Countdown to Compliance:

An In-depth Look at the Federally Mandated Operating Rules for Eligibility and Claim Status

Tuesday, December 18, 2012
3:00 pm to 4:30 pm ET
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- Sajix, Inc.
- Sharp Healthcare
- Surescripts
- The National Council for Community Behavioral Healthcare
- University of Michigan Health Informatics Program
- Vital Health Software
Advisory Council

- Holt Anderson – North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA)
- Eta S. Berner, EdD – University of Alabama at Birmingham
- Pam Cipriano, RN, PhD – Galloway
- Sally Connally – McKesson
- Gwen Darling – Healthcare IT Central
- Gwenn Darlinger – Quest Diagnostics
- Arthur Davidson, MD – Denver Health
- Mary Jo Deering, PhD – Office of the National Coordinator for Health IT
- Christine Fantaskey – Booz Allen Hamilton
- Seth Foldy – Formerly CDC
- Charles Friedman, PhD – University of Michigan
- Patricia MacTaggart – George Washington University
- Margaret Meadow – Siemens Healthcare
- Becky Monroe – VA
- Chuck Parker – Continua Health Alliance
- Kathleen Reid – Elsevier
- MaryAnne Sterling – Sterling Health IT Consulting
- Timothy A. Swope – Personalized Medicine Coalition
- Nora Super – Office of the National Coordinator for Health IT
- Steven Waldren, MD, MS – American Academy of Family Physicians
- Chantal Worzala, PhD – American Hospital Association
December 19: Helping Providers Meet Direct Requirements for MU2
Claudia Williams, ONC  Paul Tuten, ONC
http://www.nationalehealth.org/MU2DirectRequirements
Please enter your questions in the Q&A window at the bottom right of your screen.

You can also send us an email at university@nationalehealth.org, tweet a question using hashtag #NeHC, or comment on our Facebook page at www.facebook.com/nationalehealth
Today’s Panelists

• Matt Albright, Lead Health Insurance Specialist, CMS's Office of E-Health Standards and Services (OESS)
  – *OESS is the U.S. Department of Health and Human Services*’ *(HHS)* component that enforces compliance with HIPAA transaction and code set standards

• Bob Bowman, Manager, CAQH CORE
  – *CAQH CORE is a national multi-stakeholder initiative designated by HHS as the authoring entity for the mandated Eligibility for a Health Plan and Healthcare Claim Status Operating Rules*

• Richard Farmer, Director of Content Research, Passport Health Communications
  – *Passport Health was an early adopter of Eligibility and Claim Status Operating Rules and is a Phase I and Phase II CORE-certified clearinghouse*

• Gwendolyn Lohse, Managing Director, CORE, Deputy Director, CAQH

**Moderated by: Kate Berry, CEO, NeHC**
Agenda / Question & Answer Topics

• Welcome and Introductions
  – ACA Section 1104: Mandated Operating Rules
    – Federally Mandated Eligibility and Claim Status Operating Rules
    – ACA Mandated Compliance Requirements
    – Audience Q&A
  – CAQH CORE Operating Rules for Eligibility and Claim Status
    – CAQH CORE Infrastructure Operating Rule Requirements
    – CAQH CORE Eligibility Data Content Operating Rule Requirements
    – Importance of Trading Partner Collaboration
• Implementing CAQH CORE Operating Rules – A Clearinghouse Perspective
  – What’s Changing and the Impacts
• Focusing on Implementation
  – Audience Q&A
• Wrap-Up
Polling Question #1

Operating Rule Implementation Status

Pick the answer that best describes your organization’s implementation progress toward 1/1/2013 operating rule mandate?

– Just started/early phases
– Fully underway/over the hump
– Nearing completion/Done
– Not applicable
What are 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”
  - Operating rules address gaps in standards, help refine the infrastructure that supports electronic data exchange, and recognize interdependencies among transactions; they do not duplicate standards
  - Operating rules and standards work in unison; current healthcare operating rules build upon a range of standards – healthcare specific (e.g., ASC X12) and industry neutral (e.g., OASIS, W3C, ACH CCD+) – and support the national HIT agenda
- Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Operating Rules: Key Components

- Rights and responsibilities of all parties
- Security
- Exception processing
- Transmission standards and formats
- Response Times
- Liabilities
- Error resolution
CAQH CORE Integrated Model

CAQH CORE rules and their early implementation base have experienced this integrated model.

