The Medicare Access & Chip Reauthorization Act of 2015

QUALITY PAYMENT PROGRAM

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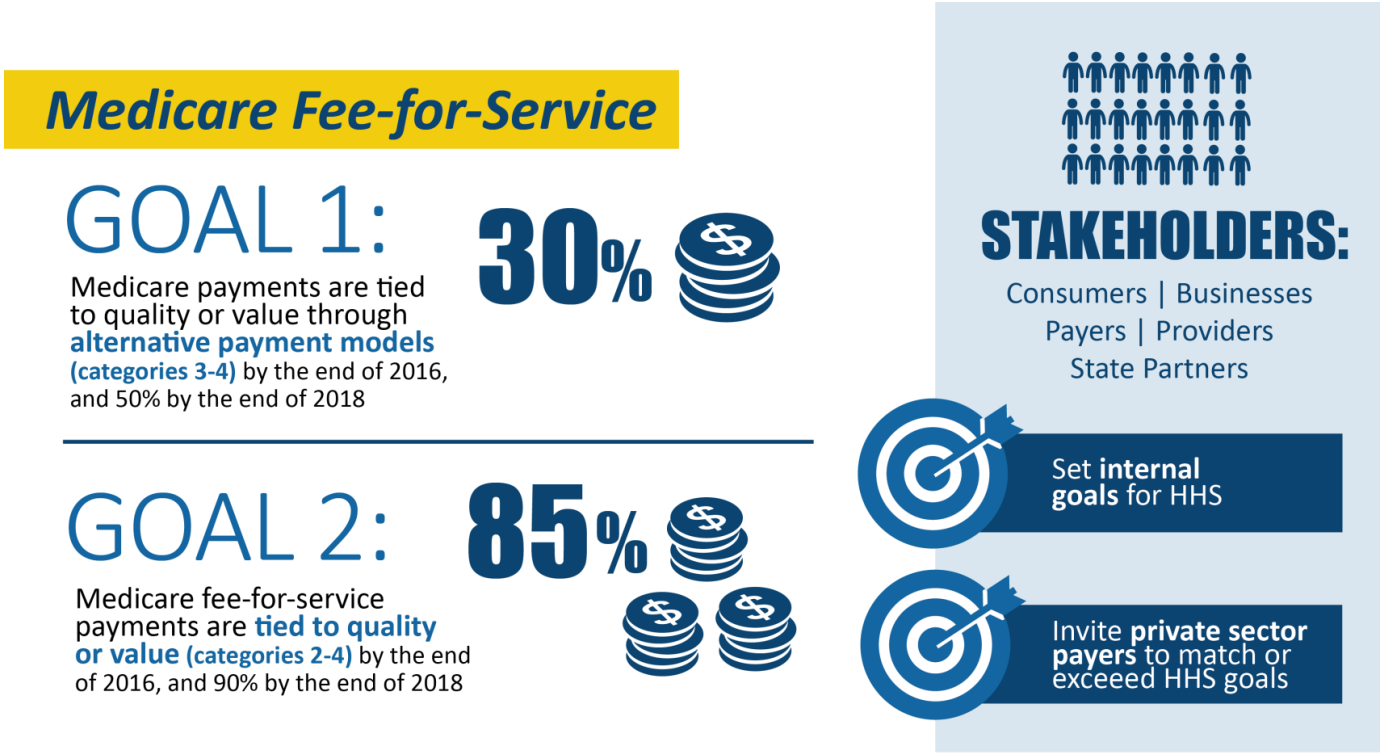
KEY TOPICS:

1) **The Quality Payment Program and HHS Secretary's Goals**
2) **What is the Quality Payment Program?**
3) **How do I submit comments on the proposed rule?**
4) **The Merit-based Incentive Payment System (MIPS)**
5) **Advanced Alternative Payment Models (APMs)**
6) **Medicaid and Private Payers**
7) **What are the next steps?**

The Quality Payment Program is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**



Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on **volume** of services, not **value.**

The Sustainable Growth Rate (SGR)

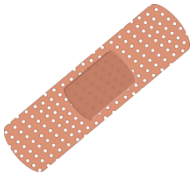
- Established in 1997 to **control the cost of Medicare payments** to physicians

IF  >   

Overall physician costs

Target Medicare expenditures

Physician payments cut across the board



Each year, Congress passed temporary **"doc fixes"** to avert cuts (no fix in 2015 would have meant a **21% cut** in Medicare payments to clinicians)

INTRODUCING THE QUALITY PAYMENT PROGRAM

Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) or **Advanced Alternative Payment Models (APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**

Quality

Resource use

Clinical practice improvement activities

Advancing care information

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)	Value-Based Payment Modifier (VM)	Medicare Electronic Health Records (EHR) Incentive Program

PROPOSED RULE

MIPS: Major Provisions

- ✓ Eligibility (participants and non-participants)
- ✓ Performance categories & scoring
- ✓ Data submission
- ✓ Performance period & payment adjustments

Who Will Participate in MIPS?

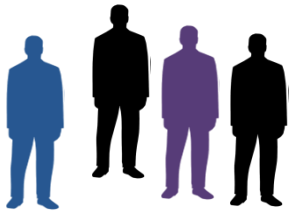
Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

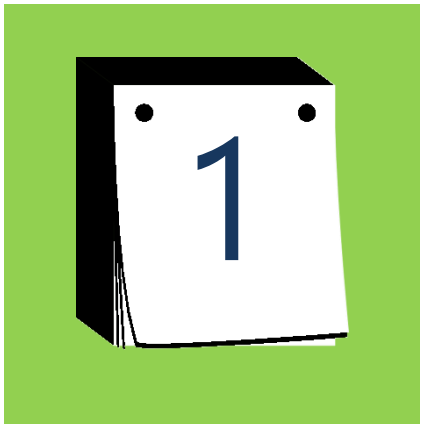
Secretary may broaden Eligible Clinicians group to include others such as



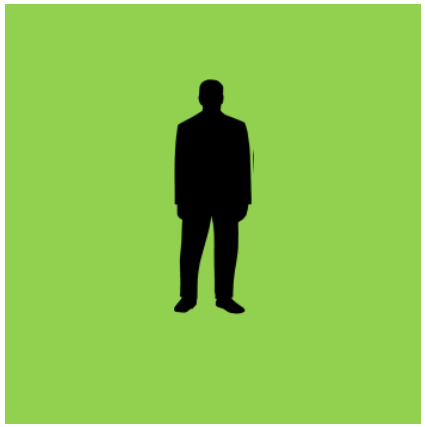
Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



