Interoperability for Value-based Care: Standardizing Information Exchange Using CORE Operating Rules

Oct. 18, 2023

Agenda

- Housekeeping and Introductions
- CAQH CORE overview
- Electronic Standards and the Role of Operating Rules
- Opportunities within Value-based Payments
- Question and answer session with the audience

Housekeeping

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

Q&A will take place at the end of the program

You can submit written questions using the **"Questions" tab** (not chat) at any time during the webinar.

Speakers

Michael Phillips
Senior Manager, CORE

Jennifer Gasperini
Director of Regulatory and Quality Affairs

Erin Weber
Vice President, CORE

CORE Overview

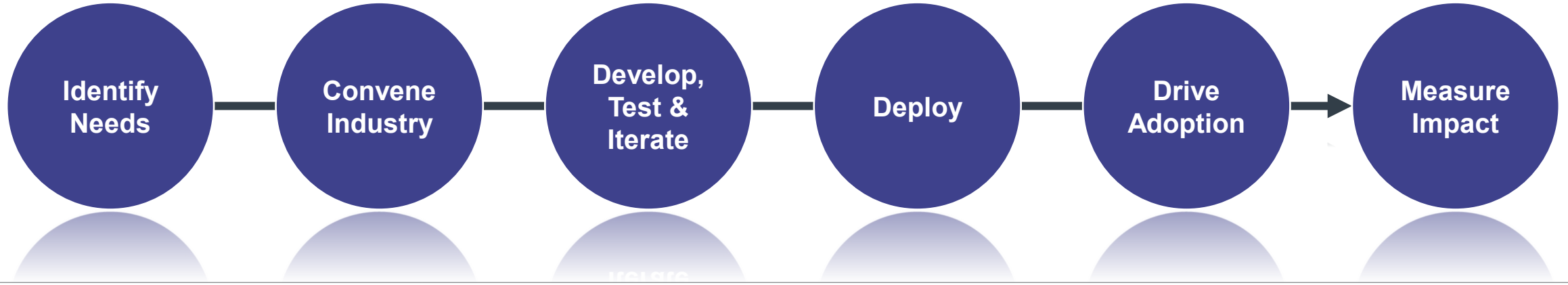
CAQH CORE Mission & Vision

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.

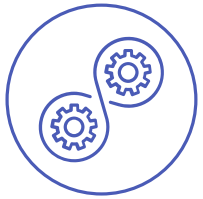
Vision

An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.



Committee on **O**perating **R**ules for Information **E**xchange

Federally designated by the Department of Health and Human Services (HHS) as the National Operating Rule Authoring Entity for all HIPAA mandated administrative transactions.



Develop business rules to help industry effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

Multi-stakeholder Board Members include health plans, providers, vendors, and government entities. Advisors to the Board include SDOs.

More than 100 CAQH CORE Participating Organizations

Government

- Arizona Health Care Cost Containment System
- California Department of Health Care Services
- Centers for Medicare and Medicaid Services (CMS)
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Health Plan of San Joaquin
- Michigan Department of Community Health
- Minnesota Department of Health
- Minnesota Department of Human Services
- Missouri HealthNet Division
- North Dakota Medicaid
- Oregon Department of Human Services
- Oregon Health Authority
- Pennsylvania Department of Public Welfare
- TRICARE
- United States Department of Treasury Financial Management
- United States Department of Veterans Affairs

Health Plans

- Aetna
- Ameritas Life Insurance Corp.
- AultCare
- Blue Cross and Blue Shield Association (BCBSA)
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- CareFirst BlueCross BlueShield
- Centene Corporation
- CIGNA
- Elevance Health
- Health Care Service Corp
- Horizon Blue Cross Blue Shield of New Jersey
- Humana
- Medical Mutual of Ohio, Inc.
- Point32Health
- UnitedHealthGroup

Integrated Plan/Provider

- Highmark Health (Highmark, Inc.)
- Kaiser Permanente
- Marshfield Clinic/Security Health Plan of Wisconsin, Inc.