Develop Rules
(research, scoping according to guiding principles, straw polls, voting, etc)

Design, Testing & Certification

Build Awareness

Promote Adoption & Early Implementers Base

Provide Assistance & Early Implementers Base

Maintain

Track Progress & ROI

Report Status
Implementing CAQH CORE Operating Rules: Driving Change through Tracking ROI

- CAQH CORE made an early commitment to track Measures of Success
  - With each CORE rule set, organizations who pursue voluntary CORE Certification are invited\(^1\) to participate in an implementation cost/effort and impact (ROI) study
- CAQH CORE Operating Rule Implementation Study Phase I Outcomes\(^2\)
  - Health Plans experienced a decrease in telephone verifications, estimated $2.7M savings
  - Providers realized approximately $2.60 cost savings per eligibility verification, i.e., a 7 minute per patient time reduction
  - Provider Claims Denial Rates decreased 10-12%
  - Clearinghouse\(^3\) time to implement new health plan connections was reduced from 6-12 weeks to 1 week

<table>
<thead>
<tr>
<th>Eligibility and Claim Status Operating Rules(^4)</th>
<th>EFT and ERA Operating Rules(^5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities Where Savings Will Occur</strong></td>
<td><strong>Activities Where Savings Will Occur</strong></td>
</tr>
<tr>
<td>Eligibility Transaction Savings</td>
<td>Reduced Staff Time/Paperwork</td>
</tr>
<tr>
<td>Claim Status Transaction Savings</td>
<td>Increase in EFT Transactions</td>
</tr>
<tr>
<td>Reduction in Claim Denials</td>
<td>Increase in ERA Transactions</td>
</tr>
<tr>
<td>Provider Savings: $785-$950M Annually</td>
<td>Provider Savings: $250-$375M Annually</td>
</tr>
</tbody>
</table>

1. Includes providers whose market share includes CORE-certified health plans.
2. Results reported by IBM regarding early Phase I CORE-certified entities included six national and regional health plans (33 million members), five clearinghouses/vendors and six providers (hospitals, physician groups and surgery center).
3. Applies when health plan was conforming with CAQH CORE Operating Rules.
4. Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions
5. Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions

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CORE Alignment With Federal Health IT Efforts

- CORE has sought to align with major federal health IT initiatives both to leverage government investments/ incentives to drive industry adoption and to ensure that HIPAA covered entities and their business associates can focus on areas for clinical/administrative alignment.

- Success has been achieved with this goal as the CORE rules and/or are well coordinated with other industry-wide efforts. CORE is committed to maintain this alignment focus.
ACA Section 1104: 
Mandated Eligibility and Claim Status Operating Rules 

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

Operating rules encourage an interoperable network and are vendor agnostic

Implement by January 1, 2013
- Eligibility for health plan
- Claims status transactions

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
Three dates are critical for industry implementation of the first set of ACA mandated Operating Rules

There are two types of penalties related to compliance

<table>
<thead>
<tr>
<th>Key Area</th>
<th>HIPAA Mandated Implementation</th>
<th>ACA-required Health Plan Certification</th>
</tr>
</thead>
</table>
| Dates            | First Date  
January 1, 2013
Compliance Date | Second Date  
December 31, 2013
Health Plan Certification Date | Third Date  
No Later than April 1, 2014
Health Plan Penalty Date |
| Description      | Who: All HIPAA covered entities  
Action: Implement CAQH CORE Eligibility & Claim Status Operating Rules | Who: Health plans  
Action: File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules | Who: Health plans  
Action: HHS will assess penalties against health plans that have failed to meet the ACA compliance requirements for certification and documentation |
| Applicable Penalties | Amount: Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year | Amount: Fee amount equals $1 per covered life until certification is complete; penalties for failure to comply cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation |

1 CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.

2 According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year; CAQH CORE will continue to offer its voluntary CORE Certification program and will share lessons learned with CMS as the Federal process is developed.

3 Covered life for which the plan’s data systems are not in compliance; shall be imposed for each day the plan is not in compliance
Enforcement of HIPAA Standards and Operating Rules

Current enforcement: Complaint-driven process
• Any individual can file a HIPAA related complaint
• Law provides penalties for non-compliance. However, organizations that exercise reasonable diligence and make efforts to correct problems are unlikely to be subject to penalties

December 31, 2013: Certification of Compliance
• File a statement of compliance; subsequent submission of documentation
• Substantial penalties for failure to meet requirements

Future: Audits mandated by Affordable Care Act
Available CMS OESS Implementation Tools:

Examples

• **HIPAA Covered Entity Charts**
  – Determine whether your organization is a HIPAA covered entity

