



Eligibility and Benefits Verification

Current State Review and Feasibility Analysis

American Dental Association

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Executive Summary

The American Dental Association (ADA) engaged Change Healthcare to assess the current state of the eligibility and benefits verification process, specifically as it relates to provider pain points, roles and responsibilities of each entity in the process, and potential solutions for improvement. Additionally, the ADA asked for an evaluation of the feasibility of implementing a unified portal solution for providers to access benefits information.

Change Healthcare interviewed a variety of stakeholders in the verification process, including practice management system vendors, dental service organizations (DSOs), and payers. Additionally, Change Healthcare evaluated emerging technology vendors with alternative approaches to gathering eligibility information.

These interviews, in conjunction with a review of other industry data and standards, led Change Healthcare to identify some key pain points for the provider offices, including:

- Inconsistent Response Data
- Leaving Workflow to Find Information
- Payer Portal Variability
- Fee Schedules

As the issues related to eligibility are multi-sided, Change Healthcare also found pain points for the payers, including:

- Call Center Expense
- Limited Capital for Investment

Change Healthcare evaluated the feasibility of a unified provider portal in these areas:

- Technical
- Data Security
- Payer Participation
- Dentist Access
- Financial (costs for development, implementation, maintenance, ongoing funding)
- Adoption/Enforcement

Based on the findings, Change Healthcare does not suggest moving forward with a portal solution at this time. Rather, the ADA may provide greater value through:

- Provider Education
- Payer Guidance
- Feedback on Best Practices for Software Vendors
- Endorsing a Product or Solution

Overview

In January 2021, the American Dental Association (ADA) released a request for proposal (RFP) for vendors to participate in the initial phase of the “Unified System for Eligibility and Benefits Verification” project. In this phase, the ADA requested documentation of the root causes for dental offices not receiving complete, current, and accurate eligibility and benefits information. Additionally, the ADA requested a review of the feasibility of establishing a unified system to resolve these underlying issues.

From this RFP process, the ADA selected Change Healthcare, the largest dental clearinghouse, to complete industry analysis, interviews, and a feasibility study for the unified system or alternative solutions that may lead to the necessary improvements for eligibility and benefits verification.

Qualifications

Change Healthcare is the largest dental clearinghouse, interacting with more than 125,000 providers each month through channel partner and direct connectivity. Change Healthcare processes more than 100 million dental electronic eligibility (270/271) transactions annually, submitting to more than 700 different dental payers. We have worked closely with payers to improve the quality of the 271 responses, and we have partnered with numerous channel partners and practice management systems to improve the front-end of the eligibility process for provider offices. Additionally, we provide board representation and sponsorship to the National Dental Electronic Data Interchange Council (NDEDIC), serve on numerous workgroups and committees within the ADA, WEDI, X12, and other industry leaders.

Approach/Methodology

Change Healthcare identified 25 dental payers, 10 large practice management system vendors, and 5 large dental service organizations (DSOs) to conduct in-depth interviews, via standard question guides, to assess:

- Current state eligibility responses, including limitations and challenges
- Support structure required to manage the eligibility and benefits verification process
- Experience with previous improvement efforts
- Provider feedback
- Appetite for a unified system
- Ideas/suggestions for improvement

Additionally, Change Healthcare reviewed aggregate 270/271 Electronic Data Interchange (EDI) data, industry standards, other industry reporting, and online materials for emerging technologies.

Findings

Current State of Eligibility and Benefits Verification

While usage of the dental electronic eligibility transaction set has increased, it still trails the medical transaction in percentage, according to the CAQH 2020 report (64% vs 84%). Change Healthcare noted a very slight improvement, even adjusted for the depressed volumes due to the COVID-19 pandemic. According to CAQH, the dental industry has more than \$760 million in cost savings opportunity overall for eligibility transactions.

While more providers are attempting to use the electronic eligibility transaction sets, payers continue to vary in the quality of the 271 eligibility transaction, as well as the investments made in the transaction. This likely impacts the adoption of electronic services.

