



# CORE *Proposed* Phase II Rules: The Next Step in Simplifying Healthcare Administrative Data Exchange

*A CAQH and WEDI Audiocast* Wednesday, May 28th, 2008 2:00 pm – 3:30 pm ET

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# Discussion Topics

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- Overview
  - CAQH
  - CORE Vision and Mission
  - CORE Phase I
- CORE *Proposed* Phase II Operating Rules
  - 270/271 Data Content
  - Patient Identifiers
    - Last Name Normalization
    - Use of AAA Error Codes
  - Claim Status
  - Connectivity
- Coordinating with State and National Initiatives
- Questions

# An Introduction to CAQH

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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

CORE™

Committee on Operating Rules  
for Information Exchange

# CORE Mission

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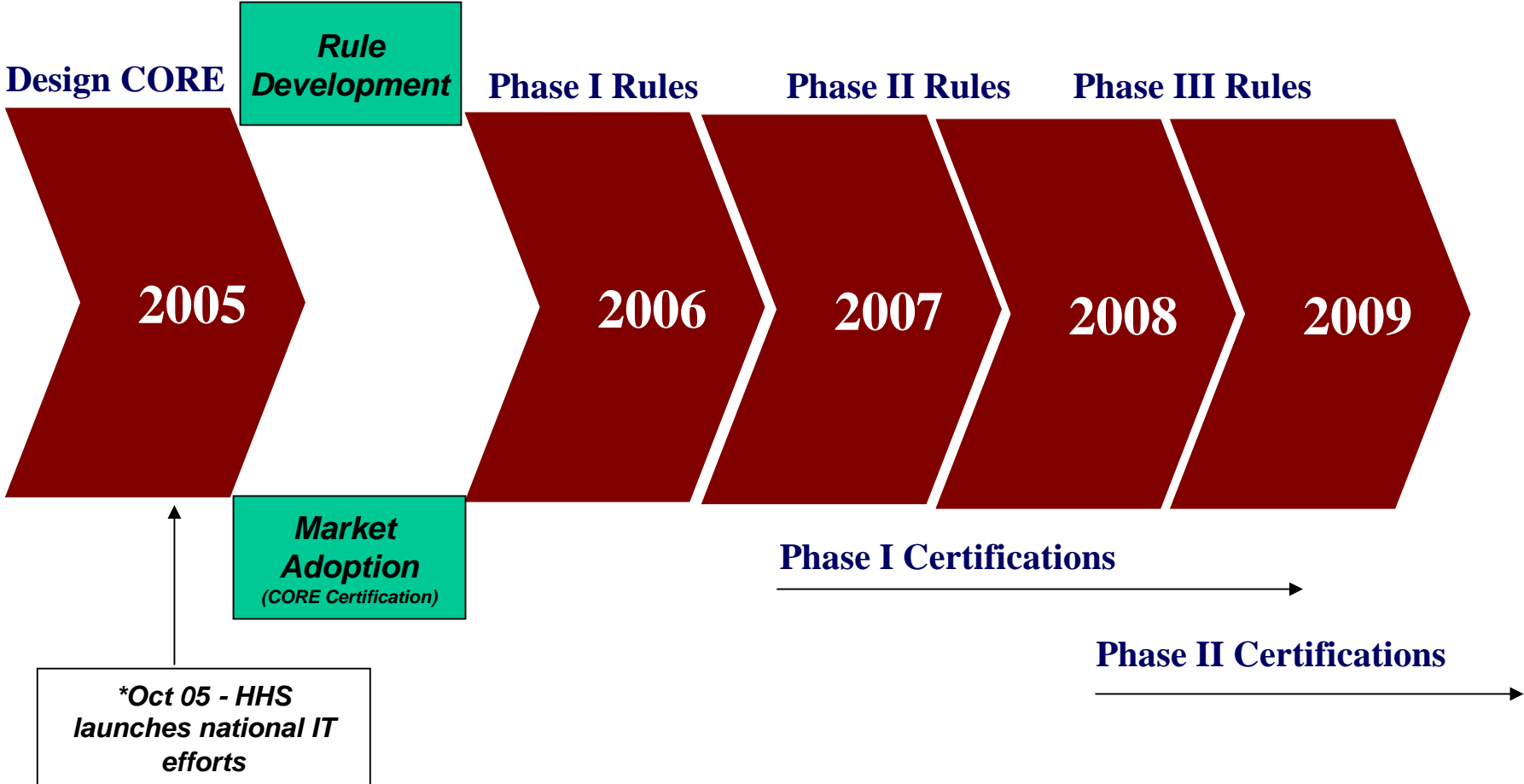
To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers

- Build on any applicable HIPAA transaction requirements or other appropriate standards such as HTTPS
- Enable providers to submit transactions from the system of their choice 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

Key things CORE will not do:

- Build a database
- Replicate the work being done by standard setting bodies like X12 or HL7

# Phased Approach

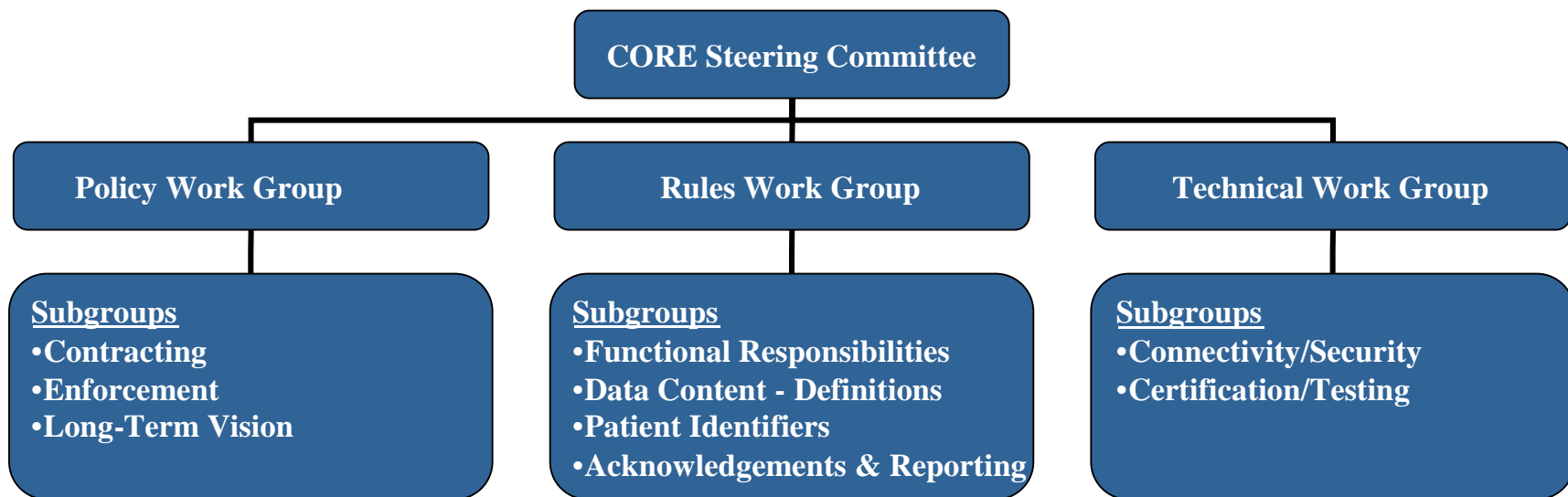


# Current Participants

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- Over 100 organizations representing all aspects of the industry:
  - 19 health plans
  - 11 providers
  - 6 provider associations
  - 19 regional entities/RHIOS/standard setting bodies/other associations
  - 37 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 Work Groups And Subgroups



# CORE Certification and Endorsement

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## Certification

- CORE-certification is required for each phase of CORE
- Recognizes entities that have met the established operating rules requirements
- Entities that create, transmit or use eligibility data in daily business required to submit to third-party testing (within 180 days of signing pledge); if they are compliant, they receive seal as a CORE-certified health plan, vendor (product specific), clearinghouse or provider

## Endorsement

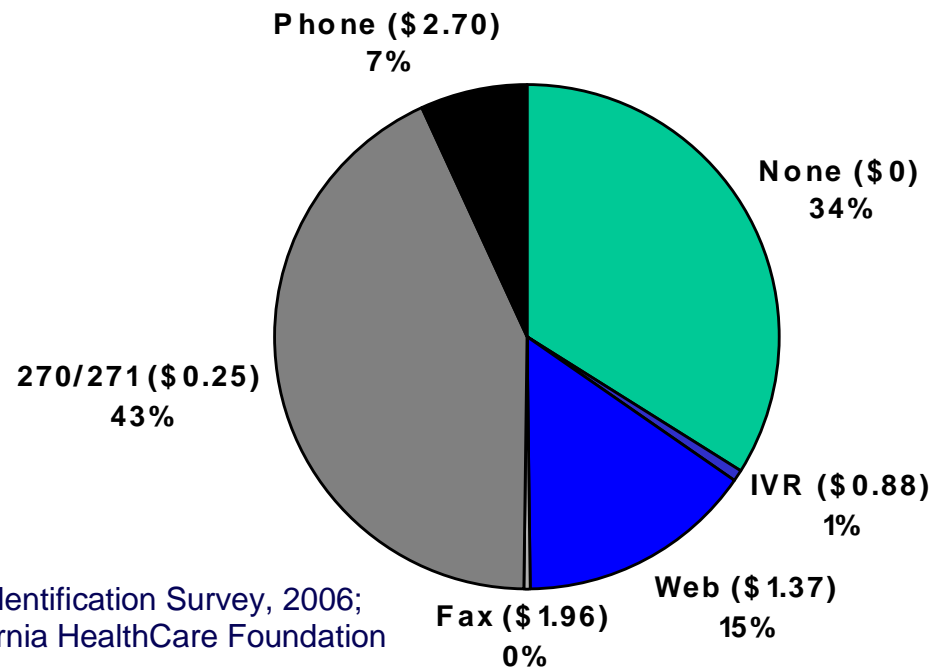
- CORE Endorsement is required for each phase of CORE
- Entities that do not create, transmit or send data – sign Pledge, receive CORE Endorser Seal

# CORE Phase I Patient ID Study: Key Opportunity

## Significant Savings

Providers (and health plans) can achieve significant savings by shifting from more labor-intensive verification methods to automated eligibility verification

**Provider Eligibility Verification by  
Type of Method  
(Average labor cost per transaction)**

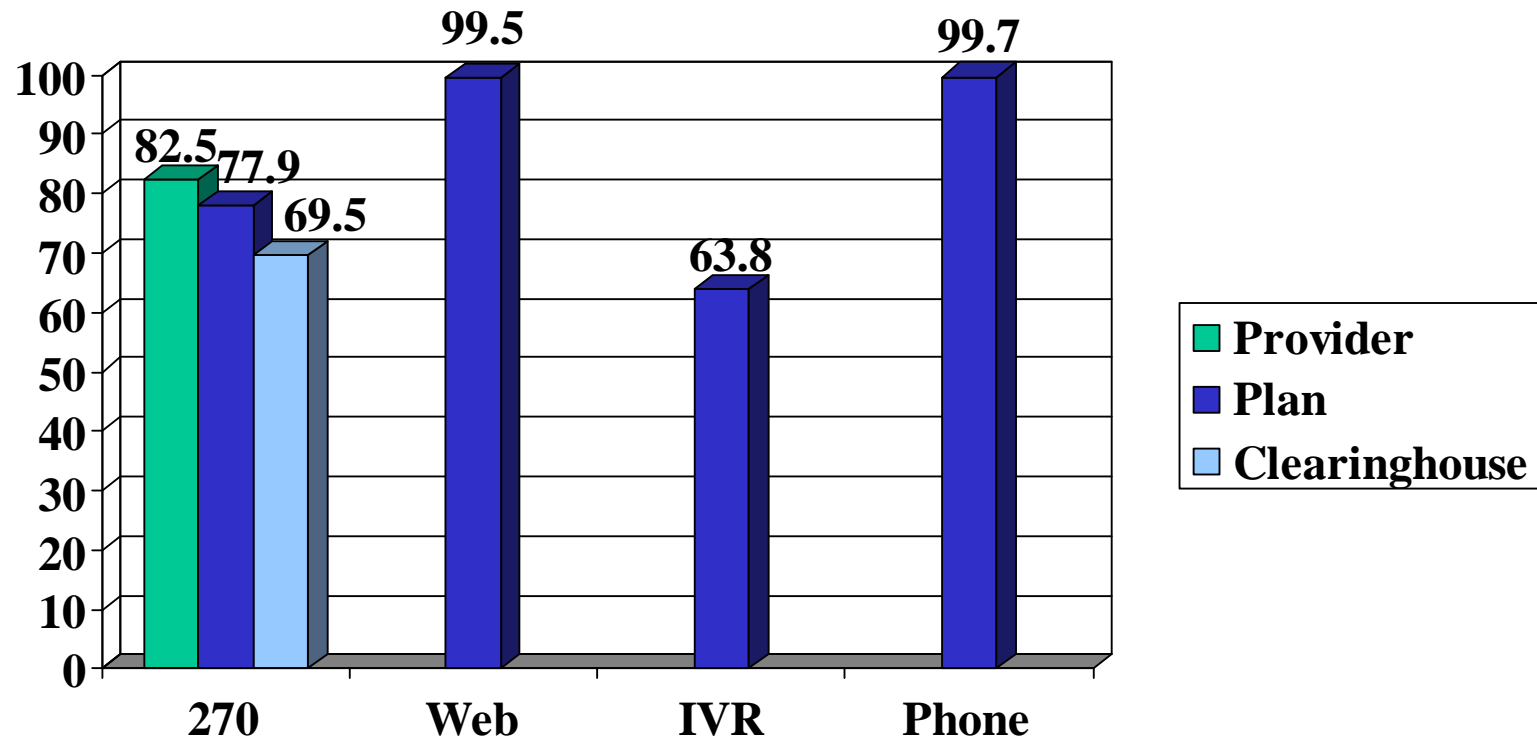


Source: CORE Patient Identification Survey, 2006;  
funded, in part, by California HealthCare Foundation

# CORE Phase I Patient ID Study: Key Challenge

## Lower Hit Rate on HIPAA Eligibility Transactions

**% of Inquiries that Result in a Valid Response on the First Pass**



Source: CORE Patient Identification Survey, 2006;  
funded, in part, by California HealthCare Foundation

# Phase I: Expected Impact

## Decrease Administrative Costs

- Call center
- Registration
- Claims processing/billing
- Mail room
- EDI management

## Increase Satisfaction

- Partners
- Patients
- Staff

## Meet Patient Expectations

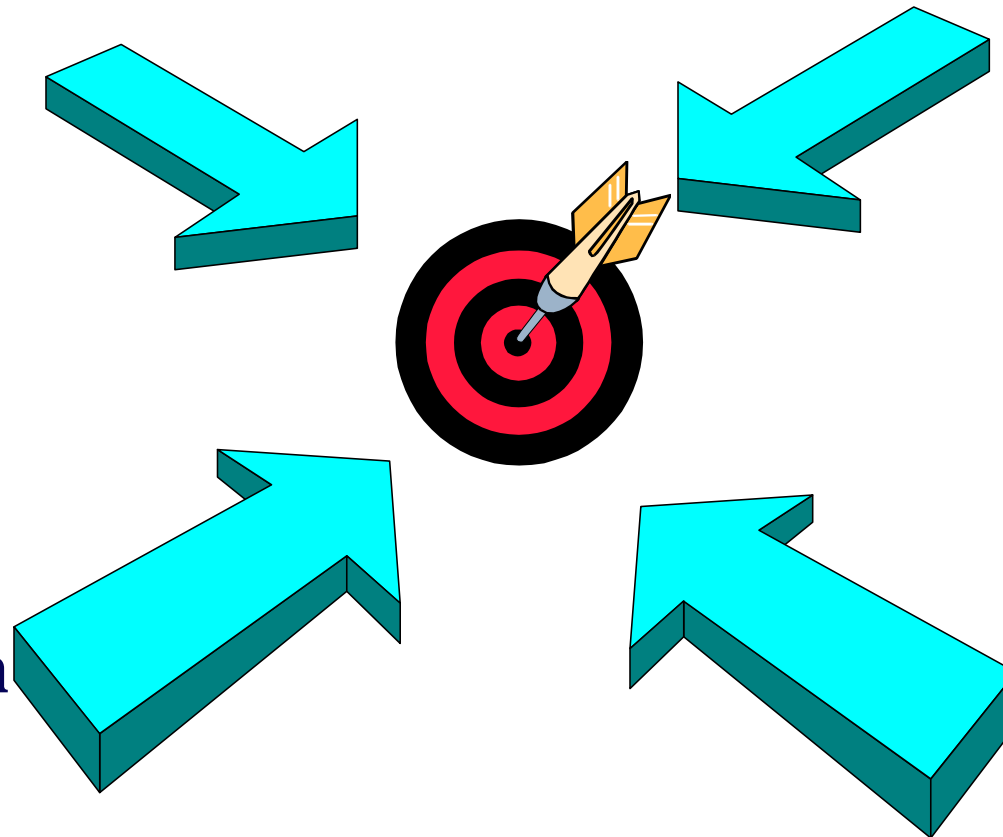
- Wait time
- Personal financial responsibility

## Improve Financial Measures

- Reduced denials
- Improved POS collections
- Decreased bad debt
- Reduced cost

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## Phase II

*(Note: All rules are in proposed form)*

**REMINDER: CORE rules are a base, not a ceiling.  
Entities can go beyond the minimum CORE requirements.**

# Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*	Phase II*
<b>Eligibility/ Benefits</b>	Static <i>Patient Financial Responsibility</i> , e.g. co-pay, base deductible	X	X
	Remaining <i>Patient Financial Responsibility</i> , e.g. remaining deductible for benefit plan and 40+ service types		X
	Data to Support Financials, e.g. dates, in/out of network differences	X	X
	Use of transaction under “Basic Level” Infrastructure/Policy Requirements	X	X
	Use of transaction under “Enhanced 1” Infrastructure/Policy Requirements		X
<b>Claims Status</b>	Use of transaction under “Basic Level” Infrastructure/Policy Requirements		X
Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use			
<b>Basic Level</b>	<ul style="list-style-type: none"> <li>• <u>Policy requirements</u>: Must offer CORE-certified capabilities to ALL trading partners</li> <li>• <u>Infrastructure requirements</u>:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Real-time: 20-seconds AND batch turn around requirements</li> <li><input type="checkbox"/> System availability: 86%</li> <li><input type="checkbox"/> Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL</li> <li><input type="checkbox"/> Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement</li> <li><input type="checkbox"/> Standard Companion Guide <i>Format and flow</i></li> </ul> </li> </ul>	X	X
<b>Enhanced 1</b>	“Basic Level”, plus, additional <u>Infrastructure requirements</u> : <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient identification rules               <ul style="list-style-type: none"> <li><input type="checkbox"/> Standard error codes</li> <li><input type="checkbox"/> Normalizing names</li> </ul> </li> <li><input type="checkbox"/> Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers</li> </ul>		X

**Note**

\*There are over 30 entities already CORE Phase I certified

\*As of May 2008, Phase II rule voting is underway; upon completion of Phase II vote, proposed Phase III scope will be reviewed and Phase III rule writing will begin

\* CORE-certification is for health plans, vendors, clearinghouses and large providers

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Questions?

- 3 Hospitals providing more than 65,000 inpatient stays annually
- Nearly 2.5 million outpatients seen annually through ER, outpatient, primary and specialty care sites
- Home health care services make more than 400,000 visits/year
- Ranks among the top one percent of all U.S. hospitals in medical innovation and technology
- Send approximately 60,000 eligibility transactions/month with future projections to 150,000/month
- Send approximately 50,000 claim status transactions/month
- Payer mix – 70% Medicare/Medicaid, 25% Commercial, 5% other/non-insured

## Provider Perspective: CORE Participation and Certification

- “Standardization” is key – customization is costly
- We see technology as a key to our survival
- This is a win-win for providers and patients
  - Providers are able to control costs and decrease bad debt through better eligibility and benefit checks
  - Patients satisfaction is increased – fewer “surprise” bills
- Felt our participation was needed to help drive market adoption, despite lack of immediate ROI
- Providers historically under represented in the healthcare debate
- Foster better communication among industry stakeholders – CORE has already begun to garner trust and break down barriers among its various members

# Phase I Overview - 270/271 Data Content Rule

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- Specifies what must be included in the 271 response to a Generic 270 inquiry or a non-required CORE service type
- Response must include
  - The status of coverage (active, inactive)
  - The health plan coverage begin date
  - The name of the health plan covering the individual (if the name is available)
  - The status of nine required service types (benefits) in addition to the *HIPAA-required Code 30*
    - 1-Medical Care
    - 33 - Chiropractic
    - 35 - Dental Care
    - 48 - Hospital Inpatient
    - 50 - Hospital Outpatient
    - 86 - Emergency Services
    - 88 - Pharmacy
    - 98 - Professional Physician Office Visit
    - AL - Vision (optometry)

