VBP Webinar Series

Overview of LAN *Roadmap for Driving High Performance in Alternative Payment Models*

October 22, 2019

2:00 – 3:00pm ET

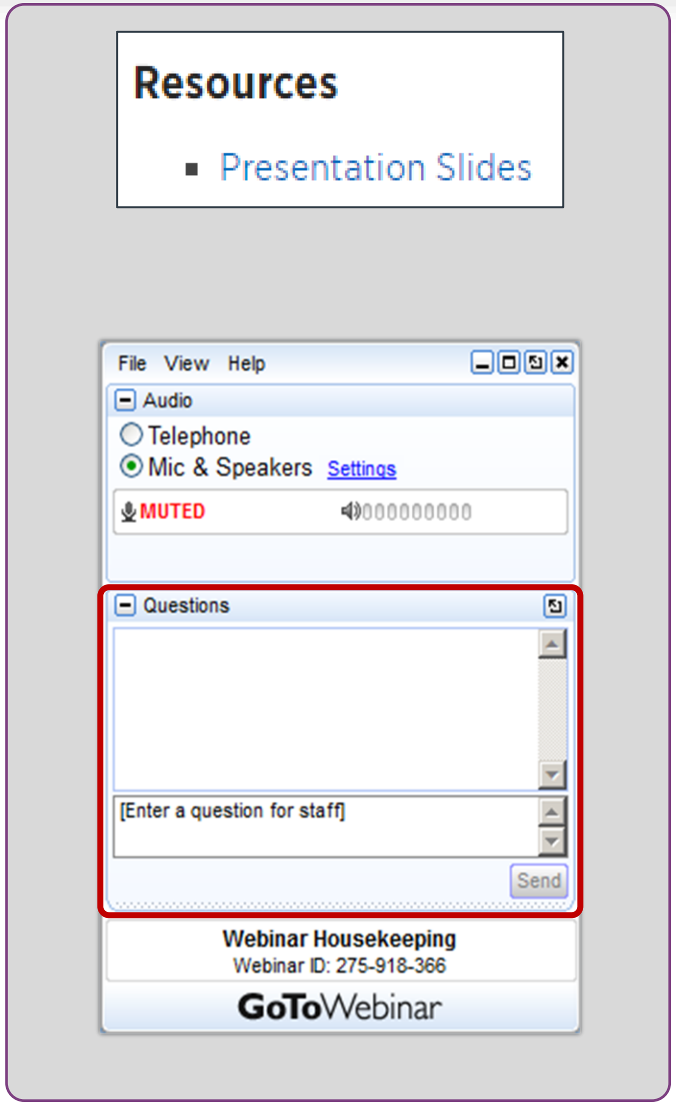
Logistics

Presentation Slides and How to Participate in Today's Session

- You can watch a recording of the presentation at www.caqh.org/core/events or on our YouTube channel after the webinar.

- The link to the webinar recording will also 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.**



Session Outline

- CAQH CORE Value-based Payments Initiative Overview
- Featured Presentation: LAN Roadmap for Driving Performance in Alternative Payment Models
- Q&A

Thank You to Our Speakers

Aparna Higgins
Founder and CEO
Ananya Health Innovations, Inc.

Erin Weber
Director
CAQH CORE

CAQH CORE Value-based Payments Initiative Overview

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.**

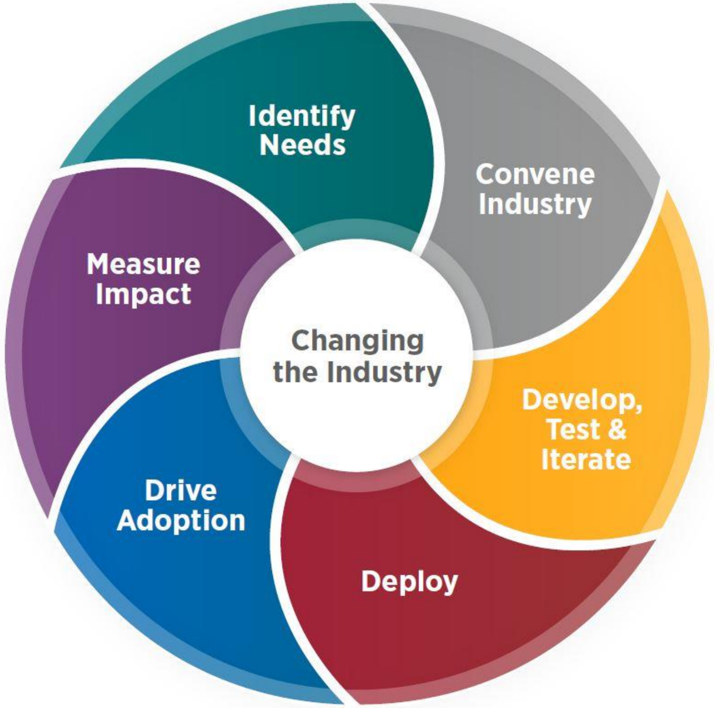
MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

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.



CAQH CORE Operating Rule Overview

CAQH CORE is the HHS-designated Operating Rule Author for all HIPAA-covered transactions, including Claims Attachments.
HIPAA covered entities conduct these transactions using the CAQH CORE Operating Rules.

	Phase I & Phase II	Phase III	Phase IV	Phase V	Phase VI
Transactions	Eligibility Claims Status	Electronic Funds Transfer Electronic Remittance Advice	Health Claims Referral, Certification and Authorization	Prior Authorization	Attachments
Manual to Electronic Savings per Transaction (2018 CAQH Index)	Eligibility: $6.52 Claims Status: $9.22	EFT: $0.65 ERA: $2.32	Claim Submission: $1.32 Prior Authorization: $7.28	$7.28	N/A
	Active				**In Progress**

Notes: (1) All Active Phases include requirements for acknowledgements, e.g., 999 Functional Acknowledgement, 277CA Claims Acknowledgement. (2) **CAQH CORE is evaluating maintenance areas and opportunities to build on existing rules to support value-based payment.**

