Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call
09/20/11

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
  – Collaboration with NACHA & NCPDP
  – Key milestones
  – 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
  – Integrated model: Rule writing, certification and testing and outreach/education

• Mission: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between 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 in phases that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption
  – 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, OASIS, W3C
  – Developing software or building a database
What are Operating Rules?

- The Patient Protection and Affordable Care Act (ACA) defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
  - Operating rules address gaps in the standards, help refine the infrastructure that supports data exchange and recognize interdependencies among transactions and the range of standards
- Prior to CORE, national operating rules for medical transactions did not exist in healthcare outside of individual trading relationships
  - Current healthcare operating rules build upon a range of standards – healthcare specific and industry neutral – and support national HIT agenda
- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing – they are used by many other industries
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
  – Healthcare-specific 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:
  – New phases of rules may be issued using the same version of the standard
  – Items required by the 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 January 2012 CORE rules will no longer require these elements
CORE Operating Rules: Iterative Milestones

CORE rules are designed around a set of transaction-based data content rules coupled with infrastructure rules; the rules complement each other and the standards.

**Phase I CORE**
*(Eligibility)*
- Approved
- Implemented
- *Certification Available*

- *Confirm patient benefit coverage and co-pay, in/out of network variances, coinsurance and base deductible information*
- *Provide timely and consistent access to this information in real-time (e.g., response times, connectivity, companion guide, *acknowledgements)*

**Phase II CORE**
*(Expanded Eligibility and Claim Status)*
- Approved
- Implemented
- *Certification Available*

- *More patient financials, e.g., YTD patient accumulators, for more services*
- *Rules to help improve patient matching*
- *Claim status "infrastructure" requirements (e.g., response time, *acknowledgements)*
- *More prescriptive connectivity requirements aligned with ONC efforts, e.g., SOAP/WSDL, digital certificates*

**Phase III CORE**
*(EFT/ERA)*
- Drafted and in voting process

*(Expanded Eligibility and Claim Status, plus Prior Auth, ID cards)*
- Drafted; initial voting

- *EFT enrollment elements, ERA enrollment elements, *CARC/RARC business scenarios with code combinations, re-association timing, and infrastructure such as *acknowledgements and connectivity*

- *Additional eligibility and claim status data content requirements*
- *Prior Authorization/Referral infrastructure*
- *277 Claim Acknowledgement for Health Care Claims (837)*
- *Standard Health Benefit/Insurance ID Card*
- *More prescriptive connectivity requirements*

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*Data not required by HIPAA v5010; operating rules support further use of v5010.*

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

- CAQH CORE Phases are designed around a set of transaction-based data content rules coupled with infrastructure rules; the rules complement each other.
- Phases establish milestones that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption.

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

*Oct 05 - HHS launches national IT efforts*
Update on Non-Rule Writing Activities
Examples:
New Participants, Certifications and Endorsers in 2011

• **Participants:**
  – Allscripts
  – BCBS of Florida
  – 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 Department of Treasury
  – Visa, Inc

• **Certifications:**
  – UnitedHealthcare: v5010 Phase I & II
  – Ingenix: Phase I & II
  – Montefiore Medical Center: Phase II
  – Passport Health Communications: Phase II
  – GE Healthcare *Centricity Business*: Phase II

• **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

* Organizations pursuing Phase I and Phase II Certification concurrently are also invited to participate
** Includes IT expenses (hardware/software), staff expense, certificate expense (seal and test fees) and time required to complete certification
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>
<thead>
<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>
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<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>
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<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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<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>
</tr>
<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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<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

<table>
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<tr>
<th>National</th>
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<td>• Collaboration with the financial services industry due to its payment / EFT operating rules, e.g., joint research, collaborative testimonies</td>
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<td>• HIPAA v5010 has non-required / recommended fields that are required by CORE to add to ROI (e.g., financial data elements)</td>
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<td>• Standards supported by CORE are both healthcare-specific and industry-neutral</td>
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<td>• 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 Nationwide Health Information Network (NHIN)</td>
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<tr>
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<td>• CORE Operating Rules have been recommended to legislature by state-sponsored, multi-stakeholder committees (e.g., TX, OH, and CO)</td>
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<td>• State Health Information Exchanges (HIEs) are considering how to implement CORE</td>
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<td>• States are submitting potential operating rules to CORE, e.g. WA, MN</td>
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Why Alignment with Other 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: Eligibility & Claim Status Milestones

