Committee on Operating Rules For Information Exchange (CORE®)

Operating Rule Implementation Topics
for Medicaid Health Plans

November 8, 2012

Session Topics

- **Introductions & Call Objectives**

- **Mandated Operating Rules**
  - Eligibility & Claim Status Key Requirements
    - Data Content Operating Rules
    - Infrastructure Operating Rules

- **Medicaid-driven Efforts in Support of Operating Rule Adoption**
  - National Medicaid EDI Healthcare Workgroup (NMEH)
  - Medicaid Information Technical Architecture (MITA)
  - A Managed Medicaid Health Plan Viewpoint

- **Implementation Assistance**

- **Audience Question & Answer**
  - Open Phone Compliance Q&A with CMS OESS
  - Operating Rule Requirements with Speaker Panel
    - Web-initiated Requests
    - Phone Requests

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Participating in Today's Interactive Event

- Download a copy of today's presentation
- The phones will be muted throughout the session; at the designated Q&A points in the program, attendees will have the opportunity to ask a question by phone
- At any time throughout today's presentation, communicate with our panelists via the web
  - Submit your question directly through the Q&A pane located at the bottom right hand corner of your screen
- Today's program consists of 45 minutes of audience Q&A
  - Ask your question by phone at the designated time by pressing * followed by the number one(1) on your keypad
  - Ask your question via the web by entering it into the Q&A pane in the lower right hand corner of your screen

Learning Objective

- Build awareness of upcoming year mandates; this is a multi-year process

- Assist Medicaid organizations in meeting the January 2013 HHS implementation deadline for the first set of Federally mandated operating rules, *Eligibility for a Health Plan and Healthcare Claim Status by*

  – Firmly understanding the Federal mandate for implementation of the healthcare operating rules

  – Discover necessary steps and best practices to successfully implement the CAQH CORE Operating Rules for Eligibility and Claim Status

  – Learn through an interactive Question & Answer session with CAQH CORE and CMS OESS staff

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Polling Question #1
Your Affiliation

Select the answer that best describes your organization

- Medicaid Health Plan

- State Medicaid Program/Agency

- Vendor or clearinghouse that supports CORE-certified transactions

- Healthcare Provider

- Implementation Consultant

- Other

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Polling Question #2
Tell Us Where You Are Located

In which geographic coverage area or region is your Medicaid program/health plan based?

- – East

- – South

- – Central

- – West

- – Not Applicable

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Mandated Operating Rules:
Eligibility & Claim Status

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

  - Requires *all HIPAA covered entities* be compliant with applicable HIPAA standards **and associated operating rules**

- The first set of mandated operating rules for Eligibility and Claim Status has been adopted into Federal regulation: *Two Months Until Compliance Date*

  - December 2011, CMS adopted [CMS-0032-IFC](#) as a Final Rule; industry implementation efforts underway for the *January 1, 2013 effective date*

    - 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

> **The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge [HERE](#).**

*On September 22, 2011, NCVHS issued a [letter](#) recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.

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

Implement by January 1, 2013

- Eligibility for health plan
- Claims status transactions

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

NOTE: Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans will apply.

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ACA Federal Compliance Requirements:
Highlights & Key Dates

Three dates are critical for industry implementation of the first set of ACA mandated Operating Rules

*There are **two types of penalties** related to compliance[1]*

Key Area	HIPAA Mandated Implementation	ACA-required Health Plan Certification	
Dates	**First Date** January 1, 2013 *Compliance Date*	**Second Date** December 31, 2013 *Health Plan Certification Date*	**Third Date** No Later than April 1, 2014 *Health Plan Penalty Date*
Description	**Who:** All HIPAA covered entities **Action**: Implement CAQH CORE Eligibility & Claim Status Operating Rules	**Who:** Health plans **Action:** File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules[2]	**Who:** Health plans **Action:** HHS will assess penalties against health plans that have failed to meet the ACA compliance requirements for certification and documentation[2]
Applicable Penalties	**Amount:** Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year	**Amount:** Fee amount equals $1 per covered life[3] until certification is complete; penalties for failure to comply cannot exceed on an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation	

