



Committee on Operating Rules for Information Exchange (CORE™) Overview

Mendocino Health Records Exchange
Steering Committee Call
September 19th, 2007

Discussion Topics

- Overview of CAQH and CORE
- CORE Phase I Operating Rules
- Becoming CORE Phase I Certified
- CORE Phase II rules development
- National framework

An Introduction to CAQH

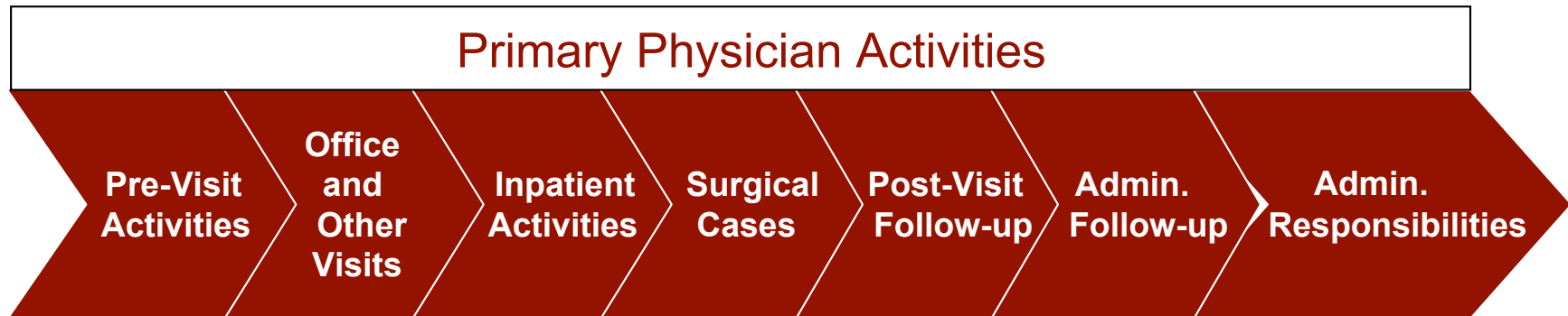
CAQH, a nonprofit alliance of leading health plans, networks and trade associations, is a catalyst for industry initiatives that streamline healthcare administration

CAQH solutions help:

- Promote quality interactions between plans, providers and other stakeholders
- Reduce costs and frustrations associated with healthcare administration
- Facilitate administrative healthcare information exchange
- Encourage administrative and clinical data integration

Provider-Payer Interaction

Physician Activities That Interact With Payers are Primarily Administrative in Nature (with Some Clinical Interaction)



- Patient inquiry
- Appt scheduling
- Scheduling verification
- Financial review of pending appts.
- Encounter form/medical record preparation

- Registration & referral mgmt.
- Admin & medical record preparation
- Patient visit
- Ancillary testing
- Charge capture
- Prescriptions

- Scheduling & referral mgmt.
- Admin & medical record preparation
- Inpatient care
- Ancillary testing
- Charge capture

- Scheduling & referral mgmt.
- Admin & medical record preparation
- Surgical care
- Post care
- Follow-up care

- Visit orders & instructions
- Education materials
- Prescriptions
- Ancillary tests
- Referrals
- Follow-up visits

- Utilization review
- Claims/bill generation
- Billing
- Payment processing
- Claims follow-up

- Personnel management
- Financial management
- Managed care
- Information systems
- Facilities management
- Medical staff affairs

simplifying healthcare administration

CAQH[®]

CORE™

Committee on Operating Rules
for Information Exchange

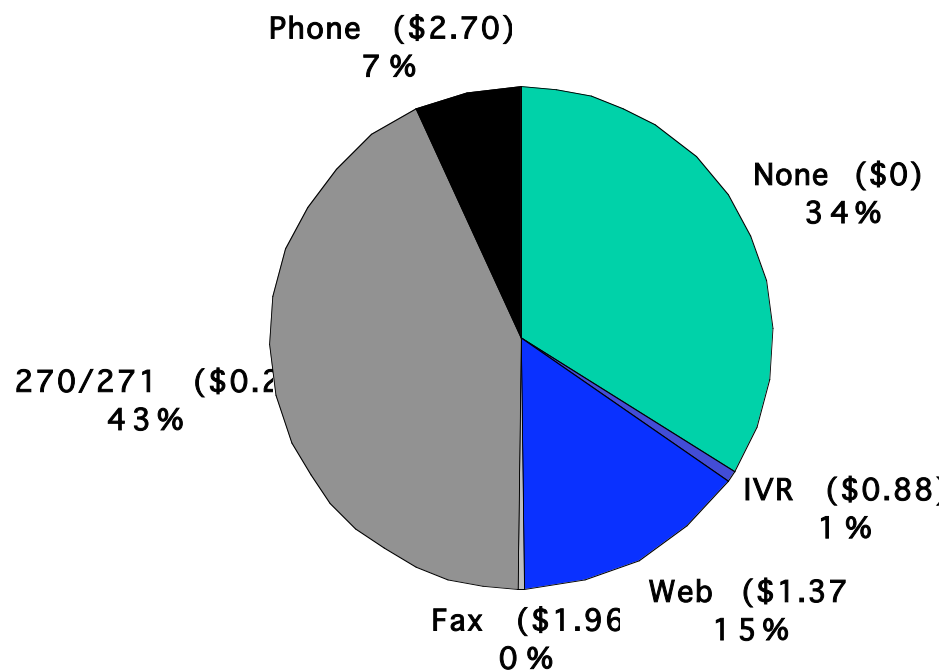
Key Challenges: Eligibility and Benefits

