EFT and ERA Implementation Insights: Models to Deliver EFT and ERA

Tuesday, February 12, 2013
3:00 pm to 4:00 pm ET
Participating in Today’s Interactive Event

• Download a copy of today’s presentation [HERE]
• The phones will be muted throughout the session
• You may directly communicate your questions at any time during today’s GoToWebinar session by submitting your question via the Q&A panel located on right hand side of your screen
• Panelists will address audience questions during the last 10 minutes of the program
Session Topics

• Welcome & Introductions
• Affordable Care Act (ACA) Mandated EFT Standard and EFT & ERA Operating Rules
  – Overview
  – Key Operating Rule Requirements
• Implementing Mandated EFT & ERA Operating Rules
• Planning and Analysis from a Clearinghouse Perspective
  – Key Considerations
  – Payer Case Studies
• Q&A
Polling Question:  
*EFT & ERA Awareness*

How would you rate your overall level of understanding of the Healthcare EFT Standard and the EFT & ERA Operating Rules?

- Very Strong
- Strong
- Fair
- Limited
- Very Limited
Purpose of Operating Rules

- The Patient Protection and Affordable Care Act (ACA) defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
- They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards
Affordable Care Act (ACA) Mandated Healthcare EFT Standard and EFT & ERA Operating Rules
Healthcare EFT Standard and EFT & ERA Operating Rules: Cross Industry Collaboration

- CAQH CORE and NACHA: The convergence and alignment of financial services and healthcare
  
  - CAQH CORE has been designated by the Department of Health and Human Services (HHS) as the operating rule authoring entity for Federal mandates related to healthcare operating rules under ACA Section 1104
  
  - NACHA – The Electronic Payments Association
    - Non-profit rule-making entity; author of the NACHA Operating Rules for almost 40 years; responsible for managing the development, administration, and governance of the ACH Network, i.e. the backbone by which funds are moved between bank accounts throughout the country
    - NACHA supports the Healthcare EFT Standard - the CCD+ and worked with CAQH CORE in development of the EFT & ERA Healthcare Operating Rules
ACA Mandated Operating Rules Compliance Dates: Required for all HIPAA Covered Entities

Operating rules encourage an interoperable network and, thereby, are vendor agnostic.

Compliance in Effect as of January 1, 2013

- Eligibility for health plan
- Claims status transactions
  
  HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules

Implement by January 1, 2014

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

Implement by January 1, 2016

- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments

Rule requirements available.
CAQH CORE EFT & ERA Operating Rules in Action

Pre-Payment: Provider Enrollment

EFT Enrollment Data Rule

ERA Enrollment Data Rule

Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation.

Claims Payment Process

Health Care Claim Payment/Advice (835) Infrastructure Rule

Uniform Use of CARCs & RARCs Rule

Payment/Advice (835)

Electronic Funds Transfer (CCD+/TRN)

Stage 1: Initiate EFT

EFT & ERA Reassociation (CCD+/835) Rule

Billing & Collections

Provider

Treasury

Bank

Bank

Treasury
Healthcare EFT & ERA Standards + Operating Rules

**ACH CCD+ & X12 v5010 835**
- **EFT**: NACHA CCD+Addenda (must contain the TRN Reassociation Trace Number data segment as defined by X12 835 TR3 version 5010)
- **ERA**: X12 v5010 835

**CAQH CORE EFT & ERA Operating Rules**
- Health Care Claim Payment/Advice (835) Infrastructure Rule
- Uniform Use of CARCs and RARCs (835) Rule
- EFT & ERA Reassociation (CCD+/835) Rule
- EFT Enrollment Data Rule
- ERA Enrollment Data Rule

Together, EFT & ERA Standards and Operating Rules will deliver efficiency and consistency across the healthcare industry.
CAQH CORE EFT & ERA Operating Rules
# Mandated EFT & ERA Operating Rules: January 1, 2014 Requirements Scope

