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Bundled Payments for Care Improvement Advanced | BPCI Advanced

Quality Payment Program's (QPP's) Intersection with BPCI Advanced Webinar Series

Welcome to today's webinar.

We will begin promptly at 2:00 PM EDT.

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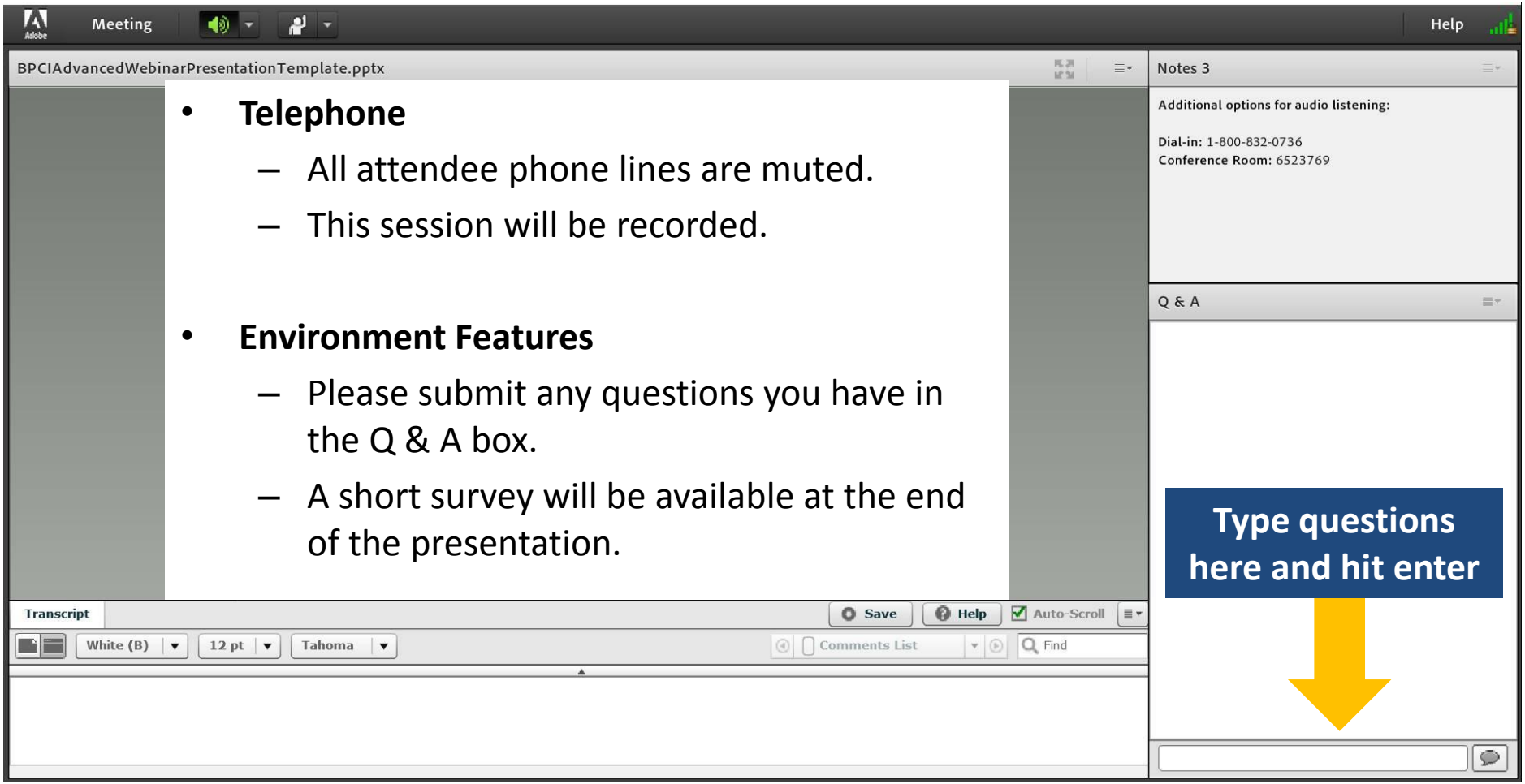

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Bundled Payments for Care Improvement Advanced | BPCI Advanced

Quality Payment Program's (QPP's) Intersection with BPCI Advanced Webinar Series: Session I

