CAQH CORE

CAQH CORE National Town Hall

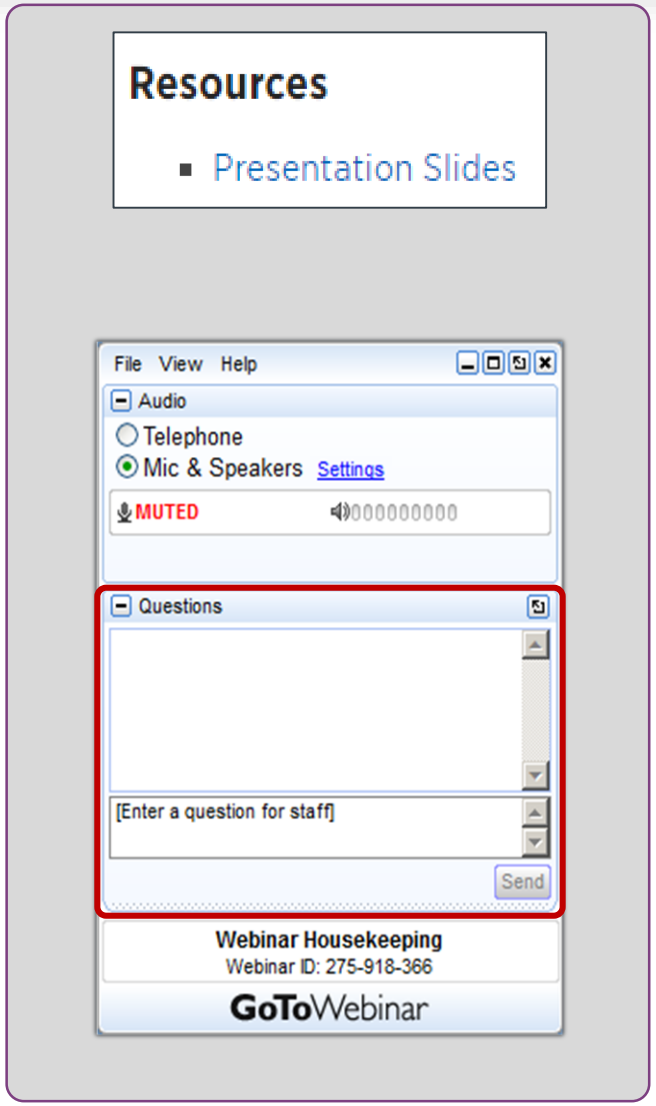
May 15, 2019

2:00 – 3:00 PM EST

Logistics

Presentation Slides and How to Participate in Today's Session

- **You can download the presentation slides at www.caqh.org/core/events after the webinar.**
- Click on the listing for today's event, then scroll to the bottom to find the Resources section for a PDF version of the presentation slides.
- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
- Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**



CAQH CORE

Session Outline

- CAQH CORE Overview and Federal Activities
- Industry-wide Effort to Address Prior Authorization
- Defining a Path to Electronic Exchange of Medical Documentation
- Streamlining Adoption of Value-based Payments
- CORE Certification: Demonstrate Commitment to Administrative Efficiency
- Q&A

CAQH CORE Overview and Federal Activities Update

Erin Weber
CAQH CORE Director

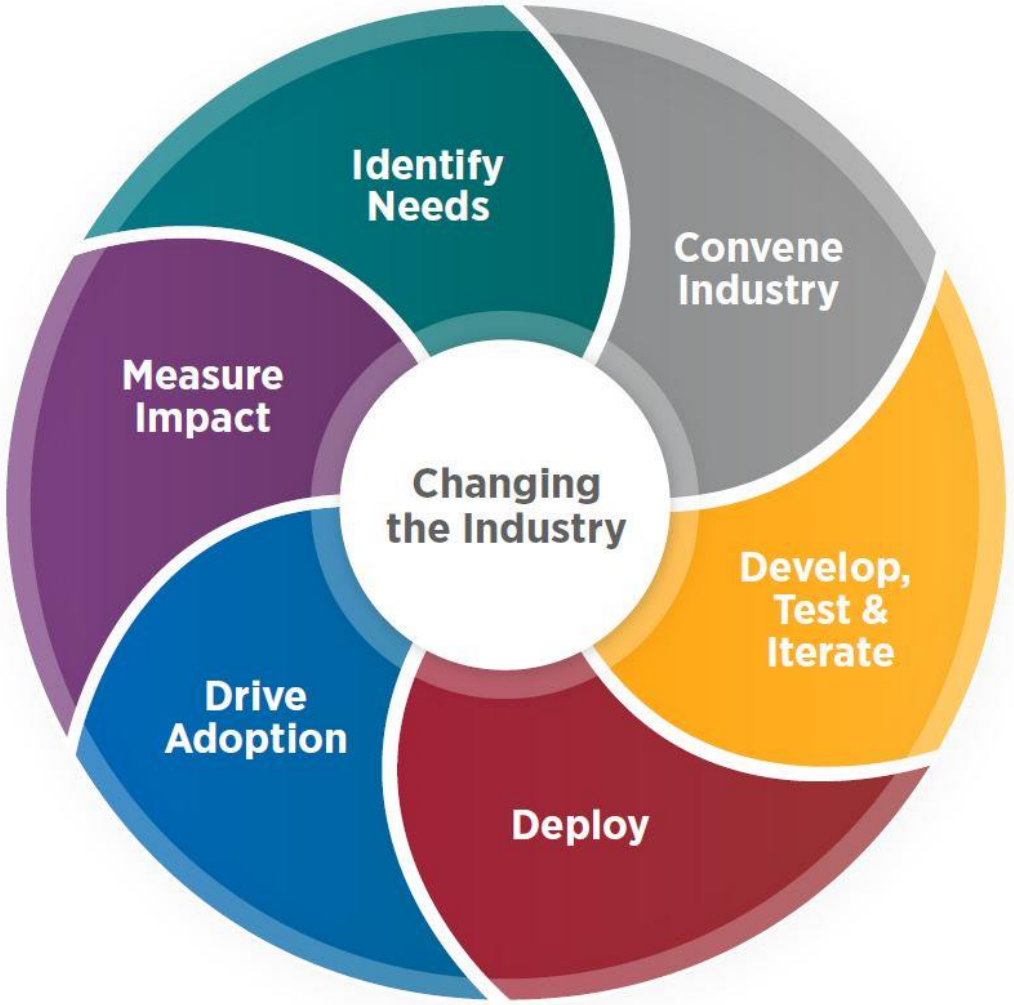
CAQH CORE Mission and Vision

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability** and align administrative and clinical activities among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION **Named by Secretary of HHS to be national author for operating rules** mandated by Section 1104 of the Affordable Care Act.

BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs.



CAQH CORE Operating Rule Overview

CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions, including Claims Attachments.
HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules.

	Phase I	Phase II	Phase III	Phase IV	Phase V	Phase VI
Transactions	Eligibility	Eligibility Claims Status	Electronic Funds Transfer Electronic Remittance Advice	Health Claims Referral, Certification and Authorization Enrollment Premium Payments	Prior Authorization	Attachments
Manual to Electronic Savings per Transaction (2018 CAQH Index)	$6.52	Eligibility: $6.52 Claim Status: $9.22	Claim Payment: $0.65 ERA: $2.32	Claim Submission: $1.32 Prior Authorization: $7.28	$7.28	N/A
	Active					**In Progress**

Notes: (1) Phases I-IV include requirements for acknowledgements, e.g., 999 Functional Acknowledgement, 277CA Claims Acknowledgement. (2) CAQH CORE is also evaluating maintenance areas and opportunities to build on existing rules to support value-based payment. (3) Operating rules for eligibility, claim status, EFT, ERA, claims, enrollment, premium payment, and referral, certification and authorization support the HIPAA mandated transactions.

