Financial Institutions Support Healthcare Payments & Remittance Automation

Additional information/resources available at
www.caqh.org

CORE
Committee on Operating Rules for Information Exchange

NACHA
The Electronic Payments Association®

PAYMENTS 2013
April 21-24 | San Diego, CA

Agenda

- Introduction: Alignment of Healthcare and Financial Services
  - Introduction to CAQH CORE
  - Overview of the ACA Mandated EFT & ERA Operating Rules
- Case Study: Implementation at a Major Health Plan
  - Overview of Aetna
  - Efforts to Drive Provider EFT and ERA Adoption
  - Status of EFT & ERA Operating Rules Implementation
- The Provider Perspective: How to Drive Use of EFT & ERA
  - Overview of HCA
  - Increasing Provider Use of EFT and ERA
  - Reaping the Benefits of Operating Rules
- Q&A

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Objectives

- Understand role of healthcare operating rules, their alignment with financial services, and how they will help break down barriers to automation of payment
- Hear an update on the status of implementation of the ACA mandated EFT & ERA operating rules
- Learn how a major health plan and health system are working to increase adoption of EFT and ERA
- Consider how financial services can assist health plans and providers as industry transitions to more automated payments

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Introduction to CAQH CORE

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CAQH: Current Initiatives

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Industry-wide stakeholder collaboration to facilitate development and adoption of industry-wide operating rules for administrative transactions. Over 130 participating organizations.

Universal Provider Datasource®

Service that replaces multiple paper processes for collecting provider data with a single, electronic, uniform data-collection system (e.g., credentialing).

CAQH Solutions EFT ENROLLMENT

Service that enables providers to enroll in electronic payments with multiple payers and manage their electronic payment information in one location, automatically sharing updates with their selected payer partners.

Objective industry forum for tracking progress and savings associated with adopting electronic solutions for administrative transactions across the industry.

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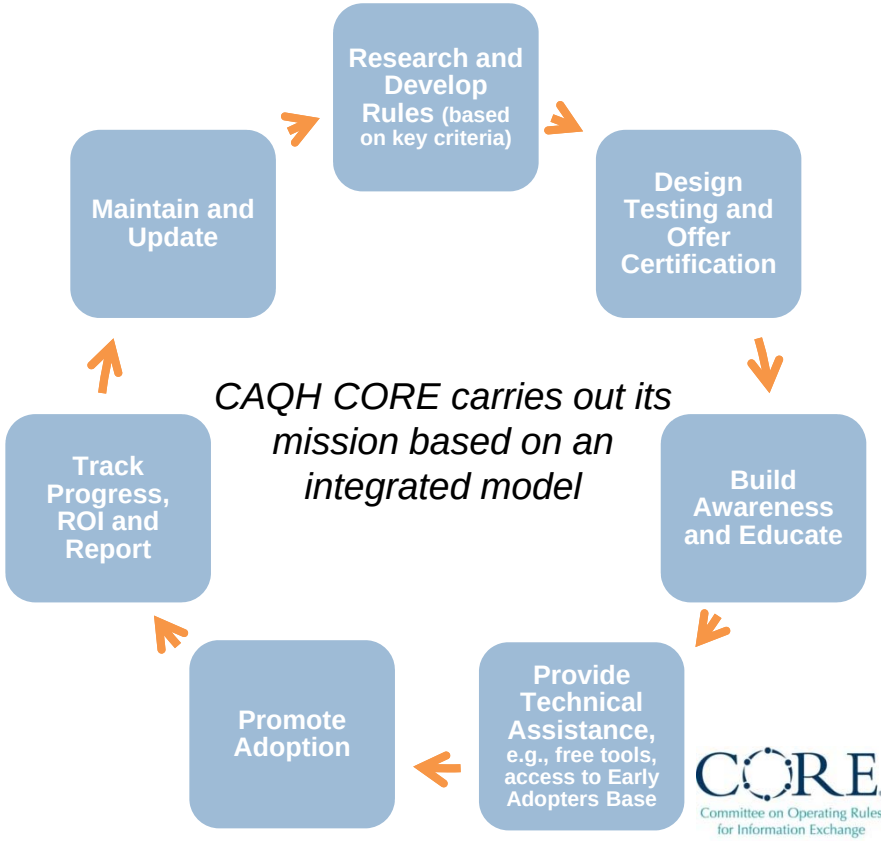
CAQH CORE

- Established in 2005
  - Serving as recognized author of ACA-mandated operating rules
- Mission: Build consensus among healthcare industry stakeholders on operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response
  - Ensure the rules can be implemented in phases that encourage feasible progress
  - Facilitate administrative and clinical data integration
  - Do not require dependency on or creation of one centralized database



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

- Johns Hopkins Medicine
- Cedars-Sinai
- CHRISTUS Health
- Dignity Health
- Mayo Clinic
- Montefiore Inspired Medicine
- American Hospital Association

Health Plans

- Kaiser Permanente
- WellPoint
- Humana
- Coventry Health Care
- UnitedHealthcare
- aetna
- Cigna
- Highmark

