Transforming Financial Transactions through CAQH CORE Operating Rules

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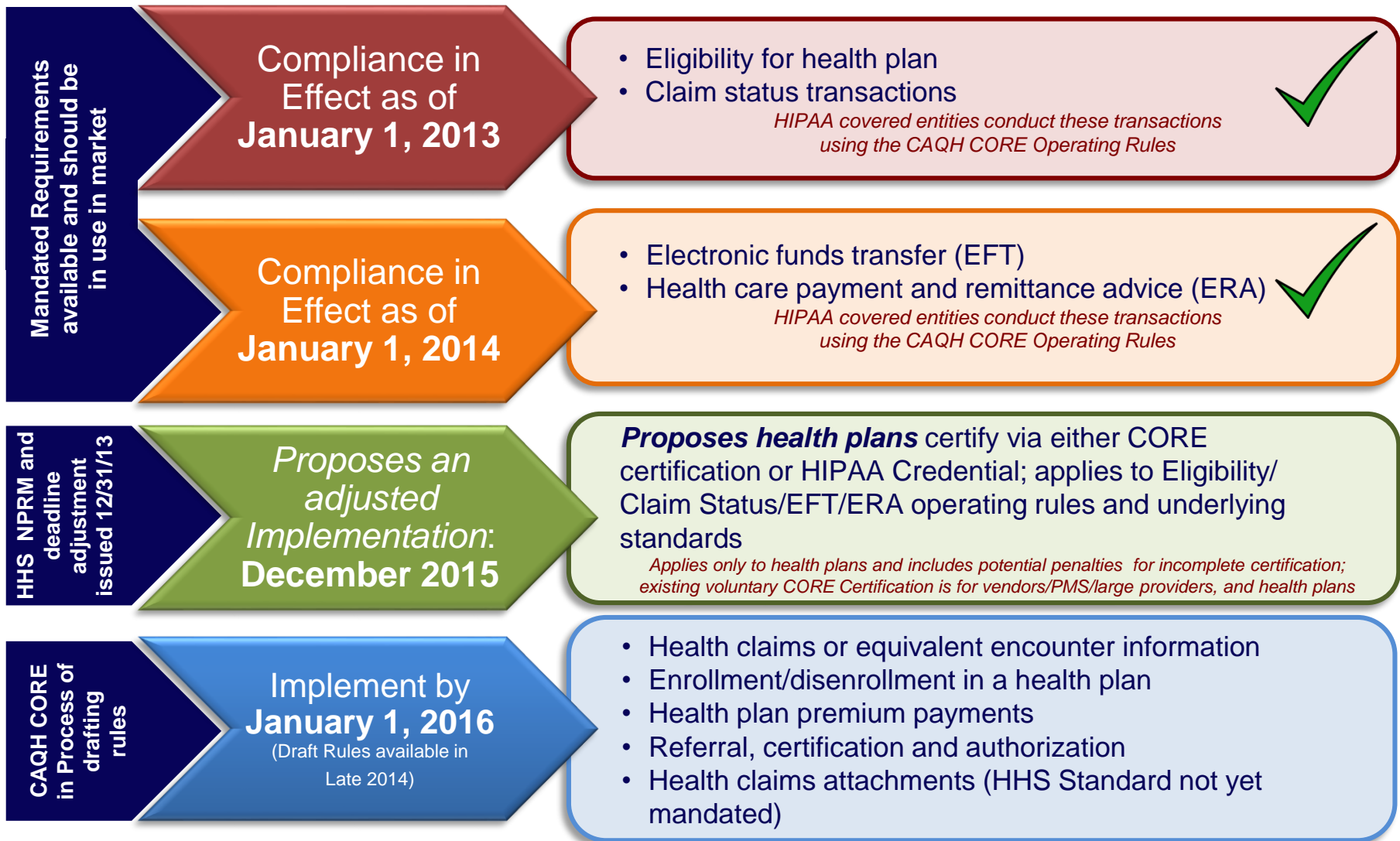
November 13, 2014

ACA Mandate and
HHS Health Plan Certification

Scope and Updates

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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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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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

NPRM Proposed Documentation of Compliance Options

CORE Phase III Certification Seal

Framework: Conformance Testing
- Involves Testing with Independent Testing Entity
- Part of the established Voluntary CORE Certification Process

OR

*HIPAA Credential**

Framework: Attestation
- Requirements outlined in NPRM
- Involves coordination with trading partners
- Draft forms here

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*May be adjusted pending final rule

Draft HIPAA Credential Forms

Per the NPRM,* *"To obtain the HIPAA Credential, a CHP would have to submit…"*

Proposed Requirements in the NPRM	Corresponding Draft Form & Purpose
"HIPAA Attestation Form…(similar to the form required for the CORE Certification)"	**Title: Draft HIPAA Credential – Attestation of HIPAA Compliance Form** **Purpose:** To enable the entity to demonstrate its good faith intention to certify HIPAA compliance
"An application form (similar to the form required to obtain a CORE Seal)….with signature verifying that all forms …are submitted….indicating that HHS may view the application and associated forms if such a request is made"	**Title: Draft HIPAA Credential - Application Form** **Purpose:** To verify that all forms have been submitted and to acknowledge that HHS may view the application
"An attestation form… in which the CHP confirms that it has successfully tested [operating rules for the three transactions] with trading partners. For each of the three transactions, the CHP must confirm that the number of transactions conducted with those trading partners collectively accounts for at least 30% of the total number of transactions conducted with providers."	**Title: Draft HIPAA Credential – Attestation of Trading Partner Testing Form** **Purpose:** To document that successful testing of transactions has occurred and to indentify trading partners with whom the entity tested

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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

Draft HIPAA Credential Forms
Requirements

Updated HIPAA Credential Draft Form Requirements

Title: Draft HIPAA Credential – Attestation of HIPAA Compliance Form

1. Attestation of Compliance with HIPAA as amended by HITECH and ACA
2. Name and signature of authorized representative
3. CHP Information, HPID

Title: Draft HIPAA Credential - Application Form

1. Name and signature of Authorized Signature
2. CHP Information, HPID

Title: Draft HIPAA Credential – Attestation of Trading Partner Testing Form

1. CHP Information, HPID
2. List of Trading Partners per Transaction with which the CHP has successfully tested
3. Trading Partner Contact Information

