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Clearinghouse Caucus Agenda
Tuesday, October 3, 2023

Pavillion
5:00 – 6:00pm

I. **Welcome and Introduction of Cooperative Exchange -** Pam Grosze, Board Chair, Cooperative Exchange and VP, Senior Product Manager, PNC Bank

II. **X12 Update -** Pam Grosze, Board Chair, Cooperative Exchange and VP, Senior Product Manager, PNC Bank

III. ***CAQH CORE Update*** – Bob Bowman

IV. ***Optum Attachments Project –*** Tara Rose, Product Manager, OptumInsight

V. ***MD MHCC New Clearinghouse Requirements*** – Pam Grosze, Board Chair, Cooperative Exchange and VP, Senior Product Manager, PNC Bank

VI. **Meeting Wrap-Up -** Pam Grosze, Board Chair, Cooperative Exchange and VP, Senior Product Manager, PNC Bank

www.cooperativeexchange.org

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Overview of Cooperative Exchange (CE)

- 18 Clearinghouse Member Companies
- Represent over 85% of the clearinghouse industry
- Over 750,000 submitting provider organizations
- Maintain over 8,000 Payer connections
- 1000 plus HIT vendor connections
- Process over 4 plus billion claims annually
- Value of transactions –over $1.1 Trillion
- Infrastructure framework supports BOTH administrative and clinical transactions

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Our Members

Availity
CHANGE HEALTHCARE
CLAIM MD
eTactics
experian health
FinThrive
InstaMed
JOPARI SOLUTIONS, INC.
mitchell
nextgen healthcare
Office Ally
OPTUM
PHIcure
PNC
SMARTDATA SOLUTIONS
TODAY'S INNOVATIONS | TOMORROW'S SOLUTIONS
SSI
TRIZETTO Provider Solutions
A Cognizant Company
veradigm
WAYSTAR
REVENUE CYCLE TECHNOLOGY

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2023 Board of Directors

Board Chair
Pamela Grosze
PC Bank

Board Past Chair
Crystal Ewing
Waystar

Secretary
Eric Grindstaff
Veradigm

Director
Dawn Duchek
Cognizant

Executive Director
Lisa Beard
M3Solutions

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Cooperative Exchange Board Elections

Watch your email, our annual board elections will be sent out soon. If you are interested in serving on the Cooperative Exchange Board of Directors, please contact our Executive Director, Lisa Beard at lisa@cooperativeexchange.org.

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X12 Update

Pamela Grosze, Cooperative Exchange
Formal Liaison to X12

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Major Activities

X12 response letter to NCVHS dated 7/31/23

- Requests reconsideration of the recommendation
  - Letter available at https://x12.org/news-and-events/news/ncvhs-response-letter
- X12 encourages organizations to submit letters of support for moving the transactions forward
  - Talking points available at https://x12.org/news-and-events/news/points-rebuttals-and-letters-support
  - The Cooperative Exchange submitted a letter on 9/13/23
    Letter available at
    ttps://www.cooperativeexchange.org/site_page.cfm?pk_association_webpage_menu=2891&pk_association_webpage=15408
- Proof of Concept update available at https://x12.org/sites/default/files/documents/x12-poc-update.pdf

Reminder - X12 Recommendations to NCVHS

- https://x12.org/news-and-events/x12-recommendations-to-ncvhs
- Waiting on next steps after NCVHS recommendation

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CAQH CORE Update

Bob Bowman
Principal, Interoperability & Standards

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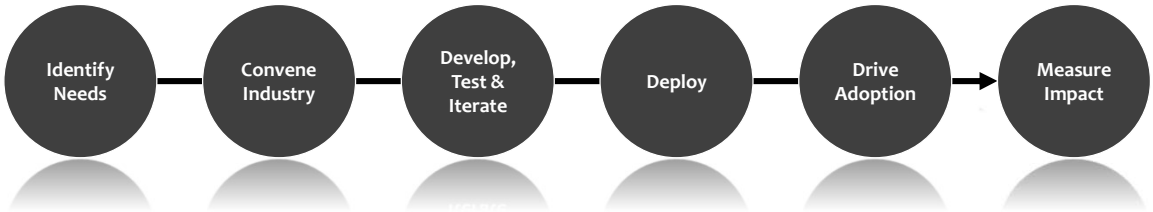
CAQH CORE Mission & Vision

Mission

Drive the creation and adoption of healthcare operating rules that **support standards, accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

Vision

An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.



