



**All Together Now -
Applying the Lessons of
FFS to Streamline
Adoption of Value-
based Payments**

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Senior Vice President, CAQH
CORE and Explorations

Session Outline

- Introduction to CAQH CORE
- CAQH CORE Value-based Payments Initiative
- Opportunities for Administrative Simplification in Value-based Payments
- Next Steps and How to Engage
- Questions

CAQH CORE

Introduction to CAQH CORE

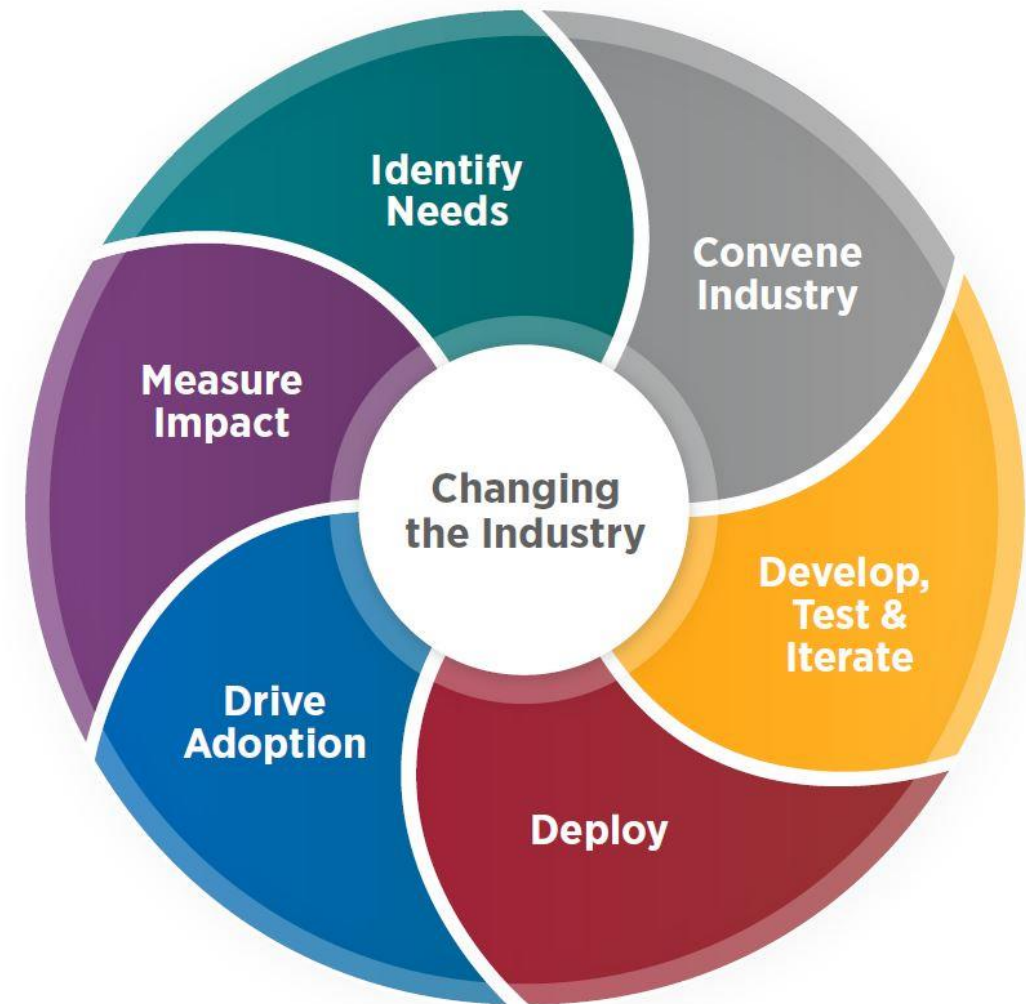
CAQH CORE Mission and Vision

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.

DESIGNATION **Named by Secretary of HHS to be national author for operating rules** mandated by Section 1104 of the Affordable Care Act.

BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs.



CAQH CORE Rule Development

What Are Operating Rules?

Operating Rules: the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.