Vendors & Clearinghouses

- AIM Specialty Health
- athenahealth
- Availity, LLC
- Averhealth
- Cedar Inc
- Cerner/Healthcare Data Exchange
- Change Healthcare
- ClaimMD
- Cloud Software Group
- Cognizant
- Conduent
- CSRA
- DXC Technology
- Edifecs
- Epic
- Experian
- Healthedge Software Inc
- HEALTHeNET
- HMS
- Infocrossing LLC
- JP Morgan Healthcare Payments
- NantHealth NaviNet
- NextGen Healthcare Information Systems, Inc.
- OptumInsight
- PaySpan
- PNC Bank
- PriorAuthNow
- SS&C Health
- Surescripts
- The SSI Group, Inc.
- TriZetto Corporation, A Cognizant Company
- Utah Health Information Network (UHIN)
- Wells Fargo
- Zelis

Providers

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Aspen Dental Management, Inc.
- Children's Healthcare of Atlanta Inc
- Cleveland Clinic
- Greater New York Hospital Association (GNYHA)
- Healthcare Financial Management Association (HFMA)
- Laboratory Corporation of America
- Mayo Clinic
- Medical Group Management Association (MGMA)
- Montefiore Medical Center
- New Mexico Cancer Center
- OhioHealth
- Ortho NorthEast (ONE)
- OSF HealthCare
- Peace Health
- St. Joseph's Health
- Virginia Mason Medical Center

Other

- Accenture
- ASC X12
- Cognosante
- Healthcare Business Management Association
- Healthcare Business Association of New York (HCBA)
- HL7
- NACHA The Electronic Payments Association
- National Association of Health Data Organizations (NAHDO)
- National Committee for Quality Assurance (NCQA)
- National Council for Prescription Drug Programs (NCPDP)
- New England HealthCare Exchange Network (NEHEN)
- Preferra Insurance Company Risk Retention Group
- Private Sector Technology Group
- Tata Consultancy Services Ltd
- Utilization Review Accreditation Commission (URAC)
- Work Group for Electronic Data Interchange (WEDI)

Account for 75% of total American covered lives.

CORE Certification
Ensuring Conformance with Operating Rule Requirements

What is CORE Certification?

CORE Certification was developed by industry, for industry by CAQH CORE Participating Organizations.

Certification obtained when an entity has demonstrated that its **IT system or product is operating in conformance** with CAQH CORE Operating Rules for specific transaction(s).

Which organizations can become CORE-Certified?

CAQH awards CORE Certification Seals to entities that **create, transmit or use** the healthcare administrative and financial transactions addressed by the CAQH CORE Operating Rules.

What are the benefits of becoming CORE-Certified?

CORE Certification offers transaction-based testing; providing an **end-to-end testing** suite that is robust and comprehensive.

CORE Certification demonstrates commitment to streamlining administrative data exchange and enables us to **lower costs and improve the efficiency** of health care delivery for our clients, customers, members and the nation.

410 Certifications have been awarded to date.

Electronic Standards and the Role of Operating Rules

Electronic Data Exchange Standards

Electronic exchange of health information facilitates previously unprecedented **speed of delivery and data uniformity.** Standards Development Organizations (SDOs) work with industry stakeholders to identify **gaps and use cases** that can be addressed using vocabulary and technical standards.

