



Administrative Simplification – What does it really mean?

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FIS Healthcare Payment Solutions



- FIS Healthcare Payment Solutions is one of the leaders in transforming the healthcare industry by accelerating the exchange of information and funds between patients, payers, providers and financial institutions.
- Formerly Metavante Healthcare Payment Solutions (acquired by FIS in 2009)
- Strong growth, both organic and through strategic acquisitions:
 - Medibank (MBI)
 - Printing For Systems (PSI)
 - AdminiSource
 - BenSoft (RepayMe)
 - CapMed
- Industry participation:



FIS Healthcare Payment Solutions

Who we are



FIS Healthcare Solutions sees an opportunity to make a measurable impact by connecting patients, providers and payers through an integrated suite of solutions that facilitate the flow of information and funds among all three parties.

Health and Financial Network (HFN)

Payer Solutions:

- ProviderNet – post-adjudication claim payment and remittance distribution
- Health ID – eligibility/ID cards and combination ID/payment cards
- HealthCollect – member premium presentment and payment solution

Provider Solutions:

- ProviderNet – post-adjudication claim payment and remittance portal.
Provider DDA registration
- HealthGateway – provider claims and receivables portal
- HealthCollect – patient bill presentment, payment and collections
- Remittance Manager – healthcare imaging and lockbox services

FIS offers a diverse array of healthcare products and services to meet both payer and provider needs to streamline and simplify their operations.



The flood gates of change are gushing...

What is Administrative Simplification?

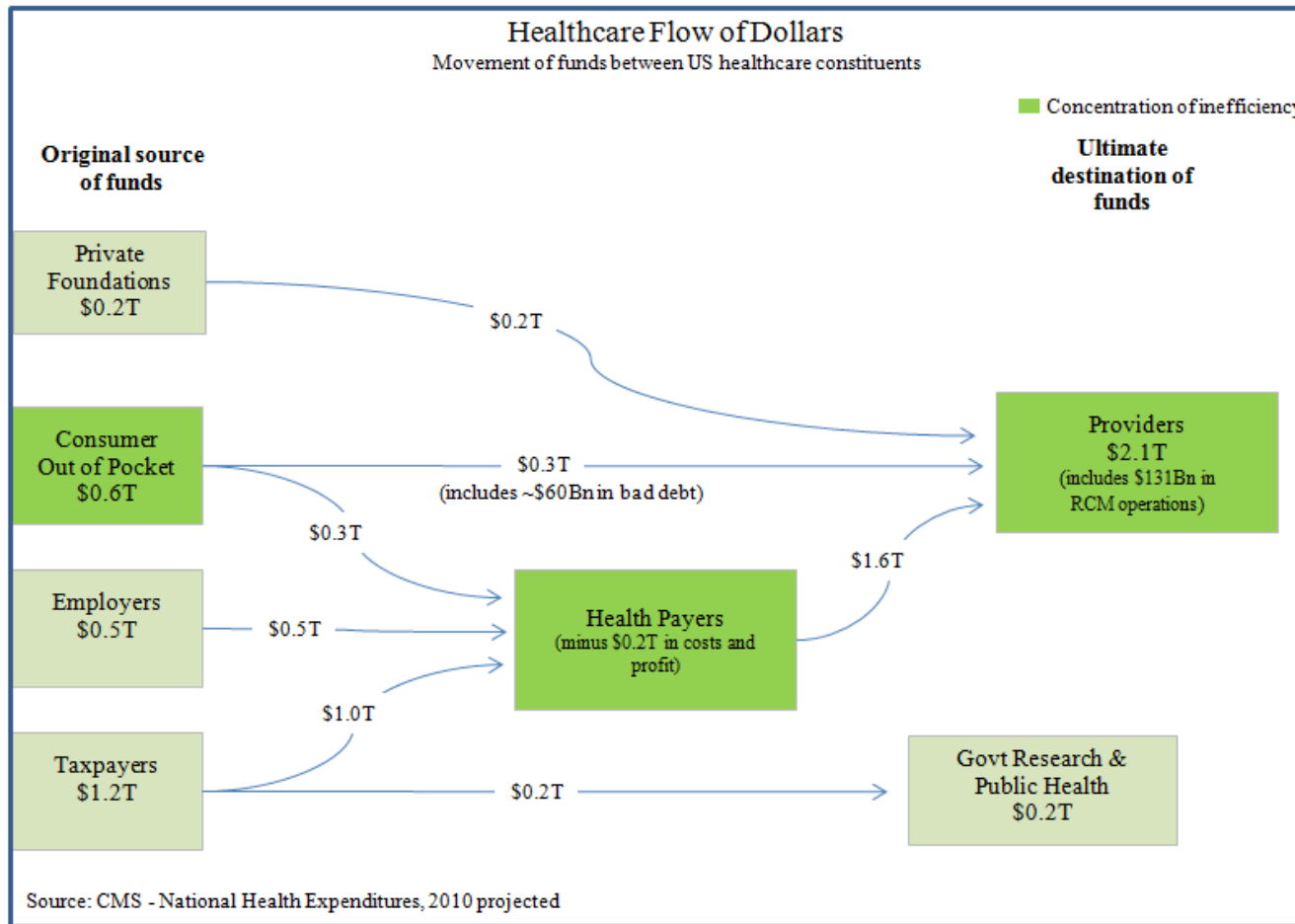


Administrative Simplification is the name tagged to Section 1104 of H.R. 3590, also referred to as the Patient Protection and Affordable Care Act.

