

simplifying healthcare administration

CAQH[®]

Committee on Operating Rules For Information Exchange (CORE[®])

*HIPAA Summit
ACA Operating Rules Update*

February 21, 2013

Additional information/resources available at www.caqh.org

Agenda

- CAQH CORE
- Update on ACA Mandated Healthcare Operating Rules
 - First Set: Eligibility & Claim Status Operating Rules
 - Lessons To-Date
 - Second Set: EFT & ERA Operating Rules
 - Implementation
 - Third Set: Attachments, Prior Authorization, Enrollment, etc.
 - Development Timeline and Initial Findings
- Brief Update on Other Activities
 - Voluntary Certification
 - Governance

CAQH: Current Initiatives



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



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



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



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



Committee on Operating Rules for Information Exchange

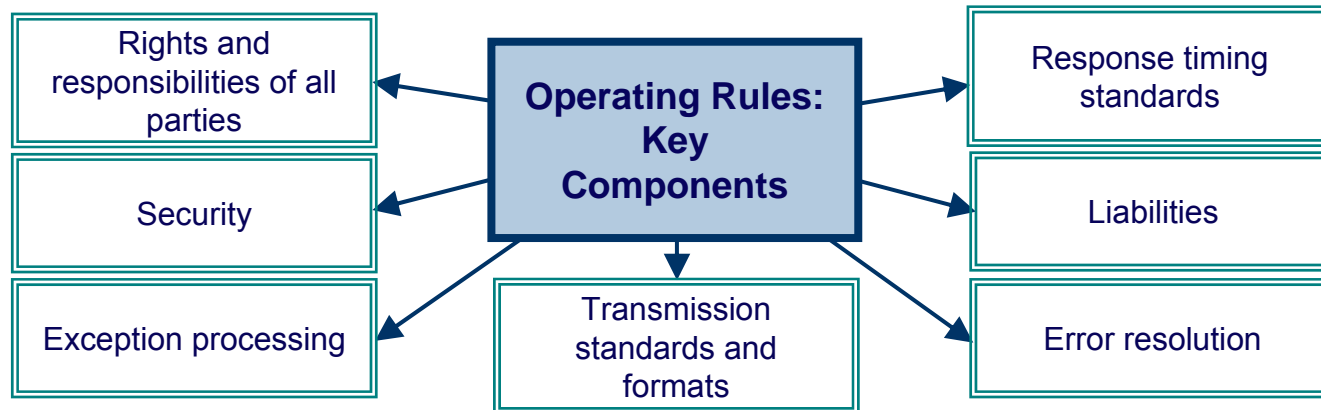
- A multi-stakeholder collaboration established in 2005
- Mission: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between providers and health plans
 - Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response
 - Facilitate administrative and clinical data integration
- Recognized healthcare operating rule author by NCVHS and HHS

