CORE
Committee on Operating Rules for Information Exchange
A CAQH Initiative

Testimony of CAQH Committee on Operating Rules for Information Exchange (CAQH CORE)
to the
National Committee on Vital and Health Statistics, Subcommittee on Standards, ACA Review Committee
Panel 2 Part 2 – Health Plan Eligibility, Benefits Inquiry and Response
June 16, 2015

As the HHS-designated authoring entity for the above-noted operating rules, CAQH CORE respectfully submits the following responses to questions posed by NCVHS to panelists.[1] The content of this testimony draws from a range of sources used in the CAQH CORE integrated model given the healthcare system does not have a centralized method(s) to track adoption:

- Ongoing multi-stakeholder input collected by CAQH CORE including: Attendees polled during free CAQH CORE webinars (14,000 in 2014), implementer presentations on CAQH CORE webinars (over 20 on eligibility), presentations at conferences (over 40 in 2014) and over 2,000 requests to CAQH CORE for information/technical assistance.
- A public CAQH CORE survey conducted for this NCHVS hearing (N=123 organizations, 39% health plans, 28% providers, 28% vendors/clearinghouses, and 5% other referenced as "May Survey").
- Entities that have achieved CAQH CORE voluntary certification for eligibility-related operating rules (specific to eligibility, 157 certifications awarded and 15 publically pledged/in process).
- *2014 CAQH Index* data, which is based on 2013 data from health plans representing 4 billion transactions for 112 million enrollees, or 45% of the privately insured U.S. population (Provider cost estimates in the *CAQH Index* were prepared by Milliman Inc.).

I. Description of Mandated Operating Rules, Intended Benefits, and Business Needs Achieved

Rule Area	Description of Rule Requirements	Intended Benefits	Business Needs Achieved
Data Content-focused Rules	• Supply health plan name and coverage dates. • Conduct enhanced patient identification and error reporting. • Supply patient-specific financial responsibility inquiries for a defined set of high volume services: base financials (co-pay, co-insurance, and base deductibles) and year-to-date remaining or accumulated amounts for individual and family, with in/out of network variances.	Drive further industry value in HIPAA transactions processing: • Productivity improvements • Labor cost savings • Patient satisfaction • Bad debt reduction with improved collections • Enhanced revenue cycle management	• Numerous entities (health plans, providers and vendors) have presented case studies on how they have adjusted their work flows to integrate the patient financial responsibility data supplied by the operating rules, thus reducing labor costs or improving collections. • Over 60% of May Survey respondents reported benefits from eligibility and benefits checks: Productivity improvements (case study evidence by as much as 50%) by reducing staff time on telephone inquiries and in collections. Both providers and health plans are seeing benefit in helping patents understand their financial responsibility. Providers more confident insurance is correct and reimbursement will be achieved. • Entities have reported value of updating processes for real-time access, with many entities only offering real-time per voluntary CORE certification results. Others using plug-and-play connectivity with high-volume users. • Entities that need to train staff on connectivity and security for operating rules are aligning such technical training with training for clinical requirements for exchange of information.
Infrastructure-focused Rules	• Establishes minimum system availability service levels. • Offers expected real-time and batch turnaround times with time-stamps. • Supports safe harbor connectivity (e.g., SOAP and digital certificates). • Provides common flow/format for companion guides. • Although not mandated, the CAQH CORE rules include Acknowledgements requirements (all CORE-certified entities are tested for their compliance with Acknowledgements).	Create national expectations for: • Timely flow of HIPAA transactions • Ability to track transactions flow among trading partners • Common documentation on requirements • Direct connection, if wanted • Security basics	

[1] HIPAA established standards for transactions as well as (from ACA) operating rules; therefore the term "transaction" is not synonymous with "standard."

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II. Current Usage and Adoption Trends

Key Indicators for Eligibility

- 13% increase in volume 2012-2013 per *CAQH Index*
- 82% current adoption rate per CAQH *Index* (105% increase 2009-2013)
- 65%+ of commercially insured are represented by health plans that are voluntarily CORE-certified on eligibility; Medicaid agencies recently joining certification effort
- $4B annual projected (direct) cost savings, 88% of which can accrue to providers

Volume data from the *2014 CAQH Index* (2013 data) show that between 2012, prior to the effective date of the ACA mandate, and 2013, the first year of the ACA operating rule mandate, there was an increase in volume of about 13% in eligibility and benefits verifications (using all means, including HIPAA transactions, portals, fax, and telephone). More providers are conducting verification for all patients, and often do so at more than one point in the patient encounter process.

