Administrative Simplification Operating Rules

December 19, 2013

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Administrative Simplification Tools

» Standards (updates for format and data content)

» Code sets (standardize and codify language used)

» Operating Rules (standardize connectivity, response time, and availability requirements)

Why Do We Need Operating Rules?

» It's all about the Providers:

- Operating rules are designed to reduce administrative burden

- Operating rules have very few requirements for providers, many benefits

Scope of Operating Rules

» **Data content requirements:** More robust eligibility response, standardized CARC and RARC code combinations ERA

» **Connectivity:** Requires "safe harbor" connection via public Internet (HTTP/S)

» **Companion Guides and Enrollment forms:** Standardized template

» **Response time:** 20 seconds or less (real time) for eligibility and claim status

» **Maintenance of rules:** Code Combinations in ERA

» Operating rules around **acknowledgements NOT** adopted

Key Dates for Operating Rules

» January 1, 2013 Compliance Date

  – Eligibility for a Health Plan (request and response)

  – Health Claim Status (request and response)

» January 1, 2014 Compliance Date

  – Health care electronic funds transfers (EFT) and remittance advice (ERA) operating rules and EFT Standards (payment and payment info)

Eligibility & Claim Status Operating Rule Set

» Operating rules for patient eligibility and health claim status transactions

» Key considerations for providers

– Easily accessible claims and eligibility information

– Secure data transmission

– Less time spent verifying information over the phone

EFT & ERA Operating Rule Set

Electronic Funds Transfer (EFT) is the transmission a health plan sends to its bank to pay provider claims electronically (through an electronic funds transfer).

Electronic Remittance Advice (ERA) is a description of payment that health plans send to providers.

EFT and ERA Operating Rules are rules enabling providers to quickly and efficiently enroll and use EFT and ERA.