Business Partner Roles

Dental Provider Office

The dental benefits verification process begins at the scheduling process within the dental provider office. Having the eligibility information at the beginning of the patient experience is crucial. The provider and staff have a variety of different methodologies for submitting requests to payers.

Practice Management System

Typically, a practice management system provides a fully integrated, all-payer solution to support administrative processes such as front office eligibility and benefits verification, back-office claim submission, and payment processing. The preferred method is for the provider to be able to submit a 270 request via the practice management system and receive a corresponding 271 response from the payer, but challenges exist in the X12 format, as it is not in a reader-friendly format. While some vendors have created workarounds for this, others have not, and thus the data presented back to the customer may be difficult to comprehend. Practice management systems may rely on clearinghouses to provide the information in another view (HTML, as an example).

Payer Portal

Many payers have developed their own portals for providers to access eligibility and benefits data. These portals may include other functionality, including claim submission and electronic payments enrollment. Since these portals are payer-specific, they may impede provider workflow due to a lack of integration and all-payer support.

Phone Call

Many providers still opt to call the payer for benefits information. This results in a longer process time for the provider, and increased operating expense for the payer, but some providers believe this to be the most successful way to retrieve accurate and complete patient eligibility data due to deficiencies in payer 270/271 EDI workflow.

Third-Party Outreach

Some provider offices outsource the phone call outreach to third-party resources. In this case, these vendors provide staff (either on- or off-shore) to do the payer outreach on the provider's behalf and provide a completed file back to the provider.

Practice Management System

Much of the provider office's administrative work takes place within the practice management system. The practice management system's primary goal is to allow full management of the provider's office in a single application, including facilitating the 270/271 process. In our interviews, practice management system vendors repeatedly noted that their providers preferred to stay within the system for eligibility work, rather than use portals or make phone calls, but at times still found those methods provided more information. One reason for this may be the presentation of the data received. Many practice management system vendors have not updated their visual representation of the eligibility and benefits data, resulting in the provider not being able to find the data quickly or easily, and in turn relying on a call to the payer. This often leads to the provider being dissatisfied with the practice management system or holding the vendor to account for incomplete or incorrect data, even though in most cases the vendor is not making any changes to data received from the payer via the 271.

Clearinghouse

Providers using EDI are likely to submit their transactions to a practice management system, who then submit to a clearinghouse to facilitate the connectivity to and from the payer. The clearinghouse has the unique ability to normalize data for the providers but is still traditionally limited by the receipt of the data (both in quality and quantity) from the payer. In some cases, the clearinghouse may work with the payer on the quality and content of the response or provide feedback to practice management system vendors on presentation.

Payer

Payers have the most significant role in this process, the most to gain from improvement to the process, and the largest lift to make that improvement happen. The payer's role is to provide the necessary benefits and eligibility data for the patient to the provider's office. While many payers have made efforts to improve 271 EDI responses over the last decade, a large gap remains. Analysis of existing response content found that the Top 25 payers (by claims volume) returned, on average, less than 50% of the recommended elements from the NDEDIC Top 56 guidelines, a leading tool for standardizing 271 responses.

One reason for this may be that many payers are increasingly investing in proprietary portals. While this may be easier for the payer, the provider may find this to be onerous, as managing credentials for each payer portal can be cumbersome, and it requires the provider to leave the practice management system workflow and manually input the information.

Pain Points and Root Causes

Provider

Inconsistent Response Data

By far, the most consistent feedback from practice management system vendors, on behalf of their provider offices, and our DSO customers was a frustration with the inconsistent quality and quantity of the 271 responses. While a few payers have a very detailed response (MetLife is consistently cited as a leading response), many provide less detail, and some simply provide a yes/no response. This lack of content requires the office to have to find the data in some other manner, most commonly through a phone call to the payer.

