CAQH CORE Value-based Payments Initiative: Industry Developing Practical Solutions

October 4, 2019

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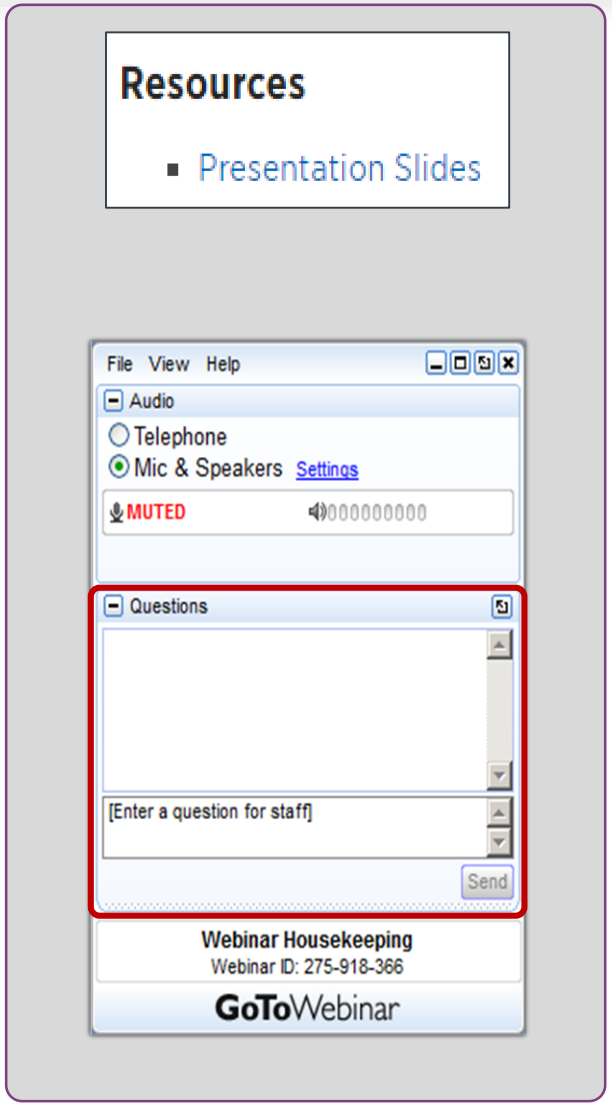

CAQH CORE

CAQH CORE Series on Value-based Payments

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

We would like to thank our speaker:

Troy Smith, Vice President, Blue Cross North Carolina

Session Outline

- Overview of CAQH CORE Value-based Payment Initiative
- CAQH CORE Value-based Payments Advisory Group
- Opportunity Area Focus: Patient-Provider Attribution
- How to Engage

CAQH CORE
Value-based Payments (VBP) Initiative

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.

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What are Operating Rules?

Operating Rules are the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted.

Industry Use Case	Standard	Operating Rule
Healthcare	Providers and health plans must use the ASC X12 v5010 270/271 Eligibility Request and Response transaction to exchange patient eligibility information.	When using the eligibility transaction, health plans must return patient financial information including copay and deductible in real-time.
Finance	Financial organizations must use ASC X9 standards in all ATM transactions with their clientele, standardizing layout, data content and messaging.	Financial organizations must use NACHA, the Electronic Payments Association, and the Federal Reserve operating rules for every automated clearinghouse (ACH) Transaction which allows consumers to use any debit card in any ATM around the world regardless of bank affiliation.

Operating Rules **do not** specify whether or how a payer/provider structures a business process supported by an electronic transaction. For example, operating rules do not specify how a patient should be attributed to a provider's population in a value-based payment arrangement; if an attribution methodology is used, operating rules could specify how attribution status is electronically exchanged.

CAQH CORE Rule Development

From Identifying Opportunities to Federal Mandate

Identify Opportunities

Environmental Scans, Industry Surveys, and Advisory Groups are used to **research opportunities for a potential rule**.