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CAQH CORE: Who We Are

Committee on Operating Rules for Information Exchange

Federally designated by the Department of Health and Human Services (HHS) as the National Operating Rule Authoring Entity for all HIPAA mandated administrative transactions.

Develop business rules to help industry effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

Multi-stakeholder Board Members include health plans, providers, vendors, and government entities. Advisors to the Board include SDOs.

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CAQH CORE℠

NCVHS Process and Recommendations

Erin Weber
Vice President, CORE

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Operating Rule Path to Federal Mandate

CAQH CORE Sends Letter to NCVHS*:
- On 5/23/22 the CAQH CORE Board sent a letter to the HHS** Federal Advisory Committee (NCVHS) proposing a set of new and updated operating rules for federal adoption.

NCVHS Collects Industry Feedback:
- NCVHS Standards Subcommittee published a Request for Comment due by 12/15/22 and held an industry hearing on 1/19/23 to review and solicit feedback on the proposed rules.

NCVHS Makes Recommendation to HHS:
- NCVHS sent a letter to the HHS Secretary on 6/30/23 recommending the proposed operating rules for adoption under HIPAA except those for attachments.

Expedited HHS Interim Final Rule Making
- If a federal adoption is the approach, HHS will issue an Interim Final Rule (IFR) to the industry with a public comment period. With no major objections, HHS then adopts the final rule and mandates the operating rules.*** Once HHS mandates an operating rule, industry is given 25 months to implement and adopt new rules.

*National Committee on Vital and Health Statistics (NCVHS) | ** Department of Health and Human Services (HHS) | ***HHS has the authority to judge whether comments are substantial and whether changes should be made to the final rule.

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NCVHS Recommendation to HHS

On **June 30, 2023** NCVHS made the following rulemaking recommendation in a letter to HHS:

	Proposed Operating Rules	NCVHS Rulemaking Recommendation
Updated	CORE Eligibility and Benefits (270/271) Infrastructure Rule CORE Claim Status (276/277) Infrastructure Rule CORE Payment and Remittance (835) Infrastructure Rule	• **Recommended** HHS conduct rulemaking to federally adopt
Updated	CORE Connectivity Rule vC4.0.0	• **Recommended** HHS conduct rulemaking to federally adopt
Updated	CORE Eligibility and Benefits (270/271) Data Content Rule	• **Recommended** HHS conduct rulemaking to federally adopt
New	CORE Eligibility and Benefits (270/271) Single Patient Attribution Data Content Rule	• **Recommended** HHS conduct rulemaking to federally adopt
New	CORE Attachments Health Care Claims Infrastructure Rule CORE Attachments Health Care Claims Data Content Rule CORE Attachments Prior Authorization Infrastructure Rule CORE Attachments Prior Authorization Data Content Rule	• **Do not** conduct rulemaking to adopt
	CORE Certification Requirement Language	• **Do not** conduct rulemaking to adopt (consistent with past recommendations)

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Updated CORE Infrastructure Rules

Eligibility, Claim Status & Remittance

Overview: The mandated CAQH CORE Infrastructure Rules* for eligibility, claim status, and remittance advice provide safe harbor connectivity and security standards and dictate requirements for system availability, uniform use of acknowledgements and processing time requirements. Updates provide enhanced security, greater system availability, flexibility to accommodate multiple payloads and conformance with the most current CORE Connectivity Rules.

Existing: HIPAA-mandated Infrastructure Rules		Updates: NCVHS Recommended Infrastructure Rules.
86% per calendar week	**Weekly System Availability**	**90%** per calendar week
N/A: Current Mandated CAQH CORE Infrastructure Rules **do not include** a quarterly system availability requirement	**Quarterly System Availability**	Health plans and their agents may use **24 additional hours** of system downtime per calendar quarter to accommodate larger system updates and maintenance
Phase I & II Connectivity Rules (vC.1.1.0 & vC.2.2.0)	**Connectivity**	**Most current** CAQH CORE Connectivity Rule (vC.4.0.0)
Companion guides must follow format and flow of CORE Master Companion Guide	**Companion Guide**	Updates include support for the non-X12 transactions to accommodate multiple standards

*CAQH CORE Eligibility & Benefits (270/271) Infrastructure Rule; CAQH CORE Claims Status (276/277) Infrastructure Rule; CAQH CORE Payment & Remittance (835) Infrastructure Rule

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Newest Version of CORE Connectivity

Overview: The **CAQH CORE Connectivity Rule vC4.0.0** is a single, uniform Connectivity Rule that supports administrative and clinical data exchange. The rule updates and aligns CAQH CORE connectivity & security requirements to support REST and other API technology, building upon prior versions of CAQH CORE Connectivity.

