Improving Operational Performance through the Implementation of Operating Rules:

A Health Plan Perspective

Tuesday, June 26, 2012
2:00 pm to 3:00 pm ET

Alison Schambach
Senior Healthcare Business Consultant
Edifecs

Robert Schleichert
Associate Vice President,
Information Systems
AultCare

Monica Cunningham
Education & Outreach Consultant
CAQH CORE
Session Topics

- Industry Insights
- CAQH CORE Operating Rule Overview
- Administrative Simplification: Affordable Care Act (ACA) Section 1104
- Implementation Strategies
- Health Plan Perspectives – AultCare
  - Operational Efficiencies
  - Implementation Insights
- Question & Answers
Today’s Learning Objectives

Attendees will:

• Explore implementation strategies for the successful implementation of *Eligibility and Claim Status Operating Rules* with a leading regional health plan

• Describe the operational efficiencies associated with the adoption of healthcare operating rules and their strategic importance

• Describe the timeline for adoption of federally mandated operating rules and identify how operating rules apply to HIPAA covered entities

• Review the first mandated operating rules set for *Eligibility for a Health Plan and Healthcare Claim Status*; and overview Draft CAQH CORE Operating Rules for Electronic Funds Transfer and Remittance Advice transactions
Industry Insights

*Edifecs*

Alison Schambach
Introduction to Edifecs

Corporate Background
- Founded in 1996 (16 years), headquartered in Bellevue, WA
- A CORE-authorized Certification Testing vendor since 2006
- Board member of the Managed Care Executive Group (MCEG)
- Actively involved in many industry workgroups such as WEDI, X12, HIMSS, and AHIP

What We Do
- Modernize front-end information exchange infrastructure
- Edifecs products streamline the processing and exchange of transactions in real time at the edge-of-the-enterprise
- Help healthcare organizations drive down administrative costs and achieve regulatory compliance

Customer Momentum
- 46 Blue plans out of total 64
- 47 commercial plans
- 71 providers
- 31 State Medicaid out of total 56

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100 Fastest Growing Companies in WA
Inc5000 fastest-growing private companies in the US
100 Best Places to work for in WA

simplifying healthcare administration
What is Administrative Simplification?

- Original definition of “Administrative Simplification” is defined as follows:

  “Title II, Subtitle F, of HIPAA which authorizes HHS to: (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.”

- Patient Protection and Affordability Act – now referred to as the Affordable Care Act (ACA) has enhanced this definition under Section 1104 amending HIPAA law to now include Operating Rules with the intent of reducing “clerical burden on patients, providers and health plans”.

1 CMS On-line Glossary of Terms
2 H.R. 3590 page 28 Section 1104
Health Cost Trends in United States

The US surpasses all other developed nations on health care spending and having a direct impact on family budgets.

Note: OECD refers to Organization for Economic Co-operation and Development
HIPAA Implementation: Health Plan Constraints

- Many organization tactically implemented unfunded mandates due to financial limitations
- Lack of automation beyond claims kept a dependency on many of the other manual business processes within health care
- The contingency period for the implementation of HIPAA transactions and code sets allowed stakeholders to continue using non-standard versions with little incentive to change
- HIPAA X12 transactions focused mainly on EDI standards and not other technology and business processes within health care
Environmental Changes Impacting Health Care Organizations

• Cost pressures forcing many to look at how to achieve administrative simplification
• More and more providers are changing their office practices and moving away from paper and manual processes
Environmental Changes Impacting Health Care Organizations

- Collaboration is becoming more of a focal point strategically for all stakeholders
- Health care regulations
  - Meaningful Use
  - MLR Requirements
  - Health Plan Certifications under the Affordable Care Act
  - Health Insurance Exchanges (HIX’s)
  - Health Information Exchanges (HIE’s)
  - Affordable Care Organizations (ACOs)
  - Medical Homes
- Technology – “We’ve got an app for that!”
  - ePrescribe
  - Telehealth
  - Social network/ online communities
What Do Healthcare Organizations Need to Consider?

• **Embrace change**: Regardless of whether we are talking about environmental or mandated change, executives need to look strategically at how they will be able to bend the cost curve while staying competitive.

