Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call

October 30, 2012

Additional information/resources available at www.caqh.org

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

• Brief Overview of CAQH CORE
  – For more information contact Omoniyi Adekanmbi at oadekanmbi@caqh.org

• Update on ACA Mandated Healthcare Operating Rules
  – First Set: Eligibility & Claim Status Operating Rules
    • Meeting the real-time response requirements
    • FAQs and Requests
    • Ready to test with trading partners?
    • CMS OESS guest speaker
  – Second Set: EFT & ERA Operating Rules
    • Interim Final Rule
    • Update process for CORE-required Code Combinations
  – Third Set: Attachments, Prior Authorization, Enrollment, etc.

• Update on Non-Rule Development Activities
  – New CORE Board

• Stay Involved with CAQH CORE
Polling Question #1: *Audience Profile*

- Choose the stakeholder type that best describes your organization
  - Healthcare provider
  - Health plan/payer
  - Clearinghouse/intermediary
  - Product/Services vendor
  - Other
Brief Overview of CAQH CORE
CAQH® and Its Initiatives

Multi-stakeholder collaboration of over 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. CORE® participants maintain eligibility/benefits data for over 150 million lives, or approximately 75% of the commercially insured, plus Medicare and some Medicaid.

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

An objective industry forum for monitoring business efficiency in healthcare. Tracking progress and savings associated with adopting electronic solutions for administrative transactions across the industry.
Committee on Operating Rules for Information Exchange

- A multi-stakeholder collaboration established in 2005
- **Mission**: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response
  - Facilitate administrative and clinical data integration
- Recognized healthcare operating rule author by NCVHS

CAQH CORE carries out its mission based on an integrated model
Purpose of 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”
• They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards
Update on Mandated Healthcare Operating Rules:  
ACA Section 1104
ACA Mandated Operating Rules Compliance Dates: 
*Required for all HIPAA Covered Entities*

### Implement by January 1, 2013
- Eligibility for health plan
- Claims status transactions

### Implement by January 1, 2014
- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions

### Implement by January 1, 2016
- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments

**NOTE:** Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans will apply.
Three dates are critical for industry 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>Dates</td>
<td>First Date&lt;br&gt;January 1, 2013&lt;br&gt;Compliance Date</td>
<td>Second Date&lt;br&gt;December 31, 2013&lt;br&gt;Health Plan Certification Date</td>
</tr>
<tr>
<td>Description</td>
<td>Who: All HIPAA covered entities&lt;br&gt;Action: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>Who: Health plans&lt;br&gt;Action: File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules</td>
</tr>
<tr>
<td>Applicable Penalties</td>
<td>Amount: Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>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</td>
</tr>
</tbody>
</table>

1 CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties 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.
Mandated Healthcare Operating Rules: First Set - Eligibility & Claim Status
Status of Mandated Eligibility & Claim Status Operating Rules: *Two Months Until Compliance Date*

- **Status:** The first set of operating rules has been adopted into Federal regulation
    - Adopted Phase I and II CAQH CORE Operating Rules for the Eligibility & Claim Status transactions, *except for rule requirements pertaining to Acknowledgements*
    - Highlights CORE Certification is *voluntary*, further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation
- ACA Section 1104 requires *all HIPAA covered entities* be compliant with applicable HIPAA standards and associated operating rules

*The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge [HERE](https://www.caqh.org).*

*On September 22, 2011, NCVHS issued a [letter](https://www.ncvhs.hhs.gov/MeetingMaterials/2011/2011%20NCVHS%20Meeting%203%2022%202011%20Meeting%20Material%20Booklet.pdf) recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.*
### Mandated Eligibility & Claim Status Operating Rules