[1] 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.
[2] According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year; CAQH CORE will continue to offer its *voluntary* CORE Certification program and will share lessons learned with CMS as the Federal process is developed.
[3] Covered life for which the plan's data systems are not in compliance; shall be imposed for each day the plan is not in compliance

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Mandated Eligibility & Claim Status Operating Rules: *Scope*

Type of Rule	Addresses	Mandated Eligibility & Claim Status Operating Rules Compliance date January 1, 2013		Voluntary Eligibility & Claim Status Operating Rule
		CAQH CORE Eligibility & Claim Status Operating Rules		
Data Content: *Eligibility*	Need to drive further industry value in transaction processing	More Robust Eligibility Verification Plus Financials	Enhanced Error Reporting and Patient Identification	"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." *HHS Interim Final Rule*
Infrastructure: *Eligibility and Claim Status*	Industry needs for common/ accessible documentation	Companion Guides	System Availability	
	Industry-wide goals for architecture/ performance/ connectivity	Response Times	Connectivity and Security	Acknowledgements*

*Please Note: In the Final Rule for *Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction,* CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.

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CAQH CORE Eligibility & Claim Status
Data Content Operating Rules

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CAQH CORE Eligibility & Claim Status Operating Rules: *Data Content Operating Rules*

Improve Eligibility Verification Through Access to More Robust Eligibility Data and Patient Financials

Key Requirements

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

CAQH CORE Eligibility & Claim Status Operating Rules: *Data Content Operating Rules – Rules 154 and 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
  - 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 <u>health plans and information sources</u>: 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

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CAQH CORE Eligibility & Claim Status Operating Rules:
Data Content Operating Rules – Rules 154 and 260 (cont.)

- **High–level rule requirements**
  - For <u>health plans and information sources</u> 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 (<u>all other content must be returned</u>):
        - **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 <u>providers, provider vendors and information receivers</u>:
    - 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

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CAQH CORE Eligibility & Claim Status Operating Rules:
Data Content Operating Rules – Rules 154 and 260 (cont.)

- *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
    - 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

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CAQH CORE Eligibility & Claim Status Operating Rules: *Data Content Operating Rules – Rules 154 and 260 (cont.)*

- **High–level rule requirements:**

  - *CORE-required Service Type Codes (continued)*

    - **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 content must be returned)

– 1 – Medical Care	– A8 – psychiatric Outpatient
– 35 – Dental Care	– AI – Substance Abuse
– 88 – Pharmacy	– AL – Vision (Optometry)
– A6 – Psychotherapy	– MH – Mental Health
– A7 – Psychiatric Inpatient	

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CAQH CORE Eligibility & Claim Status Operating Rules:
Data Content Operating Rules

Enhanced Error Reporting and Patient Identification Key Requirements

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

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CAQH CORE Eligibility & Claim Status
## *Infrastructure Operating Rules*

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CAQH CORE Eligibility & Claim Status Operating Rules:
Infrastructure Operating Rules

Connectivity*
Key Requirements

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
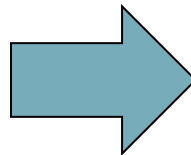
Safe Harbor
Key Requirements

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

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*Specifically designed to align with key Federal efforts, e.g., NHIN.

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CAQH CORE Eligibility & Claim Status Operating Rules:
Infrastructure Operating Rules

Companion Guide
Key Requirements

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

*Adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

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CAQH CORE Eligibility & Claim Status Operating Rules:
Infrastructure Operating Rules

**System Availability
Key Requirements**

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

*Adapted from the CAQH/WEDI Best Practices Companion Guide Template originally published January 1, 2003.

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CAQH CORE Real Time Processing:
Response Time Requirements

Response Time Requirements: CAQH CORE Rules 156 & 250

– When processing in real time, *maximum* response time for receipt of a v5010 X12 271 or X12 276 by the provider in response to a v5010 X12 270 or X12 276 must be 20 seconds

– To conform to response time requirement, *90 percent* of all transactions, as measured within a calendar month, must be returned within the 20-second maximum response time

– **NOTE:** The rules hold the health plan and its **contracted** business associates responsible for the conduct of the transaction that is applicable to them.

When Do the 20-Seconds Begin and End?

