Committee on Operating Rules For Information Exchange (CORE®)

Calling All Project Managers: Preparing to Implement the Mandated CAQH CORE Eligibility & Claim Status Operating Rules

Industry Education Session

April 9, 2012
Session Learning Objectives

Attendees will:

• Be able to describe the adoption and implementation timeline for the federally mandated operating rules

• Learn the key requirements of the CAQH CORE Operating Rules for Eligibility and Claim Status

• Understand the key analysis & planning tasks for adopting the CAQH CORE Eligibility & Claim Status Operating Rules

• Be aware of available CAQH CORE tools and resources to assist with analysis & planning and how to use them
Snapshot of Call Participants

- More than 330 individuals representing almost 200 unique entities (both CORE and non-CORE Participants)
  - All key stakeholder groups including:
    - Health Plans
    - Providers
    - Vendors
    - Clearinghouses
    - Government Entities
    - Associations
  - Range of technical and non-technical experts, examples of titles include:
    - Project Manager
    - Business Analyst/Consultant
    - IT Manager
    - Compliance Analyst
    - Product Manager
    - EDI Director
    - Government Affairs
## Agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time (including Q &amp; A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Overview of CAQH CORE</td>
<td>5 minutes</td>
</tr>
<tr>
<td>ACA Section 1104 Mandated Operating Rules</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Mandated Operating Rules: Eligibility &amp; Claim Status</td>
<td>25 minutes</td>
</tr>
<tr>
<td>• Detailed Review of CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td></td>
</tr>
<tr>
<td>Analysis &amp; Planning for Adopting the CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>35 minutes</td>
</tr>
<tr>
<td>• Click for New <a href="#">CAQH CORE Analysis &amp; Planning Guide</a></td>
<td></td>
</tr>
<tr>
<td>• Key Analysis &amp; Planning Tasks</td>
<td></td>
</tr>
<tr>
<td>Additional CAQH CORE Tools/Resources</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>
Brief Overview of CAQH CORE
CAQH®, a nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.

Multi-stakeholder collaboration of over 130 participating organizations that is developing industry-wide operating rules, built on existing standards, to streamline administrative transactions. Cover 75% of the commercially insured, plus Medicare and some Medicaid.

An industry utility that replaces multiple health plan paper processes for collecting provider data with a single, electronic, uniform data-collection system (i.e., credentialing). Over 990,000 providers self-report their information to UPD and over 650 organizations access the system, including a range of public and private entities.
Committee on Operating Rules for Information Exchange

- CAQH CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  - Integrated model: Rule writing, certification and testing, and outreach/education
- **Mission**: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
  - Enable providers to submit transactions from the system of their choice (*vendor agnostic*) and quickly receive a standardized response
  - Enable stakeholders to implement in phases that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption
  - Facilitate administrative and clinical data integration
- CAQH CORE is **not**:
  - Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7, OASIS, W3C
  - Developing software or building a database
What Are Operating Rules?

- The Patient Protection and Affordable Care Act (ACA) defines operating rules as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications”
- Operating rules address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards
  - Current healthcare operating rules build upon a range of standards – healthcare specific (e.g., ASC X12) and industry neutral (e.g., OASIS, W3C, ACH CCD+) – and support the national HIT agenda
- Operating rules encourage an interoperable network and, thereby, are vendor agnostic

Operating Rules: Key Components

- Rights and responsibilities of all parties
- Security
- Exception processing
- Transmission standards and formats
- Response timing standards
- Liabilities
- Error resolution
Operating Rules and Standards Work in Unison: Both Are Essential

- Operating rules always support standards – they already are being adopted together in today’s market and have been since 2006
  - The two should and can be implemented together without conflict
- Benefits of operating rules co-existing with and complementing standards are evidenced in other industries
  - Various sectors of banking (e.g., credit cards & financial institutions)
  - Different modes of communications and transportation
- Healthcare operating rules address and support a range of standards
  - Healthcare-specific standards, e.g., require non-mandated aspects of v5010 ASC X12 given data such as in/out of network patient responsibility are critical to administrative simplification
  - Industry-neutral standards, e.g., SOAP, WSDL, ACH CCD+
- Focus is ROI: Operating rules are built to be adaptive and responsive to administrative simplification needs before, during and after versions of standards are formally adopted
  - Coordination between operating rules and standards will be iterative as already demonstrated, e.g. new operating rules may be issued using the same version of a standard and items required by the operating rules will, in some instances, be moved into the next version of a standard and removed from rules
ACA Section 1104: 
Mandated Operating Rules
Administrative Simplification: ACA Section 1104

