Committee on Operating Rules for Information Exchange (CORE)

Presentation to 12th National HIPAA Summit

Washington, DC • April 11, 2006

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Discussion Topics

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

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An Introduction to CAQH

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

CAQH solutions help:

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

CORE

Committee On Operating Rules

For Information Exchange

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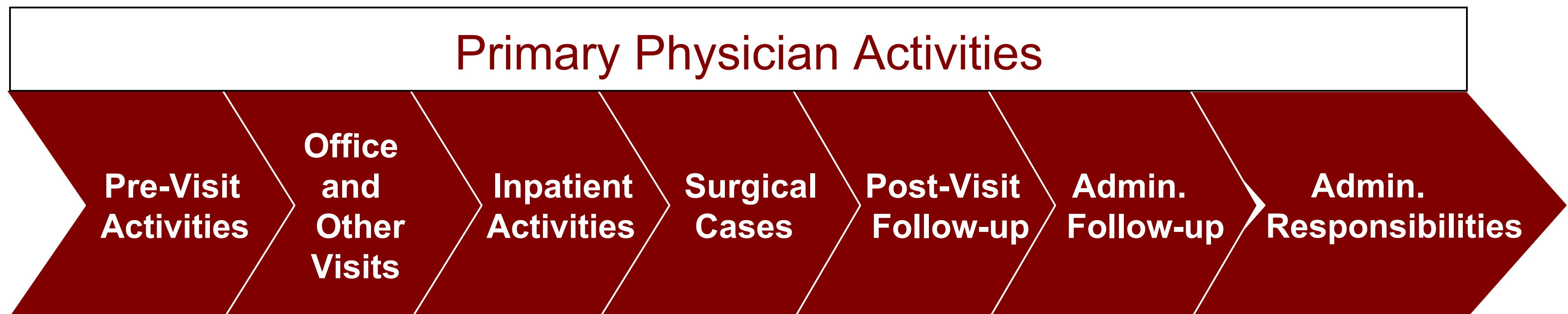
Physician-Payer Interaction

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



Pre-Visit Activities	Office and Other Visits	Inpatient Activities	Surgical Cases	Post-Visit Follow-up	Admin. Follow-up	Admin. Responsibilities
• Patient inquiry • Appt scheduling • Scheduling verification • Financial review of pending appts. • Encounter form/ medical record preparation	• Registration & referral mgmt. • Admin & medical record preparation • Patient visit • Ancillary testing • Charge capture • Prescriptions	• Scheduling & referral mgmt. • Admin & medical record preparation • Inpatient care • Ancillary testing • Charge capture	• Scheduling & referral mgmt. • Admin & medical record preparation • Surgical care • Post care • Follow-up care	• Visit orders & instructions • Education materials • Prescriptions • Ancillary tests • Referrals • Follow-up visits	• Utilization review • Claims/bill generation • Billing • Payment processing • Claims follow-up	• Personnel management • Financial management • Managed care • Information systems • Facilities management • Medical staff affairs

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Key Challenges: Eligibility and Benefits

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

Vision: Online Eligibility and Benefits Inquiry

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

Providers will send an online inquiry and know:

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

Note: No guarantees would be provided

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

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

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Vision: Online Eligibility and Benefits Inquiry

… Using any System for any Patient or Health Plan

- As with credit card transactions, the provider will be able to submit these inquiries and receive a real-time response*
  - From a single point of entry
  - Using an electronic system of their choice
- For any patient
- For any participating health plan

*Initiative will initially support batch and real-time

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- Industry-wide stakeholder collaboration launched in January 2005
- Short-Term Goal
  - Design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits
- Long-Term Goal
  - Based on outcome of initiative, apply concept to other administrative transactions
- Answer to the question: Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?

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CORE Mission

To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers

- Build on any applicable HIPAA transaction requirements
- Enable providers to submit transactions from the system of their choice and quickly receive a standardized response from any participating stakeholder
- Enable stakeholders to implement CORE phases as their systems allow
- Facilitate stakeholder commitment to and compliance with CORE's long-term vision
- Facilitate administrative and clinical data integration

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What are Operating Rules?

