

**CORE Phase II Rules:
A Phased Approach to Industry-Wide Adoption**

A CAQH and WEDI Audiocast Thursday, October 23, 2008 2:00 pm – 3:30 pm EST

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Discussion Topics

- Overview
 - CAQH
 - CORE Vision and Mission
- CORE Phase II Operating Rules
 - 270/271 Data Content
 - Patient Identifiers
 - Last Name Normalization
 - Use of AAA Error Codes
 - Claim Status
 - Connectivity
- Phase III and Beyond
 - National/Regional Coordination
 - 5010 Implications
 - Phase III Scope Filters/Topics
 - Next Steps
- Questions

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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

Current Initiatives:

- Universal Provider Datasource (UPD)
- Committee on Operating Rules for Information Exchange (CORE)*
* Focus of this presentation


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Committee on Operating Rules
for Information Exchange


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CORE Mission

 To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate 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

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Recent Statements of Support

"BCBSA is pleased to participate in CAQH CORE's efforts to streamline electronic eligibility. Simplifying provider access to patient insurance coverage information is critical and the Blues believe that CORE is a key initiative to bring the industry together for collaboration and consensus building."

Blue Cross and Blue Shield Association

"The standardized operating rules created by the CAQH CORE multi-stakeholder initiative is an important effort that will dramatically improve the efficiency and accuracy of electronic communications between patients, physicians and payers. This initiative complements the AMA's Heal the Claims Process™ campaign, which has made the elimination of waste and confusion from the medical claims process a top priority."

Joseph M. Heyman, MD
Chair of the American Medical Association Board of Trustees

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Current Participants

- 100 organizations* representing all aspects of the industry:
 - 19 health plans
 - 10 providers
 - 5 provider associations
 - 18 regional entities/RHIOS/standard setting bodies/other associations
 - 35 vendors (clearinghouses and PMS)
 - 5 others (consulting companies, banks)
 - 8 government entities, including:
 - Centers for Medicare and Medicaid Services
 - Louisiana Medicaid – Unisys
 - TRICARE
 - US Department of Veteran Affairs
 - Minnesota Dept. of Human Services
- 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.

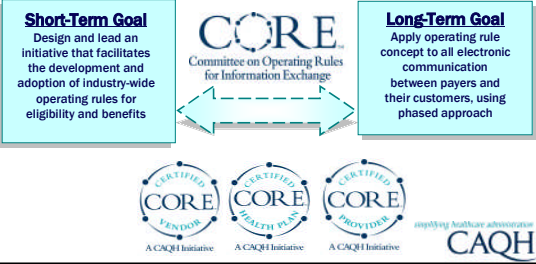
*See appendix for full list of participating organizations



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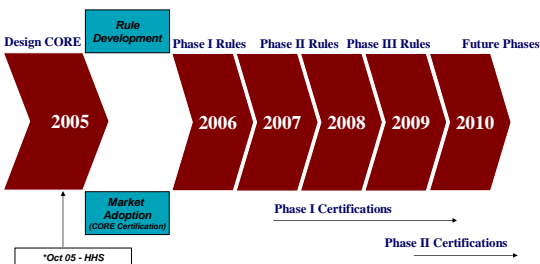
CORE Goals

- Industry-wide stakeholder collaboration launched by CAQH in Jan. 2005
- Answer to the question: Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?
- Participation from plans covering 75% of the commercially insured plus Medicare and some Medicaid



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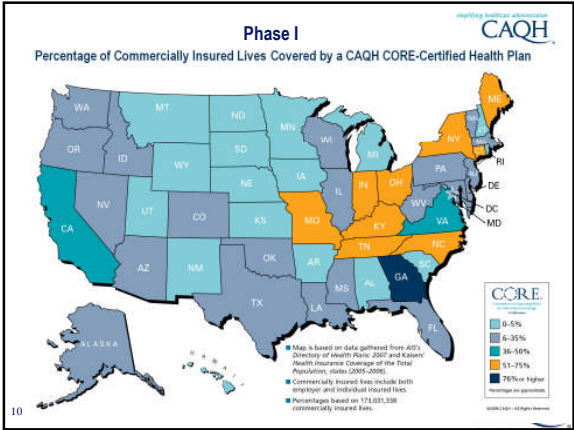
Phased Approach



