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2006 CORE Patient Identification Survey
Identifiers Subgroup

November 30, 2006

Executive Summary

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Supported by a grant from the California HealthCare Foundation, based in Oakland, California.

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In 2006, CAQH received a grant from the California HealthCare Foundation (CHCF) to define operating rules for patient identification in the HIPAA 270/271 eligibility and benefits transactions. The grant provided support for defining the business case for patient identification, drafting operating rules to support the business case and designing a California-based pilot to test the draft operating rules and estimate potential savings. This CORE Patient Identification Survey was partially funded by the CHCF grant.

The goal of the 2006 CORE Patient Identification survey was to more specifically quantify the business case for the development of operating rules related to patient identification (CORE is not developing a record locator service, centralized database or national patient ID number). The survey was divided into three sections in order to collect data from three different perspectives: (1) providers, (2) health plans, and (3) clearinghouses. The survey requested information in the following key areas:

- Eligibility verification activities via electronic and manual methods
- Eligibility rejections/errors related to patient identification issues and associated re-work
- Search and match logic used by health plans for various methods of eligibility verification
- Claims rejections/denials related to patient identification issues, associated re-work and bad debt
- Input into alternative search options for the 270 eligibility transaction
- Identity theft and fraud exposure

The survey was issued to all CORE participants and a limited number of California-based organizations. Subsequently, the survey was made available to X12N Task Group 2, Work Group 1 participants and the X12N provider caucus to encourage a broader base of responses. Survey responses were received from the following types of organizations:

<table>
<tr><th>Stakeholder Type</th><th>CORE Participant</th><th>Other Interested/Affiliated Organizations</th><th>Total</th><th>Average Total Monthly Eligibility Transactions for These Respondents</th></tr>
<tr><td>Provider</td><td>8</td><td>2</td><td>10</td><td rowspan="3">95 million</td></tr>
<tr><td>Health Plan</td><td>13</td><td>11</td><td>24</td></tr>
<tr><td>Clearinghouse</td><td>3</td><td>0</td><td>3</td></tr>
<tr><td>Other (e.g., association)</td><td>3</td><td>0</td><td>3</td><td>NA</td></tr>
<tr><td>Total</td><td>27</td><td>13</td><td>40</td><td></td></tr>
</table>

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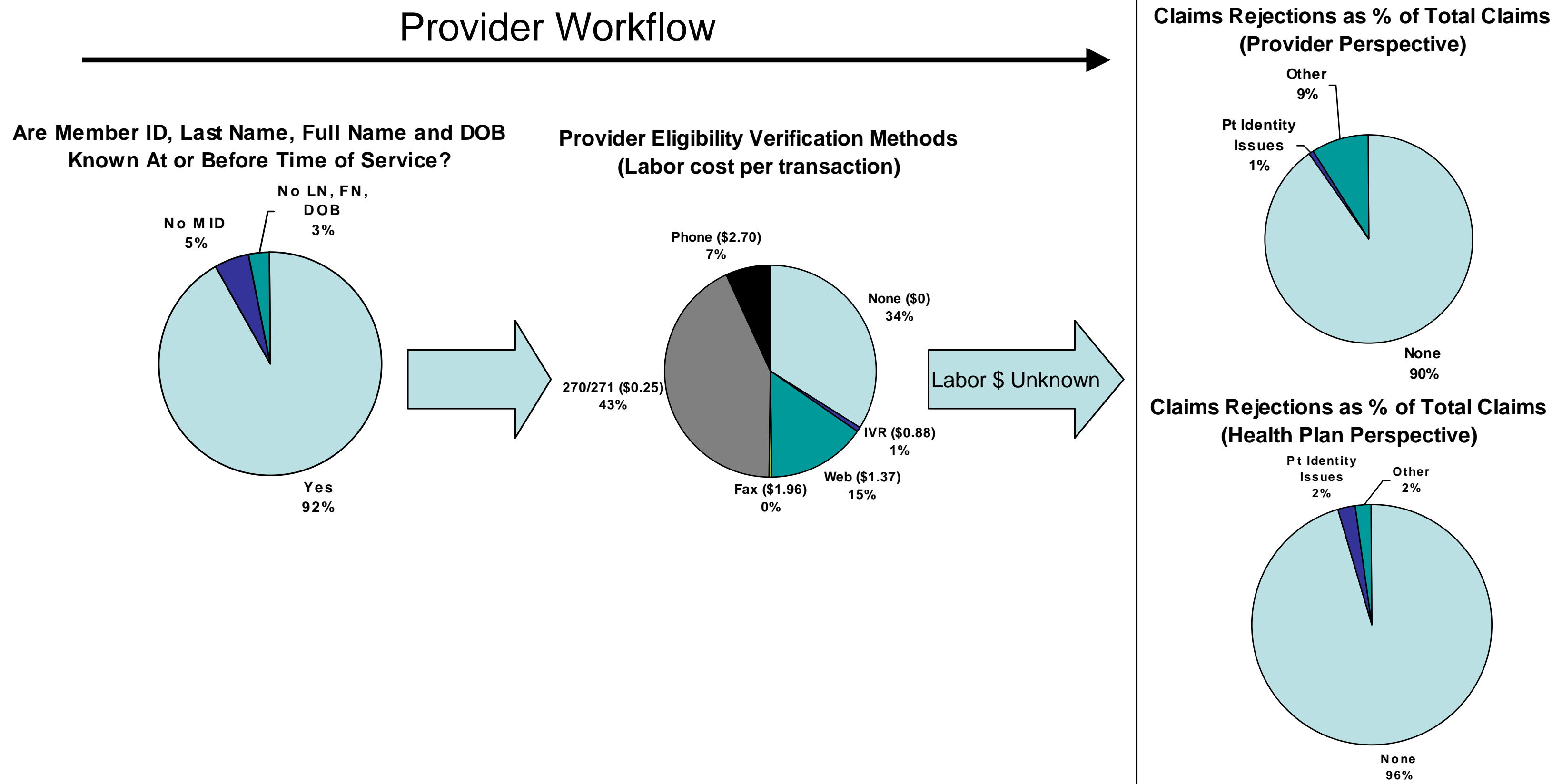
Summary Conclusions

