CAQH CORE Value-based Payment Subgroup Meeting 1

Introduction and Addressing SDOH through the Benefit Enrollment Transaction

April 27, 2023

Agenda

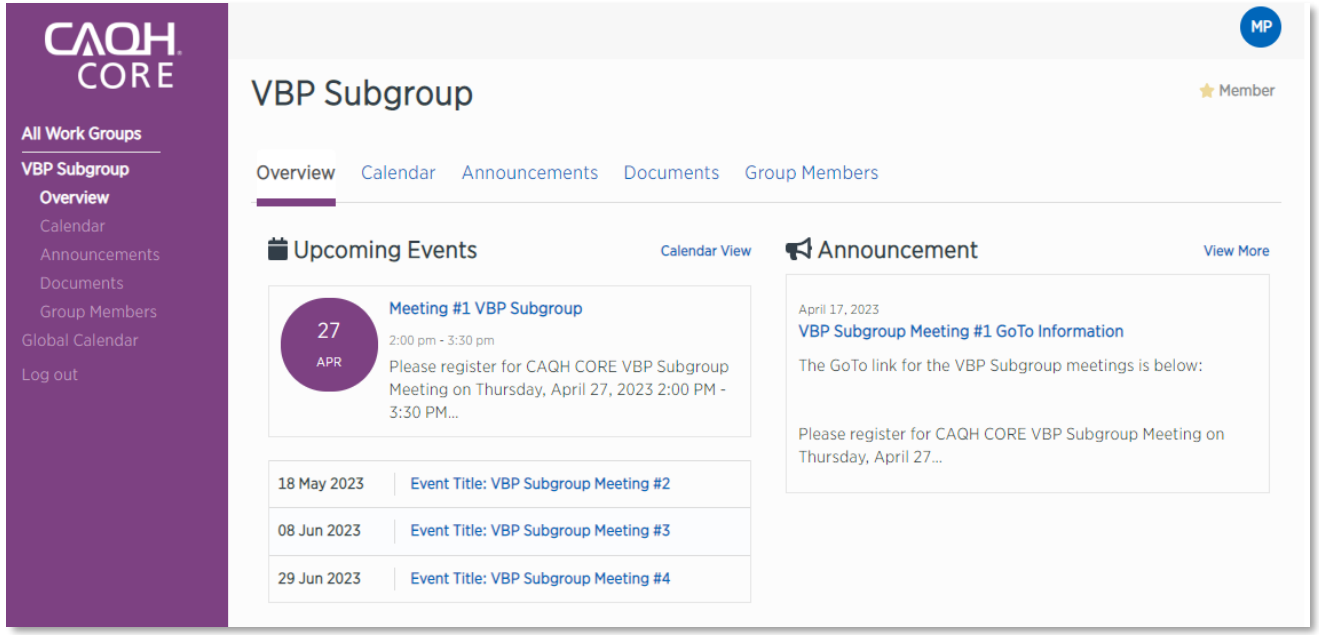
Time	Topic
2:00 PM	**Welcome, Antitrust Guidelines and Roll Call**
2:05 PM	**CAQH CORE Level Set** ▪ CAQH CORE Background ▪ Subgroup Scope, Goals, and Timeline ▪ Expectations of Participation
2:15 PM	**Research Overview** ▪ VBP Background and Considerations ▪ Topic Summary
2:30 PM	**Detailed Overview of Opportunities** ▪ Benefit Enrollment and Maintenance ▪ Claims Submission ▪ Infrastructure Rules ▪ Semantic Interoperability
2:50 PM	**Addressing SDOH Through the Benefit Enrollment and Maintenance Transaction** ▪ Transaction Overview ▪ Standard Exchange of Race and Ethnicity Data ▪ Other Data to be Exchanged
3:20 PM	**Next Steps** ▪ Straw Poll #1 Open from **May – May 11** ▪ Next Call on **May 18 from 2PM – 3:30PM EDT**

Objectives

- ✓ Understand the role of CAQH CORE and the operating rule development process.
- ✓ Know the steps taken to identify targeted opportunities for rule development.
- ✓ Detail target areas and identify where participants must provide further input.
- ✓ Recognize the need for standardization of socio-demographic data collection and exchange.
- ✓ Coalesce around next steps, appreciating the need for straw poll participation.

CAQH CORE Participant Dashboard

The **CAQH CORE Participant Dashboard** is a comprehensive resource for CAQH CORE Participants to access Subgroup information and any CAQH CORE Participant resources and events.



- The dashboard is accessible only to CAQH CORE Participants.
- Participants can view the work groups they are currently involved in and add themselves to new groups.
- Participants can view upcoming events, documents, announcements, and group member information.
- Email core@caqh.org if you need a login.

CAQH CORE Level Set

CAQH CORE Value-based Payment Subgroup Co-chairs

Michael Alwell, MPA
Vice President, Revenue Cycle, St. Joseph's Health

Naveen Maram, MD, MPH, MSHI
Vice President, Digital Operations, Centene Corporation

