Administrative
Uniformity
Committee

June 16, 2015

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Dear Ms. Deutsch,

The Minnesota Administrative Uniformity Committee (AUC) is pleased to submit the written testimony below to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards/Review Committee "Hearing on Adopted Transaction Standards, Operating Rules, Code Sets & Identifiers."

The AUC is a large, longstanding, voluntary stakeholder advisory committee representing health care public and private payers, hospitals, health care providers and state agencies, working to standardize, streamline, and simplify health care administrative processes. The AUC plays a key role as the statutorily named advisor to the Minnesota Department of Health (MDH) on the implementation of first-in-the-nation requirements for the standard, electronic exchange of health care administrative transactions. In this advisory role, the AUC fulfills two key functions:

- It serves to improve standardization needed for more automated exchanges of routine business transactions, by developing and recommending a single uniform companion guide to supplement the nationally adopted administrative transaction implementation guides.
- While rigorous technical standards are an important component of automated, efficient health care business transactions, so is the proper adoption and use of the standards in practice. The AUC helps meet this need through best practices, coding clarifications, posting information and links on its website, as well as the discussion, interchange, and problem-solving at AUC meetings and among members and stakeholders outside of meetings.

We appreciate this opportunity to provide testimony to the Review Committee as part of its important roles in:

- Gathering information regarding currently adopted standards, operating rules, code sets and identifiers used in each of the HIPAA-named administrative simplification transactions;
- Evaluating the degree to which they meet current industry business needs; and

- Identifying transactions, standards, operating rules, code sets and identifiers used in administrative simplification that require changes, deletions or new versions in order to meet industry needs.

Our testimony focuses on a subset of NCVHS questions across the topics of Value, Barriers, Opportunities, and Changes, for the transactions listed below. The selection was based on the time and resources available to prepare this testimony, as well as the administrative transactions with which the AUC has the greatest collective experience and/or current, ongoing responsibilities as a result of its consultative role in the implementation of Minnesota's health care administrative simplification requirements.

Transactions (and associated standards, code sets, identifiers, and operating rules) addressed in this testimony include:

- Health Care Eligibility Benefit Inquiry and Response (270/271);
- Health Care Claim: Professional (837);
- Health Care Claim: Institutional (837);
- Health Care Claim: Dental (837); and,
- Health Care Claim Payment/Advice (835).

In addition, the AUC has actively worked to help implement Minnesota's requirements for the standard, electronic exchange of the health care transactions above for health carriers not subject to HIPAA, including workers' compensation, property-casualty, and auto, as well as requirements for the electronic exchange of acknowledgments by all parties. While these requirements are not directly a focus of NCVHS's review hearings at this time, they have been important contributors to Minnesota's high and growing rates of electronic transactions, but also pose unique challenges. As the ACA Review Committee, we think it will be important for NCVHS to also consider especially the important roles of acknowledgments and non-HIPAA covered entities in achieving HIPAA administrative simplification goals and in meeting the administrative simplification needs of the industry.

We thank NCVHS for conducting the review hearing and for providing this opportunity to submit testimony. We would be happy to answer questions or to provide any additional information.

Sincerely,

Ann M. Hale
Senior Director, Provider Electronic Commerce and Operations, HealthPartners
AUC chair, 2015

Minnesota Administrative Uniformity Committee (AUC) Testimony to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards/ Review Committee "Hearing on Adopted Transaction Standards, Operating Rules, Code Sets & Identifiers"

AUC Responses to Selected NCVHS Questions

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AUC Responses to Selected NCVHS Questions

1. Transaction: Health Care Eligibility Benefit Inquiry and Response (270/271)

Topic: I. 270-271 VALUE

a) **Q. *Overall, does the currently adopted transactions meet the current (and near-term) business needs of the industry?***

- Answer: The AUC found that overall, the 270-271 is meeting the current and near-term business needs of the industry.

b) **Q. *Is the industry achieving the intended benefits from the transactions and their corresponding standards, code sets and identifiers?***

- Answer: The AUC found that overall, the 270-271 is achieving the intended benefits. The utility and benefit of the 270-271 has been increasing and improving over time, especially as the transaction has become more widely adopted and used.

  In many ways, these improvements and benefits are similar to those in learning a foreign language. As more learners become familiar with the language, they have increasing abilities to communicate with one another, on increasingly more complex and sophisticated topics.

