All-Payer Combination Option Overview Webinar
Wednesday, September 12, 2018

Hello, everyone. Thank you for joining today's All-Payer Combination Option Overview Webinar. The purpose of the webinar is to broaden a review of the All-Payer Combination Option, which is the combination of Advanced Alternative Payment Models and other Advanced Alternative Payment Models. Now, I will turn it over to Adam Richards, Health Insurance Specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead.

All right, well, thank you, and good afternoon, everyone. Thank you for joining us today for our discussion on the All-Payer Combination Option under the Advanced Alternative Payment Model track of the Quality Payment Program. You know, I am excited to be joined today by several of our subject matter experts -- Dr. Corey Henderson and Richard Jensen, both of whom will be leading the majority of our conversation on the All-Payer Combination Option. Before diving in, I do want to level-set a bit. The All-Payer Combination Option is one of our newer components to the Advanced APM track that will begin starting in 2019 Performance Year, and Richard will cover that all in just a few minutes, but this is an opportunity that is generating quite a bit of interest from our clinician and stakeholder communities. And, really, that's why we wanted to offer you this webinar today, really, as a refresher, if you will, to help you all understand the basics of the All-Payer Combination Option and the means by which that you could participate, if you're interested. Additionally, since our last event on All-Payer, way back when, we've really released some fantastic resources and additional information to help you all get started. Again, we'll cover that a little bit later in our discussion today. We'll spend a good chunk of our time today walking through the basics, and then we'll turn it over to all of you to ask questions toward the end. So, let's charge forward to the next slide. Again, I've just briefly touched on our agenda for our discussion today. So, we'll start with the basics behind Alternative Payment Models and Advanced Alternative Payment Models, then we'll move into our conversation on the All-Payer Combination Option, which includes coverage on how we determine Other Payer Advanced APMs and how we make qualifying APM participant determinations under the All-Payer Combination Option. We'll then review some of those newer resources that I just mentioned, and covers the resource page on qpp.cms.gov, and then we'll wrap up with your questions at the end. So, to get things started, I'm going to turn it over to Dr. Corey Henderson to provide a bit of context on Alternative Payment Models and Advanced Alternative Payment Models. Corey?

All right, thank you very much, Adam. We can go to the next slide, please. I'm going to quickly touch on the Alternative Payment Models, give you a definition here. Alternative Payment Models are new approaches to paying for medical care through Medicare that incentivizes quality and value. The CMS Innovation Center develops new payment and service delivery models. And, specifically, we wanted to talk about how we got here. So, there are four key components to MACRA that includes the APMs. The first is the CMS Innovation Center models. These are under section 1115A, other than a Health Care Innovation Award. The Medicare Shared Savings Program is also inclusive in the APMs. The demonstrations under the Health Care Quality Demonstration Program, and also demonstrations required by federal law. Next slide, please. So, with that background, it's important to note that Advanced APMs are a subset of APMs. So, we say that because APMs under an overview is a payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care. They can apply to a specific

condition, a care episode, or a specific population. They also may offer a significant opportunity for eligible clinicians who are not ready to participate in Advanced APMs. So, again, an APM is the subset, or the overarching. In the event the APM is one of the groups under that overarching group of APMs. Next slide, please. So, just a quick overview of Advanced APMs, so if you could to the next slide. So, Advanced APMs is our highest level of program participation under the APM category. Clinicians and practices, they receive greater rewards for taking on some risks related to patient outcomes. As this graphic shows, not only do you receive Advanced APM-specific rewards, but you also are eligible to receive a 5% APM incentive bonus. That is an extra incentive for a sufficient degree of participation in an Advanced APM under the Quality Payment Program. Next slide, please. So, this is an overview just for you to kind of take a look at what we mean by extra incentives and the APM incentive bonus. The first one is if you're not in an APM, an Alternative Payment Model, the incentive structure is a potential for a MIPS adjustment. You will be participating in the Merit-Based Incentive Program. If you're in an Alternative Payment Model but you're not in a MIPS APM or an Advanced APM, sticking with the second column here, you have the MIPS adjustments and you have the potential to participate and receive APM-specific rewards. That would be just for your Alternative Payment Model participation. In the MIPS APM structure, you also have the Alternative Payment Model scoring standard, which gives you some additional scoring points and opportunity to get a higher score so that you can have a better opportunity to receive a higher MIPS payment adjustment. And you also receive the APM-specific reward. Under the Advanced APM, if you reach the highest level of sufficient participation, there is no MIPS adjustment because you are eligible to receive the 5% lump sum bonus under the Qualifying APM Participant designation, and you also receive the APM-specific rewards. That designation will be described more by Richard Jensen. Next slide, please. So, here's a list of the Advanced APMs, the current list of our Advanced APMs, and some of them may have an asterisk beside them because they will not begin until the Performance Year of 2019. So just taking a mental note of this, you can finalize this information. We will share with you under the qpp.cms.gov page, APMs, and look at the APM Overview. And as we continue, we will talk more about that at the end. I'm excited to announce to you... Next slide, please. The All-Payer Combination Option and Other Payer Advanced APMs, and this discussion will be with Richard Jensen.

