Presenters for this session are:

Melissa Moorehead, Project Manager – Innovative Solutions Team
Michigan Public Health Institute

Ruth Kaufhold, Senior Consultant, Cognosante

Gwen Lohse, Deputy Director, CAQH

Bill Schuh, Principal, CSG Government Solutions
Operating Rules: Requirements, Timelines, and Implications:
The Basics of the Operating Rules

Bill Schuh
Principal
August 22, 2012
Operating Rules – The Basics

1. **SICKNESS:** This is not allowed under any circumstances. We will no longer accept your doctor’s statement as proof of illness. If you can walk to your doctor you can certainly get to work.

2. **LEAVE OF ABSENCE FOR AN OPERATION:** This provision must stop from today. We wish to discourage any thoughts that you may not need all of whatever you have, and you should not consider having anything removed.

3. **DEATH, OTHER THAN YOUR OWN:** You must arrange to attend all funerals very late in the day after your work is done. Providing this is adhered to we will consider letting you go 1 hour earlier. Please be sure to contact us by 8:00 in the morning.

4. **DEATH, YOUR OWN:** This is acceptable as an excuse, but we would like at least two weeks notice as we feel it is your duty to inform someone else of your job.

5. **PERSONAL HYGIENE:** Entirely too much time is being spent in the loo. In the future you will follow the practice of going in alphabetical order; for instance, those with surnames beginning with “A” will be allowed to go from 9:00, and so on. If you are unable to go at your appointed time you must wait until the next day when your time comes around again.

6. **QUANTITY OF WORK:** No matter how much you do, you’ll never do enough. If you disagree, please see your third party supervisor.

7. **QUALITY OF WORK:** The minimum acceptable level is perfection at all times.

8. **ADVICE FROM OWNER:** Eat a lift from the first thing in the morning and you will be jumping around all day. Since nothing worse can happen to you the rest of the day.

9. **THE BOSS IS ALWAYS RIGHT:** Even in his absence.

10. **WHEN THE BOSS IS WRONG REFER TO RULE 9.**
Section 1104 of the ACA adopts Operating Rules as defined to be “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.” These rules are meant to realize administrative simplification of HIPAA standard transactions, and will only be developed for Electronic Data Interchange (EDI) of healthcare transactions for which HIPAA standards have been adopted.
Operating Rules – The Basics

Rule #1
- ELIGIBILITY FOR A HEALTH PLAN
- HEALTH CLAIM STATUS

Rule #2
- ELECTRONIC FUNDS TRANSFERS
- HEALTH CARE PAYMENT AND REMITTANCE ADVICE

Rule #3
- HEALTH CLAIMS OR EQUIVALENTENCOUNTER INFORMATION
- ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN
- HEALTH PLAN PREMIUM PAYMENTS
- REFERRAL CERTIFICATION AND AUTHORIZATION
Operating Rules – The Basics

**Rule #1**
- **FINAL RULE PUBLISHED** – JULY 2011
- **IMPLEMENTATION DATE** – JANUARY 1, 2013

**Rule #2**
- **FINAL RULE PUBLISHED** – AUGUST 10, 2012
- **IMPLEMENTATION DATE** – JANUARY 1, 2014

**Rule #3**
- **FINAL RULE EXPECTED** – JULY 2014
- **IMPLEMENTATION DATE** – JANUARY 1, 2016
Operating Rules – The Basics

Time is running out for rule #1, are you ready?
ACA Section 1104 Mandated Operating Rules Overview:

CAQH CORE Eligibility & Claim Status
CAQH CORE Electronic Funds Transfer and Electronic Remittance Advice (EFT & ERA)

Presented by Gwen Lohse

MESC Conference
August 22, 2012
Polling Question: *Attendee Awareness*

Choose the option that best describes your awareness of the January 2013 Operating Rule Mandate

- High – actively involved in implementation efforts
- Medium – working knowledge; engaged in planning and assessment
- Low – in process of determining its applicability
- Not Sure / interested in learning more
## Mandated Eligibility & Claim Status Operating Rules

