

simplifying healthcare administration

CAQH<sup>®</sup>

# **Committee on Operating Rules For Information Exchange (CORE<sup>®</sup>)**

*Overview of Mandated CAQH CORE Eligibility & Claim Status  
Operating Rules*

March 28, 2012

# Table of Contents

---

- Brief Overview of CAQH CORE
- ACA Section 1104: Mandated Operating Rules
  - Highlights from the Legislation
  - Implementation Timeline/Compliance Deadlines
- Mandated Operating Rules: Eligibility & Claim Status
  - Status & High-Level Rule Requirements
- Appendix: Detailed Review of Mandated CAQH CORE Eligibility & Claim Status Operating Rules

---

## Brief Overview of CAQH CORE

# Committee on Operating Rules for Information Exchange: *Background*

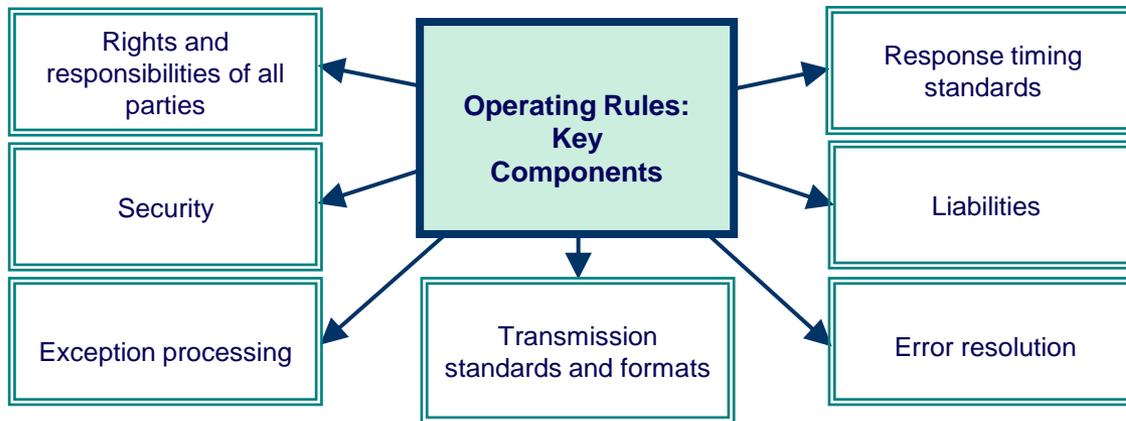
- CAQH CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  - Integrated model: Rule writing, certification and testing, and outreach/education
- Mission: To build consensus among healthcare industry 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
- CORE Participants maintain eligibility/benefits data for over 150 million lives, or approximately 75% of the commercially insured plus Medicare and state-based Medicaid beneficiaries
  - Since 2005, CAQH CORE Operating Rules have been developed through the collaboration of healthcare industry stakeholders using a consensus-based process
  - CAQH CORE Operating Rules are publicly available for free on the [CAQH website](#)

*simplifying healthcare administration*

**CAQH**<sup>®</sup>

# 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 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 of 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

