CAQH Committee on Operating Rules for Information Exchange (CORE)
CAQH CORE Value-Based Payment (VBP) Advisory Group Call
Friday, March 15, 2019, 2:00-3:30 pm ET Conference Call
Doc #2: Advisory Group Call #2 Summary 02.22.19

This document contains:

- Agenda items and key discussion points.
- Decisions and actions to be taken.
- Next steps.
- List of call participants.

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
1. Antitrust Guidelines.	• Erin Weber (CAQH CORE) opened the call and welcomed participants to the call. • Ms. Weber next reviewed the Antitrust Guidelines. Participants were asked to review the guidelines and be familiar with them.	*Discussion*

2. Roll Call and Administrative Items.	• Ms. Weber then introduced CAQH CORE Staff on the call and called roll.
	• Ms. Weber thanked the Advisory Group Participants for completing the straw poll and gave an overview of the call, which was to:
	  ○ Discuss the Proposed Evaluation Criteria.
	  ○ Begin discussion on the 19 opportunity areas related to administrative simplification, with the goal of reviewing the first ten.
		Discussion

3. Review Advisory Group Feedback – Evaluation Criteria.	• Ms. Weber informed the group that straw poll feedback was submitted by 10 out of 12 Advisory Group Members.
	• **<u>Summary of Feedback on Proposed Evaluation Criteria:</u>**
	  ○ Ms. Weber went over the suggested edits to evaluation criterion #2.
	  ▪ Danette Coleman (HealthEdge) commented that the definition supports the spirt of the comments she suggested.
	  ▪ Dave Nyman (Marshfield Clinic Health System) supported the way it was rewritten.
	  ▪ **Advisory Group Decision:** The group agreed to this adjustment.
	  ○ Ms. Weber (CAQH CORE) went over the change to criterion #4 (addition of "across stakeholders").
	  ▪ Dave Haugan (Minnesota Department of Health) asked if the intent of the change was to broaden the definition to a diverse type of stakeholders.
	  ▪ David Nyman (Marshfield Clinic Health System) supported the addition of word "diverse" to criterion #4.
	  ▪ Rob Tennant (MGMA) brought up that broadening the definition of #4 would necessitate updated #1 to reflect the scope of the criteria as being outside the payer/provider relationship. He recommended the use of the term "between/across industry stakeholders".
	  ▪ **Advisory Group Decision:** The group agreed to this adjustment.
		Discussion

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	○ Ms. Weber (CAQH CORE) discussed the addition of language to criterion #5 "Timing Considerations". ▪ **Advisory Group Decision:** The group agreed to this adjustment. ○ Ms. Weber (CAQH CORE) brought up the changes to criterion #6. ▪ Mr. Haugan (Minnesota Department of Health) thought the criterion could be written more directly and sought clarification on the word adoptability. ▪ John Kelly (Edifecs) brought up that, historically, 'doing the right thing" was useless if the infrastructure is lacking and no one is going to adopt it. He asked if enough of the industry was far enough ahead of the technology curve to get people to move in this direction and questioned whether the wording captures this. ▪ Ms. Coleman (HealthEdge) suggested that the word effort is a stronger word compared to ease. ▪ Ms. Weber (CAQH CORE) asked if there was any objection to changing the word ease to effort in #6. ▪ **Advisory Group Decision:** The group agreed to this adjustment. ○ Ms. Weber (CAQH CORE) asked the group about updating the name of criterion #8 to differentiate it from the updated #2. ▪ Mr. Tennant (MGMA) questioned whether we need to include "existing standards". He suggested a focus on not duplicating industry efforts and remarked that he liked the word conflict rather than duplicate. ▪ Ms. Weber (CAQH CORE) clarified that the ACA definition of operating rules states that they shall not duplicate or conflict with existing standards. ▪ Mr. Kelly (Edifecs) remarked that he preferred conflict as duplication in the industry currently exists, but pointed out that groups work in cooperation and that their work bolsters existing standards. ▪ Ms. Weber (CAQH CORE) proposal changing the word duplicate to conflict with. ▪ **Advisory Group Decision:** The group agreed to this adjustment. ○ Ms. Weber (CAQH CORE) presented Criterion #9 for discussion. ▪ Mr. Tennant (MGMA) remarked he would add "efficient and effective delivery of care" as we are trying to move data in a way that makes care more effective and efficient. ▪ Ms. Todd (CAQH CORE) asked if are there some things that we propose that may affect delivery of care but may have little impact on patient experience. If you put improve in, does that remove future opportunities. ▪ Mr. Kelly (Edifecs) questioned that if there is high degree of efficiency and cost savings, then	