– The 20-second requirement is the duration for the *entire round trip* of the transaction

  • The 20 seconds begin when the v5010 X12 270 Inquiry or X12 276 Request is first submitted by the provider, and end when the X12 271 or X12 277 Response is received by the provider

  • *All ensuing hops between the provider and the health plan are included in these 20 seconds*

– ACA Administrative Simplification provisions require all HIPAA covered entities (i.e., health plans, providers, clearinghouses, etc.) to comply with the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules

  • Each HIPAA covered entity within the transaction flow is bound by the CAQH CORE requirements for meeting the 20-second round trip of the transaction

– CAQH CORE recommends a *maximum* of 4 seconds per hop to meet the 20-second round trip requirement

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CAQH CORE Real Time Processing:
Potential Real Time Transaction Paths

End-to-End: 20-Second Round Trip
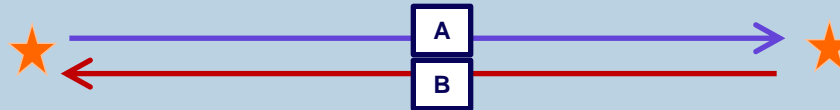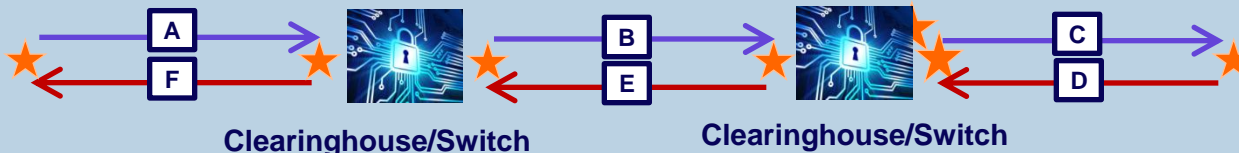**(CAQH CORE recommends _no more_ than 4 seconds per hop)**

Path #1: Direct Connection: A+B= 20 seconds or less

A

B

Healthcare Provider

Path #2: Single Clearinghouse: A+B+C+D= 20 seconds or less

A

D

B

C

Clearinghouse/Switch

Health Plan

Path #3: Dual Clearinghouse: A+B+C+D+E+F = 20 seconds or less

A

F

B

E

C

D

Clearinghouse/Switch

Clearinghouse/Switch

★ *At starred receipt and transmit points each entity must capture, log, audit, match, & report date, time, and control numbers from its own internal systems and corresponding data received from its trading partners*

Medicaid-driven Efforts in Support of Operating Rules Adoption

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National Medicaid EDI Healthcare Workgroup (NMEH)

- What is the National Medicaid EDI Healthcare Workgroup (NMEH)?
  - NMEH is a national workgroup that is a collaboration of State Medicaid Agencies' staff and vendors dedicated to meet, discuss, and share solutions to issues and initiatives surrounding Medicaid

- Currently six sub workgroups collaborate on the following topics:
  - Medicaid Information Technology Architecture (MITA)
  - _Operating Standards_
    - Calls are scheduled the 1st Monday of each month; 1:00-2:30 CT
  - Health Insurance Exchange (HIX)/Eligibility Modernization
  - Provider Screening and Enrollment
  - National Correct Coding Initiative (NCCI)
    - Codes

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MITA: Medicaid Information Technology Architecture

- What is Medicaid Information Technology Architecture (MITA) and MITA Technical Architecture Committee (TAC)?
  - MITA is a national framework to support improved systems and healthcare management for Medicaid
  - MITA TAC provides guidance to the Centers for Medicare and Medicaid Services (CMS) on establishing technical architecture standards relating to MITA

- MITA and CAQH CORE Shared Goals
  - Drive adoption of Federally supported, standards to
    - Reduce cost of provider-plan data exchange by not having plans, vendors and provider follow a wide variation in use of "standards"
    - Increase provider access to robust all-payer data
  - Provide a national solution and direction for real-time data exchange
  - Encourage public-private collaboration
  - Vendor agnostic
  - Administrative focus, with clinical alignment, thus allowing for interoperability
  - Coordination with other industry initiatives

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The Relationship Between MITA and CAQH CORE: A TAC Perspective

- TAC has taken steps to insure that the MITA technical architecture supports the alignment of MITA and CAQH CORE Operating Rules

- Shared goals and technical alignment between MITA business services and CAQH CORE Operating Rules