Adoption rates of the electronic eligibility and benefits transactions also increased significantly. The predecessor *U.S. Healthcare Efficiency Index* offered by Emdeon (2009 data) reported 40% adoption of electronic transactions for eligibility and benefits and claim status combined. The *2014 CAQH Index* shows an average of 82% adoption rate of eligibility and benefits transactions being conducted electronically, an increase of 105% in four years. Three of these four years were prior to the effective date of the ACA mandate, but during CAQH CORE's initial voluntary efforts to drive adoption due to cost savings, e.g. 10-12% reduction in denials for providers that can check eligibility with CORE-certified health plans.

Voluntary CORE certification for eligibility demonstrates increasing compliance. In 2012, pre-ACA mandate, there was a baseline of approximately 65 certifications, none of which included Medicaid agencies and all of which were primarily CAQH CORE participants. As of May 2015, CORE certifications and CORE pledges for just eligibility are over 170, with 8 recently being Medicaid agencies and more than half of the total being from non-CAQH CORE participants.

Projected cost savings from the *2014 CAQH Index*, based on direct costs only, from full adoption of eligibility and benefits transactions are $4 billion for the industry, of which providers could realize $3.52 billion, or 88% of the savings. These savings reflect well with the 2009 Institute of Medicine study, *The Healthcare Imperative: Lowering Costs and Improving Outcomes*.

III. Challenges and Opportunities for Broader Adoption

Identifying both challenges and opportunities for adoption are an ongoing part of CAQH CORE's integrated model. Some examples include:

- ***Vendor adoption role.***
  - Challenge: Anecdotal evidence from webinars, requests, and CORE certification project planning suggests practice management system (PMS) vendors, which are not HIPAA covered, as well as some HIPAA covered vendors may not make data or infrastructure changes available on a timely basis. This lag appears to occur because the vendors are waiting for demand from their provider users who are unaware to ask for the new data/infrastructure, and/or the vendor requires a contractual upgrade by the provider or health plan in order to include the new functionality, e.g. YTD deductibles. Moreover, it has been reported that real-time is delayed or can't be measured if one of the vendors in the "hops" between the health plan and provider is not in compliance.
  - Opportunities for CAQH CORE: CAQH CORE is showcasing voluntary CORE-certification among the vendor community (PMS, clearinghouses, etc.) as a way for vendors to show commitment to adoption, and reminding providers and health plans of their rights and responsibilities with regard to the mandated requirements. CAQH CORE will also consider value of defining contractual obligations; language would aid providers who choose to use electronic transactions and support a focus on accountability for evolutionary changes like mandates.
  - Opportunities for industry: All vendors that work with the transactions could be named in HIPAA as covered entities. An alternative is federally-required vendor certification and specification that vendors are business associates accountable to HIPAA (as for Privacy and Security).
- ***Health plan content supplied via transactions not as content rich as content available on telephone or web portal.***
  - Challenge: Both health plan and non-health plan respondents to the May Survey indicated that there can be more content available on web portals or telephone than that supplied via the transaction; some of this content is related to premium payment or enrollment status, which changes due to major life events or individuals learning how the newly launched health insurance exchanges (HIX) coverage process works.
  - Opportunity for CAQH CORE: Education efforts already include reminders that to be HIPAA compliant there should be an equal level of content on each health plan web portal and in the transactions. The CAQH CORE Board also is considering if voluntary operating rules that address components like the employer role could be helpful in driving more timely information on enrollment and premium payment status.

  - Opportunities for industry: Certification and general enforcement can help assure compliance. The types of entities that are named in the HIPAA legislation as covered entities could be revisited to address data sources such as employers and HIXs, which in turn could help ensure content due to outdated enrollment and premium payment information is more frequently updated.
- ***Competing projects precluding adoption.***
  - Challenge: ICD-10, EHRs, HIXs and other mandates are absorbing the same needed resources as operating rules and thus there is a ripple effect that results in a cycle of implementation challenges and federal extensions/delays. Clearinghouses and vendors particularly have reported that regulatory delays have been so common that they are counted on and planned for by all stakeholders in the industry.
  - Opportunity for industry: Coordination is needed among HHS agencies around a consolidated strategic plan and interoperability roadmap that takes into account the market resources needed for implementation. Instead of massive changes every ten years, major changes along with an incremental approach should be used so there are not multiple, significant projects that overwhelm the industry. The May Survey suggests a review of potential changes every two years may be desirable. For example, providers are anticipating at least minor modifications and additions due to changes in reimbursement models. To help support incremental changes, Federal adoption of operating rules should continue to recognize CAQH CORE incremental maintenance, such as is in place for Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) in the electronic remittance advice (ERA) transaction. Incremental maintenance could be added to eligibility operating rules related to reporting coverage on specific codes.