CAQH CORE carries out its mission based on an integrated model



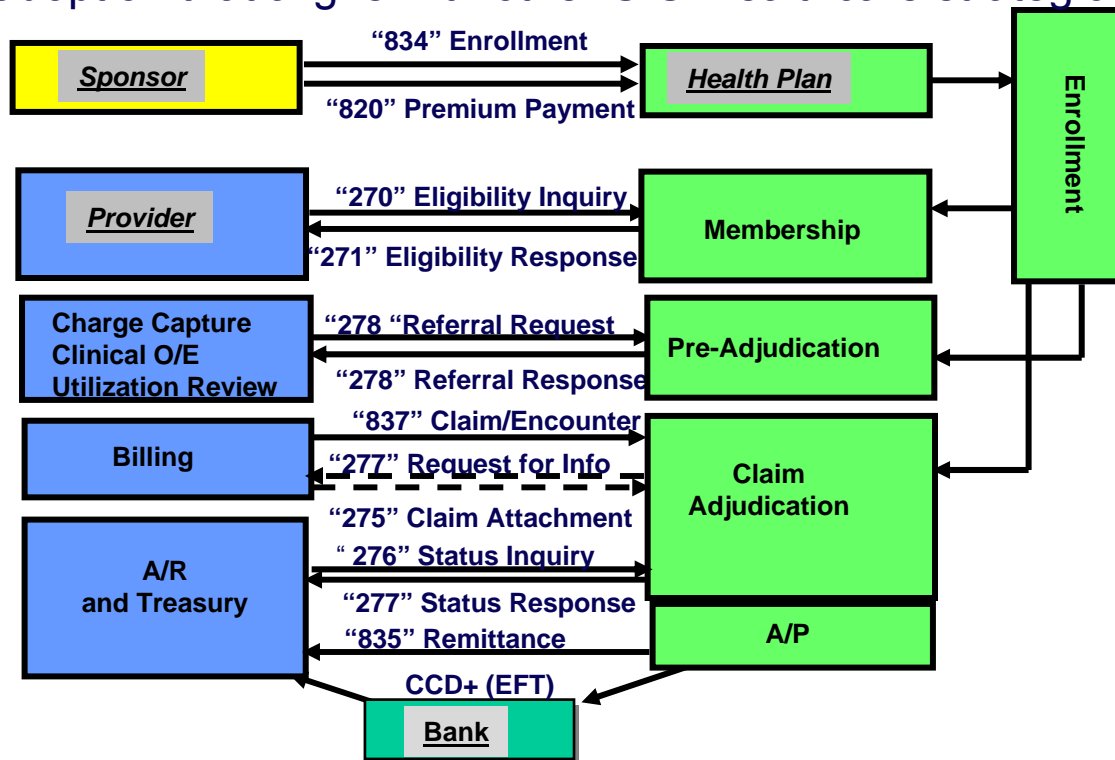
Purpose of Operating Rules

- 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.”
- They address gaps in standards, help refine the infrastructure that supports electronic data exchange and recognize interdependencies among transactions; they do not duplicate standards.



Transformation of Administrative Data Exchange

Goal: Generate a responsive, and adaptive, system-wide approach to administrative IT adoption that aligns with other U.S. healthcare strategic initiatives



Each major transaction was addressed by HIPAA in 1996, but standards alone were not enough to achieve industry Administrative Simplification. Due to the ACA and other market pressures, the revenue cycle process is experiencing significant transformation.

ACA Mandated Operating Rules Compliance Dates: *Required for all HIPAA Covered Entities*

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

**Compliance in Effect
as of January 1, 2013**

- Eligibility for health plan
- Claim status transactions

*HIPAA covered entities conduct these transactions
using the CAQH CORE Operating Rules*



**Implement by
January 1, 2014**

- Electronic funds transfer (EFT) transactions
- Health care payment and remittance advice (ERA) transactions



**Implement by
January 1, 2016**

- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments



Rule requirements available

ACA Mandated Healthcare Operating Rules: First Set - Eligibility & Claim Status

Mandated Eligibility & Claim Status Operating Rules

Rules		High-Level CAQH CORE Requirements
Data Content	Eligibility & Benefits	<p>Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:</p> <ul style="list-style-type: none"> • Health plan name and coverage dates. • Static financials (co-pay, co-insurance, base deductibles). • Benefit-specific and base deductible for individual and family. • In/Out of network variances. • Remaining deductible amounts. • Enhanced Patient Identification and Error Reporting requirements.
Infrastructure	Eligibility, Benefits & Claims Status	<ul style="list-style-type: none"> • Companion Guide – common flow/format. • System Availability service levels – minimum 86% availability per calendar week. • Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch). • Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment). • Acknowledgements (transactional).*

*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 and Claim Status Operating Rules: *Implementation Lessons Learned*

Challenges for some are the key Opportunities for others

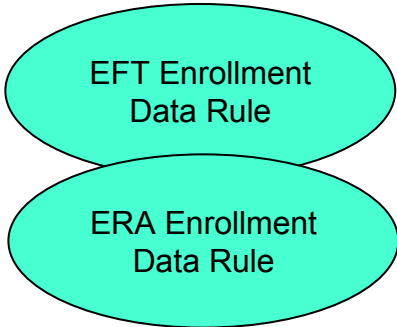
- Strategic transformation
 - Best practices and budget cycles
 - Clinical/administrative analytical needs
 - Provider awareness
- Human and financial resource management
 - Gaps in expertise
 - Managing multiple priorities
 - Education: Access and content
- Information technology
 - Moving to “real-time” and connecting IT systems
- Partnerships
 - Aligning with trading partners, e.g., Practice Management Systems