In other cases, the data received via the 271 was outdated, resulting in an incorrect estimate to the patient and the wrong amount expected as reimbursement from the payer. Some providers noted that the portal data was more updated, though numerous payers refuted this, stating the data in both the portal and the 271 should always match. Three payers did note that the 271 and portal servers were different and may experience slight lag time, but not significant. It is possible this is more of a perception issue by the provider, but more specific and detailed research would be required to determine the correct answer.

Complete, accurate, and current data is critical to the provider as they work with the patient to determine the financials of a procedure, so it is understandable that incorrect or incomplete eligibility and benefits data would be a dissatisfier. One practice management system vendor noted that they choose their employee coverage based on payers who provide the best benefits verification experience.

Payers and providers alike noted the need for standardization in responses. As an example, some payers may list limitations information in various sections, or not provide it at all.

Interestingly, we heard a repeated theme from payers saying they are sending more and more data, while providers noted they did not necessarily want more data, just the necessary data in an easy-to-use format. While a partnership among the provider, software vendor, clearinghouse, and payer to resolve the issues has not been truly successful to date, there may be an opportunity for the ADA to provide a unique value. This will be covered in more detail in the Feasibility section.

Leaving Workflow to Find Information

Providers and software vendors repeatedly noted that leaving the workflow of the practice management system, either to use a portal or make a phone call, was disruptive to the workflow. Additionally, the manual entry into the practice management software from the portal or the call leads to an increased likelihood of incorrect data entry.

Payer Portal Variability

As payers increasingly invest in their own portals, providers are encountering similar issues related to standardization and usability. Each portal is structured differently, provides different levels of content, and still requires the provider to use some level of manual effort.

Fee Schedules

One of the key elements in determining patient responsibility is the fee schedule. Even so, many payers only provide this as a mailed document, or a downloadable PDF, which still requires manual entry. Providers and practice management systems could potentially streamline this effort if the data were received via EDI or API, but payer interest in providing fee schedules was varied in our interviews.

Payer

Call Center Expense

Without exception, payers we interviewed noted that eligibility/benefits calls were the number one call type, with most noting that these calls accounted for more than half of all call center volume. One large dental payer noted that of the 25,000 calls received each day, nearly 19,000 are for eligibility, and most are from providers who do not use EDI. This translates into a significant operations expense for the payer.

To reduce, or at least control, this call volume, some payers have implemented a limit to the number of eligibility checks that can be requested per call, with the goal to drive providers to use EDI or the payer's portal. However, this more often results in providers having to spend even more time in call queues on the phone, resulting in increased dissatisfaction.

Another contributor to call volume is the use of third-party outsourced vendors to call on the provider's behalf. Providers comment to payers that it is cheaper to outsource this work than to utilize EDI. This is highly unlikely, as there are many cost-effective EDI solutions in the market.

Some payers have offered incentives to providers to use EDI in the past, with varied results. This is an area where the ADA could provide value, given the reach of its provider base and its reputation for being an education leader.

A few payers mentioned they were investigating the feasibility of not offering eligibility phone support at all, but rather insisting the provider use EDI or the online portal. It remains to be seen if this approach will be implemented, but success in this regard would likely lead others to try the same.

Limited Capital for Investment

Payers, like all businesses, face cost control issues, and must make choices for investment. This was the primary reason noted for payers investing in proprietary portals as opposed to improving the 271 responses. It is a substantial investment regardless of the path chosen, and the payer portals allow the inclusion of other services (enrollment, claim submission). Two payers noted recent improvements to their 271 responses, with tracking of expense impact to be completed over the next six months.

Another large payer noted that each time an improvement is released in their eligibility and benefits response, the feedback from providers varies. Some are grateful for the expanded content, while others feel components are still missing and will choose to call for benefits information instead. This may lead payers to deprioritize this level of investment, as the perception is that "it cannot make everyone happy."