NPRM: "For each of the [four] transactions, the CHP must confirm that it has **successfully tested** with at least three trading partners, but if the number of transactions conducted with three trading partners does not account for **at least 30 percent of the total number of transactions conducted with providers**, the CHP could confirm that it has successfully tested with up to 25 trading partners." (79 FR 305)

CAQH CORE Operating Rules

Industry Adoption Update

# Sources to Track Industry Engagement of Operating Rules
Examples

- *Voluntary CORE Certification*
    - Although current focus is tracking industry adoption of EFT & ERA Operating Rules, the industry continues to realize the benefits of Phase I and II Eligibility and Claims Status Operating Rules
        - 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, 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"[1] in the CCD+ transaction

- There has been steady growth in the use of CCD+ for healthcare EFT payments with roughly a **180% net increase in CCD+ volume** from the beginning of Q4 2013 to the end of Q3 2014
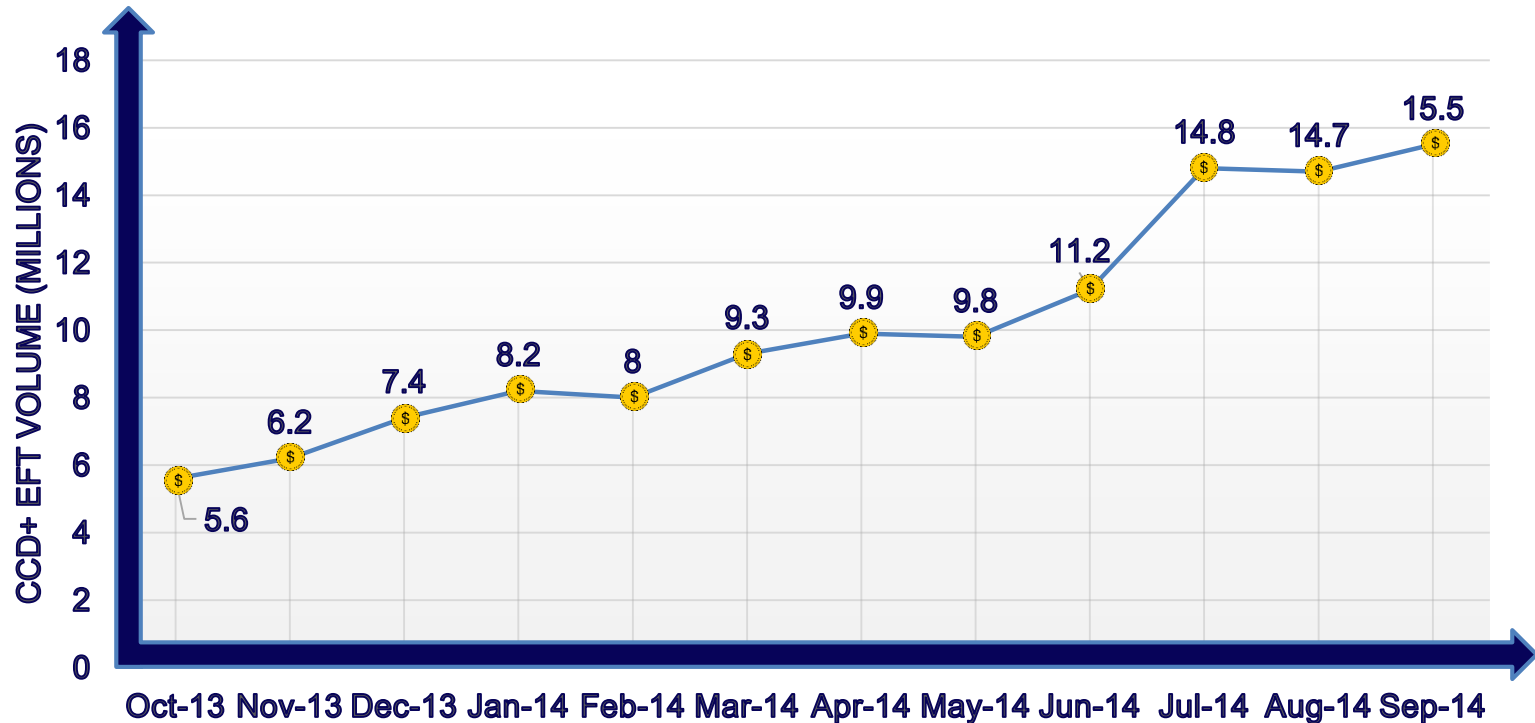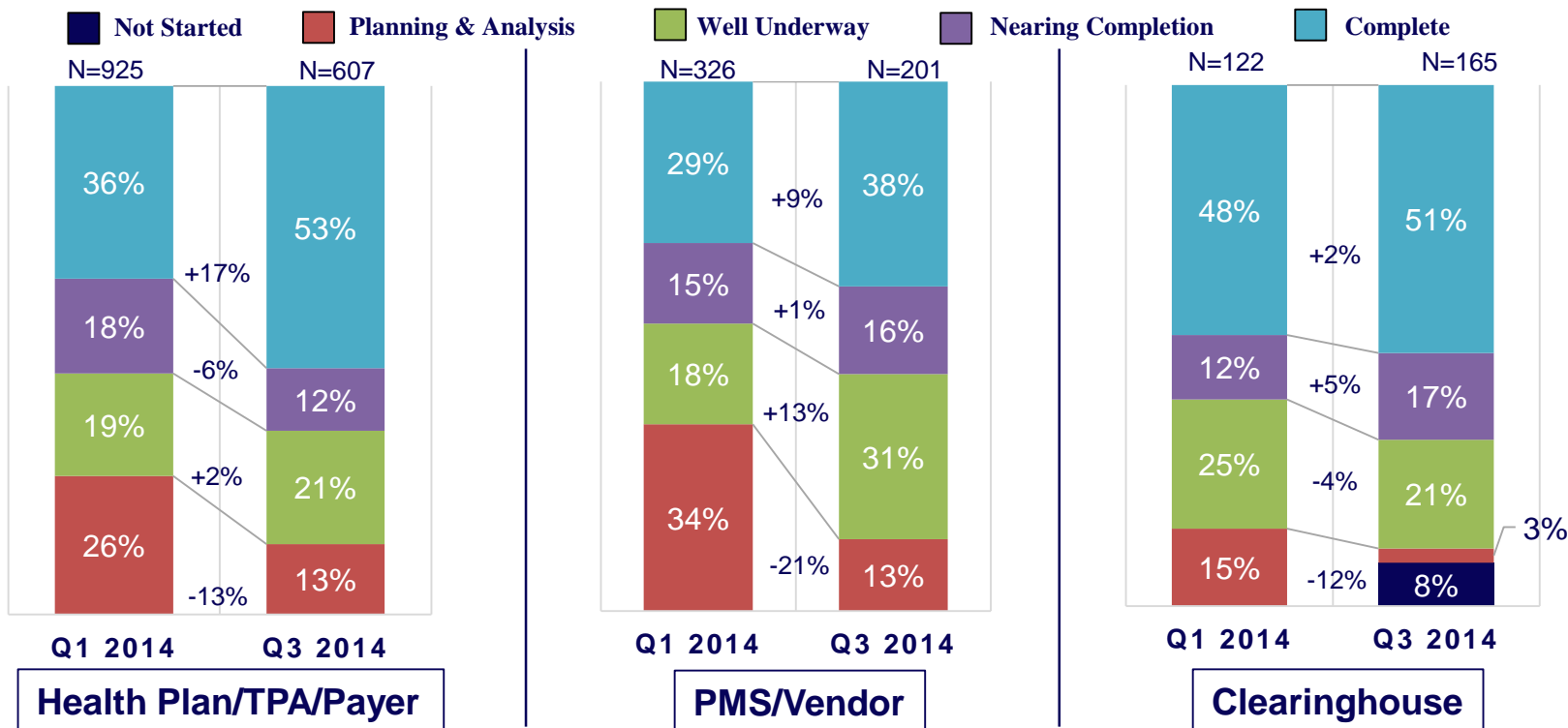

