CAQH CORE Participant Webinar

Overview of Operating Rules for Final CAQH CORE Vote

November 13, 2020

Logistics

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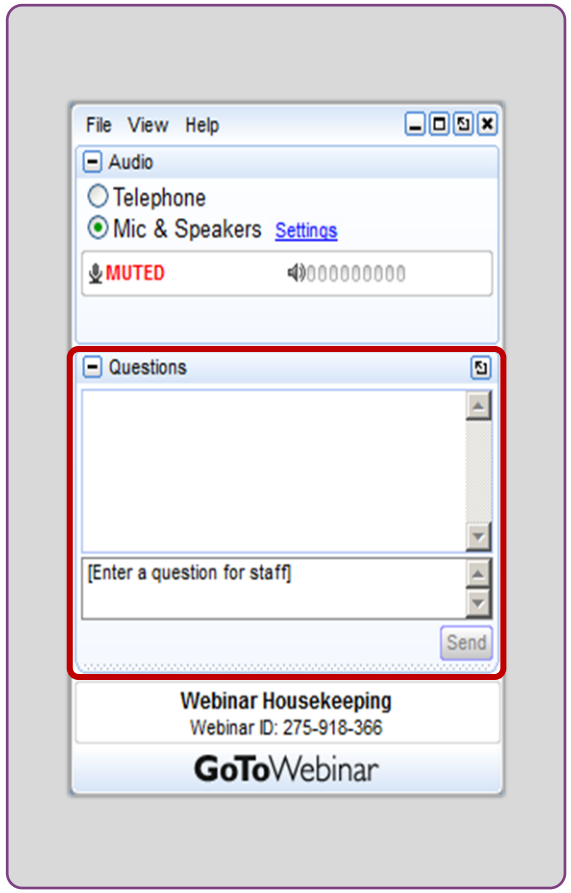

Session Outline

- CAQH CORE Voting Process Background
- Draft CAQH CORE Attribution Rules Package
  - *CAQH CORE Approach to Challenge*
  - *CAQH CORE Attribution Rule Requirements*
- Draft CAQH CORE Connectivity vC4 Rules Package
  - *CAQH CORE Approach to Challenge*
  - *CAQH CORE Connectivity vC4 Rule Requirements*
- CAQH CORE Certification Test Suites
- Next Steps: Final CAQH CORE Vote
- Q&A

Thank You to Our Speakers

Patrick Murta

Chief Interoperability Architect & Fellow, Enterprise Architecture, Humana

Co-Chair of the CAQH CORE Connectivity & Security Work Group

Erin Weber

Director

CAQH CORE

Emily TenEyck

Manager

CAQH CORE

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Manager

CAQH CORE

CAQH CORE Voting Process Background

CAQH CORE Voting Process

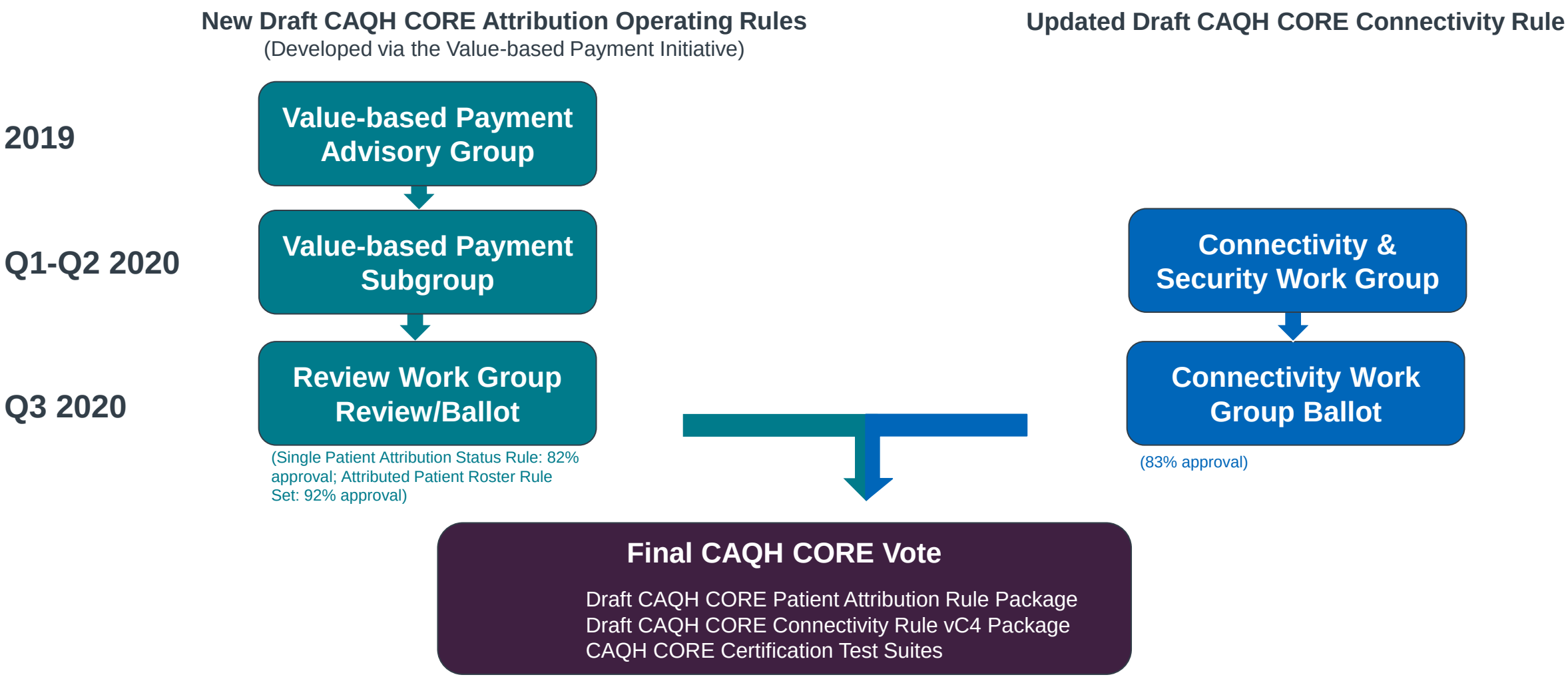
CAQH CORE Body*	CAQH CORE Requirements for Operating Rules Approval
Level 1: Subgroups & Task Groups	Formal vote is not required, but consensus is assessed via straw poll and must be achieved prior to moving to the next level of voting.
Level 2: Work Groups	Work Groups require for a quorum that 60% of all organizational participants are voting. Simple majority vote (greater than 50%) by this quorum is needed to approve a rule.
Level 3: Full Voting Membership	Full CAQH CORE Voting Membership vote requires for a quorum that 60% of all Full CORE Voting Member organizations (i.e., CAQH CORE Participants that create, transmit, or use transactions) vote on the proposed rule at this stage. With a quorum, a 66.67% approval vote is needed to approve a rule.
Level 4: CAQH CORE Board	The CAQH CORE Board's normal voting procedures would apply. If the Board does not approve any proposed Operating Rule, the Board will issue a memorandum setting forth the reasons it did not approve the proposed Operating Rule and will ask the CORE Subgroups and Work Groups to revisit the proposed Operating Rule.

*__NOTES__: Neither the CAQH CORE Board nor CAQH has veto or voting power over the CAQH CORE Operating Rules. Any entity that is a CAQH CORE participant per the CAQH CORE application process has a right to vote on the rules, understanding that **at Level 3 only entities that will *implement the rules* vote on the rules.**

Aligning Rule Development Processes

Draft Attribution Rules and Updated Connectivity Rule to be Included in Final Vote

In 2020, CAQH CORE Participants launched the CAQH CORE Voting Process for two sets of operating rules.



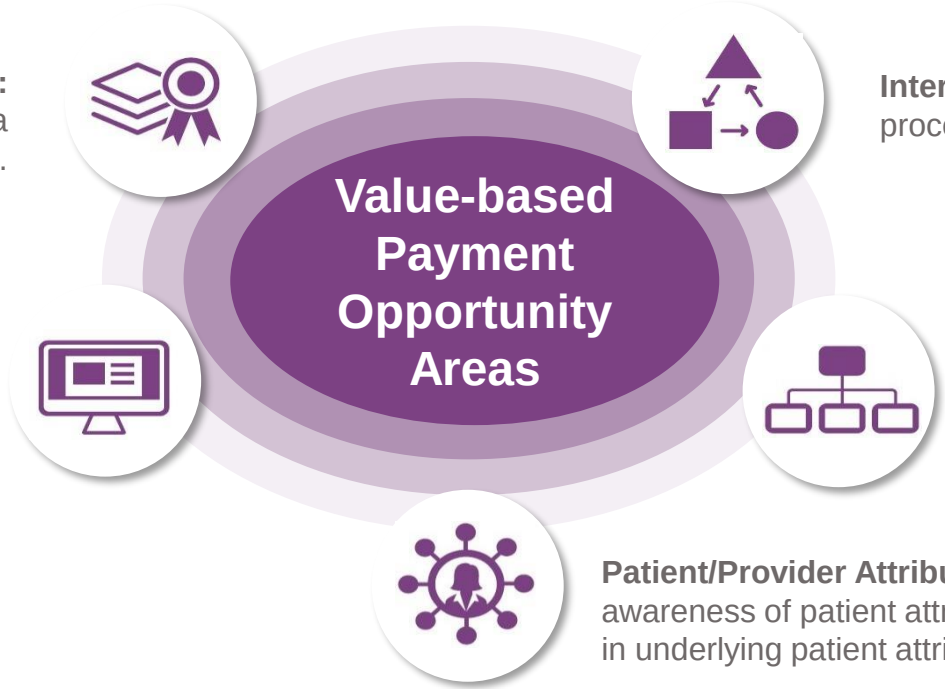
CAQH CORE Attribution Rules Package

Streamlining Adoption of Value-based Payments

CAQH CORE conducted over two years of research and identified five opportunity areas in the industry that could **smooth the implementation of value-based payments.** Stakeholders must act decisively and collaboratively to prevent value-based payment from confronting the administrative roadblocks once encountered in fee-for-service.