  The benefit and value of the 270-271 has been similarly evolving, with more users becoming more familiar with the transaction. In addition, the transition to the 5010 version of the transaction also was important as it allowed for greater information exchange and more identification and tracking. A result of this evolution is that users who have become accustomed to the transaction expect it to provide a high level of detail. In future considerations of the transaction's value, it will be important to consider whether the transaction carries sufficiently detailed, granular data. The more granular the data the more it can be used by providers who deliver complex healthcare that is more than just "an office visit" or "routine care."

c) **Q. *Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints***

d) **Q. *Have there been any studies, measurement or analysis done that documents the extent to which the transactions and their corresponding standards, code sets and identifiers, as***

adopted and in use, have improved the efficiency and effectiveness of the business processes? Please provide, as much as possible, information for specific transactions.

- Answer (for both c and d above): The benefits of the transaction are most apparent when it is not available and slower, more expensive manual eligibility inquiries and verifications must be used. One provider noted for example that using the electronic 270-271 provided eligibility results in 30 seconds. However, logging into a payer portal or calling the payer on the telephone required 5-10 minutes to obtain the same information. Other providers noted similar differences when comparing much quicker, more efficient 270-271 transactions with alternative manual processes.

  Several providers noted that tracking the percentage of eligibility determinations completed as part of the patient registration process, and tracking the claims denial rates due to eligibility issues, were key business performance indicators. As eligibility determinations increased, the rates of claims denials were reduced.

  Providers ultimately want to send clean claims to payers to be paid quickly and appropriately. In order to achieve this goal, it is important to identify any potential insurance eligibility-related issues prior to the medical service being provided. Electronic exchanges of the 270-271 are important to obtaining needed eligibility information as timely as possible in order to generate a clean claim. Sending a clean claim helps reduce not only the administrative costs of care delivery, but also helps ensure that the patient will be billed appropriately, which improves the patient experience and patient satisfaction. In this last regard – patient experience and patient satisfaction – a goal in the use of the 270-271 transaction is to determine as accurately as possible the level of benefits and coverage that the patient could reasonably expect would apply in the situation.

  One provider noted that some companies publish metrics regarding revenue cycle performance and that these sources might also be accessed to learn more about the impacts of the 270-271 transaction.

Topic: II. 270-271 BARRIERS

Q. Are there any known barriers (business, technical, policy, or otherwise) to using the transactions, standards, or operating rules?

Answers:

- Application to non-HIPAA covered entities:

  Generally, Minnesota's "e-transactions" requirements apply to payers not subject to HIPAA, including workers' compensation, auto, and property-casualty. However, a statutorily allowed exception has been granted to non-HIPAA covered entities from complying with requirements to exchange the 270-271 transaction because it does not fully meet their business needs. This poses a unique barrier to fully integrating non-HIPAA covered entities in the state's requirements.

- 271 does not allow for reporting of complex benefit structures

A provider noted that the 271 response does not permit sufficient reporting of complex benefit structures such as tiered benefits or specialty networks. At present, providers must make time consuming, expensive phone calls to obtain information related to complex benefit structures.

- Some payers are not using the transaction

  Some payers are not using the 270-271 transaction, requiring manual eligibility inquiries and responses.

- Challenges with identifying payers on patient ID cards

  Patient insurance ID cards may have multiple payer logos. This makes it difficult to identify the appropriate payer for eligibility inquiries and billing purposes.

- Use and interpretation of terms is sometimes inconsistent/confusing

  Key terms such as "active/inactive" or "subscriber ID/member ID" used in the transaction may be subject to interpretation/misuse/confusion. For example, a member may be active for the previous month, but inactive for a particular date of service.

- Timely coverage verification

  Coverage verified at the first of the month may not be accurate later and has to be re-verified. In addition, the eligibility information available to payers is only as accurate and up to date as the information provided by the enrollee's employer or health plan sponsor.

Topic: III. 270-271 OPPORTUNITIES

Q. Are there any identified areas for improvement of currently adopted transactions and their corresponding standards, code sets and identifiers?

- Answer: As discussed above under value, the benefit of the 270-271 transaction increases as more users use it more often with more detail and specificity. A key opportunity for improvement is to find ways -- in addition to mandates and penalties -- to maintain a critical mass for success.

