Transitioning to New Payment Models

Considerations and Lessons Learned from Implementing National Business Rules for Exchanging Administrative Data

March 21, 2017

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Panelists

- Gwendolyn Lohse, CAQH, Managing Director of CAQH CORE
- Cassandra Toscano, Aetna, Executive Director of Joint Venture Clinical Transformation
- Caitlin Reiche, athenahealth, Director, Performance Management

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Session Outline

- CORE Mission & Vision
- Industry Landscape: Moving from Fee for Service to Value-based Payment
- Operational Opportunity Assessment
  - CAQH CORE
  - Aetna
  - athenahealth
- Panel Discussion
- Audience Q&A

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CAQH CORE

CAQH Overview | *Convener. Collaborator. Catalyst.*

Collaborates with industry stakeholders to develop shared utilities that streamline the collection, management and use of critical provider and member data.

CAQH CORE

Convenes industry stakeholders to establish best practices by developing and implementing national business rules that maximize efficiency and savings.

CAQH Explorations

Collects and analyzes industry data to establish benchmarks as a *catalyst* for further progress.

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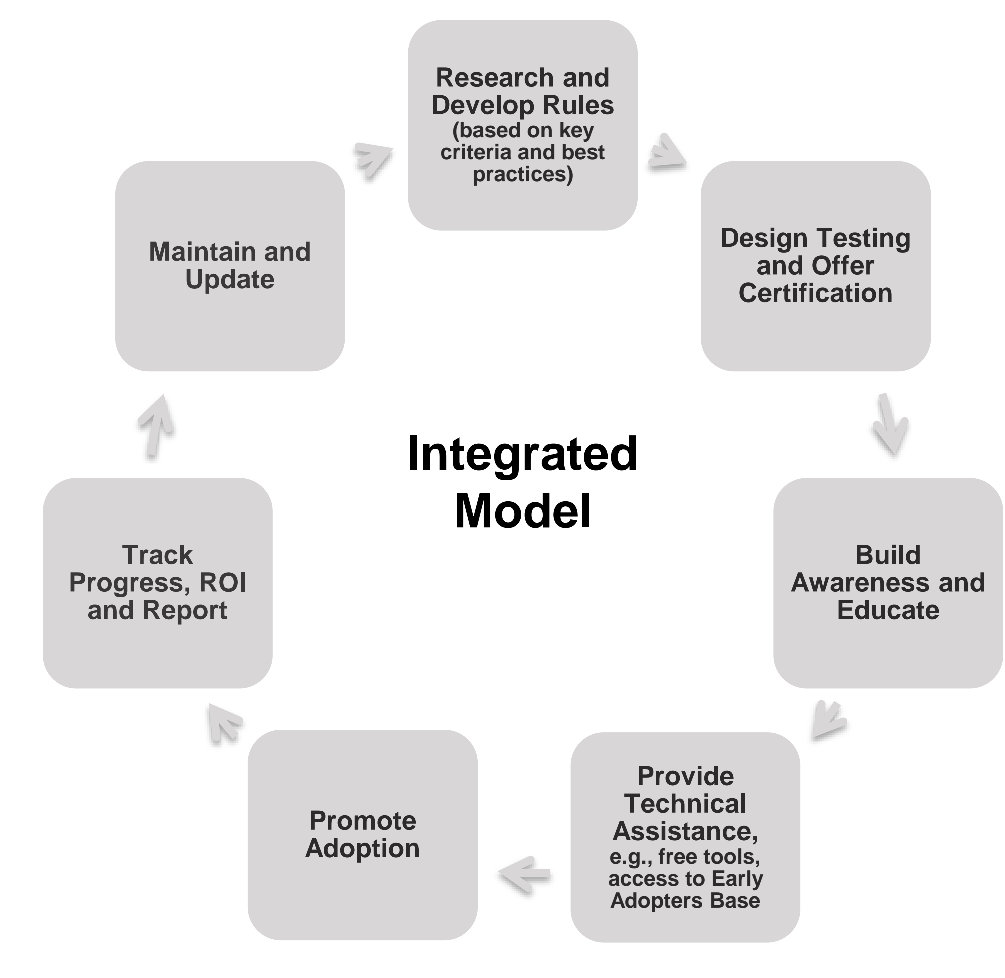
CAQH CORE Mission and Vision

MISSION Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability, and align administrative and clinical activities among providers, payers, and consumers.

