CAQH CORE

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

Thursday, January 11, 2018

2:00 – 3:00 pm ET

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Logistics

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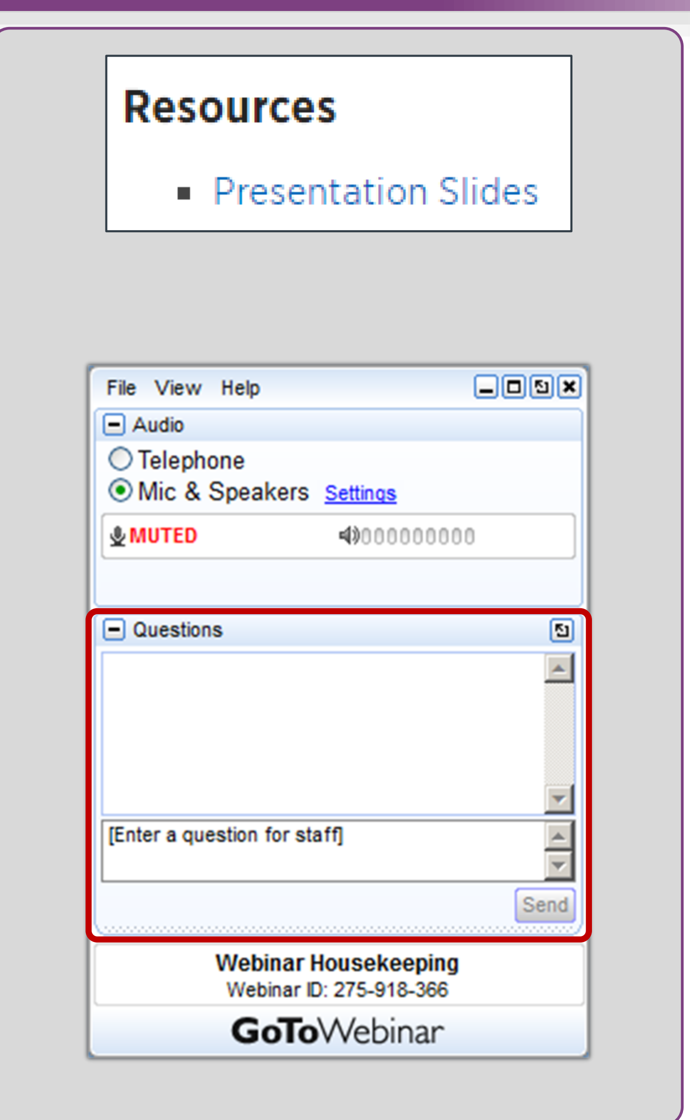

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Session Outline

- Overview of CAQH CORE Role in Value-based Payments.
- Featured Presentation: CMMI's Comprehensive Primary Care Plus.
  - Model Overview.
  - Practice Transformation.
  - Payment and Data Redesign.
- Audience Q&A.

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CAQH CORE and CMMI Webinar

This webinar is the second in an ongoing educational series from CAQH CORE to address operational challenges inherent in the transition to value-based payments.

We would like to thank our speakers:

Dr. Laura Sessums
Director of the Division of Advanced Primary Care, CMMI

Erin Weber
Director, CAQH CORE

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CAQH CORE Role in Value-based Payments

Erin Weber
CAQH CORE Director

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CAQH CORE

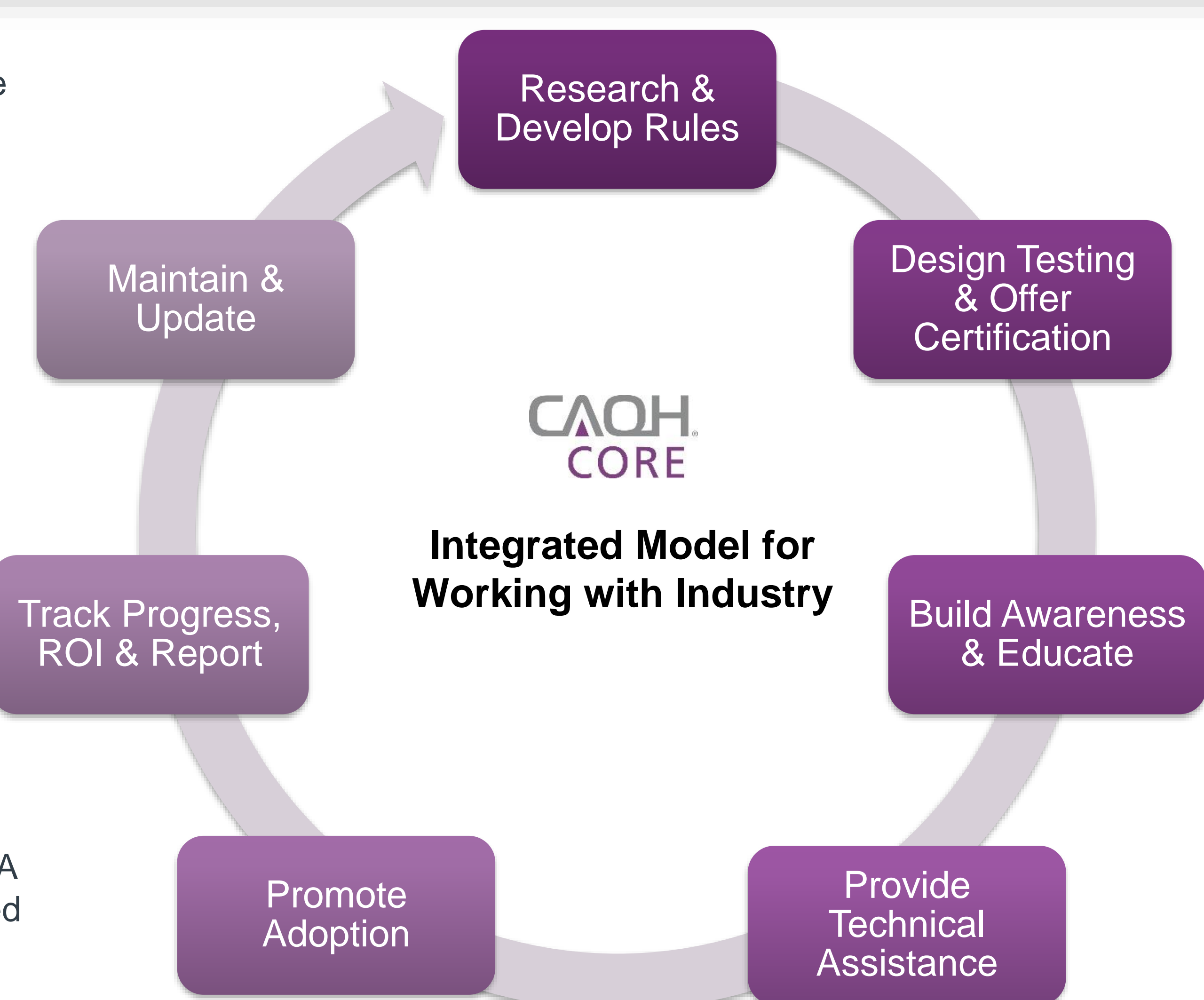
CAQH CORE Mission and Vision

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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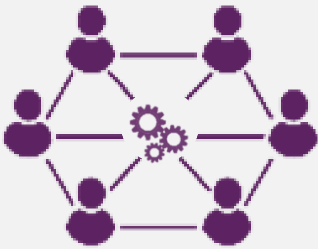
Streamlining Value-based Payments Operations

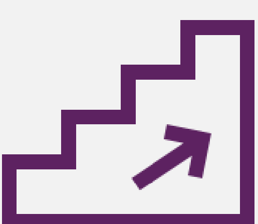
CAQH CORE is a Proven Agent of Change

Change Agent



Considerable expertise, experience and resources to **support development of a sound operational system for Value-based Payments (VBP)***.

Proven Success



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

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 more than 130 participating organizations**.

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

*The term “value-based payment” is used, recognizing that other terms may also be appropriate, such as incentive payment models, care delivery models, etc.

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From Fee-for-Service to Value-based Payments

Operational Capabilities Essential to Support Shift from Volume to Value

CAQH CORE recognizes the importance of emerging value-based payment (VBP) models in achieving improved healthcare quality and cost:

30%-50%
providers currently engaged in VBP.
(Modern Healthcare, 2017)

Expected that more than half of healthcare payments will be value-based by 2020.
(Forbes, 2017)

VBP models already accruing cost-savings with equal or better care results.
(American Hospital Association, 2016)

Transition to VBP not without challenges – improvement in operational capabilities needed to ensure success.

- Proprietary systems and processes implementing VBP have introduced operational variations, unintentionally setting up a scenario ripe for repeating prior mistakes.
- The volume-to-value transformation may slow if providers encounter barriers that make participation burdensome – need efficient, uniform operational system as support.
- Important to collaborate now within the industry to standardize and coordinate operations early, before proprietary systems and processes become entrenched.

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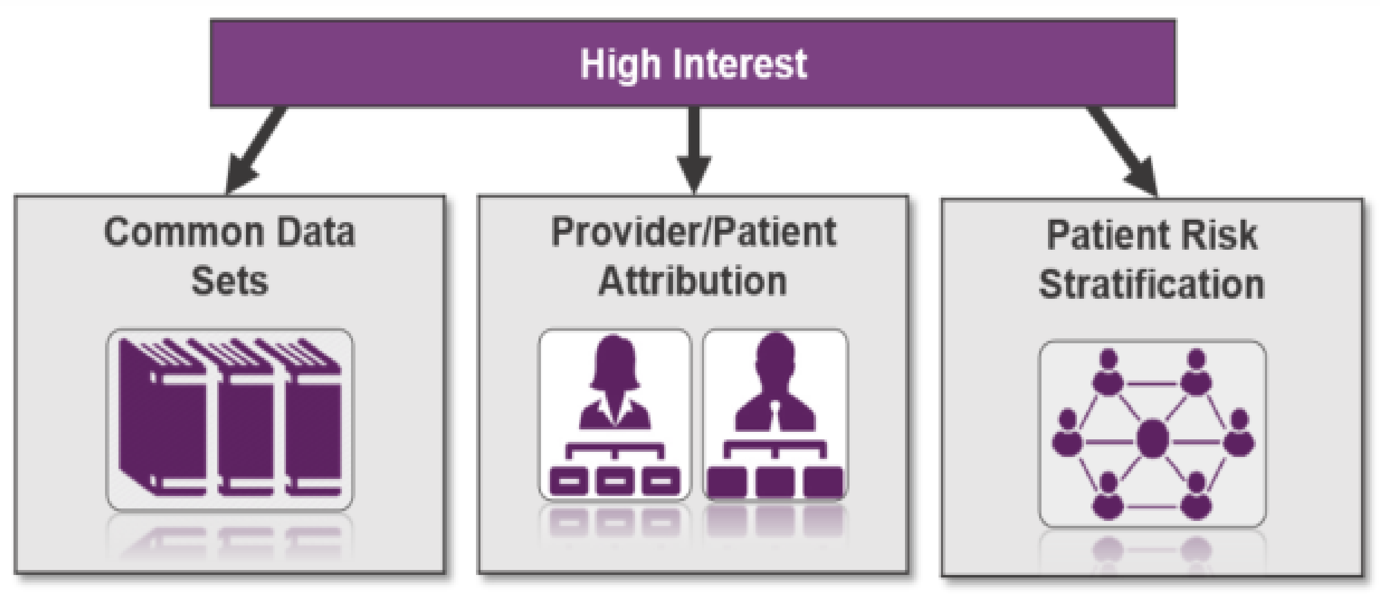
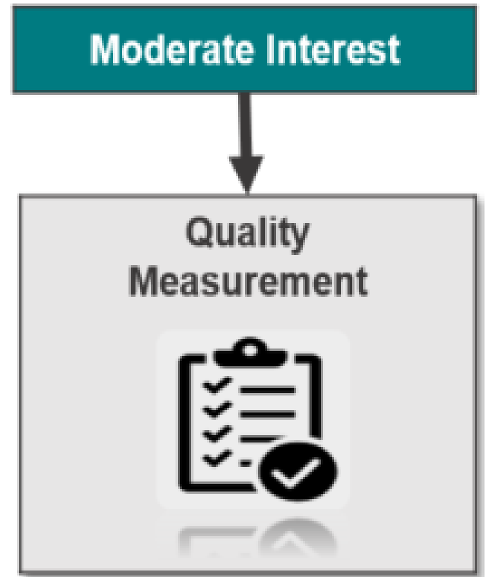
CAQH CORE Efforts on Value-based Payments

Opportunity Areas

CAQH CORE will release VBP report outlining results from its primary and secondary research including outlining problem space, opportunity areas and recommended actions.





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CAQH CORE

Challenges: Areas Impacting Value-based Payments

Data Standardization:

- Missing or inaccurate provider and patient data.
- Lack of specificity for some medical code sets (LOINC & SNOMED).
- Inconsistent use of common terms not currently standardized.

Interoperability:

- Technical interoperability with use of different information systems can affect data accuracy and validity.
- Lack of a process interoperability for how information is exchanged and how actions are interpreted by other stakeholders.

Patient Risk Stratification & Risk Assessment:

- Data needed can be costly to collect and analyze due to differing and proprietary models used by payers and providers.
- Model variation leads to provider confusion and inhibits their ability to provide timely, cost-effective care.

Quality Measurement:

- Overabundance of quality measures burden provider's ability to complete reporting requirements for VBP initiatives.

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Timeline

VBP Activities to Date and Beyond

To Date/In Progress

Stage 1: CAQH CORE Board Decision

- Board agreement that CAQH CORE must focus both on both driving unnecessary cost from fee-for-service data exchange and helping collective exchange needs for VBP.

Stage 2: Conduct Research to Identify Opportunity Areas

- Conducted extensive environmental scan and SWOT analysis to identify initial set of potential operational areas for industry action.
- Conducted structured interviews w/ ~20 multi-stakeholder entities to confirm, refute and/or add to the potential areas for action.
- Conducted survey of CAQH CORE Participants to collect feedback on interview findings.

Stage 3: Build Industry Awareness

- Present high-level research findings on CAQH CORE webinars.
- Develop VBP report outlining problem space, opportunity areas and recommendations/ strategies to address opportunity areas.
- Launch CAQH CORE VBP Industry Education Series - CAQH CORE VBP research identified strong need for more industry education on VBP.

Upcoming

(2018)

Stage 4: Upcoming CAQH CORE VBP Initiatives

- Publish VBP Report to CORE Participants & industry.
- Continue CAQH CORE VBP Education Series.
- Launch CAQH CORE VBP Advisory Group charged with advancing the recommended actions contained in the report.

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Polling Question #1

Is your organization actively working on value-based payment models/strategies?

- Yes – we are actively implementing value-based models.
- Yes – we are actively designing models for implementation.
- No.
- Unsure.

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Comprehensive Primary Care Plus

Transforming Primary Care in America

Council for Affordable Quality Healthcare, Inc.
January 11, 2018

Laura L. Sessums, JD, MD, FACP

Agenda

1 CPC+ Model Overview

- Multi-payer partnership
- Geographic regions
- Key statistics

2 Practice Transformation Activities and Supports

- Five care delivery functions drive practice transformation
- Enhanced health IT supports care delivery redesign
- Learning support for practices and payers

3 Payment and Data Redesign

- Medicare payment innovations and quality performance
- Centralized data feedback
- Alternative Payment Models (APMs) and QPP

Advancing Care Delivery and Payment

Fee-for-Service Primary Care

- Focus on volume
- High-cost services
- In-person encounters
- Fragmented care
- Provider burnout
- Payer segregation
- Little attention to social determinants of health

Practice Transformation

- Actionable milestones to deliver high quality, whole-person, patient-centered care
- Effective use of health information technology (HIT) and data analytics
- Practice learning networks

Payment Redesign

- Non-visit based care management fees
- Regional shared savings opportunity

Comprehensive Primary Care

- Focus on efficient, high quality care
- High-value utilization
- Population-based care delivery
- Engaged patients, caregivers, and families
- Multi-payer support
- Coordination across the medical neighborhood and community services

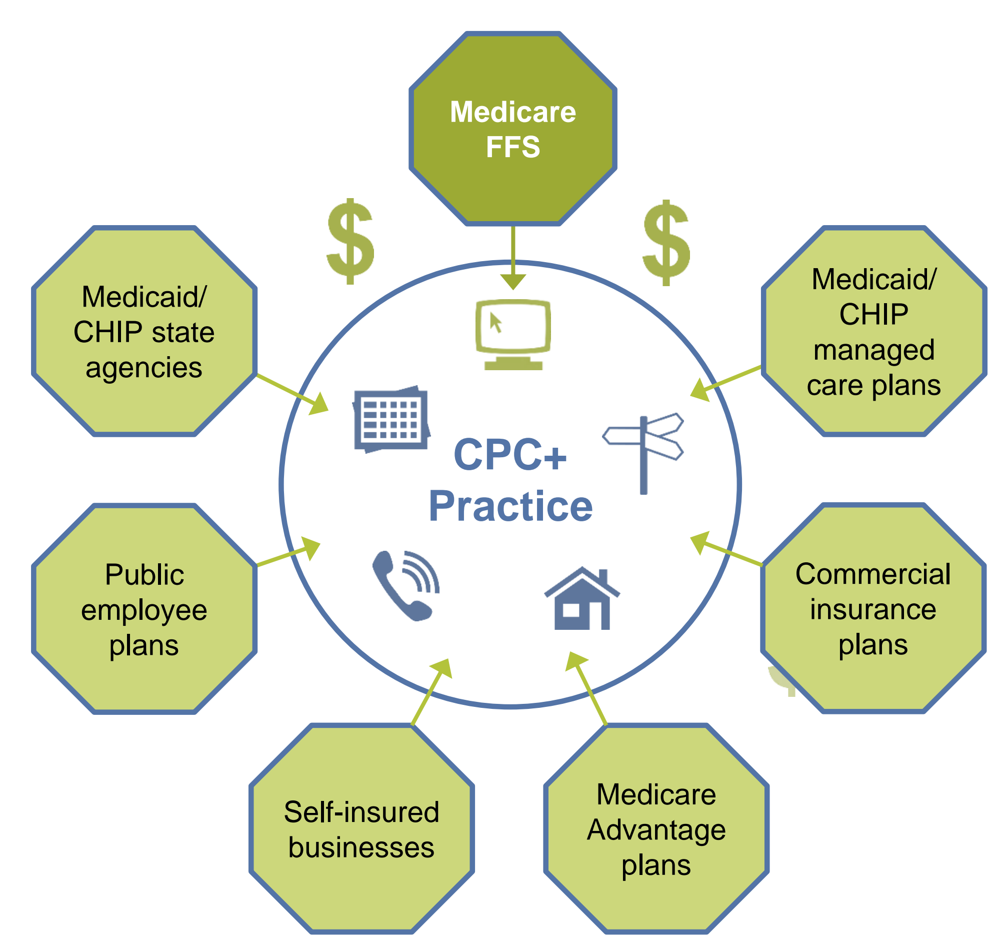
Multi-Payer Partnership Essential for Primary Care Reform

Multi-payer engagement is an essential component of CPC+.

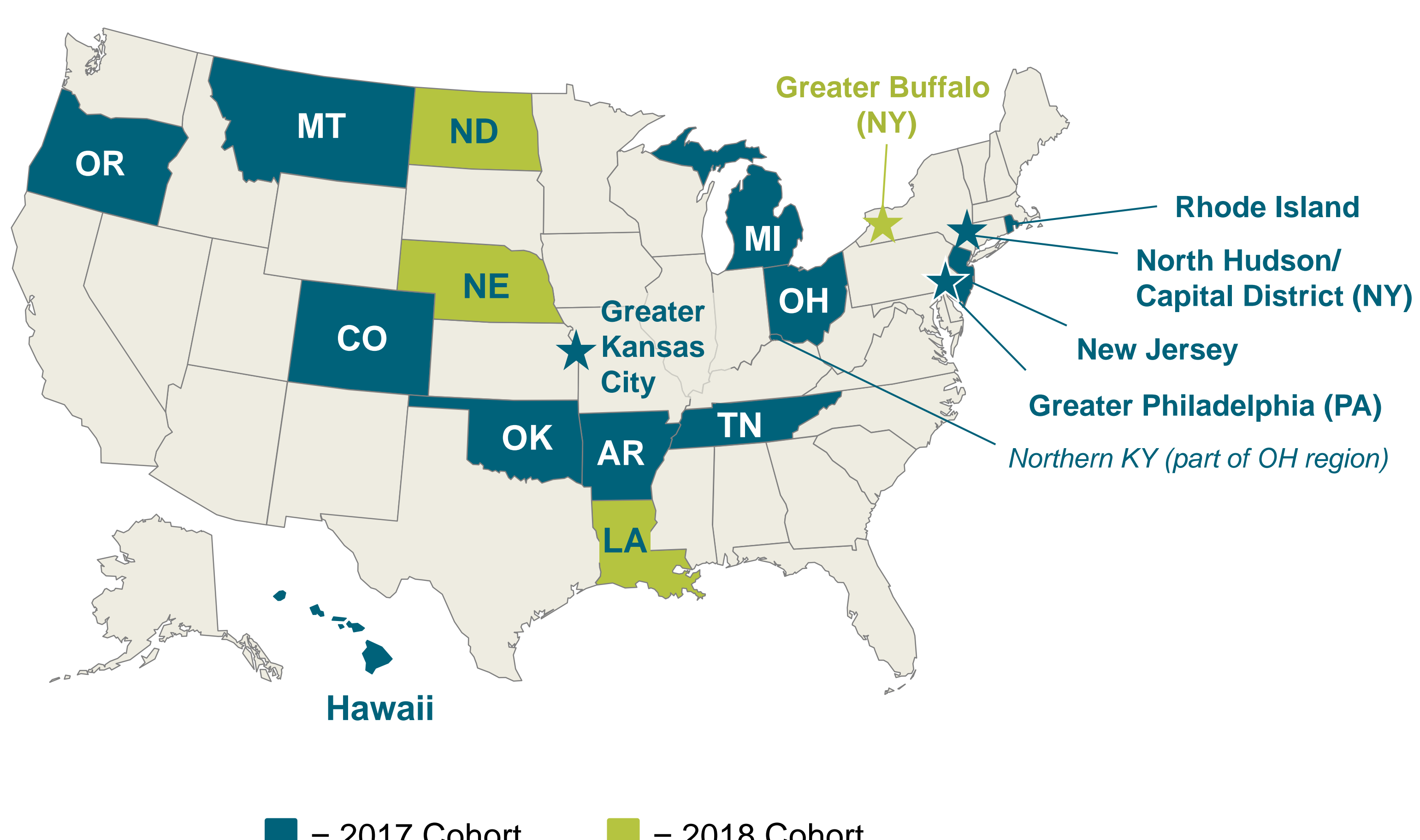
Support from any one payer covers only a portion of a practice's population.

True comprehensive primary care possible only with the support of multiple payers.

In CPC+, CMS partners with payers that share Medicare's commitment to strengthening primary care in America.