• **CMS FAQs**
  – Frequently asked questions about the ACA, operating rules, and other topics

• **Affordable Care Act Updates**
  – Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules

• **Additional Questions**
  – Questions regarding HIPAA and ACA compliance can be addressed to:
    • Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, Christine.Stahlecker@cms.hhs.gov
    • Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov
ACA Compliance Requirements

Question & Answer
<table>
<thead>
<tr>
<th>Type of Rule</th>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
<th>Voluntary Eligibility &amp; Claim Status Operating Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content: Eligibility</strong></td>
<td>Need to drive further industry value in transaction processing</td>
<td>More Robust Eligibility Verification Plus Financials</td>
<td>More Robust Eligibility Verification Plus Financials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced Error Reporting and Patient Identification</td>
<td>Enhanced Error Reporting and Patient Identification</td>
</tr>
<tr>
<td><strong>Infrastructure: Eligibility and Claim Status</strong></td>
<td>Industry needs for common/accessible documentation</td>
<td>Companion Guides</td>
<td>System Availability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Response Times</td>
<td>Connectivity and Security</td>
</tr>
<tr>
<td></td>
<td>Industry-wide goals for architecture/performance/connectivity</td>
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</tbody>
</table>

*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.*
CAQH CORE Eligibility & Claim Status

Federally Mandated Infrastructure Operating Rules
CAQH CORE Eligibility & Claim Status: Federally Mandated Infrastructure Operating Rules

Mandated infrastructure requirements apply to both ASC X12 270/271 eligibility and ASC X12 276/277 claim status transactions

- **Companion Guide**
  - Specify flow and format in health plan companion guide following the CORE v5010 Master Companion Guide Template

- **Response Time**
  - Require entities to conduct real-time processing; Batch processing is optional; however, if entity performs batch processing, then they must conform to requirements for batch
  - Specify maximum response time for both real-time and batch processing
    - Real-time: Maximum response time from submission must be 20 seconds (or less)
    - Batch: Response to transaction submitted by 9 pm E.T. must be returned by 7AM E.T. on the following business day

- **System Availability Rule**
  - Require minimum of 86 percent system availability per calendar week

- **Connectivity Rules**
  - Establish “Safe Harbor” connectivity rule using internet as delivery option to standardize transaction flow between health plan and provider; common transport and envelope standards

**NOTE:** Many of the Federally mandated CAQH CORE Infrastructure Rules also apply to the ASC X12 v5010 835 per CMS-0028-IFC.
The CAQH CORE Companion Guide Rule and Claim Status Rule require that Companion Guides covering v5010 270/271 and v5010 276/277 transactions follow the format and flow of the CORE v5010 Master Companion Guide Template.

The Companion Guide Template* organizes information into distinct sections:

- General Information
- Connectivity with the payer
- Transaction-Specific Information
- Key contact information
- Testing with the payer
- Control segment details
- Payer specific business rules
- Allows health plans (information sources) to tailor the document to meet their particular needs while still maintaining a standard template/common structure

For more detail, see CORE Rules 152 and 250

The CAQH CORE System Availability Rule and the Claim Status Rule establish guidelines for system availability and provider support for health plan eligibility and claim status transactions including:

- Minimum of **86 percent system availability** (per calendar week)
- Publish regularly scheduled downtime
- Provide one week advance notice on non-routine downtime
- Provide information within one hour of emergency downtime

For more detail, see CORE Rules 157 and 250
When processing in real time, **maximum** response time for receipt of a v5010 X12 271 or X12 276 by the provider in response to a v5010 X12 270 or X12 276 must be 20 seconds.

To conform to response time requirement, **90 percent** of all transactions, as measured within a calendar month, must be returned within the 20-second maximum response time.

**NOTE**: The rules hold the health plan and its **contracted** business associates responsible for the conduct of the transaction that is applicable to them.

**CAQH CORE Rules 156 & 250**

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**When Do the 20-Seconds Begin and End?**

- The 20-second requirement is the duration for the **entire round trip** of the transaction.
  - The 20 seconds begin when the v5010 X12 270 Inquiry or X12 276 Request is first submitted by the provider, and end when the X12 271 or X12 277 Response is received by the provider.
  - **All ensuing hops between the provider and the health plan are included in these 20 seconds**

- ACA Administrative Simplification provisions require all HIPAA covered entities (i.e., health plans, providers, clearinghouses, etc.) to comply with the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules.
  - Each HIPAA covered entity within the transaction flow is bound by the CAQH CORE requirements for meeting the 20-second round trip of the transaction.