- HIPAA does not offer relief for the current eligibility problems
 - Data scope is limited; elements needed by providers are not mandated
 - Does not standardize data definitions, so translation is difficult
 - Offers no business requirements, e.g., timely response
- Individual plan websites are not the solution for providers
 - Providers do not want to toggle between numerous websites that each offer varying, limited information in inconsistent formats
- Vendors cannot offer a provider-friendly solution since they depend upon health plan information that is not available

Key Opportunity: Significant Savings

Providers (and health plans) can achieve significant savings by shifting from more labor-intensive verification methods to automated eligibility verification.

Provider Eligibility Verification by Type of Method
(Average labor cost per transaction)



7 Source: CORE Patient Identification Survey, 2006; funded, in part, by California HealthCare Foundation

Vision: Online Eligibility and Benefits Inquiry



Give Providers Access to Information Before or at the Time of Service...

Providers will send an online inquiry and know:

- Whether the health plan covers the patient *
- Whether the service to be rendered is a covered benefit (including copays, coinsurance levels and base deductible levels as defined in member contract)
- What amount the patient owes for the service**
- What amount the health plan will pay for authorized services**

Note: No guarantees would be provided

* This is the only HIPAA-mandated data element; other elements addressed within Phase I rules are part of HIPAA, but not mandated

** These components are critically important to providers, but are not proposed for Phase I

Vision: Online Eligibility and Benefits Inquiry



... Using any System for any Patient or Health Plan

As with credit card transactions, the provider will be able to submit these inquiries and receive a real-time response*

- From a single point of entry
- Using an electronic system of their choice

- For any patient
- For any participating health plan

*Phase I requires real-time and supports batch

CORE

- Industry-wide stakeholder collaboration launched in January 2005
- Short-Term Goal
 - Design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits
- Long-Term Goal
 - Based on outcome of initiative, apply concept to other administrative transactions
- Answer to the question: Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?

CORE Mission

To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers

- Build on any applicable HIPAA transaction requirements or other appropriate standards such as HTTPS
- Enable providers to submit transactions from the system of their choice and quickly receive a standardized response from any participating stakeholder
- Enable stakeholders to implement CORE phases as their systems allow
- Facilitate stakeholder commitment to and compliance with CORE's long-term vision
- Facilitate administrative and clinical data integration

Key things CORE will not do:

- Build a database
- Replicate the work being done by standard setting bodies like X12 or HL7

What Are Operating Rules?

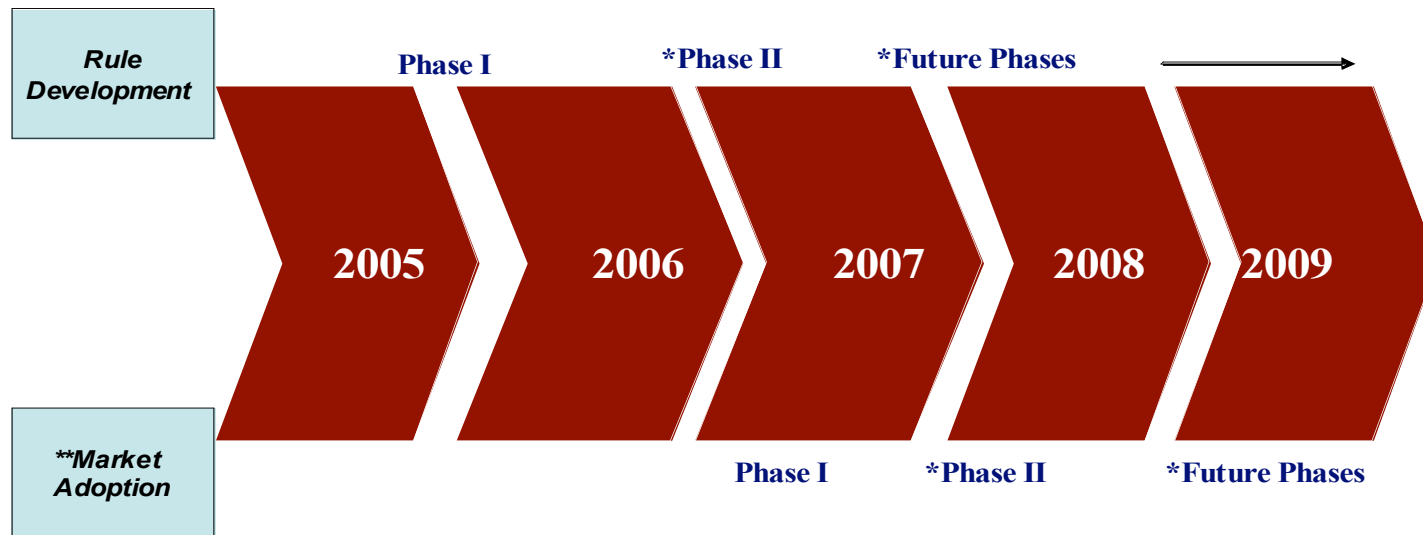
- Agreed-upon business rules for using and processing transactions
- Encourages the marketplace to achieve a desired outcome – interoperable network governing specific electronic transactions (i.e., ATMs in banking)
- Key components
 - Rights and responsibilities of all parties
 - Transmission standards and formats
 - Response timing standards
 - Liabilities
 - Exception processing
 - Error resolution
 - Security

