CORE Value-based Payment Subgroup

Meeting #5

CAQH CORE VBP Subgroup Co-chairs and Staff

July 20, 2023

Agenda and Objectives

2:00 PM	• Welcome, antitrust guidelines, roll call and housekeeping
2:10 PM	• Progress to-date • Impact of draft rule requirements • Close-out timeline
2:30 PM	• Straw Poll #4 results • X12 834 infrastructure and X12 837 data content requirements

3:00 PM	• Outstanding items
	  • Use of member preferred language
	  • Sex assigned at birth
	• Conclude
	  • Straw Poll #5 opens **week of July 24**

Objectives

1. Highlight progress-to-date, reaffirm importance of this work, and review expected close-out timeline.

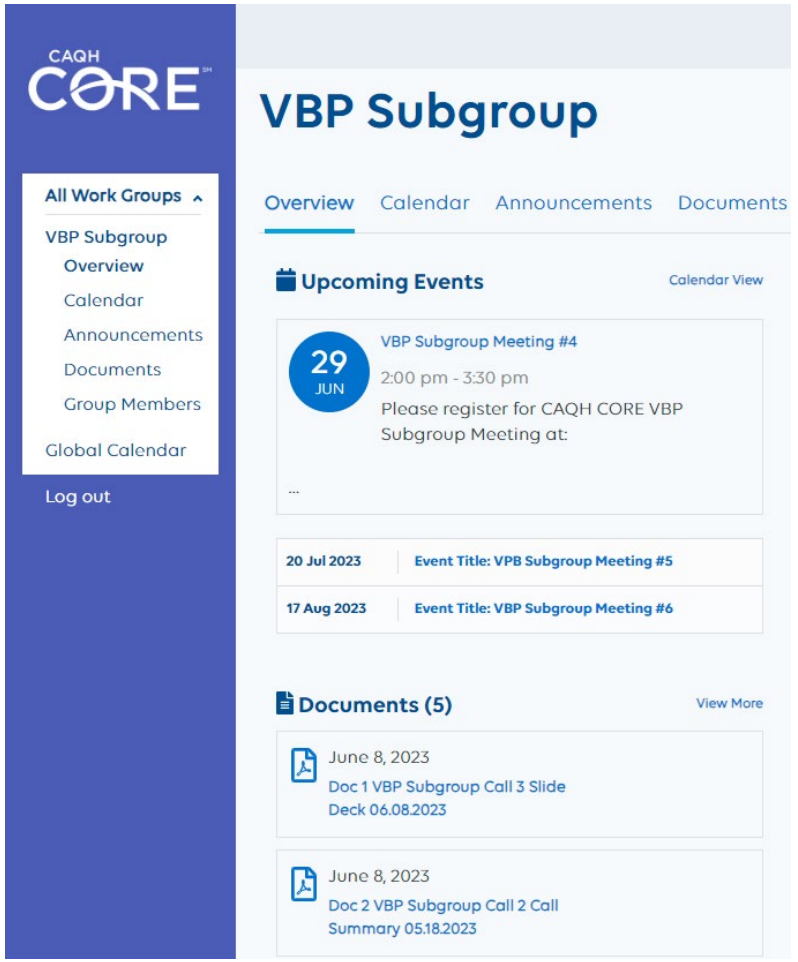
2. Understand Straw Poll results, identifying what requirements will "move forward" and what concepts have been disqualified by the Subgroup.

3. Review additional requirements brought up during Subgroup discussions in preparation for Straw Poll #5.

CAQH CORE Participant Dashboard

Comprehensive resource of VBP Subgroup materials and information

- The dashboard is accessible only to CAQH CORE Participants.
- Participants can:
  - View the workgroups they are currently involved in.
  - Add themselves to new groups.
  - Interact with announcements, upcoming events, documents and other information relevant to workgroup participation.
- Please email CORE@caqh.org if you need a login.



Exclusive Event: Health Plans, Providers and the Data Revolution
CAQH Connect 2023

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.

Save the Date! September 27-29, 2023, *Westin Georgetown, Washington, D.C.*

Attend our first-ever in-person CORE Participant Forum:

Open to all individuals from CORE Participating Organizations and any individual who is interested in joining CORE the afternoon of September 27th.

