

**CAQH Committee on Operating Rules for Information Exchange (CORE)  
Health Care Claims Focus Group Call #1  
Key Takeaways: Wednesday, October 12th, 2022, 2 pm -3:30 pm ET Call**

<i>Agenda Item</i>	<i>Key Discussion Points</i>
<b>Welcome, Antitrust Guidelines and Roll Call</b>	<ul style="list-style-type: none"> <li>Review of <a href="#">Antitrust Guidelines</a>.</li> </ul>
<b>CAQH CORE Level Set</b>	<ul style="list-style-type: none"> <li>CAQH CORE is a mission driven organization. CORE works to drive the creation and adoption of operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, payers and consumers.</li> <li>The Focus Group goal is to inform and prioritize focus areas for CAQH CORE Operating Rule Development by exploring how a data content rule can enhance the claims workflow.</li> <li>Outcomes of the focus group will include publication of industry guidance documents and inform the establishment of a CAQH CORE Health Care Claims Subgroup.</li> <li>Expectations of participants are to attend, prepare and participate in Focus Group calls, as well as share the knowledge and takeaways from the calls with the stakeholders within your organization.</li> </ul>
<b>Health Care Claims Overview</b>	<ul style="list-style-type: none"> <li>Up until now, CAQH CORE has focused on the creation of infrastructure rules to support the health care claims workflow. There is opportunity to create a data content rule to further automate health care claims workflows.</li> <li>CAQH CORE will continue to monitor federal activities related to X12 v8020 of the claims submission and payment transaction and will integrate policy impacts and industry recommendations as part of the health care claim rule development efforts.</li> </ul>
<b>Health Care Claims Areas of Opportunity</b>	<p><b><u>Claim Rejection and Notification Reporting</u></b></p> <ul style="list-style-type: none"> <li>Uniformity within detailed error code reporting can help reduce administrative burdens that land on the providers.</li> <li>CAQH CORE identified an opportunity area for data content operating rules to support the delivery of specific reasons for a claim rejection in a consistent and uniform way across all health plans.</li> <li>CAQH CORE polled call participants to choose the opportunity areas that would help improve the utility of the X12 277CA transaction for claim rejections. The top response included with top response being: uniform use of codes (claim status category + error reason).</li> </ul> <p><b><u>Value-based Payments (VBP)</u></b></p> <ul style="list-style-type: none"> <li>CORE has been active in working on operating rules to address patient attribution.</li> <li>Claims-based quality measurement is a commonly used, but limited by data lag and differing methodologies, which can lead to additional administrative burdens.</li> </ul>

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- Emerging opportunities for claims for VBP include supporting Social Determinants of Health (SDOH) information via ICD-10 Z-codes, as well as Quality Data at the point of care.
- CAQH CORE's looks to leverage and promote work being done throughout the industry to streamline and achieve consistent data elements for Value Based payments.
- CAQH CORE polled call participants to choose where CAQH CORE Health Care Claims Operating Rules could best support Value-based payment models. The top response included: identification of data elements to promote uniformity.
- Focus group discussion on VBP included how the static nature of claims could be a hindrance to changes within attribution models. CAQH CORE agreed to consider this point as part of continued research efforts.

**Telehealth**

- As public health waivers are expiring, providers who were seeing patients across state lines will have a reduction in their flexibility to treat patients. Differences in changes for telehealth waivers across state to state may create burdens for providers as well as plans as they begin to expire. Additional guidance around the different levels of waivers – both state and federal level – may be an opportunity area for consideration.
- Flexibility within the codes that can be used to submit health care claims to indicate the modality of service rendered was an opportunity area of discussion.
- Ability to reduce denials via telehealth if it is known up front that the service is not included at the time of eligibility and benefit verification was an opportunity area of discussion.
- CAQH CORE polled call participants to identify how CAQH CORE could address consistency and ease of adjudication of telehealth claims with an operating rule. The top response included: place of service indication, as well as modality used.

**Patient Data Sharing**

- Patients are expecting more access to their health information at an increased rate.
- The recent regulatory environment is supporting this desire, requiring the adoption of technologies that can better facilitate the transmission of health information between providers and patients.
- Health care claims data plays a role is facilitating the exchange of health information. Claims data can enhance API-driven data exchange between stakeholders and could help a patient develop a longitudinal health record, support research efforts, or create connections with third-party apps .
- CAQH CORE polled call participants to identify how CAQH CORE could best address the issues pertinent to patient data sharing. Top responses included: not supporting operating rule development in this space at this time, as well as specifying infrastructure, connectivity, and/or security.

