simplifying healthcare administration

CAQH®

CAQH CORE National Webinar

Benefiting from CAQH CORE Operating Rules: *A Provider-facing Vendor's Tips for Practices, Clinics and Hospitals*

CORE®

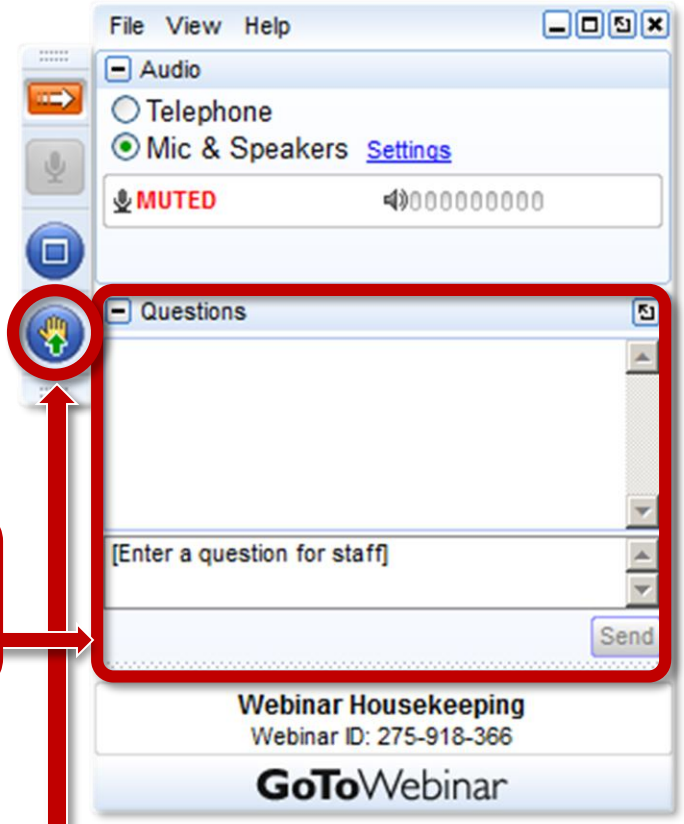
Committee on Operating Rules for Information Exchange

A CAQH Initiative

August 12, 2014
1:30 – 3:00pm ET

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



CORE
Committee on Operating Rules for Information Exchange
A CAQH Initiative

Session Topics

- Welcome Introduction
- ACA Mandate and HHS Health Plan Certification NPRM
- CAQH CORE EFT & ERA Operating Rules
  - Scope
  - Rule Requirements and Benefits
  - Tips and Best Practices for Providers
- EFT & ERA Operating Rule Implementation – *A Provider-facing Vendor's Perspective*
  - Special Guest Speaker from **NextGen Healthcare**
- Available CAQH CORE Implementation Resources
- Q&A

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

HHS NPRM on Health Plan Certification
Background

- **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

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

OR

HIPAA Credential*

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

*May be adjusted pending final rule

CAQH CORE EFT & ERA Operating Rules

Scope and Key Rule Requirements

How Will Operating Rules Benefit Providers?
EFT & ERA Operating Rules

The ACA mandated EFT & ERA Operating Rules ensure more streamlined provider enrollment and processing of the EFT & ERA transactions

- **Key Benefits**
  - ***Standardized electronic enrollment for EFT/ERA***: Providers are able to enroll in both EFT and ERA electronically with all health plans using a consistent set of data elements
  - ***Potential reduction in manual claim rework***: With health plans more consistently using denial and adjustments codes per the CORE-defined Business Scenarios, providers will have less rework
  - ***Reduction in A/R days***: Automated and timely re-association of EFT and ERA leading to efficiencies and reduced errors for payment posting

- **Savings Estimate**
  - **Between $300 million and $3.3 billion over 10 years*** for providers, including hospitals and health systems, and health plans.

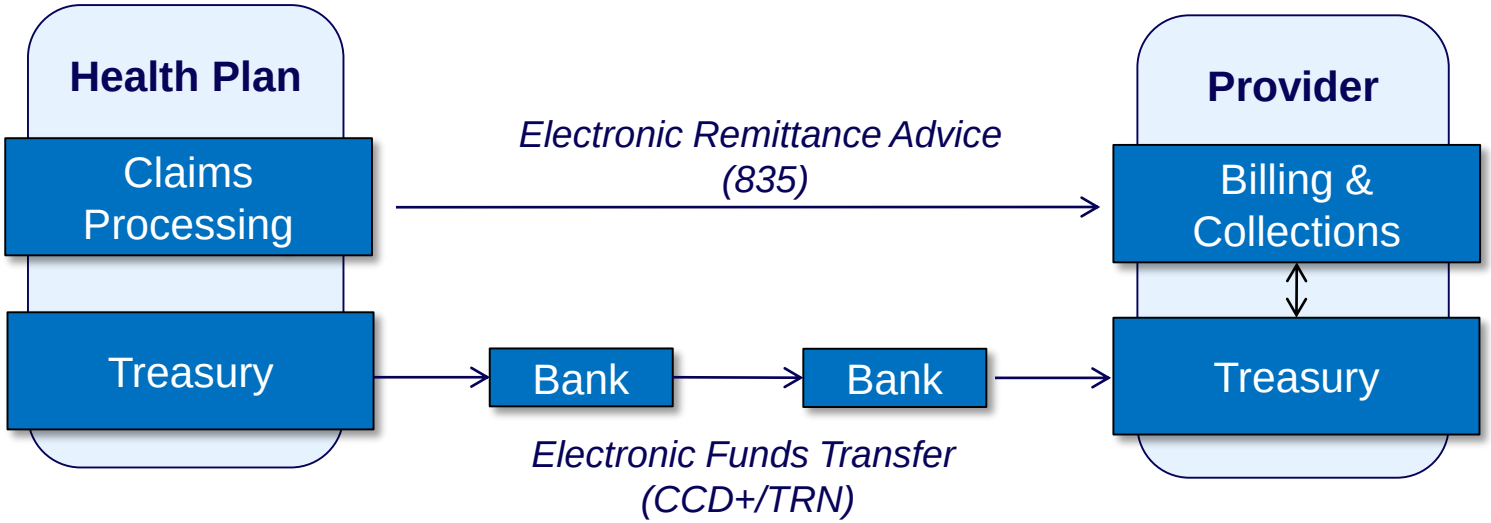
- **Timeframe**
  - Both the ACA-mandate and Medicare required compliance with the EFT Standard and the EFT & ERA Operating Rules by ***January 2014*** – Hospitals and Health Systems should work with their trading partners to achieve these benefits **NOW!**