Section 1104 of the ACA (H.R.3590)

“…Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs”

Highlights

- Updates initial August 2000 HIPAA regulation for transaction standards and code sets given world has significantly changed, and unnecessary healthcare costs/burden must be removed from the system
- Requires the Department of Health and Human Services (HHS) to appoint a “qualified non-profit entity” to develop a set of operating rules for the conduct of electronic administrative healthcare transactions
- Administrative and financial standards and operating rules must, e.g.
  - Enable the determination of eligibility and financial responsibility for specific services prior to or at the point of care
  - Be comprehensive, requiring minimal augmentation
  - Provide for timely acknowledgment, response, and status reporting
- HIPAA covered entities, and business associates engaging in HIPAA standard transactions on behalf of covered entities, must comply
- Health plans must file a statement with HHS confirming compliance; financial penalties for health plans are significant
ACA Mandated Operating Rules Approach

Operating rule writing and mandated implementation timeframe per ACA legislation

Adoption deadlines to finalize operating rules

- **July 2011**: Eligibility and Claim Status
- **July 2012**: Claims payment/advice and electronic funds transfer
- **July 2014**: Enrollment, Referral authorization, attachments, etc.

Effective dates to implement operating rules
- **January 2013**: 2013
- **January 2014**: 2015, 2016
- **January 2016**:

NOTES:
1. NCVHS is the body designated by HHS to make recommendations regarding the operating rule authors and the operating rules.
2. Statute defines relationship between operating rules and standards.
3. Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans.
4. Per statute, documentation of compliance for health plans may include completion of end-to-end testing (i.e., certification and testing).
ACA Federal Compliance Requirements: Highlights & Key Dates

The following dates are critical for industry implementation of the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules. *Note there are two types of penalties related to compliance with the mandated operating rules.*

• **January 1, 2013:** Effective Date by which HIPAA-covered entities must comply with the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules
  – *Penalties for All HIPAA-covered Entities:* The HIPAA Administrative Simplification provisions require all HIPAA-covered entities to comply with the Federally mandated requirements by their effective dates (January 1, 2013 for the eligibility and claim status operating rules). The penalties to be assessed for non-compliance were formalized in the original HIPAA legislation and updated by the Health Information Technology for Economic and Clinical Health (HITECH) rules in 2009. Due to HITECH, CMS OESS (Office of E-Health Standards and Services) penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year.

• **December 31, 2013:** Certification Date by which health plans must “file a statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules” including the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules
  – **According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year.**

*The CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.*

**CAQH CORE will continue to offer its voluntary CORE Certification program and will share lessons learned with CMS as the Federal process is developed.*
ACA Federal Compliance Requirements: *Highlights & Key Dates (cont’d)*

- **No Later than April 1, 2014:** Health Plan Penalty Date by which CMS will begin assessing penalties against health plans that have failed to meet the certification and compliance requirements for standards and operating rules per Section 1104 of the ACA, including the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules
  - *Penalties for Health Plan Certification:* The ACA requires HHS to **assess penalties** against **health plans** that fail to certify compliance; the fee amount equals $1 per covered life until certification is complete (covered life for which the plan’s data systems are not in compliance and shall be imposed for each day the plan is not in compliance).
    - Penalties for deliberate misrepresentation are twice the amount imposed for failure to comply and cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation.
  - See the [March 2012 CAQH CORE Town Hall Presentation](#) for a CMS overview of Federal regulations on HIPAA compliance

*The CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.*
Mandated Operating Rules:
Eligibility & Claim Status
Mandated Eligibility & Claim Status Operating Rules: Status