Thank you, Corey. Next slide, please. So, under the All-Payer Combination Option, the statute established two pathways to allow eligible clinicians to become QPs. The first was the Medicare option, which most of you are familiar with, where eligible clinicians achieve QP status exclusively based on their participation in the Advanced APMs that Corey was describing. And that has been in effect for 2 years now, and it will be effect for all performance years. The second pathway is the All-Payer Combination Option, which begins in Performance Year 2019. Eligible clinicians can achieve QP status through this option based on participation and a combination of Advanced APMs and what we call Other Payer Advanced APMs offered by payers other than Medicare. Next slide. The different payer types that may be considered non-Medicare, have non-Medicare payment arrangements that qualify as Other Payer Advanced APMs, they include Medicaid -- Title XIX -- Medicare Health Plans, which is a broader group that's inclusive of Medicare Advantage Plans, CMS Multi-Payer Models, and this would be, for example, our partners CTC Plus and participating payers operating Advanced APM in Medicare, and they have a similar payment arrangement in their own area. And, finally, other commercial and private payers. In this first year, we've

been working particularly with the first three and getting an understanding of what payment arrangement they have. Next year, we'll be including all of them. Okay, so now we're going to go into discuss what it means to be an Other Payer Advanced APM. Next slide. To be an Other Payer Advanced APM, the following three criteria must be met, and you should note these are similar, although not identical, to the criteria for being an Advanced APM under Medicare. First, it requires participants to use certified EHR technology. Second, it provides payment for covered professional services based on quality measures comparable to those used in MIPS Quality Performance category. And third -- and this is an either/or condition -- is either a Medicaid Medical Home Model that meets criteria that is comparable to a Medical Home Model expanded under CMS Innovation Center authority, or it requires the participants to bear more than nominal amount of financial risk. Now, I should point out that this third criteria, to date, the agency has not expanded the Medical Home Model in any way, and so that is not applicable at this point in time, and we will get into that. But what it means is that any clinician or anybody that's seeking participation in an Other Payer Advanced APM, the arrangement will require a nominal amount of risk. Next slide. So, our final rule established both an expenditure-based and a revenue-based way of assessing nominal amount standards that I've been speaking about within Other Payer Advanced APMs. For the expenditure-based nominal amount standard, the payment arrangement must include three dimensions of risk at the following levels. First of all, it must have marginal risk of at least 30%, a minimum loss rate or no more than 4%, and a total risk of at least 3% of the expected expenditures for which an APM entity is responsible under the APM. And you'll note that this is one place where we diverge from the Advanced APM criteria. This is more complex criteria and standards for meeting a nominal-amount standard. We also have a revenue-based nominal amount standard in which the first two dimensions are the same on marginal risk and minimum loss rate, and then we also applied this expressly to define the total risk in terms of revenue. This was an additional option and does not replace or supersede the expenditure-based standard. Next slide. All right, just a reminder that we did define Medicaid Medical Home Models in the regulation. This term was in the statute but undefined, and it pops up in several places, and it turns out it was instrumental in being a part of the Other Payer Advanced APMs. And our definition is almost identical to the Medical Home Model we have in our reg under Advanced APMs. It starts with a payment arrangement where participants that have been focused on primary care. It also requires empanelment of patients to primary clinicians, and this is the patient-clinician link. And then there are seven options that the model must include. At least four of these must be included in order for the model to be a Medicaid Medical Home Model. So, it offers some flexibility. We designed this so that it looks something like CTC Plus in terms of the criteria, and that's a good reference point for you to use, and the Medicaid Medical Home Model will definitely play a part in the financial risk criteria we discuss in a moment. I should point out, also, that this definition of Medicaid Medical Home Model only applies to the Quality Payment Program. It does not apply to any other aspect of either Medicare or Medicaid. Next slide. So, to be an Other Payer Advanced APM, a Medicaid Medical Home Model must require that the total annual revenue that the APM entity potentially owes or forgoes must be at least 3% of average estimated total revenue in 2019, 4% in 2020, and 5% in 2021 and later. Next slide. Okay, now I am going to be talking about the process for how Other Payer Advanced APMs are determined. Next slide. So, for each All-Payer QP performance period, CMS is proposing two pathways through which payment arrangements could be determined to be Other Payer Advanced APMs based on the information submitted by payers or eligible