Additional Review

Emerging Technologies

Some organizations have taken on the work of solving for the challenges in the eligibility and benefits verification space. Change Healthcare reached out to six of these groups in the process of this engagement, but we did not receive feedback. To that end, we reviewed publicly available materials on their websites, webinars, etc. to evaluate the offerings. Primarily, these solutions focus on providing a better visual response, which does solve for one of the provider challenges. That said, many are still primarily using EDI as the core data source, meaning they face the same quality of response challenges as the other software vendors.

Other organizations, such as Onederful, are amplifying the eligibility response with APIs. APIs do offer an opportunity to improve the content in a response, but only if the payer has that data available and is API-enabled. That said, this solution has advantages over a portal-based solution, as it places the data directly in the practice management system.

Standards

Many organizations have dedicated time and resources to the improvement of the 270/271 process.

NDEDIC

NDEDIC (National Dental Electronic Data Interchange Council) is an organization comprised of stakeholders across the dental EDI space, including providers, software vendors, DSOs, clearinghouses, and payers. The organization sponsors workgroups and task groups to investigate and improve various transactions. For example, they publish a guide called the *NDEDIC Top Dental Eligibility & Benefits Questions Response Guide* (commonly referred to as the "Top 56 guidelines"). The guide is available to NDEDIC members, or available for purchase online by non-members. NDEDIC sponsors a workgroup specifically focused on the eligibility transactions.

SCDI

The ADA Standards Committee on Dental Informatics (SCDI) Work Group 11.10 ("WG. 11.10") on Administrative Efficiency in Clinical Informatics is developing "ADA Standard No. 1102 - Electronic Dental Benefits Eligibility Verification" which will be available to ADA members and any interested party who wishes to purchase one. The desired output for this committee's work is a best practice 270/271 transaction set, and a demonstration project of this effort is proposed for later this year. As part of this demonstration, sample provider 270 inquiries will be routed through a clearinghouse, and then the corresponding 271 responses will be sent back for review. Change Healthcare has been participating and contributing to this ADA SCDI WG. 11.10 effort since its inception.

X12

X12 is the HIPAA-named Standards Development Organization (SDO) for administrative transactions, including the 270/271. The version currently adopted under HIPAA regulation is 005010X279A1 (aka "5010").

The Health Plan Eligibility Benefit Inquiry and Response transaction (270/271) allows the submitter to obtain information about a patient's coverage for services by the health plan in which they are enrolled, the benefits associated with services, and estimated patient financial responsibility. Version 5010 of the 270/271 transaction does have gaps in support of dental services, but many of these limitations can be circumvented within the structure of the transaction.

Later this year, X12 is expected to publish version 8010 of the 270/271 TR3. X12 has not yet made recommendations to CMS on specific versions for adoption under HIPAA, but such version will be 8010 or later. The next version was developed with greater input from the dental community and will eliminate many of the limitations present in version 5010. Specifically, the list of Service Type Codes, which are used for benefit reporting, has become an external code set, meaning that codes can be added to the list up to three times per year without requiring an update to the standard itself. Many dental-specific service type codes have already been added to that list. See <https://x12.org/codes/service-type-codes>.

A Dental Caucus is also active within X12.

Change Healthcare participates in the X12 Dental Caucus as well as the Eligibility Workgroup.

X12 provides a process for submitting maintenance requests for future releases of the 270/271. The ADA should utilize the maintenance process to improve the standard for dental payers and providers.

WEDI

The Workgroup for Electronic Data Interchange (WEDI) is a cross-industry coalition focusing on the use of electronic healthcare information exchange to improve healthcare information exchange, enhance quality of care, improve efficiency, and reduce costs of the American healthcare system. WEDI was named as an advisor to the Secretary of Health and Human Services on matters relating to transaction standards, along with other entities. WEDI has an active workgroup for Dental, as well as an Eligibility & Benefits workgroup. To date, WEDI has not addressed Dental Eligibility transaction issues, but this may be a good opportunity for collaboration between WEDI and the ADA.