Milestone:
January 1, 2014

Health Care EFT and ERA
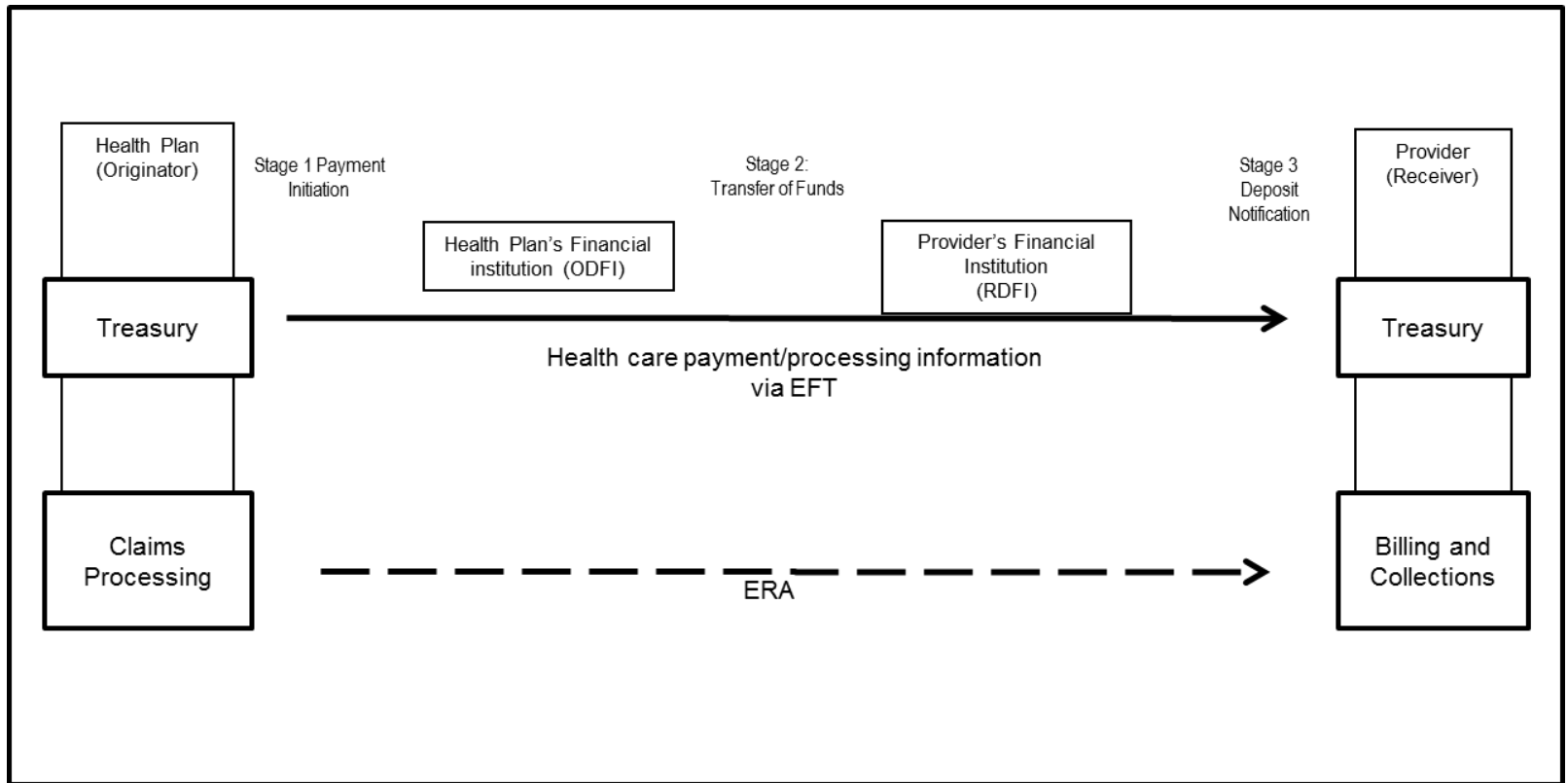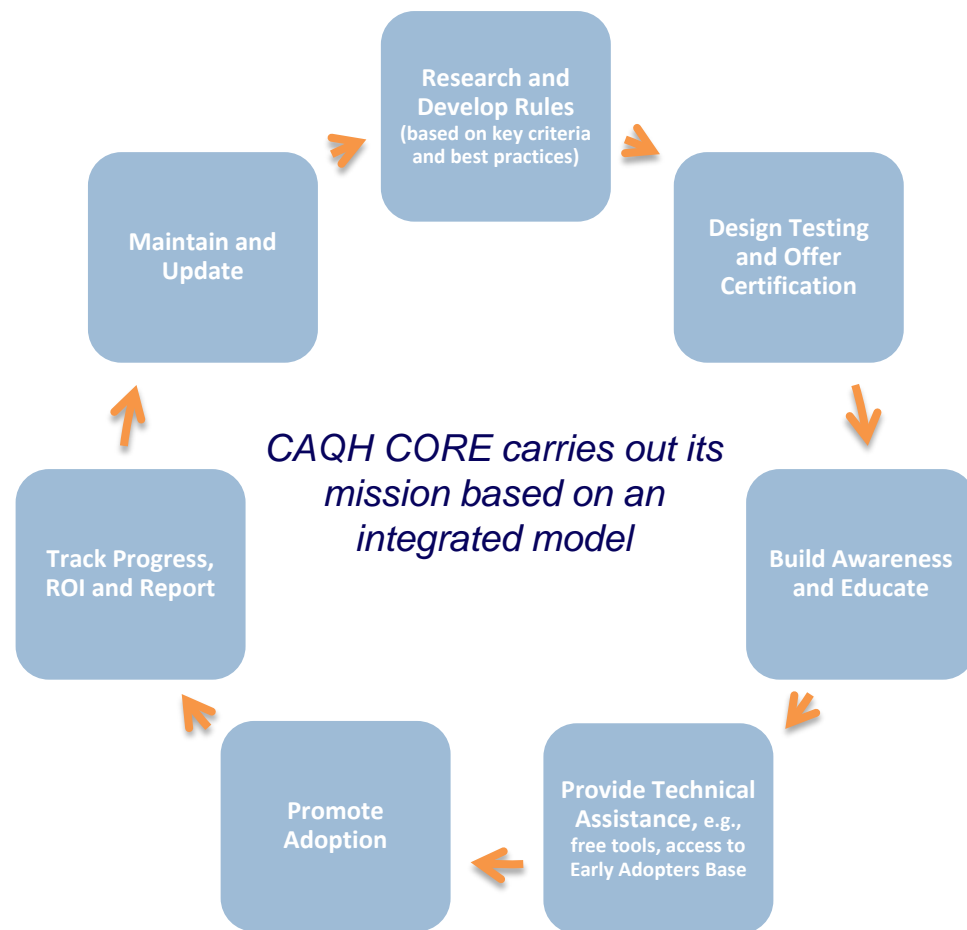
ACA mandated CAQH CORE Operating Rules