  The barriers identified in the section above present additional opportunities for improvement.

Topic: IV. 270-271 CHANGES

Q. Are there any changes that should be made to the current transaction standards, or the mandate to use them?

Answers:

- External code sets

  Some data elements could be external code sets to allow for quicker updates, replacements, additions, etc.

- Greater transparency regarding vendor capabilities and performance

The industry depends greatly on vendors, and more transparency about their capabilities and performance is needed. Information is needed for example regarding: transactions times among vendors; whether discrepancies have been identified between the eligibility data of the vendor vs. the payer; payer and vendor system downtimes, and advance announcements of scheduled downtimes; and variations among vendors in how often they update their eligibility information.

- <u>Require procedure code/diagnosis-related eligibility</u>

  The Implementation Guide for the 270-271 transaction allows for procedure code/diagnosis-related eligibility but it is not required. The AUC recommends that it be required.

- <u>Provider-specific benefits</u>

  It will be important to respond to providers with benefits specific to the provider. For example, instead of responding with both in-network and out-of-network benefits, if the provider is in-network only return the in-network benefits.

- <u>Report accumulators and maximums</u>

  It will be important to report all accumulators and maximums, for example all visit maximums and lifetime maximums, especially for large, complex surgeries and treatments anticipated in the future.

- <u>Expand the use of repetition separators and add qualifiers in the 271</u>

  Expand the use of repetition separators permitted in the EB03 data element for additional data elements to provide additional opportunities for streamlining the transaction. Examples could be EB02 or II103 and others. However, because the repetition separator does not have a qualifier, it will be important to include appropriate Repetition qualifiers to indicate to the provider how the separator is being used. When used does it mean the information is combined or not combined? For example, an EB03 with Chiropractic and Physical Therapy is returned with $10 left for accumulations. Does that mean the patient has $10 left to meet for both, or $10 for Chiropractic and $10 for Physical Therapy?

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AUC Responses to Selected NCVHS Questions

2. Transaction: Health Care Claim: Professional, Institutional, Dental (837P, 837I, 837D)

Topic: I. 837P, 837I, 837D VALUE

a) Q. ***Overall, does the currently adopted transactions meet the current (and near-term) business needs of the industry?***

- Answer:

  The AUC found that overall, the ability to exchange health care claims electronically has been beneficial and that the electronic health care claim transactions (837P, 837I, and 837D) are meeting the current and near-term business needs of the industry.

b) ***Q. Is the industry achieving the intended benefits from the transactions and their corresponding standards, code sets and identifiers?***

- Answer:

  The AUC found that overall, the 837P, 837I, and 837D are providing the intended benefits.

  The utility and benefits of the 837s increased with the adoption of version 5010. For example it was noted that prior to version 5010, when providers submitted claims with non-specific procedure codes they were subsequently contacted by payers requesting additional information regarding the codes, which providers would then prepare and submit. The 5010 837P and 837I added capabilities for including descriptions of non-specific service codes on the claim (837P: L2400 SV1-07; 837I: L2400 SV2-07). As a result, providers can now include the description in the initial transaction, and the time-consuming payer requests for additional information and provider responses that were common under 4010 are no longer needed.

c) ***Q. Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints***

d) ***Q. Have there been any studies, measurement or analysis done that documents the extent to which the transactions and their corresponding standards, code sets and identifiers, as adopted and in use, have improved the efficiency and effectiveness of the business processes? Please provide, as much as possible, information for specific transactions.***

- Answer (for both c and d above):

  While they are difficult to quantify, AUC members noted the following benefits of the claims-related transactions, code sets, and identifiers in practice:

  - Accelerated turnaround times

    Electronic claims have accelerated turnaround times compared with paper claims, resulting in some realignment and better use of staff and resources. The accelerated turnaround is due to a variety of factors, including:

    - the use of front-end edits by clearinghouses and payers that will quickly identify and report back to providers any claims errors or deficiencies so that they can be promptly addressed and the claim submitted correctly. In contrast, providers previously would be alerted to problems with paper claims submitted through the mail only after the claim reached the payer and the payer contacted the provider, a process requiring substantially more time than the current edit process for electronic claims. Automated edits also help speed up development and review of claims as fewer claims must be manually inspected and checked.
    - the HIPAA-adopted electronic claims allow providers to capture more information needed for payment, so less paper that must be manually processed is being sent.