<table>
<thead>
<tr>
<th>Rule</th>
<th>High-Level Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td></td>
</tr>
<tr>
<td>Uniform Use of CARCs and RARCs (835) Rule</td>
<td>• Identifies a <em>minimum</em> set of four CAQH CORE-defined Business Scenarios with a <em>maximum</em> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</td>
</tr>
</tbody>
</table>
| EFT Enrollment Data Rule | • Identifies a maximum set of standard data elements for EFT enrollment  
• Outlines a flow and format for paper and electronic collection of the data elements  
• Requires health plan to offer electronic EFT enrollment |
| ERA Enrollment Data Rule | • Similar to EFT Enrollment Data Rule |
| EFT & ERA Reassociation (CCD+/835) Rule | • Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association  
• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions  
• Requirements for resolving late/missing EFT and ERA transactions  
• Recognition of the role of *NACHA Operating Rules* for financial institutions |
| Health Care Claim Payment/Advice (835) Infrastructure Rule | • Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides  
• Requires entities to support the Phase II CAQH CORE Connectivity Rule.  
• Includes batch Acknowledgement requirements*  
• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |

* [CMS-0028-IFC](#) excludes requirements pertaining to acknowledgements.
CAQH CORE Uniform Use of CARCs and RARCs Rule: 
*Four Business Scenarios*

Pre CORE Rule 360

- 800+ CARCs
- 300+ RARCs
- 4 CAGCs

Post CORE Rule 360

Inconsistent Use of Tens of Thousands of Potential Code Combinations

**Four Common Business Scenarios**

**CORE Business Scenario #1:**
- Additional Information Required – Missing/Invalid/Incomplete Documentation
- (≈160 code combos)

**CORE Business Scenario #2:**
- Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim
- (≈300 code combos)

**CORE Business Scenario #3:**
- Billed Service Not Covered by Health Plan
- (≈375 code combos)

**CORE Business Scenario #4:**
- Benefit for Billed Service Not Separately Payable
- (≈35 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios
CAQH CORE Uniform Use of CARCs and RARCsc Rule: Key Rule Requirements

<table>
<thead>
<tr>
<th>Use of CORE-defined Business Scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A health plan or its PBM agent must:</td>
</tr>
<tr>
<td>- Align internal codes and business scenarios to the CORE-defined Business Scenarios</td>
</tr>
<tr>
<td>- Support the maximum CORE-required Code Combinations as specified in CORE-required Code Combinations for CORE-defined Business Scenarios.doc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements for Receivers of the v5010 835¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When receiving a v5010 X12 835, the product extracting the data (e.g., a vendor’s provider-facing system or solution) from the v5010 X12 835 for manual processing must make available to the end user text describing the codes included in the remittance advice, ensuring that the actual wording of the text displayed accurately represents the corresponding code description specified in the code lists without changing the meaning and intent of the description and text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario</td>
</tr>
</tbody>
</table>

¹Requirements do not currently apply to retail pharmacy or to an entity that is simply forwarding the v5010 X12 835 to another system for further processing.
CAQH CORE Uniform Use of CARCs and RARCs Rule:  
CAQH CORE Code Combinations Maintenance Process

- A CAQH CORE Code Combinations Task Group will convene three times per year to review the CORE-required Code Combinations for CORE-defined Business Scenarios
- Two types of review and adjustment to the CORE Code Combinations including:

**Compliance-based Review & Adjustment**

- **Goal:** Align [CORE-required Code Combinations for CORE-defined Business Scenarios](#) and the code sets
- **Frequency:** Occurs three times/year via Task Group
- **Scope:** Only considers updates to the CARC and RARC lists published (occurs three or more times per year) since the last update to the CORE Code Combinations as required by the CAQH CORE Rule 360
- Per CMS OESS, Compliance-based Adjustments will be *immediately recognized under HIPAA* given that CAQH CORE Rule 360 requires that publications from code authors be addressed

**Market-based Review & Adjustment**

- **Goal:** Address ongoing and evolving industry business needs
- **Frequency:** Occurs once per year during last Task Group convening
- **Scope:** Considers *industry submissions* based on real world usage data and/or a strong business case addressing:
  - Adjustments to the *existing* CORE-required Code Combinations for *existing* CORE-defined Business Scenarios
  - Addition of *new* CORE-defined Business Scenarios and associated code combinations
- Per CMS OESS, Market-based Adjustments will need to be recognized via a future and evolving Federal CMS OESS HIPAA requirement update process
**CAQH CORE EFT & ERA Enrollment Data Rules: Key Rule Requirements**

<table>
<thead>
<tr>
<th>Paper-based Enrollments</th>
<th>Electronic Enrollments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional</td>
<td>Must be offered</td>
</tr>
</tbody>
</table>