- Providers and health plans can achieve significant savings on eligibility verification costs by shifting from more labor-intensive verification methods (web, IVR, fax and phone) to automated 270/271 transactions. Patient identification rules that enhance data matching and provide better information on why matching did not occur should increase utilization of the 270/271 transactions.

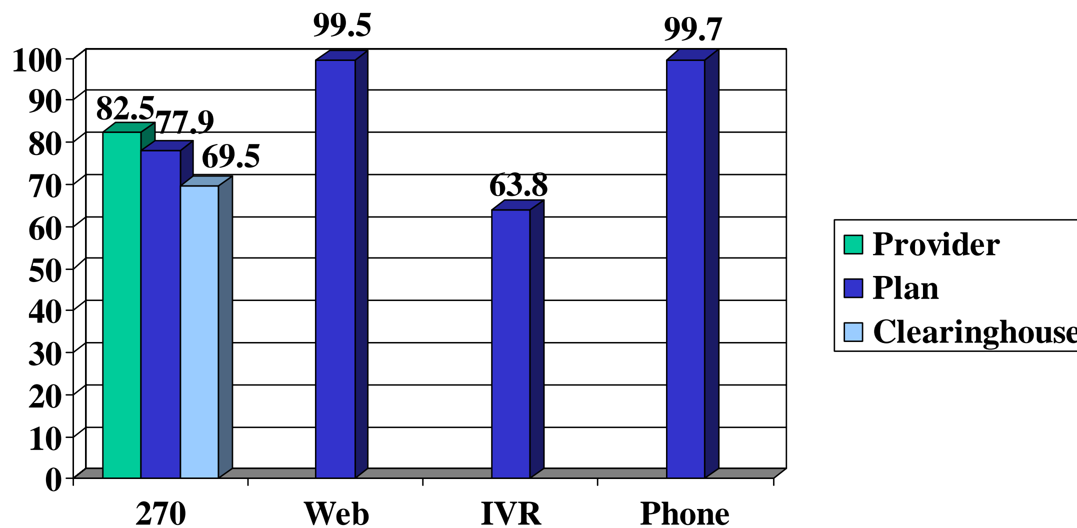
- Based on the data reported, it was not possible to reliably quantify the impact of not having a member ID number at or before the time of service. Providers are incurring processing and re-work costs to obtain key patient ID data elements in order to submit claims; however, the labor costs and associated claim amounts that are directly attributable to a missing or invalid member ID number are unknown without further research.



Key Findings – Successful Eligibility Responses

- Provider respondents estimate that they have the member ID number before or at the time of service 95% of the time on average (range: 80-99%) and all four of the HIPAA maximum data elements[1] 92% of the time on average (range: 65-99%).

- In spite of these relatively high levels of data reported, additional data from providers, health plans and clearinghouses show that automated 270/271 inquiries achieve a valid eligibility response only 70%-83% of the time. Inquiries through web-based methods and phone calls to health plan customer service representatives show much higher rates of accuracy (92%-99%).



[1] The HIPAA maximum data elements are member ID number, last name, first name, and date of birth.