*Oct 05 - HHS launches national IT efforts

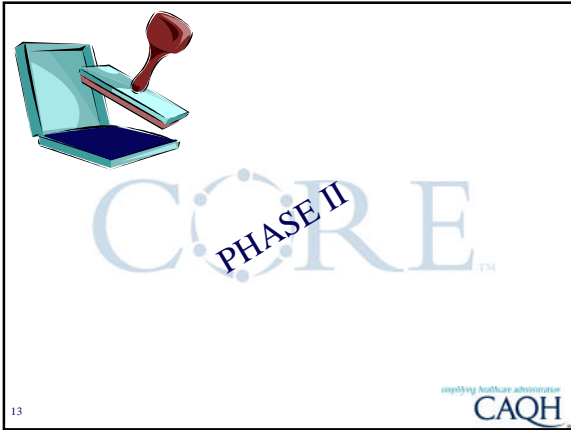


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- Entities Committed to Phase II Certification**
- CORE Participants Committed to Phase II Certification by end of Q1 2010**
- Affiliated Computer Services, Inc.
 - Aetna Inc.
 - athenahealth, Inc.
 - AultCare
 - Availity, LLC
 - BlueCross BlueShield of Tennessee
 - CSC Consulting, Inc.
 - Emedeon Business Services
 - GE Healthcare
 - HMS
 - Harvard Pilgrim Health Care
 - Health Net
 - Humana
 - Ingenix
 - Mayo Clinic
 - MedAvant Healthcare Solutions
 - MedData
 - Montefiore Medical Center
 - Navimedix
 - Passport Health Communications
 - RelayHealth
 - Siemens Medical Solutions
 - SureScripts-RxHub
 - The SSI Group, Inc.
 - VisionShare, Inc.
 - WellPoint, Inc.
- CORE NON-Participants Committed to Phase II Certification by end of Q1 2010**
- Emerging Health Information Technology
 - Medical Informatics Engineering, Inc.
 - NoMoreClipboard.com
 - Post-N-Track Corporation
- CAQH**
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- Entities Committed to Phase II Endorsement**
- CORE Participants Committed to Phase II Endorsement**
- American Academy of Family Physicians (AAFP)
 - American College of Physicians (ACP)
 - American Medical Association (AMA)
 - Edifecs
 - eHealth Initiative
 - Enclarity, Inc.
 - Foresight Corporation
 - Greater New York Hospital Association (GNYHA)
 - Healthcare Financial Management Association (HFMA)
 - Healthcare Information and Management Systems Society (HIMSS)
 - Medical Group Management Association (MGMA)
 - Microsoft Corporation
 - NACHA - The Electronic Payments Association
 - Work Group for Electronic Data Interchange (WEDI)
- CORE NON-Participants Committed to Phase II Endorsement**
- American Association of Preferred Provider Organizations (AAPPO)
 - American Health Information Management Association (AHIMA)
 - Electronic Healthcare Network Accreditation Organization (EHNAC)
 - Michigan Public Health Institute (MPHI)
 - MultiPlan
- CAQH**
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Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*	Phase II*
Eligibility/Benefits	Static Patient Financial Responsibility, e.g. co-pay, base deductible	X	X
	Remaining Patient Financial Responsibility, e.g. remaining deductible for benefit plan and 40+ service types		X
	Data to Support Financials, e.g. dates, input of new/different cases	X	X
	Use of transaction under "Basic Level" Infrastructure/Policy Requirements	X	X
	Use of transaction under "Enhanced 1" Infrastructure/Policy Requirements		X
Claims Status	Use of transaction under "Basic Level" Infrastructure/Policy Requirements		X
Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use			
Basic Level	<ul style="list-style-type: none"> * Policy requirements: Must offer CORE-certified capabilities to ALL trading partners * Infrastructure requirements: <ul style="list-style-type: none"> □ Real-time: 20-seconds AND batch turn around requirements □ System availability: 96% □ Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL □ Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement □ Standard Companion Guide Format and flow 	X	X
	Enhanced 1	<ul style="list-style-type: none"> * "Basic Level", plus, additional Infrastructure requirements: <ul style="list-style-type: none"> □ Patient identification rules □ Standard error codes □ Normalizing names □ Connectivity: Must offer two existing envelope standards using CORE approved specifications, e.g. allows for direct connect, PHR transfers 	

Note:
 *There are over 30 entities already CORE Phase I certified
 *As of July 2008, Phase II rules have been approved by CORE membership and ratified by CAQH Board; Phase III rule writing will begin Fall 2008.
 * CORE-certification is for health plans, vendors, clearinghouses and large providers