- **Status**: The first set of operating rules have been adopted into Federal regulation
  - July 2011, CMS published [CMS-0032-IFC](https://www.cms.gov/Files/document/CMS-0032-IFC.pdf) with the following key features:
    - Adopted Phase I and II CAQH CORE Operating Rules for the Eligibility & Claim Status transactions, **except for rule requirements pertaining to Acknowledgements**
    - Highlights CORE Certification is **voluntary**; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation
    - CAQH CORE is committed to assisting with roll-out of the Final Rule, including optimal packaging of rules that supports both mandated and voluntary efforts (will not change rule requirements) and continuing to support maintenance of the rules, e.g., coordinating with CMS on FAQs, hosting education sessions
  - ACA Section 1104 requires **all HIPAA covered entities** be compliant with applicable HIPAA standards and associated operating rules

*On September 22, 2011, NCVHS issued a [letter](https://www.ncvhs.hhs.gov/tracking_letter/2011/2011_B05_letter.pdf) recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.*
# Mandated Eligibility & Claim Status Operating Rules: Scope of CAQH CORE Operating Rules

## Topics that the CAQH CORE Eligibility & Claim Status Operating Rules Address:

All are within ACA-defined scope of operating rules and build on standards where appropriate

<table>
<thead>
<tr>
<th>Data Content: Eligibility</th>
<th>Address Need to Drive Further Industry Value in v5010 Investment</th>
<th>More Robust Eligibility Verification Plus Financials</th>
<th>Enhanced Error Reporting and Patient Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure: Eligibility and Claim Status</td>
<td>Address Industry Needs for Common/Accessible Documentation</td>
<td>Companion Guides</td>
<td>System Availability</td>
</tr>
<tr>
<td></td>
<td>Address Industry-wide Goals for Architecture/Performance/Connectivity</td>
<td>Response Times</td>
<td>Acknowledgements*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connectivity and Security</td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: In the [Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction](https://www.partnershipforpatients.org/hhs-books/), requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”*
5-Minute Q & A:
Questions on ACA Section 1104
Mandated Operating Rules

Additional Time for Q & A at the End of the Presentation
Detailed Review of Mandated CAQH CORE Eligibility & Claim Status Operating Rules
CAQH CORE Eligibility & Claim Status Operating Rules: Summary

- **Rules Addressing the X12 270/271 Eligibility & Benefits Transactions**
  - Data Content Related Rules
    - CAQH CORE 154 & 260: Eligibility & Benefits Data Content Rules
    - CAQH CORE 258: Normalizing Patient Last Name Rule for Eligibility
    - CAQH CORE 259: AAA Error Code Rule for Eligibility
  - Infrastructure Related Rules
    - CAQH CORE 150: Batch Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 151: Real Time Acknowledgements Rule for Eligibility (999)*
    - CAQH CORE 152: Companion Guide Rule
    - CAQH CORE 155: Batch Response Time Rule for Eligibility
    - CAQH CORE 156: Real Time Response Rule for Eligibility
    - CAQH CORE 157: System Availability Rule
    - CAQH CORE 153 & 270: Connectivity Rules

- **Rules Addressing the X12 276/277 Claim Status Transactions**
  - CAQH CORE 250: 276/277 Claim Status Infrastructure Rule*

**NOTES:**
- The CAQH CORE Eligibility & Claim Status Operating Rules were initially developed in two phases; for ease of use the rules are presented here by transaction addressed and rule type rather than by phase.
- *In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction requirements pertaining to use of Acknowledgements are NOT included for adoption.
CAQH CORE Eligibility & Claim Status Operating Rules: Structure

- CAQH CORE Operating Rules are organized around the following sections:
  - **Rule Background & Problem Space**
    - Identifies the standard transaction(s) the rule addresses
    - Describes the foundation for the rule & how the rule builds upon this foundation
    - Describes the problem space addressed and the business case for the rule requirements
  - **Rule Scope**
    - Identifies to what and when the rule applies
    - What the rule does not require and what is outside the rule scope
    - Applicable loops, segments, and data elements
    - Rule’s assumptions
  - **Detailed Rule Requirements**
    - Identifies the data content and/or infrastructure requirements for the transaction addressed
  - **Requirements for Entities Seeking Voluntary CORE Certification**
    - Identifies, at a high-level, the conformance testing requirements for entities seeking voluntary CORE Certification
Eligibility & Benefits (270/271) Data Content Rules: Rules 154 & 260

