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The Business Case for the CAQH CORE Phase I Rules

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An Introduction to CAQH

CAQH, an unprecedented nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers

CAQH solutions:

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

Current Initiatives:

CORE® – Committee on Operating Rules for Information Exchange

UPD® – Universal Provider Datasource (over 755,000 providers)

CORE®

Committee on Operating Rules
for Information Exchange

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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

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

CORE is not:

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

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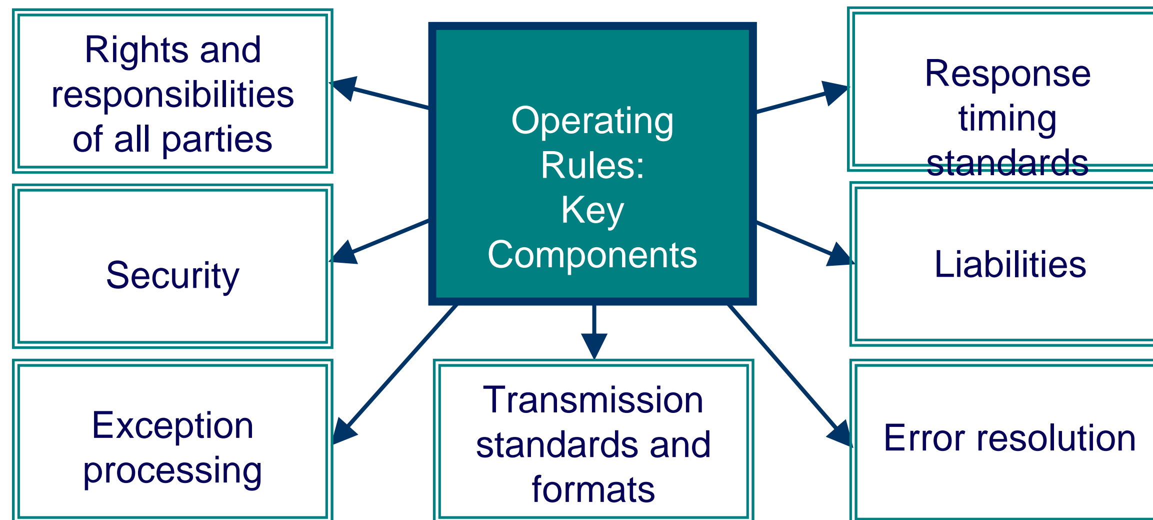
What are Operating Rules?

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



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CORE Participation, Certification, & Endorsement

Participation:

- Over 100 organizations representing all aspects of the industry
  - CORE participants maintain eligibility/benefits data for over 130 million lives, or more than 75 percent of the commercially insured plus Medicare and state-based Medicaid beneficiaries

Certification:

- To date, more than 40 healthcare organizations are certified to electronically exchange/receive basic eligibility and benefits information in accordance with the CORE Phase I rules
  - Approximately one-third of all commercially insured lives are covered by CORE Phase I-certified health plans
- Most Phase I certified organizations are committed to becoming Phase II-certified by no later than the end of Q1-2010
  - Three organizations are already Phase II certified

Endorsement:

- About 30 organizations are endorsing CORE
  - Endorsement is an option for entities that do not use, create, or transmit eligibility, benefits and/or claim status data

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CORE: A Phased Approach

CORE Phase I
✓Approved
✓Implemented

CORE's first set of rules are helping:
- Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information
- Provide access to this information in real-time via common internet protocols and with acknowledgements, etc.