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Phase I → Phase II → (and Beyond): Key Principles

- Set practical milestones to achieve within reasonable timeframes in order to maximize adoption
 - Conduct thorough research and apply lessons learned along the way
- CORE rules are a floor and not a ceiling
- CORE Phases evolve with Phase I as the foundation
- Create and apply operating rules to all transactions, starting with eligibility
- Not a standard setting body; use existing standards
- CORE will not be involved in trading partner relationships, and will not dictate relationships between trading partners
- Vendor (and payload) agnostic
- Coordinate with other key industry bodies in order to promote interoperability
 - Don't reinvent the wheel; try to minimize overlap

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CORE Phase II Rules Overview

Policies

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

Rules

*270/271 Eligibility

- Data content-related rules
 - Patient responsibility - remaining amount of deductible
 - Support additional service type codes
- Infrastructure-related rules
 - *Connectivity rule
 - Patient identification rules

276/277 Claims Status

- *Application of Phase I infrastructure rules to claims status
 - Real-time response time, batch response time, system availability, connectivity

*Building on Phase I rules.

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of Tennessee

plans for better health, plans for a better life.™

About Us

- Not for profit organization; State's leader in health care financing.
 - Flagship network includes > 150 hospitals, 19,100 physicians, and 2,100 pharmacies
- Including Medicare operations, provides services to nearly 5 million people nationwide (3 million in Tennessee)
- Provides benefits to over 17,500 companies

BCBST Perspective: CORE Participation/Certification

- CAQH member / Participate in all Work Groups (i.e., Policy, Rules, Technical)
- Phase I certified and committed to Phase II certification by Q1 2010
- BlueExchange eligibility transactions (home/host) – 378,000 per month
- Blue CORE system eligibility transactions – 65,000 per month
 - CORE is helping to grow real time eligibility transactions
 - actively working with future CORE submitters to achieve goal of over 4 million eligibility transactions per year
- Technology continues to play an ever increasing role in transforming the health care system. By working with CAQH, BlueCross BlueShield of Tennessee is supporting a coordinated, all-payer e-health strategy which can help to enhance efficiency, reduce costs and produce meaningful benefits to not only member and network providers, but all stakeholders in the health care system.

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270/271 Data Content: Phase I → Phase II

- **PHASE I** : CORE participants agree delivering consistent, detailed information is the goal, but not one achievable through a one-time, all or nothing approach



- ▶ CORE sets out to establish agreed upon practical milestones to achieve desired results within a realistic timeframe (maximize adoption)

- e.g., Phase I Data Content Rule requires the return of static patient financial information (base contract deductible), but not remaining deductible. CORE stakeholders agreed that returning remaining deductible too large a step for some entities in Phase I given all the other CORE requirements.



- ▶ CORE rules are a floor, not a ceiling; e.g., some CORE certified entities delivered remaining deductible amounts in Phase I

- **PHASE II** : Builds on Phase I Data Content Rule and requires the return of patient accumulators (i.e., remaining deductible) as well as requiring entities to support explicit inquires for additional service type codes above and beyond what was prescribed in Phase I

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Phase I Foundation: 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)

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Phase I Foundation: 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

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Phase II: 270/271 Data Content Rule

Goal: Build and expand on Phase I eligibility content

- Requires health plan to support explicit 270 eligibility inquiry for **additional 39** service type codes*
- Response must include all patient financial liability (except for the 8 discretionary service types)
 - Base contract deductible
 - Remaining deductible
 - Co-pay
 - Co-insurance
 - In/out of network amounts if different
 - Related dates
- * See appendix

EXAMPLES OF SERVICE TYPE CODES
2 Surgical
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
12 Durable Medical Equipment Purchase
13 Ambulatory Surgical Center Facility
18 Durable Medical Equipment Rental
20 Second Surgical Opinion
40 Oral Surgery
42 Home Health Care
49 Hospice
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
62 MRI/CT Scan
65 Medication Care
68 Well Baby Care
71 Diagnostic Medical
75 Dialysis
76 Chemotherapy
85 Immunizations
87 Routine Physical
82 Family Planning
89 Podiatry
99 Professional (Physician) Visit - Inpatient
A0 Professional (Physician) Visit - Outpatient
A3 Professional (Physician) Visit - Home
*A6 Psychotherapy
*A7 Psychiatric - Inpatient
*A8 Psychiatric - Outpatient
A9 Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
AH Substance Abuse
BS Cardiac Rehabilitation
86 Pediatric

