CAQH CORE

The Role of Interoperability in Value-based Payment

Guest Speaker: Dr. Kate Goodrich, Director of the CMS Center for Clinical Standards & Quality

May 3, 2018

2:00 – 3:00 PM ET

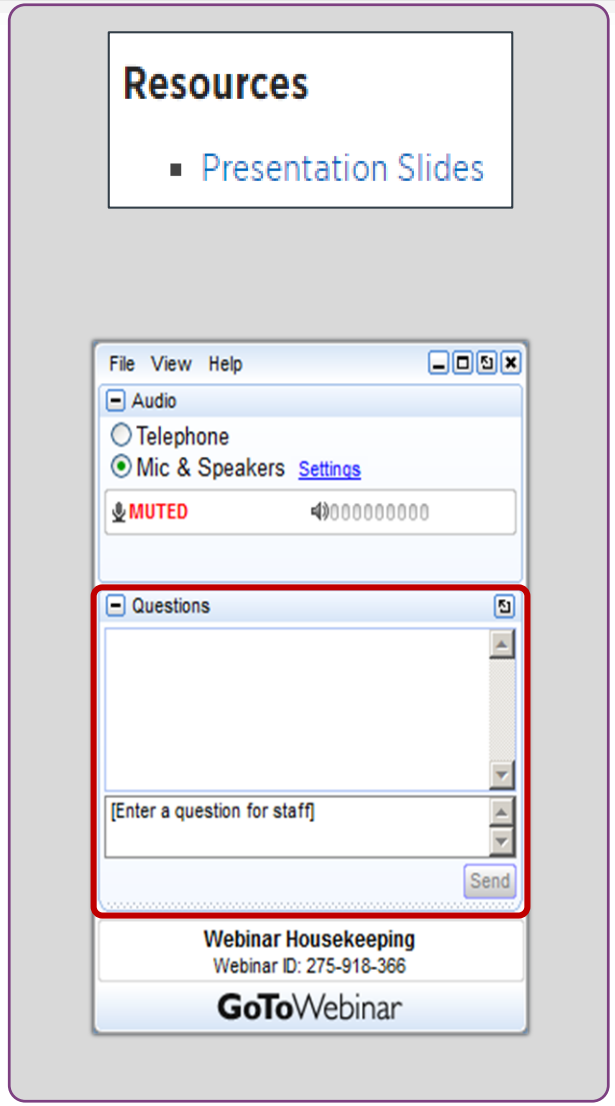
Logistics

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.

Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**



CAQH CORE Series on Value-based Payments

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

We would like to thank our speakers:

Dr. Kate Goodrich
Director, CMS Center for Clinical Standards and Quality and CMS Chief Medical Officer

Erin Weber
Director, CAQH CORE

Session Outline

- Introduction to VBP
- Overview of CAQH CORE Activities in VBP
- Featured Presentation: Value-based Purchasing and Interoperability at CMS
- Audience Q&A

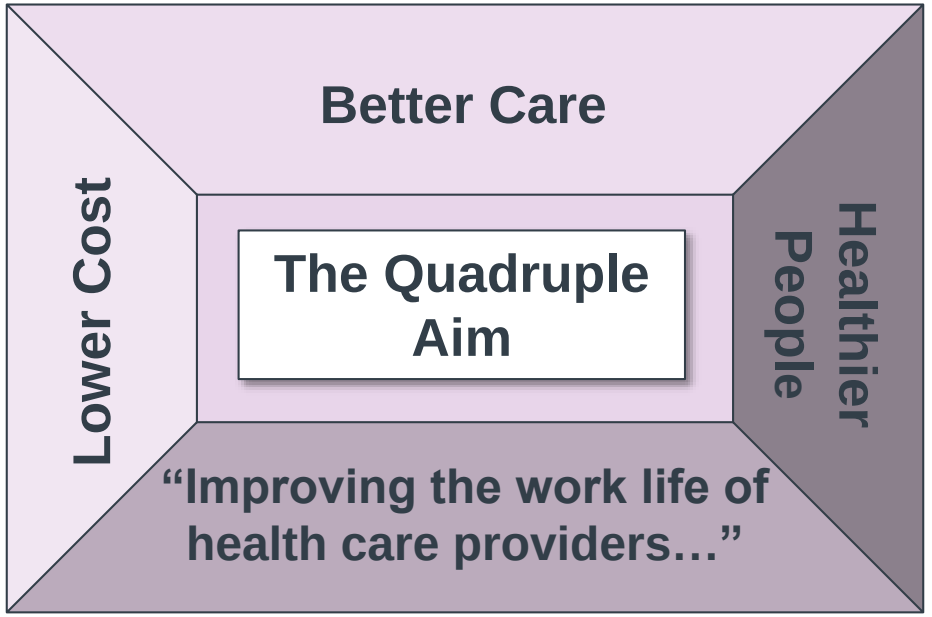
Introduction to VBP

Erin Weber
CAQH CORE Director

VBP Goals: From Triple to Quadruple Aim

- **Value-based care** is a healthcare delivery model in which providers are paid based on patient health outcomes.
- **Value-based payment** is a strategy used by purchasers to promote quality and value of health care services.

Value-based payment has the potential to improve U.S. mortality/morbidity rates and change the trajectory of national health expenditures.



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.