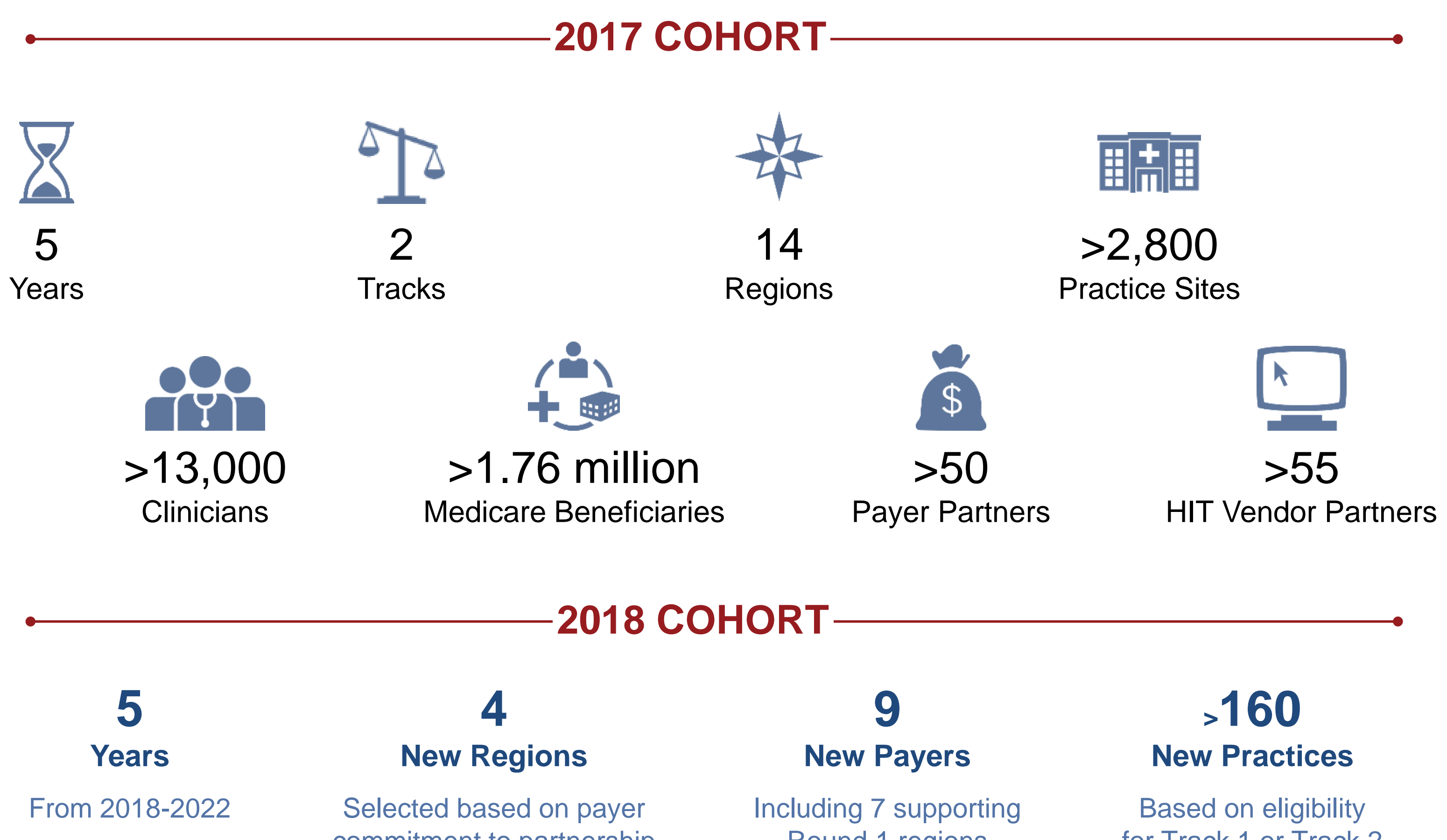


CPC+ Now Offered in 18 Regions



Comprehensive Primary Care Plus

America's Largest-Ever Initiative to Transform Primary Care



Participation in Both Program Tracks

Track 1

Over **1,400** primary care practices.

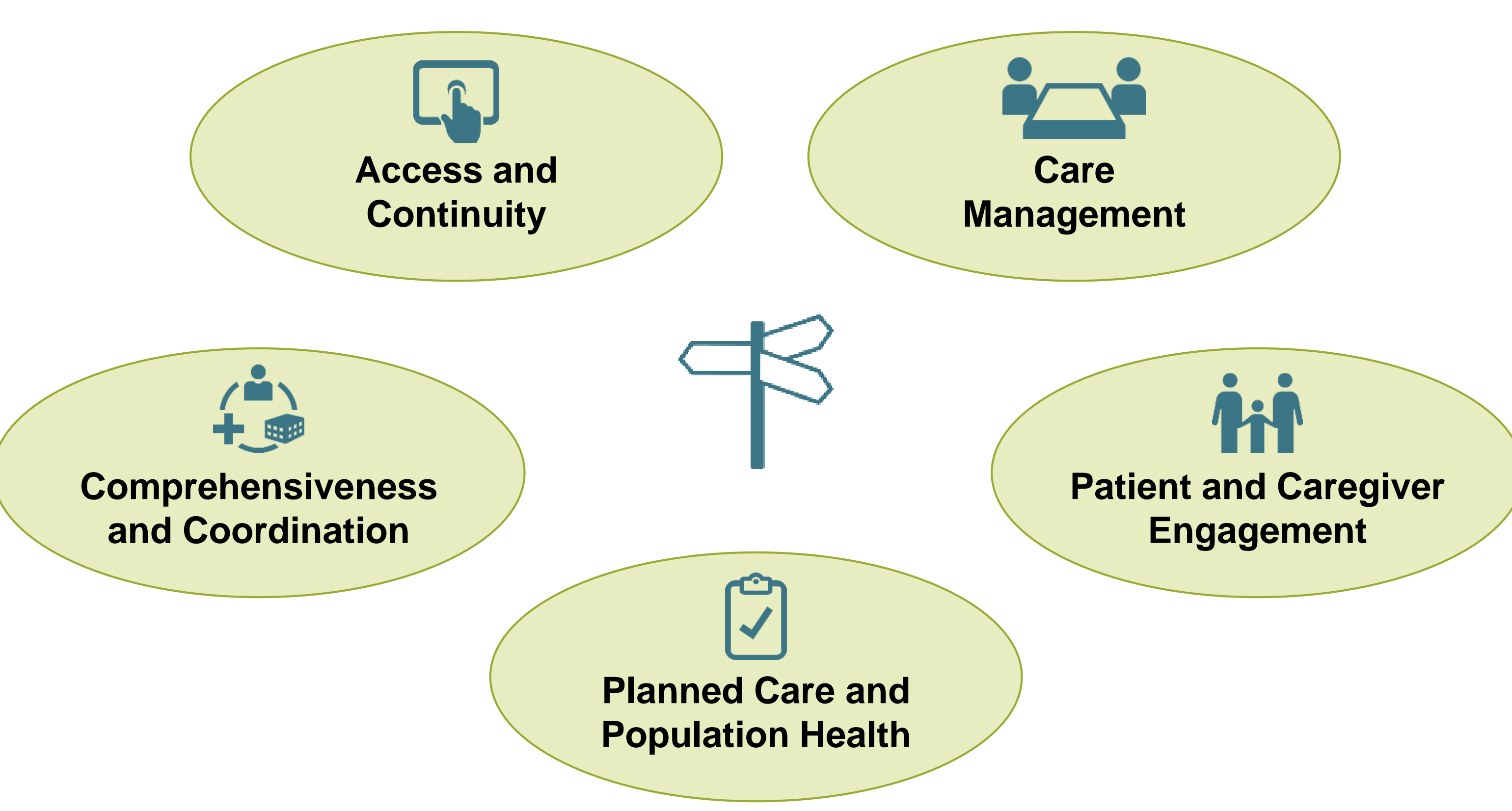
Practices will build the capabilities to deliver comprehensive primary care.

Track 2

Over **1,500** primary care practices.

