



***Committed to Improving Health Plan-  
Provider Interoperability***

***Presentation to the Ohio Advisory Committee on  
Eligibility and Real Time Claim Adjudication***

***Ohio Department of Insurance***

***July 2008***

### Discussion Topics

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**The Who**

- Overview of CAQH
- Administrative Simplification
  - CAQH Initiatives:
    - Universal Provider Datasource
    - CORE Initiative (***Topic of today's discussion***)
      - Goals, Mission and Vision
- Challenges of Health Information Exchange Today
  - Example: Eligibility/Benefits Check
  - Example: Connectivity

**The Why**

**The How**

- CORE Overview
  - CORE Phase I and II
  - Example: CORE-certified Entities
  - Coordinating with State/Regional and National Initiatives
  - Phase III

**The Why**



# Who?

## 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

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## CAQH Initiatives

- Universal Provider Datasource (UPD)
- Committee on Operating Rules for Information Exchange (CORE)
  - Today's focus will be on CORE's national interoperability and transparency approach

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## Example of a CAQH Initiative:

### Universal Provider Datasource (UPD)

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## Provider Data: Key to Credentialing and Beyond

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The Universal Provider Datasource is designed to collect broad and robust data on providers once to accommodate multiple administrative needs for multiple healthcare organizations:

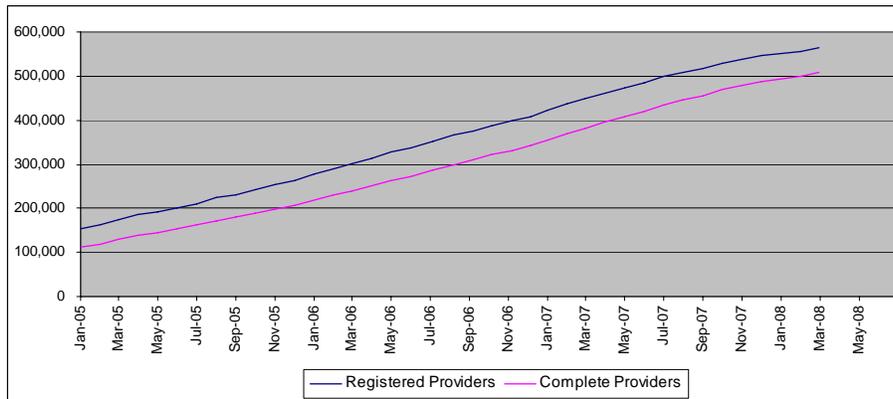
- Demographics, Licenses and Other Identifiers (including NPI)
- Education, Training and Specialties
- Practice Details
- Billing Information
- Hospital Credentials
- Provider Liability Insurance
- Work History and References
- Disclosure Questions
- Images of Supporting Documents

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## Registered Providers as of April 2008

**Current Status:** More than 600,000 unique providers have already registered with and are using the system (with nearly 10,000 new providers each registering month).



Note: Used by over 360 health plans

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## States Supporting the CAQH Application

- A growing number of states have addressed their local credentialing concerns by supporting the national standard application promoted by CAQH. These states are:
  - **District of Columbia, Indiana, Kentucky, Maryland, Ohio and Vermont:** Adopted CAQH application as their own mandated form
  - **Louisiana, New Jersey and Tennessee:** Require or allow health plans to use either the standard CAQH application or a state-specific alternative
  - **Kansas and Rhode Island:** Insurance Commissioners have agreed to promote voluntary statewide adoption of CAQH application
  - **New York:** Rejected mandating a state specific application because the CAQH application was enjoying widespread voluntary adoption
  - **Missouri:** Is actively considering switching from the current state-mandated form to the CAQH form

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## New UPD Users and Uses

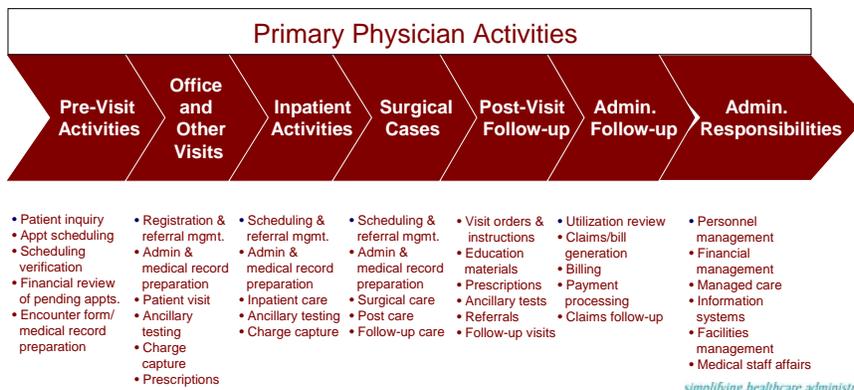
- Hospitals starting to participate
  - The Vermont Hospital Association has agreed to participate and is enrolling its members as UPD participating organizations
  - KS, RI, NH, MN and an Upstate NY Hospital Association are also considering participation through association agreements
  - Individual hospitals in several other states have started to participate and many more are recognizing and reviewing the UPD value proposition
- State Medicaid agencies exploring participation
  - PA Medicaid about to sign participation agreement
  - MI Medicaid received grant to develop single source credentialing initiative and identified CAQH application as model data collection tool
  - VA Medicaid is reviewing participation
- Emergency Responder Registries
  - CAQH is exploring the use of the UPD to enable providers to volunteer as Emergency Responders and electronically forward their data to designated state ESAR-VHP registries
    - CAQH has been approached by the Massachusetts MSAR program to use the UPD as a provider outreach and data collection tool for the MSAR program



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## Provider-Payer/Health Plan Interaction

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



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# CORE™

Committee on Operating Rules  
for Information Exchange

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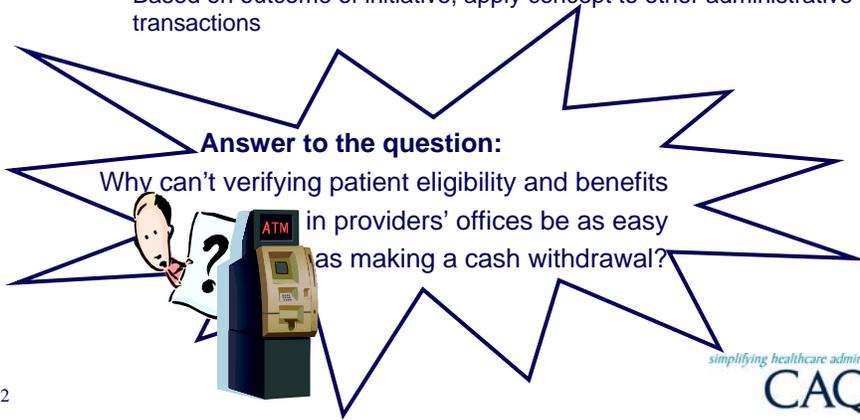
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## CORE Goals