VISION An industry-wide facilitator of a trusted, simple, and sustainable healthcare data exchange that evolves and aligns with market need. Consensus achieved through 130+ participating organizations.

DESIGNATION Established in 2007. Named by Secretary of HHS to be national author for three sets of operating rules mandated by the Affordable Care Act.

BOARD Multi-stakeholder. Voting members are HIPAA covered entities, some of which are appointed by associations such as AHA, AMA, MGMA. Advisors are non-HIPAA covered, e.g. SDOs.



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Shift from Fee for Service to Value-Based Payment Will Be a Journey

Covered populations, types of available services, patient-specific data, provider settings, data ownership, security and types of providers delivering care will all be changing in the U.S. healthcare system as this journey moves forward**.**

Operationalizing value-based payments in such an environment calls for system-wide collaboration.

Fee-for-Service	Pay-for-Performance Foundational Payments (e.g., for PCMH), Pay-for-Reporting, Pay-for-Improvement	Shifting Financial Risk →			
		Shared Savings (One-sided/ gainsharing)	Bundled (Episode) Payment	Shared Risk (Two-sided)	Full Risk (Capitation)

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Moving from Fee for Service to Value-based Payment
Industry Landscape

Medicare Access and Reauthorization Act of 2015 (MACRA)

- Creates Quality Payment Program which includes two tracks for providers: MIPS or Advanced APM.
- Consolidates payment adjustments for Physician Quality Reporting System, Value Modifier Program and Meaningful Use into single Merit-based Incentive Payment System (MIPS).
- Creates alternative payment track with incentives for physicians to participate in Advanced Alternative Payment Models (APMs).

