CAQH CORE 360 Uniform Use of CARCs and RARCs Rule:
A Health Plan Success Story!

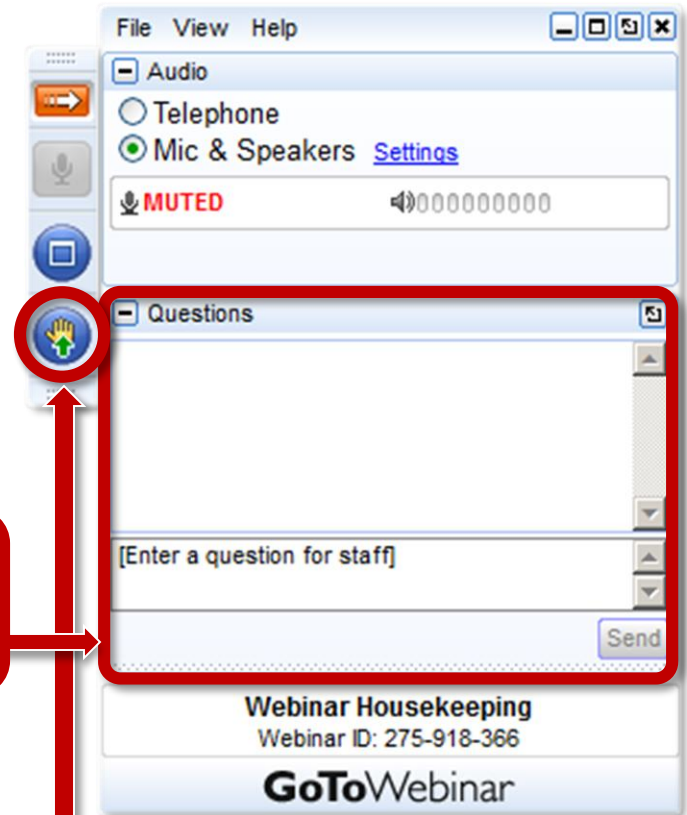July 16, 2014
2:00 pm – 3:30 pm ET

Additional information/resources available at www.caqh.org

Participating in Today's Session

- Download a copy of today's presentation on the CAQH.org website
  - Navigate to the CORE Education Events page and access a pdf version of today's presentation under the list for today's event
- The phones will be muted upon entry and during the presentation portion of the session
- At any time throughout the session, you may communicate a question via the web
  - Submit your questions on-line *at any time* by entering them into the **Q&A panel on the right-hand side of the GoToWebinar desktop**
  - On-line questions will be addressed first
- There will be an opportunity today to submit questions using the telephone
  - **When directed by the moderator**, **press the "raise hand" button** to join the queue for audio questions

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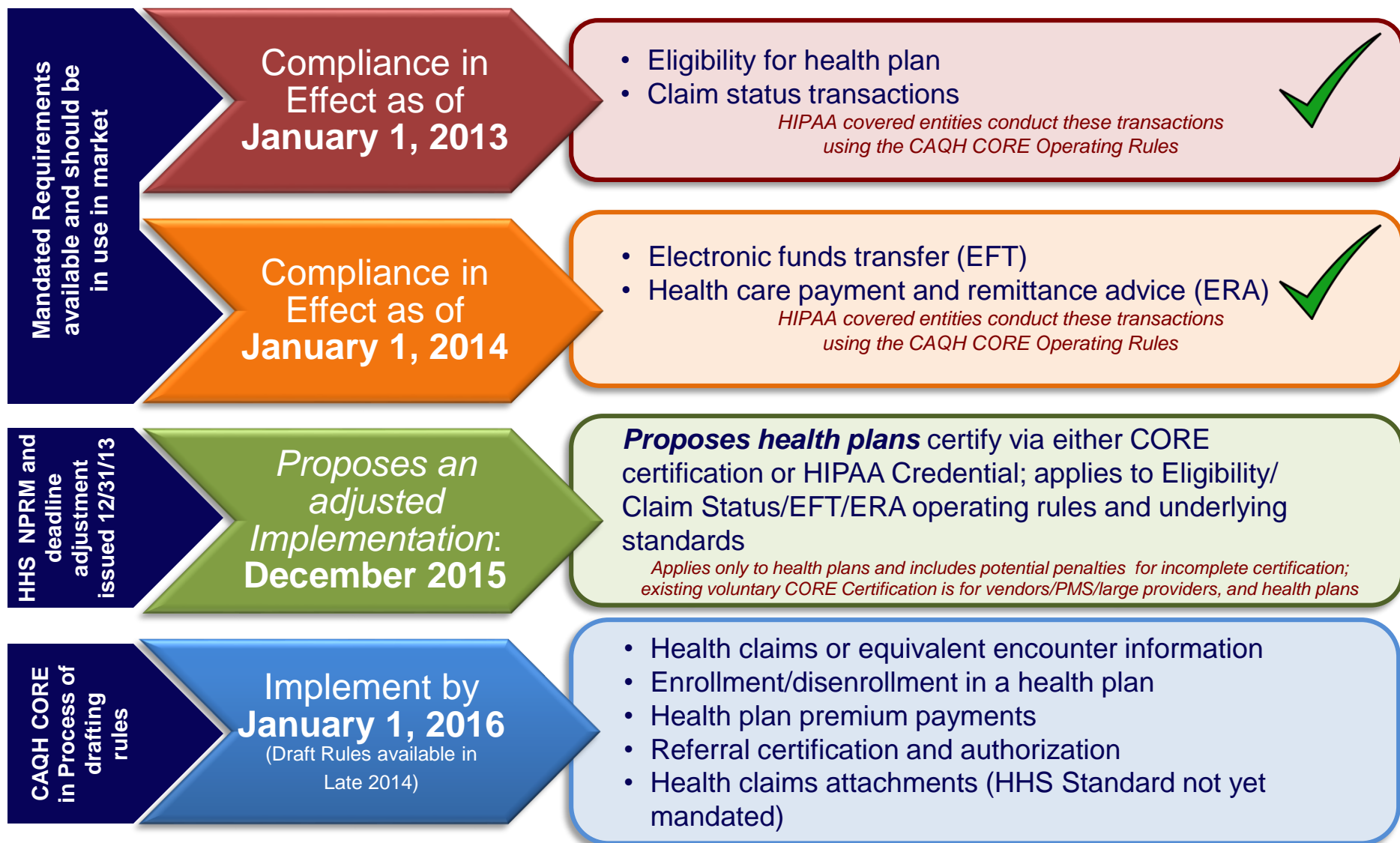
2

Session Topics

- **Welcome Introduction**

- **ACA Mandate and HHS Health Plan Certification NPRM**
  - Update on Draft HIPAA Credential Forms

- **CAQH CORE 360 Rule: Uniform Use of CARCs and RARCs**
  - Brief Overview
  - Maintenance Process Update

- **Health Plan Implementation Perspective - Cigna**
  - Guest Speakers **Marci Maisano** and **Ana Isabella**

