CAQH CORE Value-based Payment Subgroup Meeting #2

Advancing data content requirements for benefit enrollment and claims transactions

May 18, 2023

Agenda

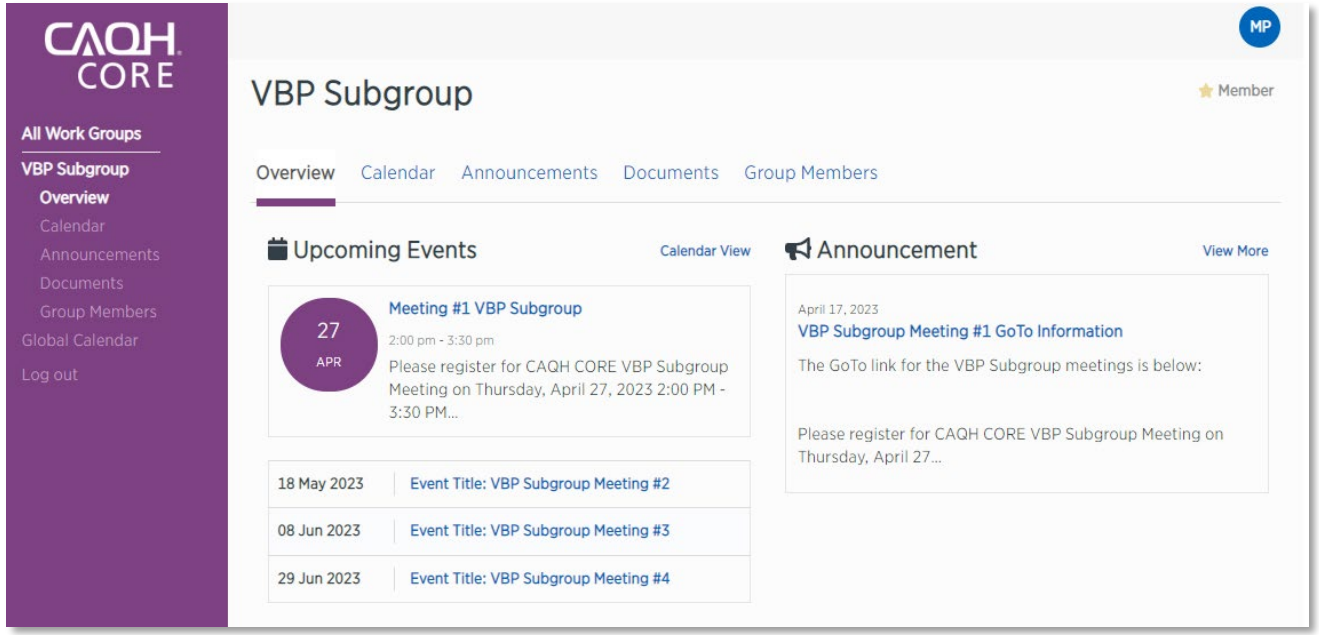
Time	Topic
2:00 PM	**Welcome, Antitrust Guidelines and Roll Call**
2:05 PM	**Straw Poll #1 Results** ▪ Support for Opportunity Areas ▪ Go-Forward Opportunities
2:35 PM	**X12 834 Data Content Requirements** ▪ Recap of Opportunity ▪ Candidate Loops and Segments
3:00 PM	**X12 837 Claim Submission** ▪ Introduction ▪ Health Care Claims Subgroup Collaboration ▪ Variation and VBP Use-Cases
3:20 PM	**Next Steps** ▪ Next Meeting on June 8, 2023, 2:00-3:30pm ET ▪ Straw Poll #2 opens on May 22

Objectives

1. Understand prioritization of operating rule opportunities based on Straw Poll results.
2. Identify targeted loops, segments, and data elements used to support socio-demographic data exchange in the X12 834.
3. Review additional claim submission opportunities, understanding purpose and collaboration.
4. Coalesce around next steps and feel prepared for Straw Poll #2.

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.

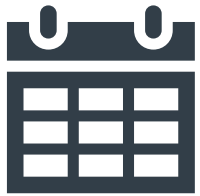


- The dashboard is accessible only to CAQH CORE Participants.
- Participants can view the work groups they are currently involved in and add themselves to new groups.
- Participants can view upcoming events, documents, announcements, and group member information.
- Email core@caqh.org if you need a login.

CAQH Connect Conference

Join us for **CAQH Connect 2023**, an event bringing together healthcare industry experts, thought leaders, and executives from the nation's government, health plans, and industry associations. We will explore trends, hear innovative thinking, and discuss the future of healthcare administration, including payment integrity.

To kick off the conference, CORE will hold its first-ever in-person **CORE Participant Forum** open to all individuals from CORE Participating Organizations the afternoon of September 27th. We invite all of you to attend the forum and stay for the entire conference.



Save the Date!

September 27-29, 2023

Westin Georgetown, Washington, D.C

Straw Poll #1 Results

CAQH CORE VBP Subgroup

Value-based Payment Subgroup – Straw Poll #1

Straw Poll background

Purpose of Straw Poll

To provide direction on opportunity areas and rule options.