A health plan (or its agent or vendors offering EFT enrollment) is required to:

- Collect no more data elements than the CORE-required Maximum EFT Enrollment Data Set; data elements marked optional may be collected at the entity’s discretion.
- Use the format, flow, and data set including data element descriptions without modification in the Maximum EFT Enrollment Data Set.
- Make available to the provider (or its agent):
  - specific written instructions/guidance to the healthcare provider for enrollment
  - instructions on the specific procedure to accomplish a change in/cancellation of their enrollment

- Include the name of the health plan/agent/ vendor offering EFT) & the purpose of the form at top of the form
- Provide additional information including where to send completed form, contact information, authorization language
- Provide instructions to access online instructions for status of enrollment
- Inform provider it must contact bank to arrange for delivery of the CORE Minimum CCD+ Reassociation Data Elements

- When using XML, exact Data Element Name and Sub-element Name must be enclosed in angle brackets (i.e., `< >`) for the standard XML element name; and all spaces replaced with an underscore `[ _ ]` character
- Offer an electronic way for provider to complete and submit the EFT enrollment
CAQH CORE EFT & ERA Reassociation (CCD+/835) Rule: Key Rule Requirements

**Elapsed Time Requirements**

- Health plan must release the v5010 X12 835 corresponding to the Healthcare EFT Standards:
  - No sooner than three business days based on the time zone of the health plan prior to the CCD+ Effective Entry Date and no later than three business days after the CCD+ Effective Entry Date
- CCD+ Effective Entry Date must be a valid banking day and corresponding v5010 x12 835 BPR16 date is the same valid banking day

**Elapsed Time Auditing Requirements**

- Health plan must ensure the v5010 X12 835 and corresponding Healthcare EFT Standards meet the elapsed time requirements ninety percent (90%) of the time as measured within a calendar month
- Health plan is required to have the capability to track and audit this elapsed time requirement

**CORE-required Minimum CCD+ Data**

- Health plan must inform provider during EFT and ERA enrollment that it will need to contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements necessary for successful reassociation
- Provider must proactively contact its financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements

**Resolving Late/Missing EFTs and ERAs**

- Health plan must establish and delivery to the provider written Late/Missing EFT and ERA Transactions Resolution Procedures
- Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835

1 Specific requirements vary slightly for retail pharmacy; see Section 4 of rule for detailed requirements for retail pharmacy
EFT & ERA Reassociation (CCD+/835) Rule (cont.):
CORE-required Minimum CCD+ Reassociation Data Elements

<table>
<thead>
<tr>
<th>CCD+ Record #</th>
<th>Field #</th>
<th>Field Name (See §6 Glossary for Definition of these Terms)</th>
<th>Informational Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Focus of Rule</strong></td>
<td><strong>CORE-required Minimum CCD+ Reassociation Data Elements</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corresponding v5010 X12 835 Data Elements</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Element Segment Position, Number &amp; Name</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>9</td>
<td>Effective Entry Date</td>
<td>BPR16-373 Date (EFT Effective Date)</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Amount</td>
<td>BPR02-782 Monetary Amount (Total Actual Provider Payment Amount)</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>Payment Related Information</td>
<td>TRN Reassociation Trace Number Segment, specifically data elements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN01-481 Trace Type Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN02-127 Reference Identification (EFT Trace Number)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN03-509 Originating Company Identifier (Payer Identifier)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• TRN04-127 Reference Identification (Originating Company Supplemental Code)</td>
</tr>
</tbody>
</table>
Healthcare Claim Payment/Advice (835) Infrastructure Rule: Key Rule Requirements

Connectivity

• Entities must be able to support the Connectivity Rule Version 2.2.0 for transmission of the v5010 835

Dual Delivery

• A health plan that currently issues proprietary paper claim remittance advices is required to continue to offer such paper remittance advices to each provider during that provider’s initial implementation testing of the v5010 X12 835 for a minimum of 31 calendar days from the initiation of implementation
• Upon mutual agreement between the provider and the health plan, the timeframe for delivery of the proprietary paper claim remittance advices may be extended
• See 4.3 for more detail

