Testimony Provided to

The Subcommittee on Standards
National Committee on Vital and Health Statistics

CORE Operating Rule Updates and Responses to NCVHS Recommendations on Implementation of the Operating Rule Provisions of the Patient Protection and Affordable Care Act

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Good morning. I am Gwendolyn Lohse, Deputy Director of CAQH®, a nonprofit alliance uniquely focused on simplifying administrative processes in healthcare. I appreciate the opportunity to provide this follow up testimony today to the Subcommittee on Standards of the National Committee on Vital and Health Statistics (NCVHS).

The CAQH Committee on Operating Rules for Information Exchange, or CORE®, was conceived and established by CAQH in 2005 to address the needs of providers and health plans to exchange more robust administrative transactions in real time. CORE is the only national effort solely engaged in the development of operating rules for the facilitation of non-retail pharmacy, administrative healthcare transactions. The CORE Operating Rules are, and have been, created through an open, transparent, quorum-based voting process with a wide range of healthcare stakeholders, including health plans, providers, vendors, associations and standards development organizations (SDOs) such as ASC X12 and the National Council for Prescription Drug Programs (NCPDP). The CORE health plan participants cover more than 150 million insured lives – as well as Medicare and some Medicaid beneficiaries. For additional information on CORE, please see our testimony from your July 2010 meeting on operating rules in relation to Section 1104 of the Patient Protection and Affordable Care Act (ACA).

I am pleased today to update the Subcommittee on those CORE activities that support implementation of the operating rule provisions in the ACA specific to Section 1104. I also will address the NCVHS recommendations, as expressed in its September 30, 2010 letter to Secretary Sebelius, and review recommendations, activities, suggestions and concerns that have been raised since the hearings in July. I will end my testimony with several observations regarding next steps.

First, however, I would like to thank the Subcommittee – as well as the full Committee – for recommending CAQH CORE as the authoring entity for operating rules for non-retail pharmacy Eligibility (ASC X12 v5010 270/271) and Claim Status (ASC X12 v5010 276/277/277CA) transactions. The CORE rules will reduce administrative costs, streamline administrative processes, standardize key business practices, and bring healthcare on par with other industries by leveraging the power and opportunities created by truly interoperable electronic communications and transactions.

General CORE Update

I am now pleased to update the Subcommittee on CORE's progress in achieving administrative simplification, as well as supporting various federal mandates beyond those recommended by NCVHS in its September 30th letter.

HIPAA v5010. The CORE Rules are helping position organizations exchanging electronic administrative information for the v5010 requirements. In fact, throughout 2006 - 2009 the CORE Phase I and II Rules were written in anticipation of v5010 requirements that will take effect at the start of 2012. As a result, the v5010 updates to the CORE Rules require only minor changes, and in some cases a number of the CORE requirements for data content will now be mandated under v5010, as operating rules do not repeat what is addressed in the standard. For

example, the CORE operating rules remove rule requirements for coverage status of nine service type codes once v5010 takes effect, as these requirements will be mandated by HIPAA. This reflects the ability of operating rules and standards to work together as the industry evolves, and it is already happening today.

Starting in April 2010, the CORE Rules Work Group reviewed the summary of v5010 revisions. A summary of the revisions, as well as the detailed edits to the Phase I and II operating rules, are available to the public via the CAQH website. ASC X12 participates on the Work Group, and recently reviewed the summary and edited rules (a Status Summary of these discussion will be provided at the Hearing). CORE will publish the revised CORE Phase I and II Rules later this year, with the full understanding that entities are not required to use v5010 until January 2012. Adjustments are also being made to the CORE testing process to support the v5010 environment. To that end, Edifecs, a CORE-authorized testing vendor that performs both Phase I and II testing, will have a beta tested v5010 CORE testing site available to the public by December 31, 2010. CORE is among the few entities that have had wide public reviews of v5010 updates.

CORE Rules Support for HIPAA Standards as Well as Other Standards. Since its inception, CORE has had a Guiding Principle that a CORE rule does not repeat what is already required (mandated) by a federally recognized standard. CORE support for the ASC X12 standards is a good example of this principle. As noted above, the Phase I and Phase II Operating Rules were updated to remove requirements that are now required (mandated) by v5010 once it becomes effective in January 2012 – this existing relationship between operating rules and standards demonstrates how the industry can move forward by working together. Furthermore, even before v5010 was required, all draft Phase III Operating Rules were written based on v5010 of the ASC X12 standards, and not v4010. CAQH CORE and NCPDP recently agreed to develop a Memorandum of Understanding, and discussions with CAQH CORE staff and ASC X12 are ongoing. CAQH CORE staff continues to attend all ASC X12 meetings and calls.

Per our July testimony, the CORE rules embrace HIPAA standards as well as industry neutral standards, and non-HIPAA mandated standards (see July 2010 Testimony for examples). CORE does not replicate or test for HIPAA requirements. Rather, CORE focuses on requirements that are complementary to HIPAA to address the goal of administrative simplification. These complementary rules include the use of SOAP web services, real-time infrastructure requirements, or use of such non-HIPAA mandated data elements such as delivering year-to-date financials. The CORE Phase II Rules build on the Phase I Rules, with additional rules for patient accumulators, real-time claims status and further connectivity. The Phase II Rules also require – supporting further use of the ASC X12 standards – the delivery of patient financial responsibility for an increased number of service codes. While neither v4010 nor v5010 require these data elements be provided electronically, the standard, notably, does provide the format by which the industry could send the information. CORE is supporting their use in a uniform manner. As discussed in detail below, CORE recently solicited suggestions from a wide range of stakeholders for enhancing the Phase I and II Rules per the NCVHS letter. Based on this outreach, as well as the growing number of CORE certifications, industry interest in accelerating adoption is high.