Format:

- **Support for Opportunity Areas:** Indicate level of support for each opportunity area.
- **Direction on Potential Rule Options:** Provide input on high-level rule requirements to refine opportunities.
  - Opportunities are 'moved forward' if majority of respondents 'Support' or 'Partially Support' requirements.
  - If more 'Partially Support' than 'Support' additional discussion will be undertaken to align with industry needs.

Summary of Opportunity Areas

1. **X12 834 Socio-demographic Data Collection & Exchange:** Use mandated and voluntary versions of the X12 834 to collect and exchange socio-demographic information, including granular race and ethnicity.
2. **X12 837 Additional Claim Submission:** Define standard submission for additional claims that can support value-based payment methodologies, such as risk adjustment and quality measurement.
3. **CAQH CORE Infrastructure Rules – VBP Enhancements:** Potential improvements to CAQH CORE Infrastructure Rules to support the administration of VBP programs.
4. **Semantic Interoperability in VBP:** Common industry definitions for VBP contractual terms that can unify language and minimize proprietary implementations.

Value-based Payment Subgroup Straw Poll #1

Breakdown of responses by stakeholder type

23 out of 32 unique organizations responded to Straw Poll #1 (72%).

Distribution of Responses	Total Straw Poll Responses	Percent of Respondents
Provider/Provider Associations	4	17%
Health Plan/Health Plan Associations	6	26%
Vendor/Clearinghouses	6	26%
Government/Other	7	31%

Prioritization and Support for X12 834 Opportunity Areas

Support for Rule Development Opportunities Within the X12 834 Transaction						
	Opportunity	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
1	*Member Preferred Language Collection and Exchange (2 abstentions)*	*71%*	*19%*	*10%*	*0%*	*0%*
2	*Race and Ethnicity Data Collection Exchange (2 abstentions)*	*67%*	*19%*	*14%*	*0%*	*0%*
3	*Gender Identity Data Collection and Exchange (2 abstentions)*	*52%*	*24%*	*19%*	*0%*	*5%*
4	*Member Marital Status Collection and Exchange (2 abstentions)*	*62%*	*14%*	*24%*	*0%*	*0%*
5	*Sexual Orientation Collection and Exchange (3 abstentions)*	*45%*	*15%*	*25%*	*5%*	*10%*
6	*Member Citizenship Status Collection and Exchange (3 abstentions)*	*30%*	*20%*	*25%*	*5%*	*20%*
7	*Exchange to providers using Plan Member Reporting Transaction (3 abstentions)*	*60%*	*10%*	*25%*	*5%*	*0%*

Rows may not add to 100% due to rounding.

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Comment Categorization

Substantive, point of clarification and non-substantive

- **Three categories of comments**
  - **Substantive:** May impact rule requirements; some comments require Subgroup discussion on potential adjustments to draft requirements.
  - **Points of clarification:** Pertain to areas where more explanation or the Subgroup is required; may require adjustments to the rule which do not change rule requirements.
  - **Non-substantive comments:** Pertain to typographical/grammatical errors, wordsmithing, clarifying language, addition of references; do not impact rule requirements.
- **The VBP Subgroup will address substantive comments, points of clarification and CAQH CORE Co-chair and staff recommendations.**
- **No non-substantive comments were received.**

X12 834 Opportunity: Substantive Comments and Points of Clarification

Substantive Comments	Co-chair and CAQH CORE Response
1. One organization acknowledged the cumbersome nature of supporting >900 race and ethnicity concepts, highlighting challenges of implementation.	1. **AGREE:** Collecting the entirety of the Race and Ethnicity Code Set may be unrealistic and supports establishing a *minimum* collection requirements based on the OMB Directive 15. Organizations should support exchange of any race and ethnicity concept using the unique identifiers contained in the code set.
2. Five organizations highlighted the potential divisiveness of collecting citizenship status and self-reported sexual orientation citing potential privacy concerns and member harm. One organization suggested that, in lieu of citizenship, “place of birth” could be collected.	2. **AGREE:** Recommend not moving forward with the collection of citizenship information given its sensitive nature. The Subgroup will reconsider the collection of sexual orientation to ensure that viable, agreed upon use-cases are determined prior to including in operating rule requirements.
3. Two organizations supported that all socio-demographic information should be shared voluntarily at the discretion of the member.	3. **AGREE:** Methods to support voluntary disclosure should be included in the operating rule requirements.

