Healthcare Administrative Transactions Simplified: The Role of Mandated Operating Rules

Monday, June 25, 2012
3:00 pm to 4:30 pm ET
Session Topics

• CAQH CORE Overview
• Administrative Simplification: Affordable Care Act (ACA) Section 1104
• The Importance of Industry Collaboration – Including Clinical and Administrative Alignment
• Preparing for the January 1, 2013 Mandate
• A Health Plan Perspective – UnitedHealth Group
• Questions & Answers
Today’s Learning Objectives

Attendees will be able to:

• Recognize the essential role of operating rules in both administrative simplification and care delivery

• Understand the timeline for adoption of federally mandated operating rules and identify the beneficial impacts to HIPAA covered entities

• Describe the key requirements for federally mandated Eligibility for a Health Plan and Healthcare Claim Status Operating Rules

• Identify key steps necessary to successfully implement Eligibility for a Health Plan and Health Care Claim Status Operating Rules
Vision of Administrative Simplification

1. Jack uses his mobile device to log onto Dr. Summa’s secure website. Jack checks appointment availability, chooses his desired slot, updates his insurance information, and sees that his insurance was verified.

2. Dr. Summa’s practice management system re-verifies Jack’s insurance and determines if there is any secondary coverage.

3. Dr. Summa’s office sends Jack an appointment confirmation email which indicates fee/co-pay.

4. Jack arrives at Dr. Summa’s office and registers. Any changes to his eligibility, benefits and payment requirements are identified and noted in the electronic health record (EHR) system and/or PMS.

5. After examining Jack, Dr. Summa determines that he needs a referral to Dr. Zippa, a cardiologist.

6. Dr. Summa’s EHR submits an electronic referral request and obtains an authorization. Dr. Summa electronically signs the EHR, which creates a real-time transaction to the office billing system which determines if edits are needed.

7. The edited electronic claim is sent to Jack’s health plan with validated diagnosis and procedure coding. The claim is adjudicated and within seconds Dr. Summa’s office receives an electronic payment and remittance advice.

8. At check-out, the office staff explains the charges to Jack, answers questions and accepts his payment. If the claim had been denied, the staff would have worked with Jack and/or Dr. Summa to make necessary corrections and resubmit the corrected claim before Jack left the office.

9. He also receives a message on his mobile device from Dr. Zippa inviting him to make an appointment.

10. Jack receives a monthly email from his health plan summarizing the services he has received from all of his providers. The summary is as easy to read as his credit card bill.

11. Through the use of utilities, standards, operating rules and automated work flow, Jack, Dr. Summa and Dr. Zippa all have experienced reduced costs and increased efficiency and Jack’s quality of care has improved.
What Are Operating Rules?

• The Patient Protection and Affordable Care Act (ACA) of 2010 amended HIPAA; its Section 1104 introduced healthcare operating rules

• The 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
  – 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

![Diagram of Operating Rules: Key Components](image)
Operating Rules and Standards Work in Unison: Both Are Essential

- In 1996 HIPAA addressed a number of major transactions in the healthcare revenue cycle, however, standards alone did not go far enough to reach Administrative Simplification goals.

- In 2010 ACA Section 1104 introduced mandated operating rules for all HIPAA covered entities; they already are being adopted together with standards and have been since 2006.

- Operating rules always support standards; healthcare operating rules address and support a range of standards; benefits of operating rules co-existing with and complementing standards are evidenced in other industries.
  - Various sectors of banking (e.g., credit cards & financial institutions)
  - Different modes of communications and transportation.

- Operating rules are built to be adaptive and responsive to administrative simplification needs before, during and after versions of standards are formally adopted.
CAQH CORE
Operating Rules Overview
CAQH® and Its Initiatives

CAQH is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

Multi-stakeholder collaboration of over 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. Cover 75% of the commercially insured, plus Medicare and some Medicaid.

An industry utility that replaces multiple health plan paper processes for collecting provider data with a single, electronic, uniform data-collection system (i.e., credentialing). Over 1 million providers self-report their information to UPD and over 650 organizations access the system, including a range of public and private entities.

