CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Innovation Accelerator Program (IAP)

Applying Alternative Payment Strategies to Activities Focused on Medicaid Beneficiaries with Complex Care Needs and High Costs

National Webinar Series

March 27, 2017

2:00pm – 3:30pm EDT

IAP Medicaid Innovation Accelerator Program

Logistics

- Please mute your line and do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in “full screen” mode
  - Please exit out of “full screen” mode to participate in polling questions
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Welcome & Overview

- **Karen LLanos**
- Director, Medicaid IAP, Center for Medicaid and CHIP Services, CMS

Polling Question

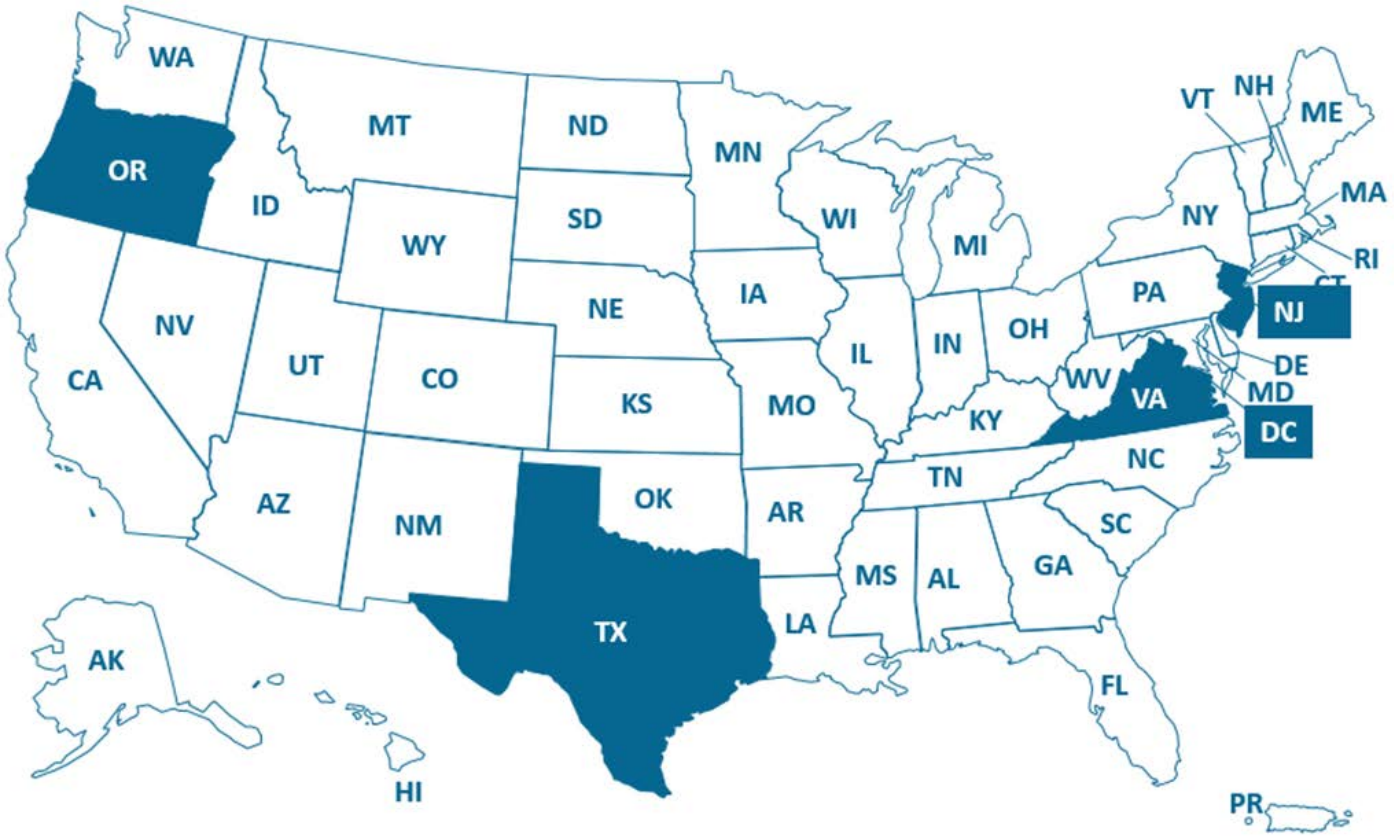
- Please select the type of organization you are representing:
  - State Medicaid Agency
  - State Agency other than Medicaid Agency
  - Managed Care Organization
  - Healthcare Provider
  - Consultant
  - Other

