Cooperative Exchange
The National Clearinghouse Association

Alternative Payment Models and Clearinghouses – Education and Impacts

White Paper by the Emerging Trends and Strategic Innovation Committee

May 5, 2017

Introduction

Alternative Payment Models, or APMs, are health plan payment systems which are not based solely on a fee-for-service model. APMs come in a variety of shapes and sizes. Most APMs have quality measures and volume measures associated with payments to providers, and begin to shift some of the risk from the plan to the provider. While Medicare has led the way with a number of voluntary and required systems, commercial health plans are also beginning to adopt these alternatives.

The Health Care Payment Learning and Action Network (HCPLAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community. By making a commitment to changing payment models, by establishing a common framework and aligning approaches to payment innovation, and by sharing information about successful models and encouraging use of best practices, the LAN can help to reduce barriers and accelerate the adoption of alternative payment models (APMs).

HCPLAN has established an overall APM Framework which lays out the variety of models in order of their transitioning from FFS to fully population based models. The Framework can be found at:

http://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf.

Purpose

The purpose of this paper is to explain some of the APM models and discuss the impact on clearinghouses of their use. Suggestions for functionalities to assist both health plans and providers in successful implementation of APMs will be the final part of this paper.

Specific APM Models

Medicare

The Medicare program has led the way with developing and implementing a number of APM models. Let's begin with a discussion of some of the CMS APM models:

Accountable Care Organizations

There are four dominant APM ACO programs designed for physician-based providers who align together through elective agreements to give coordinated high quality care to the Medicare patients they serve. Beneficiaries are aligned to "primary care specialists" and performance is benchmarked against shared savings and losses calculations under the Medicare Shared Savings Program (Shared Savings Program).

ACOs are rewarded when they're able to lower growth in Medicare Parts A and B fee-for-service costs or reduce the total cost of care (relative to their unique target) and at the same they meet performance standards on quality of care (quality metrics).

Medicare Shared Savings Program Track 1

- Offers the option of one no down risk arrangement. Risk Arrangement offers shared savings and losses of up to 80% and Risk Arrangement B offers shared savings and losses of up to 100%. First dollar shared savings for spending below the benchmark (which includes a discount) and accountable for first dollar shared losses for spending above the benchmark. To qualify for shared savings, an ACO must meet or exceed a prescribed Minimum Savings Rate (MSR), meet the minimum quality performance standards, and otherwise maintain eligibility to participate in the Shared Savings Program.

Medicare Shared Savings Program Track 2 & 3

- Under Track 2 or Track 3 ACOs qualify as an Advanced APM based on their shared savings and losses models (two-sided models). Track 2 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 60% based on their quality performance. Savings are calculated as the difference between the updated benchmark and actual expenditures, with payments for Track 2 ACOs capped at 15% of total benchmark expenditures each year. Track 3 ACOs that meet or exceed the MSR will be eligible to share in savings at a rate of up to 75% based on their quality performance. Savings are calculated as the difference between the updated benchmark and actual expenditures, with payments for Track 3 ACOs capped at 20% of total benchmark expenditures each year.

Pioneer ACO Model

- The Pioneer ACO Model was designed specifically for organizations with experience offering

coordinated, patient-centered care, and operating in ACO-like arrangements. The selected

organizations participating are chosen for their significant experience offering this type of quality care (risk entities) to their patients. ACOs qualify as an Advanced APM based on their shared savings and losses models (two-sided models). Offers the option of five payment arrangements, which share savings and losses of up to 60-75%; savings and losses sharing rate varies based on quality score. ACO savings must exceed the minimum savings rate (MSR) in order to share in savings or the minimum loss rate (MLR) to be accountable for losses.

Next Generation ACO Model

- Offers the option of two risk arrangements: Risk Arrangement A offers shared savings and losses of up to 80% and Risk Arrangement B offers shared savings and losses of up to 100%. First dollar shared savings for spending below the benchmark (which includes a discount) and accountable for first dollar shared losses for spending above the benchmark.

Commercial models may pay an additional PMPM fee to incentivize some types of chronic patients. Different quality measures are in each contract, and there are no standards. Data is not very good, significant data lags.

Bundled Payment Models

In this model, a provider (usually a hospital) is held responsible for the quality and cost of all procedures associated with a single event. Medicare has begun projects for bundled payment of hip and knee replacements, and certain cardiac surgeries. In these, the hospital is given a single payment for each event, which is supposed to cover all of the beneficiaries Medicare expenses related to the surgery and for 90 days after the surgery. The hospital is also responsible for providing quality measures. In reality, each provider continues to bill Medicare as normal, and the hospital "settles up" at the end of the year. If the total costs for events is less than the standard, the hospital gets the difference. If costs are higher, the hospital is responsible for the difference.

CPC+ (A primary care specific APM)

Although CPC+ is considered an "Advanced APM" under MACRA, it does not resemble the other Advanced APMs. The CPC+ model is designed to be a primary care site-specific model as opposed to a network model, although many of the sites chosen are also part of an ACO. There is limited risk-bearing by the CPC+ sites and they more closely resemble a PCMH model than an ACO model.

CPC+ sites can be categorized as a Track 1 or a Track 2 site. Track 1 sites are less experienced in chronic care management and alternative payment structures. Track 2 have already been involved in patient management structures and have more linkage into the community for coordinated care services. The biggest difference with Track 2 is that these sites will be asked to manage more completely patients with behavioral health issues, especially dementia.

