Quality Payment
PROGRAM

Quality Payment Program Year 2 Final Rule All-Payer Combination Option & Other Payer Advanced APMs

On November 2, 2017, the Department of Health and Human Services (HHS) issued a final rule with comment period continuing to implement policies for Calendar Year (CY) 2018 of the Quality Payment Program. This fact sheet provides an overview of final policies regarding the All-Payer Combination Option and Other Payer Advanced Alternative Payment Models (Other Payer Advanced APMs), focusing on:

- Other Payer Advanced APM Criteria
- Other Payer Advanced APM Determination Process
- Qualifying APM Participant (QP) Determinations under the All-Payer Combination Option

What is 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 advancing care information, or
2. Advanced Alternative Payment Models with Medicare (Advanced APMs), under which eligible clinicians may earn an incentive payment for sufficient participation.

How can I participate in an Advanced APM and become a Qualifying APM Participant?

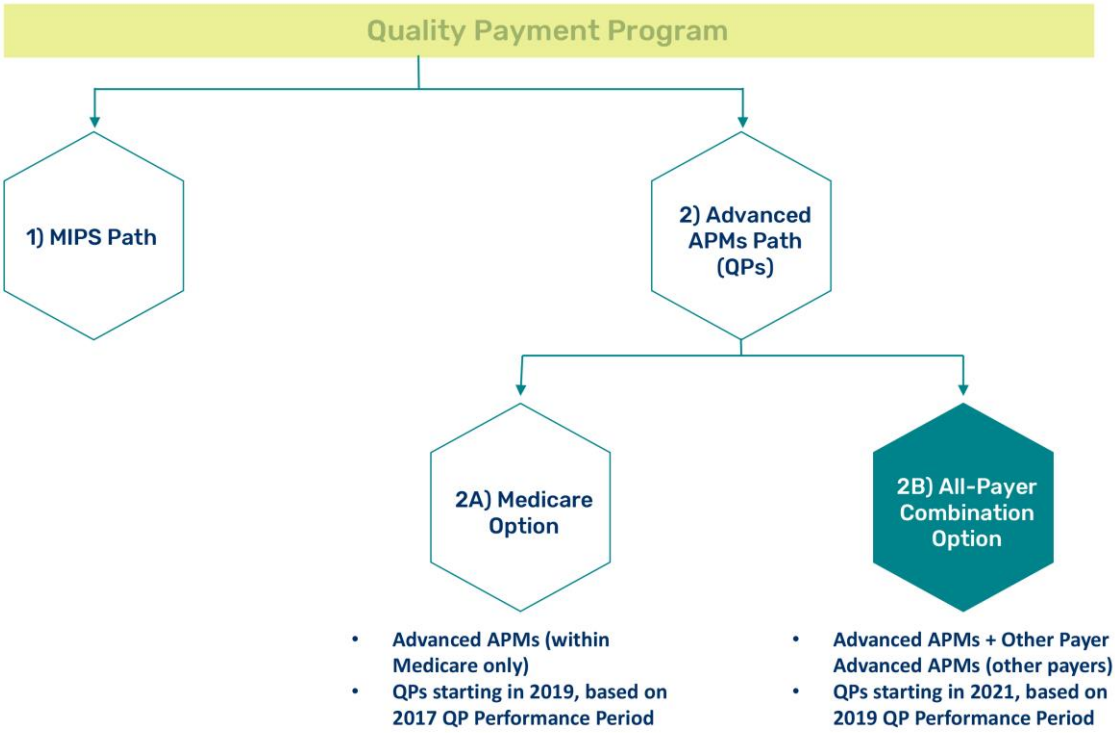
CMS identifies the alternative payment arrangements that meet the criteria to be Advanced APMs under Medicare, and Other Payer Advanced APMs with other payers such as Medicaid, Medicare Advantage, and commercial payers. Eligible clinicians who participate in an Advanced APM can become Qualifying APM Participants (QPs) for a year by meeting certain threshold levels of participation in these types of APMs, measured in terms of either their payments or patients. If an eligible clinician does not meet the threshold levels of participation to become a QP 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.

These two options for eligible clinicians to become QPs under the Quality Payment Program are the:

1. Medicare Option, which only takes into account participation in Advanced APMs with Medicare, and
2. All-Payer Combination Option, which takes into account a combination of participation in Advanced APMs with Medicare and Other Payer Advanced APMs.