CMS Compliance Review Program

- CMS is launching a Compliance Review Program to ensure accordance among covered entities with HIPAA Administrative Simplification rules for electronic health care **transaction formats, code sets and unique identifiers**. Participants will attest to whether they comply with federally mandated **operating rules**.
- In April 2019, CMS planned to randomly select nine HIPAA-covered entities—a mix of health plans and clearinghouses—for Compliance Reviews.
  - Providers will be able to participate in a separate pilot program on a voluntary basis.
- Moving forward, the Compliance Review Program will conduct periodic reviews with randomly selected entities to assess compliance.
  - The program supplements HHS's current complaint-based approach to enforcing the use of standards for electronic transactions. Anyone can still file a complaint—or test a transaction—using an online tool known as ASETT.

Noncompliance

✓ Covered entities found to be noncompliant will be given the opportunity to take actions to correct issues and achieve compliance.

✓ Covered entities who do not achieve compliance may be subjected to escalated enforcement actions.

CMS and ONC Proposed Rules to Advance Interoperability and Patient Access to Healthcare Information

CMS NPRM	ONC NPRM
Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-facilitated Exchanges and Health Care Providers	21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program
Goal: CMS aims to use its authority to advance interoperability and patient access to health information. Key touchpoints are: ▪ Enabling patients to access health information electronically without special effort through APIs. ▪ Ensuring providers have access to information on patients regardless of where they previously received care by preventing restrictions on the flow of information to other providers and payers. ▪ Ensuring that payers make enrollee electronic health information available through an API. ▪ Making it easy for patients and providers to identify providers within a plan's network.	**Goal:** ONC intends to support seamless and secure access to, exchange of, and use of electronic health information (EHI). Key provisions are: ▪ Increase innovation and competition by giving patients and their health care providers safe and secure access to health information and to new tools, allowing for more choice in care and treatment. ▪ Reduce burden and advance interoperability through the use of United States Core Data for Interoperability (USCDI) standard, new API requirements and EHI export capabilities for the purposes of switching health IT or to provide patients their electronic health information. ▪ Promote patient access through a provision enabling patients to electronically access their electronic health information (structured and/or unstructured) at no cost.

The public comment period is now open for the proposed rules. Comment period ends **Monday, June 3, 2019.**

Industry-wide Effort to Address Prior Authorization (PA)

Rachel Goldstein
CAQH CORE Senior Manager

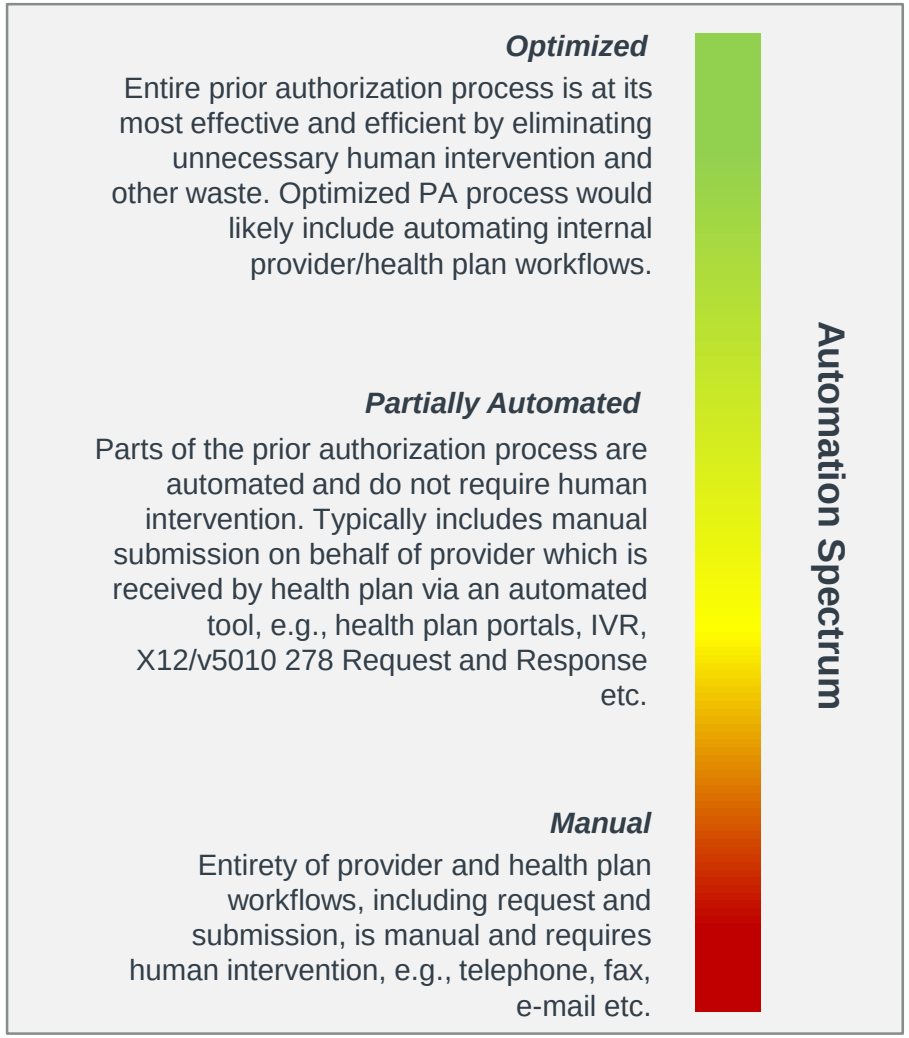
CAQH CORE Vision for Prior Authorization

Introduce targeted change to propel the industry collectively forward to a prior authorization process optimized by automation, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.

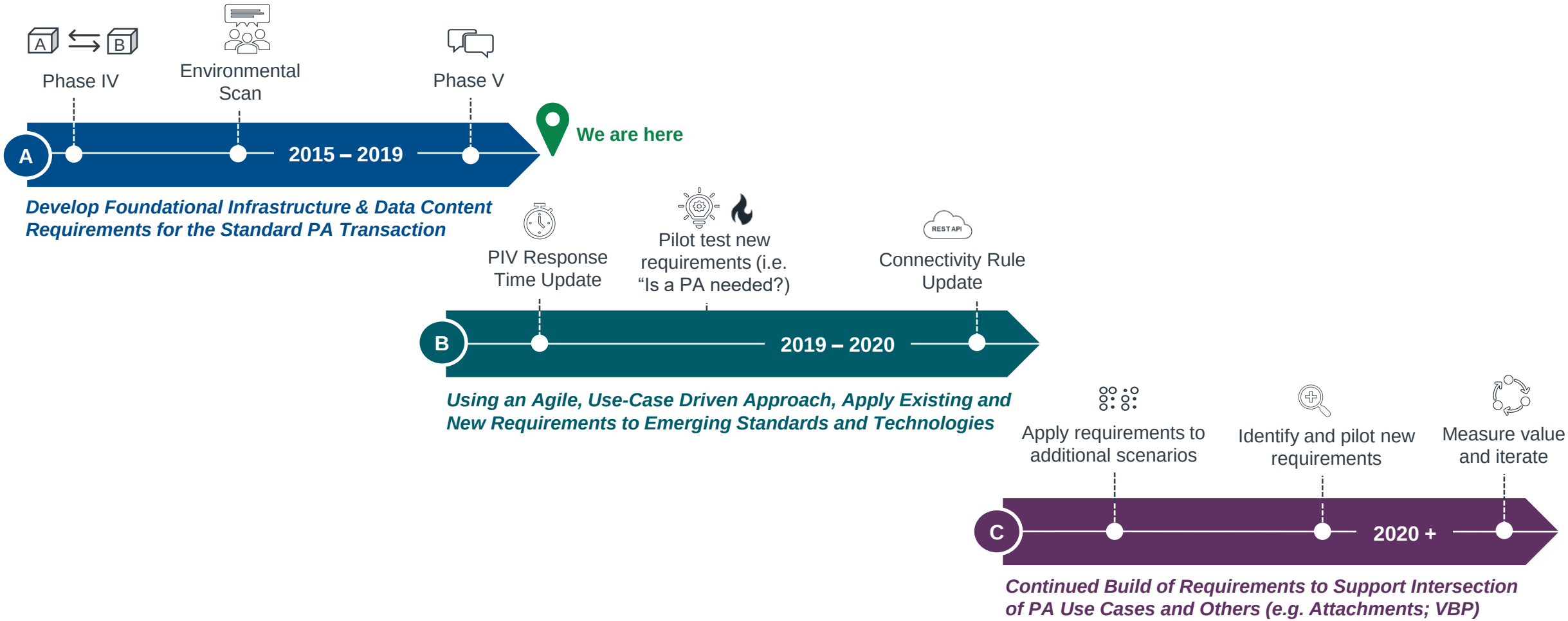
The Phase IV Operating Rule established **foundational infrastructure requirements such as connectivity, response time**, etc. and builds consistency with other mandated operating rules required for all HIPAA transactions.

