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Operating Rules: State of Development and Implementation
Authoring Entity Perspective

Testimony Provided to the
Subcommittee on Standards
National Committee on Vital and Health Statistics

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Testimony Overview

- Background.
  - Role of Authoring Entity.
  - Target Areas of Current Mandated Operating Rules.
  - Sources for Status Reporting by Authoring Entity.
- Implementation and Maintenance.
  - *Rule-Specific.*
    - Eligibility/Benefits and Claim Status.
    - Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).
  - *Industry-Level.*
- Development.
- Next Steps and Recommendations.

<u>Appendices</u>

- Integrated Model.
- Sample Polling Statistics.
- Recent CAQH CORE Certifications.

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Implementation:
Role of Operating Rule Authoring Entity

(See *Appendix for CORE Integrated Model)*

- Since the last implementation testimony to NCVHS in mid-2012, CAQH CORE has driven, expanded and participated in a range of actions aimed to:
  - Build ***awareness*** to ensure entities know roles, benefits and challenges.
    - Operating Rules are a new set of federal requirements; 2013 first mandated year.
  - ***Support implementation*** efforts as entities enter typical stages of adoption.
    - Needs greatly vary: Beginner, Intermediate, and Advanced.
  - ***Test adoption*** to ensure full understanding and end results are achieved.
    - Testing at stakeholder-specific role and requirement identifies where further work needed.
  - Conduct ***ongoing maintenance*** of operating rules where required or needed.
    - For specific operating rules, per Federal mandate, conduct frequent maintenance.
    - Based on industry implementation, make substantive or non-substantive maintenance.
    - Align efforts with SDOs to support further use of Federally mandated standards.
  - Identify and draft ***future operating rule development*** goals and requirements.
    - Consider cyclical issuance of updated versions of Federally mandated standards, some of which require operating rule update.
    - Collect ideas for expanding existing operating rules and creating new requirements.
    - Focus on ROI drivers and industry pain points.

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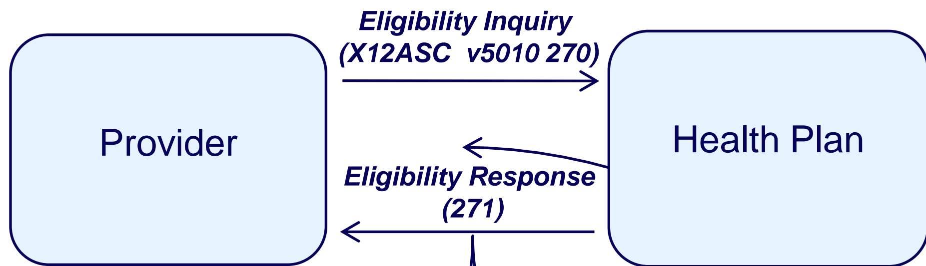
Eligibility and Claim Status Operating Rules

Effective January 1, 2013: Target Areas

Indicates where a CAQH CORE Rule comes into play

Pre- or At-time of Service

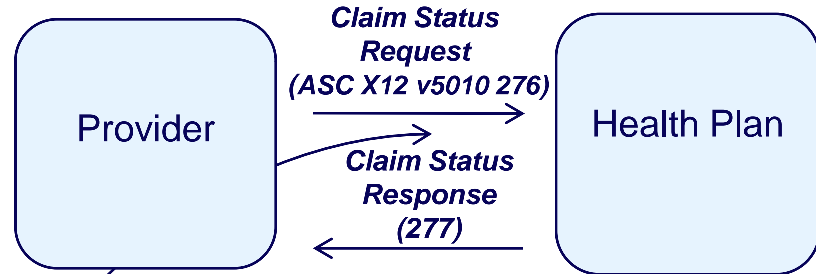


Content: Enhanced Patient Identification

Content: Uniform Error Reporting

Content: Robust Eligibility Data, e.g., Patient Financials (YTD deductibles, Co-pay, Co-insurance, in/out network variances)

Post-Claim Submission



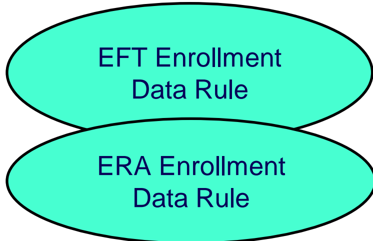
Infrastructure

- Standard Companion Guides
- Real-time and Batch Response Times
- Internet Connectivity and Security
- Increased System Availability

EFT & ERA Operating Rules
Effective January 1, 2014: Target Areas

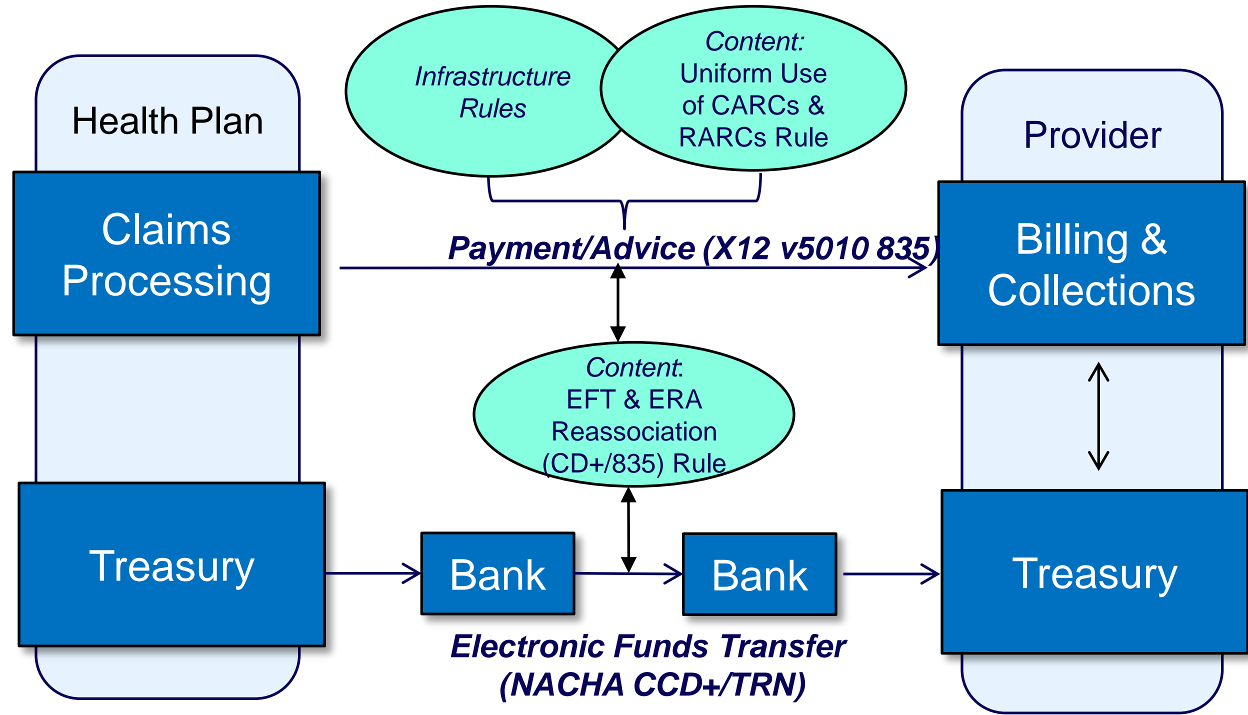
Indicates where a CAQH CORE EFT/ERA Rule comes into play