Welcome

- As part of the Medicaid IAP, we have worked with five states since October 2015 on issues such as:
  - Identifying and stratifying Medicaid beneficiaries with complex care needs and high costs (BCN) target populations
  - Designing effective care management strategies for Medicaid BCNs
  - Creating partnerships to address non-medical needs of Medicaid BCNs
  - **Applying alternative payment models to activities focused on Medicaid BCNs**

Background: IAP BCN Participating State Teams

- District of Columbia
- New Jersey
- Oregon
- Texas
- Virginia



IAP Medicaid Innovation Accelerator Program

Purpose & Learning Objectives

- Understand Alternative Payment Models (APMs) and how value-based payment strategies and initiatives to improve care for BCNs are related
- Learn from a state whose payment strategies are shifting from fee-for-service to value-based population health models
- Explore alignment of Medicaid payment strategies with other payer programs, including Medicare, and learn about payment models already familiar to providers that recognize the needs of the BCN population

Agenda

- Background: APMs and Their Role in Initiatives to Improve Care Coordination for Medicaid BCNs
  - Matt Roan, Principal, Health Management Associates
- Vermont's APM Progression
  - Mary Kate Mohlman, Director of Health Care Reform, State of Vermont
- Quality Payment Program, Medicaid and Advanced APMs: Considerations for States
  - Richard Jensen, Senior Policy Advisor, CMS Innovation Center
- Expert Reaction
  - Heather Howard, Princeton University
- Q&A
- Key Takeaways
- Closing Remarks

Background: Alternative Payment Models and Their Role in Initiatives to Improve Care Coordination for Medicaid Beneficiaries with Complex Care Needs and High Costs

Facilitator

- **Matt Roan**
- Principal, Health Management Associates

Alternative Payment Models (APM) Framework

Category 1

Fee for Service –
No Link to Quality & Value

Category 2

Fee for Service –
Link to Quality & Value

Category 3

APMs Built on
Fee-for-Service Architecture

Category 4

Population-Based
Payment

Fee-for-Service	A Foundational Payments for Infrastructure & Operations	B Pay for Reporting	C Rewards for Performance	D Rewards and Penalties for Performance	A APMs with Upside Gainsharing	B APMs with Upside Gainsharing/ Downside Risk	A Condition-Specific Population-Based Payment	B Comprehensive Population-Based Payment
Traditional FFS	Foundational payments to improve care delivery, such as care coordination fees, and payments for investments in HIT	Bonus payments for quality reporting	Bonus payments for quality performance	Bonus payments and penalties for quality performance	Bundled payment with upside risk only	Bundled payment with up- and downside risk	Population-based payments for condition-specific care (e.g., via an ACO, PCMH, or COE)	Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)
DRGs Not linked To Quality		DRGs with rewards for quality reporting	DRGs with rewards for quality performance	DRGs with rewards and penalties for quality performance	Episode-based payments for procedure-based clinical episodes with shared savings only	Episode-based payments for procedure-based clinical episodes with shared savings and losses		
		FFS with rewards for quality reporting	FFS with rewards for quality performance	FFS with rewards and penalties for quality performance	Primary care PCMHs with shared savings only	Primary care PCMHs with shared savings and losses	Partial population-based payments for primary care	Integrated, comprehensive payment and delivery system
					Oncology COEs with shared savings only	Oncology COEs with shared savings and losses	Episode-based, population payments for clinical conditions, such as diabetes	Population-based payment for comprehensive pediatric or geriatric care
					3N Risk-based payments NOT linked to quality		4N Capitated payments NOT linked to quality	

= example payment models will not count toward APM goal.

= payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

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

HCP LAN
Health Care Payment Learning & Action Network

APM Framework's Application to BCN

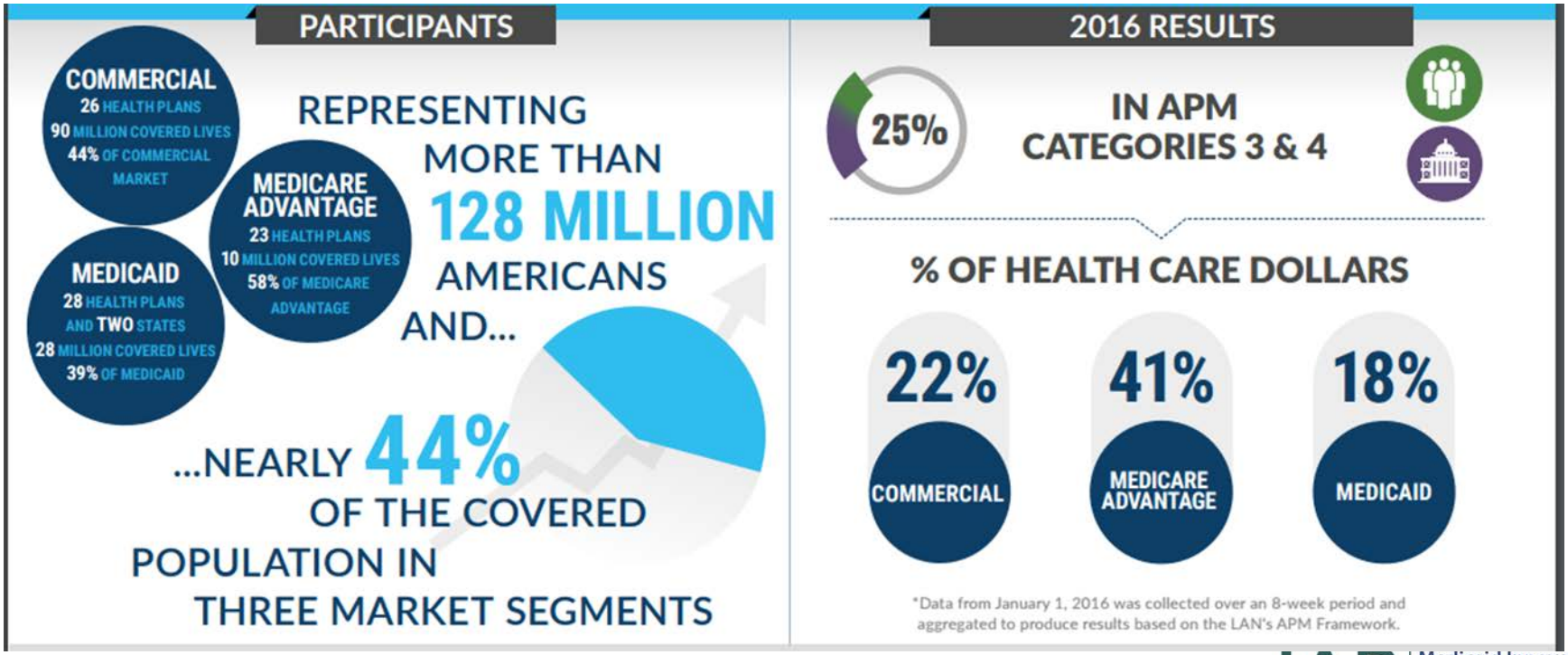
APM Category	Application to BCN Initiatives
Category 1: Fee-for-Service (FFS) Without Link to Quality or Value	• Financial incentives focused on volume rather than outcomes or prevention • Providing acute care to the BCN population may comprise a significant portion of provider revenue
Category 2: FFS with Quality Incentives	• Incentives and penalties can be designed to achieve guideline-based care for BCN population • Incentives can support process improvement/practice transformation to achieve better care coordination
Category 3: Gainsharing / Risk-Sharing	• Bundles and episodes of care built around BCN conditions • Incentives for efficient care measured against a baseline • Effectively serving BCN population generates savings to share
Category 4: Population-Based Payment	• Risk transferred to providers for full population or specific populations (i.e. BCN) • High incentive to appropriately manage/coordinate care for BCN population

Why are BCN populations important to Payment Reform?