The Phase V Operating Rules address **needed data content** in the prior authorization standard electronic transaction and **enable greater consistency across other PA exchange mechanisms.**

Ongoing efforts in 2019 to **pilot test requirements** for a provider to **determine whether an authorization is needed** and update the Phase IV Rule with a **timeframe for final determination.**



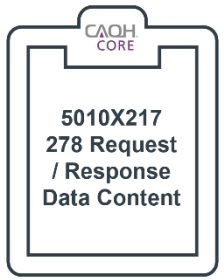
CAQH CORE Prior Authorization Roadmap



Introducing the CAQH CORE Phase V Prior Authorization Operating Rules

Newly Approved Rule Set Strengthens the Accuracy and Trustworthiness of PAs

The new CAQH CORE Phase V Prior Authorization Operating Rules are the result of a collaborative effort of more than **100 stakeholder groups** across the industry and received nearly **90% approval rating** from the voting CAQH CORE Participating Organizations.



The **Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule** targets one of the most significant problem areas in the prior authorization process: requests for medical services that are pended due to missing or incomplete information, primarily medical necessity information. These rule requirements reduce the unnecessary back and forth between providers and health plans and enable shorter adjudication timeframes and fewer staff resources spent on manual follow-up.

The **Phase V CAQH CORE Prior Authorization Web Portal Rule** builds a bridge toward overall consistency for referral and prior authorization requests and responses by addressing fundamental uniformity for data fields, ensuring confirmation of the receipt of a request and providing for system availability. This Rule supports an interim strategy to bring greater consistency to web portals given current widespread industry use, with a long-term goal of driving adoption of standard transactions.

Prior Authorization (278) Request / Response Data Content Rule

Requirements and Scope

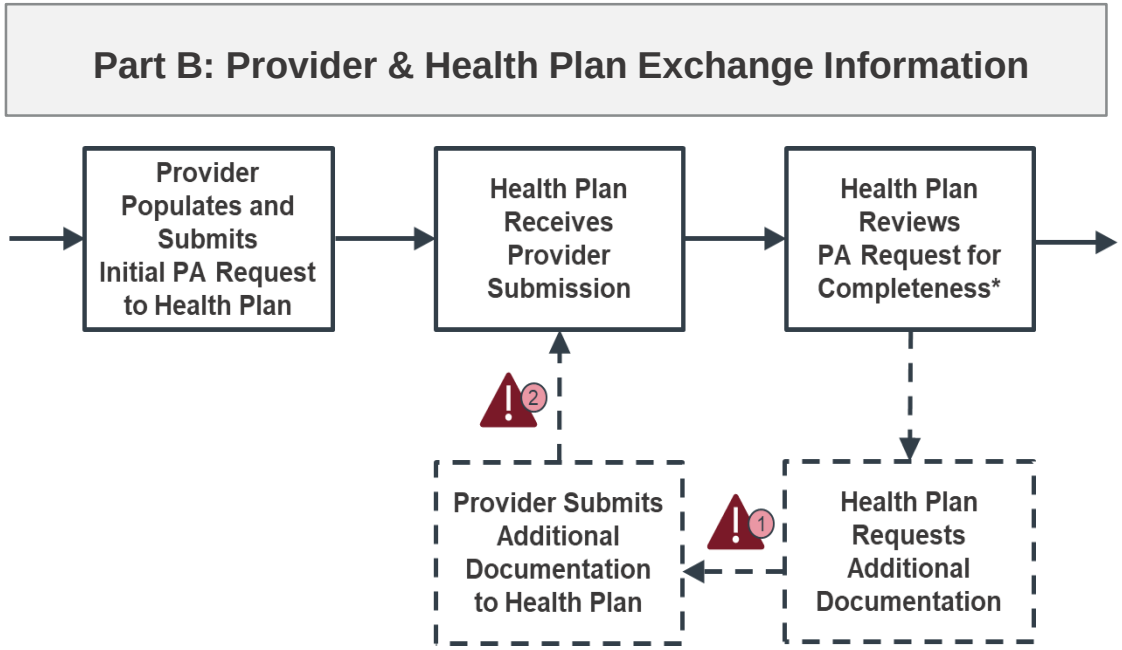
Key Rule Requirements
✓ Consistent patient identification and verification to reduce to reduce common errors and denials.
✓ Return of specific AAA error codes and action codes when certain errors are detected on the Request.
✓ Return of Health Care Service Decision Reason Codes to provide the clearest explanation to the submitter.
✓ Use of PWK01 Code (or Logical Identifiers Names and Codes & PWK01 Code) to provide clearer direction on status and what is needed for adjudication.
✓ Detection and display of all code descriptions to reduce burden of interpretation.

Scope	
In Scope	▪ Applies to the 5010X217 278 Request / Response transactions for prior authorizations for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit. ▪ Applies when any HIPAA covered entity, conducts or processes the 5010X217 278 Request / Response transaction.
Out of Scope	× Prior authorizations covered by retail pharmacy benefit. × Prior authorization specific to emergency / urgent requests. × Referral requests.

Spotlight on Phase V CAQH CORE Operating Rule Requirement

Requesting Additional Documentation for a Pended Response

The CAQH CORE Prior Authorization (278) Request / Response Data Content Rule targets a major problem area in the prior authorization process: requests for medical services that are pended due to missing or incomplete information. **The operating rule reduces the unnecessary and manual back and forth between providers and health plans by calling for the uniform use of standard codes to streamline communication electronically and reduce time to final determination and patient care.**



Pain Point: Not enough detail included in the response to know why the request was pended and what information is needed to resolve the pend.

When a PA Request is pended for additional documentation, rule requires the use of **specific standard codes in conjunction with detailing the type(s) of documentation required for the PA.**

Pain Point: With the lack of robust information in the response, providers telephone the plan to determine what is needed, or resubmit with incorrect/ incomplete information, resulting in additional pends or delays in care.

Easing the **burden of interpretation on the provider by standardized and uniform code use and requiring display of code descriptions.** Provider submits more complete requests, resulting in fewer pends, iterative requests for more information, and denials.

* Depicts the most common path for the PA process to follow. Some health plans are able to automate the adjudication process when no additional documentation is needed.