World Without CORE...

- Is like an ATM that...
 - Offers no money or bank balance, but does say you have an account
 - Does not have any real-time response...so you may wait hours to get response... or minutes ...or seconds
 - Does not have any system availability requirements...so ATM may not be available on weekends or after 9:00 p.m. weekdays
 - Does not provide you with confirmations....so you don't know if your transaction ever got completed
- And, there is no common agreements among the ATMs one uses...
 - So one needs to learn rules for each bank's ATM system

Phased Approach

CORE Timeline Overview



Notes:

*Scope of Phase II and Future Phases will be decided upon by CORE Membership

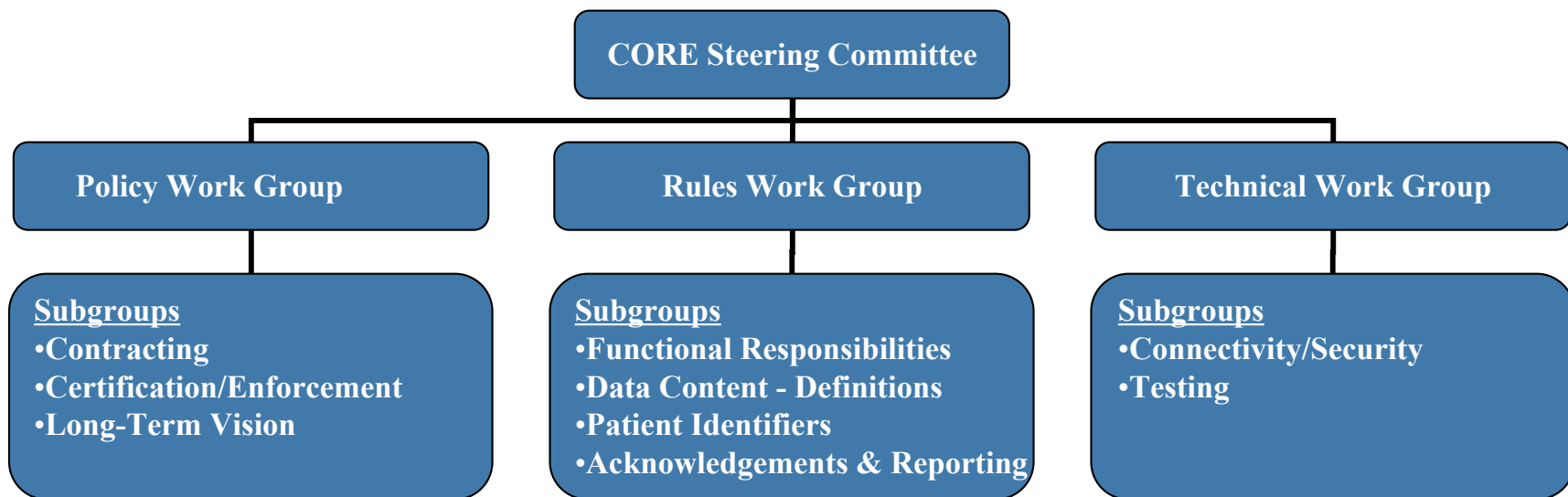
**Not all CORE participants will meet targeted market adoption timeframes; an ongoing CORE focus will be achieving/increasing adoption of established phases. CORE will look to its founding participants to achieve target market adoption timeline.

