CAQH CORE

Value-based Payment: What Have We Learned and Where Are We Headed?

March 13, 2018

2:00 – 3:00 PM ET

Logistics

Presentation Slides and How to Participate in Today's Session

You can download the presentation slides at www.caqh.org/core/events after the webinar.

- Click on the listing for today's event, then scroll to the bottom to find the Resources section for a PDF version of the presentation slides.
- Also, a copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

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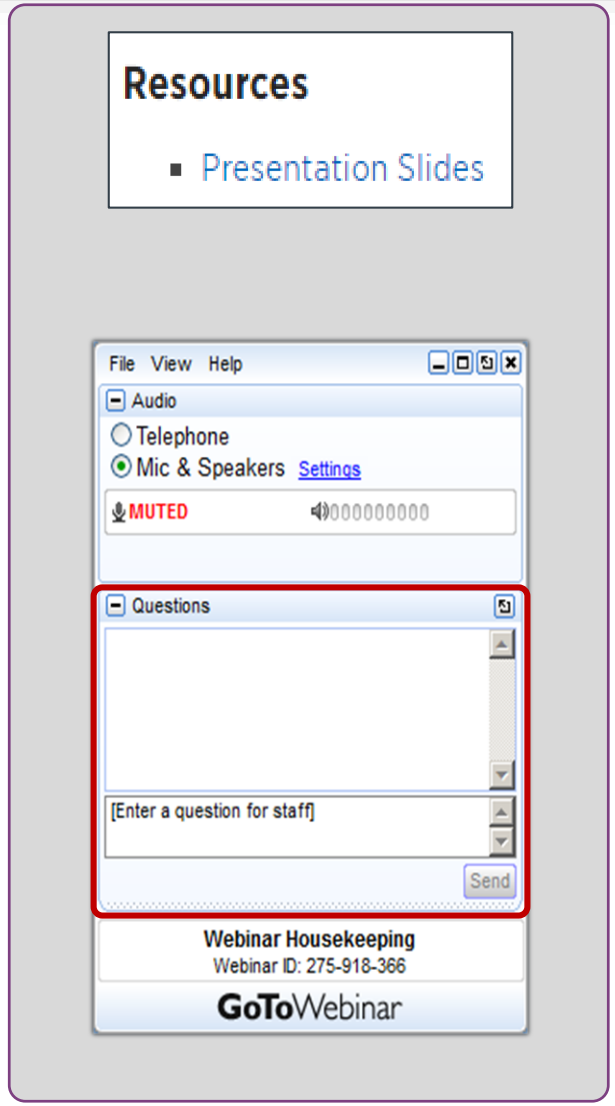


CAQH CORE Series on Value-based Payments

This webinar is the third in an ongoing educational series from CAQH CORE on industry adoption of value-based payments and the operational challenges inherent in this transition.

We would like to thank our speakers:

Ananya Health Solutions LLC

Aparna Higgins
President, Ananya Health Solutions LLC

Erin Weber
Director, CAQH CORE

Session Outline

- Overview of CAQH CORE Initiative on Value-based Payments.
- Featured Presentation: Value-Based Payment – A Bird’s Eye View.
- Q&A.

Overview of CAQH CORE Initiative on Value-based Payments

Erin Weber
CAQH CORE Director

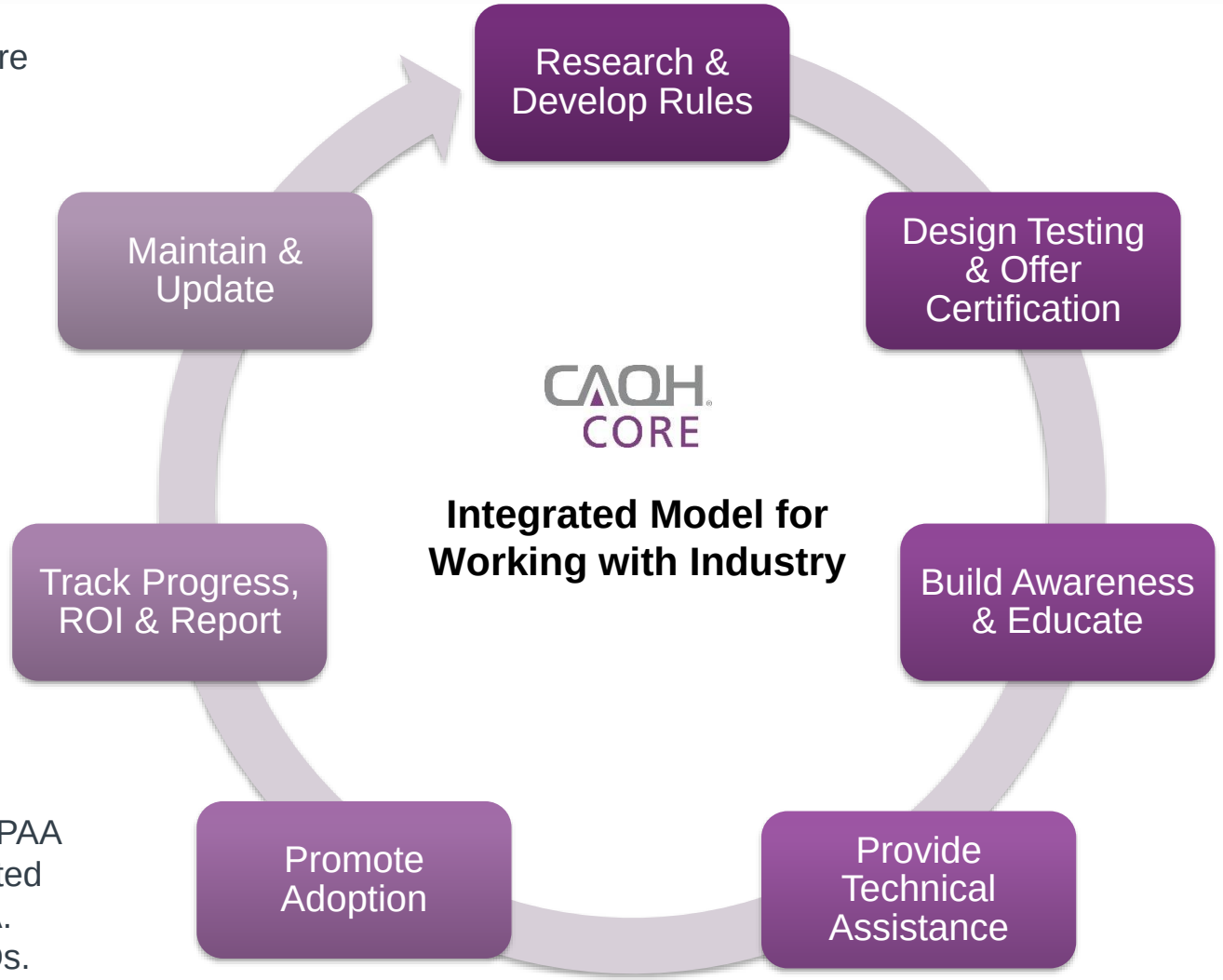
CAQH CORE Mission & Vision

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability** and align administrative and clinical activities among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

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

BOARD **Multi-stakeholder.** Voting members are HIPAA covered entities, some of which are appointed by associations such as AHA, AMA, MGMA. Advisors are non-HIPAA covered, e.g. SDOs.



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CAQH CORE is Driving Industry Value

130

CAQH CORE Participating Organizations

working in collaboration to simplify administrative data exchange through development and maintenance of operating rules.

4

Phases of Operating Rules

developed to facilitate administrative interoperability and encourage clinical-administrative integration by building upon recognized standards.

3

Federally Mandated Phases of Operating Rules

per Section 1104 of the Affordable Care Act to address and support a range of administrative transactions.

330

CAQH CORE Certifications

awarded to entities that create, transmit or use the healthcare administrative and financial transactions addressed by the CAQH CORE Operating Rules.