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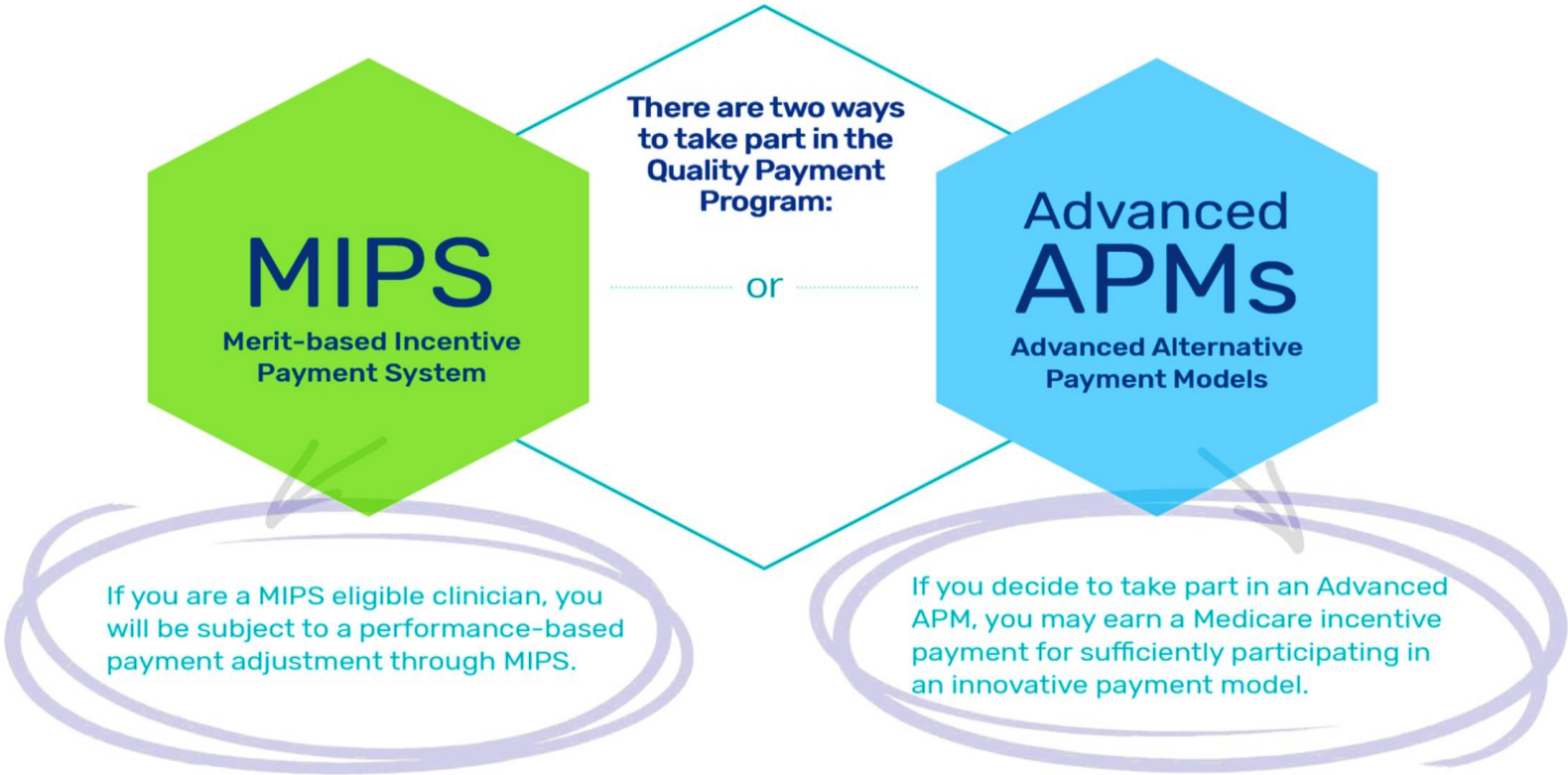
May 23, 2019

Quality Payment Program (QPP)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides for two participation tracks:



Alternative Payment Model (APM) Overview

APMs are new approaches to paying for medical care through Medicare that often incentivize quality and value. The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations to be conducted by CMS.