[1]NOTE: Some providers are receiving EFT payments without the HCCLAIMPMT identifiers in the CCD+. To identify an EFT payment as a healthcare EFT, originators of the transaction (i.e. Health Plans/Payers) need to include the HCCLAIMPMT identifier in the CCD+Addendum
[2]Fewer processing days in February 2014; may account for lower numbers.

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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

Legend: Not Started | Planning & Analysis | Well Underway | Nearing Completion | Complete

Health Plan/TPA/Payer

N=925 (Q1 2014):
- Complete: 36%
- Nearing Completion: 18%
- Well Underway: 19%
- Planning & Analysis: 26%

N=607 (Q3 2014):
- Complete: 53% (+17%)
- Nearing Completion: 12% (-6%)
- Well Underway: 21% (+2%)
- Planning & Analysis: 13% (-13%)

PMS/Vendor

N=326 (Q1 2014):
- Complete: 29%
- Nearing Completion: 15%
- Well Underway: 18%
- Planning & Analysis: 34%

N=201 (Q3 2014):
- Complete: 38% (+9%)
- Nearing Completion: 16% (+1%)
- Well Underway: 31% (+13%)
- Planning & Analysis: 13% (-21%)

Clearinghouse

N=122 (Q1 2014):
- Complete: 48%
- Nearing Completion: 12%
- Well Underway: 25%
- Planning & Analysis: 15%

N=165 (Q3 2014):
- Complete: 51% (+2%)
- Nearing Completion: 17% (+5%)
- Well Underway: 21% (-4%)
- Planning & Analysis: 3% (-12%)
- Not Started: 8%

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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

162 *Voluntary* CORE Certification Seals Awarded

24 Pending

| 0 | 20 | 40 | 60 | 80 | 100 | 120 | 140 | 160 | 180 | 200 |
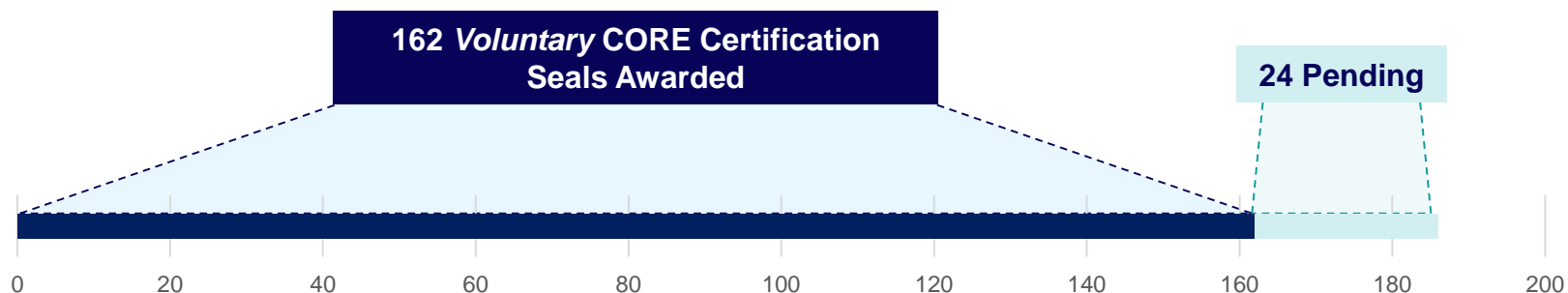
Voluntary CORE Certification Transactions

Voluntary CORE Certification is available for the following transactions:

	Phase I	**Eligibility and Benefits**
	Phase II	**Claim Status**
	Phase III	**EFT & ERA**

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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.