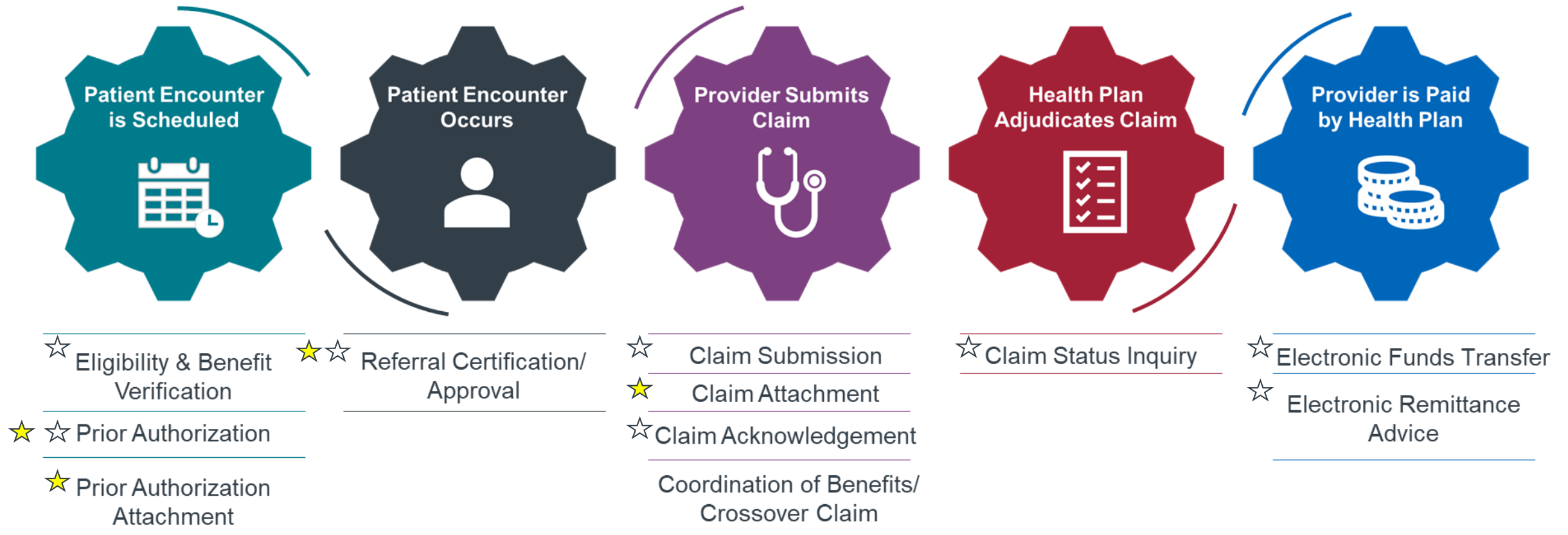
Use Case	Standard	Operating Rule
Healthcare	Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information.	When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time.*
Finance	Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging.	Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation.

Operating rules in the healthcare industry make electronic data transactions more predictable, timely and consistent, regardless of the technology.

*CORE Phase I and II Operating Rules.

CAQH CORE Rule Development

Streamlining the Revenue Cycle Workflow



☆ Existing CAQH CORE Operating Rules.

☆ CAQH CORE Operating Rules in Development.

CAQH CORE Operating Rule Overview

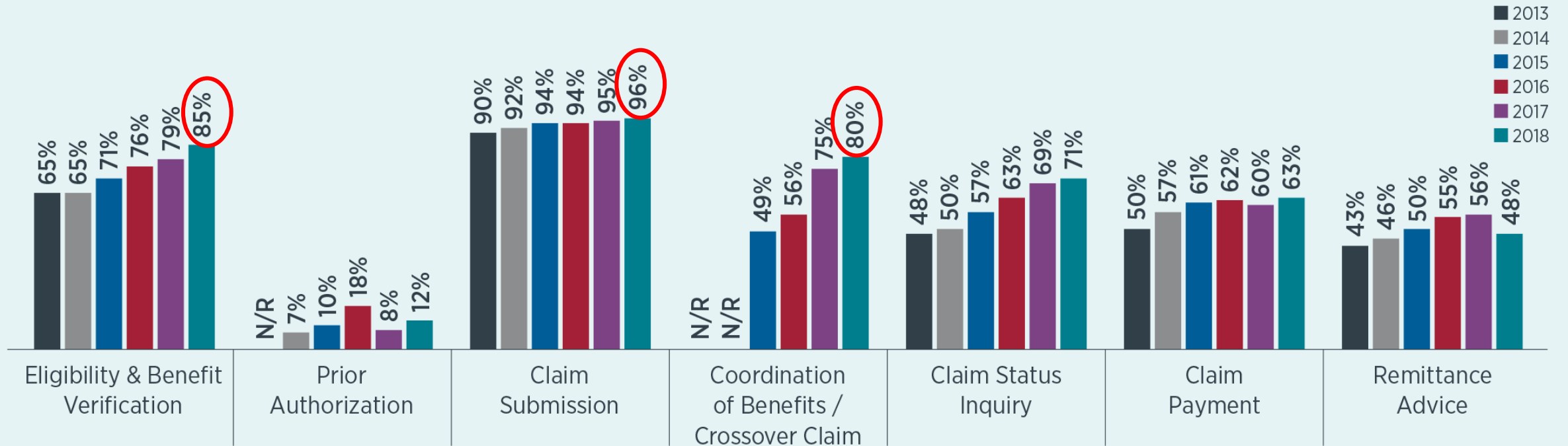
CAQH CORE is the [HHS-designated Operating Rule Author](#) for all HIPAA-covered transactions.
HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules.