**Highlights**

- Phase I and II CORE Operating Rules plus selected enhancements were recommended by NCVHS
- [CMS Interim Final Rule with Comment](#) published in Federal Register on July 8th; industry comments received through September 6th
  - Key IFC 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 Phase I and II CORE rules go [HERE](#)

For more information or to register for a Phase I and II CORE Operating Rules education session, email [CORE@caqh.org](mailto:CORE@caqh.org)
Eligibility & Claim Status IFC: Public Comment Period

• The Interim Final Rule with comment (IFC) provided the industry a 60 day period to offer comments on operating rules for the two HIPAA transactions: eligibility for a health plan and health care claim status

• During this timeframe, CAQH CORE:
  – Conducted an analysis of the CORE Operating Rules relative to the proposed regulation and identified key substantive areas for comment
  – 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
  – Prepared and shared this model comment letter with CORE participants for use in developing comments for direct submission to CMS; model letter was also available to non-CORE participants
  – Submitted CAQH CORE comment letter to CMS on September 6, 2011
CAQH CORE IFC Comment Letter: Key Substantive Areas

- Commends CMS for recognizing and defining the valuable role of operating rules in achieving administrative simplification
- Outlines why acknowledgements be included within the ACA-adopted operating rules
- Formally name CAQH CORE as the operating rules authoring entity
- Clarify the relationship of the adopted operating rules to retail pharmacy and business associates
- Urges CMS to continue to recognize voluntary certification for health plans, vendors/clearinghouses, and large providers, as exemplified by the CAQH CORE program
- CMS should uphold the CAQH CORE Companion Guide Template as the single template
- Clarification on voluntary operating rule development efforts is warranted
- Issue any modifications to or clarifications of IFC promptly and no later than January 1, 2012
Section 1104: Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Milestones

December 2010: NCVHS Subcommittee on Standards held Hearings on EFT and ERA; Authoring entity applications due Jan. 31, 2011

February 9 & 10, 2011: NCVHS Meeting to discuss applications and Issuance of NCVHS recommendations to HHS in February and March

2011: NCVHS hearings to review draft rules and policy issues

2011: CMS may move forward with IFR informed by NCVHS

July 2012: ERA and EFT Rule Adoption Deadline

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 – Fall 2011: CAQH CORE EFT & ERA Operating Rule development via the EFT & ERA Subgroup and Rule Work Group

2011: CMS may move forward with IFR informed by NCVHS
Update on CORE EFT & ERA Rules
(Rule Development in response to ACA)
In Response to ACA: CORE EFT and ERA Operating Rules Development

- CAQH CORE, in collaboration with NACHA, launched a comprehensive rule writing effort pursuant to NCVHS’ letter of direction to produce a fully vetted set of EFT and ERA operating rules for consideration including convening of a Subgroup to research, debate, and draft the rules and reported up to the CORE Rules Work Group which vetted the draft rules
  - 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*, in conformance with the NACHA Operating Rules, as the standard format for the healthcare EFT standard when EFT and ERA are sent separately**
  - 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
    - 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:
** 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
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 Draft Phase III CORE 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

• 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
CORE EFT and ERA Roadmap and Timeline

**April 2011**
- Subgroup reviewed research, discussed rule opportunity areas and agreed on criteria to create scope of rule(s)

**May/June 2011**
- Subgroup applied evaluation criteria to rule opportunity areas to agree to scope of rules and rule options within the scope

**June/July 2011**
- Subgroup agreed to rule requirements, i.e., the level of detail within identified rule options and begin “drafting” rule(s);
- Gained Rules Work Group feedback

**July/August 2011**
- Subgroup drafted rule language addressing agreed-upon rule requirements and conducted straw polls;
- Reviewed with Work Group and conducted Rule Work Group straw polls

**Sept 2011**
- Rules Work Group completes ballot on complete Draft Phase III CORE EFT & ERA Operating Rule Set;
- NCVHS is updated and CORE voting process continues

*Feedback loops to Subgroups/Work Groups from public CORE Town Hall calls and crystallization of criteria against rules and ACA developments*
Status: Draft CORE EFT & ERA Operating Rules

- Update letter to sent NCVHS on August 1st
  - 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 ~100 EFT & ERA enrollment forms, etc.), Subgroup surveys and straw polls, Town Hall feedback, and Subgroup discussion
  - Rules Work Group conducted straw polls of all operating rules developed by the EFT & ERA Subgroup