- Short-Term
  - Design and lead an initiative that facilitates the development and adoption of industry-wide operating rules for eligibility and benefits
- Long-Term
  - 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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## 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:

- Whether the 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 rules are part of HIPAA, but not mandated

\*\* This component is critically important to providers, but is not addressed in the CORE Phase I or Phase II Rules

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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 (*Vendor Agnostic*)
- For any patient
  - For any participating health plan

\*Phases I and II require real-time and support batch

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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 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 done by standard setting bodies like X12 or HL7

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## Key to CORE Success: 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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## Key Administrative Transactions Used By Providers

### \* 270-271: Eligibility inquiry and response

- An inquiry from a provider and the response from a health plan regarding a patient's eligibility for coverage, or the benefits for which a patient may be eligible

### \* 276-277: Claim status inquiry and response

- An inquiry from a provider and the response from a health plan about the processing status of a submitted claim or encounter

### 278: Prior authorization and referral

- An inquiry from a provider and the response from the health plan about a patient's prior authorization or referral for services

### 837: Claims or equivalent encounter information

- Healthcare service information provided to a health plan for reimbursement

### 835: Payment and remittance advice

- An explanation of claim or encounter processing and/or payment sent by a health plan to a provider

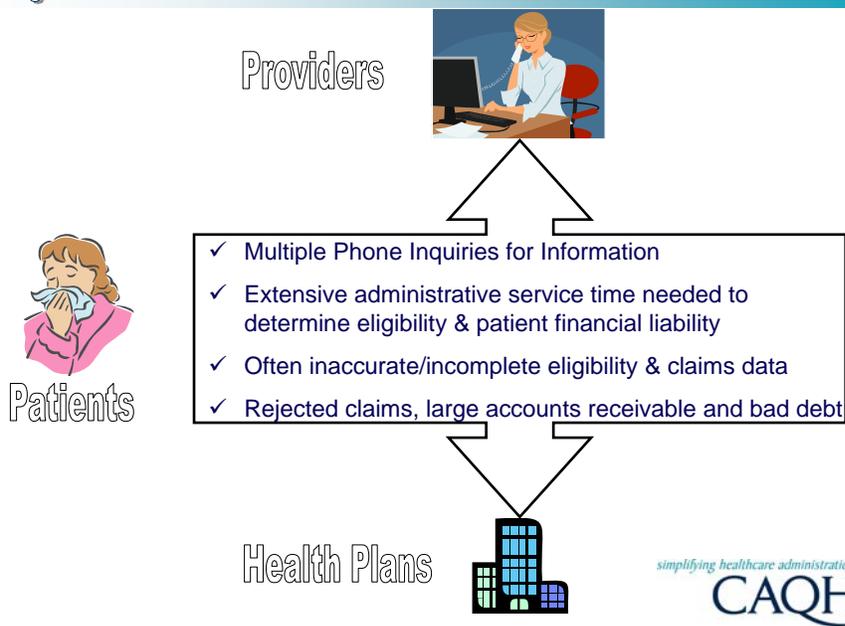
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\* Focus of Phase I and II CORE Rules

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# Why?

## Challenges of Eligibility/Benefits Check Today



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## Challenges: Eligibility and Benefits

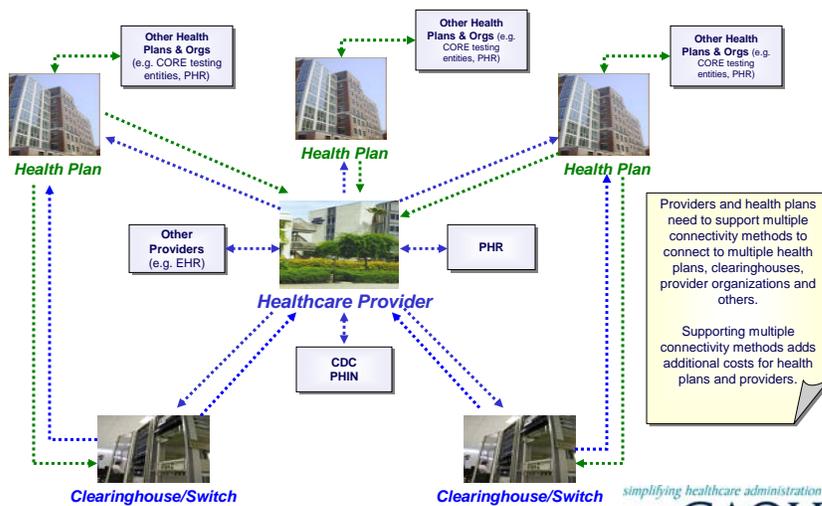
- “HIPAA” does not offer relief for the current eligibility problems
  - Data scope is limited; elements needed by providers are not mandated
  - Does not standardize data definitions, so translation is difficult
  - Offers no business requirements, e.g., timely response
- Individual plan websites are 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

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## More Challenges: Healthcare Connectivity Today

**Currently, multiple connectivity methods are needed across the industry...**



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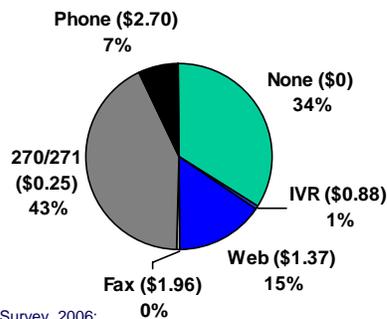
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## CORE Phase I Patient ID Study: Key Opportunity

### Significant Savings

Providers (and health plans) can achieve significant savings by shifting from more labor-intensive verification methods to automated eligibility verification

**Provider Eligibility Verification by Type of Method**  
(Average labor cost per transaction)



Source: CORE Patient Identification Survey, 2006; funded, in part, by California HealthCare Foundation

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## How CORE Operating Rules Will Help



- ✓ Standardized process to respond real time to provider administrative data request
- ✓ Improved identification of members and their benefits
- ✓ Increased volume of electronic transactions
- ✓ Reduced administrative time and costs



- ✓ Real-time reliable access to consistent, high-quality claims-related data
- ✓ Part of a national, all-payer administrative data-exchange solution
- ✓ Improved service to provider practices, health plans
- ✓ Increased volume of electronic transactions