Adoption of CORE Rules Continues. CORE is a dynamic and growing organization. Its activities continue to focus on development, adoption and certification of operating rules across healthcare. Currently, over 85 million Americans are being impacted by CORE certifications, and that number continues to grow as more entities become certified. Commitments to CORE certification include United Healthcare, which is completing its Phase I/II testing this month, and three vendors, including a GE product and Health Trio. Kaiser Permanente recently informed CAQH of its intention to become a participant, and banks have joined CORE based on their understanding that NACHA (the Electronic Payments Association) and CAQH CORE are working closely together on administrative simplification for healthcare. Education and outreach continue with such entities as Workgroup for Electronic Data Interchange (WEDI) and the Healthcare Information and Management Systems Society (HIMSS). Tracking the impact of CORE rule adoption is also moving forward; a number of providers have approached CORE regarding their intention to communicate the need for providers and vendors to become certified and track ROI.

Finally, much of the CORE work on the draft Phase III Rules continues to be valuable to industry discussions; especially with those entities that are ready to go beyond CORE Phase I and II certifications. These draft rules include Claim Status data requirements, infrastructure support for Remittance and Prior Authorization/Referral, expanded financial reporting for Eligibility, support for a standard set of human readable data elements for Health Plan Insurance ID Cards (supporting aspects of a WEDI guide), and more prescriptive connectivity requirements. All of the draft Phase III Rules have been recommended by their respective Work Groups and Subgroups for a final CORE vote, with the exception of Connectivity. This rule development work continues to support milestones that align with Federal efforts, and thus its respective CORE Subgroup is looking to the NCVHS for its recommendations in this arena as the Subgroup wishes to create a "Base" and "Advanced" Connectivity option for the market.

Responding to NCVHS Recommendations

I now would now like to respond to the NCVHS recommendations as set forth in its September 30, 2010, letter to Secretary Sebelius; as well as address concerns and suggestions made by the industry regarding CORE since the hearing in July.

Increased Involvement With States and State Medicaid Programs. CORE shares the Committee's vision and appreciates its recommendations to increase the involvement of states and state Medicaid programs in the CORE Operating Rule development and certification processes. We believe that the CORE integrated model – operating rule development, education and outreach, and certification – supports state-based visions for administrative data exchange, economies of scale and a path for infrastructure development. I am pleased to update the Subcommittee on recent work with the states.

State Involvement. Several states have demonstrated interest in learning more about the CORE Operating Rules. CORE has reached out to these and other states to discuss how it can work collaboratively to determine how existing state rules – which in the majority of cases are extremely similar to the CORE Rules – could be embraced by CORE. Emphasis in CAQH outreach was placed on states that commented to NCVHS during the July hearings, as these

states have some of the most formalized processes for administrative data exchange in place today:

- *Washington State*. CORE and the state of Washington voluntary initiative conducted a comparison of rules to identify commonalities. This analysis was made available to the Washington State Work Group focused on administrative operating rules. The state of Washington has been very engaged in the Phase I and II potential enhancement discussions that occurred based on the NCVHS request, and Washington State has communicated its support for adding several of the draft CORE Phase III Rules to the first set of mandated operating rules.

- *Minnesota.* CAQH CORE staff has had ongoing discussions with Minnesota. As with Washington State, a comparison of the CORE rules and the Minnesota state-based rules revealed significant similarities. One rule in Minnesota not originally addressed by CORE – a patient search and match logic requiring the use of the ASC X12 data fields – has been considered during the Phase I and II enhancement discussions over the last several weeks. Links to this specific Minnesota Rule were included in an open, online survey to capture feedback on potential enhancements to the CORE Phases I and II operating rules. Debate on this potential rule continues. On a recent CORE call, Medicare shared concerns it has in immediately requiring the use of this rule for the first set of ACA operating rules.

- *Several states, including Colorado, Ohio, Texas and Virginia,* have expressed interest in directly supporting the CORE Rules rather than developing state-specific rules or a state-specific effort. Of note are the results in Colorado. Effective October 1, 2010, carriers licensed in Colorado as of September 1, 2012 must "show the ability of their systems to allow real time data exchange including benefits eligibility, coverage determinations, and other appropriate provider-carrier transactions and interoperability following all CORE guidelines for data formats and system requirements." Carriers are required to become CORE Phase II certified within one year of completing certification for CORE Phase I. The new regulation also requires all carriers and providers to uniformly use the CORE rules in the exchange of HIPAA compliant healthcare information and infrastructure improvements.

- *State representation:* As part of our NCVHS follow-up, CORE is establishing a Transition Committee (see below and Appendix A) that will consider how to transition CORE governance, given the move from a voluntary to a mandated environment. Representation from the states on this Committee is viewed as essential; therefore two positions will be included. State representatives have emphasized that the Transition Committee needs to be comprised of executive-level individuals who can commit their states to participating on a new CORE Governing Board that will consider the evolving world of health information exchange (HIE) and its overall goals to improve quality, reduce costs, and connect clinical and administrative efforts.

- *Base versus ceiling:* The CORE rules have always been a base and not a ceiling – the CORE Guiding Principles specifically outline this concept to promote innovation. NCVHS will hear that several states want the flexibility for state-based operating rules to

go above and beyond the national rules so that innovative efforts can continue at a state level. CAQH CORE supports that innovation. However, it also supports the goal of a national set of mandated operating rules, understanding that both state and national pilots, and voluntary efforts, can add value and expedite future rule writing.

CORE Interactions with State Medicaid Agencies. CORE is committed to continued collaboration with and outreach to state Medicaid programs. Emphasis has been on partnering with the Centers for Medicare and Medicaid Services (CMS) in the refinement of its Medicaid Information Technology Architecture (MITA). MITA was created to foster integrated business and IT transformation across the Medicaid enterprise to improve Medicaid program administration. The collaboration between MITA and CORE has the common goal of ensuring that Medicaid information systems are aligned with industry needs and objectives regarding administrative simplification. This was recently highlighted in a presentation at the September 2010 CAQH Administrative Simplification Conference by Rick Friedman, Director, Division of State Systems, CMS/Medicaid, CHIP and Survey & Certification. Similarly, CORE has made presentations to the MITA Technical Advisory Committee (TAC) regarding shared goals and objectives and collaborative efforts. The collaboration was further showcased during the 2010 HIMSS annual meeting, at which there was a MITA demonstration that included CORE Phase II Rules. A similar demonstration is being planned for the 2011 HIMSS Conference. CORE also has reached out to the National Medicaid EDI Healthcare (NMEH) Workgroup regarding the review of potential enhancements to the Phase I and II Rules per recommendation from NCVHS.