Pre- Payment: Provider Enrollment



Content and Infrastructure: 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



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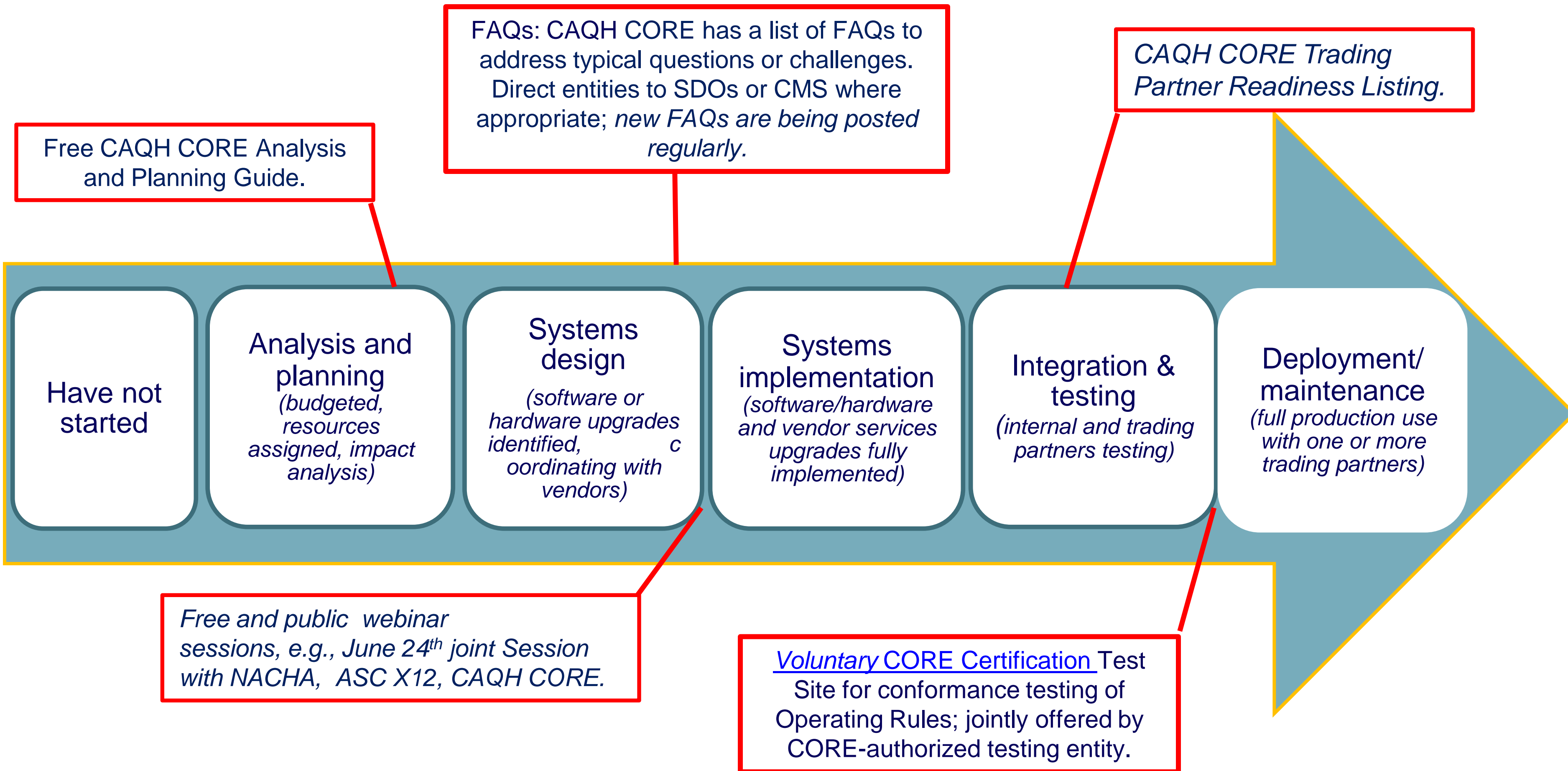
Implementation Steps for HIPAA Covered Entity: *Examples of CAQH CORE Implementation Resources*



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Snapshot: Sources for CAQH CORE Testimony on Status

(*See *Appendix for examples.*)

