Introduction

Much of the media attention regarding the Patient Protection and Affordable Care Act (PPACA) health reform legislation of 2010 has focused on changes in the relationship between payers (health plans), their beneficiaries (patients), and the purchasers of group health insurance – beneficiaries’ employers. Indeed, the Act will create some substantial changes in these relationships.

There are, however, other less-publicized provisions of the Act that will affect relationships between payers and providers (hospitals, physicians, and allied care practitioners), under the rubric of administrative simplification. Because claims clearinghouses and banks also perform necessary intermediary functions in these relationships, they will likewise be affected by the Act.

Section 1104 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services to implement new “operating rules” that will govern the exchange of health data transactions. These transactions include eligibility, claim status, electronic funds transfers, electronic remittance advices and a final “basket” of other transactions that were originally implemented under the Transactions and Code Sets Rule under the Administrative Simplification section of the Health Insurance Affordability and Accountability Act of 1996 (HIPAA).

Section 1104 acknowledges the evolution of the healthcare transaction marketplace and sets the groundwork for future development and adoption of effective, relevant operating rules and standards that will enable electronic business transformation in healthcare.

Organization of This Document

This paper is divided into six parts. The first part summarizes the formal sections of the Act that are relevant to administrative simplification. The next four parts address the challenges and solutions for the major players in the administrative-simplification ecosystem:

1. Health plans
2. Providers
3. Clearinghouses
4. Banks

The sixth and final part addresses the establishment of the Qualified Nonprofit Entity that will formalize the operating rules to be approved by the Secretary of Health and Human Services (HHS).
This paper is intended as a general informational document, serving as an introduction to the challenges created by the PPACA. A thorough analysis of these challenges is beyond the scope of this paper.

The audiences targeted in this document encompass banks, payers, providers and clearinghouses. Members of the banking community will find this paper helpful in that it may enlighten them to potential new markets and products. Those in the hospital and ambulatory / small practice community will find this paper helpful in that it will inform them of changes in their business environment. Members of the clearinghouse community are assumed to have a baseline understanding of the ramifications of PPACA, given the changes it will impose on their industry. Given the depth of the insurance industry’s involvement in the drafting of PPACA, it is assumed that members of this community are already well-informed on the topics herein addressed.

**Administrative Simplification Sections of the Act**

The section of most relevance for administrative simplification is Subtitle B – Immediate Action to Make Coverage More Affordable and More Available, Section 1104 – Administrative Simplification. This section sets forth provisions governing electronic healthcare transactions.

Section 1104 seeks to establish a set of operating rules, which are the necessary business rules and guidelines for the electronic exchange of information. HHS will adopt a single set of operating rules for the more common transactions, with the goal of creating as much uniformity in the implementation of the electronic standards as possible.

According to the Act, these operating rules shall be consensus-based and reflect the necessary business methodologies affecting health plans and healthcare providers, and the manner in which they operate. All rules must be effective pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996 (HIPAA).

More specifically, Section 1104:

- Accelerates HHS’s adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (HIPAA), such as benefit eligibility verification, prior authorization, and electronic funds transfer payments;
- Establishes a process to regularly update the standards and operating rules for electronic transactions, requires health plans to certify compliance, and enables the Secretary to assess financial penalties; and
- Endeavors to make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.

Section 1104 sets deadlines for the creation of these operating rules, and more importantly, sets firm deadlines for compliance with them. Any health plan that fails to
meet these deadlines will face (modest) financial penalties of up to $40 per year per insured person. By comparison, according to a 2009 report from America’s Health Insurance Plans’ Center for Policy and Research, on average the annual premium was $2,985 for a single person and $6,328 for a family.

For example, the operating rules for eligibility (HIPAA 270/271 transactions) and claims status transactions (HIPAA 276/277) must be established by July 1, 2011. These rules become effective January 1, 2013, and health plans must certify compliance with the rules by December 31, 2013. By April 1, 2014, the Secretary shall be authorized to assess penalties against noncompliant plans. These dates roughly correspond with the beginning of the projected coverage-expansion period authorized by the wider PPACA.

The Act creates similar deadlines for electronic funds transfer; payment and remittance advice; automated reconciliation; enrollment status; premium status; and referrals. For a summary of these deadlines, please refer to Appendix A: Table – Summary of Deadlines Created by Section 1104.

A majority of stakeholders in the provider / clearinghouse / health plan ecosystem use electronic means to perform some of these transactions, usually claim submission. Other transactions, however, such as claims payment, have not made equivalent progress towards electronic processing. It is in this domain that banks are expected to make the greatest impact on the ecosystem.

This state of uneven progress toward the goal of a fully-automated health-transactions system is challenged by the Act’s provisions. Many of the parties in this environment (predominantly the health plans) are using older business systems that are unlikely to pass muster under the Act’s operating rules. The capital investment necessary to consolidate or replace these legacy systems is often a primary reason they are still in use.

The new operating rules’ adoption deadlines are scheduled during the same period during which health plans, clearinghouses, and providers must wrestle with implementation of HIPAA 5010 transactions (January 1, 2012 deadline) and the ICD-10-CM coding system (October 1, 2013 deadline). Both of these mandates are creating significant challenges and costs for stakeholders. Sec. 1104 could significantly increase the human-resource burden, organizational complexity, and financial cost necessary to comply with 5010 and ICD-10. Additionally, already stretched-thin IT resources face a "perfect storm" of demands during the same period, including work on initiatives related to implementing Electronic Health Records (EHRs) and Health Information Exchanges (HIEs), readiness for audits under the Permanent Recovery Audit Contractor (RAC) program, and updates to HIPAA’s privacy and security requirements.

In addition to creating deadlines for operating rules and their implementation, the Act also contains provisions for the selection of a body ("Qualified Nonprofit Entity" or “Entity”) to formalize and approve the operating rules. The National Committee on Vital and Health Statistics (NCVHS) is entrusted to advise the Secretary whether an Entity is qualified under the statute and whether any operating rules proposed by the Entity meet...
several criteria. The Entity’s mission must focus on administrative simplification, represent multiple stakeholders (health plans, providers, vendors, regulatory agencies, and other standard development organizations), and use a consensus-based process for the development of operating rules.

