Medicaid in the Quality Payment Program

What is the Quality Payment Program?

Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

- Established in 1997 to **control the cost of Medicare payments** to physicians

Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

The Quality Payment Program

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.

Two tracks to choose from:

Advanced Alternative Payment Models (APMs)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

or

The Merit-based Incentive Payment System (MIPS)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

Who participates?

Who participates in MIPS?

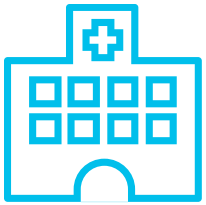
- Medicare Part B clinicians billing more than $30,000 a year **and** providing care for more than 100 Medicare patients a year.
- These clinicians include:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists

Who is excluded from MIPS?

- **Newly-enrolled Medicare clinicians**
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.
- **Clinicians below the low-volume threshold**
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients
- **Clinicians significantly participating in Advanced APMs**

Pick Your Pace for Participation during the Transitional Year

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test Pace

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

Alternative Payment Models (APMs)

What is an Alternative Payment Model (APM)?

Alternative Payment Models (APMs) are new approaches to paying for medical care through Medicare 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.

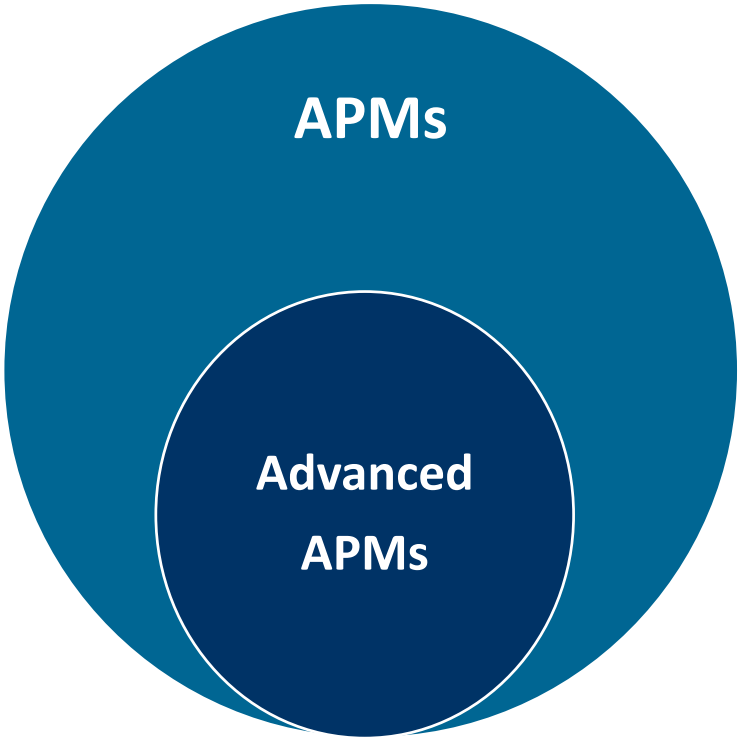
As defined by MACRA, **APMs include:**

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

Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes.
- It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

Advanced APMs
Advanced APM-specific rewards + 5% lump sum incentive

What are the Benefits of Participating in an Advanced APM as a Qualifying APM Participant (QP)?

QPs:

- Are excluded from MIPS
- Receive a 5% lump sum bonus
- Receive a higher Physician Fee Schedule update starting in 2026

The Quality Payment Program provides **additional** rewards for participating in APMs.

Potential financial rewards 

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
	If you are a **Qualifying APM Participant (QP)** =	5% lump sum bonus

Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

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.**

Advanced APMs in 2017

For the **2017 performance year**, the following models are Advanced APMs:

Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)	Comprehensive Primary Care Plus (CPC+)
Shared Savings Program Track 2	Shared Savings Program Track 3
Next Generation ACO Model	Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.

