Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call
08/09/11

Additional information/resources available at www.caqh.org
Agenda

• Brief Overview on CAQH CORE
  – For more information or to set-up an orientation call, contact Omoniyi Adekanmbi at oadekanmbi@caqh.org

• Update on Non-Rule Writing Activities
  – New 2011 CORE Certifications, Participants and Endorsers
  – CORE Measures of Success
  – Overview of the CORE Transition Committee
  – Alignment with Federal efforts

• Update on ACA Section 1104: Mandated Operating Rules
  – Current milestones for Eligibility and Claim Status transactions and status
    • Interim Final Rule for Eligibility and Claim Status
  – Current milestones for EFT and ERA transactions and status

• Status of CORE EFT & ERA Rule Development Efforts in Response to ACA
  – Key milestones
  – Collaboration with NACHA & NCPDP
  – Overview and status of draft CORE EFT & ERA operating rules

• Appendix
Brief Overview of CAQH CORE
Committee on Operating Rules for Information Exchange

- CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  - Three pillars: Rule writing, certification and testing and outreach/education to support industry-aligned rules

- Mission: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response from any participating stakeholder
  - Enable stakeholders to implement CORE phases as their systems allow
  - Facilitate stakeholder commitment to, and compliance with, CORE’s long-term vision
  - Facilitate administrative and clinical data integration

- CORE is **not**:
  - Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7
  - Developing software or building a database

simplifying healthcare administration
CORE Scope: What are Operating Rules?

- As defined in the Patient Protection and Affordable Care Act, the term refers to “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications” (the ACA has amended HIPAA)

- Prior to CORE, national operating rules for medical transactions did not exist in healthcare outside of individual trading relationships

- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing (remaining vendor agnostic is a CORE guiding principle)
Operating Rules and Standards Work in Unison: Both are Essential

- Operating rules should always support standards – they already are being adopted together in today’s market
- Benefits of operating rules co-existing and complementing standards are evidenced in other industries
  - Various sectors of banking (e.g., credit cards & financial institutions)
  - Different modes of transportation (e.g., highway & railroad systems)
- Current healthcare operating rules build upon a range of standards
  - HIPAA standards and other healthcare standards, e.g., require non-mandated aspects of v5010 ASC X12 given data such as in/out of network patient responsibility is critical to administrative simplification, ASC X12 acknowledgements
  - Industry neutral standards, e.g., SOAP and WSDL
- Scope between rules and standards will be iterative as already demonstrated: Items required by operating rules will, in some instances, be moved into the next version of a standard and removed from rules, e.g.,
  - ASC X12 v5010 includes some CORE Phase I data content requirements and thus in Jan 2012 CORE rules will no longer require these elements, e.g., status of coverage for a specific benefit
CORE Scope: Rules Development/Implementation Approach

• CORE Phases are designed around a set of transaction-based data content rules coupled with infrastructure rules
  – Rules complement each other – real value is in the package of rules
  – Phases establish milestones that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption

• To date, the transactions to which data content and/or infrastructure rules apply include:
  – Eligibility
  – Claim Status
  – *Payment and Remittance
  – *Authorizations
  – *Health ID Cards

• Infrastructure rules applied to transactions (Real Time and Batch)
  – Connectivity (i.e., communications protocol, security)
  – Acknowledgements
  – Response Time
  – System Availability
  – Companion Guide (flow and format)
  – AAA Error Code Reporting and Last Name Normalization

*Part of draft Phase III Operating Rules; note, CORE will pursue mandated and non-mandated operating rules
CORE Operating Rules Phased Development
For an overview of Phase I and II see [http://www.caqh.org/Reform/IFR_COREPI&IIOverview.PDF](http://www.caqh.org/Reform/IFR_COREPI&IIOverview.PDF)

**CORE Phase I**
- **Approved**
- **Implemented**
- **Certification Available**
  - Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information
  - Provide timely and consistent access to this information in real-time (i.e., infrastructure rules – e.g., response time, connectivity safe harbor, companion guide)

**CORE Phase II**
- **Approved**
- **Implemented**
- **Certification Available**
  - Patient accumulators (remaining deductible)
  - Rules to help improve patient matching
  - Claim status transaction “infrastructure” requirements (e.g., claim status response time)
  - More prescriptive connectivity requirements (e.g., digital certificates)

