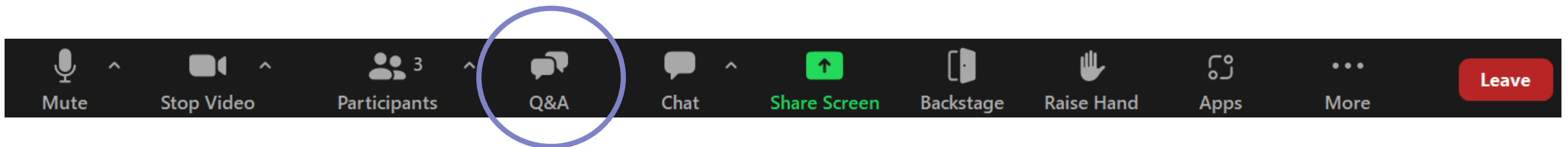# New and Updated CORE Operating Rules

April 22, 2024

Webinar Logistics

- Today's session is being recorded.

  – All attendees and registrants will receive a link to the recording after the webinar.

- Your microphones will be muted during the webinar.

- Throughout the session, you may communicate a question via the panel at the bottom of your screen:

Agenda

- CORE Operating Rules
  - Overview
  - Voting Process

- New & Updated Operating Rules
  - Value-based Payment
  - Health Care Claims
  - EFT & ERA

- Questions

- Call to Action

Thank You to Our Speakers & Co-chairs

Kiana Fitchett
Help Desk Supervisor
Horizon Blue Cross Blue Shield of New Jersey

EFT/ERA Task Group Co-chair

Michael Pattwell
Principal Business Advisor – Value Based Care
Edifecs

Value-based Payments Subgroup Co-chair

Megan Soccorso
Solutions Supervisor
Gainwell Technologies

Health Care Claims Subgroup Co-chair

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CORE Operating Rules
Overview

Rachel Goldstein, Vice President, CAQH CORE

Committee on Operating Rules for Information Exchange

LEADING INDUSTRY	Savings	ENSURING REPRESENTATION

10
CORE Operating Rules Mandated Under HIPAA

$18.3B
Cost savings opportunity by switching to fully automated transactions

100+
Multi-stakeholder Participating Organizations

CORE is a **trusted and independent operating rule author**. In addition to mandated operating rules, CORE offers operating rule sets for voluntary adoption.

The 2023 CAQH Index® estimated that 22% of money spent on administrative transactions could be saved by fulling transitioning to electronic transactions. **CORE Operating Rules help facilitate and streamline electronic adoption.**

From small provider organizations, to national health plans, CORE has the **unique ability to bring diverse industry stakeholders to the table** to tackle complex administrative problems together.

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100+ Organizations Participate in CORE to Develop Operating Rule Requirements

Account for 75% of total American covered lives.

Government

- Arizona Health Care Cost Containment System
- California Department of Health Care Services
- Centers for Medicare and Medicaid Services (CMS)
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Health Plan of San Joaquin
- Michigan Department of Community Health
- Minnesota Department of Health
- Minnesota Department of Human Services
- Missouri HealthNet Division
- North Dakota Medicaid
- Oregon Department of Human Services
- Oregon Health Authority
- Pennsylvania Department of Public Welfare
- TRICARE
- United States Department of Treasury Financial Management
- United States Department of Veterans Affairs

Health Plans

- Aetna
- Ameritas Life Insurance Corp.
- AultCare
- Blue Cross and Blue Shield Association (BCBSA)
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- CareFirst BlueCross BlueShield
- Centene Corporation
- CIGNA
- Elevance Health
- Health Care Service Corp
- Horizon Blue Cross Blue Shield of New Jersey
- Humana
- Medical Mutual of Ohio, Inc.
- Point32Health
- UnitedHealthGroup

Integrated Plan/Provider

- Highmark Health (Highmark, Inc.)
- Kaiser Permanente
- Marshfield Clinic/Security Health Plan of Wisconsin, Inc.

Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cloud Software Group
- Cognizant
- Conduent
- CSRA
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- InstaMed
- Lassie
- MCG Health
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- Surescripts
- The SSI Group, Inc.
- TriZetto Corporation, A Cognizant Company
- Utah Health Information Network (UHIN)
- Wells Fargo
- Zelis

Providers

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Aspen Dental Management, Inc.
- Children's Healthcare of Atlanta Inc
- Greater New York Hospital Association (GNYHA)
- Healthcare Financial Management Association (HFMA)
- Laboratory Corporation of America
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center
- New Mexico Cancer Center
- OhioHealth
- OSF HealthCare
- Peace Health
- St. Joseph's Health
- Virginia Mason Medical Center

Other

- Accenture
- American Dental Association (ADA)
- ASC X12
- Cognosante
- Healthcare Business Management Association
- Healthcare Business Association of New York (HCBA)
- HL7
- NACHA The Electronic Payments Association
- National Association of Healthcare Access Management (NAHAM)
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- National Dental EDI Council (NDEDIC)
- New England HealthCare Exchange Network (NEHEN)
- Preferra Insurance Company Risk Retention Group
- Private Sector Technology Group
- Sekhmet Advisors
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

CORE Operating Rules Support Key Revenue Cycle Functions

ACA Operating Rule Definition: The "necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

Patient Encounter is Scheduled	Patient Encounter Occurs	Provider Submits Claim	Health Plan Adjudicates Claim	Provider is Paid by Health Plan	Management of Health Plan Membership

Eligibility & Benefits*

Attributed Patient Roster

Prior Authorization & Referrals

Health Care Claims

Claim Status*

Payment & Remittance*

Benefit Enrollment

Premium Payment

*Rule Set Contains Federally Mandated Operating Rules

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CORE Operating Rules
Voting Process

Rachel Goldstein, Vice President, CAQH CORE

Formal CORE Voting Process

Level 1:
Subgroups &
Task Groups

Level 2:
Work Groups

Level 3:
Full Voting
Membership

Level 4:
CORE Board

Formal vote is not required, but **consensus is assessed** via straw poll and must be achieved prior to moving to the next level of voting.
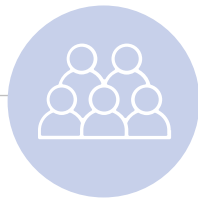
Work Groups require for a **quorum that 60% of all organizational participants are voting**. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule.

Full CORE Voting Membership vote **requires for a quorum that 60% of all Full CORE Voting Member organizations** vote on the proposed rule at this stage. **With a quorum, a 66.67%** approval vote is needed to approve a rule.

The CORE Board's **normal voting procedures would apply.**

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Recently Approved Rule Sets
Value-based Payment, Claims, and EFT & ERA Enrollment Data Rules

Value-based Payment

Standardizes sociodemographic information and aligns disparate industry terms

1.1. CORE Benefit Enrollment and Maintenance (834 X220) Rule Set
1.2. CORE Attributed Patient Roster (834 X318) Rule Set
1.3. CORE Framework for Semantic Interoperability in Value-based Payments
Operating rule sets inclusive of data content, infrastructure, and certification test scenarios

Health Care Claims

Reduce time spent throughout the claim submission process

2.1. CORE Health Care Claims Submission (837) Rule Set
2.2. CORE Claim Acknowledgment (277CA) Rule Set
Operating rules inclusive of data content, companion documents, and certification test scenarios

EFT/ERA Enrollment

Increase transparency and streamline the enrollment process

3.1. EFT & ERA Enrollment Data Rule Set
Operating rules inclusive of data content, companion documents, and certification test scenarios

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CORE Vote Results

☑ **Voting Participating Organization Quorum: 83%**   ☑ **CORE Board Approval: Unanimous**

☑ **Full Voting Membership Approval:**

	CORE Benefit Enrollment (834 X220) Rule Set	CORE Attributed Patient Roster (834 X318)	CORE Framework for Semantic Interoperability in Value-based Payment Models	CORE Health Care Claims (837) Data Content Rule Set	CORE Health Care Claims Acknowledgement (277CA) Data Content Rule	EFT & ERA Enrollment Data Rule Set
Support *(without abstains)*	87%	90%	94%	98%	95%	86%

New & Updated Operating Rules

Value-based Payment

CORE Benefit Enrollment and Maintenance (834 X220) Rule Set
CORE Attributed Patient Roster (834 X318) Rule Set
CORE Framework for Semantic Interoperability in Value-based Payment

Michael Pattwell, Principal Business Advisor – Value Based Care, Edifecs

Value-based Payment
Background

Identified Business Challenges

Coordinating a population of patients across the spectrum of care creates **program complexity**.

