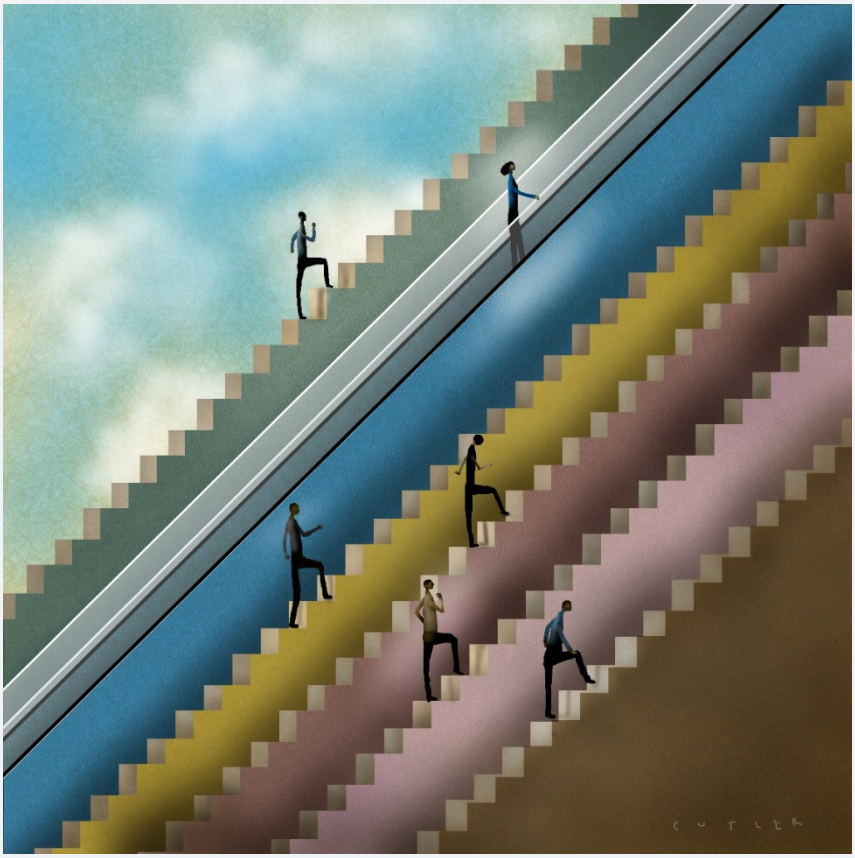
2017 CAQH Index™

Reporting Standards and Data Submission Guide – Dental Health Plans
Numbers of Transactions and Costs per Transaction

Data for Calendar Year 2017

Updated: June 2017



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OVERVIEW OF THE 2017 INDEX REPORTING STANDARDS AND DATA SUBMISSION GUIDE

This Guide accompanies the 2017 Data Collection Template that is provided to health plans responding to the 2017 Index data request for numbers of transactions and costs per transaction, manual vs. electronic, for calendar year 2017. (The 2017 Data Submission Template is illustrated in Appendix B.) This Guide contains instructions and specifications intended to help responding health plans provide data in as consistent a manner as possible.

For 2017, this Guide contains instruction and notes on the data submission both for numbers of transactions with those for costs per transaction. The section on costs per transaction is much less prescriptive – the sections below explain the data that is needed and provide worksheets with several different methods of estimating costs per transaction for manual and electronic processes.

While we hope that respondents can complete both volume and cost estimates for all seven transactions, we understand that might not be possible in all cases. The process for estimating costs per transaction include interview(s) with CAQH and our consulting analysts to help ensure that we the data are as comparable as possible among respondents, and to allow aggregation and benchmarking.

Please contact CAQH at explorations@caqh.org with any questions or comments at any time during the data submission process.

Transactions Studied for the 2017 CAQH Index

	Adopted HIPAA Standard	Description
Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter information for the purpose of reporting health care.
Eligibility and Benefit Verification	ASC X12N 270/271	An inquiry from a provider to a health plan, or from one health plan to another, to obtain eligibility, coverage, or benefits associated with the health or benefit plan, and a response from the health plan to a provider.
Claim Status Inquiry	ASC X12N 276/277	An inquiry from a provider to a health plan to determine the status of a health care claim or a response from the health plan.
Claim Payment	NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)	The transmission of payment, information about the transfer of funds, or payment processing information from a health plan to a provider.
Remittance Advice	ASC X12N 835	The transmission of explanation of benefits or remittance advice from a health plan to a provider.
Claim Attachments	No standard adopted by HHS	Additional information submitted with claims or claim appeals, such as medical records to support the claim.

Acknowledgments	Voluntary Pilot Study in 2017	Contact CAQH if wishing to voluntary report on this transaction.

Note: HIPAA = Health Insurance Portability and Accountability Act; HHS = U.S. Dept. of Health and Human Services.

NUMBERS OF TRANSACTIONS

All measures for numbers of transactions in 2017 data submission are based on data representing the January 1, 2016 to December 31, 2016 calendar year. If for any reason the data are NOT for the full calendar year, please contact CAQH so that we can adjust the aggregation approach.

All data on numbers of transactions are based on dental related health care claims and inquiries. If you include data for other non-dental healthcare claims, please categorize those results in a separate column.