# Phase I 270/271 Data Content Rule (cont'd)

## CORE Data Content Rule also Includes Patient Financial Responsibility

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 - Chiropractic
  - 48 - Hospital Inpatient
  - 50 - Hospital Outpatient
  - 86 - Emergency Services
  - 98 - Professional Physician Office Visit
- Co-pay, co-insurance and deductibles (discretionary) for
  - 1- Medical Care
  - 35 - Dental Care
  - 88 - Pharmacy
  - AL - Vision (optometry)
  - 30 - Health Benefit Plan Coverage
- If different for in-network vs. out-of-network, must return both amounts
- Health plans must also support an explicit 270 for any of the CORE-required service types

# Proposed Phase II 270/271 Data Content Rule

- Builds and expands on Phase I eligibility content
- Requires health plan to support explicit 270 eligibility inquiry for 39 service type codes
- Response must include all patient financial liability *(except for the 8 discretionary service types; a few codes from Phase I and mental health codes added in Phase II)*
  - Base contract deductible AND remaining deductible
  - Co-pay
  - Co-insurance
  - In/out of network amounts if different
  - Related dates
- Recommended use of 3 codes for coverage time period for health plan
  - 22 – Service Year (a 365-day contractual period)
  - 23 – Calendar year (January 1 through December 31 of same year)
  - 25 – Contract (duration of patient’s specific coverage)

EXAMPLES OF SERVICE TYPE CODES
2 Surgical
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
12 Durable Medical Equipment Purchase
13 Ambulatory Service Center Facility
18 Durable Medical Equipment Rental
20 Second Surgical Opinion
40 Oral Surgery
42 Home Health Care
45 Hospice
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
62 MRI/CAT Scan
65 Newborn Care
68 Well Baby Care
73 Diagnostic Medical
76 Dialysis
78 Chemotherapy
80 Immunizations
81 Routine Physical
82 Family Planning
93 Podiatry
99 Professional (Physician) Visit – Inpatient
A0 Professional (Physician) Visit – Outpatient
A3 Professional (Physician) Visit – Home
*A6 Psychotherapy
*A7 Psychiatric – Inpatient
*A8 Psychiatric – Outpatient
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
*AI Substance Abuse
BG Cardiac Rehabilitation
BH Pediatric

*\* Indicates examples of discretionary service types*

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Questions?



# WELLPOINT<sup>SM</sup>

- 14 - BCBSA Plans (Anthem, Empire, & WellPoint)  
(CA, CT, CO, GA, IN, KT, ME, MO, NH, NV, NY, OH, VA, WI )
- 14 - MEDICAID Business  
(CA, CT, CO, IN, KS, MA, TX, NH, NV, NY, OH, VA, WI, WV )
- 35+ million members (private business only)
- 44,000+ employees
- 790,000+ network providers
  - 230,000+ use online services
- 370+ million claims processed per year
- 7.1+ million telephone calls per year
- 81+ million electronic eligibility inquiries per year
  - 58% Web based

## Phase II: 270/271 *Proposed* Patient Identification Rules

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- Two Patient ID Surveys funded by California Health Care Foundation led to business justification for developing rules that enhance patient matching and provide better information on why a match did not occur:
  - Draft rule on Last Name Normalization
  - Draft rule on Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers and Names

# CORE Phase II Patient ID Study

## Valid Response Rate by Eligibility Inquiry Method

There are continued challenges with lower validation rates on the 270/271 compared to other methods. Increasing the match rate of the 270/271 is a key focus of the CORE Patient ID Rules.

Valid Response Analysis		270/271	Web	IVR	Phone
Plan A**	Valid responses	93%		NA	95%
	Patient ID errors	5%		NA	5%
	Other errors	1%		NA	0%
Plan B	Valid responses	81%	86%	81%	99%
	Patient ID errors	17%	14%	0%	1%
	Other errors	2%	0%	19%	
Plan C	Valid responses	62%	NA	NA	97%
	Patient ID errors	31%	NA	NA	3%
	Other errors	8%	NA	NA	
Plan D	Valid responses	NA	NA	NA	98%
	Patient ID errors	NA	NA	NA	2%
	Other errors	NA	NA	NA	

\*\* Plan A's usual rate of valid responses for the 270/271 is 83-85%.

Source: CORE Phase II Patient Identification Survey, 2007; funded, in part, by the California HealthCare Foundation

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# Phase II: 270/271 *Proposed* Patient Identification Rules

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- Normalizing Patient Last Name
  - **Goal:** Reduce errors related to patient name matching due to use of special characters and name prefixes/suffixes
    - Recommends approaches for submitters to capture and store name suffix and prefix so that it can be stored separately or parsed from the last name
    - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
      - Remove specified suffix and prefix character strings
      - Remove special characters and punctuation
    - If normalized name validated, return 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
    - Recommends that health plans use a no-more-restrictive name validation logic in downstream HIPAA transactions than what is used for the 270/271 transactions

## Phase II: 270/271 *Proposed* Patient Identification Rules

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- Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names in 271 response
  - **Goal:** Provide consistent and specific patient identification error reporting on the 271 so that appropriate follow-up action can be taken to obtain and re-send correct information
    - 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
    - Designed to work with any search and match criteria or logic
    - The receiver of the 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

## Phase II: *Proposed* Claims Status Rule

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- Entities must provide claims status under the CORE Phase I infrastructure requirements, e.g.,
  - Offer real-time response
    - 20 seconds or less
  - Meet CORE batch response requirements (if batch offered)
    - Receipt by 9pm ET requires response by 7am ET next business day
  - Meet CORE system availability requirements
    - 86% availability (calendar week)
  - Use of CORE-compliant acknowledgements
    - Specifies when to use TA1 and 997
  - Offer a CORE-compliant Connectivity option
    - Support HTTP/S 1.1
  - Provide a CORE-compliant Companion Guide flow and format
    - Developed jointly with WEDI

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Questions?



- Availity is an “industry” solution, not a niche player – we support all aspects of the health care value chain
- Availity market presence
  - More than 40,000 registered office locations
  - More than 450 million transactions annually
  - Conducts business in all 50 states
- More than 20 million patients benefit from Availity services
- Third largest claims clearinghouse in country
- Largest sender to Blue Exchange
- Administrative, Financial, and Clinical services in production today



## Vendor/Clearinghouse Perspective: CORE Participation and Certification

- As a vendor/clearinghouse or Health Information Exchange our goal is to help providers and payers work better together so they can better serve patients. Being CORE compliant supports that goal.
- 5.4 million real-time web portal transaction per month
  - 78% Eligibility & Benefits
  - 10% Claims Status
  - Average less than 5 second response time
- Savings is our top goal, not profit maximization
- Our mission is to reduce costs, waste, and friction in the US health care system. CORE helps us meet these goals by promoting cross-industry stakeholder participation and consensus development of business operating rules that build on HIPAA standards.