X12

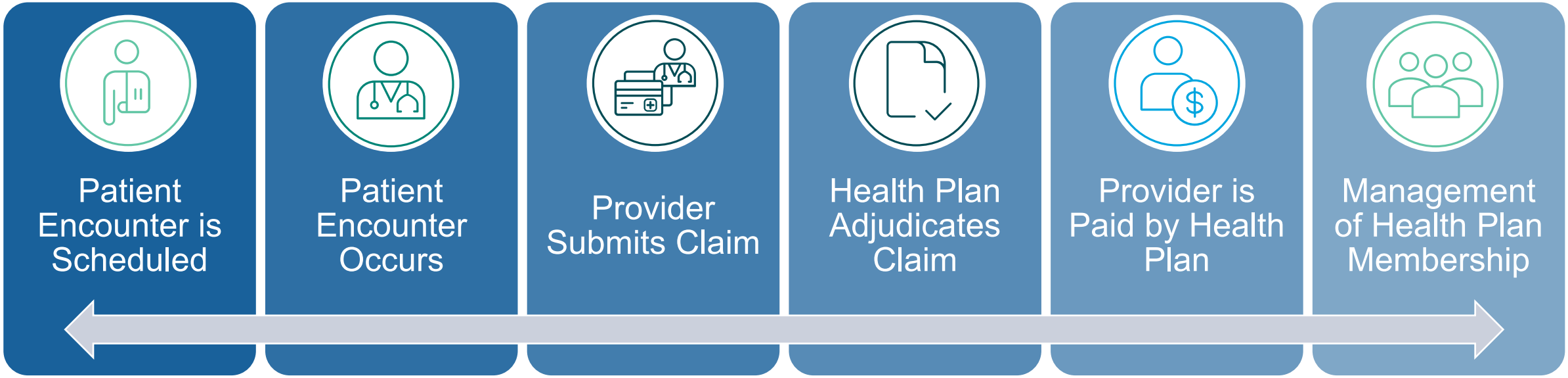
- XML-based electronic exchange standards for a variety of industries, including transportation, finance, and healthcare. An industry standard for over 40 years.
- X12 is the named Standard for several HIPAA-mandated transactions. Commonly encountered for eligibility verification and claims workflow transactions – among others.
- Consensus-based updates are accommodated annually, resulting in a comprehensive – if inflexible – standard.

HL7 International

- Natural-language based set of electronic exchange standards for healthcare. A relative “newcomer” to the industry in the administrative space.
- Use of HL7 Standards in health information exchange are emerging but are increasingly being included in Federal regulation for their ability to support API-based exchange.
- For its FHIR Standard, HL7 utilizes several “accelerator” groups that create implementation guides that facilitate use-cases to which the standard can be applied.

CAQH CORE Operating Rules Clarify Standards and Support the Revenue Cycle

Operating Rule Definition: The "necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."