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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Third Set of
CAQH CORE Operating Rules
Update

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 end of 2014; 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, especially regarding challenges / benefits of requirements set by CMS; report to be shared with CORE Participants 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)

CAQH CORE Phase IV Operating Rule Development:
Status Update

Transaction	Operating Rule Status	CORE Notes and Details

X12 v5010 278 Referral Certification & Authorization* **X12 v5010 837 P/ I/ D** Claim & Encounter Reporting		• Claims/Prior Authorization Subgroup will consider two draft rules initially drafted 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*

X12 v5010 834 Benefit Enrollment & Maintenance **X12 v5010 820** Health Plan Premium Payment		• CAQH CORE contracted with a firm with Federal and State HIX experience that conducted research on HIX use of the 834 and 820 transactions • CAQH CORE Benefit Enrollment & Maintenance/Health Plan Premium Payment Subgroup will consider infrastructure requirements later in 2014
Claim Attachments		• HHS has not adopted standard for health care claims attachments or indicated what standard(s) it might consider for the transaction • CAQH CORE conducted CORE-only calls; results of polling available

*The **Connectivity & Security Subgroup** is in the final stages of updating the Draft Phase IV CAQH CORE Connectivity Rule which applies to the claims, prior authorization, benefit enrollment & maintenance and health plan premium payment transactions.*

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

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Third Set of ACA Mandated Operating Rules
CORE Connectivity & Security Subgroup

- Since November 2013, the Connectivity & Security Subgroup began drafting the connectivity and related infrastructure options for Third Set of the ACA-mandated operating rules
  - Over 80 CAQH CORE Participating Organizations from a wide variety of stakeholders; led by Co-chair Dr. S. Luke Webster, *CHRISTUS*
- As part of the Third Set Rule Opportunities, Subgroup is considering how to align with other large scale industry connectivity initiatives given the CORE Guiding Principles for alignment
  - The CSSG recently completed an initial review of the Phase IV Connectivity Rule and subsequently sent out a straw poll (to subgroup members) to vote on their initial recommendations
- ***Join the Discussion***
  - The next Subgroup call will focus on the results of the straw poll mentioned above
    - The call will take place in December 2014 (Date TBD)
  - Subgroup calls are open to all CORE Participating Organizations
  - If you are not a CAQH CORE Participating Organization but would like more information on how to become one, please visit our website HERE

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Priorities: Infrastructure Operating Rules

- Based on detailed environmental scan, Subgroup identified high-priority **opportunity areas**; specific **rule options** for each opportunity; and finally, have determined definitive **rule requirements** for each; for example:
  - **Opportunity Area:** *Improve connectivity*
    - <u>Selected Option</u>: Converge on a single envelope standard (SOAP+WSDL) to increase interoperability, plug-and-play capabilities, and align with clinical arena
      - <u>Rule Requirement</u>: The use of SOAP+WSDL envelope method is required to be supported.
      - Reminder: Connectivity is a Safe Harbor so other connectivity methods can be used
  - **Opportunity Area:** *Improve message interaction/establish processing mode expectations*
    - <u>Selected Option</u>: Batch required; real-time optional for three of the four transactions regardless of connectivity method used (real time or batch mode)
      - <u>Rule Requirement</u>: An entity's messaging system must have the capability to receive and process large Batch transaction files if the entity supports Batch transactions; they must be received, processed and the appropriate response provided back to the sender within specified time…
      - Establish expectations, roles and responsibilities
      - Requirements for both modes, if both modes are offered

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Draft Claims/Prior Authorization Infrastructure Rules:
Status Update

- Prior to the ACA, CAQH CORE developed two *draft* operating rules addressing infrastructure requirements for claims and prior authorization:
  - Draft CAQH CORE Acknowledgements for X12 837 Claims Rule
  - Draft CAQH CORE Health Care Services Review - Request for Review/Response (X12 278) Rule

- Given all the industry activity between 2009 and now including the rollout of the ACA and industry implementation of infrastructure operating rules for three transactions (eligibility, claim status, and electronic remittance advice), CAQH CORE staff has updated the above two draft rules for Claims/Prior Authorization Subgroup consideration

- Updates to the draft infrastructure rules include:
  - Addition of ACA background information
  - Updated to align with current CAQH CORE operating rule structure
  - Broadened to include all applicable CAQH CORE infrastructure requirements
  - Inclusion of explicit processing mode requirements agreed on by the CAQH CORE Connectivity & Security Subgroup

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Get Involved!

- Any CORE Participating Organization can join any CAQH CORE group
  - If you are a CORE Participating Organization and would like to join one of these group calls, please email CORE@caqh.org

CAQH CORE Group	Current Group Focus	Frequency	Next Meeting
CORE Benefit Enrollment & Maintenance/Health Plan Premium Payment Subgroup	Develop infrastructure requirements for the enrollment/disenrollment and premium payment transactions	Wednesdays 3:00-4:30pm ET bi-weekly*	Wednesday, November 20th 3:00-4:30pm ET
CORE Claims/Prior Authorization Subgroup	Develop infrastructure requirements for the claims and prior authorization transactions	Wednesdays 3:00-4:30pm ET bi-weekly*	Wednesday, December 3rd 3:00-4:30pm ET
CORE Code Combination Task Group (CCTG)	Process improvements and preparation for 2014 Market-based Review	Tuesdays 3:00-4:30pm ET bi-weekly*	December 2014 (Date TBD)
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*	December 2014 (Date TBD)

*Frequency of calls are subject to change. Please check the CORE Participant Calendar for the most accurate Subgroup call dates and times.

CAQH CORE Implementation: Operations Perspective

Karen De Leon, Washington State Healthcare Authority,
Section Manager, Office of Medicaid Systems and Data

Gwen Blank, CNSI, Deputy Program Manager, WA

Washington State – Business Model

- Facilities Management State
  - State staff process Claims and Authorizations
  - Large, bi-lingual Customer Service Call Center
  - Perform Coordination of Benefits functions and configure Reference updates

- Implemented state-of-the art modern MMIS named ProviderOne in May 2010, with sophisticated modularity between core MMIS and numerous COTS products (e.g., Rules Engine, Contact Management, Imaging, Reports, POS)

- Provider and Client Portal

- CNSI, as our contracted vendor, operates and maintains the system

- System Overview:
  - 1.6 Million clients
    - Approx. 80% Managed Care (large recent increase due to Medicaid expansion)
  - 73K active providers, of which 30K are billing providers

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CAQH CORE Phase 1-3 Operating Rules Implementation Strategy

- Compliance with federal mandates

- Leverage mandates to drive operational efficiencies

- Streamline electronic healthcare data exchange

- Continue to increase interoperability between providers and payers

- Build on existing transactions (270/271, 276/277, 999, 835, EFT)

- Apply CMS guidelines on Seven Standards and Conditions

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Phase 1-3 CAQH/CORE Operating Rules: In Review

Phase	Rule	Brief Description
1	154	Allow 270 request up to 12 months in the past from date of inquiry and up to the end of the current month
1	155	271 response returned by next business day; 999 transaction available to submitter within one hour of receipt of 270
2	259	Standard and specific error code returned on 271 response
2	260	Support 51 service type codes on 270/271 transactions
2	270	Support two new transmission methods (HTTP MIME, SOAP + WSDL)
3	360	Update Adjustment Reason and Remittance Advice Remarks codes for specific business scenarios
3	380 and 382	Consistent enrollment process for both the Electronic Funds Transfer and Remittance Advice

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Phase 1-3 CAQH/CORE Operating Rules: In Review (cont.)