- CAQH CORE recommends a **maximum** of 4 seconds per hop to meet the 20-second round trip requirement.
CAQH CORE Eligibility & Claim Status Operating Rules:
Potential Real Time Processing Transaction Paths

End-to-End: 20-Second Round Trip
(CAQH CORE recommends no more than 4 seconds per hop)

Path #1: Direct Connection: A+B= 20 seconds or less

Path #2: Single Clearinghouse: A+B+C+D= 20 seconds or less

Path #3: Dual Clearinghouse: A+B+C+D+E+F = 20 seconds or less

At starred receipt and transmit points each entity must capture, log, audit, match, & report date, time, and control numbers from its own internal systems and corresponding data received from its trading partners.
CAQH CORE Eligibility & Claim Status Operating Rules: Infrastructure Operating Rules - Connectivity

Entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transaction, and claim status; they must follow:
• Real-time and/or batch request submission and response pickup guidelines
• Security and authentication requirements
• Response message options and error notification
• Response time, time out parameters and re-transmission guidelines
• Prescriptive submitter authentication, envelope specifications, etc.
• Payload-agnostic, can use to send any type of data

For more detail, see CORE Rules 153, 250 and 270

Safe Harbor Key Requirements

Phase I & II CAQH CORE Connectivity Rules constitute a “Safe Harbor” rule which provides for a uniform method of exchanging administrative transaction data between health plan and provider – but other methods may be used. The rules:
• Apply to information sources performing the role of an HTTP/S server and information receivers performing the role of an HTTP/S client
• Apply to real-time transactions (and batch, if offered; batch NOT required)
• Do not require trading partners to remove existing connections that do not match the rule
• Include prescriptive submitter authentication, envelope specifications, etc., (SOAP and WSDL, Name/Password or X.509 Certificate)

For more detail, see CORE Rules 153, 250 and 270

*Specifically designed to align with key Federal efforts, e.g., NwHIN.
<table>
<thead>
<tr>
<th>RULE AREA</th>
<th>KEY RULE REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>Internet</td>
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<tr>
<td>Transport</td>
<td>HTTP</td>
</tr>
<tr>
<td>Transport Security</td>
<td>SSL, TLS <em>(optional)</em></td>
</tr>
<tr>
<td>Submitter (Originating System or Client)</td>
<td></td>
</tr>
<tr>
<td>Authentication</td>
<td>Name/Password</td>
</tr>
<tr>
<td>X 509 Certificate <em>(subject to conformance requirements)</em></td>
<td></td>
</tr>
<tr>
<td>Envelope and Attachment Standards</td>
<td>SOAP 1.2 + WSDL and MTOM <em>(for Batch)</em> or</td>
</tr>
<tr>
<td></td>
<td>HTTP + MIME <em>(subject to conformance requirements)</em></td>
</tr>
<tr>
<td>Envelope Metadata</td>
<td>Metadata defined <em>(Field name, values)</em></td>
</tr>
<tr>
<td></td>
<td>New Payload Types for HIPAA and non-HIPAA Payloads</td>
</tr>
<tr>
<td>Message Interactions/</td>
<td>Real time</td>
</tr>
<tr>
<td>Routing</td>
<td>Batch <em>(Optional if used)</em></td>
</tr>
<tr>
<td>Acknowledgements, Errors</td>
<td>Specified</td>
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<tr>
<td>Basic Conformance Requirements</td>
<td>Specified</td>
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<tr>
<td>System Availability</td>
<td>Specified</td>
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<tr>
<td>Companion Implementation Guide</td>
<td>Specified</td>
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</tbody>
</table>
CAQH CORE Connectivity Operating Rules: 
Stakeholder Conformance Guidelines

- CAQH CORE Connectivity Rules apply to health plans (HTTP/S server) and health care providers (HTTP/S client)
  - The rules define conformance requirements for stakeholders based on typical role (client, server) for envelope and authentication standards
  - Diagram illustrates the typical (minimal) roles played by stakeholders (e.g., providers typically clients, health plans typically servers, clearinghouses can act as client or server)

<table>
<thead>
<tr>
<th>If your organization is a:</th>
<th>then your minimum technical role is a:</th>
<th>and CAQH CORE defines technical requirements for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Provider</td>
<td>Client</td>
<td>Client Conformance Requirements</td>
</tr>
<tr>
<td>Clearinghouse/Switch</td>
<td>Client and Server</td>
<td>Client Conformance Requirements Server</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Server</td>
<td>Server Conformance Requirements</td>
</tr>
</tbody>
</table>
CAQH CORE Connectivity Operating Rules:

