



# **The Future of CORE: Phase III and Beyond**

CAQH Administrative  
Simplification Conference  
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# Discussion Topics

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- 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

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- 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

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- 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

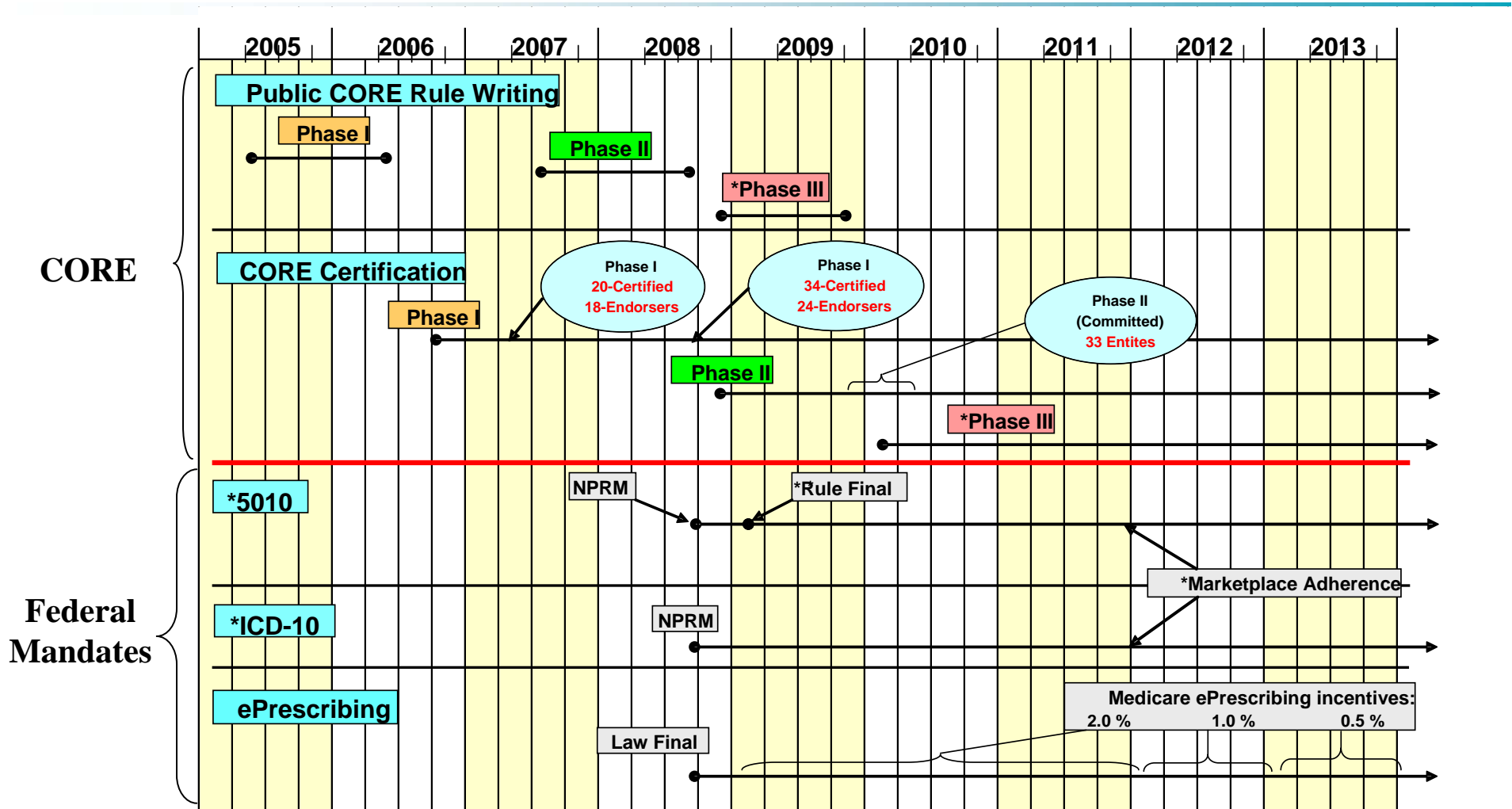
# 5010 Implications

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- 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

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- 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

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- 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*

