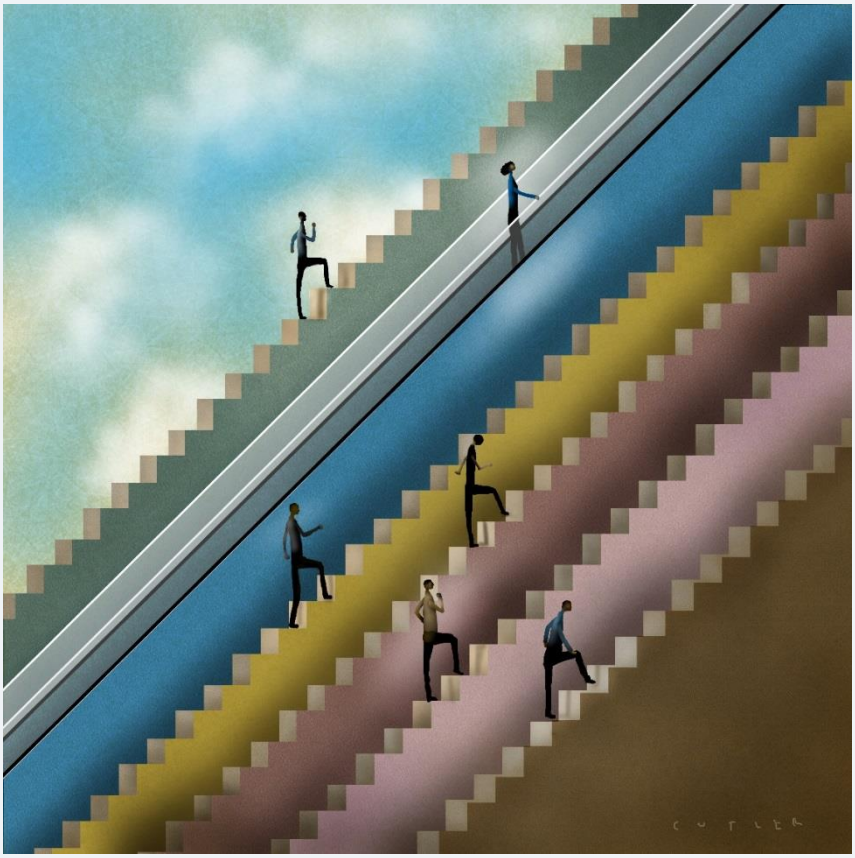
2017 CAQH Index™

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

Data for Calendar Year 2016

Updated: June 2017



CAQH Explorations | INDEX™

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OVERVIEW OF THE 2017 INDEX REPORTING STANDARDS AND DATA SUBMISSION GUIDE

This Guide accompanies the 2017 Index Data Collection Tool 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 2016. (The 2017 Data Submission Tool is illustrated in Appendix B and Appendix C.) 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 instructions 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 12 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 the data are as comparable as possible among respondents, and to allow aggregation and benchmarking.

Please contact explorations@caqh.org with any questions or comments 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.
Prior Authorization	ASC X12N 278	A request from a provider to a health plan to obtain an authorization for health care, or a response from a health plan for an authorization.
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.
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.
COB Claims	ASC X12N 837	COB claims are a subset of all claim submissions above. We define COB claims as those sent to secondary payers with an attached or included EOP information from the primary payer.
Referral Certification	ASC X12N 278	Referral certification is request from a healthcare provider to a health plan for permission to refer a patient to another provider. While this transaction an element of the Prior Authorization suite of HIPAA standardized transactions, we do NOT count it in the Prior Authorization category above.
Employer/HIX/Broker Enrollment/ Disenrollment	ASC X12N 834	Enrollment/disenrollment transactions can be initial enrollments, full file replacement (enrollment changes or to true up enrollment) or add/change/terminate enrollment.
Employer/HIX/Broker Premium Payment/ Explanation	ASC X12N 820 005010X218 (employer) 005010X306 (HIX)	The HIPAA standard electronic premium payment transaction 820 can be sent to bank to move money only; sent to bank to move money with detailed remittance info; or sent directly to payee with remittance information only.
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 medical/surgical and related health care claims and inquiries. If you include data for vision and/or dental claims, please categorize those results in a separate column. The 2017 Index data do not include retail pharmacy transactions. If your company's data DO include retail pharmacy transactions, please contact CAQH.