Michael Pattwell
Principal Business Advisor, VBC, Edifecs

CAQH CORE Staff and Subject Matter Experts

Kayla Cooper, MPH, CPHQ
Associate, CAQH CORE

Michael Phillips, MPH
Senior Manager, CAQH CORE

Erin Weber, MS
Vice President, CAQH CORE

Participating Organizations

CAQH CORE Operating Rules Streamline the Business of Healthcare

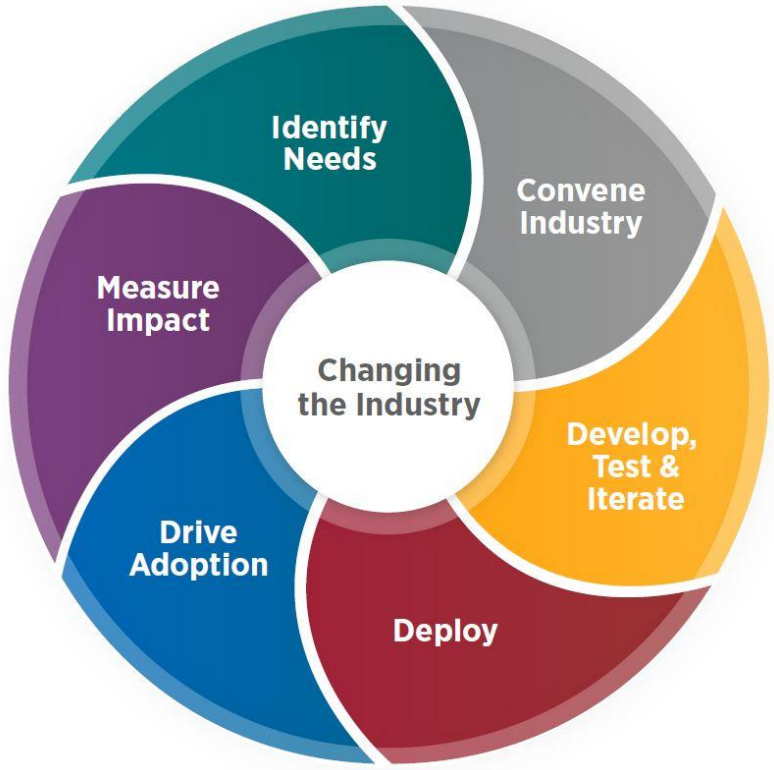
CAQH CORE develops business rules for the effective and efficient use of electronic standards. CAQH CORE is accountable to a multi-stakeholder board made up of health plans, providers, vendors, government entities, and SDO advisors. CAQH CORE participation encompasses robust representation across the same stakeholder groups and participating health plans represent **75 percent of the insured US population.**

CAQH CORE Directive

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: CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.



Operating Rules Defined

ACA Definition

- The “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”
- Federally mandated for the HIPAA adopted electronic standards.

Common in Other Industries

- Financial services, transportation, and retail are examples of other industries that rely on operating rules.
- For example, ATM data exchange.

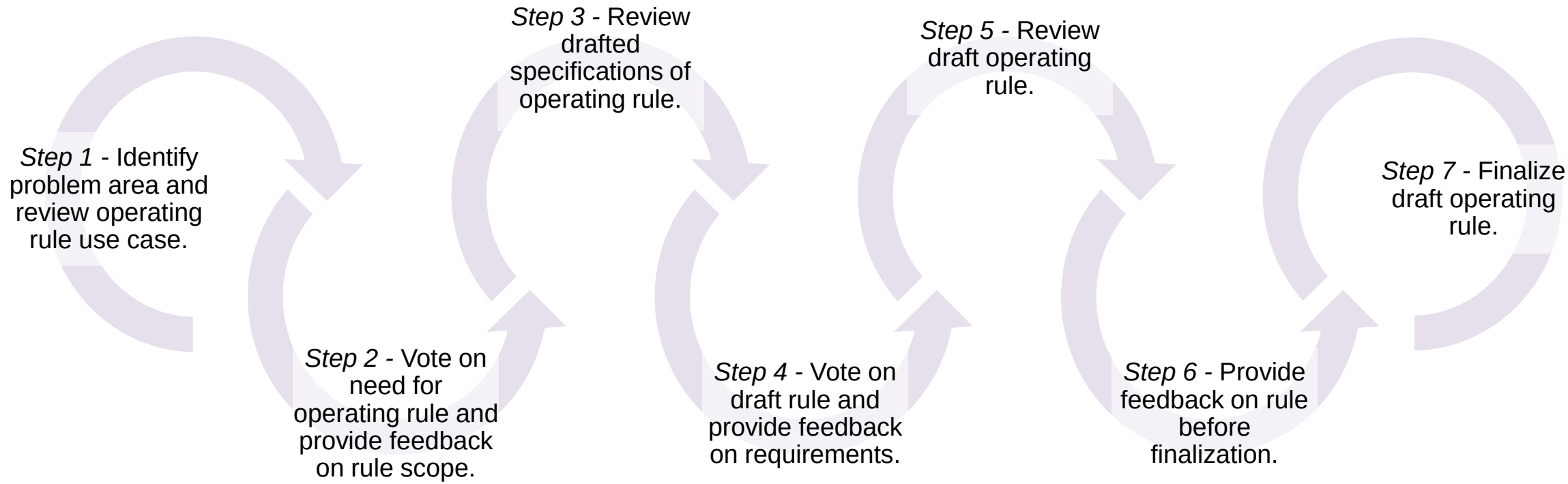
Support Revenue Cycle Automation

- Operating rules create common expectations for electronic data exchange, allowing provider and payer systems to automate communications across trading partners.
- Can address both the data content and infrastructure to support a transaction.

Rule Development Process

Iterative, consensus-based development of value-based payment operating rules

Sample Progression for Operating Rule Development



Environmental Scan	Subgroup	Review Workgroup	All CORE Vote
Dec 2022	Apr 2023	Aug 2023	Oct 2023	Nov 2023

Scope, Timeline and Expectations

Scope

Exploration, recommendation for, and development of CAQH CORE Data Content and Infrastructure Operating Rules affecting the methodologies and administration of value-based payment models.

Topics within scope of this initiative

- Uniform race and ethnicity and other socio-demographic data collection.
- EDI submission of supplementary diagnosis codes.
- Infrastructure and governance requirements.
- Unified industry terminology.

