Medicaid Innovation Accelerator Program

Aligning State Medicaid Value-Based Payment Approaches with MACRA Policies and Measures

September 26, 2018
2:00 PM – 3:30 PM ET
Logistics for the Webinar

- All lines will be muted
- Please do not put your line on hold
- Use the chat box on your screen to ask a question or leave a comment
Learning Objectives

By the end of this webinar, participants will:

• Learn about how their state Medicaid payment arrangements can qualify as Other Payer Advanced Alternative Payment Models (APM) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program

• Understand the criteria, qualification pathways, timelines and submission process for qualifying as an Other Payer Advanced APM

• Learn about how Ohio uses an episode-based payment approach to align with MACRA requirements

• Gain an understanding of the health information technology infrastructure needed to support Advanced APMs
Presenters

- Richard Jensen, Senior Policy Advisor, CMS Innovation Center
- Marjorie Yano, Payment Innovation Director, Ohio Department of Medicaid
- Monica Juenger, Director of Stakeholder Relations, Ohio Governor's Office of Health Transformation
- Arun Natarajan, Technical Director, Department of Health and Human Services, Office of the National Coordinator (ONC) for Health Information Technology
Agenda

- Welcome and Introductions
- Richard Jensen: Presentation providing an overview of the Other Payer Advanced APM Option under MACRA
- Q&A
- Marjorie Yano and Monica Juenger: Presentation on Ohio’s efforts to leverage the state’s value-based payment development to qualify as an Other Payer Advanced APM
- Q&A
- Arun Natarajan: Presentation on health information technology strategies for addressing payment models
- Q&A
OVERVIEW OF THE OTHER PAYER ADVANCED APM OPTION
Disclaimers

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but it is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides for two participation tracks:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

*If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.*

**OR**

**Advanced APMs**

Advanced Alternative Payment Models (Advanced APMs)

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

Quick Overview

- APMs are approaches to paying for health care that incentivize quality and value.
- As defined by MACRA, APMs include CMS Innovation Center models (authorized under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- Advanced APMs are a subset of APMs within Medicare. To be an Advanced APM, a model must meet the following three statutory requirements:
  - Requires participants to use certified electronic health record (EHR) technology;
  - Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
  - Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a more than nominal amount of financial risk.
- In order to achieve status as a Qualifying APM Participant (QP) and qualify for the 5% APM incentive payment for a year, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance period.
FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

Overview of the All-Payer Combination Option & Other Payer Advanced APMs
What is an Other Payer Advanced APM?

Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs under Medicare.

Payer types that may have payment arrangements that qualify as **Other Payer Advanced APMs** include:

- Title XIX (Medicaid)
- Medicare Health Plans (including Medicare Advantage)
- Payment arrangements aligned with CMS Multi-Payer Models
- Other commercial and private payers
Other Payer Advanced APM Criteria

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

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

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

3. Either: (1) is a Medicaid Medical Home Model that meets criteria that are comparable to a Medical Home Model expanded under CMS Innovation Center authority, OR (2) requires participants to bear more than nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures.
The generally applicable nominal amount standard for an Other Payer Advanced APM will be applied in one of two ways depending on how the Other Payer Advanced APM defines risk.

### Expenditure-based Nominal Amount Standard

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

### Revenue-based Nominal Amount Standard

- Nominal amount of risk must be:
  - Marginal Risk of at least 30%;
  - Minimum Loss Rate of no more than 4%; and

- For QP Performance Periods 2019 and 2020, Total Risk of 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.
A Medicaid Medical Home Model is a payment arrangement under Medicaid (Title XIX) 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.

Medicaid Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Other Payer Advanced APM.
The Medicaid Medical Home Model must require that the total annual amount that an APM Entity potentially owes a payer or foregoes under the Medicaid Medical Home Model is at least:
- 3 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2019.
- 4 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2020.
- 5 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2021 and later.
FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

All-Payer Combination Option: Determination of Other Payer Advanced APMs
There are two pathways through which a payment arrangement can be determined to be an Other Payer Advanced APM.

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

**Eligible Clinician Initiated Process**
- Deadline is after the QP Performance Period, except for eligible clinicians (ECs) participating in Medicaid payment arrangements.
- Overall process is similar for eligible clinicians across all payer types, except for the submission deadlines.
Overview – Payer Initiated Process

- Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers.

- This Payer Initiated Process will be available for Medicaid, Medicare Health Plans (e.g., Medicare Advantage, Programs of All-Inclusive Care for the Elderly plans, etc.) and payers participating in CMS Multi-Payer Models beginning in 2018 for the 2019 QP Performance Period. We intend to add remaining payer types in future years.

- Guidance materials and the Payer Initiated Submission Form will be made available prior to each QP Performance Period.

- CMS will review the payment arrangement information submitted by each payer to determine whether the arrangement meets the Other Payer Advanced APM criteria.

- CMS will post a list of Other Payer Advanced APMs on a CMS website prior to the QP Performance Period.
Overview – Eligible Clinician Initiated Process

- If CMS has not already determined that a payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or APM Entities on their behalf) may submit this information and request a determination. CMS would then use this information to determine whether the payment arrangement is an Other Payer Advanced APM.