An independent industry forum for monitoring business efficiency in healthcare tracking efficiency and electronic adoption across the industry.
Committee on Operating Rules for Information Exchange

- **CAQH CORE®** is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  - Integrated model: Rule writing, certification and testing, and outreach/education

- **Mission:** To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (*vendor agnostic*) and quickly receive a standardized response
  - Enable stakeholders to implement in phases that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption
  - Facilitate administrative and clinical data integration

- **CAQH CORE is not:**
  - Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7, OASIS, W3C
  - Developing software or building a database
CAQH CORE Integrated Model: Perspective on the Role of Authoring Entities

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

CAQH CORE Integrated Model:
- Develop Rules (research, scoping according to guiding principles, straw polls, voting, etc)
- Design Testing & Certification
- Build Awareness
- Provide Assistance & Early Implementers Base
- Promote Adoption
- Track Progress & ROI
- Maintain
- Report Status

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Multi-Stakeholder Participants

- CAQH CORE participants include a mix of stakeholders, all of whom have a formal voting role in rule development:
  - Providers
  - Health plans
  - Vendors/Clearinghouses
  - Associations
  - Standard development organizations (SDOs)
  - Government entities
  - Other organizations
Patient Protection and Affordable Care Act (ACA)
Section 1104:
Introduction of Mandated Healthcare Operating Rules
Administrative Simplification: ACA Section 1104

ACA Section 1104 (H.R.3590) - “…Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs”

Highlights

• Updates initial August 2000 HIPAA regulation for transaction standards and code sets given landscape has significantly changed, and unnecessary healthcare costs/burden must be removed from the system
• Requires the Department of Health and Human Services (HHS) to appoint a “qualified non-profit entity” to develop a set of operating rules for the conduct of electronic administrative healthcare transactions
• Administrative and financial standards and operating rules must:
  − Enable the determination of eligibility and financial responsibility for specific services prior to or at the point of care
  − Be comprehensive, requiring minimal augmentation by paper or other communications
  − Provide for timely acknowledgement, response, and status reporting
• HIPAA covered entities and business associates engaging in HIPAA standard transactions on behalf of covered entities must comply
• Health plans must file a statement with HHS confirming compliance; financial penalties for health plans are significant
Industry Context: A Spectrum of Change

- During the next several years the entire revenue cycle process will experience significant transformation due to the introduction of operating rules.
- This change can drive interoperability, facilitate greater adoption of standards and generate a responsive, and adaptive, system-wide approach that aligns with other strategic initiatives.
ACA Mandated Operating Rules Approach

Operating rule writing and mandated implementation timeframe per ACA legislation

Adoption deadlines to finalize operating rules

- July 2011 Eligibility and Claim Status
- July 2012 Claims payment/advice and electronic funds transfer
- July 2014 Enrollment, Referral authorization, attachments, etc.

Compliance dates to implement operating rules

- January 2013
- January 2014
- January 2016

NOTES:

1. The National Committee on Vital and Health Statistics (NCVHS) is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules.

2. Statute defines relationship between operating rules and standards.

3. Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans.

4. Per statute, documentation of compliance for health plans may include completion of end-to-end testing (i.e., certification and testing).

5. Statute states compliance with the applicable standard/operating rule is required no later than its effective date.
Mandated Eligibility & Claim Status Operating Rules: Status

- **Status**: The first set of operating rules has been adopted into Federal regulation
  - July 2011, CMS published CMS-0032-IFC with the following key features:
    - Adopted Phase I and II CAQH CORE Operating Rules for the Eligibility & Claim Status transactions, except for rule requirements pertaining to Acknowledgements*
    - Highlights CORE Certification as voluntary; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation
  - December 2011, CMS adopted above as a Final Rule; industry implementation efforts underway for the **January 1, 2013 effective date**
    - CAQH CORE is committed to assisting with roll-out; June 20th testified to NCVHS on status
- ACA Section 1104 requires *all HIPAA covered entities* be compliant with applicable HIPAA standards and associated operating rules

The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge [HERE](#).

*On September 22, 2011, NCVHS issued a [letter](#) recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.
# ACA Federal Compliance Requirements: Highlights & Key Dates

The following **three dates are critical** for industry implementation of the federally mandated CAQH CORE Eligibility & Claim Status Operating Rules. *Note: there are two types of penalties related to compliance with the mandated operating rules.*

<table>
<thead>
<tr>
<th>Key Area</th>
<th>January 1, 2013 Compliance Date</th>
<th>December 31, 2013 Health Plan Certification Date</th>
<th>No Later than April 1, 2014 Health Plan Penalty Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>HIPAA Mandated Implementation</td>
<td>ACA-required Health Plan Certification</td>
<td></td>
</tr>
<tr>
<td><strong>Who:</strong> All HIPAA covered entities</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Action:</strong> Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td></td>
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<tr>
<td><strong>Who:</strong> Health plans</td>
<td></td>
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</tr>
<tr>
<td><strong>Action:</strong> File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules</td>
<td></td>
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</tr>
<tr>
<td><strong>Who:</strong> Health plans</td>
<td></td>
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</tr>
<tr>
<td><strong>Action:</strong> HHS will assess penalties against health plans that have failed to meet the ACA compliance requirements for certification and documentation</td>
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<tr>
<td><strong>Applicable Penalties</strong></td>
<td>Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>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</td>
<td></td>
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</tbody>
</table>

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](http://www.cms.gov) and [enforcement process](http://www.cms.gov).

