

Quality Payment PROGRAM

Quality Payment Program

**All-Payer Combination Option & Other Payer Advanced Alternative Payment Models
Frequently Asked Questions**



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Introduction

This Frequently Asked Questions (FAQ) document answers questions regarding the All-Payer Combination Option and Other Payer Advanced Alternative Payment Models (APMs) under the Quality Payment Program. For detailed, payer-specific information on the All-Payer Combination Option, see the following fact sheets and guidance materials on the [Quality Payment Program Resource Library](#):

- **Overview of the All-Payer Combination Option & Other Payer Advanced APMs**
 - Fact Sheet: [All-Payer Combination Option & Other Payer Advanced APMs](#)
- **Medicaid**
 - Fact Sheet: [APMs: Medicaid Models & All-Payer Models](#)
 - Guidance: [Guide to Submitting Medicaid Requests for Other Payer Advanced APM Determinations](#)
 - Guidance: [Guide for Managed Care Organizations Providing State Medicaid Agencies with Information and Documentation for Submitting Medicaid Requests for Other Payer Advanced APM Determinations](#)
- **Medicare Health Plans**
 - [Medicare Health Plan Other Payer APM Determination Process Fact Sheet](#)
- **CMS Multi-Payer Models**
 - [Multi-Payer Other Payer Advanced APM Determination Process Fact Sheet](#)

What's the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended Medicare's Sustainable Growth Rate, a formula for updating Medicare Physician Fee Schedule payment rates that threatened clinicians with potential payment cliffs, and replaced it with fixed annual updates that can be modified for individual clinicians based on a Quality Payment Program. There are 2 paths in the Quality Payment Program:

1. The Merit-based Incentive Payment System (MIPS), which adjusts Medicare payments based on combined performance on measures of quality, cost, improvement activities, and Promoting Interoperability (formerly Advancing Care Information), or
2. Advanced APMs with Medicare, under which an eligible clinician who meets threshold participation levels in their Advanced APM is determined to be a Qualifying Participant (QP) and thereby earns an incentive payment.



If an eligible clinician does not meet the threshold levels of participation to become a Qualifying APM Participant (QP) and earn the incentive payment based only on participation in Advanced APMs with Medicare, starting in the 2019 performance year, they can also count their participation in Other Payer Advanced APMs to potentially become a QP for the year. Other Payer Advanced APMs include certain payment arrangements with payers other than Medicare Fee-For-Service (FFS), such as Medicaid, Medicare Health Plans (Medicare Advantage), and commercial payers.

What's the All-Payer Combination Option?

The Advanced APM path under the Quality Payment Program provides two ways for eligible clinicians to become QPs: the Medicare Option, which takes into account the clinician's participation solely in Medicare Advanced APMs, and the All-Payer Combination Option, which takes into account the clinician's participation in Advanced APMs both with Medicare and other payers. The Other Payer Advanced APMs are payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans (including Medicare Advantage plans), payers in CMS Multi-Payer Models, and other commercial payers. The Medicare Option allows eligible clinicians to become QPs through Advanced APM participation starting in the 2017 QP Performance Period. The All-Payer Combination Option allows eligible clinicians to become QPs through participation in a combination of Advanced APMs and Other Payer Advanced APMs starting in the 2019 QP Performance Period.

An eligible clinician's QP status is determined on the basis of two thresholds for applicable Advanced APM participation, one for patient count and one for payment amounts, described elsewhere in this document. Beginning in 2019, eligible clinicians who do not meet either threshold under the Medicare Option, but who still meet a minimum threshold under the Medicare Option, may request a QP determination under the All-Payer Combination Option. Eligible clinicians who are determined to be QPs through either option will receive a 5 percent APM incentive payment in the payment year (two years after the QP Performance Period year) and will not be subject to the MIPS reporting requirements or payment adjustments.

What's an Other Payer Advanced APM

Other Payer Advanced APMs are non-Medicare Fee For Service (FFS) payment arrangements with other payers such as Medicaid, Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans), payers with payment arrangements in CMS Multi-Payer



Models, and other commercial and private payer arrangements that meet the criteria to be an Other Payer Advanced APM.