Develop Rule Requirements

Rule Writing Groups including subgroups and workgroups **develop requirements.** New groups form as CAQH CORE rule writing focus changes. **Pilots and ROI assessment support quicker and broader market adoption**.

Ballot Rules

Full CAQH CORE Voting Organizations vote on the proposed rule(s). Once CAQH CORE Participants have achieved quorum and approval levels, the **CAQH CORE Board** will **vote for final approval.**

CAQH CORE Writes Letter to NCVHS

CAQH CORE writes a letter to NCVHS explaining the industry need for the operating rules along with the CORE Board approved rules.

NCVHS Makes Recommendation to HHS

NCVHS sends a letter to the Secretary regarding industry feedback given at the hearing. **NCVHS recommends** whether the **operating rules should be mandated.**

Expedited Interim Final Rule Making

HHS issues Interim Final Rule (IFR) to the industry with a 60-day open comment period. With no major objections, **HHS adopts the final rule and mandates the operating rules.***

Once HHS mandates an operating rule industry is given 25 months to implement and adopt new rules.

**HHS has the authority to judge whether comments are substantial and whether changes should be made to the final rule.*

CAQH CORE Operating Rules

Supporting the Revenue Cycle Workflow

The healthcare revenue cycle and the provider and health plan workflows built to support it, were created in a fee-for-service (FFS) healthcare environment. Since 2005, CAQH CORE has developed operating rules to support these workflows in the electronic exchange of information.

In the FFS healthcare system, claims are reimbursed for the services provided regardless of the total cost of patient care or the quality of care provided. However, this concept has evolved over the past several years.

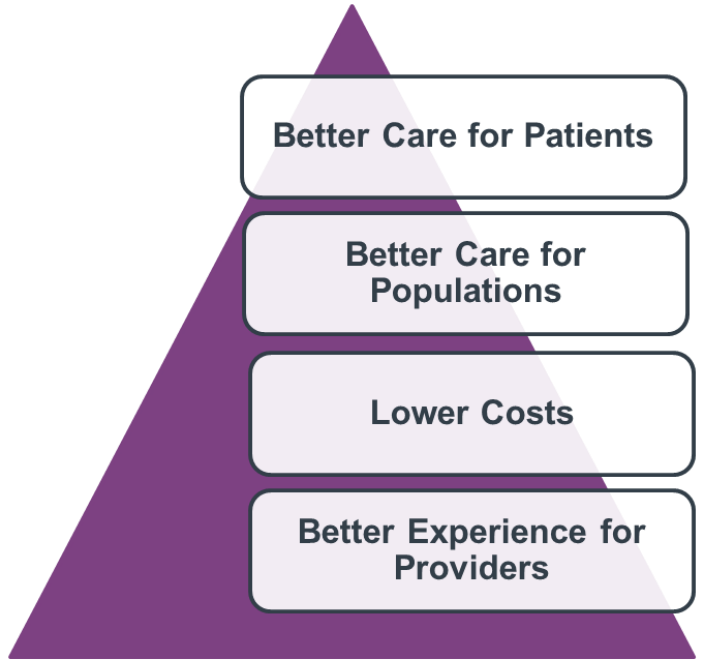
Shift from Fee for Service to Value-based Care

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 Quadruple Aim



60% of healthcare dollars are linked to value of care delivered.

(HCP LAN, 2018)

VBP models are already accruing cost-savings of **5.6%** with equal or better care results.

(Change Healthcare, 2019)

57% of provider executives do not believe they have data and tools to be successful under VBP.

(Quest Diagnostics, 2018)

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CAQH CORE Value-based Payment Initiative

Identifying a Need

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

Industry Shift

CAQH CORE Board recognized the importance of value-based payments (VBP).

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

Alignment & Collaboration

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

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.