As defined by MACRA, **APMs include:**

- ✓ CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- ✓ Shared Savings Program
- ✓ Demonstration under the Health Care Quality Demonstration Program
- ✓ Demonstration required by federal law

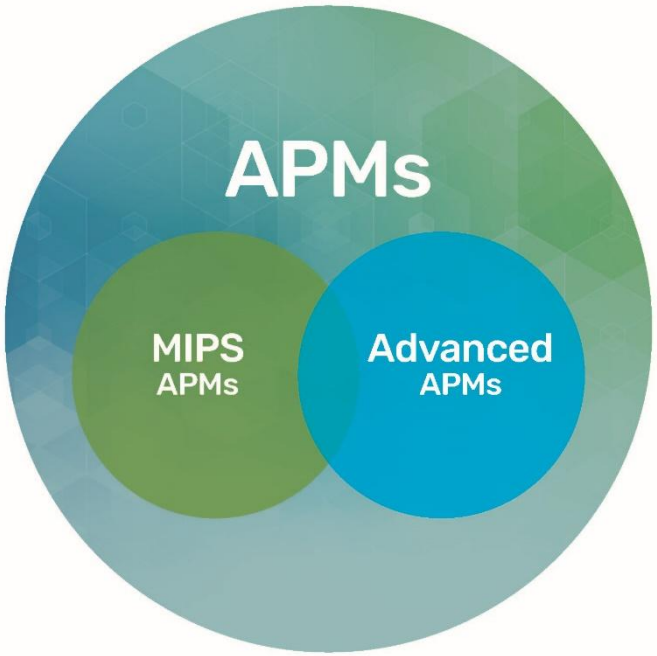
APM Overview
(Continued)

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care
- Can apply to a specific condition, care episode, or population
- MIPS APMs may offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs

Advanced APMs

- Advanced APMs are APMs that meet these three criteria:
  - Require participants to use certified EHR technology
  - Base payment for covered professional services on quality measures comparable to those in MIPS
  - Require entities to bear more than nominal financial risk, or the APM is a Medical Home Model Expanded under Innovation Center authority

ADVANCED APMS ARE A SUBSET OF APMS



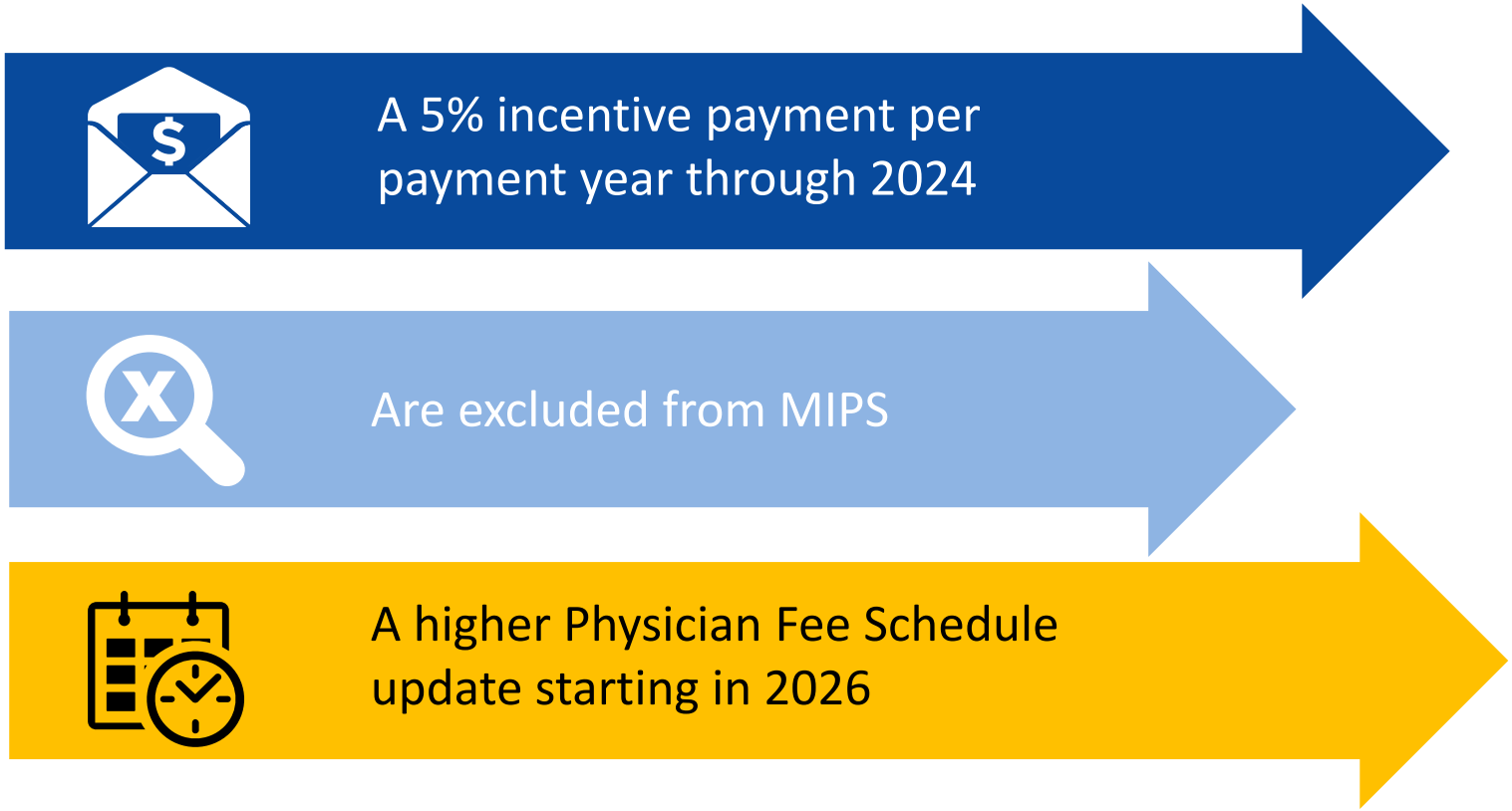
Qualifying Advanced APM Participant (QP) Determination