**Envelope Standards**

- Stakeholders in server role (e.g., health plans and clearinghouses/switches) must implement both envelope standards (SOAP+WSDL and HTTP MIME Multipart).
- Stakeholders in client role (e.g., healthcare providers or provider vendors) must implement one of the envelope standards.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Clearinghouse/Switch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Server Conformance Requirements</td>
<td>then you must implement both of these envelope standards</td>
</tr>
<tr>
<td>Healthcare Provider</td>
<td>Client Conformance Requirements</td>
</tr>
</tbody>
</table>

Then you must implement **one** of these envelope standards:

- HTTP Multipart MIME
- SOAP
CAQH CORE Connectivity Operating Rules: Submitter Authentication

- CAQH CORE Connectivity Rules support two methods for Submitter Authentication:
  - Username/Password, using CORE-conformant Envelope to send CORE-conformant Envelope Metadata Username and Password
  - X.509 Certificate based authentication over SSL standard for client certificate based authentication
- Stakeholders in server role (e.g., health plans) choose to implement one of the standards
- Stakeholders in client role (e.g., healthcare providers/provider vendors and clearinghouse components handling submissions to plans) must implement both standards

If your organization is a:

Health Plan

then implement **one** of these authentication standards

| Username/Password | X.509 Certificate over SSL |

Server Conformance Requirements

Clearinghouse/Switch | Healthcare Provider

Client Conformance Requirements

then you must implement **both** of these authentication standards

| Username/Password | X.509 Certificate over SSL |
Federally Mandated Data Content Operating Rules: ASC X12 Standards as Foundation

Building on the requirements of the ASC X12 standards and industry neutral standards, CAQH CORE Operating Rules add value as industry stakeholders gain the additional benefits of using a consistent infrastructure to deliver and receive robust and important patient eligibility and benefit data.

ASC X12 270/271 Requirements in v5010

- Eligibility Status (yes/no)
- Date
- Health Plan Name (if known)

CAQH CORE Rule Requirements

- Health Plan Name*
- Patient financials (deductible, co-pay, co-insurance)
  - In and out of network variances
  - Family and individual
  - Health Plan and benefit variances
- Enhanced Patient Name Verification
- Standard use of AAA Error Codes

* If available in responding system

Note: PLUS infrastructure operating rules to generate data flow: response time, connectivity, system availability
CAQH CORE Rules 154 and 260 require that health plans and information sources that create a 271 response to a generic 270 inquiry must include:

- The **name of the health plan** covering the individual (if available)
- Provide **patient financials** for the static financials of co-insurance, co-payment, and deductible, and return the remaining deductible amount; include in-network and out-of-network coverage and financials for **48 required service types** (benefits)

For more detail, see CORE Rules 154 and 260.

CAQH CORE Rule 258 requires health plans to **normalize submitted and stored last name** before using the submitted and stored last names:

- If normalized name validated, return 271 with CORE-required content
- If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
- If normalized name not validated, return specified AAA code

For more detail, see CORE Rule 258.

CAQH CORE Rule 259 requires health plans to return a **unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements** in order to communicate the specific errors to the submitter.

The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid.

For more detail, see CORE Rule 259.
Implementing Mandated Operating Rules: The Importance of Trading Partner Collaboration

- Providers, health plans and clearinghouses work together in a variety of ways to exchange transaction data.
- The scope of an entity’s mandated operating rules implementation project will depend upon the electronic data flows between trading partners; understand your agreements.
- Vendors play a crucial role in enabling provider clients to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them.

STREAMLINED ADMINISTRATIVE DATA EXCHANGE

Health Plans → Vendors and Clearinghouses (includes TPAs) → Providers

- CORE-Required Data & Infrastructure
- Vendor-Agnostic Rules
- Providers
- Health Plans
- Vendors and Clearinghouses (includes TPAs)
- CORE-Required Data & Infrastructure

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Implementing Mandated Operating Rules: The Vendor’s Role in Provider Adoption

All HIPAA covered entities must implement Federally mandated operating rules

• Voluntarily CORE-certified vendors can accelerate provider adoption of mandated operating rules, drive ROI and end-to-end interoperability across a trading partner network
  – Improves data flow consistently in varied settings that use various vendors
  – Providers realize documented benefits* of implementing CAQH CORE Operating Rules
    • Reduction in claims denials of 10-12%
    • Increased electronic verifications by 24%
    • Improve vendor connectivity turnaround times

• Providers must engage vendors to ensure their systems can provide the benefits that operating rules offer! *Is your Practice Management System (PMS) in conformance?*

* IBM assessed results achieved by Phase I CAQH CORE Operating Rules early adopters (represents 33 million covered lives and 1.2 million providers)

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Conformance Testing and Certification: Trading Partner Listing and Voluntary CORE Certification

• Conformance testing with your trading partners is a critical aspect to making your operating rules implementation a success
  – HIPAA covered entities can quickly communicate their organization’s readiness* to testing their conformance with trading partners by adding their company information to the CORE Partner Testing page of the CAQH website
  – If you are ready to test with trading partners, take 5 minutes and add your organization to the CAQH CORE list!