Current Participants

- Over 100 organizations representing all aspects of the industry:
 - 18 health plans
 - 10 providers
 - 5 provider associations
 - 19 regional entities/RHIOS/standard setting bodies/other associations
 - 39 vendors (clearinghouses and PMS)
 - 4 others (consulting companies, banks)
 - 7 government entities, including:
 - Centers for Medicare and Medicaid Services
 - Louisiana Medicaid – Unisys
 - TRICARE
 - US Department of Veteran Affairs
- CORE participants maintain eligibility/benefits data for over 130 million lives, or more than 75 percent of the commercially insured plus Medicare and state-based Medicaid beneficiaries.*

*See appendix for list of CORE Participants, Endorsers, and Certified Entities

CORE Work Groups And Subgroups



CORE

Phase I Operating Rules

Phase I Rules Overview

Policies

- Pledge; Strategic Plan, including Mission/Vision
- Certification and Testing (conducted by independent entities)

Rules

- 270/271 Data Content
 - Patient Responsibility (co-pay, deductible, co-insurance levels in contracts – not YTD)
 - Service Codes
- Infrastructure
 - Connectivity -- HTTPS Safe harbor
 - Response Time -- For batch and real-time
 - System Availability -- For batch and real-time
 - Acknowledgements – For batch and real-time
 - Companion Guide (flow and format standards)

Example: 270/271 Data Content Rule

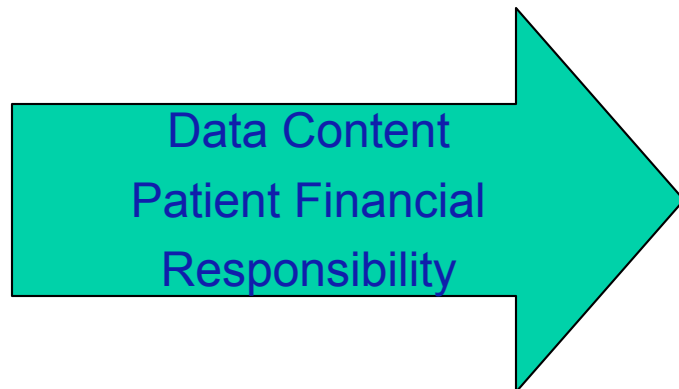
- Specifies what must be included in the 271 response to a Generic 270 inquiry or a non-required CORE service type
- Response must include
 - The status of coverage (active, inactive)
 - The health plan coverage begin date
 - The name of the health plan covering the individual (if the name is available)
 - The status of nine required service types (benefits) in addition to the *HIPAA-required Code 30*
 - 1-Medical Care
 - 33 - Chiropractic
 - 35 - Dental Care
 - 48 - Hospital Inpatient
 - 50 - Hospital Outpatient
 - 86 - Emergency Services
 - 88 - Pharmacy
 - 98 - Professional Physician Office Visit
 - AL - Vision (optometry)

Example: 270/271 Data Content Rule (cont'd)

CORE Data Content Rule also Includes Patient Financial Responsibility

- Co-pay, co-insurance and base contract deductible amounts required for
 - 33 - Chiropractic
 - 48 - Hospital Inpatient
 - 50 - Hospital Outpatient
 - 86 - Emergency Services
 - 98 - Professional Physician Office Visit
- Co-pay, co-insurance and deductibles (discretionary) for
 - 1- Medical Care
 - 35 - Dental Care
 - 88 - Pharmacy
 - AL - Vision (optometry)
 - 30 - Health Benefit Plan Coverage
- If different for in-network vs. out-of-network, must return both amounts
- Health plans must also support an explicit 270 for any of the CORE-required service types

Real World Impact



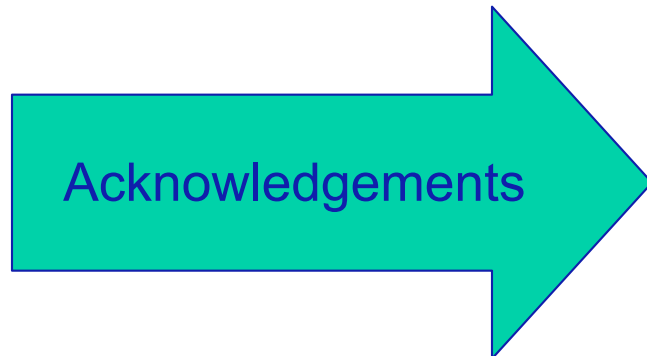
- Enables providers to inform patients of basic financial responsibility prior to or at time of service
- Gives providers a mechanism to better manage revenue and cash flow
- Enables plans to better utilize call center staff to provide higher levels of service to providers while reducing operational costs
- Enables vendors to differentiate themselves to offer improved products

Example: Acknowledgements Rule

- Specifies when to use TA1 and 997
 - Real time
 - Submitter will always receive a response
 - Submitter will receive only one response
 - Batch
 - Receivers include
 - Plans,
 - Intermediaries
 - Providers
 - Will always return a 997 to acknowledge receipt for
 - Rejections
 - Acceptances

Remember when you didn't know if your fax went through?

