



CAQH Webinar: CORE Phase I Measures of Success

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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, providers and other stakeholders
- Reduce costs and frustrations associated with healthcare administration
- Facilitate administrative healthcare information exchange
- Encourage administrative and clinical data integration

Current Initiatives:

CORE® – Committee on Operating Rules for Information Exchange

UPD® – Universal Provider Datasource (over 740,000 providers)

CORE®

Committee on Operating Rules
for Information Exchange

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.

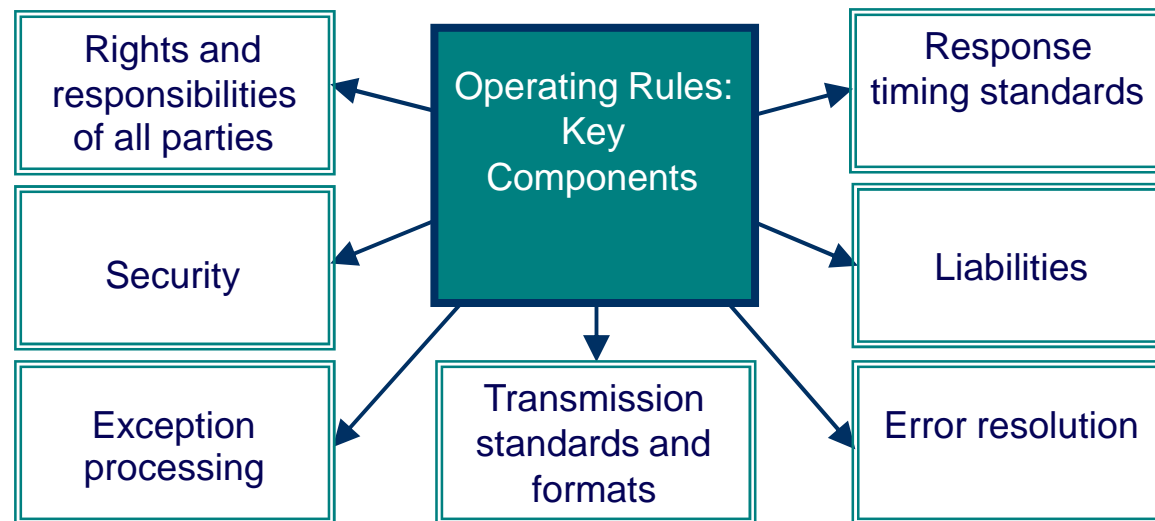
- Enable providers to submit transactions from the system of their choice (vendor agnostic) and quickly receive a standardized response from any participating stakeholder.
- Enable stakeholders to implement CORE phases as their systems allow.
- Facilitate stakeholder commitment to, and compliance with, CORE's long-term vision.
- Facilitate administrative and clinical data integration.

CORE is not:

- Building a database.
- Replicating the work being done by standard-setting bodies, e.g., X12 or HL7.

What are Operating Rules?

- Agreed-upon operating rules for using and processing transactions do not exist in healthcare outside of individual trading relationships.
- Operating rules encourage an interoperable network and, thereby, can allow providers to use the system of their choosing (*remaining vendor agnostic is a key CORE principle*).
- CORE certification informs the industry that entities are operating in accordance with the rules and support industry-wide standardization for administrative transactions.



simplifying healthcare administration

CORE Participation, Certification, & Endorsement

- Over 100 organizations representing all aspects of the industry participate in CORE
 - 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.
- To date, more than 40 healthcare organizations are certified to electronically exchange/receive basic eligibility and benefits information in accordance with the CORE Phase I rules
 - More than 65 million Americans (or approximately one-third of all commercially insured lives) are covered by CORE Phase I-certified health plans
- Most Phase I certified organizations are committed to becoming Phase II-certified by no later than the end of Q1-2010
 - Two organizations are already Phase II certified
- Approximately 30 organizations are endorsing CORE and the Phase I and Phase II rules
 - Endorsement is an option for entities that do not use, create, or transmit eligibility, benefits and/or claim status data

CORE: A Phased Approach

CORE Phase I

- ✓ Approved
- ✓ Implemented

CORE's first set of rules are helping:

- Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information.
- Provide access to this information in real-time via common internet protocols and with acknowledgements, etc.

CORE Phase II

- ✓ Approved
- ✓ Implemented

CORE's second set of rules expand on Phase I to include:

- Patient accumulators (remaining deductible).
- Rules to help improve patient matching.
- Claim status "infrastructure" requirements (e.g., response time).
- More prescriptive connectivity requirements and authentication.

