Simplifying Administrative Data Exchange, Interoperability at the CORE

CORE Education Workshop at The 13th National HIPAA Summit

Classroom Session
Washington, DC
Wednesday, September 27, 2006

Discussion Topics

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

Presenters

- Jay Eisenstock, CORE Testing Subgroup Chair, Business Program Senior Manager, Aetna
- Gwendolyn Lohse, CORE Project Director, CAQH
- Rachel Foerster, CORE Consultant, Boundary Information Group

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

Example of CAQH initiatives: Credentialing and CORE

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Committee On Operating Rules For Information Exchange

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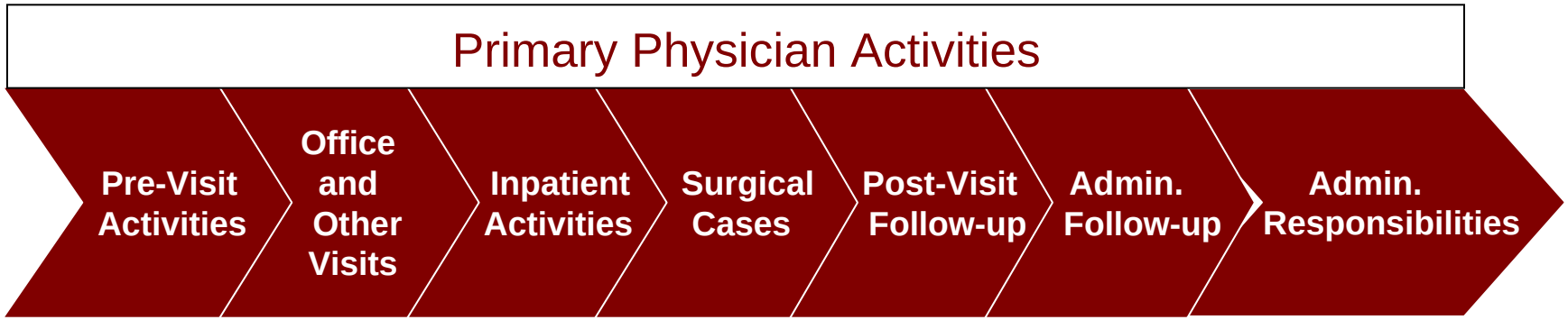
Physician-Payer Interaction

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



- 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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CORE

- Industry-wide stakeholder collaboration
- 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?*

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 or other appropriate standards such as HTTPS
- 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

Key things CORE will not do:

- Build a database
- Replicate the work being doing by standard setting bodies like x12 or HL7

CORE Guiding Principles

- All CORE Participants and CORE-certified entities will work towards achieving CORE's mission.
- All stakeholders are key to CORE's success; no single organization, nor any one segment of the industry, can do it alone.
- CAQH will strive to include participation by all key stakeholders in the CORE rule making process. CORE has established Governing Procedures; under these Procedures, each CORE member that meets CORE voting criteria will have one vote on CORE issues and rules.
- CAQH serves as the facilitator, while CORE participants draft and vote on the rules.
- Participation in CORE does not commit an organization to adopt the resulting CORE rules.
- Use of and participation in CORE is non-exclusive.
- CORE will not be involved in trading partner relationships, and will not dictate relationships between trading partners.
- To promote interoperability, rules will be built upon HIPAA, and CORE will coordinate with other key industry bodies (for example, X12 and Blue Exchange).
- Whenever possible, CORE has used existing market research and proven rules. CORE rules reflect lessons learned from other organizations that have addressed similar issues.
- CORE rules will support the Guiding Principles of HHS's National Health Information Network (NHIN).
- Where appropriate, CORE will address the emerging interest in XML.
- CAQH research indicated that there will be benefit to the health care industry as a result of adopting eligibility operating rules. CORE will have Measures of Success for Phase I (methodology to measure success and evaluate market impact) and CAQH will report aggregate findings by stakeholder type. Full benefits may not be experienced until Phase II.
- CORE will provide guidance to stakeholders regarding staff implementation and training needs.
- Safeguards will be put in place to make sure that a health plan's benefit and payment information is shared only with the requested provider and is not available to other participating health plans.
- CORE will not build a switch, database, or central repository of information.
- All CORE recommendations and rules will be vendor neutral.
- All of the Phase I rules are expected to evolve as Phase I is a starting point.
- Rules will not be based on the least common denominator but rather will encourage feasible Phase I progress.
- CORE will promote and encourage voluntary adoption of the rules.
- CORE participants do not support "phishing."

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

Examples of the use of operating rules in other industries

Current Participants

- Over 85 organizations participate representing all aspects of the industry:
  - 16 health plans
  - 10 providers
  - 5 provider associations
  - 18 regional entities/RHIOS/standard setting bodies/other associations
  - 28 vendors (clearinghouses and PMS)
  - 7 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

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.

