Committee on Operating Rules
For Information Exchange
(CORE®)

Public Town Hall Call
05/10/11

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

• **Brief Overview on the Scope of CORE** *(for more information on CAQH and CORE contact Omoniyi Adekanmbi at oadekanmbi@caqh.org to set up an orientation call)*

• **Update on Non-Rule Writing Activities**
  – New CORE Certifications, Participants and Endorsers in 2011
  – Phase II CORE Certification Measures of Success study
  – Examples: Alignment with Federal efforts
  – Overview of the CORE Transition Committee

• **Update on ACA Section 1104: Mandated Operating Rules**
  – Current milestones for Eligibility and Claim Status transactions and status
  – Current milestones for EFT and ERA transactions and status
  – Highlights from CAQH CORE Testimony to National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards 04/27/11

• **Report on Current Mandated CORE EFT & ERA Rule Development Efforts**
  – Collaboration with NACHA, scope of EFT and ERA operating rules, rule opportunity evaluation process and key milestones
  – Results of the *Industry Survey on Potential CORE Rule Opportunity Areas for EFT & ERA Transactions* including background, high-level findings and next steps
Scope of CORE
Committee on Operating Rules for Information Exchange

- CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  - Three pillars: Rule writing, certification and testing and outreach/education to support industry-aligned rules
- Mission: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers
  - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response from any participating stakeholder
  - Enable stakeholders to implement CORE phases as their systems allow
  - Facilitate stakeholder commitment to, and compliance with, CORE’s long-term vision
  - Facilitate administrative and clinical data integration
- CORE is not:
  - Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7
  - Developing software or building a database
CORE Scope: What are Operating Rules?

- As defined in the Patient Protection and Affordable Care Act, the term refers to “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
- Prior to CORE, operating rules did not exist in healthcare outside of individual trading relationships
- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing (remaining vendor agnostic is a key CORE principle)
CORE Scope: Rules Development/Implementation Approach

- CORE Phases are designed around a set of transaction-based data content rules coupled with infrastructure rules
  - Rules complement each other – real value is in the package of rules
  - Phases establish milestones that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption

- To date, the transactions to which data content and/or infrastructure rules apply include:
  - Eligibility
  - Claim Status
  - *Payment/Remittance
  - *Authorizations
  - *Health ID Cards

- Infrastructure rules applied to transactions (Real Time and Batch)
  - Connectivity (i.e., communications protocol, security)
  - Acknowledgements
  - Response Time
  - System Availability
  - Companion Guide (flow and format)
  - AAA Error Code Reporting and Last Name Normalization

*Part of draft Phase III Operating Rules; note, CORE will pursue mandated and non-mandated operating rules
CORE Operating Rules Phased Development*

CORE Phase I
- Approved
- Implemented
- Certification Available

CORE’s first set of operating rules are helping:
  - Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information
  - Provide timely and consistent access to this information in real-time (i.e., infrastructure rules – e.g., response time, connectivity safe harbor, companion guide)

CORE Phase II
- Approved
- Implemented
- Certification Available

CORE’s second set of rules expand on Phase I to include:
  - Patient accumulators (remaining deductible)
  - Rules to help improve patient matching
  - Claim status transaction “infrastructure” requirements (e.g., claim status response time)
  - More prescriptive connectivity requirements (e.g., digital certificates)

CORE Phase III
- In development

CORE’s third set of rules focus on:
  - Claim status data content requirements (276/277)
  - Infrastructure requirements for Claim Payment/Advice (835) and Prior Authorization/Referral (278)
  - EFT and Health Care Claim Payment/Advice
  - 277 Claim Acknowledgement for Health Care Claims (837)
  - Standard Health Benefit/Insurance ID Card
  - More prescriptive connectivity requirements
  - Additional eligibility financials

NOTE: All CORE Operating Rules, Policies, and Test Suites are developed and approved by CORE Participants.
CORE Scope: Rules Development/Adoption Timeline

REMINDER: CORE Operating Rules are a baseline; entities are encouraged to go beyond the minimum CORE requirements.
Update on Non-Rule Writing CORE Activities
Examples: New Certifications, Participants and Endorsers in 2011

