CAQH Committee on Operating Rules for Information Exchange (CORE)
Value-based Payments Subgroup (VBPSG)
Call #5 Summary: Thursday, February 27th, 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) 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 (CAQH CORE).	*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 (BCBS NC).
	• Mr. Smith (BCBS NC) reviewed the call documents.
	  ○ Doc #1 VBP Subgroup Call #5 Slide Deck 02/27/20
	  ○ Doc #2 VBP Subgroup Call #4 Summary 01/30/20
		Discussion

3. Summary of the 01/30/20 VBSG Subgroup Call	• On the 01/30/20 call the VBPSG:
	  ○ Reviewed the results of the Value-based Payments Subgroup Straw Poll #2
	  ○ Discussed opportunity areas for Infrastructure Operating Rules
	  ○ Determined potential items in and out of scope
	  ○ Discussed next steps
		<u>Action Required</u>
		• Approve 01/30/20 Call Summary (Doc #2)
		• Motion to approve by Tom Kuhn, ACP).
		• Seconded by Rob Pinataro, Payspan).

4. Review Results of Value-based Payment Subgroup Straw Poll #3	• Mr. Smith (BCBS NC) then began reviewing the framework and results of VBP Subgroup Straw Poll #3 (Slide 3 – 9). He then turned the call over to Ms. Gebremariam (CAQH CORE) to review the comments received. • Each use case received over 77% support; however, comments were received which require subgroup feedback. • Ms. Gebremariam (CAQH CORE) began by reviewing the substantive comments from Straw Poll #3 (Slide 10, comments 1-3). She asked the group for feedback for value-based contracts for specific services or bundled-payments. ○ Tom Kuhn (ACP) shared that, regarding a specific contract or bundled payments, he is concerned that the PCP might have some responsibility and not just the specialist that is responsible. He asked how a PCP would find out that they have an obligation to a patient under	*Discussion*

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	a bundled contract. ○ Mr. Smith (BCBS NC) asked if in those instances we want that information to come through the electronic response or should there already be communication in place between the PCP and the specialist informing them that they are both responsible for certain activities. ○ Mr. Kuhn (ACP) commented that this might be a stretch considering what they can do now. He shared that they would like to conduct this through an electronic process, but this might be a stretch for everybody and does not have to be met by this standard at this time. ○ Ms. Gebremariam (CAQH CORE) asked subgroup participants if they felt like they would have any implementation challenges. Providers have shared that this is something they liked and asked if this is achievable for plans. ○ Mr. Kuhn (ACP) clarified that substantive comment 1 which states "an inquiry for the status related to a specific service or bundled payment" would actually be the opposite and should state that "the query for a particular payment for any service or bundled payment." ○ Mr. Smith (BCBS NC) commented that, on the specialty piece, maybe being able to share who someone's PCP is would be attainable. Regarding a roster of patients on all use cases, it gave them pause because of the volume of patients and how often it could change depending on retrospective attribution. They liked the idea of being able to share information if the patient is aligned with a PCP, it's just that the sheer volume might have an effect. He also asked if the specialist would be able to pick up on that information and run with it quickly. ○ Heather McComas (AMA) asked if bundled or specific conditions are currently a data element in the request. ○ Ms. Gebremariam (CAQH CORE) answered that, as it is structured right now, for a single patient it's just general, (e.g., is this patient associated with my VBP contract and are they attributed to me). If the subgroup decided to include bundled payments as in scope, two further questions would arise 1) will that be sufficient in bundled payments even if they are not including additional information and 2) would we need more condition-specific information in order to answer that question satisfactory. ○ Ms. McComas (AMA) shared that for the response to be useful, it would have to list each possible bundle or condition and which provider is attributed in order to be comprehensive. ○ Ms. Gebremariam (CAQH CORE) shared that in order to have this case included, there would need to be subgroup consensus and additional steps. Therefore, she suggested tackling the majority of services for now and working to expand those use cases at a later date. ○ Mr. Kelly (Edifecs) suggested that there needs to be more specificity in the response. For example, a dermatologist isn't going to care about bundled payments for a knee replacement, therefore, some filtering is needed. He reminded the group that it is important to think at a high level in terms of the specialty of the submitting provider. He noted that there could be a lot of noise in each response if it isn't filtered.	