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	<p><b><u>X12-to-HL7 FHIR Translation</u></b></p> <ul style="list-style-type: none"> <li>• CAQH CORE is monitoring the development of emerging standards in the industry.</li> <li>• Recently, NCVHS recommended to HHS that HIPAA regulations allow the use of more than one standard for transactions, creating a context wherein dual, complementary standards can be supported.</li> <li>• The HL7 FHIR Claims Resource could satisfy the same, as well as additional, business cases within the health care claims workflow as the X12 standards.</li> <li>• A thoughtful approach to data uniformity within the health care claims workflow is necessary to ensure no data gaps are created by supporting two standards simultaneously.</li> <li>• CAQH CORE polled call participants to identify their main barriers when considering support of multiple standards. Top responses included: waiting for additional regulation, as well as uniform definitions and alignment of data across multiple standards.</li> <li>• Focus group participants noted that the X12 837 transactions is among the highest adopted in the industry – raising the question of why another standard should be used in its place. Although the X12 837 standard is highly adopted, the use of multiple standards opens the possibility of potential gaps in data to satisfy the use case. Ensuring that the data remains uniform across syntaxes is essential to industry to minimize administrative burdens.</li> </ul> <p><b><u>Additional Areas of Opportunity</u></b></p> <ul style="list-style-type: none"> <li>• CAQH CORE polled call participants to identify additional areas of opportunity within the health care claims workflow. Top responses included: appeals, additional VBP related topics such as SDOH data, as well as Coordination of Benefits information.</li> </ul>
<p><b>Next Steps</b></p>	<ul style="list-style-type: none"> <li>• Questions around how the polling information will be used from the group was asked. CAQH CORE indicated that polling question responses will not be final decisions, rather are being used to help guide additional areas of interest and research for the group, to support transition into the subgroup phase.</li> <li>• Next Focus Group Call to be held on Wednesday, November 2nd.</li> <li>• The background document, as well as the slide deck used for this call are available on the Participant dashboard for reference.</li> </ul>

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<b>CAQH CORE Contact Information</b>	
Michael Phillips Manager, CORE <a href="mailto:mphillips@caqh.org">mphillips@caqh.org</a>	Bob Bowman Principal, Interoperability and Standards, CORE <a href="mailto:rbowman@caqh.org">rbowman@caqh.org</a>
Taha Anjarwalla Associate Director, CORE <a href="mailto:tanjarwalla@caqh.org">tanjarwalla@caqh.org</a>	Marianna Singh Senior Associate, CORE <a href="mailto:msingh@caqh.org">msingh@caqh.org</a>
Kayla Cooper Associate, CORE <a href="mailto:kcooper@caqh.org">kcooper@caqh.org</a>	Tanner Fuchs Associate, CORE <a href="mailto:tfuchs@caqh.org">tfuchs@caqh.org</a>

**Health Care Claims Focus Group Call #1 Attendance**

<b>CAQH CORE Participating Organization</b>	<b>Last Name</b>	<b>First Name</b>	<b>Attendance</b>
Aetna	Hodges	Rose	
Aetna	Rabuffo	Mark	
Aetna	Davidson	Marianne	
American Medical Association (AMA)	McComas	Heather	X
American Medical Association (AMA)	Spector	Nancy	X
American Medical Association (AMA)	Scheid	Tyler	
Availity	Jordan	Joshua	X
Availity	Ruhl	Katie	X
Availity	Sites	Kathy	X
Availity	Barry	Michelle	
Blue Cross Blue Shield of Michigan	Knapp	Ron	X
Blue Cross Blue Shield of Tennessee	Langford	Susan	X
Change Healthcare	Trewyn	Elsa Star	X
Claim.MD	Titan	Nihal	X
Centers for Medicare and Medicaid Services (CMS)	Kessler	Thomas	X
Centers for Medicare and Medicaid Services (CMS)	Mendenhall	Gig	
Centers for Medicare and Medicaid Services (CMS)	Rooke	Fred	
Cognizant	Duchek	Dawn	X
Cognizant	Quackenbush	Don	X
Cognizant	Schulz	Andy	X
CRSA	Caldwell	Laura	X
Edifecs	Nair	Tushar	
ElevanceHealth	Martin	Victor	X
HealthNet	Gracon	Christopher	X
Kaiser Permanente	Crosby	Yolanda	X
Kaiser Permanente	Rezai	Pauny	X
Mayo Clinic	Brannan	Andrea	X
Mayo Clinic	Fortek	Rebecca	X
Michigan Department of Community Health	Fuller	Diana	X
Minnesota Department of Human Services	Yang	Chao	X
Minnesota Department of Human Services	Wandersee	Ann	
National Association of Health Data Organizations (NAHDO)	Hawley	Charles	X
NextGen Healthcare	Miller	Yolanda	X

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NextGen Healthcare	Team	Nancy	X
OhioHealth	Alexander	Mary	X
Olive AI	Townsend	Kristina	X
Optum	Duncan	India	X
Point32Health	Buckley	Nancy	
Virginia Mason Medical Center	Wallace	Jenny	X
Virginia Mason Medical Center	Ness	Lisa	X