Government Agencies

- Louisiana Medicaid – Unisys
- Michigan Department of Community Health
- Michigan Public Health Institute
- TRICARE
- United States Centers for Medicare and Medicaid Services (CMS)

Associations / Regional Entities / Standard Setting Organizations

- America's Health Insurance Plans (AHIP)
- ASC X12
- Blue Cross and Blue Shield Association (BCBSA)
- CalRHIO
- Delta Dental Plans Association
- eHealth Initiative
- Health Level 7 (HL7)
- Healthcare Information and Management Systems Society (HIMSS)
- Healthcare Financial Management Association (HFMA)
- Maryland/DC Collaborative for Healthcare IT
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- NJ Shore (WEDI/SNIP NY Affiliate)
- 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)

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Current Participants

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

Providers
- Adventist HealthCare, Inc.
- American Academy of Family Physicians (AAFP)
- American College of Physicians (ACP)
- 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
- Partners HealthCare System
- University of Wisconsin Medical Foundation (UWMF)
- University Physicians, Inc. (University of Maryland)

Vendors
- ACS State Healthcare
- Affiliated Network Services
- Athenahealth, Inc.
- Availity LLC
- CareMedic Systems, Inc.
- Edifecs
- Electronic Data Systems (EDS)
- Electronic Network Systems, Inc. (ENS)
- Emdeon
- First Data Corp. – Healthcare
- GHN-Online
- Healthcare Administration Technologies, Inc.
- HTP, Inc.
- McKesson
- 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)

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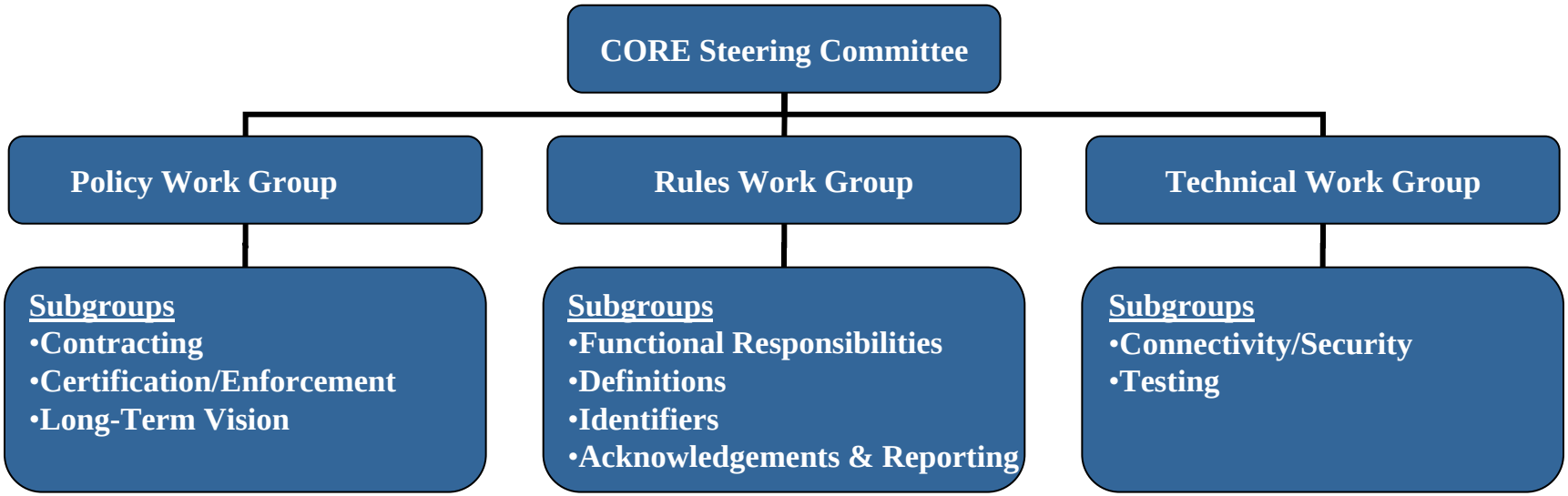
CORE Work Groups And Subgroups



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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; **Health Level 7 (HL7):** John Quinn, Chair, HL7 Technical Steering Committee

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

CORE Phase I Progress & Achievements

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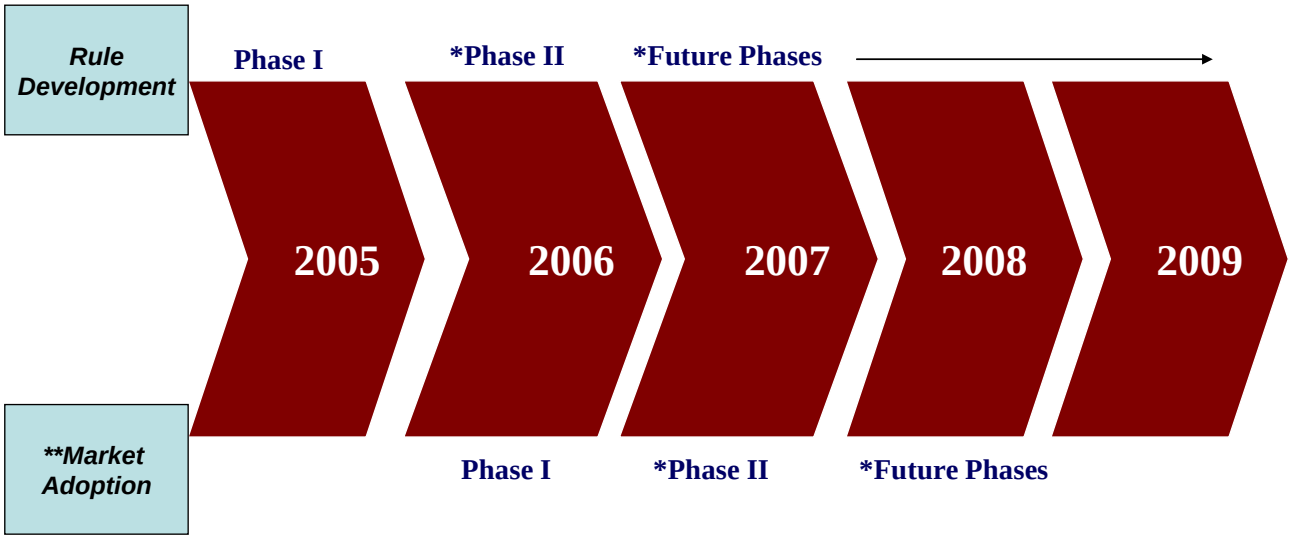
Phased Approach