FIRST year of Medicare Part B participation



Below low patient volume threshold

Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

PROPOSED RULE

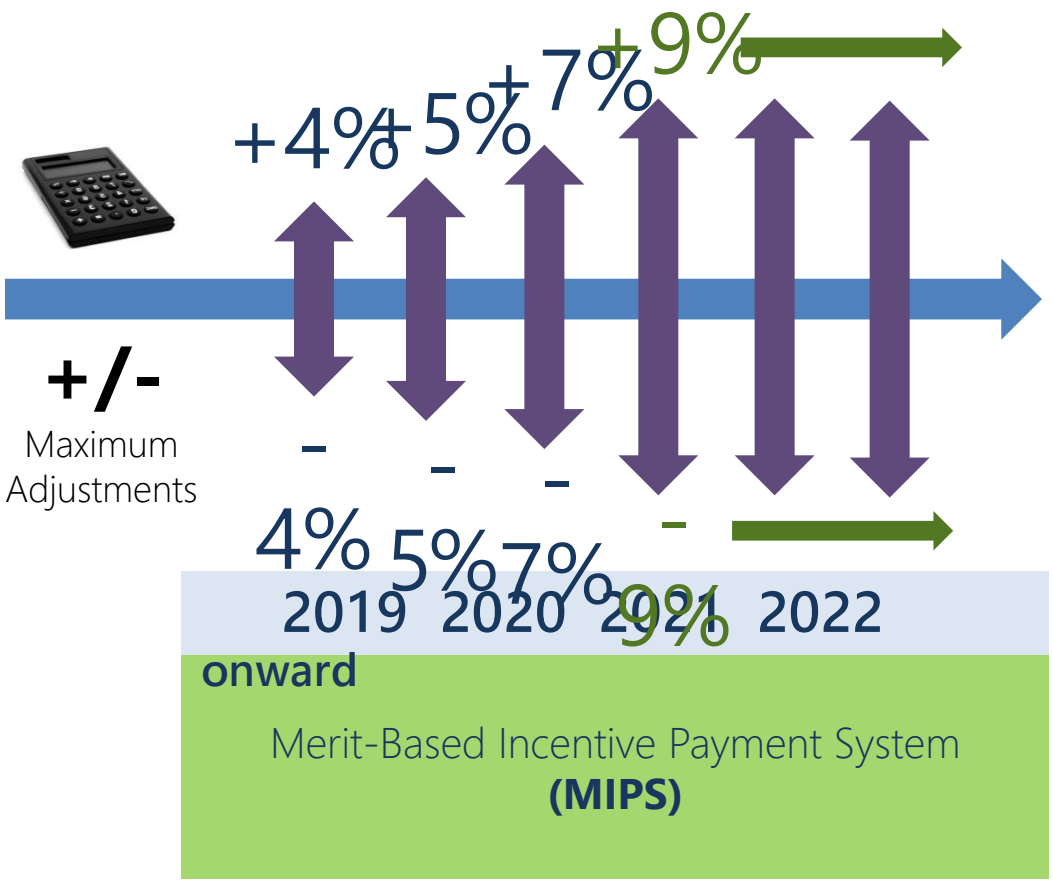
MIPS Timeline

2017	2018	July	2019	2020
Performance Period (Jan-Dec) **1st Feedback Report (July)**	**Reporting and Data Collection**	**2nd Feedback Report (July)**	**Targeted Review Based on 2017 MIPS Performance**	**MIPS Adjustments in Effect**

Analysis and Scoring

How much can MIPS adjust payments?

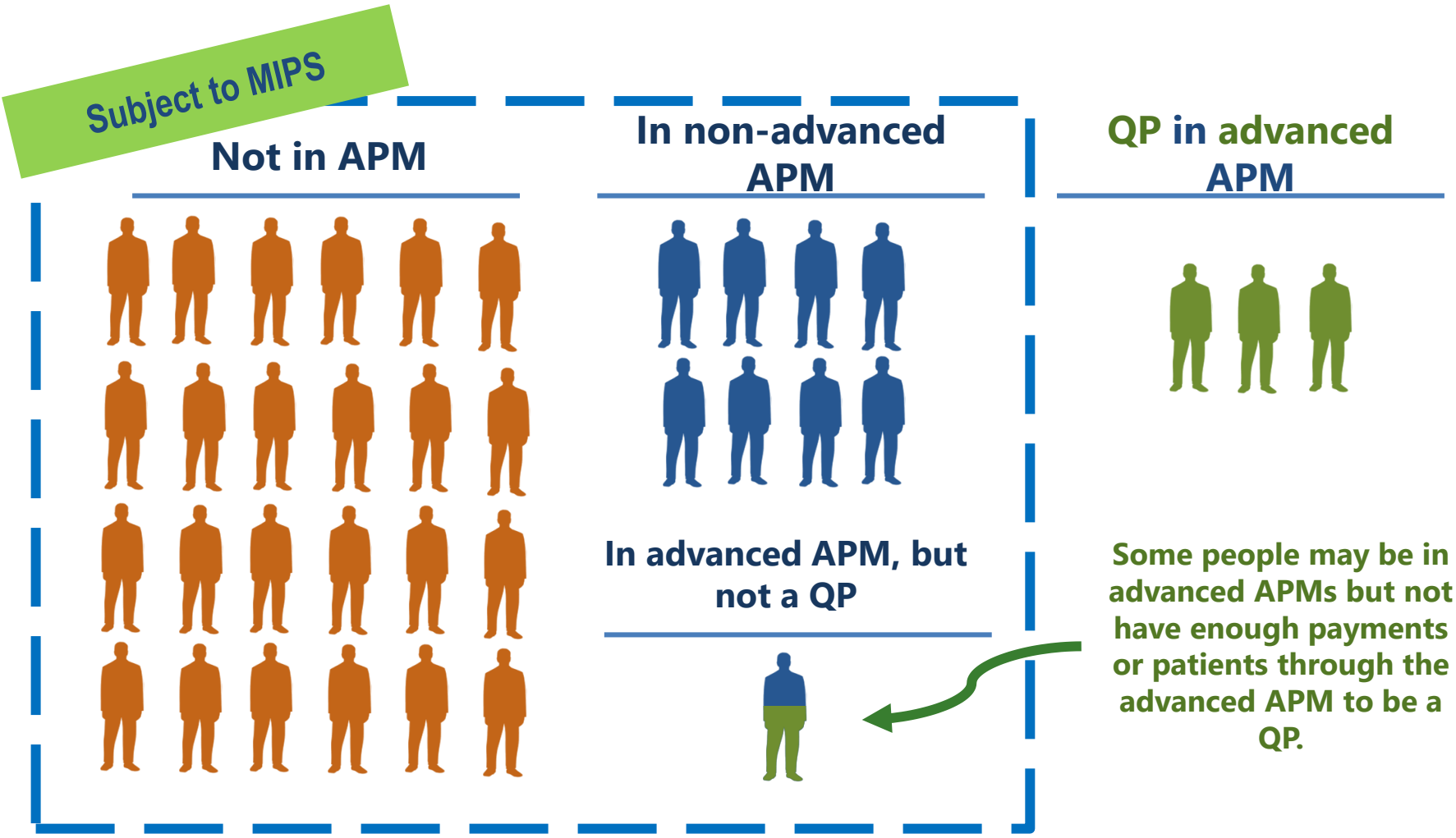
Based on a MIPS Composite Performance Score , clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

Note: Most clinicians will be subject to MIPS.



Note: Figure not to scale.

PROPOSED RULE

MPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

Or

Individual

Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

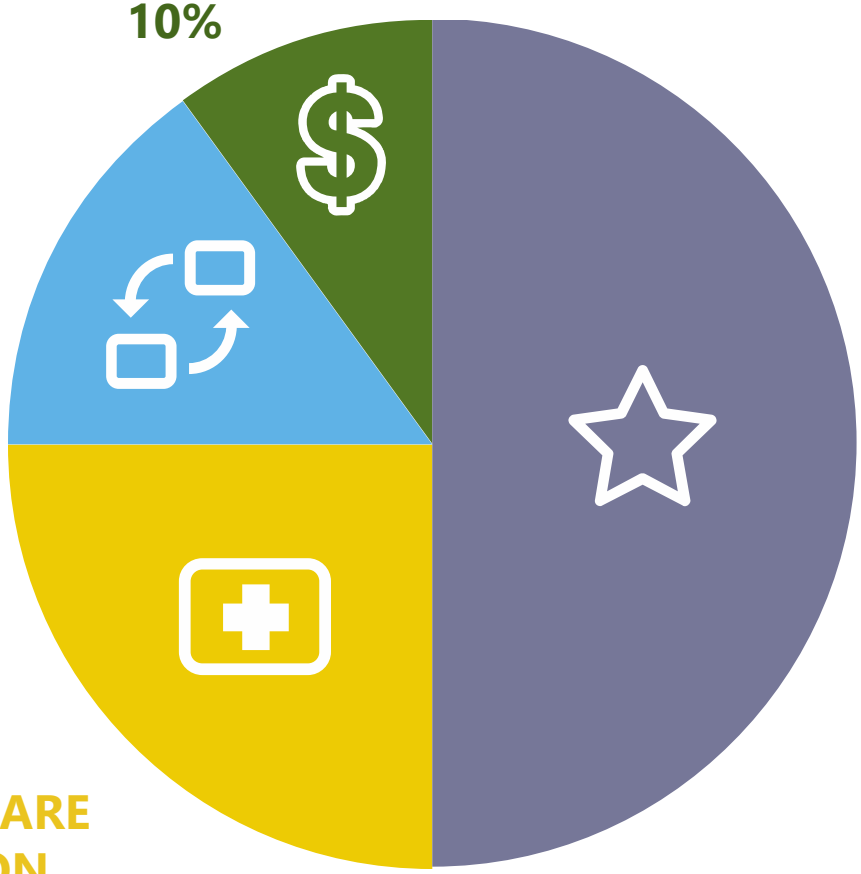
Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

