

**The Development and Evolution of
Private-Sector Operating Rules
for Eligibility and Claims Status:
A Key Component of
Administrative Simplification**

**as Mandated by the
Patient Protection and Affordable Care Act of 2010**

Testimony to

U.S. Department of Health & Human Services
National Committee on Vital and Health Statistics
Subcommittee on Standards

July 20, 2010

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I. Introduction and Acknowledgements

CAQH is pleased to submit this written testimony to the National Committee on Vital and Health Statistics (“NCVHS”) in the context of their authority to review and make recommendations based on the administrative simplification provisions of Section 1104 of the Patient Protection and Affordable Care Act (“ACA”).

CAQH is a not-for-profit alliance that is uniquely focused on simplifying administrative processes in healthcare. The organization works to promote high quality interactions between plans, providers, vendors, and other stakeholders, to significantly reduce costs associated with healthcare administration, to facilitate administrative healthcare information exchange, and to encourage administrative and clinical data integration. Over its 10-year history, CAQH has consistently demonstrated the ability to make real, measurable impact on administrative simplification. As one example, the Universal Provider Datasource (“UPD”) is now a trusted public utility used by nearly 840,000 providers and over 550 health plans and hospitals to reduce the cost of their provider data collection activities.

This testimony is based on our experience as the facilitator of the activities of a broad group of stakeholders working together as the Committee on Operating Rules for Information Exchange (“CORE”).

CORE was conceived and established by CAQH in 2005 to address health plan and provider needs to exchange more robust administrative transactions in real time. CORE is the only national effort solely engaged in the development of operating rules for the facilitation of administrative healthcare transactions. Over the past five years CORE has brought the concept of operating rules to healthcare and demonstrated that the use of these rules yields a return on investment (ROI), as well as the simplification required to operate efficiently and effectively in today’s complex environment.

CAQH provides the administrative infrastructure for CORE, and collaborates with the more than 115 participating CORE organizations that make all of the decisions regarding the scope, rules, and certification requirements that comprise the CORE initiative.

As we consider the future need for, and importance of, operating rules, and their impact on administrative simplification, we would like to recognize and acknowledge the critical roles of the pioneers who established the national vision of administrative simplification: the Accredited Standards Committee (ASC) X12, the National Council for Prescription Drug Programs (NCPDP), the Workgroup for Electronic Data Interchange (WEDI), and NCVHS. The NCVHS has played a critical role in guiding policies affecting the implementation of the Health Insurance Portability and Accountability Act (HIPAA). We are particularly appreciative of the NCVHS approach to considering administrative simplification within the broader context of how enriched data offers the potential to better address our nation’s healthcare challenges.

As NCVHS noted in a June 10, 2010 Concept Paper:

“We are entering a new chapter in the health and health care of Americans. The expansion of health care coverage, the infusion of new funds and adoption of standards for electronic health records (EHRs), and increased administrative simplification offer us the potential to use the enriched data generated to better address our country’s health and health care challenges. Having better information with which to measure and understand the processes, episodes, and outcomes of care as well as the determinants of health can bring considerable health benefits, not only to individuals but also to the population as a whole.”

This focus is consistent with the approach that CORE has taken in writing operating rules with a clear appreciation of how administrative simplification must play out within the broader health environment and the health information ecosystem. Beyond setting direction, NCVHS has played an instrumental role in advising HHS on the detailed and technical aspects of the electronic transactions standards. Aligning strategic direction with attention to business needs is critical.

This CAQH testimony is offered to assist NCVHS as it determines how to address the administrative simplification provision in Section 1104 of the ACA. We recognize the fundamental differences between the current CORE current voluntary approach and the substantial requirements and ambitious timeframes specified. We also believe an adjusted and expanded CORE initiative – one that takes advantage of broader experiences and resources through extended partnerships – is an essential vehicle through which all relevant stakeholders can deliver on the intent of the administrative simplification provisions of the ACA.

II. Historical Context and Evolution

It has been 15 years since HIPAA legislation established the foundation for administrative simplification in healthcare. Over this time, initial versions of the standards recognized by HIPAA began to facilitate the electronic transmission of administrative and claims information. However, neither providers nor health plans have fully experienced the most critical goal of HIPAA – administrative simplification. This is due to a number of factors, including:

- The standards have not been implemented in a uniform manner – and implementation did not address the larger environment in which administrative transactions are exchanged.
- The environment has evolved significantly since the original development of HIPAA – there are many new requirements and new players that are relevant today.
- Executive leadership responsible for driving change did not experience the anticipated value from HIPAA.

During the health care reform debate in 2009, the Senate Finance Committee noted the lack of uniformity *“(as) ...one of the reasons providers in the United States do not use electronic transactions for some of the most basic transactions related to health care.”* The Senate Finance Committee's draft health reform legislation, which became the blueprint for the ACA, included

an administrative simplification provision consistent with the amendments to HIPAA contained in Section 1104 of the ACA.

CORE was established based on a shared recognition by a wide range of stakeholders that operating rules were needed – in addition to standards – to achieve the goals of HIPAA, to support the evolution of clinical/administrative information exchange, to provide a method to accelerate greater standardization, efficiency and cost savings, and to offer a long-term health IT roadmap for administrative exchange.

Through the administrative simplification provision in the ACA, Congress has made selected amendments to HIPAA. The ACA amendments provide for a more comprehensive approach to administrative simplification given the transformational stage, and needs, of the industry. Specifically:

- The ACA amends the HIPAA term “standard” and its definition to reflect the transition to a “uniform standard.”
- The ACA defines operating rules as “the business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”

It offers a unique and significant opportunity to amplify the combined benefits of standards and operating rules through this approach. The intent is to reduce the clerical and administrative burdens on patients, providers, and health plans. By requiring uniform standards and operating rules, the ACA aims to increase the likelihood that useful information is available when it is needed -- either prior to or at the point of service. CAQH stands ready to work in full cooperation with the standard setting organizations by taking advantage of all the lessons learned through the CORE initiative.

During this transitional stage the many stakeholders engaged in healthcare administrative data exchange will need to collaborate closely in order to achieve the best possible results within the larger context of Health Information Exchange (“HIE”). HHS has established a strong example of the value of collaboration by coordinating its ehealth work across the offices and agencies throughout its departments such as the Office of the National Coordinator for Health Information Technology (ONC) and the Office of E-Health Standards and Services at CMS.

CAQH recognizes and appreciates the differences between the competitive model, which encourages many organizations to focus on and pursue their individual interests, and a collaborative model that harnesses many interests toward a consistent goal. We also understand that the differences in the evolution of standards and operating rules must be acknowledged when NCVHS considers how HHS can meet the mandated timeframes for adopting operating rules. We suggest that the CORE collaborative approach is the most appropriate and fully evolved option to support the industry in achieving the intent of the ACA.

III. Addressing Today's Data Exchange Environment

The data exchange environment today is impacted by history, by the rapidly evolving changes associated with the healthcare reform process, by federal investments in HIT, by factors demanding a broader perspective on administrative data exchange, and by resource allocation decisions.

In this environment, all participating entities need to determine how to address such tremendous change – independently within their own organization and collaboratively, when cross-industry opportunities are identified. Beyond the underlying structural challenges, which are influenced greatly by advances in technology and economic constraints, health care organizations will be balancing two, seemingly competitive imperatives:

- The need to lower administrative costs, and
- The need to enhance administrative infrastructure.

Within the next few years, entities working with administrative data must address all of the following:

- On or before January 1, 2011, health plans must be able to provide rebates if minimum requirements for medical loss ratios (MLRs) are not met. (Small group health plans must limit administrative costs to 25% and large groups to 20%.)
- By January 2012, health plans and providers systems must be in full compliance with HIPAA v5010.
- By October 1, 2013, health plans and providers systems must be in full compliance with ICD-10.
- Between now and 2015, stakeholders will be determining how to coordinate with national and regional efforts that result from the roll-out of the American Recovery and Reinvestment Act (ARRA) Health Information Technology Act. Key to this will be:
 - The potential role of exchanging administrative data within the National Health Information Network (NHIN).
 - State-based decisions on the role of administrative data in HIEs, and thus requirements established for health plans to participate in HIEs.

Duplication of Effort Cannot be Sustained.

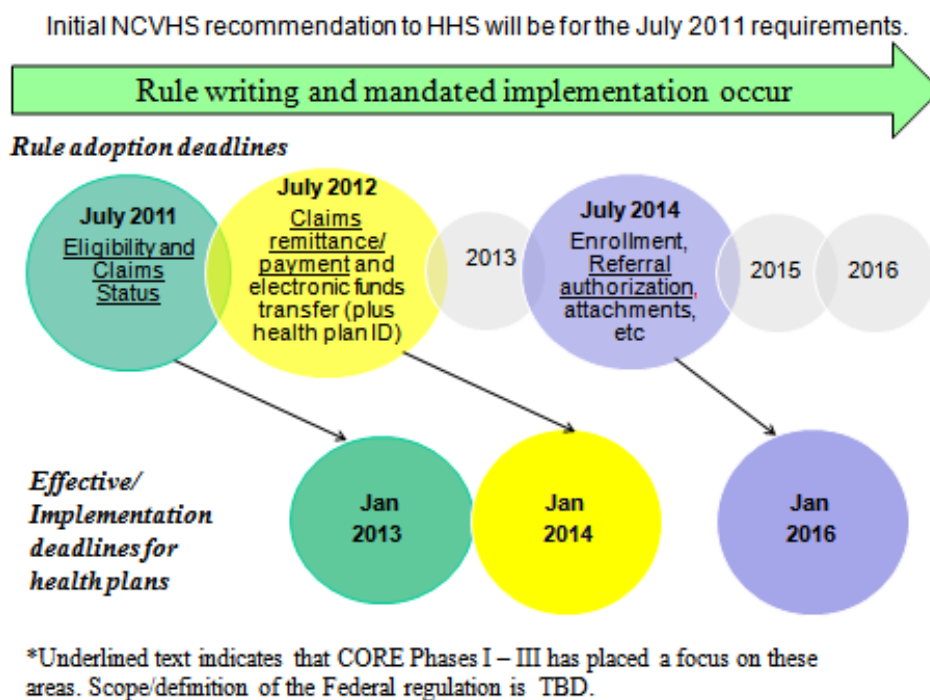
Entities will be looking at mechanisms and processes that can help them achieve these requirements without unnecessary duplication of effort. We would like to emphasize that operating rules have been, and should continue to be, an important tool to align efforts related to the exchange of administrative information – within the broader HIE environment that must align clinical *and* administrative efforts.

INITIAL FOCUS: 2011 OPERATING RULE REQUIREMENTS FOR ELIGIBILITY AND CLAIMS STATUS

The present hearings are focused on how HHS can address the aggressive timeframes established for the development of the first set of operating rule requirements specified in Section 1104 of the ACA: Eligibility and Claims Status.

In the following sections we will detail our experience in working on these specific areas, as well as the overall iterative process which CAQH believes should be embraced. Exhibit 1 outlines the high-level requirements from Section 1104, and the areas of focus for CORE to date.

Exhibit 1: HR 3590 Patient Protection and Affordable Care Act: Section 1104



WHY OPERATING RULES AND STANDARDS: CONCEPTS AND DEFINITIONS DRIVING CHANGE

Concepts

Operating rules are defined in the ACA as: *“the business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”* In addition, we believe it is helpful to consider some of the attributes associated with operating rules.

- Operating rules offer **one, singular** companion guide (i.e., a baseline playbook) for the industry that acknowledges and recognizes the many sets of standards, policies, and requirements that need to be shared among trading partners in order to achieve real, practical administrative simplification; reaching this point will require an iterative, multi-phase process.
- Operating rules are a set of integrated, complementary, and agreed-upon business rules for implementing and processing **all** administrative transactions.
- Operating rules encourage the marketplace to seek and achieve **desired outcomes**, such as an interoperable, federated network governing the conduct of specific electronic transactions (i.e., ATMs in banking) or reducing the complexities and cost in security requirements (e.g., digital certificates).
- Operating rules address the necessary **key components** in a transaction, including
 - Rights and responsibilities of all parties
 - Transmission standards and formats
 - Response timing standards
 - Liabilities
 - Exception processing
 - Error resolution
 - Security
 - Baseline testing requirements

Definitions

The need for operating rules **and** standards to co-exist is evident and well illustrated in many industries and organized activities.

- Various sectors of the banking industry, such as credit cards and financial institutions.
- Different modes of transportation, such as the highway and railroad systems.

What standards do. Standards and their specifications help to establish basic expectations -- such as characteristics of a data field, size and type of digits, and definition of that field. Viewed alone, however, or even with guidance on how to use the individual standard, the standards don't address (for example) how the game is played or how the various standards should work together to meet the goals of and functions needed by a specific industry.

What are operating rules? Operating rules build on the common language that standards create and more precisely describe the roles and responsibilities of each stakeholder that uses them. Defining these roles and responsibilities requires deep expertise in the ways different stakeholders interact within a specific industry. Accordingly, operating rules are often developed by a broad mix of business, operational, and technical experts, along with public input.

The coexistence of standards and operating has proven results. Over the past five years the healthcare industry has been embracing the co-existence of operating rules and standards, just as other industries have done before us. Through the CORE Phase I and II rules, and the draft Phase III rules, CORE has clearly demonstrated the value that operating rules bring to administrative data exchange and the unique, but co-existent, roles that standards and operating rules play. As a

result of the CORE initiative, goals such as interoperability, real-time exchange, use of patient financials, common business case scenarios, and system availability are becoming a reality.

The missions, and the applied resources, of organizations that develop standards and operating rules are different. CORE has also demonstrated why the different types of organizations that develop standards and operating rules have separate, but complementary, missions. The CORE mission is not to write standards, but to create a “playbook” that brings to reality the financial and non-financial value of administrative simplification. Those writing standards bring the expertise to focus on the development and evolution of very technical requirements. By comparison, operating rules are written by those who focus on the ways in which policies, standards, and testing can be aligned to achieve cost and process efficiencies within their industry.