Providers Ready to Take on Risk

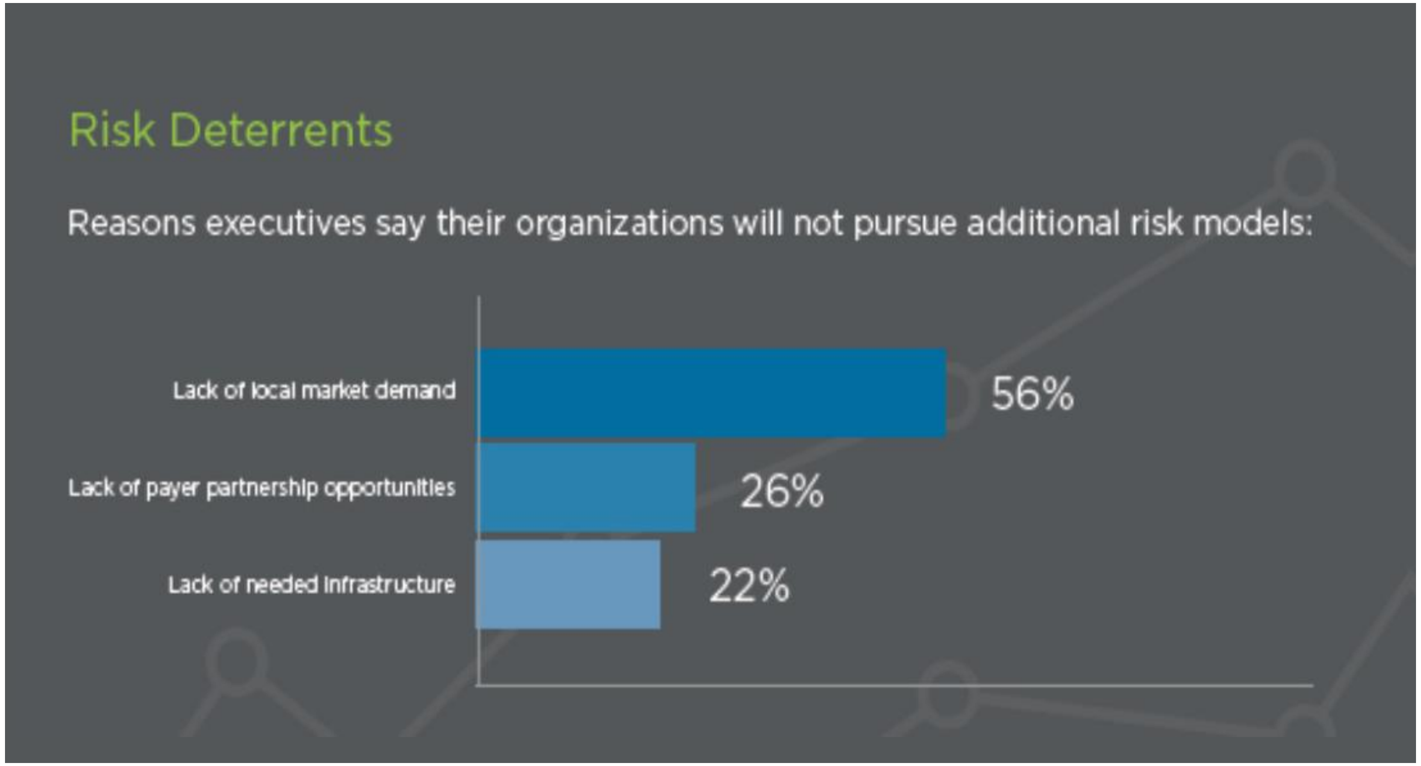
Deterrents Need to be Addressed

- 72% of health system senior executives believe their organizations have the capabilities needed to support increased levels of risk and plan to take on additional risk in the next one to three years.

  (HFMA, 2019)

- 42% of executives cite operational processes (e.g. contract execution, care coordination/management) as the top challenge to maintaining risk-based capabilities.

  (HFMA, 2019)



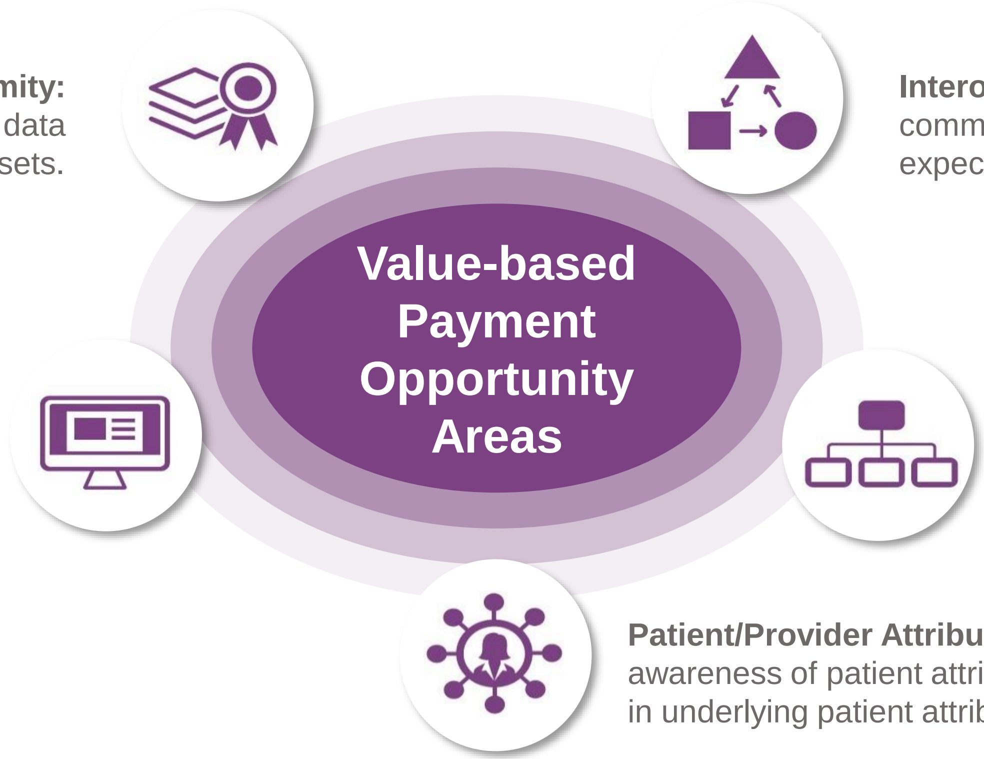
Source: Value-Based Payments News. (July 2019). *Hopkins Researchers Propose SDOH Data Integration Framework.*

Streamlining Adoption of Value-Based Payments

CAQH CORE conducted over two years of research and identified five opportunity areas in the industry that could smooth the implementation of value-based payments. Stakeholders must act decisively and collaboratively to prevent value-based payment from confronting the administrative roadblocks once encountered in fee-for-service.

Data Quality & Uniformity: Standardize identifiers, data elements, transactions and code sets.

