National Committee on Vital and Health Statistics

Panel Discussion: Value Based Care Models vs Fee-For-Service: Implications for HIPAA Standards

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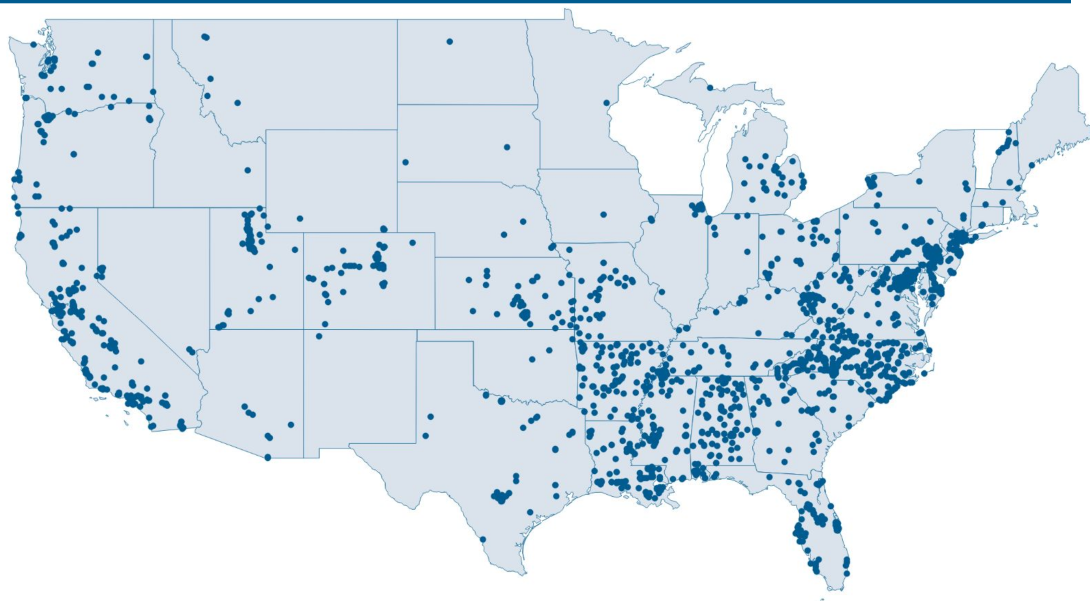
Aledade is the nation's largest network of independent primary care providers

Our mission is to build a better healthcare system for patients, practices and society.

That means meeting every patient where they are, with the coverage they have.



We partner with small and midsize practices, enabling their success and ability to remain independent.

The shift to value-based care supports practice viability, improves patient outcomes, and reduces cost of care.

Value-Based Care aligns incentives

PAYERS

VALUE-BASED CONTRACTS

Quality, and Cost Performance

Shared savings revenue

RISK-BEARING ENTITY

PRIMARY CARE PRACTICES

FEE-FOR-SERVICE

Volume, and Price Negotiations

[1] Based on 2016 and 2017 Aleade cohorts

[2] 2023 results are not finalized and are unaudited. Includes accrued and actual payments for 2023 performance along with payments for prior years that were not previously recorded

Our 200+ Payer Partnerships Span the Country

We partner with national, regional, and single-state payers on value-based agreements for all three lines of business: Medicare Advantage, Commercial, and Medicaid.

Key Examples of Aledade-Payer Partnerships

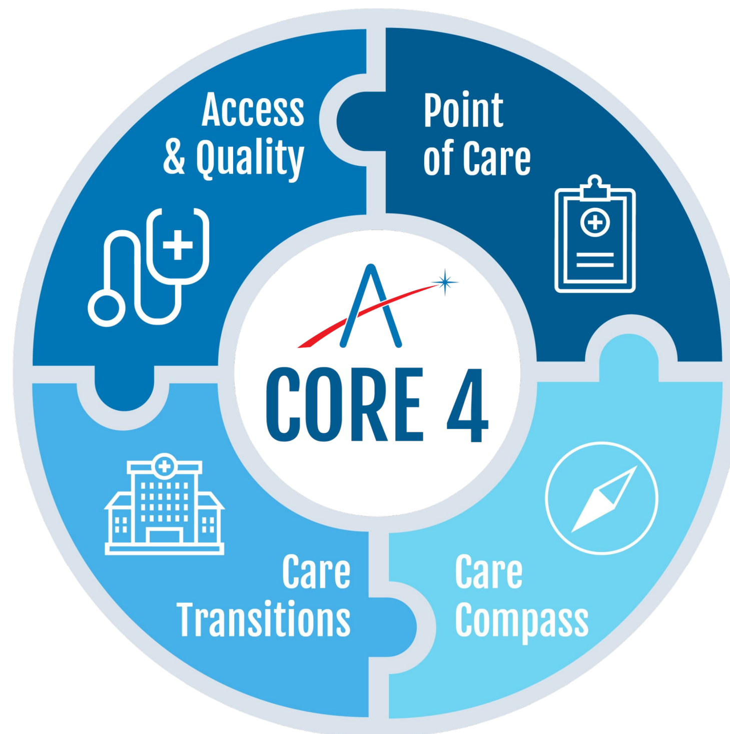
National

Regional

Local

Key Population Health Use-Cases currently use non-standard data formats

1. Attribution
2. Quality Reporting
3. Risk Adjustment
4. Revenue/Funding
5. Claims and Non-claims expenses



Attribution

- Comprehensive list of attributed members for contracted providers for every contract year
- Incorporates demographic fields used to assess opportunities to improve health equity (e.g., race, ethnicity, preferred language)
- As appropriate, incorporates PCP assignment and risk score/risk categorization

Health Plan Attribution “wish list” (monthly)

