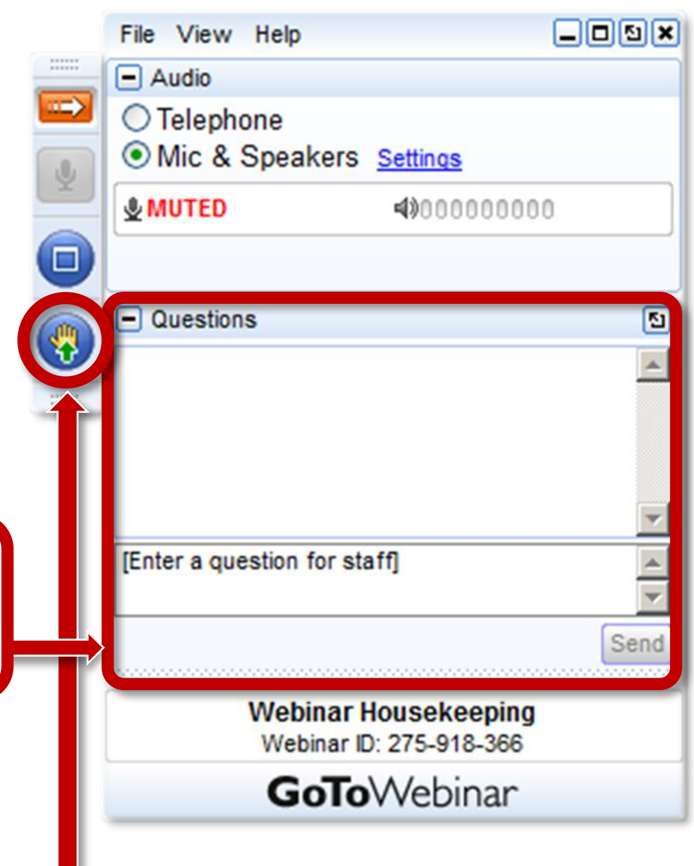
CAQH CORE:
December Town Hall Call

December 16, 2014
2:00 – 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



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Session Topics

- Welcome Introduction
- ACA Mandate Scope and Updates
- CAQH CORE Operating Rules Industry Adoption Update
- CAQH CORE Operating Rule Maintenance Process
  - Uniform Use of CARCs and RARCs Rule: 2014 Market-based Review
- Third Set of CAQH CORE Operating Rules
- HHS NPRM on Health Plan Certification Update
  - HIPAA Credential
  - CORE Certification
- Q&A

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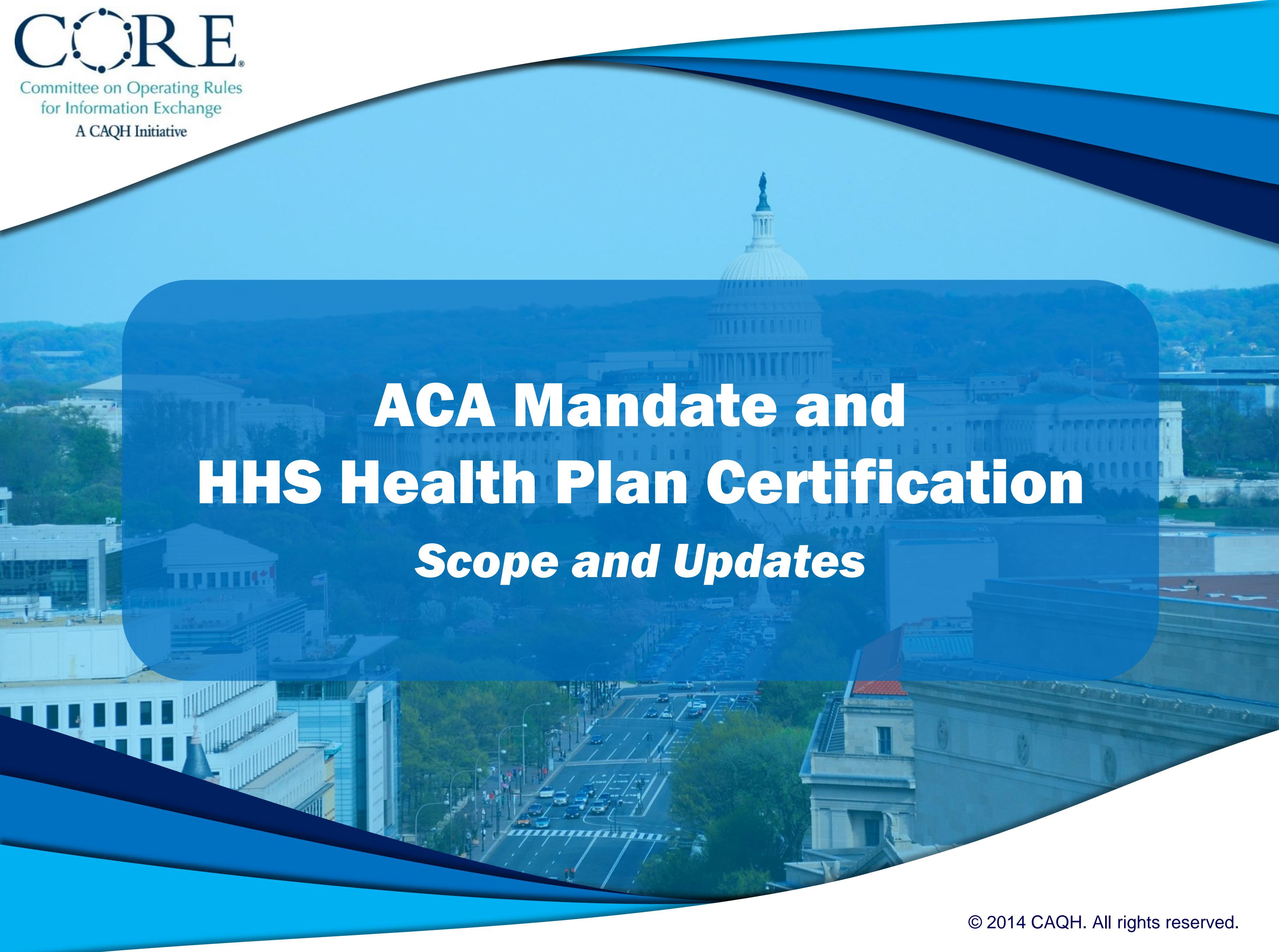
CORE
Committee on Operating Rules
for Information Exchange
A CAQH Initiative
ACA Mandate and
HHS Health Plan Certification
Scope and Updates
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Scope: ACA Mandated Operating Rules and Certification Compliance Dates

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)

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Committee on Operating Rules for Information Exchange
A CAQH Initiative

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]
    - Examples include but are not limited to: Doctors, Clinics, Psychologists, Dentists, Chiropractors, Nursing Homes, and Pharmacies
    - Covered ***ONLY*** *if they transmit any health information electronically (directly or through a business associate) in connection with a transaction for which HHS has adopted a standard*[2]
  - Health Plans *(including Self-insured and Group Health Plans, Long-term Care, Medicare, Medicaid, etc.)*
  - Healthcare Clearinghouses

[1] Covered Entity Charts
[2] HIPAA Administrative Simplification: 45 CFR §§ 160.102,
[3] HIPAA Administrative Simplification: 45 CFR § 160.103

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Polling Question #1:
EFT/ERA Adoption

What percentage of your Remittance Advices/Payments are conducted using the 835/EFT Standard (CCD+)?