- APMs can be targeted or broad based, with a trend toward broad, population-based models
- Outcomes and costs related to BCN populations can make the difference between success and failure of APMs
- If APMs fail to recognize the increased risk associated with the BCN population, providers may be reluctant to agree to payment models or serve BCN populations

Consider the Landscape

- The shift to value-based payment is occurring across the health care sector
- State Medicaid programs can look to commercial programs and Medicare for payment designs that could be a model for Medicaid payment reform
- Alignment supports provider migration to value-based payment models across the system



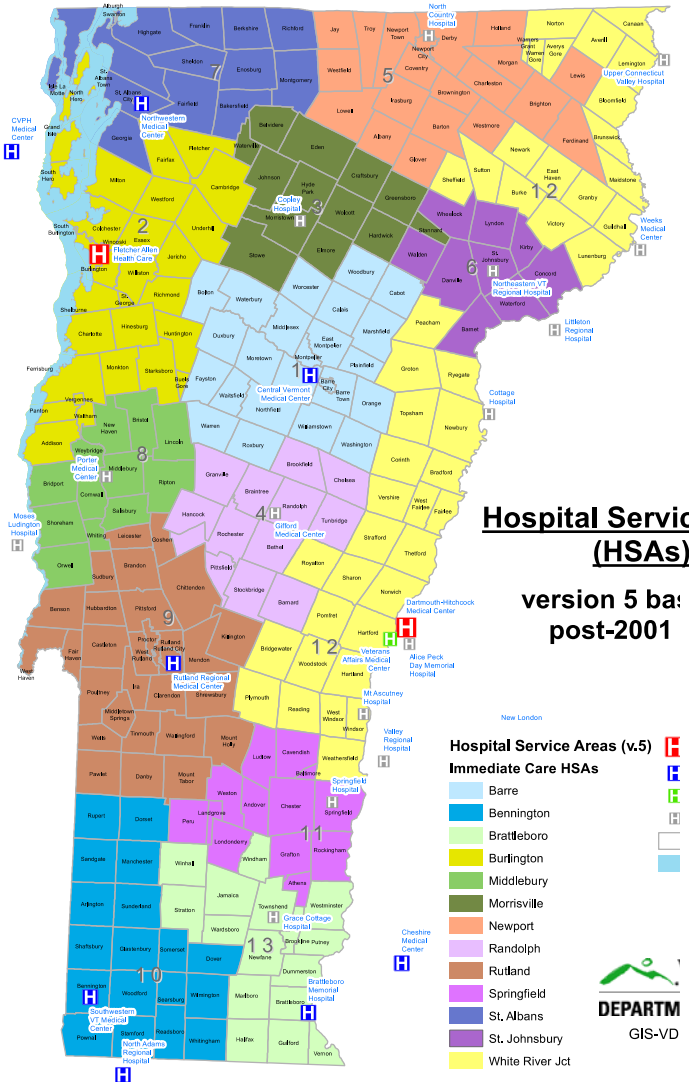
Source: http://hcp-lan.org/workproducts/apm-infographic-2016.pdf

