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The Path to Successful Utilization of Alternative Payment Models

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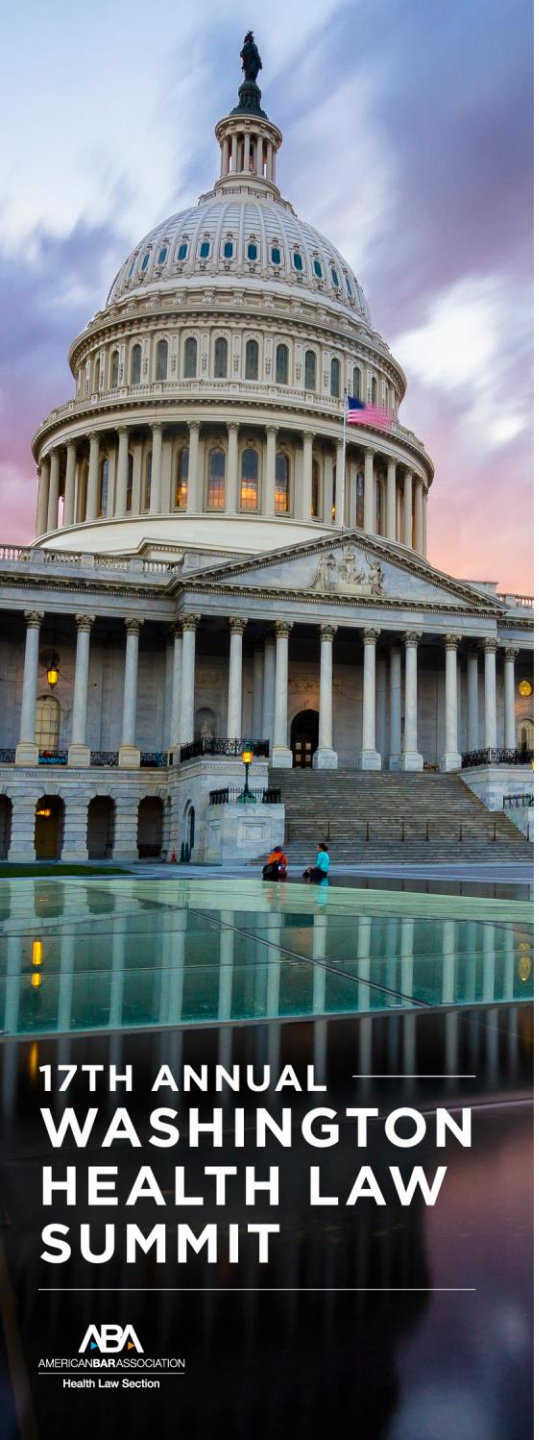
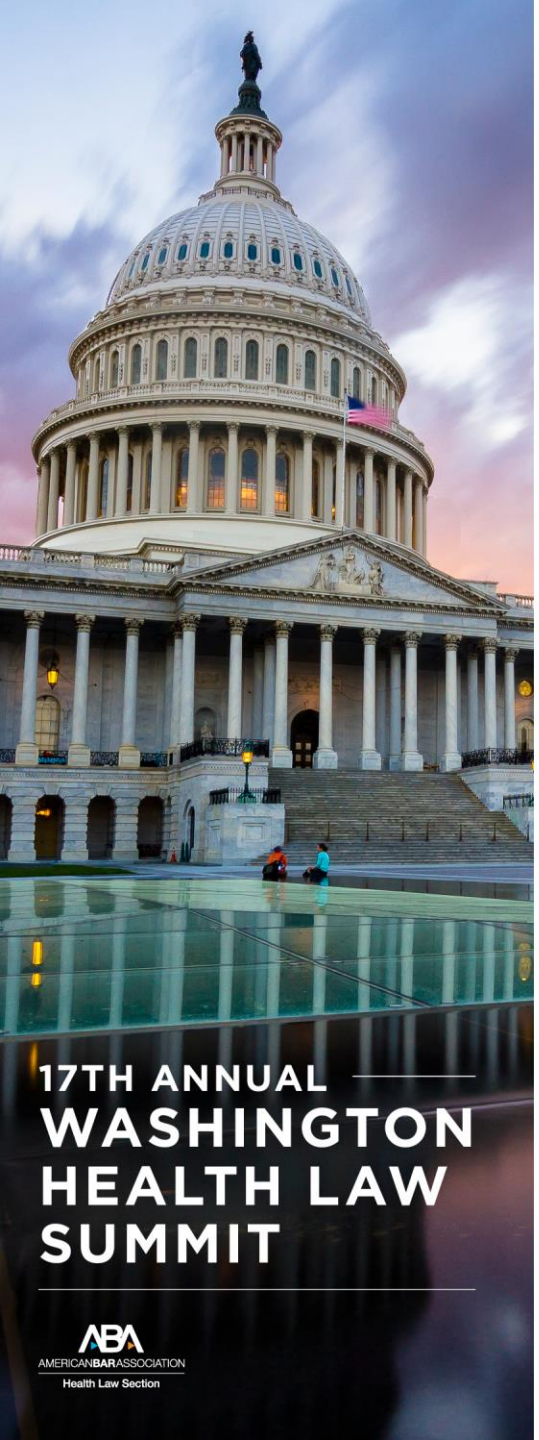


Presenter Bio

Khaled John Klele is a partner at Riker Danzig Scherer Hyland & Perretti LLP, a Morristown, New Jersey based law firm, with additional offices in Trenton, midtown Manhattan, White Plains and Stamford.

Mr. Klele practices in the Firm's Health Care Group, focusing his practice on health care regulatory and litigation work. He provides counsel to a variety of providers including independent practices, group practices, ambulatory surgery centers, laboratories, imaging centers, addiction centers, skilled nursing facilities, urgent care centers and pharmacies. He regularly assists his health care provider clients in a variety of areas, including the negotiation of provider agreements with payors, fair market evaluations, payor models, state and federal regulatory compliance, medical billing audits and litigation, Medicare and/or Medicaid audits and other health care reimbursement issues, medical board investigations and fair hearings, fraud and abuse issues, and other health care compliance and audit issues and litigation.

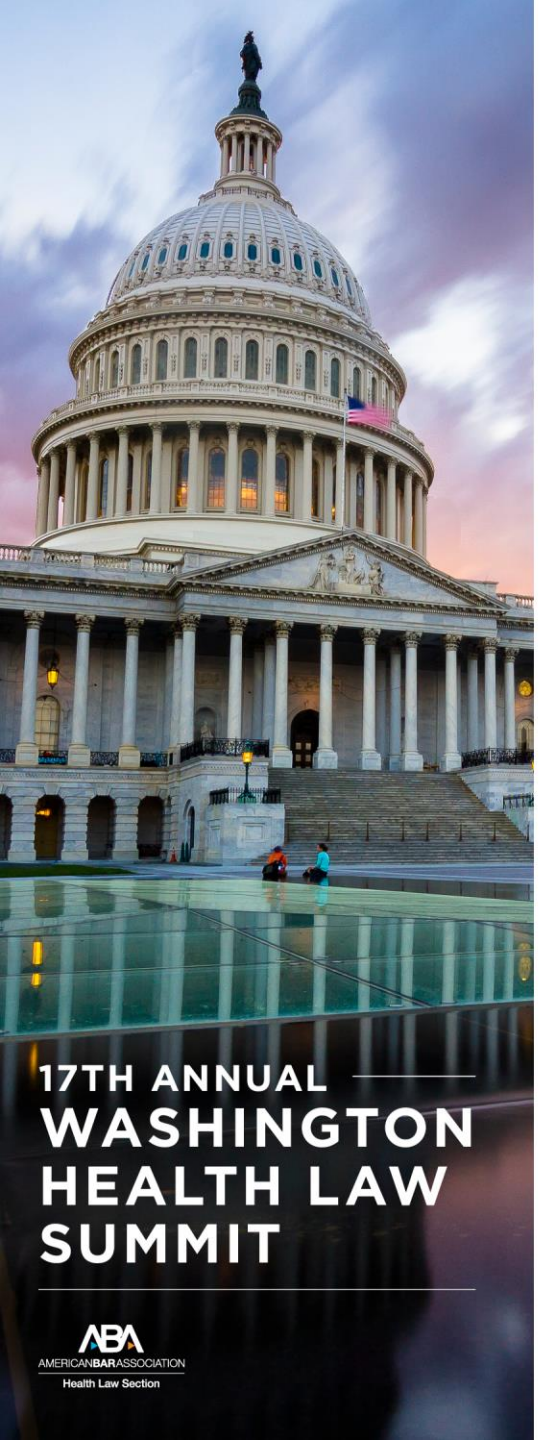
He is a the creator and frequent contributor to Riker Danzig's Health Care Law blog, "The Juris Doctor Report," and is the author of several articles in Riker Danzig's Health Care Alerts, including "The Interplay Between the Corporate Practice of Medicine and Management Services Organizations," August 12, 2019; "Supreme Court Rejects Health and Human Services' 2014 DSH Reimbursement Formula," June 4, 2019; and "New Jersey Legislature Passes 'Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act,'" April 19, 2018.



Presenter Bio

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

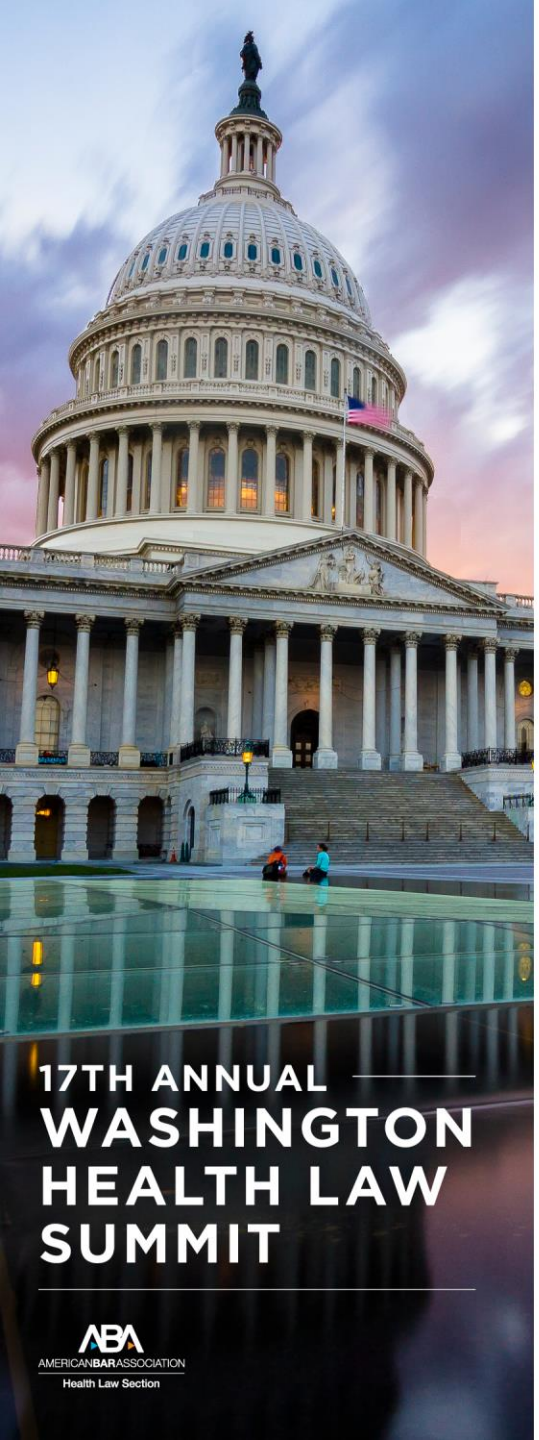
Mr. Zigrang is the co-author of the "*Adviser's Guide to Healthcare – 2nd Edition*" (AICPA, 2015), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.



Presenter Bio

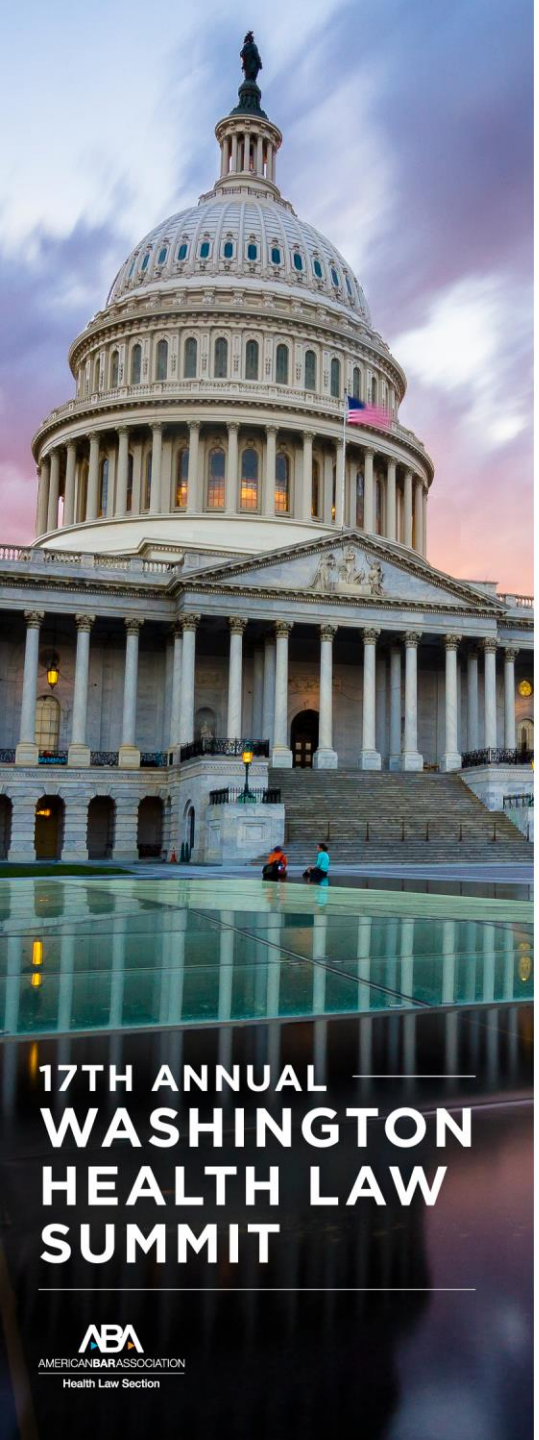
Latoya Caprice Dawkins is an associate in the Health Care Group of Riker Danzig Scherer Hyland & Perretti LLP. Ms. Dawkins brings an insider's perspective to her health care practice, having worked for an international pharmaceuticals manufacturer for over eight years. She helps physician practice groups, manufacturers, pharmacies, hospitals, and other healthcare and life sciences clients navigate the nuances and complexities of structuring strategic and effective transactions and services in today's heavily-regulated environment. Her practice includes counseling clients regarding federal and state fraud and abuse issues; Medicare/Medicaid regulatory and reimbursement issues; pharmacy benefit manager audits and licensing issues; consumer coupon and copayment assistance programs for pharmaceutical manufacturers and pharmacies; DSCSA compliance standards for hospitals, pharmacies, drug distributors and manufacturers; liability issues regarding advertising and off-label promotion; FDA enforcement actions; compliance programs; and health care transactions, including mergers and acquisitions.

Ms. Dawkins was a panelist at the 2019 Annual Health Law Symposium during the 94th Annual National Bar Association Convention. She presented on Healthcare Economic Information (HCEI) at a session on Health, Law and Economics at the event. She is a regular contributor to Riker Danzig's Health Care Law blog, "The Juris Doctor Report."

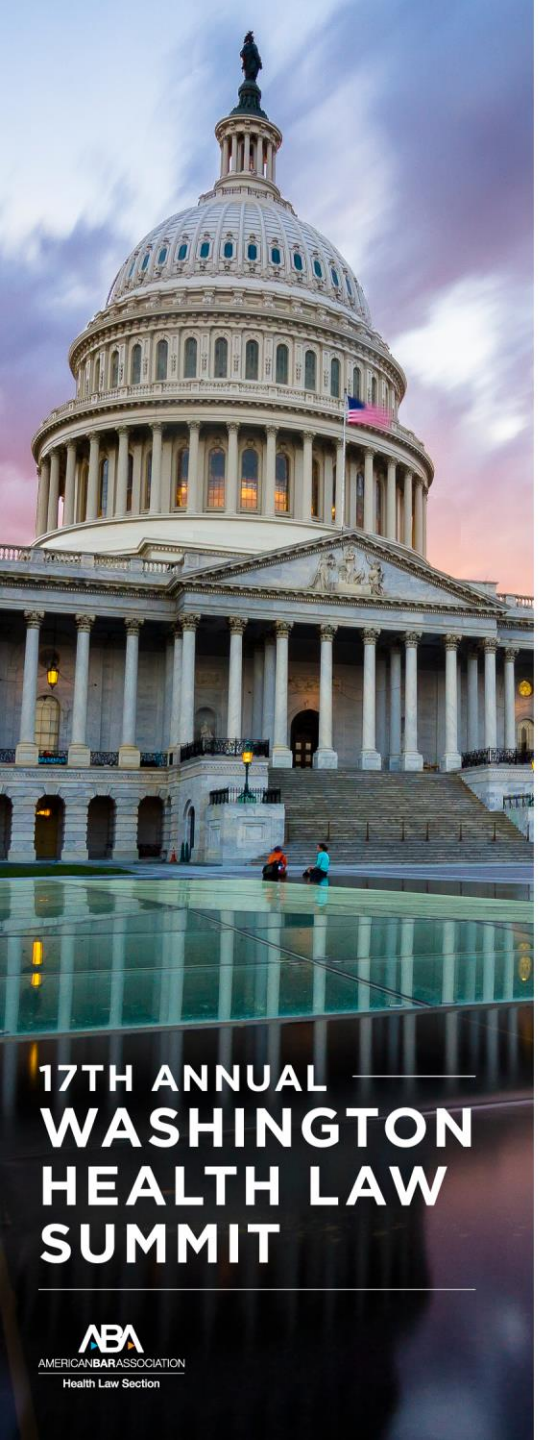


Session Overview

- Introduction
- Federal Side APMs
- Private/Commercial Side APMs
- Other Considerations
- Conclusion

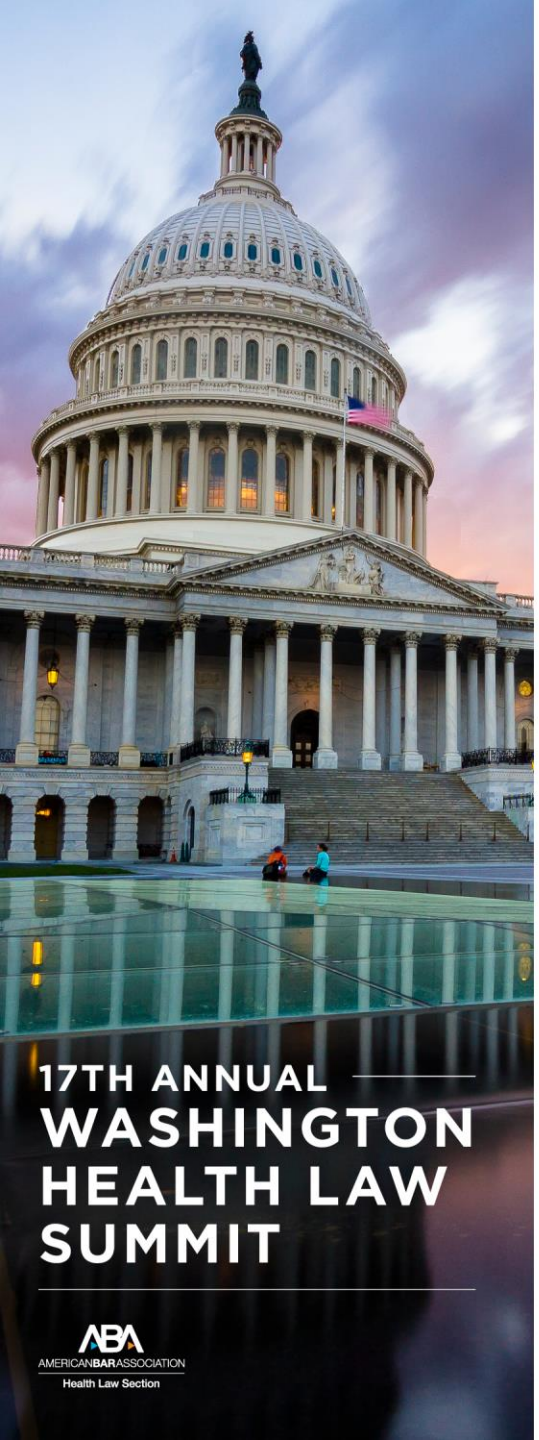


Federal Side APMs



Overview

- Background on Medicare Shared Savings Program (“MSSP”)
- Reasons for changing the MSSP and what the data shows
- Definitions that set the stage for the changes
- Overview of the changes to the MSSP
- Incentives
- How the changes have impacted ACOs based on recent data
- Decision points for structuring the right ACO or choosing which ACO to participate
- What’s next, more changes?



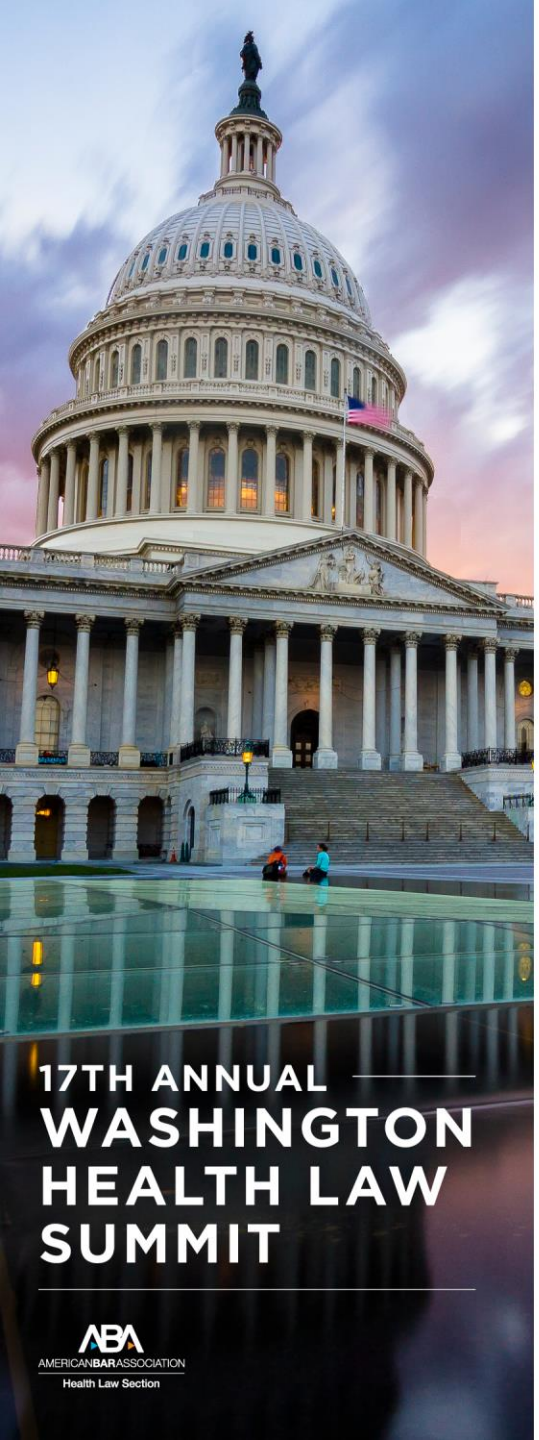
CMS established the MSSP in 2012

- Three Tracks

  Track 1 (2012): Upside only
  Track 2 (2012): Upside and downside risk
  Track 3 (2016): Upside and downside risk, which were greater than Track 2

  Track 1+ (2018): Transition model based on Track 1, but incorporates limited downside risk that was less than Tracks 2 and 3.