1. 76% - 100%
2. 51% - 75%
3. 21% - 50%
4. Under 20%
5. Not Sure

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Sources to Track Industry Engagement of Operating Rules *Examples*

- *Voluntary CORE Certification*
  - Phase I and II Eligibility and Claims Status CORE Certifications
    - Recent certifications include Meditech, Florida Medicaid, MaineCare, Oklahoma Office of Management and Enterprise Services, etc.
  - Phase III EFT & ERA CORE Certifications
    - A number of entities have completed Phase III CORE certifications with many more in the pipeline. Recent examples include Centene Corp, Excellus Blue Cross Blue Shield, Horizon Blue Cross Blue Shield of New Jersey, AultCare, Ventanex, etc.
- CORE education session polling on industry status
  - Polling data from Q1, Q2 and Q3 2014 education sessions shows steady EFT & ERA Operating Rule implementation progress across all stakeholder group
    - Polling and registration information is always BLINDED and is taken in aggregate to protect personal information of registrants/attendees
- NACHA EFT transaction volume
  - Unlike for other HIPAA transactions, use of the ACH network for CCD+ enables tracking of this transaction (if entities use trace number)

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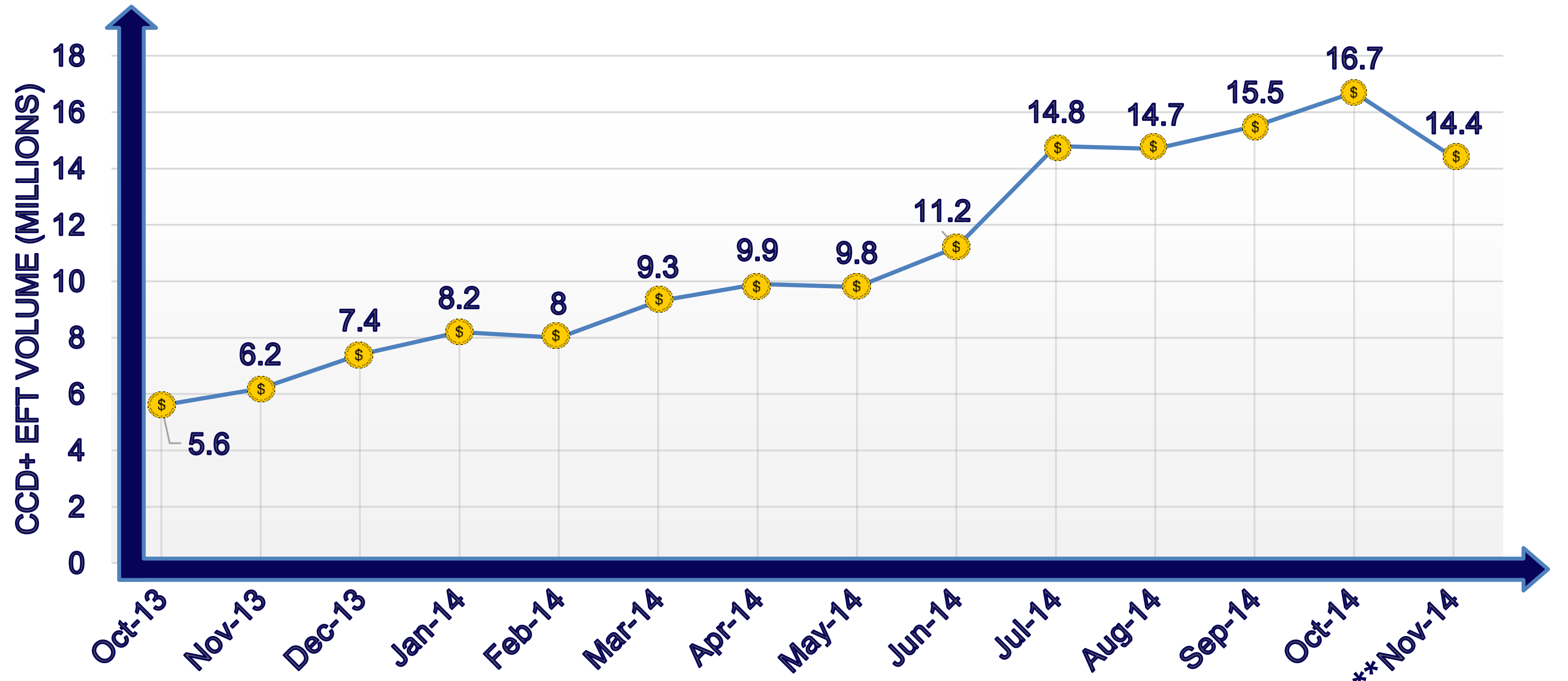
Healthcare EFT CCD+ Volume
Based on NACHA Data

- These numbers reflect EFT payments that are clearly identified as healthcare payments by the use of the specific identifier "HCCLAIMPMT"* in the CCD+ transaction
- There has been steady growth in the use of CCD+ for healthcare EFT payments with roughly a **200% net increase in CCD+ volume** from the beginning of Q4 2013 to the beginning of Q4 2014



*NOTE: Some providers are receiving EFT payments without the HCCLAIMPMT identifiers in the CCD+. To identify an EFT payment as a healthcare EFT, originators of the transaction (i.e. Health Plans/Payers) need to include the HCCLAIMPMT identifier in the CCD+Addendum
**November saw a drop in the total healthcare EFT volumes due to a limited number of processing days (18). The average number of credit transactions per day, however, was actually higher than October