SOURCE	WHAT	REPRESENTATIVE VOLUMES
***Implementation Support Webinars/Education** (CAQH CORE sponsored with joint engagement by key partners like SDOs)	Public, free. ***Many jointly done with SDOs*** and others. Content/speakers ***evolves as industry implementation cycle moves*** forward or due to feedback. Includes polling on implementation status and challenges.	More than 15 YTD with over ***12,000 registrants***; ***40% are new with*** CMS outreach. Growing provider engagement; ***1,900+ provider organizations***. Over 100 state entities; strong attendance by Medicaids.
Request Process (CAQH CORE sponsored)	*Free*. 1:1 request process for any interested entity for clarification assistance, change requests, etc. Helps ***inform direction*** of FAQs, education, maintenance and challenges by stakeholder/rule. ***Directs entities to other entities, e.g., SDOs, CMS,*** where appropriate.	YTD over ***600*** received; average response 9 days. Equal mix of low, medium or high complexity. ***More inquiries from non-CORE entities.*** Track request activity by rule set (elig/claim status, EFT/ERA), rule, and other major categories such as certification.
FAQs and Affiliated Tools (FAQs CAQH CORE sponsored and some tools)	FAQs: ***Public, free***. Key areas where clarification or guidance needed. *Directs entities when CMS as the regulator or an SDO is the respective source*. Tools: ***Free***, target implementation stage, e.g., Analysis Planning Guide, papers published by other entities.	Total of approx. 500 FAQs; 220+ posted for Eligibility and Claims Status ***and 150+ posted for EFT/ERA***. Others cover wide range, e.g., HHS certification . Where needed, FAQ sent to CMS OESS, SDOs or CORE maintenance.
Digital Awareness Campaigns (CAQH CORE sponsored)	Targeted to ***those who are not yet involved/aware***, e.g., online provider communities (SERMO), health care websites and Google word searches.	Two platforms, one of which was Google word search, produced ***over 3,700 Clicks*** to web-based Mandated Operating Rules learning page. Ongoing analysis of other approaches.
In-person and Virtual Conferences	Presentations/participation by CAQH CORE staff or participants, and range of HIPAA covered entities.	***Over 20 YTD***, e.g., NACHA Payments, Regional Payment Associations, WEDI, HIPAA Summit, MGMA state chapters.
***Voluntary CORE Certification** (CAQH CORE supported)	Public, stakeholder-specific, ***multi-stakeholder developed test script-based*** testing conducted by independent testing entity. CORE Certification to finalize review of results.	For Eligibility and Claims Status, many new certifications including health plans with ***30 million lives***. EFT/ERA site launched and ***alpha tested by early adopter health plan and vendor***.
Meetings of Key Stakeholder Bodies	CAQH CORE Subgroups and Task Groups, e.g., CARC/RARC Task Group. Attendance at non-CORE groups, e.g., NMEH (Medicaid), ASC X12 meetings.	CAQH CORE RARC/CARC Task Group has held ***10 meetings***, and issued four straw polls and two compliance-based updates***;*** finalizing market-based submission form and addressing analysis tools/steps.

First Set of Mandated Rules

Rule Specific Implementation of Eligibility/Claim Status

2013 is the first year that CAQH CORE operating rules must be integrated into the operations of HIPAA covered entities. HHS enforcement delay ended March 31, 2013.

- Compliance status is strong among commercial health plans and some clearinghouses/ vendors with significant size client base.
- Adoption still underway with providers and some regional or specialty health plans. Those still underway are challenged by:
  - ***Technical and other resources.***
    - Delivering 20-second real-time access: Some have completed eligibility real-time but not claim status, which was a less familiar transaction; thus, technical support less advanced.
    - Providing detailed data content: Patient financial data, e.g., YTD deductible by service type code, in/out network variance.
    - Confusion on complying with ASC X12 standard beyond v5010; CORE supports v5010.
  - ***Trading partner coordination:*** Determining how to work with trading partners/non-HIPAA covered vendors, especially true for providers.
  - ***Enforcement vs value:*** Viewing January 1, 2014 new ACA-required HHS (health plan or their vendors) certification penalty date as the deadline.
  - ***Starting place:*** Level of effort varies by an entity's starting point, e.g., new versus legacy systems.

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Second Set of Mandated Rules:
Rule-Specific Implementation of EFT/ERA

Deadline is January 2014. Final rule announcement issued in April 2013. Includes all EFT/ERA rules except acknowledgements and supports ongoing rule maintenance.

- Implementation efforts are well underway by those entities completed or engaged in completing first set of mandated rules. Many other entities in the early "awareness" or "planning" stages.
  - ***Knowledge of mandated, underlying standards.***
    - EFT (@40% of payments today are EFT): Growing awareness of EFT standard/ACH Network. First healthcare enhancements to the NACHA Operating Rules effective September 2013 and require health plans to identify healthcare payments.
    - CARC/RARC codes: Mixed understanding of ***existing*** approval process/authors/effective dates. Limited built-in industry analysis of code usage and code definition challenges.
    - ERA: Mixed knowledge; confusion on mandated version, e.g., v5010 or future version.
  - ***Stakeholders: HIPAA covered and non-HIPAA covered.***
    - Providers: Due to benefits, awareness is growing and expanding to other stakeholders. Rules require proactive actions, e.g., contacting bank. Smaller providers challenged.
    - Health plans: Exposure to first set of infrastructure operating rules helps; variance in capability to quickly adjust to new requirements is pronounced.
    - Vendors: Reaction from those with existing EFT/ERA client base varies by agility level. Growth in launching of products to assist with health plan or provider implementation.
    - Banks: Efforts underway to educate wide variety of financial services community on their role in educating providers; regional networks will serve key role.

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Second Set of Mandated Rules: *Rule-Specific Implementation of EFT/ERA (cont'd)*

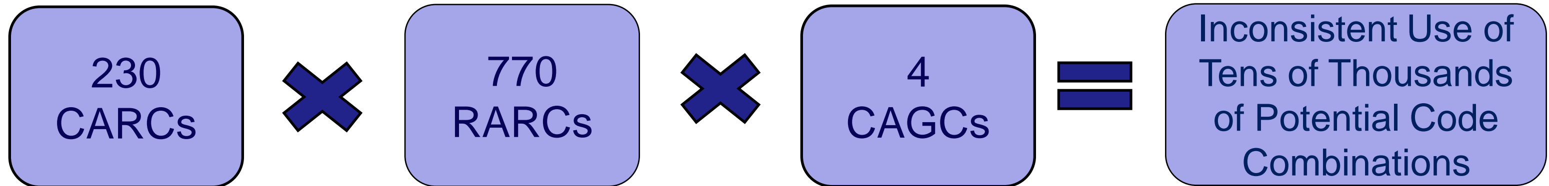
Federal implementation deadline is January 2014.