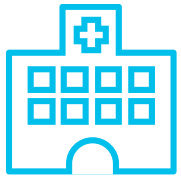
Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.
- **In future performance years**, we anticipate that the following models will be Advanced APMs:

Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)	New Voluntary Bundled Payment Model
Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)	Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
ACO Track 1+	

Medicaid and Private Payers

Medicaid Medical Home Model



- A Medicaid Medical Home Model is a payment arrangement that has the following features:
  - Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
  - Empanelment of each patient to a primary clinician; and
  - At least four of the following additional elements:
    - Planned coordination of chronic and preventive care.
    - Patient access and continuity of care.
    - Risk-stratified care management.
    - Coordination of care across the medical neighborhood.
    - Patient and caregiver engagement.
    - Shared decision-making.
    - Payment arrangements in addition to, or substituting for, fee-for-service payments.

Other Payer Advanced APMs Must Meet Certain Criteria

Other Payer Advanced APMs must meet requirements that are similar, though not identical, to the three requirements Advanced APMs must meet.

The payment arrangement:

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 **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 a more than nominal amount of financial risk.**

Other Payer Advanced APM Criterion 1: Requires use of Certified EHR Technology

1. Requires participants to use certified EHR technology
   - Requires that at least 50% of the clinicians in each APM Entity use certified EHR technology to document and communicate clinical care information with patients and other health care professionals.

Other Payer Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

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

- Ties payment to quality measures that are evidence-based, reliable, and valid.
- At least one of these measures must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.
- Medicaid Core Measures are comparable to MIPS quality measures.

Other Payer Advanced APM Criterion 3: Medical Home Expanded Under CMS Authority

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

Medical Home Model Expansion
The Other Payer Advanced APM financial risk criterion is completely met if the payment arrangement is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

Medicaid Medical Home Model Financial Risk
While no medical home models have yet been expanded, Medicaid Medical Home Models can still be Other Payer Advanced APMs if they include financial risk for participants.

The Medicaid Medical Home Model financial risk standard acknowledges that risk under the terms of a payment arrangement can be structured uniquely for smaller entities in a way that offers the potential of losses without threatening their financial viability.

Other Payer Advanced APM Criterion 3: Bear a More than Nominal Amount of Financial Risk

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.**

Financial Risk

Bearing financial risk means that the Other Payer Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to the payer.

Nominal Amount of Risk

The nominal amount of that 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 for which an APM Entity is responsible under the APM

Note that this standard has more dimensions than the correlating standard for Advanced APMs.

Medicaid Medical Home Model Criterion 3: Bear a More than Nominal Amount of Financial Risk

3. The financial risk and nominal amount standards are unique for Medicaid Medical Home Models.

Financial Risk

Bearing financial risk means that the Other Payer Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians
- Require direct payments by the APM Entity to the Medicaid program.
- Reduce an otherwise guaranteed payment.

Nominal Amount of Risk

The total amount of that risk must be:

- At least 4% of total revenue under the payer in 2019;
- At least 5% of total revenue under the payer in 2020 and beyond.

Qualifying APM Participants (QPs)

What is a Qualifying APM Participant (QP)?

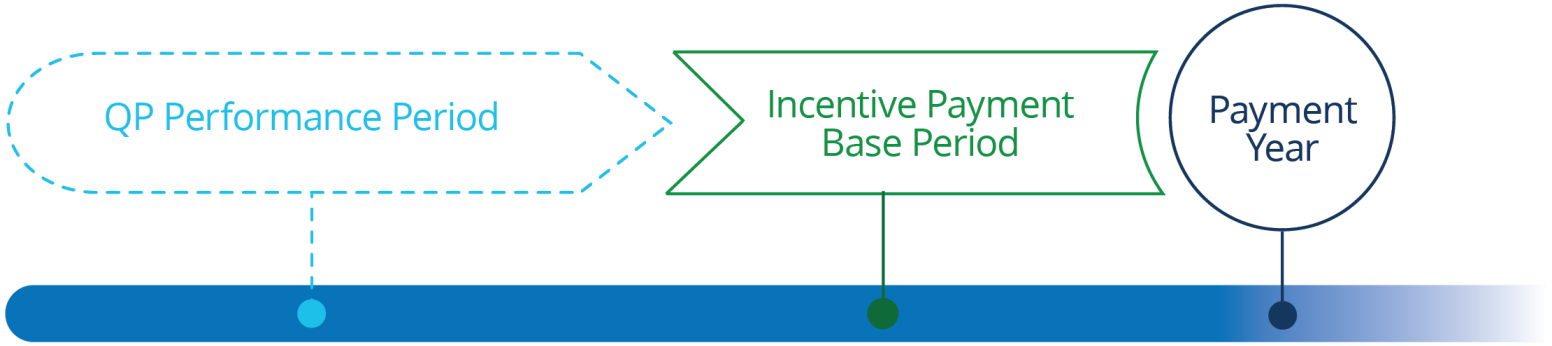
- Qualifying APM Participants (QPs) are clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.
- Starting in the 2019 QP Performance Period, participation in payment arrangements with other, non-Medicare payers can contribute to meeting the QP threshold.

