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

Quality Payment
PROGRAM

OVERVIEW OF THE OTHER PAYER ADVANCED APM OPTION

Disclaimers

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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.

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QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

MIPS and Advanced APMs

Quality Payment PROGRAM

MACRA requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides for two participation tracks:

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 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)

Quality Payment PROGRAM

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.**

Final Rule with Comment Period for Year 2

Quality Payment PROGRAM

All-Payer Combination Option Other Payer Advanced APM Criteria: Generally Applicable Nominal Amount Standard

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

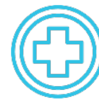
- Nominal amount of risk must be:
  - Marginal Risk of at least 30%;
  - Minimum Loss Rate of no more than 4%; and
- For QP Performance Periods 2019 and 2020, Total Risk of at least 8% of combined revenues from the payer of providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue.

Medicaid Medical Home Model

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.

Medicaid Medical Home Model Nominal Amount Standard

- 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

Final Rule with Comment Period for Year 2

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

Quality Payment PROGRAM

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.

Final Rule with Comment Period for Year 2

Quality Payment PROGRAM

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

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.

Final Rule with Comment Period for Year 2

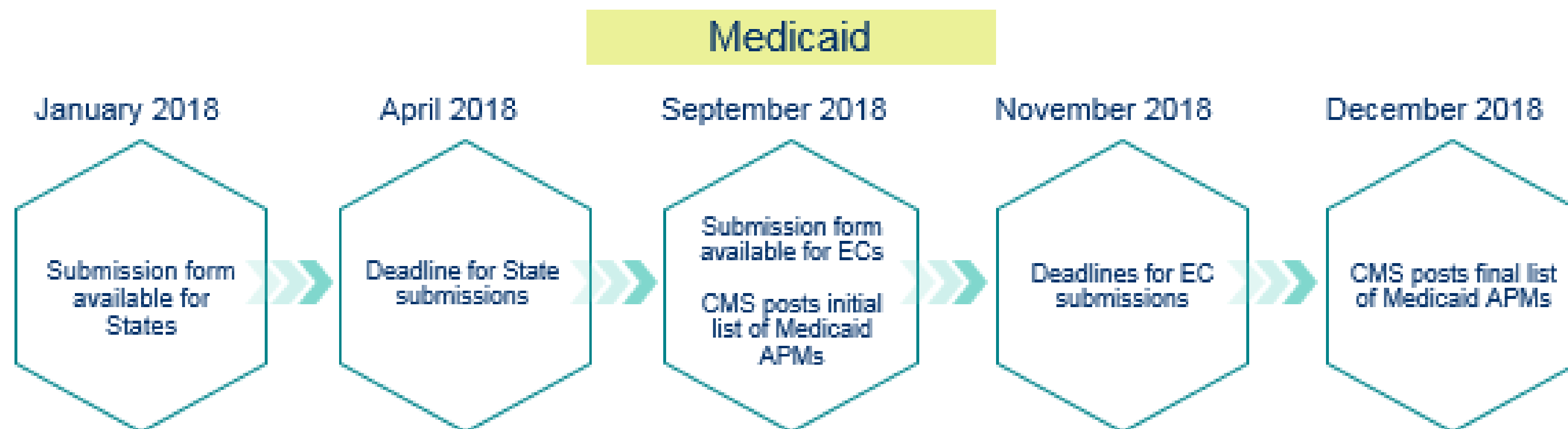
All-Payer Combination Option: Determination of Other Payer Advanced APMs

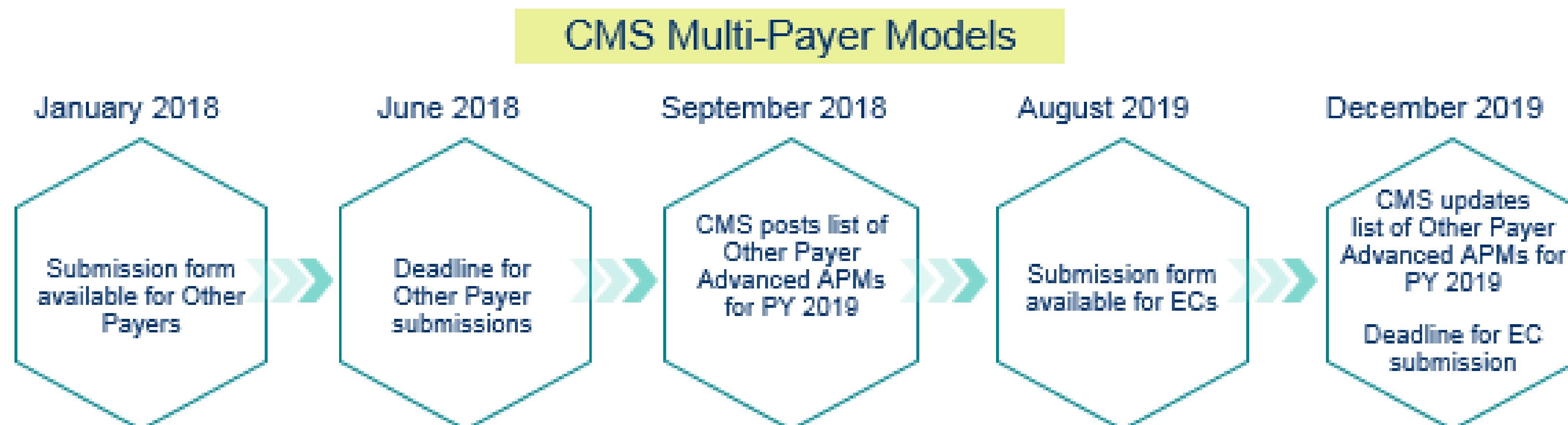
Overview – Eligible Clinician Initiated Process

- 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





Advanced APMs

Quality Payment PROGRAM

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

Medicaid Submissions

Quality Payment PROGRAM

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

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

Medicaid Submissions

Quality Payment PROGRAM

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

Payer Initiated Process		Eligible Clinician (EC) Initiated Process	
Guidance sent to states; Submission Period Opens	**Jan. 2018**	Guidance made available to ECs; Submission Period Opens	**Sept. 2018**
Submission Period Closes	**April 2018**	Submission Period Closes	**Nov. 2018**
CMS contacts states and Posts Other Payer Advanced APM List	**Sept. 2018**	CMS contacts ECs and states and Posts Other Payer Advanced APM List	**Dec. 2018**

2019 Medicaid Other Payer Advanced APMs

Lessons Learned

Quality Payment PROGRAM

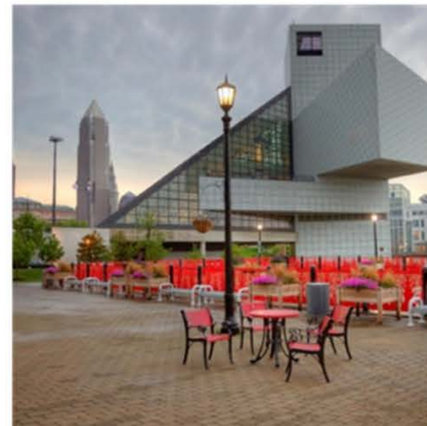
State	Payment Arrangement Name	Medicaid FFS or Managed Care	Availability/ Location
Massachusetts	Accountable Care Partnership Plan	Manage Care	Statewide
Ohio	Episode-based payments Model	Manage Care/ FFS	Statewide
Tennessee	Retrospective Episodes of Care Model	Manage Care	Statewide
Washington	Community Health Plan of Washington -- Community Health Network of Washington Population-Based Payment Model (Adult/Blind or Disabled) Option B: Individual Community Health Center Risk	Manage Care	Statewide
Washington	Community Health Plan of Washington -- Community Health Network of Washington (CHNW) Population-Based Payment Model (Family/SCHIP) Stop-Loss Option B	Manage Care	Statewide
Washington	Community Health Plan of Washington -- Community Health Network of Washington Population-Based Payment Model (Family/SCHIP) Stop-Loss Option C	Manage Care	Statewide

Medicaid Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019 https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Medicaid-Other-Payer-Advanced-APM-determination-list.pdf

