



Sneak Peak: CAQH CORE Call on Value- based Payment Report

**FOR CAQH CORE
PARTICIPANTS ONLY**

February 22, 2018

2:00 – 3:00 PM ET

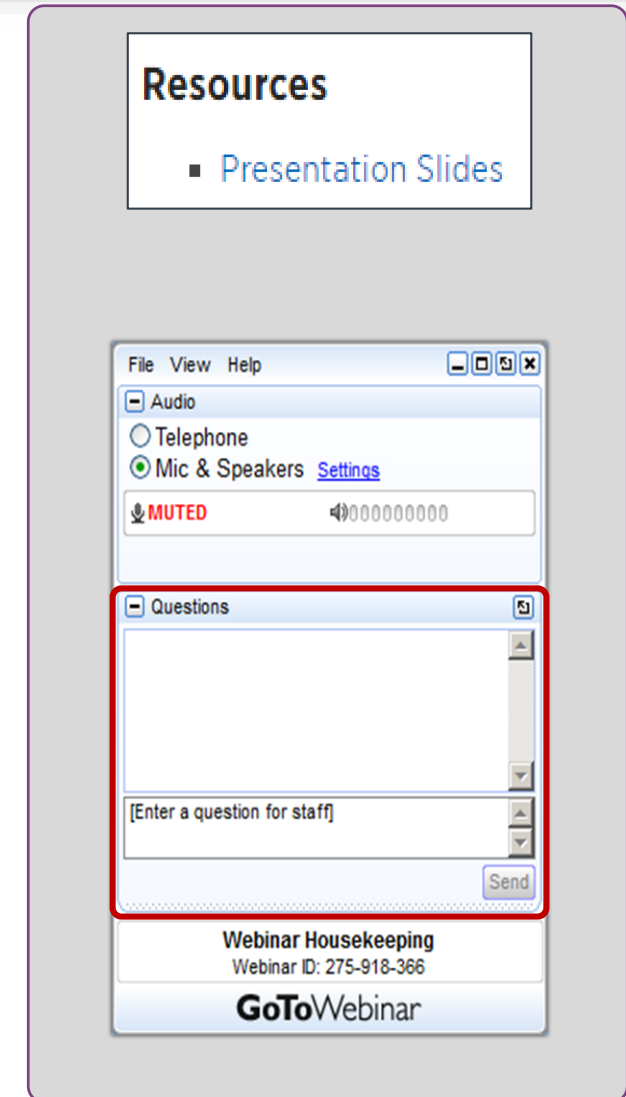
Logistics

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.**



Session Outline

- Introduction to Value-based Payments.
- Level Set: CAQH CORE Value-based Payments (VBP) Initiative.
- Opportunity Areas and Recommendations: First Look.
- Next Steps for CAQH CORE.
- Q&A.

Polling Question #1

What is your stakeholder type?

- Health Plan/Payer
- Provider
- Vendor
- Clearinghouse
- Other

Value-based Payments and CAQH CORE Activities

Erin Weber
CAQH CORE Director

Introduction to Value-based Payments

Introduction to Value-based Payment (VBP)

Definitions

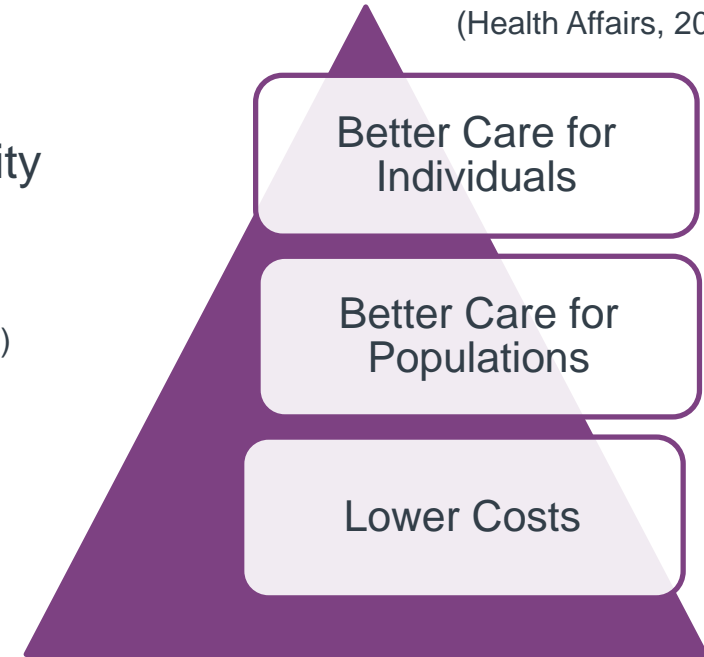
Value-based care is a healthcare delivery model in which providers are paid based on patient health outcomes. (NEJM Catalyst, 2018)

- As value focuses on quality of care and cost, many believe value-based payment has the power to improve U.S. mortality and morbidity rates and change the trajectory of national health expenditures.
- From 2015 to 2017, the number of commercial payers engaging in some type of value-based care has doubled to 24 percent. (HFMA, 2018)

Value-based payment is a strategy used by purchasers to promote quality and value of health care services. (Healthcare Incentives Improvement Institute, 2013)

The Triple Aim

(Health Affairs, 2008)



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)

Operational Challenges to Successful Transition

From Fee-for-Service to Value-based Payment

VBP* models with a goal to improve quality and reduce cost.