Please see Appendix A for additional information on regulatory and standards organizations.

Future Regulatory and Standards Items with Potential Impact

Healthcare regulations and standards continually evolve. It remains to be seen what specific impact the items below may have on the eligibility and benefits verification process.

21st Century CURES Act

This legislation was passed in 2016, with the final rule delivered in 2020. It confirms that information blocking is illegal and establishes the definitions and penalties therein. These

penalties will be levied by the Office of the Inspector General (OIG). Additionally, it provides interoperability Conditions of Certification, which will include open APIs.

Health Level Seven International (HL7)

HL7 develops and maintains standards primarily for the exchange, integration, sharing and retrieval of health information to support the clinical practice and management of health services, including standards for attachments. HL7 is a named Designated Standards Maintenance Organization under HIPAA.

Uniform Electronic Transactions in Dental Care Billing Act (IL SB 493)

This bill has passed both chambers within the Illinois General Assembly and is awaiting action by the governor, expected sometime by mid/late August 2021. If approved and signed, this bill would require all dental plan carriers and dental care providers to exchange claims and eligibility information electronically using the standard electronic data interchange transaction for claims submissions, payments, and verification of benefits required under the Health Insurance Portability and Accountability Act (HIPAA) to be compensable by the dental plan carriers.

This bill has interesting implications. Since it is only at the state level, it may provide difficulty for providers, patients, and plans in neighboring states as they are not subject to the same rules but may partake in services within Illinois. It is equally possible that other state legislatures may take this bill as a framework for work in their own states.

Challenges Related to Standards and Industry Bodies

The list of organizations with a focus and intent on improvement in the dental EDI transactions is broad, and those mentioned in this report are only a sample. The question remains then that with this much focus, why are improvements not more apparent?

Lack of coordination

Each organization has an overall goal of transaction improvement, but at times it feels there are too many groups splitting the focus. In the interviews, participants noted that it often feels each body establishes a workgroup or task force, instead of joining together for a broader impact.

Limited participation

Many of these workgroups and task forces are made up of similar membership. In most cases, the individuals willing to take time to participate in groups like this are already doing well and are motivated to do better. To get the broader industry improvement desired by all these groups, it is critical that participation expand to organizations who are not already performing well.

No enforcement ability

The inability of any of the organizations to enforce improvement and adherence was a consistent theme in the interviews. Each organization can only lead within its sphere of influence.

Feasibility and Scalability of a Unified System

As noted in the initial RFP, the ADA's vision for the ideal state is as follows:

In an ideal state, if there were no problems with verifying eligibility and benefits, dental offices would request and receive information in real-time regarding a patient's eligibility under a dental plan and information on the availability of benefits, i.e., coverage and cost on specific procedures down to the individual procedure/tooth level. This would then provide such information upfront to the patient and avoid unanticipated charges following treatment. The interface between the dental office and the payer would be consistent. The manner and format for requesting information is always the same, and information in the response is always the same.

Completeness, currency & accuracy are key attributes of the desired information. For example, the dental office might need to know whether a crown is covered by a provider in the office who is a participating provider (in-network benefit) with the plan on tooth number X on X date of service, and what the associated patient charges might be for this procedure.

This example may fall more into the "pre-treatment estimate" scenario rather than "eligibility/ benefits verification" scenario. Regardless, this example exemplifies the problem the ADA is trying to solve. The ADA is not seeking to cross the line into prior authorizations and understands that annual limits or consultant reviews may impact any final payment determinations. Dental offices ask for a simplified system to verify coverage and obtain cost estimates in real-time before treatment.

One solution to move to this ideal state, as proposed by the ADA, is a unified benefits system/portal. To that end, Change Healthcare investigated the feasibility of the approach, through our interviews, industry analysis, and internal expertise. Our analysis considered the following:

- Technical
- Data Security
- Payer Participation
- Dentist Access
- Financial (costs for development, implementation, maintenance, ongoing funding)
- Adoption/enforcement

In this section, we have included direct quotes from interview sessions.