Questions

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

September 26, 2018

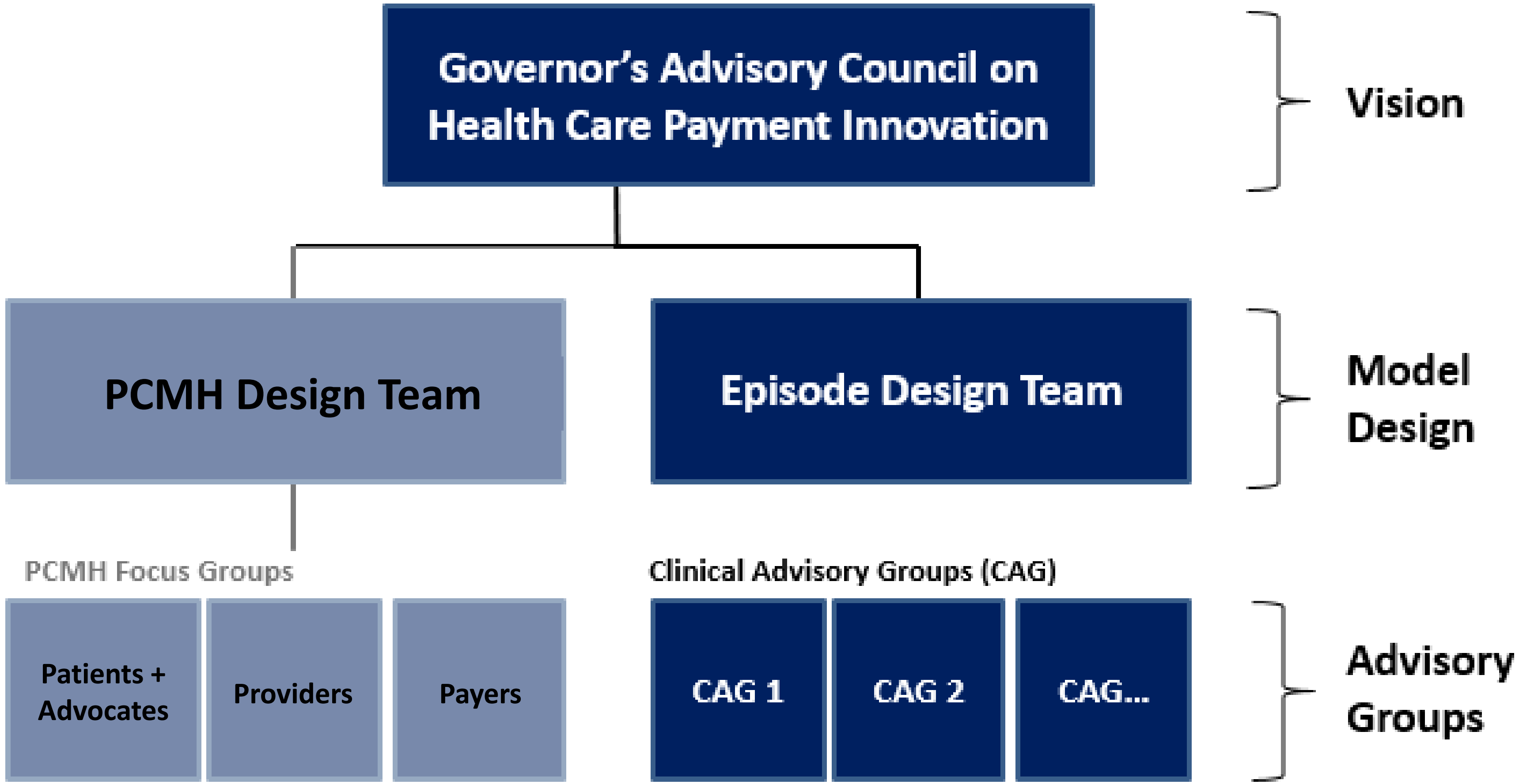


Ohio | Governor's Office of Health Transformation

Introduction and Overview

- Introduction
  - Opportunity to leverage ongoing VBP development to qualify as an Other Payer Advanced APM under MACRA
  - Importance of being proactive in seeking to sustain evolving payment arrangements and the move to VBP
  - Provider benefits in aligning Medicare and Medicaid APM participation
- Overview
  - Stakeholder process
  - Threshold methodology
  - Quality metrics
  - Certified EHR Technology
  - Qualifying as an Other Payer Advanced APM

Stakeholder process to design innovation models



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.

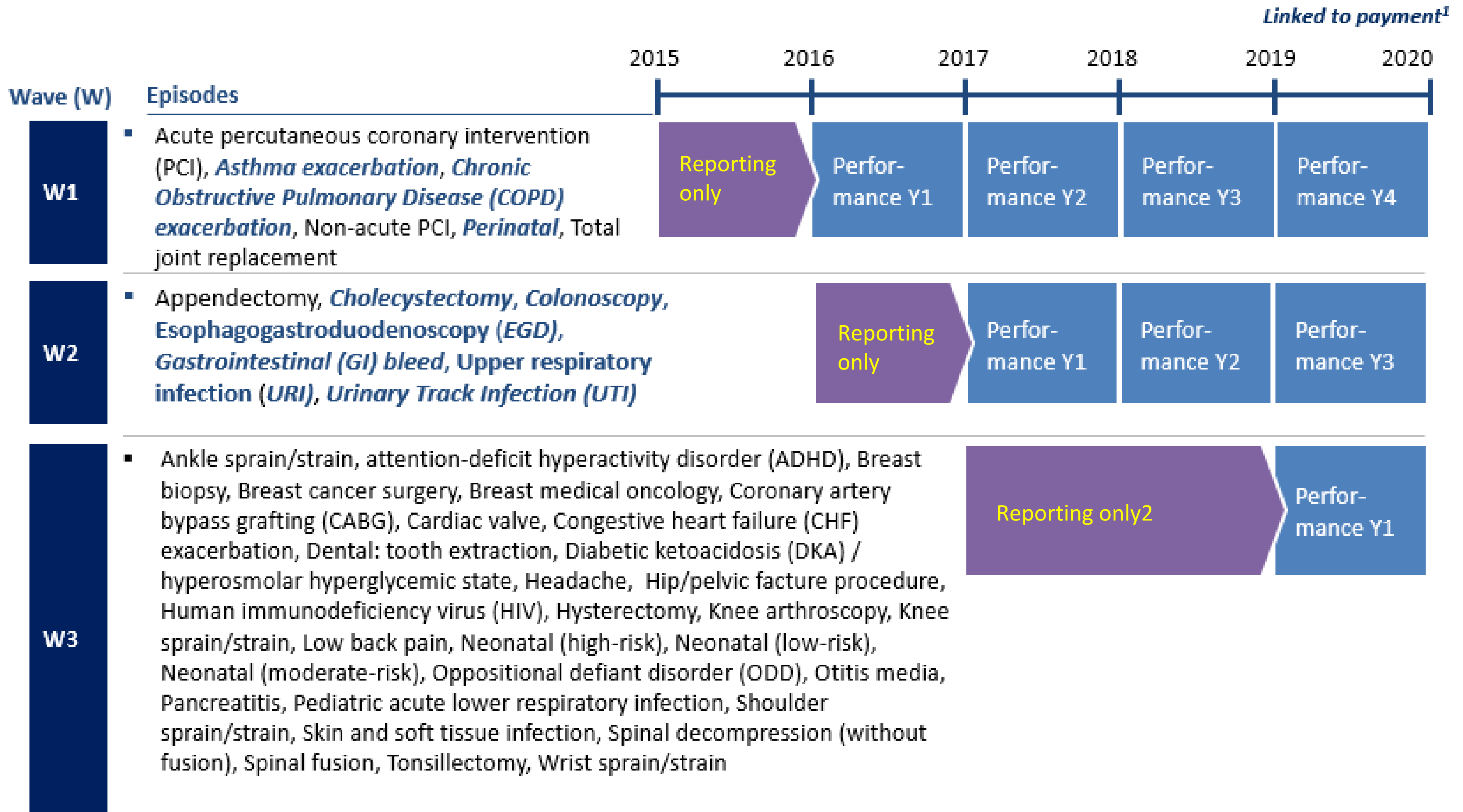
4. CAG members provide input on all elements of the base definition and final episode definitions incorporate CAG recommendations.

Example:

Asthma Exacerbation Clinical Advisory Group

- Timeframe: November 2013 – January 2014
- Number of meetings: 4
- Number of clinical experts participating: 25-30

Ohio's reporting and performance years by episode wave



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)

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Episodes quick reference (1/2)

	PAP	Trigger	Valid ages	Duration	Quality metric(s) linked to payment
Perinatal	Physician who delivers the baby	Live birth diagnosis and delivery procedure code	12 – 49 years	▪ Pre-trigger: 40 weeks prior to delivery date ▪ Post-trigger: 60 days	▪ HIV test ▪ C-section rate ▪ Follow-up visit 60 days
Asthma exacerba-tion	First facility that receives the patient	Asthma diagnosis on emergency dept (ED), observation (Obs), or inpatient (IP) claim; Contingent code with diagnosis	2 – 64 years	▪ Post-trigger: 30 days	▪ Follow-up visit 30 days ▪ Controller medication
COPD exacerba-tion	First facility that receives the patient	COPD specific diagnosis on ED, Obs, or IP facility claim; Contingent code with confirming diagnosis	18 – 64 years	▪ Post-trigger: 30 days	▪ Follow-up visit 30 days
URI	Physician or group that diagnoses the patient	URI specific diagnosis on professional claim for office or ED visit; Contingent code with confirming diagnosis	6 months – 64 years	▪ Post-trigger: 14 days	▪ Filled antibiotics if no Strep test
Cholecy-stectomy	Physician or group that performs the surgery	Professional claim for the surgery; Exclude open cholecystectomies	18 – 64 years	▪ Pre-trigger: 90 days (first visit to PAP before the surgery) ▪ Post-trigger: 30 days	▪ Infection ▪ Severe adverse outcomes

Episodes quick reference (2/2)

	PAP	Trigger	Valid ages	Duration	Quality metric(s) linked to payment
Gastro-intestinal bleed	First facility that treats the patient	GI specific diagnosis on ED or IP facility claim; Contingent code with confirming diagnosis	1 – 64 years	▪ Post-trigger: 30 days	▪ Office visit 30 days
EGD	Physician or group that performs the surgery	Professional claim for the surgery	1 – 64 years	▪ Pre-trigger: 7 days ▪ Post-trigger: 14 days	▪ ED visit 14 days
Colono-scopy	Physician or group that performs the surgery	Professional claim for the surgery	18 – 64 years	▪ Pre-trigger: 7 days Post-trigger: 14 days	▪ ED visit 14 days
UTI	Physician or group that diagnoses the patient	UTI specific diagnosis on professional claim for office or ED visit; Contingent code with confirming diagnosis	2 – 64 years	▪ Post-trigger: 30 days	▪ Advanced imaging

Threshold methodology

Retrospective thresholds reward cost-efficient, high-quality care

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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