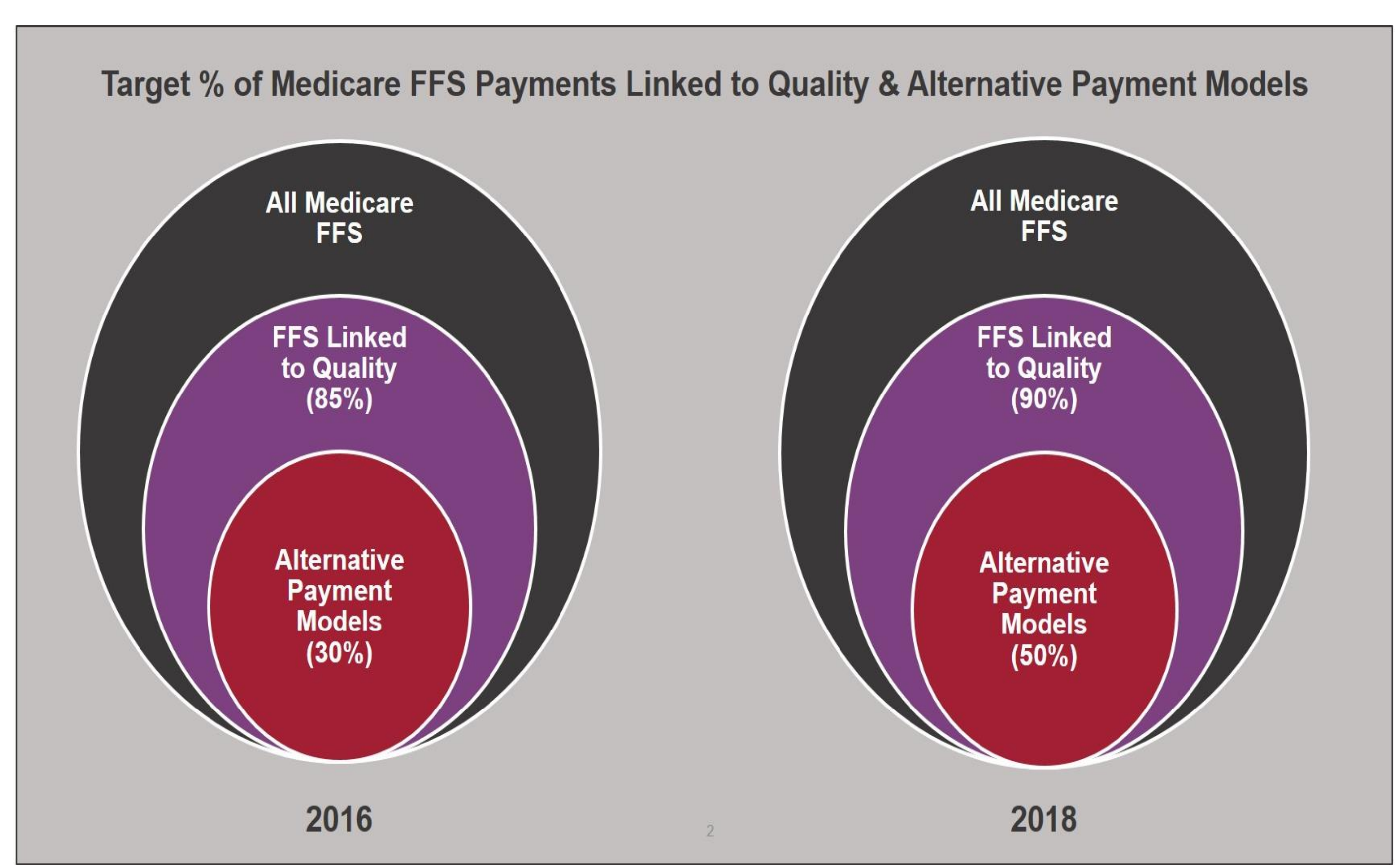

Image Source: *Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume*, CMS, January 2015.

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Moving from Fee for Service to Value-based Payment
Industry Landscape

- HHS launched Health Care Payment Learning and Action Network (LAN) to help align industry work to increase adoption of value-based payments and alternative payment models – participants represent private, public and nonprofit sectors.
- LAN established alternative payment mode framework that includes four payment model categories with increasing levels of provider accountability and population health management.

Image Source: *Alternative Payment Model (APM) Framework Final White Paper,* Health Care Payment Learning & Action Network (LAN), January 2016.

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Role of Operating Rules
System-Wide Data Exchange Expectations for Operations

- As the industry moves to value-based payment (VBP), CAQH CORE agreed its future focus must address operational activities to support VBP models, in addition to continuing to drive down unnecessary costs from FFS data exchange.
- Operating rules, per federal legislation, are “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.” They facilitate administrative interoperability by building upon recognized standards and ensuring benefit for each critical stakeholder.

INFRASTRUCTURE	CONTENT
Connectivity & Security	Supports use of recognized standards that can deliver valuable structured data or require access to unstructured data.
Response Time (Batch/Real-time)	
System Availability	
Exception Processing Error Resolution	
Roles & Responsibilities	
Companion Guides	
Acknowledgements	

Infrastructure rules apply across transactions – establishing basic expectations on how the U.S. data exchange “system” works, e.g., ability to track response times across all trading partners. Infrastructure rules can be used with any version of a standard.

Content rules support the exchange of valuable data that allow stakeholders to access information needed to manage a defined process. Content supports further use of base standards wherever possible.

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CAQH CORE Phase I-IV Impacts Billions of Transactions
Where CAQH CORE Has Set Expectations To Date

Current CAQH CORE Operating Rules		
Transaction (*Federally mandated)	**Basic National Infrastructure**[1] (Critical to healthcare ecosystem as there is not a Federated Network or Industry Hubs for these transactions)	**Uniform Data Content** (Wherever possible, deliver via requiring further use of recognized standards such as those in HIPAA)
Enrollment/Disenrollment	X	
Premium Payment	X	
***Eligibility**	X	X
Prior Authorization	X	
***Claim Status**	X	
***EFT**	X	X
***ERA**	X	X
Claim	X	

[1] Infrastructure includes: Safe harbor connectivity/security, batch/real-time turnaround times, response time tracking, acknowledgements, system availability and downtime reporting, error processing, uniformity trading partner data exchange documentation and roles/responsibilities in exchange by stakeholder; see Appendix for more detail.

- According to the 2016 CAQH Index, industry adoption levels for these electronic transactions range from 16% to >90%, depending on the transaction. However, these adoption rates don't track whether the detailed requirements are being followed.
- In labor alone - and for just six of these eight transactions - the healthcare industry could save over $8B annually by adopting these electronic transactions.

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CORE Certification Market Share Analysis
Covered Lives Impacted by CORE-certified Commercial and Public Health Plans

	Commercially Insured	Publicly Insured
Phases I & II	Seventy- Six Percent	Forty- Four Percent
Phase III	Twenty-Seven Percent	Twenty-Five Percent

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CAQH CORE Research on Value-based Payment

Over the last 18 months, CAQH CORE constructed a multi-phase project to study the *operational* areas for action that would provide the most return on investment for implementing VBP. Last phase of the project is issuance of a final report in Q2 2017 that outlines where/how CAQH CORE could take action to design and implement solutions.

First phase focused on VBP SWOT analysis; research identified **seven potential areas for industry action** to achieve success with VBP:

1. Common data sets (e.g., numerators and denominators for defining patient, population, etc.).
2. Other data sets to improve analytics.
3. Definitions or standardization of specific terms.
4. Infrastructure rules.
5. Library of strategies for patient risk stratification.
6. Directory of VBP best practices.
7. Catalog for VBP quality and/or business measures.

Second phase focused on **interviews with 20+ entities and a survey to CORE Participants** to substantiate potential areas for action and prioritize interest in the areas.

- Mix of organizations that are/are not part of ACO, Clinically Integrated Network (CIN), Patient Centered Medical Home (PCMH) and contacts at Federal and State agencies.
- Mix of duration of VBP experience, proportion of patients/beneficiaries included in VBP, market types (e.g., competitive/not competitive) and level of success.
- Geographical diversity and affiliation with/without HIEs.

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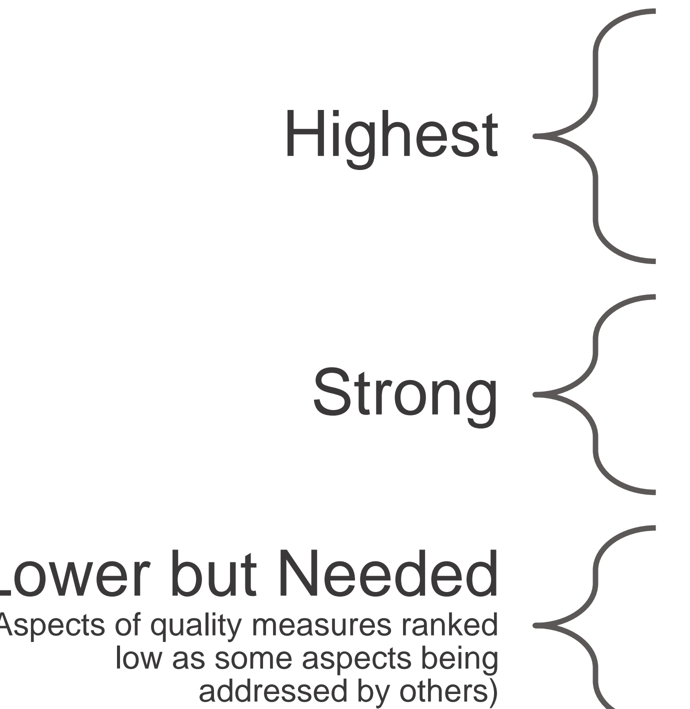
System-Wide Operational Needs
CAQH CORE High-level Findings to Date

Majority of respondents agreed with seven areas. Those that did not agree wanted to add or re-prioritize specific items including placing more emphasis on existing challenges that would persist and grow in importance with move to value-based payment.



Highest
- Common data sets and definitions (use of existing transactions/data/tools or creation of new based on new needs, access to alternative sources like registries or HIEs)
- Other data sets for analytics (provider and patient attribution)
- Patient risk stratification (library and best practices)

Strong
- Infrastructure rules and best practices in operations (technical/policy-driven interoperability, timeliness of data and reporting, care coordination requirements and physician leadership)

Lower but Needed
- Quality measures (best practices)
- Business measures and tools (standard language for terms, forms, and measurements)

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Ongoing Barriers

- Transparency/Preserving competition while standardizing
- EHR interoperability
- Patient privacy
- Proof of concept
- Learning and resource coordination
- Agreeing on ongoing value and impact

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Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

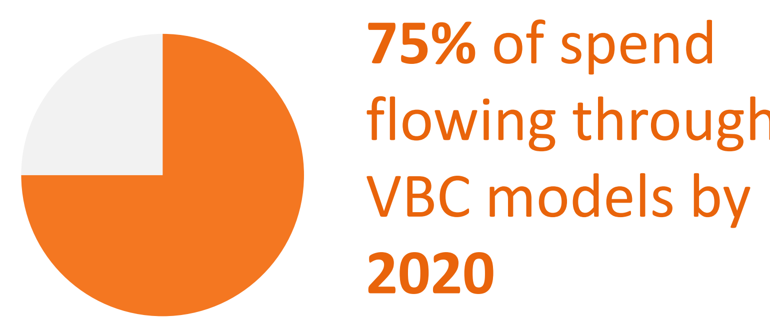
Driving sustainability in health care: Value-based contracting

