CAQH/WEDI Audiocast Education Session
Tuesday, November 10, 2009
2:00 pm –3:30 pm ET

Enabling Point-of-Care Decision Making: The Value of CORE Rules for Ancillary Health Services Providers

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Discussion Topics

- Introduction to CAQH
- CORE Overview
  - Operating rules
  - CORE Participation, Certification, and Endorsement
  - Focus on Interoperability
    - Connectivity
  - History of CORE Rules around Service Type Codes
- BCBSNC Perspective
- Spectrum Laboratory Network Perspective
- CORE Coordination with National and State Initiatives
- Questions

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CAQH: Focused on Administrative Simplification

- 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
- Current Initiatives:
  - 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

UPD® – Universal Provider Datasource (over 765,000 providers)
CORE® – Committee on Operating Rules for Information Exchange

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CAQH Success Factors

- Focus on critical challenges
  - CAQH initiatives are targeting several priority issues for the industry
  - Identify areas of differentiation which have no competitive advantage
- Inclusive approach
  - Cross-industry and public-private collaboration
- Create meaningful impact
  - CAQH initiatives are concrete, national, well-vetted solutions that are working in the marketplace today
  - Action can be taken immediately
  - Impact can be tracked across a wide group of entities
- Support from providers and other stakeholders
  - CAQH has built the trust of the provider community around administrative simplification
  - States, government groups, and others also engaged
- Experience
  - Lessons learned though development and implementation

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CORE Overview

- CORE is a multi-stakeholder collaboration of more than 100 participating organizations developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
  - Participants include health plans, providers, vendors, government agencies, associations, regional entities, standard-setting organizations and other healthcare entities
  - Encourages interoperable administrative data exchange (i.e., transmission standards and formats, security, response timing standards, etc)
  - Enables providers to submit transactions from the system of their choice and quickly receive a standardized response
  - CAQH study by IBM Global Business Services shows that industry-wide implementation of the CORE Phase I rules could yield $3 billion in savings in three years
  - Facilitates administrative and clinical data integration

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CORE Overview (cont.)

- CORE certification informs the industry that entities are operating in accordance with the rules
- The CORE rules are developed in a phased approach
  - Maximizes voluntary industry adoption of the rules
  - Enables stakeholders to implement CORE phases as their systems allow
  - Phase I and Phase II rules are finalized
  - Phase III rules are currently being developed
- CORE Phase I/II rules are incorporated in HITSP (Healthcare Information Technology Standards Panel) Interoperability Specifications
  - Administrative Transport to Health Plan
  - Patient Health Plan Eligibility Verification
- CORE is not:
  - Replicating work done by standard-setting bodies, e.g. X12, HL7
  - Building a database