PROPOSED RULE
MIPS: PERFORMANCE CATEGORIES & SCORING

MIPS Performance Categories

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Year 1 Performance Category Weights for MIPS



What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :

*Proposed quality measures are available in the NPRM

*clinicians will be **able to choose** the measures on which they'll be evaluated

PROPOSED RULE

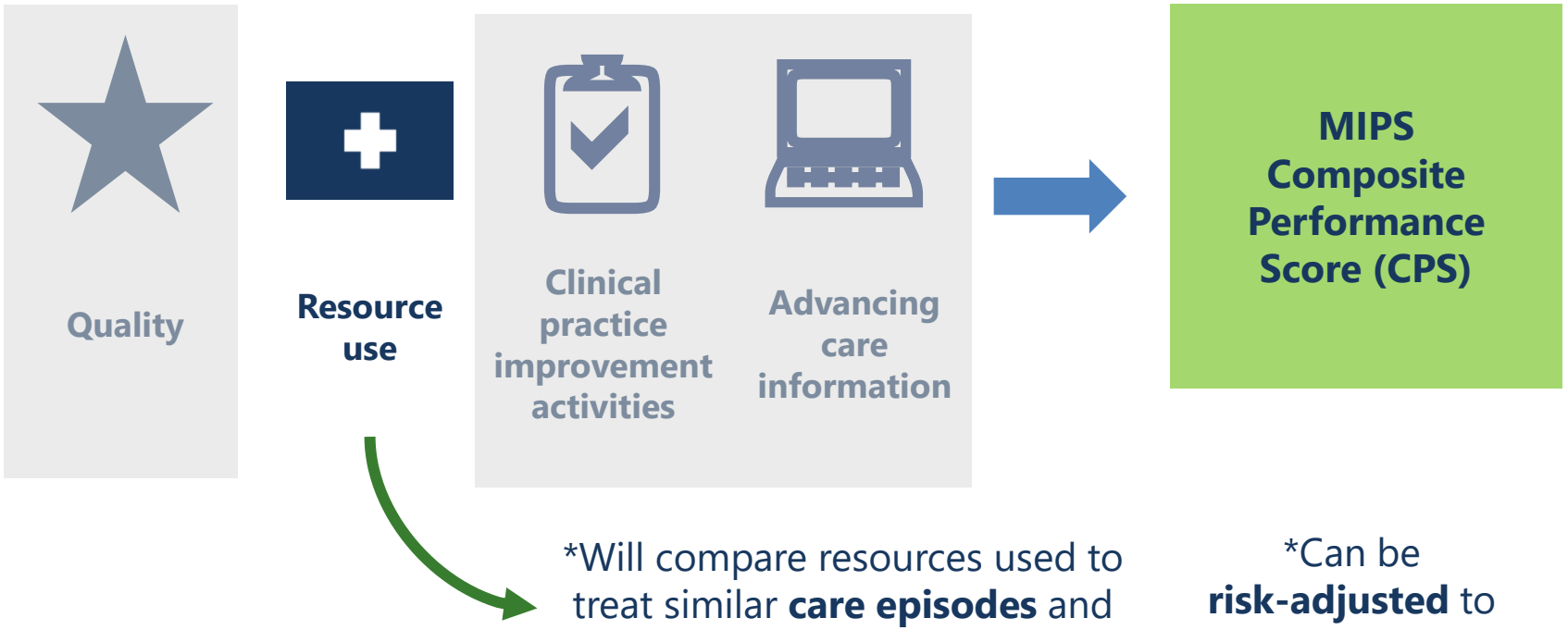
MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
  - **Reduced from 9 measures to 6 measures with no domain requirement**
  - **Emphasis on outcome measurement**
  - **Year 1 Weight: 50%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



*Will compare resources used to treat similar **care episodes** and **clinical condition groups** across practices

*Can be **risk-adjusted** to reflect external factors

PROPOSED RULE

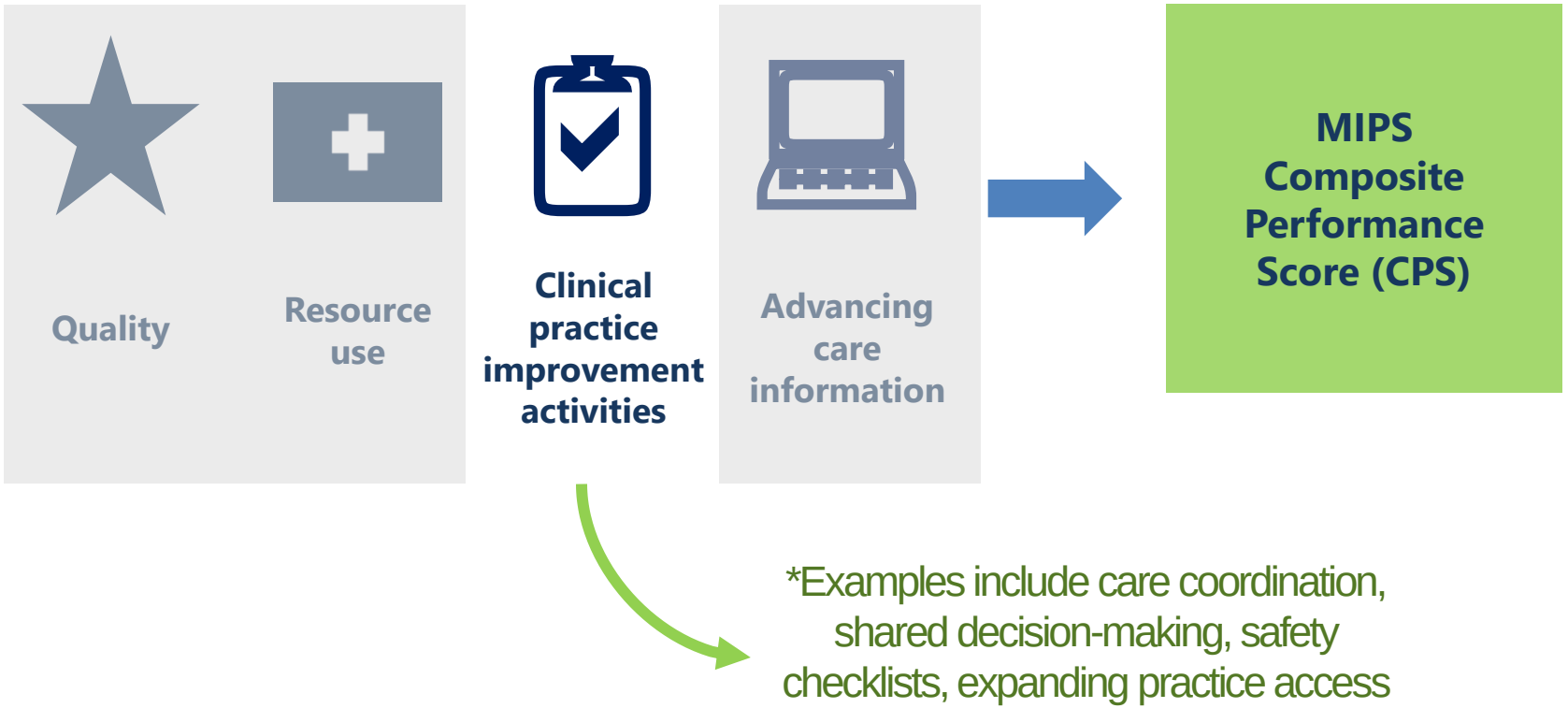
MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ **Key Changes from Current Program (Value Modifier):**
  - **Adding 40+ episode specific measures to address specialty concerns**
  - **Year 1 Weight: 10%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