*Indicates examples of discretionary service types

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

- Requires 271 response to generic 270 inquiry to include
 - Remaining deductible for Phase I required service types
 - 33 – Chiropractic
 - 48 – Hospital Inpatient
 - 50 – Hospital Outpatient
 - 86 – Emergency Services
 - 98 – Professional Physician Office Visit
- Recommended use of 3 codes for coverage time period for health plan
 - 22 – Service Year (a 365-day contractual period)
 - 23 – Calendar year (January 1 through December 31 of same year)
 - 25 – Contract (duration of patient's specific coverage)
- Co-pay, co-insurance and base/remaining deductibles **discretionary** for
 - Phase I continuation
 - 1 – Medical Care
 - 35 – Dental Care
 - 88 – Pharmacy
 - AL – Vision (optometry)
 - Phase II
 - 4 codes related to mental health and substance abuse (A6, A7, A8, A9)

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CORE Transactions: Phase I → Phase II

- CORE participants agree to the eligibility (270/271) transaction as a starting point in Phase I as it is the first step in the provider-patient interaction. CORE participants recognize the need to create rules for additional transactions if the administration of healthcare is to be truly impacted.



► **Create and apply operating rules to all transactions, starting with eligibility**

- **PHASE I**: CORE participants agree upon operating rules in Phase I for the 270/271 eligibility transaction with the goal of applying the same process to other transactions in future Phases
- **PHASE II**: CORE participants, in keeping with the achievable milestone principle, apply Phase I infrastructure rules (i.e., system availability, connectivity, acknowledgements, response time, companion guide) to the claim status (276/277) transaction
 - CORE participants overwhelming have expressed the desire to address 276/277 data content in Phase III



► **CORE Phases evolve with Phase I as foundation**

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Phase II: Claims Status Transaction Rule

Goal: Apply CORE rule writing and implementation process to transactions beyond 270/271 to improve and increase use of those transactions

- Aligned with CORE's goal to apply operating rules beyond 270/271
- Entities must provide claims status under the CORE Phase I infrastructure requirements, e.g.,
 - Offer real-time response
 - 20 seconds or less
 - Meet CORE batch response requirements (if batch offered)
 - Receipt by 9pm ET requires response by 7am ET next business day
 - Meet CORE system availability requirements
 - 86% availability (calendar week)
 - Use of CORE-compliant acknowledgements
 - Specifies when to use TA1 and 997
 - Offer a CORE-compliant Connectivity option
 - Support HTTPS 1.1
 - Provide a CORE-compliant Companion Guide flow and format
 - Developed jointly with WEDI

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Phase II: 270/271 Patient Identification Rules

- Two Patient ID Surveys funded by California Health Care Foundation led to business justification for developing rules that enhance patient matching and provide better information on why a match did not occur:
 - Last Name Normalization Rule
 - Use of AAA Error Reporting Codes Rule



► Conduct thorough research and apply lessons learned along the way

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Phase II: 270/271 Patient Identification Rules (cont'd)

- Normalizing Patient Last Name
 - Goal:** Reduce errors related to patient name matching due to use of special characters and name prefixes/suffixes
 - Recommends approaches for submitters to capture and store name suffix and prefix so that it can be stored separately or parsed from the last name
 - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
 - Remove specified suffix and prefix character strings
 - Remove special characters and punctuation
 - If normalized name validated, return 271 with CORE-required content
 - If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
 - If normalized name not validated, return specified AAA code
 - Recommends that health plans use a no-more-restrictive name validation logic in downstream HIPAA transactions than what is used for the 270/271 transactions

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Phase II: 270/271 Patient Identification Rules (cont'd)

- Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names in 271 response
 - Goal:** Provide consistent and specific patient identification error reporting on the 271 so that appropriate follow-up action can be taken to obtain and re-send correct information
 - Requires health plans to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements in order to communicate the specific errors to the submitter
 - Designed to work with any search and match criteria or logic
 - The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid

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Questions for BlueCross BlueShield of Tennessee?

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The SSI Group, Inc.