# CORE Phase II Proposed Connectivity Rule Overview

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- Rule Background and Rationale
- Basic Conformance Requirements for Key Stakeholders
- Envelope Specifications using Message Enveloping Standards
  - HTTP MIME Multipart
  - SOAP + WSDL
- Submitter Authentication Standards
  - Username/Password
  - X.509 Certificates over SSL
- Metadata

**Note:**

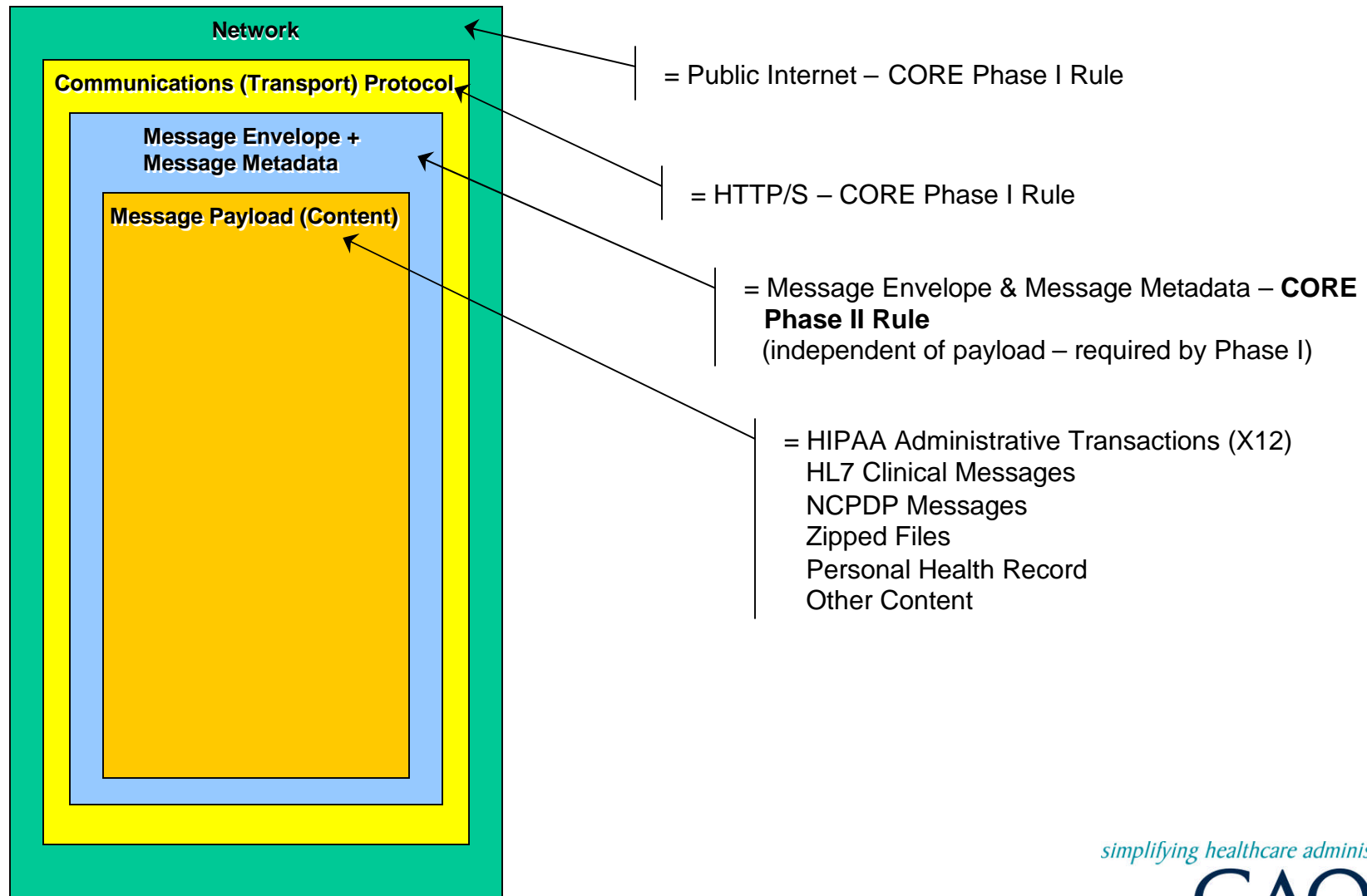
***This is not an all inclusive overview of the proposed Phase II Connectivity Rule requirements. Future audiocasts will provide a more detailed review. All proposed Phase II Rules are available at [www.caqh.org](http://www.caqh.org).***

# Proposed Phase II Connectivity Background and Rationale

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- Developed using consensus-based approach among industry stakeholders and is designed to:
  - Facilitate interoperability
  - Improve utilization of transactions
  - Enhance efficiency and help lower the cost of information exchange in healthcare
- Provides a “safe harbor”
  - Assured to be supported by any CORE-certified trading partner
- Rule *does not*:
  - Require trading partners to remove existing connections that do not match the rule
  - Require that all CORE-certified trading partners use this method for all new connections
- Uses existing standards
- All CORE rules are a base and not a “ceiling”