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](http://www.caqh.org) 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.

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Scope of CAQH CORE Operating Rules:
Phase I and Phase II

<table>
<thead>
<tr>
<th>Examples of Topics that CAQH CORE Operating Rules Address:</th>
</tr>
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<tbody>
<tr>
<td>All are within ACA-defined scope of operating rules and build on standards where appropriate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Content: Eligibility</th>
<th>Infrastructure: Eligibility and Claim Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address need to drive further industry value in transaction processing</td>
<td>Address industry needs for common/accessible documentation</td>
</tr>
<tr>
<td>More Robust Eligibility Verification Plus Financials</td>
<td>Companion Guides</td>
</tr>
<tr>
<td>Enhanced Error Reporting and Patient Identification</td>
<td>System Availability</td>
</tr>
<tr>
<td>Response Times</td>
<td>Acknowledgements*</td>
</tr>
<tr>
<td>Connectivity and Security</td>
<td></td>
</tr>
</tbody>
</table>

*Please Note: In the Interim 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. Although HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule does say “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.”
## Mandated Eligibility & Claim Status Operating Rules: January 2013 Requirements Scope

Clinical alignment was a key criteria in both data content and infrastructure development, e.g. data targeted services included in ONC efforts such as “Diagnostic X-Ray” and “Diagnostic Lab”, while connectivity aligns with NwHIN direction.

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I &amp; II CAQH CORE Requirements</th>
</tr>
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<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td>Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:</td>
</tr>
</tbody>
</table>
| **Eligibility & Benefits** | • Health plan name and coverage dates  
• Static financials (co-pay, co-insurance, base deductibles)  
• Benefit-specific and base deductible for individual and family  
• In/Out of network variances  
• Remaining deductible amounts |
| **Infrastructure** | • Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)  
• Companion Guide – common flow/format  
• Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch)  
• System Availability service levels – minimum 86% availability per calendar week  
• Enhanced Patient Identification and Error Reporting requirements  
• Acknowledgements (transactional)* |

*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.”

A PowerPoint overview of the Phase I & II CAQH CORE Rules is available [HERE](#); the complete rule sets are available [HERE](#).
Mandated EFT & ERA Operating Rules: Status

• Spring 2011 NCVHS recommended:
  – NACHA as healthcare EFT SDO and ACH CCD+ as healthcare EFT standard
  – CAQH CORE, in collaboration with NACHA, as author for EFT and ERA operating rules (pharmacy to be addressed as appropriate)
  – NACHA operating rules apply to banks, while CAQH CORE rules apply to HIPAA covered entities

• Fall 2011:
  – Draft CAQH CORE EFT & ERA Rule Set approved by CORE Rules Work Group
  – Draft CORE EFT & ERA Voluntary Certification Test Suite approved by CORE Technical Work Group

• Winter 2011:
  – NCVHS issued letter recommending HHS adopt Draft CAQH CORE EFT & ERA Rule Set
  – January 2012: CMS released Interim Final Rule for the Healthcare EFT standard; CAQH CORE commented on IFC (model letter shared with participants)

• Spring /Summer 2012:
  – CAQH CORE updated Draft EFT & ERA Operating Rules (not changing requirements) to reflect CMS recognition of EFT standard and NCVHS guidance to remove references to voluntary CORE Certification
  – NACHA issued RFC on potential adjustments to NACHA Operating Rules
    • May 18th: CORE Rules Work Group held a call on which NACHA staff provided insight/rationale for proposed enhancements and answered questions on the framework of the ACH Network
  – CAQH CORE\(^1\) approved its EFT and ERA Rule Sets

\(^1\) Only CORE Participating entities that create, transmit or use the transactions (thus implement the rules) may vote in Final CORE Vote; earlier votes include all types of entities.
Third and Final ACA Mandated Set: Status

- Alignment with clinical initiatives will be even more critical in this third set due to timing of other HIT efforts and also focus of rules

- November 2011: NCVHS began holding hearings
  - CAQH CORE provided testimony on three topics and stated interest in serving as operating rule author, key points included:
    - **Claims Attachments**: Communicated current industry landscape implies clinical and administrative coordination is critical, provided examples of potential areas for operating rules; highlighted standards and operating rules will need to work together more than ever if the industry is to meet deadline
    - **Provider Enrollment**: Outlined lessons learned from the CAQH Universal Provider Datasource (UPD) as well as CORE EFT/ERA work
    - **Maintenance of Standards & Operating Rules**: Discussed how these processes can be improved moving forward