**CORE Phase III**
- **In development**
  - Claim status data content requirements (276 / 277)
  - Prior Authorization / Referral (278)
  - EFT and Health Care Claim Payment / Advice (835)
  - 277 Claim Acknowledgement for Health Care Claims (837)
  - Standard Health Benefit / Insurance ID Card
  - More prescriptive connectivity requirements
  - Additional eligibility financials

*All CORE Operating Rules, Policies, and Test Suites are developed and approved by CORE Participants*
CORE Scope: Rules Development/Adoption Timeline

REMINDER: CORE Operating Rules are a baseline; entities are encouraged to go beyond the minimum CORE requirements.

*Oct 05 - HHS launches national IT efforts

ARRA HITECH Stimulus and ACA Health Care Reform
Update on Non-Rule Writing Activities
Examples:
New Participants, Certifications and Endorsers in 2011

- **Participants:**
  - Allina Health Systems
  - Allscripts
  - Federal Reserve Bank of Atlanta
  - HCA, Inc
  - Healthcare Billing and Collection Service (HBCS)
  - Kaiser Permanente
  - National Medicaid EDI Healthcare (NMEH) Work Group
  - NYU Langone Medical Center
  - OneHealthPort
  - The Clearing House
  - Tufts Health Plan
  - US Bank
  - US Dept of Treasury

- **Certifications:**
  - UnitedHealthcare: v5010 Phase I & II
  - Ingenix: Phase I & II
  - Montefiore Medical Center: Phase II
  - Passport Health Communications: Phase II (Q3)
  - GE Healthcare *Centricity*: Phase II (Q3)

- **Endorsers:**
  - American Academy of Family Physicians
CORE Certification Measures of Success

- CORE made an early commitment to track Measures of Success
- Health Plans, vendors and providers that are pursuing Phase II CORE Certification are invited to participate in an implementation cost and effort study; early adopter Phase II costs to health plans already available
  - Also interested in providers not certified, but trading data with certified entities
- CAQH has contracted with IBM to conduct the study and analysis
- Over two 3-month measurement periods, volunteers will be asked to record certification expenses and related effort*
  - If appropriate, IBM staff will visit your location to assist with project plan for tracking
  - Study includes a standard measurement protocol plus two data collection templates
- Cost data already available for a number of Phase II-Certified health plans
- Please contact Ezra Rosenberg at erosenberg@caqh.org if interested in participating in the study
CORE Transition Committee

- In 2010 the CAQH board made a public commitment to increase industry participation in operating rules development and adoption given CORE’s goal to support the changing environment in which operating rules are mandatory
  - Note: The CAQH Board has never voted on any CORE rule
- In early 2011, the CORE Transition Committee was launched with charge to make recommendations regarding multi-stakeholder governance of CORE and to develop a three-year governance plan that outlines structure and revenue models for CORE
  - Will preserve the CAQH CORE integrated approach to rule-writing, certification, outreach and education and reinforce CAQH CORE commitment to support ACA Section 1104 mandate
- It is anticipated that the Committee will complete its recommendations by the fourth quarter of 2011; CAQH is committed to supporting CORE during transition
  - Note: In the coming months, CORE and non-CORE participant will receive status updates from the Committee as Committee seeks feedback
# CORE Transition Committee Members