• Since its inception, CAQH CORE has offered a voluntary CORE Certification to health plans, vendors, clearinghouses, and providers
  – Learn more about voluntary CORE Certification here
  – Review the CORE Test Suites
  – Voluntary CORE Certification & Testing provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

* Includes other key IT system/service vendors that support them, such as Practice Management Systems
Summary of CAQH CORE Implementation Tools

- **Analysis and Planning Guide**
- **FAQs**: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website as appropriate given mandates
- **Request Process**: After reviewing FAQs, contact experts as needed at CORE@caqh.org
- **Voluntary CORE Certification**: Phase I & Phase II CORE Certification
  - Master Test Suites provide guidance on the stakeholder types to which the rules apply and working with trading partners; enables conformance testing for implementers
Polling Question #2
Trading Partner Operating Rule Conformance

Which answer best describes your organization’s knowledge of your trading partners’ readiness for 1/1/2013 mandate?

– We know status of most
– We know status of some
– Currently identifying their readiness
– Don’t know
– Not applicable

Trading partners include health plans, providers, vendors, clearinghouses, etc.
Implementation Perspective:
A Clearinghouse View

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About Passport Health Communications

- Passport Health Communications Inc. is a Software-as-a-Service company providing software and solutions to help hospitals and health care providers improve business operations and secure payment for their services.
- More than 300 million eligibility transactions annually pass through the Passport eCare™ brand of revenue cycle management solutions and services which is supported by Passport’s *OneSource* EDI platform.
- With 15 year history of delivering effective EDI solutions to providers; Passport services providers in all 50 states:
  - One in three U.S. hospitals
  - 8,000 physician and ancillary offices
  - 400+ payer eligibility connections
- A CAQH CORE participating organization:
  - Actively involved in CAQH CORE Operating Rules development since 2005
  - Supports CAQH CORE Certification & Testing Subgroup as Co-chair.
Passport Health Communications: Trading Partner Servicing Models

• Health Plan Facing
  – Receives and returns Eligibility 270/271 and Claim Status 276/277 transactions via direct and indirect connections with health plans
    • Supports EDI infrastructure and connectivity functions

• Provider Facing
  – Submits 270/271 Eligibility and 276/277 Claim Status inquiries on behalf of providers
    • Supports EDI infrastructure and connectivity functions
  – Supports Real Time eligibility verification services and presents data to providers via web portal solution
  – Supports additional data services to providers, e.g., routing, retries, etc.

• Highly Integrated Services for Large Providers
  – Submits 270/271 Eligibility and 276/277 Claim Status inquiries on behalf of providers
    • Supports EDI infrastructure and connectivity functions
  – Supports Real Time eligibility verification services and presents data to providers
  – Provides data services to large providers/hospitals; helps control workflow for Hospital Information System (HIS) vendor products
Passport Health Communications Experience: Combining Infrastructure with Data Content

- Infrastructure operating rule requirements provide a reliable foundation for the electronic exchange of eligibility and claim status transactions between provider, clearinghouse and health plan
- Data content operating rule requirements for an eligibility inquiry and response are delivering more consistent and usable eligibility and patient financial data to providers
- More consistent data combined with up-front business logic is resulting in streamlined eligibility verification capabilities
Mandated Eligibility 271 Response Requirement: Benefits of Generic and Explicit Eligibility Inquiry

- Assures a minimum level of transaction data is returned to the provider in the 271 eligibility response
  - A single eligibility request returns more than a Yes/No response; it includes 51 service type codes that must be supported for explicit inquiry and 12 service types for a generic request
- Ability to check insurance eligibility verification at the time of registration; obtain uniform responses
- Supports pre-admission clearance by allowing provider to focus in on corrective action and minimizes time to resolution
- Predetermination of patient financials
- Fewer follow-up inquiries to get data
- Fewer phone calls to the payer
- Improved revenue cycle management
Mandated Eligibility 271 Response Requirement:
Explicit Inquiry – Service Type Codes

