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How is CORE helping healthcare industry interoperability to take shape?

A CAQH and WEDI Audiocast Tuesday, March 17th, 2009
2:00 pm – 3:30 pm EST

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Discussion Topics

- Electronic Administrative Transactions Overview
 - Why CORE is needed
- CORE Mission, Goals and Process
 - Business case
 - Phased approach
 - Certification process
- Industry Recognition and Adoption
- Industry Coordination
 - National
 - State/Regional

An Introduction to CAQH

CAQH, an unprecedented nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on ***initiatives that simplify healthcare administration*** for health plans and providers, resulting in a ***better care experience for patients and caregivers.***

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

Administrative Healthcare Information Exchange: Today vs. Tomorrow

Today



Tomorrow

Health Plans

- Multiple provider inquiries for information
- Extensive service time needed to respond to providers and members

Vendors/Clearinghouses

- Multiple/varied business platforms and infrastructures
- Available data from plans often inconsistent/incomplete

Providers

- Multiple phone inquiries for information
- Extensive service time needed to verify coverage and patient financial information

- Streamlined electronic administrative data exchange (i.e., eligibility information, claim status, prior authorizations, etc)
- Providers have electronic access to the information they need using any technology or system of their choosing

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How Do We Get From Today to Tomorrow?

HIPAA: The Start

- Although generally viewed by the public as a healthcare privacy and security law, HIPAA laid the groundwork for administrative simplification
 - Established standard electronic healthcare administrative transactions, e.g.,
 - Claims or Encounters (837)
 - Remittance Advice (835)
 - Eligibility Inquiry and Response (270/271)
 - Prior Authorization and Referral (278)
 - Claim Status Inquiry (276/271)
- Prior to HIPAA there was no standard way to share this information
- Healthcare organizations under HIPAA are required to use these standards
- Implementation guides were developed to provide technical details and directions for how the data should be moved electronically using these standards

From HIPAA to CORE

Although HIPAA is a start, the expected efficiencies from the standardization of administrative transactions have not been realized

- Implementation guides still leave “wiggle room”, e.g., eligibility transaction only requires that a “yes/no” response be returned (4010)
- No business “infrastructure” requirements are addressed by HIPAA, e.g., timely response, connectivity
- As a Federal mandate, lengthy process required to approve updates

As an organization focused on administrative simplification, CAQH recognized an opportunity

- A national industry-driven approach could help eliminate some of the implementation guide “wiggle room” by
 1. Specifying voluntary requirements in addition to HIPAA
 2. Addressing business “infrastructure” requirements
 3. Providing roll-out of these requirements that are aggressive, but supported by the industry
- Committee on Operating Rules for Information Exchange (CORE), facilitated by CAQH, held its first workgroup call in 2006

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Where to Begin?

Eligibility (Benefits/Coverage) Verification

- This is often the first administrative interaction between provider and patient and the first step in the administration of healthcare
- More robust eligibility information leads to “cleaner” claims

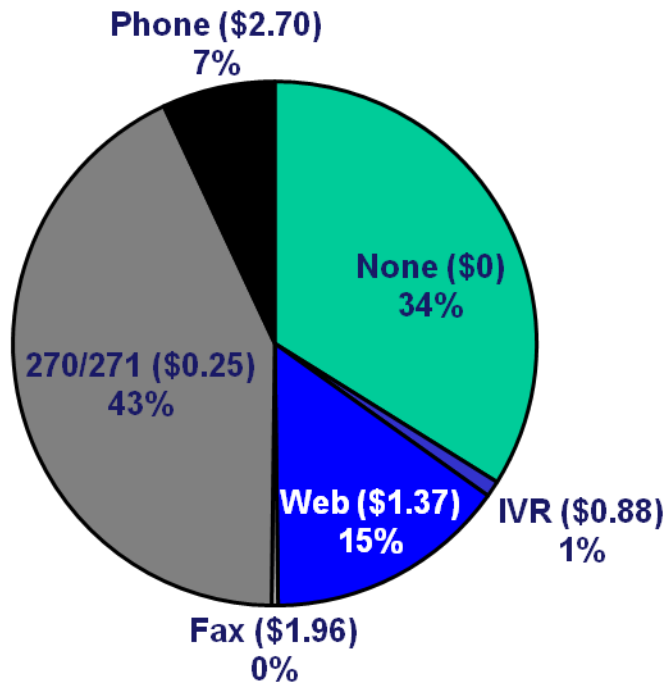
Eligibility Verification Methods

1. Phone
 - Time consuming, labor intensive
2. Websites
 - Providers need to toggle between various websites, information displayed in variable formats
3. Electronic Transaction (270/271)
 - Minimally required eligibility information does not always give the provider sufficient detail to make the transaction effective