***Note**: EFT Standard (ACH CCD+Addenda) is a industry-neutral standard that is now a HIPAA-mandated transaction standard*

* Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions

EFT and ERA Transaction Flow

- EFT and ERA Operating Rules represent the convergence of financial services and healthcare
  - Both transactions are sent using “recognized” electronic HIPAA standards
  - Aim is to increase adoption of both standards in healthcare
- Together the transactions foster the goals of administrative simplification by moving the process of reimbursement from paper to electronic
  - ERA is an electronic transaction that enables providers to receive claims payment information from health plans electronically; ERA files are intended to replace the paper Explanation of Payment (EOP)
  - EFT enables providers to receive payments from health plans electronically



Mandate EFT & ERA Operating Rules:
Phase III Rules in Action

Indicates where a CAQH CORE EFT/ERA Rule comes into play

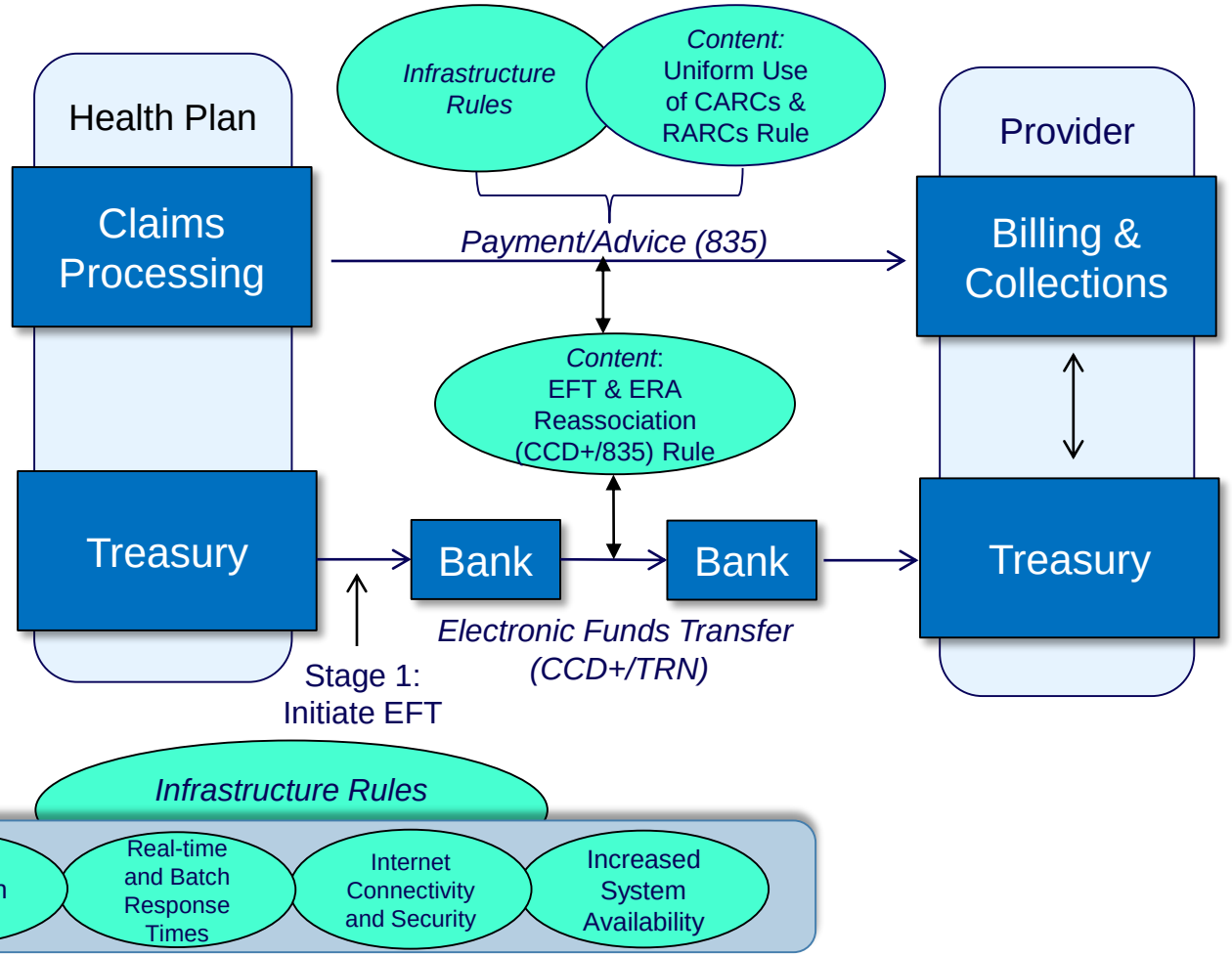
Pre- Payment: Provider Enrollment

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



Mandated EFT & ERA Operating Rules: *Requirements Scope*

Rule		High-Level Requirements
Data Content	***Uniform Use of CARCs and RARCs (835) Rule*** Claim Adjustment Reason Code (CARC) Remittance Advice Remark Code (RARC)	• Identifies a *minimum* set of four CAQH CORE-defined Business Scenarios with a *maximum* set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider
Infrastructure	***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. The complete Rule Set is available HERE.

CAQH CORE EFT & ERA Operating Rules:

Infrastructure Rule

CAQH CORE Claim Payment/Advice (835) Infrastructure Rule
Problem Addressed

HIPAA provides a foundation for the electronic exchange of claim payment information, but does not provide infrastructure to promote the move from today's paper-based system to an electronic, interoperable system