What Providers Need to Know

December 19, 2013

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CAQH CORE

- Established in 2005

- *Mission*: Build consensus among healthcare industry stakeholders on operating rules that facilitate administrative interoperability between providers and health plans, and drive adoption of operating rules and the affiliated standards

- *Vision:* Streamlined, robust, efficient, and trusted administrative data exchange based on a set of Guiding Principles such as alignment of clinical and administrative, and use of Federally mandated standards

- Designated author of ACA-mandated operating rules

CAQH CORE carries out its mission based on an integrated model

Research and Develop Rules (based on key criteria and best practices)

Design Testing and Offer Certification

Build Awareness and Educate

Provide Technical Assistance, e.g., free tools, access to Early Adopters Base

Promote Adoption

Track Progress, ROI and Report

Maintain and Update

Examples of CORE Participants

The more than 130 CORE Participants represent all key stakeholders including providers, health plans, vendors, clearinghouses, government agencies, Medicaids, standard development organizations, banks, etc.

Providers

Health Plans

Vendors

Financial Services

ACA Mandated Healthcare Operating Rules

CAQH CORE First Set of Operating Rules:
Eligibility & Claim Status

How Will Operating Rules Benefit Providers? *Eligibility & Claim Status*

> *The ACA mandated Eligibility & Claim Status Operating Rules ensure real-time access to robust eligibility and claim status data for providers*

» ***More accurate patient eligibility verification***:
– Real-time information on health plan eligibility and benefit coverage before or at the time of service
   • **Example**: Providers experienced a 24% increase in electronic eligibility verifications*

» ***Improved point of service collections***:
– Real-time provider access to key patient financials including YTD deductibles, co-pays, coinsurance, in/out of network variances via the eligibility transactions

» ***Decrease in claim denials***:
– Real-time claim status data ensures provider is aware of status in billing process
   • **Example**: Providers experienced a 10-12% reduction in denials related to eligibility*
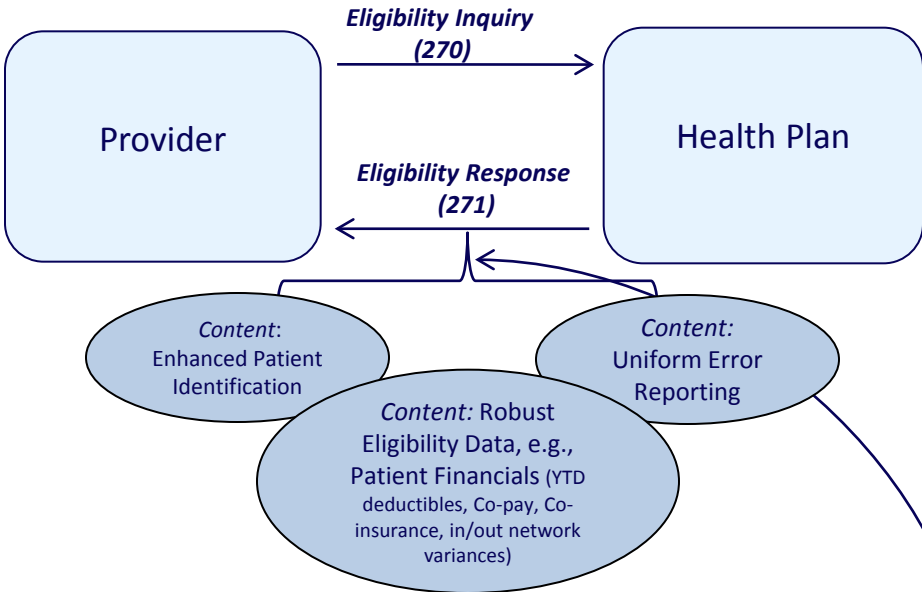
» **Timeframe**
– These ACA-mandated operating rules effective date was **January 2013** – Hospitals and health systems can benefit from them **NOW**!

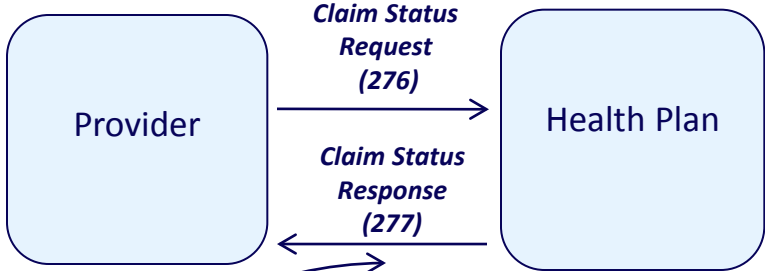* Based on the CAQH CORE Phase I Measures of Success Study when working with Phase I CORE Certified health plans.