CORE Timeline Overview



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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Phase I Scope

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

CORE Phase I Certification & Endorsement Commitments

- Please reference the **9/15/06** Press Release included in the binder materials.

CORE Rules Approval Process and Phase I Voting Results

CORE Body	Governing Procedures for Voting
Level 1: SUBGROUPS	Not addressed in governing procedures, but must occur to ensure consensus building.
Level 2: WORK GROUPS	Rules Work Group require a quorum that 60% (Policy and Technical Work Groups can be lower) of all organizational members of the Work Group be present at the meeting. Majority (50%) vote by this quorum is needed to approve a rule. To begin voting a "meeting" of the Work Group must be held, however, the meeting can be by conference call. *In Phase I, Rules Work Group approved rules by 91% with 75% participation.* *In Phase I, Technical Work Group approved rules by 89% with 72% participation.* *In Phase I, Policy Work Group approved rules by 85% with 71% participation.*
Level 3: STEERING COMMITTEE	Steering Committee requires for a quorum that 60% of the committee's voting members be present at the meeting. Majority vote (50%) by this quorum is needed to approve a rule. To begin voting a "meeting" of the Work Group must be held, however, the meeting can be by conference call. *In Phase I, Steering Committee approved rules by 100% with 100% participation.*
Level 4: CORE MEMBERSHIP	CORE membership requires for a quorum that 60% of all CORE voting organizations (defined as those members that create, transmit or use eligibility data or are a member in good standing of CAQH) be present at the meeting. With a quorum, 66.67% vote is needed to approve a rule. *In Phase I, CORE membership approved rules by 95% with 70% participation.*
Level 5: CAQH BOARD	A quorum is defined as 50% of all CAQH Board authorized votes. To disapprove of a rule, 66.67% of this quorum must vote against the rule. *In Phase I, CAQH Board approved rules by 100% with 100% participation.*

Prior level must be completed before next level is addressed.

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CAQH Board

Organization	Member	Title
Aetna	John W. Rowe	Executive Chairman
America's Health Insurance Plans	Karen M. Ignani	President and CEO
AultCare	Rick Haines	Executive Vice President & CEO
Blue Cross and Blue Shield Association	Scott Serota	President and CEO
Blue Cross and Blue Shield of North Carolina	Robert J. Greczyn, Jr.	President and CEO
Blue Cross Blue Shield of Michigan	Daniel J. Loepp	CEO
BlueCross BlueShield of Tennessee	Vicky B. Gregg	President and CEO
CareFirst BlueCross BlueShield	William L. Jews	President and CEO
Health Net, Inc.	Jay M. Gellert	President and CEO
Horizon Blue Cross Blue Shield of New Jersey	William J. Marino	President and CEO
Independence Blue Cross	Joseph Frick	President and CEO
MultiPlan, Inc.	Harvey Sigelbaum	President and Co-CEO
UnitedHealth Group	Richard Anderson	CEO Ingenix
WellPoint, Inc.	Larry Glasscock	President and CEO

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 averages after implementing Phase I CORE
  - Providers
    - Change in usages of the following methods of eligibility transactions: Phone, Fax, Real-time EDI, Batch EDI, DDE

Benefits of Phase I Rules

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

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

CORE Phase I Education Sessions

In-person Workshops:

- Thursday, November 9th, 2006, time TBD, Phoenix, AZ

Audiocast Workshop:

- Thursday, October 19th, 2006, 2:00-3:30pm ET

CORE Phase I Rules

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)

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

270/271 Data Content Rule: Certification Requirements

- Receipt by a health plan or information source of a valid generic request for eligibility 270 transaction created using the CORE Master Test Bed Data
- The creation of an eligibility response 271 transaction generated using the CORE Master Test Bed Data providing the following information about the individual identified in the 270 eligibility transaction
  - health plan name covering the individual
  - health plan begin date
  - benefit begin date
  - status of benefit coverage (service types) including indicating what benefits are covered/non-covered
  - patient financial responsibility, including in-network and out-of-network
- CORE-certified entities are required to comply with all specifications of the rule not included in the testing

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 Rules

- 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?

