The Future of CORE:
Phase III and Beyond

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Discussion Topics

• The Context for CORE Phase III
  – CORE Strategic Plan
  – Filters for Phase II Scope
  – Expected timeline of Federal mandates and implications
    • 5010
  – CORE’s immediate goals

• Potential Scope of Phase III
  – Scope of Phase I and II
  – Potential Categories for Phase III
    • Specific rule areas within categories

• Discussion and Multi-voting

• Next Steps

• Questions
CORE Strategic Plan Highlights

• Phase I
  – Write operating rules for defined set of eligibility transactions
  – Collect data on outcomes (Measures of Success)

• Phase II
  – Gain adoption of Phase I
  – Write more advanced operating rules for the complete eligibility inquiry and response transaction and another identified administrative transaction
  – Address need for further telecommunication standards
  – Collect data on outcomes

• Phase III
  – Gain adoption of Phase I and II
  – Write rules for other administrative transactions
  – Review and address changing technical modes

CORE’s Long-Term Vision: A healthcare system that universally employs real-time, standardized and accurate interactive data exchange among all stakeholders.
Filters for Phase III Scope Development

• Alignment with Federal efforts, e.g.:
  – 5010 and HIPAA NPRM
  – HITSP
  – CCHIT
  – Medicaid-MITA

• Coordination with other industry initiatives that address/plan to address implementation, e.g.:
  – BCBSA’s Blue Exchange
  – EHNAC
  – AHIP Portal goals
  – AMA Cure for Claims

• Enhancement to CORE pipeline, e.g.:
  • Scope supported by CORE-committed entities (impact on budget, potential timing, business strategies, etc)
  • Policies/rules that promote CORE-certification by trading partners

• Continuation of items identified in Phase I and/or II, but deferred to Phase III, e.g. financials for women’s reproductive services
5010 Implications

• Affects all transactions adopted by HIPAA – some to a greater extent than others
• Changes are being made in terms of:
  – Front matter: educational/instructional
  – Technical
  – Structural
  – Data content
  – Some 5010 changes for X12 eligibility transactions included in CORE Phase I Data Content Rules
• Adds new transactions
  – 278: Health Care Services - Notifications
  – Acknowledgements
• Will require significant time to identify all changes, test and implement
• Should result in improvements

Note: CORE is conducting a detailed review of 5010 to identify potential CORE rule adjustments, CORE statement on CORE-5010 alignment, and areas for which CAQH may submit public comments
CORE Year-to-Year Timeline: Health Plan and Provider IT Priorities
(as of September 2008)

* Time estimates related to Federal mandates are based on NPRMs
Key Feedback from CORE Steering Committee and CAQH Board on Filters

- Continue CORE’s focus on administrative transactions that will bring market value

- Remain aligned with federally-sponsored initiatives and take into consideration any federal requirements health plans may need to meet during Phase III launch

- Remain aligned with other industry initiatives, partner where possible
  - Where appropriate build off what others have outlined for standards and their accepted uses, as CORE can implement / help bring these visions to market

Is there additional feedback on these filters?
CORE’s Immediate Goals

• Gain Phase I and II market adoption – achieve critical mass

• Report on impact of Phase I implementation

• Continue integration with national initiatives

• Decide upon Phase III scope and begin development
  - Step 1: Phase III initial identification and research gathering (in process)
  - Step 2: CORE participant input (in process)
    - Phase II Work Groups listed potential Phase III focus
    - CAQH has received “wish list” from a number of organizations
    - CAQH staff researched current market efforts
    - Multi-voting at meeting to identify recommended areas
    - Work Group review of meeting results
    - Cost/timing assessment
  - Step 3: Detailed scoping of recommended rule areas
  - Step 4: Final selection
# Overview of CORE Requirements by Phase

## Transaction Type and Standard Data Content

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Phase I*</th>
<th>Phase II*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility/Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static Patient Financial Responsibility, e.g. co-pay, base deductible</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Remaining Patient Financial Responsibility, e.g. remaining deductible for benefit plan and 40+ service types</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Data to Support Financials, e.g. dates, in/out of network differences</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Use of transaction under “Basic Level” Infrastructure/Policy Requirements</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use of transaction under “Enhanced 1” Infrastructure/Policy Requirements</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Claims Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of transaction under “Basic Level” Infrastructure/Policy Requirements</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

## Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use

<table>
<thead>
<tr>
<th>Infrastructure/Policy Requirements</th>
<th>Phase I*</th>
<th>Phase II*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Policy requirements: Must offer CORE-certified capabilities to ALL trading partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Infrastructure requirements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Real-time: 20-seconds AND batch turn around requirements</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>□ System availability: 86%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Standard Companion Guide Format and flow</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Enhanced 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Basic Level”, plus, additional Infrastructure requirements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient identification rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Standard error codes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Normalizing names</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Note**

* There are over 35 entities already CORE Phase I certified and 30 entities that are committed to Phase II; CORE-certification is for health plans, vendors, clearinghouses and large providers.
Long-term Range of Administrative Transactions

Sponsor

- 834 Enrollment
- 820 Premium Payment

Provider

- 270 Eligibility Inquiry
- 271 Eligibility Response

- 278 Referral Request
- 278 Referral Response

Charge Capture
Clinical O/E
Utilization Review

- 277 Request for Info
- 275 Claim Attachment

Billing

- 276 Status Inquiry

A/R

- 277 Status Response

Health Plan

- 837 Claim/Encounter

Membership
Benefit Contract Mgt

Pre-Adjudication
Expert System

Claim
Adjudication

Enrollment DB

Contract
Benefits Database

A/P

835 Remittance (EOB)
Options for Phase III Scope

• Options are sourced by filters
  – Example: Items deferred from Phase II Work Groups and Subgroups

• Presented according to
  
  Category: 5 major categories
  • Expand Policy
  • Expand Infrastructure
  • Expand current transactions
  • New transactions
  • Other

Potential Rule Areas Within Categories
## Potential Phase III Scope (Page 1/5)

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Rule Areas</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Policies</td>
<td>Require <em>health plans</em> seeking Phase III certification to require 50% or more of their vendor and clearinghouse trading partners to become CORE-certified</td>
<td>• Builds CORE critical mass and encourages adoption</td>
</tr>
<tr>
<td></td>
<td>Develop more extensive certification testing, and more detailed partnerships with CCHIT and EHNAC</td>
<td>• Focuses CORE resources on certification enhancements</td>
</tr>
</tbody>
</table>
|                   | Develop policies/rules that involve banks, employers and/or TPAs:  
  – 834 Benefit Enrollment and Maintenance transaction: policy for how frequently employers provide plans with eligibility files  
  – Policy on retroactive member terminations  
  – Policies on Electronic Funds Transfer (EFT)                                                                 | • Expands types of stakeholders involved in improving claims processing                       |
|                   | Require all CORE Phase III certified entities to exchange data with one another (and whomever else they chose); moves CORE into an access role                                                                                 | • Trading partner agreements have not been part of CORE scope                                |
## Potential Phase III Scope (page 2/5)

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Rule Areas</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Expand Infrastructure</td>
<td>Expand patient identification rules</td>
<td>• Significant work completed during Phase II; Phase III would require legal involvement and consideration of 5010 alternate searches</td>
</tr>
<tr>
<td></td>
<td>– Adopt alternate search criteria including, potentially, search criteria for when the member ID number is missing</td>
<td>• Significant privacy concerns</td>
</tr>
<tr>
<td></td>
<td>Expand Phase II Connectivity and Security, e.g.,:</td>
<td>• Not addressed in 5010</td>
</tr>
<tr>
<td></td>
<td>– Move to a single authentication standard – digital certificates</td>
<td>• Clinical-administrative uses, and partnership opportunities with federal efforts and HL7</td>
</tr>
<tr>
<td></td>
<td>– Create digital certificate directory and/or list of authorized certificate authorities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Move to a single envelope standard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– More structured/standard auditing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Multi-hop messaging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create process towards a payer identifier</td>
<td>• Provider request</td>
</tr>
<tr>
<td></td>
<td>Decrease response time, e.g. move from 20 seconds to 10</td>
<td>• Not addressed in 5010</td>
</tr>
<tr>
<td></td>
<td>Increase system availability, e.g. 86% to 96%</td>
<td>• Not addressed in 5010</td>
</tr>
<tr>
<td></td>
<td>Move from CORE required 997 Acknowledgements to 999</td>
<td>• Not proposed for 5010 but recommended by WEDI</td>
</tr>
</tbody>
</table>
## Potential Phase III Scope (Page 3/5)