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## How CORE Operating Rules Will Help



- ✓ Real-time updates and online access to all-payer administrative data
- ✓ Real-time assessment and collection of patient and health plan financial liability at point of service
- ✓ Reduced administrative time and costs



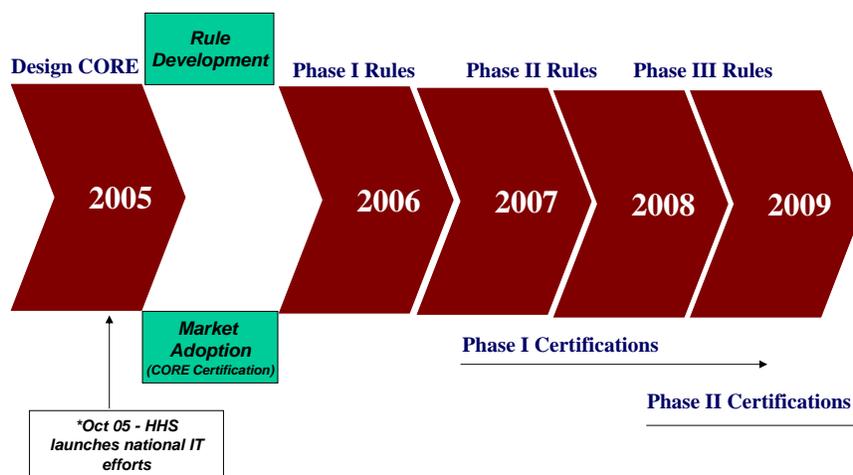
- ✓ Real-time assessment of financial liability at point of service
- ✓ Smoother claims process issue resolution
- ✓ Improved health care experience, service and satisfaction

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## How?

### Phased Approach – Crawl, Walk, Run



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## Key Lessons Learned by CORE

- Given market is fragmented, create trusted partnerships
  - Private-private
  - Public-private
- Do not reinvent the wheel – build upon, learn from and coordinate with what exists
  - Coordinate nationally, so interoperability can be achieved
- Identify leaders – leaders who will participate in identifying change and who will then implement the agreed upon change
  - Example: WellPoint providing CORE-compliant data to their Medicaid business
- Plan for making BIG change, BUT implement in reasonable milestones that add value
  - Recognized that entities have limited resources, and are managing many IT priorities
- Outline the ROI and/or benefits to each stakeholder, and get their help in communicating the benefits to their stakeholder community

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## Current Participants

- Over 100 organizations representing all aspects of the industry:
  - 19 health plans
  - 11 providers
  - 5 provider associations
  - 18 regional entities/RHIOS/standard setting bodies/other associations
  - 37 vendors (clearinghouses and PMS)
  - 5 others (consulting companies, banks)
  - 7 government entities, including:
    - Centers for Medicare and Medicaid Services
    - Louisiana Medicaid – Unisys
    - US Department of Veteran Affairs
    - Minnesota Dept. of Human Services
- 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.

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## CORE Certification and Endorsement

### Certification

- CORE-certification is required for each phase of CORE
- 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

### Endorsement

- CORE Endorsement is required for each phase of CORE
- Entities that do not create, transmit or send data – sign Pledge, receive CORE Endorser Seal

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## Example: A Health Plan Perspective

### WellPoint Background Information

- Eligibility Transactions/yr: 81M+
- 14 - BCBS Plans (Anthem & Empire – covering 35+M individuals in CA, CT, CO, GA, IN, KT, ME, MO, NH, NV, NY, OH, VA, WI)
- 13 - Medicaid Business (CA, CT, CO, IN, KS, MA, TX, NH, NV, NY, VA, WI, WV)

### WellPoint's View on CORE Involvement, Participation and Certification

- Key CORE participant, Phase I Certified
  - Serve on all Work Groups and Subgroups
  - Chair Patient Identifiers Subgroup and Data Content Subgroup Co-chair; representative on CORE Steering Committee
- Participation
  - Reduce administrative expense through increased adoption of EDI transactions
  - Respond to its providers in a consistent and single standard
  - Pledged to continue to fully support the CORE initiatives
- Impact of CORE on a national level:
  - Allow consistent eligibility transactions for WellPoint's MEDICAID contracted states
  - The Industry will experience savings as self-service transactions are adopted
  - The vision of CORE promotes increased use of the non-claim transactions

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## Example: A Vendor/Clearinghouse Perspective

### **Siemens Background Information**

- 2007 Healthcare transactions: 230M+
- Providers submitting Eligibility Transactions: 1,300
- Payers available through HDX Network for Eligibility: 250+

### **Siemens View on CORE Involvement, Participation and Certification**

- Key CORE participant
  - Chair Technical Work Group and representative on CORE Steering Committee
- Siemens/HDX encourages adoption and further development of the CORE rules
  - Developing consistent operating rules will increase EDI participation, offering customers and the industry greater communication and efficiency
- Participation with prestigious national organization is more effective than individual, separate attempts to influence change
- Siemens anticipates that CORE Connectivity Rules will help simplify future implementations

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## Example: A Provider Perspective

### **Montefiore Medical Center Background Information**

- Nearly 2.5 million outpatients seen annually
- Send approximately 60,000 eligibility transactions/month with future projections to 150,000/month
- Payer mix – 70% Medicare/Medicaid, 25% Commercial, 5% other/non-insured

### **Montefiore's View on CORE Involvement, Participation and Certification**

- Key CORE participant
  - Representative on CORE Steering Committee
- Technology and "Standardization" are key – customization is costly
- This is a win-win for providers and patients
  - Providers are able to control costs and decrease bad debt through better eligibility and benefit checks
  - Patients satisfaction is increased – fewer "surprise" bills
- Felt its participation was needed to help drive market adoption – despite lack of immediate ROI
- Providers historically are left out, fail to participate, or are "out-numbered" in the healthcare debate
- Foster better communication among industry stakeholders – CORE has already begun to garner trust and break down barriers among its various members

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## Key Principles Included in CORE Phases

- Developed using consensus-based approach among industry stakeholders and is designed to:
  - Facilitate interoperability
  - Improve utilization of electronic transactions
  - Enhance efficiency and help lower the cost of information exchange in healthcare
- Uses existing standards
- Creates a base and not a “ceiling”
  - e.g., certified entities may include additional metadata in a CORE compliant envelope to support their business needs
- Vendor agnostic
- National, multi-stakeholder approach

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## Expected Impact from Implementation of CORE Rules

### Decrease Administrative Costs

- Call center
- Registration
- Claims processing/billing
- Mail room
- EDI management