Do payments from other payers apply to QP determination?

- The "All-Payer Combination Option" will be based on a combination of Advanced APM participation and participation in "Other Payer Advanced APMs."
  - To be considered under the All-Payer Combination Option, eligible clinicians must also participate in an Advanced APM but not meet the QP threshold under the Medicare Option.
- Other Payer Advanced APMs must meet criteria similar to those for Advanced APMs.

What is the Performance Period for QPs?

- The QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for the payment year.
- The QP Performance Period for each payment year will be from **January 1 – August 31st** of the calendar year that is **two years prior** to the **payment year**.

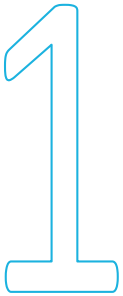


Performance Period:
QP status based on Advanced APM participation

Incentive Determination:
Add up payments for Part B professional services furnished by QP

Payment:
+5% lump sum payment made (excluded from MIPS adjustment)

All-Payer Combination Option
How do Eligible Clinicians become Qualifying APM Participants? – Step 1



- Qualifying APM Participant determinations are made at the Advanced APM Entity level, with certain exceptions:
  - individuals participating in multiple Advanced APM Entities, none of which meet the QP threshold as a group, and
  - eligible clinicians on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the Advanced APM Entity. For example, gain sharers in the Comprehensive Care for Joint Replacement Model will be assessed individually.

All-Payer Combination Option
How do you calculate Threshold Scores? – Step 2

2

- ✓ CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).
- ✓ Methods are based on payments from and patient furnished services through agreements with all payers, with certain exceptions.
- ✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

These definitions are used for calculating Threshold Scores under both methods.

The aggregate of all payments (or all patients given services) under the terms of the payment arrangement

The aggregate of all payments (or all patients given services) from the payer

All-Payer Combination Option
How do you calculate Threshold Scores? – Step 2

2

✓ Calculate the Threshold Score under the All-Payer Combination Option.

PAYMENT AMOUNT METHOD

$$$ the terms of Advances APMs and Other Payer Advanced APMs

$$$ from all payers

= Threshold Score %

PATIENT COUNT METHOD

# of patients given services under Advanced APMs and Other Payer Advanced APMs

# of patients given services under all payers

= Threshold Score %

All Payer Combination Option
How do you calculate Threshold Scores? – Step 2

2

Payments from the following sources are excluded from the calculation under the All-Payer Combination Option:

- ✓ Department of Defense Health Care Programs
- ✓ Department of Veterans Affairs Health Care Programs
- ✓ Title XIX in a state with no Medicaid Medical Home Model or APM. In order not to adversely impact physicians who have no opportunity to participate, Title XIX payments or patients would be excluded unless:
  - ✓ a state had at least one Medicaid Medical Home Model or APM in operation that is determined to be an Other Payer Advanced APM; and
  - ✓ the relevant Advanced APM Entity is eligible to participate in at least one such Other Payer Advanced APM, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs.

