![CORE - Committee on Operating Rules for Information Exchange - A CAQH Initiative]

Testimony of CAQH Committee on Operating Rules for Information Exchange (CAQH CORE)
to the
National Committee on Vital and Health Statistics, Subcommittee on Standards, ACA Review Committee
Panel 7 – Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)
June 17, 2015

As the HHS-designated authoring entity for the above-noted operating rules, CAQH CORE respectfully submits the following responses to questions posed by NCVHS to panelists.[1] The content of this testimony draws from a range of sources used in the CAQH CORE integrated model since the CAQH CORE Phase III EFT/ERA Operating Rules mandate became effective in 2014:

- Ongoing multi-stakeholder input collected by CAQH CORE including: Attendees polled during free CAQH CORE webinars (14,000 in 2014), implementer presentations on CAQH CORE webinars (over 20), presentations at conferences (over 45 in 2014) and over 2,000 requests for information/technical assistance resulting in about 400 FAQs specific to EFT/ERA, many of which highlight the industry need to learn foundational aspects of HIPAA or EFT/ERA.
- New approach: A nearly three month on-line awareness campaign focused on providers, including blogs by CAQH CORE Board provider executives on provider-only on-line communities; drove over 2,000 new views per week to CAQH CORE EFT/ERA implementation landing page and downloads of free education and implementation tools.
- A public CAQH CORE survey conducted for this NCHVS hearing (N=123 organizations, 39% health plans, 28% providers, 28% vendors/clearinghouses, and 5% other referenced as "May Survey").
- Entities that have achieved CAQH CORE voluntary certification for EFT/ERA operating rules (specific to EFT/ERA, 25 certifications awarded and over 10 publically pledged/in process).
- *2014 CAQH Index* data, which is based on 2013 data from health plans representing 4 billion transactions for 112 million enrollees, or 45% of the privately insured U.S. population (*Index* provider cost estimates were prepared by Milliman Inc.).
- Ongoing collaboration with NACHA, which tracks the volume of healthcare specific EFTs sent over the Automated Clearing House (ACH) network (see NACHA testimony).

I. Description of Mandated Operating Rules, Intended Benefits, and Business Needs Achieved

Rule Area	Description of Rule Requirements	Intended Benefits	Business Needs Achieved
Data Content-focused Rules	• Requires uniform and maintained CARCs and RARCs combinations to give the market a consistent and evolving approach to reporting and interpreting the claim. denials/adjustments. • Provides uniform and maintained ERA and EFT enrollment data set to ensure necessary data for electronic payments is provided. • Ensures delivery of EFT & ERA reassociation can occur by requiring the critical data elements for reassociating the payment and remittance advice.	Drive industry value in HIPAA transactions processing: • Productivity improvements. • Labor cost savings including reduced staff time spent on manual follow-up. • Bad debt reduction due to improved collections. • Increased ability to conduct targeted payment issue follow-up with plans. • More accurate and efficient payment of claims. • Streamlined enrollment. • Access to inexpensive electronic payment options.	• Over 50% of May Survey respondents indicated productivity improvements of various types have been achieved and over 20% have achieved direct cost savings. • Over 40% of May Survey respondents indicated that CARC and RARC code combinations have made understanding ERAs easier. • Case studies report specific work flow improvements, e.g. large health system presented that newly available CARCs/RARCs analytics has significantly reduced the number of days to receive payment for high dollar CPT codes initially denied. • More timely receipt of payment by using electronic payments.
Infrastructure-focused Rules	• Ensures online EFT/ERA enrollment/ reenrollment is available. • Establishes minimum system availability service levels. • Sets expected response times. • Supports safe harbor connectivity (e.g., SOAP and digital certificates). • Provides common flow/format for companion guides. • Although not mandated, includes Acknowledgements requirements.	Create national expectations for: • Timely flow of transactions. • Ability to track transactions. flow among trading partners • Common documentation on requirements. • Internet-based connection, if wanted • Security basics.	

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[1] HIPAA established standards for transactions as well as (from ACA) operating rules; therefore the term "transaction" is not synonymous with "standard."

II. Current Usage and Adoption Trends

It is too early in the EFT/ERA Operating Rule adoption cycle to share trends; however, initial data suggests that the industry is moving from the awareness and planning stage to the full implementation stage.

