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Committee on Operating Rules for Information Exchange (CORE)

Overview Presentation

Discussion Topics

- Overview of CAQH and CORE
- CORE Phase I Operating Rules
 - 270/271 Data Content
 - Acknowledgements
 - Response Time
 - System Availability
 - Connectivity
 - Companion Documents
- Becoming CORE Phase I Certified
- Participating in CORE Phase II rules development

An Introduction to CAQH

CAQH, a nonprofit alliance of leading health plans, networks and trade associations, is a catalyst for industry initiatives that streamline healthcare administration

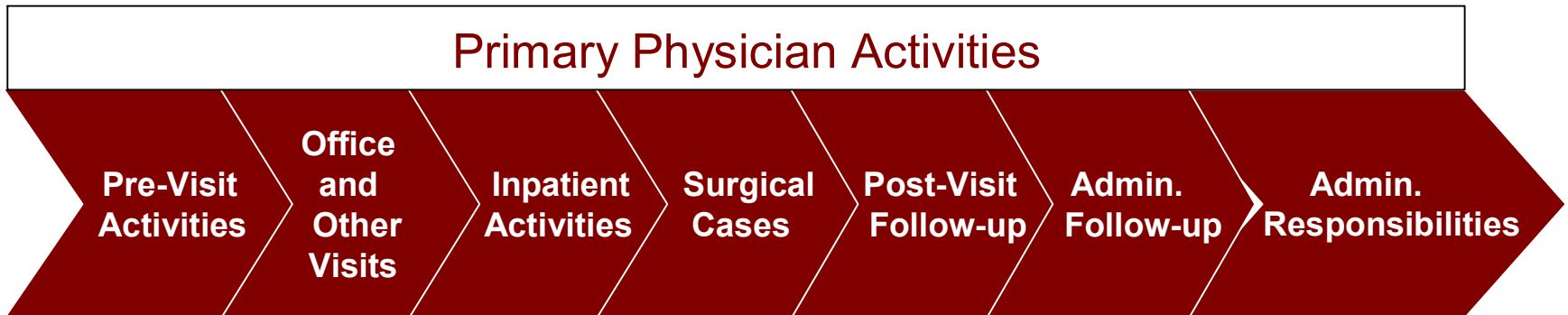
CAQH solutions help:

- 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

Physician-Payer Interaction

Physician Activities That Interact With Payers are Primarily Administrative in Nature (with Some Clinical Interaction)



- Patient inquiry
- Appt scheduling
- Scheduling verification
- Financial review of pending appts.
- Encounter form/medical record preparation

- Registration & referral mgmt.
- Admin & medical record preparation
- Patient visit
- Ancillary testing
- Charge capture
- Prescriptions

- Scheduling & referral mgmt.
- Admin & medical record preparation
- Inpatient care
- Ancillary testing
- Charge capture

- Scheduling & referral mgmt.
- Admin & medical record preparation
- Surgical care
- Post care
- Follow-up care

- Visit orders & instructions
- Education materials
- Prescriptions
- Ancillary tests
- Referrals
- Follow-up visits

- Utilization review
- Claims/bill generation
- Billing
- Payment processing
- Claims follow-up

- Personnel management
- Financial management
- Managed care
- Information systems
- Facilities management
- Medical staff affairs

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Key Challenges: Eligibility and Benefits

- HIPAA does not offer relief for the current eligibility problems
 - Data scope is limited; elements needed by providers are not mandated
 - Does not standardize data definitions, so translation is difficult
 - Offers no business requirements, e.g., timely response
- Individual plan websites are not the solution for providers
 - Providers do not want to toggle between numerous websites that each offer varying, limited information in inconsistent formats
- Vendors cannot offer a provider-friendly solution since they depend upon health plan information that is not available

Vision: Online Eligibility and Benefits Inquiry



Give Providers Access to Information Before or at the Time of Service...