The Medicare Option allows eligible clinicians to become QPs through Advanced APM participation starting in the 2019 (based on participation in 2017 QP Performance Period). The All-Payer Combination Option allows eligible clinicians to become QPs through participation in a combination of Advanced APMs with Medicare and Other Payer Advanced APMs starting in the 2021 (based on participation in 2019 QP Performance Period). Eligible clinicians who become QPs through either option are not subject to the MIPS reporting requirements or payment adjustment, and will receive a 5 percent APM incentive payment for the year.[1]

Figure 1: How the All-Payer Combination Option fits within the Quality Payment Program



1 Eligible clinicians participating in Advanced APMs with Medicare, but who do not meet the thresholds to become QPs for a year can meet lower thresholds to become Partial QPs. Eligible clinicians who are Partial QPs for a year are not subject to the MIPS reporting requirements and payment adjustment unless they choose to report to MIPS, but they do not earn a 5% APM incentive bonus payment. More information about Partial QPs may be found in Appendix 1

Other Payer Advanced APM Criteria

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 3 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.

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.

Figure 1: Generally Applicable Nominal Amount Standards for Other Payer Advanced APMs

Expenditure-based nominal amount standard	**Revenue-based nominal amount standard****
Nominal amount of risk must be: • Marginal Risk of at least 30%; • Minimum loss rate of no more than 4%; and • Total Risk of at least 3% of the expected expenditures the APM Entity	Nominal amount of risk must be: • Marginal Risk of at least 30%; • Minimum loss rate of no more than 4%; and • Total Risk of at least 8% 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.

What is the Medicaid Medical Home Model Nominal Amount Standard?

To be Other Payer Advanced APMs, Medicaid Medical Home Models can meet a different nominal amount standard. The total risk that an APM Entity potentially owes a payer or foregoes is equal to at least:

- 3% of the average estimated total revenue of the participating providers or other entities under the payer in the 2019 QP Performance Period.
- 4% in the 2020 QP Performance Period.
- 5% in the 2021 QP Performance Period and later.

The definition of what constitutes risk (apart from the minimum amount) is somewhat more flexible under the Medical Home Model nominal amount standard, and includes exposing model participants to loss of a payment that they would otherwise be entitled to under the payment arrangement.

What is 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)

Payer Initiated Process

In 2018, prior to the 2019 QP Performance Period, CMS will allow certain payers – State Medicaid Agencies[2], Medicare Advantage and other Medicare Health Plans, and payers participating in CMS-sponsored Multi-Payer payment arrangements (CMS Multi-Payer Models)[3] – 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 who 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

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

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

would be able to do so instead. That process, known as the Eligible Clinician Initiated Process, is explained in more detail below.

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)

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. CMS is requesting comment on whether to certify multiple payment arrangements for multiple years.

As noted above, only State Medicaid Agencies, Medicare Health Plans, and payers participating in CMS Multi-Payer Models will be eligible to participate in the Payer Initiated Process starting in 2018 (for the 2019 performance period). CMS intends to extend this option to all other payers in future years.

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.

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 the all information we need, we'll post the results of Other Payer Advanced APM determinations on our website at cms.gov. 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).

Public Posting and Timeline

Before the relevant QP Performance Period starts, we'll post on our website at cms.gov a list of payment arrangements determined to be Other Payer Advanced APMs through the Payer Initiated Process. After the QP Performance Period, we'll update this list to include payment arrangements determined to be Other Payer Advanced APMs based on submissions through the Eligible Clinician Initiated Process. Recall that the main difference between the two processes is that the Payer Initiated Process occurs before the QP Performance Period, and the Eligible Clinician Initiated Process occurs after the QP Performance Period (except for Medicaid payment arrangements).