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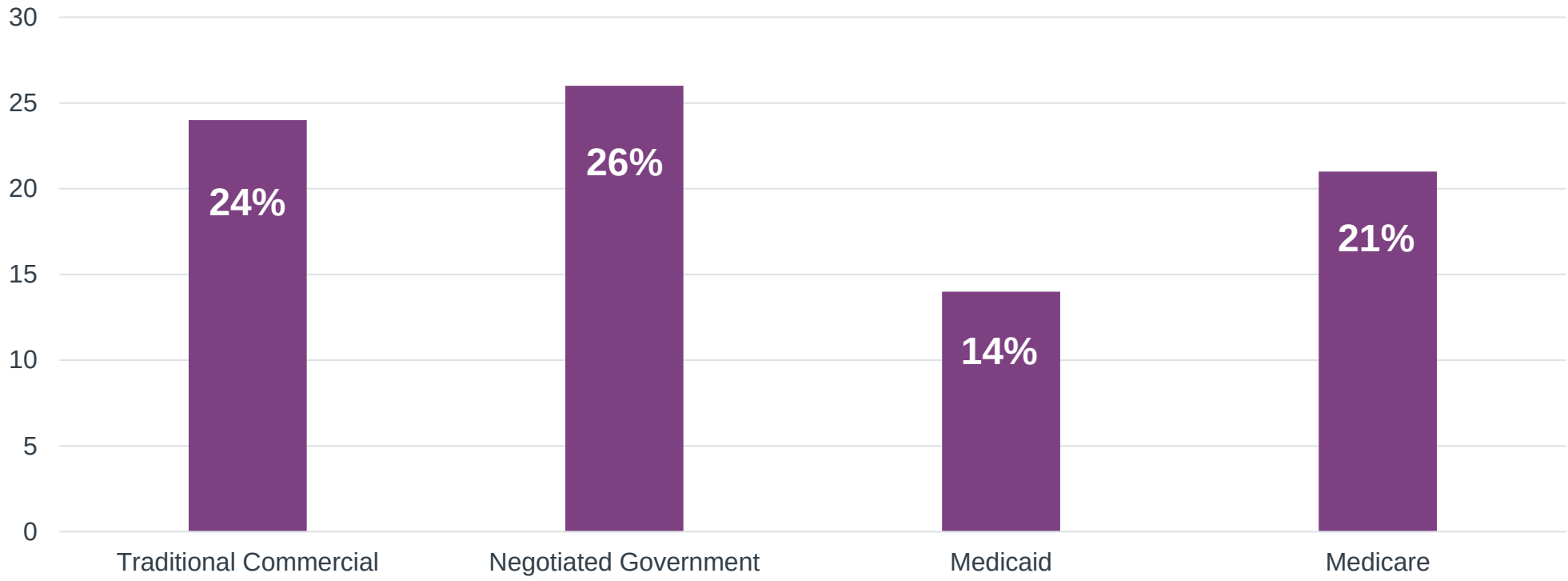
Industry VBP Readiness

A recent HFMA survey found that from 2015 to 2017, commercial payers using value-based mechanisms have increased from 12% to 24%.

Overall percentage of payments from health plans that incorporate value-based mechanisms.



Source: HFMA's Executive Survey; "Value-Based Payment Readiness Sponsored by Humana," 2018.

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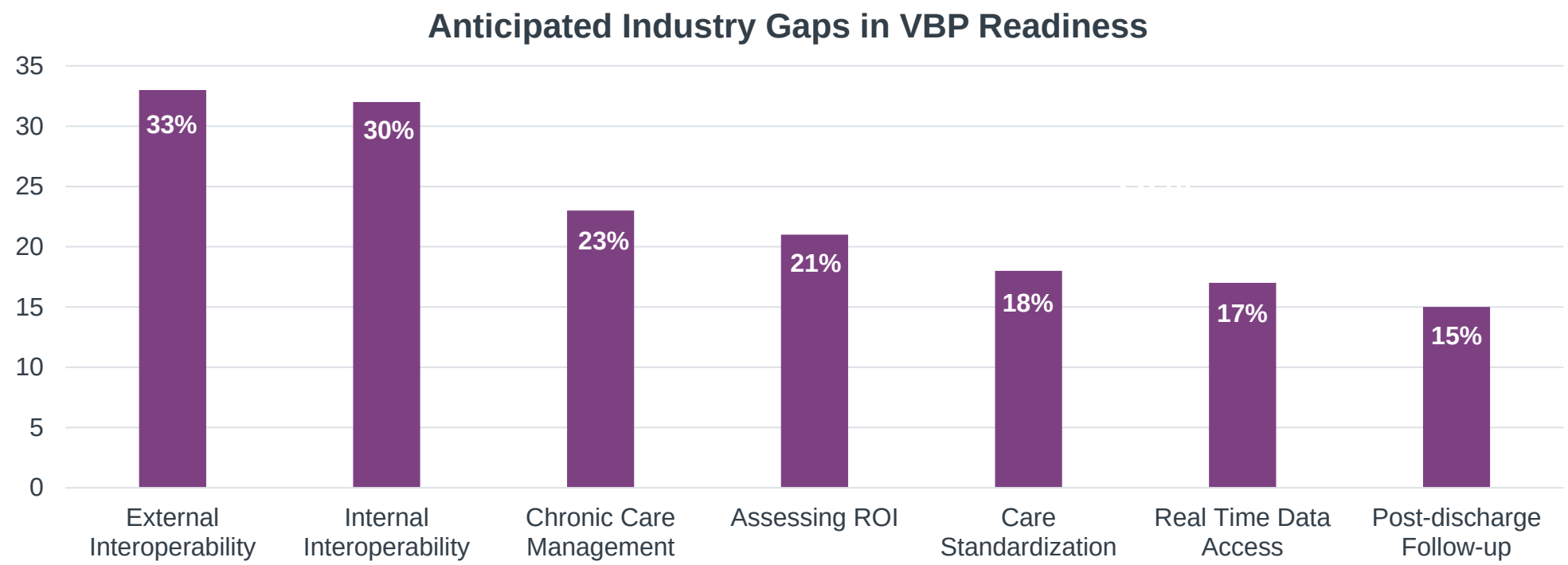
Interoperability is Critical for VBP Operational Success

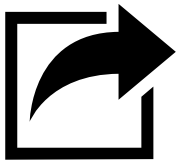
Industry Challenge

CAQH CORE research participants overwhelmingly called for improvements in interoperability – specifically technical and process interoperability.

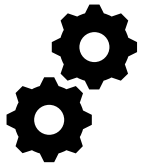


Source: HFMA's Executive Survey; "Value-Based Payment Readiness Sponsored by Humana," 2018.

Four Types of Interoperability Challenges



Process Interoperability: Common expectations for operational processes and workflows – infrastructure.



Technical Interoperability: Ability to pass data from one information system to another while maintaining accuracy and validity.

Semantic Interoperability: Agreement on shared meaning of data – vocabulary standards.

Policy Interoperability: Increased collaboration among stakeholders.

Overview of CAQH CORE Activities in VBP

CAQH CORE VBP Initiative

For over a decade, stakeholders have collaborated through CAQH CORE to bring consistency to the fee-for-service healthcare system.

Industry Shift

CAQH CORE Board recognized the importance of VBP.

Agreed that **CAQH CORE must expand its scope** to driving out unnecessary costs and inefficiencies from information exchange in both fee-for-service and VBP.