• **Think collaboratively**: Create a win-win situation across the board for all stakeholders.

• **Simplify to reduce cost**: Look at how your organization can strategically build upon what you have already accomplished in order to reduce cost.
Edifecs: Helping the Industry Implement Operating Rules

• Helping healthcare organizations demonstrate conformance with *Eligibility and Claims Status* Operating Rules
  – Provides free CORE Certification testing service as a CORE-authorized testing entity that leads to *voluntary* CORE Certification
  – Dedicated web portal available 24/7
  – On-line and live support for quick issue resolution

• Edifecs has enabled:
  – 59 health care organizations to complete *voluntary* CORE Certification Testing for Phase I CAQH CORE Operating Rules
  – 27 health care organizations to complete Voluntary CORE Certification Testing for Phase II CAQH CORE Operating Rules

Note: Edifecs Voluntary CORE Certification Testing site is distinct from Edifecs’ Operating Rules offerings. Edifecs Voluntary CORE Certification Testing program supports entities seeking the CORE Certification Seal
Reduce Administrative Costs by Augmenting HIPAA

Operating Rules streamline information exchange

- Standardized format
- Created uniformity in data exchange
- Reduced use of paper forms

Standards
- ACS X12
- NACHA
- OASIS
- W3C

Operating Rules

- Augment HIPAA transactions by providing business context
- Enhanced data content
- Enhance interoperability between trading partners by supporting industry neutral standards and other infrastructure requirements
- Limit the use of companion guides
Operating Rules: A Strategic Business Case

The CAQH CORE® Operating Rules for the Eligibility transaction resulted in an optimization of financial workflows.

Providers who were early adopters of the Phase I CAQH CORE Operating Rules reported significantly improved access to health plan eligibility, benefit coverage and patient financials in advance of or at the time of service using an electronic system of their choice.

Results achieved by providers/hospitals working with vendors and health plans that have implemented the CAQH CORE Operating Rules* include:

- **Primary benefits**
  - Decrease in claim denials (related to eligibility) 10-12%
  - Percent increase in electronic eligibility verifications 24%
  - Save 7 minutes per electronic verification $2.60 per verification

- **Secondary benefits**
  - Time saved in registration and billing
  - Reduced transaction fees and connectivity costs

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*IBM assessed results achieved by Phase I CAQH CORE Operating Rules early adopters (represents 33 million covered lives and 1.2 million providers) CAQH CORE Measures of Success Study Phase I
CAQH CORE Operating Rules Overview
CAQH® and Its Initiatives

CAQH, a nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

Multi-stakeholder collaboration of over 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. Cover 75% of the commercially insured, plus Medicare and some Medicaid.

An industry utility that replaces multiple health plan paper processes for collecting provider data with a single, electronic, uniform data-collection system (i.e., credentialing). Over 1 million providers self-report their information to UPD and over 650 organizations access the system, including a range of public and private entities.

An independent industry forum for monitoring business efficiency in healthcare; tracking efficiency and electronic adoption across the Industry.
Why Healthcare Operating Rules?

- Current healthcare operating rules support a range of standards – healthcare specific (e.g. ASC X12) and industry neutral (e.g., OASIS, W3C) – and support alignment with the national HIT agenda.
- Healthcare operating rules pair content and infrastructure rules to help data flow consistently in varied settings and with various vendors.

### Examples of Topics that Healthcare Operating Rules Address:

<table>
<thead>
<tr>
<th>Data Content</th>
<th>Addresses Need to Drive Further Industry Value in Transaction Processing</th>
<th>More Robust Eligibility Verification Plus Financials</th>
<th>Enhanced Error Reporting and Patient Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enhances what your organization already supports</strong></td>
<td>Addresses Industry Needs for Common/ Accessible Documentation</td>
<td>Companion Guides</td>
<td>System Availability</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td>Addresses Industry-wide Goals for Architecture/ Performance/ Connectivity</td>
<td>Response Times</td>
<td>Connectivity and Security</td>
</tr>
</tbody>
</table>
Patient Protection and Affordable Care Act (ACA)
Section 1104:
Mandated Healthcare Operating Rules
Administrative Simplification: ACA Section 1104