Vendors

- GE Healthcare
- RelayHealth Health Connections Brought to Life
- athenahealth
- Epic
- emdeon
- InstaMed Healthcare Payments Simplified
- FIS
- TransUnion Healthcare

Financial Services

- Bank of America
- Fifth Third Bank
- MasterCard Worldwide
- PNC
- The Clearing House At the Center of Banking Since 1853
- VISA
- US Bank

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Industry Context: Federally Mandated Operating Rules

- Today, operating rules support existing standards in many high-volume industries, e.g. cellular phones, financial services, transportation, etc.
- Prior to 2005, national operating rules for medical administrative transactions did not exist in healthcare outside of individual trading partner relationships
- In 2005 CAQH CORE began facilitating voluntary development of industry-wide healthcare operating rules
- In 2010, Section 1104 of the Patient Protection and Affordable Care Act (ACA) required that *all HIPAA covered entities* be compliant with applicable HIPAA standards **and associated operating rules**

The effective date for the first set of ACA mandated operating rules was January 2013; additional deadlines follow through 2016.

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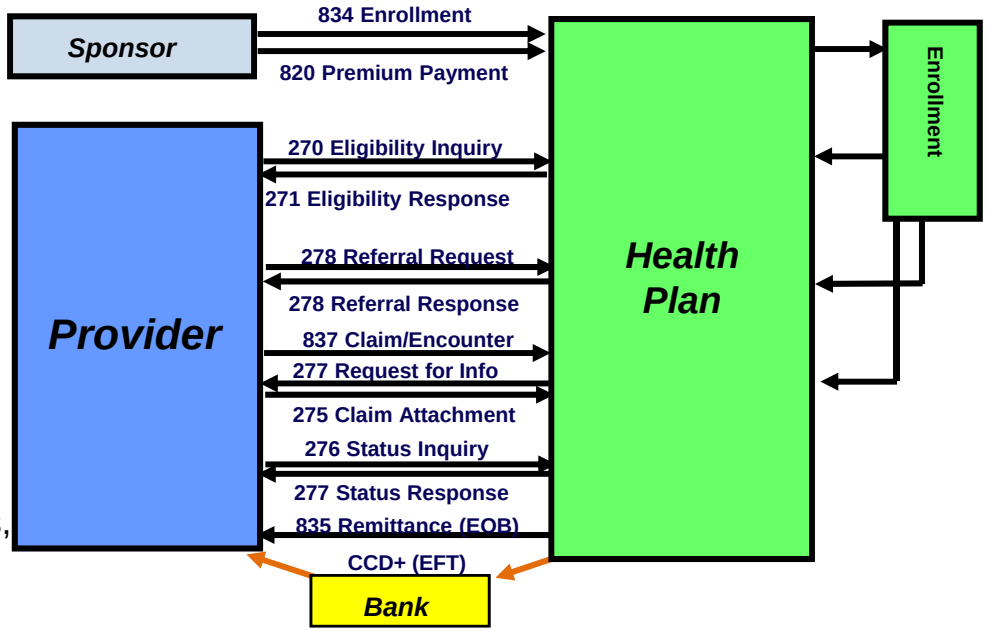
A Spectrum of Change For Healthcare

- **HHS Goal**: Generate a system-wide approach to administrative IT adoption that aligns with other U.S. healthcare strategic initiatives
- Each transaction in the healthcare revenue cycle was addressed by HIPAA in 1996; standards alone did not achieve *Administrative Simplification* – thus, ACA amended HIPAA
- Due to ACA and other pressures, during the next several years *the entire* revenue cycle process will experience significant transformation as the industry evolves
  - Transforming existing transactions through exchange of critical data, e.g. patient financials, and improved infrastructure to drive interoperability and ROI
  - Adding new transactions via new data exchange method, e.g. ACH, to drive automation



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Additional Emerging Market Pressures

Emerging Market Forces

MLR Pressures and Rate Monitoring

- Healthcare reform creates significant pressure on payers to manage cost due to:
  - MLR minimums.
  - Close monitoring of premiums.

Emerging Care Delivery and Payment Models

- Growth of payer-provider collaboration efforts in care delivery, such as ACOs and Patient-centered Medical Homes.
- Experimentation with new payment models, such as global and bundled payments.

Provider HIE and HIT Adoption

- Incentives to encourage provider adoption of HIEs and EMRs.
- Need to enhance connectivity and information sharing amongst healthcare stakeholders to enable new payer-provider collaboration efforts around care delivery.

Health Insurance Exchanges and Growth in B2C

- Shift of uninsured, individual, and small group segments towards health insurance exchanges.
- Greater competition (e.g., transparency, similar benefit packages) on the exchange market – on the basis of value, instead of price.

Imperatives

- Simplify healthcare administration to minimize administrative cost, reduce transaction delays, allow more seamless information sharing, and improve member/patient and provider experience:
  - Eliminate redundancy in transactions across healthcare system.
  - Standardize protocols to reduce exceptions and therefore delays.
  - Enhance interoperability in electronic information exchange.
  - Consolidate data sources.
  - Eliminate error-ridden paperwork through automation.
  - Reduce information technology spending through industry-wide “utilities.”
- Simplify healthcare administration to enable new care and payment delivery models.
- Commoditize functions that are not sources of competitive advantage.