Health Care Claim Payment/Advice (835) Infrastructure Rule: Key Rule Requirements

Connectivity

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

Companion Guide

- Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides for 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[1]

- 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

[1] 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.

CAQH CORE Claim Payment/Advice (835) Infrastructure Rule
Key Impact and Benefits

- Enables providers, health plans and intermediaries to extend and leverage investment in connectivity infrastructure by requiring support of Phase II CAQH CORE Connectivity Rule
- Continues to build on Phase I/II use of CAQH CORE Master Companion Guide Template so that providers can quickly find details necessary for the exchange of the X12 v5010 835
- Reduces probability that providers will discontinue receipt of X12 v5010 835 due to system issues for effective use of remittance advice data to post to patient account

CAQH CORE EFT & ERA Operating Rules:

Reassociation (CCD+/835) Rule

CAQH CORE EFT & ERA Reassociation (CCD+/835) Rule

Problem Addressed

Challenges with provider reassociation of *remittance* data to *payment* data because necessary data provider requires are incorrect, missing, not available, or have not been requested on the two transactions in a way that is meaningful to the provider or its financial institution

EFT & ERA Reassociation (CCD+/835) Rule:
Three Key Rule Requirements

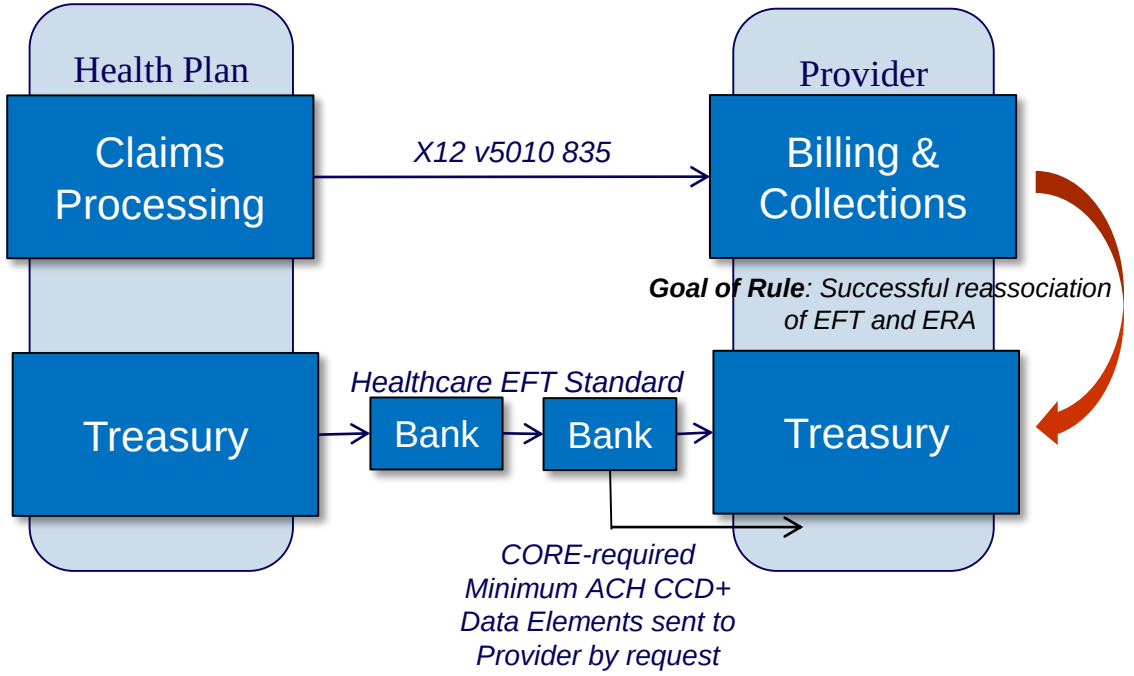
Pre- Payment: Provider Enrollment

1. CORE-required Minimum CCD+ Reassociation Data Elements:

- Health plan must inform provider during enrollment to contact bank for the delivery of CORE-required Minimum CCD+ Reassociation Data Elements (*banks not required to report*)
- Provider must proactively contact bank for data
- NOTE: The CAQH CORE EFT & ERA Enrollment Data Rules contain complementary requirements