Interoperability: Define common process and technical expectations.



Quality Measurement: Educate on need for consistent and actionable quality data while considering physician burden.

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

Patient/Provider Attribution: Improve provider awareness of patient attribution and transparency in underlying patient attribution models.

CAQH CORE Vision

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.

CAQH CORE VBP Initiative

Topic Areas for 2020 and Beyond

Move Forward

Pursue through CAQH CORE VBP Subgroup

- Patient Risk identification Prior to Point of Service
- Patient/Provider Attribution Status at Time of Eligibility Check

Pursue through Potential VBP Pilot

- Inclusion of Expanded Code Sets on Claims

Explore

Explore Synergies with Current CAQH CORE PA Discovery Pilot

- Provider Notification of Need for Additional Documentation/ Information.

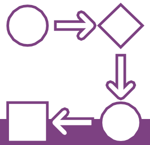
Align

Align with CAQH CORE Attachments Initiative

- Standardization of the Exchange of Additional Documentation

Patient/Provider Attribution

Attribution matches individual patients in a population with providers, which ultimately determines the patients for which a provider (as an individual or as a group) is responsible. Attribution forms the basis of analysis for metrics underpinning VBP, such as total costs of care and quality measures. While health plans supply attribution information on a regular basis, providers are often left with several questions:*



Why are they in my population?

VBP contracts between health plans and providers may include information on the methodology for assigning patients to a population. However, clinicians providing care often do not have insight into those contracts and may not know why a patient is in their population, especially if it is a patient without a prior relationship.

Who is on first?

Patients may be attributed to a singular provider or a group of providers which may leave ambiguity as to who is the primary care provider (PCP) responsible for the patient. Furthermore, patients with chronic conditions such as heart disease may have a specialist who acts as their PCP which may or not be reflected in the attribution model.

Who else is involved?

In some VBP models, providers are penalized when patients in their population visit other providers. Providers may not have insight as to where else their patient is seeking care. Preventing "leakage" is a large incentive in VBP contracts, but without visibility into patient utilization, providers are often unaware when this occurs until after the contract period.

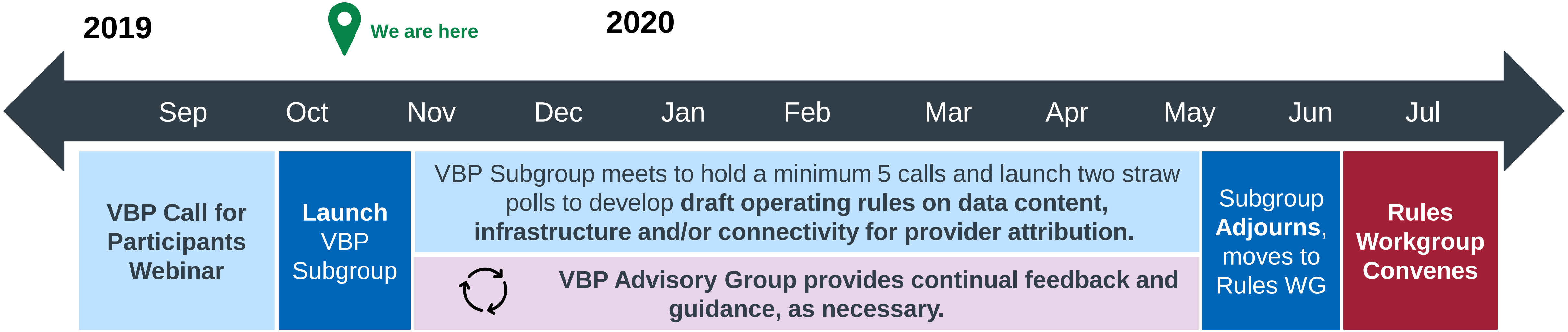
Provider success under VBP models requires knowing the answers to all these questions, but before asking these questions a provider needs to know the answer to the most important:

IS THIS PATIENT IN MY ATTRIBUTED POPULATION?

*National Quality Forum, 2016.

Next Steps for Value-based Payment Initiative

The Value-based Payment (VBP) Advisory Group adjourned in mid-May. CAQH CORE staff is now conducting additional research on the chosen opportunity areas with a plan to launch rule development efforts this September.



VBP Advisory Group
CAQH CORE Staff
VBP Rule Development Group

CAQH CORE

CAQH CORE Call to Action – Value-based Payments

- **Consider joining CAQH CORE and engaging in the Value-based Payments Subgroup.** The Value-based Payments Subgroup is open to all CAQH CORE Participating Organizations and multiple individuals from the same Participating Organization may join.
  - The Subgroup is specifically recruiting Subject Matter Experts (SMEs) in provider attribution and those familiar with the HIPAA-mandated transactions. Multiple individuals from the same organization may join.
- **Explore CAQH CORE resources on Value-based Payments.** Utilize our online resources such as our new interactive module to learn more about key opportunity areas in VBP.

Contact core@caqh.org to get involved with this initiative.

Polling Question #1

Would your organization be interested in participating in the VBP Subgroup on Patient/Provider Attribution?

- Yes
- No
- Unsure

Roadmap for Driving High Performance in Alternative Payment Models

CAQH CORE Webinar October 22, 2019

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Health Care Payment Learning & Action Network

Background

Health Care Payment Learning and Action Network

Mission: To accelerate the health care system's transition to alternative payment models (APMs) by combining and aligning the innovation, power, and reach of the private and public sectors. The shift from fee-for-service to paying for quality via APMs is aimed at achieving the following:

The LAN seeks to shift our health care system from the current fee-for-service payment model to a model that pays providers and hospitals for quality care and improved health.

In order to achieve this, we need to shift our payment structure to pay for quality of care over quantity of services.

Such alignment requires the participation of the entire health care community. The LAN is a collaborative network of public and private stakeholders.

Health Care Payment Learning and Action Network

Guiding Committee Co-Chairs

Mark McClellan, MD, PhD

Robert Margolis Professor of Business, Medicine, and Policy Director of the Robert J. Margolis Center for Health Policy at Duke University

Mark Smith, MD, MBA

Visiting Professor, University of California at Berkeley and Clinical Professor of Medicine, University of California at San Francisco

The mission of the Health Care Payment Learning and Action Network (LAN) is to accelerate the health care system's transition to alternative payment models (APMs) by combining and aligning the innovation, power, and reach of the private and public sectors. LAN has been accomplishing this mission through the creation of a widely used framework for classifying APMs and measuring APM adoption, seminal recommendation on model design, and (most recently) disseminating promising practices for successfully implementing APMs.