	Phase I	Phase II	Phase III	Phase IV	Phase V	Phase VI
Transactions	Eligibility	Eligibility Claims Status	Electronic Funds Transfer Electronic Remittance Advice	Health Claims Referral, Certification and Authorization Enrollment Premium Payments	Prior Authorization Web Portals	Attachments
Manual to Electronic Savings per Transaction (2018 CAQH Index)	\$6.52	Eligibility: \$6.52 Claim Status: \$9.22	Claim Payment: \$0.65 ERA: \$2.32	Claim Submission: \$1.32 Prior Authorization: \$7.28	\$7.28	N/A
	Active				In Progress	

Notes: (1) All Active Phases include requirements for acknowledgements, e.g., 999 Functional Acknowledgement, 277CA Claims Acknowledgement. (2) CAQH CORE is also evaluating maintenance areas and opportunities to build on existing rules to support value-based payment. (3) Operating rules for eligibility, claim status, EFT, ERA, claims, enrollment, premium payment, and referral, certification and authorization support the HIPAA mandated transactions.

Electronic Adoption of Administrative Transactions in the Medical Industry

Figure 1: Adoption of Electronic Administrative Transactions, Medical, 2013 – 2018 CAQH Index



N/R = Not Reported

The [2018 CAQH Index](#) is the industry resource for benchmarking progress to reduce a portion of the industry complexity, including tracking and reporting on adoption of electronic transactions in the medical and dental industry.

CAQH
CORE

CAQH CORE Value-based Payments Initiative

CAQH CORE Value-based Payment Initiative

Identifying a Need

For over a decade, stakeholders have collaborated through CAQH CORE to bring consistency to the fee-for-service healthcare system.

Industry Shift



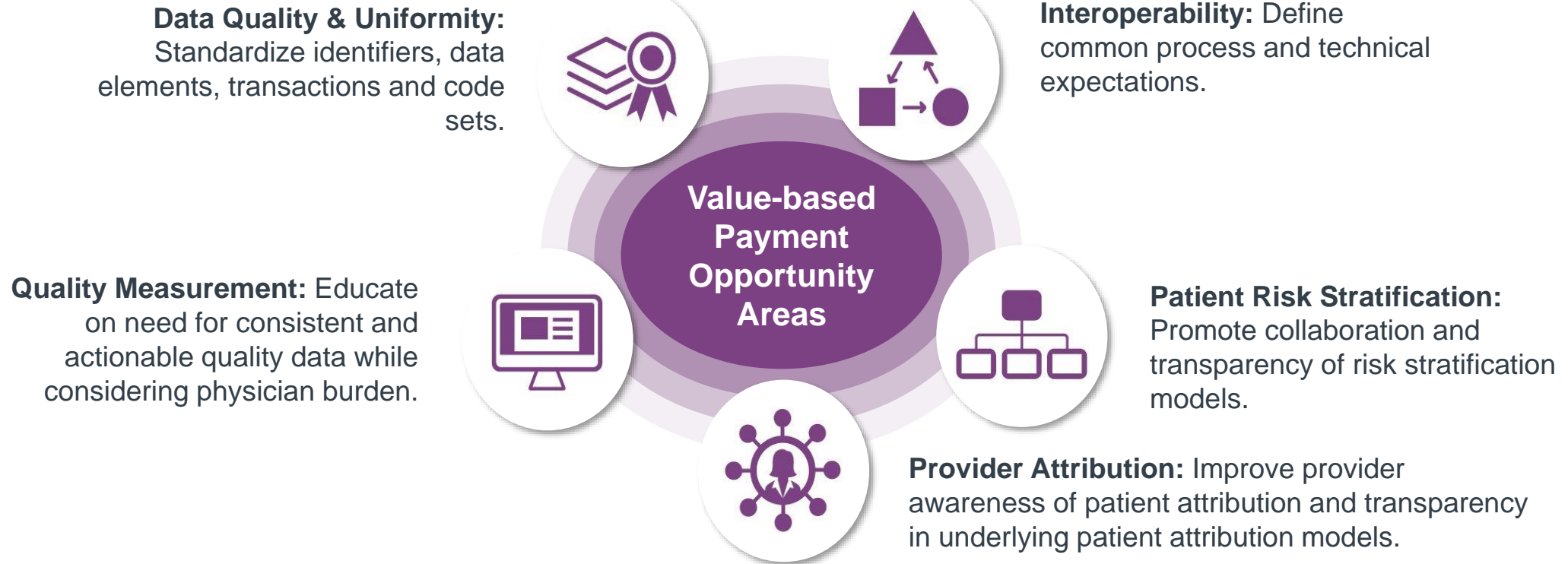
CAQH CORE Board recognized the importance of value-based payments and agreed CAQH CORE must expand its scope to driving out unnecessary costs and inefficiencies from information exchange in both fee-for-service and value-based payment.