Claim Submission

Measures and reports the percentage of all legitimate claims that are received electronically as a proportion of the total of all legitimate claims received by the health plan.

Legitimate Claim is defined as an itemized statement of rendered services and costs from a healthcare provider or facility received by the health plan for payment for health care. A claim can be submitted via a manual process using paper or electronic system either directly or through intermediary billers and claims clearinghouses.

	Adopted HIPAA Standard	Description
Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter information for the purpose of reporting health care.

The total number of Legitimate Claims represents the universe (sometimes called the denominator) for the Claims Submission calculation.

Note:

- If there is no direct claim for payment given reimbursement contracts, the transaction is considered the transmission of encounter information for the purpose of reporting health care. Encounters may or may not be included depending on the ability to report separately by the health plan. If encounters cannot be separated from claims, the participant should notify CAQH upon data submission. Encounters may be reported within the appropriate data submission field.
- Claims reported should be only those received for medical expense services for insured persons/enrollees participating in the health plan. Only ASC X12N/005010X2I2 Health Care Claim 837 I (Institutional) and 837 P (Professional) claims are the main categories of claims included at this time. However, dental and vision claims may be included on the designated columns.
- Reporting of claims to CAQH should be grouped based on commercial, Medicare, Medicaid, Dental, Medigap, or other supplementary policies when such classification is available. The Data Collection Template for numbers of transactions allows additional columns to be added for additional lines of business reported separately, and includes space for notes explaining the lines of business used. Please notify CAQH of if data within data submission. Each product will be reported separately and aggregated.

- Adjusted claims and duplicate claims may be received by the health plan system as a legitimate claim and will not be rejected until after claim logic is applied. These claims should be counted in the measure as they are received by the health plan. Processed or Adjudicated Claims would be a step beyond received and should not be used for determining a received claim as it would narrow the universe for the intended measurement.
- COB claims are included in the claims submission measure, and are also reported separately below under COB claims submission.

Electronic Claim is defined as an electronic data interchange (EDI) of the received claims submission transaction. The HIPAA standard title is ASC X12N/005010X2I2 Health Care Claim 837 I and P. Only HIPAA compliant claims should be included as an electronic claim.

Eligibility and Benefit Verification

Measures and reports the percentage of all eligibility and benefit verifications received electronically to inquire about the eligibility, coverage, or benefits associated with a benefit plan or product as a proportion of all eligibility and benefit verifications received by the health plan.

Eligibility and Benefit Verification is defined as when a health plan receives a request to obtain any of the following information about a benefit plan for an enrollee or member:

1. Eligibility to receive health care under the health plan.
2. Coverage of health care under the health plan.
3. Benefits associated with the benefit plan.

	Adopted HIPAA Standard	Description
Eligibility and Benefit Verification	ASC X12N 270/271	An inquiry from a provider to a health plan, or from one health plan to another, to obtain eligibility, coverage, or benefits associated with the health or benefit plan, and a response from the health plan to a provider.

The total number of Eligibility and Benefit Verifications represents the denominator for the Eligibility and Benefit Verifications calculation.

Note:

- Eligibility and benefit verifications are done in a variety of ways including the following:
  - Accessing enrollee or member information via a health plan's secure Web site - Portal/Direct Data Entry (DDE). Tracked individually for reporting.
  - Telephone, Interactive Voice Response (IVR) and fax. Tracked individually for reporting.
  - The ASC X12 270 Health Care Eligibility Benefit Inquiry.
- These modes of verifications should be reported separately to measure trend of electronic transaction adoption and the movement away from manual transactions and communications.

- As it may be difficult to differentiate and categorize between inquiries for eligibility, coverage and benefits, grouping of the inquiries is acceptable for reporting calculations.
- Total number of legitimate claims from the Claim Submission measure is used to provide a normalized calculation of the above sub-categories.

Electronic Eligibility and Benefit Verification is defined as an electronic data interchange (EDI) transaction when the health plan IT system receives a request to obtain information about a benefit plan for an enrollee electronically through direct data entry, via portal, or through batch file submission and the system responds with the requested eligibility and benefit information using the same modality as the inquiry. The HIPAA standard title is ASC X12 270 Health Care Eligibility Benefit Inquiry.

Note:

- ASC X12 270/271 are the standard for electronic eligibility and benefit verification for both providers and health plans and is the primary metric for the measure.
- From the health plan perspective, IVR, portal and DDE may be considered electronic as they reduce the number of manual interactions (i.e., phone calls and faxes) for health plans. Given there is value to track both types of electronic transactions, each subcategory will be reported and tracked as secondary metrics at this time. The "partially electronic" category is used to report the non-HIPAA compliant electronic transactions and includes IVR, portal and DDE.

Claim Status Inquiry

Measures and reports the percentage of all inquiries received electronically to inquire about the status of a health care claim as a proportion of all claim status inquiries received by the health plan. A normalized proportion of inquiries per 1,000 claims is calculated by subcategory to show relative volume.

Claim Status Inquiry is defined as when a health plan receives a request on the status of a claim.

	Adopted HIPAA Standard	Description
Claim Status Inquiry	ASC X12N 276/277	An inquiry from a provider to a health plan to determine the status of a health care claim or a response from the health plan.