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	○ Mr. Kelly (Edifecs) shared that one approach could be to conduct research on the more common bundle payments (e.g., what Medicare is currently doing) and see if there is a way to narrow them down. For example, in the case of the eligibility and benefit response, you can provide information on a set of common services. It might be good to take this approach in the next rounds of VBPSG calls. ○ Ms. Gebremariam (CAQH CORE) agreed that is a good idea. However, one concern is that different bundles are defined differently. For example, just the service versus service plus thirty days. She informed the group that CAQH CORE is already conducting some research into this. ○ Mr. Kelly (Edifecs) commented that it is impossible to know all the details for an exact bundled service contract but at least if some of the common bundled service opportunities are known, then the provider can have an indicator that the patient may be under some sort of bundled payment. ○ Ms. Gebremariam (CAQH CORE) agreed this is a good approach to consider. • Ms. Gebremariam (CAQH CORE) continued to review the substantive comments from Straw Poll #3 (Slide 12, comments 1-3). She asked the group for feedback for value-based contracts under the quality measurement use case. She noted that CAQH CORE recommends placing quality measures out of scope for the current rule development effort until CAQH CORE staff conducts further research to test operating rules under this specific use case. ○ There was no discussion and the subgroup agreed to place quality measures out of scope for this current rule development effort. • Ms. Gebremariam (CAQH CORE) reviewed the substantive comments from Straw Poll #3 (Slide 15 comments 1-2). She asked the group for feedback for infrastructure rules related to time requirement rule options for a single patient in batch and real time processing. ○ Mr. Smith (BCBS NC) asked if we are saying that the guiding principle is that, because we have other batch guidelines, we want to make sure we are aligning with existing standards in place today. ○ Ms. Gebremariam (CAQH CORE) replied yes, since the eligibility and benefit rules are HIPAA-mandated CAQH CORE would prefer to remain as close as possible to the current mandated guidelines rather than having voluntary rules mixed in. However, it is ultimately a group decision and if there are any implementation challenges, CAQH CORE would like to discuss that with the group. ○ Mr. Kelly (Edifecs) commented that from the use case perspective, if someone is sending a batch response then it is not urgent. For example, the night before patients come into your practice, you may run a batch and see what you can post into your system before they come in the next day. However, he is not sure what the difference is between one or two days. ○ Ms. McComas (AMA) responded that she would advocate for the overnight batch processing	

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	practice workflow because it aligns with the eligibility check/attribution check the night before the appointment. Providers would be able to know the eligibility and provider attribution for a given patient the morning of the appointment. ○ Gail Kocher (BCBSA) asked if we have previously discussed the methodology that would move the data. She is finding it hard to choose the appropriate timeframe with no discussion as to how to move and compile the data in specific systems. ○ Ms. Gebremariam (CAQH CORE) shared that that conversation is slated for the next call. We wanted to first address what data content can be exchanged and the guidelines for how that exchange would occur. ○ Ms. Kocher (BCBSA) replied that she cannot say whether overnight or batch is appropriate because it's unknown how many and what systems are available to carry and exchange the information. ○ Ms. Gebremariam (CAQH CORE) explained that this information was discussed in the previous calls and CAQH CORE staff would send the entire subgroup the data content and details from previous calls. The batch processing versus real-time discussion was then paused until the next call. • Ms. Gebremariam (CAQH CORE) reviewed the points of clarification from Straw Poll #3 (Slide 16 comments 1-2). She shared points of clarification on time requirement rule options for a single patient. ○ There was no discussion from subgroup participants on these points of clarification. • Ms. Gebremariam (CAQH CORE) reviewed the substantive comments from Straw Poll #3 (Slide 18 comment 1). She asked the group for feedback on time requirement rule options for a roster of patients. ○ Mr. Smith (BCBS NC) commented that he thinks that the real time processing of a roster of patients seems overkill. If we are getting information out on a monthly basis, just one time per month or batch processing overnight should be enough and helps minimize the development needs for health plans. ○ Mr. Kuhn (ACP) agreed that a monthly response will probably be sufficient but once in a while an overnight response might be useful. The only use case they came up with is if there are changes to the plan, then they would like the ability to get another update. ○ Mr. Kelly (Edifecs) asked if straw poll respondents had to choose only one of the options. ○ Ms. Gebremariam (CAQH CORE) answered yes. ○ Mr. Kelly (Edifecs) replied that he assumes that if participants are in favor of overnight, they would	