Cassandra Toscano

March 21, 2017

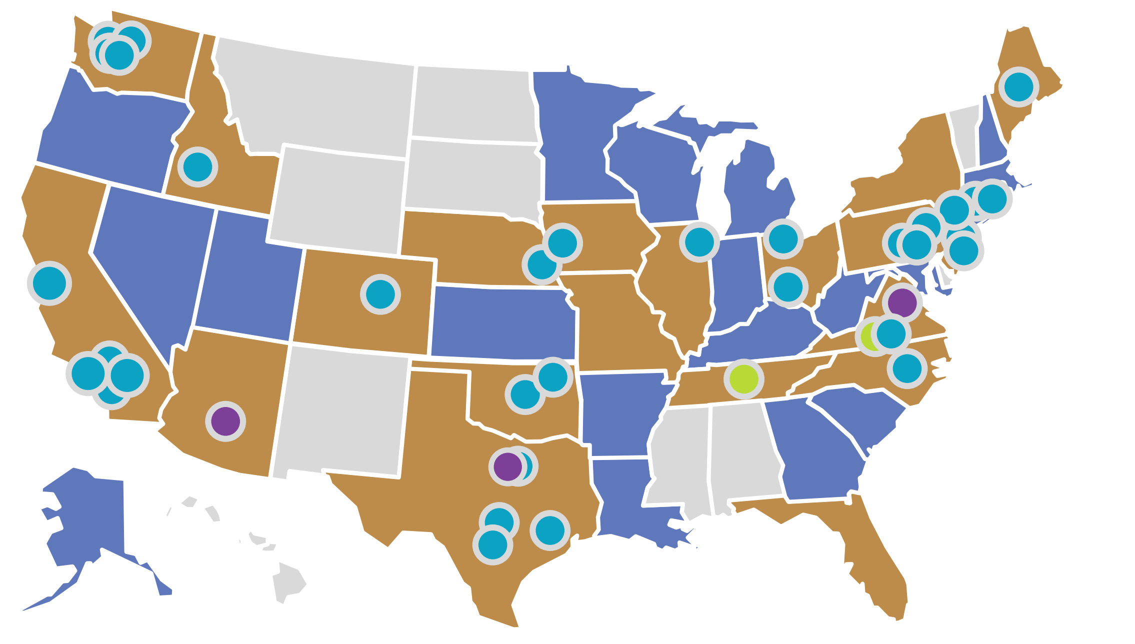
Building a healthier world by paying for value, not volume

Aetna's Goal	Where We Are Today
75% of spend flowing through VBC models by **2020**	**48%+** of medical spend through value-based contracts **6.2 million** members with value-based care providers



Aetna internal data

We already have a solid value-based presence and we're growing quickly



1,700+
Value-based contracts

48%
Of spend in value-based models

We select providers who can be successful

- States with an ACO product or plan to have by 1/1/18 (may also have other value-based products)
- States with other Aetna value-based contracts
- ACOs with fully insured product*
- ACOs with both fully insured and self-funded products*
- Joint ventures with fully insured and self-funded products (several pending state DOI licenses)

Above data as of February 2017

* Deals that meet the industry definition of an ACO: http://leavittpartners.com/2013/10/really-aco/ May represent more than one ACO contract in that location.

We're changing how health care is delivered

Our accountable care approach is unique:

- Includes more feet-on-the-street enablement with programs and technology
- Supports an innovative product – Aetna Whole Health℠
- Not just data, but advanced analytics and collaboration for more intense population health
- Holds providers accountable with more rigorous efficiency and quality measures

By transforming care we can:

Reduce waste:
8-15% savings targeted compared to Aetna broad network plans*

Improve quality:
Focus on targeted quality metrics

Improve member/patient satisfaction:
Establish baseline and increase year-over year

Improve the overall health and productivity of members and their families

*Actual results may vary, savings may be less when compared to other value-based or narrow network plans.

Population health – comparing today with the future

	Today	Future
Model	• Provider-centric model • Payer-led care management telephonic model	• Member-centric model • Provider-led care management activity at the point of care
People	• Focus on sick members only • Lack of comprehensive care coordination	• Focus on population health • Robust care coordination across the continuum of care • Patient engagement through digital technology
Technology	• Early stages of Clinically Integrated Network (CIN)	Data-driven clinical decision making: - Standardized evidence based medicine - Predictive analytics at the ACO and primary physician levels - Smart segmentation across the population - Improved care coordination workflows

Members are benefiting from improved best practices versus existing approach

Increased generic dispensing of top 4 drug groups **10.0%**

Decreased impactable surgical admits per 1,000 **14.0%**

Overall reduction in medical costs versus market expected costs **8.1%**

Baseline period: 1/1/13 – 12/31/13; Performance period: 1/1/14 – 12/31/14. Paid through 3/2015; Results for ACOs effective as of 1/1/2014 and in place for at least one year.