<table>
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<tr>
<th>Stakeholder Type</th>
<th>Organization</th>
<th>Individual</th>
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<tbody>
<tr>
<td>Hospital Association</td>
<td>American Hospital Association (AHA)</td>
<td>Linda Fishman, SVP Health Policy and Analysis</td>
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<tr>
<td>Hospital</td>
<td>Montefiore Medical Center</td>
<td>Joel Perlman, Executive Vice President</td>
</tr>
<tr>
<td>Provider Association</td>
<td>Medical Group Management Association (MGMA)</td>
<td>Robert Tennant, Senior Policy Adviser Health Informatics</td>
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<tr>
<td>Practicing Provider (with Association leadership)</td>
<td>New Mexico Cancer Center; AMA</td>
<td>Barbara L. McAneny, MD, AMA Board of Trustees</td>
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<tr>
<td>Health Plan (National)</td>
<td>WellPoint</td>
<td>AJ Lang, SVP/CIO</td>
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<tr>
<td>Health Plan (National)</td>
<td>UnitedHealthcare</td>
<td>Tim Kaja, SVP Physician &amp; Hospital Service Operations</td>
</tr>
<tr>
<td>Health Plan (Regional)</td>
<td>Blue Cross and Blue Shield of North Carolina</td>
<td>King Prather, Senior Vice President &amp; General Counsel</td>
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<tr>
<td>Health Plan Association(s)</td>
<td>America's Health Insurance Plans</td>
<td>Carmella Bocchino, Executive VP of Clinical Affairs &amp; Strategic Planning</td>
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<tr>
<td>Practice Management System/Vendor (large office)</td>
<td>GE Healthcare</td>
<td>George Langdon, VP eCommerce, Mailing &amp; Clinical Data Services</td>
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<tr>
<td>Practice Management System/Vendor (small office)</td>
<td>Allscripts</td>
<td>Mitchell Icenhower, VP of Solutions Management</td>
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<tr>
<td>Bank</td>
<td>JP Morgan</td>
<td>Martha Beard, Managing Director, Treasury &amp; Securities Services</td>
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<tr>
<td>State Entity</td>
<td>Minnesota Department of Health</td>
<td>David Haugen, Director of the Center for Health Care Purchasing Improvement</td>
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<tr>
<td>State Coalition/Association</td>
<td>National Governors Association (NGA)</td>
<td>Ree Sailors, Program Director, Health Division Center for Best Practices</td>
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<tr>
<td>CORE Chair</td>
<td>IBM &amp; CORE</td>
<td>Harry Reynolds, IBM Payer Transformation</td>
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**Notes:**
1. CAQH CORE staff serves as secretariat; others will serve as advisors, e.g. Committee speaking with governance experts
2. The new CORE governance may or may not include Transition Committee members or a similar mix of entities
Industry Alignment Is Critical: *Examples*

Activities within CORE are developed to support and integrate with state, regional and national efforts

| National | • Collaboration with the financial services industry due to its payment / EFT operating rules, e.g., joint research, collaborative testimonies  
• HIPAA v5010 has non-required / recommended fields that are required by CORE to add to ROI (e.g., financial data elements)  
• Standards supported by CORE are both healthcare-specific and industry-neutral  
• Close coordination with government agencies, such as CMS, ONC and Veterans Administration, e.g., VA one of the first CORE-certified providers, CORE connectivity designed to align with ONC-sponsored National Health Information Network (NHIN) |
| State / Regional | • CORE Operating Rules have been recommended to legislature by state-sponsored, multi-stakeholder committees (e.g., TX, OH, and CO)  
• State Health Information Exchanges (HIEs) are considering how to implement CORE  
• States are submitting potential operating rules to CORE, e.g. WA, MN |
Why Alignment with Other National Initiatives: Examples

• Collaborated with NHIN in an effort to align healthcare connectivity
  – Payoff of such alignment between such national initiatives is the potential for leveraging cross-over of clinical and administrative transactions, as appropriate, and to have informed expertise when determining next milestone

• Building a proactive, ongoing dialog to help inform future direction that considers ecosystem
  – Partnering with CMS in the refinement of MITA to ensure alignment with the administrative simplification needs of Medicaid;
    • Demonstration at the August 2011 Medicaid Management Information Systems (MMIS) Conference in Austin, TX
  – Participated in HIMSS11: ONC/FHA Interoperability Showcase Demonstration
    • Illustrated claim status transactions (ASC X12 276/277) from the CHIC HIE-Bridge (a Health Information Exchange that shares the location of patient records from facilities in northern Minnesota and Wisconsin) to Medicare via Noridian (a Medicare contractor) over the NHIN using the CORE Phase II Connectivity Rule
  – Continued collaboration with the CMS Electronic Submission of Medical Documentation (esMD) Project
CORE and ACA Section 1104 Mandated Operating Rules
Mandated Operating Rule 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 (plus health plan ID)
- **July 2014**: Enrollment, Referral authorization, attachments, etc.