Goals

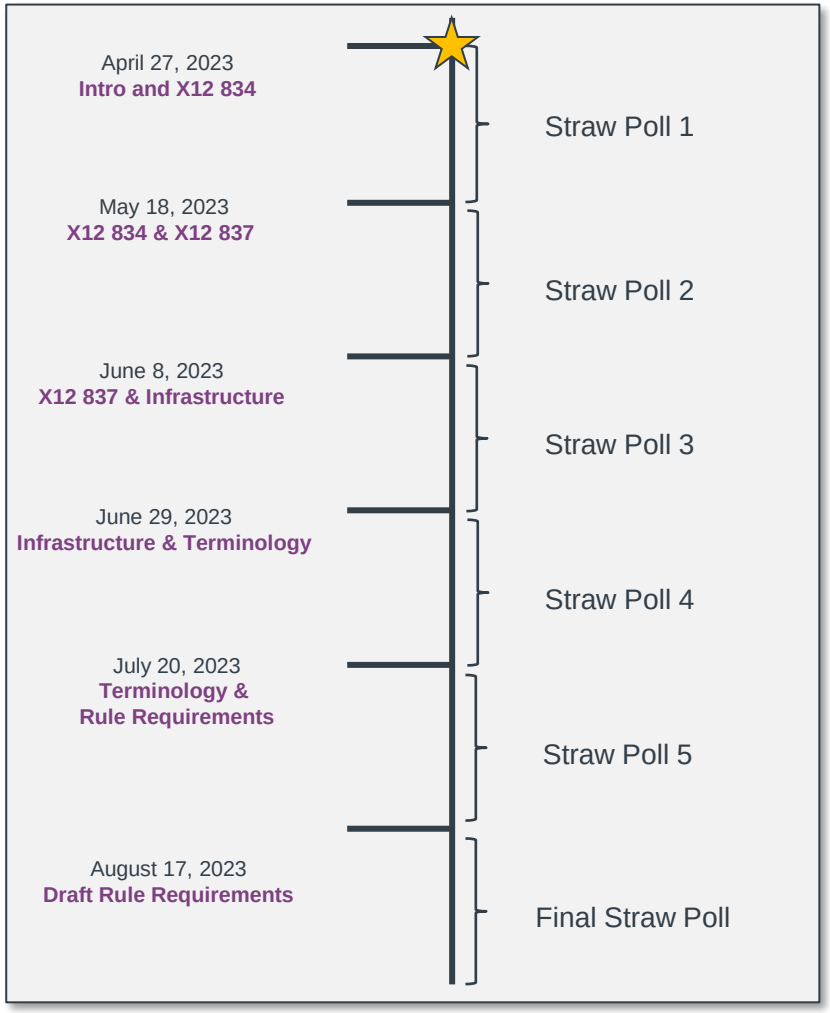
Prioritize topics for and participate in development of CAQH CORE Value-based Payment Operating Rules and other industry guidance.

Participant Expectations

Subgroup members are expected to engage in and contribute to discussions as we work toward consensus-based requirements.

- Materials are distributed ahead of meetings.
- Disseminate knowledge to others in your organizations.
- Confirm requirements using straw polls.
- Contact CORE@CAQH.org with questions.

Tentative Timeline



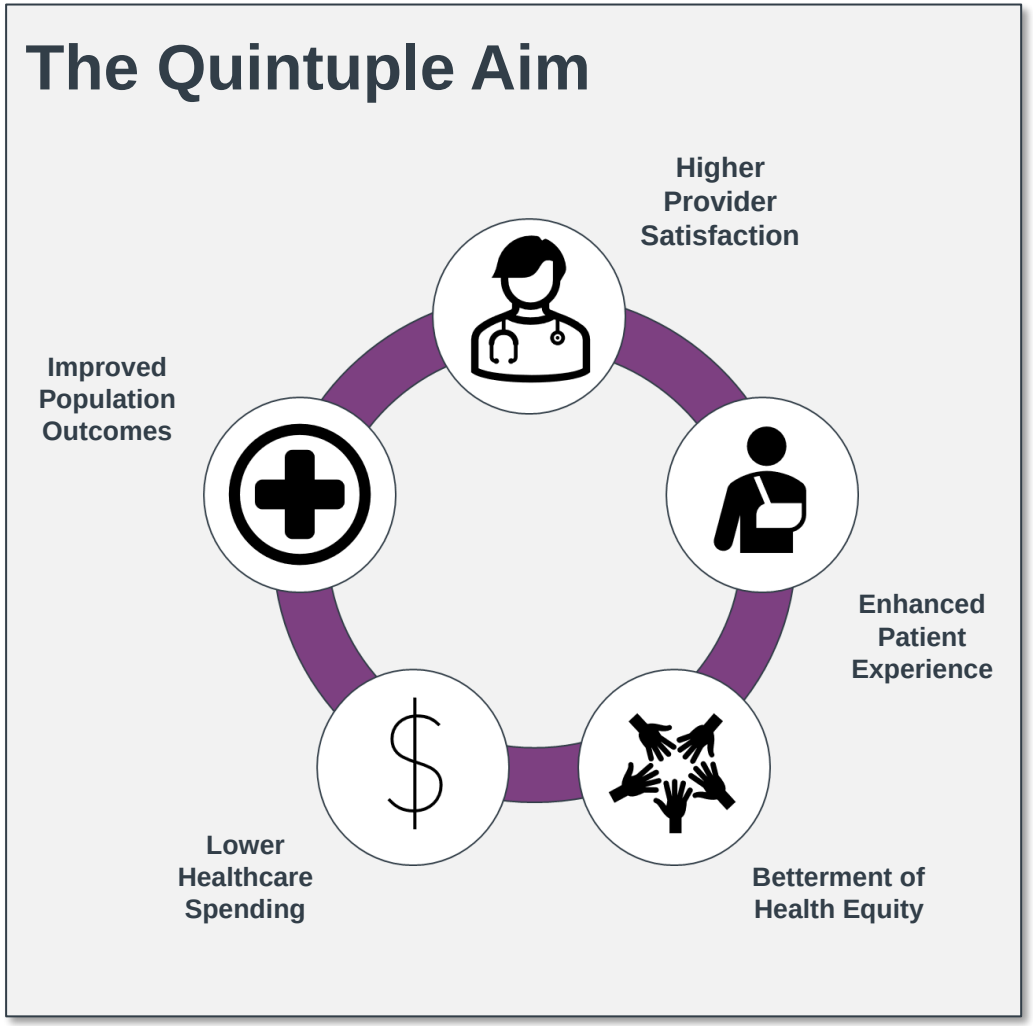
Research Background and Focus Areas

What is Value in Healthcare and Why Does it Matter?

Incentivizing outcomes over volume

“Value-based care ties the amount health care providers earn for their services to the results they deliver for their patients, such as **quality, equity, and cost of care**. Through financial incentives and other methods, value-based care programs aim to hold providers **more accountable for improving patient outcomes** while also giving them greater flexibility to deliver the right care at the right time.”

(Commonwealth Fund, 2023; emphasis added)



How Value-based Payment Models Benefit From Operating Rules

Rule requirements support the evolution of legacy FFS systems

Value-based payment is a durable part of the healthcare system. Operating rules can streamline operations while supporting innovation.