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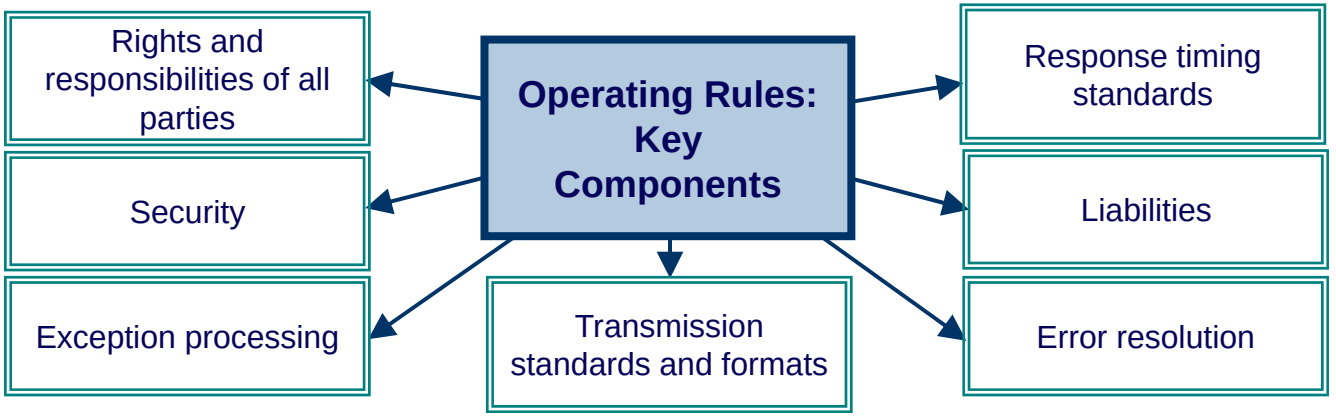
Purpose of Operating Rules

- The Patient Protection and Affordable Care Act (ACA) defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
- They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards



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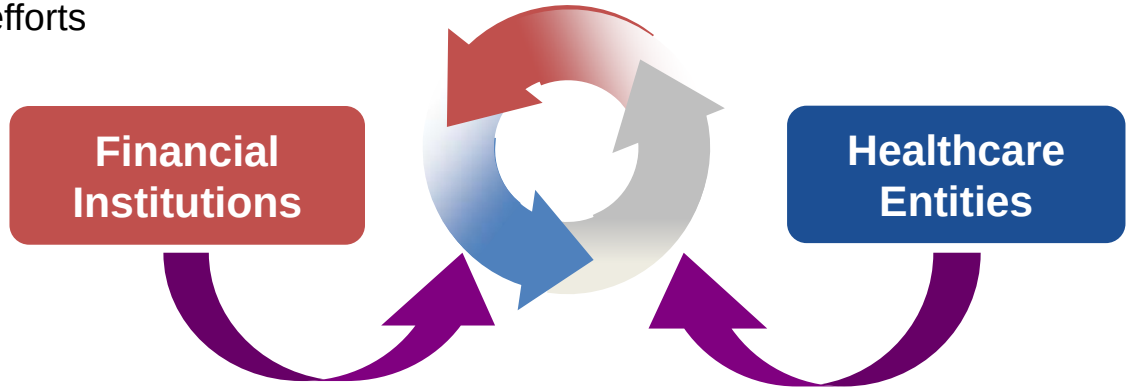
Cross Industry Collaboration for EFT & ERA Operating Rules

- CAQH CORE and NACHA: Healthcare and Financial Services Alignment
  - CAQH CORE and NACHA partnership established in 2005 and continues to build over time
  - Due to the mandated healthcare operating rules on EFT and the opportunities for the healthcare industry to transform the way payments are made, there is a convergence of financial services and healthcare
  - During development of the CAQH CORE EFT & ERA Operating Rules, CORE Participants identified key areas where new or modified *NACHA Operating Rules* could address current issues in using the NACHA CCD+ when doing EFT healthcare payments over the ACH Network
    - The *NACHA Operating Rules* and CCD+ Standard have subsequently been adjusted to help align with the healthcare operating rules
  - Ongoing collaboration between CAQH CORE and NACHA including extensive education and outreach efforts



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Overview of ACA Mandated EFT & ERA Operating Rules

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ACA Mandated Operating Rules Compliance Dates: *Required for all HIPAA Covered Entities*

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Compliance in Effect as of January 1, 2013

- Eligibility for health plan
- Claims status transactions

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

Implement by January 1, 2014

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

Implement by January 1, 2016

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

★ Rule requirements available.

