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

Presented by: Jay Eisenstock, Aetna
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.


- 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.**


- 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.**

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.


- 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.


- 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.


- 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)

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Antiquated Systems</strong></td>
<td>- Practice management and hospital information systems that have not been upgraded to keep pace with industry changes</td>
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<td><strong>Competing Priorities</strong></td>
<td>- Meaningful use, HIPAA mandated changes, ICD-10, healthcare reform, etc.</td>
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<td><strong>Disruptive Workflow</strong></td>
<td>- Office processes often need to be altered to take advantage of new technology</td>
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<td><strong>Costs</strong></td>
<td>- Technology upgrades are costly and must be considered with other practice investments</td>
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<td><strong>Perceived Lack Of Value</strong></td>
<td>- Current processes appear to work so it is often difficult to perceive the benefit</td>
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# Mandated EFT & ERA Operating Rules: January 1, 2014 Requirements Scope

<table>
<thead>
<tr>
<th>Rule</th>
<th>High-Level Requirements</th>
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<tr>
<td><strong>Uniform Use of CARCs and RARCs (835) Rule</strong>&lt;br&gt;Claim Adjustment Reason Code (CARC)&lt;br&gt;Remittance Advice Remark Code (RARC)</td>
<td>• Identifies a <em>minimum</em> set of four CAQH CORE-defined Business Scenarios with a <em>maximum</em> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</td>
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<tr>
<td><strong>EFT Enrollment Data Rule</strong></td>
<td>• Identifies a maximum set of standard data elements for EFT enrollment&lt;br&gt;• Outlines a flow and format for paper and electronic collection of the data elements&lt;br&gt;• Requires health plan to offer electronic EFT enrollment</td>
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<tr>
<td><strong>ERA Enrollment Data Rule</strong></td>
<td>• Similar to EFT Enrollment Data Rule</td>
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<td><strong>EFT &amp; ERA Reassociation (CCD+/835) Rule</strong></td>
<td>• Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for re-association&lt;br&gt;• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions&lt;br&gt;• Requirements for resolving late/missing EFT and ERA transactions&lt;br&gt;• Recognition of the role of <em>NACHA Operating Rules</em> for financial institutions</td>
</tr>
<tr>
<td><strong>Health Care Claim Payment/Advice (835) Infrastructure Rule</strong></td>
<td>• Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides&lt;br&gt;• Requires entities to support the Phase II CAQH CORE Connectivity Rule.&lt;br&gt;• Includes batch Acknowledgement requirements*&lt;br&gt;• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits</td>
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* CMS-0028-IFC excludes requirements pertaining to acknowledgements.

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The 22nd National HIPAA Summit  
February 7, 2014
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.

California Plans *
- Medicare
- Medicaid
- Kaiser Permanente
- Well Point
- Blue of California
- Health Net
- Aetna
- United Health Care
- Cigna
- Humana
- Metlife
- Plus 70 Others

Florida Plans *
- Medicare
- Medicaid
- Florida Blue
- Well Care
- Coventry
- Amerigroup
- Aetna
- United Health Care
- Cigna
- Humana
- Plus 40 Others

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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

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Questions?

Thank you

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