While integral to success, **data-sharing** between industry stakeholders **lacks consistency**.

Results of VBP programs **are mixed**, as reported by organizations such as CMMI* in a recent report.
*Center for Medicare and Medicaid Innovation

Subgroup Vision

Leverage **HIPAA-mandated benefit enrollment and claim transactions** to strengthen VBP interoperability by
- Facilitating the uniform exchange of socio-demographic data
- Empower the submission of diagnoses supporting risk-adjustment and quality measurement
- And align the usage of industry VBC terminology.

CORE Benefit Enrollment and Maintenance Operating Rules
New Data Content and Updated Infrastructure Requirements

Requirements applicable to the X12 834 include:

- Collection, exchange and processing of socio-demographic information.
  - Race and Ethnicity
  - Member Language
  - Gender Identity*

- Member privacy and consent processes.

- Best practice implementation guidelines as identified by CORE Participants.

*Discretionary requirement

UPSTREAM

Standardized, uniform data

Maintenance of member privacy

DOWNSTREAM

Optimized program design for health equity

Actionable insights and methodologies inclusive of socio-demographic information
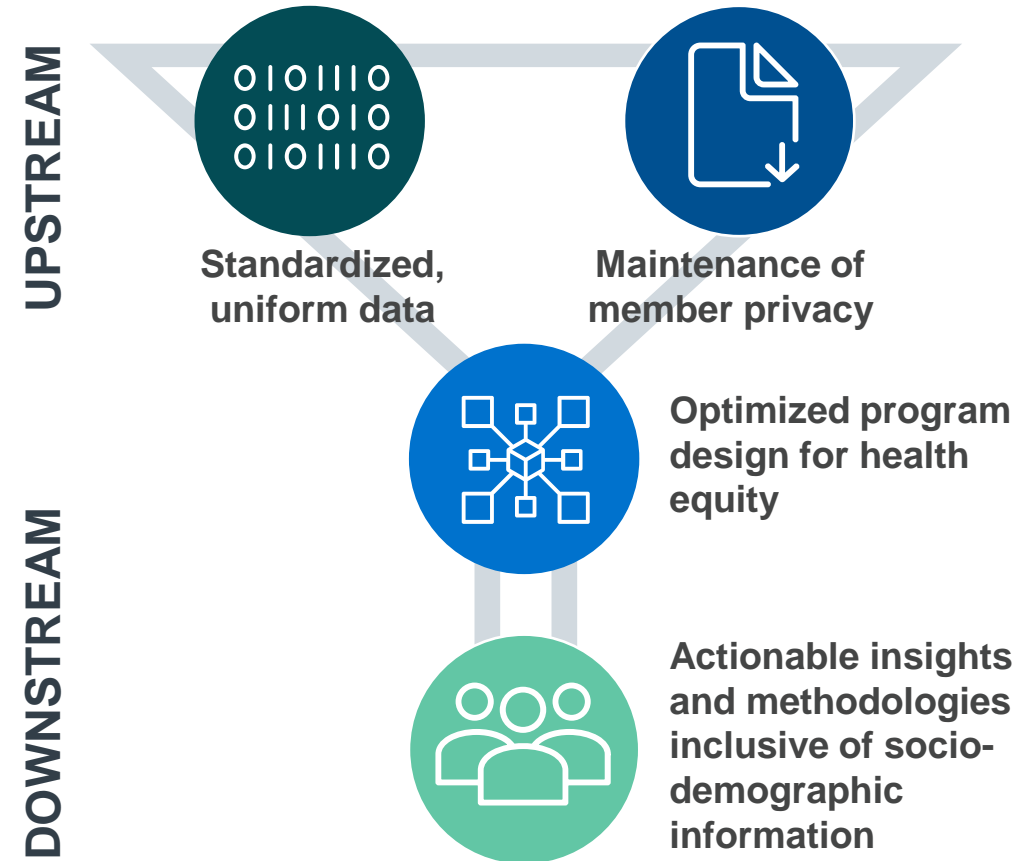
CORE Attributed Patient Roster Operating Rules
Updated Data Content and Infrastructure Requirements

