Discussion Topics

• CORE Overview
  – Operating Rules
    ➢ Benefits
  – “Phased Approach”
    ➢ Phase I, Phase II, Phase III

• CORE Impact
  – Initial Outcomes

• Examples of CORE-certified Vendor Products
  – Navimedix
    ➢ Aetna Eligibility/Benefits Inquiry within NaviNet
  – WebChart EMR
    ➢ EMR Product
  – NoMoreClipboard.com
    ➢ PHR Product

• What Physicians Can do to Bring CORE to Their Market
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, physicians and other stakeholders
- Reduce costs and frustrations associated with healthcare administration
- Facilitate administrative healthcare information exchange
- Encourage administrative and clinical data integration
The CORE Vision:

Health plans and healthcare professionals communicating—quickly and seamlessly—using any electronic system they choose.
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 physicians’ offices be as easy as making a cash withdrawal?
- Participation from health plans representing 75% of the commercially insured population (plus Medicare and Medicaid)

**Short-Term Goal**

Design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits

**Long-Term Goal**

Apply operating rule concept to all electronic communication between payers and their customers, using phased approach
What Are Operating Rules?

- Agreed-upon business rules for using and processing transactions
- Encourages an interoperable network
  - e.g. ATMs in banking, railroad industry

Key Components:
- Rights and responsibilities of all parties
- Security
- Exception processing
- Transmission standards and formats
- Response timing standards
- Liabilities
- Error resolution
CORE Mission

To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers

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

Key things CORE will not do:
- Build a database
- Replicate the work being done by standard setting bodies like X12 or HL7
Administrative Transactions
(In CORE, transaction-based rules are paired with infrastructure rules, e.g. real-times response and connectivity, to help data flow consistency in varied settings/with various vendors)
CORE “Phased” Approach

Design CORE 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
How CORE Operating Rules Are Helping

- Reduce staff time in confirming eligibility and benefits on the telephone with insurance companies
- Facilitate front end business operations so that they can more clearly identify the patient’s co-pays and “remaining” deductibles, including “in” and “out of network” benefits, prior to service
- Identify self pay patients (inactive coverage, terminations) early in the revenue cycle to provide financial assistance for the patient when necessary
- Improve accuracy, clarity and specificity of eligibility responses to ultimately reduce claims denials (i.e. outpatient benefits encompass a wide variety of services)
- Reduced administrative time and costs
- Real-time assessment of financial liability at point of service
- Smoother claims process issue resolution
- Improved health care experience, service and satisfaction
How CORE Operating Rules Are Helping

- Standardized process to respond real time to physician administrative data request
- Improved identification of members and their benefits
- Increased volume of electronic transactions
- Reduced administrative time and costs

- Real-time reliable access to consistent, high-quality claims-related data
- Part of a national, all-payer administrative data-exchange solution
- Improved service to physician practices, health plans
- Increased volume of electronic transactions
Current Participants

• Over 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
  – 36 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.
CORE Phase I

CORE’s first set of rules (Phase I) are helping physicians:

- Determine whether a health plan covers the patient
- Determine patient benefit coverage
- Confirm coverage of certain treatments and the patient’s co-pay amount, coinsurance level and base deductible levels (as defined in the member contract) for each of those service types
- Access this information in real-time and via common internet protocols

* CORE rules approval requires a vote by CORE participants and ratification by the CAQH Board

** Over 35 organizations/products are CORE-certified. This includes clearinghouses, health plans, providers, and vendors.
Phase I Overview

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

CORE Phase I Rules
• *270/271 Data Content
  – Financials related to Patient Responsibility (co-pay, deductible, co-insurance levels in contracts – not YTD)

• Infrastructure
  – *Connectivity -- HTTPS Safe harbor
  – Response Time -- For batch and real-time
  – System Availability -- For batch and real-time
  – Acknowledgements – For batch and real-time
  – Companion Guide (flow and format standards)

* Enhanced/expanded upon in Phase II
CORE’s second set of rules (Phase II) build upon and expand on Phase I to include:

- Patient accumulators (remaining deductible)
- Access to financial information for a larger group of service codes
- Rules to help improve patient matching
- Claim status transaction rules (e.g., acknowledgements, response time)

± 49 organizations have committed to becoming CORE Phase II certified or endorsers by Q4 2009/Q1 2010.
# Phase II Rules Build upon and Expand Phase I