• Certifications:
  – UnitedHealthcare: v5010 Phase I & II
  – Ingenix: Phase I & II (*committed Q2*)
  – Montefiore Medical Center: Phase II (*committed Q3*)
  – Selection of additional hospitals from the Greater New York Hospital Association (*commitments for 2011*)

• Participants:
  – Allscripts
  – OneHealthPort
  – NYU Langone Medical Center

• Endorsers:
  – American Academy of Family Physicians (*committed Q2*)

• For more information on CORE Certification, attend the complimentary CAQH CORE/Edifecs Webinar on May 19, 2011
  – Explore options and key elements to enable your organization’s v5010 compliance implementation projects to progress in sync with your CORE Certification process, [register here](#)
Phase II CORE Certification Measures of Success

- Health Plans, vendors and providers that are pursuing Phase II CORE Certification (or Phase I & II together) are invited to participate in an implementation cost and effort study
- CAQH has contracted with IBM to conduct the study and analysis
- Over two 3-month measurement periods, volunteers will be asked to record certification expenses and related effort i.e., IT expenses (hardware/software), staff expense, certificate expense (seal and test fees) and time required to complete certification
  - If appropriate, IBM staff will visit your location to assist with project plan for tracking
  - Standard measurement protocol plus two data collection templates
- Cost data already available for a number of Phase II-Certified health plans
- Please contact Ezra Rosenberg at erosenberg@caqh.org if interested in participating in the study
CORE Transition Committee

• In 2010 the CAQH board made a public commitment to increase industry participation in operating rules development and adoption given CORE’s goal to support the changing environment in which operating rules are mandatory
  – Note: The CAQH Board has never voted on any CORE rule
• At the beginning of 2011, the CORE Transition Committee was launched to make recommendations regarding multi-stakeholder governance of CORE
• The Committee is charged to develop a three-year governance plan that outlines structure and revenue models for CORE
  – Will propose ideas to enhance current CORE multi-stakeholder approach to increase participation by states, physicians, hospitals and other providers
  – Will preserve the CAQH CORE integrated approach to rule-writing, certification, outreach and education and reinforce CAQH CORE commitment to support ACA Section 1104 mandate
• It is anticipated that the Committee will complete its work and implement its recommendations by the fourth quarter of 2011; CAQH is committed to supporting CORE through its transition
## CORE Transition Committee Members

<table>
<thead>
<tr>
<th>Stakeholder Type</th>
<th>Organization</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Association</td>
<td>American Hospital Association (AHA)</td>
<td>Linda Fishman, SVP Health Policy and Analysis</td>
</tr>
<tr>
<td>Hospital</td>
<td>Montefiore Medical Center</td>
<td>Joel Perlman, Executive Vice President</td>
</tr>
<tr>
<td>Provider Association</td>
<td>Medical Group Management Association (MGMA)</td>
<td>Robert Tennant, Senior Policy Adviser Health Informatics</td>
</tr>
<tr>
<td>Practicing Provider (with Association leadership)</td>
<td>American Medical Association (AMA)</td>
<td>Barbara L. McAneny, MD, AMA Board of Trustees</td>
</tr>
<tr>
<td>Health Plan (National)</td>
<td>WellPoint</td>
<td>AJ Lang, SVP/CIO</td>
</tr>
<tr>
<td>Health Plan (National)</td>
<td>UnitedHealthcare</td>
<td>Tim Kaja, SVP Physician &amp; Hospital Service Operations</td>
</tr>
<tr>
<td>Health Plan (Regional)</td>
<td>Blue Cross and Blue Shield of North Carolina</td>
<td>King Prather, Deputy General Counsel</td>
</tr>
<tr>
<td>Health Plan Association(s)</td>
<td>America's Health Insurance Plans</td>
<td>Carmella Bocchino, Executive VP of Clinical Affairs &amp; Strategic Planning</td>
</tr>
<tr>
<td>Practice Management System/Vendor (large office)</td>
<td>GE Healthcare</td>
<td>George Langdon, VP eCommerce, Mailing &amp; Clinical Data Services</td>
</tr>
<tr>
<td>Practice Management System/Vendor (small office)</td>
<td>Allscripts</td>
<td>Mitchell Icenhower, VP of Solutions Management</td>
</tr>
<tr>
<td>Bank</td>
<td>JP Morgan</td>
<td>Martha Beard, Managing Director, Treasury &amp; Securities Services</td>
</tr>
<tr>
<td>State Entity</td>
<td>Minnesota Department of Health</td>
<td>David Haugen, Director of the Center for Health Care Purchasing Improvement</td>
</tr>
<tr>
<td>State Coalition/Association</td>
<td>National Governors Association (NGA)</td>
<td>Ree Sailors, Program Director, Health Division Center for Best Practices</td>
</tr>
</tbody>
</table>

