Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call

11/01/11

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

• Brief Overview of 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
  – CAQH CORE Measures of Success
  – Overview of the CAQH CORE Transition Committee
  – Alignment with Federal Efforts

• Update on ACA Section 1104: Mandated Operating Rules
  – Status of CAQH CORE efforts
    • Eligibility and Claim Status transactions
    • Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions

• Overview of Voluntary CORE Certification

• Appendix
  – Overview of Draft CAQH CORE EFT & ERA Operating Rules
Brief Overview of CAQH CORE
CAQH®, a nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

Multi-stakeholder collaboration of more than 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. Cover 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). Over 960,000 providers self-report their information to UPD and over 600 organizations access the system, including a range of public and private entities.
Committee on Operating Rules for Information Exchange

- CAQH 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

- CAQH 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 CAQH CORE, national operating rules for medical transactions did not exist in healthcare outside of individual trading partner 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 and have been since 2006
- 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
  - Industry neutral standards, e.g., SOAP, WSDL, ACH CCD+
- Scope between rules and standards will be iterative as already demonstrated:
  - New rules may be issued using the same version of a standard, e.g., two phases of CAQH CORE rules (Phase I and II CAQH CORE) were adopted during v4010 – and thus drove greater market benefit from v4010, informed v5010 needs and were designed with v5010 in mind so v5010 update to rules not extensive
  - Items required by the operating rules will, in some instances, be moved into the next version of a standard and removed from rules, e.g., in January 2012 CAQH CORE operating rules will no longer require a Yes/No coverage response for a service type as that requirement is now part of v5010
Operating Rules: Improving ROI of Standards Adoption

**GOAL**: Reduce administrative burden and improve value of transactions

- **Example 1**: Eligibility Request & Response (v5010 270/271) Data Content
  - HIPAA mandated response components require a generic response, e.g., status of eligibility, dates of eligibility and base contract financials
  - CAQH CORE Operating Rules further support standard to further drive ROI, e.g., require name of health plan, patient financials for key services and benefits

- **Example 2**: Normalizing Patient Last Name
  - HIPAA standards were not created to address use of name suffixes, special characters and punctuation in text data elements for names of organizations and individuals, yet these issues add to patient identification challenges
  - CAQH CORE Operating Rules specifies requirements for the health plan/information source to normalize last name validation resulting in improved patient matching and better information on why a match did not occur in an eligibility request, i.e., prefix, suffix, credentials

- **Example 3**: ACH CCD+ (standard for EFT used by the ACH Network)
  - Some providers are unaware they must request from their banks the information necessary to reassociate remittance data in v5010 835 to payment data in the ACH CCD+
  - Draft CAQH CORE EFT Operating Rules require health plans to notify their providers that they must request this information from their bank, thus enabling providers to more quickly address denials or appeal adjustments to claim amount
CAQH CORE Rules Development/Adoption Timeline

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

REMINDER: CAQH CORE Operating Rules are a baseline; entities are encouraged to go beyond the minimum CORE requirements.
Update on Non-Rule Writing Activities
CAQH CORE Participation

More than 130 organizations representing all aspects of the industry, including:

- Health plans
- Providers
- Provider associations
- Regional entities/RHIOS/standard setting bodies/other associations
- Vendors (clearinghouses and PMS)
- Others (consulting companies, banks)
- Government entities, e.g.,:
  - Centers for Medicare and Medicaid Services
  - US Department of Veteran Affairs

CAQH CORE participants maintain eligibility/benefits data for over 150 million lives, or approximately 75 percent of the commercially insured plus Medicare and state-based Medicaid beneficiaries.
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 - GE Centricity Business v5.0: Phase I & II

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

- CAQH CORE made an early commitment to track Measures of Success
- Health Plans, vendors and providers that pursue voluntary CAQH CORE Certification are invited to participate in the ROI study
  - Also need participation from providers that are not CORE-certified, but exchanging data with CORE-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 CORE-certified health plans
- Please contact Zach Fithian at zfithian@caqh.org if interested in participating in the study