Eligibility & Claim Status Operating Rules: *Rules in Action*

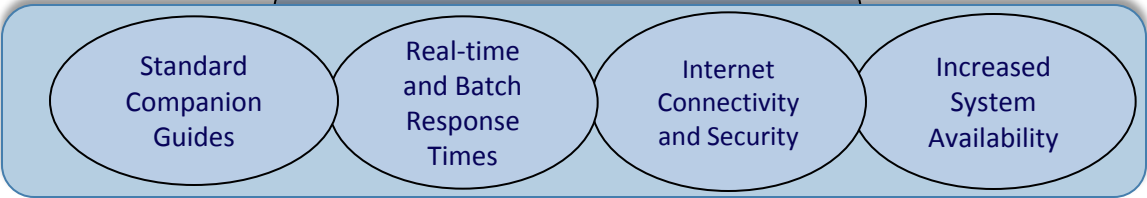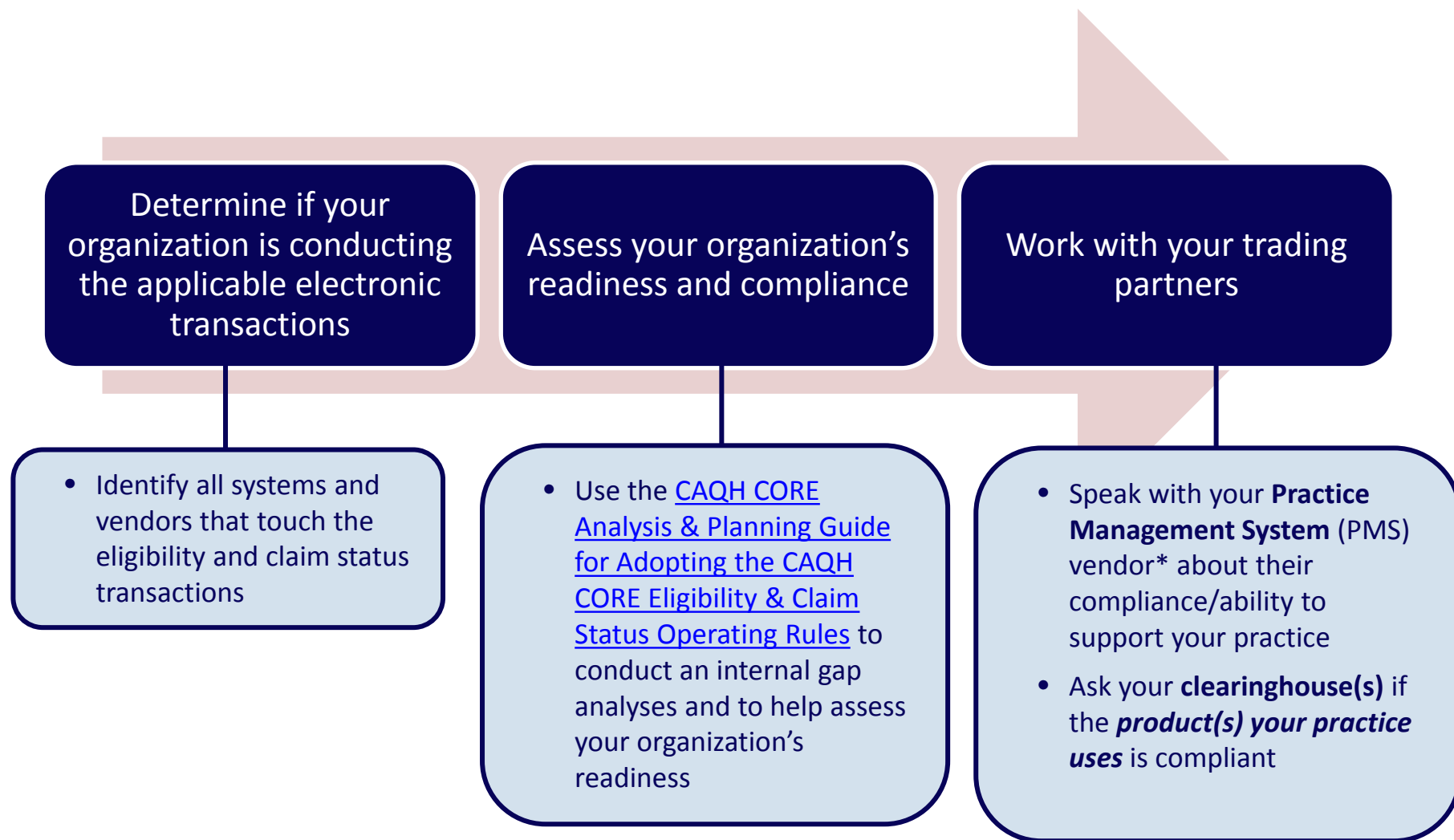*Indicates where a CAQH CORE Rule comes into play*

