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**HIPAA Covered Entities and
Their Adoption of Operating Rules
An Implementation Perspective**

*Thursday, December 8, 2011
2:00 pm to 3:30 pm ET*

<p>Robert Bowman CORE Manager CAQH</p>	<p>Richard Farmer Director, Transactions Content Passport Health Communications</p>	<p>Susan L. Langford EDI Industry Initiatives BlueCross BlueShield of Tennessee</p>
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Session Topics

- ~ Introductions
- ~ Administrative Simplification: Affordable Care Act (ACA) Section 1104
- ~ Overview of CAQH CORE Operating Rules
 - . Operating Rules Support Standards
 - . CAQH CORE Operating Rules Development
- ~ Implementation Perspectives
 - . Trading Partner Perspectives
 - . From a Clearinghouse . Passport Health Communications
 - . From a Health Plan . BlueCross BlueShield of Tennessee
- ~ Voluntary CORE Certification
- ~ Key Resources

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Today's Learning Objectives

Attendees will be able to:

- ~ Describe the importance of Section 1104 of the ACA and the role of industry operating rules in simplifying and streamlining administrative requirements for all healthcare stakeholders
- ~ Summarize the CAQH CORE Operating Rules for Eligibility for a Health Plan, Healthcare Claim Status, Electronic Funds Transfer (EFT) and Remittance Advice (ERA) transactions
- ~ Identify the various types of stakeholders and describe how specific CAQH CORE Operating Rules apply to their organization depending upon their role in the exchange of administrative data
- ~ Learn about a structured method for scoping their operating rules implementation effort including key cost/benefit metrics

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Committee on Operating Rules for Information Exchange

- CAQH CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
 - . Integrated model: Rule writing, certification and testing and outreach/education
- 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 CAQH CORE Operating Rules in phases
 - . Facilitate stakeholder commitment to and compliance with CAQH CORE long-term vision
 - . Facilitate administrative and clinical data integration
- CAQH CORE is not:
 - . Replicating the work being done by standard-setting bodies, e.g., ASC X12, HL7, OASIS, W3C
 - . Developing software or building a database

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Administrative Simplification: Patient Protection and Affordable Care Act (ACA) Section 1104

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Administrative Simplification: ACA Section 1104

Section 1104 of the ACA (H.R.3590)

Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs^[CMS-0032-RFC]*

Highlights


- Updates initial August 2000 HIPAA regulation for transaction standards and code sets given world has significantly changed, and unnecessary healthcare costs/burden must be removed from the system
- Requires the Department of Health and Human Services (HHS) to appoint a qualified non-profit entity to develop a set of operating rules for the conduct of electronic administrative healthcare transactions
- Administrative and financial standards and operating rules must, e.g.
 - . Enable the determination of eligibility and financial responsibility for specific services prior to or at the point of care
 - . Be comprehensive, requiring minimal augmentation
 - . Provide for timely acknowledgment, response, and status reporting
- HIPAA covered entities, and business associates engaging in HIPAA standard transactions on behalf of covered entities, must comply
- Health plans must file a statement with HHS confirming compliance; financial penalties for health plans are significant

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* CMS Interim Final Rule (IFR) (CMS-0032-RFC)

CAQH CORE Operating Rules Overview



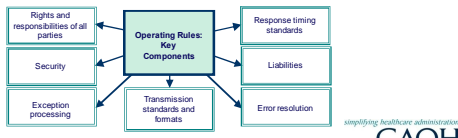
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for Information Exchange


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What Are Operating Rules?

- The [Patient Protection and Affordable Care Act \(ACA\)](#) defines operating rules as "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 address gaps in the standards, help refine the infrastructure that supports data exchange and recognize interdependencies among transactions and the range of standards
- Prior to CAQH CORE, national operating rules for medical transactions did not exist in healthcare outside of individual trading partner relationships
 - Current healthcare operating rules build upon a range of standards, healthcare specific and industry neutral, and support the national HIT agenda
- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing

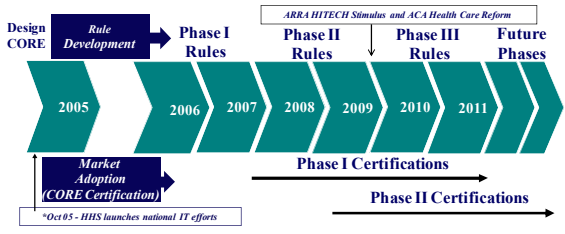



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CAQH CORE Rules Development/Adoption Timeline

- CAQH CORE Phases are designed around a set of transaction-based data content rules coupled with infrastructure rules; the rules complement each other
- Phases establish milestones that encourage feasible progress in resolving industry business needs while minimizing barriers to adoption



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CAQH CORE Operating Rules: Phased Approach

Operating Rules complement each other. The real value is in the package

Driving iterative industry-wide content and assured data flow

Phase I CORE

- ✓ Approved
- ✓ Implemented
- ✓ Voluntary Certification Available

Eligibility Benefit Request and Response

- Confirm patient benefit coverage and co-pay, in/out of network, variances, coinsurance and base deductible information*
- Provide timely and consistent access to this information in real-time (e.g., response times, connectivity, companion guide, Acknowledgements)

Phase II CORE

- ✓ Approved
- ✓ Implemented
- ✓ Voluntary Certification Available

Expanded Eligibility and Health Care Claim Status Response

- More patient financials, e.g., YTD patient accumulators, for more services*
- Rules to help improve patient matching*
- Claim status infrastructure requirements, e.g., response time, Acknowledgements
- More prescriptive connectivity requirements aligned with Office of the National Coordinator (ONC) efforts, e.g., SOAP/WSDL, digital certificates

Phase III CORE

- ✓ Drafted and in voting process

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

- EFT enrollment elements, ERA enrollment elements, CARC/RARC business scenarios with code combinations, re-association timing and infrastructure such as Acknowledgements and connectivity

- ✓ Drafted; initial stage of voting

Expanded Eligibility and Claim Status, Prior Authorization and ID cards

- Additional eligibility and claim status data content requirements*
- Prior Authorization/Referral infrastructure
- 277 Claim Acknowledgement for Health Care Claims (837)*
- Standard Health Benefit/Insurance ID Card
- More prescriptive connectivity requirements

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* Data not required by HIPAA/4010 operating rules support further use of v5010.
NOTE: All CAQH CORE Operating Rules, Policies, and Test Suites are developed and approved by CAQH CORE Participants.



Scope of Phase I and II CAQH CORE Operating Rules

Examples of Topics that Phase I and II CAQH CORE Operating Rules Address:

All are within ACA-defined scope of operating rules and build on standards where appropriate

Data Content: Eligibility	Address Need to Drive Further Industry Value in Transaction Processing	More Robust Eligibility Verification Plus Financials	Enhanced Error Reporting and Patient Identification
	Address Industry Needs for Common/ Accessible Documentation	Companion Guides	System Availability
Infrastructure: Eligibility and Claim Status	Address Industry-wide Goals for Architecture/ Performance/ Connectivity	Response Times	Acknowledgements*
		Connectivity and Security	

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* Please Note: In the Interim Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. Although IHS is not requiring compliance with any operating rules related to acknowledgment, the Interim Final Rule does say we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgment requirements in the CAQH CORE rules we are adopting here.



Eligibility 270/271: Transactional Data Content

Improve Eligibility Verification Plus Financials

CAQH CORE Data Content Rules for v5010 270/271 require that health plans and information sources that create a v5010 271 response to a generic v5010 270 inquiry must include:

- The name of the health plan covering the individual (if available)
- Patient financials for the static financials of co-insurance, co-payment, and deductible, and return the remaining deductible amount, include in-network and out-of-network coverage and financials for 48 required service types (benefits)

For more detail, see CORE Rules 154 and 252.

Enhanced Error Reporting and Patient Identification

CAQH CORE Normalizing Patient Last Name Rule requires health plans to normalize submitted and stored last name before using the submitted and stored last names:

- If normalized name validated, return v5010 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

For more detail, see CORE Rule 258.

CAQH CORE AAA Error reporting Rule 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.

The receiver of the v5010 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.

For more detail, see CORE Rule 252.

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Implementation Perspective: Trading Partner Relationships

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Healthcare Administrative Data Exchange: End-to-End Implementation Perspective

Vendor-Agnostic Operating Rules

- ~ All HIPAA-covered entities involved in the electronic exchange of eligibility or claim status transactions have a role to play in the adoption of CAQH CORE Operating Rules, i.e., providers, health plans, clearinghouses and/or vendors
- ~ When a clearinghouse or vendor is involved in data exchange between the health plan and the provider's eligibility systems, then:
 - Identifying the role and responsibility of each entity from an end-to-end perspective is an important step
 - Each entity will be responsible for their own specific implementation, testing and related resources
 - Joint integration planning between health plan and clearinghouse or provider and vendor/clearinghouse will ensure that conformance requirements and Return on Investment (ROI) goals are met

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Applicability of CAQH CORE Operating Rules

- ~ HIPAA-covered entities work together to exchange transaction data in a variety of ways
- ~ The applicability of a given CAQH CORE Operating Rule will depend upon the nature of the trading relationship between HIPAA-covered entities, e.g.,
 - Provider direct-to-health plan connection
 - ~ Health plan implements all key requirements of the Phase I and Phase II CAQH CORE Operating Rules
 - Single/dual clearinghouse-to-health plan connection
 - ~ Health plan outsources* infrastructure and connectivity functions to a clearinghouse
 - ~ The health plan-facing clearinghouse acts as a proxy for health plan's conformance with the CAQH CORE Operating Rules for the contracted services
 - Provider-to-clearinghouse/vendor connection
 - ~ Provider outsources eligibility and claims status request submission function to a clearinghouse/vendor
 - ~ Provider-facing clearinghouse or vendor solution acts as a proxy for Provider's conformance with CAQH CORE Operating Rules for the contracted services
- ~ Each of the scenarios above and their requirement variations are supported by the CAQH CORE Operating Rules



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* In some cases clearinghouse may offer full outsourcing services for eligibility and benefit verification (and/or claim status) functions, inclusive of data hosting.



Implementation Perspective:
A Clearinghouse View

Richard Farmer
Passport Health Communications

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About Passport Health Communications

- ~ Passport Health Communications Inc. is a Software-as-a-Service company providing software and solutions to help hospitals and health care providers improve business operations and secure payment for their services
- ~ More than 300 million eligibility transactions annually pass through the Passport eCare[®] brand of revenue cycle management solutions and services which is supported by Passport's OneSource EDI platform
- ~ With 15 year history of delivering effective EDI solutions to providers; Passport services providers in all 50 states
 - . One in three U.S. hospitals
 - . 8,000 physician and ancillary offices
 - . 400+ payer eligibility connections

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Passport Health Communications and CAQH CORE

- ~ A CAQH CORE participating organization:
 - . Actively involved in the development of CAQH CORE Operating Rules since 2005
 - . Currently supporting CAQH CORE Certification & Testing Subgroup as Co-chair
- ~ Passport's OneSource is a Phase I and Phase II CORE-certified clearinghouse service
 - . Provider-facing
 - Supports real-time provider eligibility verification services through direct provider connections
 - Submits/Receives v5010 270/271 Eligibility and v5010 276/277 Claim Status transactions on behalf of providers
 - Supports additional data services to providers, e.g., routing, retries, etc., in accordance with contracted provider agreements
 - . Health plan-facing
 - Receives and returns Eligibility v5010 270/271 and Claim Status v5010 276/277 transactions both directly and indirectly with health plans and their clearinghouses in accordance with contracted agreements

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CAQH CORE Operating Rules and the Clearinghouse

- ~ A clearinghouse who conforms with the Phase I and Phase II CAQH CORE Operating Rules:
 - . At a minimum meets key requirements for infrastructure and connectivity, i.e., response time, availability, safe harbor connectivity, acknowledgements and logging
 - . Facilitates the flow of CORE-required data content from end-to-end; both as the receiver of requests and the transmitter of the response
 - . Has prepared companion guides using the CORE Master Template for format and flow, if applicable
 - . May offer additional application services that conform with CAQH CORE Data Content Operating Rules, e.g., normalization of patient last name normalization

Passport Experience: Combining Infrastructure with Data Content

CAQH CORE Operating Rules Address			
Data Content Eligibility	Industry Value in Transaction Processing	More Robust Eligibility Verification Plus Financials	Enhanced Error Reporting and Patient Identification
	Common/ Accessible Documentation	Comparison Guides	System Availability
Infrastructure	Architecture/ Performance/ Connectivity	Response Times	Acknowledge metrics* Connectivity and Security