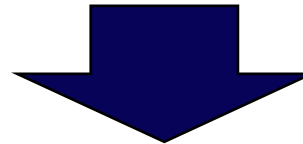
- ***Rule-specific challenges.***
  - CARC/RARC: Operating rules are driving industry transformation. To align with code committees, updates occur at least three times per year, so maintenance is ongoing. Rules maintenance is:
    - Building national versus entity-specific approach.
    - Executing approaches via phone/web; creating expectation that adherence will be tracked.
    - Encouraging alignment given key partners (e.g., ASC X12, Code Committees, associations, e.g., HIMSS for vendors) are helping to distribute updates and promote involvement in maintenance.
  - *EFT and ERA Enrollment*: Maximum data sets contain elements for which industry education needed, e.g., TIN vs NPI. Maintenance is conducted after one year, yet some want immediate maintenance for specific adjustment/remove/add, others in full adoption mode and others completed.
- ***Simultaneous priorities and limited resources, e.g.,***
  - There are numerous Federal requirements with simultaneous deadlines; highlighting areas of convergence is essential, e.g., Medicare is also requiring EFT by January 2014.
- ***Business need for each rule continues to be validated, e.g.,***
  - Current coding for claims denials and rejections is confusing, time consuming to providers and drives paper attachments, phone calls, etc; national approach essential.
  - Connectivity opens new partnerships and reduces time to connect.

Rule Example: *Uniform Use of CARCs and RARCs Rule*

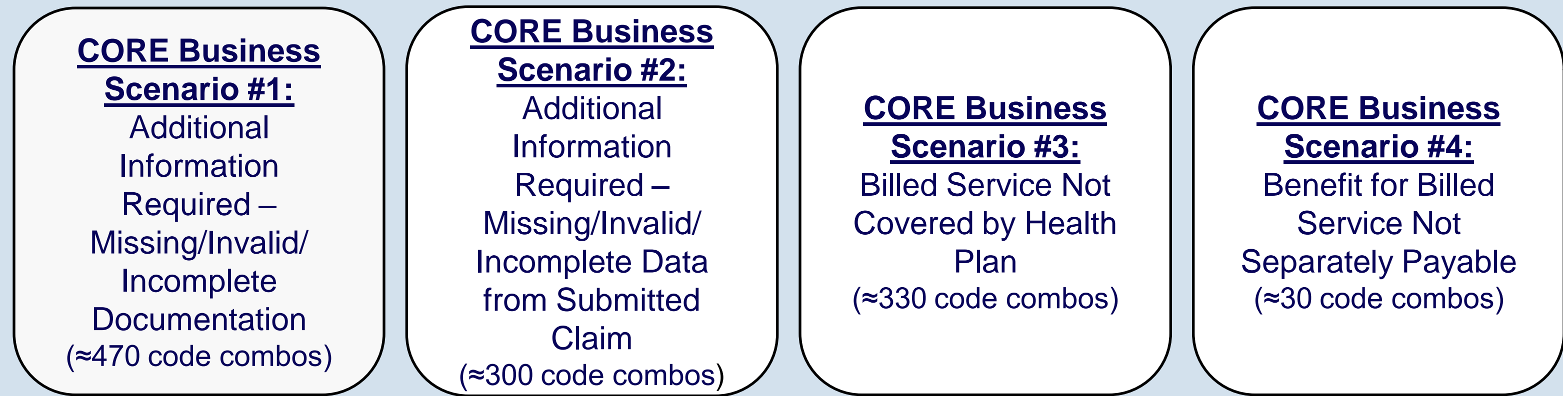
(See *Appendix for overview of the maintenance of this rule)*

Pre-CORE Rules





Post CORE Rules



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Rule-Specific Benefits and Challenges: *Eligibility, Claim Status and EFT/ERA*

(See *Appendix for sample regarding challenges; similar data available for benefits)*

The same operating rules serve as the key *benefits and challenges.*

- ***Data Content, e.g.,***
  - Eligibility financials and benefit specific coverage:
    - *Benefit:* Increases provider eligibility automation and ability to reduce bad debt.
    - *Challenges:* Significantly more health plan/vendor programming and connection of various data sources.
  - RARC/CARC Business Scenarios and code usage maximums.

- ***Infrastructure, e.g.,***
  - Connectivity safe harbor:
    - *Benefit:* Option to have direct connect, ability to reduce connection times, and support of innovation on future-focused technology options.
    - *Challenges:* Incorporating SOAP, digital certificates, etc., into IT and compliance responsibilities; determining role of trading partner.
  - Time-boxed real time response (Not real time adjudication) and/or time-boxed batch response.