- MITA and CAQH CORE Alignment

  – The CAQH CORE Connectivity Operating Rule correlates with the MITA Technical Architecture

  – The CAQH CORE Data Content-related Operating Rules correlate with the MITA Information Architecture

Implementing CAQH CORE Operating Rules:
A Health Plan Viewpoint

Susan L. Langford
EDI Industry Initiatives

About BlueCross BlueShield of Tennessee

- An independent, not-for-profit, locally governed health plan company and a member of the BlueCross BlueShield Association (BCBSA); located in Chattanooga with more than 5,000 employees
  - For more than 65 years, BlueCross BlueShield of Tennessee (BCBST) has been centered on the health and well being of Tennesseans
- Volunteer State Health Plan, Inc. (VSHP) was founded in 1993 and is also an independent licensee of the BCBSA and a licensed HMO affiliate of its parent company BCBST
  - VSHP serves approximately 500,000 members
  - VSHP focuses on managing care and providing quality health care products, services, and information for government programs
  - TennCare program's first managed care organization, and has learned from, and has built on, years of TennCare experience -- constantly improving and creating procedures and programs for a better today and a brighter future
- A CAQH Member Organization and CAQH CORE Participant
- Adoption complete; a Phase I and Phase II *voluntarily* CORE-certified health plan

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Volunteer State Health Plan

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BCBST Experience: Achieving Results over Time

- The BCBST BlueCore System is currently supporting the electronic exchange of the following CORE-compliant transactions:
  - Eligibility and Benefits volumes average over 1.2 million transactions per month
  - Claim Status volumes average over 90,000 transactions per month

	2008	2009	2010	2011	2012 Proj.
Eligibility & Benefits	600,000	3.8 million	7.6 million	12.7 million	16.6 million
Claim Status			350,000	1 million	1.2 million

- BCBST extensive collaboration/outreach effort throughout the provider/hospital community, including onsite visits and statewide presentations has enabled provider adoption
- A mixture of outreach responses have been received with varying results:
  - Currently testing CORE-compliant EDI transactions
  - Scheduling a meeting to discuss further
  - Building on 5010 implementation
  - Not prepared to pursue at this time

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BCBST Experience:
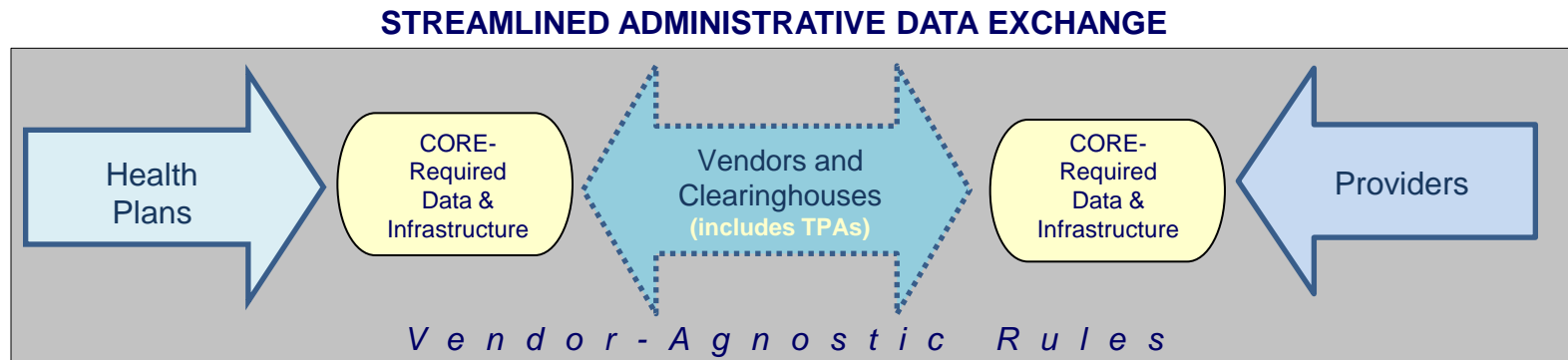# Provider Eligibility Value Statement