Providers will send an online inquiry and know:

- Which health plan covers the patient *
- Whether the service to be rendered is a covered benefit (including copays, coinsurance levels and base deductible levels as defined in member contract)
- What amount the patient owes for the service**
- What amount the health plan will pay for authorized services**

Note: No guarantees would be provided

* This is the only HIPAA-mandated data element; other elements addressed within Phase I scope are part of HIPAA, but not mandated

** These components are critically important to providers, but are not proposed for Phase I

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Vision: Online Eligibility and Benefits Inquiry



... Using any System for any Patient or Health Plan

As with credit card transactions, the provider will be able to submit these inquiries and receive a real-time response*

- From a single point of entry
 - Using an electronic system of their choice
-
- For any patient
 - For any participating health plan

*Initiative will initially support batch and real-time

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CORE

- Industry-wide stakeholder collaboration launched in January 2005
- 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
 - Based on outcome of initiative, apply concept to other administrative transactions
- Answer to the question: Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?

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 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:

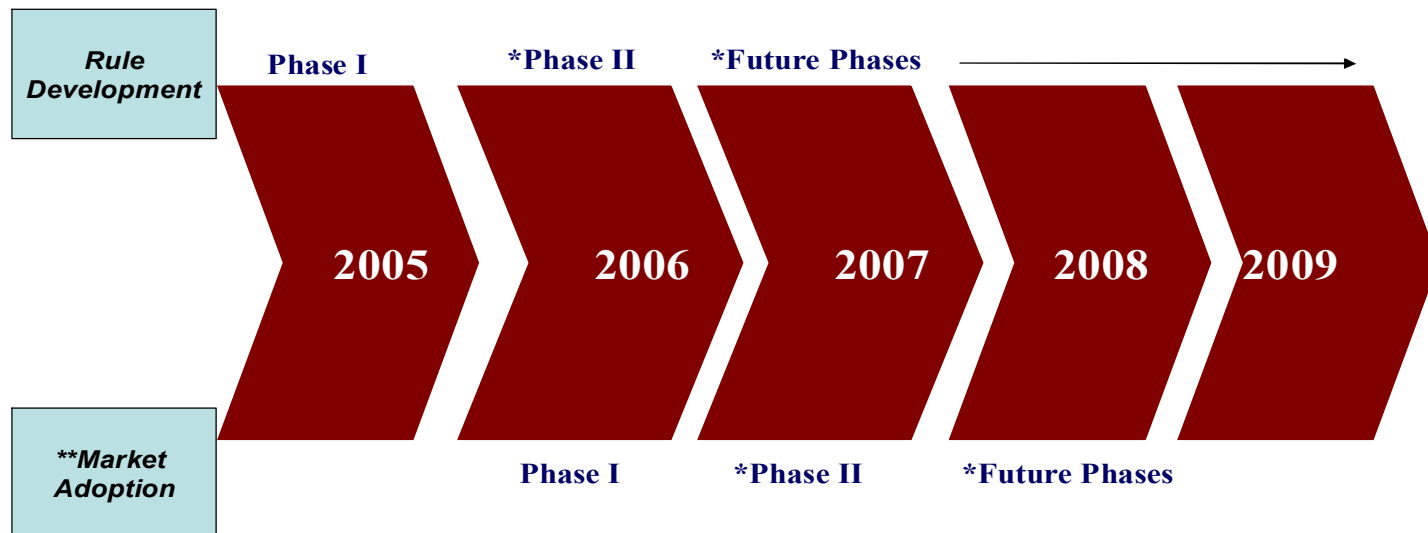
- Build a database
- Replicate the work being doing by standard setting bodies like x12 or HL7

What Are Operating Rules?