* Organizations pursuing Phase I and Phase II CORE 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 CAQH CORE’s goal to support the changing environment in which operating rules are mandatory
  – Note: The CAQH Board has never voted on any CAQH CORE Operating Rule

• In early 2011, the CORE Transition Committee was launched with charge to make recommendations regarding potential multi-stakeholder governance and revenue models for CAQH CORE
  – Will preserve the CAQH CORE integrated approach to rule-writing, voluntary 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 end of 2011; CAQH is committed to supporting CAQH CORE during transition
  – Note: In the coming months, CAQH CORE and non-CAQH CORE participants 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>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Association</td>
<td>American Hospital Association (AHA)</td>
<td>Linda Fishman, SVP Health Policy and Analysis</td>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>Health Plan (National)</td>
<td>WellPoint</td>
<td>AJ Lang, SVP/CIO</td>
</tr>
<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>
</tr>
<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>
</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>
</tr>
<tr>
<td>Practice Management System/Vendor (small office)</td>
<td>Allscripts</td>
<td>Mitchell Icenhower, VP of Solutions Management</td>
</tr>
<tr>
<td>Bank</td>
<td>JP Morgan</td>
<td>Martha Beard, Managing Director, Treasury &amp; Securities Services</td>
</tr>
<tr>
<td>State Entity</td>
<td>Minnesota Department of Health</td>
<td>David Haugen, Director of the Center for Health Care Purchasing Improvement</td>
</tr>
<tr>
<td>State Coalition/Association</td>
<td>National Governors Association (NGA)</td>
<td>Ree Sailors, Program Director, Health Division Center for Best Practices</td>
</tr>
<tr>
<td>CORE Chair</td>
<td>IBM &amp; CORE</td>
<td>Harry Reynolds, IBM Payer Transformation</td>
</tr>
</tbody>
</table>

### Notes:
1. CAQH CORE staff serves as secretariat; others will serve as advisors, e.g. Committee speaking with governance experts
2. The new CAQH CORE governance may or may not include Transition Committee members or a similar mix of entities
## Industry Alignment Is Critical: Examples

Activities within CAQH 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 CAQH CORE to add to ROI (e.g., financial data elements)  
• Standards supported by CAQH 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, CAQH CORE connectivity designed to align with ONC-sponsored [Nationwide Health Information Network](https://www.nhin.org) (NHIN) |
| --- | --- |
| State/Regional | • CAQH 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 CAQH CORE  
• States are submitting potential operating rules to CAQH CORE, e.g., WA, MN |
CAQH CORE and ACA Section 1104 Mandated Operating Rules
ACA: 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. NCVHS is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules.
2. Statute defines relationship between operating rules and standards.
3. Operating rules apply to HIPAA covered entities but penalties only for health plans.
4. Per statute, documentation of compliance may include completion of end-to-end testing (i.e., certification and testing).
Eligibility and Claim Status Operating Rules Status

Progress to Date

- June 2011 Interim Final Rule (IFC) proposes adoption of Phase I and Phase II CAQH CORE, except for acknowledgements*; highlights CORE Certification is voluntary
  - Further defines relationship between standards and operating rules, and ROI
- Submitted CAQH CORE comment letter to CMS, e.g.
  - Include Acknowledgements to realize ROI, maintain broad scope of operating rules given ACA goals, and name CAQH CORE as single operating rule author given need for industry direction and resources
- CAQH CORE dialoguing with CMS eHealth Office regarding public comments as some of the comments relate to foundational aspects of CAQH CORE
  - Limiting the scope/definition of operating rules would limit the ability of operating rules to target administrative burden

Next Steps

- CAQH CORE will work with CMS to answer questions and adjust rules as appropriate
- Once the final rule is issued, CAQH CORE will assist with the roll out and continue to support maintenance of the rules