With the first operating rules due July 1, 2011, time is short for choosing an Entity, qualifying it, and having it achieve the required deadlines and deliverables. This would appear to skew the selection toward an existing Entity or a collaborative effort between existing Entities. The Secretary will adopt these operating rules, giving consideration to the rules developed by this Entity and the recommendations of NCVHS.

Implications for Health Plans

Industry-Wide Adoption of HIPAA Transactions

According to the U.S. Healthcare Efficiency Index®, industry-wide adoption of electronic transactions is still low (see Figure 1). Electronic Claims Submissions are now widely adopted, while eligibility and claim status transactions are showing moderate adoption. Electronic payments of claims, at 10%, are very limited in their use.

With only 10% adoption, claim payment is, by far, the area with the most opportunity for the adoption of electronic transactions. It also probably has the greatest potential to
reduce healthcare costs. Since electronic payment transactions are typically faster than payments made by paper checks, an increase in electronic payments would reduce provider costs.

For some time, larger health plans have supported electronic processing of administrative transactions. Sec. 1104 will, however, place greater pressure on smaller plans to adopt and implement the entire “suite” of HIPAA transactions. Also, Sec. 1104 introduces new transactions with which plans may not have much experience, including premium payments, member enrollment / disenrollment, and Electronic Funds Transfer (EFT). Consequently, in addition to modifying existing electronic capabilities to comply with the new operating rules, plans will need to implement and operationalize additional new transactions.

Convergence with Other Unfunded Mandates

As shown in Figure 2 below, deadlines for adopting operating rules occur during the same period during which plans must implement HIPAA 5010 (January 1, 2012) and ICD-10-CM (October 1, 2013). Both of these mandates create significant challenges and costs for plans. The mandates of Sec. 1104 could significantly increase plans’ resource burden, complexity and cost for compliance with both 5010, and ICD-10.

Figure 2: Timeline of Major Deadlines


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Adoption of Machine-Readable Health Identification Cards

According to Section 1104, “The set of operating rules for eligibility for a health plan and health claim status transactions … may allow for the use of a machine readable identification card.” Note the use of the word “may,” not “must.” Thus, machine readable cards are not a definite requirement. In 2007 the Workgroup for Electronic Data Interchange (WEDI) promulgated WEDI Health Identification Card Implementation Guide Version 1.0. The intent of WEDI’s Health Identification Card Implementation Guide is to enable automated and interoperable identification for healthcare and benefit purposes using standardized identification cards. The card serves as an access key to obtain information and initiate transactions.

Many commercial plans have aggressively moved toward adoption of the WEDI standards for ID cards at significant cost. Again, it is unclear what the operating rules will be for the adoption of ID cards. Any significant departures from the WEDI standards will require re-work of the card and software, and the additional expense of re-issuing replacement cards.

Reconciliation of ERA and EFT Transactions

NACHA – The Electronic Payments Association (www.nacha.org) supports the growth of the Automated Clearinghouse Network (ACH) by managing its development, administration, and governance. This Network facilitates global commerce by serving as a safe, efficient, ubiquitous, and high-quality electronic payment system. In 2009, the ACH Network processed over 18.76 billion transactions.

When processing electronic payments, re-association of the payment with the remittance advice is critical to achieve the efficiencies that providers seek in handling electronic remittances from health plans. The ACH Network offers two formats that are compliant with the HIPAA Transaction and Code Sets. Both the CCD+ and the CTX formats are listed in the current implementation guide for the ANSI ASC X12 835 Transaction Set (version 4010) and its upcoming approved version (5010).

One of the significant burdens placed on providers is the separation of funds (check / EFT) from the information that explains what is being funded (EOB/ERA). Generally, healthcare EFT payments may arrive a day or more apart from the data documenting the payment (ERA). This is because many plans adjudicate claims in one system and disburse claims from another. The ACH network offers an improvement over paper with its “CCD+” format, which permits X12 835 ERA data and the EFT payment to travel separately, with a “re-association key” placed in the CCD+ addenda record to link the two. However, the “re-association keys” between the CCD+ (EFT) and ERA (835) are not always synchronized.

The “CTX” format addresses this shortcoming because it permits ERA data to travel with the EFT payment in the addenda record(s). The financial institution can then deliver both
data sets to the provider. Consequently, there is no need for separate re-association and/or reconciliation steps. Most plans, however, do not currently use the CTX format to combine the disbursement and adjudication data. Instead, the CCD+ is used to transmit the payment data and the 835 is used to transmit the remittance data, both being delivered separately.

Depending on the outcome of the operating rules that govern EFT and ERA, health plans may need to consider alternative claims-payment and data transport methods, including the use of CTX rather than CCD+. One concern, however, is that the CTX format may not be robust enough for ERAs that contain significant amounts of data.

There are vendor solutions available that auto-reconcile EFT and ERA without the need of a CTX file. Plans issue a payment and ERA (835) data to the vendor, then the vendor generates the ACH credit to the provider and associates that payment with the ERA data. This bundle of data (ACH credit notification and the remittance advice) is then presented in combined form in the vendor’s user interface. This combined data set enables auto reconciliation. The challenge, however, is gaining enough volume from one “channel” (or user interface) as opposed to using multiple interfaces for this information. Consolidation of as much EFT/ERA data through one interface is desirable.

**Claims Attachments**

The claims attachment transaction set is not used pervasively today. It is a very complex transaction that encompasses standard X12 data and clinical data to support:

- Adjudication of claims with the additional information;
- Assessment of Prior Authorization requests with the additional information;
- Capture of clinical data for case management needs;
- Post-payment review; and
- Mitigation of fraud and abuse.

It will be a challenge for health plans to fully integrate the use of claims attachments into their workflow for claims processing, with significant investment in resources and technology required. Additionally, depending on how the provider generates and submits the attachment, the structured data needed by the health plan could be missing, negating the ability to auto-adjudicate the claim and realize any efficiency gains. Several EHR vendors have been working on this issue. Additionally some clearinghouses offer systems that assist in this function. There are a number of vendors emerging in this space to help facilitate implementation of attachments between the provider and health plan. A broader deployment of EHRs should accelerate the industry’s transition to electronic claims attachments.

