Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call

August 1, 2013
3-4pm ET

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.
Participating in Today’s Interactive Event

• Download a copy of today’s presentation [HERE]

• The phones will be muted upon entry and during the presentation portion of the session

• At any time throughout today’s session, you may communicate with our panelists via the web
  – Submit your questions on-line at any time by entering them into the Q&A panel on the right-hand side of the WebEx desktop
  – On-line questions will be addressed first

• There will be an opportunity for the audience to submit questions through the telephone during today’s presentation
  – When directed by the operator, press * followed by the number one (1) on your keypad
Agenda

• Discussion with CMS OESS
  – Matt Albright, Deputy Director, Administrative Simplification Group, CMS

• Second Set of ACA Mandated Operating Rules: EFT & ERA
  – Recently Added EFT & ERA FAQs
  – Overview of CORE Rule 360: Uniform Use of CARCs and RARCs
  – CAQH CORE Code Combinations Task Group Update

• Third Set of ACA Mandated Operating Rules
  – Overview: Timeline and Getting Involved
  – Results from Public Survey on Specific Rule Options
  – Attachments Standards Recently Recommended by NCVHS

• Introduction to New CAQH CORE Board of Directors
  – Brief Introduction by George Conklin—CAQH CORE Chair

• Q&A
ACA Section 1104 Compliance Requirements
ACA Mandated Operating Rules Compliance Dates:
Required for all HIPAA Covered Entities

Operating rules encourage an interoperable network and are therefore vendor agnostic.

Compliance in Effect as of January 1, 2013
- Eligibility for health plan
- Claims status transactions
  HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules

Implement by January 1, 2014
- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions
  HIPAA covered entities will need to conduct these transactions using the CAQH CORE Operating Rules

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

Rule requirements available.
**ACA Federal Compliance Requirements: Highlights & Key Dates**

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></td>
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</tr>
<tr>
<td>First Date</td>
<td>January 1, 2013</td>
<td><strong>Second Date</strong></td>
</tr>
<tr>
<td>Compliance Date</td>
<td></td>
<td>December 31, 2013</td>
</tr>
<tr>
<td>Enforcement Date Extension</td>
<td>March 31, 2013</td>
<td>Health Plan Certification Date</td>
</tr>
<tr>
<td>Who: All HIPAA covered entities</td>
<td>Implement CAQH CORE</td>
<td>Who: Health plans</td>
</tr>
<tr>
<td>Action:</td>
<td>Eligibility &amp; Claim Status Operating Rules</td>
<td>File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Who: All HIPAA covered entities</th>
<th>Action:</th>
<th>Who: All HIPAA covered entities</th>
<th>Action:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules</td>
<td>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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</tbody>
</table>

| 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

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
Polling Question #1: Awareness of Eligibility and Claim Status Implementation Benefits

Four months have passed since the enforcement deadline for Eligibility and Claim Status Operating Rules Compliance

Is your organization currently experiencing any benefits (e.g., access to real-time claims status, access to electronic patient financials resulting in fewer phone calls), or in the process of working towards experiencing the available benefits (e.g. coordinating with your PMS, etc.), of Eligibility and Claim Status Operating Rules implementation?

a) Yes
b) No
c) I am not sure (in process of finding out)
d) Not Applicable to my Organization/I am NOT a HIPAA covered entity
EFT Standard and EFT & ERA Operating Rules: 
Required of All HIPAA Covered Entities

- **EFT & ERA Operating Rules**: April 2013 CMS announces [CMS-0028-IFC](#) should be considered the Final Rule and is now in effect
  - 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*
  - CMS confirms the CORE Code Maintenance processes

- **Healthcare EFT Standard**: July 2012 CMS announces [CMS-0024-IFC](#) is in effect
  - Adopts the NACHA ACH CCD plus Addenda Record (CCD+) and the X12 835 TR3 TRN Segment as the HIPAA mandated healthcare EFT standard

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*CMS-0028-IFC* excludes requirements pertaining to acknowledgements.