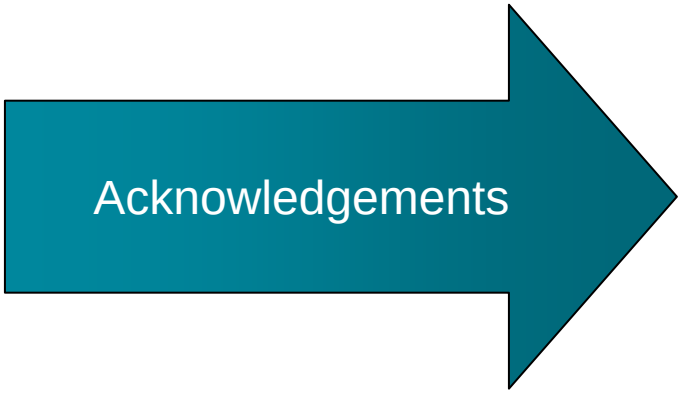
Real Time Acknowledgements Rule: Certification Requirements

- A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14-I13 Acknowledgement Requested field is ignored
  - A TA1 must NOT be returned if there are no errors in the Interchange control segments
- A 997 is returned ONLY to indicate a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group
  - A 997 must NOT be returned if there are no errors in the Functional Group and enclosed Transaction Set
- A 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 standard syntax requirements
- A 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details
- CORE-certified entities are required to comply with all specifications of the rule not included in the certification testing

Batch Acknowledgements Rule: Certification Requirements

- A TA1 is returned ONLY to indicate an Interchange error resulting in the rejection of the entire Interchange; the ISA 14-I13 Acknowledgement Requested field is ignored
  - A TA1 must NOT be returned if there are no errors in the Interchange control segments
- A 997 is returned to indicate either acceptance of the batch or rejection of a Functional Group (including the enclosed Transaction Set) error resulting in the rejection of the entire Functional Group
  - A 997 must ALWAYS be returned if there are no errors in the Functional Group and enclosed Transaction Set
- A 271 eligibility response transaction must ALWAYS be returned for an Interchange, Functional Group and Transaction Set that complies with X12 standard syntax requirements
  - A 271 eligibility response transaction may contain either the appropriate AAA Validation Request segment(s) or the data segments containing the requested eligibility and benefit status details
- The rule for use of acknowledgements for batch mode places parallel responsibilities on both submitters of the 270 inquiries (providers) and submitters of the 271 responses (health plans or information sources) for sending and accepting TA1 and 997 acknowledgements
  - The goal of this approach is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound responses
- CORE-certified entities are required to comply with all specifications of the rule not included in the certification testing

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

Response Time Rules

- 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

Response Time Rules: Certification Requirements

- Demonstrate the ability to capture, log, audit, match and report the date (YYYYMMDD), time (HHMMSS) and control numbers from its own internal systems and its trading partners

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

System Availability Rule: Certification Requirements

- Demonstrate its ability to publish to its trading partner community the following schedules:
  - Its regularly scheduled downtime schedule, including holidays.
  - Its notice of non-routine downtime showing schedule of times down.
  - A notice of unscheduled/emergency downtime.

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

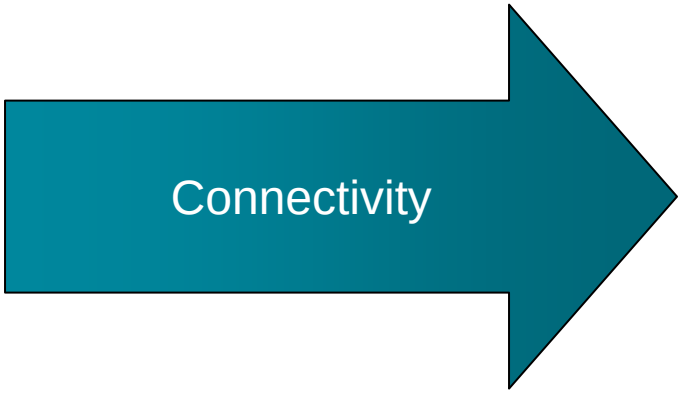
Connectivity Rule

- 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

Connectivity Rule: Certification Requirements

- The Information Source must demonstrate the ability to respond in their production environment to valid and invalid logon/connection requests with the appropriate HTTP errors as described in the Response Message Options & Error Notification section of this rule
- The Information Source must demonstrate the ability to log, audit, track and report the required data elements as described in the HTTP Message Format section of this rule
  - Authorization information
  - Payload identifier
  - Date/time stamp
- CORE-certified entities are required to comply with all specifications of the rule not included in the testing