**Vendor Management**

HIPAA regulations and the HITECH Act mandate that a Covered Entity establish a written contract with a Business Associate (BA) in a number of instances, including
whenever a Business Associate "manages" protected health information on behalf of a Covered Entity. Sec. 1104 now introduces additional responsibilities that affect how health plans manage their vendors. In addition to BA agreements, plans must also now ensure vendors are compliant with existing operating rules. Otherwise, they could be exposed to penalties for the vendors’ non-compliance. To avoid substantial penalties assessed by HHS, plans should evaluate their contracting policies. They must not only ensure vendor compliance, but also protect themselves against a vendor’s failure to maintain compliance.

Payment Using EFT

A major reason many providers elect not to receive health plan payments via EFT is a concern that supplying banking information to health plans will enable debits (aka “take-backs” or “recoupments”) as well as payments. Payers often include such terms in contracts to allow them to easily recover overpaid or disputed amounts. Currently, if a provider has not authorized a debit, the NACHA operating rules allow for prompt return of the unauthorized debit.

Many analysts expect, and predict, future legislative or regulatory action that would facilitate payments, but restrict or eliminate debits from provider accounts. This may be a necessary step to achieve more-widespread adoption of EFT and the efficiencies of electronic payment.

Additionally, several credit card-issuing companies and vendors are evaluating ways to facilitate and operationalize payments for adjudicated claims from health-plans to providers, using debit payments from patient accounts. The provider can then process the health plan payment using their existing credit card process. An impediment to provider adoption of this type of solution, however, comes in the form of high processing fees (typically 2-3% of the total amount) associated with accepting debit payments from health plans. On the other hand, it may be possible to show that decreased collection costs and bad debt associated with uncollected payments may more than offset such processing fees.

Act Requires Real Time Adjudication or Estimation

PPACA amends Section 1173 of the Social Security Act with the language, “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”

This requirement could set the stage for Real Time Claims Adjudication (RTCA) and Member Liability Estimation (MLE). Missing from the law, however, is clear direction from Congress on intent and process. This might, however, be addressed in the actual operating rules.

As is the case with many of the standard health information transactions, RTCA and MLE are not ubiquitous technology solutions deployed by all payers. There are only a
handful of health plans that can support RTCA. A key question is how to automate
decision-making as to whether a service is appropriate or the correct code has been
submitted. One approach to consider may be using RTCA for routine or “retail”
healthcare events that comprise the majority of patient encounters, while reserving
traditional adjudication for hospitalizations and other more complex encounters.

Member Liability Estimators offer an option to accomplish most of the goals of RTCA.
MLEs are software systems that can estimate a member’s liability based on contracted
rates, member benefit information and historical claims data. Early feedback from
providers is that MLEs are very helpful at reducing balance billing, given the significant
increase in high deductible plans and larger patient balances.

Conceivably, health plans could negotiate reduced rates from providers for routine
healthcare events. In exchange, they would ensure that RTCA would be supported for a
set of predictable and consistent services. The key would be reaching agreement on the
subject services and on an audit trail mechanism to minimize the potential for abuse of
the system. Payment at the time of service and reduced claim submission costs could
offset the reduced rates.

**Agreement or Conflict with Other Operating Rules Projects**

The Council for Affordable Quality Healthcare (CAQH) launched the Committee on
Operating Rules for Information Exchange (CORE) with the goal of building consensus
on a set of operating rules. These rules will enhance interoperability between providers
and payers, streamline eligibility, benefits, and claim data transactions and reduce the
amount of time and resources providers spend on administrative functions. Many plans
have been pursuing compliance with CORE standards for quite some time.

NCVHS has recommended that HHS adopt the CORE standards for non-pharmaceutical
eligibility and claim status transactions (after testimony provided on July 20, 2010). The
National Council for Prescription Drug Programs (NCPDP) was selected to establish
pharmaceutical health data transaction operating rules. Both groups must work with the
Designated Standards Maintenance Organization (DSMO) that was instituted for
transactions in the Health Insurance Portability and Accountability Act (HIPAA).

In addition, NCVHS and HHS are now working on hearings tentatively scheduled in
December 2010 for determining which non-profit entities will manage the EFT and ERA
operating rules. It is difficult to conceive an alternative non-profit entity for EFTs other
than NACHA, as this is their sole responsibility and domain for the banking industry.

**Implications for Providers**

Much of the discussion of implications for providers covers the challenges facing
ambulatory physician practices. Hospitals enjoy substantially greater use of electronic
transactions in their revenue cycle. Overall, the physician segment of the healthcare
payment ecosystem should be a net beneficiary of the Act.
Currently, these providers are saddled with many of the costs, both direct and indirect, of inconsistent and poorly-applied operating rules. Many, though certainly not all providers, manage this complexity by using clearinghouses to streamline and standardize their workflows.

By establishing deadlines for both the creation of standards/operating rules and the implementation of these rules, the Act levels a playing field currently littered with potholes and boulders. Smaller providers, with their limited operating-overhead resources, comprise the segment that will reap the most pronounced benefits. The initial concerns, however, toward realizing this benefit is the front end cost for technology. Thus, it is critical that operating rules specify return on investment (ROI) by provider segment, as this will change based on provider setting, in order to gain the anticipated adoption. These benefits will come primarily in the form of improved back-office workflows, which should accrue toward reduced days in Accounts Receivable. Some providers may have to make capital investments in new IT systems to realize these benefits.

In general, many of the manually-intensive aspect of today’s revenue cycle workflow could be streamlined and expedited – and this is true of both the physician and enterprise or institutional settings. By early 2013, if they have access to the appropriate electronic tools, providers should be able to verify patient eligibility and query the status of a pending claim instantaneously.

Early 2014 should usher in the largest quality-of-life improvement for provider’s revenue cycles. By this time, if new operating rules are effectively deployed, providers who have invested in the appropriate remittance information technologies could enjoy the benefits of having all reimbursements transferred electronically to their bank accounts. Payers must certify their systems are in compliance with applicable standards for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice.

Additionally, the information explaining these reimbursements will also be provided electronically. It is anticipated that will result in significant reduction in the use of paper checks and paper Explanation of Benefits (EOB) forms. Furthermore, and most importantly, the information delivered to providers will allow for automatic reconciliation. This improvement alone will eliminate significant back-office overhead costs attributable to associating payments with patients’ accounts and related general ledger categories, as well as instigating and streamlining workflows that initiate from the remittance, such as secondary billing and denial management.