<table>
<thead>
<tr>
<th>Type of Rule</th>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content: Eligibility</strong></td>
<td>Need to drive further industry value in transaction processing</td>
<td>More Robust Eligibility Verification Plus Financials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhanced Error Reporting and Patient Identification</td>
</tr>
<tr>
<td><strong>Infrastructure: Eligibility and Claim Status</strong></td>
<td>Industry needs for common/accessible documentation</td>
<td>Companion Guides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>System Availability</td>
</tr>
<tr>
<td></td>
<td>Industry-wide goals for architecture/performance/connectivity</td>
<td>Response Times</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connectivity and Security</td>
</tr>
</tbody>
</table>

### Mandated Eligibility & Claim Status Operating Rules

**Scope**

**Voluntary Eligibility & Claim Status Operating Rule**

“"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**

*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.*
## Mandated Eligibility & Claim Status Operating Rules: January 1, 2013 Requirements Scope

<table>
<thead>
<tr>
<th>Rules</th>
<th>High-Level Phase I &amp; II CAQH CORE Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content</strong></td>
<td><strong>Eligibility &amp; Benefits</strong> Respond to generic and explicit inquiries for a defined set of 50+ high volume services with:</td>
</tr>
<tr>
<td></td>
<td>• Health plan name and coverage dates</td>
</tr>
<tr>
<td></td>
<td>• Static financials (co-pay, co-insurance, base deductibles)</td>
</tr>
<tr>
<td></td>
<td>• Benefit-specific and base deductible for individual and family</td>
</tr>
<tr>
<td></td>
<td>• In/Out of network variances</td>
</tr>
<tr>
<td></td>
<td>• Remaining deductible amounts</td>
</tr>
<tr>
<td></td>
<td>• Enhanced Patient Identification and Error Reporting requirements</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td><strong>Eligibility, Benefits &amp; Claims Status</strong></td>
</tr>
<tr>
<td></td>
<td>• Companion Guide – common flow/format</td>
</tr>
<tr>
<td></td>
<td>• System Availability service levels – minimum 86% availability per calendar week</td>
</tr>
<tr>
<td></td>
<td>• Real-time and batch turnaround times (e.g., 20 seconds or less for real time and next day for batch)</td>
</tr>
<tr>
<td></td>
<td>• Connectivity via Internet and aligned with NHIN direction, e.g., supports plug and play method (SOAP and digital certificates and clinical/administrative alignment)</td>
</tr>
<tr>
<td></td>
<td>• Acknowledgements (transactional)*</td>
</tr>
</tbody>
</table>

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”

A PowerPoint overview of the Phase I & II CAQH CORE Rules is available [HERE](#); the complete rule sets are available [HERE](#).
Example: Eligibility & Benefits Normalizing Patient Last Name Rule

Scope & High-Level Rule Requirements

• Scope of the rule:
  – Applies to the X12 270/271 transaction and specifies requirements for a health plan (or information source) to normalize a person’s last name during any name validation or matching process by the health plan (or information source)

• High-level rule requirements:
  – Requires health plans to normalize submitted and stored last name before using the submitted and stored last names
    • Remove specified suffix and prefix character strings, special characters and punctuation
  – If normalized name validated, move forward
  – If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
  – If normalized name not validated, return specified AAA code
Mandated EFT & ERA Operating Rules: January 2014 Compliance Deadline

- **Status:** The second set of operating rules have been adopted into Federal regulation
  - August 2012, CMS published CMS-0028-IFC with the following features:
    - Adopted Phase III CAQH CORE Operating Rules for the Electronic funds transfer (EFT) and Health care payment and remittance advice (ERA) transactions *except for rule requirements pertaining to Acknowledgements.* Covered entities must be in compliance by January 1, 2014
    - The interim final rule comment period will remain open for 60 days (10/9/2012)
      - CAQH CORE will solicit input and provide CMS organized feedback
      - CAQH CORE will distribute a model comment letter in upcoming weeks for use by entities as they see appropriate

- **Background:**
  - Spring 2011 - NCVHS recommended:
    - NACHA as healthcare EFT SDO and ACH CCD+ as healthcare EFT standard
    - CAQH CORE, in collaboration with NACHA, as author for EFT and ERA operating rules (pharmacy to be addressed as appropriate)
  - Winter 2011:
    - NCVHS issued letter recommending HHS adopt Draft CAQH CORE EFT & ERA Rule Set
  - Summer 2012:
    - CMS announces the Interim Final Rule (CMS-0024-IFC) adopting healthcare EFT standards is a final rule that is in effect now (These Standards influence Operating Rules)
## Uniform Use of CARCs and RARCs (835) Rule
Claim Adjustment Reason Code (CARC) Remittance Advice Remark Code (RARC)
- Identifies a minimum set of four CAQH CORE-defined Business Scenarios with a maximum set of CAQH CORE-required code combinations that can be applied to convey details of the claim denial or payment to the provider

