CAQH CORE

CAQH CORE Value-based Payment (VBP) Webinar Series:

Quality Measures in Value-based Payment

Thursday, August 23, 2018
2:00 – 3:00 pm ET

Logistics

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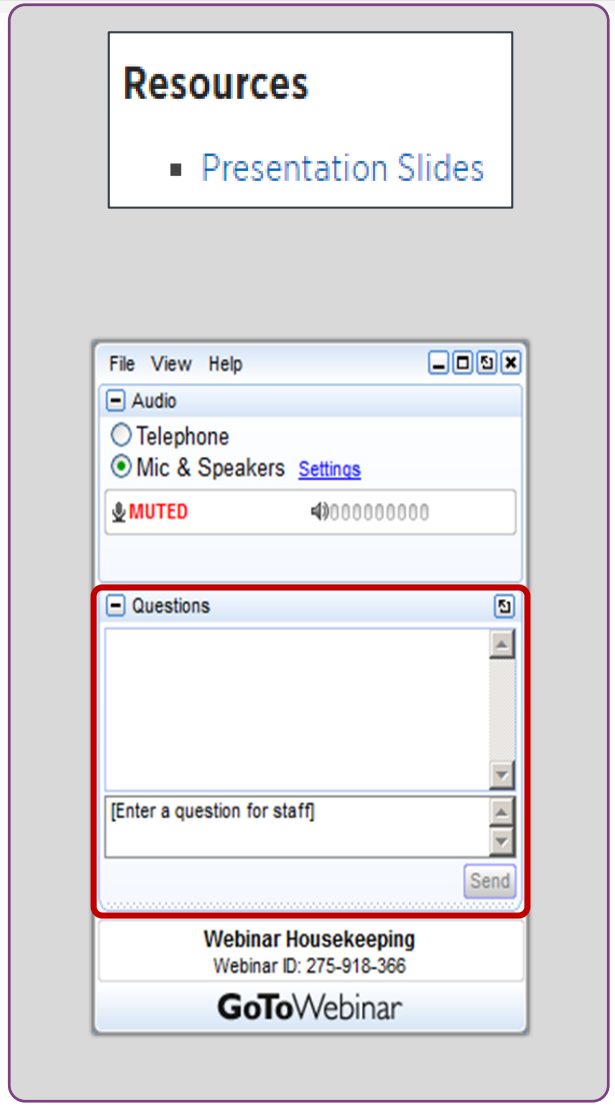

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Session Outline

- Overview of CAQH CORE Value-based Payment Initiative
- Featured Presentation: Quality Measures in Value-based Payment
- Audience Q&A

Overview of CAQH CORE Value-based Payment Initiative

Lina Gebremariam
CAQH CORE Manager

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 Value-based Payment (VBP) implementation.

Contents of Report

5 Opportunity Areas

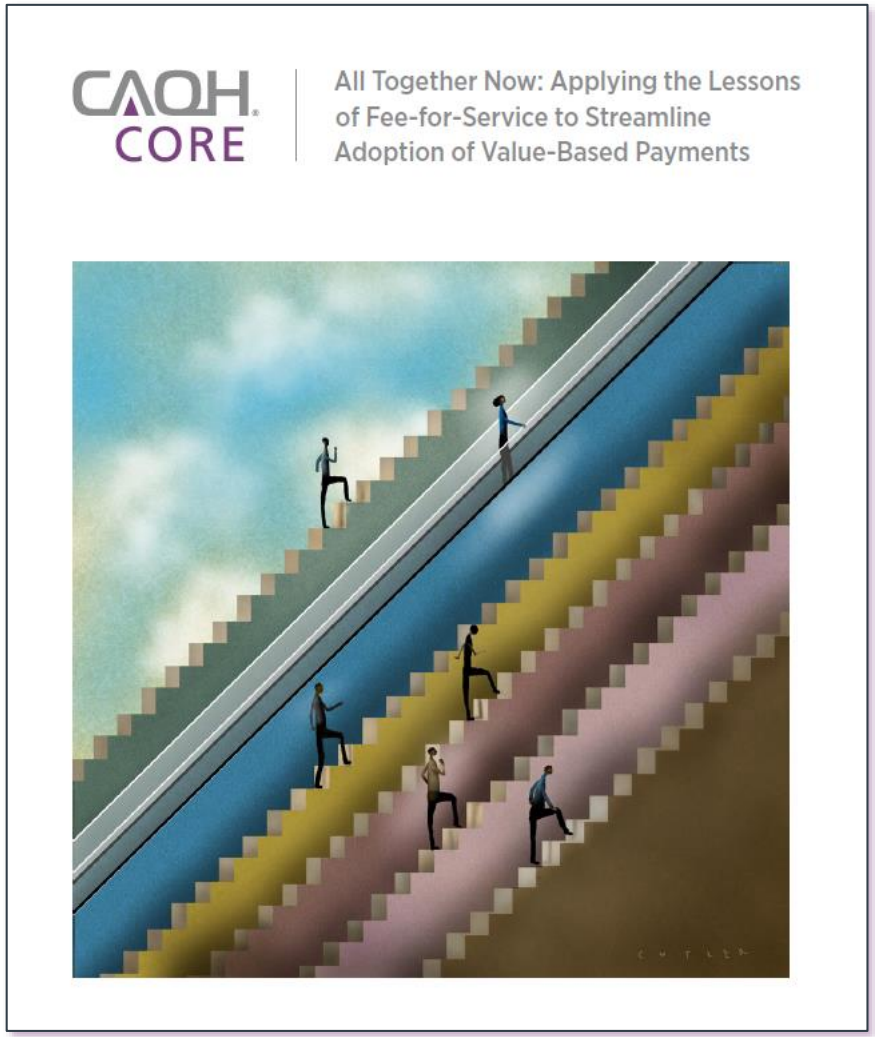
Unique operational challenges associated with VBP.