An eligible clinician's QP status is determined by two thresholds for Advanced APM participation:

1. Patient count
2. Payment amounts

Advanced APM Benefits for Participants

Clinicians and practices can receive **greater rewards** for taking on some risk related to patient outcomes. Participants that achieve QP status receive the following benefits:



QP – Status Thresholds

Requirements for Incentive Payments for Significant Participation in Advanced APMs (QP Status Thresholds) **Clinicians must meet payment or patient requirements*						
Performance Year	2017	2018	**2019**	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	**50%**	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	**35%**	35%	50%	50%

QP – All Payer and Other APM Thresholds

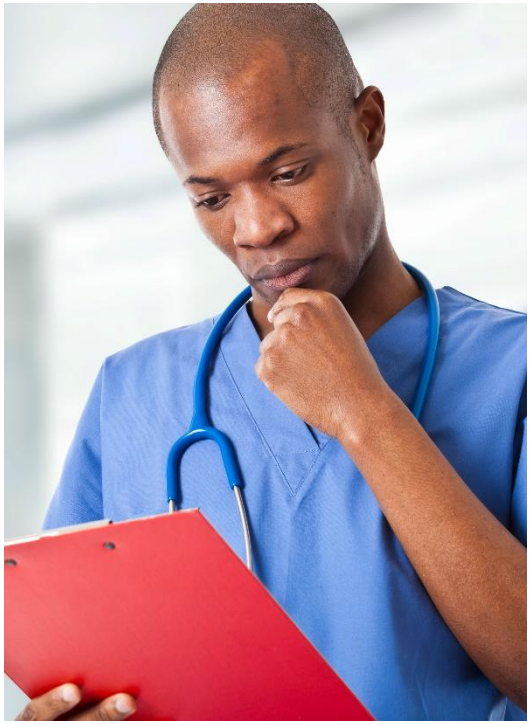
All-Payer Combination Option (Could exceed thresholds with Medicare only, but must meet the Medicare minimum and then can add other Payer Participation)									
Payment Year	2017	2018	**2019**		2020		2021		2022 and later	
QP Payment Amount Threshold	N/A	N/A	**50%**	**25%**	50%	25%	75%	25%	75%	25%
QP Patient Count Threshold	N/A	N/A	**35%**	**20%**	35%	20%	50%	20%	50%	20%
			Total	***Medicare***	***Total***	***Medicare***	***Total***	***Medicare***	***Total***	***Medicare***

Partial QP Overview

Eligible clinicians may also earn Partial QP status by meeting lower thresholds in:

1. Patient count
2. Payment amounts

If the Advanced APM is also a MIPS APM, Partial QPs have the option to be excluded from MIPS and receive a neutral payment adjustment, or to participate in MIPS



Partial QP – Status Thresholds

Medicare-Only Partial QP Thresholds in Advanced APMs (Minimums for Partial QP Status)						
Payment Year	**2019**	2020	2021	2022	2023	2024 and later
Percentage of Payments	**20%**	20%	40%	40%	50%	50%
Percentage of Patients	**10%**	10%	25%	25%	35%	35%

QP – Performance Period/Snapshot Dates

- CMS will assess eligible clinicians' participation in Advanced APMs to determine if they earn QP status for the payment year
- The QP Performance Period for each payment year will be from **January 1—August 31** of the calendar year that is **two years prior to the payment year**
- The **5 percent incentive payment** is determined using Part B payments for covered professional services **in the year prior to the payment year**

Advanced APM Tracks only

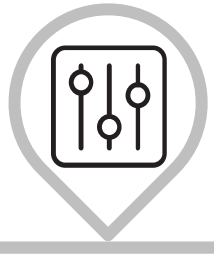
The eligible clinician must be on the APM Participation List for at least one of the three QP determination snapshot dates during the QP Performance Period.

