



Voluntary & Mandatory Operating Rule Interdependency: Industry Perspective on Transition to a New Operating Rule Environment

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Discussion Topics

- Level Setting
 - Today's data exchange environment
 - Operating rules, standards, and health reform/PPACA
 - Moving from voluntary to mandated environment
- Overview
 - CAQH and CORE
- Perspectives
 - Health Plan Currently CORE-certified
 - AultCare
 - Vendor's Role
 - RelayHealth
 - Health Plan Working Toward CORE Certification
 - United Healthcare

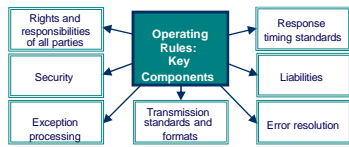
Today's Data Exchange Environment

- Beginning with the mandated specifications of HIPAA and the expansion and extension of those provisions through the Patient Protection and Affordable Care Act (ACA), there is significant pressure on organizations to achieve internal business strategies, as well as meet industry-wide and legislative requirements
 - While improving infrastructure and lowering costs
 - Within the limitations of resource constraints
- Meaningful change must acknowledge these imperatives while aligning with the broader healthcare environment, e.g., HITECH, state initiatives, and clinical/administrative data integration
- Replication of effort should be avoided in all stages of operating rule development and standards coordination, from development to implementation
 - Resources must be aligned to take greatest advantage of industry expertise and vision

What are Operating Rules?

- As defined in the [Patient Protection and Affordable Care Act \(ACA\)](#), the term refers to "...the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications...."
- 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*)
- Prior to CORE, operating rules did not exist in healthcare outside of individual trading relationships



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Operating Rules and Standards

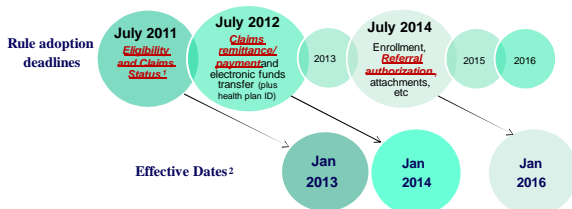
- Standards establish expectations and outline the detailed format of a transaction
- Focusing on business imperatives, operating rules build on the standards and more precisely describe the roles and responsibilities of each stakeholder
 - Operating rules also address gaps to deliver transactional value
 - Rules help refine the infrastructure that supports data exchange
- Operating rules and standards are both essential:
 - Co-exist and work together; operating rules should always support standards
 - Require different resources and skills set
 - Support different missions and objectives
 - Benefits of operating rules co-existing and complementing standards is evidenced in other industries
 - Various sectors of banking (e.g., credit cards & financial institutions)
 - Different modes of transportation (e.g., highway & railroad systems)

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PPACA Section 1104: Mandated Operating Rule Approach

Operating rule writing and mandated implementation as addressed by ACA Section 1104



Notes: (1) Red italicized font indicates that CORE Phases I-III has placed a focus on these areas. Scope/definition of the Federal regulation is TBD but NCVHS has recommended CORE Phase I and II, with enhancements (2) Documentation of compliance will be identified by Federal regulation and is to include completion of end-to-end testing (i.e., certification and testing).

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Industry Adaptation to a Mandated Environment

- Five years of CORE voluntary effort to create and adopt operating rules may be leveraged as industry moves toward a mandated environment
 - CAQH CORE recommended (09/2010) by NCVHS as authoring entity for eligibility and claim status transaction operating rules (non-retail pharmacy)
 - CORE Phase I and Phase II recommended as the initial rule set
- To support a mandated environment, aspects of CORE will need to be adapted, and additional resources secured to advance the effort
 - Leadership and infrastructure
 - Governance and organization structure
 - Expand number/type of participants
 - Financial re-structuring to support an unfunded mandate
 - Reassess voting process
 - Future scope, content and development of rules
 - Education and outreach

CORE[®]

Committee on Operating Rules
for Information Exchange
A CAQH Initiative

An Introduction to CAQH and CORE

- 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:
 - CORE[®] – Committee on Operating Rules for Information Exchange
 - UPD[®] – Universal Provider Datasource

Committee on Operating Rules for Information Exchange

- CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
- Mission: To build consensus among healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers
 - Enable providers to submit transactions from the system of their choice (*vendor agnostic*) 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
- Vision: Provider access to administrative information before or at the time of service, using electronic system of their choice, for any patient or health plan
- CORE is not:
 - Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7
 - Developing software or building a database

CORE Goals

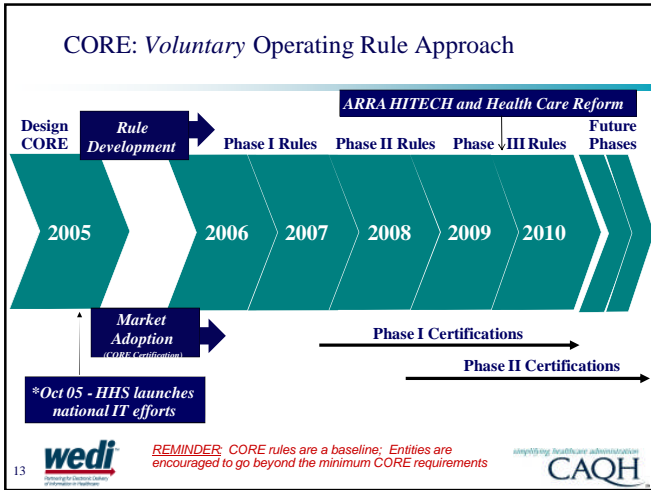
- Facilitate provider access to administrative information before or at the time of service, *using the electronic system of their choice, for any patient or health plan*



Note: See [NCVHS Testimony](#) for changes to CORE that will need to occur due to move from voluntary to mandated process

CORE Operating Rule Phases

- CORE Phases are designed around a set of transaction business content rules coupled with infrastructure rules
 - Rules complement each other
 - Phases allow milestones to be established that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption
- Transactions to which data content and/or infrastructure rules apply
 - Eligibility (270/271)
 - Claim Status (276/277)
 - *Payment/Remittance (835)
 - *Authorizations (278)
 - *Health ID Cards
 - (*Part of draft Phase III rules)
- Infrastructure rules applied to transactions (Real Time and Batch)
 - Connectivity (i.e., communications protocol, security)
 - Acknowledgements
 - Response Time
 - System Availability
 - Companion Guide (flow and format)
 - AAA Error Code Reporting and Last Name Normalization

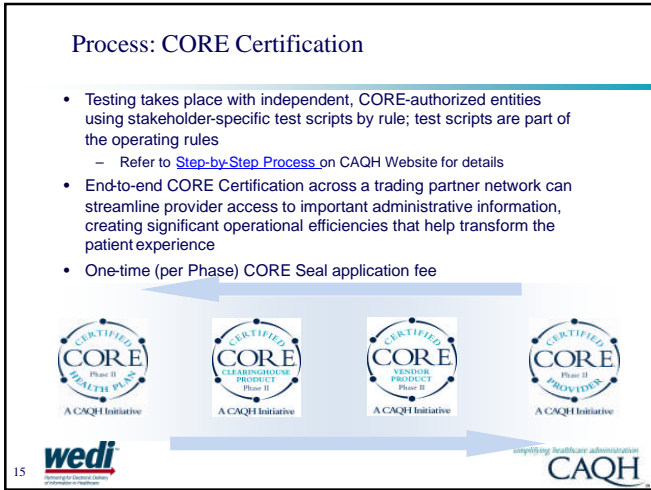


Status: CORE Phases

CORE Phase I ✓ Approved ✓ Implemented	CORE's first set of rules are helping: <ul style="list-style-type: none"> • Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information • Provide timely and consistent access to this information in real-time via common internet protocols (i.e., infrastructure rules)
CORE Phase II ✓ Approved ✓ Implemented	CORE's second set of rules expand on Phase I to include: <ul style="list-style-type: none"> • Patient accumulators (remaining deductible) • Rules to help improve patient matching • Claim status transaction "infrastructure" requirements (e.g., claim status response time) • More prescriptive connectivity requirements with digital certificates and submitter authentication
CORE Phase III ✓ In development	CORE's third set of rules focus on: <ul style="list-style-type: none"> • Claim status data content requirements (276/277) • Claim Payment/Advice (835), Prior Authorization/Referral (278) infrastructure requirements • Acknowledgements for v5010 (837) Health Care Claims • Standard Health Benefit/Insurance ID Card • More prescriptive connectivity requirements • More eligibility financials

wedi www.wedi.com **CAQH** certifying health care administration

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CORE: Five Years of Experience and Lessons Learned