Vermont's Alternative Payment Model (APM) Progression

Speaker

- **Mary Kate Mohlman**
- Director, Health Care Reform, State of Vermont

Vermont's Delivery System

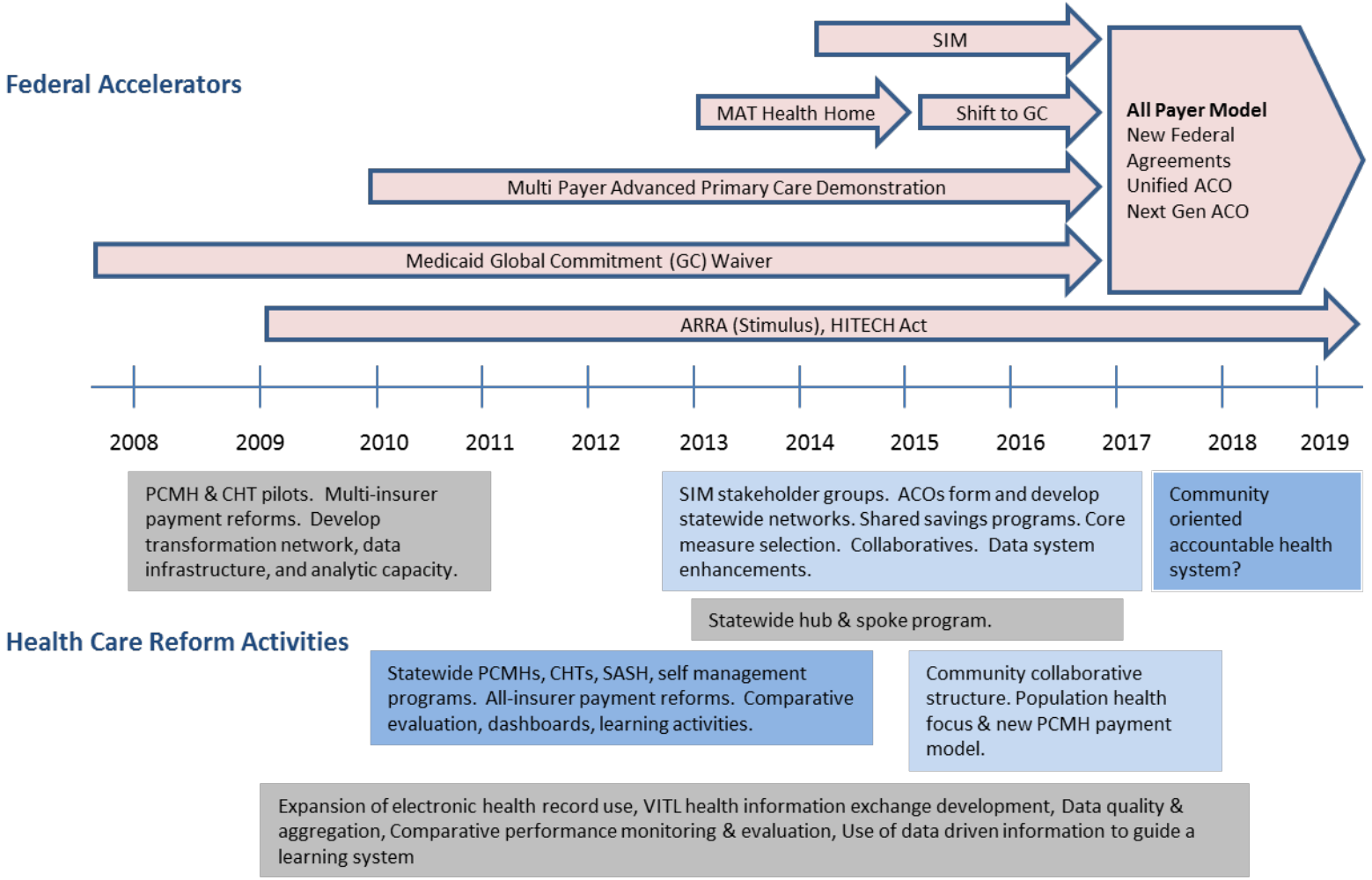


- **Some Features of Vermont's Health System**
  - 14 community hospitals, including 8 critical access hospitals (fewer than 25 beds)
  - 1 in-state academic medical center, plus Dartmouth-Hitchcock, provide most tertiary care
  - 11 FQHCs serving more than 120,000 Vermonters
  - Fewer than 2000 physicians, more than half of whom are employed
  - 3 health insurance carriers, only 2 in small group market
  - 3.7% uninsured

Building the Foundation: Key Players

- **Blueprint for Health** – first all-payer initiative, pilots initiated in 2008, statewide program in 2010
  - Payment reform
  - Patient-centered medical homes (PCMH)
  - Community health teams (CHTs)
- **Green Mountain Care Board**, 2011
  - Regulatory authority over hospital budgets, health insurance rates, and Certificates of Need
  - Assessment of payment reforms and their impact
  - Act 113: Oversight of accountable care organizations (ACO) participating in alternative payment models, specifically the All-Payer ACO Model
- **Accountable Care Organizations**, 2013
  - Participated in shared savings programs
  - Integrating current 3 ACOs into one ACO modeled on Next Gen ACO
- **State Innovation Model (SIM)**, 2013
  - Payment model design
  - Practice transformation
  - Health data infrastructure

Building the Foundation: Timeline



Early Efforts on Support for Individuals with Complex Care Needs

- Blueprint for Health, multi-payer support for:
  - Patient-Centered Medical Homes (PCMH)
    - Emphasis on care coordination and management
    - Team-based care
  - Community Health Teams (CHT)
    - Include the following disciplines:
      - Nursing
      - Social Work
      - Nutrition Science
      - Pharmacy
      - Administrative Support
    - Work in communities and in practices
    - Interact with specialty care, mental health and substance abuse programs, self-management programs, and social, economic, and community services

