

## TRANSCRIPT

WEBINAR TITLE: Aligning State Medicaid Value-Based Payment Approaches with MACRA Policies and Measures  
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### SPEAKERS

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### PRESENTATION

Scott Leitz: Hello everyone and good evening or good afternoon depending on where you're at. This is Scot Leitz from NORC at the University of Chicago and I want to invite everyone to today's webinar on Aligning State Medicaid Value-Based Payment Approaches with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Policies and Measures. We're very excited that you're able to join us this afternoon to hear a number of excellent presentations on this topic. A couple of logistics as we get started with today's webinar. All lines will be muted. We do ask that you please don't put your line on hold since sometimes it can trigger hold music that will play in the webinar, as you have questions that come up, please use the chat box on the screen to ask a question or leave a comment on the presentations. The learning objectives will be that we're hopeful participants will learn how state Medicaid payment arrangements can qualify as Other Payer Advanced Alternative Payment Models (APM) under the Medicare Access and CHIP Reauthorization Act of 2015, commonly known as MACRA, Quality Payment Program (QPP). You should also be able to understand the criteria, qualification pathways, timelines and submission process for qualifying as an Other Payer Advanced APM. We'll be hearing from Ohio, and hopefully you'll be able to learn how Ohio uses an episode-based payment approach to align with MACRA requirements. Then we're hopeful that you will gain an understanding of the Health Information Technology infrastructure needed to support Advanced APMs. We have an excellent group of presenters today, you'll be hearing from: Richard Jensen, Senior Policy Advisor, Centers for Medicare and Medicaid Services (CMS) Innovation Center. You'll be hearing from Marjorie Yano, Payment Innovation Director, Ohio Department of Medicaid and Monica Juenger, who is Director of Stakeholder Relations, Ohio Governor's Office of Health Transformation. You'll also be hearing from Arun Natarajan, who is the Technical Director, Department of Health and Human Services, Office of the National Coordinator, or ONC, for Health Information Technology. As an overview of the agenda, we're going through the welcome and introductions right now. Then you'll be hearing from Richard Jensen, we'll pause after Richard's presentation, Richard will be presenting on an overview of the Other Payer Advanced APM Option under MACRA, then we'll pause for a Question and Answer (Q&A). We'll then hear from Monica and Marjorie Juenger who will be providing a presentation on Ohio's efforts to leverage the state's Value-Based Payment development to qualify as an Other Payer Advanced APM, then we'll pause after their presentation for a Q&A. Then we'll be hearing from Arun and we will pause after his presentation to go through a Q&A. With that, I'll turn it over to Richard.

Richard Jensen: Thank you Scott. So I have a little disclaimer here as we do with all presentations out of CMS. Moving right along. I wanted to talk to you today about the Quality Payment Program, and it grew

out of the MACRA legislation and requires CMS by law to implement an incentive program. This is for clinicians in the Part B program. Specifically we refer to it as the Quality Payment Program. And it provides for two participation tracks: first there is the Merit-Based Incentive Payment Program. Majority of clinicians will be in this program. A value-based program that provides incentives for meeting certain standards and other criteria. Today we have the Advanced APM models or program. Starting in performance year 2017, this program had clinicians that met certain requirements were allotted to be excluded from the Merit-Based Incentive Payment System (MIPS) reporting and adjustments and instead received a 5% lump sum incentive payment for their Part B professional services and obviously that was a significant incentive that Congress created for clinicians to pursue. Let me talk you through, explain a few parts/components to the Advanced APM program, then we'll jump to the all-payer combination option. Alternative Payment Models which I realize is a generic term has a specific definition in MACRA law. Any of the models put out by the CMMI Innovation Center, other than the Health Care Innovation Awards, the Medicare shared savings program is considered an Alternative Payment Model and then other demonstrations under the Health Care Quality Demonstration Program you can think of that as the universe of APMs.

Now Advanced APMs are a subset of APMs within Medicare, and in order for a model to be an Advanced APM it has to meet three requirements: participants need to use Certified EHR Technology (CEHRT), payments are tied to quality measures comparable to those in MIPS, medical home model or require participants to bear more than a nominal amount of risk. Those are the three key requirements for a model to be an Advanced APM. In order to count as a qualifying clinician, a QP and qualify for the 5% bonus, they must receive a certain percentage of payments through Advanced APM. They must have a certain level of participation in Advanced APMs. Now I wanted to jump ahead to get into the all-payer combination option that will be beginning during the 2019 performance year, meaning the third year in the quality payment program. The question arises why is the all-payer coming up at this time? I mentioned that becoming a QP requires a certain participation level. By law, beginning in 2019 that participation level will jump to 50%, the bar will be raised. Clinicians could get to 50% not only from Medicare, but include Other Payer Advanced APMs. It is the raising of that threshold which is why the all-payer is being rolled out in 2019. So what is an Other Payer Advanced APM? Well we've defined it as in certain groupings, literally it's any payment that is not Medicare. Specifically we think of it in terms of Title XIX or Medicaid payment arrangements potentially. Medicare health plans, which is more general terminology we use, which includes Medicare Advantage payment arrangements. We include payments arrangements that align with our CMS multi-payer models such as with Comprehensive Primary Care (CPC) plus models where we have commercial plans as partners. And finally, any other commercial or private payers.