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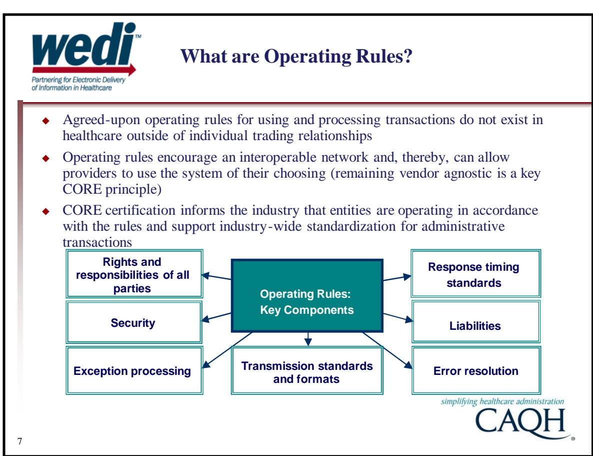
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Partnering for Electronic Delivery of Information in Healthcare
What are Operating Rules?
Agreed-upon operating rules for using and processing transactions do not exist in healthcare outside of individual trading relationships
Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing (remaining vendor agnostic is a key CORE principle)
CORE certification informs the industry that entities are operating in accordance with the rules and support industry-wide standardization for administrative transactions
Rights and responsibilities of all parties
Security
Exception processing
Operating Rules: Key Components
Transmission standards and formats
Response timing standards
Liabilities
Error resolution
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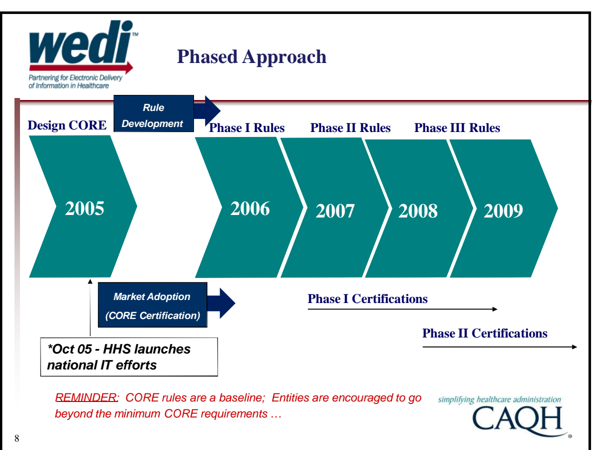
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Partnering for Electronic Delivery of Information in Healthcare
Phased Approach
Design CORE
Rule Development
Phase I Rules
Phase II Rules
Phase III Rules
2005
2006
2007
2008
2009
Market Adoption (CORE Certification)
Phase I Certifications
Phase II Certifications
*Oct 05 - HHS launches national IT efforts
REMINDER: CORE rules are a baseline; Entities are encouraged to go beyond the minimum CORE requirements …
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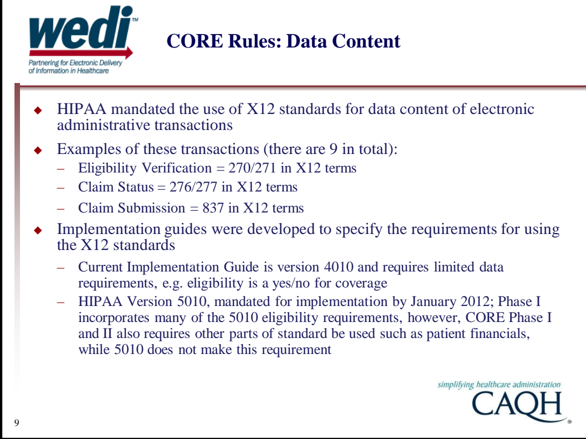
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Partnering for Electronic Delivery of Information in Healthcare
CORE Rules: Data Content
HIPAA mandated the use of X12 standards for data content of electronic administrative transactions
Examples of these transactions (there are 9 in total):
– Eligibility Verification = 270/271 in X12 terms
– Claim Status = 276/277 in X12 terms
– Claim Submission = 837 in X12 terms
Implementation guides were developed to specify the requirements for using the X12 standards
– Current Implementation Guide is version 4010 and requires limited data requirements, e.g. eligibility is a yes/no for coverage
– HIPAA Version 5010, mandated for implementation by January 2012; Phase I incorporates many of the 5010 eligibility requirements, however, CORE Phase I and II also requires other parts of standard be used such as patient financials, while 5010 does not make this requirement
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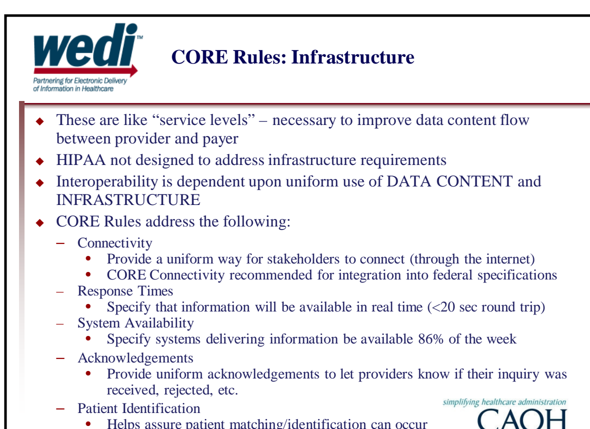