The CORE focus on, and collaboration with, Medicaid is demonstrated in the area of certification. Vendors and health plans serving Medicaid managed care continue to become CORE certified, and CORE-certified entities continue to apply the CORE rules to their Medicaid transactions, e.g., WellPoint – a CORE-certified health plan – serves over ten state Medicaid agencies. HIEs are also reviewing the concept of CORE-certification work with Medicaid agencies, based on provisions in the recent HITECH section of the stimulus legislation. Moving forward, coordination with NMEH and individual state Medicaid agencies, a number of which participate in CORE, will be increasingly important.

Potential Enhancements to CORE Phase I and Phase II Rules. In its September 30th letter, NCVHS suggested that CORE consider enhancements to its Phase I and II Rules that would further address the needs of states and providers. In the *44 working days* between the NCVHS recommendation letter and the December NCVHS hearings, CORE has undertaken a number of activities to address the Committee recommendations. These include:

Enhancement Identification. CORE staff first reached out to the states to receive their input on how the CORE Phase I and II Rules could be enhanced. One result of this outreach was a detailed comparison of state rules and CORE Rules, with a focus on the Minnesota mandated approaches. Provider associations were also informed that discussions would be held, and a number of them issued announcements to their list-serves. Next, stakeholders – CORE and non-CORE – were given the opportunity to suggest potential enhancements to the Phase I and Phase II Rules. This feedback occurred in several ways.

An electronic survey was developed and made available through the CAQH website to capture suggestions and organize them, so that they could be discussed on the calls.[1] The survey deadline was extended more than a week beyond the "Tiger" Calls that were scheduled to review the survey results. The aim was to engage as wide a range of stakeholder input as possible. Teleconferences sponsored by the CORE Rules Work Group were held on November 11th and 12th to review the survey results, as the results primarily related to rules assigned to this CORE Work Group, e.g., more financial data for eligibility inquiries. These calls were open to all CORE participants, as well as non-participants. The calls were widely publicized: through the CAQH list-serve participants and website; through announcements at meetings, such as an in-person WEDI meeting; through stakeholders, such as the AMA; and through the CMS, which provided the call-in information to association representatives and asked them to get the word out through their networks. The goal was to engage as wide a range of stakeholder input as possible – within a very compressed timeframe. Over 65 organizations joined these calls or completed the survey, representing a mix of public/private, providers, health plans, associations, states, vendors, SDOs, and others. Given the compressed timeframe, focus was placed on enhancements related to Eligibility and Claim Status that were already well developed by CORE, states or other organizations. Both CORE participants and non-participating organizations were asked to vote for, or against, inclusion of each enhancement, understanding both the timeframe and the existing Phase I and II Rules scope. Survey respondents were also provided the opportunity to write-in additional enhancements to be considered.

Based on the survey results, fourteen major candidate suggestions were reviewed in detail on the Tiger Calls:

- Nine related to Eligibility and Benefits;
- Five related to Claim Status; and
- Several write-ins were also received, primarily related to expanding potential rules already on the survey.

Roughly half of the fourteen items were already included in the draft CORE Phase III Rules, while most of the other candidate rules would need to have rules written before they could move forward through the CORE voting process. For example, the ongoing CORE support for acknowledgements which were available in the draft CORE Phase III Rules were included; and the State of Minnesota search and match criteria was placed on the survey with some detail on potential caveats received by Minnesota-based entities. A list of the potential enhancements and their status at the time of this written testimony is included in Appendix B.

Balloted Enhancements. After reviewing the Tiger Call and survey results, the Rules Work Group agreed to ballot six major potential rule enhancements for vote. It is important to highlight:

- There were more enhancements related to Claim Status – four of the six – on the final ballot, as CORE Phase II requires only infrastructure for Claims Status.
- The primary ballot items for Eligibility related to more service type code financials.

[1] A copy of the survey and results are available on the CORE website at http://www.caqh.org/CORE_feedback.php

- The items excluded from the ballot were those for which no operating rule existed or more work was needed on the suggested enhancement. For example, the WEDI/ASC X12 Companion Guide was placed on the survey. The WEDI/ASC X12 Guide contains three templates for a Companion Guide rather than the one template in the current CORE Rule, so a direct rewrite of the current CORE Rule could not be accomplished. Only two of the three templates were published at the time of the survey, but a note was added to the ballot to determine if there was interest to further review the Guide. All other questions on the survey requested support/non-support/abstention for existing operating rules.

The result of the Rules Work Group Ballot will be shared with NCVHS on December 3rd, as final results are not available upon submission of this Testimony. Overall, many of the draft Phase III Rules – which took CORE participants eight months to write and approve for vote – were the rules most supported for inclusion in the ballot. Many of these areas complement areas focused on by the states, such as delivery of more financials and uniform approaches to Claim Status delivery.

In addition to the work by the Rules Work Group, the CORE Technical Work Group reviewed an enhanced Phase II Connectivity Rule developed by the Connectivity Subgroup. This enhanced rule included primarily minor changes, as well as a reference to TLS for transport security to address feedback from Medicare and ongoing draft Phase III Rule discussions on the evolution from SSL to TLS. NCPDP input during the SSL-TLS discussions was invaluable based on their work with e-prescribing. Results of the CORE Technical Work Group Ballot will also be shared on December 3rd. It is important to highlight that the Connectivity discussions demonstrate:

- The significant agreement on how operating rules need to be aggressive given the evolving world of health information, such as connectivity and authentication, while also recognizing market maturity.
- Milestones regarding connectivity and authentication, such as the Phase II CORE Connectivity Rule, are critical to success. Such milestones provide the industry a direction and a foundation on which to build.
- The Safe Harbor concept in the CORE Rule allows for existing connectivity methods to be maintained, while also encouraging entities to expand skill sets focused on this quickly evolving area that has been, and continues to be, embraced in daily data exchange.