Some of the many goals of Administrative Simplification include:

- Reduce clerical burden
- Increase electronic transaction adoption
- Standardize operating rules for:
 - Eligibility (270/271)
 - Claims status (276/277)
 - Claims payment and remittance (835)
 - Enrollment and referral authorization
- Ensure compliancy of standards

Inefficiency in Grand Proportion



Reaction to Change



How do you deal with change?

- Do you like change?
- Do you welcome it?
- Do you hide from it?

Common responses:

- Wait and see
- Embrace it
- Take it to the courts
- Consult trusted advisor

In a speech Monday, Health and Human Services Secretary Kathleen Sebelius said she and the president realize the program is "certainly far from perfect."

Last week, the Democratic-controlled Senate passed a bill to repeal an expanded tax-reporting requirement in the law that upset small businesses, and Mr. Obama has signaled he would sign it.

Republicans contend the midterm elections show voters want the overhaul tossed out. Now that their repeal bill has effectively died in Congress...

Source: Wall Street Journal, February 08, 2011

Healthcare Ecosystem Needs an Overhaul



Healthcare expenditures are projected to be approximately **\$4.6 trillion** or **20 percent of GDP** by 2017. No other comparably sized, industry segment in the U.S. has such weak administrative standards, adoption of existing standards and disjointed, legacy operating platforms.

Do you recall when each individual health plan did provider credentialing? It was painful, time consuming and inefficient for both payers and providers, but it had to be done.

The result: Through CAQH, industry leaders stepped forward and created what is now called the Universal Provider Database (UPD), a centralized repository for the collection of provider data. To date, more than 860,000 healthcare providers and professionals are participating. CAQH's UPD initiative is now the industry standard with wide support.

Successful change is possible...mandated or not.



Living and Breathing Administrative Simplification

Today's Data Exchange Environment

Challenge

- Beginning with the mandated specifications of HIPAA and the expansion and extension of those provisions through the Patient Protection and Affordable Care Act (ACA), there is significant pressure on organizations to achieve internal business strategies as well as meet industry-wide and legislative requirements
 - While improving infrastructure and lowering costs
 - Within the limitations of resource constraints

Solution

- Meaningful change must acknowledge these imperatives while aligning with the broader healthcare environment (e.g., HITECH, state initiatives and clinical/administrative data integration)

CAQH Initiatives

CAQH is a non-profit alliance focused on administrative simplification in healthcare.



Multistakeholder collaboration to facilitate the development and adoption of industry-wide operating rules for administrative transactions.



Service that replaces multiple paper processes for collecting provider data with a single, electronic, uniform data-collection system (i.e., credentialing).

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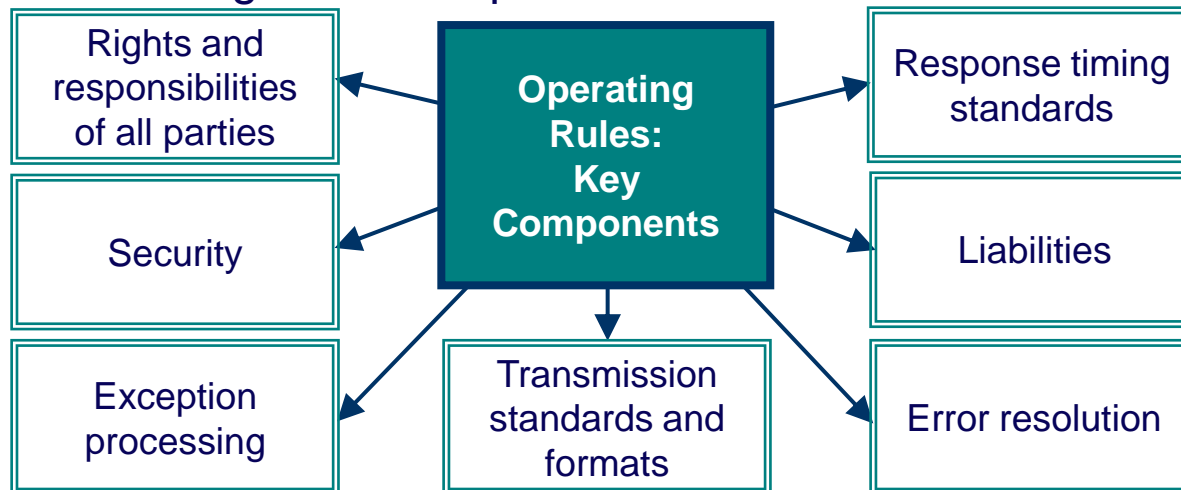
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CAQH CORE

- HIPAA provided the initial platform for administrative simplification, however, neither providers nor health plans experienced the intended result.
- CORE was established by CAQH in 2005 based on a shared recognition that operating rules could build upon standards.
 - CORE is a multistakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions.
 - Range of standards and policies needed: *Non-mandated aspects of the HIPAA standards, non-HIPAA healthcare standards and industry-neutral standards.*
 - CAQH does not vote on any CORE rule.
- Section 1104 of the ACA offers the opportunity to amplify the combined benefits of standards and operating rules.

What are Operating Rules?

- As defined in the [Patient Protection and Affordable Care Act \(ACA\)](#), the term refers to “...*the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications....*”
- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing (*remaining vendor agnostic is a key CORE principle*).
- Prior to CORE, operating rules did not exist in healthcare outside of individual trading relationships.