X12 834 Opportunity: Points of Clarification

Point of Clarification	Co-chair and CAQH CORE Response
1. Two organizations submitted that data elements from USCDI vocabulary standards are not included in the X12 standard and a maintenance request or request to reference an external code set should be submitted to X12 to support this information prior to inclusion in an operating rule.	1. Based on review of the TR3 and on-going liaison with X12, exchange of race and ethnicity data using the CDC Race and Ethnicity Code Set is indicated for use in the X12 TR3 as the external code set supporting select demographic fields. Though not referenced as external code sets, exchange of gender identity and sexual orientation can be facilitated using alphanumeric reference fields within the transaction.
2. One organization expressed concern over differing versions of the USCDI standard, stating that the industry has just begun coalescing around version 2 and referencing version 3 may be premature or conflict with current priorities.	2. Versioning of USCDI will be discussed by the Subgroup when determining rule requirements. Whenever possible, CAQH CORE encourages rule development that references 'most recent' or 'current' versions as a method to address dynamic industry requirements. CAQH CORE also acknowledges the recent proposal of USCDI v3 in an ONC Proposed Rule. If finalized, an operating rule could aid alignment, implementation, and conformance with this requirement.
3. One organization believes that exchange would be better accomplished using the X12 270/271 allowing point-of-care review and use of socio-demographic information.	3. CAQH CORE will take this under advisement and use it to inform opportunities for the upcoming CAQH CORE Eligibility and Benefits Task Group, launching later this year.
4. One organization supports the harmonization of OMB and CDC Race and Ethnicity Code Sets. Another organization highlighted the existence of the OMB Directive 15 for consideration.	4. The OMB Directive 15 is fulfilled by exchange of unique identifiers in the CDC Race and Ethnicity Code Set.
5. One submitter acknowledges that some socio-demographic information is collected using web applications and other standards.	5. Consideration of other standards and submission methods is necessary when developing operating rules. One goal of this Subgroup is to ensure uniform exchange across multiple methods and standards.
6. One organization acknowledged potential implementation challenges but recognized that the indicated data collection aligns with internal and industry priorities.	6. The Subgroup will consider the resources necessary for implementation during rule development.
7. One submitter recommended adding social screening date and time.	7. This information is required for collection in demographic data segments in the X12 standard.
8. One organization acknowledged the benefit of the proposed collection at the point of enrollment and renewal.	8. N/A
9. One organizations pointed out the voluntary nature of the Member Plan Reporting transaction in limiting its implementation.	9. Though implementation may be limited, this transaction is a strong method for sharing actionable information with providers. It aids the industry in standardizing exchange in VBP, reducing reliance on proprietary approaches.

Prioritization and Support for X12 837 Opportunity Areas

Support for Rule Development Opportunities Within the X12 837 Transaction						
	Opportunity	**Support**	**Partially Support**	**Neutral**	**Partially Do Not Support**	**Do Not Support**
1	**Quality / Outcome Measurement** (2 abstentions)	76%	10%	14%	0%	0%
2	**Risk Adjustment / Stratification** (3 abstentions)	85%	0%	15%	0%	0%
3	**Social Determinants of Health Using ICD-10 Z-codes** (1 abstention)	73%	9%	18%	0%	0%
4	**Patient Attribution / Assignment** (2 abstentions)	71%	5%	14%	5%	5%
5	**Payment Determination / Incentives** (2 abstentions)	71%	5%	24%	0%	0%

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X12 837 Opportunity: Substantive Comments and Points of Clarification

Substantive Comments	Co-chair and CAQH CORE Response
1. One organization suggested splitting out certain terms, such as quality measurement, to differentiate between outcomes and process adherence.	1. **AGREE:** Additional refinement of terminologies and use-cases is necessary as the Subgroup gets deeper into rule development.
2. Three organizations made suggestions for other use-cases; including: - Use of richer SDOH data sets. - Use for public health and economics. - Use of the X12 837 for data integrity checks.	2. **FOR DISCUSSION:** More specificity on these recommended use-cases is needed.

Point of Clarification	Co-chair and CAQH CORE Response
3. One organization expressed that submission of these diagnosis codes should be voluntary.	3. An operating rule would not require submission of diagnosis codes. The purpose of this polling is to identify VBP-centered use-cases that can be applied to an operating rule for uniform additional claim submissions. This opportunity was identified through industry environmental scanning and research.
4. Two organizations suggested that 12 diagnosis codes on a professional claim is too limiting and is a hindrance to the submission of certain diagnoses, such as Z-codes.	4. This comment aligns with what was found through CAQH CORE research and environmental scanning and is the basis for why operating rule requirements for a uniform additional claim submission are being pursued collaboratively between the CAQH CORE Health Care Claims Subgroup and CAQH CORE Value-based Payment Subgroup.
5. Two organizations indicated that other or updated standards and exchange methods should be considered in rule development. Importantly: - Maintaining the ability to exchange information outside the claim submission. - Supporting newer versions of the X12 837 standard.	5. The intent of this rule making process is not to disallow other methods of submission, whether accommodated through web portals or through other electronic standards, such as HL7 FHIR. If the X12 837 standard is updated, CAQH CORE can update operating rules to be inclusive of new or edited requirements.
6. One organization expressed unfamiliarity with the claims use-cases presented, requesting more information.	6. Time allowing, each use-case will be reviewed during this presentation.
7. Two organizations express their support for this work.	7. N/A