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	how is patient's assessment of value part of the equation. This may be outside of scope of group, but as an evaluation criterion, the patient experience would be something that would get an extra point. ▪ Mr. Tennant (MGMA) noted that improved billing is also one of the objectives, which also improves the patient experience, which seems to be a lot of what we are on about. ▪ Ms. Weber (CAQH CORE) proposed using "Supports and improves patient experience and the efficient and effective delivery of patient care". ▪ **Advisory Group Decision:** The group agreed to this adjustment. • Ms. Weber then turned the group over to Lina Gebremariam (CAQH CORE) to go over the draft opportunity areas.	
3. Review Advisory Group Feedback – Opportunity Areas.	• Ms. Gebremariam (CAQH CORE) walked through the draft opportunity areas, asking the Advisory Group Participants to respond to the discussion questions in Doc #1. • **<u>Summary of Feedback on Opportunity Area 1, Discussion Question 1</u>** ○ Mr. Smith (Blue Cross Blue Shield of North Carolina) brought up that his organization navigates this issue often and views it conservatively as a PHI violation, noting that it needs to be mitigated as soon as possible. ▪ Ms. Coleman (HealthEdge) added that she made a similar comment, pointing out that it is a question that might vary by state. ○ Ms. Todd (CAQH CORE) suggested that we can specify in the language that patient information would only be shared with the provider they are attributed to and add a note to the subgroup that this issue needs legal review. ▪ Ms. Coleman (HealthEdge) agreed. ○ Mr. Tennant (MGMA) wondered if we should add "patient" attribution. He added that in some VBP arrangements, a subset is attributed and in others, the entire panel is. If they are a provider's current patient it is not a violation of HIPPA but if they are not, it would be. • **<u>Summary of Feedback on Opportunity Area 1, Discussion Question 2</u>** ○ Mr. Nyman (Marshfield Clinic Health System) commented that his organization has 90% attributed to a provider or system. They understand privacy concerns and remarked that if it was built into system, it should not delay response time. ○ Another participant asked about the degree of difficulty for some payers to implement and if this would be a barrier for health plans. • **<u>Summary of Feedback on Opportunity Area 1, Discussion Question 3</u>**	

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	○ Mr. Nyman (Marshfield Clinic Health System) asked how ready the industry is in the way they do their attribution currently to be able to make it computable in real time. ○ Mr. Smith (Blue Cross Blue Shield of North Carolina) commented that this would depend on the broader adoption with each physician and how much of a plan's medical expense is aligned with a risk-based contract. • **<u>Summary of Feedback on Opportunity Area 2</u>** ○ Mr. Nyman (Marshfield Clinic Health System) commented that the challenge his organization has had when doing contracting with value-based providers is that different plans use different approaches. He recommends avoiding proprietary items and going with a broader approach. ○ Mr. Tennant (MGMA) remarked that from a provider prospective, if you wanted to automate and you want vendors to support, it would be easier if there were a designated code set. ○ Ms. Todd (CAQH CORE) commented that there is a desire to streamline coding and asked if it would it be helpful in contracts if there were a refence to the attribution model that is used with different patient populations between the plan/providers with some code refence and if that was used in the communication back to the provider. This would provide a way to track the patients back to which part of the contract is applicable. ○ Oraida Roman (Humana) asked if this is pertinent to the person who is doing the eligibility check, and what would they do with that code confirmation at that point. ○ Kathleen Giblin (National Quality Forum) asked if the reason they need that information is to find out if they are attributed to a VBP arrangement and if you need to find out what their benefits are. ▪ Ms. Coleman (HealthEdge) responded that it is possible, but that it usually at the system level that it would be configured in the benefits specific to that person. ○ Ms. Todd (CAQH CORE) asked the group if they wanted to refence this to a later opportunity area on cost sharing as it may be an area for refinement. ○ Mr. Nyman (Marshfield Clinic Health System) commented that it was true from a provider lens, whether in a VBP arrangement or not. He said that providers he hears from do not know if a member is in a VBP arrangement, and does not treat them differently, so he wonders what the value of knowing that is. ▪ Mr. Tennant (MGMA) agreed, adding that physicians don't have the time to find out where patients are attributed. ○ Ms. Todd (CAQH CORE) commented that there may be a question of where the eligibility information goes? If it goes to a provider or billing office, if it is a piece of information for billing to determine	

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	coverage, it may be of interest. ○ Mr. Kelly (Edifecs) commented that when the X12 270 transaction was released, it didn't have much impact, but once it started getting directly integrated into the scheduling system of provider's EMRs it became important. It took time to automate it into the provider workflow, but the start was having it available. Mr. Kelly further remarked that for a time the industry will be dependent on some download batch file which will go into whatever system they are using, but once it is incorporated into real time transactions then it will become more automated into provider database workflow. ▪ Mr. Haugan (Minnesota Department of Health) added that it sounded like there was agreement that VBP arrangements are important to downstream billing, but that that seemed different than knowing who is attributed to different providers. ○ Mr. Nyman (Marshfield Clinic Health System) commented that there would have to be code in the eligibility response that identifies risk arrangement and if there is a contract, adding that both values would be essential. ○ Mr. Tennant (MGMA) commented that often the provider doesn't know how or why the cost is attributed to them. ○ Mr. Nyman (Marshfield Clinic Health System) added that if there was a transaction, it ends up being more of an X12 835 issue vs care management level. • **Summary of Feedback on Opportunity Area 3** ○ Ms. Coleman (HealthEdge) commented it would be hard to come up with codes that would fit into each health plan/provider arrangement. ▪ Ms. Roman (Humana) agreed, adding that when Humana tries to standardize, each provider wants something different, so they end up changing it. ▪ Another participant remarked that there is a lot of value in looking at how to automate business policies and asked if there is value in convening a long-term group to do something like the Code Combos Maintenance Group. ○ Ms. Coleman (HealthEdge) asked if there would be value in knowing specific VBP arrangements. ▪ Mr. Nyman (Marshfield Clinic Health System) responded that there is value in knowing these arrangements, but these models push back more responsibility to the provider. ○ Mr. Kelly (Edifecs) commented that being in a value-based contract may cause physicians to think more about the reputation of the doctor they refer patients to than if they were in a traditional arrangement. He suggested this might change the referral pattern. • **Summary of Feedback on Opportunity Area 4 & 6**	