Overall, CORE made substantial efforts *in a very short period of time* to identify and vote on potential enhancements to CORE Phase I and II. Some entities were not comfortable in working within the compressed timeframes, or adding more rules; while others clearly expressed strong interest to add enhancements. At the time of this written testimony, CORE voting on the enhancements is not completed. CORE will look to NCVHS and HHS as to whether CORE should complete its layered voting process beyond that which has already occurred by the Work Groups. The next step would be a review by the CORE Steering Committee, and then rules are finalized with an all-CORE vote on (for or against) the total package of enhancements. These additional steps would most likely take a few weeks should CORE continue to work under a compressed timeframe rather than its expeditious, but longer, process.

Provider Outreach: Rule Writing and Adoption. CORE supports involving a wider range of stakeholders in the CORE Operating Rules process – e.g., health plans, vendors/clearinghouses/ practice management systems, and providers. These stakeholders also need to be included in rule adoption efforts. Because of their critical importance, emphasis has been placed on provider outreach, and CORE is considering a range of innovative ways to solicit input. For example, AMA and MGMA have included CORE certification as a suggested requirement for providers to look for when selecting a practice management system (PMS). CAQH, AMA and MGMA have agreed to collaborate on outreach to the top five PMSs that are not yet CORE-certified. In addition, AMA has issued a copy of the survey on potential CORE Phase I and II rule enhancements to its membership. There also will be a webinar with the AMA on December 2nd to review CORE with its State Federation Staff, and a CAQH-WEDI audiocast also on December 2nd to hear from entities that have been Phase II certified or are completing testing. AHA joined the Tiger Calls, and has now become a CORE participating organization. Several other provider organizations have approached CORE about assisting with ROI studies that are specific to provider impact. CORE is determining how IBM, which CORE retained to track operating rule ROI, can assist these provider organizations with their measures of success. CAQH has recently retained a new staff member to assist with provider outreach, given its importance and the amount of effort necessary to be effective. Finally, it is important to note: *Achieving greater provider adoption could be greatly expedited if Stage 2 of HITECH Meaningful Use includes a requirement for the ACA operating rules. CAQH CORE hopes NCVHS will consider this in its recommendations.*

Implementation Concerns.

Companion Guides. The Committee expressed concerns at the July hearing regarding companion guides, and clearly stated in its September 30th recommendation letter that it did not wish to encourage the perpetual use of companion guides, although it did acknowledge their limited need in certain cases. CAQH CORE shares the NCVHS view, as operating rules encourage a significant reduction in variation in companion guides by providing an industry set of operating rules to which companion guides can point – this is done in other industries and can be achieved in healthcare. State work on operating rules also demonstrates the role that they can play to greatly reduce the use of companion guides. Any suggestion that operating rules are unnecessary, or should be incorporated into implementation guides instead of adopted as required by Congress, does not acknowledge the clear intent of Section 1104. Congress has plainly and unequivocally mandated that the Secretary "shall adopt a single set of operating rules for each transaction" adopted under HIPAA "with the goal of creating as much uniformity in the implementation of the electronic standards as possible." [2] With a common format for companion guides, which is one of the existing CORE Rules, as well as the detailed operating rules for infrastructure and content, the industry is supporting the stated NCVHS goal and the ACA intent.

Standards and Operating Rules. In July, testimony was received from ASC X12 regarding potential conflicts between the CORE Operating Rules and the standards. Some have argued that operating rules cannot affect the content of the standard transactions. The Statute does not support this argument. Indeed, the statute actually states the opposite because it specifically contemplates that operating rules will address data content. The Statute notes that both the standards and associated operating rules adopted by the Secretary shall "to the extent feasible

[2] Social Security Act (SSA) § 1173(g)(1), added by ACA § 1104(b)(2)(C).

and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care" and "provide for timely acknowledgement, response, and status reporting...". [3] Additionally, it states that both must "describe all data elements . . . in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse)." [4] Finally, the statute expressly requires that the non-profit entity authoring the operating rules must be an entity that "builds on the transaction standards issued under [HIPAA]." [5]

It is true that operating rules may not "conflict with" and must be "consistent with" the adopted standard to which they relate. The CORE Operating Rules do not re-define or constrain requirements in the implementation guides for the standards, or add, modify or delete any requirements. Rather, the CORE Operating Rules and resulting data content delivery add value to the use of the standards across the industry in a manner that, according to numerous technical experts serving on CORE Work Groups as well as the range of CORE-certified entities, is consistent with the requirements of the standards. The operating rules are bolstering adoption of the standards. The integration of operating rules, including voluntary certification, into the fabric of the industry is a change – but one that public and private stakeholders have been embracing for years.

CORE is eager to work with all stakeholders to assist both NCVHS and HHS in carrying out this statutory mandate. For example, CAQH CORE staff has held several calls with ASC X12 leadership to discuss discrete areas of concern held by the leadership with the goal of achieving resolution. Operating rules cannot move forward, however, without acknowledging and embracing the statute's language and its requirements for the development of operating rules.

Future goals for the timing of Operating Rules and Standards must be considered. The last five years of CORE rule writing, certification and outreach – as well as the enhancement work achieved over the last 40 or so business days – are an indication that many in the industry are ready to move to a more regular cycle for standards and operating rules. This said, such a transition will require an ongoing commitment to administrative simplification, the goals of the ACA Section 1104 and working in a collaborative manner.