# Achieving Connectivity Interoperability Requires Standards



# Key Criteria Met by Short Listed Envelope Standards

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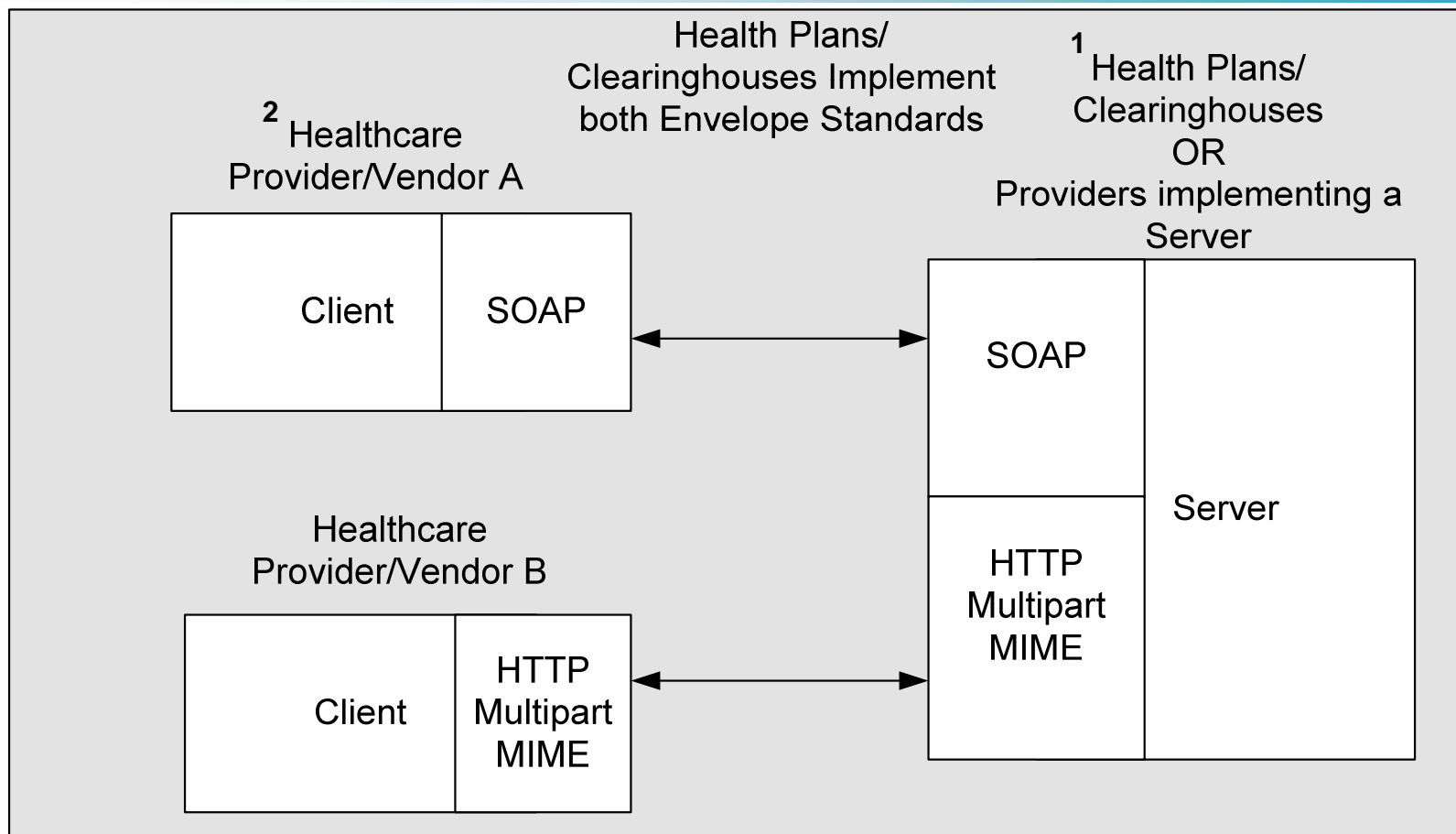
- Technical business goals
  - Supports rules based routing
  - Supports Real time (request/reply, or synchronous) transaction processing
  - Supports Point-to-Point message exchange
  - Supports Batch (or asynchronous) message exchange
- Security goals
  - Supports identification
  - Supports submitter authentication, with ability to encrypt
  - Supports HIPAA security regulations
- Messaging goals
  - Payload agnostic (to enable interoperability)
  - Message metadata
- Implementation business principles
  - Language neutral (e.g., payloads like X12, HL7 have language specific envelopes that vary in metadata content and position)
  - Platform neutral

## Proposed Phase II Connectivity Background and Rationale (cont'd)

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- Decision on supporting two message envelope standards
  - SOAP+WSDL
    - Well aligned with HITSP and HL7
    - Lends itself to future rule development using Web-services standards for more advanced requirements (e.g., reliability)
  - HTTP MIME Multipart
    - Relatively simple and well understood protocol framework
    - CORE-certified entities have already implemented HTTP as part of Phase I
  - Incremental “stepped” approach:
    - Facilitates adoption in a market that is still maturing
    - Facilitates interoperability relative to the current state of envelope standard variability in the marketplace

# Phase II Connectivity: Envelope Conformance



<sup>1</sup> *Health Plans, Health Plan Vendors, Clearinghouses or Providers implementing a server must support\* both envelope standards.*

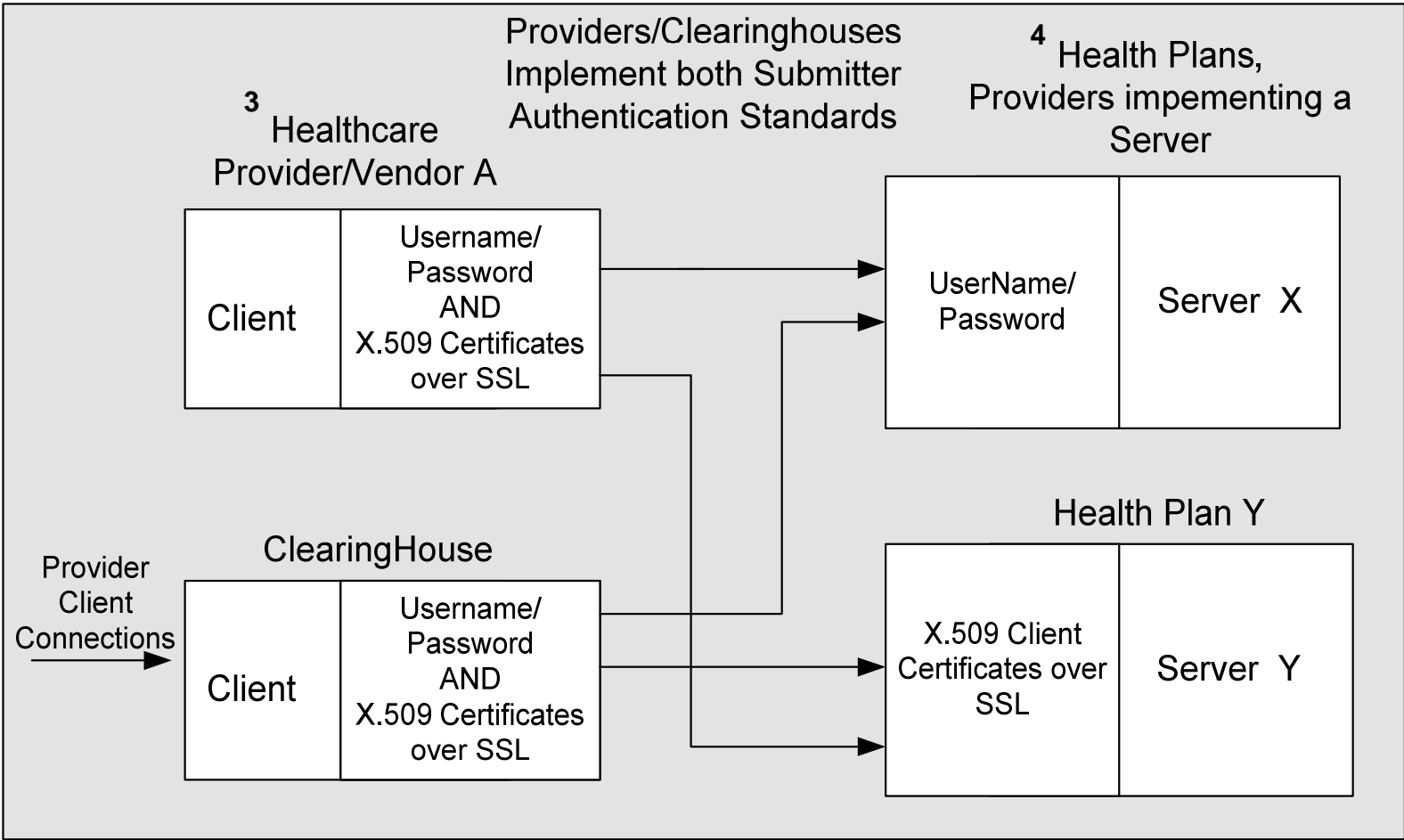
<sup>2</sup> *Providers and Provider Vendors acting as a client need only support one of the envelope standards.*

*Note: Standards are paired with a metadata list  
\* Refer to Rule for definition*