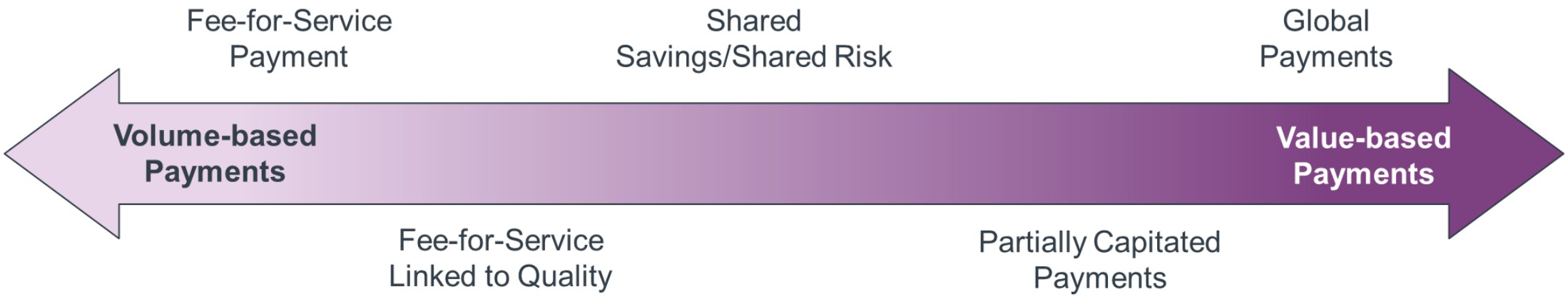
Patient/Provider Attribution: Improve provider awareness of patient attribution and transparency in underlying patient attribution models.

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 Value-based Payment Initiative

Continuum of VBP Models



CAQH CORE Value-based Payment Initiative

CAQH CORE VBP Advisory Group

In early 2019, CAQH CORE launched the VBP Advisory Group made up of industry executives and thought-leaders. These participants were charged with prioritizing opportunity areas for CAQH CORE rule development action (e.g. subgroup or pilot).

athenahealth

BlueCross BlueShield of North Carolina

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

edifecs

HEALTHEDGE

Humana

Marshfield Clinic Health System

DEPARTMENT OF HEALTH

Montefiore

NATIONAL QUALITY FORUM

MGMA

UnitedHealthcare

The Advisory group began with CAQH CORE research of the five categories in VBP requiring stakeholder collaboration and looked at list of 19 opportunity areas to prioritize for operating rule development.

CAQH CORE Value-based Payment Initiative

Special Thanks to Our Speaker

Troy Smith
Vice President

BlueCross BlueShield of North Carolina

Polling Question #1

What percentage of your business falls under a value-based payment initiative/contract?

- 0 – 25%?
- 25%-50%?
- 50%-75%?
- 75%-100%?
- N/A

CAQH CORE Value-based Payment Advisory Group

Troy Smith
Vice President, BCBSNC

Sample Opportunities for Administrative Simplification in VBP

Provider often does not know if a patient is attributed to them until after care is delivered.

Provider is not always aware of quality metrics required by patient's specific health plan.

Provider is unclear as to what additional documentation is required to fulfill contractual obligations.

Claim cannot convey pertinent clinical and health information not related to a service provided during visit.

Remittance advice does not fully explain how provider payment relates to VBP arrangements (e.g. were quality metrics met?).

Opportunity: Return patient attribution information when provider submits an eligibility check.

Opportunity: Return requirements for quality measure reporting or specific measure gaps when provider submits eligibility check.

Opportunity: Upon submission of a healthcare claim, health plan immediately returns necessary additional documentation.

Opportunity: Standardize additional documentation, data content, format, and method of transfer for critical clinical information that is non-service related.

Opportunity: Outline provider next steps in remittance advice to ensure full payment at the end of the fiscal year, e.g. reporting requirements. Also specify in remittance advice whether performance metrics met.