Episode	Ohio episode quality metric	Example of externally endorsed comparable measures[3]	Source
Asthma	Percent of episodes with a follow-up visit within 30 days	▪ Follow-up within 1 to 4 weeks of ED visit[1]	▪ Journal article[1]
	Percent of episodes where patient receives an controller medication	▪ Medication management for people with asthma	▪ NQF number 1799[2] ▪ MIPS 444
COPD	Percent of episodes with a follow-up visit within 30 days	▪ Follow-up visits within 30 days of initial hospitalization[4]	▪ Journal article[4]
Perinatal	Rate of HIV testing during the 280 days prior to delivery	▪ HIV testing during the 280 days prior to delivery	▪ NQF number 0606[5]
	C-Section Rate	▪ Caesarean section	▪ NQF number 0471[6]
	Percent of episodes with a follow-up visit within 60 days	▪ Deliveries that had a postpartum visit on or between 21 and 56 days after delivery	▪ NQF number 1517[7] ▪ MIPS 336
Cholecystectomy	Rate of surgical site infection up to 30 days after the operative procedure	▪ Rate of surgical site infections within 30 days after the operative procedure	▪ NQF measure 0299[8] ▪ MIPS 357
	Severe adverse outcome rate	▪ 30-day adverse outcomes after cholecystectomy and related procedures[9]	▪ Journal article
Colonoscopy	Percent of episodes with an ED visit within 14 days	▪ Rate of unplanned hospital visits (ED, Observation stay, or unplanned inpatient admission) within 7 days of an outpatient colonoscopy	▪ NQF number 2539[10]
GIH	Percent of episodes with an office visit within 30 days	▪ Follow-up visit within 4 weeks of discharge[11]	▪ MedPac
URI	Percent of episodes with filled antibiotics without a strep test	▪ Rate of antibiotics usage[12]	▪ Choosing Wisely
UTI	Percent of episodes with advanced imaging	▪ Use of imaging for only complicated UTI [13]	▪ Journal article

1 https://www.ncbi.nlm.nih.gov/pubmed/11468604 additional information available https://www.atsjournals.org/doi/pdf/10.1513/pats.P09ST6 2 http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69922 3 Differences exist in the detail of the implementation of the episode and externally endorsed comparable quality measures 4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2977945/ 5 http://www.qualityforum.org/QPS/0606
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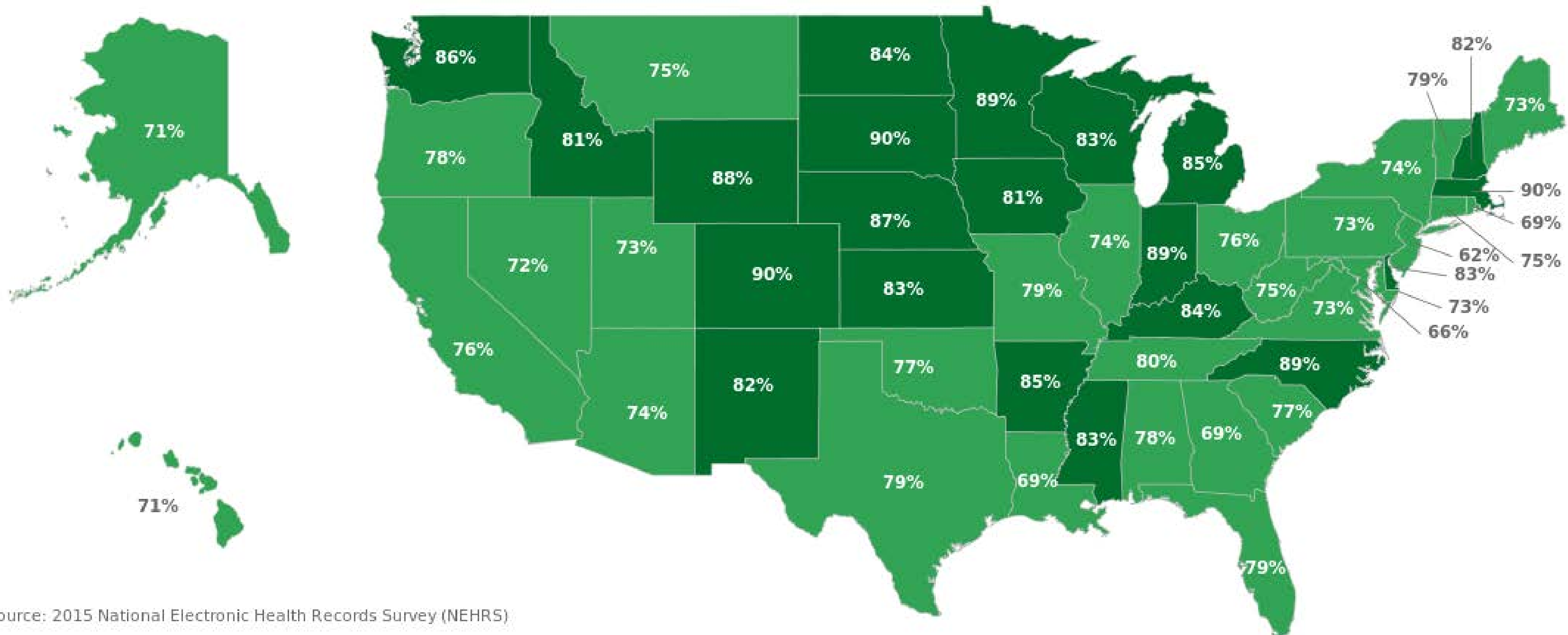
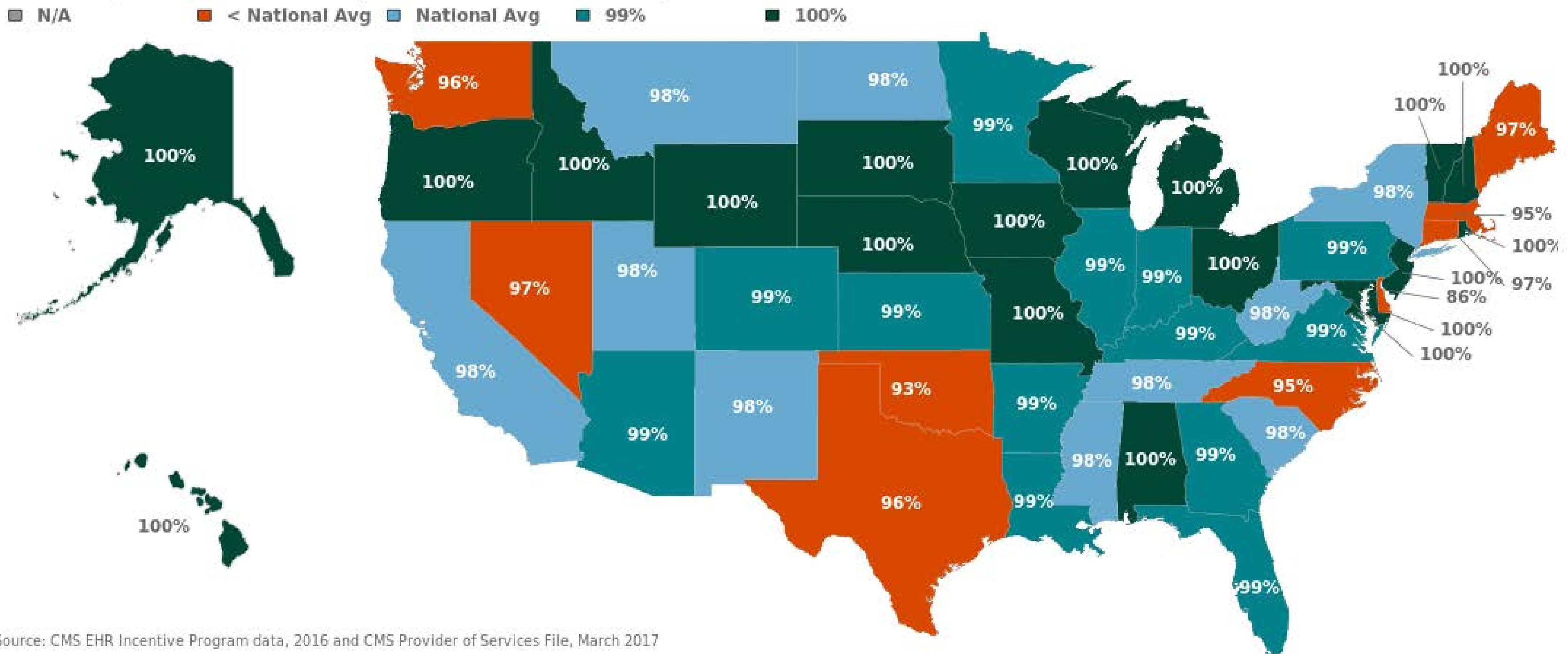
How many Ohio Hospitals & Physicians use Certified EHR Technology (CEHRT)?

76% of Ohio physicians have adopted certified EHR technology



Source: *https://dashboard.healthit.gov/apps/physician-health-it-adoption.php Accessed: 3/13/2018*

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



https://dashboard.healthit.gov/quickstats/pages/FIG-Hospitals-EHR-Incentive-Programs.php *Accessed: 3/13/2018*

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.

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- Even without a formal requirement imposed on participating providers, Ohio's Episodes of Care meets the Other Payer Advanced APM standard.