**Volume-based Payment
(Fee-for-Service)**

**Outcomes-related
Payment**

**Pay-for-
Performance**

**Bundled
Payments**

**Shared
Savings**

**Shared
Risk**

**Full
Risk**

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.

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

Polling Question #2

What is your role related to VBP at your organization?

- Management and Oversight.
- Contracting/Relations.
- Claims Adjudication and Reconciliation.
- Quality Measurement.
- Other or N/A.

Level Set: CAQH CORE VBP Initiative

Level Set: CAQH CORE VBP Initiative

CAQH CORE is Uniquely Positioned to Help Streamline Value-based Payment 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

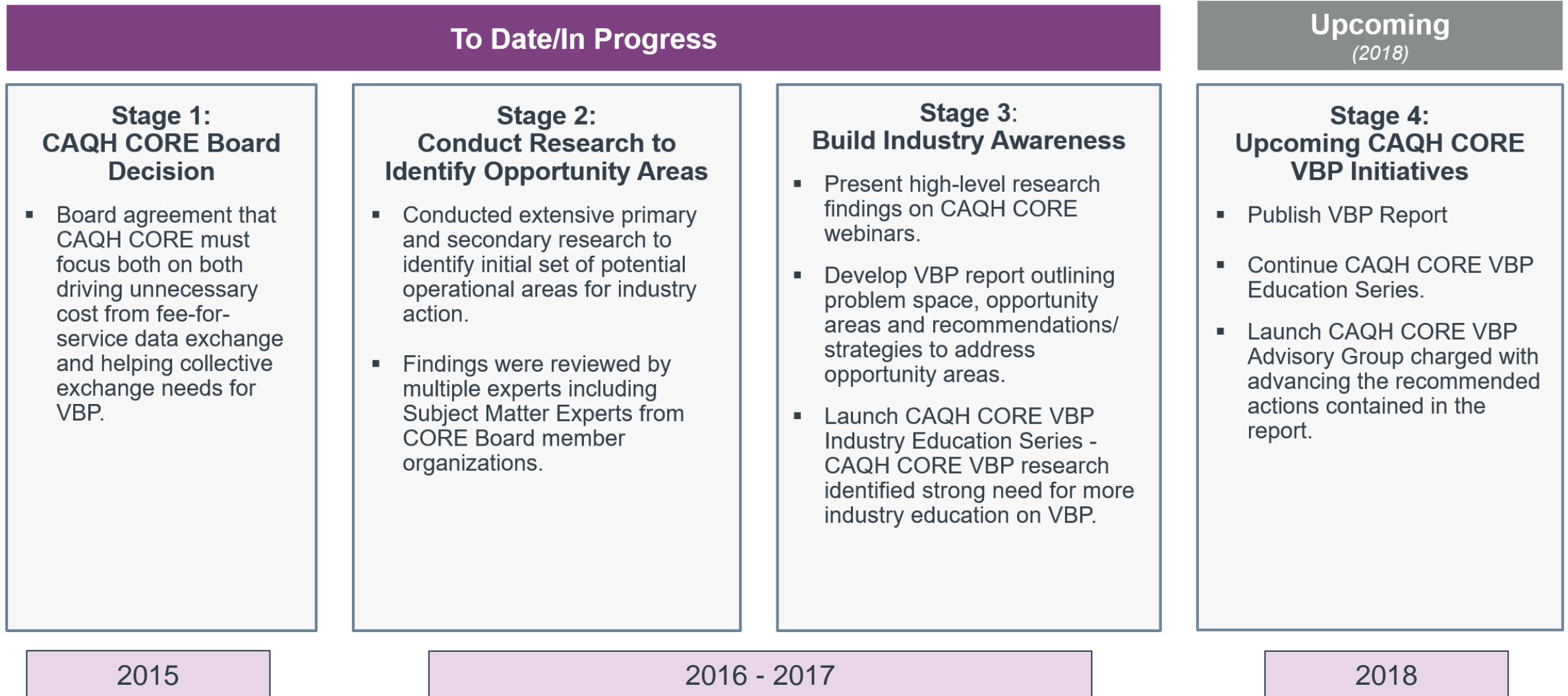


Expertise developing operating rules for the administrative and financial areas where providers and health plans must work together -- **ability to harmonize practices between providers and health plans, with 130 participating organizations.**

By collaborating now and applying lessons learned 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.**