ACA Section 1104 (H.R.3590) - “...Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs”

Highlights

• Updates initial August 2000 HIPAA regulation for transaction standards and code sets given landscape has significantly changed, and unnecessary healthcare costs/burden must be removed from the system

• Requires the Department of Health and Human Services (HHS) to appoint a “qualified non-profit entity” to develop a set of operating rules for the conduct of electronic administrative healthcare transactions

• Administrative and financial standards and operating rules must:
  – Enable the determination of eligibility and financial responsibility for specific services prior to or at the point of care
  – Be comprehensive, requiring minimal augmentation by paper or other communications
  – Provide for timely acknowledgement, response, and status reporting

• HIPAA covered entities and business associates engaging in HIPAA standard transactions on behalf of covered entities must comply

• Health plans must file a statement with HHS confirming compliance; financial penalties for health plans are significant
ACA Mandated Operating Rules Approach & Timeline

Operating rule writing and mandated implementation timeframe per ACA legislation

Adoption deadlines to finalize operating rules

- July 2011 Eligibility and Claim Status
- July 2012 Claims payment/advice and electronic funds transfer
- July 2014 Enrollment, Referral authorization, attachments, etc.

Compliance dates to implement operating rules

- January 2013
- January 2014
- January 2016

NOTES:
1. The National Committee on Vital and Health Statistics (NCVHS) is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules.
2. Statute defines relationship between operating rules and standards.
3. Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans.
4. Per statute, documentation of compliance for health plans may include completion of end-to-end testing (i.e., certification and testing).
5. Statute states compliance with the applicable standard/operating rule is required no later than its effective date.
Mandated Eligibility and Claim Status Operating Rules
Mandated Eligibility & Claim Status Operating Rules: Status

• **Status**: The first set of operating rules has been adopted into Federal regulation
  
  – July 2011, CMS published [CMS-0032-IFC](#) with the following key features:
    • Adopted Phase I and II CAQH CORE Operating Rules for the Eligibility & Claim Status transactions, *except for rule requirements pertaining to Acknowledgements*.
    • Highlights CORE Certification as *voluntary*; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation.
  
  – December 2011, CMS adopted above as a Final Rule; industry implementation efforts underway for the [January 1, 2013 effective date](#)
    • CAQH CORE is committed to assisting with roll-out; June 20th testified to NCVHS on status.

• ACA Section 1104 requires *all HIPAA covered entities* be compliant with applicable HIPAA standards and associated operating rules.

The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge [HERE](#).

*On September 22, 2011, NCVHS issued a [letter](#) recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.*
# ACA Federal Compliance Requirements: Highlights & Key Dates

The following **three dates are critical** for industry implementation of the federally mandated CAQH CORE Eligibility & Claim Status Operating Rules. *Note: there are two types of penalties related to compliance with the mandated operating rules.*

<table>
<thead>
<tr>
<th>Key Area</th>
<th>January 1, 2013 Compliance Date</th>
<th>December 31, 2013 Health Plan Certification Date</th>
<th>No Later than April 1, 2014 Health Plan Penalty Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>HIPAA Mandated Implementation</td>
<td>ACA-required Health Plan Certification</td>
<td></td>
</tr>
<tr>
<td>Who: All HIPAA-covered entities</td>
<td>Who: Health plans</td>
<td>Who: Health plans</td>
<td></td>
</tr>
<tr>
<td>Action: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules</td>
<td>HHS will assess penalties against health plans that have failed to meet the ACA compliance requirements for certification and documentation</td>
<td></td>
</tr>
<tr>
<td>Applicable Penalties</td>
<td>Amount: Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>Amount: Fee amount equals $1 per covered life until certification is complete; penalties for failure to comply cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation</td>
<td></td>
</tr>
</tbody>
</table>

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6 According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year; CAQH CORE will continue to offer its [voluntary CORE Certification program](https://www.caqh.org/about/caqh-core) and will share lessons learned with CMS as the Federal process is developed.