Event speakers include current and former CAQH CORE Board Members:

Anika Gardenhire

Chief Customer Experience Officer
Centene Corporation

Linda Reed

SVP and Chief Information Officer
St. Joseph's Health

Margaret Schuler

SVP, Practice Support Operations and Revenue Cycle Management
Aspen Dental

Troy Smith

VP, Cost of Care and Value Programs
Blue Cross Blue Shield of North Carolina

Register Here!
go.caqh.org/CAQHConnect2023

Progress Check-in

What Have We Done? How Did We Get There?

Strengthened Exchange of Socio-demographic Data

CAQH CORE Data Content Operating Rule for the Benefit Enrollment and Maintenance Transaction

- **Impactful** socio-demographic data inclusions, standardizing exchange.
- Enhanced **health plan-to-provider** exchange of socio-demographic information.
- Infrastructure rules **inclusive of value-based payment** requirements.

Significant because:

- Generates **usable** socio-demographic data for VBP designers and participants.
- Addresses with **CMMI** evaluations that data availability and quality slows health equity progress.

Empowered Engagement with VBP Methodologies

CAQH CORE Data Content Operating Rule for the Health Care Claim Submission Transaction

- **Alignment** of industry requirements for additional claim submissions.
- **Structure** for the inclusion of information supporting value-based methodologies, such as risk adjustment.
- Component of a **suite** of operating rule requirements to reduce burden.

Significant because:

- Enhances **reporting of non-medical factors** increasingly used for quality and risk adjustment.
- Encourages **greater provider engagement** in the administration of VBP by easing reporting.

Created a Framework for Semantic Interoperability

CAQH CORE Framework for Semantic Interoperability in Value-based Payment Models

- **Clarity** around disparate concepts and terms prevalent in VBP.
- **Resource** for industry stakeholders to reference and for CAQH CORE to better define VBP in operating rules.
- Functions as a **compilation** of disconnected industry efforts.

Significant because:

- Centers language used in VBP that can otherwise **confuse contracting or policy efforts**.
- Creates a **basis for CAQH CORE Operating Rules** and aligns disparate industry initiatives.

Key Dates Toward Finalization

Event/ Deliverable	Date	Notes
Straw Poll #3	Closes: August 4, 2023	Extended
VBP Subgroup #5	July 20, 2023	
Straw Poll #5	Closes: August 4, 2023	
VBP Subgroup #6	August 17, 2023	Discuss straw poll results, prepare for operating rule review
Straw Poll #6	Distributed to Subgroup week of August 21, 2023	Line-by-line reviews of DRAFT operating rules.
Framework for Semantic Interoperability	Final draft distributed to Subgroup week of August 23, 2023	
Review Workgroup	Convene by September 30, 2023	Draft VBP Operating Rules are first on the agenda

Operating Rules being Drafted for Presentation to and Review by the VBP Subgroup

- **NEW** Draft CAQH CORE Benefit Enrollment and Maintenance (X12 834) Data Content Operating Rule
- **NEW** Draft CAQH CORE Health Care Claim Submission (X12 837) Data Content Operating Rule*
- **UPDATED** Draft CAQH CORE Attributed Patient Roster (X12 834) Data Content Operating Rule.
- **UPDATED** Draft CAQH CORE Benefit Enrollment and Maintenance (X12 834) Infrastructure Rule
- **UPDATED** Draft CAQH CORE Attributed Patient Roster (X12 834) Infrastructure Rule

***Partial review of section to which the VBP Subgroup contributed; Claims Subgroup will review draft rule in full.**

Status of Straw Poll #3: Semantic Interoperability Framework

- Initial response to the terms and concepts included in Straw Poll #3 are generally favorable with thoughtful requests for revision.
- Over half of VBP Subgroup organizations have responded to-date.
- To ensure completeness of input, Straw Poll #3 will remain open until **Friday, August 4.**
- Review is on-going; CORE staff may reach out with questions or requests for clarification.
- Results will NOT be included in any follow-up straw polls and "final draft" concepts and definitions will be based on feedback/input received by that date.
  - Next opportunity to provide feedback will be during the Review Work Group review.