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The CORE Integrated Model for Operating Rules

- **Mission:** To build consensus among all essential healthcare stakeholders on a set of operating rules that facilitate administrative interoperability – starting with eligibility, and then moving sequentially to the other transactions in the claims process
- **Vision:** Provider access to administrative information before or at the time of service, *using the electronic system of their choice*, for any patient or health plan
- **Main components:**
 - A rule development and writing process, including an open, transparent approval/voting approach
 - Education and outreach
 - A certification and endorsement process (*testing occurs via independent entities and is transaction-based*)

Results: Tangible outcomes in a compressed timeframe

CORE Participation, Certification and Endorsement

Participation:

- More than 120 multistakeholder organizations, representing all aspects of the industry
 - CORE participants maintain eligibility/benefits data for more than 150 million lives, or approximately 75 percent of the commercially insured plus some Medicare and state-based Medicaid beneficiaries

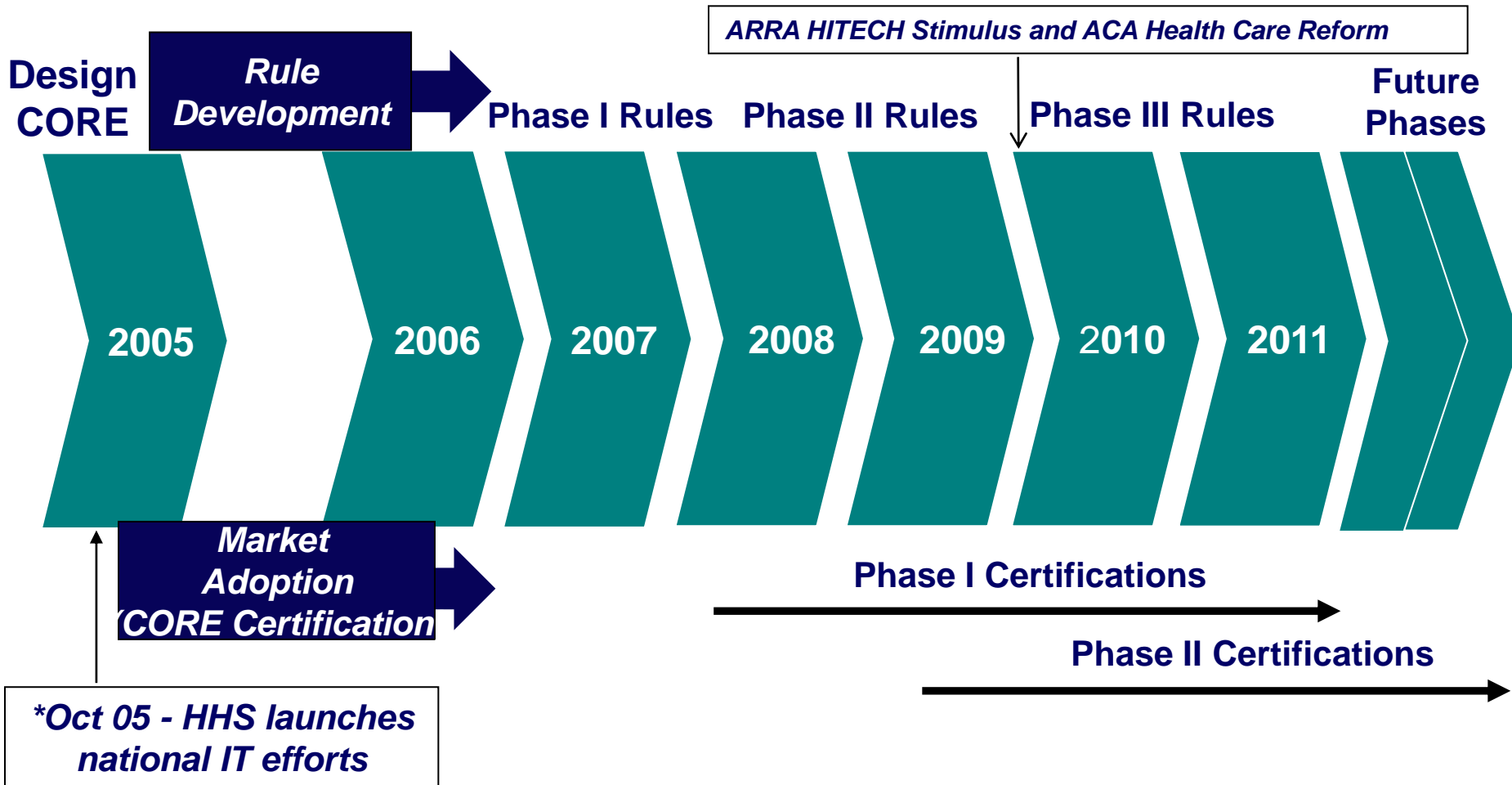
Certification:

- To date, more than 50 healthcare organizations are certified to electronically exchange/receive basic eligibility and benefits information in accordance with the CORE Phase I rules
 - Over one-third of all commercially insured lives are covered by CORE Phase I-certified health plans
- Approximately two dozen organizations are Phase II-certified, with many others committed for 2011
 - Key organizations such as Aetna and WellPoint are Phase II-certified

Endorsement:

- About 30 organizations are CORE endorsers (e.g., AMA)

CORE: *Voluntary* Operating Rule Development and Implementation Approach



REMINDER: CORE rules are a baseline; Entities are encouraged to go beyond the minimum CORE requirements

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CORE Phase I, II and III Operating Rules: Overview

Phase I alone provides significant ROI, e.g. 10-12 percent reduction in provider bad debt