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Value-based Payments Advisory Group

Overview

This Advisory Group began in February as an industry collaboration to guide the development of common approaches for the exchange of data in VBP in order to reduce administrative burden and improve the patient experience of care. The Advisory Group:

- Discussed the FFS revenue cycle workflow and pain points for those participating in VBP.
- Reviewed a list of 19 draft opportunity areas to address pain points and relieve administrative burden as related to VBP which were condensed to 15.
- Rated support of opportunity areas on a Likert scale from “Strongly Do Not Support” to “Strongly Support”.
- #1 Ranked the opportunity areas in order of priority for a CAQH CORE Rule Development Group to pursue. Topics 1, 4, 7, 8, and 11 were selected to move forward.

ID	Challenge	Opportunity Area Example
1.	**Attribution Status**	Health Plan electronically shares patient attribution status with provider at time of eligibility check.
2.	**Attribution Method**	Health Plan shares information on the attribution methodology with provider at time of eligibility check.
3.	**Type of Benefit Plan/VBP Contract Transparency**	Health Plan shares information on type of plan/contract patient is enrolled in at time of eligibility check.
4.	**Patient Risk Identification**	Stakeholders agree upon standards for health plans and providers to communicate health status and risk factors prior to patient encounter.
5.	**Refined Patient Financial Responsibility**	Health Plan shares more specific eligibility/cost sharing information for patients based on health status/diagnosis and/or procedure/service relevant to value-based benefit plans.
6.	**Provider Identification on Claims**	Stakeholders agree upon the common provider identification data set to be used for data exchange in VBP arrangements.
7.	**Identifying Need for Additional Documentation**	Stakeholders agree upon standards for health plans to communicate required clinical information for providers to capture during a patient encounter.
8.	**Including Non-Service Related Information on Claims**	Providers use the health care claim to convey non-service related clinical information (e.g. quality metrics or health status information) to the health plan.
9.		Stakeholders may not truncate medical codes during the health care claim submission and adjudication process.
10.		Vendors and health plans must update their systems with the most recent medical code sets within X days of release.
11.	**Requesting and Receiving Additional Documentation**	Stakeholders agree on upon standards for providers to report clinical information, including quality measures.
12.	**Quality Reporting**	Stakeholders agree on standards for health plans to communicate quality measure attainment status and deficiencies to providers during the health care claim adjudication process .
13.	**Financial Reporting**	Health Plans use the remittance advice to convey information about the payment sent to the provider including potential impact to their end of year VBP.
14.	**Contract Transparency**	Stakeholders to create a minimum list of contract terms that must be discussed prior to entering a VBP agreement to be coded and included in a patient’s eligibility response.
15.	**Data Standardization**	Stakeholders to create standardized definitions across common terms associated with VBP arrangements to ease confusion across models (e.g. admission, event and clinical guidelines).

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Value-based Payment Advisory Group Top Opportunity Areas

Summary of CAQH CORE Recommendations

Move Forward

Pursue through CAQH CORE VBP Subgroup

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

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

Value-based Payment Advisory Group Top Opportunity Areas

Move Forward in Rule Development Process (Traditional Approach)

CAQH CORE will pursue two opportunity areas through a CAQH CORE VBP Subgroup.

CAQH CORE staff has continued to research these two opportunity areas and draft potential requirements. Research uncovered that the SMEs related to each opportunity area are different, therefore separate Subgroups are needed. The first Subgroup will launch in October to tackle provider attribution.

Patient/Provider Attribution Status

Challenge: Providers are often unaware of their patient's attribution status within their VBP contracts at the point of service, leaving care gaps and other reporting unclear until well after the patient visit.

Opportunity Area: Health plan electronically shares patient attribution status at the time of the patient eligibility check.

Patient Risk Identification

Challenge: Providers or health plans may be unaware of patient health status/risk factors that may impact patient care, cost-sharing, or data reporting requirements under VBP arrangements.