Note:

- Claim status inquiries are done in a variety of ways including the following:
  - Accessing claim information via a health plan's secure Web site - Portal/Direct Data Entry (DDE). Tracked individually for reporting.
  - Telephone, Interactive Voice Response (IVR) and fax. Tracked individually for reporting.
  - The ASC X12 276 Health Care Claim Status Request.
  - These modes of requests should be reported separately to measure trend of electronic transaction adoption and the movement away from manual transactions and communications.

- As it may be difficult to differentiate and categorize between inquiries for appeals, resubmissions and the status of the claim within the adjudication cycle, inquiries on claim status should be counted when there is the ability to track separately.
- Total number of legitimate claims from Claim Submission is used to provide a normalized calculation of the above sub-categories.

Electronic Claim Status Inquiry is defined as an electronic data interchange (EDI) transaction when the health plan IT system receives a request on claim status electronically through direct data entry via portal or through real time and batch file submission and system responds with requested status update using the same modality as the inquiry. The HIPAA standard title is the ASC X12N/005010X212 276 Health Care Claim Status Request.

Subcategories will be reported between HIPAA compliant electronic transactions and non-HIPAA compliant transactions. Non-HIPAA compliant transactions that are electronic or automatic will be considered automated and reported separately.

Note:

- ASC X12 276 is the standard for electronic claim status inquiry for both providers and health plans and is the primary metric for the measure.
- From the health plan perspective, IVR, portal and DDE may be considered electronic as they reduce the number of manual interactions (i.e., phone calls and faxes) for health plans. Given there is value to track both types of electronic transactions, each subcategory will be reported and tracked as secondary metrics at this time. The “partially electronic” category is used to report the non-HIPAA compliant electronic transactions and includes IVR, portal and DDE.

Claim Payment

Measures and reports the percentage of transactions used by the health plan to make a payment to the health care provider as a proportion of all health care claim payments by the health plan.

Claim Payment is defined as any transfer of funds or payment to the financial institution of a health care provider for a health care claim.

	Adopted HIPAA Standard	Description
Claim Payment	NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)	The transmission of payment, information about the transfer of funds, or payment processing information from a health plan to a provider.

Note:

- HSA and member payments should not be included.
- Claim payment may be done in a variety of ways including the following:

- Cash, check or similar paper instrument.
- Payment via a credit or virtual card network.
- Electronic Funds Transfer (EFT) via the ACH Network.

- Claims submitted from the prior year may be paid within the payments being reported (e.g., claim submitted on December 15 is paid or payment is sent on January 15).

Electronic Claim Payment or Electronic Funds Transfer (EFT) is defined as any electronic data interchange (EDI) transfer of funds (EFT), other than a transaction originated by cash, check, or similar paper instrument that is initiated through via Automated Clearing House (ACH) transfers. Virtual cards and other forms of electronic payment should not be included in the EFT, and should be reported separately.

Note:

- Claims adjudicated resulting in $0 payment (zero pay) are included.

Claim Remittance Advice

Measures and reports the percentage of transactions used by the health plan to send a remittance advice directly to a health care provider as a proportion of all health care remittance advice messages by the health plan.

A *Remittance Advice (RA)* is defined as a document or a transmission of a message supplied by the health plan or payer that provides notice of and explanation reasons for payment, adjustment, denial and/or uncovered charges of a medical claim back to the provider or facility. The RA may accompany payment and is sometimes referred to as an explanation of payment (EOP).

	Adopted HIPAA Standard	Description
Remittance Advice	ASC X12N 835	The transmission of explanation of benefits or remittance advice from a health plan to a provider.

Note:

- Claim Remittance Advice is reported and tracked by remittances made in the measurement year along with the number of claims represented within the cohort of remittances.
- A Remittance Advice may reference claims submitted in the prior year (e.g., claim submitted on December 15 is remittance is sent on January 15).
- A Remittance Advice or other Electronic EOP may be viewed via a health plan's secure Website. These modes should be reported separately to measure the trend of electronic transaction adoption and the movement away from manual transactions and communications.
    - From the health plan perspective, this may be considered electronic leading to a reduction in paper based RAs.
    - The count of electronic EOPs posted on web portals should be the number of postings, NOT the number of hits or page views.

Electronic Remittance Advice (ERA) is defined as an explanation of the health care payment or an explanation of why there is no payment for the claim that is transmitted electronically through the health care payer payment or claims processing system and is received by the provider or provider's agent (e.g., clearinghouse, billing service). The ERA includes detailed identifiable health information. The ERA may be submitted electronically through a secure message or batch file.

Note:

- The HIPAA standard title is ASC X12 005010X221A1 835 Health Care Claim Advice.

Attachments

An attachment is defined as a submission of supplementary information to justify or provide extra information for a claim or prior authorization request. A claim attachment can be attached to an original claim submission, resubmission, or appeal.

The purpose of the new attachment measures is to create a benchmark count of the frequency of claim submissions and prior authorization inquiries and requests that are accompanied by attachments containing additional information to justify the claim or authorization.