Claims Payment Process

2. Elapsed Time Requirements:
Health plan must release the 835 no sooner than three business days before and no later than three business days after the CCD+ Effective Entry Date 90% of time and track/audit this elapsed time requirement



3. Resolving Late/Missing EFTs/ERAs:
Health plan must establish written Late/Missing EFT and ERA Transactions Resolution Procedures

CAQH CORE EFT & ERA Reassociation (CCD+/835) Rule
Key Impact and Benefits

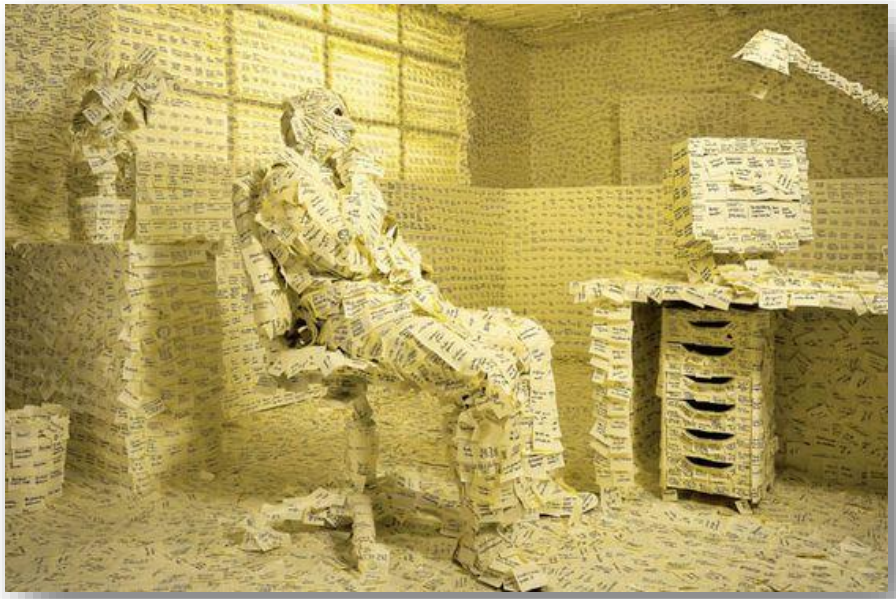
- Coordinates healthcare and financial services industry
  - When receipt of payment occurs with minimal elapsed time between receipt of remittance advice, providers can more quickly match payments with data and post to patient accounts on a more timely basis
- Provides assurance that trace numbers between payments and remittance can be used by providers
- Reduces level of open accounts receivable by enabling provider to generate cross-over claims to other payers and to collect payment from patient
- Enables provider to more quickly address denials or appeal adjustments to claim amount

CAQH CORE EFT & ERA Operating Rules:

Uniform Use of CARCs and RARCs Rule

CAQH CORE Uniform Use of CARCs & RARCs (835) Rule
Problem Addressed & Key Impact

- Providers do not receive uniform code combinations for same or similar business scenarios from all health plans; as a result, are unable to automatically post claim payment adjustments and denials accurately and consistently
- Inconsistent use of thousands of Code Combinations between Payers forces Providers to keep detailed notes on what Code Combinations are used by which Payer and what those combinations mean…



All of those Post-it Notes can add up!

CAQH CORE Uniform Use of CARCs & RARCs (835) Rule
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

CAQH CORE Code Combinations Maintenance Process

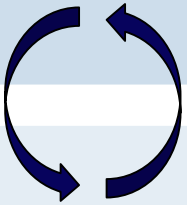
CORE Business Scenario #1: Additional Information Required – Missing/Invalid/ Incomplete Documentation (414 code combos)

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)

Stability of *CORE Code Combinations* maintained



Supports ongoing improvement of the *CORE Code Combinations*

CAQH CORE Compliance-based Reviews

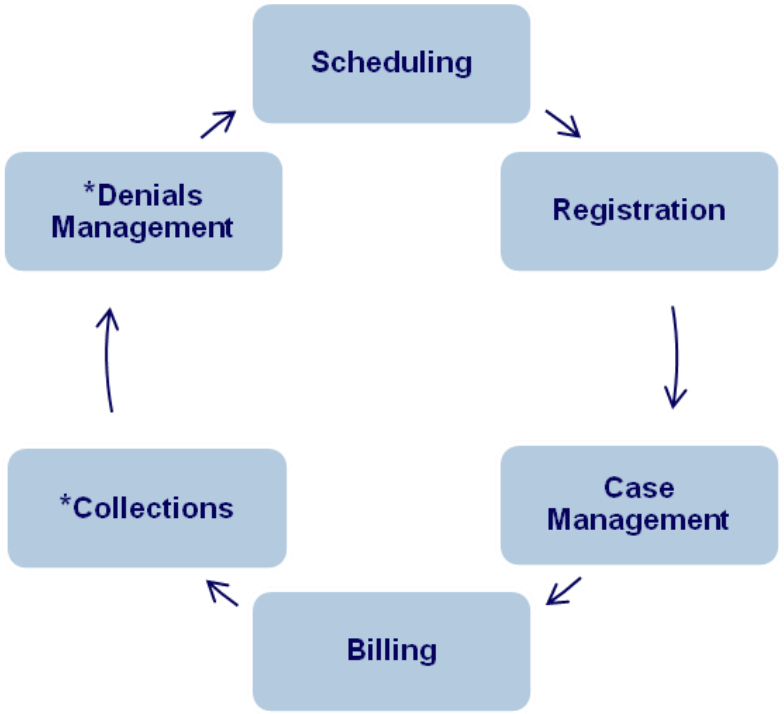
- Occur 3x per year
- Triggered by tri-annual updates to the published CARC/RARC lists by code authors
- Include only adjustments to code combinations to align with the published code list updates (e.g. additions, modifications, deactivations)