### Increase Satisfaction

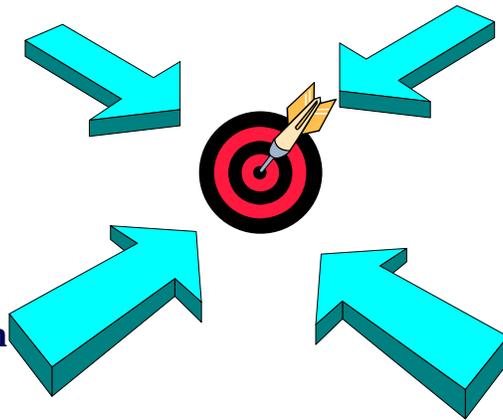
- Partners
- Patients
- Staff

### Meet Patient Expectations

- Wait time
- Personal financial responsibility

### Improve Financial Measures

- Reduced denials
- Improved POS collections
- Decreased bad debt
- Reduced cost



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## Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*	Phase II*
<b>Eligibility/ Benefits</b>	Static <i>Patient Financial Responsibility</i> , e.g. co-pay, base deductible	X	X
	Remaining <i>Patient Financial Responsibility</i> , e.g. remaining deductible for benefit plan and 40+ service types		X
	Data to Support Financials, e.g. dates, in/out of network differences	X	X
	Use of transaction under "Basic Level" Infrastructure/Policy Requirements	X	X
	Use of transaction under "Enhanced 1" Infrastructure/Policy Requirements		X
<b>Claims Status</b>	Use of transaction under "Basic Level" Infrastructure/Policy Requirements		X
<b>Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use</b>			
<b>Basic Level</b>	<ul style="list-style-type: none"> <li>• <b>Policy requirements:</b> Must offer CORE-certified capabilities to ALL trading partners</li> <li>• <b>Infrastructure requirements:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Real-time: 20-seconds AND batch turn around requirements</li> <li><input type="checkbox"/> System availability: 86%</li> <li><input type="checkbox"/> Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL</li> <li><input type="checkbox"/> Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement</li> <li><input type="checkbox"/> Standard Companion Guide <i>Format and flow</i></li> </ul> </li> </ul>	X	X
<b>Enhanced 1</b>	"Basic Level", plus, additional <b>Infrastructure requirements:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient identification rules               <ul style="list-style-type: none"> <li><input type="checkbox"/> Standard error codes</li> <li><input type="checkbox"/> Normalizing names</li> </ul> </li> <li><input type="checkbox"/> Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers</li> </ul>		X

Note : \*There are over 30 entities already CORE Phase I certified. CORE-certification is for health plans, vendors, clearinghouses and large providers.

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REFER TO APPENDIX FOR RULE DETAILS 

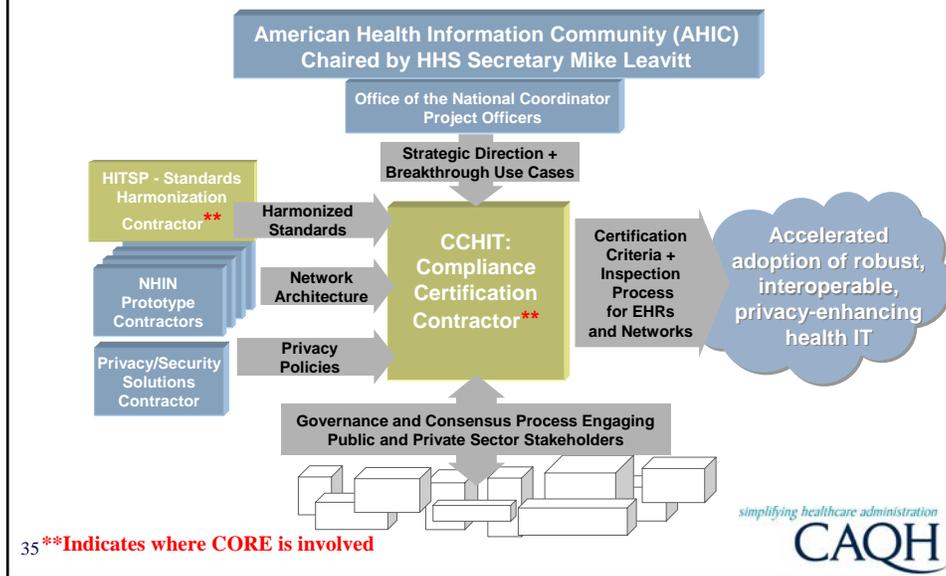


**Coordinating With State/Regional  
and  
National Initiatives**  
 (Helping to Connect the Dots)

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## CCHIT and HITSP Roles Within HHS Health IT Strategy



## State-Based Outreach: Examples

State-based approaches are emerging, and CAQH is working with the trade associations to encourage CORE's national approach:

- Ohio
  - Recent legislation called for the formation of an advisory committee to present recommendations on issues related to electronic information exchange, including eligibility. CAQH has offered its assistance to the committee as an educational resource given CORE was noted in legislation.
- Colorado
  - Commission report delivered to state legislature in February 2008 stated the cost savings for healthcare administrative simplification. CAQH presented CORE to government and private stakeholders in March
- Texas
  - Texas Department of Insurance had CAQH present CORE in response to state legislation that focuses on administrative simplification and mentions CORE; CORE has presented twice, most recently in March.
- Virginia
  - Secretary of Technology reviewing how technology can reduce the state's healthcare costs; CAQH presented CORE three times, most recently to a statewide Committee in April

(Note: Minnesota did pass state-specific eligibility rules in Dec. 2007, however, they are complementary to CORE Phase I data content requirements)

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## Medicaid and CORE

- Why Medicaid and CORE?
  - Interest for all stakeholders
    - Medicaid is a key portion of most provider's payer mix
    - Electronic eligibility, and other administrative transactions, can have a significant impact on efficiency for all stakeholders – public, private, payers, providers, etc - when all-payer solutions are available
  - Interest at Federal level
    - CORE complements a number of federally-sponsored health IT initiatives, e.g. ONC, as well as HIPAA
    - CMS's Center for Medicaid and State Operations is designing the Medicaid Information Technology Architecture (MITA) - CORE rules mirror much of what MITA wants to design for:
      - Data content
      - Connectivity
    - CORE is an example of a public-private collaboration
  - Interest at state level
    - Specific Medicaid's reviewing or participating in CORE, and some participating plans and clearinghouse manage Medicaid business
    - CORE could help Medicaid's address the administrative requirements of the Deficit Reduction Act (DRA)
    - CORE could be way to have Medicaid's involved in RHIOs / state mandates regarding health care administrative cost reduction

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## World Without CORE...