Compliance date for both the Healthcare EFT Standard and EFT & ERA Operating Rules is January 1, 2014
Discussion with CMS OESS

Matt Albright, Deputy Director, Administrative Simplification Group, CMS
Receiving Health Care Payment Electronically (EFT)

• If you (provider) are using paper checks to receive payments, EFT operating rules have made it easier to enroll in EFT across different health plans by requiring a standard form. All providers should consider switching to EFT, and providers who have Medicare patients are required to use EFT in 2014.

• Health care EFT payment through the ACH Network, in contrast to payments through card payments or FedWire, is the adopted standard for EFT. While other methods of EFT are not prohibited, a health plan must transmit health care payments through the ACH Network (as Medicare does) if requested by the provider.

• In general, a health plan cannot incentivize a provider to use an alternate transaction method other than the adopted standard or dis-incentivize a provider from using a standard transaction.
Health Plan Certification of Compliance in Section 1104 of ACA

• Health plans must certify compliance with standards and operating rules.
• HHS plans to issue a proposed and final rule.
• HHS does not expect to require any documentation that would have had to be produced prior to the effective date of the final rule.
Scope of Operating Rules as Reflected in HHS Regulations Adopted to Date

- Requirements that facilitate transactions.
- Data content of standards (cannot “duplicate” or “conflict”).
- Processes for updating certain elements of the operating rules.
- Requirements to use standards yet unnamed under HIPAA that support HIPAA transactions.
- “Standard transaction” is a transaction that complies with both applicable standards and operating rules.
Second Set of Mandated Healthcare Operating Rules: 

*EFT & ERA*
Mandated EFT & ERA Operating Rules:  
January 1, 2014 Requirements Scope

<table>
<thead>
<tr>
<th>Rule</th>
<th>High-Level Requirements</th>
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<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td></td>
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<tr>
<td>Uniform Use of CARCs and RARCs (835) Rule</td>
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<tr>
<td>Rule 360</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>
<tr>
<td>EFT Enrollment Data Rule</td>
<td></td>
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</tbody>
</table>
| Rule 380 | • 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 |
| Rule 382 | • Similar to EFT Enrollment Data Rule |
| EFT & ERA Reassociation (CCD+/835) Rule |
| Rule 370 | • 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 |
| Rule 350 | • 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. The complete Rule Set is available [HERE](#).
Pre-Payment: Provider Enrollment

- EFT Enrollment Data Rule
- ERA Enrollment Data Rule

Content: Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation.

Claims Payment Process

Stage 1: Initiate EFT

Electronic Funds Transfer (CCD+/TRN)

Infrastructure Rules

- Standard Companion Guides
- Real-time and Batch Response Times
- Internet Connectivity and Security
- Increased System Availability

Content: Uniform Use of CARCs & RARCs Rule

Content: EFT & ERA Reassociation (CD+/835) Rule

Payment/Advice (835)

Provider

Billing & Collections

Health Plan

Claims Processing

Treasury

Bank

Bank

Treasury

Indicates where a CAQH CORE EFT/ERA Rule comes into play.
Examples of EFT & ERA Operating Rules FAQs:

ERA Infrastructure Rule

Section 4.1 of the CAQH CORE 350 Rule requires entities to support the CAQH CORE 270: Connectivity Rule Version 2.2.0 to send/receive the X12 v5010 835. The CAQH CORE 270 Rule requires health plans and clearinghouses to publish a Connectivity Companion Guide. Is this Connectivity Companion Guide the same as the health care claim payment/advice Companion Guide referenced in Section 4.4 of the CAQH CORE 350 Rule?

Q:

Does the CAQH CORE 350 Rule specify processing mode requirements for exchange of the X12 v5010 835?

Q:

My organization is a health plan. As part of our X12 v5010 835 error handling process, we currently send a proprietary paper remittance advice (RA) in lieu of an out of balance X12 v5010 835. Does the CAQH CORE 350 Rule require that we discontinue this error handling process after the dual-delivery period has ended?

Q:

Access all EFT & ERA Operating Rule FAQs HERE
Examples of EFT & ERA Operating Rules FAQs:

**EFT/ERA Reassociation Rule**

**Q:** The CAQH CORE 370 Rule requires providers to proactively contact their financial institutions to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for successful reassociation of the EFT and ERA. As a provider, what information do I need to send to my financial institution to arrange for delivery of these data elements?