Existing: HIPAA-mandated Connectivity Rule

Key Requirements:

- Use of **public internet** connection and **HTTP transport** standards to establish an industry **Safe Harbor**
- Employs **Username and Password** with optional use of **digital certificate** for authentication
- Use of both **SOAP and MIME** messaging standards
- **Defined metadata** to relieve burden of implementation and reduce variances across industry
- Supports **batch** and **real time** interactions meeting industry needs
- Specifies **error handling** processes and messaging requirements
- Requires development and implementation of a **capacity plan**

Updates: NCVHS Recommended Connectivity Rule

Updates:

- Continues **Safe Harbor** Connectivity requirements to support **SOAP messaging standards**
- Incorporation of HTTPS and more stringent security standards – **TLS 1.2 or higher**
- Requirement to use digital certificate for authentication – **X.509**
- Implementation of stronger authorization standards – **OAuth 2.0**
- Add support for the exchange of **Attachments transactions – including X12 275, HL7 C-CDA, FHIR, etc.**

and

Addition of REST standards in vC4.0.0:

- Support for standard-agnostic REST style web resources
- Messaging in human-readable JAVA format
- Support for API integration and versioning standards for CORE Connectivity

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Updated and New CORE Eligibility & Benefits Data Content Rule

Overview: The **CAQH CORE Eligibility & Benefits Data Content Rule Update** enhances the exchange of eligibility information between health plans and providers through requirements including providing financial information, especially co-insurance, co-payment, deductible, remaining deductible amounts, and coverage information for a set of service types in real time.

Existing: HIPAA-mandated Eligibility & Benefits Data Content Rule

- Respond in **real-time response** (20 seconds or less) or next day for a batch response time.
- Support detailed responses for **52 Service Type Codes (STCs)**.
- Return **patient financial responsibility** for co-pay, co-insurance and deductible.
- Return benefit information at **least 12 months into the past**, up to the end of the current month.
- Use **standard characters**, cases, prefixes and suffixes for last names.
- Follow defined reporting of errors using **AAA error codes**.

Updates and New NCVHS Recommended Eligibility & Benefits Data Content Rules

- Return detailed eligibility and benefit information for **tiered benefit coverage**.
- Support **126 additional STCs**.
- Return **maximum and remaining benefits** for 10 STCs.
- Indicate if included STCs or procedure codes require **prior authorization** or certification.
- Use CMS place of service codes when service is available through **telehealth**.
- Return eligibility and benefit information at the **procedure code level** for PT, OT, surgery, and imaging.
- **New:** Single Patient Attribution Data Content Rule requires returning **patient attribution status and effective dates of attribution**.

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CAQH CORE℠

2023 Operating Rule Development

Erin Weber
Vice President, CORE

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2023 Operating Rule Development Efforts

Initiative	Identify Opportunities	Develop Rule Requirements	Ballot Rules
Health Care Claims Data Content	✓	In Progress	
Value-based Payments	✓	In Progress	
CORE Code Combinations	✓	*Ongoing Maintenance*	
EFT/ERA Enrollment Data	✓	Recently Launched	
NCPDP/CORE Medication Eligibility	✓	Launching Soon	
Claim Status	Launching Soon		

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2023 Operating Rule Development
Health Care Claims

Business Challenges

Inconsistent Data
Information shared in claim transactions between providers and payers varies significantly, increasing administrative burden and requiring manual intervention for claims management.

Increasing Denial Rates According to the Change Healthcare 2022 Revenue Cycle Denials Index, the average initial denial rate across 1,500 hospitals in the United States was almost 12% in the first half of 2022 compared to just 10% in 2020 and 9% in 2016.

2023 CORE Rule Development Group Vision

Establish **data content requirements** for transactions supporting claim submission, acknowledgment, and error reporting to help avoid rejections and costly downstream appeals.

Environmental scanning and additional research conducted in 2022 and early 2023 identified preliminary opportunities to address business challenges.

The Subgroup launched on April 13, 2023 to begin evaluating opportunity areas for rule development..