- **Problem addressed by rules**
  - Minimal delivery of eligibility information including variable support for service type requests; limited patient eligibility and benefits information at the point of service; limits the possibility of an “all payer” solution

- **Scope of the rules**
  - Applies when an entity uses, conducts or processes the X12 270/271 transactions; X12 271 response relates to both generic and explicit inquiries
  - Requirements address certain situational elements and codes; are in addition to requirements contained in the v5010 X12 270/271 Implementation Guides

- **High–level rule requirements**
  - For health plans and information sources:
    - X12 271 response to both generic and explicit X12 270 inquiries must include:
      - Name of the health plan covering the individual (if available)
      - Patient financials for:
        - Co–insurance and co–payment
        - Base and remaining deductibles (including both individual and family deductibles)
          - When health plan base deductible date is not the same date as the health plan coverage date for the individual, begin date for the base health plan deductible must be returned
          - When benefit-specific base deductible date is not the same date as the health plan coverage dates for the individual, begin date for base benefit-specific deductible only must be returned
          - If financial responsibility is different for in-network vs. out-of-network, both amounts must be returned
Eligibility & Benefits (270/271) Data Content Rules: Rules 154 & 260 cont’d

• High-level rule requirements*
  – For health plans and information sources cont’d:
    • Requirements for returning the CORE-required eligibility & benefits data for specific STCs:
      – For a generic X12 270 inquiry (i.e., STC 30), health plans and information sources must return CORE-required data for 13 total CORE-required service type codes
      – For an explicit X12 270 inquiry including one of 51 CORE-required service type codes, health plans and information sources must return CORE-required data
      – For both generic & explicit X12 270 inquiries, health plans and information sources have the discretion to choose to return patient financial responsibility for 9 CORE-required service type codes (all other content must be returned):
        • NOTE: Patient financial responsibility is discretionary for these 9 STCs because they are too general for a response to be meaningful, typically a “carve-out” benefit, or related to behavioral health or substance abuse.
    – For providers, provider vendors and information receivers:
      • Detect and extract all data elements to which this rule applies as returned by the health plan or information source in the X12 271 response
      • Display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 271 response data content

*Requirements are above and beyond the minimum compliant response required by the v5010 TR3.
Eligibility & Benefits (270/271) Data Content Rules: Rules 154 & 260 cont’d

- **High-level rule requirements:**
  - **CORE-required Service Type Codes**
  - **Generic Response STCs:** STCs for which plans/information sources must return CORE-required eligibility & benefits data in response to a *generic* X12 270 inquiry (i.e., STC 30)
    - 1 – Medical Care
    - 30 – Health Benefit Plan Coverage
    - 33 – Chiropractic
    - 35 – Dental Care
    - 47 – Hospital
    - 48 – Hospital – Inpatient
    - 50 – Hospital – Outpatient
    - 86 – Emergency Services
    - 88 – Pharmacy
    - 98 – Professional (Physician) Visit – Office
    - AL – Vision (Optometry)
    - MH – Mental Health
    - UC – Urgent Care
  - **Explicit Response STCs:** STCs for which plans/information sources must return CORE-required eligibility & benefits data in response to an *explicit* X12 270 inquiry
    - 1 – Medical Care
    - 2 – Surgical
    - 4 – Diagnostic X–Ray
    - 5 – Diagnostic Lab
    - 6 – Radiation Therapy
    - 7 – Anesthesia
    - 8 – Surgical Assistance
    - 12 – Durable Medical Equipment Purchase
    - 13 – Facility
    - 18 – Durable Medical Equipment Rental
    - 20 – Second Surgical Opinion
    - 33 – Chiropractic
    - 35 – Dental Care
    - 40 – Oral Surgery
    - 42 – Home Health Care
    - 45 – Hospice
    - 47 – Hospital
    - 48 – Hospital – Inpatient
    - 50 – Hospital – Outpatient
    - 98 – Professional (Physician) Visit – Office
    - 99 – Professional (Physician) Visit – Inpatient
    - A0 – Professional (Physician) Visit – Outpatient
    - A3 – Professional (Physician) Visit – Home
    - A6 – Psychotherapy
    - A7 – Psychiatric Inpatient
    - A8 – psychiatric Outpatient
    - AD – Occupational Therapy
    - AE – Physical Medicine
    - AF – Speech Therapy
    - AG – Skilled Nursing Care
    - AI – Substance Abuse
    - AL – vision (Optometry)
    - BG – Cardiac Rehabilitation
    - BH – Pediatric
    - MH – Mental Health
    - UC – Urgent Care
Eligibility & Benefits (270/271) Data Content Rules: Rules 154 & 260 cont’d