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

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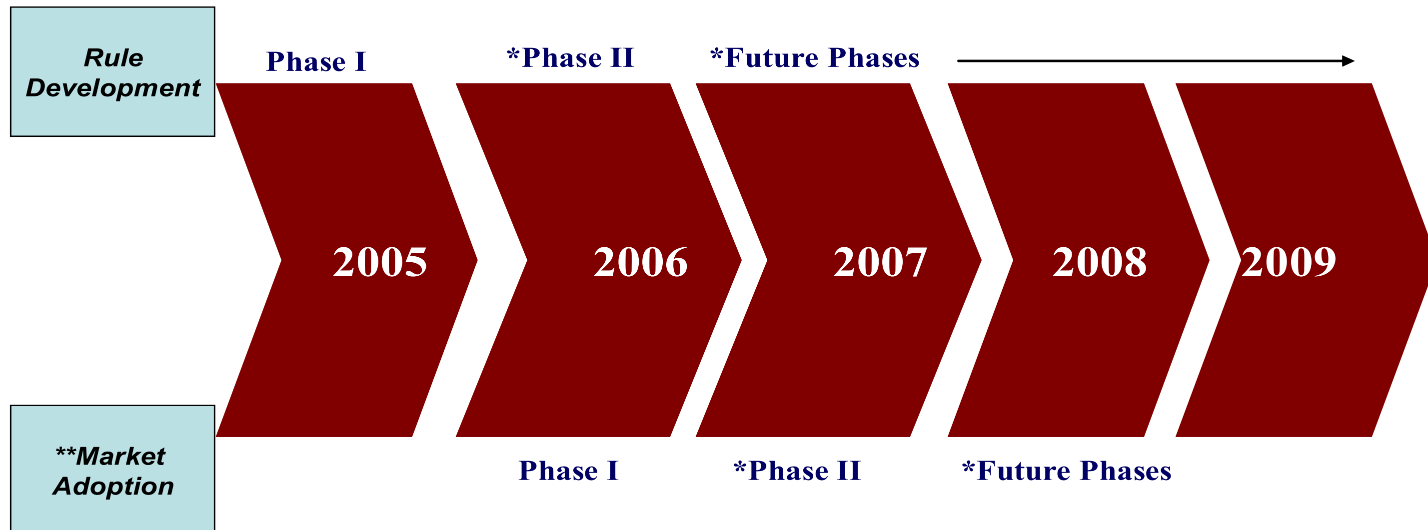
Phased Approach