CPC+ Track 2 sites have agreed to contract with a vendor that can provide advanced care coordination support. CMS is looking for vendors that have the technical capability to 1) risk stratify patients; 2) provide care plans that can be used to transmit information electronically; and 3) provide support in the behavioral health area. CMS is not requiring these vendors to have the Track 2 module certified to CMS/ONC specifications, a move away from the requirement that all healthcare IT modules must meet CMS certification standards. Track 2 sites will need to have this advanced technical capability in place by January, 2019.

To support the new payment model (Per Member Per Month or PMPM), the CPC+ sites will be required to submit financial information to CMS on a site-specific basis at the beginning and end of the year. Sites will need to include information on salary, IT costs, and overhead costs. No CPC+ funds can be used for IT improvements to support the program. If the practice is a Track 2, payments may be a blended payment between PMPM and fee for service (FFS). Track 1 will continue to be FFS with a specified PMPM payment made at the beginning of each quarter.

Workflow requirements will include establishment of agreements in the community to provide support for patients in the program. These agreements can include agreements with non-covered entities which creates issues with access to PHI.

The last part of the model that will affect both workflow and movement of PHI is the involvement of commercial payers in the CPC+ model. For sites participating in CPC+, there is the understanding that designated private payers in the CPC+ region will participate with the sites for increased PMPM payment for the additional work in managing these patients. The number of payers can vary from just a few in some regions to a high of 12 commercial payers in Ohio, the largest region by participation. These commercial payers have not laid out yet their requirements for increased payment for the patient management piece, although it will need to be linked to quality outcomes.

Commercial Models

Aetna and Cigna, among other plans, have made significant commitments to ACOs, looking to achieve a larger portion of their payments towards these programs. Humana has begun bundled payment programs for hip and knee replacements, along with Cigna. Empire BlueCross BlueShield has taken part in following care coordination measures established by The Joint Commission. Empire BlueCross BlueShield and other Blue Cross Blue Shield health plans across 13 states are providing financial incentives to their hospital networks for reaching Integrated Care Certification from The Joint Commission.[1]

[1] https://healthpayerintelligence.com/news/private-payers-follow-cms-lead-adopt-value-based-care-payment, Oct 17, 2016.

What Are the Different Functions Expected for Providers in APMs

With the use of both quality measures and management of patient visits to various providers, providers will have to collect and track much more information in the RCMs and EHRs. In addition, they will need to have much more robust reporting systems. We should expect providers to know:

For bundled payments:

- Is the patient part of a bundled payment arrangement
- What services are part of the bundle?
- Who gets the bundled payment?
- How should I bill?
- How do I get reimbursed from the bundle?
- Do I have to report anything?

For ACOs

- Is the patient attributed to me as part of an ACO
- What are the quality measures associated with the patient?
- How can I communicate with other members of the ACO?
- What are my ACO reporting requirements?
- What privacy and security protections are in place so that I can receive and send appropriate clinical information within the ACO?

For the CPC+

- How is financial oversight provided on a site-specific level?
- How is the financial information transmitted to CMS?
- How are electronic connections into the medical neighborhood community established?
- How is consent to access to PHI established in a non-covered entity?
- What agreements/contractual arrangements/BAAs are in place to support this access?

Clearinghouse Capabilities:

We recognize that health plans set the rules for these APMs, including reporting requirements; and providers are expected to follow them. However, clearinghouses already serve as an important communications link between and among providers and health plans. With the increased emphasis on communicating payment, quality, and clinical information; clearinghouses may want to look to capitalize on their communications and exchange capability.

While not the complete solution for every situation, there are some functionalities that clearinghouses should seek to assist providers in APM situations. These could include:

a) Collection of clinical data

Clearinghouses could seek to collect some clinical data from providers for reporting to other providers and to health plans. This data could be used to calculate quality and volume measures, and allow provider to track their progress in meeting certain quality goals.

b) Collection of administrative data

Clearinghouses are already a rich source of data transmissions between plans and providers. With some tweaks, administrative data on claims and eligibility may be able to help providers track their volumes and identify which patients are part of which APM.

c) Merging administrative data with clinical data

As more sophisticated measures emerge for APMs, clearinghouses could assist in the merging of administrative data and clinical data to paint a more complete picture of the provider's caseload and standing in the APM.

d) Monitoring payments and making comparisons

Providers are often interested in how they compare with their peers or against certain population measures. This will also assist them in understanding their performances and in negotiations with health plans on APM remuneration.

e) Educating providers on improving their standing

With large numbers of customers, clearinghouses are in an ideal position to bring education to providers on how to survive in APMs. With data on payments and standing, clearinghouses could show customer what they need to do to improve their payments.

f) Distribution of data

In these models, much depends on the knowledge of providers about the other services their patients are receiving. With connections to many providers in an area, a clearinghouse could serve as a notification point for providers to understand the services that other providers are billing for (if legitimately part of the APM). This provider to provider communication could also be used to assist providers in sharing patient information for consulting and treatment purposes.

g) Privacy and Security Concerns

Within APM models, much depends on exchanging PHI among providers and with health plans. It will be critical to assure that only the right information goes to the right destination in a secure fashion. Clearinghouses have significant capabilities that they can bring in protecting information and information flows to assure the privacy and security of the data exchanges.

Acknowledgements

The Cooperative Exchange Emerging Trends and Strategic Initiatives Committee Members have contributed to this paper.

Co-chairs: Betty Lengyel-Gomez, Conduent
Joan Kossow, The SSI Group

Tammy Banks, Optum

Mike Denison, Change Heathcare

Kathy Sites, Availity, LLC

A special thanks to Stanley Nachimson, Nachimson Advisors, for his contribution and guidance in the development of this white paper.