<table>
<thead>
<tr>
<th>Transaction Type and Standard Data Content</th>
<th>Phase I*</th>
<th>Phase II*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility/Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static Patient Financial Responsibility, e.g. co-pay, base deductible</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Remaining Patient Financial Responsibility, e.g. remaining deductible for benefit plan and 40+ service types</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Data to Support Financials, e.g. dates, in/out of network differences</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use of transaction under “Basic Level” Infrastructure/Policy Requirements</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use of transaction under “Enhanced 1” Infrastructure/Policy Requirements</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Claims Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of transaction under “Basic Level” Infrastructure/Policy Requirements</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use**

<table>
<thead>
<tr>
<th>Basic Level</th>
<th>Phase I*</th>
<th>Phase II*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy requirements</strong>: Must offer CORE-certified capabilities to ALL trading partners</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Infrastructure requirements</strong>:</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>✘ Real-time: 20-seconds AND batch turn around requirements</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>✘ System availability: 86%</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>✘ Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>✘ Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>✘ Standard Companion Guide <em>Format and flow</em></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enhanced 1</th>
<th>Phase II*</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Basic Level”, plus, additional Infrastructure requirements:</td>
<td></td>
</tr>
<tr>
<td>✘ Patient identification rules</td>
<td>X</td>
</tr>
<tr>
<td>✘ Standard error codes</td>
<td></td>
</tr>
<tr>
<td>✘ Normalizing names</td>
<td></td>
</tr>
<tr>
<td>✘ Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* *There are over 30 entities already CORE Phase I certified. CORE-certification is for health plans, vendors, clearinghouses and large providers.*
CORE *Proposed* Phase III

- Focus on improving the electronic delivery of additional administrative transactions
- Builds upon Phase I and II

<table>
<thead>
<tr>
<th>Category</th>
<th>Rule Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Current Transactions</td>
<td><strong>Claim Status</strong>: Build out data content, e.g. service date, claim submitter trace number</td>
</tr>
<tr>
<td></td>
<td><strong>Eligibility</strong>: Develop rules related to provider network identification and improved patient identification</td>
</tr>
<tr>
<td>Add New Transaction (s)</td>
<td><strong>Remittance advice</strong>: Build out data content</td>
</tr>
<tr>
<td></td>
<td><strong>Referrals</strong>: Build out data content</td>
</tr>
<tr>
<td>Expand Policies</td>
<td>Require health plan trading partners to be CORE-certified</td>
</tr>
<tr>
<td>Connectivity</td>
<td>Build upon connectivity given it allows for connections to all other health IT applications, such as e-prescribing, and is a key aspect of interoperability</td>
</tr>
<tr>
<td>Other</td>
<td>Implementation of WEDI ID Card Guide</td>
</tr>
</tbody>
</table>

* CAQH is currently reviewing feedback from CORE participants and conducting research regarding these proposed areas of rule writing. Phase III rule writing is expected to begin in December 2008*
CORE Impact: Initial Outcomes
Current Industry Recognition, Coordination and Certification Adoption

• Participation
  – Over 75% of the commercially insured, plus CMS, SDOs, a wide range of vendors, physician and other healthcare provider associations, RHIOs, etc.

• Phase I and II certifications/commitments to certify
  – Over 35 entities covering over 48% of the commercially insured
  – Includes Department of Veterans Affairs, which beta tested both the Phase I and Phase II certification testing product
  – Includes key vendors that offer physician IT solutions such as practice management systems and portals

• Endorsements and Statements of Support
  – Over 25 endorsements including eight provider associations such as the American Medical Association and standards setting bodies
  – Statements of Support from both trade associations representing the payer industry and the trade association representing PPOs
Current Industry Recognition, Coordination and Certification Adoption (cont’d)

• Federal recognition:
  – CORE has been integrated into the HIMSS Interoperability Showcase for several years, demonstrating how administrative data can be integrated with clinical data
  – MITA 2009 Strategic Plan includes collaborating with CORE
  – HITSP specifications, which have been recognized by the Secretary of HHS, will be integrated into federal contracts

• State interest (CORE is viewed as a national approach that can be implemented regionally):
  – In 2008, four states began actively considering requiring CORE in response to legislative demands for reducing administrative cost savings, increasing use of electronic transactions and expanding physician access to electronic benefit information
    • Colorado
    • Ohio
    • Texas
    • Washington
Benefits to Physicians

Value of “End-to-End” CORE Certification

- Health Plans take all-payer approach to delivering useful and accurate eligibilities/benefits, patient financial status, and claims status data to partners.