QP – Performance Period 2019

QP Performance Period | Incentive Payment Base Period | Payment Year

2019 | Performance Period:

QP status based on Advanced APM participation



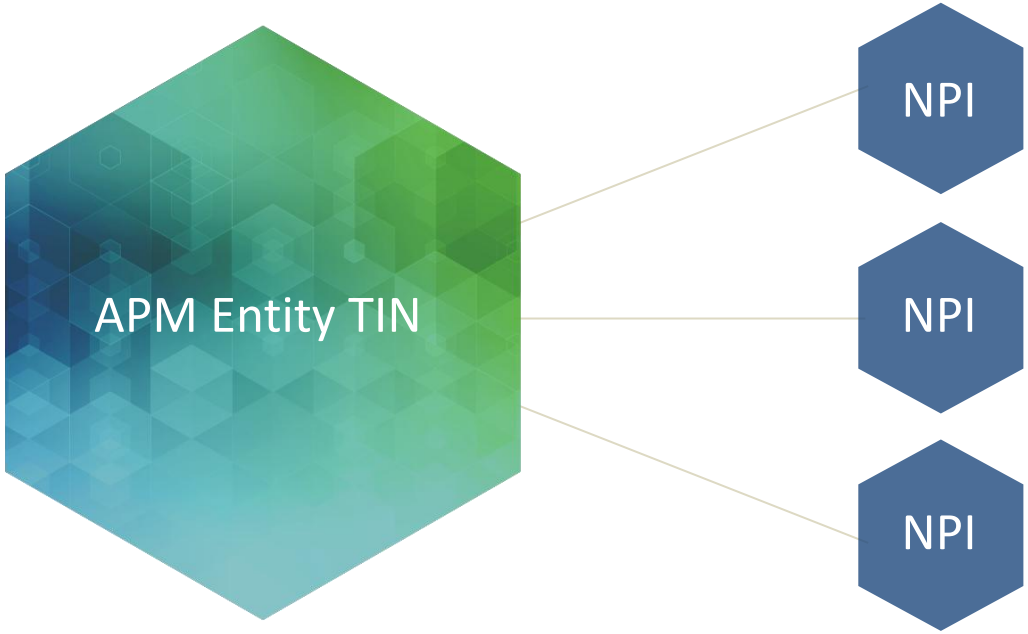
2020 | Incentive Determination:

Add up payments for **Part B** covered professional services furnished by QP

2021 | Payment

+5% lump sum payment made

APM Structure



(eligible clinicians)

An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.

APM APM Entity TIN

TIN Taxpayer Identification Number

NPI National Provider Identifier

Poll Question 1

If participants achieve QP status, do they receive a MIPS payment adjustment?

A. Yes
B. No
C. They can decide to either be excluded from MIPS or to participate in MIPS

All-Payer Combination Option & Other Payer Advanced APMs

Performance Year (PY) 2019
All-Payer Combination Option

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 PY 2019
- Eligible clinicians achieve QP status based on a combination of participation in both:
  - Advanced APMs with Medicare
  - Other Payer Advanced APMs offered by other payers

Other Payer Advanced APMs

Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria 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** 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 a nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures**

Other Payer Advanced APM Criteria
(Continued)

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 percent
  - Minimum Loss Rate of no more than 4 percent
  - 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 percent
  - Minimum Loss Rate of no more than 4 percent
- 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% of the average estimated total revenue of the participating providers or other entities under the payer in 2019

4% of the average estimated total revenue of the participating providers or other entities under the payer in 2020

5% of the average estimated total revenue of the participating providers or other entities under the payer in 2021 and later

All Payer Combination Option: Determination of Other Payer Advanced APMs

Determinations 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 participating in Medicaid payment arrangements
- Overall process is similar for eligible clinicians across all payer types, except for the submission deadlines

Payer Initiated Process Overview

- Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based upon information voluntarily submitted by payers
- This Payer Initiated Process will be available for Medicaid, Medicare Health Plans (e.g., Medicare Advantage, PACE plans) 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

Eligible Clinician Initiated Process Overview

- 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

Timeline for Determinations of Other Payer Advanced APMs

Medicaid

January 2019	April 2019	September 2019	November 2019	December 2019
Submission form available for States	Deadline for State submissions	Submission form available for eligible clinicians. CMS posts initial list of Medicaid APMs	Deadlines for eligible clinicians submissions	CMS posts final list of Medicaid APMs