Transparency. We agree with NCVHS regarding the need for transparency and inclusion; these approaches have been at the heart of CORE since its inception. CORE has always had an open and transparent process. For example, CORE has always assigned resources to the production of written minutes and documentation of operating rules research and discussions; all of which are made available on the CAQH website, including viewing of most items by non-CORE participants.[6] In addition to the website, CORE utilizes other means of reaching out to both participants and non-participants. This includes articles in the CAQH online newsletter, *Catalyst*; a recent industry survey of potential enhancements to CORE Phase I and II Rules; and

[3] SSA § 1173(a)(4)(A)(i) and (iii), added by PPACA § 1104(b)(2)(B).
[4] SSA § 1173(a)(4)(A)(iv), added by PPACA § 1104(b)(2)(B).
[5] SSA § 1173(g)(2)(D), added by PPACA § 1104(b)(2)(C).
[6] See, for example, the minutes of the November 11, 2010, teleconference, which are available at http://www.caqh.org/Host/CORE/Survey/RWGTigerTeamSummary11-11-10.pdf.

presentations at numerous public industry meetings, such as WEDI and HIMSS. Opportunities for industry input are well-publicized and made widely available – practices that CORE will continue and expand going forward, including open Town Hall calls. Finally, a transparent voting process is utilized for the CORE Rules. The commitment to this voting process is evident in the steps taken by CORE in response to the NCVHS request for potential enhancements to the Phase I and II Rules.

Governance. Since the July hearings, CORE also launched efforts to address NCVHS concerns regarding CORE governance. A significant first step in this direction was made in April, when the CAQH Board approved a modification to the CORE Governing Procedures to remove the right of the CAQH Board to veto the operating rules approved by the CORE participants through the open voting process. Historically, this CAQH Board right has never been exercised, and the participant-approved rules in all cases have become the final rules.

At its recent November meeting, the CAQH Board of Directors acted on its conviction that multi-stakeholder governance is the model that would best support the achievement of shared industry goals. As such, the Board has agreed to transition CORE to a formal multi-stakeholder governance structure, including state representation. To design the potential structure, a CORE Transition Committee has been established to guide this process, with a composition and charge that speak to the goal of developing a new industry model. This Transition Committee is described in Appendix A. An earlier version was shared with the CMS eHealth Office and since that point a representative from the National Governors Association (NGA) has been added per suggestion of the CAQH Board. As you will note, membership is sought at the executive level, including individuals who can commit their organization on matters of policy and budget. Executive-level leadership from entities that need to implement the operating rules can envision how to connect the rules to other initiatives, such as the clinical/administrative data connection and coordination with health information exchanges. Achieving interdependencies and coordination among related imperatives is essential to realize true administrative simplification. Executive leadership will also consider how to address synergies and economies of scale, such as infrastructure needs.

The CAQH Board affirmed that while this governance transition is being accomplished, CAQH will continue to support CORE with appropriate resources in order to meet the timelines and deliverables of Section 1104. *It is important to note: This Transition Committee is not the new CORE Governing Board - it is a Committee focused on developing potential new models for how to govern and fund CORE going forward.*

Certification. In its September 30th letter, NCVHS offered several recommendations for naming a certification entity for implementing operating rules, as required under ACA. The Committee also raised concerns regarding CORE certification fees, so I would like to clarify our fee structure. The costs to obtain a CORE Seal are based on a sliding scale that reflects the stakeholder landscape. There is a one-time cost for each phase of CORE certification, unless an entity becomes de-certified. Fees range from $500 for providers with net annual revenues of up to $1 billion, to $6,000 for health plans or vendors with $75 million and above in net annual revenue. Government entities are fee-exempt. Re-certification is required by entities that undergo significant mergers or acquisitions. The complete fee schedule is available on the CAQH

website. Entities that adjust their information systems and policies in order to meet operating rule certification requirements allocate significant resources to do so, and we believe that the current CORE fee schedule is modest and equitable when considering the makeup of the stakeholders and the marketplace.

As stated in our July testimony, an independent entity completes CORE *testing;* however, the inclusion of *certification* into the CORE operating model is essential for the rules to be robust and multiple interdependencies to be embraced and thoughtfully considered. For example, testing requirements for each rule should be outlined when the rule writing occurs so that those who voted and created the rule based on solid research can assist those that outline how best the testing could ensure the objective(s) of the rule is met.

DSMO Participation. Finally, I would like to address the NCVHS recommendations that CORE, as an operating rule author, be designated as a Designated Standards Maintenance Organization (DSMO), and its participation would be required in the DSMO Committee that would review version updates and changes to operating rules. CAQH CORE appreciates the intent of the recommendation – to help stimulate broader stakeholder involvement in the development of standards and operating rules as well as to help streamline the adoption and updating processes for HIPAA administrative standards. However, we believe this recommendation should be carefully reexamined for a variety of practical and legal reasons.

To begin with, we believe that the CORE operating rules and related policies are not in the realm of the DSMO and SDOs. The ACA Statute makes a clear distinction between standards and operating rules. In fact, uniform standards and operating rules are separate but complementary efforts. We also would note that other industries make the clear distinction between standards and operating rules.

The DSMO is a specific entity that was created by regulation to receive and process requests for adopting a new standard or modifying an adopted standard in the suite of HIPAA transactions. The DSMO Committee has jurisdiction over changes to HIPAA transaction standards. Importantly, however, it does not have jurisdiction over other key standards, such as OASIS, SOAP, authentication and security, because the regulatory provision establishing the DSMO (45 C.F.R. § 162.910) appears to apply the DSMO process only to standards developed and adopted as HIPAA's administrative simplification rules. The CORE operating rules support standards and policies that are not in the realm of current SDOs, such as those mentioned previously.

In addition, the DSMO Committee consists of a subset of SDOs. Its membership does not include a number of stakeholders, such as other SDOs, states, Medicaid agencies, health information exchanges and the National Health Information Network (NHIN) – all of which are critical to the adoption and decision making related to the various operating rules. As a result, the concept of requiring that CORE as an operating rules author become a DSMO, and that the DSMO Committee approve and review all operating rules needs further analysis. Such a requirement, in fact, goes beyond the ACA Statute by imposing requirements upon authoring entities for operating rules that are not set forth in Section 1104. This section creates specific requirements for the designated non-profit entities, and the Secretary should not rewrite the Statute to impose these additional requirements.

We do share the concerns of the SDOs regarding the length of time needed for approval of updates and changes to HIPAA transactions and code sets via the DSMO process. Nevertheless, this process is part of the impetus for establishing statutory requirements for operating rules under ACA Section 1104, and it does not recognize the evolution in the marketplace such as the establishment of the Office of the National Healthcare Coordinator (ONC). Further, if the DSMO Committee must pass on operating rules, this would not support the efficient and timely rulemaking required under the ACA. It also would be counter to the adoption process set forth in the Statute, which simply requires NCVHS consultation.