About Us

- 270 Million Total/ 20 Million Eligibility Transactions Annually
 - Representing over \$300 Billion in Healthcare Transactions Each Year
- 800+ Individual Payers, 540 Direct Payer Connections
- First organization to become CORE-certified

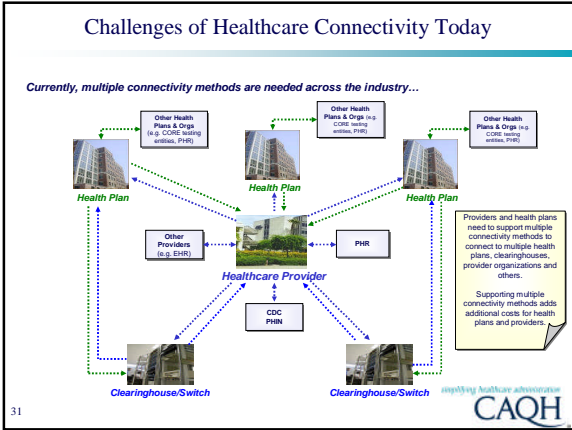
SSI Perspective: CORE Participation/Certification

- SSI is a vendor and a clearinghouse
- SSI works with both providers and payers and therefore sees the challenges faced by all stakeholders
- Inconsistent eligibility content/format across payers creates difficulties for vendors and clearinghouses in offering provider-friendly solutions
- CORE rules will help to drive innovation in "all-payer" eligibility solutions
- Need to create national, industry-wide best practices that promote interoperability
 - CORE Phase II Connectivity Rule is helping to lead this charge

CORE Connectivity

It's not all about the content

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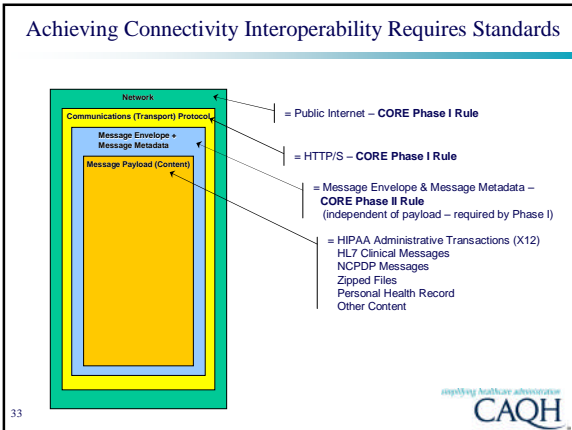
What Happens Without Operating Rules?

→ Access and Implementation Is Costly and Challenging

Entity	Message Envelope <small>(envelopes vary and implementations of same envelope standard varies)</small>	Authentication
Health plan A	WS (SOAP + WSDL schema I)	WS-Security
Clearinghouse A	HTTP POST: name/value pair	User/password
Clearinghouse B	HTTP POST	User/password
Clearinghouse C	HTTP POST with MIME	User/password encoded in MIME
Clearinghouse D	WS (SOAP+WSDL schema II)	User/password basic authentication
RHIO A	WS(SOAP+WSDL schema III)	Digital signature with X.509 certificate
RHIO B	MIME	User/password encoded in MIME

Note: Small sampling, range in variation is great

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CORE Connectivity: Phase I → Phase II

- CORE participants agree supporting multiple connectivity methods for administrative electronic transactions adds costs for health plans and providers
 - **PHASE I**: CORE participants decide CORE Phase I Connectivity Rule will support HTTP/S 1.1 over the public internet for eligibility transactions. This a high-level first step toward connectivity interoperability with the understanding that more detailed requirements would be outlined in later Phases.

CORE Principle

- ▶ **Not a standard setting body; use existing standards**

- **PHASE II**: With the understanding in Phase I that a more definitive connectivity rule is required in order to facilitate interoperability, CORE participants specify requirements for envelope standards and submitter authentication methods.

CORE Principle

- ▶ **CORE will not be involved in trading partner relationships, and will not dictate relationships between trading partners**
 - CORE Connectivity Rule does not require trading partners to remove existing connections that do not match the CORE Connectivity rule
 - CORE Connectivity Rule does not require CORE-certified entities use the CORE connectivity rule for all new connections

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CORE Connectivity



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Phase I Foundation: Connectivity Rule Components

- CORE-certified entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transactions
 - Rule creates "safe-harbor" – a method of connectivity supported by all CORE-certified entities
- Real-time requests
- Batch requests, submissions and response pickup
- Security and authentication data requirements
- Response time, time out parameters and re-transmission
- Response message options & error notification

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CORE Phase I Connectivity: Lessons Learned

- Industry has many connectivity approaches (proprietary and non-proprietary) with large installed bases
- Stakeholders are ready to come together and build consensus on connectivity methods for interoperability
- CORE Phase I is a step in the right direction – from proprietary and/or private networks, to public Internet (HTTP/S)
- While having a uniform transport standard is an important first step, many variations exist within CORE Phase I compliant implementations - interoperability requires a more definitive rule

