




CORE™
Industry Collaboration Leveraging Existing Testing Efforts to Help Prepare for Uptake and Adoption of National IT Standards


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HIMSS09 Interoperability Showcase

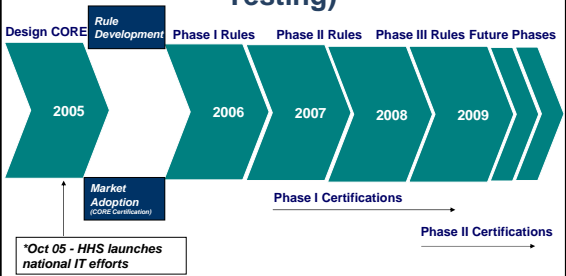
CORE™
 Committee on Operating Rules for Information Exchange
 A CAQH Initiative

CORE is more than 100 industry stakeholders – health plans, providers, vendors, government agencies, associations, regional entities, standard-setting organizations and other healthcare entities. Working in collaboration, they are building consensus on a set of operating rules that will:

1. Enhance interoperability between providers and payers
2. Streamline administrative data transactions (e.g., eligibility, claim status)
3. Reduce the amount of time and resources providers spend on administrative functions – time better spent with patients
 - Data Content Requirements
 - Infrastructure Requirements (e.g., connectivity, response time)




Rule Development Coupled with Implementation (Certification Testing)



The diagram illustrates a timeline from 2005 to 2009. Key milestones include:

- 2005:** Design CORE, Market Adoption (CAQH Certification), and HHS launching national IT efforts.
- 2006:** Rule Development and Phase I Rules.
- 2007:** Phase II Rules.
- 2008:** Phase III Rules.
- 2009:** Future Phases.

 Certification milestones include Phase I and Phase II Certifications starting in 2006.



Demonstration Objective

Leveraging the industry's existing testing efforts to help prepare for uptake and adoption of national IT standards

- CORE Rules and Certification - Testing Aspects of 5010
 - CORE Rules written with 5010 in mind
 - CORE Rules go beyond 5010 (e.g., connectivity, non-required 5010 data elements)

Administrative and Clinical Convergence

- CORE Rules and Certification – Include aspects of HITSP
 - Example: HITSP09 - Consultation & Transfer of Care
 - T85 – Administrative Transport to Health Plans
 - Includes CORE Connectivity Rule



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HIPAA Mandated Version 005010

- Latest iteration of implementation guide for administrative transactions mandated by HIPAA – federally mandated compliance by January 2012
- Replaces current version 004010A1
- Examples of X12 standard transactions under HIPAA - used by providers and health plans:

270-271: Eligibility inquiry and response

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

276-277: Claim status inquiry and response

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

278: Prior authorization and referral

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

837: Claims or equivalent encounter information

- Healthcare service information provided to a health plan for reimbursement

Note: For each transaction, only part of the standard is required



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CORE/5010 Crossover: Respond to Generic Eligibility Inquiry

CORE: Required by Phase I <i>effective</i>	5010: Federal Mandate <i>for Jan. 2012</i>
406	•Name of health plan (if available)
•Name of health plan (if available)	•Health plan coverage begin date
•Health plan coverage begin date	•Status of coverage (active, inactive)
•In/out of network coverage variance	•Status of following service types:
•Status of coverage (active, inactive)	✓ 1 Medical Care
•Status of following service types such as*:	✓ 33 Chiropractic
✓ 1 Medical Care	✓ 35 Dental Care
✓ 33 Chiropractic	✓ 86 Emergency Services
✓ 35 Dental Care	✓ 88 Pharmacy
✓ 86 Emergency Services	✓ 98 Prof. Office Visit
✓ 88 Pharmacy	✓ AL Vision
✓ 98 Prof. Office Visit	✓ 47 Hospital
✓ AL Vision	✓ MH Mental Health
	✓ UC Urgent Care

*Other service types required in CORE

NOTE: Bold italicized font indicates service type variance between CORE Phase I and 5010



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CORE/5010 Crossover: Return Patient Financials

- The return of patient financials has been included in CORE requirements – using the HIPAA standards - since Apr 06 well ahead of the recommendations in 5010 to return such information

Patient Financial	Required by CORE Phase I 4/06 or CORE Phase II since 7/08 (either 6 or 4 yrs prior to 5010)	Recommended by 5010 (not mandated)
Co-pay	X	X
Coinsurance	X	X
Deductible (static)	X	X
YTD Deductible	X (Phase II)	No
In/out of network variances	X	No