Mandated Healthcare Operating Rules: Second Set - EFT & ERA

CAQH CORE EFT & ERA Operating Rules in Action

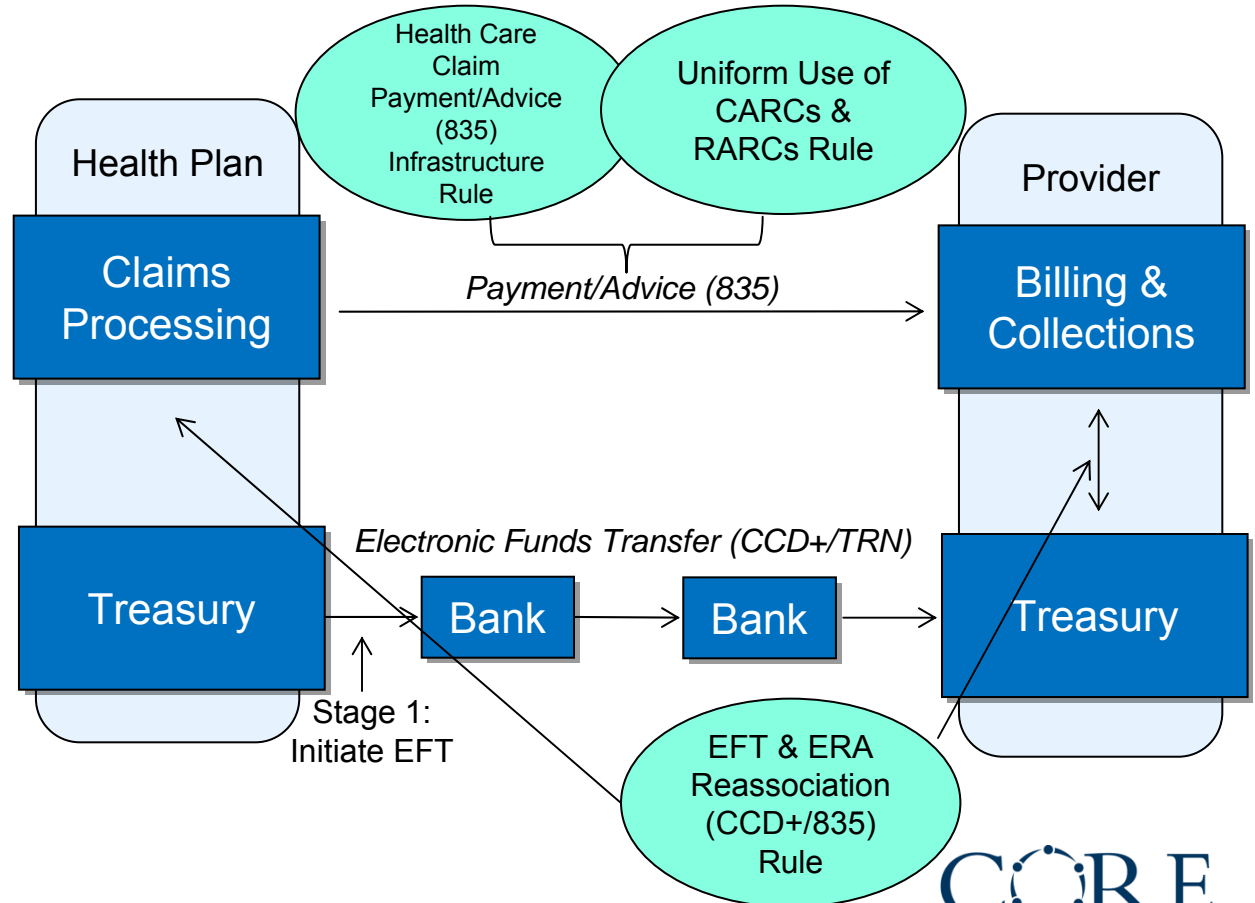
Indicates where a CAQH CORE EFT/ERA Rule comes into play