- Milestone driven approach
 - Establishes a feasible road-map focused on value proposition
 - Federal mandated efforts are iterative, paralleling CORE phased approach
- Multi-stakeholder, consensus-based and transparent process
 - Clear guiding principles; anti-trust provisions
 - Consensus reached through discussion, surveying, straw polls, and transparent voting process
 - Documentation available to all CORE participants using a shared access tool
 - 115+ participating organizations, covering all segments of the industry
 - Includes SDOs, government, health plans, providers, vendors, etc. Health plans represent approximately 75% of the commercially insured
 - Recognizes interdependencies within individual organizations and across all stakeholders
 - Certified and committed entities represent 55% of the commercially insured

CORE: Five Years of Experience and Lessons Learned (cont'd)

- Has resulted in tangible outcomes in a compressed timeframe
 - Tracking of ROI (based on CORE Phase I rules)
 - 10-12% reduction in provider claim denials
 - Average savings of nearly \$3.00 per patient eligibility verification phone call
 - Estimated cost savings of \$3 billion over three years
- Education and outreach vital
 - Awareness building, e.g. webinars, newsletters, provider association distribution
 - Demonstration projects, e.g. connectivity at HIMSS IHE, VeriSign pilot in MA
 - Trading partner tools
 - Coordination and recognition through alignment with state and Federal efforts:
 - Federal: MITA and NHIN
 - States: Colorado, Ohio, Texas, Virginia; Minnesota, Washington
- Budget and resource considerations
 - Expertise and time provided by representatives of participating organizations
 - Full-time staff supplemented by contracted experts
 - Commitment/involvement of senior executive leadership

AultCare:
CORE - Certification *Complete*
(Health Plan Example)

AultCare



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AultCare: Overview

- Began in 1985 in Ohio and rooted as a community-focused healthcare provider
 - Vertically-integrated health delivery system with Aultman Hospital
 - Growth from 4,000 members in 1985 to more than 500,000 covered individuals.
 - 95% retention rate of clients!!
 - More than 2,200 companies trust AultCare for their employees' health coverage
 - NCQA and URAC accredited
 - Ranked Top Plan in Ohio by NCQA's "Health Insurance Plan Rankings-2010-2011-Private"
- Combined Recognition
 - In 2005, Aultman Hospital and AultCare were the first combined hospital and health plan in the nation to be recognized by J.D. Power & Associates for providing both hospital patients and health plan members with an outstanding patient and member experience

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AultCare: Overview (cont'd)

- Transaction Activity (CORE-certified)
 - Monthly Activity ~100,000
 - Daily ~3000
 - Growing
- Higher volume transactions
 - Claims
 - 90% Electronic (80% native, 10% optical character recognition)
 - Payment
 - 40% EFT & ERA, ~ 70 providers
- Limited volume transactions; expected to grow over time and with adoption of mandated rules
 - Enrollment
 - Eligibility Inquiry
 - Claim Status Inquiry
- User Profile
 - 20 active users (i.e., provider groups, clearinghouses)

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AultCare: CORE Involvement

- Details
 - CAQH member
 - CORE participant since planning and inception
 - CORE Phase II - certified health plan
 - Phase I Certified March 28, 2007
 - Phase II Certified February 17, 2010
 - Part of Phase I CORE Measures of Success Study
- Rationale
 - Achieving CORE Phase II certification means providers working with AultCare have access to consistent and robust electronic administrative data, such as eligibility, benefits, and patient financial information not required by HIPAA
 - The Phase II rules enables improved access to claims status via CORE infrastructure rules
 - Value add for a vertically-integrated health system; as both an insurer and a provider, CORE rules can serve as localized internal guidelines while remaining aligned with national directions (e.g., protocols for connecting to NHIN for which CORE connectivity rule is aligned)
 - Expecting increasing adoption of electronic transactions as a result of certification

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AultCare: CORE Considerations

- Build or Buy System?
 - Understand your core competencies
 - Know your data
- CORE Certification Helps to Position for Future Growth
 - NCVHS / ACA : Voluntary to Mandated Environment
 - Expecting volumes to increase
 - Drives administrative cost down
- Portal Transition
 - In the process of switching from one system to another; CORE certification has set the bar high for new system
 - 250 active users
 - Increase automation
 - Provide security

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AultCare: CORE Experience

- Local Uptake Drives Industry-wide Adoption
 - A publicity campaign and provider communication increased awareness
 - Vendors/clearinghouses becoming certified and participating in CORE because users are asking for it
 - MSO (management service organization) –helps drive provider adoption
- Active Provider Advisory Group
 - Technically Savvy
 - Multi-disciplinary
 - Relentless; helping to drive electronic adoption (e.g., 835)

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AultCare: CORE Certification

