

Claims Processing for the Alternative to FFS Payment: *Practice Engagement*

Virtual Session

Primary Care Payer Action Collaborative

April 18, 2018

1:00-2:30 pm (EST)

Session Objectives

- Provide a high-level exploration of claims processing workflows and how systems are modified to enable alternative to fee-for-services (FFS) with perspectives from CMS, CareOregon, Blue Cross Blue Shield (BCBS) of Louisiana (LA), and Anthem.
- Identify pitfalls and lessons learned as these four organizations planned for and/or implemented their alternative-to-FFS payment using a panel discussion format.

Speakers

- Sarah McHugh, CPC+ Team Lead, Center for Medicare and Medicaid Innovation, CMS; and Chris Coutin, CPC+ Data Feedback/ Payment Operations Lead, Center for Medicare & Medicaid Innovation, CMS
- Mary Kjemperud, Director, Network & Clinical Support, CareOregon; and Amy Barnwell, Supervisor, Provider Configuration & Encounter Data, CareOregon
- Randall Halcomb, Payment Innovation Programs Director, Anthem
- Tamara Mayo, VP, Provider Reimbursement & Payment Innovation, BCBS of LA; and Michelle Stevens, Director, Payment Innovations, BCBS of LA

I. Alternative to FFS Payment Implementation

- CareOregon implemented a modified Track 2 program on January 1, 2018, and plans to launch the full Track 2 program on July 1, 2018. Full implementation was delayed, as the claims system and data necessary to set the rates were not ready. Over the past year, CareOregon has been working with practices to ensure they understand billing and know what is required of them to participate. Contracting and acceptance of the CPC+ program is going well for CareOregon (estimated to be at about 50% of eligible practices to date). CareOregon has both Medicare and Medicaid lines of business, with Medicaid making up the majority. To support practices and payers in administering CPC+, CareOregon has set the minimum threshold for membership to 150 at the individual clinic level, and 2,000 at the large system level.
- Anthem's CPC+ design planning was managed over an 18 month period. This included implementation of three different claims processing systems (two versions of FACETS and a proprietary corporate system). Anthem launched a limited pilot on April 1, 2018, and aims to have voluntary participation for all Track 2 practices beginning in January 2019. A small percentage of providers thus far have agreed to move forward with Track 2, but interest does appear to be growing among the small practices and large integrated networks.
- BCBS of LA is one of three participating CPC+ payers in Louisiana. They have been planning and developing their alternative to FFS model for over a year, and regularly meet with other payers. BCBS is planning for a July 2018 launch data and expects CPC+ to include five Track 2 practices and over 100 providers. Track 2 will have three layers of payment including:
 1. The basic care management fee, adjusted based on risk and quality;
 2. The FFS payment for E&M services, which will be reduced by the provider selected amount; and

3. Partial capitation, paid in the form of an additional care management fee on attributed members.

All lines of business will be included for BCBS of LA, including ASO. The agreements with ASO clients describe the components considered as part of claims; the account teams are provided with information on the CPC+ program, and billing is separated out between partial FFS and partial capitation. BCBS of LA has not quantified the membership threshold and does not anticipate having one. BCBS of LA remains in conversation with providers regarding uptake for Track 2.