Technical considerations

The first aspect of our feasibility review assessed the technical aspects of providing a unified portal solution. No doubt, this would be a significant development project. Consistent feedback in the interviews revealed some technical "must-haves," including:

- Single Sign-On (SSO)
- Application Programming Interfaces (APIs)
- Limited manual work from the provider

One common question was around the gathering of the eligibility data. Would the ADA expect to host the data, or simply receive the data from the payer? Each provides a set of advantages and challenges. On the one hand, hosting the data would take more development work--and is not likely the ADA's core skill set--but would provide assurance the data meets the required formatting. On the other hand, it would be easier to retrieve the data via API or 270/271, but that poses the same challenge as the current landscape in that payers may not return consistent data.

"It would just be easier to use the EDI transactions in the way they were intended."

Several customers in each profile mentioned that it would make more sense for the ADA to partner with a clearinghouse on this project, given that the necessary connectivity and infrastructure likely exists.

"Why wouldn't the ADA just partner with a clearinghouse for this work?"

Data Security considerations

The most consistent concern from the payer perspective was the data security and privacy of a unified solution. Establishment of a unified portal would require trading partner agreements with the ADA, which brings about its own timeline and implementation challenges. One payer noted, "this seems like a risk nightmare." There is also an inconsistent desire for APIs across the payer spectrum. While some are using them today for various data transfers, others remain hesitant to implement. Payers have complex and detailed security review protocols, and an endeavor like this would require substantial review. As one payer noted, "it would take us a year just to get this through security review." Another payer shared concerns that some of their government plans may have additional privacy regulations that would impact participation.

Payer Participation considerations

The greatest contributor to the success or failure of a unified portal is the participation of the dental payers. "Unless all payers participate, this will not have enough value to be useful," stated one DSO leader. Another provider noted, "There are so many payers who do not offer good eligibility responses already. Why would they participate in this?" This feedback appeared in numerous interviews.

Payers also questioned the likelihood of participation, given their investments in EDI and their own proprietary portals. Several payers noted that similar concepts have been attempted by other industry groups, and the resulting solution "has gone very poorly."

"[Payers] have so many conflicting spend priorities. I just don't see this getting moved to the top of the list."

Dentist Access considerations

Overwhelmingly, feedback from our DSO and software vendor conversations reiterated the importance of remaining within the practice management system workflow. “Providers overwhelmingly prefer to stay within their practice management system.” “If there is not a way to get the data back into the practice management system, this only adds more effort to the provider.”

There was also skepticism about the likelihood of the provider accessing a portal for this data. As one DSO leader stated, “If a dentist has the ability to access this portal, they have the ability to submit EDI.” Another software vendor noted, “Dentists are scared of change. What would make them switch to this?”

Those that represented provider segments (software vendors and DSOs) consistently reiterated that portal solutions are disruptive to the provider office workflow and adding another portal to that mix does not solve the issue. Rather, “payers should focus on correcting and improving their 271 responses.” This would allow the provider to remain within the practice management system workflow. It is important to note the challenge there then falls to the software vendor to provide the response data in an easy-to-use format.

Financial considerations

The expense of developing and maintaining a unified portal is going to be significant. Chief cost considerations include:

- IT resources for design, development, testing, and rollout
- Security review and testing, both initial and ongoing
- Infrastructure and hosting
- Support staffing

Payers expressed hesitancy about paying to participate in this effort, citing their own investments in portals and EDI improvements. If the ADA chooses to fund this internally, expect it to become a significant line-item expense.

Adoption/enforcement considerations

In tandem with the participation concerns, interviewees also expressed skepticism about the ADA’s ability to drive adoption and enforce usage of a unified portal. One payer quote captured the consistent feedback most clearly: *“If the ADA can enforce the quality of the data in this portal, why can’t they enforce the quality of the data in the existing EDI transactions?”*

Questions also arose about the oversight of the portal and the data quality. Given that the ADA does not have regulatory enforcement power over eligibility and benefits data, what authority and measures can it use to improve quality and lead payers to contribute their correct data?