CORE Phase III

- ✓ In
Development

CORE's third set of rules focus on:

- Claim status data requirements.
- Remittance.
- Prior Authorization / Referral.
- Standard Health Benefit / Insurance ID Card.
- More prescriptive connectivity requirements as well as digital authentication.

Phase I Rules Overview (Focus of this Study)

Policies

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

Rules

- *270/271 Data Content
 - Financials related to Patient Responsibility (co-pay, deductible, co-insurance levels in contracts – not YTD)
 - Service Codes
- 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)

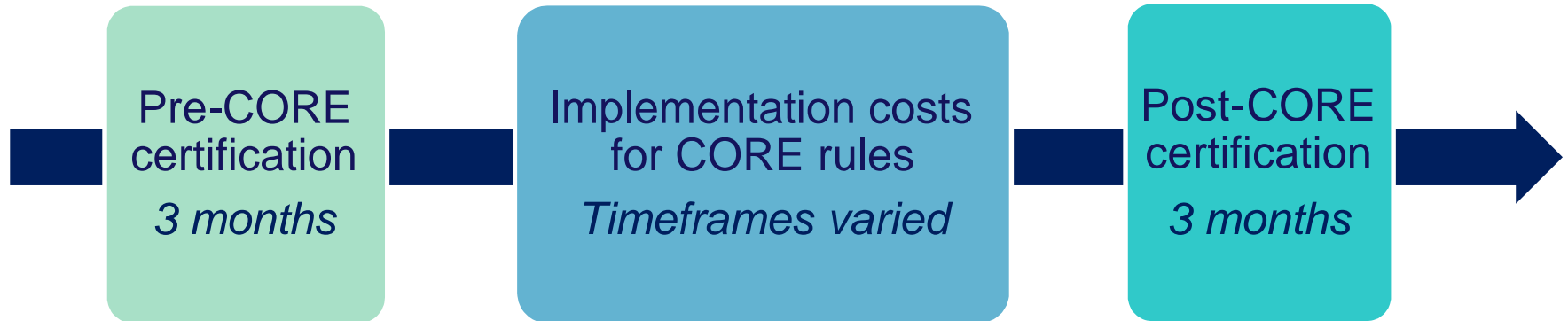
**Being enhanced/expanded upon in Phase II*

Conducting the Study

Study Overview

- The study assessed results achieved by health plan early adopters of CORE Phase I Rules and selected vendor and provider partners
- Approach
 - Analyzed data from three-month period prior to health plan CORE certification and one year later
 - Eligibility verification methods and volumes
 - Eligibility-related claim rejections and denials
 - Call center and customer satisfaction
 - Costs of adoption
 - Interviewed participants
- Participation
 - 6 national and regional health plans, representing
 - 33 million commercial members, 1.2 million providers
 - 22 million eligibility verifications per month, 30 million claims per month
 - 5 clearinghouses and vendors
 - 6 providers: hospitals, physician groups, surgery center

Metrics and Cost Timeline



A CAQH Initiative

Data Collection

- Recruit committed participants and their trading partners
- Data requested to complete the study came from each stakeholder type and was based on uniform metrics and interviews
- Data sources include:
 - System-generated or ad hoc reports, including financial reports, system audit reports and claim submitter/scrubber reports generated for providers or received from payers
 - Tracking components of the requested data over a certain period
 - Estimating data through discussions with registration/accounting/customer service staff
- Conducted on-site meetings
- Held team meeting calls for health plan participants

Metrics Tracked and Costs

Metrics were compared to a baseline, the costs of CORE adoption, and the ongoing implementation of CORE

Examples:

- Training expense
- Staff FTEs and wage rates
- Eligibility inquiry data volume, cost, labor
- Provider call center volumes
- Member call center volumes
- Claims related data volume, cost, labor
- Provider and customer satisfaction
- IT hardware and software costs

Team Meeting Process

- Team meetings of health plan participants were held on a regular basis from study conception to completion. Discussions were held to:
 - Assess timelines for data gathering and analysis
 - Present updates on internal data collection
 - Report trading partner updates
 - Recruitment
 - Data collection
 - Validate and discuss measures
 - Validate factors affecting measures
 - Share observations
 - Resolve questions
 - Impart lessons learned