**Q:** Section 4.2 of the CAQH CORE 370 Rule specifies a maximum timeframe within which health plans must release the X12 v5010 835 for transmission (i.e., make the transaction initially available for pick-up). Does the CAQH CORE 370 Rule also require the pick-up of the X12 v5010 835 to occur within this timeframe?

Access all EFT & ERA Operating Rule FAQs [HERE](#)
Examples of EFT & ERA Operating Rules FAQs:

**EFT & ERA Enrollment Data Rules**

Q: My organization is a health plan. As part of our EFT enrollment form/method, we currently ask providers to identify the service location for which they want to enroll to receive EFT via a proprietary location identifier. Can we continue to collect this location identifier using the CAQH CORE-required Maximum EFT Enrollment Data Set?

Q: The HIPAA provisions require use of a National Provider Identifier (NPI) only to identify HIPAA covered providers in a transaction standard. Why does the CAQH CORE 382 Rule require inclusion of both TIN and NPI as sub-elements for the “Provider Identifier” Data Element in DEG2 and “Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)” Data Element in DEG7?

Access all EFT & ERA Operating Rule FAQs [HERE](#).
Examples of EFT & ERA Operating Rules FAQs: Uniform Use of CARCs and RARCs Rule

As a health plan, are we allowed by the CAQH CORE 360 Rule to use code combinations that are not included in the CORE-required Code Combinations for CORE-defined Business Scenarios for other business scenarios beyond the minimum set of CORE-defined Business Scenarios?

I am a vendor, CAQH CORE 360 Rule, Section 4.2, Basic Requirements for Receivers of the X12 v5010 835, requires that provider facing products display text describing the CORE-defined Claim Adjustment/Denial Business Scenarios and Code Combinations to the end user. Is there specific text that such products must display?

To what types of entities do the requirements in Section 4.2, Basic Requirements for Receivers of the X12 v5010 835, of the CAQH CORE 360 Rule apply?

How long does my health plan have to comply with the updates to the CAQH CORE CARC/RARC Code Combinations for the existing scenarios?

Access all EFT & ERA Operating Rule FAQs HERE
Examples of EFT & ERA Operating Rules FAQs: General EFT & ERA

Q: My organization is a provider office. We currently do not receive electronic claim payment and remittance information from all health plan trading partners. Do the CAQH CORE EFT & ERA Operating Rules require us to accept claim payment and remittance information via the Healthcare EFT Standards and X12 v5010 835 from all health plans?

Q: When will Voluntary CORE Certification be available for the EFT & ERA Operating Rules?

Access all EFT & ERA Operating Rule FAQs HERE
CAQH CORE Rule 360:
Uniform Use of CARCs and RARCs
Example: **CAQH CORE Uniform Use of CARCs and RARCs Rule - Four Business Scenarios**

**Pre-CORE Rules**
- 230 CARCs
- 770 RARCs
- 4 CAGCs

**Post CORE Rules**

**Inconsistent Use of Tens of Thousands of Potential Code Combinations**

**Four Common Business Scenarios**

<table>
<thead>
<tr>
<th>CORE Business Scenario #1:</th>
<th>CORE Business Scenario #2:</th>
<th>CORE Business Scenario #3:</th>
<th>CORE Business Scenario #4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Information Required – Missing/Invalid/Incomplete Documentation (≈470 code combos)</td>
<td>Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim (≈300 code combos)</td>
<td>Billed Service Not Covered by Health Plan (≈330 code combos)</td>
<td>Benefit for Billed Service Not Separately Payable (≈30 code combos)</td>
</tr>
</tbody>
</table>

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios.
CAQH CORE Code Combinations Maintenance Process

CORE Business Scenario #1:
Additional Information Required – Missing/Invalid/Incomplete Documentation (≈470 code combos)

CORE Business Scenario #2:
Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim (≈300 code combos)

CORE Business Scenario #3:
Billed Service Not Covered by Health Plan (≈330 code combos)

CORE Business Scenario #4:
Benefit for Billed Service Not Separately Payable (≈30 code combos)