Eligibility & Benefits*

Attributed Patient Roster

Prior Authorization & Referrals

Health Care Claims

Claim Status*

Payment & Remittance*

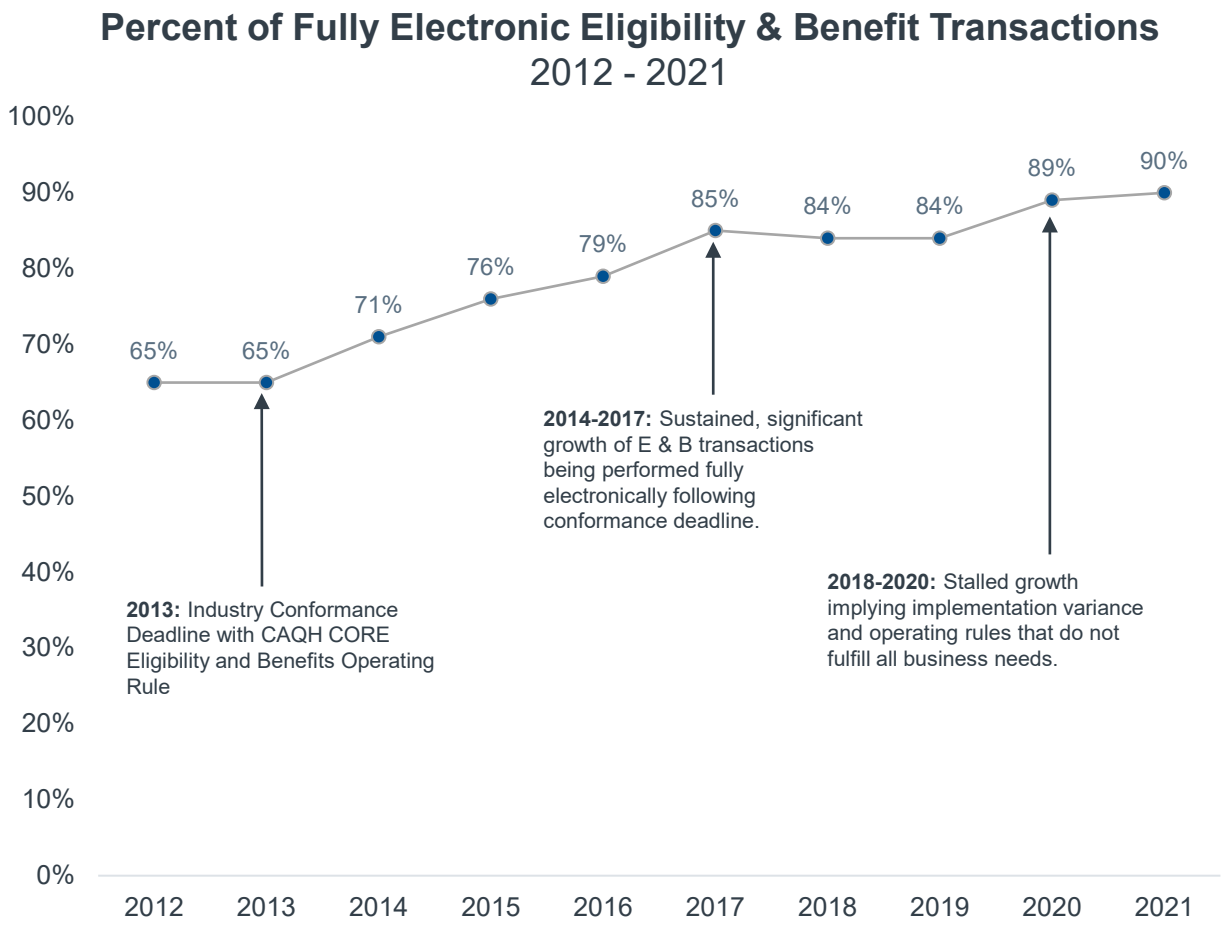
Benefit Enrollment

Premium Payment

**Rule Set Contains Federally Mandated Operating Rules*

Example: Impact of CAQH CORE Eligibility & Benefits Operating Rules

Operating Rules have Saved Industry Approximately $18 Billion to Date



Cost savings opportunities from transitioning from manual to electronic transactions:

- Prior to the pandemic (2019), cost savings opportunity of **$8.64** per eligibility transaction related to complex benefit designs associated with **benefit limits, tiered benefits, procedures**, etc.
- During the pandemic (2020), **telehealth** drove cost savings opportunity of **$15.09** per transaction.
- In 2021, as patients returned to office visits, cost savings opportunity decreased, but remained high at **$11.78** per transaction.

Status of CAQH CORE Eligibility & Benefits Operating Rules

Federally mandated with proposed updates recommended for adoption by NCVHS.

NCVHS Recommendation to HHS

On **June 30, 2023** NCVHS made the following rulemaking recommendation in a letter to HHS:

Recommended Operating Rules		Overview

Data Content	**UPDATED:**
	CORE Eligibility and Benefits (270/271) Data Content Rule
		• For services and procedures, requires a health plan return:
		  • Requirements for prior authorization.
		  • Details about benefit structure and patient financial responsibility.
		  • Telehealth coverage defined by CMS Place of Service.

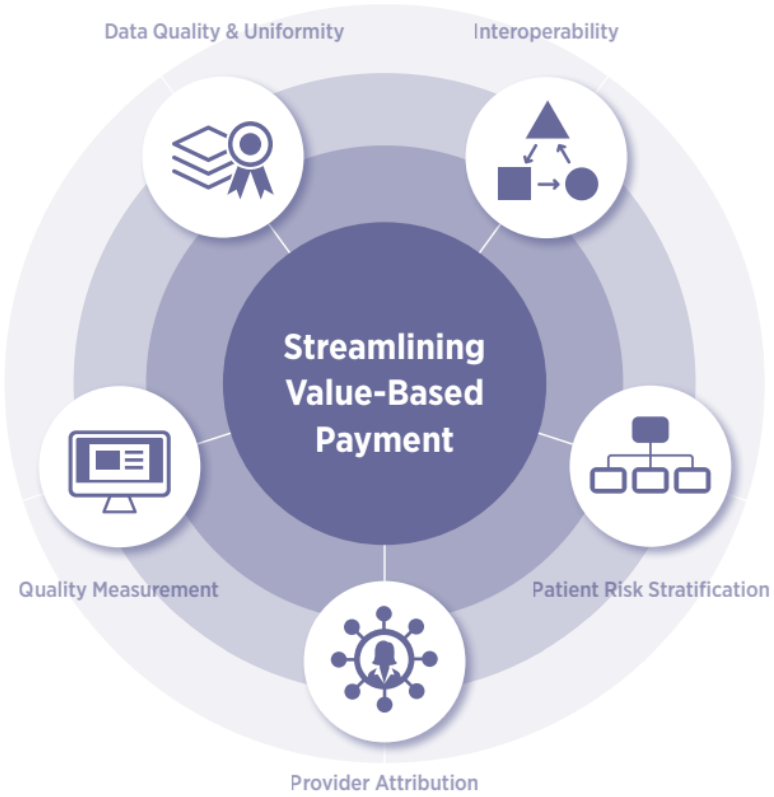
	NEW: **CORE Eligibility and Benefits (270/271) Single Patient Attribution Data Content Rule**	• For patients aligned to a population health value-based contract, returns: • Patient attribution status to a provider using standardized language.