Effective dates to implement operating rules

- **January 2013**:
- **January 2014**:
- **January 2016**:

Notes:
1. Per statute, documentation of compliance may include completion of end-to-end testing (i.e., certification and testing).
2. NCVHS is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules.
Section 1104: Current Milestones of *Eligibility & Claim Status*

**Highlights**

- Phase I and II CORE Operating Rules plus selected enhancements were recommended by NCVHS.
- **CMS Interim Final Rule with Comment** issued and comments are due within 60 days of publication in Federal Register. Key concepts include:
  - HHS determined “…CAQH CORE is qualified to be the operating rules authoring entity for non-retail pharmacy…”
  - Requires adoption of the CAQH CORE Phase I and II operating rules (updated for v5010) except for Acknowledgements
  - CAQH CORE certification is voluntary

For a PowerPoint overview of the CORE Phase I and II rules go to [http://www.caqh.org/Reform/IFR_COREPI&IIOverview.PDF](http://www.caqh.org/Reform/IFR_COREPI&IIOverview.PDF)

For entities seeking a walk through of the CORE Phase I and II rules or with questions, email **CORE@caqh.org**
Interim Final Rule: Comment Period

- The Interim Final Rule (IFR) with comment provides a 60 Day period for industry comments on operating rules for two HIPAA transactions: eligibility for a health plan and health care claim status
  - Comments due on September 6th

- CAQH CORE conducted an analysis of the CORE Operating Rules relative to the proposed regulation and identified key substantive areas for comment
  - For a copy of the CAQH CORE analysis go to http://www.caqh.org/Reform/FullIFR_E&CSInputRequest8-1-11.pdf

- CAQH CORE solicited input from CORE participants related to the key substantive areas and any additional comments to be considered for incorporation into a model letter for use by interested entities
  - The model letter will be shared on August 12th and can be used by entities as a template for submitting comments directly to CMS; non-CORE participants interested in receiving the model letter should contact CORE@caqh.org
CAQH CORE: Key Substantive IFR Comment Areas

- Thank HHS for recognizing the valuable role of operating rules in achieving administrative simplification and for adopting the CAQH CORE Phase I and II Operating Rules.
- Adopt CAQH CORE Phase I and II Operating Rules for Acknowledgements to improve workflow and fully achieve ROI.
- State the strong support of your organization for all of the included CAQH CORE Phase I and II Operating Rules (as the operating rules only achieve full ROI when used together).
- Encourage prompt issuance of a slightly modified Final Rule.
- Support the concept of national operating rules and best practice sharing.
- Formally name CAQH CORE as an operating rule authoring entity.
- Recommend that CMS consider naming CAQH CORE as the single operating rule authoring entity for medical transactions.
- Voice support for the voluntary CAQH CORE Certification process.
Section 1104: Milestones for *Electronic Funds Transfer (EFT)* & *Electronic Remittance Advice (ERA)* Rules

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>December 2010:</strong> NCVHS Subcommittee on Standards held Hearings on EFT and ERA; Authoring entity applications due Jan. 31, 2011</td>
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<td><strong>Feb. 9 &amp; 10, 2011:</strong> NCVHS Meeting to discuss applications and Issuance of NCVHS recommendations to HHS in February and March</td>
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<td><strong>2011:</strong> NCVHS to review draft rules and policy issues</td>
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<td><strong>2011:</strong> CMS may move forward with IFR informed by NCVHS</td>
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<tr>
<td><strong>July 2012:</strong> ERA and EFT Rule Adoption Deadline</td>
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### Highlights

- **In December 2010,** three organizations proposed to be authors for the ACA EFT and ERA operating rules including CAQH CORE; ten organizations provided testimony regarding next steps for EFT and ERA operating rules:
  - CAQH CORE and NACHA - The Electronic Payments Association proposed to work in collaboration to meet the needs of the ACA for EFT and ERA
    - Healthcare and financial industry operating rules would complement one another
  - February 17, 2011: NCVHS recommended NACHA as healthcare EFT SDO and its ACH CCD+ standard format
    - Data and dollars flow separately
  - March 23, 2011: NCVHS recommended CAQH CORE be the authoring entity in collaboration with NACHA
    - Fully vetted rules to be submitted to NCVHS by August 1, 2011
    - CAQH CORE to establish mechanisms for greater direct engagement of SDOs, and broader provider participation
    - Clarify the scope, focus and limitations between operating rules and standards
  - **April - August 2011:** CAQH CORE EFT & ERA Operating Rule development via the EFT & ERA Subgroup and Rule Work Group
Update on CORE EFT & ERA Rules
(Rule Development in response to ACA)
EFT and ERA: Operating Rules Build On Standards