So now we're going to discuss what it actually means to be an Other Payer Advanced APM. As I alluded to, we have three criteria. These are very similar although not identical to the criteria for Advanced APMs. One: it requires that participants use Certified Electronic Health Record (EHR) Technology, currently that 50% do so. Also provides payments for covered professional services based on quality measures comparable to MIPS quality performance categories. And third, and this is in many ways the most important, more complex criteria, it's an either or, either it's a Medicaid medical home model that meets certain criteria that is comparable to the Medical Home model expanded under the CMS Innovation Center or it requires participants to bear a more than a nominal amount of financial risk. I want to spend some time on this third criteria, both due to its complexity and its relevance. First of all, the first part of that refers to an expanded model by CMS, and to date we have not expanded a medical home model. So currently the first part of that criteria is not in effect. And therefore the nominal amount piece is and what that means is that any payment arrangement that is going to meet the Other

Payer Advanced APM criteria is going to have to have some downside risk. Let me talk about that now. So we put out a generally applicable nominal amount standard in our rules. We did that in two ways. One was to view it as an expenditure-based nominal amount standard and the second was to view it as a revenue-based nominal amount standard. In the first, by the way you can see that these have similarities as well. Both of the standards include a requirement that the marginal risk in the model must be at least 30% and that the minimal loss rate can be no more than 4%. The difference between the two is that the expenditure-based nominal amount standard has a requirement that the total risk be at least 3% of expected expenditures the APM entity is responsible for. In other words, there is a benchmark that is calculated so that risk is measured in that way. The revenue-based nominal amount standard says that in the next few time periods total risk must be at least 8% of combined revenues from the payer of providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue. In other words, it has to be designed as a revenue based model in order to use that particular standard. So we do have some flexibility here, although I think most models at this point in time would be consistent with the expenditure-based nominal amount standard.

I was mentioning earlier a Medicaid medical home model. We created this term because it wasn't in the statute. Although it wasn't defined in the Statute, it does crop up in many places and was instrumental to be a part of the Other Payer Advanced APM. It starts by saying that a payer arrangement where the participants are focused on Primary Care, it also must empanel patients to primary care physicians and that's our patient-physician link. Then there are seven options that the model must have, at least four of which they must meet to meet the criteria. In other words, four of those lines on the right side must be met in order for it to be a Medicaid medical home model. Just to give you some context this was designed to look something like a Comprehensive Primary Care (CPC) Plus model, if you are familiar with that, that's a good reference. I also want to point out that this definition only applies to the Quality Payment Program, it has no other relevance to Medicaid per se. So the reason we established this, for a large part, this definition was going back to the criteria, the third criteria I mentioned before, where there hasn't been a medical home model expanded by CMS and because of that we must apply downside risk. We realized that for clinicians that are in the Medicaid medical home models, accepting downside risk is problematic due to the populations they serve and for other reasons. So by defining the Medicaid medical home model we also created a different nominal amount standard. So for Medicaid medical home models we have the requirement here that the nominal amount of risk must be at 3% of revenue in the first year, 4% of average estimated revenue in the second year, and 5% in the third year which would be performance year 2021 and later. As you can see this is slightly less, not as high a bar for those particular models.

Now one of the interesting things of course is, when I was talking about the Medicare portion of the Advanced APM part of the program, those are all CMS models so we know all about those models we know whether they meet the criteria or not because we designed them. But the All-Payer Combination Option puts a burden on CMS to make determinations about the status of payment arrangements out in the marketplace. Again whether they be for Medicaid or commercial payers or Medicare Advantage (MA) plans, so we had to devise a way to get information from the marketplace and decide whether or not payment arrangements in fact are Other Payer Advanced APM. So what we did this year is we implemented two pathways beginning this year by which we can receive information on payment arrangements and make determinations. One is called the Payer Initiated process and the other is the Eligible Clinician initiated process. And the first thing you should notice is that the Payer Initiated process, we did with deadlines prior to the first Qualifying Participants (QP) performance year, meaning the beginning of 2019. We put out information and advertise communication etc.... to a variety of payers, including State Medicaid agencies to ask them to submit information on their payment

arrangements and provide us documentations such that we could do an assessment and determine whether they met the Other Payer Advanced APM criteria. For Medicaid that occurred between January and April of this year. Later on down the road, for most clinicians at the end of 2019, after the performance period is over, we will also have a process where they report on payment arrangements that they believe to be Other Payer Advanced APMs, but which we have not recognized through the Payer Initiated process. This Payer Initiated process was voluntary and we have no mandate and cannot require payers to submit this information, but we did get this information and we are in the process of posting what we have determined are Other Payer Advanced APMs on our website and then later in 2019, clinicians can look at this information and if they think they are actually in a payment arrangement that meets our criteria, but that has not been recognized, they can send that information into us after the fact. Obviously that is voluntary on their part although if it's reaching the participation rate in order to get the 5% bonus, it's necessary and you might not view it such much as a voluntary process.

Just to let you know, we did have time periods I'll go to in a minute. As I mentioned, the Medicaid time frame in particular - this is going to be an annual process. Starting next year we will be asking the same states if they want to send the same payment arrangements for the subsequent years. So in 2019, we would have a period where we will ask them to send in their payment arrangements implemented in 2020. We put out a lot of guidance materials on this. We have a Payer Initiation submission form that is automated, that you can get to through our website. We also did quite a bit of technical assistance, both with the state of Ohio and with a number of states and we can talk about this more in the future, but we will certainly be available to provide technical assistance really at any time a state is interested. I realize that this is kind of a complex program for states to get into initially and I certainly understand needing to spend some time on it and needing some assistance and we're certainly available to help with that. So we have posted the Medicaid payment arrangements that came in from State Medicaid agencies and we're in the process of posting Medicare Advantage and Other Payers, they should be up in the next couple of weeks.