## EFT Enrollment Data Rule
- Identifies a maximum set of standard data elements for EFT enrollment
- Outlines a straw man template for paper and electronic collection of the data elements
- Requires health plan to offer electronic EFT enrollment

## ERA Enrollment Data Rule
- Similar to EFT Enrollment Data Rule

## EFT & ERA Reassociation (CCD+/835) Rule
- Addresses provider receipt of the CAQH CORE-required Minimum ACH CCD+ Data Elements required for reassociation
- Addresses elapsed time between the sending of the v5010 835 and the CCD+ transactions
- Requirements for resolving late/missing EFT and ERA transactions
- Recognition of the role of NACHA Operating Rules for financial institutions

## Health Care Claim Payment/Advice (835) Infrastructure Rule
- Specifies use of the CAQH CORE Master Companion Guide Template for the flow and format of such guides
- Requires entities to support the Phase II CAQH CORE Connectivity Rule
- Includes batch Acknowledgement requirements
- Defines a dual-delivery (paper/electronic) to facilitate provider transition to electronic remits

Complete CAQH CORE EFT & ERA Operating Rules Set available [HERE](#).
Example: ERA Enrollment Data Rule

**Scope & High-Level Rule Requirements**

- **Scope of the rule:**
  - Applies to entities that enroll providers in ERA
  - Outlines what is out of scope for the rule, e.g., the collection of data for other business purposes and how health plans may use or populate the enrollment data

- **High-level rule requirements:**
  - Identifies a maximum set of approximately 65 standard data elements for enrollment; with related data elements grouped into 10 Data Element Groups (DEGs)
    - Includes a DEG specific to retail pharmacy information
  - Outlines a strawman template for paper and electronic collection of the data elements
  - Should a health plan decide to have a combined EFT/ERA form or other combined enrollment form, the CORE-required data elements for ERA enrollment, including terminology, must be included in the combined form
  - Requires health plan to offer electronic ERA enrollment
    - A specific electronic method is not required
  - Identifies that a process will be used to review the maximum data element set on an annual or semi-annual basis to meet emerging or new industry needs
Administrative Simplification
Compliance

Complaints and **Penalties** are just part of the story…

Melissa Moorehead, Project Manager
August, 2012
TWO **TYPES** OF PENALTIES FOR NONCOMPLIANCE?!!

- Complaint-driven process codified in HITECH
- Attestation, certification, and documentation requirements from ACA section 1104
Compliance with Operating Rules is REQUIRED

❖ HIPAA Compliance Issue:
   ❖ Privacy and Security compliance enforced by the Office of Civil Rights
   ❖ Administrative Simplification (TCS) compliance enforced by the Office of eHealth Standards and Services

❖ Penalties up to $1.5M could be assessed …right now!

❖ Penalties will increase with enforcement of attestation/certification requirements
CURRENT process

- OESS hears complaints concerning noncompliance with HIPAA standards (5010) and operating rules for TCS and IDs

- Persistent violations may result in a civil monetary penalty of up to $1.5M
CURRENT process

 Enforcement strategy is to seek the cooperation of all parties to the complaint and help entities correct deficiencies

 Investigates and offers corrective action plan assistance

 Usual time frame allotted = 90 days
CURRENT process – more information

See attached slide deck about ASET (Administrative Simplification Enforcement Tool)

CORE Town Hall March 2012

(http://www.caqh.org/Host/CORE/CORETownHall03-13-12.pdf)
1/1/2013 –

- ASET complaints possible from the first set of operating rules effective date (1/1/13)

- **12/31/13** Health Plans required to *attest* to compliance, *certify* compliance, *document* compliance

- **4/1/14** the Secretary **SHALL** assess a penalty fee of $1/life/day… until certification is complete (health inflation adjustable, doubled for misrepresentation) – on health plans only
TO-BE process

“Certification rule” TBR

- Will include
  - Definitions
  - Attestation
  - Documentation of end-to-end testing

- No corrective action plan for false attestation!
- “Periodic Audits”
- 11/2014 Fines payable
STANDARDS and Operating Rules Attestation Dates