- Agreed-upon business rules for using and processing transactions
- Encourages the marketplace to achieve a desired outcome – interoperable network governing specific electronic transactions (i.e., ATMs in banking)
- Key components
 - Rights and responsibilities of all parties
 - Transmission standards and formats
 - Response timing standards
 - Liabilities
 - Exception processing
 - Error resolution
 - Security

Phased Approach

CORE Timeline Overview



Notes:

*Scope of Phase II and Future Phases will be decided upon by CORE Membership

**Not all CORE participants will meet targeted market adoption timeframes; an ongoing CORE focus will be achieving/increasing adoption of established phases. CORE will look to its founding participants to achieve target market adoption timeline.

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Current Participants

- Nearly 85 organizations participating representing all aspects of the industry:
 - 16 health plans
 - 9 providers
 - 6 provider associations
 - 16 regional entities/RHIOS/standard setting bodies/other associations
 - 26 vendors (clearinghouses and PMS)
 - 6 others (consulting companies, banks)
 - 5 government entities, including:
 - Centers for Medicare and Medicaid Services
 - Louisiana Medicaid – Unisys
 - TRICARE
- CORE participants maintain eligibility/benefits data to nearly 125 million commercially insured lives, plus Medicare beneficiaries

Current Participants

- **Health Plans**
 - Aetna, Inc.
 - Blue Cross Blue Shield of Michigan
 - Blue Cross and Blue Shield of North Carolina
 - BlueCross BlueShield of Tennessee
 - CareFirst BlueCross BlueShield
 - CIGNA
 - Excellus BlueCross BlueShield
 - Group Health, Inc.
 - Health Care Service Corporation
 - Health Net, Inc.
 - Health Plan of Michigan
 - Humana, Inc.
 - Independence Blue Cross
 - Kaiser Permanente
 - UnitedHealth Group
 - WellPoint, Inc.
- **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
 - Healthcare Financial Management Association (HFMA)
 - Healthcare Information & Management Systems Society
 - Maryland/DC Collaborative for Healthcare IT
 - 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)
- **Providers**
 - Adventist HealthCare, Inc.
 - American Academy of Family Physicians (AAFP)
 - American College of Physicians (ACP)
 - American College of Radiology (ACR)
 - American Hospice, Inc.
 - American Medical Association (AMA)
 - Greater New York Hospital Association
 - HCA Healthcare
 - Laboratory Corporation of America (LabCorp)
 - Mayo Clinic
 - Medical Group Management Association (MGMA)
 - Montefiore Medical Center of New York
 - University of Wisconsin Medical Foundation (UWMF)
 - University Physicians, Inc. (University of Maryland)
 - U.S. Oncology
- **Government Agencies**
 - Louisiana Medicaid – Unisys
 - Michigan Department of Community Health
 - Michigan Public Health Institute
 - TRICARE
 - United States Centers for Medicare and Medicaid Services (CMS)

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Current Participants

- **Vendors**

- ACS State Healthcare
- Affiliated Network Services
- Athenahealth, Inc.
- Availity LLC
- CareMedic Systems, Inc.
- EDIFECs
- Electronic Data Systems (EDS)
- Electronic Network Systems (ENS)
- Emdeon
- First Data Corp.
- GHN-Online
- HTP, Inc.
- InterPayNet
- MedAvant Healthcare Solutions
- MedCom USA
- MedData
- Microsoft Corporation
- NaviMedix
- Passport Health
- Post-N-Track
- Quovadx
- RxHub
- Siemens / HDX
- SureScripts
- The TriZetto Group, Inc.
- ViPS (a Division of Emdeon)

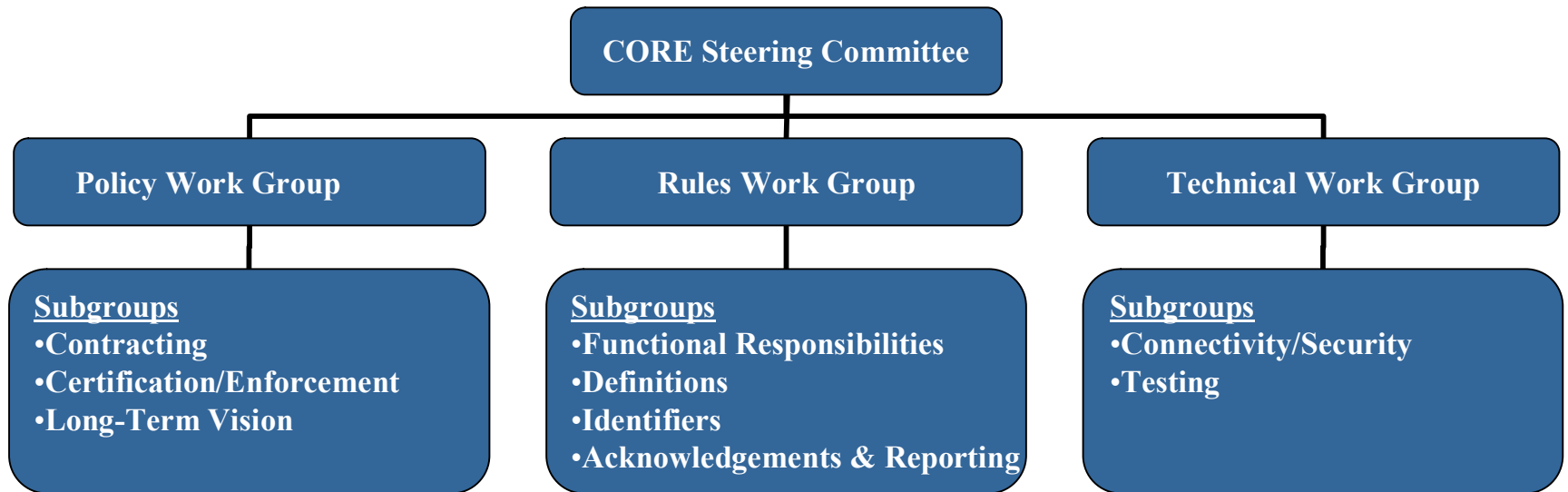
- **Other**

- ABN AMRO
- Accenture
- Data Processing Solutions
- Marlabs, Inc.
- PNC Bank
- PricewaterhouseCoopers LLP

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CORE Work Groups And Subgroups



CORE Leadership

POSITION	COMPANY	INDIVIDUAL
Chair	BCBSNC	Harry Reynolds, Vice President
Vice Chair	HCA	Eric Ward, CEO of Financial Services
Policy Work Group Chair	Humana	Bruce Goodman, Senior Vice President & CIO
Rules Work Group Chair	PNC Bank	J. Stephen Stone, SVP & Director of Product Management
Technical Work Group Chair	Siemens	Mitch Icenhower, Director, HDX
At Large Members: Health Plan 1	Aetna	Paul Marchetti, Head of Network Contracting, Policy and Compliance
At Large Members: Health Plan 2	BCBSMI	Deborah Fritz-Elliott, Director, Electronic Business Interchange Group
At Large Members: Vendor Org.	TriZetto	Dawn Burriss, Vice President, Constituent Connectivity
At Large Members: Provider Organization	Montefiore	J. Robert Barbour, JD, Vice President, Finance for MD Services and Technical Development
At Large: Other Organization	HIMSS	H. Stephen Lieber, President & CEO

Other (Ex-officio or Advisor):

CAQH: Robin Thomashauer, Executive Director; **CMS:** Stanley Nachimson, Senior Technical Advisor, Office of E-Health Standards and Services; **ASC X12:** Donald Bechtel, Co-Chair, X12 Healthcare Task Group (also with Siemens); **WEDI:** Jim Schuping, Executive Vice President; **NACHA:** Elliott McEntee, President and CEO

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CORE

Phase I Operating Rules

Phase I Scope

- Pledge, Strategic Plan, including Mission/Vision
- Certification and Testing (conducted by independent entities)
- Connectivity -- HTTPS Safe harbor
- Response Time -- For batch and real-time
- System Availability -- For batch and real-time
- Content
 - Patient Responsibility (co-pay, deductible, co-insurance levels in contracts – not YTD)
 - Service Codes (9 for Phase I)
- Acknowledgements
- Companion Guide (flow and format standards)

270/271 Data Content Rule

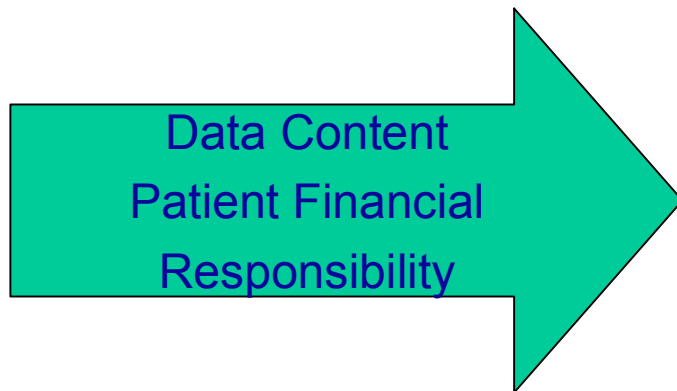
- Specifies what must be included in the 271 response to a Generic 270 inquiry or a non-required CORE service type
- Response must include
 - The status of coverage (active, inactive)
 - The health plan coverage begin date
 - The name of the health plan covering the individual (if the name is available)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

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
 - 47 - 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

Real World Impact



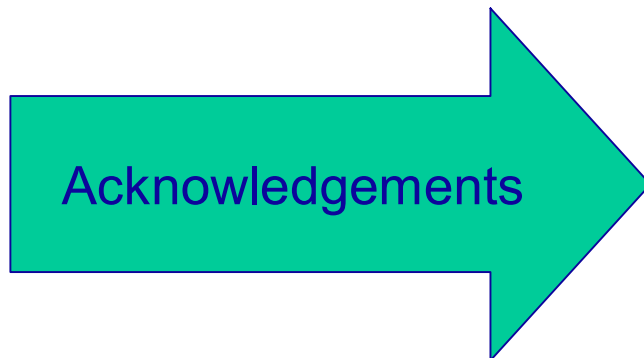
- Enables providers to inform patients of basic financial responsibility prior to or at time of service
- Gives providers a mechanism to better manage revenue and cash flow
- Enables plans to better utilize call center staff to provide higher levels of service to providers while reducing operational costs
- Enables vendors to differentiate themselves to offer improved products

Acknowledgements Rule

- Specifies when to use TA1 and 997
 - Real time
 - Submitter will always receive a response
 - Submitter will receive only one response
 - Batch
 - Receivers include
 - Plans,
 - Intermediaries
 - Providers
 - Will always return a 997 to acknowledge receipt for
 - Rejections
 - Acceptances

Remember when you didn't know if your fax went through?

Real World Impact



- Enables prompt, automated error identification in all communications, reducing provider and plan calls to find problems
- Industry no longer required to program a multiplicity of different proprietary error reports thus simplifying and reducing the cost of administrative tasks
- Eliminates the “black hole” of no response by confirming that batches of eligibility inquiries have been received without phone calls