For the 2017 Index, we are studying two types of attachments, those submitted with claims or claims appeals, and those related to prior authorization or pre-certification requests. Attachments will be counted in the following categories for both types (claim-related and prior authorization related):

- Received via Paper Delivery (mail, FedEx etc.)
- Received by Fax
- Non-standardized -- Received by Email (PDF)
- Non-standardized -- Website/Portal Submission
- Standardized Electronic Transmission (HL7)
- Standardized Electronic Transmission (X12)
- Other (specify in comments)

	Adopted HIPAA Standard	Description
Claim Attachments	No standard adopted by HHS	Additional information submitted with claims or claim appeals, such as medical records to support the claim.
Prior Authorization Attachments	No standard adopted by HHS	Additional information submitted with a prior authorization or pre-certification request, such as medical records to explain the need for a particular procedure or service.

Claim-Related Attachments. The universe (denominator) for counting claim-related attachments is the same as that for Claim Submission above. As with Claim Submission, claim attachments will be counted for all "legitimate claims" received.

A *Legitimate Claim* is defined as an itemized statement of rendered services and costs from a health care provider or facility received by the health plan for payment for health care. A claim can be submitted via a manual process using paper or electronic system either directly or through intermediary billers and claims clearinghouses.

Notes for counting claim-related attachments:

- If possible, attachments should be counted even if there is no direct claim for payment given reimbursement contracts; such transactions are considered the transmission of encounter information for the purpose of reporting health care. Encounters may or may not be included depending on the ability to report separately by the health plan. If encounters cannot be separated from claims, the participant should notify CAQH upon data submission. Encounters may be reported within the appropriate data submission field.
- Claims reported should be only those received for medical expense services for insured/enrollees participating in the health plan. Only ASC X12N/005010X2I2 Health Care Claim 837 I (Institutional) and 837 P (Professional) claims are included at this time. Claim attachments associated with dental and vision transactions may be reported separated in the appropriate column.
- Adjusted claims and duplicate claims may be received by the health plan system as a legitimate claim and will not be rejected until after claim logic is applied. These claims should be counted in the measure as they are received by the health plan. Processed or Adjudicated Claims would be a step beyond received and should not be used for determining a received claim as it would narrow the universe for the intended measurement.
- Attachments may be received via initial claims submissions or subsequent claims appeal processes.

Prior Authorization Attachments. The universe (denominator) for prior authorization attachments is the number of prior authorization transactions for Medical/Surgical (No Rx) events counted above.

Prior authorization or pre-certification transactions are defined as inquiries and submissions of information from healthcare practitioners and facilities, i.e., physicians' offices, hospitals, and outpatient facilities, as well as responses and confirmations from health plans. For the 2017 Index, we are including all transactions related to medical/surgical prior authorization events, including initial inquiries and subsequent submissions of information and responses that may include attachments. These inquiries from healthcare providers may include inquiries related to authorization for prescription drug benefits. Prior authorization attachments associated with dental and vision claims may be reported separated in the appropriate column.

COSTS PER TRANSACTION

For the current 2017 Index, we are combining the data request for costs per transaction with the data requests for numbers of transactions for payers. CAQH will continue to sponsor a separate data acquisition project for costs per transaction of healthcare providers.

Health plans that participated in the 2013 and 2016 Index may already have developed methods of estimating costs per transaction for manual and electronic processes. However, many health plans will not have data on costs per transaction at hand, and may need assistance from CAQH in developing processes to estimate costs per transaction. The table below illustrates the desired result fields for the costs per transaction data submission. The Data Submission Templates also contain worksheets that illustrate some (but certainly not all) methods of estimating those costs from data that may be available.

Note:
When a particular type of transaction can be handled in more than one way (such as individual vs. batch processing), and therefore there are different costs per transaction within a type of transaction, please use a blended average rate.

Costs for manual transactions for claim payment/RA are estimated on a per claim basis, NOT at per-mailing basis (when multiple payments/RAs are including in a bundled mailing). This is to compare transaction costs for mailed claim payments vs. those for electronic claim payments.

Worksheets for Estimating Costs Per Transaction

The Data Submission Templates provided to responding health plans include three worksheets for estimating transaction costs (see Appendix C). In some cases, internal surveys of persons handling transactions with healthcare providers may be necessary. For example, asking persons to allocate the time they spend on different transactions may be a useful foundation for building estimates of costs per transaction.

The first worksheet builds from total hours worked per transaction, and links directly to the number of transactions from the responding plan's separate report on numbers of transactions. Using estimates of overhead costs as a percentage of labor costs, estimates of total "fully loaded" costs per transaction are developed.

The second worksheet builds from the numbers of transaction handled per hour. Again, the total numbers of transactions, labor costs per hour, and overhead cost percentages are applied to build estimates of costs per transaction.

The third worksheet builds from a known budget for handling provider transactions, and uses estimates of time spent by transaction type as a percentage of all work time to allocate work effort to various transactions. This method may be the most commonly used by responding plans. It would likely require a survey of personnel handling provider transactions in order to allocate work time to each transaction.