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Level Set: CAQH CORE VBP Initiative

CAQH CORE is Uniquely Positioned to Help Streamline VBP Operations

For more than a decade, **CAQH CORE has brought healthcare stakeholders together to develop, agree upon and adopt operating rules** to improve the exchange of electronic transactions.

Proven Success

Significant improvements in fee-for-service operations, reducing cost and improving care delivery and administrative coordination.

Change Agent

Considerable expertise, experience and resources to **support development of a sound operational system for VBP**.

Industry Collaboration

Expertise developing operating rules for the administrative and financial areas where providers and health plans must work together – **ability to harmonize practices between providers and health plans, with 130 participating organizations**.

By collaborating now and applying lessons learned from successes in the fee-for-service space, CAQH CORE aims to energize an effort **ensuring the historic volume-to-value shift continues to be unimpeded by administrative hassles.**

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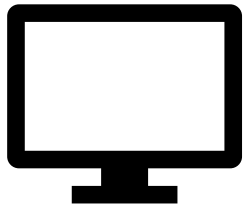
CAQH CORE VBP Initiative

Current and Upcoming Efforts



Education Series

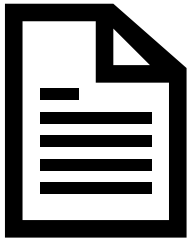
- Launched CAQH CORE VBP Industry Education Series in November 2017 and have held three VBP webinars, reaching over 700 people.
- CAQH CORE will continue the educational series throughout 2018.

The next webinar in the series about CAQH CORE's VBP Report is April 10th. Register here.

Research & Report

- Conducted extensive primary and secondary research to identify initial set of potential operational areas for industry action.
- Developed VBP Report outlining problem space, opportunity areas and recommendations/strategies to address opportunity areas.

The report will be released in the next few weeks.



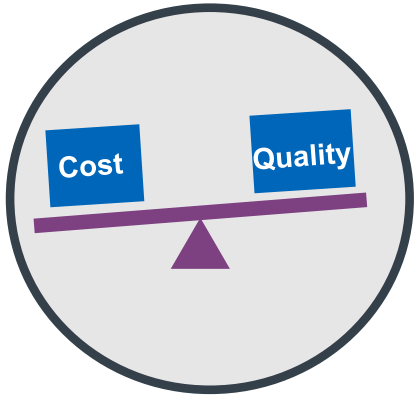
Advisory Group

CAQH CORE will launch a VBP Advisory Group in 2018. The Advisory Group will be charged with prioritizing and advancing the recommended actions contained in the report that best align with CAQH CORE's mission.

CAQH CORE

CAQH CORE VBP Report

Report Objective



The VBP Standardization Challenge

The success of VBP is fundamentally dependent upon **smooth and reliable business interactions** between stakeholders. Investments in standardized methods of communication can deliver industry value if there are **consistent expectations and rules of the road** related to VBP. Stakeholders are eager to collaborate; however echoed one common theme – **non-uniformity is currently the norm in value-based payment operations.**

CAQH CORE Report

5 Opportunity Areas

Proposes five opportunity areas identified as unique operational challenges associated with VBP.

9 Recommendations

Includes nine recommendations and strategies to address these challenges which may be implemented by CAQH CORE and/or others.

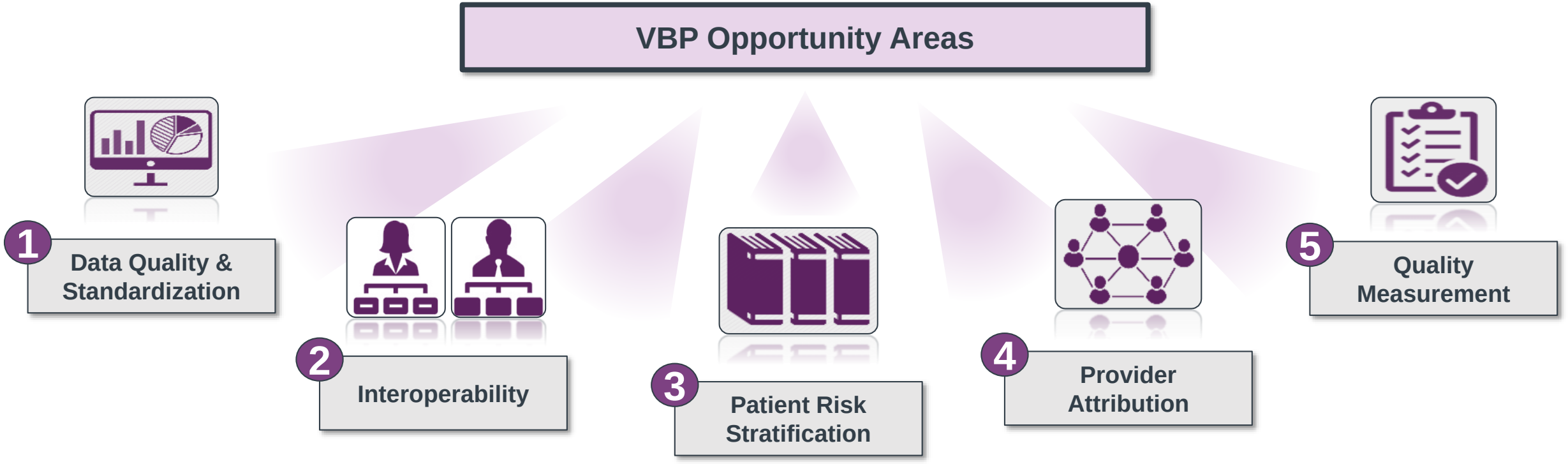
12+ Candidate Orgs

Identifies over a dozen candidate organizations – industry organizations and leaders – to successfully propel VBP operations forward.

CAQH CORE VBP Report

Opportunity Areas Identified for Sustainable Industry-wide Success

VBP Opportunity Areas



Non-standardized data, workflows, operations and data collection pose challenges to successfully implementing VBP. The report identifies a select set of opportunities where a more uniform approach would streamline VBP operations for both health plans and providers without compromising the competitive value of VBP models.

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Polling Question #1

What is your role related to VBP at your organization?

1. Management and Oversight.
2. Contracting/Relations.
3. Claims Adjudication and Reconciliation.
4. Quality Measurement.
5. Other or N/A.