- Guidance materials and the Eligible Clinician Initiated Submission Form will be provided during the QP Performance Period with submission due after the QP Performance Period.
  - Note, eligible clinicians or APM Entities participating in Medicaid payment arrangements will be required to submit information for Other Payer Advanced APM determinations for those Medicaid payment arrangements only prior to the QP Performance Period.

- CMS will review the payment arrangement information submitted by APM Entities or eligible clinicians to determine whether the payment arrangement meets the Other Payer Advanced APM criteria.
Advanced APMs

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

**Medicaid**
- **January 2018**: Submission form available for States
- **April 2018**: Deadline for State submissions
- **September 2018**: Submission form available for ECs
  - CMS posts initial list of Medicaid APMs
- **November 2018**: Deadlines for EC submissions
- **December 2018**: CMS posts final list of Medicaid APMs

**CMS Multi-Payer Models**
- **January 2018**: Submission form available for Other Payers
- **June 2018**: Deadline for Other Payer submissions
- **September 2018**: CMS posts list of Other Payer Advanced APMs for PY 2019
- **August 2019**: Submission form available for ECs
- **December 2019**: CMS updates list of Other Payer Advanced APMs for PY 2019
  - Deadline for EC submission
Advanced APMs

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

**Medicare Health Plans**

- **April 2018**: Submission form available for Medicare Health Plans
- **June 2018**: Deadline for Medicare Health Plan submissions
- **September 2018**: CMS posts list of Other Payer Advanced APMs for PY 2019
- **August 2019**: Submission form available for ECs
- **December 2019**: CMS updates list of Other Payer Advanced APMs for PY 2019
  - Deadline for EC submissions

**Remaining Other Payer Payment Arrangements**

- **January 2018** to **December 2018**: Other Payer Advanced APM determinations will not be made for performance year 2019. We intend to add this option in future years.
- **August 2019**: Submission form available for ECs
- **December 2019**: CMS updates list of Other Payer Advanced APMs for PY 2019
  - Deadline for EC submissions
**Medicaid Submissions**

Table 1: Steps for submitting Medicaid payment arrangement information to CMS for Other Payer Advanced APM Determinations

<table>
<thead>
<tr>
<th>Payer Initiated Process</th>
<th>Eligible Clinician Initiated Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the Payer Initiated Process, State Medicaid Agencies will submit information such as:</td>
<td>Like States, eligible clinicians would submit payment arrangement information such as:</td>
</tr>
<tr>
<td>• Name of Payer and Payment Arrangement;</td>
<td>• Name of Payer and Payment Arrangement;</td>
</tr>
<tr>
<td>• Description of how the payment arrangement meets the Other Payer Advanced APM criteria (CEHRT use, quality measure use, and financial risk); and</td>
<td>• Description of how the payment arrangement meets the Other Payer Advanced APM criteria (CEHRT use, quality measure use, and financial risk); and</td>
</tr>
<tr>
<td>• Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation).</td>
<td>• Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation).</td>
</tr>
</tbody>
</table>
# Medicaid Submissions

Table 2: Performance Year 2019 Timeline for Medicaid Other Payer Advanced APM Determinations

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Guidance sent to states; Submission Period Opens</td>
<td></td>
<td>Guidance made available to ECs; Submission Period Opens</td>
<td></td>
</tr>
<tr>
<td>Submission Period Closes</td>
<td>April 2018</td>
<td>Submission Period Closes</td>
<td>Nov. 2018</td>
</tr>
<tr>
<td>CMS contacts states and Posts Other Payer Advanced APM List</td>
<td>Sept. 2018</td>
<td>CMS contacts ECs and states and Posts Other Payer Advanced APM List</td>
<td>Dec. 2018</td>
</tr>
<tr>
<td>State</td>
<td>Payment Arrangement Name</td>
<td>Medicaid FFS or Managed Care</td>
<td>Availability/Location</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Massachusetts</td>
<td>Accountable Care Partnership Plan</td>
<td>Manage Care</td>
<td>Statewide</td>
</tr>
<tr>
<td>Ohio</td>
<td>Episode-based payments Model</td>
<td>Manage Care/ FFS</td>
<td>Statewide</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Retrospective Episodes of Care Model</td>
<td>Manage Care</td>
<td>Statewide</td>
</tr>
<tr>
<td>Washington</td>
<td>Community Health Plan of Washington -- Community Health Network of Washington Population-Based Payment Model (Adult/Blind or Disabled) Option B: Individual Community Health Center Risk</td>
<td>Manage Care</td>
<td>Statewide</td>
</tr>
<tr>
<td>Washington</td>
<td>Community Health Plan of Washington -- Community Health Network of Washington (CHNW) Population-Based Payment Model (Family/SCHIP) Stop-Loss Option B</td>
<td>Manage Care</td>
<td>Statewide</td>
</tr>
<tr>
<td>Washington</td>
<td>Community Health Plan of Washington -- Community Health Network of Washington Population-Based Payment Model (Family/SCHIP) Stop-Loss Option C</td>
<td>Manage Care</td>
<td>Statewide</td>
</tr>
</tbody>
</table>

Leveraging and Aligning State VBP Developments to Qualify as an Other Payer Advanced APM

September 26, 2018
Introduction and Overview

• Introduction
  o Opportunity to leverage ongoing VBP development to qualify as an Other Payer Advanced APM under MACRA
  o Importance of being proactive in seeking to sustain evolving payment arrangements and the move to VBP
  o Provider benefits in aligning Medicare and Medicaid APM participation

• Overview
  o Stakeholder process
  o Threshold methodology
  o Quality metrics
  o Certified EHR Technology
  o Qualifying as an Other Payer Advanced APM
Stakeholder process to design innovation models

Governor’s Advisory Council on Health Care Payment Innovation

PCMH Design Team

Episode Design Team

Vision

Model Design

Advisory Groups

PCMH Focus Groups

Patients + Advocates
Providers
Payers

Clinical Advisory Groups (CAG)

CAG 1
CAG 2
CAG...
Clinical advisory group process

1. State calls for nominations of clinical experts from around the state to advise on Episode of Care design. Nominations are solicited from relevant specialty societies, Medical Associations, provider organizations, hospitals, and private practitioners. Nominations are limited to providers who practice in a specialty related to a given episode (e.g., obstetricians for the perinatal episode).

2. Providers are notified of their nomination into the CAG.

3. CAGs meet 3 – 4 times (~2 hour meetings) over the course of 6 - 8 weeks to discuss the ‘base definition’ and provide input on elements of the episode definition, including quality measures:
   - Nationally syndicated quality measures are considered when developing Episode of Care base definitions
   - CAGs operate like consensus-based entities, using clinical guidelines to refine quality measures specific to each episode
   - Analytics on quality measures are performed to model how principal accountable providers (PAPs) perform on quality measures as defined, based on historical data.

4. CAG members provide input on all elements of the base definition and final episode definitions incorporate CAG recommendations.

Example:
Asthma Exacerbation Clinical Advisory Group

- Number of meetings: 4
- Number of clinical experts participating: 25-30
Ohio’s reporting and performance years by episode wave

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>Acute percutaneous coronary intervention (PCI), <em>Asthma exacerbation</em>, <em>Chronic Obstructive Pulmonary Disease (COPD) exacerbation</em>, Non-acute PCI, <em>Perinatal</em>, Total joint replacement</td>
<td>Reporting only</td>
<td>Performance Y1</td>
<td>Performance Y2</td>
<td>Performance Y3</td>
<td>Performance Y4</td>
<td></td>
</tr>
<tr>
<td>W2</td>
<td>Appendectomy, <em>Cholecystectomy</em>, <em>Colonoscopy</em>, <em>Esophagogastroduodenoscopy (EGD)</em>, <em>Gastrointestinal (GI) bleed</em>, <em>Upper respiratory infection (URI)</em>, <em>Urinary Track Infection (UTI)</em></td>
<td>Reporting only</td>
<td>Performance Y1</td>
<td>Performance Y2</td>
<td>Performance Y3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>W3</td>
<td>Ankle sprain/strain, attention-deficit hyperactivity disorder (ADHD), Breast biopsy, Breast cancer surgery, Breast medical oncology, Coronary artery bypass grafting (CABG), Cardiac valve, Congestive heart failure (CHF) exacerbation, Dental: tooth extraction, Diabetic ketoacidosis (DKA) / hyperosmolar hyperglycemic state, Headache, Hip/pelvic facture procedure, Human immunodeficiency virus (HIV), Hysterectomy, Knee arthroscopy, Knee sprain/strain, Low back pain, Neonatal (high-risk), Neonatal (low-risk), Neonatal (moderate-risk), Oppositional defiant disorder (ODD), Otitis media, Pancreatitis, Pediatric acute lower respiratory infection, Shoulder sprain/strain, Skin and soft tissue infection, Spinal decompression (without fusion), Spinal fusion, Tonsillectomy, Wrist sprain/strain</td>
<td>Reporting only2</td>
<td>Performance Y1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Payment episode status only determined for W1 and W2 so far; decisions to be made in future for W3
2 Reporting for Wave 3 episodes extended to CY2018 given need to incorporate physician feedback through reactive clinical process into episode design prior to performance periods (most Wave 3 episodes designed and launched on accelerated timelines without Clinical Advisory Groups)
## Episodes quick reference (1/2)