Opportunity Area: Stakeholders agree upon standardized data elements, documentation, format, timing and/or exchange mechanism for bidirectional health plan and provider communication concerning risk factors prior to the point of service.

Value-based Payment Advisory Group Top Opportunity Areas

Move Forward in Rule Development Process (Agile Approach)

CAQH CORE will pursue one opportunity area through a potential CAQH CORE VBP Pilot Program.

As this opportunity area is more tightly scoped an operating rule requirement, CAQH CORE will consider a pilot program to test its value to the industry.

Inclusion of Expanded Code Sets with Healthcare Claim

Challenge: In an FFS system, the healthcare claim is used by a provider to tell a health plan what services have been provided. However, in VBP models, the outcome of that service is often just as important to satisfy care gaps, quality measures, and/or performance metrics.

Opportunity Area: Providers may include expanded code sets (e.g. LOINC or CPT II) to convey non-service-related clinical information.

Value-based Payment Advisory Group Top Opportunity Areas

Explore Synergies with CAQH CORE Prior Authorization Initiative

CAQH CORE recommended exploring synergies between one opportunity area and the current CAQH CORE Prior Authorization Discovery Pilot Program.

CAQH CORE is in the process of launching a pilot program to test methods of notifying a provider whether a prior authorization is needed and what additional information/documentation a provider may need to submit for approval. The learnings from this pilot program will help scope the infrastructure necessary for the notification of additional information/documentation to address VBP use cases.

Provider Notification of Need for Additional Information/ Documentation

Challenge: Providers are often unaware what additional information/documentation is needed by a health plan to address care gaps, quality measures or performance metrics.

Opportunity Area: Stakeholders agree upon standardized data elements, documentation, format, timing and/or exchange mechanism for a health plan to communicate what additional information/documentation is necessary to satisfy a VBP contract.

Value-based Payment Advisory Group Top Opportunity Areas

Align with CAQH CORE Attachments Initiative

CAQH CORE recommended aligning one opportunity area with the CAQH CORE Attachments Initiative.

As the HHS-designated operating rule authoring entity, CAQH CORE is required to create operating rules to help standardize the exchange of additional documentation. CAQH CORE launched an Advisory Group this fall which will evaluate VBP use cases discussed by the VBP Advisory Group.

Standardization of the Exchange of Additional Documentation

Challenge: Health plans often request additional documentation to complete information on care gaps, quality measures and performance metrics. However, the wide variety of formats and exchange mechanisms across health plans may delay provider submission and subsequent adjudication.

Opportunity Area: Stakeholders agree upon standardized data elements, documentation, format, timing, and/or exchange mechanism (e.g. X12 275, FHIR etc.) for health plan to request and for providers to submit additional clinical documentation related to care gaps, quality measures, and performance metrics.

Polling Question #2

Would your organization be interested in participating in a CAQH CORE pilot project on the inclusion of expanded code sets on claims?

- Yes.
- No.
- Unsure.

Inclusion of Expanded Code Sets with Healthcare Claim

Challenge: In an FFS system, the healthcare claim is used by a provider to tell a health plan what services have been provided. However, in VBP models, the outcome of that service is often just as important to satisfy care gaps, quality measures and/or performance metrics.

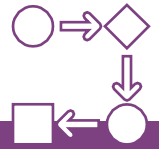
Opportunity Area: Providers may include expanded code sets (e.g. LOINC or CPT II) to convey non-service-related clinical information.

Value-based Payment Subgroup Opportunity Area Focus: Patient/Provider Attribution

Helina Gebremariam
CAQH CORE Manager

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

Patient/Provider Attribution

Identifying Patients Prior to Point of Service

Providers currently receive monthly, quarterly, or annual reports that list the patients in their population for a VBP contract. These lists are delivered in various formats across health plans with varying degrees of information. Since these lists are delivered in aggregate, providers often do not have time to deviate from their pre-appointment workflow to log into a different system and look-up to see if a patient with a scheduled visit is attributed to them.