To address concerns that have been raised on this subject, specific points may help to clarify:

- Standards and operating rules need to co-exist to bring ROI and interoperability to healthcare administration.
- Operating rules should always support standards, with particular emphasis on certain aspects of those standards, and this support ensures focus on the ecosystem of healthcare administrative data exchange and the larger environment.
- Operating rules support standards based upon criteria driven by industry functionality. Version updates of the standards are developed by standards development organizations (SDOs). Operating rules should always support the version updates in accordance with federal regulations, state regulations, industry needs, and cost-benefit alignment.
- The skill sets and resources required in the development and implementation of operating rules and standards are not the same.
- The CORE rules have supported the use of non-mandated aspects of the HIPAA standards, non-HIPAA healthcare standards, and industry-neutral standards.
- The CORE rules are in compliance with all existing Federal mandates, *including ASC X12 standards mandated under HIPAA, in which not all aspects of the X12 Implementation Guides (TRs) are required for use.* Specifically, CORE Phase I and II rules were written with v5010 in mind and thus changes to the CORE Phase I and II rules resulting from v5010 are minimal. The draft Phase III rules were written with full awareness of v5010, although v5010 is not required until January 2012.

IV. CORE: Its Progress, Roadmap and Its Integrated Model

OVERVIEW

CORE Mission and Vision

CORE is a national, multi-stakeholder, collaborative, initiative launched more than five years ago, creating the first and only organization developing and implementing national operating

rules for healthcare administrative transactions. The CAQH decision to embrace the concept of operating rules as a method to address the administrative data exchange needs of the industry was determined based on the experience of other industries that have significant volumes of transactions.

The CORE mission is to build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers. The CORE rules enable provider access to healthcare administrative information before or at the time of service, using the electronic system of their choice, for any patient, or health plan.

The CORE vision is to apply this approach to patient eligibility, and subsequently – as outlined in its long-term plan – to apply the approach to all transactions in the claims process. To achieve this vision, CORE facilitates stakeholder commitment to the promotion of administrative and clinical data integration.

It is important to appreciate that CORE is **not** building a database and it is **not** replicating the work being done by SDOs (e.g., X12 and HL7).

Over the past several years the CORE mission and vision have been communicated in a variety of ways. Broad industry and public awareness have been a goal from the very earliest stages.

In Spring 2006, the Day in the Life of a Patient (see Appendix A) was created by the Long-Term Vision Subgroup to highlight the potential impact of operating rules on the patient and the provider. In the Spring of 2009, CAQH sponsored a campaign to drive awareness of CORE. The centerpiece of the campaign contained the names of over 100 participating entities – with their approval – and spoke directly to the value of the collaboration on CORE.

Exhibit 2: March 2009 CORE Awareness Campaign (see next page)

HEALTHCARE LEADERS: LET'S ALL GET ON THE SAME PAGE.

Imagine an American healthcare system where doctors and hospitals can instantly verify patient insurance information before or at the time of care. From any health plan. With any electronic system.

It's happening today through a set of rules created by the Committee on Operating Rules for Information Exchange (CORE).

By implementing the CORE rules, CORE-certified organizations are speaking the same language. Improving data consistency. Reducing paperwork. Advancing system interoperability. And supporting information transparency for consumers.

It's time to get on the same page. Get certified to use the CORE rules or become a CORE Endorser. Learn more by visiting www.coreconnect.org.



Thanks to these additional leading organizations who are helping to establish the CORE rules.

HEALTH PLANS

Blue Cross Blue Shield of Michigan
CareFirst Blue Cross Blue Shield
CIGNA
Coventry Health Care
Blue Cross Blue Shield
Group Health, Inc.
Health Care Service Corporation
Health Plan of Michigan
Horizon Blue Cross Blue Shield of New Jersey
Independence Blue Cross
UnitedHealth Group

ASSOCIATIONS / REGIONAL ENTITIES / STANDARD SETTING ORGANIZATIONS
America's Health Insurance Plans (AHIP)
ASC X12
Blue Cross and Blue Shield Association (BCBSA)

Other Dental Plans Association

Health Level 7 (HL7)
Healthcare Association of New York State
Healthcare Billing and Management Association
LINKUS (Initiative of GNYHA)
National Committee for Quality Assurance (NCQA)
National Council for Prescription Drug Programs (NCPDP)
NI Stone (MED/SHIP NY Affiliates)
Private Sector Technology Group
Utah Health Information Network (UHIN)

GOVERNMENT AGENCIES

Louisiana Medicaid - Unify's
Michigan Department of Community Health
Minnesota Department of Human Services
Oregon Department of Human Resources

OTHER

Omega Technology Solutions
PNC Bank
PricewaterhouseCoopers LLP
PROVIDERS
Adventist HealthCare, Inc.
Catholic Healthcare West
Cedars-Sinai Health System
Healthcare Partners Medical Group
Mobility Medical, Inc.
New York-Presbyterian Hospital
North Shore-LIJ Health System
Physician HealthCare Network, PC
Spectrum Laboratory Network
University Physicians, Inc. (University of Maryland)

VENUERS / CLEARINGHOUSES

CareMedic Systems, Inc.
Electronic Data Systems (EDS)
Electronic Network Systems, Inc. (ENS)
(an Ingenix Division)
First Data
Gateway EDI, LLC
Healthcare Administration Technologies, Inc.
IBM Corporation
Ingenix
InterMed
iPay Gateway
National Account Service Company (NASCO)
NextGen Healthcare Information Systems, Inc.
Paycom, a Mays Company
Records Technology, Inc.
Secure EDI Health Group, LLC
The Trietto Group, Inc.

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for Information Exchange

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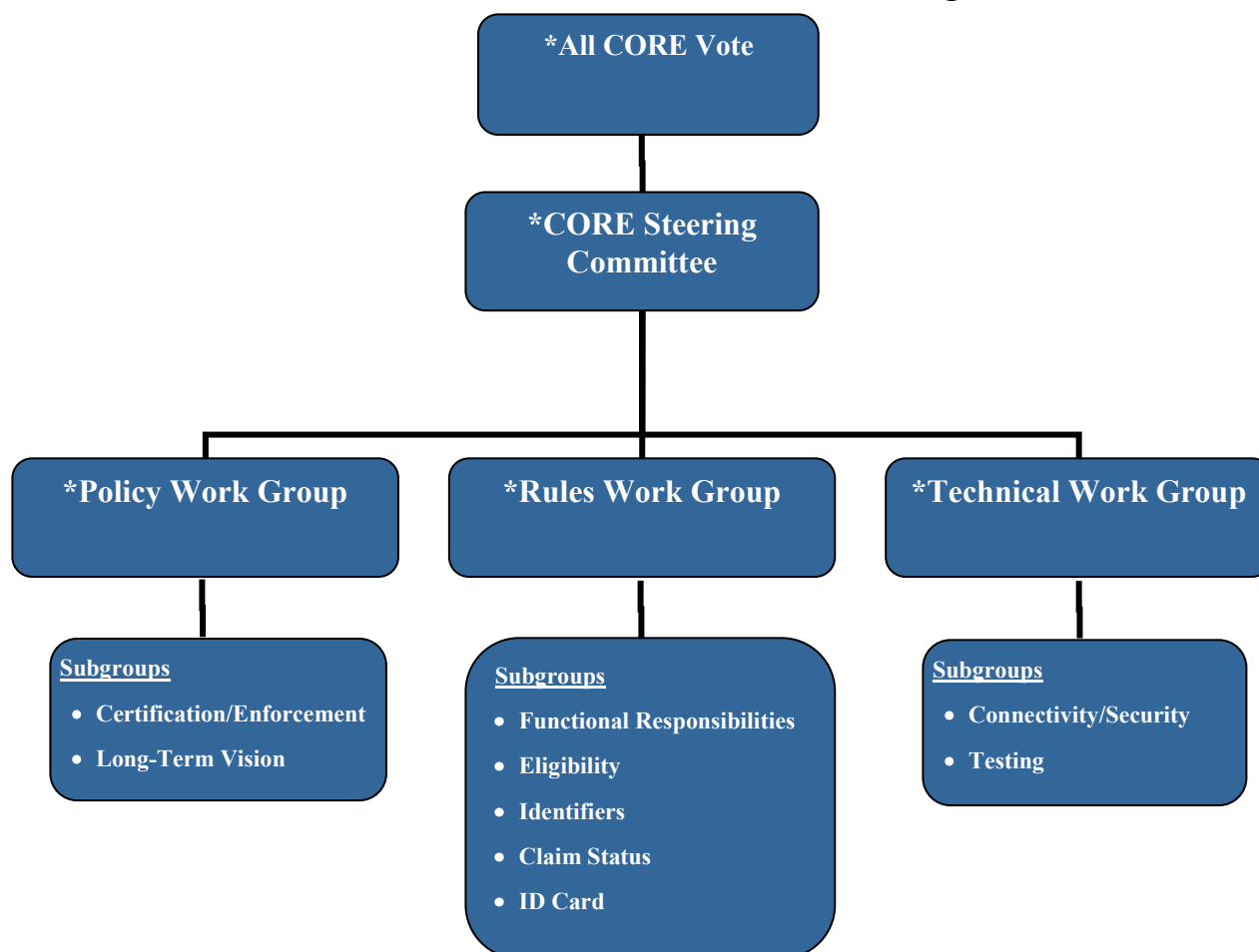
The CORE Structure

CORE is built around its integrated model that recognizes interdependencies between the operating rules and the affiliated components:

- Rule and testing requirement writing that is supported by both research and development, and design and voting policies that are guided by established Governing Procedures
- Education and outreach that helps to inform the rule writing direction as well as those not currently participating in CORE
- Certification that incorporates the interdependencies of the rules to achieve a manageable process.

The role of CAQH within the CORE structure is exclusively to provide facilitation and administrative services. The CORE operating rules are developed using a transparent process, by and through a defined set of Work Groups and Subgroups. The rules are approved through a multi-stakeholder voting process with several steps. The voting structure is presented in Exhibit 3 below.

Exhibit 3: Structure of Rule Writing



*Chair, Vice Chair, Work Group Chairs, At Large Members from Health Plans, Vendor and Providers, plus Ex-officios from CAQH management, SDOs, WEDI, CMS, and NACHA

Education and outreach is managed by internal CAQH staff (communications and project managers) who offer direct feedback and insight into the rule writing process, assuring alignment with guiding principles -- such as coordination with other industry efforts.

Certification is managed by assigned CAQH staff, who guide interested entities through the multi-pronged CORE certification process established by the CORE participants.

CORE Guiding Principles

Maintaining adherence to a set of Guiding Principles has been essential to the development of CORE operating rules.

Early in the development of CORE, a set of Guiding Principles were created and agreed upon by all CORE participants. The existence and regular review of these principles has ensured that the CORE rules stay focused on the intended goals.

CORE key Guiding Principles include:

- To promote interoperability, rules will be built upon HIPAA and other standards; and CORE will coordinate with other key industry bodies, e.g., the Blue Cross and Blue Shield Association Blue Exchange.
- CORE does not create or promote proprietary approaches to electronic interactions/transactions.
- All stakeholders are key to the success of CORE; no single organization, nor any one segment of the industry, can do it alone.
- Whenever possible, CORE uses existing market research and proven rules. CORE rules reflect lessons learned from other organizations that have addressed similar issues.
- CORE will not be involved in trading partner relationships, and will not dictate relationships between trading partners.
- All CORE recommendations and rules will be vendor neutral.
- Where appropriate, CORE will address the emerging interest in XML, or other evolving standards.
- CORE rules will support the Guiding Principles of the NHIN.
- CORE rules create a base and not a “ceiling” – entities are encouraged to go beyond the rules.
- CORE rules address both *batch* and *real-time*, with a movement towards real-time.
- All of the CORE rules are expected to evolve in future phases.

Area-specific Guiding Principles add further support for the CORE mission and vision.

Many of the CORE Subgroups, such as Certification and Testing, have complemented the main CORE Guiding Principles with area-specific Guiding Principles that address the intended goal or

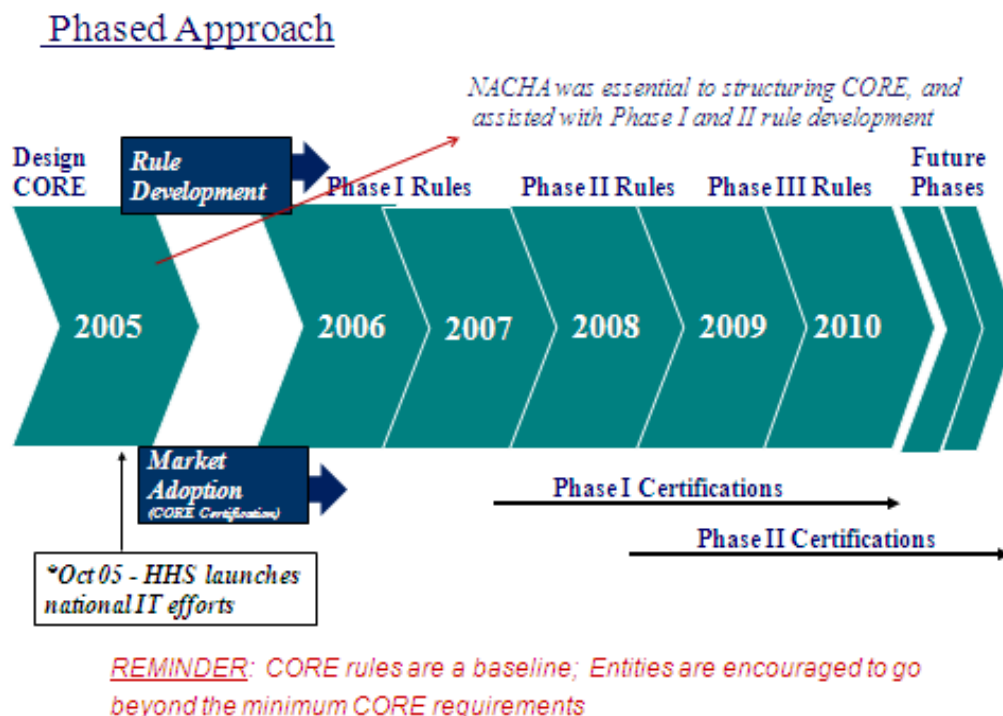
goals of their group. Examples of area-specific Guiding Principles adopted by the Certification and Testing Subgroup include the following:

- CORE will not certify phases that CORE has not clearly defined and voted upon.
- Certification will be available for both real-time and batch processing. However, if an entity does not support batch transactions, it will not be required to comply with the batch rules. An entity that supports both real-time and batch will be required to comply with rules for both. The test scripts allow for the ability to test for both types of processing for each rule.
- Entities seeking CORE certification will be required to adopt all rules of a phase that apply to their business and will be responsible for all their own company-related testing costs. CORE-certified entities may work with non-CORE-certified entities if they so desire.