clinicians, and we're labeling these two processes the Payer Initiated Process and the Eligible Clinician Initiation Process. The intent of the Payer Initiated Process is to identify and publicize Other Payer Advanced APMs prior to the All-Payer QP performance period so that eligible clinicians will have the most complete information available to them regarding their opportunities to become QPs. Now, in general, the Payer Initiated Process, which is voluntary, involves similar steps for each payer type, which I mentioned earlier, but is designed to align with existing processes for payment arrangements authorized under timeline teams, Medicare Health Plans, and payment arrangements in our multi-payer models. The Eligible Clinician Initiated Process will be after the QP performance period, except for Medicaid, and the process is similar across all ECs -- eligible clinicians -- and payer types. I might have mentioned the Eligible Clinician Initiated Process could also be considered voluntary, but only in the sense that the All-Payer Option is voluntary. In other words, if a clinician is trying to seek out QP status, they really need to look into it. Next slide. So, a little more on the Payer Initiated Process. Payers are able to request or review multiple other payer arrangements through the Payer Initiated Process. They can submit more than one. And CMS would make separate determinations on every submission. Payers are also able to submit other payment arrangements with different tracks within a particular model and can request information on each track. Again, note that the Medicare Health Plan is the broad group of payment arrangements, including Medicare Advantage, Medicare, Medicaid plans, cost plans, et cetera. The main difference, as I've mentioned before, between Payer Initiated Process and Eligible Clinician Initiated Process is that this process happens before the QP Performance Period, and the Clinician Initiated Process will happen after the QP Performance Period, except for Medicaid. So next we'll discuss the Eligible Clinician process. Next slide, please. Like the Payer Initiated Process, Other Payer Advanced APM determination, APM entities and eligible clinicians would have an opportunity to request determinations of whether Other Payer arrangements they participate in are in fact Other Payer Advanced APMs. This will only be necessary for payment arrangements that were not yet determined to be Other Payer Advanced APMs through the Payer Initiated Process. In other words, if a clinician sees a payer arrangement they're already in in the Payer Initiated Process list that we post, they don't need to go through this process of turning in information for us. In general, the eligible clinician process would involve similar steps through each payer type but would be designed to align with existing processes for payment arrangements. Next slide. So, this slide provides you the timelines for determination of Other Payer Advanced APMs. The first row is showing you our timeline for Medicaid, and you can see that for Medicaid, both the Payer Initiated Process and the Eligible Clinical Initiated Process occur in the same year, and this year, in 2018, we've actually gone through much of this already. The submissions were made early in the year, with a January-through-April deadline. And then the EC submission process, the forms were made later in the year, and they are available online now at our website, and the deadline for EC submissions on Medicaid is November 1st, and I'll talk a little bit more in detail about that in a minute. So, prior to the start in each relevant All-Payer Performance Period, we intend to post the Other Payer Advanced APMs who we determine through the Payer Initiated Process are under Title XIX, that we've determined are in fact Other Payer Advanced APMs. And then based on the eligible clinicians submitting additional information on Medicaid payment arrangements this fall, we'll revise that list and post it as final in December. Now, the second row here, we tell you how we handle CMS Multi-Payer Partner Models. That is our commercial payers and how they submit things. And you can see here, it's a

similar process in that we ask them to submit information between January and June 2018. We have been analyzing that, and we will, this month -- it's not posted yet, but this month we will post a list of Other Payer Advanced APMs that our Multi-Payer Partners submitted to us. And, again, we have this up early so that eligible clinicians can look at it and know what payment arrangements are available before they go to into the QP Performance Period in January. The eligible clinicians under Multi-Payer will have an opportunity in late 2019 to submit their payment arrangement if they want to see if they are Other Payer Advanced APMs, and we'll revise the list again at that time. Next slide. I mentioned our Medicaid activity to date. We just wanted to let you know, and we have here that we do have a list posted of Medicaid Other Payer Advanced APMs determined this year, for the 2019 QP Performance Period, and this list is posted on our QPP website. We have the link here on the slide. In addition, I mentioned that eligible clinicians who want to submit Medicaid payment arrangements can do so between now and November 1st, and, again, we have a link here to go and find the submission form that they can use. Again, it's submitting information on payment arrangements that clinicians believe -- in fact, need our Other Payer Advanced APMs, but for one reason or another were not on our list that we posted already. And as I said, we will take that information and analyze it and revise the list based on the outcome of that analysis by December 2018. Next slide. And so, the last group I want to mention is the Medicare Health Plans, and I won't go into all the details other than to say in receiving input from the Payer Initiated Process, we did this in conjunction with Medicare Advantage bidding process. We used the HPMS system, and forms were submitted to us by the June deadline, and similarly, we are just now completing our analysis of that, and we will be posting all of the Medicare Health Plan-related Other Payer Advanced APM determinations we have made a little later this month. Similarly, eligible clinicians who are in Medicare Health Plans or Medicare Advantage Plans who believe they have some additional payment arrangements to be recognized will have an opportunity toward the end of 2019 to submit those to us for our determination. Next slide. Now, we are going to take a few minutes to discuss how QP determinations are actually made under the All-Payer Combination Option. I've spent quite a bit of time here telling you how we decided whether or not these payment arrangements are in fact Other Payer Advanced APMs. Now I want to tell you how we put it all together. And I should mention that the QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs and Other Payer Advanced APMs to determine if they are QPs for that particular year. And the QP Performance Period for each payment year under All-Payer is the same as the periods or snapshots, as we call them, under the Medicare option. That is, participation can be from January 1st to March 31st, January 1st to June 30th, or January 1st through August 31st. Next slide. So, as we've already mentioned, the All-Payer Combination is first available next year, and there are five steps to doing a QP determination under this option. And the same steps with some differences apply to partial QP determinations. The first step is an eligible clinician must have sufficient participation in an Advanced APM, a Medicare Shared Savings Program for example, or other model within a certain band, and, for example, the way we treat is if an eligible clinician has less than 25% through an Advanced APM, they would ineligible to use the All-Payer Combination Option for that year. In other words, participating in a Medicare Advanced APM is a necessary condition to using the All-Payer Combination Option. If an eligible clinician has at least 25% but less than 50% of his or her payments through the Advanced APM that year, then the clinician is eligible for the All-Payer Combination Option. And if an eligible clinician has at least 50% of payments through an Advanced APM,

