Quality Payment Program
Session #3: Alternative Payment Models and Relevant Resources for Value Based Care

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Stratis Health

• Independent, nonprofit, Minnesota-based organization founded in 1971
  – Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
  – Working at the intersection of research, policy, and practice

• Part of the Lake Superior Quality Innovation Network serving Michigan, Minnesota, and Wisconsin, under the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.

• Program areas
  – Health disparities
  – Health information technology
  – Rural health
Objectives

- Understand the key concepts of the QPP’s Alternative Payment Models
- Discover the benefits of Medical Home Models in providing care to your patients
- Understand how collaborating care across settings can improve quality and decrease costs
- Learn how to engage clinicians and patients in order to achieve common goals
- Learn what steps your hospital /clinic needs to take to begin transforming to a value based care system
- Explore available resources and tools relevant to your hospital and clinics
Overview of the Quality Payment Program
The 2 Tracks of the Quality Payment Program

QPP

MIPS  OR  APM
QPP Path 1: Merit-Based Incentive Payment System (MIPS)

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
</tbody>
</table>

Note: These are default weights; the weights can be adjusted in certain circumstances.
Track 2: Alternative Payment Model and Advanced APMs

- An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.
  - APMs can apply to a specific clinical condition, a care episode, or a population.
  - For clinicians not ready to participate in Advanced APMs

- Advanced APMs are a subset of APMs
  - Practices earn more for taking on some risk related to their patients' outcomes.
  - You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.

https://qpp.cms.gov/learn/apms
Alternative Payment Models

Quality Payment Program

Advanced APMs
Qualified Participants
*More downside risk
*5-8% of providers

MIPS APMs
Eligible Clinicians

MIPS
Eligible Clinicians

*92%- 95% of providers

Source: CMS Quality Payment Program – Train-The-Trainer
Alternative Payment Models in the QPP

APM
Advanced APM
MIPS APM
Alternative Payment Models: Incentivize Quality and Value

APMs offer opportunities to Eligible Clinicians not quite ready for Advanced APMs
## Benefits for Eligible Clinicians Participating in a APM

### Qualifying Professional
- APM specific benefits
- Focus on Quality and Efficiency
- No MIPS payment adjustments
- 5% lump sum bonus
- Receive higher Physician Fee Schedule update starting in 2026

### Non-Qualifying Professional
- APM specific benefits
- Focus on Quality and Efficiency
- MIPS payment adjustments
  - Higher scoring for MIPS
- Potential for exceptional performance bonus

https://qpp.cms.gov/learn/apms
Alternative Payment Models as Defined by MACRA

- CMS Innovation Center Model
  - under section 115A
  - other than a Health Care Innovation Award

- MSSP (Medicare Shared Savings Program)

- Demonstrations under the Health Care Quality Demonstration Program

- Demonstrations required by federal law
Alternative Payment Models in the QPP

APM

Advanced APM

MIPS APM
Advanced APMs Must Meet 3 Criteria

1. Require participants to use certified EHR technology

2. Payment for covered services based on quality measures comparable to those used in (MIPS)

3. Either:
   — be a Medical Home Model expanded under CMS Innovation Center authority; or
   — bear more than a nominal amount of financial risk

Source: CMS Quality Payment Program – Train-The-Trainer
Advanced APM Criterion 1: Requires Use of Certified EHR Technology

• At least 50% of the clinicians in each APM Entity required to use certified EHR technology (CEHRT) to document and communicate clinical care information with patients and other health care professionals.