Value-Based Payment: A Bird's Eye View

Aparna Higgins
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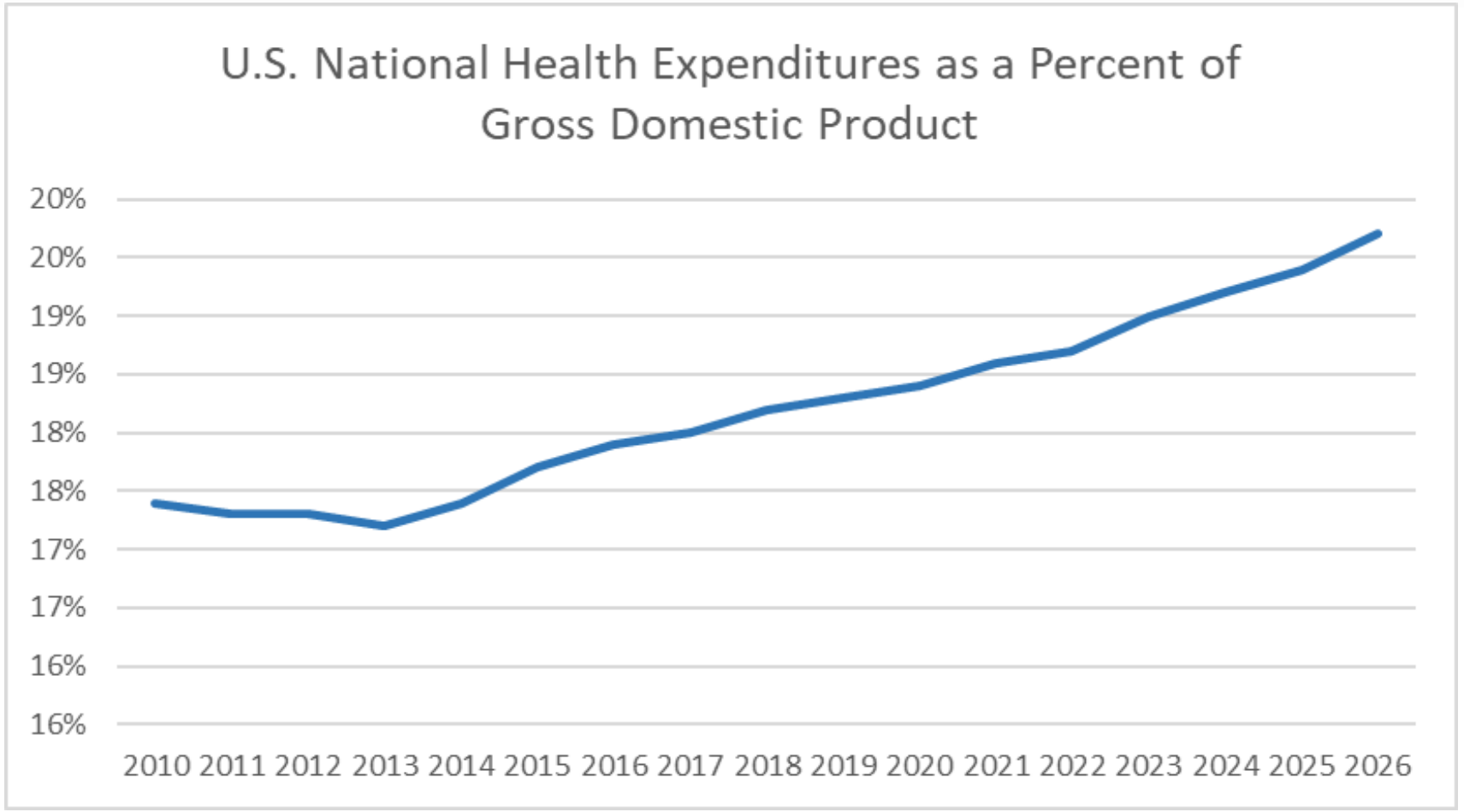
VBP Alphabet Soup

Featured Presentation Agenda

- Value-based Payment
  - Rationale
  - Definitions and Framework
- Key Private Sector Trends
- Medicare VBP Initiatives
- State VBP Activities
- Challenges and the Road Ahead

Value-based Payment – Rationale

Continued Growth in US Healthcare Spending



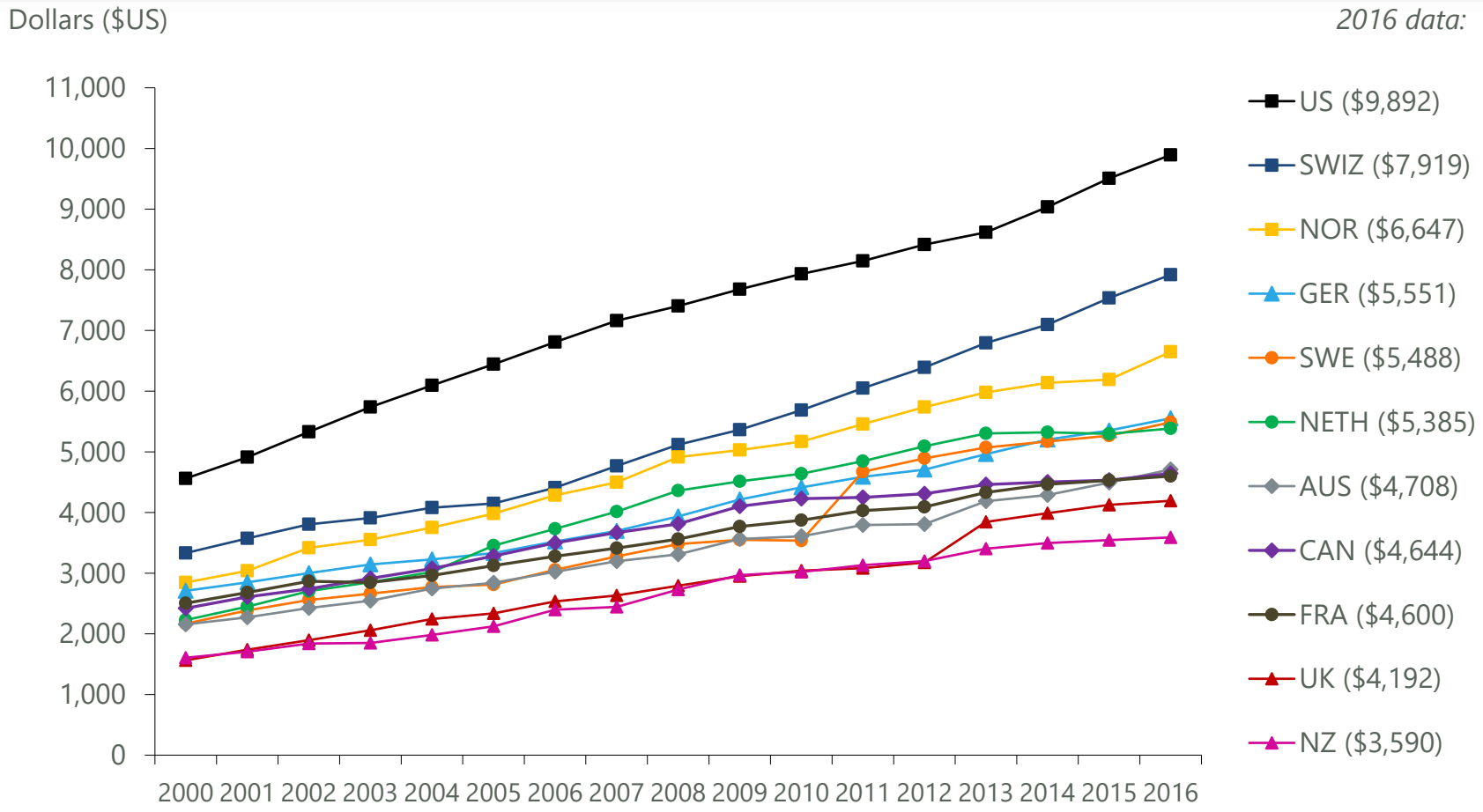
Growth in US Healthcare Expenditures 2008-2016: 4.2%.

CMS projecting annual average growth rate of 5.5% per year 2017-2026.

Crowding-out effect: Shift resources away from other priorities such as education.

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

Health Care Spending per Capita, 2000–2016



Note: Adjusted for differences in cost of living.

The Commonwealth Fund

Current expenditures on health per capita, adjusted for current US$ purchasing power parities (PPPs). Based on System of Health Accounts methodology, with some differences between country methodologies (Data for Australia uses narrower definition for long-term care spending than other countries).
Source: OECD Health Data 2017.

Select Population Health Indicators, 2015

	Life expectancy at birth Years	**Infant mortality** Deaths per 1,000 live births	**Obesity rate** Percent (%) SM, self-reported; M, measured	**Daily smokers** Percent (%) of population over 15 years
Australia	82.5	3.2	27.9 (M)*	13**
Canada	81.7 **	4.8 ***	25.8 (M) **	14*
France	82.4	3.7	15.3 (SR) *	22.4*
Germany	80.7	3.3	23.6 (M) ***	20.9**
Netherlands	81.6	3.3	12.8 (SR)	19
New Zealand	81.7	5.0 **	30.7 (M)	15
Norway	82.4	2.3	12.0 (SR)	13
Sweden	82.3	2.5	12.3 (SR)	11.2
Switzerland	83	3.9	10.3 (SR) ***	20.4***
United Kingdom	81	3.9	26.9 (M)	19*
United States	78.8	5.8 *	38.2 (M) *	11.4*
OECD median	**81.3**	**3.3**	**18.0 (M/SR)**	**18.9**

The Commonwealth Fund

^ Or nearest year: * 2014 data; ** 2013 data; *** 2012 data. (M) Measured; (SR) Self-reported. 'OECD median' reflects the median of 35 OECD countries.
Source: OECD Health Data 2017.