7 Covered life for which the plan’s data systems are not in compliance; shall be imposed for each day the plan is not in compliance.
# Mandated Eligibility & Claim Status Operating Rules: January 2013 Requirements Scope

## Data Content

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I &amp; II CAQH CORE Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility &amp; Benefits</strong></td>
<td>Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:</td>
</tr>
<tr>
<td></td>
<td>• Health plan name and coverage dates</td>
</tr>
<tr>
<td></td>
<td>• Static financials (co-pay, co-insurance, base deductibles)</td>
</tr>
<tr>
<td></td>
<td>• Benefit-specific and base deductible for individual and family</td>
</tr>
<tr>
<td></td>
<td>• In/Out of network variances</td>
</tr>
<tr>
<td></td>
<td>• Remaining deductible amounts</td>
</tr>
</tbody>
</table>

## Infrastructure

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I &amp; II CAQH CORE Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility, Benefits &amp; Claims Status</strong></td>
<td>• Connectivity via Internet and aligned with NwHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)</td>
</tr>
<tr>
<td></td>
<td>• Companion Guide – common flow/format</td>
</tr>
<tr>
<td></td>
<td>• Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch)</td>
</tr>
<tr>
<td></td>
<td>• System Availability service levels – minimum 86% availability per calendar week</td>
</tr>
<tr>
<td></td>
<td>• Enhanced Patient Identification and Error Reporting requirements</td>
</tr>
<tr>
<td></td>
<td>• Acknowledgements (transactional)*</td>
</tr>
</tbody>
</table>

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note "we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein."

A PowerPoint overview of the Phase I & II CAQH CORE Rules is available HERE; the complete rule sets are available HERE.
Future ACA Operating Rule Mandates
EFT and ERA: Healthcare and Financial Services

- To enable the ACA’s Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) operating rules mandate, there must be coordination between healthcare and financial services.

- 835/ERA is a healthcare standard; EFT/CCD+ used by many industries.

Interim Final Rule for the Healthcare EFT standard
EFT and ERA:
Healthcare and Financial Services Collaboration

- **NACHA – The Electronics Payment Association**
  - Established in 1974; a financial services entity whose rules are used by 15,000 banks; *The NACHA Operating Rules* are used by bank throughout the country
  - NACHA manages the development, administration and governance of the ACH Network, the backbone for the electronic movement of money and data
  - The **ACH Network** is a batch processing, electronic payments system governed by *The NACHA Operating Rules*; it provides for the interbank clearing of electronic payments for participating depository financial institutions

- **CAQH CORE has and continues to be coordinating with NACHA**
  - Began working together in 2005; began coordinating operating rule writing in 2010
  - CAQH CORE participants identified key areas where new or modified *NACHA Operating Rules* could address current issues in use of NACHA CCD+ transaction for EFT healthcare payments over the ACH Network
  - CAQH CORE continues to assist NACHA in gaining healthcare input on *NACHA Operating Rules* for EFT
Mandated EFT & ERA Operating Rules: Status

• Spring 2011 NCVHS recommended:
  – NACHA as healthcare EFT SDO and ACH CCD+ as healthcare EFT standard
  – CAQH CORE, in collaboration with NACHA, as author for EFT and ERA operating rules (pharmacy to be addressed as appropriate)
  – NACHA operating rules apply to banks, while CAQH CORE rules apply to HIPAA covered entities

• Fall 2011:
  – Draft CAQH CORE EFT & ERA Rule Set approved by CORE Rules Work Group
  – Draft CORE EFT & ERA Voluntary Certification Test Suite approved by CORE Technical Work Group

• Winter 2011:
  – NCVHS issued letter recommending HHS adopt Draft CAQH CORE EFT & ERA Rule Set
  – January 2012: CMS released Interim Final Rule for the Healthcare EFT standard; CAQH CORE commented on IFC (model letter shared with participants)

• Spring /Summer 2012:
  – CAQH CORE updated Draft EFT & ERA Operating Rules (not changing requirements) to reflect CMS recognition of EFT standard and NCVHS guidance to remove references to voluntary CORE Certification
  – NACHA issued RFC on potential adjustments to NACHA Operating Rules
    • May 18th: CORE Rules Work Group held a call on which NACHA staff provided insight/rationale for proposed enhancements and answered questions on the framework of the ACH Network
  – CAQH CORE8 approved its EFT and ERA Rule Sets