Outcomes Assessed

- Eligibility verification activities via electronic and manual methods
- Claim rejections/denials/re-adjudication and associated re-work due to errors related to eligibility
- Call center volumes and costs associated with eligibility
- Claims rejections/denials related to patient identification issues, associated re-work and bad debt
- Provider, member, and employer satisfaction overall and specifically with respect to eligibility

Lessons Learned for the Next CORE Measures Study

- Measuring the impact of CORE rules requires a commitment by certified organizations and their trading partners to *measure outcomes that can be attributed to CORE rules implementation*
 - Recruit trading partners and coordinate measures early in process
- Organizations need to define baseline and appropriate measures to identify ROI and results
- Process to track CORE impact can be streamlined and simplified
 - Collaboration enables evaluation and sharing of comparable measures
 - Apples to apples comparisons difficult to obtain; requires limited operational variability or openness regarding metric definitions
- Before CORE-certification, it can be helpful to provide guidelines for metrics
 - Attract more participants in future studies
 - Encourages assessment of CORE ROI tracking
- Need to increase industry willingness for transparency among organizations
 - Openness regarding trading partner relationships

CAQH IBM Study Results

Results Common Across Stakeholders

- More robust and accessible eligibility methods have enhanced the flow of information between providers and health plans
 - More patient visits are verified
 - Richer content reduces the need for secondary phone verification
 - Real-time methods show most growth
 - Providers need a variety of methods - integrated and “on demand” transactions, as well as direct data entry
- CORE rules help stakeholders leverage investments
 - Common infrastructure supports multiple methods
 - Solutions reusable with new partners
 - Infrastructure will support new transaction types in the future
- Streamlined implementation with CORE partners
 - Better technical skill and resources
 - Less customization, reduced testing
 - Lower cost connectivity using the public internet
- Costs to achieve CORE certification vary widely, depending on how much technology change is required

Health Plan Results

- CORE certification, along with organizational-specific eligibility initiatives, yields strong results
 - Providers rapidly take advantage of new capabilities, e.g. real-time transactions
 - Extensive communication to providers, targeted outreach as needed, and collaboration with vendor partners improve adoption rate of electronic methods

- Key results - average return for individual health plans in the study *
 - Payback can be less than one year (considers only the shift from telephone to electronic verification)

One-time costs of certification	\$ 542,800
Annual ongoing costs **	\$ 49,200
Annual savings due to shift from telephone to electronic	\$ 2,666,800

- Progress towards having all visits verified
Ratio of verifications to claims **Up from .63 to .73**

* Results for 4 health plans, with an average of 8 million members each, that submitted verification transaction data. Savings represent cost avoidance due to avoided telephone verifications. See appendix for details.

** Updated 5/1 to reflect additional data

Health Plan Electronic Eligibility Volumes

- Total electronic eligibility was up 33% in one year for participating health plans
- Due to shift towards electronic methods, health plans can handle increased verification volumes with same staff

Change in health plan electronic eligibility volumes one year after CORE certification *

Method	% change in volumes – TOTAL for all plans	Largest % change for an individual plan	Smallest % change for an individual plan	Comments
Real-time electronic eligibility, integrated and “on demand” (using 270/271)	39%	900%	10%	Largest / smallest % changes exclude a plan that did not previously offer real-time
Real-time electronic eligibility via direct data entry (using health plan or branded portal product)	30%	57%	18%	<ul style="list-style-type: none"> • User enters data directly via a portal and receives an immediate response • If via a portal product, the vendor sends the inquiry on to the plan as a 270/271 transaction • Plan response meets the CORE rules for availability, content and response time
Total electronic eligibility (real-time “on demand” + real-time DDE + batch)	33%	74%	15%	Includes batch which was only reported by one plan and decreased when real-time was offered

* Percent change 1q2008 over 1q2007. Plans in the study had high baseline electronic eligibility volumes compared to the industry, so results could be even more substantial for health plans with lower electronic verification rates.