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Health Care Claims Rule Development Focus Areas

Telehealth POS + Modifier Placement	277CA Data Alignment	COB Claim Submission
DRAFT CORE Data Content Operating Rule for the Health Care Claim Transaction - Telehealth Claim Submission	**DRAFT CORE Data Content Operating Rule for the 277CA Transaction**	**DRAFT CORE Data Content Operating Rule for the Health Care Claim Submission Transaction**
• Modifier assignment for POS 10 and 02 is standardized to modifiers 93, 95, or GT. • Definitions of POS + modifier combinations are established in an **accessible reference** resource.	• Claim Status Category Codes (CSCC) and Claim Status Code (CSC) errors and rejection reasons are standardized into business scenarios and code combinations. • Standardized data used to associate the 277CA transaction with an 837 transaction. • Standardized data used to associate a 277CA error code with an 837 service line item.	• Standardized **minimum required data elements** for successful processing of COB. • Standardized **format** for listing health plan COB data requirements. • Alignment on **electronic access** of health plan COB data requirements.
Significant because: • A rule provides needed clarity on place of service and modifier alignment.	**Significant because:** • Standardized use of the 277CA could increase transaction adoption. • With improved data quality and greater transaction adoption comes simplified claim resubmission.	**Significant because:** • Lack of uniform 837 COB requirements creates additional administrative burden. • Uniform data content requirements can remediate questions on payment or care attribution, among other items.

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2023 Operating Rule Development

Value-based Payments

Business Challenges

Inconsistent Data. Data-sharing is integral to success in VBP; however, exchanging key data such as SDOH information between industry stakeholders lacks standardization, thus hindering efficient data exchange and negatively impacting patient care.

Limited Results. A recent report from the Center for Medicare and Medicaid Innovation (CMMI) shows that VBP programs produce only modest cost-savings without significant improvements in care quality.

Program Complexity. Coordinating a population of patients across the spectrum of care poses difficulties that could be eased by defining terms and definitions across VBP programs.

2023 CORE Rule Development Group Vision

Leverage **HIPAA-mandated benefit enrollment and claim transaction** to facilitate uniform exchange of socio-demographic information and strengthen interoperability in VBP by aligning technical infrastructure requirements and industry terminology.

Environmental scanning and additional research conducted in 2022 and early 2023 identified preliminary opportunities to address business challenges.

The Subgroup launched on April 27, 2023 to begin evaluating opportunity areas for rule development..

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Value-based Payment Rule Development Focus Areas

Strengthened Exchange of Socio-demographic Data	Empowered Engagement with VBP Methodologies	Created a Framework for Semantic Interoperability
NEW DRAFT Benefit Enrollment and Maintenance (X220) Data Content Rule **UPDATED DRAFT Benefit Enrollment and Maintenance (X220) Infrastructure Rule** **UPDATED DRAFT Attributed Patient Roster (X318) Data Content and Infrastructure Rules** • **Impactful** socio-demographic data inclusions, standardizing exchange. • Enhanced **health plan-to-provider** exchange of socio-demographic information. • Infrastructure rules **inclusive of value-based payment** requirements.	**NEW DRAFT Health Care Claim (X221 / X222) Submission Data Content Rule** • **Alignment** of industry requirements for additional claim submissions. • **Structure** for the inclusion of information supporting value-based methodologies, such as risk adjustment. • Component of a **suite** of operating rule requirements to reduce burden.	**NEW DRAFT CORE Framework for Semantic Interoperability in Value-based Payment Models** • **Clarity** around disparate concepts and terms prevalent in VBP. • **Resource** for industry stakeholders to reference and for CAQH CORE to better define VBP in operating rules. • Functions as a **compilation** of disconnected industry efforts.
Significant because: • Generates **usable** socio-demographic data for VBP designers and participants. • Addresses with **CMMI** evaluations that data availability and quality slows health equity progress.	**Significant because:** • Enhances **reporting of non-medical factors** increasingly used for quality and risk adjustment. • Encourages **greater provider engagement** in the administration of VBP by easing reporting.	**Significant because:** • Centers language used in VBP that can otherwise **confuse contracting or policy efforts.** • Creates a **basis for CAQH CORE Operating Rules** and aligns disparate industry initiatives.

5 NEW or UPDATED Operating Rules and 1 CORE and Industry Resource to drive automation and adoption of value-based payment models.

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2023 Operating Rule Development

EFT/ERA Enrollment Data Rules Update

Business Needs

Industry stakeholders requested that CORE make substantive adjustments to the enrollment data sets to **improve the ability to detect fraud and support streamlined workflows.**

Ongoing need to drive payment and remittance automation through **greater adoption of EFT/ERA standards.**

2023 CORE Rule Development 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.

In Q2 of 2023, **CORE conducted industry interviews to evaluate current and emerging business needs** to improve EFT/ERA enrollment which identified five opportunity areas for Task Group consideration.