PROPOSED RULE

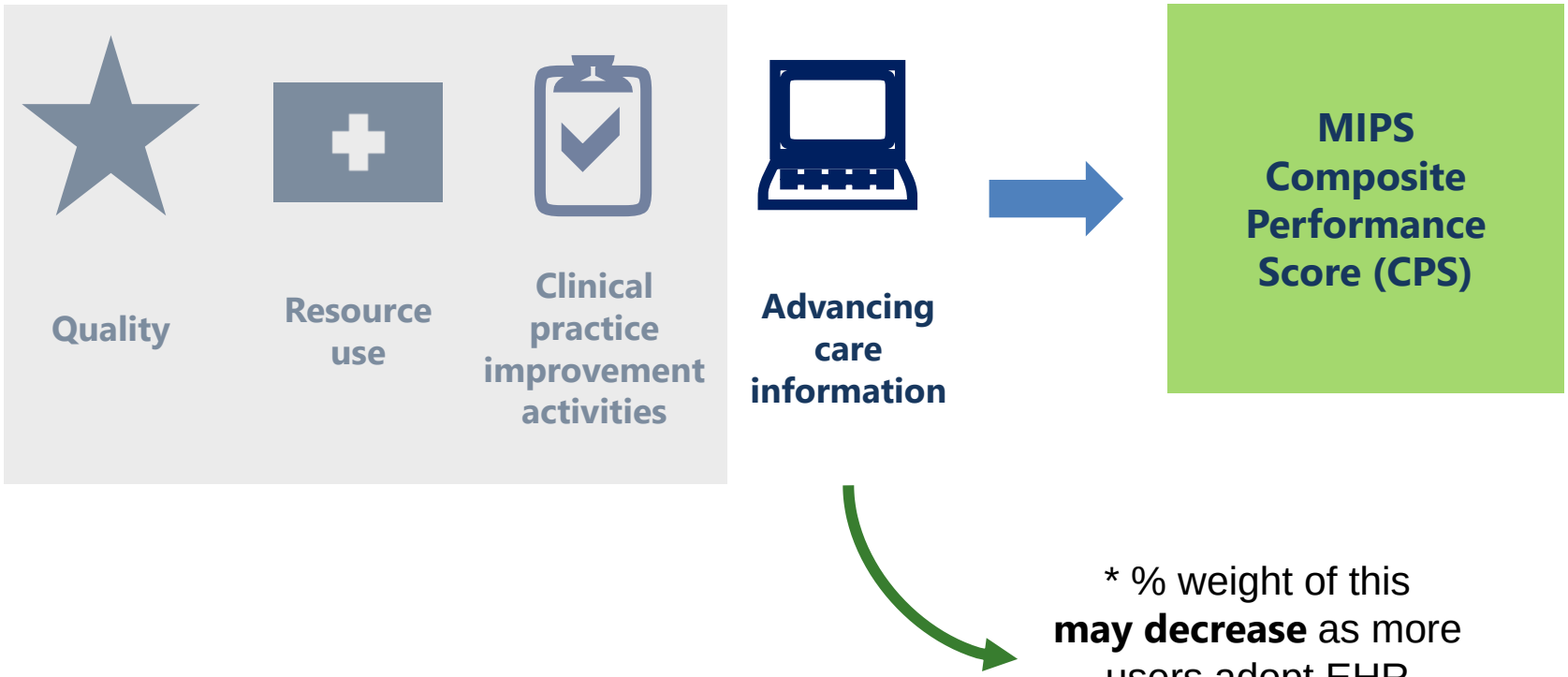
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

- ✓ **Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Key Changes from Current Program:**
  - **Not applicable (new category)**
  - **Year 1 Weight: 15%**

What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale** :



PROPOSED RULE
MPS: Advancing Care Information Performance Category

Who can participate?

All MIPS Eligible Clinicians

Participating as an..

Individual

or

Group

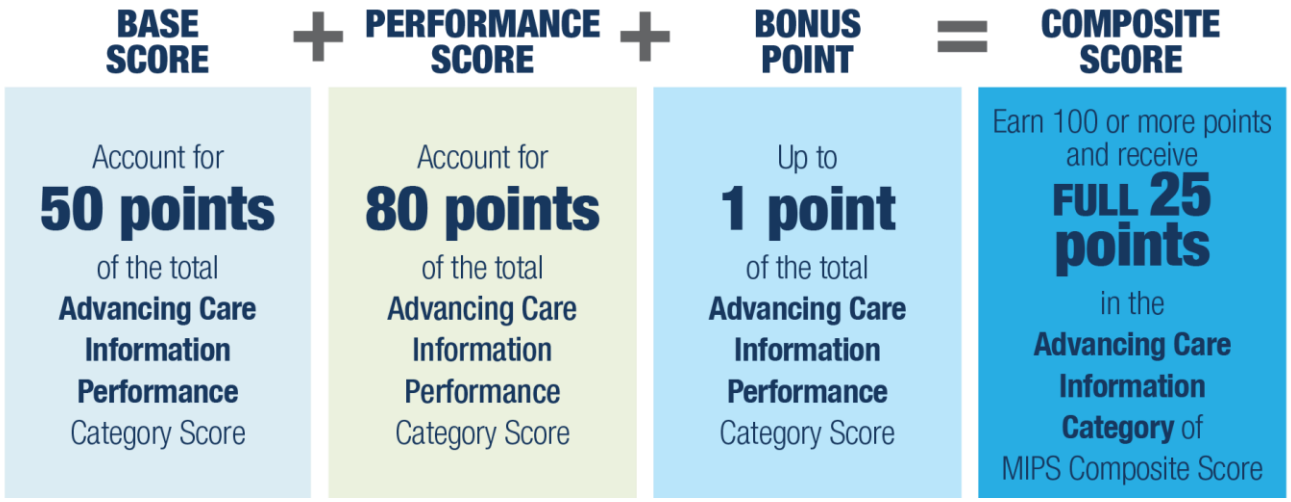
Optional for 2017

NPs, PAs, Clinical Nurse Specialists, CRNAs

Not Eligible

Facilities (i.e. Skilled Nursing facilities)

PROPOSED RULE
MPS: Advancing Care Information Performance Category



The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

PROPOSED RULE
MPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

PROPOSED RULE
MPS: Advancing Care Information Performance Category

THE PERFORMANCE SCORE

The performance score accounts for up to 80 points towards the total Advancing Care Information category score

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

Patient Electronic Access

Coordination of Care Through Patient Engagement

Health Information Exchange

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale :**

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.

Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Advancing care information	25%	• Base score of 50 points is achieved by reporting at least one use case for each available measure • Up to 10 additional performance points available per measure • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	• Similar to quality

✓ Unified scoring system:
1. Converts measures/activities to points
2. Eligible Clinicians will know in advance what they need to do to achieve top performance
3. Partial credit available

PROPOSED RULE
MIPS PERFORMANCE PERIOD & PAYMENT ADJUSTMENT

PROPOSED RULE

MIPS: Payment Adjustment

- ✓ **A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.**
- ✓ **A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.**
- ✓ **A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.**

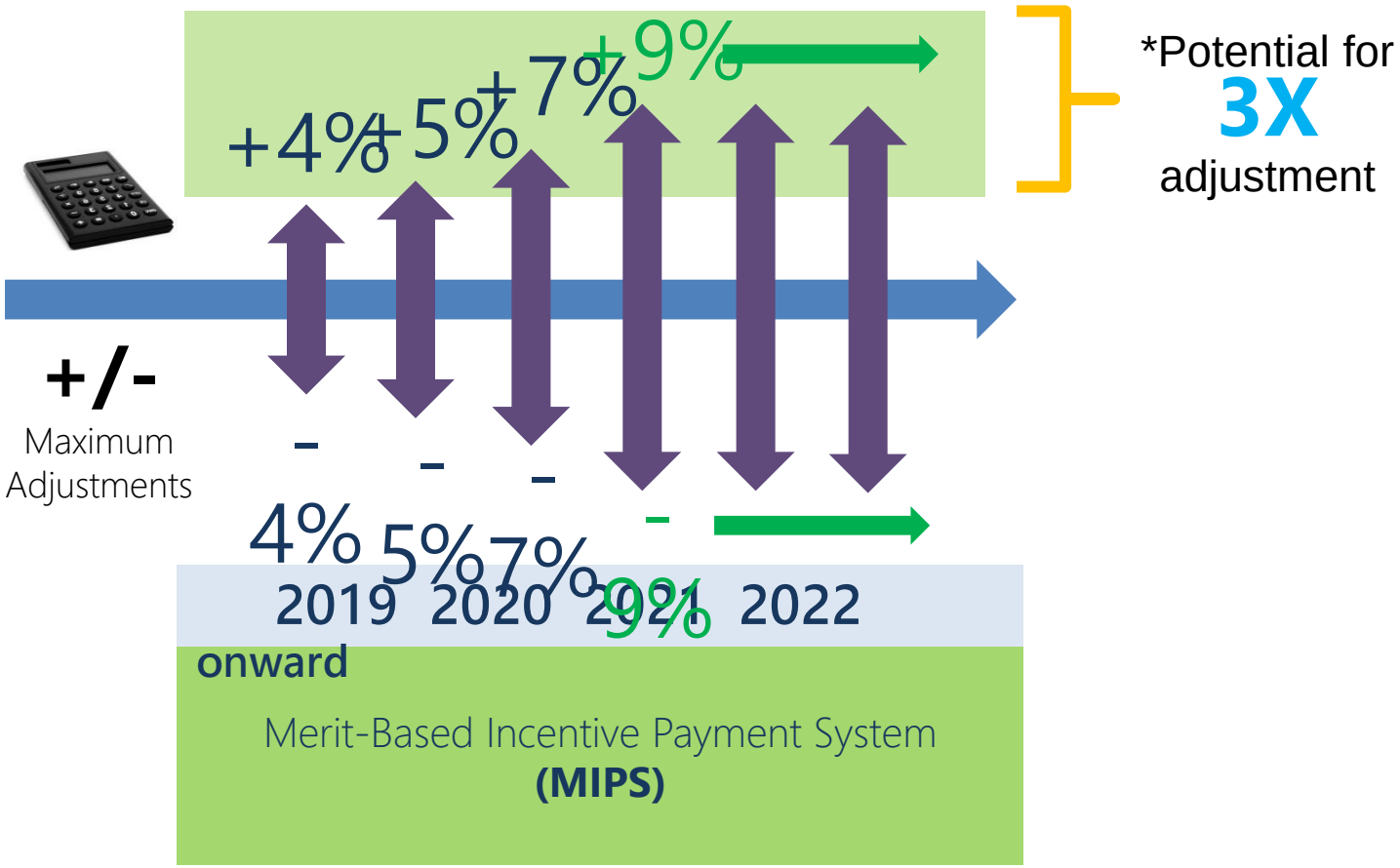
PROPOSED RULE

MIPS: Payment Adjustment

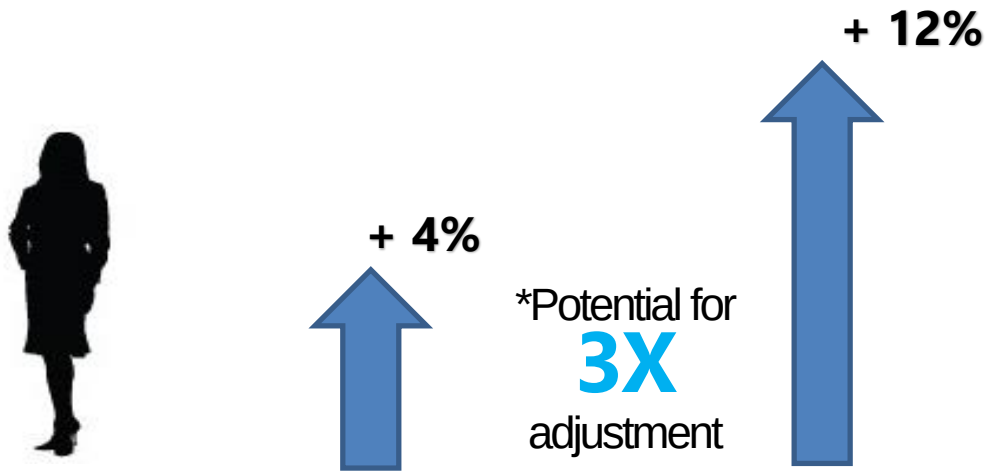
- ✓ **A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.**
- ✓ **An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an "additional performance threshold," defined as the 25th quartile of possible values above the CPS performance threshold.**

How much can MIPS adjust payments?

