Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call

January 22, 2012

Additional information/resources available at www.caqh.org

This document is for educational purposes only; in the case of a question between this document and CAQH CORE Operating Rule text and/or Federal regulations, the latter take precedence.
Agenda

• Brief Overview of CAQH CORE
• Update on ACA Mandated Healthcare Operating Rules
  – First Set: Eligibility & Claim Status Operating Rules
    • Enforcement Delay & Complaint Process: Q&A with CMS OESS
  – Second Set: EFT & ERA Operating Rules
    • Update on Compliance-based Adjustments to CORE-required Code Combinations
  – Third Set: Attachments, Prior Authorization, Enrollment, etc.
    • Rule Development Timeline
    • Survey of Potential Operating Rule Opportunity Areas
• Update on Other Activities
  – New Board, certifications and education
• Q&A
Brief Overview of CAQH CORE
CAQH® and Its Initiatives

Multi-stakeholder collaboration of over 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. CORE® participants maintain eligibility/benefits data for over 150 million lives, or approximately 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). More than 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 objective industry forum for monitoring business efficiency in healthcare. Tracking progress and savings associated with adopting electronic solutions for administrative transactions across the industry.
Committee on Operating Rules for Information Exchange

- A multi-stakeholder collaboration established in 2005
- **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
  - Facilitate administrative and clinical data integration
- Recognized healthcare operating rule author by NCVHS and HHS

CAQH CORE carries out its mission based on an integrated model
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”

They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards.
Mandated Healthcare Operating Rules:
First Set - Eligibility & Claim Status
ACA Mandated Operating Rules Compliance Dates: Required for All HIPAA Covered Entities

Operating rules encourage an interoperable network and, thereby, are vendor agnostic.

Compliance in Effect as of January 1, 2013
- Eligibility for health plan
- Claim status transactions
  *HIPAA covered entities comply with the CAQH CORE Operating Rules when conducting these 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
## Mandated Eligibility & Claim Status Operating Rules:
### Scope – Effective as of January 1, 2013

**Enforcement Action Begins March 31, 2013**

<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:</strong> Eligibility</td>
<td>Need to drive further industry value in transaction processing</td>
<td>More Robust Eligibility Verification Plus Financials</td>
<td>“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.”</td>
</tr>
<tr>
<td><strong>Infrastructure:</strong> Eligibility and Claim Status</td>
<td>Industry needs for common/accessible documentation</td>
<td>Enhanced Error Reporting and Patient Identification</td>
<td><strong>Acknowledgements</strong></td>
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<tr>
<td></td>
<td></td>
<td>伴侶指南</td>
<td>HHS Interim Final Rule</td>
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<tr>
<td></td>
<td></td>
<td>系统可用性</td>
<td></td>
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<td></td>
<td></td>
<td>响应时间</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>连接性和安全</td>
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</tr>
</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 acknowledgements, per the Interim Final Rule.*
Three dates are critical for 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>
<tbody>
<tr>
<td><strong>Dates</strong></td>
<td><strong>First Date</strong></td>
<td><strong>Second Date</strong></td>
</tr>
<tr>
<td>January 1, 2013</td>
<td>December 31, 2013</td>
<td>No Later than April 1, 2014</td>
</tr>
<tr>
<td><strong>Compliance Date</strong></td>
<td><strong>Health Plan Certification Date</strong></td>
<td><strong>Health Plan Penalty Date</strong></td>
</tr>
<tr>
<td><strong>Enforcement Date Extension</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 31, 2013</td>
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</tbody>
</table>

**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

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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.

4. Per the Jan 2, 2013 CMS OESS announcement of the 90-day Period of Enforcement Discretion for Compliance with Eligibility and Claim Status Operating Rules.
Compliance with Eligibility & Claim Status Operating Rules: 90-Day Period of Enforcement Discretion

- On January 2, 2013, CMS OESS* announced a 90-Day Period of Enforcement Discretion to reduce the potential of significant disruption to the healthcare industry
  - Notwithstanding OESS’ discretionary application of its enforcement authority, the compliance date for using the operating rules remains January 1, 2013
- Enforcement action will begin March 31, 2013 with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the ACA mandated Eligibility and Claim Status Operating Rules
- HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules, and all applicable covered entities that are preparing to do so, are encouraged to determine their readiness to use the operating rules as of January 1, 2013 and expeditiously become compliant