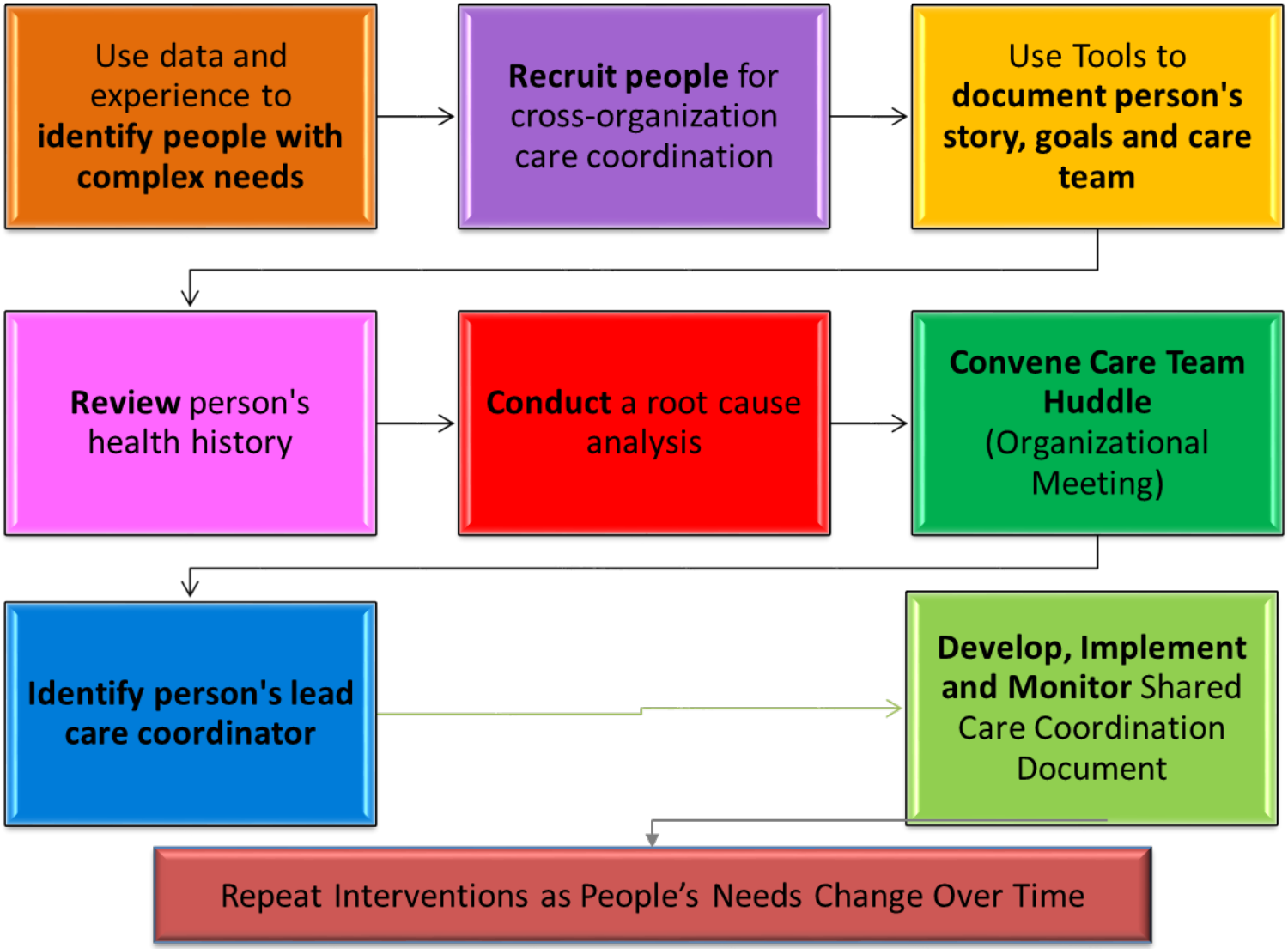
Progression on Support for Individuals with Complex Care Needs

- Three ACOs emerged in Vermont
  - Aligned Measurement Across Shared Savings Programs
- State Innovation Model (SIM) supported
  - Care model development
  - Payment model testing
- Development of Community Collaboratives
  - Formed under the joint leadership of ACOs and Blueprint for Health
  - Merging workgroups further strengthened the community clinical linkages going deeper into the health system
    - Blueprint workgroups strength in primary care and community linkages
    - ACOs workgroups strength in hospital and specialty practice participation