CAQH CORE Compliance-based Reviews
- Occur 3x per year
- Triggered by tri-annual updates to the published CARC/RARC lists by code authors
- Include only adjustments to code combinations to align with the published code list updates (e.g. additions, modifications, deactivations)

CAQH CORE Market-based Reviews
- Occur 1x per year
- Considers industry submissions for adjustments to the CORE Code Combinations based on business needs (addition/removal of code combinations and potential new Business Scenarios)
- Opportunity to refine the CORE Code Combinations as necessary to ensure the CORE Code Combinations reflect industry usage and evolving business needs
Update from the CORE Code Combinations Task Group

• Task Group has been meeting on a regular basis since March
  – Composed of more than 40 CAQH CORE Participating Organizations from a wide variety of stakeholders; led by four multi-stakeholder Co-Chairs:
    • Shannon Baber, *UW Medicine*
    • Janice Cunningham, *RelayHealth*
    • Heather Morgan, *Aetna*
    • Deb Smith-Fedon, *United Healthcare*
  – Compliance-based Review Work Efforts:
    • Completed a Compliance-based Review based on the 03/01/13 published code list updates and published the *May 2013 CORE Code Combinations*
    • Starting another Compliance-based Review based on the 07/01/13 published code list updates this month
  – Market-based Review Work Efforts:
    • Focus for last two months has been discussion on the 2013 Market-based Review
      – Agreed on scope of 2013 Market-based Review
      – Developed an online form which entities will use to submit potential Market-based Adjustments
Level Set: Scope of 2013 Market-based Review

Per the CAQH CORE Code Combination Maintenance Process, the 2013 Market-based Reviews (MRB) consider two types of industry submissions – Code Combination Adjustments and ideas for potential New Business Scenarios.

1. Code Combination Adjustments
   - **Scope:** Includes *code additions/removals* for existing CORE-defined Business Scenarios
   - **High-Level Approval Process:** Submissions are reviewed and approved by CAQH CORE Code Combinations Task Group
   - **Status for 2013 MBR:** Task Group will collect industry submissions for code combination additions/removals

2. New Business Scenarios
   - **Scope:** Includes addition of *new* CORE-defined Business Scenarios and/or *substantive adjustments* to existing CORE-defined Business Scenarios
   - **High-Level Approval Process:** Any adjustment or addition to the CORE-defined Business Scenarios will require substantive adjustment to CAQH CORE 360 Rule and thus require formal CAQH CORE Approval and Voting Process:
     - Task Group
     - Rules Work Group
     - All-CORE Vote
   - **Status for 2013 MBR:** Given rule is not yet mandated and ongoing industry implementation, an “Early Call for Submissions of New Business Scenario Ideas” will occur; Task Group will **only** be collecting ideas for potential New Business Scenarios in 2013 – no voting will occur and a second, “Formal Call” will occur in 2014
2013 Market-based Review Includes *Only* “Early Call” for Potential New Business Scenarios

Per the CORE Code Combinations Task Group, the 2013 Market-based Review will *only* include an “early call” for submissions of potential New Business Scenarios; no New Business Scenarios will be added as priority is refinement of existing CORE-required Code Combinations in the existing CORE-defined Business Scenarios.

<table>
<thead>
<tr>
<th>Market-based Review Year:</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<td><em>Early Call for Submissions</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ideas for Potential New Business Scenarios</td>
<td><em>Formal Call for Submissions</em></td>
</tr>
<tr>
<td></td>
<td>Potential New Business Scenarios and Adjustments to Existing Scenarios</td>
<td></td>
</tr>
<tr>
<td>Will Associated Code Combinations be Collected?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Will New Business Scenarios be Added?</td>
<td>No</td>
<td>Yes (if approved)</td>
</tr>
</tbody>
</table>

**Rationale for Scope**

- Enables the Task Group to get a sense of potential New Business Scenarios and a jump start on outlining future scenario options understanding that:
  - CAQH CORE 360 Rule is not mandated until 01/01/14
  - Industry experience with the current Business Scenarios is needed prior to adding more
  - Entities are still busy implementing the existing four CORE-defined Business Scenarios

- Provides industry a second opportunity to submit potential New Business Scenarios given current focus on implementation
- Will require more detailed submissions including code combinations and any adjustments to existing CORE-defined Business Scenarios
- Submissions from 2013 will inform approach for 2014
Estimated Timeline for 2013 Market-based Review