- Spring 2011: NCVHS recommendation included the following statement:
  - “NCVHS will advise the Secretary to name a single entity that will serve as the responsible body to develop and maintain operating rules in coordination with other entities. Operating rules would be created for the remaining transactions as needed and will be developed through the coordination and active engagement of individuals or organizations with appropriate expertise.”
The Importance of Industry Collaboration

*Foundational Elements of Healthcare Interoperability*
Healthcare Administrative Data Exchange: An End-to-End Perspective

- All HIPAA covered entities involved in the electronic exchange of administrative transactions have a role to play in the adoption of CAQH CORE Operating Rules, i.e., providers, health plans, clearinghouses and/or vendors.
- HIPAA covered entities work together to exchange transaction data in a variety of ways. The applicability of a given CAQH CORE Operating Rule will depend upon the nature of the trading relationship between HIPAA-covered entities, e.g.,
  - Provider direct-to-health plan connection
  - Single/dual clearinghouse-to-health plan connection
  - Provider-to-clearinghouse/vendor connection
Operating Rules Align with National Health IT Agenda

A CAQH CORE Operating Rules guiding principle is to align with other Health IT efforts in order to create alignment across the industry.

CAQH CORE Phase I
CAQH CORE Phase II
CAQH CORE Phase III

Note: ONC = Office of the National Coordinator

2006  2007  2008  2009  2010  2011  2012  2013
The ‘Meaningful’ Use of Healthcare Administrative Data

Administrative healthcare transactions exchanged between providers and health plans and their vendors can contribute to national efforts\textsuperscript{2} to “Improving Quality, Safety, Efficiency and Reducing Health Disparities”

\textsuperscript{2}ONC policy initiative related to Meaningful Use
CAQH CORE Operating Rules Applied: Example of Coordination of National Initiatives

“The Nationwide Health Information Network (NwHIN) is being developed to provide a secure, nationwide, interoperable health information infrastructure that will connect providers, consumers, and others involved in supporting health and healthcare.”

• Operating rules are vendor agnostic; CAQH CORE Connectivity Operating Rules align with the NwHIN; they create opportunities for linkages between administrative and clinical data
  – Medicaid Information Technology Architecture (MITA)
    • CAQH CORE Operating Rules are incorporated into MITA’s national framework for improved systems development and health care management across the enterprise
  – Coordination with Office of the National Coordinator (ONC) e.g. CMS Electronic Submission of Medical Documentation (esMD) Project
    • Attachments and connectivity play a role
  – The Veterans Administration (VA) was an early CORE-certified provider
  – Participation in public-private demonstration projects focused on real-world implementation of nationally recognized efforts related to the integration of administrative data with Health Information Exchanges (HIE)

3 Nationwide Health Information Network (NwHIN): Background & Scope
CAQH CORE Operating Rules at the State Level

Colorado
Effective October 1, 2010, (in Proposed New Regulation 4-2-32) the Colorado Department of Regulatory Agencies Division of Insurance requires carriers licensed in Colorado as of September 1, 2012 to "show the ability of their systems to allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions following all CORE guidelines for data formats and system requirements."

Ohio
The Ohio Advisory Committee on Eligibility and Real Time Claim Adjudication recommends adoption of the CORE Operating Rules for payer and provider exchanges of patient eligibility information in its January 2009 Report on Eligibility and Real Time Claim Adjudication (pursuant to HB125, section 7).

Texas
In its December 2008 Report and Recommendations Relating to the Facilitation of Electronic Health Insurance Data Exchange (pursuant to HB 522), the Texas Committee on Electronic Data Exchange recommends insurers in the state of Texas use the CAQH CORE Phase I rules for the electronic exchange of eligibility information.

Virginia
A multi-stakeholder, industry-led effort, with state involvement, endorsed CORE.
Preparing for the January 2013 Mandate
Voluntary CORE Certification

- Since its inception, CAQH CORE has offered a voluntary CORE Certification; available to health plans, vendors, clearinghouses and providers
  - Encourages trading partners to work together on data flow and content needs
  - Facilitates maximum ROI when all entities in data exchange conform
  - Informs the industry that a company IT systems or product operates in accordance with the CAQH CORE Operating Rules

- Key guiding principles of CORE program
  - Certification and testing are done by separate entities; CORE-authorized testing vendors build web-based Test platform, and site is alpha/beta tested by CORE participants
  - Multi-stakeholder CORE process approves Test Suite for each rule set, including test scripts by stakeholder type
  - Free or very low-cost – and easily accessible to all parties
  - Does not replace internal or trading partner testing