Data Quality & Uniformity: Standardize identifiers, data elements, transactions and code sets.

Interoperability: Define common process and technical expectations.



Quality Measurement: Educate on need for consistent and actionable quality data while considering physician burden.

Patient Risk Stratification: Promote collaboration and transparency of risk stratification models.

Patient/Provider Attribution: Improve provider awareness of patient attribution and transparency in underlying patient attribution models.

CAQH CORE VISION FOR VBP | A common infrastructure that drives adoption of value-based payment models by reducing administrative burden, improving information exchange and enhancing transparency across clinical and administrative verticals.

Value-based Payments Advisory Group Participants

In 2019, CAQH CORE launched the **VBP Advisory Group** made up of industry executives and thought leaders. Participants were charged **with prioritizing opportunity areas for CAQH CORE rule development action** (e.g. subgroup or pilot).

athenahealth

BlueCross BlueShield of North Carolina

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

edifecs

HEALTHEDGE

Humana

Marshfield Clinic Health System

DEPARTMENT OF HEALTH

Montefiore

NATIONAL QUALITY FORUM

MGMA

UnitedHealthcare

Value-based Payments Advisory Group Overview

The Advisory group began with CAQH CORE research of the five categories in VBP requiring stakeholder collaboration and looked at a list of 19 opportunity areas to prioritize for operating rule development.

The Advisory Group:

Discussed the FFS revenue cycle workflow and pain points for those participating in VBP.

Reviewed a list of 19 draft opportunity areas to address pain points and relieve administrative burden as related to VBP, which were condensed to 15.

Rated support of opportunity areas on a Likert scale from "Strongly Do Not Support" to "Strongly Support".

#1 *Ranked the opportunity areas in order of priority for a CAQH CORE Rule Development Group to pursue.*

Move Forward

- **Pursue through CAQH CORE VBP Subgroup**
  - Patient/Provider Attribution Status at Time of Eligibility Check
  - Patient Risk Identification Prior to Point of Service
- **Pursue through Potential VBP Pilot**
  - Inclusion of Expanded Code Sets on Claims

Explore

- **Explore Synergies with Current CAQH CORE PA Discovery Pilot**
  - Provider Notification of Need for Additional Documentation/ Information

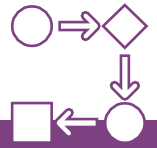
Align

- **Align with CAQH CORE Attachments Initiative**
  - Standardization of the Exchange of Additional Documentation

Value-based Payments Subgroup Initiative

Patient Attribution Challenge

Attribution matches individual patients in a population with providers, which ultimately determines the patients for which a provider (as an individual or as a group) is responsible. Attribution forms the basis of analysis for metrics underpinning VBP, such as total costs of care and quality measures.* While health plans supply attribution information on a regular basis, providers are often left with several questions:



Why are they in my population?

VBP contracts between health plans and providers may include information on the methodology for assigning patients to a population. However, clinicians providing care often do not have insight into those contracts and **may not know why a patient is in their population**, especially if it is a patient without a prior relationship.

Who is on first?

Patients may be attributed to a singular provider or a group of providers which may leave **ambiguity as to who is the primary care provider (PCP) responsible for the patient.** Furthermore, patients with chronic conditions such as heart disease may have a specialist who acts as their PCP which may or not be reflected in the attribution model.

Who else is involved?

In some VBP models, providers are penalized when patients in their population visit other providers. **Providers may not have insight as to where else their patient is seeking care.** Preventing “leakage” is a large incentive in VBP contracts, but without visibility into patient utilization, providers are often unaware when this occurs until after the contract period.

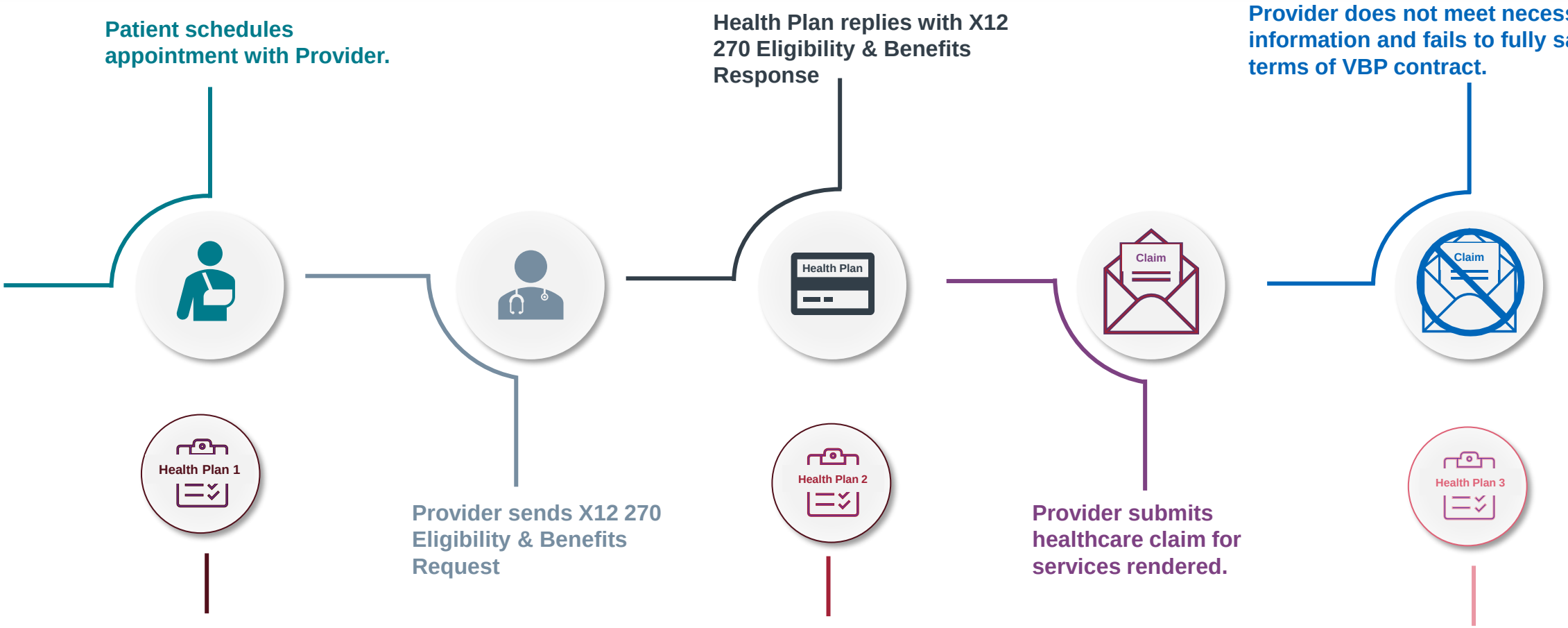
Provider success under VBP models requires knowing the answers to all these questions,
but before asking these questions a provider needs to know the answer to the most important question:

IS THIS PATIENT IN MY ATTRIBUTED POPULATION?

*National Quality Forum, 2016

Value-based Payments Subgroup Initiative

Current State of Exchanging Patient Attribution Information



CAQH CORE

Exchanging Attribution Data

Scope of CAQH CORE Value-based Payments Subgroup

The CAQH CORE Value-based Payments Subgroup (VBPSG) worked for 10 months to develop data content and infrastructure requirements for the exchange of patient attribution status for both a single patient and a roster of patients. The goal was to develop operating rules that regardless of exchange format or mechanism, will ensure providers have consistent expectations of the data content and infrastructure surrounding the exchange of patient/provider attribution status.

Standardize Data Content Requirements

Draft operating rule requirements to **standardize the data elements a health plan may request** to return patient/provider attribution **and the data elements they must return.** Data would be uniform across any exchange mechanism or format.

Improve Exchange Infrastructure

Draft infrastructure operating rules requirements to **improve the reliability** of the exchange of patient/provider attribution **through requirements such as system availability, exchange frequency, response time, acknowledgements, etc.**

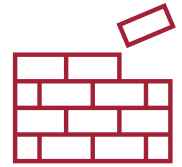
Specify Exchange Formats

Draft operating rules **for the standard and additional optional electronic exchange** of patient/provider attribution information.

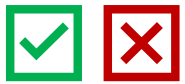
This approach was developed to meet the current industry needs. As new and emerging standards such as FHIR continue to be developed, tested and implemented, CAQH CORE will continue to monitor and coordinate with related industry initiatives to ensure alignment without duplication of efforts.