CAQH CORE Market-based Reviews

- 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

CAQH CORE Uniform Use of CARCs & RARCs (835) Rule
Key Impact and Benefits

- ***Potential reduction in manual claim rework*:**
  - With more consistent use of denial and adjustments codes per the CORE-defined Business Scenarios, providers will have less rework and can automate payment posting
- ***Improved denials management*:**
  - Providers able to more accurately understand reasons for claim adjustments and denials due to more consistent code use across plans
- ***Improved collections*:**
  - Providers can more effectively obtain payment from patients, more quickly generate cross-over claims to other payers, and reduce open accounts receivable
- ***Reduction in cost-to-collect*:**
  - Consistent use of the CARCs and RARCs will enable providers to spend less time/money resolving adjustments and denials
- ***Aggregated Data Analysis:***
  - Cross-industry ability to analyze detailed data, e.g., attachment types



*Indicates revenue cycle components where CAQH CORE 360 Rule will have greatest impact

CAQH CORE EFT & ERA Operating Rules:

EFT & ERA Enrollment Data Rules

CAQH CORE EFT & ERA Enrollment Data Rules
Problem Addressed

- Providers are challenged by the variances in the processes and data elements requested when enrolling in EFT and ERA across multiple Health Plans
- This results in unnecessary manual processing of multiple forms requesting a range of information – not necessarily the same information between Health Plans– and, in the case when it is the same, often using a wide variety of data terminology for the same semantic concept (i.e. “Routing Number” vs. “Bank Routing Number”)
- Key elements are excluded from many enrollment forms including those with a strong business need to streamline the collection of data elements (e.g. TIN vs. NPI provider preference for payment) and those essential for populating the EFT Standard (ACH CCD+) and the ASC X12 v5010 835

EFT & ERA Enrollment Data Rules:
Key Rule Requirements

- A health plan (or its agent or vendors offering EFT enrollment) is required to:
  - Offer an electronic way for provider to ***complete and submit*** the EFT enrollment
  - Collect only the CORE-required Maximum EFT Enrollment Data Set; includes some optional data elements
  - Use the format, flow, and data element descriptions without modification in the EFT Enrollment Data Set
  - Make available to the provider (or its agent) specific written instructions/guidance to the provider for enrollment and the specific procedure to accomplish a change in/cancellation of their enrollment
  - Additional requirements specific to electronic and paper-based enrollment noted in the rule and in appendix of this presentation
- These operating rules **DO NOT** preclude health plans from:
  - Adding Capabilities to the electronic EFT enrollment method designed to improve functionality and ensure data integrity and comprehensiveness
  - Collecting additional data elements in locations beyond the EFT enrollment form for other purposes beyond EFT enrollment

CAQH CORE EFT & ERA Enrollment Data Rules
Key Impact and Benefits

- Simplifies provider EFT & ERA enrollment by having health plans collect the same consistent data from all providers – mitigates hassle factor for providers when enrolling in EFT & ERA with multiple health plans and addresses existing issue that many elements needed for EDI aren't collected, e.g., requires health plans to support electronic collection of data (paper can continue)
- Addresses situations where providers outsource financial functions
- Enables health plans to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains

CAQH CORE EFT & ERA Operating Rules

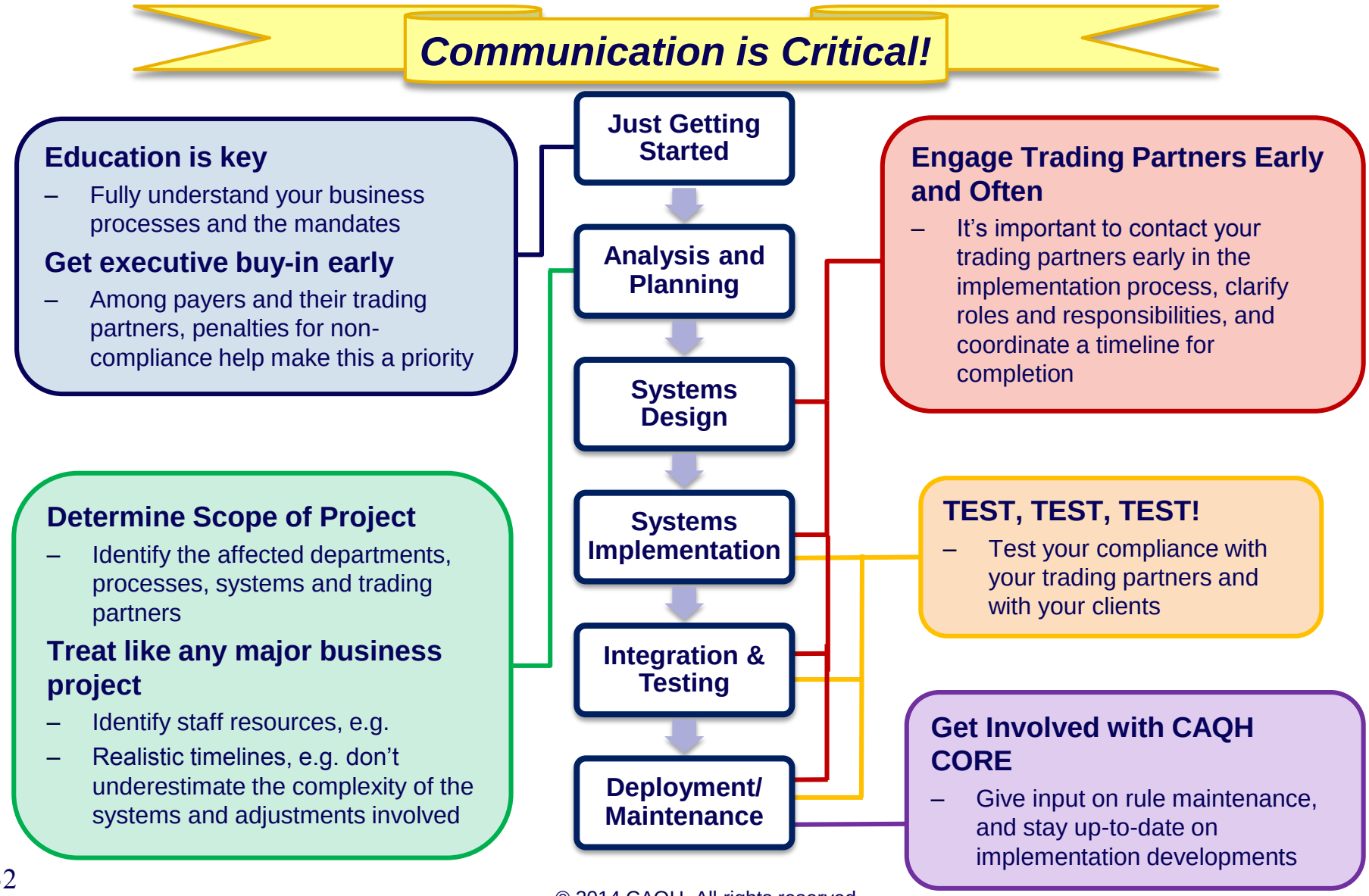
Implementation Tips and Best Practices

Polling Question #1:
CORE EFT & ERA Operating Rule Implementation Challenges

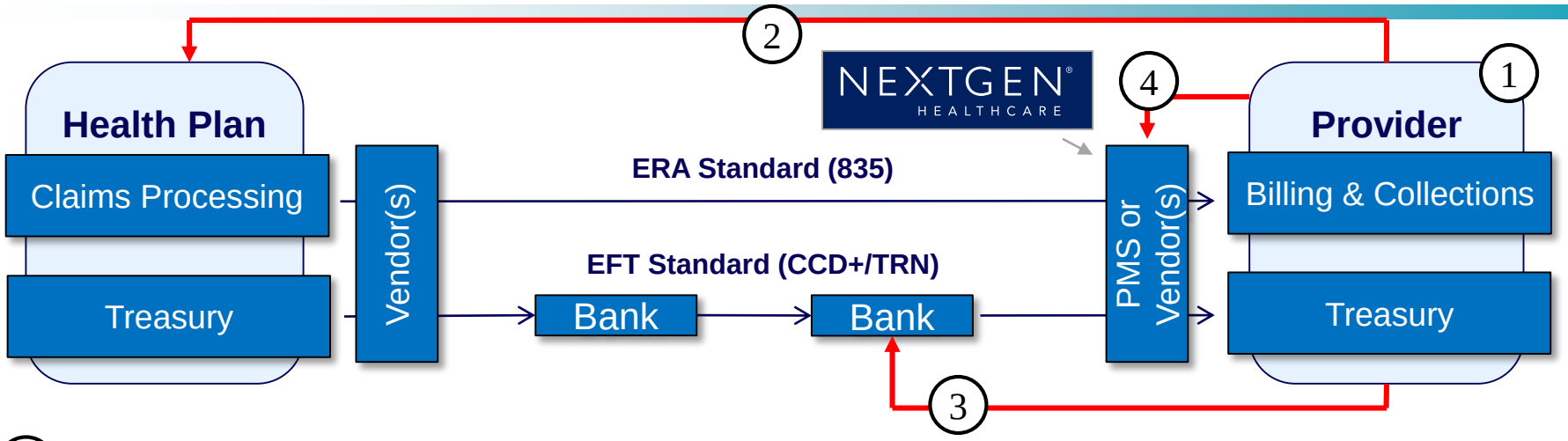
Which of the following would you consider to be the biggest challenge to your organization's implementation of the CAQH CORE EFT & ERA Operating Rules:

1. Fully understanding the CORE Operating Rules
2. Fully understanding my organization's role and/or responsibility in the implementation process
3. Overcoming resource constraints (i.e. time, staff, internal expertise)
4. Identifying and completing necessary system updates
5. Working and testing with Trading Partners (e.g. lack of communication between your organization and your vendor)