ASC X12 Standards

CAQH CORE Operating Rules

ROI Vision of Administrative Simplification

ASC X12 v5010 270/271
TR3 1.4.7

Implementation-Compliant Use of the 270/271 Transaction Set

Requires support for an explicit inquiry for a combined set of 51 Service Type Codes, building off of 12 that are required in the CORE 154 Rule (see code list on next page)

Expands access to status of benefit coverage and patient financials for Service Types
Mandated Eligibility 271  Response Requirement

Explicit Inquiry Requirements

• An explicit ASC X12 270 inquiry with 51 CORE–required service type codes must be supported; ASC X12 271 response to explicit ASC X12 270 inquiry must include Patient financials for base and remaining deductible, co-insurance and co-payment for each of 51 CORE-required service type codes when amounts are different than for Service Type Code 30 – Health Plan Coverage, plus any in/out of network variances

- 1 – Medical Care
- 2 – Surgical
- 4 – Diagnostic X–Ray
- 5 – Diagnostic Lab
- 6 – Radiation Therapy
- 7 – Anesthesia
- 8 – Surgical Assistance
- 12 – Durable Medical Equipment Purchase
- 13 – Facility
- 18 – Durable Medical Equipment Rental
- 20 – Second Surgical Opinion
- 33 – Chiropractic
- 35 – Dental Care
- 40 – Oral Surgery
- 42 – Home Health Care
- 45 – Hospice
- 47 – Hospital
- 48 – Hospital – Inpatient
- 50 – Hospital – Outpatient
- 51 – Hospital – Emergency Accident
- 52 – Hospital – Emergency Medical
- 53 – Hospital – Ambulatory Surgical
- 62 – MRI/CAT Scan
- 65 – Newborn Care
- 68 – Well Baby Care
- 73 – Diagnostic Medical
- 76 – Dialysis
- 78 – Chemotherapy
- 80 – Immunizations
- 81 – Routine Physical
- 82 – Family Planning
- 86 – Emergency Services
- 88 – Pharmacy
- 93 – Podiatry
- 98 – Professional (Physician) Visit – Office
- 99 – Professional (Physician) Visit – Inpatient
- A0 – Professional (Physician) Visit – Outpatient
- A3 – Professional (Physician) Visit – Home
- A6 – Psychotherapy
- A7 – Psychiatric Inpatient
- A8 – psychiatric Outpatient
- AD – Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy
- AG – Skilled Nursing Care
- AI – Substance Abuse
- AL – vision (Optometry)
- BG – Cardiac Rehabilitation
- BH – Pediatric
- MH – Mental Health
- UC – Urgent Care
Passport Health Communications Experience: 
**AAA Error Code Reporting Operating Rule**

- Implementation of the CAQH CORE AAA Error Code Reporting Operating Rule
  - Establishes a standard way for the health plan (or information source) to report error conditions when they are unable to create a v5010 271 eligibility transaction for the requested patient or subscriber
  - Use of the business rule helps to streamline the providers ability to find members with less trial and error
    - Gives provider enough detail to determine which information is missing or incorrect when an eligibility and benefits inquiry does not return a valid match, e.g., generic responses such as “Not found” are limited with this operating rule
  - Puts necessary information in the hands of the provider to reduce the barriers associated with identifying health plan members
  - Results in a reduction in provider’s administrative expense
Passport Health Communications Experience:
 Normalize a Patient’s Last Name Operating Rule

• Implementation of the CAQH CORE Normalizing a Patient’s Last Name Rule
  – Puts into place specific instructions for how a health plan (or information source) normalizes a person’s last name during any name validation or matching process by the health plan (or information source); defines how to handle names when searching
  – Requires payers to normalize when matching
  – Streamlines the providers ability to find members with less trial and error
    • Prior to implementing an operating rule last name inconsistencies slowed down provider processing, e.g.,
      – Last name suffix, e.g., Jr., Sr.
      – Hyphenated last names, e.g. Smith-Jones
      – Use of apostrophe, e.g., O’Connor, O’Malley
  – When Normalizing Patient Last Name Rule is applied, a provider eliminates an issues resolution
  – Providers experience reduced costs
Passport Health Communications Experience:  
**Key Payer Implementation Considerations**

- Invest time communicating with your trading partners; tell them about the changes you are making to eligibility and benefits data
  - Written communications are essential
  - Describe how CORE-compliant data is going to present differently
  - Send out multiple notices, e.g., conduct a drip campaign, consider post cards, etc.