Concepts Included in Straw Poll #3

Concept	Point of clarification
Payment	• Capitated Benchmark • Reconciliation vs. Adjudication • Care Coordination Payments
Episodic Care	• Initiation not limited to trigger • IP/OP differentiation • Medical not the correct word
Risk Adjustment	• Assurance each field has relevance • Application to commercial insurers • Use of the word statistical
Patient Attribution	• Concepts of "global" attribution; regional • Prescribing/referring provider
Quality Measurement	• Combine terms where possible • Provide greater context
Population Health Programs	• Performance periods not always applicable • Appreciate differentiation between ACO/MCO • Outside organization definitions (FTC, AHRQ)
Inclusion/Exclusion in VBP	• Consider risk adjustment exclusion
Patient in VBP	• Merge definitions where possible • Align terms with other parts of survey • Provide greater detail where appropriate
Participant in VBP	

Straw Poll #4 Results

CAQH CORE Benefit Enrollment and Maintenance Infrastructure Rule

HIPAA-mandated X12 v5010 834 Benefit Enrollment and Maintenance (X220)

CAQH CORE Attributed Patient Roster Infrastructure Rule

Voluntary X12 v5010 834 Plan Member Reporting (X318)

Straw Poll #4 Overview

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 Straw Poll

1. **X12 834 Infrastructure Requirements:** Assurance that CAQH CORE Infrastructure Requirements for the Benefit Enrollment and Maintenance Transaction and Attributed Patient Roster Operating Rule are:
   1. Aligned with data content updates proposing the exchange of socio-demographic data.
   2. Matched to other CAQH CORE Infrastructure Operating Rules and EDI best practices.

2. **Standardized Submissions of Additional Claims for a Single Encounter:** Aligning industry requirements around common data content requirements supporting the submission of additional claims for a single encounter. This supports day-to-day workflows and strengthens provider engagement with VBP methodologies.

Participant Response Rates

20 out of 34 (59%) organizations have responded to Straw Poll #4.

Participant Type	Response Percentage
Provider/Provider Association	**20%**
Health Plan/Health Plan Association	**20%**
Vendor or Clearinghouse	**30%**
Government/Other	**40%**

Infrastructure Requirements: Disclosure Language

Requirement to include socio-demographic disclosure language in Section 10 of the transaction-specific companion guide following the flow and format of the CAQH CORE Master Companion Guide Template

Operating Rule	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
CAQH CORE Benefit Enrollment and Maintenance Infrastructure Rule	65%	5%	20%	10%	0%
CAQH CORE Attributed Patient Roster Infrastructure Rule (n=19)	63%	0%	26%	11%	0%

Infrastructure Requirements: Disclosure Language Comments

	Substantive Comment	CORE Response
1	One commenter encouraged this requirement to be reconsidered as voluntary as some may not choose to use/exchange socio-demographic information.	**DISAGREE:** Operating rule requirements are not yet final, and consensus recommendations are being built in this Subgroup. Presently, majority respondents support the **required** exchange of at least one socio-demographic concept. Therefore, as proposed, inclusion of disclosure language into the transaction specific companion guide would function as a rule requirement, but also be beneficial in its ability to act as an easily locatable type of informed consent for members who are considering whether to disclose or not disclose sensitive information.
2	One commenter shared that disclosure language may be more appropriate for inclusion in the companion guide appendix, not section 10 which addresses actual data content for X12 834 processing.	**FOR DISCUSSION:** The intent of proposing in Section 10 was to ensure it was displayed prominently and appeared consistent with other operationalizations of companion guides that can include contextual information in addition to loops, segments, and data elements required for processing. Is it better to include this information in an appendix?

	Non-Substantive Comment	CORE Response
3	Two commenters supported data transparency and – when possible – consent for data use.	**AGREE:** Disclosure is essential to support consent and maintain privacy of sensitive member information.

Recommendation: Require inclusion of disclosing language in the transaction-specific companion guide.

Infrastructure Requirements: Response Time

Requirement to include real-time processing mode requirements – for those who support real-time processing mode - in the CAQH CORE Attributed Patient Roster Infrastructure Rule.

Operating Rule	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
CAQH CORE Attributed Patient Roster Infrastructure Rule	**55%**	**5%**	**35%**	**0%**	**5%**

Infrastructure Requirements: Response Time Comments

	Substantive Comment	CORE Response
1	One commenter pointed out that real time processing and acknowledgments are currently explicitly excluded from this rule in [section] 2.2. There is not a need to change this state.	**DISAGREE:** Exclusion from section 2.2 is informed by the language included in the rule requirements. Upon incorporation of real time processing mode requirements in section 4, if approved, section 2.2 would be updated for consistency. Note, also, that real-time processing mode requirements are only applicable to entities who choose to conduct real-time processing – real time would not be required. Trading partner agreements would dictate such arrangements.
2	A commenter suggested that this requirement may need a lead-in time to full compliance. They questioned whether other transactions had the same speed requirement at first.	**FOR DISCUSSION:** Other transactions have the same speed and conformance requirements. Best practice dictates aligning any added requirement with the suite of other CAQH CORE Infrastructure Rules. Are there considerations specific to VBP that should be considered?