**Compliance date January 1, 2013**

<table>
<thead>
<tr>
<th>Type of Rule</th>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content:</strong> Eligibility</td>
<td>Need to drive further industry value in transaction processing</td>
<td>More Robust Eligibility Verification Plus Financials</td>
</tr>
<tr>
<td><strong>Infrastructure:</strong> Eligibility and Claim Status</td>
<td>Industry needs for common/accessible documentation</td>
<td>Companion Guides</td>
</tr>
<tr>
<td></td>
<td>Industry-wide goals for architecture/performance/connectivity</td>
<td>Response Times</td>
</tr>
</tbody>
</table>

**Voluntary Eligibility & Claim Status Operating Rule**

“We are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”

*HHS Interim Final Rule*

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*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.*
Eligibility & Claim Status Operating Rules
Meeting the Real-Time Response Requirements
CAQH CORE Real Time Processing: Potential Real Time Transaction Paths

**End-to-End: 20-Second Round Trip**
(CAQH CORE recommends no more than 4 seconds per hop)

**Path #1: Direct Connection: A+B= 20 seconds or less**

**Path #2: Single Clearinghouse: A+B+C+D= 20 seconds or less**

**Path #3: Dual Clearinghouse: A+B+C+D+E+F= 20 seconds or less**

*At starred receipt and transmit points each entity must capture, log, audit, match, & report date, time, and control numbers from its own internal systems and corresponding data received from its trading partners*
Response Time Requirements: CAQH CORE Rules 156 & 250

- When processing in real time, maximum response time for receipt of a v5010 X12 271 or X12 276 by the provider in response to a v5010 X12 270 or X12 276 must be 20 seconds

- To conform to response time requirement, 90 percent of all transactions, as measured within a calendar month, must be returned within the 20-second maximum response time

- NOTE: The rules hold the health plan and its contracted business associates responsible for the conduct of the transaction that is applicable to them.

When Do the 20-Seconds Begin and End?

- The 20-second requirement is the duration for the entire round trip of the transaction
  - The 20 seconds begin when the v5010 X12 270 Inquiry or X12 276 Request is first submitted by the provider, and end when the X12 271 or X12 277 Response is received by the provider
  - All ensuing hops between the provider and the health plan are included in these 20 seconds

- ACA Administrative Simplification provisions require all HIPAA covered entities (i.e., health plans, providers, clearinghouses, etc.) to comply with the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules
  - Each HIPAA covered entity within the transaction flow is bound by the CAQH CORE requirements for meeting the 20-second round trip of the transaction

- CAQH CORE recommends a maximum of 4 seconds per hop to meet the 20-second round trip requirement
Federally Mandated CAQH CORE Infrastructure Rules: Summary of Other Processing Requirements

All HIPAA covered entities must support real time processing of the X12 270/271 and X12 276/277 transactions; the CAQH CORE Infrastructure Rules work together to support real time processing.

• **Connectivity Rules**
  – Specify that real time processing is required and batch processing is optional but if entities do support batch, they must implement and conform to all applicable batch processing requirements outlined in the Federally mandated CAQH CORE Operating Rules.

• **Logging and Auditing Requirements: Connectivity, Real-time and Batch Response Rules**
  – Each entity must capture, log, audit, match, and report date, time, and control numbers from its own internal systems and the corresponding data received from its trading partners; helps identify where response time lags may occur.
  – Message receivers must track times of any received inbound messages, respond with outbound message for that payload ID, and include date and time message was sent in the CORE metadata element “Time Stamp”;
    – NOTE: if health plan is using another connectivity method, CAQH CORE recommends that the health plan still implement the audit log requirements of CAQH CORE Connectivity which can be used to resolve any issues regarding compliance and identify where a bottleneck may occur.