- Vendors play a crucial role in accelerating provider adoption, ROI and interoperability across trading partner network
  - Small providers rely on their vendors/PMS to achieve their administrative cost saving goals
  - Large providers can work with their vendors to obtain CORE Certification
CAQH CORE Implementation Support

• Interactive tools that are free or low cost, e.g.,
  – Analysis and Planning Guide
  – Respond to incoming industry Implementation Requests process via CORE@caqh.org; facilitate referrals to others such as ASC X12 and CMS
  – Listing of FAQs
  – Polling evaluations to gauge usefulness of content, knowledge base, challenges, etc.
  – Voluntary CORE Certification, in conjunction with our CORE-authorized Certification Testing Vendor

• Educational programming
  – Free education opportunities and archives of past sessions at the CORE events page of our website
  – Variety of venues, different modalities with evolving in-depth content/focus
  – Collaboration with other organizations on programming, e.g. NeHC, NMEH, WEDI

• Business Case Awareness through tracking ROI and conducting Measures of Success Studies in conjunction with IBM
CAQH CORE Implementation: Analysis and Planning Guide

**Stakeholder & Business Type Evaluation:**

**Objective:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE Operating Rules (e.g. products, business lines, etc.)

**Inventory & Impact Assessment Worksheet:**

**Objective:** Understand how many of your systems/products are impacted by each CAQH CORE Operating Rule and understand with which vendors you will need to coordinate.

**Gap Analysis Worksheet:**

**Objective:** Understand the level of system(s) remediation necessary for adopting each CAQH CORE Operating Rule requirement; results of completed *Gap Analysis Worksheet* will allow for development of a detailed project plan.

NOTE: Each of the above tools can be found in the CAQH CORE *Analysis & Planning Guide*.
CAQH CORE Implementation Support: Tracking ROI

- Organizations who pursue voluntary CORE Certification are invited to participate in an implementation cost/effort and impact (ROI) study
  - Also providers whose market share includes CORE-certified health plans
- CAQH CORE made an early commitment to track Measures of Success
- CAQH CORE Operating Rule Implementation Study Phase I Outcomes
  - Health Plans experienced a decrease in telephone verifications, resulting in an 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 time to implement new health plan connections was reduced from 6-12 weeks to 1 week when the health plan was conforming with CAQH CORE Operating Rules
- CAQH CORE Operating Rule Implementation Study - Phase II
  - Measures of Success Study currently In Progress

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4 Results reported by early Phase I CORE-certified entities which included six national and regional health plans (33 million members), five clearinghouses/vendors and six providers (hospitals, physician groups and surgery center.)
Health Plan Perspective

UnitedHealth Group

Ross Lippincott
Vice President, Provider and Network Services Operations
UnitedHealth Group: Corporate Profile

OUR HEALTH BENEFITS BUSINESS: UNITEDHEALTHCARE

UnitedHealthcare

Helping People Live Healthier Lives

UnitedHealthcare Community & State
UnitedHealthcare Employer & Individual
UnitedHealthcare Medicare & Retirement

“Health in Numbers”
- Serving 35 million Americans at every stage of life
- Innovation-driven growth
- Exceptionally well positioned to evolve and grow through health care reform

FOUNDATIONAL COMPETENCIES
- Domain knowledge around care management and care resources
- Actionable health care information and intelligence
- Advanced, enabling technology

OUR HEALTH SERVICES BUSINESS: OPTUM

Optum

Making the Health Care System Work Better for Everyone

OptumInsight
- Health care information technology
- Consumer engagement and support
- Integrated care delivery
- Pharmacy
- Health financial services

OptumHealth
OptumRx

“Good for the System”
A dedicated and independent business providing services to:
- 6,000 hospital facilities
- 250,000 health care professionals
- 60 million consumers

CAQH
UnitedHealth Group: Corporate Profile (cont.)

- UnitedHealth Group is an active collaborator on industry initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers
- A CAQH Member and CORE Participating Organization
- Current CAQH Board Chair: David S. Wichmann, CFO, UnitedHealth Group and President, UnitedHealth Group Operations and Technology
- A Phase I and Phase II CORE-certified health plan
Health in Numbers
UnitedHealthcare: Transaction Services Profile

Operational Objective: Collaborate with our customers to transition phone calls to electronic transactions, and transition batch to real-time