- Your trading partners need to know *what data* you are changing and *when* it is going to change
  - It’s critical to their uninterrupted use of important eligibility and benefit data

- For example, health plans should tell their providers when suffix changes related to implementation of the CAQH CORE Operating Rule for Normalization of Last Name will take effect
Passport Health Communications Experience: 
**Key Provider Implementation Considerations**

• The availability of more robust data may necessitate system adjustments and/or enhancements
  – Payers must respond to provider eligibility inquiries in real-time; PMS systems need to receive and display the enhanced data to providers
  – PMS and HIS systems that consume the data and subsequently pass it to downstream systems must effectively communicate the data to other systems

• **Data Content:** Be aware of *what is impacted* and *what is changing*
  – Eligibility data content is changing for the better
  – Downstream processes that consume, present & use eligibility data may be impacted

• **Implementation:** Be aware of *what you should do*
  – Pay attention to the changes that are coming
  – Know what data is changing for each of your payers and how it will be different
  – Which of your systems will be impacted?
    • Practice Management Systems (PMS) - products installed in providers offices that depend upon eligibility and benefit information to function properly
    • HIS / revenue systems
Passport Health Communications Experience: Lessons Learned

• Our history tells us…..
  – Servicing the proprietary and one-off needs of our customers was not sustainable
  – HIPAA ASC X12 transactions provided a structure that supports the variety of ways that payers presented eligibility data to providers
  – CORE Operating Rules are offering us business logic to build upon the ASC X12 transactions
  – Applying business logic, along with infrastructure rules, up front in the form of eligibility operating rules is ensuring that the necessary data content is available to the provider in a very usable and consistent method
  – Finding health plan members is imperative and data content is the key

• For today’s clearinghouses, CAQH CORE Operating Rules are reducing the cost of doing business; they will help providers streamline workflow

• Is that really all? EDI data will be even more important in the future
  – Access to ‘good’ data is key to long-term cost savings as systems evolve
  – Given the right data, sophisticated Hospital Information Systems (HIS) and Practice Management Systems (PMS) can do more than you might expect
Countdown to Compliance:

Ask Your Implementation Question
Structured Question & Answer

• Infrastructure - Topic #1
  – Companion Guides
  – Response Time
  – System Availability

• Infrastructure - Topic #2
  – Connectivity
  – Security

• Eligibility Data Content – Topic #3
  – Eligibility Verification
  – Patient Financials
  – Enhanced Error Reporting
  – Patient Identification

• General Implementation – Topic #4
  – Trading Partner Collaboration and Conformance Testing
Please take a moment to fill out the survey that will appear once you log out of the webinar.

Questions or Suggestions? Email: National EHealth Collaborative university@nationalehealth.org
Federally Mandated CAQH CORE Operating Rules, contact CORE@CAQH.org

Didn’t get your question answered? You can continue today’s discussion by joining the NeHC University group in NeHC’s online community:
http://www.nationalehealth.org/collaborate/groups/NeHCUniversity
Free CAQH CORE Education Events

• Coming Soon! …our 2013 Calendar with a focus on EFT and ERA Operating Rules

• Upcoming CAQH CORE Town Hall Calls
  – January 22, 2013, 3-4 PM ET
  – March 12, 2013, 3-4 PM ET

• Listen to past education sessions including:
  – CAQH CORE and ASC X12 Webinar: Implementing ACA Mandated Operating Rules Related to Eligibility Data Content
  – CORE Infrastructure Operating Rules - Ask Any Question
Mandated Eligibility & Claim Status Operating Rules

Reference Links

- **CAQH CORE Operating Rules - ASC X12 270/271 Eligibility Transaction**
  - Data Content Related Rules
    - CAQH CORE 154 & 260: Eligibility & Benefits Data Content Rules
    - CAQH CORE 258: Normalizing Patient Last Name Rule for Eligibility
    - CAQH CORE 259: AAA Error Code Rule for Eligibility
  - Infrastructure Related Rules
    - CAQH CORE 150: Batch Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 151: Real Time Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 152: Companion Guide Rule
    - CAQH CORE 155: Batch Response Time Rule for Eligibility
    - CAQH CORE 156: Real Time Response Rule for Eligibility
    - CAQH CORE 157: System Availability Rule
    - CAQH CORE 153 & CAQH CORE 270: Connectivity Rules

- **CAQH CORE Operating Rules - ASC X12 276/277 Claim Status Transaction**
  - CAQH CORE 250: 276/277 Claim Status Infrastructure Rule*

*NOTE: In the *Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction*, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note "we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein."