CAQH CORE

Advancing Interoperability and Value-based Payment with Blue Cross NC

June 3, 2021

1:00-2:00 pm EST

Agenda

- CAQH CORE Overview & Value-based Payment Initiatives
- Featured Presentation: “Blue Cross NC: Advancing Interoperability and Value-based Payments”
- Panel Discussion
- Q&A

Logistics

Presentation Slides and How to Participate in Today's Session

- Accessing webinar materials
  - You can download the presentation slides now from the "Handouts" section of the GoToWebinar menu.
  - You can download the presentation slides and recording at www.caqh.org/core/events after the webinar.
  - A copy of the slides and the webinar recording will also be emailed to all attendees and registrants in the next 1-2 business days.
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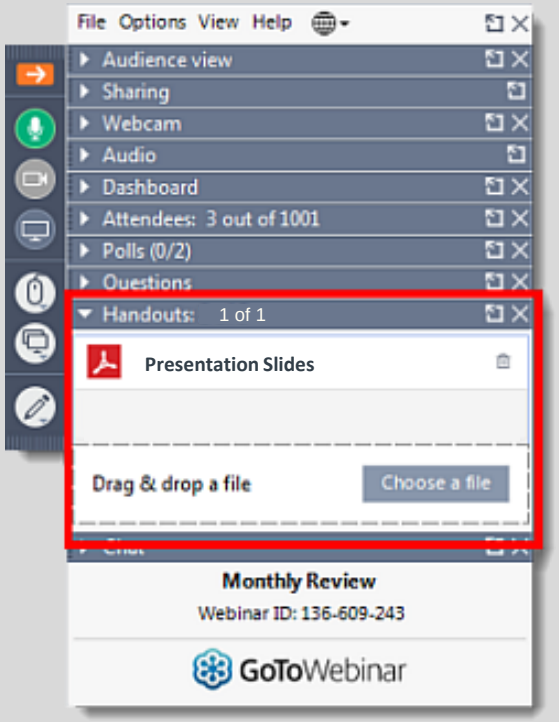

CAQH CORE Overview & Value-based Payment Initiatives

Erin Weber
Director, CAQH CORE

CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

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 CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.

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

CAQH CORE 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 (X12, HL7, NACHA, NCPDP) and WEDI.

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What are Operating Rules?

Operating Rules are 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.
CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions.

Industry 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.

CAQH CORE Operating Rules

Rule Set	Infrastructure	Connectivity Rule Application	Data Content	Other
Eligibility & Benefits	Eligibility (270/271) Infrastructure Rule	Connectivity Rule vC1.0.0 Connectivity Rule vC2.0.0	Eligibility (270/271) Data Content Rule	Single Patient Attribution Data Rule
Claim Status	Claim Status (276/277) Infrastructure Rule	Connectivity Rule vC2.0.0		
Payment & Remittance	Claim Payment/ Advice (835) Infrastructure Rule		EFT/ERA 835/CCD+ Data Content Rule	EFT/ERA Enrollment Data Rules
Prior Authorization & Referrals	Prior Authorization (278) Infrastructure Rule	Connectivity Rule vC3.0.0	Prior Authorization (278) Data Content Rule	Prior Auth Web Portal Rule
Health Care Claims	Health Care Claim (837) Infrastructure Rule			
Benefit Enrollment	Benefit Enrollment (834) Infrastructure Rule			
Premium Payment	Premium Payment (820) Infrastructure Rule			
Attributed Patient Roster	Attributed Patient Roster (834) Infrastructure Rule	Connectivity Rule vC4.0.0*	Attributed Patient Roster (834) Data Content Rule	

Rules in purple boxes are federally mandated.

*Connectivity Rule vC4.0.0 can be used to support all rule sets for CORE Certification.

CAQH CORE Focus: Streamlining Implementation of Value-based Payments

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.

Operating Rules Opportunity Areas

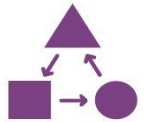
Completed

Patient/Provider Attribution: Establish consistent expectations for the electronic exchange of attributed patient rosters.

Under Consideration

Quality Measurement: Promote consistent quality measure exchange methods to improve reporting within the healthcare industry, while considering physician burden. Evaluate the use of standard templates and codes sets for data exchange.