- Official Rules Work Group ballot on the Draft CORE EFT & ERA Operating Rule Set currently in progress
  - Ballot includes five draft rules which the Work Group reviewed and adjusted
  - Results will be shared with the Work Group on its September 22 call and with NCVHS by the end of the month
## Overview: Draft EFT & ERA Operating Rules

<table>
<thead>
<tr>
<th>Draft Rule</th>
<th>High-Level Requirements</th>
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| **EFT Enrollment Data Rule**                   | ▪ Identifies a maximum set of standard data elements for EFT enrollment  
▪ Outlines a straw man template for paper and electronic collection of the data elements  
▪ Requires health plan to offer electronic EFT enrollment                                                                                                                                                      |
| **ERA Enrollment Data Rule**                   | ▪ Similar to EFT Rule                                                                                                                                                                                                 |
| **EFT & ERA Reassociation (CCD+/835) Rule**    | ▪ Addresses provider receipt of the CORE-required Minimum ACH CCD+ Data Elements required for reassociation  
▪ 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                                                                                                                                |
| **Uniform Use of CARCs and RARCs (835) Rule**  | ▪ Identifies a *minimum* set of four CORE-defined Business Scenarios with a *maximum* set of CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider |
| **ERA Infrastructure (835) Rule**              | ▪ 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  
▪ Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits                                                                                                                                 |

The draft CORE EFT & ERA Operating Rule Set is available [HERE](#).  
See Appendix for overview of each rule.
Getting Involved with CORE
Thank You For Joining Us: Stay Involved

• Participate in CORE Operating Rules Development
  – Join your industry colleagues as a CORE Participant and then also join Subgroups or Work Groups, if not already involved
• Implement the CORE Operating Rules: Become CORE-certified
  – Pledge your organization’s commitment to conduct business in accordance with Phase I and/or Phase II CORE Operating Rules
• Participate in our industry outreach activities and education programs
  – Join our Speakers Bureau
• Join us at another CORE Education Event
  – Tuesday, September 27th, 1:00-2:00 pm ET: CAQH CORE and Edifecs Webinar
    • Voluntary CORE Certification and Testing: Achieving Healthcare Interoperability
      - The Role of Providers and their Practice Management System Vendors
    – Thursday, September 29th, 2:00-3:30 pm ET: Next WEDI Audiocast
• Attend an upcoming CORE Town Hall Call (open to public)
  – November 1st, 3:00-4:00 pm ET
  – December 13th, 3:00-4:00 pm ET
Appendix:
Overview of draft CORE ERA and EFT Operating Rules
# Update on Draft Phase III CORE EFT & ERA Operating Rule Set: Table of Contents

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<th>Draft Phase III CORE EFT &amp; ERA Operating Rule Set</th>
<th>Slides</th>
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<tr>
<td><strong>Draft EFT Enrollment Data Rule</strong>&lt;br&gt;• Reminder: Problem Space Addressed and Key Impact&lt;br&gt;• Reminder: Scope and High-Level Requirements&lt;br&gt;• Draft Rule Adjustments Per Work Group Discussions</td>
<td>32-34</td>
</tr>
<tr>
<td><strong>Draft ERA Enrollment Data Rule</strong>&lt;br&gt;• Reminder: Problem Space Addressed and Key Impact&lt;br&gt;• Reminder: Scope and High-Level Requirements&lt;br&gt;• Draft Rule Adjustments Per Work Group Discussions</td>
<td>35-37</td>
</tr>
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<td><strong>Draft Uniform Use of CARCs and RARCs (835) Rule &amp; CORE-Required Code Combinations for CORE-defined Business Scenarios</strong>&lt;br&gt;• Reminder: Problem Space Addressed and Key Impact&lt;br&gt;• Reminder: Scope and High-Level Requirements&lt;br&gt;• Draft Rule Adjustments Per Work Group Discussions</td>
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<td>41-43</td>
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<tr>
<td><strong>Draft Claim Payment/Advice (835) Infrastructure (835) Rule</strong>&lt;br&gt;• Reminder: Problem Space Addressed and Key Impact&lt;br&gt;• Reminder: Scope and High-Level Requirements&lt;br&gt;• Draft Rule Adjustments Per Work Group Discussions</td>
<td>44-45</td>
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Draft EFT Enrollment Data Rule

Reminder: Problem Addressed & Key Impact

• Problem addressed by the draft rule:
  – Separate, non-standard provider EFT enrollment required by health plans; key elements excluded from many enrollment forms include those:
    • With a strong business need to streamline the collection of data elements (e.g., TIN vs. NPI provider preference for payment)
    • Essential for populating the ACH CCD+ Standard and the ASC X12 v5010 835
  – Key impact:
    – Simplifies provider EFT enrollment by having health plans collect the same consistent data from all providers – mitigates hassle factor for providers when enrolling in EFT 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