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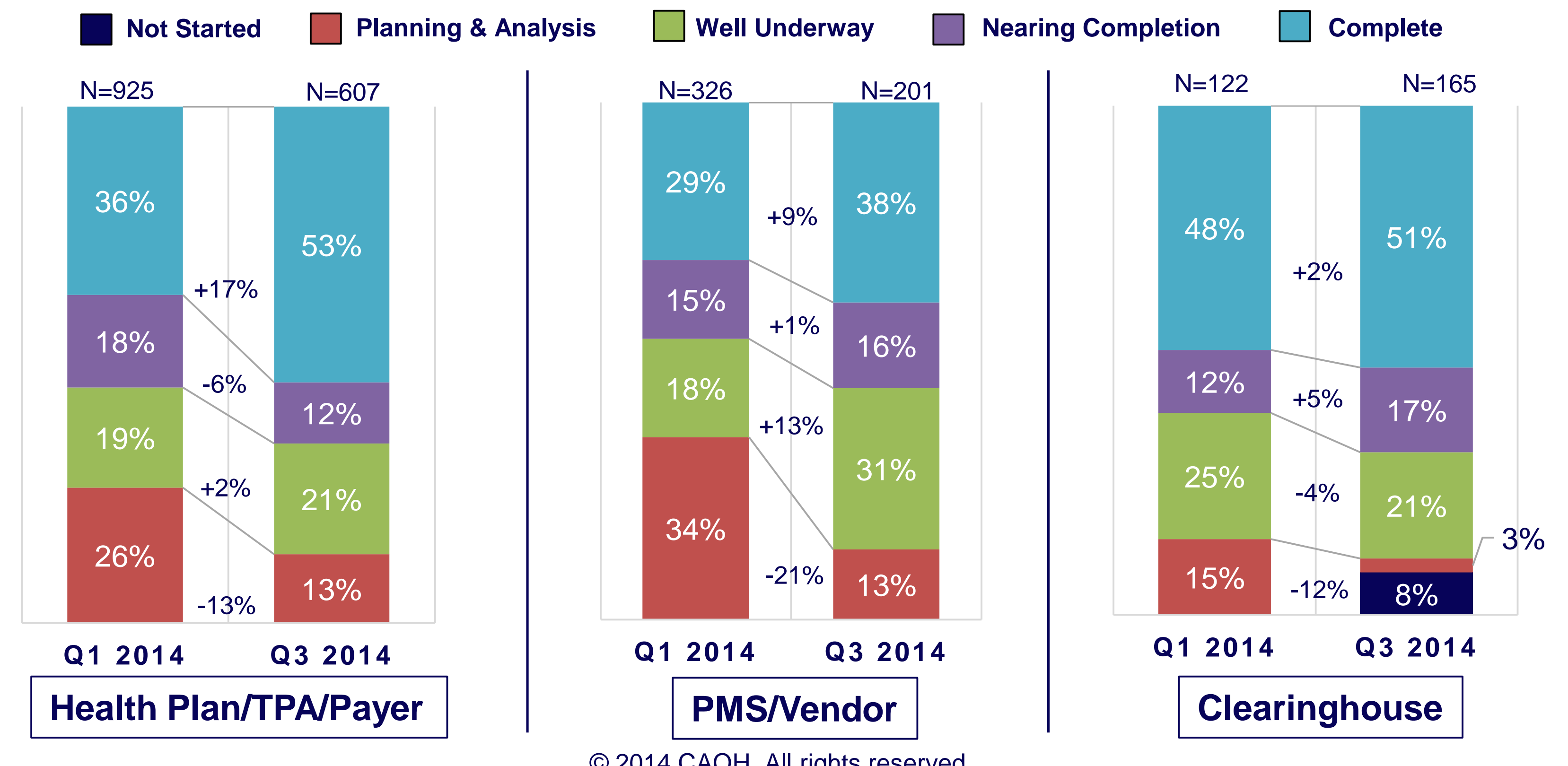
Status of EFT & ERA Operating Rule Implementation: *CAQH CORE 2014 Self-Reported Polling Response Data*

- Pre-registration questions were used to identify implementation status and challenges
  - All stakeholder types have made great strides in their implementation with more than 50% of all stakeholder types having either completed implementation or are well on their way towards completion
    - Health Plans have had the biggest increase in completed implementations between Q1 and Q3 (+17%).
    - PMS/Vendors have increased in all categories from Well Underway through Completion between Q1 and Q3 (+23% total).
    - Clearinghouses still are highest in the key categories of Well Underway, Nearing Completion or Complete (89% for Q3)
  - Resource constraint remains the main challenge to implementation



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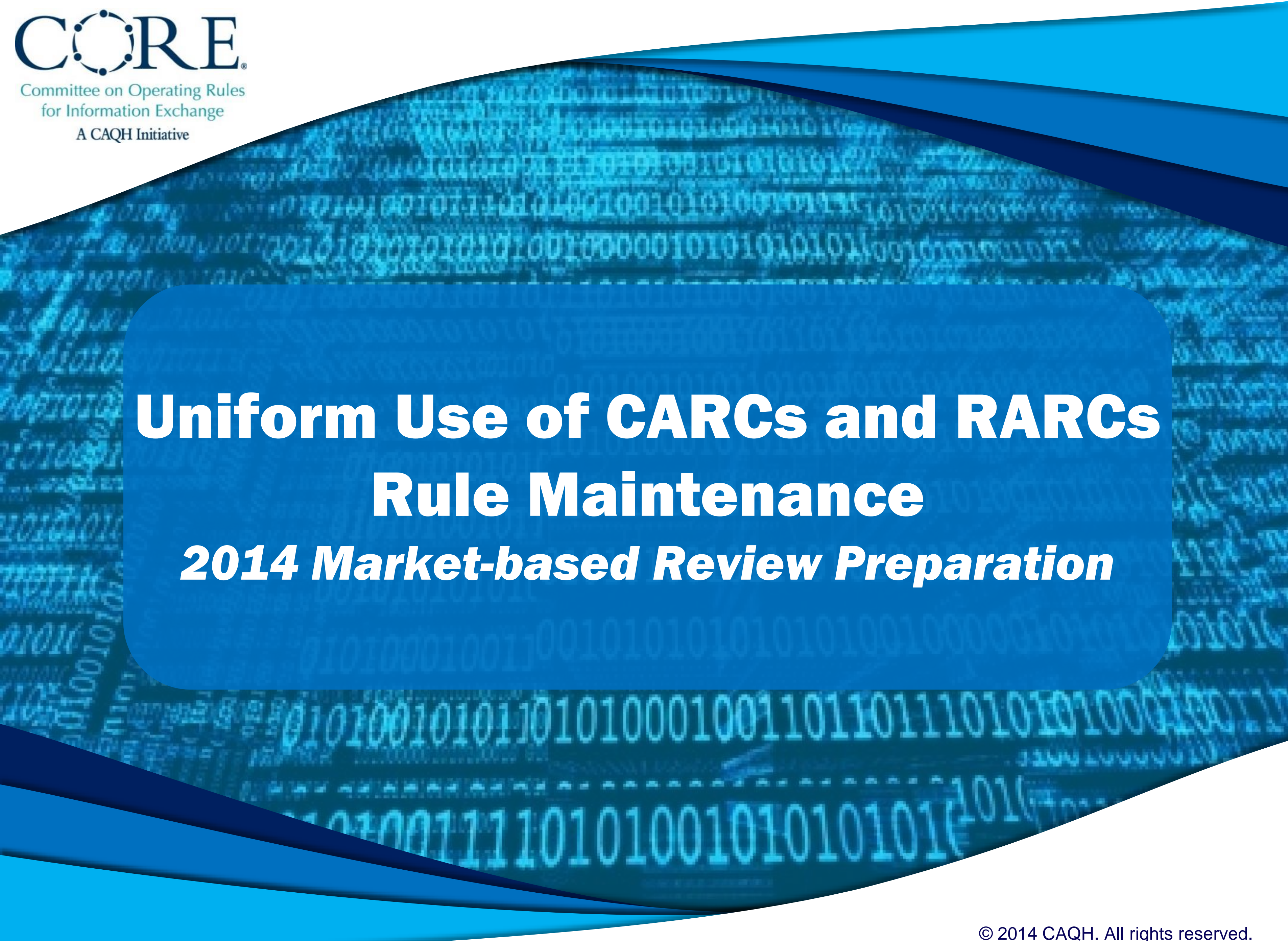

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CAQH CORE Code Combinations Maintenance Process

CORE Business Scenario #1:
Additional Information Required – Missing/Invalid/ Incomplete Documentation
(≈380 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
(≈650 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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2014 Market-based Review Process
Basic Information and Scope