Pre- Payment: Provider Enrollment



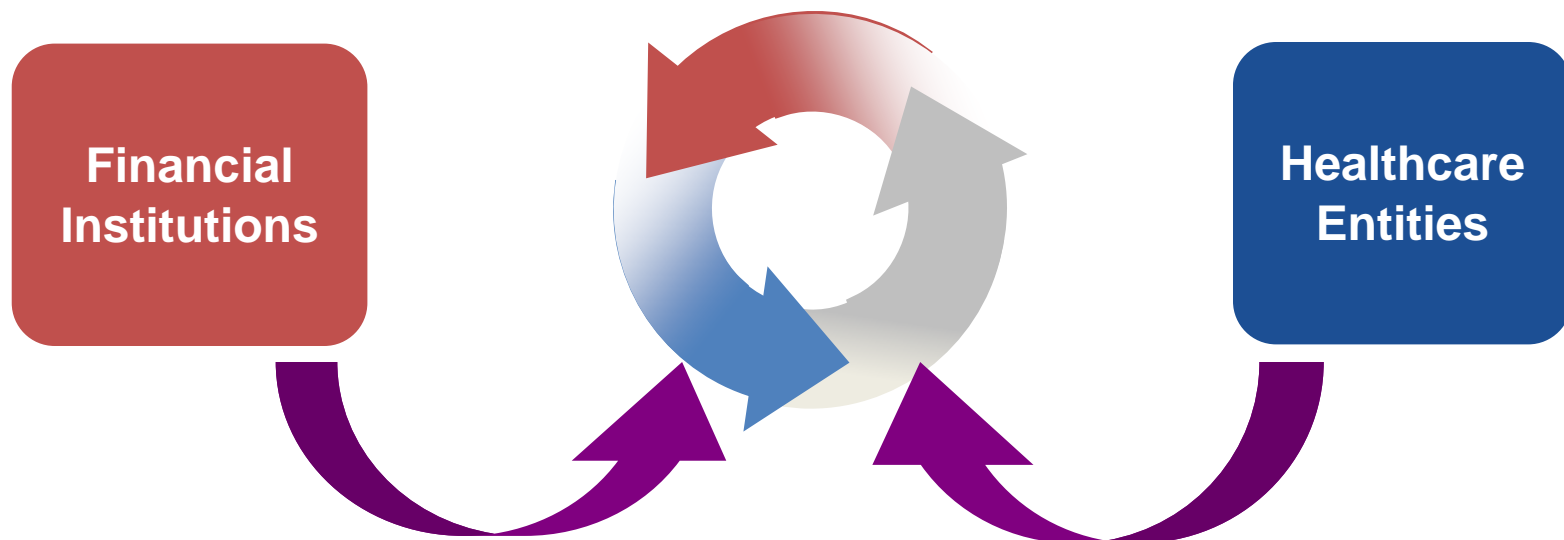
Provider first enrolls in EFT and ERA with Health Plan(s) and works with bank to ensure receipt of the CORE-required Minimum ACH CCD+ Data Elements for reassociation

Claims Payment Process



The Confluence of Health Care and Financial Services

- NACHA is supporting payments sent through banks from plans to providers
 - NACHA maintains the Healthcare EFT Standard - the CCD+ - and worked with CAQH CORE in development of the EFT & ERA Healthcare Operating Rules



Mandated EFT & ERA Operating Rules:

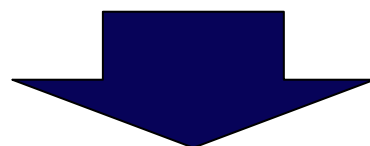
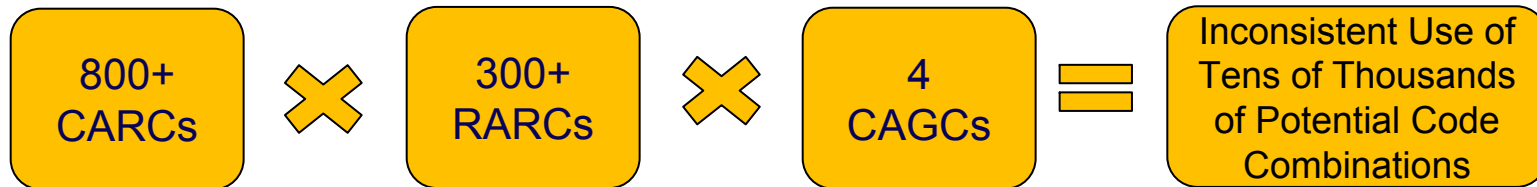
January 1, 2014 Requirements Scope