- **Available CAQH CORE Implementation Resources**

- **Q&A**

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ACA Mandate and HHS Health Plan Certification

Scope and Updates

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Scope: ACA Mandated Operating Rules and Certification Compliance Dates

Mandated Requirements available and should be in use in market

Compliance in Effect as of January 1, 2013

- Eligibility for health plan
- Claim status transactions

  HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules ✓

Compliance in Effect as of January 1, 2014

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

  HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules

HHS NPRM and deadline adjustment issued 12/31/13

Proposes an adjusted Implementation: December 2015

Proposes health plans certify via either CORE certification or HIPAA Credential; applies to Eligibility/ Claim Status/EFT/ERA operating rules and underlying standards

Applies only to health plans and includes potential penalties for incomplete certification; existing voluntary CORE Certification is for vendors/PMS/large providers, and health plans

CAQH CORE in Process of drafting rules

Implement by January 1, 2016
(Draft Rules available in Late 2014)

- Health claims or equivalent encounter information
- Enrollment/disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments (HHS Standard not yet mandated)

Who Must Comply with Standards and Operating Rules?
Required of All HIPAA Covered Entities[1]

- ACA Section 1104 mandates that all HIPAA covered entities comply with *healthcare operating rules*; additional guidance on HIPAA covered entity designations may be found [HERE](#)

- HIPAA Administrative Simplification standards, requirements and implementation specifications apply to[2]:
  - Healthcare Providers: *Any person or organization who furnishes, bills, or is paid for healthcare in the normal course of business[3]*
    - Covered **ONLY** if they transmit protected health information electronically (directly or through a business associate) in connection with a transaction covered by the HIPAA Transaction Rule[2]
    - Examples include but are not limited to: Doctors, Clinics, Psychologists, Dentists, Chiropractors, Nursing Homes, and Pharmacies
  - Health Plans *(including Self-insured and Group Health Plans, Long-term Care, Medicare, Medicaid, etc.)*
  - Healthcare Clearinghouses

[1] [Understanding HIPAA Privacy: For Covered Entities and Business Associates](#)
[2] [HIPAA Administrative Simplification](#): 45 CFR §§ 160.102, 164.500
[3] [HIPAA Administrative Simplification](#): 45 CFR § 160.103

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HHS NPRM on Health Plan Certification
Background

- Level-set Definitions
  - **Controlling health plan** (CHP, definition from HPID regulation 45 CFR 162.103) a health plan that controls its own business activities and policies, or is controlled by an entity that is not a health plan
  - **Subhealth plans** (SHPs) A health plan whose business activities, actions or policies are directed by a CHP
- **ACA Administrative Simplification: Certification of Compliance for Health Plans**
  - Mandated under the Affordable Care Act (ACA), Section 1104
  - Although compliance with the Standards and Operating Rules is required of all HIPAA-covered entities, *certification of compliance is only required of Controlling Health Plans (CHP)*
    - See Appendix for comparison between enforcement and associated penalties that *currently* apply to all HIPAA covered entities for standards and operating rules, and the additional certification penalty that will apply to health plans
  - First Federal regulation on certification of entities that conduct administrative transactions; NPRM indicates that program will evolve over time
  - Penalty-driven using snapshot of time

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HHS NPRM on Health Plan Certification
Background cont'd

- **Notice of Proposed Rule Making (NPRM)** published in *Federal Register*, December 31, 2013. Comment period ended April 3, 2014 (see comments: www.regulations.gov)
  - Proposed requirement of health plan certification, and reporting number of covered lives, required by December 31, 2015

NPRM Proposed Certification Options

CAQH CORE Phase III Certification Seal

OR

HIPAA Credential

- Includes Seals for Phases I and II
- Involves Testing with Independent Testing Entity
- Part of the established Voluntary CORE Certification Process

- Requirements outlined in NPRM
- Includes Attestation-based documents
- Process and actual documents are in development by CAQH CORE

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CAQH CORE 360 Rule:

Uniform Use of CARCs and RARCs

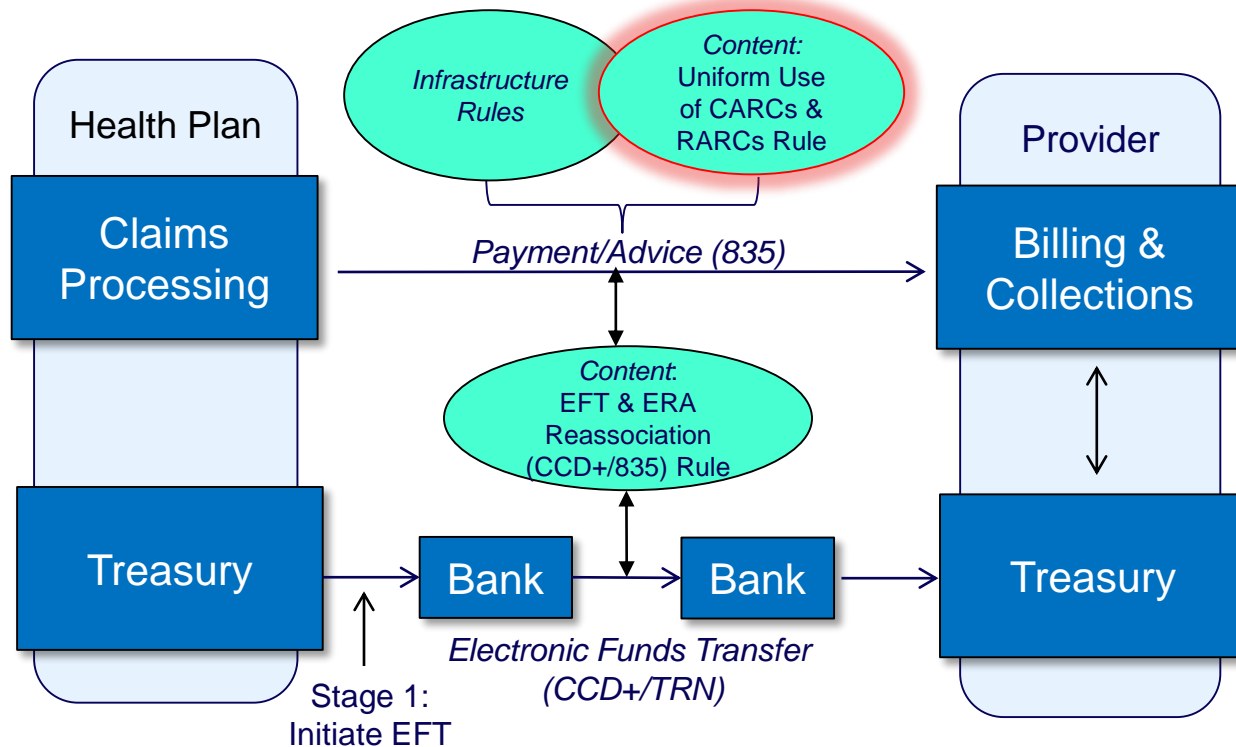# EFT & ERA Operating Rules:
Rules in Action