Timeline is dependent on the volume of Market-based Submissions

Aug | Sept | Oct | Nov | Dec | Jan | Feb
--- | --- | --- | --- | --- | --- | ---

Call for Market-based Submissions via Online Form
60-Day Submission Period

- Every CORE participating organization and those non-CORE participating organizations that create, use, or transmit the HIPAA mandated transactions will be eligible to submit Market-based Adjustments
- One submission per organization

Task Group Review of Submissions

- Any CAQH CORE participating organization and their representatives can join
- Any entity can become a CAQH CORE Participating Organization; [join](#) cost is extremely low/free

Publication of Updated version of the CORE Code Combinations
Uniform Use of CARCs & RARCs: *What HIPAA Covered Entities Should Have by January 1, 2014*

1. A process to implement the CORE Code Combination updates
   - Applies to: Health plans, clearinghouses and providers that use the ASC X12 835
   - NOTE: Updates are made **three times per year** to align with the tri-annual code list updates from the code authors with which entities are already familiar

2. Accessing the current version:
   - The [CORE-required Code Combinations for CORE-defined Business Scenarios](#) are updated three times a year
   - The most current version is ALWAYS available for free at the link and on multiple locations on the CAQH CORE website
     - Formal announcements are sent to all stakeholders through multiple channels when new versions are issued, and a request that stakeholders distribute the update, e.g. sent to ASC X12, WEDI, NUBC
     - Entities may email [core@caqh.org](mailto:core@caqh.org) to request a marked-up version of the [CORE-required Code Combinations for the CORE-defined Business Scenarios](#) that highlights adjustments made between versions
   - CAQH CORE will offer a dedicated webpage for the CAQH CORE 360 Rule and the Code Combinations Maintenance Process – **Coming Soon!**
     - In addition to current announcements, future versions of the CORE-required Code Combinations for the CORE-defined Business Scenarios will also be announced on the webpage and deprecated versions will be available for reference
Polling Question #2:

**CARCs and RARCs Implementation Readiness**

Is your organization actively working on Uniform Use of CARCs and RARCs implementation readiness—either within your own organization or with another entity that needs to do so?

a) Yes  
b) No  
c) I am not sure
Third Set of Mandated Healthcare Operating Rules:
Attachments, Prior Authorization, Enrollment, etc.
Third Set of Mandated Operating Rules

Effective Date of January 2016

- The remaining ACA-driven operating rule mandate 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

- Process to develop Operating Rules
  - **Q1 2012 - Q2 2013:** Build industry awareness of upcoming option to participate in rule writing, ACA goals, CORE Guiding Principles and existing CORE operating rules; Conduct environmental assessment, e.g., research key opportunities, identify out of scope items, draft White Papers/environmental scans, conduct public surveying
  - **Q3 2013:** Launch Subgroups to review and develop potential rule options and seek input.
    - First Subgroups to launch will be Connectivity and Premium Payment/Enrollment-Disenrollment
    - Will meet every other week for hour and a half and all CORE Participants can join; notification will be issued via email and CAQH CORE website updated with schedule.
  - **Q4 2013:** Subgroups continue their work, Work Group/public channels continue to provide feedback.
  - **Q1 2014:** Detailed draft rule requirements developed in preparation for formal Work Group ballot prior to full CORE vote.
Follow-up Public Survey of Potential Operating Rule Opportunity Areas for Third Set

• For each of the five transactions, respondents were asked to:
  – Indicate their preference for applying rule requirements from the CAQH CORE infrastructure rules, e.g. Connectivity
  – Indicate the data content rule opportunity areas considered a high priority
  – Write in a rule opportunity area, in the event that what the respondent considers to be the highest priority is not available in the list

• Based on two industry surveys (second of which provided rule options), White Paper research, environmental scan and other industry activities:
  – Infrastructure: Significant interest in enhancing CORE Connectivity and Security (and other infrastructure) requirements as these operating rule requirements can apply to the majority of the transactions and help with the data flow.
  – Content: Interest in specific areas of content for certain transactions; with ongoing interest to have operating rules support further use of ASC X12.
  – Incremental maintenance: Based on EFT/ERA, interest in including rule language that allows rules to be agile and respond to market change/opportunities.
CAQH CORE Public Surveys of Potential Opportunity Areas: Claims and Encounters – EXAMPLE