Field Value
Attributed Practice TIN
Attributed Provider NPI
Unique Member Identifier (Member ID)
Group ID
MBI
Reason Code
Line of Business
Product Designation
Member Type
Member First Name
Member Last Name
Member Date of Birth
Member Gender
Member Zip Code
Attribution start date
Attribution end date
Pharmacy Indicator
Vision Indicator
Dental Indicator
Risk score
Race
Ethnicity
Language Preference
Foster Indicator
…

CMS Assignment list report (monthly)

Variable Name
MBI
HICN
First Name
Last Name
Sex
Birth Date
Date of Death
County Name
State Name
County Number
Voluntary Alignment Flag
Designated Primary Clinician ACO Participant TIN
Designated Primary Clinician NPI
Claims-Based Assignment Flag
Claims-Based Assignment Step Flag
Previously Assigned Beneficiary Flag
Newly Assigned Beneficiary Flag
Medicare Part D Enrollment Flag
Beneficiary excluded for one or more reasons
Beneficiary had a date of death prior to the start of the performance year
Beneficiary is excluded due to other reasons not listed in the ALR
Beneficiary had at least 1 month of Part A-only or Part B-only Coverage
Beneficiary had at least 1 month in a Medicare Health Plan
Beneficiary does not reside in the United States
Beneficiary included in other Shared Savings Initiatives
Monthly Eligibility Flag 1
…

Quality

HEDIS Engine Reports/ Care Gaps

- List of all denominator members in the Care Gaps identified, along with current status
- As available, incorporates prioritization based on health plan predictive analytic capabilities

Medication Adherence Lists

- List of all members considered for medication adherence, along with current status

Quality "Flat File"

- "Flat files" are files that match clinical values scraped from Aledade practice EHRs and from lab feeds (LabCorp and Quest) to patient-specific open care gaps. Their submission ensures compliant clinical values are received by payers for relevant outcomes-based quality measures.

Key Field Value

Unique Member Identifier
Attributed Provider TIN
Member Phone Number
Member DOB
Member Zip Code
Last PCP Visit
Measure Year
Measure Name
Status Indicator
Eligibility Date
Discharge Date
Due Date
Non-Compliance Reason
Test Kit
Last Service Date
File Generation Date
Attributed PCP NPI
Line of Business
Contract or Market Identifier

Risk Adjustment

CMS-Based Risk Adjustment Files (Medicare Advantage Contracts)

- For attributed members, MAO-004 Encounter Data Diagnosis Eligible for Risk Adjustment Report; informs MAOs of the risk adjustment eligibility of diagnosis data submitted on accepted Encounter Data Records (EDRs) and Chart Review Records (CRRs)
- For attributed members, the Monthly Membership Detail data file (MMR), which details beneficiary-level payments and adjustments, as well as information about the risk adjustment factor and payment rate
- For attributed members, Model Output Report (MOR) generated by the Risk Adjustment System (RAS) and reports the Hierarchical Condition Categories (HCCs) used to calculate each beneficiary's risk scores
- Formats - same as dictated by CMS

Alternate Submission Method (ASM) Diagnosis File

Payer accepts supplemental flat file submission of diagnosis codes for risk adjustment and complete code capture purposes.

Field Value
Attributed Practice TIN
Attributed Provider NPI
Unique Member Identifier
Date of Birth
Claim Number
Begin DOS
Through DOS
Submission Date
Claim Type
Allowed Flag
Allowed Reason
Dx Code 1
Add/Delete 1
Dx Code 2
Add/Delete 2
….
Sex
ESRD
Age Group
Medicaid
HCC 1
HCC 2

Claims and Non-claims expenses

Medical Claims

- All paid professional and institutional medical claims for the attributed members (i.e., *all billed services for the member*, not just services billed by contracted provider)
- Includes all claims regardless of status (reversed, denied, rejected, adjusted)
- Clearly denotes spending categories under management (e.g., outmember, inmember, DME, pharmacy, specialty pharmacy, post-acute, etc.)
- Denotes full diagnosis code (i.e., not truncated values)
- Clearly denotes member, provider, and paid amounts for each claim line;

All non-claim-based expenses for all attributed members including but not limited to

- capitated arrangements,
- bundled payments,
- supplemental benefits,
- vendors,
- internal programs, etc.

Field Value
Attributed Practice TIN
Attributed Provider NPI
Unique Member Identifier
Expense Name
Expense Description
Expense Month
Paid Amount

Key Field Value
Unique Member Identifier
Claim ID
Line Number
Claim Status
Claim Type
Billing Provider NPI
Billing Provider TIN
Rendering Provider NPI
Provider Specialty
Attending Provider NPI
Place of Service
Bill Type Code
DRG Code
Insurance Paid Amount
Insurance Allowed Amount
Patient Responsibility Amount
Paid Amount Service Line
Paid Date
Admit Date
Admit Type Code
Discharge Date
Discharge Status Code

Revenue/ Funding

Complete revenue and funding data for attributed members

Field Value
Attributed Practice TIN
Attributed Provider NPI
Unique Member Identifier
Part A Premium
Part B Premium
Part D Premium
Part D Reinsurance
LIS Amount
Individual Member Premium
Group Member Premium
Medicaid/ICP
Part A Contract Term
Part B Contract Term
Part D Contract Term
Total Revenue
Total Funding
Contract Number
PBP
Segment ID

Conclusion

1. The importance of further standards alignment within health care especially across the administrative and clinical domains. There’s a greater need now for data to be interoperable regardless of use case

2. The need to ensure flexibility to work together to test, update, and advance use of FHIR based standards to support administrative/clinically-mixed transactions (e.g., prior auth, claims attachments) where there’s potential efficiencies to be gained.
   - It’s ok at times to have two standards-based ways to do things, so long as that’s clear to the industry and plans are made for a transition.