Operating Rules: Results of 2010-2011 Priorities Exercise

Not an official voting exercise: Informal activity to identify market priorities that will inform industry as it moves from voluntary to mandated operating rule environment.
Operating Rules: Priorities Exercise Summary

Table of Contents

Exercise Overview ................................................................. Slide 3

Results Summary
Station A (Eligibility/Claim Status)........................................ Slide 4
Station B (ERA/EFT)............................................................... Slide 5
Station C (Integrated Model)................................................... Slide 6

Appendix: Detailed Results
Eligibility/Benefits and Claim Status Priorities (2011 Rules)....... Slide 8
ERA/EFT Priorities (2012 Rules)............................................... Slide 10
Integrated Model Priorities ..................................................... Slide 11
Operating Rules: Exercise Overview

Goal:
• Identify priorities to inform industry as it moves from voluntary to mandated environment.

Method:
• Conducted at CAQH 2010 Administrative Simplification Conference; not official vote.
• Stakeholders attending session separated into 4 groups (i.e., health plans/payers, healthcare providers, HIT vendors/clearinghouses/others, and government entities).
• Three stations were set-up and each person selected 3 priorities at each station.

Areas of focus:
• **Station A**: Eligibility/Benefits and Claim Status Priorities (*July 2011 Rules*)
  – Priority areas based on existing work such as draft Phase III Scope (i.e., data content beyond Phase I/II) and existing state requirements; priorities are *in addition to current* Phase I and II rules.

• **Station B**: Electronic Claims Payment/Advice (ERA) and EFT Priorities (*July 2012 Rules*).
  – Priority areas based on draft Phase III Scope (i.e., claim status data content requirements) and other existing work such as that of NACHA.

• **Station C**: Integrated ModelPriorities.
  – Priority areas based on CORE voluntary rule implementation experience with operating rule development, certification and testing.
  – Operating rule certification and testing to be informed by future NCVHS hearings and recommendations to HHS.
Operating Rules: Station A Results Summary

Overall Top Priorities:

• Eligibility/Benefits and Claim Status (2011 Rules) in addition to current Phase I and II CORE Rules on eligibility and benefits (see Appendix for summary of current rules):
  1. Common search and match logic:
     - Framework of defined scenarios for information sources to utilize in “finding” a patient based on data submitted by the information requestor.
  2. Uniform use of a set of claims status category and claims status codes:
     - Addressed in draft Phase III Rule.
  3. Standard use of acknowledgements (e.g., use of 277CA):
     - Addressed in draft Phase III Rule.

Stakeholder Trends:

• Based on priority choices, health plan desired intent appears to be a focus on claim status, while providers indicate more of an eligibility focus.
• Providers indicate minimal support for real time claim history availability (i.e., timeframe for which health plans must continue to provide claim details).
Operating Rules: Station B Results Summary

Overall Top Priorities:

- Electronic Claims Payment/Advice (ERA) and EFT (2012 Rules):
  1. Build out 835 healthcare claim payment/advice data content requirements.
  2. A single NACHA format for EFT+ ERA (i.e., CCD+ or CTX).

Stakeholder Trends:

- Building out 835 healthcare claim payment/advice data content requirements highly supported across all stakeholders.
- Virtually no support for system availability requirements among all stakeholders.
- Vendors/clearinghouses strongly support connectivity requirements.
- Providers want to be careful as healthcare determines how to leverage EFT best practices from financial industry (i.e., NACHA).
Operating Rules: Station C Results Summary

Overall Top Priorities:

• Integrated Model Priorities (*Focus over next six months*):
  1. Research and development for ERA/EFT operating rules.
  2. Build more provider and vendor commitment (Reminder: Federal mandate is solely focused on health plans).
  3. Develop new approaches and extended options for education and outreach.