Timeline, Phases, and Scope of the Phases

Working in phases provides a milestone-driven roadmap for success. The magnitude of the effort required in writing operating rules for healthcare administrative processes is significant -- and there is no “magic bullet.” As outlined in Exhibit 4, the CORE operating rules have been developed in phases through the use of an iterative process, with each phase building upon the other and providing greater value while addressing new innovations. Keeping the CORE long-term vision in view, the phases emphasize a balance between setting aggressive and meaningful milestones while recognizing that all entities are managing multiple priorities.

Exhibit 4: CORE Phases to Date



The scope of each phase is critical. To begin the process of creating national operating rules, the scope of the CORE Phase I rules was guided by CAQH with input from the initial participants. Moving forward, the scope of the CORE Phase II and Phase III rules have been determined by the CORE participants through an open process in which a roadmap of options from the Long-Term Vision Subgroup was supplemented by proposals from any and all interested CORE participants. The proposals were then prioritized according to consensus-based support from the CORE participants; techniques such as multi-voting and on-line surveying were applied to gather insight from the majority of CORE participants.

To offer one example, the Phase II inclusion of the status of a patient's year-to-date deductible, rather than standard paper EOB, was driven by provider and health plan interest in reducing the cost associated with provider inquiries regarding patient financial responsibility.

After the high-level scope of a phase is determined, the assigned Subgroups and Work Groups completing the detailed rule writing process are charged with defining the rule requirements that will address the charge assigned to them. For example, in Phase I the process of gaining agreement on the definition of real-time eligibility was the responsibility of CORE participants via the rule writing process.

CORE Participants

CORE participants include entities from all segments of the health care industry, and any entity is welcome. CORE participants include providers, vendors, CMS and other government agencies, associations, regional entities, standard-setting organizations, and health plans maintaining eligibility/benefits data for over 150 million lives. This includes almost 75 percent of the US commercially insured, as well as Medicare and state-based Medicaid beneficiaries.

The CORE participants determine the scope of the CORE rules, the CORE policies, and the strategic direction. Each participating entity makes a voluntary decision to become CORE certified or a CORE endorser depending upon their type of organization. Upon becoming a CORE participant, an organization is welcome to participate in the rule writing effort for any rule that is under development. Participants are a mix of those entities that can become CORE certified and those entities (like standard setting organizations) that can advise on the process of creating industry operating rules. See Appendix B for a list of the CORE participants, and Exhibit 5 for a summary.

Exhibit 5: CORE Participants Breakdown by Certification or Endorsement

	CORE participating organizations
Total number of organizations	116
Percentage of participating organizations that can become core endorsers (entities who don't have systems to certify)	36%
Percentage of participating organizations that can become CORE certified (Phase I or II)	64%

Cost for participation in CORE. CORE participation fees are kept low to encourage participation, especially for providers, government entities, and SDOs. The cost for participating in CORE is based upon an annual stakeholder-specific participation fee. The annual fees range from no charge (for government entities and SDOs) to an upper limit of \$6,000 per annum for health plans or vendors with \$75 million and above in net annual revenue. See Appendix C for an outline of the participation fees by category.

Benefits of participation in CORE. CORE participants can take part in any CORE Subgroup or Work Group and thus help develop the CORE rules; they also vote on the CORE rules according to their stakeholder type. Additionally, they are invited to actively contribute to CORE research and development activities, including ROI studies and outreach such as presenting at state-based meetings or national conferences.

The CORE Rule-Writing Process

The CORE rule-writing process embraces adaptation to feedback, industry coordination, and interdependencies. As outlined in Exhibit 6, there are multiple stages in the development of each CORE rule before it is submitted to the official voting process.

Exhibit 6: Rule Development Process (Before Voting)



Each individual operating rule crafted by the CORE participants is developed based upon extensive market research – including a gap analysis of relevant standards and other industry efforts. After a lengthy and thorough research stage is complete, a draft business case is developed.

Example of Research:

- CORE Phase I and Phase II Patient Identification Studies, funded by the California Healthcare Foundation, provided the key drivers for the CORE Phase II rules on patient identification.

Example of Business Case Development:

- The CORE Phase II Connectivity Business Case placed considerable weight on aligning with the national connectivity effort, e.g., NHIN, and therefore included some items in the CORE rule requirements for Phase II while deferring others due to overall market maturity.

Internal operations support interdependent process. The multiple Subgroups developing separate, but complementary rules, follow similar policies and procedures with regard to operationalizing their tasks:

- The Subgroups meet every two weeks and the Work Groups meet every month. At every meeting there is a clear set of goals, guiding principles, and deadlines that are driven by the group work plan and charge. Prior to each meeting, CAQH staff are responsible for drafting meeting minutes and working with the Subgroup or Work Group chair(s) on the agreed upon agenda.
- Almost all meetings are held by conference call, using webinars whenever beneficial; a conscious decision was made not to rely upon in-person meetings, given economic constraints.
- The status of ongoing efforts of all other CORE groups are briefly reviewed at every meeting, reminding the participants that their rule is part of the larger whole.
- CAQH staff and consultants typically have three or four team calls to review the draft materials in progress for a specific CORE group. A wide range of techniques are used to gain input at all stages, with heavy emphasis on blinded and aggregated feedback that requires every comment to be documented and consensus taken on how to proceed. Additionally, emphasis is placed on ensuring that there are a wide range of stakeholder types available for input on each rule. For example, CAQH staff frequently contacts provider associations to request their assistance in gaining feedback on a draft rule requirement.

Throughout the process, a systematic tracking of interdependencies among the various rules is one of the most important tools maintained by the CAQH staff. As an example, a key criterion for the draft CORE Phase III Connectivity Rule was the obligation to meet the needs of v5010 transactions.

Voting on Rules, Including Testing Requirements for Each Rule

The CORE rule voting process is transparent and inclusive, and highlights the roles of those who need to implement the rules: health plans, vendors, and providers.

To create meaningful rules, CORE designed its voting process to include robust vetting by all participants. No specific set of rules moves to the next level of voting until that complete set of rules has been approved at the previous level. For every level, CAQH staff are responsible for

distributing ballots, summarizing votes and comments, and sharing the results with the appropriate body so they can discuss unresolved issues. Every comment is documented and reviewed by the respective body. The quorums selected mirror those used by other collaborative industry efforts such as NACHA – The Electronic Payments Association. Edits are made based on the comments received, and iterations of the rules based on the comments have proven invaluable to creating substantive rules that support existing standards and coordinate with other industry efforts.

Not all participating entities choose to vote on the rules, and many participants only vote if they have a concern. This said, CORE has strict quorums that were developed by lessons learned in other settings.

Exhibit 7: CORE Voting Process

CORE Body	Governing Procedures for Voting
Level 1: SUBGROUPS	Not addressed in governing procedures, but must occur to ensure consensus building and to gain feedback on detailed rules.
Level 2: WORK GROUPS	Work Groups require a quorum that 60% 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.
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.
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 the transactions) be present at the meeting. With a quorum, 66.67% vote is needed to approve a rule.

It is important to note the following points with regard to approval or non-approval of the CORE rules:

- Neither the CAQH Board nor CAQH staff have any veto or voting power related to the CORE rules.
- In the current CORE process, every voting entity receives one vote; size or entity type does not matter.
- Any CORE participating organization can join any CORE Subgroup or Work Group, and therefore have the right to vote on the products of that Subgroup or Work Group.
- On the final CORE “membership” vote, entities that do not implement the rules and thus will not need to live by the rules, e.g., associations, SDOs, large consulting firms, small consulting firms, etc., do not have a vote.

The CORE Certification and Testing Process

An integrated certification process is critical to successful market implementation of the CORE Operating Rules, and every stakeholder type touching the data must follow the rules.

Established in 2007 as a vehicle for facilitating the implementation of CORE Phase I rules (and their testing requirements), the CORE certification process now extends to the CORE Phase II

rules (introduced in 2009), and is anticipated to support market adoption of the CORE Phase III rules in 2010.

The CORE Certification process was established to validate voluntary implementation of CORE Operating Rules by: health plans, vendors, clearinghouses/electronic health networks, and providers.

The actual CORE Certification and Testing Policy is part of the CORE rules and has four components, each of which has steps which must be completed prior to moving on to the next component:

- Pre-certification Planning and Systems Evaluation.
 - CAQH has developed a set of tools that entities can use to gauge their applicability and readiness to meet the certification.
- Signing and Submitting the CORE Phase I and/or II Pledge/Addendum by an executive-level staff member.
- CORE Certification Testing with a CORE-authorized testing entity.
- Applying for the CORE Seal.
 - Entities submit a report that demonstrates the successful completion of testing based on their stakeholder-type, along with supporting documentation that is required by the CORE Certification Policy and Seal Application.
 - CAQH staff review completed applications within a 30-day time period for rule applicability, successful test script completion, other required documentation such as HIPAA attestations, and any other statements that demonstrate an entity's implementation of CORE Operating Rules.
 - If successful, the entity will earn a CORE Certification Seal for the CORE Phase for which it applied.

As CORE represents a phased approach to operating rule adoption, an entity must complete the phases in order, or simultaneously. The CORE documents required to complete each component step are indicated and accessible through links on the CAQH website.

Rules on certification include key policies. To address the realities of the marketplace, the CORE rules on certification incorporate policies that include items such as a CORE exemption policy for health plans that are conducting IT system migrations and/or completing a merger or acquisition.

Cost of certification. The fee for the CORE Seal is based on a stakeholder-specific fee scale. This fee is a one-time cost for each phase of CORE certification, unless an entity becomes de-certified. The fees range from no charge for government entities, to \$6,000 for health plans or vendors with \$75 million and above in net annual revenue. See Appendix C for an outline of the costs.

Support of non-duplication and collaboration in the marketplace. To support the concept of non-duplication of resources, CORE certification has been recognized as complementary to accreditation and certification programs offered by organizations such as the Electronic Healthcare Network Accreditation Commission (EHNAC). CAQH involvement with these

organizations has enabled stakeholders to achieve key milestones and meet complementary requirements within a larger industry framework – understanding that certifications will not be overlapping. Demonstrations that included CORE certification by the Medicaid Infrastructure Technology Architecture (MITA) and the NHIN CONNECT Gateway (at industry events like the HIMSS IHE Interoperability Showcase) illustrate the capability for CORE certification to contribute to the transformation of the marketplace.

Benefits of having a certification seal. CORE certification provides useful tools, such as the CORE Seal, that enables entities to demonstrate their achievement of streamlined information exchange. Certified vendors, in particular, have used the CORE certification process to improve their time-to-market with new products, streamline their data handling and connectivity processes, and deliver added value to their provider clients. Providers, in turn, can look to their vendor, or become certified directly.

CORE-Authorized Testing Entities

CORE testing is conducted by authorized, third-party testing vendors that are approved by CAQH via comprehensive alpha and beta testing. For example, the initial set of vendors seeking to be authorized included three vendors, only one of which was approved during the first evaluation period.

These authorized testing vendors must use the approved test suite with every stakeholder being tested, thereby treating each stakeholder equally. The primary components of testing include: transaction-based, simulated testing of data exchange, testing of system functionality (i.e., electronic), and manual uploading of specified documentation (e.g., system logs) to assist with verifying rule requirements.

The cost for CORE certification testing. The authorized testing entities determine how much to charge entities for the testing. To date, one of the two authorized testing entities has decided to require no fee for certification testing. The other entity charges a one-time fee by stakeholder type.

CORE Certifications and Endorsements to Date

Through the voluntary model, certification or endorsement is not required for CORE participants; however, more than 43% of the participants have pursued certification or endorsement for their organization. Exhibit 8 provides some detail on participants who have implemented.

Exhibit 8: CORE Implementation

Percentage of Total CORE Participants That Have Implemented CORE Operating Rules Through Certification	
Percentage that are CORE Phase I Certified	44%
Percentage that are CORE Phase I Certified + Committed	47%
Percentage that are CORE Phase II Certified	19%
Percentage that are CORE Phase II Certified + Committed	35%

CORE Certifications. To date more than 50 organizations – a mix of large vendors, plans, and providers -- have earned the Phase I Seal, and more than half of these entities have already achieved or are committed to achieving Phase II Certification. Phase I certified entities are providing and exchanging robust and consistent data for over 85 million health plan members located throughout the US.

Exhibit 9: Certifications Impact on Commercially Insured Lives

Percentage of Total Commercial Market Share Impacted	
Percentage participating	75%
Percentage that are CORE Phase I certified (with commitments)	55%
Percentage that are CORE Phase II certified (with commitments)	50%

Endorsements. More than 30 organizations that do not use, create, or transmit eligibility, benefits, and/or claim status data are endorsing CORE.

See Appendix B for a list of CORE certified entities, CORE endorsers, and entities committed to CORE certification.

Tracking of ROI

Tracking of and communicating ROI is a key concept in the CORE mission and vision.

One of the CORE guiding principles is to track the effects of the adoption of the operating rules. Highlights of the results from an in-depth study of the adoption of Phase I rules conducted by IBM Global Business Services in 2009 included the following:

- Adoption leads to a 10-12% reduction in claim eligibility denials for participating providers, with a 24% increase in the number of patients verified.
- Industry-wide implementation of CORE Phase I could save the industry an estimated \$3 billion over 3 years.

The study reviewed CORE certifications by health plans covering over 33 million lives, a range of vendors and a range of providers, including academic medical centers and an ambulatory outpatient center.

For greater detail on the conduct and results of the Phase I Outcomes Study, see Appendix D.

In addition to information about the financial impact of the CORE rules, data from such studies assist CAQH in encouraging certified organizations to communicate the considerable benefits and cost savings accrued from working collaboratively through operating rules. The data also provides information that stakeholders can use to engage and educate other members of their community about the benefits of adoption.