I mentioned here there are some more details about the Eligible Clinician initiated process, it's going to be kind of the same process: they're going to have to submit details, fill out a submission form and provide us with some documentation, most likely of their contract with their payer to show us that it is in fact it meets the criteria and I think I don't need to say much more about that other than to note and I'm going to be talking in some more detail about this. The exception to the schedule I just talked about. Exception for APM entities or clinicians participating in Medicaid payment arrangements. We are in the middle of a reporting period. We are asking that eligible clinicians in Medicaid who believe they are in an Other Payer Advanced APMs that we have not recognized to send in the information right now. In other words, before the 2019 period. It's a little complex, it happens that there are some reasons to exclude Medicaid payments when we calculate participation rates. It's one of the few payment groups where we can exclude payments and therefore it's important to educate Medicaid clinicians on which payment arrangements are in fact Other Payer Advanced APMs to have a total list prior to the performance period of 2019. Therefore we have an earlier submission time for them.

This is a timeline and I've spoken to some of this, but just to let you know again that this year we had some submissions from States in January. The deadline to submit was April 1<sup>st</sup>, 2018. We spent the summer looking at the submissions and then we posted on September 1<sup>st</sup> which Medicaid APMs we felt were Other Payer Advanced APMs and the deadlines for the Eligible Clinicians (ECs) I was speaking to will be November 1<sup>st</sup>, 2018. I won't go through the other payers right now for the limited amount of time, but you can see that we have similar flows for the other payers in terms of timing.

Okay I mentioned the Medicaid submissions. We had a payer process which we mentioned earlier in the year, we opened up earlier this month and it continues to be November 1<sup>st</sup> where eligible clinicians can submit information and that includes the name of the payer, the payment arrangement, a description of the payment arrangement, specifically addressing the criteria. In other words, is CERT required, what are the quality measures used and are payments tied to that and finally, can you describe the financial risk and nominal amount standards that the payment arrangement has in place. So that's what we're in the process of asking Medicaid clinicians to submit at this time.

Again, these are timelines I already mentioned that most of these early in the year, was the states submitting things and currently we're taking submissions from clinicians. We will revise the Medicaid list of Other Payer Advanced APMs by December of this year based on submissions we get from clinicians.

So this is the output of this year's termination process. As you can see, four states sent in information about their payment arrangements that we determined were in fact Other Payer Advanced APMs. I won't go into a lot of detail here and you'll be hearing from the state of Ohio, but you can see that we had a couple of episode-based models come in. We had one Accountable Care Organization (ACO) model come in from Massachusetts. Washington sent in three models for one of their Managed Care Organizations (MCOs) and we do require MCOs to submit all of this in the Medicaid program through the state agency. And so three of their models were determined to be Other Payer Advanced APMs.

I am just getting close to the end of my time I just wanted to mention, and by the way, this is all on our website. I just wanted to mention that this was an interesting year in working with States. We certainly provided technical assistance to more than the four states that submitted this year. We did not hear or get submissions from them. As you can imagine it could have been for one reason or another, but I expect that next year we will have a larger group of states submitting as states are getting used to this program and are understanding it better and as we've said, we certainly can provide assistance through during the year to help you. I think Scott that's it for me now.

Scott: Richard, great, thank you so much for that great overview. We do have time for questions and I want to again remind people to use the chat box to submit your question and we do have a couple that have come in Richard if I can start with one. The first one is, is one-on-one support available to better understand whether a state APM model in development could count as an Other Payer Advanced APM.

Richard: So there are a few things. As I mentioned we do have material on our website. You can see fact sheets and get a better description of what we're doing. In terms of one-on-one support, as I've said both myself and some other people on my staff are really available at any time if a state has some questions for us. There is no commitment to this just asking us questions, we're happy to talk about concepts about the criteria. If you want to submit off the application line, submit materials and get into some deep discussions as far as meeting the criteria we're happy to have to do that and really between now and January 1st is a good time to be talking with us because the window will be opening up again the following year to take submissions in January.

Scott Leitz: Thank you and thank you for making yourself available for those questions. Another question was a clarification question: can the speaker explain a bit more about why the Medicaid arrangements might be excluded from the Advanced APM methodology calculations.

Richard Jensen: Sure, and it's a very good question and I was running through a lot of material here. The All-Payer Combination Option and Scott I think we'll have an appendix that will go along with this presentation. Where it shows how we actually make the calculations and quantify whether a particular clinician or APM entity has enough participation from other payers to get the 5% bonus or not. The statute is very clear it doesn't say we have Medicare calculations and then we're going to have calculations of Other Advanced APMs that you're involved with. It says, All-Payer. As it turns out, when we run the ratio, in other words, of your payments or patients relative to your overall payments or patients. In the numerator you can think of as your payments or patients associated with Advanced APMs, whether they are Medicare or Other Payers and then denominator is all of your payments or patients, it's a straight ratio. In terms of putting that numerator and denominator together, the law requires that we include all of the payers that the clinician receives payments from. In other words, they're not just bringing in payers for whom they have a relationship that they're working with an Other Payer Advanced APMs. They have to bring the other payers in whether or not those other payers have an Advanced APM. The issue with regard to Medicaid and excluding Medicaid, one exception in doing that calculation was with regard to Medicaid. What the law says is if the Medicaid program in your state does not have Other Payer Advanced APM you can leave Medicaid out of that calculation. In other words, you can exclude all Medicaid payments from the denominator. So you can see that can have a significant impact for clinicians when calculating their participation rate if they're in the All-Payer Combination Option. So we needed to recognize all Medicaid Other Payer Advanced APMs around the country prior to the 2019 period beginning. Because if there was something that was in a particular state a clinician would want to get in and participate in it. I hope that explains it; I realize this is kind of a technical issue, but that was the reason why we excluded Medicaid.