Phase	Rule	Description
1, 2, 3	152, 250, 350	Update CGs to align with CAQH CORE Companion Guide Template
1	153	HTTP/S Version 1.1 connectivity
1, 2	151 and 250	Returning 999 for 270 and 276 real-time
1, 2	150 and 250	Returning 999 for 270 and 276 batch
1	156	Return 271 and 277 within 20 seconds of submission
1	157	Publish system availability through CGs and Listserv
2	258	Implement standardized use of first and last name for 270
2	259	Implement the use of specific error codes for 270 (AAA)
3	370	EFT and 835 to share the same four (4) data elements (Re-association)

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Implementation Timelines

- Phase 1 and 2:
  - Gap Analysis last quarter 2012
  - Implemented in two (2) Operational releases
  - First release September 2013 – 270/271 real-time (HTTP MIME, SOAP + WSDL) and batch (HTTPS MIME)
  - Second release December 2013 – 270/271 batch (SOAP+WSDL); 276/277 batch and real-time (HTTPS MIME, SOAP + WSDL)
  - Provider Portal Changes (Eligibility)

- Phase 3:
  - Gap Analysis last quarter 2013
  - CARCs/RARCs
  - EFT and ERA updates: December 2013
  - Provider Portal changes

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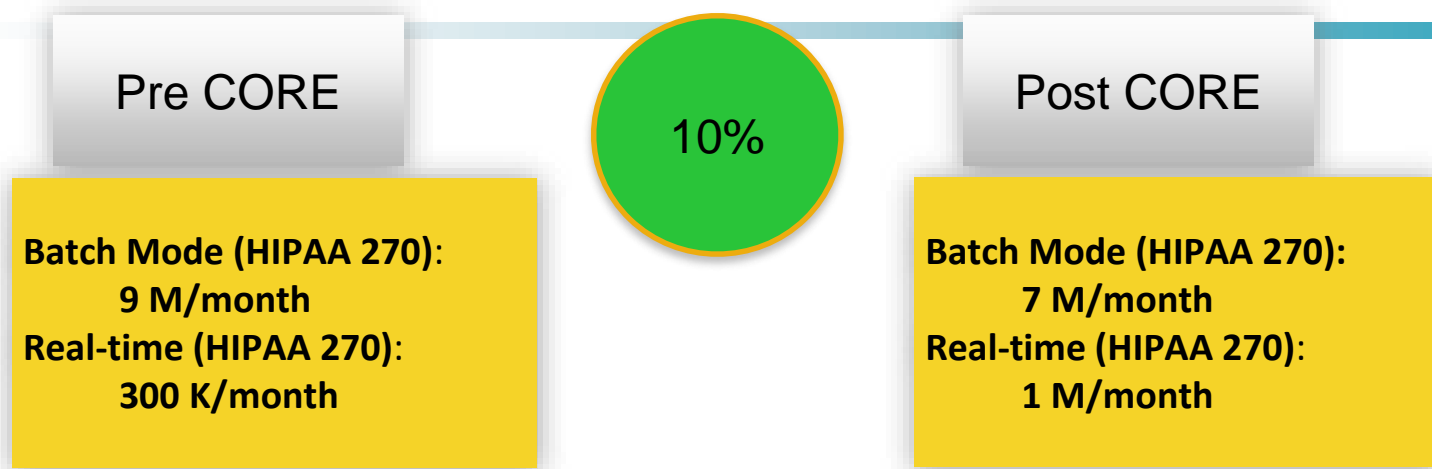A CAQH Initiative

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Implementation Challenges – State Staff

- Understanding, digesting, and analyzing rules

- AAA Error Codes – expansive mapping of codes required

- Required coordinated testing with vendor; worked together in vendor offices

- EFT/RA Re-association; working with different State agency

- CARCs/RARCs
  - Review of close to 1000 adjudication edits; 250 required updates
  - Review of all text files or online adjudication staff instructions

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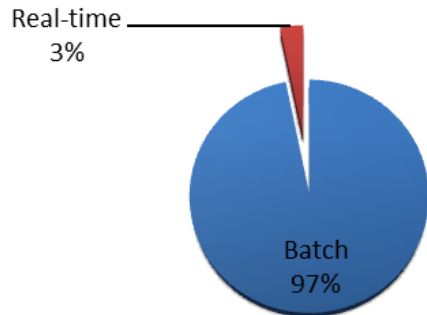for Information Exchange
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Implementation Learnings

- Created Business Plan identifying HCA's approach to achieve CORE compliance
  - Leveraged Master Spreadsheet from CAQH CORE Committee (Business Scenarios)

- Worked closely with CNSI to identify how technical platform could expanded to support HCA's Business Plan with a complete technical solution

- Used configurability of ProviderOne (MMIS) for HCA Business to enable business edits

- Coordinated testing on-site with Vendor

- Providers interested in 270/271 real-time testing only

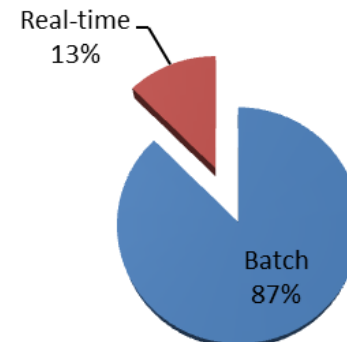- Seeing early positive returns on claim denials related to real-time eligibility

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Administrative Efficiency: Real-time Access for Eligibility

Pre CORE	10%	Post CORE
Batch Mode (HIPAA 270): 9 M/month **Real-time (HIPAA 270):** 300 K/month		**Batch Mode (HIPAA 270):** 7 M/month **Real-time (HIPAA 270):** 1 M/month