- **12/31/13** Eligibility/Claims Status and EFT/ERA

- **12/31/15** encounter information, enrollment and disenrollment, premium payments, health claims attachments, referral certification and authorization
The enforcement of the transactions, code sets and identifier rules was delegated to the Office of eHealth Standards and Services (OESS) within the Centers for Medicare & Medicaid Services (CMS),

OESS administers enforcement of the standards for:

- Transactions and Code Sets
- Identifiers and
- Operating rules (beginning January 2013)
Complaints about the Standards

- Filing a complaint
  - Quickest:
    - Internet using the Administrative Simplification Enforcement Tool (ASET): [https://htct.hhs.gov/](https://htct.hhs.gov/)

  Mail: Centers for Medicare & Medicaid Services, HIPAA TCS Enforcement Activities, P.O. Box 8030, Baltimore, MD 21244–8030
Complaint Procedures

- Why should you file a complaint?
  1. Impact on your business operations
  2. Increase overall industry use of the standards
  3. Help increase credibility for the use of the standards
  4. Reduce your costs decreasing inconsistency
Complaining Procedures (2)

- Complaints must meet all of the following requirements:
  - Be filed in writing, either electronically or on paper. CMS cannot accept emailed, faxed or telephonic complaints.
  - Describe the nature of the act believed to be a violation – for example, an entity is not using the required version of the standard
  - Include examples, if possible
  - Include the complainants contact information, including name, email address, mailing address and telephone number
  - Include contact information for the entity that is the subject of the complaint - a name, phone number or email
  - Anonymous complaints are not considered valid
  - Include any previous actions and attempts to resolve the complaint
  - Be filed within 180 days of when the complainant knew or should have known that the violation occurred
Complaint Procedures

- After receiving an official complaint, OESS will:
  - Perform an initial review based on the information
  - Acknowledge the complaint within 14 days
Complaint Procedures

If, after reviewing the requested documentation, OESS determines that a compliance failure by a covered entity may have occurred, it will:

- Advise the filed against entity that a complaint has been filed
- Allow the filed against entity the opportunity to dispute the complaint
Enforcement Philosophy

The primary desired outcome is to obtain voluntary compliance and to provide guidance when necessary.
In cases of non-compliance …

If the violation persists or an entity fails to successfully complete an approved corrective action plan (CAP)

- OESS may issue an investigational subpoena in accordance with 45 CFR 160.504

- After finding that a violation remains, the Secretary will pursue other options, such as, but not limited to, civil monetary penalties
OESS Websites

- http://www.cms.hhs.gov/regulationsandguidance/ - OESS Administrative Simplification Website for Transactions and Code Sets, Unique Identifiers and the Affordable Care Act

- https://htct.hhs.gov - HIPAA Administrative Simplification Enforcement Tool (ASET) electronic complaint submission
NMEH Operating Standards Sub-Workgroup

State of the States
As stated in the CORE Phase I & II Interim Final Rule, these operating rules are expected to assist providers in receiving more robust and complete responses to their inquiries for eligibility and claim status information. The standards and associated operating rules adopted by the Secretary shall:

1. To the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care.

2. Be comprehensive, requiring minimal augmentation by paper or other communications.

3. Provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals).

4. Describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).
Planning
- Based on the IFR, develop a minimum requirements baseline to begin the planning process
- CAQH Certification is **not** required for compliance
- Acknowledgements are **not** required for compliance

Gap Analysis
- Utilize the CAQH CORE gap analysis tool
  - States have found this tool very helpful in analyzing the gaps between their MMIS and the Phase I & II rules
- Identify affected areas of the system and/or operations that are impacted by the gaps
The data content rule for the 271 Eligibility Response

- Patient Liability Determination
  - Claim data may be needed to determine actual liability
  - Some states do not have “standard” co-pays and/or deductibles to provide in the response

- Benefits Determination and/or status
  - Claim data may be needed to determine actual benefits

- Financial Liability
  - Spend down is sometimes unknown to the MMIS at the time of a 270

- Data resides in other systems and/or State Agencies
  - Extracting data from other systems within the “round-trip” online response requirements could prove problematic
States Feedback, cont’d