Scott Leitz: Thank you very much Richard in helping to clarify that. So in thinking, if a state is considering looking at an Other Payer Advanced APM. Do you have any thoughts on maybe one or two practical pieces of advice or guidance you want to give them?

Richard Jensen: Well, aside, if you want, trying to really figure this out aside from giving us a call and getting some technical assistance (TA) my guidance. My advice is taking a close look at the criteria, the three criteria I mentioned and look at our regulation and our material describing that, and we have a lot of material talking about it on their website. Most people in the field are very familiar with CEHRT and adoption of that and that's not terribly difficult. There are some specifics about the quality measure issue that you want to take a look at. We do require that the quality measures be reliable and valid etc... that you're using. I think the one you really want to focus in on is the nominal risk standards we use and try to get an understanding of that, because they are multi-dimensional: there is marginal risk, minimum loss rate, and then total risk. Take some time to look at that and see how they translate with your particular model. I think Ohio is going to talk a little bit about this in a minute: how it played out with them. We know that models are not necessarily designed with the marginal risk component per se and a minimum loss rate etc... But we do interpret those standards and walk through them. I guess my advice is to take a look at our regulations and explanations of them of the nominal risk side and see if it makes sense within the context of what you're doing with your payment arrangements or what you're planning to do and then let's have a talk and see if we can help you some.

Scott Leitz: Great, thank you Richard. One additional question has come in, and that's has the program proven to be more or less challenging for states who have or have not expanded Medicaid coverage?

Richard Jensen: Boy, that's an interesting question. I have to actually say that I have not looked at that question specifically. If you look at our list, off the top of my head I think three of this states expanded

and one did not. I have not had that come up as an issue and perhaps Ohio can address that better than I. We have not seen any patterns particularly, we don't have a big enough number here. I did not see it affect any of their terminations one way or another.

Scot Leitz: Great, thank you. What additional one that has come in is that given that Medicaid beneficiaries are among the most vulnerable patients. Does CMMI intend to evaluate or monitor utilization and outcomes to ensure that the models are working as intended? If so, can you say a little bit about your evaluation and monitoring plans?

Richard Jensen: Sure. One thing is that QPP and Advanced APM and Other Payer Advanced APM, we are assessing your participation rate. If you look at everything I've discussed today we're not actually monitoring how well clinicians are doing within their models or with how well the models are doing. We're simply saying: does this payment arrangement meet our criteria and what's the participation rate. It's a targeted incentive payment to get into these arrangements and participate in them. We do not know. How well you're doing within the model itself does not impact whether you become a QP and receive the bonus payment. I will say, however, obviously with our own models on the Medicare side we are obviously monitoring and evaluating each of those. I would say that the Medicaid models themselves, we are not going to be involved with evaluating those directly. We are going to be making sure that our program works well and they'll be some follow-up to make sure the state models in fact do meet their criteria over time and taking a look at that and seeing how well our part of the program works. But if the question relates to how well the individual state models are working per se, we're not the group that's going to be doing that. There are other entities and offices that will be taking a look at that.

Scott: Great, thank you so much Richard. Thank you for your presentation today I think with that we will move on to Marjorie and Monica from Ohio, so I will turn it over to them.

Marjorie Yano: Great, thank you so much. Again, thank you for teeing us up for our portion of the conversation. This is Marjorie Yano, the Payment Innovation Director and Monica Juenger from the Governor's Office of Health transformation. I also have with me Emma Esmont who is part of our Payment Innovation Team at the Department of Medicaid. All of us will be tag teaming to share this information with you today.

A quick overview of things we want to cover today and opportunity to highlight work Ohio did, once we realized we had the opportunity to apply as an advanced APM and some of the work we did to develop that application and make sure how do we talk about this model developed and designed before this opportunity and how do we use language that makes sense for the application and are able to articulate meeting the criteria that Richard just outlined.

We'll go through a number of things, including the ways that we talked about, describing how we are meeting the three criteria. First just an overview of our stakeholder process for two models, so Ohio received a State Innovation Model (SIM) grant, and through that grant work we are implementing two programs in the state of Ohio. The first is the Patient-Centered Medical Home (PCMH) Program- Ohio's CPC plus program. Ohio's Comprehensive Primary Care. The second is our episodes work which is what we applied and qualified for as an Other Payer Advanced APM.

The vision is - we had a governor's advisory council on healthcare innovation design teams to help design both of these models and programs they would eventually become and then specifically on the episodes side, we just wanted to highlight the ways we connected with providers during the design stage.