Key Opportunity: Significant Savings

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

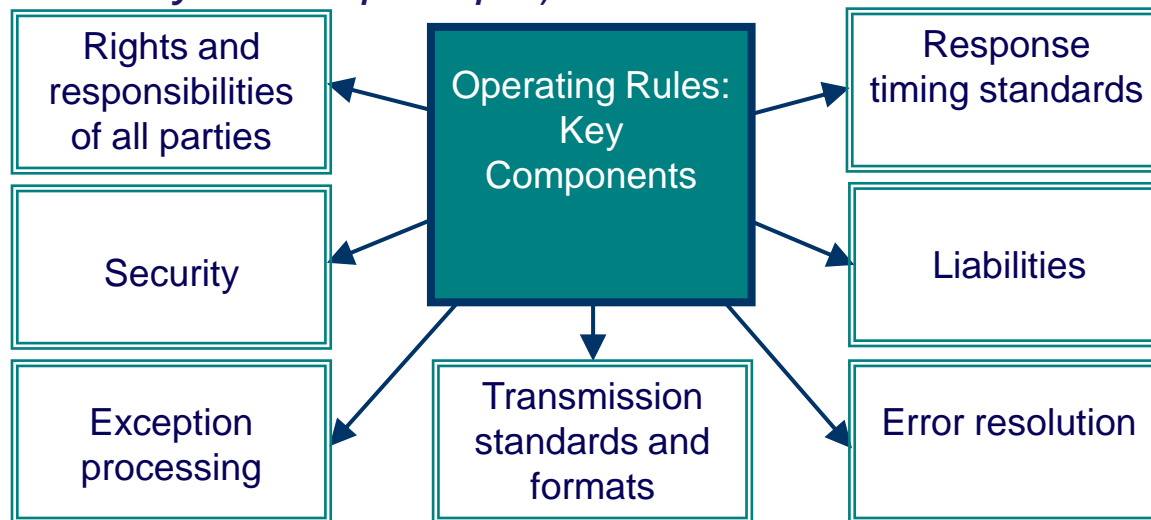
**Provider Eligibility Verification by
Type of Method
(Average labor cost per transaction)**



How to Begin?

Why can't verifying eligibility and benefits in the provider's office be as easy as using an ATM?

- Unlike banking and railroads, industry agreed-upon business rules for using and processing transactions do not exist in healthcare outside of individual trading relationships
- Operating (business) rules encourages an interoperable network, thereby allowing providers to use the system of their choosing (*remaining vendor agnostic is a key CORE principal*)



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Who Needs to be Involved?

All healthcare industry stakeholders need to be involved in order to realize an agreed upon end-to-end process which allows interoperable electronic data exchange



Committee on Operating Rules
for Information Exchange

A CAQH Initiative

CORE is more than 100 industry stakeholders – health plans, providers, vendors, CMS and other government agencies, associations, regional entities, standard-setting organizations and other healthcare entities. Working in collaboration, they are building consensus on a set of operating rules that will:

- Enhance interoperability between providers and payers
- Streamline administrative data transactions (e.g., eligibility, claim status)
- Reduce the amount of time and resources providers spend on administrative functions – time better spent with patients

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Following full page ad* appeared in the Wall Street Journal on March 11th, 2009 and will also run in *Modern HealthCare*, *Managed Healthcare Executive*, *Healthcare IT News*, *Health Data Management* and *Roll Call*

HEALTHCARE LEADERS:

**LET'S ALL GET ON
THE SAME PAGE.**

By implementing the CORE rules, CORE-certified organizations are speaking the same language:

- Improving data consistency
- Reducing paperwork
- Advancing system interoperability
- Supporting information transparency for consumers

**Refer to additional documentation for full page ad*

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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 applicable HIPAA transaction requirements
- Enable providers to submit transactions from any system
- Enable stakeholders to implement CORE in phases
- Facilitate stakeholder commitment to and compliance with CORE
- 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

CORE Goals

- Industry-wide stakeholder collaboration facilitated by CAQH
- Participation from 75% of the commercially insured population (plus Medicare and Medicaid)

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

Apply operating rule concept to all electronic communication between payers and their customers, using phased approach



A CAQH Initiative



A CAQH Initiative



A CAQH Initiative

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- Participated in CORE Since Inception
- CORE Phase I Certified
- Largest Direct Provider to Payor Network
- Manage over 20 Million Eligibility Transactions Per Month
- Award-Winning SaaS Intelligent Network