- Spring 2013 Survey asked for ranking of highest-priority options submitted on an initial survey. Preliminary findings indicate:
  - Support for adoption of concept of enhanced CAQH CORE Infrastructure Rules to improve the exchange of the claim
    - 999 Acknowledgements
    - Connectivity
      - Real time submission*
      - Batch submission
    - Response times
    - Companion Guide – flow and format
    - Real Time Claims Adjudication (RTA)*
  - Strong support for adoption of infrastructure/data content rules for the:
    - 277CA (Draft Rule can be found [here](#))
      - Claim acknowledgment
      - Standardize usage of error codes

* Note: Real time submission is not Real Time Adjudication; these are two different concepts. Submission is linked to connectivity and a real time acknowledgement response whereas the RTA encompasses the ERA.
CAQH CORE Public Surveys of Potential Opportunity Areas: Claims and Encounters – EXAMPLE cont’d

• Spring 2013 Survey preliminary findings indicate:
  – Support for the adoption and uniform use of data content rules for the v5010 837:
    • Clarity on and requirements for COB
      ▪ Standardize use of claim types, especially when there are multiple payers, i.e., 837I, 837P, and 837D (e.g., Medicare receives an 837I, but the secondary payer requires an 837P)
      ▪ Ensure that all payers can accept all claims electronically in situations of COB, not just primary payers
      ▪ Promote uniformity by requiring the usage of CAS segments in secondary claims must mirror what was reported in the original 835
      ▪ Clarity on the differences between claims processing between Medicare Supplemental coverage (i.e. Medigap) and other types of medical coverage – both private and public
    • Clarity on and requirements for encounters and dental pre-determinations
    • Attachments: Identify data fields in the v5010 837 that could reduce the need for claim attachments
      ▪ Additionally identify trace number and matching criteria between the 837 claim and the claim attachment
Third Set of Mandated Operating Rules: Attachments

- The HIPAA-mandated data standard(s) for Attachments is needed since operating rules always support recognized standards; all other transactions already have underlying HIPAA data standards.
  - In late June, NCVHS issued a letter to the HHS Secretary recommending a range of Attachments standards.
    - About ten standards referenced from various authors including HL7, ASC X12, LOINC, NCPDP.
      - Addresses query, response (content) and acknowledgements (which have yet to be mandated by HHS for other transactions); pharmacy specifically called out.
      - Recommends application to a range of transactions and activities needing ‘supplemental information’.
    - Highlights the role of privacy and security, infrastructure operating rules, testing and education.
    - Recognizes a phased, incremental approach is needed.
  - Based on CAQH CORE White Paper and other industry efforts, there is strong interest to align Attachment operating rules with Meaningful Use requirements
    - Key to this alignment would be HL7 CDA standard, which is used for Electronic Medical Records (EMRs).
    - CAQH CORE White Paper to be issued at end of August, prior to CORE Subgroup work.
### Approval of CAQH CORE Operating Rules

<table>
<thead>
<tr>
<th><em>CAQH CORE Body</em></th>
<th><strong>CAQH CORE Requirements for Rules Approval</strong></th>
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<tbody>
<tr>
<td>Level 1: Subgroups and Task Groups</td>
<td>Not addressed in governing procedures, but must occur to ensure consensus building.</td>
</tr>
<tr>
<td>Level 2: Work Groups</td>
<td>Work Groups require for a quorum that 60% of all organizational participants are voting. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule.</td>
</tr>
<tr>
<td>Level 3: Full Voting Membership</td>
<td>Full CORE Voting Membership vote requires for a quorum that 60% of all Full CORE Voting Member organizations (i.e., CORE Participants that create, transmit, or use transactions) vote on the proposed rule at this stage. With a quorum, a 66.67% approval vote is needed to approve a rule.</td>
</tr>
<tr>
<td>Level 4: CAQH CORE Board</td>
<td>The CAQH CORE Board's normal voting procedures would apply. If the Board does not approve any proposed Operating Rule, the Board will issue a memorandum setting forth the reasons it did not approve the proposed Operating Rule and will ask the CORE Subgroups and Work Groups to revisit the proposed Operating Rule.</td>
</tr>
</tbody>
</table>

