Committee on Operating Rules 
For Information Exchange 
(CORE®) 

Public Town Hall Call 

March 12, 2013 

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

• Overview of CAQH CORE

• Update on ACA Mandated Healthcare Operating Rules
  – First Set: Eligibility & Claim Status Operating Rules
    • Enforcement action begins March 31, 2013
  – Second Set: EFT & ERA Operating Rules
    • New implementation resources
  – Third Set: Attachments, Prior Authorization, Enrollment, etc.
    • NCVHS Attachments Hearing
    • Survey on potential Operating Rule areas

• Update on Other Activities
  – New CAQH Initiatives, Certifications, and Education

• Q&A
Brief Overview of CAQH CORE
CAQH: Current Initiatives

Industry-wide stakeholder collaboration to facilitate development and adoption of industry-wide operating rules for administrative transactions. Over 130 participating organizations.

Service that replaces multiple paper processes for collecting provider data with a single, electronic, uniform data-collection system (e.g., credentialing).

Service that enables providers to enroll in electronic payments with multiple payers and manage their electronic payment information in one location, automatically sharing updates with their selected payer partners.

Objective industry forum for tracking progress and savings associated with adopting electronic solutions for administrative transactions across the industry.
CAQH CORE

- Established in 2005
  - Serving as recognized author of ACA-mandated operating rules
- Mission: Build consensus among healthcare industry stakeholders on 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
  - Ensure the rules can be implemented in phases that encourage feasible progress
  - Facilitate administrative and clinical data integration
  - Do not require dependency on or creation of one centralized database

CAQH CORE carries out its mission based on an integrated model

Research and Develop Rules (based on key criteria)

Design Testing and Offer Certification

Build Awareness and Educate

Provide Technical Assistance, e.g., free tools, access to Early Adopters Base

Promote Adoption

Track Progress, ROI and Report

Maintain and Update

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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.

Operating Rules: Key Components

- Rights and responsibilities of all parties
- Security
- Exception processing
- Transmission standards and formats
- Response timing standards
- Liabilities
- Error resolution
ACA Mandated Operating Rules Compliance Dates:
Required for all HIPAA Covered Entities

Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Compliance in Effect as of January 1, 2013

• Eligibility for health plan
• Claim status transactions
  
  HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules

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

Rule requirements available.
Mandated Healthcare Operating Rules: First Set - Eligibility & Claim Status
**Mandated Eligibility & Claim Status Operating Rules:**

**Scope – Effective as of 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: Eligibility</strong></td>
<td>Need to drive further industry value in transaction processing</td>
<td>More Robust Eligibility Verification Plus Financials</td>
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<tr>
<td></td>
<td></td>
<td>Enhanced Error Reporting and Patient Identification</td>
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<tr>
<td><strong>Infrastructure: Eligibility and Claim Status</strong></td>
<td>Industry needs for common/accessible documentation</td>
<td>Companion Guides</td>
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<td></td>
<td></td>
<td>System Availability</td>
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<td></td>
<td>Industry-wide goals for architecture/performance/connectivity</td>
<td>Response Times</td>
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<tr>
<td></td>
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<td>Connectivity and Security</td>
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</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, per the Interim Final Rule.*

**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

Acknowledgements*

**Enforcement Action Begins**

March 31, 2013
**ACA Federal Compliance Requirements: Highlights & Key Dates**

*Three dates* are critical for 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>
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<tbody>
<tr>
<td><strong>Dates</strong></td>
<td>First Date January 1, 2013</td>
<td>Second Date December 31, 2013</td>
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<tr>
<td></td>
<td>Compliance Date</td>
<td>Health Plan Certification Date</td>
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<td>Enforcement Date Extension</td>
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<tr>
<td></td>
<td>March 31, 2013^4</td>
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</tr>
<tr>
<td><strong>Description</strong></td>
<td>Who: All HIPAA covered entities</td>
<td>Who: Health plans</td>
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<td></td>
<td>Action: Implement CAQH CORE</td>
<td>Action: File statement with HHS</td>
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<tr>
<td></td>
<td>Eligibility &amp; Claim Status</td>
<td>certifying that data and information</td>
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<tr>
<td></td>
<td>Operating Rules</td>
<td>systems are in compliance with the</td>
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<tr>
<td></td>
<td></td>
<td>standards and operating rules^2</td>
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<tr>
<td><strong>Applicable Penalties</strong></td>
<td>Amount: Due to HITECH, penalties</td>
<td>Amount: Fee amount equals $1 per</td>
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<td>for HIPAA non-compliance have</td>
<td>covered life^3 until certification is</td>
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<td></td>
<td>increased, now up to $1.5</td>
<td>complete; penalties for failure to</td>
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<td>million per entity per year</td>
<td>comply cannot exceed on an annual basis</td>
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<td>an amount equal to $20 per covered life</td>
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<td></td>
<td></td>
<td>or $40 per covered life for deliberate</td>
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<tr>
<td></td>
<td></td>
<td>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](http://www.cms.gov) 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](http://www.caqh.org) 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