Prior Authorization Web Portals Rule

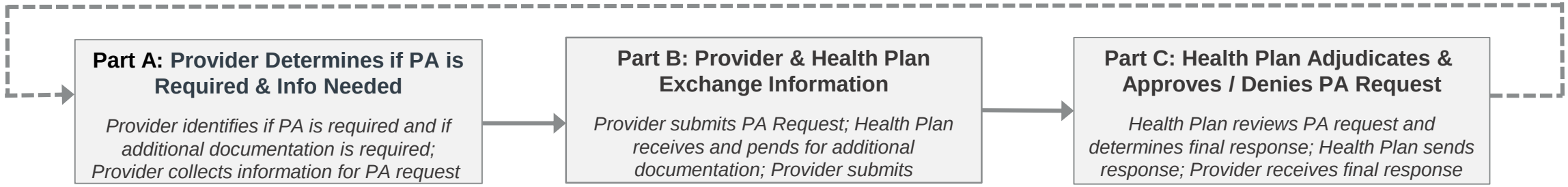
Requirements and Scope

Key Rule Requirements
✓ Use of the 5010X217 278 Request / Response TR3 Implementation Names or Alias Names for the web portal data field labels to reduce variation.
✓ System availability requirements for a health plan to receive requests, to enable predictability for providers.
✓ Confirmation of receipt of request to reduce manual follow up for providers.
✓ Adherence to the requirements outlined in the 278 Request / Response Data Content Rule when the portal operator maps the collected data from the web portal to the 5010X217 278 transaction.

Scope	
In Scope	▪ Applies to any web portal used to submit a referral as well as prior authorizations for procedures, laboratory testing, medical services, devices, supplies or medications within the medical benefit. ▪ Applies when any entity and its agent make available a web portal to a provider to submit a prior authorization request or referral.
Out of Scope	× Prior authorizations covered by retail pharmacy benefit. × Does not require any entity to conduct, use or process a prior authorization or referral via a web portal if it does not currently do so.

Phase IV & V CAQH CORE Operating Rules Address Key Pain Points in the Prior Authorization Process

Key Components of the Prior Authorization Process*



Part A: Provider Determines if PA is Required & Info Needed

Provider identifies if PA is required and if additional documentation is required; Provider collects information for PA request

- ★ **Consistent patient identification** to reduce common errors and associated denials.
- ★ **Application of standard X12 data field labels to web portals** to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.
- ☆ **Standard Companion Guide format** to ensure trading partners are informed of the nuances required for successful transaction processing.

Part B: Provider & Health Plan Exchange Information

Provider submits PA Request; Health Plan receives and pends for additional documentation; Provider submits

- ☆★ **System availability** requirements for a health plan to receive a PA request.
- ★ **Consistent review of diagnosis, procedure and revenue codes** to allow for full adjudication.
- ★ **Consistent use of codes** to indicate errors/next steps for the provider, including need for additional documentation.
- ★ **Detection and display of code descriptions** to reduce burden of interpretation.
- ☆★ **Confirmation of receipt of PA submission** to reduce manual follow-up for providers.
- ☆ **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- ☆ **Time requirement for initial response.**

Part C: Health Plan Adjudicates & Approves / Denies PA Request

Health Plan reviews PA request and determines final response; Health Plan sends response; Provider receives final response

- ☆ **Consistent connectivity and security methods** between trading partners to improve timely flow of transactions and data.
- ★ **Detection and display of code descriptions** to reduce burden of interpretation.

☆ *Requirement in CAQH CORE Phase IV Operating Rule*

★ *Requirement in CAQH CORE Phase V Operating Rule*

* Depicts the most common path for the PA process to follow.

Prior Authorization Next Steps

Join us for the May 29 Webinar to learn about the Phase V CAQH CORE Prior Authorization Operating Rules from the Phase V Co-Chairs.

Start planning efforts for CORE Certification for the Phase IV & V Operating Rules. Phase IV Certification is currently available, and Phase V will be available by the end of the year.

Stay tuned for additional resources including the Phase V CAQH CORE Analysis & Planning Guide and Phase V FAQs to be posted to the CAQH CORE website in June 2019.

Stay engaged in prior authorization requirements development by participating in the **Phase IV Response Time Task Group** or considering a **pilot project**. CAQH CORE continues to focus on:

- Minimizing the timeframe to a final determination via enhancements to the Phase IV 278 Infrastructure rule.
- Improving the electronic discovery of prior authorization rules, requirements and determinations through pilots measuring impact of potential new operating rules.
- Streamlining the exchange of “Attachments” (i.e. medical information/supplemental documentation) to support prior authorizations.

Phase IV Prior Authorization Response Time Requirement Enhancements

Phase IV Task Group Launching in May

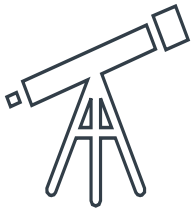
Phase IV Task Group Objective:

- Evaluate opportunities to strengthen the Phase IV CAQH CORE 452 Health Care Services Review –Request for Review and Response (278) Infrastructure Rule v4.0.0 to include a response time requirements for a final PA determination and update the PIV Certification Test Suite accordingly.
- The goal of the potential requirements is timely delivery of patient care and reduced administrative burden stemming from manual status checks and inconsistent timeframes.

Approach:

- After 73% of CAQH CORE Participating Organizations engaged in PA rule development indicated support for a PA response time requirement, CAQH CORE staff conducted an extensive review of national and state-level response time requirements.
- The Phase IV Task Group will involve a higher level of involvement (but shorter time frame) than traditional group participation.
- Task Group participants are either **Subject Matter Experts (SMEs)** with knowledge of how their organization operates with respect to final determination response times or an **Executive-Level Sponsor** interested in development of the requirement and supportive of their SME's efforts.

Coming Soon: CAQH CORE Prior Authorization Pilot Project



Vision:

Rapidly develop and track the impact of existing and potentially new CAQH CORE prior authorization operating rule requirements that support automation, add value to existing and emerging standards and reduce administrative burden for providers and health plans.

Goal:

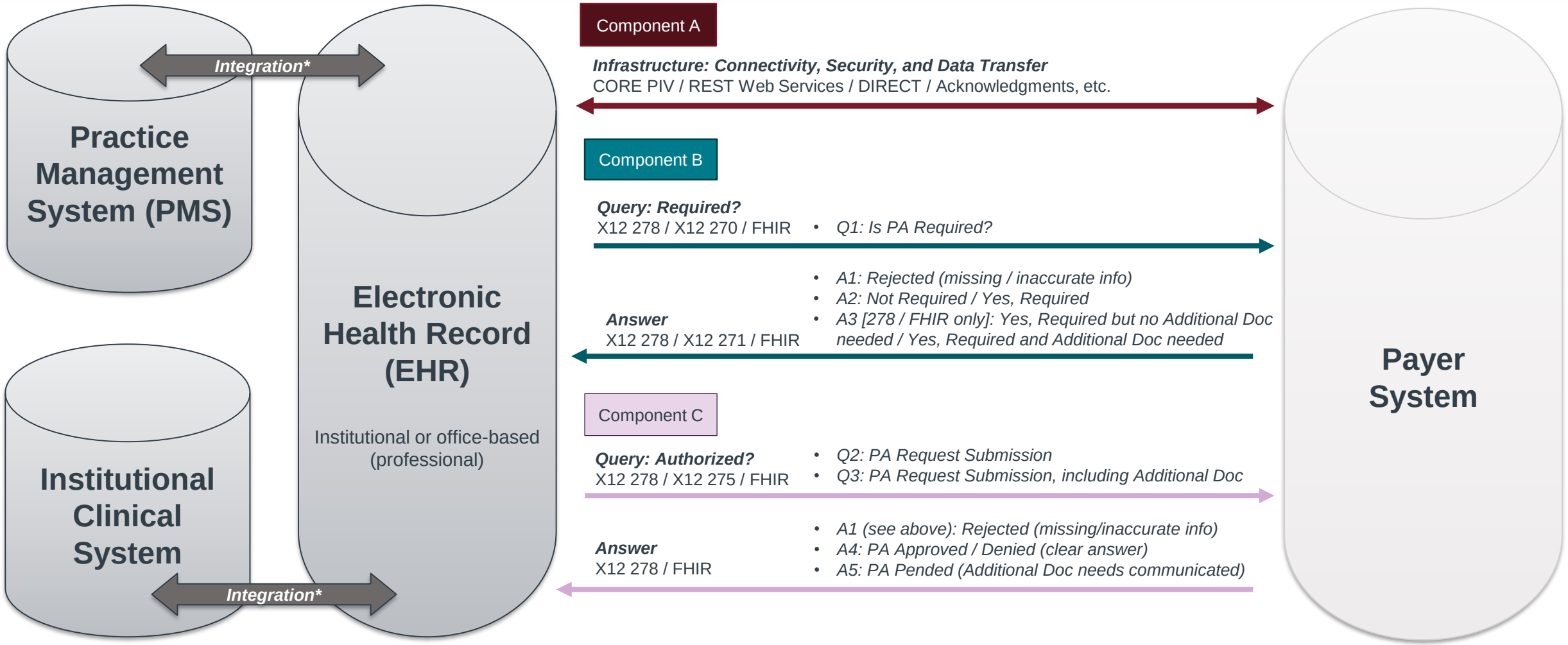
- Design and implement pilots with partner organizations in 2019 to assess impact of existing / new data content and infrastructure requirements for the electronic discovery of prior authorization rules, requirements, and determinations.

