Quality Payment
PROGRAM

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

ALL PAYER COMBINATION OPTION

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This publication is a general summary that explains certain aspects of the Medicare Program, but it is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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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.
- This is a Final Rule with Comment Period. You can 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

Final Rule with Comment Period for Year 2

When and Where to Submit Comments

- We will not consider feedback during the presentation as formal comments on issues open for comment. We ask that you please submit your comments in writing.
- See the Final Rule with Comment Period for information on submitting these comments by the close of the 60-day comment period on January 2, 2018. When commenting refer to file code CMS 5522-FC.
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Resource Library Update

- To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of QPP resources to CMS.gov.

- QPP.CMS.GOV redirects to the CMS.GOV Resource Library:
  - CMS.GOV Resource Library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html
  - Final Rule Materials Posted: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

Final Rule with Comment Period for Year 2

Agenda

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

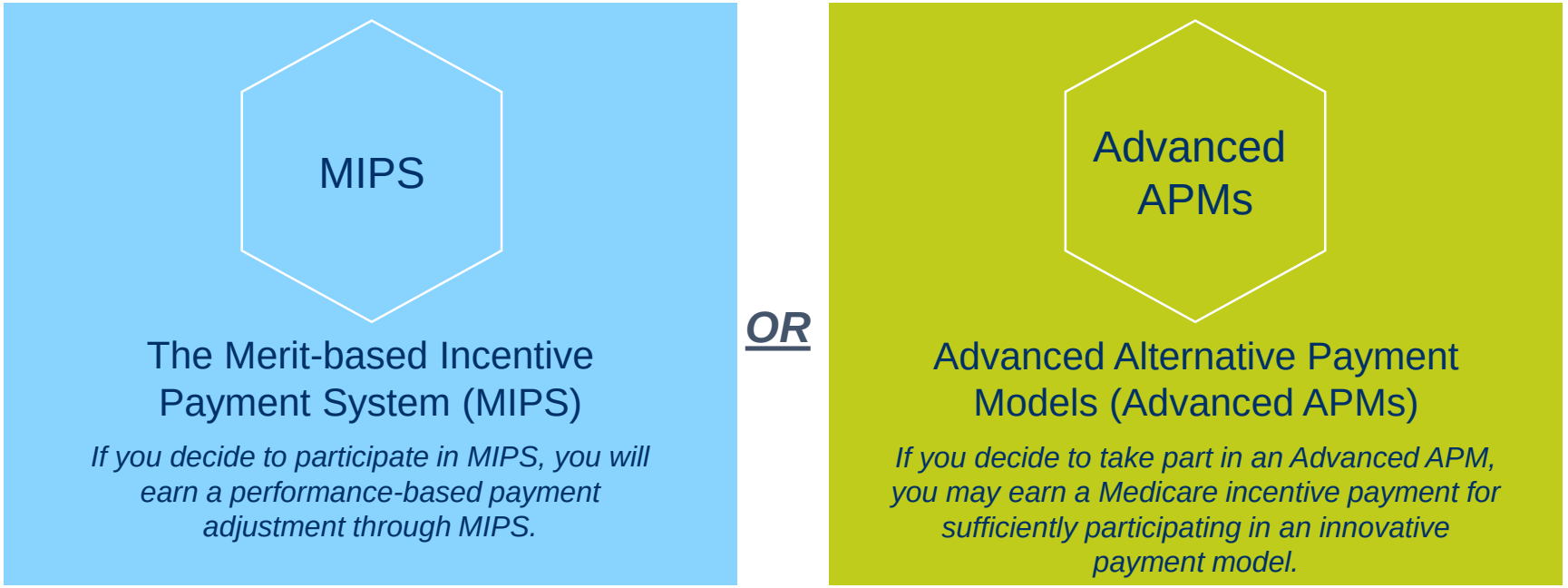
QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

MIPS and Advanced APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:



Quality Payment Program

Considerations

- 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.

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

Alternative Payment Models (APMs)

Alternative Payment Models (APMs)

Quick Overview

- APMs are approaches to paying for health care that incentivize quality and value.
- As defined by MACRA, APMs include CMS Innovation Center models (authorized under section 1115A, other than a Health Care Innovation Award), MSSP (Medicare Shared Savings Program), demonstrations under the Health Care Quality Demonstration Program, and demonstrations required by federal law.
- Advanced APMs are a subset of APMs within Medicare. To be an Advanced APM, a model must meet the following three statutory requirements:
  - Requires participants to use **certified EHR technology**;
  - Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
  - 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 achieve status as a Qualifying APM Participant (QP) and 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 period.