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Draft EFT Enrollment Data Rule

Reminder: Scope & High-Level Rule Requirements

• Scope of the draft rule:
  – Applies to entities that enroll providers in EFT
  – 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 approximately 70 standard data elements for enrollment; with related data elements grouped into 8 DEGs (Data Element Groups)
  – 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 EFT enrollment, including terminology, must be included in the combined form
  – Requires health plan to offer electronic EFT enrollment
    • A specific electronic method is not required
  – Identifies that a process will be used to review the maximum data element set on an annual or semi-annual basis to meet emerging or new industry needs

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Draft EFT Enrollment Data Rule

Draft Rule Adjustments Per Work Group Discussions

• Examples of high-level substantive adjustments:
  – Clarification of out of scope items (e.g., collection of data for other business purposes, how data are collected, organizations internal exchange of information)
  – Added clarifying language regarding Data Element Groups (DEGs)
  – Adjustments to approximately 20 data elements including:
    • Additions to retail pharmacy specific data elements
    • Changes to address data elements to accommodate international addresses (e.g., “State” to “State/Province”; “Zip Code” to “Zip Code/Postal Code”)
    • Making some required data elements optional

• Non-substantive adjustments:
  – Have been made to draft rule (e.g., typographical/grammatical errors, word-smithing, clarifying language)

NOTE: For specific adjustments see detailed tracking documents posted to the 08/24/11 Rules Work Group notice on the CAQH Calendar.
Draft ERA Enrollment Data Rule

Reminder: 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 include 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 and their agents to 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 and their agents to collect standardized data for complex organizational structures and relationships, e.g., retail pharmacy chains

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Draft ERA Enrollment Data Rule

Reminder: 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 approximately 65 standard data elements for enrollment; with related data elements grouped into 10 DEGs (Data Element Groups)
  – 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 electronic method is not required
  – Identifies that a process will be used to review the maximum data element set on an annual or semi-annual basis to meet emerging or new industry needs

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Draft ERA Enrollment Data Rule

Draft Rule Adjustments Per Work Group Discussions

• Examples of high-level substantive adjustments:
  – Applicable edits to Draft EFT Enrollment Rule made to Draft ERA Enrollment Data Rule, e.g.,:
    • Clarification of out of scope items
    • Clarifying language about Data Element Groups (DEGs)
    • Adjustments to data elements/sub-elements
  – Additional edits include:
    • Adjustment to description of data element Method of Retrieval to include clearinghouses and other intermediaries

• Non-substantive adjustments:
  – Have been made to draft rule (e.g., typographical/grammatical errors, word-smithing, clarifying language)

NOTE: For specific adjustments see detailed tracking documents posted to the 08/24/11 Rules Work Group notice on the CAQH Calendar.
Draft Uniform Use of CARCs and RARCs (835) Rule

Reminder: Problem Addressed & Key Impact

• Problem addressed by the draft rule:
  – Providers do not receive uniform code combinations for same or similar business scenarios from all health plans; as a result, are unable to automatically post claim payment adjustments and denials accurately and consistently
  – Focus on minimum business scenarios with maximum set of code combinations targeting 80% of major provider usage problems/high volume code combinations
    • Without business scenarios and maximum set of 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 high-volume issues
  – Providers can more effectively use ERA 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)

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Reminder: 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 minimum set of four CORE-defined Business Scenarios with maximum set of code combinations to convey claim denial/adjustment details (codes in separate document)
  – Establishes QI maintenance process to review and update CORE-required Code Combinations
  – Enables health plans and PBM agents to:
    • Use new/adjusted codes with CORE-defined Business Scenarios prior to QI review
    • Develop additional, non-conflicting business scenarios when CORE-defined Business Scenario do not meet business needs
  – Identifies applicable CORE-defined Business Scenarios for retail pharmacy

<table>
<thead>
<tr>
<th>CORE-defined Business Scenario</th>
<th>Total CORE-required Code Combinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation</td>
<td>Includes approximately 160 code combinations</td>
</tr>
<tr>
<td>Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim</td>
<td>Includes approximately 300 code combinations</td>
</tr>
<tr>
<td>Scenario #3: Billed Service Not Covered by Health Plan</td>
<td>Includes approximately 375 code combinations</td>
</tr>
<tr>
<td>Scenario #4: Benefit for Billed Service Not Separately Payable</td>
<td>Includes approximately 35 code combinations</td>
</tr>
</tbody>
</table>