APPENDIX A 2017 INDEX ADVISORY COUNCIL

Organization	Advisory Council Member
Aetna	Jay Eisenstock
AHIP	Tom Meyers
Anthem	Katy Blomeke
BCBS of Michigan	John Bialowicz
Streamline Health, Inc. (Cooperative Exchange)	Richard Nelli
CAQH	Robin Thomashauer
CAQH	Gwendolyn Lohse
CIGNA	Paul Keyes
Florida Blue	Tab Harris
InstaMed	Bill Marvin
MGMA	Rob Tennant
Milliman, Inc.	Andrew Naugle
Nachimson Advisors, LLC	Stanley Nachimson
NORC at University of Chicago	Kennon Copeland
Premier Inc.	Erik Swanson
THINK-Health and Health Populi	Jane Sarasohn-Kahn
UnitedHealthcare	Diana Lisi

APPENDIX B DATA COLLECTION TOOL – NUMBERS OF TRANSACTIONS

Note: The Data Collection Templates may be modified or corrected in subsequent versions. See http://caqh.org/index_contribute.php for the latest information.

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2017 CAQH Index Data Submission Information (Dental Data for Calendar Year 2016)

Organization Name:	
Point of Contact Name:	
Point of Contact Email:	
Point of Contact Telephone:	

General Comments and Assumptions of Data Submission and Reporting Entity:

The data submission form below allows your company to split out results in a separate column for particular business lines and/or regions. Please describe the business and/or region for each column used in the following section.

Product or Business Information	Total	Dental	Other breakout?	Other breakout?
Members Represented (2016 calendar year average or mid-year):	0			
Member Months Represented (2016 calendar year)	0			
Number of Contracted Non-Physician Network Providers (NPs, PAs etc.):	0			
Number of Contracted Network Physicians (M.D. and D.O.):	0			
Number of Contracted Network Hospital and Outpatient Facilities:	0			

Comments:

Please fill in the numbers of transactions in the rows below for each column described above, according to the specifications in the 2017 Reporting Standards and Data Submission Guide.

Code	Type of Transaction	Total	Dental	Other breakout?	Other breakout?
	Claim Submission				
CSMP	Manual - Provider	0			
CSMF	Manual - Facility	0			
CSH837P	Electronic (HIPAA 837P) Provider	0			
CSH837I	Electronic (HIPAA 837I) Facility	0			
CSTOT	**Total Claims Submitted**	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				

Comments:

	Eligibility and Benefit Verification (does NOT include Referral)	Total	Dental	Other breakout?	Other breakout?
EVTEL	Inquiries (Telephonic)	0			
EVFAX	Inquiries (Fax)	0			
EVIVR	Inquiries (IVR)	0			
EVPOR	Inquiries (Portal/DDE)	0			
EVH270	Inquiries (HIPAA 270)	0			
EVTOT	**Total Inquiries**	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				
Comments:					

	Claim Status	Total	Dental	Other breakout?	Other breakout?
CSTEL	Inquiries (Telephonic)	0			
CSFAX	Inquiries (Fax)	0			
CSIVR	Inquiries (IVR)	0			
CSPOR	Inquiries (Portal/DDE)	0			
CSH276	Inquiries (HIPAA 276)	0			
CSTOT	**Total Inquiries**	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				
Comments:					

	Claim Payment	Total	Dental	Other breakout?	Other breakout?
CPPAYPAP	Count of Payments Made - Printed Check or Paper Based Instrumen	0			
CPPAYBNK	Count of Payments Made - Bank/Virtual Card Network	0			
CPPAYACH	Count of Payments Made - EFT via ACH Network	0			
CPPAYTOT	**Total Payments Made**	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				
Comments:					

	Claim Remittance Advice (First Year Data Collection)	Total	Dental	Other breakout?	Other breakout?
CRAPAP	Count of Printed or Paper Based Remittance Advice	0			
CRAEOB	Count of Portal Remittance Advice or Other Electronic EOP	0			
CRRAH835	Count of Electronic Remittance Advice (HIPAA 835)	0			
CRRATOT	**Total Remittance Advices Sent**	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				
Comments:					