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CORE Rules: Infrastructure
These are like "service levels" – necessary to improve data content flow between provider and payer
HIPAA not designed to address infrastructure requirements
Interoperability is dependent upon uniform use of DATA CONTENT and INFRASTRUCTURE
CORE Rules address the following:
Connectivity
Provide a uniform way for stakeholders to connect (through the internet)
CORE Connectivity recommended for integration into federal specifications
Response Times
Specify that information will be available in real time (<20 sec round trip)
System Availability
Specify systems delivering information be available 86% of the week
Acknowledgements
Provide uniform acknowledgements to let providers know if their inquiry was received, rejected, etc.
Patient Identification
Helps assure patient matching/identification can occur
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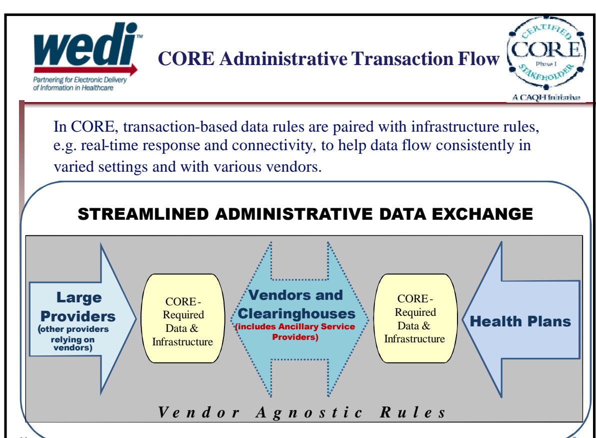
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Partnering for Electronic Delivery of Information in Healthcare
CORE Administrative Transaction Flow
In CORE, transaction-based data rules are paired with infrastructure rules, e.g. real-time response and connectivity, to help data flow consistently in varied settings and with various vendors.
STREAMLINED ADMINISTRATIVE DATA EXCHANGE
Large Providers
(other providers relying on vendors)
CORE-Required Data & Infrastructure
Vendors and Clearinghouses
(includes Ancillary Service Providers)
CORE-Required Data & Infrastructure
Health Plans
Vendor Agnostic Rules
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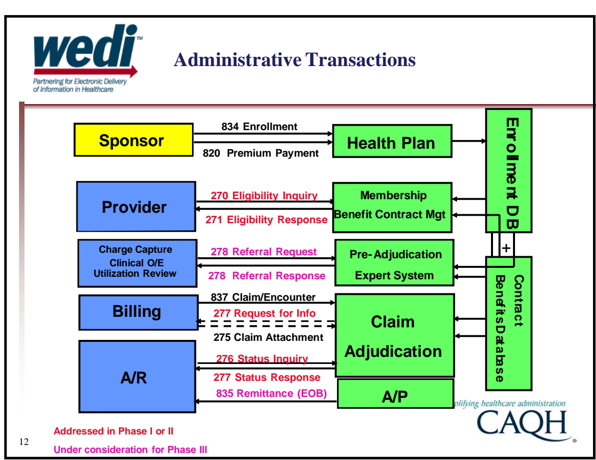
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Partnering for Electronic Delivery of Information in Healthcare
Administrative Transactions
Sponsor
834 Enrollment
820 Premium Payment
Health Plan
Provider
270 Eligibility Inquiry
271 Eligibility Response
Membership
Benefit Contract Mgt
Charge Capture
Clinical O/E
Utilization Review
278 Referral Request
278 Referral Response
Pre-Adjudication
Expert System
Billing
837 Claim/Encounter
277 Request for Info
275 Claim Attachment
Claim
Adjudication
A/R
276 Status Inquiry
277 Status Response
835 Remittance (EOB)
A/P
Enrollment DB
Contract
Benefits Database
CAQH
Addressed in Phase I or II
Under consideration for Phase III
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CORE Phases