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.

Prior Authorization

Measures and reports the inquiries, requests, and submissions received by the health plan from healthcare providers for the purpose of obtaining a pre-certification or prior authorization of a service or procedure. Prior authorization transactions are used to clarify whether a treatment or procedure is covered for particular circumstances of patient care.

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. Prior authorization requests and responses may pertain to many different health care events, including reviews for: treatment authorization, pre-admission certifications, certifications for health care services (such as home health and ambulance), extension of certifications, and certification appeals.

Note that referral certification requests, which use the same electronic HIPAA standard as prior authorization/pre-certification (278) are being counted separately (see below), and are NOT included in the counts of prior authorization transactions.

For the 2017 Index, we are counting prior authorization transactions for medical/surgical benefits, as well as inquiries from healthcare providers (hospitals and physicians' offices etc.) to get authorization for coverage of prescription drugs. However, we are not attempting to count inquiries made directly from pharmacies – the focus for 2017 counts will be transactions involving hospitals, physicians, and other healthcare practitioners. Optional responses on the numbers of inquiries from healthcare providers related to health plan members' prescription drug benefits, for plans that can break out Rx inquiries vs. those for medical surgical benefits, can be made in the comments.

	Adopted HIPAA Standard	Description
Prior Authorization	ASC X12N 278	A request from a provider to a health plan to obtain an authorization for health care; or a response from a health plan for an authorization.

For the 2017 Index, all transactions related to prior authorization, including initial inquiries and subsequent submissions of information and responses, will be counted. Therefore, some benefit events may generate multiple transactions. Each transaction counts, and should be categorized by manual or electronic processes per below. For example, an initial inquiry might be a telephone request for a determination of whether a prior authorization is necessary for a particular procedure or service. A follow up request might be an electronic transaction providing specific information or following the health plan's procedures to approve the covered status of a particular procedure or service for a particular patient.

The 2017 Index data submission includes transactions in the following categories:

- Telephone
- Fax or Email
- Interactive Voice Recognition (IVR)
- Non-standardized Website/Portal Transmission
- Standardized Electronic Transmission HIPAA 278
- Other (specify in comments)

Note:

- This category does NOT include referrals.

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 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.

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.

Coordination of Benefits (COB) Claims

COB claims are sent to a secondary payer with the primary payer's remittance advice after the primary payer has adjudicated the claim.

The COB measure will determine to what extent the 837 COB claim submission capability is being used relative to paper COB claim submission, and is intended to help understand the frequency and costs associated with processing COB claims

Paper COB claims from EDI enabled and non-EDI able providers make up a substantial portion of claims still being submitted on paper.

The new COB claims measure is a subset of the larger Claim Submission measure:

	Adopted HIPAA Standard	Description
COB Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter information for the purpose of reporting health care that is coded as for coordination of benefits.

Most claims submitted are either on paper or via standardized electronic transaction (837). However, since many COB claims may have attachments, we are using a larger set of possible categories for COB claim transmissions to allow for COB claims with attachments:

- Received via Paper Delivery (mail, FedEx etc.)
- Received by Fax
- Non-standardized -- Received by Email (PDF)
- Non-standardized -- Website/Portal Submission
- Standardized Electronic Transmission (837)

Note: this measure should include ONLY medical claims, not auto or liability secondary claims.

Notes for counting COB claims: Claims reported should be only those received for medical expense services for insured/enrollees participating in the health plan. For standardized electronic claims, only ASC X12N/005010X2I2 Health Care Claim 837 I (Institutional) and 837 P (Professional) claims are included at this time.

Note on separating COB claims: Some responding health plans may be able to separately count commercial COB and Medicare COB claims. If this separate counting is possible, please use the extra columns to separate the counts and label them. The total column should add to all COB claims.

Note on COB claim attachments. Claim attachments are counted under the claim attachment category above. Some responding health plans may be able to separately count COB claim attachments from other claim attachments. If this separate counting is possible, please use the extra columns under the Claim Attachments category to break out counts of COB claim attachments. The total column for Claim Attachments should add to all claim attachments.