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Healthcare EFT & ERA Standards + Operating Rules

ACH CCD+ & X12 v5010 835

- **EFT**: NACHA CCD+Addenda (must contain the TRN Reassociation Trace Number data segment as defined by X12 835 TR3 version 5010)
- **ERA**: X12 v5010 835

CAQH CORE EFT & ERA Operating Rules

- Provider enrollment in EFT and ERA
- Infrastructure for supporting the ERA
- Uniform use of codes for conveying claim adjustments/denials
- Reassociation of the EFT and ERA

Together, EFT & ERA Standards and Operating Rules will deliver efficiency and consistency across the healthcare industry

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CAQH CORE EFT & ERA Operating Rules in Action

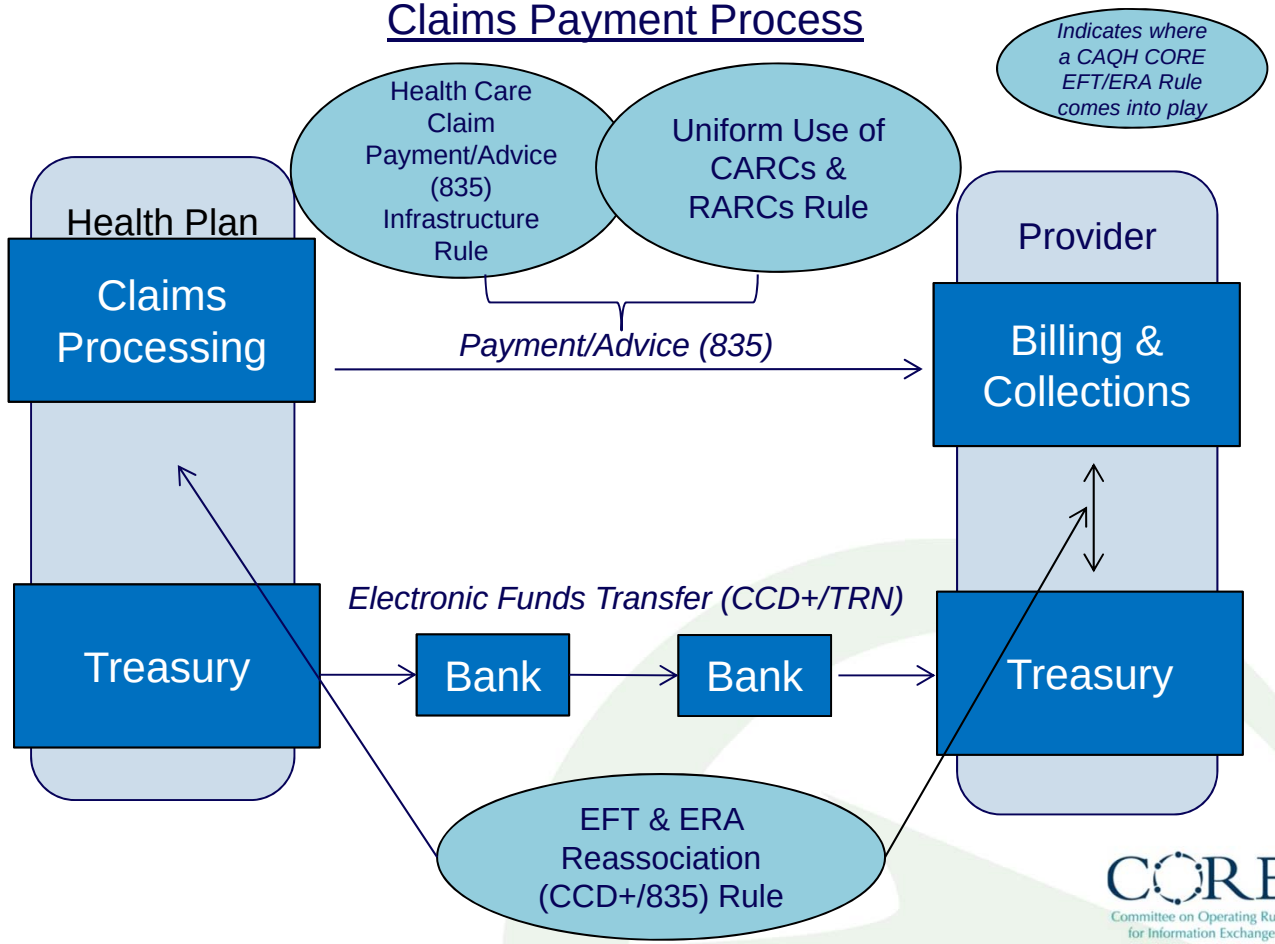
Pre- Payment: Provider Enrollment

EFT Enrollment Data Rule

ERA Enrollment Data Rule

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

Claims Payment Process



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EFT Enrollment Data Rule: Key Rule Requirements

- A health plan (or its agent or vendors offering EFT enrollment) is required to:
  - Offer an electronic way for provider to ***complete and submit*** the EFT enrollment
  - Collect only the CORE-required Maximum EFT Enrollment Data Set; includes some optional data elements
  - Use the format, flow, and data element descriptions without modification in the EFT Enrollment Data Set
  - Make available to the provider (or its agent) specific written instructions/guidance to the provider for enrollment and the specific procedure to accomplish a change in/cancellation of their enrollment
  - Additional requirements specific to electronic and paper-based enrollment noted in the rule