4 Per the [Jan 2, 2013 CMS OESS announcement](http://www.cms.gov) of the 90-day Period of Enforcement Discretion for Compliance with Eligibility and Claim Status Operating Rules.
Compliance with Eligibility & Claim Status Operating Rules: 90-Day Period of Enforcement Discretion

- On January 2, 2013, CMS OESS* announced a 90-Day Period of Enforcement Discretion to reduce the potential of significant disruption to the healthcare industry.
- Enforcement action will begin March 31, 2013 with respect to HIPAA covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the mandated Eligibility and Claim Status Operating Rules.
- OESS began accepting complaints associated with compliance beginning January 1, 2013.
  - Covered entities that are the subject of complaints (known as “filed-against entities”) must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period.
  - For more information review CMS’s Administrative Simplification Enforcement Tool (ASET), which is a web-based application where entities may file a complaint against a covered entity for potential non-compliance related to Transactions and Code Sets and Unique Identifiers.

* OESS is the U.S. Department of Health and Human Services’ (HHS) component that enforces compliance with HIPAA transaction and code set standards, including operating rules, identifiers and other standards required under HIPAA by the Affordable Care Act.
Polling Question #1: Readiness Profile

• Which answer best describes the status of your organization’s progress toward implementing the mandated January 1, 2013 operating rules?

A. Just started/early phases
B. Fully underway/over the hump
C. Nearing completion/done
D. Not applicable (not a HIPAA covered entity)

(If you are ready to test with trading partners, add your organization HERE: http://caqh.org/COREPartnerTesting.php)
Eligibility & Claim Status Free Implementation Tools

• **If your implementation efforts are just getting started (Note: entities should be beyond this point given January 2013 compliance date):**
  – Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules: Provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis & planning

• **If your implementation is fully underway or nearing completion:**
  – Education Sessions: CAQH CORE holds frequent sessions with partners such as WEDI, associations, and Medicaid workgroups that often include speakers from organizations that have implemented the CAQH CORE Operating Rules
  – FAQs: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website on a regular basis
  – Request Process: Contact technical experts as needed at CORE@caqh.org

• **If your implementation is complete or nearly complete:**
  – Voluntary CORE Certification: Phase I & Phase II
    – 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

• **CORE Operating Rule Readiness:** If you are ready to test your implementation of operating rules with trading partners, then, **take 5 minutes** and tell others about your readiness
Mandated Healthcare Operating Rules:
Second Set - EFT & ERA
Mandated EFT & ERA Operating Rules

- **EFT Standard**: July 2012 CMS announces CMS-0024-IFC is in effect adopting the NACHA ACH CCD plus Addenda Record (CCD+) and the X12 835 TR3 TRN Segment as the HIPAA mandated healthcare EFT standard
  - Health plans are required to offer providers the ability to send claim payment via the healthcare EFT standard

- **EFT & ERA Operating Rules**: August 2012 CMS published an Interim Final Rule with Comment, CMS-0028-IFC; 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*
  - All HIPAA covered entities must be in compliance with the operating rules

*Entities should be actively working to be in compliance by January 1, 2014

* CMS-0028-IFC excludes requirements pertaining to acknowledgements.
CAQH CORE EFT & ERA Operating Rules in Action

Pre- Payment: Provider Enrollment

EFT Enrollment Data Rule
ERA Enrollment Data Rule

Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation

Claims Payment Process

Health Plan

EFT Enrollment Data Rule

ERA Enrollment Data Rule

Stage 1: Initiate EFT

Electronic Funds Transfer (CCD+/TRN)