The Task Group launched on August 15, 2023 to begin evaluating opportunity areas for rule updates.

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EFT/ERA Enrollment Data Rules Update
Five Opportunity Areas

1	2	3	4	5
Enhancement to Data Sets	**Flexible Data Sets**	**Fraud Detection**	**Bulk Enrollment**	**Notification of Enrollment, Disenrollment, or Updates**
Revise and improve data element groups and elements.	Enable flexible arrangement and externalization of data sets.	Strengthen fraud detection capabilities through the addition of new data elements.	Facilitate efficient enrollment across multiple entities.	Establish clear requirements for notifying providers of enrollment, disenrollment, or updates.

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Upcoming Initiative
Eligibility & Benefits

Launching Soon: Joint Eligibility Rule Development with NCPDP

- Collaboration between CAQH CORE and the National Council for Prescription Drug Programs (NCPDP).
- Task Group will consider the development of **updated eligibility (X12 270/271) data content operating rule requirements** to support exchange of detailed coverage and benefit information for medication covered under the medical benefit.

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Thank you!

Website: *www.CAQH.org/CORE*

Email: *CORE@CAQH.org*

The CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.

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Optum

Electronic Attachments Innovators

Early Adopters Crossing the Chasm

Tara Rose
Capability Manager
Optum/Legacy Change Interoperability & Regulatory Strategy

October 3, 2023

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The Healthcare industry can save millions with attachment automation.

217M

Cost Savings for the Medical Industry

5 Minutes

Average Time Savings Opportunities – Per Transaction

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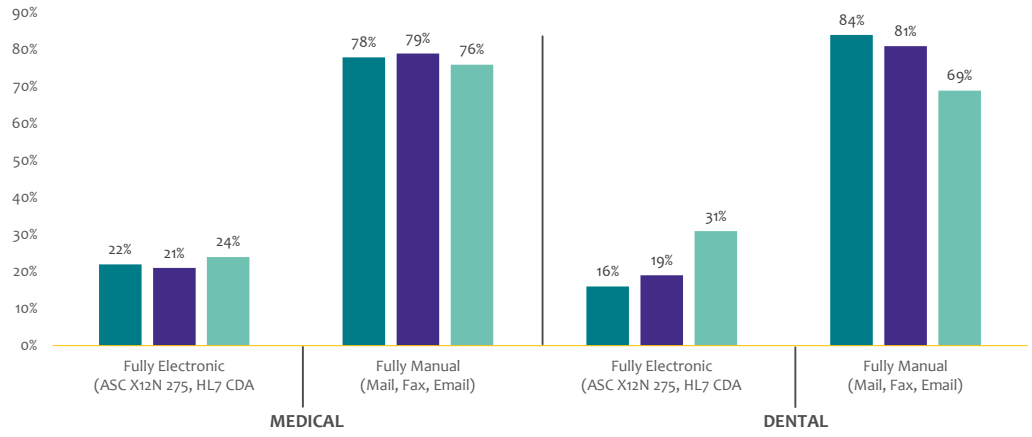
Crossing the Chasm – *Early Majority*

ADOPTION

Medical Plan Adoption of Attachments

2020-2022 CAQH Index



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Why Now?

- Automate manual business processes
- Reduce administrative cost
- Providers requesting EDI vs manual/portal workflow processes
- Reduce Stakeholder Revenue Cycle
- Enhance delivery of patient care

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How was it implemented?

Claim Attachments – X12 275 Additional Information to Support a Health Care Claim or Encounter

Payer	Claim Type			Attachment Model		HL7 CCDA		Non HL7 Unstructured	Version		Acknowledgements (999)		Acknowledgement (824)		
	P	I	D	Unsolicited (275)	Solicited (277RFI)	Unstructured	Structured		5010	6020	5010	6020	5010	6020	8020
NGS	X	X		X	X	X	X			X	X				
Elevance Health	X	X	X	X	X			X	X		X		X		
United Healthcare	X	X		X				X		X		X		X	
Aetna	X	X	X	X	X	X				X		X		X	
Humana															
*On Roadmap															

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How was it implemented?