Improving care delivery, cost and overall population health

Pay-for-Performance[1]	Patient Centered Medical Home[2]	ACO Attribution[3]	ACO Product[5]
$1.12 PMPM or **$171M savings** over 3 years	**$0.81 PMPM savings** Consistent quality measure improvement from 2014 to 2015	**$7.74 PMPM** or **$17M savings**[4] Improved on majority of utilization metrics	**$29.25 PMPM** or **$32M savings**[6] Outperformed diabetes testing and cancer screening benchmarks[7]

Lessons we've learned

Transformation builds over time

Guided transformation is more effective

Comprehensive reporting is critical

1 Savings based on three-year study of all hospital P4P results for 2012, 2013 and 2014, as compared to expected costs. Study was completed July 2015. Savings are concentrated in the Northeast, where 31 of 41 P4P hospitals are in effect.

2 As compared Medical cost measure is reconciled results, only. Other results reflect FY 2015 versus FY 2014 and could reflect some interim results. PMPMs are risk adjusted. Market represents attributed non-VBC members.

3 Includes all ACO attribution models effective January 1, 2014, or prior, as compared to expected target costs.

4 When ACOs are a key component of the network. Actual results may vary, savings may be less when compared to other value-based network plans.

5 Includes all product ACO models through Q3 2015 reconciliation results, as compared to expected target costs.

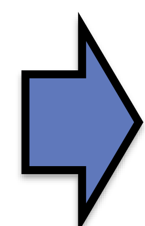
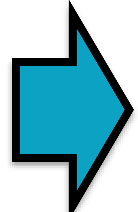
6 Compared to broad Aetna network plans. Actual results may vary, savings may be less when compared to other value-based or narrow network plans.

7 Quality measures are most recent for members effective through Q2 2015.

Accountable care is a journey – not a destination

PRINCIPAL PHASES:

We are here

ACO Development		**Build Value**		**Accelerate Performance**
Collaborate and share resources		Cost and clinical improvements		Deliver unmatched value

We will team with ACOs that have:

- Strong leadership, AIM commitment
- Technology, process and people investment
- Willing to move from FFS to value-based

We will collaborate:

- Build comprehensive population health management
- Improve member experience
- Link doctor payments to support goals
- Progress or ACO contract modified

We will deliver value:

- Translating efficiency into sustained trend reduction
- Delivering differentiated member experience
- Improving member health outcomes

POPULATION HEALTHIER

athenahealth's service-based approach

athenahealth Population Health

We align to our Clients' business objectives

FINANCIAL HEALTH & STABILITY

- Drive appropriate utilization
- Optimize site of care
- Support appropriate HCC coding
- Increase in-network retention
- Identify and close gaps in care

PATIENT MANAGEMENT

- Manage fluctuating attribution
- Stratify patient population
- Identify appropriate patients for care management
- Monitor and manage rising risk population
- Promote patient self-management
- Patient outreach

PROVIDER ALIGNMENT

- Understand and influence provider referral patterns
- Support appropriate HCC coding
- Enable development of pre-visit planning workflows

QUALITY PERFORMANCE

- Monitor and track quality performance
- Identify and close gaps in care
- Improve quality scores

Our successful population health clients follow a similar path to success…

UNDERSTAND COSTS & UTILIZATION

- Track Total Medical Expenditure (TME) & cost drivers, and accurately attribute costs and interventions to rendering providers

REDUCE NETWORK LEAKAGE

- Pay yourself, rather than your competitors, for services you can supply & reduce non-covered service line expenses through price transparency

MAXIMIZE PAY-FOR-PERFORMANCE REIMBURSEMENT

- Monitor your population directly against contracts, get every dollar available by closing gaps in care, and meet all quality gates

IDENTIFY EARLY OPPORTUNITIES FOR UTILIZATION REDUCTIONS

- Target reductions where there is clear opportunity for savings (i.e. 30 day-readmit, never events, complications and *stuff you don't do*)

SUPPORT CHRONIC CARE AND DISEASE MANAGEMENT

- Control expenses not disease-by-disease, but by managing the sickest cohorts across multiple conditions (hot-spotting)