  The December 2018 Final Rule ("December Final Rule") made significant changes to the MSSP



As of 2018, 561 ACOs affecting 10.5 million Medicare Beneficiaries

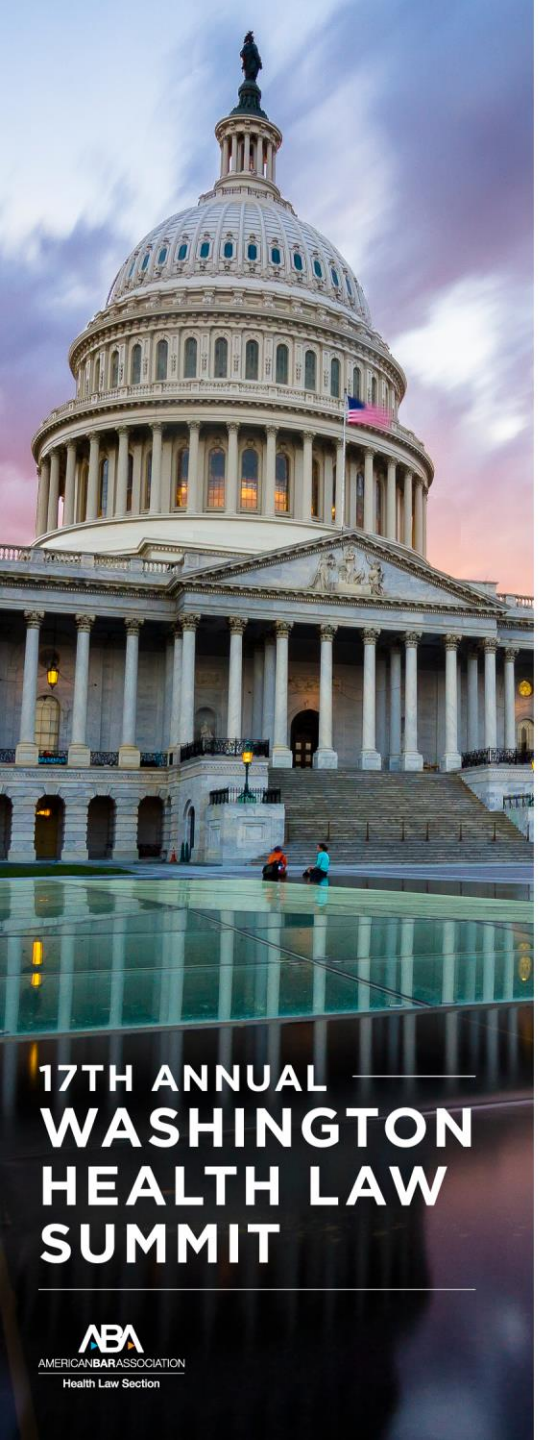
460 were in Track 1

8 were in Track 2

38 were in Track 3

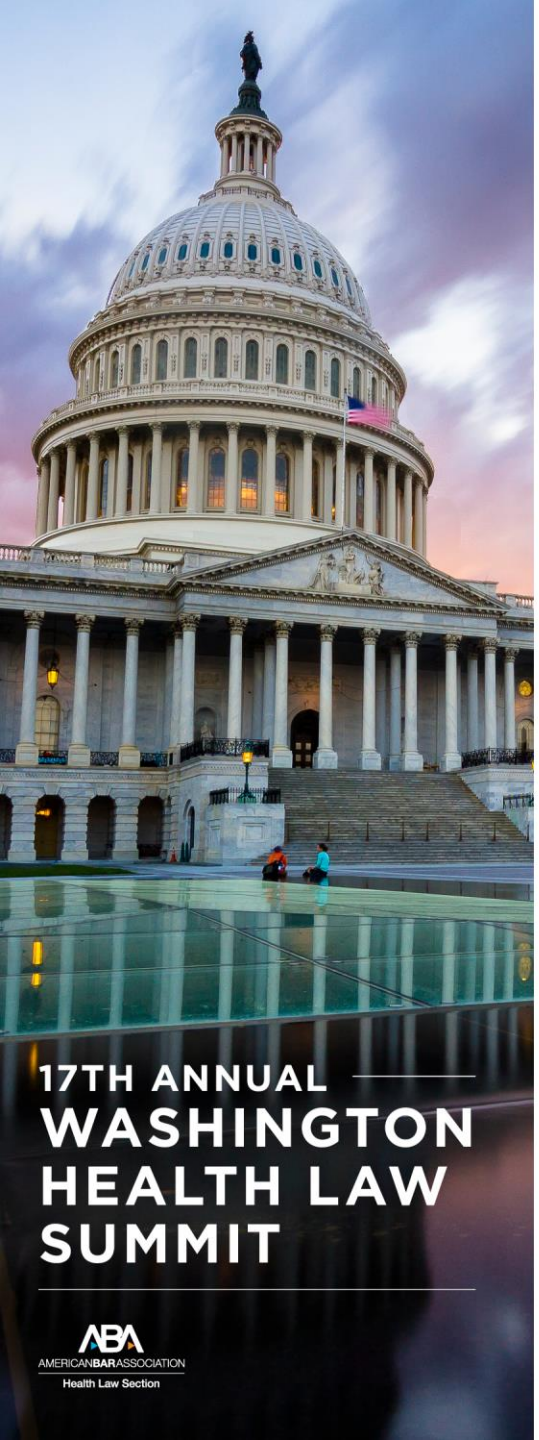
55 were in Track 1+

MSSP Track 1	MSSP Track 1+	MSSP Track 2	MSSP Track 3
460	55	8	38



Reasons for Changes

- Low number of Track 1 ACOs moving to two-sided models
- CMS found that the availability of a lower-risk, two-sided model, such as the Track 1+ Model, was effective in moving Track 1 ACOs to a two-sided model
- CMS concerned about consolidation in health care from Track 1 ACOs
- More ACOs in two-sided models means more savings.

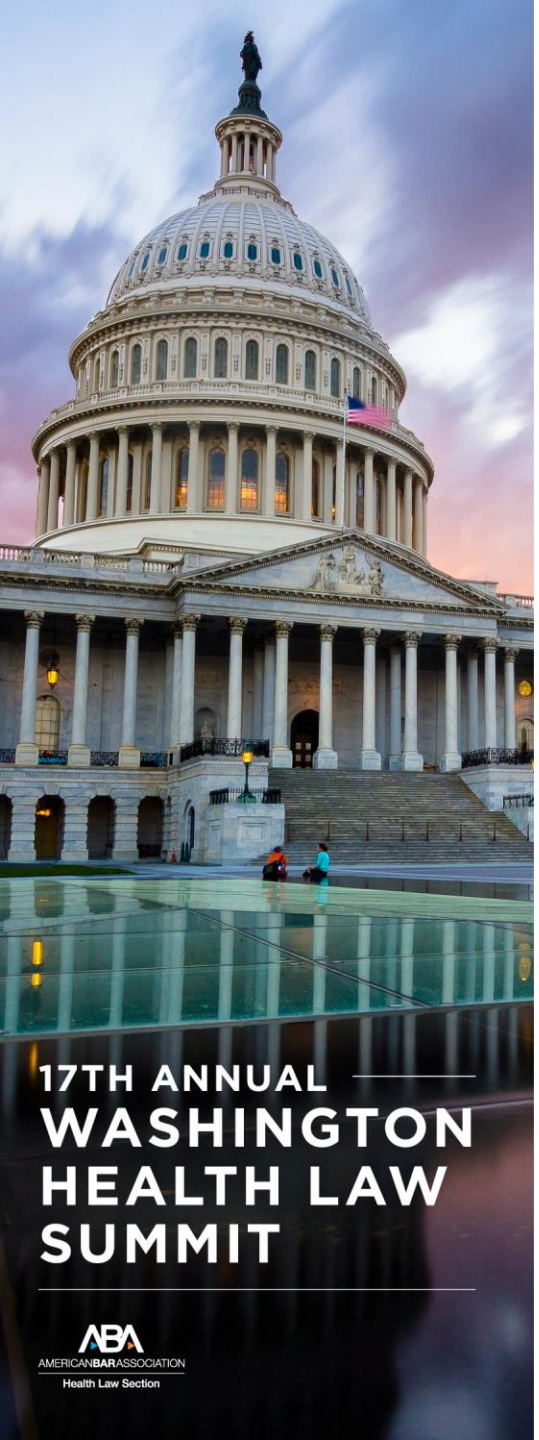


Two Sided Models Performed better than One Sided Models

- 2016: 68% of ACOs (15 of 22 ACOs) in two sided models had shared savings compared to 29% in upside only models
- 2017: 51% of ACOs (20 of 39 ACOs) in two sided models had shared savings compared to 33% in upside only models
- 2018: ACOs in two sided models reduced spending by $96 per beneficiary compared to $68 in upside only models

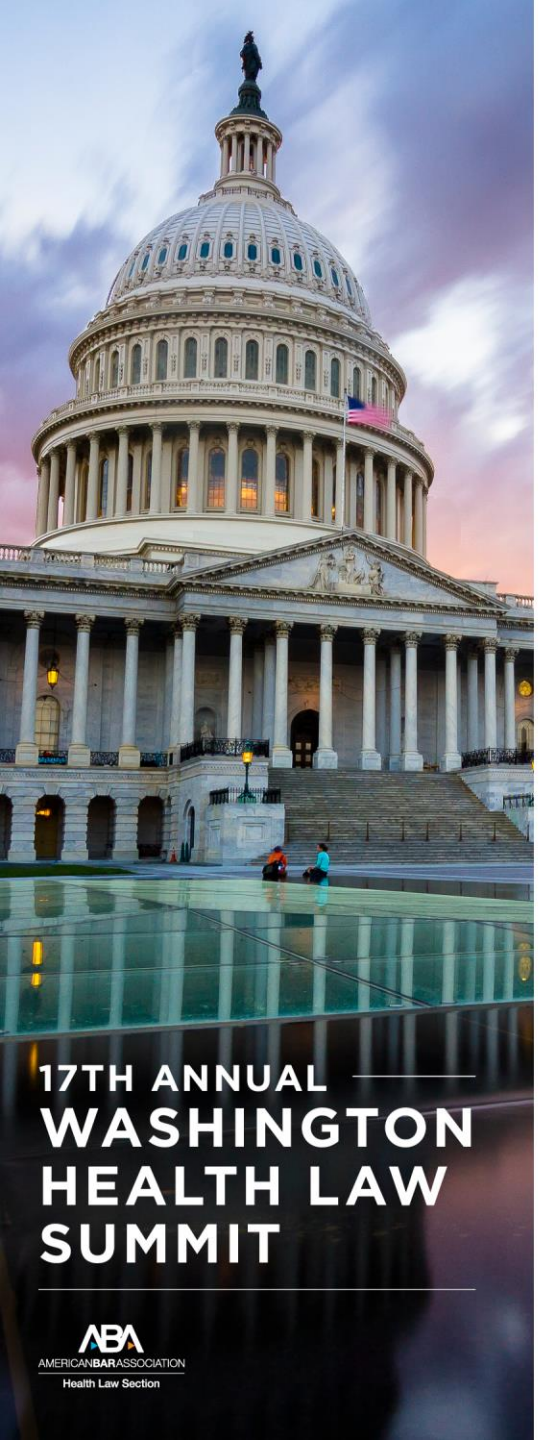
Low Revenue ACOs performed better than High Revenue ACOs

- 2016: 41% of low revenue ACOs shared savings compared to 23% of high revenue ACOs
- 2017: 44% of low revenue ACOs shared savings compared to 28% of high revenue ACOs
- 2018: Low revenue ACOs reduced spending by $180 per beneficiary compared to $27 for high revenue ACOs.



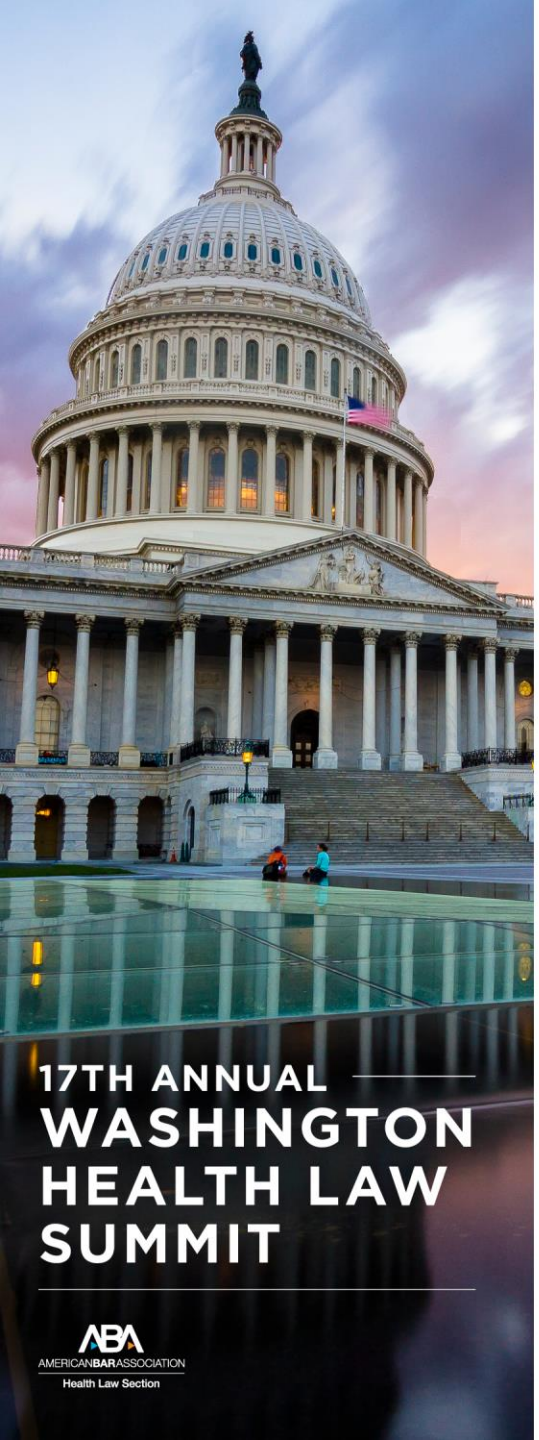
The longer ACOs are in the program, the better they perform

ACOs in Track 1 had limited appetite to enter a two-sided model when comparing risk of loss to the ability to control total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries



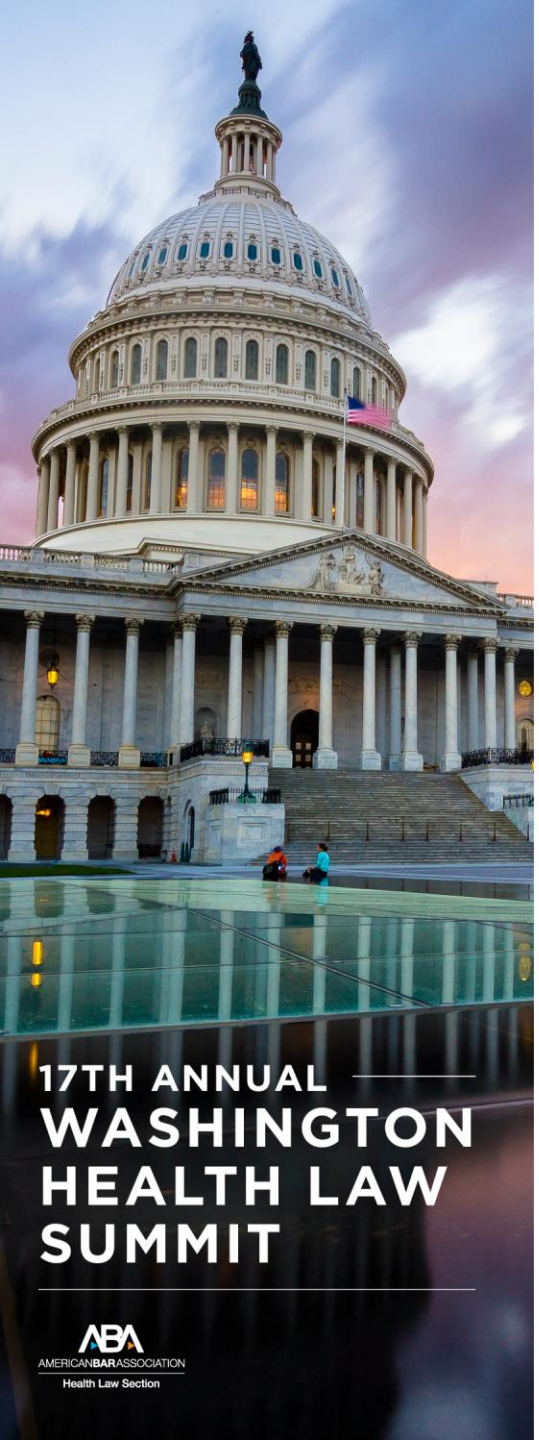
Purpose of the Changes

- Limit upside model terms to move ACOs to two sided models
- Provide incentives to two sided models to encourage transition
- Eliminate gaming by addressing rejoining after termination



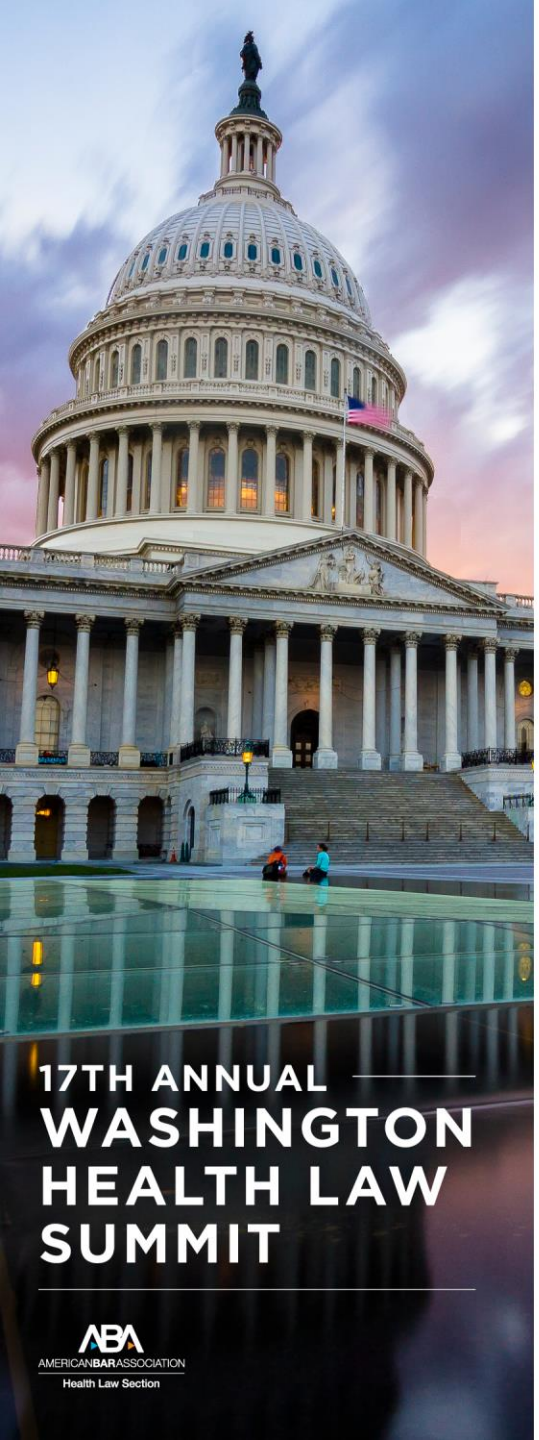
CMS Themes for the Changes

- CMS used an ACOs ability to control spending to develop changes in the MSSP.
- High revenue ACOs, which typically include hospital systems, are generally more capable of accepting higher risk because they control the continuum of care of their patients and, thus, can better control their assigned beneficiaries' total Medicare Parts A and B FFS expenditures.
- Low revenue ACOs, which typically include physician groups, have less control over their assigned beneficiaries' total Medicare Parts A and B FFS expenditures because they are in less control of their patients’ continuum of care.



New Definitions

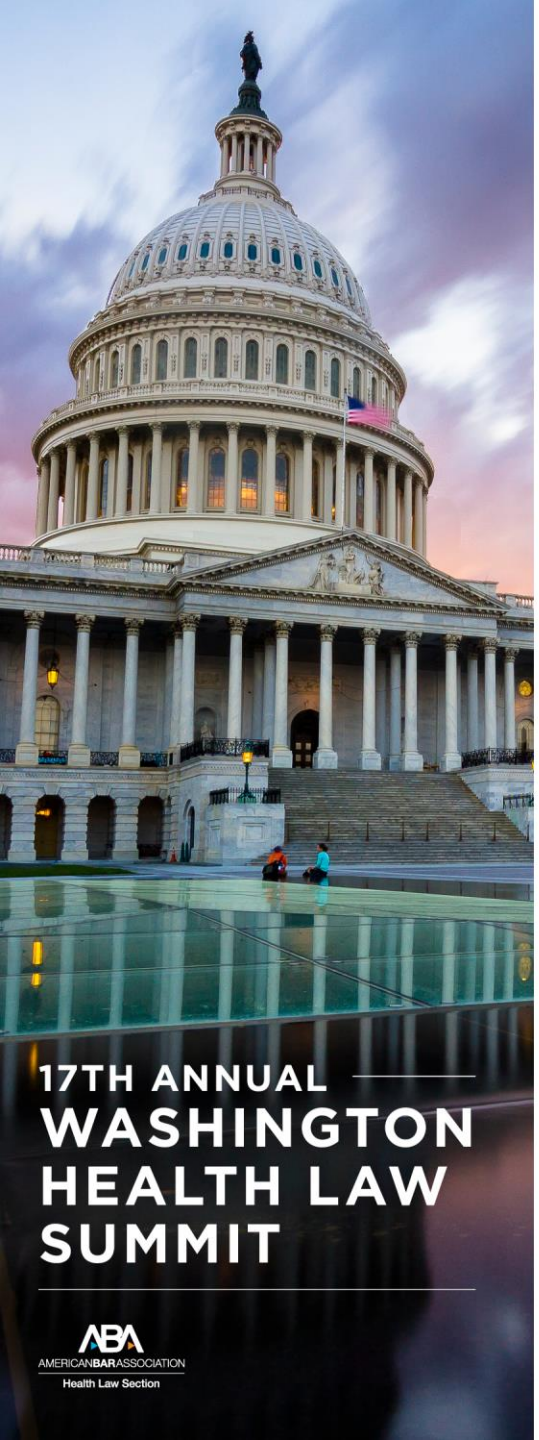
- High revenue ACO: Total Medicare Parts A and B FFS revenue of its ACO participants is at least 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.
- Low revenue ACO: Total Medicare Parts A and B FFS revenue of its ACO participants is less than 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.
- CMS looks at total revenue and expenditures of Medicare Parts A and B FFS from the ACO’s assigned beneficiaries and non-assigned beneficiaries.



New Definitions

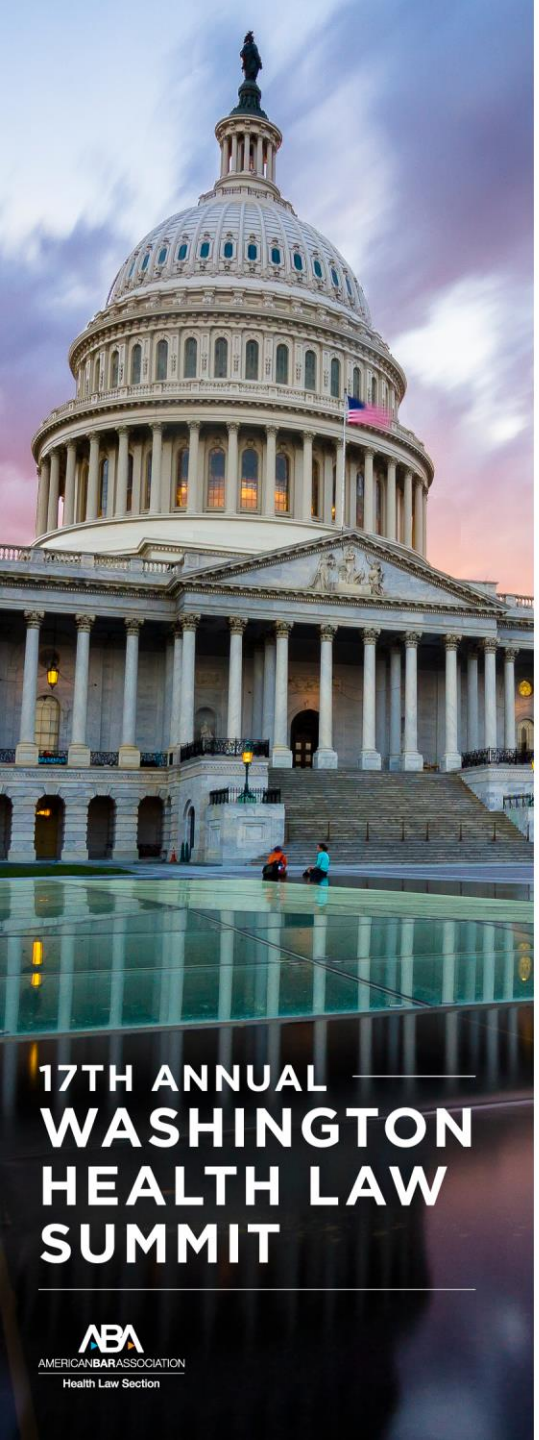
- Experienced ACO: (1) The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO, or that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3 or (2) 40 percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3, in any of the 5 most recent performance years prior to the agreement start date.

- Inexperienced ACO: (1) The ACO is a legal entity that has not participated in any performance-based risk Medicare ACO initiative, and has not deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3; and (2) Less than 40 percent of the ACO's participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second Shared Savings Program agreement period under Track 2 or Track 3, in each of the 5 most recent performance years prior to the agreement start date.



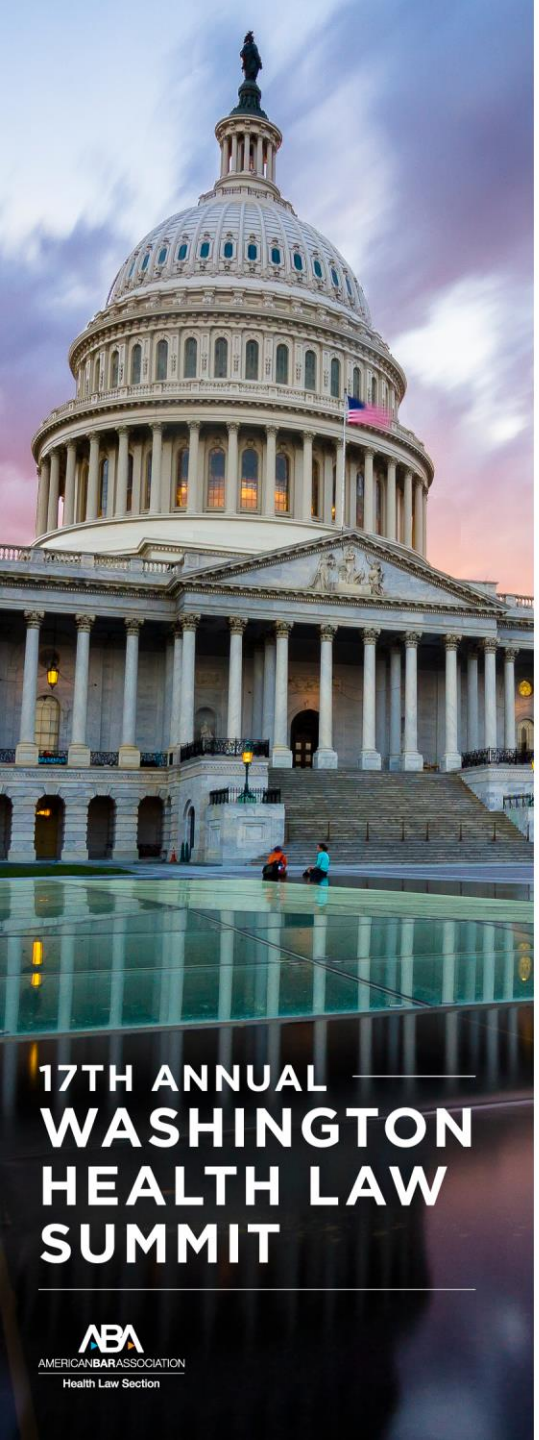
New Definitions

- Medicare ACO initiatives includes any two sided model including Track 2, Track 3 or the ENHANCED track, and the BASIC track (including Level A through Level E) of the MSSP. Also includes the recent Innovation Center ACO Models involving two sided risk: The Pioneer ACO Model, Next Generation ACO Model, the performance-based risk tracks of the CEC Model (including the two-sided risk tracks for LDO ESCOs and non-LDO ESCOs), and the Track 1+ Model.