Rules	Phase I	Phase II	Phase III (draft)
Eligibility Data Content	For 10 key services: <ul style="list-style-type: none"> • Coverage information • Static financials (co-pay, co-insurance, base deductibles) • In/out of network variances 	For 40+ services provide: Phase I requirements + YTD deductible	For 30+ more services provide: <ul style="list-style-type: none"> • All financial information required in Phase I and II, plus annual out of pocket maximums
Infrastructure	<ul style="list-style-type: none"> • Connectivity via Internet • Acknowledgements (transactional) • Real-time and batch turnaround times • System availability • Companion Guide flow/format 	<ul style="list-style-type: none"> • Connectivity: Phase I + plug and play method (SOAP) and digital certificates • Patient identification 	<ul style="list-style-type: none"> • Connectivity enhancements to speak to coordination with other industry efforts. • Establishes process that allows for tracking claims in the adjudication system
Claims Status	N/A	<ul style="list-style-type: none"> • Connectivity via internet • Acknowledgements (transactional) • Real-time and batch turnaround times • System availability • Companion Guide flow/format 	<ul style="list-style-type: none"> • Maintain claim history for 24+ months from time claim enters adjudication system • “Floor” of code combinations to bring uniformity/consistent in reporting status
Claim Payment/ Advice Remittance	N/A	N/A	<ul style="list-style-type: none"> • Promotes increased availability and usage of transaction through application of CORE infrastructure rules • Sets timeline for dual paper-electronic delivery
Prior Authorization	N/A	N/A	<ul style="list-style-type: none"> • Promotes increased availability and usage of transaction through application of CORE infrastructure rules
Health ID Card	N/A	N/A	<ul style="list-style-type: none"> • Specifications for human-readable data elements, two of which are also machine-readable

Federal Imperatives Impacting Administrative Simplification: Highlights

- **HIPAA v5010:** January 2012 – Deadline for health plan and provider systems
- **ICD-10:** Oct. 1, 2013 – Deadline for health plan and provider systems
- **The American Recovery and Reinvestment Act (ARRA) Health Information Technology (HITECH) Act:** Through 2015 – Stakeholders will be determining how to coordinate with national and regional efforts
 - Nationwide Health Information Network (NHIN)
 - State-based decisions on the role of administrative data in HIEs and Medicaid
 - More than half a billion dollars given to HIEs
 - HIEs require Connectivity; CORE Connectivity is well aligned with federal efforts (e.g., NHIN)
 - Providers: “Meaningful Use” of Health Information Technology via Certified EMRs (\$40 billion)
 - Three stages: Stage 1 already released and initially included the CORE rules, but were removed; administrative transactions may be included in a future stage
- **The Patient Protection and Affordable Care Act (ACA):** Through 2017 – Stakeholders are required to meet iterative deadlines

The ACA Contains Several Administrative Simplification Provisions

- On or before Jan. 1, 2011, health plans must be able to provide rebates if minimum requirements for medical loss ratios (MLRs) are not met [Sec. 1001 and 10101, Sec. 9016]
 - Small group health plans must limit administrative costs to 20 percent and large groups to 15 percent
- The Secretary will develop standards for uniform Explanation of Coverage documents provided by Health Plans, including standard definitions for insurance and medical terms [Sec. 1001]
- Provides an accelerated schedule for the review and update of Standards and Operating Rules (every two years beginning April, 2014) [Sec. 1104]
- Operating Rules and an “authoring entity” are added to provide uniformity in the implementation of the electronic standards [Sec. 1104]

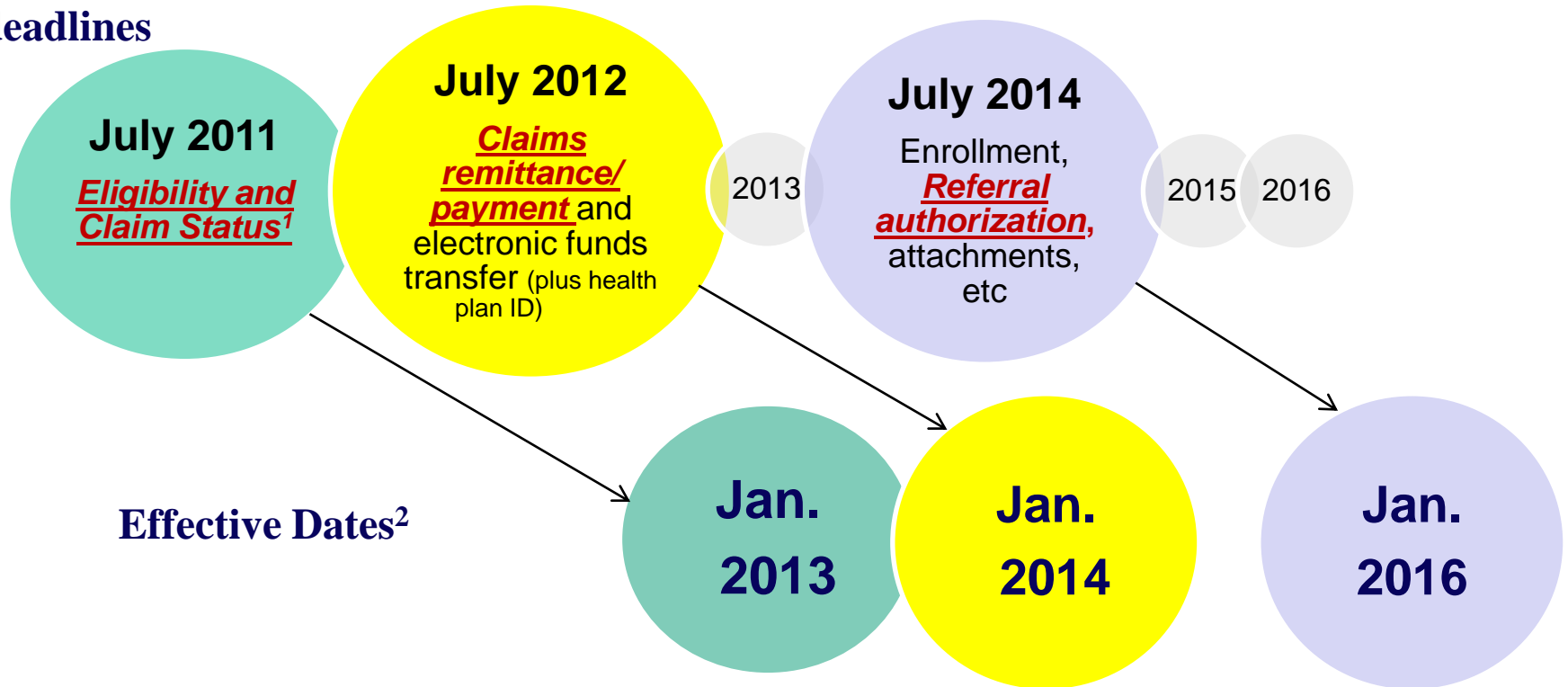
Section 1104 Details (HR3590)