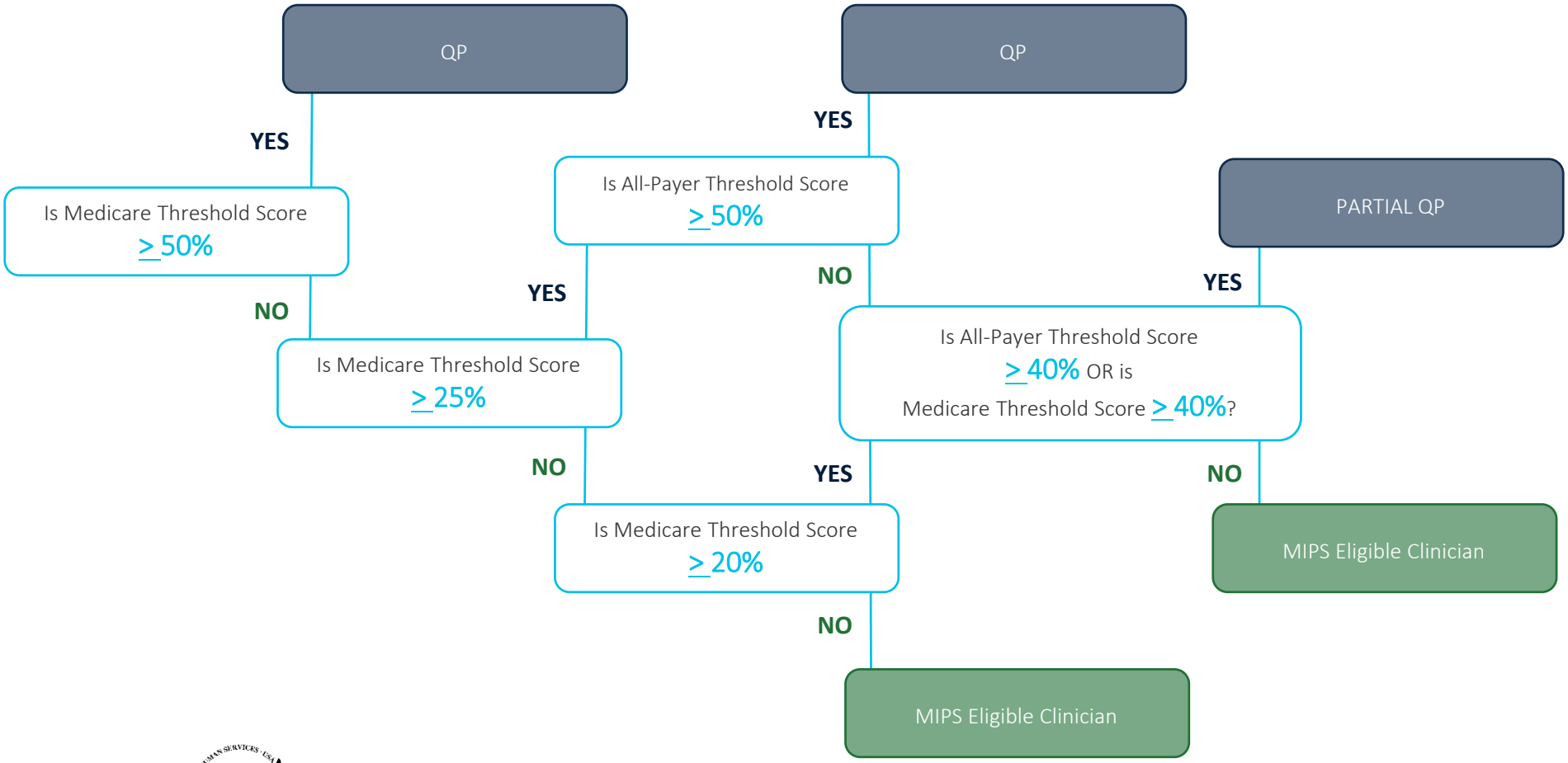
How do Eligible Clinicians become Qualifying APM Participants? – Step 3

3

✓ The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

All-Payer Combination Option										
Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