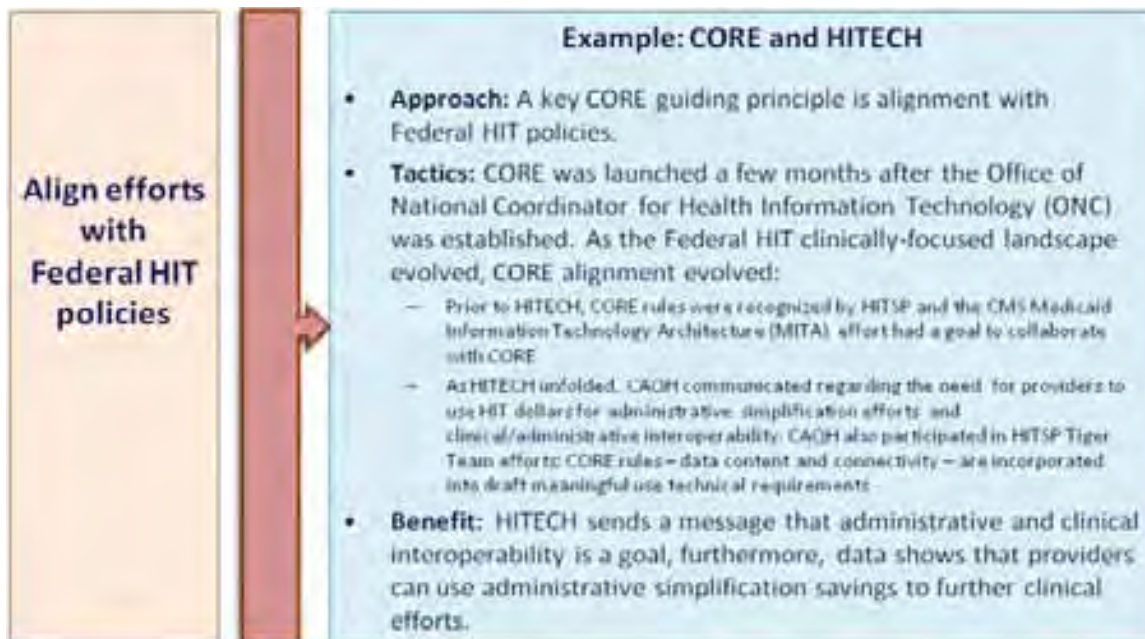
Education and Outreach

Collaboration and alignment has been embraced with regard to both education and outreach.

Over the past five years, CORE participants and CAQH staff have presented CORE in over 60 significant venues such as the Institutes of Medicine (IOM) or Medicaid-specific conferences. These venues offered the opportunity to learn from market experience and understanding, while also identifying areas for collaboration. CORE also has conducted many technology-enabled education sessions with partners such as WEDI and HIMSS. WEDI audiocasts have ranged from a discussion on data content to connectivity to trading partner alignment. Moreover, CORE has carried out many demonstrations – such as demonstrating with CMS at the 2009 HIMSS IHE on CORE rules and 5010 testing – that focus on educating the industry on the importance of industry alignment.

Benefits of outreach: Recognition of the CORE Operating Rules. Beyond their application by certified entities, the CORE Phase I and Phase II Operating Rules were incorporated into the Healthcare Information Technology Standards Panel (“HITSP”) specifications. HITSP was created by ONC to promote interoperable technology in healthcare. Additionally, a number of states (including Colorado, Ohio, Texas, and Virginia), have recommended the application of the CORE rules. Other states (e.g., Minnesota, Oregon and Utah) have incorporated aspects of the rules, such as the data content or connectivity rules, into their initiatives. Moreover, Medicaid strategic plans for health information exchange have also recognized the potential value of collaborating with CORE.

Exhibit 10: CORE Alignment With HITECH



Leadership, Expertise, and Dedicated Resources

Significant leadership, expertise, and the availability of dedicated resources have been important to facilitate the development of CORE.

Without dedicated resources, CAQH believes that CORE would not have been able to make the progress it has, nor to do so in a span of just five years. We strongly urge the industry to consider the critical importance of the breadth of resources brought to this initiative by the wide range of stakeholders:

- Participants and volunteers:
 - The involvement, participation, and commitment of senior executives from health plans and other organizations has encouraged CORE to maintain a strong focus on the intended mission and vision, while also delivering on its commitment to track impact; this level of senior leadership has driven early adopters and/or research pilot participants.
 - The involvement of other industry leaders, including those from WEDI, ASC X12, and others.
 - The expertise and time given by staff members of participating organizations.
- Dedicated, paid staff:
 - A wide range of administrative, communications, project management, and technical staff have been retained by CAQH to facilitate CORE. CAQH has more than seven full-time people who are solely devoted to moving the CORE initiative forward.
- Technical and strategic expertise:
 - CAQH frequently identifies very specific technical and strategic expertise, and contracts with that expertise to support the rule writing, outreach, and certification

projects. Prime examples include experts needed to support development of the Connectivity Rules and those needed to research the goals of certain states with regard to administrative simplification and HIEs.

Budget

CAQH covers over 85% of all CORE expenses.

CORE generates some amount of revenue from participation and certification fees, as previously stated. However, there is no cost to access the rules; they are available on the CAQH Website and can be accessed by any interested organization. CAQH believes that this approach supports industry adoption.

CORE expenses can be categorized into six areas:

- Rule writing design and support
- Certification support
- Education/outreach
- Communications
- Legal
- Technical support

ROADMAP: SCOPE OF THE CORE RULES TO DATE

All Phase I, II and draft Phase III rules take the same approach. They apply a range of complementary policy, business and technical requirements that speak to the realities of how health plans and providers can use electronic transactions to move the industry roadmap forward while maintaining current operations.

All Stakeholders are Specifically Addressed in the Rules

CORE Rules specify requirements for each type of stakeholder that has a role in the flow of the data, which include the testing requirements for each rule. These stakeholders include health plans, vendors, clearinghouses and large providers. It is expected that, as with HITECH Meaningful Use, smaller providers will rely upon their vendors; but the providers need certification to guide their decisions. The rule requirements and policies drive the conformance¹ language for each stakeholder, and then a test suite for the Phase is written and approved by the CORE participants with tests specific to each stakeholder role and functions.

Who Created the Rules?

With regard to the current CORE rules, all of the participants were critical throughout rule writing. This said, depending upon the rule, certain organizations were essential at certain stages. For example:

¹ Conformance is the testing that each stakeholder completes to demonstrate that its system complies with the rule requirements specific to its role.

- X12 was a critical contributor and provided excellent feedback on all of the CORE rules, based on X12 standards. X12 participated in the rule balloting at several stages throughout Phase I and II, and has been following Phase III closely, including sending Phase III draft work products to the X12 committees for review. CAQH staff has been attending all X12 meetings to ensure ongoing coordination and awareness.
- Technology savvy health plans and vendors were critical during the Connectivity Rule writing, as Connectivity is an area in which many healthcare entities do not have specialized skill sets.
- Provider involvement – from both individual hospitals as well as national associations – has been essential for all rules, and especially those related to data and policies in which the CORE Subgroup and Work Groups needed to consider overall business requirements from a market perspective.

A Roadmap: High-Level Overview of the Phase I, Phase II and draft Phase III Rule Requirements for Eligibility and Claims Status²

Incremental Milestones that Support a Long-term Vision. Within the last five years, the CORE rule writing process has served to create a set of robust requirements that are being implemented across the country in a wide range of care delivery settings. There is no doubt that more can be accomplished, however, entities need to agree upon the content and timing of the milestones that will move the industry as quickly as possible to achieve its long-term goals.

Exhibit 10 provides an overview of the requirements the CORE participants have agreed upon with regard to eligibility and claims status.

Exhibit 10:
A Road Map: CORE Rules Specific to Eligibility and Claims Status³

CORE Rule Requirement Phase I, II & III	Transaction(s) to Which Requirement Applies		Requirements included in current Federal regulations (including v5010 of HIPAA)?	Critical Decisions Made by CORE: Industry Roadmap	Key Benefits to Market
	Eligibility ⁴ (X12 270/271)	Claims Status (X12 276/277)			
Real-time Response Time	X	X	No; ACA legislates need	How to define real-time and response time.	Current Eligibility Data at or before the time of service; setting expectations.
Batch Response Time	X	X	No	How to define turnaround time.	Data within a uniform predictable time frame; setting expectations.

² Note: Draft CORE Phase III rules also address Prior Authorization, Remittance and Claim Acknowledgements; however, given the focused responsibility of the NCVHS, CAQH testimony is highlighting the CORE rules to date on Eligibility and Claims Status.

³ Ibid.

⁴ CORE Phase I and II rules were written with v5010 in mind, while draft Phase III was written following release of v5010. The Phase I and II rules have been reviewed for v5010 compliance and adjustments have been identified. See Appendix D.

CAQH CORE Testimony to NCVHS on Operating Rules (July 20, 2010)

CORE Rule Requirement Phase I, II & III	Transaction(s) to Which Requirement Applies		Requirements included in current Federal regulations (including v5010 of HIPAA)?	Critical Decisions Made by CORE: Industry Roadmap	Key Benefits to Market
	Eligibility ⁴ (X12 270/271)	Claims Status (X12 276/277)			
System Availability	X	X	No	How to begin to define system availability in a market where health care delivery is 24x7 in a market paradigm that is currently 9x5 to 24x7.	Administrative data availability that aims to align with care delivery hours.
Acknowledgements For Real-time	X	X	No; ACA legislates need	How to gain market adoption of X12 and WEDI work.	Addressing “black-hole” of no response, and reducing need for sending several inquiries on same question.
Acknowledgements for Batch	X	X	No; ACA legislates need	How to gain market adoption of X12 and WEDI work.	Addressing “black-hole” of no response, and reducing need for sending several inquiries on same question.
Acknowledgements for Where Claim is in the Adjudication Process		X	No; ACA legislates need	How to gain market adoption of X12 and WEDI work.	Addressing “black-hole” of no response, and reducing need for sending several inquiries on same question.
Connectivity, Security and Authentication	X	X	No	Setting stage for change in Phase I, and making significant improvement to common industry methods in Phase II. Methodical analysis and alignment with ONC clinical vision for connectivity, e.g. NHIN CONNECT /Direct, as well as other industry efforts such as HIMSS’s IHE.	Payload agnostic (can use method to send any data, e.g. clinical, administrative). Safe Harbor to directly connect to trading partners (plug and play goal). Supported by HITSP for administrative transport; incorporated into X12/WEDI real-time adjudication connectivity method; supported by NCPDP on condition of adjustments to further address pharmacy.
ID Card	X	X	No; ACA references potential need	How best to support WEDI work in human-readable data elements given electronic requirements did not have long-term alignment on impact and expectations.	For patient identification, ID card data elements are needed. Incremental step towards long-term goal of integrated, electronic health ID card.
Patient Matching	X		No	Support for X12 standards on error codes.	Fewer eligibility rejections for patient not-found, resulting in more accurate claim submissions.
Companion Guide (flow and format)	X	X	No	Developed with WEDI. Agreeing operating rules drive data content and data flow, while Companion Guide drives how to present requirements and what requirements need to be presented.	Providers have ability to expect the same Table of Contents when reviewing a payer Companion Guide. Content becomes more consistent and easier to read and use.

CORE Rule Requirement Phase I, II & III	Transaction(s) to Which Requirement Applies		Requirements included in current Federal regulations (including v5010 of HIPAA)?	Critical Decisions Made by CORE: Industry Roadmap	Key Benefits to Market
	Eligibility ⁴ (X12 270/271)	Claims Status (X12 276/277)			
Patient Financials (Co-pay, deductible, YTD deductibles, in/out of network variances, out of pocket maximums) for over 50+ services (benefits)	X		No; ACA legislates need	Alignment on services like laboratory and x-ray. How best to support X12 work. Incremental additions in Phase I, II and draft III. Not addressing timely enrollment responsibility role of employers and health plan sponsors.	Delivery of financials impacting provider bad debt. Adds significant ROI to use of v4010 and v5010 for providers, patients and health plans.
Patient Coverage reporting that is Service Type (e.g., benefit) Specific	X		None required in v4010, Only 10 of the 50+ CORE required services (benefits) required in v5010	Developing operating rules that required this prior to v5010 being mandated.	High volume services can be verified before or at the time of service.
Using Common Business Scenarios to Communicate the Most Common Claims Status Codes		X	No	Applying CORE-approach towards extensive CORE participant research and analysis of internal Business Scenarios .	Entities can place resources towards the value of learning a consistent set of industry-wide business scenarios along with consistent use of claim status category and claim status code combinations.
Consistent Delivery of a Agreed upon Set of Claims Status Codes		X	No	Incremental additions in Phase II and draft Phase III.	High expectations on messages critical to managing claims and denials.
Uniform and Objective Certification and Testing Requirements	X	X	No	Policies recognizing market realities such as mergers/ acquisitions, system migrations, range of trading partners, etc. HIPAA compliance assured through attestation; CORE testing and certification focused on CORE rules compliance and not HIPAA compliance.	Identifying and providing a testing approach to CORE rule compliance that is Web-based, online, and consistent at low or no cost. Provides every entity a tool to know if their system changes worked, and if their trading partners are also embracing changes. Concrete tool for use in RFPs and marketing/sales outreach.

Rules Included in Each Phase

Phases Build Upon One Another. Given the wide range of maturity in the marketplace, some entities have decided to certify on both Phase I and II and are prepared to complete Phase III testing immediately, while others are working through the phases by starting to educate themselves on Phase I. There is significant detail behind each of these rules, and the progress achieved by the CORE participants has demonstrated that the industry is prepared to agree upon an integrated set of operating rules.

Exhibit 11: CORE Phase Overview Summary

CORE Phase I ✓Approved ✓Implemented	<p>Phase I – which has 14 rules/policies including testing - are helping:</p> <ul style="list-style-type: none"> • 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	<p>Phase II – which has 11 rules /policies including testing - expand on Phase I to include:</p> <ul style="list-style-type: none"> • Patient accumulators (remaining deductible) • Rules to help improve patient matching • Claim status “infrastructure” requirements (e.g., response time) • More prescriptive connectivity requirements with submitter authentication
CORE Phase III ✓In development	<p>Draft Phase III rules – which will have at least 10 rules/policies including testing - focus on:</p> <ul style="list-style-type: none"> • Claim status data requirements (276/277), and Claim acknowledgement • Claim Payment/Advice (278), Prior Authorization/Referral (835) infrastructure requirements • Standard Health Benefit/Insurance ID Card • More prescriptive connectivity requirements as well as digital authentication • More eligibility financials

Why Items Were Deferred

Finding Balance and Agreeing to Priorities. To obtain industry-wide change, there must be a constant balancing between an aggressive set of operating rules and timing for adopting the rules. This balance must recognize the limits of human, strategic and technical resources and the interest in research-based change. Each of the areas covered by the CORE Rules was selected following significant debate on prioritization and market readiness. For the industry to address the long-term roadmap, priorities must be selected and managed to completion. Accomplishing the significant change realized by the CORE rules to date was enabled by the multi-phased development based on key milestones linked to identified value.