- New requirements for administrative and financial transactions; standards and operating rules must:
 - Enable the determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care
 - Be comprehensive, requiring minimal augmentation by paper or other communications
 - Provide for timely acknowledgment, response and status reporting that supports a transparent claims and denial management process (including adjudication and appeals)
 - 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)
- Health plans must file a statement with HHS confirming compliance with these operating rules

ACA Section 1104: *Mandated* Operating Rule Approach

Operating rule writing and mandated implementation timeframe

Rule adoption
deadlines



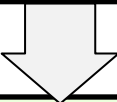
Notes: (1) *Red italicized font indicates* that CORE Phases I–III has placed a focus on these areas. Scope/definition of the Federal regulation is TBD but NCVHS has recommended CORE Phase I and II, with enhancements (2) Documentation of compliance will be identified by Federal regulation. Health plans must demonstrate that the plan conducts the electronic transactions in a manner that fully complies with the regulations provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians. HHS may designate independent, outside entities to certify that a health plan has complied with the requirements.

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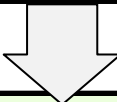
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Section 1104: *Current Milestones of Eligibility & Claim Status*

July 2010: NCVHS Hearings on Qualified Nonprofit Entities for Mandated Operating Rule Development



Sept. 30, 2010: NCVHS Recommendation to HHS on Qualified Nonprofit Entities and Rules



Dec. 3, 2010: Update to NCVHS CORE Phase I and II enhancements (draft CORE Phase III and state rules)



Mid 2011: Draft rules issued by CMS for comment (Note: final rules need to be approved by July 2011)

Status

- Two non-profit candidates recommended by NCVHS to fill rule development role:
 1. CAQH CORE for non-retail pharmacy
 2. National Council for Prescription Drug Programs (NCPDP) for retail pharmacy
- CORE Phase I and II rules recommended by NCVHS as base for first rule set; CORE working with industry to determine what else could be added in short timeframe (e.g., state requirements, draft CORE Phase III rules)
- Expectation that key goals expressed at hearings will move forward, e.g.
 - Voting on operating rules must continue to be transparent and multistakeholder
 - Desire of providers to have shared governance of operating rule entity
 - This remains an unfunded mandate, and an “adjusted” CAQH CORE would need to transition over a period of time
 - Mandated rules are one part of process

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Section 1104: Current Milestones Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Dec. 3, 2010: NCVHS Subcommittee on Standards held Hearings on EFT and ERA; Authoring entity applications due Jan 31, 2011

Feb. 9 & 10, 2011: NCVHS Full Committee Meeting to discuss applications

2011: CMS will move forward informed by NCVHS recommendation

July 2012: EFT and ERA Rule Adoption Deadline

Status

- In December 2010, four organizations proposed to be authors for the ACA EFT and ERA operating rules:
 - Healthcare (non-retail pharmacy):**
 - CAQH CORE
 - X12
 - Healthcare (retail pharmacy):**
 - NCPDP (Medco representative)
 - Financial:**
 - NACHA (also does EFT standard)
- In December 2010, 10 organizations provided testimony regarding next steps for EFT and ERA operating rules:
 - The majority of the testifiers expressed very similar recommendations on opportunities and approaches.
- CAQH CORE and NACHA have proposed that they would work in collaboration to meet the needs of the ACA non-retail pharmacy healthcare operating rules for EFT and ERA.
 - Healthcare operating rules and financial industry operating rules would complement one another.
 - Submitted joint application Jan. 31, 2011
 - NCVHS is discussing the applications this week.

CORE Administrative Transaction Flow

End-to-end CORE Certification across a trading partner network can streamline access to important administrative information and create significant operational efficiencies.



STREAMLINED ADMINISTRATIVE DATA EXCHANGE



Transaction-based data rules are paired with infrastructure rules to help data flow consistently in varied settings and with various vendors.