CORE Phase II
✓Approved
✓Implemented

CORE's second set of rules expand on Phase I to include:
- Patient accumulators (remaining deductible)
- Rules to help improve patient matching
- Claim status "infrastructure" requirements (e.g., response time)
- More prescriptive connectivity requirements and authentication

CORE Phase III
✓In Development

CORE's third set of rules focus on:
- Claim status data requirements
- Remittance
- Prior Authorization / Referral
- Standard Health Benefit / Insurance ID Card
- More prescriptive connectivity requirements as well as digital authentication

Phase I Rules Overview

(Focus of the CORE Phase I Measures of Success Study)

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

Rules
- *270/271 Data Content
  - Financials related to Patient Responsibility (co-pay, deductible, co-insurance levels in contracts – not YTD)
  - Service Codes
- Infrastructure
  - *Connectivity -- HTTPS Safe harbor
  - Response Time -- For batch and real-time
  - System Availability -- For batch and real-time
  - Acknowledgements – For batch and real-time
  - Companion Guide (flow and format standards)

**Enhanced/expanded upon in Phase II*

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Conducting the CORE Phase I Measures of Success Study

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Study Overview

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

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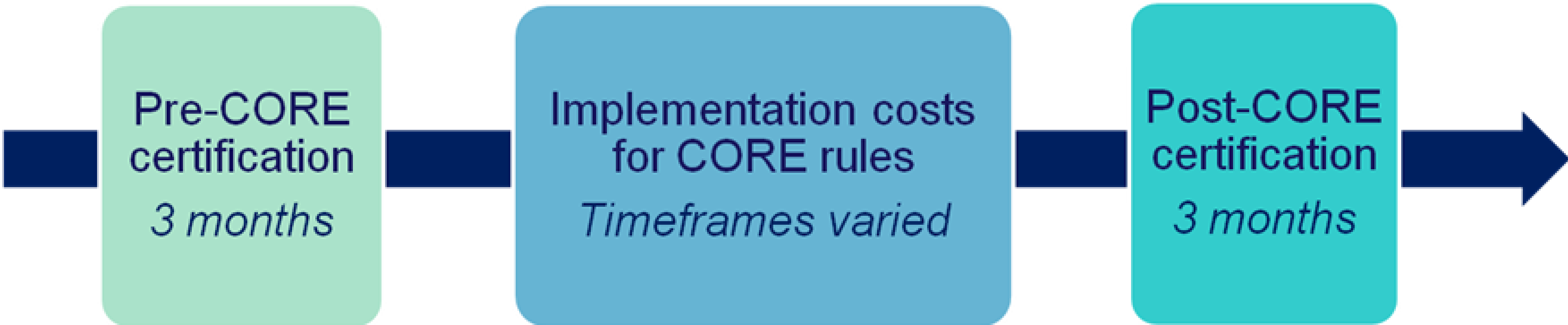
Metrics and Cost Timeline



Data Collection

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

Metrics Tracked and Costs

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

Examples:

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

Team Meeting Process

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

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Outcomes Assessed

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

Participant Perspective

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About BlueCross BlueShield of Tennessee

- State's largest health benefit plan company
- More than 2.3 million members
- Including Medicare and Medicaid operations, provides services to nearly 5 million people nationwide; provides benefits to nearly 22,800 companies
- Pays 65 million claims and more than $17 billion in benefits in 2008
- Has more than 4,300 employees
- Offices in Jackson, Johnson City, Knoxville, Memphis, Nashville
- Is one of the largest TennCare providers (MCOs) in the state with approximately 515,000 members
- Has a flagship network of providers, called Blue Network P, that includes more than:
  - 152 hospitals
  - 20,263 physicians
  - 2,108 pharmacies

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BlueCross BlueShield of Tennessee and CORE

- CORE Phase I certified
  - Applies to Commercial, Medicare Advantage and Medicaid lives
  - Participant in CORE Phase I Measures of Success Study
- Committed to CORE Phase II certification by Quarter 1 – 2010
- Participating in developing operating rules
- CORE Phase I Business Partners:
  - Athena Health
  - Emdeon Business Services
  - HMS
  - InstaMed
  - Passport Health Communications
  - Siemens / HDX
  - Spectrum Laboratory Network
  - Summit Medical Group

BlueCross BlueShield of Tennessee View on CORE

- Enhances trading partner relationships
  - CORE-certified channels streamline administrative data exchanges
  - Vendor-agnostic technology