- ~ Infrastructure operating rule requirements provide a reliable foundation for the electronic exchange of eligibility and claim status transactions between provider, clearinghouse and health plan
- ~ Data content operating rule requirements for an eligibility inquiry and response are delivering more consistent and usable eligibility and patient financial data to providers
- ~ More consistent data combined with up-front business logic is resulting in streamlined eligibility verification capabilities

Passport Experience: CAQH CORE Data Content Rules

- ~ Implementation of CAQH CORE Operating Rules related to data content:
 - . Assures a minimum level of transaction data that should be returned to the provider in the v5010 271 eligibility response
 - ~ A single eligibility request returns more than a Yes/No response; it includes 48 service type codes that must be supported for explicit inquiry and 12 service types for a generic request
 - . Ability to check insurance eligibility verification at the time of registration; obtain uniform responses
 - . Supports pre-admission clearance by allowing provider to focus in on corrective action and minimizes time to resolution
 - . Predetermination of patient financials
 - . Fewer follow-up inquiries to get data
 - . Fewer phone calls to the payer
 - . Improved revenue cycle management

Passport Experience: AAA Error Code Reporting Operating Rule

- ~ Implementation of the CAQH CORE AAA Error Code Reporting Operating Rule
 - . Establishes a standard way for the health plan (or information source) to report error conditions when they are unable to create a v5010271 eligibility transaction for the requested patient or subscriber
 - . Use of the business rule helps to streamline the providers ability to find members with less trial and error
 - ~ Gives provider enough detail to determine which information is missing or incorrect when an eligibility and benefits inquiry does not return a valid match, e.g., generic responses such as *Not found* are limited with this operating rule
 - . Puts necessary information in the hands of the provider to reduce the barriers associated with identifying health plan members
 - . Results in a reduction in providers administrative expense

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Passport Experience: Normalizing a Patient's Last Name Operating Rule

- ~ Implementation of the CAQH CORE Normalizing a Patient's Last Name Rule
 - . Puts into place specific instructions for how a health plan (or information source) normalizes a person's last name during any name validation or matching process by the health plan (or information source); defines how to handle names when searching
 - . Requires payers to normalize when matching
 - . Streamlines the providers ability to find members with less trial and error
 - ~ Prior to implementing an operating rule last name inconsistencies slowed down provider processing, e.g.,
 - . Last name suffix, e.g., Jr., Sr.
 - . Hyphenated last names, e.g. Smith-Jones
 - . Use of apostrophe, e.g., O'Connor, O'Malley
 - . When Normalizing Patient Last Name Rule is applied, a provider eliminates an issues resolution
 - . Providers experience reduced costs

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Lessons Learned


- ~ Our history tells us that...
 - . Servicing the proprietary and one-off needs of our customers was not sustainable
 - . HIPAA ASC X12 transactions provided a structure that supports the variety of ways that payers presented eligibility data to providers
 - . CORE Operating Rules are offering us business logic to build upon the ASC X12 transactions;
 - . Applying business logic, along with infrastructure rules, up front in the form of eligibility operating rules is ensuring that the necessary data content is available to the provider in a very usable and consistent method
 - . Finding health plan members is imperative and data content is the key
- ~ For today's clearinghouses, Phase I and Phase II CAQH CORE Operating Rules reduce the cost of doing business
- ~ Is that really all? EDI data will be even more important in the future
 - . Access to good data is key to long-term cost savings as systems evolve
 - . Given the right data, sophisticated Hospital Information Systems (HIS) and Practice Management Systems (PMS) can do more than you might expect

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**Implementation Perspective:
A Health Plan Viewpoint**


Susan L. Langford
EDI Industry Initiatives

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About BlueCross BlueShield of Tennessee


- “ For more than 65 years, BlueCross BlueShield of Tennessee (BCBST) has been centered on the health and well being of Tennesseans
- “ An independent, not-for-profit, locally governed health plan company and a member of the BlueCross BlueShield Association; located in Chattanooga with more than 5,000 employees
- “ Provide services to 3 million members in Tennessee and across the country, and health benefits to about 16,000 customer companies
- “ BCBST’s flagship provider network includes:
 - . 188 hospitals
 - . 21,919 physicians
 - . 2,265 pharmacies

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BCBST: Involvement with CAQH CORE