Main Drivers for Shifting the Paradigm to VBP

Continued Rise in Healthcare Costs

Wasteful Spending/Inappropriate Care

Provider Openness/ Readiness

Significant Room for Improvement in Quality

Move Care Delivery Model from Silos to Integrated Care

Value-based Payment – Definitions and Framework

Making Sense of the VBP Alphabet Soup

Value-based Payment

- Tying payment to value.
- Value measured by two dimensions – quality and cost.
- Primary focus on payment to providers.
- VBP for medical technology, such as drugs, devices etc., emerging.

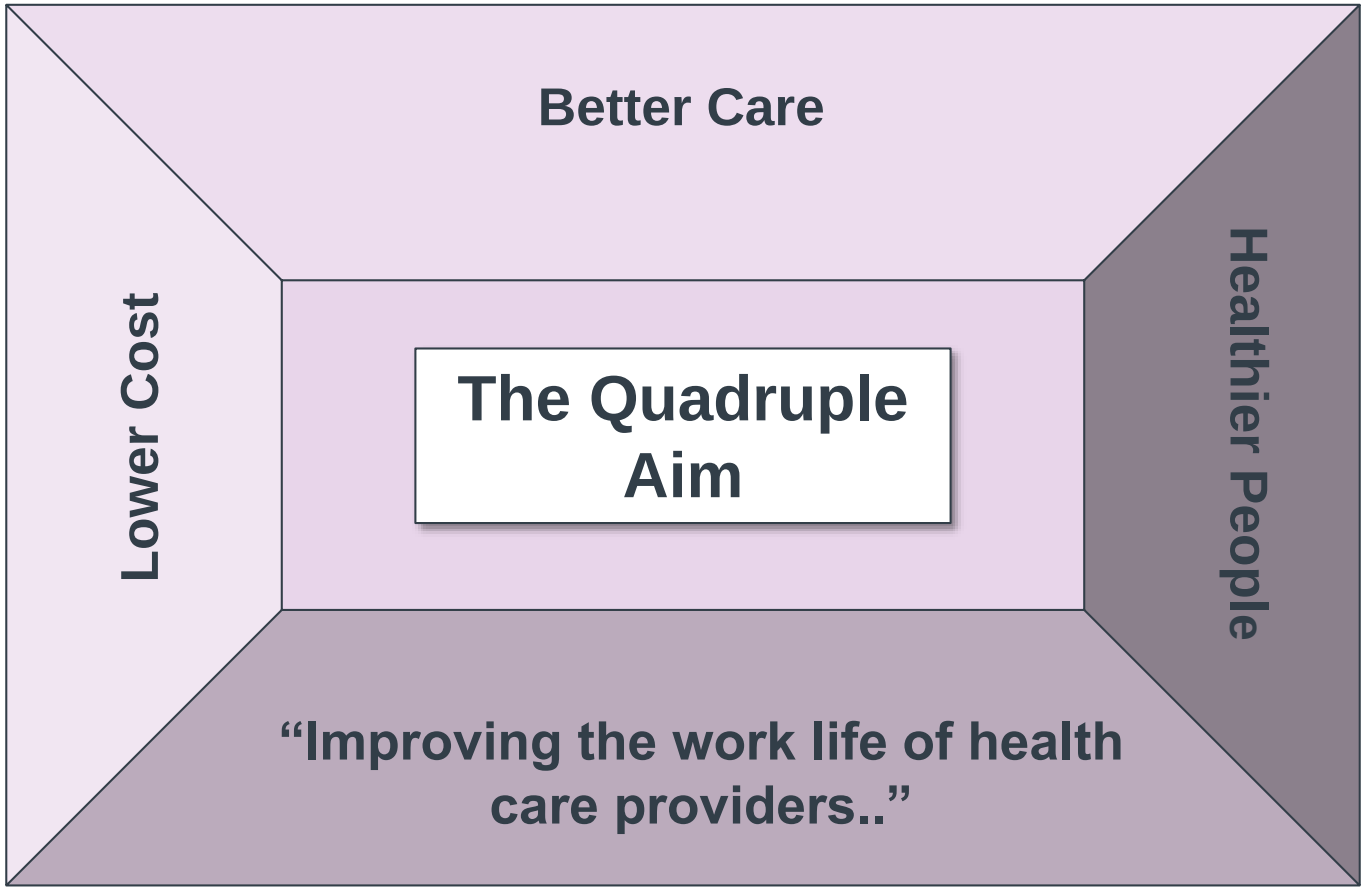
Alternative Payment Models

- Often used synonymously with VBP, especially for providers.
- Unlike traditional FFS which has no links to quality or value.

Delivery System Reform

- Changing care delivery models – moving from silos to integrated care for patients.
- Payment is a lever to achieve delivery system reform.

VBP Goals: From Triple to Quadruple Aim



Source: "From triple to quadruple aim: care of the patient requires care of the provider"; Bodenheimer T[1], Sinsky C[2].Ann Fam Med. 2014 Nov-Dec;12(6):573-6. doi: 10.1370/afm.1713.

Alternative Payment Model Components

Payment/Incentive Method

- Using non-FFS methods of payment.
- Examples include pay for performance, care management fee, shared savings, shared risk, partial to full capitation.

Quality Measurement

- Assess provider performance.
- Clinical quality: e.g. Hemoglobin A1c control for diabetics.
- Patient experience with care – survey-based measures.

Patient Attribution

- Methods to assign responsibility/ accountability for quality and costs of patients to providers.

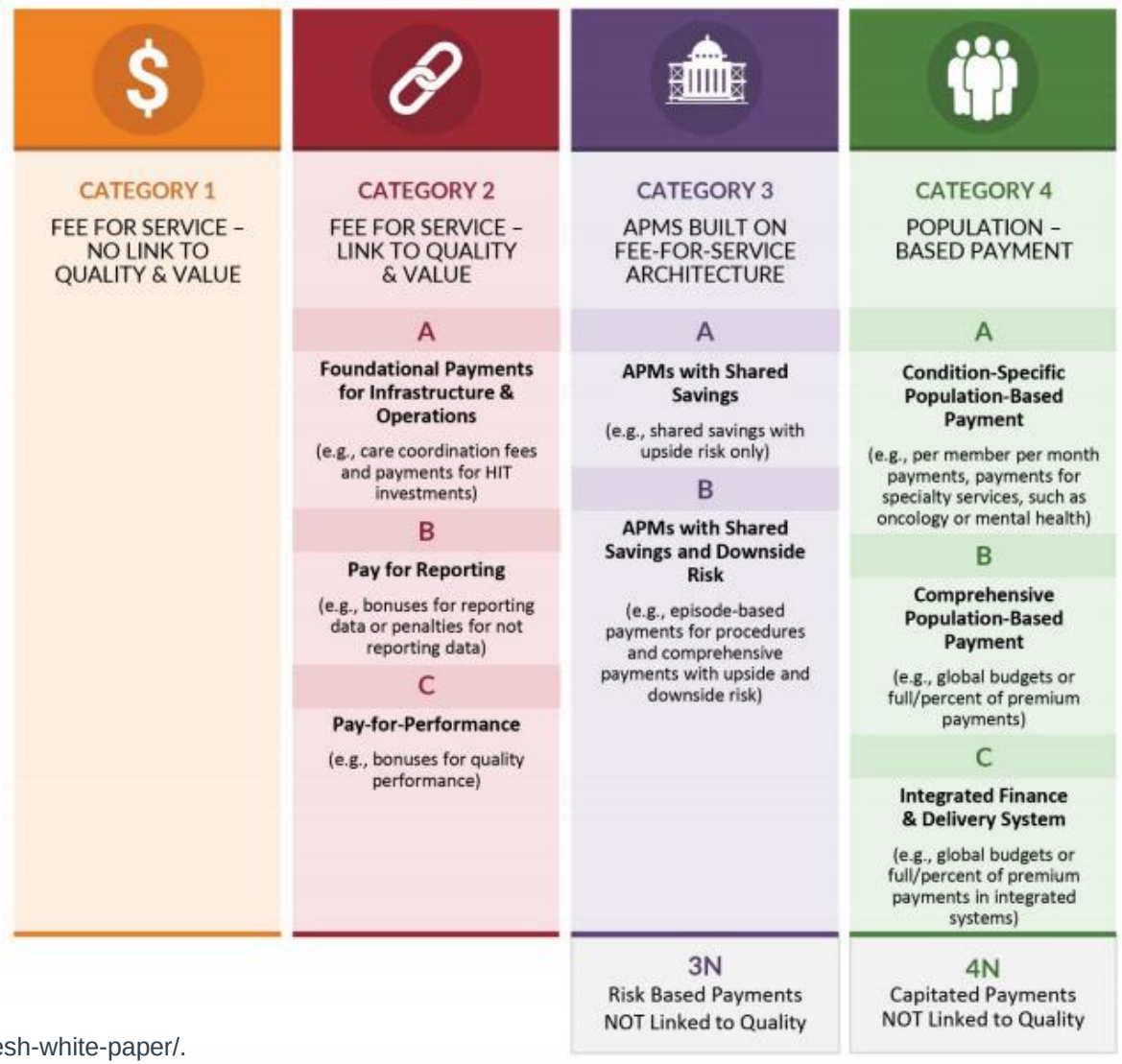
Financial Benchmarking

- Establish cost/spending targets that providers need to meet to earn incentives.

Data & Information

- Sharing of data and information dashboards to help providers manage attributed patients.

Alternative Payment Model Spectrum



Source: https://hcp-lan.org/groups/apm-refresh-white-paper/.

Ananya Health Solutions LLC

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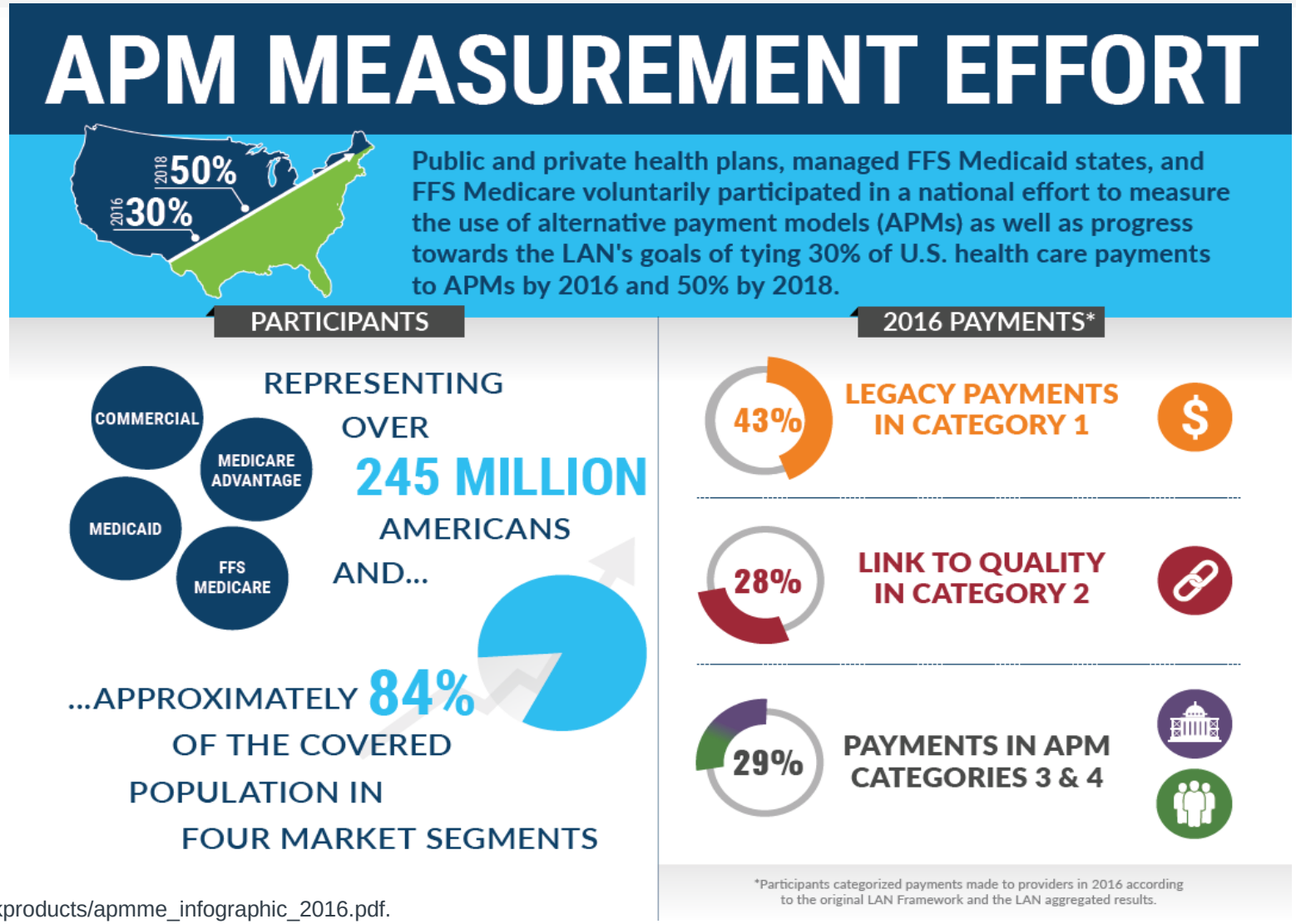
Alternative Payment Model – Key Facts and Figures



Source: http://hcp-lan.org/workproducts/apmme_infographic_2016.pdf.

Key Private Sector Trends

Key Private Sector Trends

Growth in VBP Efforts

Attention to Minimizing Impact of Price

Focus on Reducing Wasteful Expenditure/ Inappropriate Utilization

Customize Initiatives in Terms of Provider Readiness

Examples of Private Sector VBP Models

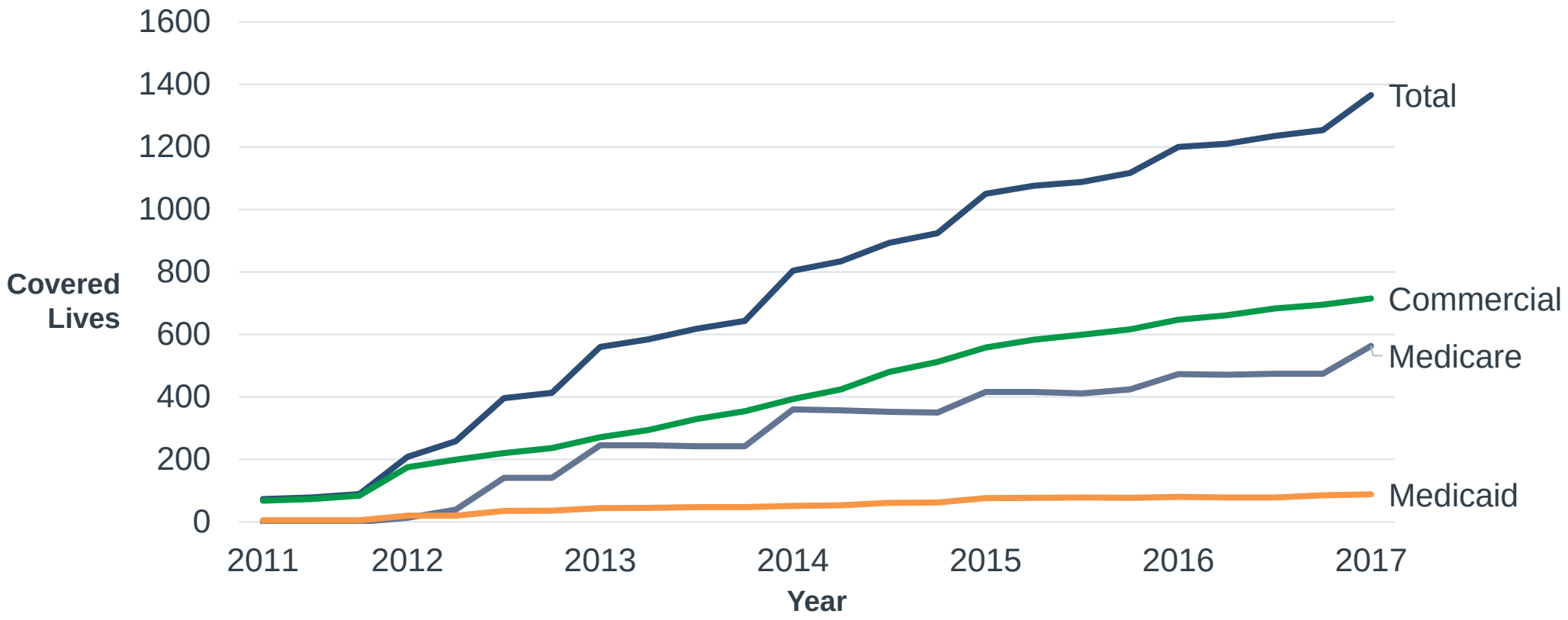
Population Health Models – Primary Care Focused	Specialty Care Models – Bundled Payments
Patient-centered Medical Homes (PCMH) Accountable Care Organizations (ACO)	Oncology Orthopedic Surgery Maternity Cardiology

VBP Model Definitions

- **"PCMH** is an approach to delivery of primary care that is patient-centered, comprehensive, coordinated, accessible, and committed to quality and safety."
- **"ACO** is a group of health care providers who agree to share responsibility for the quality, cost, and coordination of care with aligned incentives for a defined population of patients."
- **Bundled payment**, sometimes referred to as episode-based payment, is a single payment for all services related to a clinical episode of care for the patient.

Sources:
https://www.pcpcc.org/about/medical-home.
https://www.aafp.org/practice-management/payment/acos.html.

Growth in ACOs Across Payers



Source: https://www.healthaffairs.org/do/10.1377/hblog20170628.060719/full/.

Provider Readiness Factors for Entering VBP Models in Private Sector

Criteria	How Applied
Demonstrated Experience	▪ NCQA or URAC certification of the ACO. ▪ Participation in CMS demonstrations. ▪ Contracted HMO risk arrangements. ▪ Participation in collaborative learning opportunities (e.g., webinars, local market virtual sessions).
Health IT Capabilities	▪ Use of EHR and disease registry. ▪ Meeting “Meaningful Use” requirements.
Commitment to Care Delivery Transformation	▪ Documented ACO and clinical management governance processes. ▪ Detailed clinical action plans including approaches to improving patient safety and patient health status. ▪ Ensuring 24/7 availability of providers.

Source: Aparna Higgins, Kristin Stewart, Grant Picarillo, Nicole Brainard, Kirstin Dawson, *American Journal of Accountable Care Health Plan–Provider Accountable Care Partnerships: How Have They Evolved?*, March 2016.

Provider-Health Plan Relationships in VBP

Types	How Implemented
Data	▪ Claims history. ▪ Claims extracts for attributed population continually provided. ▪ Hospital and emergency department census.
Analytic Reports	▪ Predictive analytics and early identification of members at risk for disease or condition exacerbation. ▪ Identification of high-risk members who can benefit from care management support. ▪ Benchmarking reports – compare ACO performance on quality and costs to targets and peers. ▪ Reports that allow ACOs to assess performance of other providers and determine appropriate referrals.
Care Management	▪ Care transition programs for patients discharged from hospitals. Referrals to Centers of Excellence. ▪ Disease and case management.
Consultative Support	▪ Assistance with development of first-year plans for ACO. ▪ Staff resources that help providers use the data and analytic reports and identify opportunities for improvement.

Source: Aparna Higgins, Kristin Stewart, Grant Picarillo, Nicole Brainard, Kirstin Dawson, *American Journal of Accountable Care Health Plan–Provider Accountable Care Partnerships: How Have They Evolved?*, March 2016.

Are Private Sector VBP Models Delivering Value?

Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

Independent evaluation by academic researchers at Harvard University.

Demonstrated the following results since program inception in 2009:

- Quality of care – both preventive and management of chronic conditions better than national average.
- Significant cost savings – increased from 2.4% in 2009 to 10% in 2012 when compared to control group.

Source: https://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html.

Are Private Sector VBP Models Delivering Value?

VBP Outcomes Data (Self-reported from Select National Plans)
Magnitude of Cost and Quality Improvements Vary Across Health Plans

Improvements in Quality

- Decrease in ED visits: 7% -59%.
- Decrease in Inpatient admits: 6% - 28%.
- Improvements in clinical quality such as preventive screenings, diabetic management, etc.
  - Higher HEDIS scores by 26%.
  - Ten percent better overall quality performance.
  - Six to 14% increases in screenings, well visits, maternity care diabetes management.

Cost Savings

- Four percent lower total cost of care vs. control group.
- Savings generated:
  - 44% lower costs for specific procedures, such as spine and joint surgery.
  - $424 million between 2008-2016.

Sources:
https://www.cigna.com/assets/docs/newsroom/ccc-aco-program-proof-points-2016.pdf?WT.z_nav=newsroom%2Fknowledge-center%2Faco%3BBody%3Bpdf.
https://www.uhc.com/valuebasedcare/report;https://www.humana.com/provider/support/vbc/results.

Medicare VBP Initiatives

CMMI Innovation Model Categories – Ongoing/Announced

Categories	Number of Models Being Tested
Accountable Care	5 Models
Bundled Payment	5 Models
Primary Care Transformation	4 Models
Initiative Focused on Medicaid/CHIP Populations	3 Models
Initiatives focused on Medicare-Medicaid (Duals) Enrollees	2 Initiatives
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	15 Initiatives
Initiatives to Speed the Adoption of Best Practices	7 Initiatives

Source: https://innovation.cms.gov/initiatives/index.html#views=models;last accessed March 12, 2018

Overview of Characteristics of CMMI Primary Care Initiatives

	CPC	FQHC	IAH	MAPCP	SIM-Model Test Round 1	HCIA-PCR
Convener	CMS	CMS	CMS	State entity	State entity	Individual awardees
Participants	About 500 primary care practices operating in 7 geographical regions.	About 500 FQHCs, mostly in rural areas, which provide primary care and serve 200+ Medicare beneficiaries.	15 primary care practices, which provide home visits across 14 states to Medicare patients with chronic conditions/disabilities.	About 850 practices in 8 states (VT, ME, NC, RI, NY, PA MI, MN); practices include some FQHCs, rural health clinics, and CAHs.	6 states (AR, MA, ME, MN, OR, VT); some overlap with MAPCP (ME, MN, VT) and CPC (AR, OR).	14 awardee organizations; only 8 included in this study* *(mix of community-based organizations, providers, payers).*
Participating Payers	Multi-payer model—commercial insurers, Medicare, Medicaid, CHIP (4-8 payers per region).	Single-payer model—Medicare FFS.	Single-payer model—Medicare FFS.	Multi-payer model, which varies by state—Medicare, Medicaid, and commercial insurers (4-9 payers per state).	Varies by state—Medicaid in all states; multi-payer in 3 states (AR, OR, and VT); Medicare is not participating in any state.	Varies by award, but not Medicare of Medicaid.
Period of Performance	October 2012—December 2016	November 2011—October 2014	June 2012—September 2017	July 2011—December 2016	October 2013—April 2018	June 2012—June 2015 (some June 2016)
Distinguishing Features	• Multi-payer model in 7 regions. • Generous financial support, intensive TA, and data provision. • Milestone approach to help practice transform.	• Single-payer. • Low financial support from Medicare, although complemented by funding from HRSA and other sources. • Goal was to have FQHCs become PCMHs and get NCQA recognition.	• Home-based care model, not PCMH. • 15 experienced practices, so no up-front support and little TA from CMS. • Patients had multiple chronic conditions and ADL limitations.	• Multi-payer model in 8 states. • Variation by states in model, financial support, and TA. • CMS joined ongoing initiatives in many states. • Practices had to have PCMH recognition on entry or within 6-18 months.	• Goal is to transform the state's health care system and have 80% of payments in each state under value-based or alternative payment models. • Multiple interventions in each state. • More emphasis on payment models and infrastructure (e.g., health IT/HIE). • Medicare FFS not a participating payer.	• Each award was a separate delivery reform intervention, some were multiple interventions. • Smaller initiatives which were tailored to the specific local situations. • Lump-sum awards. • Little CMS involvement post-award.

