simplifying healthcare administration

CAQH

2007 CORE Phase II Patient Identification Study
Identifiers Subgroup

December 13, 2007

Executive Summary

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Accurate patient identification is a critical first step in verifying health insurance eligibility – without it, health plan coverage cannot be confirmed and downstream transactions may fail or require supplemental manual lookup methods to determine the member's coverage status with a health plan. These additional efforts add unnecessary costs to the healthcare system that could be reduced if patient identification processes were improved. Through CAQH's CORE initiative, and with the support of the California HealthCare Foundation (CHCF), operating rules are being developed to improve the patient identification process in the HIPAA 270/271 eligibility and benefits verification transactions.

In 2006, CAQH received an initial grant from CHCF to define the business case for accurate patient identification and to draft operating rules to support the business case. Based on the initial grant's research findings, two rules were developed to (1) improve patient name matching on the 270/271 and (2) provide specific information on why eligibility transactions failed to locate a patient in a health plan's database.

In 2007, CAQH designed a follow-on study (Phase II study) to better quantify the impact of missing or invalid member IDs – a key data gap in the initial study. With additional funding support from CHCF and input from the CORE Identifiers Subgroup and Linxus, a New York City-based collaborative of health plans and providers, the Phase II study was designed and launched. The objectives of the CORE Phase II Patient Identification Study were to:

1. Measure the business impact on providers and health plans of a missing or invalid member ID number, including:
   - Whether more flexible health plan matching criteria (i.e., alternate searches) are linked to lower costs, better patient matching, and more timely claims payments for providers and/or health plans
   - The root causes for missing member ID numbers

2. Use the business impact findings to draft additional CORE operating rules and/or policies to reduce administrative costs and improve the accuracy of patient identification during eligibility verification.

CAQH conducted the business impact study with providers and health plans in California and New York. Provider participants included both inpatient facilities and ambulatory physician practices. Health plan participants included two plans with more flexible patient matching criteria (i.e., "name search" plans) and two plans with more stringent criteria (i.e., requiring a member ID number).

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Six providers collected data for the study. Four of the six performed a combined time study and ad hoc reporting analysis, and two of the six provided retrospective data.

Summary Observations

Based on analysis of the provider and health plan data received, the table below highlights the key observations, related business impact and potential for industry improvement through CORE rules, policies or other industry actions.

Observation	Business Impact Identified in Phase II Study Results	Potential for Industry Improvement
1. Routine use of eligibility verification using any method[1] has substantial benefits.	• Higher rate of paid accounts when verification attempted • Higher eligibility validation rates across methods • Find changes in insurance information earlier in the process	• Educate providers about the value of routine eligibility verification
2. There are continued challenges with lower validation rates on the 270/271 compared to other methods and between initial and final verification attempts.	• Encourages use of higher-cost verification methods that have higher validation rates (e.g., web, phone) and more flexible search options • Lower initial validation rates on the 270/271 causes re-work	• Draft CORE rule on last name normalization • Draft CORE rule on AAA error reporting • Develop a CORE rule on alternate/name searches
3. The rate of missing member ID numbers varies by provider and care setting but ranges from 0-10% of accounts for these study providers. In addition, 4-12% of accounts had member ID number changes during the study timeframe.	• Missing and invalid member ID numbers cause re-work and affect providers' ability to do eligibility verification; however, patient names are almost always available and could be used as an alternative to help identify the patient • Relatively high percentage of patient accounts are in flux while missing and	• Develop a CORE rule on alternate/name searches

[1] Eligibility verification methods included in the study were: 270/271 transactions, web, IVR, and phone.

Observation	Business Impact Identified in Phase II Study Results	Potential for Industry Improvement
	invalid member ID numbers are researched and resolved	
4. Health plan data show that a name search consistently achieves a high validation rate across plans for calls to customer service representatives. While validation rates are lower for 270 transactions when a member ID is not available, a match is made almost half of the time.	• Name searches can achieve a unique match • Name search validation through electronic means reduces phone calls to health plans and patients. One large health plan achieved successful eligibility matches without a member ID for 500,000 transactions in one month, which resulted in a significant number of avoided calls.	• Develop a CORE rule on alternate/name searches
5. It was difficult to determine the level of provider administrative savings when working with health plans that support name searches versus those that do not.	• Multiple confounding variables make it difficult to quantify the impact of name search availability on providers • Not all study providers use the 270/271 to check eligibility as a first step, and the number of 270 transactions submitted without patient IDs to plans that support a name search was relatively small, making it difficult to draw firm conclusions based on the provider data. • Plans that support a name search may encourage more attempts because providers know that flexible matching criteria are used. Conversely, providers may reduce verification efforts with plans that do not support a name search, especially in situations where the member ID is missing.	• Evaluate name search savings potential
6. Social security number is often used as an alternative to the member ID and results in a high validation rate.	• The reliance on SSN as an alternate to member ID is expected to decrease over time as fewer providers and health plans collect and store this information	• Develop a CORE rule on alternate/name searches

Observation	Business Impact Identified in Phase II Study Results	Potential for Industry Improvement
7. Approximately 2% of claims are denied because the patient was not covered for the date of service in question. One provider in the study showed that 77% of these denials (or 1.5% of overall claims) had a valid eligibility verification received from the plan. This may be an indication of retroactive member changes impacting claims.	• Providers may check eligibility and then later be penalized for retroactive member changes.	• Refer to the CORE Policy Work Group for consideration

Recommendations and Next Steps

The Phase II Patient ID Study confirmed several findings from the Phase I study and provided additional insights into the challenges providers and health plans face with missing and invalid member IDs. Although it was difficult to consistently calculate the specific cost savings associated with alternate searches that do not require a member ID, there is enough evidence that alternate searches would improve the validation rate of the 270/271 and reduce the re-work that providers and health plans encounter when member ID problems occur.

As a result, the CORE Identifiers Subgroup recommends that it move forward in developing a rule related to alternate/name searches. This work will begin in 2008.