NCVHS Panel: Value Based Care Models vs. Fee-For-Service - Implications for HIPAA Standards

Erin Weber, MS, Chief Policy & Research Officer, CAQH

April 11, 2024

Agenda

- CAQH & CORE Overview
- Research-informed Approach to Value-based Care
- CORE Value-based Care Operating Rules and Resources
- Interoperability in Value-based Care
  - Support through revenue cycle transactions
  - Roadmap to real-time data exchange
- Data Standards to Accommodate Exchange Across Entities
- Call To Action: Real-time Health Data Exchange

About CAQH

Our Vision

To align the healthcare ecosystem around essential solutions that power a **More connected, less costly** experience for all

- **Simplifying** financial processes
- **Reducing** administrative burdens
- **Enhancing** experiences
- **Improving** data exchange
- **Supporting** standards
- **Driving** interoperability

CAQH Solutions
leverage data and tech to reduce costs and transform healthcare.

CAQH CORE
develops operating rules that lead to standards to streamline healthcare.

CAQH Insights
track opportunities to improve healthcare practices.

Health Plans

Providers

Medicaid Programs

Technology Partners

CORE brings together industry stakeholders to develop operating rules that drive healthcare data exchange

Committee on Operating Rules for Information Exchange

Leading Industry

CORE is a **trusted and independent operating rule author**. In addition to mandated operating rules, CORE offers operating rule sets for voluntary adoption.

Savings

The 2023 CAQH Index® estimated that 22% of money spent on administrative transactions could be saved by fulling transitioning to electronic transactions. **CORE Operating Rules help facilitate and streamline electronic adoption.**

Ensuring Representation

From small provider organizations, to national health plans, CORE has the **unique ability to bring diverse industry stakeholders to the table** to tackle complex administrative problems together.

More than 100 healthcare organizations participate in CORE to develop operating rule requirements

Account for 75% of total American covered lives.

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
- 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
- InstaMed
- Lassie
- MCG Health
- 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