Alignment & Collaboration

Healthcare stakeholders must act decisively and collaboratively to prevent VBP from confronting the administrative roadblocks once encountered in fee-for-service. **CAQH CORE has expertise is developing industry solutions.**

New CAQH CORE Report: All Together Now

The report found there is a need for industry collaboration to minimize variations and identified opportunity areas that, if improved, would smooth VBP implementation.

Contents of Report

5 Opportunity Areas

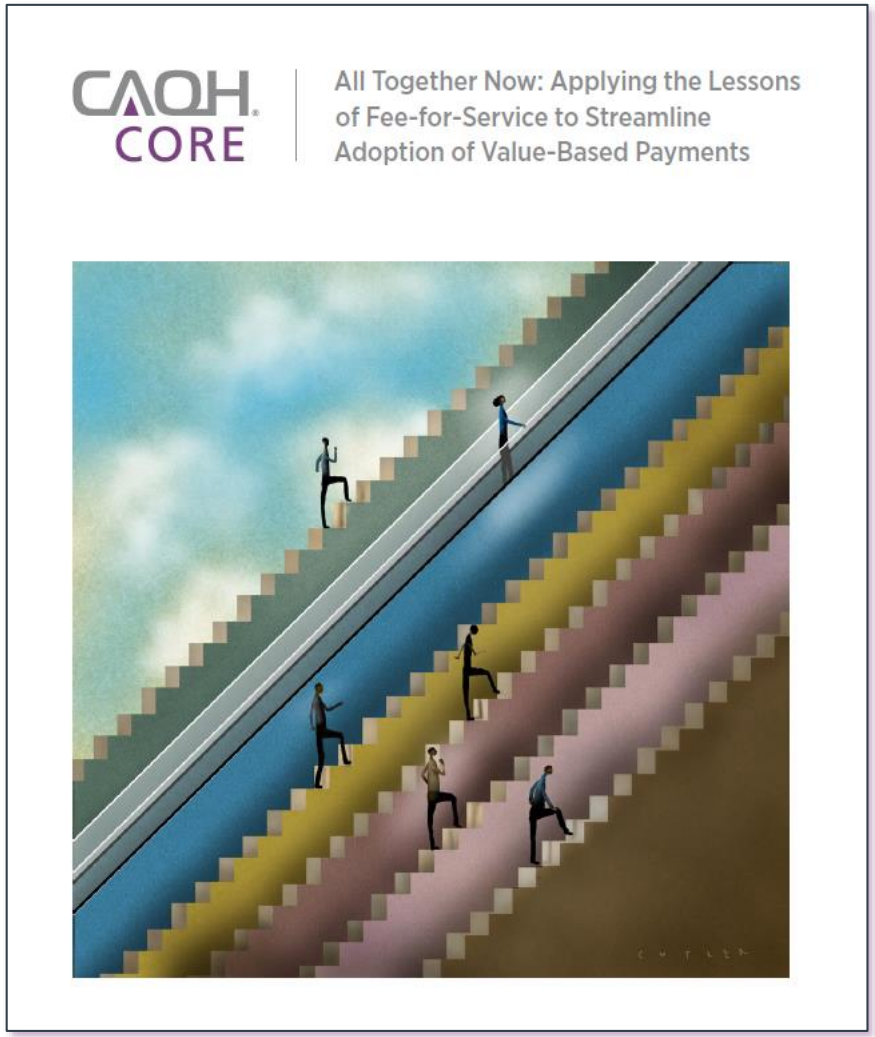
Unique operational challenges associated with VBP.

9 Recommendations

Address challenges and may be implemented by CAQH CORE/others.

Candidate Organizations

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



CAQH CORE Vision for VBP

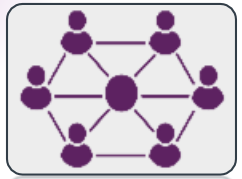
Our vision is a common foundation that drives adoption of evolving VBP models by reducing administrative burden, improving information exchange and enhancing transparency.

VBP Opportunity Areas

1. Data Quality & Standardization

2. Interoperability

3. Patient Risk Stratification



4. Provider Attribution

5. Quality Measurement

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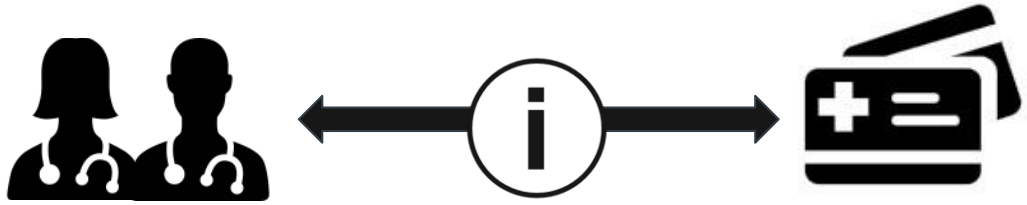
Opportunity Areas for Action

Interoperability

Industry Challenge

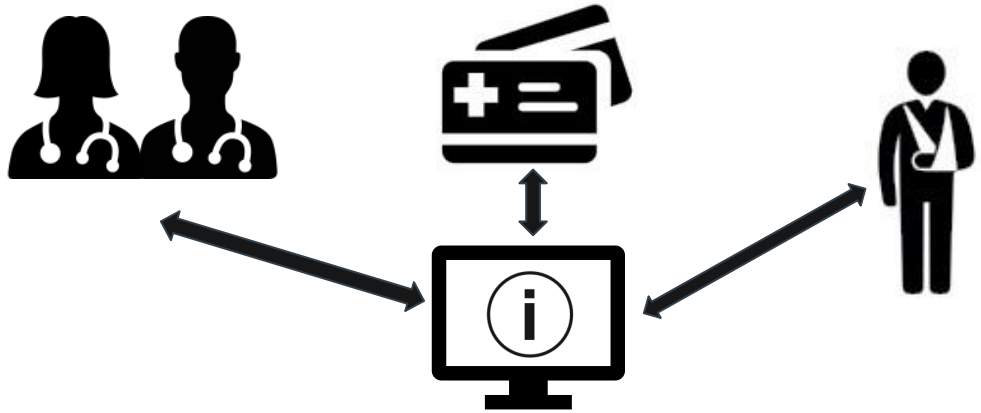
Data retrieval and integration roadblocks cause delays in quality-of-care analytics and prevent real-time, actionable information from reaching the point of care.

