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The Technical Building Blocks
of Industry Transformation

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Agenda

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An Introduction to CAQH

- CAQH, an unprecedented nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers
- CAQH Solutions:
 - Help promote quality interactions between plans, providers and other stakeholders
 - Reduce costs and frustrations associated with healthcare administration
 - Facilitate administrative healthcare information exchange
 - Encourage administrative and clinical data integration
- Current Initiatives:
 - CORE® – Committee on Operating Rules for Information Exchange
 - UPD® – Universal Provider Datasource

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CORE Overview

- CORE is a multi-stakeholder collaboration developing industry-wide operating rules, built on existing standards, to streamline administrative transactions
- MISSION: To build consensus among the essential healthcare industry stakeholders on a set of operating rules that facilitate administrative interoperability between health plans and providers
 - Enable providers to submit transactions from the system of their choice (*vendor agnostic*) and quickly receive a standardized response from any participating stakeholder
 - Enable stakeholders to implement CORE phases as their systems allow
 - Facilitate stakeholder commitment to, and compliance with, CORE's long-term vision
 - Facilitate administrative and clinical data integration
- CORE is not:
 - Building a database
 - Replicating the work being done by standard-setting bodies, e.g., X12 or HL7

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CORE Goals

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

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



Long-Term Goal
Apply operating rule concept to other administrative transactions in claims process, using phased approach

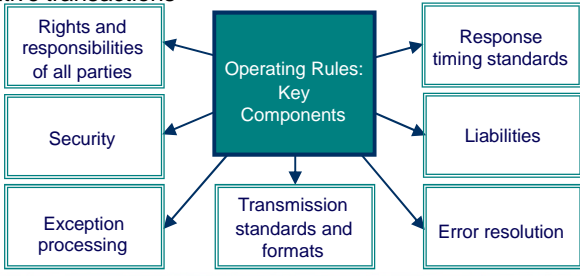
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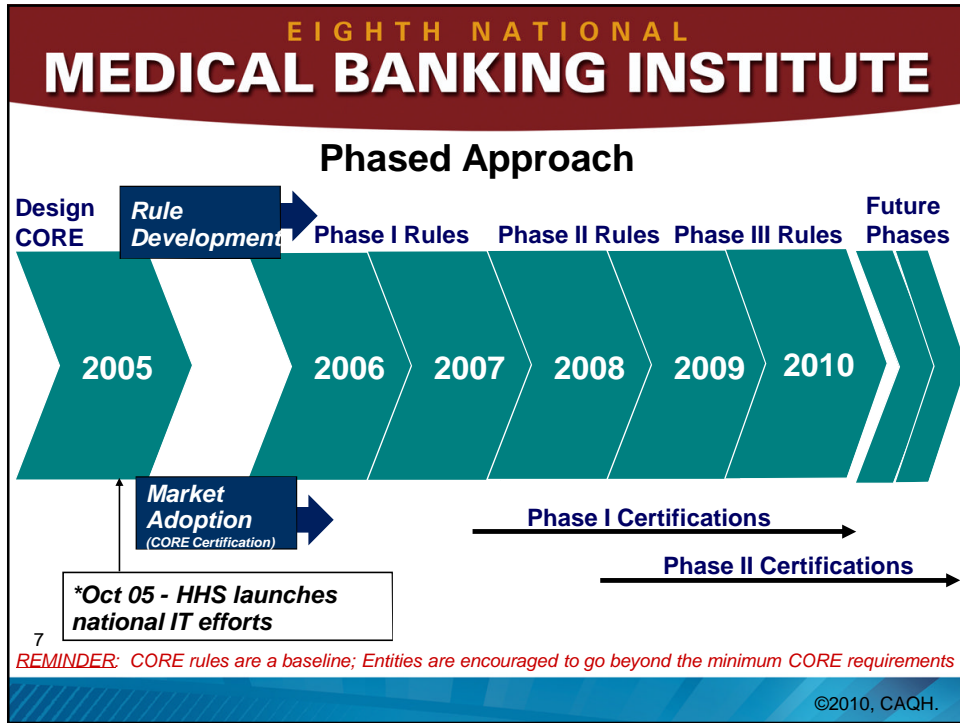
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What are Operating Rules?