Referral Approval/Certification

Referral transactions are requests from a health care provider to a health plan to obtain authorization for referring an individual to another health care provider.

Referral transactions are classified in the same suite of are transactions as prior authorization/pre-certification of insurance for medical procedures or goods and services. However, the referral certification transaction is quite different, since it confirms coverage for services delivered by a referred provider, rather than for a particular service.

	Adopted HIPAA Standard	Description
Referrals	ASC X12N 278	A request from a provider to a health plan to obtain … authorization for referring an individual to another provider; or a response from a health plan regarding a referral certification request.

Our intent goal is to get information on the numbers of referral certification transactions, their mode (electronic vs. manual) and costs. Referral certification may be used extensively by some health plans and not very frequently by others. Referral certification procedures may be more apt to be performed via standardized electronic transaction than other prior authorization transactions,

The 2017 Index data submission includes referral certification transactions in the categories of transaction types as prior authorization/pre-certification:

- Telephone
- Fax or Email
- Interactive Voice Recognition (IVR)
- Non-standardized Website/Portal Transmission
- Standardized Electronic Transmission HIPAA 278

- Other (specify in comments)

Note:

- This category does NOT include prior authorization/pre-certification.

Enrollment/Disenrollment Transactions

We are studying two transactions that are not claim related, and are not performed between health plans and providers. The first of these is enrollment/disenrollment transactions, which are communications between health plans and employers, brokers, or health insurance exchanges regarding enrollment lists, or modifications to enrollment list (drop, add, change)

	Adopted HIPAA Standard	Description
Employer/HIX/Broker Enrollment/ Disenrollment	ASC X12N 834	Enrollment/disenrollment transactions can be initial enrollments, full file replacement (enrollment changes or to true up enrollment) or add/change/terminate enrollment.

There is one main category for reporting all or total Enrollment/Disenrollment transactions, and a separate optional breakout for transactions from health insurance exchange (HIX) Enrollment/Disenrollment transactions.

The Enrollment/Disenrollment transaction can encompass a periodic full update of an employer's health plan enrollees, or it can be a change to an existing enrollment dataset, with modification instructions to add, delete, or modify coverage terms for particular enrollees.

Most employers, brokers, or HIXs will likely use one particular method of enrollment/disenrollment transactions exclusively. We are asking health plan respondent for counts of employers/brokers/HIXs (in total) by the type of method they use. We are also asking for the number of enrollees (covered lives) and the total numbers of transactions in these categories:

Enrollment-Disenrollment (Paper by Mail or Fax)
Enrollment-Disenrollment (Spreadsheet or Custom File)
Enrollment-Disenrollment (Portal/Website Data Entry)
Enrollment-Disenrollment (HIPAA 834)

Employer Premium Payment

We are studying two transactions that are not claim related, and are not performed between health plans and providers. The second of these is employer premium payments, which are communications between employers and health plans, and their banks, regarding authorization to make a premium payment and explanations of premium payments.

	Adopted HIPAA Standard	Description
Employer/HIX/Broker Premium Payment/ Explanation	ASC X12N 820 005010X218 (employer) 005010X306 (HIX)	The HIPAA standard electronic premium payment transaction 820 can be sent to bank to move money only; sent to bank to move money with detailed remittance info; or sent directly to payee with remittance information only.

This measure is designed to create an initial baseline for electronic premium payment transactions. The HIPAA 820 transaction can be used by employers and brokers, and (potentially) health insurance exchanges (HIXs) to initiate the movement of funds via their bank, also to communicate with health plans on the details of payment. Analogous to a remittance advice that accompanies health plan claim payments, information on the premium payment can be sent to the health plan with the payment, or as a separate explanation.

As with Enrollment/Disenrollment transactions, there is one main category for reporting all or total Premium Payment transactions, and a separate optional breakout for transactions from health insurance exchange (HIX) Enrollment/Disenrollment transactions.