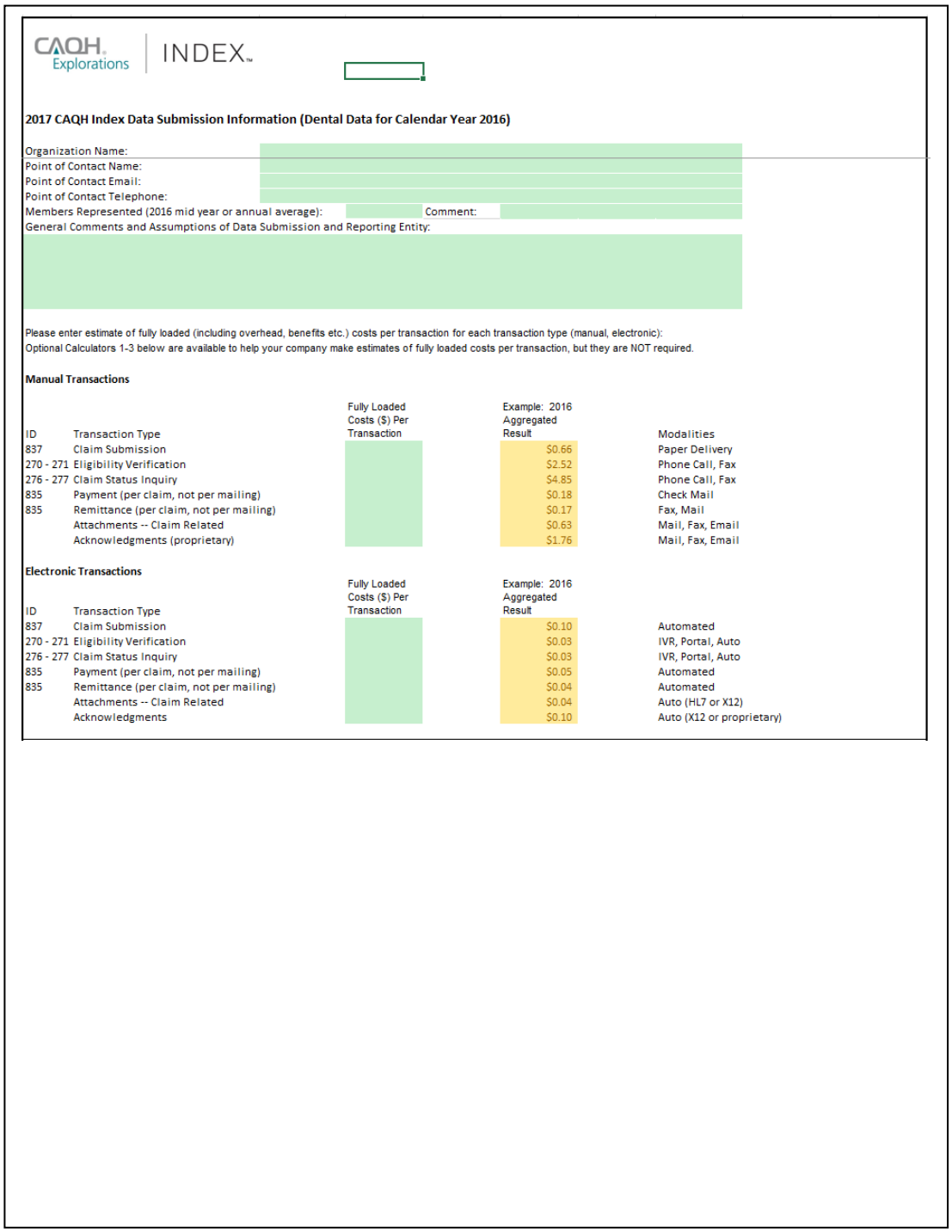
	Claim Attachments (First Year Data Collection)	Total	Dental	Other breakout?	Other breakout?
ACMAIL	Received via Paper Delivery (mail, FedEx etc.)	0			
ACFAX	Received by Fax	0			
ACPDF	Non-standardized Received by email (PDF)	0			
ACOR	Non-standardized Website/portal submission	0			
ACHL7	Standardized Electronic Transmission (HL7)	0			
ACX12	Standardized Electronic Transmission (X12)	0			
ACTOT	**Total Claim-Related Attachments**	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				
Comments:					

	Acknowledgments (First Year Data Collection)	Total	Dental	Other breakout?	Other breakout?
	Claim Acknowledgment for 837 (277CA Transaction)	0			
	Claim Acknowledgment for 837 (Proprietary Acknowledgment)	0			
	Eligibility and Benefit Verification (999 Functional Acknowledgmer	0			
	Eligibility and Benefit Verification (Proprietary Acknowledgment fc	0			
	Claim Status Inquiry (999 Functional Acknowledgment for 276)	0			
	Claim Status Inquiry (Proprietary Acknowledgment for 276)	0			
	Total Acknowledgment Transactions	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)				
Comments:					

Additional Comments or Overflow Comments:

APPENDIX C DATA COLLECTION TOOL – COSTS PER TRANSACTION

Note: The Data Collection Templates may be modified or corrected in subsequent versions. See http://caqh.org/index_contribute.php for the latest information. Formulas will auto compute when actual data is entered.



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2017 CAQH Index Data Submission Information (Dental Data for Calendar Year 2016)

Organization Name:
Point of Contact Name:
Point of Contact Email:
Point of Contact Telephone:
Members Represented (2016 mid year or annual average): Comment:
General Comments and Assumptions of Data Submission and Reporting Entity:

Please enter estimate of fully loaded (including overhead, benefits etc.) costs per transaction for each transaction type (manual, electronic):
Optional Calculators 1-3 below are available to help your company make estimates of fully loaded costs per transaction, but they are NOT required.