Value-based Payments Attribution Rules Package Overview

Single Patient Attribution Status Data Content Rule



Builds upon the mandated CAQH CORE Eligibility & Benefits (270/271) Data Content and Infrastructure Rules.



Requires a health plan (or its agent) to return the **patient attribution status (yes/no/partial) and effective dates of attribution**.

Attributed Patient Roster Rule Set

Data content rule **standardizes the minimum data elements a health plan must return** to identify patients within the VBP population, including a VBP contract name and effective dates of attribution.

Infrastructure rule **standardizes expectations for exchange** and **requires health plans to send providers an updated attributed patient roster** (including updated dates of effective attribution) **at least once per month.**

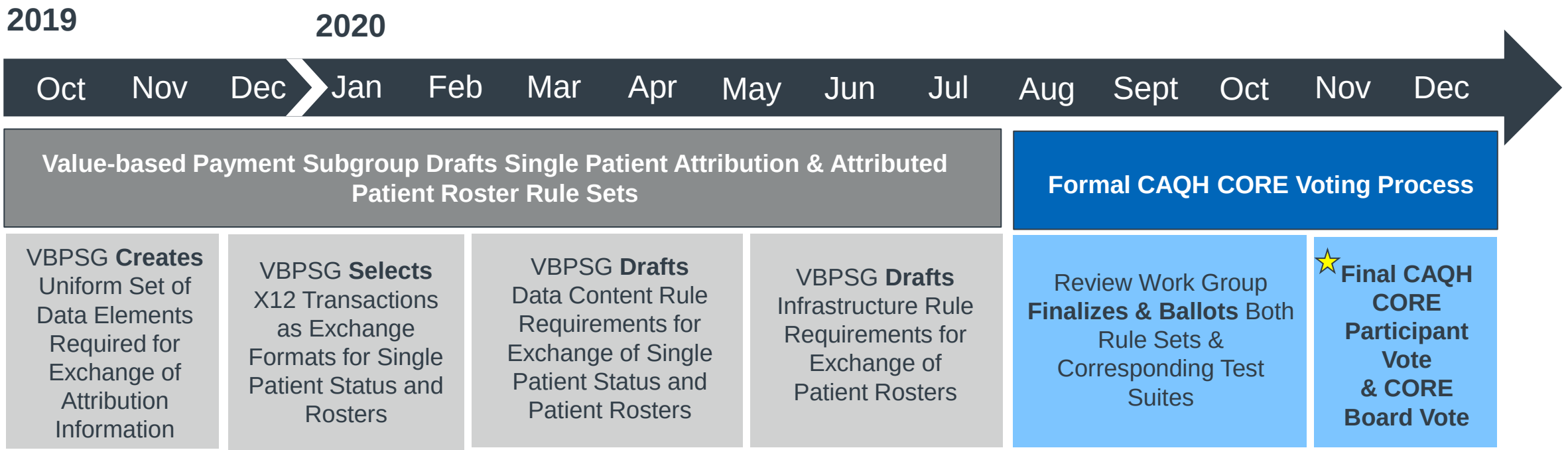
Value-based Payments Subgroup Initiative

Special Thanks to our Co-chair

Troy Smith
Vice President Healthcare Strategy and Payment Transformation,
BlueCross BlueShield North Carolina

Over 50 CAQH CORE Participating Organizations, consisting of a diverse set of stakeholder types, participated in the Value-based Payments initiative.

Timeline for the Value-based Payment Attribution Rule Sets



***NOTE**: Timeline may be subject to adjustments based on CAQH CORE Participant needs*.

In 2021 CAQH CORE will also launch a Quality Measures Reporting Pilot CAQH CORE will develop a Pilot & Measurement Initiative to test the use of expanded code sets (e.g., LOINC or CPT II Codes) with healthcare claims to convey non-service-related clinical information, such as outcomes measures, to reduce physician reporting burden. For more information on this pilot or to inquire about participating please contact CORE@caqh.org.

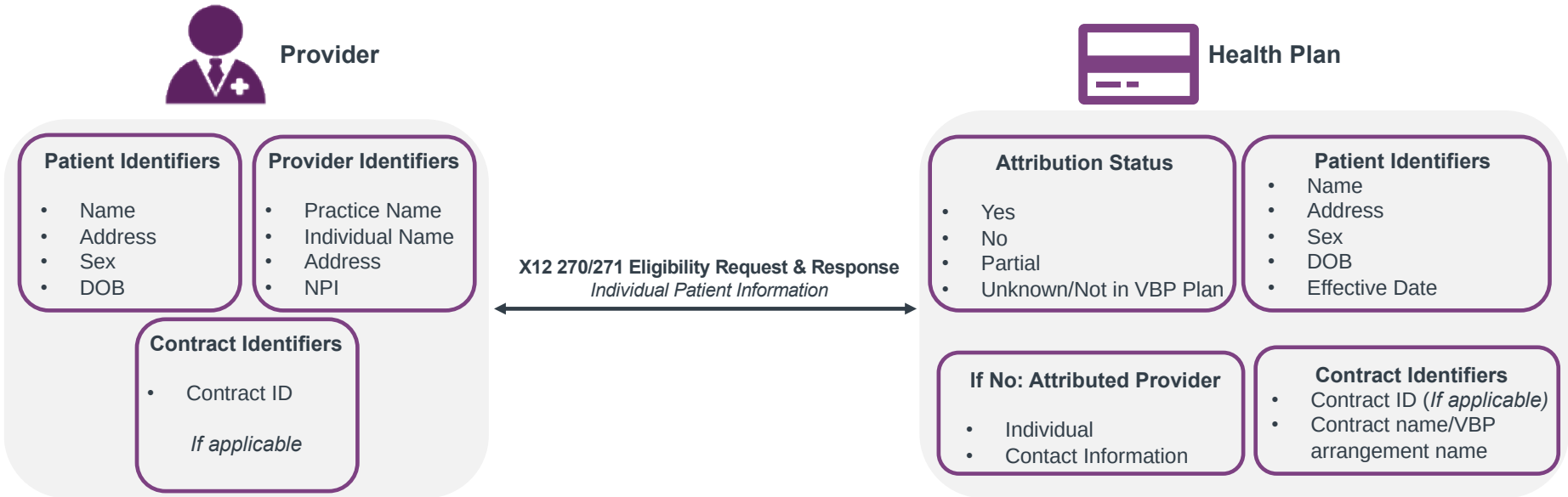
CAQH CORE Attribution Rules Package: Detailed Requirements

- Eligibility & Benefits (X12 270/271) Single Patient Attribution Status Data Content Rule
- Attributed Patient Roster (X12 005010X318 834) Data Content & Infrastructure Rules

Exchanging Attribution Status of a Single Patient

Using the X12 270/271 Transactions

The Eligibility Benefit & Verification Transaction is the most common administrative transaction conducted between a provider and a health plan. The Draft CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule builds on existing mandated eligibility operating rules to **provide the attribution status of a single patient through expanded data content returned in an Eligibility & Verification Response.**



With an industry adoption rate of 84% for eligibility inquiries, the X12 270/271 transactions create a consistent pathway for providers to receive a single patient's attribution status. Use of these transactions will also help bridge the gap by meeting providers' needs now as the industry continues to pilot and test new and emerging standards and technology.

Source: 2019 CAQH Index

CAQH CORE

Exchanging Attribution Status of a Single Patient

Building on Current CAQH CORE Operating Rules

The CAQH CORE Eligibility Operating Rules, which are federally mandated, set requirements for data content, infrastructure and connectivity when using the X12 270/271 transactions. The Draft CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule builds upon this set through **additional data content requirements for the return of patient attribution status for specific use cases.**

CAQH CORE Eligibility & Benefits Operating Rule Requirements for 271 Response

Data Content	
#	**Rule Requirement**
1.	Return of Health Plan Name
2.	Return of Patient Financial Responsibility (Including co-insurance, co-payment, deductibles and remaining deductibles)
3.	Return of Eligibility Dates
4.	Return of In/Out of Network Variances

Infrastructure	
#	**Rule Requirement**
1.	Use of v5010 999 and 271 for Acknowledgements (Batch and Real Time)
2.	Standard Flow and Format of Companion Guides
3.	Overnight Batch Response Requirement
4.	20-second Real Time Response Requirement
5.	Minimum 86% System Availability Requirement

Connectivity	
#	**Rule Requirement**
1.	HTTP/S Transport Method
2.	Standard Flow and Format of Companion Guides
3.	SOAP and Digital Certificates and Clinical/Administrative Alignment

Exchanging Attribution Status of a Single Patient

When Rules Requirements Apply

The VBPSG decided to limit the scope of this data content operating rule to only VBP models that cover most patient services. The VBPSG agreed that a limited scope applying to the simplest VBP models would enable more rapid adoption and implementation of the operating rule, while allowing more mature organizations to pilot expanded use cases which could serve as real world evidence for further rule development.