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CORE: Five Years of Experience and Lessons Learned

- Milestone driven approach
 - Establishes a feasible road map focused on value proposition
 - Federal mandated efforts are iterative, paralleling CORE phased approach
- Multistakeholder, consensus-based and transparent process
 - Clear guiding principles; anti-trust provisions
 - Consensus reached through discussion, surveying, straw polls and transparent voting process
 - Documentation available to all CORE participants using a shared access tool
 - More than 120 participating organizations, covering all segments of the industry
 - Includes SDOs, government, health plans, providers, vendors, etc. Health plans represent approximately 75 percent of the commercially insured.
 - Recognizes interdependencies within individual organizations and across all stakeholders
 - CORE-certified and committed health plans represent 55 percent of the commercially insured.

CORE: Five Years of Experience and Lessons Learned

(cont'd)

- Has resulted in tangible outcomes in a compressed timeframe:
 - Tracking of ROI (based on CORE Phase I rules)
 - 10 – 12 percent reduction in provider claim denials
 - Average savings of nearly \$3.00 per patient eligibility verification phone call
 - Estimated cost savings of \$3 billion over three years
- Education and outreach vital:
 - Awareness building (e.g., webinars, newsletters, provider association distribution)
 - Demonstration projects (e.g., connectivity at HIMSS IHE, VeriSign pilot in MA)
 - Trading partner tools
 - Coordination and recognition through alignment with state and federal efforts:
 - Federal: MITA and NHIN
 - States: Colorado, Ohio, Texas, Virginia, Minnesota, Washington
- Budget and resource considerations:
 - Expertise and time provided by representatives of participating organizations
 - Full-time staff supplemented by contracted experts
 - Commitment/involvement of senior executive leadership

* Minnesota and Washington included aspects of the CORE rules

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CORE: Looking Forward

- Adapt given move from a voluntary to a mandated-voluntary approach
 - Governance, structure and resource requirements
- Continue to work in collaboration to meet the requirements of Section 1104, e.g.
 - Content and scope of mandated operating rules require very deliberate, thoughtful, and transparent industry agreement: *All stakeholders must be at the table and focused on real world impact*
 - Lessons learned/best practices need to be shared and strongly considered (state-based efforts are critical to this), and partnerships embraced
- Continue focus on long-term vision driving CORE and Section 1104
 - *This is a journey with many milestones: Mandate is one part of the whole*
 - Align provider and vendor adoption (consider role of meaningful use)
 - Track and share ROI for all stakeholders to identify real world impact
 - Research, pilot, debate and create operating rules needed to continue to move forward (e.g., policies regarding digital certificate use)
 - Maintain Web-based, objective testing and certification process to guide successful implementation
 - Partner on outreach and education

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Next Steps: EFT and ERA Research

- CORE Phase III work, partnerships, internal infrastructure and mission speaks to CORE's commitment to EFT and ERA operating rules
- CAQH and NACHA conducted in-depth interviews with key stakeholders including providers, health plans, vendors, clearinghouses and banks (including FIS) and are developing a white paper out of this and other research activities.
 - Key business issues identified through the research include:
 - Provider EFT enrollment with payers is inefficient and time consuming for all stakeholders
 - Providers require more accurate, standard and valid EFTs and ERAs from payers
 - Providers face significant challenges with re-association when the EFT and ERA are sent separately, which are compounded when there are long delays between receiving the two transactions
 - Providers want sufficient information on ERAs to match payments to contractual obligations during the payment posting process
 - Providers are concerned about the debiting of their accounts with the use of EFT
 - The white paper will address these business issues (and more) and included recommendations for moving the industry forward
- Responded to application from NCVHS to become an authoring entity for EFT and ERA operating rules for non-retail pharmacy
- Currently collecting names of individuals interested in participating in EFT and ERA Subgroups and Work Groups for rule development

How to Get Your Organization Involved Today

Administrative Simplification requires a multistakeholder effort:

- Become a CORE Participating Organization
 - Collaborate with multistakeholders to develop operating rules in Rules Creation
 - Contribute to research related to EFT and ERA operating rules
 - Enlarge the circle of stakeholders in the rules development process
 - Ensure the rules are being written with the end-user in mind
- Achieve CORE Certification
 - Encourage adoption of the CORE Phase I and Phase II Rules
 - Experience operational efficiencies resulting from the consistent delivery of eligibility, benefit and claim status information
 - Measure the benefits of implementing CORE Phase I and II Rules
- Spread the Word
 - Associate your organization publicly with a national administrative simplification initiative
 - Encourage end-to-end adoption of rules through trading partner relationships
 - Host CORE educational sessions and generate industry awareness

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Is it Bigger than a Breadbox?

A Road Map Full of Mountains



Provider Obstacles	Payer Obstacles
<p>Rely heavily on third parties for patient collections, lockbox, administrative / financial record keeping and clearinghouse(s)</p>	<p>The post adjudication workflow is built around paper. In house, EFT provider adoption efforts have largely failed</p>
<p>Patients are confused – not sure when and what to pay</p> <ul style="list-style-type: none"> • Patient payments – average days outstanding ~ 90 days • Patient payments – bad debt \$60B annually and growing 	<p>Claims are processed on 1 to 4 legacy, adjudication platform(s). Implementing HIPAA v 5010</p>
<p>Payer paper checks and remittances are expensive to handle and process. ~ \$10 per payment package to post and reconcile</p>	<p>“For profit” organizations are facing margin compression. MCR requirements</p>
<p>Payer and patient payments are disjointed</p>	<p>Not known for great provider relations</p>
<p>ICD – 10 Meaningful Use requirements PMS unable to auto post HIPAA ANSI X-12 835</p>	<p>Commercial, fully insured membership is declining as more employers/members move to High Deductible Health Plans</p>

Getting a Head Start Now...