By statute, the criteria for payment arrangements to be Other Payer Advanced APMs are similar, but not identical, to the criteria for Advanced APMs under Medicare.

To be an Other Payer Advanced APM, payment arrangements must meet the following three criteria:

1. **Require use of certified EHR technology (CEHRT).** The other payer payment arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity Group to use CEHRT to document and communicate clinical care information.
2. **Base payments for covered professional services on quality measures that are comparable to those used in the MIPS quality performance category.** The payment arrangement must base payment on quality measures that are evidence-based, reliable, and valid, at least one of which must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.
3. **Require participants to bear a certain amount of financial risk.** A payment arrangement meets the financial risk if actual expenditures exceed expected aggregate expenditures, or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Social Security Act.

How does CMS define “CMS Multi-Payer Model” for purposes of the Quality Payment Program?

A CMS Multi-Payer Model is an Advanced APM in which CMS partners with other payers (such as Medicaid, Medicare Health Plans, and commercial payers) to create aligned incentives for health care providers across both Medicare and other payer populations. Examples of CMS Multi-Payer Models include the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model.



What's the Generally Applicable Nominal Amount Standard for Other Payer Advanced APMs?

We assess whether a payment arrangement meets the generally applicable nominal amount standard to be an Other Payer Advanced APM in one of two ways depending on how the payment arrangement defines risk.

Expenditure based Nominal Amount Standard	Revenue based Nominal Amount Standard**
<p>Nominal amount of risk must be:</p> <ul style="list-style-type: none">• Marginal Risk of at least 30 percent;• Minimum loss rate of no more than 4 percent; and• Total Risk of at least 3 percent of the expected expenditures the APM Entity is responsible for under the APM	<p>Nominal amount of risk must be:</p> <ul style="list-style-type: none">• Marginal Risk of at least 30 percent;• Minimum loss rate of no more than 4 percent; and• Total Risk of at least 8 percent of combined revenues from the payer to providers and other entities under the payment arrangement

**Note that total combined revenues from a payer include any financial risk payments or supplemental service payments including but not limited to payments comparable to care management fee payments, shared savings payments, or other types of performance-based incentive payments typically used in APMs and Advanced APMs with Medicare.

The revenue-based standard will apply only to models in which risk for APM Entities is expressly defined in terms of revenue and is an alternative option to the expenditure-based nominal amount standard.

Is there an All-Payer QP Performance Period?

The performance period is the same for both the Medicare Option and the All-Payer Combination Option, and is January 1 through August 31 of the calendar year that is two years prior to the payment year. Just as we do in the Medicare Option, we will make QP determinations using the data submitted by eligible clinicians or APM Entities for one of three snapshot dates: March 31, June 30, and August 31.



What's the Other Payer Advanced APM Determination Process?

To collect the necessary information and determine whether an Other Payer payment arrangement meets the criteria to be an Other Payer Advanced APM, we will use the following two processes:

1. Payer Initiated Other Payer Advanced APM Determination Process; (Payer Initiated Process); and
2. Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process)

What's the Payer Initiated Process?

Beginning in 2018, prior to the 2019 QP Performance Period, CMS will allow certain payers—State Medicaid Agencies,¹ Medicare Advantage and other Medicare Health Plans, and payers participating in CMS Multi-Payer Models²—to voluntarily submit information to CMS about their payment arrangements with eligible clinicians. This Payer Initiated Process is designed to reduce reporting burden for APM Entities and eligible clinicians, while allowing CMS to collect the information it needs to make Other Payer Advanced APM determinations. Payers that choose to participate would assist their networks of clinicians by carrying out the task of sending the information regarding the payment arrangement to CMS.

If a payer chooses not to submit their payment arrangement information to CMS (or isn't eligible to do so), then eligible clinicians or APM Entities participating in the payment arrangement would be able to do so instead. That process, known as the Eligible Clinician Initiated Process, is explained in more detail below.

How does the Payer Initiated Process work?