Future Opportunities

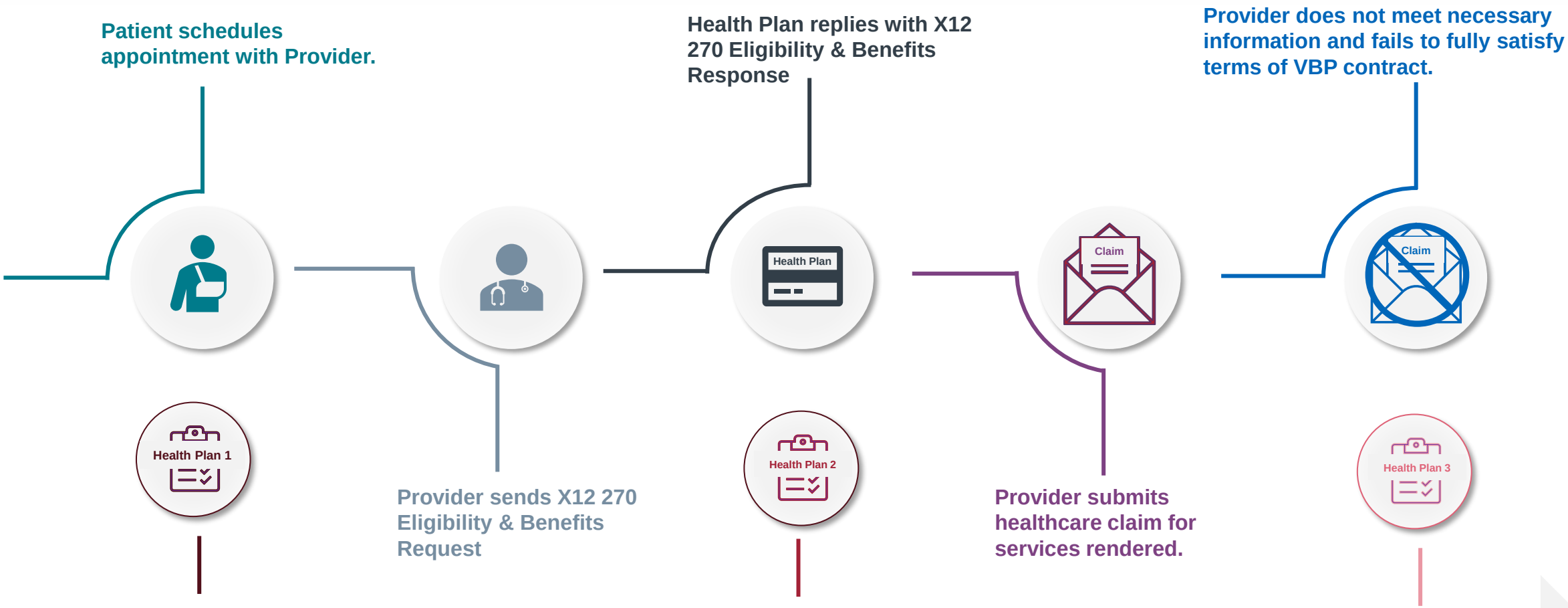


Interoperability: Define common process and technical expectations.

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

Data Quality & Uniformity: Promote more consistent definitions of data elements and adoption of certain medical and non-medical code sets.

Current State of Exchanging Patient Attribution Information



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Attributed Patient Roster Operating Rules

Challenge: Providers receive **attributed patient rosters** for value-based contracts at varying intervals (weekly, monthly, quarterly, annually) and using various formats (often excel downloads from FTP sites). There are currently no industry standards for the exchange of patient/provider attribution information.

Attributed Patient Roster Operating Rules

1. CAQH CORE Participants chose to develop attributed patient roster operating rules using the **X12 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.

2. 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.

3. 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.**

CAQH CORE continues to monitor industry adoption and other emerging industry efforts – including those led by HL7 related to FHIR bulk data – by tracking usage and lessons learned to align data content needs among stakeholders.

Single Patient Attribution Status Data Content Rule

Challenge: Providers are often unaware of their **patient's attribution status** within their VBP contracts at the point of service, leaving care gaps and other reporting unclear until well after the patient visit. There are currently no industry standards for the exchange of patient/provider attribution information.