Real World Impact



- Enables prompt, automated error identification in all communications, reducing provider and plan calls to find problems
- Industry no longer required to program a multiplicity of different proprietary error reports thus simplifying and reducing the cost of administrative tasks
- Eliminates the “black hole” of no response by confirming that batches of eligibility inquiries have been received without phone calls

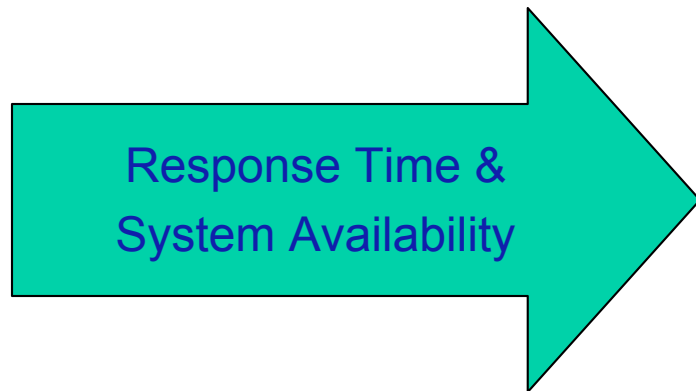
Example: Response Time Rule

- Real time
 - Maximum: 20-second round trip
- Batch
 - Receipt by 9:00 p.m. Eastern Time requires response by 7:00 a.m. Eastern Time the next business day
- CORE participants in compliance if they meet these measures 90 percent of time within a calendar month

Example: System Availability

- Minimum of 86 percent system availability
 - Publish regularly scheduled downtime
 - Provide one week advance notice on non-routine downtime
 - Provide information within one hour of emergency downtime

Real World Impact



- Enables providers to reliably know when to expect responses to eligibility inquiries and manage staff accordingly
- Encourages providers to work with practice management vendors, clearinghouses and plans that are CORE-certified and thus comply with the rules
- Identifies to the industry that immediate receipt of responses is important and lets all stakeholders know the requirements and expectations
- Enables vendors to differentiate themselves to offer improved products

Real World Impact



- Like other industries have done, supports healthcare movement towards at least one common, affordable connectivity platform. As a result, provides a minimum “safe harbor” connectivity and transport method that practice management vendors, clearinghouses and plans that are CORE-certified can easily and affordably implement
- Enables small providers not doing EDI today to connect to all clearinghouses and plans that are CORE-certified using any CORE-certified PMS
- Enables vendors to differentiate themselves to offer improved products cost-effectively

Phase I Rules Impact: Health Plans

- Increase in electronic eligibility inquiries and a commensurate decrease in phone inquiries
- Reduced administrative costs
- More efficient process for providing eligibility and benefits information to providers
- May need to change IT capabilities to meet rules and data relationships with vendors
- Will need to sign CORE pledge and prove systems compliance by seeking CORE certification

Phase I Rules Impact: Providers

- All-payer eligibility solutions from CORE-certified vendors
- Because the data will be sourced directly from the relevant health plan(s), providers can be assured of data accuracy
- Improved Customer Service to Patients/Subscribers:
 - redundant registration interviews eliminated
 - advance notification of potential financial liability, e.g., non-covered services, out of network penalties
 - prior authorization/referral requirements met in advance
 - claims filed to right payer and paid, patients not caught in middle
- Data entry and errors diminished through integrated 271
- Reduced staff time in confirming eligibility and benefits
- Reduced bad debt related to eligibility issues
- Reduced claim denials due to eligibility

Phase I Measures of Success: Tracking ROI

- CAQH will track and report Phase I Measures of Success
- Volunteers are being sought in each key stakeholder category
 - Measures will allow CAQH to publish impact by stakeholder category
- Examples of metrics
 - Health plans
 - Change in call center volume related to eligibility/benefit inquiries; average number and percentages of calls per week (per 1,000 members) before CORE adoption versus averages after implementing Phase I CORE
 - Providers
 - Change in usages of the following methods of eligibility transactions: Phone, Fax, Real-time EDI, Batch EDI, DDE

Becoming CORE Phase I Certified

CORE Pledge

- CORE certification is voluntary
- Binding “Pledge”
- By signing Pledge, CORE entities agree to adopt, implement and comply with Phase I eligibility and benefits rules as they apply to each type of stakeholder business
- The Pledge will be central to developing trust that all sides will meet expectations
- Organizations have 180 days from submission of the Pledge to successfully complete CORE certification testing

