



Wednesday, February 6, 2019

9:00 am – 10:30 am

Teleconference/WebEx ONLY - ([Participant Instructions](#))

## AUC Claims DD TAG

### AGENDA

1. Meeting to Order
2. Welcome & Introductions – Please e-mail your attendance to [susan.lee@allina.com](mailto:susan.lee@allina.com)
3. Anti-trust Statement – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>
4. Approve Previous Meeting Minutes
5. CAQH-CORE “Value Based Payments Advisory Group”  
It is examining operational challenges associated with adopting value-based payment (VBP) models.
6. Changing the meeting schedule to quarterly
7. Other Business
8. Meeting Summary & Next Steps
9. Next Meeting – Teleconference/WebEx ONLY (9-10:30am)

April 2, 2019

# All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments

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Operationalizing Value Based Health Care in a Fee for Service world

# CORE report and response: Operationalizing Value Based Health Care in a FFS world

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Looking for AUC help/input in providing feedback to CORE

Today –

- CORE
- Value Based Health Care
- Operationalizing VBP
- CORE study and report
- CORE Advisory group
- Key challenges/opportunities
- Next steps

# CAQH/CORE

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- More than 130 organizations – providers, health plans, vendors, government agencies, and standard-setting bodies – developing operating rules to simplify healthcare administrative transactions
- Operating rules: (per ACA) “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”
- Designated by the Secretary of the Department of Health and Human Services (HHS) as the author for [federally mandated operating rules](#) per Section 1104 of the ACA.

# Value Based Health Care

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“... a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes.”

“Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The “value” in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.”

# Interest in Value Based Care

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- Value-based payment now drives a sizable—and growing—proportion of the U.S. healthcare system.<sup>1,2,3,4</sup>
- Because value focuses both on the quality of care and on its cost, many believe value-based payment has the power to improve individual care and population health while changing the trajectory of national health expenditures.<sup>5</sup>

# Operationalizing VBP

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- The success of value-based payment is ... dependent upon smooth and reliable business interactions between all stakeholders ... especially between healthcare providers and health plans.
- The .... direct collaboration required for value-based payment stands in stark contrast to more limited stakeholder interactions in the fee-for-service market.

# CORE 18 month [study and report](#)

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- CAQH CORE conducted an 18-month study to examine value-based payment operational processes and to identify opportunity areas that, if improved, would streamline implementation of value-based payment.

All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments. CAQH-CORE.  
<https://www.caqh.org/sites/default/files/core/value-based%20payments/core-value-based-payments-report.pdf>

# VBP brings new demands, challenges

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- Much more data needed
  - Quality
  - Attribution of patients to providers
  - “Apples to apples comparisons” -- Risk assessment, risk adjustment
- Differing, siloed systems
  - Claims vs. EHRs
  - Separate data warehouses and reporting
- Differing terminology, language

# Findings

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- Many features of value-based payment do not align with the current fee-for-service operational system.
- .... proprietary systems and processes for implementing value-based payment have already begun to introduce operational variations.
- Without collaboration to minimize variations, the current environment is ripe for repeating a scenario that cost stakeholders billions of dollars and slowed and complicated adoption of fee-for-service transactions.
- ... by applying lessons learned..., CAQH CORE hopes to energize an effort to ease value-based payment operational inefficiencies.

# Non-uniformity is currently the norm in value-based payment implementation

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More standardization is needed

- ... especially for “data quality and standardization, interoperability, patient risk stratification, provider attribution and quality measurement.”

# Opportunities

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- Report ... identifies five opportunity areas and makes nine recommendations.
- For each of the opportunity areas, the report describes the unique challenges associated with value-based payment and makes at least one recommendation.

# Advisory Group to review

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- Advisory Group Participants are asked to review the below list and provide feedback on amendments, additions or deletions. Advisory Group Participants should consider:
  - Are these the correct challenges for CAQH CORE Participants to focus on?
  - Does the proposed opportunity area adequately address the challenge?
  - Are there challenges and opportunities that are missing?