Batch Acknowledgements

• A receiver of a v5010 X12 835 transaction must return:
  - A v5010 X12 999 Implementation Acknowledgement for each Functional Group of v5010 X12 835 transactions to indicate that the Functional Group was either accepted, accepted with errors or rejected, and
  - To specify for each included v5010 X12 835 transaction set that the transaction set was either accepted, accepted with errors or rejected
• A health plan must be able to accept and process a v5010 X12 999 for a Functional Group of v5010 X12 835 transactions
• When a Functional Group of v5010 X12 835 transactions is either accepted with errors or rejected, the v5010 X12 999 Implementation Acknowledgement must report each error detected to the most specific level of detail supported by the v5010 X12 999 Implementation Acknowledgement

Companion Guide

• Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides for the v5010 835

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1 Requirements do not currently apply to retail pharmacy
2 NOTE: CMS-0028-IFC does not adopt the Batch Acknowledgement Requirements in Section 4.2 of CAQH CORE Rule 350, as the Secretary has not yet adopted HIPAA standards for acknowledgements.
EFT & ERA Operating Rules: 
Implementing Mandated Operating Rules
Analysis & Planning Guide for Implementing the CAQH CORE EFT & ERA Operating Rules

- The new Analysis and Planning Guide provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis and planning for implementation of the CAQH CORE EFT & ERA Operating Rules
- Guide should be used by project staff to:
  - Understand applicability of the CAQH CORE Operating Rule requirements to organization’s systems and processes that conduct the EFT and ERA transactions
  - Identify all impacted external and internal systems and outsourced vendors that process EFT & ERA transactions
  - Conduct detailed rule requirements gap analysis to identify system(s) that may require remediation and business processes which may be impacted

- The guide includes three tools to assist entities in completing analysis and planning:
  - Stakeholder & Business Type Evaluation
  - Systems Inventory & Impact Assessment Worksheet
  - Gap Analysis Worksheet
CAQH CORE Analysis & Planning Tools in Guide

**Stakeholder & Business Type Evaluation**

**Objective:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE EFT & ERA Operating Rules (e.g., products, business lines, etc.)

**Systems Inventory & Impact Assessment Worksheet**

**Objective:** Understand how many of your systems/products are impacted by each CAQH CORE Operating Rule and understand with which vendors you will need to coordinate

**Gap Analysis Worksheet**

**Objective:** Understand the level of system(s) remediation necessary for adopting each CAQH CORE Operating Rule requirement; results of completed Gap Analysis Worksheet will allow for development of a detailed project plan
CAQH CORE Implementation Resources

- Master the **CAQH CORE EFT & ERA Operating Rules**
- Start your implementation efforts by using the **Planning and Analysis Guide**
- Attend a free CAQH CORE **Education Event** on the ACA mandated EFT & ERA Operating Rules
- Access general **FAQs** regarding the ACA operating rules mandate; more EFT & ERA FAQs coming soon
- New resources coming soon:
  - CORE Certification Test Site for the EFT & ERA Operating Rules
- Submit your questions to the CAQH CORE Request Process by emailing **core@caqh.org**
The Importance of Trading Partner Collaboration

- HIPAA-covered entities work together to exchange data in a variety of ways
- Understand your electronic payment data flows associated with your trading partner and vendor agreements
- Vendors play a crucial role in enabling provider clients to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them
Implementation Planning from a Clearinghouse Perspective

Chris Seib
Chief Technology Officer
and Co-Founder
InstaMed
About InstaMed

InstaMed’s Healthcare Payments Network transforms the business of healthcare by connecting healthcare providers, payers and patients for highly secure and mission critical communications, administrative transactions and payments

- Powers healthcare payments for 200,000+ providers nationally, e.g. 400+ hospitals and 100+ billing services
- Integrated with 40+ PMS
- Processes $30 billion in healthcare payments annually at a rate of $1,000+ per second

**Early Adopter of CAQH CORE Operating Rules**

- The InstaMed Platform and Network was one of the first Phase I and Phase II CORE-certified clearinghouses
- Supporter of CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rules

**CAQH CORE Participating Organization**

- Member of the CAQH CORE EFT and ERA Subgroup
- Participant in CAQH CORE measurement studies
Models for Payers to Deliver EFT and ERA

**A**
INTERNAL: Payer generates the HIPAA compliant 835 and delivers the EFT and ERA directly to the Provider

**B**
THIRD PARTY: There are multiple types of third party models to generate the HIPAA compliant 835 and delivers EFT and ERA on behalf of the Payer
EFT & ERA Operating Rule Implementation: 
**Health Plan Trading Partner Relationships**