Technical Interoperability



Currently**, a limited set of pre-defined data** flows between known trading partners has been **implemented in non-uniform ways**. VBP needs data exchange to happen in real time, with full data privacy and security.

Process Interoperability



VBP requires **new and complex process capabilities**; there is a need to deliver patient management information at various points during an episode of care that is **accessible to all parties** involved.

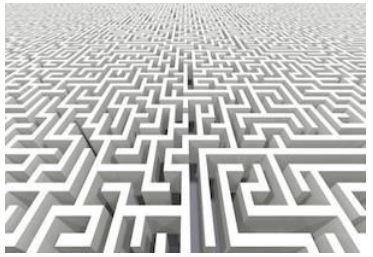
Recommendation

Interoperability

Recommendations and Strategies	
Promote technical interoperability by encouraging use of existing/emerging standards and technologies. • Encourage testing and promotion of new/emerging standards. • Educate on importance of data sharing to eliminate data blocking. • Explore how to assure expectations for marketplace adoption.	**Promote process interoperability by cataloging VBP best practices.** • Compile and disseminate workflow and policy best practices. • Address workflow and policy processes in operating rules.

Non-CMS Federal Efforts on Interoperability Impacting VBP

The Office of the National Coordinator for Health Information Technology



21st Century Cures Act

Covers an array of healthcare issues, including addressing health IT challenges with interoperability.

ONC Interoperability Roadmap

The Office of the National Coordinator for Health IT (ONC) is responsible for advancing connectivity and interoperability of health IT.

ONC has a 10 year plan for advancing interoperability.

Trusted Exchange Network

ONC is addressing how health information networks attest using a trusted exchange framework and common agreement for exchanging data among themselves.

Polling Question #1

Which opportunity area has the most potential to improve the operational components of VBP in your organization?

- Data Quality & Standardization
- Interoperability
- Patient Risk Stratification
- Provider Attribution
- Quality Measurement

Quality Payment
PROGRAM

Value-based Purchasing and Interoperability at CMS

Kate Goodrich, MD MHS

Director, Center for Clinical Standards & Quality, Chief Medical Officer

Centers for Medicare & Medicaid Services

Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

CMS support of health care Delivery System Reform will result in better care, smarter spending, and healthier people

Evolving future state

Public and Private Sector

Key characteristics

- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Systems and Policies

- Fee-For-Service Payment Systems

Key characteristics

- Patient-centered
- Incentives for outcomes
- Sustainable
- Coordinated care

Systems and Policies

- Value-based purchasing
- Accountable Care Organizations
- Episode-based payments
- Medical Homes
- Quality/cost transparency

Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

FOCUS AREAS

- Pay Providers
- Deliver Care
- Distribute Information

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

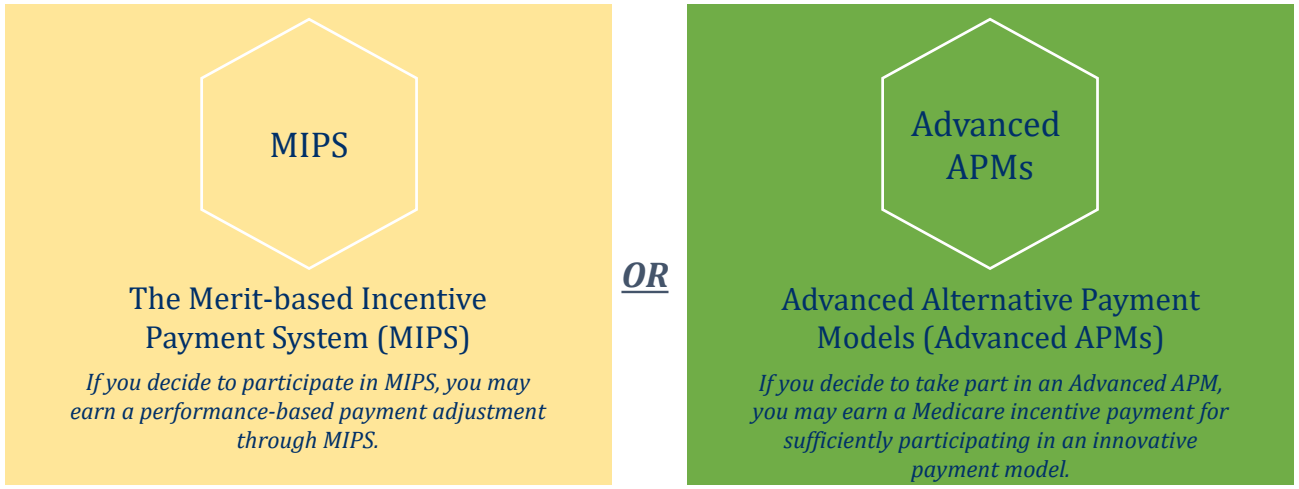
CMS Strategic Goals

- Empower patients and doctors to make decisions about their health care
- Usher in a new era of state flexibility and local leadership
- Support innovative approaches to improve quality, accessibility, and affordability
- Improve the CMS customer experience

Quality Payment Program

We've heard concerns that too many quality programs, technology requirements, and measures get between the doctor and the patient. That's why we're taking a hard look at reducing burdens. We aim to improve Medicare by helping doctors and clinicians concentrate on caring for their patients rather than filling out paperwork.

Clinicians have two tracks to choose from:



Quality Payment Program

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

MIPS Performance Categories Year 2

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

Advanced APMs
Generally Applicable Nominal Amount Standard

Transition Year 1 (2017) Final

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for the QP performance period in 2017 and 2018, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 (2018) Final

**The 8% revenue-based standard is extended for two additional years, through performance year 2020.

- Total potential risk under the APM must be equal to at least either:
  - 8% of the average estimated Parts A and B revenue of the participating APM Entities for QP Performance Periods 2017, 2018, 2019, and 2020, OR
  - 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Advanced APMs in 2017

- For the 2017 performance year, the following models are Advanced APMs:

Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)	Comprehensive Primary Care Plus (CPC+)
Shared Savings Program Track 2	Shared Savings Program Track 3
Next Generation ACO Model	Oncology Care Model (Two-Sided Risk Arrangement)

- The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.

