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# EFT and ERA, Eligibility and Claims Status and CAQH EFT Enrollment Utility

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# The Promise

- HHS estimates that electronic processing would generate savings of $1.00 per claim for health plans, $1.49 for physicians and $0.86 for hospitals. HHS assumed that electronic processing would grow with standardization, creating a total savings of $29.9 billion over ten years (2002 to 2011), before the offsetting costs of implementing privacy and security protections

Source: Federal Register 65 Fed Reg.. 82462, 82761 (December 28, 2000)

- A study by Milliman Technology and Operations Solutions in 2006 showed a comparative cost of paper versus electronic transactions for a typical provider. The results show $42,000 per provider in savings, should all transactions become electronic.

Source: Electronic Transaction Savings Opportunities for Physician Practices. Milliman Technology and Operations Solutions, 2006

- Recently, representatives of the health insurance industry announced that more than $750 Billion in unnecessary health care costs could be saved through administrative simplification and standardization.

Source: HBMA Analysis (June 16, 2009)

- Affordable Care Act provision cuts red tape, saves up to $4.5 billion. Streamlining electronic funds transfers in health care will bring total savings to more than $16 billion over 10 years

Source: HHS.gov (January 5, 2012)

# Opportunities

***It is estimated that at least 7% of health care expenditures are for administrative expenses.***

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

- The Healthcare Administrative Simplification Coalition, or HASC, estimates one quarter of total U.S. health care spending is for administrative functions instead of actual services provided to patients. Further, even a modest **10 percent optimization** of administrative processes and technologies **would save the U.S. health care system approximately $500 billion over ten years**.

Source: "Bringing Better Value: Recommendations to Address the Costs and Causes of Administrative Complexity in the Nation's Healthcare System", July 2009

- According to MGMA studies, the annual **cost of redundant clerical work approaches $25,000 per physician**. In addition to the administrative work that is essential to the normal operations of a busy practice, the typical 10-doctor medical group spends $247,500 on regulation- or contract-required but unnecessary administrative tasks that provide little benefit to patients. The **cost of physician and staff hours spent on administrative tasks** related to pharmaceutical formularies, prior authorizations, claims, billing, credentialing and contracting are estimated to range from **$23 to $31 billion annually**.

Source: "Bringing Better Value: Recommendations to Address the Costs and Causes of Administrative Complexity in the Nation's Healthcare System", July 2009

# Real Time Eligibility

***One of the most common problems in medical billing is utilizing an incorrect or an inactive insurance policy. Real-time eligibility requests are an accurate method for the provider to preemptively determine if the patient has active insurance and the associated plan detail.***

***For 2010, the U.S. Healthcare Efficiency Index reported a rate of only 40% for the utilization of electronic eligibility.***

Source: U.S. Healthcare Efficiency Index National Progress Report on Healthcare Efficiency 2010

- Reduces time-consuming phone calls to payers for eligibility and benefits information.
- Providers may experience faster claim turnaround times and fewer returned or denied claims due to eligibility issues.
- Increase collections by verifying every patient's insurance benefits.
- Payers reduce administrative expenses through fewer phone calls, claim denials, etc.

# Claim Status Inquiry

***electronically check the status of production claims after they have passed the front-end edits.***

***For 2010, the U.S. Healthcare Efficiency Index reported a rate of only 40% for the utilization of electronic claim status inquiry.***

Source: U.S. Healthcare Efficiency Index National Progress Report on Healthcare Efficiency 2010

- Allows the provider to identify where a claim is in the processing cycle — paid, denied, or pending.
- Eliminates the need for manual entry of individual queries or calls to a payer to obtain this information.
- The response is designed to enable automatic posting of the status information to patient accounts, again eliminating the need for manual data entry by provider staff members.
- Payers reduce administrative expenses through fewer phone calls.

# Electronic Funds Transfer

***A fast, safe, reliable, efficient, and low-cost method to receive payments.***

- Providers can receive claims payments transmitted directly to their bank account(s) up to one week faster than with paper checks.
- Account reconciliation is simplified. The account statement includes a single dollar amount for the total amount of the EFT transactions, as opposed to multiple individual check amounts that must be reconciled.
- Better management of claims denials.
- No risk of paper checks being stolen or lost.
- Automated data entry and reporting for improved accuracy.
- Financial institution service charges are reduced. Typically, it costs more to process a paper check than an EFT transaction.
- The potential for errors is reduced, because an EFT requires less manual handling than a paper check.