they're already a QP through Medicare alone. So, as you can see on this slide, the relevant band for All-Payer Combination Option are those clinicians and APM entities that are going to fall between 25% and 50%. The other two ends of the band don't matter. Next slide. So, the second step is that if an eligible clinician requests CMS to determine his or her QP status through the All-Payer Combination Option, CMS would need to know if they are in any Other Payer Advanced APMs or not. And the eligible clinician would do a couple of things. One is, if they think they're in a payment arrangement that's not already on our list, they would submit the information on that payment arrangement and have us do a determination. And, again, this is toward the end of 2019. Or if they see that they are in a payment arrangement that's already listed, they would inform us, in fact, that they are in one of those payment arrangements that's in our list. CMS needs information about all of the Other Payer Advanced APMs that a clinician may be in during this QP Performance Period. And so, clinicians should keep in mind that submitting information about payment arrangements through the Eligible Clinician Initiated Process is important, although it does not automatically get them to become an Other Payer Advanced APM. Next slide. Okay, so the third step -- and this is similar to the Medicare option -- CMS makes a QP determination based on both the payer amount and patient count method. CMS will calculate threshold scores under each method and will use the better of the two scores to determine the eligible clinician, whether they're a QP or not. So, to make these calculations, in addition to needing to know which Other Payer Advanced APMs an eligible clinician is in, CMS also needs the payment amount and patient count information for both the Other Payer Advanced APMs and arrangements that other payers are in that are not Other Payer Advanced APMs. And they need to report this to us. They need to report the numerator, meaning the payment and payment arrangements through their Other Payer Advanced APMs that are aggregated around the time periods we mentioned before, and then they need to give us the denominator of the ratio. That is all the other payments and patients through which they participate. So, let me make this clear -- the All-Payer Combination Option is just that -- all-payer. If the clinician submits information, they have to submit information for all the payers they are receiving revenue from or participating with. They can't just pick the ones that have an innovative model in place, something we consider an Advanced APM arrangement. In other words, cherry-picking the best payment arrangement is not how this is set up. The statute is very clear that it has to be a ratio of all the payers which a clinician is doing business with. Next slide. So, Step 4 is that, with this information, CMS makes a QP determination, first under the Medicare option -- generally speaking -- at the APM entity level, and for the All-Payer Combination Option, we would make a determination usually at the individual level, but we can do either. CMS will then calculate the threshold scores, the ratio I just mentioned, under both the payment amount and patient count method, and we will choose the results that are most advantageous to the clinician. I can go into some more detail on that if you need it, but that's our final calculation. We get a threshold score. And then we go through, as discussed in the next slide, talking about exactly how that fits into our decision making. So, next slide. Oh, I'm sorry. Next slide. Now, I've been alluding to an exception for Medicaid, and this is something that's explicit in the statute and doesn't apply to other payers. Basically, the law says that if a particular state Medicaid agency does not have any Other Payer Advanced APM in place, then Medicaid payments may be excluded from the calculation I was just describing. In other words, there's no Medicaid payments or patients in the numerator or the denominator. On the other hand, if a Medicaid payment arrangement is in place in this state, whether the clinician participates in it or not, Medicaid payments must be

included in the calculation, in particular, in the denominator. We also laid out in our rule that we would apply this at a sub-state level, at a regional level, as we know that some Medicaid models are applied regionally within a state, and then depending on where the clinician did the plurality of their business, we would decide whether or not they needed to include Medicaid payments in or out of their arrangement. I will say that of the first group of state payment arrangements we received this year and determined to be Other Payer Advanced APMs, they are all statewide, and the sub-state rule didn't come into effect. Next slide. So, Step 5, after we've done the calculation, this is really our determination process, or decision tree, if you will. We notify eligible clinicians of their QP status. The first thing is we see if they admit 50% threshold just under Medicare, and if so, we declare them a QP. If they had a lower score than the Medicare threshold but was still above 25%, as I said, that's where the All-Payer Combination Option comes into account. And if they were exceeding 50% through the All-Payer Combination Option, that threshold score, again, we would declare them to be a QP. And then there are different levels that fall out here, depending on how their scores come out, either through the Medicare threshold score or the All-Payer threshold score, which may result in them becoming a partial QP or dropping back into the Medicaid-eligible pool. And, again, these are dependent on which particular snapshot the clinician or APM entity chose to use as their time period. So, I know that's a lot to digest. Of course, that's why we're having another webinar, because you probably, for those of you that have been around, you've seen this before, but it's becoming a more salient issue as we're actually in operation now and moving towards 2019. I am going to hand it back over to Corey now to continue in letting you know some of our resources.

Yeah, thank you, guys, for participating in this call today. I hope it was very informative. We've been trying to answer as many questions as we can through the Chat Box. Will you go to the next slide, please? So, if you can go to the next slide after "Resources," I believe. Yep. So, I just wanted to make sure you guys had an opportunity to take a look at this because this is a primer for where you can find a lot of the questions and answers to what we're providing in the chat box. There's a lot of information out there around the Alternative Payment Models, many of these fact sheets. If you take a look at this page here, though, there's a tab for each year. We're talking about Performance Year 2019. So, when you go to the APM Overviews, make sure you scroll to the middle of the page and you click on "Performance Year 2019." And if you go to the next slide, please. And on this slide, you'll find that there's going to be an opportunity for you to be able to get more information around APM policy. Next slide, please. Slide 34. And then as you get further down the bottom of the page, you'll find All-Payer Combination Option specific information. Next slide, please. Slide 35. And on Slide 35, you'll also find that we have taken a screenshot that there are Eligible Clinician Initiated submission forms and links to the document for you to be able to download. Next slide, please. And, in addition, there are resources that you can select the hot links here. Many of them, you will find for a lot of the questions being asked today, the All-Payer Combination Option glossary, which is about 3/4 of the way down on this page. And then the one right before that, the All-Payer Combination Option and Other Payer Advanced APMs FAQs. A lot of the questions and answers will be there, and if there are specifics around APMs, then this whole page will be very helpful to you as it relates to the All-Payer and Other Payer Combination Option. But prior to that, the Alternative Payment Model specifics, having that background is very helpful as it relates to combining and getting to a place where you can look into meeting QP status. Next slide, please. So, with that

stated, I'm going to hand this back over to Adam Richards, as he will talk to you about help and support resources.

All right, well, thank you, Corey, and thank you, Richard, for walking us through the All-Payer Combination Option, certainly Alternative Payment Models, Advanced Alternative Payment Models. I know it's a lot of information, so we're going to turn it over to you in about a minute or two. So, this is your two-minute warning, I suppose. So, if we move on to the next slide, just to quickly run through some of the technical assistance related to support that we have available to you all. And this is really for those of you clinicians, practices out there that are beginning to think about the transition toward an Alternative Payment Model and certainly an Advanced Alternative Payment Model. I think you've learned a lot today about the All-Payer Combination Option and the benefits that this option has for participating in Advanced APMs. So, there is plenty of support out there to help you along the way and through the process, whether it's just general questions about the All-Payer Combination Option or Advanced APMs, these groups can certainly help answer those questions. But also, again, for those of you who are interested in beginning that practice transformation, beginning to move into an APM, I do recommend the Transforming Clinical Practice Initiative. The have Practice Transformation Networks available. Not only can they help you with that transition over to an APM, but they can certainly help you in the MIPS component, too, of the Quality Payment Program if you are a MIPS-eligible clinician. I will say, as Corey alluded to earlier, qpp.cms.gov, our Quality Payment Program website, is a great starting point for all information on the Quality Payment Program. Then, of course, we also have our service center available to answer your questions. So, I highly recommend all of these resources. I'll also quickly plug our Quality Payment Program listserv. A lot of the information that we communicate from both tracks of the program goes out through that listserv. So, it is available just by going to our main page on qpp.cms.gov, scrolling to the bottom, and entering your e-mail address. So, if we move on to the next slide, and I'll get through this in about 30 seconds, and then we'll take your questions. This is an opportunity that we wanted to present and we've been presenting to a number of our participants on webinars. We are looking for some volunteers -- we call them user testers -- who are interested in continuing to help us improve the Quality Payment Program website and experience. So, if you are interested in providing your feedback on all aspects of qpp.cms.gov, and you can see the list of things we're looking for there. You know, please reach out to QPP User Research Lead. The link is on this slide, so when we do close this slide, you'll be able to go right in and e-mail our lead, if you’re interested. Okay, so that was a lot to cover. We're going to jump into our Q&A session. So, I’m going to jump ahead a few slides, just to present that information to you all. At this time, I'm going to ask our moderator just to go through the information on how you can get into the phone queue.

We are now going to start the Q&A portion of the webinar. You can ask a question via chat or phone. To ask your question via the phone, dial 1-866-452-7887. Again, the number is 1-866-452-7887. If prompted, please provide ID number 5887044. Again, if prompted, provide Conference ID 5887044. Once you join the conference, please press star-1 on your telephone keypad to join the Q&A. Again, that is star-1 on your telephone keypad.

Okay, so, we're going to give you just a couple of seconds to get into the phone queue. Again, directions are onscreen. We are trying to answer a number of your questions that are coming in through the Q&A at this point.

We do have some of our subject-matter experts with us in the room. We know there are a lot of questions coming in. I think we're going to take a couple right now. So, this is Adam Conway. I apologize, there is multiple Adams in the room here, and I'm just going to queue a question for Richard that reflects a couple of questions that I've seen so far, which is around "What are the necessary conditions to access the All-Payer Combination Option, including what kind of APM provider we need to be participating in to access this option?"

Well, there's a couple parts to that. First of all, as I mentioned, it's only relevant for clinicians who are already in Medicare Advanced APMs. And, in fact, at least participating at the 25% level. So that's one part of the answer. The other part of the answer is "What is the criteria for an Other Payer Advanced APM?" The criteria, as I said, are very similar to the criteria for Advanced APM in that they must require CERT from their participants, that they're using CERT, that the payment is tied to Quality Measures, particularly MIPS-comparable quality measures. And third, that certain financial risk is taken on, or nominal risk standards are met. A shorthand for that is to simply say that downside risk has to be present and something that the clinicians are taking on. Specifically, I walked through the three components of that -- marginal risk, minimum loss rate, and the total risk levels. And I can go through that again, if necessary. But the way to think about it is, the payment arrangement must meet those three criteria in order to be an Other Payer Advanced APM.

Thanks.

Okay, thank you, Richard. Let's go over to our phone line at this time. Do we have anyone on the call?

There are no questions in queue at this time. If you would like to ask a question, please press star then the number 1 on your telephone keypad. Again, that's star, then the number 1.

Okay. And so, with that said, we'll return back over to our Q&As, our chat, because we do have a lot of good questions coming in. Adam, do you have a few more?

Sure. I've seen a number of questions around the type of risk that providers must take on in order to qualify in Other Payer Advanced Alternative Payment Models. Specifically, some folks have asked about the definitions around marginal risk and minimum loss, total risk, and so on. Richard, I don't know if we want to ask our moderators to go back to that slide or if you just want to take that one.

I can probably handle that. So, when we describe marginal risk, we're talking about the amount by which there are losses. What proportion is the clinician taking on? And we say that it must be at least 30%. For example, if there's a $100 loss, the clinician would have to be responsible for $30, at least. And this begins with first dollar. So, we're talking about a portion. In the marketplace, there's some arrangements where the marginal risk is actually greater than that. In fact, there's some capitation arrangements where it's 100%. And there are also examples throughout the marketplace where there are levels below 30% that are being used, and in our rule, we have set the level of marginal risk. It must be set at 30% in order to be considered meeting our standard. The other piece is minimum loss rate. You can think of a minimum loss rate as that measure around zero total risk

outward, where a payment arrangement would have allowed a certain amount of losses, minimal losses, that are not the responsibility of the clinician, and often, I think in payment arrangements, this is set -- if it exists at all, it's set at about 2%. You can kind of think of this -- It's viewed as the noise that's going on in the marketplace and the payment arrangement that for very low levels of losses, you don't hold the clinician accountable, and we simply say that that level can be up to 4%, and it meets our criteria. If it gets above 4%, we think that's too high. And, finally, with regard to total risk, we are saying that if the payment arrangement is based on a benchmark or a targeted price, we say that 3% of expected expenditures should be the minimum threshold. And if it's a revenue-based model of some sort that measures things in terms of revenue, then it should be at 8%. So that's how we draw up our three dimensions in terms of the nominal amount standard.

All right, thanks, Richard. There's a question here that I can take while Adam and Richard look through some of the other questions in the Chat Box here. This question is regarding a physician who's already qualified as a QP, that's a qualifying APM participant. In other words, they've met or exceeded the threshold that we've set. I assume here it's a case for 2018. They're asking if there's any notification that that clinician needs to provide to CMS that they have met that threshold or whether CMS will provide information to the clinician. And we are providing that notification through an NPI Lookup on qpp.cms.gov where you can type in your NPI. It will then provide a number of details to you about what your QP status is and what model and organization you've achieved that status through, if applicable.

Perfect.