Prior Authorization Attachments – X12 275 Additional Information to Support a Health Care Services Review

Payer	Health Care Services Type		Attachment Model		HL7 CCDA		NON HL7 Unstructured	Version		Acknowledgements (999)		Acknowledgement (824)		
	Request for Review & Response (278 X217)	Notification of Acknowledgement (X216)	Unsolicited (275)	Solicited 278 X217 (275) Response	Unstructured	Structured		5010	6020	5010	6020	5010	6020	8020
NGS	X		X		X	X			X	X				
Elevance Health	X		X	X			X	X						
United Healthcare														
Aetna	X	?	X		X				X		X		X	
Humana														
*On Roadmap														

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Key Performance Indicators (KPIs)

Measuring Success

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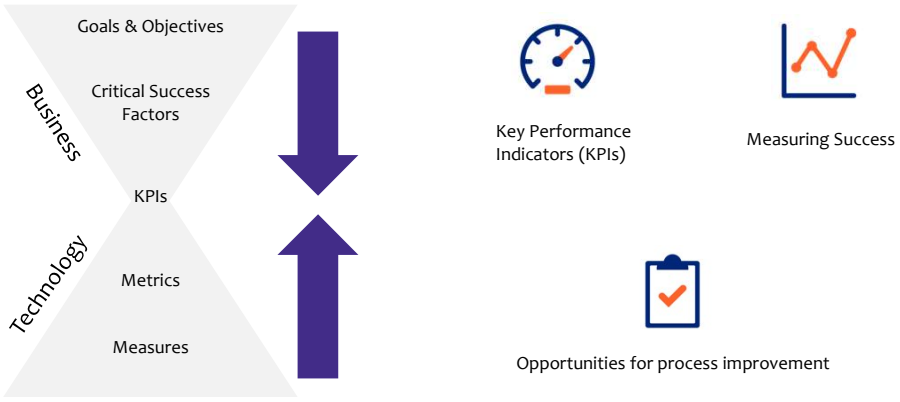
How Do You Know You Are Successful?



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Elevance

Key Performance Indicator	Results
Improved Payment Cycle	43 to 19 days
Reduced Denials	Decreased 20% in past 18 months
Reduced Appeals	
Reduced Claim Status Phone Calls	Reduced 7% in the past 18 months
Reduced Solicited Attachment Response Times	60 days to 14 days

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National Government Services (NGS)

Key Performance Indicator	Results
Improved Payment Cycle	35 days to 17 days
EDI Adoption Ratio	Increased 320% over past three years
% of Medical Records Documentation Sent via X12	15% (does not include portal) – Paper, Fax and Portal volume is decreasing
Average Claim Dollar Amount that requires attachments	$3000 to $4000
Reduced Solicited Attachment Response Times	Expected to decrease response times. Measuring continues due to limited use. Unsolicited model is highest adoption
Implementation Timeframe	6 months to implement X12 275 with embedded HL7

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United Healthcare/Optum

Key Performance Indicator	Planned Success Matrix
Improved Payment Cycle/Reduced Appeals	Increase first-pass claim adjudication
Reduced Denials	Goal – reduce missing attachment-driven denials by 5-10%
EDI Adoption Ratio	15% 2024 30% 2025 40% 2026 50% 2027
Key Performance Indicator	**Success Matrix**
Actual 275 Attachment to 837 Claim Match	Since Phase A implementation on 4/16/2023 – **27.68K**
Trading Partner Onboarding	**4** trading partners updating agreements **6** trading partners in active discussion

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athenahealth

Key Performance Indicator	Results
Improved Average Days to Remittance for Claims	Reduction of 38% in days to remittance from 39 days to 24 days when submitting attachments electronically vs on paper
Reduction in Administrative Cost & Burden	Costs vary based on vendor; however, paper submission is more expensive than electronic submission. 275 EDI submission is also preferred to portal submission due to ease of implementation
Ease of Onboarding	Athena can turn on 275 functionality within a day, no action needs to be taken from providers. No additional cost is incurred by providers.
Provider Interest	As soon as a payer announces 275 availability, providers reach out to inquire if athena will utilize the transaction to submit attachments.