Stakeholder Trends:

• Both vendors/clearinghouses and providers in support of building more commitment to operating rule adoption among their industry peers.
• Improving upon the CORE testing process does not appear to be a significant priority among any stakeholder-type at this time – although there is ongoing support for testing.
Appendices
Appendix: Station A Detailed Results
Eligibility/Benefits and Claim Status Priorities (2011 Rules)

**Assumptions:**
1. PPACA legislation directs HHS Secretary to promulgate a unique health plan identifier rule.
2. NCVHS recommended HHS Secretary adopt CORE Phase I and II Rules with enhancements from stakeholders. CORE Phase I and II contain data content and infrastructure requirements for eligibility/benefits and infrastructure requirements only for claim status. (For Phase I and II Rule summary see accompanying Station A: Supplemental Information poster board)

### Priorities to add to existing Phase I and II Rules
(Note: Options developed from draft CORE Phase III and existing state requirements, e.g., MN)

<table>
<thead>
<tr>
<th>Eligibility/Benefits</th>
<th>VOTE - By Stakeholder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional data content requirements not included in CORE Phase I and Phase II Rules: Identification of provider contracted network and product type</td>
<td>Health Plan 2 Vendor/Clrghouse 10 Provider 3 Govt 1</td>
<td>16</td>
</tr>
<tr>
<td>Targeted patient financials/coverage reporting : Limit response to just what was asked for (i.e., targeted response; not “everything but the kitchen sink”)</td>
<td>Health Plan 1 Vendor/Clrghouse 14 Provider 3 Govt 2</td>
<td>20</td>
</tr>
<tr>
<td>Common patient search and match logic (Note: One state has mandated the use of specific search scenarios; CORE rules to date do not address)</td>
<td>Health Plan 8 Vendor/Clrghouse 16 Provider 7 Govt 7</td>
<td>38</td>
</tr>
</tbody>
</table>

### Claim Status

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>VOTE - By Stakeholder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniform use of a set of claims status category and claims status codes</td>
<td>Health Plan 11 Vendor/Clrghouse 14 Provider 4 Govt 1</td>
<td>30</td>
</tr>
<tr>
<td>Standard use of acknowledgements (e.g., use of 277CA to inform provider if v5010 837 claim was &quot;rejected&quot; or &quot;accepted for adjudication&quot;)</td>
<td>Health Plan 12 Vendor/Clrghouse 10 Provider 1 Govt 4</td>
<td>27</td>
</tr>
<tr>
<td>Real time claim history availability</td>
<td>Health Plan 2 Vendor/Clrghouse 4 Provider - Govt 6</td>
<td>12</td>
</tr>
</tbody>
</table>
## Station A: Supplemental Information

**CORE Phase I and II Rules**

*for Eligibility/Benefits and Claim Status*

### Area/Focus (all rules include test scripts for each rule)

<table>
<thead>
<tr>
<th></th>
<th>PI</th>
<th>PI</th>
</tr>
</thead>
</table>

### Eligibility/Benefits Transaction

**Data Content**

- Respond to generic and explicit inquiries for a defined set of service type codes with coverage and patient responsibility information (Note: Number of codes that must be supported expanded from Phase I to Phase II)  
  - PI  
  - PI

- For inquiry response, return health plan name, coverage dates, coinsurance, copayment, benefit-specific and base deductible for individual and family as well as any in and out of network variances
  - PI

- For inquiry response, return information above and remaining deductible
  - PI

**Infrastructure**

- Response time requirements for real time and batch (e.g., 20 sec or less for real time and next day for batch)
  - PI

- Companion guide common format (Note: Format based on WEDI/CORE approved template)
  - PI

- Standard use of acknowledgements
  - PI

- System availability service levels and notifications (e.g., 86% availability/calendar week)
  - PI

- Connectivity (Requirements progressively more prescriptive from Phase I to Phase II)
  - PI  
  - PI