Requirements applicable to the X12 834 include:

- Sharing of socio-demographic information facilitated by the X220 834.
  - Race and Ethnicity
  - Member Language
  - Gender Identity*

- Reinforcement of privacy, consent and sensitivity of member information.

- Alignment to CORE real-time and batch processing mode protocols.

*Discretionary requirement

UPSTREAM

Enrollment to health plan with socio-demographic data collection facilitated by X220 834.

Acme Health Plan

Information shared with health plan that can use it to in program design to target health disparities.

DOWNSTREAM

Providers receive socio-demographic information as part of monthly patient rosters – empowering action in addressing disparities.

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CORE Framework for Semantic Interoperability in Value-based Payment

Definitions encompassing industry best practices for the design and administration of value-based care programs.

- Seven sections of succinctly defined concepts and terminologies commonly present in VBP contracts.

- Guiding document and definitions for value-based concepts named and contemplated in CORE Operating Rules.

- Adaptable and expandable to other initiatives as future concepts and use-cases are identified by industry partners.

CORE Framework for Semantic Interoperability in VBP

- I. General Concepts
- II. Episodic Care
- III. Population-based Models
- IV. Patient Attribution
- V. Risk Adjustment
- VI. Quality
- VII. Payment

Value-based Payment Operating Rules
Industry Value
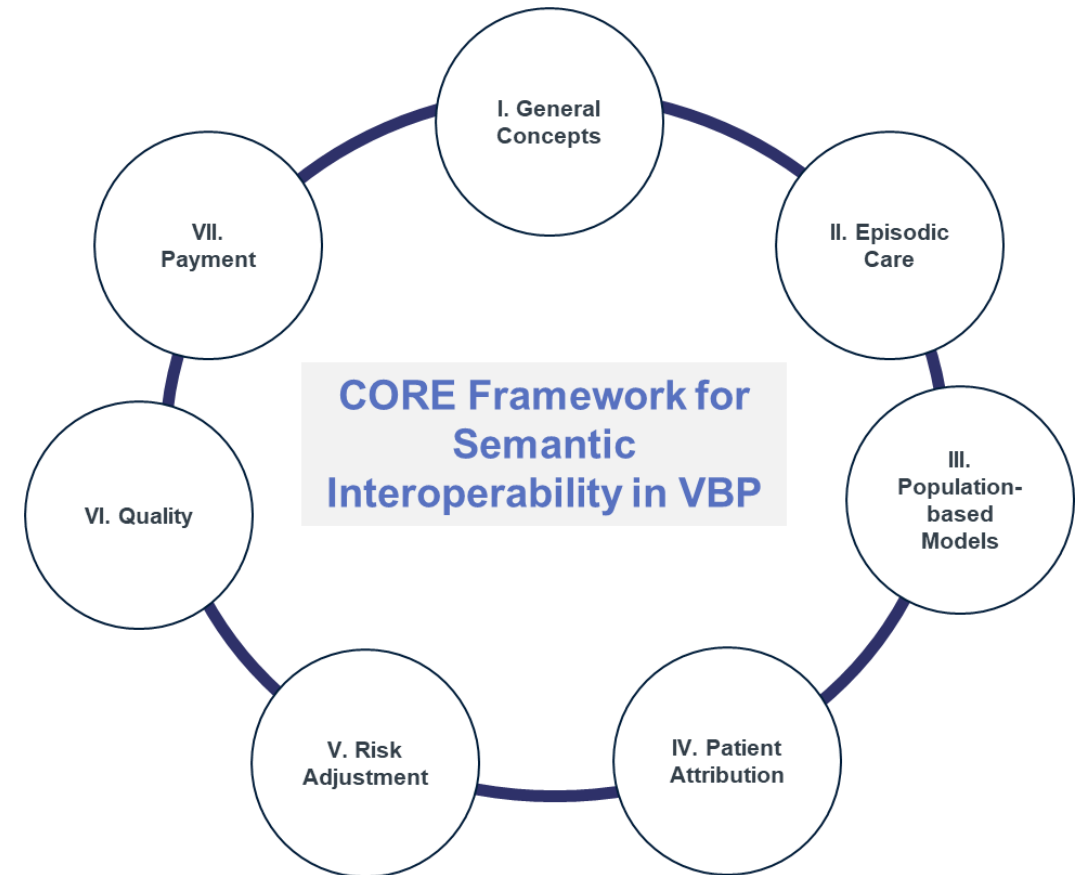
CORE Benefit Enrollment and Maintenance Operating Rules:

Standardize the intake of socio-demographic information without compromising maintenance of patient privacy.

CORE Attributed Patient Roster Operating Rules:

Create a **predictable** mechanism to share attribution information inclusive of socio-demographic data with participants in a value-based contract.

CORE Framework for Semantic Interoperability in Value-based Payment:

Aligns disparate industry definitions for terms and concepts commonly encountered in value-based payment programs, easing comprehension among engaged stakeholders.
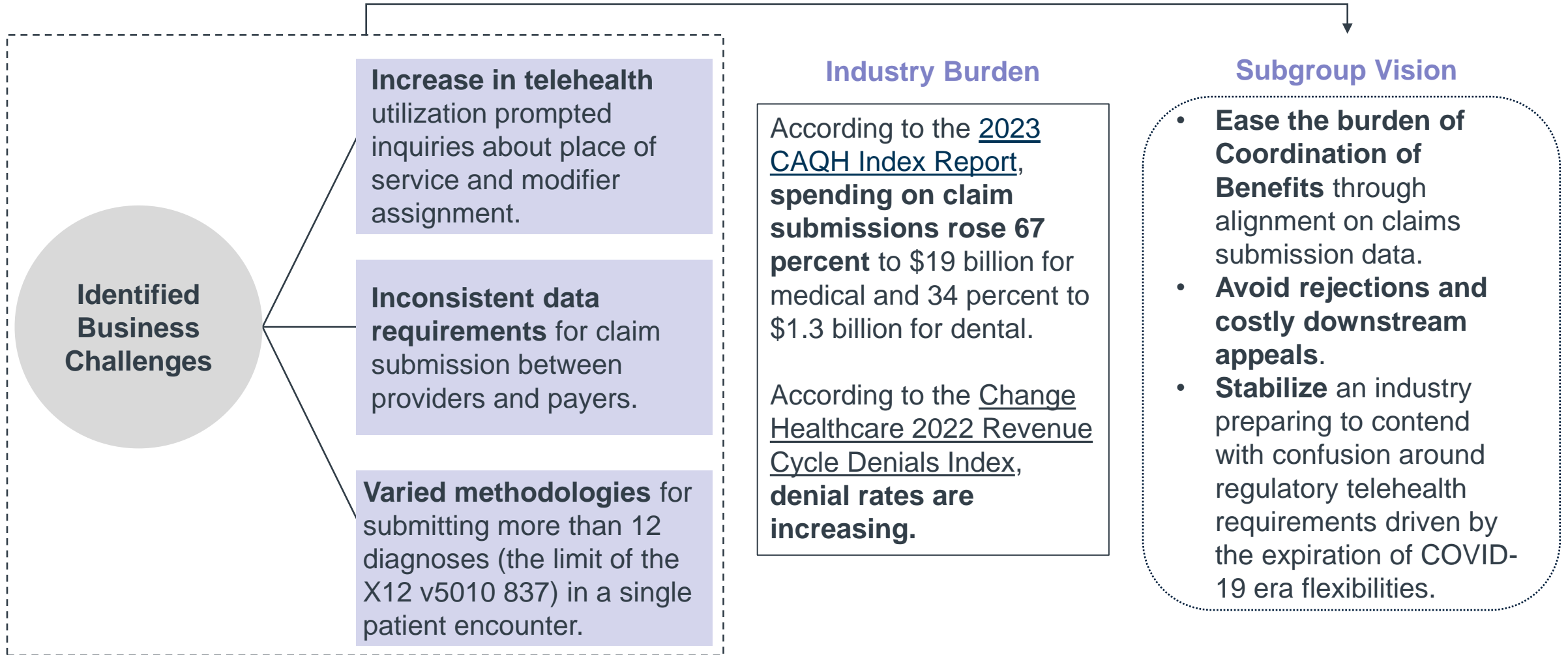
New Operating Rules