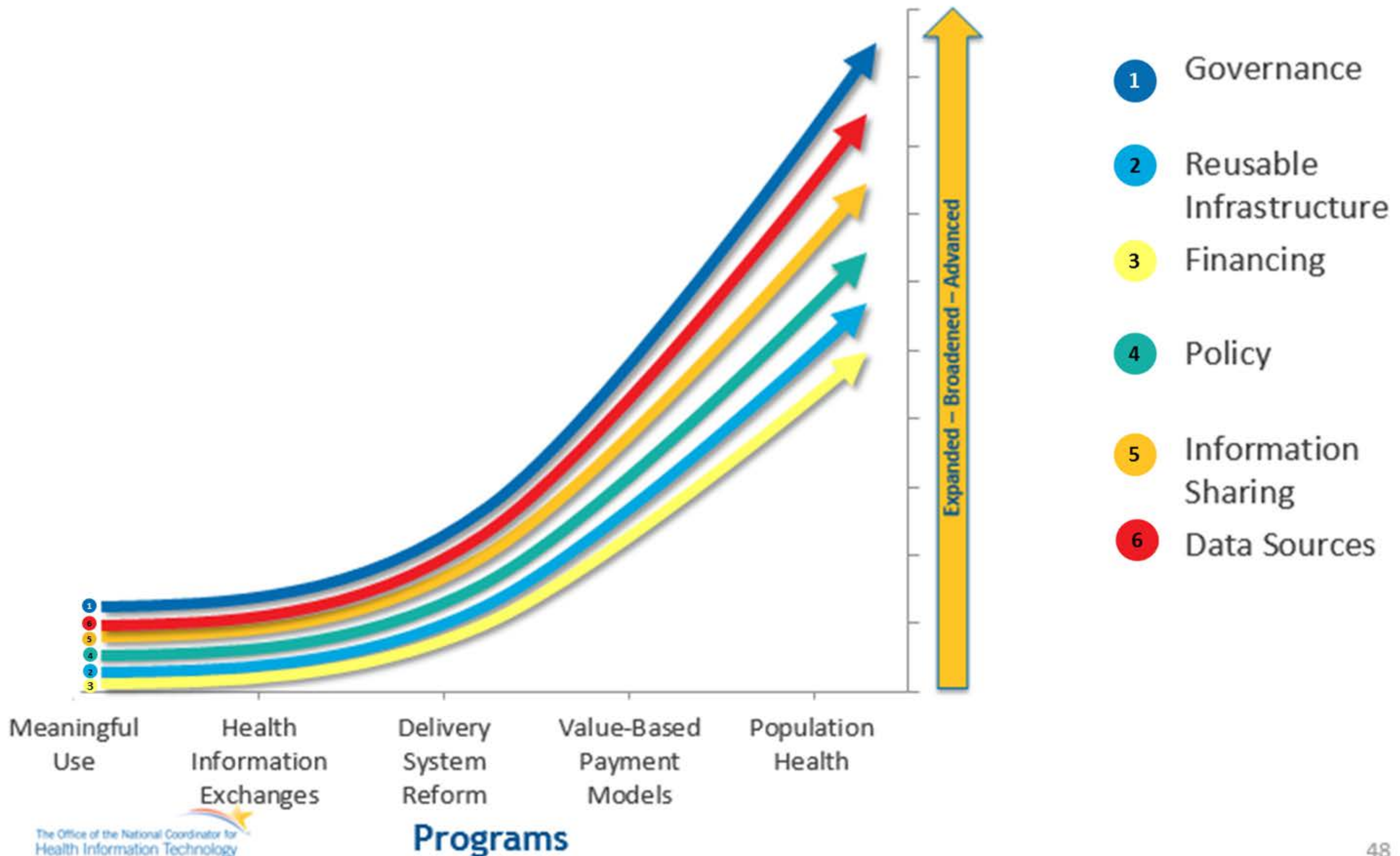
Questions

The Office of the National Coordinator for Health Information Technology

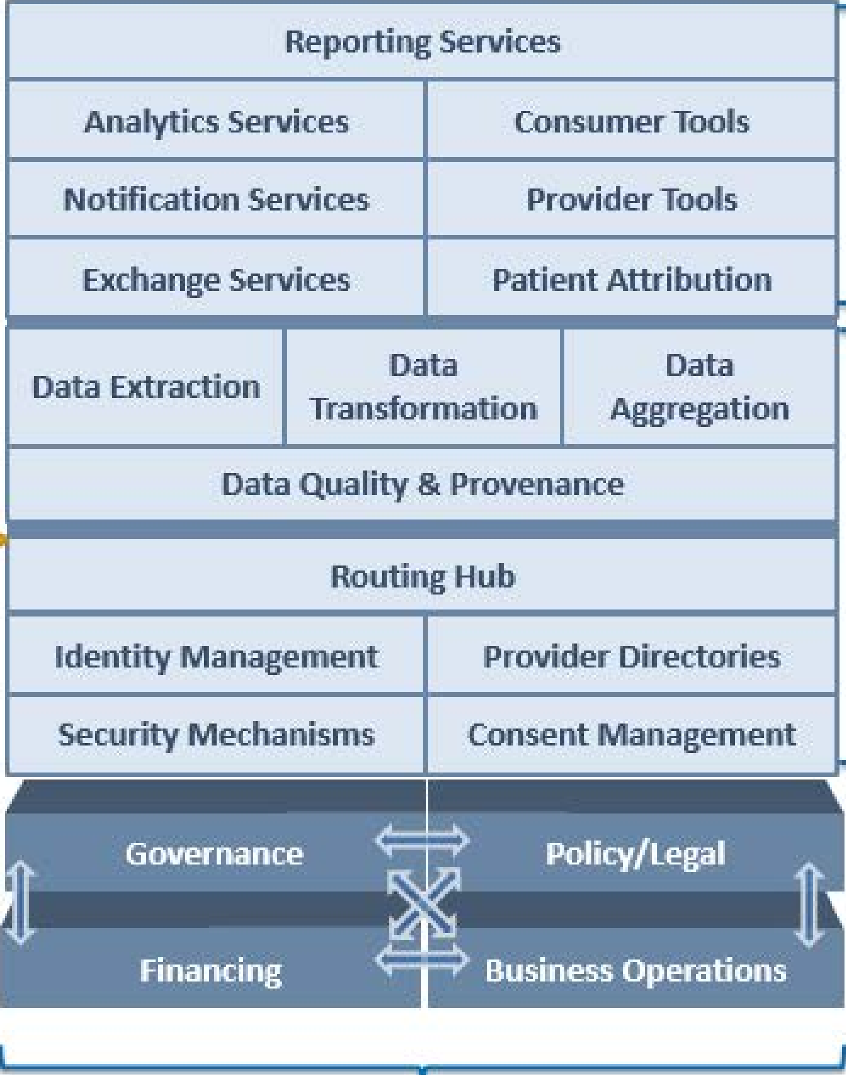
Health Information Technology (IT) Strategies for Addressing Payment Models

Arun Natarajan

Advancing Health IT Supporting Multiple State Priorities



Health IT Modular Infrastructure to Support Data/Information



Health IT functionalities that vary by prioritized activity

Core infrastructure for all health IT activities

Foundational components for participant trust & value

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

Meaningful Use and MACRA

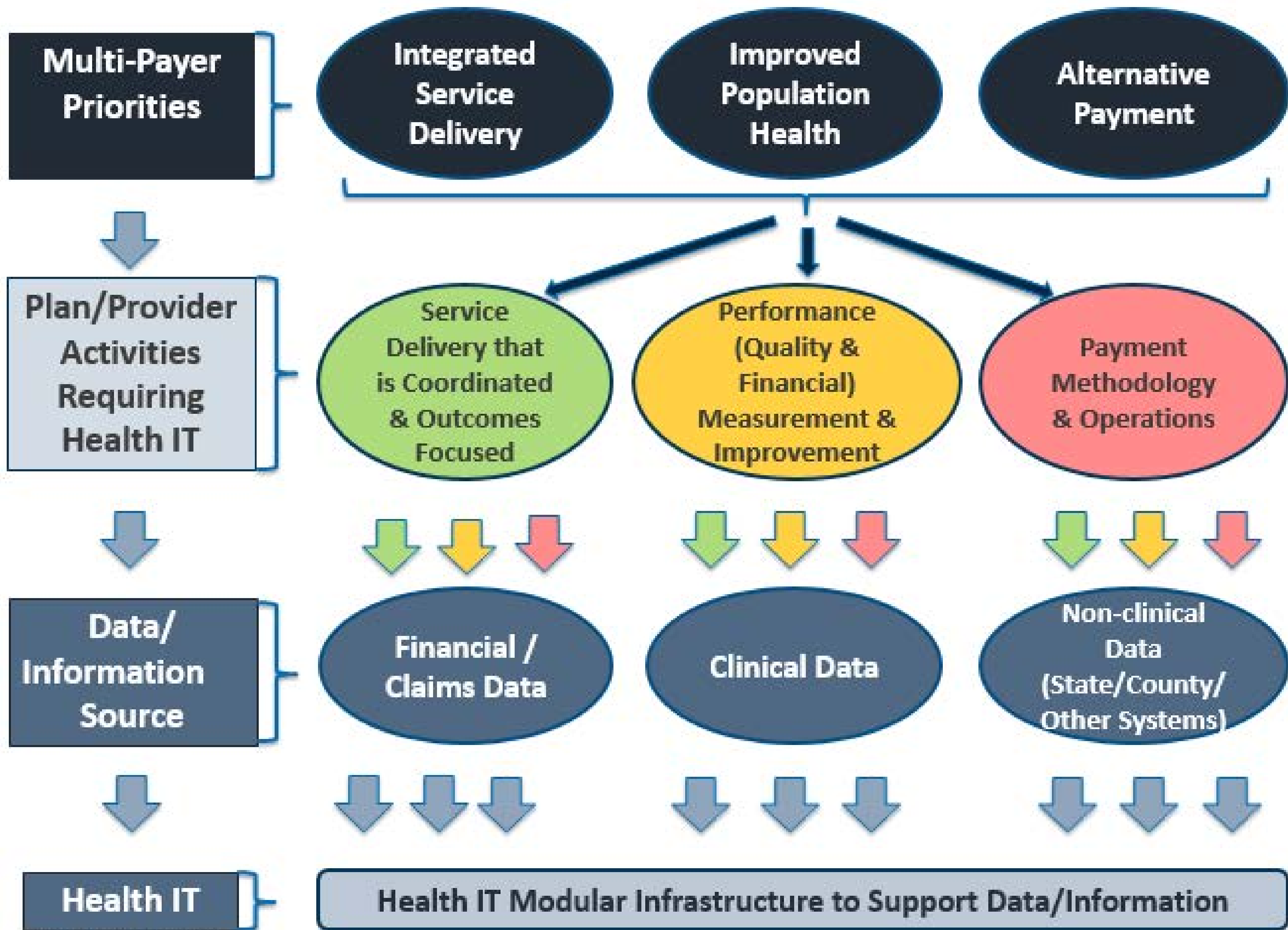
CMS provides incentives to encourage eligible clinicians to use health IT, most notably certified EHR technology. Certified EHR technology makes it possible for clinicians to submit information electronically to CMS in a format CMS can process.