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

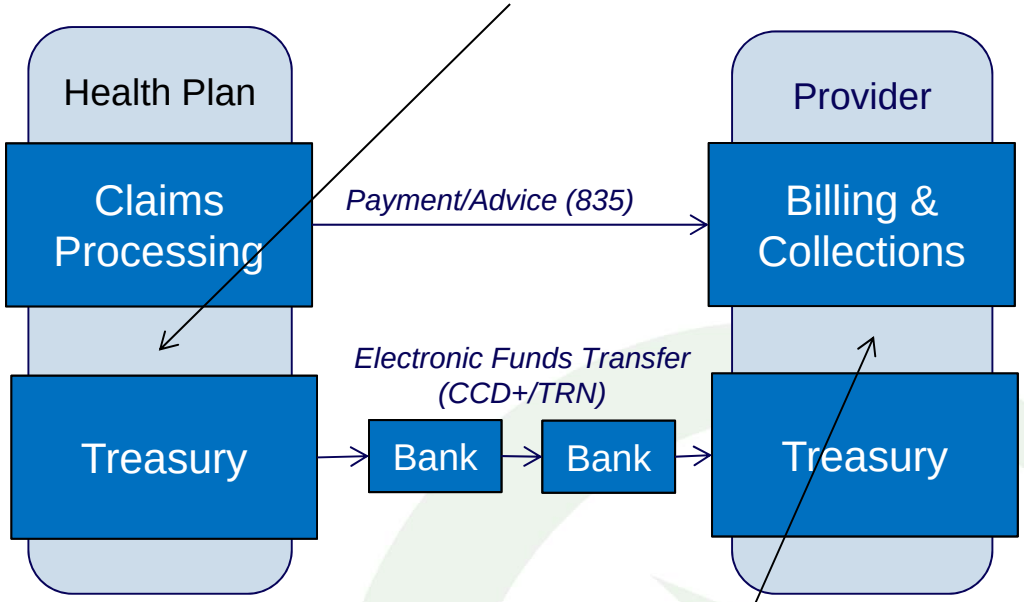
Pre- Payment: Provider Enrollment

(1) CORE-required Minimum CCD+ Reassociation Data Elements:

- Health plan must inform provider during enrollment to contact bank for the delivery of CORE-required Minimum CCD+ Reassociation Data Elements
- Provider must proactively contact bank for data

Claims Payment Process

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



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

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Early Observations

- Sources for tracking implementation efforts are numerous and include the CAQH CORE Request Process, Polling and Q&A sessions during education events, and Voluntary CORE Certification

- Key Observations
  - Foundation for operating rules already established from the first set
    - HIPAA covered entities familiar with concept and goals of operating rules; entities developing project plans earlier than with first set
    - Already understanding that implementations require coordination with vendors
    - Awareness of key infrastructure requirements already exists given similarity to first set
  - Human and financial resource management challenges
    - Gaps in expertise and lack of learning sources; competing priorities
  - Information technology considerations
    - Adopting newly mandated standards, e.g., EFT (estimated 30% adoption rate), Attachments
    - Connecting internal IT systems and departments in order to deliver and analyze detailed data
    - Growing comfort level in sharing operational realities, e.g., when and which IT systems will be sunsetted
  - Partnership development is essential
    - Trying to align internal timelines with those of key trading partners, especially PMSs
    - Requiring contractors share in vision and act with intent that ongoing change is an expectation

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Case Study:
Implementation at a Major Health Plan

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Snapshot of Aetna

Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits.

- **Membership**
  - Over 18 million medical members
  - More than 13 million dental members
  - Approximately 8.7 million pharmacy members
- **Health care networks**
  - More than 1 million health care professionals
  - More than 597,000 primary care doctors and specialists
  - More than 5,400 hospitals
- Broad range of insurance and employee benefits products:
  - Consumer-directed health plans such as Health Savings Account, Health Reimbursement Account and Retiree Reimbursement Accounts
  - Case management; disease management and patient safety programs; integrated medical, dental, pharmaceutical, behavioral health and disability information
  - Convenient tools and easy-to-understand information for members that can help them make better-informed decisions about their health and financial well-being
- National Presence
  - Benefits through employers in all 50 states, with products and services targeted specifically to small, mid-sized and large multi-site national employers
  - Serves individuals and Medicare and Medicaid beneficiaries in certain markets

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Efforts to Drive Provider EFT and ERA Adoption

- Aetna's business strategy to shift providers toward automated payments includes two key components:
  - Focus on turning off provider's paper Explanation of Benefits (EOBs) and checks
  - Drive to an electronic solution such as encouraging the enrollment in ERA or if appropriate, our on-line EOB
- Aetna tracks and measures success for paper shut off as a percent of claims off paper, e.g. no paper EOB ***or*** check
  - Medical and Dental combined = 67% (Medical only is 74%)
  - If we look at total providers in our database, the figure is around 43%

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Communication is Key to Driving Adoption

- Aetna uses a multi-channel communication strategy to drive provider adoption of EFT and ERA
- Communication methods to advocate adoption include:
  - Encourage enrollment in EFT, partnerships with ERA vendors to build support for provider outreach to enroll in ERA and/or EFT
  - Outreach phone calls to providers who submit ERA enrollment without enrolling in EFT, attaching an EFT enrollment form to ERA confirmation emails
  - Articles published in Aetna's Provider Newsletters marketing the value of electronic solutions
  - Distribution of hundreds of thousands of EFT enrollment forms with paper checks to providers to encourage them to enroll in EFT
  - Monthly live webinars to educate providers on Aetna's reconciliation tools and the benefits of EFT
  - Collaboration with industry groups such as the Health Billing Management Association to educate their members on the benefits of EFT and to gain the organization's support to encourage their membership to enroll

In our experience, it takes multiple attempts and follow-up to get the provider's attention and for the provider to then follow-up and submit their EFT enrollment form. Persistence pays off.