*On September 22, 2011, NCVHS, NCVHS issued a letter recommending Acknowledgements are formally recognized standards and that CORE operating rules for these standards also be recognized
Overview: Phase I & II CAQH CORE Eligibility and Claim Status Operating Rules

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I and Phase II Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td><strong>Eligibility &amp; Benefits</strong></td>
</tr>
<tr>
<td>Respond to generic and explicit inquiries for a defined set of 50+ high volume services, with:</td>
<td></td>
</tr>
<tr>
<td>▪ Health plan name and coverage dates</td>
<td></td>
</tr>
<tr>
<td>▪ Static financials (co-pay, co-insurance, base deductibles)</td>
<td></td>
</tr>
<tr>
<td>▪ Benefit-specific and base deductible for individual and family</td>
<td></td>
</tr>
<tr>
<td>▪ In/Out of network variances</td>
<td></td>
</tr>
<tr>
<td>▪ Remaining deductible amounts</td>
<td></td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td><strong>Eligibility &amp; Benefits</strong></td>
</tr>
<tr>
<td>▪ Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)</td>
<td></td>
</tr>
<tr>
<td>▪ Companion Guide – common flow/format</td>
<td></td>
</tr>
<tr>
<td>▪ Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch)</td>
<td></td>
</tr>
<tr>
<td>▪ System Availability service levels – minimum 86% availability per calendar week</td>
<td></td>
</tr>
<tr>
<td>▪ Enhanced Patient Identification and Error Reporting requirements</td>
<td></td>
</tr>
<tr>
<td>▪ Acknowledgements (transactional)*</td>
<td></td>
</tr>
<tr>
<td><strong>Claims Status</strong></td>
<td><strong>Eligibility &amp; Benefits</strong></td>
</tr>
<tr>
<td>▪ Connectivity via Internet</td>
<td></td>
</tr>
<tr>
<td>▪ Real-time and batch turnaround times</td>
<td></td>
</tr>
<tr>
<td>▪ System Availability</td>
<td></td>
</tr>
<tr>
<td>▪ Companion Guide flow/format</td>
<td></td>
</tr>
<tr>
<td>▪ Acknowledgements (transactional)*</td>
<td></td>
</tr>
</tbody>
</table>

*IFR did not require Acknowledgment operating rules

See [HERE](#) for PowerPoint overview of the Phase I and II CAQH CORE Operating Rules
Draft CAQH CORE EFT & ERA Operating Rules
• **Progress to Date**
  - In February 2011, NCVHS recommended NACHA (financial services operating rule entity) as a healthcare EFT SDO and its ACH CCD+ as a standard format (pharmacy to be addressed in CAQH CORE Operating Rules as appropriate)
  - In March 2011, NCVHS recommended CAQH CORE, in collaboration with NACHA, as author; pharmacy addressed in CAQH CORE Operating Rules as appropriate
    - CCD+ is a NACHA standard; data and dollars travel separately
    - Five draft rules developed by CAQH CORE process; federal agencies actively involved
  - In September, draft rules approved by CAQH CORE Rules Work Group
  - NCVHS updated on rule’s status in September

• **Next Steps**
  - Move *Draft CAQH CORE EFT & ERA Operating Rules* to final stage of CAQH CORE voting, taking Final HHS Rule on Federally mandated Eligibility and Claim Status regulation into consideration for potential adjustments; finalizing CORE Certification Test Suite for voluntary CORE Certification
  - Project potential impact of *Draft CAQH CORE EFT & ERA Operating Rules* and share with HHS
  - CMS will work with NCVHS to determine appropriateness of draft rules for potential Interim Final Rule; CAQH CORE to support as appropriate
# Overview: Draft CAQH CORE EFT & ERA Operating Rules

<table>
<thead>
<tr>
<th>Draft Rule</th>
<th>High-Level Requirements</th>
</tr>
</thead>
</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 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 |
| **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 CAQH CORE Connectivity Rule  
| | - Includes Batch Acknowledgement Requirements  
| | - Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits |
| **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 |

See appendix for a more detailed overview or go [HERE](#) for complete Draft CAQH CORE EFT & ERA Operating Rule Set.
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 partnership has pursued additional activities, e.g., extensive research on EFT & ERA opportunity areas.
  - During the development of the *Draft CAQH CORE EFT & ERA Operating Rules*, the CAQH 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 draft rules convey these opportunities to NACHA.