• High-level rule requirements:
  – CORE-required Service Type Codes cont’d

• Discretionary Response STCs: STCs for which plans/information sources have the discretion to choose to return patient financial responsibility in response to both generic and explicit X12 270 inquiries (All other CORE-required data content must be returned)
  – 1 – Medical Care
  – 35 – Dental Care
  – 88 – Pharmacy
  – A6 – Psychotherapy
  – A7 – Psychiatric Inpatient
  – A8 – psychiatric Outpatient
  – A1 – Substance Abuse
  – AL – Vision (Optometry)
  – MH – Mental Health
Eligibility & Benefits Normalizing Patient Last Name Rule: Rule 258

- **Problem addressed by rule**
  - Transactions may be rejected when demographic data submitted by the healthcare provider does not match similar demographic data held by the health plan

- **Scope of the rule**
  - Applies to the X12 270/271 transaction and specifies requirements for a health plan (or information source) to normalize a person’s last name during any name validation or matching process by the health plan (or information source)

- **High-level rule requirements**
  - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
    - Remove specified suffix and prefix character strings, special characters and punctuation
    - If normalized name validated, move forward
    - If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
    - If normalized name not validated, return specified AAA code
Eligibility & Benefits AAA Error Code Reporting Rule: Rule 259

- **Problem addressed by rule**
  - Lack of specificity and standardized use of AAA error codes; providers inability to determine which information is missing or incorrect when an eligibility and benefits inquiry does not return a valid match

- **Scope of the rule**
  - Defines a standard way to report errors that cause a health plan (or information source) not to be able to respond with an X12 271 showing eligibility information for the requested patient or subscriber

- **High-level rule requirements**
  - Requires health plans to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements in order to communicate the specific errors to the submitter *(designed to work with any search and match criteria or logic)*
  - The receiver of the X12 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid
Eligibility & Benefits Acknowledgement Rules (Batch & Real-Time): Rules 150 & 151*

- **Problem addressed by rules**
  - Inconsistent/non-standard use of acknowledgements leads to “black hole”

- **Scope of the rules**
  - Applies to submitters of X12 270 inquiry and receivers of X12 271 response for real time and batch transactions specifying when to use the ASC X12 005010X231A1 Implementation Acknowledgement for Health Care Insurance (999)

- **High-level rule requirements**
  - **Real-Time**
    - Submitter will always receive a response (i.e., an X12 271 or 999)
    - Submitter will receive only one response
  - **Batch**
    - Receivers include
      - Plans, intermediaries, providers
    - Will always return a 999 to acknowledge receipt for
      - Rejections
      - Acceptances

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are **NOT** included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”
Eligibility & Benefits Companion Guide Rule: Rule 152

• Problem addressed by rule
  – Formats across the country used by health plan for their specific companion guides vary significantly and thus introduce an added layer of administrative cost and operational complexity for trading partners

• Scope of the rule
  – Applies to health plans or information sources that publish companion guides
  – Developed with input from multiple health plans, system vendors, provider representatives and healthcare/HIPAA industry experts

• High-level rule requirements
  – Companion Guides covering Eligibility Benefit Request and Response (270/271) must follow the format and flow of the CAQH CORE v5010 Master Companion Guide Template
  – Companion Guide Template* organizes information into distinct sections
    • General Information
    • Transaction-Specific Information
    • Appendix
  – Allows health plans (information sources) to tailor the document to meet their particular needs while still maintaining a standard template/common structure

Eligibility & Benefits **Response Time Rules (Batch & Real-Time): Rules 155 & 156**

- **Problem addressed by rules**
  - Lengthy and/or unpredictable eligibility and benefits response times impacts workflow, practice productivity and patient experience