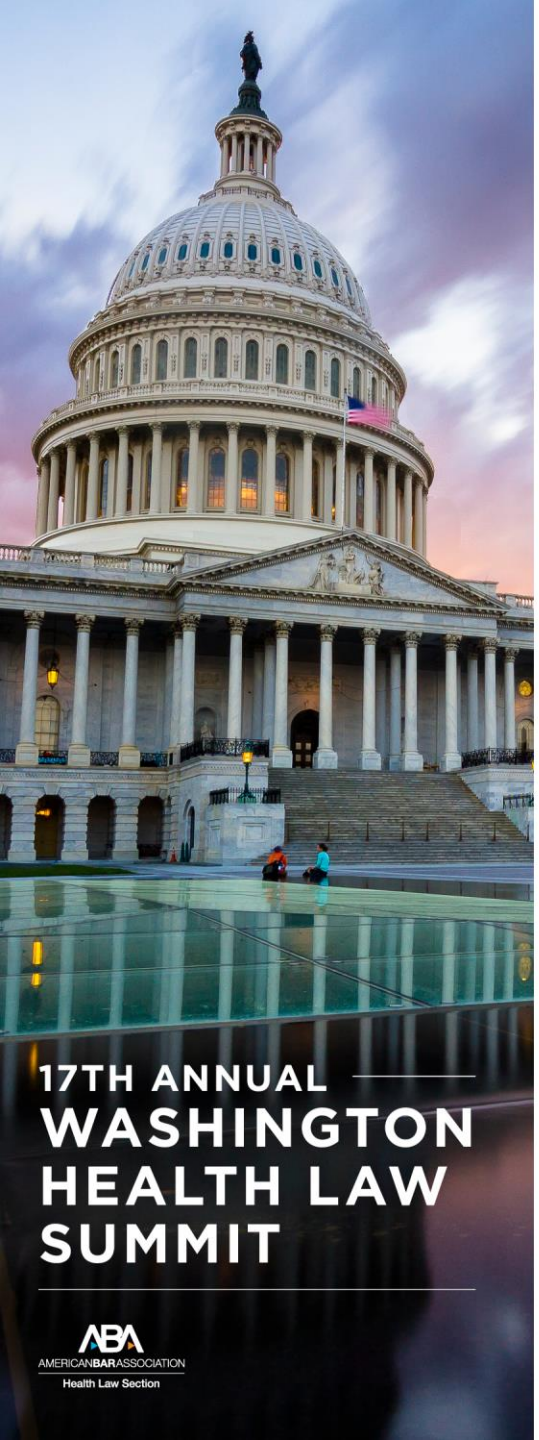
New Definitions

- Renewing ACO: An ACO that continues its participation in the program for a consecutive agreement period, without a break in participation.
- Re-entering: An ACO that is the same legal entity as an ACO that previously participated in the program and is applying to participate in the program after a break in participation, because its agreement expired or terminated. It also includes a new legal entity and more than 50 percent of its participants were included on the ACO participant list in any of the 5 most recent years.



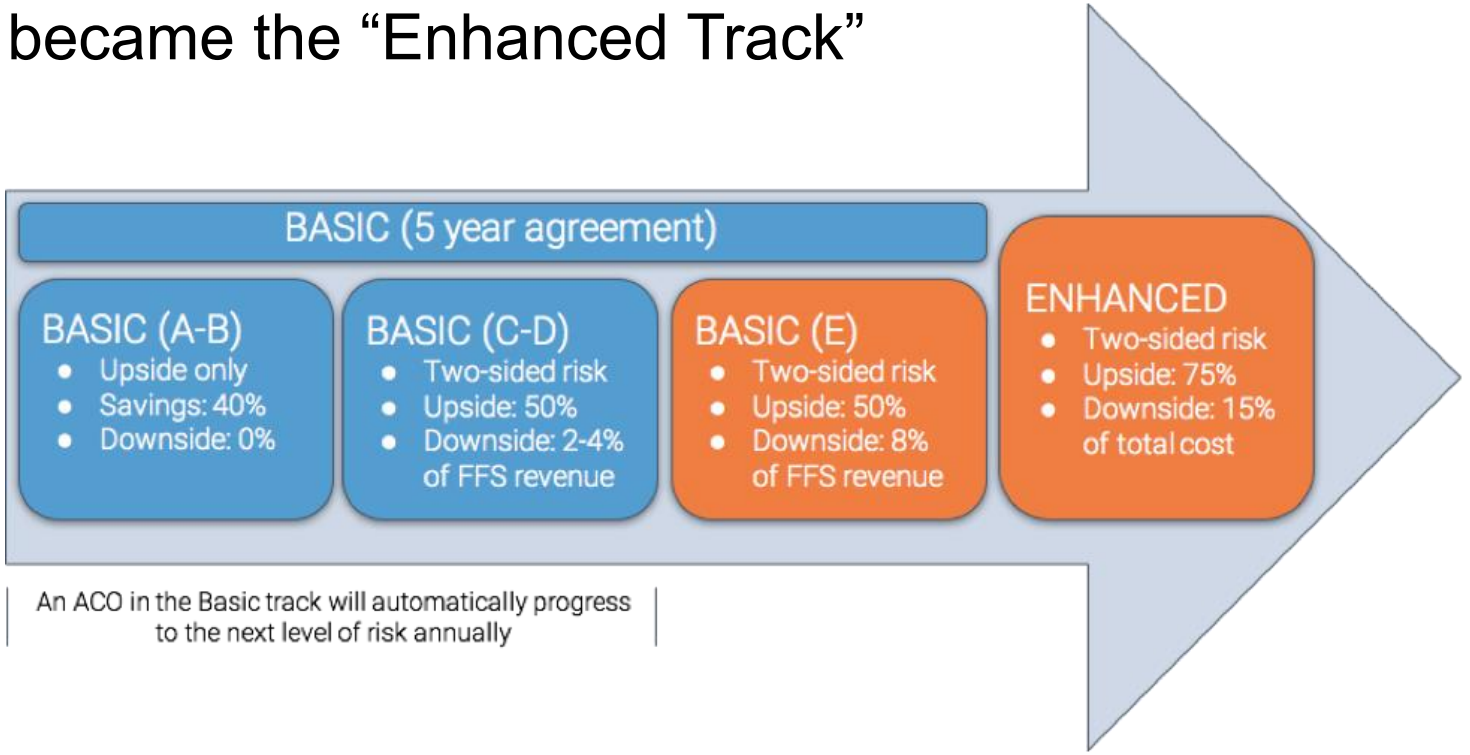
Summary of Major Changes

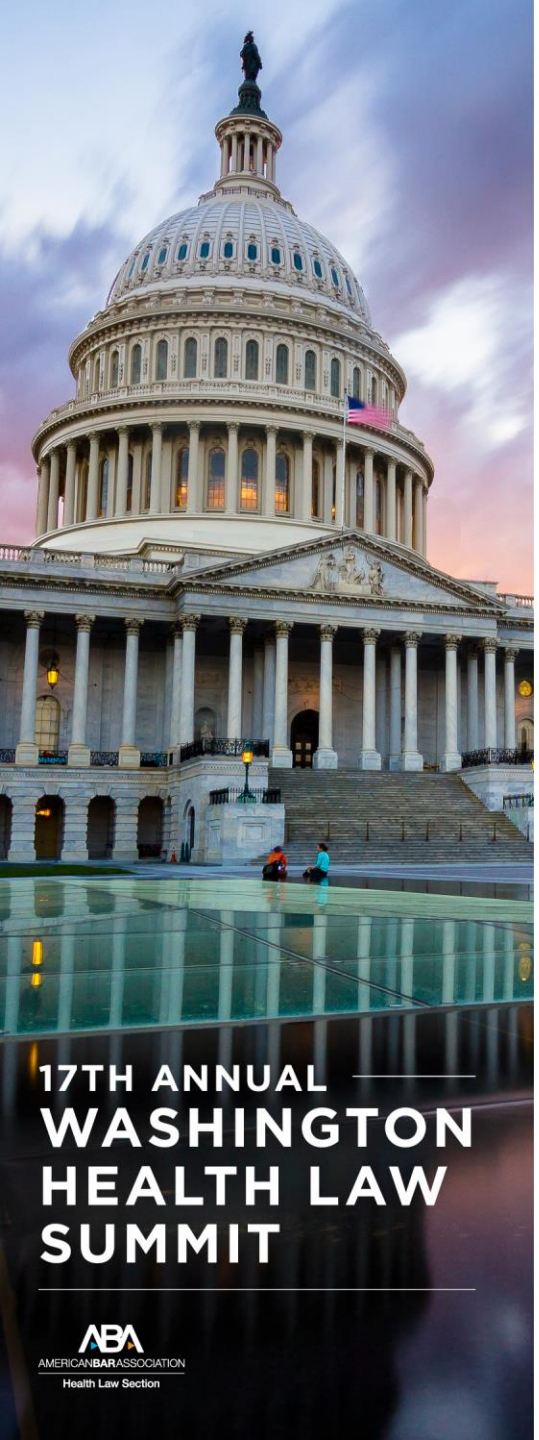
- Changed the models to expedite an ACOs transition to two-sided models
- Changed the agreement term from 3 years to five years
- Revised the Beneficiary Assignment Methodology
- Increased incentives to join two sided models
- Revised the benchmarking



Changes to Models

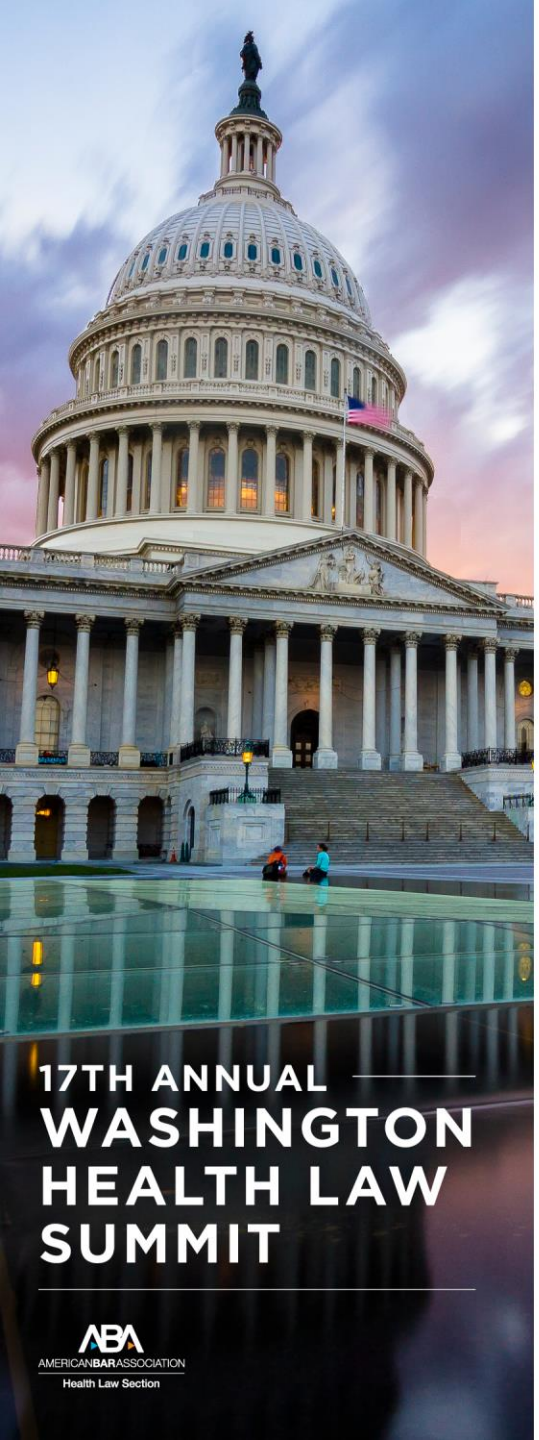
- Eliminated Tracks 1 and 2
- Created a “Basic Track” that has five levels with Level E modeling Track 1+
- Track 3 became the “Enhanced Track”





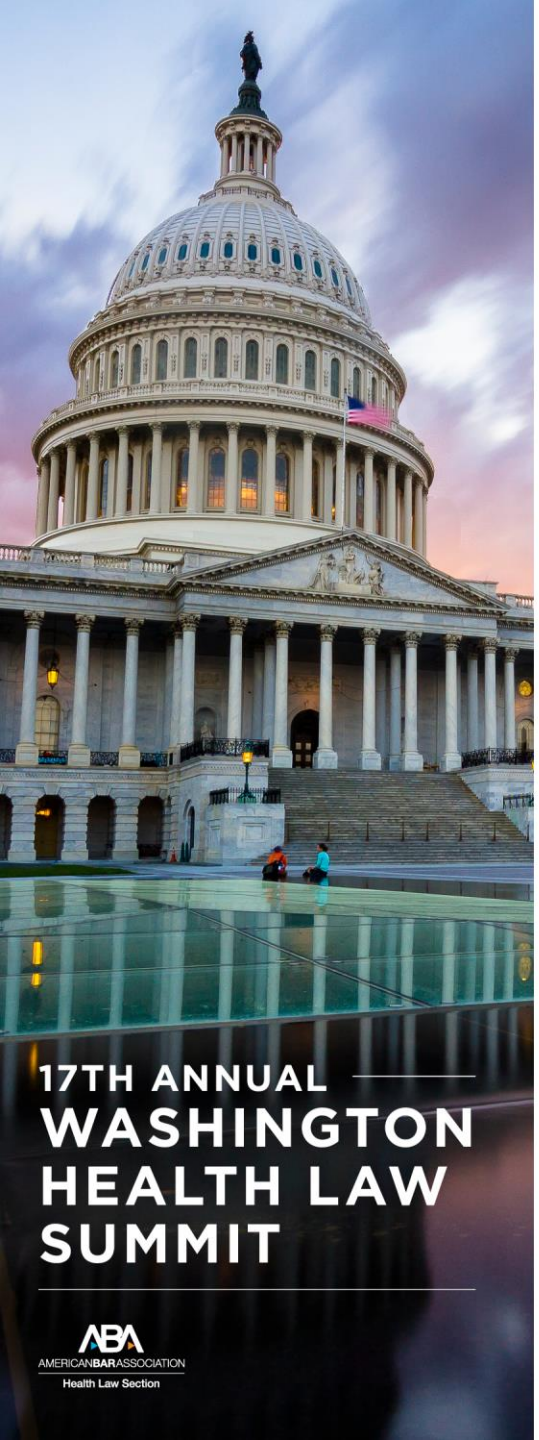
The Five Levels of the Basic Track

- Level A: Upside Only, with up to 40% of savings and cap of 10% of benchmark
- Level B: Upside Only, with up to 40% of savings and cap of 10% of benchmark
- Level C: Two sided model. Savings of up to 50% of savings and cap of 10% of benchmark. Losses of up to 30% of losses and a cap of 2% of Medicare FFS revenue of ACO participants, but not more than 1% of the benchmark.
- Level D: Two sided model. Savings of up to 50% of savings and cap of 10% of benchmark. Losses of up to 30% of losses and a cap of 4% of Medicare FFS revenue of ACO participants, but not more than 2% of the benchmark.
- Level E: Two sided model (former Track 1+ Model). Savings of up to 50% of savings and cap of 10% of benchmark. Losses of up to 30% of losses but not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (for example, 8 percent in 2019-2020), capped at the amount that is 1 percentage point higher than the percentage of the updated benchmark specified in the expenditure-based nominal amount standard under the Quality Payment Program (for example, 4 percent in 2019-2020)



The Enhanced Track

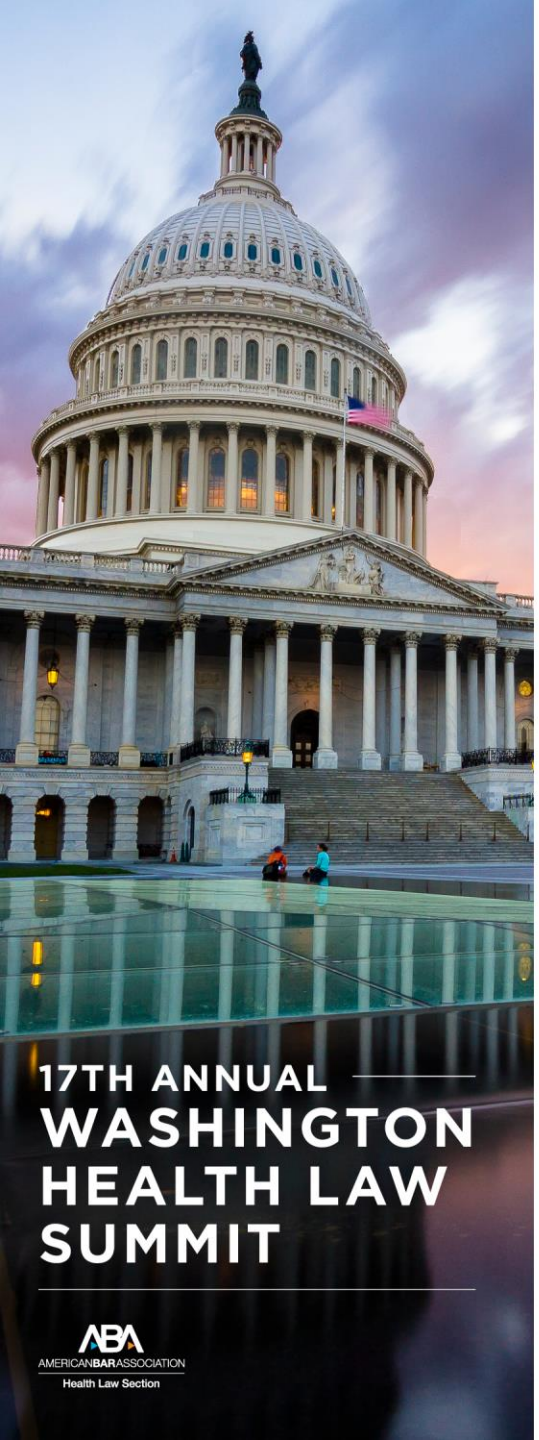
- Based on Track 3
- Maximum shared savings rate of 75 percent, not to exceed 20 percent of benchmark.
- Loss sharing rate determined based on the inverse of the final sharing rate, but not less than 40 percent (that is, between 40-75 percent), not to exceed 15 percent of benchmark.



Participation Options

Low Revenue

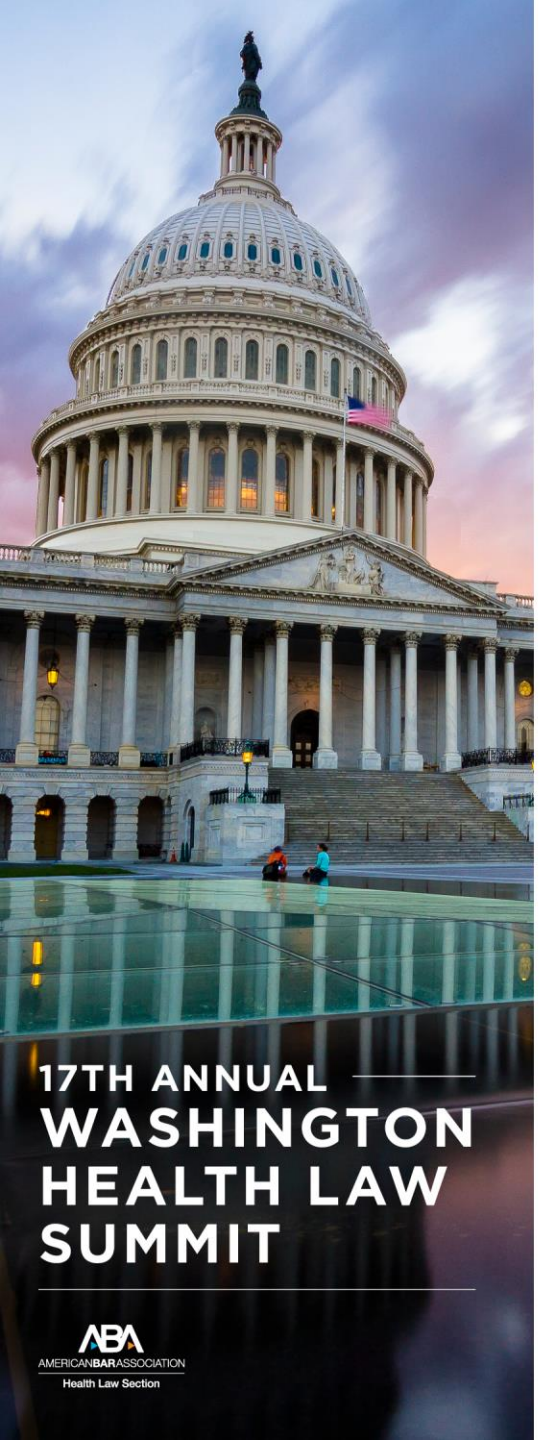
- New Inexperienced ACO may enter at any Basic Level
- New Experienced ACO cannot enter Levels A to D
- Re-entering Inexperienced ACOs cannot enter Level A
- Re-entering Experienced ACO cannot enter Levels A to D
- Renewing Inexperienced ACO cannot enter Level A
- Renewing Experienced ACO cannot enter Levels A to D



Participation Options Con't

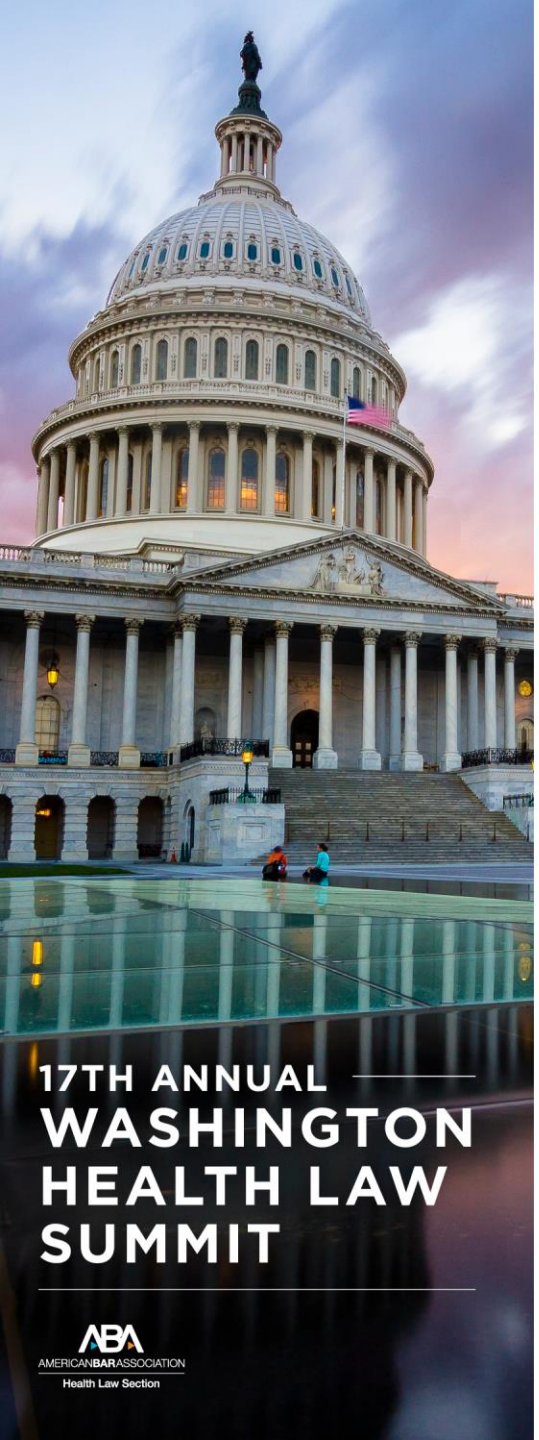
High Revenue:

- New Inexperienced ACO may enter at any Basic Level
- New Experienced ACO cannot enter the Basic Track
- Re-entering Inexperienced ACO cannot enter Level A
- Re-entering Experienced ACO cannot enter Basic Track
- Renewing Inexperienced ACO cannot enter Level A
- Renewing Experienced ACO cannot enter Basic Track except for ACOs with a first or second agreement period beginning in 2016 or 2017 in the Track 1+ Model can enter Level E.



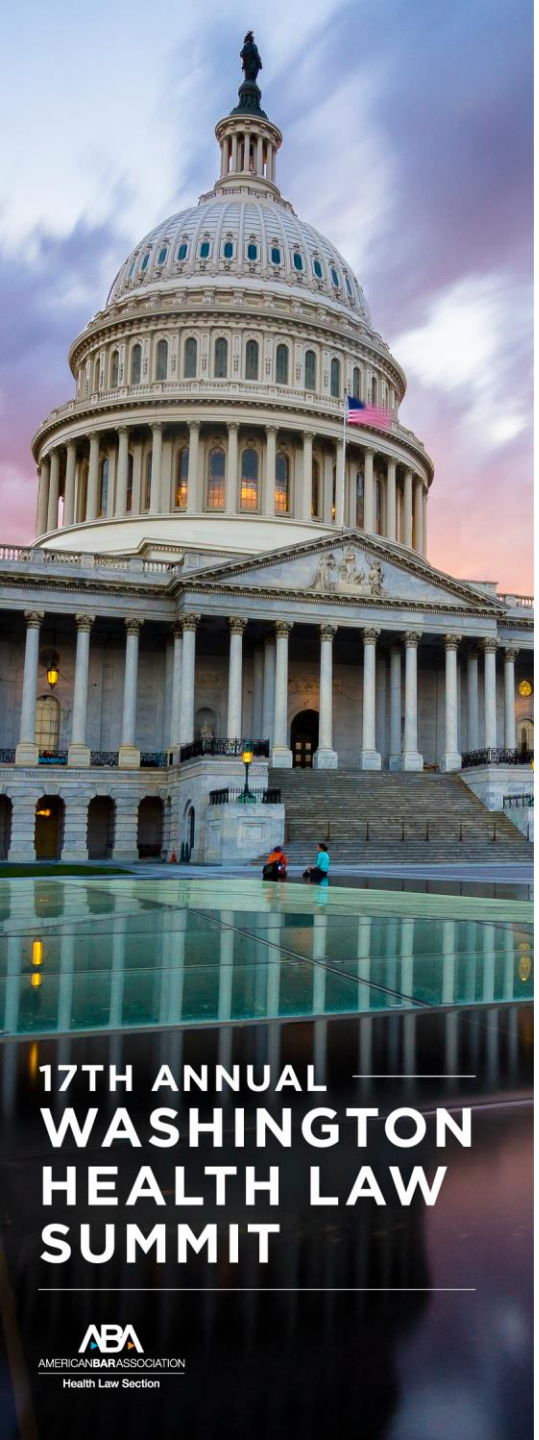
The Glide Path

- An ACO is automatically advanced to the next level of the Basic Track at the start of the performance year. However:
  - An ACO may elect to advance more quickly, but you cannot go backwards with one exception.
  - A Low Revenue ACO that is inexperienced may elect to remain in Level B for a 3rd Performance Year, but then must move to Level E at the start of the 4th Performance Year.



