Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call

December 11, 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
    - Top FAQs and Requests
    - Ready to test with trading partners?
    - Voluntary CORE Certification
  - Second Set: EFT & ERA Operating Rules
    - Update process for CORE-required Code Combinations
  - Third Set: Attachments, Prior Authorization, Enrollment, etc.
    - Submit your ideas to CAQH CORE
- Update on Non-Rule Development Activities
  - New CORE Board
- Q&A (phone-only)
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

NOTE: Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans will apply.
# ACA Federal Compliance Requirements: Highlights & Key Dates – Eligibility & Claim Status

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 January 1, 2013</td>
<td>Second Date December 31, 2013</td>
</tr>
<tr>
<td></td>
<td>Compliance Date</td>
<td>Health Plan Certification Date</td>
</tr>
<tr>
<td>Description</td>
<td>Who: All HIPAA covered entities</td>
<td>Who: Health plans</td>
</tr>
<tr>
<td></td>
<td>Action: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>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 an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation</td>
</tr>
</tbody>
</table>

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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 the 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: *Less than One Month Until Compliance Date!*

- **Status:** The first set of operating rules has been adopted into Federal regulation
  - December 2011, CMS adopted [CMS-0032-IFC](#) as a Final Rule; industry implementation efforts underway for the **January 1, 2013 effective date**
    - 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**

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*The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge [HERE](#).*

*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.*
### Mandated Eligibility & Claim Status Operating Rules
**Scope – 21 Days to Deadline!**

<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: Eligibility</strong></td>
<td>Need to drive further industry value in transaction processing</td>
<td>More Robust Eligibility Verification Plus Financials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced Error Reporting and Patient Identification</td>
</tr>
<tr>
<td><strong>Infrastructure: Eligibility and Claim Status</strong></td>
<td>Industry needs for common/accessible documentation</td>
<td>Companion Guides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>System Availability</td>
</tr>
<tr>
<td></td>
<td>Industry-wide goals for architecture/performance/connectivity</td>
<td>Response Times</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connectivity and Security</td>
</tr>
</tbody>
</table>

*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 acknowledgements.*

“*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**

**Acknowledgements**
Polling Question #2: Readiness Profile

• Which answer best describes the status of your organization’s progress toward implementing the mandated January 1, 2013 operating rules?
  – Just started/early phases
  – Fully underway/over the hump
  – Nearing completion/done
  – Not applicable (not a HIPAA covered entity)
Eligibility & Claim Status Operating Rules
Top FAQs – What Are Implementers Asking?
Compliance, Applicability, Real-time/Batch

- Are exemptions available for HIPAA covered entities that complete implementation of the mandated CAQH CORE Eligibility & Claim Status Operating Rules after January 1, 2013?
- Do the certification compliance requirements differ by health insurance plan type (e.g., self-funded vs. fully insured) or number of covered lives?
- If they do not currently use these transactions, are health plans required to implement the X12 270/271 and X12 276/277 transactions as part of ACA Section 1104 compliance?
- What if my organization doesn’t offer real-time?
- What is the date on which HHS may check compliance of provider vendor systems?

Ask your Compliance Question at the CAQH CORE “Open Mic” Q&A Session with CMS OESS staff
December 13, 2012
3:30 PM ET – 5:00 PM ET
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>III</td>
<td>D</td>
<td>5</td>
<td>How much does Voluntary CORE Certification testing cost?</td>
</tr>
<tr>
<td>IV</td>
<td>D</td>
<td>6</td>
<td>Does CAQH CORE Rule 152 require HIPAA covered entities to publish a companion guide if they do not currently do so?</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>H</td>
<td>7</td>
<td>How should the X12 270/271 transactions be tracked throughout a system/application to demonstrate conformance with the response time requirements specified in CAQH CORE Rule 156?</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>
<tr>
<td>IV</td>
<td>N</td>
<td>40</td>
<td>How should entities track the X12 270/271 and/or X12 276/277 transactions when using another connectivity method, as permitted by the CAQH CORE Connectivity Safe Harbor?</td>
</tr>
</tbody>
</table>
FAQs: Infrastructure Operating Rules

Response Time Requirements

- 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.

CAQH CORE Rules 156 & 250

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.
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.
Trading Partner Testing and Collaboration
Providers, health plans and clearinghouses work together in a variety of ways to exchange transaction data.

The scope of an entity’s mandated operating rules implementation project will depend upon the electronic data flows between trading partners; understand your agreements.

Vendors play a crucial role in enabling provider clients to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them.
Testing and Certification: Trading Partner Listing and Voluntary CORE Certification

- Testing with your trading partners is a critical aspect to making your operating rules implementation a success
  - HIPAA covered entities can quickly communicate their organization’s readiness* to testing their conformance with trading partners by adding their company information to the CORE Partner Testing page of the CAQH website
  - *If you are ready to test with trading partners, take 5 minutes and add your organization to the CAQH CORE list!