CORE has a transparent and open process for creating and approving operating rules, as well as the broad stakeholder participation contemplated by NCVHS and the ACA. CORE also uses version control through the development of its operating rule phases. We welcome the continued opportunity to work hand-in-hand with the wide range of SDOs, and other stakeholders.

See Appendix C for a complete listing of current CORE Participating Organizations.

Next Steps

As you have seen from the testimony of CAQH CORE and others on the panel today, much has been accomplished, but much remains to be done. The ACA statutory requirements indicate that the industry must immediately commit resources to the later transactions outlined in the legislation to assure the development of well-integrated, value-driven operating rules within short timeframes. Indeed, the deadlines are very tight. CAQH CORE remains committed to the goal of administrative simplification and, with this in mind, is moving ahead with the industry and its stakeholders. CAQH CORE believes, and has demonstrated, that operating rules can be regularly issued and adopted, while continuing to support standards. We believe the industry expects continued development of operating rules on both a voluntary and mandatory basis given the pressures such as Medical Loss Ratio (MLR) and the need to have a tested roadmap.

EFT/ERA Transactions on Deck. This afternoon, the Subcommittee will hear testimony on the options for naming authoring entities for operating rules for Electronic Funds Transfers (EFT) and Electronic Healthcare Payment and Remittance Advice (ERA). You will hear more about the experiences of CORE and NACHA – The Electronic Payments Association. To this end, CAQH has committed to partner with NACHA as the healthcare industry outlines EFT and ERA Operating Rules, as well as with such critical ongoing partners as HIMSS. The NACHA EFT Operating Rules are already used by over 14,000 financial institutions. The healthcare industry can benefit from the expertise in rule making in the financial services industry, especially in the cases where healthcare transactions are already being supported.

NCVHS Recommendations are Needed for the Authoring Entities for Remaining Transactions. Based on the ACA requirements and deadlines, we strongly believe that the NCVHS needs to make recommendations on an authoring entity for the other transactions outlined in the Statute – specifically, health claims, enrollment/disenrollment in a health plan, health plan premium payments, and referral certification and authorization. We believe that the Statute envisioned one – and only one – such entity for the non-retail pharmacy operating rules, and that the reading of

the Statute supports this view. Successful rules need to consider the interdependencies of the rules, the interdependencies within the stakeholder organizations, the interdependencies between stakeholders – and – the resources applied by the industry for participation and adoption. The resources for the industry to staff, fund, and participate in multiple organizations working on similar/overlapping topics will negatively impact the timing and quality of national operating rules. CAQH CORE is the logical choice for non-retail pharmacy operating rules, especially given its existing partnership with NACHA whose EFT standards and rules are well established. Such an approach will build on CORE expertise and experience as the recommended authoring entity for the Eligibility/Benefits and Claim Status transaction and its ongoing work on other transactions, as well as provide one-stop for non-retail pharmacy healthcare operating rules in a very diverse industry.

As stated above and provided in more detail in our EFT/ERA testimony, coordination with NACHA and support for its banking operating rules will be essential for certain healthcare operating rules – and both NACHA and CAQH CORE are committed to a successful and coordinated outcome. To name multiple entities will create market confusion; add burden to providers, states, health plans and other stakeholders in negotiating among multiple entities and their unique processes; and increase costs due to duplication of efforts and lack of economic synergies and economies of scale. Certainly, the Statute envisions administrative simplicity and cost savings, which we believe can be achieved with one authoring entity for non-retail pharmacy healthcare operating rules.

Conclusion

In conclusion, I want to thank the Subcommittee for this opportunity to provide an update on the CORE activities to meet the ACA Section 1104 requirements, as well as address the NCVHS recommendations. CORE is deeply committed to the ACA goal of administrative simplification, and is moving forward in concert with a wide range of stakeholders to make them a reality.

I look forward to your questions. Thank you.

APPENDIX A

CORE Governance Transition Team

Why a Transition Committee?

As operating rules evolve from voluntary to mandatory, CORE will transition its governance structure to support the new environment. The CAQH Board expressed their intent on this matter in an August 2010 letter *to NCVHS*. As noted in this letter, over the past five years CAQH has served as a sponsor for CORE and at no time influenced or changed the outcome of the CORE participant vote. This said, implementation of Section 1104 of the PPACA has encouraged CAQH to further its commitment to have CORE serve as a multi-stakeholder effort. To this end, a multi-stakeholder governance structure will be established – going beyond the current multi-stakeholder Steering Committee that has primarily overseen the CORE rule writing process. The CORE Transition Committee is charged with creating a transition model for CORE governance and its associated components over the course of the next several months. During this time CORE will maintain a solid focus on its ongoing deadlines and consistently update the Transition Committee on the status of previously established goals.

Committee Charge: *Outline a three year strategic, structural and financial model for CORE; and establish critical milestones for the 2011 transition period.*

1. Propose model(s) for CORE governance structure, including:
   - Rule approval/voting process, e.g., potentially change role of vendors in voting process and consideration of regional voting "blocks" to gain additional provider participation.
   - Governance decision making/voting process and role/responsibility of governance committee, CAQH CORE staff and CORE participants.
   - Legal status.
   - Critical partnerships.
   - Bylaw revision.
2. Draft three year budget, including:
   - Options that move CORE towards a sustainable model.
     - Expectation: A multi-year approach will be used to transition CORE into a fully sustainable entity; creative funding models such as regional hospital groupings will be considered.
     - Participation fees and their relation to voting rights.
     - Projected ongoing need for CAQH funding in Years one through three.
     - CAQH staff will review 2011 Budget with Committee; Budget does not include a significant increase in participant fees given the status of Section 1104 decision making.