Hospitals



Physicians



Patients



Retail Rx



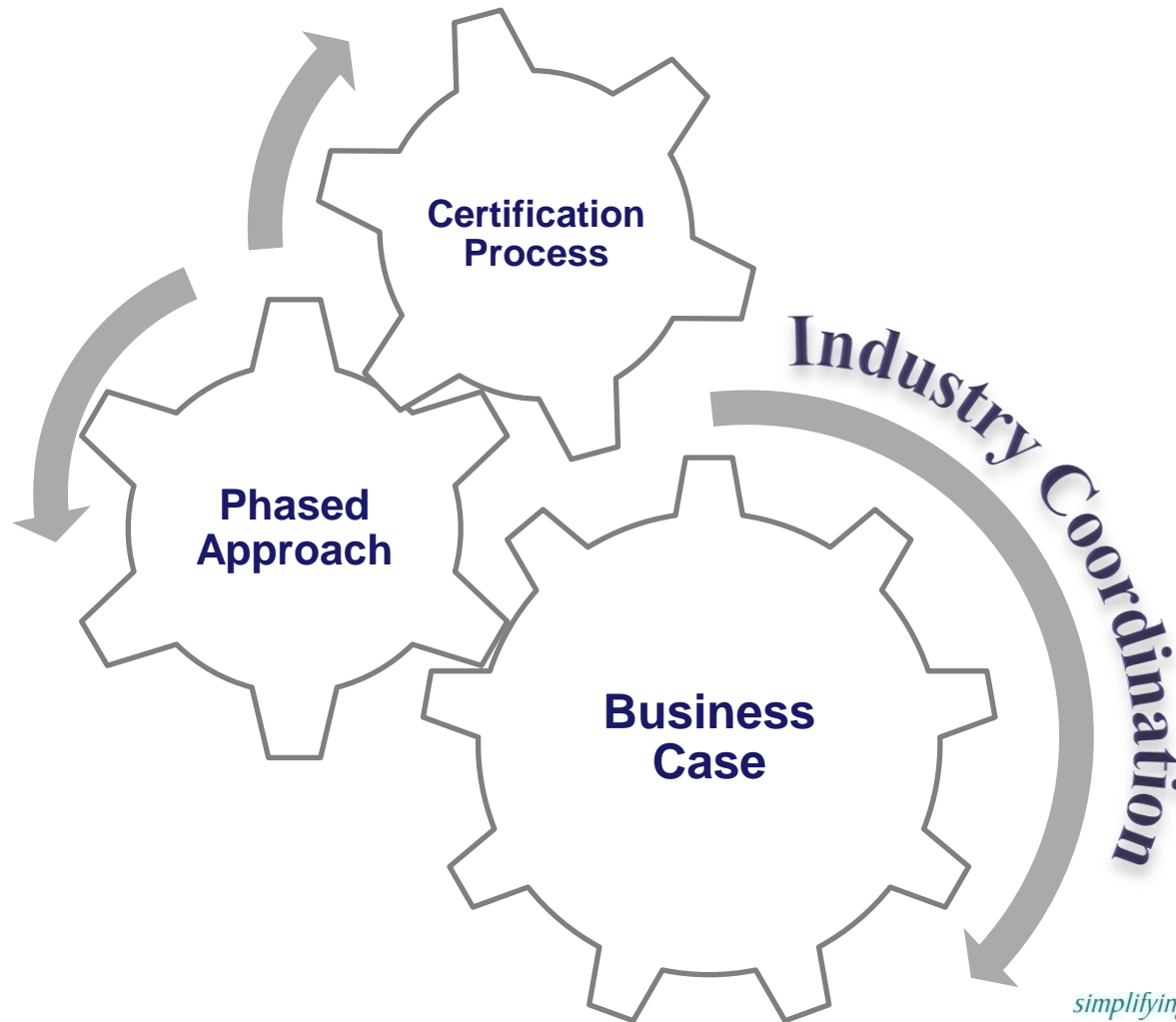
Payors



Financial Institutions

RelayHealth Connectivity

CORE Process



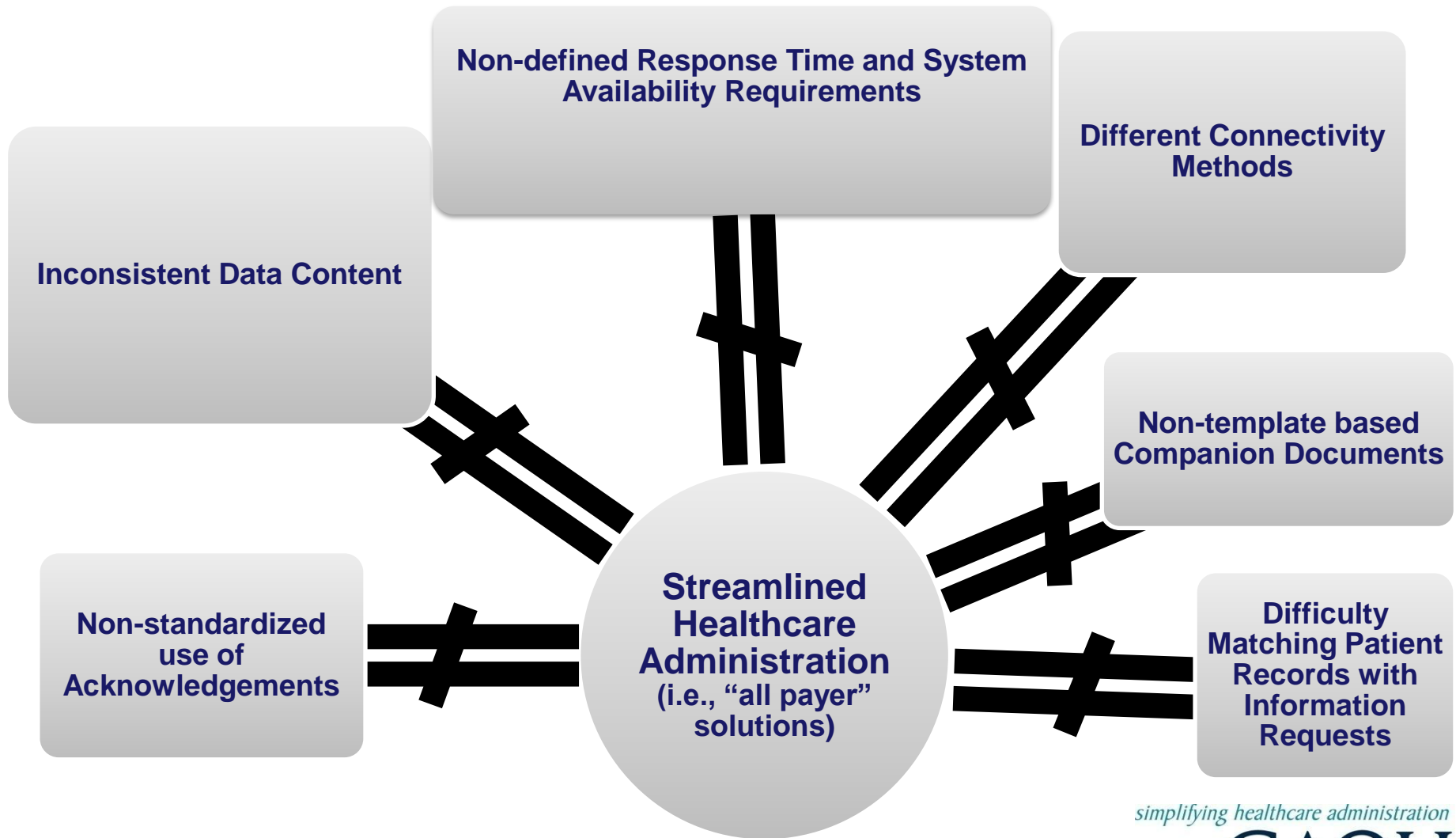
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CORE Process

1. Develop rules built upon a strong business case
 - Rules need to improve some part of the process in order for the marketplace to readily adopt
 - Barriers to adoption must be recognized in order to plan accordingly
 - The business case also helps to decide how large a step the marketplace can accommodate and when the marketplace is ready for such a step
2. Phased approach is key
 - Develop rules and implement them using an incremental approach with achievable milestones
 - Helps to maximize rule adoption
3. Couple rule development with a certification testing process
 - Testing helps insure uniform implementation of CORE rules
 - Helps to build trust among trading partners

Barriers to Streamlined Healthcare Administration



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Acknowledgements

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

Acknowledgements

Issue:

Inconsistent/non-standard use of acknowledgements leads to “black hole”

Solution:

CORE Acknowledgments Rule: Replaces the multiple responses (and sometimes non-responses) that occur now between parties. It reduces the number of responses that must be transmitted and also standardizes the variety of responses that must be supported by all parties. Standardized acknowledgments eliminates “black hole” of no response, thereby reducing phone calls and duplicative submissions



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Acknowledgements

WHY STANDARD ACKNOWLEDGMENTS ARE A BETTER WAY OF DOING BUSINESS FOR ALL PARTICIPANTS

Health Plan Eligibility Acknowledgements

- Providers want to see health plans support acknowledgements so that errors are reported back to the providers in a standardized fashion.
- Extensive use of standards-based acknowledgment automation provides rapid notice of an error that can be resolved quickly without phone calls.

Provider Eligibility Acknowledgements