* OESS is the U.S. Department of Health and Human Services’ (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, identifiers and other standards required under HIPAA by the Affordable Care Act.
Compliance with Eligibility & Claim Status Operating Rules: CMS OESS Complaint –Driven Enforcement Process

- OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013
  - If requested by OESS, covered entities that are the subject of complaints (known as “filed-against entities”) must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period

- For more information review CMS’s [Administrative Simplification Enforcement Tool](#) (ASET), which is a web-based application where entities may file a complaint against a covered entity for potential non-compliance related to Transactions and Code Sets and Unique Identifiers
  - Anyone may use ASET to file a compliant
  - Each complaint is reviewed for validity and completeness by CMS OESS
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
Polling Question #1: *Readiness Profile*

- Which answer best describes the status of your organization’s progress toward implementing the mandated January 1, 2013 operating rules?
  - Just started/early phases
  - Fully underway/over the hump
  - Nearing completion/done
  - Not applicable (not a HIPAA covered entity)

(If you are ready to test with trading partners, add your organization HERE: [http://caqh.org/COREPartnerTesting.php](http://caqh.org/COREPartnerTesting.php))
Q&A

ACA Federal Compliance with CMS OESS Staff

Gladys Wheeler
Enforcement, CMS OESS

Matthew Albright
Lead Health Insurance Specialist, CMS OESS

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen
Mandated Healthcare Operating Rules:
Second Set - EFT & ERA
Mandated EFT & ERA Operating Rules:  
January 2014 Compliance Deadline

- The second set of operating rules has been placed in Federal regulation
  - August 2012: CMS published an Interim Final Rule with Comment, CMS-0028-IFC, with the following features:
    - Adopts Phase III CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA) transactions except for rule requirements pertaining to Acknowledgements*; covered entities must be in compliance by January 1, 2014
  - The interim final rule comment period closed on October 9, 2012
    - CAQH CORE developed a model comment letter for organizations to use as appropriate
  - No changes to the HHS IFR have been announced. HHS has publically stated that interim final rules stand as final rules. Entities should be working towards the January 2014 adoption date.

- Next Steps for CAQH CORE:
  - Developing CAQH CORE resources to support industry implementation of the CAQH CORE EFT & ERA Operating Rules including:
    - FAQs based on lessons learned/questions received through CAQH CORE Request Process
    - Drafting Analysis & Planning Guide for Adopting the CAQH CORE EFT & ERA Operating Rules
    - With CAQH CORE-authorized testing entity Edifecs, create beta and alpha Voluntary CORE Certification Test Site for Q1 2013 (Will your organization volunteer to beta test?)

*On September 22, 2011, NCVHS issued a letter recommending that Acknowledgements be adopted as formally recognized standards, and that the CAQH CORE Operating Rules for these standards also be recognized.
## Mandated EFT & ERA Operating Rules:
### January 1, 2014 Requirements Scope

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

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.
CAQH CORE Code Combinations Maintenance Process

- A CAQH CORE Code Combinations Task Group will convene three times per year to review the CORE-required Code Combinations for CORE-defined Business Scenarios
- Two types of review and adjustment to the CORE Code Combinations including:

  **Compliance-based Review & Adjustment**
  - **Goal:** Align CORE-required Code Combinations for CORE-defined Business Scenarios and the code sets
  - **Frequency:** Occurs three times/year via Task Group
  - **Scope:** Only considers updates to the CARC and RARC lists published (occurs three or more times per year) since the last update to the CORE Code Combinations as required by the CAQH CORE Rule 360
  - Per CMS OESS, Compliance-based Adjustments will be immediately recognized under HIPAA given that CAQH CORE Rule 360 requires that publications from code authors be addressed

  **Market-based Review & Adjustment**
  - **Goal:** Address ongoing and evolving industry business needs
  - **Frequency:** Occurs once per year during last Task Group convening
  - **Scope:** Considers industry submissions based on real world usage data and/or a strong business case addressing:
    - Adjustments to the existing CORE-required Code Combinations for existing CORE-defined Business Scenarios
    - Addition of new CORE-defined Business Scenarios and associated code combinations
    - Per CMS OESS, Market-based Adjustments will need to be recognized via a future and evolving Federal CMS OESS HIPAA requirement update process
Example: CAQH CORE Code Combinations Maintenance Process Over One Year