Alignment & Collaboration



Healthcare stakeholders must act decisively and collaboratively to prevent value-based payment from confronting the administrative roadblocks once encountered in fee-for-service.

Streamlining Adoption of Value-Based Payments



CAQH CORE Vision

A common infrastructure that drives adoption of value-based payment models by reducing administrative burden, improving information exchange and enhancing transparency.

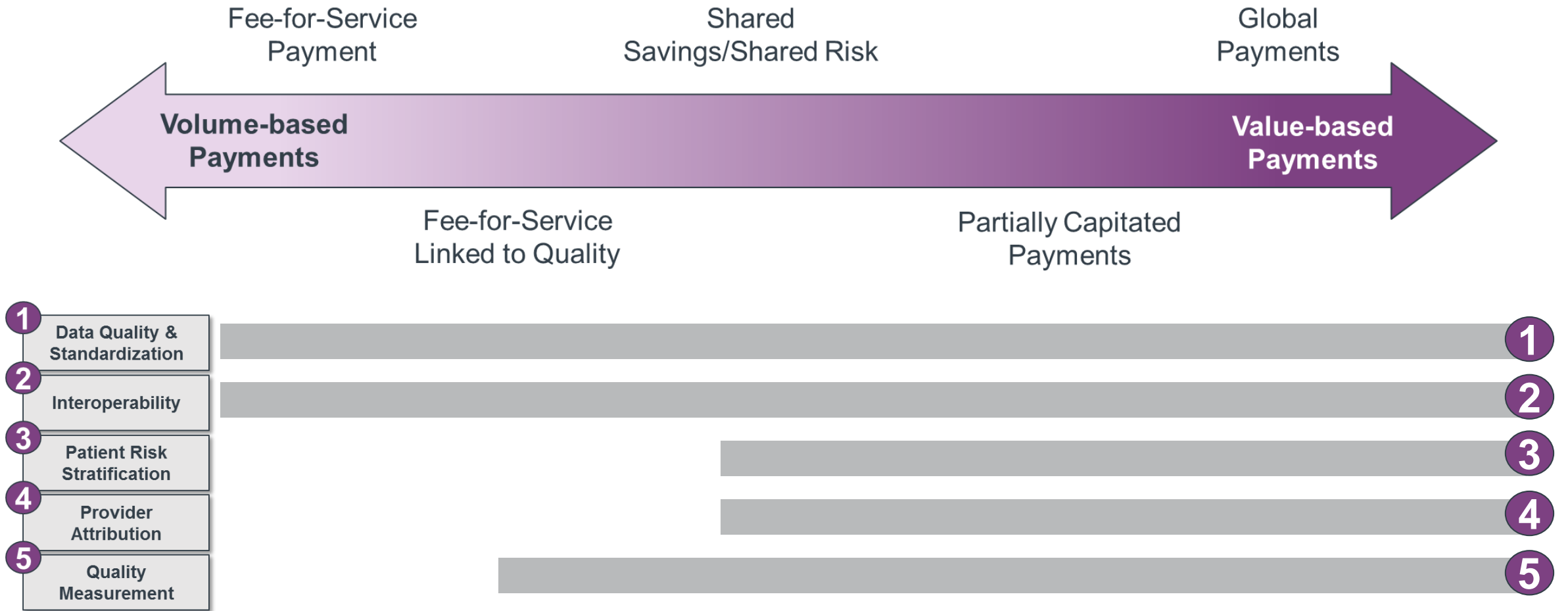
CAQH CORE [Report](#)

Identified five opportunity areas in the industry that could smooth the implementation of value-based payments.