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

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

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Current Participants

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

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Current Participants

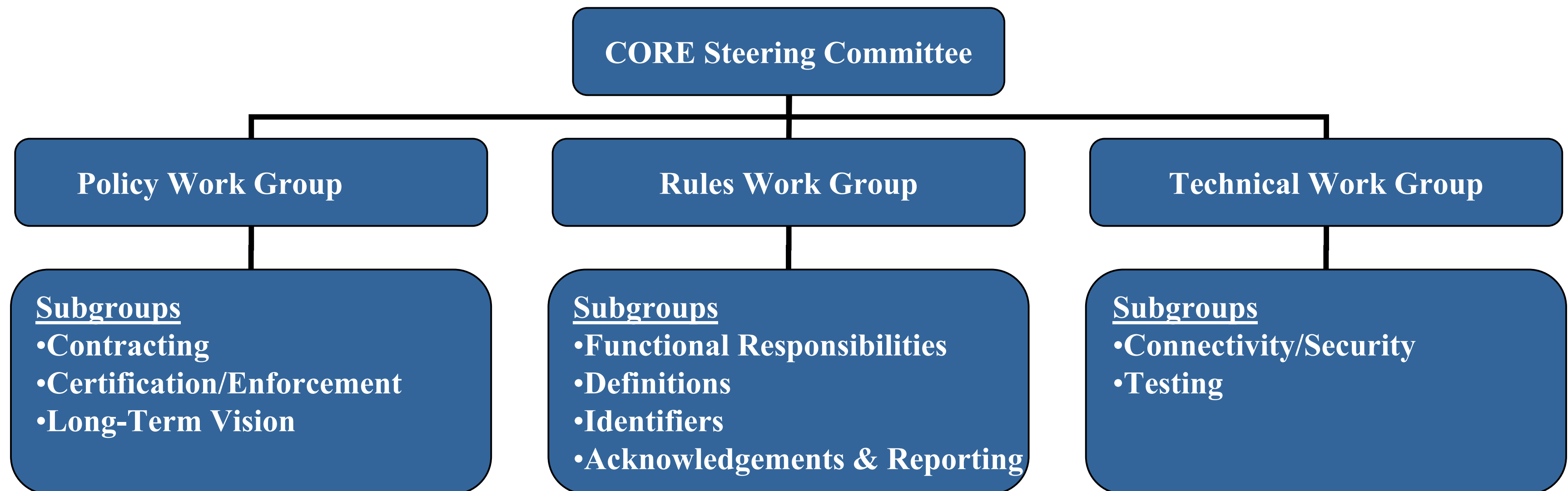
- **Health Plans**
  - Aetna, Inc.
  - Blue Cross Blue Shield of Michigan
  - Blue Cross and Blue Shield of North Carolina
  - BlueCross BlueShield of Tennessee
  - CareFirst BlueCross BlueShield
  - CIGNA
  - Excellus BlueCross BlueShield
  - Group Health, Inc.
  - Health Care Service Corporation
  - Health Net, Inc.
  - Health Plan of Michigan
  - Humana, Inc.
  - Independence Blue Cross
  - Kaiser Permanente
  - UnitedHealth Group
  - WellPoint, Inc.
- **Associations / Regional Entities / Standard Setting Organizations**
  - America's Health Insurance Plans (AHIP)
  - ASC X12
  - Blue Cross and Blue Shield Association (BCBSA)
  - Delta Dental Plans Association
  - eHealth Initiative
  - Healthcare Financial Management Association (HFMA)
  - Healthcare Information & Management Systems Society
  - Maryland/DC Collaborative for Healthcare IT
  - National Committee for Quality Assurance (NCQA)
  - National Council for Prescription Drug Programs (NCPDP)
  - NJ Shore
  - Private Sector Technology Group
  - Smart Card Alliance Council
  - Utah Health Information Network (UHIN)
  - Utilization Review Accreditation Commission (URAC)
  - Work Group for Electronic Data Interchange (WEDI)
- **Providers**
  - Adventist HealthCare, Inc.
  - American Academy of Family Physicians (AAFP)
  - American College of Physicians (ACP)
  - American College of Radiology (ACR)
  - American Hospice, Inc.
  - American Medical Association (AMA)
  - Greater New York Hospital Association
  - HCA Healthcare
  - Laboratory Corporation of America (LabCorp)
  - Mayo Clinic
  - Medical Group Management Association (MGMA)
  - Montefiore Medical Center of New York
  - University of Wisconsin Medical Foundation (UWMF)
  - University Physicians, Inc. (University of Maryland)
  - U.S. Oncology
- **Government Agencies**
  - Louisiana Medicaid – Unisys
  - Michigan Department of Community Health
  - Michigan Public Health Institute
  - TRICARE
  - United States Centers for Medicare and Medicaid Services (CMS)

Current Participants

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

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

CORE Work Groups And Subgroups



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CORE Leadership

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

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

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Phase I Operating Rules

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Phase I Scope

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

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270/271 Data Content Rule

The CORE Data Content Rule

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

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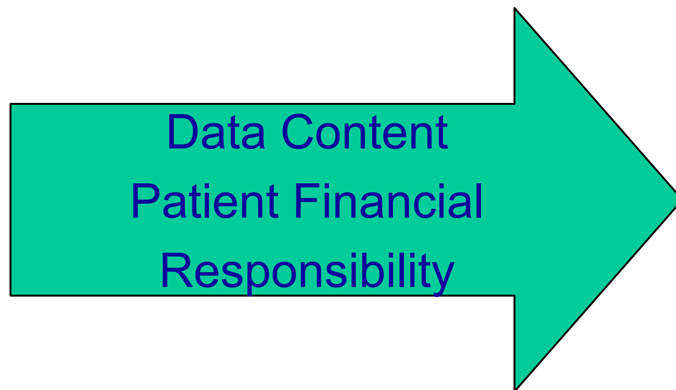
270/271 Data Content Rule