  - The ability to send secondary and tertiary claims electronically is important

    When electronic claim submission first became a reality most payers were only able to accept and pay on claims where they were the primary payer. With the advent of 5010 more payers could now receive and process secondary and tertiary claims – with the benefits of more efficient electronic claims submissions compared with paper. Those payers able to receive and process the CAS section of the electronic claim which holds primary, or primary and secondary EOB information, could then pay providers more quickly.

  - High rates of e-billing through state mandates and other efforts increase benefits for everyone participating

    Participation in "e-billing" in Minnesota is high, due at least in part to a state mandate requiring the standard exchange of HIPAA adopted electronic claims and other transactions. In addition, the mandate is very broad and, unlike federal HIPAA, applies to workers' compensation, property-casualty, and auto carriers. At the same time, Minnesota has benefited from a 20+ year collaboration of health care providers and payers known as the Minnesota Administrative Uniformity Committee (AUC) working to share information, best practices, and other support to achieve the benefits of electronic health care business transactions.

    While CAQH's annual "Efficiency Index" reported a national average rate of electronic claims of 92% in 2013, Minnesota's health plans reported receiving more than 97% of claims electronically. As more participants exchange transactions consistently and electronically, the level of costly special treatment and exceptions

to the general practice decline. At the same time, increasing the proportion of claims and other transactions flowing electronically provides greater return to initial investments and sunk costs made to transition to health care "e-commerce."

- HIPAA's emphasis on standardization and uniformity are important in their own right

The HIPAA-adopted claims transactions have helped reduce, but not eliminate claims adjudication issues and denial. However, HIPAA's emphasis on standard, uniform approaches to data exchange is important in its own right, as they provide a common foundation and structure for better communicating and addressing perceived issues and problems.

Topic: II. 837 BARRIERS

Q. Are there any known barriers (business, technical, policy, or otherwise) to using the transactions, standards, or operating rules?

Answers:

- Lack of adopted HIPAA standard and mandate for claims attachments

While the HIPAA adopted electronic claims transactions often are capable of transmitting greater information from providers to payers than paper versions, additional supplemental information in the form of claims attachments is often necessary and must also be exchanged in addition to or with electronic claims. However, a national electronic claims attachment standard has not been adopted under HIPAA, and no mandate is in effect at this time requiring the use of electronic attachments.

As a result, attachments are often submitted and processed on paper or through a variety of other nonstandard means. Some payers may accept electronic attachments, but many do not. A recent CORE presentation for example noted that most attachments are "unstructured paper or electronic submission of paper images" sent by US Postal Service or by fax, and noted ten different types of commonly used methods for submitting the information in attachments, ranging from word processing documents to spreadsheets to picture and pdf files.

The resulting range of attachments options can be confusing and unwieldy. While the 837 electronic claims transactions include instructions for sending data to use in linking attachments that have been faxed with claims that have been submitted electronically, in practice the instructions may not be followed, or are difficult to comply with, resulting in lost attachments and denied claims.

- Variations in rules and requirements are contrary to goals of consistency and uniformity for electronic data exchange

Individual states, particularly state Medicaid programs, may have unique rules and requirements that are contrary to goals of consistent, uniform, standard electronic data exchanges. For example, in our discussions we learned of one nearby state Medicaid program that requires legacy provider ID numbers that have become outmoded and superseded by the transition to NPIs.

- <u>Interpretations, communication, and practices related to EDI standards and rules sometimes vary</u>

  Despite improvements in national standards and growing use and familiarity with the HIPAA-adopted transactions and codes sets, variation persists in how the transactions and code sets are interpreted and used in practice. For example, payers may vary significantly in their acceptance of canceled and replacement claims, with some payers requiring submission of a voided claim prior to the submission of a clean claim and others having different requirements. In other cases, information and instructions may be still conveyed in the nomenclature adopted for paper claims – use of terms such as "form locator numbers" for example -- that are now obsolete and confusing in the context of EDI-based exchanges of health care administrative data. As with any practice that reduces overall consistency and uniformity in data exchange, these variations can lead to unnecessary administrative expense and burden.