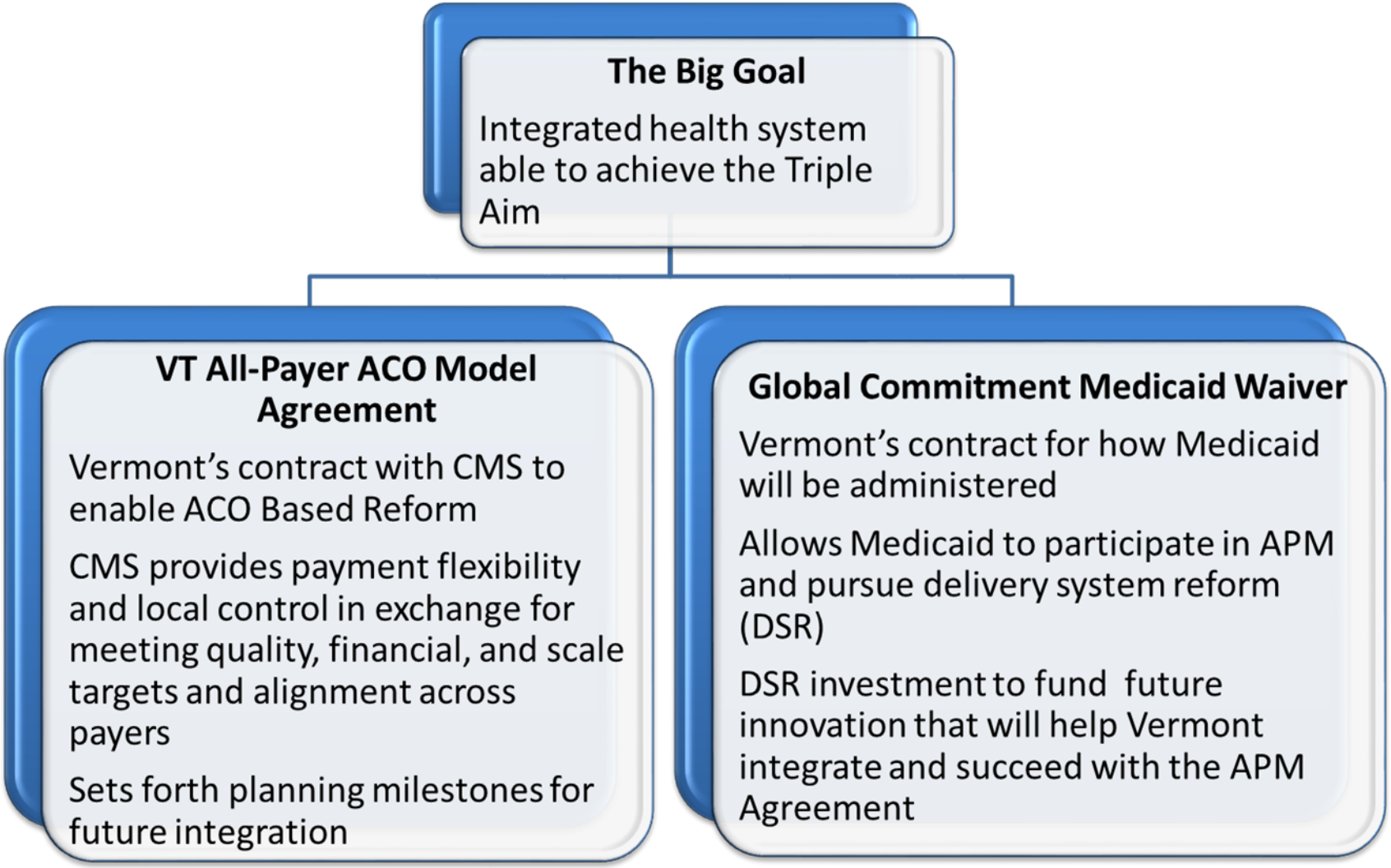
Integrated Communities Care Management Learning Collaborative

- Joint initiative supported by the Blueprint for Health, Green Mountain Care Board, SIM, and ACOs
  - Incorporated into Community Collaboratives as performance improvement project
- Key Priorities:
  - To better serve all Vermonters (especially those with complex physical and/or mental health needs), reduce fragmentation with better coordination of care management activities…
  - …[To] better integrate social services and health care services in order to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters…