Single Patient Attribution Status Data Content Rule

1. Uses the X12 270/721 Eligibility & Benefits transaction and builds upon the mandated CAQH CORE Eligibility & Benefits (270/271) Data Content and Infrastructure Rules through **additional data content requirements for the return of patient attribution status for specific use cases.**

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

3. 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 within existing workflows. Use of these transactions will also help bridge the gap by meeting provider needs now as the industry continues to pilot and test new and emerging standards and technology.

Benefits of Patient Attribution Operating Rules

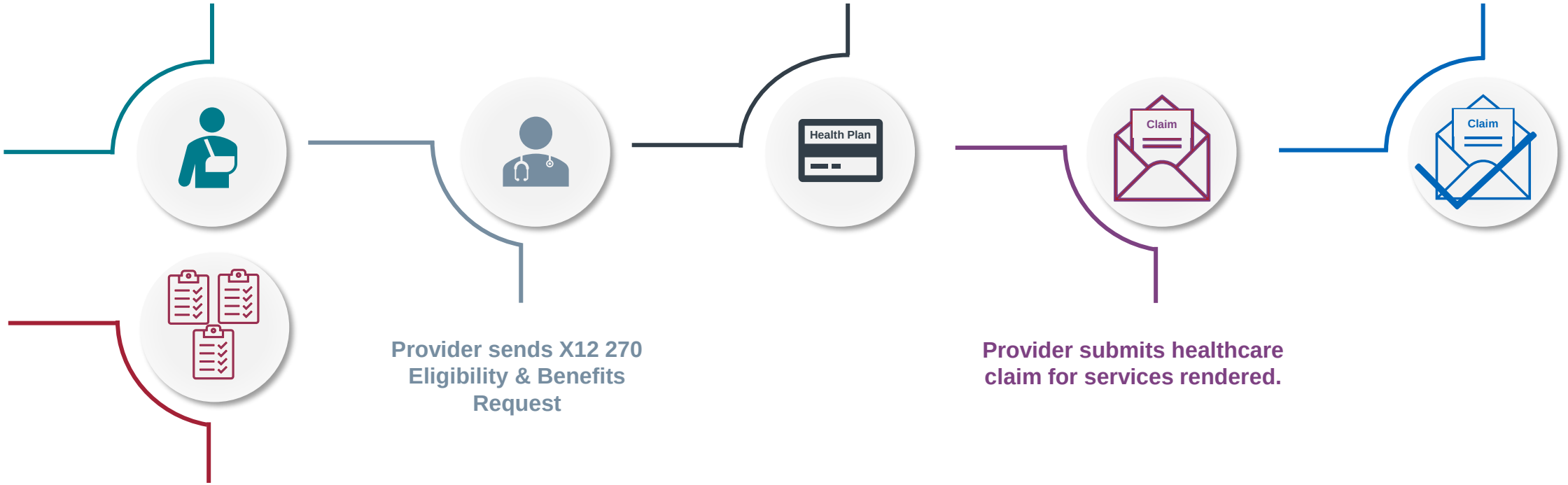
Patient schedules appointment with Provider.

Provider sends X12 270 Eligibility & Benefits Request

Health Plan replies with X12 271 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 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.***

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Next Steps

Attributed Patient Roster Operating Rules

- CORE Certification on the Single Patient Attribution Rule and the Attributed Patient Roster Operating Rule Set will be available in early 2022.

Value-based Payment Quality Measure Reporting Research

- CAQH CORE is planning a Pilot & Measurement Initiative to support the exchange of **non-service-related clinical information**, such as outcomes measures, to **reduce physician reporting burden** between health plans and providers.
- Staff are conducting an environmental scan to understand current pain points and opportunities to support more consistent and uniform data exchange.
- Potential opportunities areas are scoped to include development of a **standard quality measure reporting CDA template** and/or promotion of **provider adoption of CPT II codes** to increase data submitted with healthcare claim via a pilot. Industry interviews and discussions are ongoing.