Another payer stated, “If there is a mandate, we will participate, but how are providers going to be incentivized to use it?” Similar feedback was shared in other interviews, and it is worth investigation. The ADA has been and remains a strong proponent for EDI adoption, but there remains a wide gap in EDI usage across the industry. What different approaches would be

utilized in this scenario? If provider adoption is low, and thus payers still receive calls about eligibility and benefits, it may limit future participation.

Recommendations

Based on our interview data and extensive knowledge of the eligibility transaction and challenges therein, it is Change Healthcare's recommendation that the ADA does not proceed with creation of a unified portal. Our primary concerns with the approach include:

- Cost for development and maintenance
- Payer participation
- Data quality enforcement
- Provider adoption
- Challenges in integrating with dental practice management systems

There are other areas where the ADA may be able to provide significant value in driving improvement for eligibility and benefits verification.

Provider Education

Providers may continue to believe that EDI is too expensive and that it is cheaper to call the payer, or to use third-party call resources to call on their behalf. The ADA can provide education to dispel this myth.

One item for education is the ASETT offering from CMS. From the user guide:

CMS believes it is especially important for individuals to have the ability to file complaints and permit CMS to investigate potential non-compliance. This application is called the Administrative Simplification Enforcement and Testing Tool, or ASETT. It specifically enables individuals or organizations to file a HIPAA and/or Patient Protection and Affordable Care Act (ACA) complaint against a HIPAA covered entity for potential non-compliance with the non- Privacy/Security provisions of HIPAA.

Providers may not be aware this tool exists.

Payer Guidance

The ADA can partner with other industry groups, such as NDEDIC, NADP, CAQH, etc., to promote a set of standards to payers for modeling their 271 responses (for example, the NDEDIC Top 56 guide). As payers increasingly standardize a response, or provide the necessary data elements, it should increase trust in the industry that an electronic transaction is accurate. This then contributes to the provider education work. This suggestion was echoed by a payer who noted "the ADA has done a lot of work to standardize the claim form, so they may be able to do the same for eligibility." The ADA can also influence standards groups via maintenance requests and feedback on future work. A few payers noted their dissatisfaction with the NDEDIC guide due to it being behind a paywall.

Feedback on Best Practices for Software Vendors

A consistent theme in both these interviews and Change Healthcare's ongoing work around improvement in this space is that while there may be sufficient data in the response, it is not displayed in a user-friendly manner. This causes frustration for the provider, who then calls the payer or uses the payer portal. The ADA could engage consultants or other organizations with

knowledge to design a “best-in-class” viewing experience to share with practice management systems.

One overall challenge from the vendor perspective is the lack of oversight and ability to enforce standards. However, practice management systems have much to gain from a market growth standpoint. Providers may choose to not purchase the eligibility modules in their software system, or to utilize lower cost solutions. As practice management systems improve the display and transparency of the eligibility solution, it will likely entice providers to include the offering in their bundles, resulting in economic growth for the vendor.

Endorse a Product or Solution

From the RFP, the ADA noted the ideal state in which:

...dental offices would request and receive information in real-time regarding a patient's eligibility under a dental plan and information on the availability of benefits, i.e., coverage and cost on specific procedures down to the individual procedure/tooth level. This would then provide such information upfront to the patient and avoid unanticipated charges following treatment. The interface between the dental office and the payer would be consistent. The manner and format for requesting information is always the same, and information in the response is always the same.

While the prior thought has been to return more and more data, a mindset shift must occur to only provide what is necessary for this patient visit, and to provide it in an easily viewable format. This concept is similar to today's pharmacy model. Change Healthcare, for example, offers a solution with this goal in mind. Other organizations are attempting to solve for this via APIs, and there may be others focused on this as well. Rather than developing an entirely new portal solution, the ADA may provide more benefit by endorsing an existing solution.

