CAQH Committee on Operating Rules for Information Exchange (CORE)
Value-based Payments Subgroup (VBPSG)
Call #4 Summary: Thursday, January 30, 2020, 2:30-4:00 pm ET Conference Call

This document contains:

- Agenda items and key discussion points.
- Decisions and actions to be taken.
- Next steps.
- Call attendance.

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
1. Antitrust Guidelines	• Lina Gebremariam (CAQH CORE Manager) opened the call and introduced Troy Smith (Blue Cross Blue Shield of North Carolina) as CAQH CORE Value-based Payment Subgroup Co-Chair presenting on the call. • Troy Smith (BCBSNC) reviewed the Antitrust Guidelines, noting that they are published on the CAQH CORE Calendar along with the meeting materials. He then passed the call back to Ms. Gebremariam.	*Discussion*

2. Roll Call and Administrative Items	• Ms. Gebremariam (CAQH CORE) called roll. [See call participant roster at the end of this meeting summary to view call attendees and affiliated organizations]. She then turned the call back over to Mr. Smith.
	• Mr. Smith (BCBSNC) reviewed the call documents.
	  ○ Doc #1 VBP Subgroup Call #4 Slide Deck 01/30/20
	  ○ Doc #2 VBP Subgroup Call #3 Summary 12/12/19
		Discussion

3. Summary of the 12/12/19 VBSG Subgroup Call	• On the 12/12/19 call the VBPSG:
	  ○ Reviewed results of the Value-based Payments Subgroup Straw Poll #1
	  ○ Discussed next steps
		<u>Action Required</u>
		• Approve 12/12/19 Call Summary (Doc #2)
		• Motion to approve by John Kelly (Edifecs).
		• Seconded by Andrea Priester (AMA).

4. Review Results of Value-based Payment Subgroup Straw Poll #2	• Mr. Smith (BCBS NC) then began reviewing the framework and results of VBP Subgroup Straw Poll #2 (Slide 4 – 8). He then turned the call over to Ms. Gebremariam (CAQH CORE) to review the comments received.
	• Ms. Gebremariam (CAQH CORE) began by reviewing the Substantive Comments from Straw Poll #2 (Slide 9 – 15). She asked the group for feedback for a comment around patient privacy received on Provider Identification Codes (Slide 10, comment 1)
	  ○ John Kelly (Edifecs) concurred that the NPI is publicly available information and is confused as to what the privacy concern is about. He also asked, regarding comment 2, if we are assuming that the notion of the contract identifier is widely understood within the industry.
	  ○ Mr. Smith (BCBSNC) asked if Mr. Kelly's questions were around a concern with provider privacy.
		Discussion

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	○ Mr. Kelly (Edifecs) responded that he agrees with CORE that it is not a privacy issue. He clarified that his second comment was asking the group for clarification around the Provider Contract Identifier. He wants to know if it already exists and if it is something you can put in a transaction that gives you information on where a patient is associated and under which contract. ○ Mr. Smith (BCBSNC) responded that he thought this question may need more delineation, as this could be asking many things; what risk-based contract you are in, is it a product-based risk contract, or network participation agreement. He thought this was ultimately to provide better visibility into what arrangement this linkage would fall under, but he is not sure how universal this data set would be. ○ Mr. Kelly (Edifecs)asked if there is a place in health plan's system where you could put this information into a field if we made this a requirement or option. ○ Rob Pinataro (Payspan) replied that the data field does exist. In his organization, it is referred to as the Registration Code, and it ultimately identifies the relationship to the payer and the business line that they are in. He believes it already exists for other plans, but may not be referred to as the Provider Contract Identifier. ○ Thom Kuhn (American College of Physicians) asked if someone could further define required versus optional, particularly if something is required but he does not have it, can information still be exchanged. ○ Ms. Gebremariam (CAQH CORE) responded that the expectation around required fields are that health plans would request this information always, but you would still be able to send that information back, it would then be up to the health plan if they were then able to process it. ○ Kate Bouchard (Aetna) responded, regarding the Provider Contract Identifier, that Aetna does have a unique identifier for each of the respective value-based contracts at the member level. ○ Patti Laughren (Humana) responded the same. ○ Heather McComas (American Medical Association) commented that her organization was the one that originally commented with the objection to sharing the provider's NPI. They believe that name and address should be enough information for a health plan to identify a provider. They do not see the need to return an additional numerical for identification, especially if there are different options and they can select from the use of an NPI or TIN. ○ Ms. Gebremariam (CAQH CORE) clarified that, since the last call, CORE removed the option of using the TIN, but because NPI is publicly available information, they kept it as an option. ○ Ms. McComas (AMA) stated that she still did not see the purpose in using it, even though she was aware that it was publicly available information, when name and address were enough. ○ Mr. Kelly (Edifecs) responded that you would need more information than just name and address if you were talking about coordinating between individuals. The use of NPI would eliminate confusion when practices have multiple addresses listed. ○ Ms. McComas (AMA) responded that it is AMA policy to only disclose NPI on a need-to-know	