- The majority of CAQH CORE EFT & ERA Operating Rule requirements apply to health plans; health plans interact and work with their trading partners in a variety of ways; below are two scenarios of how a health plan might approach their implementation project

  - **Health Plan A**
    - Health Plan A implements CAQH CORE EFT & ERA Operating Rules in their entirety
    - Health Plan A’s implementation is independent of any third party relationship

  - **Health Plan B**
    - Health Plan B outsources the processing of the ASC X12 v5010 835 or Healthcare EFT Standard transactions to a clearinghouse, business associate, third party vendor, etc.
      - The third party entity conducting EFT & ERA transactions according to the CAQH CORE Operating Rules may be different than the third party entity that is handling eligibility and claim status transactions for the health plan
    - Both health plan and clearinghouse pursue implementation activities; their implementation is independent of one another
# Implementation Considerations: Electronic Data Interchange

<table>
<thead>
<tr>
<th>ASC X12 v5010 835 or Healthcare EFT</th>
<th>Implementation</th>
<th>Compliance</th>
<th>Vendor Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT Resources Required</td>
<td>Analysis of resources &amp; requirements</td>
<td>Jan. 1, 2014 Mandate</td>
<td>Understand scope of agreements</td>
</tr>
<tr>
<td>-</td>
<td>Comprehensive testing plan</td>
<td>Bank account handling</td>
<td>Accountability for monitoring payments and daily reconciliation</td>
</tr>
<tr>
<td>-</td>
<td>Pilot providers</td>
<td>-</td>
<td>Customer service and provider support management</td>
</tr>
</tbody>
</table>

**Q:** Do you generate a ASC X12 v5010 835 transaction today or do you have a proprietary format?  
**Q:** Have you identified a lead resource across each department impacted by this project?  
**Q:** Do you have an internal SME on healthcare and banking compliance?  
**Q:** Do you know all businesses involved in the project and which resources are accountable for each aspect?
## InstaMed Experience - Implementation Considerations: Provider Adoption

<table>
<thead>
<tr>
<th>Provider Adoption</th>
<th>Call Center</th>
<th>Daily Monitoring &amp; Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify pilot providers</td>
<td>Streamline operations up front to reduce call volume</td>
<td>Monitor all payment activity &amp; exceptions (including non-business days)</td>
</tr>
<tr>
<td>Define the outreach and enrollment processes</td>
<td>Staff training for provider enrollment questions</td>
<td>Daily reconciliation of all payments</td>
</tr>
<tr>
<td>Process automation</td>
<td>-</td>
<td>Manage bank account changes and KYC (Know Your Customer) processes</td>
</tr>
</tbody>
</table>

**Q:** What is your marketing approach to reach your providers to maximize adoption?  
**Q:** Have you educated your call center resources to handle the volume of EFT enrollment inquiries?  
**Q:** Are you equipped to quickly complete KYC and bank account changes?
## InstaMed Experience: Payer Case Studies: Implementation Model A

### Resources

<table>
<thead>
<tr>
<th>Resources</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager – 350-400 hours</td>
<td>Payer can select which clearinghouses they support (any the providers use)</td>
<td>Resources</td>
</tr>
<tr>
<td>Claims/EDI Operations – 250-300 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Relations – 200-250 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance – 200-250 hours</td>
<td>Payer controls their own payment timing</td>
<td>Managing bank account changes</td>
</tr>
<tr>
<td>IT – 250-300 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 1,250-1,500 hours over 6-9 months

Source: Data from 3 payers from 2011-2012
## InstaMed Experience:  
**Payer Case Studies: Implementation Model B**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager – 17-30 hours</td>
<td>Manage compliance</td>
<td>Managing third party relationships</td>
</tr>
<tr>
<td>Claims/EDI Operations – 14-22 hours</td>
<td>Provider Adoption</td>
<td>Updating file to 835 standard</td>
</tr>
<tr>
<td>Provider Relations – 12-16 hours</td>
<td>Monitor payment activity and bank account management</td>
<td></td>
</tr>
<tr>
<td>Finance – 13-15 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT – 13-17 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

69-100 hours over 8-10 weeks
InstaMed Experience:
*Final Insights*

- Accurately Assess Resource Bandwidth and Hard and Soft Costs Associated with Your Approach
- Understand Full Scope of Project and All Parties Involved
- Measure the Success Upon Execution
- Compliance is Key
- Results and Benefits
- Project Completion Date
Question & Answer