- **CAQH CORE and NCPDP: Medical and Pharmacy alignment**
  - For each rule requirement, applicability to Retail Pharmacy was discussed and, for each rule, applicability of one of the following approaches determined:
    - 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.
Voluntary CORE Certification
Voluntary CORE Certification in a Mandatory Operating Rules Environment

CAQH CORE will maintain voluntary CORE Certification and contribute to ACA dialog

ACA Administrative Simplification Requirements

**Background:** Applies to all HIPAA covered entities. Requires health plans to demonstrate compliance with applicable HIPAA standards and associated operating rules, references concepts of certification and testing, and notes penalties only apply to health plans not all covered entities.

**Status:** HHS will issue specific guidance on how plans will demonstrate compliance with the CMS. CMS Interim Final Rule (IFR) with comment for eligibility and claim status transactions emphasized that the current CORE Certification process is voluntary and noted that HHS will develop a process to verify health plan compliance with the mandated rules. CMS will issue an NPRM; penalties for non-compliance will begin to be assessed April 1, 2014.

CORE Certification:

- Provides all organizations across the trading partner network (e.g., health plans, vendors, clearinghouses, providers) useful, accessible, and relevant guidance in meeting obligations under the CAQH CORE rules
- Encourages trading partners to work together on data flow and content needs
- Offers vendors practical means for informing potential and current clients of what health plans are offering operating rules
- Achieves maximum ROI because all entities in data exchange follow the rules; once CORE-certified, need to follow rules to all trading partners
Voluntary CORE Certification: Overview

- CAQH CORE certifies four types of entities that create, transmit or use eligibility and claim status data: health plans, providers, vendors and clearinghouses (includes HIEs)
  - CORE Certification is voluntary and achieved by organizations that can demonstrate their systems operate in accordance with CAQH CORE Operating Rules
  - Phase I and Phase II CORE Certification may be conducted sequentially or concurrently
  - Cost of testing and certification is extremely low or free
- Certification and testing are separate activities
  - Testing is completed by CORE-authorized testing entities and occurs on-line based on stakeholder-specific test scripts
  - Certification is completed by CAQH CORE and occurs after testing is complete
- Nearly 60 organizations are CORE-certified with an additional 30 in the pipeline
  - One-third of commercially-insured lives covered by Phase I CORE-certified plans
Getting Involved with CAQH CORE
Thank You For Joining Us: Stay Involved

• Participate in CAQH CORE Operating Rules Development
  – Join your industry colleagues as a CAQH CORE Participant and then also join Subgroups or Work Groups, if not already involved

• Implement the CAQH CORE Operating Rules: Become CORE-certified
  – Pledge your organization’s commitment to conduct business in accordance with the Phase I and/or Phase II CAQH CORE Operating Rules

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

• Join us at another CAQH CORE Education Event
  – November 30th, 2:00-3:00 pm ET: CAQH CORE and Edifecs Webinar
    • Joint Edifecs and CORE Voluntary Certification Series - Part 4: A Clearinghouse Perspective
  – December 6th, CAQH Booth at the Blue National Summit
  – December 8th, 2:00-3:30 pm ET: Next WEDI and CAQH CORE Audiocast
  – December 13th, 3:00-4:00 pm ET: CAQH CORE Town Hall Call (open to public)
  – January 24th, 3:00-4:00 pm ET: CAQH CORE Town Hall Call (open to public)