	Non-substantive Comments	CORE Response
3	A commenter stated that they did not know how well provider systems could handle the requirement to respond within 20 seconds, nor how they would track this measure.	Note that this requirement, if added, would only apply to organizations choosing to conduct the X12 834 (x318) in real-time – real time is not required to be supported.
4	A commenter did not identify any issues supporting real-time transactions.	N/A

Recommendation: Add real-time processing mode requirements into the CAQH CORE Attributed Patient Roster Infrastructure Rule.

Straw Poll #4 Results

Data Content for the HIPAA-mandated X12 v5010 837 Claim Submission Transaction

X12 837 Data Content: Overarching Claim Submission Comments

Substantive Comment	CORE Response
One commenter shared that this proposal must be voluntary, referencing the administrative burden, and the lack of need for a patient history to be shared via claims. They also note that no discussion has been undertaken on this topic and it is inferior to and duplicative of work being undertaken by FHIR/ Da Vinci. This commenter was joined by another stating that the simplest solution is just to allow for more instances of the HI segment on the 837.	**AGREE:** Agree that, if a health plan does not support this workflow, they would not be required to conform, but for those that do or are considering its use, data content requirements provide a consistent basis for submission and adjudication. In other words, the proposals could be considered as a best practice for implementers. The proposal, as it was presented, is based on existing workflows in the healthcare industry. The genesis of the proposal is observed variation for how it is carried out across the health plans. Agree that expanding the HI segment on the X12 837 is the simplest solution; however, v5010 is still the standard. Required conformance with v8020 (and beyond) is still years away and, though other promising solutions are being developed and tested, this proposal accommodates workflows as they are currently carried out. Operating rules can be amended as standards and approaches are changed to meet evolving industry needs. Please note that, in response to other aspects of the commenter, operating rule requirements are not yet final, and consensus recommendations are being built in this Subgroup for further consideration at a Review Work Group. The requirements are then presented to all CORE Participating Organizations for a vote before being approved by the CORE Board.

X12 837 Data Content: Clarification

Value-based payment models incentivize the collection, documentation, and exchange of diagnostic information to support quality measurement, risk adjustment and other methodologies. Automating the capture all documented diagnoses during single encounter benefits patients, participants, and health plans.

Intent of proposals.

- Aligns **existing** health plan requirements to submit an additional claim for a single encounter.
- Increases provider **engagement** with VBP methodologies by providing a mechanism for the submission of supporting diagnoses.
- Supports health plan **quality performance** through the submission of diagnoses contributing to quality measures.

What draft proposals are not intended to do.

- Require providers to transmit the entirety of a patient's health record to a health plan.
- Require a minimum – or maximum – number of diagnoses that must be submitted on a claim.
- Dictate specific value-based payment methodologies that health plans must employ – in other words, health plans do not need to give up proprietary models.

X12 837 Data Content: Additional Claim Submission – Initial CPT

Indicating what CPT codes must be included on an initial claim for a health plan to accept an additional claim for the same encounter.

Operating Rule	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
Initial CPT	**20%**	**10%**	**40%**	**5%**	**25%**

For those who supported, what method should be used.

Operating Rule	% Support
Evaluation and Management	**33%**
VBP-associated	**50%**
Other	**17%**

X12 837 Data Content: Additional Claim Submission Comments – Initial CPT

	Substantive Comments	CORE Response
1	Several commenters cautioned that CPT codes are highly regulated by the AMA and restricting use or proposing uses that go beyond what is intended may not be the most appropriate course of action. On top of this consideration, in practice, nor every encounter results in a specific CPT being recorded and therefore relying on indicated sets may not be operationally realistic.	**AGREE:** The context provided by commenters was helpful. Though we note that specifying specific CPT codes is a method used in practice, the opportunity for variability plus the implementation lift for those not currently using this "gating," justify concerns with this proposal. This point paired with low support means that this requirement will not be proposed.
2	Several other commenters suggested the benefit of submitting new codes for consideration, particularly if there is an unmet need with the current available set of CPT codes.	**AGREE:** CAQH CORE can liaise with the appropriate code committees to ensure industry needs are met.