Level Set: CAQH CORE VBP Initiative

Activities in VBP to Date and Beyond



Opportunity Areas and Recommendations

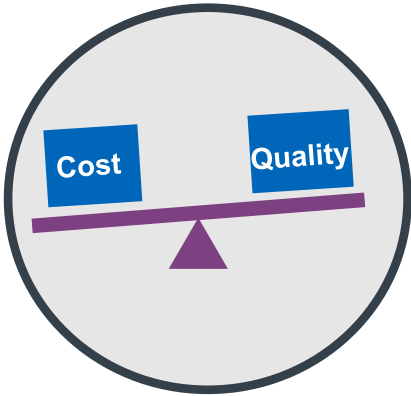
First Look

Erin Weber
CAQH CORE Director

Helina Gebremariam
CAQH CORE Senior Associate

CAQH CORE VBP Report

Report Objective



The VBP Standardization Challenge

The success of VBP is fundamentally dependent upon **smooth and reliable business interactions** between all stakeholders. Investments in standardized methods of communication among stakeholders can deliver value to the entire industry if there are **consistent expectations and rules of the road** related to value-based payment. While stakeholders are eager to collaborate, they echoed one common theme in research for this report: **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.

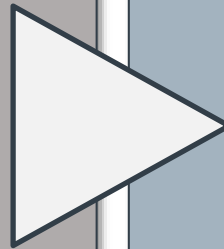
12+ Candidate Orgs

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

SECONDARY RESEARCH

Environmental Scan

- Defined terms and trends associated with varied VBP models.
- Conducted a literature review.
- Confirmed need for streamlining administrative processes associated with VBP.



PRIMARY RESEARCH

Interviews

- Conducted structured interviews w/ ~20 multi-stakeholder entities to confirm, refute &/or add to the potential areas for action.
- Conducted survey of CAQH CORE Participants to collect feedback on interview findings.



Opportunity Areas and Recommendations

CAQH CORE VBP Report

Opportunity Areas Identified for Sustainable Industry-wide Success

VBP Opportunity Areas



1

Data Quality & Standardization



2

Interoperability



3

Patient Risk Stratification



4

Provider Attribution



5

Quality Measurement

Opportunity Areas for Action

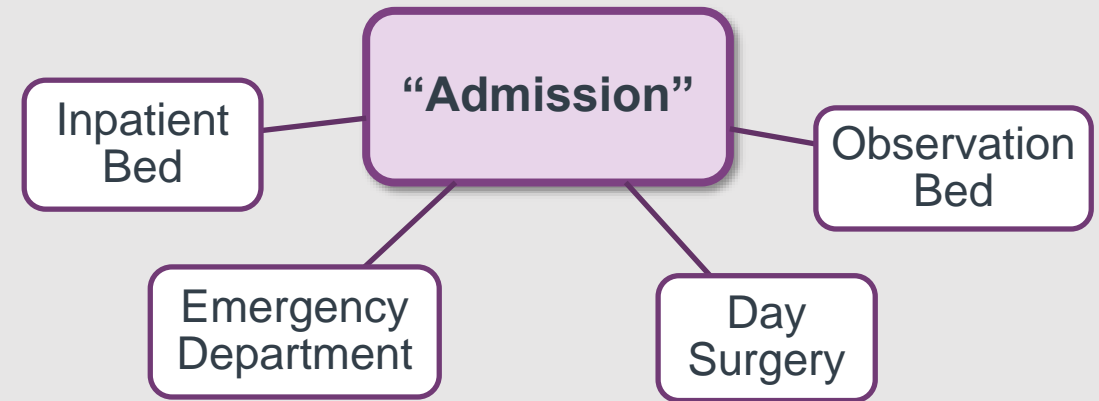
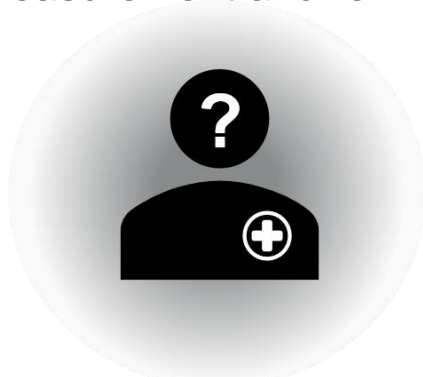
1. Data Quality and Standardization

Industry Challenge

Health plans and healthcare providers agreed there is a challenge of “too much data.” **Non-standardized data and data quality** pose far greater challenges to VBP operations. **Improving the accuracy, completeness and timeliness of data and enabling easier access to high-quality data are priority areas.**

A predominant issue surrounding data quality is **missing or inaccurate provider identification.**

Challenges arise when the provider’s specialty, relationship to the patient and current information is unclear. These factors are critical to determine patient cost, quality measurement and reimbursement.



Inconsistent use of common terms impacts the assessment of patient financial responsibility.