- In an automated environment, a provider transmission of a standard acknowledgement that the eligibility response was formatted incorrectly will immediately inform the health plan of a processing error without any calls to the health plan's call center.
 - The health plan response to an error will be faster, and issues will be corrected more rapidly.

Clearinghouse Acknowledgements

- Clearinghouses will be expected to support the standard health plan and provider acknowledgment requirements.
- As a result, automated error reporting for both eligibility inquiries and responses will make their jobs easier since clearinghouses will not longer be required to program for a multiplicity of different proprietary acknowledgements.

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Data Content



**Business
Case**

Data Content

Issue:

Minimal required eligibility information under HIPAA (4010) and variable support for service type codes create barriers to use of 270/271 as well as limiting ability of vendors to design all-payer solutions. This issue still exists under recently approved updated Guide (5010)

Solution:

CORE 270/271 Data Content Rule: Agreement on a more robust and consistent eligibility response helps reduce additional phone calls and allows vendors to design more robust “all-payer” products



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Data Content



Business
Case

WHY RESPONDING WITH MORE CONSISTENT, COMPREHENSIVE BENEFITS IS A BETTER WAY OF DOING BUSINESS FOR ALL PARTICIPANTS

- If providers are given comprehensive benefit information, they are much better positioned to inform patients of coverage and potential out-of-pocket costs.
 - Increasing use of high deductible plans driving the need to better understand a patient's financial responsibility
 - If the provider is only informed at a minimum that a patient has current coverage, they often have to call the health plan to obtain more detail.
- Vendors/clearinghouses can offer improved service to provider practices, health plans
- CORE data content rules written with 5010 in mind so they help to close the gap for 5010 implementation