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



MIPS: Scaling Factor Example

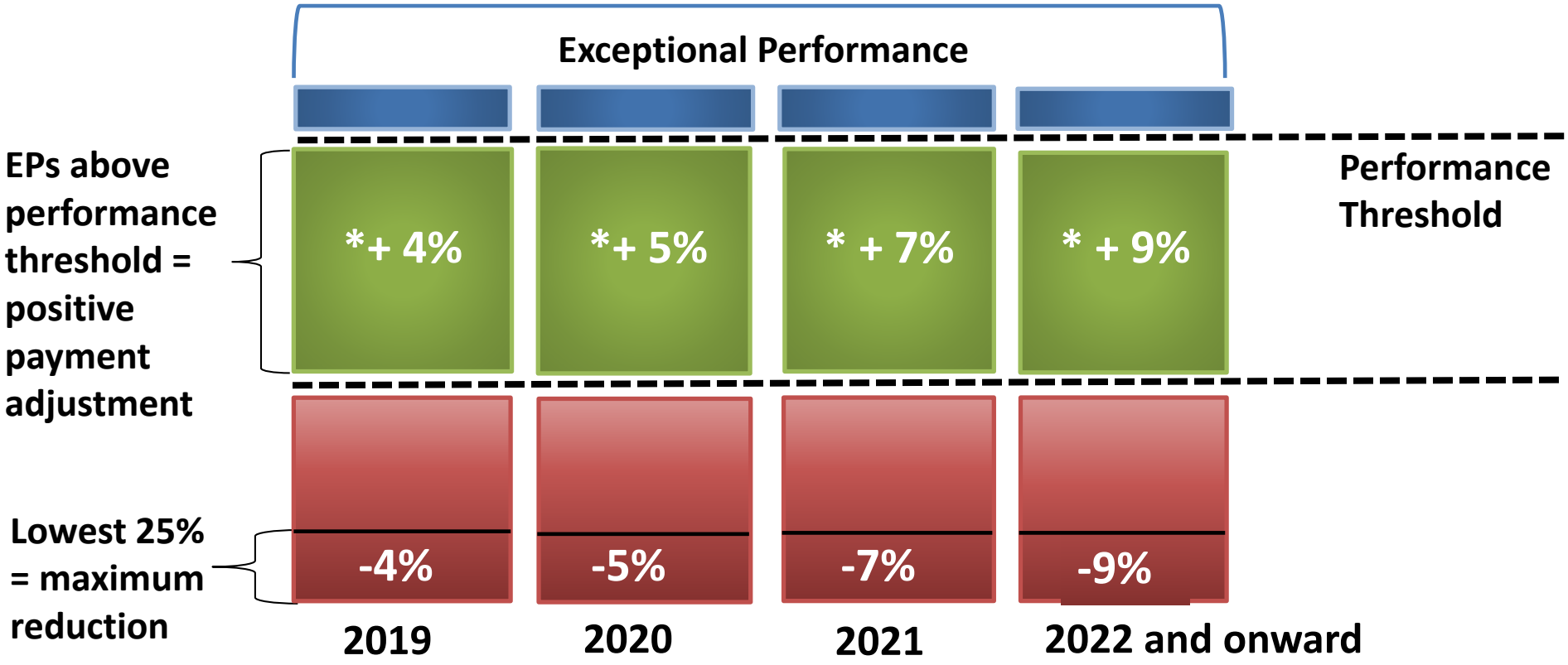


Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

Note: This scaling process will only apply to positive adjustments, not negative ones.

MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024



**MACRA allows potential 3x upward adjustment BUT unlikely*

INCENTIVES FOR ADVANCED APM PARTICIPATION

What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

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

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

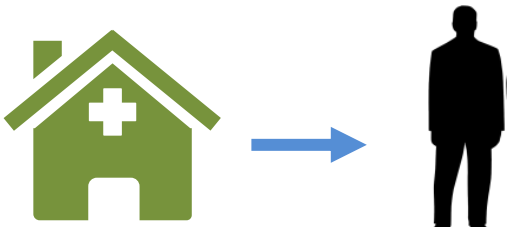
Advanced APMs meet certain criteria.

As defined by MACRA, Advanced APMs **must meet the following criteria**:

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

NOTE: MACRA **does NOT** change how any particular APM functions or rewards value. Instead, it **creates extra incentives** for APM participation.

How do I become a Qualifying APM Participant (QP)?



Advanced APM **QP**

You must have a **certain %** of your patients or payments through an **Advanced APM**.

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

PROPOSED RULE

How do Eligible Clinicians become QPs?

Eligible Clinicians to QP in 4 STEPS

Eligible Clinicians **QP**

1. QP determinations are made at the **Advanced APM Entity level**.
2. CMS calculates a **"Threshold Score"** for each Advanced APM Entity.
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2017 performance for 2019 payment).
- ✓ Aligns with the MIPS performance period.

MEDICAID AND PRIVATE PAYERS

What about Medicaid or private payers APMs? Can they help me qualify to be a QP?

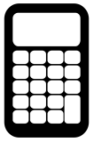
Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP.

"All-Payer Combination Option"

IF the "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs":

Certified EHR use

Quality Measures



Financial Risk

PROPOSED RULE

Medicaid Medical Home Models

Medicaid Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Other Payer Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**

A **Medicaid Medical Home Model is an Other Payer APM** 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:
  - 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.

PROPOSED RULE

Other Payer Advanced APM Criterion **1**: Requires use of CEHRT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 75% of an APM Entity's eligible clinicians must use CEHRT.

- ✓ An Other Payer Advanced APM must **require at least 75% of the eligible clinicians in each APM Entity to use CEHRT** to document and communicate clinical care.

PROPOSED RULE

Other Payer Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures

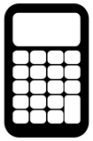
Quality Measures

- ✓ An Other Payer Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Other Payer Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

- ✓ **Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:
  - Quality measures that are endorsed by a consensus-based entity; or
  - Quality measures submitted in response to the MIPS Call for Quality Measures; or
  - **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**

PROPOSED RULE

Other Payer Advanced APM Criterion 3: Requires APM Entities to Bear More than Nominal Financial Risk



Financial Risk

An Other Payer Advanced APM must meet **two standards**:

Financial Risk Standard

APM Entities must bear risk for monetary losses.

&

Nominal Amount Standard

The risk APM Entities bear must be of a certain magnitude.

- ✓ The Other Payer Advanced APM financial risk criterion is **completely met** if the APM is a **Medicaid Medical Home Model** that meets criteria comparable to Medical Home Models **expanded under CMS Innovation Center Authority**
- ✓ Medicaid Medical Home Models that **have not meet the standard above** will have **unique financial risk and nominal amount standards**.

PROPOSED RULE

Other Payer Advanced APM Criterion **3**: Financial Risk Criterion

The Other Payer Advanced APM **requires** one or more of the following **if actual expenditures exceed expected expenditures**:

Financial Risk Standard

✓ **Direct payment** from the APM Entity

OR

✓ **Reduction in payment rates** to the APM Entity or eligible clinicians

OR

✓ **Withhold of payment** to the APM Entity or eligible clinicians

PROPOSED RULE

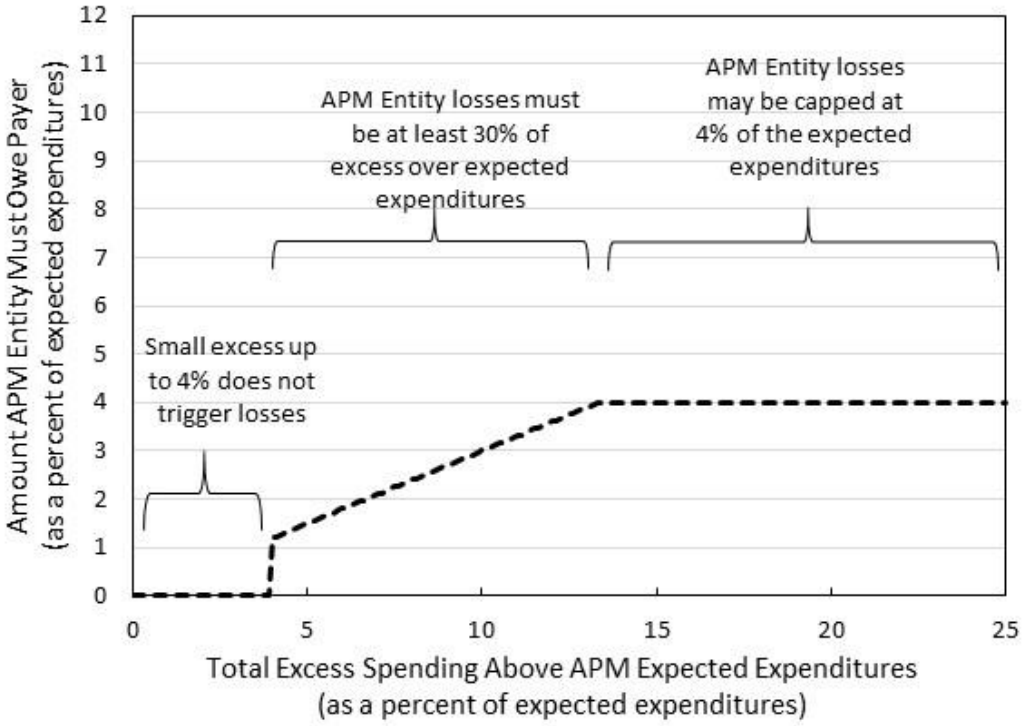
Other Payer Advanced APM Criterion **3**: Financial Risk Criterion

Nominal Amount Standard

The **amount of risk** under an Other Payer Advanced APM must at least meet the following components:

- ✓ **Total risk** of at least 4% of expected expenditures
- ✓ **Marginal risk** of at least 30%
- ✓ **Minimum loss ratio** (MLR) of no more than 4%.