CORE Phase I ✓ Approved ✓ Implemented	CORE's first set of rules are helping: • Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information • Provide access to this information in real-time via common internet protocols and with acknowledgements, etc.
CORE Phase II ✓ Approved ✓ Implemented	CORE's second set of rules expand on Phase I to include: • Patient accumulators (remaining deductible) • Rules to help improve patient matching • Claim status "infrastructure" requirements (e.g., response time) • More prescriptive connectivity requirements with submitter authentication
CORE Phase III ✓ In Development	CORE's third set of rules focus on: • Allowing providers to have real-time access to claims status (276/277) • Delivering real-time initiation of authorization requests for providers (278) • Giving providers real-time acknowledgement of receipt of payments (835) • Giving real-time verification of claim acceptance or rejection to providers (837) • Providing a common set of human readable data elements for ID Cards • Detailing more prescriptive connectivity requirements as well as digital authentication

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General Interoperability Challenges

Challenges	How do CAQH Initiatives Address?
Market is fragmented	Create trusted partnerships – Private-private, Public-private – Build on best practices and standards
Coordination	Do not reinvent the wheel – Build upon, learn from and coordinate with what exists – Every entity still needs to meet its own strategic plan and meet regulations
Leadership	Identify leaders who will participate in identifying change and then implement the agreed-upon change
Magnitude of what needs to be done – no "magic bullet"	Plan for making BIG change, BUT implement in reasonable milestones that add value – Recognize that entities have limited resources, and are managing many IT priorities, e.g. 5010, ICD-10
Proof of Concept - ROI	Outline the ROI and/or benefits to each stakeholder, and get their help in communicating the benefits to their stakeholder community – BCBSNC has seen over a 200% increase in its real-time eligibility transactions since becoming CORE certified

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CORE Participation, Certification and Endorsement

Complete list found at: http://www.caqh.org/pdf/COREcerts.pdf

- Participation
  - Over 100 organizations representing all aspects of the industry
    - 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
- Certification
  - To date, more than 40 healthcare organizations are certified to electronically exchange/receive basic eligibility and benefits information in accordance with the CORE Phase I rules
    - Approximately one-third of all commercially insured lives are covered by CORE Phase I-certified health plans
  - Most Phase I certified organizations are committed to becoming Phase II-certified by no later than the end of Q1-2010
    - Three organizations are already Phase II certified
- Endorsement
  - About 30 organizations are endorsing CORE
  - Endorsement is an option for entities that do not use, create, or transmit eligibility, benefits and/or claim status data

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The Importance of Connectivity to Interoperability

- Administrative data exchange components include both data content and infrastructure
- Connectivity is an essential part of infrastructure that must be addressed to enable interoperability of the data
  - The CORE connectivity rule reflects market standards and will be enhanced in future phases as the market evolves
- For end-to-end interoperability, trading partners involved in the administrative data exchange should be operating with the same requirements and must have compatible connectivity
- The CORE connectivity rule facilitates the goal of clinical and administrative data integration

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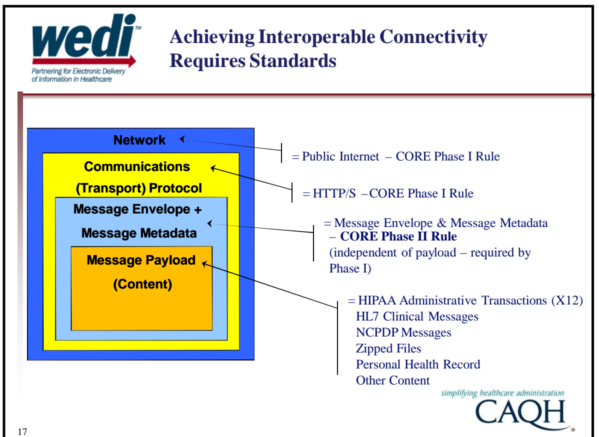
Achieving Interoperable Connectivity Requires Standards



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CORE Phase II Connectivity Rule Overview