Response Time/System Availability

Response Time and System Availability

Issue:

Lengthy response times (both real time and batch) and limited system availability reduce workflow and productivity

Solution:

CORE Response Time/ System Availability Rules:

- Enable providers to reliably know when to expect responses to eligibility inquiries and manage staff accordingly
- Identifies to the industry that immediate receipt of responses is important and lets all stakeholders know the requirements and expectations





Response Time/System Availability

THE CORE RULES IN “FUNCTIONAL RESPONSIBILITY” FOCUS ON TWO KEY BUSINESS NEEDS WHEN USING AUTOMATED ELIGIBILITY TRANSACTIONS:

1. System Availability

- Providing health care services is a 24x7x365 business for many providers. With an increasing number of emergency rooms visits, emergency service providers need to verify eligibility and benefits at all hours of the day, as well as on weekends.
- Even physician offices and urgent care services are moving to evening hours, as well as Saturday and Sunday hours. For eligibility inquiry to be of value to many providers, systems that support the eligibility sources cannot routinely be down for extended periods of time.
- To support real time transactions, the system's that support the eligibility transactions for both clearinghouses and health plans (or information sources) must be mostly available anytime.

2. Response Time

- For online transactions to be adopted by more providers, these transactions must be both faster and less costly than the alternatives of website lookup or telephonic inquiry.
- A 20 second round trip requirement has been set by CORE Phase I Rule. This standard is under the estimated website look up time of 44 seconds by one health system.
- By reducing staff time spent in look ups and waiting for website responses, providers will be more incentivized to adopt online eligibility.

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Connectivity



Business
Case

Connectivity

Issue:

Variable connectivity methods increases cost and complexity of exchanging information

Solution:

CORE Connectivity Rule: Supports healthcare industry movement towards common, affordable connectivity methods and enables small providers not doing EDI today to connect to all clearinghouses and plans that are CORE-certified using any CORE-certified PMS



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Connectivity

WHY SUPPORTING STANDARDIZED COMMUNICATIONS/ CONNECTIVITY IS A BETTER WAY OF DOING BUSINESS FOR ALL PARTICIPANTS

Health Plan Standard Communication/Connectivity

- Many large organizations support multiple technical communications capabilities to support the technical choices of their trading partners with direct connect and Internet-based options. Having a standard technical communications specification used by all trading partners reduces electronic communications cost for everyone because the standard will always be accepted by the other trading partners for real time and batch transactions.
- The standard technical communications specification could also be used for some or all of the other HIPAA transactions

Provider Standard Communication/Connectivity

- Most providers, especially small providers, find it expensive and technically challenging to support multiple communication/connectivity technical equipment and protocols to be able to communicate electronically.
- Having a single, public Internet-based standard that can be used with all clearinghouses and health plans significantly lowers the provider's technology cost and provides a standard communications/connectivity infrastructure that can also support provider-to-provider patient data transactions.



Companion Guide Template

Companion Guide Template

Issue:

Variance in format and structure can be confusing to trading partners.

Solution:

CORE Companion Guide Rule: Helps to ensure that health plans companions guides written by health plans and other information sources are similar in structure, making it easier for providers to find information more quickly.



Patient Identification



**Business
Case**

Patient Identification


Issue:

If demographic data submitted by provider is not exactly the same as stored in health plan system, transactions may be rejected or denied

Solution:

CORE Patient Identification Rules: Addresses certain aspects of the identification of individuals to enhance automated, real time processing of transactions.

- Last Name Normalization – removing special characters/suffixes/prefixes prior to searching can enhance matching
- AAA Error Codes – Improved specificity and standardized use of the AAA codes give providers better feedback to understand what information is missing or incorrect in order to obtain a valid match



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Patient Identification

WHY IMPROVING PATIENT IDENTIFICATION IS A BETTER WAY OF DOING BUSINESS FOR ALL PARTICIPANTS

- Unique identification of an individual is not only an essential requirement for the successful use of the HIPAA-adopted X12N 270/271 Implementation Guide for Eligibility transactions, but also a critical component of identity management – which includes authentication, authorization, transaction control, audit, etc.
- As the U.S. healthcare community continues to accelerate the move to electronic health records (EHR) and personal health records (PHR) it is increasingly important that the exchange of individual names and other demographic data between healthcare providers and health plans be standardized to the extent reasonable and practicable.
- The development of a comprehensive standard for the unique identification of individuals in healthcare is not within the scope of CORE. However, it is reasonable for CORE to develop various rules addressing certain aspects of the identification of individuals that will enhance the automated real time processing of eligibility inquiries and responses.