- Is like an ATM that...
  - Offers no money or bank balance, but does say you have an account
  - Does not have any real-time response...so you may wait hours to get response... or minutes ...or seconds
  - Does not have any system availability requirements...so ATM may not be available on weekends or after 9:00 p.m. weekdays
  - Does not provide you with confirmations....so you don't know if your transaction ever got completed
- And, there is no common agreements among the ATMs one uses...
  - So one needs to learn rules for each bank's ATM system

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## Current Participants

- **Health Plans**
  - Aetna, Inc.
  - AulCare
  - Blue Cross Blue Shield of Michigan
  - Blue Cross and Blue Shield of North Carolina
  - BlueCross BlueShield of Tennessee
  - CareFirst BlueCross BlueShield
  - CIGNA
  - Coventry Health Care
  - Excellus Blue Cross Blue Shield
  - Group Health, Inc.
  - Harvard Pilgrim HealthCare
  - Health Care Service Corporation
  - Health Net, Inc.
  - Health Plan of Michigan
  - Horizon Blue Cross Blue Shield of New Jersey
  - Humana Inc.
  - Independence Blue Cross
  - UnitedHealth Group
  - WellPoint, Inc.
- **Providers**
  - Adventist HealthCare, Inc.
  - American Academy of Family Physicians (AAFP)
  - American College of Physicians (ACP)
  - American Medical Association (AMA)
  - Catholic Healthcare West
  - Cedars-Sinai Health System
  - Greater New York Hospital Association (GNYHA)
  - HealthCare Partners Medical Group
  - Mayo Clinic
  - Medical Group Management Association (MGMA)
  - Mobility Medical, Inc.
  - Montefiore Medical Center of New York
  - New York-Presbyterian Hospital
  - North Shore LIJ Health System
  - Partners HealthCare System
  - University Physicians, Inc. (University of Maryland)
- **Government Agencies**
  - Louisiana Medicaid – Unisys
  - Michigan Department of Community Health
  - Michigan Public Health Institute
  - Minnesota Department of Human Services
  - Oregon Department of Human Resources
  - United States Centers for Medicare and Medicaid Services (CMS)
  - United States Department of Veterans Affairs
- **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
  - Health Level 7
  - Healthcare Association of New York State
  - Healthcare Billing and Management Association
  - Healthcare Financial Management Association (HFMA)
  - Healthcare Information & Management Systems Society
  - LINXUS (an initiative of GNYHA)
  - 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)

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## Current Participants (continued)

- **Vendors**
  - ACS EDI Gateway, Inc.
  - athenahealth, Inc.
  - Avality LLC
  - CareMedic Systems, Inc.
  - ClaimRemedi, Inc.
  - Claredi (an Ingenix Division)
  - EDIFECs
  - Electronic Data Systems (EDS)
  - Electronic Network Systems (ENS) (an Ingenix Division)
  - Emdeon Business Services
  - Enclarity, Inc.
  - First Data Corp.
  - GE Healthcare
  - GHN-Online
  - Health Management Systems, Inc.
  - Healthcare Administration Technologies, Inc.
  - HTP, Inc.
  - IBM Corporation
  - Infotech Global, Inc.
  - InstaMed
  - MedAvant Healthcare Solutions
  - MedData
  - Microsoft Corporation
  - NASCO
  - NaviMedix
  - NextGen Healthcare Information Systems, Inc.
  - Passport Health Communications
  - Payerpath, a Misys Company
  - RealMed Corporation
  - Recondo Technology, Inc.
  - RelayHealth
  - RxHub
  - Siemens / HDX
- SureScripts
- The SSI Group, Inc.
- The TriZetto Group, Inc.
- VisionShare, Inc.
- **Other**
  - Accenture
  - Foresight Corp.
  - Omega Technology Solutions
  - PNC Bank
  - PricewaterhouseCoopers LLP

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## Implementation: Phase I – Certified Entities/Products

### Clearinghouses

- ACS EDI Gateway, Inc. / ACS EDI Gateway, Inc. Eligibility Engine
- Availity, LLC / Availity Health Information Network
- Emdeon Business Services / Emdeon Real-Time Exchange
- Emdeon Business Services / Emdeon Batch Verification
- Health Management Systems, Inc. / HMS
- MD On-Line, Inc./ACCE\$\$ Patient Eligibility Verification
- MedAvant Healthcare Solutions / Phoenix Processing System
- MedData / MedConnect
- NaviMedix, Inc. / NaviNet
- Passport Health Communications / OneSource
- RelayHealth / Real Time Eligibility
- RxHub / PRN
- Siemens Medical Solutions / Healthcare Data Exchange
- The SSI Group, Inc. / ClickON® E-Verify

### Health Plans

- Aetna Inc.
- AultCare
- Blue Cross and Blue Shield of North Carolina
- BlueCross BlueShield of Tennessee
- Health Net
- WellPoint, Inc. (and its 14 blue-licensed affiliates)

### Providers

- Mayo Clinic
- Montefiore Medical Center
- US Department of Veterans Affairs

### Vendors

- athenahealth, Inc. / athenaCollector
- CSC Consulting, Inc./CSC DirectConnect<sup>sm</sup>
- Emerging Health Information Technology, LLC / TREKS
- GE Healthcare / EDI Eligibility 270/271
- RelayHealth / RevRunner
- Medical Informatics Engineering, Inc. (MIE) / WebChart EMR \*
- NoMoreClipboard.com
- Post-N-Track / Doohickey™ Web Services
- The SSI Group, Inc. / ClickON® Net Eligibility
- VisionShare, Inc. / Secure Exchange Software

\* Product also certified by the Certification Commission for Healthcare Information Technology (CCHIT<sup>sm</sup>). For accurate information on certified products, please refer to the product listings at [www.cchit.org](http://www.cchit.org).

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## Implementation: Phase I – Endorsers

### Endorsement

- Accenture
- American Academy of Family Physicians (AAFP)
- American Association of Preferred Provider Organizations (AAPPO)
- American College of Physicians (ACP)
- American Health Information Management Association (AHIMA)
- California Regional Health Information Organization
- Claredi, an Ingenix Division
- Edifecs, Inc.
- eHealth Initiative
- Electronic Healthcare Network Accreditation Commission (EHNAC)
- Enclarity, Inc.
- Foresight Corporation
- Greater New York Hospital Association and Linus
- Healthcare Financial Management Association (HFMA)
- Healthcare Information and Management Systems Society (HIMSS)
- Medical Group Management Association (MGMA)
- Michigan Public Health Institute
- Microsoft Corporation
- MultiPlan, Inc.
- NACHA – The Electronic Payments Association
- Pillsbury Winthrop Shaw Pittman, LLP
- Smart Card Alliance
- URAC
- Workgroup for Electronic Data Interchange (WEDI)

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# Questions?