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	○ Mr. Smith (Blue Cross Blue Shield of North Carolina) remarked that health plans use a mix of clinical and claims data to determine how risk is emerging and being managed. ○ Ms. Todd (CAQH CORE) asked that, with clinical and risk data being needed, is there value in standardizing some of the communication between plans and providers? Not necessarily what is shared, but how it is communicated. ▪ Mr. Smith (Blue Cross Blue Shield of North Carolina) suggested that the eligibility check could be used to communicate risk. He added that they would have to figure out what information would be put in and how to structure it. ▪ Mr. Nyman (Marshfield Clinic Health System) added that providers would benefit by knowing who is in the rising risk category and that Health Plans need to be able to share this data with providers. ▪ Mr. Kelly (Edifecs) brought up that while payers might know something about patient outside of providers care, on the other hand, providers know a lot about patients that they don't bill for, and payers don't have any way currently to access that information. ○ Ms. Todd (CAQH CORE) skipped ahead to opportunity area 6, asking if there is a high value on the information flow between providers and payers and if there is there a way to address this through a standardization of information exchanged. ▪ Mr. Tennant (MGMA) questioned the ability of payers being able to tell providers about risk factors. ▪ Another participant replied that payers are spending a lot of money to gather information from 3rd party sources other than providers. They have a lot of investment and gather information providers cannot, and this could be something they report back. ○ Mr. Tennant (MGMA) asked that, from a provider's standpoint, if you have 15 minutes for an appointment and you're getting a flood of data, how do we ensure this is data they can use? ▪ Mr. Smith (Blue Cross Blue Shield of North Carolina) commented that both perspectives are correct and added that his organization is investing in outside sources for data like LexisNexis. ○ Ms. Coleman (HealthEdge) remarked that we all agree that information exchange is beneficial, but asked where/what is best time to do that. ▪ Ms. Roman (Humana) agreed, adding that the exchange needs to be bi-directional, but she is not sure it needs to be at the eligibility check level because that would be a lot of information each time you're doing an eligibility check. ○ Ms. Coleman (HealthEdge) added that she agreed. She remarked that some providers perform an	

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	eligibility check multiple times a week for the same patient. ○ Ms. Gebremariam (CAQH CORE) noted that the Advisory Group is not limited to the five HIPAA-mandated transactions. The group may consider other transactions or other standards such as FHIR.	
4. Next Steps for the Advisory Group.	• Ms. Gebremariam (CAQH CORE) outlined next steps for the group to work on for the next week and half. Value-Based Payments Advisory Group Participants would: ○ Plan to attend upcoming calls. • CAQH CORE staff would: ○ Draft a summary of today's call and update the evaluation criteria and opportunity areas discussed. • Ms. Gebremariam (CAQH CORE) then adjourned the call.	**Actions/Responsibilities:** • Agreed to next steps

Call Documents
Doc #1: VBP Advisory Group Call #2 Deck 03.15.19
Doc #2: VBP Advisory Group Call #1 Summary 02.22.19
Doc #3: VBP Advisory Group Straw Poll Results Full Comments 03.15.19

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CAQH CORE Value-Based Payments Advisory Group Roster

Participating Organization	First Name	Last Name	Attended
athnahealth	Brian	Bhuta	X
athnahealth	Joia	Ramchandani	
Blue Cross Blue Shield of North Carolina	Troy	Smith	X
Centers for Medicare and Medicaid Services (CMS)	Melanie	Combs-Dyer	
Centers for Medicare and Medicaid Services (CMS)	Thomas	Kessler	X
Edifecs	John	Kelly	X
Edifecs	Michael	Pattwell	X
HealthEdge	Dannette	Coleman	X
Humana	Oraida	Roman	X
Marshfield Clinic Health System	David	Nyman	X
MGMA	Rob	Tennant	X
Minnesota Department of Health	David	Haugen	X
Montefiore Health System	Stephen	Rosenthal	X
National Quality Forum	Kathleen	Giblin	X
United Healthcare	Jordan	Reigel	