Recommendation: Do not apply initial claim CPT requirements to additional claim data content.

X12 837 Data Content: Additional Claim Submission – Matching Information

The CORE Claims Subgroup identified several data elements that should match between an initial claim and additional claim submitted for the same encounter. The VBP Subgroup was asked to evaluate whether the recommendation as sufficient ‘as-is’ or if additional information should be added.

Method	% Support
Claim Subgroup Recommendation *Member ID, Rendering Provider NPI, Billing Provider NPI, Dates of Service*	**89%**
Claim Subgroup Recommendation PLUS *Claim Subgroup Recommendations + TBD VBP Subgroup Recommendations*	**11%**

N=19

X12 837 Data Content: Additional Claim Submission Comments – Matching

	Other Data Elements Proposed	CORE Response
1	Referring physician and specialty	To be considered during in-call polling.
2	Create a correlation ID using claim ID + '_' + rendering NPI	To be considering during in-call polling.

	Non-substantive Comments	CORE Response
3	One commenter expressed that, without knowing what additional information is included in PLUS, could not evaluate.	Clarification that the intent of PLUS was for participants to propose what other information was required.

Recommendation: Follow Claim Subgroup guidance and require additional claims match the initial claim on member ID, rendering provider NPI, billing provider NPI, and dates of service – at a minimum.

Matching Information: In-call Poll #1

Three additional data elements were proposed by the CORE VBP Subgroup for consideration to be added to claim matching data requirements. These were:

- Referring provider
- Specialty
- Concatenated data element using claim ID + '_' + rendering NPI

Please indicate your support re-polling matching information in Straw Poll #5 with the additional data elements considered.

a. Yes, please re-poll matching information inclusive of these new suggestions.

b. No, follow CORE Claim Subgroup Recommendations as a **minimum** requirement, meaning implementers can add additional information on top of the CORE requirements.

X12 837 Data Content: Additional Claim Submission – Claim Frequency Code

Indicating what CFC code must included on an additional claim to specify its relationship to the initial claim submission.

Operating Rule	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
CFC	**40%**	**5%**	**45%**	**0%**	**10%**

For those who supported, what method should be used.

Method	% Support
CFC 0	**33%**
CFC 1	**11%**
Conditional	**33%**
Other	**22%**

X12 837 Data Content: Additional Claim Submission Comments – CFC

	Substantive Comments	CORE Response
1	A commenter stated that, since CFC 1 is used for the initial claim in professional claims, it should not be used for subsequent claims that are non-payable claims	**AGREE:** This aligns with understandings from environmental scanning and engagement and appears to be the best approach if CFC standardization is accepted.
2	A commenter stated that a new code should be developed and incorporated into the code set specifically designed for this scenario so codes are not reused for another purpose.	**FOR DISCUSSION:** Clarify that CFC proposals are related to workflows currently used in practice. CAQH CORE can liaise with appropriate coding committees to assess the need for a new, more appropriate code that could be submitted for consideration.
3	One commenter stated that CFC 1 may be more appropriate to link initial and additional claims – assuming this is only applicable to the 837I. Another commenter added that distinction between the 'I' and 'P' should be considered.	**FOR DISCUSSION:** Clarify that this proposal is applied holistically to the 837 transaction. Most scenarios are more likely to affect the 'P' but conventions could be applied to other aspects of the 837. Should operating rules remain agnostic to the 837 or specify application to the 837P?
	Non-substantive Comments	**CORE Response**
4	One commenter expressed their preference is to use CFC 0, but is confirming that CFC 0 is allowed in the 837P.	Proposals, including the potential use of CFC 0 on an 837P claim, are based on existing policies and procedures at health plans.
5	A commenter asked whether there should there be a timing component considered?	Note that health plans typically apply a timing requirement for when additional claim must be submitted by. Environmental scanning and engagement shows this is typically 180 days.

Recommendation: Do not require use of CFC code for additional claim data content requirements but, if used, recommend the use of CFC 0 until new code is created and used for this purpose.

X12 837 Data Content: Additional Claim Submission – CPT on Additional Claim

Indicating what CPT codes must be included on an additional claim to indicate low-or-no resource, justifying a nominal or zero billed amount.

