

CORE: Building Internal and External Partnerships: Streamlined EDI

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Discussion Topics

- CAQH Overview
- CORE Overview
- CORE Operating Rules
 - Phase I & II Overview
 - Phase III Update
- CORE Phase I Implementation Results
- Harmonizing with Industry Efforts
 - Blue Exchange
 - Others
- Participation and Certification
- Q & A


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An Introduction to CAQH

- CAQH, an unprecedented nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.
- CAQH solutions:
 - Help promote quality interactions between plans, providers and other stakeholders
 - Reduce costs and frustrations associated with healthcare administration
 - Facilitate administrative healthcare information exchange
 - Encourage administrative and clinical data integration


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CAQH Initiatives



Committee on Operating Rules
for Information Exchange

Industry-wide stakeholder collaboration to facilitate the development and adoption of industry-wide operating rules for administrative transactions.




Service that replaces multiple health plan paper processes for collecting provider data with a single, electronic, uniform data-collection system (i.e. credentialing). Over 750,000 providers as of August 2009.

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CAQH Success Factors

- Focus on critical challenges
 - CAQH initiatives are targeting several priority issues for the industry
 - Identify areas of differentiation which have no competitive advantage
- Inclusive approach
 - Cross-industry and public-private collaboration
- Create meaningful impact
 - CAQH initiatives are concrete, national, well-vetted solutions that are working in the marketplace today
 - Action can be taken immediately
 - Impact can be tracked across a wide group of entities
- Support from providers and other stakeholders
 - CAQH has built the trust of the provider community around administrative simplification
 - States, government groups, and others also engaged
- Experience
 - Lessons learned though development and implementation

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Committee on Operating Rules
for Information Exchange

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CORE Mission

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

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

CORE is not:

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

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CORE Goals

- Answer to the question: Why can't verifying patient eligibility and benefits in providers' offices be as easy as making a cash withdrawal?
- Participation from 75% of the commercially insured plus Medicare and some Medicaid

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
Apply operating rule concept to other administrative transactions in claims process, using phased approach

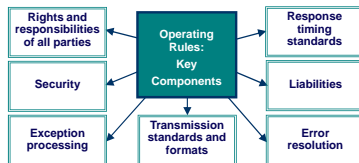


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What are Operating Rules?

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



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CORE Participants

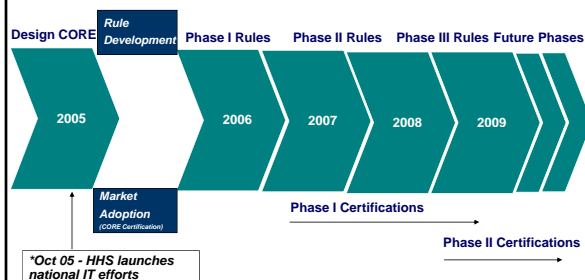
- Over 100 organizations representing all aspects of the industry:
- 20+ health plans
 - 15 providers
 - 6 provider associations
 - 18 regional entities/RHIOS/standard setting bodies/other associations
 - 36 vendors (clearinghouses and PMS)
 - 6 others (consulting companies, banks)
 - 8 government entities, including:
 - Centers for Medicare and Medicaid Services
 - US Department of Veteran Affairs

CORE participants maintain eligibility/benefits data for over 130 million lives, or more than 70 percent of the commercially insured plus Medicare and state-based Medicaid beneficiaries.

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Phased Approach



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REMINDER: CORE rules are a baseline; Entities are encouraged to go beyond the minimum CORE requirements



CORE: A Phased Approach

CORE Phase I

- ✓ Approved
- ✓ Implemented

CORE's first set of rules are helping:

- Electronically confirm patient benefit coverage and co-pay, coinsurance and base deductible information
- Provide access to this information in real-time via common internet protocols and with acknowledgements, etc

CORE Phase II

- ✓ Approved
- ✓ Implemented

CORE's second set of rules expand on Phase I to include:

- Patient accumulators (remaining deductible)
- Rules to help improve patient matching
- Claim status "infrastructure" requirements (e.g., response time)
- More prescriptive connectivity requirements

CORE Phase III

- In development

CORE's third set of rules focus on:

- Claim status data requirements
- Remittance
- Prior Authorization / Referral
- Standard Health Benefit / Insurance ID Card
- More prescriptive connectivity requirements as well as digital authentication

