Quality Payment
PROGRAM

ALL PAYER COMBINATION OPTION:

Quality Payment Program Year 2 Proposed Rule

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Question & Answer (Q&A) Session

- There will be a Q&A session if time allows. However, CMS must protect the rulemaking process and comply with the Administrative Procedure Act.
- Participants are invited to share initial comments or questions, but only comments formally submitted through the process outlined by the Federal Register will be taken into consideration by CMS.
- See the proposed rule for information on how to submit a comment.

Proposed Rule for Year 2

When and Where to Submit Comments

- The proposed rule includes proposed changes not reviewed in this presentation so please refer to the proposed rule for complete information.
- We will not consider feedback during the presentation as formal comments on the rule so please submit your comments in writing.
- See the proposed rule for information on submitting these comments by the close of the 60-day comment period on **August 21, 2017**. When commenting refer to **file code CMS 5522-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:
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- For additional information, please go to: qpp.cms.gov

Proposed Rule for Year 2

Agenda

- Overview
- Advanced APMs
- All-Payer Combination Option & Other Payer Advanced APMs
  - Other Payer Advanced APM Determination Process
  - All-Payer Combination Option QP Determinations
- Resources

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

MIPS and Advanced APMs

The Quality Payment Program is:

- Promoting greater value in Medicare Part B payments for more than 600,000 clinicians
- Improving care across the entire healthcare delivery system

Clinicians have two tracks to choose from:

The Merit-based Incentive Payment System (MIPS)

If you are in MIPS, you may earn a performance-based MIPS payment adjustment.

OR

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

Quality Payment Program

Strategic Objectives

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

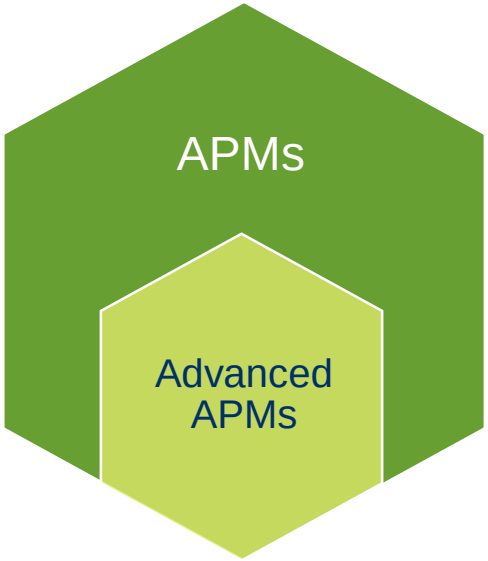
PROPOSED RULE FOR YEAR 2

Alternative Payment Models (APMs)

Alternative Payment Models (APMs) and Advanced APMs

- An Alternative Payment Model (APM) is a payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- APMs can apply to a specific condition, episode of care, or a population.

Advanced APMs are a subset of APMs.



What are Alternative Payment Models (APMs)?

- The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations that CMS conducts.

As defined by MACRA, APMs include:

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

What are Advanced APMs?

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;

2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and

3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

In order to qualify for the 5% APM incentive payment for a year, eligible clinicians must receive a certain percentage of payments for covered professional services or see a certain percentage of patients through an Advanced APM during the associated performance year.

Advanced APMs: Financial Risk Standards

- In the Year 1 Final Rule CMS established a general financial risk standard, applicable to all APMs, and a separate financial risk standard for Medical Home Models.
- CMS also finalized general nominal amount standards and a specific Medical Home Model nominal amount standard as part of those financial risk standards.
- In the Year 2 Proposed Rule CMS is proposing some minor changes to these Advanced APM policies.

General Nominal Amount Standard
The total amount of that risk must be equal to at least either:

- 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities; OR
- 3% of the expected expenditures for which an APM Entity is responsible under the APM.