- Real-time 270/271 & 276/277 (eligibility and claims status) caught most states by surprise
  - Current methods are batch EDI and Web Page DDE
  - The feasibility of real-time
    - Determine ROI when functionality demand is low
  - Interest from Providers appears low
  - Time intensive tools for testing
- CAQH CORE is very good about responding to clarifications on the rules
- CAQH CORE gap analysis tool is very helpful
States Feedback, cont’d

- States should take the time to comment on the EFT/ERA IFC
- Stakeholders should be involved in the authoring process for operating rules
- Applicability of operating rules in state government is lacking
- State Comptroller offices are being consulted for input to an EFT standard
- Difficult to react to short comment period timeframes
- Compliance and/or certification measurements are undefined
- The Operating Rules adopted were written before the ACA, unless an organization was interested in CAQH certification, there was no compelling reason an MMIS would be at the table
- Terminology “conformance” and “CORE certification” are difficult to follow from an MMIS HIPAA compliance standpoint
  - CORE Certification is not mandatory
  - Not all the CORE rules are necessary for HIPAA compliance
Meeting the January 1, 2013 Deadline: Tools for Getting Started

- 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.

  Guide has three tools for project staff to:
  - Understand applicability of the CAQH CORE Operating Rule requirements to organization’s systems that conduct the eligibility and/or claim status transactions.
  - Identify all impacted external and internal systems and outsourced vendors that process eligibility and/or claim status transactions.
  - Conduct detailed rule requirements gap analysis to identify system(s) that may require remediation and business process which may be impacted.

- The guide includes three tools to assist entities in completing analysis and planning:
  - Stakeholder & Business Type Evaluation
  - Systems Inventory & Impact Assessment Worksheet
  - Gap Analysis Worksheet
CAQH CORE Implementation Tools

• The following resources are available to support implementation for eligibility and claims status*:
  
  – **Voluntary CORE Certification**: Provides verification that your IT systems or product operates in accordance with the federally mandated operating rules and is available to health plans, vendors, clearinghouses and providers who are implementing the operating rules and conducting testing using the a CORE-authorized testing vendor
  
  – **Phase I & Phase II CORE Certification Master Test Suites**: Initially developed for voluntary CORE Certification but same concepts, e.g., role of trading partners, apply for general adoption of the CAQH CORE Operating Rules
  
  – **Analysis & Planning Guide for Adopting the CAQH CORE Eligibility & Claim Status Operating Rules**: Provides guidance for Project Managers, Business and System Analysts, and other project staff to complete systems analysis and planning; includes a Stakeholder & Business Type Evaluation, Systems Inventory & Impact Assessment Worksheet, and Gap Analysis Worksheet
  
• FAQs and General/Interpretation Questions:
  
  – 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
  
  – After reviewing other tools & resources, information requests can be submitted to the CAQH CORE Request Process at CORE@caqh.org

* Similar resources are being developed to support implementation of the CAQH CORE EFT & ERA Operating Rules
Thank You For Joining Us: Stay Involved

• **Get Ready!** Ensure your organization is prepared by **January 1, 2013**, the Mandated Eligibility & Claim Status Operating Rules deadline:
  
  – Encourage *voluntary* **CORE Certification** and CORE Certification Testing
    
    • CORE certification is voluntary; but testing the use of the standards and operating rules is important, and should be included in implementation planning
  
  – Learn more about the rules [HIPAA v5010 Phase I & II CAQH CORE Eligibility & Claim Status Rules](#)

• Contribute directly to the rule development process by joining CAQH CORE as a Participating Organization; applications can be found [HERE](#) and at [www.caqh.org](http://www.caqh.org)

• Take advantage of *free* education opportunities and archives of past sessions at the [CORE events](#) page of our website

• Attend upcoming **Town Hall Call** meetings
  
  – Tuesday, September 11th, 3:00 – 4:00 pm ET
Are you engaged in the rule process?
How can the NMEH Operating Standards subworkgroup help you with the current set of operating rules?
NMEH
National Medicaid EDI Healthcare Workgroup

Bill Schuh
BSchuh@CSGdelivers.com
Direct: (312) 444-2760

Gwen Lohse
glohse@caqh.org
Direct: (202) 778.1142
Fax: (202) 861.1454

Melissa Moorehead
mmoorehe@mphi.org
Direct: (517) 324-6011
Mobile: (517) 648-0451

Ruth Kaufhold
ruth.kaufhold@cognosante.com
Direct: (480) 423-8184 ext. 5926
Mobile: (804) 347-6484