Pre- or At-time of Service

Provider

Eligibility Inquiry (270) →

Health Plan

← **Eligibility Response (271)**

Content: Enhanced Patient Identification

Content: Robust Eligibility Data, e.g., Patient Financials (YTD deductibles, Co-pay, Co-insurance, in/out network variances)

Content: Uniform Error Reporting

Post-Claim Submission

Provider

Claim Status Request (276) →

Health Plan

← **Claim Status Response (277)**

Infrastructure Rules

- Standard Companion Guides
- Real-time and Batch Response Times
- Internet Connectivity and Security
- Increased System Availability

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Eligibility & Claim Status Operating Rules Implementation: *Key Actions for Hospitals and Providers*

Determine if your organization is conducting the applicable electronic transactions

Assess your organization's readiness and compliance

Work with your trading partners

- Identify all systems and vendors that touch the eligibility and claim status transactions

- Use the CAQH CORE Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules to conduct an internal gap analyses and to help assess your organization's readiness

- Speak with your **Practice Management System** (PMS) vendor* about their compliance/ability to support your practice
- Ask your **clearinghouse(s)** if the *product(s) your practice uses* is compliant

* REMINDER: **PMSs are not all HIPAA-covered entities**, and thus are not mandated to be compliant - so provider requests are critical!

ACA Mandated Healthcare Operating Rules

CAQH CORE Second Set of Operating Rules: EFT & ERA

How Will Operating Rules Impact Providers? *EFT & ERA Operating Rules*

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

» *Standardized electronic enrollment for EFT/ERA*:
  – Providers will be able to enroll in both EFT and ERA electronically with all health plans using a consistent set of data elements

» *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 reassociation of EFT and ERA leading to efficiencies and reduced errors for payment posting

» Timeframe

  – Both the ACA-mandate and Medicare require compliance with the EFT Standard and the EFT & ERA Operating Rules by *January 2014*

  – Hospitals and Health Systems can start working with their trading partners to achieve these benefits **NOW!**

ACA mandated EFT & ERA Operating Rules*:
Scope and Requirements

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 Rule	• Addresses provider receipt of the CAQH CORE-required Minimum EFT Standard Data Elements required for reassociation with the ERA • Requires that a health plan release the ERA no sooner than 3 business days before or three business days after EFT is available in provider's bank • Requires Health Plans to provide written late/missing EFT and ERA resolution procedures
	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

*Access a high-level overview of the EFT & ERA Operating Rules HERE.

**CMS-0028-IFC excludes requirements pertaining to acknowledgements. The complete Rule Set is available HERE.

Uniform Use of CARCs and RARCs Rule:
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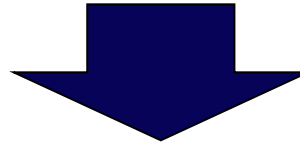

Pre-CORE Rules

243 CARCs ✕ 899 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 (332 code combos)

CORE Business Scenario #2: Additional Information Required – Missing/Invalid/ Incomplete Data from Submitted Claim (306 code combos)

CORE Business Scenario #3: Billed Service Not Covered by Health Plan (453 code combos)

CORE Business Scenario #4: Benefit for Billed Service Not Separately Payable (40 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
(332 code combos)

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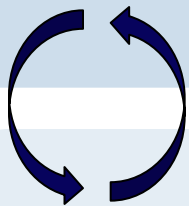(306 code combos)

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

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

Stability of CORE Code Combinations maintained

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)

Supports ongoing improvement of the CORE Code Combinations

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

EFT & ERA Implementation Steps for Providers: *CAQH CORE Resources and Tools*

Free Tools and Resources Available

Flowchart

- Just Getting Started
- Analysis and Planning
- Systems Design
- Systems Implementation
- Integration & Testing
- Deployment/Maintenance

Education is key

- 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
- Learn more about the Healthcare EFT Standard by using NACHA's (standard setting body) **Healthcare Payments Resources Website**

Determine Scope of Project and identify roles and responsibilities

- The **Analysis and Planning Guide** provides guidance to complete systems analysis, gap analysis, identification of trading partner impact and planning for implementation;

Require action from your trading partners

- **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

Show me the Seal!