8 Only CORE Participating entities that create, transmit or use the transactions (thus implement the rules) may vote in Final CORE Vote; earlier votes include all types of entities.
### CAQH CORE EFT & ERA Operating Rules: Overview

<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><strong>Uniform Use of CARCs and RARCs (835) Rule</strong></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 straw man template 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 reassociation  
- 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                                                                                                                                                                                                                     |
| **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                                                                                                                                                                                                                      |
Third and Final ACA Mandated Set: Status

• Alignment with clinical initiatives will be even more critical in this third set due to timing of other HIT efforts and also focus of rules

• November 2011: NCVHS began holding hearings
  – CAQH CORE provided testimony on three topics and stated interest in serving as operating rule author, key points included:
    • **Claims Attachments**: Communicated current industry landscape implies clinical and administrative coordination is critical, provided examples of potential areas for operating rules; highlighted standards and operating rules will need to work together more than ever if the industry is to meet deadline
    • **Provider Enrollment**: Outlined lessons learned from the CAQH Universal Provider Datasource (UPD) as well as CORE EFT/ERA work
    • **Maintenance of Standards & Operating Rules**: Discussed how these processes can be improved moving forward

• Spring 2011: NCVHS recommendation included the following statement:
  – “NCVHS will advise the Secretary to name a single entity that will serve as the responsible body to develop and maintain operating rules in coordination with other entities. Operating rules would be created for the remaining transactions as needed and will be developed through the coordination and active engagement of individuals or organizations with appropriate expertise.”
Implementation Strategies:

*Industry Collaboration and Return on Investment (ROI)*
All HIPAA covered entities involved in the electronic exchange of administrative transactions have a role to play in the adoption of CAQH CORE Operating Rules, i.e., providers, health plans, clearinghouses and/or vendors.

HIPAA covered entities work together to exchange transaction data in a variety of ways. The applicability of a given CAQH CORE Operating Rule will depend upon the nature of the trading relationship between HIPAA-covered entities, e.g.,

- Provider direct-to-health plan connection
- Single/dual clearinghouse-to-health plan connection
- Provider-to-clearinghouse/vendor connection
Voluntary CORE Certification

• Since its inception, CAQH CORE has offered a voluntary CORE Certification; available to health plans, vendors, clearinghouses and providers
  – Encourages trading partners to work together on data flow and content needs
  – Facilitates maximum ROI when all entities in data exchange conform
  – Informs the industry that a company IT systems or product operates in accordance with the CAQH CORE Operating Rules

• Key guiding principles of CORE program
  – Certification and testing are done by separate entities; CORE-authorized testing vendors build web-based Test platform, and site is alpha/beta tested by CORE participants
  – Multi-stakeholder CORE process approves Test Suite for each rule set, including test scripts by stakeholder type
  – Free or very low-cost – and easily accessible to all parties
  – Does not replace internal or trading partner testing

• Vendors play a crucial role in accelerating provider adoption, ROI and interoperability across trading partner network
  – Small providers rely on their vendors/PMS to achieve their administrative cost saving goals
  – Large providers can work with their vendors to obtain CORE Certification
CAQH CORE Implementation Support

- Interactive tools that are free or low cost, e.g.,
  - Analysis and Planning Guide
  - Respond to incoming industry Implementation Requests process via CORE@caqh.org; facilitate referrals to others such as ASC X12 and CMS
  - Listing of FAQs
  - Polling evaluations to gauge usefulness of content, knowledge base, challenges, etc.
  - Voluntary CORE Certification, in conjunction with our CORE-authorized Certification Testing Vendor

- Educational programming
  - Free education opportunities and archives of past sessions at the CORE events page of our website
  - Variety of venues, different modalities with evolving in-depth content/focus
  - Collaboration with other organizations on programming, e.g., NeHC, NMEH, WEDI

- Business Case Awareness through tracking ROI and conducting Measures of Success Studies in conjunction with IBM
Health Plan Perspective

AultCare

Robert Schleichert
AultCare: An Integrated Delivery System
AultCare: Company Overview