Medical Home Model Nominal Amount Standard **
The total amount of risk under a Medical Home Model must be at least the following amounts:

- 2.5% of estimated average total Medicare Parts A and B revenue (2017)
- 3% of estimated average total Medicare Parts A and B revenue (2018)
- 4% of estimated average total Medicare Parts A and B revenue (2019)
- 5% of estimated average total Medicare Parts A and B revenue (2020 and later)

** For performance year 2018 and thereafter, the medical home standard applies only to APM Entities with fewer than 50 clinicians in their parent organization

Advanced APMs: Year 2 Proposed Changes

1. For the generally applicable nominal amount standard, CMS proposes to extend the 8% revenue-based standard for two additional years, through performance year 2020.

2. For the Medical Home Model nominal amount standard, CMS proposes to increase the risk more gradually over time beginning at 2% of total revenue in Performance Year 2018 and increasing one percent each year until reaching 5% for Performance Year 2021 and later.

3. Beginning in 2018, the Medical Home Model financial risk standard applies only to APM Entities with fewer than 50 clinicians in their parent organization. CMS is proposing to exempt Round 1 Comprehensive Primary Care Plus Model (CPC+) participants from this requirement.

PROPOSED RULE FOR YEAR 2

Overview of the All-Payer Combination Option & Other Payer Advanced APMs

Proposed Rule for Year 2

All-Payer Combination Option: Overview

The MACRA statute created two pathways to allow eligible clinicians to become QPs.

Medicare Option

- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs within Medicare fee-for-service.

All-Payer Combination Option

- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in:
  - Advanced APMs within Medicare fee-for-service; and
  - Other Payer Advanced APMs offered by other payers.

What is an Other Payer Advanced APM?

Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs.

Payer types that may have payment arrangements that qualify **as Other Payer Advanced APMs** include:

- ✓ Title XIX (Medicaid)
- ✓ Medicare Health Plans (including Medicare Advantage)
- ✓ CMS Multi-Payer Models
- ✓ Other commercial and private payers

Other Payer Advanced APM Criteria

- The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used for Advanced APMs:

1. Requires at least 50 percent of eligible clinicians to **use certified EHR** technology to document and communicate clinical care information.

2. Base payments on **quality measures that are comparable to those used in the MIPS** quality performance category.

3. Either: (1) is a Medicaid Medical Home Model that meets criteria that is comparable to a Medical Home Model expanded under CMS Innovation Center authority, OR (2) Requires participants to bear more than nominal amount of financial risk.

Proposed Rule for Year 2

All-Payer Combination Option Other Payer Advanced APM Criteria : Generally Applicable Nominal Amount Standard

Year 1 Final Rule Policy

- 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 is responsible for under the APM.

Year 2 Proposed Rule Policy

- CMS proposes to add a revenue-based nominal amount standard for total risk of 8%.
- This standard would be an additional option and would only apply to models in which risk for APM Entities is expressly defined in terms of revenue.

Medicaid Medical Home Model

A Medicaid Medical Home Model is a payment arrangement under Medicaid (Title XIX) 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 additional elements:

- ☐ 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.

Medicaid Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Other Payer Advanced APM.

Proposed Rule for Year 2

Advanced APMs: Medicaid Medical Home Model Nominal Amount Standard

Year 1 Final Rule Policy

- Total potential risk for an APM Entity under the Medicaid Medical Home Model must be equal to at least:
  - 4 percent of the APM Entity's total revenues under the payer in 2019.
  - 5 percent of the APM Entity's total revenues under the payer in 2020 and later.

Year 2 Proposed Rule Policy

- CMS proposes that the total potential risk for an APM Entity under the Medicaid Medical Home Model must be equal to at least:
  - 3 percent of the APM Entity's total revenues under the payer in 2019.
  - 4 percent of the APM Entity's total revenues under the payer for 2020.
  - 5 percent of the APM's total revenue's under the payer for 2021 and later.

PROPOSED RULE FOR YEAR 2

All-Payer Combination Option: Determination of Other Payer Advanced APMs

Proposed Rule for Year 2

All-Payer Combination Option: Determination of Other Payer Advanced APMs

CMS proposes two pathways through which a payment arrangement can be determined to be an Other Payer Advanced APM.