• Shared Savings Program requires that clinicians report at the group TIN level according to MIPS rules.
Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

• Base payments on quality measures comparable to those used in the MIPS quality category
  – evidence-based, reliable, and valid

• At least one must be an outcome measure
  – if at least one applicable measure is available on the MIPS measure list

Source: CMS Quality Payment Program – Train-The-Trainer
Advanced APM Criterion 3: Nominal Amount of Financial Risk

• Either
  – is a Medical Home Model expanded under CMS Innovation Center authority
    OR
  – Requires Participants to bear more than nominal amount of financial risk

Source: CMS Quality Payment Program – Train-The-Trainer
**Advanced APM Criterion 3: Nominal Amount of Financial Risk**

**Bearing Financial Risk:** the Advanced APM may do one or more of the following if *actual* expenditures exceed *expected* expenditures:

- *Withhold* payment for services to the APM Entity and/or the APM Entity’s eligible clinicians
- *Reduce* payment rates to the APM Entity and/or the APM Entity’s eligible clinicians
- Require *direct payments* by the APM Entity to CMS

**Total Amount of Risk**
- Must be equal to at least either:
  - 8% of the average *estimated total* Medicare Parts A and B revenues of participating APM Entities; OR
  - 3% of the *expected expenditures* for which an APM Entity is responsible under the APM.

Source: CMS Quality Payment Program – Train-The-Trainer
2017 Advanced APMs

1. Comprehensive ESRD Care (CEC) - Two-Sided Risk
2. Comprehensive Primary Care Plus (CPC+)
3. Next Generation ACO Model
4. Shared Savings Program - Track 2
5. Shared Savings Program - Track 3
6. Oncology Care Model (OCM) - Two-Sided Risk
7. Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
8. Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Current List available on QPP.CMS.GOV
Two steps to Earn a 5% Advanced APM Incentive Payment in 2019

1. Meet Threshold in 2017 Performance Year
   – 25% of 2017 MPBPFS* payments received through an Advanced APM* OR
   – 20% of 2017 MPBPFS* patients seen through an Advanced APM*

2. Submit quality data required by your Advanced APM in 2017 Performance Year

*ECs who have not met these thresholds in #1 will need to submit data under MIPS to avoid a downward payment adjustment

*MPBPFS= Medicare Part B Physician Fee Services

https://qpp.cms.gov/learn/apms
Qualifying APM Participants (QP)
Clinic Requirement for Advanced APM Track

Must be in a Qualified Advanced APM

Beginning in 2021, threshold % may be reached through a combination of Medicare and other payer arrangements furnished through an Advanced APM Entity (i.e., private payers and Medicaid)
Calculating Payment and Patient Thresholds for QPs

2. The two methods for calculation are Payment Amount Method and Patient Count Method.

**Payment Amount Method**

\[
\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score } \%
\]

**Patient Count Method**

\[
\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score } \%
\]

CMS Webinar: Alternative Payment Models in the Quality Payment Program, Nov, 2016
How Eligible Clinicians Become QPs

• Qualifying APM Participant determinations are made at the Advanced APM Entity level

• Exceptions: If EC
  1. participates in multiple Advanced APM Entities, none of which meet the QP threshold as a group
  2. Is on an Affiliated Practitioner List when that list is used for the QP determination because there are no eligible clinicians on a Participation List for the Advanced APM Entity

  • Ex: gain sharers in the Comprehensive Care for Joint Replacement Model will be assessed individually

CMS Webinar: Alternative Payment Models in the Quality Payment Program, Nov., 2016
How Eligible Clinicians Become QPs

• CMS will calculate a “Threshold Score” for each Advanced APM Entity’s payment amount and patient count
  – Threshold score is based on Medicare Part B professional services and the APMs attributed beneficiaries
  – CMS will use the method that results in a more favorable QP determination
Three Snapshot Dates for EC to Be on APM Participation List

- EC must meet threshold criteria to be on APM List

- EC must be on APM participation list on at least one of these dates during the performance period

- If clinician does not qualify, then reports under standard MIPS

CMS Webinar: Alternative Payment Models in the Quality Payment Program, Nov., 2016
How Are QPs Determined During the Performance Period?