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

Companion Guide 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

Companion Guide Rule: Certification Requirements

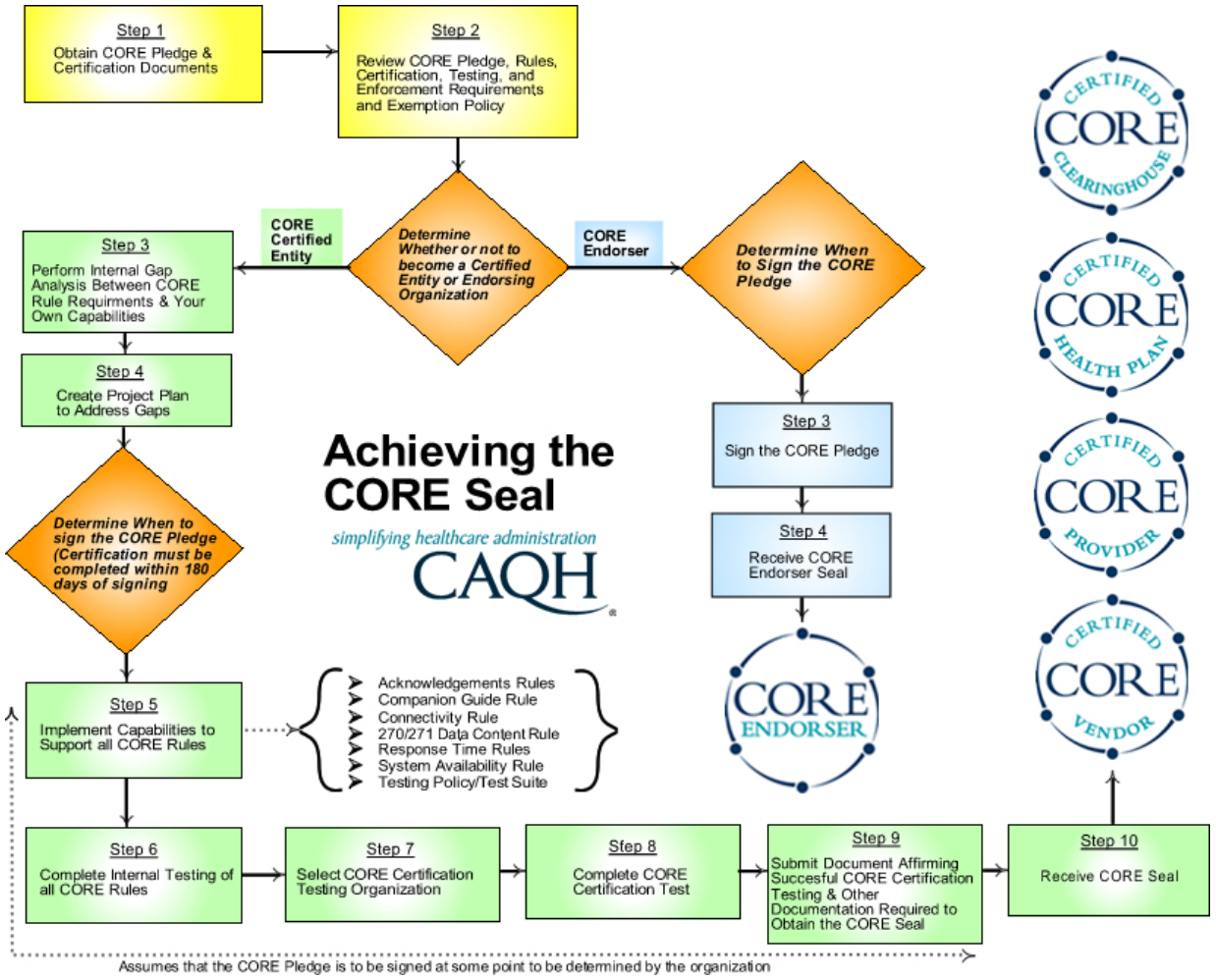
- Submission to an authorized CORE Certification Testing Vendor the following
  - A copy of the table of contents of its official 270/271 companion document
  - A copy of a page of its official 270/271 companion document depicting its conformance with the format for specifying the 270/271 data content requirements
- Submission may be in the form of a hard copy paper document, an electronic document, or a URL where the table of contents and an example of the 270/271 content requirements of the companion document is located

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

Becoming CORE Phase I Certified - Policies

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 by a CORE-authorized testing vendor (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

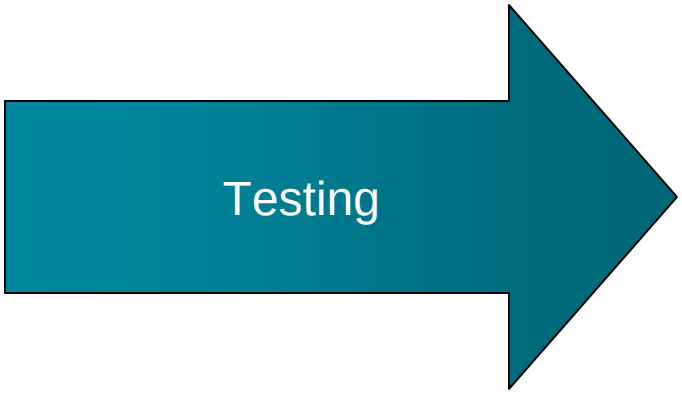
Real World Impact

- 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

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 CORE Phase I rules; 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
  - CORE RFI issued in Summer 2005; CORE RFP issued in Fall 2005 to identify vendors that were capable of conducting standard CORE-certification testing
  - CORE-authorized certification testing vendors to date
    - Edifecs - Product available at no charge (Please reference 8/16/06 Press Release in binder materials)
  - Vendors under review by CORE
    - Claredi, an Ingenix company

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

Phase I testing was not designed to be exhaustive, e.g. no volume capacity testing

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; or small providers) — No fee

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Adoption and Implementation of CORE Phase I Rules

Implementation Planning

- Obtain all (Download from http://www.caqh.org/CORE_phase1.html)
  - CORE Phase I Policies and Rules, Version 1.0.0
  - Certification Testing Suite and Supplement, Versions 1.0.0
  - Master Test Bed Data, Version 1.0.0

- Review all CORE documents to gain complete understanding
  - Download CORE Phase I FAQs http://www.caqh.org/CORE_cert_faq.html
  - Certification Process Overview

Perform Internal Gap Analysis

- After analysis, determine when your organization can sign the CORE Pledge
  - Must complete CORE Certification testing within 180 days of signing Pledge