Unless you have large economies of scale and significant talent expertise, an internal build probably doesn't make financial sense for each one of the transaction sets included within Section 1104.

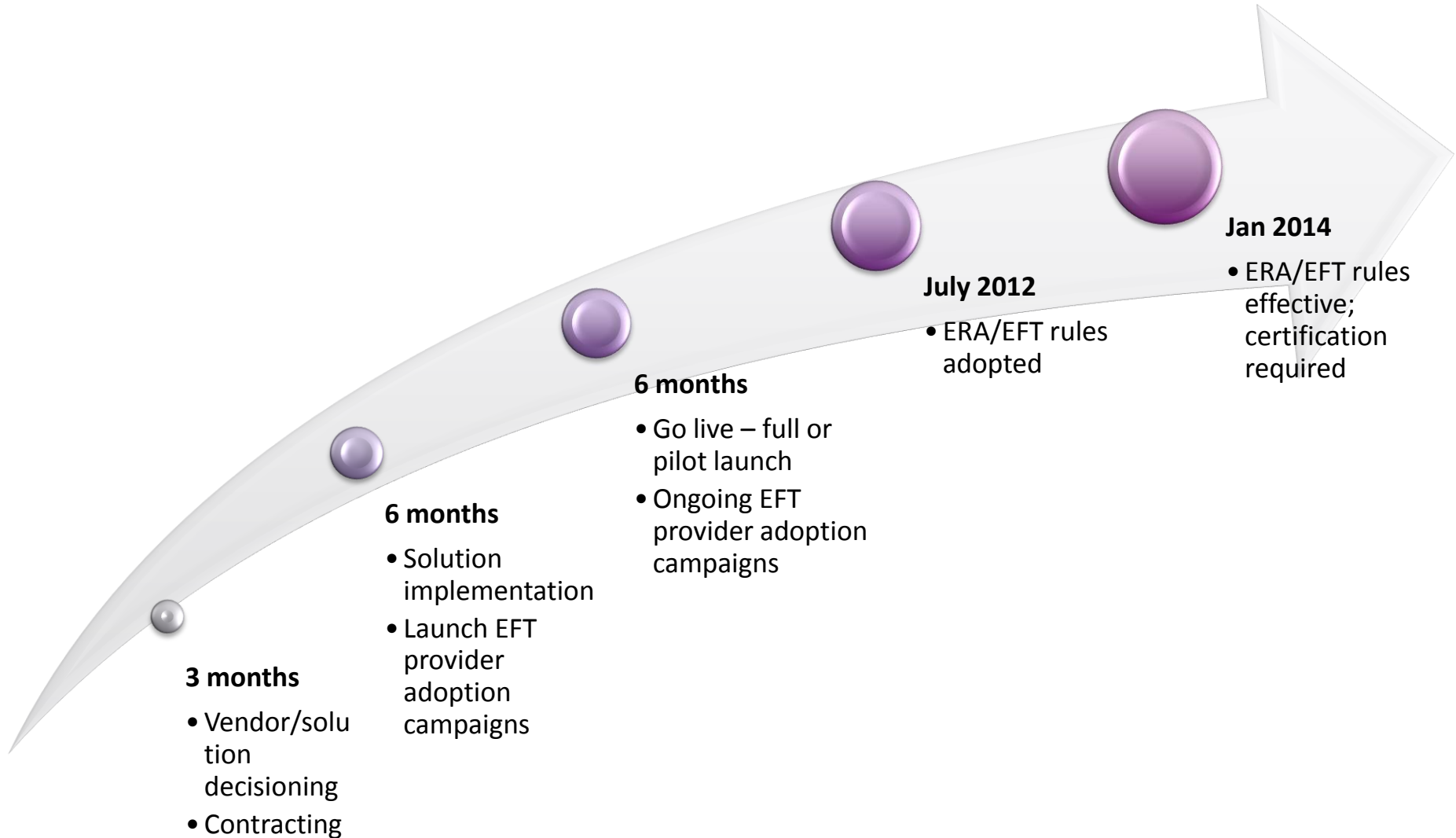
One of the more complex and challenging requirements is the union of electronic payments (EFT) and electronic remittance advices (ERA)...

Questions that you should be considering:

- Is your organization producing a compliant ANSI X-12 835?
- Is your organization using HIPAA-compliant procedure and remark codes within the 835?
- How many adjudication platforms will this solution have to connect to?
- How is your relationship with your providers?
- Will they trust you to securely host their banking information (DDA and ABA)?
- Will providers enroll with each individual payer they do business with?
- And the list goes on...

Third-party service vendors are bound to the same compliancy standards as payers. Compliancy certification can be obtained through a third-party solution.

Make Sure the Math Works



3 months

- Vendor/solution decisioning
- Contracting

6 months

- Solution implementation
- Launch EFT provider adoption campaigns

6 months

- Go live – full or pilot launch
- Ongoing EFT provider adoption campaigns

July 2012

- ERA/EFT rules adopted

Jan 2014

- ERA/EFT rules effective; certification required

Wide Spread Adoption



Each of the transaction sets within Section 1104 have two basic deployment components: technical and provider adoption

Using the EFT/ERA requirement as our example:

Provider profile:

- 5 – 10 physician office
- PMS can't auto post an 835
- 4 – 6 payer relationships
- 95 percent of claims submitted electronically
- 80 percent of payer payments are paper
- Not using a billing company/lockbox
- Using a clearinghouse for HIPAA transactions