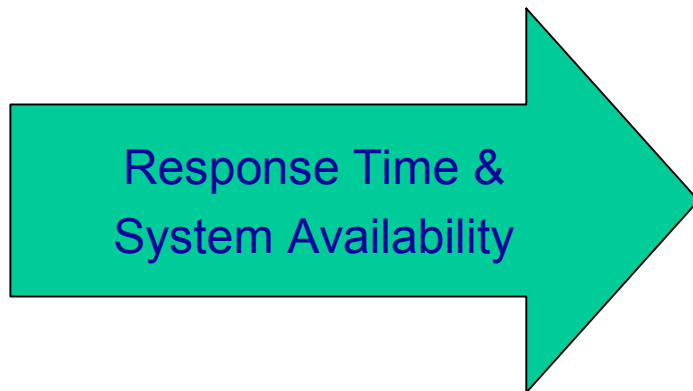
Response Time Rule

- Real time
 - Maximum: 20-second round trip
- Batch
 - Receipt by 9:00 p.m. Eastern Time requires response by 7:00 a.m. Eastern Time the next business day
- CORE participants in compliance if they meet these measures 90 percent of time within a calendar month

System Availability

- Minimum of 86 percent system availability
 - Publish regularly scheduled downtime
 - Provide one week advance notice on non-routine downtime
 - Provide information within one hour of emergency downtime

Real World Impact



- Enables providers to reliably know when to expect responses to eligibility inquiries and manage staff accordingly
- Encourages providers to work with practice management vendors, clearinghouses and plans that are CORE-certified and thus comply with the rules
- Identifies to the industry that immediate receipt of responses is important and lets all stakeholders know the requirements and expectations
- Enables vendors to differentiate themselves to offer improved products

Connectivity Rule

- CORE-certified entities must support HTTP/S 1.1 over the public Internet as a transport method for both batch and real-time eligibility inquiry and response transactions
- Real-time requests
- Batch requests, submissions and response pickup
- Security and authentication data requirements
- Response time, time out parameters and re-transmission
- Response message options & error notification
 - Authorization errors
 - Batch submission acknowledgement
 - Real-time response or response to batch response pickup
 - Server errors

Real World Impact



- Like other industries have done, supports healthcare movement towards at least one common, affordable connectivity platform. As a result, provides a minimum “safe harbor” connectivity and transport method that practice management vendors, clearinghouses and plans that are CORE-certified can easily and affordably implement
- Enables small providers not doing EDI today to connect to all clearinghouses and plans that are CORE-certified using any CORE-certified PMS
- Enables vendors to differentiate themselves to offer improved products cost-effectively

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Companion Documents Rule

- CORE-certified entities will use the CORE Companion Document format/flow for all their 270/271 companion documents
 - CORE participants would not be asked to conform to standard Companion Guide language
- “Best Practices” Companion Guide format developed by CAQH/WEDI in 2003

Real World Impact



- Provides a consistent format to the industry for presenting a health plan's requirements for the 270/271 Eligibility Transactions
- Enables the industry to minimize need for unique data requirements
- Promotes industry convergence of multiple formats and requirements into a common companion document that will reduce the burden of maintaining a multiplicity of companion documents

Phase I Rules Impact: Health Plans

- Increase in electronic eligibility inquiries and a commensurate decrease in phone inquiries
- Reduced administrative costs
- More efficient process for providing eligibility and benefits information to providers
- May need to change IT capabilities to meet rules and data relationships with vendors
- Will need to sign CORE pledge and prove systems compliance by seeking CORE certification