Terms to describe the date and time of an event -- “admission” -
- make it **difficult to measure** timeliness and nature of care
and could have **different reimbursement rates.**

Data Quality and Standardization

Recommendation

CAQH CORE Recommendation

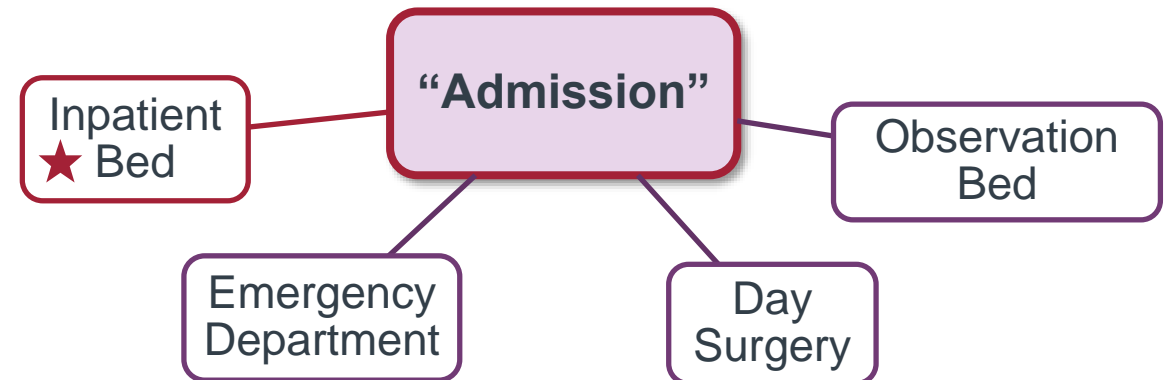
1. **Promote and enforce data set and data element standards** that would benefit VBP execution, especially where federally mandated.
2. **Pursue voluntary agreement on adoption of applicable uniform definitions** and, as needed, **additional data elements** in HIPAA-mandated transactions.

Use of the National Provider Identifier (NPI) has been required in all HIPAA-mandated transactions since 2007, but **identifiers** like the tax identification number (TIN), proprietary identifiers and Medicaid IDs are used, sometimes in combination. Keeping this data updated presents another challenge since changes to the NPI Database are **not made in real time**.



The role of the provider must be clear to accurately disperse shared savings or shared risk; **accurate use of NPI could alleviate this burden.**

Not all data necessary for VBP is part of a standardized medical or non-medical code set. **Consistent adoption** of medical and non-medical code sets, as well as **uniform use of definitions**, will improve care delivery and care management capabilities, promote transparency in VBP and strengthen the ability to perform quality and cost analysis.



Polling Question #3

What poses the greatest data quality and standardization challenge for VBP? (Check all that apply.)

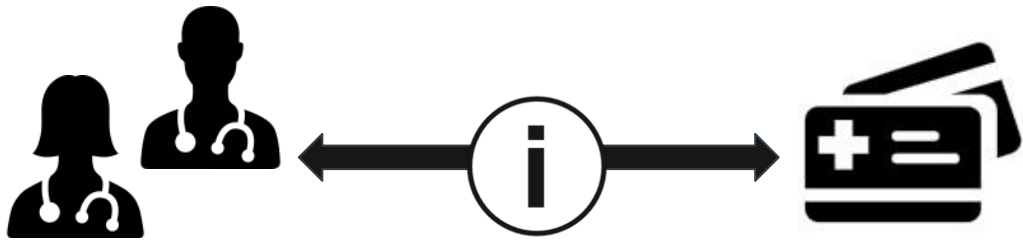
- Non-standardized data.
- Lack of data quality (accuracy, completeness or timeliness of data).
- Inaccurate or missing provider identification.
- Inconsistent use of common terms.
- Other (Elaborate in Questions panel).

Opportunity Areas for Action

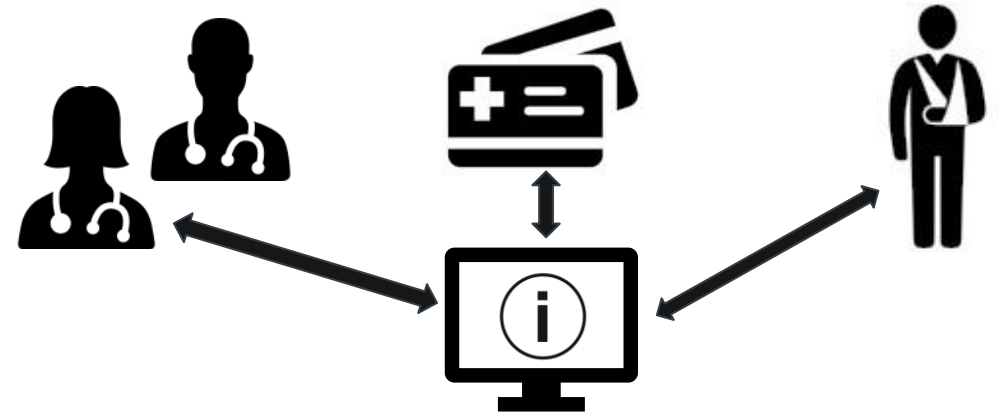
2. Interoperability

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. Need **improvements in both technical and process interoperability**, i.e. the ability to pass data from one information system to another while maintaining accuracy/validity and having common expectations for workflows, connectivity processes, data timeliness, etc.



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.



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.