Communication
+ Trust
+ Realized Benefits
= Adoption

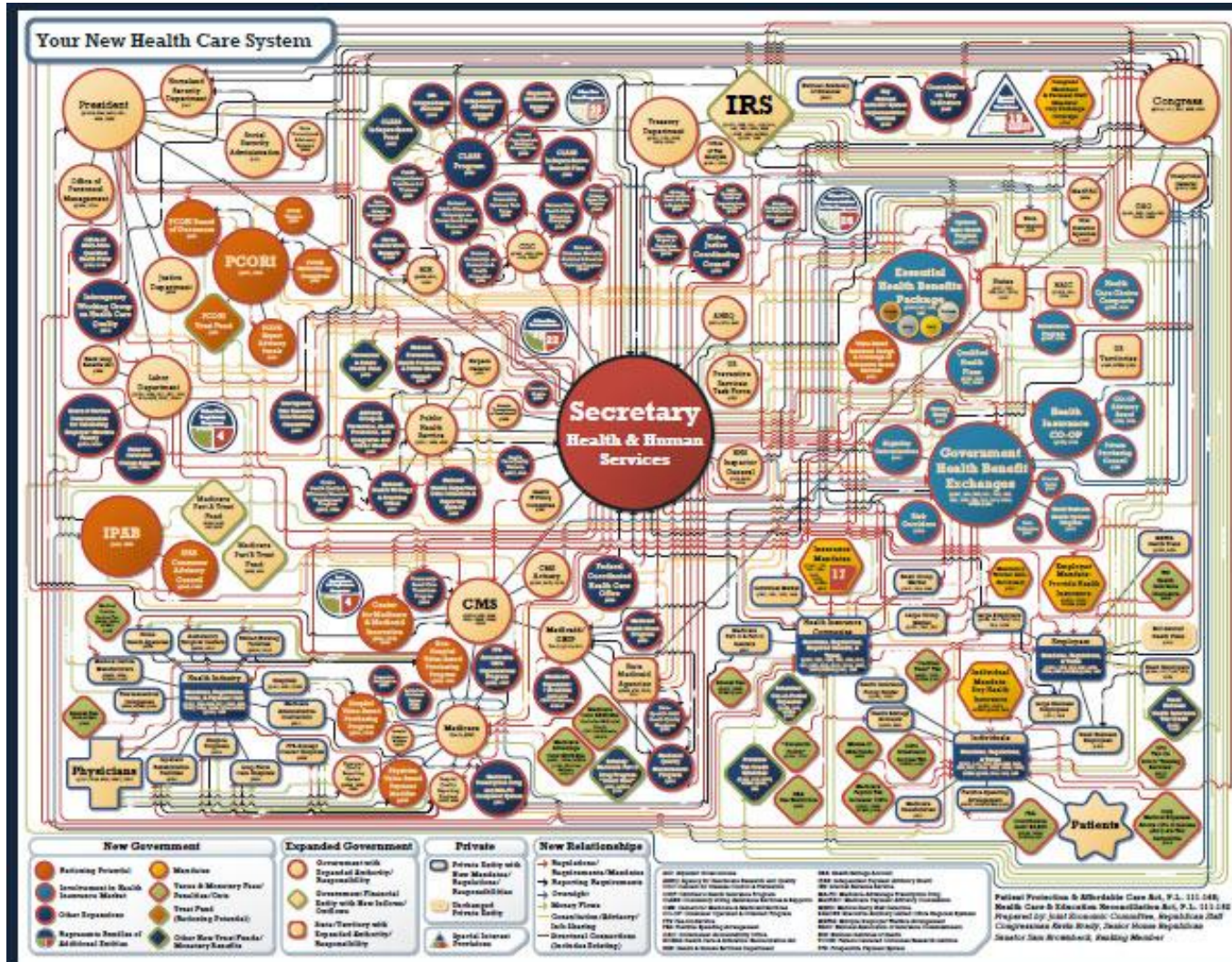
What's needed to obtain mass provider EFT adoption?

- Standard 835 usage across all payers
- An integrated EFT and ERA; reconcile to each other
- Multipayer EFT enrollment
- Secure hosting of banking information
- Clear ACH debit and credit authorization rules
- "Straight through processing" of data into PMS



Rounding Third and Heading For Home

Is Simplification Necessary?



What's Happening to Your Health Plan?



"Over the past decade, premiums for Americans who get their insurance at work have more than doubled," says Jessica Santillo, a spokeswoman at the Department of Health and Human Services.

Employers already are passing on a bigger share of their healthcare costs to employees than they have over the previous decade, according to data from the Kaiser Family Foundation. The Menlo Park, Calif.-based nonprofit found this year that family premiums for firms went up 3 percent in 2010, but workers' share of those costs rose 14 percent.

But some companies, citing the new mandates, say costs are rising too fast: In a survey of more than 1,000 employers, Mercer, a human-resources consulting firm, found that corporate healthcare costs would rise by 10 percent next year if firms made no changes to their plans. Many are finding that they have little choice but to switch a greater share of costs to employees.

Source: Wall Street Journal, October 9, 2010

Get Involved



- Appoint someone from your organization to get involved
- Adopt and implement the new standards
- Refuse to transact with paper – GO GREEN
- Look for third-party solution vendors who are involved and guaranteeing their product(s) compliancy
- Payers – work together with your providers
- Providers – work together with your payers
- Third-party solution vendors – bridge the gap between payers and providers

Late last year, FIS launched ProviderNet, an integrated print and electronic, post adjudication payment solution in anticipation of the growing market need and healthcare reform.



Thank You

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