- CORE Implementation and Testing Experience
 - Having been involved with CORE since inception along with major trading partners, systems were designed and maintained with anticipation of CORE rule requirements
 - As a result of pre-planning, the gap analysis when seeking CORE certification revealed minimal adjustments; cost to implement CORE on the lower end of health plan implementation spectrum
 - RULES PROMOTE ADOPTION
- Role of Vendor
 - In the current voluntary operating rule environment
 - Played pivotal role in CORE-centric system development
 - Active WEDI Member – contributes to industry discussion and stays on top of industry developments
 - Anticipated for the forthcoming mandated environment
 - Remain a vital part of information exchange “ecosystem” in delivering robust information from health plans to providers in a timely and consistent manner
 - Continued active role in contributing to rule development

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RelayHealth/McKesson: CORE – Certification (Provider Vendor Example)

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McKesson Overview

- 177 year old company, founded in 1833 by John McKesson and Charles Olcott to sell therapeutic drugs
- Ranked 14th on FORTUNE 500 list with \$106.6 billion annual revenue
- Employs 32,000 people worldwide
- Two business categories:
 - [Distribution solutions](#). McKesson is the largest pharmaceutical distributor in North America, distributing one-third of the medicines used every day to more than 40,000 U.S. pharmacy locations
 - [Technology solutions](#). McKesson systems automate, streamline and simplify the business of healthcare
- Has the largest customer base in the healthcare industry, including:
 - 200,000 physicians
 - 10,000 long-term care sites
 - 5,000 hospitals
 - 600 health care payors
 - 750 homecare agencies

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McKesson Technology Solutions: RelayHealth Enabling Better Health Through Connectivity



RelayHealth: CORE Involvement

- Details
 - Active CORE Participant; co-chair Eligibility Subgroup, Rules Work Group
 - Phase II Certified Clearinghouse:
 - Payor Connectivity Services
 - Phase II Certification In Process (already Phase I certified Vendor Products)
 - RelayClearance EDI (aka Real Time Eligibility)
 - RelayClearance Plus (aka RevRunner)
- Rationale
 - Deliver cost savings benefits for two sides of our market – providers and health plans
 - Extension of our role as a trusted connectivity partner to health plans



RelayHealth: CORE Experience

- CORE Certification “Lessons Learned”
 - Get the right people on the bus – need a mix of product management, business, development and EDI SME’s
 - Align internal and external teams early – RelayHealth and AultCare went through Phase I certification simultaneously and were able to coordinate transaction testing
 - Take the time to understand testing criteria in detail, especially test file submission formats
 - Don’t schedule over a holiday!
 - We finished our work over Christmas holidays which added unneeded complexity



United Healthcare: CORE - Certification *In Process* (Health Plan Example)

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United Healthcare: Overview

- National health plan serving ~37M members across three health benefit units
 - United Healthcare Employer & Individual; ~25M members
 - United Healthcare Medicare & Retirement (includes Medicare Advantage); 1 in 5 Medicare beneficiaries
 - United Healthcare Community & State; working with states, municipalities and other government agencies to serve those Americans in greatest need
- Service Volume
 - 2009 transaction volume thru Ingenix averaged 6.6 million real time eligibility and claim status inquiries per month
 - 2009 volume thru B2B (non-Ingenux) averaged 8.25 million transactions per month for both transaction types combined

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United Healthcare: CORE Involvement

- Details
 - CAQH Member
 - Current CAQH Board Chair: David S. Wichmann, Executive VP, UnitedHealth Group and President, UnitedHealth Group Operations
 - Active CORE participant; co-chaired Phase III Health ID Card Subgroup through a subsidiary (OptumHealth Financial)
 - Currently engaged in CORE Phase I/Phase II 5010 implementation, testing, and certification
- Rationale
 - Use position as a market leader to help drive administrative simplification; keep the industry moving towards a better electronic delivery mechanism
 - Create efficiencies for both provider and payer (e.g., reduce time spent on the phone)

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United Healthcare: Lessons Learned To-Date

- CORE Implementation and Experience: Project Planning
 - Pre-Planning
 - Initially, a small team of people focused on understanding CORE rules (I/II)
 - Determined segments of business to engage in order to achieve Enterprise certification; enlisted business and IT sponsors from impacted areas
 - Conducted sessions to identify our Enterprise requirements
 - Conducted cost/benefit analysis of the project, and achieved senior mgmt support
 - Gap Analysis
 - Based on Enterprise requirement analysis, each business segment/operating platform used the Enterprise requirements to understand the work required from their area
 - Output was a more detailed set of segment-specific business requirements
 - System Development
 - Engaged solutions architecture group to begin alternatives analysis; completed design and reached out to vendors to assess their CORE compliance
 - Arranged to use Ingenix to meet connectivity rule requirements, and engaged them in planning efforts
 - Understanding testing process
 - Registered on the CORE authorized testing vendors website and arranged for a high level demo