Key Areas for Market Impact: Public and Private Payers

The CORE mission and vision supports a provider being able to conduct all administrative transactions, using the system of their choice, for any payer. This vision requires that considerable collaboration occur across the payer community, recognizing the providers do not want different approaches by payers based on their public or commercial status.

Example: Medicaid. CORE has been working to align its rules with the strategic direction for Medicaid information systems being developed by the Medicaid Information Technology Architecture (MITA), which is a phased approach to bring interoperability and administrative simplification to Medicaid. At the HIMSS 2010 IHE Showcase, MITA demonstrated its use of the CORE rules and their compatibility with NHIN CONNECT.

Example: Medicare. Throughout the history of CORE, the Medicare Business Office and its eHealth Office have both been strong contributors to the rule development. In 2008, CAQH and CMS collaborated on a comparison of the CORE eligibility rules and the Medicare eligibility requirements, identifying where gaps existed and where CORE rules did not apply.

Key Areas for Coordinated Service Area Reporting

CORE supports a provider conducting all administrative transactions, for any health plan, no matter the service. This requires that considerable collaboration occur across the sectors of healthcare.

Example: Pharmacy. One of the CORE Guiding Principles is to not duplicate what already exists. Over the past several years CORE has aimed to align with pharmacies through work with both NCPDP and Surescripts, which is CORE-certified. Collaboration has occurred where cross-over is most obvious:

- Service-level coverage: CORE Phase I supports coverage reporting using the 270/271 for pharmacy service type code (88).
- Connectivity: Agreed that the industry will benefit by entities adopting a common connectivity framework over which health information exchanges can occur. We partnered to jointly complete several actions to meet this goal, using the Phase II Connectivity Rule as the foundation.
- ID cards: Patients and providers would like an integrated ID card for medical and pharmacy. Currently there are several questions the medical industry needs to answer in order to align with decisions already made by and operationalized in the pharmacy industry, e.g., magnetic strip and the role of health plan identifier. NCPDP was extremely helpful as CORE determined the appropriate scope for the draft Phase III ID Card Rule.

Moving forward it will be essential that the administrative simplification operating rules required by ACA acknowledge the considerable work already conducted by NCPDP to automate the pharmacy industry. For the 270/271, NCPDP has a pharmacy-specific Implementation Guide.

Benefit of the Integrated Rule Set

The interdependencies of the data, how it flows and how to build trust among the parties should not be underestimated. CORE lessons learned have shown that an integrated operating rule set is essential to ensure that complex, interdependent business functions are supported to achieve enterprise and trading partner goals. The CORE approach is based on coordinated processes to develop this complex set of integrated rules.

Whether it is ensuring that the Connectivity Rule can send the additional data driving reduction in phone calls, that the response time is not impacted by additional data, or that the testing approach provides a methodology to recognize the role of patient matching, no one operating rule can stand alone, just as no one entity can transform the industry alone.

THE CO-EXISTENCE OF STANDARDS AND RULES: CORE EXAMPLES

As already described, uniform standards and operating rules are separate but complementary efforts. The examples that follow illustrate how the CORE Operating Rules relate to the range of standards that required to make operating rules successful and to align the multitude of industry efforts focused on the same issues and concerns. The examples include:

- Non-mandated aspects of the HIPAA standards.
- Non-HIPAA mandated healthcare standards.
- Industry-neutral standards.
- Best practice guides developed in healthcare.

Even though there has been much work done to date, there is an ongoing need to collaborate on how these work products can lead to the development of realistic operating rules that provide for alignment of efforts and strategic milestones.

Example #1: CORE Rules and Non-Mandated Aspects of the HIPAA Standards

Eligibility: Driving ROI by providing key information.

Patient Financials: For the Eligibility transaction (270/271), neither v4010 nor v5010 require the use of a number of data fields that could reduce the cost of manual processes and reduce provider bad debt. These non-mandated data elements of transaction 270/271 are denoted “situational” data elements and include: in/out of network variances on benefit-specific coverage, co-pays, base deductibles, and YTD deductibles. The CORE rules require that health plans populate these situational elements with the appropriate data, thus ensuring that the provider has a more robust knowledge of the benefits available to the patient. In response to the CORE Operating Rules and resulting industry usage and comfort, v5010 did include some of the Phase I requirements for delivering benefit coverage, e.g., added yes/no benefit covered for seven services. In turn, the Phase I and II rules are removing these requirements to ensure non-duplication.

Service Type Coverage Detail: Additionally, CORE is supporting the delivery of this financial data for over 50+ high-volume service type codes (STC) that are in the 270/271 but are not mandated for use in either the v4010 or v5010. These high-volume service type codes were included in the CORE rules due to key criteria such as reduction in manual processes, and complementing industry efforts underway for delivery of data electronically, e.g., laboratory or x-ray results. To meet their full value, the STC need to be uniformly defined. CORE developed draft definitions for STC where they were not available, but noted in the CORE rules that ASC X12 had a key role in the creation of these definitions. To address this Phase I finding, ASC X12 decided in 2009 to create a new committee – separate from ASC X12. Once this new committee has completed its work, the definitions will be included in the standard and the operating rules will follow the standard.

CORE certification and testing in this area of claims status will be critical as this data is critical to providers.

Claims Status: Reducing Confusion by Providing Framework

Neither v4010 nor v5010 require consistent messages on the status of a claim via the 276/277 transaction. Specifically, the use of codes (Claims Status Category and Claims Status Codes) that reflect the most common reasons for the status of a claim, or the typical framework that drives the common business scenarios in which the claim status is derived, is not addressed. For example, v5010 has over 700 claim status codes that a health plan can choose from to report the status, but only three of these codes are required by the standard for use: a) Cannot provide further status electronically; b) For more detailed information, see remittance advice; and, c) More detailed information in letter.

After significant research, CORE Phase III developed rules to communicate the consistent use of the most commonly used codes and associated these codes with agreed upon common business scenarios as derived from surveying current approaches, a process which neither v4010 nor v5010 addressed.

CORE certification and testing in this area of claims status will be critical as this data is critical to providers.

Example #2: CORE Rules and Non-HIPAA Healthcare Standards

Acknowledgements: Addressing a “Black Hole” in Administrative Data Exchange.

Although acknowledgments are not mandated by HIPAA or other federal healthcare efforts, CORE has worked across its stakeholders to drive industry adoption for the consistent use of acknowledgments. CORE Operating Rules address both industry-neutral acknowledgments and healthcare-specific acknowledgments.

Acknowledgements provide both parties assurance that the use of electronic administrative data exchange is working for a given transaction. The CORE Operating Rules support acknowledgments in the areas in which the operating rules are focused, e.g. eligibility, claims status. For acknowledgments, CORE has sought to support the work already done by ASC X12, which wrote the standard, and WEDI.

CORE certification and testing in this area of acknowledgments has been critical to closing the “black hole” of unacknowledged inquiries.

Example #3: Non-HIPAA, Industry-Agnostic Standards

Connectivity: Promoting Interoperability. Connectivity is required to achieve real-time data exchange, and the Internet is an essential tool that can be used to accomplish this goal. Given the CORE focus to date (eligibility, claims status, referrals, and remittance), as well as its guiding principle to align with federal efforts, Phases I and II support standards developed by SDOs that have established national and international recognition, such as those of:

- The Internet Engineering Task Force (IETF).
- The Organization for the Advancement of Structured Information Standards (OASIS).
- The World Wide Web Consortium (W3C).

The CORE rule inclusion of the standards (SOAP, WSDL, SSL, HTTP, etc.) developed by these SDOs was guided by key criteria – such as clinical-administrative alignment, real-time data delivery, support for HIPAA mandates. The end results were rules that include policies and support for the phased adoption of these standards, thus addressing the maturity of the administrative data exchange ecosystem.

CORE certification and testing in this area of connectivity has been critical as providers, health plans, and vendors all need to connect to each other, and support the application of these standards to healthcare administration.

Example #4: Non-HIPAA, Non-SDO-Developed Implementation Guides

ID Cards: Recognizing the need for phases. WEDI, CORE, NCPDP, and many others support the vision of a common health identification card. The CORE Phase III rule writing process for this area aimed to support the use of the WEDI Health Identification Card Implementation Guide (2007), which incorporated the underlying ANSI INCITS 284 Identification Cards – Health Care Identification Cards (1997) standard.

After much analysis on the purpose of the ID card specific to administrative simplification, the draft CORE Phase III operating rule for the ID card requires the standard use of all nine human readable data elements – two of which are machine readable – and all of which assist with patient identification. The CORE rule did not require the use of the full WEDI guide for two main reasons: 1) the underlying standards were a decade old and the environment in which the guide was designed has changed significantly, and 2) specific to the health plan identifier standard included in the guide, there was no consensus on the expectations regarding use, and thus on the benefit to all impacted implementers, e.g., when and how routing of all healthcare transactions would be impacted.

CAQH is currently participating in the WEDI effort to revisit the goals that this effort aims to support. CORE certification and testing for the human readable data elements will be critical, as having consistent access to data that supports patient identification at the point of care can greatly benefit providers as they address coverage and benefit inquiries.

Cyclical Approach of Operating Rules and Uniform Standards

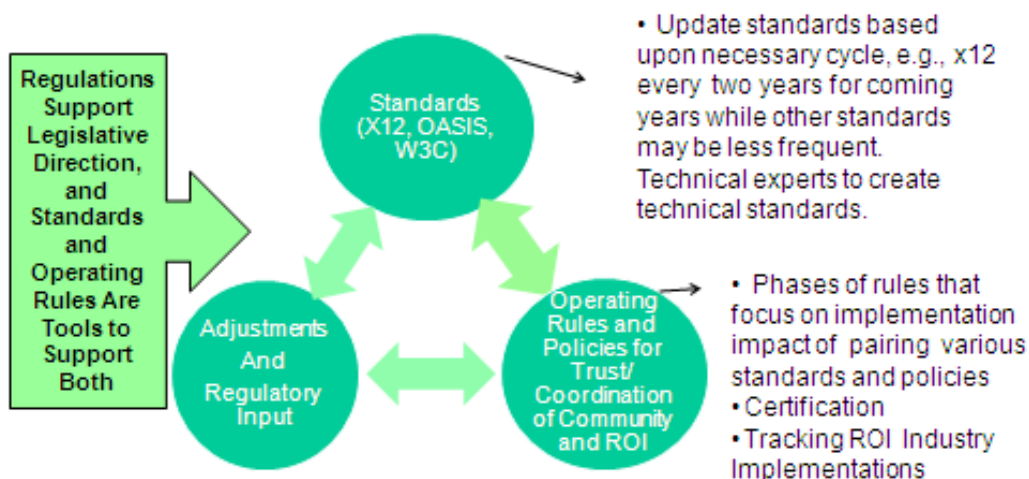
Based upon our experience to date we view, as presented in Exhibit 12, a cyclical approach to the relationship between operating rules and standards as being essential. An iterative sharing of experience and knowledge will best support data exchange.

Exhibit 12

Operating Rules Build on Regulations, Incorporate Various Forms of Standards and Establish Rules of the Road

It is critical that there is an ongoing feedback loop between rules and standards. Examples:

- CORE to X12: Experience with requiring X12 acknowledgements, definitions needed for X12 270/271 service type codes for which financials need to be delivered, critical mass use of YTD deductibles, in/out of network.
- X12 to CORE: Updated acknowledgements for batch/real-time and edits, AAA code changes
- NCPDP - CORE: Agreed industry will benefit from adopting a common connectivity framework over which health information exchanges can occur; NCPDP adopted, but required some adjustments to CORE Connectivity, e.g., address use of MTOM for real time to support transport of non-printable characters in the message payload.



A Non-Government, Industry-Based Entity for Operating Rules

SDOs and the standards they develop are critically important to achieving the goal of interoperability in the healthcare system. That said, to achieve true interoperability and administrative simplification, organizations in the healthcare industry must integrate standards developed by various SDOs -- recognizing their interdependencies as well as the overarching goals they aim to meet. When one SDO updates a standard or group of standards, other areas outside the purview of the SDO may also be affected.

V. Adaptation of CORE: Transition from a Voluntary to Mandatory Paradigm

As proud as we are of CORE's accomplishments, many of the CORE participants and CAQH recognize that the characteristics of the voluntary effort are different than those required of the new mandatory effort.

To align with the needs of the mandatory environment established by the ACA, CORE should be adapted. Those adaptations should include structural changes and expansion of available resources.

RECOMMENDED THEMES FOR IMPLEMENTING THE OPERATING RULES ASPECT OF ACA, SECTION 1104

Based upon the CORE lessons learned, discussions with CORE participants, discussions with members of the Reaction Panel expected to address this hearing, and other stakeholders with pertinent expertise, CAQH recommends that specific themes be embraced in implementing Section 1104:

Maintain Clarity of Purpose and Process

- Focus on the policy goals.
- Assume an ongoing iterative process – there is no silver bullet.
- Recognize and respect the different roles of standards and operating rules, and assure their integration.
- Align with the broader HIT environment.

Commit to a Strong Infrastructure

- Ensure a true, multi-stakeholder effort.
- Maintain transparency and consensus-based processes, especially voting.
- Prioritize education, given the significant number of new requirements and the changing paradigm.
- Pursue research and development to inform future phases of development and identify opportunities for industry alignment.
- Establish financial sustainability for the ongoing process.
- Recognize one entity responsible for all integrated aspects of operating rule development, user certification, and education – the various components of operating rules development and applications each have a purpose.

Respond to Realities

- Support adaptability.
- Recognize the compressed timeframes and competing demands for resources.
- Recognize that all entities in the chain of data exchange contribute to success; the full benefits of administrative simplification will not occur unless all entities in the transaction process make changes.
- Build upon what exists – do not try to reinvent the wheel.

Support and Understand Lessons Learned: Before reviewing these recommended changes, we also want to encourage the maintenance of principles that have had significant impact on evolution in the healthcare industry.

- Structure: Ensure the involvement of, and awareness building through, senior executives of health plans and provider organizations.

- Health plans and hospitals – no matter their size – need the ability to participate and vote on rules development and approval.
- Voting rights should **not** be based upon a scale related to financial support – such a model will not encourage collaboration.
- Developing operating rules is an iterative process – it has taken banking 25 years, the cable industry 20 years, etc.
- The financing of the operating model should not occur through a one-time grant; the industry needs to make a commitment – financially and non-financially – to support this process.