Piloted Rule Requirements:

- Support various connectivity and security methods.
- Work in concert with existing and emerging standards (X12, HL7 FHIR, etc.).
- Support timely and complete response to the provider that facilitates patient care and increases confidence for provider payment.
- Focus on specific categories of service; e.g., Imaging, Cardiology, Oncology, Surgery, etc.

PA Pilots to Add Value to Existing and Emerging Standards

Conceptual Model: CAQH CORE Operating Rules Support Pilot Components

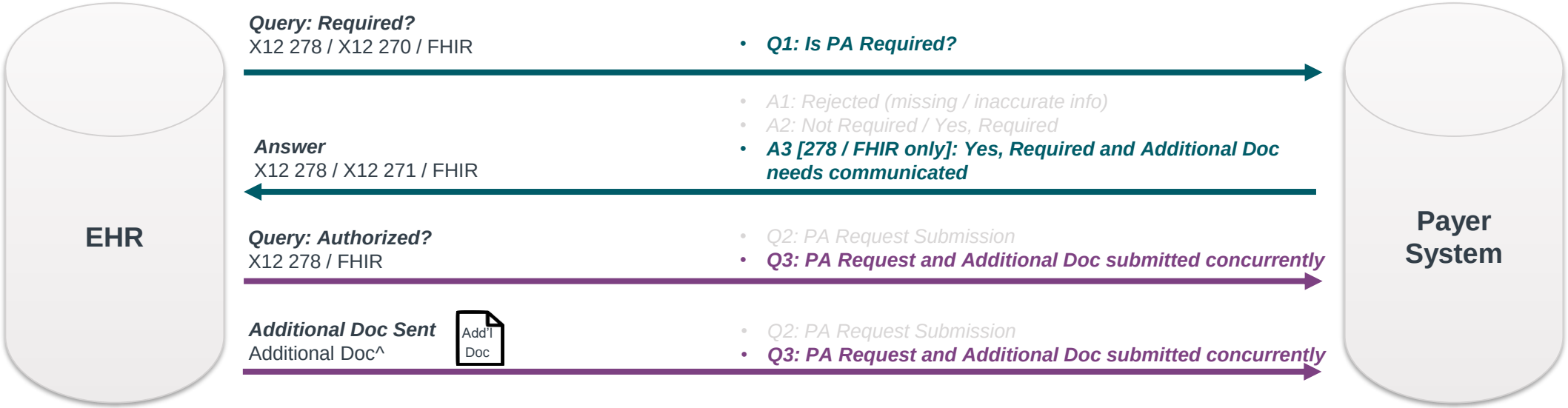


* These systems are rarely integrated. An alternate workflow could have the PMS and Payer systems communicating back and forth, instead of the EHR. However, for the purpose of this conceptual model, integration is assumed as a precondition.

Attachments / Additional Documentation Workflow #1

SOLICITED ATTACHMENTS WORKFLOW #1: PA REQUEST & ATTACHMENTS SUBMITTED CONCURRENTLY

Additional Documentation needs are identified in Component B (A3); Documentation submitted in parallel to Request in Component C



Add'l Doc

^ ***Electronic Exchange Mechanisms*** *(X12 275 / FHIR / DIRECT / Portal)* **+ *Structured and Unstructured Payload*** *(CDA / PDF / JPEG / Other)*
OR ***CORE Connectivity*** + ***Structured and Unstructured Payload*** *(CDA / PDF / JPEG / Other)*

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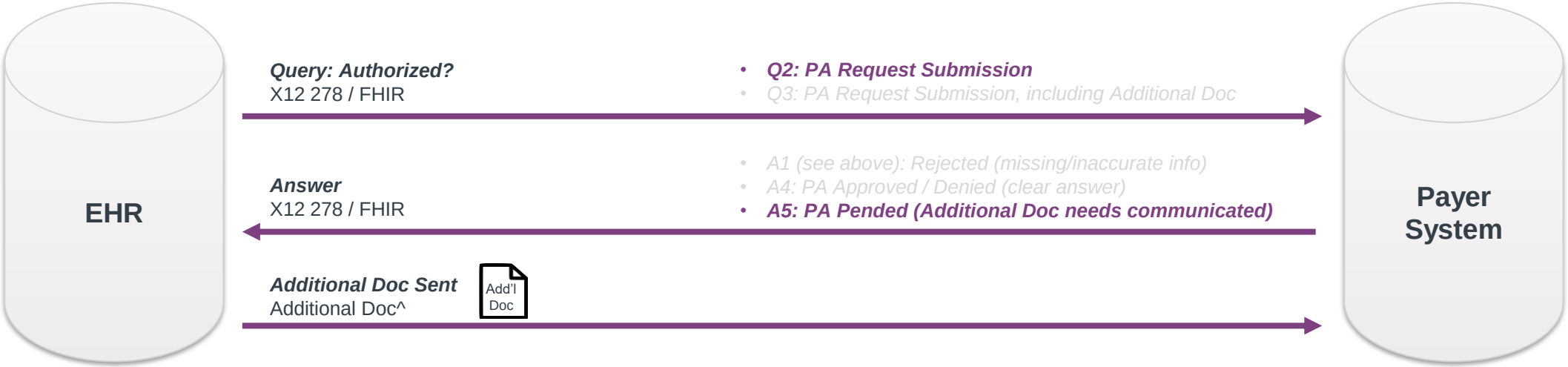
Attachments / Additional Documentation Workflow #2

SOLICITED ATTACHMENTS WORKFLOW #2: ATTACHMENTS SENT AFTER PA REQUEST

Additional Documentation needs are identified in Component C, via PA Response (A5); Documentation sent to Health Plan following receipt of that PA Response.