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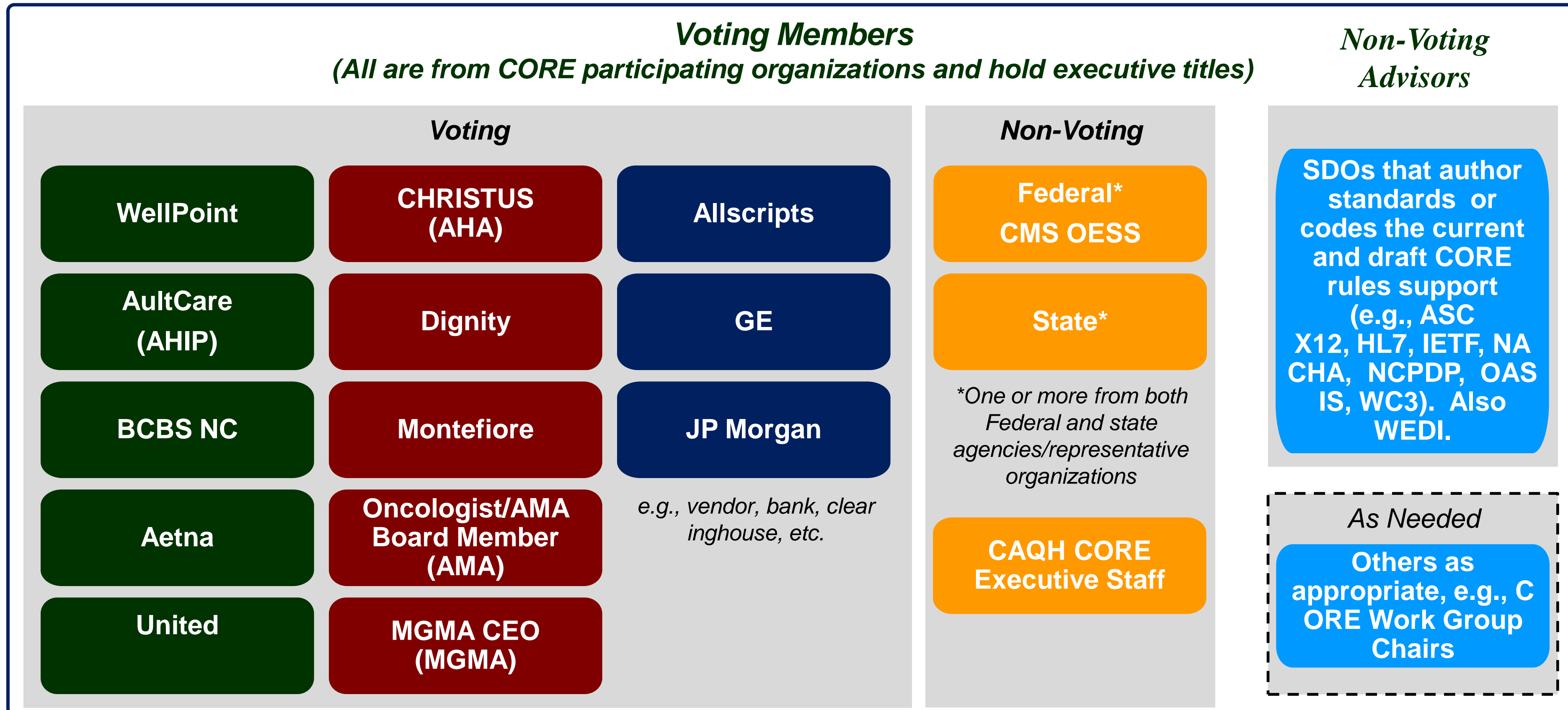
Industry-Level: Ongoing Challenges

- Mandated adoption versus laws of supply and demand.
  - Providers required only to use standards and operating rules if they choose to use electronic transactions.
  - Practice management/patient financial systems (PMS) vendors not mandated or incentivized to support electronic transactions for providers.
- Lack of a coordinated network (non-IT) connecting relevant organizations responsible for implementation and supporting various locations.
  - Unmet need for free, clear, multi-pronged education.
  - Lack of plug-and-play or interactive implementation support tools.
  - Differing view on how to reach ROI. Few business cases, but many opinions.
- Competition for limited resources to meet many new requirements in a quickly changing market.
  - Various levels of resources are overcommitted, e.g., Adoption by public entities demonstrate challenge:
    - Some Medicaids making progress, others lack resources.
    - Medicare making progress in key areas, e.g., early announcement regarding CARC/CARC.
  - New subject matter experts getting integrated into work flow, e.g., SSL, SOAP.

Furthering CAQH CORE Multi-Stakeholder Governance: *Board Composition*



- Chair: CIO, CHRISTUS Health Systems; Vice Chair: CIO, WellPoint.
- Does not change multi-stakeholder approval of rules or focus on implementers at last stage of voting.
- *Funding and governance remain separate*; CAQH continues to fund over 90% of CORE's expenses.

Third Set of Mandated Operating Rules

Attachments, Prior Authorization, Claim, Enrollment/ Disenrollment and Premium Payment

- With CORE model, setting the development scope and building awareness is essential. Work with third set validated this focus.
  - Over 200 entities directly contributed to two public surveys.
    - First survey was open-ended; second had specific rule options (based on responses from first survey, white paper research and implementation status) plus write-in option.
  - Priorities, relationships, leaders, etc., have surfaced; many entities have identified their experts and volunteered to be leaders.
- To ensure resources are targeted to the task at hand, especially given timelines and ROI needs, regulatory scope is a key evaluation criteria.
  - ***Regulatory language regarding maintenance:*** Federal regulations can recognize and support language that allows for cyclical/incremental increase in requirements. Operating rules will incorporate such language.
  - ***HIPAA Covered Entities*: ** There is strong interest in applying operating rules to Employers (Premium Payment and Enrollment) and PMSs; however, operating rules proposed for federal mandate cannot apply to these non-HIPAA covered entities.
  - ***Acknowledgements:*** Overwhelming support to expand operating rules on acknowledgements; however, without a policy decision on adopting Acknowledgements (either as infrastructure or as stand-alone transaction), the resources to draft such rules are not warranted.
  - ***Expansion of current rules*: ** There is interest in expanding existing mandated Eligibility data content requirements of mandated operating rules; however, CMS will not propose a mandate of such rules at this time.

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Third Set of Mandated Operating Rules (cont'd)

Attachments, Prior Authorization, Claim, Enrollment/ Disenrollment and Premium Payment

(See *Appendix for migration roadmap)*

- ROI on standards remains elusive; ROI is, and will be, a key operating rule evaluation criteria for all involved stakeholders.
  - ***Authoring entities of standards and operating rules:*** Last several months have allowed for a growing appreciation of complementary, but separate, roles to drive electronic adoption.
  - ***Industry knowledge of standards:*** Opportunity not well understood; need more accessible information, clarity of message (mandated vs optional aspect of standard) and business cases.
- Market is mixed on future vision and is in different stages; migration roadmap shared by CORE in last testimony can be applied to all transactions.
  - ***Future and independencies:*** Allow for flexibility to evolve to new payment models; connect to clinical wherever possible to drive provider adoption.
  - ***Data content vs infrastructure:*** Expand infrastructure across all transactions and consider rules that expand structured data incrementally, e.g., Business Scenarios.
  - ***Roadmap:*** Help industry to reasonably jump from paper to structured data.
- Timeline/process requires frequent, focused, resourced, and virtual meetings.
  - **Q4 2012 / Q1 2013:** Build industry awareness of upcoming option to participate in rule writing, ACA goals, CORE Guiding Principles and existing CORE operating rules; conduct environmental assessment, e.g., research key opportunities, identify out of scope items, draft White Papers/environmental scans.
  - **Q2 2013:** Survey on specific opportunities, launch subgroups to review and develop potential rule options.
  - **Q3 2013:** Subgroups continue work, Work Group/public channels provide feedback; update NCVHS.
  - **Q4 2013:** Detailed draft requirements prepared for Work Group ballot in preparation for full CORE vote.
  - **Q1 2014:** Operating rules forwarded to CMS OESS.