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	basis. ○ Mr. Smith (BCBSNC) responded to Ms. McComas, asking what the threshold is for having it be a valid need to know. ○ Ms. McComas (AMA) replied that she did not know if they have a definition of that, but still felt that it was unnecessary to disclose the NPI. ○ Mr. Smith (BCBSNC) replied that if a health plan discloses the NPI to a practice where there are already two providers with the same name, the practice would likely already have that information. ○ Ms. McComas (AMA) replied that if it is the requesting provider and the patient is not attributed to them, then the health plan's response to your inquiry would include the other physician's NPI. She thinks there are other ways to positively identify the provider without including the NPI. ○ Mr. Kelly (Edifecs) suggested looking at the actual information exchange flow and validate that someone needs to know who the individual doctor is. If this is the case, he would argue that you do need to include the NPI. ○ Ms. Todd (CAQH CORE) suggested moving on to the next section to see if there are any additional comments. She suggested that the group can keep this discussion in for feedback and voting in a future Straw Poll. She also pointed out that CAQH CORE is evaluating this issue from a legal perspective, specifically looking at if we can share one provider's information with another provider. • Ms. Gebremariam (CAQH CORE) continued her overview, moving on to slide 11. ○ Mr. Kelly (Edifecs) observed that there is value in looking at what information is being exchanged through these non-automated methods, such as patient address, and that this is probably a good barometer to use when evaluating if they should be included in the data sets. • Ms. Gebremariam (CAQH CORE) continued with slide 12 and 13, Points of Clarification. ○ Ms. McComas (AMA) asked if it was also possible in this case that there was a partial attribution at play, but the requesting provider would not be one of the attributed providers. ○ Ms. Gebremariam (CAQH CORE) responded that in that case the response would come back as no, as the question being asked is, "is this patient attributed to me?" while a partial response would indicate that the patient was attributed to that physician and at least one other person. ○ Ms. McComas (AMA) responded that she thinks she is misunderstanding how this exchange is working. She wants to know if you get information back from the health plan if you are not one of the attributed providers. ○ Ms. Todd (CAQH CORE) interjected that CAQH CORE has decided to include, as a potential data element, information going back to a requesting provider on the provider that patient is attributed to, regardless of if they are partial or not. CAQH CORE is currently is conducting some legal analysis to see if they can send that information out or if there are privacy	

Agenda Item	Key Discussion Points	Decisions and Actions
	protections in place. ○ Mr. Kelly (Edifecs) then asked about the information that would be relayed in a transaction, would anyone who requested information get a response or only individuals who had a vested interest. ○ Ms. Todd (CAQH CORE) responded that there is a very simple way this transaction can work. A provider asks if they are the attributed provider and the health plan responds back yes, no or partial, and that is the only information the provider receives back. What she was previously referring to was that they are keeping in scope, pending a legal review, that if a provider asks about attribution, can the health plan send back information on any other providers that the patient is seeing in order to facilitate care coordination. These are two separate use cases, but one is solely related to whether information on another provider can go back, and CAQH CORE will keep this specific discussion open for now and the rest of those operating rules would apply for the time being. ○ Mr. Kelly (Edifecs) responded that just because something was legal didn't make it appropriate, and he wondered what the likelihood would be of a provider being altruistic enough to loop in the attributed provider if their patient came to you, and is that worth disclosing proprietary business information. ○ Thomas Kuhn (American College of Physicians) responded that another theoretical use case could be that the provider wanted to know when the patient that was attributed to them stopped being attributed, so he thinks the "not attributed" reply is not going to be helpful. ○ Ms. Gebremariam (CAQH CORE) responded that that was why the dates of attribution were changed from an optional field to a required field, so that the start and end date would be listed. ○ Mr. Kuhn (ACP) then responded that because of the way the use case was defined, when a query is sent, if the patient is no longer attributed to the provider, then the response would just be not attributed, not necessarily with the dates. ○ Ms. Gebremariam (CAQH CORE) replied that the provider can then send a request for the end date. • Ms. Gebremariam (CAQH CORE) turned the call back over to Mr. Smith to review the responses for Infrastructure Opportunity Areas (Slides 15-18). • Mr. Smith (BCBSNC) then began a review of the subgroup comments. ○ Mr. Kelly (Edifecs) wondered, on slide 18, if the monthly roster is enough for the kind of business questions you are going to be asked at the population level, and if so, what is purpose of the real time. He also posed the question to the plans, does the in-between roster request justify the burden on the part of the payer to put into population roster production. ○ Mr. Smith (BCBSNC) responded that, from a health plan perspective, they are sending out that monthly form regardless. If you think about claims runout or you're doing other retrospective	