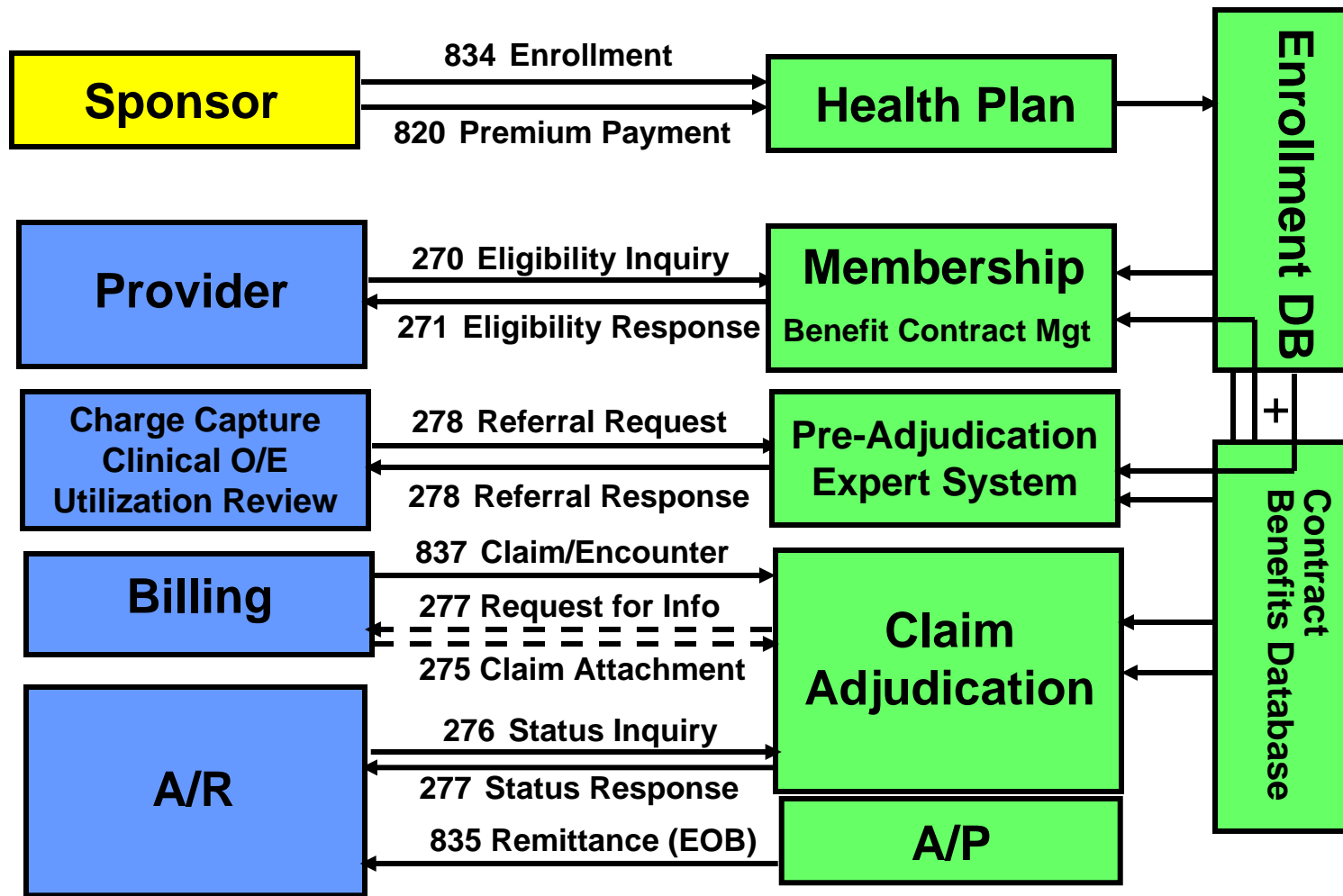
# Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*	Phase II*
<b>Eligibility/ Benefits</b>	Static <i>Patient Financial Responsibility</i> , e.g. co-pay, base deductible	X	X
	Remaining <i>Patient Financial Responsibility</i> , e.g, remaining deductible for benefit plan and 40+ service types		X
	Data to Support Financials, e.g. dates, in/out of network differences	X	X
	Use of transaction under “Basic Level” Infrastructure/Policy Requirements	X	X
	Use of transaction under “Enhanced 1” Infrastructure/Policy Requirements		X
<b>Claims Status</b>	Use of transaction under “Basic Level” Infrastructure/Policy Requirements		X
Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use			
<b>Basic Level</b>	<ul style="list-style-type: none"> <li>• <u>Policy requirements</u>: Must offer CORE-certified capabilities to ALL trading partners</li> <li>• <u>Infrastructure requirements</u>:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Real-time: 20-seconds AND batch turn around requirements</li> <li><input type="checkbox"/> System availability: 86%</li> <li><input type="checkbox"/> Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL</li> <li><input type="checkbox"/> Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement</li> <li><input type="checkbox"/> Standard Companion Guide <i>Format and flow</i></li> </ul> </li> </ul>	X	X
<b>Enhanced 1</b>	“Basic Level”, plus, additional <u>Infrastructure requirements</u> : <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient identification rules                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Standard error codes</li> <li><input type="checkbox"/> Normalizing names</li> </ul> </li> <li><input type="checkbox"/> Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers</li> </ul>		X