Prioritization and Support for VBP Infrastructure Opportunity Areas

Support for Rule Development Opportunities for CAQH CORE Infrastructure Rules						
Opportunity		Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
1	**Electronic Policy Access Requirements** (3 abstentions)	60%	5%	30%	5%	0%
2	**Minimum Frequency for Report and/or Data Sharing** (4 abstentions)	63%	0%	32%	5%	0%
3	**Maximum File Size Requirements** (3 abstentions)	55%	5%	30%	0%	10%
4	**VBP Contract Template** (2 abstentions)	52%	0%	29%	5%	14%

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Infrastructure Opportunity: Substantive Comments and Points of Clarification

Substantive Comments	Co-chair and CAQH CORE Response
1. Three organizations expressed concern over development and use of a VBP contract template, citing that VBP is progressive, fast-moving and innovative. A template may not contemplate all business scenarios.	1. **FOR DISCUSSION**: The intent of a VBP Contract Template would not be to inhibit program innovation or iteration. Instead, the intent of a contract template is to provide a template that could help the industry with predictable and reproducible implementations, similar to how the CORE Master Companion Guide Template defines a flow and format to support EDI implementations. The template would not seek to override proprietary methodologies.

Point of Clarification	Co-chair and CAQH CORE Response
2. One organization expressed concern over maximum file size requirements, requesting more information about what this would entail to better gauge support.	2. CAQH CORE refers to attachment operating rules that contain this requirement. In those rules, CAQH CORE and its participating organizations noted unnecessary rejections of submissions because file sizes were too large. An operating rule requirement compelled health plans to accept a higher maximum file size to avoid rejections. Given the sometimes-extensive reporting requirements in VBP, this requirement could be co-opted to support more streamlined submissions between providers and health plans.
3. One organization expressed desire for clarification of the proposals.	3. CAQH CORE realizes that additional clarification is necessary when pursuing infrastructure rules. These opportunities were derived from a myriad of existing infrastructure requirements for their potential to be co-opted into VBP. The opportunities will be discussed in greater detail at future meetings.

Prioritization and Support for Semantic Interoperability

Support for Rule Development Opportunities for Semantic Interoperability						
	Opportunity	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
1	**High-level Definition** (4 abstentions)	74%	16%	11%	0%	0%
2	**When Definitions are not Applicable*** (4 abstentions)	68%	16%	16%	0%	0%
3	**Minimum Inclusion Requirements** (4 abstentions)	58%	21%	21%	0%	0%
4	**Episodic Care** (2 abstentions)	76%	10%	14%	0%	0%
5	**Payment** (2 abstentions)	81%	5%	14%	0%	0%
6	**Risk Adjustment / Stratification** (3 abstentions)	75%	10%	15%	0%	0%
7	**Patient Attribution / Assignment** (2 abstentions)	71%	14%	14%	0%	0%
8	**Quality / Outcome Measurement** (2 abstentions)	71%	14%	14%	0%	0%
9	**Population Health Program** (2 abstentions)	71%	14%	10%	5%	0%
10	**Inclusion / Exclusion** (2 abstentions)	71%	14%	14%	0%	0%
11	**Patient** (3 abstentions)	75%	5%	15%	5%	0%
12	**Participant** (3 abstentions)	70%	10%	20%	0%	0%

Rows may not add to 100% due to rounding.

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Semantic Interoperability: Substantive Comments and Points of Clarification

Substantive Comments	Co-chair and CAQH CORE Response
1. Two organizations suggested CAQH CORE consider existing work in this space to ensure industry alignment.	1. **AGREE**: The Subgroup will not duplicate but may build on existing work. Common definitions have been consistently identified as a pain point through environmental scanning and research since CAQH CORE released its initial report on value-based payments in 2018.
2. One organization suggested splitting quality measurement between outcomes and processes, and further recommended adding terms for remote patient care (e.g., telehealth); types of models; financial outcomes (e.g., penalties, bonuses), and provider. Another organization advocated for the definition of value-based reimbursement, care and payments. Yet another organization encouraged alignment of terms that are used in different context outside of value-based care.	2. **FOR DISCUSSION**: Additional refinement and additions to the definition lists are necessary and will be explored by the Subgroup as we advance further into rule and content development.

Point of Clarification	Co-chair and CAQH CORE Response
3. One organization submitted that this should be at the discretion of the health plans.	3. The intent of defining these terms is not to override proprietary methodologies but rather to unify industry around a common vernacular for common terms in VBP, a point identified by industry stakeholders as a frequent challenge in CAQH CORE's environmental scanning and research.
4. One organization submitted detailed feedback about the example definition for patient attribution that was used to illustrate the concept of the semantic interoperability framework on the straw poll.	4. This feedback will be taken it into consideration as the Subgroup seeks to finalize definitions for patient attribution.