CORE Certification

- Recognizes entities that have met the established operating rules requirements
- Entities that create, transmit or use eligibility data in daily business required to submit to third-party testing (within 180 days of signing pledge); if they are compliant, they receive seal as a CORE-certified health plan, vendor (product specific), clearinghouse or provider
- Entities that do not create, transmit or send – sign Pledge, receive CORE Endorser Seal
- CORE-certification is required for each phase of CORE

Certification Testing

- Based on Phase I CORE Test Suite
 - For each rule there are standard conformance requirements by stakeholder
 - Suite outlines scenarios and stakeholder-specific test scripts by rule
 - Not testing for HIPAA compliance, only Phase I CORE; however, entities must attest that, to the best of their knowledge, they are HIPAA compliant
- Phase I testing is not exhaustive, (e.g. does not include production data or volume capacity testing)
- Testing conducted by CORE-authorized certification testing entities



<https://core.claredi.com>



<http://core.edifecs.com>

CORE Certification Seals



A CAQH Initiative



A CAQH Initiative



A CAQH Initiative



A CAQH Initiative



A CAQH Initiative

Phase II Rule Writing Underway

Goal: Increase amount of data content and access
so need for using more costly transaction methods, e.g. phone, is reduced

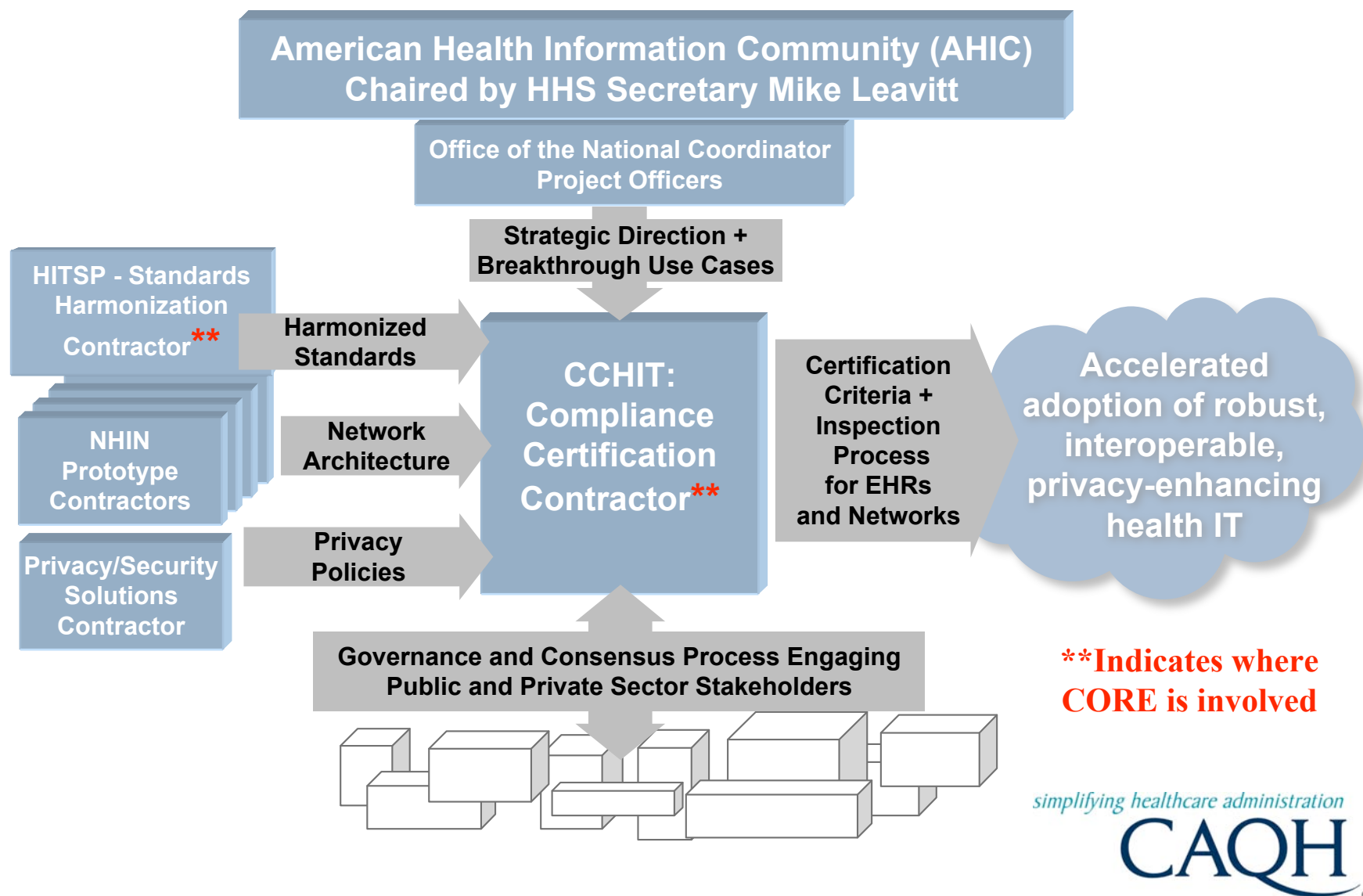
Eligibility

- Patient identification: Reducing % of eligibility errors by improving patient matching and achieving a higher rate of valid transactions
- Providing financial data that providers want, e.g. estimated YTD/accumulated member financials
- Connectivity: Making connectivity methods more open and standard
 - CORE progress in this area could enhance all aspects of interoperability

Claims Status

- Increase use of transaction, and thus (as research shows), reduce call volumes

Coordinating with Other National Initiatives



State-Based Outreach

- State-based approaches are emerging, and CAQH will work with the trade associations to encourage CORE's national approach
 - Mid-America Coalition on Health Care (Kansas; government and non-government entities)
 - Reviewing CORE to determine if it meets the Coalition's goal to reduce administrative costs
 - Minnesota
 - Legislation formed Committee to review options for reducing administrative costs, particularly eligibility; CORE is being reviewed as part of this process
 - New York Health Plan Association (NYHPA)
 - Planning to use NY state grant dollars to encourage CORE-certification by regional health plans and providers
 - Ohio
 - Ohio State Medical Association invited CAQH to present CORE given related draft legislation
 - Rhode Island Health Insurance Commissioner and Rhode Island Quality Institute