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 Value-based Payment

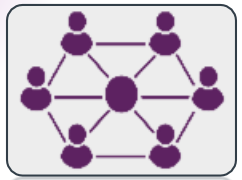
The CAQH CORE vision is a common private/public infrastructure that drives adoption of value-based payment models by reducing administrative burden, improving information exchange and enhancing transparency.

Value-based Payment Opportunity Areas

1. **Data Quality & Standardization:** Standardize identifiers, data elements, transactions and code sets.

2. **Interoperability:** Define common process and technical expectations.

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



4. **Provider Attribution:** Improve provider awareness of patient attribution and transparency in underlying patient attribution models.

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

Opportunity Areas for Action

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.

850 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)

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**.

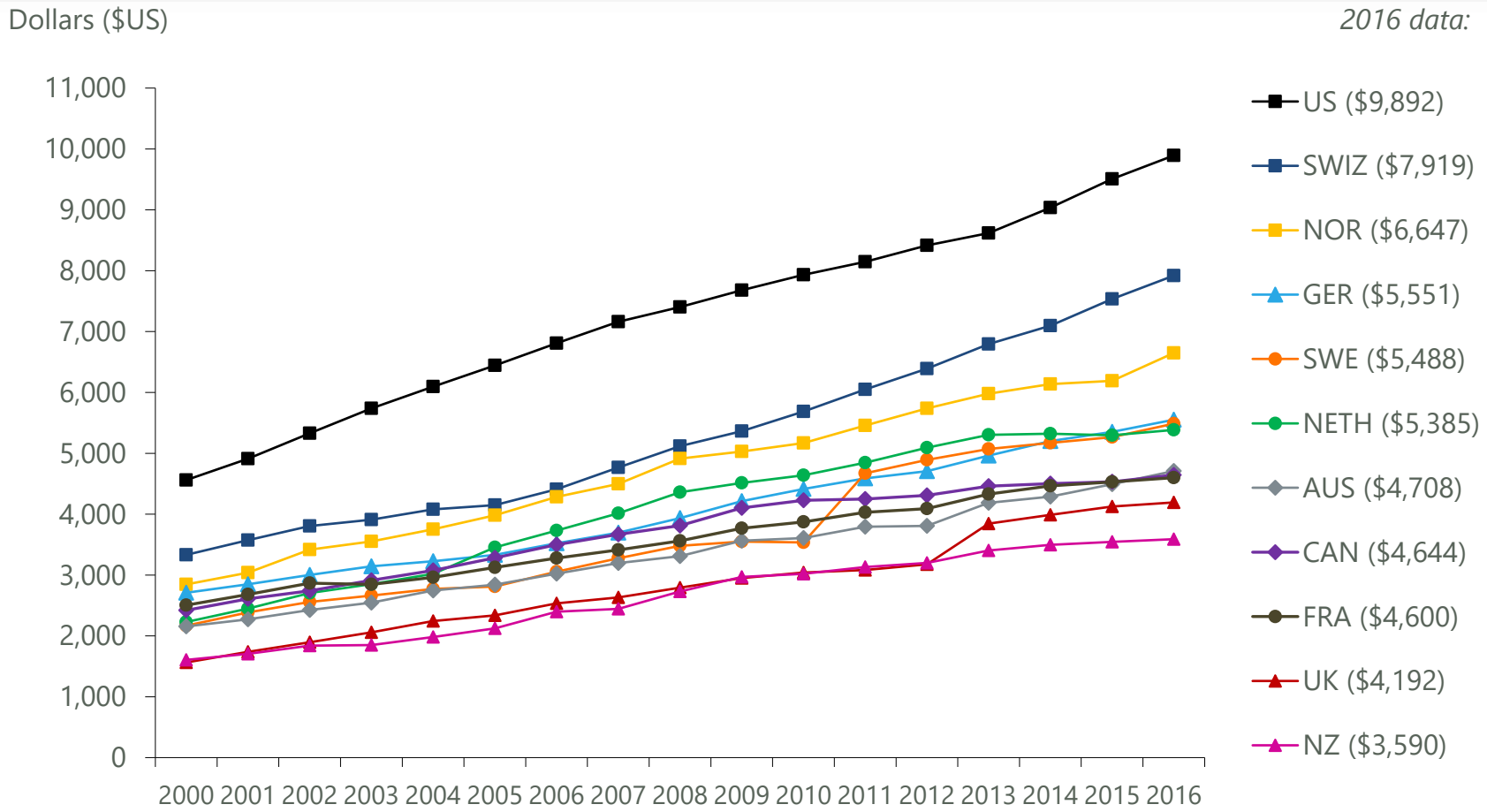
Effective measurement of process performance and outcomes is foundational to VBP.