Payment/Advice (835)

Uniform Use of CARCs & RARCs Rule

Health Care Claim Payment/Advice (835) Infrastructure Rule

Provider

Billing & Collections

Bank

EFT & ERA Reassociation (CCD+/835) Rule

Bank

Treasury

Indicates where a CAQH CORE EFT/ERA Rule comes into play

simplifying healthcare administration
# Mandated EFT & ERA Operating Rules: January 1, 2014 Requirements Scope

<table>
<thead>
<tr>
<th>Data Content</th>
<th>Rule</th>
<th>High-Level Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniform Use of CARCs and RARCs (835) Rule</td>
<td>Rule 360</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** | Rule 380 | - Identifies a maximum set of standard data elements for EFT enrollment  
- Outlines a flow and format for paper and electronic collection of the data elements  
- Requires health plan to offer electronic EFT enrollment |
| ERA Enrollment Data Rule | Rule 382 | - Similar to EFT Enrollment Data Rule |
| **EFT & ERA Reassociation (CCD+/835) Rule** | Rule 370 | - 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** | Rule 350 | - 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 |

* [CMS-0028-IFC](#) excludes requirements pertaining to acknowledgements.
Example: CAQH CORE Uniform Use of CARCs and RARCs Rule - Four Business Scenarios

Pre CORE Rules

- 800+ CARCs
- 300+ RARCs
- 4 CAGCs

Post CORE Rules

- Inconsistent Use of Tens of Thousands of Potential Code Combinations

Four Common Business Scenarios

1. **CORE Business Scenario #1:** Additional Information Required – Missing/Invalid/Incomplete Documentation (≈470 code combos)
2. **CORE Business Scenario #2:** Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim (≈300 code combos)
3. **CORE Business Scenario #3:** Billed Service Not Covered by Health Plan (≈330 code combos)
4. **CORE Business Scenario #4:** Benefit for Billed Service Not Separately Payable (≈30 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios.
CORE-required Code Combinations v3.0.1 January 2013: Updated Version Available for Implementation

• Background
  – The CAQH CORE Code Combinations Maintenance Process requires the CORE-required Code Combinations for the CORE-defined Business Scenarios be updated to align with the current published CARC and RARC lists which are maintained by external Code Committees (and updated at least three times per year) no less than three times annually

• Status
  – CORE-required Code Combinations for the CORE-defined Business Scenarios v3.0.1 January 2013 is now available on the CAQH CORE website for use with CAQH CORE 360 Rule

• Next Steps
  – Version 3.0.1 is the first of regular version updates to the CORE Code Combinations for use with CAQH CORE 360 Rule; HIPAA covered entities should have a process to implement the CORE Code Combination updates on a regular basis
  – The next Compliance-based review will be held this spring based on the March 2013 published CARC and RARC lists

• FAQs
  – Click HERE for a list of FAQs related to the CAQH CORE Code Combinations Maintenance Process
CAQH CORE Analysis & Planning Guide: EFT & ERA Operating Rules

- The new Analysis and Planning Guide provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis and planning for implementation of the CAQH CORE EFT & ERA Operating Rules.

- Guide should be used by project staff to:
  - Understand applicability of the CAQH CORE Operating Rule requirements to organization’s systems and processes that conduct the EFT and ERA transactions.
  - Identify all impacted external and internal systems and outsourced vendors that process EFT & ERA transactions.
  - Conduct detailed rule requirements gap analysis to identify system(s) that may require remediation and business processes which may be impacted.

- The guide includes three tools to assist entities in completing analysis and planning:
  - Stakeholder & Business Type Evaluation
  - Systems Inventory & Impact Assessment Worksheet
  - Gap Analysis Worksheet
**CAQH CORE Analysis & Planning Tools in Guide**

**Stakeholder & Business Type Evaluation**

**Objective:** Understand what aspects of your business and/or outsourced functions are impacted by the CAQH CORE EFT & ERA Operating Rules (e.g., products, business lines, etc.)

**Systems Inventory & Impact Assessment Worksheet**

**Objective:** Understand how many of your systems/products are impacted by each CAQH CORE Operating Rule and understand with which vendors you will need to coordinate.