For all of our episodes, especially our early episodes, we have a Clinical Advisory Group (CAG) where we reached out to providers through associations, hospitals, to really get that clinician view and input as we were designing our episodes and model in general. These met periodically during the design phase- for example if you were developing asthma exacerbation, in first episode wave to launch, it launched in 2015, the CAG for that particular episode met between November 2013 and January of 2014 - four meetings about two hours in length with 25-30 clinicians participating. A lot time spent with that group to get input, discussions, and really make sure we are getting clinical input as we were putting together each of our episodes.

Out of that design process, this next slide shows where we are. Ohio has launched 43 episodes to date- as I mentioned our first wave of episodes went into reporting in 2015 currently we have 9 episodes that are tied to financial incentives. From this page those are in bold and italics. A series of those began its performance period in 2016 and another set of those began its performance period in 2017. And if these 9 episodes that are currently linked to financial incentives that we highlighted in our application for QPP- we do have a number of episodes that are remain in reporting only.

It's just a little bit additional information in particular around these 9, so to orient folks to some of the elements of episodes as exist for Ohio, the first column you'll see here is the name of the episode, and next to that we have a column which describes a Principle Accountable Provider (PAP) which we describe in Ohio as the quarterback of an episode. And really it's the provider who is in the best position to direct care over the life of the episode including around things such as quality and cost. The episode trigger is that thing we look for to know that an episode is occurring or has occurred and I will note that our model is a retrospective model and we pull all of this from claims, it is a claims based program.

We also define the age range we're looking at for a particular episode as well as the duration. An episode may or may not have a pre-trigger window and or a post-trigger window, a time period before and after where we want to look at. For example for perinatal, we want to look at that prenatal care and also post-natal care. We capture those in the pre- and post-natal windows. And finally, we'll go into this into more detail in a later slide, we have identified quality metrics for each of our episodes. A number of those quality metrics are linked to payments such that in order for a provider to be eligible to earn a positive incentive payment or gain sharing they need to be meeting and passing those quality metrics. These episodes also have a number of quality metrics that are not tied to payment but which are included on our reporting for informational purposes only. And again, same information on this next slide for the remaining 4 episodes- tied to financial incentives.

Now we want to start talking through how we worked to articulate that Ohio's episode model meets the criteria that Richard laid out so nicely earlier. So just as a note the slides we are about to walk through for the most part are entirely what we submitted as part of our application process. So just for you all to know these are in fact what we shared as part of that application. So with respect to our threshold, this

first slide is what we call our PAP curve. This is simply an illustrative version of it, this is not real, but each vertical bar represents an individual PAP and specifically represents the average cost for our PAPs- they are average risk-adjusted for reimbursement for episode. We'll go into some details in next slide, but generally when we look at these thresholds for our episodes model, when we look at our acceptable threshold, any provider that is above this acceptable threshold so those in red to the left of the slide those are the providers that would be eligible for what we call a negative incentive payment, which is risk- sharing.

Again this will come up a number of times one of the things we really worked on in developing our application is how to take language that we used to describe our Ohio model and translate it into the language that CMS uses in the QPP worlds and Advanced APM language for that application. Negative incentive payment would translate to risk-sharing. Our commendable threshold, the horizontal line in green, providers that fall below that line, so those that are in green to the right hand side of the PAP curve, those vertical bars in green represent PAPs who are below the commendable threshold on spend and who are also meeting applicable quality metrics and are therefore eligible for what we call positive incentive payments or gain sharing. Providers noted in blue are those that while they may be below the commendable threshold on spend, are not meeting quality metrics and so we do not issue positive incentive payments to those PAPs. And then I'll touch on our positive incentive limit on our next slide.

Like I mentioned as we were working on our application and articulating how we meet the qualifications for QPP, this first bullet highlights one of the areas where we needed to translate language so our acceptable threshold is the target cost, it represents the highest cost Medicaid can accept for a given episode and above that there is some risk. The commendable threshold again at which providers will be rewarded as long as your quality metrics are met and obviously this is driving towards performance. And I mentioned that positive incentive limit is the point at which a provider is still rewarded but the reward is capped and this is to avoid driving savings beyond the point where we can reasonably expect quality care. Not wanting to drive costs so low that it is at the expense of good quality care for our Medicaid members. And then anyone falling in between the acceptable and commendable threshold are in a neutral zone and they don't see any risk or gain-sharing.

Then just a few notes on how we determined our threshold, when we were developing thresholds for particular episodes we start with setting the acceptable threshold so that target cost or the line which determines if a provider is at risk for a negative incentive payment. And we set that acceptable threshold at an all-Medicaid level such that 10% of providers are above the acceptable threshold that would be subject to a negative incentive payment assuming there is no behavior change. And then to set the commendable threshold, that threshold is set such that at the all-Medicaid level you're getting budget neutrality between the positive and negative payments that would be assessed.

And so then when we calculate those payments, our payments are, the thresholds are set at the all-Medicaid level we actually calculate payments at the individual payer level, so in Ohio we have 5 Medicaid managed care plans, all of which are required to participate in this model and we also still have some portion of our population in fee-for-service and the incentive payment amount for PAPs is at 50% once we get that number.

Emma Esmont: So this is Emma, taking over for this slide. So when we were looking at our QPP application, we wanted to look at aligning our program with QPP as it related to the risk methodology. So the first requirement was marginal risk the APM entity potentially owes or forgoes at least 30%. So in Ohio our principle accountable providers or PAPs are accountable for 50% of the spend proportionate to the difference between their average risk-adjusted spend in the acceptable threshold. The next requirement was that the minimum loss rate (MLR) in which the APM entity operates is no more than 4% so in Ohio the principle accountable providers are assessed a negative incentive for the risk adjusted spend of any amount above the acceptable threshold, therefore the MLR is 0% and the total risk in the last requirement was the total risk the APM entity potentially owes or forgoes is at least 8% of total revenue and for that our principal accountable providers are at risk for 100% of the total amount calculated to determine their negative incentive.