Manual Transactions

ID	Transaction Type	Fully Loaded Costs ($) Per Transaction	Example: 2016 Aggregated Result	Modalities
837	Claim Submission		$0.66	Paper Delivery
270 - 271	Eligibility Verification		$2.52	Phone Call, Fax
276 - 277	Claim Status Inquiry		$4.85	Phone Call, Fax
835	Payment (per claim, not per mailing)		$0.18	Check Mail
835	Remittance (per claim, not per mailing)		$0.17	Fax, Mail
	Attachments -- Claim Related		$0.63	Mail, Fax, Email
	Acknowledgments (proprietary)		$1.76	Mail, Fax, Email

Electronic Transactions

ID	Transaction Type	Fully Loaded Costs ($) Per Transaction	Example: 2016 Aggregated Result	
837	Claim Submission		$0.10	Automated
270 - 271	Eligibility Verification		$0.03	IVR, Portal, Auto
276 - 277	Claim Status Inquiry		$0.03	IVR, Portal, Auto
835	Payment (per claim, not per mailing)		$0.05	Automated
835	Remittance (per claim, not per mailing)		$0.04	Automated
	Attachments -- Claim Related		$0.04	Auto (HL7 or X12)
	Acknowledgments		$0.10	Auto (X12 or proprietary)

IMPORTANT NOTE -- THE CALCULATORS BELOW ARE OPTIONAL -- THEY MAY BE HELPFUL FOR CALCULATING FULLY LOADED COSTS PER TRANSACTION

Calculator 1 -- An Optional Method of Computing Fully Loaded Costs Per Transaction

Manual Transactions

ID	Transaction Type	Hours	Labor Cost/Hour	Labor Costs	Overhead Rate (IT, Vendor, Benefits, Admin)	Fully Loaded Cost ($)	FROM VOLUME: Number of Transactions	WHAT WE WANT: Fully Loaded Costs ($) Per Transaction
837	Claim Submission	4	20	$80.00	3%	$82	0	
270 - 271	Eligibility Verification			$0.00		$0	0	
276 - 277	Claim Status Inquiry			$0.00		$0	0	
835	Payment (per claim, not per mailing)			$0.00		$0	0	
835	Remittance (per claim, not per mailing)			$0.00		$0	0	
	Attachments -- Claim Related			$0.00		$0	0	
	Acknowledgments (proprietary)			$0.00		$0	0	

Electronic Transactions

ID	Transaction Type	Hours	Labor Cost/Hour	Labor Costs	Overhead Rate (IT, Vendor, Benefits, Admin)	Fully Loaded Cost ($)	FROM VOLUME SHEET: Number of Transactions	WHAT WE WANT: Fully Loaded Costs ($) Per Transaction
837	Claim Submission			$0.00		$0	0	
270 - 271	Eligibility Verification			$0.00		$0	0	
276 - 277	Claim Status Inquiry			$0.00		$0	0	
835	Payment (per claim, not per mailing)			$0.00		$0	0	
835	Remittance (per claim, not per mailing)			$0.00		$0	0	
	Attachments -- Claim Related			$0.00		$0	0	
	Acknowledgments			$0.00		$0	0	

Calculator 2 -- Another Optional Method of Computing Fully Loaded Costs Per Transaction

Manual Transactions

ID	Transaction Type	Modalities	Transactions Per Hour	Labor Cost/Hour	Labor Costs Per Transaction	Overhead Rate	WHAT WE WANT: Fully Loaded Cost per Transaction ($)
837	Claim Submission	Paper Delivery			#DIV/0!	3%	
270 - 271	Eligibility Verification	Phone Call, Fax			#DIV/0!	0%	
276 - 277	Claim Status Inquiry	Phone Call, Fax			#DIV/0!	0%	
835	Payment (per claim, not per mailing	Phone Call, Fax			#DIV/0!	0%	
835	Remittance (per claim, not per maili	Check Mail			#DIV/0!	0%	
	Attachments -- Claim Related	Fax, Mail			#DIV/0!	0%	
	Acknowledgments (proprietary)	Mail, Fax, Email			#DIV/0!	0%	

Electronic Transactions		Modalities	Transactions Per Hour	Labor/IT/Support Costs Per Transaction	Labor/IT/Support Costs Per Transaction	Overhead Rate	
837	Claim Submission	Automated		0	#DIV/0!	3%	
270 - 271	Eligibility Verification	IVR, Portal, Auto		0	#DIV/0!	0%	
276 - 277	Claim Status Inquiry	IVR, Portal, Auto		0	#DIV/0!	0%	
835	Payment (per claim, not per mailing	IVR, Portal, Auto		0	#DIV/0!	0%	
835	Remittance (per claim, not per maili	Automated		0	#DIV/0!	0%	
	Attachments -- Claim Related	Automated		0	#DIV/0!	0%	
	Acknowledgments	Auto (HL7 or X12)		0	#DIV/0!	0%	

Calculator 3 -- Another Optional Method of Computing Fully Loaded Costs Per Transaction

Manual Transactions		FROM VOLUME SHEET:			WHAT WE WANT:	
ID	Transaction Type	Transactions	Fully Loaded Cost of All Provider Transactions, with Percent of Cost by Transaction -- Manual	Estimated Percentage of Costs by Transaction Type (not required to sum to 100%)	Fully Loaded Costs of These 10 Transactions - Manual	Fully Loaded Cost per Transaction ($)
					$0.00	
837	Claim Submission	0			$0	
270 - 271	Eligibility Verification	0			$0	
276 - 277	Claim Status Inquiry	0			$0	
835	Payment (per claim, not per mailing)	0			$0	
835	Remittance (per claim, not per maili	0			$0	
	Attachments -- Claim Related	0			$0	
	Acknowledgments (proprietary)	0			$0	
				0.0%		

