An Open Road

To Sensible e-Healthcare Business Data

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Our nation's transition to a paper-free healthcare system has many physicians feeling like the cure has been worse than the disease. For all of the benefits of e-health, some practitioners and their staffs feel they are spending more time and money on administration than ever before, often at the expense of patient care.

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Finally, a glimmer of hope: In one part of the healthcare economy—the exchange of electronic business-related data—we are starting to see greater efficiencies and fewer headaches. It's still early, but real progress is being made in the way we share information on eligibility, claim status, and payments.

Rules of the Road

This forward movement isn't happening by accident. It's the result of a provision, Section 1104, in the Affordable Care Act (ACA) which calls on the U.S. Department of Health and Human Services (HHS) to establish a set of rules of the road that health plans and their business partners must use when exchanging administrative data. These operating rules are mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for claims-related electronic transactions as part of the federal vision for health data interoperability.

Think of these operating rules as the driving laws that everyone must follow. Always drive on the right. Turn right on red only after coming to a full stop. Use your turn signals.

When everyone understands and follows the rules, we get to our destination fast and with few mishaps. It works the same way with healthcare administrative data. When everyone adheres to the operating rules, eligibility is verified quickly and accurately, claim status is easily available, funds are exchanged seamlessly and securely, and all parties are clear on which services have been rendered.

To develop these operating rules, HHS turned to the CAQH Committee on Operating Rules for Information Exchange (CORE), a nonprofit collaboration of public and private health plans, hospitals and health systems, vendors, and other players across the industry. Over five years, CAQH CORE has issued operating rules covering all major categories of healthcare business transactions including eligibility and benefits verification, payment and remittance, prior healthcare authorization, employee premium payment, and enrollment and disenrollment in a health plan.

Making It Happen

But having a set of rules in place is one thing. Making sure they are followed is quite another. To provide organizations confidence that the entities they are

exchanging data with are adhering to the rules, CAQH CORE also developed a voluntary certification program. To date, more than 300 certifications have been awarded— including to some of the nation's leading healthcare entities—and many additional applications are pending. These are promising signs that rules of the road are being widely adopted across health plans, clearinghouses, vendors, and providers. HHS rules establishing a certification program are pending.

There are currently four phases of certification. The amount of effort and time it takes for an organization to complete a phase depends on how quickly it identifies gaps in its IT systems and corrects them. From that point, the testing period generally takes 20-60 days.

So, what does CORE Certification mean to providers? A lot. When every entity in the transaction follows the operating rules, physicians, group practices, and hospitals have real-time access to information such as eligibility information for all public and private payers, including year-to-date deductibles, copays, and coinsurance. The rules ensure that providers can access the status of claims in 20 seconds or less and establish a common set of claim denial codes so that providers know what has been paid, what hasn't, and why.

Providers can now also easily trace payment from plans. For example, every health plan now must offer providers the ability to be paid electronically and with a trace number that details what is being paid for and when they can expect it—no more guessing if a check was lost in the mail.

These are important steps toward an efficient e-health world with fewer hassles and lower administrative costs, but there is still a long way to go. Although many of the largest players in the industry are CORE Certified, not everyone is. And, just like our highways, it only takes one driver ignoring the rules to cause a wreck. We need greater adoption.

What You Can Do

What can you do to take advantage of this early progress and contribute to it? First, because providers rely on vendors to conduct business transactions, consider requiring your partners to be CORE Certified. This not only assures that their administrative transactions flow smoothly, it also contributes to the efficiency of the healthcare economy. We are asking our vendors and health plans to become CORE Certified, and we encourage you to do the same.

Second, large health systems and group practices should become CORE Certified themselves. It is a fairly straightforward process with a modest investment and a high return on investment through efficiencies, short payment cycles, and a productive staff. For example, providers can decrease denied claims by making it easier to connect to payers to verify patient eligibility automatically before or during patient visits.

Today, we are frustrated by systems that are supposed to make our jobs easy but only get in the way. With increasing costs and risks, it's harder than ever to practice medicine. CORE Certification is a tangible step you can take toward effective business operations for yourself and an efficient healthcare system for everyone.

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