Illustration of the amount of risk an APM Entity must bear in an Other Payer Advanced APM:



PROPOSED RULE

Other Payer Advanced APM Criterion 3: Example

The following is an example of a risk arrangement that would **meet the Other Payer Advanced APM financial risk criterion**:

An APM consists of a **two-sided** shared savings arrangement:

- ✓ If the APM Entity's actual expenditures exceed expected expenditures (the "benchmark"), then the APM Entity **must pay CMS 60% of the amount that expenditures that exceed the benchmark**.
- ✓ The APM Entity **does not have to make any payments** if actual expenditures exceed the benchmark by **less than 2%** of the benchmark amount.
- ✓ There is a **stop-loss provision** so that the APM Entity could pay up to but no more than a **total amount equal to 10%** of the benchmark.

PROPOSED RULE

Other Payer Advanced APM Criterion **3**: Medicaid Medical Home Model Financial Risk Criterion

The Medicaid Medical Home Model **requires** one or more of the following **if actual expenditures exceed expected expenditures**:

Medicaid Medical Home Model Financial Risk Standard

✓**Direct payment** from the APM Entity

OR

✓**Reduction in payment rates** to the APM Entity or eligible clinicians

OR

✓**Withhold of payment** to the APM Entity or eligible clinicians

OR

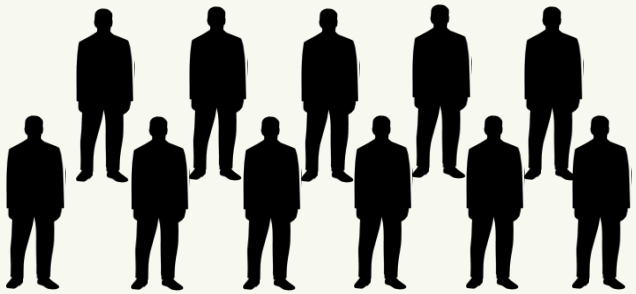
✓**Reduces** an **otherwise guaranteed** payment or payments

PROPOSED RULE

Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Nominal Amount Standard

Medicaid Medical Home Model Nominal Amount Standard:

Subject to Size Limit

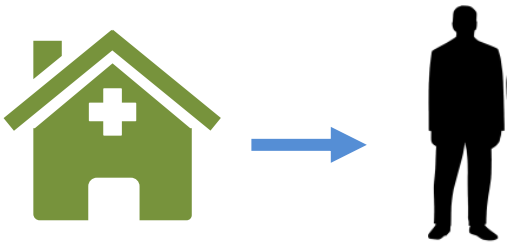


The Medicaid Medical Home Model standards **only apply to APM Entities with ≤ 50 eligible clinicians** in the APM Entity's **parent organization**

To be an Other Payer Advanced APM, the **amount of risk** under a Medicaid Medical Home Model must be at least the following amounts:

- ✓ **4% of payer revenue (2019)**
- ✓ **5% of payer revenue (2020 and later)**

All-Payer Combination Option
How do I become a Qualifying APM Participant (QP)?



Advanced APM **QP**

You must have a **certain %** of your patients or payments through an **Advanced APMs and Other Payer Advanced APMs**.

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2021-2024; then QPs receive higher fee schedule updates starting in 2026

PROPOSED RULE

All-Payer Combination Option
How do Eligible Clinicians become QPs?

Eligible Clinicians to QP in 4 STEPS

Eligible Clinicians **QP**

1. Eligible clinicians submit information to CMS regarding their participation in **Other Payer Advanced APMs**.
2. CMS calculates a **"Threshold Score"** for each Advanced APM Entity, including Medicare and All-Payers (**2 stages)**.
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2019 performance for 2021 payment).
- ✓ Aligns with the MIPS performance period.

PROPOSED RULE

All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 1

- ✓ **QP determinations are made at the Other Payer Advanced APM Entity level.**
- ✓ **All participating eligible clinicians are assessed together.**

Other Payer Advanced APM

Other Payer Advanced APM Entities

Eligible Clinicians

PROPOSED RULE

All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 2

- ✓ **CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).**
- ✓ **All-Payer Combination Option is based on the sum of payments for Medicare Part B and payments from all other payers, with exceptions.**
- ✓ **Methods are based on professional services and beneficiaries attributed to Advanced APM Entities.**
- ✓ **CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.**

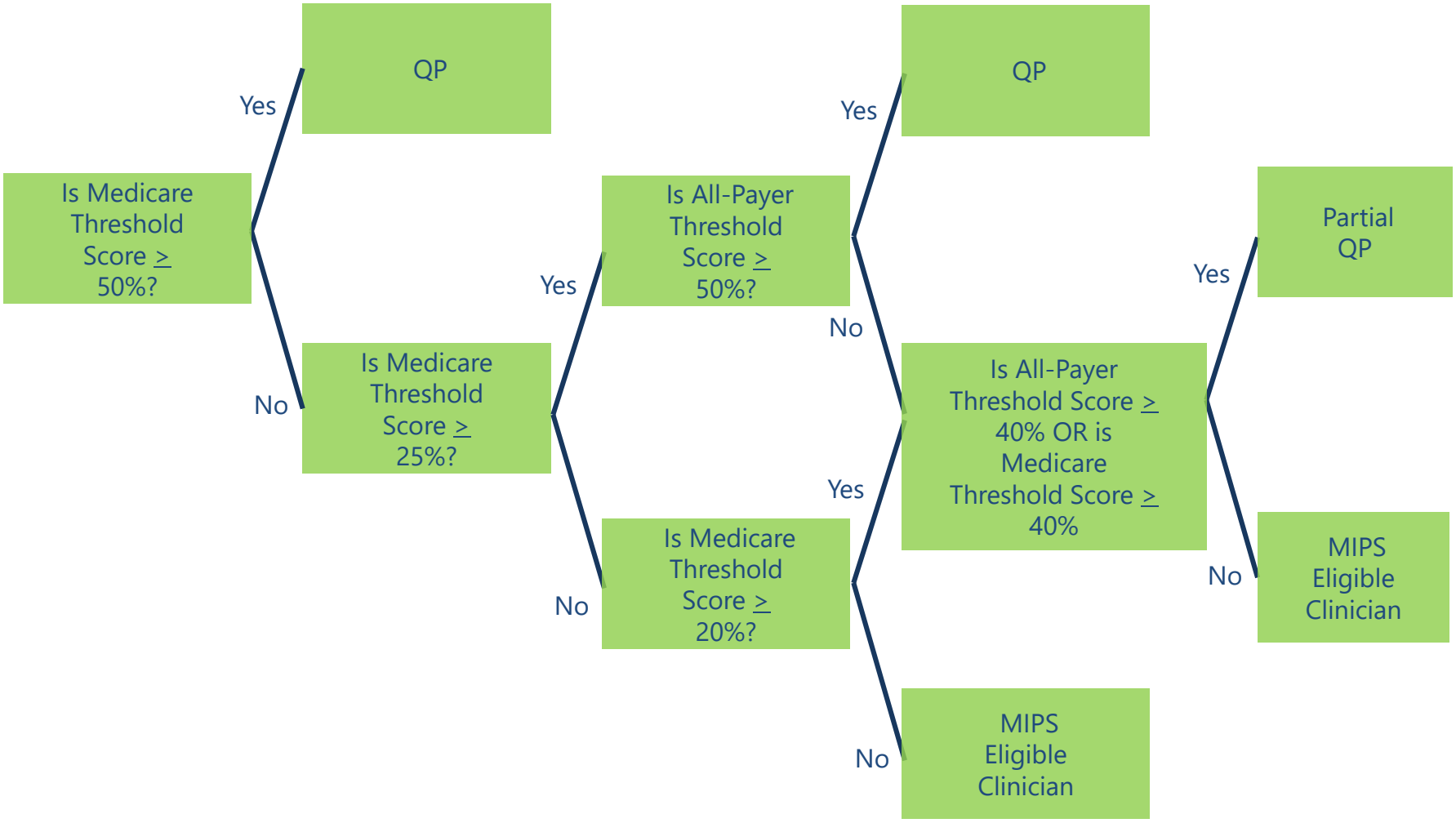
These definitions are used for calculating Threshold Scores under both methods.