- **Basic Information**
  - 2014 MBR was launched on **11/26/2014**
  - All adjustment recommendations must be submitted to CAQH CORE via the online MBR Form by **5pm ET on Monday, 1/26/2015** (60-day Submission Period)
  - CAQH CORE will publish any adjustments to the CORE Code combinations based on the 2014 MBR in June 2015
  - Adjustments must be requested using the latest version of the CORE Code Combinations
    - The latest version is *CORE-required Code Combinations for the CORE-defined Business Scenarios v3.0.3 October*
- **Scope of the 2014 MBR**:
  - **Code Combinations Adjustments** – includes code additions/removals/relocations for existing CORE-defined Business Scenarios
  - **Potential new CORE-defined Business Scenarios** – Includes formal call for potential additions of new CORE-defined Business Scenarios
    - In addition to New Business Scenarios, submitters will also have to identify Code Combinations to associate with these requested new CORE-defined Business Scenarios

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2014 MBR Submission Process
Market-based Code Adjustment Requests

Entities may submit code adjustments to the existing CORE-defined Business Scenarios as well as for potential new CORE-defined Business Scenarios; Potential adjustments may include:

Types of Additions	Types of Removals	Types of Relocations
Add CARC and RARC along with a CAGC(s)	Remove CARC and all associated RARCs and CAGC(s)	Remove CARC and ***all*** associated RARCs from an *existing* CORE-defined Business Scenario and add to another *existing* CORE-defined Business Scenario with associated CAGC(s)
Add CARC along with a CAGC(s)	Remove RARC and associated CAGC(s) from existing CARC	Remove CARC and ***all*** associated RARCs from an *existing* CORE-defined Business Scenario and add CARC and ***some or no*** associated RARCs to another *existing* CORE-defined Business Scenario with associated CAGC(s)
Add RARC to an existing CARC along with a CAGC(s)	Remove CAGC(s) from existing CARC	Remove CARC and ***all*** associated RARCs from an existing CORE-defined Business Scenario and add to a requested New Business Scenario with associated CAGC(s)
Add CAGC to an existing CARC	Remove CAGCs from existing CARC and associated RARC	Remove CARC and ***all*** associated RARCs from an existing CORE-defined Business Scenario and add CARC and ***some or no*** associated RARCs to a requested New Business Scenario with associated CAGC(s)
Add CAGCs to an existing CARC and its associated RARC		

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2014 MBR Submission Process
NEW Business Scenario Code Adjustment Requests

For each requested potential *new* CORE-defined Business Scenario, respondents submit code combinations for association with the requested scenario; Potential adjustments for requested new Business Scenarios may include:

- **Addition** of **new** code combinations where the CARC is NOT currently in the existing *CORE Code Combinations*
- **Relocation** of a *CORE Code Combination* from an *existing* CORE-defined Business Scenario to the requested *new* Business Scenario

Types of Additions	Types of Relocations
Add new CARC and RARC along with a CAGC(s)	Remove CARC and ***all*** associated RARCs from an *existing* CORE-defined Business Scenario and add to the requested *New* CORE-defined Business Scenario with associated CAGC(s)
Add new CARC along with a CAGC(s)	Remove CARC and ***all*** associated RARCs from an *existing* CORE-defined Business Scenario and add CARC and ***some or no*** associated RARCs to the requested *New* CORE-defined Business Scenario with associated CAGC(s)

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2014 MBR Submission Process
Basics

Eligible Submitters:

- All CORE Participants plus *non-CORE Participants* that create, use, or transmit HIPAA-covered transactions may submit potential Market-based entries
- NOTE: Each organization is limited to ONE SUBMISSION (may contain multiple entries); please coordinate with your colleagues

How to Submit:

- The CAQH CORE Code Combinations Task Group designed content for an online *Market Based Review submission form* (MBR Form) to collect the necessary input from the industry
- Submissions will ***only*** be accepted through the online MBR Form. CAQH CORE, CCTG Co-Chairs and CAQH Staff will not be able to accept direct email submissions of the MBR Form

When to Submit:

- All eligible submitters can access the online MBR Form **NOW!**

Submission Deadline:

- All eligible submitters must complete their submissions by **1/26/2015** – No submissions will be accepted after that date

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2014 MBR Submission Process
Flow and Format of Online Form

Part One

General Overview and Submitter Information

Submitters provide basic demographic information and the number of entries that their organization plans to submit

After completion of Part One, you will be sent a ***unique link*** that MUST be used to access parts two and three of the online MBR Form

This link can be used as many times as needed by multiple individuals at your organization

Part Two

Adjustments to *Existing* CORE-defined Business Scenarios

Submitters complete an entry for a code addition, a code removal, or code relocation

- Each code addition/removal or relocation submitted is considered a ***single entry****. An entity's ***final submission*** may have multiple entries

Part Three

Adjustments for Potential *New* CORE-defined Business Scenarios

Submitters complete an entry for potential new CORE-defined Business Scenarios

- Submitters must also identify new code combinations to add under this business scenario or relocate code combinations from existing Business Scenarios; scenarios submitted without associated codes will not be considered

*A confirmation email for each entry will be sent to the email address identified in Part One; this email will contain a unique entry ID which can be used to delete any erroneous submissions by entering the ID on Part Two or Three of the online MBR Form

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CORE
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Third Set of
CAQH CORE Operating Rules
Update
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Third Set of ACA Mandated Operating Rules
In Development

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

- Goal: Draft of rules by early 2015; will primarily be infrastructure.
  - Infrastructure rule development underway
    - Infrastructure requirements will apply across transactions; built on existing draft rules (e.g. real time processing mode and/or batch processing mode required)
  - *Both of these transactions are being used in the Insurance Exchanges (HIXs)
    - Firm with Federal and State HIX experience summarized lessons learned; report shared with the Benefit Enrollment & Maintenance/Premium Payment Subgroup to verify that findings are consistent with their HIX experience and how it compares to non-HIX
  - Attachment standard(s) not issued by CMS; however, CORE presenting potential vision
    - Held a series of CORE-only calls to review and verify CORE findings on current volumes, attachment formats, future plans and related ROI, knowledge levels, etc.
    - Research indicates industry neutral standards, e.g., PDF, may have significant benefit and that industry-wide education will be key given current level of knowledge of key standards such as HL7 C-CDA
    - Determining when appropriate timing will be to draft operating rules based on status of standard(s)

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Regulatory Status of Remaining Operating Rules

ACA § 1104

Requires HHS to adopt and update operating rules for HIPAA transactions

HHS

Sept. 2012: HHS designates CAQH CORE as the operating rule authoring entity for remaining transactions:

1. Health claims or equivalent encounter information
2. Health plan enrollment/disenrollment
3. Health plan premium payments
4. Referral certification and authorization
5. Health claims attachments*

CAQH CORE

GOAL: A set of draft rules by early 2015, while emphasizing flexible deadlines. CAQH CORE will submit any rules approved by the CORE Participants via the CORE Voting Process to HHS/NCVHS as appropriate

* **NOTE**: HHS has not adopted a standard for health claims attachments or indicated what standard(s) it might consider for the transaction, and an effective date for these operating rules is not included in the ACA. Thus, the immediate focus of CAQH CORE will not include attachments.

