation of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act. This letter provides guidance on section 1104 of the Affordable Care Act pertaining to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA) Administrative Simplification. Specifically, the bulletin describes standards for the adoption of operating rules for eligibility for a health plan and health care claim status transactions.

By implementing these requirements, States will improve the automation of health care administrative processes and benefit from reduced transaction costs (e.g., reduced time and effort related to contacting physicians and health plans for resolution of claims, denial of claims, and additional postage and paperwork costs).

**Background**

Congress addressed the need for a consistent framework for electronic health care transactions and other Administrative Simplification issues through HIPAA, enacted on August 21, 1996. HIPAA amended the Social Security Act (the Act) by adding Part C, Administrative Simplification, to Title XI of the Act, and required the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged electronically, and to achieve greater uniformity in the transmission of health information. Electronic data interchange enables providers and payers to process financial and administrative transactions faster and at a lower cost than paper transactions.

The National Committee on Vital and Health Statistics (NCVHS), established by Congress to serve as an advisory body to HHS on health data, statistics, and national health information policy, was assigned a significant role in the Secretary's adoption of operating rules under section 1173(g)(3) of the Act, as amended by section 1104(b)(3)(C) of the Affordable Care Act. Section 1173(a)(4)(A) of the Act (as added by section 1104(b)(2) of the Affordable Care Act) requires that the standards and associated operating rules adopted by the Secretary shall:

i. To the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care;

ii. Be comprehensive, requiring minimal augmentation by paper or other communications;
iii. Provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and
iv. Describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

On July 8, 2011, HHS published an Interim Final Rule with Comment (IFC) to adopt operating rules to support the adopted standard transactions for the eligibility for a health plan and health care claim status transactions effective January 1, 2013 (76 FR 40458). This rule implements section 1173(g) of the Act, as amended by section 1104(b)(2) of the Affordable Care Act. This IFC and these operating rules are expected to assist providers in receiving more robust and complete responses to their inquiries for eligibility and claim status information. For convenience, the IFC can be reviewed at http://edocket.access.gpo.gov/2011/pdf/2011-16834.pdf. Frequently Asked Questions can be viewed on CMS' Web site at https://questions.cms.hhs.gov/app/answers/list/kw/operating%20rules/search1

HHS has adopted operating rules for the eligibility and claim status transactions which require health plans, including Medicaid plans, to:

- Use standardized companion guide templates for the format of these guides;
- Normalize the submitted and stored last name (e.g., remove any special characters, suffixes/prefixes) before matching for eligibility inquiries;
- Return specified AAA codes for each error condition;
- Follow certain connectivity rules;
- Meet certain content requirements for the eligibility transaction, including that:
  - At a minimum, eligibility responses must include dates of eligibility for past and future dates at a benefit level if the benefit level is different from the contract level;
  - The patient's financial responsibility is included for each benefit at the base contract amount for in- and out-of-network providers, as well as the patient's co-pay, deductible, and coinsurance amounts prior to the point of care; and
  - The name of the health plan; and
- Meet certain service and performance timeframes for eligibility and claim status transactions:
  - Systems be operational 86 percent of the time per calendar week and regular system downtimes are published;
  - Batch transactions, if received by 9:00 p.m. eastern standard time, must have a response sent by 7:00 a.m. eastern standard time the following day; and
  - Real-time transactions must have a response sent within 20 seconds or less.

We are highlighting the individual operating rules here so that States are aware of the requirements. It will be important for States to secure a copy of the operating rules which are available at no charge from the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange® (CORE) Web site at www.caqh.org. Further, CAQH CORE staff are available for technical questions and guidance, and CORE conducts frequent town hall meetings and webinars that are free of charge.

In addition, we note the elements of the operating rules that HHS did NOT adopt. HHS did not adopt the requirement for CORE certification. This is the comprehensive testing process governed by CAQH CORE which is used to validate the use of the operating rules. CORE certification is voluntary; but testing the use of the standards and operating rules is important, and should be included in State implementation planning.

HHS also did not adopt the requirements in the operating rule regulation that pertain to the use of the acknowledgement standards, though they may be used on a voluntary basis between trading partners. HHS did not require use of the acknowledgement standards because they had not been adopted through the regulatory process, even though NCVHS recommended their adoption. HHS is expected to publish a rule to adopt the standards, but, at this time, they are voluntary.

State Medicaid agencies must conduct a gap analysis to determine if operational changes are needed to comply with these operating rules and to be able to provide the newly required information. Further, States must analyze their current Medicaid information technology (IT) infrastructure to determine if hardware and/or software modifications are needed in order to meet these requirements and the operating rule compliance date of January 1, 2013.

Federal Financial Participation (FFP) is available to States that make modifications to their Medicaid IT infrastructure in order to comply with these operating rules; however, in order to be eligible for enhanced funding, a State's system must comply with seven standards and conditions specified by CMS through regulation (see *Federal Register*, Vol. 76, No. 75, dated April 19, 2011 – http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf. Ninety percent FFP is available for the design, development, and implementation of the Medicaid management information system (MMIS) and/or the State's eligibility and enrollment system that meet, among other things, the requirements of section 1104 of the Act. For continuing operations of the Medicaid system, States can receive 75 percent FFP. In order to be eligible for enhanced FFP, States must submit an Advanced Planning Document to CMS for review and prior approval.

Over the next several years HHS will publish several additional regulations adopting operating rules for each of the transactions adopted under HIPAA. States are encouraged to participate with the NCVHS as they review and make recommendations about future operating rules to ensure that State Medicaid program interests and needs are addressed. We strongly encourage States to become involved in the development of operating rules and to ensure that there is consistent representation and participation in the work groups. Information regarding current work on operating rules and about participation is available on the CAQH Web site at www.caqh.org.

If you have any questions regarding the IFC or the aforementioned operating rules, please contact Donna Schmidt of my staff at 410-786-5532 or by email at donna.schmidt@cms.hhs.gov.

We appreciate the strides States are making in ensuring a consistent framework for electronic health care transactions and Administrative Simplification.