• **System Availability Rules**
  – All system components required to process X12 270 or X12 276 and return a response must be available no less than 86 percent per calendar week (calendar week defined as 12:01 am Sunday to 12:00 am the following Sunday).
Eligibility & Claim Status Operating Rules
Top FAQs – What are Implementers Asking?
Polling Question #2: Readiness Profile

- Which stage best represents your organization’s readiness to comply with the January 2013 mandate?
  - Conducting planning and requirements analysis
  - Systems design and development in process
  - *Internal systems* implementation testing underway
  - *Trading partner* implementation testing underway
  - Deployment and rollout with trading partners underway or complete (may include Voluntary CORE Certification)
  - Not Applicable (a non-HIPAA covered entity)
Examples of System Availability Questions

- **How is system availability calculated in light of holiday, scheduled, and non-routine downtime?**
  - Each health plan will establish its own holiday schedule and publish it in accordance with the rule. The CAQH CORE rule requires that a health plan’s system be available to process the Eligibility and Claim Status transactions 86% of the time during a calendar week. System availability is tracked as the percentage of hours that the system is up and available to process the transactions. Any time that the system is not available for processing (e.g. holiday, non-routine, scheduled, emergency, etc.) is counted as the system downtime. This applies for both Real Time and Batch processing.

- **When does downtime start? At first awareness by the health plan or actual start time?**
  - For system outage notification it would be first awareness of system outage by the health plan.
  - When measuring the duration of system outage – it would be from the actual time of the outage.

- **Is a health plan responsible for ensuring overall system availability as defined in the CORE rule when the health plan has outsourced any covered functions to a business associate?**
  - Yes. As a business associate of the health plan, the health plan should require a contracted entity like a clearinghouse to notify its trading partners of the downtime as required by the CORE rule. The overall health plan’s system availability (as defined in the CORE rule) is impacted if its business associate system is down.
Recently Added CAQH CORE FAQs

CAQH CORE has a searchable PDF list of FAQs to address typical questions regarding the mandated Eligibility & Claim Status Operating Rules grouped by rule; FAQs are updated on an ongoing basis based on industry feedback and the CORE Request Process.

<table>
<thead>
<tr>
<th>Section</th>
<th>Sub-Section</th>
<th>#</th>
<th>Examples of Recently Added Eligibility &amp; Claim Status FAQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>F</td>
<td>17</td>
<td>Can an X12 271 response to an explicit X12 270 inquiry containing one of the CORE-required Service Type Codes (STCs) identified in Rule Subsection 1.4 provide information about STCs beyond the requested CORE-required STC?</td>
</tr>
<tr>
<td>IV</td>
<td>F</td>
<td>20</td>
<td>Do the CAQH CORE Eligibility Data Content Rules (CAQH CORE Rules 154 and 260) require health plans to support date ranges in an ASC X12 270 Inquiry?</td>
</tr>
<tr>
<td>IV</td>
<td>F</td>
<td>23</td>
<td>Do The CAQH CORE Eligibility &amp; Benefits Data Content Rules (CAQH CORE Rules 154 And 260) require health plans to address the situation where a patient’s benefit coverage changes from the time of the X12 270 inquiry to the date of service?</td>
</tr>
<tr>
<td>IV</td>
<td>J</td>
<td>55</td>
<td>Can I combine multiple transaction sets (i.e., X12 270/271 and 276/277) in a single companion guide?</td>
</tr>
<tr>
<td>IV</td>
<td>L</td>
<td>8</td>
<td>How does a health plan identify the correct error condition description to return when multiple error conditions are mapped to the same code?</td>
</tr>
<tr>
<td>IV</td>
<td>M</td>
<td>8</td>
<td>As CAQH CORE Rules 154 and 260 do not require that the X12 271 response to an X12 270 inquiry include a specified grouping of Service Type Codes (STCs), are health plans/information sources prohibited from returning such a STC grouping in the X12 271 response?</td>
</tr>
<tr>
<td>IV</td>
<td>N</td>
<td>38</td>
<td>Does CAQH CORE Rule 270 require the use of the MAC address?</td>
</tr>
<tr>
<td>IV</td>
<td>N</td>
<td>39</td>
<td>What is the specific method for an entity to conform to the CAQH CORE Rule 270 audit log requirements?</td>
</tr>
</tbody>
</table>
Implementing Mandated Operating Rules: The Importance of Trading Partner Collaboration

- HIPAA-covered entities work together to exchange transactions in a variety of ways
- Understand your electronic data flows associated with your administrative agreements
- Vendors play a crucial role in enabling provider clients to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them!
  - Providers rely on their vendors/Practice Management System Vendors (PMS) to achieve their administrative cost saving goals and achieve end-to-end interoperability
  - Health plans and clearinghouses work together in a variety of ways
Are You Ready for Trading Partner Testing?