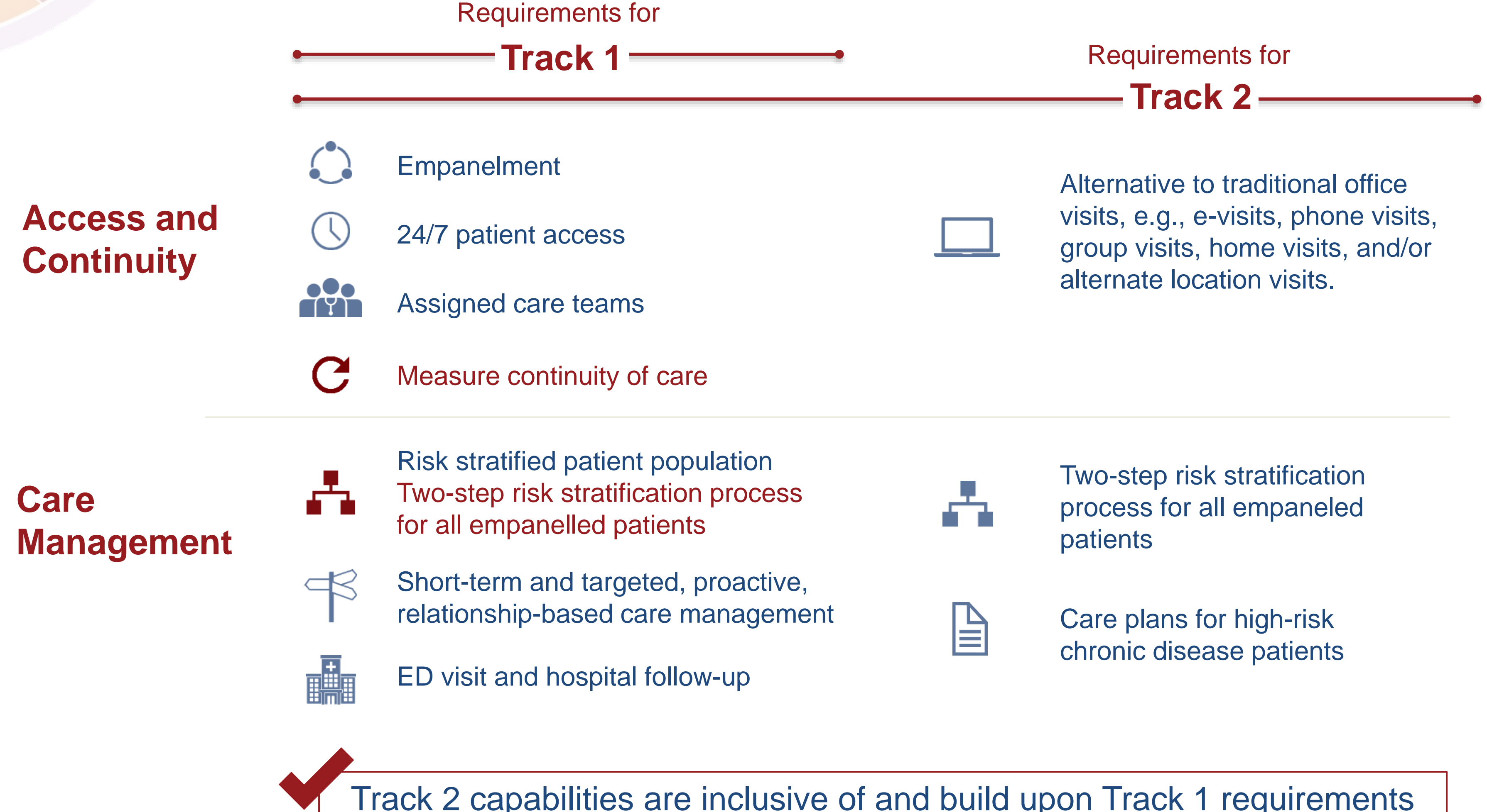
Practices will increase the **comprehensiveness** of care through enhanced **health IT**, improve care of patients with **complex needs**, and inventory resources and supports to meet patients' **psychosocial needs.**

Five Functions Guide CPC+ Care Delivery Transformation



Online Resources: Care Delivery Transformation Brief, Video, and Practice Requirements

CPC+ Practices Enhance Care Delivery Capabilities each Program Year



CPC+ Practices Enhance Care Delivery Capabilities each Program Year

	Requirements for **Track 1**	Requirements for **Track 2**
Comprehen-siveness and Coordination	Identification of high volume/cost specialists Improved timeliness of notification and information transfer from EDs and hospitals Collaborative care agreements Behavioral health integration	Collaborative care agreements Comprehensive Medication Management Psychosocial needs assessment and inventory of resources and supports Address common psychosocial needs Behavioral health integration Development of practice capabilities for patient subpopulation with complex needs
Patient and Caregiver Engagement	At least annual Patient and Family Advisory Council (PFAC) At least biannual PFAC Assessment of practice capabilities to support patient self-management Patient self-management support for at least three high-risk condition	At least biannual PFAC At least quarterly PFAC, and integrate recommendations into care Advance care planning
Planned Care and Population Health	At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy	At least weekly care team review of all population health data

CPC+ Health IT Requirements

Certified Health IT is Required for Tracks 1 and 2

Requirements for Track 1

Maintain/Adopt 2014 or 2015 Edition **Certified EHR Technology** by January 1, 2017. Maintain/adopt 2015 CEHRT by January 1, 2019

eCQM reporting – adopt 2014 or 2015 Edition certified health IT for the c(1)-c(3) functions – capture; import and calculate; and report eCQMs.

Adopt technology which allows **the filtering of data by practice site** and TIN/NPI by January 1, 2017. Adopt technology meeting the 2015 Edition c(4) function (filter) by December 31, 2018

Requirements for Track 2

(By 2019) Adopt technology certified to the 2015 Edition "**Care Plan**" criterion.

(By 2019) Adopt technology certified to the 2015 Edition "**Social, Behavioral, and Psychological Data**" criterion"

Track 2 capabilities are inclusive of and build upon Track 1 requirements.

Required Health IT Functionalities in CPC+ Track 2

Health IT vendor partners committed to supporting Track 2 Practices in developing and implementing these advanced functionalities across the five years of CPC+.

Now Available

Risk stratify the practice site patient population; identify and flag patients with complex needs

Empanel patients to the practice site care team

Produce and display eCQM results at the practice level to support continuous feedback

Coming in 2019-2021

Screen for social and community support needs and link the identified need(s) to practice identified resources

Establish patient focused care plans to guide care management

Document and track patient reported outcomes

Opportunities for Stakeholder Learning, Collaboration, and Support

CPC+ Practice Portal

Online tool for reporting, feedback, and assessment on practice progress.

Web-based platform for CPC+ stakeholders to share ideas, resources, and strategies for practice transformation.

Learning Communities

National webinars and annual National Stakeholder Meeting

- Cross-region collaboration.

Virtual and in-person regional learning sessions

- Engagement with CPC+ stakeholders.
- Outreach and support from regional learning faculty.

Opportunities for Practice and Payer Engagement

The following meetings are available to interested payer partners:

Regional Payer Table

Regional Payer Meetings, as determined by payers

National Payer Table

CMS-Led Webinars

LAN PAC Virtual Meetings

Annual LAN Summit

Milbank Multi-State Collaborative Meetings

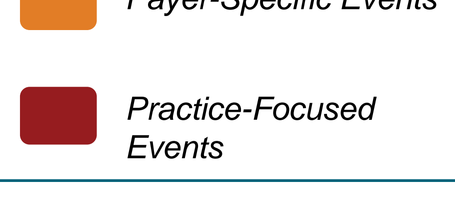
CPC+ Regional Learning Communities

Regional Learning Events

Planning Quarterly Learning Events *(in 2018)*

Quarterly Payer/Practice Leadership Meetings *(in 2018)*

Practice Action Groups & Affinity Groups *(in 2018)*



CPC+ National Learning Communities

National Learning Webinars

Data Aggregation

Coordination with CMS Data Feedback Contractor (Deloitte)

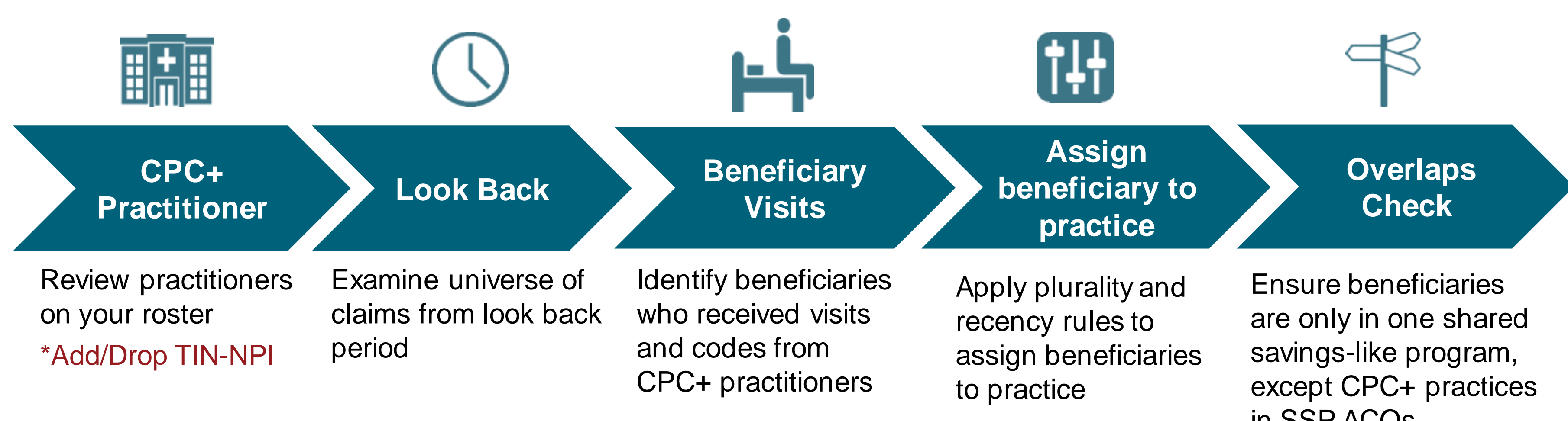
Three Payment Innovations Support CPC+ Practice Transformation

	Care Management Fee (PBPM)	**Performance-Based Incentive Payment** (PBPM)	**Payment Structure Redesign**
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average (ranges from $6 to $30)	$2.50 opportunity	N/A (Medicare FFS)
Track 2	$28 average (ranges from $9 to $100)	$4.00 opportunity	Hybrid Payment: a combination of upfront “Comprehensive Primary Care Payment” and reduced FFS claims

CPC+ practices also in the Medicare Shared Savings Program participate in their ACO’s shared savings/loss arrangement INSTEAD of receiving CPC+ incentive payments.