- Implementing CAQH CORE Eligibility & Claim Status Operating Rules accelerates the availability of eligibility and benefit information, which in turn makes front-end real-time eligibility verification possible
  - Improvements in revenue cycle management
    - Pre-visit financial clearance
    - Delivery of quick on-line confirmation of patient insurance and benefit coverage directly from the payer
    - Immediate improvement in the number of denied claims and write-offs for uncovered services
    - Enhanced patient services by speeding up patient registration
    - Significant reduction in a provider's accounts receivables
  - Gains in operational efficiencies and administrative savings
    - Reduction in time spent on the phone talking to payers allows the provider/hospital office to focus on more critical administrative tasks
    - Operational cost reduction by eliminating the need for excessive call inquiries
    - True integration with practice management/hospital information systems

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Implementation Best Practices, or Lessons Learned from the Perspective of BCBST

- Solutions to unique Medicaid challenges:
  - Implement more robust search options for member eligibility to increase possibility of member match when patient presents with no ID card
  - Leverage eligibility verification capabilities for Medicaid recoupment efforts and coordination of benefits with Commercial when Medicaid was originally thought to be primary
- Educational Tips:
  - Support Staff should have capacity to answer technical and business questions as Trading Partners get familiar with new web service connectivity and transaction data content; May require training
    - Adjudication system eligibility configuration
    - Web error messages
    - SOAP
    - Java

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Implementation Assistance

Implementing Mandated Operating Rules:
The Importance of Trading Partner Collaboration

STREAMLINED ADMINISTRATIVE DATA EXCHANGE

Health Plans → CORE-Required Data & Infrastructure → Vendors and Clearinghouses **(includes TPAs)** → CORE-Required Data & Infrastructure ← Providers

V e n d o r - A g n o s t i c   R u l e s

- HIPAA-covered entities work together to exchange transaction data in a variety of ways

- The scope of an entity's operating rules implementation will depend upon the electronic data flows between trading partners; understand your agreements

- Vendors play a crucial role in enabling provider clients to realize the benefits of industry adoption of CAQH CORE Operating Rules; engage them

  - Providers rely on their vendors/Practice Management System Vendors (PMS) to achieve their administrative cost saving goals and achieve end-to-end interoperability

  - Health plans and clearinghouses work together in a variety of ways

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CAQH CORE Implementation Tools

- The 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 and planning

- Phase I & Phase II CORE Certification and Master Test Suites:
  - Initially developed for *voluntary* CORE Certification; same concepts; provides guidance on the stakeholder types to which the rules apply and working with trading partners

- CAQH CORE Trading Partner Testing Readiness
  - Organizations that are ready to test operating rules implementation with trading partners are encouraged to add a contact to the new page highlighting readiness for the January 1, 2013 Eligibility and Claim Status Operating Rules implementation deadline

- General/Interpretation Questions: other tools & resources, information requests can be submitted to the CAQH CORE Request Process at CORE@caqh.org
  - All responses complete formal review process by CAQH CORE experts based on request type/complexity
  - More than 650 unique requests (every item is tracked and logged) processes in 2012

- FAQs: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website as appropriate given mandates

- Access to Past Education Sessions - CAQH CORE hosts:
  - Frequent sessions with partners (WEDI, provider/payer associations, Medicaid workgroups, etc.) that include speakers from entities that have implemented the rules

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Examples: CMS OESS Implementation Tools

- **HIPAA Covered Entity Charts**
  - Determine whether your organization is a HIPAA covered entity

- **CMS FAQs**
  - Frequently asked questions about the ACA, operating rules, and other topics

- **Affordable Care Act Updates**
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules

- Additional Questions
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, Christine.Stahlecker@cms.hhs.gov
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov

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Upcoming Education Sessions

- Monthly NHEM calls with CAQH CORE and CMS OESS attendance
    - Calls are scheduled the 1st Monday of each month; Next call December 3rd 1:00-2:30 CT
    - Contact Melissa Moorehead at mmoorehe@mphi.org for additional details
- Upcoming *free* CAQH CORE Education Events
    - CAQH CORE and InstaMed Webinar - "*Operating Rule Implementation Topics: Working with* **Trading Partners**", Tuesday, November 13, 2012 | 2:00 PM ET - 3:00 PM ET
    - CAQH CORE Open Mic Session - Ask Any Question Tuesday, November 20, 2012 | 2:00pm - 3:00pm ET **(CMS OESS attendance)**
    - CAQH CORE and ASC X12 Webinar – "*Implementing Eligibility and Claim Status Operating Rules: Operating Rules and Supporting* **Data Content** *Delivery"* November 28, 2012 | 2:00PM ET - 3:30PM ET
    - CAQH CORE and NACHA Joint Education Session **EFT/ERA** Thursday, November 29, 2012 | 2:00PM ET - 3:00PM ET

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Polling Question #3
Operating Rule Implementation Challenges

What is your organization's biggest operating rule implementation challenge?