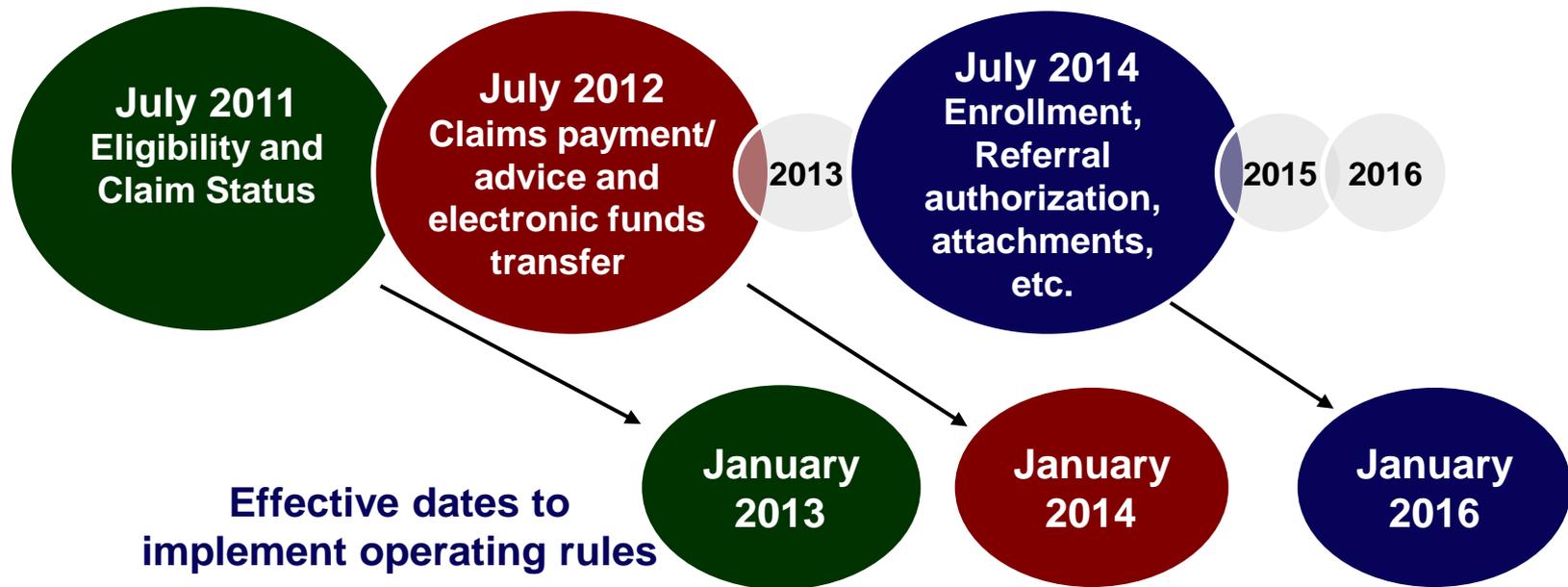
*simplifying healthcare administration*

**CAQH**<sup>®</sup>

# ACA Mandated Operating Rules Approach

Operating rule writing and mandated implementation timeframe per ACA legislation

## Adoption deadlines to finalize operating rules



### 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).

*simplifying healthcare administration*

**CAQH**<sup>®</sup>

# ACA Federal Compliance Requirements: *Highlights*

- *All HIPAA covered entities* (health plans, providers, clearinghouses, etc.) must be in compliance with operating rules by their effective dates
  - Due to HITECH in November 2010, OESS (CMS Office of E-Health Standards and Services) penalties for non-compliance have increased, now up to \$1.5 million per entity per year; the CMS website [details](#) this enforcement process
- The Administrative Simplification provisions in the ACA require *health plans* “to file a statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules”\*
  - According to CMS, regulation detailing the health plan certification process is under development; details surrounding a potential process will be released later this year
  - [Penalties](#) for failure to certify will equal \$1 per covered life until certification is complete; 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
  - Certification schedule comes after the various effective dates for standards and operating rules
- See [March 2012 CAQH CORE Town Hall Presentation](#) for CMS Overview of Federal Regulations on HIPAA Compliance

\*Refer to [CMS Source](#)

10 **NOTE:** CAQH CORE will continue to offer its *voluntary* CORE Certification program and will share lessons learned with CMS as the Federal process is developed.

*simplifying healthcare administration*

**CAQH**<sup>®</sup>

---

## 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](#) 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
  - December 2011, CMS adopted above as a Final Rule; industry implementation efforts underway for the **January 1, 2013 effective date**
    - CAQH CORE is committed to assisting with roll-out of the Final Rule and continuing to support maintenance of the rules, e.g., coordinating with CMS on FAQs, hosting education sessions
    - CAQH CORE is working with users to identify future optimal packaging of CAQH CORE Rules for ease of use that supports both mandated and voluntary efforts; packaging will not change the rule requirements
- ACA Section 1104 requires *all HIPAA covered entities* be compliant with applicable HIPAA standards **and associated operating rules**

*The effective date for the first set of operating rules for eligibility & claim status is January 1, 2013; additional deadlines follow through 2016.*

*simplifying healthcare administration*



# 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*

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

\*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 270/271: *Transactional Data Content*

## Improve Eligibility Verification Plus Financials

CAQH CORE Data Content Rules for v5010 270/271 require that health plans and information sources that create a v5010 271 response to a generic v5010 270 inquiry must include:

- The **name of the health plan** covering the individual (if available)
- **Patient financials** for the static financials of co-insurance, co-payment, and deductible, and return the remaining deductible amount; include in-network and out-of-network coverage and financials for **48 required service types (benefits)**

For more detail, see CORE Rules [154](#) and [260](#)

## Enhanced Error Reporting and Patient Identification

CAQH CORE Normalizing Patient Last Name Rule requires health plans to **normalize submitted and stored last name** before using the submitted and stored last names:

- If normalized name validated, return v5010 271 with CORE-required content
- 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

For more detail, see CORE Rule [258](#)

CAQH CORE AAA Error reporting Rule 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.

The receiver of the v5010 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.

For more detail, see CORE Rule [259](#)

*simplifying healthcare administration*

# Eligibility 270/271 & Claim Status 276/277: *Uniform Operational Documentation*

## Companion Guides

The CAQH CORE Companion Guide Rule and Claim Status Rule require that Companion Guides covering v5010 270/271 and v5010 276/277 transactions **follow the format and flow of the CORE v5010 Master Companion Guide Template.**

The Companion Guide Template\* organizes information into distinct sections:

- General Information
- Connectivity with the payer
- Transaction-Specific Information
- Key contact information
- Testing with the payer
- Control segment details
- Payer specific business rules
- Allows health plans (information sources) to tailor the document to meet their particular needs while still maintaining a standard template/common structure

For more detail, see CORE Rules [152](#) and [250](#)