Blue Cross NC: Advancing Interoperability and Value-based Payments

About Blue Cross NC

- North Carolina's largest health insurer with nearly 4 million members
- Insure the majority of North Carolina's commercial market
- Approximately 5,000 employees
- $9.9 billion in revenue in 2020
- Recognized as a national leader in moving away from fee-for-service payment model
- Using technology/data/analytics to personalize health care that is simpler, better, more affordable

Interoperability Ecosphere

Patient Repository

Provider Repository

Payer Repository

Data Elements	Solution Capability
Demographics Drivers of Health Benefits	Patient Portal Access to Digital Health
Demographics Large Systems Aggregators Independents	Provider Portal Access to Plan Data Access to Patient's Plan Data
BCBSNC/External Plan Insights Quality & Risk Compliance Spend Outcomes	Insights Benefits Quality Risk Compliance Spend Outcomes

Goals

Engaged
Decision Making
Transparency
Access

Outcomes
360 Health View
Administrative Relief
Speedy Access
Intervention

Lower Med Ex
Decreased Admin Ex
Group Attraction
Managed Care Coordination

Better Health Care for All

Accelerate to Value

Rationale for the A2V program

Primary Care Practices are in Distress:

- Suppressed demand for health services associated with COVID-19 pandemic.
- Nationwide, ambulatory visits to practices declined by 60%, which is only marginally offset by increased telehealth utilization.
- Statewide select practices reported an average 40% decline in revenue compared to prior year.

Financial insolvency of independent primary care practices has led to:

- Furloughed or laid off employees and practice closures that threaten critical access to care for members
- Independent primary care practices at critical risk for acquisition by health systems which drives consolidation in the market. This also allows national payers to capitalize on opportunities to acquire distressed practices.

Risk of significant market consolidation of PCPs into health systems would raise BCBSNC costs substantially. A preliminary analysis suggests that if all independent primary care providers acquired it would **significantly raise medical expense.**

Guiding Principles

1. Provide **Financial Stability** to independent primary care providers ✓

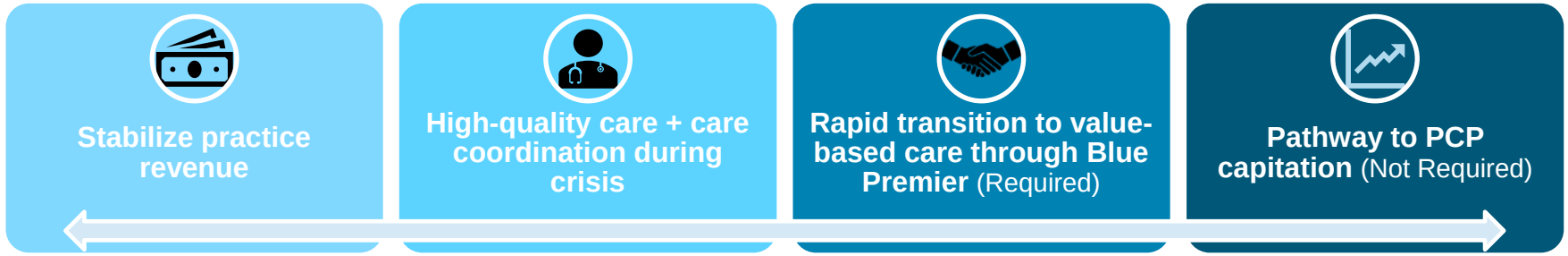
2. Ensure Blue Cross NC **member access** to high-quality care with appropriate care coordination, particularly during the healthcare crisis ✓

3. Provide a bridge to **participate in the Blue Premier** program ✓

4. Help stabilize independent PCP to assure they **remain independent** ✓

Accelerate To Value: Program Overview

There are four key parts to the program:



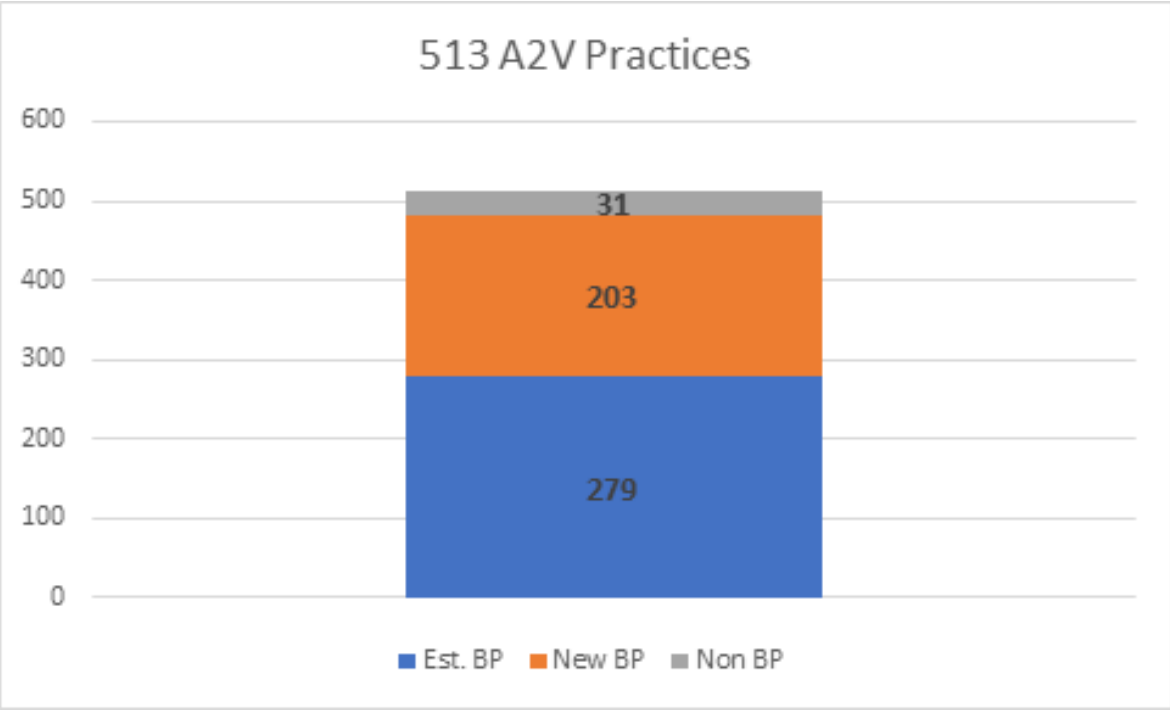
- Upfront payment to practices to what an average practice would have earned for core primary care service
- "Catch up" payments to make course corrections along the way to maintain 2019 levels

- For our Blue Cross NC members, practices pledge to:
  - Ensure access
  - Promote telehealth
  - Provide care delivery and care coordination activities responsive to COVID-19 pandemic

- Join a Blue Premier accountable care organization (ACO) by December 31, 2020
- Options to join a Blue Premier ACO through Aledade or an existing Blue Premier clinically integrated network (CIN)