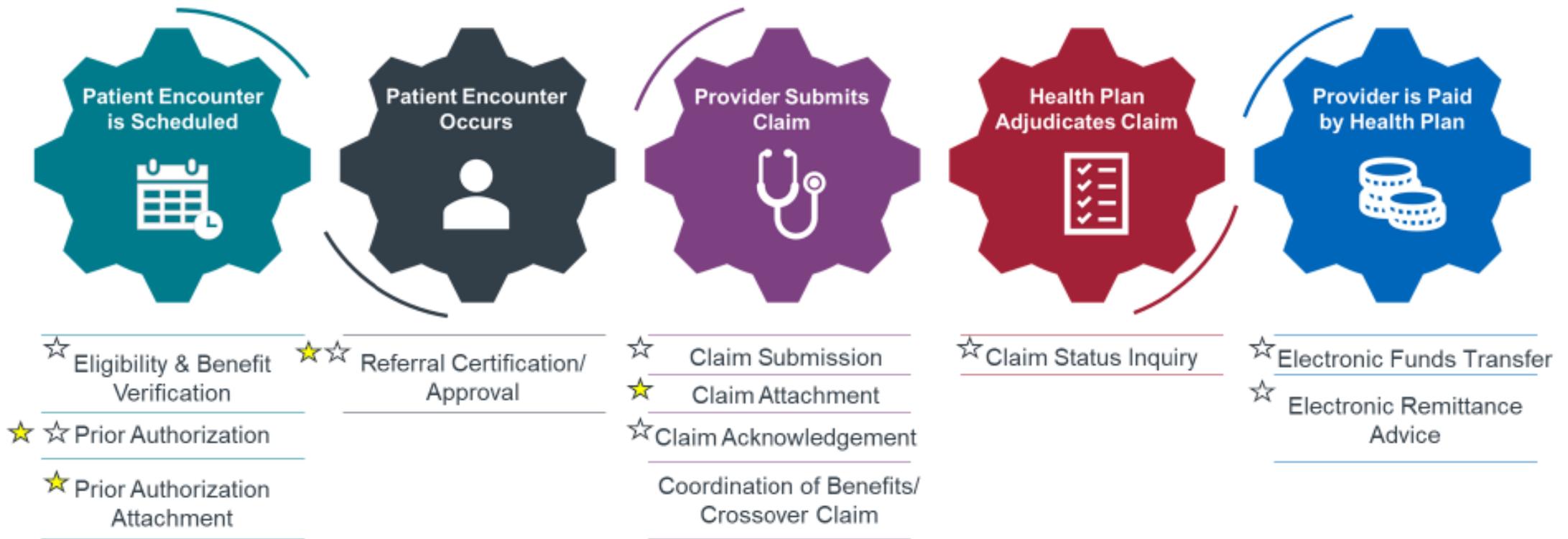
# Current (largely FFS) “Revenue Cycle Workflow”

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Figure 1. Revenue Cycle Workflow



# Current workflow and X12 EDI transactions



☆ Existing CAQH CORE Operating Rules.

☆☆ CAQH CORE Operating Rules in Development.

# Sample Opportunities for Administrative Simplification in VBP

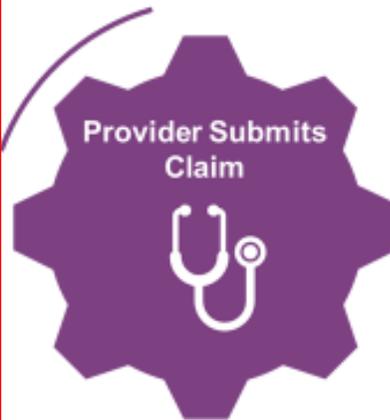
Provider often does not know if a patient is attributed to them until after care is delivered.

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

Provider is unclear as to which NPI and/or TIN to submit. May have multiple NPIs or TINs.

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:** Standardize use of NPI Type I and Type II in claims submissions.

**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.

# Patient Encounter is Scheduled

1.	<b>Provider Attribution:</b> Provider does not know whether the patient is attributed to them in a value-based arrangement.	Patient Information	<b>Health Plan</b> shares patient attribution information with provider at time of eligibility check. Information requirements could include: <ul style="list-style-type: none"> <li>• Patient attribution status (yes, no, partial, other) to provider</li> <li>• Provider for whom patient is attributed (can help with care coordination if patient is not attributed to provider requesting eligibility information)</li> </ul>
2.	<b>Provider Attribution Method:</b> Provider does not know how or why patient was attributed to them.	Contractual Information	<b>Health Plan</b> shares information on the attribution methodology with provider at time of eligibility check. Information requirements could include <ul style="list-style-type: none"> <li>• Codes to reference attribution method specified in provider contract</li> <li>• Codes to reference industry standard methodologies</li> </ul>
3.	<b>Type of Benefit Plan/VBP Contract:</b> Provider does not know if patient is part of a VBP arrangement associated with specific reporting requirements.	Patient Information, Contractual Information	<b>Health Plan</b> shares information on type of plan/contract patient is enrolled in at time of eligibility check. Information requirements could include: <ul style="list-style-type: none"> <li>• Codes to reference benefit plan/contract type specified in provider contract</li> <li>• Codes to reference provider identification used in contract (i.e. TIN, NPI, group practice identifier, etc.)</li> </ul>
4.	<b>Patient Risk Identification:</b> Provider is unaware of patient health status/risk factors that may impact cost sharing under value-based benefit plans and/or data reporting requirements under VBP contracts for specific patient populations.	Patient Information, Clinical Information, Contractual Information	<b>Health Plan</b> shares information on relevant and known health status (e.g. diabetes) and risk factors (e.g. social determinants of health) pertinent to differential cost sharing and data reporting requirements. Information requirements could include: <p>Historical diagnosis codes related to conditions with differential cost sharing and specific data reporting requirements.</p> <ul style="list-style-type: none"> <li>• Codes for demographic information related to social determinants of health</li> </ul>
5.	<b>Refined Patient Financial Responsibility:</b> From existing eligibility and benefit checks a provider may not be aware of differential cost sharing related to patient health status (e.g. reduced cost sharing for diabetic specialist visits under value-based benefit plans).	Patient Information, Clinical Information, Contractual Information	<b>Clarification/Refinement of Eligibility and Benefit Check Operating Rules for Health Plans</b> to share more specific cost sharing information for patients based on health status/diagnosis relevant to value-based benefit plans.