Please submit your question:

• **Via the Web**: Enter your question into the Q&A pane
Free Upcoming CAQH CORE Education

- **In-Person Conferences:** Look for us at the following upcoming events
  - [National HIPAA Summit West](#) - February
  - GE Users Conference – April
  - [NACHA: Payments 2013](#) - April

- **Webinars:** Mark your calendars & join us again
  - [CMS OESS Open Mic: Ask Your Compliance Questions](#) - Implementing ACA-Mandated Operating Rules
    - Wednesday, February 20, 2013 from 2:00 pm - 3:00 pm ET
    - Wednesday, March 20, 2013 from 2:00 pm - 3:00 pm ET
  - [CAQH CORE Town Hall](#) – a bi-monthly information session open to the public
    - March 12, 2013, 3:00 pm - 4:00 pm ET

- **Visit Us at CAQH CORE Booth # 2468 at the upcoming HIMSS Annual Conference, March 3-7, 2013**
The second set of operating rules has been placed in Federal regulation

- August 2012: CMS published an Interim Final Rule with Comment, **CMS-0028-IFC**, with the following features:
  - Adopts Phase III CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA) transactions *except for rule requirements pertaining to Acknowledgements*; covered entities must be in compliance by **January 1, 2014**
  - The interim final rule comment period closed on October 9, 2012
    - CAQH CORE developed a [model comment letter](#) for organizations to use as appropriate
  - No changes to the HHS IFR have been announced. HHS has publically stated that interim final rules stand as final rules. Entities should be working towards the January 2014 adoption date.

*On September 22, 2011, NCVHS issued a letter recommending that Acknowledgements be adopted as formally recognized standards, and that the CAQH CORE Operating Rules for these standards also be recognized.*
CAQH CORE Project Planning & Analysis Considerations: Health Plans

- The majority of the CAQH CORE EFT & ERA Operating Rule requirements apply to health plan systems and processes
- If your health plan outsources to a clearinghouse or business associate the processing of the ASC X12 v5010 835 or Healthcare EFT Standard transactions to providers you may have some unique implementation considerations:
  - Depending on the scenario, the health plan may not need to implement some rule requirements directly while the clearinghouse/intermediary/business associate will need to implement them on behalf of the health plan
  - For the EFT and ERA transactions, intermediaries/business associates may include other types of entities not involved in the implementation of the ACA-mandated Phase I and II CAQH CORE Eligibility and Claim Status Operating Rules, such as third-party payment vendors; the health plan, therefore, might have different trading partners to consider when implementing the CAQH CORE EFT & ERA Operating Rules
Key Questions:  
Based on InstaMed’s Experiences

- **HIPAA-compliant 835 (ASC X12 v5010 835)**  
  - Do you generate a HIPAA-compliant 835 today or do you have a proprietary format?

- **Implementation Planning**  
  - Have you identified a lead resource across each department impacted by this project?  
  - Have you created a project plan with a full analysis of resources and requirements?  
  - Have you created a comprehensive testing plan?  
  - Who is in charge of identifying and working with pilot providers?  
  - Have you identified a target go-live date?

- **Provider Adoption:**  
  - What is your marketing approach to reach your providers to maximize adoption?  
  - How do you best reach your providers?  
  - What is your process for enrolling providers?  
  - Who will train providers on your EFT/ERA functionality?  
  - What type of data do you have on your providers?  
  - Have you educated your call center resources to handle the volume of EFT enrollment inquiries?
Key Questions (continued):  
*Based on InstaMed’s Experiences*

- **Daily Monitoring and Audits**
  - How often do you monitor payment activity and reconcile claim payments?
  - Who is in charge of handling Notification of Changes (NOC) and other bank account/organization changes?
  - Are you equipped to quickly complete KYC and bank account changes?

- **Vendor Relationships**
  - Do you know all businesses involved in the project and which resources are accountable for each aspect?
  - How many vendor relationships are you managing?
  - With whom are you entering into agreements?
  - Who handles your customer service inquiries?
  - Who handles provider customer service inquiries?

- **Compliance Requirements**
  - Do you have an internal SME on healthcare and banking compliance?
  - Who has access to provider bank account information?