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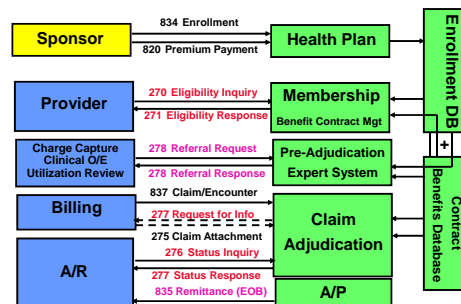
CORE Operating Rules

*REMINDER: CORE rules are a base, not a ceiling;
Entities can go beyond the minimum CORE requirements*

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Administrative Transactions

In CORE, transaction-based rules are paired with infrastructure rules, e.g. real-time response and connectivity, to help data flow consistency in varied settings and with various vendors.



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Addressed in Phase I or II Under consideration for Phase III

CORE Rules: Data Content

- HIPAA mandated the use of X12 standards for data content of electronic administrative transactions
- Examples of these transactions (there are 9 in total):
 - Eligibility Verification = 270/271 in X12 terms
 - Claim Status = 276/277 in X12 terms
 - Claim Submission = 837 in X12 terms
- Implementation guides were developed to specify the requirements for using the X12 standards
 - Current Implementation Guide is version 4010 and requires limited data requirements, e.g. eligibility is a yes/no for coverage
 - Version 5010, mandated for implementation by January 2012, recommends a number of additional data elements but does not require their use, e.g., the return of patient financials has been included in CORE requirements, using the HIPAA standards, since April 2006 – well ahead of the recommendations in 5010 to return such information

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CORE Rules: Infrastructure

- These are like "service levels" - necessary to improve data content flow between provider and payer
- HIPAA not designed to address infrastructure requirements
- Interoperability is dependent upon uniform use of DATA CONTENT and INFRASTRUCTURE
- CORE Rules address the following:
 - Connectivity**
 - Provide a uniform way for stakeholders to connect (through the internet)
 - CORE Connectivity recommended for integration into federal specifications
 - Response Times**
 - Specify that information will be available in real time (20 sec or less round trip)
 - System Availability**
 - Specify systems delivering information be available a certain amount of time (86%)
 - Acknowledgements**
 - Provide uniform **acknowledgements** to let providers know if their inquiry was received, rejected, etc.
 - Patient Identification**
 - Helps assure patient matching/identification can occur

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CORE Phase II Certifications Update

- Three CORE Phase II Certifications have been achieved to date
 - Harvard Pilgrim Health Care (April 2009)
 - NaviNet (May 2009)
 - eServices Group, Inc. (August 2009)
- Nearly 30 organizations are committed to Phase II certification by Q4-2009 or Q1-2010, including
 - Blue Cross Blue Shield of North Carolina
 - BlueCross BlueShield of Tennessee
 - CareFirst Blue Cross Blue Shield
 - WellPoint
- Additional 20 organizations are endorsing CORE and the Phase I rules – and committed to endorsing Phase II rules

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Phase III: Rule Writing Scope

- Data content of the 270/271 Eligibility
 - Extend data content and product identification
 - Sensitive Benefits: Potential research/white paper to be conducted by WEDI, CAQH, and other TBD stakeholders
- Data content of the 276/277 Claims Status, e.g.
 - Consistent usage of claims status category codes and entity identifiers
 - Establish minimum time period for claim status to be available
 - Application of acknowledgements
- Infrastructure and/or Data Content for the 278 and 835
 - Application of Phase I and Phase II infrastructure rules
- Enhance Phase II Connectivity Rules as appropriate
 - Conducting pilot with VeriSign
- Health Plan Insurance ID Card
 - Assumes WEDI ID Card as foundation

5010 requirements and ONC efforts will play a critical role in rule details

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CORE Phase I Implementation Results

Helping Improve Transactions to Meet Expectations



Phase I Measures of Success Study

Study Approach

- IBM assessed results achieved by health plan early adopters (representing 33 million covered lives) of CORE Phase I Rules and selected vendor and provider partners.
- Determined ROI by analyzing metrics (i.e., eligibility verification methods and volume) achieved by health plans, provider groups and HIT vendors three months prior to health plan CORE certification and one year later.