Pre CORE implementation Batch and Real-time 270

Real-time 3%

Batch 97%

Post CORE Implementation Batch and Real-time 270

Real-time 13%

Batch 87%

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Administrative Savings: Reduced Claim Rejections

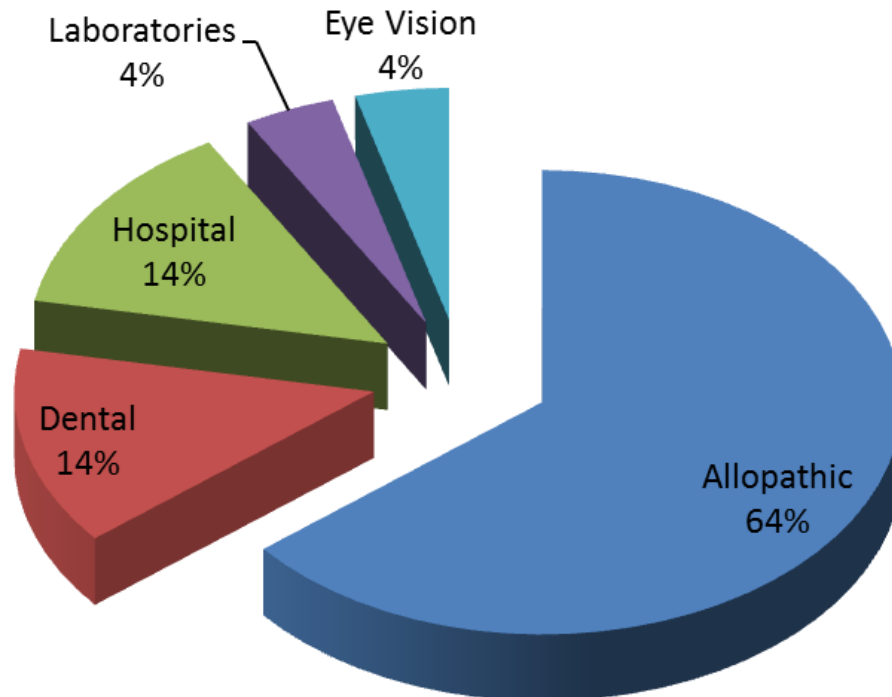| Pre CORE	16%	Post CORE
Claims that were rejected because of invalid or wrong member information before CORE Go Live (last 12 months)		Claims that were rejected because of invalid or wrong member information after CORE Go Live (last 10 months)
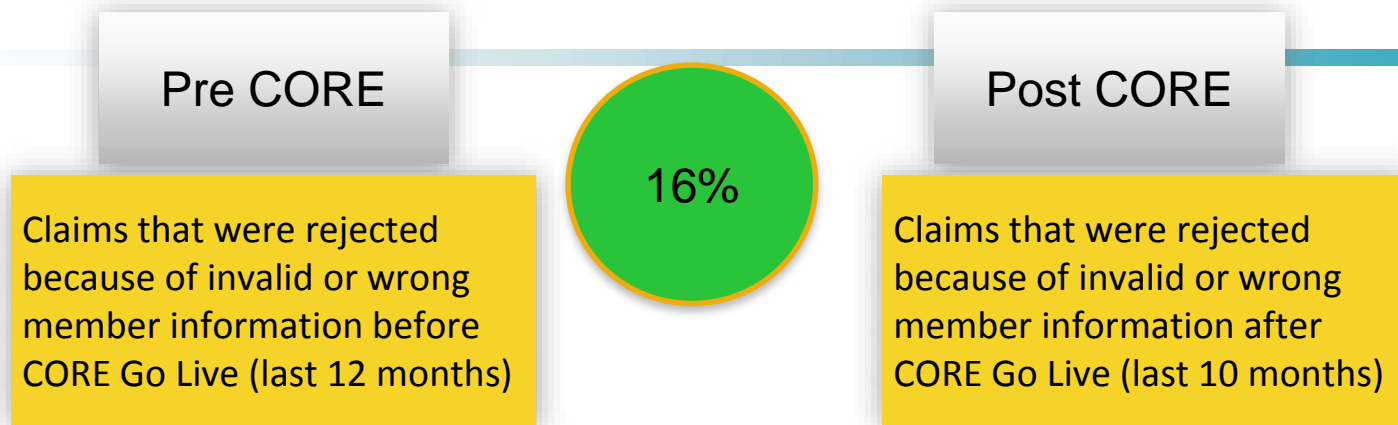
EDIT #	EDIT DESCRIPTION	Total Count Before CORE	Average Count/Month (For 12 months)	Total Count After CORE	Average Count/Month (For 10 months)	% in Reduction
02101	MISSING CLIENT ID	1503	125	556	56	56
02105	CLIENT'S LAST NAME DOES NOT MATCH OUR ELIGIBILITY INFORMATION	310795	25900	264165	26417	-2
02110	CLIENT ID NOT ON FILE	291924	24327	191068	19107	21
02121	RECIPIENT GENDER MISSING OR INVALID	18258	1522	14743	1474	3
02125	RECIPIENT DOB MISMATCH	191783	15982	158418	15842	1
TOTAL		814263	67855	628950	62895	16

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Administrative Efficiency: Eligibility Specific Inquiry

Pre CORE

All generic inquiries

<.1%

Post CORE

16% providers submitting specific inquiries
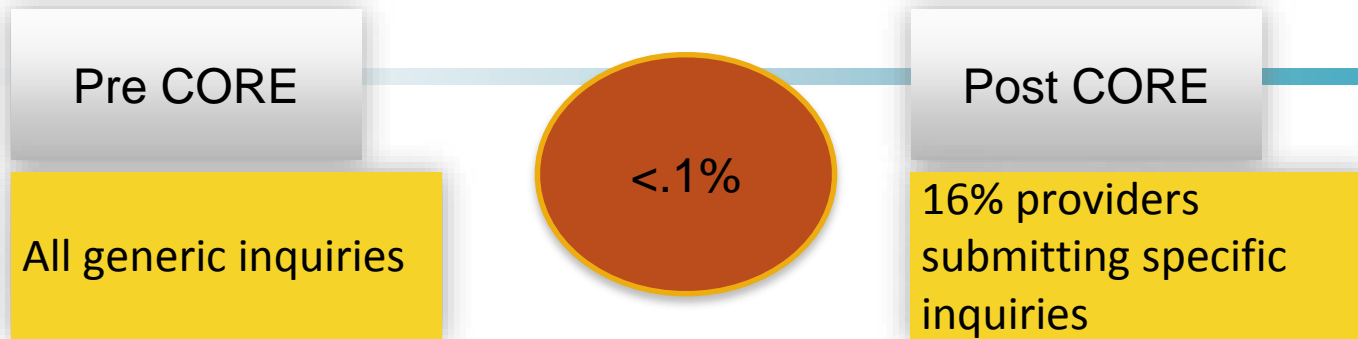
Provider Types Conducting 270 Specific Inquiries