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## Appendix

- Basic Infrastructure Requirements
  - Phase I
- 270/271 Data Content Rule
  - Phase I and II
- Patient Identifier Rule
  - Phase II
  - Patient ID Study
- 276/277 Claim Status Rule
  - Phase II
- Connectivity Rule
  - Phase I and II
- Phase III Priorities

## Phase I: Basic Infrastructure Requirements

- Offer real-time response
  - 20 seconds or less
- Meet CORE batch response requirements (if batch offered)
  - Receipt by 9pm ET requires response by 7am ET next business day
- Meet CORE system availability requirements
  - 86% availability (calendar week)
- Use of CORE-compliant acknowledgements
  - Specifies when to use TA1 and 997
- Offer a CORE-compliant Connectivity option
  - Support HTTP/S 1.1
- Provide a CORE-compliant Companion Guide flow and format
  - Developed jointly with WEDI

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## Phase I Overview - 270/271 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
    - 48 - Hospital Inpatient
    - 50 - Hospital Outpatient
    - 86 - Emergency Services
    - 88 - Pharmacy
    - 98 - Professional Physician Office Visit
    - AL - Vision (optometry)

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## Phase I 270/271 Data Content Rule (cont'd)

### CORE Data Content Rule also Includes Patient Financial Responsibility

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 - Chiropractic
  - 48 - 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

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## Phase II 270/271 Data Content Rule

- Builds and expands on Phase I eligibility content
- Requires health plan to support explicit 270 eligibility inquiry for 39 service type codes
- Response must include all patient financial liability *(except for the 8 discretionary service types; a few codes from Phase I and mental health codes added in Phase II)*
  - Base contract deductible AND remaining deductible
  - Co-pay
  - Co-insurance
  - In/out of network amounts if different
  - Related dates
- Recommended use of 3 codes for coverage time period for health plan
  - 22 – Service Year (a 365-day contractual period)
  - 23 – Calendar year (January 1 through December 31 of same year)
  - 25 – Contract (duration of patient's specific coverage)

### EXAMPLES OF SERVICE TYPE CODES

2 Surgical
4 Diagnostic X-Ray
5 Diagnostic Lab
6 Radiation Therapy
7 Anesthesia
8 Surgical Assistance
12 Durable Medical Equipment Purchase
13 Ambulatory Service Center Facility
18 Durable Medical Equipment Rental
20 Second Surgical Opinion
40 Oral Surgery
42 Home Health Care
45 Hospice
51 Hospital - Emergency Accident
52 Hospital - Emergency Medical
53 Hospital - Ambulatory Surgical
62 MRI/CAT Scan
65 Newborn Care
68 Well Baby Care
73 Diagnostic Medical
76 Dialysis
78 Chemotherapy
80 Immunizations
81 Routine Physical
82 Family Planning
93 Podiatry
99 Professional (Physician) Visit – Inpatient
A0 Professional (Physician) Visit – Outpatient
A3 Professional (Physician) Visit – Home
*A6 Psychotherapy
*A7 Psychiatric – Inpatient
*A8 Psychiatric – Outpatient
AD Occupational Therapy
AE Physical Medicine
AF Speech Therapy
AG Skilled Nursing Care
*A1 Substance Abuse
B6 Cardiac Rehabilitation
BH Pediatric

\* Indicates examples of discretionary service types



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## Phase II: 270/271 Patient Identification Rules

- Two Patient ID Surveys funded by California Health Care Foundation led to business justification for developing rules that enhance patient matching and provide better information on why a match did not occur:
  - Draft rule on Last Name Normalization
  - Draft rule on Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers and Names

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## CORE Phase II Patient ID Study

### Valid Response Rate by Eligibility Inquiry Method

There are continued challenges with lower validation rates on the 270/271 compared to other methods. Increasing the match rate of the 270/271 is a key focus of the CORE Patient ID Rules.

Valid Response Analysis		270/271	Web	IVR	Phone
Plan A**	Valid responses	93%		NA	95%
	Patient ID errors	5%		NA	5%
	Other errors	1%		NA	0%
Plan B	Valid responses	81%	86%	81%	99%
	Patient ID errors	17%	14%	0%	1%
	Other errors	2%	0%	19%	
Plan C	Valid responses	62%	NA	NA	97%
	Patient ID errors	31%	NA	NA	3%
	Other errors	8%	NA	NA	
Plan D	Valid responses	NA	NA	NA	98%
	Patient ID errors	NA	NA	NA	2%
	Other errors	NA	NA	NA	

\*\* Plan A's usual rate of valid responses for the 270/271 is 83-85%.

Source: CORE Phase II Patient Identification Survey, 2007; funded, in part, by the California HealthCare Foundation

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## Phase II: 270/271 Patient Identification Rules

- Normalizing Patient Last Name
  - **Goal:** Reduce errors related to patient name matching due to use of special characters and name prefixes/suffixes
    - Recommends approaches for submitters to capture and store name suffix and prefix so that it can be stored separately or parsed from the last name
    - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
      - Remove specified suffix and prefix character strings
      - Remove special characters and punctuation
    - If normalized name validated, return 271 with CORE-required content
    - If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
    - If normalized name not validated, return specified AAA code
    - Recommends that health plans use a no-more-restrictive name validation logic in downstream HIPAA transactions than what is used for the 270/271 transactions

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## Phase II: 270/271 Patient Identification Rules

- Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names in 271 response
  - **Goal:** Provide consistent and specific patient identification error reporting on the 271 so that appropriate follow-up action can be taken to obtain and re-send correct information
    - Requires health plans to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements in order to communicate the specific errors to the submitter
    - Designed to work with any search and match criteria or logic
    - The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid

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## Phase II: Claims Status Rule

- Entities must provide claims status under the CORE Phase I infrastructure requirements, e.g.,
  - Offer real-time response
    - 20 seconds or less
  - Meet CORE batch response requirements (if batch offered)
    - Receipt by 9pm ET requires response by 7am ET next business day
  - Meet CORE system availability requirements
    - 86% availability (calendar week)
  - Use of CORE-compliant acknowledgements
    - Specifies when to use TA1 and 997
  - Offer a CORE-compliant Connectivity option
    - Support HTTP/S 1.1
  - Provide a CORE-compliant Companion Guide flow and format
    - Developed jointly with WEDI