CMS Multi-Payer Models

January 2019	June 2019	September 2019	August 2019	December 2019
Submission form available for Other Payers	Deadline for Other Payer submissions	CMS posts list of Other Payer Advanced APMs for PY 2019	Submission form available for eligible clinicians	CMS updates list of Other Payer Advanced APMs for PY 2019. Deadline for eligible clinicians submission

Medicaid Eligible Clinician Initiated Process

A list of Payer and Clinician submitted Medicaid Other Payer Advanced APMs determined for the 2019 QP Performance Period through the Payer Initiated Process was posted September 1, 2018

- https://qpp.cms.gov/apms/advanced-apms

The period for eligible clinicians to submit Medicaid payment arrangements for the 2020 QP Performance Period is open from September 1, 2019 to November 1, 2019

- Submission forms can be found at https://qpp.cms.gov/apms/all-payer-advanced-apms

CMS will post an updated list of Medicaid Other Payer Advanced APMs in December 2019

Timeline for Determinations of Other Payer Advanced APMs

Medicare Health Plans

April 2019	June 2019	September 2019	August 2020	December 2020
Submission form available for Medicare Health Plans	Deadline for Medicare Health Plan submissions	CMS posts list of Other Payer Advanced APMs for PY 2019	Submission form available for ECs	CMS updates list of Other Payer Advanced APMs for PY 2019. Deadline for EC submissions.

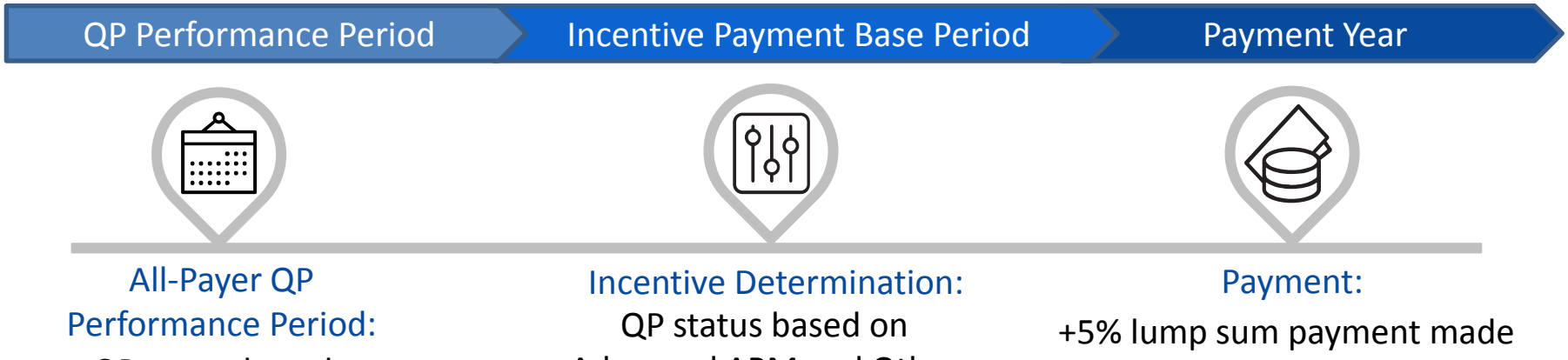
Remaining Other Payer Payment Arrangements

January 2019	December 2019	August 2020	December 2020
Other Payer Advanced APM determinations will not be made for PY 2019. We intend to add this option in future years.		Submission form available for ECs	CMS updates list of Other Payer Advanced APMs for PY 2019. Deadline for EC submissions.

All Payer Combination Option: QP Determinations

QP Performance Period

- The All-Payer QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs and Other Payer Advanced APMs to determine if they will be QPs for the payment year
- The All-Payer QP Performance Period will be from January 1 through June 30 of the year that is two years prior to the payment year. Under this proposal, CMS will make QP determinations under the All-Payer Combination Option from either January 1 - March 31, January 1 – June 30, or January 1 – August 31



Poll Question 2

What benefits do participants receive in an Advanced APM?

A. A 5% incentive payment per payment year through 2024
B. A higher Physician Fee Schedule update starting in 2026
C. Are excluded from MIPS
D. All of the above

QP Determination Process

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 PY 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).

QP Determination Process
(Continued)

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 will only have the option to submit their payment arrangement information **prior to the relevant QP Performance Period.

QP Determination Process
(Continued)

3

QP Determinations under the All-Payer Combination Option:

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.

QP Determination Process
(Continued)

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 or APM Entity level (as determined and submitted by the APM Entity).