     Note: CAQH has retained an external firm to outline potential revenue options based upon models applied by other industries with high-volume transaction business; research will be shared with Transition Committee for its consideration.
   - Projected annual costs, based on the CORE long-term vision to maintain the components of its model, including:
     - Rule writing: Voluntary (e.g., ID cards) and mandatory (addressing all parts of Section 1104 of PPACA, e.g., Eligibility/Benefits and Claim Status, EFT/ERA, etc.).
     - Education and outreach.
     - Certification and contracted testing.
     - Infrastructure requirements: e.g., skilled human resources with full-time commitment to CORE, marketing/media, policy, etc.
   - Identification of variables that could greatly impact CORE revenue and costs: (1) Another entity is selected by HHS to write the non-retail pharmacy EFT/ERA operating rules required by PPACA, and (2) Certification envisioned by Section 1104 is conducted by entity other than CORE.
3. Propose three to five year goals and vision beyond mandated rule area.
   - NOTE: CAQH staff will share current goals and vision.

4. Review of CAQH communication plans regarding transition, including:
    - Informing CORE participants of charge, timeline, etc., and methods to solicit feedback.
5. Feedback on CAQH CORE ongoing efforts to position CORE to:
    - Testify at future NCVHS hearings regarding Section 1104.
    - Contribute to Meaningful Use debate.
    - Manage increased rule writing workload and volume of participants.
    - Any others items as deemed appropriate by Committee.

Timeline and Milestones

2010

Q4

- CAQH leadership:
    - Gain CAQH Board input on draft Transition Committee charge, timeline and composition.
    - Update CMS on status of Transition Committee.
- Committee:
    - **Secure commitment of Committee Members.**
    - Agree upon charge, timeline and composition.
    - Review and discuss potential revenue models.
    - Review and discuss potential structural models.

2011

Q1

- Committee:
    - Agree upon Year 1-3 revenue and structural/voting model and solicit public feedback.

Q2

- Committee:
    - Make adjustments on proposed models based on feedback and seek commitments from critical stakeholders.

Q3

- Committee:
    - Initiate CORE transition, including initial changes to revenue streams; model selected will be significantly impacted by outcome of the EFT/ETA and Certification Hearings as CORE revenue options will be greatly reduced if not selected to do this work.
    - Formally invite initial CORE Governance Board.

Membership Composition and Structure

Members

- Total: Fourteen members.
- Decision making by consensus; voting if necessary.

Requirements for Voting Members

- Executive-level leadership (e.g., SVP, CTO, CIO) that has essential role in their organization's budgetary and strategic decisions, and can commit their organization.
    - Note: Based on experience, it is essential the Transition Committee and the new CORE Governance Board consist of executive level management to assure maximum effectiveness.
- Represent a CORE participating organization.
- Maintain attendance at 80% of all Committee meetings/conference calls.
    - Estimated that Committee will hold monthly calls for six months and potentially one in-person meeting.

Assumptions

- Serving as a Transition Committee member *neither excludes one from serving on the new CORE Governance Board nor guarantees one a position on the new Board*.
- *The new CORE Board composition may or may not be similar to Transition Committee composition, e.g., Board will most likely have ex-officios such as SDOs.*

PROPOSED COMMITTEE MEMBERS		
Organization or Stakeholder Type	**Voting or Advisory**	**Organization: Individual TBD** *(SVPs, CTOs, CIOs, etc)*
Hospital Association	Voting	American Hospital Assoc (AHA)
Hospital	Voting	TBD
Provider Association	Voting	MGMA
Practicing Provider (volunteer leader from an Association)	Voting	American Medical Assoc (AMA)
Health Plan (National)	Voting	WellPoint
Health Plan (National)	Voting	United Healthcare
Health Plan (Regional)	Voting	BCBSNC
Health Plan Association	Voting	Rotating AHIP and BCBSA
Practice Management System/Vendor (large office)	Voting	TBD
Practice Management System/Vendor (small office)	Voting	TBD
Bank	Voting	TBD
State Entity 1	Voting	Minnesota
State Entity 2	Voting	National Governors Assoc (NGA)
CORE Chair	Advisory; will serve as Committee Chair/Facilitator	*CORE: Harry Reynolds , IBM Payer Transformation*

Notes:

(1) CAQH leadership will serve as Secretariat, and CAQH staff will conduct/manage research and modeling requested by Committee.
(2) Options, agenda items and discussion materials will be shared with CMS eHealth Office for its input.
(3) Committee will involve Advisors/Subject Matter Experts/CORE partners, as needed.
(4) This is NOT the new CORE Board; it is the Transition Committee that considers new governance models.

APPENDIX B

Status of Potential Enhancements to CORE Phase I and II Operating Rules for Eligibility and Claim Status