Under the Payer Initiated Process, payers would submit payment arrangement information such as:

- Name of Payer and payment arrangement;
- Description of how the payment arrangement meets the Other Payer Advanced APM criteria (CEHRT use, quality measure use, and financial risk); and
- Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation)

¹ State Medicaid Agencies can also submit information for Medicaid Managed Care health plans.

² Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) Plans.



We'll review the submitted payment arrangement information to determine whether the payment arrangement meets the Other Payer Advanced APM criteria. If payers don't send in all the information we need, we'll let them know and ask that they send us more information. Once we have what we need and review it, we'll post the results of Other Payer Advanced APM determinations on our website at cms.gov. For arrangements submitted under the Payer Initiated Process, this would happen prior to the beginning of the QP Performance Period. Payers will be able to request review of multiple payment arrangements they have through the Payer Initiated Process, though CMS will make separate determinations for each of those arrangements.

What's the Eligible Clinician Initiated Process?

The Eligible Clinician Initiated Process is designed to provide eligible clinicians and APM Entities with an opportunity to submit information to CMS about any payment arrangements they are participating in when their payer does not do so (or isn't eligible to).

A major difference between the Payer Initiated and Eligible Clinician Initiated Processes is that the Payer Initiated Process happens before the QP Performance Period, and the Eligible Clinician Initiated Process generally happens afterward (except for Medicaid payment arrangements, where both the Payer Initiated Process and the Eligible Clinician Initiated Process happen before the QP Performance Period).

Starting in 2019, after the QP Performance Period, if we haven't already determined that a payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or their APM Entities) have the option to submit their information and ask for a determination.

How does the Eligible Clinician Initiated Process work?

Like payers, eligible clinicians would submit payment arrangement information:

- Name of Payer and Payment Arrangement;
- Description of how the payment arrangement meets the Other Payer Advanced APM criteria (CEHRT use, quality measure use, and financial risk); and
- Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation).



If the submitted information isn't complete, we'll let the eligible clinician or APM Entity know and ask them to send in the information we need. Once we have all the information we need, we'll post the results of Other Payer Advanced APM determinations on a CMS website. For payment arrangements submitted under the Eligible Clinician Initiated Process, we'll post an updated list after the end of the QP Performance Period (except for Medicaid payment arrangements).

How will CMS calculate the payment amounts and patient counts under the All-Payer Combination Option?

Calculation of the Threshold Score under the All-Payer Combination Option is based on participation in both Advanced APMs and Other Payer Advanced APMs. We'll calculate these threshold Scores in two stages – first under the Medicare Option and second, if requested, under the All-Payer Combination Option, applying the most advantageous result to eligible clinicians.

The Threshold Scores calculated based on payment amounts and patient counts under the All-Payer Combination Option will be compared to the QP Thresholds in the tables below to determine whether eligible clinicians are QPs for the year. The eligible clinicians are then notified of their QP status. The payment amount and patient threshold counts are displayed in Tables 1 and 2 below.



Table 1: All-Payer Combination Option – Payment Amount Method

Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Count Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Patient Count Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

*Total includes Advanced APM (Medicare FFS) and Other Payer Advanced APM (Medicaid and other payers) participation



Table 2: All-Payer Combination Option – Patient Count Method

Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

*Total includes Advanced APM (Medicare FFS) and Other Payer Advanced APM (Medicaid and other payers) participation