Bundled Clinical Episodes: A New Concept

- BPCI Advanced requires new thinking
- Participants must now coordinate the entire episode

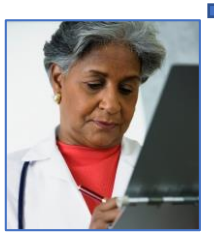
FFS **Bundled Clinical Episode**

Hospital

Hospital

SNF

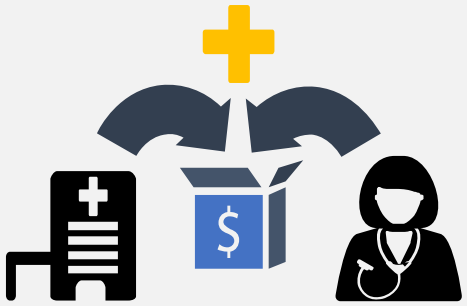
Patient's Home



Cardiologist

PCP

New Model: BPCI Advanced Tests a Different Approach to Payment



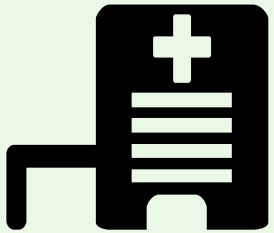
A bundled clinical episode links physician, hospital, and post-acute care payments to quality and cost

Participants may earn **additional payments from CMS**, but may owe money back to CMS, if costs are higher than expected

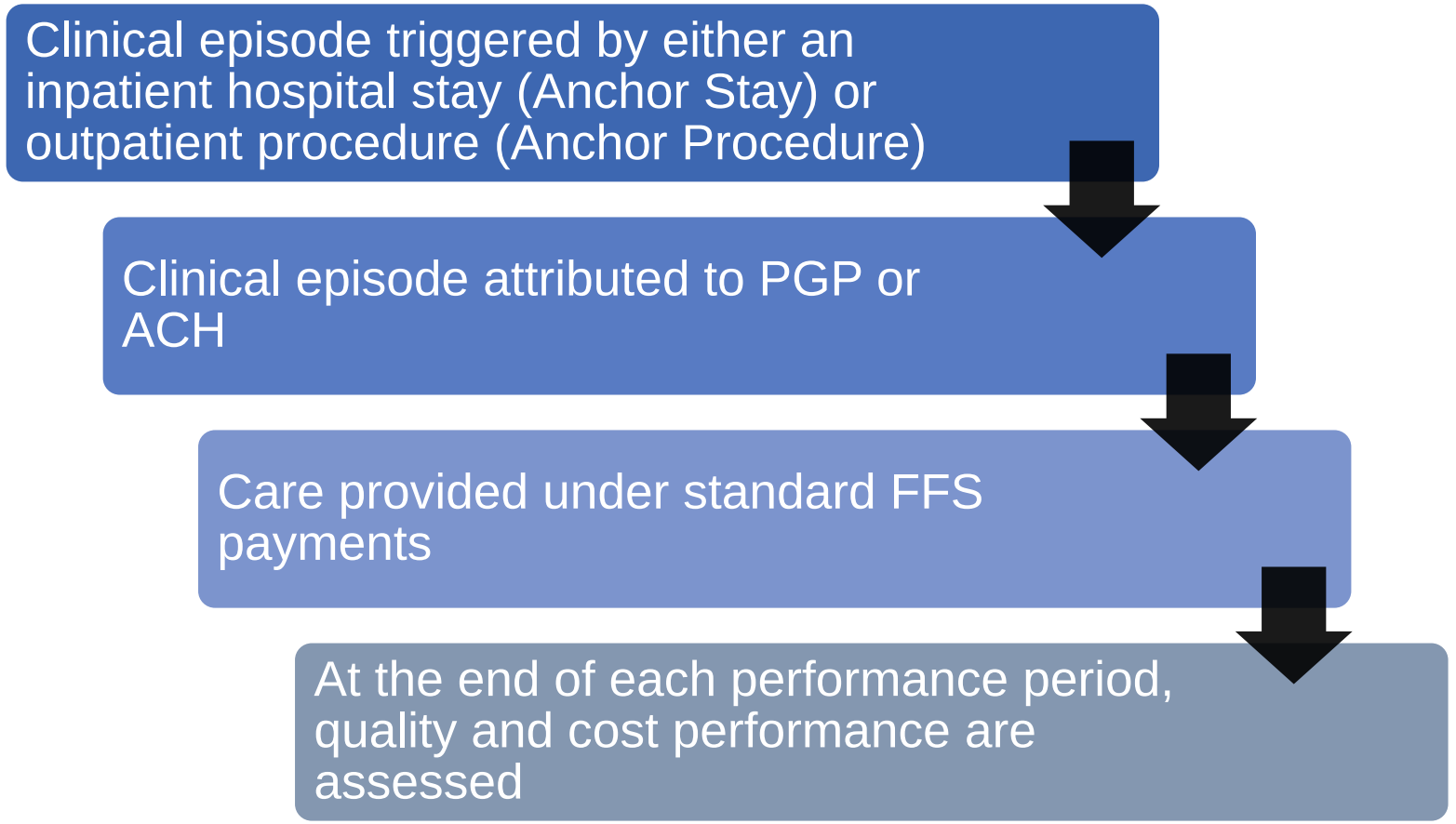
Who Leads Clinical Episodes?

Physician Group Practices (PGPs)

Acute Care Hospitals (ACHs)