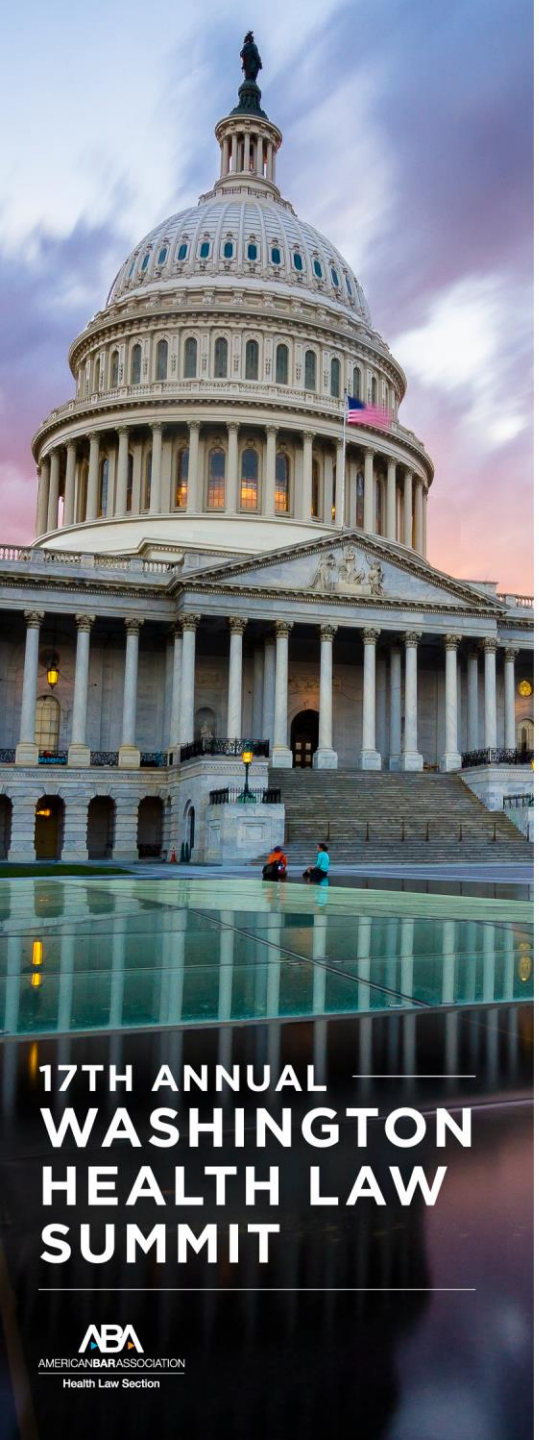
Agreement Lengths

- CMS changed the agreement length from 3 years to 5 years.
- Low revenue ACOs: Can stay in the Basic Track for two agreement periods (for a total of 10 years) and are not sequential, which would allow low revenue ACOs that transition to the ENHANCED track after a single agreement period the opportunity to return to the BASIC track, but under Level E.



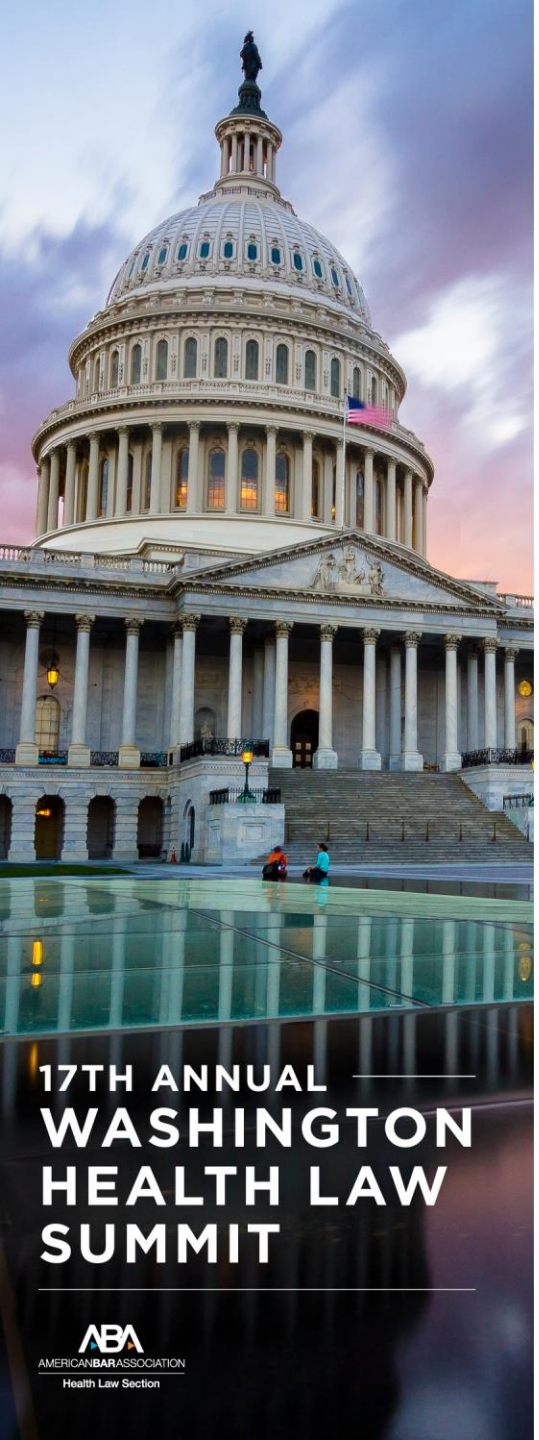
MSR/MLR Selection

- One Sided Models: The same methodology that was used for Track 1 will apply.
- Two Sided Models: ACOs can have a (1) fixed MSR/MLR option from 0% to 2% in .5% increments or (2) a variable MSR/MLR based on the number of beneficiaries assigned to the ACO.
- Fixed MSR/MLR is more popular. Among 101 ACOs participating in two sided models in PY 2018, 80 are subject to one of the fixed options, including 18 with a MSR and MLR of zero percent.



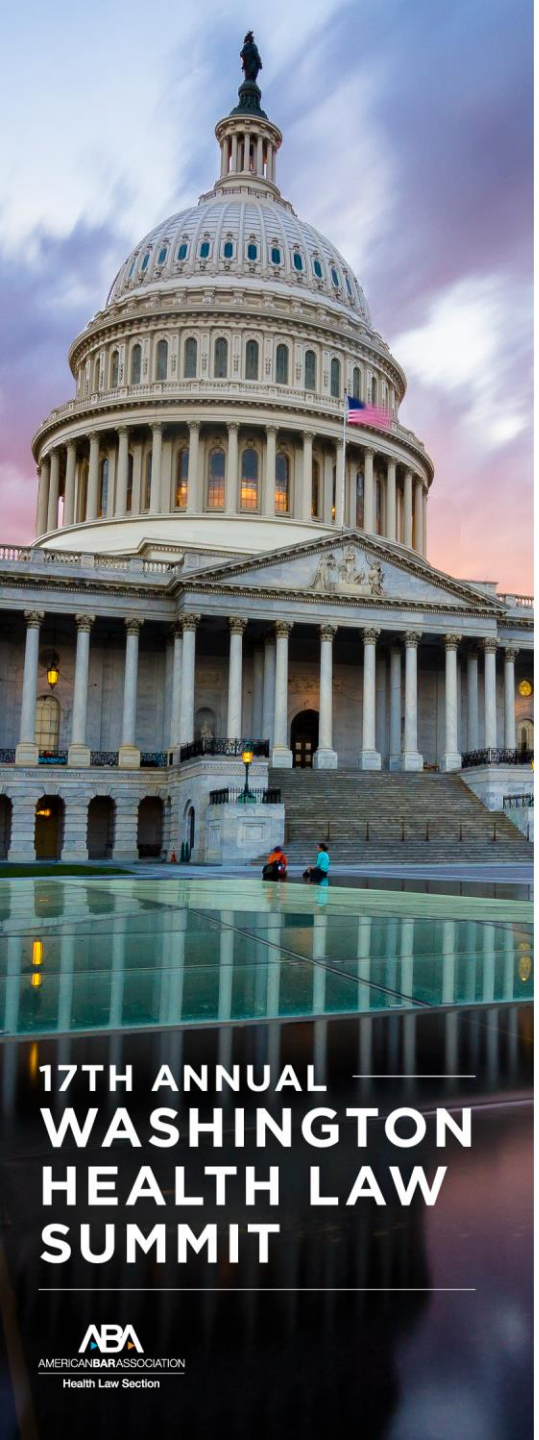
Beneficiary Assignment Methodology

- Two types of assignments: (1) Preliminary prospective assignment with retrospective reconciliation or (2) Prospective assignment.
- Track 1 and Track 2 had the preliminary prospective assignment with retrospective reconciliation. The Track 1+ Model and Track 3 used a prospective assignment methodology.
- ACOs now have the opportunity to annually elect their choice of beneficiary assignment methodology during each performance year.
- If change beneficiary assignment methodology, then that will change your historical benchmark calculation



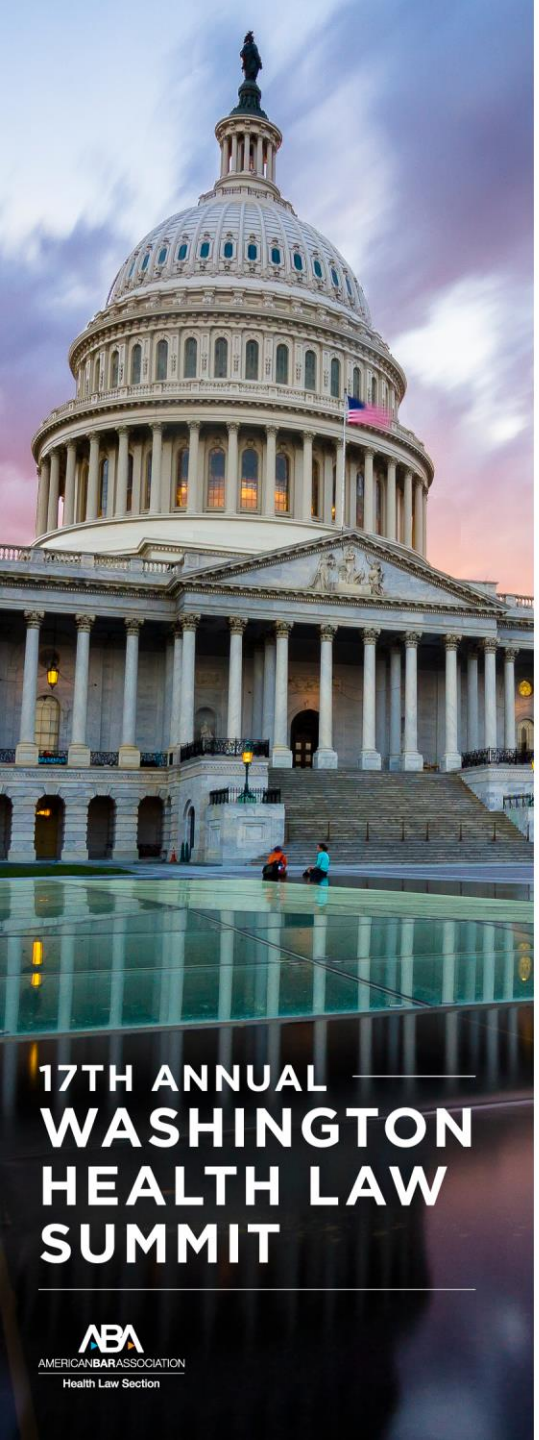
Benchmarking Changes

- Changed benchmarking to focus on regional FFS expenditures as opposed to national.
- Benchmark established based on 3 year historic Medicare Parts A and B expenditures and beneficiary assignment method selected.
- Annual updates to the benchmark based on blended national and regional growth rates with caps on regional factors.
- Could benefit regional ACOs if expenditures are below national levels.
- Rebasing before every subsequent agreement period.



Incentives

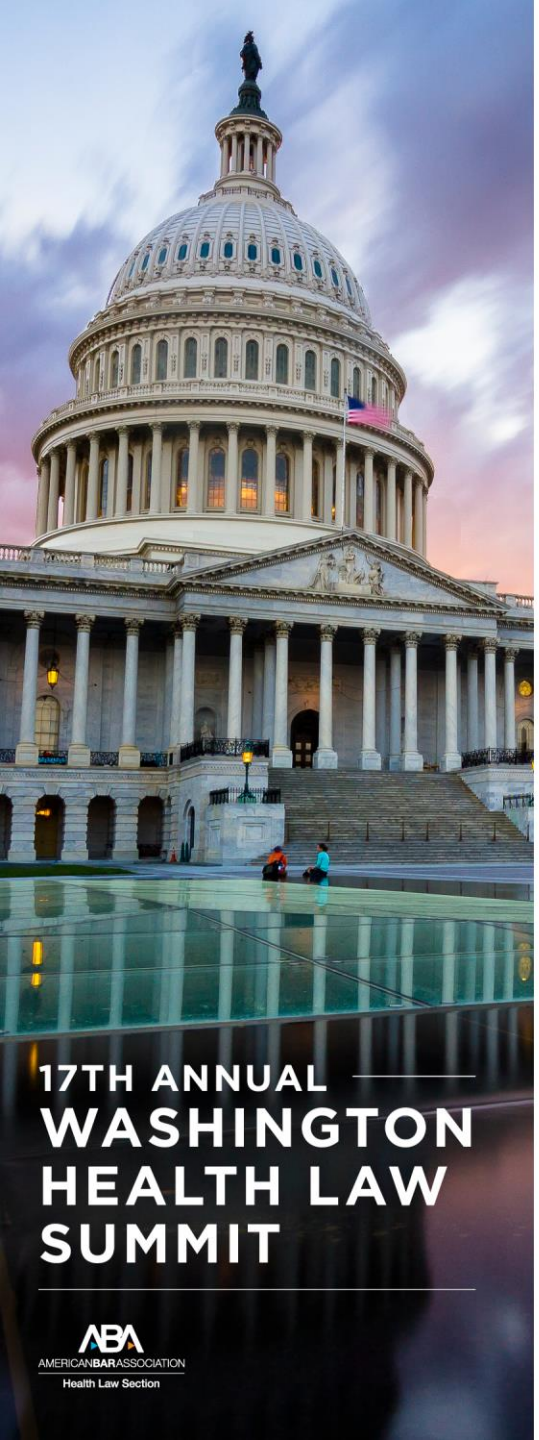
- APMs: Two-sided ACOs are eligible to receive APM Incentive Payments in the corresponding payment year between 2019 through 2024, and then higher fee schedule updates starting in 2026.
- SNF 3-Day Rule Waiver: Previously limited to Track 3 and prospective assignment methodology, but the new rule expands it to any two sided model and any beneficiary assignment methodology. CMS also expanded the rule so that CAHs and other rural hospitals furnishing SNF services under swing bed agreements are included in the SNF 3-Day Rule Waiver.
- Telehealth Services: After January 1, 2020, telehealth services can be billed by ACOs in a two sided model as long as ACO elects prospective assignment. In addition, the beneficiary's home can be the "originating site," but no facility fee may be charged.



Incentives Con't

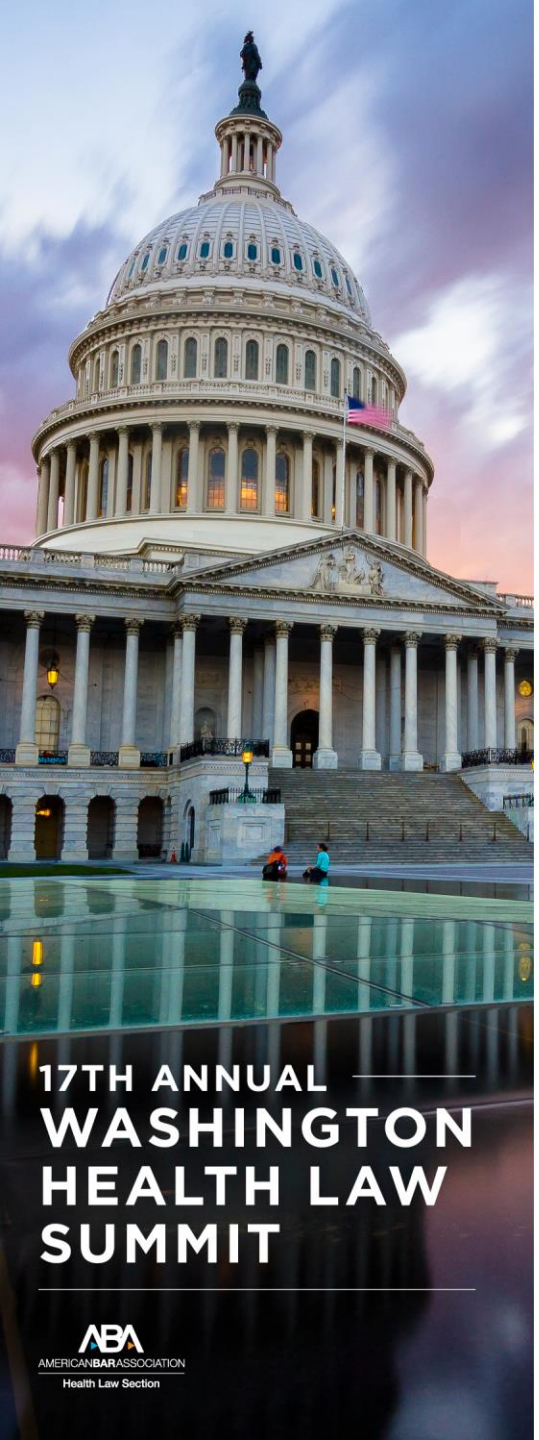
Beneficiary Incentives: Starting July 1, 2019, ACOs can expand their beneficiary incentive program to include monetary incentives as long as the program is approved by CMS:

- Limited to two sided models and applies regardless of beneficiary assignment
- The beneficiary must receive a "qualifying service" i.e., a primary care service from a participant with a primary care designation
- Must provide the incentive for each qualified service furnished
- The same incentive must be provided to each eligible beneficiary and can be in the form of a check, debit card or traceable cash equipment but no more than $20.
- Other limitations, i.e., no marketing and cannot use outside monies to fund BIP

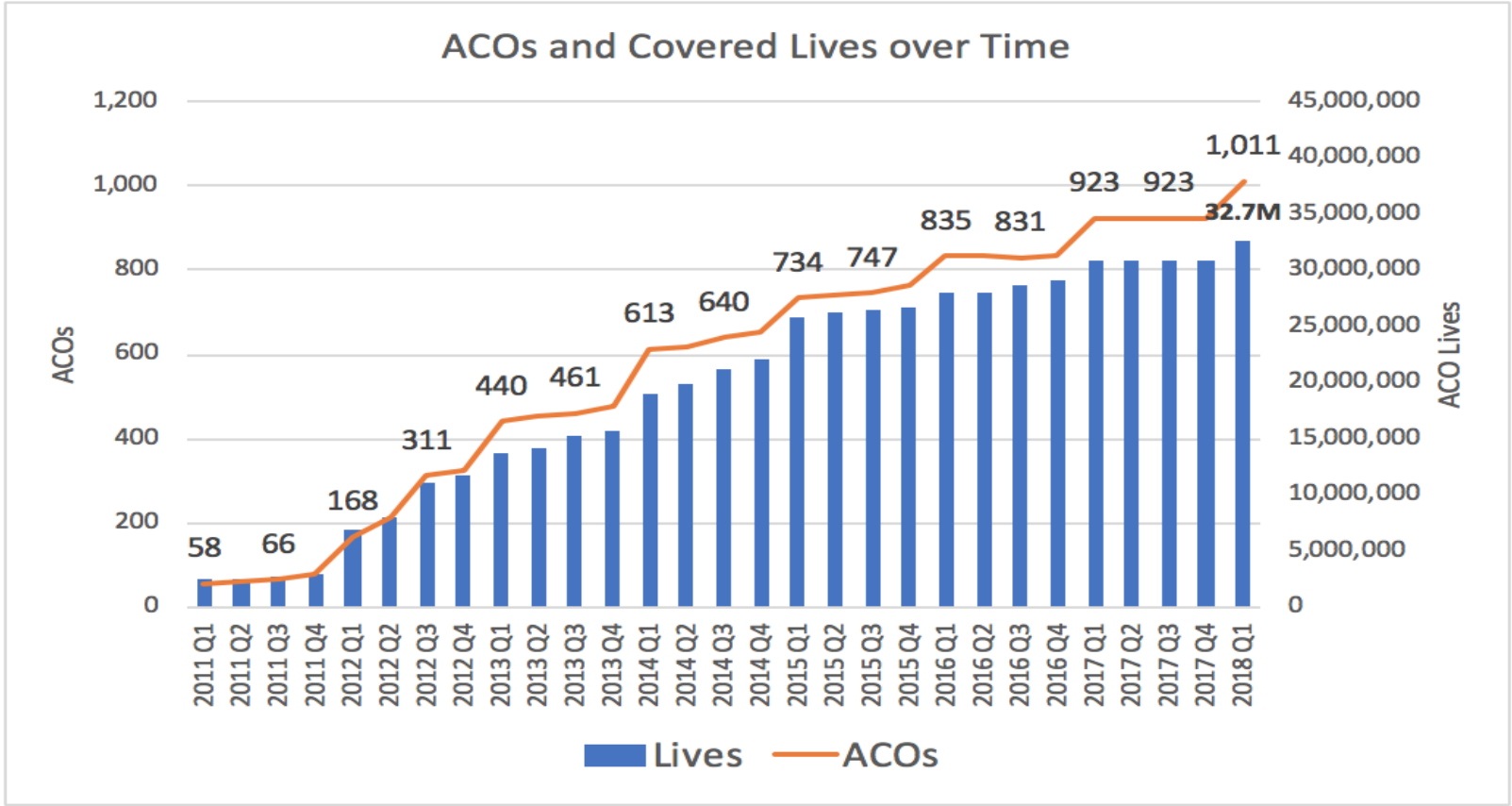


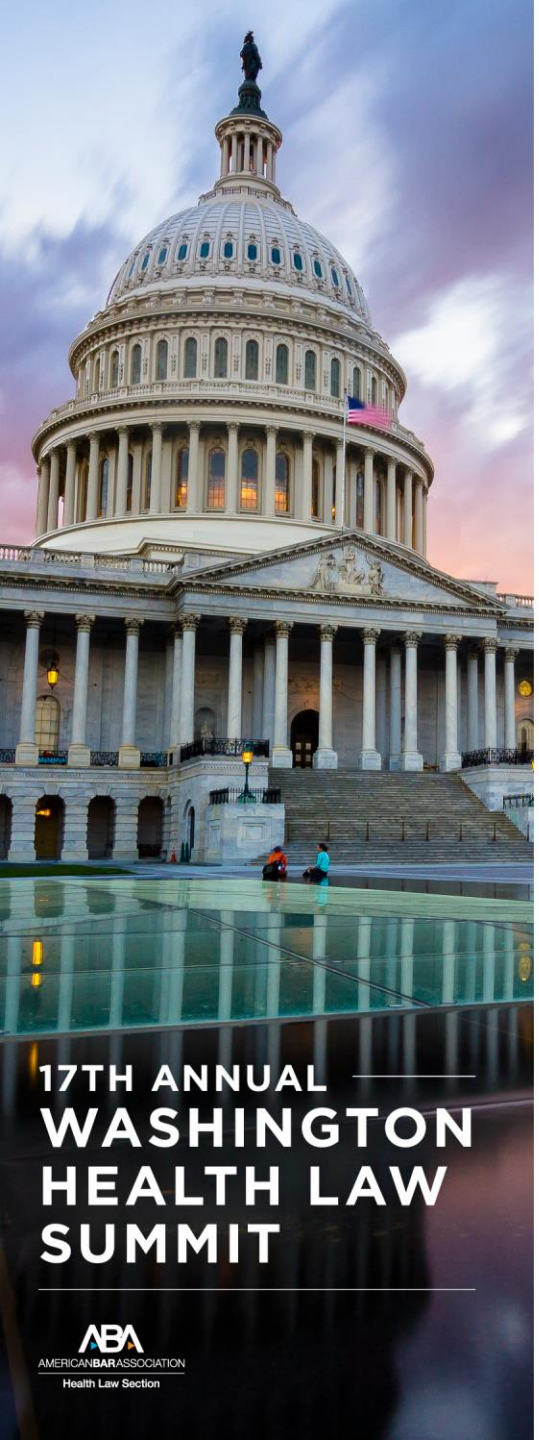
Statistics Since Pathways to Success

Pathways



The Importance of ACOs





CMS Authorized Programs & Activities

Reducing & Preventing Health Care Associated Infections
Reducing & Preventing Adverse Drug Events
Community Living Council
Multiple Chronic Conditions
National Alzheimer's Project Act
Partnership for Patients
Million Hearts
National Quality Strategy
Data.gov

HHS

Survey & Cert.
Target surveys
Quality Assurance Performance Improvement

CMMI & Medicaid
Accountable Care Organizations
Community Based Transitions Care Program
Dual eligible coordination
Care model demonstrations & projects
1115 Waivers

Payment
Coverage of services
Physician Feedback report
Quality Resource Utilization Report
Hospital Readmissions Reduction Program
Health Care Associated Conditions Program

Program Integrity
Fraud & Abuse Enforcement

CMS

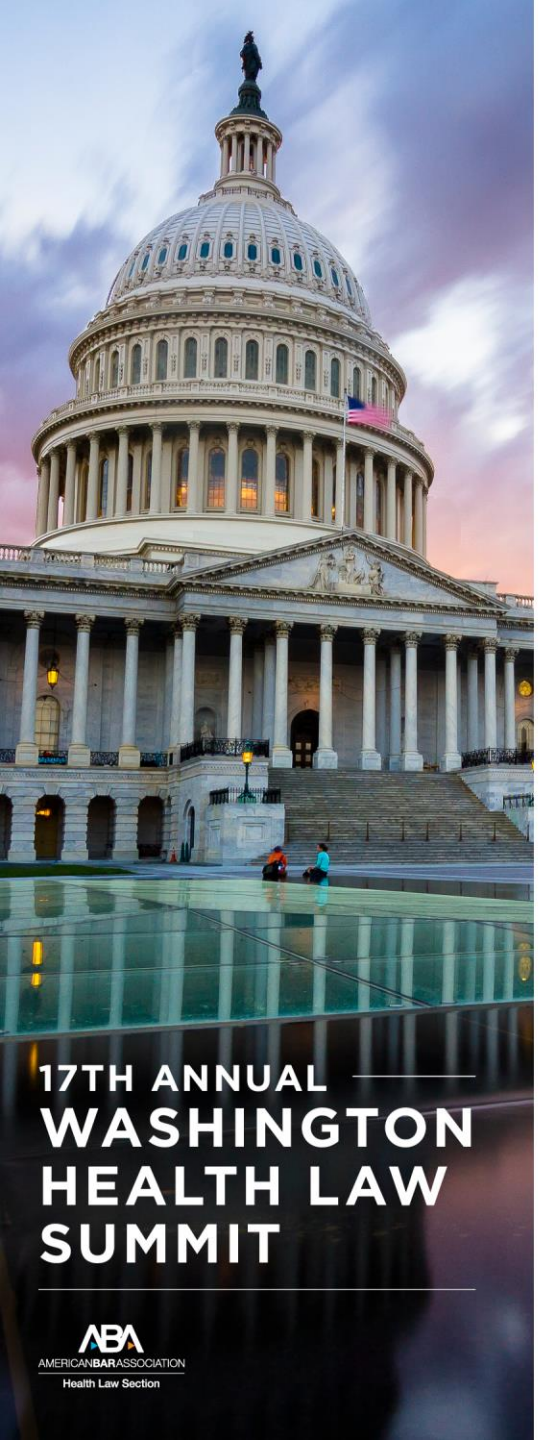
Value-based Purchasing
ESRD QIP
Hospital VBP
Physician value modifier
Plans for Skilled Nursing Facility and Home Health Agencies,
Ambulatory Surgical Centers