CORE Data Content Rule also Includes Patient Financial Responsibility

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 - Chiropractic
  - 47 - Hospital Inpatient
  - 50 - Hospital Outpatient
  - 86 - Emergency Services
  - 98 - Professional Physician Office Visit
- Co-pay, co-insurance and deductibles (discretionary) for
  - 1- Medical Care
  - 35 - Dental Care
  - 88 - Pharmacy
  - AL - Vision (optometry)
  - 30 - Health Benefit Plan Coverage
- If different for in-network vs. out-of-network, must return both amounts
- Health plans must also support an explicit 270 for any of the CORE-required service types

Real World Impact



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

Acknowledgements Rule

- Specifies when to use TA1 and 997
  - Real time
    - Submitter will always receive a response
    - Submitter will receive only one response
  - Batch
    - Receivers include
      - Plans,
      - Intermediaries
      - Providers
    - Will always return a 997 to acknowledge receipt for
      - Rejections
      - Acceptances
- *Remember when you didn't know if your fax went through?*

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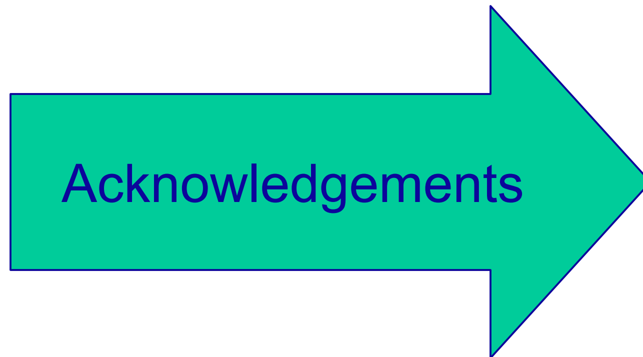
Real World Impact



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

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Response Time Rule

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

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System Availability

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

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Real World Impact

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

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Connectivity Rule

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

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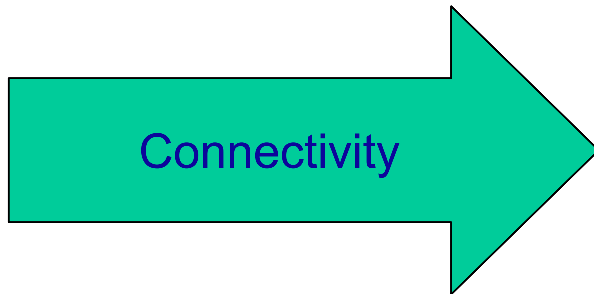
Real World Impact



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

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Companion Documents Rule

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

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Real World Impact

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

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Phase I Rules Impact: Health Plans

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

Phase I Rules Impact: Providers

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

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Phase I Measures of Success: Tracking ROI

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

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Becoming CORE Phase I Certified