*NOTES: Either CAQH CORE Board CAQH does not have veto or voting power over the CAQH CORE Operating Rules. Any entity that is a CAQH CORE participant per the CAQH CORE application process has a right to vote on the rules, understanding that at Level 3 only entities that will implement the rules vote on the rules. CORE Work Groups/Subgroups do not meet on a constant basis, only during rule writing or maintenance periods.*
CAQH CORE Board of Directors

Introduction and Update
CAQH CORE Board Composition

### Permanent Members
*(all will be from CORE participating organizations)*

<table>
<thead>
<tr>
<th>Voting</th>
<th>Non-Voting</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellPoint</td>
<td>Allscripts</td>
</tr>
<tr>
<td>AultCare (AHIP)</td>
<td>JP Morgan</td>
</tr>
<tr>
<td>BCBS NC</td>
<td>Vendor (Replacement Underway) e.g., vendor, bank, clearinghouse, etc.</td>
</tr>
<tr>
<td>Aetna</td>
<td>CMS OESS*</td>
</tr>
<tr>
<td>United</td>
<td>State* (e.g., NAMDJ)</td>
</tr>
</tbody>
</table>

### Non-voting Advisors

- SDOs that author standards or codes the current and draft CORE rules support (e.g., ASC X12, HL7, IETF, NACHA, NCPDP, OASIS, WC3). Also WEDI.
- CAQH CORE Executive Staff
- As Needed
- Others as appropriate, e.g., CORE Work Group Chairs

**As Needed**

- Permanent Members (all will be from CORE participating organizations)
- Non-voting Advisors
Please submit your question:

- Enter your question into the Q&A pane in the lower right hand corner of your screen
Update on Non-Rule Development Activities
Changes to the *NACHA Operating Rules* to Align with Healthcare

- NACHA—the SDO for the EFT Standard (CCD+)—has refined the details within the *NACHA Operating Rules* to align with Healthcare Operating Rules
  - Entities currently sending payments over the ACH Network must implement these changes to the NACHA Operating Rules by **September 20, 2013**

<table>
<thead>
<tr>
<th>Overview of NACHA Rule Changes</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Identification of Health Care EFTs</strong></td>
<td>The rule requires health plans to clearly identify CCD Entries that are Health Care EFT Transactions through the use of the specific identifier “HCCLAIMPMT”</td>
</tr>
<tr>
<td><strong>Additional Formatting Requirements for Health Care EFTs</strong></td>
<td>For a CCD Entry that contains the healthcare indicator, as described above, the health plan must include an addenda record that contains the ASC X12 Version 5010 835 TRN (Reassociation Trace Number) data segment; and to identify itself in the transaction by its name as it would be known by the provider</td>
</tr>
<tr>
<td><strong>Delivery of Payment Related Information (Reassociation Number)</strong></td>
<td>The rule requires an RDFI to provide or make available, either automatically or upon request, all information contained within the Payment Related Information field of the Addenda Record, no later than the opening of business on the second Banking Day following the Settlement Date. Further, this Rule would require the RDFI to offer or make available to the healthcare provider an option to receive or access the Payment Related Information via a secure, electronic means</td>
</tr>
<tr>
<td><strong>Addition of New EDI Data Segment Terminator</strong></td>
<td>The rule provides for the use of a second data segment terminator, the tilde (“~”), to any data segments carried in the Addenda Record of the CCD Entry</td>
</tr>
<tr>
<td><strong>Health Care Terminology within the NACHA Operating Rules</strong></td>
<td>The rule includes healthcare-related definitions</td>
</tr>
</tbody>
</table>
About Voluntary CORE Certification

• Since its inception, CAQH CORE has offered a voluntary CORE Certification to health plans, vendors, clearinghouses, and providers
  – Voluntary CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules
  – CORE Certification is stakeholder-specific
    • Each entity completes testing specific to their stakeholder type in order to become CORE Certified

• CAQH CORE Certification is available for the following transactions
  – Eligibility and Claim Status (Phase I and Phase II)
  – EFT and ERA (Phase III) – Just Released!