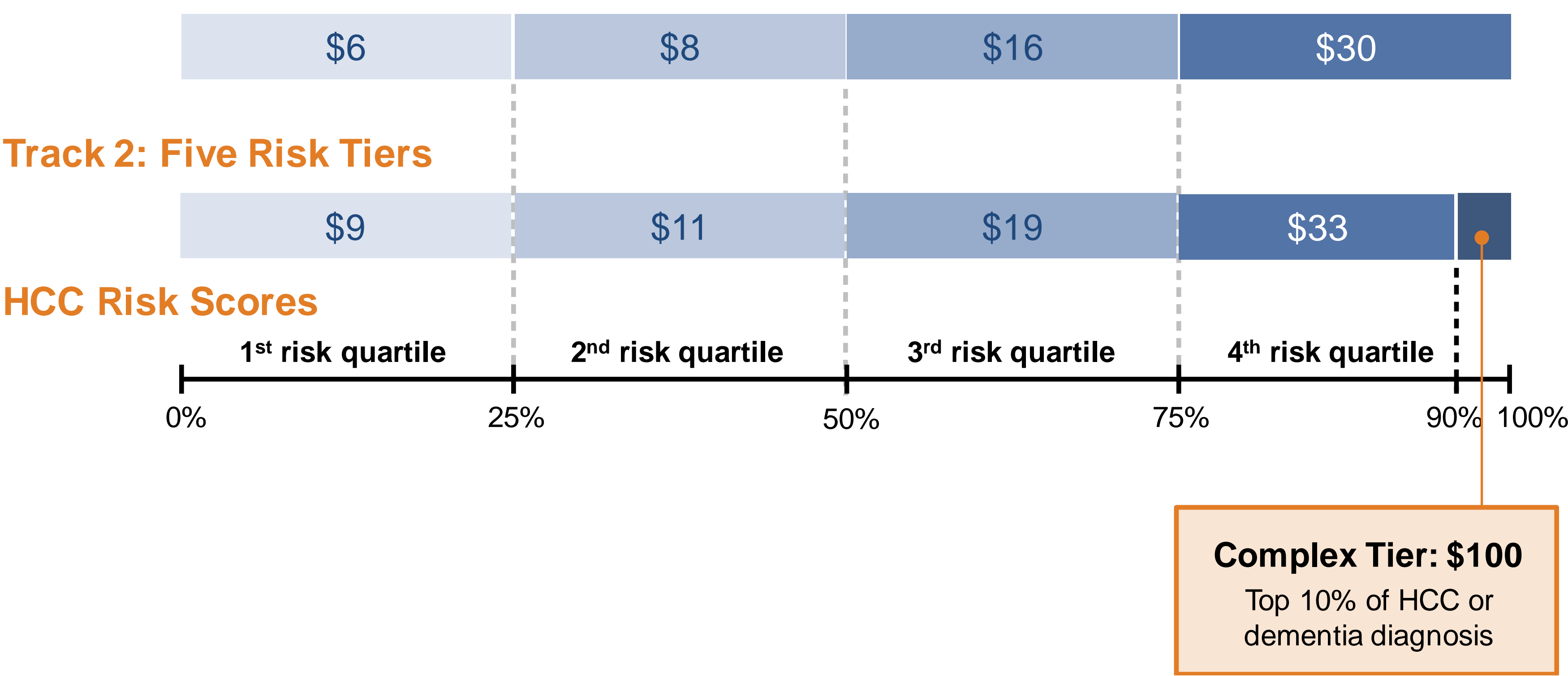
Attribution Methodology

*Practice composition changes must be updated for CMS' records



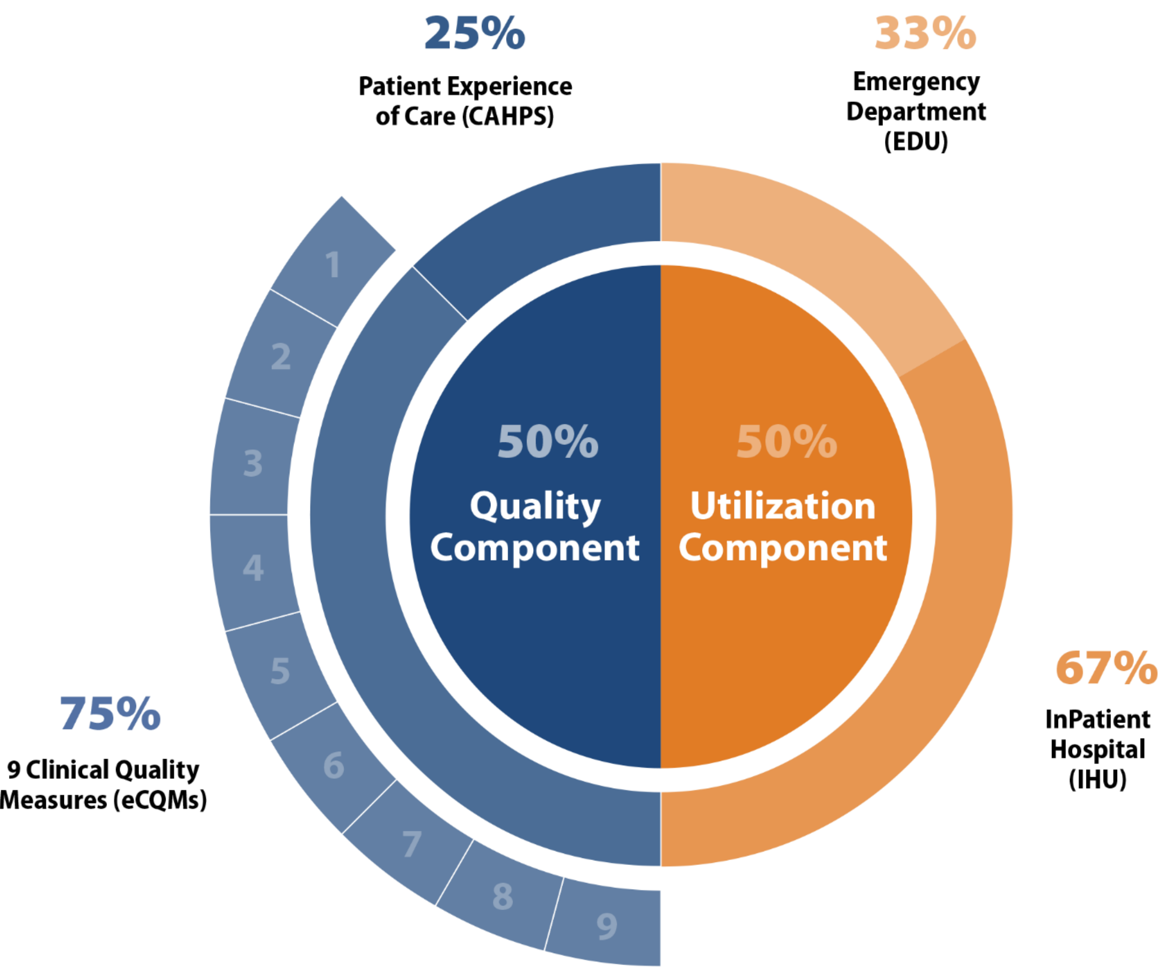
Care Management Fee

CMS uses CMS-HCC scores: Hierarchical Condition Categories



Performance-Based Incentive Payment

Based on performance on CAHPS, eCQMs, and Utilization metrics

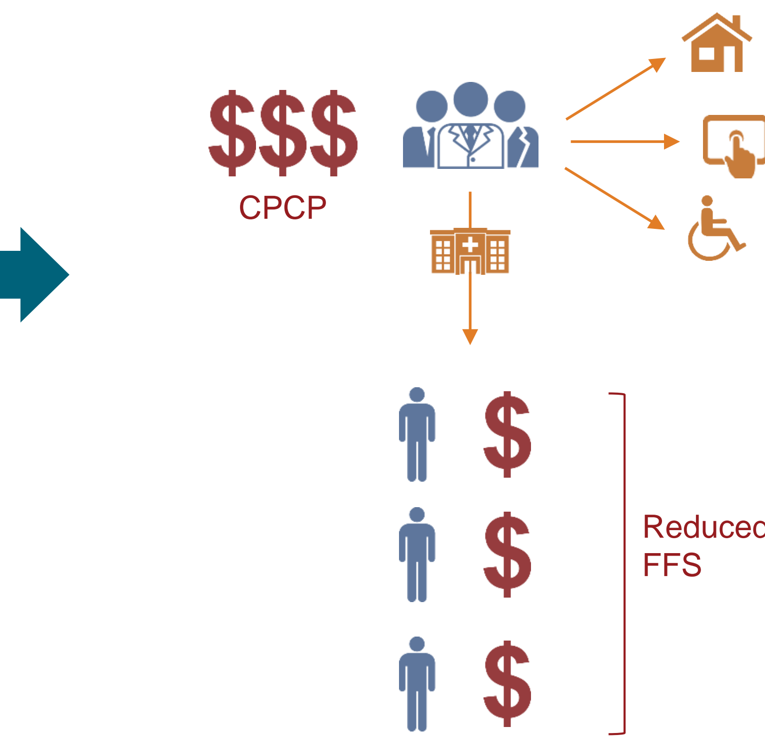


Track 2 Hybrid Payment

Designed to Promote Flexibility in Care Delivery and Population Health Beyond Office Visits

Traditional practice paid only through FFS; must see patients in office to receive reimbursement

CPC+ Track 2 practice paid roughly half of FFS payments upfront in "Comprehensive Primary Care Payment" (CPCP) to give clinicians more flexibility in how/where they deliver care