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# Phase II Connectivity: Submitter Authentication



<sup>3</sup> *Providers, Provider Vendors or Clearinghouses acting as a client must support\* both submitter authentication standards.*

<sup>4</sup> *Health Plans, Health Plan Vendors or Providers implementing a server need only support one submitter authentication standard.*

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\* Refer to Rule for definition

# Phase II Connectivity: Metadata Will be Outside the Payload

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Concept applied in Phase I, and confirmed again in Phase II

## Rationale:

- Facilitates connectivity standardization as well as administrative and clinical integration
- Accelerates industry interoperability
- Entities are able to do auditing and authentication without parsing payload/bring payload into their system
- Payload agnostic
  - Allows CORE's connectivity rules to evolve to future phases independent of payload standard evolution; in other CORE rules, e.g. Data Content, adoption of payloads are promoted for content, e.g. 270/271
  - Supports approach of other national initiatives

# CORE Connectivity: Metadata

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Decision: Use same metadata for request and response

- Payload Type
- Processing Mode
- Payload Length
- Payload ID
- Time Stamp
- User Name
- Password
- Sender Identifier
- Receiver Identifier
- CORE Rule Version
- Checksum
- Error Code
- Error Message

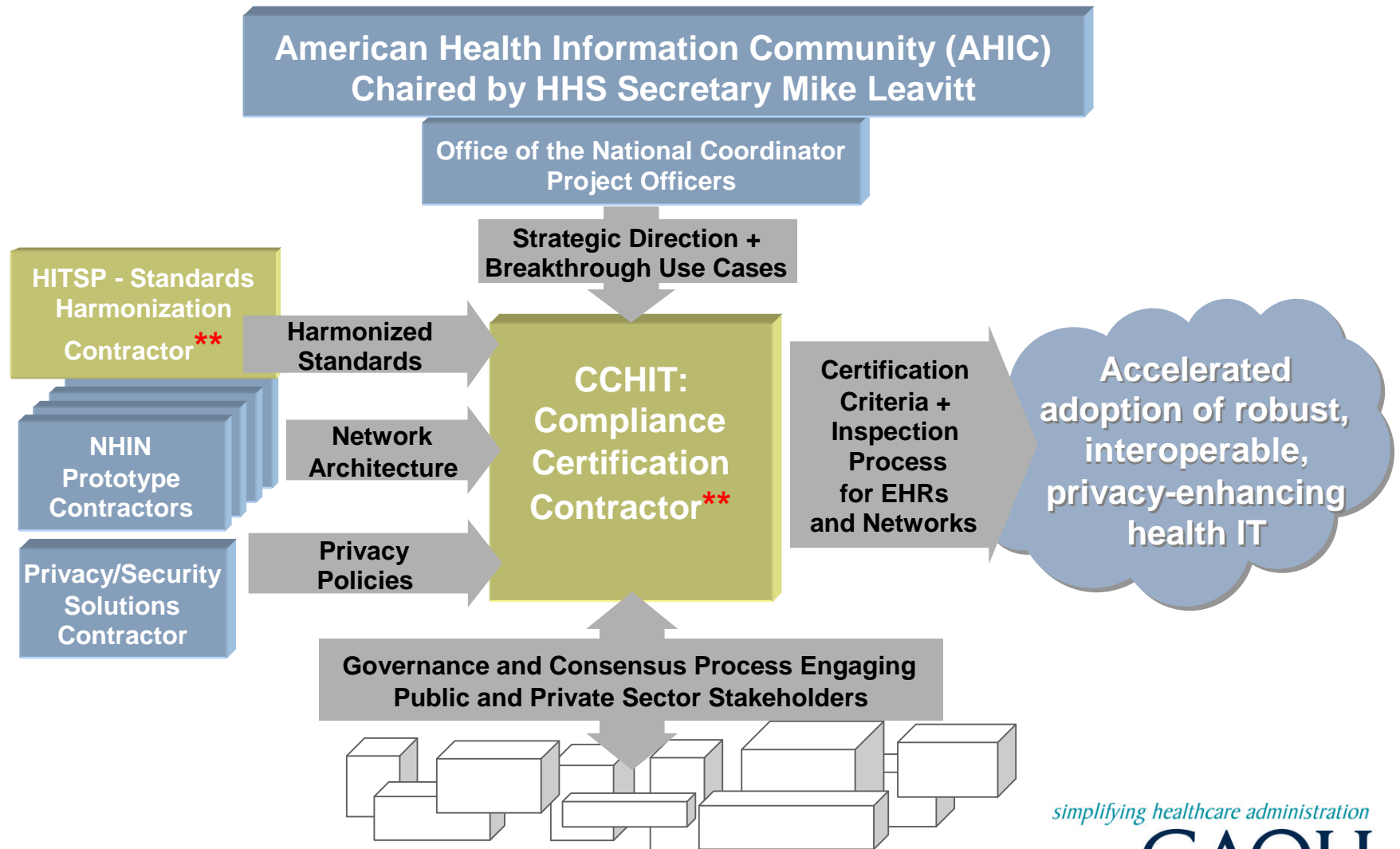
**\*\* See proposed CORE Phase II Rule for detailed descriptions, intended use for each element**

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Questions?

# Coordinating With National Initiatives

# CCHIT and HITSP Roles Within HHS Health IT Strategy



42 \*\*Indicates where CORE is involved

# CORE Coordination with National Initiatives

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## HITSP

- The CORE Phase I Data Content Rule is recognized in the Healthcare Information Technology Services Panel (HITSP) Consumer Empowerment Specifications officially recognized by HHS Secretary Mike Leavitt in January 2008
  - ★ This recognition means that those CORE rules, included in HITSP's Consumer Empowerment Interoperability Specifications, can be incorporated into federal agencies' requirements
  - Inclusion of the CORE rules demonstrates the need for a national approach to clinical and administrative data integration
  - Draft HITSP Medication Management Specifications recognize Phase I CORE rules

# State-Based Outreach: Examples

State-based approaches are emerging, and CAQH is working with the trade associations to encourage CORE's national approach:

- Colorado
  - Commission report delivered to state legislature in February 2008 stated the cost savings for healthcare administrative simplification. CAQH presented CORE to government and private stakeholders in March.
- Ohio
  - Recent legislation called for the formation of an advisory committee to present recommendations on issues related to electronic information exchange, including eligibility. CAQH has offered its assistance to the committee as an educational resource given CORE was noted in draft legislation.
- Rhode Island Health Insurance Commissioner and Rhode Island Quality Institute
  - State legislation requires a reduction in healthcare administrative costs; state is reviewing CORE to determine if it can be a vehicle to address the legislation
- Texas
  - Texas Department of Insurance had CAQH present CORE in response to state legislation that focuses on administrative simplification and mentions CORE; CORE has presented twice, most recently in March.
- Virginia
  - Secretary of Technology reviewing how technology can reduce the state's healthcare costs; CAQH presented CORE to a statewide Committee in April

(Note: Minnesota did pass state-specific eligibility rules in Dec. 2007, however, they are complementary to CORE Phase I data content requirements)

# Next Steps

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- Phase II Voting Timeline
  - Proposed Phase II Rules and Policies are expected to be voted on by the CORE membership in June 2008, followed by CAQH Board approval
- Phase II Adoption
  - The Phase II certification testing process is expected to begin shortly after rule approval, with the first Phase II Certification Seals expected to be granted in 4<sup>th</sup> quarter 2008
- Phase III Discussions
  - Phase III Discussions will also begin shortly after Phase II Rule approval
  - Preliminary potential topics for Phase III discussion include identifying the patient, pharmacy benefits/e-prescribing and prior authorization

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Additional Questions?