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Phase IV Operating Rule Development: Status Update

Transaction/Rule Area	Operating Rule Status	Notes

X12 v5010 278
Referral Certification & Authorization*
 	
X12 v5010 837 P/ I/ D
Claim & Encounter Reporting
		• CAQH CORE Claims/Prior Authorization Subgroup considered two draft rules initially developed in 2009 and updated by CAQH CORE staff to align with the ACA and current CAQH CORE rule structure:
		  • *Draft Phase IV CAQH CORE 278 Infrastructure Rule*
		  • *Draft Phase IV CAQH CORE 837 Infrastructure Rule*
		• Subgroup has approved the two draft rules for Rules Work Group review

X12 v5010X220 834 Benefit Enrollment & Maintenance **X12 v5010X218 820** Health Plan Premium Payment		• CAQH CORE Benefit Enrollment & Maintenance/Health Plan Premium Payment Subgroup launched in November and is considering infrastructure requirements • CAQH CORE contracted with a firm with Federal and State HIX experience that conducted research on HIX use of the 834 and 820 transactions to ensure alignment with operating rules for HIPAA covered entities given potential overlap in health plan IT systems
Connectivity & Security		• Draft Phase IV CAQH CORE Connectivity Rule, which applies to the claims, prior authorization, benefit enrollment & maintenance and health plan premium payment transactions is currently under Straw Poll review by the CAQH CORE Connectivity and Security Subgroup

*Specifically, the X12N/005010X217 Health Care Services Review - Request for Review & Response (278)

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CAQH CORE Claims/Prior Authorization Subgroup: *Status Update*

TIMEFRAME

September – December 2014: CAQH CORE Claims and Prior Authorization Subgroup (CPASG) convened to update the 2009 draft claims and prior authorization infrastructure rules for the Phase IV CAQH CORE Operating Rules

PARTICIPANTS

Over 62 CAQH CORE Participating Organizations from a wide variety of stakeholders; led by Co-chairs Merri-Lee Stine (Aetna), Kevin Chambers (Virginia Mason Medical Center), and Dawn Sprague (TriZetto Corporation)

STATUS

Conducted Straw Polls on draft claims and prior authorization infrastructure rules; approved two draft rules for Rules Work Group Review

JOIN

- Subgroup calls open to all CORE Participating Organizations
- Email core@caqh.org to be added to the CPASG

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CAQH CORE Connectivity & Security Subgroup:
Status Update

TIMEFRAME

November 2013 – December 2014: CAQH CORE Connectivity & Security Subgroup (CSSG) convened to draft connectivity and related infrastructure options for Third Set of ACA-mandated operating rules

PARTICIPANTS

Currently over 80 CAQH CORE Participating Organizations from a wide variety of stakeholders; led by Co-chair S. Luke Webster, CHRISTUS

STATUS

Conducted Straw Poll on high-priority opportunity areas, message interaction, and processing mode expectations; reviewing and discussing results in December meeting.

JOIN

- Subgroup calls open to all CORE Participating Organizations
- Next Subgroup meeting will be held on **December 18th**
- Email core@caqh.org to be added to the CSSG

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CAQH CORE Benefit Enrollment & Maintenance/ Premium Payment Subgroup: *Status Update*

TIMEFRAME

November 2014 – March 2015: CAQH CORE Benefit Enrollment & Maintenance/Premium Payment Subgroup (BEPPSG) convened to draft infrastructure rules for the Benefit Enrollment & Maintenance and health plan premium payment transactions

PARTICIPANTS

Currently over 50 CAQH CORE Participating Organizations from a wide variety of stakeholders; led by Co-chair Bob Doan, Health Care Service Corporation (HCSC) and an additional Co-Chair

STATUS

Currently conducting Straw Poll on applicability of infrastructure requirement to the HIPAA mandated transactions (e.g. ASC X12N v5010X220 834 and ASC X12N v5010X218 820); Collected feedback on third-party HIX research on use of the 834/820 to consider any commonalities/challenges between the HIX and non-HIX environments are taken into account and goal of aligning overlapping systems/resources is met

JOIN

- Subgroup calls open to all CORE Participating Organizations
- Next Subgroup meeting will be held on **January 15th**
- Email core@caqh.org to be added to the BEPPSG

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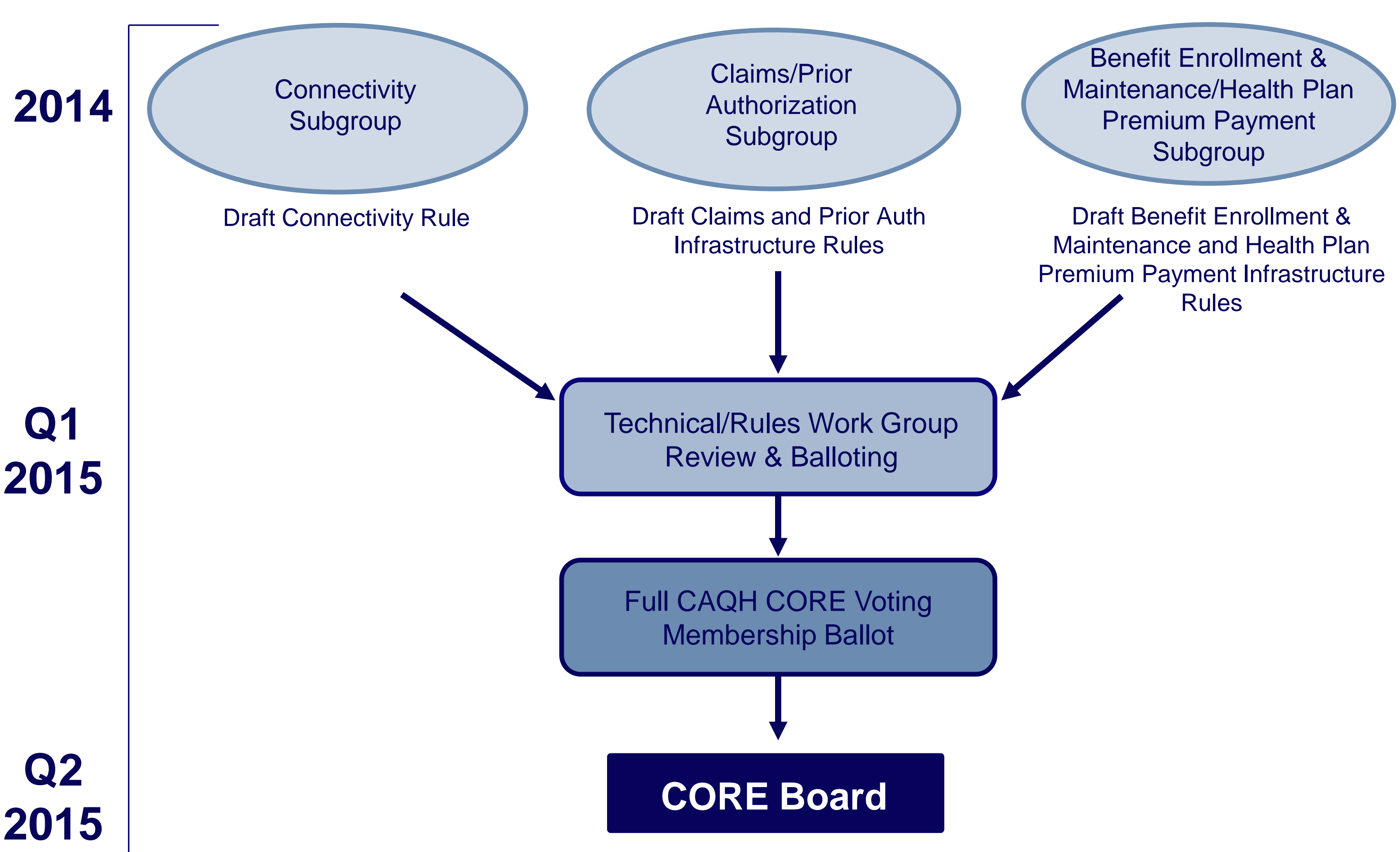
Process for Development of Phase IV CAQH CORE Operating Rules