Payer Initiated Determination Process

- Voluntary.
- Deadline **before** the All-Payer QP Performance Period.
- Specific deadlines and mechanisms for submitting payment arrangements will vary by payer type in order to align with pre-existing processes and meet statutory requirements.

Eligible Clinician Initiated Determination Process

- Deadline **after** the All-Payer QP Performance Period, **except** for eligible clinicians participating in Medicaid payment arrangements.
- Overall process is similar for eligible clinicians across all payer types , except for the submission deadlines.

Proposed Rule for Year 2

All-Payer Combination Option: Determination of Other Payer Advanced APMs

Overview – Proposed Payer Initiated Process

- Prior to each All-Payer QP Performance Period, CMS would make Other Payer Advanced APM determinations based on information voluntarily submitted by payers.
- This payer-initiated process would be available for Medicaid, Medicare Health Plans (e.g., Medicare Advantage, PACE plans, etc.) and CMS Multi-Payer Models beginning in 2018 for the 2019 All-Payer QP Performance Period. We intend to add remaining payer types in future years.
- Guidance materials and the Payer Initiated Submission Form would be made available prior to each All-Payer QP Performance Period
- CMS would review the payment arrangement information submitted by each payer to determine whether the arrangement meets the Other Payer Advanced APM criteria.
- CMS would post a list of Other Payer Advanced APMs on a CMS website prior to the All-Payer QP Performance Period.

Proposed Rule for Year 2

All-Payer Combination Option: Determination of Other Payer Advanced APMs

Overview – Proposed Eligible Clinician Initiated Process

- If CMS has not already determined that a payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or APM Entities on their behalf) would have the option to submit this information and request a determination. CMS would then use this information to determine whether the payment arrangement is an Other Payer Advanced APM.
- Guidance materials and an Eligible Clinician Initiated Submission Form would be provided during the All-Payer QP Performance Period with submission due after the All-Payer QP Performance Period.
  - Note, eligible clinicians or APM Entities participating in Medicaid payment arrangements would submit information for Other Payer Advanced APM determinations prior to the All-Payer QP Performance Period.
- CMS would review the payment arrangement information submitted by APM Entities or eligible clinicians to determine whether the payment arrangement meets the Other Payer Advanced APM criteria.

Proposed Rule for Year 2

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations APMs

MEDICAID

January 2018	April 2018	September 2018	November 2018	December 2018
• Submission form available for States	• Deadline for State submissions	• Submission form available for ECs • CMS posts initial list of Medicaid APMs	• Deadline for EC submissions	• CMS posts final list of Medicaid APMs

CMS MULTI-PAYER MODELS

January 2018	June 2018	September 2018	August 2019	December 2019
• Submission form available for Other Payers	• Deadline for Other Payer submissions	• CMS posts list of Other Payer Advanced APMs for PY 2019	• Submission form available for ECs	• CMS updates list of Other Payer Advanced APMs for PY 2019 • Deadline for EC submissions

Proposed Rule for Year 2

All-Payer Combination Option: Performance Year 2019 Timeline for Other Payer Advanced APM Determinations APMs

MEDICARE HEALTH PLANS

April 2018	June 2018	September 2018	August 2019	December 2019
• Submission available for Medicare Health Plans	• Deadline for Medicare Health Plan submissions	• CMS posts list of Other Payer Advanced APMs for PY 2019	• Submission form available for ECs	• CMS updates list of Other Payer Advanced APMs for PY 2019 • Deadline for EC submissions

REMAINING OTHER PAYER PAYMENT ARRANGEMENTS

January 2018	—	December 2018	August 2019	December 2019
• No prospective Other Payer Advanced APM determination for performance year 2019. We intend to add this option in future years.			• Submission form available for ECs	• CMS updates list of Other Payer Advanced APMs for PY 2019 • Deadline for EC submissions