**Notes:**

1. CAQH CORE staff serves as secretariat; SDOs and others will serve as advisors
2. The new CORE governance may or may not include Transition Committee members or a similar mix of entities
CORE Transition Committee High-Level Timeline and Milestones

✓ Q4 2010 CAQH leadership
  – Gain CAQH Board input on Transition Committee charge, timeline and composition
  – Update CMS on status of Transition Committee; will be an ongoing process
  – Begin inviting Committee members

✓ Q1 2011 Transition Committee
  – Review and discuss charge, general timeline, and process; announce Committee

• Q2 2011 Committee
  – Gain agreement on assumptions and evaluation approach
  – Review and outline potential revenue and governance models
  – Update CAQH Board, CORE participants and others as appropriate; gain insights
  – Agree upon recommended model(s) and critical steps to evolution

• Q3 2011 Committee
  – Solicit formal external feedback; make adjustments on proposed models based on feedback and seek commitments from critical players

• Q4 2011 Committee
  – Initiate CORE transition including launch of new CORE governing structure
Examples: Ongoing CORE Alignment with the NHIN and Other Federal Efforts

• CAQH CORE has collaborated with NHIN initiatives for many years in an effort to support the alignment of standards for healthcare connectivity
  – Alignment between these two national initiatives offers potential to leverage both for clinical and administrative transactions

• Recent CAQH CORE efforts aligning with the federal efforts include:
  – Emphasis on partnering with CMS in refining MITA to ensure alignment with the administrative simplification needs of Medicaid
    • Upcoming demonstration at the August 2011 Medicaid Management Information Systems (MMIS) Conference in Austin, TX
    • Illustrated claim status transactions (ASC X12 276/277) from the CHIC HIE-Bridge (a Health Information Exchange that shares the location of patient records from facilities in northern Minnesota and Wisconsin) to Medicare via Noridian (a Medicare contractor), over the NHIN using the Phase II CORE Connectivity Rule
  – Continued collaboration and alignment of CORE Connectivity with the CMS Electronic Submission of Medical Documentation (esMD) Project
  – Ongoing support of migration to v5010 given operating rules provide synergies for greater ROI when using standards
CORE and ACA Section 1104 Mandated Operating Rules
ACA Section 1104: *Mandated* Operating Rules

Operating rule writing and mandated implementation as addressed by ACA Section 1104

**Rule adoption deadlines**

- **July 2011**
  - Eligibility and Claims Status

- **July 2012**
  - Claims remittance/payment and electronic funds transfer (plus health plan ID)

- **July 2014**
  - Enrollment, Referral authorization, attachments, etc

**Effective Dates**

- Jan 2013
- Jan 2014
- Jan 2016

**Notes:**
1. Per statute, documentation of compliance may include completion of end-to-end testing (i.e., certification and testing).
2. NCVHS is the body designated by NCVHS to make recommendations regarding the operating rule authors and the operating rules.
Section 1104: *Current Milestones of Eligibility & Claim Status*

**Status**

- Two non-profit candidates recommended by NCVHS to fill rule development role:
  1. CAQH CORE for non-pharmacy
  2. National Council for Prescription Drug Programs (NCPDP) for pharmacy

- Phase I and II CORE Operating Rules recommended by NCVHS as base for 1st rule set; CORE working with industry to determine what else could be added in short timeframe, e.g., state requirements, draft CORE Phase III Operating Rules