Coverage
National & Local decisions
Mechanisms to support innovation (CED, parallel review, other)

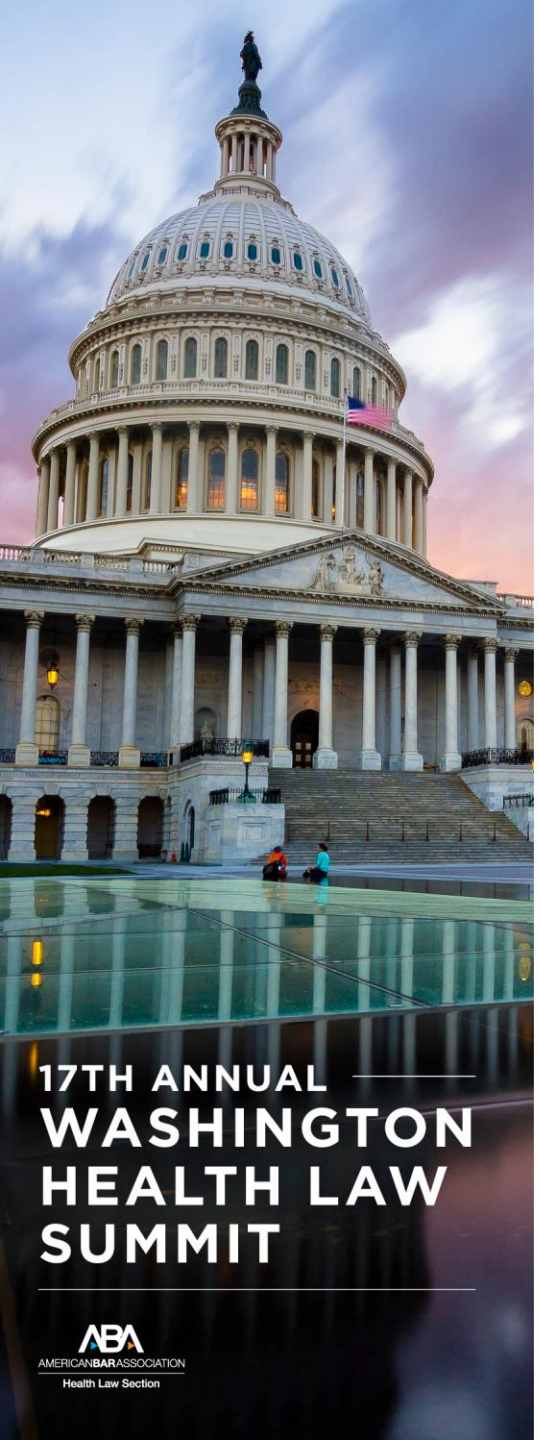
Quality Improvement
QIOs
ESRD Networks

Clinical Standards
Hospitals, Home Health Agencies, Hospices, ESRD facilities

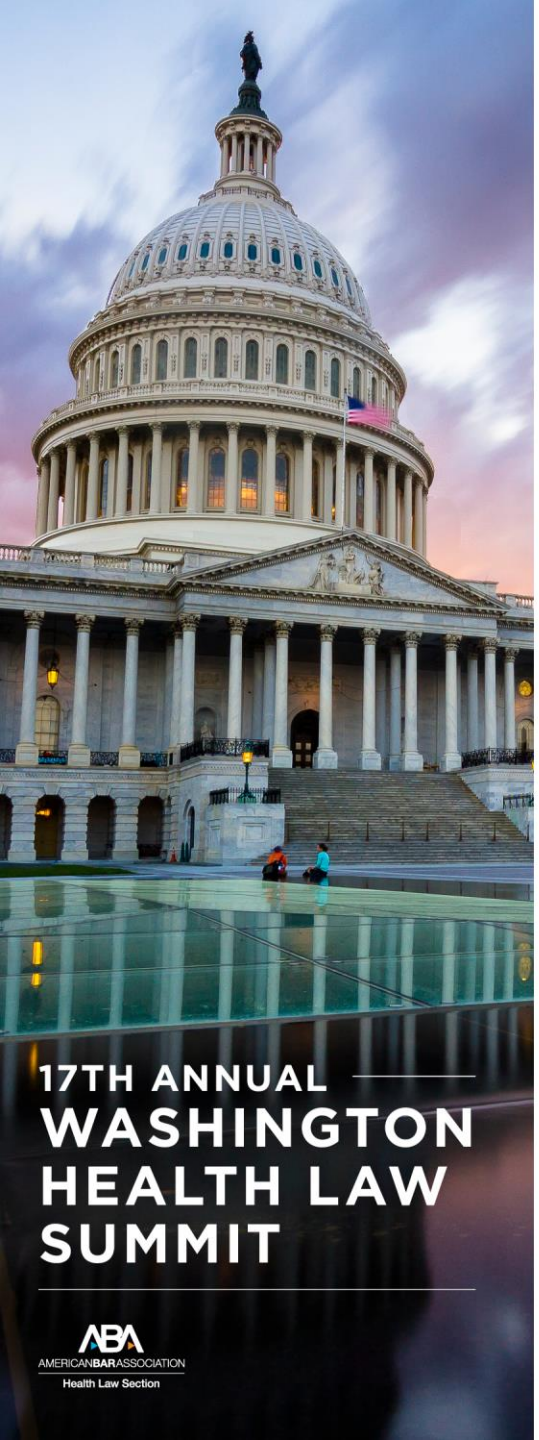
Quality & Public Reporting
Hospital Inpatient Quality Hospital Outpatient
In-patient psychiatric hospitals
Cancer hospitals
Nursing homes
Home Health Agencies
Long-term Care Acute Hospitals
In-patient rehabilitation facilities
Hospices



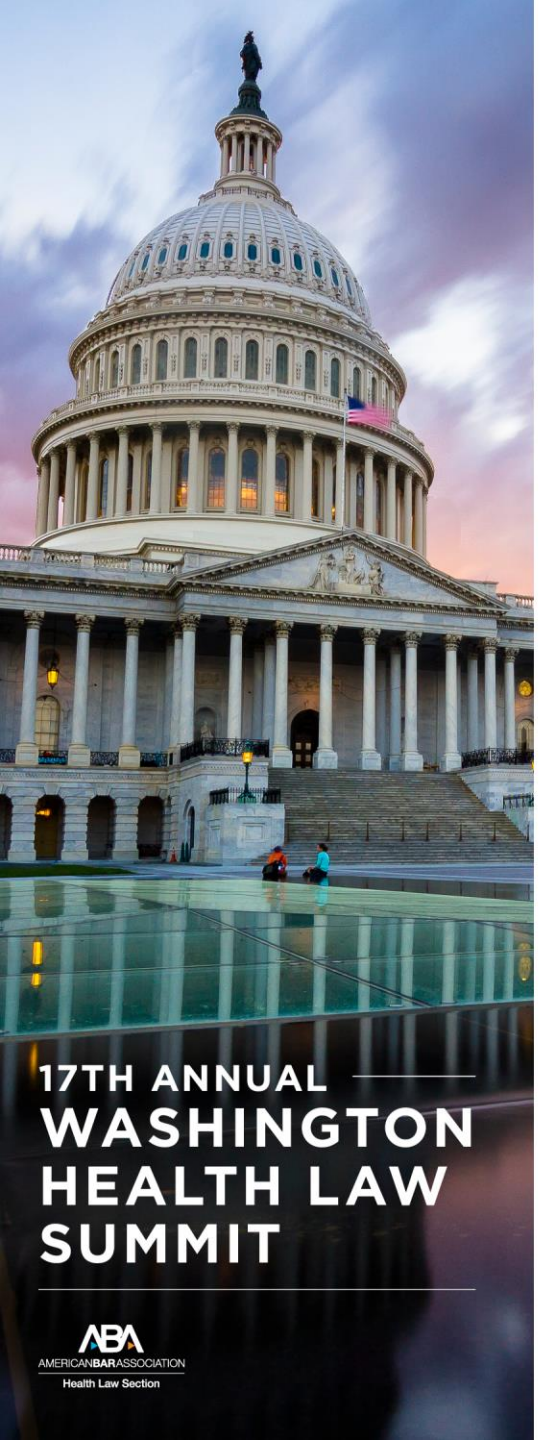
CMS final rule aggressively moves ACOs into two-sided risk – Offers flexibilities in the beneficiary assignment, telemedicine, and beneficiary incentives.



Recent statistics since the new models came out



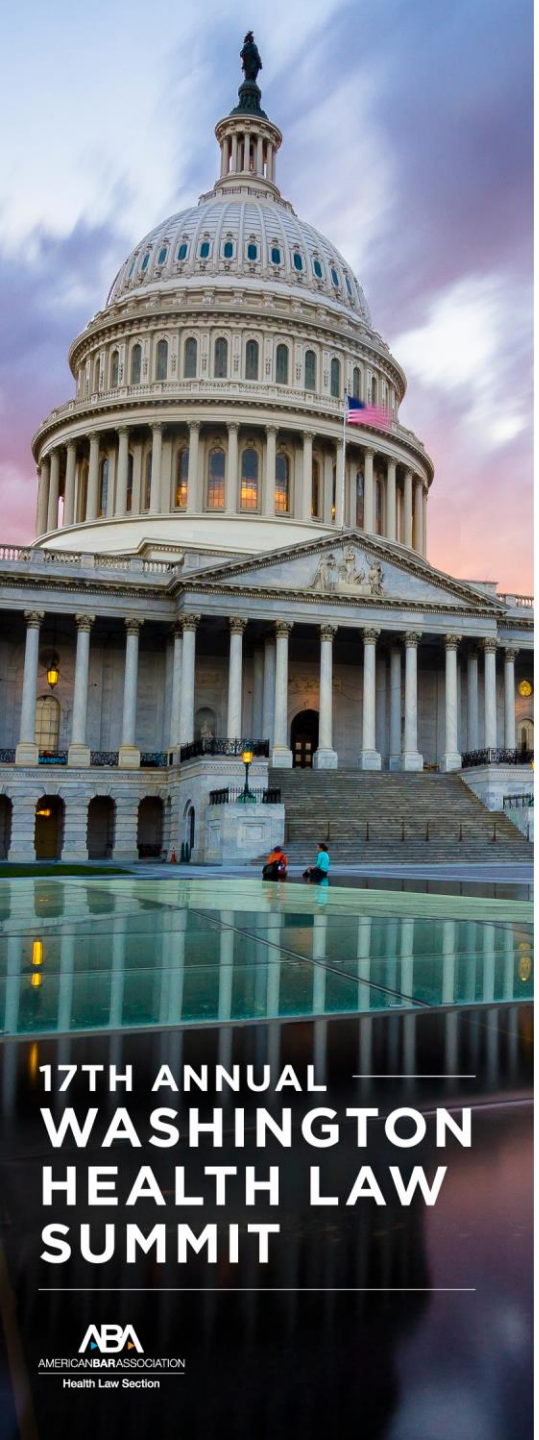
Of the 561 Medicare ACOs that participated in the program last year, 82% were in an upside only risk arrangement.



Statistics Since Pathways to Success

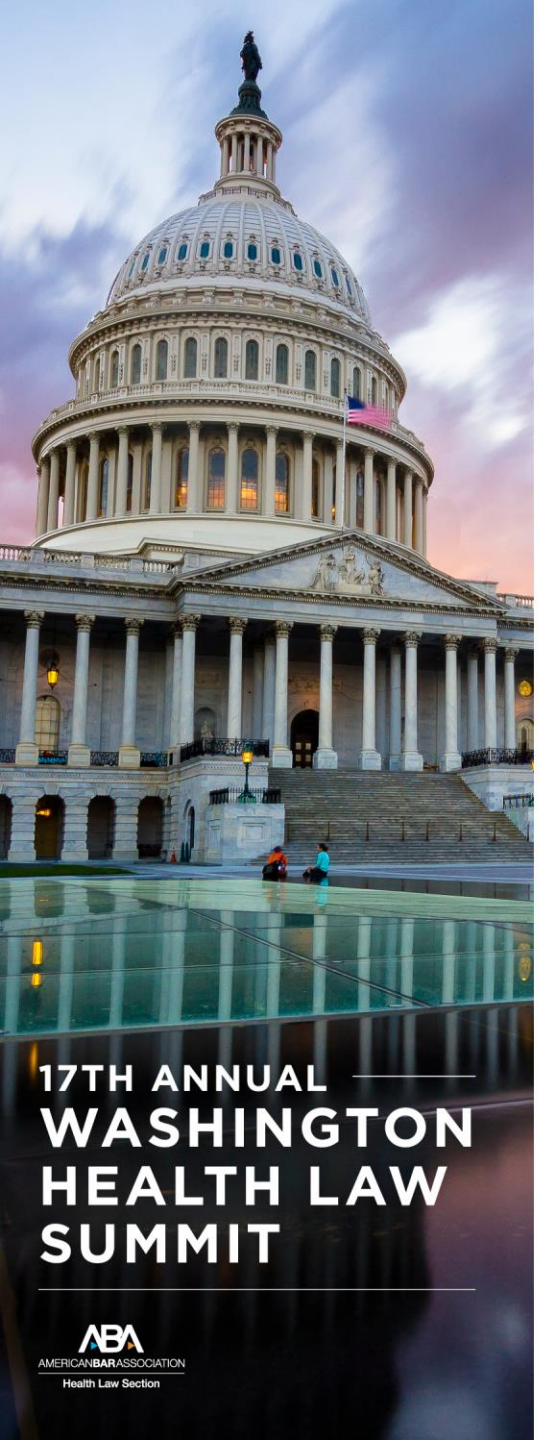
Pathways

- ACO participation in the MSSP fell for the first time since the program launched in 2012, and less than half the number of new ACOs joined this year.
- 40 percent of the 203 ACOs whose contracts expired at the end of last year elected not to continue in the program under Pathways to Success rules
- CMS approved 206 ACOs to begin on the July 1, 2019 start date, which increased the percentage of ACOs taking on downside risk from 19% to 29%. The second application cycle has a Jan. 1, 2020 start date.
- Medicare beneficiaries receiving care from a health care provider in an ACO as of July 1, 2019 increased by 400,000 to more than 10.9 million Medicare fee-for-service beneficiaries.



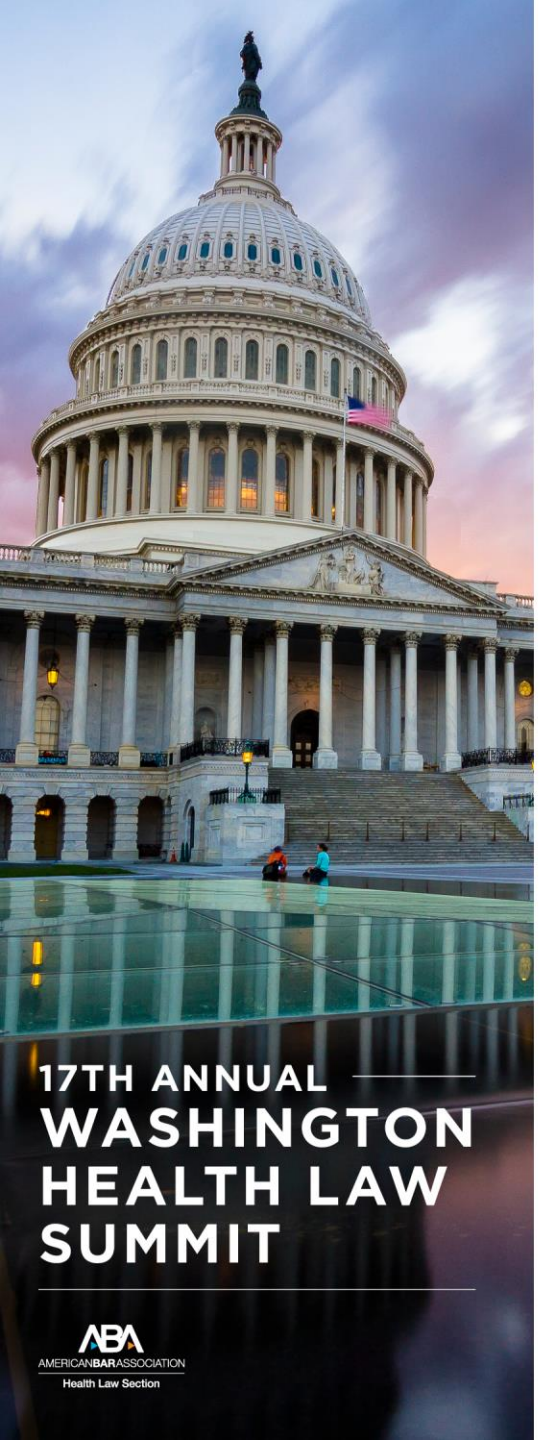
CMS offered existing MSSP ACOs an opportunity to transition to Pathways to Success before their current MSSP contracts expired.

Over 330 ACOs were eligible to move to new program rules early by July 1, 2019, yet only five percent of the organizations agreed to do it

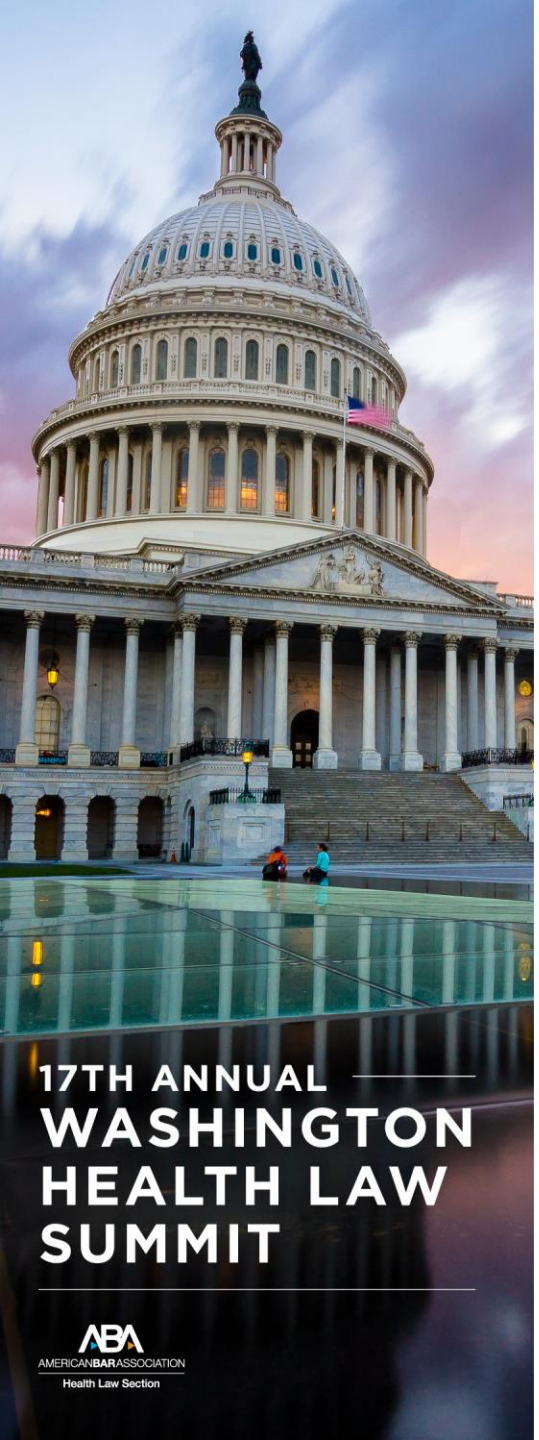


Pathways

- Most of those risk-sharing gains are from existing ACOs, not those new to or re-entering the program after time away.
- Forty-three of the new ACOs are in Level A or B of the basic track, which do not require downside risk.
- Only 20 of the 113 ACOs are in tracks with a level of downside risk that qualifies as an Advanced APM are new ACOs.

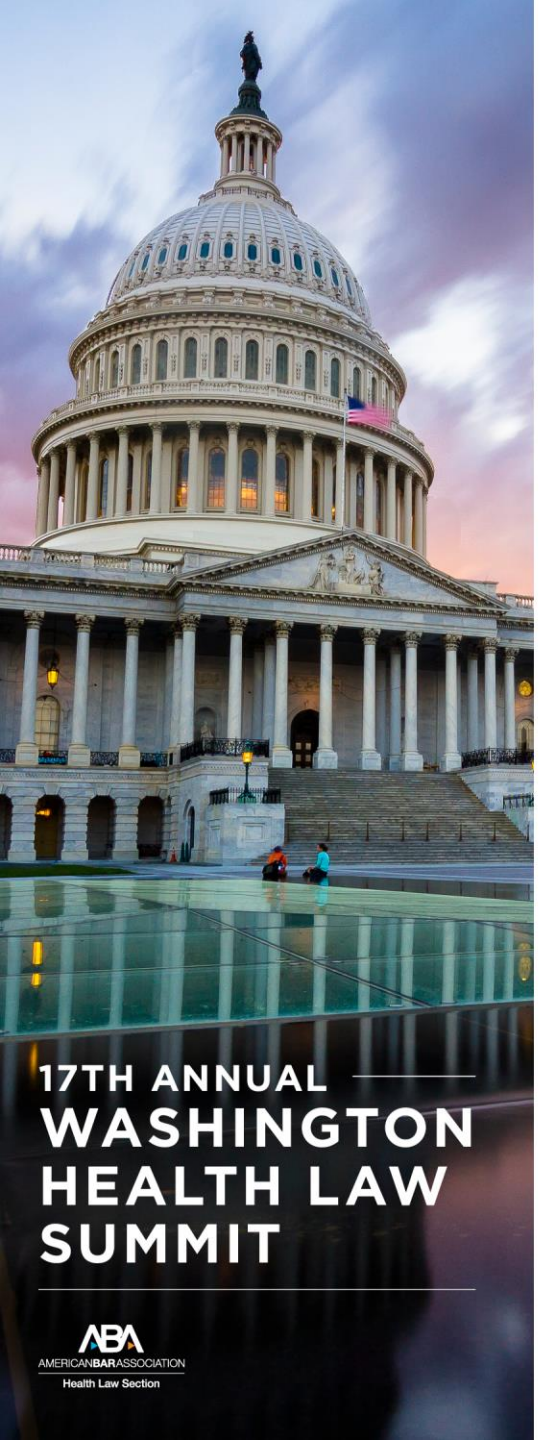


ACO programs with higher financial risk levels compared to the MSSP are generating greater savings.



Certain ACOs have done better than their peers

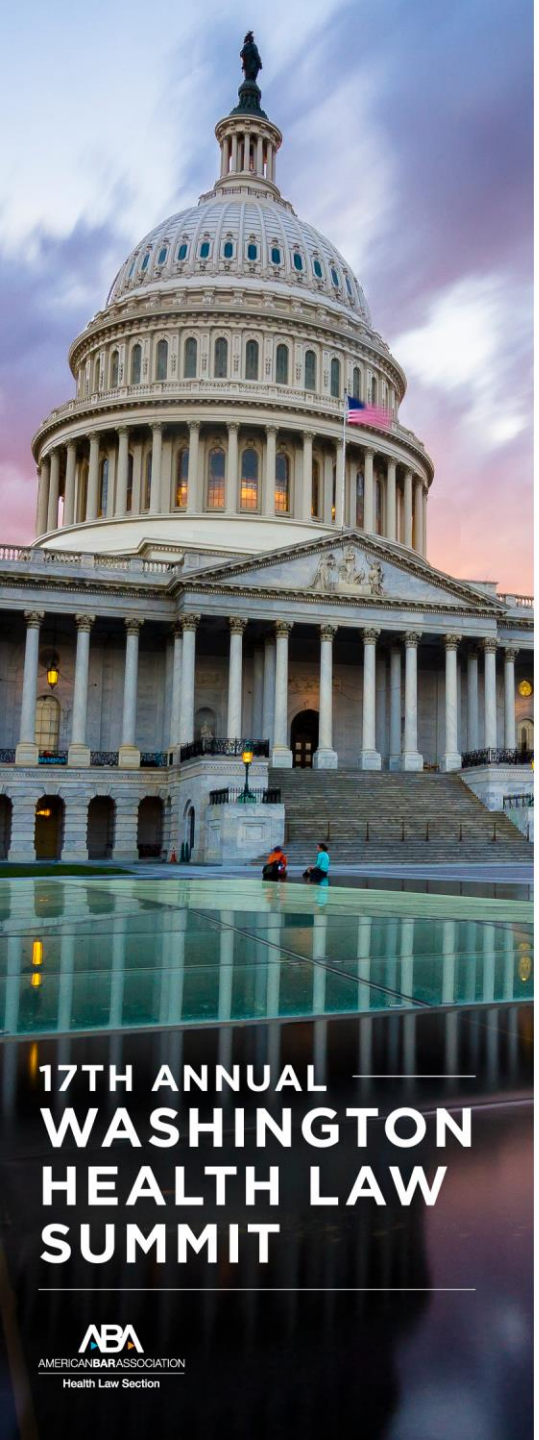
- For example, one top-performing ACO asked patients with certain chronic illnesses to call and report their health status to a care coordinator every day. The strategy led to 43% fewer ED visits and 47% fewer hospital readmissions in the second year of the program, according to the report.