- Vendors and clearinghouses can connect to plans more easily and add value to products and services thanks to consistency in all-payer approach.

- Physicians can derive benefit from predictable transactions and achieve more efficient practice administration to drive down operating cost.
Benefits to Physicians (cont’d)

Value of Real-time transactions for physicians and patients

- Physicians are better able to control costs and decrease bad debt through:
  - Consistent eligibility/benefit checks
  - Verification of patient financial responsibility
  - Immediate claims status retrieval
  - Early review of remittance advice

- Patient satisfaction increases: fewer unknowns at the point of service and “surprise” bills in the mail
Example from BCBSNC of Rapid Realtime Adoption

Results
• Increase in transaction activity (Interplan and Local)
• Majority swing to realtime data transactions
• Physician recognition of CORE Certification process and practice management implications

Source of Transactions

<table>
<thead>
<tr>
<th>April 2007</th>
<th>March 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 82,230 270 to BCBSNC</td>
<td>• 298,244 270 to BCBSNC</td>
</tr>
<tr>
<td>– 19.5% Blue Exchange Realtime</td>
<td>– 41% Blue Exchange Realtime</td>
</tr>
<tr>
<td>– 80.5% Batch</td>
<td>– 56% Local Realtime</td>
</tr>
<tr>
<td></td>
<td>– 3% Batch</td>
</tr>
</tbody>
</table>

- 82,230 Total, 81% batch 270 April 2007
- 384,943 Total, 9% batch 270 July 2008
Preliminary Study Findings

• Observations regarding physician eligibility processes
  – Problems with manual verifications (web and telephone)
    • Verifiers require significant expertise and training time due to tremendous variation in tools and information across plans affects training time
    • Systems may supply incomplete information about the responsible plan that can require informed research to resolve
    • Some health plan IVR and phone systems are significant source of problems, e.g. dropped calls and endless loops
    • Long telephone wait times lead to multi-tasking with a higher risk of error as verifiers switch back and forth between two patient records
    • Verifiers report inconsistent information based on methods: realtime 270, website, IVR, telephone. They tend to believe the person on the phone.
  – Inconsistent manual eligibility processes
    • Eligibility process varies tremendously across departments and individuals
    • Variation in plan methods and information makes it harder to design consistent processes
    • Individuals may give up on a particular method or website based on bad experiences and then never try again, so that improvements by the plan may never be seen by the targeted users
Preliminary Study Findings

• Role of vendors is critical
  – Vendors play a significant role in establishing the trading partner relationships for health plans
  – Physicians can gain access to CORE-certified transactions through various vendor services or directly from plans
    • Provider Management System (PMS), Hospital Information System (HIS) or Billing system
    • Clearinghouse offering transaction scrubbing, formatting and routing
    • Portal offering direct data entry which creates a real-time 270/271 transaction with the health plan
  – CORE-certified vendors that work closely with health plans in physician outreach can significantly accelerate physician adoption of new health plan capabilities, and industry-wide communications would improve these communications

• Potential CORE impact on physicians
  – Ability to design and enforce consistent process based on timely real-time CORE transactions will reduce error rates and reduce costs
  – As the penetration of CORE and consistent verifications increase, physicians should realize reductions in training time, and suffer less disruption and risk exposure during staff turnover
  – The industry has the opportunity to communicate more effectively industry-wide on the detailed technical aspects as well as on standard commonly understood content
Examples of CORE-certified Vendor Products
(Note: CORE Operating Rules are Vendor Agnostic)
Interoperability is the goal. This will take industry collaboration.
  - All stakeholders are key to CORE’s success; no single organization, nor any one segment of the industry, can do it alone.

Standards-based real-time communications between health plans and physicians is critical to sustaining healthy relationships as well as revenue streams, but standards alone aren’t enough.