- Expectation that key goals will move forward, e.g.,
  - Voting on operating rules must continue to be transparent and multi-stakeholder
  - Desire of providers to have shared governance of operating rule entity
  - This remains an unfunded mandate, and an “adjusted” CAQH CORE would need to transition over a period of time
  - Mandated rules are one part of process
Section 1104: Current Milestones of Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)

December 2010: NCVHS Subcommittee on Standards held Hearings on EFT and ERA; Authoring entity applications due Jan. 31, 2011

Feb. 9 & 10, 2011: NCVHS Full Committee Meeting to discuss applications and Issuance of NCVHS recommendations to HHS in February and March

2011: CMS will move forward informed by ongoing NCVHS recommendation

July 2012: ERA and EFT Rule Adoption Deadline

Status

- In December 2010, three organizations proposed to be authors for the ACA EFT and ERA operating rules including CAQH CORE; ten organizations provided testimony regarding next steps for EFT and ERA operating rules:
  - Majority of the testifiers expressed similar recommendations
- CAQH CORE and NACHA proposed to work in collaboration to meet the needs of the ACA for EFT and ERA
  - Healthcare and financial industry operating rules would complement one another
- February 17, 2011: NCVHS recommended NACHA as healthcare EFT SDO and its CCD+ format
- March 23, 2011: NCVHS recommended CAQH CORE be the authoring entity in collaboration with NACHA
  - Fully vetted rules to be submitted to NCVHS by August 1, 2011
  - CAQH CORE to establish mechanisms for greater direct engagement of SDOs, and broader provider participation
  - Clarify the scope, focus, and limitations between operating rules and standards
- April - August 2011: CORE EFT & ERA Operating Rule development via the EFT & ERA Subgroup and Rule Work Group
CAQH CORE Testimony to
National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards
04/27/11
Key Message on Acknowledgements

“The industry should not miss this moment, as it may be a number of years before another such opportunity is presented on a national scale. The healthcare industry should expect that for every deadline for operating rules in the ACA, one set of integrated, non-retail pharmacy operating rules be adopted, and that integrated set includes Acknowledgements.”

— CAQH CORE Testimony Provided To The Subcommittee on Standards, National Committee on Vital and Health Statistics, April 27, 2011
CAQH CORE NCVHS Testimony:
Standard Acknowledgement Transactions

- Testimony focused on major themes:
  - Robust business case for using Acknowledgements for healthcare EDI
  - Adoption of Acknowledgements should be national, and accomplished in a phased, transaction-specific approach in operating rules
    - Adoption has been and is already occurring via the CORE Operating Rules - this should continue given interdependencies
  - Use of Acknowledgements must be business driven, not technically driven
  - Standards and operating rules are separate but complementary tools
    - Both are needed with regard to Acknowledgements; operating rules help to drive the adoption of standards
    - Interaction across Acknowledgements and the other requirements of operating rules drives ROI achieved through implementation; same ROI cannot be achieved if Acknowledgments are removed from the Phased Rules Set
  - The healthcare community needs infrastructure, communication and interoperability within and across its sectors
  - Online certification testing provides tool for trading partners to understand complementary roles in Acknowledgement process and verify systems are ready to respond in real-time and batch per operating rules
Testified on existing CORE Operating Rules related to Acknowledgements (see appendix for detailed table):

- Since inception, CORE participants have supported use of Transaction Acknowledgement Standards as part of the necessary business processes to improve healthcare EDI
- Several CORE Operating Rules incorporate Acknowledgement Standards already frequently used or in the process of being more broadly adopted
- Highlights of current CORE Operating Rules relationship to Acknowledgement Standards include:
  - All CORE Operating Rules support acknowledgements at several layers
  - All CORE Operating Rules, including those relating to Acknowledgments, support the consistent use of published standards by SDOs, whether or not required by HIPAA
  - All CORE Operating Rules consider the use of Acknowledgements for real-time as well as batch, and do so with regard to market maturity, business needs and the goal to reduce costs, understanding that Acknowledgements are not needed in every instance of an exchange of information
CORE NCVHS Testimony: Current Maintenance and Modifications for Standards and Operating Rules