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.

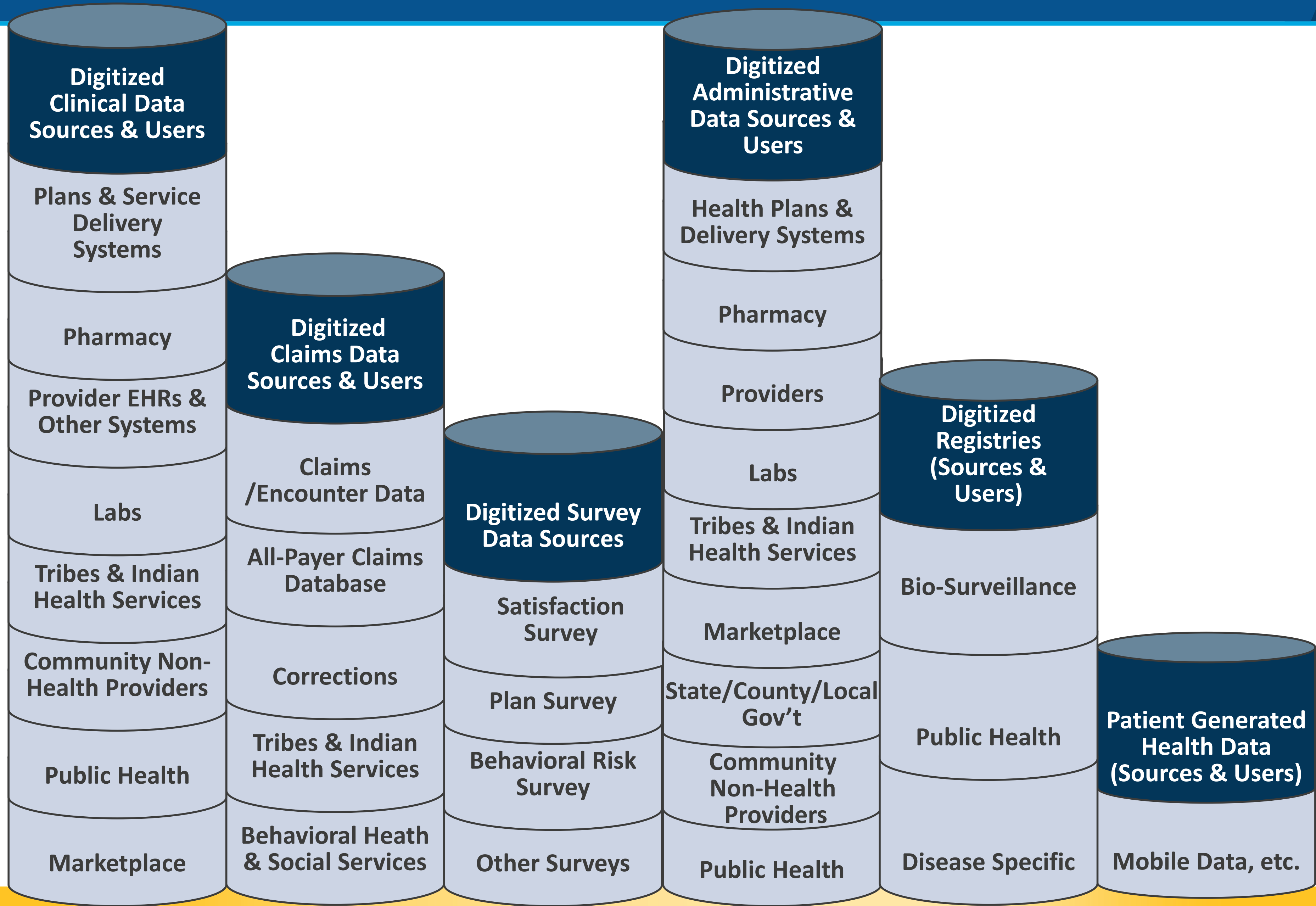
1. Requires at least 50 percent of eligible clinicians to **use certified EHR** technology to document and communicate clinical care information.

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

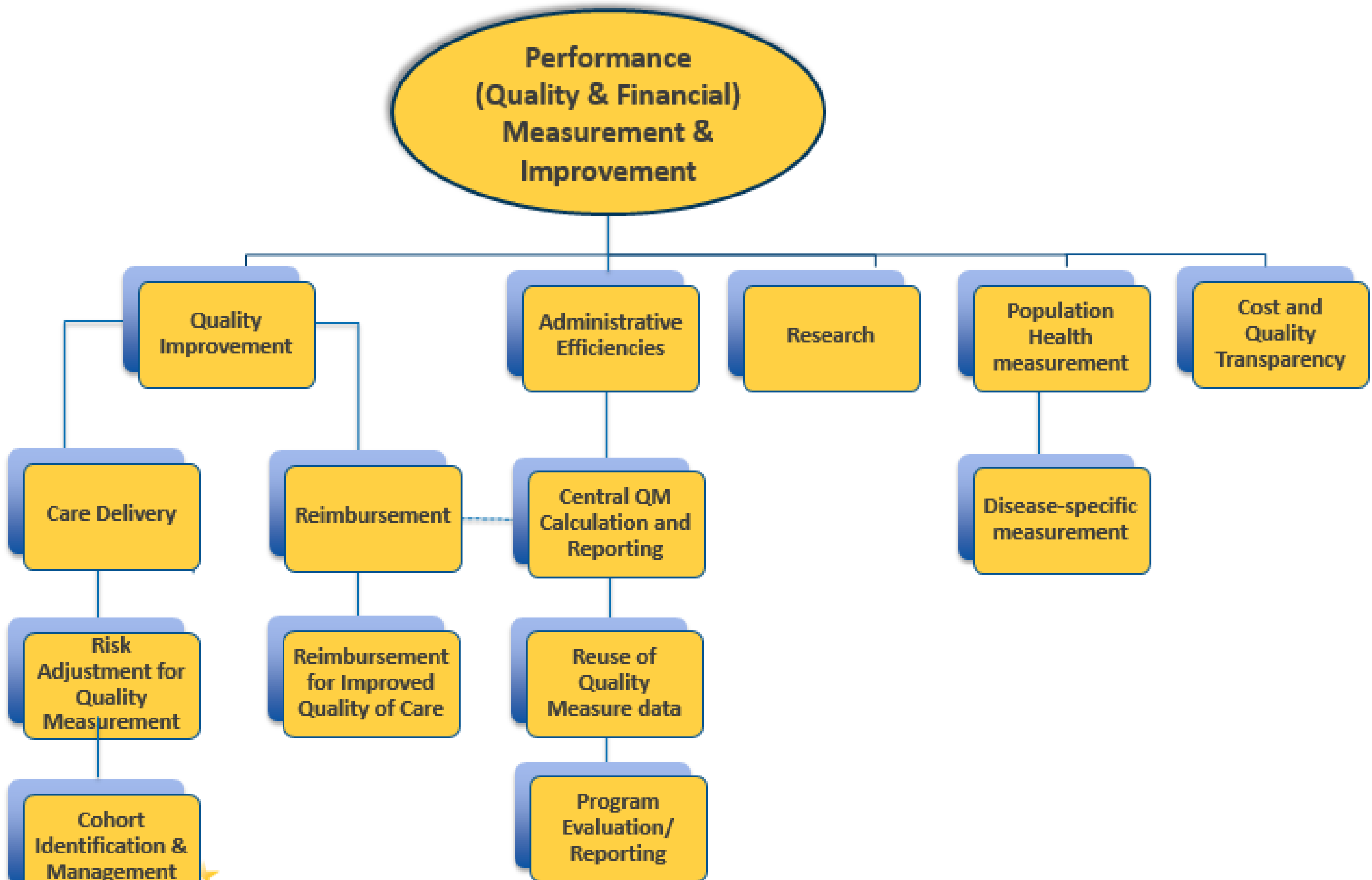
3. Either: (1) is a Medicaid Medical Home Model that meets criteria that is **comparable to a Medical Home Model expanded** under CMS Innovation Center authority, OR (2) Requires participants to **bear more than nominal amount** of financial risk.