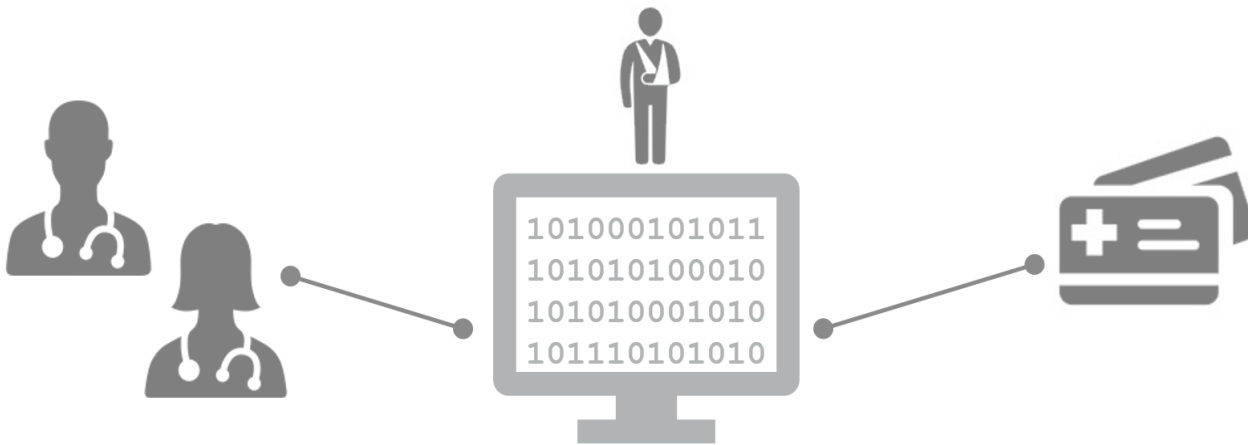
Improved patient communications by providers and health plans are necessary to support patient engagement and shared decision-making. Process changes may also require new agreements, partners, contracts, workflows and data collection.

Interoperability

Recommendation

CAQH CORE Recommendation

1. Promote technical interoperability by **encouraging use of existing and emerging standards and technologies.**
2. Promote process interoperability by **cataloging VBP best practices.**



A fully interoperable EHR system **capable of sharing longitudinal patient-level data** about individuals would support the development of better outcomes-based payment structures, dramatically advancing VBP. **Interoperable systems would support more fluid data interactions** needed to fuel actionable and trustworthy analytics for care management, quality measurement, patient attribution, risk adjustment, payment and more.

More carefully choreographed workflows, processes and policies would allow stakeholders to make more reliable comparisons and act on timelier insights.



Polling Question #4

What poses the greatest interoperability challenge?

- Technical Interoperability (the inability to pass data from one information system to another while maintaining accuracy/validity).
- Process Interoperability (lacking common expectations for workflows, connectivity processes, data timeliness, etc.).
- Other (Elaborate in Questions panel).

Opportunity Areas for Action

3. Patient Risk Stratification

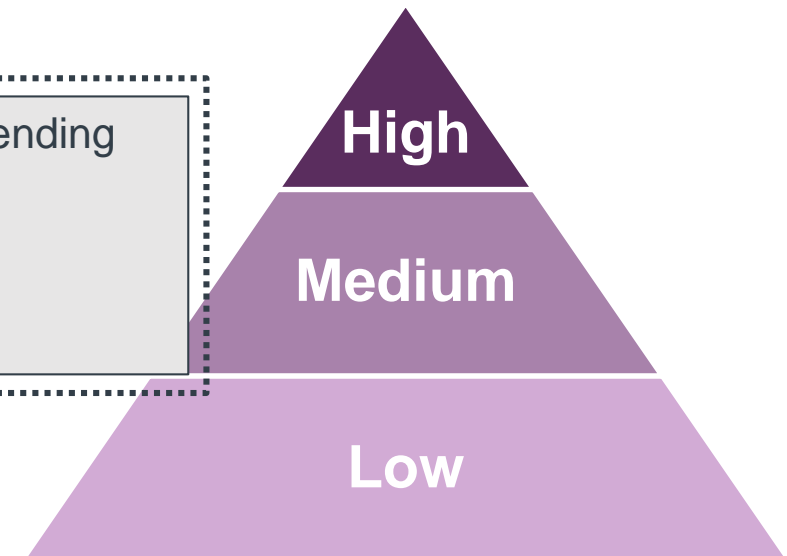
Industry Challenge

Models for patient risk stratification and patient risk determination vary considerably across the industry. Research identified two dominant operational challenges:

- **Lack of Transparency:** Providers are unclear how health plans are using risk assessment – and whether risk adjustment tools are being applied for patient risk stratification. This lack of clarity may impact the health plan-provider relationship which is critical to successful VBP outcomes.
- **Lack of Uniformity:** Even when plans are using a patient risk stratification methodology, each contract between a health plan and provider may use different/modified methodology.

The methods for determining patient risk stratification can be complex and varied depending on the purpose and different types of patient populations.

Overcoming this hurdle would **reduce administrative burden** so providers can focus resources on appropriate patient populations, and reduce their potential provider risk.