***Aetna is taking steps to help providers maintain their cash flow. One of the best tools available is Aetna's Electronic Funds Transfer (EFT) option.***

# Electronic Remittance Advice

***Typically a two to four day difference in receipt of a paper remittance versus an electronic remittance advice.***

***For 2010, the U.S. Healthcare Efficiency Index reported an electronic claim submission rate of 85% but only 46% of remittance advices were sent electronically.***

Source: U.S. Healthcare Efficiency Index National Progress Report on Healthcare Efficiency 2010

- Electronic Remittance Advice (ERA) reduces manual posting of claim payments and reconciling patient accounts, thereby saving practices time and money.
- Eliminates keying information from paper documents which is inefficient and error-prone.
- Paper remittances present storage and retrieval challenges forcing providers to research paper archives in order to manage their secondary claims.
- Standardized ERA transactions allow providers to more easily conduct electronic transactions with multiple health plans.

# Obstacles

***Life is really simple, but we insist on making it complicated.***

Confucius (China's most famous teacher, philosopher, and political theorist, 551-479 BC)

| | |
|---|---|
| **Antiquated Systems** | ▪ Practice management and hospital information systems that have not been upgraded to keep pace with industry changes |
| **Competing Priorities** | ▪ Meaningful use, HIPAA mandated changes, ICD-10, healthcare reform, etc. |
| **Disruptive Workflow** | ▪ Office processes often need to be altered to take advantage of new technology |
| **Costs** | ▪ Technology upgrades are costly and must be considered with other practice investments |
| **Perceived Lack Of Value** | ▪ Current processes appear to work so it is often difficult to perceive the benefit |

# Mandated EFT & ERA Operating Rules: January 1, 2014 Requirements Scope

| | Rule | High-Level Requirements |
|---|---|---|
| Data Content | ***Uniform Use of CARCs and RARCs (835) Rule***<br>Claim Adjustment Reason Code (CARC)<br>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<br>• Outlines a flow and format for paper and electronic collection of the data elements<br>• Requires health plan to offer electronic EFT enrollment |
| | ***ERA Enrollment Data Rule*** | • Similar to EFT Enrollment Data Rule |
| | ***EFT & ERA Reassociation (CCD+/835) Rule*** | • Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association<br>• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions<br>• Requirements for resolving late/missing EFT and ERA transactions<br>• Recognition of the role of *NACHA Operating Rules* for financial institutions |
| | ***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<br>• Requires entities to support the Phase II CAQH CORE Connectivity Rule.<br>• Includes batch Acknowledgement requirements*<br>• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.



*Slide used with permission from CAQH*

# The Current Industry Model

## Each individual Plan and Provider exchanging exact same data on an unique individual 1-2-1 basis


* The Plans represented in this graphic are for representational purposes only and are not an indication that the Plan is an active participant in the Solution.