Volume and adoption data from the *2014 CAQH Index* (2013 data) does not address 2014 data; the EFT/ERA operating rules were not mandated for use until January 1, 2014. The *2014 Index* does show that between 2012 and 2013 the average percentage of ERAs (51% in 2014) and EFTs (58% in 2014) conducted electronically remained relatively the same. Adoption rates of the ERA transaction, however, increased between 2009, when the predecessor *U.S. Healthcare Efficiency Index* offered by Emdeon reported 25% adoption of the ERA transaction, which means an increase of over 100% in four years. At least part of the increase can be attributed to the availability of the CAQH CORE ERA and EFT Operating Rules, and early adoption of those by the CAQH CORE participants. NACHA does has the ability to track EFT adoption in a more real-time manner via the ACH network, on which all EFTs travel, and its 2014/2015 measurement indicate that adoption of EFT is increasing (see NACHA testimony).

> **EFT/ERA Operating Rules Are Still in the Early Stages of the Lifecycle**
> Mandate
> Awareness
> Planning
> Implementation
> Tracking and Measurement
> Improvement

Voluntary CORE certification for EFT/ERA demonstrates increasing compliance. Since the initial offering of voluntary CORE Certification for EFT/ERA in late 2013, over 25 certifications have been achieved and over 10 certification applications are in review. Many of the certifications are achieved by two stakeholders: large health plans, which first need to achieve Phase I and II CORE Certifications before moving to Phase III, or vendors that focus solely on the EFT/ERA space of the claims cycle. Moreover, in 2015, two Medicaid agencies have begun the EFT/ERA CORE certification process and many of the entities that are CORE-certified for eligibility and claim status operating rules are planning for voluntary EFT/ERA CORE-certification. These certification project plans indicate that health plan trading partner coordination is critical as many health plans outsource aspects of their EFT/ERA functions to business associates (agents of the health plans), and thus CORE certification testing requires these health plans to demonstrate that these business associates are CORE-certified.

Projected cost savings from the 2014 *CAQH Index*, based on direct costs only, for full adoption of the ERA and EFT transactions are $2.28 billion for the industry, of which providers could realize $1.21 billion. These savings reflect well with the broader 2009 IOM study, The Healthcare Imperative: Lowering Costs and Improving Outcomes. Beyond direct costs savings, there many other indirect cost savings associated with EFT/ERA Operating Rules that are being highlighted in public studies by each critical healthcare stakeholder type: health plan, vendors, clearinghouses and providers.

III. Challenges and Opportunities for Broader Adoption

The industry is still learning how to take full advantage of the CAQH CORE EFT/ERA Operating Rules. Full compliance by all stakeholder types is still underway. Identifying challenges and opportunities for adoption are an ongoing part of CAQH CORE's integrated model. Some examples include:

- *Provider knowledge base and required action.*
  - o Challenge: To gain the benefits of the EFT and ERA Operating Rules providers must contact both their banks and their health plans, unless those entities proactively contact the providers. Many providers are just becoming aware of the EFT/ERA operating rule mandate.
  - o Opportunities for CAQH CORE and its industry partners: CAQH CORE has created a range of free implementation tools such as the sample letters that providers can use to contact their health plans and banks. CAQH CORE has partnered with many entities, e.g., WEDI, MGMA, AMA, AHA, NACHA, to offer free education events and tools. Such efforts will continue and will highlight case studies.
- *Vendor adoption role.*
  - o Challenge: Anecdotal evidence suggests practice management system (PMS) vendors, which are not HIPAA covered entities, may not make EFT/ERA data or infrastructure changes available on a timely basis. This lag appears to occur because the vendors are waiting for demand from their providers who are unaware to ask. For example, the vendor used by a multi-billion health system cannot yet accommodate the CARC/RARC Code Combinations and Business Scenarios that are now supplied via the EFT/ERA Operating Rules.
  - o Opportunities for CAQH CORE: CAQH CORE is encouraging voluntary CORE-certification among the vendor community (PMS, EHRs with revenue cycle, clearinghouses, etc.) as a way for vendors to show commitment to adoption. A call to