Most employers, brokers, or HIXs will likely use one particular method of enrollment/disenrollment transactions exclusively. We are asking health plan respondent for counts of employers/brokers/HIXs (in total) by the type of method they use. We are also asking for the number of enrollees (covered lives) and the total numbers of transactions in these categories:

Premium Payment (Mail Delivery/Printed Check)
Premium Pay/Adv (Spreadsheet or Custom File)
Premium Pay/Adv (Portal/Website Data Entry)
Premium Payment (HIPAA 820 00501X218 or 00501x306)

Note that HIX premium payment transactions use a modified version of the HIPAA 820, which is numbered HIPAA 820 00501X306. The version used by employers is HIPAA 820 00501X218.

COSTS PER TRANSACTION

If you have not submitted cost data in the prior year, we request you submit data for this data collection cycle to add to the database. We have moved to an every other year data collection for costs per transaction. We are combining the data request for costs per transaction with the data requests for numbers of transactions for payers in the data collection tool. CAQH will continue to sponsor a separate data acquisition project for costs per transaction of healthcare providers.

Health plans that participated in prior Index submissions 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.

Notes:
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.

Calculators for Estimating Costs Per Transaction

The Data Submission Tools provided to responding health plans include three calculators 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 calculator 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 calculator builds instead 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 calculator 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 (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.

Expand columns to the right if needed and explain in the comments

Product or Business Information	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	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							
Comment:								

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.

A pilot first-year data collection of Acknowledgements is requested. Please report if your organization is able to track these transactions (Row 81).

Code	**Type of Transaction**	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	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	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Claims Submitted, January 1 to December 31, 2016							
		Voluntary first-year reporting of Acknowledgements requested below (Rows 82 and 83)							

Code	**Eligibility and Benefit Verification (does NOT incl**	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	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	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Eligibility and Benefit Verification Inquiries, January 1 to December 31, 2016							
		Voluntary first-year reporting of Acknowledgements requested below (Rows 84 and 85)							

	Claim Status	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	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	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Claim Status Inquiries, January 1 to December 31, 2016							
		Voluntary first-year reporting of Acknowledgements requested below (Rows 186 and 187)							

	Claim Payment	Total	Commercial	Medicare	Medicaid	Dental	Vision	Other	Other
	Count of Payments Made -								
CPPAYP/	Printed Check or Paper	0							
CPPAYBI	Count of Payments Made - Bank/Virtual Card Network	0							
CPPAYA(	Count of Payments Made - EFT via ACH Network	0							
CPPAYTC	**Total Payments Made**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Claim Payments Made, January 1 to December 31, 2016							

	Claim Remittance Advice	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	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							
CRRAH83	Count of Electronic Remittance Advice (HIPAA 835)	0							
CRRATO	**Total Remittance Advices Sent**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Remittance Advices Sent, January 1 to December 31, 2016							

	Prior Authorization (Medical/Surgical -- No Pharr	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
PATEL	Prior Authorization Requests (Telephonic)	0							
PAFAX	Prior Authorization Requests (Fax/Email)	0							
PAIVR	Prior Authorization Requests (IVR)	0							
PAPOR	Prior Authorization Requests (Portal/Website)	0							
PAH270	Prior Authorization Request (HIPAA 278)	0							
PATOT	**Total Prior Authorization Requests**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Prior Authorization Requests, January 1 to December 31, 2016							