**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



simplifying healthcare administration



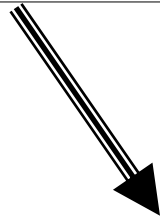
# Options for Phase III Scope

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- 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)

Category	Potential Rule Areas	Comments
<b>Expand Policies</b>	Require <i>health plans</i> seeking Phase III certification to require 50% or more of their vendor and clearinghouse trading partners to become CORE-certified	<ul style="list-style-type: none"> <li>• Builds CORE critical mass and encourages adoption</li> </ul>
	Develop more extensive certification testing, and more detailed partnerships with CCHIT and EHNAC	<ul style="list-style-type: none"> <li>• Focuses CORE resources on certification enhancements</li> </ul>
	Develop policies/rules that involve banks, employers and/or TPAs: <ul style="list-style-type: none"> <li>– 834 Benefit Enrollment and Maintenance transaction: policy for how frequently employers provide plans with eligibility files</li> <li>– Policy on retroactive member terminations</li> <li>– Policies on Electronic Funds Transfer (EFT)</li> </ul>	<ul style="list-style-type: none"> <li>• Expands types of stakeholders involved in improving claims processing</li> </ul>
	Require all CORE Phase III certified entities to exchange data with one another (and whomever else they chose); moves CORE into an access role	<ul style="list-style-type: none"> <li>• Trading partner agreements have not been part of CORE scope</li> </ul>

## Potential Phase III Scope (page 2/5)

Category	Potential Rule Areas	Comments
<b>Expand Infrastructure</b>	Expand patient identification rules <ul style="list-style-type: none"> <li>– Adopt alternate search criteria including, potentially, search criteria for when the member ID number is missing</li> </ul>	<ul style="list-style-type: none"> <li>• Significant work completed during Phase II; Phase III would require legal involvement and consideration of 5010 alternate searches</li> <li>• Significant privacy concerns</li> </ul>
	Expand Phase II Connectivity and Security, e.g.: <ul style="list-style-type: none"> <li>– Move to a single authentication standard – digital certificates</li> <li>– Create digital certificate directory and/or list of authorized certificate authorities</li> <li>– Move to a single envelope standard</li> <li>– More structured/standard auditing</li> <li>– Multi-hop messaging</li> </ul>	<ul style="list-style-type: none"> <li>• Not addressed in 5010</li> <li>• Clinical-administrative uses, and partnership opportunities with federal efforts and HL7</li> </ul>
	Create process towards a payer identifier	<ul style="list-style-type: none"> <li>• Provider request</li> </ul>
	Decrease response time, e.g. move from 20 seconds to 10	<ul style="list-style-type: none"> <li>• Not addressed in 5010</li> </ul>
	Increase system availability, e.g.86% to 96%	<ul style="list-style-type: none"> <li>• Not addressed in 5010</li> </ul>
	Move from CORE required 997 Acknowledgements to 999	<ul style="list-style-type: none"> <li>• Not proposed for 5010 but recommended by WEDI</li> </ul>