All right, thank you, Adam. We did see a couple of questions come in, and this is really nice to see. Folks are thinking about where can they get additional information on what Alternative Payment Models are active in their region, who's enrolling, so on and so forth. So, I'm going to turn it over to Corey to answer that question.

Yes, so, for some, I've already provided -- If you go to innovation.cms.gov, and on that page, we have an option there about halfway down on the page where we give you a question, and that question says, "Where innovation is happening," and you can select the state. Under that is our innovation models, but right above that, where innovation is happening, if you just hit "Go" there, you don't have to select a state, it will take you to a mapping option that allows you to see what's going on nationally, regionally, and you can narrow that down. And then that also allows for you to look at other data and reports. At the very bottom of that same page, innovation.cms.gov, we have a Data and Reports option that allows for you to look at some research, some data sets, and you can find specific areas where you can find innovation taking place in your region or area, and that's by either region or model name, if you're looking for something in particular. But, please, come to the innovation.cms.gov page for additional information around any of the models, and we'll be happy to always share with you recent milestones and updates that you'll find.

Perfect. Thank you, Corey. Okay, we're going to go rapid-fire here. So, we did get a question that came in through the chat. It is "How will Advanced APMs submit the All-Payer data at the APM entity level?" Is that via the Quality Payment Program portal? Just some additional information, we're a Track III ACO who's a QP this year, but the percent goes up next year, so

the all-payer option is attractive." Richard, where would folks go to submit their All-Payer data?

Sure. Well, first of all, this is probably a terminology issue. You're asking about Advanced APM data, and we already have that. That's the Medicare, but I think you're referring to data from the Other Payer Advanced APM. In other words, your participation, whether it's dollars or patients. How do you submit that data? It'll be late 2019, and you'll submit it through the QPP portal, and you'll go to the portal, and we will have a tool. It'll actually be one of our sales force tools set up at that point, and there will be -- Corey can help me here, but basically a place an the site that you tap, and it'll allow you to go in and fill out a form, and you would submit your data through that form.

That's correct.

And it'll be pretty straightforward. It'll say, you know, give us the numerator and denominator for each of your payers, not just the ones that have Other Payer Advanced APM arrangements, but each of them so that we have all the payers in our ratio. And as I also mentioned before, we would like to get both payment information and patient participation so that we can do the calculations two ways, and we'll give you the benefit of the doubt on that in terms of what's more advantageous to you. But, yes, it's through the QPP Portal that you go to submit that information.

Okay, perfect. We don't have anyone in queue for the phone line, so I know we're getting close to the top of the hour. Maybe we'll take one last question here. Just to clarify, because I've seen this a few times, as well. This came in from one of our primary care groups. So, clinicians must already be participating in an Advanced APM with Medicare in order to qualify as an Advanced APM using Other Payer options? But I think that's to qualify for the All-Payer.

QP. Yeah.

Yes. In order to become a QP using the All-Payer Combination Option, or, in other words, in addition to the participation and the Medicare Advanced APMs using participation in Other Payer Advanced APMs, there has to be -- as I say, it's a necessary condition, that you're participating in Advanced APMs. And, in fact, it's specified in the law, and the minimum threshold is specified in the law of 25%, that you must be participating in a Medicare Advanced APM. And that goes into out years, even as the overall threshold goes up.

Okay. Perfect. Thank you so much. well, I know we're getting close to the top of the hour, so I do want to thank our subject matter experts for being here with us today to walk us through the All-Payer Combination Option. Again, folks, if you do need resources, there's qpp.cms.gov. There's a lot of great information under our Alternative Payment Model tab to really help you get started. Of course, we do have the free technical assistance. Our Service Center is here to help if you have any additional questions. I'll also mention that we will post the recording, as well as the slides, in the coming weeks. So please be on the lookout for that. Of course, we'll communicate that through the QPP listserv. So, if you haven't done so already, please sign up for our listserv. I'll also mention -- there are three slides included as an appendix to this slide deck. I encourage you to take a look at those because it does have some information about terminology

related to APMs and Advanced APMs, some of the things that we were talking about here today. I think they'll really help you as you're working in the Advanced APM track. So, again, we want to thank everyone for being here today, and we'll talk to you again soon.

Thank you. This concludes today's conference. You may now disconnect.