<table>
<thead>
<tr>
<th>PAP</th>
<th>Trigger</th>
<th>Valid ages</th>
<th>Duration</th>
<th>Quality metric(s) linked to payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perinatal</strong></td>
<td>Physician who delivers the baby</td>
<td>12 – 49 years</td>
<td>Pre-trigger: 40 weeks prior to delivery date; Post-trigger: 60 days</td>
<td>HIV test; C-section rate; Follow-up visit 60 days</td>
</tr>
<tr>
<td><strong>Asthma exacerbation</strong></td>
<td>First facility that receives the patient</td>
<td>2 – 64 years</td>
<td>Post-trigger: 30 days</td>
<td>Follow-up visit 30 days; Controller medication</td>
</tr>
<tr>
<td><strong>COPD exacerbation</strong></td>
<td>First facility that receives the patient</td>
<td>18 – 64 years</td>
<td>Post-trigger: 30 days</td>
<td>Follow-up visit 30 days</td>
</tr>
<tr>
<td><strong>URI</strong></td>
<td>Physician or group that diagnoses the patient</td>
<td>6 months – 64 years</td>
<td>Post-trigger: 14 days</td>
<td>Filled antibiotics if no Strep test</td>
</tr>
<tr>
<td><strong>Cholecystectomy</strong></td>
<td>Physician or group that performs the surgery</td>
<td>18 – 64 years</td>
<td>Pre-trigger: 90 days (first visit to PAP before the surgery); Post-trigger: 30 days</td>
<td>Infection; Severe adverse outcomes</td>
</tr>
</tbody>
</table>
## Episodes quick reference (2/2)

<table>
<thead>
<tr>
<th>PAP</th>
<th>Trigger</th>
<th>Valid ages</th>
<th>Duration</th>
<th>Quality metric(s) linked to payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastro-intestinal bleed</td>
<td>First facility that treats the patient</td>
<td>1 – 64 years</td>
<td>Post-trigger: 30 days</td>
<td>Office visit 30 days</td>
</tr>
<tr>
<td></td>
<td>GI specific diagnosis on ED or IP facility claim;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contingent code with confirming diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EGD</td>
<td>Physician or group that performs the surgery</td>
<td>1 – 64 years</td>
<td>Pre-trigger: 7 days</td>
<td>ED visit 14 days</td>
</tr>
<tr>
<td></td>
<td>Professional claim for the surgery</td>
<td></td>
<td>Post-trigger: 14 days</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Physician or group that performs the surgery</td>
<td>18 – 64 years</td>
<td>Pre-trigger: 7 days</td>
<td>ED visit 14 days</td>
</tr>
<tr>
<td></td>
<td>Professional claim for the surgery</td>
<td></td>
<td>Post-trigger: 14 days</td>
<td></td>
</tr>
<tr>
<td>UTI</td>
<td>Physician or group that diagnoses the patient</td>
<td>2 – 64 years</td>
<td>Post-trigger: 30 days</td>
<td>Advanced imaging</td>
</tr>
<tr>
<td></td>
<td>UTI specific diagnosis on professional claim for office or ED visit;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contingent code with confirming diagnosis</td>
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</tbody>
</table>
Threshold methodology
Retrospective thresholds reward cost-efficient, high-quality care

NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost.
Episodes Based Payments: Thresholds

- The Acceptable Threshold is the *Target Cost*, and is the highest cost Medicaid can accept for a given episode.

- The Commendable Threshold is the cost at which a provider will be rewarded, as long as all applicable quality metrics are met. This is meant to further incentivize providers to drive towards value.

- The Positive Incentive Limit is the cost at which a provider is rewarded, assuming all applicable quality metrics are met, but the reward is capped so as not to drive savings beyond the point where quality care can reasonably be provided.

- Providers between the Acceptable and Commendable Thresholds are neither exceeding the *Target Cost* nor performing well enough to be rewarded for low cost quality care.
Ohio Medicaid spend threshold methodology

Determining...

Threshold levels

- Ohio Medicaid sets cost & quality thresholds for fee-for-service (FFS) & managed care plans (MCPs)
- Ohio Medicaid sets one acceptable threshold for all of Medicaid so that ~10% of providers are above the acceptable threshold, assuming no behavior change\(^1\)
- Ohio Medicaid sets one commendable threshold for all of Medicaid such that it would be budget neutral after positive and negative incentive payments, assuming no change in the PAP curve\(^2\)

Payments

- For Ohio Medicaid, including the managed care plans, the incentive payment amount for PAPs is 50%
- Payments will be proportional to the total non-risk adjusted spend for each PAP

1 The threshold will be set midway between the avg. cost for the last provider above acceptable and the first one not. Including 10% of providers means including the minimum number of providers such that at least 10% of providers are included
2 Assumes all providers pass the quality measures
Episode Based Payments: Alignment with QPP

- **Marginal risk the APM entity potentially owes or forgoes is at least 30%**.
  PAPs are accountable for 50% of spend proportionate to the difference between their average risk-adjusted spend and acceptable threshold.

- **Minimum Loss Rate (MLR) in which the APM entity operates is no more than 4%**.
  PAPs are assessed a negative incentive for average risk adjusted spend of any amount above the acceptable threshold. Therefore, the MLR is 0%.

- **Total risk the APM entity potentially owes or forgoes is at least 8% of total revenue**.
  PAPs are at risk for 100% of the total amount calculated to determine their negative incentive.
What are Ohio’s Episodes of Care quality metrics?
Intense clinical design process identified robust quality measures for 9 episodes linked to payment

For the 9 episodes Ohio has linked to payment to date...