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	approaches, there may not be enough difference, or complexity, to make the cost-benefit worth it to do the in-between status. If we are requiring monthly exchange of information, then this may be overkill. ○ Mr. Kelly (Edifecs) responded that even if a provider wants to be extremely proactive and start reaching out as soon as they get a new member, then the information they need is only around the new members, they don't need a whole new roster. ○ Mr. Kuhn (ACP) agreed with Mr. Kelly and added that it would be an additional burden to providers to have to dedupe their rosters. ○ Mr. Smith (BCBSNC) asked the other health plans on the call to weigh in. ○ Ms. Laughren (Humana) responded that they do exchange monthly rosters, and they are trying to get as close to real-time as possible. ○ Ms. Bouchard (Aetna) responded that they also send out monthly files and would include members that have historically been attributed to the provider population in addition to the new ones. They do not separate out new members but do have filtering capabilities in the file they send. ○ Mr. Smith (BCBSNC) posed the question to the group around real-time or two-day processing, asking if this is something that we would want in the rules initially, or does the group think this is something we would expand into later. ○ Mr. Kelly (Edifecs) asked if he is producing the roster once a month, and then is requesting a batch roster, which is returned in two days, is this an accurate summary of how batch rosters are assembled. He believes the majority of members are going to produce rosters on the first or the 30th of the month anyway, and in that case would suspect that two days for a batch file would be fine. He would also suspect that a 20-second response for a real-time request doesn't necessarily mean a real-time, updated delta from the first of the month. If you define it as (if you are asked in real-time for the first of the month batch) you just need to pull up a copy of that file and send it in 20 seconds, then that is not an issue. However, if you are asking to calculate a new batch with any changes from the first of the month in 20 seconds, he is not sure if that would be possible. ○ Ms. McComas (AMA) commented that, it sounds like this would be a push from the plans to the providers that would happen every month. She asked the plans if any of them push changes, without a request, in between those monthly updates? ○ Ms. Laughren (Humana) responded that they have it available on their software management tool. ○ Ms. McComas (AMA) responded that providers would still have to come to the plan to get it. ○ Ms. Laughren (Humana) responded that she was correct and that they would have to log on to get the information. ○ Ms. Bouchard (Aetna) commented that Aetna is limited to a monthly load and refresh of their system.	

Agenda Item	Key Discussion Points	Decisions and Actions
	○ Ms. McComas (AMA) commented that she agreed with Mr. Kelly, that these changes were most likely made at the beginning or end of the month. She asked if a patient who had been added after the monthly file roster update would be captured as a new patient if the provider ran an inquiry on the new patient in the middle of the month. ○ Ms. Gebremariam (CAQH CORE) responded that this would be the two different use cases between the roster of patients and an individual patient check run at the time of eligibility. Whenever the health plan refreshes that information, those dates of applicability would be clearly labeled on the response back to the provider. ○ Ms. Todd (CAQH CORE) added that there is a need for both a roster of patients to be communicated on a relatively frequent basis and also to be able to check on a specific patient at a point in time to get that patient specific information as needed. She asked the group, with the ability to use the eligibility checks or some other transaction to obtain information on a specific patient, is there also need to be able to request a roster outside of the once a month update the plans could be required in a rule to push out. ○ Ms. Laughren (Humana) commented that she thought, yes, there is a need for both. • Mr. Smith (BCBSNC) moved on to reviewing use cases In and Out of Scope Results (Slides 20 – 22). While reviewing slide 22, *Provider Attribution Risk Case – Value-based contract for Specific Services or Bundled Payments* and discussing the possible need of provider/health plans to exchange additional information to satisfy the questions around attribution status. He posed the question, if a PCP were to run this inquiry concerning a diabetic patient, for example, what information would they need to properly coordinate care if this patient were attributed to an endocrinologist for a diabetes bundle. Would the response be yes, no or partial? ○ Mr. Kelly (Edifecs) asked if one would have to supply the condition/diagnostic/procedure code that would have the plan say that you are at risk for this service when conducting a single patient request or would you just be sending in the patient's name and getting back that they are attributed to programs. ○ Mr. Smith (BCBSNC) responded that it was envisioned to be a basic response, for example, that this patient is aligned with x program and x doctor. ○ Mr. Kelly (Edifecs) responded that, if you do that, in the health care response you are not only giving the contract code back, but you are also giving the text of the label for that contract. Since the contract codes are going to be mutually agreed to contract codes and because you are going to do specific conditions, you are going to have to apply some kind of text to the code, otherwise it is not going to be apparent that this is not a general risk contract, this is a specific disease contract. ○ Ms. Todd (CAQH CORE) commented that the discussion that has been going on back and forth is the exact question that she thinks the CAQH CORE staff has. If someone is in just a bundled payment contract – they are in a diabetes program, maternity bundle, etc, - and the	