Just as with FFS, CAQH CORE will work with current standards to create uniform data content when sharing attribution information, define the exchange method and forms, and set requirements for when this information must be shared.

Examples of Potential Operating Rules to be Discussed by VBP Subgroup:

Data Content — What data elements should be shared when requesting and sending attribution status?

Infrastructure — What is the ideal timeframe to communicate attribution status?

Connectivity — What exchange methods and formats can be used when sending and receiving attribution status (e.g. SOAP, REST, X12, FHIR etc.)?

Patient/Provider Attribution

Data Content

Requesting attribution status prior to the point of service requires provider and patient identifying information for health plans to link a patient to a provider's population in their VBP contract.

Below is an example of what data content may be needed to share attribution information at the point of eligibility (i.e. prior to point of service):

Request for Attribution Status

Provider Sends Combination of:

- **Patient Identifying Information**
- **Provider Identifying Information**
- **Contract Identifying Information**

Attribution Status Response:

Health Plans Returns Combination of:

- **Attribution Status** *(Yes/No/Partial)*
- **Attributed Provider Information** *(if not requester)*
- **Patient Care Gaps**

This request and response could pertain to a singular provider requesting information for a singular patient or a group of providers requesting information on a group of patients or any combination, a singular provider requesting information on a single patient, etc. Infrastructure and connectivity operating rules would provide consistency in how that information is exchanged.

Patient/Provider Attribution

Infrastructure & Connectivity

Whether requesting the attribution status of a single patient or a group of patients, operating rules can support a consistent method and format for the exchange of this information and set industry expectations for when this exchange occurs.

Infrastructure operating rules would increase the reliability of attribution information by defining how often this information should be exchanged, the timeframe for an acknowledgement of a receipt of an attribution status request and a timeframe for a final attribution status response.

A connectivity safe harbor would define exchange methods and formats that should be used when exchanging attribution information. This would eliminate bulky Excel files in favor of truly electronic exchanges via REST or SOAP using consistent standards such as X12 or FHIR.

Infrastructure and connectivity operating rules work across use cases. An update to the CORE Connectivity Operating Rules is planned for 2020.

How to Get Involved

Erin Weber
CAQH CORE Director

Healthcare administration is rapidly changing.

Join Us

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.

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.

CAQH CORE

2019 CAQH CORE Participation

Summary of Organizations

Participating Organizations—spanning multiple stakeholder types–work together to develop and implement the rules of the road and streamline the business of healthcare.

Complete list of CAQH CORE Participating Organizations available here.

CAQH CORE Participation enables healthcare organizations to:

- **Lead development of rules** that remove unnecessary cost and complexity from the healthcare system.
- Ensure that rules continue to **meet evolving business needs** and **address specific markets.**
- **Stay up to date** on industry developments, upcoming regulations & real-world case studies.
- Develop guidelines for **measurement and tracking of ROI across the industry.**

CAQH CORE

Call for Participants

Expectations & Commitment

Call for Participants – Who Should Join?

- 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.

What is the commitment?

- Attend and actively participate in meetings.
- Participate in workbooks/straw polls and cast votes as appropriate.
- Stay up to date on meeting materials
  - CAQH CORE staff assist Co-chairs with drafting meeting materials.
  - Meeting summaries are created after each call/meeting and approved by the participants.

SME's should have:

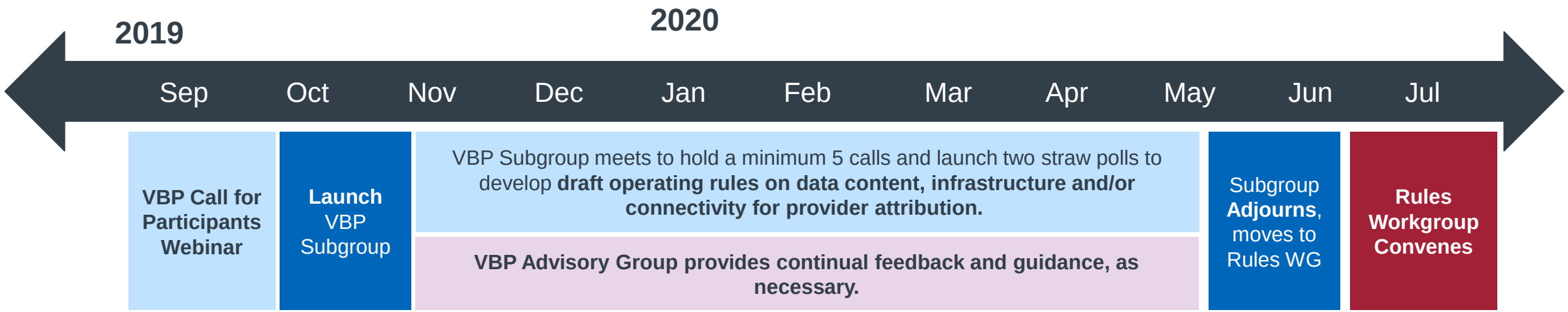
- Knowledge of how their organization operates today.
- Understanding of how a standard requirement would impact their organization, both in terms of feasibility to implement as well as value across business functions.
- Ideally, SME's would work in departments such as Network Contracting, Population Health, Patient Access, Care Management, Utilizations Management, Authorized Business Systems and Care & Disease Management.

CAQH CORE Value-based Payment Initiative

Next Steps

The VBP Subgroup on Patient/Provider Attribution will launch with a web conference on Wednesday, October 16th from 3 pm to 4 pm ET.

Subsequent VBP Subgroup Calls will occur approximately once a month on Thursdays from 2:30 pm to 4 pm ET.



Polling Question #3

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

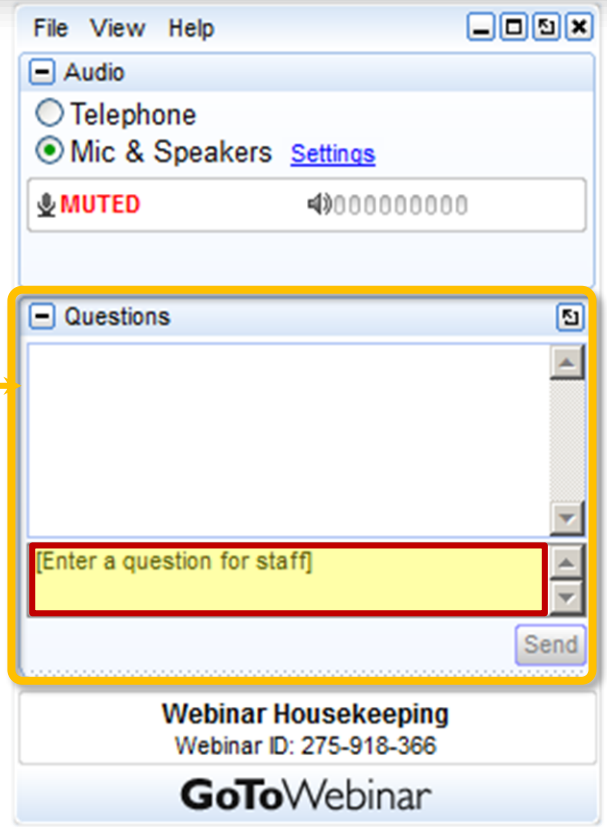
- Yes
- No
- Unsure

Audience Q&A

Please submit your questions

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

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



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Resources

- Presentation Slides

CAQH CORE

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 to 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

CAQH CORE Town Hall National Webinar

October 10, 2019 2:00-3:00 PM EST

CAQH CORE Value-based Payment Webinar Series: Overview of LAN Roadmap for Driving High Performance in Alternative Payment Models

October 22, 2019 2:00-3:00 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.