Several of these themes should be emphasized:

Adherence to Timelines Requires Use of Existing Tools and Creating Aggressive Milestones.

Of all the current requirements, adherence to the statutory timeframes is essential to successful adoption – the industry must determine how to ensure aggressive milestone-driven change. We hope that NCVHS will stress the importance of meeting deadlines for administrative simplification in the same manner it has stressed the importance of the implementation deadline for the updated versions of the ICD-10 code sets. While the Section 1104 timeframes are ambitious, they can be met if we work to build upon the foundation that has been established.

Maintenance of an Integrated Model. The CORE integrated model has facilitated the substantive progress that has been achieved, and we strongly encourage NCVHS to consider how the administrative simplification envisioned by ACA can be realized through application of this model, understanding that adjustments and expanded resources are needed. The model includes three functional components:

- ***Operating Rule R&D, Design and Testing Requirements:*** The rules development process begins with research to identify the needs and the background work necessary to begin the process of developing an operating rule. This research then moves into the structures and processes unique to a consensus-building process for sets or packages of operating rules that must complement one another, and integrate testing requirements. The synergies of coordinated rule writing has been critical to achieving success.
- ***Education and Outreach:*** These activities support adoption and implementation within the voluntary paradigm. Outreach to and involvement in state-based, federal, and privately driven efforts enable others to build on the CORE work, and for CORE to complement the work of others. The education will need to be available more broadly to support the mandated use of operating rules.
- ***Certification:*** An established certification process that is relevant to Section 1104 requirements for certification, and has already been supported by a range of health plans, vendors, providers and independent testing organizations.

The CORE integrated model is complemented by infrastructure provided by CAQH, a non-profit whose mission is uniquely focused on national initiatives for administrative simplification. Using this model has enabled the development of consensus-based operating rules that entities have implemented in their daily business with all their trading partners, thus enabling true market change.

PARTNERSHIPS AND COORDINATION

To build on the foundation established, the full involvement of the current participants and CAQH relationships are essential. For example, with regard to education and input WEDI will continue to be an essential partner.

Expanding Support for CORE: HIMSS and NACHA

In addition, in order to assure that the necessary breadth of resources is available for the first set of the required ACA transactions, as well as for those going forward, CAQH has outlined a partnership with HIMSS and NACHA. These two organizations have been instrumental in working with CAQH on CORE over the last five years. Applying additional resources that are available through a unique partnership among these organizations will enhance the ability to realize the timeframes established in a meaningful way.

The key rationale for this partnership is to provide CORE with access to a broader set of dedicated resources and attributes, including experienced leadership, subject matter expertise, and staff with skill sets to guide and implement the process over time.

- HIMSS, which helped to establish CORE and has been a CORE endorser since 2006, is the industry voice on the optimal use of information technology in healthcare. Its educational, professional development, and advocacy resources are all designed to support this mission. It is committed to using its thought leadership on financial systems, lessons learned as one of the Healthcare Information Technology Standards Panel (HITSP) administrators, Integrating the Healthcare Enterprise (IHE) sponsorship, and educational tools for the success of operating rules.
- NACHA also assisted in the creation of CORE, has been participating in rule writing, and has been a CORE endorser since 2006. As the rule writing entity for the banking industry, it is committed to applying its lessons learned to the development of operating rules for the healthcare payment process. NACHA has demonstrated extensive experience in maintaining the participation of a critical mass of entities in the implementation of a set of operating rules.

This expanded partnership is a natural reflection of the shared goals of the three organizations for transforming the healthcare data exchange environment within the broader healthcare framework. The partnership also speaks to the unique, but complementary, missions of the organizations and their staff competencies. For example, HIMSS will bring added resources to the CORE educational and outreach activities, while NACHA will bring important strengths to the R&D capacity and educational tools. HIMSS is also uniquely positioned to offer support for the level of educational outreach required at this time of widespread change. NACHA technical knowledge and practical experience will be invaluable as the CORE model begins the process of developing new sets of operating rules involving complex transactions.

Overall, the benefits of this partnership include:

- An adaptive and transparent rule-making process.
- Expertise to meet the necessary requirements of the mandated rules.
- Inclusive participation of a broader range of industry participants.

ADAPTING CORE FOR THE FUTURE

If CORE is selected to help drive the change outlined in the ACA, the structure of the organization will have to be adapted. The changes and enhancements suggested below have been identified based upon the CORE lessons learned, as well as discussions with a wide range of industry experts and interested parties. We are confident that, through collaboration, these changes can be developed in a way that acknowledges the concerns of the community and effectively positions the effort for success.

Organizational Structure

Governance/Leadership

- The governance structure of CORE will need to be examined to assure appropriate representation.
- A liaison role with ONC should be considered, given that CMS eHealth Office is already involved in the CORE leadership structure.
- The roles of different types of stakeholders need to be revisited. For example, the role and composition of the CORE Subgroups, Work Groups, and Steering Committee should be adjusted in order to reflect both the added diversity of the CORE participating organizations and a commitment to consensus development; e.g., CORE could use co-chairs from different stakeholder groups for each Work group.

Participants. An adjusted and expanded CORE model would reflect enhanced participation by existing stakeholders and expanded participation from a more diverse group of new stakeholders. The objective is to bring new perspectives to the deliberations, e.g., employers and HIEs, broader representation from entities such as banks, and greater involvement by code committees, such as NUBC and NUCC.

Voting. Voting is truly where the decisions are made. In addition to the suggested participant and governance considerations, the voting process should be adapted to reflect the participation of a wider, more diverse group of stakeholders. Key considerations include:

- Greater provider representation: All multi-stakeholder organizations in healthcare appreciate the challenges in gathering input from providers. One option could be the use of regional councils (a process that the banking industry uses) which would then inform the national workgroups. Associations such as the American Hospital Association could be critical to the development of such a regional advisory system.
- Medicaid representation: Many state Medicaid agencies rely upon their vendors, which serve as their fiscal agents; it will therefore be important to consider whether Medicaid agencies can appoint their vendors to serve as their proxies.

- Independent consultants: It may be appropriate to consider addressing their voting rights through the use of public comment.
- Vendors: It will be important to consider the value of vendor expertise and resources in the rule writing and their role in the final voting processes.

Financing. Moving forward, CORE will need to evolve to a business model that addresses short- and long-term sustainability requirements, while respecting the availability of organizational resources. As a result, the current revenue streams will need to be reviewed and likely modified. A sustainable financing model must reflect the range of market realities; the asymmetry of the resources of participating organizations; and the significant value of the public good created through the deliberations.

Future Scope, Content, and Development of the Operating Rules

CORE experience has shown that the research and thought leadership required for development of a new set of rules requires substantial lead time. Therefore, collaborative efforts need to be aligned so that the next phase of rules will meet the legislative timeframes. This will require use of the most inclusive and accepted solutions, including an approach that leverages past investments and adapts rule-making techniques used across industries. The partnership between CAQH, HIMSS, and NACHA – and how they work with existing partners such as WEDI and the SDOs – will be crucial.

The policies included in the rules need to be revisited. For example, exemptions need to be maintained, as they were developed to recognize the realities of the marketplace -- such as system migration -- but adjustments are needed. As an example, an effort that involves Medicaid agencies will have to acknowledge the significant migrations that will occur in the coming years while they also manage an influx of new members due to ACA.

Education and Outreach

An emphasis on education is critical to this effort. As outlined earlier, CORE we has begun the process of educating the industry on the value of operating rules, as well as on the expertise, resources and time needed for adoption. However, the types and sophistication of organizations that will become involved over the next several years will be much greater. It will be necessary to expand the education channels that have been established, as well as to develop creative new mechanisms to broaden the uptake. As an example, Regional Extension Centers may be able to provide support to this end. The partnership with HIMSS and NACHA will also bring established techniques, venues and audiences that will be valuable.

Coordination and sharing of best practices cannot occur without ongoing outreach to inform and garner necessary support. As with education, traditional approaches can be expanded, but newer methods will need to be enlisted to broaden engagement and commitment. Certainly a mandate brings inherent outreach opportunities, however engaging in a wide range of industry activities will be important to create clear understanding and appreciation for the effort.

Additional Resources Needed to Support the Expanded Components of the Integrated, Mandated Model. The resource needs of a consensus-based organization will increase as a result of the dynamics of operating within a mandated paradigm. For example, a public comment process will be needed, as will staff to manage this process. The deliberations may be more challenging because the decisions will be implemented as a requirement, rather than as a choice of the participant operating in a voluntary initiative.

In addition, CORE will need to consider new rulemaking techniques. This added requirement could significantly increase operating costs, a factor which must be addressed as part of identifying the best way to meet both the short- and long-term sustainability requirements of an adjusted and expanded CORE model.

VI. Conclusion

The executive summary of the recent NCVHS concept paper on enhanced information capacities noted that:

“Given the rapidity of the changes now under way, we cannot over-emphasize the urgency of this endeavor and the need to move ahead with deliberate speed.”

While the NCVHS was referring to a broader array of changes than administrative simplification, this sense of urgency is entirely relevant as NCVHS deliberates how HHS can adopt three sets of operating rules:

- Eligibility and claims status in 2011;
- EFT and claim payment/remittance advice in 2013; and
- Four additional administrative transactions in 2014.

As the NCVHS advises the Secretary on how HHS can adopt, and the industry can implement, operating rules in a timely manner, we encourage you to seriously consider the value of the *integrated and iterative* process developed and implemented by CORE.

CAQH is committed to move beyond the current paradigm. The lessons learned and suggested areas for change demonstrate the depth of knowledge that CORE and CAQH can bring to the development and implementation of a successful set of operating rules that will be well received and adopted with alacrity. In addition, the expanded partnership with HIMSS and NACHA will bring the broader resources essential to a successful roll-out over the next four years and beyond. The combined use of government-mandated standards and operating rules for the healthcare industry will benefit from the experience of other industries, and from acknowledging the time needed to write truly meaningful operating rules.

We also urge NCVHS to consider the significant level of variation in the adoption of health information technology to date, and thus the need to have a model that creates reasoned and results-driven operating rules, while respecting the variation in HIT resources across the industry.

The success that was achieved by CORE-certified users of the Phase I operating rules can be replicated throughout the country. This would include administrative cost savings of an average of \$4.60 per transaction and the intangible benefits of patient convenience and comfort when a benefit determination can be made in real-time. The level of work required to drive such industry-wide change is significant and should not be underestimated. Collaboration on education – both public and private – will play a critical role moving forward.

With the necessary adjustments and expansions, the CORE model – with CAQH as the designated nonprofit entity – is an experienced and established collaboration that HHS can rely upon when adopting operating rules which are consistent with Congress' goal for administrative simplification. As passionate as we feel about the need to implement administrative simplification in a timely manner, we are similarly convinced that this integrated model for operating rules is the best solution for moving forward.

CAQH, on behalf of the broad group of CORE participants, thanks you for your commitment to this important initiative. We truly appreciate the leadership that the NCVHS continues to bring to the national discussion of health information policy.

Appendices

- A. View of “A Day in the Life” of a Patient in 2015
- B. CORE Participating / Certified / Endorser Entities
- C. CORE Participation Fees and CORE Certification Seal Fees
- D. CORE Phase I ROI Results Press Release
- E. CORE Phase I and Phase II 5010 Alignment

View of “A Day in the Life” of a Patient in 2015

The scenario described below can only be achieved for providers and patients across the U.S. through collaboration by all the key stakeholders in the healthcare industry. It will require thoughtful sequencing of initiatives to leverage health plan IT investments and integrate operating rules efficiently with related industry efforts, such as EHR (Electronic Health Record), Universal Provider Datasource (UPD) and NHIN (National Health Information Network) development.

Appointment Scheduling: Jack uses his hand-held communication device to log onto the secure Website of his primary physician, Dr. Summa. Jack checks the appointment day and time availability, chooses his desired appointment slot, updates his insurance information, sees that his insurance was verified, and logs off. Dr. Summa’s office notes the appointment request and creates an appointment in the office scheduling system, which automatically re-verifies Jack’s insurance. Once re-verified, Dr. Summa’s office sends Jack an appointment confirmation email. The email indicates the fee/co-pay he will need to pay at the time of the appointment. In preparation for his appointment, Jack accesses his personal health record (PHR) through his health plan’s Website and downloads it to his hand-held communication device. His PHR was originally created by his previous insurer, following a standard adhered to by his new plan.

Appointment: Jack arrives at Dr. Summa’s office. An office staff member compares his face or other biometric to an image or data in his authorized PHR. The staff member registers Jack, which automatically re-verifies Jack’s eligibility, benefits, and payment requirements and immediately transfers that data to the office’s electronic health record (EHR) system.

After examining Jack, Dr. Summa determines that he needs a new prescription and recommends a referral to Dr. Zippa, a cardiologist who has recently moved into the area after practicing for several years at a leading academic medical center in another state. (Dr. Zippa has been credentialed and contracted with Jack’s health plan in less than a week using the data he has maintained on the Universal Provider Datasource.) Dr. Summa checks Jack’s medication history and his eligibility for prescribed medications through the EHR system. The EHR alerts Dr. Summa about a potential adverse medication interaction, recommends generic alternatives, and details pharmacy costs for the drugs. Jack agrees to take the generic medication. The EHR automatically transmits an e-prescription to Jack’s pharmacy. Dr. Summa creates a referral request and obtains a referral authorization. Dr. Summa electronically signs the EHR, which creates a real-time transaction to the office billing system and notifies Dr. Summa immediately if any edits are needed. If so, Dr. Summa updates the EHR to address any required edits. The edited electronic insurance claim is sent to Jack’s health plan with the diagnosis and procedure coding validated as consistent with the EHR documentation. The claim is adjudicated, and Dr. Summa’s office receives an electronic payment within seconds.



Post-Appointment: At check-out, the office staff member informs Jack of his charges for the visit, answers charge questions and accepts his payment. If the claim had been denied, the staff member would have worked with Jack and/or Dr. Summa to make necessary corrections and resubmit the corrected claim in order to settle payment before Jack leaves the office.

On his way home, Jack stops at the pharmacy to pick up his prescription. He receives counseling from the pharmacist regarding the newly prescribed medication and pays for his medication. Once home, he finds an email from Dr. Summa's office reminding him to take his medication as prescribed and make a follow-up appointment. Another email from Dr. Zippa's office reminds him to make an appointment. Dr. Summa's office periodically sends reminder emails about taking his medication. Once a month, Jack receives an email from his health plan that summarizes all of the healthcare services he has received that month and year-to-date from all providers. The summary is as easy to read as his credit card bill.