- Health Plan Operations
  - Our customer servicing center handled more than 28 million Benefit/Eligibility and Claim Status calls in 2011
  - Over 300 million claims were processed in 2011
- Eligibility and Benefits
  - Currently support the electronic exchange of eligibility transactions both in real-time and batch
  - 2012 electronic eligibility inquiries volumes are approximately 170 million annually
  - 95% of these eligibility transactions are handled in real-time
- Claim Status
  - Currently supporting the electronic exchange of claim status transactions both in real-time and batch
  - Real-time claim status inquiry volumes in 2012 averaging ~260,000/day
UnitedHealthcare: Transaction Flow and Channels

Electronic channels support the following HIPAA ASC X12 transactions:

- Real-Time eligibility (270/271), claim status (276/277) – using v5010
- Batch eligibility, claim status, referrals (278), payment advice (835), and claim (837)

Note: UnitedHealthcare (UHC) also supports web portal inquiries but is encouraging the adoption of electronic transaction processing.
UnitedHealthcare Trading Partner Relationships: Health Plan to Clearinghouses

Clearinghouse volume is mainly routed through our Optum Insight clearinghouse to ensure transaction consistency, increase efficiencies, and support achievement of administrative simplification goals.

- Ensuring all transactional links are ready and operational is important to avoiding incremental value lost during the data exchange.
  - UHC exchanges ASC X12 transactions with both clearinghouses and provider direct submitters, with the following business relationship scenarios:
    - Provider direct to health plan connection
    - Provider-to-clearinghouse/vendor connection
    - Provider to single/multiple clearinghouse to health plan connection
  - Several direct connects with large providers represent significant volume.
  - UHC is connected to a vast majority of national clearinghouses.
  - Majority of transactions are received from these clearinghouses.
UnitedHealthcare Trading Partner Relationships: Health Plan to Providers

• Engaging providers is an important element of the value chain
  – During our initial CORE implementation planning effort we conducted research and gathered provider input
  – We are educating providers about the incremental functionality provided by CAQH CORE conformant transactions
  – Provider utilization and adoption
    • UnitedHealthcare receives electronic eligibility inquiries from approximately 40% of providers
    • 99% of provider claim status inquiries are requested in real-time

• Crossover Between Administrative and Clinical
  – Real-time eligibility and claim status inquiries have the potential to reduce administrative effort for these inquiries, reduce claim rejections and denials related to eligibility, and allow providers to focus resources on clinical services
Healthcare Operating Rules Implementation
UnitedHealthcare Operating Rule Implementation: Project Background

• UnitedHealthcare decided to implement CAQH CORE Operating Rules and pursue voluntary CORE Certification in early 2009 to coincide with our HIPAA v5010 implementation
  
  – v5010 is the second version of the HIPAA administrative transaction standards; v4010 was the first version
  
  – The CAQH CORE Operating Rules support existing standards and v5010 is a key example - CAQH CORE Operating Rules target greater use to drive the goal of administrative simplification, e.g. for v5010 eligibility standard CAQH CORE Operating Rules require use of fields in the standard such as YTD deductible status and in/out of network variances

• Rationale for adopting CAQH CORE Operating Rules:
  
  – Results from an internal research analysis indicated as many as 30% of call center service requests could be resolved by adopting the CORE Operating Rules for eligibility response transactions
  
  – Management’s interest in leveraging voluntary CORE Operating Rules to gain valuable experience and insight about the benefits associated with implementing industry operating rules prior to federal and state mandates
UnitedHealthcare Operating Rule Implementation: Strategic Alignment

• UnitedHealthcare Executive Management supported the implementation of CAQH CORE Operating Rules as a critical organizational priority.

• Approach: Enterprise-wide requirements were created for the HIPAA v5010 compliance project as well as for the implementation of Phase I and II CORE Operating Rules.
  – These requirements were shared with the different business segments for incorporation into their own business segment specific requirements.
  – Any issues or questions regarding the enterprise requirements were handled by one team to ensure consistency across the enterprise.

• Key Decision: Pursue Phase I and II CAQH CORE Operating Rule implementation concurrently.
  – Planning, analysis, design, coding and testing efficiencies.
  – The requirements for Phase I and II CAQH CORE Operating Rule implementation impacted the same IT systems.
  – The need for rigorous internal testing required focused effort.
  – Pursue voluntary CORE Certification to validate implementation results and inform the industry of conformance with CAQH CORE Operating Rules.
UnitedHealthcare Operating Rule Implementation: Project Organization

• Business and IT management
  – A centralized joint Business and IT PMO (project management organization) was formed to manage risk, issues, budget and timeline related to both efforts
  – CAQH CORE Operating Rule Implementation project touched the same pieces of code as other projects underway, so coordination was crucial