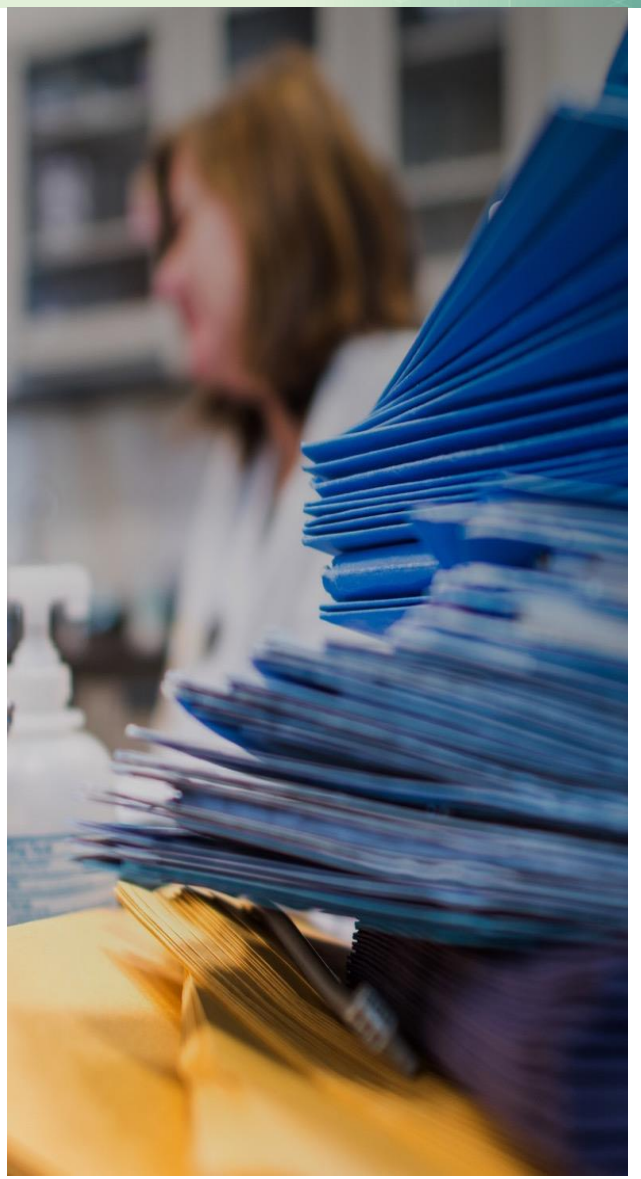
How Does BPCI Advanced Work?



PATIENTS OVER PAPERWORK

OUR TOP PRIORITY AT CMS IS PUTTING PATIENTS FIRST

CMS is committed to reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience.



GOALS

Patient over Paperwork aims to:

- Increase the number of customers – clinicians, institutional providers, health plans, etc. engaged through direct and indirect outreach
- Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance; and
- Increase the proportion of tasks that CMS customers can do in a completely digital way

APPROACH

CMS has set up an agency-wide process to evaluate and streamline our regulations and our operations with the goal to reduce unnecessary burden, increase efficiencies and improve the customer experience

- Formal Requests for Information
- Customer Centered Work groups
- Journey Mapping
- Meaningful Measurement Framework
- Promoting Interoperability
- Engaging Stakeholders

PATIENTS
OVER PAPERWORK

Examples of Work to Date

1. Greatly **reduced the number of EHR measures and thresholds** required for Meaningful Use and QPP
   - Re-engineering these programs for future years to **focus on interoperability** and further reducing burden for providers
2. Developed an **API for data submission** under QPP that can be used for reporting to MIPS for clinicians using registries or QCDRs
3. Developed a very user friendly **website for QPP** for obtaining information and submitting data
4. E/M Med Student Documentation
   - Now allow teaching physicians to verify in the medical record student documentation of E/M services, **rather than re-documenting** the student's notes

Meaningful Measures

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas:
- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas:
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas:
- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Reported Functional Outcomes

Work with Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas:
- Equity of Care
- Community Engagement

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas:
- Healthcare-Associated Infections
- Preventable Healthcare Harm

Make Care Affordable
Meaningful Measure Areas:
- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

**All presentation images are still under development.*

Meaningful Measures

- Remove low value measures
- Develop and implement measures that fill gaps in the framework – only high value measures
- Intensive work with Health IT organizations, registries and clinicians to reduce the burden of measurement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healthe
data

Putting Data in the Hands of Patients

What this means for CMS

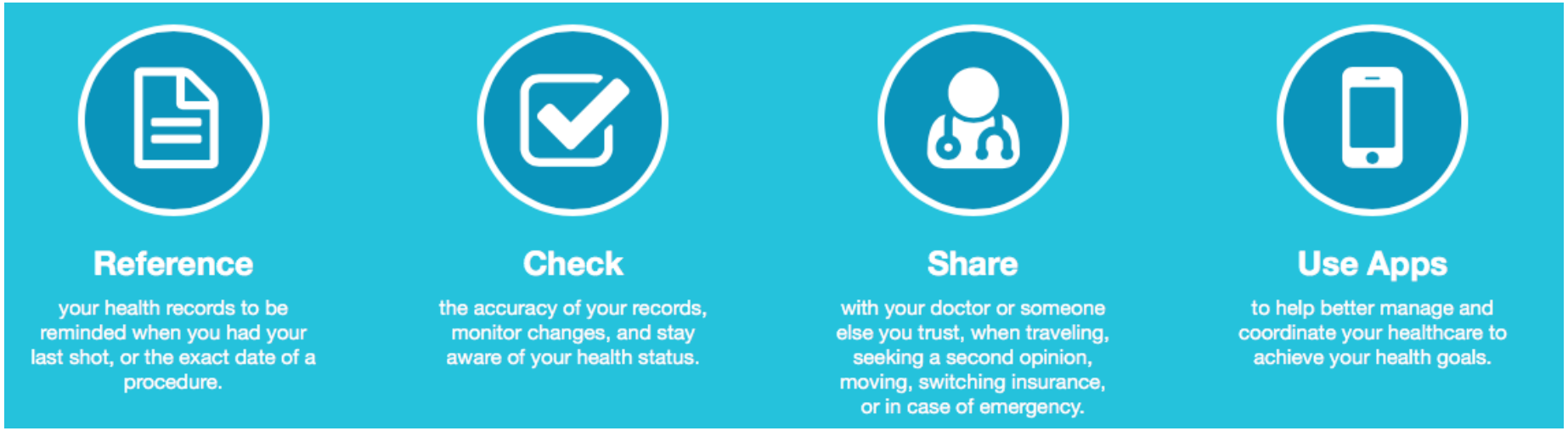
- Blue Button 2.0
  - Developer-friendly, standards-based API
  - Developer preview program – open now (over 100 developers so far)
  - Data security is of the utmost importance
- Overhaul of Meaningful Use and Advancing Care Information in QPP
  - Program alignment
  - Strong emphasis on interoperability and privacy/security
  - Flexibility
  - Lower burden
- 2015 edition Certified EHR Technology
- Prevention of Information Blocking
- Working with Commercial Payers in MA and Exchanges
- Star Ratings
- Require data sharing to participate in Medicare?

Quality Payment
PROGRAM

Medicare's Blue Button 2.0

What is Blue Button?