- For each of the three QP determinations, CMS will use claims data from period “A” for the APM Entity participants captured in the snapshot at point “B.” CMS then allows for claims run-out during period “C” and finalizes QP determinations at point “D.”

- If an APM Entity meets the QP threshold, subsequent eligible clinician additions to the Participation List do not automatically confer QP status to those eligible clinicians. If the group meets the QP threshold for a subsequent QP determination, then the new additions become QPs.
How Eligible Clinicians Become QPs

Threshold Scores below the QP threshold = no QPs

Advanced APM

Advanced APM Entities

Eligible Clinicians

Threshold Scores above the QP threshold = QP status

CMS Webinar: Alternative Payment Models in the Quality Payment Program, Nov, 2016
Alternative Payment Models in the QPP

APM

Advanced APM

MIPS APM
MIPS Alternative Payment Models

- Certain (APMs) include MIPS eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries

Benefits:
- Reduced burden by Streamlining MIPS reporting and scoring
- Participants receive special MIPS scoring under the “APM scoring standard”
  - Additional scores in Improvement activities for participating in APM
- Focus on goals and objectives of the APM entity
  - All ECs receive same MIPS score
  - Models APM-related performance as much as possible
MIPS APM Scores for Improvement Activities

- EC will receive additional scores in the improvement activity performance category for participating in MIPS APMs

- Most Advanced APMs are also MIPS APMs

- If EC participating in the Advanced APM does not meet the threshold of having sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS according to the APM scoring standard

Source: CMS Quality Payment Program – Train-The-Trainer
MIPS APMs Requirements

APM Scoring standard applies if:

- APM Entities participate in the APM under an agreement with CMS;
- APM Entities include one or more MIPS eligible clinicians on a Participation List; and
- APM bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality.

CMS Webinar: Alternative Payment Models in the Quality Payment Program, Nov., 2016
Key Dates for APM Scoring Standard

- To be considered part of the APM Entity for the APM scoring standard, an eligible clinician must be on an APM Participation List on at least one of the following three snapshot dates (March 31, June 30 or August 31) of the performance period.

- If not, then EC reports to MIPS under the standard MIPS scoring method.
MIPS APMs That Qualify for APM Scoring Standard in 2017

1. Medicare Shared Savings Program Accountable Care Organizations
   - MSSP Track 1
   - MSSP Tracks 2 and 3
2. Next Generation ACO Model
3. Comprehensive ESRD Care (CEC) Model
   - CEC (LDO arrangement)
   - CEC (non-LDO arrangement one-sided risk arrangement)
   - CEC (non-LDO two-sided risk arrangement)
4. Oncology Care Model (OCM)
   - (one-sided risk arrangement)
   - OCM (two-sided risk arrangement)
5. Comprehensive Primary Care Plus (CPC+) Model –
   - meets the criteria to be a Medical Home Model

- **Green** indicates Advanced APMs, who’s participants qualify for APM-MIPS scoring if they don’t meet the AAPM threshold

A current list of MIPS APMs is posted at [QPP.CMS.GOV](QPP.CMS.GOV)
Medical Home Models
A Medical Home Model or Medicaid Medical Home Model is an APM or payment arrangement under title XIX, respectively that we determine to have the following required elements:

- Primary care focus with participants that include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services
QPP: Medical Home Model
Expanded under CMS Innovation Center Authority

Must have 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, FFS payments (for example, shared savings, population-based payments).
Engaging Patients to Achieve Common Goals
CMS Broad Approach to Person and Family Engagement

1. Policies, Programs and Quality Improvement

2. Benefit Design, Value and Incentives

3. Engagement in Decision Making, Care Coordination, Prevention and Treatment

4. Family and Caregiver Support and Engagement

CMS Person and Family Engagement Plan: Values

- Supports three broad aims of the National Quality Strategy
  - Better Care, Healthier People & Communities, Affordable Care

1. **Person Centered**: engage with providers, empower patients, communicate personal preferences

2. **Health Literacy**: ensure every person is able to understand the information presented to them to make informed decisions about their care.