Overview: What is the Roadmap?

The Roadmap…

…is the LAN's capstone product, which builds on LAN's seminal work on APM classification, measurement, and design recommendations

…is a unique contribution to the field of health care payment reform, developed interviews with payers and providers who are experiencing success in ten different APMs

…is an interactive implementation guide that public and private payers can use to work with providers, and other stakeholders to accelerate the creation and adoption of high-performing APMs

…details promising practices from three domains – APM Design; Payer-Provider Collaboration; and Person-Centered Care – that provide operational guidance for designing and implementing APMs

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Where the Roadmap Fits in the LAN Portfolio

2015

APM Framework increasingly seen as industry standard
- Used by 75 commercial payers and CMS
- Adopted by at least 10 states,

2016

- Clinical Episode Payment Models White Papers
- Population-based Payment Model White Papers.
- First Measurement Effort

2016

LAN work on performance measurement foundational in informing the CMS MM initiative and formally acknowledged by CMS

2017

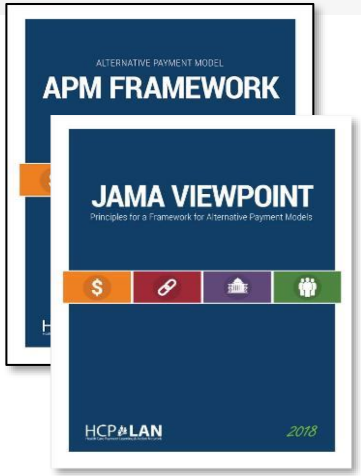
MAC Resource Bank, online resource bank built on the Clinical Episode Payment work group design elements.

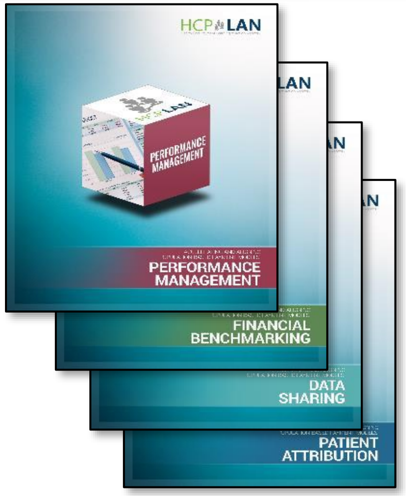
2017

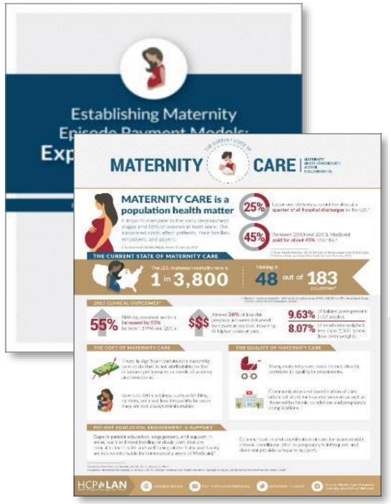
Measurement Reports, a compilation of data collected regarding APM adoption. The largest and most comprehensive of its kind at the national level.

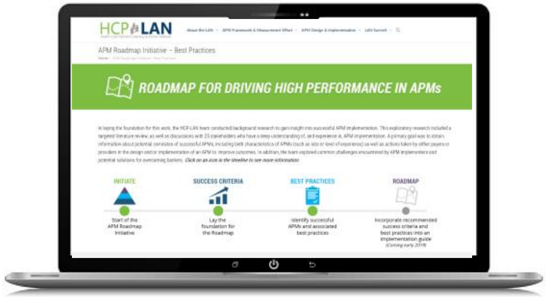
2018

LAN Roadmap, a collection of best practices and implementation steps for APMs.