action such as this helps remind providers and health plans of their rights and responsibilities with regard to the mandated requirements.
  - o Opportunities for industry: All entities that work with the transactions should be named in HIPAA as covered entities. An alternative is federally-required vendor certification and specification that vendors are business associates directly accountable to HIPAA (as for Privacy and Security).
- *Virtual bank cards are highly controversial. Current operating rules for EFT do not apply to virtual bank cards.*
  - o Challenge: MGMA survey (April 2015) found two-thirds of physician practices have been asked to accept virtual bank cards; in many cases being sent a virtual bank card via mail, fax, or email by a health plan or vendor without request by practice. Standard bank fees apply to each transaction. Nearly half of practices were unaware they could refuse the cards and receive payment by the HIPAA mandated EFT standard. Feedback to CAQH CORE has also identified that fees charged for virtual bank cards vary significantly, and most include a processing fee related to the size of the transaction value. Moreover, many in the market are not aware that all the benefits of the CAQH CORE Operating Rules such as reassociation do not apply if virtual bank cards are used.
  - o Opportunity: All providers must learn their rights to ask for HIPAA mandated EFT. Additionally, HHS should publish FAQs regarding what HIPAA regulations require and give more definition around the term "reasonable fees" for the mandated electronic EFT option available to providers if they choose to use it. The CAQH CORE Board is considering whether voluntary operating rules addressing virtual cards would be beneficial to the marketplace.
- *Content delivery issues plus content supplied via transactions not as rich as what is available on telephone or web portal.*
  - o Challenge: Entities report that not all the content required by the EFT/ERA operating rules is consistently being offered. This includes the enrollment data sets, the re-association data elements and the CARC/RARCs Code Combinations and Business Scenarios.
  - o Opportunity for CAQH CORE and industry: Education must continue to reminder provider to know their rights, and to remind health plans and clearinghouses of their responsibilities as HIPAA covered entities.
  - o Opportunities for industry: Certification and general enforcement can help assure compliance.
- *Competing projects.*
  - o Challenge: ICD-10, EHRs, HIXs and other mandates are absorbing the same needed resources as operating rules thus there is a ripple effect that results in a cycle of implementation challenges and federal extensions/delays. Many say regulatory delays are so common that they are counted on and planned for by all stakeholders in the industry.
  - o Opportunity for industry: Coordination is needed among HHS agencies around a consolidated strategic plan that takes into account the market resources needed for implementation. Instead of massive changes every ten years, major changes along with an incremental approach should be used so there are not multiple, significant projects that overwhelm the industry. The May Survey suggests a review of potential changes every two years may be desirable. For example, providers are anticipating at least minor modifications and additions due to changes in reimbursement models. To help support incremental changes, Federal adoption of operating rules should continue to recognize CAQH CORE's incremental maintenance, such as is in place for CARC/RARC Code Combinations and Business Scenarios.

IV. Opportunities for Improvement Including Alternatives, Process for Updating, and Potential Changes to Operating Rules and/or Mandates

It is very early in the lifecycle of the EFT/ERA Operating Rules to act upon potential improvements or changes to the operating rules. The industry wants more time to determine what improvements or changes are needed beyond addressing the challenges presented above. This said, the mandated CAQH CORE EFT/ERA Operating Rules do have ongoing maintenance included, and there are very focus activities on ensuring that this maintenance is done in a high quality manner and meets industry needs (see below for details).

The CAQH CORE processes to update and publish changes to operating rules depends on the nature of the **changes.**
- *Substantive changes in operating rules* require the formal CAQH CORE authoring process to be followed, which is an open and balanced process to assure a business need exists (as identified through public polling, periodic environment scans/research and voting), work flow can change and rule requirements are technically feasible. The level of pilot testing performed depends on the extent to which the proposed operating rules already are being used among early adopters or market leaders, e.g. some entities are supplying non-mandated data content.

Commitment to Improvement
The executive-level, multi-stakeholder CAQH CORE Board is committed to data content, infrastructure and maintenance.
The Board supports the purpose of the ACA Review Committee.
See Appendix for CAQH CORE Board statement.

