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Conference & Exhibition | March 5–9, 2018

Las Vegas | Venetian – Palazzo – Sands Expo Center

Advanced Alternative Payment Models

Session 153, March 7, 2018

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ENGAGED

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Conflict of Interest

Corey Henderson, DrPH, MPA

Has no real or apparent conflicts of interest to report.

Learning Objectives

- Provide an overview of Advanced Alternative Payment Model participation in 2018
- Identify the differences between all-payer and other payer options
- Provide an overview of the APM scoring standard and identify scoring differences between year 1 and year 2 of the program

Advanced Alternative Payment Models (APMs)

Alternative Payment Models (APMs)

Quick Overview

- APMs are approaches to paying for health care that incentivize quality and value.
- The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations that CMS conducts.

As defined by MACRA, **APMs include:**

- ✓ CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- ✓ Medicare Shared Savings Program
- ✓ Demonstration under the Health Care Quality Demonstration Program
- ✓ Demonstration required by federal law

Advanced APMs

Advanced APM Criteria

- Advanced APMs are a subset of APMs. To be an Advanced APM, a model must meet the following three statutory requirements:

The APM:

1. Requires participants to use **certified EHR technology**;
2. Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
3. Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a more than nominal amount of financial risk**.**

- In order to qualify for the 5% APM incentive payment for a year, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance year.

Advanced APMs

Financial Risk Criterion

- In the Year 1 Final Rule CMS established a general financial risk standard, applicable to all APMs, and a separate financial risk standard for Medical Home Models.
- CMS also finalized general nominal amount standards and a specific Medical Home Model nominal amount standard as part of those financial risk standards.

General Nominal Amount Standard
The total amount of that risk must be equal to at least either:

- 8% of the average estimated total Medicare Parts A and B revenues participating APM Entities; OR
- 3% of the expected expenditures for which an APM Entity is responsible under the APM.

Medical Home Model Nominal Amount Standard
The total amount of risk under a Medical Home Model must be at least the following amounts:

- 2.5% of estimated average total Medicare Parts A and B revenue (2017)
- 3% of estimated average total Medicare Parts A and B revenue (2018)
- 4% of estimated average total Medicare Parts A and B revenue (2019)
- 5% of estimated average total Medicare Parts A and B revenue (2020 and later)

- In the Year 2, CMS finalized changes to these Advanced APM financial risk and nominal amount standards.

Advanced APMs

Generally Applicable Nominal Amount Standard

- ***Change:*** *Extend the 8% revenue-based nominal amount standard for an additional two years, through performance period 2020.*

Transition Year 1 (2017) Final

Total potential risk under the APM must be equal to at least either:

- 8% of the average estimated Parts A and B revenue of providers and suppliers in participating APM Entities for the QP performance period in 2017 and 2018, OR
- 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Year 2 (2018) Final

The 8% revenue-based standard is extended for two additional years, through performance year 2020.

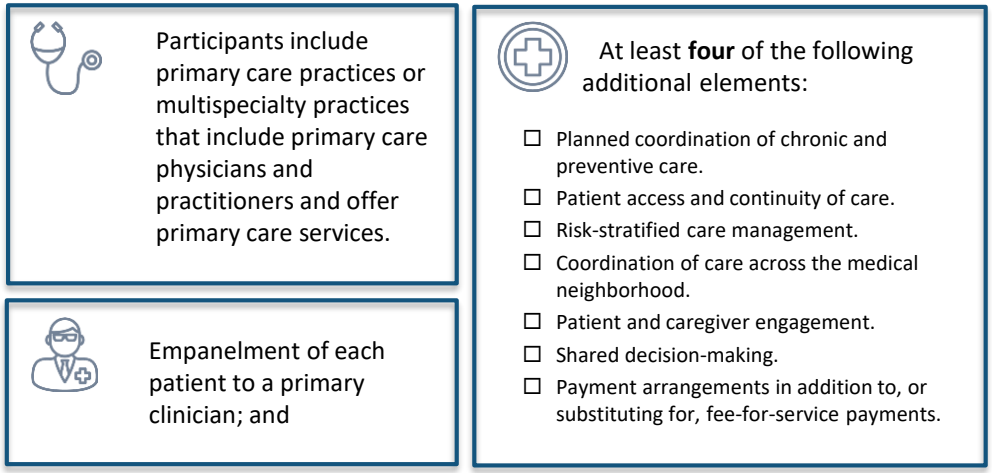
Total potential risk under the APM must be equal to at least either:

- 8% of the average estimated Parts A and B revenue of providers and suppliers in participating APM Entities for QP Performance Periods 2017, 2018, 2019, and 2020, OR
- 3% of the expected expenditures an APM Entity is responsible for under the APM for all performance years.