- Laboratories 4%
- Eye Vision 4%
- Hospital 14%
- Dental 14%
- Allopathic 64%

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Technical Implementation Details

Logical Implementation of CORE Architecture
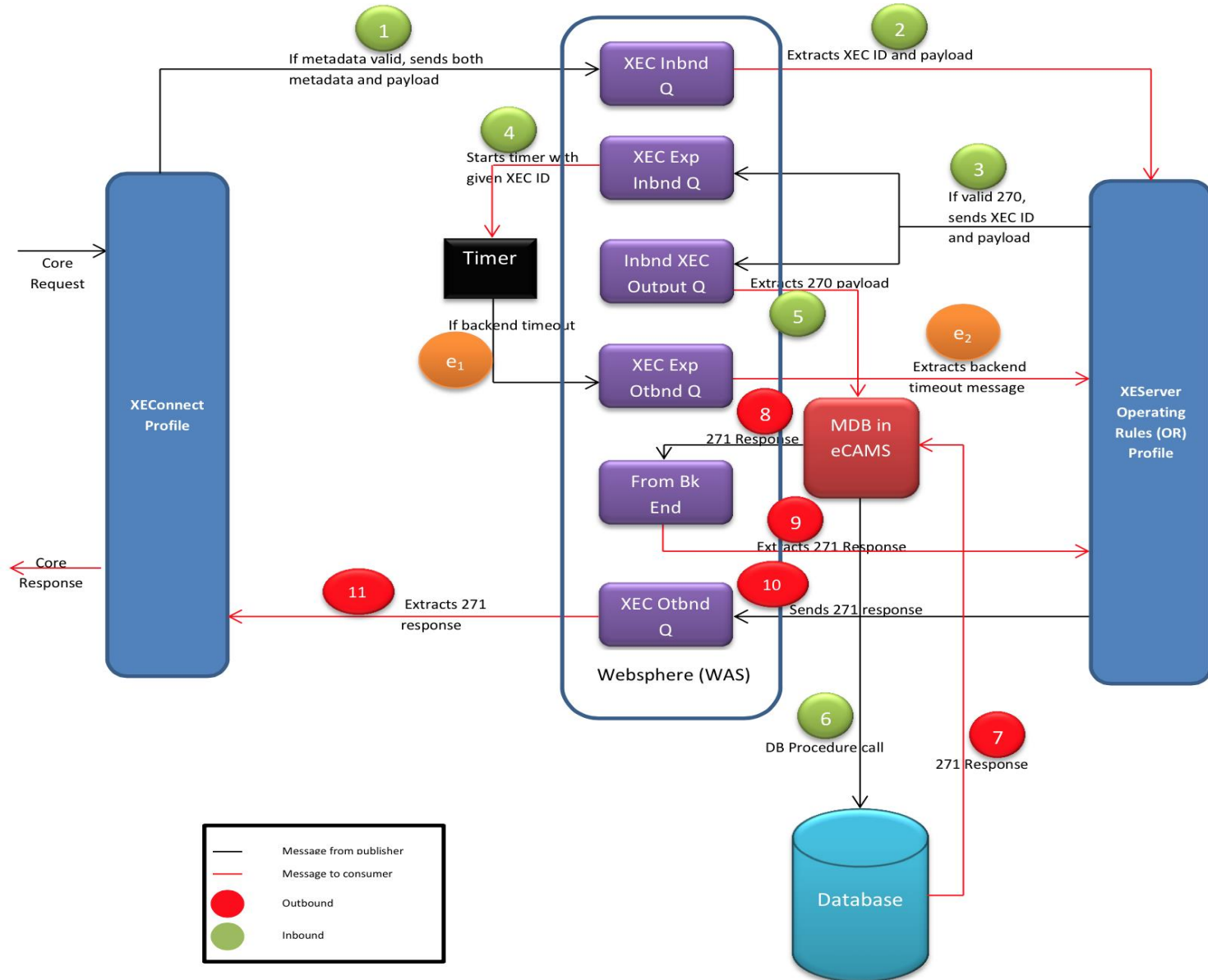
Technical Details

- High emphasis on JMS for integration

- IBM WebSphere SIB (Cluster)

- Regular expression for parsing HIPAA files

- Edifecs XEserver 8.0.2
  - XEConnect Profile
  - OR Profile

- PL/SQL table types

- IBM WebSphere Tivoli

- Wireshark to identify the usage of ports

- HTTP tunneling

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Core Utilities

- Test Tools
  - eCAMS Functionality Tester
  - HTTP/MIME Standalone Client
  - HTTP/MIME Load Testing Client
  - JMS Queue Tester
  - Test File Generator

- Operations Support Tools
  - HealthBeat
  - eCAMS Report Generator
  - Edifecs XEConnect Report Generator

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ProviderOne System Enablement

- **Business Edits and Configurations**
  - HCA State Staff able to complete edits reducing costs (system development)

- **HCA completes rules engine changes (RuleIT)**
  - HCA State Staff able to implement Business Policy in Business rule engine independently

- **Used existing eCAMs crosswalk between BSP (Benefit Service Package) and Service Type to accommodate CORE Service Types (270)**

- **Used existing eCAMS crosswalk and expanded to support CARC and RARC for CORE Phase 3**