Interoperability

Technical interoperability is nascent in VBP, creating siloes that inhibit care coordination and delay the involvement of community-based services.

Uniform Data

Non-uniform data limits generalized analysis and population-level insights, delaying innovation, targeted interventions, and the streamlined collection for SDOH.

Complexity

To decrease cost and promote better outcomes, VBP models have become increasingly reliant on complex network development, performance monitoring and burdensome contracting.

CAQH CORE Roadmap to Value-based Payments

Research and industry input prioritized topics relevant to value-based payment

CORE Prioritization

- Identified as priority area on CAQH CORE Participant Survey – **Over 110 organizations.**
- **Unanimous approval** by the CAQH CORE board to pursue value-based payment operating rule development.

Identify Opportunities

- **Reviewed original CAQH CORE VBP Environmental Scan**
  - Evaluate relevance of key operational areas.
- **Interviewed industry representatives**
  - Comprehensive interviews with payers, providers, vendors and SDOs.
- **Established a VBP Focus Group**
  - Tested key assumptions with subject matter experts to develop a potential slate of VBP operating rules and industry guidance.

Publications

- **VBP Issue Brief**
  - Health equity/SDOH
  - Program complexity
  - Infrastructure improvements
  - Terminology/contractual alignment
- **Thought Leadership**
  - Blog posts
  - 1-page overviews
  - Webinars

Engaged organizations during stakeholder interviews

- Center for Medicare and Medicaid Innovation
- Montefiore
- WEDI
- University of Southern Maine
- Edifecs
- Cleveland Clinic
- Aultcare
- Mayo Clinic
- Cognizant
- Change Healthcare
- Tricare
- NCPDP
- athenahealth
- BCBS North Carolina
- Point32 Health
- New England Healthcare Exchange Network

Identified Opportunities for Operating Rule Development

Foundational topics minimize complexity and support innovation

Alignment to Research
Incorporation of SDOH into VBP model design advances health equity and informs the development of interventions that target disparities.

X12 834 Benefit Enrollment

Align race and ethnicity data collection to standardize electronic exchange and improve the data quality and integrity of socio-demographic information.

CAQH CORE VBP Infrastructure Rules

Identify operational gaps in CAQH CORE infrastructure rules and recommend additions for VBP data exchange.

Alignment to Research
Addresses program complexity related to program administration and the involvement of community-based organizations.

Alignment to Research
Streamlines interoperability and data exchange and supports health equity/SDOH.

X12 837 Claim Submission

Unify industry pathways for EDI submission of supplementary diagnosis information that supports VBP methodologies.

Alignment of VBP Terminology

Develop “best practice” definitions for industry use to align contractual terminology and common VBP methodologies.

Alignment to Research
Addresses program complexity related to the initiation of VBP contracts between health plans and providers.

Benefit Enrollment and Maintenance Transaction (X12 834)

Aligning socio-demographic data collection and exchange to improve data integrity

Background

- Race and ethnicity information is important for the design and implementation of large-scale interventions designed to combat health inequities.
- Outside of federal requirements, there is no single standard for the collection and exchange of race and ethnicity information.
- Benefit enrollment is a platform for health plans to uniformly collect and transmit race and ethnicity data, increasing data integrity and equity by design in VBP.
- Additional socio-demographic information can be transmitted using the benefit enrollment transaction including, gender identity and preferred language.

Commonly used race and ethnicity code sets

Code set	Notes
OMB 1997	Requirement for federal programs, minimum standard all other collection efforts are held to
X12 v5010 TR3	Provides some greater detail for race
HHS 2011	Provides some greater detail for ethnicity
CDC Race and Ethnicity	Greatest detail with >900 race and ethnicity concepts

Opportunity for standardization: Variable datasets and implementation practices lead to incompatible data collection efforts. Operating rules could support the use of comprehensive data sets for the collection and exchange of race and ethnicity data. For example, using the CDC Race and Ethnicity Code Set could **increase granularity** and **standardize transfer using an included unique identifier field.**

Indications for use/exchange: X12 v5010 and v8030, HL7 FHIR / LOINC, manual transfer

Claim Submission Transaction (X12 837)

Support for VBP methodologies through supplementary diagnosis submission

Background

- Chronic conditions and non-clinical factors influencing care are commonly recorded as secondary diagnoses upon patient presentation; these contribute to value-based methodologies.
- Some or all secondary diagnoses may be de-prioritized on a claim because providers are limited to submitting 12 diagnosis codes on a single professional claim – fewer if their PMS is outdated.
- Using the X12 837 Claim Submission transaction, CAQH CORE Operating Rules can unify the industry around a single best practice pathway for the submission of claims to supplement diagnoses.

Key considerations in aligning supplementary diagnosis submissions

Submission Point	Consideration
Scope of initial claim	All claims or only those with evaluation and management *99202 - 99499*
Matching information	Matching information must avoid duplicates *Member number, dates of service, providers*
Procedure Code	Low or no resource HCPCS included on claim *99499 or 99080*
Amount	Nominal amount necessary to avoid rejections *$0.00 or $0.01*
Claim Frequency	Coded as initial or zero-amount claim *Claim frequency code '1' or '0'*
Primary Diagnosis	ICD-10 must qualify as principal diagnosis *Proprietary lists; avoid duplication*
Supplemental Diagnosis	Define use-cases within VBP Risk adjustment, quality measurements, attribution

Opportunity for standardization: The CAQH CORE Health Care Claims Subgroup is considering technical requirements for this submission pathway and will solicit input from the CAQH CORE Value-based Payment Subgroup to identify **specific use-cases and considerations pertinent to VBP models**. The VBP Subgroup will evaluate the output from the Claims Subgroup when considering the addition of rule language addressing VBP methodologies.

Indications for use/exchange in: X12 v5010 and v8020

Applying CAQH CORE Infrastructure Requirements to VBP

Identify and address operational gaps for VBP-related transactions

Background

- CAQH CORE Infrastructure Operating Rules create a “highway” for streamlined data exchange supporting mandated and voluntary healthcare transactions.
- VBP is supported by a suite of EDI and manual transactions and thus infrastructure operating rules are applicable to its administration; new requirements may address business gaps in the current infrastructure rule set.
- The CAQH CORE Value-based Payment Subgroup will evaluate the infrastructure rules for the targeted X12 834 & 837 – and other transactions to identify business gaps and the potential for updated rule requirements.