PROPOSED RULE FOR YEAR 2

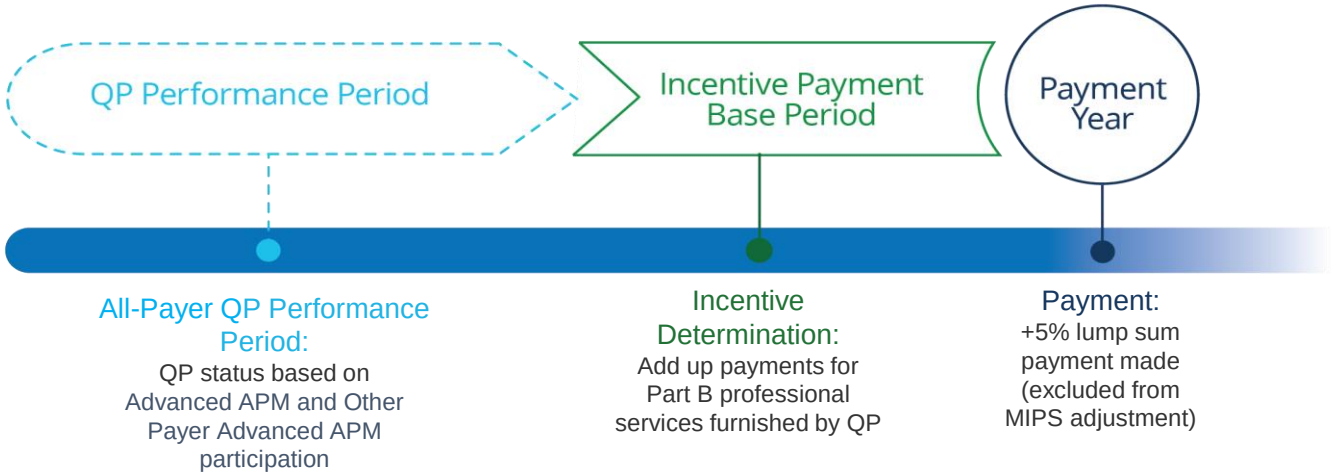
All-Payer Combination Option: QP Determinations

Proposed Rule for Year 2

All-Payer QP Performance Period

- CMS is proposing that the All-Payer QP Performance Period is the period during which CMS would assess eligible clinicians' participation in Advanced APMs and Other Payer Advanced APMs to determine if they will be QPs for the payment year.

- CMS proposes that the All-Payer QP performance Period would be from January 1 through June 30 of the year that is two years prior to the payment year. Under this proposal, CMS would make QP determinations under the All-Payer Combination Option from either January 1 - March 31 or from January 1 – June 30.



Proposed Rule for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step One: Participate in an Advanced APM in Medicare

1

- An Eligible Clinician needs to participate in an Advanced APM in Medicare to a sufficient extent to be eligible to become a QP under the All-Payer Combination Option.
- For performance year 2019, based on the payment amount method, sufficient means:

<25%	• Eligible Clinician is ineligible to become a QP under the All-Payer Combination Option.
25% - 50%*	• Eligible Clinician may become a QP through the All-Payer Combination Option.
≥50%	• Eligible Clinician becomes a QP based on Medicare Option alone. • Participation in the All-Payer Combination Option is not necessary.

*Eligible clinicians must have **greater than or equal to** 25% and **less than** 50% of payments through an Advanced APM(s).

Proposed Rule for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step Two: Participate in an Other Payer Advanced APM

2

An Eligible Clinician needs to be in at least one Other Payer Advanced APM during the relevant All-Payer QP Performance Period.

Under the proposed policy, from August 1-December 1 after the close of the All-Payer QP Performance Period, eligible clinicians seeking a QP determination under the All-Payer Combination Option can:*

1. Inform CMS that they are in a payment arrangement that CMS has determined is an Other Payer Advanced APM.
2. Submit information to CMS on a payment arrangement where CMS will make an Other Payer Advanced APM determination.