Pre- Payment: Provider Enrollment

EFT Enrollment Data Rule

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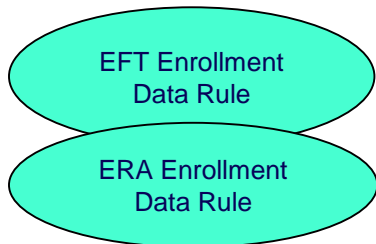
Content: Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation

Claims Payment Process

Infrastructure Rules

Content: Uniform Use of CARCs & RARCs Rule

Health Plan

Claims Processing

Payment/Advice (835)

Provider

Billing & Collections

Content: EFT & ERA Reassociation (CCD+/835) Rule

Treasury

Bank

Bank

Treasury

Electronic Funds Transfer (CCD+/TRN)

Stage 1: Initiate EFT

Infrastructure Rules

Standard Companion Guides

Real-time and Batch Response Times

Internet Connectivity and Security

Increased System Availability

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CORE 360 Rule: Uniform Use of CARCs and RARCs
Scope & High-level Rule Requirements

- Foundational requirements
  - HIPAA covered entities should currently support the X12 v5010 835 transaction

- Scope of the rule
  - Applies to entities that use, conduct or process the X12 v5010 835 transaction
    - Builds on your *existing* X12 v5010 835 implementation bringing consistency and uniformity by establishing uniform business scenarios and code combinations

- High-level rule requirements
  - Identifies *minimum* set of four CORE-defined Business Scenarios with a *maximum* set of code combinations to convey claim denial/adjustment details (codes in separate document)
  - Establishes quality improvement maintenance process to review and update the *CORE Code Combinations*
  - Enables health plans and PBM agents to:
    - Use new/modified codes with CORE-defined Business Scenarios prior to CAQH CORE Compliance-based Review
    - Develop additional, non-conflicting business scenarios when CORE-defined Business Scenario do not meet business needs
  - Requires receivers of the X12 v5010 835 (e.g., a vendor's provider-facing system or solution) to make available to the end user (i.e. the provider) text describing the CARC/RARC/CAGCs included in the remittance advice and text describing the corresponding CORE-defined Business Scenario
  - Identifies applicable CORE-defined Business Scenarios for retail pharmacy

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CORE 360 Rule: Uniform Use of CARCs and RARCs
Four Business Scenarios

Pre-CORE Rules

| 244 CARCs | ✖ | 812 RARCs | ✖ | 4 CAGCs | = | Inconsistent Use of Tens of Thousands of Potential Code Combinations |
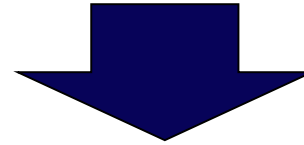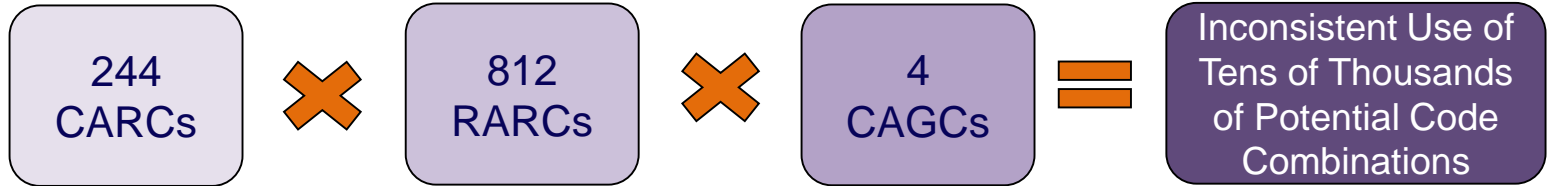
Post CORE Rules

Four Common Business Scenarios

CORE Business Scenario #1:
Additional Information Required – Missing/Invalid/ Incomplete Documentation
(414 code combos)

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

CORE Business Scenario #3:
Billed Service Not Covered by Health Plan
(645 code combos)

CORE Business Scenario #4:
Benefit for Billed Service Not Separately Payable
(60 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios

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CARCs and RARCs Code List Maintenance
External to CAQH CORE

As the recognized Federal standard/code authors, Code Maintenance Committees and ASC X12 are responsible for maintaining CARC/RARC/CAGC definitions and meet in-person on a tri-annual basis. Adjustments to the definition of such codes must be addressed via the specific author. All adjustments will be published by Washington Publishing Company (WPC) on their website three times per year.

CARCs
(CARC Code Committee)

- Total # of CARCs: **244**
  - not all in *CORE Code Combinations*
- There are approximately 35 CARC Committee members representing a variety of stakeholder including health plans, associations, vendors, and government entities
- Entities can complete the CARC Change Request Form found HERE*

RARCs
(RARC Code Committee)

- Total # of RARCs: **812**
  - not all in *CORE Code Combinations*
- The RARC Committee members represent various components of CMS
- Entities can complete the RARC Change Request Form found HERE

CAGCs
(ASC X12)

- Total # of CAGCs: **4**
  - All are in *CORE Code Combinations*
- Part of the ASC X12 standard, therefore, **can *only* be revised when a new HIPAA mandated version of X12 standards is issued**; current version is ASC X12 v5010
- Entities can submit a request to ASC X12

*Before submitting a CARC Change Request Form, entities are first encouraged by the Committee to contact a member of the committee to "*facilitate their request by allowing someone familiar with the approval process to discuss an alternate solution (if appropriate) for their need, or enabling that committee member to obtain additional background information which could help with the request*". Committee list is available HERE.

CAQH CORE Code Combinations Maintenance Process

CORE Business Scenario #1:
Additional Information Required – Missing/Invalid/ Incomplete Documentation
(414 code combos)

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

CORE Business Scenario #3:
Billed Service Not Covered by Health Plan
(645 code combos)

CORE Business Scenario #4:
Benefit for Billed Service Not Separately Payable
(60 code combos)

CAQH CORE Compliance-based Reviews

Stability of *CORE Code Combinations* maintained

- Occur 3x per year
- Triggered by tri-annual updates to the published CARC/RARC lists by code authors
- Include only adjustments to code combinations to align with the published code list updates (e.g. additions, modifications, deactivations)

CAQH CORE Market-based Reviews
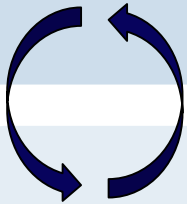
Supports ongoing improvement of the *CORE Code Combinations*

- Occur 1x per year
- Considers industry submissions for adjustments to the *CORE Code Combinations based on business needs* (addition/removal of code combinations and potential new Business Scenarios)
- *Opportunity to refine the CORE Code Combinations as necessary to ensure the CORE Code Combinations* reflect industry usage and evolving business needs

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Uniform Use of CARCs and RARCs Rule