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CORE
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for Information Exchange
A CAQH Initiative
HHS Health Plan Certification
Documentation of Compliance
HIPAA Credential and CORE Certification
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HHS NPRM on Health Plan Certification

Ultimate goal:

"Reduce the clerical burden on patients, health care providers, and health plans"

- HIPAA (42 U.S.C. 1320d Note)

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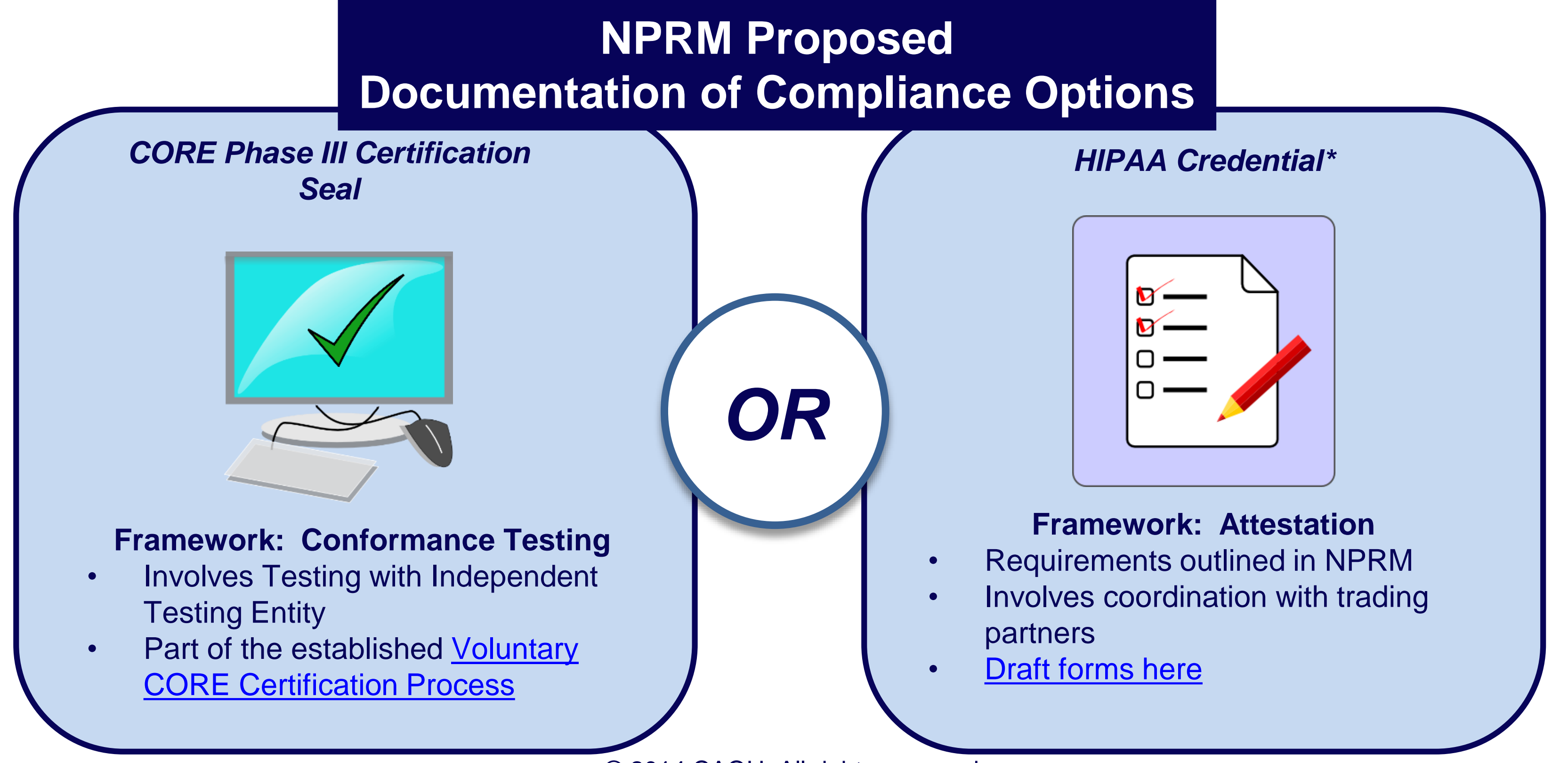
HHS NPRM on Health Plan Certification
Background

- **Notice of Proposed Rule Making (NPRM)** published in *Federal Register*, January 2, 2014
- Before December 31, 2015, Controlling Health Plans (CHPs) must submit to HHS:
  - Documentation of Compliance, and
  - Number of Covered Lives
- **As of December, 2014**, a final rule has not been published