Cost of CORE Certification for Health Plans

- For most health plans, reported total costs of adoption and certification were moderate

Cost	Average	Low	High
Total cost of adoption	\$542,800	\$8,000	\$1,720,000
Per member costs of adoption	\$.0852	\$0.0005	\$0.4886
Ongoing annual costs *	\$49,200	\$ 0	\$79,000

- IT staff expense was the largest cost
- Factors affecting reported costs
 - Complexity, especially the number of systems that must be modified
 - Starting point: the gap between capabilities and the CORE standards
 - Expense allocation practices: plans may allocate some costs to CORE implementation or to IT overhead

Health Plan Telephone Verification: Costs and Estimated Savings Due to the Shift to Electronic Methods

- For participating plans, the shift away from telephone verification yielded estimated average savings of \$2.7m, over 17% of telephone verification costs
- Assumption/Caveats:
 - Estimated savings assume total verifications would be unconstrained by health plan or provider staff resources. However, without adoption of electronic methods, total inquiries would not have grown so fast as call center wait times and abandoned calls would have increased, and provider staffs could not have performed that number of verifications via telephone.

	Prior to CORE certification (baseline actual)	One year after CORE certification (actual)	<i>Projected post-certification telephone verifications without shift (hypothetical)</i>	<i>Avoided telephone verifications and costs savings (estimated)</i>
Annual number of verifications - all methods	204,560,940	266,339,732		
Annual number of telephone verifications	17,225,304	18,506,780	<i>22,428,470</i>	<i>3,921,690</i>
Telephone verifications as % of total verifications	8.4%	6.9%		
Cost per telephone verification	\$ 2.72			
Annual cost for telephone verifications	\$46,852,827	\$50,338,442	<i>\$61,005,438</i>	<i>\$10,666,997</i>
Average per plan	\$11,713,207	\$12,584,610	<i>\$15,251,360</i>	<i>\$2,666,750</i>

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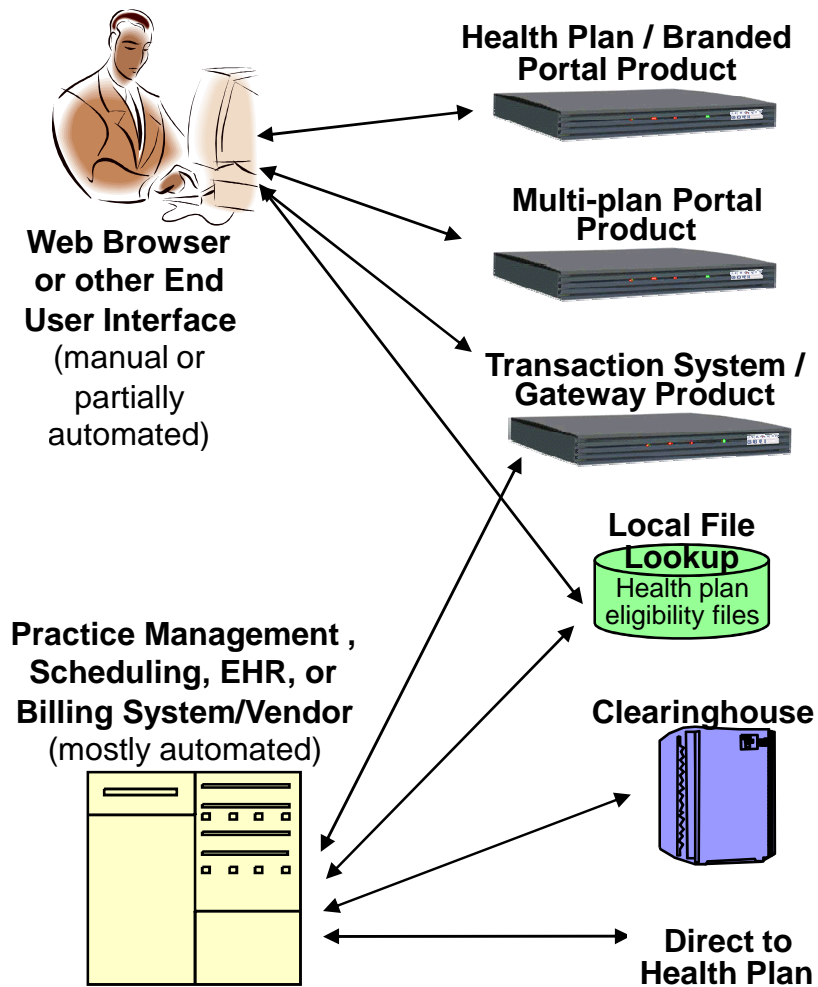