Attributed (beneficiaries for whose cost and quality of care the APM Entity is responsible)

Attribution-eligible (all beneficiaries who could potentially be attributed)

PROPOSED RULE

All-Payer Combination Option 2021 - 2022



PROPOSED RULE

All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 2 Exclusions

Excluded Payments and Patients:

- ✓ **Department of Defense health care programs**
- ✓ **Department of Veterans Affairs health care programs**
- ✓ **Title XIX in a state with no Medicaid Medical Home Model or APM.** In order not to adversely impact physicians who have no opportunity to participate, Title XIX payments or patients would be excluded *unless*:

  (1) a state had at least one Medicaid Medical Home Model or APM in operation that is determined to be an Other Payer Advanced APM; and

  (2) the relevant Advanced APM Entity is eligible to participate in at least one such Other Payer Advanced APM, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs.

PROPOSED RULE

All-Payer Combination Option
How do you calculate the Medicare Threshold Score?

STEP 2 – STAGE 1

- ✓ **The two methods for calculation are Payment Amount Method and Patient Count Method.**
- ✓ **The two stages for calculating are Medicare first, then all-payers.**

Payment Amount Method

$$$ for Part B professional services to **attributed beneficiaries**

$$$ for Part B professional services to **attribution-eligible beneficiaries**

= **Threshold Score %**

Payments

Patient Count Method

of **attributed beneficiaries** given Part B professional services

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of **attribution-eligible beneficiaries** given Part B professional services

= **Threshold Score %**

Patients

PROPOSED RULE

All-Payer Combination Option
How do you calculate the All-Payer Threshold Score?

STEP 2 – STAGE 2

✓ **If the Medicare Threshold Score is not above the QP threshold, then calculate the All-Payer Threshold Score.**

Payment Amount Threshold Score			Patient Count Threshold Score		
$$$ for Part B professional services to **attributed beneficiaries**	+	**$$$** under the terms of **Other Payer Advanced APMs**	**#** of **attributed beneficiaries** given Part B professional services	+	**#** of **patients** given services under **Other Payer Advanced APMs**
$$$ for Part B professional services to **attribution-eligible beneficiaries**		**$$$** for from **all other payers***	**#** of **attribution-eligible beneficiaries** given Part B professional services		**#** of **patients** given services under **all other payers***

PROPOSED RULE

All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 3

✓ **The All-Payer Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.**

All Payer Combination Option Payment Amount Method — **Payments**

Payment Year	2019	2020	2021		2022		2023		2024+	
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%

All Payer Combination Option Patient Count Method — **Patients**

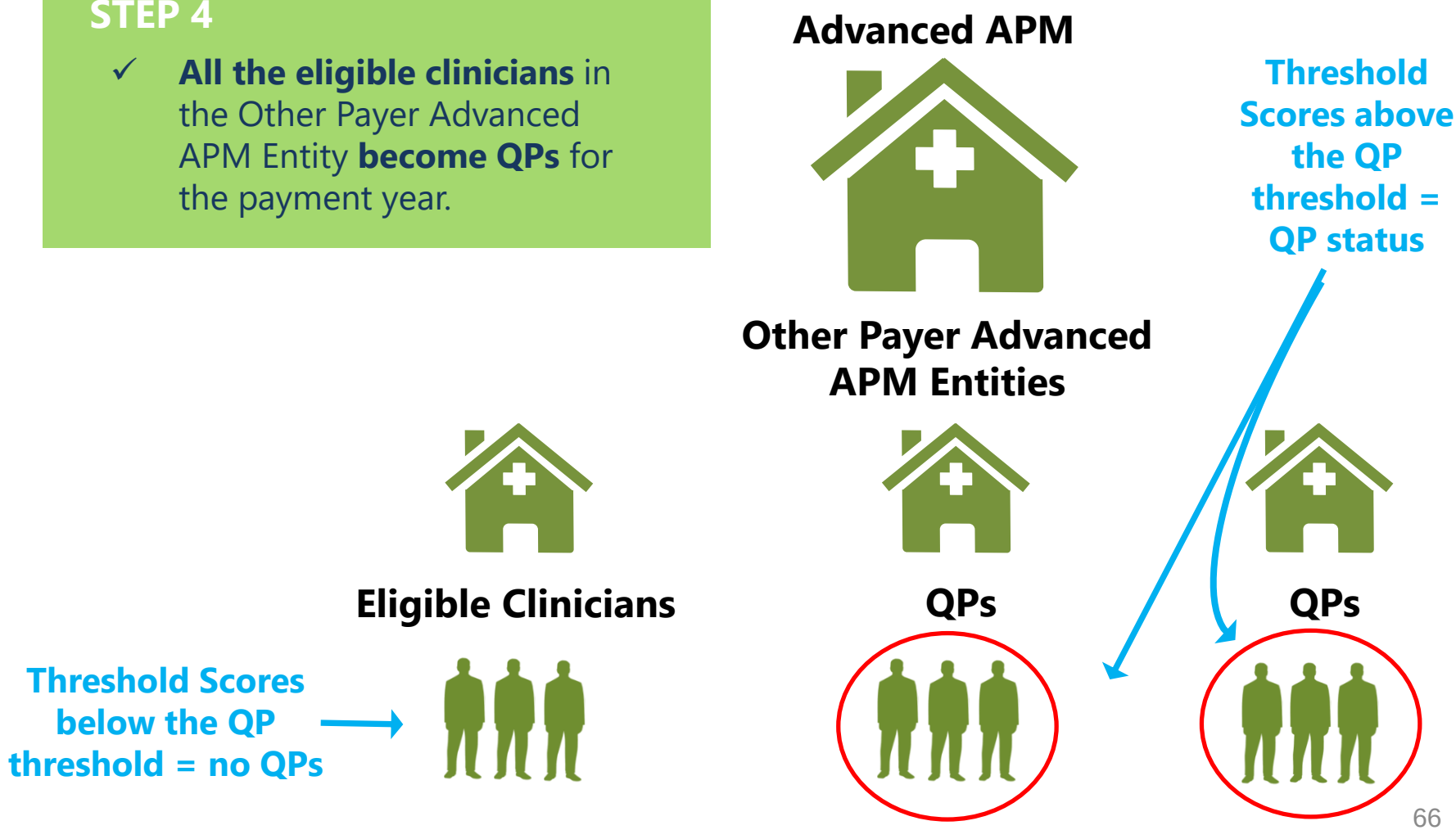
Payment Year	2019	2020	2021		2022		2023		2024+	
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	35%	50%	35%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	25%	35%	25%

PROPOSED RULE

All-Payer Combination Option
How do Eligible Clinicians become QPs?

STEP 4

- ✓ **All the eligible clinicians** in the Other Payer Advanced APM Entity **become QPs** for the payment year.



Find additional information about the Quality Payment Program, including fact sheets, upcoming webinars and more at: http://go.cms.gov/QualityPaymentProgram

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