Electronic Transactions						
ID	Transaction Type	Transactions	Fully Loaded Cost of All Provider Transactions, with Percent of Cost by Transaction -- Electronic	Estimated Percentage of Costs by Transaction Type (not required to sum to 100%)	Fully Loaded Costs of These 10 Transactions - Electronic	Fully Loaded Cost per Transaction ($)
					$0.00	
837	Claim Submission	0			$0	
270 - 271	Eligibility Verification	0			$0	
276 - 277	Claim Status Inquiry	0			$0	
835	Payment (per claim, not per mailing)	0			$0	
835	Remittance (per claim, not per maili	0			$0	
	Attachments -- Claim Related	0			$0	
	Acknowledgments	0			$0	
				0.0%		

APPENDIX D GUIDING PRINCIPLES TO MEASUREMENT AND REPORTING

CAQH and the Index Advisory Council believe that when collecting and reporting industry data it is imperative that the results are collected and reported consistently and accurately from one entity to another and from year to year. While there will always be some inherent differences between business operations and there will be barriers and challenges to defining measurement standards that can be applied across the large and diverse healthcare industry, all steps should be taken to set guiding principles, standardized definitions and a foundation to measurement and reporting.

There are many characteristics, attributes and methodologies that are important to defining useful, actionable and reliable measurement and reporting.

Measures should be relevant, meaningful and address processes and outcomes that are applicable and actionable for improvement (e.g., Improve Results, Reduce Cost, Increase Efficiency).

- Meaningful and Important
    - Significant to those being measured and the findings are useful for action.
    - The item of measurement is prevalent enough to warrant measurement and/or the financial implications are large enough to be considered for measurement.
- Controllable and Actionable
    - Impact can be made acting on the results of the measurement.
    - The item of measurement controllable and action can be taken to improve that which is being measured.
- Strategically Important or Cost Effective
    - The measurement drives competition and recognition in the marketplace.
    - Promotes efficient uses of resources, or reduce waste/low cost-effective activities.
- Variation and Potential for Improvement
    - Wide variation shows an opportunity for improvement, cost reduction and control.
    - Benchmarking against current state and working towards better performance drives improvement and efficiency.

Standardized methods, data availability and clear definitions are required for consistent, valid and accurate measurements for comparison and action. Measurement should not create an unnecessary burden for data collection and reporting and use a reliable methodology that is feasible to implement.

- Evidence Based
    - There is strong evidence supporting the need for measurement.
    - There guidelines or standards documenting the benefits and need for measurement.
- Reproducible, Valid and Accurate
    - Measures should produce the same results when applied to the same population and setting using the same method.
    - Measures are logical and precisely evaluate what is being studied or measured.
- Data Availability and Comparability
    - Data is accessible and available.

    - Stratification to account for differences among variables and reporting entities (e.g., entity type, geography, size, level of sophistication).
    - If there is potential for inconsistent measurement or manipulation that is undetectable, clear instructions and documentation must be provided to address limitations.
- Precise Specifications for data extraction, analysis methods and reporting
    - The measurement is clearly defined and reproducible by an independent third party.
    - Clear definitions and standardized reporting methods to drive repeatable and consistent measurement are necessary to achieve adoption and use of results as industry benchmarks.

APPENDIX E 2017 DATA SUBMISSION ACKNOWLEDGMENT

CAQH Index® Data Submission Acknowledgment

This Data Submission Acknowledgment (the "Acknowledgment") governs the contribution of healthcare data by the organization identified below ("Submitter") to the Council for Affordable Quality Healthcare ("CAQH") in connection with the CAQH Index® ("Index") program and website located at www.caqh.org.

Submitter acknowledges that the value of the Index is dependent on full and accurate data from the contributing organizations. Accordingly, Submitter agrees to submit complete and faithful data to the Index in the designated format and in accordance with data submission standards made available to respondents. Submitter represents that any data submitted is accurate and has not been falsified.

Supplier hereby grants to CAQH, the operator of the Index, a non-exclusive, irrevocable, royalty-free, worldwide license to manipulate the data submitted by Submitter, to incorporate such data into the Index, and to present such data as aggregated into the Index for public use on the Index website. Supplier represents that it has all rights necessary to grant such license to CAQH, and will defend and hold harmless CAQH against any claims to the contrary.

The Index aggregates data to report on industry trends. Accordingly, CAQH agrees that it will keep the disaggregated data submitted by Submitter confidential and will not disclose it to third parties other than (i) to subcontractors for the purpose of aggregating the data into the Index; and (ii) if and as required by applicable law. CAQH owns all data as modified and/or aggregated into the Index, and any use of the Index data is governed by the terms available on the Index website or under a separate license agreement.

NEITHER PARTY, ITS EMPLOYEES, OFFICERS, DIRECTORS, MEMBERS, AND/OR REPRESENTATIVES WILL BE LIABLE FOR ANY SPECIAL, INDIRECT, INCIDENTAL, EXEMPLARY, CONSEQUENTIAL LOSSES OR OTHER DAMAGES ARISING OUT OF OR IN CONNECTION WITH THIS ACKNOWLEDGMENT.

This Acknowledgment is governed by the laws of the State of New York.

Acknowledged and Agreed: _____

Organization: _____

By: _____

Name: _____

Title: _____

Date: _____