- **System enabled MEVs to use same interface as providers**

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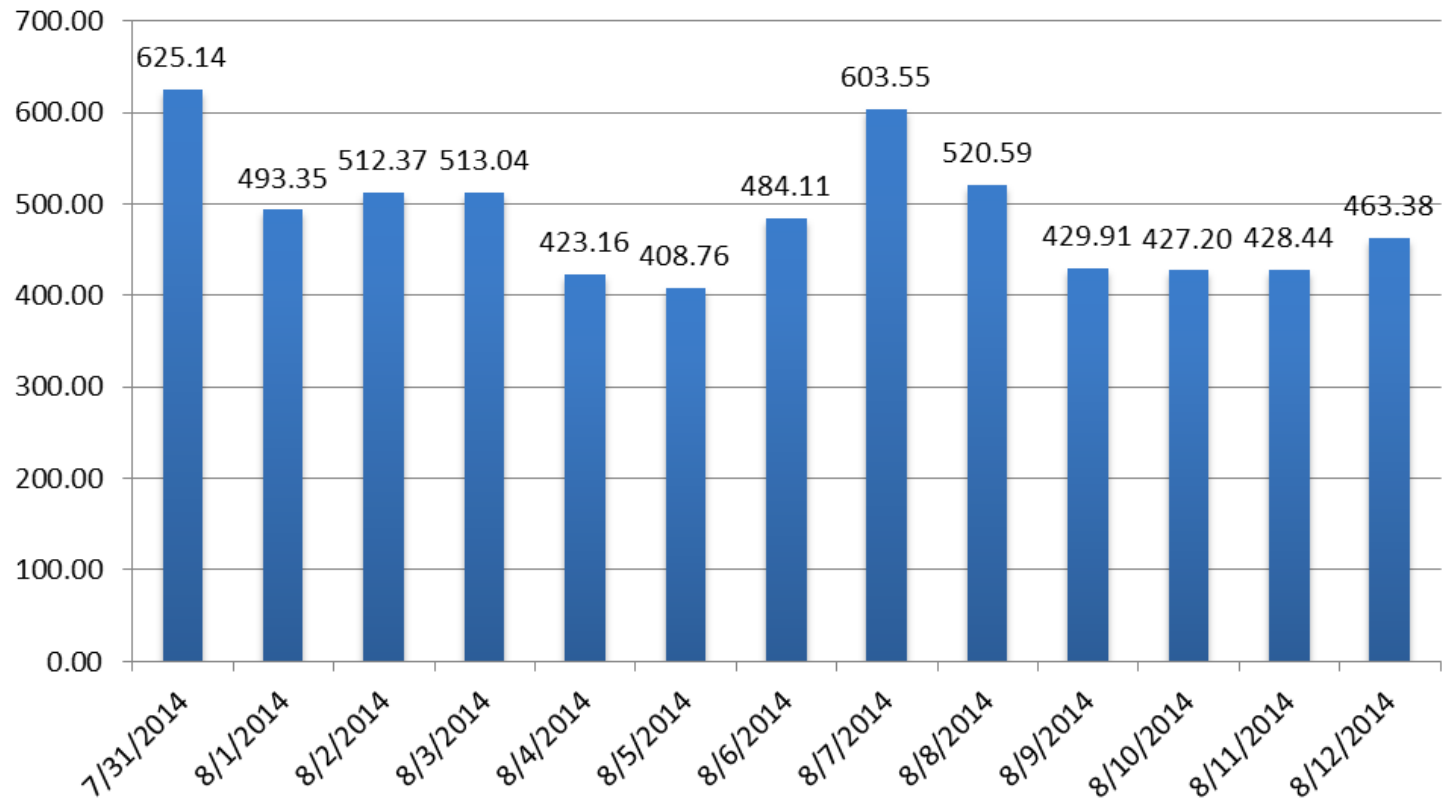for Information Exchange
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System in Action: HealthBeat Production Statistics

REAL-TIME 270/271 REQUEST COUNT
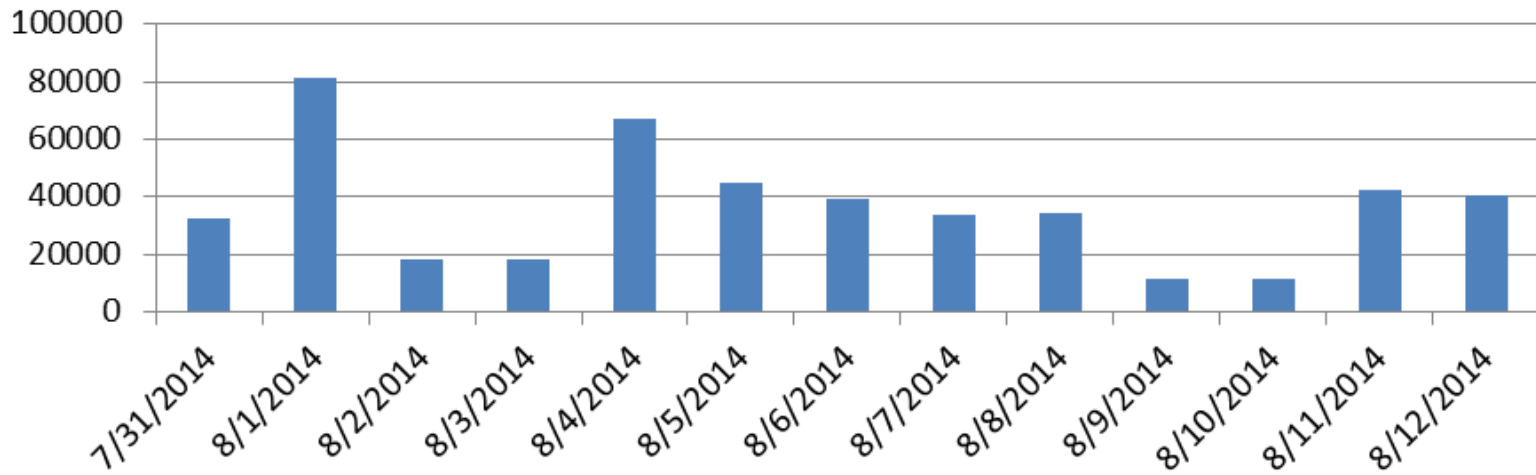
System in Action: HealthBeat Production Statistics (cont.)

REAL-TIME AVG RESPONSE TIME (in ms)

THANK YOU!

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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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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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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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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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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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