- Testimony focused on four interrelated themes regarding what is working and what can be improved
  - The rapidly changing world of HIT for administrative simplification must support vision for innovation and cost reduction – alignment on key tools and milestones
  - Strong governance and solid funding are both critical in order to guide what must be modified and maintained - leadership is key
  - Tactical processes for updating operating rules must be guided by the strategic vision and governance
    - Public access to current rules and modifications
    - Increased transparency, access and use of existing information
    - High-level analyses and project plans that guide detailed modifications
    - Certification testing results that feed into rule maintenance and modification
    - Two to three year cycles for operating rules with practical certification policies and outreach activities to support adoption
    - Improving the current process for standards modification and availability of public tools
  - Consistent, *yet iterative*, coordination will be needed between authoring entities for operating rules and SDOs
    - Operating Rules can come before or after a version of a standard – this is already occurring and the result is more robust adoption of electronic transactions
Operating Rules can come before or after a version of a standard – this is already occurring and the result is more robust adoption of electronic transactions

- Example: During last five years, two sets of CORE Operating Rules built on more aggressive use of HIPAA v4010; some of these CORE rule requirements are mandated by v5010, others are still optional in v5010, e.g., YTD deductibles optional in v5010 but required by CORE Operating Rules
  - Per CORE Guiding Principles, CORE Operating Rules addressing standards and implementation guides adopted under Federal mandate are modified when new versions are mandated

- Example: Operating rules guide the business-driven use of industry-neutral standards not mandated under HIPAA that enable and facilitate operation of a HIPAA-adopted standard, e.g., HTTPS, SOAP 1.2
Update on CORE EFT & ERA Rules
(Mandatory Rule Development)
Since 2005, CORE has collaborated both with the financial industry EFT operating rule authoring organization NACHA -The Electronic Payment Association and ASC X12 to build upon the standards
  - CORE continues to build upon the work begun in Phase III CORE to develop rules related to healthcare payments
    • Healthcare operating rules for EFT and ERA will support existing standards; will consider business rules and guidelines that are unique or intrinsic to healthcare claim payment transactions, including requirements for health plans and providers

CORE EFT & ERA detailed rule writing
  - Subgroup meets weekly on Thursdays from 2:00 – 3:30 pm ET
  - Reports to CORE Rules Work Group, which will speak monthly
## CORE EFT and ERA Operating Rules Scope

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<thead>
<tr>
<th>ERA Focused</th>
<th>In Scope</th>
<th>Out of Scope</th>
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<tbody>
<tr>
<td>Operating rules that build on the ASC X12 v5010 835 TR3 by:</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Clarifying ambiguity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Filling gaps</td>
<td></td>
<td></td>
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<tr>
<td>• Building on data content specifications</td>
<td></td>
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</tr>
<tr>
<td>Operating rules that duplicate or conflict with the requirements of the ASC X12 v5010 835 TR3 (e.g., balancing, etc.)</td>
<td></td>
<td>X</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EFT Focused: Thin Layer of Healthcare Operating Rules on EFT</th>
<th>In Scope</th>
<th>Out of Scope</th>
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<tbody>
<tr>
<td>Operating rules that build on the ACH CCD+ standard for EFT by:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Clarifying ambiguity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Filling gaps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Building on data content specifications</td>
<td></td>
<td></td>
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<tr>
<td>Operating rules that duplicate or conflict with the requirements of the NACHA Operating Rules or the ACH CCD+ standard</td>
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<td>X</td>
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<tr>
<td>Operating rules for the ACH CTX standard for EFT (given NCVHS recommendation for CCD+ and timeline)</td>
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<td>X</td>
</tr>
<tr>
<td>Operating rules related to the ACH Network and/or connectivity from one depository institution account to another within the ACH Network</td>
<td></td>
<td>X</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EFT &amp; ERA Focused</th>
<th>In Scope</th>
<th>Out of Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential operating rules addressing infrastructure (e.g., acknowledgements)</td>
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<td>X</td>
</tr>
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</table>
CORE Process for Evaluation of EFT and ERA Rule Opportunity Areas

1. Identify and agree on Rule Opportunity Areas
2. Review evaluation criteria and business case
3. Prioritize Rule Opportunity Areas using evaluation criteria
4. Present “top” Rule Opportunity Areas to Rules Work Group