- Since its inception, CAQH CORE has offered a voluntary CORE Certification to health plans, vendors, clearinghouses, and providers
  - Learn more about voluntary CORE Certification here
  - Voluntary CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules

* Includes other key IT system/service vendors that support them, such as Practice Management Systems
Campain to Drive Final Awareness of January 1, 2013 Deadline and CAQH CORE Implementation Resources

- **Goal**: In final month, build awareness among HIPAA covered entities not currently engaged.
  - **Templates for Electronic Communications**: Activate your third party channels by making available website copy, e-newsletter copy, social media messages;
    - Messages highlight that there is now access to patient insurance information in real-time, which enables providers to make informed decisions about treatment options and reduces administrative burdens
    - Templates can be accessed for use [HERE](#) - edit/use as your organization wants
  - **Web Ads**: Web-based digital banner ads with a clear call-to-action will be seen on a range of targeted healthcare trade websites and newsletters, including:
  - Search Engine Marketing
  - Reinforce call to action through existing CAQH CORE efforts

**Days to the federally-mandated CAQH CORE Eligibility & Claims Status Operating Rules Implementation Deadline**

Learn more about CAQH CORE resources available to help your organization meet the Patient Protection and Affordable Care Act's Jan 1, 2013 operating rule mandate.
Summary: Key Implementation Resources

- Review the CMS FAQs
- 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
- Highlight that are you ready to test with trading partners CORE Partner Testing
- Complete voluntary CORE Certification
  - Contact technical experts as needed at 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 to CQH CORE other tools and/or topics for sessions
Upcoming CAQH CORE Education Sessions

- List of upcoming CAQH CORE Education Sessions available [HERE](#); highlights include below:
  - December 13, 2012: “Open Mic” on January 2013 Deadline – Key Tips and FAQs *(with CMS OESS)* 3:30 PM ET – 5:00 PM ET
  - December 18, 2012: Joint NeHC and CAQH CORE Education Session, *Is Your Organization Ready to Meet the Compliance Deadline?* 3 PM ET - 4:30 PM ET
  - Numerous education sessions to come in 2013 with a focus on EFT & ERA Operating Rules

- Upcoming CAQH CORE Town Hall Calls
  - January 22, 2013, 3-4 PM ET
  - March 12, 2013, 3-4 PM ET

- Listen to past education sessions including:
  - [CAQH CORE and ASC X12 Webinar: Implementing ACA Mandated Operating Rules Related to Eligibility Data Content](#)
  - [CAQH CORE 'Open Mic' Session with CMS OESS: Are You Ready for January 1, 2013?](#)
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 placed in 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
    
    • CAQH CORE developed a [model comment letter](#) for organizations to use as appropriate
  
  – No changes to the HHS IFR have been announced. HHS has publically stated that interim final rules stand as final rules. Entities should be working towards the January 2014 adoption date.

• **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 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 beta and alpha Voluntary CORE Certification Test Site for January 2013 (volunteer to beta test?)
  
  – Launch formal CAQH CORE Code Combination Maintenance Process for the **CORE-required Code Combinations for CORE-defined Business Scenarios for CAQH CORE Rule 360**

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

<table>
<thead>
<tr>
<th>Rule</th>
<th>High-Level Requirements</th>
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</table>
| **Uniform Use of CARCs and RARCs (835) Rule**  
Claim Adjustment Reason Code (CARC)  
Remittance Advice Remark Code (RARC) | • Identifies a *minimum* set of four CAQH CORE-defined Business Scenarios with a *maximum* set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider |
| **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 re-association  
• Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions  
• Requirements for resolving late/missing EFT and ERA transactions  
• Recognition of the role of *NACHA Operating Rules* for financial institutions |
| **Health Care Claim Payment/Advice (835) Infrastructure Rule** | • 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 |

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*CMS-0028-IFC* excludes requirements pertaining to acknowledgements.
CAQH CORE Code Combinations Maintenance Process

- Level Set: *What is already in Section 3.5 of CAQH CORE Rule 360?*
  - Recognizes that the CAQH CORE rule supports the ASC X12 v5010 mandated standard
  - Focuses on four key business scenarios (with associated code combinations) as a starting point
  - Recognizes that the CAQH CORE rule supports code sets that are subject to revision three or more times a year; for the CARCs and RARCs, Code Committees external to the ASC X12 Standards Committee are authors of the published codes and meet at least three times per year
  - Recognizes that CAQH CORE Rule 360 enables immediate use by the industry of new codes added to the code lists since the last adjustments to the CORE-required Code Combinations for the CORE-defined Business Scenarios and prohibits the use of deactivated codes
  - Establishes an open CAQH 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
Two Types of Review and Adjustment

- A CAQH CORE Code Combinations Task Group will convene three times per year to review the CORE-required Code Combinations for the CORE-defined Business Scenarios.
- Two types of review and adjustment to the CORE Code Combinations including:

  **Compliance-based Review & Adjustment**
  - **Goal:** Align CORE-required Code Combinations for the CORE-defined Business Scenarios and the code sets.
  - **Frequency:** Occurs three times/year via Task Group.
  - **Scope:** Only considers updates to the CARC and RARC lists published (occurs three or more times per year) since the last update to the CORE Code Combinations as required by the CAQH CORE Rule 360.
  - Per CMS OESS, Compliance-based Adjustments will be immediately recognized under HIPAA given the CAQH CORE Rule 360 requires that publications from code authors be addressed.