Rule		High-Level Requirements
Data Content	Uniform Use of CARCs and RARCs (835) Rule <small>Claim Adjustment Reason Code (CARC) Remittance Advice Remark Code (RARC)</small>	<ul style="list-style-type: none"> Identifies a <i>minimum</i> set of four CAQH CORE-defined Business Scenarios with a <i>maximum</i> set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider
	EFT Enrollment Data Rule	<ul style="list-style-type: none"> Identifies a maximum set of standard data elements for EFT enrollment Outlines a flow and format for paper and electronic collection of the data elements Requires health plan to offer electronic EFT enrollment
Infrastructure	ERA Enrollment Data Rule	<ul style="list-style-type: none"> Similar to EFT Enrollment Data Rule
	EFT & ERA Reassociation (CCD+/835) Rule	<ul style="list-style-type: none"> Addresses provider receipt of the CAQH CORE-required MinimumACH CCD+ Data Elements required for re-association Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions Requirements for resolving late/missing EFT and ERA transactions Recognition of the role of <i>NACHA Operating Rules</i> for financial institutions
	Health Care Claim Payment/Advice (835) Infrastructure Rule	<ul style="list-style-type: none"> Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides Requires entities to support the Phase II CAQH CORE Connectivity Rule. Includes batch Acknowledgement requirements* Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits

* [CMS-0028-IFC](#) excludes requirements pertaining to acknowledgements.

CAQH CORE Uniform Use of CARCs and RARCs Rule: *Four Business Scenarios*

**Pre CORE
Rule 360**



**Post CORE
Rule 360**

Four Common Business Scenarios

CORE Business Scenario #1:

Additional Information Required – Missing/Invalid/Incomplete Documentation (≈160 code combos)

CORE Business Scenario #2:

Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim (≈300 code combos)

CORE Business Scenario #3:

Billed Service Not Covered by Health Plan (≈375 code combos)

CORE Business Scenario #4:

Benefit for Billed Service Not Separately Payable (≈35 code combos)

Code Combinations not included in the CORE-defined Business Scenarios may be used with other non-CORE Business Scenarios

EFT & ERA Operating Rules: *Stakeholder Impact and Benefit Examples*

Health Plans

- **Implementation Impact Examples:**
 - Standardizing EFT & ERA enrollment; implementing electronic methods
 - Support CORE Connectivity for X12 835 transactions
 - Utilize CORE Code Combinations
- **Benefit Examples:**
 - More efficient enrollment process
 - Uniform use of code combos reduces errors in providers' interpretation of codes and streamlines processing for health plans

Providers

- **Implementation Impact Examples:**
 - Proactively contact financial institution to arrange for delivery of CCD+ Data Elements required for reassociation
 - Implementation of EFT and ERA may require new/different systems/staffing
- **Benefit Examples:**
 - Standardized enrollment means predictable and common process
 - Automated and timely re-association of EFT and ERA leading to efficiencies and reduced errors

Vendors

- **Implementation Impact Examples:**
 - Remediate systems to perform operating-rule-compliant functions on behalf of providers and/or health plans
- **Benefit Examples:**
 - Uniform infrastructure/connectivity leads to more reliable and secure transactions
 - Operating-rule-compliant software helps vendors to adequately function as business associates of HIPAA covered entities

CAQH CORE Analysis & Planning Tools in Guide

Stakeholder & Business Type Evaluation

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



Systems Inventory & Impact Assessment Worksheet

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



Gap Analysis Worksheet

Objective: Understand 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

EFT & ERA Implementation Resources

- [EFT & ERA Analysis and Planning Guide](#)
 - Assists entities with implementing EFT & ERA Operating Rule requirements
- Free CAQH CORE [Education Events](#): EFT & ERA Webinars with a range of partners, e.g.
 - SDOs: ASC X12, NACHA
 - Government: CMS OESS and Medicaid
 - Implementers: Vendors
 - Associations: MGMA, AHA
- CAQH CORE Request Process
 - Entities can submit questions about the EFT & ERA Operating Rules to CORE@caqh.org
- New resources coming soon:
 - EFT & ERA rule-specific FAQs
 - Voluntary CORE Certification Test Site for the EFT & ERA Operating Rules

Mandated Healthcare Operating Rules:

Third Set – Attachments, Prior Authorization, Enrollment, etc.