Consider existing industry efforts and applicability to CORE EFT and/or ERA operating rules and align wherever possible, e.g.,
- CAQH CORE and NACHA research, and existing CORE rules
- WEDI White Papers
- ASC X12
- UHIN
- Minnesota State Administrative Uniformity Committee
- Washington State Healthcare Forum
- (Previous NY effort) LINXUS
- Others? (If there are other industry efforts to be considered please contact CAQH CORE staff)

Rule Opportunity Area evaluation criteria:
- Be within scope of the operating rules as defined by ACA Section 1104
- Support CORE Guiding Principles, e.g., align with Federal HIT efforts
- Balance between anticipated industry benefit relative to the industry adoption cost (ROI)
- Can be developed within the NCVHS time frame (08/01/11 deadline)
Industry Survey on Potential EFT & ERA Operating Rules

• Survey Background
  – Given the 08/01/11 NCVHS deadline for industry-vetted EFT and ERA operating rules, industry stakeholders were asked to provide feedback on the CORE list of potential new Rule Opportunity Areas to assist the EFT & ERA Subgroup in prioritizing Rule Opportunity Areas for rule development.
  – Survey respondents were asked to rate 12 potential Rule Opportunity Areas as either “high” or “low” priority based on evaluation criteria and select among four approaches for addressing uniform use of CARCs and RARCs.

• Summary of Survey Respondents

<table>
<thead>
<tr>
<th>Entity Type</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers/Provider Associations</td>
<td>41</td>
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<tr>
<td>Health Plans/Dental Plans/Health Plan Associations</td>
<td>30</td>
</tr>
<tr>
<td>Clearinghouses/Vendors</td>
<td>20</td>
</tr>
<tr>
<td>Financial Institutions</td>
<td>6</td>
</tr>
<tr>
<td>Government Agencies (State and Federal)</td>
<td>12</td>
</tr>
<tr>
<td>Other Stakeholder Types (SDOs, Regional Entities, etc.)</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total (49% were CORE Participating Entities)</strong></td>
<td><strong>119</strong></td>
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</table>
**Survey Results**

Five Rule Opportunity Areas ranked as “High Priority” by >65% of respondents:

1. Identify a set of data elements required for a standardized healthcare EFT enrollment
2. Uniform use of CARCs and RARCs (reconfirmed)
3. Require the accurate identification of the health plan making the EFT payment or the funding of the payment by the health plan through a third party
4. Develop operating rules that address the elapsed time between sending of both EFT and ERA by payers and receipt of both EFT and ERA by payees
5. Enable providers to specify preference for EFTs and ERAs to be based on Tax Identification Number (TIN) or National Provider Identifier (NPI) to ensure payment gets deposited to correct bank account and the correct posting to accounts receivable

**Survey Comments**

Survey comments supported two new Rule Opportunity Areas not previously included in survey:

1. Provider a crosswalk of the CCD+ and 835 data elements to ensure appropriate mapping
2. Identify a set of data elements required for a standardized healthcare ERA enrollment

Subgroup Agreement on Top Seven “High Priority” Rule Opportunity Areas to Pursue for Rule Development
Next Steps: Areas of Opportunity for Operating Rules

### Seven High Priority Rule Opportunity Areas
- Reach EFT & ERA Subgroup agreement on Rule Options/Approaches for each High Priority Rule Opportunity Area – there are many ways in area could be addressed via rules
- Begin developing detailed Rule Requirements for agreed-on Rule Options (will be shared publically for input)

### Existing Draft CORE Phase III ERA Infrastructure Rule
- Will be included in the complete draft EFT & ERA Operating Rule Set for Rules Work Group review

### Lower Priority Opportunity Areas
- Place on list for future operating rules or to be revisited if the initial High Priority Rule Opportunity Areas are completed or determined unfeasible given the NCVHS timeline
NOTE: If your organization is not a CORE participating entity, there will be several opportunities to provide comments on Rule Opportunity Areas, e.g. survey, and draft rules. Please contact Erin Richter at erichter@caqh.org.
Getting Involved with CORE
How to Get Your Organization Involved Today

• Participate in CORE Operating Rules Development
  – Join your industry colleagues as a contributor to CORE rule development by becoming a CORE participating entity