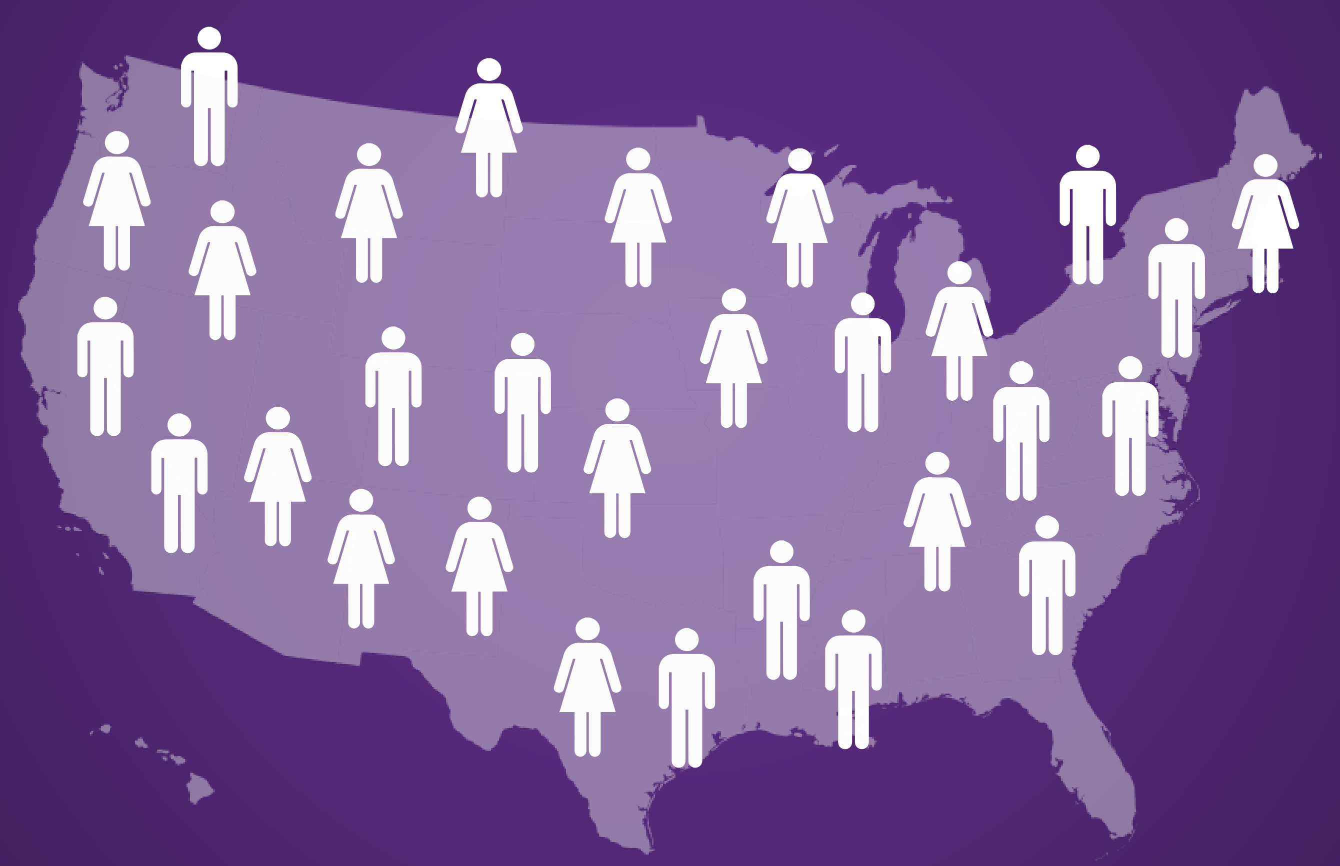
PREDICT WHO WILL END UP DEVELOPING ISSUES

- Identify and monitor patients with high risk scores but low previous-year expenses