Key Findings

- All stakeholders achieved cost-savings and accelerated use of "real-time" transactions.
- Health I.T. adoption accelerates and ROI increases when there are interoperable solutions that benefit both providers and health plans.
- An industry-wide implementation of CORE Phase I rules would be a win-win scenario for providers and health plans that could yield an estimated \$3 billion of savings to the industry over three years.



CORE Phase I Measures of Success Study (continued)

Stakeholder-Specific Findings

Providers

- Provider groups working with CORE participating health plans saw 10-12% fewer claim denials, a 20% increase of patients verified prior to a visit, and higher rates of paid accounts.
- Electronic verifications by providers took about seven minutes less than telephone verifications, saving about \$2.10 per verification.

Health Plans

- Health Plans realized payback in less than one year.
- Every health plan saw savings – average annual reduction in administrative costs can be over \$2.5 million per plan.

Vendors and Clearinghouses

- Vendors and clearinghouses play a crucial role in accelerating adoption of electronic transactions.
- The time needed by vendors and clearinghouses to connect to trading partners significantly reduces with a common approach to connectivity.



Health Plan Results

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

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

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

- Progress towards having all visits verified
 - Ratio of verifications to claims **Up from .63 to .73**

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

** Updated 5/1 to reflect additional data



Health Plan Electronic Eligibility Volumes

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

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

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

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



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

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

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



Cost of CORE Certification for Health Plans

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

Cost	Average	Low	High
Total cost of adoption	\$542,800	\$8,000	\$1,720,000
Per member costs of adoption	\$.0852	\$0.0005	\$0.4886
Ongoing annual costs *	\$49,200	\$ 0	\$79,000

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

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* Revised 5/1/09 ongoing cost average



Potential Savings Due to Industry-wide CORE Phase I Certification

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

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Harmonizing with Industry Efforts

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BlueExchange and CORE: Commonalities

Mission and Vision

- National solution
- Increase use of electronic inquiries
- Reduce labor-intensive processes
- Promote interoperability

Technology and data focus

- Focused on adopting administrative data transactions (X12 HIPAA)
 - Eligibility and claims status
- Create sets of rules that entities can follow
- Goes beyond what was required under HIPAA

Rules: Writing process

- Developing standard rules through research and consensus building
- Final rules created through voting process
- Done in phases/versions

Compliance approach

- Comply with entire set of rules, not just some
- Certification process to ensure rules compliance

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BlueExchange and CORE: Points of Departure

	CORE	BlueExchange
Approach to Achieving Mission and Vision	Does not offer or manage any health plan products	Facilitates communication between Blue Plans
Participants	Health plans, vendors, clearinghouses, large providers, standard setting bodies, provider associations	Blue Plans
Technology	No switch, voluntary rules and policies for each stakeholder type to follow	Standard electronic software, consisting of data compliant formats, procedures, and rules, that provides a centralized inter-Plan communication tool
Rules and Adoption	Available to any interested party; actual certification requires signing a public pledge at a time that is decided upon by each individual organization	Available only to Blue Plans; adoption in a specific date range is a requirement for Blue Plans
Compliance Approach	Testing by CAQH-authorized CORE-certification vendors	Internal Blue Plan process

High Level Overview of Transactions Addressed by CORE and BlueExchange

Transaction or Standard	CORE (Phase)	BlueExchange
Eligibility	I & II	✓
Service types with Associated Financials* e.g. Co-pay, Co-insurance, deductibles, as well as In- and out-of-network variances	I & II	✓
Real-time standards	I & II	✓
Batch turnaround standards	I & II	✓
System availability standards	I & II	✓
Acknowledgements	I & II	✓
Claim Status	II	✓
Data	--	✓
Real-time standards	II	✓
Batch turnaround standards	II	✓
System availability standards	II	✓
Acknowledgements	II	✓
Connectivity	I & II	NA
Patient ID Rules	II	--

*Small variances on number and type of service type codes required by Phase or version.