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Jopari Solutions

Key Performance Indicator	Results
% of Denials due to missing attachments (unsolicited model)	35% Reduced to 5%
% of Solicited Requests due to missing attachments	25% Reduced to 5%
% of Appeals due to missing attachments	80% Reduction
Payment Revenue Cycle	35 days reduced to 16 days
Payer Status Follow Ups	75% Reduction
Onboarding Provider Timeframe - Variables: Attachment Model/EDI Readiness	83% reduction from weeks to days Leverage existing IT connectivity and workflow processes
EDI Adoption Ratio	Insert data points: Processing over 2.7 million 275s

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Implementation Challenges and Resolutions

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Implementation Challenges and Resolutions

- Enrollment
- Management Buy In
- Setup and Implementation
- Operations/Claim Matching – Across Systems Platforms
- Accommodating for Stakeholder EDI readiness (low to high tech)
- File Size Limitations
- Defining Unsolicited Model Criteria
- LOINC Mapping
- Payer lack of HL7 experience from a development perspective
- Mapping the X12 277 Request for Additional Information (277RFAI) from the paper letter

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United Healthcare/Optum

Implementation Challenges	Resolutions
Getting Started – Timing is everything!	Our internal EDI Teams worked for several months to provide the compelling story, Cost Benefits Analysis and obtained funding to move forward with EDI Attachments in November 2019. While working through cross-functional requirements and estimations in Q1 2020, the COVID pandemic hit and required a sharp pivot to other high-profile initiatives
Learning a new transaction	Socializing the new complex transaction across stakeholders, business analysts, architects, developers, operations staff, etc., took time and required detailed analysis to include decisions around the BDS Segment.
End-2-End Solution	1. Worked with business contacts for define suite of use cases (which ultimately were used for test scenarios) in order to refine end-2-end solution. 2. UHC has many claim adjudication platforms across several lines of business; it took a large number of people (cross-functionally) several months to land on final consistent (one-size fits all solution) to associate claim to attachment. 3. Defined if claim received first with electronic attachment indicator how long to hold onto claim (while looking for attachment) before releasing to adjudication platform vs. if attachment received first how long to hold onto attachment (while looking for claim) before rejecting
Does the Claim require an Attachment?	Initial MVP roll-out included logic to evaluate claims with the electronic attachment indicator to determine if the attachment is needed for adjudication. -Ultimately removed this logic as it was too restricting for Pilot Program; may re-evaluate in the future

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United Healthcare/Optum

Implementation Challenges	Resolutions
Creating/Executing Test Files – 275 and 837	The Quality Assurance areas for each system impacted required some ramp-up time on test file creation. • Testing included checking system execution • Full claim and full 275 test files for every system – positive and negative • Replicating timing for both positive and negative results to mirror what will happen in production • If any defect uncovered, required repeat of test scenario with modifications to test files to avoid duplicates in lower environments • Optum/UHC executed nearly 300 claim and attachment files in preparation for MVP Pilot in end-2-end testing
Operational Readiness	Implemented technology solutions for appropriate visibility into watching production transactions run through the system and associate to claim transactions. • Training for Claim Adjudication and Customer Support staff to know what to look for and where • Established communication loop between technology and business to ensure system functionality and validate reporting capabilities in preparation for next launch and KPI tracking

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How To Get Engaged

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How To Get Engaged

Organization Name	Attachment Program Contact Name/Division	Web URL	Phone
Aetna	Providers must contact their clearinghouse vendor or their Aetna provider network representative	Aetna's EDI Clearinghouses	N/A
Elevance Health	Availity	www.availity.com	1-800-Availity (282-4548)
NGS	Providers should contact their clearinghouse vendors	www.NGSMedicare.com	J6: 877-273-4334 JK: 888-379-9132
United Healthcare/Optum		UHC EDI Contacts	supported@uhc.com 800-842-1109
Athenahealth		www.athenahealth.com	800-981-5084
Jopari Solutions		www.jopari.com	800-630-3060 info@jopari.com

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Q&A

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Maryland Bill on Sharing Patient Data

Pamela Grosze, The Cooperative Exchange Board Chair

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Summary:

Maryland passed a new law in June protecting reproductive health data from disclosure if a patient has legally obtained services.

The law:

- Regulates the disclosure of certain information related to legally protected health care by custodians of public records, health information exchanges, and electronic health networks (clearinghouses are considered electronic health networks);
- Requires that the regulations adopted by the Maryland Health Care Commission regarding clinical information to be exchanged through the State-designated health information exchange restrict data of patients who have obtained legally protected health care;
- Establishes the Protected Health Care Commission.

Informal comment period ends **October 4, 2023**.
Requirements go into effect **December 1, 2023**
Entities required to complete an attestation by **12/18/23** that logic is in place to meet these requirements or that it is not technically feasible to do so.