Infrastructure	**UPDATED:**
	CORE Eligibility and Benefits (270/271) Infrastructure Rule
	CORE Claim Status (276/277) Infrastructure Rule
	CORE Payment and Remittance (835) Infrastructure Rule
		• Enhances frequency and consistency of electronic exchange by:
		  • Increasing weekly system availability requirements to 90%.
		  • Strengthening security and connectivity requirements.
		  • Promoting uniformity, regardless of the Standard used.

Connectivity	**UPDATED:**
	CORE Connectivity Rule vC4.0.0
		• Modernizes security and transfer requirements by:
		  • Updating certification and authentication protocols
		  • Facilitating exchange of multiple versions of standards.
		  • Expanding support for REST APIs, applicable to HL7 FHIR.

Opportunities within Value-based Payments

Emerging Trends and Obstacles in Value-based Payment



Health Equity by Design in VBP: Value-based contracts are recognized for their potential role in promoting equitable healthcare. Models have begun incorporating methodologies to identify, act upon and mitigate harmful social influences that lead to poor or inequitable outcomes.

Program Complexity and Administration: Value-based payment models have always been complicated to administer. As models mature to meet new priorities and deliver on their potential, participants are encountering challenges related to infrastructure investments, network development and contracting, and engagement with methodologies.

Value-based Drug Pricing: Value or outcomes-based drug pricing is seen as a popular way to encounter rising prescription drug costs in the U.S. Recent regulatory changes may stimulate implementation of these contracts. Known obstacles around interoperability, complexity and quality measurement will challenge this field, as well.

Existing CORE Operating Rules Supporting Value-based Care

Patient schedules appointment with Provider

Provider sends X12 270 E&B Request

Health Plan replies with X12 271 E&B Response conforming to the **CORE Single Patient Attribution Status Data Content Rule**

Provider submits healthcare claim for services rendered

Health Plan adjudicates claims payment at end of the fiscal year

Provider receives single patient attribution information at the point of service plus **a monthly patient roster** via a standard format from health plans in conformance with **Attributed Patient Roster Rule Set**. *Uniform format enables data to be easily integrated into the provider system.*

CORE Single Patient Attribution Rule:
Returns attribution status during eligibility verification.
Recommended by NCVHS for federal adoption.

CORE Attributed Patient Roster Rule:
Standardizes exchange of patient rosters on **at least a monthly basis**.
Flexible rule that allows standardized exchange of patient demographics.

2023 Operating Rule Development
Value-based Payments

Business Challenges

Inconsistent Data
Data-sharing is integral to success in VBP; however, exchanging key data such as SDOH information between industry stakeholders lacks standardization, thus hindering efficient data exchange and negatively impacting patient care.

Limited Results
A recent report from the Center for Medicare and Medicaid Innovation (CMMI) shows that VBP programs produce only modest cost-savings without significant improvements in care quality.

Program Complexity
Coordinating a population of patients across the spectrum of care poses difficulties that could be eased by defining terms and definitions across VBP programs.

2023 CORE Rule Development Group Vision

Leverage **HIPAA-mandated benefit enrollment and claim transaction** to facilitate uniform exchange of socio-demographic information and strengthen interoperability in VBP by aligning technical infrastructure requirements and industry terminology.