CPC+ Data Feedback Approach

Attribution/Payment Data

- Quarterly list of Medicare FFS beneficiaries attributed, by risk tier
- Quarterly financial support amounts

Quality Data

- Performance on Electronic Clinical Quality Measures and CAHPS surveys, compared to other practices

Data Sharing Levers

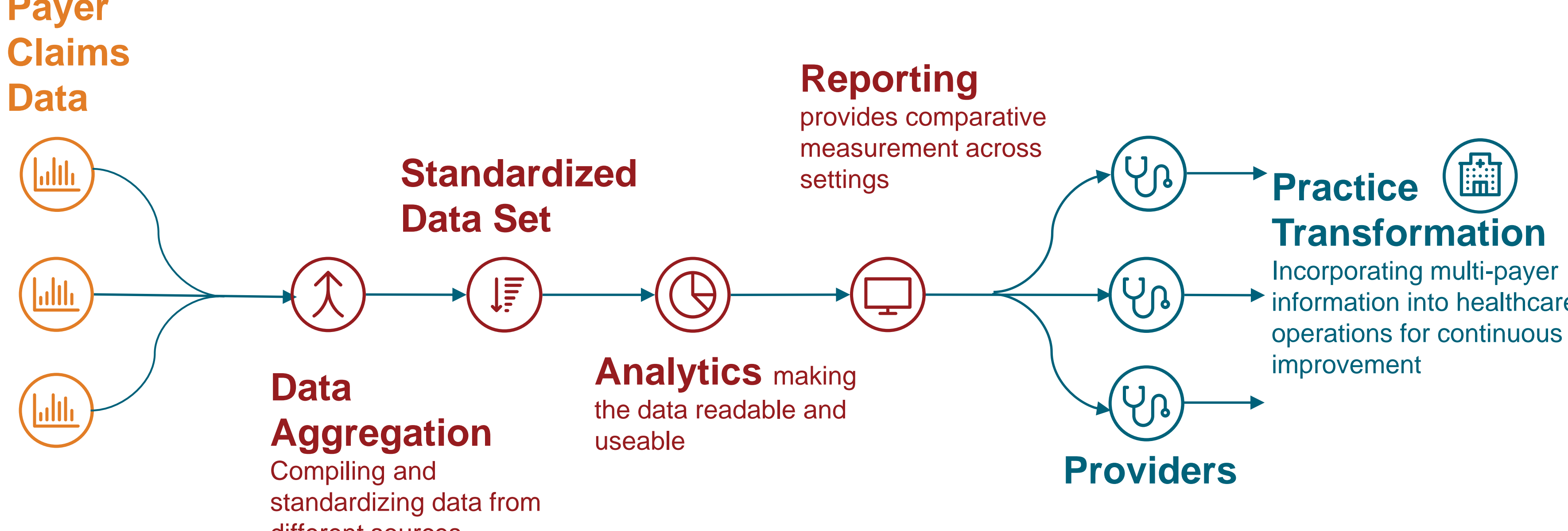
Cost and Utilization Data

- **Expenditures**: professional services, inpatient, outpatient, SNFs, etc.
- **Utilization**: inpatient, 30-day readmission, ED utilization

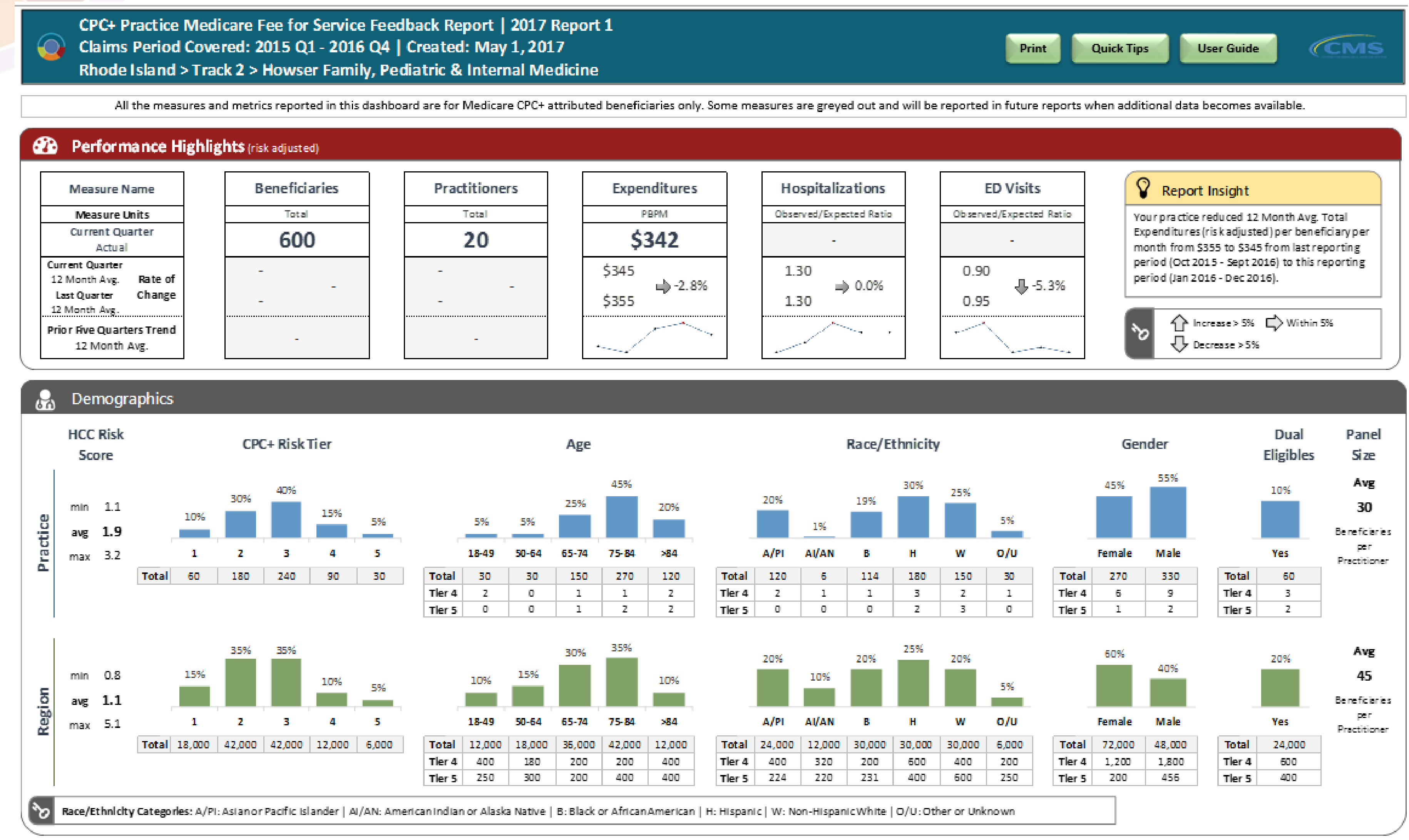
Multi-Payer Aggregation

- Aligned report with multi-payer data
- Allows clinicians to view entire patient population
- Reduces burden; enhances care coordination and population health