- Open Standards
  - Message Envelope Requirements Support Two Standards
    - SOAP 1.2 + WSDL + MTOM
    - Recommends two standards: HTTP + MIME Multipart
  - Submitter Authentication
    - Username/Password (WS-Security Username Token)
    - X.509 Certificate over SSL (two-way SSL)
- Envelope Metadata
  - Field names (e.g., SenderID, ReceiverID)
  - Field syntax (value-sets, length restrictions)
  - Semantics (suggested use)
- Error Handling, Auditing

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Phase II: Connectivity Background and Rationale

- Developed using consensus-based approach among industry stakeholders and is designed to:
  - Facilitate interoperability relative to the current state of variability in the marketplace
  - Improve utilization of transactions
  - Enhance efficiency and help lower the cost of information exchange in healthcare
  - Serve as an incremental "stepped" approach to streamline operations in a market that is still maturing
- Provides a "safe harbor"
  - Assured to be supported by any CORE-certified trading partner
  - However, other methods can be used if trading partners support these methods
- Rule *does not*:
  - Require trading partners to remove existing connections that do not match the rule

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CORE Eligibility and Benefits Rules: Service Type Codes

- Phase I Eligibility and Benefits Data Content (270/271) rule require
  - 271 response to include explicit coverage and static patient financial for the generic code 30 – Health Benefit Plan Coverage - plus 9 additional Service Type codes such as Hospital Inpatient
    - Patient financials: co-pay, co-insurance, base deductibles, in/out of network variations
- Phase II Data Content extended and enhanced in Phase I requirements
  - 271 response to include *YTD remaining deductible* amounts for 9 Phase I required Service Type codes, plus patient financial responsibility (including YTD remaining deductible) and coverage status (active/inactive) reporting for an additional 39 Service Type codes
    - Patient financial responsibility for both in-network and out-of-network delivered
    - 39 Service Type codes include services such as: Diagnostic Lab, Diagnostic X-ray, Immunizations, Newborn Care, etc.
- Top priority for Phase III consideration is to expand the list of Service Type codes for which patient financial responsibility reporting is required

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Using CORE Rules to Increase Electronic Transaction Volumes

An independent licensee of the Blue Cross and Blue Shield Association

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About BCBSNC

- 3.7 Million Members
- 4,794 Employees
- 35,000 Network Providers
  - 30,000 use online services
- 34 Million claims processed per year
  - 100,000 per day
- 27,000 telephone calls per day
- 18.5 Million electronic eligibility inquiries per year
  - 75% Internet based

- **Our Opportunity**
  - **Grow administrative transaction capabilities (beyond eligibility)**

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Gaps in Eligibility/Benefits Verification Prior to CORE Phase I Certification

- System availability was below CORE Phase I requirement of 86% per week
- 270/271 existed only as a batch transaction with a 15 - minute average response time
- Data elements for CORE Phase I compliant 271 response were not captured and returned in current eligibility transactions
- IS resources were dedicated to competing projects internal to BCBSNC

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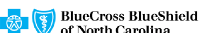
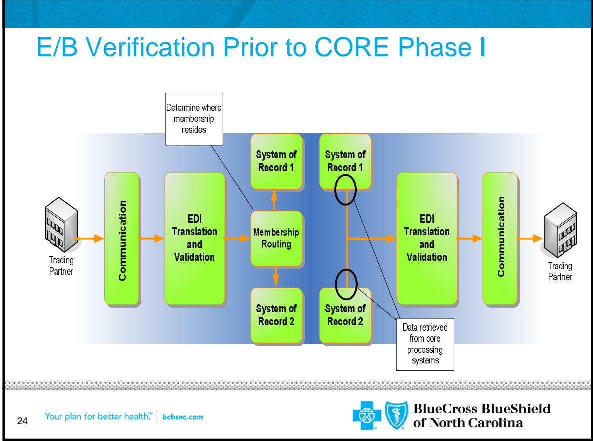