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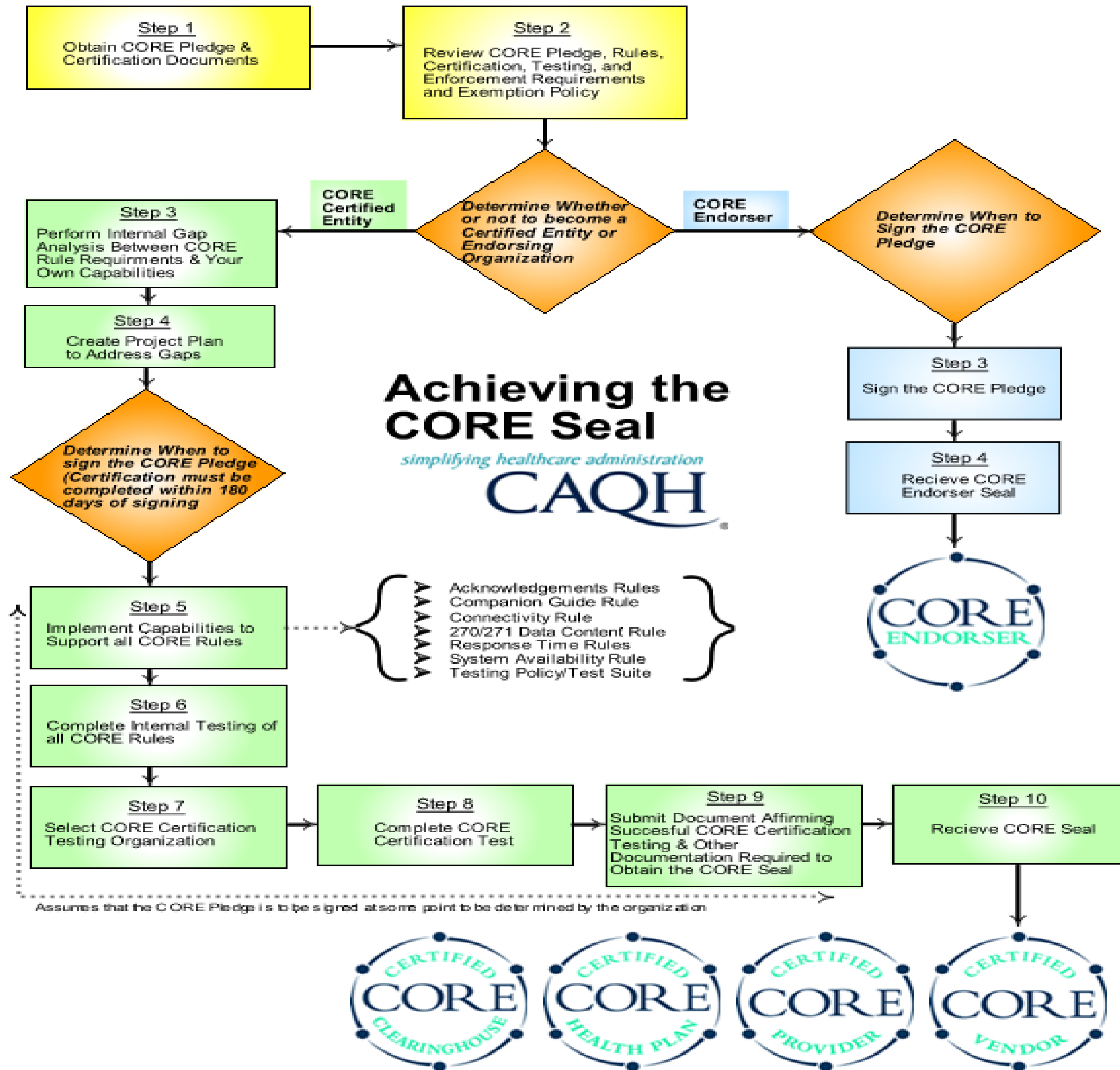
Achieving the CORE Seal



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CORE Pledge

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

CORE Certification

- Recognizes entities that have met the established operating rules requirements
- Entities that create, transmit or use eligibility data in daily business required to submit to third-party testing (within 180 days of signing pledge); if they are compliant, they receive seal as a CORE-certified health plan, vendor (product specific), clearinghouse or provider
- Entities that do not create, transmit or send – sign Pledge, receive CORE Endorser Seal

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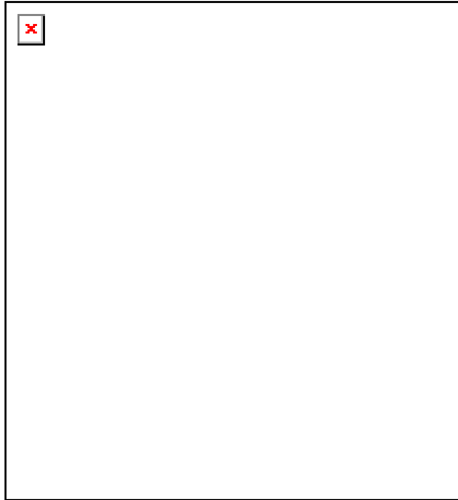
Certification Testing