Rule Requirements Apply When:

- The individual is located in the health plan's (or information source's) eligibility system **AND**
- A health plan conducts provider attribution status for the support of an overall value-based contract pertaining to most patient services (i.e. HCPLAN category three and four alternative payment models excluding episode and service specific models)* **AND**
- A health plan (or information source) receives a generic v5010 270 **OR** A health plan (or information source) receives an explicit v5010 270 for a specific service type required in the CAQH CORE Eligibility& Benefits (270/271) Data Content Rules.**

Rule Requirements *Do Not* Apply When:

- A health plan conducts provider attribution status for the support of value-based contracts associated with specific episodes or bundled payments **OR** provider attribution status for the support of quality measurement.

*Category Three APM: Based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category Three payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. ; Category Four APM: Involve prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care; https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

**There are 50+ service type codes required by the Phase I - II Eligibility Rules that can be found here. Examples include medical care, hospital-inpatient, hospital-outpatient, home health care etc.

Exchanging Attribution Status of a Single Patient

Rule Requirements

The Draft CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule consists of **three rule requirements** which enable the return of patient attribution information in the X12 271 Response.

Rule Requirement 4.1: ***Basic Requirements for Providers, Information Receivers, Health Plans & their Agents***

- Requires conformance with current Eligibility & Benefits Operating Rule Set..

Rule Requirement 4.2: ***Identification of Subscriber/Dependent Attribution***

- Requires return of explicit attribution status and effective dates of attribution for each of the CORE service type codes required by the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule submitted in a X12 270 Request.

- Requires a health plan and its agent to develop and make available to the healthcare provider specific written instructions and guidance for the healthcare provider on its implementation of this operating rule and the following definitions of attribution and attribution status:

Attribution Status	Definition
Attribution Status: Yes	Patient is attributed to requesting provider.
Attribution Status: No	Patient is not attributed to requesting provider. If determined permissible by counsel, health plan and its agent should return the contract Single Patient Attribution Data including attributed provider information (e.g. provider name, NPI and address).
Attribution Status: Partial	Patient is attributed to more than one provider, including the requesting provider. If determined permissible by counsel, health plan and its agent should return the contract Single Patient Attribution Data including attributed provider information (e.g. provider name, NPI and address).
Attribution Status: Not Applicable	Patient attribution does not apply. Patient does not belong to a value-based care population.

Rule Requirement 4.3: ***Attribution Basic Requirements for Receivers of the X12 271 Response***

- Requires a product extracting the data from the X12 271 Response for manual processing to make available to the end user the exact wording of the text included in the MSG segment.

CAQH CORE Attribution Rules Package: Detailed Requirements

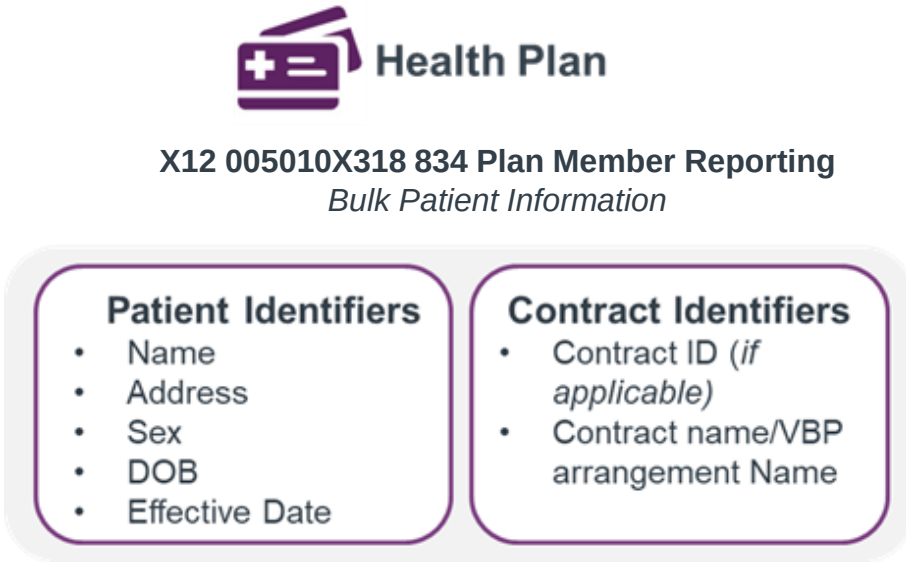
- Eligibility & Benefits (X12 270/271) Single Patient Attribution Status Data Content Rule
- Attributed Patient Roster (X12 005010X318 834) Data Content & Infrastructure Rules

Exchanging Attributed Patient Rosters

Using the X12 00510X318 834 Transaction

The Attributed Patient Roster Rule Set defines data content and infrastructure requirements for health plans to supply providers with regular patient roster updates in a standard electronic format. This bulk data exchange will replace cumbersome excel file downloads from FTP sites and allow for more seamless integration into the provider's existing workflow.

- Of the three versions of the X12 834 Benefit Enrollment transaction, the VBPSG chose to develop operating rules for the **X12 005010X318 834 Plan Member Reporting** transaction as it was designed to support the transfer of member information both directly to providers and through intermediaries such as clearinghouses and value-added networks.
- The Attributed Patient Roster Rule Set specifies the loops, segments, and data elements to be used in the X12 v5010X318 834 transaction to send a providers a current list of attributed patients.
- Using a standard data set across all health plans reduces implementation costs and provider burden across the industry.



CAQH CORE

Exchanging Attributed Patient Rosters

When Rules Requirements Apply

As with the attribution data for a single patient, the VBPSG decided to draft this operating rule to apply only to the simplest types of attribution – those applying to population-based models that cover the majority of patient services. Through adoption and implementation of this operating rule, CAQH CORE hopes to gather real world evidence to allow the expansion of this operating rule to include all types of value-based payment models.

Rule Requirements Apply When:

- A health plan and its agent make available to a provider a complete roster of patients attributed to a specific value-based contract **AND**
- A health plan conducts provider attribution status for the support of an overall value-based contract pertaining to most patient services (i.e. HCPLAN category three and four alternative payment models excluding episode and service specific models).*

Rule Requirements *Do Not* Apply When:

- A health plan conducts provider attribution status for the support of value-based contracts associated with specific episodes or bundled payments **OR** provider attribution status for the support of quality measurement.

*Category Three APM: Based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category three payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. ; Category Four APM: Involve prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care; https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

**There are 50+ service type codes required by the Phase I - II Eligibility Rules and can be found here. Examples include medical care, hospital-inpatient, hospital-outpatient, home health care etc.

Exchanging Attributed Patient Rosters

Data Content Rule Requirements

The Draft CAQH CORE Attributed Patient Roster (0050510X318 834) Data Content Rule consists of **three rule requirements.**

Rule Requirement 4.1: ***Basic Requirements for Providers, Information Receivers, Health Plans & their Agents***

- Requires conformance with current published and adopted CAQH CORE Connectivity Rule.
- Requires a health plan or its agent delivering a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to
  - Identify the provider receiving the roster
  - Identify the Subscribers and Dependents covered by the value-based health plan

Rule Requirement 4.2: ***Identification of Health Plan Contract***

- Requires a health plan or its agent delivering a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to identify the details of the value-based health plan.

Rule Requirement 4.3: ***Identification of Attributed Provider for Subscriber/Dependent***

- Requires a health plan or its agent delivering a current roster of patients covered by the VBP contract using the X12 v5010X318 834 transaction to return the appropriate Attributed Provider Information for each Subscriber and Dependent.

Exchanging Attributed Patient Rosters

Drafting an Infrastructure Rule for the X12 00510X318 834 Transaction

While CAQH CORE does offer an infrastructure rule for the X12 005010X220 834 Benefit Enrollment Transaction, the differences in the directionality of the transaction from the X318 834 Plan Member Reporting transaction required a new infrastructure rule specific to this use case.

Benefit Enrollment (X12 005010X220 834) Transaction

Transaction is a one way "push" from an employer to a health plan, therefore infrastructure requirements sit on both sides of the transaction – both for the sender and recipient.

Attributed Patient Roster (X12 005010X318 834) Transaction

Transaction is a one way "push" from a health plan to a provider where the provider then picks up the transaction from a mailbox. Therefore infrastructure requirements sit only on the transaction sender and not the recipient.

This small but important difference makes the Attributed Patient Roster transaction more like the Electronic Remittance Advice (835) transaction. This required updates to the rule language to reflect that only batch processing applies as it is a transaction "pick-up" and that there are no rule requirements on the transaction recipient.

Exchanging Attributed Patient Rosters

Infrastructure Rule Requirements

The Draft CAQH CORE Attributed Patient Roster (0050510X318 834) Infrastructure Rule generally aligns with all other CAQH CORE Infrastructure Rules.

The VBPSG also drafted a monthly exchange requirement, specifying a minimum frequency for health plans to make updated rosters available.

#	Rule Requirement	Requirement Description
1.	**Connectivity**	Requires conformance with the most current version of the CAQH CORE Connectivity Rule
2.	**System Availability**	Requires health plans and their agents to adhere to 86% system availability per calendar week and specifies reporting requirements
3.	**Acknowledgements**	Requires receivers to return X12 v5010 999 Implementation Acknowledgement
4.	**Companion Guide**	Published companion guides must follow CAQH CORE v5010 Master Companion Guide Template
5.	**NEW for Attribution: Monthly Exchange Requirement**	Requires health plans and their agents to make an updated patient roster available via the X12 v5010X318 834 transaction at least once per month. Updated patient rosters must also include updated effective dates of attribution where applicable.