As barriers to use of electronic transactions begin to be removed, an end-to-end solution starts to take shape

Robust and Consistent Data Content

- 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

Standardized Acknowledgements

- Eliminates “black hole” of no response, thereby reducing phone calls and duplicative submissions

Patient Identification

- Improved patient matching helps increase “first pass” rate

Known Response Times and System Availability

- Enables providers to reliably know when to expect responses to eligibility inquiries and manage staff accordingly
- Identifies to the industry that immediate receipt of responses is important and lets all stakeholders know the requirements and expectations

Connectivity Convergence

- Supports healthcare movement towards at least one common, affordable connectivity platform
- Enables small providers not doing EDI today to connect to all clearinghouses and plans that are CORE-certified using any CORE-certified PMS

Companion Document Templates

- Promotes industry convergence of multiple formats and requirements into a common companion document that will reduce the burden of maintaining a multiplicity of companion documents

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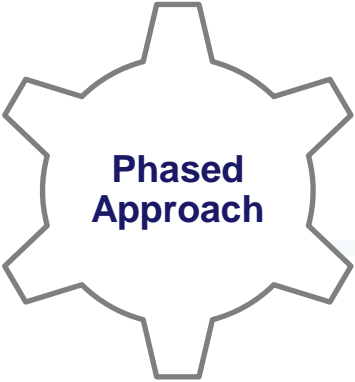
Questions

About Aetna

- 17.7M medical members
- 20M calls per year
- Over 120M electronic eligibility inquiries per year
- CORE Participant and Phase I Certified (Committed to Phase II)
 - Heavily involved in rule writing process
 - Co-chair workgroups/subgroups
 - Serve as subject matter experts
- CAQH member and CEO Ronald Williams is Board Chair
- Policy requirements for new vendors to be CORE-certified

Why CORE Participation and Certification?

- Part of a national initiative that is transforming electronic administrative data exchange
- Reduce administrative costs/Increase in electronic eligibility inquiries and a commensurate decrease in phone inquiries
- More efficient process for providing eligibility and benefits information to providers



Phased Approach

Incremental approach using achievable milestones was created to maximize commitment to market adoption of CORE operating rules

CORE rules must strike a balance between marketplace ability to adopt, with the urgency to improve the process and realize savings

- Must also maintain momentum with significant enough steps
- Business case helps define the milestones

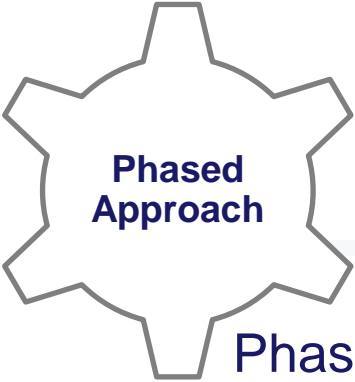
Phase I Focus: Eligibility Transaction – 270/271

- *An inquiry from a provider (270) and the response from a health plan (271) regarding a patient's eligibility for coverage, or the benefits for which a patient may be eligible*

Phase I Rules Overview

- 270/271 Data Content - Specify what must be included in a 271 eligibility response to a generic 270 inquiry
 - Status of 9 required service codes
 - Financials related to Patient Responsibility (co-pay, co-insurance , deductible – yearly, not remaining deductible)
 - In and out of network variances
- Infrastructure
 - Connectivity – must support HTTPS “Safe harbor”
 - Response Time – 20 sec or less for real-time
 - System Availability – minimum 86% per calendar week
 - Acknowledgements – Specifies when to use TA1 and 997
 - Companion Guide (flow and format standards)

Note: - CORE rules are a floor not a ceiling, entities are encouraged to go beyond
- CORE rules contain batch requirements as well
- Phase I Rules are approved by the CORE membership



Phase II Rules Overview

Phase II Focus: Build upon Phase I & apply rules to claim status

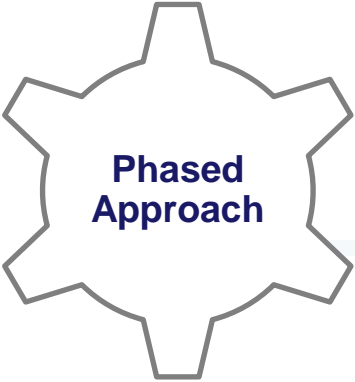
- Phase I was an incremental step to start momentum toward increasing the use and effectiveness of electronic administrative transactions
- Phase II sets the bar higher, but not unachievable

Phase II 270/271 Data Content Rule

- Includes Patient accumulators – e.g., remaining amount of deductible
 - Example of an incremental step. Phase I business case concluded it may be too large a step in Phase I given the other requirements
 - Example of a market driver – increasing number of high-deductible health plans is driving demand by providers for ready access to this type of information
- Requires support of additional 39 service type codes for which a response is required for an explicit inquiry
 - This requirements further shapes a uniform response from payers
 - Uniform responses from payers allow vendors/clearinghouses to more easily design systems

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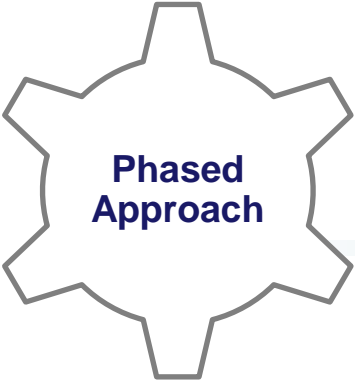
Phase II: Infrastructure Rules