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OR ***CORE Connectivity*** + ***Structured and Unstructured Payload*** *(CDA / PDF / JPEG / Other)*

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Polling Question #1

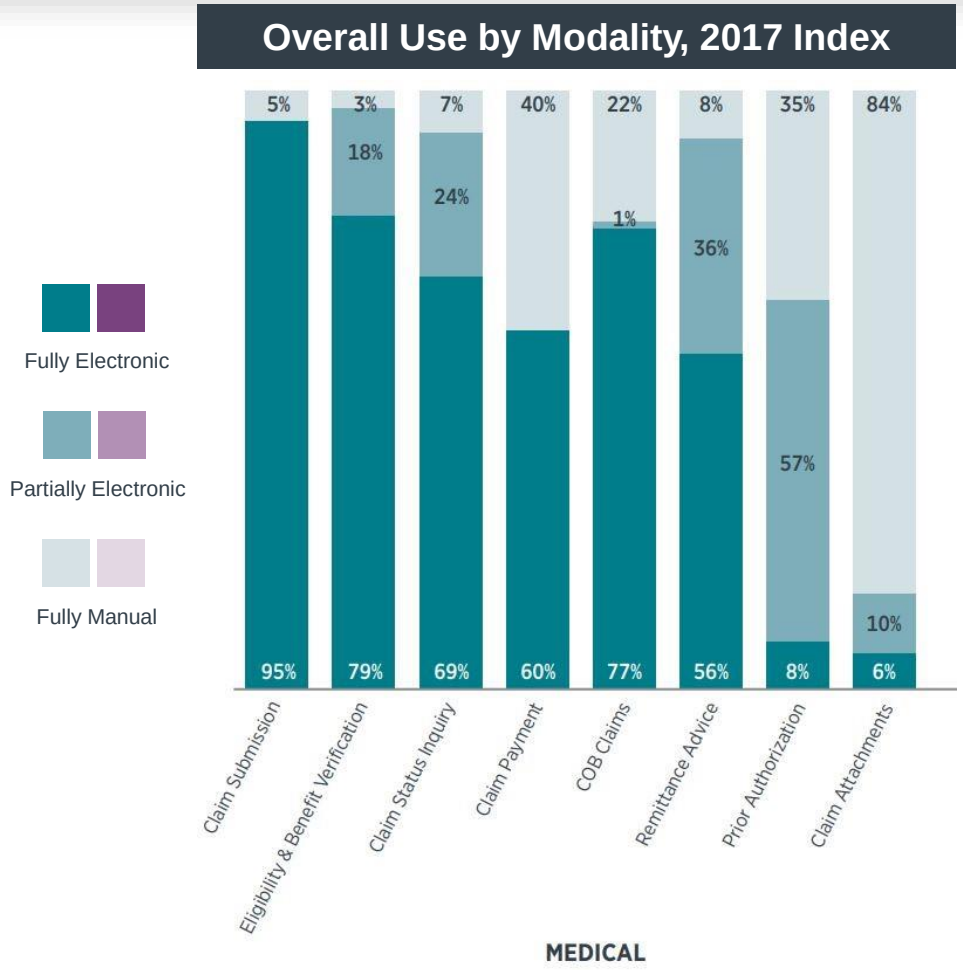
Which of the following Prior Authorization work efforts is your organization interested in engaging with or would like more information on? (Select all that apply.)

- Phase IV Prior Authorization Response Time Task Group
- Prior Authorization Pilot
- Phase V Prior Authorization CORE Certification - Beta Testing

Defining a Path to Electronic Exchange of Medical Documentation

Taha Anjarwalla
CAQH CORE Senior Manager

Current State of Industry



The 2017 CAQH Index estimated 204 million claim attachment transactions annually between healthcare providers and health plans. **Only six percent of these were processed using a standard electronic method.**

The CAQH Index has also studied prior authorization attachments, but has not yet been able to calculate and report benchmarks for this transaction.

More data is needed to fully articulate the scope of the attachments challenge. All health plans and healthcare providers are encouraged to participate in the 2019 CAQH Index study.

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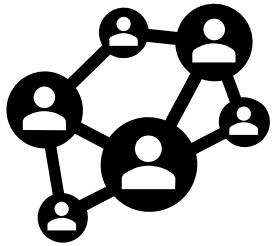
CAQH CORE Environmental Scan on Attachments

CAQH CORE launched an environmental scan to understand industry pain points and identify ways in which we can use our collaborative, multi-stakeholder model to support and accelerate the adoption of electronic attachment transactions.

We gathered insights from more than **40 entities** representing providers, health plans, vendors, clearinghouses and government.



On a recent CAQH CORE webinar, attendees were asked to identify the primary reason for delay in adopting electronic attachment transactions:

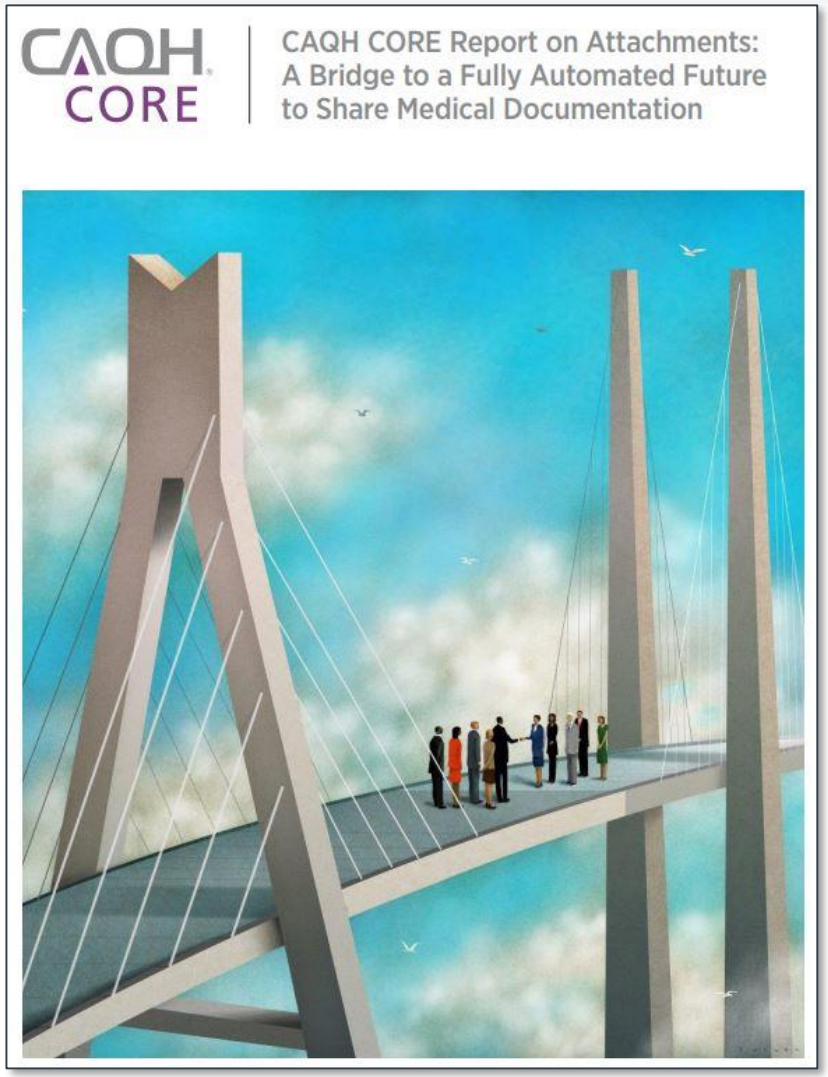
The majority of respondents (44%) identified **waiting for regulatory direction** as the primary reason for delay; 23% reported waiting for industry direction, and only 9% of organizations listed budget constraints as a reason for delay.

CAQH CORE® Report on Attachments: A Bridge to a Fully Automated Future to Share Medical Documentation

The *CAQH CORE Report on Attachments: A Bridge to a Fully Automated Future to Share Medical Documentation*, published in May 2019, examines the challenges associated with the exchange of medical information and supplemental documentation used for healthcare administrative transactions. The report identifies five areas to improve processes and accelerate the adoption of electronic attachments.

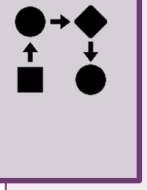
Full Report

Press Release



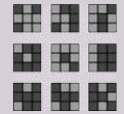
Opportunities to Improve the Exchange of Attachments

The CAQH CORE Attachments Environmental Scan has identified five opportunity areas that can support and accelerate industry adoption of electronic attachment transactions by creating a more uniform approach.



#1 Workflows

- Workflows map out chronological processes to accomplish complex tasks, often detailing sequential steps by parties in different organizations or locations.



#2 Data Variability

- Data variability is the degree to which data shared between parties diverges from the expected structure.