Provider Results

- Primary benefit: decrease claim denials and accounts receivable
- Secondary benefits
 - Time saved in registration and billing
 - Reduced transaction fees and connectivity costs
- Provider benefits realized
 - Decrease in claim eligibility denials **10 - 12%**
 - Increase % of patients verified * **24%**
 - Save 7 minutes per electronic verification **\$2.60 per verification**
- Typical eligibility initiatives
 - Automate verifications and integrate with registration and patient accounting to maximize efficiency
 - Verify and collect patient liability at time of service - for every visit
 - Upgrade practice management, EMR or billing systems and/or add eligibility products
 - Directly connect to health plans to reduce clearinghouse fees

* Some providers doubled the number of patients verified

Provider Methods of Electronic Verification



Advantages / Features for Providers

- Simple technology solution, accessible to very small provider with no systems other than internet
- Low cost connectivity, no transaction fees
- Current info

- Simple technology solution, accessible to very small provider with no systems other than internet
- Low cost connectivity
- Access many plans on one site
- Less expertise / single sign-on

- Adds capability missing from operational systems
- Validate / scrub transactions
- May reduce transaction fees
- May integrate with provider operational systems

- Fast response
- No connectivity or health plan response capability required

- Access to many plans through one connection
- Validate / scrub transactions
- Reformat / translate transactions for health plans
- May integrate with provider operational system

- No transaction fees
- Current information
- Integrate with operational systems and workflows
- Minimal office staff time and effort

Disadvantages

- Not integrated with other systems for transaction creation or update
- High office staff time

- Not integrated with other systems for transaction creation or update
- High office staff time
- Transaction fees

- May be difficult or costly to implement / integrate

- File currency lags
- Requires file downloads and maintenance

- Transaction fees
- May require IT staff to setup, maintain or to take full advantage

- High IT skill to set up, maintain and integrate

Vendor and Clearinghouse Results

- Vendors and clearinghouses play a crucial role in accelerating adoption of electronic transactions
 - Extend the reach for health plans
 - Give providers access to transactions
- Operational benefits
 - Simplified operations, fewer custom and proprietary connectivity solutions
 - Easier to integrate/automatically update client systems with patient eligibility and benefits info
- Example of results
 - Time to implement a connection with a CORE-certified health plan vs. time to connect to a non-certified health plan **1- 5 days vs. 6-12 weeks**
- Why they seek certification
 - Competitive success depends on staying at leading edge for interoperability
 - They anticipate that CORE certification will become a foundation standard for interoperability in the industry
- Risk: Direct connectivity can cut into business

Lessons Learned for Health Plans Seeking CORE Certification

- Project management and planning
 - Strong project management needed to coordinate across many departments and systems
 - Don't underestimate time and resources
- Performance and capacity
 - Volumes can ramp up very quickly and real-time peaks can drive need for more capacity
 - Back end systems affect ability to meet response time rules
 - Comprehensive testing should include backend systems, performance, and user acceptance testing over and above CORE testing
- Accelerating provider adoption
 - Use multiple communication vehicles for provider outreach
 - Focus on large submitters and those with many claim eligibility errors
 - Collaborate with wide range of vendor and clearinghouse partners
- Determine how you will measure success and ensure that data is captured
 - Methods, volumes and associated costs
 - Claim rejects / denials
 - Connectivity costs
 - Time and effort to set up new partners
 - Call center
 - Provider/customer satisfaction

Participant Perspectives

About WellPoint

- Nation's largest health benefits company
- Blue Cross and/or Blue Shield licensee in parts of 14 states
- CORE-certified, along with 14 of its subsidiaries
- MEDICAID Business in 13 states
 - (CA, CT, CO, IN, KS, MA, TX, NH, NV, NY, VA, WI, WV)
- 35+ million members
- 42,000+ employees
- 790,000+ network providers
 - 230,000+ use online services
- 81+ million electronic eligibility inquiries per year

WellPoint View on CORE

Participation

- Developing operating rules that are helping create positive changes in the industry
 - Reducing administrative expense
 - Building consistency in transactions
 - Accelerating adoption of electronic exchanges and HIT
 - Contributing to payer-provider interoperability

Certification

- Allows consistency in transactions for MEDICAID contracted states
- Rules complement national technology objectives
- Enables near instant access and delivery of patient information to providers, establishing platform for meeting stimulus incentives

About Pinehurst Surgical Clinic

- Group practice, physician-owned, multi-specialty surgical organization
- Serve a 15 county area in North Carolina
- One of the largest multi-specialty surgical groups in the country
- Approximately 40 physicians
- Support staff of 280
- Primary practice location is Pinehurst with six supporting satellite locations