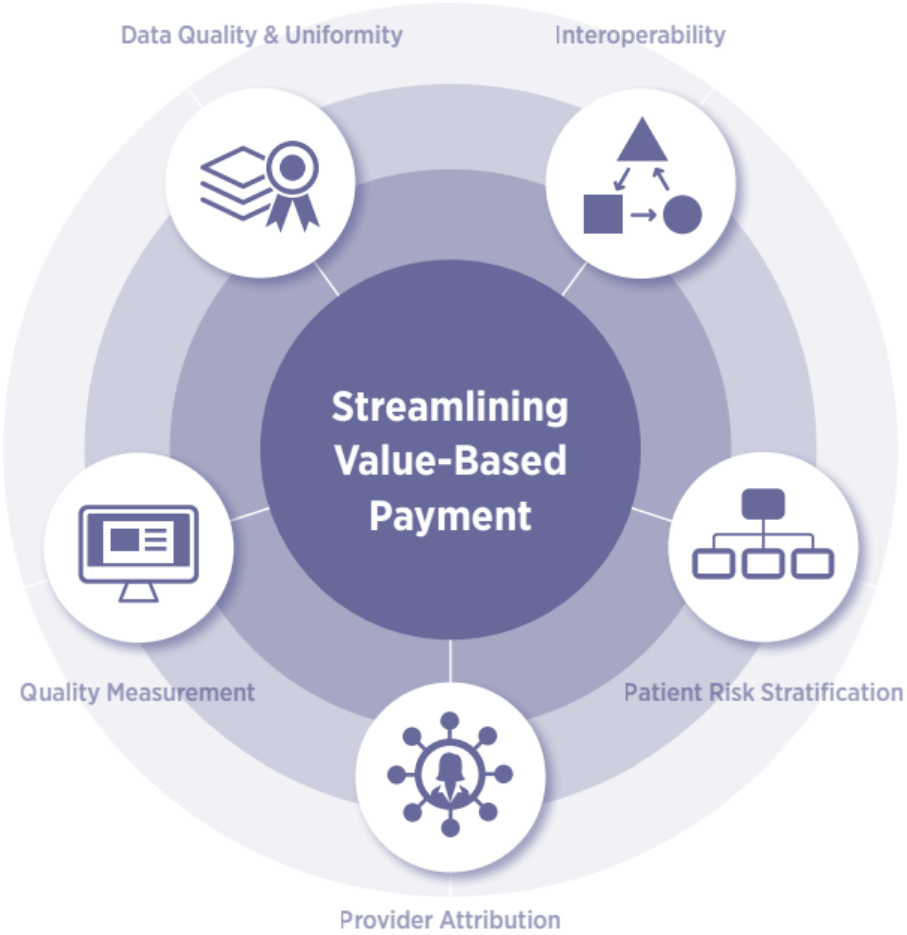
Providers

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Aspen Dental Management, Inc.
- Children's Healthcare of Atlanta Inc
- 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
- OSF HealthCare
- Peace Health
- St. Joseph's Health
- Virginia Mason Medical Center

Other

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

Implementation of value-based care models is challenging due to complex methodologies and nascent technical and data interoperability



Health Equity by Design in VBC: Value-based care models incorporate methodologies to collect and use social determinant of health (SDOH) data to address health inequities.

Program Complexity and Administration: Value-based care models are challenging to comprehend and administer, issues that are compounded by difficulties contracting and navigating unaligned definitions.

CORE Operating Rules simplify the administration of value-based care and identify uniform data that advances interoperability

CORE Value-based Care Enablement Operating Rules

1. CORE Patient Attribution Operating Rules*
Point-of-care and monthly exchange of member attribution data for population health models.

2. CORE Health Equity Operating Rules
Standardized collection and exchange of member socio-demographic data.

3. CORE Health Care Claims Operating Rules
Standard pathways for the submission of additional diagnoses at a single encounter.

4. CORE Connectivity Rule vC4.0.0*
Enables real-time exchange through web-based APIs using SOAP and REST connectivity protocols.

CORE Framework for Semantic Interoperability: Consensus-based Uniform Definitions for VBC Terms

5. Standardization of VBC Terminology
Consensus-built definitions for common VBC concepts for industry use and reference.

*Contains Operating Rules Recommended for Federal Mandate by the National Committee for Vital and Health Statistics (NCVHS) on June 30, 2023.

Established data standards are the engine for current value-based care implementations; operating rules enhance their application

Revenue cycle transactions support the administration of value-based care models

Member & Roster Management
X12 834

- Member data management at enrollment, renewal, and maintenance.
- Exchange of members attributed to participants in a VBC contract using a standardized roster.

Eligibility and Benefit Structure
X12 270/271

- Member benefit design and coverage requirements returned at the point-of-care.
- Point-of-care data identifying member attribution to participants in a VBC contract.

Claim Submission and Processing
X12 837

- Claim expenditure informs benchmarks for FFS and capitated VBC models.
- Diagnosis and procedure code submissions contribute to VBC methodologies and the documentation of non-medical factors impacting care.