Topic: III. 837 OPPORTUNITIES

Q. Are there any identified areas for improvement of currently adopted transactions and their corresponding standards, code sets and identifiers?

- Answer:

See topic II above regarding challenges.

Topic: IV. 837 CHANGES

Q. Are there any changes that should be made to the current transaction standards, or the mandate to use them?

- <u>Answers:</u>

See topic II above regarding challenges.

Topic: V. Additional question specific to health care claims

Q. What is the degree to which clean claims are being achieved?

Answer:

This question was difficult to answer because there are varying definitions of "clean claim" and because provider systems may be set up differently, creating different metrics for clean claims. The Minnesota Department of Human Services, the agency administering the state's Medical Assistance (Medicaid) program, noted that it only accepts electronic claims, and so that it receives a very high rate of clean claims.

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AUC Responses to Selected NCVHS Questions

3. Transaction: Health Care Claim Payment/Advice (835)

Topic: 835 VALUE

a) **Q. *Overall, does the currently adopted transactions meet the current (and near-term) business needs of the industry?***

The AUC found that except in a few cases as noted below under "barriers" and "opportunities," overall the 835 transaction is meeting the current and near-term needs of the industry. The AUC's efforts to clarify the transaction in use (e.g., Minnesota 835 companion guide, discussions) have helped to meet industry needs. Nationally, the 835 operating rules continue to be adjusted and refined with feedback to CORE, which is helpful, and it will be important for that feedback and improvement to continue so that the transaction continues to best meet industry needs.

b) Q. Is the industry achieving the intended benefits from the transactions and their corresponding standards, code sets and identifiers?

As above, the AUC found that except in a few cases as noted below, overall the 835 transaction is achieving the intended benefits from the transactions and their corresponding standards, code sets and identifiers.

In discussion, it was noted regarding identifiers in particular, that of the four HIPAA originally mandated identifiers, the patient ID has not been implemented, the employer ID is not a concern, and provider IDs seem to be universally used and flowing well. The health plan ID (HPID) has resulted in health plan enumeration but little other benefit. HPID was originally envisioned as an aid to transaction routing, but is not serving that purpose and there are other methods for routing transactions. As a result, if the intent of HPID was to aid routing, it does not serve that purpose and does not have routing benefits worth the cost of implementation.

c) Q. Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints

Several AUC providers noted that approximately 90% of payments are posted electronically via the 835, illustrating that the transaction is generally meeting business needs. In addition, it was also noted that sufficiently detailed CARC and RARC codes are being used more consistently, further improving the transaction's ability to meet business needs.

d) Q. Have there been any studies, measurement or analysis done that documents the extent to which the transactions and their corresponding standards, code sets and identifiers, as adopted and in use, have improved the efficiency and effectiveness of the business processes? Please provide, as much as possible, information for specific transactions.

As noted above, several AUC providers noted that approximately 90% of payments are posted electronically via the 835. This has translated to operational efficiencies, including:

- One provider organization reported reducing the staffing of its cash posting team by 2 FTEs through attrition over a 5-6 year period and anticipates a further 1 FTE staff reduction through attrition in the coming year. Other providers noted similar staffing reductions.
- Denial follow-ups are more efficient because Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and Remittance Advice Remark Codes can be related to eligibility, registration, and other issues that can be addressed proactively.

Topic: 835 BARRIERS

Q. Are there any known barriers (business, technical, policy, or otherwise) to using the transactions, standards, or operating rules?

- Application to non-HIPAA covered entities:
  Minnesota's statutory "e-transactions" requirements apply to payers not subject to HIPAA, including workers' compensation insurers. Implementing the e-transactions requirements for non-HIPAA covered entities such as workers' compensation has been challenging. It is difficult to determine the degree to which the 835 transaction is meeting workers' compensation needs or is aiding the exchange of desired information because compliance remains low.
- It is not possible to validate the operating rules in all cases:
  CORE allows only certain combinations of CARCs and RARCs. However, the 835 does not link CARCs to RARCs, so if there are multiple CARCs and RARCs for a single service line, there are number of CARCs x number of RARCs combinations. Some combinations could be valid while simultaneously some could be invalid. When validating the 835, payers can only assume that if any combination is valid, the 835 is OK.
- Payers may be paying for multiple lines of business, making it difficult for the provider to know when to institute contractual adjustments vs. patient responsibility.
  When the line of business is not delineated in the 835, the provider may not know how to react.