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History:

Chapters 790 and 791 of the 2021 Laws of Maryland *Public Health – State Designated Exchange – Clinical Information* require EHNs to submit electronic health care transactions originating from a Maryland-based provider to the State Designated health information exchange for public health and clinical purposes. **Clearinghouses are defined as EHNs under the law and required to certify with MHCC.**

The Cooperative Exchange submitted a comment letter to the Commission, and participated in meetings discussing the requirements, which have stalled since March 2022.

This new law adds additional restrictions on data that can be shared by an EHN with an HIE.

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Specific Requirements:

BEGINNING **DECEMBER 1, 2023**, A HEALTH INFORMATION EXCHANGE OR ELECTRONIC HEALTH NETWORK MAY NOT DISCLOSE **MIFEPRISTONE DATA OR THE DIAGNOSIS, PROCEDURE, MEDICATION, OR RELATED CODES FOR ABORTION CARE AND OTHER SENSITIVE HEALTH SERVICES** AS DETERMINED BY THE SECRETARY UNDER SUBSECTION (D) OF THIS SECTION TO A **TREATING PROVIDER, A BUSINESS ENTITY, ANOTHER HEALTH INFORMATION EXCHANGE, OR ANOTHER ELECTRONIC HEALTH NETWORK** UNLESS THE DISCLOSURE IS:

FOR THE ADJUDICATION OF CLAIMS; OR

TO A SPECIFIC TREATING PROVIDER AT THE WRITTEN REQUEST OF AND WITH THE CONSENT OF:

(I) A PATIENT, FOR SERVICES FOR WHICH THE PATIENT CAN PROVIDE CONSENT UNDER STATE LAW; OR

(II) A PARENT OR GUARDIAN OF A PATIENT, FOR SERVICES FOR WHICH THE PARENT OR GUARDIAN CAN PROVIDE CONSENT UNDER STATE LAW.

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CE Member Concerns:

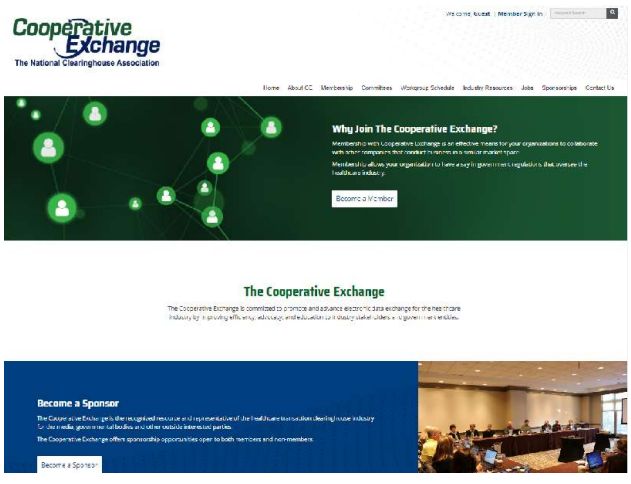
- Clearinghouses are not the "source of truth" for the data, and do not have the relationship with the patient to validate identities for the data
- There may be multiple transactions for the same encounter, how to determine which is the "right one"
- Clearinghouses pass through data, do not review contents beyond what is required to confirm compliance. May be up to the providers to designate data protections
- State has not defined what is covered under "reproductive health", so how to attest in Dec without those requirements?
- Attestation is to state EHNs have the logic in place to meet these requirements, does not address the exemption for claim adjudication
  - What comprises "related to claim adjudication"? E.G. Eligibility check, no service performed
  - Clearinghouses maintain that all services with claim data are related to claims processing. We need the ability to choose that exemption in the attestation.
- Unclear in the legislation what data this relates to – only for data shared with HIE or all data to all payers?
- We are looking for additional exemptions for clearinghouses.

Additional Concerns?

Next Steps

- The Cooperative Exchange Industry Affairs Committee will be preparing a comment letter to submit on the new legislation
- Industry Affairs Committee and Emerging Trends Committee will continue to monitor and provide information
  - Will attempt to set up a call with MHCC to review concerns

Visit The Cooperative Exchange Website
www.cooperativeexchange.org



To download the Clearinghouse Caucus presentation, visit our website under the **Industry Resources** Tab, then visit the **Clearinghouse Caucus** page.

Cooperative Exchange Members can login to the Members Only area to download our Monthly Membership Meeting presentations and our Educational webinars are archived to listen on-demand.

www.cooperativeexchange.org

2023 Membership Meeting Calls

October 20, 2023

November 17, 2023
Annual Meeting (Virtual)

December – no meeting

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Thank You for Attending!

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