• Attend a Future Town Hall Call (free)
  – Tuesday, June 28th, 3:00-4:00 pm ET
  – Tuesday, August 9th, 3:00-4:00 pm ET
  – Tuesday, September 20th, 3:00-4:00 pm ET

• Join us at one of our upcoming Education Events
  – If you are a CORE participant, volunteer to be on speakers bureau
  – Webinars/Audiocasts
    ▪ May 19, 2011: Complimentary webinar to explore options and key elements to enable your organization’s v5010 compliance implementation projects to progress in sync with your CORE Certification process, register here
    ▪ June 22, 2011: WEDI audiocast regarding EFT and ERA healthcare operating rules
  – Conferences
    ▪ National Medicaid Congress 6/13/11-6/15/11
    ▪ Government Health IT Conference 6/14-6/15
    ▪ AHIP Institute 6/15/11-6/17/11
    ▪ MMIS Conference 7/31/11-8/4/11
    ▪ 9th Annual Health Care Quality Congress 8/1/11-8/3/11
How to Get Your Organization Involved Today (cont’d)

• CORE Industry Outreach
  – Have a CAQH CORE representative visit your organization or event
  – Implement the CORE Operating Rules: Become CORE-Certified
    – For entities that create, transmit or use eligibility and claim status data
    – Pledge your commitment to conduct business in accordance with Phase I and/or Phase II CORE Operating Rules
    – Quickly realize operational efficiencies resulting from secure, timely and consistent delivery of eligibility, benefit and claim status information
    – Measure the benefits of implementing Phase I and II CORE Operating Rules
• Endorse CORE
  – For entities that Do Not create, transmit or use eligibility or claim status data
  – Publicly associate your organization with a national administrative simplification initiative
  – Encourage end-to-end adoption of rules among your trading partners that can implement CORE
Appendix: CORE Rules Related to Acknowledgements
# CORE Rule Requirements Related to Acknowledgements

## Summary of CORE Operating Rule Requirements Related to Acknowledgements:
*Phase I and Phase II Rules updated for v5010 and draft Phase III Rules*

<table>
<thead>
<tr>
<th>Layer</th>
<th>Transaction</th>
<th>CORE Real-Time Acknowledgements</th>
<th>CORE Batch Acknowledgements</th>
</tr>
</thead>
</table>
| **Payload** | Eligibility Inquiry (270/271) | ● TA1 (not addressed in CORE Rule)  
● 999 required when and only when 270 submission is rejected  
● 271 response returned when 270 submission not rejected | ● TA1 (not addressed in CORE Rule)  
● 999 always required for both provider and health plan to report successful receipt, including errors and/or rejection  
● 271 Response returned when 270 not rejected |
| | Claim Status (276/277) | ● TA1 (not addressed in CORE Rule)  
● 999 required by when and only when 276 submission is rejected  
● 277 Response returned when 276 submission not rejected | ● TA1 (not addressed in CORE Rule)  
● 999 always required for both provider and health plan to report successful receipt, including errors and/or rejection  
● 277 Response returned when 276 not rejected |
| | Health Care Claim (837) | ● 277CA Claim Acknowledgement required whether or not claim submitted in real-time or batch (real-time adjudication out of scope) | ● 277CA Claim Acknowledgement required whether or not claim submitted in real-time or batch (real-time adjudication out of scope) |
| | Prior Authorization (278) | ● TA1 (not addressed in CORE Rule)  
● 999 required when and only when 278 submission is rejected  
● 278 Response returned when 278 submission not rejected | ● TA1 (not addressed in CORE Rule)  
● 999 always required for both provider and health plan to report successful receipt, including errors and/or rejection  
● 278 Response returned when 278 submission not rejected |
| | Claim Payment/Advice (835) | N/A | ● 999 always required for provider to notify health plan of successful receipt, including errors and/or rejection |
| **Transport Layer** | Applies to all payloads | HTTP/S (industry neutral standard)  
SOAP or MIME (industry neutral standard) | HTTP/S (industry neutral standard)  
SOAP or MIME (industry neutral standard) |
| **Message Layer** | | | CORE Connectivity Rule includes requirements for how provider obtains Acknowledgements |