- Ensuring conformance of internal systems and/or those of vendors/clearinghouses/fiscal intermediary

- Overall organizational readiness to comply by January 2013

- Vendor readiness

- Understanding operating rule detailed requirements

- Availability of skilled and knowledgeable resources

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Audience Question & Answer Session

- **CMS OESS: Compliance with Chris Stahlecker**

  – Open Phone

- **Operating Rule Requirements with Speaker Panel**

  – Web-initiated Requests

  – Phone Requests

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Appendix

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Medicaid-specific: Question #1

- **As we do not plan pursuing voluntary CORE certification does this impact whether specific rule requirements apply to us or not?**

  - No. All CAQH CORE Rules and their requirements apply to all HIPAA-covered entities given that the ACA amends HIPAA. Voluntary CORE certification is not a factor in determining applicability of the rule. The only exception is that the acknowledgement rules have been specifically excluded from the mandated set of operating rules.
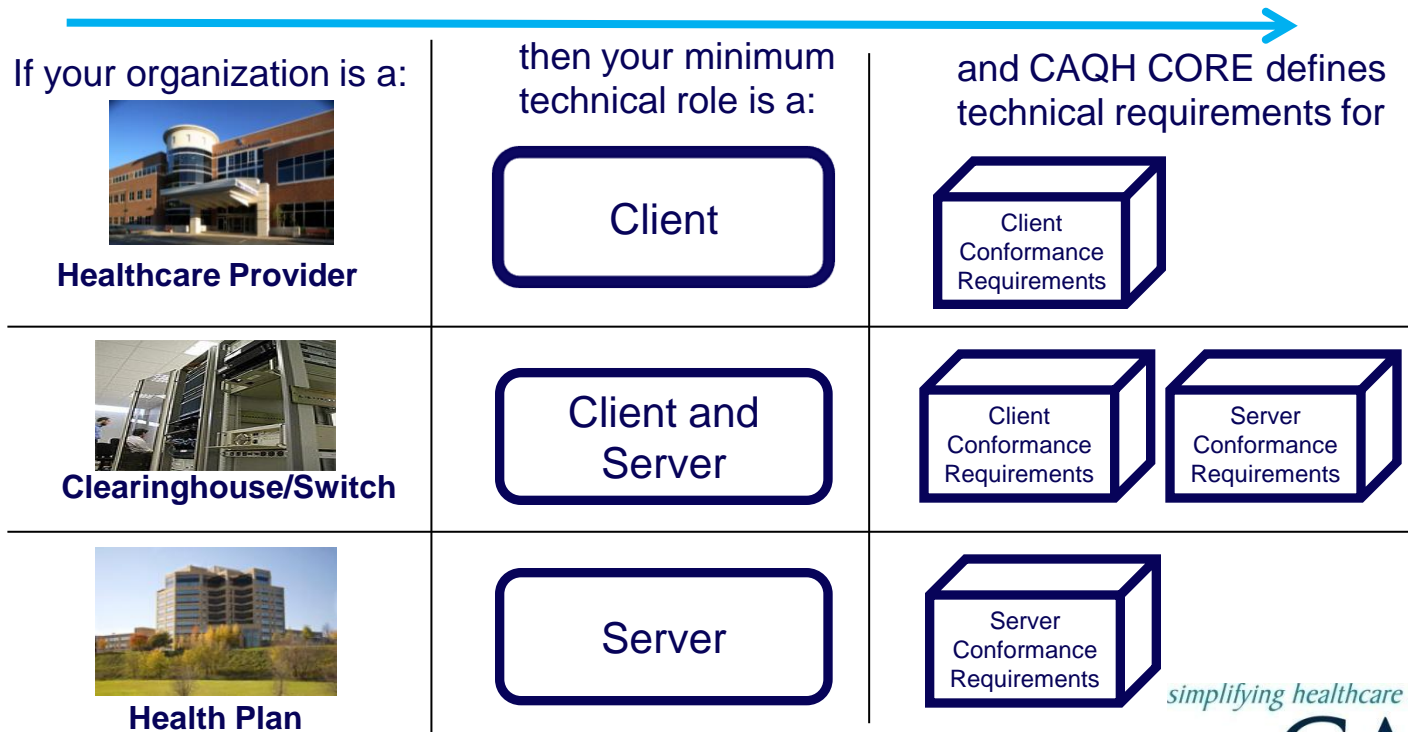
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Medicaid-specific: Question #2