## System Availability

The CAQH CORE System Availability Rule and the Claim Status Rule establish guidelines for system availability and provider support for health plan eligibility and claim status transactions including:

- 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

For more detail, see CORE Rules [157](#) and [250](#)

*simplifying healthcare administration*

**CAQH**<sup>®</sup>

# Eligibility 270/271 & Claim Status 276/277: *Infrastructure*

## Response Time

Phase I and Phase II CAQH CORE Operating Rules include **maximum response processing guidelines**:

- Real-time Response of Maximum: 20-second round trip
- Batch (*if offered*) Response Receipt by 9 pm ET requires response by 7 am ET 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

*For more detail, see CORE Rules [155](#), [156](#) and [250](#)*

## Acknowledgements\*

Phase I and Phase II CAQH CORE Operating Rules include **assurances that sent transactions are accurately received** and to facilitate health plan correction of errors in outbound messages

For Real-time transactions, submitter will always receive a response (i.e., a v5010 271 or v5010 999), only one response; Batch Receivers include Plans, intermediaries and providers will always return a v5010 999 to acknowledge receipt for Rejections and Acceptance

*For more detail, see CORE Rules [150](#), [151](#) and [250](#)*

\***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”.

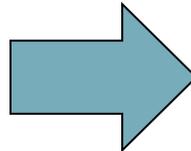
# Eligibility 270/271 & Claim Status 276/277: *Infrastructure (cont'd)*

## Connectivity\*

CORE-certified entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transaction, and claim status; they must follow:

- Real-time and/or batch request submission and response pickup guidelines
- Security and authentication requirements
- Response message options and error notification
- Response time, time out parameters and re-transmission guidelines
- Prescriptive submitter authentication, envelope specifications, etc.
- Payload-agnostic, can use to send any type of data

For more detail, see CORE Rules [153](#), [250](#) and [270](#)



## Safe Harbor

Phase I & II CAQH CORE Connectivity Rules constitute a **“Safe Harbor” rule which provides for a uniform method of exchanging administrative transaction data** between health plan and provider –*but other methods may be used. The rules:*

- Apply to information sources performing the role of an HTTP/S server and information receivers performing the role of an HTTP/S client
- Apply to real-time transactions (and batch, *if offered; batch NOT required*)
- Do not require trading partners to remove existing connections that do not match the rule
- Include prescriptive submitter authentication, envelope specifications, etc., (SOAP and WSDL, Name/Password or X.509 Certificate)

For more detail, see CORE Rules [153](#), [250](#) and [270](#)

simplifying healthcare administration

CAQH<sup>®</sup>

---

Appendix:  
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.

*simplifying healthcare administration*

**CAQH**<sup>®</sup>

# 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; constrains design of all payer solutions

- **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
- The requirements specified in these rules address certain situational elements and codes and 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 a generic X12 270 inquiry must include:
    - The name of the health plan covering the individual (if available)
    - Patient financials for the static financials of co-insurance, co-payment, and base and remaining deductibles for **13** total CORE-required service type codes
      - 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

# Eligibility & Benefits (270/271) Data Content Rules:

## *Rules 154 & 260 cont'd*

### – For health plans and information sources (cont'd):

- Must also support an *explicit* X12 270 inquiry for **51** CORE–required service type codes
  - X12 271 response to *explicit* X12 270 inquiry must include patient financials for the static financials of co–insurance, co–payment, and base and remaining deductibles for:

- 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
- 51 – Hospital – Emergency Accident
- 52 – Hospital – Emergency Medical
- 53 – Hospital – Ambulatory Surgical
- 62 – MRI/CAT Scan
- 65 – Newborn Care
- 68 – Well Baby Care
- 73 – Diagnostic Medical
- 76 – Dialysis
- 78 – Chemotherapy
- 80 – Immunizations
- 81 – Routine Physical
- 82 – Family Planning
- 86 – Emergency Services
- 88 – Pharmacy
- 93 – Podiatry
- 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*

- For health plans and information sources (cont'd):
  - For both *generic & explicit* X12 270 inquiries, return of patient financial responsibility is discretionary when reporting on these CORE-required service type codes:
    - 1 – Medical Care
    - 35 – Dental Care
    - 88 – Pharmacy
    - A6 – Psychotherapy
    - A7 – Psychiatric Inpatient
    - A8 – psychiatric Outpatient
    - AI – Substance Abuse
    - AL – Vision (Optometry)
    - MH – Mental Health
  - For all responses, if financial responsibility is different for in-network vs. out-of-network, must return both amounts
- High-level rule requirements 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
  - Display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the X12 271 data content

# 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.”

simplifying healthcare administration

CAQH<sup>®</sup>

# Eligibility & Benefits Real-Time 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

*simplifying healthcare administration*



# 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
- Real-time and/or batch\* request submission and response pickup guidelines
- Security and authentication requirements
- Response message options and error notification
- Response time, time out parameters and re-transmission guidelines

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

# 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.”