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Rule Areas</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Current Transactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>276/277 Claims Status</td>
<td>Apply Phase II infrastructure rules to claims status (patient ID, connectivity)</td>
<td>• Not addressed in 5010</td>
</tr>
<tr>
<td></td>
<td>Build out data content. Options would include:</td>
<td>• Transaction being built out by many plans due to provider use/request</td>
</tr>
<tr>
<td></td>
<td>– Rules for responding with both the pend and paid status on the 277; Require use of claims status code (STC segments) fields</td>
<td>• Builds off Phase II</td>
</tr>
<tr>
<td></td>
<td>– Specify minimum 277 response data content to 276 inquiry</td>
<td></td>
</tr>
<tr>
<td>270/271 Eligibility</td>
<td>Increase # of CORE-required service type codes (and associated financials, e.g. remaining deductible, co-pays, co-insurance, in/out of network variances)</td>
<td>• Will need to involve attorneys in sensitive benefit discussions</td>
</tr>
<tr>
<td></td>
<td>– Codes that could be added: Codes HITSP needs, codes not addressed in Phase II due to sensitive benefit issue, carve-outs not supported in Phase II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop rules and roadmap related to provider network identification/transparency, includes Phase II deferred work on product identification</td>
<td>• Key issue for provider associations; also being discussed at state level</td>
</tr>
<tr>
<td></td>
<td>Increase use of more detailed cost-related codes and data in transaction, e.g. procedure level codes, lifetime maximums</td>
<td>• Move towards RTA</td>
</tr>
</tbody>
</table>
## Potential Phase III Scope (4/5)

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Rule Areas</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Transactions</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **837 I, P, D Healthcare Claims**             | Apply Phase I& II infrastructure rules to claims transactions, e.g. real-time response time, system availability, connectivity, acknowledgements (rule requiring health plans to acknowledge each claim submitted) and companion guide                                                                 | • Not addressed in 5010  
• Move toward RTA                                                                                                                                                                                                                                    |
| **278 Authorizations, Precertifications & Referrals** | Apply Phase I& II infrastructure rules to prior authorization & referral transactions, e.g. real-time response time, system availability, connectivity, acknowledgements and companion guide                                                                                       | • Not addressed in 5010, but required to use transaction in 5010  
• Provider request                                                                                                                                                                                                                                       |
| **835 Electronic Payment/Remittance Advice**  | Apply Phase I& II infrastructure rules to electronic remittance advices, e.g. real-time response time, system availability, connectivity, acknowledgements                                                                                                                                 | • Move toward RTA  
• Not addressed in 5010                                                                                                                                                                                                                                       |
| **834 Benefit Enrollment/Disenrollment**      | Described on page 12.                                                                                                                                                                                                                   | • Requested as focus by provider associations and several plans                                                                                                                                                                                                  |
Potential Phase III Scope (5/5)

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Rule Areas</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>PHRs: Support adoption of standard PHR that will be used by CORE-certified health plans (275)</td>
<td>• Allows entities not to do more work on HIPAA transactions given they will be working to meet 5010 requirements</td>
</tr>
<tr>
<td></td>
<td>Design rules that support e-prescribing and pharmacy e-health efforts. Revisit Phase II proposal in this area to determine feasibility and current interest.</td>
<td>• Aligns CORE with other industry efforts focused on interoperability</td>
</tr>
<tr>
<td></td>
<td>Require implementation of WEDI Standard ID Card Guide</td>
<td>• Can be used as a vehicle to access information delivered by CORE</td>
</tr>
</tbody>
</table>
Discussion

• Solicit any additions or adjustments to the scoping list

• Discuss potential rule areas and their link to the appropriate filter
Phase III Timing Options

- Option 1: Begin Phase III rule writing process immediately after scope is approved (Fall 2008)
- Option 2: Begin after critical mass of organizations become Phase II certified (late 2009)
- Option 3: Before 5010 required implementation
- Option 4: After 5010 required implementation
- Option 5: Other?
Multi-Voting

- Distribute colored stickers by stakeholder type
  - Health plans [red]
  - Providers [yellow]
  - Vendors/clearinghouses [green]
  - Associations/regional entities/SDOs [light blue]
  - Government entities [dark blue]
  - Other [orange]

- Up to 5 votes per organization on scope items
- 1 vote per organization on timing option
- Discuss results
Results of Multi-Voting

- Will be presented at the meeting
  - Most selected categories
  - Most selected rules areas
  - Any key variations by stakeholder type
  - Key comments
Next Steps

October
• Detailed scoping of recommended rule areas and timing
  – Share multi-voting results with Work Group
  – Document Work Group input
  – Conduct interviews with committed entities about cost and timing of recommended Phase III scope to determine key barriers

November (after 5010 and ICD-10 comments are submitted)
• Final selection
  • Led by CORE Steering Committee