Note that eligible clinicians in Medicaid payment arrangements only would have the option to submit their payment arrangement information **prior to the relevant All-Payer QP Performance Period.*

Proposed Rule for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step Three: Submit Payment Amount and Patient Count Information

3

Under the proposed rule, between August 1 and December 1 after the close of the All-Payer QP Performance Period, eligible clinicians seeking QP determinations under the All-Payer Combination Option would submit the following information:

- Payments and patients through Other Payer Advanced APMs, aggregated between January 1 – March 31 and January 1 – June 30.
- All other payments and patients through other payers, aggregated between January 1 – March 31 and January 1 – June 30.

Proposed Rule for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 4: CMS Calculates Threshold Scores

4

Year 1 Final Rule Policy

QP determinations under the All-Payer Combination Option would be made at either the APM Entity or individual eligible clinician level, depending on the circumstances.

Year 2 Proposed Rule Policy

CMS proposes to make QP determinations at the eligible clinician level only.

CMS will calculate Threshold Scores under both the payment amount and patient count methods, applying the more advantageous of the two:

Payment Amount Method

$$$ through Advanced APMs and Other Payer Advanced APMs

$$$ from all payers (except excluded $$$)

= **Threshold Score %**

Patient Count Method

# of patients furnished services under Advanced APMs and Other Payer Advanced APMs

---

# of patients furnished services under all payers (except excluded patients)

= **Threshold Score %**

Proposed Rule for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 4: CMS Calculates Threshold Scores

4

The MACRA statute directs us to exclude certain types of payments (and we will for associated patients).

Specifically, that list of excluded payments includes, but is not limited to, Title XIX (Medicaid) payments where no Medicaid APM (which includes a Medicaid Medical Home Model that is an Other Payer Advanced APM) is available under that state program. CMS is proposing to further elaborate on how we implement this exclusion

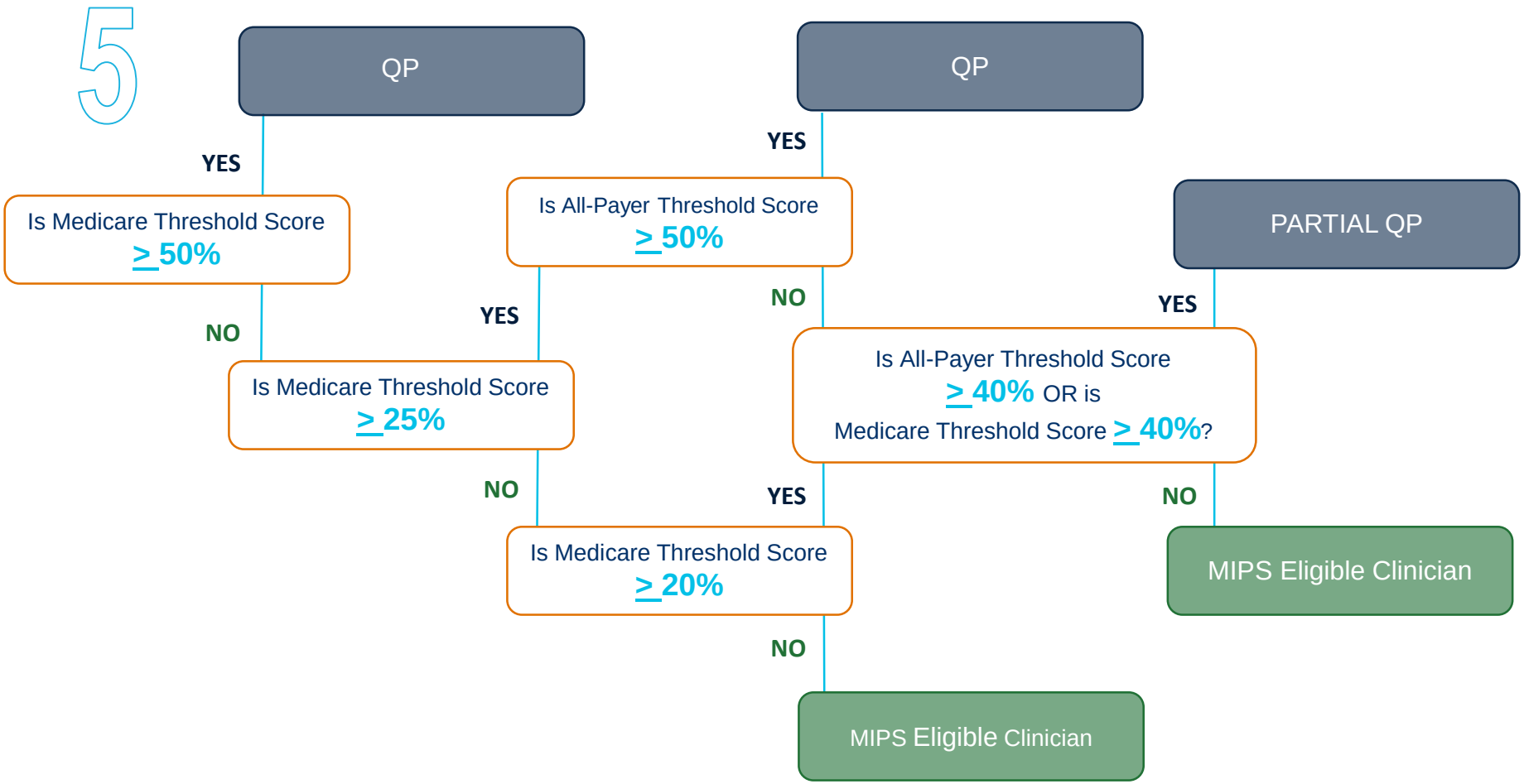
In last year's rulemaking, CMS stated that Title XIX (Medicaid) payments or patients will be excluded from the numerator and denominator for the QP determination unless:

- A state has at least one Medicaid Medical Home Model or Medicaid APM in operation that is determined to be an Other Payer Advanced APM; and
- The relevant APM Entity is eligible to participate in at least one Other Payer Advanced APM, regardless of whether the APM Entity actually participates in an Other Payer Advanced APM.

In the case where the Other Payer Advanced APM is implemented at the sub-state level, CMS is proposing that title XIX payments and associated payments will be excluded unless CMS determines that there is at least one Medicaid APM available in the county where the eligible clinician sees the most patients and that eligible clinician is eligible to participate in the Other Payer Advanced APM based on their specialty.

Proposed Rule for Year 2

All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 5: Notification of QP Status and Next Steps



QUALITY PAYMENT PROGRAM

Resources

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide:
https://qpp.cms.gov/resources/education

Proposed Rule: Comments Due 8/21/2017

- See the proposed rule for information on submitting these comments by the close of the 60-day comment period on **August 21, 2017**. When commenting **refer to file code CMS 5522-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
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QUALITY PAYMENT PROGRAM

Appendix

Proposed Rule for Year 2

Request for Feedback: APM Proposals

- Examples of where feedback is requested regarding APMs are shown in the parentheses:
  - Advanced APM nominal amount standard (appropriate level for the revenue-based standard).
  - Medical Home Model Nominal Amount Standard (whether to change the nominal amount standard for Medical Home Models so that the minimum required amount of total risk increases more slowly).
  - Medicaid Medical Home Nominal Amount Standard (whether to change the nominal amount standard for Medical Home Models so that the minimum required amount of total risk increases more slowly)
  - Other Payer Advanced Determination Process (seek comment on our proposed Payer Initiated and Eligible Clinician Initiated Processes).
  - QP Determinations under the All-Payer Combination Option (whether to make QP determinations at the eligible clinician level only).
  - Other Payer Advanced APM nominal amount standard (whether to add a revenue-based nominal amount standard of 8 percent for total risk, in addition to the existing expenditure-based nominal amount standard).


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