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## CORE Phase I Connectivity Rule Overview

- 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

*NOTE: CORE Rules are a base and not a ceiling*

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## CORE Phase I Connectivity Rule: Benefits



- 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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## CORE Phase I Connectivity Rule: Challenges

- As expected, the long-term level of rule specificity to enable connectivity interoperability was not yet achieved. Significant variations in:
  - Names for Phase I metadata, names and location for other critical metadata
  - Message envelope structure
  - Authentication methods
  - Routing approaches
  - Security related information
- CORE Phase I was intended as an incremental “step” toward interoperability
- Remember – Crawl, Walk, Run

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## CORE Phase I “Real World” Implementations

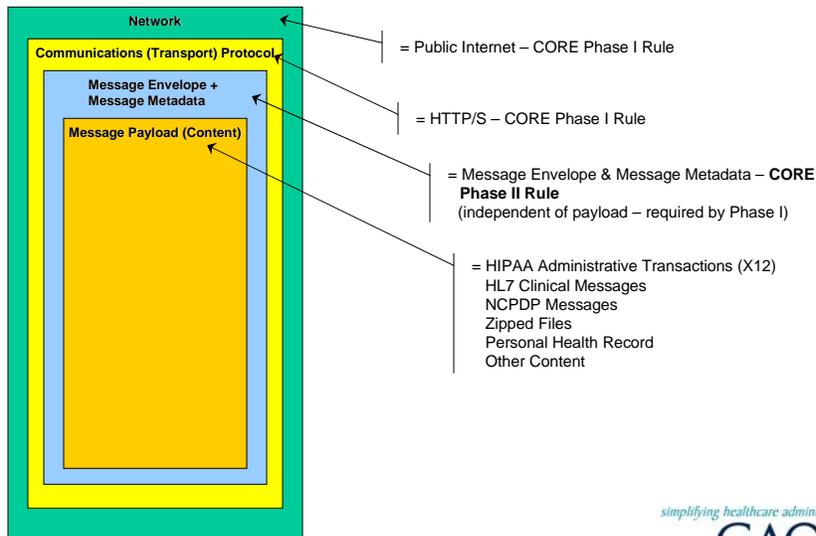
Entity	Message Envelope	Authentication
Health plan A	WS (SOAP + WSDL schema I)	WS-Security
Clearinghouse A	HTTP POST: name/value pair	User/password
Clearinghouse B	HTTP POST	User/password
Clearinghouse C	HTTP POST with MIME	User/password encoded in MIME
Clearinghouse D	WS (SOAP+WSDL schema II)	User/password basic authentication
RHIO A	WS(SOAP+WSDL schema III)	Digital signature with X.509 certificate
RHIO B	MIME	User/password encoded in MIME

**Note: Small sampling, range in variation is great**

## CORE Phase I Connectivity: Lessons Learned

- Industry has many connectivity approaches (proprietary and non-proprietary) with large installed bases
- Stakeholders are ready to come together and build consensus on connectivity methods for interoperability
- CORE Phase I is a step in the right direction – from proprietary and/or private networks, to public Internet (HTTP/S)
- While having a uniform transport standard is an important first step, many variations exist within CORE Phase I compliant implementations - interoperability requires a more definitive rule

## Achieving Connectivity Interoperability Requires Standards



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## CORE Phase II Connectivity Rule Overview

- Open Standards
  - Message Envelope
    - SOAP 1.2 + WSDL + MTOM
    - HTTP + MIME Multipart
  - Submitter Authentication
    - Username/Password (WS-Security Username Token)
    - X.509 Certificate over SSL (two-way SSL)
- Envelope Metadata
  - Field names (e.g., SenderID, ReceiverID)
  - Field syntax (value-sets, length restrictions)
  - Semantics (suggested use)
- Error Handling, Auditing

*CORE connectivity rules can be used to send administrative or clinical data as CORE selected standards that are aligned with other industry efforts*

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## Phase II : Rationale for Two Envelope Standards

- Decision on supporting two message envelope standards
  - SOAP+WSDL
    - Well aligned with HITSP and HL7
    - Lends itself to future rule development using Web-services standards for more advanced requirements (e.g., reliability)
  - HTTP MIME Multipart
    - Relatively simple and well understood protocol framework
    - CORE-certified entities have already implemented HTTP as part of Phase I
  - Incremental “stepped” approach:
    - Facilitates adoption in a market that is still maturing
    - Facilitates interoperability relative to the current state of envelope standard variability in the marketplace

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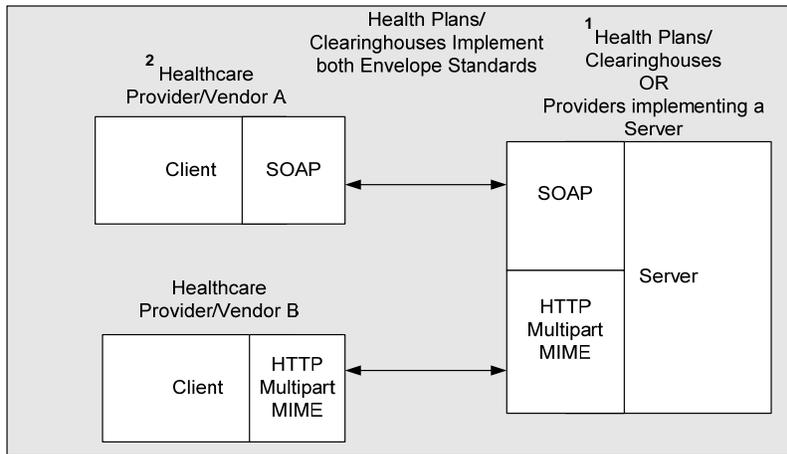
## Envelope Analogy

- US Post Office Rules and other market options
  - Specific requirements for envelope size, addressing and use of postal barcode
    - Impose surcharge on mailers not conforming to requirements to offset costs to handle non-standard envelopes
  - FedEx, UPS, etc all have their own standard envelope requirements but include basic “metadata”
- Implications for CORE?
  - Use standard envelope and metadata to
    - Increase interoperability leading to increased use of administrative transactions
    - Improve efficiency
    - Reduce cost

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## Phase II Connectivity: Envelope Conformance



<sup>1</sup> Health Plans, Health Plan Vendors, Clearinghouses or Providers implementing a server must support\* both envelope standards.

<sup>2</sup> Providers and Provider Vendors acting as a client need only support one of the envelope standards.