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	at least be in favor of two-night, meaning that 46% of participants are in favor of this. He explained that this is inconsistent with comments discussed during this call. He agreed that asking for the whole roster frequently over the course of the month seems like a burden. ○ Ms. Gebremariam (CAQH CORE) asked if any participants have a business need for real time processing of a roster. ○ Ms. McComas (AMA) asked the plans on the call how often a roster would change and noted that a monthly push should be sufficient. ○ Mr. Smith (BCBS NC) shared that for his plan, even though they have the ability to capture PCP selection, it wouldn't be until the next month when they are running the next month's report and creating a claim abstract for their ACOs that that change would actually come through. They are not real time broadcasting PCP selection currently because their reports are conducted on a monthly and quarterly basis and there is a bit of a time shift to when the change become visible. ○ Ms. McComas (AMA) asked if the current information would be available in an individual member query, not a roster query, if a patient changes in the middle of the month and the practice did a single patient inquiry either as part of a batch or real time response. ○ Mr. Smith (BCBS NC) replied that it would depend on how it was defined. They haven't solved the method of how they are sending this information. If they are using one of the fields in the current EDI transactions, then that transaction must pull from a set of tables and it is unclear if the EDI transaction is pulling from the attributed roster table or if it's publishing it that quickly. It might still be a monthly publication to handle the overnight or real time single instance requests. Additionally, Mr. Smith noted that he is not sure if many plans can broadcast the changes in real time and if they are available to all forms of inquiry. He further clarified that it will probably have to run on a monthly basis so that things can be cascaded and run on a routine basis with communication going out from there. ○ Ms. McComas (AMA) agreed it is logical that the roster would contain monthly information. She has concerns about changes that happen in between specialties with a lag and how can providers can be unaware of attribution in between roster pushes. She noted that it could be concerning that PCP is not aware of that responsibility from a member's point of view. ○ Mr. Smith (BCBS NC) commented that we may want to balance how far plans are going with their value-based payment contracting. Some plans may be conducting this only on Medicare Advantage or ACA business. Some plans may not be including group business on their value-based payment contracts yet as far as what they want providers to have for an ACO or risk-based contract. He wonders if this is something the subgroup may want to grow into because there needs to be a critical mass before this topic can be properly discussed. ○ Ms. Gebremariam (CAQH CORE) commented that some organizations are trying to develop the capability to update more frequently, but the vast majority is updating monthly.	

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	○ Mr. Kelly (Edifecs) shared that the monthly roster is a static database and if you hit it at any time during the month you would still get the same answer. This is different than saying that the roster/reporting that you send out would be updated more than monthly. If the reality is that plans keep this in a separate file, they run the process, they create the roster file and that roster file drives everything, then there is no new information. For example, if the roster file gets run as of April 1st and then a claim comes in on April 3rd, is that claim run retroactively to when the roster was last updated? Those are the type of nuances that come into play that will be critical to a provider in terms of risk. ○ Ms. McComas (AMA) shared that her concern would be that the attribution effective date might be prior to the date of the roster that the patient is added to the roster. ○ Mr. Kelly (Edifecs) commented that someone's going to look at the information and say x patient is under xy risk contract and then the provider must decide where to send them for a referral. For example, if the provider asks for an expensive hospital procedure that is not part of their ACO, should they be convinced to get a cheaper/faster service. Additionally, if I am counting on a transaction to advise me in that conversation, then it is bad if the information is not correct. ○ Ms. Gebremariam (CAQH CORE) shared that the date fields added to the minimum and maximum data sets will be very important and it is critical that the provider has clear guidance and understanding of that data applicability and if that specific health plan may retroactively change that patient status based on a claim that they received in the intermittent month. ○ Mr. Smith (BCBS NC) commented that he wonders how often this occurs. Most of the time in his plan, patients are using a third-party enrollment vendor who guide them through the annual enrollment process or sometimes it could be through a spreadsheet and other times its members filling out paper forms and the plan is keying in the responses. For his plan, the idea that patients are changing PCP through selection often is not there yet because it is not part of the core enrollment process for most patients. They are not even seeing a large percentage of members choosing a PCP. Additionally, they mainly use claims to drive PCP attribution. He stated that he does not think the volume or consumer behavior is there yet and reiterated that the subgroup may want to grow into this over time as the industry progresses. ○ Mr. Kuhn (ACP) agreed with Mr. Smith's comments and expanded on them by saying that the roster is going to be stable throughout the month. The chance that the PCP office would want to get a refresh of the roster is going to be a very rare occurrence and there is not a business case for it currently. However, there needs to be the capability built in for an overnight batch of a roster in case there are system failures or for some reason a practice needs it. ○ Mr. Kelly (Edifecs) clarified that more than a month exchange is more related to the process on the provider side not so much that the data is going to be updated constantly during the month. It will be the same roster no matter when they ask for it, but for whatever reason they may have the ability to receive another copy. ○ Ms. Kocher (BCBSA) responded if that's the case, then definitions need to be more clearly	