• Role of Vendors
  – Inventoried the vendors who play a part in the transmission of UHC transactions, to ensure their alignment with rules and to understand their role in UHC’s CORE Certification
  – Because UHC is segmented it made the most sense for Optum Insight, who has connections to the various segments, to be used for meeting CAQH CORE connectivity rule requirements
  – This was the optimal solution and allowed us to develop CAQH CORE connectivity once and re-use it for the different business segments
UnitedHealthcare Operating Rule Implementation: Project Phases

• Pre-Planning
  – Initially, a small team of people focused on understanding Phase I and Phase II CAQH CORE Operating Rules
  – Determined segments of business to engage in order to achieve Enterprise certification; enlisted business and IT sponsors from impacted areas
  – Conducted sessions to identify our Enterprise requirements
  – Conducted cost/benefit analysis of the project; achieved senior management support

• Gap Analysis
  – Based on Enterprise requirement analysis, each business segment/operating platform used Enterprise requirements to understand work required for their area

• System Development
  – Engaged solutions architecture group to begin alternatives analysis; completed design and reached out to vendors to assess their CORE compliancy
  – Arranged to use Optum Insight to meet connectivity rule requirements, and engaged them in planning efforts

• Understanding testing process
  – Registered on the CORE-authorized testing vendor website; arranged for a demo
UnitedHealthcare Operating Rule Implementation: Lessons Learned

- **CAQH CORE Operating Rule Specific Challenges**
  - Last name normalization rule (Phase II) due to large membership
  - Timing; competing industry regulations (transition to v5010), reconciling CAQH CORE Operating Rules and Minnesota state specific rules is resource intensive
  - Implementation challenged by the fact that our gateway (Optum Insight) was implementing eligibility and claim status operating rules at the same time

- **Perspective on Transition to Mandated Operating Rules**
  - Operating rules and standards have worked in a complementary fashion in other industries prior to CAQH CORE introducing the concept to healthcare
  - UHC continues to be a market leader in educating the industry, maintaining momentum of adoption and working with our trading partners
  - Review the CAQH CORE rules posted on the CAQH website, consult CORE FAQ’s, and contact CAQH staff if questions arise
Lessons Learned: Test Planning & Systems Evaluation

• A full understanding of CAQH CORE Operating Rules requirements and how they impact your organization’s IT systems is essential
• Upfront business/systems planning and analysis is a major component of the project
• Technical and business analyst resources must be available and work closely together throughout the full lifecycle of the project
  – Need somebody who really knows your health benefits products and how they are implemented in your systems
• Pursuing operating rule implementation concurrently with UnitedHealthcare’s v5010 testing and deployments enabled both the business and IT teams to address the gaps immediately
  – *Future ACA operating rules will help drive value of v5010 implementation*
• If you rely on vendors, make sure they are involved early in the planning process
• UnitedHealthcare maintains a dedicated testing environment to ensure stability throughout testing
Lessons Learned: *Voluntary* CORE Certification Testing

- *Voluntary* CORE Certification Testing played an important role in our overall test strategy and validation of conformance with operating rules.

- Consider early on how CORE Master Test Bed Data (for testing eligibility rules) will be loaded and used within the context of your system environment; advanced planning for test data setup is very critical.
  - It took approximately 8 weeks to set up the data due to complexity of the UnitedHealthcare claim platforms.
  - Detailed understanding of the CORE Master test data along with your external interfaces/dependencies, and the data flow between applications, is very critical.

- Majority of the CAQH CORE requirements were rigorously tested internally before executing first test script.

- Execute the test scripts first that you have concerns with as you can run the test scripts as many times as you want, and this will give you more lead time to fix any problem areas.

- Weekly staff meetings to assess progress once testing began were important.
Healthcare Operating Rules

Deployment
UnitedHealthcare Operating Rules Deployment

MARCH 2011 – UnitedHealthcare becomes the first national payer to achieve CAQH CORE certification on the v5010 code base!

UnitedHealthcare delivered CAQH CORE Phase I and Phase II functionality in conjunction with deployment of HIPAA 5010 changes:

• UnitedHealthcare served as an alpha-tester for CAQH/Edifecs for their v5010 CORE certification scripts.

• As our trading partners transitioned to exchanging v5010 transactions with us they have been able to take advantage of the expanded CORE functionality for Eligibility and Claim Status transactions.