Note: Standards are paired with a metadata list; \* Refer to Rule for definition

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## Basic Conformance Requirements Rationale

### Standards

- **SOAP+WSDL** : Well aligned with HITSP, HL7, and current direction of market
- **HTTP MIME Multipart** : Simple, mature protocol; Large installed user base

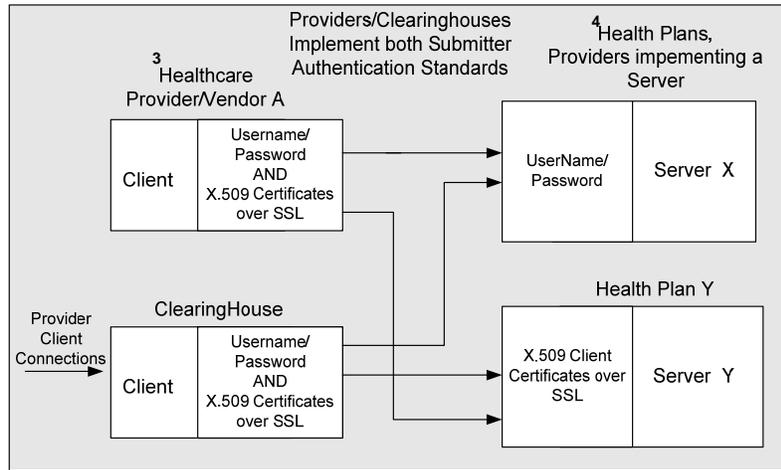
### Conformance Requirements Rationale

- Health Plans/Clearinghouses are typically “Servers” and Health Providers are typically “Clients”
- Servers can accept more client connections by supporting two envelope standards (big improvement from the current state of industry)
- Server sites typically have higher technical expertise than Client sites. Increased complexity of supporting two envelope standards may not be significant for Server sites

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## Phase II Connectivity: Submitter Authentication



<sup>3</sup> Providers, Provider Vendors or Clearinghouses acting as a client must support\* both submitter authentication standards.

<sup>4</sup> Health Plans, Health Plan Vendors or Providers implementing a server need only support one submitter authentication standard.

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\* Refer to Rule for definition

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## Basic Conformance Requirements Rationale

### Standards

- **Username/password:** Simple, ubiquitous
- **X.509 Certificate over SSL:** Aligned with HITSP/IHE (ATNA)

### Conformance Requirements Rationale

- Health-Plans/Clearinghouses act as "Servers", Health Providers act as "Clients"
- Server implementations manage identities, credentials, hence more complex to support both authentication methods at Server
- Client implementations only install their own credentials for each connection to Health-Plan/Clearinghouse, hence simpler to support two authentication methods at Client

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## CORE Phase II Connectivity: Metadata

Decision: For simplicity, use same metadata for request and response

- Payload Type
- Processing Mode
- Payload Length
- Payload ID
- Time Stamp
- User Name
- Password
- Sender Identifier
- Receiver Identifier
- CORE Rule Version
- Checksum
- Error Code
- Error Message

**\*\* See CORE Phase II Rule for detailed descriptions, intended use for each element**

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## Phase II Connectivity: Metadata Will be Outside the Payload

*Concept applied in Phase I, and confirmed again in Phase II.*

Rationale:

- Facilitates connectivity standardization as well as administrative and clinical integration
- Accelerates industry interoperability
- Entities are able to do auditing and authentication without parsing payload/bring payload into their system
- Payload agnostic
  - Allows CORE's connectivity rules to evolve to future phases independent of payload standard evolution; in other CORE rules, e.g. Eligibility Data Content, adoption of payloads are promoted for content
  - Supports approach of other national initiatives

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## Phase II Envelope Metadata Requirements

- Metadata provides the ability to
  - Identify both sender and receiver
  - Authenticate sender and authorize access
  - Identify type of payload
  - Route payload to the correct receiver entry point for the type of payload
  - Audit date/time of message
  - Specify payload size in either kilo or megabytes
- Metadata must be independent of the payload (content) {[CORE Phase I Decision](#)
  - Does not require receiver to examine payload
- Metadata needs to be standardized for
  - Metadata element names
  - Intended use of each metadata element (as agreed to by the trading partners)
  - Requirement for presence of each metadata element (required/optional)
  - Structure of message envelope

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## Phase II Connectivity Challenges: Envelope Metadata

### Challenges of Payload Specific Metadata

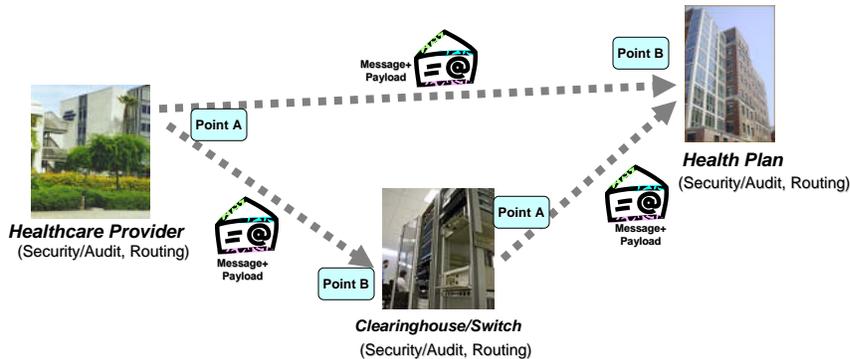
- Not all metadata is present in all types of payload
  - Some payload standards are content focused with no transport/message metadata (e.g., HL7 does not have routing and security information so they are supporting the adoption of an existing envelope standard)
- Different payloads use different structure, position, syntax, semantics for the same metadata
  - HL7 and X12 message structures are different
  - Standards for different payload types are evolving independently of one another

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## Intended Use of Metadata in CORE Phase II

All message exchanges are point-to-point even when the message goes through one or more intermediaries before receipt by the ultimate end point.



Multi-hop message exchange is not a Phase II requirement

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## Phase III Priorities?

- Administrative rules that complement clinical goals of Federal government, e.g., detailed payment information for lab services
- Rules related to transactions not yet addressed in Phase I or II
  - Data content aspects of Claims Status
  - Terms and definitions used in electronic remittances
  - Referrals/ Prior authorizations
  - Coordination of benefits
- More detailed cost information
  - Additional data related to patient financial responsibility
  - Procedure-level data?
- Support for the electronic delivery of pharmacy benefit information
  - Detailed proposal created in Phase II, deferred to Phase III
- Policies encouraging CORE-certified entities to require certain of their trading partners to be CORE-certified
- Further enhancement of Connectivity rules

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