- **Scope of the rules**
  - Apply when an entity uses, conducts or processes the X12 270/271 transactions

- **High-level rule requirements**
  - Real-Time Response
    - Maximum: 20-second round trip
  - Batch Response (only applies if batch offered by entity)
    - Receipt by 9:00 p.m. Eastern Time requires response by 7:00 a.m. Eastern Time the next business day
  - Conformance with this rule will be considered achieved if entities meet these measures 90 percent of the time within a calendar month
Eligibility & Benefits System Availability Rule: Rule 157

- **Problem addressed by rule**
  - Limited system availability impacts workflow and reduces productivity

- **Scope of the rule**
  - Applies when an entity uses, conducts or processes the 270/271 transactions

- **High-level rule requirements**
  - Minimum of 86 percent system availability (per calendar week)
    - Publish regularly scheduled downtime
    - Provide one week advance notice on non-routine downtime
    - Provide information within one hour of emergency downtime
Eligibility & Benefits Connectivity Rules: Rules 153 & 270

• **Problem addressed by rules**
  – Multiple methods for exchanging eligibility and benefits data both manually and/or electronically drive elevated transaction costs and increase operational complexity

• **Scope of the rules**
  – Using the internet as a delivery option, establishes a “Safe Harbor” connectivity rule which standardizes the flow of administrative transactions between health plan and provider
    • Rule 270 builds on Rule 153 to include more prescriptive submitter authentication, envelope specifications, etc.
  – Applies to information sources performing the role of an HTTP/S server and information receivers performing the role of an HTTP/S client
  – Applies to both batch and real time transactions
  – **Does not** require trading partners to remove existing connections that do not match the rule
Eligibility & Benefits Connectivity Rules: Rules 153 & 270 cont’d

• **High-level rule requirements**
  – Support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transactions, using specified envelope standards
  – Real-time and/or batch* request submission and response retrieve/pickup guidelines
  – Security and authentication requirements
  – Response message options and error notification
  – Response time, time out parameters and re-transmission guidelines

<table>
<thead>
<tr>
<th>Rule Area</th>
<th>High Level Rule Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitter (Originating System or Client) Authentication</td>
<td>Name/Password or X.509 Certificate (subject to conformance requirements)</td>
</tr>
<tr>
<td>Transport Security</td>
<td>SSL 3.0 is required for certification, but TLS is supported for FIPS 140 compliance</td>
</tr>
<tr>
<td>Envelope and Attachment Standards</td>
<td>SOAP 1.2 + WSDL and MTOM (for Batch) or HTTP+MIME (subject to conformance requirements)</td>
</tr>
<tr>
<td>Envelope Metadata</td>
<td>Metadata defined (Field names, values) (e.g., <strong>PayloadType</strong>, <strong>Processing Mode</strong>, <strong>Sender ID</strong>, <strong>Receiver ID</strong>)</td>
</tr>
<tr>
<td>Payload level Security</td>
<td>Considered and deferred to later Phase</td>
</tr>
<tr>
<td>Acknowledgements, Errors</td>
<td>Enhanced, with additional specificity on error codes</td>
</tr>
</tbody>
</table>

*Only applies if batch offered by entity.
Claim Status Infrastructure Rule: Rule 250

- **Problem addressed by rule**
  - Lack of industry foundation for efficient data flow and timely response

- **Scope of the rule**
  - Applies when an entity uses, conducts or processes the X12 276/277 transactions

- **High-level rule requirements**
  - Entities must provide claim status in accordance with the CAQH CORE Operating Rules infrastructure requirements, for example:
    - Offer real-time response (20 seconds or less)
    - Meet CORE batch response requirements (if you offer batch)
    - Meet CORE system availability requirements
    - Use of CORE Acknowledgements Rules*
    - Offer a CORE Connectivity option
    - Follow the flow and format as defined in CAQH CORE 152 Companion Guide Rule

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are **NOT** included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note "we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein."
5-Minute Q & A:
Questions on the CAQH CORE Eligibility & Claim Status Operating Rules Requirements

Additional Time for Q & A at the End of the Presentation
Analysis & Planning for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules
CAQH CORE Rules Systems Development Project