Pinehurst Surgical Clinic View on CORE

- Enhances trading partner relationships
 - Work with CORE-certified vendors
 - Vendor-agnostic technology
- Builds a foundation for EHRs that will streamline administrative processes for patients and providers
 - Complements ARRA and HITECH objectives to reduce costs, improve quality, and modernize healthcare
 - Complements criteria necessary for meeting HITECH stimulus requirements
- Promotes adoption of a single set of standards
 - Helps deliver faster, more accurate responses from health plans
 - Consistent information can be accessed and received, despite health plan
- Supports integration of administrative and clinical data

Savings Projection for Industry-wide Implementation of CORE Phase I

Potential Savings Due to Industry-wide CORE Phase I Certification

Savings 2010 – 2012, using \$4.60 per transaction, 2.6b claims

	2010	2011	2012	3-year Total
Savings / Electronic Eligibility Volumes				
Estimated Number of Electronic Eligibility Transactions, Baseline 10% CAGR	572 m	629 m	692 m	1,893 m
Estimated Number of Electronic Eligibility Transactions with CORE, 25% CAGR	650 m	813 m	1,016 m	2,478 m
Additional Electronic Eligibility Transactions due to CORE	78m	183 m	324 m	585 m
Savings due to additional electronic transactions due to CORE	\$359 m	\$843m	\$1,488 m	\$2,690 m
Foundation for other administrative healthcare transactions	\$90 m	\$211 m	\$372 m	\$673 m
TOTALS	\$449 m	\$1,054 m	\$1,860 m	\$3,363 m
Other Impacts				
Percentage of visits verified with CORE (target 100%)	55%	61%	69%	n/a
Reduced Claims Denials due to eligibility	10 to 12% reduction denials; .5% to 1.5% of net patient revenue			
Reduced time to set up new information exchange partners	20% to 80%			
Reduced connectivity costs	t.b.d.			

Savings Projection for Industry-wide Implementation of CORE Phase I: Assumptions

- 1.3 billion eligibility verifications per year in the US
 - Approximately 200m commercial covered lives, 2.6 billion claims per year, assume only 50% of claims are verified for eligibility
- Current average percent of eligibility that occurs electronically: 40% (per CHT; CAQH pilot group was higher)
- Projected growth in electronic eligibility
 - Assume a baseline increase 10% per year
 - Impact of CORE: increase electronic eligibility by 25% per year (study participants averaged 33% one-year increase in electronic transactions)
- Savings per transaction: \$4.60
 - Electronic vs. telephone transactions
 - Health plans \$2.50, Providers \$2.10 (CAQH CORE study – conservative estimates, actual averages reported by study participants were \$2.72 for health plans, \$2.60 for providers)
- Other Impacts
 - For each 10% increase in electronic eligibility transactions, there is an increase of 3 percentage points in the total number of eligibility verifications (electronic plus manual)
 - Eligibility denial write-offs as % of net patient revenue: 2.5%
 - Impact on other 8 main administrative transactions
 - 25% of impact on eligibility (assumes other phases of CORE, which address the other transactions that are not mandated) given mix of adoption and mix of use/volumes, e.g. every claim does not generate prior authorization check

Future Plans

- Certified entities will leverage the investment in CORE
 - As their partners' capabilities evolve, continue to shift transactions from custom eligibility solutions to standard real-time and batch electronic transactions – an ongoing process
 - Leverage the infrastructure enhancements made for eligibility for CORE to support additional types of transactions
 - Incorporate newer technology such as smart cards and real-time adjudication into the eligibility process
 - Align CORE initiatives with projects such as 5010 implementation and Blue exchange in order to reduce the number of discrete system changes and realize the broadest benefits to transaction adoption at a reasonable cost
- Non-certified providers look forward to continued enhancements to the eligibility process
 - Increase use of electronic eligibility
 - Modify workflow to ensure eligibility is verified at key dates and process steps
 - Train staff to take advantage of additional data from CORE-certified health plans
 - Increase automation by integrating point eligibility solutions with existing practice management, EMR and financial systems and/or upgrade those systems

In Closing

“CORE is transforming the way our industry communicates. With the Phase II rules now in place and work begun on Phase III, CORE is effectively achieving its mission to create an all-payer approach to streamlined administrative data exchange.”

Ronald A. Williams, CAQH Board Chairman
Chairman and Chief Executive Officer, Aetna

Questions?

- To learn more about CORE, please contact:

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