- “ A CAQH member organization
- “ A CAQH CORE participant
 - . Actively involved in the development of CAQH CORE Operating Rules through participation in CAQH CORE Rules, Policy and Technical Work Groups
- “ A Phase I and Phase II CORE-certified health plan
 - . Phase I CORE-certified in June 2007; Phase II in May 2010
 - . BlueCore System is currently supporting the electronic exchange of the following CORE-compliant transactions:
 - “ Eligibility and Benefits volumes average over 1 million transactions per month
 - “ Claim Status volumes average over 80,000 transactions per month
- “ Passport Health Communications, a Phase I and Phase II CORE-certified clearinghouse, is one of our top volume submitters of electronic Eligibility/Benefits and Claim Status transactions

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BCBST: Health Plan Trading Relationships

- By working with CAQH CORE and other healthcare industry stakeholders, BCBST is supporting a coordinated, all-payer e-health strategy which can help to enhance efficiency, reduce costs, and produce meaningful benefits to not only members and network providers, but all stakeholders in the healthcare system
- Having implemented all of the key conformance requirements for Phase I and Phase II CAQH CORE Operating Rules, BCBST electronically exchanges eligibility and claim status data directly with each of its trading partners
 - Clearinghouses (non-exclusive arrangement)
 - Billing agents
 - Hospitals/Providers
 - Other health plans

Operating Rules Facilitate Interoperability

- As a CORE-certified health plan, BCBST extends the benefits of CAQH CORE Operating Rules to a network of vendors and providers regardless of CORE certification status by providing:
 - Greater value through the delivery of more robust and consistent data
 - Increased confidence in the accuracy of data content
- BCBST has found that when trading partners adopt CAQH CORE Operating Rules a true end-to-end automated environment can be realized, e.g.,
 - CORE-certified providers do not have to perform internal conversions to non-standard content or formats
 - CORE-certified vendors experience greater standardization and uniform data exchange between CORE-certified trading partners

BCBST Experience: Provider Eligibility Value Statement

- Implementing Phase I and Phase II CAQH CORE Operating Rules accelerates the availability of eligibility and benefit information, which in turn makes front-end real-time eligibility verification possible
- Business benefits realized include:
 - Improvements in revenue cycle management
 - Pre-visit financial clearance
 - Delivery of quick on-line confirmation of patient insurance and benefit coverage directly from the payer
 - Immediate improvement in the number of denied claims and write-offs for uncovered services
 - Enhanced patient services by speeding up patient registration
 - Significant reduction in a provider's accounts receivables
 - Gains in operational efficiencies and administrative savings
 - Reduction in time spent on the phone talking to payers allows the provider/hospital office to focus on more critical administrative tasks
 - Operational cost reduction by eliminating the need for excessive call inquiries
 - True integration with practice management/hospital information systems

BCBST Experience: Achieving Results over Time

Working with entities, that have high volumes of eligibility/benefits and/or claim status phone inquiries, is a primary factor in BCBST's year-over-year growth in electronic data exchange

BlueCore System Transaction Volumes By Year				
	2008	2009	2010	2011
Eligibility & Benefits	600,000	3.8 million	7.6 million	12.6 million
Claim Status			350,000	1 million

Phase I

Phase II

- Continued efforts to facilitate EDI transaction implementation have helped to promote an environment for additional reductions in administrative costs
- To further increase voluntary adoption, BCBST has undertaken an extensive collaboration/outreach effort throughout the provider/hospital community, including onsite visits and statewide presentations
- A mixture of outreach responses have been received with varying results, e.g.
 - Currently testing CORE-compliant EDI transactions
 - Scheduling a meeting to discuss further
 - Pursue after 5010 implementation
 - Not prepared to pursue at this time

Health Plan Implementation: Getting Started

- BlueCross BlueShield of Tennessee approached CAQH CORE Operating Rule implementation in the following way:
 - Engaged senior management
 - Identified areas in organization that could take advantage of the better eligibility and claim status information provided by the CORE-compliant EDI transactions
 - Gained understanding of each of the Phase I and Phase II CORE Operating Rules
 - Conducted a partnership assessment . . . focused on existing trading partner relationships first
 - Contacted trading partners and asked about their readiness to incorporate the Operating Rules into their business processes
 - Conducted a technical assessment and determined readiness
 - Outlined budgeting needs for implementation
- The time to Get Started is NOW