Remediate Internal Systems

- Close all gaps identified
- Conduct all required internal systems testing
- Educate internal staff on CORE rules and requirements
- Determine eligibility for CORE Health Plan IT Exemption

Health Plan X Interplan Requirements v. CORE

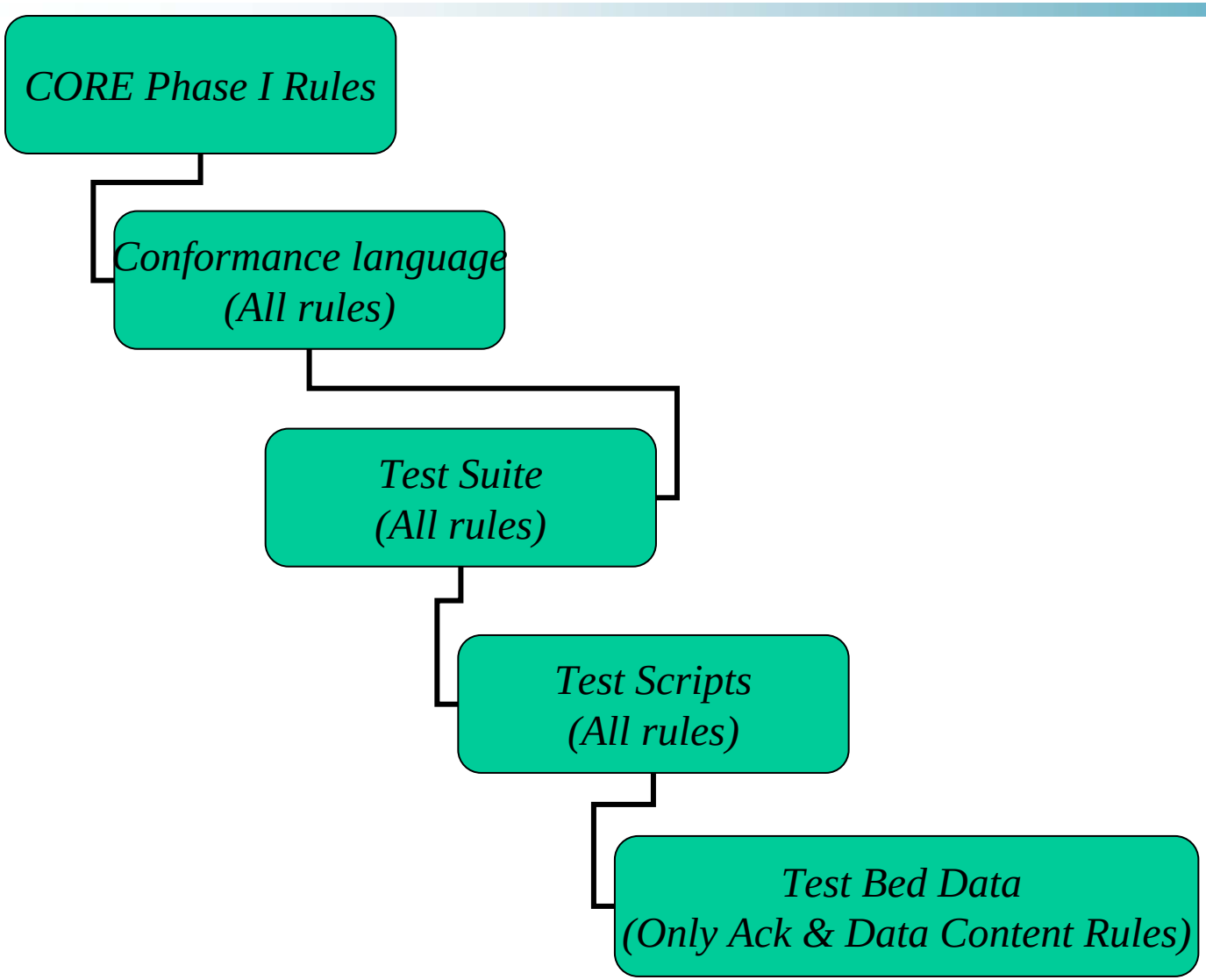
- Health Plan X Initial 271 Response was “yes/no”
- To prepare for CORE-Certification, have to:
  - Improve system availability through development of a Master Directory of Member Eligibility
  - Expand 270/271 data content capabilities
  - Develop secure data exchange to meet HTTP/S rule
  - Increase response time through middleware
  - Recruit trading partners

Health Plan X CORE Timeline and Resources

- **Timeline**
  - 2006
    - April - Final CORE Phase I Rules published
    - May – June – High level approach determination
    - July – August – Initial design
    - September – Acquire hardware
    - October – December – Build Solution
  - 2007
    - January – February – Test
    - March – Production
    - March – CORE-Certification testing
- **Budget**
  - Hardware - $600K
  - People - $1.1M

    Total - $1.7M

CORE Certification Testing



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CORE Certification Testing Suite