• AultCare provides local, affordable and quality health-care administration for more than 2,300 local companies
  – Established in 1985 and located in Canton, Ohio
  – One of the largest hospital-based PPOs in the Midwest
  – HMO, PPO, Self-funded, Medicare Advantage, Commercial Insured, Individual Plans, Workers Comp & Disability programs

• AultCare Health Plan is committed to clinical quality and customer service
  – 95% retention rate of clients!!
  – Ranked top health plan in Ohio by NCQA in 2010
  – Received Ohio Award for Excellence, the highest quality based award in the State of Ohio, in recognition of its customer-focused performance excellence

• AultCare in combination with Aultman Hospital received first national J.D. Power & Associates for outstanding patient and member experiences

9 A vertically-integrated health delivery system
AultCare: Provider Network Operations

- **Integrated Delivery System Components**
  - Consists of 20,000 providers serving 500,000 covered lives
  - Aultman Hospital & Satellite Facilities
    - Management Services Organization (MSO)
    - AultCare PPO network
    - Non-PPO providers

- **AultCare Service Orientation**
  - Servicing 500,000 covered lives
  - Commitment to providers to ease their administrative burdens
  - CAQH CORE Operating Rules helped us to achieve those goals
  - Provider Steering Committee

- **Administrative Simplification Goals**
  - Automate everything
  - Encourage adoption
  - Accept customer goals
AultCare: A Leader in Clinical Quality and Customer Excellence

• AultCare is a leader in its commitment to administrative simplification
  – A founding member of CAQH
  – A Phase I and Phase II CORE-certified health plan
  – A participant in the CAQH CORE and IBM Measures of Success Study
• Committed to industry collaboration and recognition of the role that multi-stakeholder initiatives play in breeding operational success
• “We do what our customers ask “…they asked for more automation, and we automated as much as one can
  – Through our ongoing provider councils, providers shared their needs
  – CAQH CORE Operating Rules provided a mechanism to implement consistent practices across our trading partner network and to gain agreement on the what, how & when of information exchange for eligibility and claim status
  – We were able to implement a local HIE that permits sharing information amongst provider groups
AultCare: Eligibility Transaction Profile

- Health Plan Operations – 2011 Volumes
  - Customer service center answered more than 200,000 calls
  - Over 2.5 million claims processed
- Eligibility and Benefits / Claim Status
  - Our systems process the electronic exchange of approximately 1.8 million eligibility transactions inquiries annually
- **28% per year increase** since 2010 in electronic eligibility inquiry volumes
AultCare: EFT and ERA Transaction Profile

• Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
  – 50% of AultCare provider payments are EFT and ERA transactions received by approximately 150 providers
  – Deployment Approach: Began in 2009 working with the 20% of providers that represented 80% of claims payments to hospital-based practices

• Factors Affecting Rates of Adoption
  – Year One – High volume providers
  – Year Two – Impact of Ohio requirements
  – Year Three – Diverging Lines and slower rate of increase
    • Provider relations working with small practices
    • Leveraging trading partner relationships
AultCare: Electronic Exchange System Capabilities

- **Health Plan Systems**
  - Internal
    - TriZetto QicLink Claims Management System
    - Data Warehouse (Internal)
  - Cloud
    - Phase I and Phase II CORE-certified HIPAA compliant gateway and flexible platform for managing transactions and connectivity [PCS]
    - Web Portal

- **AultCare supports electronic exchange of eligibility, claims status, healthcare payment/advice and claims transactions for providers**
  - Real-time 270/271, 276/277
  - Batch 270/271, 276/277, 835, and 837

- **Secure web portal**
  - Usage / functionality includes:
    - Eligibility and benefit information
    - Claim Submission & Claim Status inquiry
    - Claim Payment via EFT & ERA
    - Provider education/communication
AultCare: Systems Interoperability

**Integrated Processing**

1. PCS system supports HIPAA transaction submissions and acknowledgments. These are CORE-certified transactions. The system is a CORE-certified vendor product.

2. The PCS system is updated daily from the Data Warehouse, including eligibility, claims, accumulators and plan information.