- Asthma acute exacerbation
- COPD acute exacerbation
- Perinatal
- Cholecystectomy
- Colonoscopy
- EGD
- GI hemorrhage
- URI
- UTI

... 5 distinct CAGs were convened, comprised of:

- 120+ clinical participants
- 20 in person meetings
- Representation from large provider systems across the state (e.g., Cleveland Clinic, Ohio State, Ohio Health, TriHealth, Promedica)
- Representation from large provider associations (e.g., Ohio Hospital Association, Ohio State Medical Association, Ohio Association of Family Physicians, Ohio Osteopathic Association, ACOG, Ohio Children’s Hospital Association, American College of Emergency Physicians, American College of Surgeons, etc.)

During the CAG process, clinicians were asked to provide input on all elements of the episode definition, including quality measures, bringing in input from their colleagues.
## Examples of episode quality metrics and externally endorsed comparable measures

<table>
<thead>
<tr>
<th>Episode</th>
<th>Ohio episode quality metric</th>
<th>Example of externally endorsed comparable measures</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Percent of episodes with a follow-up visit within 30 days</td>
<td>Follow-up within 1 to 4 weeks of ED visit</td>
<td>Journal article</td>
</tr>
<tr>
<td></td>
<td>Percent of episodes where patient receives an controller medication</td>
<td>Medication management for people with asthma</td>
<td>NQF number 1799</td>
</tr>
<tr>
<td></td>
<td>Percent of episodes with a follow-up visit within 30 days</td>
<td>Follow-up visits within 30 days of initial hospitalization</td>
<td>MIPS 444</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Rate of HIV testing during the 280 days prior to delivery</td>
<td>HIV testing during the 280 days prior to delivery</td>
<td>NQF number 0606</td>
</tr>
<tr>
<td></td>
<td>C-Section Rate</td>
<td>Caesarean section</td>
<td>NQF number 0471</td>
</tr>
<tr>
<td></td>
<td>Percent of episodes with a follow-up visit within 60 days</td>
<td>Deliveries that had a postpartum visit or between 21 and 56 days after delivery</td>
<td>NQF number 1517 MIPS 336</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Rate of surgical site infection up to 30 days after the operative procedure</td>
<td>Rate of surgical site infections within 30 days after the operative procedure</td>
<td>NQF measure 0299 MIPS 357</td>
</tr>
<tr>
<td></td>
<td>Severe adverse outcome rate</td>
<td>30-day adverse outcomes after cholecystectomy and related procedures</td>
<td>Journal article</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Percent of episodes with an ED visit within 14 days</td>
<td>Rate of unplanned hospital visits (ED, Observation stay, or unplanned inpatient admission) within 7 days of an outpatient colonoscopy</td>
<td>NQF number 2539</td>
</tr>
<tr>
<td></td>
<td>Percent of episodes with an office visit within 30 days</td>
<td>Follow-up visit within 4 weeks of discharge</td>
<td>MedPac</td>
</tr>
<tr>
<td></td>
<td>Percent of episodes with filled antibiotics without a strep test</td>
<td>Rate of antibiotics usage</td>
<td>Choosing Wisely</td>
</tr>
<tr>
<td></td>
<td>Percent of episodes with advanced imaging</td>
<td>Use of imaging for only complicated UTI</td>
<td>Journal article</td>
</tr>
</tbody>
</table>

2. [https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier-id&ItemID=69922](https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier-id&ItemID=69922) Differences exist in the detail of the implementation of the episode and externally endorsed comparable quality measures
6. [https://academic.oup.com/ndt/article/14/11/2754/1807920](https://academic.oup.com/ndt/article/14/11/2754/1807920)
How many Ohio Hospitals & Physicians use Certified EHR Technology (CEHRT)?
76% of Ohio physicians have adopted certified EHR technology

100% of All Eligible Ohio Hospitals have demonstrated Meaningful Use (MU) of Certified Health IT

Source: CMS EHR Incentive Program data, 2016 and CMS Provider of Services file, March 2017

Does the Payment Arrangement meet QPP’s Other Payer Advanced APM standard?

• Given these data, we are confident that at least 50% of Ohio Medicaid providers participating in the Episodes of Care payment model use CEHRT.

• Even without a formal requirement imposed on participating providers, Ohio’s Episodes of Care meets the Other Payer Advanced APM standard.
Questions
Advancing Health IT Supporting Multiple State Priorities

1. Governance
2. Reusable Infrastructure
3. Financing
4. Policy
5. Information Sharing
6. Data Sources
Health IT Uses in the Context of Payment Models

- **Health IT Capabilities for Addressing Payment Models**
  - Clinical Data Capture at Point of Care
  - Care Coordination Management
  - Quality Measurement
  - Data Aggregation and Attribution
  - Risk Scoring
  - Financial Management

- **Four Types of Payment Categories (Taken from Health Care Payment Learn & Action Network APM Framework)**
  - Category 1 – Fee-for-Service – No link to Quality and Value
  - Category 2 – Fee-for-Service – Link to Quality and Value
  - Category 3 – APMs Built on FFS Architecture
  - Category 4 – Population Based Payment
ONC and Certified EHR’s