Early 2016 will see automation of pre-certification and prior-authorization workflows. This will substantially reduce the administrative burden on providers’ “upstream” or “front office” employees. In the long run, all these changes will create an overall gain for providers. In the short run, however, some challenges will be created.
Specifically, all of the transactions specified by the operating rules assume end-to-end electronic processing. Many providers in the United States use electronic transactions for at least part of their revenue cycle, mostly focused on claim submission. The technology required for remittance management, however, is different and though sometimes offered by the same vendor used for claims management, could involve significant additional investments on the part of providers.

It appears that the landscape contemplated by the Act assumes electronic processing for the entire revenue cycle. This assumption creates challenges for hospital and physician practices that still using paper for their revenue cycle workflow. It also impacts providers that are heavily invested in practices using legacy systems whose transaction operating rules may not be compliant with the new standards.

This challenge will not come in the form of a direct regulatory mandate. Rather, it will come in the form of a change in the relationship with health plans. Health plans, in their effort to meet compliance deadlines, will be changing the manner in which they communicate with, and reimburse, their participating providers. If participating providers want to be reimbursed, their systems will increasingly need to be capable of communicating with and receiving payment (EFT) and remittance advice (ERA) transactions from plans.

As more plans communicate electronically, providers will find they must carefully review new 835 remits and adapt to how plans use remark codes. For example, a common problem today is a plan incorrectly using a remark code to indicate a contractual adjustment when they should use a patient-responsibility code. These errors and omissions are unlikely to be eliminated by adoption of the Act’s requirements.

The response to this challenge is probably simple but expensive for many providers: replacing or upgrading the billing system and/or integrating “bolt-on” information technology solutions that could extend the lifespan of existing investments. Providers’ relationships with billing systems vendors may include a larger software package suite that also can include contracting with the software vendor’s Clearing House. (VAR or “value added reseller” type of arrangement.) This is a very common practice in the industry especially among mid to large size software vendors. Also, traditional EHR systems have not included a billing system unless the provider is purchasing a specific vendor suite that provided the option of both.

Thus, the options will likely create direct and indirect costs. The direct costs will be in the form of software licenses and infrastructure upgrades to accommodate the new system. Notable is the likelihood that system vendors and clearinghouses will pass their own costs through to the providers in the form of increased licensing fees. The indirect costs will be in the form of training, temporary increases in accounts receivable during the transition period, and (potentially) personnel costs related to employee turnover. These latter items are transitory and should run their course within the first six months following the transition to a new system.
This challenge can be mitigated in several ways. First, as noted earlier, new up-to-date practice management systems may be bundled with EHR systems. Through HITECH incentives and grants, monies are being made available to providers to support the purchase and use of these systems. In principle, providers taking advantage of a qualifying system should be able to weather the upcoming changes with minimal revenue cycle disruption. In addition, banks and clearinghouses offer intermediary services that provide compliancy and automation of many of the anticipated workflow steps. Both pathways will impact the practice’s overall cost structure. Note that in many cases, these additional services are billed on a per transaction basis.

Another potential solution for small hospitals and/or physician groups who are unable to budget for the requisite information technology updates is to engage medical billing service providers who essentially outsource the revenue cycle in total or in part. These services are available in many cities across the country. Some are also available online. Intermediary services provided by banks or clearinghouses are often available as well.

Nonetheless, even if some of these services are outsourced to banks, clearinghouses or medical billing services, several challenges remain. These outsourcing vendors will incur costs for software upgrades and development and those costs will tend to be passed through to the customer – the provider. Workflow disruptions and personnel retraining must also be considered regardless of whether a provider uses a bundled suite of services or outsources some components of the revenue cycle.

Implications for Clearinghouses

While there is still uncertainty about the impact of the Affordable Care Act, Section 1104 clearly spells out an aggressive timeline for the adoption of electronic business process transformation of the provider’s business office. In fact, if the implementation of these objectives is in accord with the spirit of the Act, it could have a profound influence on the current healthcare claims clearinghouse business model.

To understand the spirit under which the Act was enacted, it is important to look to both the House and Senate versions of the respective bills. For example, when reviewing the sections of the House and Senate bills pertaining to the objective of establishing transaction standards and operating rules, it is interesting to note the differences between the two versions.

Senate Version (HR 3590)
Section (g), paragraph 1
(1) IN GENERAL—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and healthcare providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.
Section (i), paragraph 5
OPERATING RULES FOR OTHER STANDARDS ADOPTED BY THE SECRETARY - The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

House Version (HR 3962)
Section 1173A, Subsection (a), Paragraph (2), Subparagraphs (A, B)
GOALS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS - The goals for standards under paragraph (1) are that such standards shall, to the extent practicable--

(A) be unique with no conflicting or redundant standards;
(B) be authoritative, permitting no additions or constraints for electronic transactions, including companion guides;

Section 1173B, Subsection (a)
(a) In General - The Secretary shall adopt a single, binding, comprehensive companion guide, that includes operating rules for each X12 Version 5010 transaction described in section 1173(a)(2), to be effective until the new version of these transactions which comply with section 1173A are adopted and implemented.

It could be argued the Senate version is not as specific as the House version, because it allows greater latitude in crafting the governing regulations. By law, this process will be left up to a cacophony of “interested parties,” including payers, providers, consultants, and government agencies. In the process of performing their responsibilities, these “interested parties” should look beyond the Senate version of the legislation as it is written, and take into consideration the House version to seek an understanding of the real meaning and “spirit” of the law.

By contrast, the House version is more specific in defining the requirements. It helps provide more clarity and insight into the intent of the legislation. The House version clearly spells out the following objectives:

- Prohibit conflicting or redundant standards;
- Eliminate additions or constraints for electronic transactions, including companion guides;
- Mitigate the use of hard-copy proof-of-service and communication attachments;
- Enable real-time (or near real-time) determination of an individual's financial responsibility prior to or at the point of service;
- Enable near real-time adjudication of claims;
- Payers to provide timely acknowledgment, response, and status reporting applicable for any electronic transaction; and
- Require that all reason and remark codes be described in unambiguous terms.

Assuming the regulatory and rule-making processes are in keeping with what appears to be the spirit of the law, we should expect to eventually have an administrative transaction
environment where variability is eliminated. This would allow only one companion guide per transaction type and apply very strong operating rules. If this is the case, much of the functionality and value proposition of today’s clearinghouse business model could be influenced such that there will be less need for traditional clearinghouse services.