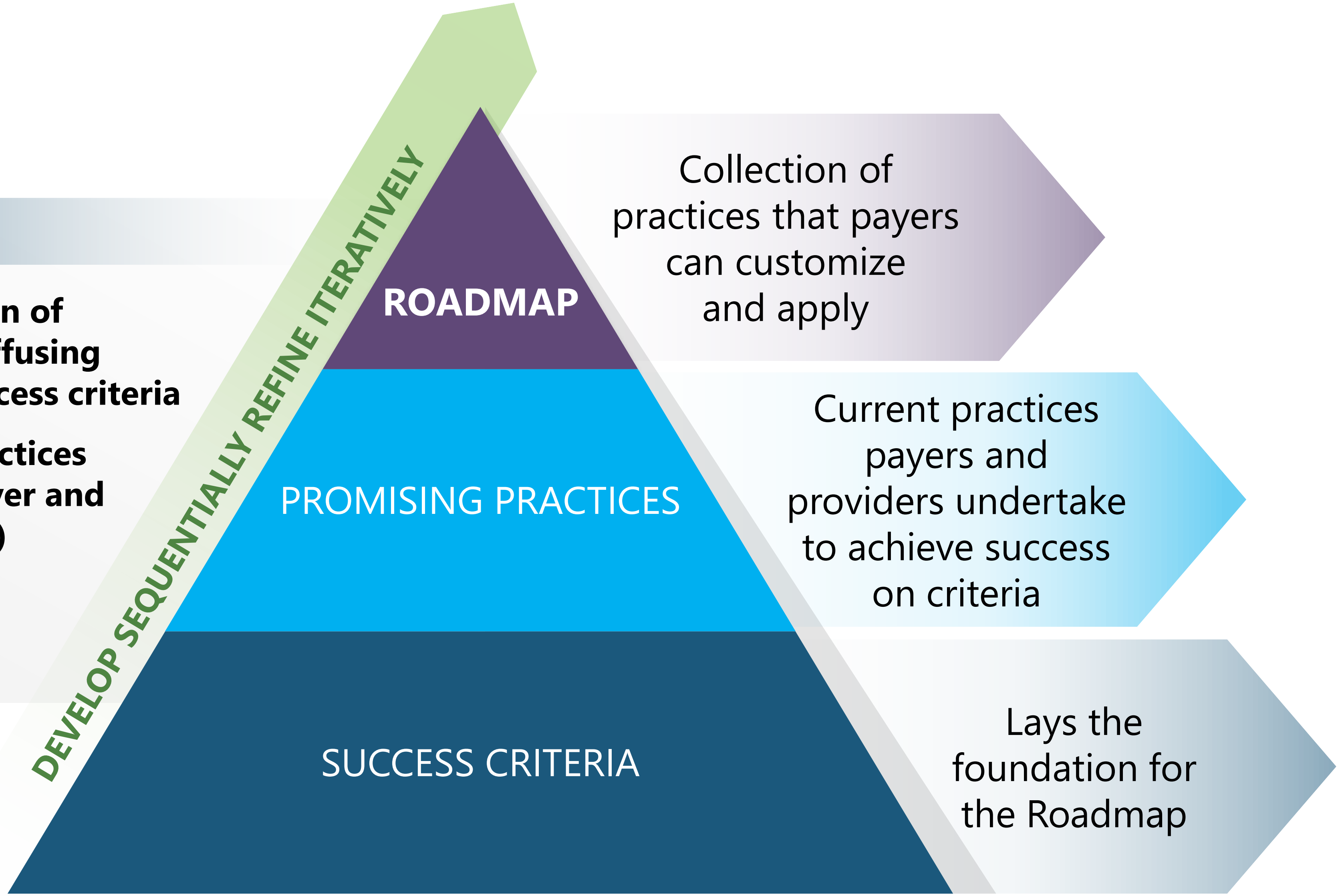




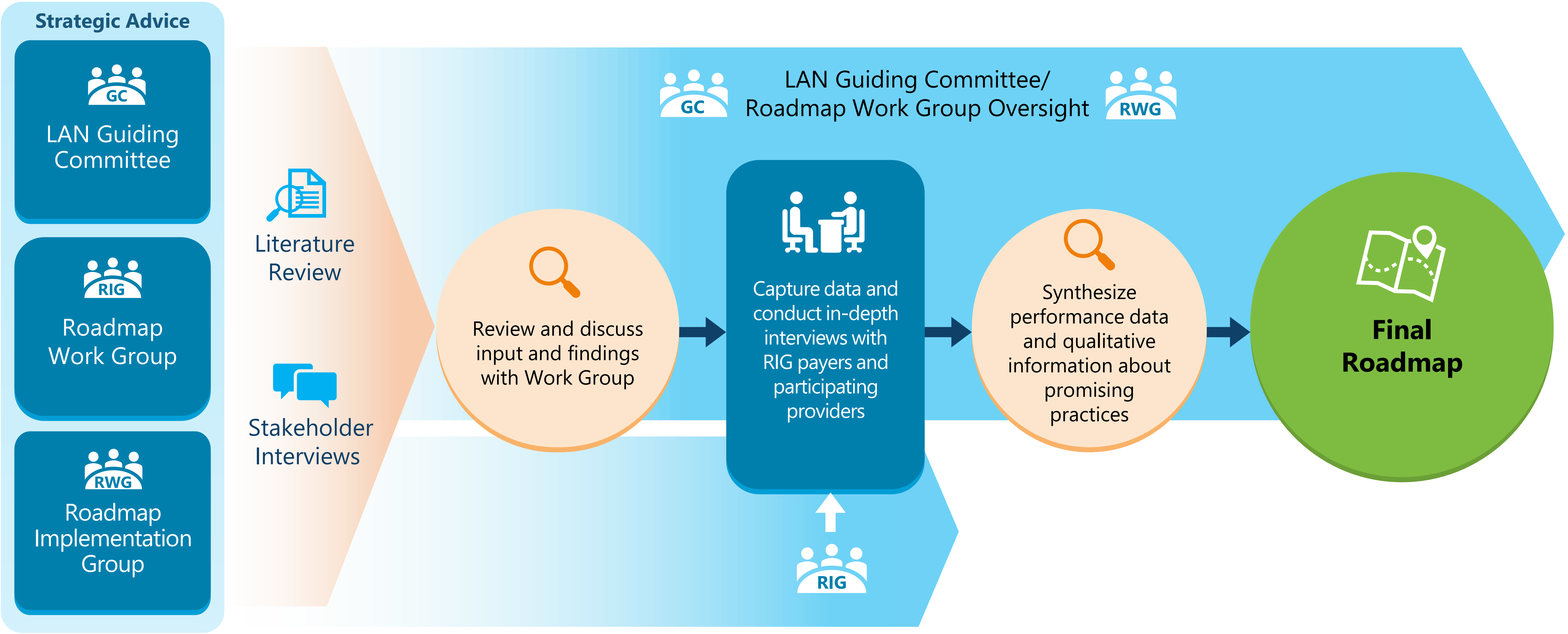
Approach for the APM Roadmap

GOALS

- **Accelerate the adoption of successful APMs by diffusing information about success criteria**
- **Identify promising practices (drawn from multi-payer and other successful APMs)**
- **Develop a Roadmap for implementation**



Roadmap Development Process



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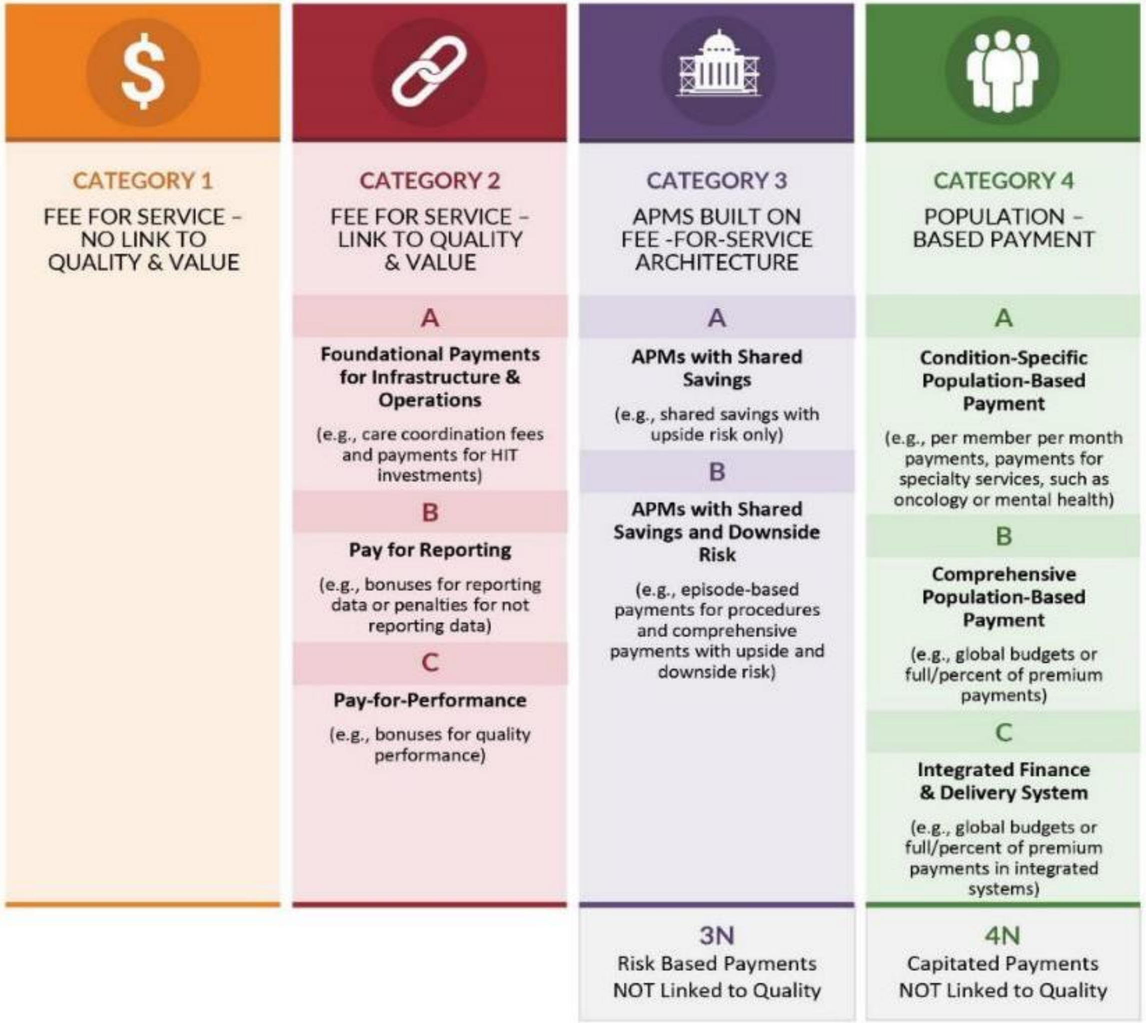
APM Framework

