Committed to Improving Health Plan-Physician Interoperability

Presentation to the AMA Federation
CORE Educational Audiocast
December 2008

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

CORE
Committee on Operating Rules for Information Exchange
The CORE Vision

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

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

☑ Approved*
☑ Implemented**

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 Phase II

- Approved
- Implemented
- Committed

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>Basic: Patient Financial Responsibility, e.g. co-pay, base deductible</td>
<td></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, input of network differences</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Use of transaction under “Basic Level” Infrastructure/Policy Requirements</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Use of transaction under “Basic Level” Infrastructure/Policy Requirements</td>
<td></td>
<td>X</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>

**Enhanced 1**

<table>
<thead>
<tr>
<th>Basic Level</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Basic Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Policy requirements; Must offer CORE-certified capabilities to ALL trading partners</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use</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: 99%</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 Format and flow</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Enhanced 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Basic Level” plus, additional Infrastructure requirements;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Patient identification rules</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Standard error codes</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Normalizing names</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allow for direct connect, PHR transfers</td>
<td></td>
<td>X</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>Claim Status: Build out data content, e.g. service date, claim submitter trace number</td>
</tr>
<tr>
<td></td>
<td>Eligibility: Develop rules related to provider network identification and improved patient identification</td>
</tr>
<tr>
<td>Add New Transaction(s)</td>
<td>Remittance advice: Build out data content</td>
</tr>
<tr>
<td></td>
<td>Referrals: 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</td>
<td>298,244</td>
</tr>
<tr>
<td>270 to BCBSNC</td>
<td>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>3% Batch</td>
<td></td>
</tr>
</tbody>
</table>
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

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

For help and tips on using this screen, click 'Help/Tip' directly above the Help/Tip field.

We want you to know:

- Electronic Eligibility Inquiry

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Member Name</th>
<th>Gender</th>
<th>DOS</th>
<th>Product Name</th>
<th>Relationship</th>
<th>Liability Status</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567</td>
<td>SCOTT, JOHN</td>
<td>MALE</td>
<td>01/01/2000</td>
<td>MEDICAL</td>
<td>FAMILY</td>
<td>ACTIVE COVERAGE</td>
<td>Select</td>
</tr>
<tr>
<td>2345678</td>
<td>SCOTT, LINDA</td>
<td>FEMALE</td>
<td>02/15/1987</td>
<td>MEDICAL</td>
<td>SPOUSE</td>
<td>ACTIVE COVERAGE</td>
<td>Select</td>
</tr>
<tr>
<td>3456789</td>
<td>SCOTT, DANIEL</td>
<td>MALE</td>
<td>04/15/1992</td>
<td>MEDICAL</td>
<td>CHILD</td>
<td>ACTIVE COVERAGE</td>
<td>Select</td>
</tr>
</tbody>
</table>

We want you to know:

- Patient financials returned according to Phase I requirements.

Aetna Eligibility & Benefits Inquiry workflow within NaviNet - CORE Phase I Compliant

<table>
<thead>
<tr>
<th>Date</th>
<th>Status</th>
<th>Coverage Level</th>
<th>In Network?</th>
<th>Limitation Description</th>
<th>Amount Limit</th>
<th>Amount</th>
<th>Availability</th>
<th>Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Individual</td>
<td>YES</td>
<td>FACILITY OF HOSPITAL</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Individual</td>
<td>YES</td>
<td>FACILITY OF EMERGENCY</td>
<td>$100.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Individual</td>
<td>YES</td>
<td>FACILITY OF ER PC</td>
<td>$50.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Individual</td>
<td>YES</td>
<td>FACILITY OF ER PC</td>
<td>$20.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Individual</td>
<td>YES</td>
<td>FACILITY OF ER PC</td>
<td>$10.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Family</td>
<td>YES</td>
<td>COPAY/EXPENSECPAY/EXPENSE</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02/04/2008</td>
<td>Active Coverage</td>
<td>Family</td>
<td>YES</td>
<td>COPAY/EXPENSECPAY/EXPENSE</td>
<td>$0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

Eligibility/benefit information returned according to Phase I Requirements

---

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

---

Insurance Information

<table>
<thead>
<tr>
<th>Subscriber Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: David Smith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address: 123 Main St, Suite 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State: Anytown, NY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plan Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name: AnyHealth FPO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan #: 123456789</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Coverage Level: Family
- Coverage Status: Active
- Annual Deductible: $100
- Annual Deductible: $500

Physician Office Visit: $20 copay, in-network
- Chiropractic: $20 copay, in-network
- Inpatient Hospital: Covered at 100% after Deductible
- Outpatient Hospital: Covered at 100% after Deductible
- Emergency Services: Covered at 100% after Deductible
- Vision Coverage: $0
- Dental Coverage: None
- Pharmacy/Dental Coverage: None
- $20 copay
- $100 individual deductible
- $150 family deductible

---

Subscriber Information

<table>
<thead>
<tr>
<th>Subscriber Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: John Doe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address: 123 Main St, Suite 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State: Anytown, NY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Source Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name: Texas POS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan #: 123456789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage Level: Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage Status: Active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Office visit: $10 copay, after $10 deductible
- Inpatient Hospital Visit: 0% coverage after $100 deductible
- Outpatient Hospital Visit: 0% coverage after $1000 deductible
- Emergency Hospital Visit: 0% coverage after $100 deductible
- Pharmacy Coverage: 0% copay, after $50 deductible
- Vision coverage: EMP
- Dental coverage: EMP

---

Receiver Information

<table>
<thead>
<tr>
<th>Receiver Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Jill Johnson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address: 123 Main St, Suite 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City, State: Anytown, NY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefit Information

<table>
<thead>
<tr>
<th>Benefit Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Name: AnyHealth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan #: 123456789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group #: 123456789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage Level: Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage Status: Active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Office visit: $10 copay, after $10 deductible
- Inpatient Hospital Visit: 0% coverage after $100 deductible
- Outpatient Hospital Visit: 0% coverage after $100 deductible
- Emergency Hospital Visit: 0% coverage after $100 deductible
- Pharmacy Coverage: 0% copay, after $50 deductible
- Vision coverage: EMP
- Dental coverage: EMP
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?

Gwen Lohse
Managing Director, CORE
glohse@caqh.org 202-778-1142

Steven Zlotkus
Marketing/Business Development
szlotkus@caqh.org 202-778-3226

www.caqh.org