Next Steps for CAQH CORE Based on Lessons Learned

(See Appendix for entities who are engaged but not direct CAQH CORE participants)

- As the Operating Rules authoring entity, CAQH CORE will continue to work to:
  - Strategically and tactically ***involve those not fully engaged***.
    - Generate simple provider business cases to drive adoption; needed to support for furthering requirements.
    - Drive PMS adoption via CORE certifications.
  - ***Support industry investment***, establish targeted, meaningful, and future-focused metrics.
    - Focus on ROI, e.g., adoption rate connection to reduction in cost, higher quality data, and lower expenses.
    - Determine balance of focusing resources on improving existing or driving future direction.
  - ***Refine and improve*** implementation support to align with adoption cycle.
    - Diversify approaches to both coordinate free, public education and provide interactive tools.
    - Hold more interactive beginner vs. advanced session with early adopter panelists.
    - Continue approach to jointly outreach with SDOs. Further analyze evaluations, polling data, etc.
  - ***Refine and improve maintenance and development*** to support aligned vision and actions, e.g.,
    - With SDOs, HHS/CMS and HIPAA Covered Entities:
      - Further focus and build on areas of convergence that can provide ROI.
      - Track, consider and dialog on future versions of standards knowing CAQH CORE guiding principles encourage that:
        - » Data content of existing operating rules can/should be incorporated into updated versions of mandated standards.
        - » Operating rules can support further use of existing version of mandated standard.
        - » Identify strategic timing and value of maintenance opportunities versus expansion into new requirements.
      - Ensure ongoing cross-effort involvement.
    - For CAQH CORE maintenance and development:
      - Extend interactive time with implementers and rule developers, and continue to encourage research by participants.
      - Outreach more to the silent majority; continue to maintain focus on quorums, documentation and targeted goals by call/group.
      - To address s*cope and timing* realities, maintain focus on guiding principles, e.g., ROI, and ability to execute.
      - Improve tools and use of web to: publish schedules, opportunities for rule writing groups, access to clarification assistance, and exchange by early implementers to gather and dialog on potential maintenance ideas/requests.
      - Refine rule naming and identification convention; continue to draft rules without references to role of CORE-certification.

Recommendations Based on Lessons Learned

- CMS and NCVHS, with support from industry, should:
  - Through recommendations, ***set an expectation regarding the implementation support*** that any public or private authoring entity, or recognized advisor, must meet.
    - Each major HIPAA requirement needs a devoted owner with resources to execute specific and targeted requirements, and coordinate with critical partners.
    - Mandated requirements should be free, public, and easily accessible; issuance of implementation tools should follow requirement publication with a focus on driving volumes and diversifying engaged entities.
  - Work with HHS to ensure public entities serve as ***adoption "beacons".***
  - Use available contracting, enforcement levers, etc., to ***engage non-HIPAA covered entities***.
  - Ask for analysis on provider adoption levels for existing administrative requirements as well as ROI; if necessary, ***generate re-assessment of adoption methods*** being required.
  - Support testing of standards, etc., prior to mandate; after mandate, use available levers to encourage all HIPAA covered entities ***to test and certify after adoption***.
  - Expend strategic energy to ***gain allocation of additional resources*** to support NCVHS role, and ensure NCVHS serves as ACA Administrative Maintenance Committee.
- All authoring entities and other advisory entities should:
  - Consider ***when and why*** to focus on development of new requirements, maintenance, and/or implementation support.
  - Track and analyze different types of engagement and market impact.
  - Engage "***non-advanced" participants***, and provide layman's terminology.

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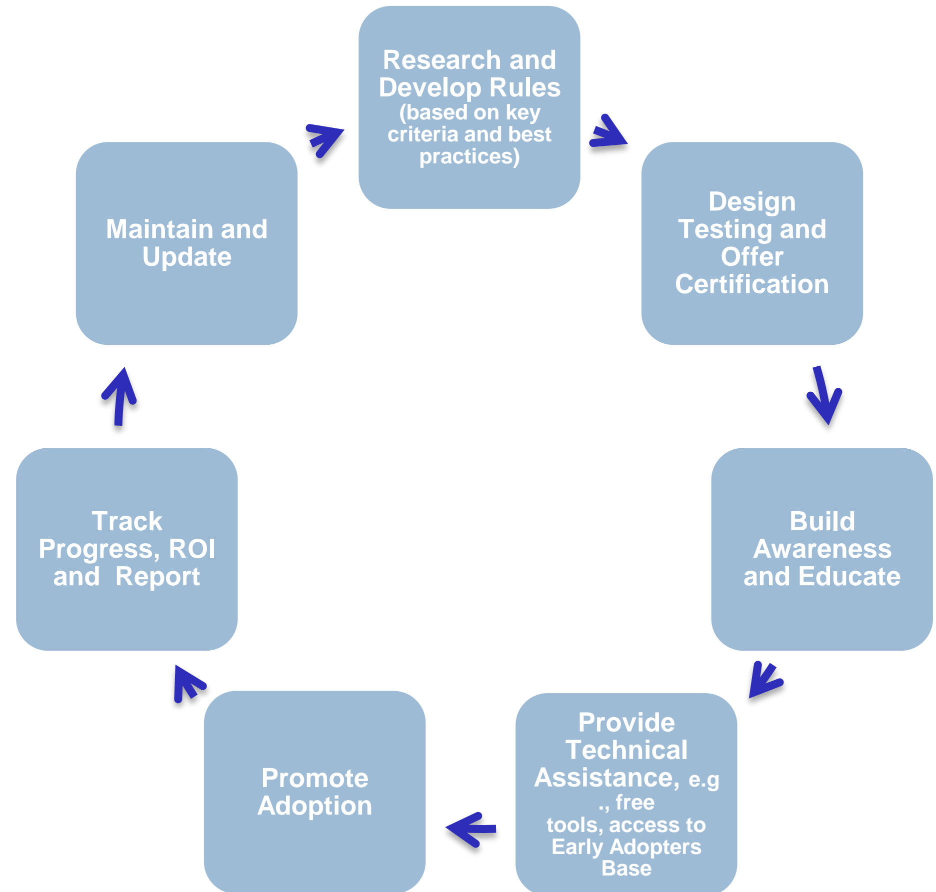
Conclusion