26K
providers on Population Health

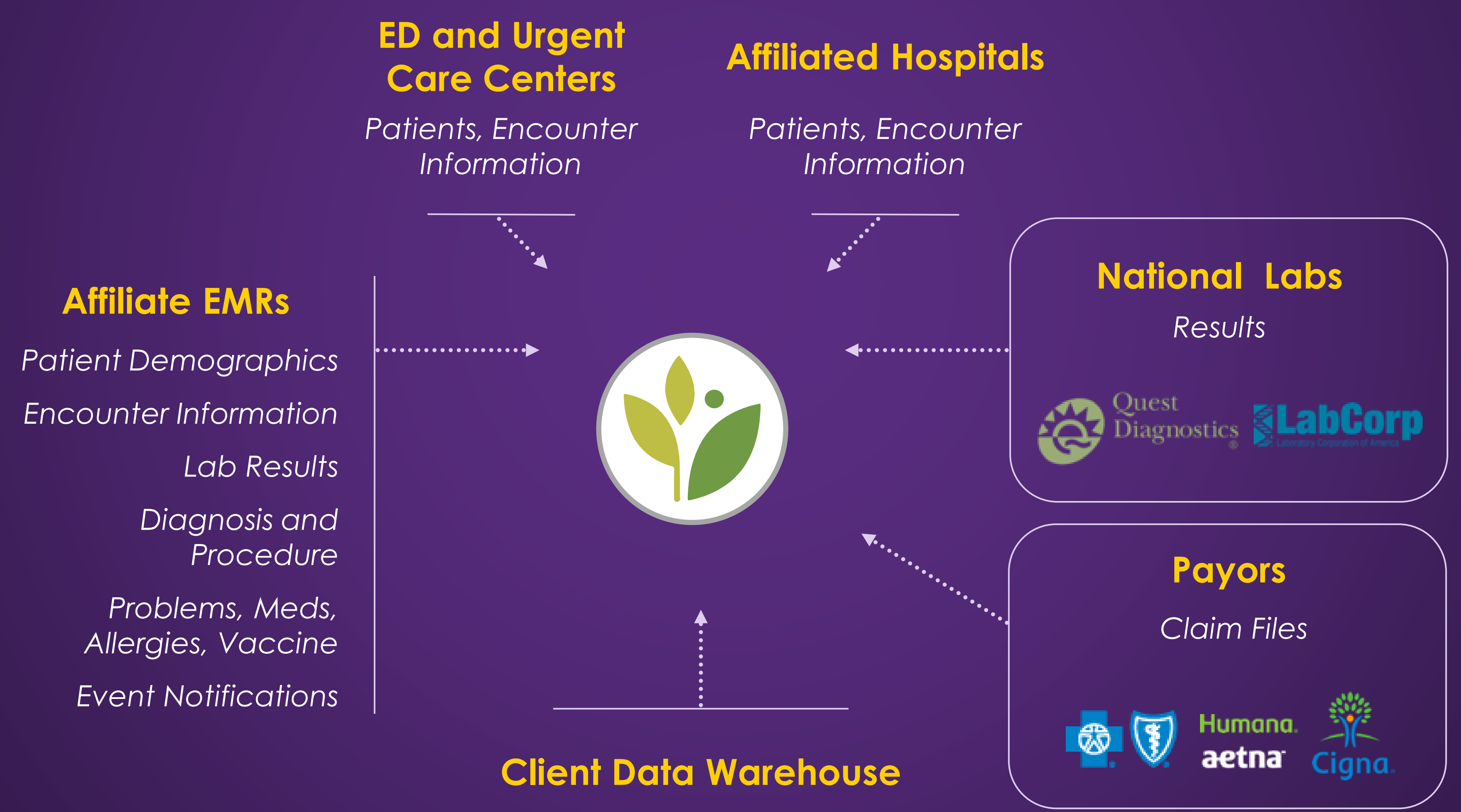
2.2M
covered lives being managed

$20B
TME administered through our service



The **largest connected network** in healthcare

We **aggregate comprehensive data** to enable insight across our Client's patients and network.



Our Clients Outperform

2015 MSSP ACO Shared Savings Recipient

NATIONWIDE
of all ACOs
29%

ATHENAHEALTH ACO clients
73%

Shared Savings per Beneficiary

NATIONAL AVERAGE
$85

ATHENAHEALTH CLIENTS
$185

2.2% increase in in-network utilization

5.3% decrease in readmission rates (2013-2016)

Discussion Question #1

What interoperability challenges has your organization experienced in executing Fee for Service and what lessons learned can be applied to the Value-based Payment environment?

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Discussion Question #2

From your experience, what aspects of Value-based Payment models may benefit from proprietary approaches and where is collaboration essential?

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Discussion Question #3

What administrative data and/or transactions have you found are essential to operate in the Fee for Service environment?

Do you believe the same or different transactions are needed to execute Value-based Payment models?

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Discussion Question #4

What metrics and benchmarks does the industry need to track the success of Value-based Payment models?

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