One of the vital functions clearinghouses perform is to normalize the variability, dysfunction, and lack of any real enforced standards relating to administrative transactions. Currently, there is no practical way for providers to comply with the hundreds of payer companion guides, much less monitor and implement the continuous barrage of modifications (i.e., 5010 implementation). The second major function is the maintenance of either direct connections or routing channels to deliver and retrieve transactions with payers.

In recent years, clearinghouses have expanded their scope of services by providing useful and convenient “value added” offerings, including claims management, claims scrubbing, automated secondary claims and electronic attachments. In this respect, clearinghouses have helped to bring order to the chaotic claim-adjudication, remittance, and payment environment. It also suggests that clearinghouses have engaged in a pathway for expanding value in the revenue cycle beyond traditional services of transaction conversion to partial to comprehensive electronic business transformation.

The administrative-simplification era being ushered in by the Act raises more questions than it answers for clearinghouses:

- What happens when the chaos of the current administrative transaction process is regulated out of existence with real transaction standards?
- What happens in a world with only one companion guide per transaction type?
- What happens when there are strict operating rules?
- What about the challenge for practice management software vendors to offer a “Clearinghouse-In-a-Box” software or service module that includes direct routing to payers?
- How will the clearinghouse business model need to change?
- When the smoke clears, will there be a need for clearinghouses?

The likely answer to the final question is, “yes; there will be a need for clearinghouses in some form”. The question is not as much: “Will clearinghouses’ business model and value proposition have to change?” as it is: “How will they need to change?”

For a glimpse into the future, one can look at the banking industry’s clearinghouse infrastructure. In early 1960s, banks were required to put the Magnetic Ink Character Recognition (MICR) line on all checks. This MICR line contained all the information needed to electronically read the check, identify the bank, and route the check for delivery and settlement. The Federal Reserve required that all clearinghouses conform to this strict standard. No deviations were, or have been, allowed. In fact, if an institution did not conform, it could not use the Federal Reserve clearinghouse network to present checks on the payer bank. Further, all local clearinghouses were required by law to establish and enforce strict operating rules.
Again, in 1984 the Federal Reserve implemented a new set of protocols for the “wire transfer” of funds and settlement transactions involving member banks. The Federal Reserve’s rules were quite simple: if a bank did not strictly comply with the new protocols and transaction standards, it could not use the Federal Reserve for any clearing or settlement functions. Simply put, the bank was out of business.

Based on the interpretation of the spirit of this law, some variation of this scenario could unfold regarding healthcare transaction standards. If this happens, one of the key functions of a clearinghouse may be substantially lessened, or virtually eliminated. There would be only one companion guide and only one set of operating rules, which would level the playing field by making it more feasible for software vendors and providers to send transactions directly to the payers.

This leaves the direct connections or routing channels to thousands of payers as the core value proposition that the traditional clearinghouse might offer. The question would be: “Will that be enough?” The value of being able to send all administrative transactions to one entity that can route them to any payer is, and should continue to be, a strong value proposition.

There is a possibility, however, the market will need a much smaller number of entities to provide this function. In recent years we have seen a “race to the bottom” regarding the commoditization of clearinghouse services.

The Act may accelerate this trend, resulting in significant market consolidation. Among the value-added services that are being contemplated, clearinghouses with a strong base of direct connections to payers and broad connectivity to practice management and hospital software vendors, EHR vendors, laboratory companies, Pharmacy Benefit Managers (PBMs), etc., may have the opportunity to become players in the HIE market that will be created by the Act.

The Medical Group Management Association (MGMA) is already on record suggesting that clearinghouses could bring their collective existing networks and connectivity to the table as a core competency. This would require that clearinghouses work together to adopt a long-standing banking industry practice, known as “coopetition,” to create a comprehensive connectivity network that could be provided to local, regional and national HIEs.

The fate of the clearinghouse market in healthcare is uncertain today as a result of the new health reform environment. One thing, is certain, however – change is inevitable.

**Implications for Banks**

**Banks’ Unique Competencies**
The administrative simplification provisions of the PPACA call for adoption of uniform standards and rules for healthcare payments in order to increase payment efficiency and decrease the administrative burden on those in the healthcare transaction chain. The addition of “electronic funds transfers” \(^1\) to the list of transactions for which standards are to be developed will further integrate banks in the realm of health reform.

The banking industry has, through its evolution, developed efficient standards for the movement of funds and accompanying data from bank to bank. Banking’s restrictive regulatory framework set the boundaries within which these standards had to be developed. Accordingly, the infrastructure was constructed with particular attention to maintaining the privacy of information and integrity of transactions.

This experience caused banking executives to believe their institutions had a solid foundation for providing healthcare transaction solutions. The result has been a variety of payment processing solutions, each with their own advantages and disadvantages. Fortunately, not only are there advances in technology, but also progress in banking regulations that now enable more-efficient payment processing solutions in the healthcare marketplace.

While checks are still a common form of payment transmission, the Check 21 Act allows for scanning paper checks to convert them to electronic files, which greatly speeds up the process of clearance and settlement. Payment processes that involve the Federal Reserve include wire transfers (FedWire) and automated clearinghouse transactions via FedACH. These are available to all banks that have a relationship with Federal Reserve member banks, either directly or through a correspondent bank relationship.

Banks are the common link shared by all the stakeholders in healthcare transactions. Since all stakeholders interact with banks, the banks are in a unique position to assist in providing efficient healthcare payment solutions, especially with regard to improving data-transfer efficiency between all the stakeholders. Nonetheless, revision of the healthcare payment system is fraught with complexity. Primarily this is due to the many interdependencies between the stakeholders: providers (hospitals, physicians, and similar entities); payers (public and private); banks; third-party administrators; employers; and consumers. All of these stakeholders move different data within different systems via different and unique methodologies.

The fundamental data set is demographic information pertaining to an individual. Depending on the relationship of this individual to the various stakeholders, this data is paired with information regarding health plan enrollment, medical treatment details, insurance eligibility, claims data, and banking information, some of which can be quite detailed, such as diagnostic and treatment codes required for claims processing.

The greatest challenge is relating account and payment information with claims information, to ensure healthcare providers are reimbursed efficiently and correctly. Unfortunately, claims-documentation and payment-remittance data files are often sent to the provider separately from payments. This separation greatly complicates reconciliation of the payment with the items for which payment is being made. Frequently payers aggregate many claims when sending payment to reduce their transaction costs; this only compounds the problem. In a single claim, any single, (and often multiple) individual line item(s) might be handled in any one of the following ways: paid in full; reduced for coverage reasons; or denied due to questions of appropriateness of a given treatment or procedure.