Great, so next we'll dive into some of our episodes of care quality metrics and how we described those for purposes of our application. So as I mentioned in the beginning of the presentation we have 9 episodes that are linked to payment and then we went through some additional details about our CAG process for those episodes. So just an additional rundown on this slide of participation, in-person meetings, and then representation from a number of our large provider systems within the state, and then again, a number of our provider associations also participated. And just to reiterate again, the purpose of this was just recognizing the importance of that clinical perspective in the development of episodes and particularly in the space of quality metrics- what does it make sense for us to be measuring when it comes to quality and how best to do that. So recognizing that it is that critical to get input during the development phase.

So here we have for our application, we identified these examples of externally endorsed comparable measures and found them through a number of sources including MIPS and National Quality Forum (NQF) internal articles to support the measures and to demonstrate that Ohio's quality metrics are valid and reliable. And I think this was also one of the areas where because we relied and used our CAG process, a number of our quality metrics have some variation with these externally endorsed comparable measures to make them sort of Ohio specific and really targeted at our provider population our Medicaid population. To Emma's point, we found these as examples of comparable measures to what we use for our episodes model.

The next part of the application was around the use of Certified EHR Technology in the space. So this dashboard here displays, is from the Healthit.gov website and this demonstrates that 76% of Ohio physicians have adopted Certified EHR Technology so we know that providers are using EHRs in the state at a pretty high level. And then this map also from the Healthit.gov dashboard shows that 100% of all eligible Ohio hospitals have demonstrated meaningful use of certified Health Information Technology (IT). So again we know that we have good saturation with Certified EHRs in the state.

So I provided that background to say that even though the episodes of care model does not have a formal requirement for the use of Certified EHR Technology we are confident that at least 50% of Ohio Medicaid providers participating in Episodes of Care are using Certified EHR Technology. And I will note here that our approval is contingent on a change to the Certified EHR criterion included in the calendar year 2019 physician fee schedule proposed rule that states that would require a payer or eligible

clinician to provide documentation to CMS that for calendar year of 2019 Certified EHR Technology is used to document and communicate clinical care under the arrangement by at least 50% of the eligible clinicians. And with that, we're onto questions.

Scott Leitz: Great thank you Ohio for that great overview of your approach. A couple of questions have come in. One is, how long do beneficiaries in Ohio have to be seen by a particular provider in order to be attributed to that provider for purposes of payment and quality measurement?

Monica Juenger: Hi, so this is Monica Juenger, with the Governor's Office of Health Transformation. This is a great question, so the duration of the episode is really dependent by the episode definition and each episode has its own as Marjorie described, has its own trigger window that may or may not include time period before the actual event and time period after the actual event. The most perfect example of an episode is a perinatal episode. A pre-trigger window, as you can imagine, is actually a very long episode, the pre-trigger window is actually the duration of up to 9 months prior to the delivery of a baby and the post-trigger window for a perinatal episode for a baby is 6 weeks after the birth of a baby. In that particular episode, which I think is actually our longest episode as you can imagine, Medicaid does deal with churn from a general standpoint and there are other factors that may determine whether a person is eligible, an attributive member a person is within or considered what we call a valid episode within uh the definition of the episode itself. So you know, long-story short it really depends by episode but certainly hear the concern that other factors could play a role in the amount a churn of a Medicaid program.

Scott Leitz: Great, thank you. Another question, if Ohio were to give maybe one or two pieces of practical advice to maybe states that are considering looking at the advanced payment option, what advice would you give, if given that opportunity?

Monica Juenger: So really what we benefitted from, in particular with this application and working for becoming another advanced APM, we had the good fortune of talking with our friends in Tennessee. Tennessee has also implemented an episodes of care model that is similar but in some ways different from Ohio's model.

So it was great for us to dialog with them, as we were working on our application to just brainstorm, talk things through that was I think very invaluable to us. And certainly also, to Richard's earlier point we had great support from our federal partners in some conversations as we were getting ready to submit our applications so my advice would be if you have another state that is in a similar boat, to reach out and have some conversations. I know we're always happy to have those conversations as well and then certainly engaging the federal folks for guidance and conversation as well.

Scott Leitz: Great thank you. Another one has come in. And this might be our final question. Do you know how many providers will prospectively qualify for All-Payer Combination Options in Ohio with the episode model fulfilling the Other Payer aspect of the Option?

Monica Juenger: That is a great question and unfortunately I don't have numbers in front of me to know that answer off the top of my head.

Scott Leitz: That's a very fair response. Thank you Ohio for that wonderful overview of your approach. With that we will turn it over to Arun.