II. Syncing Attribution to the Payment Model

- CareOregon’s model currently uses the code list provided by CMS for the CPC design. An active facilitation group of 14 payers is working collectively to land on a consistent group of codes included in capitation under CPC+. Having numerous payers can make coming to an agreement difficult, but they have conceptually tried to agree on the approach and decided not to limit the plans’ ability to make limited additions to the codes. CareOregon’s current reduction in FFS is set at 30%, creating the pool for capitation; the aim is to ensure budget neutrality. CareOregon uses the QNXT claims processing system.
 - For Track 2, Care Oregon is handling attribution by requiring providers to submit claims with a billing NPI that shows where services were rendered to connect payment accordingly. This is essential, since CareOregon assigns members at the clinic level. Some large systems have expressed concerns about the site billing data requirements , so communication and education on both sides has been helpful. More accuracy on the provider side will both help with CPC+ as well as the big picture (i.e. MACRA) going forward. CareOregon pays attribution based on assignment, but an algorithm also takes into account assignment based on patterns in care.
- Anthem has also followed the CMS design for payment in CPC+. Anthem has heard similar concerns from providers regarding basing capitation on historical assessment of utilization of codes. In response, Anthem has incorporated the ability for their contracting team to provide additional incentives, or they make adjustments to the overall historical rates based on how comprehensive the member’s primary care is with the practice. Anthem has the ability to pass through the partial capitation portion of the payment, and the partial FFS reimbursement flows through at a discounted amount. Together, the ASO clients get a full picture of what they are paying for members in CPC+.
 - Members are attributed at the practitioner level, which is flagged for the practitioner’s tax ID and NPI. Anthem rolls up a few levels above the practitioner level to reflect the (accountable care organization) ACO or provider organization that they have contracted with. Anthem has experienced challenges when the same practitioner bills under different entities, and how/if to exclude members as well as claims from the alternative-to-FFS model.
- BCBS of LA uses FACETS for their claims system. To handle the billing for self-funded groups, the care management fee (CMF) flows through the normal billing process but is then separated into a value-based payment (VBP) section. For non-claims incentive payments, they create pseudo claims and flow them through the billing process in the same way. Rather than going through the claims system, they are sent to the separate VBP billing section. BCBS of LA attributes members at the individual primary care physician level, and then rolls up to the tax ID, and then the entity level.

III. Staffing

- CareOregon’s network and clinical support team was key in bringing together the contracting and provider services teams to work on claims processing. CareOregon also brought in the alternative payment team, system configurations team, business and population analytics team, and information technology team.
- Anthem’s claims processing efforts for CPC+ involved dozens of resources across the organization, including subject matter experts (i.e. director level leaders in claims processing, process experts for claims who were able to participate in discussions with the IT team, and claims peers).
- BCBS of LA had a similar makeup for their claims processing team, but also included the actuarial department as well as accounting to adjust to the new methodology.

IV. Operational Challenges

- CareOregon has faced challenges with determining the location where members have been seen based on claims received. This impacts reporting and the way in which they assign members. CareOregon continues to have conversations with larger clinics groups or practices about proper billing practices and identifying the site of service appropriately on the claim. It has been critical to ensure that the right claims and systems individuals are on the calls to help with the data. In retrospect, CareOregon would have involved the business and population analytics team with claims analysis sooner. They began noticing the inconsistencies in the attribution data and the way in which clinics were billing about six months prior to the launch date. Additionally, as a Medicaid plan, CareOregon sees regular churn and a new influx of approximately 70,000 members. Because they are capitating based on historical assessment of utilization of codes, CareOregon has discussed doing regular reconciliation or adjustments in six month increments going forward.
- BCBS of LA experienced a challenge with the CMF paid via claims, when payments were not fully suppressed from the member view, and members raised concern. BCBS of LA learned the importance of educating the customer service team and communicating with the self-funded groups.
- Similarly, CMS has faced operational challenges that the agency did not originally account for, such as in changes in enrollment. To address members moving between Track 2 practice sites, CMS implemented a logic change for practices sharing the same member IDs under the same billing TIN. The agency then did a reprocessing of the claims, and payment adjustments will be made.

V. Testing and Validation

- To manage the testing process in anticipation of the pilot, Anthem’s testing team generated and tested several claims scenarios (e.g., different mixes of services from the same claim) prior to implementation. Anthem continues to monitor claims to ensure they are being processed as expected.
- To manage the testing process prior to “go-live,” the BCBS of LA claims will be created and produced on a separate payment report. An internal team will then review and validate the payments in testing and production prior to sending to providers.
- CMS ran a testing process for claims in CPC+; however, they were not able to anticipate all scenarios. Over time, CMS has worked with their operations contractors to provide reporting and analytics on specific claims. Any anomalies are flagged and validated if necessary.
- CMS also has a methodological accommodation to prepare for risk to the agency as well as to the practices. They have built in flexibility through a partial reconciliation payment adjustment

for outlier cases. CMS will compare expected 2017 payments to actual 2017 payments and adjust 2019 CPCPs (either up or down) for the outliers. This requires waiting for claims run out to fully assess the method.