- **We are a Medicaid agency and will have challenges with the CORE rule requirement of reporting eligibility and benefit information for a member to the end of the current month as we currently do not support future dated eligibility requests.**

    - The CAQH CORE Phase I and II Eligibility Benefits 270/271 Data Content Rules requires health plans to support 270 Inquiries up to 12 months in the past and to the end of the current month. Therefore the health plan must respond to a 270 Inquiry with the appropriate 271 Response to report on the eligibility and benefits information that are pertinent to the request – even if the request falls into a future date up to the end of the current month.

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Medicaid-specific: Question #3

- **Does CORE consider the deductible to be the equivalent to "Spend down" or "Cost of Care"?**

  - No. "Spend Down" and "Cost or Care" amounts and their corresponding codes in the ASC X12N v5010 270/271 Technical Report Type 3 (TR3) are not equivalent to a _deductible_ as defined in the X12 270/271 TR3. "Spend Down" and "Cost or Care" are specific to Medicaid and are assigned different codes in the TR3. The CAQH CORE Eligibility & Benefits Data Content Rules do not address returning information specific to "Spend Down" and/or "Cost of Care".

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Federally Mandated CAQH CORE Connectivity Rules:
Stakeholder Conformance Guidelines

- CAQH CORE Connectivity Rules apply to health plans (HTTP/S server) and health care providers (HTTP/S client)

  - The rules define conformance requirements for stakeholders based on typical role (client, server) for envelope and authentication standards

  - Diagram illustrates the typical (minimal) roles played by stakeholders (e.g., providers typically clients, health plans typically servers, clearinghouses can act as client or server)

If your organization is a:	then your minimum technical role is a:	and CAQH CORE defines technical requirements for
Healthcare Provider	Client	Client Conformance Requirements
Clearinghouse/Switch	Client and Server	Client Conformance Requirements / Server Conformance Requirements
Health Plan	Server	Server Conformance Requirements

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Federally Mandated CAQH CORE Connectivity Rules: *Envelope Standards*

- Stakeholders in server role (e.g., health plans and clearinghouses/switches) must implement both envelope standards (SOAP+WSDL and HTTP MIME Multipart)

- Stakeholders in client role (e.g., healthcare providers or provider vendors) must implement one of the envelope standards

If your organization is a:	then you must implement <u>both</u> of these envelope standards
Health Plan **Clearinghouse/Switch** Server Conformance Requirements	HTTP Multipart MIME SOAP
Healthcare Provider Client Conformance Requirements	then you must implement <u>one</u> these envelope standards HTTP Multipart MIME SOAP

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Federally Mandated CAQH CORE Connectivity Rules: *Submitter Authentication*

- CAQH CORE Connectivity Rules support two methods for Submitter Authentication:
  - Username/Password, using CORE-conformant Envelope to send CORE-conformant Envelope Metadata Username and Password
  - X.509 Certificate based authentication over SSL standard for client certificate based authentication
- Stakeholders in server role (e.g., health plans) choose to implement one of the standards
- Stakeholders in client role (e.g., healthcare providers/provider vendors and clearinghouse components handling submissions to plans) must implement both standards

If your organization is a:	then implement <u>one</u> of these authentication standards
Health Plan Server Conformance Requirements	**Username/ Password** **X.509 Certificate over SSL**
Clearinghouse/Switch **Healthcare Provider** Client Conformance Requirements	then you must implement <u>both</u> of these authentication standards **Username/ Password** **X.509 Certificate over SSL**

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