Operating Rule Maintenance

Maintenance: Uniform Use of CARCs and RARCs Rule *CORE Code Combinations Task Group (CCTG)*

- Composed of more than 40 CAQH CORE Participating Organizations from a wide variety of stakeholders; led by four multi-stakeholder Co-Chairs:
  - Shannon Baber, *UW Medicine*
  - Janice Cunningham, *RelayHealth*
  - Heather Morgan, *Aetna*
  - David DuBay, *UnitedHealth Group*

- Conducts three Compliance-based Reviews (CBR) and one Market-based Review (MBR) per year

  - **Recent Compliance-based Review Work**
    - Successfully met deadlines for Completion of all three Compliance-based Reviews for 2013
    - Completed Compliance-based Review for code adjustments published by WPC on **March 1, 2014**
    - In the process of launching the next CBR based on the latest code sets published **July 1, 2014**
      - This is a minor update as there are only a few modifications and new codes to consider.
      - Dates for these calls have not been finalized; more information to come

  - **Recent Market-based Review Work**
    - Completed first annual MBR which was launched on **December 13, 2013**

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Maintenance: Uniform Use of CARCs and RARCs Rule
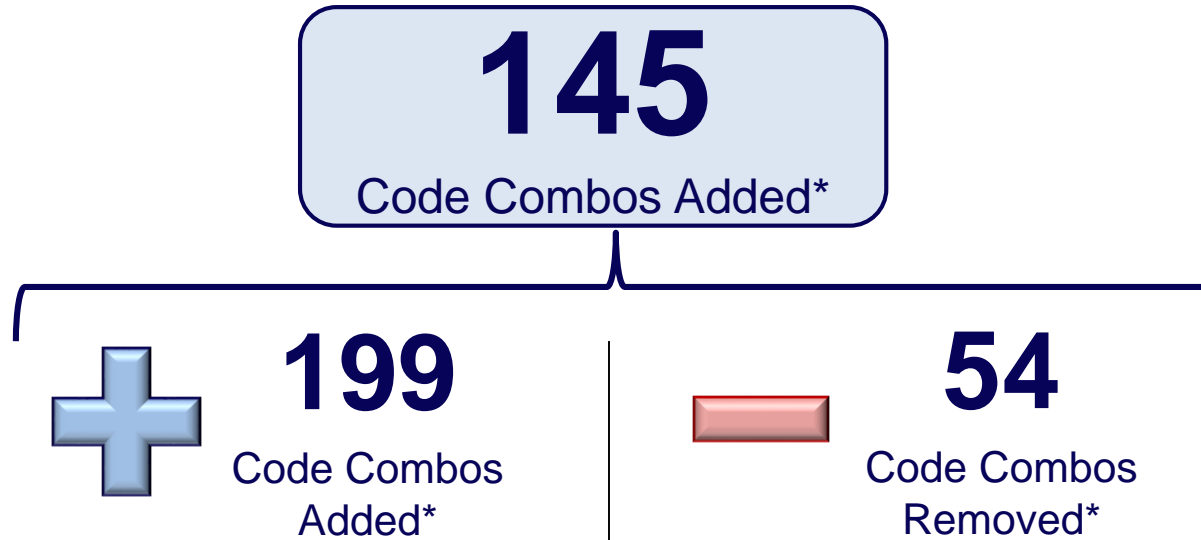## *Updated CORE Code Combination List (v3.1.1)*

- CAQH CORE has updated the *June Code Combination List v3.1.0* (released last month) based on four minor adjustments made to the 2013 MBR. These additions include:
  - **Addition** of CAGC PR to CARC 165 (standalone) and to CARC 165 with RARC N630 in CORE-defined Business Scenario #3
  - **Addition** of CAGC PR to CARC 10 (standalone) and to CARC 10 with RARC N657 in CORE-defined Business Scenario #3

- This new *July CORE Code Combination List (v3.1.1)** was released on **July 2nd** and is now available on our Website

Compliance-based Review
CBR for code adjustments published by WPC on **March 1, 2014**

Market-based Review
Launched on **December 13, 2013**

July 2014 v3.1.1
CORE Code Combination List

Adjustments to MBR
Including the four additions outlined above

*A marked-up version of the *July 2014 CORE Code Combinations* showing both Compliance-based and Market-based Adjustments between v.3.0.4 and v.3.1.1 is available HERE. The Change Log in the second tab of the *CORE Code Combinations* provides a list of all adjustments made to the *CORE Code Combinations*.

Maintenance: Uniform Use of CARCs and RARCs Rule
CORE Code Combinations v3.1.1 Overview

Summary of Adjustments in the Current Version of the *CORE Code Combinations*

145
Code Combos Added*

+ 199
Code Combos
Added*

– 54
Code Combos
Removed*

Version 3.1.1 of the *CORE Code Combinations* includes updates based on:

- **Compliance-based adjustments** as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of March 2014

- **Market Based Adjustments** due to 2013 Market-based Review
  - Including four additional adjustments outlined in previous slide

- **Emergency Code Combination Additions Requests** approved in 2014 (4 total)

*These totals include 10 Code Combinations that were removed from one Business Scenario and added to another due to the MBR

Maintenance: Uniform Use of CARCs and RARCs Rule
Compliance-based Adjustments

March 2014 Compliance-based Review Process and Scope:

- As the recognized Federal standard/code authors, Code Maintenance Committees and ASC X12 are responsible for maintaining CARC/RARC/CAGC definitions and publish updated CARC/RARC/CAGC lists on a tri-annual basis
- In March 2014 updated versions of these lists were published and included Code modifications, deactivations and additions
- The publication of these lists triggers the Compliance-based Review for the *CORE Code Combinati*ons

Overview of *CORE Code Combination* Updates based on March CBR:

Business Scenario #1	Business Scenario #2	Business Scenario #3	Business Scenario #4
17	**12**	**7**	**1**
RARC Description Modifications	RARC Description Modifications	RARC Description Modifications	RARC Description Modifications
59	**1**	**11**	**1**
RARCs Added	RARC Added	RARCs Added	RARC Added
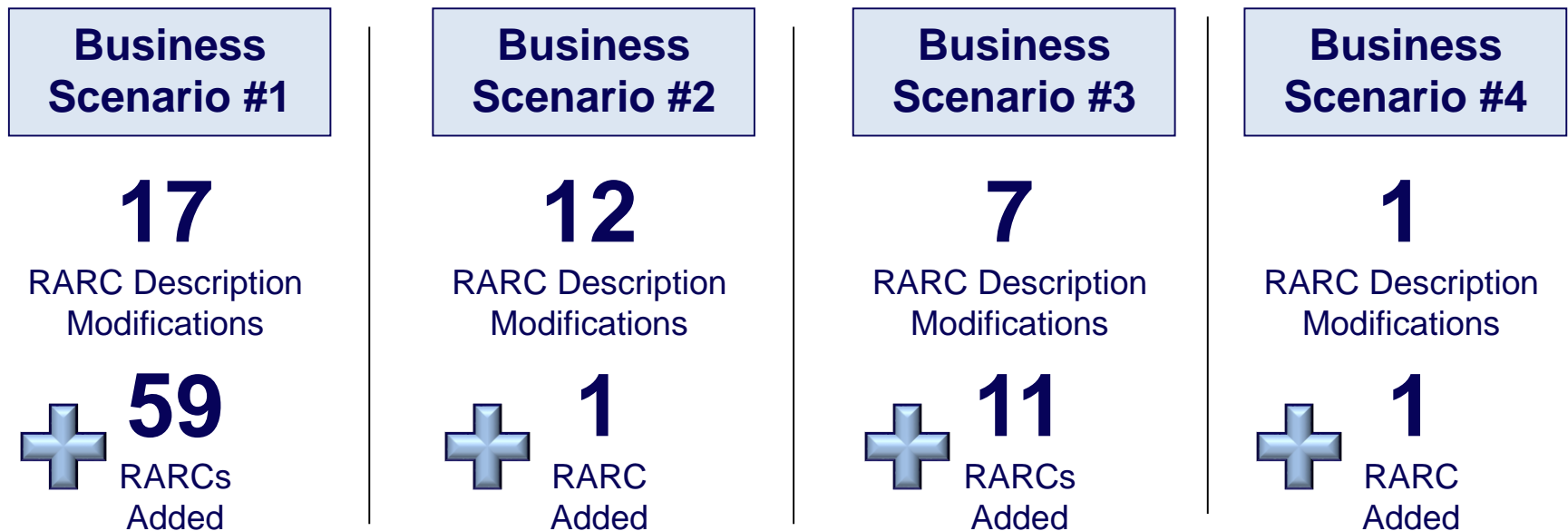
Maintenance*: Uniform Use of CARCs and RARCs Rule*
First Market-based Review Adjustments

2013 Market-based Review Process and Scope:

- In December 2013 CAQH CORE initiated a 60 day public period during which industry submissions addressing code combination additions and removals to the existing *CORE Code Combinations* for existing CORE-defined Business Scenarios could be submitted

- This was the first Market-based Review conducted since Federal mandate

Overview of MBR Submissions Received:

- A total of **1,181 submissions** for additions/removals were received

- Of the 1,181 total submissions received, there were **437 unique requests** for additions/removals

- Of the 437 unique requests, there were **80 unique CARCs** to be considered for adjustments

MBR Code Combination Adjustments:

134
Code Combos
Added

54
Code Combos
Removed

Maintenance: Uniform Use of CARCs and RARCs Rule
Compliance and Resources

Updated Version of the *CORE Code Combinations*	**Compliance Date** (Applies as of January 1, 2014 to all HIPAA-covered Entities)
July 2014 v3.1.1 (released July 2nd)	**October 2, 2014**

HIPAA covered entities have **90 days** from the date of publication of an updated version of the *CORE Code Combinations* until compliance with that version is required; any outlier deadlines set by Code Committees, e.g. code isn't deactivated for 180 days, are addressed in CORE policy

Available Resources

- For more information please visit CAQH CORE's dedicated webpage for CAQH CORE 360 Rule and the Code Combinations Maintenance Process

  - You can access and download the July CORE Code Combinations List v3.1.1 on this webpage

    - In addition to current announcements, future versions of the *CORE Code Combinations* will also be announced on the webpage and deprecated versions will be available for reference

  - Entities may email core@caqh.org to request a marked-up version of the *CORE Code Combinations* that highlights adjustments made between versions

Polling Question:
CORE Code Combination Updates

Does your organization currently have a consistent process in place to adjust internal CARC and RARC coding based on the CORE Code Combination updates that occur three times a year?

1. Yes

2. No

3. Not sure

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CAQH CORE 360 RULE: UNIFORM USE OF CARCs & RARCs

Cigna's Implementation

Marci Maisano
Ana Isabella
Cigna

GO YOU.

ABOUT Cigna

Go deep   Go global   Go individual

Diversified Product Portfolio

About Cigna – Global

Cigna (NYSE: CI) is a global health service company dedicated to helping people improve their health, well-being and sense of security.

*All products and services are provided exclusively through operating subsidiaries of Cigna Corporation, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York.

*Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy and vision care benefits, and other related products including group disability, life, and accident coverage

*Cigna has sales capability in 30 countries and jurisdictions, with approximately 75 million customer relationships throughout the world.

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Cigna's role in Standards & Operating Rules development

Key Highlights

Participant in the CAQH CORE workgroup to draft the CORE Operating Rules and the CORE Code Combinations Task Group

Provided a technical review of the 835 at the NDEDIC (National Dental EDI Council) 2014 EDI Summit

Many different campaigns underway to increase adoption

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ERA & EFT Volumes

EFT:
- Percentage of total payments made Year to date: **61.29%**
- Total number of EFT payments made Year to date: **39,944,072**

ERA:
- Percentage of total Healthcare Professionals (HCP) Enrolled Year to Date: **37.59%**
- HCP Population Enrolled Year to Date: **89,772**

General Implementation considerations and challenges

Technology Background

Cigna Processes claims for many different products on nine different claim systems
- CARCs and RARCs were already being supported, but not always clearly mapped
- Each system has a set of proprietary codes they support with their own definitions for each code