#3 Exchange Mechanism

- Exchange mechanisms refer to the means of data exchange for a transaction between a health plan and provider.

#4 Infrastructure

- The fundamental instructions every data exchange system needs to work: how to connect with other machines, negotiate security protocols and basic expectations for each transaction.

#5 Utilities

- Utilities are “single-source-of-truth” resources maintained for the use of industry by a trusted party capable of facilitating collaboration and driving consensus among parties.

CAQH CORE Participant Call to Action

Industry leaders have been working to more closely align healthcare administrative and clinical systems. While many believe the capacity to integrate data is now within reach, clinical and administrative data has remained siloed. Industry-wide electronic exchange of attachments will help achieve this desired alignment.

Achieving this vision, however, will first require industry to collaborate in an effort that addresses and overcomes a range of challenges, many of which are identified in this report. CAQH CORE needs and values the input of all CAQH CORE Participants and will need their expertise and guidance moving forward in Attachment efforts.

Future Next Steps

Future steps include monitoring federal activity for publication of an attachment standard **NPRM** and launching an **Attachments Advisory Group and Subgroup** given the CAQH CORE role as the designated operating rules authoring entity.

Attachments Webinar Series: Defining a Path to Electronic Exchange of Medical Documentation

WEDNESDAY, JULY 10, 2:00 – 3:00 PM

Polling Question #2

Is your organization interested in getting involved in the CAQH CORE efforts on Electronic Attachments?

- Yes
- No
- Unsure/need more information

Streamlining Adoption of Value-based Payments

Helina Gebremariam
CAQH CORE Manager

CAQH CORE Value-based Payment Initiative

Streamlining the Adoption of Value-based Payments

CAQH CORE research indicates healthcare stakeholders must act decisively and collaboratively to prevent value-based payment from confronting the administrative roadblocks once encountered in fee-for-service.

Industry Report

All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments, a CAQH CORE report published in 2018, analyzes operational challenges that may slow or add costs to the implementation of value-based payment.

VBP Advisory Group

In early 2019, CAQH CORE launched the VBP Advisory Group made up of industry executives and thought-leaders. These participants were charged with prioritizing opportunity areas for CAQH CORE rule development action (e.g. subgroup or pilot).

Vision: A common infrastructure that drives adoption of value-based payment models by reducing administrative burden, improving information exchange and enhancing transparency.

CAQH CORE Value-based Payment Initiative

CAQH CORE VBP Advisory Group Participants

CAQH CORE Value-based Payment Initiative

Sample Opportunities for Administrative Simplification in VBP

Provider often does not know if a patient is attributed to them until after care is delivered.

Provider is not always aware of pertinent patient risk identification information (e.g. visits to other providers) at time of care.

Claim cannot convey pertinent clinical and health information not related to a service provided during visit.

Provider is not always aware of what additional documentation is necessary for a health plan to adjudicate a claim.

Remittance advice does not fully explain how provider payment relates to VBP arrangements (e.g. were quality metrics met?)

Opportunity: Return patient attribution information when provider submits an eligibility check.

Opportunity: Return patient risk identification information prior to point of service.

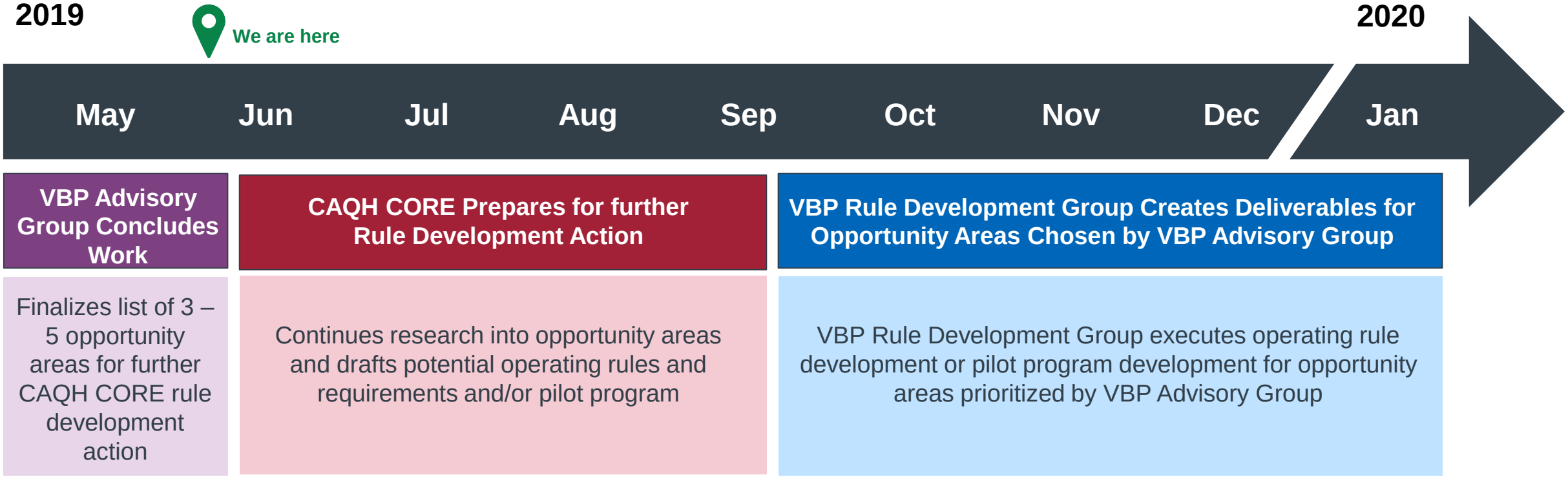
Opportunity: Require the inclusion of expanded code sets (e.g. LOINCs or CPT II codes) on claims to convey non-service related information.

Opportunity: Standardize provider notification of need for additional documentation to address care gaps, quality measures or performance metrics.

Opportunity: Improve contract performance reporting at time of claims reconciliation.

Next Steps for Value-based Payment Initiative

The Value-based Payment (VBP) Advisory Group will adjourn at the end of this month. CAQH CORE staff will then conduct additional research on the chosen opportunity areas and launch rule development groups this fall. Please be on the look out for a call for participants late this summer.



VBP Advisory Group
CAQH CORE Staff
VBP Rule Development Group

CAQH CORE

CORE Certification: Demonstrate Commitment to Administrative Efficiency

Taha Anjarwalla
CAQH CORE Senior Manager

CORE Certification

Developed by Industry, for Industry to Promote Administrative Efficiency

CORE Certification is the most robust and widely-recognized industry program of its kind – the Gold Standard. The approach allows organizations to demonstrate their ability to reduce administrative costs through adoption of operating rules.

Requirements are developed by broad, multi-stakeholder industry representation via transparent discussion and polling processes.

Requirements testing is conducted by third party vendors that are experts in EDI and testing.

CAQH CORE serves as a neutral, Certification administrator.