- **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 also a shifting focus from process measures to patient-reported outcomes measures.** Process measures are foundational for measuring value. However, effective patient-reported outcomes measures can capture patient health status while keeping provider collection burden at a minimum and empowering patient decision-making.

Quality Measurement in Value-based Payment

Aparna Higgins
CAQH CORE Consultant
President and CEO, Ananya Health Solutions

Health Care Spending per Capita, 2000–2016



Note: Adjusted for differences in cost of living.

The Commonwealth Fund

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

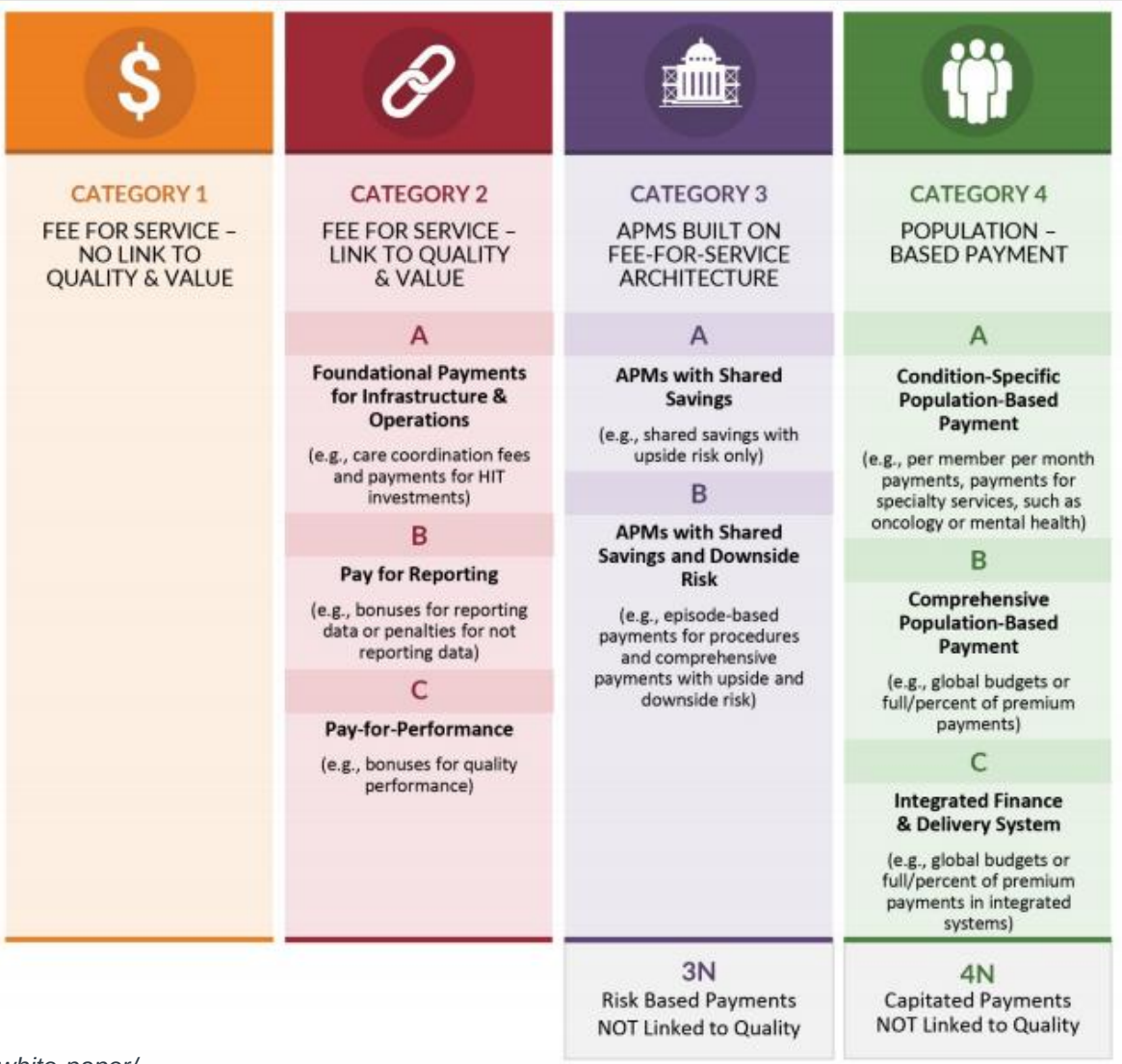
Select Population Health Indicators, 2015