Advanced APMs

Medical Home Model

- A Medical Home Model is an APM that has the following features:



- Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Advanced APM.

Advanced APMs

Medical Home Model: 50 Clinician Cap (50 eligible clinician limit)

Transition Year 1 (2017) Final

For performance year 2018 and thereafter, the medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization.

Year 2 (2018) Final

2017 Participants in Round 1 of the Comprehensive Primary Care Plus Model are exempted from the 50 clinician cap.

Advanced APMs

Medical Home Model Nominal Amount Standard

- ***Change:*** *Increasing the minimum required amount of total risk increases more gradually, maintaining the standard at 2.5% in 2018 and ramping up to 5% in 2021 and thereafter.*

Transition Year 1 (2017) Final

- Total potential risk that an APM Entity potentially owes CMS or foregoes must be equal to at least:
  - 2.5% of the average estimated total Part A and B revenues of all providers and suppliers participating APM Entities for performance year 2017.
  - 3% … for performance year 2018.
  - 4% … for performance year 2019.
  - 5% … for performance year 2020.

Year 2 (2018) Final

- Total potential risk that an APM Entity potentially owes CMS or foregoes must be equal to at least:
  - 2.5% of the average estimated total Part A and B revenues of all providers and suppliers in participating APM Entities for performance year 2018.
  - 3% … for performance year 2019.
  - 4% … for performance year 2020.
  - 5% … for performance year 2021 and after.

Advanced APMs

All-Payer Combination Option &

Other Payer Advanced APMs

All-Payer Combination Option

Overview

- The MACRA statute created two pathways to allow eligible clinicians to become QPs.

Medicare Option

- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs within Medicare fee-for-service.

All-Payer Combination Option

- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in Advanced APMs within Medicare fee-for-service, **AND** Other Payer Advanced APMs offered by other payers.

All-Payer Combination Option

Other Payer Advanced APMs

- Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs.
- Payer types that may have payment arrangements that qualify **as Other Payer Advanced APMs** include:

- ✓ Title XIX (Medicaid)
- ✓ Medicare Health Plans (including Medicare Advantage)
- ✓ CMS Multi-Payer Models
- ✓ Other commercial and private payers

All-Payer Combination Option

Other Payer Advanced APM Criteria

- The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used for Advanced APMs:

1. Requires at least 50 percent of eligible clinicians to **use certified EHR** technology to document and communicate clinical care information.

2. Base payments on **quality measures that are comparable to those used in the MIPS** quality performance category

3. Either: (1) is a Medicaid Medical Home Model that meets criteria that is **comparable to a Medical Home Model expanded** under CMS Innovation Center authority, OR (2) Requires participants to **bear more than nominal amount** of financial risk.

All-Payer Combination Option

Other Payer Advanced APMs: Nominal Amount Standards

- ***Change:*** *Keep marginal risk and minimum loss rate. Established an additional 8% revenue-based nominal amount standard for total risk.*

Transition Year 1 (2017) Final

- Nominal amount of risk must be:
  - Marginal Risk of at least 30%;
  - Minimum Loss Rate of no more than 4%; and
  - Total Risk of at least 3% of the expected expenditures the APM Entity is responsible for under the APM.

Year 2 (2018) Final

- Established a revenue-based nominal amount standard for Total Risk of 8%.
- This is an alternative to the 3% expenditure-based standard. Payment arrangements qualifying under this standard would still need to meet Marginal Risk and Minimum Loss Rate requirements.

Advanced APMs

All-Payer Combination Option: Determination of Other Payer Advanced APMs

- Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers, which we refer to as the Payer Initiated Process.
- This Payer Initiated Process is available for Medicaid, Medicare Advantage, and payers aligning with CMS Multi-Payer Models for performance year 2019. We intend to add remaining payer types in future years.
- APM Entities and eligible clinicians will also have the opportunity to submit information regarding the payment arrangements in which they were participating in the event that the payer has not already done so, which we refer to as the Eligible Clinician Initiated Process.
- For Medicaid payment arrangements, APM Entities and eligible clinicians will be able to submit information prior to the relevant QP Performance Period. For all other payment arrangements, APM Entities and eligible clinicians will be able to submit information after the relevant QP Performance Period.