- Leverage **Voluntary CORE Certification** as a quality check for ensuring that your trading partners are compliant with the EFT & ERA Operating Rules

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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EFT & ERA Operating Rules Implementation:
Checklist for Hospitals and Providers

❑ **Determine if your organization is conducting the ERA and EFT Standard Transactions**

- o If needed, request healthcare EFT payments from your payers by using the *Sample Provider EFT Request Letter*

❑ **Educate yourself on the EFT & ERA Operating Rules**

- o Read the EFT & ERA Operating Rules and listen to past EFT & ERA Education Sessions
- o Access our Provider-focused website that offers action-oriented information and key steps toward implementation

❑ **Assess your organization's readiness/compliance**

- o Use the *CAQH CORE Analysis & Planning Guide for EFT & ERA Operating Rules* to conduct internal gap analyses and to help assess your organization's readiness

❑ **Require action from your trading partners**

- o Understand health plan and applicable vendor agreements and options for payment and remittance information
- o Contact financial institution and use the *Sample Provider EFT Reassociation Data Request Letter* to discuss how you will be receiving EFT and payment related information
- o Ensure that your trading partners are compliant with the EFT & ERA Operating Rules by leveraging Voluntary CORE Certification*

❑ **Submit your input on claim and denial codes**

- o Access information about claim and denial codes through our CAQH CORE Code Combination Website
- o Register for one of our Market Based Review (MBR) Training Sessions on December 20th (HERE) or January 9th (coming soon) to learn how to use the Online MBR Submission Form

Your Engagement and Participation: *How to Contribute*

- ❑ **[Join](#) CAQH CORE to directly contribute**
  - ○ The most effective way for individual organizations to ensure they have direct input on the operating rules is to become a CORE Participating Organization
    - Participation on Subgroup/Work Group rules-writing calls, surveys, straw polls, and ballots; eligibility to Co-Chair
    - Entity vote on CAQH CORE Operating Rules at Work Group and Full CORE Membership voting levels
    - Access to CAQH CORE Education Sessions specific to CORE Participating Organizations
- ❑ **Implement Operating Rules at your organization and track ROI – let us know what you find!**

Your Engagement and Participation:
How to Contribute

❑ **Submit Market-based Adjustments to the CORE Code Combinations through our <u>online submission form</u>**

- o Attend the upcoming Market-based Review Training Sessions on <u>December 20th</u> and January 9th to learn more

❑ **Complete CAQH CORE Industry Surveys**

- o CAQH CORE periodically conducts industry-wide surveys for directional feedback on operating rule opportunities; email <u>core@caqh.org</u> to be added to the distribution list

❑ **Work directly with standard setting bodies like CMS OESS, NACHA and the various code committees**

❑ **Host Educational sessions within your organization/system**

❑ **Attend CAQH CORE Education Sessions**

❑ **Offer to speak on future CAQH CORE Education Sessions**

- o We are always looking for industry implementers that are willing to speak about their implementation experiences

Thank You!

Contact CORE@caqh.org with questions

HIPAA Enforcement – Current Process

» The current HIPAA Transactions & Code Set (TCS) and Affordable Care Act (ACA) operating rules enforcement process is primarily complaint-driven.

» The CMS website, http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Enforcement offers a wide range of helpful information about Enforcement.

EFT Payment Considerations

» EFT Standard (financial standard: CCD+) is an Automated Clearing House (ACH) payment network standard

» In EFT rules, entities have a choice: ACH or other payment network

» Health plans must transmit payments through ACH network if requested by the provider

Questions?

» For information on claims, eligibility, EFT, and ERA operating rules, visit the eHealth website (http://www.cms.gov/eHealth/) and look for Administrative Simplification under the Programs tab

● For information on HIPAA, operating rules, standards and identifiers, visit the ACA section at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act