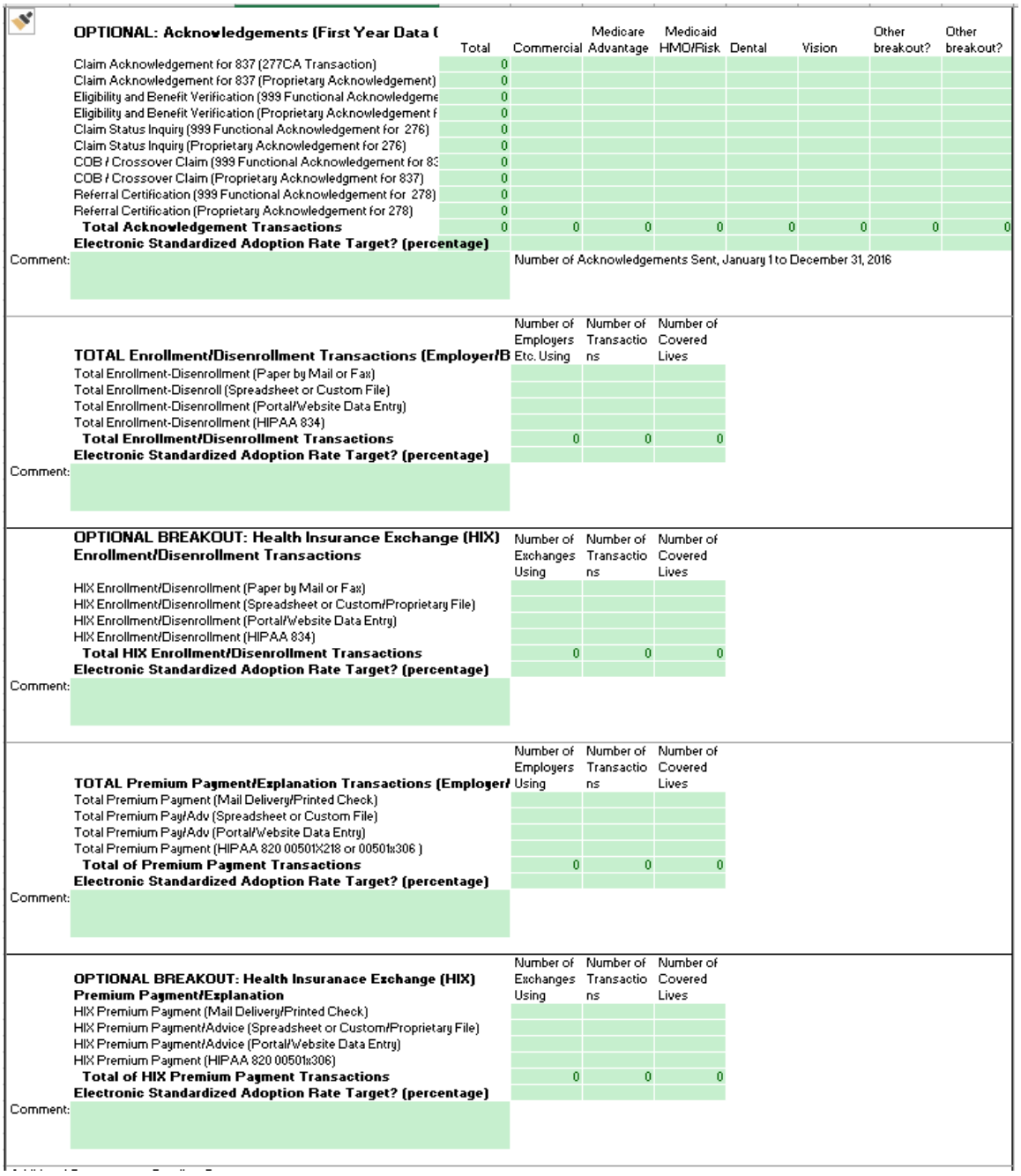
	Attachments -- Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type -- for	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
ACMAIL	Received via Paper Delivery (mail, FedEx etc.)	0							
ACFAX	Received 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	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:		Number of Claim-Related Attachments, January 1 to December 31, 2016							

	Attachments -- Prior Authorization	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
APMAIL	Received via Paper Delivery (mail, fedex etc.)	0							
APFAX	Received by Fax	0							
APPDF	Received by email (PDF)	0							
APOR	Website/portal	0							
APHL7	Standardized Electronic Transmission (HL7)	0							
APX12	Standardized Electronic Transmission (X12)	0							
APTOT	**Total Prior Authorization-Related Attachments**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:			Number of Prior Authorization Attachments, January 1 to December 31, 2016						

	Coordination of Benefits Claims (use breakout columns, such as columns J and K, to breakout by type -- for example commercial COB vs.	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
COBPAP	Received via Paper Delivery (mail, FedEx etc.)	0							
COBFAX	Received by Fax	0							
COBEMA	Non-standardized Received by email (PDF)	0							
COBWEB	Non-standardized Website/portal submission	0							
COB837	COB Transactions via Standardized 837	0							
COBTOT	**Total COB Claims**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:			Number of COB Claims, January 1 to December 31, 2016						
			Voluntary first-year reporting of Acknowledgements requested below (Rows 189 and 193)						