Decision Points

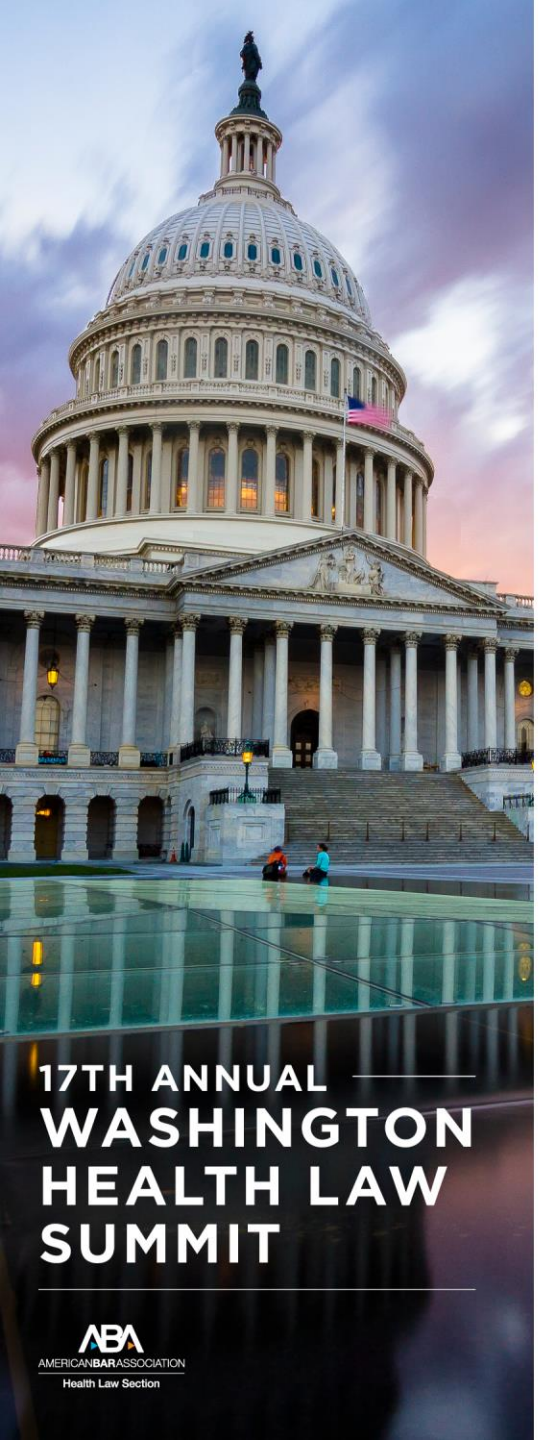
- Low/High Revenue ACO
- Inexperienced/Experienced ACO
  - Low Revenue ACO can stay in Basic Track for up to 10 years
- Beneficiary Assignment
- MSR/MLR Selection
- Basic Track or Enhanced Track
- Regional or National ACO for Benchmarking

- Up-Side Only or Two Sided Models
  - Two Sided Models Can Obtain Incentives
    - APM Incentive Payments
    - SNF 3-Day Waiver
    - Telehealth
    - Beneficiary Monetary Incentives



What's Next, More Changes?

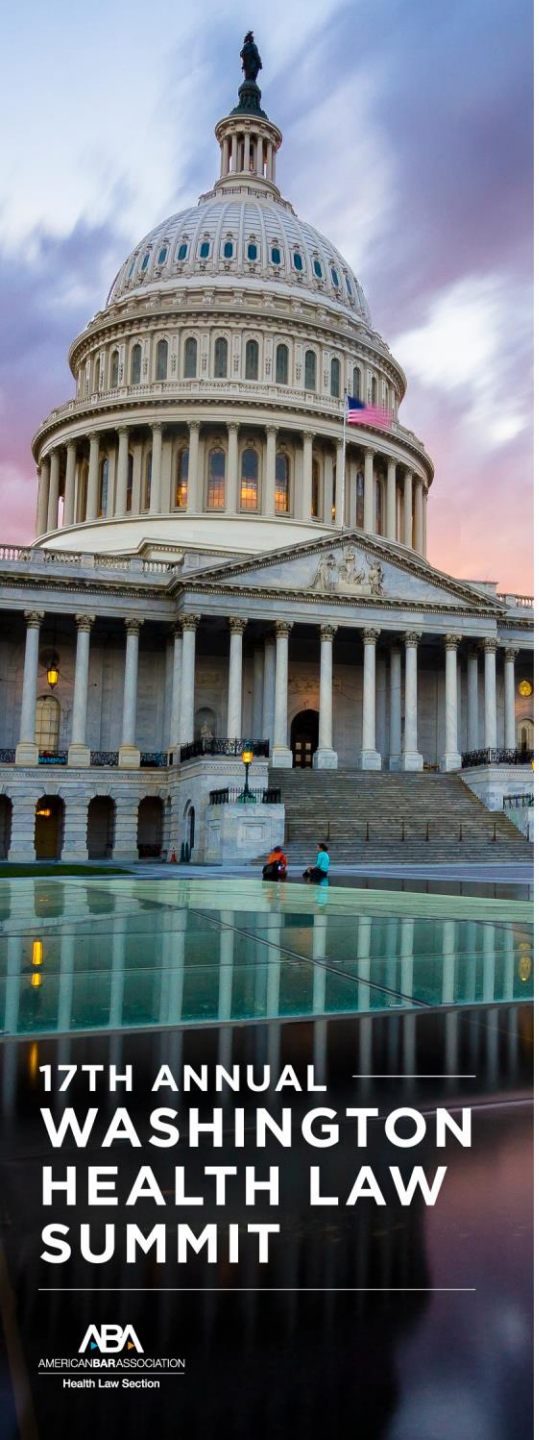
- In 2017, CMS realized a savings of $314 million from the program.
- In 2018, CMS realized a savings of $739.4 million (i.e., $73 per beneficiary) based on a total of $1.7 billion in savings.
- ACOs are getting better at achieving savings while CMS continues to analyze data to create policies that encourage and/or achieve savings.
- More CMS action to curb consolidation (Site Neutral Policy, Transparency Rules, Off-Campus Provider-Based Rule)



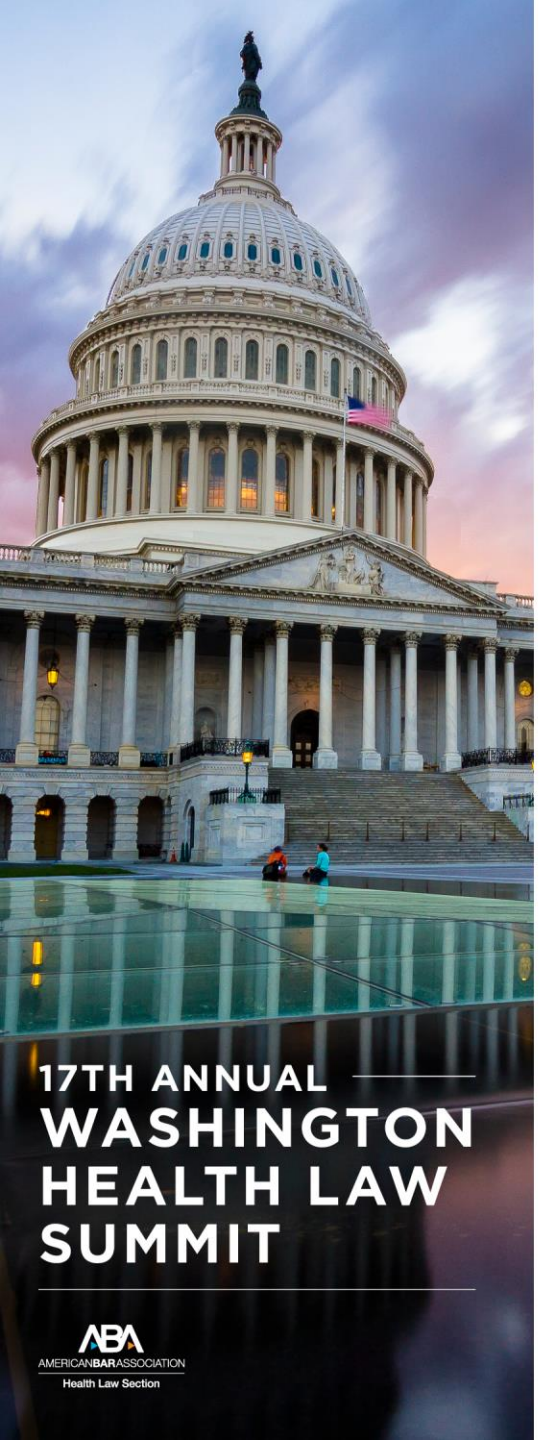
What's Next: More Changes

The OIG studied 20 high performing ACOs to determine what they were doing to reduce spending. The study found that these ACOs implemented strategies that fall into seven categories:

- Working with physicians
- Engaging beneficiaries
- Managing beneficiaries with costly or complex needs
- Managing hospitalizations
- Managing skilled nursing and home healthcare
- Addressing behavioral health needs and social determinants of health
- Using technology for information sharing



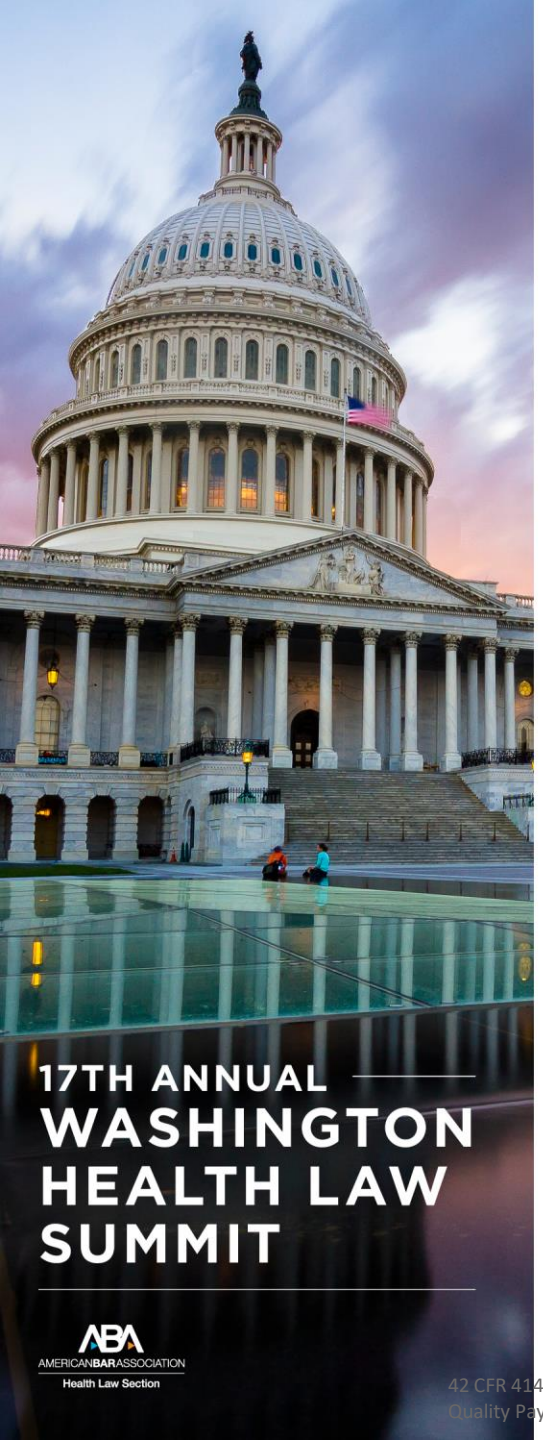
Private Side APMs



Other-Payer Advanced Alternative Payment Models (APMs) Option

- Non-Medicare fee-for-service payment arrangements with any payor other than traditional Medicare that meets certain criteria
- Option began in 2019
  - Submissions began January 2019 for payors
  - Won't begin until August 2020 for clinicians

"All-Payer Advanced Alternative Payment Models (APMs) Option" Centers for Medicare & Medicaid Services, Quality Payment Program, https://qpp.cms.gov/apms/all-payer-advanced-apms (Accessed 10/1/19).

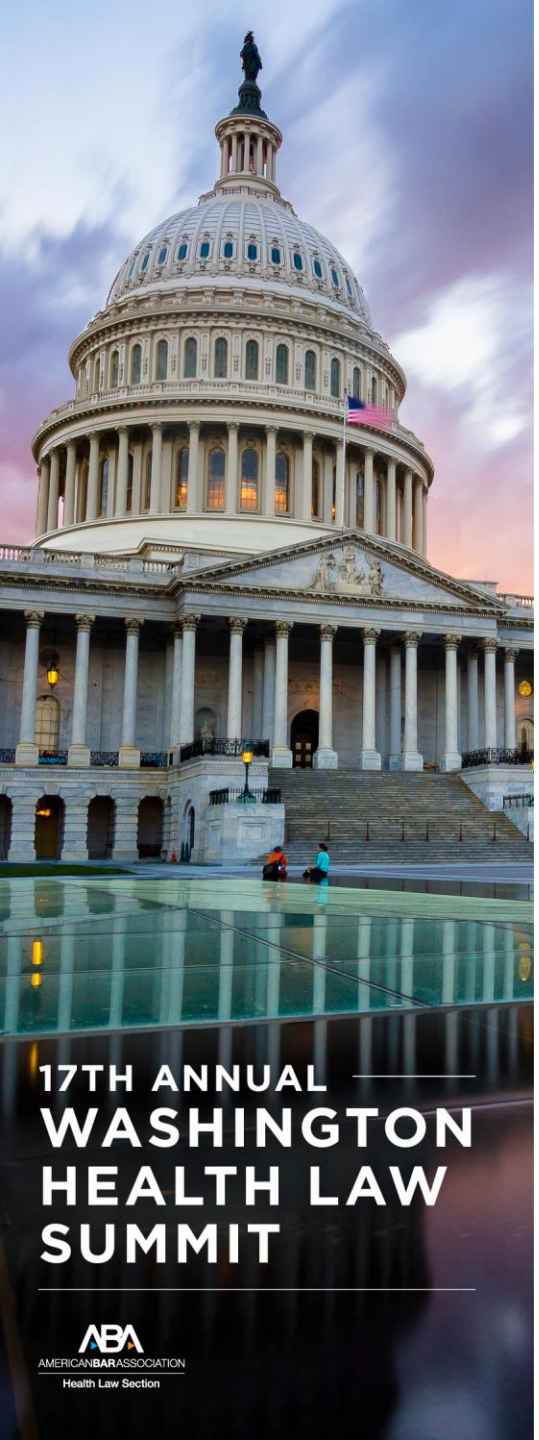


Other-Payer Advanced Alternative Payment Models (APMs) Option

Criteria

- Payment arrangements must both:
  1. Fall into one of the below categories:
     - Medicaid
     - Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid, 1876 Cost Plans, PACE plans)
     - CMS Multi-Payer 4 Models
     - Commercial/Private Payor Arrangements

42 CFR 414.1420; "All-Payer Advanced Alternative Payment Models (APMs) Option" Centers for Medicare & Medicaid Services, Quality Payment Program, https://qpp.cms.gov/apms/all-payer-advanced-apms (Accessed 10/1/19).

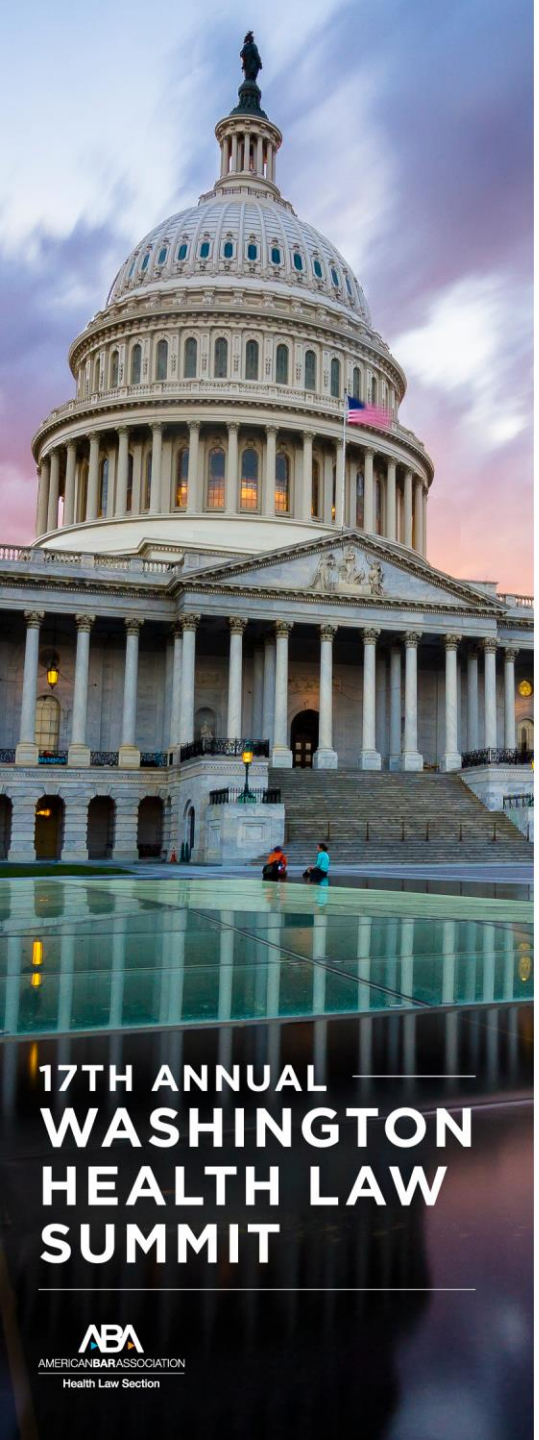


Other-Payer Advanced Alternative Payment Models (APMs) Option

Criteria

2. Meet Other-Payer Advanced APM criteria:
   - At least 50% of APM's eligible clinicians must use *certified EHR technology* (CEHRT)
   - Must base payments for covered professional services on quality measures comparable to MIPS Quality performance category
     - Measures must be evidence-based, reliable, and valid, with at least 1 outcome measure if there is an applicable measure on the MIPS measure list

42 CFR 414.1420; "All-Payer Advanced Alternative Payment Models (APMs) Option" Centers for Medicare & Medicaid Services, Quality Payment Program, https://qpp.cms.gov/apms/all-payer-advanced-apms (Accessed 10/1/19); "CMS Multi-Payer Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019" Centers for Medicare & Medicaid Services, Quality Payment Program, available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/181/2019%20CMS%20Multi-Payer%20Other%20Payer%20APM%20Determination%20List.FINAL.pdf (Accessed 10/2/19).
CMS has proposed increasing this percentage to 75% beginning January 1, 2020.

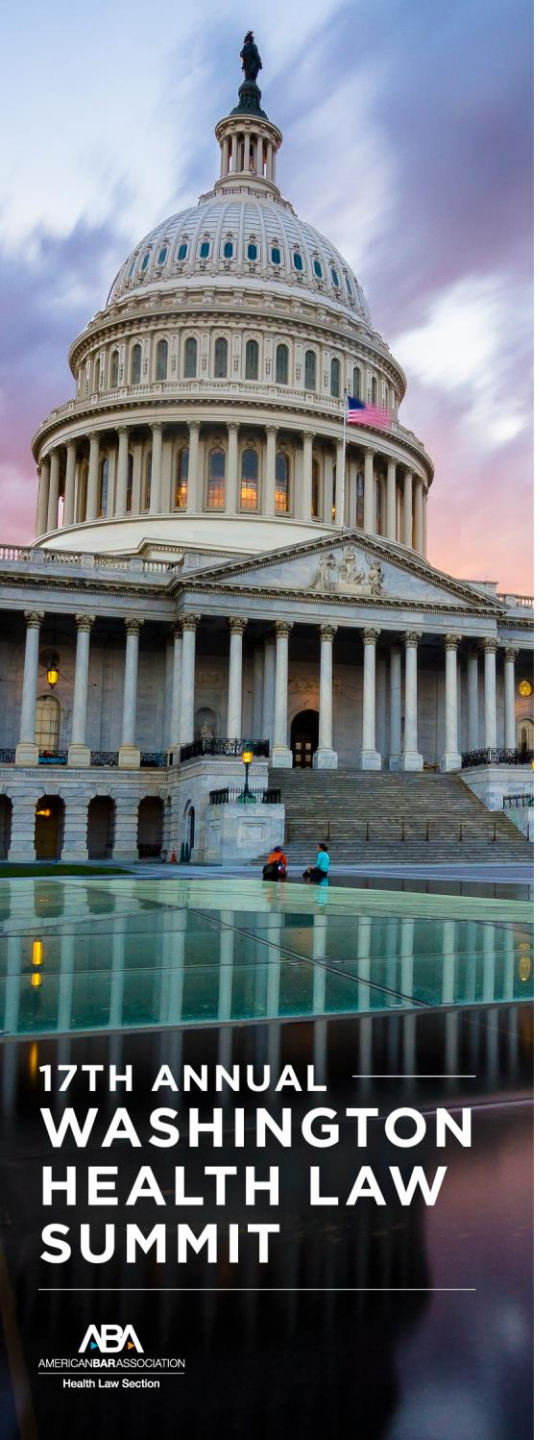


Other-Payer Advanced Alternative Payment Models (APMs) Option

Criteria

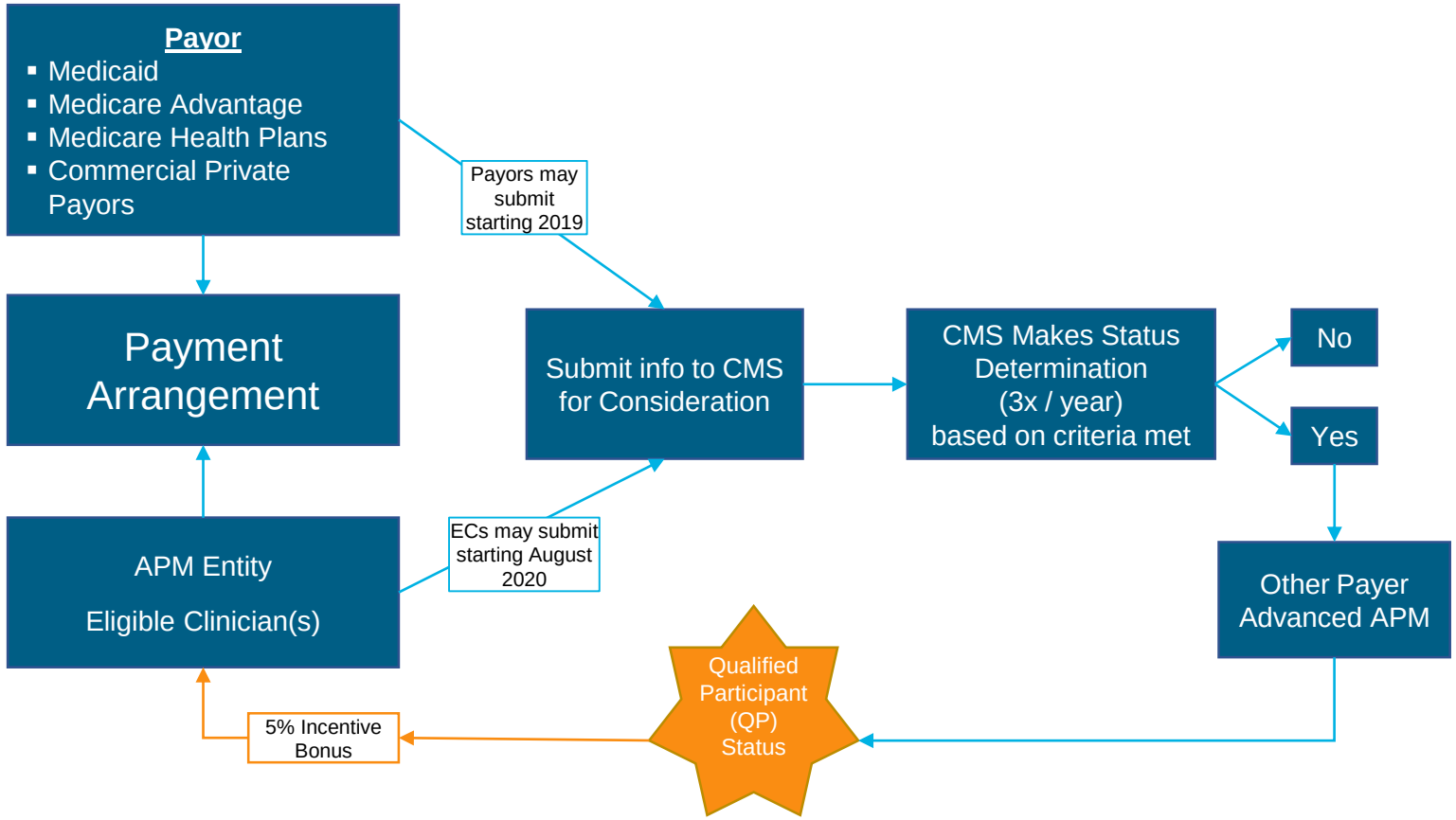
2. Meet Other-Payer Advanced APM criteria:
   - Participants must bear a certain amount of financial risk
     - A payment arrangement meets the financial risk if:
       - The arrangement is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models
       - If/When actual expenditures exceed expected aggregate expenditures, "*the payer withholds payment for services, reduces payment rates, or requires direct payment by the APM Entity to the payer*"

The amount an APM would owe a payer, or foregoes under the arrangement, but at be at least 85 of the total revenue from the payer, or 3% of the expected expenditures, and also must include a marginal risk of ≥ 30% and a minimum loss rate of ≤ 4%. "CMS Multi-Payer Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019" Centers for Medicare & Medicaid Services, Quality Payment Program, available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/181/2019%20CMS%20Multi-Payer%20Other%20Payer%20APM%20Determination%20List.FINAL.pdf (Accessed 10/2/19).