IV. Opportunities for Improvement Including Alternatives, Process for Updating, and Potential Changes to Operating Rules and/or Mandates

To drive greater adoption rates and cost savings, there are opportunities for improvement within the rule requirements and process, and for the mandates as noted above. Opportunities for operating rule requirements include:

- **Data content:** New data content that entities prioritized via the May Survey and other venues are focused on patient-specific data: benefit limitations/maximums, annual out of pocket maximums, and insurance enrollment/payment status. This data was viewed as what could help meet provider needs and reduce health plan phone calls. Delivery of this content is achievable with an updated version of the existing operating rules, or a new version of the underlying standards. Additionally, there is interest in requiring coordination of benefits (COB) data. A voluntary shared data source effort, COB Smart, recently demonstrated that such data delivery by health plans is feasible, and provides return of investment. The effort built a shared data source with 1.3M patients and its continuously updated COB findings are free to providers, and supply not only the data but help verify where patient-specific COB exists. Finally, there is interest to better address electronic data needs for growing services like long-term care, hospice and carve-outs.
- **Infrastructure:** Just over half of the CORE Certifications for eligibility are real-time only. There is some interest to shorten the real-time response time of 20 seconds; however, many indicate that until HHS addresses compliance of all the entities moving the transactions (aka "hops") and thus entities can time stamp their role in the CAQH CORE turnaround times, a faster response time should not be a priority. Beyond response time, there is interest in increasing security requirements.

***The CAQH CORE processes to update and publish changes to operating rules depend on the nature of the* changes.**

- ***Substantive changes in operating rules*** require the formal CAQH CORE authoring process to be followed, which is an open and balanced process to assure a business need exists (as identified through public polling, periodic environment scans/research and voting), work flow can change and rule requirements are technically feasible. The level of pilot testing performed depends on the extent to which the proposed operating rules already are being used among early adopters or market leaders.
- ***Non-substantive changes in operating rules*** are those that do not materially impact the entities that need to comply with the operating rules, such as correcting typographical errors or removing content from operating rules that has been incorporated into a new mandated version of the underlying standard. Non-substantive changes do not require CAQH CORE balloting.
- ***Ongoing maintenance of existing operating rules*** requires a formal process of obtaining multi-stakeholder input. This process has been used successfully for maintenance of CARCs and RARCs and for EFT and ERA enrollment data sets.

Commitment to Improvement

The executive-level, multi-stakeholder CAQH CORE Board is committed to data content, infrastructure and maintenance.

The Board supports the purpose of the ACA Review Committee**.**

See Appendix for CAQH CORE Board statement.

V. Lessons Learned

The CAQH CORE experience and related health IT efforts identify the following lessons learned to achieve the CAQH CORE vision of trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

Lessons learned for CAQH CORE and its industry partners:

1. **Education**, **technical assistance**, more **real world case studies**, and specific **demonstrations of return on investment** were reported by over 40% of May Survey respondents as necessary for full adoption. CAQH CORE's integrated model has provided *free* education and technical assistance which lowers the implementation cost and knowledge gap barriers. Entities have urged CAQH CORE to continue its efforts, and other organizations should contribute to such efforts so entities ***"know their rights and roles".***
2. Focus the industry not only on meeting the requirements, but the significant value of how compliance allows entities to **leverage and improve daily work flows**. CAQH CORE sharing of such stories can expand.
3. Continue the **CAQH CORE voluntary certification program** as it provides trading partners the assurance of compliance and leverage to require ongoing compliance. Additionally, CORE Certification, which includes a documentation-based enforcement policy, can encourage the industry to focus on **resolving issues versus unproductive "finger pointing".** Providers should require health plans and vendors with whom they contract to be voluntarily CORE-certified.
4. Continue to **support significant adoption tracking** efforts such as the CAQH Index and voluntary CORE Certification.
5. CAQH CORE currently has a **balanced number of stakeholder** participants (health plans, providers, and clearinghouses/vendors) who implement the operating rules and thus are able to vote on substantive changes. It is vital to keep this balance and enhance total number of participants through new engagement strategies to gather input on business needs. CAQH CORE needs to continue to offer free outreach to the public at large.
6. Maintain **cross-industry alignment** as a key CAQH CORE criteria. Consistent with its approach to assuring that its operating rules are aligned with applicable federal requirements and industry business needs, CAQH CORE should continue to **align its infrastructure operating rules** with requirements that address the privacy and security of protected health information, including with ONC-mandated requirements and industry best-practices on thwarting cyber threats. For data content, CAQH CORE operating rules have adopted **data content** only when the content has been identified as a business need, plus it is optional under the mandated ASC X12 version, e.g. v5010. CAQH CORE is a strong supporter for ASC X12 adopting any existing CAQH CORE data content when the next version of the underlying HIPAA standard is mandated. Until such time, CAQH CORE will continue to encourage delivery of key content by supporting further use of the existing ASC X12 version.

Lessons learned for federal consideration:

7. Revisit the definition of which entities are considered **HIPAA covered entities,** as noted above in Sections III and IV.
8. Communicate when **federally-required certification and accessible enforcement** will serve as steps in driving compliance. CAQH CORE encourages certification that has testing and a multi-stakeholder focus. The lack of a **non-punitive focused enforcement of** the HIPAA transactions is frequently cited as a missing component of HIPAA.
9. Have a dialog how the **Federal mandate could encourage some level of adoption by providers**, who currently are required only to use the HIPAA transactions if they choose to conduct them electronically.
10. **Adopt acknowledgements,** either with HHS inclusion of acknowledgements as an integral part of the CAQH CORE operating rules, or a federal mandate that adopts acknowledgements as independent standards. Including acknowledgements under HIPAA would be consistent with recommendations made numerous times by NCVHS and many other organizations.

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Appendix

CAQH CORE Board Statement:
Commitment to Content, Infrastructure and Maintenance

June 2015

CAQH CORE Operating Rules set national responsibilities and requirements for timely, accurate electronic transactions within the healthcare claims cycle. These operating rules address both the necessary infrastructure (such as response times, acknowledgements) and basic content (such as patient financial responsibility) needed to conduct the daily business of healthcare. The operating rules support further use of existing standards wherever possible. Significant work is still needed for all HIPAA transactions to improve both infrastructure and content, and thus achieve true interoperability between all parties in this work flow.

CAQH CORE began as a voluntary effort. As such, before any CAQH CORE operating rules were mandated, CAQH CORE drove voluntary adoption and maintenance of operating rules. The mandated CAQH CORE operating rules now include a feature for CAQH CORE to conduct ongoing maintenance based on use, need and lessons learned. This model has proved successful, and complements more substantive maintenance updates. CAQH CORE believes that a cycle of maintenance for mandated operating rules and standards will help drive the CORE vision of an ever-evolving, improving system of electronic transactions. Regular updates driven by market needs can help transform our current claims process.

As part of its commitment to address both infrastructure and content - and its commitment to maintenance overall - the CAQH CORE Board embraces the Review Committee (RC) formed by the Affordable Care Act (ACA). It is anticipated that the RC will support the industry in its efforts to have regularly scheduled updates of both operating rules and standards, rather than waiting for approval of new legislation to make needed updates, which have previously focused on major overhauls. CAQH CORE also hopes the RC will recognize the value of ongoing maintenance, when such an option is appropriate.

Gaining uniform agreement on basic infrastructure was prioritized by both CAQH CORE and non-CORE participants as the first step in the Phase IV Operating Rules development. Reasons include: the range of current market capabilities for the transactions addressed, the array of trading partners that send and receive these transactions, and that two of the transactions are between the health plan and a non-HIPAA covered entity - the employer. In 2016, CAQH CORE will drive the adoption of the Phase IV infrastructure, including acknowledgements, and conduct its ongoing maintenance of earlier CORE phases. Additionally, it will work with the industry to identify priority draft content needs for Phase IV Operating Rules and any new needs for existing CAQH CORE phases. CAQH CORE will update the RC on this work. Meanwhile, CAQH CORE will continue to push for voluntary adoption of operating rules and apply the CORE Certification process to highlight those entities serving as market leaders.