3. **Accountability**: include the patient’s voice, data and evidence in policy decisions and seeks to make information transparent. Encourages persons and providers to co-create health care goals

4. **Respect**: mutual respect between individuals and the providers

CMS Person and Family Engagement Cycle

Person & Family Engagement Cycle

- Promote Informed Decision Making
- Encourage Engagement & Self Management
- Promote PFE Best Practices
- Share Preferences and Values
- Co-Create Goals

QIC Affinity Group

Improving Healthcare Experiences & Outcomes

Engaging Clinicians to Achieve Common Goals
Quadruple Aim to Address Workforce Burnout

Triple aim of the National Quality Strategy
- Better Care, Healthier People & Communities, Affordable Care

Fourth aim addresses clinician and staff satisfaction
- Return the joy in clinicians work
- Prevent workforce burnout due to multiple increased demands
  - EHR use and documentation
  - Technology use: Health Information Exchange, patient portals, etc.
  - Quality reporting to multiple mechanisms
  - Changes in care delivery: PCMH, Team care, patient engagement processes
  - Increased transparency: Physician Compare, Hospital Compare, etc., Patients’ access to records
  - Increased Care Coordination process
  - Value-based Care
  - Population management

- Requires a team approach
  - different than what providers and patients are accustomed to
  - Culture change takes time
  - Starts with LEADERSHIP

https://integrationacademy.ahrq.gov/resources/new-and-notables/quadruple-aim-proposed-address-workforce-burnout
Actions to Engage Clinicians

• Maintain a balance between workforce satisfaction and patient satisfaction

• Use staff teams to complete EHR documentation and prescription processing.
  – Ex: Medical assistants and nurses can help with chronic disease management and preventive care (with adequate training)

• Empower physicians & other clinicians to lead transformation
  – Have all clinicians work at the top of their licenses: Physicians, Advanced Practice RNs and Physician Assistants
  – Involve clinicians in transformation planning process, problem solving and QI efforts
  – Provide Education and get feedback early and often on processes
  – Assess staff satisfaction on ongoing basis

• Make quality improvement efforts meaningful and relevant
  – Technology for clinicians, IT, and finance
  – Dashboards, point of care costs
  – Employ analytics to identify high risk patients, populations, and predictive analysis

https://integrationacademy.ahrq.gov/resources/new-and-notables/quadruple-aim-proposed-address-workforce-burnout
Value Based Care in Small and Rural Settings
Assess Organizational Readiness for Value-Based Care

- **Value-Based Care Strategic Planning Tool ©**
  - assess value-based care capacities across eight categories.

- **Value-Based Care Readiness Report**
  - assess your organization’s readiness for value-based care
  - develop action plans

- Completed in tandem with organizational leadership, clinical, IT, quality, and finance representatives

- **TIP:** It is not the score that matters as much as awareness of the practice transformations required in a Value-based health care system

Assess Current and Future Technology Needs

- **2014** Certified EHR in 2017
- **2015** Certified EHR by 2018
  - PH reporting, accept patient information into EHR, accept/request SOC, online patient access and education, clinical reconciliation

- Health Information Exchange

- **Patient Portals and API** (Application Program Interface) *Not all EHRs accept API*
  - allows patients to bring their records to integrate into your EHR
Assess Care Coordination Partnerships and Data Needs

• Current state: What data do you exchange now and with whom?
• Future state: What data would you like to exchange and with whom?