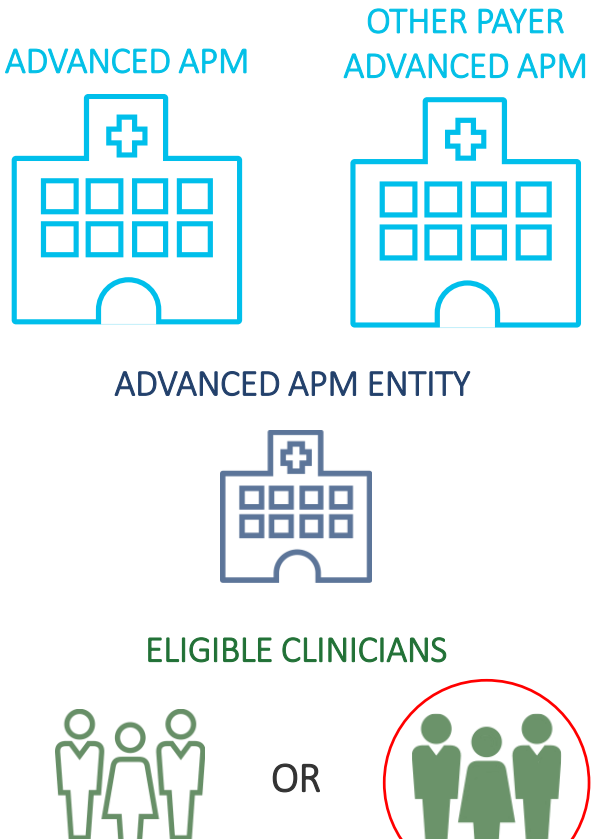
QP Determination Tree
Payment Years 2021 - 2022



How do Eligible Clinicians become Qualifying APM Participants? – Step 4

4

✓ All the eligible clinicians in the Advanced APM Entity become QPs for the payment year.



Additional Topics

Meaningful Use in Medicaid

- MIPS applies to clinicians providing services under Medicare Part B.
- MIPS does not replace the Medicaid EHR Incentive program, which will continue through 2021.
- Clinicians who are eligible for the Medicaid EHR Incentive Program will continue to attest to their respective State Medicaid Agencies to receive their payments.
- If those clinicians are also Medicare Part B clinicians, they may also participate in MIPS.

Impact on Indian Health Service (IHS) and Tribes

- CMS supports the pursuit of developing Other Payer Advanced APMs under a variety of health care payment programs.
- Payment arrangements not included under Medicare Part B could potentially qualify as Other Payer Advanced APMs for performance periods in 2019 and later.
- IHS, Tribal and Urban Indian health care programs would be eligible for such a designation if they meet the criteria.

Physician-Focused Payment Model Technical Advisory Committee

- MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.
- The PTAC is a federal advisory committee that provides independent advice to the Secretary. The PTAC is supported by HHS Office of the Assistant Secretary for Planning and Evaluation.
- This committee provides a unique opportunity for stakeholders to participate in the development of new models and to help determine priorities for the physician community

PFPM Technical Advisory Committee (PTAC)

PFPM = Physician-Focused Payment Model

Goal to encourage new **APM options** for Medicare clinicians

Submission of model proposals by Stakeholders

Technical Advisory Committee

11 appointed care delivery experts that review proposals, submit recommendations to HHS Secretary

Secretary comments on CMS website, CMS considers testing proposed models

Models with favorable response go to CMS Innovation Center

How Does the PTAC Work?

- Proposed model is submitted to the PTAC.
- PTAC reviews and provides comments and recommendations on proposals to the Secretary.
- Secretary of the Department of Health and Human Services reviews the recommendations of PTAC and posts a detailed response on the CMS website.
- Models that receive a favorable response will go to the CMS Innovation Center.
- Models that are implemented will go through the CMS developmental process for APMs.

Additional Comments on All-Payer Combination Option

- We are seeking additional comments by the close of the 60 day comment period on December 19, 2016 for further consideration on a few topics in the final rule. When commenting refer to file code CMS-5517-FC. The All-Payer Combination Option topics include:
  - Establishing a process to review state payment arrangements to determine if they meet Other Payer Advanced APM criteria;
  - The amount and structure of the nominal amount standard for Other Payer Advanced APMs; and
  - Submission of information requirements.

When and where do I submit comments?

- The **final rule with comment** includes changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the **60-day comment period** on **December 19, 2016**. When commenting refer to file code **CMS-5517-FC**.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- **For additional information, please go to: QPP.CMS.GOV**

Where can I go to learn more?

Help Is Available

qpp.cms.gov

CMS has organizations on the ground to provide help to clinicians who are eligible for the Quality Payment Program:

TCPI

Transforming Clinical Practice Initiative (TCPI): TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click here to find help in your area.

QIN-QIOs

Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs): The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found here.

APM Learning Systems

If you're in an APM: The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the Learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.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