Phase I Rules Impact: Providers

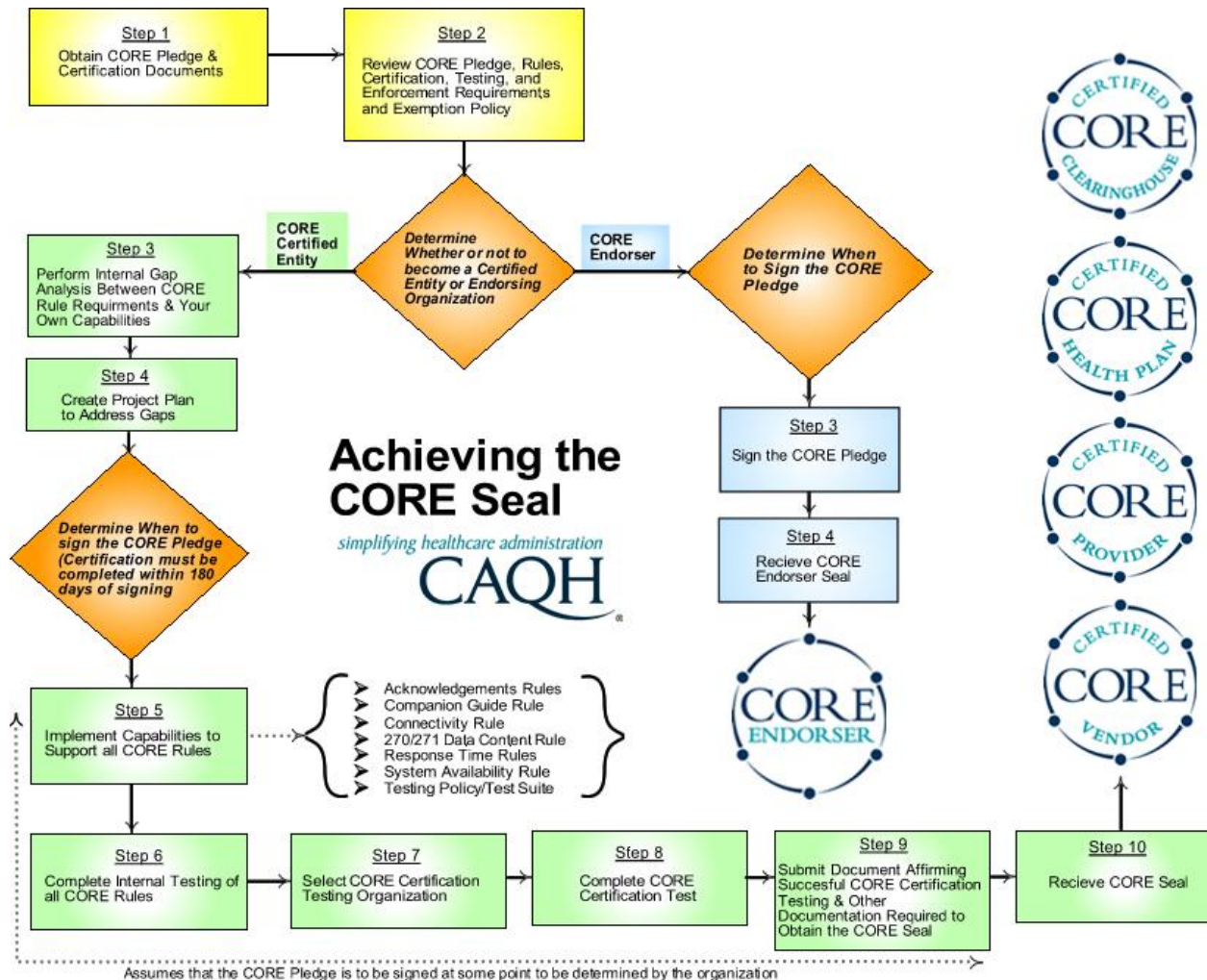
- All-payer eligibility solutions from CORE-certified vendors
- Because the data will be sourced directly from the relevant health plan(s), providers can be assured of data accuracy
- Improved Customer Service to Patients/Subscribers:
 - redundant registration interviews eliminated
 - advance notification of potential financial liability, e.g., non-covered services, out of network penalties
 - prior authorization/referral requirements met in advance
 - claims filed to right payer and paid, patients not caught in middle
- Data entry and errors diminished through integrated 271
- Reduced staff time in confirming eligibility and benefits
- Reduced bad debt related to eligibility issues
- Reduced claim denials due to eligibility