**Banks’ Challenges and Opportunities**

Resolving the issue of associating claims data and payment information provides banks with distinct challenges and opportunities. While daunting, the issues above are not insurmountable. Some banks have already built solutions not only to speed the receipt of payment, but also to ensure that the provider has all the information needed to efficiently track payment. This, in turn, reduces manual intervention.

Challenges include integration of claims-processing and payment-processing infrastructures, physical matching of paper documentation, HIPAA privacy and data security standards and compliance and commitment to servicing the healthcare space.

Banks offer many services that can improve the efficiency in the healthcare sector. Existing banking offerings include lockbox processes, image capture and EOB conversion, in addition to reassociation and reconciliation services to improve straight through processing. One of the opportunities for banks is to gain a larger share of the high-volume, high-dollar US healthcare market.

**Claim / Payment Integration**

The standard HIPAA claim remittance advice file (835 file) contains information from a payer (usually a health plan) to the provider indicating what has and has not been paid. The actual payment is typically sent, via the banking network, in the form of an ACH transaction (or a paper check). Unfortunately, many payers generate the 835 file on different systems than the EFT file, thereby creating a “disconnect” between the payment data and the funds that are independently sent to the provider. This burdens the provider with manual intervention to reconcile the payment with the claims being reimbursed. Some banks and third party processors have developed and deployed re-association and reconciliation tools to address this need.

The National Automated Clearinghouse Association, which is the ruling body for the ACH network, has already proposed standards for inclusion of claims information in ACH files. As discussed above (see “Implications for Health Plans: Reconciliation of ERA and EFT Transactions”), the two ACH file types already compliant with HIPAA transaction code sets (CCD+ and CTX) contain resources which allow either re-
association of the payment information with the claims information, or actually allow the 835 file information to be included with the payment transaction.

The CCD+ file uses a “re-association key” that is also included in the 835 file. This re-association key can be used to re-synchronize the claims and payment data by the provider’s practice management software. The CTX file actually allows the transmittal of the 835 data along with the payment. Unfortunately, however, the format in which this data set is included has a limitation of 9,999 addenda fields with 80 characters each. This can cause difficulties in including 835 data.

By contrast, however, the CTX file already includes the 835 information, thus eliminating the need to re-associate the data. The bank can use the CTX file to produce a readable transaction report that greatly simplifies the provider’s reconciliation process. Some banks already have systems that take advantage of the ACH/835 working standards. To the extent that payers can be persuaded to regularize the use and implementation of these standards, payment reconciliation could be greatly simplified and automated.

An additional challenge is the growth of Consumer-Directed Health Plans / High-Deductible Health Plans, which place the consumer as the direct payer of the initial healthcare costs. One manifestation of this environmental change is the existence of multiple “purses” from which providers must collect payment. In addition to the health plan, a provider may need to obtain payment for services directly from the patient (under the patient’s insurance deductible or co-pay provisions), or from an employer account such as a Flexible Spending Account or Health Reimbursement Account. These tax-favored accounts exist for the benefit of the employee for payment of healthcare and other expenses. Banks offer tools that can mitigate this “multi-purse” challenge.

One solution currently in use is the multi-purse debit card. This is a debit card linked to multiple accounts such as a consumer’s Health Savings Account together with an employer’s Flexible Spending Account. The card technology allows the prioritization or exclusion of accounts from the payment process on the basis of SEC codes and adjudication technology. This ensures payments are debited from the proper accounts, in the proper order. The provider need only have the debit card information to initiate payment, and does not have to be concerned about from which particular account the funds originate.

The shift of healthcare payment responsibility to consumers has made providers more worried about availability of funds to cover the consumers’ share of cost. In response to this understandable and legitimate concern, payers are looking for tools to assure providers of adequate funds availability, particularly for the consumer-funded portion of the reimbursement. Banks offer solutions such as Internet / Web services that offer health plans real-time access to balances in consumer healthcare accounts (HSAs, reimbursement accounts, etc.). Many banks that operate in the healthcare marketplace are able to share this information, either by direct authorization of the account holder, or using special terms and conditions included in the Health Savings Account agreement.
Additionally, if the accountholder authorizes access to the account by the health plan (this generally requires the accountholder’s express authorization) a health plan can consolidate funds from the consumer account with the insurance payment to provide full payment to the provider in a single transaction, without active involvement of the consumer in authorizing payment. An additional challenge will always exist in persuading accountholders to authorize a health plan to have open access to their account(s). Incentives in the form of discounts or rebates could potentially help in this regard.

**HIPAA Privacy and Security Standards**

Of course, these processes must be conducted in compliance with the privacy and data security requirements of the Gramm-Leach-Bliley Act (GLBA) as well as HIPAA privacy and security standards. Because banks must be GLBA-compliant across all their service lines, they are generally well prepared to meet the requirements of HIPAA. This is important because while financial transactions are exempt from HIPAA compliance, the inclusion of HIPAA 835 information in financial transactions may result in the bank becoming a HIPAA “Business Associate.” Under ARRA, Business Associates are now directly subject to HIPAA and all associated reporting requirements. This generally means that the bank becomes subject to HIPAA privacy and security standards, which includes certain reporting requirements.

Prior to ARRA, a financial institution would generally only become subject to HIPAA after signing a business associate agreement with a HIPAA-covered entity. Usually, this would have been a health plan, which required the bank to enter into the agreement in order to fulfill its own requirements as a Covered Entity. Passage of ARRA included, among other things, provisions that cause a Business Associate to be subject to all of the requirements of the HIPAA Security Rule and parts of the Privacy Rule that pertain to use and disclosure. They are also directly subject to some of the new privacy requirements such as Breach Notification and Accounting of Disclosures. In addition, therefore, they are also subject to the compliance monitoring, enforcement and penalties associated with these provisions (for more information on BAs and HIPAA modifications, visit the HIMSS website).

Thus, it has become incumbent upon banks choosing to do business in the healthcare industry to become familiar with the requirements of HIPAA and implement proper processes and procedures to ensure compliance for privacy and security. Should NACHA create a new file standard exclusively for healthcare transactions, this would be of great assistance to banks for the purposes of identifying HIPAA-associated transactions, which would hopefully reduce their compliance burdens.