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United Healthcare: Lessons Learned To-Date (cont'd)

- Role of Vendors
 - Inventoried the vendors who play a part in the transmission of UHC transactions, to ensure their alignment with rules and to understand their role in UHC certification
 - Because UHC is segmented it made the most sense for Ingenix, who has connections to the various segments, to be used for meeting CORE connectivity rule requirements
 - This was the optimal solution and allowed us to develop the CORE connectivity once and re-use it for the different business segments
- IT management
 - CORE certification is being done concurrently with the v5010 development as a lot of the same pieces of code needed to be touched for both projects
 - A centralized PMO (project management organization) has been formed to manage risk, issues, budget and timeline related to both efforts
 - Weekly meetings with Edifecs and CORE have been established as start of testing approaches

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United Healthcare: Lessons Learned To-Date (cont'd)

- CORE Rule Specifics
 - Some challenges
 - Last name normalization rule (Phase II) due to large membership
 - Timing; competing industry regulations (transition to v5010) reconciling the changes in search functionality between HIPAA v4010, v5010, CORE rules and MN state specific rules is resource intensive
 - Implementation also challenged by the fact that the gateway (i.e., Ingenix) is obtaining CORE certification at the same time
- Perspective on Transition to Mandated Operating Rules
 - Operating rules and standards have worked in a complementary fashion in other industries prior to CAQH CORE introducing the concept to healthcare
 - Continue to be a market leader in educating the industry, maintaining momentum of adoption and working with our trading partners
 - Review the v5010 CORE rules posted on the CAQH website and consult CORE FAQ's, contact CAQH staff if questions arise

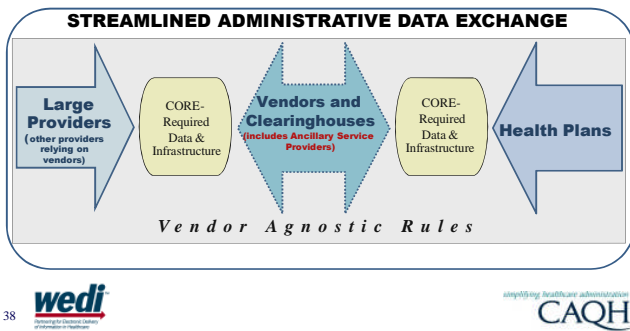
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Evolving Healthcare Ecosystem: “It takes a village....”

Streamlined Administrative Data Exchange


In CORE, pairing infrastructure with transaction-based rules helps data flow consistently in varied settings with various stakeholders



Why Trading Partners Are Critical

- Completes the “information exchange loop”
- Enables real-time and consistent batch turnaround
- Significantly reduces need for customized solutions
- Streamlines exchange between health plans and providers
- Positions alignment with other Federal efforts, e.g. HITECH
- Builds trusting relationships – and encourages ideas on administrative/clinical alignment, e.g. connectivity

Section 1104: *Current Milestones of Eligibility & Claim Status*

	Status
<p>July 2010: NCVHS Hearings on Qualified Nonprofit Entities for Mandated Operating Rule Development</p>	<ul style="list-style-type: none"> Two non-profit candidates recommended by NCVHS to fill rule development role: <ol style="list-style-type: none"> CAQH CORE for non-pharmacy National Council for Prescription Drug Programs (NCPDP) for pharmacy
<p>Sept. 30, 2010: NCVHS Recommendation to HHS on Qualified Nonprofit Entities and Rules</p>	<ul style="list-style-type: none"> CORE Phase I and II rules recommended by NCVHS as base for 1st rule set; CORE working with industry to determine what else could be added in short timeframe, e.g. state requirements, draft CORE Phase III rules
<p>Dec. 3, 2010: Update to NCVHS CORE Phase I and II enhancements (draft CORE Phase III and state rules)</p>	<ul style="list-style-type: none"> Expectation that key goals expressed at hearings will move forward, e.g. <ul style="list-style-type: none"> Voting on operating rules must continue to be transparent and multi-stakeholder Desire of providers to have shared governance of operating rule entity This remains an unfunded mandate, and an "adjusted" CAQH CORE would need to transition over a period of time Mandated rules are one part of process
<p>Early 2011: Draft rules issued by CMS for comment (Note: final rules need to be approved by July 2011)</p>	

Q & A

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