- For this aspects of the ACA, NCVHS has recommended that HHS adopt the *NACHA ACH CCD+* format, in conformance with the NACHA Operating Rules, as the standard format for the healthcare EFT standard when EFT and ERA are sent separately*
  - *NACHA ACH CCD+ Standard* is an ACH standard for EFT. CCD is a Corporate Credit or Debit entry which is used to make/collect payments to/from corporate organizations
- ERA operating rules build upon the existing HIPAA-adopted ASC X12 005010X221 Health Care Claim Payment/Advice (835) Technical Report Type 3
- Operating Rules can address gaps in standards, such as additional content available by using standard but not required, or identify infrastructure needed to ensure electronic transaction flow among standards

* NCVHS recommended standard, see [February 17, 2011 NCVHS Recommendation to HHS Secretary](#):
Mandated Operating Rules:
CORE EFT and ERA Rules Development

- CAQH CORE, in collaboration with NACHA, convened a Subgroup pursuant to NCVHS’ letter of direction to produce a fully vetted set of EFT and ERA operating rules for consideration
  - Meet weekly and is comprised of CORE participating organizations; EFT and ERA Subgroup reports to the CORE Rules Work Group
    - EFT rule development focus
      - Create a thin layer of healthcare specific EFT operating rules that complements the existing NACHA Operating Rules, and address reassociation of ERA and EFT
      - Builds upon the NACHA ACH CCD+ Standard*
    - ERA rule development focus
      - Identify priority rule areas, rule options, and detailed rule requirement via research review, surveys, feedback on findings, etc., including reassociation of ERA and EFT
      - Builds upon the v5010 ASC X12 835 Payment/Remittance Advice standard
  - CORE Operating Rules for EFT and ERA
    - Build upon existing CORE operating rules, including draft ERA infrastructure rules
    - Support existing standards and consider business rules that are unique or intrinsic to healthcare claim payment transactions

* NACHA ACH CCD+ Standard is an ACH standard for EFT. CCD is a Corporate Credit or Debit entry which is used to make/collect payments between two organizations.
# Key Milestones for EFT/ERA Operating Rule Development

<table>
<thead>
<tr>
<th>Milestone Number</th>
<th>Milestone Description</th>
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<tbody>
<tr>
<td>1 (Completed)</td>
<td>Subgroup agreement on High Priority <em>Rule Opportunity Areas</em> with industry input</td>
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<td>2 (Completed)</td>
<td>Subgroup agreement on a CORE <em>Rule Option/Approach</em> to address each High Priority Rule Opportunity Area</td>
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<tr>
<td>3 (Completed)</td>
<td>Subgroup agreement on <em>detailed Rule Requirements</em> for each CORE Rule Option/Approach</td>
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<tr>
<td>4 (Completed)</td>
<td>Subgroup development and straw polls of <em>draft EFT &amp; ERA Operating Rules</em></td>
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<tr>
<td>5 (In Progress)</td>
<td>Rules Work Group review and straw polls of <em>draft EFT &amp; ERA Operating Rules</em></td>
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<tr>
<td>6 (September 2011)</td>
<td>Rules Work Group ballot on all <em>draft EFT &amp; ERA Operating Rules</em></td>
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Cross Industry Collaboration and Needs

• **CAQH CORE and NACHA: Healthcare and Financial Services alignment**
  – Due to the mandated healthcare operating rules on EFT & ERA, there is a convergence of financial services and healthcare so the partnership has pursued additional activities, e.g., extensive research on EFT & ERA opportunity areas.
  – During the development of the EFT & ERA operating rules, the CORE participants identified key areas where either new or modified *NACHA Operating Rules* could address current issues in using the NACHA CCD+ when doing EFT healthcare payments over the ACH Network and will convey these opportunities to NACHA.
    • NACHA maintains operating rules for financial services (11,000+ institutions)