Medical → Behavioral → Dental

Claim Engines

CARCs/RARCs
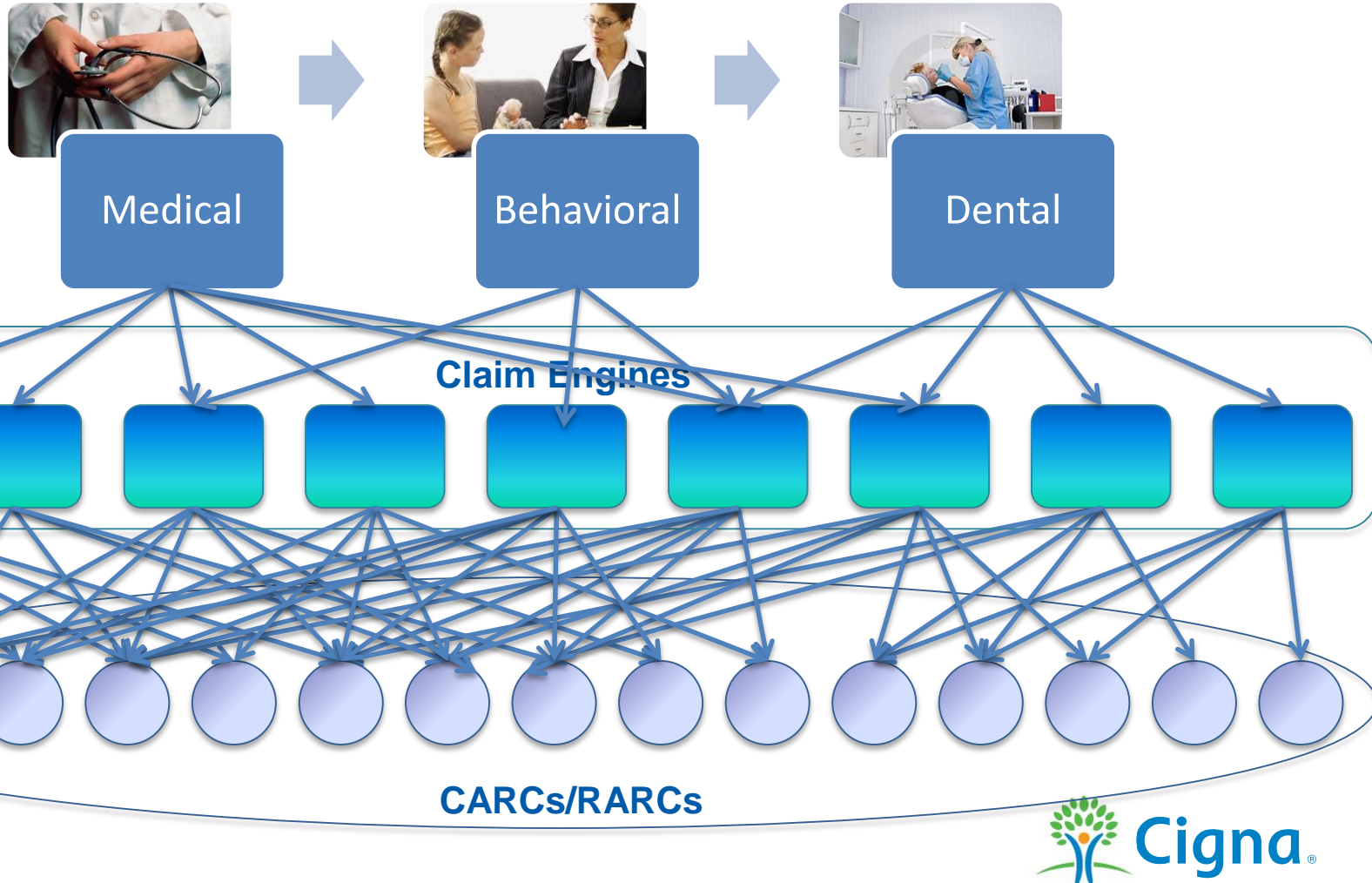
Resources

- Identify key resources within your organization
- Assign One point person to coordinate all efforts; keeps teams on task and organized (Project Manager).
- Understand each person's strengths
- We did not require IT resources as we already supported CARCs and RARCs
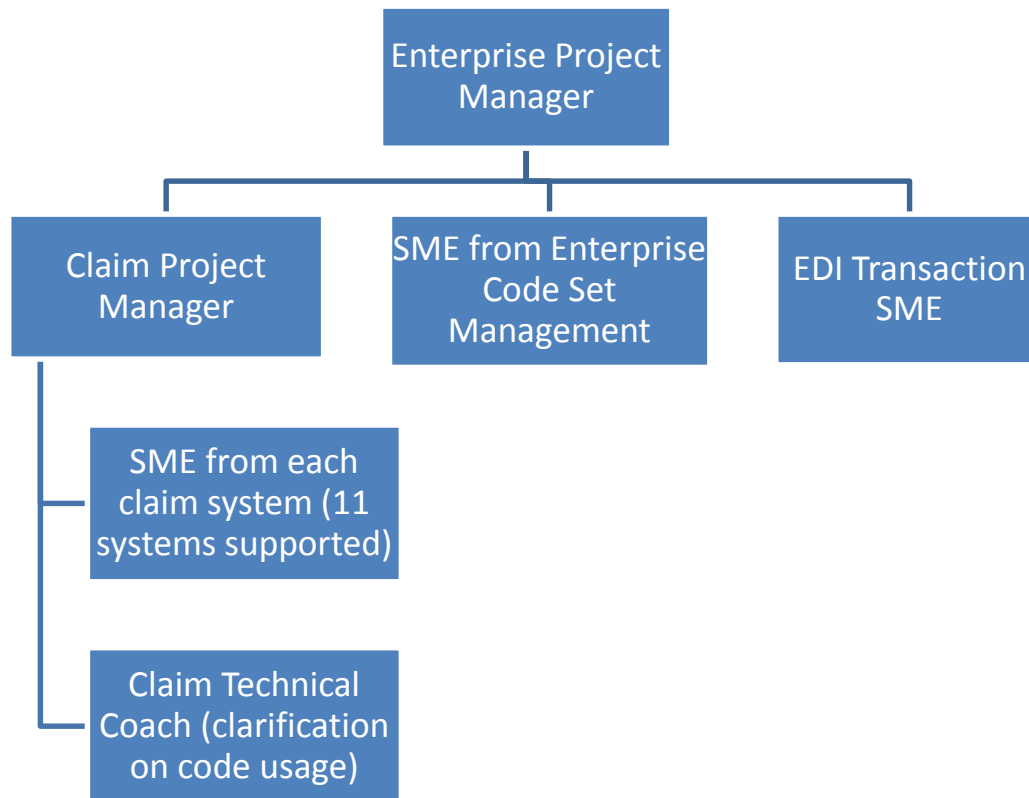
Implementation Steps

Implementation Process

- Created a Project Plan
- Created Mapping Templates
- Gathered SMEs who understand proprietary code sets
- Provided overview of CARC and RARC
- Gathered business scenarios to ensure clear understanding
- Reviewed every proprietary adjustment code across ever claim engine
- Based on scenarios mapped proprietary codes to CARC and RARC
- Loaded new maps into cross walks
- Audited maps to confirm the mapping matched scenarios and there were no CARCs missing a RARC where expected
- Implemented new CARC and RARC codes

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General Implementation considerations and challenges

Post Implementation

- Developed a Report of proprietary code to CARC and RARC and business scenario to monitor if changes are made
- Developed process for mapping when there is the creation of new proprietary codes
  - A new proprietary code is created
  - Review to see what scenario it matches
  - If it matches, map to the CARC and RARC
  - If it doesn't match a scenario there is a process for internal review
  - If we feel none of the CARC or RARC matches, created a process to request new code and add to the next CAQH Straw Poll

Challenges

- Time & Resources
  - Review of every proprietary code took a lot of time and dedicated resources to complete.
  - Solve: Dedicated so many hours a week to working on the review until completion. It did require management to identify this initiative as a priority.
- Various explanations for the same adjustment required clarification across claim systems
  - Solve: Claim processing coaches clarified usage for each claim engine.
  - Worked with Policy and Procedures to determine the correct explanation for the code.