• Listen to the upcoming NCVHS Committee Meeting
  – November 16th – 17th, tentative topics include enrollment, attachments, etc.
Appendix:
Overview of *Draft CAQH CORE EFT & ERA Operating Rules*
### Draft CAQH CORE EFT & ERA Operating Rule Set

<table>
<thead>
<tr>
<th>Rule Set</th>
<th>Slides</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Draft EFT Enrollment Data Rule</strong></td>
<td>32-33</td>
</tr>
<tr>
<td>• Problem Space Addressed and Key Impact</td>
<td></td>
</tr>
<tr>
<td>• Scope and High-Level Requirements</td>
<td></td>
</tr>
<tr>
<td><strong>Draft ERA Enrollment Data Rule</strong></td>
<td>34-35</td>
</tr>
<tr>
<td>• Problem Space Addressed and Key Impact</td>
<td></td>
</tr>
<tr>
<td>• Scope and High-Level Requirements</td>
<td></td>
</tr>
<tr>
<td><strong>Draft Uniform Use of CARCs and RARCs (835) Rule &amp; CORE-Required Code Combinations for CORE-defined Business Scenarios</strong></td>
<td>36-37</td>
</tr>
<tr>
<td>• Problem Space Addressed and Key Impact</td>
<td></td>
</tr>
<tr>
<td>• Scope and High-Level Requirements</td>
<td></td>
</tr>
<tr>
<td><strong>Draft EFT &amp; ERA Reassociation (CCD+/835) Rule</strong></td>
<td>38-39</td>
</tr>
<tr>
<td>• Problem Space Addressed and Key Impact</td>
<td></td>
</tr>
<tr>
<td>• Scope and High-Level Requirements</td>
<td></td>
</tr>
<tr>
<td><strong>Draft Claim Payment/Advice (835) Infrastructure (835) Rule</strong></td>
<td>40-41</td>
</tr>
<tr>
<td>• Problem Space Addressed and Key Impact</td>
<td></td>
</tr>
<tr>
<td>• Scope and High-Level Requirements</td>
<td></td>
</tr>
</tbody>
</table>
Draft EFT Enrollment Data Rule

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 addresses 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

Rules Work Group Ballot Approved
Draft EFT Enrollment Data Rule

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 Data Element Groups (DEGs)
    • Includes a DEG specific to retail pharmacy information
  – 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

*Rules Work Group Ballot Approved*
Draft ERA Enrollment Data Rule

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 addresses 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

Rules Work Group Ballot Approved
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 approximately **65** standard data elements for enrollment; with related data elements grouped into **10** Data Element Groups (DEGs)
    • Includes a DEG specific to retail pharmacy information
  – 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

Rules Work Group Ballot Approved
Draft Uniform Use of CARCs and RARCs (835) Rule

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)

Rules Work Group Ballot Approved
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 minimum set of four CORE-defined Business Scenarios with maximum set of code combinations to convey claim denial/adjustment details (codes in separate document):

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

- 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

Rules Work Group Ballot Approved
Draft EFT & ERA Reassociation (CCD+/835) Rule

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
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 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

Rules Work Group Ballot Approved
Draft Claim Payment/Advice (835) Infrastructure Rule

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 CAQH CORE Connectivity Rule version 2.2.0
  - Continues to build on Phase I/II use of CAQH 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

Rules Work Group Ballot Approved
Draft Claim Payment/Advice (835) Infrastructure 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 CAQH CORE Master Companion Guide Template for flow and format of such guides
  – Requires entities to support Phase II CAQH 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)
  – Rule explicitly states the above rule requirements do not apply to retail pharmacy; rule references the NCPDP Connectivity Rule Version 1.0 which is aligned with the CAQH CORE Connectivity Rule for use with retail pharmacy

Rules Work Group Ballot Approved