• **CAQH CORE and NCPDP: Medical and Pharmacy alignment**
  – For each rule requirement, discussing applicability to Retail Pharmacy and, for each rule, determine applicability of one of the following statements/approaches:
    • Reference to a specific NCPDP pharmacy effort is included; include high-level on how CAQH CORE and NCPDP are coordinated to focus industry improvement in the shared area of interest addressed in the specific rule.
    • Pharmacy is addressed in the operating rule directly (or via reference to NCPDP effort/document as noted above).
    • Pharmacy is excluded from the operating rule as it is not applicable and/or further research needs to be conducted.
Status: Draft CORE EFT & ERA Operating Rules

• Update letter to sent NCVHS on August 1\textsuperscript{st}
  – \url{http://www.cagh.org/Reform/NCVHS_EFTERA_Letter8-1-11.pdf}
  – Each draft rule has been well vetted through the multiple stages of development and its focus was deemed a priority among the many suggestions initially considered
  – Development of draft rules based upon significant detailed research (e.g., crosswalk of 835-to-CCD+, review of state-based efforts, analysis of \textasciitilde100 EFT & ERA enrollment forms, etc.), Subgroup surveys and straw polls, Town Hall feedback, and Subgroup discussion

• Draft CORE EFT & ERA Operating Rules being reviewed by the CORE Rules Work Group:
  – Rules Work Group conducted straw polls of operating rules developed by the EFT & ERA Subgroup
  – Work Group has approved four draft rules, with adjustments, for Work Group ballot; Work Group still reviewing results of its straw poll on \textit{draft Uniform Use of CARCs and RARCs Rule} and \textit{draft ERA Infrastructure (835) Rule} was previously straw polled by Work Group during earlier Phase III rule development and approved for Work Group ballot

• September 2011: Rules Work Group ballot on draft EFT & ERA Operating Rules
  – \textbf{NOTE:} All draft rules are subject to change based on the Rules Work Group final ballot
# Overview: Draft EFT & ERA Operating Rules

<table>
<thead>
<tr>
<th>Draft Rule</th>
<th>High-Level Requirements</th>
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<tbody>
<tr>
<td><strong>EFT Enrollment Data Rule</strong></td>
<td>- Identifies a maximum set of standard data elements for EFT enrollment</td>
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<td>- Outlines a straw man template for paper and electronic collection of the data elements</td>
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<td></td>
<td>- Requires health plan to offer electronic EFT enrollment</td>
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<tr>
<td><strong>ERA Enrollment Data Rule</strong></td>
<td>- Similar to EFT Rule</td>
</tr>
<tr>
<td><strong>EFT &amp; ERA Reassociation (CCD+/835) Rule</strong></td>
<td>- Addresses provider receipt of the CORE-required Minimum ACH CCD+ Data Elements required for reassociation</td>
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<td>- Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions</td>
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<td>- Requirements for resolving late/missing EFT and ERA transactions</td>
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<td>- Recognition of the role of <em>NACHA Operating Rules</em> for financial institutions</td>
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<tr>
<td><strong>Uniform Use of CARCs and RARCs (835) Rule</strong></td>
<td>- Identifies a <em>minimum</em> set of four CORE-defined Business Scenarios with a <em>maximum</em> set of CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</td>
</tr>
<tr>
<td><strong>ERA Infrastructure (835) Rule</strong></td>
<td>- Specifies use of the CORE Master Companion Guide Template for the flow and format of such guides</td>
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<td>- Requires entities to support the Phase II CORE Connectivity Rule</td>
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<td>- Includes Batch Acknowledgement Requirements</td>
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<td>- Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits</td>
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See Appendix for overview of each rule and link to current draft. If a non-CORE participant, please contact CAQH staff with comments.
Getting Involved with CORE
Thank You For Joining Us: Stay Involved

• Participate in CORE Operating Rules Development
  – Join your industry colleagues as a contributor to CORE rule development by becoming a CORE Participating Organization, if not already involved

• Attend a Future Town Hall Call (open to public)
  – Tuesday, September 20th, 3:00-4:00 pm ET

• Implement the CORE Operating Rules: Become CORE-Certified
  – Pledge your commitment to conduct business in accordance with Phase I and/or Phase II CORE Operating Rules
  – Quickly realize operational efficiencies resulting from secure, timely and consistent delivery of eligibility, benefit and claim status information

• Participate in our industry outreach activities and education programs
  – Join our Speakers Bureau

• Join us at another CORE Education Event
Appendix:
Overview of draft CORE ERA and EFT Operating Rules
Draft ERA Enrollment Data Rule

Scope & High-Level Rule Requirements

• Scope of the draft rule:
  – Applies to entities that enroll providers in ERA
  – Outlines what is out of scope for the rule, e.g., the collection of data for other business purposes and how health plans may use or populate the enrollment data

• High-level rule requirements:
  – Identifies a maximum set of standard data elements for enrollment
    • Example: Draft ERA enrollment rule contains approximately 25 required and 15 optional data elements (with additional sub-elements)
  – Outlines a strawman template for paper and electronic collection of the data elements
  – Should a health plan decide to have a combined EFT/ERA form or other combined enrollment form, the CORE required data elements for ERA enrollment, including terminology, must be included in the combined form
  – Requires health plan to offer electronic ERA enrollment
    • A specific methodology is not required

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g., crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Problem Addressed & Key Impact

• Problem addressed by the draft rule:
  – Separate, non-standard provider ERA enrollment required by health plans; key elements excluded from many enrollment forms includes those:
    • With a strong business need to streamline the collection of data elements (e.g., preference for aggregation of remittance data – TIN vs. NPI)
    • Essential for populating the ACH CCD+ Standard and the ASC X12 v5010 835

• Key impact:
  – Simplifies provider ERA enrollment by having health plans collect the same consistent data from all providers – mitigates hassle factor for providers when enrolling in ERA with multiple health plans and addressed existing issue that many elements needed for EDI aren’t collected, e.g., requires health plans to support electronic collection of data (paper can continue)
  – Addresses situations where providers outsource financial functions
  – Enables health plans to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Draft EFT & ERA Reassociation (CCD+/835) Rule

Scope & High-Level Rule Requirements

- **Scope of the draft rule:**
  - Applies to entities that use, conduct or process the v5010 835 and the CCD+ transactions

- **High-level rule requirements:**
  - Addresses provider receipt of the CORE-required Minimum ACH CCD+ Data Elements required by providers for successful re-association (Effective Entry Date, Amount, Payment Related Information)
  - Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions
    - For medical, the health plan must release for transmission to the health care provider the v5010 835 corresponding to the ACH CCD+ no sooner than three business days prior to the ACH CCD+ Effective Entry Date and no later than three business days after ACH CCD+ Effective Entry Date
    - For retail pharmacy, the health plan may release for transmission the v5010 835 any time prior to the ACH CCD+ Effective Entry Date of the corresponding EFT; and no later than three days after the ACH CCD+ Effective Entry Date
  - Outlines requirements for resolving late/missing EFT and ERA transactions
  - Recognizes the role of NACHA Operating Rules for financial institutions and potential changes

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Draft EFT & ERA Reassociation (CCD+/835) Rule

Problem Addressed & Key Impact

• Problem addressed by the draft rule:
  – Challenges with provider re-association of remittance data to payment data because the necessary data required by the provider are either incorrect, missing, or not available, or have not been requested in the same way on the two transactions that is meaningful to the provider or its financial institution

• Key impact of draft rule:
  – Coordinates the healthcare and financial services industry. When receipt of payment occurs with minimal elapsed time between receipt of remittance advice, providers can more quickly match payments with the data in order to post to patient accounts on a more timely basis
  – Provides assurance that trace numbers between payments and remittance can be used by providers
  – Reduces level of open accounts receivable by enabling provider to generate cross-over claims to other payers and to collect payment from patient
  – Enables provider to more quickly address denials or appeal adjustments to claim amount

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Draft Uniform Use of CARCs and RARCs (835) Rule

Scope & High-level Rule Requirements

• Scope of the draft rule:
  – Applies to entities that use, conduct or process the v5010 835 transaction

• High-level rule requirements:
  – Identifies four Business Scenarios with a maximum set of CARCs/RARCs/CAGCs combinations that can be applied to convey details of the claim denial or payment adjustment to the provider
    • CORE Participants submitted and reviewed several hundred code combinations for inclusion in the maximum set of CORE-required Code Combinations for each CORE-defined Business Scenario
  – Draft Business Scenarios include:
    1. Additional Information Required – Missing/Invalid/Incomplete Documentation
    2. Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim
    3. Billed Service Not Covered by Health Plan
    4. Benefit for Billed Service Not Separately Payable
  – Note: The CORE-required Code Combinations are included in a separate document referenced in the draft rule - Draft CORE-required Code Combinations for CORE-defined Business Scenarios.doc

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Draft Uniform Use of CARCs and RARCs (835) Rule

Problem Addressed & Key Impact

- Problem addressed by the draft rule:
  - Providers do not receive the uniform and consistent CARC/RARC/CAGC code combinations for the same or similar business scenarios from all health plans and, as a result, are unable to automatically post claim payment adjustments and claim denials accurately and consistently
  - Focus on business scenarios with a maximum set of code combinations that target 80% of the major provider usage problems/high volume code combinations, e.g.,
    - Without business scenarios and a maximum set of associated code combinations, there are over 800 RARCs, approximately 200 CARCs and 4 CAGCs resulting in thousands of possible code combinations for review by providers

- Key impact:
  - Begins to address a significant industry challenge by addressing the high-volume issues
  - Enables providers to more effectively use remittance advice data when definitions for claim payment adjustments or denials are consistent across all health plans, resulting in better revenue cycle and cash flow management. Providers can more effectively obtain payment from patients, more quickly generate cross-over claims to other payers, and reduce open accounts receivable
  - Requires more focus on the use of standard codes (not proprietary codes)

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Draft ERA Infrastructure (835) Rule
Scope & High-Level Rule Requirements

• Scope of the draft rule:
  – Applies to entities that use, conduct or process the v5010 835 transaction

• High-level rule requirements:
  – Specifies use of the CORE Master Companion Guide Template for the flow and format of such guides
  – Requires entities to support the Phase II CORE Connectivity Rule
  – Includes Batch Acknowledgement Requirements
    • These requirements for use of Acknowledgements for batch mode places parallel responsibilities on both receivers of the v5010 835 and senders of the v5010 835 for sending and accepting v5010 999 Acknowledgements; the goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound transactions
  – Addresses the need for providers to be able to conduct a parallel 835 implementation process whereby the health plan will continue to deliver its proprietary claim remittance advice while the provider assures itself that the 835 can successfully replace the proprietary remittance advice

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Draft ERA Infrastructure (835) Rule

Problem Addressed & Key Impact

- Problem addressed by the draft rules:
  - HIPAA provides a foundation for the electronic exchange of claim payment information, but does not provide infrastructure to promote the move from today’s paper-based system to an electronic, interoperable system

- Key impact:
  - Enables providers, health plans and intermediaries to extend and leverage investment in connectivity infrastructure by requiring support of CORE Connectivity Rule
  - Continues to build on Phase I/II use of CORE Master Companion Guide Template so that providers can quickly find details necessary for the exchange of the v5010 835
  - Reduces probability that providers will discontinue receipt of v5010 835 due to system issues for effective use remittance advice data to post to patient account

Notes: (1) All draft rules are subject to change based on Rules Work Group final ballot; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented.
Links to Draft CORE EFT & ERA Operating Rules

1. Draft EFT Enrollment Data Rule

2. Draft ERA Enrollment Data Rule

3. Draft Uniform Use of CARCs and RARCs (835) Rule
   – Draft CORE-required Code Combinations for CORE-defined Business Scenarios

4. Draft EFT & ERA Reassociation (CCD+/835) Rule

5. Draft ERA Infrastructure (835) Rule

Notes: (1) All draft rules are subject to change based on Rules Work Group review; (2) Detailed research (e.g. crosswalk of 835-to-CCD+, review of state-based efforts, analysis of ~100 EFT & ERA enrollment forms), Subgroup surveys and discussion informed development of draft rules and is documented and available to CORE participants