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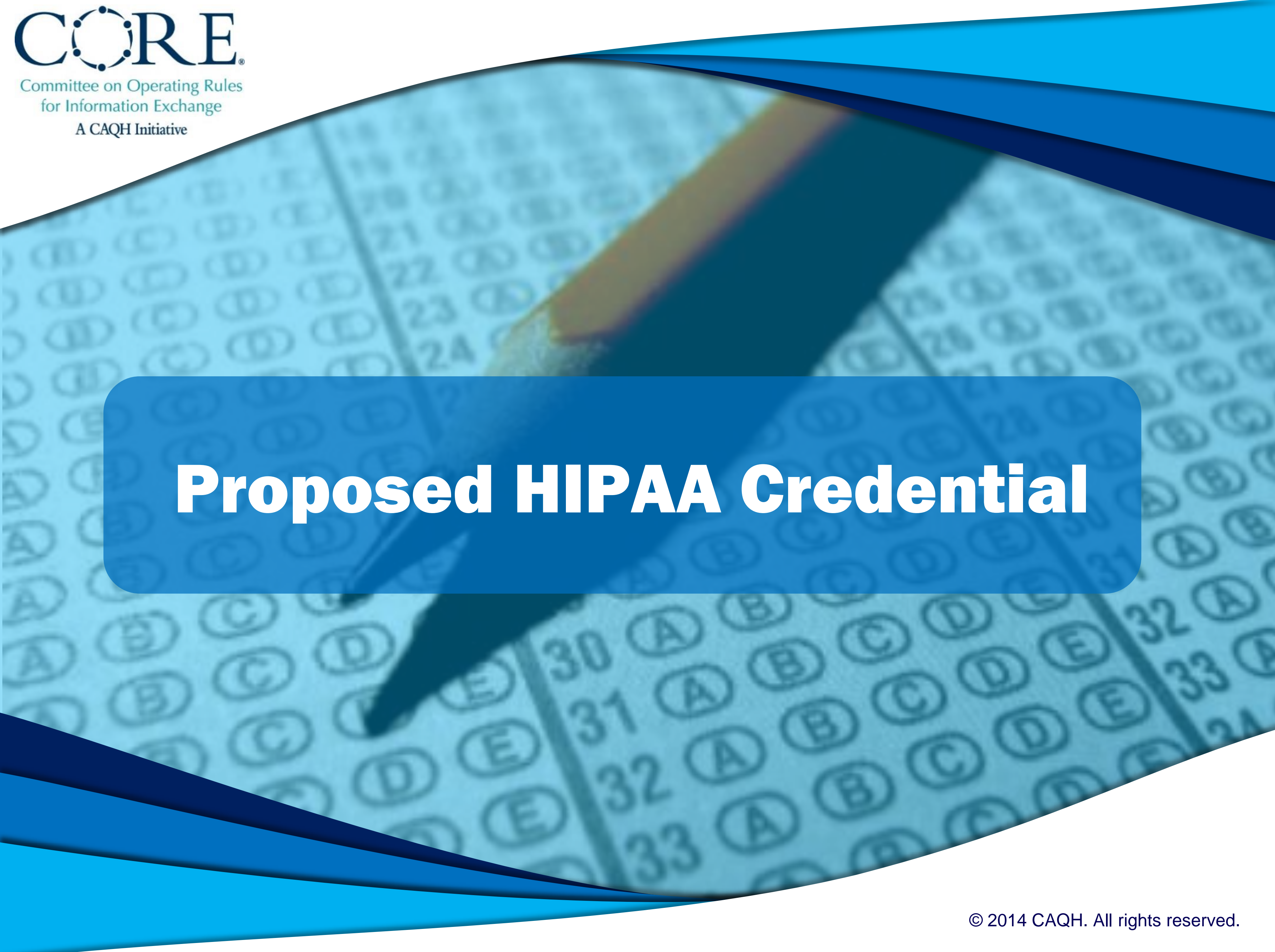
*May be adjusted pending final rule



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Draft HIPAA Credential Forms
Industry Feedback and CTSG Tasks

- **Industry Feedback collected on initial draft forms:**
  - **Over 250 comments** were received from both CORE Participants and non-Participants
- **CAQH CORE Certification & Testing Subgroup (CTSG)**, comprised of CORE Participants,* was tasked with adjudicating both the substantive and non-substantive comments on the initial draft forms
- CTSG conducted **Market Assessment** to “case test” the draft forms
  - The Subgroup subsequently made the form simpler, clearer, and better aligned the language with the requirements of the NPRM
- Updated draft forms published in September, 2014

These draft forms are for illustrative purposes only and cannot be used to apply for the HIPAA Credential. These draft forms are subject to change based on the release of an HHS Final Rule.

**For more information on how to become a CORE Participating Organization, please visit our website HERE*

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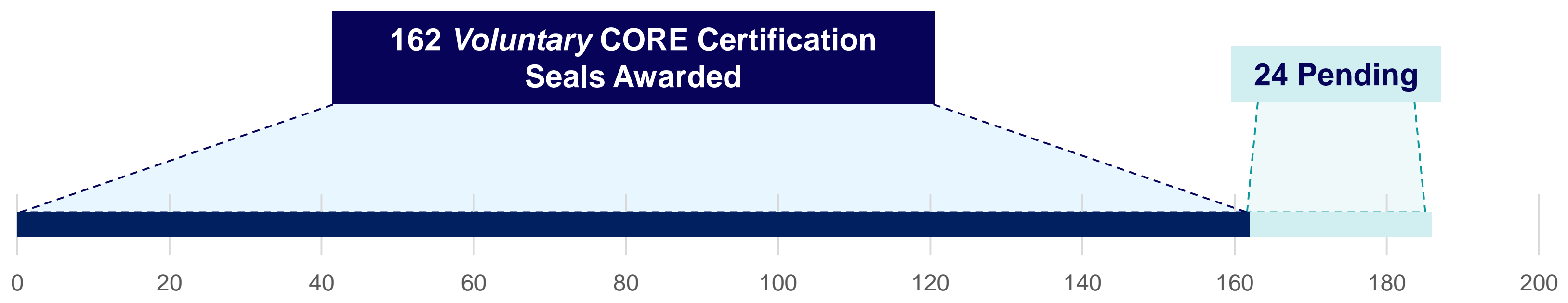
Voluntary CORE Certification

- CAQH CORE offers *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
  - **More than 150 CORE Certifications** have been achieved with over 20 Certifications currently pending. Access a list of these organizations HERE



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Voluntary CORE Certification: *Benefits*

Give Assurance:

The CORE Certification Seal demonstrates that an organization is operating in conformance with federally-mandated operating rules, and that it has streamlined its billing and administrative processes for maximum cost savings.

Pay it Forward:

When an organization becomes CORE Certified, it gives their customers the opportunity to leverage the organization's CORE Certification and become CORE Certified as well.

Attract Attention:

CORE Certified organizations and solutions/products are recognized on the CAQH CORE® website and featured in press releases and national webinars.

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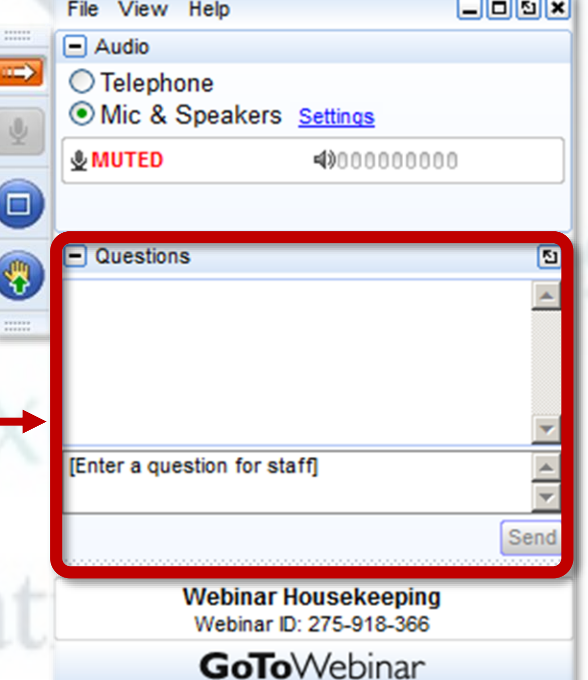
Q&A