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented.
Draft Uniform Use of CARCs and RARCs (835) Rule

Draft Rule Adjustments Per Work Group Discussions

- **Examples of high-level substantive adjustments:**
  - Added clarifying language to *Basic Requirements for Receivers of the v5010 835* for entities that extract data for manual processing or act as a switch
  - Adjustments to address applicability to retail pharmacy:
    - Added level-setting section on retail pharmacy industry, real time claim adjudication and use of v5010 835
    - Clarification of rule requirements for retail pharmacy including note explaining why Business Scenario #4 does not apply to retail pharmacy
  - Substantive adjustments to maximum set of Core-required Code Combinations
    - Scenario #1: 7 new CARCs, 26 new code combos from new RARCs, 8 RARCs removed
    - Scenario #2: 21 new CARCs, 32 new code combos from new RARCs, 1 RARC removed
    - Scenario #3: 46 new CARCs, approximately 150 new code combos from new RARCs
    - Scenario #4: 3 new CARCs, 15 new code combos from new RARCs, 1 RARC removed
- **Non-substantive adjustments:**
  - Have been made to draft rule (e.g., typographical/grammatical errors, word-smithing, clarifying language, edits to references)

**NOTE:** For specific adjustments see detailed tracking documents posted to the 08/24/11 Rules Work Group notice on the [CAQH Calendar](#).
Draft EFT & ERA Reassociation (CCD+/835) Rule
Reminder: Problem Addressed & Key Impact

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

• Key impact of draft rule:
  – Coordinates health care 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 data and 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

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Draft EFT & ERA Reassociation (CCD+/835) Rule

Reminder: Scope & High-Level Rule Requirements

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

• High-level rule requirements:
  – Addresses provider receipt of *CORE-required Minimum ACH CCD+ Data Elements* (e.g., Effective Entry Date, Amount, Payment Related Information) required by providers for successful reassociation
  – Addresses elapsed time between sending of v5010 835 and CCD+ transactions
    • Medical: Health plan must release for transmission to provider the v5010 835 corresponding to the CCD+ no sooner than *three* business days prior to CCD+ Effective Entry Date and no later than *three* business days after CCD+ Effective Entry Date
    • Retail pharmacy: Health plan may release for transmission v5010 835 any time prior to the CCD+ Effective Entry Date of corresponding EFT and no later than *three* days after 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 to the *NACHA Operating Rules*
Draft EFT & ERA Reassociation (CCD+/835) Rule

Draft Rule Adjustments Per Work Group Discussions

• Examples of high-level substantive adjustments:
  – Included footnote in the draft rule to add clarity for the appropriate use of “Company Name” field in the CCD+
  – **NOTE:** Significant work was done at the Subgroup level, including development of a 835-to-CCD+ crosswalk, to develop and adjust the rule prior to Work Group review and straw poll; Subgroup discussion documents available on the CAQH calendar

• Non-substantive adjustments:
  – Have been made to draft rule (e.g., typographical/grammatical errors, word-smithing, clarifying language, edits to references)

**NOTE:** For specific adjustments see detailed tracking documents posted to the 08/24/11 Rules Work Group notice on the CAQH Calendar.
Draft Claim Payment/Advice (835) Infrastructure Rule

Reminder: Problem Addressed & Key Impact

- Problem addressed by the draft rule:
  - 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 Phase II CORE Connectivity Rule version 2.2.0
  - 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 of remittance advice data to post to patient account

NOTE: Detailed research, Work Group straw polls and discussion informed development of draft rules and is documented
Draft Claim Payment/Advice (835) Infrastructure Rule

Reminder: 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 flow and format of such guides
  – Requires entities to support Phase II CORE Connectivity Rule
  – Includes batch acknowledgement requirements
    • Requirements place parallel responsibilities on both senders and receivers of the v5010 835 for sending and accepting v5010 999 Acknowledgements to assure transactions are accurately received and facilitate health plan correction of errors in outbound transactions
    • Addresses health plans’ dual delivery of the v5010 835 and proprietary remittance advices
      • Addresses the need of providers to continue to receive proprietary remittance advice and the v5010 835 concurrently so that the provider can effectively migrate to the v5010 835 alone (31 days/ 3 payment cycles)

**NOTE:** For detail on Phase III Rules Work Group straw poll and adjustment of the draft rule, see the 01/25/10 Rules Work Group call documents on the [CAQH Calendar](#).