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

$$$ from all payers (except excluded $$$)

= **Threshold Score %**

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)

= **Threshold Score %**

QP Determination Process
(Continued)

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

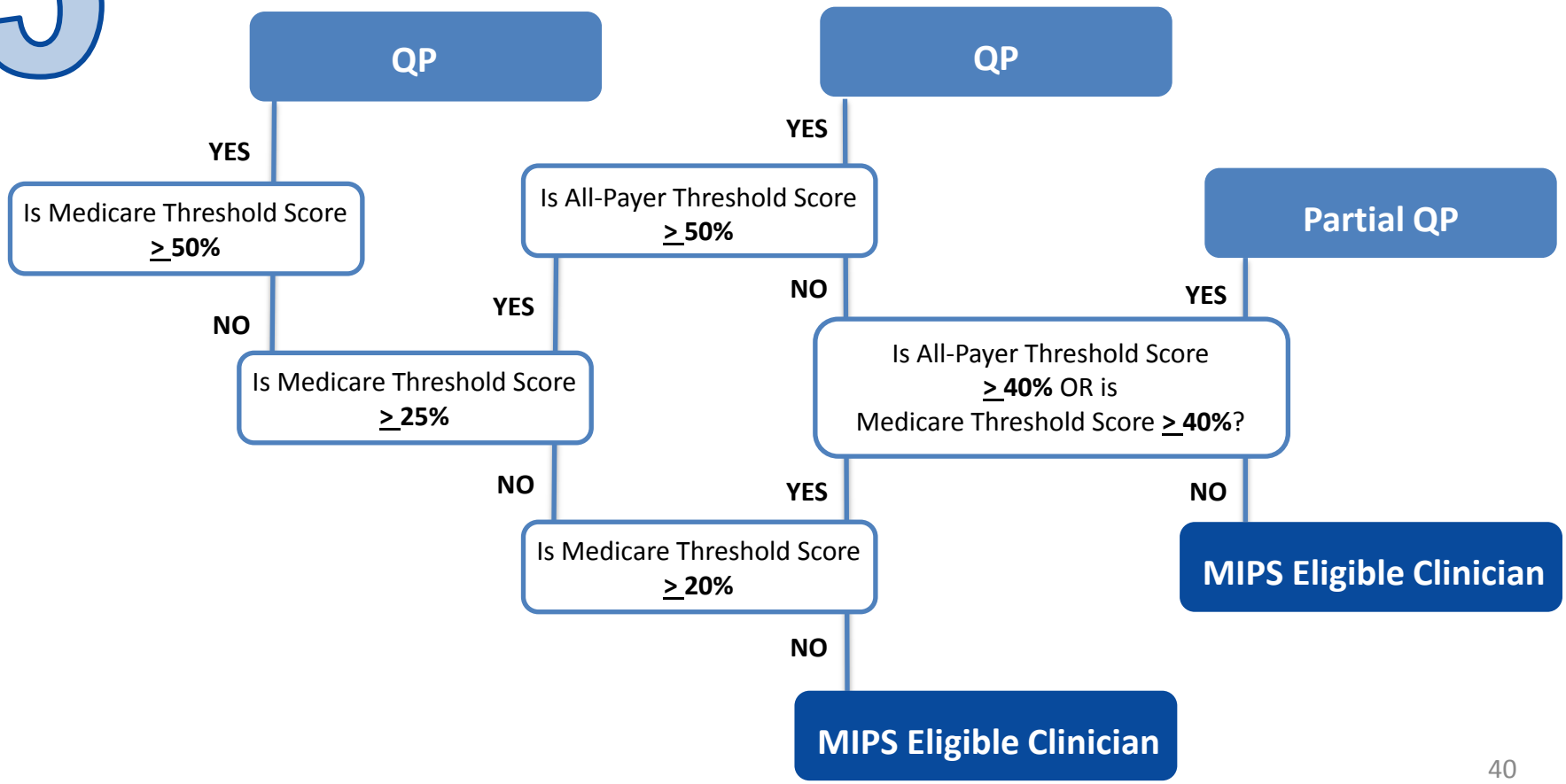
Specifically, that list of excluded payments includes, but is not limited to, Title XIX (Medicaid) payments where no Medicaid APM (which includes a Medicaid Medical Home Model that is an Other Payer Advanced APM) is available under that state program.

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.