Connectivity Rule

- Builds upon Phase I, but more prescriptive (e.g., specifies envelope and submitter authentication conformance requirements)
- Add digital certificates for authentication

Patient Identification Rules

- Business case research restated industry issues with matching patient – more robust information is not useful if it can't be returned because “patient not found”
- Phase II rules created to help improve matching
 - Normalizing last names (e.g., remove special characters)
 - Standardizing the use of error codes that help submitters identify what may be preventing a match



Phase II: Claim Status

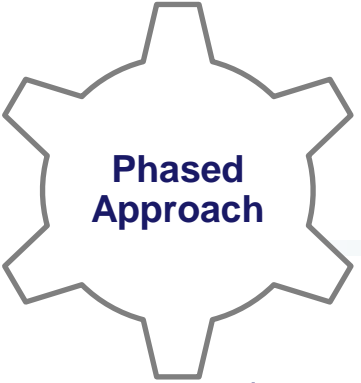
276/277 Claims Status Transaction - Application of Phase I Infrastructure

- In line with CORE's long term goal to apply operating rules to transactions other than eligibility
- Rules applied: response time, system availability, connectivity
 - For real time and batch
- Addressing the data content of the claim status transaction targeted for Phase III, again as warranted by the Phase II business case

NOTE: Phase II Rules approved by CORE membership

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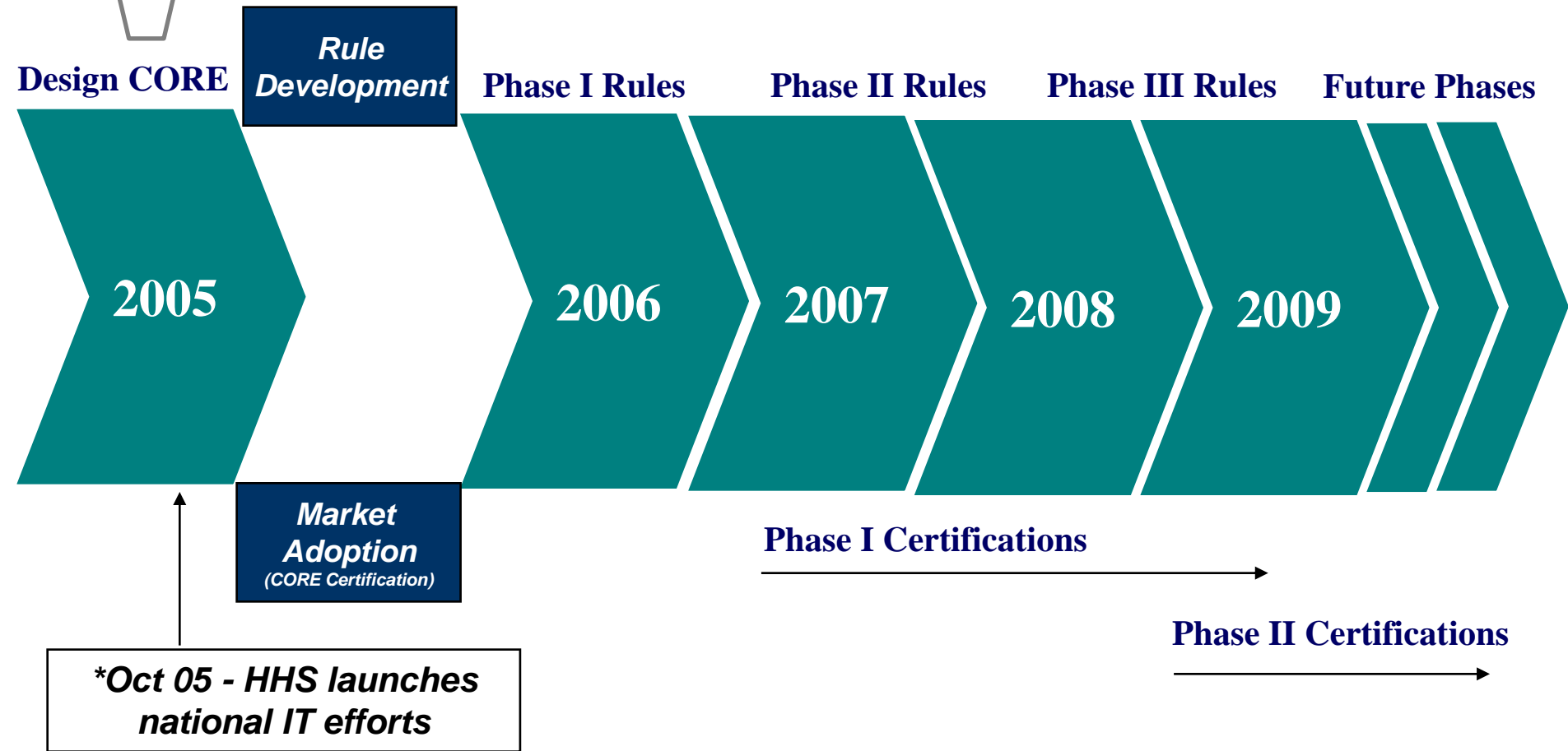
Phase III: In Design Stage