If the banking system positions the ACH Network as a resource of choice for processing EFT / ERA transactions, all the financial entities (including the ACH operators) that “touch” the transaction, even those forwarding the transaction among the various “nodes” of the network, should rigorously pursue a gap analysis of HIPAA requirements and
publicize the results and/or remediate any gaps. A detailed explanation of encryption / re-enforcement should be part of a public disclosure designed to remove any myths or uncertainties around this process. This will have the effect of instilling confidence in the system and facilitate its use to achieve overall industry efficiency that is clearly needed in healthcare administrative processes.

Recently, four leading organizations (EHNAC, HIMSS, NACHA, WEDI) issued a new HIPAA / HITECH compliance guide that can help a bank through the maze of data privacy and security regulations within HIPAA and HITECH. Additionally, HIMSS has developed a “HIMSS MBProject Gold Seal” online tool that acts as a “diagnostic kit” for organizations that are offering medical banking services and seek to understand privacy and security requirements under HIPAA and HITECH.

**Paper Documentation**

One of the greatest challenges of the current healthcare payments system is the existence of paper documentation and paper payments in the transaction chain. If these documents can be converted to electronic form earlier in the process, money movements can become more efficient and clear. The passage of the Check 21 Act\(^2\) and associated regulation provided the regulatory framework for immediate conversion of paper checks to electronic format by a recipient or their bank.

The services banks offer to accelerate payment processing includes lockbox services, scanning with optical character recognition (OCR) processing, remote capture, and Web-based bill pay services. Lockbox services allow for faster collection and deposit of funds to providers. Rather than having the payer transport checks to the provider who then has to take the checks to the bank for processing, the bank provides a post office box in close proximity to the bank, and optimally a box that receives multiple deliveries per day. The bank then collects the checks (also optimally more than once a day) and immediately processes the checks for deposit. In the case of healthcare payments, the bank’s services also include scanning the check, together with the payment coupon or explanation of payment that should accompany the check.

This would be followed by OCR processing to convert the payment and EOB information into a report that can be used by the provider to reconcile payments. The more advanced intelligent OCR systems will actually create an 835-formatted file which can be used by the provider’s revenue cycle software for posting and reconciliation. In the area of patient statements, use of OCR scan lines on the remittance stub can dramatically increase speed and efficiency in remittance management using a lockbox.

Banks also, of course, provide Web-based bill payment services. For the healthcare industry, this is, in most cases, an incomplete solution. Few banks have integrated

sufficient healthcare capabilities into their bill-pay solutions to do more than send a bare-minimum electronic payment to a provider. A more workable solution, however, may be on the horizon. Banks could integrate with a health plan’s claims website, via secure Web services for data sharing, coupled with federated identity management (single sign-on). This would allow consumers to interact with the health plan and authorize payment by the bank in the same Web session.

In turn, this would enable health plans to associate payments with claims information on the front end. Therefore, they would be capable of transmitting complete payment and remittance information together. This data-coupling would greatly simplify the provider’s payment-reconciliation process. Banks may not need to build these capabilities themselves if vendors become available to provide solutions for the banks and their customers. This could be similar to the vendors that emerged to provide mobile phone solutions for online banking.

**Making a Commitment to Healthcare**

It is evident that in order to be successful at providing solutions to the healthcare payments space, a bank must commit significant technological and financial resources, in addition to brainpower. Only when the banking industry makes these commitments will it be able to fully realize the opportunities presented, while providing efficient solutions to all of the stakeholders in the healthcare chain.

There is a significant impact looming for banks as they experience a likely revenue drop, which they have experienced throughout the shift from paper transactions to electronic transactions in recent years. However, this is critically important because these same banks are impacted by the recent financial reform (Dodd-Frank Bill) that could impact bank revenue. Like any other business, banks seek new business lines to add or replenish revenue streams. As technology and standards evolve, more and more banks have the potential to participate in automated healthcare payments processing and this will tend to increase services availability to providers of every size.

**Thoughts on the “Qualified Non-Profit Entity”**

PPACA, Section 1104, authorizes the Secretary of the Department of Health & Human Services (HHS) to implement new operating rules developed by a qualified nonprofit entity that meets the following requirements:

1. Focuses its mission on administrative simplification;
2. Demonstrates a multi-stakeholder and consensus-based process for development of operating rules;
3. Has a public set of guiding principles to ensure the operating rules and process are open and transparent, as well as supports nondiscrimination and conflict of interest policies; and
4. Builds on the transaction standards issued under HIPAA.
NCVHS is required to advise the Secretary after hearing recommendations from the non-profit entity. The legislation requires the Secretary to promulgate an Interim Final Rule recommended by NCVHS. In addition, the Secretary is required to accept and consider public comments on any interim final rule published under this section for 60 days after the date of publication.

In order to represent all of the stakeholders fairly, the non-profit entity that is selected by HHS should have a neutral, multi-stakeholder orientation. Because Section 1104 is an unfunded mandate, it could become a challenge to find the proper “platform” that can objectively advise HHS as it begins the transformation of the healthcare marketplace from paper to electronic business processes. The workload will be substantial. The venue for gaining industry consensus will need to be robust. We believe HIMSS could offer a substantial resource for organizing and promoting dialogue across the industry.

To address these challenges, the “non-profit entity” could be a group of non-profits that have a similar objective to advance administrative simplification for the greater good of society. The collective non-profit entity could act to counter-balance the for-profit stakeholders, so all of the primary stakeholders are represented in the process of operating rules development and voting. Ensuring neutrality is vital to the process outlined in the law.

Because the operating rules will significantly impact the claims and payment processes, it is vital that the entity consult (at minimum) with providers of health services, health plans and insurance carriers, banks, and providers of healthcare financial systems (information technology in particular). Other groups that should have a voice are government, employers and consumers.

The non-profit entity, or group of entities, should have a very clear “non-bias” towards any single stakeholder. Although the penalties for non-implementation of the operating rules are focused on health plans and insurers, the impact of electronic operating rules in health data processing will affect all stakeholders. The systemic nature of these impacts suggests the need for a platform that can ensure feedback and comment across the entire stakeholder community.