In addition to serving as the framework for the LAN's measurement effort, the APM Framework is being used by states to collect data and encourage APM adoption:

- **AZ, CA, NY, SC, VA, TX, OR, and WA use the framework in their Medicaid MCO contracts to require MCOs to focus APM implementation on particular models [1]**
- **Arizona and Washington State use the framework categories to identify an overall benchmark for provider payments through APMs [1]**
- **Michigan requires its MCOs to increase the use of APMs, and to report on an annual basis to the state using the APM Framework as a data collection tool, with modifications**



1 https://www.shvs.org/resource/?topic=data-evaluation,payment-reform&type

Scope

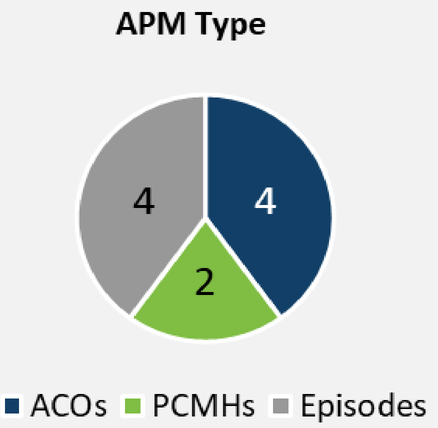
9 regional and national

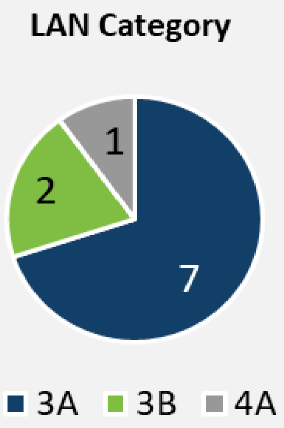
payers are participating in the initiative, including The Centers for Medicare and Medicaid Services

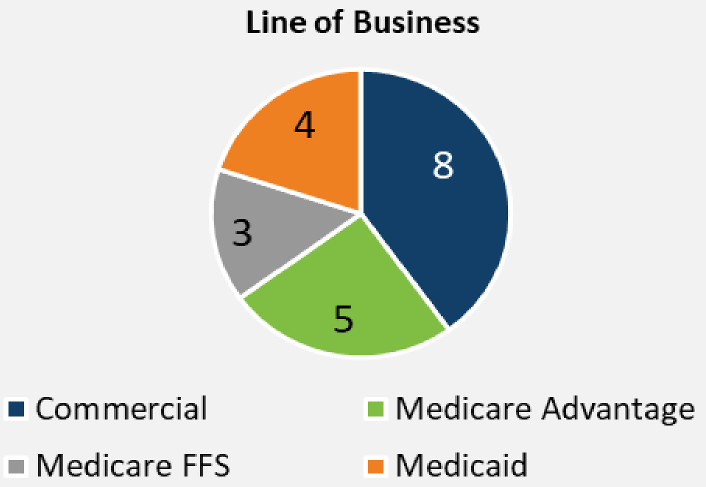
These participating payers represent approximately

135 million covered lives

Scope of APMs Considered

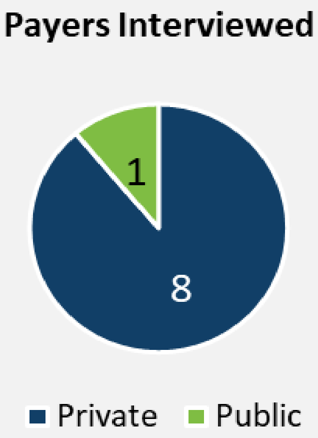


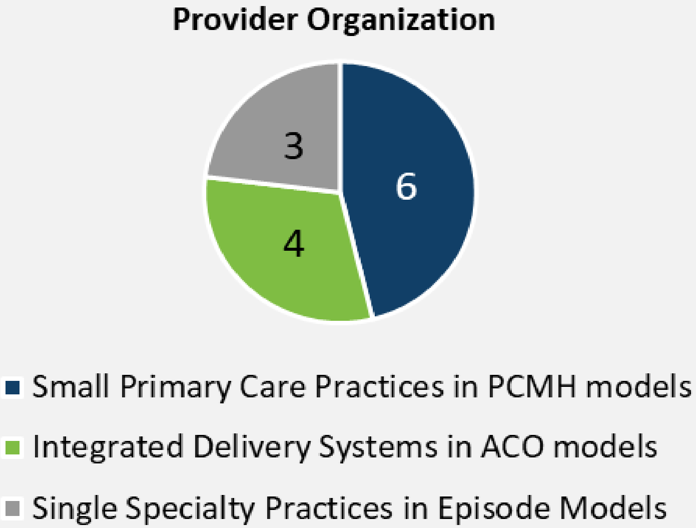




Note: Some APMs covered multiple lines of business

Scope of Payer and Provider Interviews





Findings and Promising Practices

Featured Domains and Themes

APM Design	Payer-Provider Collaboration	Person-Centered Care
Payment Structure & Financial Risk	Collaboration on APM Design & Provider Engagement	Patient Engagement
Benchmarking & Utilization	Data Sharing & Analytics	Health Equity
Quality Measurement	Care Management Support	
Patient Attribution	Leadership & Organizational Culture	Benefit Design
Multi-Payer Alignment		