- *Non-substantive changes in operating rules* are those that do not materially impact the entities that need to comply with the operating rules, such as correcting typographical errors or removing content from operating rules that has been incorporated into a new mandated version of the underlying standard. Non-substantive changes do not require CAQH CORE balloting. Should a non-substantive update be made, the public is made aware and the versioning of the impacted CAQH CORE Operating Rule is updated accordingly.
- *Ongoing maintenance included in mandated operating rules* requires a formal process of obtaining multi-stakeholder input. This process has been used successfully for maintenance of CARCs and RARCs and for EFT and ERA enrollment data sets. Such maintenance requires consistent, accessible and robust resources. Highlights of the existing responsibilities CAQH CORE has for ongoing maintenance as the designed operating rule author are presented below.
    - CARCs and RARCs code combinations operating rule maintenance process is performed three times a year, consistent with the code authors' publishing schedule. One of these updates includes a Market-based Review that seeks public comments on all the Code Combinations. The process entails industry submittal of code combination adjustments demonstrating that the proposed adjustment follows specific evaluation criteria, and has a strong business case and if possible is supported by real world usage data. There are multi-stakeholder chairs that oversee the process and many places for input, including from non-CORE participants. Many hours – staff and participants – are applied to this process as well as other resources such as an on-line data collection and voting tool. Between 2013 and 2014 there has been a focus on constant evolution of the code combinations given the market needs for clean and clear code combinations. (See sample findings below). Where before the CAQH CORE EFT/ERA Operating Rules there could many, many thousands (possibly 200,000) of potential CARC/RARC code combinations, the operating rules maintenance process has reduced this and has focused its efforts to refine a list of 1,600 Code Combinations that address the major Business Scenarios driving claim issues. This work has been a significant effort by all involved and helped inform the industry of the need to coordinate the separate and distinct code authors.

2013 vs. 2014 Market-based Reviews
Outcome of Analyzing Industry Submissions

Submissions

- **2014**: 65% fewer potential adjustment submissions were received as compared to 2013; contributing factors include:
    - Significant reduction in number of duplicate submission received; from 2013 process, industry learned that number of entities submitting a single request does not impact CORE Participant review
    - Improvements to online survey tool (e.g., allowing respondents to submit single request to relocate a code combination rather than having to submit an addition and removal request)

Outcomes

- **2014**: 258 total adjustments approved, resulting in ~60 more submissions than 2013; overall approval rate increased (67% in 2014 vs. 45% in 2013) due to quality and type of submissions received:
    - 2014 submissions better adhered to CORE Code Combination Evaluation Criteria and primarily focused on refining the code combination messages rather than creating new concepts

Process

- **2014**: Use of technology as well as targeted, data driven discussion allowed for more expedited Task Group decision-making, with a focus on health plan and provider consensus

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- The EFT and ERA enrollment sets are reviewed annually and follow a similar maintenance process: criteria-driven, multi-stakeholder led, informed by data, and consensus-based with regular straw polls. In 2014, the Task Group decided to only make non-substantive changes, while in 2015 they plan to look at substantive changes.

V. Lessons Learned

The CAQH CORE experience and related health IT efforts identify the following lessons learned to achieve the CAQH CORE vision of trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

Lessons learned for CAQH CORE and its industry partners:

1. **Education**, **technical assistance**, more **real world case studies**, and specific **demonstrations of return on investment** were reported by over 40% of May Survey respondents as necessary for full adoption. CAQH CORE's integrated model has provided *free* education and technical assistance which lowers the implementation cost and knowledge gap barriers. Entities have urged CAQH CORE to continue its efforts, and other organizations should contribute to such efforts so entities *"know their rights and roles".*
2. Focus the industry not only on meeting the requirements, but the significant value of how compliance allows entities to **leverage and improve daily work flows**. CAQH CORE sharing of such stories can expand.
3. Continue the **CAQH CORE voluntary certification program** as it provides trading partners the assurance of compliance and leverage to require ongoing compliance. Additionally, CORE Certification, which includes a documentation-based enforcement policy, can encourage the industry to focus on **resolving issues versus unproductive "finger pointing".** Providers should require health plans and vendors with whom they contract to be voluntarily CORE-certified.
4. Continue to **support significant adoption tracking** efforts such as the CAQH Index and voluntary CORE Certification.
5. CAQH CORE currently has a **balanced number of stakeholder** participants (health plans, providers, and clearinghouses/vendors) who implement the operating rules and thus are able to vote on substantive changes. It is vital to keep this balance and enhance total number of participants through new engagement strategies to gather input on business needs. CAQH CORE needs to continue to offer free outreach to the public at large.
6. Maintain **cross-industry alignment** as a key CAQH CORE criteria. Consistent with its approach to assuring that its operating rules are aligned with applicable federal requirements and industry business needs, CAQH CORE should continue to **align its infrastructure operating rules** with requirements that address the privacy and security of protected health information, including with ONC-mandated requirements and industry best-practices on thwarting cyber threats. For data content, CAQH CORE operating rules have adopted **data content** only when the content has been identified as a business need, plus the needed data is optional under the mandated standard. CAQH CORE will continue this approach with the goal of meeting business needs and **supporting the investment the industry has made** in the mandated standards. Wherever possible, CAQH CORE should encourage incremental and ongoing maintenance of its data content requirements so aligning with recent major investments in standards are a priority.