Health Care Claims

CORE Health Care Claims (837) Rule Set
CORE Claim Acknowledgment (277CA) Rule Set

Megan Soccorso, Solutions Supervisor, Gainwell Technologies

Health Care Claims
Background

Identified Business Challenges

Increase in telehealth utilization prompted inquiries about place of service and modifier assignment.

Inconsistent data requirements for claim submission between providers and payers.

Varied methodologies for submitting more than 12 diagnoses (the limit of the X12 v5010 837) in a single patient encounter.

Industry Burden

According to the 2023 CAQH Index Report, **spending on claim submissions rose 67 percent** to $19 billion for medical and 34 percent to $1.3 billion for dental.

According to the Change Healthcare 2022 Revenue Cycle Denials Index, **denial rates are increasing.**

Subgroup Vision

- **Ease the burden of Coordination of Benefits** through alignment on claims submission data.
- **Avoid rejections and costly downstream appeals**.
- **Stabilize** an industry preparing to contend with confusion around regulatory telehealth requirements driven by the expiration of COVID-19 era flexibilities.

CORE Health Care Claims and Claim Acknowledgement Operating Rules
New and Updated Data Content Requirements

Transaction

| Health Care Claims X12 837 | Claim Acknowledgment X12 277CA | Health Care Claims X12 837 |

Workflow Implications

Pre-submission:
Simplified coding

Pre-adjudication:
Clear error messaging

During adjudication:
Improved COB

Requirements

- Conditional POS + modifier requirements.
- Inclusion of data to support matching between initial and supplementary claims for VBP arrangements.

- Specified claim (837) and claim acknowledgment (277CA) reassociation and error data.
- *CORE-required Error Code Combinations for CORE-defined Claim Rejection* Business Scenarios.

- Inclusion of data to support COB workflows.

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Health Care Claims Operating Rules
Industry Value

Health Care Claims Rule:

Reduced time spent navigating billing requirements for accurate telehealth and VBP claims submission.

Reduced time spent in coordination of benefits conversations between providers, patients, and health plans.

Claim Acknowledgment Rule:

Reduced time interpreting errors to make updates to submitted claims.