Due to the foundation of interoperability, Jack, Dr. Summa, and Dr. Zippa all have experienced reduced costs and increased efficiency, and Jack's quality of care has improved.

APPENDIX B



CAQH Committee on Operating Rules for Information Exchange (CORE) (as of July 2010)

Health Plans

Aetna Inc.
AultCare
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 Health Care
Health Care Service Corporation
Health Net, Inc.
Health Plan of Michigan
Highmark, Inc.
Horizon Blue Cross Blue Shield of New Jersey
Humana Inc.
Medical Mutual of Ohio
UnitedHealth Group
WellPoint, Inc.

Associations / Regional / Standard Setting Organizations

America's Health Insurance Plans (AHIP)
ASC X12
Blue Cross and Blue Shield Association
Delta Dental Plans Association
Health Level 7 (HL7)
Healthcare Association of New York State
Healthcare Billing and Management Association
Healthcare Financial Management Association
Healthcare Information & Management Systems Society
LINXUS (initiative of GNYHA)
National Committee for Quality Assurance
National Council for Prescription Drug Programs
NJ Shore (WEDI/SNIP NY Affiliate)
Private Sector Technology Group
Utah Health Information Network
Utilization Review Accreditation Commission
Work Group for Electronic Data Interchange (WEDI)

Government Agencies

Arizona Health Care Cost Containment System
Louisiana Medicaid – Unisys
Michigan Department of Community Health
Michigan Public Health Institute
Minnesota Department of Human Services
Oregon Department of Human Resources
TRICARE
US Centers for Medicare and Medicaid Services (CMS)
US Department of Veterans Affairs
Washington State Office of the Insurance Commissioner

Other

Accenture
Cognizant
Deloitte Consulting LLP
Hubbert Systems Consulting (HSC)
Merck & Co., Inc.
Omega Technology Solutions
OptumHealth Financial Services
Payformance
PNC Bank
PricewaterhouseCoopers LLP
TIBCO Software, Inc.
VeriSign, 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
Johns Hopkins Medicine
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
Physician HealthCare Network, PC
Spectrum Laboratory Network
Texas Medical Association
University Physicians, Inc. (University of Maryland)
UNMC Physicians
Valley Health
Wisconsin Medical Society

Vendors / Clearinghouses

ACS EDI Gateway, Inc.
Antares Management Solutions (a subsidiary of MMO)
athenahealth, Inc.
Availity LLC
Capario
CareMedic Systems, Inc.
Edifecs
Emdeon
Enclarity, Inc.
FIS Global
Gateway EDI
GE Healthcare
HERAE, LLC
HMS
HP Enterprise Services, LLC
iHCFA, LLC
Ingenix, Inc.
InstaMed
MedData
mPay Gateway
National Account Service Company (NASCO)
NaviNet
NextGen Healthcare Information Systems, Inc.
Passport Health Communications
Payerpath, a Misys Company
QS/I Data Systems
RealMed Corporation
Recondo Technology, Inc.
RelayHealth
Secure EDI Health Group, LLC
Siemens / HDX
Surescripts
The SSI Group, Inc.
The TriZetto Group, Inc.
VisionShare, Inc.

CORE Certifications, Commitments and Endorsements as of July 2010

	Product Name	Phase I Rules Certified	Phase II Commitment/ Certification Status
CLEARINGHOUSES			
ACS EDI Gateway, Inc.	EDI Direct - Eligibility Engine	✓	✓
Availity, LLC	Availity Health Information Network-Web Portal	✓	✓
Caprio	Phoenix Processing System	✓	✓
Emdeon	RT Transaction Processing and Data Hosting	✓	✓
eServices Group, Inc.	UNITE	✓	✓
Gateway EDI	RTE Individual & Integrated Transactions	✓	
HealthFusion, Inc.	HealthFusion RT	✓	
HMS	HMS	✓	
Ingenix	TBD	Q3 2010	Q3 2010
InstaMed	InstaMed Platform and Network	✓	✓
MD On-Line, Inc.	ACCES\$ Patient Eligibility Verification	✓	
MedData	MedConnect	✓	
NaviNet	NaviNet	✓	✓
Nelwerkes	Nelwerkes.com Real Time Eligibility	✓	
Office Ally	Real Time Eligibility	✓	
Passport Health Communications	OneSource	✓	Q3 2010
Post-N-Track	Doohicky™ Web Services	✓	✓
Practice Insight	TBD	Q3 2010	
RealMed Corporation	RealMed Revenue Cycle Management	✓	
RelayHealth	Real Time Eligibility	✓	Q3 2010
SecureEDI / Immediata	SecureEDI Clearinghouse	✓	
Siemens / HDX	Healthcare Data Exchange	✓	✓
Surescripts	Surescripts Prescription Benefit	✓	Q3 2010
The SSI Group, Inc.	ClickON® E-Verify Suite	✓	✓
ZirMed	TBD	Q4 2010	

VENDORS			
athenahealth	athenaCollector	✓	✓
CSC	CSC DirectConnect®	✓	Q3 2010
EmergingHealth	TREKS	✓	
eServices Group, Inc.	XJ Series Gateway Services	✓	✓
GE Healthcare	EDI Eligibility 270/271	✓	Q3 2010
HealthTrio, LLC	TBD	Q4 2010	Q4 2010
Medical Informatics Engineering, Inc.	WebChart EMR	✓	
Medical Present Value (MPV)	MPV Eligibility	✓	
NoMoreClipboard.com	NoMoreClipboard	✓	
Recondo Technology, Inc.	SurePayHealth	✓	Q3 2010
RelayHealth	PCS	✓	✓
RelayHealth	RevRunner	✓	Q3 2010
The SSI Group Inc.	ClickON® E-Verify Suite	✓	✓
VisionShare, Inc.	Secure Exchange Software Interactive	✓	Q3 2010

	Phase I Rules Certified	Phase II Commitment/ Certification Status
HEALTH PLANS		
Aetna, Inc.	✓	✓
Anthem Colorado*	✓	✓
Anthem Connecticut*	✓	✓
Anthem Indiana*	✓	✓
Anthem Kentucky*	✓	✓
Anthem Maine*	✓	✓
Anthem Nevada*	✓	✓
Anthem New Hampshire*	✓	✓
Anthem Ohio*	✓	✓
Anthem Virginia*	✓	✓



CORE Certifications, Commitments and Endorsements as of July 2010

	Phase I Rules Certified	Phase II Commitment/ Certification Status
Aultcare	✓	✓
Avmed Health Plans	✓	
Blue Cross of California*	✓	✓
Blue Cross Blue Shield of Georgia*	✓	✓
Blue Cross Blue Shield of Missouri*	✓	✓
Blue Cross Blue Shield of North Carolina	✓	Committed
BlueCross BlueShield of Tennessee	✓	✓
Blue Cross Blue Shield of Wisconsin*	✓	✓
CIGNA	✓	
Empire Blue Cross Blue Shield*	✓	✓
Harvard Pilgrim Health Care	✓	✓
HealthNet	✓	Committed
Humana Inc.	✓	Committed
UnitedHealthcare	Q4 2010	Q4 2010
WellPoint	✓	✓
* Indicates a WellPoint Company		

PROVIDERS		
Mayo Clinic	✓	Q3 2010
Montefiore Medical Center	✓	
Spectrum Laboratory Network	✓	
Summit Medical Group	✓	
US Department of Veterans Affairs	✓	
Wake Forest University Health Sciences	✓	

	Endorsement of CORE	
	Phase I	Phase II
ASSOCIATIONS / REGIONAL ENTITIES		
American Academy of Family Physicians	✓	Committed
American Association of Preferred Provider Organizations	✓	Committed
American College of Physicians	✓	Committed
American Health Information Management Association	✓	Committed
American Medical Association		✓
California Regional Health Information Organization	✓	
Center for Health Transformation	Committed	Committed
eHealth Initiative	✓	Committed
Electronic Healthcare Network Accreditation Commission	✓	Committed
Greater New York Hospital Association	✓	Committed
Healthcare Financial Management Association	✓	Committed
Healthcare Information and Management Systems Society	✓	Committed
Medical Group Management Association	✓	Committed
Michigan Public Health Institute	✓	Committed
NACHA - The Electronic Payments Association	✓	✓
National eHealth Collaborative	Committed	Committed
Smart Card Alliance Council	✓	✓
URAC	✓	
Virginia Health Exchange Network	Committed	Committed
Workgroup for Electronic Data Interchange (WEDI)	✓	Committed

CORE Certifications, Commitments and Endorsements as of July 2010

	Endorsement of CORE	
	Phase I	Phase II
COMPANIES		
Accenture	✓	
Claredi, an Ingenix Division	✓	
Cognizant	✓	✓
Edifecs, Inc.	✓	Committed
eMids Technologies, Inc.	✓	
Enclarity, Inc.	✓	Committed
FIS Global	✓	✓
HCCO	✓	✓
HIPAA QA	✓	✓
Microsoft Corporation	✓	Committed
MultiPlan, Inc.	✓	Committed
Pillsbury Winthrop Shaw Pittman, LLP	✓	
TIBCO Software, Inc.	✓	✓

✓ = Completed



CORE Participation Fees by Stakeholder Category:

- ☐ **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:** A recognized standard setting organization or an entity whose primary purpose is to advise such organizations.
 - ☐ No annual participation fee
- ☐ **Government Advisory:** No annual participation fee
 - ☐ **Voting Government Member:** Entity that creates, transmits or uses eligibility data and decides to serve as a voting member.
 - ☐ **Non-voting Government Member:** Entity that does not create, transmit or use eligibility data or an entity that creates, transmits or uses eligibility data but does not want to serve as a voting member.

CORE Certification Seal Fees by Stakeholder Category:

Health Plans

- ☐ Below \$75 million in net annual revenue \$4,000 fee
- ☐ \$75 million and above in net annual revenue \$6,000 fee

Clearinghouses

- ☐ Below \$75 million in net annual revenue \$4,000 fee
 EHNAC HNAP-EHN accredited – apply 10% (\$400) discount
- ☐ \$75 million and above in net annual revenue \$6,000 fee
 EHNAC HNAP-EHN accredited – apply 10% (\$600) discount

Vendors

- ☐ Below \$75 million in net annual revenue \$4,000 fee
- ☐ \$75 million and above in net annual revenue \$6,000 fee

Providers

- ☐ Up to \$1 billion in net annual revenue \$ 500 fee
- ☐ \$1 billion and above in net annual revenue \$1,500 fee

☐ **Endorser**

(Only for entities that do not create, transmit or use eligibility data.) No fee



Fee Notes:

1. There is no charge to Federal or State government entities to receive the CORE Seal.
2. There is no charge to CAQH member plans to receive the CORE Seal.
3. This fee is a one-time cost for each Phase of certification, unless an entity becomes decertified or if major changes to the rules are approved by a full CORE vote (Reference CORE: Eligibility and Benefits Certification Policy).
4. Per the CORE Phase I Certification Policy, vendor products, and not entire vendor organizations, receive the Certification Seal.
5. The CORE Certification Seal fee does not include the fee for CORE certification testing, which is standard for each stakeholder type. The CAQH website (www.caqh.org) can be accessed for a list of CORE-authorized testing companies and their associated testing fees.
6. CORE participation and CORE certification are two separate activities. If you are interested in participating in CORE, review the CORE Participant Application. CORE participants can assist with writing the rules/policies in addition to voting on the next phase of rules.
7. Any Clearinghouse/EHN entity actively seeking CORE certification as of June 1, 2009 or later that has already achieved EHNAC HNAP-EHN accreditation can take advantage of the partnership program discount. The Clearinghouse/EHN will indicate that it holds a current EHNAC HNAP-EHN accreditation when submitting a CORE Seal application. (CAQH will confirm EHNAC-EHN accreditation status independently.) View more information about EHNAC HNAP-EHN accreditation at www.chnac.org.

**STUDY RESULTS SHOW CAQH CORE CERTIFICATION DRAMATICALLY
CUTS ADMINISTRATIVE COSTS, ACCELERATES I.T. ADOPTION
BY PROVIDERS AND HEALTH PLANS**

Industry-wide Implementation Could Yield \$3 Billion of Savings in Three Years

Washington, DC – (June 2, 2009) – CAQH® announced today that a study of results achieved by health care providers and health plans that are certified to use the Phase I rules of its Committee on Operating Rules for Information Exchange® (CORE) showed dramatic cost savings, accelerated use of real-time electronic transactions, improved claims verifications and reduced claims denials.

The findings confirm the value of using national standards for streamlined administrative data exchange as a key component of creating a national ehealth solution, which is a priority of the \$20 billion in designated stimulus funding for health I.T.

Based on results from the study, the estimated potential savings from an industry-wide implementation of the CORE Phase I rules are more than \$3 billion in three years. These savings could grow exponentially as additional phases of CORE rules are implemented.

“As the federal stimulus seeks to be a catalyst to fund workable health I.T. solutions that benefit all stakeholders, CORE is a model for the real results that can be achieved by streamlining routine administrative tasks and promoting interoperability,” said Ronald A. Williams, Chairman and Chief Executive Officer of Aetna, Inc., an early adopter of CORE. “The results demonstrate that CORE is a practical solution that is already paying dividends.”

Conducted for CAQH by IBM’s Global Business Services, the study assessed six CORE-participating health plans that represent 33 million covered lives (Aetna, AultCare, BlueCross BlueShield of North Carolina, BlueCross BlueShield of Tennessee, Health Net, and WellPoint affiliated health plans), as well as leading provider groups and vendors using the CORE Phase I rules. Key findings of the study show:

- Electronic insurance eligibility verifications took approximately seven minutes less than telephone verifications, saving providers \$2.10 per verification. There are more than 1 billion claims verified for eligibility each year in the U.S.
- Providers working with CORE-certified health plans saw 10-12% fewer claims denials, resulting in improved practice payment.
- Providers working with CORE-certified health plans saw a 20% increase of patients verified prior to a visit, significantly reducing administrative burden at the point of care.
- Health plans that became CORE-certified had a payback in less than 12 months. For example, by switching from telephone to real-time electronic claims verification, the average annual reduction in administrative costs can be more than \$2.5 million per plan.

“CORE is invaluable for reducing the paper chase and telephone tag that has plagued our profession for far too long,” said Joel Perlman, CFO, EVP Finance of Montefiore Medical Center in New York. “Having this national solution will make it easier for everyone perform real-time electronic transactions, and devote more staff resources to patient care.”