- **The Blue Button symbol identifies places to get your personal health records electronically**
- **With Blue Button, you can:**



A Brief History of Blue Button

2010

May 2010: CMS & VA hold innovation event to increase consumer access to data through PHRs

Aug 2010: VA releases Blue Button download

Sept 2010: CMS releases Blue Button download

2018

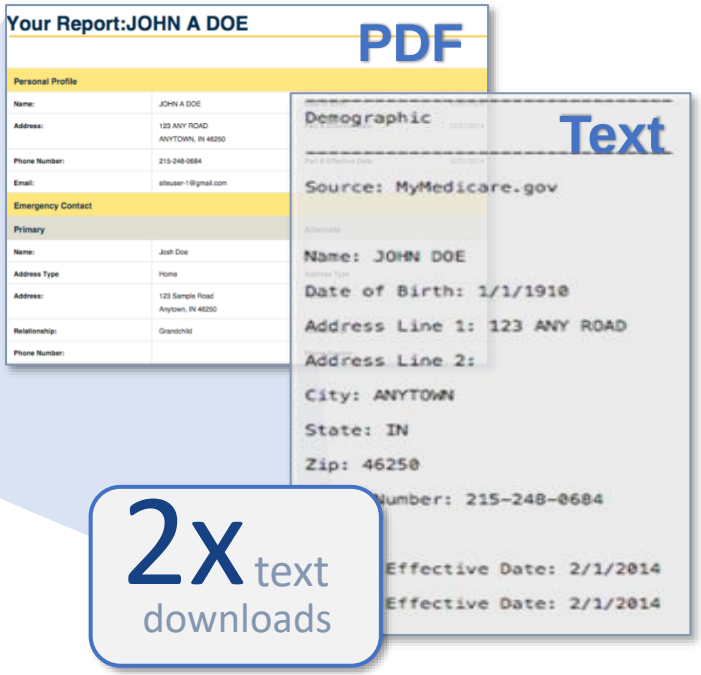
March 2018: CMS launches Blue Button 2.0 to add developer-friendly, standards-based API to the existing text and PDF downloads

CMS Blue Button in Use Pre-2018

Federally Inspired
Blue Button Community
- VA
- DoD (TRICARE)
- CMS

20–30k
Downloads per Month

Private sector applications ingest, optimize, and visualize data from Blue Button text files



1.5M
CMS users

Beneficiaries can download up to 3 years of claims data
- Hospital
- Physician
- Prescription drugs

2x text downloads

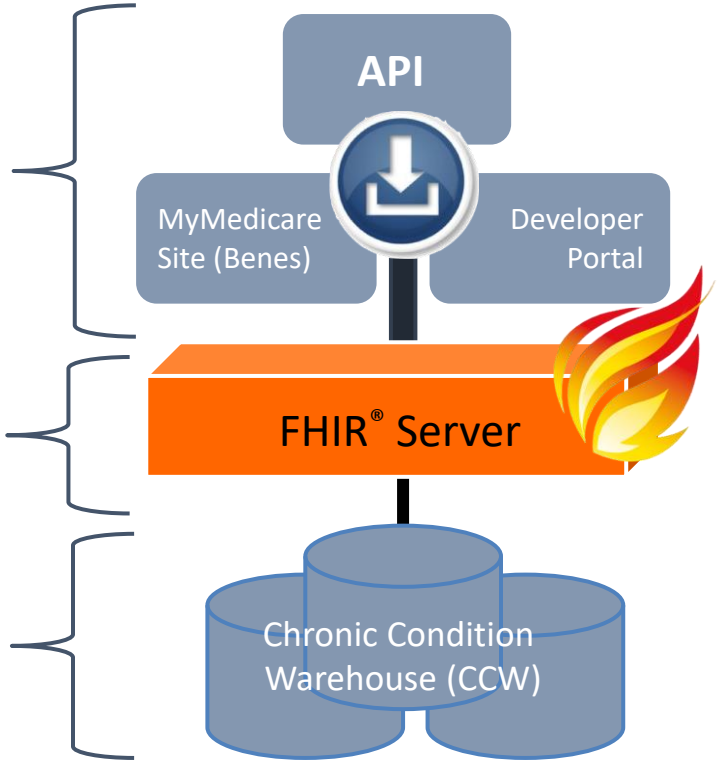
Why Improve Blue Button?

- The original Blue Button was an essential first step, but it left the patient to do the heavy lifting to use and/or share their health data
- Patients should have access and control to easily and securely share their data with whomever they want, making the patient the center of our health care system
- Vision for Blue Button 2.0 at CMS:

Developer-friendly, standards-based data API that enables beneficiaries to connect their data to the applications, services, and research programs they trust

Medicare Blue Button 2.0 Design

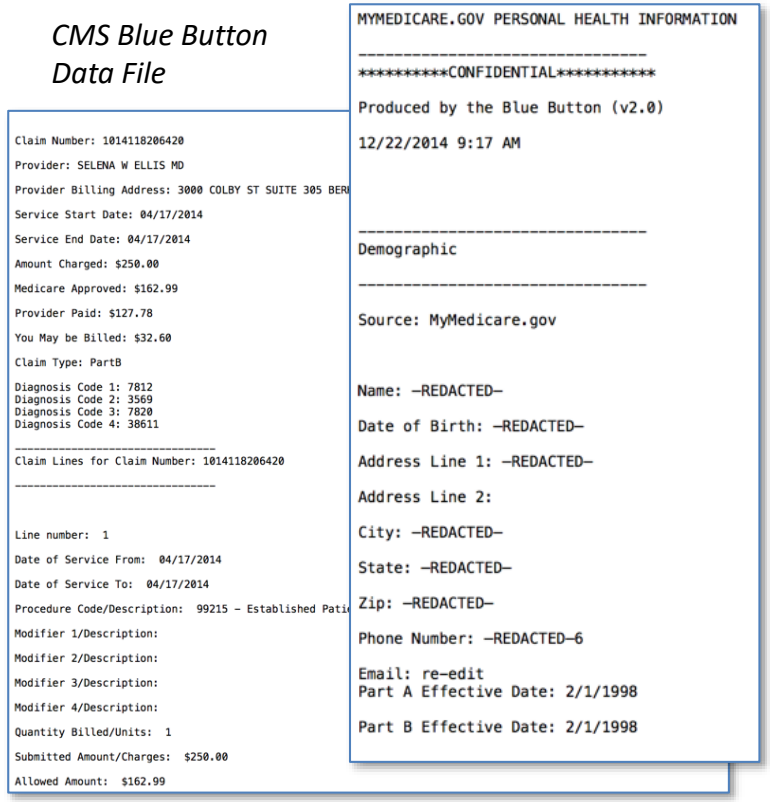
- Open source front-end application that manages developer and beneficiary access. Beneficiary access is integrated with MyMedicare.gov
- Standard open source reference implementation of Fast Healthcare Interoperability Resource (FHIR®) server
- Claims data for 53M Medicare beneficiaries sourced from the CCW



Why Do We Need an API?