Next Steps

CAQH CORE has launched an Advisory Group to guide the work effort.

Continuum of Value-based Payment Models



Examples of VBP Challenges in the Revenue Cycle Workflow

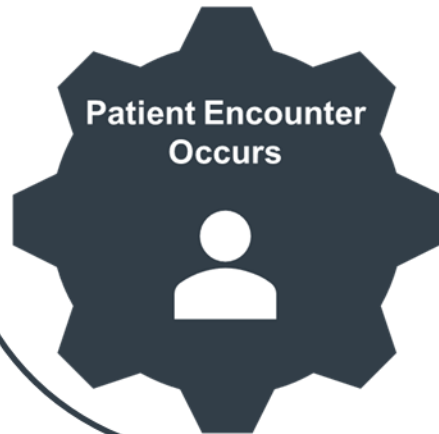
Provider often does not know if a patient is attributed to them until after care is delivered.

Provider is not always aware of quality metrics required by patient's specific health plan.

Provider is unclear as to which NPI and/or TIN to submit. May have multiple NPIs or TINs.

Claim cannot convey pertinent clinical or health information not related to a service provided during visit.

Remittance advice does not fully explain how provider payment relates to VBP arrangements (e.g. were quality metrics met?).



Eligibility & Benefit Verification

Prior Authorization

Prior Authorization Attachment

Referral Certification/ Approval

Claim Submission
Claim Attachment

Claim Acknowledgement

Coordination of Benefits/
Crossover Claim

Claim Status Inquiry

Electronic Funds Transfer

Electronic Remittance Advice

Opportunities for Administrative Simplification in Value-based Payments

Sample Opportunities for Administrative Simplification in VBP

Provider often does not know if a patient is attributed to them until after care is delivered.

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Opportunity: Return patient attribution information when provider submits an eligibility check.

Opportunity: Return requirements for quality measure reporting or specific measure gaps when provider submits eligibility check.

Opportunity: Standardize use of NPI Type I and Type II in claims submissions.

Opportunity: Standardize additional documentation, data content, format and method of transfer for critical clinical information that is non-service related.

Opportunity: Outline provider next steps in remittance advice to ensure full payment at the end of the fiscal year, e.g. reporting requirements. Also specify in remittance advice whether performance metrics met.

Opportunities for Administrative Simplification in VBP

Example: Attribution

Fee-for-Service (FFS):

Providers need information on patient coverage delivered in real time.

Technology Solution

Health plans offer and providers accept electronic eligibility, coverage, and benefit transactions in real time.

X12 270/271 Health Care Eligibility Benefit Inquiry/Response

Supporting Business Solution

CAQH CORE operating rules require submission and return of certain uniform data elements in real time for electronic eligibility, coverage, and benefit transactions.

CAQH CORE 260: Eligibility Data Content Rule

Value-based Payments (VBP):

Providers need to know patient coverage information and whether a patient is attributed to them prospectively.

Current Technology Solutions

Health plans create proprietary provider portals to provide population and member level attribution data content monthly/quarterly.

Provider Portals

Emerging API technology and data format requirements for certain coverage use cases.

HL7 DaVinci Coverage Requirements Discovery Use Case

Potential Business Solution

CAQH CORE operating rules could prescribe a uniform use of the X12 270/271, X12 834 and/or HL7 FHIR Patient Resource Extension to define member level attribution data content in a specific VBP arrangement updated routinely or in real-time.

Opportunities for Administrative Simplification in VBP

Example: Quality Measures

Fee-for-Service (FFS):

Providers are paid for clinical services as conveyed by the health care claim. Incorrect or missing information can lead to substantial delays or unpaid claims.

Technology Solution

Providers can submit health care claims electronically, and may check on the status of a submitted claim.