Summary of Go-Forward Opportunities

Broad Support	Support, with Considerations	Need Clarification/Uncertain	Low Support
Race and ethnicity	Gender Identity	Sexual Orientation	Citizenship Status
Preferred Language	Plan Member Reporting	Infrastructure Requirements	
Marital Status	ALL claims use-cases		
	ALL semantic interoperability		

Key insights

- Accepted vocabulary and standards should be incorporated into rulemaking – perhaps with edits.
- We need a compelling case to collect and exchange sensitive information.
- Subgroup **should not** undertake activities that could lead to misuse of sensitive information.
- Points of clarification are needed for topics outside of X12 834 – will begin with Claims Submission today.

Potential Operating Rule Requirements

X12 834 Benefit Enrollment and Maintenance

X12 Plan Member Reporting

Recap of Socio-demographic Data Variance

Demonstrating business need for uniformity using the HIPAA-mandated X12 834

Race and Ethnicity

Limitations of X12 v5010 Standard

- Situational usage.
- Coding incompatibilities.
- "Rolled-up" categories.

Limitations of CDC Race and Ethnicity

- Limited industry uptake.
- Hierarchical and UID code confusion.
- Extremely comprehensive.

Potential Solution

Develop operating rule requirements that require the exchange of race and ethnicity data using unique identifiers included in the CDC Race and Ethnicity Code Set. Align industry around a minimum set of concepts.

Gender Identity

Limitations of X12 v5010 Standard

- Uses non-comprehensive concepts
  - Female
  - Male
  - Unknown

Limitations of USCDI v3 Standard

- Multiple USCDI versions.
- References multiple standards.
- Requires use of free-text in X12.

Potential Solution

Develop operating rule requirements that support enhanced exchange of self-reported gender identity concepts using a combination of structured and reference fields in the X12 834 transaction.

Sexual Orientation

Limitations of X12 v5010 Standard

- Completely unstructured.
- Reportable in REF segments.
- Not currently in standard.

Limitations of USCDI v3 Standard

- Multiple USCDI versions.
- References multiple standards.
- Variable privacy/consent rules.

Potential Solution

Utilize mutually defined 'REF' data segments in the X12 834 transaction to support the exchange of self-reported sexual orientation, potentially helping to fulfill emerging regulatory requirements.

Other data concepts, such as member preferred language, can be collected solely using structured fields in X12 834.

Operating Rules Advance the Exchange of Socio-demographic Information

Business rules leverage existing structures and industry priorities

Observed variation around the collection and exchange of race and ethnicity and other socio-demographic data justifies the development and publication of operating rules for the HIPAA-mandated and voluntary X12 834 transactions.

Best Practices

Industry best practices for data collection exist but are not uniformly implemented across stakeholders.

Capable Standard

An accepted standard accommodates collection and exchange of best practice data and code sets.

Industry Support

Collection of social information is an industry priority and empowers future VBP initiatives that improve and streamline healthcare for all.

Summary Opportunities for Rule Development

HIPAA-mandated X12 834: Benefit Enrollment and Maintenance

	High-level Requirements	Application in X12 v5010
Collection and exchange of Race and Ethnicity Data	1. Collection of race and ethnicity data as two questions data. 2. Use of unique identifier CDC Race and Ethnicity Code Set.	**Loop 2100A** - Member Name **DMG** – Member Demographics *DMG05-01 thru 03* Multiple instances up to 10x repeat
Collection and exchange of marital status and preferred language	3. Require collection of structured demographic fields in X12. 4. Align reporting of member language with ISO 639.	**Loop 2100A** - Member Name **DMG** – Member Demographics *DMG04* **LUI –** Member Language *LUI01 & 02*
Collection and exchange of sexual orientation and gender identity (SOGI) data	5. Collection of SOGI using elements of USCDI vocabulary standards. 6. Use combo of structured and mutually defined reference fields.	**Loop 2100A** - Member Name **DMG** – Member Demographics *DMG03 (Gender only)* **Loop 2750 –** Reporting Category **REF –** Reporting Category Ref *REF01 & 02*

Option to NOT DISCLOSE must be available to all members

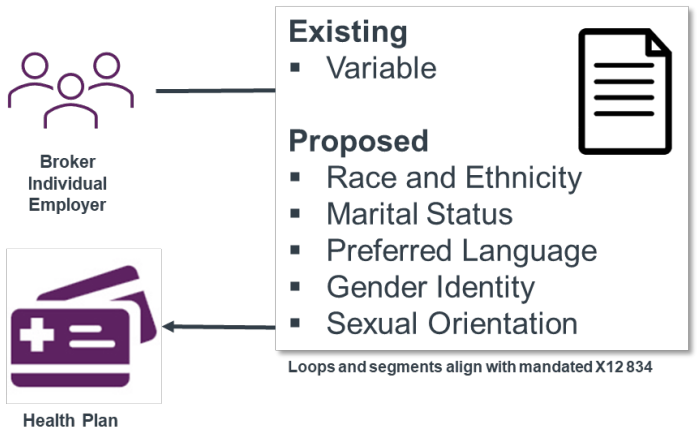
Closing the Data Exchange "Loop" in the X12 834