Value-based Payments Subgroup Initiative

Impact of Draft Rules

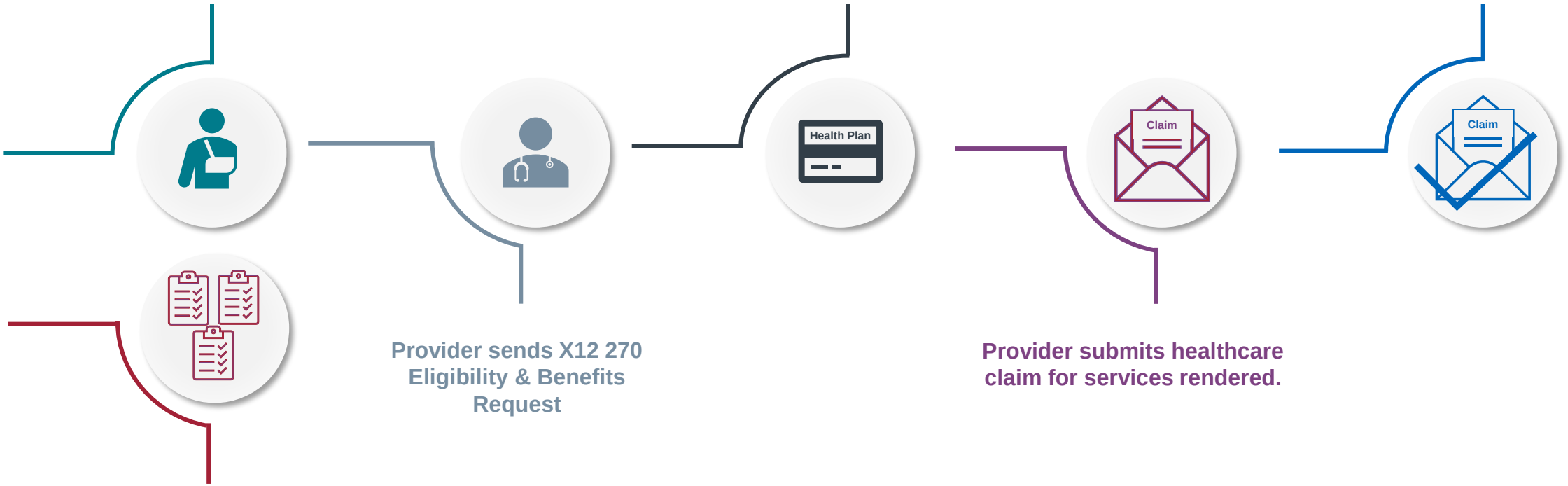
Patient schedules appointment with Provider.

Provider sends X12 270 Eligibility & Benefits Request

Health Plan replies with X12 270 Eligibility & Benefits Response conforming to the Single Patient Attribution Status Data Content Rule.

Provider submits healthcare claim for services rendered.

Health Plan adjudicates claims payment at end of fiscal year.



Provider receives monthly patient rosters 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.

CAQH CORE

Draft CAQH CORE Connectivity Rule vC4.0.0

Overview of the CAQH CORE Connectivity Initiative

The CAQH CORE Connectivity Rules address connectivity and security of administrative and clinical data exchange and establish a national base guiding healthcare communication.

CORE Connectivity Roadmap: Increased Interoperability and Improved Connectivity & Security

Existing

CAQH CORE Connectivity Versions C1 & C2
Federally Mandated for *CORE Eligibility and Claim Status Transactions*

Standardized transport allowed for greater online access due to uniformity in transport protocols.

Requirements were developed more than ten years ago; no longer align with industry best practices for connectivity and security.

CAQH CORE will sunset vC1 and vC2 if vC3 is federally mandated.

Currently Before NCVHS

CAQH CORE Connectivity Version C3
Applies to *all transactions currently addressed by CAQH CORE Operating Rules*

CAQH CORE has proposed vC3 for federal mandate to replace vC1 and vC2 for eligibility, claim status and ERA and support prior authorization.

Mandate would create a base connectivity protocol across all transactions; requires single transport & envelope standard, robust authentication and security standards and specific metadata.

Future Update

CAQH CORE Connectivity Version C4
Under Development
Will Apply to *all transactions addressed by CAQH CORE Operating Rules including claim and PA attachments rules in development.*

Supports clinical and administrative data exchange. Updates and aligns CAQH CORE connectivity & security requirements to support REST and other API technology.

CAQH CORE Board may propose future updates to the federally mandated connectivity requirements to align with vC4.

CAQH CORE Participants will continue to **update and maintain the Connectivity Rule at regular intervals** over time to align with current interoperability, privacy and security standards**.**

CAQH CORE Connectivity Update

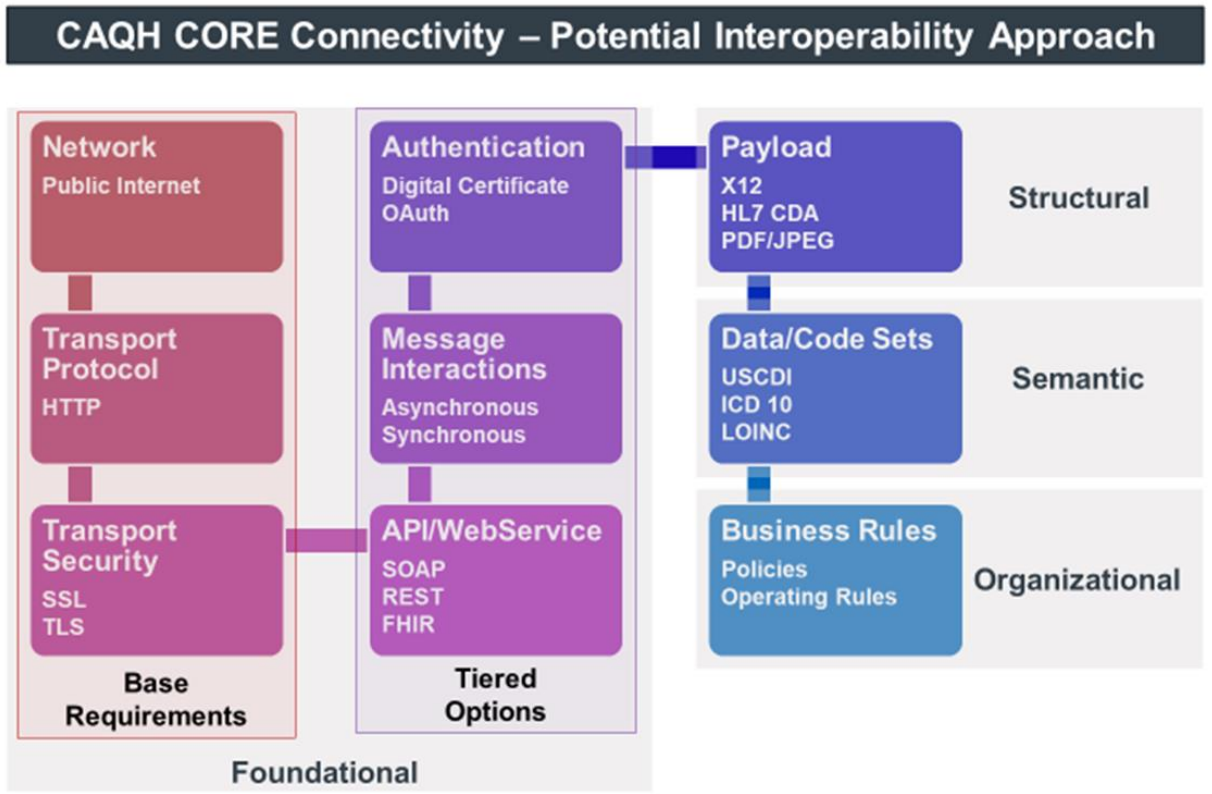
CAQH CORE Connectivity Approach to Interoperability

CAQH CORE Connectivity Rule vC4 Goals:

- Align the CAQH CORE Connectivity Rule vC4 to support frameworks proposed in the **CMS and ONC interoperability rules.**
- Establish a **Safe Harbor** that aligns with existing IT implementations and supports emerging approaches for exchanging data.
- Develop **single, uniform Connectivity Rule** that support the intersection of administrative and clinical data exchange.

Key Updates to CORE Connectivity Requirements:

- Require the use of **TLS v1.2 higher for security** over the public internet for increased security.
- Define **authentication and authorization methods** to establish trust within an exchange including the addition of **OAuth 2.0** as an authorization standard.
- Add support and requirements pertaining to **REST APIs** including specifying **API endpoint naming conventions and versioning** to ensure CORE Connectivity serves as a bridge between existing and emerging standards.
- Add support for the exchange of **attachments transactions** to advance the intersection of clinical and administrative interoperability.