VBP Subgroup Co-Chairs

Michael Alwell
St. Joseph's Health

Naveen Maram
Centene Corporation

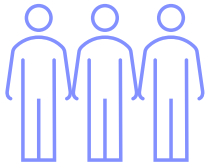
Michael Pattwell
Edifecs

Intervention Targets to Promote Data Uniformity, Engagement, and Security

CORE and its Participating Organizations identified **iterative** changes that could be applied to commonly used and accepted standards that align industry datasets while promoting incorporation and engagement with methodologies impacting health equity, risk adjustment and quality measurement.

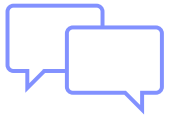
Benefit Enrollment and Maintenance

Harmonization of Race and Ethnicity Reporting



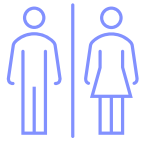
- Only about 50% of health plans collect this information, and those who do use inconsistent datasets, limiting upstream data quality.
- **Solution:** Align race and ethnicity reporting and exchange to the **CDC Race and Ethnicity Code Set.**

Reporting and Exchange of Patient/Member Language



- Standards support the situational or optional exchange of member language and use – limiting adoption.
- **Solution:** Require collection and exchange of member language aligned to the **ISO-639-3 data set.**

Support for Self-reported Gender Identity



- Self-reported gender identity is an evolving data category, currently limited by inconsistent exchange.
- **Solution:** Indicate a standard approach and dataset for those who choose to share and exchange.

Claim Submission

Mechanisms to Submit More Secondary Diagnoses

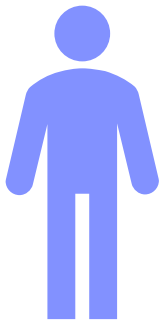
- Limited diagnosis fields interrupt providers' ability to reliably or consistently submit supporting, secondary diagnoses.
- **Solution:** Establish uniform submission guidelines for the submission of additional claims at a single encounter.

Why are Enrollment Rules Powerful for Providers?

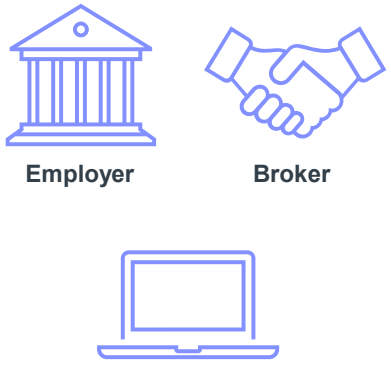
Strengthened data content requirements streamlines and increases the quality of upstream data collection, enhancing the ability for meaningful socio-demographic information to be used in the design and administration of value-based payment programs.

X12 005010X220 834

Step 1: Individual enrolling in or renewing health insurance does so through one of multiple routes available.



Step 2: Agents acting on behalf of the health plan to enroll an individual into coverage **collect demographic information from the individual during the process.**



Step 3: The health plan receives information from enrollment through an **X12 834** and processes this information into their system for use. The **proposed CORE Benefit Enrollment and Maintenance Data Content Rule** standardizes the information and datasets used in the X12 834.

X12 005010X318 834

Step 4: The health plan then can send the socio-demographic and other information to providers participating in a sponsored value-based contract, facilitated by the **voluntary CORE Attributed Patient Roster Operating Rule (X12 005010X318 834).**

How Does a Claims Rule Streamline VBP Operations?

Streamlining Ability		Example
Risk Adjustment	Risk adjustment models often leverage chronic conditions that may not be immediately applicable to the current clinical presentation.	**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.	**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.	**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.	**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.	**ICD-10 Z-codes for social risk:** Z59.1 – Inadequate housing.

Understanding the Exchange and Use of Sensitive Information

Operating Rules Requiring or Advising the Exchange of Socio-demographic Data Require Disclosure of Collection and Use and Member/Patient Consent