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

The Commonwealth Fund

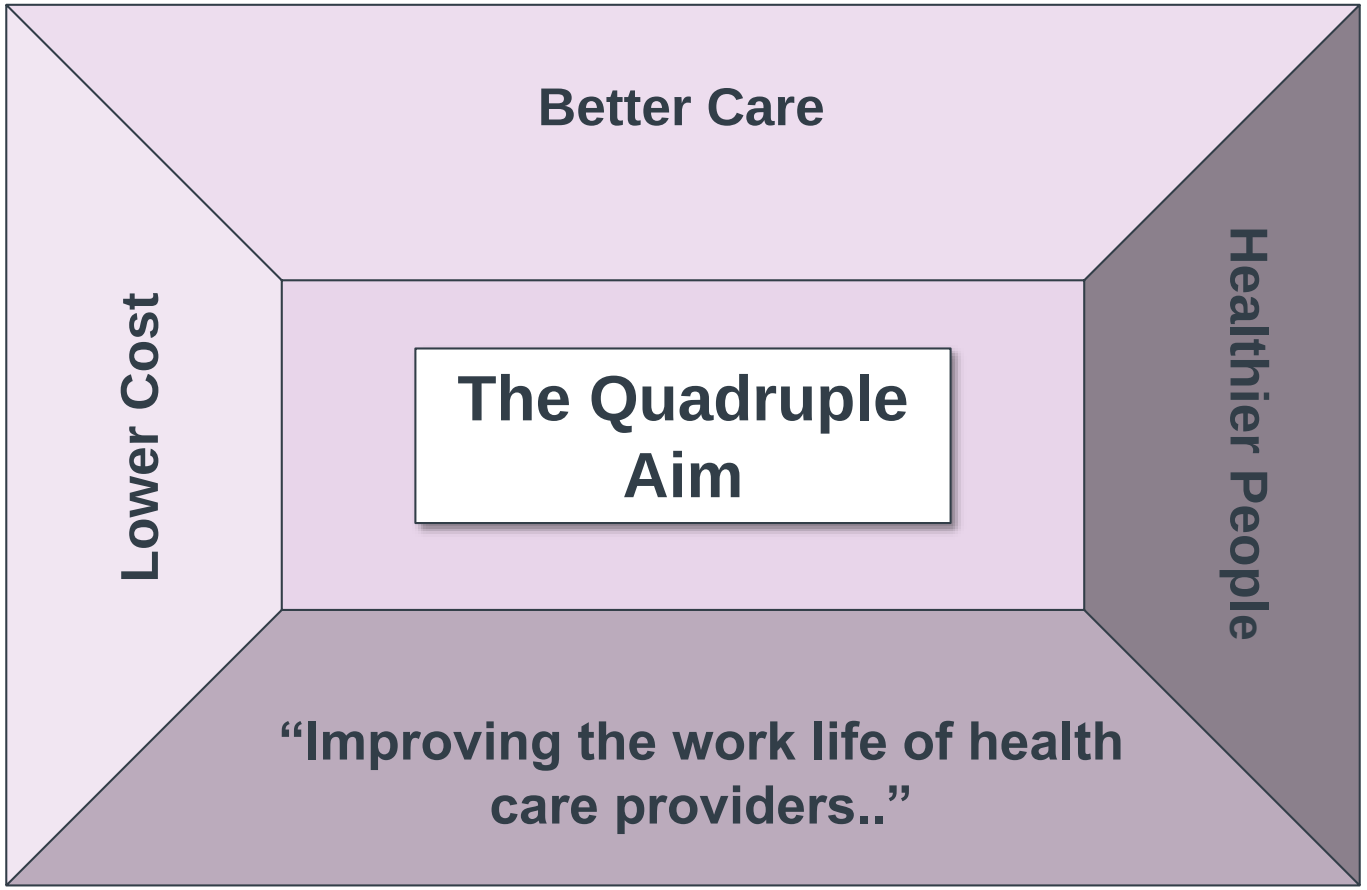
^ Or nearest year: * 2014 data; ** 2013 data; *** 2012 data. (M) Measured; (SR) Self-reported. 'OECD median' reflects the median of 35 OECD countries.
Source: OECD Health Data 2017.