Aetna and NaviMedix have implemented CORE Phase I recommendations to improve web-based administrative solutions.
Aetna Eligibility & Benefits Inquiry workflow within NaviNet - CORE Phase I Compliant
Aetna Eligibility & Benefits Inquiry workflow within NaviNet - CORE Phase I Compliant

<table>
<thead>
<tr>
<th>Date: 02/04/2008 - 02/04/2008</th>
<th>Status: Active Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage Level</strong></td>
<td><strong>In Network?</strong></td>
</tr>
<tr>
<td>Individual</td>
<td>YES</td>
</tr>
<tr>
<td>Individual</td>
<td>YES</td>
</tr>
<tr>
<td>Individual</td>
<td>YES</td>
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<td>Individual</td>
<td>YES</td>
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<td>Individual</td>
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<td>YES</td>
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<td>Individual</td>
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<tr>
<td>Individual</td>
<td>YES</td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
</tbody>
</table>

Patient financials returned according to Phase I requirements
WebChart EMR can send an electronic eligibility request to a plan and display a CORE Phase I rule compliant eligibility/benefits response:

• CORE operating rules also address “infrastructure” requirements including response time specifications
  – In the case of CORE, real time transactions such as these are required to take place in 20 seconds or less
NoMoreClipboard.com – Phase I CORE-certified PHR

NoMoreClipBoard.com PHR is also able to send and receive CORE Phase I compliant transactions:

- Electronic transactions are taking place in a consistent and robust fashion through use of CORE operating rules
- CORE operating rules have been applied to transactions beyond eligibility (e.g., claim status in Phase II) and future CORE phases will continue to evolve to include other transactions
  - End goal is to achieve seamless real-time claims adjudication

Eligibility/benefit information returned according to Phase I requirements

<table>
<thead>
<tr>
<th>Subscriber Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILL K PULSPHER</td>
</tr>
<tr>
<td>9804 WINBURN</td>
</tr>
<tr>
<td>HOUSTON TX, 77011</td>
</tr>
<tr>
<td>Date of Birth: 12/3/1982, Gender: M</td>
</tr>
<tr>
<td>Subscriber ID: 5643796</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Source Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Source: PLANA CERTIFICATION PAYER (00999)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Receiver Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>GUFFIDA, DENISE J (5568086)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name: TEXAS PCS</td>
</tr>
<tr>
<td>Plan #: 2614320</td>
</tr>
<tr>
<td>Group #: 19482002</td>
</tr>
<tr>
<td>Coverage Begin Date: 9/24/2005</td>
</tr>
<tr>
<td>Coverage Level: Employee Individual Only</td>
</tr>
<tr>
<td>Office visit: $15 copay then 10% deductible</td>
</tr>
<tr>
<td>Inpatient Hospital Visit: 60% coverage after $250 deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Visit: 90% coverage after $1000 deductible</td>
</tr>
<tr>
<td>Emergency Hospital Visit: 90% coverage after $100 deductible</td>
</tr>
<tr>
<td>Pharmacy Coverage: $0 copay after $50 individual deductible</td>
</tr>
<tr>
<td>Vision coverage: EMP</td>
</tr>
<tr>
<td>Dental coverage: EMP</td>
</tr>
</tbody>
</table>
What Physicians Can do to Bring CORE to Their Market
What You Can Do

1. Support CORE
   • Associate your organization publicly with the premier national Administrative Simplification initiative
   • Host CORE educational sessions to generate awareness and drive adoption
   • Give voice to physician needs for simplified claims cycle management by encouraging vendors, clearinghouses and plans to get involved in CORE

2. Participate in Phase III Rules Creation
   • Helps enlarge the circle of stakeholders in rule-writing process
   • Delivers critical physician input and involvement in rule-writing
   • Ensures that the rules are being written with the end-user in mind
   • Work Groups are forming now!
What You Can Do

3. Encourage Certification of CORE Phase I and Phase II Rules …

- By large physician practices* or facilities:
  - Realize immediate practice administration results by taking advantage of the additional data and health IT infrastructure CORE is bringing to market through its CORE-certified entities
  - Completes the end-to-end adoption cycle

- By Vendors and Clearinghouses (serving smaller practices):
  - Deliver exceptional services to clients thanks to all-payer content and predictable data streams
  - Accelerate delivery of new features and services thanks to consistent connectivity and content delivery rules

- By Health Plans:
  - Transform claims cycle workflow through consistent content delivery, predictable formatting, baseline connectivity, and real-time availability
  - Improve physician network and member satisfaction through meaningful transparency measures

* Small physician practices or solo practitioners are not expected to become CORE-certified, but rather reap the benefits of CORE operating rules through CORE-certified vendors/clearinghouses.
Questions?

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