  **Market-based Review & Adjustment**
  - **Goal:** Address ongoing and evolving industry business needs.
  - **Frequency:** Occurs once per year during last Task Group convening.
  - **Scope:** Considers industry submissions based on real world usage data and/or a strong business case addressing:
    - Adjustments to the existing CORE-required Code Combinations for existing CORE-defined Business Scenarios.
    - Addition of new CORE-defined Business Scenarios and associated code combinations.
  - Per CMS OESS, Market-based Adjustments will need to be recognized via a future and evolving Federal CMS OESS HIPAA requirement update process.

**SHORT-TERM GOAL:** By January 2013, issue updated CORE-required Code Combination document due to Compliance-based Adjustments only, which are based on published code updates since initial development of the CORE Code Combinations.
Example: CAQH CORE Code Combinations
Maintenance Process Over One Year

Jan  | Feb  | March | April | May  | June  | July  | Aug  | Sept | Oct  | Nov  | Dec

- Code Committees Meeting
- Code Set Updates Published
- CORE Task Group Compliance Review
- CORE Code Combos Published

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- CORE Task Group Compliance Review
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- Code Committees Meeting
- Code Set Updates Published
- CORE Task Group Compliance Review
- CORE Code Combos Published

- Publishing of any Market-based Adjustments dependent upon Federal update process
- 60-day Industry Submission Period
Mandated Healthcare Operating Rules:
Third Set – Attachments, Prior Authorization, Enrollment, etc.
Third Set of Mandated Operating Rules: Status

- Remaining operating rule mandate, effective January 1, 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 attachments

- 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 to launch
Third Set of Mandated Operating Rules: 
*Share Your Wish List with CAQH CORE*

- **Regulatory alignment**
  - CAQH CORE goal is to create a set of *draft* operating rules by end of 2013; regulation to be issued in mid-2014
    - Q1: Key opportunities identified via research and survey findings, out of scope options; Q2: Potential rule options; Q3: Straw polling; Q4: Draft rules

- **Preparation and planning is underway**
  - Securing expertise and evolving market participation
    - Technical experts identified; relevant new participants have been contacted; recruiting additional staff; surveying and conducting interviews to identify rule opportunities
  - Gaining status of broader environmental factors that will impact process, e.g.
    - Entities that have implemented first mandated set have strong knowledge base – will be essential to the development process
    - As other Federally-driven initiatives ramp up, the critical goal of where and how to align grows, e.g. Connectivity and attachments will require clinical/administrative alignment

**Action Step for Industry**

- All industry stakeholders are encouraged to submit their “*top five*” *wish list items* for the third set of mandated operating rules [HERE](#) or email them to core@caqh.org
- Wish lists items will assist with CORE public surveying on rule options and CAQH CORE Subgroup dialog. Can only list five – please be clear if focus is data content or infrastructure and for which transaction(s) each wish applies
- CORE Participants are encouraged to identify internal subject matter experts to represent your organization on the CAQH CORE Subgroups and Work Groups in 2013
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 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 consider future funding options beyond CAQH
  - The Transition Committee has identified nominees
# Draft CAQH CORE Board Composition

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

<table>
<thead>
<tr>
<th>Voting</th>
<th>Non-Voting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan</td>
<td>Hospital</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Broader Care Delivery</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Provider (Proposed by AHA)</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Provider (Proposed by AMA)</td>
</tr>
<tr>
<td>Health Plan (Proposed by AHIP)</td>
<td>Provider (Proposed by MGMA)</td>
</tr>
</tbody>
</table>

## Non-voting Advisors

- **Federal**
  (e.g., CMS OESS)
- **State**
  (e.g., NAMD)

*(One or more from both Federal and state agencies/representative organizations)*

- **CAQH CORE Executive Staff**

- **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.

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

For detail on the new CAQH CORE Board visit [HERE](#)
Thank You For Joining Us: Stay Involved

• Ensure your organization – and that of your trading partners - 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

• Join us at another CAQH CORE Education Event

• Learn the basics of voluntary CORE Certification

• Contact CORE@caqh.org regarding rule interpretations or to submit requests for information/clarification