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Progress Toward EFT & ERA Operating Rule Implementation

- Aetna is fine-tuning its existing procedures to ensure compliance – and to be able to demonstrate compliance – with all the provisions of the ACA mandated CAQH CORE EFT & ERA Operating Rules
  - Examples:
    - Partnering with CAQH to offer an electronic solution for provider EFT enrollment
    - Close examination of our ERA and EFT enrollment forms and processes, and updating where necessary
    - Removal of extraneous data item (Provider Business Grouping) from EFT Addenda
    - Creation of a report to confirm ERAs and EFTs are created within 3 business days of each other
    - Review of approximately 6,000 internal “action codes” that are mapped to Group/CARC/RARC codes, sorting them where applicable into the 4 CORE-defined Business Scenarios, and ensuring mapping is appropriate
- Work is already underway and we expect to complete these activities before the end of 2013

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Role of Financial Institutions to Support Provider Adoption

- How can financial services institutions assist in efforts to drive provider adoption of EFT and ERA?
  - Aetna receive consistent feedback from providers refusing to enroll in EFT unless banks “eliminate EFT per-transaction fees”
  - Presenting a short business case helps providers understand total transaction cost is less even with transaction fees
    - While the fees are a real issue for providers, much is likely to be gained through education; financial institutions can:
      - Assist with educating providers in the savings to be realized by going to electronic solutions
      - While an immediately visible fee will be encountered, financial institution and health plans need to work together to help providers understand the savings they will see through elimination of manual, paper processes

If we work together, we will move the paper process to an electronic solution that is more efficient for each organization, small or large.

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The Provider Perspective:
How to Drive Use of EFT & ERA

HCA
Hospital Corporation of America

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Snapshot of Hospital Corporation of America (HCA®)

- **About**
  - Founded in 1968
  - Largest US “tax paying” hospital operator
  - Located in 20 states and England

- **Size**
  - Locally managed facilities include 163 hospitals & 110 freestanding surgery centers
  - Extensive physician practice management
  - Employs 199,000 associates
- **Patient Care**
  - 18 million patient encounters each year
  - 4-5% of all inpatient care delivered in US is provided by HCA facilities
- **Revenue**
  - In 2012, HCA had more than $33 billion in revenue

HCA Hospital Corporation of America℠

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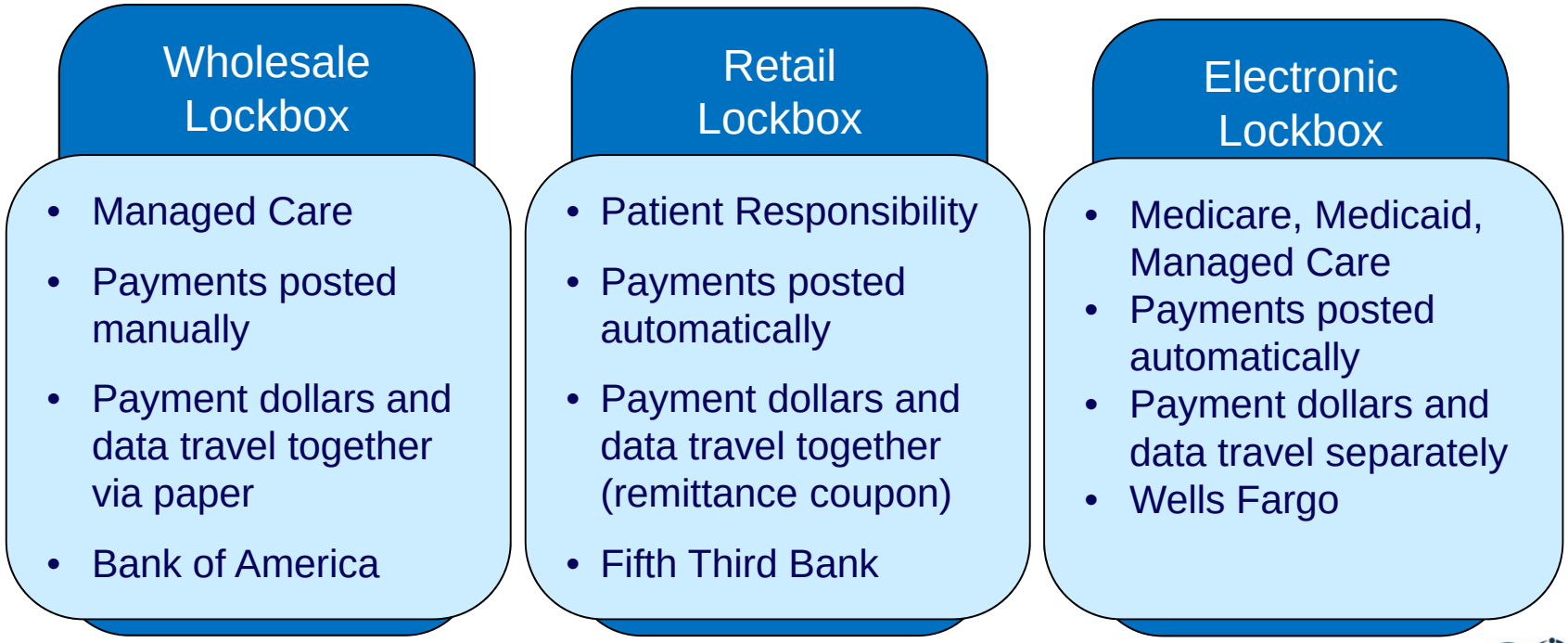
Collection/Payment Posting Process