Working with Trading Partners

We looked for input from our trading partners and health care professionals where we had opportunities to provide additional clarification

- Partners include:
  - Clearinghouses
  - Practice Management System
  - Third-party website
  - Health care professionals

Example: Cosmetic procedure claims were being explained as a plan policy denial. Remapped to a more specific cosmetic procedure denial

When a large number of changes are made, notifications are sent to our vendors to make them aware

We have a process with a large practice management system vendor to receive regular feedback to ensure mapping is clear

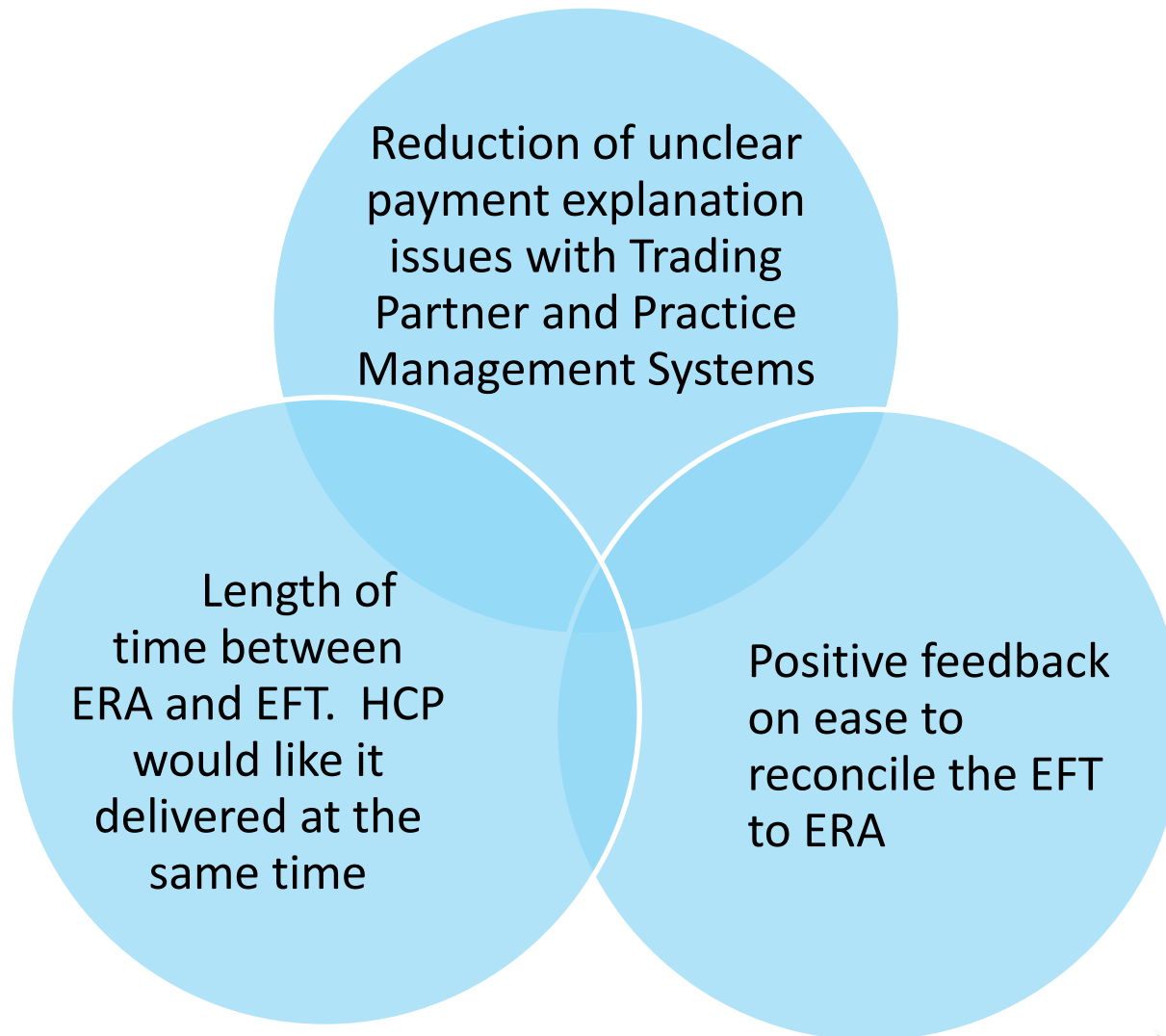Note: This work is ongoing. Recommend having a regular feedback process.

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Internal Code Maintenance Process

- A team is notified what the updates are and when codes are no longer being used
- The team works with our proprietary code SMEs as necessary to map to the scenarios
- Once the mapping is complete it is updated to the cross walk
- The cross walk is implemented

Healthcare Professional Feedback received since Implementation of EFT/ERA Operating Rules

Reduction of unclear payment explanation issues with Trading Partner and Practice Management Systems

Length of time between ERA and EFT. HCP would like it delivered at the same time

Positive feedback on ease to reconcile the EFT to ERA

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CAQH CORE EFT & ERA Operating Rules
Available CORE Resources

Voluntary CORE Certification

- Since its inception, CAQH CORE has offered a *voluntary* CORE Certification to health plans, vendors, clearinghouses, and providers
  - *Voluntary* CORE Certification provides verification that your IT system or product operates in accordance with the federally mandated Operating Rules
  - CORE Certification is stakeholder-specific
    - Each entity completes testing specific to their stakeholder type in order to become CORE Certified
  - **150 CORE Certifications** have been achieved with 22 Certifications currently pending. Access a list of these organizations HERE
- CAQH CORE Certification is available for the following transactions
  - Eligibility and Claim Status (Phase I and Phase II)
  - EFT and ERA (Phase III)
- Key Benefits
  - Provides all organizations across the trading partner network useful, accessible and relevant guidance in meeting obligations under the CAQH CORE Operating Rules
  - Encourages trading partners to work together on data flow and content needs
  - Offers vendors practical means for informing potential and current clients on which of their products – **by versions** - follow Operating Rules, including Practice Management Systems
  - Achieves maximum ROI because all entities in data exchange follow the Operating Rules; once CORE-certified need to follow Operating Rules with all trading partners
  - Means for voluntary enforcement dialog and steps

Note: Learn more about *voluntary* CORE Certification here

Promote Provider Adoption of EFT & ERA Operating Rules
Take Action Now!

Contact Your Health Plans!

- To benefit from new EFT and ERA mandates, ensure your provider organization has requested the transactions from its health plans and EFT & ERA Operating Rule implementation status
- To help facilitate this request, CAQH CORE developed the *Sample Provider EFT Request Letter*
- Providers can use this sample letter as template email or talking points with health plan contacts to request enrollment in EFT/ERA and benefits of operating rules
- The tool includes background on the benefits EFT, key steps for providers, an actual letter template, and glossary of key terms

Contact Your Banks!