“CORE” Infrastructure Requirements	Ability to Facilitate VBP Specificity
CORE Connectivity Requirements	
System Availability	
Batch & Real-time Processing and Response Time	
Master VBP Contract Template	Y
Data Submission Requirements	Y
File Size Maximum	P
Frequency of Data Exchange	C

Y = Yes, requirements can be modified to support specific VBP operations
P = Partial, requirements should be considered in how they support specific VBP operations
C = Current, implemented as part of Attributed Patient Roster (X12 834) Infrastructure Rule

Pursuing Semantic Interoperability

Creating industry standard definitions for common inclusions

Background

- VBP terminologies and methodologies are not aligned between sponsoring health plans and other stewards, challenging the uniform administration across contracts.
- Value-based care is subject to **interpretative definitions** that lead to variable operationalization of models and key methodologies.
- Alignment of key contracting terms and methodologies can unify industry language and create common expectations that streamline program administration.

DRAFT Concept and Semantic Interoperability Framework

General definition: Accepted, concise description of what a concept or term is and to what it applies.

***Example**: Patient Attribution is the method by which a patient is assigned to a provider, entity, or organization participating in a value-based contract.*

Minimum inclusions: Minimum concepts that must be included in a methodology or term for it to meet industry-wide implementations.

Population Health		Bundled Payments	
Patient is assigned to a provider, entity or organization through…			
OR	Plurality of claims, visits, spend	OR	ICD-10-CM code
	Voluntary alignment		ICD-10-PCS or HCPCS code
Assignment is determined through…			
OR	Retrospective assignment		Prospective assignment with retrospective true-up
	Prospective assignment with retrospective true-up		*N/A*
Patient cannot be assigned to…			
AND	More than one provider	AND	More than one provider
	More than one population-health program		The same bundle in different programs
OR	Other VBP initiatives as defined in contract	OR	Other VBP initiatives as defined in contract

When definition does not apply: Industry-defined exceptions that outline when deviations from the definition are acceptable.

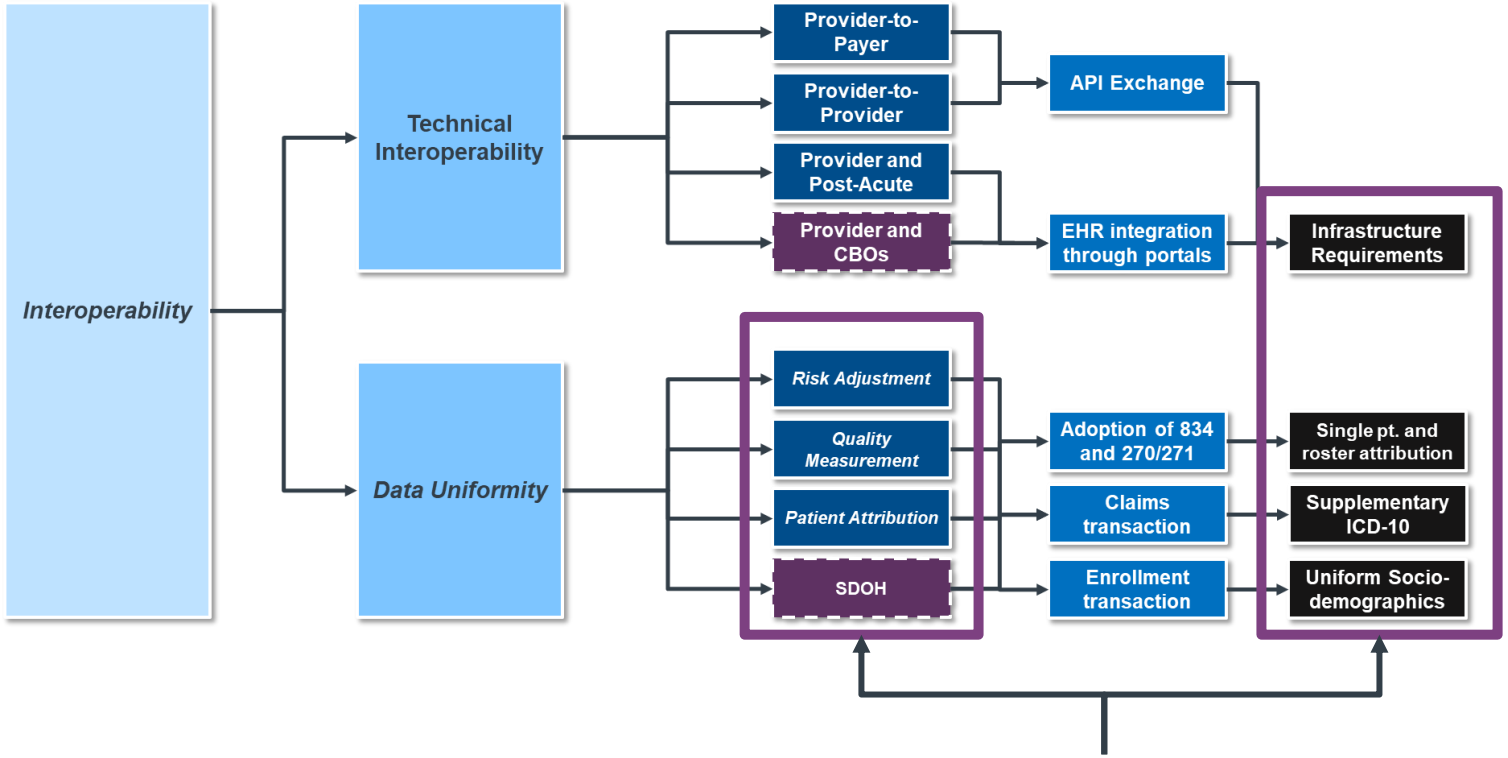
***Example:** Specialty care models, including those targeting oncology or advanced renal diseases, may see patients assigned to the appropriate specialist in lieu of plurality or billing/rendering provider of bundled payment trigger code.*

CAQH CORE

Facilitation of an Inter-dependent Framework

Appreciating the connection between topics prior to diving into detail

CAQH CORE Value-based Payment Rule Development Framework



Candidate areas for alignment of definitions for methodology and contractual terminology

- Proposed rule development takes iterative steps and minimizes variability while providing a foundation for innovation.
- CAQH CORE will distribute a **straw poll** gauging support for high-level operating rule requirements.
- Review the background and justification for standardizing socio-demographic data exchange for the Benefit Enrollment and Maintenance transaction (X12 834).