**Gap Analysis Worksheet**

**Objective:** Understand level of system(s) remediation necessary for adopting each CAQH CORE Operating Rule requirement; results of completed Gap Analysis Worksheet will allow for development of a detailed project plan.
Additional EFT & ERA Implementation Tools

- **CAQH CORE EFT & ERA Operating Rules**: Master your understanding of the ACA mandated EFT & ERA operating rule requirements.

- **Education Sessions**: CAQH CORE holds frequent sessions with partners such as WEDI, associations, and Medicaid workgroups that often include speakers from organizations that have implemented the CAQH CORE Operating Rules.

- **FAQs**: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; new EFT & ERA FAQs will be posted regularly.

- **Request Process**: Contact technical experts as needed at **CORE@caqh.org**.

- **Coming Soon**: **Voluntary CORE Certification Test Site** for conformance testing of the EFT & ERA Operating Rules; jointly offered by CAQH CORE-authorized testing entity Edifecs.
Polling Question #2: EFT & ERA Implementation Challenges

• Which CAQH CORE EFT & ERA Operating Rule does your organization anticipate requiring the greatest amount of resources to implement?

A. CAQH CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule

B. CAQH CORE 360 Uniform Use of CARCs and RARCs (835) Rule

C. CAQH CORE 370 EFT & ERA Reassociation (CCD+/835) Rule

D. CAQH CORE 380 EFT Enrollment Data Rule & CAQH CORE 382 ERA Enrollment Data Rule

E. Not applicable (not a HIPAA covered entity)
Mandated Healthcare Operating Rules:
Third Set – Attachments, Prior Authorization, Enrollment, etc.
Third Set of Mandated Operating Rules

Effective Date of January 2016

- The remaining ACA-driven operating rule mandate 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
Process to Develop Operating Rules: *Timeline*

- **Q3 2012:**
  - CAQH CORE recommended as operating rule author by HHS.

- **Q4 2012 / Q1 2013:**
  - Build industry awareness of upcoming option to participate in rule writing, ACA goals, CORE Guiding Principles and existing CORE operating rules; assisted by partners, e.g., AHA, Medicaid groups, WEDI, SDOs, CMS OESS, CORE Town Hall.
  - Conduct environmental assessment, e.g., research key opportunities, identify out of scope items; issue White Paper.

- **Q2 2013:**
  - Launch Subgroup to review, develop and agree on potential rule options and seek input from Work Group and public channels.

- **Q3 2013:**
  - Subgroup continues its work, Work Group/public channels continue to provide feedback; update NCVHS.

- **Q4 2013:**
  - Detailed draft rule requirements prepared for formal Work Group ballot in preparation for full CORE vote.

- **Q1 2014:**
  - Operating rules forwarded to CMS OESS.
Recent CAQH CORE Testimony to NCVHS: Attachments

- This February, the National Committee on Vital and Health Statistics (NCVHS), the key advisory body to HHS on HIPAA-related regulations, had its Subcommittee on Standards hold a hearings on Attachments.
  - Testimony relating to Attachment standards and operating rules given by SDOs, industry stakeholders, government entities, and operating rule author

- CAQH CORE testimony is available HERE. The testimony addressed:
  - Relationship between standards and operating rules
  - Process to develop operating rules for attachments
  - CAQH CORE research and findings to date, e.g.
    - 40+ interviews
    - Participation in other national initiatives
    - Dialog with SDOs
    - Alignment with large scale adoption programs, e.g. Meaningful Use, esMD
    - Public survey
    - Analyze of RARC and CARC code usage for describing Attachment issues with claim
  - Preliminary options for operating rules and relevant lessons learned

- Industry is at an early stage of adoption and understanding.
  - Clinical-administrative alignment must be a key evaluation factor as well as flexibility to recognize evolving methods.
Summary of February 2013 CAQH CORE Testimony to NCVHS on Attachments

- Research findings highlighted current industry status on Attachments use and adoption:
  - **Definition:** Support for defining “attachment” broadly in light of a range of industry efforts, e.g. audit requests for medical records, Meaningful Use (MU) Stage 2, and health reform: ‘Additional information’ supplied by one party for the specific need(s) of another party.
  - **Business Use:** ‘Additional information’ is used in traditional financial/administrative transactions as well as other forms of information exchange.
  - **Formats:** Current formats reflect an industry migration path that is based on market readiness and return on investment (ROI)
    - **Step 1:** Example - US Postal Service
    - **Step 2:** Example - email of Word, PDF, scanned image such as JPG, TIF, many others
    - **Step 3:** Automated structured data such as HL7’s C-CDA delivered through formal data exchange methods such as CAQH CORE Connectivity that support industry-neutral standards (SOAP, digital certificates); see Appendix

Attachments Migration Path

- **Step 1:** Paper
- **Step 2:** Electronic Transmission of Paper
- **Step 3:** Structured Data Exchange
Potential Opportunities for Attachments: Address Migration Path for Standards and Operating Rules

Support migration from paper to electronic submission of paper.