E/B Verification Prior to CORE Phase I



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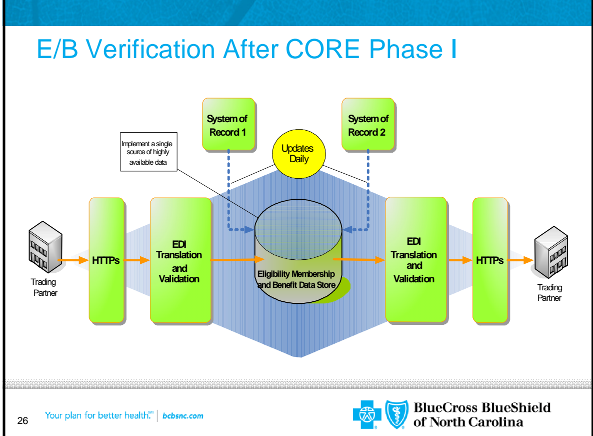
CORE Phase I Certification Plan

- To ensure CORE Phase I rule requirements could be met:
  - BCBSNC combined resources for BCBSA mandated 2007 eligibility requirements project (EEI3) and CAQH
  - Designed and developed a Data mart ("Oneview") to support 86% system availability of eligibility data
  - Developed solutions to extract full eligibility data load and nightly data loads from back end source systems
  - Internal web services were developed to extract data from the Data-mart
  - Developed a real-time SOAP (Simple Object Access Protocol) connectivity which allows higher degree of interoperability and the ability to leverage across multiple business functions. SOAP is an open standard developed by World Wide Web Consortium
- Production changes implemented April 2007
- Certification received June 2007

E/B Verification After CORE Phase I



Phase I Lessons Learned

- BCBSNC implemented SOAP/HTTP/s instead of a more simplistic HTTP/s approach
  - Worked with the CORE-authorized testing vendor to decouple the transport mechanism (HTTP/S) from the Phase I rule data content validation to support BCBSNC's selected method of connectivity with vendor
- Integration of CORE master test bed data into backend system is complex and requires extensive resources and knowledge of backend system
  - Involved benefits configuration and back end resources to support EDI analyst knowledge to support testing

Measures of Success

April 2007	April 2008	April 2009
• 82,230 270 to BCBSNC – 19.5% Blue Exchange Real-time – 80.5% Batch	• 322,205 270 to BCBSNC – 38% Blue Exchange Real-time – 52% Local Real-time – 10% Batch	• 619,634 270 to BCBSNC – 10% Blue Exchange Real-time – 76% Local Real-time – 14% Batch

- Increase in transaction activity (Interplan and Local)
- Majority swing to real-time data transactions
- Provider recognition of CORE Certification process and practice management implications

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Approach to Phase II Certification

- Gap Analysis and Planning
  - Midway through Phase II analysis lifecycle for 2010
    - Connectivity specification is very well defined (introduced SOAP with Phase I)
    - Accomplished some of the Phase II required work (for accumulator values) in our Phase I approach
  - Prefer to use open standards which allow for easier integration of adaptive appliances to support provider-facing applications, i.e. eligibility tracking

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Support for Ancillary Services

- Ancillary Health Services
  - Spectrum came online thru Local Real-time in September 2009
  - Phase II requires explicit coverage and patient liability responses for Service Type 5 – Diagnostic Lab Services

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About Spectrum Laboratory Network

- Mission: to create a centralized clinical reference laboratory serving its constituent health care systems and Spectrum's clients in a multi-state area
- Provides hospital quality, exceptional customer service, and nationally recognized web-based order entry and delivery of results technology
- Full-service regional medical laboratory headquartered in Greensboro, NC
- Today, Spectrum covers the Southeast providing laboratory services to over
  - 7,000 physicians
  - Hospitals, nursing homes, home health, clinics, urgent care facilities, business and industries, etc.