Benefit Enrollment and Maintenance Opportunities

Standardization of Race and Ethnicity Data Collection & Exchange

X12 834 Benefit Enrollment and Maintenance

Opportunity to standardize racial and ethnic data collection, exchange, and analysis

Collection and analysis of Race and Ethnicity data catalyzes health equity in US Healthcare.

- Identifies population level risk exposure by race, highlighting where additional resources are required.
- Contributes to the identification of quality disparities for health plans and providers.
- Aids in the detection of potential bias in algorithms used in decision-support.
- Informs the incentivization of data collection and interventions that directly address health disparities.

The collection and utility of the race and ethnicity data is limited.

- Data collection by health plans does not adhere to a single standard, harming interoperability and exchange.
- Perceptions of legality by health plans and other stakeholders – both true and not – stunt collection efforts.
- Beneficiaries are cautious of data collection efforts, citing misuse and bias, and beliefs that categories are under-representative.

Operating Rules targeting the X12 834 transaction can align data collection and aid durable interventions.

- Can aid in standardizing point-of-enrollment race and ethnicity data collection across health plans.
- Can address under-representation of racial and ethnic categories by leveraging detailed industry data sets.
- Can support the thoughtful allocation of resources to disenfranchised or underserved individuals enrolled in health plans.

Relevance to Healthcare Industry Stakeholders

Direct impact on health plans with downstream effects for providers and vendors

Health Plans

Rule requirements streamline data collection of important sociodemographic data, improving data quality, program design, and support for emerging regulations.

Providers

Rule requirements provide better representation of patient populations, resulting in meaningful program design and alignment of measurement with provider priorities.

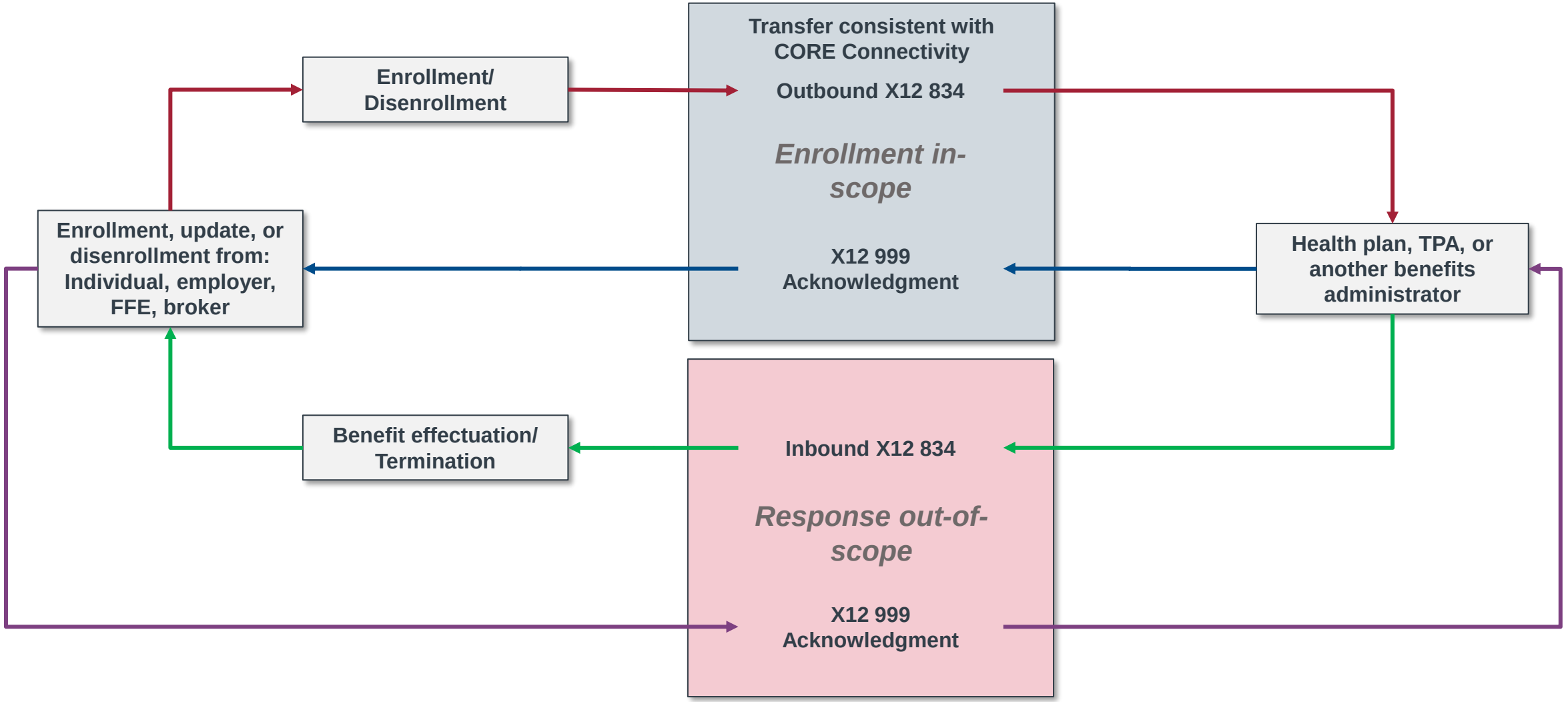
Usage could promote provider-driven data set alignment in the X12 837

Vendors

Rule requirements impact vendor support for the X12 834 transaction while informing new approaches or opportunities across multiple product types.

X12 834 Enrollment, Maintenance & Disenrollment Exchange

Operating rules would focus on enrollment workflows



Collecting Race and Ethnicity Data at Enrollment

Current practices do not conform to a single standard

Federal Collection Requirements

Office of Management and Budget (1997)

- Required for all federal programs
- Collects 5 race categories and 2 ethnicity categories in 2 questions.
    - White
    - Black or African American
    - American Indian or Alaska Native
    - Asian
    - Native Hawaiian or Other Pacific Islander

Health and Human Services (2011)

- Required for federal population health surveys.
- Expands on OMB 1997 requirements.
- Enhanced granularity, particularly for ethnicity.
    - Hispanic ethnicity split between Mexican, Puerto Rican, Cuban and others.