Alternative Payment Model Spectrum



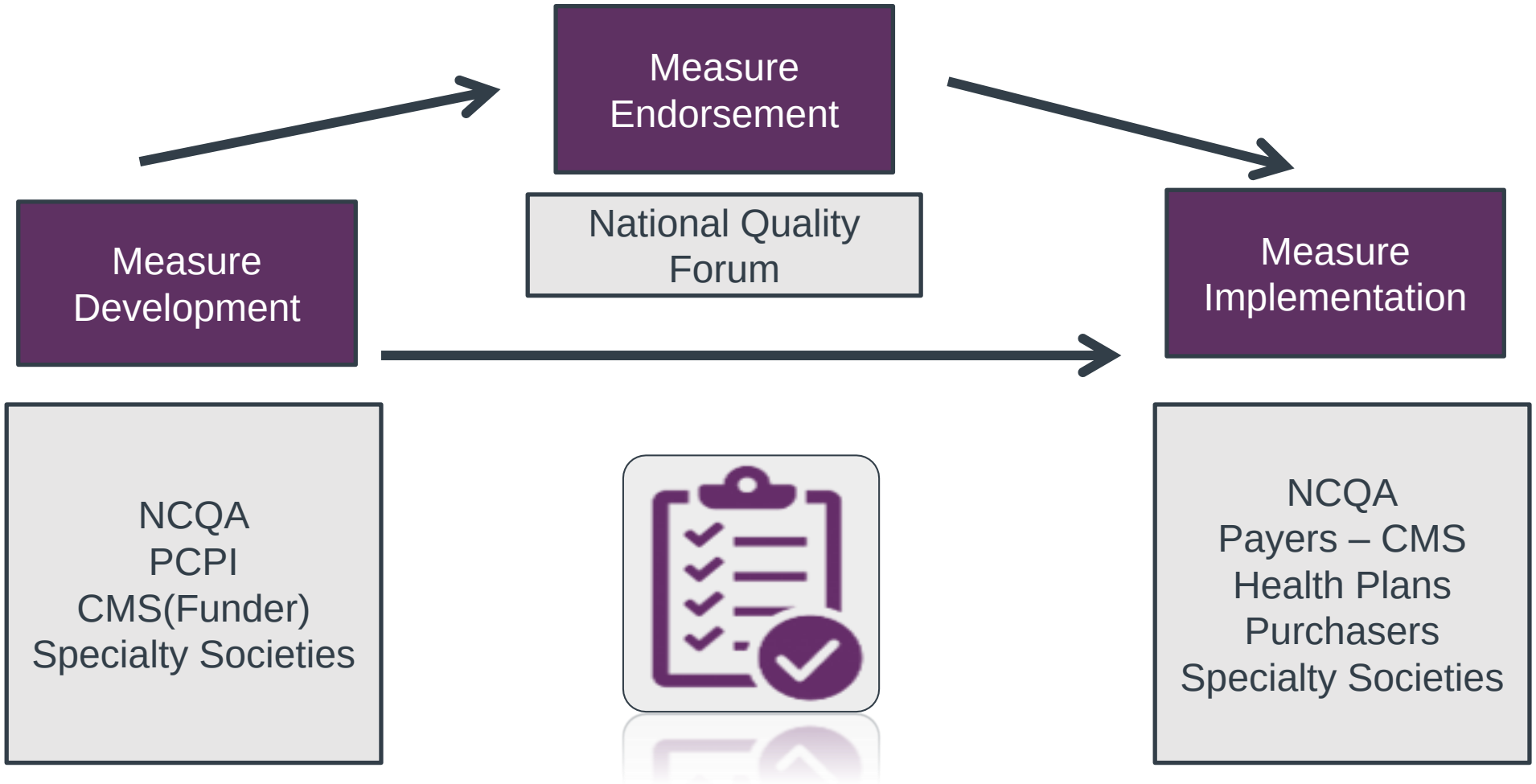
Source: https://hcp-lan.org/groups/apm-refresh-white-paper/.

VBP Goals: From Triple to Quadruple Aim



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

Quality Measurement Enterprise



Measure Types

Donabedian Framework

- Structure – Assesses features of an organization relative to its capacity to deliver care, e.g. nurse staffing ratios, adoption of EHRs.
- Process – Assesses if a clinical process of care was performed (or not) during care delivery, e.g. hemoglobin A1c testing for diabetic, childhood immunizations.
- Outcomes – Assesses health status of a patient that could be the result of one or more healthcare interventions, e.g. blood pressure control.

Source: http://www.nejm.org/doi/full/10.1056/NEJMsa1404026.

Data Sources

- Administrative Claims.
- Patient-Reported – Instruments used to collect data from patients.
  - PHQ-9 – Used in depression.
  - CAHPS – Family of surveys used to assess satisfaction.
- Medical Record.
  - Paper.
  - Electronic.
- Clinical Registries.

Types of VBP Models

- Purpose of measurement in value-based payment – selection and accountability.
- Quality improvement measures are important – internal to healthcare organizations.

Population-Based Payment (PBP) Models – Primary Care Focused

Patient-Centered Medical Homes
Accountable Care Organizations

Specialty Models – Episode Based

Oncology
Orthopedic Surgery
Maternity

Selection of Quality Measures in VBP

Types of Criteria Used for Selecting Measures

- Scientific acceptability – evidence-base, validity and reliability.
- Feasibility of data collection.
- National Quality Forum endorsed.
- Burden versus benefit associated with data collection.
- Alignment with national programs such as Medicare.

Measurement in Population Based Payment (PBP) Models

Health Plans - Domains

- Prevention.
- Treatment/Management of Chronic Conditions.
- Utilization.
- Patient Safety.
- Patient Experience.
- Overuse/Inappropriate Use.

Measurement in Population Based Payment (PBP) Models

Health Plans

Prevention

- Cancer screenings – breast, colon, cervical.
- Childhood immunizations.
- Well visits for children.
- Healthy weight for adults.

Treatment/Management of Chronic Conditions

- Diabetes.
- Cardiovascular disease.
- Asthma.
- Depression.
- Hypertension.

Measurement in Population Based Payment (PBP) Models

Health Plans

Utilization

- Readmissions.
- Preventable ED visits.
- Ambulatory care sensitive conditions – Agency for Healthcare Research and Quality Measures.