Agenda Item	Key Discussion Points	Decisions and Actions
	provider asks the plan if this patient is attributed to them, then is getting that provider information from the plan enough for the plan to say yes or no – and by the nature of it being an endocrinologist or OB requesting it, is that enough to share the information. Or, thinking in and out of scope, is there additional information that is needed other than the contract ID that is going back, that would have an additional description. From our research, we think that the basic level is enough, because if you have the contract ID, then you know what the contract is and what it is covering, but want to validate that there isn't some additional piece of information that is needed related to a bundled payment. ○ Mr. Kelly (Edifces) replied that, if he were a primary care provider, and had a patient coming in under a maternity bundle who was attributed to someone else for this condition, then this is probably a conversation he would want to have with the patient or the scheduler. He thinks having some sort of communication beyond the contract ID number would be useful and that having only the contract ID number in cases where the patient is not attributed to him would not be of much use. ○ Mr. Kuhn (ACP) agreed, adding that as a primary care provider, he would want to know all contracts related to this patient. ○ Ms. Laughren (Humana) responded that from the context of a provider wanting to know if a patient is attributed to them or attributed to another type of contract, versus a PCP wanting to know if that patient is associated with a specialty bundle. She thinks it would be challenging to relay to a different provider about the status of that patient in other value-based programs. She thinks you could tell a provider whether that patient is attributed to them, but to display how the patient is attributed across other value-based programs sounds like a bigger challenge. ○ Ms Gebremariam (CAQH CORE) asked Ms. Laughren to expand on her comment, asking about instances where a patient might be attributed to both a PCP and an ACO. For example, a patient that became pregnant and was partially attributed to a specialty maternity bundle. She asked if it would still be complicated to share that information. ○ Ms. Laughren (Humana) replied that it would not be difficult to share the specific contracted provider associated with that bundle, but to display that for others would be very challenging. ○ Mr. Kelly (Edifecs) commented that a lot of contracting for these kind of bundled payment contracts are configured in the adjudication system, not in the membership system, and that presents a challenge. Many payers are going to be challenged, not once some transaction is being applied into the processing system but being able to ask a question before there is any claim. ○ Ms. Todd (CAQH CORE) commented that this then raises two follow up questions – one, has your prospective changed on bundled payments being in scope for attribution or not and two, do you think it is okay to start with a more simple use-case approach. ○ Ms. Laughren (Humana) commented she thinks of attribution being more closely related to primary care. When you get into specialty bundles and things of that nature, she feels it is	

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	important for physicians to know who is in their bundles and who is attributed and that can be done through reporting. However, she does not know if it is the same type of monthly reporting for primary care and wants to point out that those are not equal. She does not lump all the value-based programs together and thinks primary care versus specialty care should be looked at differently. Additionally, some are prospective, some are retrospective, and the dynamics of that are within the contract with the provider. ○ Ms. McComas (AMA) responded that these are complicated questions and asked if the yes/no/partial/invalid options would just be for specialist bundles. She also wonders what the implications are for returning various attributions for various bundles, and what the care implications are. She commented that it seemed very complicated and she suggests more research. ○ Ms. Laughren (Humana) asked that as the group comments on items in and out of scope and talk about value-based contracts for specific bundles or services, we should think of it in terms of primary care versus specialty care. ○ Ms. Gebremariam (CAQH CORE) confirmed that that was our intent in the Straw Poll, but she thinks the conversation needed to take place with the subgroup for everyone to understand what the intent was. After this conversation, we will ask this question again on the following Straw Poll. ○ Mr. Kelly (Edifecs) gave the example of a patient breaking their arm and going to see an orthopedic doctor. In this case, the PCP is not at risk for care, there is no risk arrangement, the orthopedic doctor is not in the patient's ACO, but the hospital has a bundled payment contract for knee replacement. The only way the payer would know whether or not to say anything is that the patient who is not attributed to any PCP contract is showing up at a facility with a certain doctor who is under a bundled payment contract for knee surgery. He asked how many payers in the country have systems sophisticated enough to populate that data element. ○ Ms. Todd (CAQH CORE) commented that she thought that was a good question, and when the next straw poll goes out, we may be able to sus out that question further. • Mr. Smith (BCBSNC) continued reviewing slide 23 – asking the group to comment if they thought it was too complicated for Phase I. ○ Ms. Laughren (Humana) and Ms. Priester (AMA) both commented that they thought it was too complicated. • Mr. Smith (BCBSNC) then turned it back over to Ms. Gebremariam.	
5. Value-based Payments Subgroup Next Steps	• Ms. Gebremariam (CAQH CORE) then walked the group through the roles and expectations of VBP Subgroup Participants in completing the VBP Subgroup Straw Poll #3 (Slides 24-26). She clarified that it would be emailed to Subgroup Participants on Wednesday, 2/5/20 and responses would be due by Wednesday, 2/14/20. • Ms. Gebremariam (CAQH CORE) encouraged Subgroup Participants to attend the next VBP	*Discussion*