Arun Natarajan: My name is Arun Natarajan. I am with the Office of the National Coordinator for Health IT. Just to follow up on what Ohio just said, states are always able to contact ONC or CMS and get technical assistance from us or advice. You can chat us up and we can share perspective based on the work that we're doing with all 50 states, District of Columbia and the five territories. One of the interesting things to think about is the four states Richard talked about, Massachusetts, Ohio, Tennessee, and Washington, were states that were receiving active technical assistance as part of the SIM grant program. In that regard, all states were required to develop Health IT plans and think about how they impacted their operational plans, and in many ways, all four states benefited from that experience as they moved into these Medicaid alternative advanced APMs. I would like to start off the discussion, as we're thinking about Health IT, by taking a quick step back. At this point, with over 7 to 10 billion dollars spent on EHR incentive payments through the meaningful use incentive program, now called promoting interoperability program (same program, different name), there's been a lot of spend and infrastructure laid down at the provider level in terms of adopting Certified EHR Technologies.

One of Richard's slides, which I'll be reiterating and talking about in a few moments here is three requirements for the Other Payer Advanced APMs are: At least 50 % of eligible clinicians use Certified EHR Technologies, that meaningful use program really laid infrastructure and foundation for a lot of physicians and clinicians in hospitals already having adopted Certified EHR Technology. Base payments on quality measures, comparable to those in the MIPS quality performance category. Understanding the Health IT infrastructure to advance the collection and reporting of quality measures is significant. Again, the second bar here, as we go from meaningful use to Health Information Exchange (HIE), is your HIEs are very well equipped in many of your states to help capture and collect quality measures. As we kind of move across the spectrum here, what we see here is that in a very simplistic way, Health IT began in many ways with meaningful use has moved into Health Information Exchange, we are seeing a lot of delivery system reform and then Value-Based Payment models and ultimately thinking about population health. And Health IT needed to support this continuum (as we get towards population health), is what I want to focus on.

This next slide you can't see the little boxes in the yellow square there, but further on in the deck I tried to expand them. But what they includes is all of the data sources – 1<sup>st</sup> stack is digitized clinical data, 2<sup>nd</sup> column or stack – claims data, 3<sup>rd</sup> stack – other digitized survey data sources (beneficiary surveys like Consumer Assessment of Healthcare Providers and Systems (CAHPS), plan surveys, 4<sup>th</sup> silo – administrative data sources, 5<sup>th</sup> silo – registry, 6<sup>th</sup> stack – patient generated health data. This is not meant to be all-inclusive, but there is a whole lot of data out there. When thinking about Health IT infrastructure that states are trying to develop that support state needs, health plan needs, provider needs, and beneficiary needs, all those data sources need to come into play and be viewed as somewhat interoperable. So that data sitting on left side, and then you have stack – the Health IT modular infrastructure to support these programs. In general, we think about the stack at ONC as being the Health IT modular infrastructure to support the state defined objectives of their Medicaid program (whatever they might be). So whatever those state defined objectives are, all of these boxes to varying levels need to be ticked off.

I would like you to take a minute right now and look at these boxes and ask yourself, do you understand what each of these boxes is trying to get?

As we look at foundational components of these boxes – we see governance, policy, legal, financing, and business operations. That’s the foundation. Foundation is that it’s important in the governance box, to get your payers/providers/patients together, have everyone agree on the goals of health care plan/or what the objectives are, once defined goals to get clearly understood, how are we going to measure success? Then we can discuss how to get information flowing in order to measure that success. This doesn’t sound like it’s in Health IT, but it actually is. Getting all stakeholders – state, provider, and beneficiary stakeholders together so there’s clear understanding and a shared vision around what it is that we’re trying to do and how we’re going to measure it and supporting each other to share information so that we can measure it to define success and view success is really critical for effective information flow.

When we break into questions/answers, if you have a questions on what maybe a routing hub is or a consumer tool? Please jot it down and then when we’re done with segment, we can address them.

So this modular infrastructure to support data and information flowing - is the technical assistance that ONC provides to states. We help states think through what each box means for state infrastructure and how they can help build out these boxes where they need them to be built out, and how they can interoperate with their health plans and providers.

As we continue to think about Health IT infrastructure in context of these other alternative payment models, why do we need to think of Health IT? We clearly saw that in the case of Ohio, we saw that many of their measures as well as the way in which they were measuring, their alternative payment models being done retrospectively through claims based measures. There are other ways we can think about other APMs other than retrospective payment approach. Health IT capabilities are critical in a couple of areas, including clinical data capture at the point of care, care coordination management, quality measurement (we need to think about e-specified measures originally for the basis of quality, but ultimately as these Other Payer Advanced APM criteria indicate, not only for the basis of quality, but also for the basis of payment), data aggregation and attribution are critical (as we move beyond just claims based measures, we need to ensure we understand attribution. This is identity management, this looks at who is an individual and knowing who is an individual in terms of, is John Doe the same person as John C Doe? That fundamental notion of being able to electronically understand who a person is and identify unique individuals and track events that are occurring to an individual across the entire Health IT eco system and to be able to aggregate all encounters that the individual had, are critical. And that is one of the ideas data aggregation and attribution are trying to get at. Risk scoring and financial management also can have a heavy Health IT infrastructure component.

As we think about the notion of VBP and Other Payer Advanced APMs, the LAN framework was very helpful here at ONC. We use this as a go to when providing technical assistance to states. On one end, we look at FFS (no link to quality and value) and then as we move from volume to Value-Based Payment, LAN has these categories, they go from categories 1 to 4. Category 2 – we are looking at FFS, and then Category 3 - APM built on FFS architecture, and ultimately Category 4, which is population based payment.

As I mentioned earlier, the Other Payer Advanced APM criteria - there are three of them. First, is at least 50% of eligible clinicians using Certified EHR Technology. ONC oversees Health IT certification program, where private vendors can come and get their technology certified for various functionalities.