Appendix B. Summary – Potential Enhancements to Phase I and II CORE Rules Status as of November 30th, 2010 – For Discussion Only (see CAQH website for formal information)		
Candidate Items (Based on Applicable Work Group "Tiger Team" calls and survey feedback)	**Approved for ballot by Applicable CORE Work Group**	**Work Group Ballot Results to be Reported to NCVHS (Quorum & simple majority [50%] met)**
Eligibility/Benefit Potential Enhancements		
From the Draft CORE Phase III Rules		
1. Include additional benefit reporting for more service type codes, includes patient financials (base/YTD deductible, co-pay, co-insurance and base annual/YTD out-of-pocket).	**Yes**	**Not Approved**
2. Include additional benefit reporting that incorporates "grouped benefits" in responses (i.e., return related benefit information).	**Yes**	**Not Approved**
3. Include refined language related to discretionary reporting of carve-out and sensitive benefits.	**Yes**	**Not Approved**
4. Replace X12 997 Functional Acknowledgement with the X12 999 Implementation Acknowledgement.	**Yes**	**Approved**
Not Yet Drafted/And or Reviewed by CORE		
5. Require an eligibility inquiry response to include provider network identification information (in/out of network is already in CORE Phase I and II). ***Rule would need to be written.***	**No**	**N/A**
6. Require an eligibility inquiry response to include the code indicating the types of health plan (e.g., HMO, PPO). ***Rule would need to be written.***	**No**	**N/A**
7. Limit the number of service type codes that can be submitted in an eligibility inquiry/Limit the number of codes that can be returned in a response. ***Rule would need to be written.***	**No**	**N/A**
8. Communicate to NCVHS interest in reviewing WEDI/XI2 Companion Guide and consider developing a rule.	**Yes**	**Approved**
9. Establish uniform search/match logic (based on MN requirements).	**No**	**N/A**
Claims Status Potential Enhancements		
From the Draft CORE Phase III Rules		
1. Acknowledge v5010 837 claim submissions with a 277CA.	**Yes**	**Approved**
2. Uniform use of claim status category and claim status codes.	**Yes**	**Approved**
3. Maintain claim history for minimum 24-months.	**No**	**N/A**
4. Replace the X12 997 Functional Acknowledgement with the X12 999 Implementation Acknowledgement.	**Yes**	**Approved**
Not Yet Drafted and/or Reviewed by CORE		
5. Communicate to NCVHS interest in reviewing WEDI/XI2 Companion Guide and consider developing a rule.	**Yes**	**Approved**
Write-in Item from Survey: Not Considered for Ballot		
Approximately five items were received, the majority of which added additional requirements for items already on the ballot or were very specific, e.g. limit and/or standardize use of MSG (message) segments.	*It was agree by the Work Group that all write-in candidates would not be added to ballot given existing list of candidates*	
Connectivity Potential Enhancements		
1. Adopt 4 enhancements to CORE Phase II Connectivity Rule; primarily formal references or support for both v5010 and draft CORE Phase III rules, clarifications due to FAQs, errata. Key discussion was reference to TLS given rule requires SSL, but entities can go above and beyond with all CORE rules.	**Yes**	**TBD**

NOTES:

(1) Since the posting of the online survey, portions of the WEDI/X12 Companion Guide and associated documentation have been published and made available to the industry. These documents have not been through the CORE rules review process at this time.

(2) All items not approved for ballot will be considered in future CORE rule-making and in many cases were already on the business case lists for the various areas.

(3) The primary areas supported by the survey/Tiger calls and their resulting ballots related to industry interest in expanded uniform data delivery and ongoing CORE support for acknowledgements. Critical changes to other rule areas, e.g. response time, were not proposed nor were changes to policies, e.g CORE rules are a base not a ceiling, CORE Connectivity is a Safe Harbor rule

CAQH Committee on Operating Rules for Information Exchange (CORE) (Participating Organizations as of December 2010)

Health Plans
Aetna Inc.
AultCare
Blue Cross Blue Shield of Michigan
Blue Cross and Blue Shield of North Carolina
BlueCross BlueShield of Tennessee
CareFirst BlueCross BlueShield
CIGNA
Coventry Health Care
Excellus Blue Cross Blue Shield
GHI, an EmblemHealth Company
Harvard Pilgrim Health Care
Health Care Service Corporation
Health Net, Inc.
Health Plan of Michigan
Highmark, Inc.
Horizon Blue Cross Blue Shield of New Jersey
Humana Inc.
Kaiser Permanente
Medical Mutual of Ohio
UnitedHealth Group
WellPoint, Inc.

Associations / Regional / Standard Setting Organizations
America's Health Insurance Plans (AHIP)
ASC X12
Blue Cross and Blue Shield Association
Delta Dental Plans Association
Health Level 7 (HL7)
Healthcare Billing and Management Association
Healthcare Financial Management Association
Healthcare Information & Management Systems Society
LINXUS (initiative of GNYHA)
National Committee for Quality Assurance
National Council for Prescription Drug Programs
NJ Shore (WEDI/SNIP NY Affiliate)
Private Sector Technology Group
Utah Health Information Network
Utilization Review Accreditation Commission
Work Group for Electronic Data Interchange (WEDI)

Government Agencies
Arizona Health Care Cost Containment System
Louisiana Medicaid – Unisys
Michigan Department of Community Health
Michigan Public Health Institute
Minnesota Department of Health and Human Services
Oregon Department of Human Resources
TRICARE
US Centers for Medicare and Medicaid Services (CMS)
US Department of Veterans Affairs
Washington State Office of the Insurance Commissioner

Other
Accenture
Bank of America
Cognizant
Cognosante
Deloitte Consulting LLP
Fifth Third Bank
HIPAA Ready LLC
Hubbert Systems Consulting (HSC)
Merck & Co., Inc.
OptumHealth Financial Services
Payformance
PNC Bank
PricewaterhouseCoopers LLP
TIBCO Software, Inc.
VeriSign, a Symantec Business

Providers
Adventist HealthCare, Inc.
American Academy of Family Physicians (AAFP)
American College of Physicians (ACP)
American Hospital Association (AHA)
American Medical Association (AMA)
Catholic Healthcare West
Cedars-Sinai Health System
Greater New York Hospital Association (GNYHA)
Healthcare Partners Medical Group
Johns Hopkins Medicine
Mayo Clinic
Medical Group Management Association (MGMA)
Mobility Medical, Inc.
Montefiore Medical Center of New York
New York-Presbyterian Hospital
North Shore LIJ Health System
Physician HealthCare Network, PC
Spectrum Laboratory Network
Texas Medical Association
University Physicians, Inc. (University of Maryland)
UNMC Physicians
Valley Health
Wisconsin Medical Society

Vendors / Clearinghouses
ACS EDI Gateway, Inc.
Antares Management Solutions (a subsidiary of MMO)
athenahealth, Inc.
Availity LLC
Capario
Edifecs
Emdeon
Enclarity, Inc.
FIS Global
Gateway EDI
GE Healthcare
HERAE, LLC
HMS
HP Enterprise Services, LLC
Ingenix, Inc.
InstaMed
MedData, a TransUnion Healthcare Division
mPay Gateway
National Account Service Company (NASCO)
NaviNet
NextGen Healthcare Information Systems, Inc.
Passport Health Communications
Payerpath, a Misys Company
RealMed, an Availity Company
Recondo Technology, Inc.
RelayHealth
Secure EDI Health Group, LLC
Siemens / HDX
Surescripts
The SSI Group, Inc.
The TriZetto Group, Inc.
VisionShare, Inc.