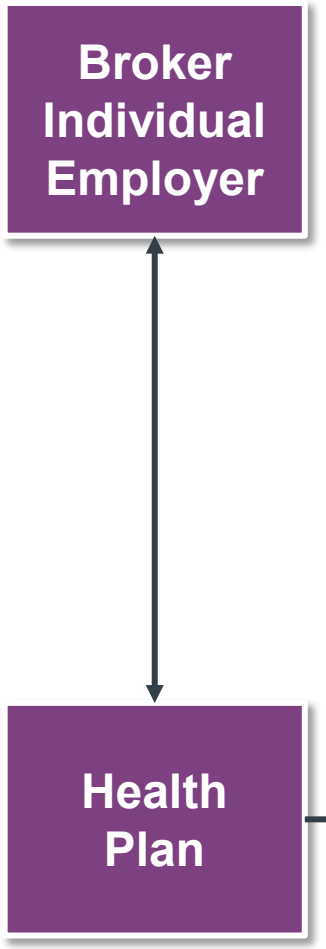
Leveraging voluntary X12 834: Plan Member Reporting

CAQH CORE Operating Rules can assist in making socio-demographic information **actionable** in VBP contracts.

Creation of a New Rule

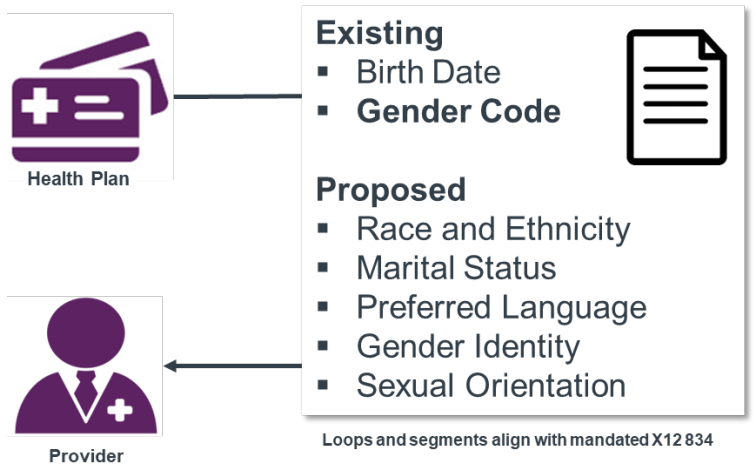
HIPAA-mandated X12 v5010 834
Enrollment / Disenrollment / Maintenance





Edits to an Existing Rule (Attributed Patient Roster)

Voluntary X12 v5010 834
Plan Member Reporting



Legality of Collecting & Exchanging Socio-demographic Information

Collection of sensitive information must conform to regulation…and common sense

SOGI Data

Concerns about privacy

- SOGI data is a federal-level priority (Executive Order 14075).
- Collection is advantageous, but privacy requirements are ambiguous.
- There is no blanket federal law outlining permissible collection and exchange of SOGI data and state statutes are variable.

Race and Ethnicity Data

Legal and encouraged

- No federal restrictions for health plans to request, collect or exchange race and ethnicity.
- Only **6 states** prohibit collection of race and ethnicity as part of an insurance application.
- Collection of this information may complement other initiatives, such as EEO.

Respectful and consistent usage is imperative to populations impacted by collection and exchange.

Outstanding Questions and Discussions

Straw Poll #2 to will confirm DRAFT data content requirements

The second straw poll will address specific rule requirements.
The Subgroup must decide what additional information should be contemplated, in alignment with **best practice collection, exchange, and use of the information.**

Three Pillars of Socio-Demographic Data Exchange

Standardized Collection	Standardized Exchange	Standardized Use
Consistent expectations for contents and timing of point-of-enrollment collection. Statement on forms and companion guides detailing permissible use.	Uniform data elements used to communicate collected information. Alignment around data sets and information that can be used regardless of standard.	Incorporation of actionable information to strengthen value-based care reports. Predictability of when health plans share information for consumption.

1. Is there a need to indicate **how data was collected**?
2. How **frequently** must information be collected?
3. How can an operating rule control for **misuse**?
4. What **minimum standards** should collection conform to?