- **Jan**: Code Committees Meeting
- **Feb**: Code Committees Meeting
- **March**: Code Set Updates Published
- **April**: Code Set Updates Published
- **May**: CORE Task Group Compliance Review
- **June**: CORE Task Group Compliance Review
- **July**: CORE Code Combos Published
- **Aug**: CORE Code Combos Published
- **Sept**: CORE Code Combos Published
- **Oct**: CORE Code Combos Published
- **Nov**: Publishing of any Market-based Adjustments dependent upon Federal update process
- **Dec**: 60-day Industry Submission Period
January 2013 Compliance-based Review of the CORE Code Combinations

- The CAQH CORE Code Combinations Task Group convened in December 2012 to launch its first Compliance-based Review, with a goal of publishing an updated CORE-required Code Combination document by the end of January 2013.
- The Task Group completed a straw poll on potential Compliance-based Adjustments and approved the majority of recommended Compliance-based Adjustments on its 01/17/13 call; members are now in the process of reaching consensus on a few remaining code combinations that required additional review.
  - Overtime, the criterion applied to Market-based Adjustments and Compliance-based Adjustments will use data and discussions to reach the goal of simplification and automated processing.

### Potential Changes to CORE Code Combinations Due to Compliance-based Review
(Based on CAQH CORE Recommendations to Task Group)

<table>
<thead>
<tr>
<th>CORE-defined Business Scenario</th>
<th>Published June 2012 v3.0.0</th>
<th>Proposed January 2013 v3.0.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario #1:</strong> Additional Information Required – Missing/Invalid/Incomplete Documentation</td>
<td>Includes approximately 160 code combinations</td>
<td>Includes approximately 493 code combinations</td>
</tr>
<tr>
<td><strong>Scenario #2:</strong> Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim</td>
<td>Includes approximately 300 code combinations</td>
<td>Includes approximately 305 code combinations</td>
</tr>
<tr>
<td><strong>Scenario #3:</strong> Billed Service Not Covered by Health Plan</td>
<td>Includes approximately 375 code combinations</td>
<td>Includes approximately 400 code combinations</td>
</tr>
<tr>
<td><strong>Scenario #4:</strong> Benefit for Billed Service Not Separately Payable</td>
<td>Includes approximately 35 code combinations</td>
<td>Includes approximately 34 code combinations</td>
</tr>
</tbody>
</table>
Mandated Healthcare Operating Rules:
Third Set – Attachments, Prior Authorization, Enrollment, etc.
Third Set of Mandated Operating Rules: Status

- Remaining operating rule mandate, effective **January 1, 2016**, will address the following transactions:
  - Health claims or equivalent encounter information
  - Enrollment and disenrollment in a health plan
  - Health plan premium payments
  - Referral certification and authorization
  - Claims attachments

- Secretary of HHS **recommended** CAQH CORE as author for all remaining ACA mandated operating rules
  - CAQH CORE will use its open process to develop a set of draft rules for consideration to fulfill the third set of Federally mandated operating rules
  - Research and planning underway for rule development and activities including public surveys, in-depth interviews, summary of scope of current and draft standards and identification of potential rule opportunities/areas out scope
  - All CORE Guiding Principles will be followed, e.g., build on existing standards, align with other Federal health IT initiatives, address content and infrastructure
CAQH CORE Rules Development Process: Third Set

- CAQH CORE will use its open process and a timeline to complement ACA needs:
  - **Q1 2013**: Key opportunities/out of scope areas will be identified via research, survey findings, and call discussions
  - **Q2 2013**: Potential rule options will be developed, reviewed, and agreed upon by CORE Subgroups and Work Groups
  - **Q3 2013**: CORE Subgroup and Work Group discussion and straw polling will be conducted
  - **Q4 2013**: Detailed documentation of draft rule requirements by CORE Participants
- CORE Participants are encouraged to identify internal subject matter experts to represent their organizations
  - Having experience with implementing the first and second rule sets will be very useful
Industry Survey of Potential Operating Rule Opportunity Areas for ACA Section 1104 Third Set