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CAQH<sup>®</sup>

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# Appendix

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- CORE Participating Organizations
- CORE-Certified Entities and Endorsers

# Current Participants

- **Health Plans**

- Aetna, Inc.
- AultCare
- Blue Cross Blue Shield of Michigan
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- CareFirst BlueCross BlueShield
- CIGNA
- Coventry Health Care
- Excellus Blue Cross Blue Shield
- Group Health, Inc.
- Harvard Pilgrim HealthCare
- Health Care Service Corporation
- Health Net, Inc.
- Health Plan of Michigan
- Horizon Blue Cross Blue Shield of New Jersey
- Humana Inc.
- Independence Blue Cross
- UnitedHealth Group
- WellPoint, Inc.

- **Providers**

- Adventist HealthCare, Inc.
- American Academy of Family Physicians (AAFP)
- American College of Physicians (ACP)
- American Medical Association (AMA)
- Catholic Healthcare West
- Cedars-Sinai Health System
- Greater New York Hospital Association (GNYHA)
- HealthCare Partners Medical Group
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Mobility Medical, Inc.
- Montefiore Medical Center of New York
- New York-Presbyterian Hospital
- North Shore LIJ Health System
- Partners HealthCare System
- University Physicians, Inc. (University of Maryland)

- **Government Agencies**

- Louisiana Medicaid – Unisys
- Michigan Department of Community Health
- Michigan Public Health Institute
- Minnesota Department of Human Services
- Oregon Department of Human Resources
- TRICARE
- United States Centers for Medicare and Medicaid Services (CMS)
- United States Department of Veterans Affairs

- **Associations / Regional Entities / Standard Setting Organizations**

- America's Health Insurance Plans (AHIP)
- ASC X12
- Blue Cross and Blue Shield Association (BCBSA)
- Delta Dental Plans Association
- eHealth Initiative
- Health Level 7
- Healthcare Association of New York State
- Healthcare Billing and Management Association
- Healthcare Financial Management Association (HFMA)
- Healthcare Information & Management Systems Society
- LINUXUS (an initiative of GNYHA)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- NJ SHORE
- Private Sector Technology Group
- Smart Card Alliance Council
- Utah Health Information Network (UHIN)
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

# Current Participants (continued)

- **Vendors**

- ACS EDI Gateway, Inc.
- athenahealth, Inc.
- Availity LLC
- CareMedic Systems, Inc.
- ClaimRemedi, Inc.
- Claredi (an Ingenix Division)
- EDIFECs
- Electronic Data Systems (EDS)
- Electronic Network Systems (ENS) (an Ingenix Division)
- Emdeon Business Services
- Enclarity, Inc.
- First Data Corp.
- GE Healthcare
- GHN-Online
- Health Management Systems, Inc.
- Healthcare Administration Technologies, Inc.
- HTP, Inc.
- IBM Corporation
- Infotech Global, Inc.
- InstaMed
- MedAvant Healthcare Solutions
- MedData
- Microsoft Corporation
- NASCO
- NaviMedix
- NextGen Healthcare Information Systems, Inc.
- Passport Health Communications
- Payerpath, a Misys Company
- RealMed Corporation
- Recondo Technology, Inc.
- RelayHealth
- RxHub
- Siemens / HDX

- SureScripts
- The SSI Group, Inc.
- The TriZetto Group, Inc.
- VisionShare, Inc.

- **Other**

- Accenture
- Foresight Corp.
- Omega Technology Solutions
- PNC Bank
- PricewaterhouseCoopers LLP

# Implementation: Phase I – Certified Entities/Products

## Clearinghouses

- ACS EDI Gateway, Inc. / ACS EDI Gateway, Inc. Eligibility Engine
- Availity, LLC / Availity Health Information Network
- Emdeon Business Services / Emdeon Real-Time Exchange
- Emdeon Business Services / Emdeon Batch Verification
- Health Management Systems, Inc. / HMS
- MedAvant Healthcare Solutions / Phoenix Processing System
- MedData / MedConnect
- NaviMedix, Inc. / NaviNet
- Passport Health Communications / OneSource
- RelayHealth / Real Time Eligibility
- RxHub / PRN
- Siemens Medical Solutions / Healthcare Data Exchange
- The SSI Group, Inc. / ClickON® E-Verify

## Health Plans

- Aetna Inc.
- AultCare
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- Health Net
- WellPoint, Inc. (and its 14 blue-licensed affiliates)

## Providers

- Mayo Clinic
- Montefiore Medical Center
- US Department of Veterans Affairs

## Vendors

- athenahealth, Inc. / athenaCollector
- CSC Consulting, Inc./CSC DirectConnect<sup>sm</sup>
- Emerging Health Information Technology, LLC / TREKS
- GE Healthcare / EDI Eligibility 270/271
- HTP, Inc. / RevRunner
- Medical Informatics Engineering, Inc. (MIE) / WebChart EMR \*
- NoMoreClipboard.com
- Post-N-Track / Doohickey™ Web Services
- The SSI Group, Inc. / ClickON® Net Eligibility
- VisionShare, Inc. / Secure Exchange Software

\* Product also certified by the Certification Commission for Healthcare Information Technology (CCHIT<sup>sm</sup>). For accurate information on certified products, please refer to the product listings at [www.cchit.org](http://www.cchit.org).

# Implementation: Phase I – Commitments to Certification

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## Commitment to Certify in 2008

### Clearinghouses

- MD On-Line, Inc.

### Health Plans

- Blue Cross Blue Shield of Michigan
- CareFirst BlueCross BlueShield
- Humana, Inc.

### Vendors

- Quovadx

# Implementation: Phase I – Endorsers

## **Endorsement**

- Accenture
- American Academy of Family Physicians (AAFP)
- American Association of Preferred Provider Organizations (AAPPO)
- American College of Physicians (ACP)
- American Health Information Management Association (AHIMA)
- California Regional Health Information Organization
- Claredi, an Ingenix Division
- Edifecs, Inc.
- eHealth Initiative
- Electronic Healthcare Network Accreditation Commission (EHNAC)
- Enclarity, Inc.
- Foresight Corporation
- Greater New York Hospital Association and Linxus
- Healthcare Financial Management Association (HFMA)
- Healthcare Information and Management Systems Society (HIMSS)
- Medical Group Management Association (MGMA)
- Michigan Public Health Institute
- Microsoft Corporation
- MultiPlan, Inc.
- NACHA – The Electronic Payments Association
- Pillsbury Winthrop Shaw Pittman, LLP
- Smart Card Alliance
- URAC
- Workgroup for Electronic Data Interchange (WEDI)