Third Set of Mandated Operating Rules

- Secretary of HHS recommended CAQH CORE as author; CAQH CORE will use its open process to complement ACA needs:
 - **Q1 2013:** Key opportunities/out of scope areas being identified via research, survey findings, and call discussions
 - **Q2 2013:** Potential rule options will be developed, reviewed, and agreed upon by CORE Subgroups and Work Groups
 - **Q3 2013:** CORE Subgroup and Work Group discussion and straw polling will be conducted
 - **Q4 2013:** Detailed documentation of draft rule requirements by CORE Participants
- All CORE Guiding Principles will be followed, e.g., build on existing standards, align with other Federal health IT initiatives, address content and infrastructure. Example of key discussion items:
 - What is an achievable migration path to fully structured data/attachments?
 - How can operating rules and Meaningful Use Stage 3 align to drive adoption?

Voluntary CORE Certification

- Since its inception, CAQH CORE has offered a voluntary CORE Certification to health plans, vendors, clearinghouses, and providers
 - Learn more about *voluntary* CORE Certification [here](#)
 - *Voluntary* CORE Certification provides verification that your IT systems or product operates in accordance with the federally mandated operating rules
- Certification and testing are separate activities
 - Testing is completed by *CORE-authorized testing entities* and occurs on-line based on stakeholder-specific test scripts; test scripts developed by CORE participants
 - Cost of testing and certification is extremely low or free
 - CORE Certification is a 4-step process:
 - 1. Pre-certification Planning and Systems Evaluation:**
 - Understand requirements of the CORE Operating Rules and scope your internal efforts to adopt rules
 - CORE has free gap analysis tool; email CORE@CAQH.org
 - 2. Sign and Submit the CORE Pledge:**
 - Formally communicate your intent to pursue CORE Certification
 - 3. CORE Certification Testing:**
 - Comprised of three phases: Pre-testing, Testing and Post-testing
 - Testing is by stakeholder-specific test scripts by rule
 - 4. Apply for the CORE Certification Seal:**
 - Entities successfully achieving CORE Certification will receive a CORE “Seal” from CAQH that corresponds with the CORE Phase and stakeholder-type

Voluntary CORE Certification (cont'd)

- Recently completed and committed CORE Certifications include:
 - Health Plans
 - Kaiser Permanente Colorado
 - Blue Cross Blue Shield of Nebraska
 - Rocky Mountain Health Plans
 - Clearinghouses
 - DoradoSystems - Insurance Validator
 - HealthFusion - HealthFusion® Real-Time
 - Office Ally - Office Ally Clearinghouse
 - RelayHealth - RelayExchange™
 - Vendors
 - Loxogon - Loxogon Alloy™
 - GE Healthcare - Centricity Business Version 5.0 Claim Status
 - NextGen Healthcare - Real-Time Transaction Server



CAQH CORE Board Composition

Permanent Members (all will be from CORE participating organizations)

Voting

Health Plan	Hospital	Other
Health Plan	Broader Care Delivery	Other
Health Plan	Provider (Proposed by AHA)	Other
Health Plan	Provider (Proposed by AMA)	e.g., vendor, bank, clearinghouse, etc.
Health Plan (Proposed by AHIP)	Provider (Proposed by MGMA)	

Non-Voting

- Federal*
(e.g., CMS OESS)
- State*
(e.g., NAMD)
- *(One or more from both Federal and state agencies/representative organizations)*
- CAQH CORE Executive Staff

Non-voting Advisors

SDOs that author standards or codes the current and draft CORE rules support (e.g., ASC X12, HL7, IETF, NACHA, NCPDP, OASIS, WC3). Also WEDI.

As Needed
Others as appropriate, e.g., CORE Work Group Chairs