More detailed

Code Sets for Exchange

X12 v5010 TR3

- Composite race and ethnicity.
- Fulfills OMB requirements.
- Reportable through DMG fields in X12 834.
- Includes additional categories to support more detailed collection.

CDC Race and Ethnicity Code Set

- Most granular collection and exchange dataset.
- Includes self-reported race and ethnicity concepts.
- Contains unique identifier for standard exchange.

X12 834 Benefit Enrollment and Maintenance

Implementation is not guaranteed and reporting of detailed categories is limited

Data and Implementation Shortcomings

- Only **48%** of available X12 834 companion guides indicate situational exchange and acceptance of race and ethnicity information.
- Proprietary code sets are inconsistent with the X12 TR3. For example, Black is coded as ‘3’ in a proprietary MMIS dataset but must be converted to ‘N’ or ‘B’ for transmission in the X12 code set.
- Exchange using X12 v5010 code set “rolls-up” race and ethnicity categories. A more comprehensive dataset can better capture granular detail about populations to inform specific interventions.

Example of Race and Ethnicity “Roll-up” into X12 TR3 Reporting

HHS 2011	X12 834 TR3	X12 Description
Chinese	A	Asian or Pacific Islander
Filipino		
Japanese		
Korean		
Vietnamese		
Other Asian		
Other Pacific Islander		

HHS 2011	X12 834 TR3	X12 Description
Mexican, Mexican American, Chicano/a	H	Hispanic
Puerto Rican		
Cuban		
Another Hispanic, Latino/a or Spanish Origin		

X12 834 Benefit Enrollment and Maintenance

Promoting the use of a comprehensive dataset to standardize exchange

Standardized Exchange Using CDC Code Set

- The CDC maintains a comprehensive dataset that provides granular, self-reported race and ethnicity concepts derived from the US Census.
- The code set is structured with unique identifiers that support standardized electronic exchange of information. Unique identifiers do not change over time.
- Additionally, the dataset supports hierarchical concepts that aid in analysis. These may change over time as new concepts are introduced.
- X12 v5010 834 supports exchange of this information using demographic fields. It is also indicated for use in USCDI, select FHIR implementation guides, and informs select LOINC terms.
- X12 v8030 uses the CDC code set as the principal data source for exchange in *situational* fields.

Race/Ethnicity	CDC Unique ID	Hierarchy
American Indian or Alaska Native	3001-5	R1
Asian	5000-5	R2
Black or African American	6000-4	R3
Native Hawaiian or Other Pacific Islander	7000-3	R4
White	8000-2	R5
Some Other Race	9000-1	R6

Hispanic or Latino	2201-2	E1
Not Hispanic or Latino	2300-2	E2

Values are representative of 2022 updates currently in a comment period.

CDC Race and Ethnicity Code Set

Operating rules can align industry to the usage comprehensive code sets

Approximately **18% of available X12 834 companion guides** indicate race and ethnicity data sharing using the CDC resource.

Code Set Confusion	Proprietary Implementation
Unique identifiers and the hierarchical codes are both in-use. Industry stakeholders must migrate to the unique identifier to ensure durability.	Health plans proprietarily collect race and ethnicity data most relevant to their population. Support for the comprehensive list of concepts improves data quality, integrity and exchange.

In-call Poll Question #1

Most commonly, what race and ethnicity constructs does your organization encounter or use?

a. OMB 1997 requirements (5 racial and 2 ethnic categories)

b. Race and ethnicities indicated in the X12 834 TR3

c. HHS 2011 requirements (Greater definition of ethnicity)

d. CDC Race and Ethnicity Code Set

e. Some combination of the above

Additional Socio-demographic Data to be Considered

Race and ethnicity is a single construct in the pursuit of equitable care

Gender Reporting

- Leverage detailed gender-identity standards

Preferred Language

- Require preferred language collection

Other Opportunities

- Structured fields
  - Marital status
  - Citizenship status
- Unstructured fields
  - Sexual orientation
- Others?

Gender Reporting Standards Referenced in USCDI v3

Gender Value	Exchange Code	Required in X12 (version)
Male	**SNOMED**: 446151000124109	Yes (v5010 & 8030)
Female	**SNOMED**: 446141000124107	Yes (v5010 & 8030)
FTM/Transgender Male/Trans Man	**SNOMED**: 407377005	Partial (v8030, unspecified)
MTF/Transgender Female/Trans Woman	**SNOMED**: 407376001	Partial (v8030, unspecified)
Identifies as non-conforming gender	**SNOMED**: 446131000124102	No
Additional gender category or other, please specify	**HL7 v3**: OTH	No
Choose not to disclose	**HL7 v3**: ASKU	Partial (v5010 & 8030, unspecified)

Source: https://www.healthit.gov/isa/representing-patient-gender-identity

Remaining Questions and Barriers to Adoption

- **Is method of collection important to indicate in data content requirements for this operating rule?**
  - Self-reported is the gold standard for race and ethnicity reporting, is their value in capturing that?

- **What are expectations for collection frequency?**
  - Post-enrollment limitations?
  - How long does information remain valid?

- **What rule requirements can overcome potentially limiting perceptions?**
  - Misunderstanding about the legality of collection.
  - Perceptions among disenfranchised communities that the data will be misused.

- **How do we overcome various data collection practices?**
  - ONC Certification requires use of the USCDI, but this does not apply to payers or providers.
  - Proposals for data collection templates.

Subgroup Next Steps

CAQH CORE VBP Subgroup Participants:

- Complete Straw Poll #1 **by Thursday, May 11, end of day.**
- Participate in the next CAQH CORE VBP Subgroup Call on **Thursday, May 18, from 2:00-3:30 PM ET.**

CAQH CORE Staff & Co-Chairs:

- Distribute Straw Poll #1 to participants **by Monday, May 1, end of day.**
- Draft a call summary for today's call.
- Analyze responses from Subgroup Straw Poll #1 in preparation for Subgroup Call #2 on Thursday, May 18.