Increased utilization of the Claim Acknowledgment (277CA) transaction.
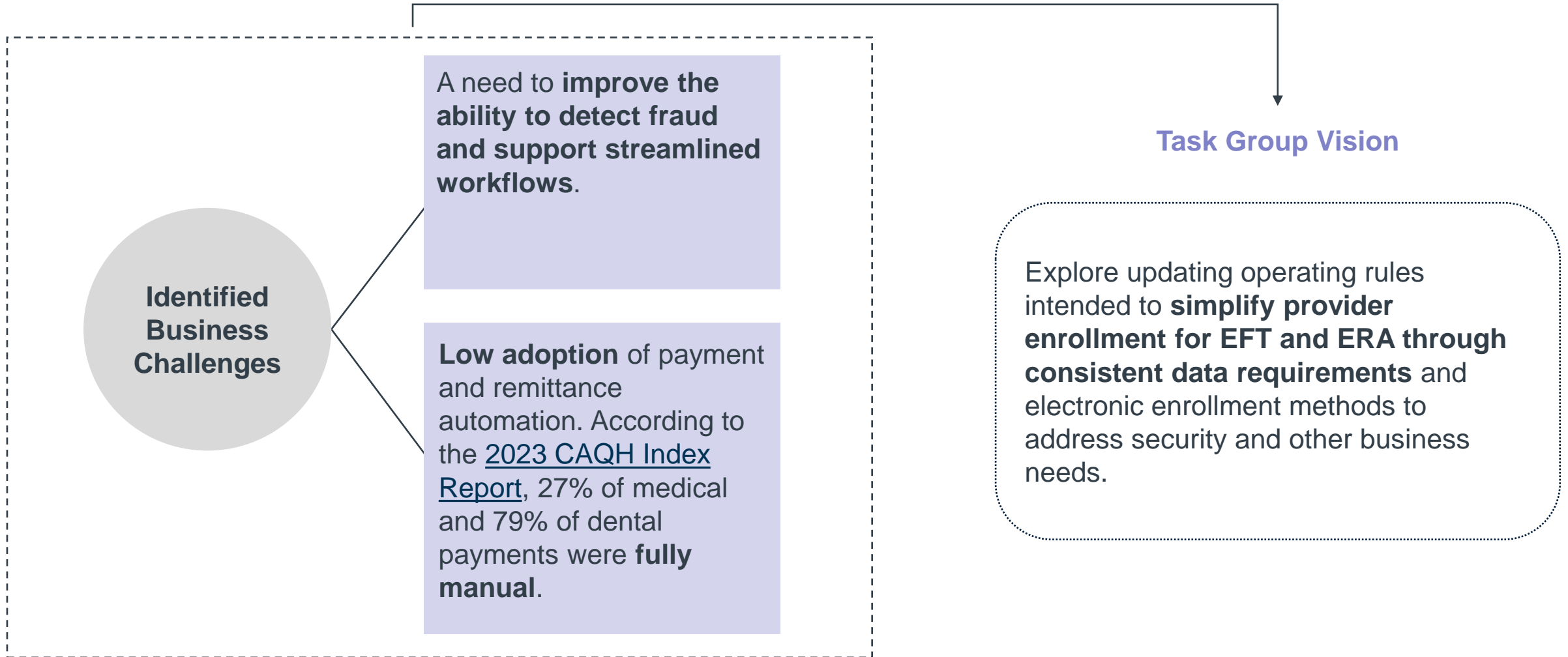
Shorter adjudication timelines.

Updated Operating Rules

EFT/ERA

CORE EFT & ERA Enrollment Data Rule Set

Kiana Fitchett, Health Desk Supervisor, Horizon Blue Cross Blue Shield of New Jersey

Identified Business Challenges

A need to **improve the ability to detect fraud and support streamlined workflows**.

Low adoption of payment and remittance automation. According to the 2023 CAQH Index Report, 27% of medical and 79% of dental payments were **fully manual**.

Task Group Vision

Explore updating operating rules intended to **simplify provider enrollment for EFT and ERA through consistent data requirements** and electronic enrollment methods to address security and other business needs.

CAQH CORE

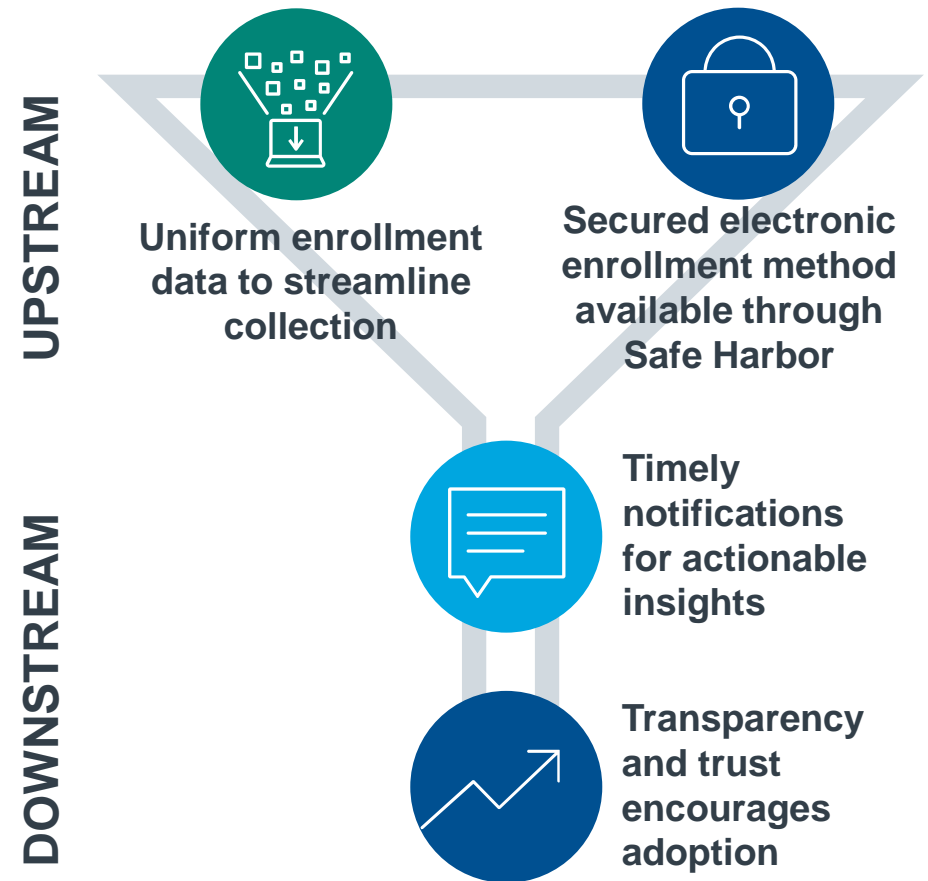# CORE EFT & ERA Enrollment Data Rules
Updated Rule Requirements