Patient Experience

- Getting appointments.
- Communications.
- Willingness to recommend.

Patient Safety

- Post-operative complications.
- Hospital-acquired infections.
- Condition-specific mortality.

Overuse/Inappropriate use

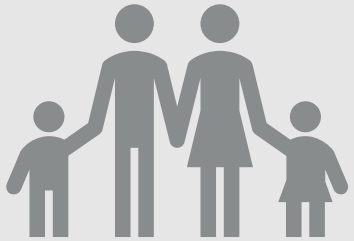
- Appropriate imaging for low back pain.
- Appropriate treatment for adults with acute bronchitis.

Measures Used in Specialty Payment Models

Health Plans

Oncology

- Adherence to clinical pathways.
- ED visits/hospitalizations.
- Side effects from treatment.
- Time to relapse for treated patients.
- Diagnostic radiology use.
- Hospice days for patients who died.



Maternity Care

- Early elective delivery.
- C-section.
- Post-partum care with depression screening.
- NICU infection rates.
- Low birth weight measures.
- Normal birth weight.

Joint Replacement

- Pulmonary embolism for knee and hip replacement.
- Readmissions.
- Post-operative complications.
- Average length of inpatient stay.
- 30-day wound infection rate.

MACRA Overview

MACRA was signed into law in April 2015.

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

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

The **Alternative Payment Model (APM)** Path offers a five percent bonus for eligible APMs. Per statute APMs include certain Innovation Center projects, Medicare Shared Savings Program accountable care organizations, and demonstrations required by federal law. In addition, eligible APMs must:

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

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Population-Based Payment Models

Quality Measures in Medicare's Alternative Payment Models

Model Name	Number of Measures
Bundled Payment for Care Improvement Initiative	7
CEC	18
Comprehensive Primary Care Plus	19
Medicare Shared Savings Program (MSSP)	24 (proposed)
Next Generation Accountable Care Organization	Aligned with MSSP reporting requirements
Oncology Care Model	12
Comprehensive Care for Joint Replacement (CJR)	2

Quality Measures in Medicare ACOs

- Medicare Shared Savings Program.
- Patient/Caregiver Experience.
- Care Coordination/Patient Safety.
- Preventive Health.
- Clinical Care for At-risk Populations.

Quality Measures in Medicare APMs

Bundled Payment Care Improvement Initiative –Advanced

- All-cause Hospital Readmission Measure.
- Advanced Care Plan.
- Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin.
- Complications.
- Mortality.
- Length of stay.
- AHRQ Patient Safety Indicators.

Comprehensive Care for Joint Replacement

- Total hip/total knee complications measure.
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures.

Quality Measures in Medicare APMs

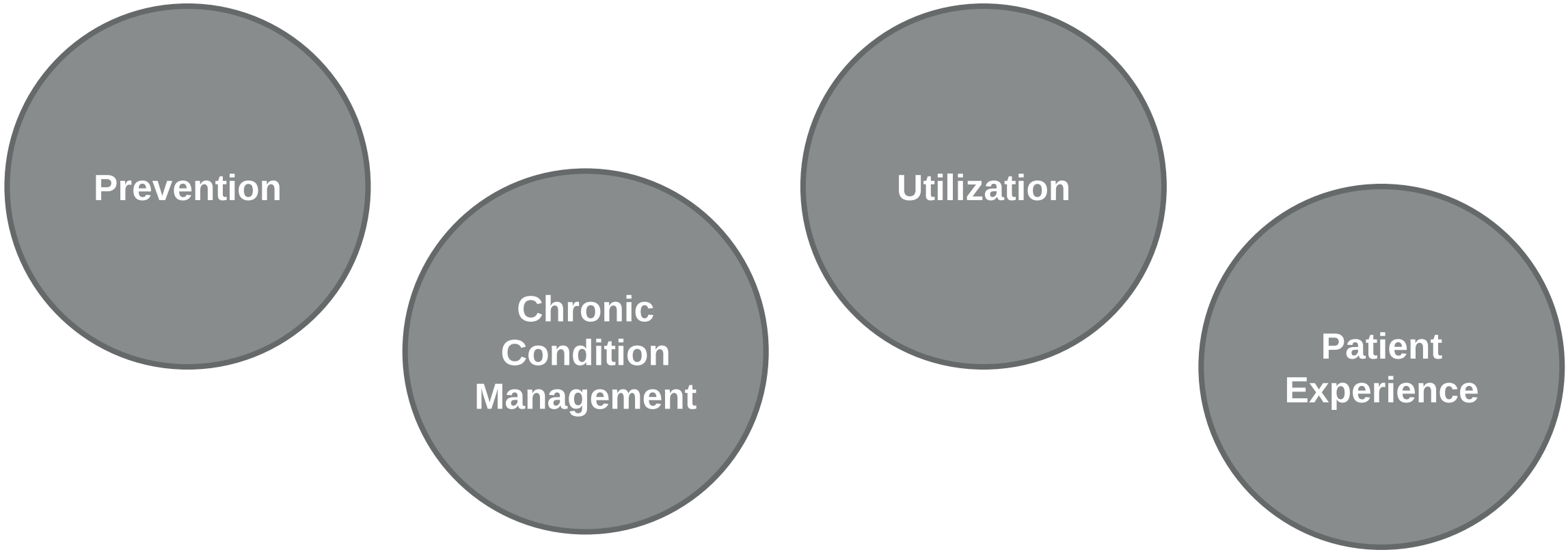
Oncology Care Model

- All-cause hospital admissions.
- ED visits.
- Appropriate use of hospice.
- Pain assessment and management.
- Depression screening.
- Patient-reported experience of care.
- Timeliness of chemotherapy.