Multi-Payer Priorities
Integrated Service Delivery
Improved Population Health
Alternative Payment
Plan/Provider Activities Requiring Health IT
Service Delivery that is Coordinated & Outcomes Focused
Performance (Quality & Financial) Measurement & Improvement
Payment Methodology & Operations
Data/ Information Source
Financial / Claims Data
Clinical Data
Non-clinical Data (State/County/ Other Systems)
Health IT
Health Information Technology
Health IT Modular Infrastructure to Support Data/Information

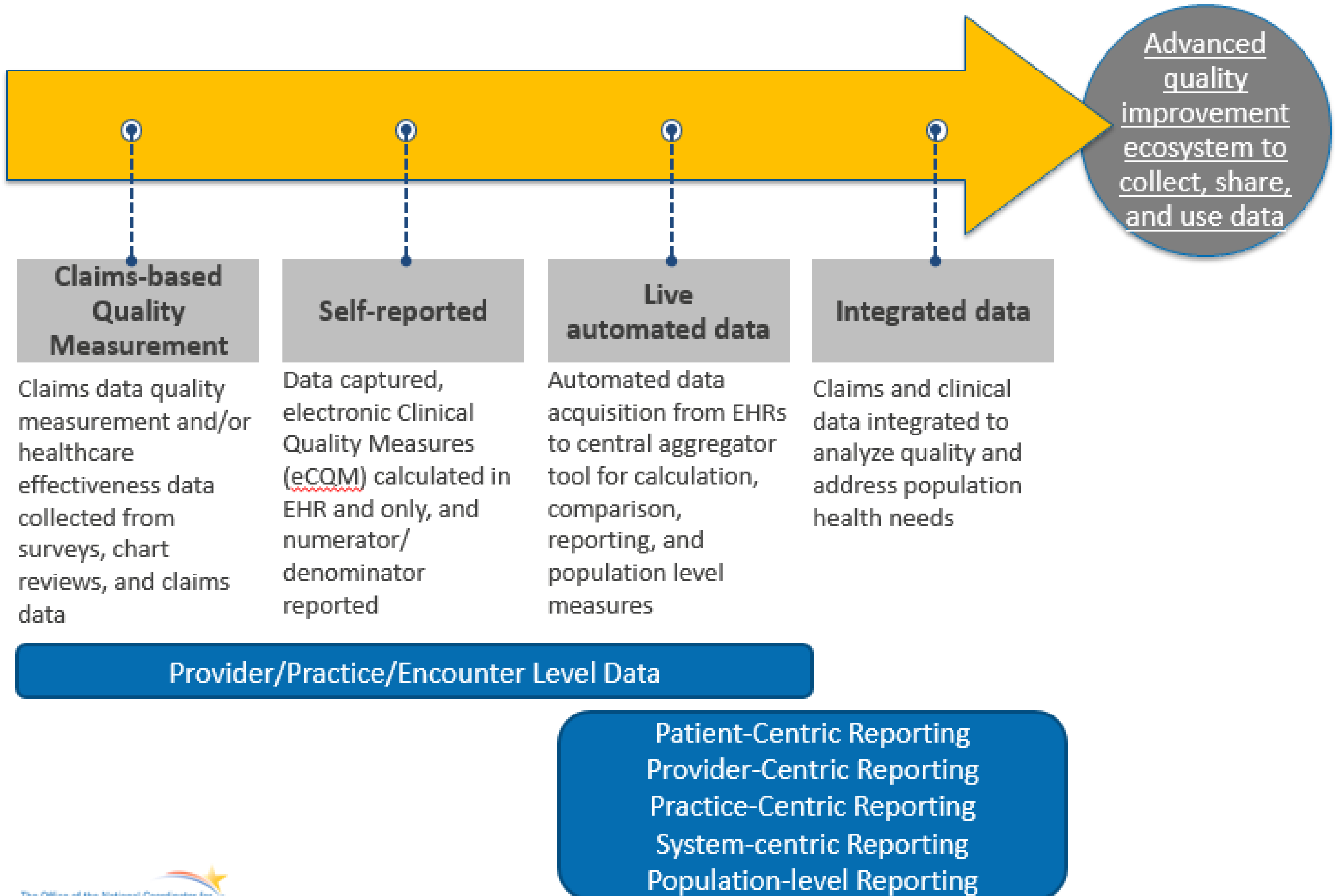
Data sources and Health IT infrastructure



Priority Use Cases for Clinical Quality Measure Information



Quality Measurement Continuum



The Office of the National Coordinator for Health Information Technology

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 two distinctly different approaches to using data from EHRs to generate results of CQMs

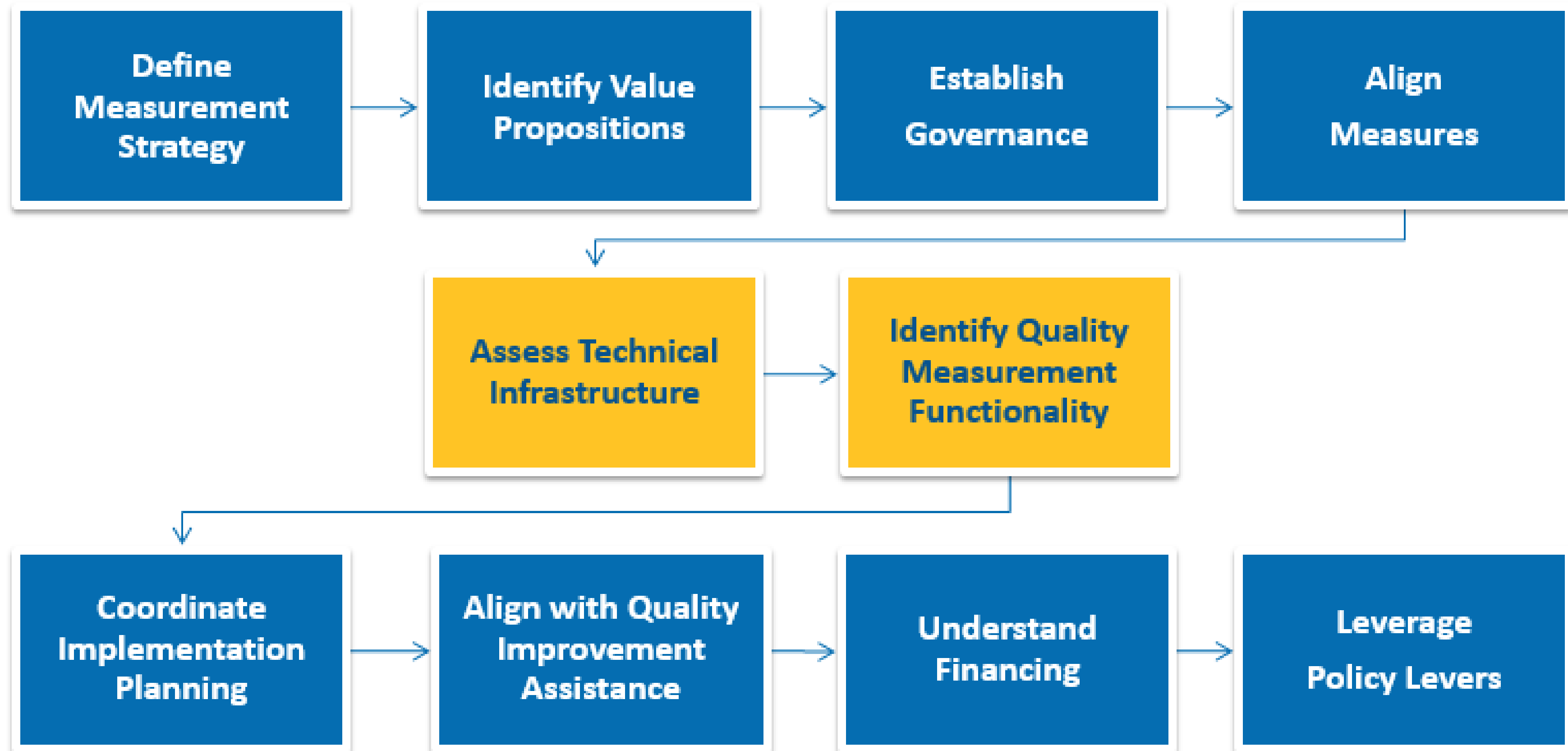
Measure Extraction

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



Timing

Immediate needs and long-term strategy

Type and Location of Technology & Transport Mechanisms

Fed/State/Co./ Other

Workforce & Technology

Capabilities & Capacity

Financing

Ability to Leverage Medicaid Funding/ Cost-Allocation

Governance

Data & Health IT Access & Usability

Policy & Privacy

Privacy-HIPAA – 42 CFR Part 2- Other

Data Source, Data Flow & Technology

Data Timeliness, Consistency of Definitions & Accuracy Linking of Data

Considerations, Challenges, and Potential Barriers

1. Technology
2. Trust
3. Business Case/Financial
4. Work Force

Questions

IAP Medicaid Innovation Accelerator Program

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

IAP Medicaid Innovation Accelerator Program

Appendices

Appendix A: Other Payer Advanced APM Informational Slides

Final Rule with Comment Period for Year 2

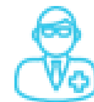
Agenda

- 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)

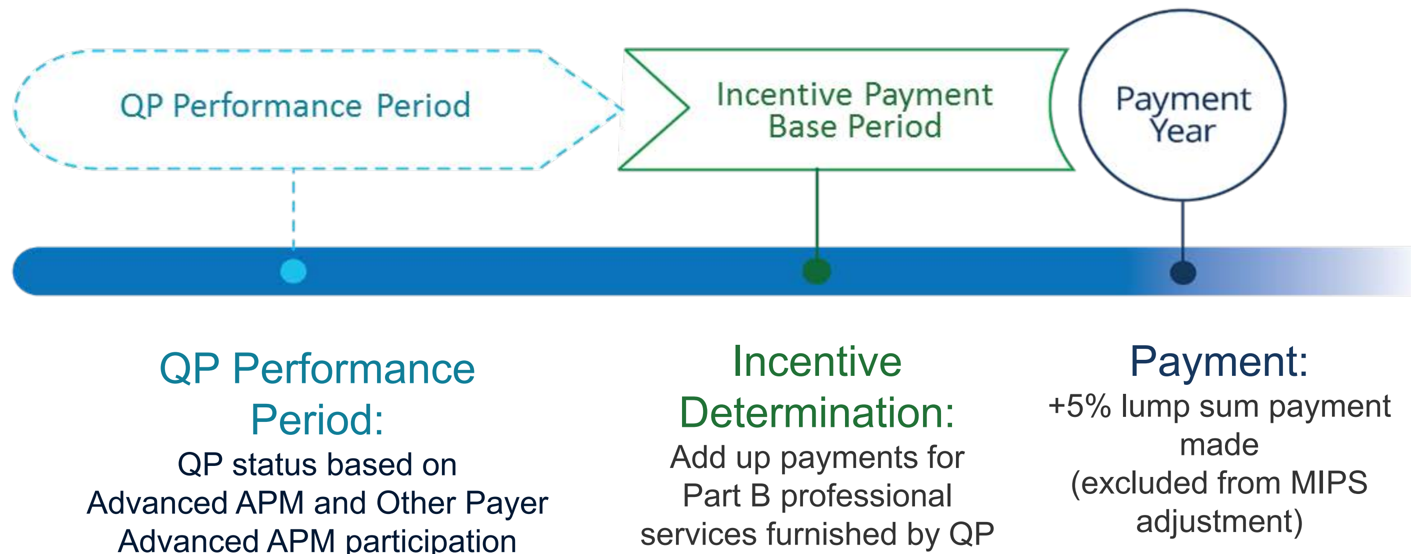
All-Payer Combination Option: QP Determinations

Final Rule with Comment Period for Year 2

Quality Payment PROGRAM

QP Performance Period

- 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

Quality Payment PROGRAM

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).