Agenda Item	*Key Discussion Points*	*Decisions and Actions*
	articulated. If she sees batch and the expectation is to respond overnight, that implies that any changes between this cycle and the last cycle will need to be included. The difference needs to be better articulated because it makes a big difference in how someone must respond. She agrees with Mr. Smith (BCBS NC) in that the health plans are not there yet, and the consumer behavior is also not there yet. ○ Ms. Gebremariam (CAQH CORE) shared that the group consensus is that real time is not necessary for now but perhaps there needs to be room to build for batch capabilities with those date fields. ○ Mr. Kelly (Edifecs) commented that we must separate real time as a process for requesting and receiving information from a real time calculation of updated data. Real time is something that participants support even though the data content would be the same whether it's the first or the middle of the month. ○ Ms. Kocher (BCBSA) agreed that we need to be clear how the terms batch and real time are being interpreted. ○ Ms. Gebremariam (CAQH CORE) shared that she was referring to just this use case of a roster of patients. While there may be a use case for requesting data intermittently, that roster does not need to be returned within 20 seconds. An overnight or two days would suffice. ○ Mr. Smith (BCBS NC) reminded the group that the topic can be discussed more on the next call. • Ms. Gebremariam (CAQH CORE) reviewed the substantive comments from Straw Poll #3 (Slide 20 comment 1-2). She asked the group for feedback on the time requirement rule options for a single patient and a roster of patients. ○ Ms. McComas (AMA) asked how this information relates to the work that the CAQH CORE Connectivity Work Group is performing. ○ Ms. Gebremariam (CAQH CORE) shared that system availability will not be addressed by the Connectivity & Security Work Group. Instead, they will be focused on making connectivity consistent across all transactions and updating CORE connectivity to make it compatible with APIs and REST. Typically, CAQH CORE considers things like system availability and time requirements within the infrastructure rules and not connectivity. ○ Ms. McComas (AMA) shared that she is pushing for a higher system availability requirement because only 86% allows the system to be down a whole day, but health care is 24/7 business and other industries have higher system availability requirements already. ○ Ms. Gebremariam (CAQH CORE) asked health plans on the call if that increase in 10% would be feasible. ○ Mr. Smith (BCBS NC) answered that it depends upon what is being done to the core systems that weekend some months, such as early in the year, have a lot of releases because his plan gets ready for open enrollment in October. Thus, there might be a heavy weekend where down time is needed. He prefers to move towards the 86% rule in order to align with other time rule	