Other-Payer Advanced Alternative Payment Models (APMs) Option

Process



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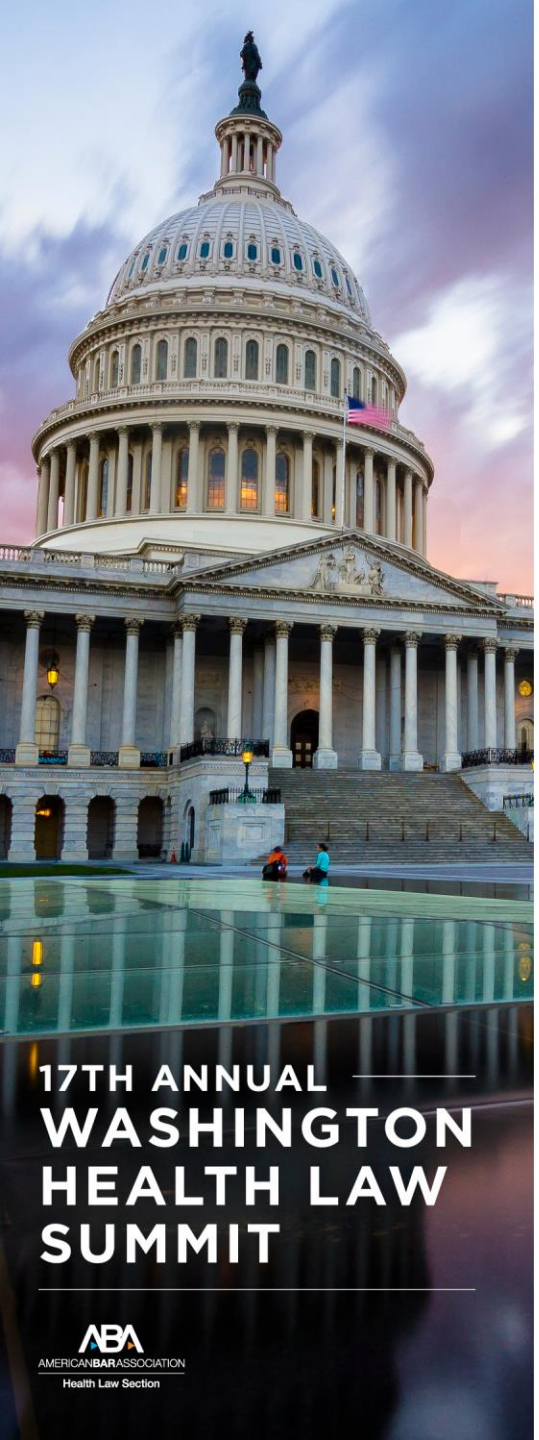


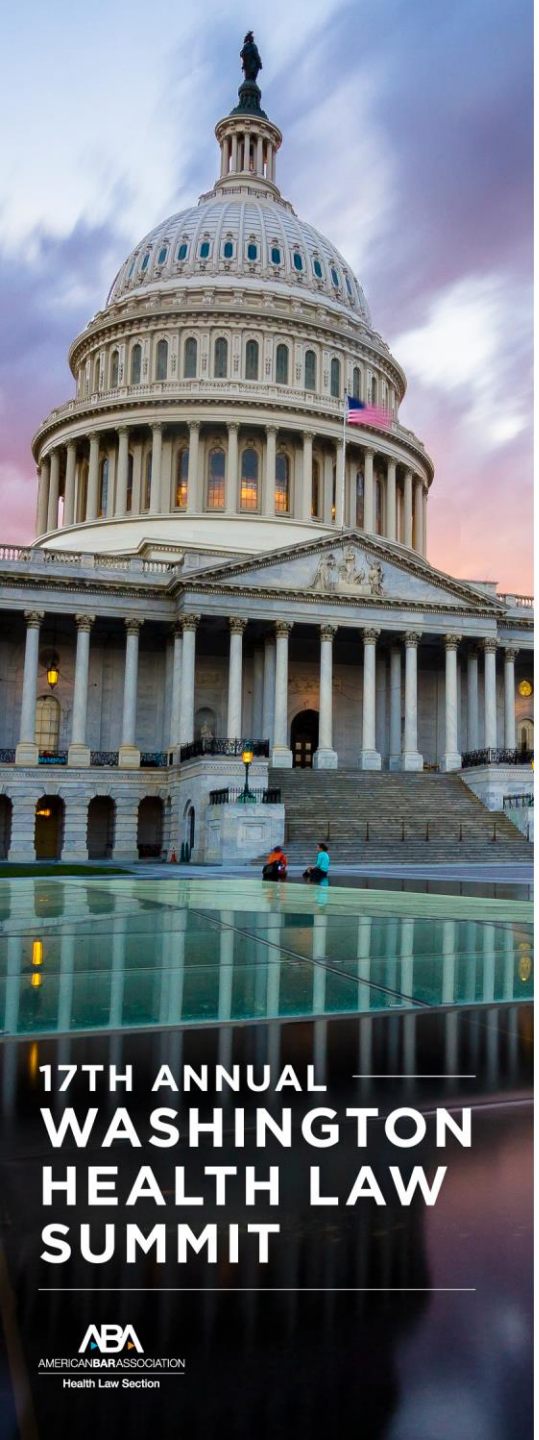
Other-Payer Advanced Alternative Payment Models (APMs) Option

Participants

- CMS Multi-Payer Payment Arrangements – Other Payer Advanced APMs, Performance Year 2019

Entity Name	Payment Arrangement Name	Advanced APM Alignment	Location
Hawaii Medical Service Association	Payment Transformation Program	CPC+	Hawaii
Independence Blue Cross/Keystone Health Plan East	Primary Care Advancement Model - HMO Track	CPC+	Greater Philadelphia Area

"CMS Multi-Payer Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019" Centers for Medicare & Medicaid Services, Quality Payment Program, available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/181/2019%20CMS%20Multi-Payer%20Other%20Payer%20APM%20Determination%20List.FINAL.pdf (Accessed 10/2/19).

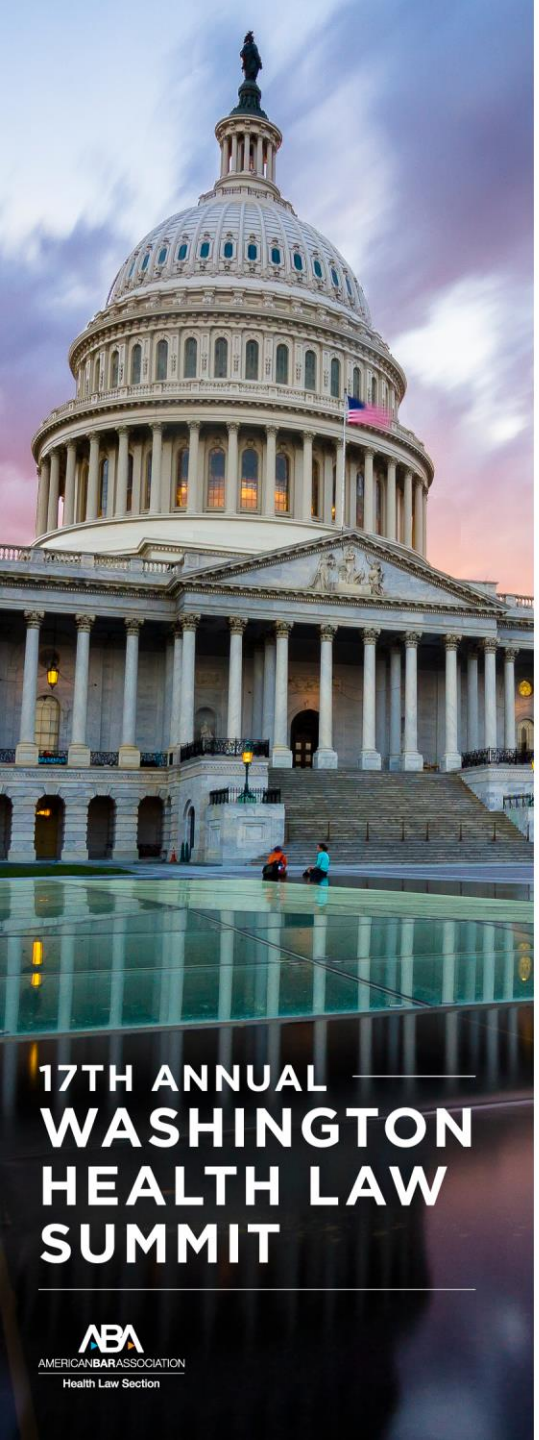


Other-Payer Advanced Alternative Payment Models (APMs) Option

End Goal

- Become a *Qualifying Alternative Payment Model Participant* (QP): An eligible clinician who has met or exceeded the payment amount or patient count thresholds based on participation in an Advanced APM
  - Will receive 5% APM incentive payment
  - Will not be subject to MIPS Reporting Requirements

"All-Payer Advanced Alternative Payment Models (APMs) Option" Centers for Medicare & Medicaid Services, Quality Payment Program, https://qpp.cms.gov/apms/all-payer-advanced-apms (Accessed 10/1/19).



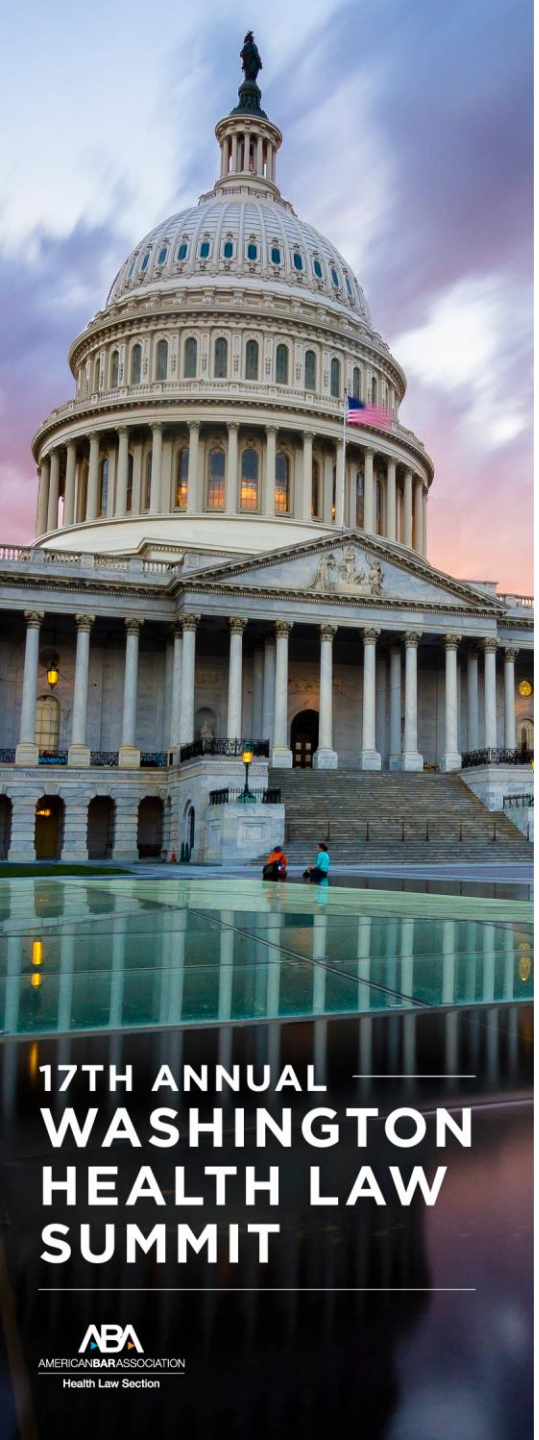
Other-Payer Advanced Alternative Payment Models (APMs) Option

Payment Thresholds

All-Payer Combo Payment Thresholds	2019
Medicare Minimum for QP status	25%
Total QP Payment Amount (Medicare AAPM=25% + Other Payer AAPM=25%)	50%
Medicare Minimum for Partial QP status	20%
Total Partial QP Payment Amount (Medicare AAPM=20% + Other Payer AAPM=20%)	40%

All-Payer Combo Patient Thresholds	2019
Medicare Minimum for QP status	20%
Total QP Payment Amount (Medicare AAPM=20% + Other Payer AAPM=15%)	35%
Medicare Minimum for Partial QP status	10%
Total Partial QP Payment Amount (Medicare AAPM=10% + Other Payer=15%)	25%

"2019 Quality Payment Program All-Payer Combination Advanced APMs" American Association of Nurse Anesthetists, 2019, available at: https://www.aana.com/docs/default-source/quality-aana.com-web-documents-(all)/fact-sheet-combo-apms-1-may-2019.pdf?sfvrsn=71ff2e98_2 (Accessed 10/2/19).



Continuum of Private APMs

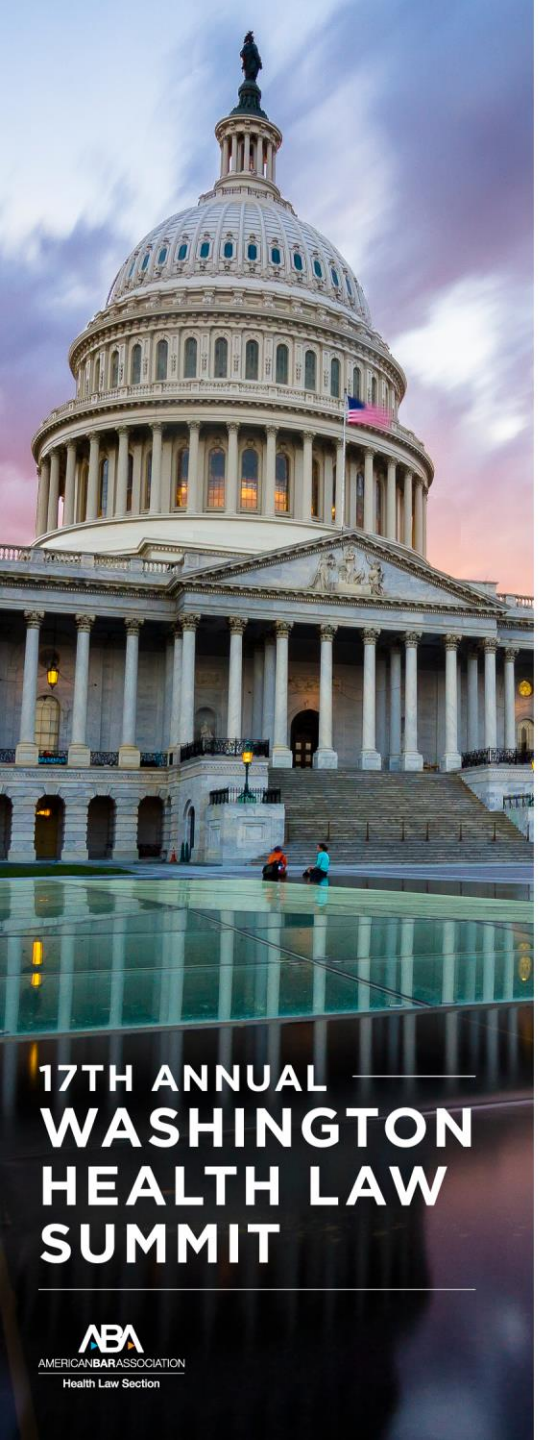
(1) FFS – No Link to Quality/Value	(2) FFS – Link to Quality/Value	(3) APM built on FFS Architecture	(4) Population Based Payment
	▪ Foundational Payments for Infrastructure & Operations ▪ Pay For Reporting ▪ Pay for Performance	▪ APMs with Shared Savings (1-Sided Risk) ▪ APMs with Shared Savings and Shared Losses (2-Sided Risk)	▪ Condition-Specific Population-Based Payment ▪ Comprehensive Population-Based Payment ▪ Integrated Finance & Delivery System

Categories

Examples

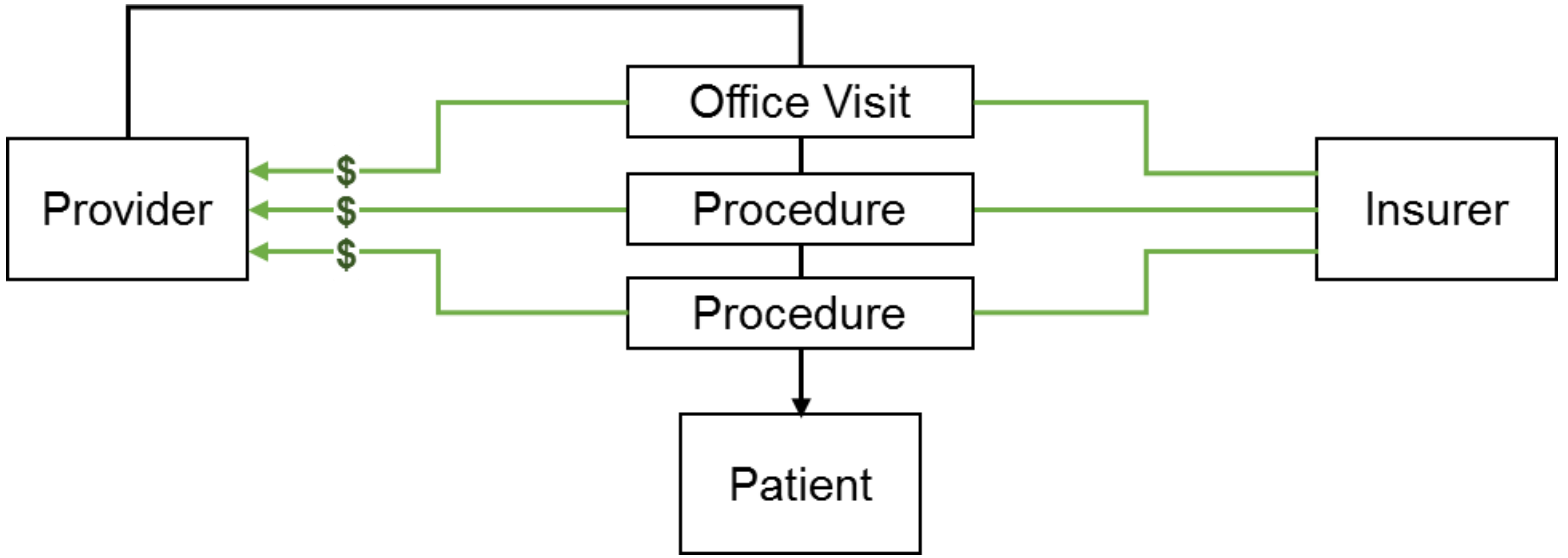
AmeriHealth Caritas - PerformPlus© Program	Anthem – Quality In Sights Hospital Incentive Program	Cigna Collaborative Care – large physician groups	Anthem Enhanced Personal Healthcare Model	MD-Value In Prevention (VIP) Personalized Preventive Primary Care	Presbyterian Health Plan, Albuquerque, New Mexico	UnitedHealthcare Episode Payment Program for Cancer Therapy	Tufts Health Plan, Watertown, Massachusetts
Cigna Collaborative Care Hospitals	Anthem-Quality Cancer Care	CMS Comprehensive Primary Care (CPC) Initiatives	Capital District Physicians' Health Plan (CDPHP®) Enhanced Primary Care (EPC) Program	Integrated Healthcare Association (IHA) Value Based Pay for Performance Program (VBP4P)	Minnesota Integrated Health Partnership		

"Addendum to the Alternative Payment Model (APM) Framework White Paper" Health Care Payment Learning & Action Network, January 12, 2016, https://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf (Accessed 11/1/19).

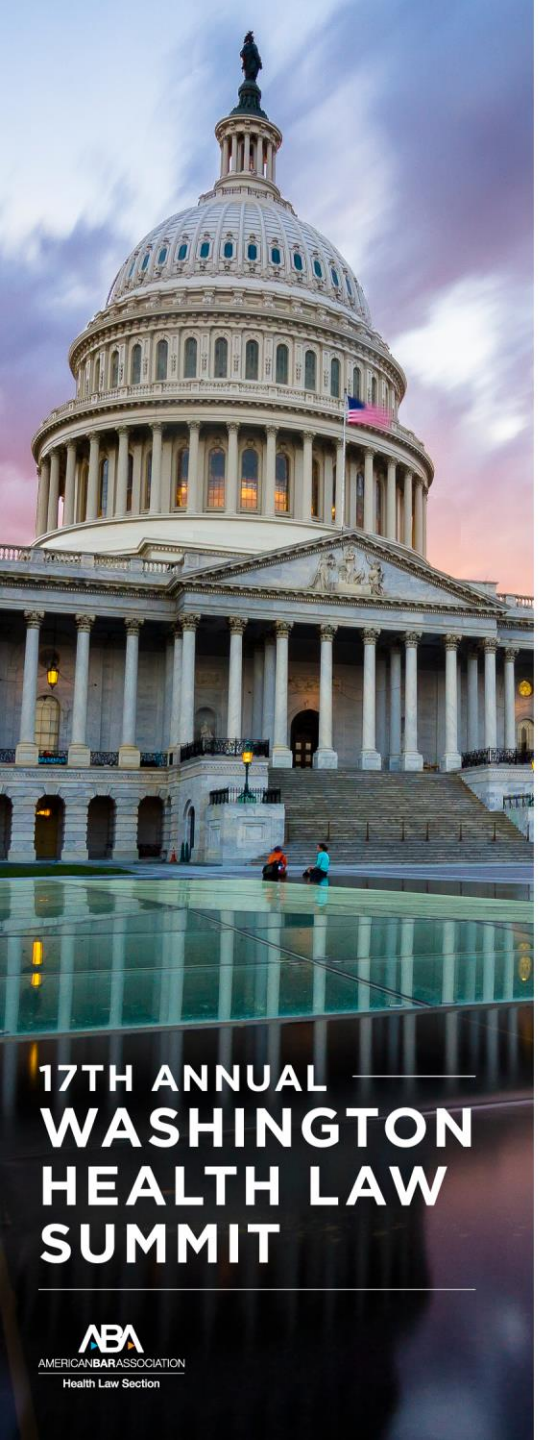


Typical Models

(1) Episodic Fee-For-Service (FFS) Models

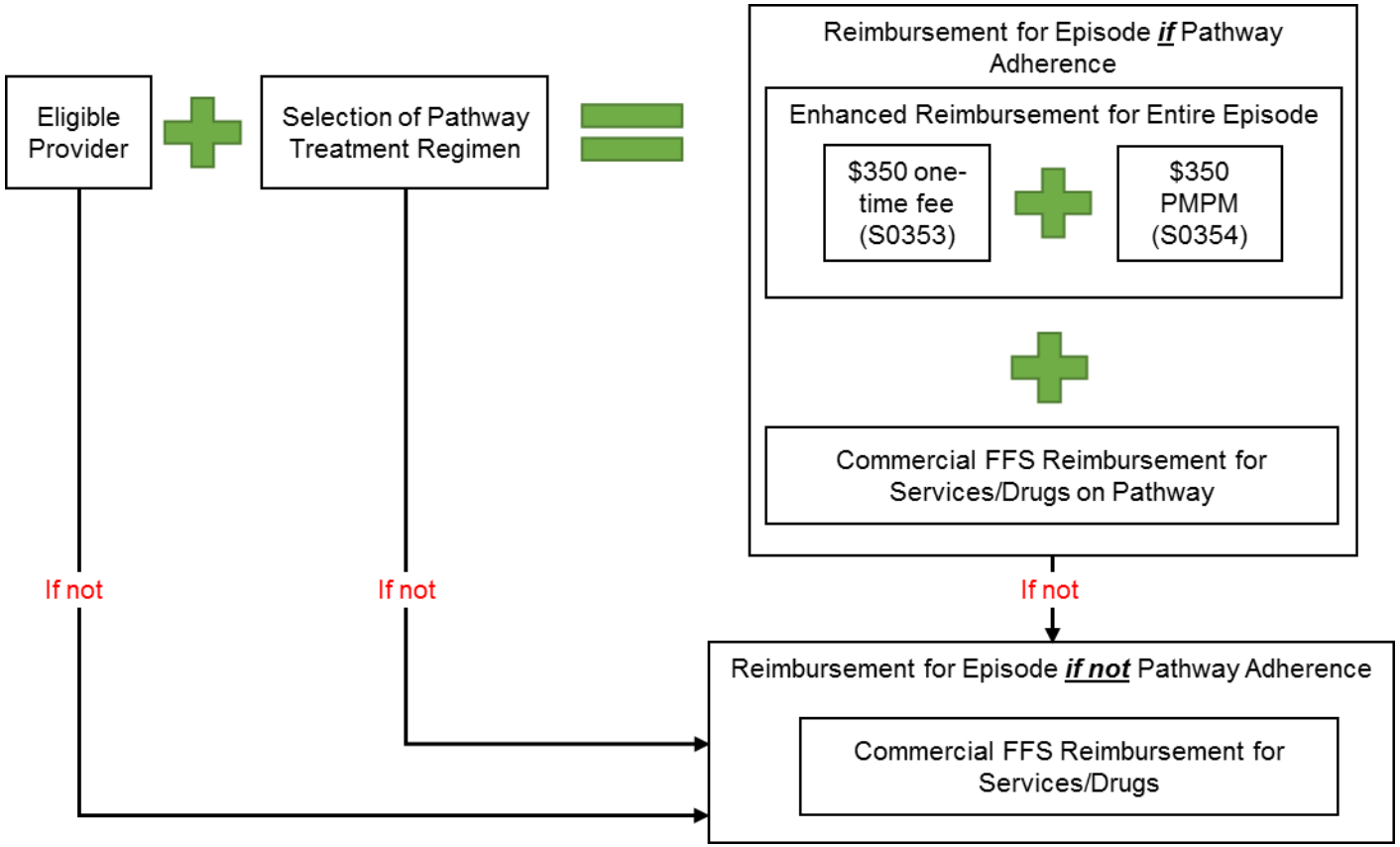


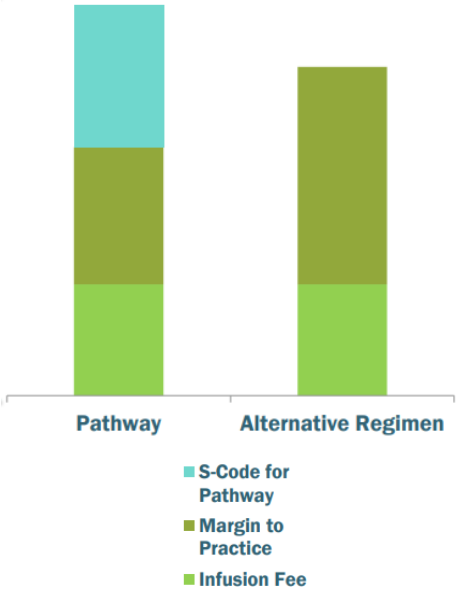
- Payments not linked to quality or value