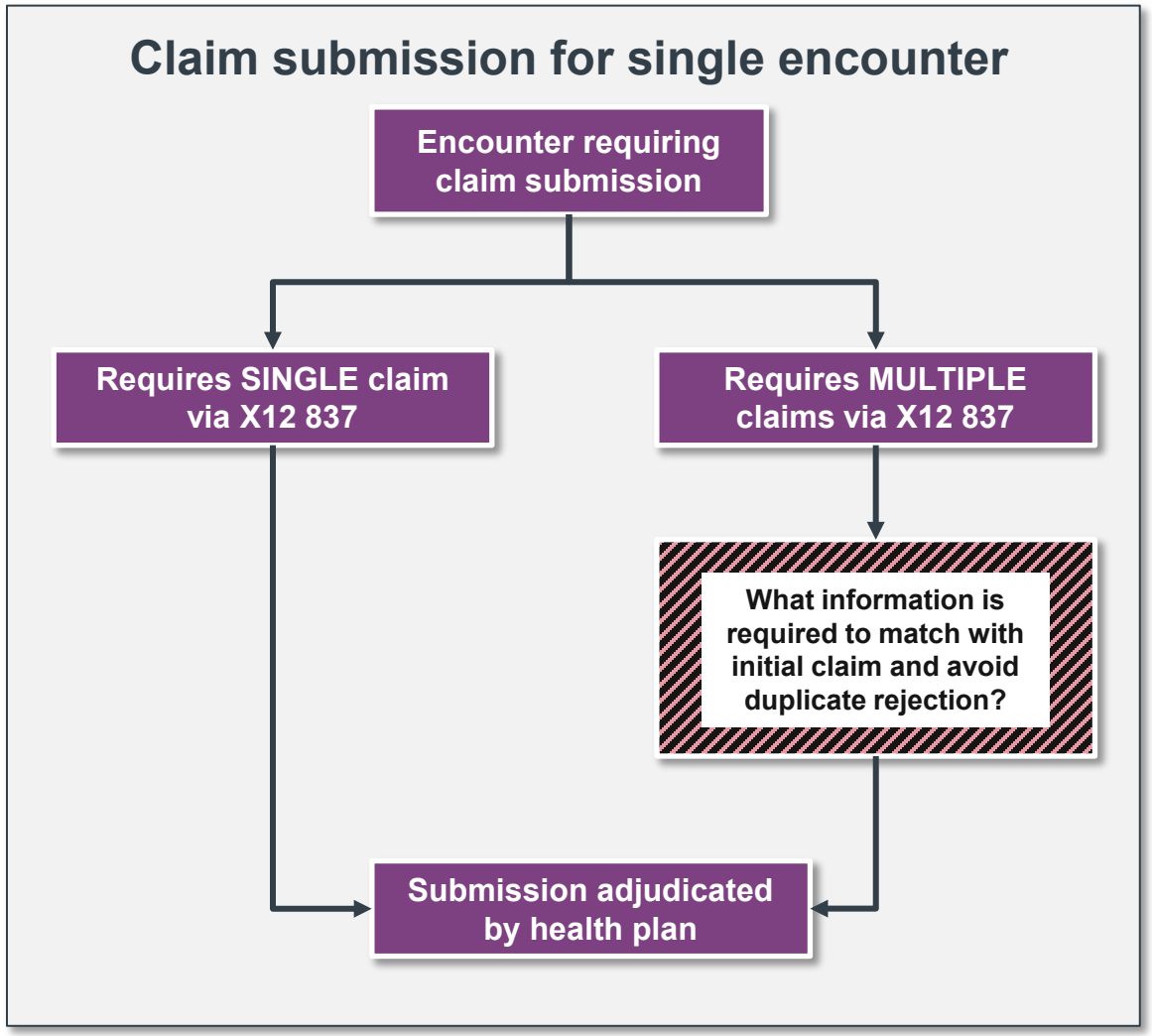
Potential X12 837 Rule Requirement

Standard Submission of Additional Diagnoses for a Single Encounter

Mechanisms of Reporting Supplementary Diagnoses

Supplemental diagnoses support VBP methodologies, coordination, and documentation

- Chronic conditions, factors influencing healthcare, and social determinants of health **influence treatment decisions and support administrative components of value-based care programs**.
- Diagnostic information can be **de-prioritized** on an X12 837 claim submission because other clinical factors are **either more important or more relevant** to the clinical presentation.
- Non-inclusion of supplemental diagnoses on claims is **perpetuated by limited diagnosis fields** on the CMS-1500 / X12 837.
- Standard pathways for the submission of additional claims that include supplementary diagnoses accommodates collection of important clinical and social conditions.



Interaction of Health Care Claims and VBP Subgroups

Collaboration to ensure operating rule language is complete and inclusive of business scenarios

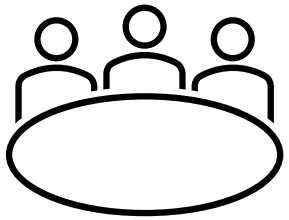
The VBP Subgroup will review technical requirements and establish standard use-cases.

Health Care Claims Subgroup

- Establish technical requirements for additional claim submission.
- Indicate best practice implementation into the structure of the X12 Standard.

In addition to…

- Other use cases within the X12 837 and data content for X12 277CA.



VBP Subgroup

- Identify VBP use-cases that benefit from additional claim submission.
- Develop industry-standard definitions for VBP use-cases.

In addition to…

- Streamlining point-of-enrollment data collection and administration of VBP programs.

Variation in How Supplementary Diagnoses are Submitted

Submission of greater than 12 diagnoses for a single encounter requires an additional claim

Health plans support the submission of additional claims to include supplemental ICD-10 diagnosis codes when the number of codes on an initial claim exceeds 12.

Implementation is not uniform, potentially leading to manual intervention or confusion among stakeholders.