Figure 2: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations

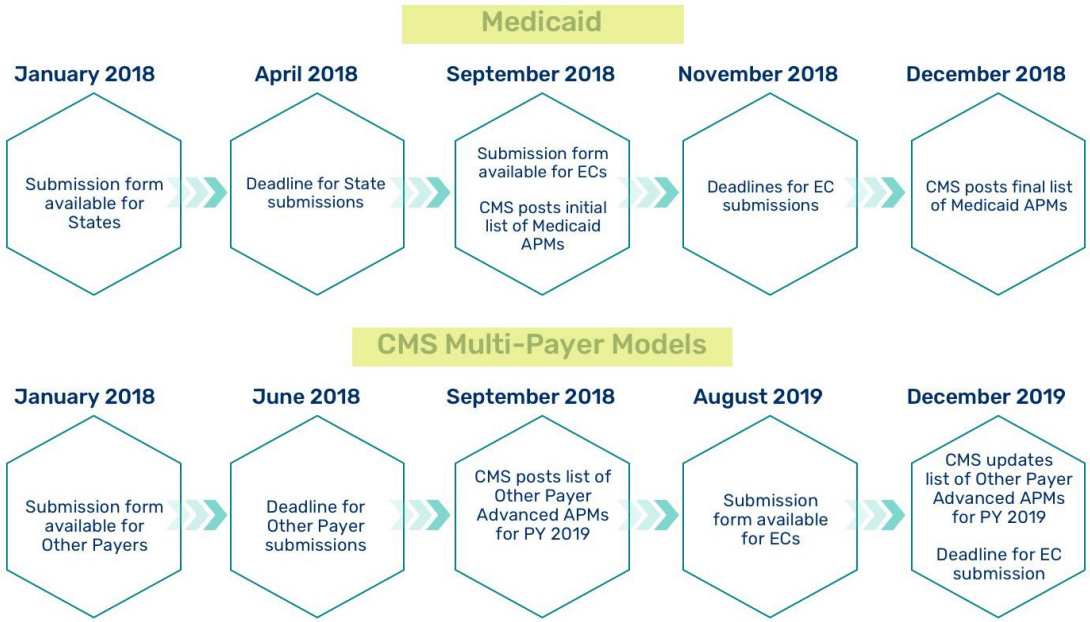
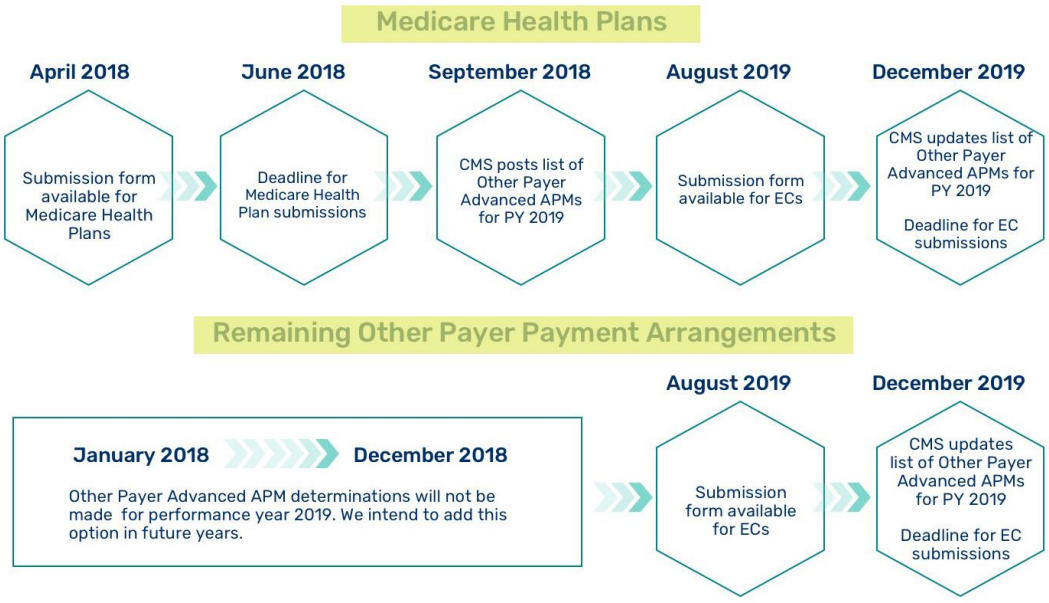


Figure 2: Performance Year 2019 timeline for Other Payer Advanced APM determinations



What are QP Determinations under the All-Payer Combination Option?

First, we'll determine which other payer payment arrangements qualify as Other Payer Advanced APMs. Then, we'll determine which eligible clinicians who have achieved participation thresholds based on their payments or patients through Advanced APMs with Medicare and Other Payer Advanced APMs are QPs. Eligible clinicians who are QPs for a year under the All-Payer Combination Option are not subject to the MIPS reporting requirements and payment adjustment, and qualify for the 5 percent APM incentive bonus payment in the payment year.

QP determinations under the All-Payer Combination Option will be made at either the individual clinician or APM Entity level. Eligible clinicians may submit payment and patient count information at both levels and CMS will apply the more advantageous of the two.

To attain QP status under the All-Payer Combination Option, eligible clinicians have to do 3 things:

1. Participate in an Advanced APM (with Medicare) to a sufficient degree;
2. Participate in an Other Payer Advanced APM to a sufficient degree; and

3. Submit required payment amount and patient count information to us.

Each of these requirements is explained in more detail below:

1. Participate in an Advanced APM

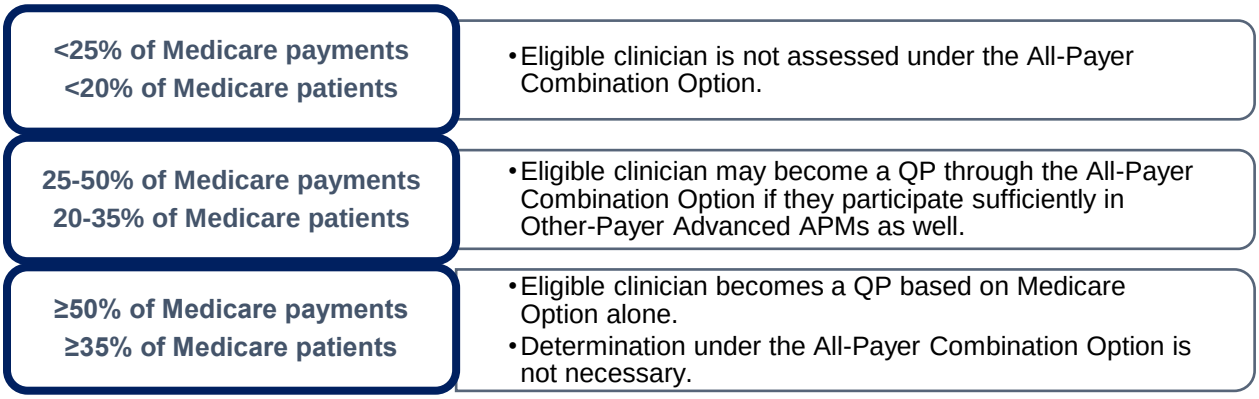
An eligible clinician needs to participate in an Advanced APM to a sufficient extent to be eligible for consideration under the All-Payer Combination Option. For the 2019 QP Performance Period, this means the eligible clinician must either:

- Have more than 25% but less than 50% of their Medicare Part B payments for covered professional services through Advanced APMs with Medicare; or
- See more than 20% but less than 35% of their Medicare patients through Advanced APMs.

Eligible clinicians whose participation in an Advanced APM falls below this range are not evaluated using the All Payer Combination Option. Eligible clinicians whose participation in an Advanced APM is higher than this range would become QPs through the Medicare Option, so there would be no need to evaluate them using the All Payer Combination Option.

The threshold levels of Advanced APM participation will become more stringent starting in performance year 2021 (see Appendix 1 for more information).

Figure 3: 2019 performance year payment and patient count thresholds for Advanced APM participation under the All-Payer Combination Option



2. Participate in an Other Payer Advanced APM (while also participating in an Advanced APM).

In addition to participating in an Advanced APM, eligible clinicians also have to participate to a sufficient degree in at least one payment arrangement that CMS determines is an Other Payer Advanced APM for the relevant QP Performance Period. For the 2019 QP Performance Period, this means that eligible clinicians must either have:

- At least 50% of their total combined payments through Advanced APMs with Medicare and Other Payer Advanced APMs, or
- See at least 35% of their total combined patients through Advanced APMs with Medicare and Other Payer Advanced APMs.

We'll know if eligible clinicians meet these standards when we calculate Threshold Scores using the following methodology:

Payment Amount

$$\frac{\textbf{\$\$\$} \text{ through Advanced APMs and Other Payer Advanced APMs}}{\textbf{\$\$\$} \text{ from all payers (except excluded \$\$\$)}} = \text{Threshold Score}$$

Patient Count Method

$$\frac{\#\text{ of patients furnished services under Advanced APMs and Other Payer Advanced APMs}}{\#\text{ of patients furnished services under all payers (except excluded patients)}} = \text{Threshold Score}$$

Eligible clinicians may qualify as QPs by meeting these thresholds for sufficient participation in Advanced APMs with Medicare and Other Payer Advanced APMs at either the eligible clinician Level or the APM Entity level.

3. Submit payment amount and patient count information to us.

Eligible clinicians or APM Entities will need to submit this information to us so we can make a QP determination for them under the All-Payer Combination Option:

- Patients and payments through Other Payer Advanced APMs; and
- Total patients and payments (including those not through Other Payer Advanced APMs) for all payers (other than those under Medicare).

The QP Performance Period for the All-Payer Combination Option is the same as for the Medicare Option: January 1 through August 31. Eligible clinicians will be QPs if they meet the criteria for sufficient participation during any of 3 snapshot periods during the Performance Period:

- January 1- March 31,
- January 1 through June 30, or
- January 1 through August 31.

Eligible clinicians or APM Entities must submit QP determination requests for the All-Payer Combination Option to us between August 1 and December 1, after the end of the QP Performance Period. They may submit information on payment amounts or patient counts for any or all of the 3 snapshot periods. Information can be submitted at either the individual level or the APM Entity level.

Based on the information submitted, CMS will determine whether the eligible clinician meets the required thresholds for sufficient Advanced APM and Other Payer Advanced APM participation to become a QP in any of the three snapshot periods. CMS will notify eligible clinicians of the results of their QP determination.

Appendix 1: Threshold Scores

The tables below show the percentages of patients/payments in Advanced APMs with Medicare and Other Payer Advanced APMs that eligible clinicians must meet to be QPs or Partial QPs in each performance period.

Figure 4: 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) and Other Payer Advanced APM (Medicaid and other payers) participation.

Figure 5: All-Payer Combination Option – Patient Count Method

Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024 and later**	
QP Patient 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) and Other Payer Advanced APM (Medicaid and other payers) participation.