Medicaid Accountable Care

Quality Measurement

Domains of Measurement



Private Sector Results: Are We Delivering Value?

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

Improvements in Quality

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

Cost Savings

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

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

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Medicare Program: Are We Delivering Value?

- Participants' progress towards practice transformation.
- Collectively 4 out of 6 primary care initiatives did not show significant differences between intervention and control groups on:
  - ED visits, Medicare spending, hospital admissions and 30-day readmissions.
  - Mixed results at the setting level associated with each initiative.
  - Four initiatives led to decreased Medicare spending for the high risk population and disabled beneficiaries.

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

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

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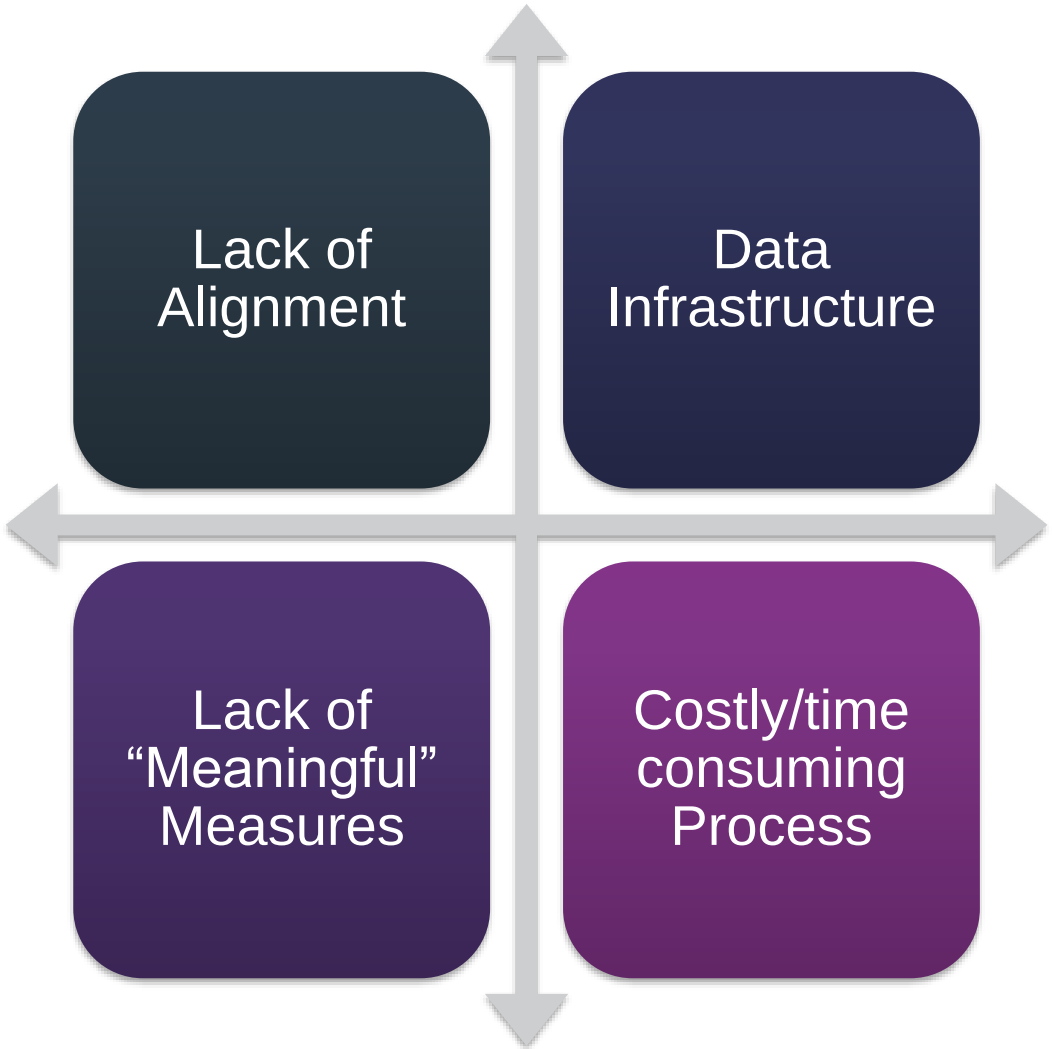
Challenges in Quality Measurement



Challenges in Quality Measurement

Lack of Alignment

Measure Cacophony

- Studies have documented use of 546 measures by private payers in their contracts with providers → but only 26 HEDIS measures were used by half the health plans.
- Lack of congruence in the measures used by public and private payers in their value-based payment programs.
- Other analyses of 48 measure sets across 25 states have shown: 509 measures in use → only 20% of these "distinct measures" used by more than one program.