# Patient encounter occurs

6.	<p><b>Patient Risk Stratification:</b> Provider is unaware of the requirement to collect specific risk factors and demographic information during patient encounter under VBP arrangement.</p>	Patient Information	<p><b>Stakeholders</b> agree upon standardized definitions, format, and method of transfer for health plans to communicate information that providers should collect on social determinants of health during a patient encounter.</p>
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ID	Challenge	Data Need	Opportunity
7.	<p><b>Care Gaps, Quality Measures, and Performance Metrics:</b> Provider is unaware of what non-service related clinical and health information on a patient to share with the health plan for quality measures and performance metrics under VBP contracts.</p>	Clinical Information, Contractual Information	<p><b>Stakeholders</b> agree upon standardized data elements, code sets, values, documentation, format, timing, and method of transfer for health plans to communicate required clinical information for providers to capture during a patient encounter.</p>

# Provider Submits Claim

8.	<p><b>Provider Identification on Claims:</b> Value-based contracts are often signed using a provider's tax identification number (TIN); however, providers often submit health care claims using their national provider identifier (NPI). Furthermore, since providers often have several TINs and NPIs, the submitted NPI or TIN often does not match the identifier in the health plan system.</p>	Provider Information	<p><b>Stakeholders</b> agree upon a standard for use of the TIN and NPI on a healthcare claim related to their VBP contract.</p>
9.			<p><b>Health Plans</b> are required to link TINs from VBP contract to individual provider's NPIs in their healthcare claim systems to eliminate unnecessary back and forth caused by provider misidentification.</p>
10.			<p><b>Stakeholders</b> agree upon the common provider identification data set as outlined by the <a href="#">CAQH Provider Data Action Alliance</a> which defines core provider data elements and their definitions to ease the challenge of provider identification.</p>
11.	<p><b>Clinical Reporting:</b> Providers use medical code sets to convey information on the service provided to a patient during a given event. However, health plans often require non-service related clinical information for outcomes measures which cannot be easily conveyed on a health care claim in a standardized manner. Furthermore, as these medical code sets are updated on a non-regular schedule, systems may not be using the most recent code set available.</p>	Clinical Information	<p><b>Providers</b> must use LOINCs on health care claims to share non-service related clinical information with health plans.</p>
12.			<p><b>Providers, Health Plans, and Vendors</b> may not truncate medical codes during the health care claim submission and adjudication process which often leaves an incomplete picture of patient care.</p>
13.			<p><b>Vendors</b> must update their systems with the most recent medical code sets within X days of release to ensure all systems are working with the best information available.</p>
14.			<p><b>Stakeholders</b> agree on upon standardized code sets, values, format and method of transfer (e.g. X12 275 Attachments, HL7 FHIR Resources) for providers to report clinical information.</p>
15.	<p><b>Quality Reporting:</b> Providers often cite quality measure reporting as the largest source of administrative burden due to the lack of standardization among measures, the way they are transmitted to the health plans, and how often they must be reported.</p>	Clinical Information	<p><b>Stakeholders</b> agree on standard documentation, format, timing, and method of transfer (X12 275 Attachments, HL7 FHIR Resources, Other?) for providers to submit quality measure information.</p>

# Health Plan Adjudicates Claim

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16.	<b>Quality Reporting:</b> Health Plans may wait until the end of the reporting year to notify providers that certain quality measure reporting expectations have not been met.	Clinical Information, Contractual Information	<b>Stakeholders</b> agree on data elements, format, and method of transfer for health plans to communicate quality measure attainment status and deficiencies to providers during the health care claim adjudication process when health plans are often requesting additional clinical documentation and information.
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# Provider Paid by Health Plan

17.	<b>Financial Reporting:</b> As most VBP arrangements still use a FFS payment structure to adjudicate health care claims, the remittance advice a provider receives along with payment does not provide an accurate picture of what their payment may look like at the end of the year.	Financial Information, Contractual Information	<b>Health Plans</b> use the remittance advice to convey information about the payment sent to the provider including potential impact to their end of year value-based payment. For example, a health plan could communicate if services paid on this claim exceeded the budget for a bundled payment arrangement and may result in losses for the year if future bundled services do not perform at target.
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# Input, additional resources?

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- Reactions/thoughts?
- Other studies, reports?
- Ideas, examples, problem solving?