- Typical systems development life cycle consists of five steps
  - CAQH CORE tools/resources assist with completing **Step 1: Analyze & Plan** as this sets the stage; a solid understanding of the CAQH CORE Operating Rules combined with an effective planning effort is the basis for a successful implementation project

*Focus and Scope of CAQH CORE Tools is Step 1*

**Step 1:** Analyze & Plan

- **Step 2:** Systems Design
- **Step 3:** Implementation
- **Step 4:** Integration & Testing
- **Step 5:** Deploy & Maintain

*The effective date for the first set of operating rules for eligibility & claim status is January 1, 2013.*
CAQH CORE Rules Analysis & Planning

- **Required Tasks for Step 1: Analyze & Plan**

  - **Task A:** Staff Education & Training
  - **Task B:** Determine Your Organization’s “Stakeholder & Business Type(s)”*
  - **Task C:** Conduct a “Systems Inventory & Impact Assessment”*
  - **Task D:** Conduct a Detailed Rule Requirements “Gap Analysis”*
  - **Task E:** Develop a Detailed Project Plan

*Indicates CAQH CORE tool is available

- CAQH CORE provides an [Analysis & Planning Guide](#) to assist with completion of the required tasks for adoption of the CAQH CORE Eligibility & Claim Status Operating Rules.

- At completion of Step 1 entities will have:
  - Created an impact analysis outlining internal & external systems impacted by the CAQH CORE Rules
  - Developed a detailed project plan to adopt applicable CAQH CORE Rule requirements
CAQH CORE Analysis & Planning Guide: Overview

• The new *Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules* provides guidance for Project Managers, Business Analysts, System Analysts, Architects, and other project staff to complete systems analysis & planning.

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

• The guide includes three tools to assist entities in completing analysis & planning:
  – Stakeholder and Business Type Evaluation
  – Systems Inventory & Impact Assessment Worksheet
  – Gap Analysis Worksheet
**Stakeholder & Business Type Evaluation:**

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

---

**Systems Inventory & Impact Assessment Worksheet:**

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

---

**Gap Analysis Worksheet:**

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

---

Each of the above tools can be found in the CAQH CORE *Analysis & Planning Guide*. 
Task A: Staff Education and Training

- Thoroughly review and understand the CAQH CORE Eligibility & Claim Status Operating Rules (Phase I & II)
  - View PowerPoint Overview of the CAQH CORE Eligibility & Claim Status Operating Rules
- Conduct general education and awareness of the CAQH CORE Rules across the impacted areas in your organization
- Consider attending CAQH CORE Education Sessions
  - CAQH CORE holds frequent sessions with partners; many include speakers from organizations that have already implemented the rules
  - Past sessions available for download on CAQH CORE website
Task B: Determine Your Organization’s Stakeholder Type(s) Using the CAQH CORE Stakeholder & Business Type Evaluation

- Evaluate your stakeholder type(s) to determine which CAQH CORE Rules apply to your organization; understand role of your intermediaries
  - CAQH CORE Rule requirements are tied to applicable stakeholder type(s): provider, health plan, clearinghouse, and vendor
- Generally consider which trading partners you need to work with on planning and implementation
- When a clearinghouse or vendor is involved in data exchange between health plan and provider’s systems, then:
  - Identifying the role and responsibility of each entity end-to-end is an important step
  - Joint integration planning between health plan and clearinghouse or provider and vendor/clearinghouse will ensure conformance requirements and ROI goals are met
Task C: Conduct a Systems Inventory Using the CAQH CORE Systems Inventory & Impact Assessment Worksheet

- Relative to your stakeholder type(s):
  - Identify and inventory all impacted external and internal systems and outsourced vendors that process the eligibility &/or claim status transactions
  - Determine which functions for each identified impacted system/outsourced vendor are in-house developed and maintained, commercial off the shelf (COTS) system, or outsourced to a third party
  - Determine potential options for addressing the CAQH CORE Operating Rule requirements applicable to your stakeholder type(s), e.g.:
    - Remediate an in-house developed system
    - Replace or upgrade any COTS system
    - Work with third party vendor to ensure they meet CAQH CORE Operating Rule requirements
Task D: Conduct a Detailed Rule Requirements Gap Analysis Using the CAQH CORE Gap Analysis Worksheet