- Complements ARRA and HITECH objectives to reduce costs, improve quality, and modernize healthcare
- Promotes national adoption of a single set of rules
  - Enables delivery of faster, more accurate responses
- Supports integration of administrative and clinical data

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BCBST and CORE: Sampling of Efficiencies

- BlueCross BlueShield of Tennessee achieved CORE Phase I Certification on June 28, 2007

Date	Approximate Real-time EDI Transaction Volume* (per month)
June 2007	< 200
June 2008	20,000
April 2009	200,000
August 2009	390,000

- Initially leveraged development for BlueExchange EEI3 for CORE
- Later leveraged development services for BX and CORE to provide automated responses to phone inquiries (VRU)
- Long-term, plan to use same services for all inquiries including web-based
- Standardization is key to success in reusability of developed assets

*Excludes on-line web portal inquiries; they are not translated to EDI formats for processing

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BlueExchange and CORE

- BlueExchange is a set of operating requirements followed by Blue Plans
- BlueExchange complements CORE rules
- BlueExchange and CORE:
  - Creating national solutions to increase the use of electronic inquiries
    - Reduce labor-intensive processes
    - Promote interoperability
  - Focusing on adopting administrative data transactions (X12 HIPAA)
    - Eligibility and claims status
    - Goes beyond what was required under HIPAA
  - Developing standard rules through research and consensus building
    - Final rules created through voting process
    - Requirements completed in phases/versions
    - Certification process to ensure operating in accordance with rules

BCBST Perspective: CORE Future

- BCBST will continue to play an active role in CORE
- CORE is helping to create interoperability among stakeholders
- As more trading partners implement CORE rules and new CORE rules further streamline administrative exchanges, expect to see further efficiencies realized when assessing measures
- CORE continues to work towards a national solution that can support all payers, while complementing BlueExchange
- CORE helps prepare stakeholders for forthcoming national standards
  - In anticipation of the industry moving from HIPAA Version 4010 to Version 5010, CORE Phase I and Phase II rules incorporate many of the features found in the X12 5010 TR3s to address the common information needs for patient eligibility

CAQH IBM CORE Phase I
Measures of Success Study Results

Results Common Across Stakeholders

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

Health Plan Results

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

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

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

  - Progress towards having all visits verified

Ratio of verifications to claims	**Up from .63 to .73**

** Results for 4 health plans, with an average of 8 million members each, that submitted verification transaction data. Savings represent cost avoidance due to avoided telephone verifications. See appendix for details.*
*** Updated 5/1 to reflect additional data*

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Health Plan Electronic Eligibility Volumes

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

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

Method	% change in volumes – TOTAL for all plans	Largest % change for an individual plan	Smallest % change for an individual plan	Comments
Real-time electronic eligibility, integrated and "on demand" (using 270/271)	**39%**	900%	10%	Largest / smallest % changes exclude a plan that did not previously offer real-time
Real-time electronic eligibility via direct data entry (using health plan or branded portal product)	**30%**	57%	18%	•User enters data directly via a portal and receives an immediate response •If via a portal product, the vendor sends the inquiry on to the plan as a 270/271 transaction •Plan response meets the CORE rules for availability, content and response time
Total electronic eligibility (real-time "on demand" + real-time DDE + batch)	**33%**	74%	15%	Includes batch which was only reported by one plan and decreased when real-time was offered

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

Cost of CORE Certification for Health Plans

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

Cost	Average	Low	High
Total cost of adoption	$542,800	$8,000	$1,720,000
Per member costs of adoption	$0.0852	$0.0005	$0.4886
Ongoing annual costs *	$49,200	$ 0	$79,000