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Need for Consistent Electronic Eligibility Transactions

- Simplify Ancillary Provider Administrative Workflow
- Problem: Lab engagement is up to the discretion of the physician and/or patient
  - 25% of all orders come directly from a Client draw with no interaction/verification
  - 20% of all orders come over on paper
  - If the Patient is sent to or chooses a draw station the Physician forwards an e-script or paper order to authorize the draw
    - only POS patient interface
    - only opportunity to verify patient information in person
- Solution: eligibility verification at POS, prior to the draw
  - Allows verification of eligibility prior to taking the sample
  - Moves eligibility to POS where interaction with Patient/Subscriber can clarify eligibility
  - Allows for alternate payment arrangements when eligibility fails
  - Future: will allow for upfront collection of co-pay for lab services

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Earning the CORE Seal

- Phase I certification was a transition and a learning process for Spectrum
- CORE Certification introduced IT shop to Web Service
- The Gap Analysis was short
- Spectrum used existing resources
- Spectrum worked closely with Edifecs
- Recommend experienced resources be assigned to projects of this scope

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CORE Phase I Implementation

- Allows Spectrum to enhance services that:
  - Verify eligibility for orders submitted *prior* to billing
  - Increase volume of electronic eligibility
    - Service Type 30 –explicit 270 in production now
    - Service Type 5 – explicit 270 in test mode (Phase II)
  - Deliver efficiencies that enhance revenue potential and reduce exposure to bad debt

CERTIFIED CORE PROVIDER
A CAQH Initiative

- Provides new technical capabilities that improve access to upstream data
  - Consistent connectivity and interfacing with plans and vendors
  - Eligibility and patient liability information will be more accessible via CPOE

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Value of CORE Certification

- Enhances Spectrum's ability to do business directly with more plans, i.e. BCBSNC, connect more readily to CPOE vendors, and streamline draw-site administration
- Has increased our choice of vendors and other contacts
- Will enhance the variety of ordering and reporting options tailored to meet the specific needs of Spectrum clients
  - Currently interfacing with 150+ EMR/PMS vendors
- Reduces time identifying connectivity methods and simplify mapping

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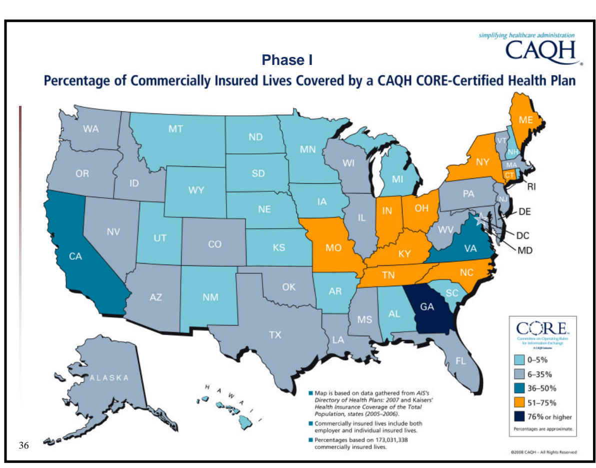

CORE's Impact: Assessing Phase I Results

- Study Approach
  - IBM assessed results achieved by health plan early adopters (representing 33 million covered lives) of CORE Phase I Rules and selected vendor and provider partners
  - Determined ROI by analyzing metrics (e.g., eligibility verification methods and volume) achieved by health plans, provider groups and HIT vendors three months prior to health plan CORE certification and one year later
- Key Findings
  - All stakeholders achieved cost-savings and accelerated use of "real-time" transactions
  - Health I.T. adoption accelerates and ROI increases when there are interoperable solutions that benefit both providers and health plans
  - An industry-wide implementation of CORE Phase I rules would be a win-win scenario for providers and health plans that could yield an estimated $3 billion of savings to the industry over three years
  - Go to www.caqh.org for detail

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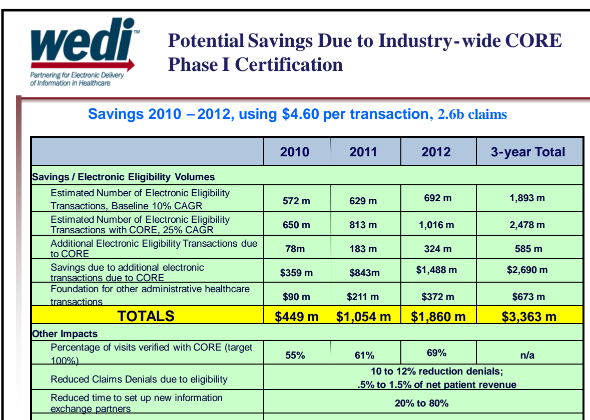