The regulation does not specify when HHS needs to select the appropriate non-profit entity, or group of entities. Given the timeline for adopting standards and operating rules, however (July 1, 2011 for eligibility and claims status), NCVHS has acted promptly by convening the first testimony around eligibility and claim status on July 20, 2010. This was essential to allow for rules development, voting, vetting, recommendations, NCVHS review and, finally, adoption by the Secretary into law.

Following the testimony, where HIMSS, X12, NACHA, CAQH and many other groups participated, NCVHS made two recommendations: that CAQH/CORE be selected for non-pharmaceutical operating rules develop for eligibility and claim status, and, that NCPDP (National Council for Prescription Drug Programs) be selected for pharmaceutical operating rules around these two transactions. The NCVHS also
recommended that the process of operating rules development be vetted by the “Designated Standards Maintenance Organization” (DSMO) as adopted under the original HIPAA statute.

NCVHS is now moving forward with recommendations for the next set of operating rules per PPACA – electronic funds transfer (EFT) and electronic remittance advice (ERA). As EFTs are governed today by NACHA, it is hard to imagine that another non-profit entity would be selected for overseeing the development of operating rules that use EFT in the business of healthcare. As per our previous discussion, the EFT is a payment order. There are no unique or distinguishing characteristics that would require separate operating rules development for its use in healthcare.

The ERA is entirely another matter, however, as it contains health information that is both protected under HIPAA/HITECH, as well as information that is required to accurately manage a claim’s disposition or management. In all reality, from the provider’s perspective, once a claim is submitted only half the work is done – and it could be argued that less than half the work is done. Submitting a claim does not guarantee payment by any means. Claims are often denied for any number of reasons. The ERA transaction carries this information back to the provider and because of this, it is the “roadmap” for securing payment for denied, pending or partially paid claims. As a result, it is highly likely that much of the operating rules work will reside around the ERA.

HIMSS Medical Banking Project has focused on the value of this transaction, and instigated widespread market activity around it, since 2001. The ERA is the precipitating transaction that can facilitate much workflow automation in the provider’s business office. This includes cash posting, contractual allowance processing, financial class updates, reject note postings, secondary billing, denial management and contract management. Automation of remittance management can lead to a tidal wave of efficiency in the typical provider’s office, estimated to by some $35 billion annually in savings, and as a result, operating rules that facilitate better use or adoption of the ERA can have a powerful effect on healthcare.

The NCVHS will hold hearings on operating rules around EFT and ERA on December 3, 2010 and will likely render a decision on the non-profit entities that will be selected to oversee these areas shortly thereafter. In support of our membership, HIMSS presented testimony in the first NCVHS hearing. We will also participate in the second testimony around operating rules for healthcare.

**Conclusions and Forward Statements**

The Patient Protection and Affordable Care Act will create substantial changes in the relationships between payers, providers (hospitals, physicians, and allied care practitioners), claims clearinghouses and banks. Certainly, after the Act becomes fully implemented, the ecosystem of interactions between these stakeholders (and the software vendors that support them) will be markedly different.
We believe the Act will create winners and losers among these stakeholders. Healthcare providers stand to be net beneficiaries of the Act as their revenue cycle workflows will be streamlined, though at some cost. Banks will find solid new business opportunities in the healthcare industry marketplace due to the focus on processing efficiencies around EFT and ERA, and it is likely they will team with healthcare financial systems vendors using medical banking models to optimize this new and emerging area.

Payers are likely to incur substantial costs of compliance and this should be recognized in the Medical Loss Ratio (MLR) policy area. Though the recent NAIC recommendation around MLR excluded claims processing expenses (labeling them “administrative”), the opportunities for electronic business transformation around payment areas is relatively new and unchartered for the vast majority of providers. While large providers have been able to take advantage of the efficiency gains of EFT/ERA, most of the smaller providers, including small hospitals and ambulatory settings, still manage much of the payment area using paper. As ACA, Section 1104 targets this area for transformation, aligning MLR with this so payers can apply this within the MLR threshold should be seriously considered by policy makers. Otherwise, product innovations could be passed on to customers and providers in the form of higher premiums or reduced reimbursement.

Clearinghouses may be the hardest hit by the Act. Their business model today is to provide some order and regularity to healthcare transactions. In the future the Act will impose order and regularity on both payers and providers. Thus, clearinghouses may have to re-think their business models.

Overall, the Act’s provisions appear to be favorable for facilitating much needed electronic business transformation in healthcare. Beyond creating efficiency, transformation in this area will do much to improve the quality of healthcare by enabling better decisions by the enterprise or practice. By focusing the healthcare industry on electronic business transformation, there are many opportunities for providers, payers, consumers, banks and other stakeholders in healthcare to reap significant benefits.
### Appendix A: Summary of Deadlines Created by Section 1104

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<th>Transaction</th>
<th>Comments</th>
<th>Adoption Date</th>
<th>Effective Date</th>
<th>Compliance</th>
<th>Penalties</th>
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<td>Eligibility and Benefits (270/271)</td>
<td>May allow for the use of a machine-readable ID card</td>
<td>07/01/2011</td>
<td>01/01/2013</td>
<td>12/31/2013</td>
<td>4/1/2014</td>
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<td>Claims Status Inquiry / Response (276/277)</td>
<td>May allow for the use of a machine-readable ID card</td>
<td>07/01/2011</td>
<td>01/01/2013</td>
<td>12/31/2013</td>
<td>4/1/2014</td>
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<td>Electronic Funds Transfer (EFT)</td>
<td></td>
<td>01/01/2012</td>
<td>01/01/2014</td>
<td>12/31/2013</td>
<td>4/1/2014</td>
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<td>Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA/835)</td>
<td>Allows for automated reconciliation of payment to remittance advice</td>
<td>07/01/2012</td>
<td>01/01/2014</td>
<td>12/31/2013</td>
<td>4/1/2014</td>
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<td>Health Claims or Encounters (837 P and I)</td>
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<td>01/01/2016</td>
<td>12/31/2016</td>
<td>4/1/2014</td>
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<td>Enrollment / Disenrollment (834)</td>
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<td>07/01/2014</td>
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<td>Health Plan Premium Payment (820)</td>
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<td>01/01/2016</td>
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<td>Referral Certification and Authorization (278)</td>
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Acknowledgements

This paper is the result of a joint effort of the HIMSS Medical Banking and Financial Systems Committee. Members of the project team who collaborated on this paper include:

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