- HIPAA is a critical part of healthcare reform.
  - More strategic decision and policy making is needed around all aspects of HIPAA.
  - Clear and simple tools are essential to drive mass adoption.
- CAQH CORE, as an authoring entity, has made significant progress in last year, and recognizes ongoing need to make further improvements to execute its role; has demonstrated ability to evolve, e.g.,
  - Lifecycle involvement and awareness by industry-wide base.
  - Multi-pronged implementation with growing metrics/analytics.
  - Targeted maintenance.
  - Expanded multi-stakeholder governance.
  - Thoughtful development focus.
- The industry is working to make lasting adoption, maintenance and development decisions regarding operating rules.
  - This informed focus is critical to delivering a proposed third set of mandated operating rules in Q1 2014 that have ability to meet shared guiding principles, e.g., ROI, harmonizing of major initiatives, broader engagement and adoption.

Appendices

CAQH CORE: Integrated Model

- Established in 2005.
- Non-profit, multi-stakeholder, HHS recognized author.
- Operating rules focus on administrative interoperability between *providers and health plans and are* built on guiding principles, e.g.,
  - Transparency.
  - Meaningful milestones.
  - Implementer-focused.
  - Rules ***support and do not duplicate*** recognized standards: HIPAA mandated and industry neutral.
  - Rules are updated when new versions of standards are issued.



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Example of CAQH CORE Education Polling: *Eligibility and Claim Status Challenges*

CAQH CORE Eligibility Operating Rule Implementation Challenges By Stakeholder Type

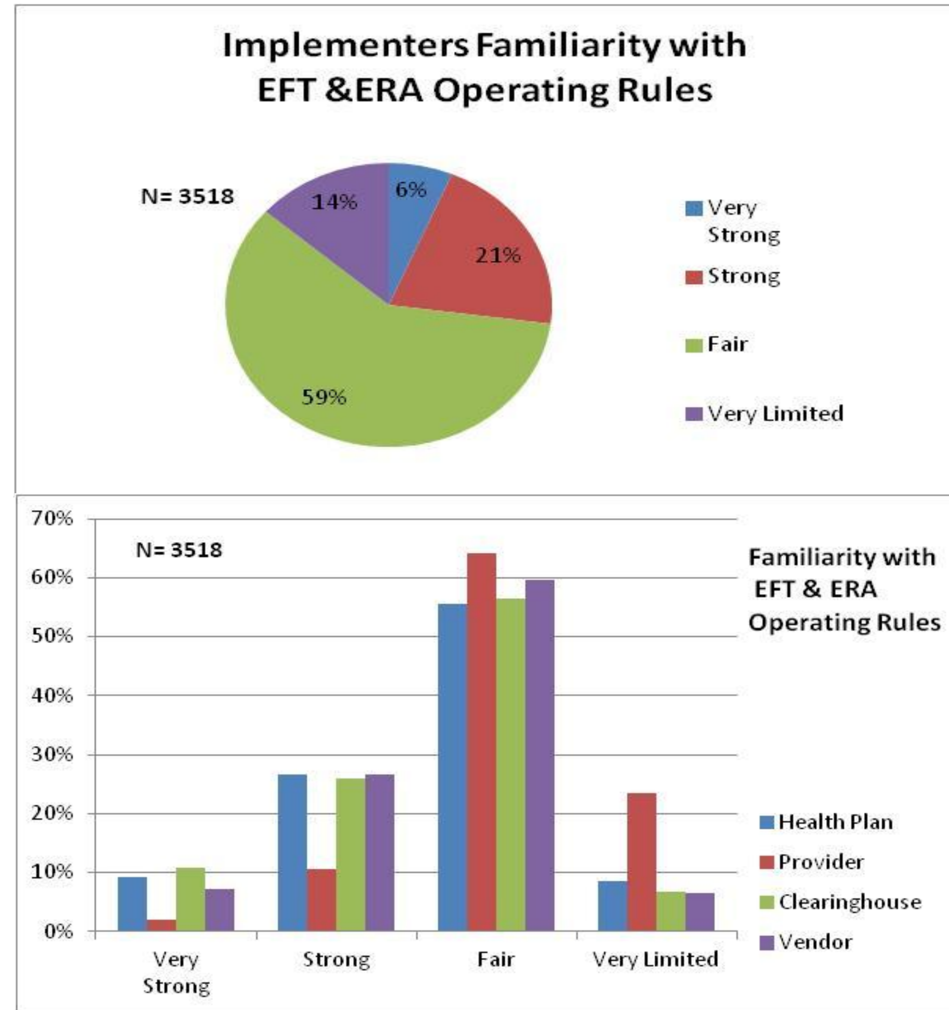
Source: ASC X12/CAQH CORE March 26, 2013 “Open Mic” 4th in a Series. Approximately 300 attendees with portion answering polling.

Example of CAQH CORE Education Polling: *EFT and ERA Operating Rule Familiarity*

Across stakeholder categories, approximately 60% of respondents reported a *“Fair”* understanding of the EFT and ERA Operating Rules.