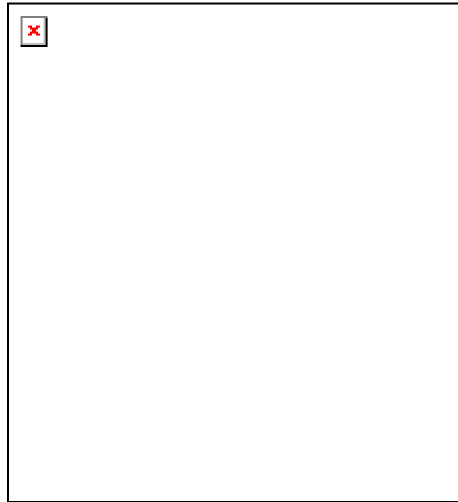
- Based on Phase I CORE Test Suite
  - For each rule there is standard conformance requirements by stakeholder
  - Suite outlines scenarios and stakeholder-specific test scripts by rule
  - Not testing for HIPAA compliance, only Phase I CORE; however, entities must attest that, to the best of their knowledge,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

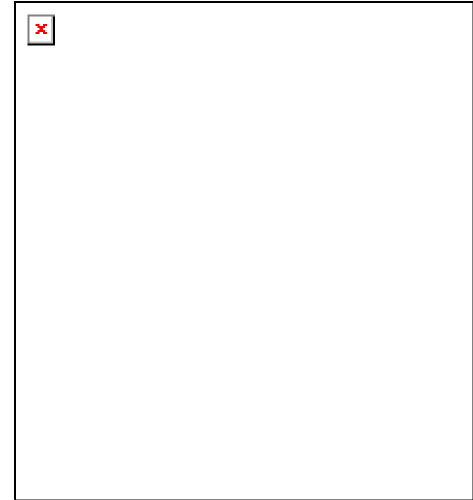
Real World Impact

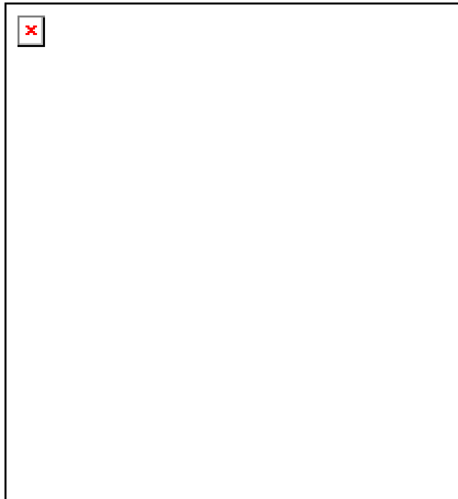
- Informs the industry that CORE-certified entities not only support their stakeholder-specific rules but have also implemented the required capabilities
- Provides a reasonable building block towards industry-wide conformance testing (and validation) for administrative transactions

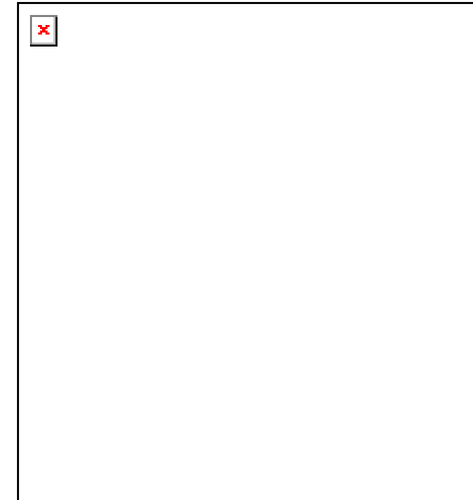
CORE Certification Seals











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CORE Seal Fees

Health Plans	
• Below $75 million in net annual revenue	$4,000 fee
• $75 million and above in net annual revenue	$6,000 fee
Vendors	
• Below $75 million in net annual revenue	$4,000 fee
• $75 million and above in net annual revenue	$6,000 fee
Providers	
• Up to $1 billion in net annual revenue	$ 500 fee
• $1 billion and above in net annual revenue	$1,500 fee
Endorser (only for entities that do not create, transmit or use eligibility data)	No fee

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Real World Impact

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

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Phase II: Areas Under Consideration

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

*Research is already underway

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Participating in CORE Phase II Rules Development

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

In Closing

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

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

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