Implementation Steps for HIPAA Covered Entities:
Best Practices and Lessons Learned



How to Maximize Benefits of EFT & ERA Operating Rules
Provider Actions



1. Determine if your organization is conducting the applicable electronic transactions
   - If you conduct the X12 v5010 835 and ACH CCD+, these transactions must comply with the Operating Rules
   - Assess organizational readiness/compliance and Identify all systems and vendors that touch X12 v5010 835 and the Healthcare EFT Standard transactions
     - Use CAQH CORE Analysis and Planning Guide
2. Understand health plan agreements and options for payment and remittance information
   - Request healthcare EFT payments from your payers, both public and private, using the *Sample Provider EFT Request Letter*
3. Contact financial institution to request delivery of the EFT and payment related information including the reassociation trace numbers
   - To help facilitate this request, CAQH CORE developed the *Sample Provider EFT Reassociation Data Request Letter*
4. If applicable, ensure vendor or PMS has updated its systems to align with the CORE Operating Rules
   - Encourage your vendor (and Health Plan) to become CORE Certified

NEXTGEN®
HEALTHCARE

NextGen Preparing and Implementing CAQH CORE Phase III Operating Rules

Introduction
Preparing and Implementing
Challenges and Solutions

August 12th, 2014

About NextGen

- Specialized for ambulatory: software, workflows, best practices
- 20+ years expertise; 80K physicians; half billion MU dollars
- Servicing physicians in 42 specialties
- *NextGen Practice Management (Small and Group Practices)* – CORE Phase I & II Certified Product
- Services Provided:
  - ✓ EHR & Practice Management Systems
  - ✓ HIE & EHR Connect
  - ✓ Patient Portal
  - ✓ Analytics – Dashboard & HQM
  - ✓ Population Management Services
  - ✓ RCM Services
  - ✓ Consulting Services
  - ✓ EDI

Preparing and Implementing CAQH CORE Phase III Operating Rules

Preparing for Phase III Operating Rules

Planning for Phase III

- Attended Industry Calls and Town-Halls offered by CAQH CORE, NACHA, and WEDI.
- CAQH Analysis & Planning Guide helped to identify our stakeholder type and our requirements as a Practice Management System.
- Regularly contacted CAQH CORE when clarification was required.
- Reviewed FAQ's from CAQH CORE's Website.

Planning for Phase III Operating Rules

Implementing Phase III

Knowledge gained in the planning phase led to:

- Business Analysts creating design specs for Rules 360 and 372
- Resources and time frames established for key roles:
  - ✓ Business Analyst
  - ✓ Development
  - ✓ QA
  - ✓ Development Coordinators
  - ✓ Product Design

Planning for Phase III Operating Rules

Implementing Phase III- CARC RARC Combinations

- Determined Rule 360 would not require coding changes to ERA transactions within our application.
- Implemented changes into our current ERA Posting Report providing details of each CARC RARC Combination reported by the payer.
- CARC's uniqueness to only one Business Rule expedited the Implementation Process.
- Applied logic driven by the CARC/CAGC Code to identify which Business Rule would be reported for a CARC RARC Combination match.

Maintenance of the CARC RARC Versions

- Developed a web-based utility that updates the application with the latest Version of CARC RARC Combinations.
- The web-based utility is not contingent on the application's release cycle allowing for faster updates into the application.
- The utility is able to validate the current user's release and update accordingly.
- The Module is updated in accordance to the Combinations releases which occur three times a year.

Planning - Phase III Operating Rules - EFT/ERA Reassociation

- Currently developing a web-based utility for ERA-EFT Re-association.
- The utility can be scheduled to browse ERA and EFT files directories based off the TRN, Check Date, and Amount.
- The utility will identify/report EFT's and ERA's that do not have a match within the 3 days.
- ACH Tools
- Implementation is completed and expected for release within the next couple of weeks.

Challenges and Solutions:

- Resource Constraints with other priorities.
  - ✓ **Solution**: Meetings with key members to raise internal awareness of Industry Requirements and benefits to users.
- Existing system ERA report format limitations.
  - ✓ **Solution**: Several design sessions on how to handle complete description of the CARC RARC Combinations.
- CARC RARC Maintenance
  - ✓ **Solution**: Meetings with PM and EDI developers determining that a web-base utility offered the best solution for our users.

Client Outreach

- Engaged several Provider clients to determine level of interest.
  - ✓ Responses varied as concerns about workflow changes and uncertainty of long term benefits.
  - ✓ Recently we have seen more interest as provider awareness is rising!
  - ✓ Many users expect the reconciliation process to go from 2 weeks to a few days!
- Training includes application demo's reporting of CARC RARC Combinations.
- User Documentation for 360 and 372 is currently under way to provide the latest utility information.