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

** Revised 5/1/09 ongoing cost average*

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

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

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

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Provider Results

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

* *Some providers doubled the number of patients verified*

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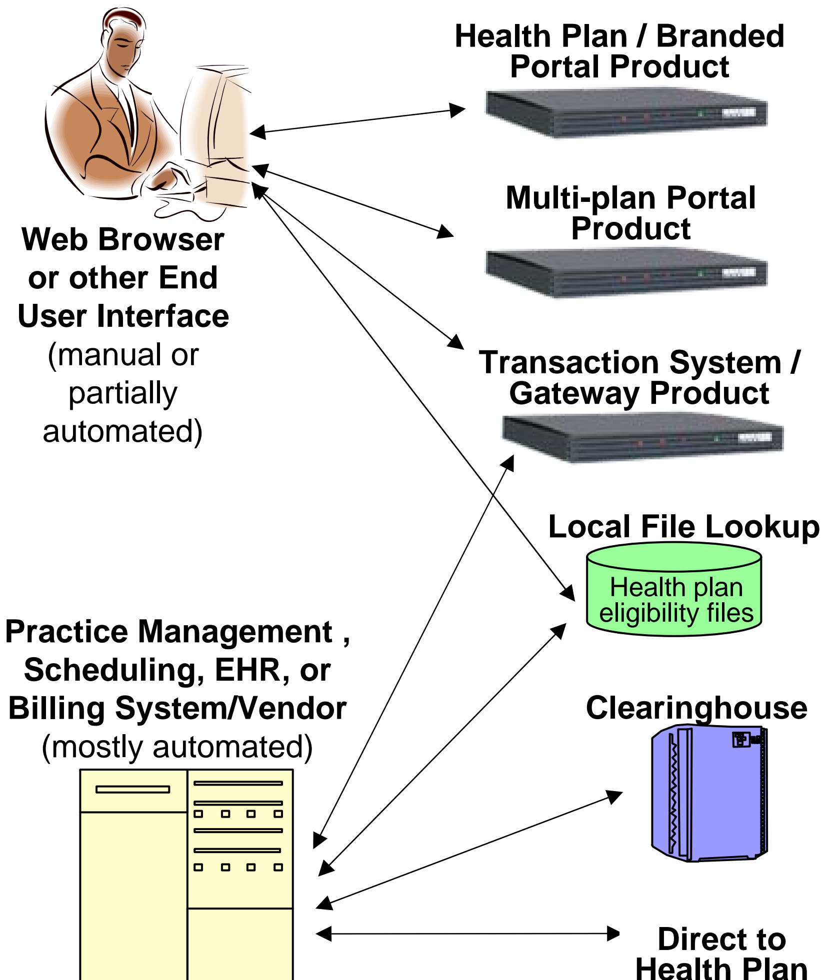
Provider Methods of Electronic Verification



Method	Advantages / Features for Providers	Disadvantages
Health Plan / Branded Portal Product	• Simple technology solution, accessible to very small provider with no systems other than internet • Low cost connectivity, no transaction fees • Current info	• Not integrated with other systems for transaction creation or update • High office staff time
Multi-plan Portal Product	• Simple technology solution, accessible to very small provider with no systems other than internet • Low cost connectivity • Access many plans on one site • Less expertise / single sign-on	• Not integrated with other systems for transaction creation or update • High office staff time • Transaction fees
Transaction System / Gateway Product	• Adds capability missing from operational systems • Validate / scrub transactions • May reduce transaction fees • May integrate with provider operational systems	• May be difficult or costly to implement / integrate
Local File Lookup	• Fast response • No connectivity or health plan response capability required	• File currency lags • Requires file downloads and maintenance
Clearinghouse	• Access to many plans through one connection • Validate / scrub transactions • Reformat / translate transactions for health plans • May integrate with provider operational system	• Transaction fees • May require IT staff to setup, maintain or to take full advantage
Direct to Health Plan	• No transaction fees • Current information • Integrate with operational systems and workflows • Minimal office staff time and effort	• High IT skill to set up, maintain and integrate

Vendor and Clearinghouse Results

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

Lessons Learned for the Next CORE Measures Study

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

Savings Projection for Industry-wide Implementation of CORE Phase I

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Potential Savings Due to Industry-wide CORE Phase I Certification

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

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

In Closing

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

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

Questions?

- To learn more about CORE, please contact:

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