The Office of the National Coordinator for Health Information Technology (ONC) oversees the Health IT Certification Program for health IT modules — including electronic health records (EHR). The certification program sets several nationwide standards including:

- Health IT standards
- Implementation specifications
- Certification criteria

https://www.healthit.gov/playbook/certified-health-it/

The Certified Health IT Product List (CHPL) is a comprehensive and authoritative listing of all certified Health Information Technology which has been successfully tested and certified by the ONC Health IT Certification program. All products listed on the CHPL have been tested by an ONC-Accredited Testing Laboratory (ONC-ATL) and certified by an ONC-Authorized Certification Body (ONC-ACB) to meet criteria adopted by the Secretary of the Department of Health and Human Services (HHS).

https://chpl.healthit.gov/#/resources/overview
CMS provides incentives to encourage eligible clinicians to use health IT, most notably certified EHR technology. Certified EHR technology makes it possible for clinicians to submit information electronically to CMS in a format CMS can process.

The current CMS incentive program that encourages health IT adoption is the Medicare Access and CHIP Reauthorization Act (MACRA), which includes the QPP with multiple clinician payment tracks. Participation in QPP rewards clinicians' use of certified health IT.

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

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

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

- **Digitized Clinical Data Sources & Users**
  - Plans & Service Delivery Systems
  - Pharmacy
  - Provider EHRs & Other Systems
  - Labs
  - Tribes & Indian Health Services
  - Community Non-Health Providers
  - Public Health
  - Marketplace

- **Digitized Claims Data Sources & Users**
  - All-Payer Claims Database
  - Corrections
  - Tribes & Indian Health Services

- **Digitized Survey Data Sources**
  - Satisfaction Survey
  - Plan Survey
  - Behavioral Risk Survey
  - Other Surveys

- **Digitized Administrative Data Sources & Users**
  - Health Plans & Delivery Systems
  - Pharmacy
  - Providers
  - Labs
  - Tribes & Indian Health Services
  - Marketplace
  - State/County/Local Gov’t
  - Community Non-Health Providers
  - Public Health

- **Digitized Registries (Sources & Users)**
  - Bio-Surveillance
  - Public Health
  - Disease Specific

- **Patient Generated Health Data (Sources & Users)**
  - Mobile Data, etc.
Priority Use Cases for Clinical Quality Measure Information

Performance (Quality & Financial) Measurement & Improvement

- Quality Improvement
  - Care Delivery
    - Risk Adjustment for Quality Measurement
    - Cohort Identification & Management
  - Reimbursement
    - Reimbursement for Improved Quality of Care

- Administrative Efficiencies
  - Central QM Calculation and Reporting
    - Reuse of Quality Measure data
    - Program Evaluation/Reporting

- Research

- Population Health measurement
  - Disease-specific measurement

- Cost and Quality Transparency
Quality Measurement Continuum

- **Claims-based Quality Measurement**: Claims data quality measurement and/or healthcare effectiveness data collected from surveys, chart reviews, and claims data.
- **Self-reported**: Data captured, electronic Clinical Quality Measures (eCQM) calculated in EHR and only, and numerator/denominator reported.
- **Live automated data**: Automated data acquisition from EHRs to central aggregator tool for calculation, comparison, reporting, and population level measures.
- **Integrated data**: Claims and clinical data integrated to analyze quality and address population health needs.

**Provider/Practice/Encounter Level Data**

- Patient-Centric Reporting
- Provider-Centric Reporting
- Practice-Centric Reporting
- System-centric Reporting
- Population-level Reporting
Choosing a Strategy for Using EHR Data for Quality Measurement

To help determine an actionable strategy for using clinical data from EHRs to measure quality, there are two distinctly different approaches to using data from EHRs to generate results of CQMs:

**Measure Extraction**
Each organization or provider site generates measure results (numerator, denominator) using their own EHR data and a set of measure specifications.

**Data Extraction**
Patient level data is transmitted from each EHR to a centralized infrastructure where measure results are generated for all participant sites.
Implementation Guide 10 Key Activities

1. Define Measurement Strategy
2. Identify Value Propositions
3. Establish Governance
4. Align Measures
5. Assess Technical Infrastructure
6. Identify Quality Measurement Functionality
7. Coordinate Implementation Planning
8. Align with Quality Improvement Assistance
9. Understand Financing
10. Leverage Policy Levers
Considerations, Challenges, and Potential Barriers

1. Technology
2. Trust
3. Business Case/Financial
4. Work Force
Questions
Key Takeaways on MACRA Alignment

• MACRA provides opportunities and payment incentives for providers and health plans to move into models of payment that reward high quality, cost effective care

• State Medicaid programs have an opportunity to leverage MACRA and align their VBP approaches to enable providers to participate

• Health IT adoption can play a critical role in not only underpinning the advancement of VBP arrangements but also in qualifying as an Other Payer Advanced APM

• States such as Ohio are taking the lead on aligning their Medicaid VBP approach with federal legislation by advancing an episode-based model that meets MACRA requirements
Thank You for Joining Today’s Webinar!