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CORE Phase II Decision: Definitive Connectivity Rule

Goal: Create more definitive rule to reduce variation in implementations

Key Rationale*

- As expected, variations existed in Phase I Connectivity Rule Implementation
- Creating a more definitive rule will facilitate connectivity standardization, and can be applied equally across the healthcare information exchange, such as clinical transport messaging
- **CORE Principles**
 - ▶ Payload agnostic
 - ▶ Vendor agnostic
- A definitive rule will assist in accelerating industry interoperability
- A definitive rule will help create momentum toward a connectivity foundation for the industry

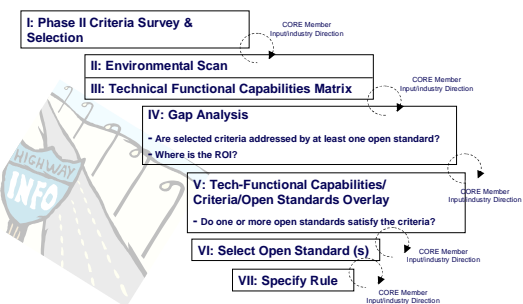
Methodology

- Make decisions based on criteria, open standards, environmental scan, member inputs and CORE goal to gain implementation

* Not a comprehensive list

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CORE Phase II Connectivity Rule: Roadmap Overview



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CORE Phase II Connectivity Rule Overview

- Open Standards
 - Message Envelope
 - SOAP 1.2 + WSDL + MTOM
 - HTTP + MIME Multipart
 - Submitter Authentication
 - Username/Password (WS-Security Username Token)
 - X.509 Certificate over SSL
- Envelope Metadata
 - Field names (e.g., SenderID, ReceiverID)
 - Field syntax (value-sets, length restrictions)
 - Semantics (suggested use)
 - Outside the payload to facilitate interoperability and reduce costs
- Error Handling, Auditing

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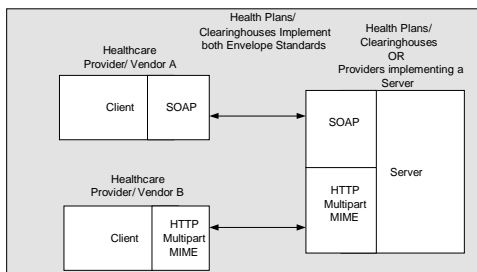
Phase II Connectivity: Rationale for Two Envelope Standards

- Decision on supporting two message envelope standards
 - SOAP+WSDL
 - Well aligned with HITSP and HL7
 - Lends itself to future rule development using Web-services standards for more advanced requirements (e.g., reliability)
 - HTTP MIME Multipart
 - Relatively simple and well understood protocol framework
 - CORE-certified entities have already implemented HTTP as part of Phase I
 - Incremental “phased” approach:
 - Facilitates adoption in a market that is still maturing
 - Facilitates interoperability relative to the current state of envelope standard variability in the marketplace

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Phase II Connectivity: Envelope Conformance



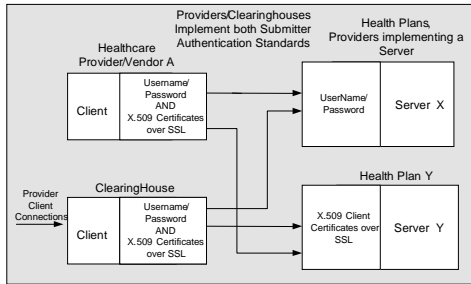
¹ Health Plans, Health Plan Vendors, Clearinghouses or Providers implementing a server must support^{*} both envelope standards.
² Providers and Provider Vendors acting as a client need only support one of the envelope standards.

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Note: Standards are paired with a metadata list; * refer to Rule for detail



Phase II Connectivity: Submitter Authentication



³ Providers, Provider Vendors or Clearinghouses acting as a client must support⁴ both submitter authentication standards.

⁴Health Plans, Health Plan Vendors or Providers implementing a server need only support one submitter authentication standard.

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* Refer to Rule for definition



Phase II Connectivity: Metadata Will be Outside the Payload

Concept applied in Phase I, and confirmed again in Phase II

Rationale:

- Facilitates connectivity standardization as well as administrative and clinical integration
- Accelerates industry interoperability
- Entities are able to do auditing and authentication without parsing payload/bring payload into their system
- Payload agnostic
 - Allows CORE's connectivity rules to evolve to future phases independent of payload standard evolution; in other CORE rules, e.g. Data Content, adoption of payloads are promoted for content, e.g. 270/271
 - Supports approach of other national initiatives⁰

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Questions for The SSI Group, Inc.?