Source: https://innovation.cms.gov/Files/reports/primarycare-finalevalrpt.pdf.

Sampling of CMMI Models

Population Health Models	Specialty/Bundled Payment Models
Medicare Shared Savings Program (MSSP)	Oncology Care Model
Comprehensive Primary Care Plus	Comprehensive Joint Replacement (CJR)
NextGen ACOs	Bundled Payment for Care Improvement
	Comprehensive End-stage Renal Disease (ESRD)

MACRA Overview

MACRA Signed Into Law April 2015

Merit -Based Incentive Payment System (MIPS) Path offers potential bonuses or penalties depending on how eligible professionals perform in four categories:

- Quality – drawn from existing Medicare Part B Physician Quality Reporting System (PQRS).
- Resource Use – drawn from existing Medicare Part B value-based payment modifier program.
- Meaningful Use of certified electronic health records technology.
- Clinical practice improvement activities.

Alternative Payment Model (APM) Path offers a 5% bonus for eligible APMs that include certain Innovation Center projects, Medicare Shared Savings Program ACOs, and required demonstrations. In addition, must:

- Participate in a quality program.
- Use certified EHR technology; and
- Bear “more than nominal financial risk” or be qualifying medical home.
- To qualify for the 5% bonus must also have certain threshold of their Part B covered by professional services furnished through APM entity.

Are Medicare VBP Models Delivering Value?

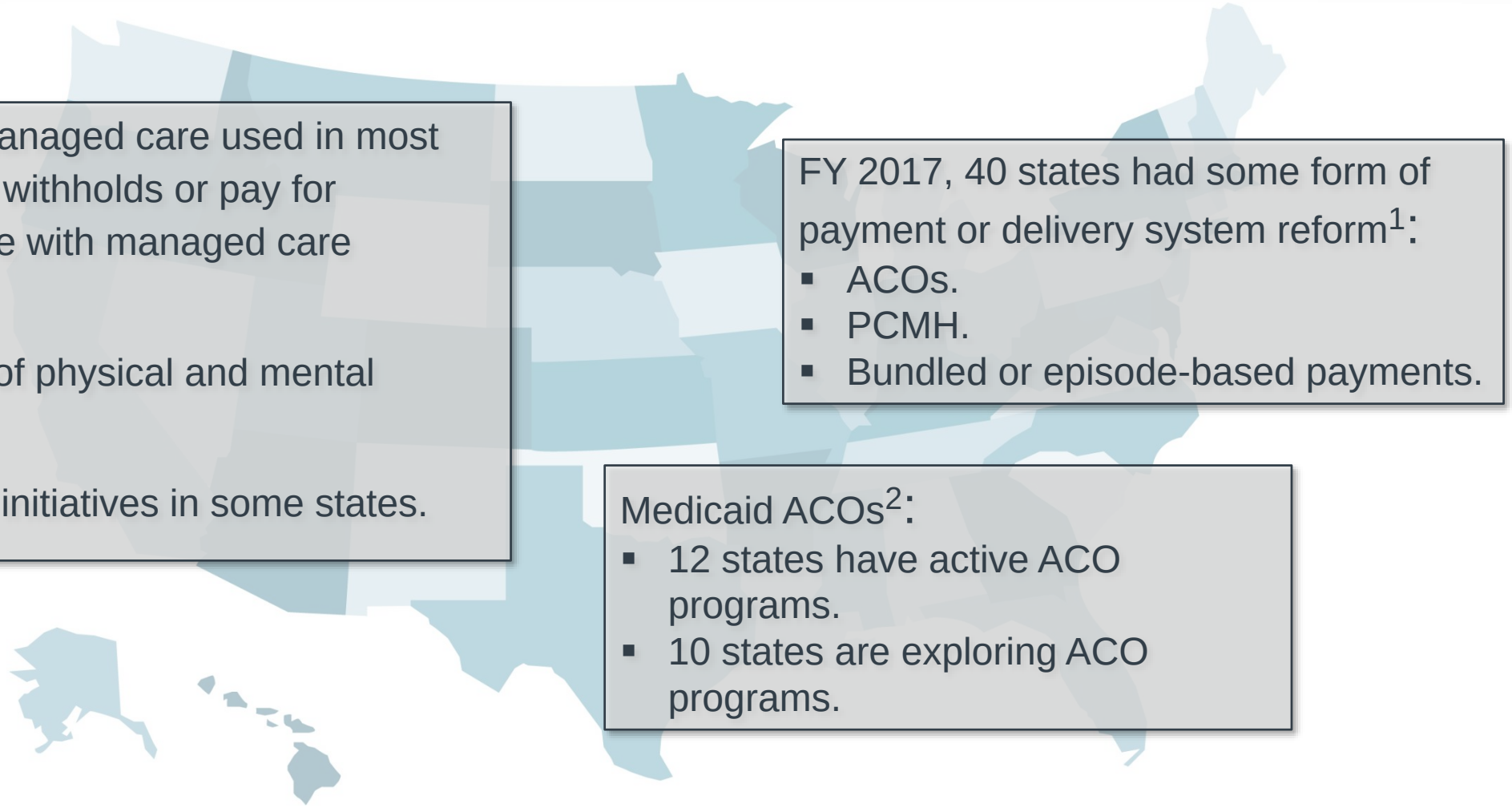
- Participants' progress towards practice transformation.
- Collectively four out of six primary care initiatives did not show significant differences between intervention and control groups on:
  - ED visits, Medicare spending, hospital admissions and 30-day readmissions.
  - Mixed results at the setting level associated with each initiative.
  - Four initiatives led to decreased Medicare spending for the high risk population and disabled beneficiaries.

Program	Outcomes
Medicare Shared Savings Program	▪ In 2016, 56% of Medicare Shared Savings Program ACOs saved relative to their financial benchmark and 31% earned shared savings bonus. ▪ Average composite quality score for ACOs was 93.4%.
Pioneer ACO	▪ Six of the eight Pioneer ACOs generated savings and none had losses.
NextGen ACO	▪ 60% of ACOs earned savings and the remaining shared losses with Medicare.
Comprehensive ESRD Model	▪ 92% of participants received a shared savings bonus. ▪ Net savings rate of approx. $1,500 per beneficiary. ▪ Better than expected quality and mortality rates.

Sources:
https://www.healthaffairs.org/do/10.1377/hblog20171120.211043/full/.
https://innovation.cms.gov/Files/reports/primarycare-finalevalrpt.pdf.

State VBP Activities

VBP: What is Happening in States?



- Medicaid managed care used in most states. Use withholds or pay for performance with managed care contracts.
- Integration of physical and mental health.
- Multi-payer initiatives in some states.

FY 2017, 40 states had some form of payment or delivery system reform[1]:

- ACOs.
- PCMH.
- Bundled or episode-based payments.

Medicaid ACOs[2]:

- 12 states have active ACO programs.
- 10 states are exploring ACO programs.

Sources:
1. https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/.
2. https://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/.

Challenges and Road Ahead

Overall Challenges in Transition to VBP

Better Evidence

- Independent evaluations.
- Understanding what is the optimal mix of VBP components and environmental factors that can help achieve quadruple aim.

Data and Infrastructure

- Lack of timely availability of information for providers – claims lag.
- Clinical data (EHR, registry) – more timely but costly.
- Interoperability.

Payer Alignment on VBP Model Component Ware

- Attribution.
- Quality Measures.
- Financial Benchmarking.
- Data and Information Sharing.

Patient/Consumer Engagement in Healthcare

- Benefit design.
- Patient activation.

Addressing Social Determinants of Health (SDOH)

Socio-environmental factors such as housing, nutrition, environment and their impact on health.

"It's the Prices Stupid" – Need to address prices if we are to control costs.

The Road Ahead for Medicare

Value-based transformation is a top priority for HHS.

Areas of Emphasis:

- **Patients/consumers having greater control over their health data.**
- **Price transparency.**
- **Bolder experimentation in Medicare.**
- **Reducing government regulations that hinder VBP.**

Source: https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html.

The Road Ahead – All Payers

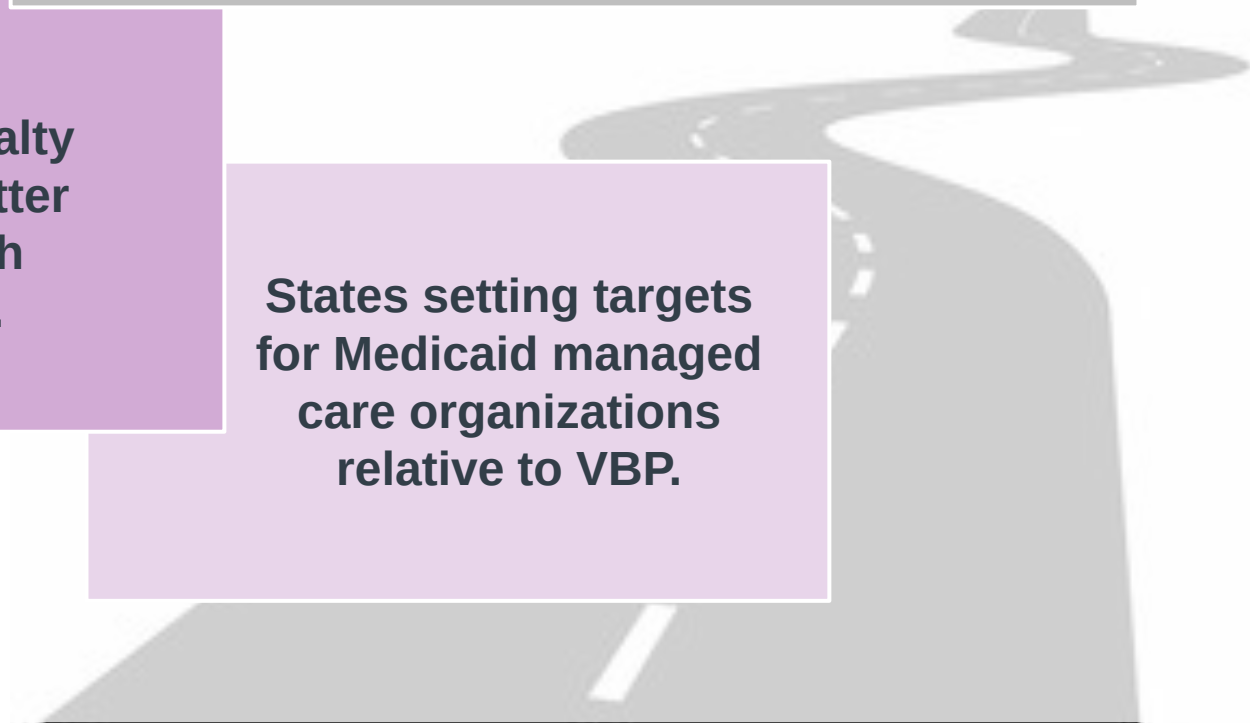
Ongoing experimentation and implementation of VBP models.

Multi-payer alignment of components, building on experience of existing multi-payer efforts.

Models of specialty care that are better integrated with primary care.

States setting targets for Medicaid managed care organizations relative to VBP.

Linking benefit design to VBP.



Polling Question #2

Which webinar topic is of most interest/relevance to you? (Select all the apply.)

1. Overview of CMMI Efforts in VBP.
2. State Efforts in VBP – Medicaid and Beyond.
3. Interoperability – Federal, State and Private Sector Efforts.
4. Other (Please describe in Questions).

CAQH CORE Participant Q&A

Please submit your questions and comments:

Submit written questions or comments on-line by entering them into the **Questions panel on the right-hand side of the GoToWebinar dashboard.**

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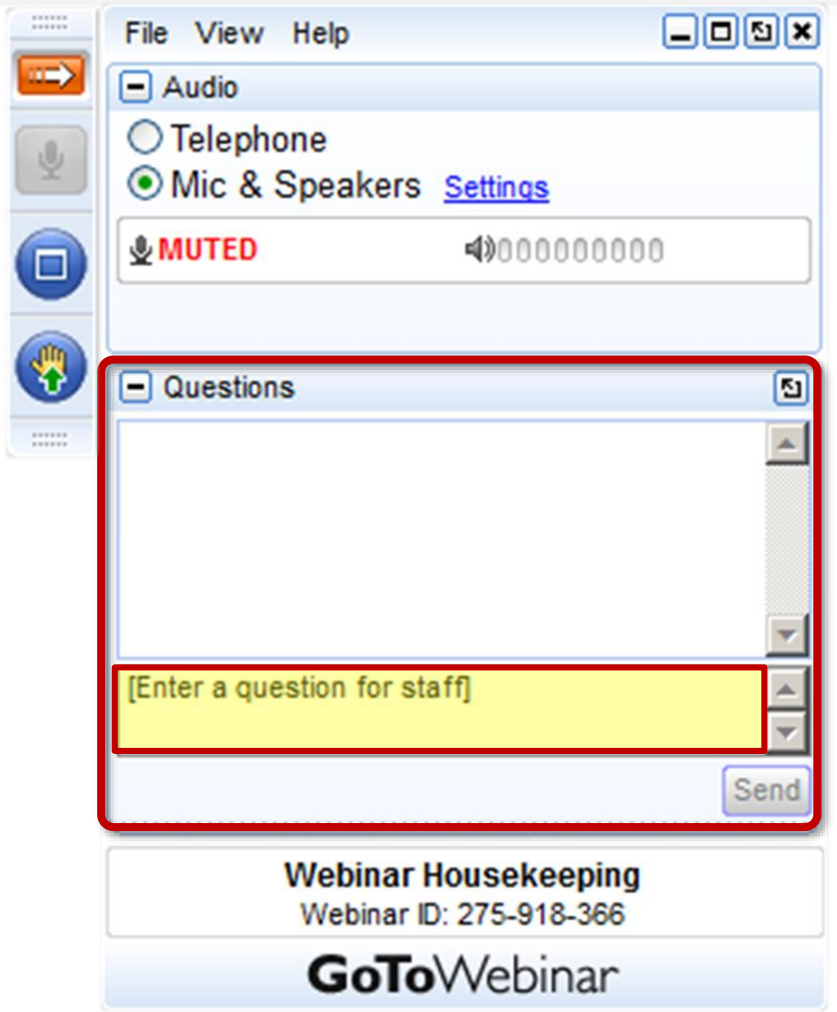

CAQH CORE VBP Education Series

Previous

Implementing Successful Value-based Payment: Alternative Payment Models with CMMI

THURSDAY, JANUARY 11TH, 2018

CAQH CORE and eHealth Initiative Webinar: Data Needs for Successful Value-based Care Outcomes

MONDAY, NOVEMBER 20TH, 2017

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TUESDAY, APRIL 10TH, 2018 – 1 PM ET

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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.