Topic: 835 IMPROVEMENTS

Q. Are there any identified areas for improvement of currently adopted transactions and their corresponding standards, code sets and identifiers?

- Payer identification of lines of business:
  It will be helpful for payers to identify lines of business (MVA, workers' compensation, TPL, indemnity, etc.). One partial solution is to ensure that the claim filing indicator code

(CLP06) is being used and used correctly. Another option is to submit the payer organization ID to identify the line of business; 835s that are returned would be based on the payer ID (one for workers' compensation, another for MVA, etc.).

- Address issues of long-delayed, after-the-fact payment recoupment:
  Payers are using the 835 to recoup payments on aged claims without submitting further explanatory information, making it difficult to understand the basis for the recoupment and to reconcile accounts. One possible solution would be to establish a time limit for using the 835 for recoupment purposes; beyond a certain claim age, other methods than the 835 would be used for recoupment purposes.

- Add another required business scenario to 835 operating rules:
  The AUC has submitted suggested changes to the operating rules to CORE (the AUC submitted a request for a new business case scenario to provide for CARC, RARC, and group codes for the business scenario "Additional Information Required – Missing/Invalid/Incomplete Information from the Patient.").

- Improve the level of information communicated on the 835 to aid in meeting related financial and accounting needs, such as determinations and audits of federal Disproportionate Share Hospitals (DSH) payments:
  The AUC has been working with the Minnesota Department of Human Services (DHS), the agency that administers the state's Medical Assistance (Medicaid) and other publicly funded health care programs, on best practices for use of the 835 for reporting particular public program enrollment and source of funding (state/federal) needed by hospitals for determinations and audits of federal Disproportionate Share Hospitals (DSH) payments.

Topic: 835 CHANGES

Q. Are there any changes that should be made to the current transaction standards, or the mandate to use them?

- As noted above, Minnesota's health care e-transactions requirements apply to payers not subject to HIPAA. While this has often been challenging, it has been important to meeting goals for the most standard, automated, efficient exchanges of health care administrative transactions. In planning for any broader scale extension of HIPAA transactions and code sets requirements to entities currently not subject to HIPAA, it will be important to allow sufficient time and technical assistance for overcoming any implementation challenges.

- While Electronic Funds Transfer (EFT) is often discussed in conjunction with the 835, EFT is encouraged but not required under Minnesota's e-transactions statute. However, the AUC did observe:
  - Perhaps 70-75% of payers are offering some type of EFT. However, in many cases the EFT is not linked to the 835 – providers must go to the payers' websites to retrieve their remittance advice data. Optimally, the EFT and eRA should be linked -- if payers are paying via EFT they should be sending appropriate 835s.

- Payers are using virtual credit cards to make payments in lieu of EFT. The credit card arrangements can be expensive for providers. In addition, some providers' systems are set up to register credit card payments as patient self-pay, creating billing and account reconciliation issues. As a result, providers want to be paid via check or EFT.

4. AUC Membership

- American Association of HealthCare Administrative Management (AAHAM)
- Aetna
- Aging Services of Minnesota
- Allina Hospitals & Clinics
- Blue Cross Blue Shield of MN
- Care Providers of Minnesota
- CentraCare Health Systems
- Children's Hospitals & Clinics of MN
- CVS Pharmacy
- Delta Dental of Minnesota
- Essentia Health
- Fairview Health Services
- HealthEast
- HealthEZ
- HealthPartners - Health Plan
- HealthPartners - Medical Group and Regions Hospital
- Hennepin County Medical Center
- Mayo Clinic
- Medica
- Metropolitan Health Plan
- MMGMA
- MN Chiropractic Association
- MN Council of Health Plans
- MN Dental Association
- MN Dept of Human Services
- MN Dept of Labor and Industry
- MN HomeCare Association
- MN Hospital Association
- MN Medical Association
- MN Pharmacists Association
- Olmsted Medical Center
- Park Nicollet Health Services
- PrairieCare
- PreferredOne
- PrimeWest Health
- Ridgeview Medical Center
- Sanford Health
- Sanford Health Plan
- Silverscript
- St. Luke's
- U of M Physicians
- UCare
- UnitedHealth Group Information Technologies
- WPS Health Insurance