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Phase III and Beyond ...




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CORE Coordination: National

CORE Principle → Coordinate with other key industry bodies in order to promote interoperability

- Health Information Technology Standards Panel (HITSP)
 - Consumer Empowerment Interoperability Specification 03 (IS03) recognized by HHS Sec. Leavitt in January 2008
 - Includes CORE Phase I Data Content Rule
 - Medication Management IS07 under Panel Review
 - Includes complete CORE Phase I Rule set
 - CORE Phase II Connectivity Rule under consideration for Health Plan Transport interoperability specification
- Certification Commission for Health Information Technology (CCHIT)
 - CORE Phase I Data Content Rule included in 2008 Ambulatory Certification Criteria




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CORE Coordination: State/Regional

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

<p>Colorado Commission report delivered to state legislature in February 2008 stated the cost savings for healthcare administrative simplification. CAQH presented CORE to government and private stakeholders in March. Legislation (SB 135) established a work group to review and recommend healthcare technology and tools.</p>	<p>Ohio Recent legislation called for the formation of an advisory committee to present recommendations on issues related to electronic information exchange, including eligibility. CORE was noted in draft legislation and CAQH was invited to present at the advisory committee's July and September meetings, and WellPoint spoke at its August meeting.</p>
<p>Texas Texas Department of Insurance had CAQH present CORE in response to state legislation (HB 522) that focuses on administrative simplification and mentions CORE. CORE has presented three times, most recently on 10/15/08.</p>	<p>Virginia Secretary of Technology reviewing how technology can reduce the state's healthcare costs; CAQH presented CORE three times, most recently to a statewide Committee in April.</p>

(Note: Minnesota did pass state-specific eligibility rules in Dec. 2007, however, they are complementary to CORE Phase I data content requirements)



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5010 Implications for CORE

- CORE supports adoption of 5010
- CORE supports the NCVHS recommendation on timing (3 yr development and testing roll out)
 - Refer to NCVHS letter to HHS Secretary Leavitt dated September 26, 2007
 - Link to letter: <http://ncvhs.hhs.gov/070926lt.pdf>
- In terms of alignment with 5010, CORE updates will be minimal
 - CORE has included much of the 5010 eligibility content and related requirements in its Phase I and Phase II rules. **As a result, CORE-certified entities should be farther ahead toward 5010 adoption than many others in the industry.**
- CORE supports a public/private collaboration and voluntary approach to continue the process of moving the industry forward in a timely manner

Note: CORE conducted a detailed review of 5010 to identify potential CORE rule adjustments. CAQH submitted public comments on 10/21/08. These comments are available on the CAQH website.

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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

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Top Five Phase III Rule Areas From Multi-voting*

Category	Rule Area	% of Total Votes
Expand Current	Build out data content for claims status	13%
New Transaction	Build out data content for 835 ERA	10%
Other	Require implementation of WEDI ID Card Guide	9%
Expand Current	270/271 – Develop rules related to provider network identification	7%
Expand Policies	Require trading partners to be CORE-certified	7%

NOTE: 18 other topics were reviewed, none receiving more than 5% support

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*Informal voting poll conducted at CAQH Administrative Conference

Phase III Timing Options From Multi-Voting*



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?

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*Informal voting poll conducted at CAQH Administrative Conference



Phase III Next Steps

October/November

- 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/December (after 5010 and ICD-10 comments are submitted)

- Final selection
 - Led by CORE Steering Committee

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“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 chairman of the board and chairman and CEO of **Aetna**

Questions?