CAQH CORE Connectivity & Security Work Group

Special Thanks to our Co-chairs

Patrick Murta
Solutions Architect Fellow, Humana

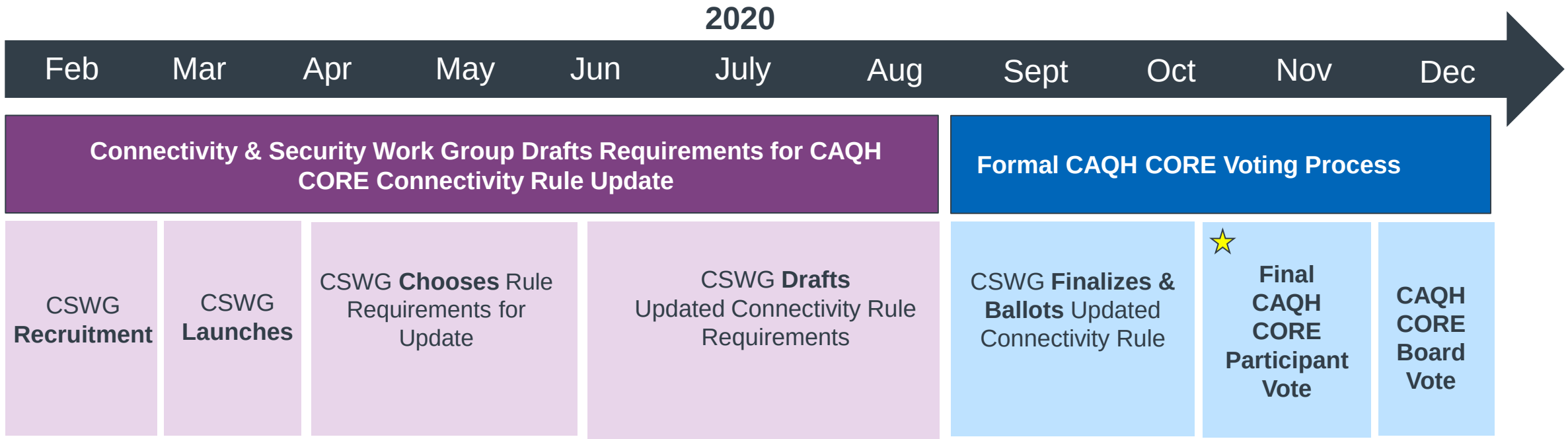
Michael Privat
Vice President Digital Cloud Migration, Availity

Megan Soccorso
Business Product Senior Specialist, Cigna

Over 25 CAQH CORE Participating Organizations, consisting of a diverse set of stakeholder types, participated in the Connectivity & Security development process.

CAQH CORE Connectivity & Security Update Roadmap

Overall Timeline



***NOTE**: Timeline may be subject to adjustments based on CAQH CORE Participant needs*.

CAQH CORE Connectivity Rule vC4.0.0

- Updates to SOAP Requirements
- New REST Requirements

Summary of Key Updates to SOAP Requirements

Scope: The rule applies to SOAP requirements when trading partners exchange **any X12 transactions specified in CAQH CORE Operating Rules.** The scope for the SOAP and REST requirements are identical and therefore are only included once in the rule (Section 3).

NOTE: The uniform rule remains payload agnostic, meaning that the SOAP and REST services are not aware of the content they are serving, and the rule may be applied to non-X12 payload types (e.g., HL7 C-CDA, .pdf, .doc, etc.).

Key Updates to SOAP Requirements			
#	**Connectivity Area**	**CORE Connectivity Rule vC3.1.0 SOAP Requirements**	**CAQH CORE Connectivity Rule vC4.0.0 SOAP Requirements**
1	**Network**	Public Internet	**No Changes**
2	**Transport Protocol**	HTTP/S	**No Changes**
3	**Security**	SSL 3.0 or TLS 1.1. or higher	**TLS 1.2 or higher (remove SSL 3.0)**
4	**Message Protocol**	SOAP + WSDL; XML	**No Changes**
5	**Authentication**	X.509 Digital Certificate	**No Changes**
6	**Authorization**	N/A	**Add support for OAuth 2.0**
7	**Web Services: SOAP**	Payload Types	**Add support for X12 275 v6020**
		Processing Modes: Real Time and Batch	**No Changes**
		Message Envelope Structure	**No Changes**
		Envelope Metadata	**No Changes**
		Communication of Errors and Status	**No Changes**

CAQH CORE Connectivity vC4.0.0 SOAP Requirements

Deep Dive: SOAP Authentication and Authorization Requirements

Authentication Requirement: The rule requires HIPAA-covered entities and their agents, including health plans and healthcare providers and their respective agents, to support the use of X.509 Mutual Authentication over TLS 1.2 or higher when exchanging messages using SOAP.

- ✓ **Applies to** HIPAA-covered health plans and providers
- ✓ **No change** from CAQH CORE Connectivity Rule vC3.1.0

Authorization Requirement: The rule requires HIPAA-covered health plans and their agents to support OAuth 2.0 Client Authorization over TLS 1.2 or higher. HIPAA-covered providers and their agents may *optionally* use OAuth 2.0 Client Authorization over TLS 1.2 or higher when exchanging messages using SOAP.

- ✓ **Applies to** HIPAA-covered health plans
- ✓ **Optionally Applies to** HIPAA-covered providers
- ✓ **New Requirement** in CAQH CORE Connectivity Rule vC4.0.0

CAQH CORE Connectivity Rule vC4.0.0

- Updates to SOAP Requirements
- New REST Requirements

CAQH CORE Connectivity vC4.0.0 REST Requirements

Summary of Key REST Requirements

Scope: The rule applies to REST requirements when trading partners exchange **any X12 transactions specified in CAQH CORE Operating Rules.** The scope for the SOAP and REST requirements are identical and therefore are only included once in the rule (Section 3).

NOTE: The uniform rule remains payload agnostic, meaning that the SOAP and REST services are not aware of the content they are serving, and the rule may be applied to non-X12 payload types (e.g., HL7 C-CDA, .pdf, .doc, etc.).

Key REST Requirements		
#	**Connectivity Area**	**REST Standards and Requirements**
1	**Network**	Public Internet
2	**Transport Protocol**	HTTP/S
3	**Security**	TLS 1.2 or higher
4	**Authentication**	X.509 Digital Certificate
5	**Authorization**	OAuth 2.0
6	**Web Services: REST**	Message Protocol
		Payload Types
		Versioning
		HTTP Methods
		Error Handling
		API Endpoints

REST standards and requirements **align with updated SOAP** standards and requirements

New REST Requirement Connectivity Areas

CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: REST API Interface Format, Authentication and Authorization Requirements

REST API Format: The rule requires the use of **JavaScript Object Nation (JSON) for REST Interfaces** to reduce variations and enable greater interoperability in the market.

Authentication Requirement: The rule requires HIPAA-covered entities and their agents, including health plans and healthcare providers and their respective agents, to support the use of X.509 Mutual Authentication over TLS 1.2 or higher when exchanging messages using REST.

- ✓ **Applies to** HIPAA-covered health plans and providers
- ✓ **New Requirement** in CAQH CORE Connectivity Rule vC4.0.0
- ✓ **Mirrors** SOAP Authentication Requirement

Authorization Requirement: The rule requires HIPAA-covered entities and their agents to support OAuth 2.0 (mutual client based authorization) over TLS 1.2 or higher when exchanging messages using REST.

- ✓ **Applies to** HIPAA-covered health plans and providers
- ✓ **New Requirement** in CAQH CORE Connectivity Rule vC4.0.0
- ✓ **Differs** from SOAP Authorization Requirement

CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: REST Versioning Requirements

URI Versioning is explicit, enables version navigation and discovery, and simplifies version management.

1. **Versioning** for REST APIs should be **maintained via the URI Path.**

2. To communicate the use of the Safe Harbor method, **versioning for the CAQH CORE Connectivity Rule** should be maintained via the URI Path.

HTTP Method	Server	CAQH CORE Connectivity Rule	REST API Version
POST	https://www.acmehealthplan.com	/caqhcorevC4.0.0	/v1

The text highlighted in yellow refers to a modifiable variable for versioning management.

CAQH CORE

CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: Specifications for API Endpoint Naming Conventions (Normative)

1. The REST requirements specify that each X12 transaction set and non-X12 payload types point to a specific endpoint.

2. API Endpoints should follow a normative naming convention.

HTTP Method	Server	CAQH CORE Connectivity Rule	REST API Version	Endpoint Name
POST	https://www.acmehealthplan.com	/caqhcorevC4.0.0	/v1	/eligibility

The text highlighted in green below refers to a **modifiable endpoint variable** (green highlighted column) and can be interchanged with the appropriate endpoint, which will be dependent on the specific transaction being exchanged.