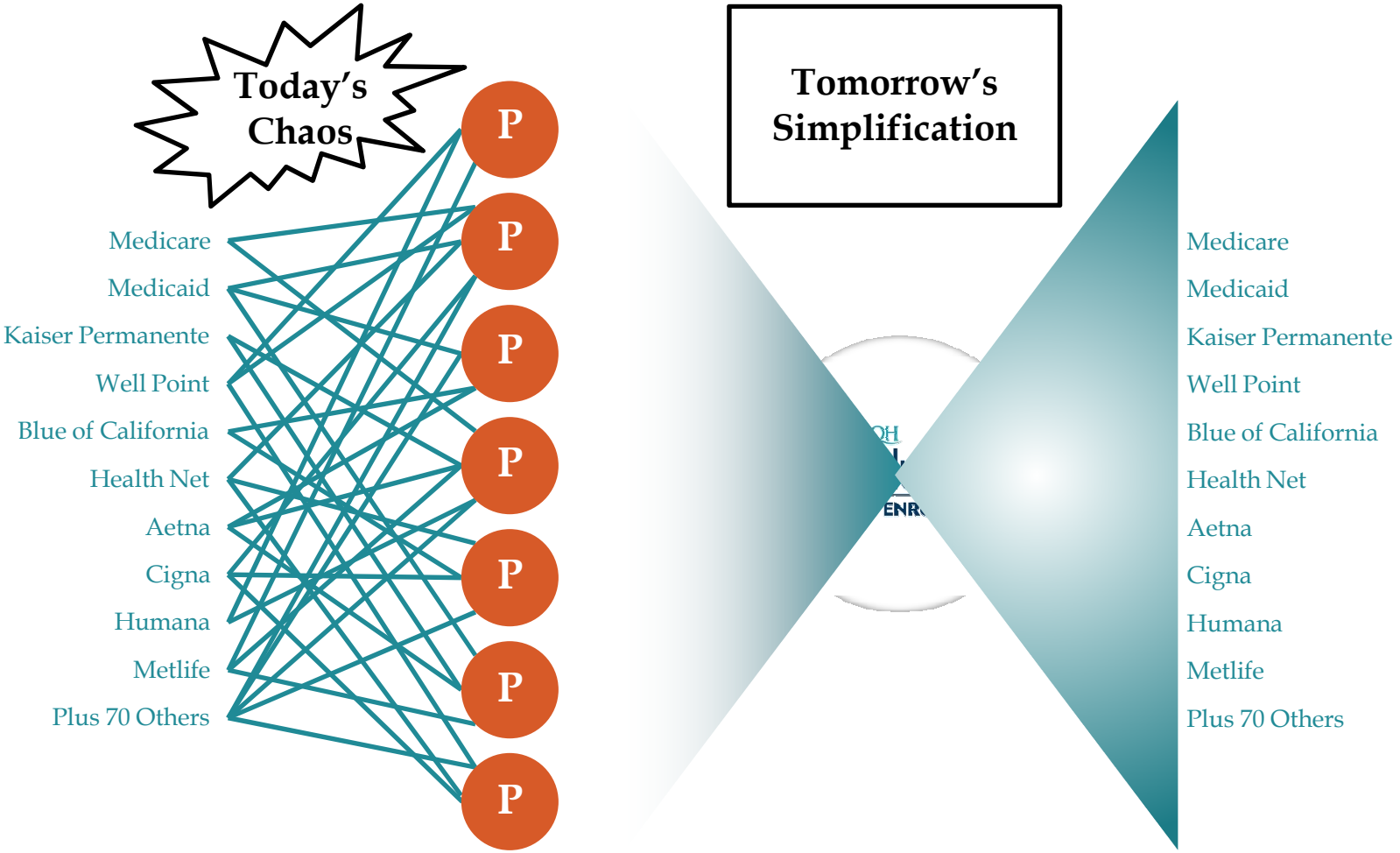
# The Transformational Model

**With CAQH EnrollOne Provider enrolls once and maintains one profile for ALL participating Plans.**


* The Plans represented in this graphic are for representational purposes only and are not an indication that the Plan is an active participant in the Solution.