Operating Rule	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
CPT	**20%**	**10%**	**50%**	**0%**	**20%**

For those who supported, what method should be used.

Method	% Support
99499	**67%**
99080	**0%**
Other	**33%**

X12 837 Data Content: Additional Claim Submission Comments – Additional CPT

	Substantive Comment	CORE Response
1	Two commenters expressed: why limit to one [99499; 99080]? Why not include both codes that are currently used?	The recommendation to support only one code, 99080 or 99499, was rejected by the Subgroup. We will not be moving forward with any requirement to limit the CPT that is included on an additional claim for a single encounter.
2	One commenter suggested the use CPT modifiers for quality.	**DISAGREE:** Assuming the commenter is referring to modifiers such as 1P, etc. to indicate that the CPT is submitted for reporting purposes, based on environmental scanning and engagement, this would not align with current reporting practices and potentially introduce more variability.

	Non-substantive Comments	CORE Response
3	A commenter stated that CPT is a uniform language and should not be redefined or repurposed from their intended use. CORE can consider submission for a new CPT code if current sets do not fulfill requirements.	Clarify the proposal to use either 99499 or 99080 is due to their use in current workflows.
4	A health plan respondent stated that they do not require a particular CPT in this scenario.	This context is appreciated. This requirement will not be included in draft operating rules.

Recommendation: Do not specify what CPT must be included on an additional claim. Note that industry implementation often uses 99080 and 99499.

X12 837 Data Content: Additional Claim Submission – Secondary Diagnosis

Requirements dictating how to avoid additional claim rejection if only submitted to include a non-qualifying principal or first-listed diagnosis.

Operating Rule	Support	Partially Support	Neutral	Partially Do Not Support	Do Not Support
Secondary Diagnosis	**30%**	**5%**	**45%**	**0%**	**20%**

For those who supported, what method should be used.

Method	% Support
Carry-over	**71%**
No Change	**29%**
Other	**0%**

X12 837 Data Content: Additional Claim Submission Comments – Secondary Diag.

	Non-substantive Comments	CORE Response
1	One commenter asked for an example of what is being proposed. Statin it was is not clear if the principal diagnoses (so the claim must be an 837I) is being repeated on the additional claim or not.	1. The proposal is asking whether a qualifying PDX, not necessary the first listed diagnosis, should be included on the additional claim when the additional is only submitted to include non-qualifying PDX or first listed diagnosis. 2. Straw Poll #4 only referred to principal diagnosis, where it should have also referenced 'first listed diagnosis' to clarify its application to the professional claim. Environmental scanning shows that additional claim policies, which this proposal seeks to align, require that the first listed diagnosis qualify for that position.
2	A commenter cautioned that data content rules are hard to implement when they require cross checking with previous / other claims, it is better to do this in adjudication.	Appreciate this input and viewpoint. Clarify that the rule requirements, as proposed, sought to move some of the burden out of adjudication to help prevent duplication and rejections.
3	A commenter suggested that no change may not be the correct terminology if it implies claims can still be rejected under the current state.	The intent of no change was to imply that adjudication systems as they are presently structured can accept this without intervention.
4	One commenter stated that the carry-over option provides another data element that matches between claims by requiring a qualifying principal diagnosis to be included from the initial claim.	Agree that this could be a valuable "link" between initial and additional claims.

Recommendation: Do not create requirements to specify what type of ICD-10 code must be included in the principal or first listed spot on an X12 837 submission. Note that submitters should defer to health plan guidance about what types of diagnoses must occupy the principal or first listed diagnosis.

Follow-ups for X12 v5010 834 Data Content

Use of Member Preferred Language

Sex Assigned at Birth

Additional Data Content Requirements for the X12 v5010 834

Clarifying data content requirements for Member Preferred Language and Gender Reporting applicability to Sex Assigned at Birth.

Use of Member Preferred Language

- Indication of how member preferred language is used. Values include:
  - Speaking
  - Reading
  - Writing
  - Native Language
- Operating rule can leverage existing data elements in the LUI segment of the X12 v5010 834 to require exchange.
- **Follow-up**: Should this be required for each reported preferred language?

Sex Assigned at Birth

- Industry implementations of gender code may vary between recording legal sex, birth sex, or gender identity.
- Existing CAQH CORE proposals leverage the DMG03 field to support gender identity reporting.
- Sex assigned at birth is important to capture and exchange for clinical purposes.
- **Follow-up**: How is the gender code field currently applied in the X12 TR3? How does this affect proposals? How can we support collection and exchange of sex assigned at birth?