• Examples
  – Address the need for a basic standard for electronic exchange of paper due to business use and ROI, e.g., recognize a limited number of basic platforms for unstructured content such as PDF or TIF.
  – Similar to what has been done with other CAQH CORE operating rules, require that additional information requests and responses be transmitted electronically. Definition of electronic under HIPAA is broad and can support multiple approaches.
  – Use infrastructure-focused operating rules to help standardize, or provide transparency of, logic for when/what/how much additional information will be accepted or is required (unsolicited attachments).
  – Build on the interdependencies with the first two sets of Federally mandated operating rules given the implementation base, e.g., evolve CORE Connectivity and apply as safe harbor.

Also support initial migration from electronic submission of paper to electronic exchange of structured data.

• Examples:
  – Support HL7 C-CDA; start by supporting a very limited number of business scenarios, e.g., medical audits, or selected components of its structured data for claim adjudication issues, e.g., post-operative report, prior authorization. Allow for additional business scenarios when ROI is demonstrated along with alignment with other Federal efforts; address market changes (e.g., bundled payments, ACOs). As with current operating rules, Attachment operating rules can provide ability to add scenarios.
  – Support standardization of code sets and adherence to standards that already exist, e.g., use only up-to-date CPT codes.
  – Encourage a common data model, including data definition standards, as industry develops and uses more structured data, e.g., support beginning stages of standardizing content using LOINC Attachment Type codes.
CAQH CORE Public Survey of Potential Operating Rule Opportunity Areas for Third Set

- Survey asked for top industry priorities that met definition of operating rules.
  - Reminder: Survey did not provide options, rather industry provided its priorities
- Over 170 unique entity registrants; over 70 entities representing a wide range of stakeholder types provided detailed priorities.
  - Open for two months; 33% of respondents were providers, 37% health plans; 54% of total respondents were non-CORE participants
  - Health Claims or Equivalent Encounter Information had wide range of ideas; industry use of Health Plan Enrollment/Disenrollment mixed.
- For all transactions, ideas provided for both data content and infrastructure operating rules.
  - Examples of data content
    - Health Claims or Equivalent Encounter Information (ASC X12 837): Include trace numbers and matching criteria.
    - Health Plan Enrollment/Disenrollment (ASC X12 834): Standardize error reporting to reduce manual operational costs in membership systems.
    - Referral Certification and Authorization (278): Standardize data content and qualifiers, including uniform use of response codes.
  - Examples of infrastructure
    - Health Claims or Equivalent Encounter Information (ASC X12 837): Ensure that all payers can accept coverage electronically in situations of COB, not just primary coverage and require acknowledgements
    - Health Plan Enrollment/Disenrollment (834): Require an electronic enrollment solution be offered and support CAQH CORE Connectivity safe harbor.
Follow-up CAQH CORE Public Survey of Potential Operating Rule Opportunity Areas for Third Set

• CAQH CORE will publish results of the first survey.
  – Results will include all submitted industry priorities that:
    • Meet definition of operating rules
    • Address the transactions in the third set of ACA-driven operating rules
• As with other CAQH CORE operating rules, a follow-up survey will be issued to receive feedback on provided priorities/options plus receive any additional ideas
  – Results will be considered by CORE participants as they begin rule development process
  – Second survey to be issued next week; open for three weeks.
How to Contribute to Development of Third Set

• **Entities are encouraged to join CAQH CORE to contribute.**
  – The most effective way for individual organizations to assure they have direct input on the mandated and voluntary operating rules is by becoming a CORE Participating Organization; any entity may join. Cost is extremely low or free. Benefits include:
    • Participation on Subgroup/Work Group calls, straw polls, and eligibility to Chair
    • Entity vote on CAQH CORE Work Group and Full CORE Membership voting levels
    • Access to CAQH CORE Education Sessions specific to CORE Participating Organizations