# The Transformational Model

## Said another way…

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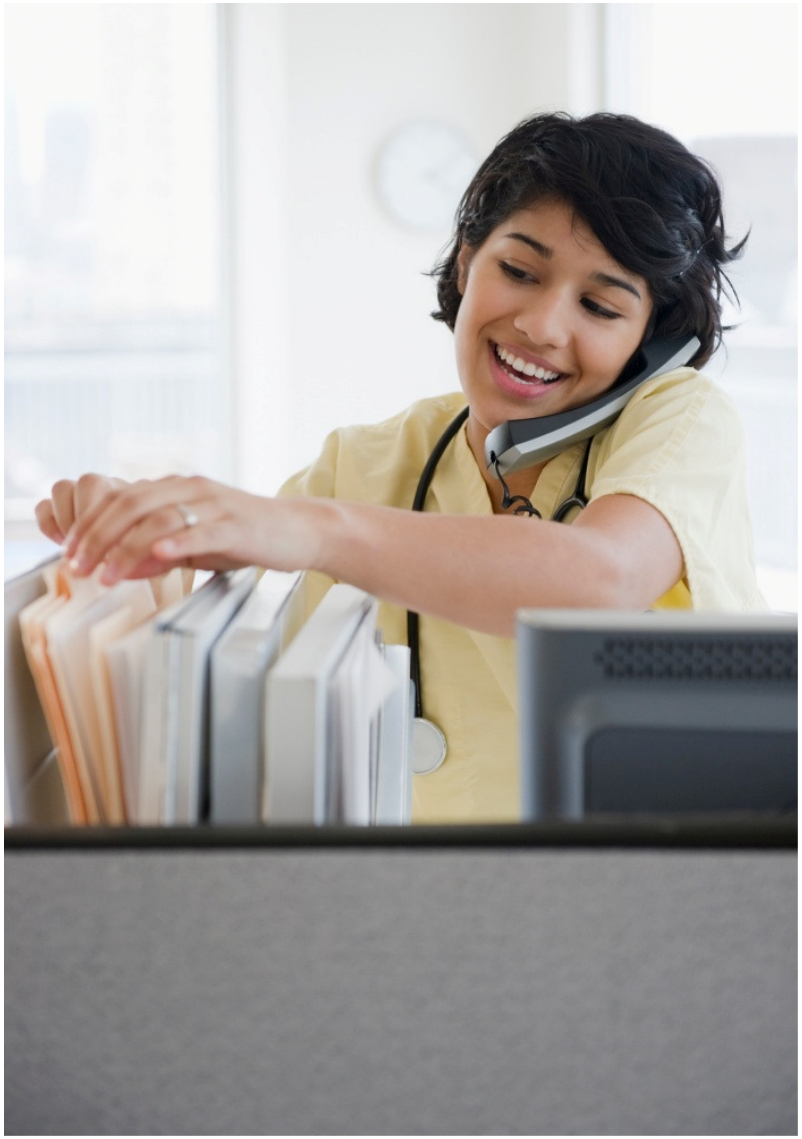
# Benefits for Providers

**One-Stop Shop –** Single, easy-to-use *single* point of entry for providers to enroll in EFT and manage enrollment information with multiple payers.

**No Cost –** No charge for providers to use; participating health plans pay a low annual subscription to cover the costs to build and run the service.

**Secure –** Robust encryption, firewalls and strong password requirements to safeguard sensitive data and ensure that providers have complete control of their data.

**Flexible –** Focused on enrollment; allows providers to use whichever downstream payment processing or remittance advice presentment solution that they prefer.



# Key Considerations for Payers

- Built to either augment a Payers' existing Enrollment process or be the Payer's sole Enrollment solution.
- Current enrollment processes require the Provider to fill out and submit the exact same data elements for each Payer EFT/ERA.
- Each Payer is gathering and maintaining the exact same Provider data elements as every other Payer.
- Providers can only manage a limited number of Payer enrollments, since each is a one-off requiring the Provider to enroll at each individual Payer portal whether the enrollment is electronic or paper-based.
- Focused on enrollment; not intended to interfere with other downstream payment processing or remittance advice presentment solutions.
- Provides more compelling onboarding path for small providers.
- Moves traditional functions to lower cost /shared industry service:
  - Provider adoption campaigns and support.
  - Document processing (e.g., check and/or bank letter image).
  - Pre-note transactions.
- Aligns with ACA-mandated EFT Enrollment Operating Rule requirements effective January 2014.
- Use-Based Pricing structure based on Enrollment volume levels.

# Enrollment Validation Processes

## CAQH is currently focused on two goals:

- ✓ To drive enrollment through a standardized, consolidated, and automated process
- ✓ To achieve efficiencies by moving redundant health plan functions, like enrollment validation, into a shared industry-wide service

**Additionally, participating health plans can provide feedback into the CAQH solution so that fraudulent enrollments can be deactivated**

**CAQH also continues to look for additional enhancements to its enrollment validation process**

## Current enrollment validation includes three major components:

**Out-of-band identity verification**
CAQH will call the provider entity, via a phone number obtained outside of the enrollment process, to confirm that the user is affiliated with the provider entity

**Document validation**
CAQH indexes a voided check or bank letter for each enrollment to confirm that the provider name, routing number and account number on the document matches what was supplied in the enrollment

**Pre-note transaction**
CAQH will, through its bank, conduct a pre-note transaction to confirm that the account included in the enrollment can receive funds

# Questions?

Thank you

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