• Consider community and regional partners
  – Incoming and outgoing referral sources (specialists, clinics, hospitals) and others:
  – Community/public health, behavioral health, long term and short stay facilities, assisted living, subacute care
Next Steps for Hospitals in Health Care Transformation

• Work with Community and other Eligible Clinicians to the same goals: Health care Quality and safety
  – Begin long term planning for Community and Population Health Management and Increased care collaboration across settings
  – Involve Clinicians early and often, invest in education time

• Increasing pressure on those receiving FFS payments to move to APM

• Competition, growth among APMs: opportunity vs tension

• Increasing physician employment and/or collaborative agreements

• Value Based Care affects hospitals: Post-Acute care will be a focus for savings

• Push toward registry and electronic reporting, and data transparency
  – Physician Compare, Hospital Compare, NH Compare
  – State initiatives, i.e. Minnesota Community Measures

• Prepare for 2015 CEHRT with enhanced functionality for patient engagement, care collaboration and Health Information Exchange
Develop an Action Plan

- Clinicians
- Patients
- Staff
- Leadership
Relevant Resources!
Support for Small Practices

• MACRA designates $20 million a year for five years to fund training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer and those working in underserved areas

• Support organizations can help small practices:
  – select appropriate quality measures and health IT to support their unique needs
  – train clinicians about the new improvement activities
  – assist practices in evaluating their options for joining an Advanced APM
  – Make sure clinicians are able to focus on what is most important: the needs of their patients

* Support organizations to be announced soon (mid-Jan)
Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs)

• 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives to increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical care quality

• Interactive map of QIN/QIOs
Transforming Clinical Practices Initiative

• **Transforming Clinical Practice Initiative (TCPI):** TCPI is designed to support >140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies.
  – **Healthcare Communities:** supports healthcare transformation

• Benefits for clinicians:
  – **Learn about MIPS and how to move** toward participating in Advanced APMs.
APM: Innovation Center’s Learning Systems

• Collaborative forum for sharing emerging strategies and tactics to support successful performance within an APM

• connect you with specialized information regarding how participation in an APM, whether an Advanced APM or MIPS APM, affects QPP participation

• More information available through your APM
Most of Your Questions Can be Answered on the QPP Website

**CMS Website**

Quality Payment Program Help Desk:
- 8am – 8pm EST / 7am – 7pm EST
- Phone: (866) 288-8292
- Email: [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)
QPP Resources

- Centers for Medicare and Medicaid Quality Payment Program
- QPP Final rule published Oct. 14, 2014 (2,398 pages)
- QPP Executive Summary (24 pages)
- QPP: Quality Measures page:
- QPP Education page (past and upcoming webinars about QPP)
- Lake Superior Quality Innovation Network
- Previous and upcoming webinars
Additional CMS Resources

- CMS Certified Survey Vendor (CAHPS)
- CMS EHR Reporting
- CMS GPRO Web Interface
- CMS Hospital Compare Website
- CMS: MACRA Home Page and links to materials
- PQRS Measures Codes
- CMS Physician Compare Website
- CMS Qualified Clinical Data Registry
- CMS Registry Reporting
Additional Resources

- [Agency for Healthcare Research and Quality: Defining the PCMH](#)
- [CMS: Person and Family Engagement Strategy, Nov. 2016](#)
- [National Rural Health Resource Center: Value-Based Care Strategic Planning Tool](#)
CMS Acronyms

- AAPM – Advanced Alternative Payment Model
- ACI – Advancing Care Information (New MU)
- APM – Alternative Payment Model
- IA – Improvement Activities
- MACRA - Medicare Access & CHIP Reauthorization Act
- MIPS – Merit-Based Incentive Payment System
- MPBPFS – Medicare Part B Physician Fee Schedule
- PQRS – Physician Quality Reporting System
- VBM or VM – Value Based Modifier
Are you involved in any of the following programs?

*Choose as many as applicable

1. APM (Alternative Payment Model)
2. Advanced APM
3. PCMH – (Primary Care Medical Home Model)
4. Other Medical Home Model
5. TCPI (Transforming Clinical Practice Initiative)
6. QIN (Quality Improvement Organization) or QIO (Quality Innovation Network)
7. Other Value Based Payment Model
Questions?

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www.stratishealth.org
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.