Lessons Learned

- BCBST has learned that it is a challenge to sell the usefulness of EDI adoption
 - It is difficult to prove the value of EDI and the CAQH CORE Operating Rules before customers can see it in action
 - It is an ongoing process finding ways to show our customers how EDI transactions can fit into, and even enhance, their daily business processes
 - BCBST will continue outreach efforts to increase adoption
- Implementing healthcare operating rules on a voluntary basis is a good business practice
 - Best Practice standards ensure quality
 - Operating Rules plan to address mandate, but also other industry needs that are not mandated

Next Steps

- ~ Get involved as a CAQH CORE Participating Organization!
- ~ It is critical that stakeholders throughout the healthcare system are involved in the CAQH CORE Operating Rule writing process to share their needs and perspectives
 - . Collaboration across stakeholders breeds success
 - . Each stakeholder is critical to the process
- ~ Those who have already started down the path of implementing Phase I and Phase II CAQH CORE Operating Rules are ahead of the curve in aligning with the upcoming national mandates
 - . Voluntary operating rules provide a cornerstone for mandated rules

Voluntary CORE Certification

Voluntary CORE Certification

- ~ CAQH CORE will maintain a *voluntary* CORE Certification process that provides all organizations across the trading partner network guidance in meeting their obligations under the CAQH CORE Operating Rules
- ~ CORE Certification:
 - . Encourages trading partners to work together on data flow and content needs
 - . Offers health plans, providers, vendors and/or clearinghouses practical means for informing their trading partners that they are handling the exchange of Eligibility and Claim Status transactions in accordance with the CAQH CORE Operating Rules
 - . Enables achievement of maximum ROI because all entities in data exchange follow the operating rules; once CORE-certified need to follow operating rules with all trading partners



Voluntary CORE Certification and Testing

- ~ Voluntary CORE Certification is a CAQH CORE process which results in the awarding of a CORE Certification Seal
- ~ To date, nearly 60 organizations are CORE-certified with over one-third of all commercially insured lives covered by Phase I CORE-certified health plans
- ~ CORE Certification is awarded to entities that create, transmit or use eligibility and claim status data, i.e. health plans, providers, vendors/products and clearinghouses/services
- ~ Entities who pursue *voluntary* CORE Certification must successfully complete CORE Certification Testing; they are:
 - . Required to adopt each of the CAQH CORE Operating Rules applicable to the phase and stakeholder type for which they are seeking CORE Certification
 - . Required to complete CORE Certification Testing for:
 - A specific phase of the CAQH CORE Operating Rules, i.e., Phase I or Phase II
 - Stakeholder-specific test scripts for each CAQH CORE Operating Rule
- ~ Entities who pursue *voluntary* CORE Certification may:
 - . Complete phases of CORE Certification sequentially or concurrently

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* A list of CORE-certified entities can be found [HERE](#).



Measures of Success: Tracking ROI

- ~ CAQH CORE made an early commitment to track Measures of Success
- ~ CAQH CORE contracted with IBM to conduct tracking and analysis for Phase I and Phase II* studies
- ~ Phase I outcomes are available from health plans covering 33 million lives and their vendor and provider partners, e.g.,
 - . Provider groups working with CORE-certified health plans saw 10-12% fewer claim denials and a 20% increase of patients verified prior to a visit
 - . The time needed by vendors and clearinghouses to connect to trading partners significantly reduces with a common approach to connectivity
- ~ Health Plans, vendors and providers that pursue *voluntary* Phase II CORE Certification are invited to participate in the ROI study
 - . Also need participation from providers that are not CORE-certified, but are exchanging data with CORE-certified entities

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* Cost data already available for a number of Phase II-Certified health plans. Please contact Caquery Fulham at CFulham@caqh.org for interest in participating in the study.



Question & Answer Session

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Key Resources

This presentation is available at the [CORE Education Events](#) page

Prepare by reading [Interim Final Rule with Comment \[CMS-0032-IFC\]](#)
[Upcoming Mandates - Operating Rules](#)

Learn more about [CORE Operating Rules updated for v5010](#)
[CORE Certification: A Step-by-Step Process](#)
[IBM Phase I Measures of Success Study](#)

Monica B. Cunningham
CAQH
CORE Consultant, Education & Outreach

For more information, please contact
CORE@caqh.org

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