Contact CORE@caqh.org with any questions.

Appendix

Today's Call Documents

Document Name
Doc 1 VBP Subgroup Call 1 Deck 04.27.23

CORE Staff	Email Address
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CAQH CORE Value-based Payments Subgroup

Roster

Participant	Title and Organization
Elyse Pegler	Aetna
James Murray	Aetna
Alka Acari	Aetna
Terry Cunningham	AHA
Andrea Preisler	AHA
Linda Walsh	AMA
Laura Scott	AMA
Heather McComas	AMA
Robert Otten	AMA
Erica Martin	AMA
Era Rodriguez	Arizona Health Cost Containment System
Danielle Vincent	Aultcare
Jacob Boron	Aultcare
Kathy Sites	Availity
Health Sammons	BCBS NC
Troy Smith	BCBS NC
Natasha Sallie	BCBS MI
Ron Knapp	BCBS MI
Carol Larson	BCBS MI
Cynthia Monarch	BCBS MI
Jack Green	BCBS MI
Susan Langford	BCBS TN
Chuck Chervitz	CMS
Charlene Parks	CMS
Sadaf Ali	CMS
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Adam Keating	Cleveland Clinic
Sanjeev Suri	Cleveland Clinic

Participant	Title and Organization
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Tania Mason	Cognizant
Vincent Carrillo	Cognizant
Andrew Schulz	Cognizant
Parag Pancholi	Cognizant
Patricia Wijtyk	Cognizant
Kevin Day	Edifecs
Vik Sachdev	Edifecs
Tushar Nair	Edifecs
Anitha Aerabati	Elevance Health
Megan Soccorso	Gainwell Technologies
Rashmi Bokkasada	HealthEdge
Parag Desai	HealthEdge
Gheisa-Ly Rosario Diaz	LabCorp
Linda Jaeger	LabCorp
Denny Brennan	MHDC/NEHEN
David Delano	MHDC/NEHEN
Janice Karin	MHDC/NEHEN
Kenia Cruz	Montefiore
Charles Hawley	NAHDO
Amy Costello	NAHDO
Margaret Weiker	NCPDP
Nancy Team	NextGen
Alison Schambach	Tata Consultancy Services
Pinki Patel	Tata Consultancy Services
Dorothy Egan	Tata Consultancy Services
Mary Sussman	Tata Consultancy Services
Brian Petry	TRICARE
Dawn Erckenbrack	TRICARE
Kiran Kalluri	UnitedHealthGroup
Lynn Chapple	UnitedHealthGroup
Robert Tennant	WEDI
Kristina Berger	Zelis

CAQH CORE VBP Subgroup

Activity schedule for calls 1 and 2

Work Group Activity	Date	Topic

Subgroup Call #1
 	
TOPIC(S): Introduction & Benefit Enrollment Transaction
	Thursday 4/27/23
	2:00 – 3:30 PM ET
		▪ Level Set.
		▪ Subgroup Scope.
		  • Roles, responsibilities, and expectations.
		  • Research and operating rule topics.
		▪ Benefit Enrollment Background.
		▪ Next Steps including VBP Subgroup Straw Poll #1.

Subgroup Straw Poll #1 **TOPIC(S):** Benefit Enrollment and Infrastructure Requirements	**Monday 5/1/23 – Thursday 5/11/23**	▪ Indicate level of support for high-level operating rule requirements for the benefit enrollment transaction. ▪ Identify additional socio-demographic details to include in benefit enrollment operating rule. ▪ Provide guidance for detailed infrastructure operating rule requirements and targets.
Work Group Call #2 **TOPIC(S):** Benefit Enrollment & Claims Transactions	**Thursday 5/18/2023** 2:00 – 3:30 PM ET	▪ Review results of Straw Poll #1. ▪ Review detailed benefit enrollment rule requirements. ▪ Introduce health care claims transaction. ▪ Next Steps including RWG Straw Poll #2.
Straw Poll #2 **TOPIC(S):** Benefit enrollment and health care claims	**Monday 5/24/23 – Thursday 6/4/23**	▪ Indicate level of support for detailed benefit enrollment data content rule requirements. ▪ Indicate level of support for high level health care claims data content rule requirements.

CAQH CORE will update content as agenda clarifies between calls

Infrastructure Requirements for Healthcare Transactions

Detailed requirements common across operating rules

Infrastructure Requirement	Benefit Enrollment	Premium Payment	Eligibility and Benefits	Attributed Roster	Prior Authorization	Prior Authorization Attachments	Claim Submission	Claim Status	Claim Attachments	Payment Remittance
CORE Connectivity Communication, security, and safe harbor requirements	X	X	X	X	X	X	X	X	X	X
CORE Companion Guide Template Standardized formatting	X	X	X	X	X	X	X	X	X	X
Batch Processing Acknowledgment and/or response time requirement [if applicable]	X	X	X	X	X	X	X	X	X	X
System Availability % Weekly / quarterly uptime and downtime reporting requirements	X	X	X	X	X	X	X	X	X	
Real-time Processing Acknowledgment and/or response time requirements [if applicable]	X	X	X		X	X		X	X	
Data Error Handling Uniform use of data error messages						X	X		X	
Max File Size File size accepted for processing						X			X	
Electronic Policy Access Identification of Submission and Receival Requirements or Definitions									X	
Dual Delivery Paper / Electronic Paper ween-off time following EDI implementation										X
Final Determination Time requirements to complete adjudication and close out					X					
Minimum Fulfillment Requirements Time windows information must be exchanged				X						

Example: Definition Framework for VBP Methodologies

Patient attribution

Population Health		Bundled Payments	
Patient is assigned to a provider, entity or organization through…			
OR	Plurality of claims, visits, spend	**OR**	ICD-10-CM code
	Voluntary alignment		ICD-10-PCS or HCPCS code
Assignment is determined through…			
OR	Retrospective assignment	**AND**	Prospective assignment with retrospective true-up
	Prospective assignment with retrospective true-up		*N/A*
Patient cannot be assigned to…			
AND	More than one provider	**AND**	More than one provider
	More than one population-health program		The same bundle in different programs
OR	Other VBP initiatives as defined in contract	**OR**	Other VBP initiatives as defined in contract