In evaluating a solution, the ADA should assess tools that get as close as possible to the desired goal of real-time estimation.

Other key components to consider:

- Ability to integrate with practice management systems (either directly or indirectly via API)
- Portal or web-based tool for the provider to access the information in the absence of a practice management system
- Broad payer connectivity for EDI, including 270/271 capabilities
- Data warehouse infrastructure to account for scalability and growth potential
- Ease of use for the provider, and data that can be trusted
- Speed of transaction, with responses as close to real-time as feasible

Appendix

Standards-Setting and Standards Development and Related Organizations

Standard-setting organizations (SSOs)/Standards development organizations (SDOs) develop, coordinate, and revise technical standards. Designated Standards Maintenance Organizations (DSMOs) are organizations named by the Secretary of Health and Human Services (HHS) to maintain standards adopted under HIPAA and to receive and process requests to adopt new standards or modify existing standards.

Advisory Groups

- American Dental Association
 - The ADA serves as the statutory [42 U.S.C. 1372d-1] consultant to the Secretary of Health and Human Services (HHS) concerning adoption of any standard developed, adopted, or modified by a standard setting organization, or other standard being considered by the Secretary before adoption.
- NCVHS – National Committee on Vital and Health Statistics
 - The NCVHS serves as the statutory [42 U.S.C. 242k(k)] public advisory body to the Secretary of Health and Human Services (HHS) for health data, statistics, privacy, and national health information policy and the Health Insurance Portability and Accountability Act (HIPAA). The Committee advises the HHS Secretary, reports regularly to Congress on HIPAA implementation, and serves as a forum for interaction between HHS and interested private sector groups on a range of health data issues.
- WEDI – Workgroup for Electronic Data Interchange
 - WEDI was formed in 1991 by Secretary of HHS, Dr. Louis Sullivan to identify opportunities to improve the efficiency of health data exchange and was named in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation as an advisor to the Secretary.

Designated Standard Maintenance Organizations

- ADA DeCC – Dental Content Committee of the American Dental Association
 - The DeCC is a named Designated Standards Maintenance Organization under HIPAA. This ADA committee initiates and reviews content change requests affecting any HIPAA administrative simplification standard electronic transaction on behalf of the dental sector. DeCC's purview includes the dental claim (837D) and the eligibility transactions (270/271).
- ASC X12 – Accredited Standards Committee
 - ASC X12 develops and maintains standards for electronic data interchange relating to business transactions. ASC X12N, the Insurance Subcommittee of ASC X12, develops and maintains standards for healthcare administrative transactions. ASC X12 is a named Designated Standards Maintenance Organization under HIPAA.

- HL7 – Health Level Seven
 - HL7 develops and maintains standards primarily for the exchange, integration, sharing and retrieval of health information to support the clinical practice and management of health services, including standards for structured attachments. HL7 is a named Designated Standards Maintenance Organization under HIPAA.
- NCPDP – National Council for Prescription Drug Programs
 - NCPDP maintains EDI standards for the retail pharmacy industry. NCPDP is a named Designated Standards Maintenance Organization under HIPAA.
- NUBC – National Uniform Billing Committee
 - NUBC maintains content for institutional electronic and paper claims. It is chaired by the American Hospital Association (AHA). NUBC is a named Designated Standards Maintenance Organization under HIPAA.
- NUCC – National Uniform Claim Committee
 - NUCC maintains content for professional electronic and paper claims. It is chaired by the American Medical Association (AMA). NUCC is a named Designated Standards Maintenance Organization under HIPAA.

Designated Authoring Entity for Operating Rules

- CAQH CORE – Committee on Operating Rules for Information Exchange
 - The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.

References

CAQH. (2020). *2020 CAQH INDEX®*.

Administrative Simplification Enforcement and Testing Tool (ASETT) Quick Start User Guide, Centers for Medicare and Medicaid Services