QP Determination Process
(Continued)

5

2019 Performance Year – Payment Amount Method



Resources

Technical Assistance

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISCMail@us.ibm.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

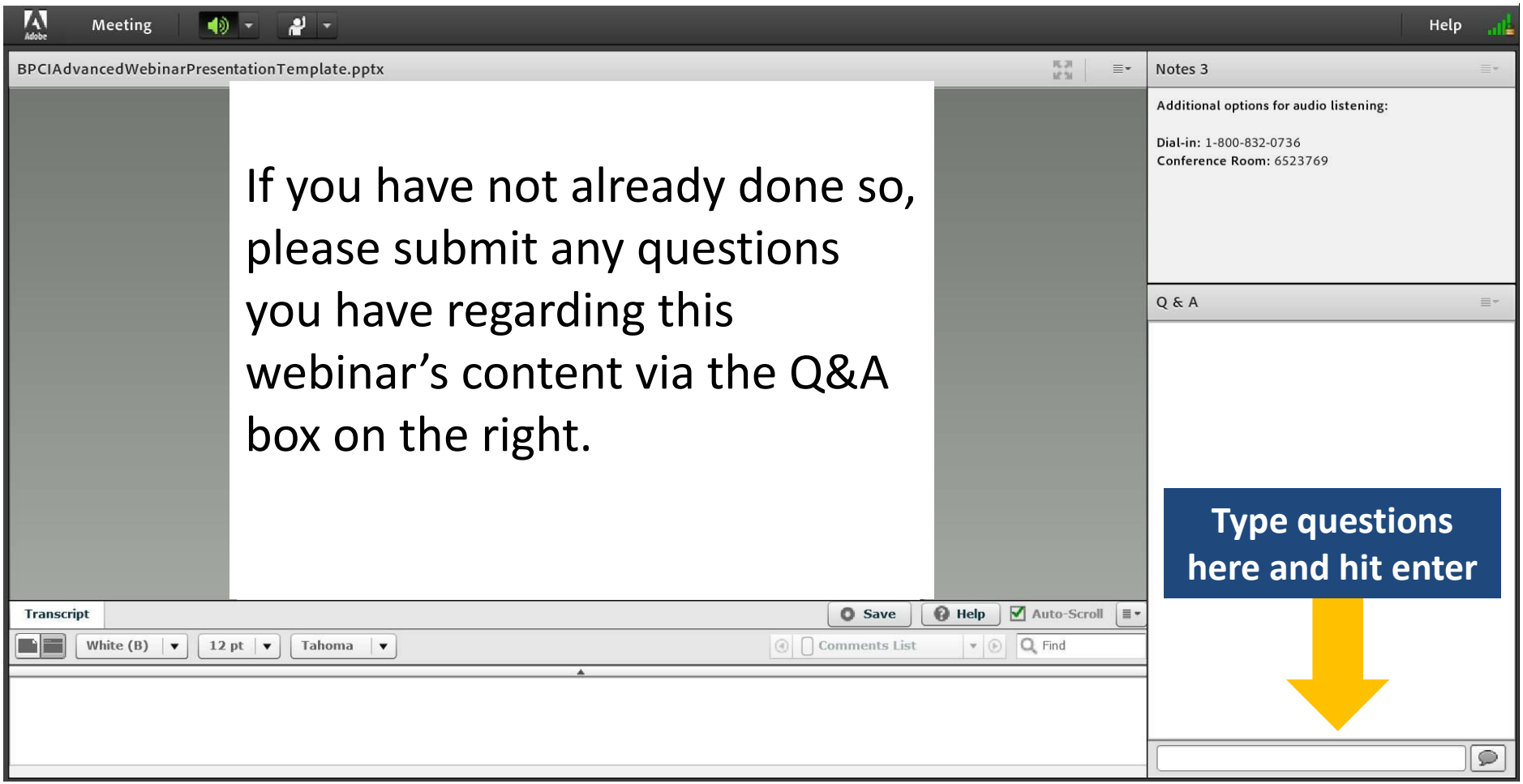
All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Questions?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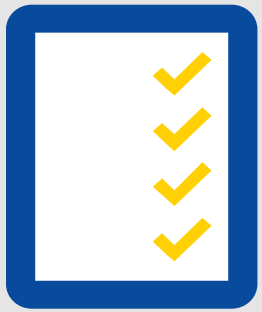
Additional Questions

If you have additional questions:

- Visit BPCI Advanced homepage at https://innovation.cms.gov/initiatives/bpci-advanced
- email the BPCI Advanced Model team at BPCIAdvanced@cms.hhs.gov



Please complete the short nine-question survey that appears at the end of today's event. https://deloittesurvey.deloitte.com/Community/se.ashx?s=3FC11B260B45E06E