- Improve the likelihood of a patient being found during a search (e.g., health plans must normalize patient/subscriber last name in the 270 request and how it is stored within their system and map 271 errors to specific AAA error codes)
  - PI

### Claim Status Transaction

- All CORE Phase I Infrastructure requirements (see above) applied
  - PI

---

Note: For more comprehensive list of CORE rules requirements, ask CAQH staff
Assumptions:
1. A balanced 835 is required by the HIPAA mandated v4010/v5010 TR3 Implementation Guides (i.e., total payment amount must equal the sum of all claim amounts minus sum of all provider adjustments). There is no option or situation that excludes a payer from meeting this requirement.
2. HIPAA mandates use of either CCD+ or CTX format for ERA+EFT.
3. Current NCVHS recommendations are only relevant to eligibility/benefit and claim status transactions. Additional NCVHS hearings are anticipated to develop recommendations on ERA/EFT rules.

<table>
<thead>
<tr>
<th>Priorities</th>
<th>VOTE - By Stakeholder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Plan</td>
<td>Vendor/ Clrnhouse</td>
</tr>
<tr>
<td>System availability (e.g., hrs administrative data can be exchanged)</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Connectivity: Allow connections to all other health IT applications (e.g., payload agnostic exchanges, envelope standards, digital certificates)</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Standard use of acknowledgements (i.e., TA1, 999)</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Build out 835 healthcare claim payment/advice data content requirements</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Leverage NACHA Best Practices for EFT from Financial Services Industry (e.g., facilitate appropriate use of the ACH Network where dollars and remittance data can move together)</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>A single NACHA format for EFT+ERA (i.e., CCD+ or CTX)</td>
<td>7</td>
<td>16</td>
</tr>
</tbody>
</table>
Assumptions:
1. Rule writing process, including development of test scripts for each rule, needs to move forward to address NCVHS request for industry review of CORE Phase I and II rules.
2. Certification and testing process required by HHS for operating rules is TBD; meanwhile, CORE will offer current voluntary approach, including ongoing partnership with authorized, independent entities that conduct testing using CORE-approved test scripts.

<table>
<thead>
<tr>
<th>Priorities</th>
<th>VOTE - By Stakeholder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating rules research and development for ERA/ETA - In collaboration with other organizations, identify needs (i.e., gaps, standards and policies) and the background necessary to begin the operating rule writing process</strong></td>
<td>Health Plan: 11 Vendor/Clrighouse: 19 Provider: 6 Govt: 5</td>
<td>41</td>
</tr>
<tr>
<td><strong>Develop new approaches and extended options for education and outreach - Helps inform the rule writing direction and content, supports rule adoption and implementation; could include coordination with RECs, etc and would be done with partners, e.g. HIMSS</strong></td>
<td>Health Plan: 8 Vendor/Clrighouse: 12 Provider: 2 Govt: 3</td>
<td>25</td>
</tr>
<tr>
<td><strong>Improve upon CORE Testing Process, e.g. consider Deidentified Data - Further streamline uniform and objective testing requirements (e.g., web-based) by stakeholder by rule and share lessons learned with CMS</strong></td>
<td>Health Plan: 2 Vendor/Clrighouse: 3 Provider: 1 Govt: 4</td>
<td>10</td>
</tr>
<tr>
<td><strong>ROI tracking of current CORE Phase I and II Certifications – Conducted through established procedures that incorporates the interdependencies of the rules - requires more involvement by providers</strong></td>
<td>Health Plan: 2 Vendor/Clrighouse: 14 Provider: 4 Govt: 1</td>
<td>21</td>
</tr>
<tr>
<td><strong>Build more provider and vendor commitment – Given reform applies only to health plans, develop process to have more vendors and providers become certified/adopt/be aware of the CORE Phase I and II Rules</strong></td>
<td>Health Plan: 7 Vendor/Clrighouse: 20 Provider: 5 Govt: 5</td>
<td>37</td>
</tr>
</tbody>
</table>