- Health Plans, Clearinghouses and Vendors reported similar levels of knowledge about the rules.
- Providers familiarity was deemed to be *Fair* or *Limited.*

Source: Level of EFT/ERA Operating Rule Familiarity was asked during registration at six of the education sessions held in April and May 2013.



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Maintenance Example: Mandated Code Combinations

Compliance-based reviews: Task Group already completed two Compliance-based reviews and issued two code combination updates***.*** ***Market-based review for 2013:*** Refine and improve the CORE Code Combinations in the *existing* four Business Scenarios based on broad input (CORE and non-CORE) using agreed-upon submission filters. Initial submission process drafted.

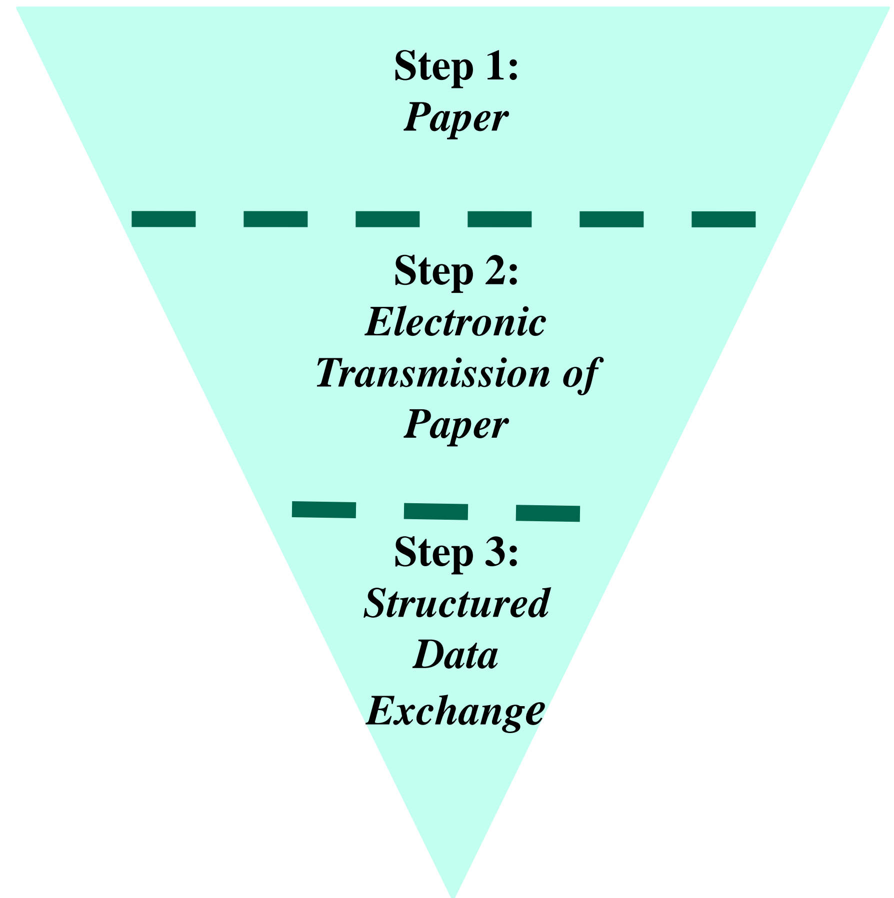
CORE Business Scenario #1	CORE Business Scenario #2	CORE Business Scenario #3	CORE Business Scenario #4
≈470 code combos	≈300 code combos	≈330 code combos	≈30 code combos
Evaluation Criteria	Evaluation Criteria	Evaluation Criteria	Evaluation Criteria
Data Usage	Data Usage	Data Usage	Data Usage
Business Case	Business Case	Business Case	Business Case
CORE Business Scenario #1	**CORE Business Scenario #2**	**CORE Business Scenario #3**	**CORE Business Scenario #4**
X code combos	X code combos	X code combos	X code combos

Participant dialog, debate and decisions around submissions on:

Task Group: CAQH CORE Participating entities are encouraged to join the Task Group; entities may join CAQH CORE at anytime. Four multi-stakeholder Co-Chairs.

Migration Path for Format and ROI

For the many down-stream business needs that drive paper-based exchanges *after* the initial HIPAA transaction, many entities are in Step 1; however, they want to move to Step 2 due to ROI, and/or Step 3 once ROI is established.



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Examples of *Non-CORE Participants* Engaged in Eligibility and Claim Status Implementation

- These non-CORE participants responded to a poll during a May education session stating that they were receiving specific value in Eligibility and Claim Status operating rule implementation, e.g., real time access to claim status and/or eligibility high response, plus data content financials and “all rules”; AAA error and connectivity also selected.
  - Big Bend Hospice
  - BlueCross BlueShield of South Carolina
  - Clinical Pathology Laboratories
  - Cancer Care of North Florida
  - Dallas Primary Care Specialists
  - Iowa Medicaid
  - SUNY Downstate Medical Center
  - Sutter Physician Services
  - University of Miami Miller School of Medicine
  - Yakima Valley Memorial
- Prior to March 2013 enforcement extension, these non-CORE participants reported on a poll that they were done or nearing completion, e.g.,
  - Bluegrass Family Health
  - Geisigner Health System
  - Marshfield Clinic
  - Tampa General Hospital
  - Premera Blue Cross
  - Medical Physicians Imaging, Inc.

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Recently Completed CORE Certifications
CORE and non-CORE Participants

- Blue Cross and Blue Shield of Nebraska - Phase I & II
- HealthFusion for its *HealthFusion® Real-Time* product - Phase II
- Humana Inc. - Phase II
- Loxogon, Inc. for its *Loxogon Alloy™* product - Phase I
- NextGen Healthcare for its *NextGen Practice Management* product - Phase I & II
- Office Ally for its *Office Ally Clearinghouse* product - Phase II
- OptumInsight for its *Optum Netwerkes 2.2.0* product - Phase II
- RelayHealth for its *RelayExchange* product - Phase II
- Rocky Mountain Health Plans - Phase I and II
- Smart Data Solutions for its *Smart Data Stream* product - Phase I and II
- Centene – Phase I and II (includes long-term care)