Benefits of Phase III Operating Rules

- Standardization of CARC RARC Combinations is expected to limit the manual time spent on denial management by staff members.
- Providers have input on CARC RARC Combinations via the Market-Base Adjustments online.
- Multi-payer enrollment for EFT and ERA through CAQH CORE's website.
- Faster turn around in balancing/posting 835/EFTs

Recommendations

- Visit the CORE Website to educate yourself on the Operating Rules.
- Contact your Practice Management System to find out about their compliancy.
- Join the subgroup/Industry listservs to become aware of consistent changes.
- Contact your health plans and banks

CAQH CORE EFT & ERA Operating Rules
Available CORE Resources

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CAQH CORE Implementation Resources
EFT/ERA Tools for Providers

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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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

Importance of *Voluntary* CORE Certification
Healthcare Providers

- Although most CAQH CORE Operating Rule requirements apply to health plans, hospitals and health systems and their vendors/clearinghouses play an equally important role
  - *Without hospitals determining how to gain benefit, benefit will not accrue*
- Providers should encourage their vendors/clearinghouses to become voluntarily CORE-certified
  - Providers' certification often relies on their vendor/clearinghouse becoming certified
  - Vendors are key in ensuring your hospital is benefiting from this ACA-mandate
- *Voluntary* CORE Certification helps healthcare providers by:
  - Easily identifying business partners committed to using the operating rules
  - Allowing vendors, such as ***Emdeon***, to demonstrate their successful implementations and you to simply check for that demonstration
  - Imposing accountability, requiring certified payers and vendors to comply, without exception
  - Adding value beyond the mandated operating rules by checking compliance with voluntary CORE rules, such as operating rules related to Acknowledgements

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

Examples: Get Involved!

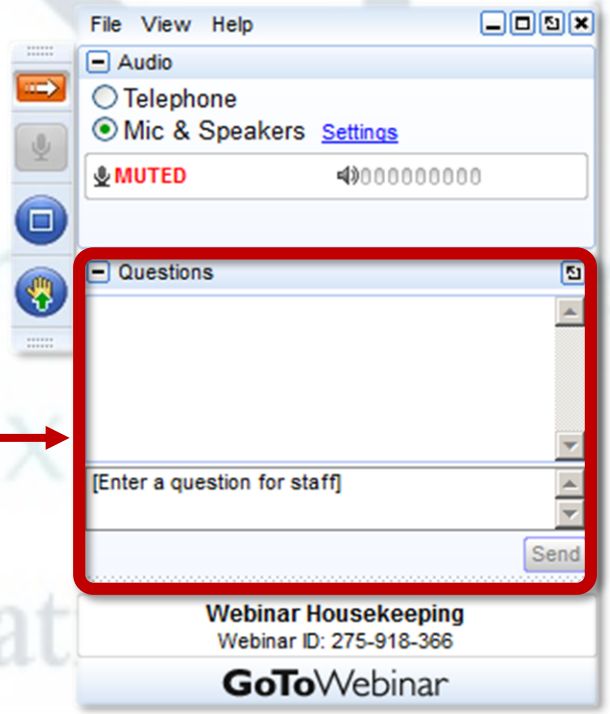
- Any CORE Participating Organization can join any CORE group
  - If you are a CORE Participating Organization and would like to join one of these group calls, please email CORE@caqh.org
  - If you are not a CAQH CORE Participating Organization but would like more information on how to become one, please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

CORE Group	Current Group Focus	Frequency	Next Meeting
CORE Code Combination Task Group (CCTG)	Compliance-based Review of the (currently unpublished) July CARC/RARC/CAGC code list updates	Two calls remaining: September 9th September 23rd	Tuesday, August 12th 3:00-4:30pm 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, August 13th 3:00-4:30pm ET
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, August 14th 2:30-4:00pm ET
CORE Certification and Testing Subgroup	Reviewing and addressing industry feedback for the Draft HIPAA Credential Forms	Final Call	Friday, September 5th 2:00-3:30pm ET

Q&A

Please submit your question:

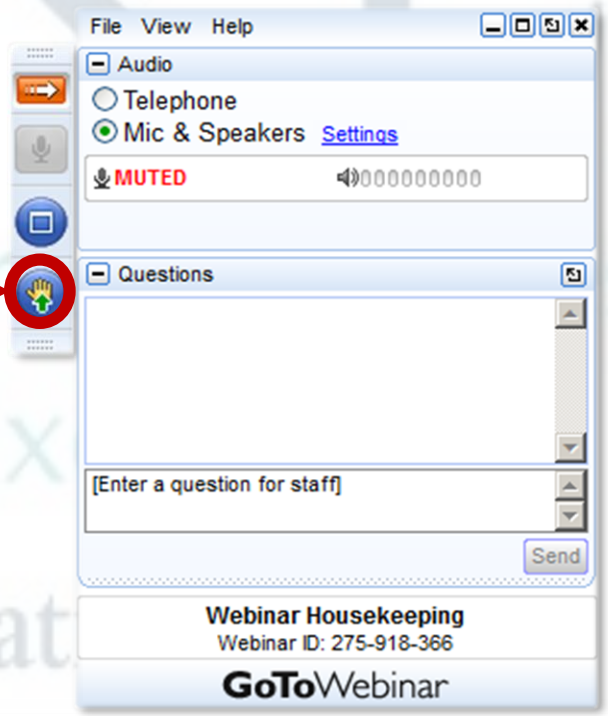
- **Via the Web**: Enter your question into the Q&A pane in the lower right hand corner of your screen



Q&A

Please submit your question:

- **By Phone or VoIP**: When prompted for audio portion of Q&A, please press "Raise Hand" Button to queue up to ask a question



***NOTE**: 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

CORE
Committee on Operating Rules for Information Exchange
A CAQH Initiative

APPENDIX

Additional Information and Resources

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”

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).