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



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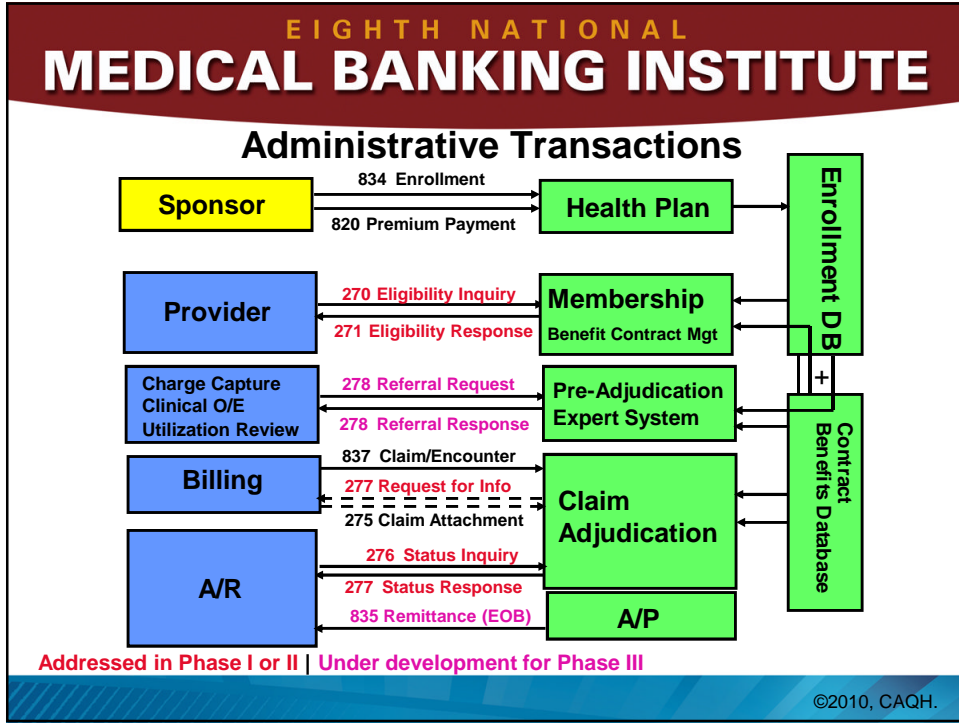


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Status: CORE Phases

<p>CORE Phase I</p> <ul style="list-style-type: none"> ✓ Approved ✓ Implemented 	<p>CORE's first set of rules 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.
<p>CORE Phase II</p> <ul style="list-style-type: none"> ✓ Approved ✓ Implemented 	<p>CORE's second set of rules 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
<p>CORE Phase III</p> <ul style="list-style-type: none"> ✓ In development 	<p>CORE's third set of rules focus on:</p> <ul style="list-style-type: none"> • Claim status data requirements (276/277) • 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

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Phase I Measures of Success Study

Study Approach:

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

Key Findings:

- All stakeholders achieved cost-savings and accelerated use of “real-time” transactions, e.g. provider denials decreased by 10-12%
- Health I.T. adoption accelerates and ROI increases when there are interoperable solutions that benefit both providers and health plans
- An industry-wide implementation of CORE Phase I rules would be a win-win scenario for providers and health plans that could yield an estimated \$3 billion of savings to the industry over three years

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Certification: ROI for CORE Phase I

All stakeholders have benefited from ...

- More robust and accessible eligibility methods to enhance the flow of information between providers and health plans
 - More patient visits are verified, e.g. 24% increase for providers
 - Richer content reduces the need for secondary phone verification
 - Real-time methods show most growth
 - Providers need a variety of methods - integrated and “on demand” transactions, as well as direct data entry
- Scalability of infrastructure investment
 - Common infrastructure supports multiple methods
 - Solutions reusable with new partners
 - Infrastructure will support new transaction types in the future
- Streamlined implementation with other CORE partners
 - Better technical skill and resources
 - Less customization, reduced testing
 - Lower cost connectivity using the public internet

Source: 2009 CAQH CORE Phase I Measures of Success Study, IBM Global Business Services

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CORE Participation, Certification, & Endorsement

Participation:

- Over 115 multi-stakeholder organizations representing all aspects of the industry
 - Maintain eligibility/benefits data for over 130 million lives, or more than 75 percent of the commercially insured plus Medicare and state-based Medicaid beneficiaries

Certification:

- To date, more than 40 healthcare organizations are certified to electronically exchange/receive transactions in accordance with the CORE rules
 - Approximately one-third of all commercially insured lives are covered by CORE Phase I-certified health plans
 - Key organizations such as Aetna and WellPoint already Phase II certified

Endorsement:

- About 30 organizations are endorsing CORE, e.g. AMA, AAFP, HIMSS

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Aetna Overview

- One of the nation's leaders in health care, dental, pharmacy, group life, and disability insurance, and employee benefits
- Over 19 million medical members
- Over 35,000 employees
- More than 939,000 health care professionals
- More than 538,000 primary care doctors and specialists at 5,148 hospitals
- Process over 150 million electronic eligibility inquiries per year
- Process over 230 million claims per year

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(as of September 30, 2009)

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Participant Perspective: Aetna and CORE

CORE Participation/Certification

- CORE participant and Phase II Certified
- Serve on CAQH Board and CORE Steering Committee

Employing CORE As An Interoperability Solution

- Require all vendor trading partners to be CORE-certified and conduct administrative data exchange in accordance with the CORE operating rules
- Aetna supporting connectivity through CORE rules – which are also integrated into HITSP requirements and aligned with NHIN, MITA and CONNECT
 - Avoids the need to implement custom solutions