Please take a moment to complete a short feedback survey.

https://norc.az1.qualtrics.com/jfe/form/SV_9TS5kUvAkT63qN7
Appendices
Appendix A: Other Payer Advanced APM Informational Slides
Final Rule with Comment Period for Year 2

Agenda

• Overview
• Advanced APMs with Medicare
• All-Payer Combination Option & Other Payer Advanced APMs
  - Other Payer Advanced APM Determination Process
  - All-Payer Combination Option QP Determinations
• Implementation to Date
The MACRA statute created two pathways to allow eligible clinicians to become QPs.

**Medicare Option**
- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs with Medicare.

**All-Payer Combination Option**
- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in:
  - Advanced APMs with Medicare; and
  - Other Payer Advanced APMs offered by other payers.
FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

All-Payer Combination Option: QP Determinations
The All-Payer Combination Option allows Eligible Clinicians to become QPs through participation in a combination of Advanced APMs with Medicare and Other Payer Advanced APMs starting in the 2019 QP Performance Period.

CMS will assess eligible clinicians’ participation in Advanced APMs with Medicare and – where applicable – Other Payer Advanced APMs to determine if they will be QPs for the payment year (this is explained in more detail in the next slide).
Final Rule with Comment Period for Year 2
All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step One: Participate in an Advanced APM in Medicare

1. An Eligible Clinician or APM Entity needs to participate in an Advanced APM with Medicare to a sufficient extent to qualify for the All-Payer Combination Option.
   - For performance year 2019, based on the payment amount method, sufficient means:

   - **<25%**
     - Eligible Clinician or APM Entity does not qualify to participate in All-Payer Combination Option.
   - **25% - 50%***
     - Eligible Clinician or APM Entity does qualify to participate in the All-Payer Combination Option.
   - **≥50%**
     - Eligible Clinician or APM Entity attains QP status based on Medicare Option alone.
     - Participation in the All-Payer Combination Option is not necessary.

*Eligible clinicians must have greater than or equal to 25% and less than 50% of payments through an Advanced APM(s).
Under the All-Payer Combination Option, an Eligible Clinician or APM Entity needs to be in at least one Other Payer Advanced APM during the relevant QP Performance Period.

Eligible clinicians or APM Entities seeking a QP Determination under the All-Payer Combination Option will**:

1. Inform CMS that they are in a payment arrangement that CMS has determined is an Other Payer Advanced APM; and

2. Submit information to CMS on a payment arrangement where CMS will make an Other Payer Advanced APM determination.

**Note that eligible clinicians in Medicaid payment arrangements only would have the option to submit their payment arrangement information prior to the relevant QP Performance Period.
Between August 1 and December 1 after the close of the QP Performance Period, eligible clinicians or APM Entities seeking QP determinations under the All-Payer Combination Option would submit the following information:

- Payments and patients through Other Payer Advanced APMs, aggregated between January 1 – March 31, January 1 – June 30, and January 1 – August 31.

- All other payments and patients through other payers except those excluded, aggregated between January 1 – March 31, January 1 – June 30, and January 1 – August 31.

Eligible clinicians may submit information on payment amounts or patient counts for any or all of the 3 snapshot periods. Information can be submitted at either the individual level or the APM Entity level.
Final Rule with Comment Period for Year 2
All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 4: CMS Calculates Threshold Scores

QP Determinations under the All-Payer Combination Option:

Eligible clinicians and APM Entities will have the option to request All-Payer QP determinations. Eligible clinicians can request at either the individual level, and APM Entities can request at the APM Entity level.

CMS will calculate Threshold Scores under both the payment amount and patient count methods, applying the more advantageous of the two:

Payment Amount Method

$$ through Advanced APMs and Other Payer
Advanced APMs

$$ from all payers (except excluded $$)

\[ \frac{\text{Threshold Score \%}}{\text{Payment Amount Method}} \]

Patient Count Method

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

# of patients furnished services under all payers (except excluded patients)

\[ \frac{\text{Threshold Score \%}}{\text{Patient Count Method}} \]
The MACRA statute directs us to exclude certain types of payments (and we will for associated patients).

Specifically, that list of excluded payments includes, but is not limited to, Title XIX (Medicaid) payments where no Medicaid APM (which includes a Medicaid Medical Home Model that is an Other Payer Advanced APM) is available under that state program.

In the case where the Medicaid APM is implemented at the sub-state level, Title XIX (Medicaid) payments and associated patients will be excluded unless CMS determines that there is at least one Medicaid APM available in the county where the eligible clinician sees the most patients and that eligible clinician is eligible to participate in the Other Payer Advanced APM based on their specialty.
Final Rule with Comment Period for Year 2
All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 5: Notification of QP Status and Next Steps

[Diagram showing the process for determining QP status based on threshold scores.]
Resource Library Update

- To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of QPP resources to CMS.gov.