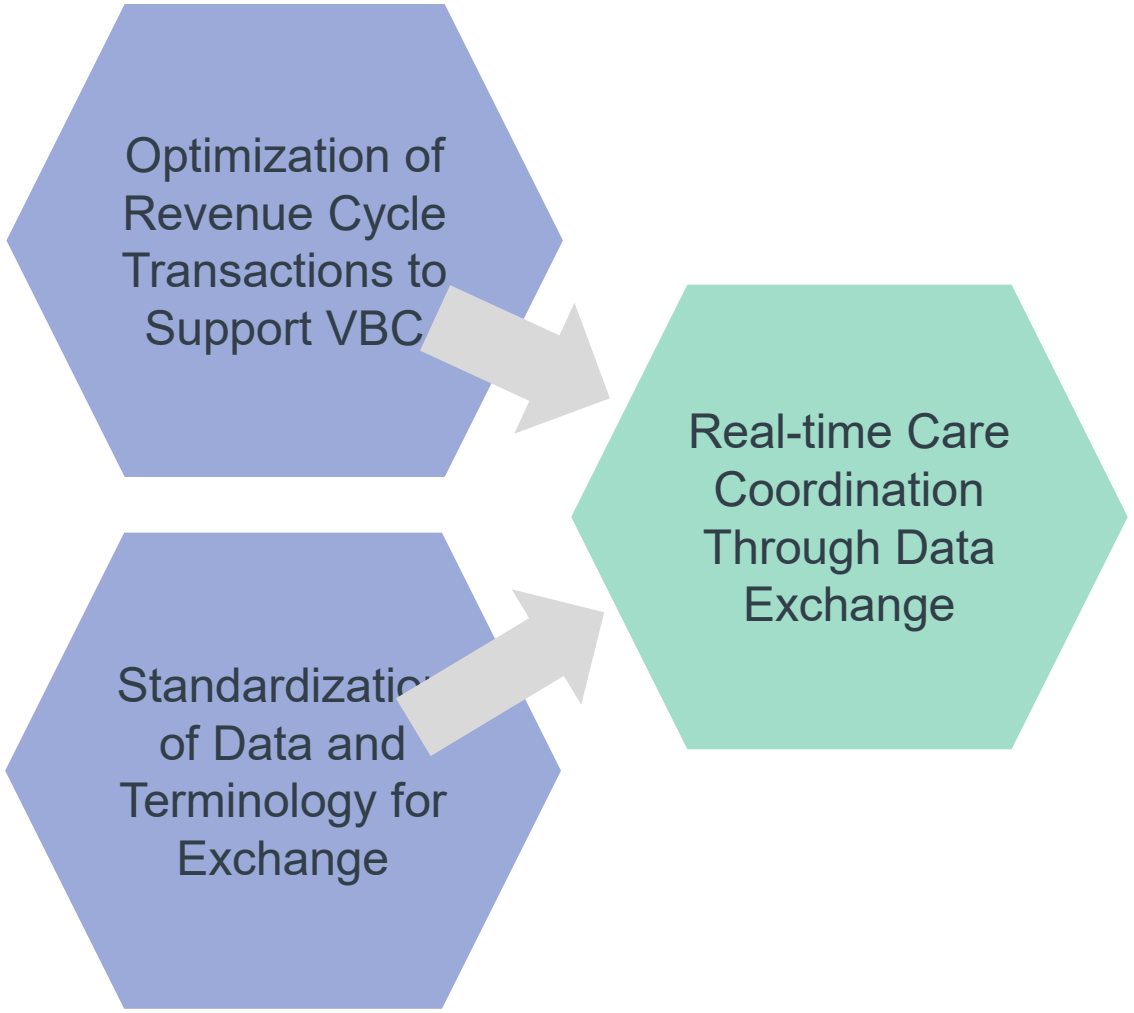
Payment and Remittance Communication
X12 835

- VBC models impact what participants receive through fee-for-service.
- Remittance advice can communicate adjustments related to participation in value-based contracts.

Real-time data exchange for care coordination in VBC is enhanced by efforts to optimize and standardize revenue cycle workflows

X12 standards updated to reflect business needs for VBC; **Operating rules** fill gaps in data needs and support transition to **APIs** through connectivity and infrastructure expectations.