Lessons learned for federal consideration:

7. Revisit the definition of which entities are considered **HIPAA covered entities,** as noted above in Sections III.
8. Communicate when **federally-required certification and accessible enforcement** will serve as steps in driving compliance. CAQH CORE encourages certification that has testing and a multi-stakeholder focus. The lack of a **non-punitive focused enforcement of** the HIPAA transactions is frequently cited as a missing component of HIPAA.
9. Have a dialog how the **Federal mandate could encourage some level of adoption by providers**, who currently are required only to use the HIPAA transactions if they choose to conduct them electronically.
10. **Adopt acknowledgements,** either with HHS inclusion of acknowledgements as an integral part of the CAQH CORE operating rules, or a federal mandate that adopts acknowledgements as independent standards. Including acknowledgements under HIPAA would be consistent with recommendations made numerous times by NCVHS and many other organizations.

Appendix

CAQH CORE Board Statement:
Commitment to Content, Infrastructure and Maintenance
June 2015

CAQH CORE Operating Rules set national responsibilities and requirements for timely, accurate electronic transactions within the healthcare claims cycle. These operating rules address both the necessary infrastructure (such as response times, acknowledgements) and basic content (such as patient financial responsibility) needed to conduct the daily business of healthcare. The operating rules support further use of existing standards wherever possible. Significant work is still needed for all HIPAA transactions to improve both infrastructure and content, and thus achieve true interoperability between all parties in this work flow.

CAQH CORE began as a voluntary effort. As such, before any CAQH CORE operating rules were mandated, CAQH CORE drove voluntary adoption and maintenance of operating rules. The mandated CAQH CORE operating rules now include a feature for CAQH CORE to conduct ongoing maintenance based on use, need and lessons learned. This model has proved successful, and complements more substantive maintenance updates. CAQH CORE believes that a cycle of maintenance for mandated operating rules and standards will help drive the CORE vision of an ever-evolving, improving system of electronic transactions. Regular updates driven by market needs can help transform our current claims process.

As part of its commitment to address both infrastructure and content - and its commitment to maintenance overall - the CAQH CORE Board embraces the Review Committee (RC) formed by the Affordable Care Act (ACA). It is anticipated that the RC will support the industry in its efforts to have regularly scheduled updates of both operating rules and standards, rather than waiting for approval of new legislation to make needed updates, which have previously focused on major overhauls. CAQH CORE also hopes the RC will recognize the value of ongoing maintenance, when such an option is appropriate.

Gaining uniform agreement on basic infrastructure was prioritized by both CAQH CORE and non-CORE participants as the first step in the Phase IV Operating Rules development. Reasons include: the range of current market capabilities for the transactions addressed, the array of trading partners that send and receive these transactions, and that two of the transactions are between the health plan and a non-HIPAA covered entity - the employer. In 2016, CAQH CORE will drive the adoption of the Phase IV infrastructure, including acknowledgements, and conduct its ongoing maintenance of earlier CORE phases. Additionally, it will work with the industry to identify priority draft content needs for Phase IV Operating Rules and any new needs for existing CAQH CORE phases. CAQH CORE will update the RC on this work. Meanwhile, CAQH CORE will continue to push for voluntary adoption of operating rules and apply the CORE Certification process to highlight those entities serving as market leaders.