Patient Risk Stratification

Recommendation

CAQH CORE Recommendation

1. **Increase** industry awareness of the threats data inaccuracy/unavailability and methodology variation pose to VBP operational success.
2. **Promote** industry collaboration and transparency of risk stratification models and their content.



The total number of risk stratification models is unknown. There are approximately seven publicly available models most commonly used for risk stratification, with others emerging as VBP use accelerates. These models are based, to some degree, on comorbidity. However, specificity is not readily available. Furthermore, there has been no known cost analysis or demonstration of the effectiveness of each model to guide the industry in best use.

Polling Question #5

What poses the greatest patient risk stratification challenge?

- Lack of transparency (Providers not knowing what patient risk stratification model a health plan is using).
- Lack of uniformity (Different methodologies used in contracts between health plans and providers).
- Other (Elaborate in Questions panel).

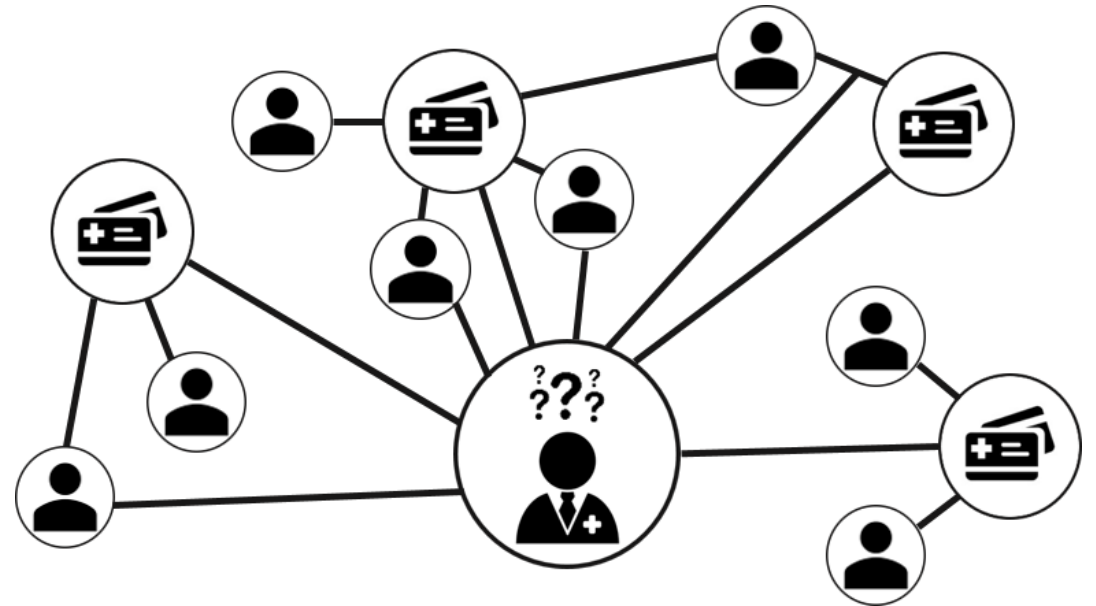
Opportunity Areas for Action

4. Provider Attribution

Industry Challenge

In VBP models, “attribution” assigns accountability for individual patients to providers. **Providers encounter barriers in understanding attribution models** when they engage in VBP arrangements, including **how patients are attributed to them and variations in attribution methodologies**.

A provider with 10 health plan contracts could potentially have patients attributed in a multitude of ways and the logic behind the attribution may vary.



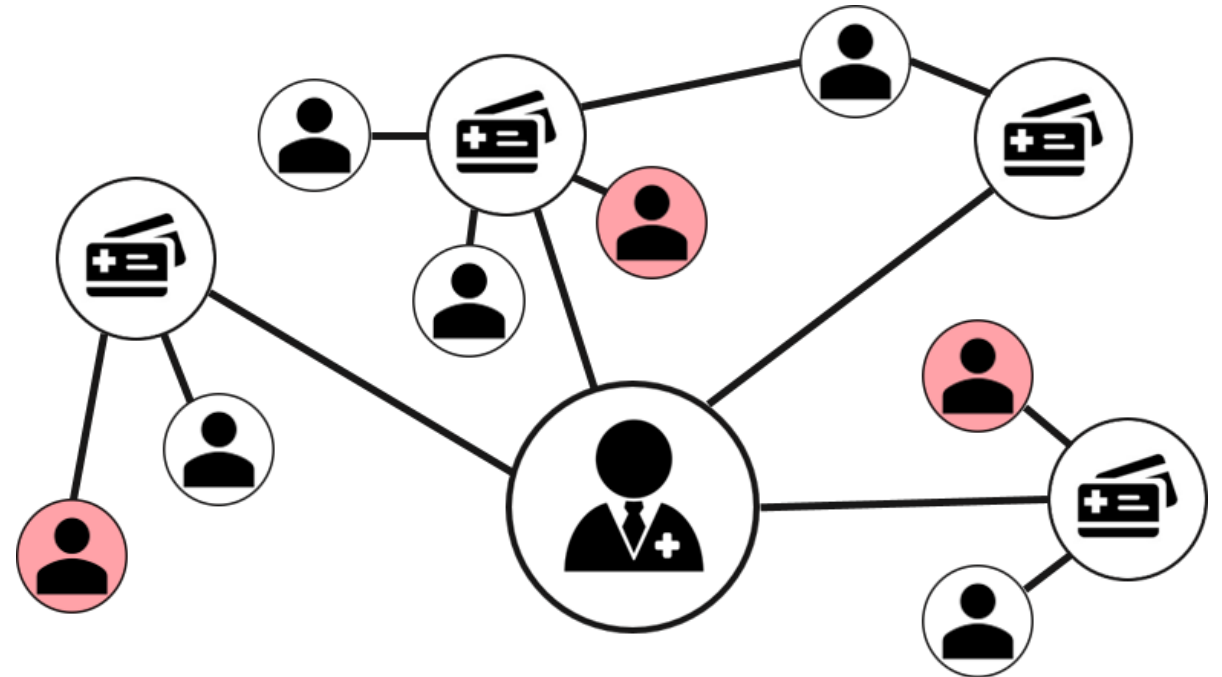
Without full understanding of the methodology used, providers can make erroneous assumptions, which could lead to ineffective decisions about patient needs.