DESIGN (APM Design)

IMPLEMENTATION (Payer-Provider Collaboration; Person-Centered Care)

Payer Practices: APM Design

Payers use the following practices to succeed in APMs:

Payment Structure and Financial Risk

- Align payment structure with provider capabilities
- Closely align bundled payments to clinical models
- Establish provider accountability for infrastructure investments
- Create smooth transitions to risk

Benchmarking and Utilization

- Historical benchmarks drive year-over-year improvements
- Regional benchmarks drive greater efficiencies in care delivery
- Case-mix adjustment in episode models
- Utilization indices minimize insurance risk

Patient Attribution

- Use prospective attribution to minimize uncertainty about accountability
- Use retrospective attribution to accurately assign patients
- Share regularly updated attribution lists with providers

Quality Measurement

- Widespread use of HEDIS, and need to move to outcomes orientation
- Establish core sets and episode-specific measures

Multi-Payer Alignment

- Accelerate alignment with support from state leadership and market-dominant stakeholders
- Establish effective forums for collaboration

Provider Perspectives: APM Design

Providers use the following practices to succeed in APMs:

Downside Risk	Quality Measurement	Multi-Payer Alignment
• Cascade financial incentives for individual clinicians • First demonstrate success in upside-only models • Ensure access to claims data and attribution lists • Develop long-term, sustainable business strategies	• Develop quality improvement strategies • Redesign workflows to seamlessly integrate data entry • Establish teams to integrate EHR and claims data from multiple payers	• Increase alignment (e.g., on quality measures, data sharing, and episode definitions) to reduce provider burden

Payer Practices: Payer-Provider Collaboration

Payers use the following practices to succeed in APMs:

Collaboration on APM Design and Provider Engagement

- Collaborate with providers on incremental approaches to design and implementation
- Develop multidisciplinary assessments of provider capabilities
- Conduct Joint Operating Committee meetings

Data Sharing and Analysis

- Weigh tradeoffs between timeliness and accuracy
- Share information on a schedule that corresponds to how it is used
- Tailor analytic support to provider capabilities

Care Management Support

- Establish care transformation teams
- Establish centralized care coordinators

Leadership and Culture

- Consider leadership a critical component of provider capabilities
- Engage executive and clinical leadership

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Provider Perspectives: Payer-Provider Collaboration

Providers use the following practices to succeed in APMs:

Preparing APMs

- Build data capabilities (e.g., monitoring quality performance, EHR capabilities)
- Change staffing models and increase staff responsibilities
- Collaborate with other providers
- Develop episode-based model strategies (e.g., utilization management, clinical guidelines)

Data Analytics

- Aggregate payer data and integrate with EHR data
- Establish processes to acting on internal and payer analyses
- Develop sophisticated data analytic capabilities for integrated delivery systems
- Work with payers to receive claims data

Care Coordination

- Contact, engage, and educate high risk patients
- Use data and analysis to identify opportunities for care coordination
- Coordinate with hospital to reduce utilization
- Integrated behavioral health and primary care

Leadership and Culture

- Establish team-based approaches to care delivery
- Establish leadership by investing in population health
- Use financial and non-financial incentives to engage clinicians in value-based care

Payer Practices: Person-Centered Care

Payers use the following practices to succeed in APMs:

Patient Engagement	Health Equity	Benefit Design
• Directly engage patients via alignment campaigns and care compacts • Support providers' patient engagement efforts with alternative payments	• Directly engage patients via centralized multidisciplinary teams • Support provider efforts to address social determinants with alternative payments	• Value-based benefit design is in early stages of implementation, due to lack of demand from purchasers • Create value-based benefit designs for ACO products

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Provider Perspectives: Person-Centered Care

Providers use the following practices to succeed in APMs:

Patient Engagement	Health Equity
• Execute broad engagement strategies via patient portals, social media, and community partners • Execute targeted communication and information sharing programs • Establish patient advisory councils • Increase access and utilize telemedicine	• Assess patients' socioeconomic needs • Use case management to address social determinants • Address socioeconomic needs via targeted programs (e.g., food, transportation, housing)

The Path Forward

The Roadmap addresses the challenges of APM adoption in the context of the following areas:

Quality Measurement

Patient Engagement

Downside Risk

Multi-Payer Alignment

Benefit Design

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Full Navigation Menu

Roadmap for Driving High Performance in Alternative Payment Models

The *Roadmap for Driving High Performance in Alternative Payment Models* is a pilot study that focuses on a small sample of APMs. The promising practices detailed in the *Roadmap* reflect activities payers and providers are currently performing in the field and are based solely on information captured during 22 interviews with payers and providers. These interviews focused on 10 APMs nominated by eight regional and national plans, as well as the Center for Medicare and Medicaid Innovation.

Executive Summary

Acknowledgements

Video Tutorial

www.hcp-lan.org/apm-roadmap-tool

What is the Roadmap?

APM Design

Payer-Provider Collaboration

Person-Centered Care

The Path Forward

Additional Resources

ALIGNING FOR SHARED ACCOUNTABILITY

LAN SUMMIT

Health Care Payment Learning & Action Network

OCTOBER 24, 2019

Capitol Hill Hyatt Regency Hotel
Washington, DC

For more information visit:

www.lansummit.org

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Audience Q&A

Please submit your questions

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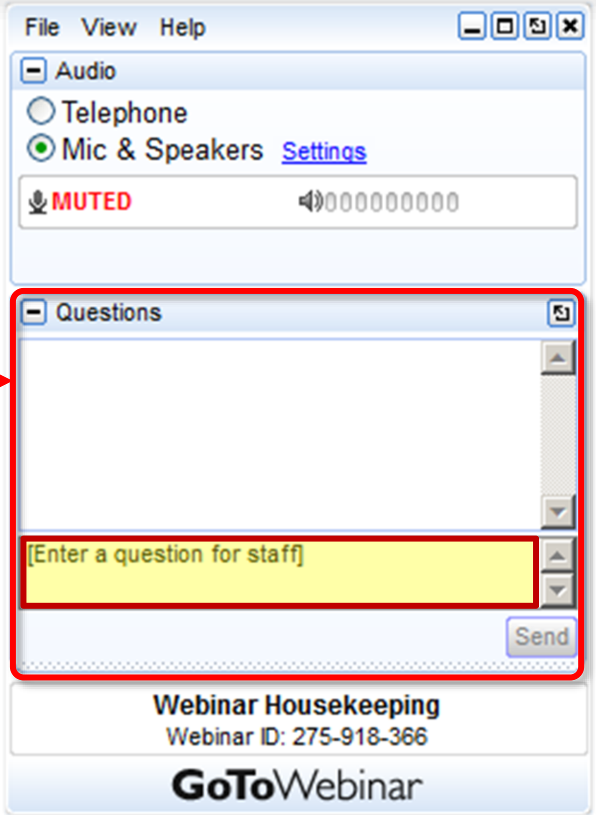

You can also submit questions at any time to CORE@caqh.org

Download a copy of today’s presentation slides at caqh.org/core/events

- Navigate to the Resources section for today’s event to find a PDF version of today’s 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.

Healthcare administration is rapidly changing.

Collaborate across stakeholder types to develop operating rules.

Present on CAQH CORE education sessions.

Engage with the decision makers that comprise 75% of the industry.

Represent your organization in work groups.

Join Us

Influence the direction of health IT policy

Drive the creation of operating rules to accelerate interoperability

Click **here** for more information on joining CAQH CORE as well as a complete list of Participating Organizations.

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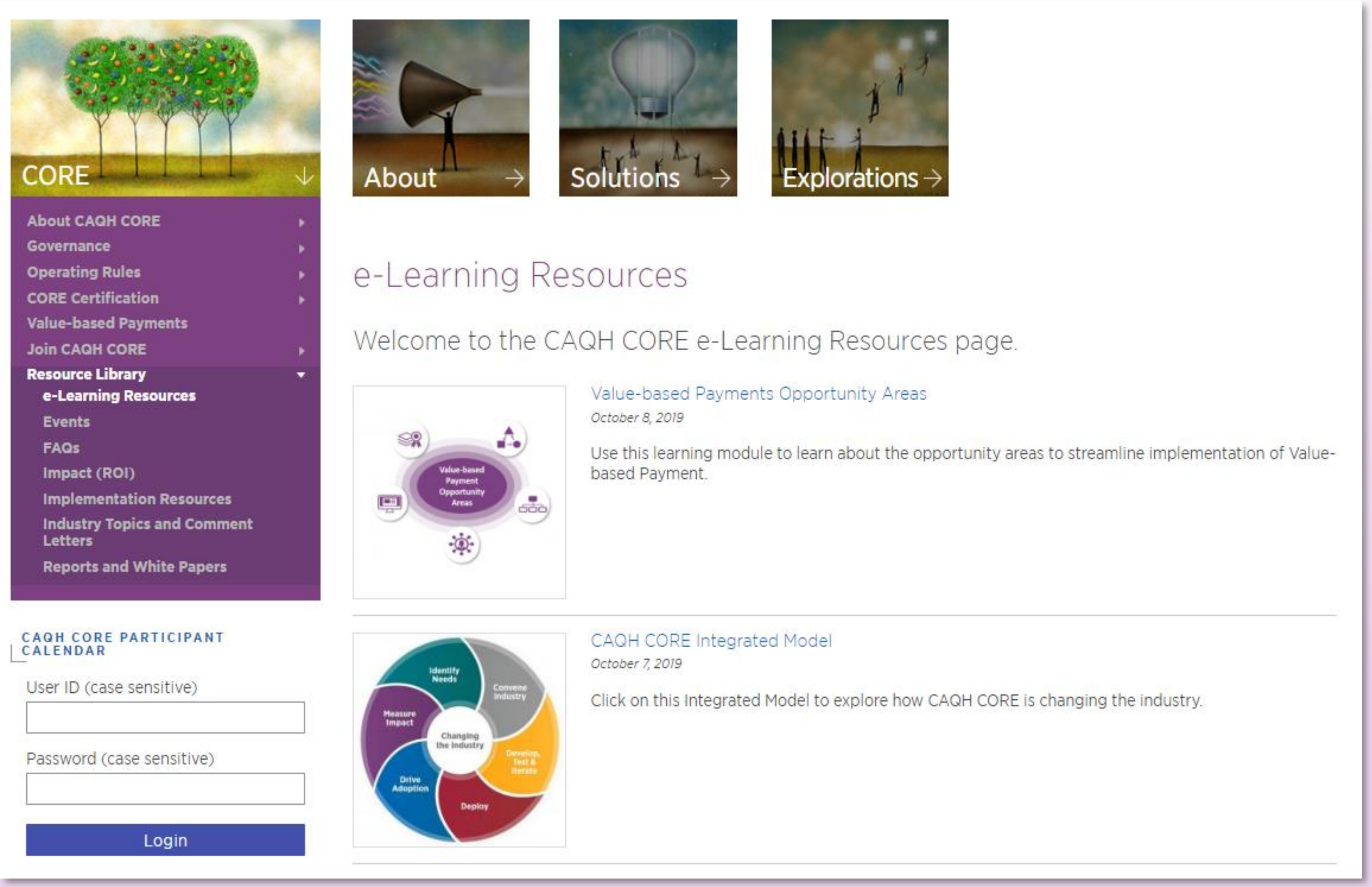
Resource Library



Utilize our **interactive online tools** to learn more about the CORE Certification process and the CAQH CORE model.

Explore our **YouTube** page to access over 75 CAQH CORE tutorials and webinar recordings.

Listen to a tutorial on the **Phase V Operating Rules**.

Go to our **FAQs** page for answers to questions on topics such as operating rule implementation and CORE Participation.

Read out our recent white paper "**Moving Forward: Building Momentum for End-to-End Automation of the Prior Authorization Process**."

Upcoming CAQH CORE Education Sessions

X12 and CAQH CORE Webinar Series:
Introduction to the 835 Transaction, Standard and Operating Rules
November 5, 2019 3-4 PM EST

CAQH CORE Participant-only Webinar:
Prepare for Vote on Updates to Final Prior Authorization Determination Timeframes
November 21, 2019 2-3 PM EST

Thank you for joining us!

@CAQH

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.