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

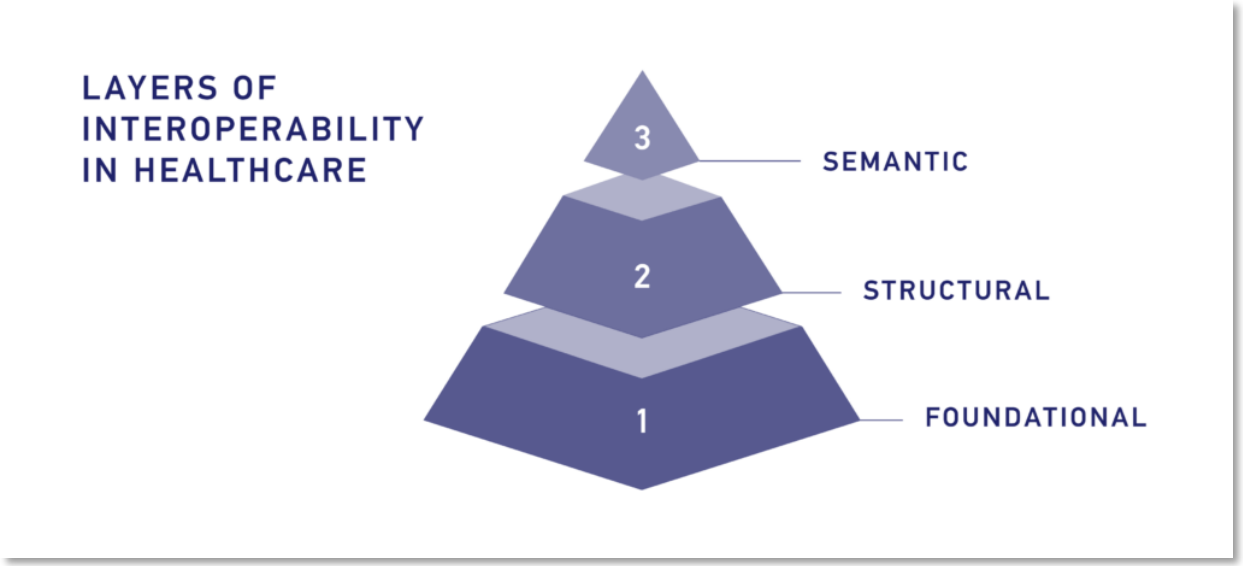
- No federal restrictions for health plans to request, collect or exchange race and ethnicity.
- Only **6 states** prohibit collection of race and ethnicity as part of an insurance application.
- Collection of this information may complement other initiatives, such as EEO.

Promoting Semantic Interoperability in Value-based Payment Administration

Semantic interoperability refers to the ability of computer systems to exchange data with unambiguous meaning, typically facilitated by the electronic exchange of standard terminology.

VBP is subject to **interpretative definitions** meaning that concepts and terminologies are not applied consistently between implementations, lending to industry confusion and contracting difficulties.

The **CORE Framework for Semantic Interoperability leverages** this concept to align definitions and show the interrelatedness of concepts in VBP.



Picture credit: Kodjin Interoperability Suite.

Value-based Payment Rule Development Focus Areas

Strengthen Exchange of Socio-demographic Data

NEW DRAFT Benefit Enrollment and Maintenance (X220) Data Content Rule

UPDATED DRAFT Benefit Enrollment and Maintenance (X220) Infrastructure Rule

UPDATED DRAFT Attributed Patient Roster (X318) Data Content and Infrastructure Rules

- **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.

Empower Engagement with VBP Methodologies

NEW DRAFT Health Care Claim (X222 / X223) Submission Data Content Rule

- **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.

Maintain a Framework for Semantic Interoperability

NEW DRAFT 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 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 CORE Operating Rules** and aligns disparate industry initiatives.

5 NEW/UPDATED Operating Rules and 1 CORE Industry Resource to drive automation and adoption of value-based payment models.

Next Steps

CORE Continues its Involvement in the VBP Space

1

Finalize Development

The Operating Rules presented today represent a lengthy, consensus-based process. They are now being refined in a final step prior to going before all Participating Organizations for approval. Then the march to Federal Mandate, if indicated, begins.

2

Future Opportunities

Tremendous opportunities remain to leverage common transactions and data exchange to support VBP administration and demonstrate ROI of rule adoption. These opportunities lie in continued attribution work, payment flows, and ensuring connectivity and coordination between traditional and non-traditional stakeholders.

3

Get Involved!

CORE Participating Organizations are the engine that drives this development process. Provider insights are always welcomed as CORE and its partners seek to integrate different perspectives into rule development and enlighten the link between data exchange and clinical management.

Questions

Thank you!

Website: *www.CAQH.org/CORE*

Email: *CORE@CAQH.org*

The CORE 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.