- The CORE Certification Testing Suite uses two master scenarios to describe both the real time and batch business processes for end-to-end insurance verification/eligibility inquiries using business language, not technical specifications
  - Master scenario #1: Single/Dual Clearinghouse Provider-to-Health Plan Model
  - Master scenario #2: Provider Direct to Health Plan Model
- The overall business process for insurance verification/eligibility inquiry does not change from a business viewpoint for each CORE rule. Rather, each CORE rule addresses a critical interoperability activity/task within the common business process
- Using only two master scenarios for all rules simplifies rule test scenario development since the key variables for each rule will be only the actual conformance language of the rule, each test scenario's test objectives, assumptions, and detailed step-by-step test scripts
- Test scenarios for each rule contains the following sections:
  - Actual language of each rule covered by the test scenario
  - Test objectives and certification conformance requirements by rule
  - Test assumptions by rule
  - Detailed step-by-step test scripts addressing each conformance requirement by rule indicating each stakeholder to which the test script applies
  - Each stakeholder may indicate that a specific test script does not apply to it and is required to provide a rationale for indicating a specific test script is not applicable

Real Time Acknowledgements Rule Certification Test Step-by-Step Test Scripts

DETAILED STEP-BY-STEP TEST SCRIPT

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[3]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[4]
1.	A TA1 is returned on an invalid X12 Interchange	An X12 Interchange containing only a TA1 rejecting the entire interchange		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
2.	A TA1 is not returned on a valid X12 Interchange	No TA1 is returned		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
3.	A 997 is returned on an invalid Functional Group	An X12 Interchange containing only a 997 FA		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
4.	A 997 is not returned on a valid X12 Interchange	No 997 is returned		☐ Pass	☐ Fail	☐	☒	☒	☒	☐
5.	A 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set	An X12 Interchange is returned containing only a 271 transaction set		☐ Pass	☐ Fail	☐	☒	☒	☒	☐

Batch Acknowledgements Rule Certification Test Step-by-Step Test Scripts

DETAILED STEP-BY-STEP TEST SCRIPT

Test #	Criteria	Expected Result	Actual Result	Pass/Fail		Stakeholder[5]				
						Provider	Health Plan	Clearinghouse	Vendor	N/A[6]
1.	A TA1 is returned on an invalid X12 Interchange	An X12 Interchange containing only a TA1 rejecting the entire interchange		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
2.	A TA1 is not returned on a valid X12 Interchange	No TA1 is returned		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
3.	A 997 is returned on an invalid Functional Group	An X12 Interchange containing only a 997 FA		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
4.	A 997 is returned on a valid X12 Interchange	An X12 Interchange containing only a 997 FA		☐ Pass	☐ Fail	☒	☒	☒	☒	☐
5.	A 271 Eligibility Response transaction set is always returned for a valid 270 Eligibility Inquiry Transaction set	An X12 Interchange is returned containing only a 271 transaction set		☐ Pass	☐ Fail	☒	☒	☒	☒	☐

Committee on Operating Rules for Information Exchange (CORE)

Supplement to

CORE Certification Testing Suite Version 1.0.0
Using the CORE Master Test Bed

Version 1.0.0

Applies to

- CORE Rule 154: 270-271 Data Content
- CORE Rule 150: Batch Acknowledgements
- CORE Rule 151: Real Time Acknowledgements

For all other rules please see the CORE Phase I Testing Suite Version 1.0.0

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CORE Master Test Bed Data
(for Acknowledgement and Data Content Rules Only)

- All entities seeking CORE certification will be required to test against the CORE Master Test Bed Data
- Data will be made available to all entities seeking CORE certification for use of pre-certification internal self-testing
- All CORE Authorized Certification Testing Vendors will use the CORE Master Test Bed Data
  - Use of other test data not allowed; use will result in unsuccessful testing
- The CORE Master Test Bed Data comprised of 24 base data cases for several subscribers, dependents and associated health plan coverage
- The base data cases are described in English in the tables in the CORE Certification Testing Suite Supplement
- The CORE Master Test Bed Data is supplied in the ASC X12 Standard Version 004010 valid format using the 270 Eligibility Inquiry and 271 Eligibility Inquiry Response transaction sets for ease of extracting and loading into test databases

CORE-Certification Steps

- Testing conducted by CORE-authorized certification testing entities
  - CORE-authorized certification testing vendors to date
    - Edifecs - Product available at no charge
  - Vendors under review by CORE
    - Claredi, an Ingenix company
- Steps:
  1. Select a CORE-authorized Certification Testing Vendor
  2. Enroll with selected vendor
  3. Complete certification testing
  4. Complete and submit all required documentation to CORE to obtain CORE Certified Seal

CORE-Authorized Certification Testing Vendors

- Vendor will briefly discuss their
  - CORE-Certification Testing Enrollment Process
  - Approach to conducting CORE-Certification Testing
  - Projected timeline to complete CORE-Certification Testing
  - Costs for CORE-Certification Testing

Go Live

- Display CORE-Certified Seal

- Announce CORE-Certification to Trading Partners
  - CORE Trading Partner Tool Kit

  (found online at: http://www.caqh.org/CORE_trading.html)

CORE Deployment Assistance

- CORE Educational Workshops
- CORE website and FAQs
- CAQH staff and technical consultants
- CORE-authorized certification testing vendors
- CORE participants

CORE Trading Partner Campaign

- Each CORE participant, and certified entity, is being asked to recruit their trading partners through the use of a CORE Trading Partner Tool Kit
  - CORE participants will experience the true benefit of CORE when all entities involved in their end-to-end transactions are CORE-certified
  - Tool Kit contains stakeholder-specific letter and email templates that CORE participants can edit as they see appropriate.
  - Tool Kit can be found online at: http://www.caqh.org/CORE_trading.html