## Potential Phase III Scope (Page 3/5)

Category	Potential Rule Areas	Comments
<b>Expand Current Transactions</b>		
<b>276/277 Claims Status</b>	Apply Phase II infrastructure rules to claims status (patient ID, connectivity)	<ul style="list-style-type: none"> <li>• Not addressed in 5010</li> </ul>
	Build out data content. Options would include: <ul style="list-style-type: none"> <li>– Rules for responding with both the pend and paid status on the 277; Require use of claims status code (STC segments) fields</li> <li>– Specify minimum 277 response data content to 276 inquiry</li> </ul>	<ul style="list-style-type: none"> <li>• Transaction being built out by many plans due to provider use/request</li> <li>• Builds off Phase II</li> </ul>
<b>270/271 Eligibility</b>	Increase # of CORE-required service type codes (and associated financials, e.g. remaining deductible, co-pays, co-insurance, in/out of network variances) <ul style="list-style-type: none"> <li>– 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</li> </ul>	<ul style="list-style-type: none"> <li>• Will need to involve attorneys in sensitive benefit discussions</li> </ul>
	Develop rules and roadmap related to provider network identification/transparency, includes Phase II deferred work on product identification	<ul style="list-style-type: none"> <li>• Key issue for provider associations; also being discussed at state level</li> </ul>
	Increase use of more detailed cost-related codes and data in transaction, e.g. procedure level codes, lifetime maximums	<ul style="list-style-type: none"> <li>• Move towards RTA</li> </ul>

# Potential Phase III Scope (4/5)

Category	Potential Rule Areas	Comments
<b>New Transactions</b>		
<b>837 I, P, D Healthcare Claims</b>	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) <i>and companion guide</i>	<ul style="list-style-type: none"> <li>• Not addressed in 5010</li> <li>• Move toward RTA</li> </ul>
<b>278 Authorizations, Precertifications &amp; Referrals</b>	Apply Phase I& II infrastructure rules to prior authorization & referral transactions, e.g. real-time response time, system availability, connectivity, acknowledgements <i>and companion guide</i>	<ul style="list-style-type: none"> <li>• Not addressed in 5010, but required to use transaction in 5010</li> </ul>
	Build out data content	<ul style="list-style-type: none"> <li>• Provider request</li> </ul>
<b>835 Electronic Payment/ Remittance Advice</b>	Apply Phase I& II infrastructure rules to electronic remittance advices, e.g. real-time response time, system availability, connectivity, acknowledgements	<ul style="list-style-type: none"> <li>• Move toward RTA</li> <li>• Not addressed in 5010</li> </ul>
	Build out data content, e.g.: <ul style="list-style-type: none"> <li>- Require use of non-mandated fields such as “allowed amount”, “class of contract”, “date of claim receipt”</li> <li>- Move toward line item relationship to 837</li> <li>- Require standard use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)</li> </ul>	<ul style="list-style-type: none"> <li>• Requested as focus by provider associations and several plans</li> </ul>
<b>834 Benefit Enrollment/ Disenrollment</b>	Described on page 12.	

## Potential Phase III Scope (5/5)

Category	Potential Rule Areas	Comments
Other	PHRs: Support adoption of standard PHR that will be used by CORE-certified health plans (275)	<ul style="list-style-type: none"> <li>Allows entities not to do more work on HIPAA transactions given they will be working to meet 5010 requirements</li> </ul>
	Design rules that support e-prescribing and pharmacy e-health efforts. Revisit Phase II proposal in this area to determine feasibility and current interest.	<ul style="list-style-type: none"> <li>Aligns CORE with other industry efforts focused on interoperability</li> </ul>
	Require implementation of WEDI Standard ID Card Guide	<ul style="list-style-type: none"> <li>Can be used as a vehicle to access information delivered by CORE</li> </ul>

# Discussion

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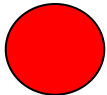
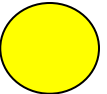
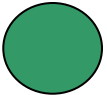
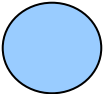
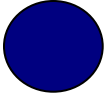
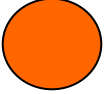
- Solicit any additions or adjustments to the scoping list
- Discuss potential rule areas and their link to the appropriate filter

# Phase III Timing Options

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- 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

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

# Next Steps

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## **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