Understanding the requirements for certification can be found at [healthit.gov](http://healthit.gov) with certified Health IT playbook and finding a list of certified Health IT products which can be found at “the chapel,” which is the certified Health IT product list. And both of these URLs are included here in the presentation.

As we understand the notion of meaningful use in MACRA, of the three categories here, three real pillars here: Number one it requires at least 50% of eligible clinicians are using a Certified EHR. Second one, is that they are basing payments based on quality measures, and quality measures ideally are e-specified. E-specified quality measures being used for basis of quality and in this case, ultimately used for the basis of payment.

This next slide is a little complicated but we are trying to distill three things. One, that the providers that we are dealing with, are dealing with multiple payers. Their requirements are multiple and sometimes incredibly burdensome. And at the state level, we need to be thinking through, in the context of Medicaid Other Advanced APMs, we need to be thinking through the Health IT infrastructure that can support service delivery, population health, and alternative payments. And that Health IT infrastructure needs to be ensuring that services are coordinated, that measurement (both quality and financial) can be e-specified, and ultimately, that e-specified quality measures can be used for the basis of payment. And those data information sources on the third column there are really focused on financial and claims based data, clinical data, and non-clinical data.

Earlier on, I referenced a box of various data sources. This is that data source box a little be more expanded. So when we are thinking about e-specified measures – here are some priority use cases we have for clinical quality measures as we think about quality improvement, administrative efficiencies, and population health. As we think about this notion of quality improvement, we break into care delivery and reimbursement. This is a good visual we use to think about how do we understand quality measure information. And as we think about quality measures and that continuum, at a very basic level, all states can immediately run with quality measures that are claims based quality measurement. Moving towards self-reported quality measurement to live automated data feed to thinking about integrated data feeds, which is the intersection between claims and clinical data and other data sources.

Choosing a strategy for EHR data for quality measurements is also critical thing to talk about and here we’re talking about both measure extraction and data extraction. The ways we can think about clinical quality measurement, there are multiple ways you can do it. This is a high level approach. As we’re trying to build our other advanced APM criteria, these are again different ways we can think about that. Questions?

Scott Leitz: Is there support available for states that would like guidance on advancing Health IT to support advanced APM approach?

Arun Natarajan: ONC is here to provide support. We have a team for looking at states and multiple ways we can provide that support. You can reach out to Arun directly or to CMS colleagues and they can channel you to appropriate ONC contact.

Scott Leitz: As states consider advanced APMs, recommendations how they should go about assessing IT needs that might be there for providers or others?

Arun Natarajan: When assessing IT needs at a state level – seven different areas that kind of give you main considerations: Data sources, data flow, and technology; timing - immediate needs, long term/short term needs; location of technology and transport mechanisms; workforce and technology; financing and governance, patients/providers/payers to table and clear understanding of goals of the system/how to define goals/legal mechanisms to see if goals have been met; policy and privacy, as we go beyond claims based measures, we'll be confronted with 42 Code of Federal Regulations (CFR) Part 2. And then we provide implementation guide in identifying ten key activities in this slide deck – this can also help with how you can identify state Health IT needs.

Scott Leitz: Can you provide an example of how health system made some advances in Health IT infrastructure to meet the needs of Advanced APM.

Arun Natarajan: Care coordination and having planned coordination activities around chronic and preventative care. Tennessee has care coordination platform and portal for PCMH program and has been leveraged across state. Speaking about electronic care plan capture/sharing and having clinical decisions support based on that, this is something that need to happen across our program. These are infrastructure components that is going to support our systems for many years to come. This has been an opportunity that when states have seized it, they have had the ability to begin a process of transforming.

Scott Leitz: How long do patients have to be seen by a particular provider to be attributed to that provider for purpose of given model?

Richard Jensen: We would rely on states model for how they do that themselves. When we have clinicians report into us, we'll use the same snapshot period that we use for Medicare Advanced APM programs. The snapshot periods are participation from January 1 to March 31; or January 1 to June 30<sup>th</sup>; or June 1 to August 31<sup>st</sup>. We have those three snapshot periods and then just for the Medicare program, the APM entity or clinicians can choose one of those three snapshot periods for participation rates. That's really all I have to say about the attribution issue.

Scott: Great, thank you Richard. Well I want to first start by thanking all the speakers today, Richard and Arun, and the Ohio team. You all provided really great overviews related to this issue both from a state and federal perspective. Some of the key takeaways from today's MACRA alignment webinar really relate to that MACRA provides opportunities and payment incentives for providers and health plans to move into top models of payment that reward high quality and cost-effective care. State Medicaid programs have an excellent opportunity to leverage MACRA and align their Value-Based Payment approaches to enable providers to participate. As Arun indicated, Health IT adoptions can definitely play a critical role in not only underpinning the advancement of Value-Based Payment arrangements but also in qualifying as an Other Payer Advanced APM and as we heard from Ohio, states such as Ohio are taking the lead in aligning their Medicaid Value-Based Payment approach with federal legislation by advancing an episode-based model that meets the MACRA requirements. And there are other opportunities and we would encourage you to look at those and certainly engage with Richard and Arun and others as you think about that. In closing, we want to thank you for joining today's webinar, it was a very rich discussion, a lot of really wonderful information. Please fill out the short feedback survey, this

will help guide some future developments, and give feedback on how today's webinar went. With that, we will close the webinar and thank you for participating today.