- Approaches being used by some CORE participants to recruit their trading partners
  - Working through their RHIOs to build regional momentum for CORE certification and endorsement
  - Asking their key trading partners to become CORE-certified so that, together, trading partners can track the impact of increased use of electronic eligibility transactions

Internal Benefit Measurements

- Identify opportunity areas
  - Decreased administrative costs
    - Call center
    - Patient registration
    - Claims processing/billing
    - Mail room
    - EDI management
  - Increased satisfaction
    - Trading Partners
    - Patients/Members
      - Meeting expectations
        - » Wait time
        - » Personal financial responsibility
    - Internal Staff
  - Improved financial measures
    - Reduced claims denials
    - Improved POS collections
    - Decreased bad debit
    - Reduced costs
- Implement benefit measurement capabilities
  - Identify “before” costs in selected opportunity areas
  - Review results quarterly
- Ramp up with CORE-certified Trading Partners

CORE Phase II

Phase II: Areas Under Consideration

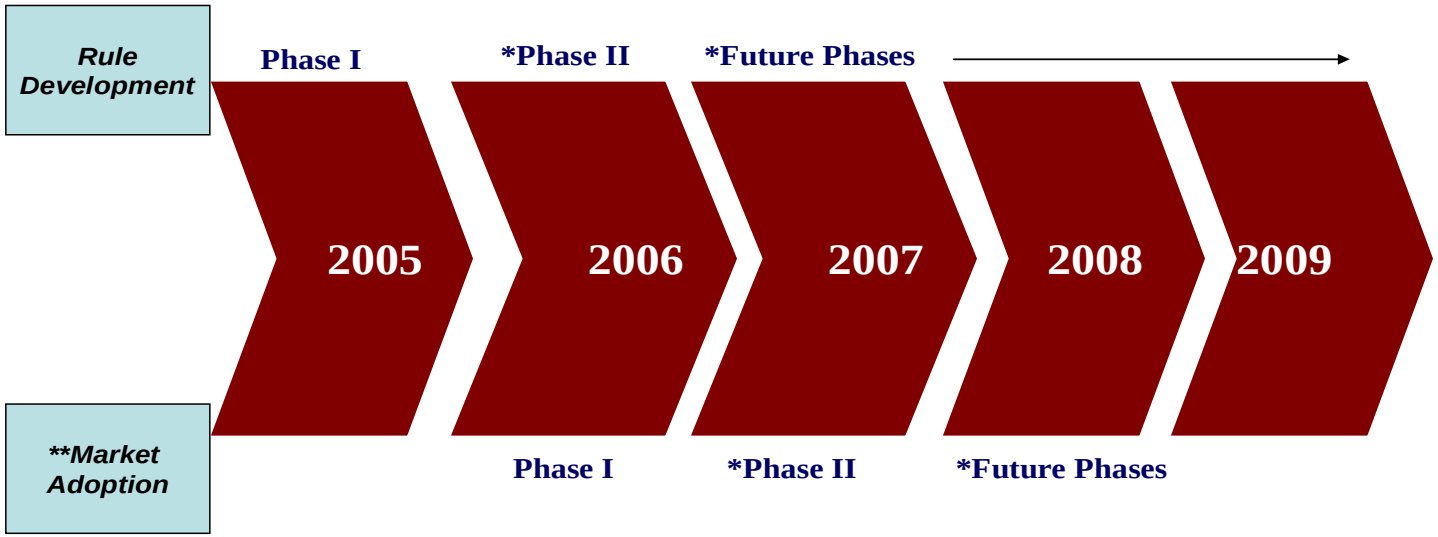
- Patient identification logic
- More detailed components of eligibility transactions not addressed in Phase I, including:
  - Estimated patient responsibility (e.g., YTD member financials)
  - What amount the health plan will pay for authorized services (procedure code needed?)
  - Financial data on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

CORE & Other Industry Initiatives

- CORE is working closely with the following initiatives to ensure CORE's administrative rules are part of national interoperability efforts:
  - HITSP (CORE is recognized as key to Consumer Empowerment requirements)
  - CCHIT
  - IHE

Phase II: Timeline

CORE Timeline Overview



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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CORE Participation: Time Commitment and Cost

Cost

- ***Full Health Plan or Vendor Member***: Must create, transmit or use eligibility data in daily business
  - Below $75 million net annual revenue: $4,000 annual participation fee
  - $75 million and above net annual revenue: $6,000 annual participation fee
- ***Full Provider Member:*** All provider organizations that create, transmit or use eligibility data in daily business
  - Up to $1 billion in net annual revenue: $500 annual participation fee
  - $1 billion - $3 billion in net annual revenue: $1,000 annual participation fee
  - Over $3 billion in net annual revenue: $3,000 annual participation fee
- ***Private Advisory:*** Organization that does not create, transmit or use eligibility data
  - $1,500 annual participation fee
- ***Standard Setting/Technical Advisory***: No annual participation fee
- ***Government Advisory****:* No annual participation fee

Time Commitment (level of participation involvement is up to each entity)

- Work Groups meet once a month via conference call
- Subgroups meet 2-3 times a month via conference call
- 2 in-person meetings a year
- Voting process (Subgroup recommendation, Work Group voting, membership voting)

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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

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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*

www.CAQH.org