• Testing with your trading partners is a critical aspect to making your operating rules implementation a success, as well as that of those entities with which you exchange HIPAA transactions

• Given the Federal deadline for the 1st set of operating rules is January 1, 2013, CAQH CORE is now hosting a website to highlight those organizations in trading partner testing for eligibility and claim status

• HIPAA covered entities (or other key IT systems that support them, such as Practice Management Systems) can quickly list that their organization is ready to test with its trading partners
  – Those entities using the website that are voluntarily CORE-certified have their CORE Certification Seal listed, given such entities already are using the CORE rules in daily exchange and thus able to test with their trading partners

• The website can be found at http://caqh.org/COREPartnerTesting.php

If you are ready, add your organization today!
Additional CAQH CORE Implementation Resources

- Ensure your organization is ready to comply with the **January 1, 2013** mandated Eligibility & Claim Status Operating Rules deadline
  - **Phase I** & **Phase II** CORE Certification Master Test Suites: Provide guidance on the stakeholder types to which the rules apply and working with trading partners
  - CAQH CORE has a [list of FAQs](#) to address typical questions regarding the operating rules; updated FAQs being loaded to website as appropriate given mandates
  - *Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules*: Provides systems analysis and planning guidance for Project Managers, Business & System Analysts, etc. and includes, e.g. Systems Inventory & Impact Assessment Worksheet
  - After reviewing other tools & resources, information requests can be submitted to the CAQH CORE Request Process at [CORE@caqh.org](mailto:CORE@caqh.org)

- Complete voluntary [CORE Certification](#)
  - Contact technical experts as needed at [CORE@caqh.org](mailto:CORE@caqh.org) with rule interpretations, questions on conformance testing requirements, or requests for additional information
  - Attend a CAQH CORE Education Session (see next slide)
  - Suggest other tools and/or topics for sessions
Upcoming CAQH CORE Education Sessions

- List of upcoming CAQH CORE Education Sessions available [HERE](#); highlights include below – *all will have Q*’*&A component*:
  - November 8, 2012: CAQH CORE - “Implementation Topics for Medicaid Health Plans”, 2 PM ET – 3:00 PM ET ([with CMS OESS](#))
  - November 13, 2012: CAQH CORE and InstaMed Webinar - “Operating Rule Implementation Topics for Providers”, 2 PM ET - 3:00 PM ET
  - November 20, 2012: “Open Mic” on January 2013 Deadline – Key Tips and FAQs ([with CMS OESS](#))

- Upcoming CAQH CORE Town Hall Calls
  - December 11, 3-4 PM ET
  - January 22, 3-4 PM ET
Key Take-Aways: January 2013 Deadline

• Eligibility and Claims Status Operating Rule implementation is being achieved by a number of diverse organizations
• Use lessons learned by others that have implemented, e.g. for some content is key challenge, for others challenge is the infrastructure or testing
• Work with your business associates
• Take advantage of existing resources
• The CMS certification requirements for operating rules/standards/identifiers is different than January 2013 deadline
  – This HHS program under development – share your concerns, ideas or questions now
Mandated Healthcare Operating Rules:

CMS OESS Speaker
Mandated Healthcare Operating Rules:
Second Set - EFT & ERA
Mandated EFT & ERA Operating Rules:
January 2014 Compliance Deadline