All-Payer Combination Option

Other Payer Advanced APM Determinations

- ***Change:*** *CMS established two pathways through which a payment arrangement can be determined to be an Other Payer Advanced APM.*

Transition Year 1 (2017) Final

Eligible Clinicians (or APM entities on their behalf) would report information about the payment arrangements they participate in after the 2019 QP Performance Period (except for Medicaid)

Year 2 (2018) Final
Payer Initiated Determination Process

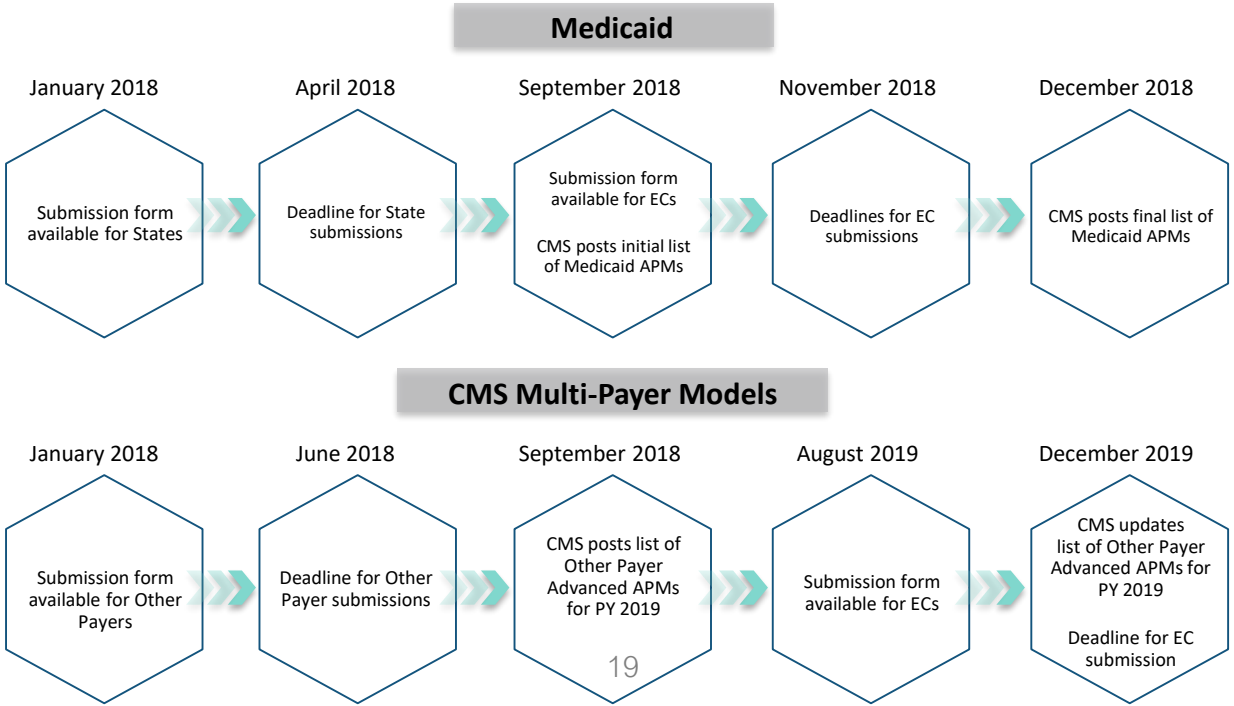
- Voluntary.
- Deadline **before** the All-Payer QP Performance Period.
- Specific deadlines and mechanisms for submitting payment arrangements will vary by payer type in order to align with pre-existing processes and meet statutory requirements.

Eligible Clinician Initiated Determination Process

- Deadline **after** the All-Payer QP Performance Period, **except** for eligible clinicians participating in Medicaid payment arrangements.
- Overall process is similar for eligible clinicians across all payer types , except for the submission deadlines.