Member Preferred Language: In-call Poll #1

The Member Language (LUI) Segment in the X12 v5010 834 can be repeated >1 times. Member Preferred Language is reported using LUI01 and LUI02 fields. Indication of use is exchanged in the LUI04 field and contains the following values:

- 5 – Language Reading
- 6 – Language Writing
- 7 – Language Speaking
- 8 – Native Language

QUESTION: How should indication of use be exchanged in relation to collection of preferred language using the ISO 639-3 Standard?

a. All reported preferred languages must include use indications.

b. Only one preferred language must include an indication of use.

c. Indication of use should be optionally applied to all preferred languages.

d. Other (Please come off mute or put your input in chat)

Sex Assigned at Birth

As proposed, the CAQH CORE X12 834 Data Content Operating Rule would support the optional exchange and processing of self-reported member gender identity.

The Subgroup raised questions regarding how existing X12 v5010 TR3 requirements are interpreted and implemented by health plans and how data content operating rules can fill any gaps.

X12 Requests for Interpretation
Do not directly address sex assigned at birth

2331: Nonbinary gender should be reported using 'U'.

2435: v5010 TR3 reports gender, if Legal Sex required, MR should be submitted.

Reminder: CAQH CORE Gender Identity Data Content Proposal

DMG03 = M, F, or U (required)

REF02 = Applicable USCDI v3 SNOMED or HL7 v3 code with alphanumeric descriptions for 'other'

Note: other fields are included in the proposal. The fields shown here contain the detailed member information.

Sex Assigned at Birth: In-call Poll #2

Definitions of sex and gender have evolved since v5010 of the X12 TR3 leaving room for interpretative implementation of DMG03.

QUESTION: How have the Gender Code values from v5010 of the X12 TR3 been interpreted and implemented across industry?

a. Birth sex of a member/patient/individual

b. Legal sex of a member/patient/individual

c. Gender identity of a member/patient/individual

d. Other (Please come off mute or enter in chat)

Sex Assigned at Birth: In-call Poll #3

Present CAQH CORE data content proposals for the recommended exchange of gender identity leverage the required DMG03 Gender Code field to “inform” what is included in the REF02 field.

*For example: The value of ‘M’ in DMG03 has been interpreted to mean ‘Male’ gender and therefore implementers can **optionally** process the relevant SNOMED male gender identity concept in REF02.*

QUESTION: Regardless of your support for the recommended exchange of gender identity using the X12 v5010 834, what is your supported approach for interacting DMG03 Gender Code and REF02 fields.

a. As proposed is the best approach, DMG03 indicates gender identity and REF02 supplements this reporting.

b. DMG03 indicates **birth sex**, so gender identity reporting must be decoupled because it can differ from DMG03.

c. DMG03 indicates **legal sex**, so gender identity reporting must be decoupled because it can differ from DMG03.

d. Other (Please come off mute or enter in chat)

Sex Assigned at Birth: In-call Poll #4

QUESTION: Assuming that the DMG03 Gender Code is interpreted as gender identity and the CAQH CORE proposal to supplement its reporting is the best approach:

Do you support the proposal of a data content requirement to exchange and process sex assigned at birth using the X12 v5010 834?

a. Yes, an operating rule can support exchange of this information while awaiting standards updates.

b. Maybe, but a better approach is addressing variability of use of the field, potentially using operating rules to better define the use of DMG03.

c. No, do not support the exchange of sex assigned at birth and/or it is supported elsewhere by the standard.

d. Other (Please come off mute or enter in chat)

Next Steps from Subgroup Meeting #3

CAQH CORE Team

- Develop and distribute **by week of July 23, 2023.**

Subgroup Participants

- Complete and submit Straw Poll #5 by **EOD, Friday, August 4, 2023**.
  - Straw Poll #3: CORE will follow-up individually with organizations for who we are awaiting response.
  - Straw Poll #5: Follow-up items identified in today's call
    - Member preferred language use
    - Sex assigned at birth
    - X12 837 matching information [if indicated]

Next Meeting

- Thursday, August 17, 2023, from 2pm – 3:30pm ET.