	X12N 837-P		Other
Data Submission	Health Plan A	Health Plan B	Health Plan C
Initial Claim	-	Must include E/M CPT code	Employs proprietary formats
Supplementary Claim Match to Initial Claim	Member	Original claim number	
	Billing Provider		
	Rendering Provider		
	Dates of Service		
Procedure Code	99499	99080, if accepted, 99499, if not	
Amount	$0.00 or $0.01	$0.00 or $0.01	
Claim Frequency	'1' to indicate original	'0' to indicate non-payment	
Primary Diagnosis	-	One clinical ICD-10 from initial claim	
Supplemental Diagnosis	-	Document in positions 2 through 12	

Generally, supplemental claims must be submitted within accepted timelines (180 days) and be supported by documentation in the medical record.

Information Included to Match an Additional Claim

Information is relatively consistent, but implementation varies

Matching	What information is necessary to match an additional claim to an initial claim submission?
Service Limitations	Can or should additional claims only be submitted for select services or product lines?
Procedure Code	What CPT must be included on additional claim to differentiate from unique encounter?
Frequency Code	Should a specific claim frequency code be used or is it situational relative to submission?
Principal Diagnosis	How are inappropriate principal diagnoses included on an additional claim?

Health Care Claims are a Basis for Value-based Methodologies

Additional claim pathways benefit performance and care coordination

Risk Adjustment

Risk adjustment models often leverage chronic conditions that may not be immediately applicable to the current clinical presentation.

Example Hierarchical Condition Categories:

E11.9 – Type 2 Diabetes Mellitus w/o complications.

Attribution

ICD-10 defined conditions can be used for attribution or reconciliation in episodic or specialty care models when targeting a specific patient population.

Example Medicare Oncology Care Model:

C30.xx – Malignant neoplasm of nasal cavity or middle ear.

Payment / Incentives

ICD-10 codes can be used to document conditions or services whose reporting leads to physician incentives through pay-for-reporting or pay-for-performance.

Example HEDIS Adult BMI Assessment:

Z68.51 – BMI <5th percentile for age.

Quality Measurement

ICD-10 diagnoses are often used to identify applicable cohorts and outcomes of interest in the quality measures used in value-based care programs.

Example Complications following THA/TKA:

T84.033D – Mechanical loosening of internal left knee prosthetic joint, subsequent encounter.

Non-medical Factors

ICD-10 codes can document social risks and other non-medical factors that influence care, empowering care coordination helping quantify social risks

Example ICD-10 Z-codes for social risk:

Z59.1 – Inadequate housing.

Next Steps

- **X12 834 Data Content**
  - **Straw Poll #2:** CAQH CORE send Straw Poll #2 via email on **Monday, May 22** including detailed requirements for an X12 834 data content operating rule.
    - > Will contain ***initial* detailed requirements** for benefit enrollment and plan member reporting operating rules.
    - > Please begin engaging with your **EDI experts** to submit a response.

- **X12 837 Data Content**
  - Awaiting technical direction from the Health Care Claims Subgroup.
  - VBP Subgroup will refine language and perform a secondary evaluation of technical requirements.

- **Next meeting**
  - **June 8, 2023 from 2pm-3:30pm ET**

Appendix

Today's Call Documents

Document Name
Doc 1 VBP Subgroup Call 2 Deck 05.18.2023
Doc 2 VBP Subgroup Call 1 Call Summary 04.27.2023

CORE Staff*	Email Address
Erin Weber, VP, CORE	eweber@caqh.org
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CAQH CORE VBP Subgroup

Activity Schedule for Call 1 and 2

Work Group Activity	Date	Topic
Subgroup 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.
Subgroup Call #3 **TOPIC(S):** Benefit Enrollment & Claims Transactions	**Thursday 6/8/2023** 2:00 – 3:30 PM ET	▪ Review results of Straw Poll #2. ▪ Refine benefit enrollment rule requirements. ▪ Introduce infrastructure requirements, if indicated ▪ Review detailed claims requirements ▪ Next Steps including RWG Straw Poll #3.
Straw Poll #2 **TOPIC(S):** Health care claims and infrastructure requirements	**Monday 6/12/23 – Thursday 6/22/23**	▪ Indicate level of support for claims and infrastructure operating rule content

CAQH CORE will update content as agenda clarifies between calls

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
Nancy Spector	**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
Mike Denison	Change Healthcare
Summerpal Kahlon	Change Healthcare
Annette Kemplin	CIGNA
Jeff Narog	CIGNA
Gunes Raack	Cleveland Clinic
Scott Dynda	Cleveland Clinic
Michelle Medina	Cleveland Clinic
Robert Jones	Cleveland Clinic
Adam Keating	Cleveland Clinic
Sanjeev Suri	Cleveland Clinic

Participant	Title and Organization
Kyle Kroenig	Cognizant
Tania Mason	Cognizant
Vincent Carrillo	Cognizant
Andrew Schulz	Cognizant
Patricia Wijtyk	Cognizant
Kevin Day	Edifecs
Vik Sachdev	Edifecs
Tushar Nair	Edifecs
Anitha Aerabati	Elevance Health
Joe McGuire	**Epic**
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