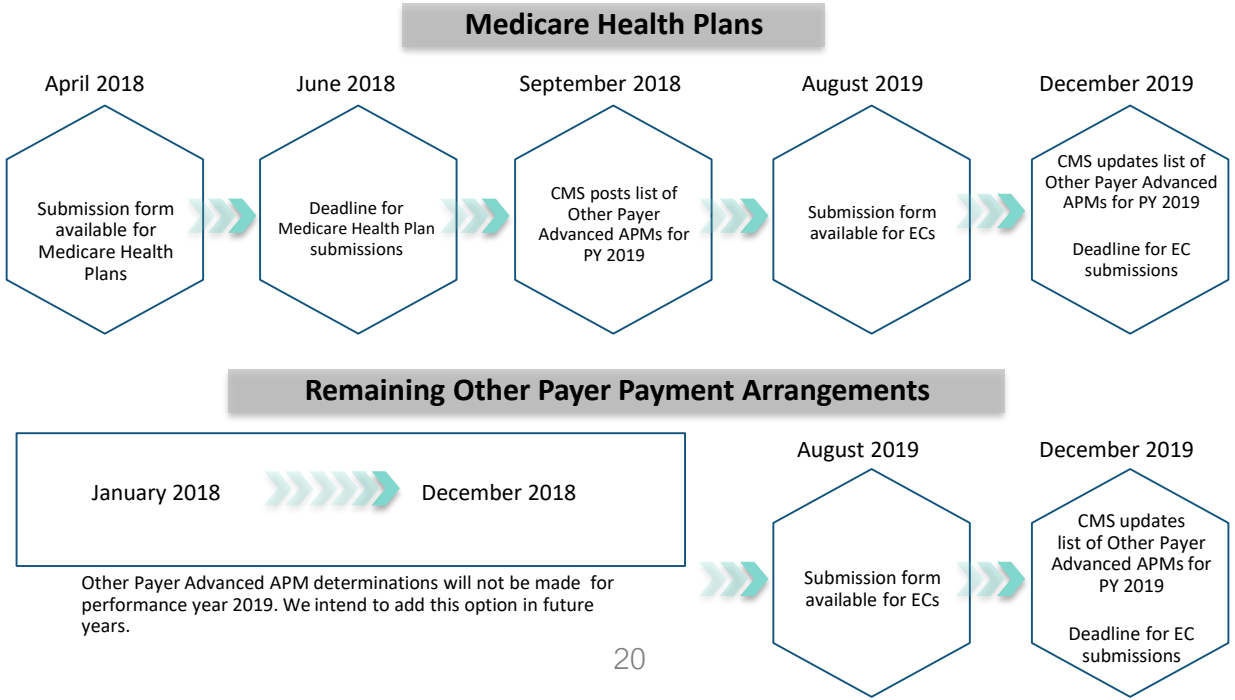
Advanced APMs

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations



Advanced APMs

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations



All-Payer Combination Option

QP Determinations

- ***Change:*** *Provide eligible clinicians and APM entities flexibility to have All-Payer QP determinations be conducted at the individual or APM entity level.*

Transition Year 1 (2017) Final	Year 2 (2018) Final
QP determinations under the All-Payer Combination Option would generally be made at the APM Entity level, with certain limited exceptions.	Eligible clinicians have the option to either be assessed at the individual level or at the APM Entity level. Like in the Medicare Option, eligible clinicians would need to meet the relevant patient or payment count threshold as of one of three snapshot dates: March 31, June 30, and August 31.

New Advanced APM

Bundled Payments for Care Improvement Advanced (BPCI Advanced)

- On January 9, the Innovation Center announced the launch of **BPCI Advanced,** a new voluntary bundled payment model.
- BPCI Advanced qualifies as an Advanced APM under the Quality Payment Program.
- The Model Performance Period for BPCI Advanced start on October 1, 2018 and runs through December 31, 2023.
- The Request for Applications (RFA) is available on the CMMI website. The application and all required documents must be submitted via the BPCI Advanced Application Portal by **March 12, 2018 at 11:59 p.m. EST.**
- Learn more: https://innovation.cms.gov/initiatives/bpci-advanced/

APM Scoring Standard for MIPS APMs

APM Scoring Standard

Quick Refresher

- The APM scoring standard offers a special, minimally-burdensome way of participating in MIPS for eligible clinicians in APMs who do not meet the requirements to become QPs and are therefore subject to MIPS, or eligible clinicians who meet the requirements to become a Partial QP and therefore able to choose whether to participate in MIPS. The APM scoring standard **applies to APMs that meet the following criteria**:

  - ✓ APM Entities participate in the APM under an **agreement with CMS**;
  - ✓ APM Entities include one or more **MIPS eligible clinicians** on a Participation List; and
  - ✓ APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on **cost/utilization** and **quality**.