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Aetna Lessons Learned

- In addition to data, plan for infrastructure updates/changes
 - CORE can help provide tools for a gap analysis
 - From the initial assessment through certification testing your internal experts will need to be involved
- Interoperability can best be achieved through the CORE rules when end-to-end transactions are performed in accordance with the rules
 - i.e. the health plan, vendors/clearinghouses, large provider groups involved in the data exchange are all CORE-certified

Next Steps

- Continue participation in development of CORE rules – with focus on identification of needed industry utilities and approaches
- Assess gaps for potential Federal requirements and the next phase of CORE
- Ensure trading partners are prepared to implement CORE certification

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Industry Collaboration

- Activities within CORE are developed to support and integrate with state, regional and Federal efforts
- Federal:
 - HITECH Act
 - HHS Meaningful Use draft currently includes administrative data exchange
 - ONC Specifications currently incorporates CORE rules
 - HITSP interoperability specifications
 - Integrates CORE rules – content and infrastructure, with focus on connectivity
 - MITA: Medicaid Information Technology Architecture
 - i.e. complement direction of ONC office for NHIN and CONNECT
 - HIPAA 5010
 - CORE rules require non-mandated aspects that are business focus, e.g. financials
- State/Regional:
 - CORE rules have been recommended to legislature by state-sponsored, multi-stakeholder committees, e.g., TX, OH, and CO
 - State-sponsored Health Information Exchanges (HIEs) determining about potential role for CORE

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HIEs: Aligning Regional and National Efforts

- Regional/state efforts will need to align with national objectives in order to achieve secure and interoperable data exchange
- States will need to prioritize objectives
 - Improving quality of care and patient outcomes
 - Improving the cost-effectiveness of care
 - Enhancing the capabilities of public health
- The Office of the National Coordinator (ONC) issued a Funding Opportunity Announcement (FOA) regarding state health information exchange (HIE)
 - Requires states to detail strategic and operational information exchange activities in five domains:
 1. Governance
 2. Finance
 3. Technical infrastructure
 - Includes developing services that support meaningful use objectives, e.g. in *draft* meaningful use objectives, electronic eligibility verification is one objective
 4. Business and technical operations
 5. Legal/policy issues

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Considerations for HIEs

- How can you avoid “reinventing the wheel?”
- How quickly can you take cost out of the system - both design and implementation?
- How will you earn stakeholder trust to keep data secure?
- Are there existing best practices that aligns with the HIE’s framework?
- How will your solution be rolled out as a successful proof of concept?
- What requirements and milestones will be achieved?
- How will you demonstrate that future enhancements support shared strategic goals?
- How will you demonstrate ROI?

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HITECH: CORE Relevance to HIEs

- CORE addresses HIE goals; i.e. CORE can be *an infrastructure component of a statewide technical architecture*
 - CORE facilitates *electronic eligibility verification*;
 - *Draft* of meaningful use includes requirement for providers to achieve and demonstrate this functionality
 - The plug-and-play nature of the CORE operating rules gives an HIE an immediate start in giving providers concrete functionality
 - The CORE rules include *connectivity/security* requirements, which are aligned with the draft Federal technical specifications
- The implementation of CORE could take place on two levels:
 - At the statewide policy level, building the use of CORE into statewide requirements; and
 - At the individual HIE level, including stakeholders who “plug in” as CORE-certified

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What is Next for CORE?

- With rules, address further data content needs for administrative transactions
 - Complete the phased approach across the revenue cycle, e.g. EFT
- Identify further infrastructure needs and determine role of CORE rules
 - Digital certificate policies, e.g. VeriSign pilot
 - Support of directory services, e.g. payer IDs
 - Connection to CAQH’s UPD (800,000 providers)
- Conduct ongoing Measures of Success studies
 - Quantify and report out ROI
- Continue collaborative industry approach
 - Wherever possible, help to align industry efforts CORE efforts, e.g. AHIP/BCBSA portal project and integration of CORE rules
- Expand methods to drive adoptions of the CORE rules
 - Trading partner networks
 - Leverage the plug-and-play nature of health information exchanges (HIEs)

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CAQH-VeriSign Pilot

Background

- System to System authentication using digital certificates is a part of CORE Connectivity Rules
- Effective enforcement of authentication requires "rules of the road" for trust and certificate practices

Objectives

- Identification of policy and standards gaps in the implementation of X.509 Digital Certificates for a vendor neutral PKI environment for streamlined node authentication:
 - Evaluate policy and standards requirements for interoperability while supporting a limited set of PKI providers (Certificate Authorities) to ensure vendor neutrality
 - Pilot using VeriSign PKI, but with ability to add other PKI vendors
 - Evaluate requirements for a single digital credential per Healthcare Provider issued and potential rules-of-the-road for PKI vendors such that all entities can recognize and accept that credential
 - Administrative simplification
- Determine alignment with direction of ONC, Nationwide Health Information Network (NHIN) and other national regulations and standards
- Lessons learned will be incorporated into CORE rules, if appropriate

Participants

- CAQH, VeriSign, New England Health Exchange Network (NEHEN), and CORE-certified entities, e.g. Harvard Pilgrim

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Questions & Answers

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