Sources: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0007.
http://www.bailit-health.com/articles/091113_bhp_lackofalignment.pdf.

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Core Quality Measures Collaborative (CQMC)

Aligning Measurement Across Payers

Aim 1

- Recognize high-value, high impact, evidence-based measures that promote better patient health outcomes, and provide useful information for improvement, decision-making and payment.

Aim 2

- Reduce the burden of measurement and volume of measures by eliminating low-value metrics, redundancies and inconsistencies in measure specifications and quality measure reporting requirements across payers.

Aim 3

- Refine, align and harmonize measures across payers to achieve congruence in the measures being used for payment and other accountability programs.

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Core Quality Measures Collaborative (CQMC)

Core Measure Sets

- ACO / PMCH
- Gastrointestinal
- HIV / Hepatitis C
- Pediatrics
- Medical Oncology
- Orthopedics
- Cardiology
- OB / GYN

Core Quality Measures Collaborative (CQMC)

Stakeholder Groups Involved

Progress Towards Alignment

AHIP Foundation Survey of Health Plans in 2016-2017 to Assess Adoption of Core Sets:

- The survey **assessed adoption of seven out of the eight core sets** and excludes pediatrics.
- Of the 88 measures across the seven core sets, **51% of the measures could be calculated using administrative data sources**, 25% needed data from registries, 22% needed electronic clinical data or paper charts, and 2% needed survey data.
- Approximately **three-quarters of the plans who responded to the survey had taken some level of action relative to the core measure** sets, including adopting these measures into contracts.
- The **ACO/PCMH/Primary Care core set was associated with the highest rate of adoption** by the plans.
- A **higher percentage of measures using administrative data** were adopted compared with measures that required clinical data from charts or registries.

Continuing Challenges in Quality Measurement

Lack of Meaningful Measurement	Lack of Adequate Data Infrastructure	Costly & Time Consuming Process
▪ Relevancy – primary care versus specialty. ▪ Usefulness to patients. ▪ Siloed assessment of care.	▪ Lack of interoperability. ▪ Lack of data liquidity. ▪ Ongoing challenges with using EHRs for quality measurement.	▪ Measure development process is slow and costly. ▪ Studies show that physician practices incurred annual costs of over $15.4 billion to report quality measures.

Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1258.

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Quality Measurement for VBP – Path Forward

- Focus on health and healthcare quality.
- Longitudinal assessment of patient's care – care settings and over time.
- Better integration of primary care and specialty measurement.
- Primary focus on measures of outcomes.
  - Clinical.
  - Patient reported.
  - Patient experience.
  - Cross-cutting.
- Promote better data infrastructure through data liquidity.
  - CMS Blue Button 2.0.
  - Mobile apps.

Source: https://www.healthaffairs.org/do/10.1377/hblog20180810.433339/full/.

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right hand corner of your screen.

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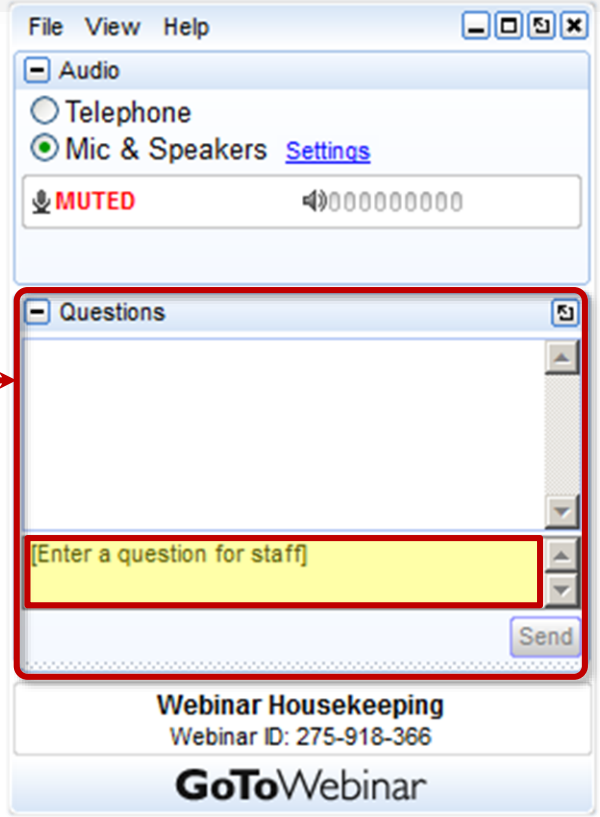

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Resources

- Presentation Slides

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Upcoming CAQH CORE Education Sessions

Prior Authorization Industry Landscape

TUESDAY, SEPTEMBER 25TH, 2018 – 2 PM ET

3rd Annual Value-Based Care Summit

All Together Now: Applying the Lessons of FFS to Streamline Adoption of Value-based Payments

Erin Weber, CAQH CORE

October 17-19, 2018

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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.