• **Non-CORE participant can also actively contribute in a range of ways.**
  – **CAQH CORE Town Hall Calls**
    • CAQH CORE holds bi-monthly Town Hall calls which provide attendees an update on recent activities including status of rule development; email core@caqh.org to be added to the distribution list
  – **CAQH CORE Industry Surveys**
    • CAQH CORE periodically conducts industry-wide surveys for directional feedback on operating rule opportunities; email core@caqh.org to be added to the distribution list
  – Attend or listen to NCVHS hearings
  – Submit comments to CAQH CORE or CMS OESS
Update on Non-Rule Development Activities
Voluntary CORE Certification

• 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

• Recently completed Phase I CORE Certifications include:
  – Kaiser Colorado (health plan)
  – Loxogon for Loxogon Alloy (vendor)

• Recently completed Phase II CORE Certifications* include:
  – HealthFusion for HealthFusion® Real-Time (vendor)
  – OfficeAlly for Office Ally Clearinghouse (vendor)
  – RelayHealth for RelayExchange (vendor)
  – Humana (health plan)
  – Rocky Mountain (health plan)

*Entities must complete Phase I CORE Certification prior or concurrent to Phase II.
Two New CAQH Initiatives

• CAQH EFT Enrollment Solution ([http://www.caqh.org/PR201301.php](http://www.caqh.org/PR201301.php))
  – Instead of enrolling individually with each payer, CAQH offers a secure, online system that allows providers to enroll in electronic payments with multiple payers at no cost

• CAQH Coordination of Benefits Solution ([http://www.caqh.org/PR201302.php](http://www.caqh.org/PR201302.php))
  – Creates a source of timely and accurate coverage status, enabling providers to determine primary and secondary coverage for patients who are insured by more than one policy; confusion over insurance status can occur with patients who have lost or changed jobs or have multiple sources of coverage
  – Committed health plans include Aetna, AultCare, BCBS of Michigan, BCBS of North Carolina, BCBS of Tennessee, CareFirst BCBS, Cigna, Health Net, Inc., Horizon Healthcare Services, Inc., Kaiser Permanente, UnitedHealth Group, and WellPoint, Inc., on behalf of its affiliated health plans; together these organizations cover more than 165 million lives
Upcoming CAQH CORE Education Sessions

• Join us for these free CAQH CORE webinars held jointly with:
  – CMS OESS: “The Very Basics of Mandated Operating Rules for Providers”
    • Wednesday, March 20, 2013 from 2:00pm-3:00pm ET
  – ASC X12: “Eligibility and Claims Status Transactions: A Deep Dive”
    • Tuesday, March 26, 2013 from 2:00 pm to 3:30 pm ET
  – NACHA: “Save the Date” for an in-depth look at the EFT Standard and EFT & ERA Operating Rules
    • Tuesday, April 10, 2013 from 2:00 - 3:00 pm ET

• Hear More about Operating Rules at an industry event
  – HFMA Central Ohio, March 14
  – ACAP, March 15
  – GE Centricity Live: 2013, April 14 – April 17
  – NACHA: Payments 2013, April 21 – April 24

• Visit the CORE Education Events page of the CAQH website
  – Access free recordings of previous education events & stay informed of upcoming joint webinars with key partners such as NACHA, ASC X12, vendors and provider associations
Q&A

Please submit your question:
- **By Phone**: Press * followed by the number one (1) on your keypad
- **Via the Web**: Enter your question into the Q&A pane in the lower right hand corner of your screen
Thank You for Joining Us!
Appendix
Federally Mandated CAQH CORE Connectivity Rules: Message Structure

The CAQH CORE Connectivity Rules with metadata is prescriptive to facilitate interoperability of administrative transactions

= Public Internet (TCP/IP).

= HTTP over SSL (HTTP/S); includes security of payload during transmission (X.509 certificate over SSL or TLS; username/password).

= Message Envelope & Message Metadata: Independent of payload; two options for envelope, HTTP MIME Multipart and SOAP + WSDL based on technical criteria and market use.

= HIPAA Administrative Transactions (X12).
  - HL7 Clinical Messages.
  - Zipped Files.
  - Personal Health Record.
  - Other Content.