Integrated Communities Care Management Learning Collaborative



All-Payer ACO Model (2018): Creating an Integrated Health System



Creating an Integrated Health System

- The two agreements allow Vermont to take a "one-model" approach to payment reform and integration
  - ACOs are the vehicle for All-Payer Model Financial Target Services, i.e. Medicare Part A and B services and their commercial and Medicaid equivalents, to engage in payment and delivery system reform
    - APM agreement sets forth the structure and Global Commitment (GC) Waiver allows Medicaid to innovate
- Vermont Medicaid Next Generation Contract (2017)
  - Contract between Medicaid and ACO to establish up-side and down-side risk in 4 hospital service areas
  - ~30,000 attributed Medicaid lives
  - Opportunity to test alternative payments before broader All-Payer ACO Model goes into effect

Vermont Care Organization

- Merging Vermont's ACOs into one over time
- Common measurement and analytics
- Ability to take risk proposed in Next Generation ACO model
- Common risk-stratified population health model informed by health care reform to date (Blueprint, Community Collaboratives, ICCM, etc.)
- **Aligns delivery reform and community networks with payment reforms**

All Payer ACO Model Measures

- Overarching Population Health Goals
  1. Improved access to primary care
  2. Reduced deaths from suicide and drug overdose
  3. Reduced prevalence and morbidity of chronic disease

     (Chronic Obstructive Pulmonary Disorder, Diabetes, Hypertension)

IAP Medicaid Innovation Accelerator Program

Green Mountain Care Board – Act 113

- The Vermont Legislature passed a legislation that gave the Green Mountain Care Board authority to oversee and evaluate ACOs engaged in alternative payment models
  - *"The Board shall ensure that the following criteria are met… (2) the ACO has established appropriate mechanisms and care models to provide, manage, and coordinate high-quality health care services for its patients, including incorporating the Blueprint for Health, coordinating services for complex high-need patients, and providing access to health care providers who are not participants in the ACO."*
- The Board is currently in the rule making stage

Summary

- **Foundation**
  - Preparing practices with multi-payer payments
  - Developing network of providers that can bridge medical and community services
  - Building cooperation and trust within communities
  - Evidence-base initiatives, driven by data
- **Building next level – APMs**
  - Integrating the care continuum

Medicaid in the Quality Payment Program

Speaker

- **Richard Jensen**
- Senior Policy Advisor, CMS Innovation Center

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What is the Quality Payment Program?

Medicare Payment Prior to MACRA

- **Fee-for-service** 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.
- <u>Two tracks to choose from:</u>

Advanced Alternative Payment Models (APMs)	or	The Merit-based Incentive Payment System (MIPS)
If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.		If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

Advanced Alternative Payment Models

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 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.**

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

QPs:

- Are excluded from MIPS
- Receive a 5% lump sum bonus

Receive a higher Physician Fee Schedule update starting in 2026

What is a Qualifying APM Participant?

- Qualifying APM Participants (QPs) are clinicians who have a certain **percentage 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.

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 https://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 (Certified Electronic Health Record Technology (CEHRT))
- Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
- ACO Track 1+
- New Voluntary Bundled Payment Model
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

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 Advance 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

- 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

Where can I go to learn more?

Help Is Available: http://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. To find help in your area, go to: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

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 at: http://qioprogram.org/contact-zones?map=qin.

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.

Reactor

- **Heather Howard**
- Director, State Health and Value Strategies, Princeton University

Discussion & Questions

Key Takeaways

- APMs can be targeted or broad based, with a trend towards broad, population-based models
- Outcomes and costs related to BCN populations can make the difference between success and failure under APMs
- If APMs fail to recognize the increased risk associated with the BCN population, providers may be reluctant to agree to payment models or serve BCN populations
- It is important to build bridges between medical and community services to create successful BCN and APM models
- Medicaid agencies pursuing BCN initiatives and related payment models should consider capitalizing on MIPS and Advanced APMs

Resources

- Health Care Payment Learning and Action Network Alternative Payment Model Framework
  - https://hcp-lan.org/workproducts/apm-whitepaper.pdf
- Health Care Payment Learning and Action Network Progress Tracking
  - https://hcp-lan.org/groups/apm-fpt-work-products/apm-report/

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