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Implementation: Phase I – Certified Entities/Products

Clearinghouses

- ACS EDI Gateway, Inc. / ACS EDI Gateway, Inc. Eligibility Engine
- Availity, LLC / Availity Health Information Network
- Emdson Business Services / Emdson Real-Time Exchange
- Emdson Business Services / Emdson Batch Verification
- Health Management Systems, Inc. / HMS
- MedAvant Healthcare Solutions / Phoenix Processing System
- MedData / MedConnect
- NavMedix, Inc. / NavNet
- Passport Health Communications / OneSource
- RelayHealth / Real Time Eligibility
- RxHub / PRN
- Siemens Medical Solutions / Healthcare Data Exchange
- The SSI Group, Inc. / ClickON9 E-Verify

Health Plans

- Aetna Inc.
- AulicCare
- 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
- CSC Consulting, Inc./CSC DirectConnectsm
- Emerging Health Information Technology, LLC / TREKS
- GE Healthcare / EDI Eligibility 270/271
- HTP, Inc. / RevRunner
- Medical Informatics Engineering, Inc. (MIE) / WebChart EMR *
- NoMoreClipboard.com
- Post-N-Track / Doochiekey™ Web Services
- The SSI Group, Inc. / ClickON9 Net Eligibility
- VisionShare, Inc. / Secure Exchange Software

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



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Implementation: Phase I – Endorsers

Endorsement

- Accenture
- American Academy of Family Physicians (AAFP)
- American Association of Preferred Provider Organizations (AAPPO)
- American College of Physicians (ACP)
- American Health Information Management Association (AHIMA)
- American Medical Association (AMA)
- California Regional Health Information Organization
- Claredi, an Ingenix Division
- eHifica, Inc.
- eHealth Initiative
- Electronic Healthcare Network Accreditation Commission (EHNAC)
- Enclarity, Inc.
- Foresight Corporation
- Greater New York Hospital Association and Linxus
- Healthcare Financial Management Association (HFMA)
- Healthcare Information and Management Systems Society (HIMSS)
- Medical Group Management Association (MGMA)
- 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)



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270/271 Data Content Rule Service Type Codes

Expanded Subset of Service Type Codes for Phase II (X12 270/271 Code and Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Return patient financial responsibility information (basic co-pay and co-insurance information and Remaining deductible amount)?
1 Medical Care	Y	Y (Phase II)	Discretionary
2 Surgical		Y	Mandatory
4 Diagnostic X-Ray		Y	Mandatory
5 Diagnostic Lab		Y	Mandatory
6 Radiation Therapy		Y	Mandatory
7 Anesthesia		Y	Mandatory
8 Surgical Assistance		Y	Mandatory
12 Durable Medical Equipment Purchase		Y	Mandatory
13 Ambulatory Service Center Facility		Y	Mandatory
18 Durable Medical Equipment Rental		Y	Mandatory
20 Second Surgical Opinion		Y	Mandatory
30 Health Benefit Plan Coverage	Y		Mandatory
33 Chiropractic	Y	Y (Phase II)	Mandatory
35 Dental Care	Y	Y (Phase II)	Discretionary
40 Oral Surgery		Y	Mandatory
42 Home Health Care		Y	Mandatory
45 Hospice		Y	Mandatory
46 Hospital - Inpatient	Y	Y (Phase II)	Mandatory
50 Hospital - Outpatient	Y	Y (Phase II)	Mandatory
51 Hospital - Emergency Accident		Y	Mandatory
52 Hospital - Emergency Medical		Y	Mandatory
53 Hospital - Ambulatory Surgical		Y	Mandatory

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62 MRICAT Scan		Y	Mandatory
65 Newborn Care		Y	Mandatory
68 Well Baby Care		Y	Mandatory
73 Diagnostic Medical		Y	Mandatory
76 Dialysis		Y	Mandatory
78 Chemotherapy		Y	Mandatory
80 Immunizations		Y	Mandatory
81 Routine Physical		Y	Mandatory
82 Family Planning		Y	Mandatory
86 Emergency Services	Y	Y (Phase II)	Mandatory
86 Pharmacy	Y	Y (Phase II)	Discretionary
93 Podiatry		Y	Mandatory
99 Professional (Physician) Visit - Office	Y	Y (Phase II)	Mandatory
99 Professional (Physician) Visit - Inpatient		Y	Mandatory
A0 Professional (Physician) Visit - Outpatient		Y	Mandatory
A3 Professional (Physician) Visit - Home		Y	Mandatory
A6 Psychotherapy		Y	Discretionary
A7 Psychiatric - Inpatient		Y	Discretionary
A8 Psychiatric - Outpatient		Y	Discretionary
AD Occupational Therapy		Y	Mandatory
AE Physical Medicine		Y	Mandatory
AF Speech Therapy		Y	Mandatory
AG Skilled Nursing Care		Y	Mandatory
AI Substance Abuse		Y	Discretionary
AL Vision (Otometry)	Y	Y (Phase II)	Discretionary
BG Cardiac Rehabilitation		Y	Mandatory
BH Pediatric		Y	Mandatory

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