CORE Certifications Phase I-IV

Market Penetration Continues to Grow

361 Certifications have been awarded since the program's inception.

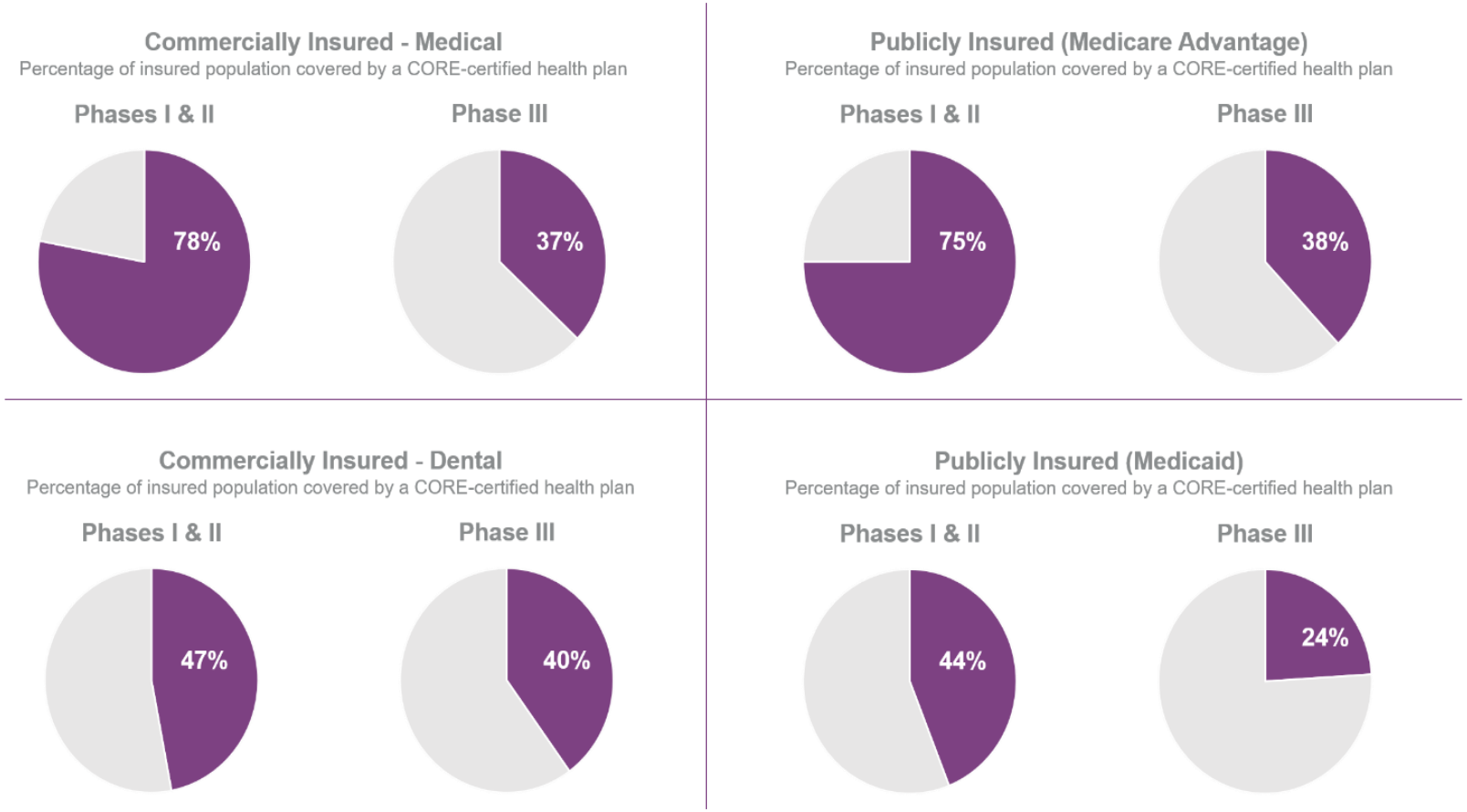
Congratulations to our most recent CORE Certifications!

eligibill

HealthTrio® LLC

FRONTRUNNER HEALTH CARE

SecurityHealth Plan℠



CAQH CORE

CORE Certification Program Updates

- **Bundled Certification**:
  - CAQH CORE offers certification for multiple phases of operating rules. To promote operating rule adoption and certification, a 20% discount on initial certification fees is now offered to organizations completing multiple certifications at once.
- **Re-certification**:
  - CORE Certification currently reflects a “snapshot in time” towards adherence to operating rules.
  - With evolving technology, mergers/acquisitions and system upgrades, there is a need to assess ongoing conformance with the operating rules to maintain program integrity. Re-certification enables ongoing conformance should existing rule requirements be updated over time to align with market needs.
  - CAQH CORE will adopt policies and requirements for re-certification **every three years** to ensure the value of the CORE Seal is preserved. **Re-certification will launch for newly certified entities beginning in 2020**.
  - Any updates to the CAQH CORE Operating Rules will be incorporated within the re-certification process.
- **Phase IV CORE Certification:**
  - Phase IV CAQH CORE Operating Rules cover infrastructure requirements for the X12N 837, X12N 278, X12N 820 and X12N 834 transactions.
  - To become Phase IV CORE-certified, stakeholders are required to test for the 837 and 278 transaction, if applicable. Testing for the 820 and 834 employer-based transactions is now **optional** for Phase IV CORE Certification.

Demonstrate Due Diligence with CORE Certification

Prepare for Potential Compliance Reviews

Healthcare providers, health plans, payers and other HIPAA-covered entities must comply with federally mandated standards and operating rules.

CORE Certification provides a way for organizations to **demonstrate their IT system or product is operating in conformance** with applicable requirements of the specific phase(s) of the CAQH CORE Operating Rules.

CORE Certification Prepares Industry for Compliance Reviews

- Entities selected to participate in the CMS Compliance Review Program must attest compliance with federally mandated operating rules.
- CORE Certification helps entities demonstrate, document and certify conformance with federally mandated standards and operating rules and engenders confidence in attestations.

Polling Question #3

Is your organization interested in learning more about or pursuing CORE Certification?

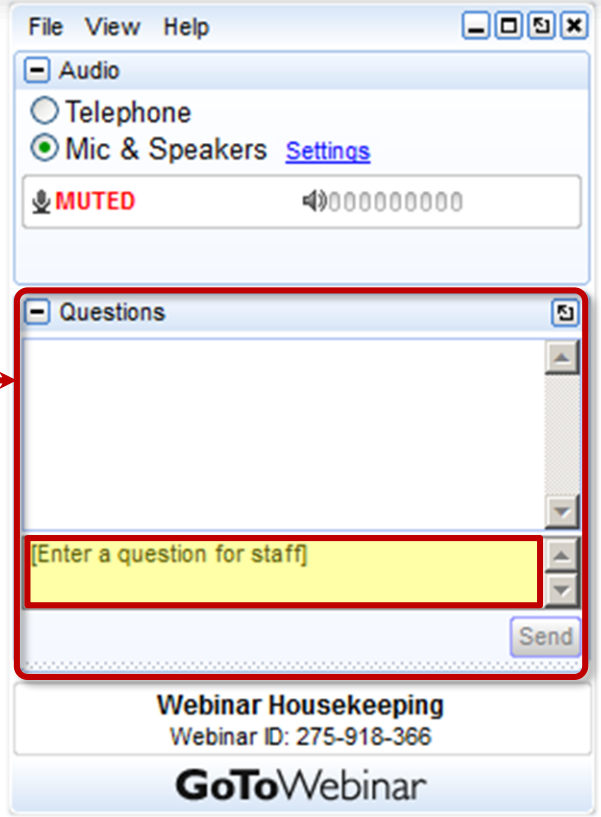
- Yes
- No
- Unsure/need more information
- Already CORE Certified

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



Download a copy of today’s presentation slides at caqh.org/core/events

- Navigate to the Resources section for today’s event to find a PDF version of today’s presentation slides.
- Also, a copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

Resources

- Presentation Slides

CAQH CORE

Upcoming CAQH CORE Education Sessions

Take the Next Step in Administrative Efficiency: Phase V CAQH CORE Prior Authorization Operating Rules
WEDNESDAY, MAY 29, 2:00 – 3:00 PM

State Medicaid Experiences with Value-based Payments, with Center for Health Care Strategies and Minnesota Medicaid
THURSDAY, JUNE 6, 2:00 – 3:00 PM

CORE Certification Webinar Series: Security Health Plan Demonstrates Commitment to Administrative Efficiency
THURSDAY, JUNE 20, 2:00 – 3:00 PM

CONFERENCES

2019 WEDI Spring Conference
MAY 20-22, 2019

HFMA 2019 Annual Conference
JUNE 23-26, 2019

Thank you for joining us!

@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.