- To maximize the benefits available through the CAQH CORE Reassociation Rule, providers must request delivery of the necessary data for EFT and ERA reassociation
- To help facilitate this request, CAQH CORE developed the *Sample Provider EFT Reassociation Data Request Letter*
- Providers can use this sample letter as template email or talking points with bank contacts to request delivery of the reassociation data
- The tool includes background on the benefits of the letter, key steps for providers, an actual letter template, and glossary of key terms

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Implementation Steps for HIPAA Covered Entities
EFT & ERA Tools and Resources

Free Tools and Resources Available

Education is key
Get executive buy-in early

- Read the **CAQH CORE EFT & ERA Operating Rules**
- Listen to archive of past **CAQH CORE Education Sessions** or register to attend a future one
- Search the EFT & ERA **FAQs** for clarification on common questions
- Use our **Request Process** to Contact technical experts throughout implementation

Determine Scope of Project

- The **Analysis and Planning Guide** provides guidance to complete systems analysis and planning for implementation. Information attained from the use of this guide informs the impact of implementation, the resources necessary for implementation, as well as, what would be considered an efficient approach to, and timeline for, successful implementation.

Just Getting Started

↓

Analysis and Planning

↓

Systems Design

↓

Systems Implementation

↓

Integration & Testing

↓

Deployment/Maintenance

Engage Trading Partners Early and Often

- **Provider's**: Use the EFT/ERA **Sample Health Plan** and **Sample Financial Institution** Letters as a way to help facilitate the request to receive EFT from your health plans and the request for delivery of the necessary reassociation data elements from your financial institutions

TEST, TEST, TEST!

- Leverage **Voluntary CORE Certification** as a quality check, a way to test with partners, and as a way of communicating compliance to the industry and other trading partners

Get Involved with CAQH CORE

- **Join** as a Participant of CAQH CORE in order to give input on rule-writing maintenance by joining a task group and to stay up-to-date on implementation developments

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Examples: Get Involved!

- Any CORE Participating Organization can join any CORE group
  - If you are a CORE Participating Organization and would like to join one of these group calls, please email CORE@caqh.org
  - If you are not a CAQH CORE Participating Organization but would like more information on how to become one, please visit our website HERE

CORE Group	Current Group Focus	Frequency	Next Meeting
CORE Connectivity and Security Subgroup	Drafting the connectivity and related infrastructure options for Third Set of the ACA-mandated operating rules	Thursdays 2:30-4:00pm ET *bi-weekly*	**Thursday, July 17th** 2:30-4:00pm ET
EFT/ERA Enrollment Data Set Maintenance Task Group	Identifying and addressing any adjustments to the Enrollment Data Sets, and developing an ongoing annual maintenance process	Wednesdays 3:00-4:30pm ET *bi-weekly*	**Wednesday, July 23rd** 3:00-4:30pm ET
CORE Certification and Testing Subgroup	Reviewing and addressing industry feedback for the Draft HIPAA Credential Forms and creating	One call remaining	**Tuesday, August 5th** 2:00-3:30pm ET
CORE Code Combination Task Group (CCTG)	Compliance-based Review of the (currently unpublished) July CARC/RARC/CAGC code list updates	Cyclical based on CBR and MBR; at least six calls per cycle	See CARC/RARC page

Q&A

Please submit your question:

- <u>Via the Web</u>: Enter your question into the Q&A pane in the lower right hand corner of your screen
- <u>By Phone of VoIP</u>: When prompted for audio portion of Q&A, please press "Raise Hand" Button to queue up to ask a question

<u>**NOTE**</u>*: In order to ask a question during the audio portion of the Q&A please make sure that you have entered the **"Audio PIN"** (which is clearly identified on your user interface) by using your telephone keypad.*

Thank You for Joining Us!

website: www.CAQH.org

email: CORE@caqh.org

 @CAQH

APPENDIX

Additional Information and Resources

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Available NACHA Resources

- **Healthcare Payments Resources Website**
  - Provides a repository of information on a wide variety of topics for both financial institutions and the healthcare industry. Includes links to many other resources, as well as customized information to help "translate" concepts from one industry to the other (FAQs, reports, presentations).

- **Healthcare EFT Standard Information**
  - Located within the healthcare industry tab of the above website, specific information can be found on the healthcare EFT standard.

- **Healthcare Payments Resource Guide**
  - Publication designed to help financial institutions in implementing healthcare solutions. It give the reader a basic understanding of the complexities of the healthcare industry, identify key terms, review recent healthcare legislation, and discuss potential impacts on the financial services industry.
  - Order from the NACHA eStore "Healthcare Payments" section

- **Revised ACH Primer for Healthcare Payments**
  - A guide to understanding EFT payment processing. Introduces the healthcare industry to the Automated Clearing House (ACH) Network, explains ACH transaction flow and applications, and includes two "next steps checklists," one each for origination and receipt.

- Ongoing Education and Webinars
  - Check the Healthcare Payments Resource Website for "Events and Education"

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Available CMS OESS Resources

- [HIPAA Covered Entity Charts](#)
  - Use the HIPAA Covered Entity Charts to determine whether your organization is a HIPAA covered entity

- [CMS FAQs](#)
  - Frequently asked questions about the ACA, operating rules, and other topics

- [Affordable Care Act Updates](#)
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules

- [CMS eHealth University](#)
  - [What Administrative Simplification Does For You](#) – This fact sheet explains the basics behind how Administrative Simplification will help improve health care efficiency and lower costs
  - [Introduction to Administrative Simplification](#) – This guide gives an overview of Administrative Simplification initiatives and their purposes
  - [Introduction to Administrative Simplification: Operating Rules](#) – A short video with information on Administrative Simplification operating rules

- Additional Questions
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov

Relationship between Ongoing HIPAA Enforcement and HHS Health Plan Certification

The complaint-driven HIPAA Enforcement Process is an established and existing program that will be maintained *in addition to* the HHS Health Plan Certification program; the two programs are complementary

	Complaint-Driven HIPAA Enforcement Process	**Proposed HHS Health Plan Certification of Compliance**
Applicable Entities	All HIPAA covered entities	Health plans
Action Required	Implement CAQH CORE Eligibility & Claim Status and EFT & ERA Operating Rules, and applicable Standards	File statement with HHS that demonstrates health plan has obtained a CAQH CORE Certification Seal for Phase III or HIPAA Credential and thus are in compliance with the standards and operating rules
Compliance Date	*First Set* – **January 1, 2013** *Second Set* – **January 1, 2014**	**December 31, 2015** (proposed)
Applicable Penalties	Due to HITECH, penalties for HIPAA non-compliance have increased, now up to **$1.5 million per entity per year**	Fee amount equals **$1 per covered life until certification is complete**; penalties cannot exceed $20 per covered life or $40 per covered life (for deliberate misrepresentation) on an annual basis
Verification of Compliance	***Ongoing*** complaint-driven process to monitor compliance prompted by anyone filing a complaint via CMS's Administrative Simplification Enforcement Tool (ASET) for non-compliance with the standards and/or operating rules	"***Snapshot***" of health plan compliance based on when the health plan obtains CORE Certification/HIPAA Credential and files statement with HHS

Example of complementary nature of HIPAA Enforcement Process and Proposed HHS Health Plan Certification:
An entity could file a complaint for non-compliance against an HHS-certified Health Plan using the HIPAA Enforcement Process if they believe the Health Plan has fallen out of compliance since their certification (e.g. A certified Health Plan acquires another non-compliant Health Plan).

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