• Key Benefits
  – Provides all organizations across the trading partner network useful, accessible and relevant guidance in meeting obligations under the CAQH CORE Operating Rules
  – Encourages trading partners to work together on data flow and content needs
  – Offers vendors practical means for informing potential and current clients on which of their products – by versions - follow operating rules, including Practice Management Systems
  – Achieves maximum ROI because all entities in data exchange follow the operating rules; once CORE-certified need to follow operating rules with all trading partners
  – Means for voluntary enforcement dialog and steps

Note: Learn more about voluntary CORE Certification HERE.
Two New CAQH Initiatives

• CAQH EFT Enrollment Solution ([http://www.caqh.org/PR201301.php](http://www.caqh.org/PR201301.php))
  – Instead of enrolling individually with each payer, CAQH offers a secure, online system that allows providers to enroll in electronic payments with multiple payers at no cost

• CAQH Coordination of Benefits Solution ([http://www.caqh.org/PR201302.php](http://www.caqh.org/PR201302.php))
  – Creates a source of timely and accurate coverage status, enabling providers to determine primary and secondary coverage for patients who are insured by more than one policy; confusion over insurance status can occur with patients who have lost or changed jobs or have multiple sources of coverage
  – Committed health plans include Aetna, AultCare, BCBS of Michigan, BCBS of North Carolina, BCBS of Tennessee, CareFirst BCBS, Cigna, Health Net, Inc., Horizon Healthcare Services, Inc., Kaiser Permanente, UnitedHealth Group, and WellPoint, Inc., on behalf of its affiliated health plans; together these organizations cover more than 165 million lives
Implementation Steps for HIPAA Covered Entities: Where Are You?

**Just Getting Started**
- Analysis and planning (budgeted, resources assigned, impact analysis)

**FAQs:**
- New EFT & ERA FAQs are being posted regularly

**Systems design** (software or hardware upgrades identified, coordinating with vendors)

**Systems implementation** (software/hardware and vendor services upgrades fully implemented)

**Integration & testing** (internal and trading partners testing)

**Deployment/maintenance** (full production use with one or more trading partners)

**CORE Partner Testing Page:**
- Communicate your readiness for conformance testing with Trading Partners

**Voluntary CORE Certification Test Site** for conformance testing of the EFT & ERA Operating Rules; jointly offered by CAQH CORE-authorized testing entity Edifecs

**Free CAQH CORE Analysis and Planning Guide**
CAQH CORE EFT & ERA Operating Rules: Additional Implementation Tools

• **Just Getting Started/Planning & Analysis**
  – CAQH CORE EFT & ERA Operating Rules: Master your understanding of the ACA mandated EFT & ERA operating rule requirements
  – The Analysis and Planning Guide provides guidance to complete systems analysis and planning for implementation of the CAQH CORE EFT & ERA Operating Rules

• **Systems Design/Implementation**
  – Education Sessions: CAQH CORE holds frequent sessions with partners such as WEDI, associations, and Medicaid workgroups that often include speakers from organizations that have implemented the CAQH CORE Operating Rules
  – FAQs: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; *new EFT & ERA FAQs are being posted regularly*
  – Request Process: Contact technical experts as needed at CORE@caqh.org

• **Integration/Testing**
  – CORE Operating Rule Readiness: 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

• **Deployment/Maintenance**
  – Voluntary CORE Certification: Test Site for conformance testing of the EFT & ERA Operating Rules are now available; jointly offered by CAQH CORE-authorized testing entity Edifecs
Upcoming CAQH CORE Education Events

• Join us for a free CAQH CORE webinar
  – Operating Rule Education Series: CARCs and RARCs Deep Dive, August 21
  – CAQH CORE and Edifecs: EFT & ERA CORE Certification, September 12
• Hear More about Operating Rules at an industry event
  – CMS 2013 eHealth Summit, August 2
• Visit the CORE Education Events page of the CAQH website
  – Access free recordings of previous education events & stay informed of upcoming joint webinars with key partners such as NACHA, ASC X12, vendors and provider associations