- **Status:** The second set of operating rules has been proposed for Federal regulation
  - August 2012 - CMS published an Interim Final Rule with Comment, [CMS-0028-IFC](#), with the following features:
    - Adopts Phase III CAQH CORE Operating Rules for the Electronic Funds Transfer (EFT) and Health Care Payment and Remittance Advice (ERA) transactions except for rule requirements pertaining to Acknowledgements*
    - Covered entities must be in compliance by January 1, 2014
  - The interim final rule comment period closed on October 9, 2012
    - During the comment period CAQH CORE:
      - Developed a model comment letter for organizations to use as appropriate
      - Submitted a CAQH CORE comment letter

*On September 22, 2011, NCVHS issued a letter recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.*
The final CAQH CORE Model Comment Letter highlighted eight key comment areas and recommendations:

1. Importance of keeping the five areas in the EFT & ERA Operating Rule Set intact due to interdependencies between rules
2. Correct the name of the CCD to be Corporate Credit or Debit Entry (CCD)
3. Address the need to adopt a standard and operating rules for electronic acknowledgments
4. Address a means to review and amend operating rules on a timely basis
5. Provide guidance on cost/benefit analysis associated with provider and health plan implementation of the EFT & ERA Operating Rules
6. Seek ways to encourage more providers to adopt the health care EFTs and remittance advice standards as well as other HIPAA transactions standards
7. Address the current exclusion of banks under HIPAA if alternative forms of transmission vehicles/standards – which are allowed by the Standard for Health Care EFTs and Remittance Advice Transactions – carry detailed remittance advice information which includes PHI
8. Provide education and guidance on use of operating rules
## CAQH CORE EFT & ERA Operating Rules: Overview

<table>
<thead>
<tr>
<th>Rule</th>
<th>High-Level Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Uniform Use of CARCs and RARCs (835) Rule</strong></td>
<td>• Identifies a <em>minimum</em> set of four CAQH CORE-defined Business Scenarios with a <em>maximum</em> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider</td>
</tr>
</tbody>
</table>
| **EFT Enrollment Data Rule** | • Identifies a maximum set of standard data elements for EFT enrollment  
• Outlines a 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 Enrollment Data Rule |
| **EFT & ERA Reassociation (CCD+/835) Rule** | • Addresses provider receipt of the CAQH 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 |
| **Health Care Claim Payment/Advice (835) Infrastructure Rule** | • Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides  
• Requires entities to support the Phase II CAQH CORE Connectivity Rule  
• Includes batch Acknowledgement requirements  
• Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |

Complete CAQH CORE EFT & ERA Operating Rules Set available [HERE](#).
Mandated EFT & ERA Operating Rules: Next Steps

For CAQH CORE:

- Develop CAQH CORE resources to support industry implementation of the CAQH CORE EFT & ERA Operating Rules (in progress), including:
  - FAQs based on lessons learned in CORE rule writing and questions received through CAQH CORE Request Process
  - Drafting *Analysis & Planning Guide for Adopting the CAQH CORE EFT & ERA Operating Rules*
  - With CAQH CORE-authorized testing entity Edifecs, create site beta and alpha Voluntary CORE Certification Test Site for January 2013 (volunteer to beta test?)
  - If you have suggestions for additional implementation tools, please email core@caqh.org
- Launch formal Maintenance Process for the CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE Rule 360

For HHS/CMS:

- Review comments on the IFC and provide notification of Final Rule
Maintenance Process for CORE-required Code Combinations

- **Level Set: What is already in Section 3.5 of CAQH CORE Rule 360?**
  - Recognizes that the CORE rule supports the ASC X12 v5010 mandated standard
  - Recognizes that the CORE rule supports code lists that are subject to revision three or more times a year; code committees are authors of the published codes and meet three times per year
  - Recognizes that CORE Business Scenarios and combinations are updated to address changes to codes and updates are immediately acknowledged, e.g. cant use deleted code, can use new codes
  - As a starting point, focuses on the key business scenarios
  - Establishes that there is an open CORE process for soliciting feedback and input from the industry on a periodic basis, no less than three times per year for updating the [CORE-required Code Combinations for the CORE-defined Business Scenarios](#)
    - A public request will be made to receive real-world data and the analysis to support the addition of new code combinations and/or business scenarios; will continue to track volatility of the codes