Current Methods of Coordination: Blue Plans & CORE

Participation in organizational structures

- CAQH
 - CEO of BCBSA serves on CAQH Board of Directors
 - A number of CEOs from Blue plans, including WellPoint, serve on the CAQH Board
- CORE
 - Like other CORE participants (Blue and non-Blue Plans), BCBSA serves on CORE Work Groups and Subgroups; through this participation CORE determines area of potential conflict with BlueExchange
 - WellPoint has co-chaired Work Groups and served on the CORE Steering Committee

Strategy

- BCBSA and CAQH staff meet frequently to discuss strategy and scope of CORE/BlueExchange to ensure their efforts are complementary with regard to data and technical rules

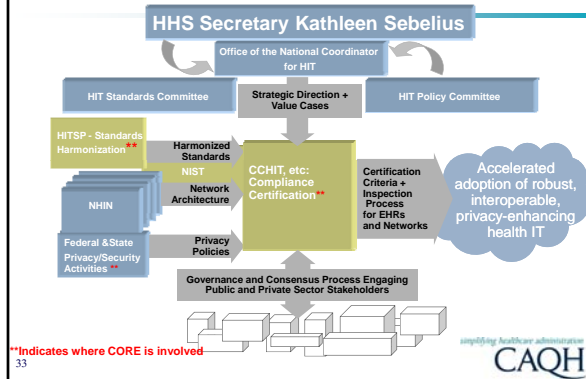
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CORE Participants - Blue CORE Caucus

- Independence Blue Cross
- BlueCross BlueShield of Tennessee
 - Phase I certified
 - Committed to Phase II certification
- Excellus
- WellPoint
 - Phase I certified
 - Committed to Phase II certification
- HCSC/BlueCross BlueShield of Illinois
- BlueCross BlueShield of North Carolina
 - Phase I certified
 - Committed to Phase II certification
- CareFirst
 - Committed to Phase I certification
- BlueCross BlueShield of Michigan
- BlueCross BlueShield Association

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CORE in Relation to the “Evolving” Landscape



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Examples: Industry Coordination

- Activities within CORE are developed to support and integrate with federal/national efforts, e.g.:
 - CORE rules complement BlueExchange
 - HIPAA 5010: CORE Phase I/II rules incorporate many of the features required to address the common information needs for patient eligibility
 - CORE Phase I/II rules are incorporated into HITSP interoperability specifications
 - CORE connectivity rules are being considered for recommendation as the national standard by the joint WEDI/X12 RTA Communications Workgroup
 - Industry associations are considering how CORE can contribute to national industry efforts
 - e.g. AHIP Portal

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Examples: Industry Coordination

- Activities within CORE are developed to support and integrate with regional efforts too, e.g.:
 - CORE rules have been recommended by state-sponsored, multi-stakeholder committees
 - Colorado
 - Ohio
 - Texas
 - State-based/HIEs are supporting CORE
 - Tennessee
 - Virginia
 - CAQH is providing education on CORE to state stakeholders
 - California
 - Massachusetts
 - Washington
 - Wisconsin

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Administrative Data Exchange and HITECH

- Complementing ARRA's HITECH objectives is critical
 - Foundation is needed to fulfill "meaningful use" objectives
 - Reducing costs, streamlining administration are shared objectives
- In June, CAQH provided comments on ONC's preliminary draft definition – CAQH's key messages:
 - Administrative data is critical to meeting the policy objectives of "meaningful use"
 - Establishing a linkage to administrative data gives providers incentives to move to an all electronic, efficient and high quality, decision supported process
 - Short-term savings from revenue cycle improvement can help bridge gap until longer-term ROI from clinical contributions is realized
 - "Meaningful use" should build upon existing momentum
- In July, ONC released revised criteria for its "meaningful use" framework
 - A 2011 objective for providers (including hospitals) to check eligibility electronically with public and private payers, where possible; a second 2011 objective for providers to submit claims electronically
 - Corresponding 2011 measures look at the percentage of these transactions that are performed electronically

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Participation and Certification

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Participating in CORE Phase III 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 CORE at core@caqh.org for more information on CORE

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Certification: Earning the CORE Seal

Enhances trading partner relationships

- Work with CORE-certified vendors
- Vendor-agnostic technology

Builds a foundation for interoperable EHRs, PHRs, etc that will streamline processes for patients and providers

- Complements ARRA/HITECH objectives to reduce costs, improve quality, and modernize healthcare
- Complements *draft* criteria necessary for meeting HITECH stimulus requirements

Promotes adoption of a single set of standards

- Helps deliver faster, more accurate responses from health plans
- Consistent information can be accessed and received, despite health plan

Supports integration of administrative-clinical data



A CAQH Initiative

Health Plans,
Vendors/ clearinghouses
Provider organizations (large)

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In Closing

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

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

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Questions?

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