- **More secure for beneficiaries**
- **A better alternative to screen scraping**
  - Apps have resorted to automating login to retrieve Blue Button files for beneficiaries
- **More granular management of connected applications**
- **Data is presented in a structured form for easier processing**
  - Parsing text file is challenging

CMS Blue Button Data File



```
MYMEDICARE.GOV PERSONAL HEALTH INFORMATION
--------------------------------
**********CONFIDENTIAL**********
Produced by the Blue Button (v2.0)
12/22/2014 9:17 AM

--------------------------------
Demographic
--------------------------------
Source: MyMedicare.gov

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Date of Birth: -REDACTED-
Address Line 1: -REDACTED-
Address Line 2:
City: -REDACTED-
State: -REDACTED-
Zip: -REDACTED-
Phone Number: -REDACTED-6
Email: re-edit
Part A Effective Date: 2/1/1998
Part B Effective Date: 2/1/1998
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Claim Number: 1014118206420
Provider: SELENA W ELLIS MD
Provider Billing Address: 3000 COLBY ST SUITE 305 BER
Service Start Date: 04/17/2014
Service End Date: 04/17/2014
Amount Charged: $250.00
Medicare Approved: $162.99
Provider Paid: $127.78
You May be Billed: $32.60
Claim Type: PartB
Diagnosis Code 1: 7812
Diagnosis Code 2: 3569
Diagnosis Code 3: 7820
Diagnosis Code 4: 38611
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Claim Lines for Claim Number: 1014118206420
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Line number:  1
Date of Service From:  04/17/2014
Date of Service To:  04/17/2014
Procedure Code/Description:  99215 - Established Pati
Modifier 1/Description:
Modifier 2/Description:
Modifier 3/Description:
Modifier 4/Description:
Quantity Billed/Units:  1
Submitted Amount/Charges:  $250.00
Allowed Amount:  $162.99
```

IPPS Proposed Rule: Medicare and Medicaid Promoting Interoperability Programs

Major proposals in IPPS

Quality, Interoperability, Patients over Paperwork

- Application of Meaningful Measures Framework
  - Focus on outcome/safety measures
  - Removed 19 measures; de-duplicate another 21
- Overhaul of Meaningful Use
- Price Transparency
- RFI on Interoperability as a requirement to participate in Medicare

Meaningful Use = Promoting Interoperability

- Focus on measures that require interoperability and sharing of health data with patients
- Signals a change in how we view patient data and the safe transmission in health record systems
- Reduced and modified measures to reduce burden
- Improve alignment between Hospitals and QPP

Proposals for Promoting Interoperability

- Name Change
  - Promoting Interoperability Program
- EHR 90 day reporting period in 2019 and 2020
- Requires 2015 edition CEHRT in 2019
  - Use of API for sharing data with patients
  - Updated, Interoperability-focused CCDE
  - Supports bi-directional data exchange for multiple use cases
- Scoring Methodology Proposal
  - Removes “all or none” aspect of the program
  - Scores are based on performance across 6 measures
  - Reduced the number of required measures
  - Security risk analysis is a “gateway” measure

Contact Information

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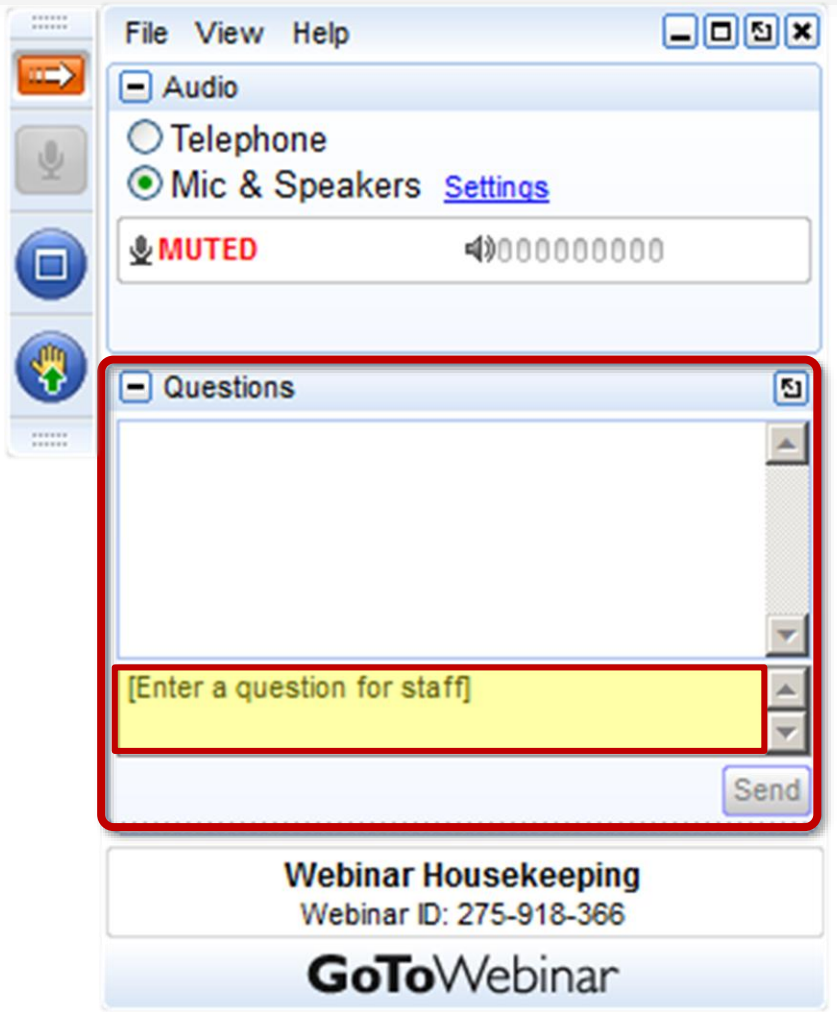
CAQH CORE Q&A

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.**

Attendees can also submit questions or comments via email to core@caqh.org.



CAQH CORE VBP Education Series

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