Appendix

Today's Call Documents

Document Name
Doc 1 VBP Subgroup Call 5 Deck 07.20.023
Doc 2 VBP Subgroup Call 4 Call Summary 06.29.2023

CORE Staff*	Email Address
Erin Weber, VP, CORE	eweber@caqh.org
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CAQH CORE Value-based Payments Subgroup
Roster

Participant		Organization
Elyse	**Pegler**	Aetna
Terrence	**Cunningham**	American Hospital Association (AHA)
Andrea	**Preisler**	American Hospital Association (AHA)
Nancy	**Spector**	American Medical Association (AMA)
Linda	**Walsh**	American Medical Association (AMA)
Lauren	**Scott**	American Medical Association (AMA)
Heather	**McComas**	American Medical Association (AMA)
Robert	**Otten**	American Medical Association (AMA)
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Jacob	**Boron**	Aultcare
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Heather	**Sammons**	BCBSNC
Deborah	**Swain**	BCBSNC
Troy	**Smith**	BCBSNC
Natasha	**Sallie**	BCBSMI
Ron	**Knapp**	BCBSMI
Carol	**Larson**	BCBSMI
Cynthia	**Monarch**	BCBSMI
Jack	**Green**	BCBSMI
Paul	**Ozdarski**	BCBSMI
Susan	**Langford**	BCBSTN
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Chuck	**Chervitz**	Centene Corporation
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Jeffrey	**Narog**	CIGNA
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Michelle	**Medina**	Cleveland Clinic
Robert	**Jones**	Cleveland Clinic
Adam	**Keating**	Cleveland Clinic
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Participant		Organization
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Tania	**Mason**	Cognizant
Vincent	**Carrillo**	Cognizant
Andrew	**Schulz**	Cognizant
Patricia	**Wijtyk**	Cognizant
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Alka	**Arcari**	CVS Health
Michael	**Pattwell**	Edifecs
Kevin	**Day**	Edifecs
Vik	**Sachdev**	Edifecs
Tushar	**Nair**	Edifecs
Anitha	**Aerabati**	Elevance Health
Joe	**McGuire**	Epic
Megan	**Soccorso**	Gainwell Technologies
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Katie	**Gilfillan**	Healthcare Financial Management Association
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Christopher	**Gracon**	HEALTHeNET
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Janice	**Karin**	Massachusetts Health Data Consortium/NEHEN
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Amy	**Costello**	NAHDO
Margaret	**Weiker**	NCPDP
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Alison	**Schambach**	Tata Consultancy Services Ltd
Pinki	**Patel**	Tata Consultancy Services Ltd
Dorothy	**Egan**	Tata Consultancy Services Ltd
Mary	**Sussman**	Tata Consultancy Services Ltd
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Dawn	**Erckenbrack**	TRICARE
Kiran	**Kalluri**	UnitedHealthGroup
Lynn	**Chapple**	UnitedHealthGroup
Robert	**Tennant**	WEDI
Kristina	**Berger**	Zelis

Avoiding Rejection or Denial of Non-Qualifying Principal Diagnoses

- Select categories of diagnosis codes cannot be used in the principal diagnosis position.
- Non-qualifying principal diagnoses will be denied and/or rejected.
- What steps can health plans take to accommodate additional claims submissions that *only* contain non-qualifying principal diagnoses?
  - Carry-over principal diagnosis from initial claim.
  - Allow VBP-related codes.
  - Other.

Non-qualifying Principal Diagnosis Code Types

Code Category	Description
Manifestation codes	When clinical presentation has manifested due to an underlying condition
“Code first” notes	Clinical presentation arose due to underlying condition that is not a manifestation code
Sequela codes	Sequela generally requires two codes sequenced with the condition or nature of the sequela being coded first
Malignant neoplasm associated with transplanted organ	First code is complications of transplanted organs
Conditions due to external or toxic agents	Assign code for external or toxic agent first
Gout	Lead-induced, renal impairment, or other condition to which gout is secondary should be coded first
Symptoms and signs of systemic inflammation and infection	Underlying conditions of non-infectious SIRS or Severe Sepsis must be coded first
Burns and Corrosions of external body surfaces or those confined to eye and internal organs	Assign first the chemical and intent, followed by corrosion burn code.
Poisoning (adverse and underdosing)	Nature of the adverse event should be coded first and codes for underdosing should never be coded first
External causes of morbidity	External causes should never be sequenced first
Factors influencing health status	***Broadly, Z-code categories, including indicators of social risk.***

Example list compiled from multiple health plans, shared for illustrative purposes.