Provider Attribution *Recommendation*

CAQH CORE Recommendation

1. **Improve** provider awareness of patient attribution through clearly defined and accurate provider data.
2. **Streamline** and improve transparency in use of attribution models.

Extensive variation in attribution models and the frequent lack of transparency make it difficult for providers to understand how their patients are attributed. This confusion can lead to gaps in managing the care of patients who are attributed to them. By improving this transparency, both patients and providers are empowered in decision-making.



Ultimately, accurate cost and quality comparisons can be made to know whether VBP goals are being achieved.

Polling Question #6

What poses the greatest provider attribution challenge?

- Lack of accurate data on assigned patients.
- Lack of timely data on assigned patients.
- Lack of transparency regarding the provider attribution model being used.
- Other (Elaborate in Questions panel).

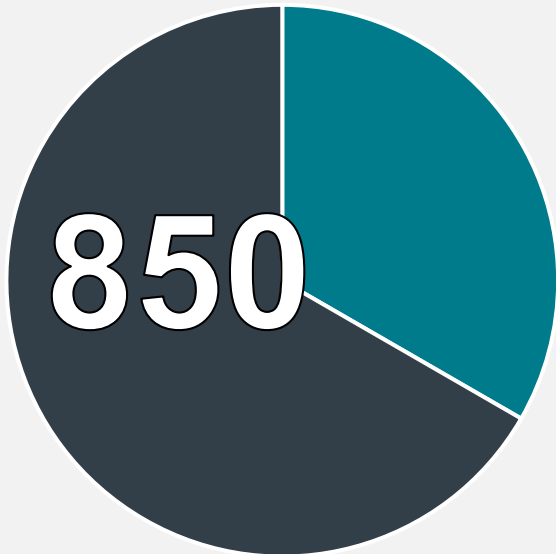
Opportunity Areas for Action

5. Quality Measurement

Industry Challenge

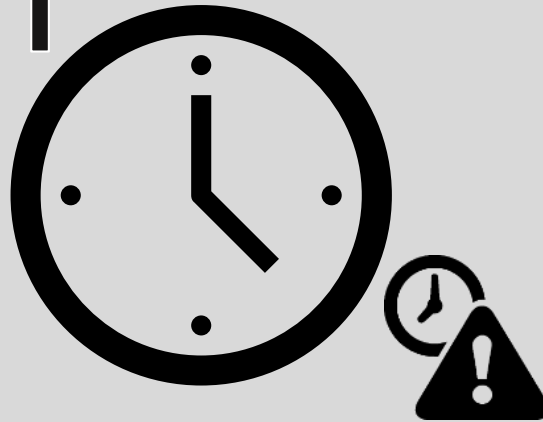
Though quality measures are clinical, **gathering data and producing reports is an operational burden**. Providers reported three overarching challenges across quality measure programs.

- **Too many measures:** Over-proliferation of quality measures and lack of consistency in the measures required across health plans and performance initiatives.
- **Too much reporting:** Burdensome processes for generating quality reports.
- **Too little insight:** Absence of meaningful measures that identify actionable next steps for providers and patients.



Unique measures collected in 33 CMS programs. Only 1/3 of these measures were used in more than 2 CMS programs. (HCANYS, 2016)

15.1



Hours per physician per week entering information for the sole purpose of reporting on quality measures from external entities. (MGMA, 2016)

The overabundance of and lack of meaningful quality measures leads to **communication with consumers that is confusing or not useful**. It is also **difficult for providers to know how to improve their care and services**.

Opportunity Areas for Action

Quality Measurement

CAQH CORE Recommendation

Support industry efforts to address quality measure challenges and promote standardization by providing education to address the need to:

- ✓ **Improve consistency in quality measures** across programs.
- ✓ **Reduce quality measure data collection burden.**
- ✓ **Require quality measures to be actionable.**



**Effective
measurement of
process performance
and outcomes is
foundational to VBP.**



A variety of state and regional efforts are focused on improving quality measurement and reporting. The Network for Regional Healthcare Improvement (NRHI) has identified more than 30 such collaboratives.