“The study shows that when a health I.T. solution like CORE benefits both providers and health plans, adoption of electronic data interchange accelerates and ROI increases. This scenario advances the goals of the American Reinvestment and Recovery Act, including the need to lower overall healthcare costs and improve the quality of care,” said Barbara Archbold, Healthcare Sales and Solutions Leader for IBM's Global Business Services. “Meeting such goals becomes easier and more attractive when everyone in the industry is playing by the same rules.”

A synopsis of results from the CAQH CORE study is available at www.coreconnect.org.

About CORE

CORE is a collaboration of more than 100 industry stakeholders developing a multi-phase set of uniform business rules to streamline administrative data exchange, which enable consistent provider access to patient insurance information prior to or at the time of service. To date, CORE has created and promulgated two phases of rules, which are built on national standards such as HIPAA.

The CORE rules address data critical to the healthcare revenue cycle, such as patient eligibility and benefits, patient financial liability for various service types, patient deductibles/co-pays and year-to-date patient accumulators. The rules also cover specific requirements for exchanging that data, including system connectivity, system availability, patient identification, claims status, maximum response times (batch and real-time), and the consistent use of standard acknowledgements.

CORE participants have begun the process to develop Phase III rules, which will focus on improving the electronic exchange of additional administrative transactions, such as prior authorization and remittance advice.

About CAQH

CAQH, a nonprofit alliance of health plans and trade associations, serves as a catalyst for healthcare industry collaboration on initiatives that simplify and 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 and encourage administrative and clinical data integration. Visit www.caqh.org for more information.

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CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III Rules Work Group
CORE Phase I/II Rule Upgrade to Support HIPAA v5010
Draft for discussion only – 06/11/10

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CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III Rules Work Group CORE Phase I/II Rule Upgrade to Support HIPAA v5010 Draft for discussion only – 06/11/10

1. Background

Consistent with the CORE policy that whenever the underlying standards addressed by CORE rules are modified as a result of national or state legislation or regulation, CAQH fully initiated in 3rd quarter 2009 The CORE Phase I/II Rule Upgrade to Support HIPAA v5010 Project. This document provides a high-level overview of this project and high-level findings for potential substantive revisions. To-date, findings have identified the following CORE rules for substantive changes:

- Phase I CORE Eligibility & Benefits Data Content Rule
- Phase II CORE Eligibility & Benefits Data Content Rule
- Phase II CORE AAA Error Code Reporting Rule

2. Project Approach

CAQH staff and consultants reviewed all Phase I/II CORE Operating Rules and Policies to identify both substantive and non-substantive gaps between the CORE rules and those v5010 HIPAA-mandated transactions addressed by the CORE I and II Operating Rules.

- **Substantive** – Changes or additions to operating rules that change the purpose, scope, requirements, or technical transaction data content of CORE operating rules
- **Non-substantive** – Editorial changes to existing operating rules that do not change the purpose, scope, requirements, or technical transaction data content of CORE operating rules

3. HIGH-LEVEL Project Scope

Review and identify potential changes within:

- Technical data content in CORE operating rules that is based on HIPAA version 4010A1 Implementation Guides
- Technical scripts and test data that comprise the CORE Certification Test Suite that is based on HIPAA version 4010A1 Implementation Guides

Act upon findings:

- Revise CORE rules and Test Suite that address transaction data content based on the technical gap analysis so that the revised rules appropriately support the mandated HIPAA v5010
- Work with the CORE-authorized certification testing vendor(s) to revise the certification testing website as needed to support the revisions to the CORE certification Test Suite

Out of scope tasks:

- Revisions to existing CORE rules covering technical content not directly related to migration from Version 4010A1 implementation guides to HIPAA Version 5010 TR3s
- Revisions to existing CORE rules to address *recommendations* in HIPAA-mandated ASC X12 5010 TR3s that are *not mandated* by the final rule *HIPAA Electronic Transaction Standards 45 CFR Part 162 dated January 16, 2009*. (Note: To date, HIPAA adopts full TR3, however, only mandates aspects of the TR3)
- Revisions of CORE Phase I/II operating rules addressing transactions, process, and rules/policies that are not in the scope of the HIPAA-mandated v5010 transactions, code lists, and code sources. (*Examples: Connectivity, response time, system availability, etc – which are not in HIPAA scope, but may refer to HIPAA*)
- Revisions to the draft Phase III CORE operating rules, given draft Phase III is based on v5010 of the HIPAA-mandate

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4. Key Timelines

- 2010 Spring: Discuss identified changes with targeted participants (ASC X12, WEDI, BCBSA, Rules Work Group)
- Q2 2010: Obtain Work Group approval of identified rule changes and hold CORE Conference Call
- Q3 2010: Finalize list of changes to certification process due to rule adjustments (Note: Entities already Phase I or II certified will NOT need to get recertified due to CORE HIPAA attestation)
- Q3 2010: Publish updated rules and update testing tools

Reminder: 5010 compliance is not required until January 2012

5. High-level Findings to Date

Since CORE rules do not repeat the HIPAA-mandated “minimum” requirements in the HIPAA v5010 TR3s, the majority of potential revisions to the Phase I/II CORE rules are to remove several sections of the Phase I/II CORE Eligibility & Benefits Data Content Rules. Other revisions are to remove some sentences in the CORE rules that are included in the HIPAA v5010 TR3s and thus are no longer needed in the CORE rules. The overall implications and impact for CORE-certified entities and entities currently going through CORE certification or considering CORE certification is minimal since these entities will already be HIPAA v5010 compliant and are required to attest to this as part of becoming CORE certified.

CORE review has not identified substantive changes in the other Phase I/II CORE rules addressing infrastructure, e.g., system availability, real-time/batch response time, connectivity. Rather, changes to these rules will be non-substantive in nature as these rules are not based upon HIPAA adopted standards.

The table below is a high-level summary of the substantive gap analysis findings for the CORE rules listed in §1 above.

High-Level Findings of Substantive Gap Analysis Between CORE Phase I/II Rules Based on HIPAA-Mandated Transactions: v4010A1 and v5010 Specifications		
CORE Rule Name	Summary of Recommended Revision and Implications	Gap Analysis Summary
<i>Phase I CORE Eligibility Data Content Rule (270/271)</i>	<i>Revision A:</i> Remove certain sections of CORE rule requirements as requirements are now <u>mandated</u> in v5010. <i>Implication A:</i> CORE-certified entities are already compliant with these 5010 mandates, while post-January 2012 CORE-certified entities will no longer be tested on these requirements as all CORE-certified entities sign a HIPAA Attestation.	<i>11 Rule Sections to be deleted that address:</i> Requirements for a non-financial response to a generic inquiry for 9 service types (e.g. 33- Chiropractic, 48-Hospital Inpatient, etc.). <i>Note: A non-financial response addresses status of coverage and dates</i>
	<i>Revision B:</i> (1) Revise wording in sections of CORE rule. The majority of wording revisions are because CORE rules do	<i>11 Rule Sections to be revised</i> If sentence is in 5010,

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High-Level Findings of Substantive Gap Analysis Between CORE Phase I/II Rules Based on HIPAA-Mandated Transactions: v4010A1 and v5010 Specifications		
CORE Rule Name	Summary of Recommended Revision and Implications	Gap Analysis Summary
	<p>not repeat HIPAA-mandated (“minimum”) requirements, but rather CORE rules focus on requirements that are not mandates, e.g., returning patient financial responsibility information.</p> <p>(2) Replace one code (307 – eligibility date) with a new code required in 5010.</p> <p>(3) Add 3 service type codes not included in CORE-required response to a generic inquiry (47-Hospital, MH-Mental Health, UC-Urgent Care) to the existing CORE requirements.</p> <p>Implication B: CORE-certified entities are already compliant with these 5010 mandates, while post-January 2012 CORE-certified entities will no longer be tested on the requirements as all CORE-certified entities sign a HIPAA Attestation.</p>	<p>remove from CORE rules, e.g. CORE Phase I rules required that base deductible was a dollar amount, this specification is now part of 5010.</p> <p>One date code update and three service type codes added.</p>
Phase II CORE Eligibility Data Content Rule (270/271)	<p>Revision A:</p> <p><u>Remove</u> certain sections of CORE rule requirements as requirements are now <u>mandated</u> in v5010.</p> <p>Implication A:</p> <p>CORE-certified entities are already compliant with these 5010 mandates, while post-January 2012 CORE-certified entities will no longer be tested on the requirements as all CORE-certified entities sign a HIPAA Attestation.</p>	<p>6 Rule Sections to be deleted</p> <p>Requirements for a non-financial response to a generic inquiry for 9 service types (e.g. 33- Chiropractic, 48-Hospital Inpatient, etc.)</p> <p><i>Note: A non-financial response address status of coverage and dates</i></p>
	<p>Revision B:</p> <p>(1) Revise wording in sections of CORE rule. The majority of wording revisions are because CORE rules do not repeat HIPAA-mandated (“minimum”) requirements, but rather CORE rules focus on requirements that are not mandates, e.g. returning patient financial responsibility information.</p> <p>(2) Replace one code (307 – eligibility date) with a new code required in 5010.</p> <p>(3) Add 3 service type codes not included in CORE-required response to a generic inquiry (47-Hospital, MH-</p>	<p>9 Rule Sections to be revised</p> <p>If sentence is in 5010, remove from CORE rules, e.g. CORE Phase I rules required that base deductible was a dollar amount, this specification is now part of 5010.</p> <p>One date code update and three service type codes</p>

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High-Level Findings of Substantive Gap Analysis Between CORE Phase I/II Rules Based on HIPAA-Mandated Transactions: v4010A1 and v5010 Specifications		
CORE Rule Name	Summary of Recommended Revision and Implications	Gap Analysis Summary
	<p>Mental Health, UC-Urgent Care) to the existing CORE requirements.</p> <p>Implication B:</p> <p>CORE-certified entities are already compliant with these 5010 mandates, while post-January 2012 CORE-certified entities will no longer be tested on the requirements as all CORE-certified entities sign a HIPAA Attestation.</p>	added.
Phase II AAA Error Reporting Rule	<p>Revision A:</p> <p>(1) Replace Code 75 with Code 72 Invalid/Missing Subscriber/Insured ID for CORE Error Condition #7.</p> <p>(2) Replace Code 75 with Code 73 Invalid/Missing Subscriber/Insured ID for CORE Error Condition #8.</p> <p>Implication A:</p> <p>CORE-certified entities are already compliant with these 5010 mandates, while post-January 2012 CORE-certified entities will no longer be tested on the requirements as all CORE-certified entities sign a HIPAA Attestation.</p> <p>Revision B:</p> <p>Remove Error Conditions #14, #15, and #18</p> <p>Remove corresponding notes in error conditions #16, and #17</p> <p>Implication B:</p> <p>CORE-certified entities are already compliant with these 5010 mandates, while post-January 2012 CORE-certified entities will no longer be tested on the requirements as all CORE-certified entities sign a HIPAA Attestation.</p>	<p>1 Rule Section to be revised</p> <p>HIPAA v5010 situational note placing constraints on when these error codes may be used.</p> <p>Removal of 3 error conditions now part of 5010.</p>
High-Level Non-Substantive Revisions to CORE Phase I/II Rules		
<ul style="list-style-type: none"> • Document Revision Date • Document Revision Number • Revise Reference from V4010 in Documents to V5010 		

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6. CORE Rule v5010 Upgrade FAQs

Q1: If my organization is already CORE Phase I and/or Phase II certified, what is the impact of these rule revisions?

A1: Since CORE Phase I and Phase II rules were written with v5010 in mind and were designed to complement and go beyond the HIPAA v5010 mandated requirements, the CORE rule revisions can be addressed concurrent with your HIPAA v5010 implementation.

Q2: My organization is considering becoming or in process of becoming CORE Phase I and/or Phase II certified, what is impact of these rule revisions?

A2: Since CORE Phase I and Phase II rules were written with v5010 in mind and were designed to complement and go beyond the HIPAA v5010 mandated requirements, the CORE rule revisions can be addressed concurrent with your HIPAA v5010 implementation.

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Appendix: CORE Requirements for Acknowledgements

Although acknowledgments are not mandated by HIPAA or other Federal health care efforts, CORE has since its inception worked collaboratively among its stakeholders to drive industry adoption for the consistent use of acknowledgments. The same approach to support non-mandated standards in a phased approach was taken by CORE with other standards such as WSDL or HTTPS. The CORE rules have been supporting such standards when there is the existence of a business need and where an operational solution can be delivered that includes a standard, complementary rule requirements and a cost/benefit-based adoption plan can be developed. With regard to Acknowledgements, CORE has sought to support the work done by X12 and WEDI while also maintaining the CORE goals of critical mass implementation and real-world cost-benefit considerations such as frequency of version control. As with all CORE rules, the CORE rules regarding the use of acknowledgements is supported not only through the rule requirements, but also in the CORE certification and testing process.

Phase I and Phase II rules include requirements for the ASC X12 TA1 and the 997 in association with the CORE rules for using the 270/271 Eligibility and Benefits Request and Response in real-time and batch. In Phase II, CORE also has requirements for these acknowledgements when using the CORE rule for 276/277 Claim Status Request and Response in real-time and batch. Current Phase I/II CORE certified health plans cover over 40% of the commercially insured (CORE participating health plans cover almost 75% of the commercially insured). In 2009, the acknowledgement standards were updated and thus the draft Phase III CORE rules require the use of the 999 rather than the 997 (for Functional Acknowledgments) and does not include requirements for the TA1 as this standard is under review by ASC X12 for enhancements. Although CORE supports the use of the TA1, CORE will remove it from the Phase I and Phase II rules until ASC X12 review is completed and the updated standard published. Moreover, the draft Phase III rules require the 277CA for the acknowledgement of 837 Claim transactions.

CORE participants should discuss how to proceed with potential revisions to the CORE Phase I and Phase II specific to acknowledgements. The discussion should take into consideration:

- Although not mandated, acknowledgements have consistently been a key part of the CORE operating rules as they complement things such as real-time turnaround, batch turnaround times and connectivity ---- all of which are critical to successful operating rules.
- Adoption to date by CORE has shown demonstrated ROI, and acknowledgements are part of that process.
- What is the cost-benefit of version changes for those entities who have been early CORE rule adopters as demonstrated through CORE certification.
- Existing timelines for 5010 implementations and their relation to Acknowledgements.