#	Payload Type	Transaction Name	Endpoint Name (normative)
1	X12_270_005010X279A1	Health Care Eligibility Benefit Inquiry and Response	eligibility
2	X12_275_006020X314	Additional Information to Support Health Care Claim or Encounter	claimAttachment
3	X12_275_006020X316	Additional Information to Support Health Care Services Review	paAttachment
4	X12_276_005010X212E1_2_3	Health Care Claim Status Request and Response	claimStatus
5	X12_277_005010X213	Health Care Claim Request for Additional Information	claimStatusRFAI
6	X12_277_006020X313	Health Care Claim Request for Additional Information	claimStatusAI
7	X12_277_005010X214E1_2	Health Care Claim Acknowledgment	claimStatusCA
8	X12_278_005010X217E1_2	Health Care Services Review – Request and Response	servicesReview
9	X12_278_005010X215	Health Care Services Review – Inquiry and Response	servicesReviewIR
10	X12_278_005010X216E2	Health Care Services Review – Notification and Acknowledgment	servicesReviewNA
11	**X12_820_005010X218A1**	Payroll Deducted and Other Group Premium Payment for Insurance Products	payrollDeducted
12	**X12_834_005010X220A1**	Benefit Enrollment and Maintenance	benefitEnrollment
13	X12_834_005010X307	Health Insurance Exchange Enrollment	exchangeEnrollment
14	X12_834_005010X318	Plan Member Reporting	memberReporting
15	X12_835_005010X221	Health Care Claim Payment / Advice	remittanceAdvice
16	**X12_837_005010X223**A1_2	Health Care Claim – Institutional	claimInstitutional
17	**X12_837_005010X222**A1	Health Care Claim – Professional	claimProfessional
18	**X12_837_005010X224**A1_2	Health Care Claim – Dental	claimDental
19	X12_999_005010X231A1	Implementation Acknowledgement for Health Care Insurance	ackNack
20	X12_TA1_Response_00501X231A	Interchange Acknowledgment Segment	iaAckNack

CAQH CORE Connectivity vC4.0.0 REST Requirements

Deep Dive: REST Metadata Parameter Fields, Descriptions, Intended Use and Values

1. The parameters specified in the tables below **pertain to the REST exchange only**.

2. These **parameters serve as a base** of what is required by the CORE REST Requirements. **Entities may include additional parameters**, as needed.

Metadata	Description	Requirement	Values	Example
HTTP Request Metadata				
Accept	Media type(s) that is/are acceptable for the response.	Mandatory	application/json	**Accept**: application/json
Authorization	Authorization credentials for HTTP authorization.	Mandatory	A valid OAuth 2.0 token.	**Authorization**: Bearer [Access Token]
Content-Type	The Media type of the body of the request.	Mandatory	application/json	**Content-Type**: application /json
Date	The date and time at which the message was originated.	Mandatory	HTTP-date format[i]	**Date**: Tue, 23 Jun 2020 08:12:31 UTC
Host	The domain name of the server	Mandatory	server domain	**Host:** https://www.acmehealthplan.com

Metadata	Description	Requirement	Field Constraints or Value-sets	Example
HTTP Response Metadata				
Content-Type	The media type of the response content.	Mandatory	application/json	**Content-Type**: application/json
Date	The date and time at which the message was originated.	Mandatory	HTTP-date format	**Date**: Tue, 23 Jun 2020 08:12:31 UTC
Last Modified	The last modified date for the requested object.	Mandatory	HTTP-date format	**Date**: Tue, 23 Jun 2020 08:12:31 UTC
Status Code	The Status line in the HTTP response indicates whether the server responded to the request successfully, or if there was an error.	Situational: When a request is successful or fails, the resource server must responds using the appropriate HTTP status code.	Please see Section 4.3.6.1 for a definition of status and error codes.	**Status**: 401
WWW-Authenticate	Defines the authentication method that should be used to gain access to a resource.	Situational: If the protected resource request does not include authentication credentials or does not contain an access token that enables access to the protected resource, the resource server MUST include the HTTP WWW-Authenticate response header field	HTTP Bearer Authorization Scheme[i]	**WWW-Authenticate:** Bearer

Draft CAQH CORE Connectivity vC4.0.0

Safe Harbor: Connectivity Supported by Stakeholder Type

Like previous CAQH CORE Connectivity Rules, this rule update is a **Safe Harbor** and the following conformance requirements will apply to stakeholders that choose to implement the CAQH CORE Connectivity Rule vC4.0.0 (which includes both SOAP and REST requirements):

1. **Health Plans or Clearinghouses (Server) must support all connectivity methods (SOAP and REST).**
2. **Providers or Vendors (Client) must support at least one connectivity method (SOAP or REST).**

NOTE: While trading partners may also choose to utilize another connectivity method that is mutually agreeable, **if the trading partner insists on using the CORE Safe Harbor, that request must be accommodated**.

Summary of CAQH CORE Connectivity Update

The Draft CAQH CORE Connectivity Rule vC4.0.0 is a single, uniform Connectivity Rule that support administrative and clinical data exchange. The rule updates and aligns CAQH CORE connectivity & security requirements to support REST and other API technology, building upon prior versions of CAQH CORE Connectivity.

Existing: CAQH CORE Connectivity Rule vC.3.1.0

Establishes a Safe Harbor Connectivity Method that drives industry alignment by converging on common Connectivity standards and requirements.

Key Connectivity vC3.1.0 SOAP Requirements:

- Support for **Simple Object Access Protocol (SOAP)*** based web services with specific metadata, message structure, and error handling
- Use of **HTTPS* (SSL 3.0, or optionally TLS 1.1 or higher** for compliance with FIPS 140-2 TLS 1.1 or higher in lieu of SSL 3.0) over the **Public Internet TCP/IP***
- Establishes a **Safe Harbor** Connectivity Method*
- **X.509 Digital Certificate** Submitter Authentication (mutual authentication)*

***** Continue to be supported in the Draft CAQH CORE Connectivity Rule vC4.0.0

Update: Draft CAQH CORE Connectivity Rule vC.4.0.0

The updates to CORE Connectivity will serve as a bridge between the existing and emerging standards and protocols to ensure industry interoperability needs are met.

Updates to CORE Connectivity vC3.1.0 SOAP Requirements:

- Add support for the exchange of **Attachments transactions**
- Specify **TLS 1.2 or higher** for security
- Add **OAuth 2.0** as an authorization standard

New REST Requirements:

- Support for **REST** style web resources for X12 and non-X12 exchanges.
- Use of **JSON** to exchange REST messages
- Support for specific **HTTP Methods (e.g. POST and GET)**
- Support for **REST API and CORE Connectivity Rule Versioning**
- Use of specific **HTTP Error/Status Codes** and specifications **for REST Error Handling**
- Specify **API Endpoint Naming Conventions**

Future Connectivity Opportunities: Once a single Connectivity Rule is established across all CAQH CORE operating rule sets, CAQH CORE Participants will continue to update the rule to align with current interoperability, privacy and security standards.

CAQH CORE

CORE Certification Test Suites

CORE Certification – Industry Gold Standard

Developed by CAQH CORE Participants for Industry to Promote Adoption

The CORE Certification program was developed by **CAQH CORE Participants,** including health plans, providers, vendors, government agencies and associations, to promote industry-wide adoption of operating rules for the HIPAA-covered administrative transactions.

CORE Certification provides **assurance** to organizations that their IT systems/products conform to operating rules and deliver value afforded by the rules.

CORE Certification provides an end-to-end testing suite that is **robust**, **comprehensive** and **complementary** across all operating rules.

381

certifications have been awarded.

aetna

Harvard Pilgrim HealthCare

MAYO CLINIC

CHANGE HEALTHCARE

DELTA DENTAL

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

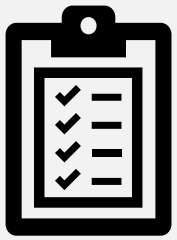
Department of Veterans Affairs

CVS caremark

athenahealth

CAQH CORE

CORE Certification Test Suite Updates



The CAQH CORE Certification Test Suite defines testing and evaluation criteria for organizations seeking to demonstrate that they have successfully implemented operating rule requirements.

- **Value Based Payment Initiative:**
  - **Update to the Eligibility & Benefits CAQH CORE Certification Test Suite**: Addition of new test scenarios to test and certify implementations of the CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule.
  - **Attributed Patient Roster CAQH CORE Certification Test Suite**: Development of a new test suite to test and certify implementations of the CAQH CORE Attributed Patient Roster (0050510X318 834) Infrastructure and Data Rules.

- **CAQH CORE Connectivity:**
  - CORE Certification Testing requirements for connectivity and security are **incorporated across all CAQH CORE Certification Test Suites** for each set of published CAQH CORE Operating Rules. There is no stand-alone CAQH CORE Certification Test Suite for CAQH CORE Connectivity Rules.
  - Since the CAQH CORE Connectivity Rule v4.0.0 is an update to the CAQH CORE Connectivity Rule vC3.1.0, **CAQH CORE will revise existing connectivity-based certification test scripts** to add components of the CAQH CORE Connectivity Rule v4.0.0.

Next Steps:
CAQH CORE Final Vote

Final Vote for Full CAQH CORE Voting Participating Organizations

Due by Friday 12/04/20

Vote Overview:

- **Who:** Primary representatives and contacts engaged in Phase IV Rule Update Development from Full CAQH CORE Voting Participating Organizations (i.e. entities that create, transmit, or use healthcare administrative data) in good standing received the Official Final CORE Vote Ballot.

- **What:** For the draft Connectivity Rule and Value-based Payments Rules being balloted, organizations will be asked to select “Support", “Do Not Support", or "Abstain" to indicate whether or not your organization **supports the two Rule Packages**:
  - **Draft CAQH CORE Connectivity Rule vC4.0.0**
  - **Draft CAQH CORE Patient Attribution Rules**
- **When:** Voting representatives from each voting participating organization in good standing received the Official Final CORE Vote Ballot **Monday, 11/16/20.** The ballot will be open until **close of business Friday, 12/04/20.**

How to Complete your Organization’s Ballot:

- A submission link will be sent out to organizations on Monday, 11/16/20 and must be completed **by close of business Friday, 12/04/20.**
- The vote is to be submitted by CAQH CORE Participants only; please coordinate to submit one response for your organization.
- The results of the Final CAQH CORE Vote will be shared via email following the balloting period.
- NOTE: In accordance with CAQH CORE Policy, all responses will be kept strictly confidential and will be reported in aggregate.