There is a renewed effort to address quality measurement challenges through various core measurement projects. In 2014, America's Health Insurance Plans (AHIP) convened industry leaders to form The Core Quality Measures Collaborative which released seven sets of core quality measures to align payers on quality measures to support VBP.

Polling Question #7

Would you like to be contacted for a follow-up interview or site visit for the CAQH CORE VBP Initiative?

- Yes, please contact me.
- Not at this time.

Next Steps for CAQH CORE

Erin Weber
CAQH CORE Director

Upcoming Events

To learn more about the recommendations and strategies towards streamlining the industry for VBP, be sure to read the CAQH CORE VBP report.
The report will be released in late March.

Stay tuned for an industry webinar about the full report on **April 10, 2018** with guest speaker **Dr. Susan Turney, FACP, CEO of Marshfield Clinic Health System**. For more information about this or other events, please visit www.caqh.org/core/events.

CAQH CORE VBP Advisory Group

CAQH CORE’s next step in this initiative is to form an Advisory Group. This group will be charged with narrowing down the list of potential opportunity areas for action to one or more strategies that CAQH CORE will pursue. The group will then continue to provide guidance and insight to “Tiger Teams” responsible for executing the selected opportunity area recommendations.

	2018											2019		
	Q1		Q2			Q3			Q4			Q1		
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CAQH CORE VBP Report Release														
CAQH CORE Continues Research and Education														
VBP Advisory Group														
VBP Tiger Team 1														
VBP Tiger Team 2														

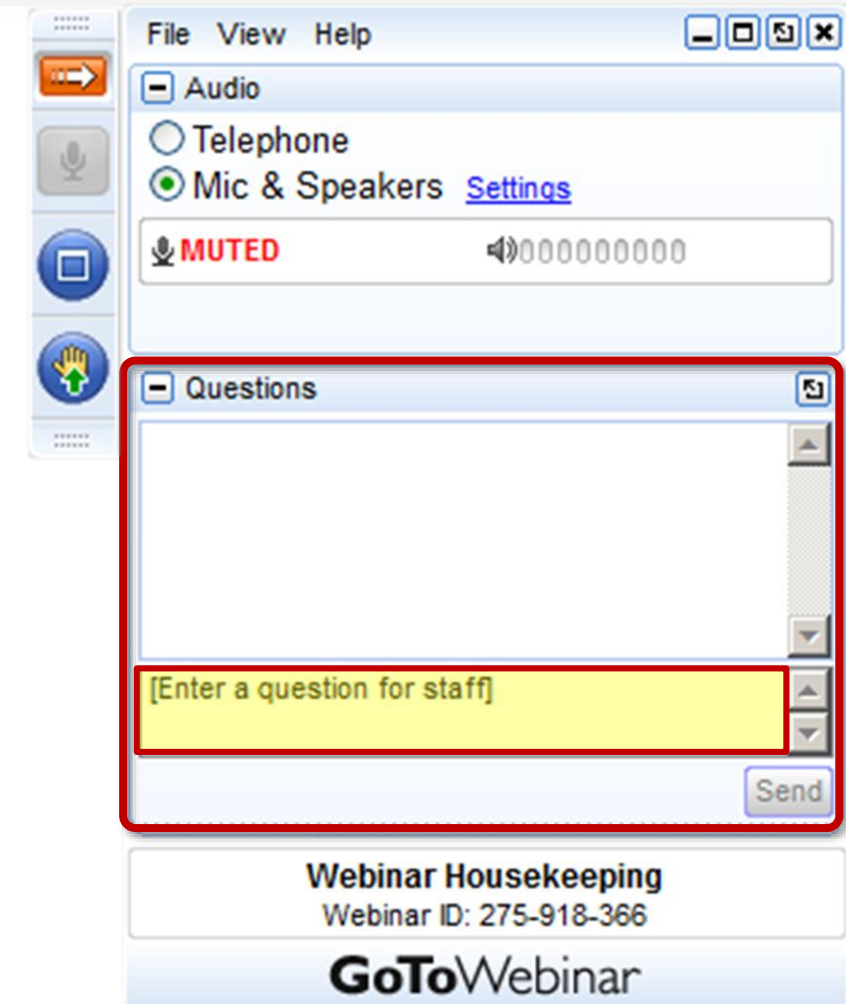
“Tiger Teams” may run concurrently or run for different amounts of time depending on the given opportunity area. With guidance from the Advisory Group, these teams will be responsible for key VBP deliverables.

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.**

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



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

Upcoming

Overview of Value-based Payment Trends

TUESDAY, MARCH 13TH, 2018 – 2 PM ET

CAQH CORE Value-based Payments Report: Applying the Lessons of FFS to Streamline Adoption

TUESDAY, APRIL 10TH, 2018 – 1 PM ET

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

Thank you for joining us!



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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.