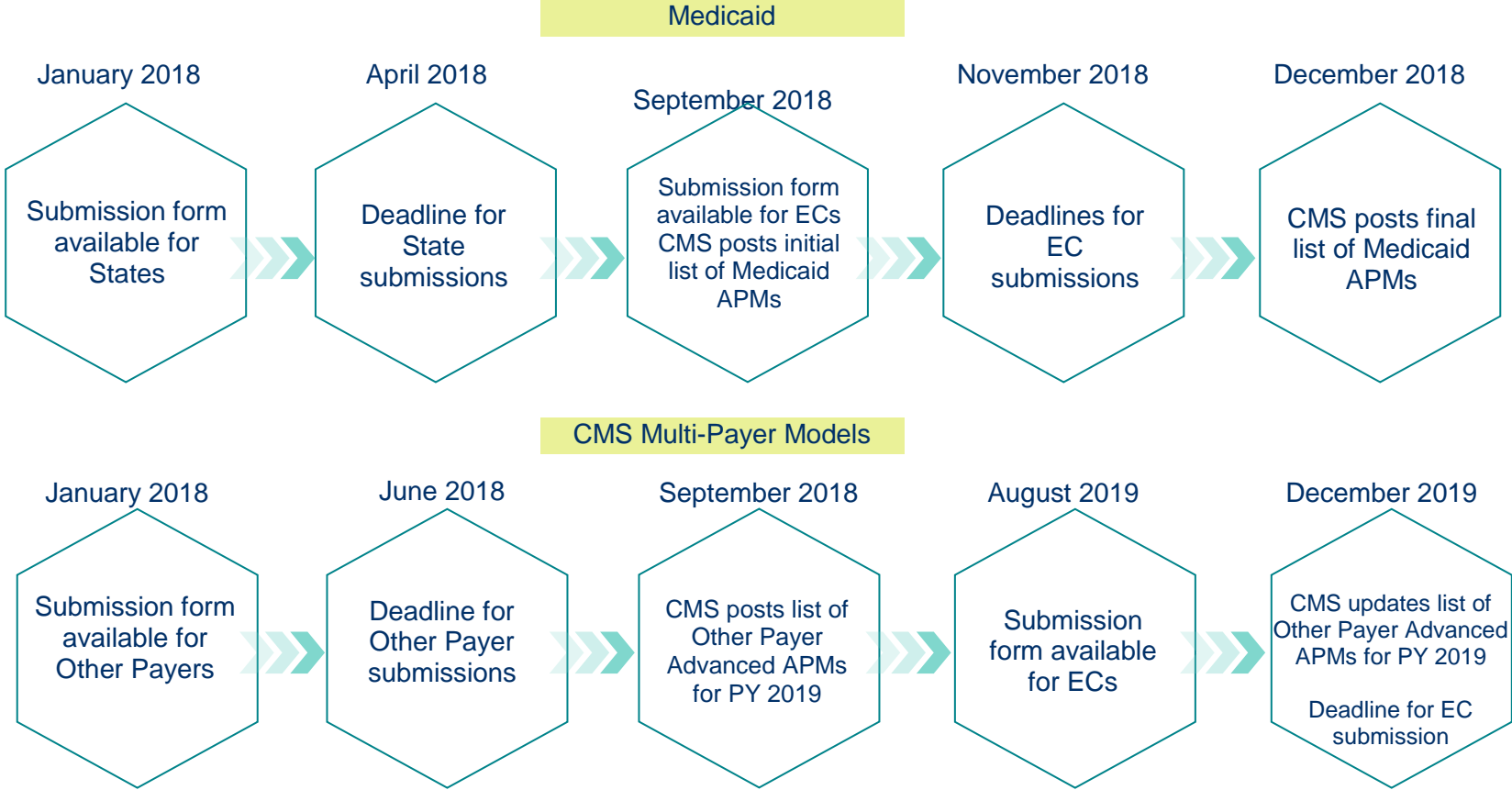
How do eligible clinicians become QPs under the All-Payer Combination Option? When would QP Determinations be made during the All-Payer Combination Option?

To attain QP status under the All-Payer Combination Option, eligible clinicians must: participate in a combination of Advanced APMs (Medicare FFS) and Other Payer Advanced APMs to a sufficient extent; and submit required payment amount and patient count information to CMS. Eligible clinicians will have the option to either be assessed at the individual level or at the APM Entity level.

The Performance Period for the All-Payer Combination Option will be that same as the Performance Period for the Medicare Option: January 1 through August 31. Eligible clinicians will be QPs if they meet the criteria for sufficient participation in any of three snapshot periods during the Performance Period: January 1 through March 31, January 1 through June 30, or January 1 through August 31. Eligible clinicians would submit QP determination requests to CMS between August 1 and December 1, after the end of the Performance Period. The Performance Year 2019 Timeline for Other Payer Advanced APM Determinations is displayed in Figure 1 below.



Figure 1: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations



Medicare Health Plans



Medicare Health Plans