If you have any questions, please contact us at CORE@CAQH.org.

Overview of Operating Rules for Final CAQH CORE Vote

Draft CAQH CORE Attribution Rules

Single Patient Attribution Status Data Content Rule:

- Builds upon the CAQH CORE Eligibility & Benefits (270/271) Data Content and Infrastructure Rules which include real-time and batch response time, system availability and companion guide requirements.
- **Data content rule** requires a health plan (or its agent) to return the following attribution data in the Eligibility & Benefits Request transaction: Attribution Status; Effective dates of attribution status, and Attributed provider if different than requesting provider.

Attributed Patient Roster Rule Set:

- **Data content rule** standardizes the minimum data elements a health plan must return to identify patients within the VBP population, including a VBP contract name and effective dates of attribution.
- **Infrastructure rule** standardizes expectations for exchange, including system availability and companion guide requirements. The rule also requires health plans to send providers an updated attributed patient roster (including updated dates of effective attribution) at least once per month.

CAQH CORE Certification Test Suite:

- **Eligibility & Benefits CAQH CORE Certification Test Suite**: defines testing and evaluation criteria for organizations seeking to demonstrate that they have successfully implemented Single Patient Attribution Data Content Rule.
- **Attributed Patient Roster CAQH CORE Certification Test Suite:** defines testing and evaluation criteria for organizations seeking to demonstrate that they have successfully implemented the Attributed Patient Roster Rule Set

Draft CAQH CORE Connectivity Rule vC.4.0.0

Updates to CORE Connectivity vC3.1.0 SOAP Requirements:

- Add support for the exchange of **Attachments transactions**
- Specify **TLS 1.2 or higher** for security
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- Support for **REST API and CORE Connectivity Rule Versioning**
- Use of specific **HTTP Error/Status Codes** and specifications **for REST Error Handling**
- Specify **API Endpoint Naming Conventions**

Vote Options:

"Support", "Do Not Support", or "Abstain"

Deadline:

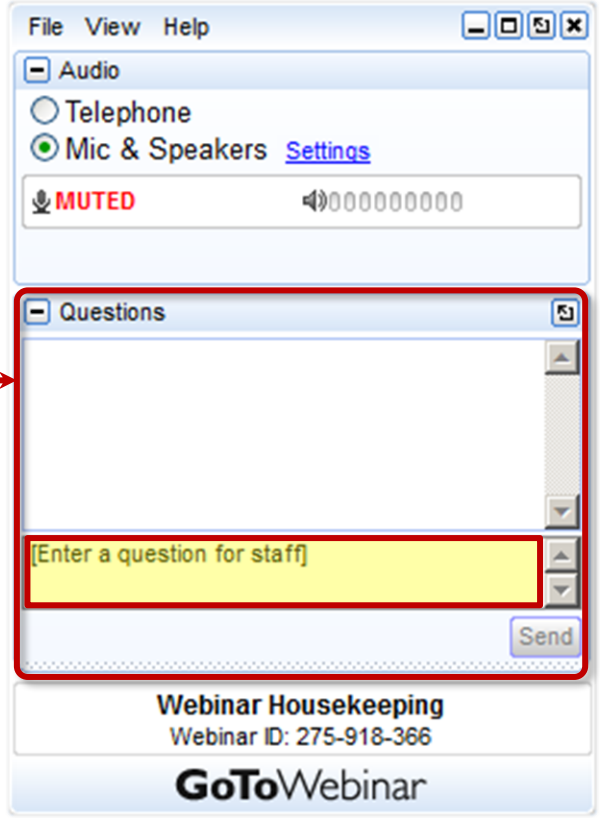
Close of business Friday, 12/04/20

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right-hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



- The slides and webinar recording will be emailed to attendees and registrants in the next 1-2 business days.

Thank you for joining us!

 @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.

APPENDIX: List of Voting Participating Organizations*

Voting Participating Organizations are entities that create, transmit, or use healthcare administrative data.

- AccuReg Inc.
- Aetna / Coventry Health Care
- Allscripts
- Ameritas Life Insurance Corp.
- Anthem Inc. / AIM Specialty Health
- Arizona Health Care Cost Containment Sys
- Athenahealth / Virence Health
- AultCare
- Availity, LLC
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of North Carolina
- Blue Cross Blue Shield of Tennessee
- California Dept of Health Care Services
- CareFirst BlueCross BlueShield
- Centers for Medicare and Medicaid (CMS)
- Cerner/Healthcare Data Exchange
- Change Healthcare
- CHRISTUS Health
- CIGNA
- Cleveland Clinic
- Conduent
- CSRA Inc.
- DST Health Solutions
- DXC Technology
- Edifecs
- Experian
- Federal Reserve Bank of Atlanta
- Florida Agency for Health Care Administration
- Government Employees Health Association
- Harvard Pilgrim Healthcare
- Health Care Service Corporation
- Health Net Inc. / Centene
- Health Plan of San Joaquin
- HEALTHeNET
- Highmark, Inc.
- HMS
- Horizon BCBS of New Jersey
- Humana
- Infocrossing LLC
- InstaMed
- Jopari Solutions
- Kaiser Permanente
- Laboratory Corporation of America
- Louisiana Medicaid – Molina
- Marshfield Clinic / Security Health Plan
- Mayo Clinic
- Medical Mutual of Ohio, Inc.
- Michigan Department of Community Health
- Minnesota Department of Health
- Missouri HealthNet Division
- Mobility Medical, Inc.
- Montefiore Medical Center
- NantHealth NaviNet
- New Mexico Cancer Center
- NextGen Healthcare Information Systems
- North Dakota Medicaid
- OhioHealth
- OODA Health
- Oregon Dept of Human Services / Health Authority
- Ortho NorthEast (ONE)
- PaySpan
- Pennsylvania Department of Public Welfare
- PNC Bank
- Tampa General Hospital
- The SSI Group, Inc.
- TIBCO Software, Inc.
- TransUnion
- TrialCard
- TRICARE
- TriZetto Corporation, A Cognizant Company
- Tufts Health Plan
- UC Davis Health
- United States Department of Veteran Affairs
- UnitedHealth Group / Optum / Unitedhealthcare
- Verata Health
- Virginia Mason Medical Center
- Waystar
- Wells Fargo

*Only organizations in good standing that use or transmit healthcare administrative transaction are eligible to vote in the Final CORE Vote.

CAQH CORE Prior Authorization

Suitability Evaluation Criteria

The CAQH CORE Board Evaluation Criteria (which include the CAQH CORE Guiding Principles) apply to all CORE rule development. For Prior Authorization rule development, PA-specific criteria are also used. The PA-specific criteria were developed by the CAQH CORE PA Advisory Group.

#	PA Evaluation Criteria	Description
1.	Effective Approach	Opportunity must be an effective approach to increasing electronic PA adoption, minimizing manual processes, and/or incentivizing automated final adjudication of PA requests.
2.	Broad Set of Clinical Services	Affects a broad set of clinical services that require PA.
3.	Benefits Across Stakeholder Types	Opportunity should offer business benefits or ROI across stakeholder groups.
4.	Does Not Pose Barrier to Existing Federal or State Regulations	Opportunity area does not pose a barrier to existing federal or state regulations.
5.	Supports Attachments (Additional Documentation)	Supports adoption of electronic additional documentation through multiple formats and delivery mechanisms.
6.	Advances Interoperability	Supports interoperability between clinical and administrative systems.
7.	Patient Centric	Supports the patient experience and the delivery of timely care.

#	CAQH CORE Board Evaluation Criteria
1.	Strategic and organizational fit (CORE Guiding Principles).
2.	Goal and expected impact/accomplishment.
3.	ROI: Benefit to provider, health plan and system (immediate or long-term).
4.	Ability to drive participation/adoption/ease of implementation.
5.	Timing considerations.

#	CAQH CORE Guiding Principles
1.	CAQH CORE will not create or promote proprietary approaches to electronic interactions/transactions.
2.	Whenever possible, CAQH CORE has used existing market research and proven rules. CAQH CORE Rules reflect lessons learned from other organizations that have addressed similar issues.
3.	CAQH CORE will suggest migration steps to promote successful and timely adoption of CAQH CORE Rules.
4.	All CAQH CORE recommendations and rules will be vendor neutral.
5.	Rules will not be based on the least common denominator but rather will encourage feasible progress, promote cost savings, and efficiency.
6.	To promote interoperability, rules will be built upon HIPAA, and align with other key industry initiatives.
7.	Where appropriate, CAQH CORE will address the emerging interest in evolving standards.
8.	CAQH CORE will not build a switch, database, or central repository of information.
9.	CAQH CORE participants do not support “phishing.”
10.	CAQH CORE Rules address both Batch and Real Time, with a movement towards Real Time (where/when appropriate).
11.	All of the CAQH CORE Rules are expected to evolve in future phases.