HIPAA 5010 Bottom Line:
UnitedHealthcare worked to get its “house” in order early and was able to work with direct submitters and clearinghouses in a proactive approach to help ensure trading partner compliance.
Deployment: CAQH CORE Operating Rules
UnitedHealthcare Eligibility Implementation Results

![270 Eligibility Chart](chart-image)
Deployment: CAQH CORE Operating Rules
UnitedHealthcare Claim Status Implementation Results

276 Claim Inquiry

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Deployment: CAQH CORE Operating Rules
UnitedHealthcare Claim Status Implementation Results
Continuing the Push for Adoption and Utilization

• Recently deployed enhanced EDI reporting to provide additional visibility around who is using the transactions and who is not (and could benefit)
• Result will be targeted outreach toward “heavy hitters”
• We have seen a reduction in calls to date
• Exact reduction attributable to CAQH CORE certified transactions unclear (but enhanced EDI reporting will help confirm)
• Provider Relations organization continues to emphasize value and encourage utilization
UnitedHealth Group: Challenges Going Forward

“If you build it they will come.”
May work in baseball, but not the case here…

• Provider Readiness/Willingness to Adopt
  – Providers are not as engaged as health plans
    • THIS IS A RISK!
  – Practice Management Systems: Will vendors find value in supporting?
    • Vendors are not HIPAA covered entities; clearinghouses are covered

• Expectation around HHS ACA-mandated certification and maintenance
  – Lack of consistent expectations across stakeholders
  – In many instances legislative language needs clarification
  – Given the non-compliance penalty for health plans, it is critical to establish achievable
dates for deployment
  – Clinical and Administrative data share the same challenges

• Periodic reviews
  – Is there a better approach than what is currently used; current process can be
    cumbersome and lengthy
  – Health plans assume much risk & expense adopting when providers and vendors may not
    be willing/capable of adopting
UnitedHealthcare: Future Implementation Plans

• Next set of mandates: EFT/ERA
  – Assembled primary PMO team
  – Requested and obtained initial funding
  – Beginning planning and analysis
  – Applying lessons learned from the CAQH CORE Eligibility & Claim Status Operating Rules project
  – Assigning accountability and ensuring enterprise engagement

• Future Operating Rules:
  – Continuing to collaborate with CAQH on the next iteration of the operating rules
  – Sharing results of call analysis to help identify the next set of enhancements
  – Continue efforts supporting increased functionality and automation
Eligibility Benefits – Beyond CORE Phase I and II

### CORE Data Element Analysis - Addition of New Data Elements - Benefit / Eligibility Status

<table>
<thead>
<tr>
<th>Data Element</th>
<th>In Isolation</th>
<th>Running Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>31.04%</td>
<td>31.04%</td>
</tr>
<tr>
<td>Notification Required</td>
<td>40.00%</td>
<td>40.00%</td>
</tr>
<tr>
<td>Specific CPT Covered</td>
<td>34.33%</td>
<td>47.16%</td>
</tr>
<tr>
<td>Care Coordination #</td>
<td>31.34%</td>
<td>53.43%</td>
</tr>
<tr>
<td>Lifetime Max</td>
<td>33.43%</td>
<td>54.03%</td>
</tr>
<tr>
<td>Remaining Maternity Items</td>
<td>31.34%</td>
<td>56.12%</td>
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<tr>
<td>Complete DME</td>
<td>31.34%</td>
<td>60.60%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>33.43%</td>
<td>63.28%</td>
</tr>
<tr>
<td>Full Eligibility</td>
<td>32.84%</td>
<td>66.57%</td>
</tr>
<tr>
<td>Full General Benefits</td>
<td>33.43%</td>
<td>71.94%</td>
</tr>
<tr>
<td>Full Diagnostic</td>
<td>33.13%</td>
<td>81.79%</td>
</tr>
</tbody>
</table>

### Notes

- Baseline Functionality of 4010 / 5010 / CORE
- Lifetime Max Met, and Lifetime Max Limit
- Circumcision, Delivery, Length of Stay, Newborn Coverage, Notification After Min Stay, Post and Pre-Natal Testing, Tubal Ligation, Ultrasound
- Diabetic Testing, Disposable Medical supply, Durable Medical supply, Max Allowed per Year, Orthotic / Prosthetic Benefit
- MHSA Partial, Intermedia IP and OP, Max Ben Remaining, UHC Benefit Given, Vendor/Carrier Phone #
- Medicare Crossover Apply, Medicare COW, Medicare Non-Dupe, Medicare Requires Notification, UHC use Mdcr Guideline, OI - COW, OI Non Dupe, OI Primary
- Contracted Lab, Not Covered, Podiatry, Pre-D needed, RAPS, Status (PreD/MCR/non-clm appls)
- Cat Scan, Colonoscopy, Medical, MRI/CAT, Nuclear Medicine, PET, Sleep Study, Stress Test

*In isolation assumes baseline elements + the specific line item added only (for instance, only add Full Eligibility, or Complete DME)*

*Running Total includes all data elements above it on the worksheet*
Questions & Answers