- **All** industry stakeholders are invited to complete the [CAQH CORE Industry Survey of Potential Operating Rule Opportunity Areas for ACA Section 1104 Third Set](#) and share their organizations’ priorities for the third set of ACA-mandated operating rules
  - **Suggestions must fall within the definition and scope of operating rules as defined by the ACA**
  - The survey should take about 15-20 minutes to complete
  - Please coordinate a single response with subject matter experts within your organization as appropriate
  - Deadline to complete is 5 pm ET on 02/05/13
- As with prior CAQH CORE rules development, additional surveys seeking feedback on proposed rule areas and options will follow per CAQH CORE Subgroup and Work Group consideration

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Join CAQH CORE!

All industry stakeholders are encouraged to join CAQH CORE to have direct input on rules development; Click [HERE](#) to learn more about CORE Participation
Update on Non-Rule-Development Activities
New CORE Board

- The CORE Transition Committee was launched with the charge to recommend a model to extend both CAQH CORE multi-stakeholder governance and funding
  - CAQH CORE’s rule writing process is already multi-stakeholder
  - Over ninety percent of CAQH CORE’s expenses are covered by CAQH
- Status: Committee has developed a new CORE Governance Model
  - Expands existing CAQH CORE process for multi-stakeholder operating rules development by creating a multi-stakeholder CORE Board to oversee budget, policy developments, etc.
  - Requires that providers and health plans need consensus to move positions forward; vendors, standards development organizations (SDOs), government and others also serve on the Board
  - Structure is implementer-focused, executive leadership-driven, and results-oriented
  - Voting on the CAQH CORE rules will remain quorum-based with necessary CAQH CORE Subgroup and Work Group approvals and emphasis on implementers in final stages of voting
  - New Board will consider future funding options beyond CAQH
  - The Transition Committee has identified nominees
- For detail on the new CAQH CORE Board visit HERE
Voluntary CORE Certification

• 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](#)
  – *Voluntary* CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

• Recently completed and committed CORE Certifications include:
  – DoradoSystems - Completed Phase I & II certification as a clearinghouse
  – HealthFusion completed Phase II certification for HealthFusion® Real-Time
  – Blue Cross Blue Shield of Nebraska (Phase I & II: Q2 2013)
  – Rocky Mountain Health Plans (Phase I & II: Q1 2013)
  – Kaiser Permanente Colorado (Phase I: Q1 2013)
  – Office Ally, Office Ally Clearinghouse (Phase II: Q1 2013)
  – Smart Data Solutions, Smart Data Stream Clearinghouse (Phase I & II: Q1 2013)
  – Loxogon, Loxogon Alloy™ (Phase I: Q1 2013)
  – NextGen Healthcare, Real-Time Transaction Server (RTS) (Phase I & II: Q1 2013)
  – RelayHealth, RelayExchange™ (Phase II: Q1 2013)
  – GE Healthcare, Centricity Business Version 5.0 Claim Status (Phase I & II: Q1 2013)
Free 2013 CAQH CORE Education

- Mark your calendars & join us again at an upcoming webinar, e.g.
  - ASC X12 and CAQH CORE Webinar: An In-Depth Look at the ASC X12 270/271 Transaction - Eligibility Data Content Standards and Operating Rules
    - Tuesday, January 31, 2013 from 2:00 - 3:00 pm ET
  - NACHA and CAQH CORE Webinar: Learn from the Experts - Mandated Electronic Funds Transfer (EFT) Standard and Healthcare Operating Rules for EFT and Electronic Remittance Advice (ERA)
    - Thursday, February 7, 2013 from 1:00 - 2:00 pm ET
  - InstaMed and CAQH CORE Webinar: EFT and ERA Implementation Insights - Models to Deliver EFT and ERA
    - Tuesday, February 12, 2013 from 3:00 – 4:00 pm ET
  - CAQH CORE Town Hall: A bi-monthly information session open to the public
    - March 12, 2013, 3:00-4:00 pm ET
- Visit the CORE Education Events page of the CAQH website to register for sessions and access recordings of previous education events