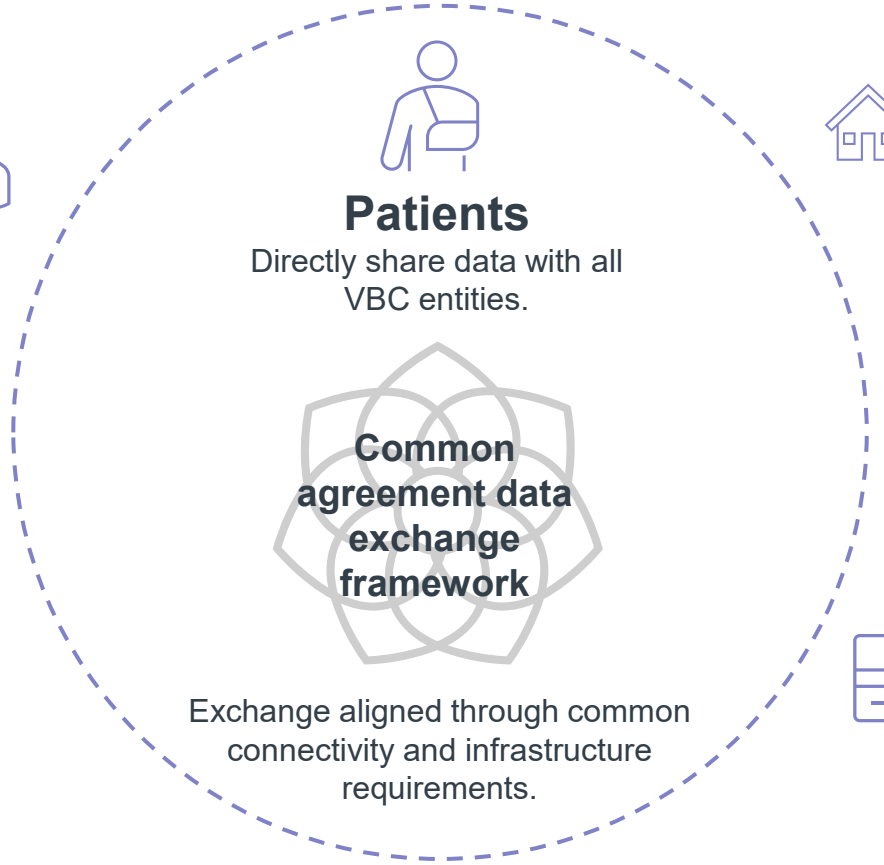
Industry is addressing data non-uniformity, examples include: defining **SDOH data** via HL7 FHIR-accelerator Gravity Project, building out the **USCDI** via ONC initiatives, addressing **semantic interoperability** for common VBC terms through CORE.



Real-time exchange and aggregation of data for care coordination in VBC models results from and is enhanced by efforts to **optimize existing workflows** and standardize how **data is understood and shared.**

A uniform data exchange framework is required to address multi-disciplinary data sharing and reporting across impacted value-based care stakeholders

Data that is non-uniform or of poor quality at **any** intersection point leads to non-optimal care coordination.



Providers
Data collected and exchanged based on patient encounters.

Community Organizations
Data collected and exchanged based on social care referrals.

Post-Acute Care
Data collected and exchanged through discharge planning and direct care.

Health Plans
Data collected and exchanged through patient encounter data and interaction with members.

The current state of value-based care is functional; advancement to real-time exchange requires defined, bold action

A faster, more flexible standards adoption process addresses infrastructure and data content incompatibilities.

Revenue cycle transactions support value-based care and related initiatives.	Addressing value-based activities in real-time requires a range of standards.	Uniform data is central to success in value-based care; regardless of source.	Technical interoperability and data uniformity enhance accountable care goals.
▪ CORE Operating Rules support novel solutions for existing transactions. ▪ New versions of standards explicitly support value-based care.	▪ HL7 FHIR and X12 facilitate real-time aggregation and exchange of data. ▪ Seamless, point-of-care coordination is the next step in value-based care data exchange.	▪ Data uniformity enhances and streamlines data exchange. ▪ The claim transaction is the current “vehicle” for exchange – the data is what is important.	▪ Members benefit from an accountable care relationship with integrated, uniform data exchange. ▪ Industry must come together and be bold to promote uniform, consistent data exchange.

Appendix

Opportunities for data exchange in value-based care are interconnected and should not be addressed in silos