

**Administrative Simplification Provisions in the  
Patient Protection and Affordable Care Act of 2010 (ACA)**

Sec. 1104 – Administrative Simplification

Sec. 10109 – Development of Standards for Financial and Administrative Transactions

*Operating Rules General Provisions (1104(b)(1)–(3))*

Establishes that the standards and associated operating rules adopted by HHS shall, among other things, require minimal augmentation by paper or other communication, describe all data elements (including reason and remark codes) in unambiguous terms, and prohibit additional conditions except where necessary to implement state or federal law or protect against fraud and abuse.

Defines Operating Rules as necessary business rules and guidelines for electronic exchange of information not defined by a standard or its implementation specifications.

Requires HHS to adopt a single set of consensus-based operating rules for each transaction for which standard has been adopted.

Defines criteria for qualified nonprofit entities to provide recommendations on operating rules (entities such as CAQH).

Assigns NCVHS to advise HHS on whether nonprofit entity meets criteria, and whether the recommended operating rules shall be adopted.

*Operating Rules Implementation (1104(b)(4))*

Requires HHS to adopt operating rules by regulation following recommendations from developer of operating rules, NCVHS and consultation with providers.

Establishes July 1, 2011 as deadline to adopt operating rules for eligibility and claim status transactions, so that they are effective no later than January 1, 2013 (may allow the use of a machine readable identification card).

Establishes July 1, 2012 as deadline to adopt operating rules for Electronic Fund Transfer (EFT) and claim payment/remittance advice transactions, so that they are effective no later than January 1, 2014. Operating rules for EFT and claim payment must allow for automated reconciliation of the electronic payment with the remittance advice.

Establishes July 1, 2014 as deadline to adopt operating rules for health claims or equivalent encounter information, health plan enrollment/disenrollment, health plan premium payment, referral certification and authorization transactions, so that they are effective no later than January 1, 2016.

Requires HHS to use expedite rulemaking (interim final rule with 60 days public comment) in applying any standard or operating rule recommended by NCVHS for the transactions noted above.

*Health Plan Certification Requirements (1104(b)(5)(h))*

Requires health plans to file a certification statement with HHS no later than December 31, 2013 certifying that the data and information systems for such plan are in compliance with the standards and operating rules for EFT, eligibility, claim status and health care payment/remittance advice transactions.

Requires health plans to file a certification statement with HHS no later than December 31, 2015 certifying that the data and information systems for such plan are in compliance with the standards and operating rules for health claims or equivalent encounter information, health plan enrollment/disenrollment, health plan premium payment, referral certification and authorization transactions AND health claims attachments.

Requires that documentation provided to support certification statement demonstrates that plans conduct the electronic transactions in a manner that fully complies with the regulations and that plans has completed end-to-end testing with their partners.

Requires health plans to extend requirements to business associates through Business Associate Agreements.

Requires health plans to file a certification statement with HHS certifying that the data and information systems are in compliance with any applicable revised standards and associated operating rule adopted under interim final rule promulgated by HHS.

Requires HHS to conduct periodic audits to ensure that health plans are in compliance with standards and operating rules.

*HHS Review Committee Provisions (1104(b)(5)(i))*

Requires HHS to establish a Review Committee no later than January 1, 2014 to advise HHS on evaluation and review of the adopted standards and operating rules. Review Committee can be NCVHS.

Requires HHS, acting through the Review Committee, to conduct hearings to evaluate and review the adopted standards and operating rules, starting no later than April 1, 2014 and not less than biennially thereafter.

Requires the Review Committee to deliver a report no later than July 1, 2014 (and not less than biennially thereafter) providing recommendations for updating and improving such standards and operating rules; a single set of operating rules per transactions must be provided, maintaining the goal of maximum uniformity in the implementation of electronic standards.

Any amendment of adopted standards and operating rules that has been approved by the Review Committee must be adopted via interim final rulemaking no later than 90 days after receipt of Committee's report.

Effective date of amendment adopted through interim final rule shall be 25 months following the close of 60-day public comment period.

Requires HHS to adopt a single set of operating rules for any transaction for which a standard has been adopted.

*Provisions on Penalty Fees (1104(b)(5)(j))*

Requires HHS to assess a penalty fee against a health plan that failed to meet requirements; the fee amount equals \$1 per covered life until certification is complete. Covered life for which the plan's data systems are not in compliance and shall be imposed for each day the plan is not in compliance.

Penalty fee for deliberate misrepresentation is twice the amount imposed for failure to comply.

Penalty fee increases annually by the annual percentage increase in total national health care expenditures.

Penalty cannot exceed on an annual basis an amount equal to \$20 per covered life or \$40 per covered life for deliberate misrepresentation.

*Unique Health Plan Identifier Provisions (1104(c)(1))*

Requires HHS to promulgate final rule to establish a unique health plan identifier based on input from NCVHS in a manner that the rule is effective no later than October 1, 2012.

*Electronic Fund Transfer Transaction Provisions (1104(c)(2))*

Requires HHS to promulgate final rule to establish a standard for EFT no later than January 1, 2012, so that the rule is effective no later than January 1, 2014.

*Health Care Claim Attachment Provisions (1104(c)(3))*

Require HHS to promulgate final rule to establish a standard and a single set of operating rules for health claim attachments that is consistent with X12 version 5010 no later than January 1, 2014, so that compliance is required by January 1, 2016.

*Consultation with NCVHS, HIT Policy Committee, HIT Standards Committee, SDOs (10109(a)-(b))*

Requires HHS to solicit no later than January 1, 2012, and not less than every 3 years thereafter, input from NCVHS, HIT Policy Committee, HIT Standards Committee and SDOs on whether there could be greater uniformity in financial and administrative activities and items; whether such activities should be considered financial and administrative transactions for which adoption of standards and operating rules would improve the operation of the health care system.

Requires HHS to solicit input no later than January 1, 2012 on whether:

- the application process, including use of uniform application form for enrollment of health care providers by health plans can be made electronic and standardized.
- standards and operating rules shall apply to health care transactions of auto insurance, workers' compensation and other programs or persons not currently covered.
- standardized forms could apply to financial audits required by health plans, federal and state agencies, and others.
- there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans.
- health plans should be required to publish their timeliness of payment rules.

*ICD-9 - ICD-10 Crosswalks Provisions (10109(c))*

Require HHS to task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting no later than January 1, 2011 to receive input on the crosswalk between ICD-9 and ICD-10 posted on CMS website and make recommendations on appropriate revisions to the crosswalk. Any revised crosswalks shall be treated as a code set for which a standard has been adopted.