Potential Savings Due to Industry-wide CORE Phase I Certification

Savings 2010 – 2012, using $4.60 per transaction, 2.6b claims

	2010	2011	2012	3-year Total
Savings / Electronic Eligibility Volumes				
Estimated Number of Electronic Eligibility Transactions, Baseline 10% CAGR	572 m	629 m	692 m	1,893 m
Estimated Number of Electronic Eligibility Transactions with CORE, 25% CAGR	650 m	813 m	1,016 m	2,478 m
Additional Electronic Eligibility Transactions due to CORE	78m	183 m	324 m	585 m
Savings due to additional electronic transactions due to CORE	$359 m	$843m	$1,488 m	$2,690 m
Foundation for other administrative healthcare transactions	$90 m	$211 m	$372 m	$673 m
TOTALS	**$449 m**	**$1,054 m**	**$1,860 m**	**$3,363 m**
Other Impacts				
Percentage of visits verified with CORE (target 100%)	55%	61%	69%	n/a
Reduced Claims Denials due to eligibility	10 to 12% reduction denials; .5% to 1.5% of net patient revenue			
Reduced time to set up new information exchange partners	20% to 80%			
Reduced connectivity costs	t.b.d.			

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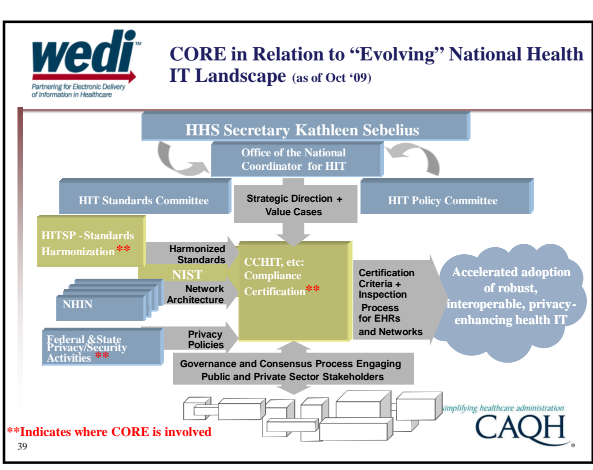

National HIT Efforts

- Focus on clinical and administrative efficiencies – e.g., reduce costs, modernize processes, improve quality, promote interoperability
- Federally-funded incentives to improve healthcare quality efforts coming from various Federal organizations
  - Medicare and Medicaid are applying efforts to streamline HIT, such as MITA – Medicaid Information Technology Architecture
  - Incentives (through direct reimbursement) for EHR utilization and tech support and training provided to Regional Extension Centers (RECs)
  - Health Information Exchanges (HIEs) are playing an increasingly important role due to funding availability, e.g., CareSpark, Indiana Health Information Exchange (IHIE), New England Healthcare EDI Network (NEHEN)
- Multi-stakeholder committees at the state-wide level have been charged with outlining and recommending legislative options – e.g. TX, OH, and CO have recommended CORE

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CAQH Relevance to Meaningful Use and HIEs

- The American Recovery and Reinvestment Act (ARRA) and its provision, the Health Information Technology for Economic and Clinical Health Act (HITECH), are offering Federally-funded incentives to enable public-private initiatives to develop HIT solutions that facilitate movement of administrative and clinical information and improve existing quality programs
- "Meaningful Use" is in the process of being more clearly defined, but currently extends beyond the clinical use of EHRs
  - A 2011 objective is for providers to check eligibility electronically with public and private payers, where possible
  - Corresponding 2011 measures look at the percentage of these transactions that are performed electronically
- HIE planning can integrate CAQH efforts: CAQH is developing toolkits to assist state/regional efforts in addressing Federal requirements
  - CORE rules offer HIEs tools to satisfy Federal meaningful use requirements for administrative functionality and provide building blocks for additional functionality
  - Medicaid collaboration key to HIEs; CORE is well-aligned with

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