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MIE WebChart: Example of a CORE-Certified implementation – ahead of 5010

WebChart EMR, a CORE Phase I certified EMR, can send an electronic eligibility request to a plan and display eligibility/benefits response according to CORE rules

- CORE operating rules go beyond HIPAA by addressing "infrastructure" requirements e.g., response time specifications
 - Due to CORE, real time transactions such as these are required to take place in 20 seconds or less

Response to generic inquiry according to CORE Phase I Requirements

Insurance Information	
Subscriber Information:	David Cone 3 Elm St, 5th Floor Atlanta, GA 30307 Gender: Male Date of Birth: 3/4/1973 Member ID: 5642256
Health Plan Information:	Company: Plans A Plan Name: Georgia PPO Plan #: 2039125 Group #: 19482002
Coverage Level:	Family
Coverage Status:	Active starting 1/1/2006
Annual Deductible:	Individual: \$250 Family: \$500
Physician Office Visit:	\$20 co-pay, in-network
Chiropractic:	\$20 co-pay, in-network
Department Hospital:	Covered at 100% after Deductible
Outpatient Hospital:	Covered at 100% after Deductible
Emergency Services:	Covered at 100% after Deductible
Vision Coverage:	None
Dental Coverage:	None
Pharmacy/Drug Coverage:	\$20 co-pay \$25 individual/\$75 family deductible



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Edifecs Corporate Summary

Leader in Compliance, Quality & Interoperability Solutions for Improving Business Performance

Established	1996 (12 years), Privately Held
Headquarters	Bellevue, Washington
Customers	Global Markets: Over 1,100 top-tier accounts in banking, insurance, securities, utilities, and high tech. Healthcare: Over 350 clients
Solutions	<ul style="list-style-type: none"> Data Quality and Compliance Adaptors: Improve the quality of transactional data, and ensure compliance with government, industry and community standards Healthcare Transaction Gateway: Healthcare-centric, real-time, standards independent, multi-channel port that manages all transactional data
Headcount	~100 (75 in Products & Engineering)




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HITSP/CORE Crossover: IS09

CORE rules incorporated in HITSP Interoperability Specifications

- Administrative and Clinical data flow convergence
 - Example: Consultation & Transfer of Care (HITSP IS09)

Demonstrate use of CORE Connectivity Rule

- Payload agnostic – can transport administrative and clinical content
- Harvard Pilgrim is an early adopter; tested using Edifecs CORE Testing System 

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CORE/HITSP IS09 Crossover:

T85 - Administrative Transport to Health Plan

T85 Construct Incorporates CORE Phase II Connectivity Rule

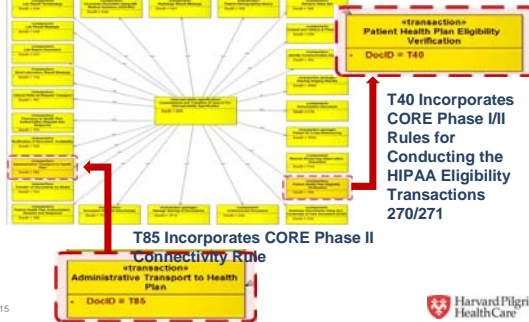
- Builds on Phase I Rule which supports HTTP/S 1.1 over the public internet as transport method for batch and real-time transactions (eligibility)
- Envelope and Submitter Authentication Conformance Specifications
 - Submitter Authentication
 - Username/Password over SSL
 - X.509 Certificate over SSL
 - Message Envelope Standards
 - SOAP+WSDL
 - HTTP MIME
- Request and Response Handling, Error and Audit Handling
- Response, Timeout and Retransmission Requirements
- Metadata outside the Payload
 - Facilitates connectivity standardization as well as administrative and clinical integration (Accelerates industry interoperability)
 - Entities are able to do auditing and authentication without parsing payload/bring payload into their system
 - Payload agnostic



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CORE/HITSP IS09 Crossover: T40 Patient Health Plan Eligibility Verification
T85 Administrative Transport to Health Plan

HITSP IS09 Consultation & Transfer of Care Interoperability Specification



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Visit CAQH Showcase Kiosk

Live Demonstration

Edifecs CORE Certification Testing
System
and
CORE Phase II Connectivity Rule via
HIPAA Eligibility 270/271 Transaction



Visit CAQH Showcase Kiosk

Questions?