- For each impacted systems from the Systems Inventory & Impact Assessment Worksheet, determine responsibility for each CAQH CORE Rule requirement
- Document any gaps between the existing system’s capability and each rule requirement
- Determine level of system(s) remediation necessary to adopt the business requirements of the CAQH CORE Operating Rules
- Identify and document any business processes which may also be impacted by each CAQH CORE Rule requirement and to what extent each process is impacted
Task E: Develop a Detailed Project Plan

A detailed project plan typically includes the following key activities:

- Determine required resources to complete project (estimate resources, time and money)
- Develop detailed Functional Requirements Document
- Create detailed Systems Design Document describing required functions and capabilities
- Implement necessary system enhancements
- Test to demonstrate conformance with Functional Requirements Document
- Deploy (i.e., implement system into production environment)
- Conduct trading partners implementation testing

- Consider seeking voluntary CORE Certification*
  - CAQH CORE offers voluntary CORE Certification to the four stakeholder types that create, transmit or use eligibility and claim status data: health plans, providers, software/services vendors, and clearinghouses

*NOTE: The voluntary CORE Certification Program offered by CAQH CORE is separate from the CMS Federal operating rules compliance program mandated by the ACA. Information on the CMS compliance program regarding operating rules is under development and can be found HERE.
5-Minute Q & A:
Questions on Analysis & Planning for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules

Additional Time for Q & A at the End of the Presentation
Additional Resources for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules
CAQH CORE Eligibility & Claim Status Rules: Resources

• **FAQs:**
  – CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; in the process of reviewing these FAQs and updating as appropriate given mandates
    • Example: FAQ #227: CAQH CORE 259: AAA Error Code Reporting Rule
      – **Question:** Does this rule require specific search or match criteria logic to be used when validating member demographic data?
      – **Answer:** No, the CAQH CORE AAA Error Code Reporting Rule does not require a Health Plan/Information Source to use any specific search and match criteria or logic.
    • If question not listed as an FAQ, email question to core@caqh.org

• **Phase I & Phase II CORE Certification Master Test Suites:**
  – Initially developed for voluntary CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CAQH CORE Operating Rules
  – Provide guidance on the stakeholder types to which the rules apply and working with trading partners

• **Education Sessions:**
  – CAQH CORE holds frequent sessions with partners (WEDI, CHIME, and Medicaid) and many include speakers from organizations that have already implemented the rules; past sessions available on CAQH CORE website

• **General/Interpretation Questions:**
  – After reviewing other tools & resources, email CORE@caqh.org for additional interpretations or general questions
CAQH CORE Eligibility & Claim Status Rules:  
*Voluntary CORE Certification*

- Consider pursuing *voluntary* CORE Certification
  - **WHY:** CORE Certification Testing offers a mechanism to test your ability to exchange eligibility and claim status transaction data with your trading partners
  - **WHAT:** CORE Certification is awarded to organizations that *voluntarily* complete CORE Certification Testing; CORE Certification testing is stakeholder specific and demonstrates an applicant’s system(s) conform with applicable CAQH CORE Rules

- Key benefits of *voluntary* CORE Certification
  - Demonstrates to the industry adoption of the CAQH CORE Operating Rules via a recognized industry “Seal”
  - Encourages trading partners to work together on transaction data content, infrastructure and connectivity needs
  - Independent testing of operating rules implementation can reduce the amount of work to required for successful trading partner testing
  - Promotes maximum ROI when all stakeholders in the information exchange are known to conform with the CAQH CORE Operating Rules

- Currently, **60 organizations** are Phase I CORE-certified; 27 also Phase II CORE-certified

- Certification and testing are *separate activities*
  - Testing is performed online by CAQH CORE-authorized testing vendor; Certification is completed by CAQH CORE and occurs after successful testing is completed

*NOTES:*
(1) The voluntary CORE Certification Program offered by CAQH CORE is separate from the CMS Federal operating rules compliance program mandated by the ACA. Information on the CMS compliance program regarding operating rules is under development and can be found [HERE](#).
(2) Entities are required to complete the rule requirements pertaining to acknowledgements to achieve *voluntary* CORE Certification.
Question & Answer