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



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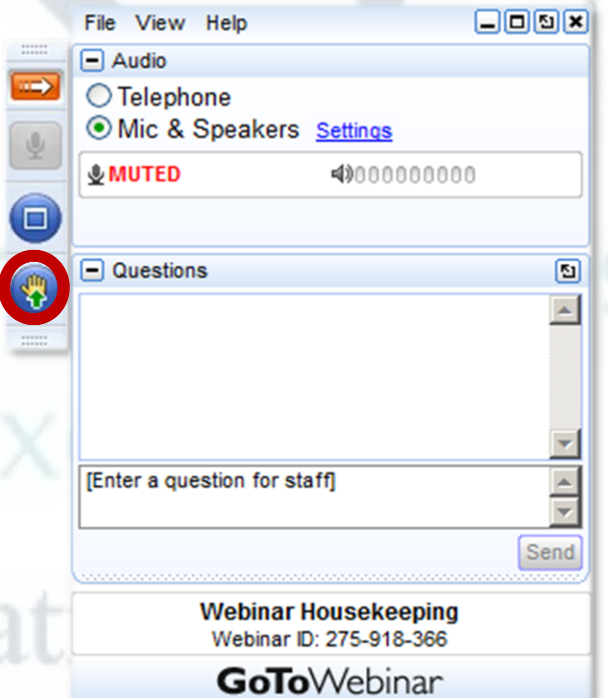
Q&A

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.*

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Thank You for Joining Us!

website: www.CAQH.org

email: CORE@caqh.org

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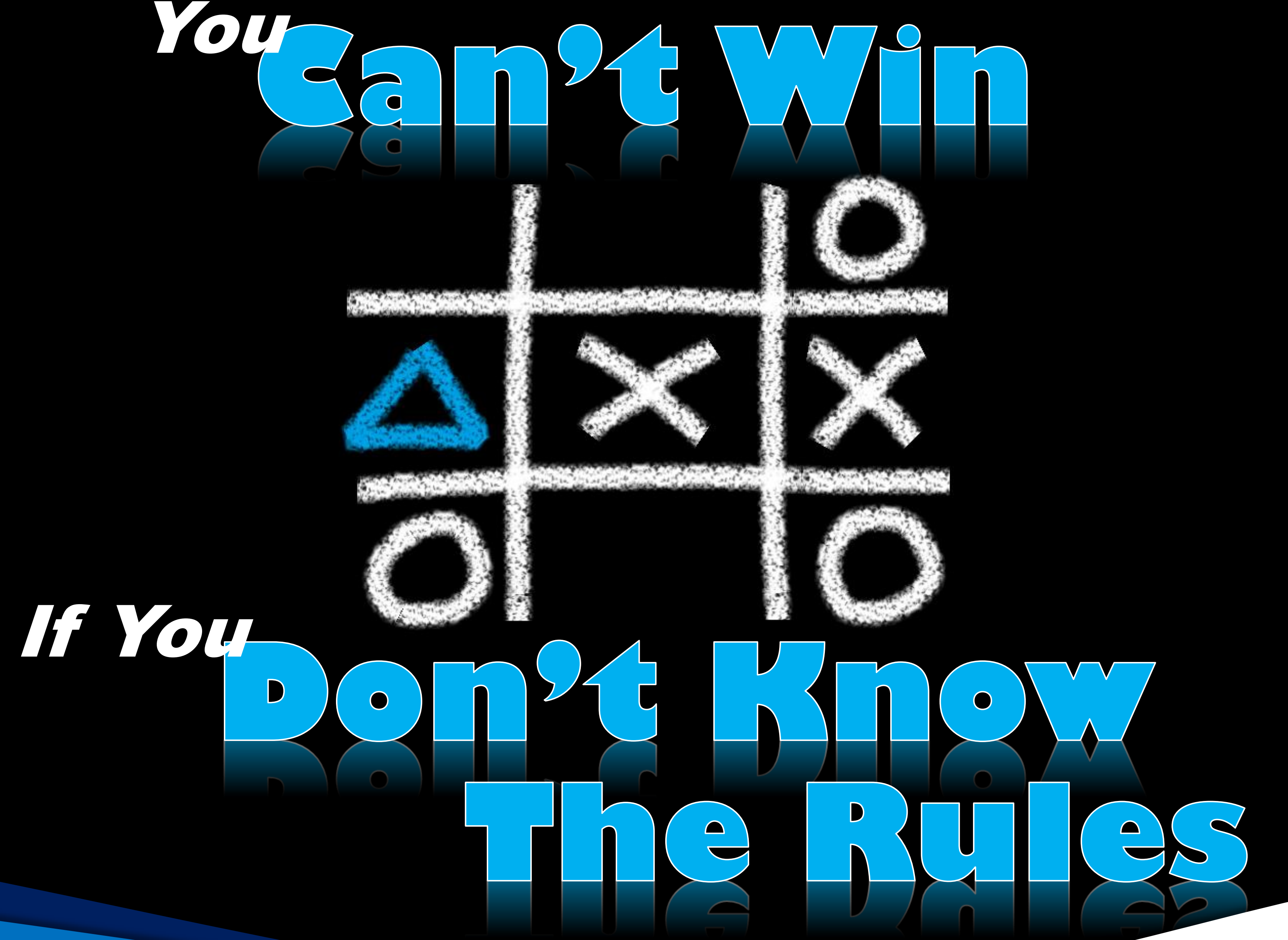

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APPENDIX

Additional Information and Resources

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Implementation Steps for HIPAA Covered Entities
Free Tools and Resources

CAQH CORE has a ***NEW*** **Implementation Resources webpage** which contains descriptions of and links to all available free tools and resources including those outlined below and many others!

Education is key
Get executive buy-in early

- Read the **CAQH CORE 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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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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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

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2014 MBR Submission Process
Best Practices

Use a Single Email Address for Submissions

- If possible, create a shared email for the organization team completing the submissions
- If using employee email, forward the email address to another team member if employee is OOO

Keep a Detailed Spreadsheet of submissions with their Entry ID and All Additional Information

- This will allow you to easily find the Entry ID for any submitted adjustments that you need to alter or delete

Deletions:

- In drop down list for deletions the new scenarios will appear as **EIDXXX_://name of scenario**
- Deleted scenarios will still be shown in list of potential scenarios to be added to; if codes are added subsequent to a scenario deletion, these code combinations will be ignored from the submissions,
  - **INSTEAD:** submit a NEW scenario with a slightly modified name and add codes to that scenario
- Deleted entries will still be listed in the drop down as **EIDXXX_://** without any codes of scenario name

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2014 MBR Submission Process
Additional Resources

Is there anything I can download that will walk me through the MBR Submission Process?

- Detailed instructions to assist in the completion of the online CAQH CORE 2014 Market-based Adjustments Form are available HERE

Where can I see what a completed 2014 MBR Form looks like?

- A sample completed CAQH CORE 2014 Market-based Adjustments Form is also available HERE for consultation as entities plan their submission

Where can I find the materials from this training session?

- The slide deck and video recording of today's training can be found on the CAQH CORE education session webpage will be offered explaining the MBR submission process

What if I have any other questions?

- If you have any questions, please send them to CORE@caqh.org

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CAQH CORE Uniform Use of CARCs & RARCs Rule
Impact for Providers

Provider 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

Importance of CORE Code Combination Maintenance Process

In order for your provider organization to receive the full benefits of this rule, it is beneficial for you to take part in the CORE Code Combination Maintenance Process. Submitting adjustments via the 2014 Market-based Review (which is **NOW OPEN**) ensures that the CORE Code Combinations and Business Scenarios:

- Reflect your specific business cases/needs
- Are thorough, precise and accurate
- Address the problem space in the most effective way

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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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