- HCA uses a combination of three types of lockbox services delivered via a network of 8 shared service centers:



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Hospital Corporation of America

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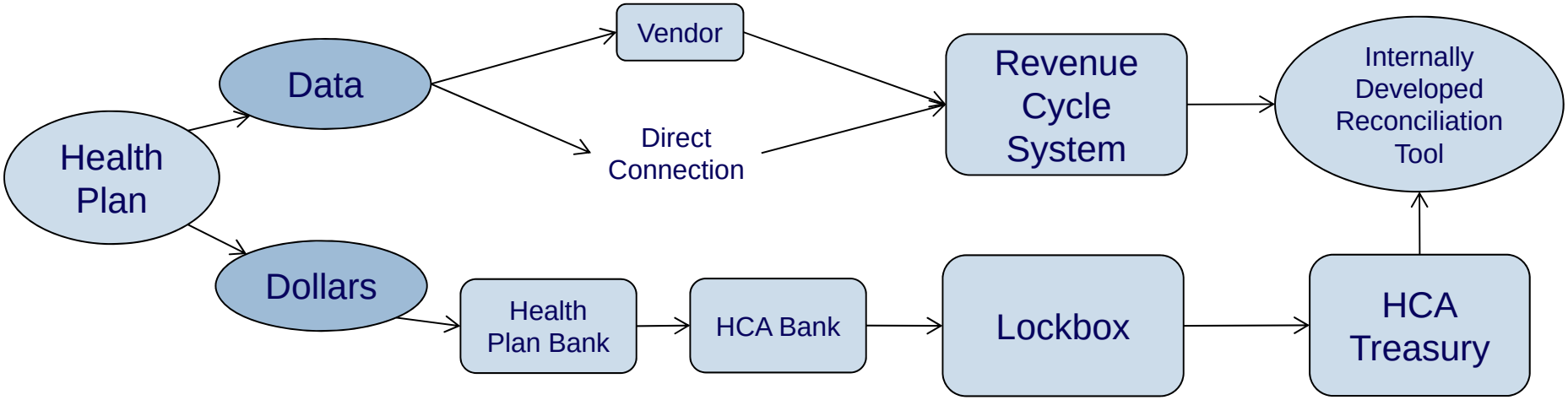
EFT and ERA Transaction Flow at HCA

- Information Technology & Services (IT&S) and Revenue Cycle departments manage processing of the ERA at HCA via a home-gown patient accounting system
- Corporate Treasury department manages processing of payments (primarily CCD and CCD+) via in-house treasury workstation
- Internally developed reconciliation tool reassociates payments with remittance