	Referral/Approval	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
REFCTEL	Referral Requests (Telephonic)								
REFCFAX	Referral Requests (Fax/Email)								
REFCIVR	Referral Requests (IVR)								
REFCWEE	Referral Requests (Portal/Website)								
REFC278	Referral Request (HIPAA 278)								
REFCTOT	**Total Remittance Certification/Approval**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:			Number of Referral/Approval Requests, January 1 to December 31, 2016						
			Voluntary first-year reporting of Acknowledgements requested below (Rows 190 and 191)						

	Prior Authorization (RX -- Request from Provider:	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
PATEL	Prior Authorization Requests (Telephonic)	0							
PAFAX	Prior Authorization Requests (Fax)	0							
PAIVR	Prior Authorization Requests (IVR)	0							
PAPOR	Prior Authorization Requests (Portal/Website)	0							
PAH270	Prior Authorization Request (HIPAA 278)	0							
PATOT	**Total Prior Authorization Requests**	0	0	0	0	0	0	0	0
	Electronic Standardized Adoption Rate Target? (percentage)								
Comment:			Number of Prior Authorization Requests, January 1 to December 31, 2016						



OPTIONAL: Acknowledgements (First Year Data (

	Total	Commercial	Medicare Advantage	Medicaid HMO/Risk	Dental	Vision	Other breakout?	Other breakout?
Claim Acknowledgement for 837 (277CA Transaction)	0							
Claim Acknowledgement for 837 (Proprietary Acknowledgement)	0							
Eligibility and Benefit Verification (999 Functional Acknowledgeme	0							
Eligibility and Benefit Verification (Proprietary Acknowledgement f	0							
Claim Status Inquiry (999 Functional Acknowledgement for 276)	0							
Claim Status Inquiry (Proprietary Acknowledgement for 276)	0							
COB / Crossover Claim (999 Functional Acknowledgement for 83	0							
COB / Crossover Claim (Proprietary Acknowledgment for 837)	0							
Referral Certification (999 Functional Acknowledgement for 278)	0							
Referral Certification (Proprietary Acknowledgement for 278)	0							
Total Acknowledgement Transactions	0	0	0	0	0	0	0	0
Electronic Standardized Adoption Rate Target? (percentage)								

Comment: Number of Acknowledgements Sent, January 1 to December 31, 2016

TOTAL Enrollment/Disenrollment Transactions (Employer/B	Number of Employers Etc. Using	Number of Transactions	Number of Covered Lives
Total Enrollment-Disenrollment (Paper by Mail or Fax)			
Total Enrollment-Disenroll (Spreadsheet or Custom File)			
Total Enrollment-Disenrollment (Portal/Website Data Entry)			
Total Enrollment-Disenrollment (HIPAA 834)			
Total Enrollment/Disenrollment Transactions	0	0	0
Electronic Standardized Adoption Rate Target? (percentage)			

Comment:

OPTIONAL BREAKOUT: Health Insurance Exchange (HIX) Enrollment/Disenrollment Transactions	Number of Exchanges Using	Number of Transactions	Number of Covered Lives
HIX Enrollment/Disenrollment (Paper by Mail or Fax)			
HIX Enrollment/Disenrollment (Spreadsheet or Custom/Proprietary File)			
HIX Enrollment/Disenrollment (Portal/Website Data Entry)			
HIX Enrollment/Disenrollment (HIPAA 834)			
Total HIX Enrollment/Disenrollment Transactions	0	0	0
Electronic Standardized Adoption Rate Target? (percentage)			

Comment:

TOTAL Premium Payment/Explanation Transactions (Employer/	Number of Employers Using	Number of Transactions	Number of Covered Lives
Total Premium Payment (Mail Delivery/Printed Check)			
Total Premium Pay/Adv (Spreadsheet or Custom File)			
Total Premium Pay/Adv (Portal/Website Data Entry)			
Total Premium Payment (HIPAA 820 00501X218 or 00501x306)			
Total of Premium Payment Transactions	0	0	0
Electronic Standardized Adoption Rate Target? (percentage)			

Comment:

OPTIONAL BREAKOUT: Health Insuranace Exchange (HIX) Premium Payment/Explanation	Number of Exchanges Using	Number of Transactions	Number of Covered Lives
HIX Premium Payment (Mail Delivery/Printed Check)			
HIX Premium Payment/Advice (Spreadsheet or Custom/Proprietary File)			
HIX Premium Payment/Advice (Portal/Website Data Entry)			
HIX Premium Payment (HIPAA 820 00501x306)			
Total of HIX Premium Payment Transactions	0	0	0
Electronic Standardized Adoption Rate Target? (percentage)			

Comment:

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 (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
278	Prior-Authorization/Pre-Certification		$3.98	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
	Attachments -- Prior Authorization		$0.45	Mail, Fax, Email
837	Coordination of Benefits (COB) Claims			Mail, Fax, Email
278	Referral			Phone Call, Fax

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
278	Prior-Authorization/Pre-Certification		$0.04	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		NA	Auto (HL7 or X12)
	Attachments -- Prior Authorization		NA	Auto (HL7 or X12)
837	Coordination of Benefits (COB) Claims		NA	Automated, Portal
278	Referral		NA	IVR, Portal, Auto

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 (see Example in the following tab)

Manual Transactions

ID	Transaction Type	Hours	Labor Cost/Hour	Labor Costs	Overhead Rate (IT, Vendor, Benefits,	Fully Loaded Cost ($)	FROM VOLUME: Number of Transactions	WHAT WE WANT: Fully Loaded Costs ($) Per Transaction
837	Claim Submission			$0.00		$0	0	#DIV/0!
270 - 271	Eligibility and Beneift Verification			$0.00		$0	0	#DIV/0!
278	Prior-Authorization/Pre-Certification			$0.00		$0	0	#DIV/0!
276 - 277	Claim Status Inquiry			$0.00		$0	0	#DIV/0!
835	Claim Payment			$0.00		$0	0	#DIV/0!
835	Claim Remittance Advice			$0.00		$0	0	#DIV/0!
	Attachments -- Claim Related			$0.00		$0	0	#DIV/0!
	Attachments -- Prior Authorization			$0.00		$0	0	#DIV/0!
837	Coordination of Benefits (COB) Claims			$0.00		$0	0	#DIV/0!
278	Referral/Approval			$0.00		$0	0	#DIV/0!

Electronic Transactions

ID	Transaction Type	Hours	Labor Cost/Hour	Labor Costs	Rate (IT, Vendor, Benefits,	Fully Loaded Cost ($)	FROM VOLUME SHEET: Number of Transactions	WHAT WE WANT: Fully Loaded Costs ($) Per Transaction
837	Claim Submission			$0.00		$0	0	#DIV/0!
270 - 271	Eligibility and Beneift Verification			$0.00		$0	0	#DIV/0!
278	Prior-Authorization/Pre-Certification			$0.00		$0	0	#DIV/0!
276 - 277	Claim Status Inquiry			$0.00		$0	0	#DIV/0!
835	Claim Payment			$0.00		$0	0	#DIV/0!
835	Claim Remittance Advice			$0.00		$0	0	#DIV/0!
	Attachments -- Claim Related			$0.00		$0	0	#DIV/0!
	Attachments -- Prior Authorization			$0.00		$0	0	#DIV/0!
837	Coordination of Benefits (COB) Claims			$0.00		$0	0	#DIV/0!
278	Referral/Approval			$0.00		$0	0	#DIV/0!

Calculator 2 -- Another Optional Method of Computing Fully Loaded Costs Per Transaction (see Example in the following tab)

Manual Transactions

ID	Transaction Type	Modalities	Transactions Per Hour	Labor Cost/Hour	Labor Costs Per Transaction	verhead Rate	WHAT WE WANT: Fully Loaded Cost per Transaction
837	Claim Submission	Paper Delivery			#DIV/0!	0%	#DIV/0!
270 - 271	Eligibility and Beneift Verification	Phone Call, Fax			#DIV/0!	0%	#DIV/0!
278	Prior-Authorization/Pre-Certification	Phone Call, Fax			#DIV/0!	0%	#DIV/0!
276 - 277	Claim Status Inquiry	Phone Call, Fax			#DIV/0!	0%	#DIV/0!
835	Claim Payment	Check Mail			#DIV/0!	0%	#DIV/0!
835	Claim Remittance Advice	Fax, Mail			#DIV/0!	0%	#DIV/0!
	Attachments -- Claim Related	Mail, Fax, Email			#DIV/0!	0%	#DIV/0!
	Attachments -- Prior Authorization	Mail, Fax, Email			#DIV/0!	0%	#DIV/0!
837	Coordination of Benefits (COB) Claims	Mail, Fax, Email			#DIV/0!	0%	#DIV/0!
278	Referral/Approval	Phone Call, Fax			#DIV/0!	0%	#DIV/0!