 - State legislation requires a reduction in healthcare administrative costs; state is reviewing CORE to determine if it can be a vehicle to address the legislation
 - Texas
 - Texas Department of Insurance invited CAQH to present CORE in response to state legislation that focuses on administrative simplification and mentions CORE
 - Virginia
 - Secretary of Technology reviewing how technology can reduce the state's healthcare costs; CAQH presented CORE to a statewide Committee

Medicaid and CORE

- Why Medicaid and CORE?
 - Interest for all stakeholders
 - Medicaid is a portion of many provider's payer mix; electronic eligibility can have significant impact on efficiency for all stakeholders – public, private, payers, providers, etc - when all-payer solutions are available
 - Interest at Federal level
 - CORE complements a number of federally-sponsored health IT initiatives, e.g. CCHIT, as well as HIPAA
 - CMS's Center for Medicaid and State Operations is designing the Medicaid Information Technology Architecture (MITA); CORE rules mirror much of what MITA wants to design for eligibility data content and infrastructure
 - CORE is an example of a public-private collaboration
 - Interest at state level
 - CORE can help Medicaid agencies address the administrative requirements of the Deficit Reduction Act (DRA)
 - CORE can be way to have Medicaid agencies involved in RHIOs / state mandates regarding health care administrative cost reduction

Medicaid and CORE (cont'd)

- How is Medicaid currently connected to CORE?
 - Various entities serve as participants in the CORE rule writing process
 - Vendors that operate the eligibility IT systems for a number of state-based Medicaid programs, e.g. EDS
 - Individual Medicaid agencies, e.g. Louisiana Medicaid
 - CAQH is working to engage:
 - CMS Center for Medicaid and State Operations, and their regional directors
 - State-based Medicaid agencies working on RHIOs, e.g. Kansas, Virginia
- What are CAQH's current goals for CORE and Medicaid?
 - Education
 - Encourage state-based Medicaid agencies to become CORE-certified
 - Encourage health plans to achieve CORE certification for their Medicaid products

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www.CAQH.org

Contact information:

core@caqh.org, (202) 778-3226

Appendix

- CORE Participants
- CORE-Certified Entities
- CORE Endorsers

Current Participants

- **Health Plans**

- Aetna, Inc.
- AultCare
- Blue Cross Blue Shield of Michigan
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- CareFirst BlueCross BlueShield
- CIGNA
- Coventry Health Care
- Excellus BlueCross BlueShield
- Group Health, Inc.
- Health Care Service Corporation
- Health Net, Inc.
- Health Plan of Michigan
- Humana Inc.
- Independence Blue Cross
- Kaiser Permanente
- UnitedHealth Group
- WellPoint, Inc.