- **Draft CORE-required Code Combinations Maintenance Process**
  - Draft process to be reviewed by CAQH CORE Co-Chairs and shared with CMS OESS
  - Call for Participants for the CORE Code Combinations Task Group
  - Task Group will review and vote on potential updates to the [CORE-required Code Combinations for the CORE-defined Business Scenarios](#)

- **Short-term Goal for Code Combination Maintenance Process:**
  - Update the [CORE-required Code Combinations for the CORE-defined Business Scenarios](#) by end of 2012; per the CORE rule, align with recent Code List updates and industry usage on four Business Scenarios
Mandated Healthcare Operating Rules:
Third Set – Attachments, Prior Authorization, Enrollment, etc.
Third Set of Mandated Operating Rules: Status

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

• September 2012: Secretary of HHS designates CAQH CORE as author for all remaining ACA mandated operating rules
  – CAQH CORE will use its open process to develop a set of draft rules for consideration to fulfill the third set of Federally mandated operating rules; research and planning underway for rule development and activities like public surveys
  – All CORE Guiding principles will be followed, e.g. build on existing standards, align with other Federal health IT initiatives, address content and infrastructure
  – Schedule to be issued; Connectivity Subgroup will be one of the first Subgroups groups to launch
Update on Non-Rule Development Activities
CORE Transition Committee: Draft Model Created

- The CORE Transition Committee was launched with the charge to recommend a model to extend both CAQH CORE multi-stakeholder governance and funding
  - CAQH CORE’s rule writing process is already multi-stakeholder
  - Over ninety percent of CAQH CORE’s expenses are covered by CAQH
- Status: Committee has developed a draft new CORE Governance Model
  - Expands existing CAQH CORE process for multi-stakeholder operating rules development by creating a multi-stakeholder CORE Board to oversee budget, policy developments, etc.
  - Requires that providers and health plans need consensus to move positions forward; vendors, standards development organizations (SDOs), government and others also serve on the Board
  - Structure is implementer-focused, executive leadership-driven, and results-oriented
  - Voting on the CAQH CORE rules will remain quorum-based with necessary CAQH CORE Subgroup and Work Group approvals and emphasis on implementers in final stages of voting
  - New Board will oversee items such as strategic partnerships, budget, communications; ensure it addresses any concerns on CORE integrated model (rule development, certification/testing, outreach/education) and, consider new funding models
# Draft CAQH CORE Board Composition

<table>
<thead>
<tr>
<th>Permanent Members</th>
<th>Non-Voting Advisors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(all will be from CORE participating organizations)</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

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<th>Non-Voting</th>
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<td>Other</td>
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<tr>
<td>Hospital</td>
<td>Federal* (e.g., CMS OESS)</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Other</td>
</tr>
<tr>
<td>Broader Care Delivery</td>
<td>State* (e.g., NAMD)</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Other</td>
</tr>
<tr>
<td>Provider (Proposed by AHA)</td>
<td>*(One or more from both Federal and state agencies/representative organizations)</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Other</td>
</tr>
<tr>
<td>Provider (Proposed by AMA)</td>
<td>CAQH CORE Executive Staff</td>
</tr>
<tr>
<td>Health Plan (Proposed by AHIP)</td>
<td>CAQH CORE Executive Staff</td>
</tr>
<tr>
<td>Provider (Proposed by MGMA)</td>
<td>As Needed</td>
</tr>
</tbody>
</table>

*Others as appropriate, e.g., CORE Work Group Chairs

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Thank You For Joining Us: *Stay Involved*

- Ensure your organization is ready for the **January 1, 2013** Mandated Eligibility & Claim Status Operating Rules deadline:
  - HIPAA v5010 Phase I & II CAQH CORE Eligibility & Claim Status Rules
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