Final Rule with Comment Period for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step Two: Participate in an Other Payer Advanced APM

Quality Payment PROGRAM

2

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.

Final Rule with Comment Period for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step Three: Submit Payment Amount and Patient Count Information

Quality Payment PROGRAM

3

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.

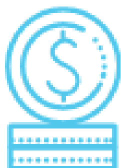
All-Payer Combination Option: How do Eligible Clinicians become QPs? Step 4: CMS Calculates Threshold Scores

4

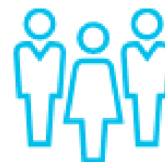
QP Determinations under the All-Payer Combination Option:

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



Patient Count Method

$$$ through Advanced APMs and Other Payer Advanced APMs
÷ **$$$** from all payers (except excluded $$$) = **Threshold Score %**

# of patients furnished services under Advanced APMs and Other Payer Advanced APMs
÷ **# of patients** furnished services under all payers (except excluded patients) = **Threshold Score %**

Final Rule with Comment Period for Year 2

Quality Payment PROGRAM

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 4: CMS Calculates Threshold Scores

4

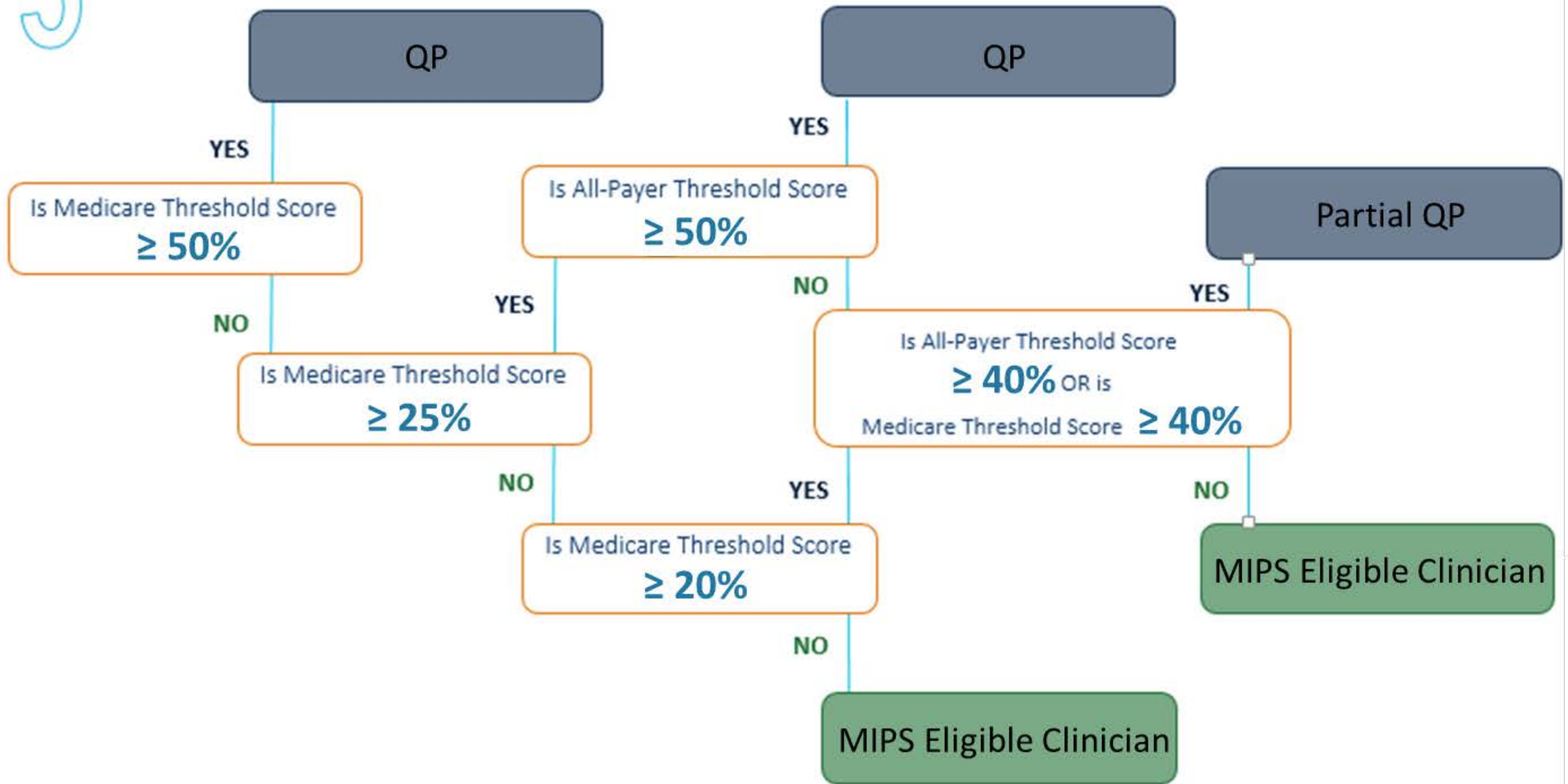
The MACRA statute directs us to exclude certain types of payments (and we will for associated patients).

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



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.

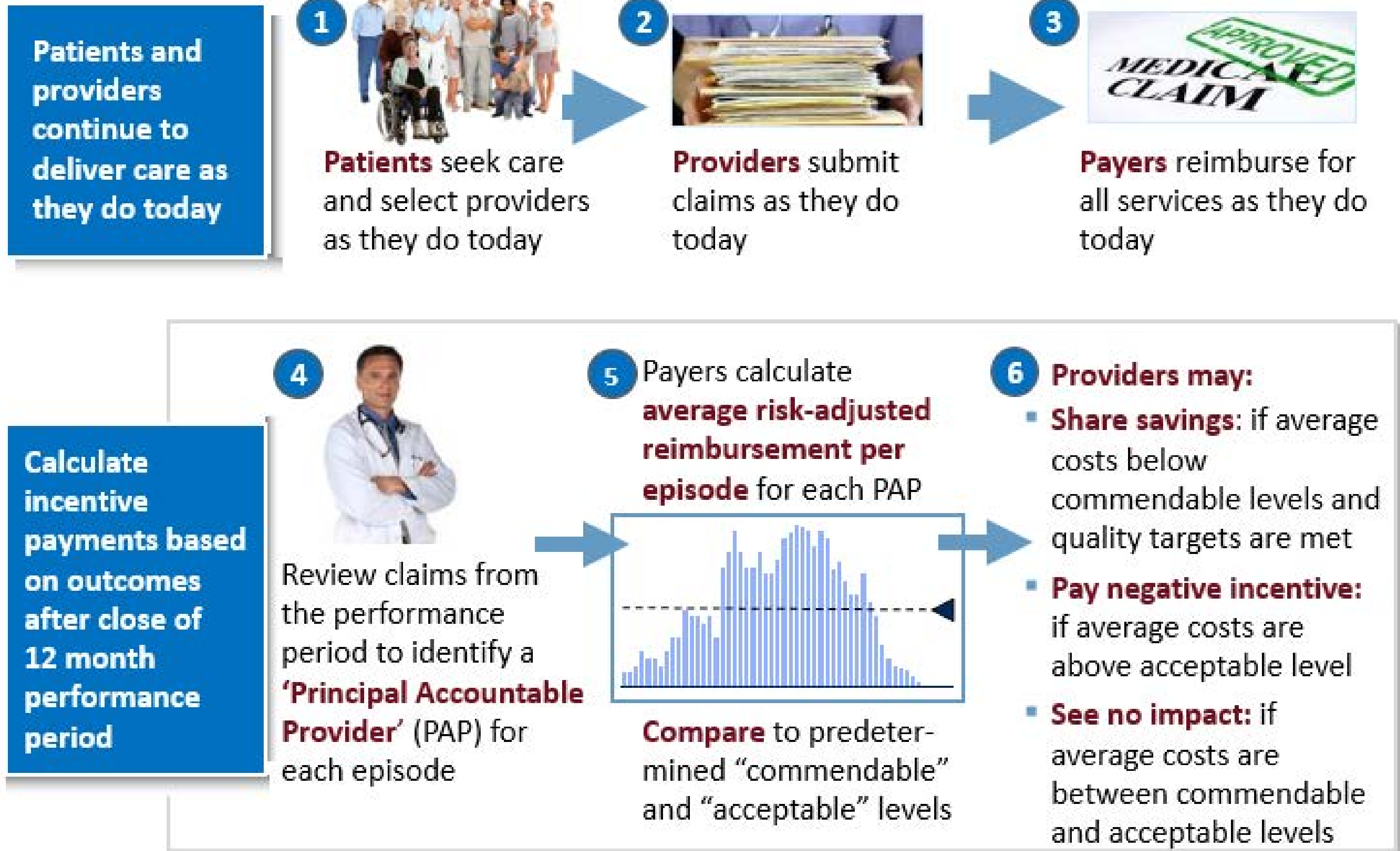
- QPP.CMS.GOV redirects to the CMS.GOV Resource Library:

  - CMS.GOV Resource Library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

  - Final Rule Materials Posted: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

Appendix B: Ohio Slides

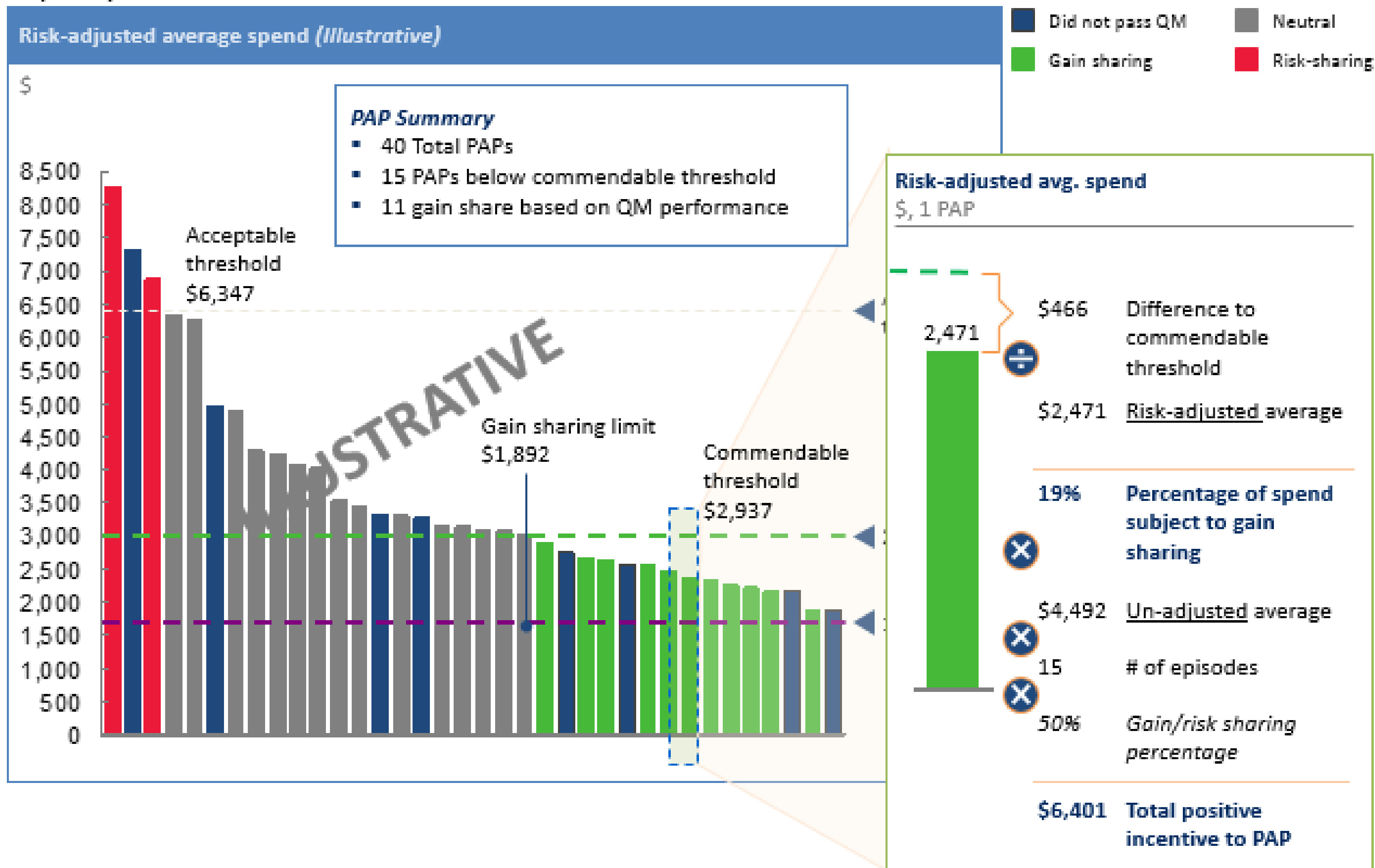
Retrospective episode model mechanics



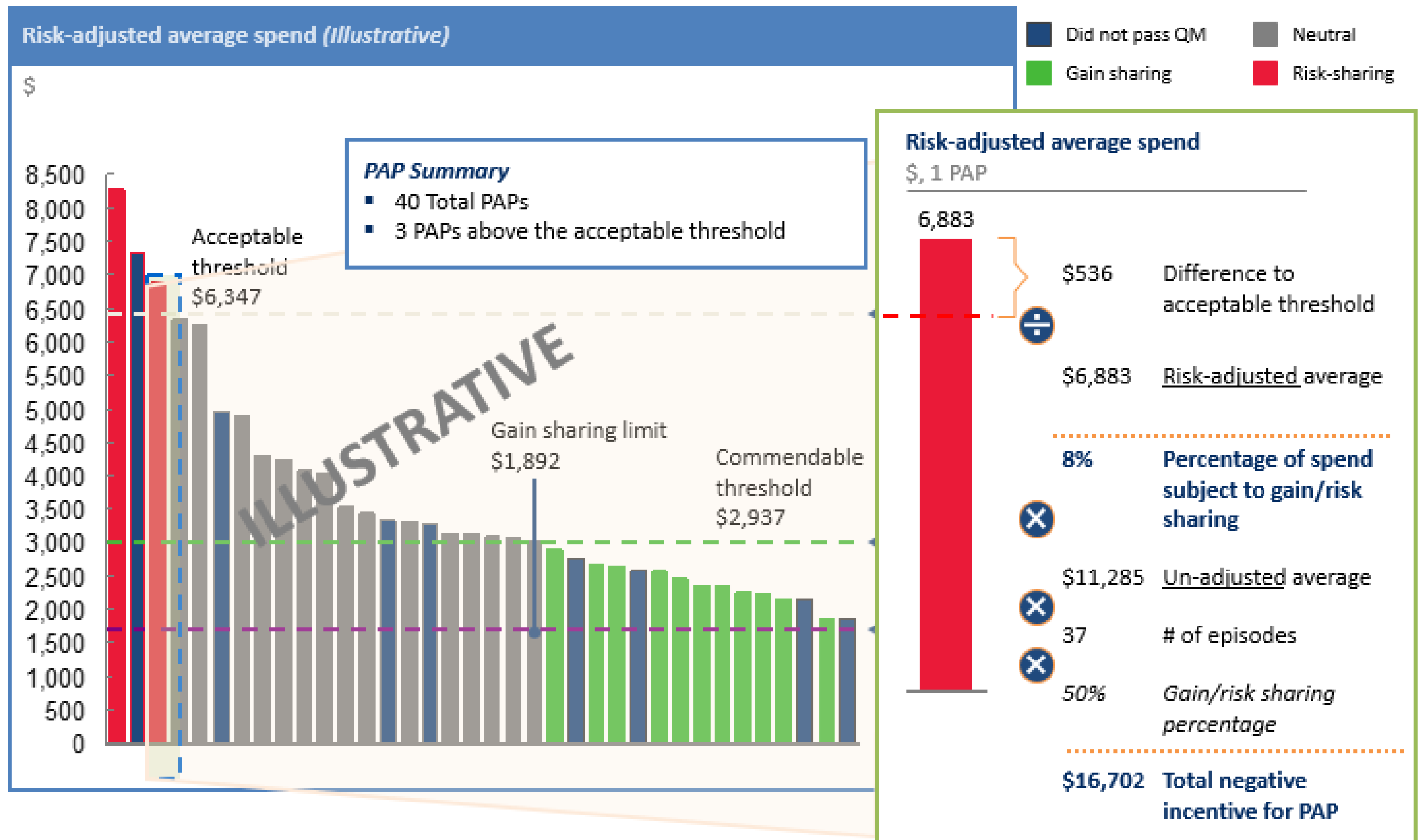
Elements of the Episode Definition

Category	Description
1 Episode trigger	▪ Diagnoses or procedures and corresponding claim types and/or care settings that characterize a potential episode
2 Episode window 3 Claims included	▪ **Pre-trigger window:** Time period prior to the trigger event; relevant care for the patient is included in the episode ▪ **Trigger window:** Duration of the potential trigger event (e.g., from date of inpatient admission to date of discharge); all care is included ▪ **Post-trigger window:** Time period following trigger event; relevant care and complications are included in the episode
4 Principal accountable provider	▪ 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
5 Quality metrics	▪ Measures to evaluate quality of care delivered during a specific episode
6 Potential risk factors	▪ Patient characteristics, comorbidities, diagnoses or procedures that may potentially indicate an increased level of risk for a given patient in a specific episode
7 Episode-level exclusions	▪ 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

Positive incentive (gain-sharing) is calculated based on average episode spend for providers that pass quality metrics



Negative incentive (risk-sharing) is calculated based on average episode spend



Ohio Medicaid Provider Network Data	
Providers with Active Ohio MD/DO Licenses (as of 3/13/2018)	48,320
Providers Participating in Ohio Medicaid (as of 3/12/2018)	40,172
Percent of Licensed Providers in Ohio Medicaid Network	83.0%

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