Data Set Enhancements:

- Externalization of enrollment data sets for flexibility and alignment with current and emerging business needs.

Updated Rule Requirements:

- Support for bulk enrollment.

- Addition of fraud detection measures to safeguard enrollment data.

- Establishes notification and timeframe requirements.

- Requires disclosure of applicable EFT fees.

- Provision of opt-in/out instructions for alternative payments.

UPSTREAM

Uniform enrollment data to streamline collection

Secured electronic enrollment method available through Safe Harbor

DOWNSTREAM

Timely notifications for actionable insights

Transparency and trust encourages adoption

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EFT/ERA Enrollment Data:

Streamline the enrollment process for healthcare providers switching to electronic payments, ensuring a **consistent and efficient experience** across different health plans.

Increased transparency keeps providers informed every step of the way during the enrollment process.

Poll for Upcoming Initiatives

Questions

Call to Action

Call to Action

Become a CORE Participant

Collaborate with decision makers that comprise 75% of the industry to drive creation of operating rules and accelerate interoperability.

Get CORE Certified

Does your organization use standard transactions on a day-to-day basis? Demonstrate conformance and commitment to streamlining administrative data exchange.

Participate in Pilot Initiatives

Work with CORE to measure the impact of operating rules and corresponding standards on organizations' efficiency metrics.

Be an Advocate

Stay up to date on new policy initiatives and send in comment letters to provide support and feedback.

E-mail core @caqh.org

Upcoming Events

Webinars

- **Prior Authorization Impacts on Patient Access Professionals**
  May 15th, 2:00 PM

  [Register Here]

- **Dive into the X12 835 Transaction & Operating Rules**
  June 27th 2:00PM

  [Register Here]

Sign up for all future CORE Webinars here:
CORE Education Series

Conferences

- **NDEDIC Summit,**
  Nashville, TN
  - May 7th 1:15 PM: *Opportunities to Improve the Dental Revenue Cycle Workflow through Electronic Adoption: 2023 CAQH Index® Findings and CAQH CORE Operating Rules*

- **WEDI Spring Conference**
  Virtual
  - May 14th 12:45 PM: *CAQH Index Report*
  - May 15th 2:45 PM: *Industry Collaboration to Improve Provider Data Quality*
  - May 16th 12:45 PM *Standards Development and Operating Rules Organization Updates*

- **HFMA Annual Conference**
  Las Vegas, NV
  - June 26th 3:00 PM: *How CORE Operating Rules Streamline the Revenue Cycle: from Eligibility to Payment*

Resources

- <u>Published CORE Operating Rules</u>

- <u>CORE Resource Library</u>
    - Frequently Asked Questions
    - Implementation Guides

Thank you!

E-mail CORE@CAQH.ORG to Get Involved!