What are MIPS APMs?

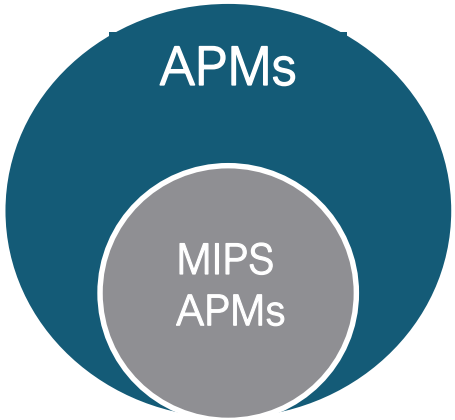
Goals

- Reduce eligible clinician reporting burden.
- Maintain focus on the goals and objectives of APMs.

How does it work?

- Streamlined MIPS reporting and scoring for eligible clinicians in certain APMs.
- Aggregates eligible clinician MIPS scores to the APM Entity level.
- All eligible clinicians in an APM Entity receive the same MIPS final score.
- Uses APM-related performance to the extent practicable.

MIPS APMs are a Subset of APMs



25

APM Scoring Standard

Category Weighting for MIPS APMs

In the 2017 Final Rule, we finalized different scoring weights for Medicare Shared Savings Program and the Next Generation ACO model, which were assessed on quality, and other MIPS APMs, which had quality weighted to zero. For 2018 we are proposing to align weighting across all MIPS APMs, and assess all MIPS APMs on quality.

Transition Year (2017)

Domain	SSP & Next Generation ACOs	Other MIPS APMs
	50%	0%
	0%	0%
	20%	25%
	30%	75%

Year 2 (2018) Final

All MIPS APMs
50%
0%
20%
30%

APM Scoring Standard

Additional Changes for Year 2

- We finalized additional details on how the quality performance category will be scored under the APM scoring standard for non-ACO models, who had quality weighted to zero in 2017.
  - In 2018, participants in MIPS APMs will be scored under MIPS using the quality measures that they are already required to report on as a condition of their participation in their APM.
- Additionally, we established a fourth snapshot date of **December 31st** for full TIN APMs (Medicare Shared Savings Program) for determining which eligible clinicians are participating in a MIPS APM for purposes of the APM scoring standard.
  - This allows participants who joined full TIN APMs between September 1st and December 31st of the performance year to benefit from the APM scoring standard.

Quality Payment Program

Help & Support

Technical Assistance

Available Resources

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISCMail@us.ibm.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

Questions

Corey Henderson, DrPH, MPA

Additional CMS Education Sessions

Session	Date	Time	Location
Innovation in the Medicaid Enterprise: A State and Federal Priority Partnership	Thursday, March 8	11:30 a.m.-12:30 p.m.	Lando 4204
Quality Payment Program Developer Tools & EHRs Town Hall	Thursday, March 8	1-2 p.m.	Lando 4204
New Medicare Card (SSNRI)	Thursday, March 8	2:30-3:30 p.m.	Lando 4204

CMS Office Hours Schedule - Wednesday

Booth #10110	
New Medicare Card (SSNRI)	1-3 p.m.
Advanced Alternative Payment Models	2:30-3:30 p.m.
Blue Button 2.0 API	2:30-3:30 p.m.
EHR Incentive Program – Hospitals	3-4 p.m.
CMS Quality Systems Improvements to Data Access	3-4 p.m.
QPP	4:30-5:30 p.m.

CMS Office Hours Schedule - Thursday

Booth #10110	
New Medicare Card (SSNRI)	9:30-11 a.m.
QPP	10-11:30 a.m.
Data Element Library	11 a.m.-12 p.m.
Advanced Alternative Payment Models	11:30 a.m.-1 p.m.
New Medicare Card (SSNRI)	1-3 p.m.
Electronic Clinical Quality Measures	1:30-3:30 p.m.
CMS Quality Systems Improvements to Data Access	2-3 p.m.
Advancing Care Information	2:30-3:30 p.m.
Blue Button 2.0 API	2:30-4 p.m.