X12 837 Health Care Claim

X12 276/277 Health Care Claim Status Request/Notification

Supporting Business Solution

CAQH CORE operating rules require the standardization of data elements on the health care claim to improve the efficiency of claims adjudication. Operating rules also require the return of certain uniform data elements in real time for electronic claim status notifications.

***CAQH CORE Phase II Data Content Rules
&
CAQH CORE 250: Claim Status Rule***

Value-based Payments (VBP)

Providers are paid for clinical outcomes which cannot be conveyed via the current health care claim EDI standard.

Current Technology Solutions

Health plans create proprietary provider portals to allow providers to send in quality data, often done at the end of the year.

Provider Portals

Potential Business Solution

CAQH CORE operating rules could prescribe the use of the X12 275 Patient Information transaction or an API such as HL7's FHIR to relieve provider reporting burden and standardize the reporting of measures.

Next Steps and How to Engage

Role of CAQH CORE VBP Advisory Group

Purpose

- Provide guidance to CAQH CORE on opportunities to streamline value-based payments and collaborate with industry leaders.
- Identify and select specific strategies for CAQH CORE Subgroup to pursue, resulting in a pre-defined work product/deliverable.
- Provide continual feedback and approval of work products developed by CAQH CORE Subgroup to ensure meaningful industry impact.

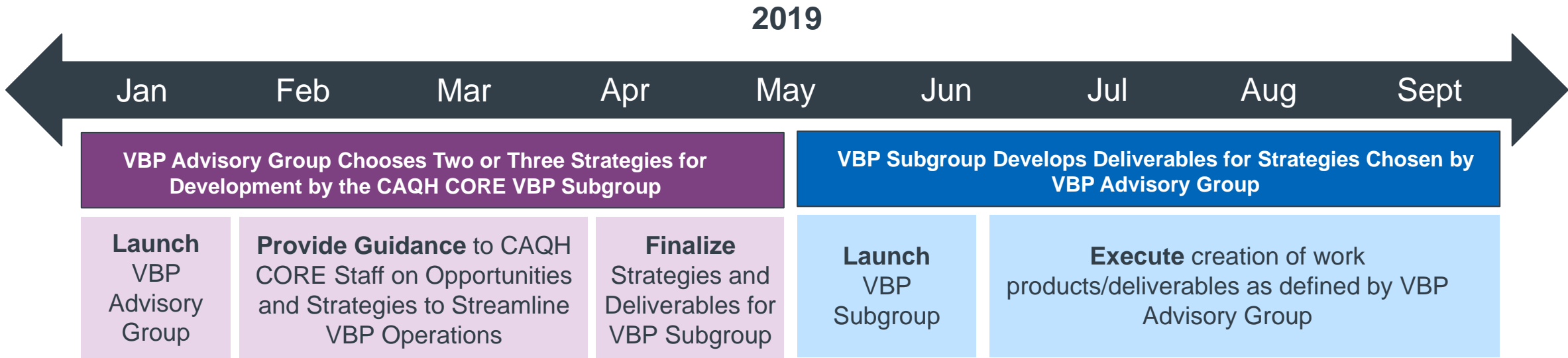
Scope of Work

- Review, provide feedback and evaluate a list of specific strategies to streamline VBP within each of the five opportunity areas from the CAQH CORE VBP Report.
- Assist in recruitment of SMEs to participate in Subgroups for each selected strategy.
- Review, approve and monitor completion of Subgroup project plan with milestones to ensure agreed upon deliverables are completed timely.
- Provide deliverable oversight and approval.

Advisory Group Participating Organizations

athenahealth | Blue Cross Blue Shield North Carolina | Centers for Medicare and Medicaid Services (CMS) | Edifecs | Health Edge | Humana | Marshfield Clinic Health System | Medical Group Management Association (MGMA) | Minnesota Department of Health | Montefiore Medical Center | National Quality Forum (NQF) | UnitedHealthcare

Next Steps for Value-based Payment Initiative



		VBP Advisory Group
		VBP Subgroup

Become a CAQH CORE Participating Organization to Maximize Impact



Represent your organization.



Work with other industry leaders.



Address common industry challenges.



Present on CAQH CORE education sessions.

Healthcare administration is rapidly changing.

Be a part of CAQH CORE's mission to drive the creation and adoption of new healthcare operating rules.

Click [here](#) for more information and to access our new resources for joining CAQH CORE as a Participating Organization.

Questions?



@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH 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.