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	requirements for the other CAQH CORE transactions. ○ Ms. Kocher (BCBSA) also shared that it depends how many systems are involved in each release. It's not that health plans don't want to have more time, it depends on the scope of changes that are going in, how many systems are involve and what their interdependencies are. ○ Rob Tennant (MGMA) commented that it seems that CAQH CORE has not done a survey to see how hard it is to adhere to the 86% system availability versus a higher percentage. ○ Erin Weber (CAQH CORE) shared that CAQH CORE relies on the straw polls to hear from participating organizations. CAQH CORE uses the 86% rule because it is consistently in the rules across all transactions. Over the next few years, it will be important to see if 86% is the right number for all transactions or if they need to be revised individually. There needs to be a broader discussion around the transactions with infrastructure system availability requirements for those that could be higher. ○ Mr. Kelly (Edifecs) shared that he doesn't think that 86% sounds high because it's over the course of seven days and you only have the weekend off to perform any changes and updates. This changes the perspective since Monday to Friday it's around 95% or higher for system availability. ○ Ms. McComas (AMA) commented that there is nothing in the rules stating that the updates must be done on a Sunday when business would not typically be disruptive. Plans could also decide to do this middle of day Tuesday when it could be disruptive depending on how it plays out. ○ Robert Bowman (CAQH CORE) shared that the CAQH CORE rule requirements do address the timeframes as well as regularly scheduled downtimes. If the plan must be out on a Tuesday for the typical quarterly turn, then they must notify providers and make sure that it is available for them. There are also requirements that allow for emergency breakdown times. These timeframes must be communicated so that providers are aware. ○ Ms. Kocher (BCBSA) commented that most plans are doing major releases a minimum of twice a year. They might do small enhancements weekly or monthly, but once a year is not sufficient. ○ Mr. Tennant (MGMA) asked if Ms. Kocher (BCBSA) would be comfortable if that change was to occur on a Sunday in order to minimize disruptions. ○ Ms. Kocher (BCBSA) replied that she does not know of any plans that are currently conducting serious downtime for a huge release on a Monday through Friday. They typically occur late Friday afternoon and people are working all weekend so that systems are available on Monday. ○ Mr. Smith (BCBS NC) shared that if they did a midweek downtime and something went wrong and people would have to call in asking for help, it could be $8-10 per call. Finding the least disruptive weekend to do the release is preferable due to potential higher costs incurred. ○ Mr. Kelly (Edifecs) asked if it seems that for this set it is okay to continue for now with the 86% system availability rule. ○ Ms. Kocher (BCBSA) agreed and commented that she doesn't think it's appropriate or fair to attempt to correlate healthcare with other industries. There are different formats, different	

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	systems and different federal requirements. Having multiple operating rules with different thresholds is problematic and difficult because a lot of systems touch more than one transaction. One system may impact three or more transactions. ○ Ms. Gebremariam (CAQH CORE) shared that the consensus is that 86% system availability is right for this group and set for now. She emphasized that CAQH CORE will conduct further research across all transactions in the future.	
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 #4 (Slides 24-26) including a review of the due date of Friday, 03/13/20. • Ms. Gebremariam (CAQH CORE) encouraged VBP Subgroup participants to attend the next VBP Subgroup call on Thursday, 03/26/20 when CAQH CORE VBPSG Co-chairs and staff will discussing the results of the straw poll. • Ms. Gebremariam (CAQH CORE) then adjourned the call.	*Discussion*

Call Documentation
Doc 1: VBPSG Call #5 Agenda 02.27.20.pdf
Doc 2: VBPSG Call #4 Summary 1.30.20.pdf

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VBP Subgroup Call #5 Attendance

CAQH CORE Participating Organization	Last Name	First Name	Attendance
Aetna	Bouchard	Katherine	
Aetna	Eberhart	Lisa	
Aetna	Kahn	Zachary	
American College of Physicians	Rockwern	Brooke	
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	
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	
Centene	Decarlo	Mary Ellen	
DST Health Solutions	Lynam	Mary	x
Edifecs	Kelly	John	x
Edifecs	Patwell	Michael	x
HealthEdge	Hanna	Doug	x
HEALTHeNet	Gracon	Christopher	x
HMS	Woodford	Jason	
HMS	McRae	Henry	
Humana	Laughren	Patricia	
Marshfield Clinic	Gilbertson	Ann	
Mayo Clinic	Darst	Laurie	
Mayo Clinic	Sobolik	Jerry	
Medical Group Management Association (MGMA)	Tennant	Robert	
Minnesota Department of Human Services	Millage	Pansi	x

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