3. The TriZetto QicLink™ system updates the Data Warehouse.

4. Trading Partners (Providers, Clearinghouses, etc.) can access the PCS system for HIPAA transactions.

5. A testing environment is also available to assist with adoption.

6. Higher level information is available through our Web Portal. It is our plan to make calls for HIPAA transactions from the Web Portal to the PCS system to further simplify the process.
AultCare: Trading Partner Relationships

- AultCare exchanges ASC X12 transactions with both clearinghouses and provider direct submitters in a variety of ways, e.g.,
  - Provider direct-to-health plan connection
  - Clearinghouse-to-health plan connection
  - Health plan-to-provider
  - Health plan-to-financial institution
  - Health plan-to-clearinghouse

- The bulk of our transactions are received from clearinghouses and several direct connects with high volume providers
Implementing CAQH CORE Operating Rules

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

**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.

Each of the above tools can be found in the CAQH CORE *Analysis & Planning Guide*. 

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AultCare: Key Implementation Considerations

**IT Perfection** - nothing is perfect, yet we want it to be, and strive for it

- Project Approach – tackle operating rules bit by bit and develop momentum
- Technology
  - Build or Buy
  - Relationships with source systems
    - Data Warehouse
    - Claims System
    - TXN System
  - Data extraction and transfer
    - System contentions
    - Plan Design capture
    - Eligibility combinations
    - Claim Status combinations
- Regulatory Compliance Impacts, i.e. ICD-10
AultCare: Our Approach

Determine your key competencies; do what you’re good at; depend on others for the rest!

- Enlisted 3rd party vendor to provide infrastructure services
  - Web portal
  - CORE-certified vendor
- Outsourced data content programming to system experts
  - Benefit plans
  - Accumulators
  - Claims status
- Insourced data mapping, file exchanges, & testing
- Pursued Phase I and Phase II Voluntary CORE Certification
- Actively engaged Trading Partners to adopt
AultCare: Our Keys to Success

• Know your systems, Know your data, Know your competencies
• Plan, plan, plan
  – Conceptual design
  – Trading partner impacts
  – Provisioning
  – System limitations
• Test, Test, Test
  – Internal Systems
  – Trading Partner Integration
• Early and Often - Involve your providers, clearinghouses and vendors
• Keep It Simple for your trading partners to promote adoption
  – Assist with testing and training
  – Communicate
  – Make it business critical!
AultCare: Implementation Benefits Realized

• Operational Efficiency and Effectiveness
  – Uptake
    • Double digit year-over-year rates of increase in electronic eligibility transaction utilization
    • Call volume reductions
  – One Source of Truth
    • Members, providers, customer service
  – Turn-around time
    • Inquiries
    • Payments
  – Reduced cost

• Business Critical System
  – Trading Partners

• Looked to as technology leaders meeting the information exchange needs of providers, members and the community
AultCare: Health Plan and Provider Collaboration

• It’s a value-add for vertically integrated health systems; as both an insurer and a provider, CAQH CORE Operating Rules serve as localized internal guidelines

• Local uptake drives industry-wide adoption
  – Conducted research and gathered information about provider needs through convening a provider user group
  – A publicity campaign combined with ongoing provider communication increased overall awareness
  – Our MSO (Management Service Organization) helped drive provider adoption
  – We saw vendors/clearinghouses becoming CORE-certiﬁed in response to end-user requests to adopt the CAQH CORE Operating Rules

• An active ‘Provider Advisory Group’ was critical
  – Technically Savvy
  – Multi-disciplinary
  – Relentless; helping to drive electronic adoption of future administrative transactions (e.g., 835)
AultCare: Future Plans & Suggestions

• Start Now!

• January 2013 federal mandated deadline for Eligibility and Claim Status Operating Rules Readiness
  – Supporting our PPO and non-PPO providers by continuing to develop awareness of the need to work with practice management system vendors to ensure product compliance; encourage *voluntary* CORE Product Certification

• Next set of mandates: EFT/ERA
  – AultCare is conducting its *Gap Analysis* assessment against the CAQH CORE EFT and ERA Operating Rules
  – Requires significant communication and testing with providers
  – Providers will need to change their posting process; This is HUGE!
  – Everybody wins, health plans more so!

• Web Integration
  – Support direct inquiries to our PCS system by members, providers, and clients
  – Reduce the cost of entry for certain provider groups
  – Enhance adoption
Question & Answer