- General AAA error codes have the highest volume of reported errors for the 270/271 transactions (i.e., Patient not found, Subscriber/insured not found).[2] These two AAA error codes accounted for 6%-20% of *all reported eligibility transactions*.

Types of Eligibility Errors (% of ALL 270 transactions)	Providers	Plans	Clearing-houses
Patient/Subscriber not found	11.0%	6.4%	20.5%
Invalid/Missing/Duplicate ID	0.6%	8.4%*	1.7%
Invalid/Missing Date of Birth	0.2%	3.2%	0.7%
Invalid/Missing Name	0.1%	1.9%	0.2%
Other Patient ID errors	3.9%	0.9%	0.2%
Non-eligibility related errors (e.g., system timeout, provider authorization)	1.7%	1.3%	7.2%

- These findings suggest:
  - The patient demographic data providers have may not match information that health plans have.
  - More interactive methods of eligibility verification, such as web searches and calls to customer service, are more time consuming than automated 270/271s but result in better matching.
  - Improved specificity and standardized use of the AAA codes would give providers better feedback to understand what information is missing or incorrect in order to obtain a valid match.

[2] One large national health plan had a significant volume of AAA errors for **invalid** (not missing) subscriber ID, which resulted in a relatively high overall error rate for this AAA code across all health plans.

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Key Findings – Potential Cost Savings and Data Gaps

- As expected, 270/271 transactions have the lowest per transaction labor cost for providers ($0.25). Overall labor costs across all methods of eligibility verification average $0.51 per transaction for provider respondents.
  - If all eligibility verification was performed through the 270/271 transaction and high levels of accurate matching were achieved, providers could potentially reduce eligibility verification costs by up to 50%. ***For the 8 provider respondents to this part of the survey, it would reduce eligibility verification costs from $2.7 million annually to $1.3 million. If these savings were extrapolated to all providers nationally, the savings would be significant.***

  - Health plans would also realize significant savings with a shift to 270/271 transactions given that the average labor cost per call is $1.38 and $0 for a 270/271. ***For the 16 health plan respondents that provided eligibility data, the annual labor savings could be as much as $78 million annually.***

- Almost half of all claims rejections are due to patient identification issues, according to health plan respondents.
  - This represents 2% of all claims submitted.
  - Rejected claims require re-work by providers (and plans) or the potential loss of this revenue.

- The survey requested detailed data from providers to quantify the re-work related to failed eligibility verification and denied claims as well as information on bad debt related to patient identification problems. While a few providers attempted to estimate this information, the numbers were highly variable and not reliable. This is a key gap in estimating potential cost savings and will be assessed further in the Phase II CORE Patient ID Study.

Key Findings – Alternate Search Options

- All health plan respondents have a primary EDI search option for the 270/271 transaction that requires a member ID. 10% of these plans allow an alternate search on last name, first name and date of birth. The data were inconclusive for both providers and health plans on whether allowing a name/DOB search results in higher level of EDI utilization and/or lower claims rejection rates. This also will be studied in the Phase II CORE Patient ID Study.

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- Providers and health plans have widely divergent views on their most-preferred alternate search options:
    - Providers ranked highest an alternate search that would include last name, first name and date of birth; whereas, health plans ranked this option almost last.
    - Health plans ranked highest an alternate search that would include member ID and date of birth; providers ranked this option almost last.

- Both provider and health plan respondents showed support for one of the two required alternate search options under consideration in the revised draft of the X12N V5010 (Member ID, Last Name and First Name).

- Almost all providers and health plans respondents noted that they had not experienced any instances of fraud/identify theft or HIPAA privacy complaints related to release of eligibility data. Two plans noted very limited occurrences.

Recommendations and Next Steps

The CORE Patient Identification Survey results indicate a clear opportunity for providers and health plans to achieve savings by shifting eligibility verification from more labor-intensive methods (web, IVR, fax and phone) to automated 270/271s. Patient identification rules that enhance data matching and provide better information on why matching did not occur should increase utilization of 270/271 transactions. In addition, other improvements already addressed in the CORE Phase I Rules and under consideration in CORE's Phase II scope should help in promoting the usefulness of the 270/271 transactions. Based on the survey results, the CORE Identifiers Subgroup is pursuing a two-pronged approach:

1. Develop operating rules for patient identification when the member ID is available that will enhance data matching and provide better information on why matching did not occur. Rules will be drafted to achieve the following:
    a. Improved data matching on name, special characters
    b. Better information on why matching did not occur (e.g., standardize use of AAA error codes)
2. Design a follow-on study to measure the impact of a missing or invalid member ID number and to assess cost differences for health plans that support alternate searches in order to determine whether to develop additional rules in this area.

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