- Opportunity in 2022 to adopt a PCP capitation model

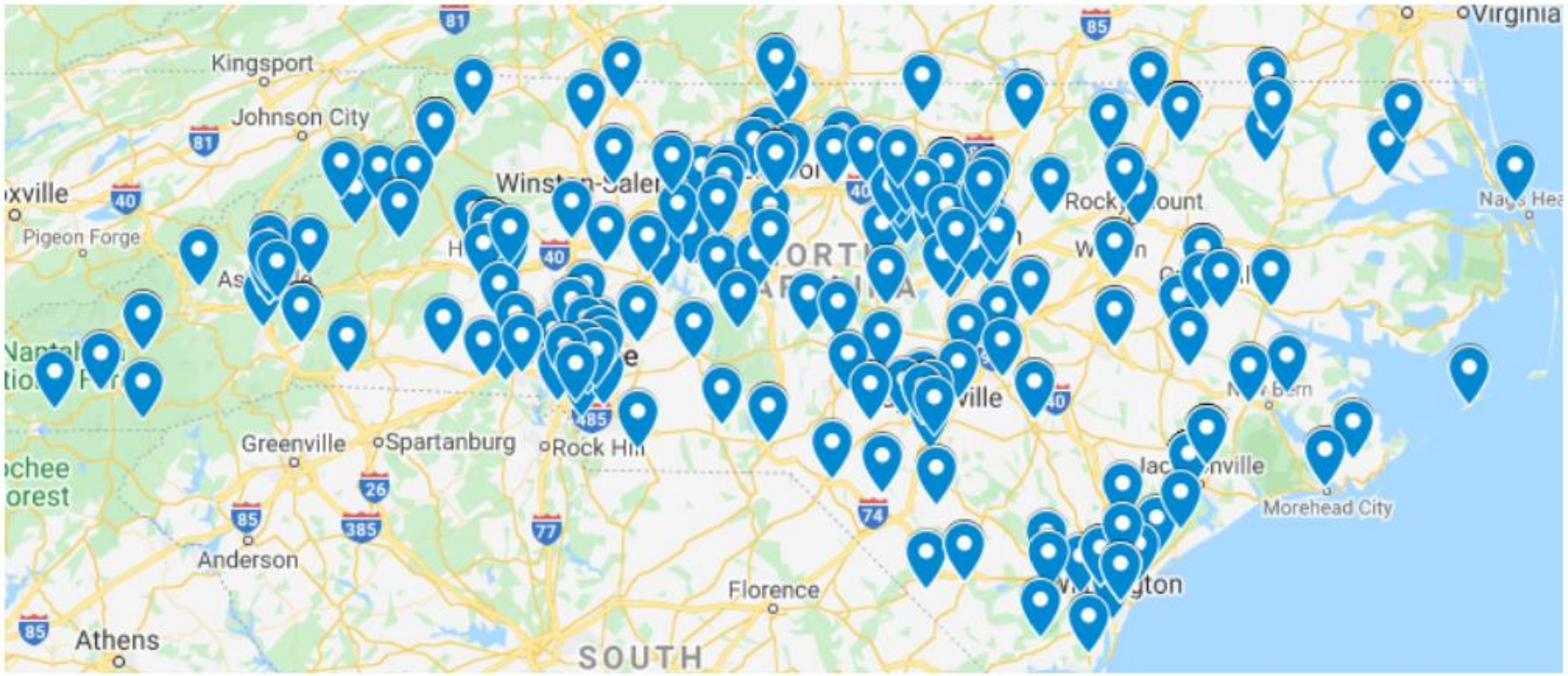
A2V Outcomes and Success



87% of eligible A2V practices joined a Blue Premier ACO

- 300K existing commercial members;145K new BP members
- 13K existing MA members; 3800 new BP members

Blue Premier ACOs Growth across NC from the A2V Program



Total A2V Practices and Membership:

- 513 practices
- 449,035 Commercial
- 16,580 MA

Conversation with Blue Cross NC & CAQH CORE

Troy Smith
VP, Healthcare Strategy & Payment Transformation
Blue Cross NC

Erin Weber
Director
CAQH CORE

Jessica Porras
Senior Manager
CAQH CORE

Moderator

Audience Q&A

Please submit your questions

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

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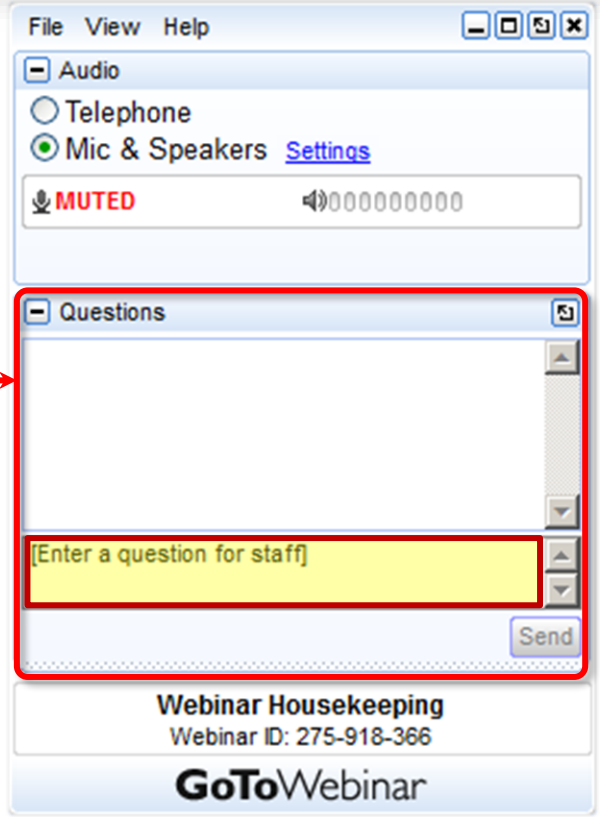

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Upcoming CAQH CORE Education Sessions and Events

CAQH CORE & NACHA, with InstaMed – “Trends & Data on Healthcare Payments”

June 22, 2021 2:00-3:00 PM EST

Thank you for joining us!

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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.