Payment and Remittance Flow at HCA



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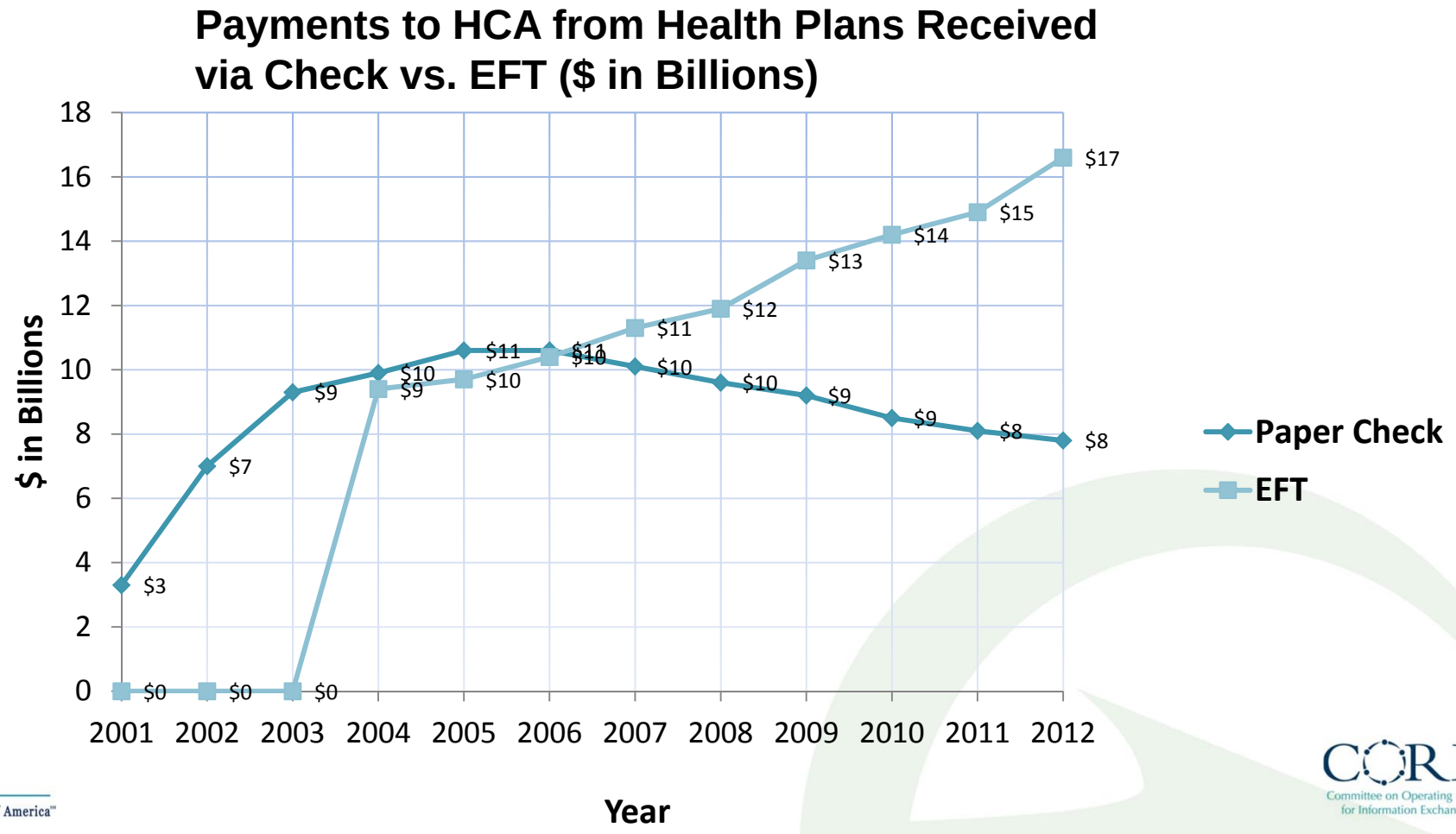
A Steady Transition to EFT Over Time



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Implementation at HCA: EFT/ERA Task Force

- Convened with goal of identifying opportunities to further automate payments at HCA in 2004 with organized monthly meetings
  - Prior to 2004, meetings were episodic and "project-driven"
- Task Force composed of HCA representatives from Revenue Cycle, IT&S, Corporate Treasury, and Reimbursement
- Key Task Force considerations include:
  - Health plan revenue volume
  - Health plan number of accounts
  - Number of HCA facilities impacted
  - Difficulty relative to manual payment posting
  - Contractual obligation
- Centralized versus de-centralized collection
  - Still a large audience of health plans that do not provide enough identifying information in the CCD+ to take money in at corporate level and apply the funds directly to the providing hospital

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Preparing for EFT & ERA Operating Rules

- In order to meet the January 1, 2014 deadline for implementation of the ACA mandated EFT & ERA Operating Rules, HCA is:
  - Already receiving the full CCD+ from Wells Fargo to assist with reassociation
  - May take advantage of new healthcare EFT standard and operating rules to require those health plans currently not providing payment via EFT to do so
  - Confirming compliance of internal systems

Challenges/Barriers to Greater Provider Adoption of EFT and ERA

- File delivery methodologies (sophistication of some health plans)
- Cost associated with clearinghouse/vendors
- Ongoing maintenance and continued effort to add more health plans
- Development resources (human)
- Loose standards/Interpretation of standards
- No mandate for use of EFT until 2014
- Inability to fully centralize at large health systems due to lack of identifying information (e.g. NPI) on the CCD+ from some health plans

Moving the Industry Forward

How will ACA mandated EFT & ERA Operating Rules help drive provider adoption of EFT & ERA?

- EFT Mandate/Standard EFT Format
- Reassociation opportunity (missing NPI remains a challenge)
- More standard enrollment process

How can financial services assist in driving adoption from a provider perspective?

- Ensure Provider clients aware of ability to receive EFT
- Deliver what you receive – no modifications
- Possible re-association products/services
  - Be prepared to respond to requests for the CORE-required Minimum CCD+ Reassociation Data Elements
- Education of both health plans and providers on value of EFT

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Q&A

Additional CAQH CORE Resources

- Become a CORE Participant
- Join us for *free* CAQH CORE Education Events
- Review the CAQH CORE Operating Rules for free
- Access general FAQs regarding the ACA operating rules mandate
- Submit your questions to the CAQH CORE Request Process by emailing core@caqh.org

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