- QPP.CMS.GOV redirects to the CMS.GOV Resource Library:
  - Final Rule Materials Posted: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html
Appendix B: Ohio Slides
Retrospective episode model mechanics

1. Patients and providers continue to deliver care as they do today
2. Patients seek care and select providers as they do today
3. Providers submit claims as they do today
4. Payers reimburse for all services as they do today

4. Calculate incentive payments based on outcomes after close of 12 month performance period

Review claims from the performance period to identify a 'Principal Accountable Provider' (PAP) for each episode

5. Payers calculate average risk-adjusted reimbursement per episode for each PAP

Compare to predetermined “commendable” and “acceptable” levels

6. Providers may:
   - Share savings: if average costs below commendable levels and quality targets are met
   - Pay negative incentive: if average costs are above acceptable level
   - See no impact: if average costs are between commendable and acceptable levels
## Elements of the Episode Definition

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode trigger</strong></td>
<td>▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode</td>
</tr>
<tr>
<td><strong>Episode window</strong></td>
<td>▪ <strong>Pre-trigger window</strong>: Time period prior to the trigger event; relevant care for the patient is included in the episode</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Trigger window</strong>: Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included</td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Post-trigger window</strong>: Time period following trigger event; relevant care and complications are included in the episode</td>
</tr>
<tr>
<td><strong>Claims included</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Principal accountable provider</strong></td>
<td>▪ Provider who may be in the best position to assume principal accountability in the episode based on factors such as decision making responsibilities, influence over other providers, and portion of the episode spend</td>
</tr>
<tr>
<td><strong>Quality metrics</strong></td>
<td>▪ Measures to evaluate quality of care delivered during a specific episode</td>
</tr>
<tr>
<td><strong>Potential risk factors</strong></td>
<td>▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode</td>
</tr>
<tr>
<td><strong>Episode-level exclusions</strong></td>
<td>▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate a type of risk that, due to its complexity, cost, or other factors, should be excluded entirely rather than adjusted</td>
</tr>
</tbody>
</table>
Positive incentive (gain-sharing) is calculated based on average episode spend for providers that pass quality metrics.

**Risk-adjusted average spend (Illustrative)**

- **PAP Summary**
  - 40 Total PAPs
  - 15 PAPs below commendable threshold
  - 11 gain share based on QM performance

- **Acceptable threshold**: $6,347
- **Gain sharing limit**: $1,892
- **Commendable threshold**: $2,937

- **Risk-adjusted avg. spend**: $2,471
- **Difference to commendable threshold**: $466
- **19% Percentage of spend subject to gain sharing**: $4,492
- **Un-adjusted average**: $4,492
- **15 # of episodes**: $6,401
- **50% Gain/risk sharing percentage**

**$6,401 Total positive incentive to PAP**
Negative incentive (risk-sharing) is calculated based on average episode spend

Risk-adjusted average spend (Illustrative)

PAP Summary
- 40 Total PAPs
- 3 PAPs above the acceptable threshold

<table>
<thead>
<tr>
<th>Risk-adjusted average spend</th>
<th>6,883</th>
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<tbody>
<tr>
<td>Difference to acceptable threshold</td>
<td>$536</td>
</tr>
<tr>
<td>Risk-adjusted average</td>
<td>$6,883</td>
</tr>
<tr>
<td>Percentage of spend subject to gain/risk sharing</td>
<td>8%</td>
</tr>
<tr>
<td>Un-adjusted average</td>
<td>$11,285</td>
</tr>
<tr>
<td># of episodes</td>
<td>37</td>
</tr>
<tr>
<td>Gain/risk sharing percentage</td>
<td>50%</td>
</tr>
<tr>
<td>Total negative incentive for PAP</td>
<td>$16,702</td>
</tr>
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</table>
### Ohio Medicaid Provider Network Data

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers with Active Ohio MD/DO Licenses (as of 3/13/2018)</td>
<td>48,320</td>
</tr>
<tr>
<td>Providers Participating in Ohio Medicaid (as of 3/12/2018)</td>
<td>40,172</td>
</tr>
<tr>
<td>Percent of Licensed Providers in Ohio Medicaid Network</td>
<td>83.0%</td>
</tr>
</tbody>
</table>
Intense clinical design process identified robust quality measures for 9 episodes linked to payment

For the 9 episodes Ohio has linked to payment to date...

- Asthma acute exacerbation
- COPD acute exacerbation
- Perinatal
- Cholecystectomy
- Colonoscopy
- Esophagogastroduodenoscopy (EGD)
- GI hemorrhage (GIH)
- Upper respiratory infection (URI)
- Urinary tract infection (UTI)

... 5 distinct Clinical Advisory Groups (CAGs) were convened, comprised of:

- 120+ clinical participants
- 20 in person meetings
- Representation from large provider systems across the state (e.g., Cleveland Clinic, Ohio State, Ohio Health, TriHealth, Promedica)
- Representation from large provider associations (e.g., Ohio Hospital Association, Ohio State Medical Association, Ohio Association of Family Physicians, Ohio Osteopathic Association, ACOG, Ohio Children’s Hospital Association, American College of Emergency Physicians, American College of Surgeons, etc.)

During the CAG process, clinicians were asked to provide input on all elements of the episode definition, including quality measures, bringing in input from their colleagues.