Phase III Focus : Build upon earlier Phases and apply rules to other administrative transactions

- 270/271 Data Content
 - Address rules related to provider network identification
- Infrastructure
 - Connectivity – Build upon Phase I and Phase II
 - Insurance ID cards – Address rules on standard ID cards (WEDI ID Card Implementation Guide will be key)
- 276/277 Claims Status Transaction
 - Build out data content
- 835 Remittance Advice
 - Add rules to support infrastructure around the transaction and build out data content
- 278 Authorizations/Precertifications and Referrals Transaction
 - Add rules to support infrastructure around the transaction and build out data content



Couple Rule Development with Certification Testing Process



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CORE Certification

- Rules must be adopted by the marketplace in order for benefits to be realized
- CORE-certification is required for each phase of CORE
- Recognizes entities that have implemented and 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 Testing

- Based on CORE Master Test Suite developed for each Phase
 - 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 for implementation of CORE Rules
 - Entities must attest that, to the best of their knowledge, they are HIPAA compliant
- CORE testing is not exhaustive, (e.g. does not include production data or volume capacity testing)
- CORE Certification Testing is voluntary
- Testing conducted by CORE-authorized certification testing entity

Phase I and Phase II Testing



Phase I Testing Only



Questions

Current Industry Recognition and Certification Adoption

- Participation (Rule writing process)
 - Over 75% of the commercially insured, plus CMS, SDOs, a wide range of vendors, provider associations, RHIOs, etc.
- Phase I and II certifications/commitments to certify (Implement Rules)
 - Over 35 entities covering over 1/3 of the commercially insured
 - Includes key vendors that offer provider IT solutions such as practice management systems and portals
- Endorsements and Statements of Support
 - Over 25 endorsements including eight provider associations such as the American Medical Association and standards setting bodies
 - Statements of Support from both trade associations representing the payer industry and the trade association representing PPOs

Coordination

Allows organizations to leverage work already done in order to fill in gaps – “Don’t reinvent the wheel”

Examples:

- Healthcare Information Technology Standards Panel (HITSP) which “harmonizes” and integrates standards to support interoperability, incorporates the CORE Phase I and Phase II Rules
- CORE Phase III Rules will utilize work done by the Work Group for Electronic Data Interchange (WEDI) when considering standard implementation guidelines for Health Insurance ID Cards
- CORE Phase I Rules incorporated in Certification Commission for Health Information Technology (CCHIT) requirements for 2007 Final Criteria for Ambulatory EHR Interoperability
- MITA - A national framework being developed to support improved systems development and health care management for the Medicaid enterprise is considering incorporating CORE rules

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State/Regional Coordination

State-based approaches to reducing healthcare costs are emerging, and CAQH is working to encourage CORE's national approach:

Colorado

Legislation (SB 135) established a work group to review and recommend healthcare technology and tools. CAQH presented CORE to government and private stakeholders in December 2008 as well as in pre-legislation discussion.

Texas

Texas Department of Insurance had CAQH present CORE in response to state legislation (HB 522) that focuses on administrative simplification and mentions CORE; CAQH presented CORE several times. CORE rules implementation by health plans has been recommended and will be reviewed by the state legislature in 2009.

Ohio

Legislation (HB 125) called for the formation of an advisory committee to present recommendations on issues related to electronic information exchange, including eligibility. CAQH was invited to present CORE several times in 2008. CORE participant RelayHealth was a member of the committee. The committee has made recommendations to adopt CORE rules; recommendations to be reviewed by the state legislature in 2009.

Virginia

Virginia Health Information Exchange Network, a public-private collaboration that includes the Secretary of Technology, is committed to leveraging the work done by CORE.

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National and State/Regional Challenges Mirror One Another

- The challenges faced by CORE on a national level exist at the state/regional level
- State and regional efforts have an opportunity to come together to serve as regional change agents, using CORE as a readily available tool

Challenges	How does CORE Address?
Complexity of the issues	Significant outreach and education <ul style="list-style-type: none"> • <i>National</i> solution, achieved via stakeholder-milestones that can be applied locally • This is not just a content issue: “Flow” of information is also important (i.e., infrastructure requirements such as connectivity, response time, system availability)
All stakeholders need to be at the table	CAQH builds awareness among its CORE members of any state efforts, and invites these members and their trading partners to participate in outreach; more outreach is needed among trading partners if a regional/state effort is going to be a catalyst
Coordination	Encourage local, state, regional and national efforts to work together
No instant fix or “magic bullet”	Share CORE’s research, expertise and lessons learned – change is a phased process

In Closing

“CORE is transforming the way our industry communicates. With the Phase II rules now in place and work begun on Phase III, CORE is effectively achieving its mission to create an all-payer approach to streamlined administrative data exchange.”

Ronald A. Williams, CAQH Board Chairman
Chairman and Chief Executive Officer, Aetna

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