Data Aggregation Flow



Practice Performance & Demographics (Dummy Data)



CPC+ Payment Under the Medicare Quality Payment Program

CPC+ Practitioners Receive MIPS Special Scoring or Exemption

Merit-based Incentive Payment System (MIPS) Eligible Clinician in a

MIPS APM

Report only one MIPS category

OR

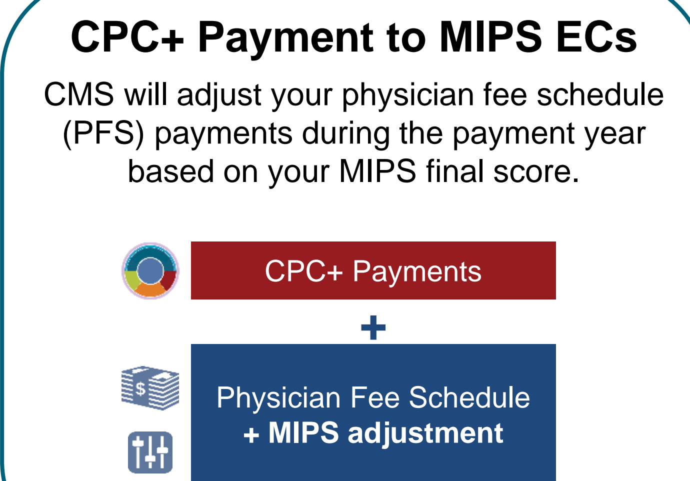
Qualifying APM Participant (QP) in an

Advanced APM

Exempt from MIPS reporting

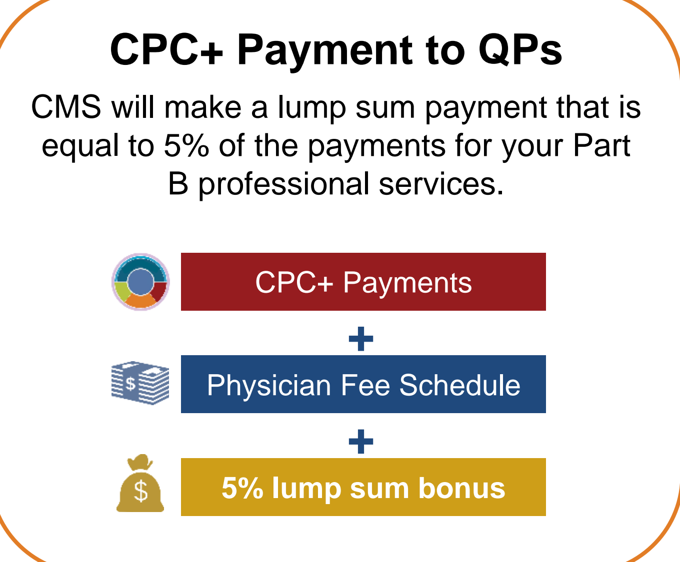
CPC+ Payment to MIPS ECs

CMS will adjust your physician fee schedule (PFS) payments during the payment year based on your MIPS final score.

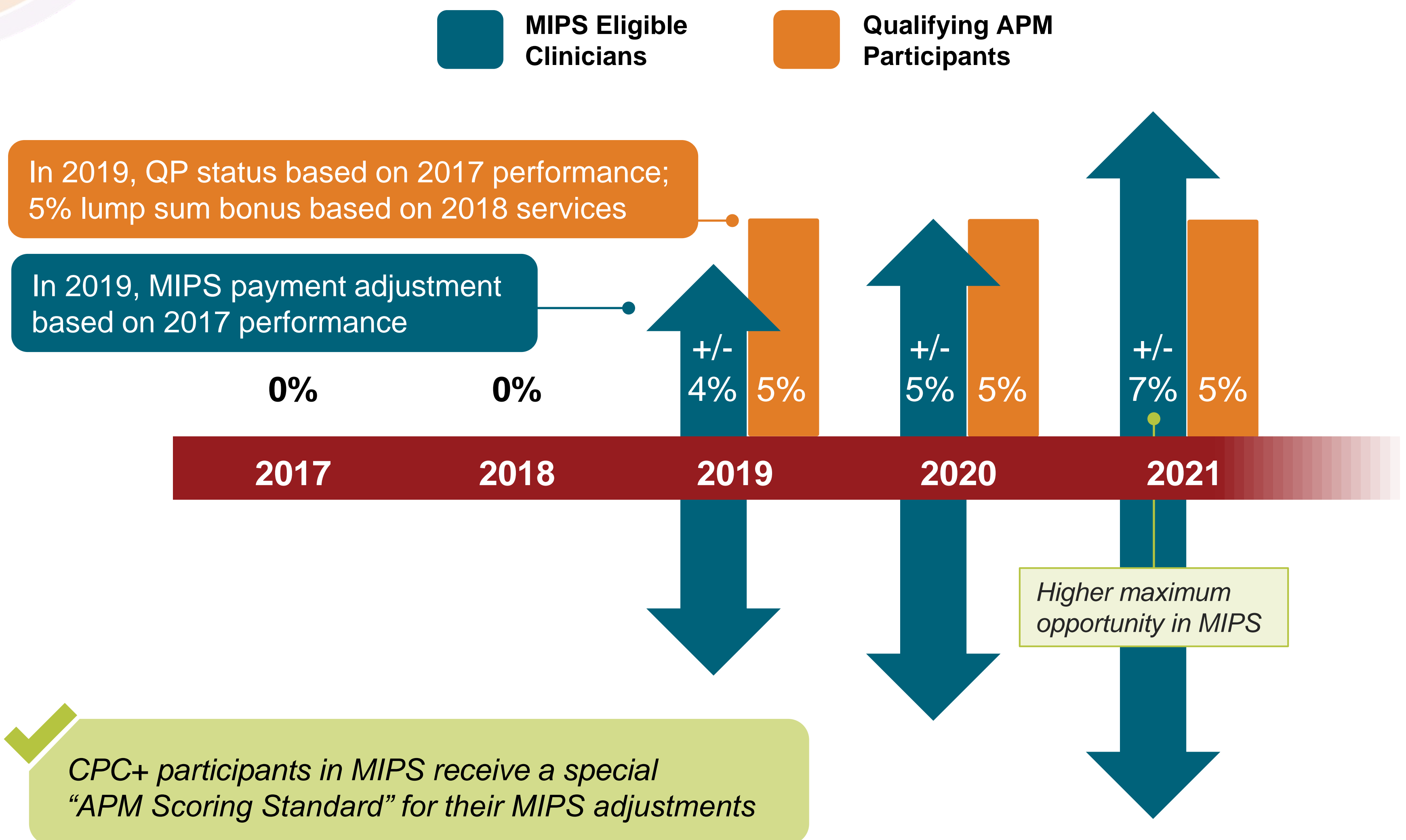


CPC+ Payment to QPs

CMS will make a lump sum payment that is equal to 5% of the payments for your Part B professional services.



Magnitude of MIPS Payment Adjustments Changes Over Time



For More Information on CPC+

Visit

https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

Email

CPCplus@cms.hhs.gov

Polling Question #2

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

- Overview and trends in VBP federal and industry initiatives.
- Interoperability.
- Patient Risk Stratification.
- Provider/Patient Attribution.
- Quality Measurement.

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Resources
- Presentation Slides

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Upcoming CAQH CORE Education Sessions

Use and Adoption of Attachments in Healthcare Administration, Part IV: Clinical Document Architecture (CDA) Basics
THURSDAY, JANUARY 18TH, 2018 – 2 PM ET

CAQH CORE Town Hall National Webinar
TUESDAY, FEBRUARY 6TH, 2018 – 2 PM ET

To register for these, and all CAQH CORE events, please go to **www.caqh.org/core/events**

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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.

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