Electronic Transactions			Transactions Per Hour	Labor/IT/Support Costs Per	Labor/IT/Support Costs Per	verhead Rate	
837	Claim Submission	Automated		0	#DIV/0!	0%	#DIV/0!
270 - 271	Eligibility and Beneift Verification	IVR, Portal, Auto		0	#DIV/0!	0%	#DIV/0!
278	Prior-Authorization/Pre-Certification	IVR, Portal, Auto		0	#DIV/0!	0%	#DIV/0!
276 - 277	Claim Status Inquiry	IVR, Portal, Auto		0	#DIV/0!	0%	#DIV/0!
835	Claim Payment	Automated		0	#DIV/0!	0%	#DIV/0!
835	Claim Remittance Advice	Automated		0	#DIV/0!	0%	#DIV/0!
	Attachments -- Claim Related	Auto (HL7 or X12)		0	#DIV/0!	0%	#DIV/0!
	Attachments -- Prior Authorization	Auto (HL7 or X12)		0	#DIV/0!	0%	#DIV/0!
837	Coordination of Benefits (COB) Claims	Automated, Portal		0	#DIV/0!	0%	#DIV/0!
278	Referral/Approval	IVR, Portal, Auto		0	#DIV/0!	0%	#DIV/0!

Calculator 3 -- Another Optional Method of Computing Fully Loaded Costs Per Transaction (see Example in the following tab)

Manual Transactions		FROM VOLUME SHEET:				WHAT WE WANT:	
			Cost of All Provider Transactions, with Percent of Cost by Transaction - Manual	Estimated Percentage of Costs by Transaction Type (not required to sum to	Fully Loaded Costs of These 10 Transactions -- Manual	Fully Loaded Cost per Transaction ($)	
ID	Transaction Type	Transactions			$0.00		
837	Claim Submission	0			$0	#DIV/0!	
270 - 271	Eligibility and Beneift Verification	0			$0	#DIV/0!	
278	Prior-Authorization/Pre-Certification	0			$0	#DIV/0!	
276 - 277	Claim Status Inquiry	0			$0	#DIV/0!	
835	Claim Payment	0			$0	#DIV/0!	
835	Claim Remittance Advice	0			$0	#DIV/0!	
	Attachments -- Claim Related	0			$0	#DIV/0!	
	Attachments -- Prior Authorization	0			$0	#DIV/0!	
837	Coordination of Benefits (COB) Claims	0			$0	#DIV/0!	
278	Referral/Approval	0			$0	#DIV/0!	
				0.0%			

Electronic Transactions			Cost of All Provider Transactions, with Percent of Cost by Transaction - Electronic	Estimated Percentage of Costs by Transaction Type (not required to sum to	Fully Loaded Costs of These 10 Transactions -- Electronic	Fully Loaded Cost per Transaction ($)	
					$0.00		
837	Claim Submission	0			$0	#DIV/0!	
270 - 271	Eligibility and Beneift Verification	0			$0	#DIV/0!	
278	Prior-Authorization/Pre-Certification	0			$0	#DIV/0!	
276 - 277	Claim Status Inquiry	0			$0	#DIV/0!	
835	Claim Payment	0			$0	#DIV/0!	
835	Claim Remittance Advice	0			$0	#DIV/0!	
	Attachments -- Claim Related	0			$0	#DIV/0!	
	Attachments -- Prior Authorization	0			$0	#DIV/0!	
837	Coordination of Benefits (COB) Claims	0			$0	#DIV/0!	
278	Referral/Approval	0			$0	#DIV/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: _____