- **Providers**

- Adventist HealthCare, Inc.
- American Academy of Family Physicians (AAFP)
- American College of Physicians (ACP)
- American Medical Association (AMA)
- Catholic Healthcare West
- Greater New York Hospital Association (GNYHA)
- HCA Healthcare
- LINXUS (an initiative of GNYHA)
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Mobility Medical, Inc.
- Montefiore Medical Center of New York
- North Shore LIJ Health System
- Partners HealthCare System
- University Physicians, Inc. (University of Maryland)

- **Government Agencies**

- Louisiana Medicaid – Unisys
- Michigan Department of Community Health
- Michigan Public Health Institute
- Oregon Department of Human Resources
- TRICARE
- United States Centers for Medicare and Medicaid Services (CMS)
- United States Department of Veterans Affairs

- **Associations / Regional Entities / Standard Setting Organizations**

- America's Health Insurance Plans (AHIP)
- ASC X12
- Blue Cross and Blue Shield Association (BCBSA)
- Delta Dental Plans Association
- eHealth Initiative
- Health Level 7
- Healthcare Association of New York State
- Healthcare Billing and Management Association
- Healthcare Financial Management Association (HFMA)
- Healthcare Information & Management Systems Society
- Maryland/DC Collaborative for Healthcare IT
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- NJ SHORE
- Private Sector Technology Group
- Smart Card Alliance Council
- Utah Health Information Network (UHIN)
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

Current Participants (continued)

- **Vendors**

- athenahealth, Inc.
- Availity LLC
- CareMedic Systems, Inc.
- ClaimRemedi, Inc.
- Claredi (an Ingenix Division)
- EDIFECS
- Electronic Data Systems (EDS)
- Electronic Network Systems (ENS) (an Ingenix Division)
- Emdeon Business Services
- Enclarity, Inc.
- First Data Corp.
- GE Healthcare
- GHN-Online
- Health Management Systems, Inc.
- Healthcare Administration Technologies, Inc.
- HTP, Inc.
- IBM Corporation
- Infotech Global, Inc.
- InstaMed
- IVANS, Inc.
- MedAvant Healthcare Solutions
- MedCom USA
- MedData
- Microsoft Corporation
- NASCO
- NaviMedix
- NextGen Healthcare Information Systems, Inc.
- Passport Health Communications
- Payerpath, a Misys Company
- Quovadx
- Recondo Technology, Inc.
- RelayHealth
- RxHub
- SafeMed, Inc.
- Siemens / HDX
- SureScripts
- The SSI Group, Inc.
- The TriZetto Group, Inc.
- VisionShare, Inc.

- **Other**

- Accenture
- Foresight Corp.
- PNC Bank
- PricewaterhouseCoopers LLP

Implementation: Phase I – Certified Entities/Products

Clearinghouses

- ACS EDI Gateway, Inc. / ACS EDI Gateway, Inc. Eligibility Engine
- Emdeon Business Services / Emdeon Real-Time Exchange
- Emdeon Business Services / Emdeon Batch Verification
- MedAvant Healthcare Solutions / Phoenix Processing System
- NaviMedix, Inc. / NaviNet
- Passport Health Communications / OneSource
- RelayHealth / Real Time Eligibility
- Siemens Medical Solutions / Healthcare Data Exchange
- The SSI Group, Inc. / ClickON® E-Verify

Health Plans

- Aetna Inc.
- AultCare
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- Health Net
- WellPoint, Inc. (and its 14 blue-licensed affiliates)

Providers

- Mayo Clinic
- Montefiore Medical Center
- US Department of Veterans Affairs

Vendors

- athenahealth, Inc. / athenaCollector
- Emerging Health Information Technology, LLC / TREKS
- GE Healthcare / EDI Eligibility 270/271
- HTP, Inc. / RevRunner
- Medical Informatics Engineering, Inc. (MIE) / WebChart EMR *
- NoMoreClipboard.com
- The SSI Group, Inc. / ClickON® Net Eligibility
- VisionShare, Inc. / Secure Exchange Software

* Product also certified by the Certification Commission for Healthcare Information Technology (CCHITsm). For accurate information on certified products, please refer to the product listings at www.cchit.org.

Implementation: Phase I – Commitments to Certification

Commitment to Certify by Q3/Q4 2007

Health Plans

- Humana Inc.

Vendors

- Availity, LLC

Commitment to Certify in 2008

Health Plans

- Blue Cross Blue Shield of Michigan
- CareFirst BlueCross BlueShield

Implementation: Phase I – Endorsers

Endorsement

- Accenture
- American Academy of Family Physicians
- American College of Physicians
- American Health Information Management Association
- California Regional Health Information Organization
- Claredi, an Ingenix Division
- Edifecs, Inc.
- eHealth Initiative
- Enclarity, Inc.
- Foresight Corporation
- Greater New York Hospital Association and Linxus
- Healthcare Financial Management Association
- Healthcare Information and Management Systems Society
- Medical Group Management Association
- Michigan Public Health Institute
- Microsoft Corporation
- MultiPlan, Inc.
- NACHA – The Electronic Payments Association
- Pillsbury Winthrop Shaw Pittman, LLP
- Smart Card Alliance
- URAC
- Workgroup for Electronic Data Interchange (WEDI)