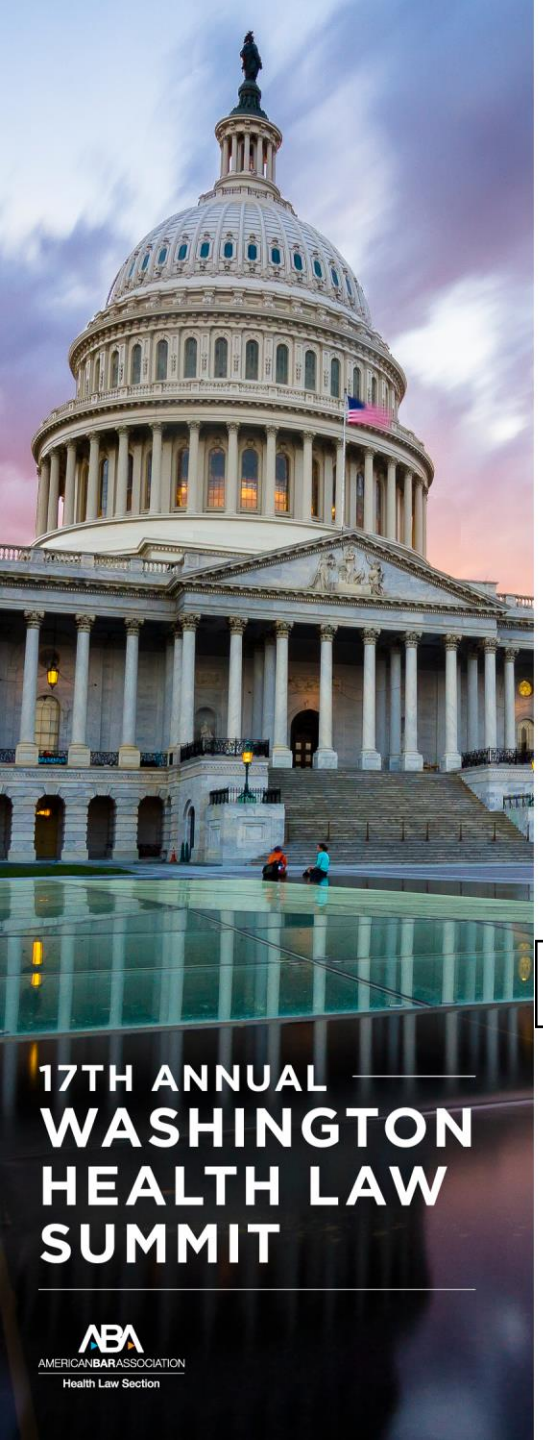
Typical Models

(2) Enhanced FFS Example: Anthem Cancer Treatment Pathways



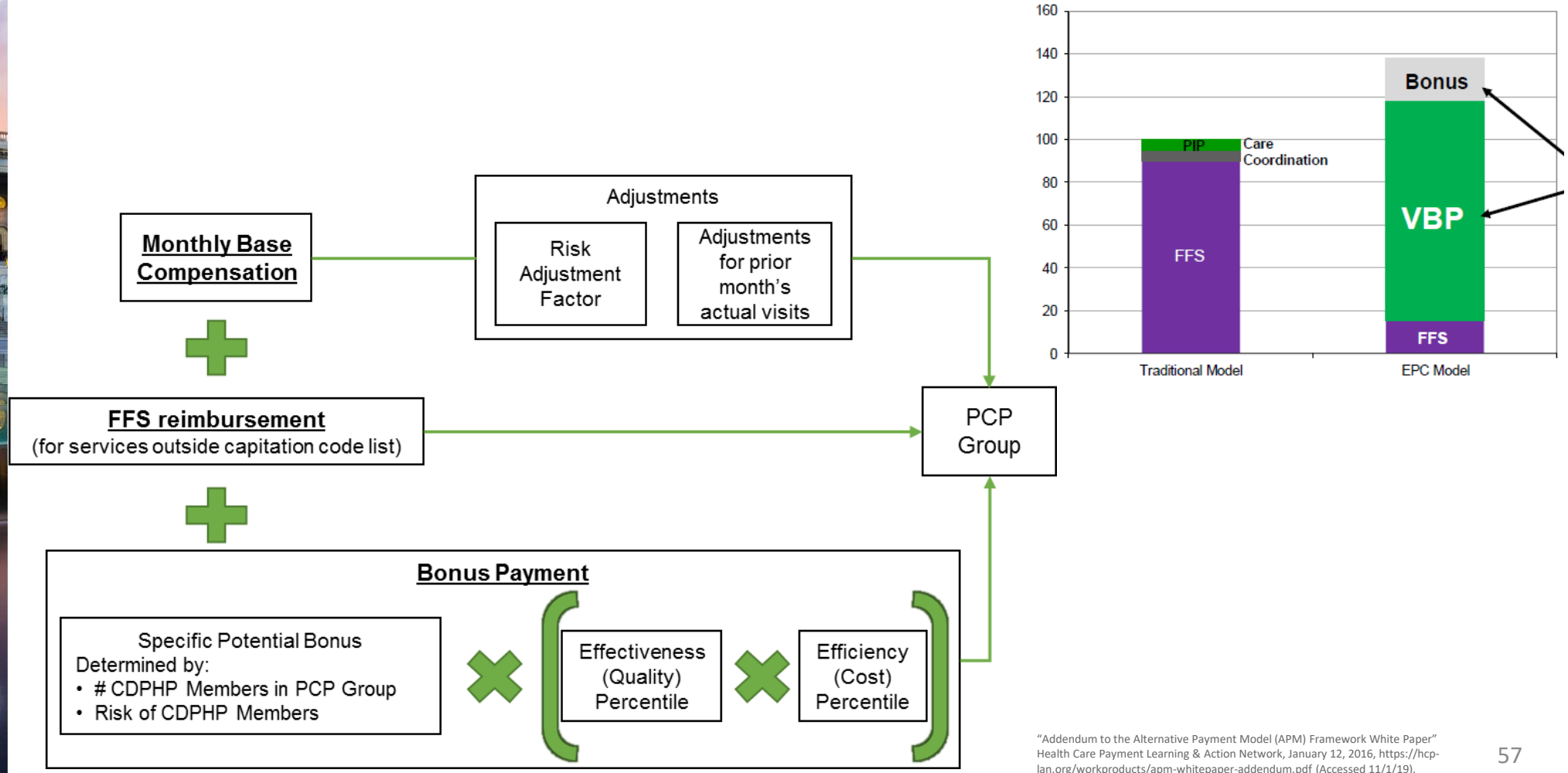


"Addendum to the Alternative Payment Model (APM) Framework White Paper" Health Care Payment Learning & Action Network, January 12, 2016, https://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf (Accessed 11/1/19); "Anthem Cancer Pathways Program Rewards Network Docs for High-Quality Cancer Care" The AIS Report on Blue Cross and Blue Shield Plans, Vol. 14, No. 5 (May 2015); "Anthem Cancer Care Quality Program: Reimbursement FAQs" AIM Specialty Health, https://aimproviders.com/wp-content/uploads/2018/10/CancerCare_EnhancedReimbursementFAQ.pdf (Accessed 11/1/19).

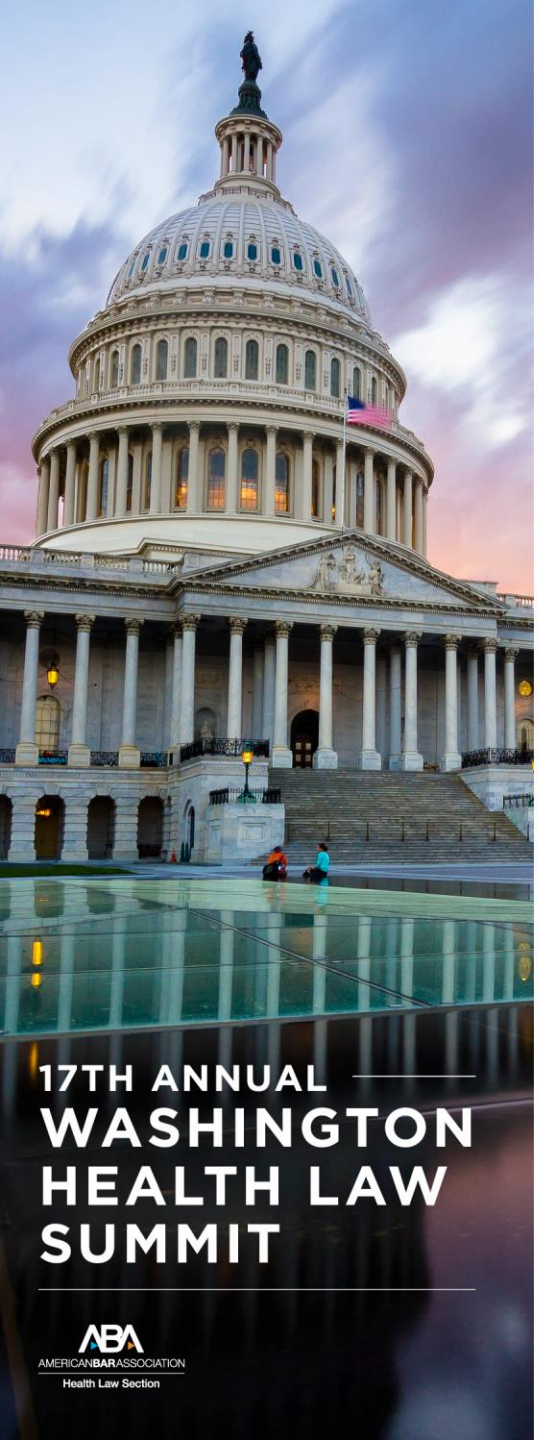


Typical Models

(3) APMs Built on FFS Architecture Example: Capital District Physicians' Health Plan (CDPHP®) - Enhanced Primary Care (EPC) Program

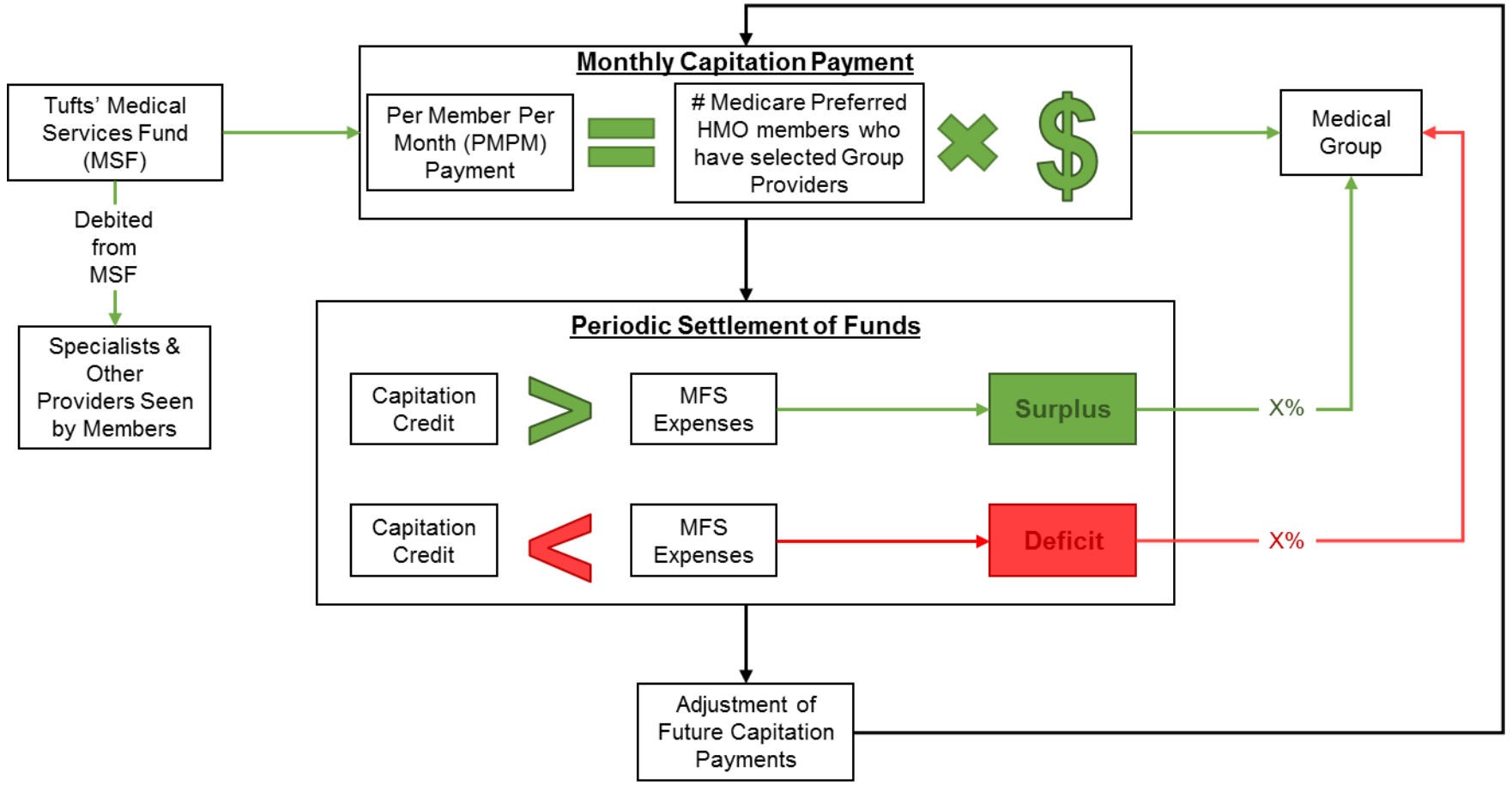


"Addendum to the Alternative Payment Model (APM) Framework White Paper" Health Care Payment Learning & Action Network, January 12, 2016, https://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf (Accessed 11/1/19).

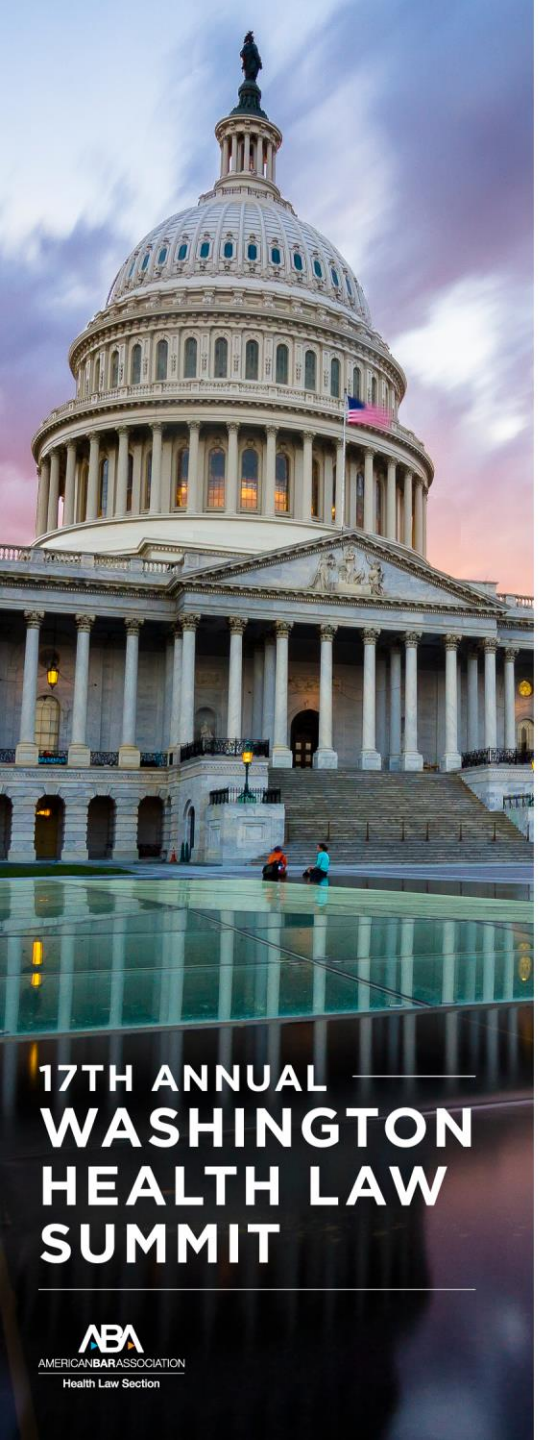


Typical Models

(4) Population Based Payment Example: Tufts Health Plan

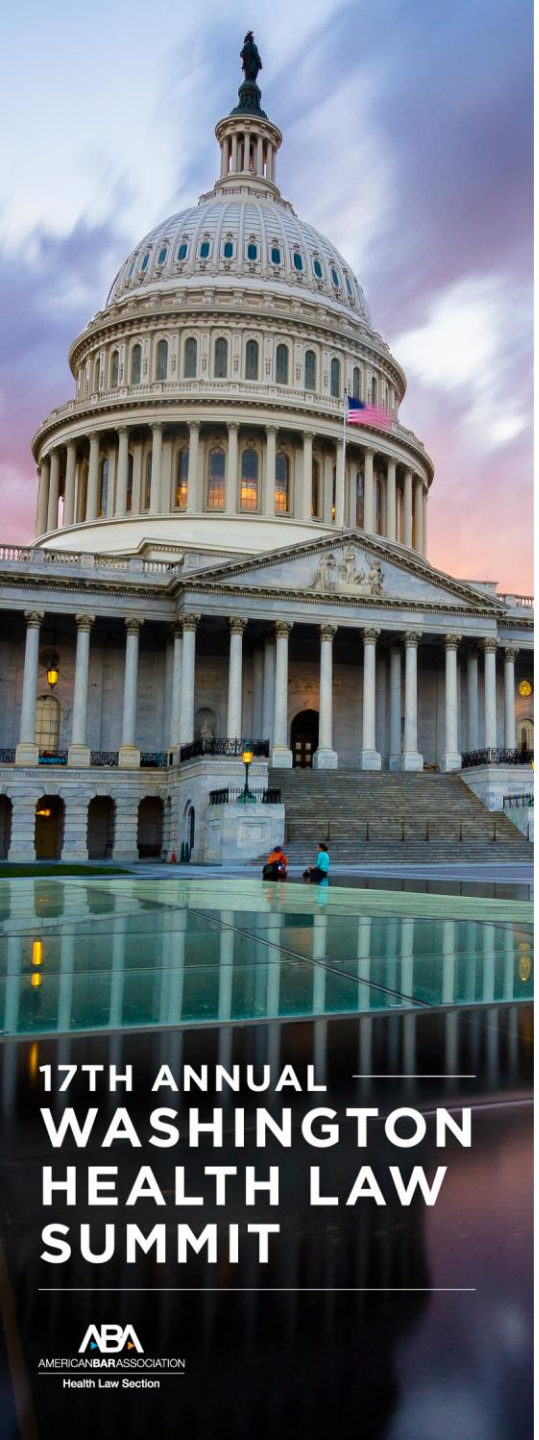


"Addendum to the Alternative Payment Model (APM) Framework White Paper" Health Care Payment Learning & Action Network, January 12, 2016, https://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf (Accessed 11/1/19); "2019 Senior Products Provider Manual" Tufts, https://tuftshealthplan.com/documents/providers/provider-manuals/sp-provider-manual (Accessed 11/1/19).

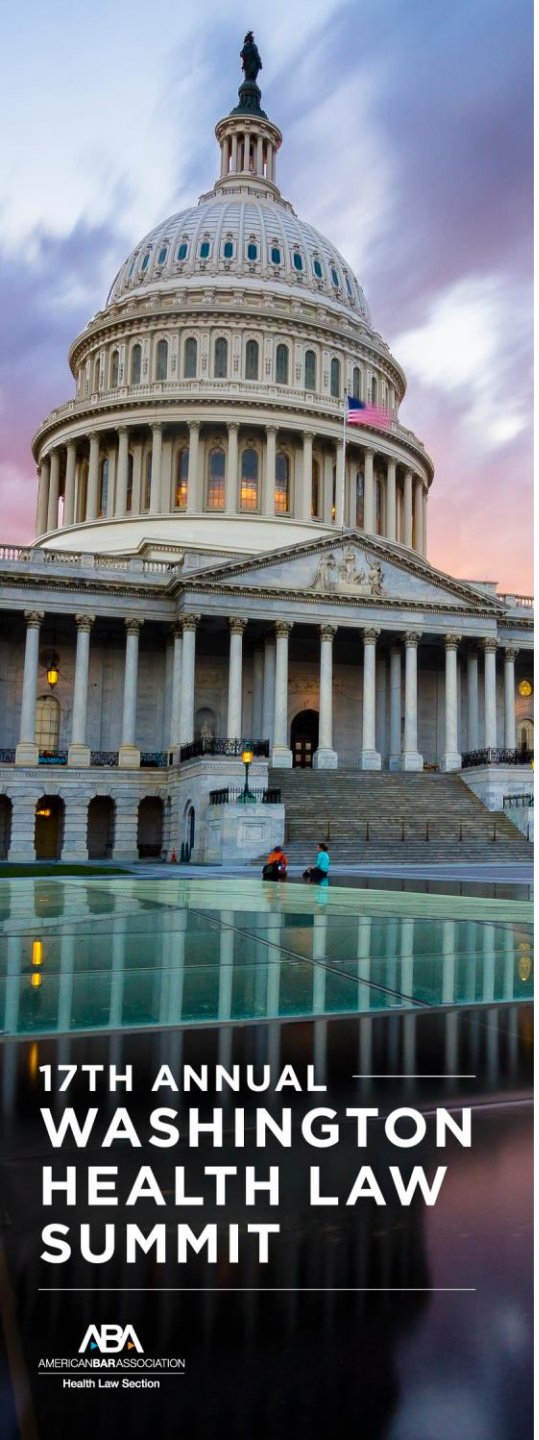


Real-World Examples

- FMV payment allocation
- Economic inputs of participants
- Achievability of quality metrics

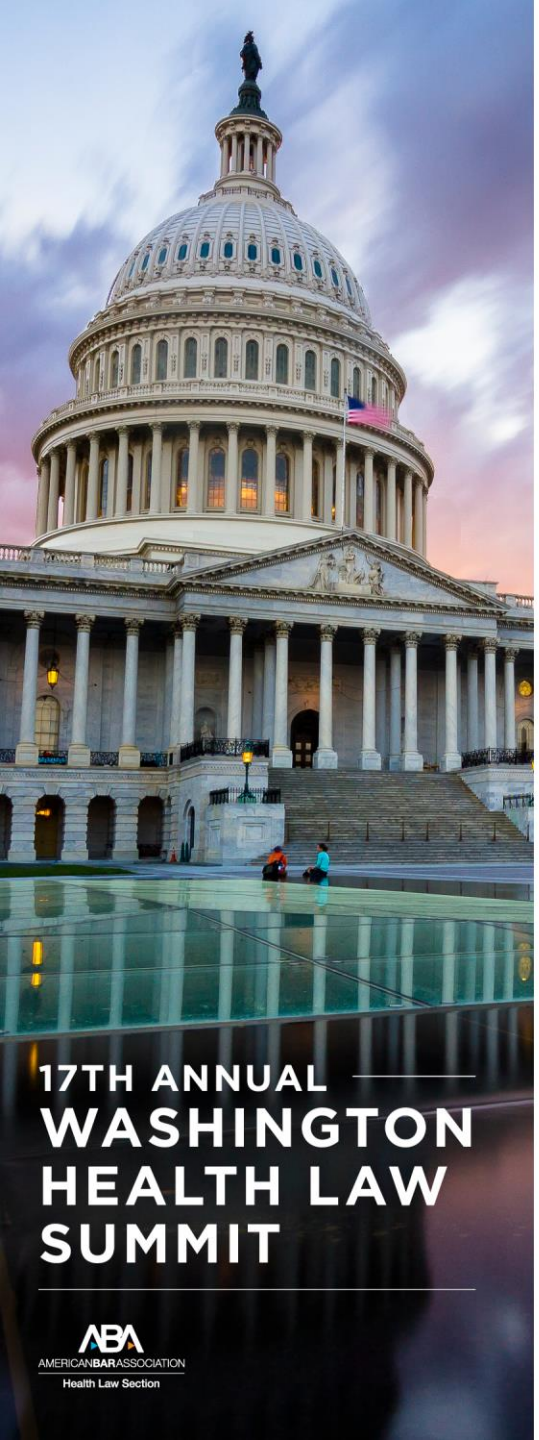


Other Considerations



How are rural hospitals fairing?

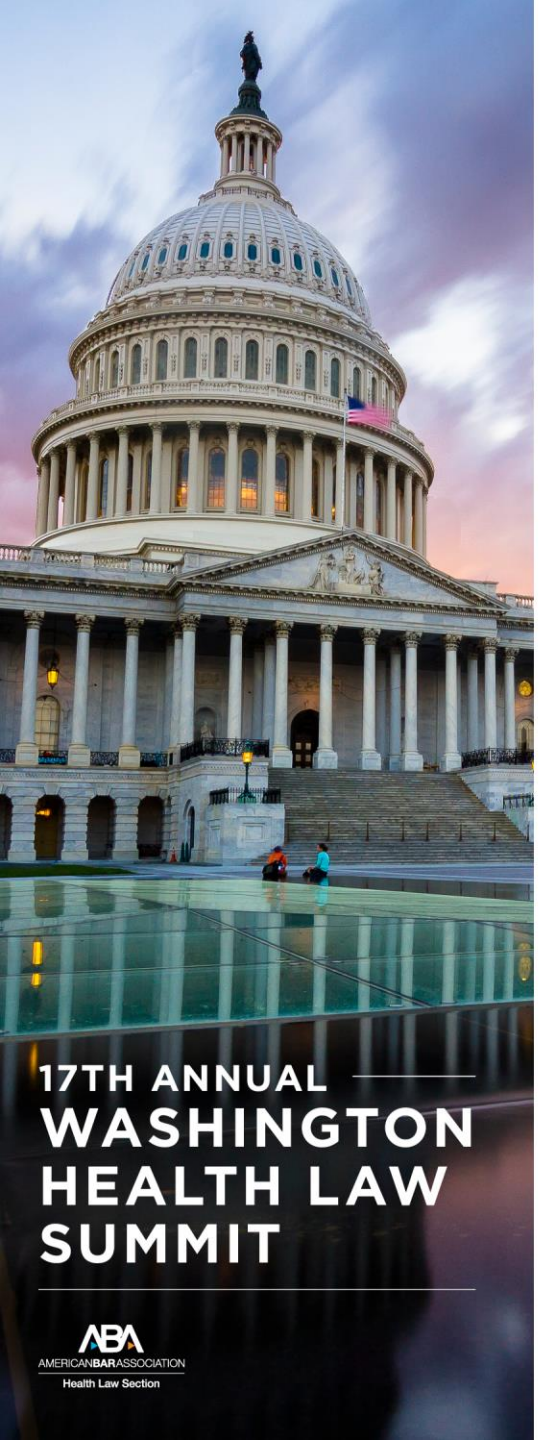
- *The New England Journal of Medicine* studied the early effects for ACOs in underserved areas and found that participation in ACO shared savings by providers serving rural and underserved areas was associated with lower Medicare spending than that among non-ACO providers.
- The MSSP is the largest and most effective quality advancement programs today, serving more than 1 million rural Medicare beneficiaries in 2017. Rural ACO participants experience an average 15-point increase in quality scores in their first year — improving care while adding new revenue streams.



Further Rural Hospital Considerations

- Unique Challenges
  - Large geographic dispersion of patients
  - Low episode volume
  - Lack of experience & resources related to value-based reimbursement administration
  - Non-interoperable health IT systems
- Changes to Payment Models
  - Rural Community Hospital Demonstration: Testing cost-based reimbursement for small rural hospitals too large to be Critical Access Hospitals
  - Frontier Community Health Integration Project Demonstration: Testing new models of integrated, coordinated health care in the most sparsely-populated rural counties
  - Risk Adjustment changes to the HRRP

"AHA Wants More Alternative Payment Models for Rural Hospitals" By Jacqueline LaPointe, February 7, 2019, Revcycle Intelligence, https://revcycleintelligence.com/news/aha-wants-more-alternative-payment-models-for-rural-hospitals (Accessed 11/1/19).



Questions & Answers