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	Subgroup call on Thursday, 2/27/20 when CAQH CORE Staff would be discussing the results. • Ms. Gebremariam (CAQH CORE) then adjourned the call.	

Call Documentation
Doc 1: VBPSG Call #5 Agenda 2.27.20.pdf
Doc 2: VBPSG Call #4 Summary 1.30.20.pdf

CAQH CORE Contact Information

April Todd
SVP, CORE
atodd@caqh.org

Erin Weber
Director, CORE
eweber@caqh.org

Lina Gebremariam
Manager, CORE
hgebremariam@caqh.org

CAQH Committee on Operating Rules for Information Exchange (CORE)
Value-based Payments Subgroup (VBPSG)
Call #4 Summary: Thursday, January 30, 2019, 2:30-4:00 pm ET Conference Call

VBP Subgroup Call #4 Attendance

CAQH CORE Participating Organization	Last Name	First Name	Attendance
Aetna	Bouchard	Katherine	X
Aetna	Eberhart	Lisa	
Aetna	Kahn	Zachary	X
American College of Physicians	Rockwern	Brooke	X
American College of Physicians	Kuhn	Thom	X
American Medical Association (AMA)	Preisler	Andrea	X
American Medical Association (AMA)	McComas	Heather	X
American Medical Association (AMA)	Otten	Robert	
American Medical Association (AMA)	Lefebvre	Celine	
ASC X12	Barry	Cara	
ASC X12	Cathy	Sheppard	
AthenaHealth	Gobin	Adam	
Blue Cross and Blue Shield Association (BCBSA)	Cullen	Rich	
Blue Cross and Blue Shield Association (BCBSA)	Kocher	Gail	
Blue Cross Blue Shield of Michigan	Ahmed	Faris	
Blue Cross Blue Shield of Michigan	Maldoddi	Laxmikanth	X
Blue Cross Blue Shield of North Carolina	Smith	Troy	X
Blue Cross Blue Shield of Tennessee	Langford	Susan	X
Centers for Medicare and Medicaid Services (CMS)	Doo	Lorraine	
Centene	Chervitz	Chuck	X
Centene	Decarlo	Mary Ellen	
DST Health Solutions	Lynam	Mary	
Edifecs	Kelly	John	X
Edifecs	Patwell	Michael	X
HealthEdge	Hanna	Doug	
HEALTHeNet	Gracon	Christopher	X
HMS	Woodford	Jason	
HMS	McRae	Henry	
Humana	Laughren	Patricia	X
Marshfield Clinic	Gilbertson	Ann	
Mayo Clinic	Darst	Laurie	
Mayo Clinic	Sobolik	Jerry	X
Medical Group Management Association (MGMA)	Tennant	Robert	
Minnesota Department of Human Services	Millage	Pansi	

CAQH Committee on Operating Rules for Information Exchange (CORE)
Value-based Payments Subgroup (VBPSG)
Call #4 Summary: Thursday, January 30, 2019, 2:30-4:00 pm ET Conference Call

CAQH CORE Participating Organization	Last Name	First Name	Attendance
NACHA	Herd	Mike	
NACHA	Smith	Brad	X
Payspan	Pinataro	Rob	X
Trizetto	Mann	Jennifer	X
Trizetto	Waymire	Shaun	
Trizetto	Neal	Anne	
United States Department of Veterans Affairs	Lawhead	Judy	X
United States Department of Veterans Affairs	Greene	Romona	
Unitedhealthcare	Northrop	Benjamin	X