Phase I Measures of Success: Tracking ROI

- CAQH will track and report Phase I Measures of Success
- Volunteers are being sought in each key stakeholder category
 - Measures will allow CAQH to publish impact by stakeholder category
- Examples of metrics
 - Health plans
 - Change in call center volume related to eligibility/benefit inquiries; average number and percentages of calls per week (per 1,000 members) before CORE adoption versus averages after implementing Phase I CORE
 - Providers
 - Change in usages of the following methods of eligibility transactions: Phone, Fax, Real-time EDI, Batch EDI, DDE

Becoming CORE Phase I Certified

Achieving the CORE Seal



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CORE Pledge

- CORE certification is voluntary
- Binding “Pledge”
- By signing Pledge, CORE entities agree to adopt, implement and comply with Phase I eligibility and benefits rules as they apply to each type of stakeholder business
- The Pledge will be central to developing trust that all sides will meet expectations
- Organizations have 180 days from submission of the Pledge to successfully complete CORE certification testing

CORE Certification

- 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
- Entities that do not create, transmit or send – sign Pledge, receive CORE Endorser Seal

Certification Testing

- Based on Phase I CORE Test Suite
 - For each rule there is standard conformance requirements by stakeholder
 - Suite outlines scenarios and stakeholder-specific test scripts by rule
 - Not testing for HIPAA compliance, only Phase I CORE; however, entities must attest that, to the best of their knowledge, they are HIPAA compliant
- Phase I testing is not exhaustive, (e.g. does not include production data or volume capacity testing)
- Testing conducted by CORE-authorized certification testing entities
 - RFI issued in Summer 2005
 - RFP issued in November 2005
 - Authorized companies will have market products by early Q2 2006
 - Cost of testing determined by authorized companies; RFI responses indicated free to low-cost goal would be reached

Real World Impact



- Informs the industry that CORE-certified entities not only support their stakeholder-specific rules but have also implemented the required capabilities
- Provides a reasonable building block towards industry-wide conformance testing (and validation) for administrative transactions

CORE Certification Seals



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CORE Seal Fees

Health Plans

- Below \$75 million in net annual revenue \$4,000 fee
- \$75 million and above in net annual revenue \$6,000 fee

Vendors

- Below \$75 million in net annual revenue \$4,000 fee
- \$75 million and above in net annual revenue \$6,000 fee

Providers

- Up to \$1 billion in net annual revenue \$ 500 fee
- \$1 billion and above in net annual revenue \$1,500 fee

Endorser (only for entities that do not create, transmit or use eligibility data)

No fee

Real World Impact



- Provides mechanism to identify practice management vendors, clearinghouses and plans that are CORE-certified and, thus, to the best of CORE's knowledge compliant with the rules
- Sends a clear signal that compliance with administrative transactions is important and that there is a process to remove non-compliant organizations
- Enables vendors to differentiate themselves to offer improved products
- Publicly communicates the seriousness of this voluntary effort

Phase II: Areas Under Consideration

- Patient identification logic*
- More detailed components of eligibility transactions not addressed in Phase I, including:
 - Estimated patient responsibility (e.g., YTD member financials)
 - What amount the health plan will pay for authorized services (procedure code needed?)
 - Financial data on additional service type codes, such as carve-outs
- Enhancements to other aspects of Phase I
 - Faster response time
 - Greater system availability
 - HTTPS message format standards
- Initial set of rules for another transaction type, e.g. 835

*Research is already underway

Participating in CORE Phase II Rules Development

- CORE is developing the operating rules that will govern the exchange of information as it relates to eligibility and benefits, and potentially other administrative transactions
- It is critical that there is engagement from stakeholders throughout the healthcare system
- By participating, your organization will be contributing to a solution that addresses the complexity found in today's healthcare system
- Download application and join us today
 - http://www.caqh.org/ben_join.html
- Contact Gwendolyn Lohse at glohse@caqh.org for more information on CORE

In Closing

“The work of CORE is not something that one company – or even one segment of the industry – can accomplish on its own. We will all benefit from the outcome: an easier and better way of communicating with each other.”

-- *John W. Rowe, M.D., Executive Chairman of Aetna*

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