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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 with Medicare.

All-Payer Combination Option

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

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All-Payer Combination Option: Overview

CMS is additionally exploring opportunities for a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative alternative payment arrangements under Medicare Advantage that qualify as Advanced APMs by allowing credit for participation in such Medicare Advantage arrangements prior to 2019 and incentivizing participation in such arrangements in 2018 through 2024.

This demonstration would provide clinicians with incentives for participation in an Advanced APM with Medicare Advantage alone (without having to concurrently participate in an Advanced APM with Medicare).

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

Overview of the Medicare Option

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 with Medicare during the associated performance year.

Advanced APMs

To be an Advanced APM, an APM must meet both the financial risk and nominal amount standards. Most often, APMs will need to meet the generally applicable financial risk and nominal amount standards. Medical Home Models, a subset of APMs, can satisfy the financial risk criterion by meeting the special Medical Home Model financial risk and nominal amount standards.

Generally Applicable 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 all providers and suppliers in 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 (QP Performance Period 2017)
- 2.5% of estimated average total Medicare Parts A and B revenue (2018)
- 3% of estimated average total Medicare Parts A and B revenue (2019)
- 4% of estimated average total Medicare Parts A and B revenue (2020)
- 5% of estimated average total Medicare Parts A and B revenue (2021 and later)

** For performance year 2018 and thereafter, the Medical Home Model nominal amount standard applies only to APM Entities with fewer than 50 eligible clinicians in their parent organization, except for 2017 Participants in Round 1 of the Comprehensive Primary Care Plus Model.

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

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

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 under Medicare.

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

- ✓ Title XIX (Medicaid)
- ✓ Medicare Health Plans (including Medicare Advantage)
- ✓ Payment arrangements aligned with 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 under Medicare:

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 are 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 if actual aggregate expenditures exceed expected aggregate expenditures.**

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

The generally applicable nominal amount standard for an Other Payer Advanced APM will be applied in one of two ways depending on how the Other Payer Advanced APM defines risk.

Expenditure-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 is responsible for under the APM.

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
- For QP Performance Periods 2019 and 2020, Total Risk of at least 8% of combined revenues from the payer of providers and other entities under the payment arrangement if financial risk 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.

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Medicaid Medical Home Model Nominal Amount Standard

Medicaid Medical Home Model Nominal Amount Standard

- The Medicaid Medical Home Model must require that the total annual amount that an APM Entity potentially owes a payer or foregoes under the Medicaid Medical Home Model is at least:
  - 3 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2019.
  - 4 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2020.
  - 5 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2021 and later.

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

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

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

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

Payer Initiated Process

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

Eligible Clinician Initiated Process

- Deadline is **after** the 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.

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

Overview – Payer Initiated Process

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

Final Rule with Comment Period for Year 2

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

Overview – 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) may 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 the Eligible Clinician Initiated Submission Form will be provided during the QP Performance Period with submission due after the QP Performance Period.
    - Note, eligible clinicians or APM Entities participating in Medicaid payment arrangements will be required to submit information for Other Payer Advanced APM determinations for those Medicaid payment arrangements only prior to the QP Performance Period.
- CMS will 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.

Advanced APMs

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

Medicaid

January 2018
Submission form available for States

April 2018
Deadline for State submissions

September 2018
Submission form available for ECs

CMS posts initial list of Medicaid APMs

November 2018
Deadlines for EC submissions

December 2018
CMS posts final list of Medicaid APMs

CMS Multi-Payer Models

January 2018
Submission form available for Other Payers

June 2018
Deadline for Other Payer submissions

September 2018
CMS posts list of Other Payer Advanced APMs for PY 2019

August 2019
Submission form available for ECs

December 2019
CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submission

Advanced APMs

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

Medicare Health Plans

April 2018
Submission form available for Medicare Health Plans

June 2018
Deadline for Medicare Health Plan submissions

September 2018
CMS posts list of Other Payer Advanced APMs for PY 2019

August 2019
Submission form available for ECs

December 2019
CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submissions

Remaining Other Payer Payment Arrangements

January 2018 – December 2018
Other Payer Advanced APM determinations will not be made for performance year 2019. We intend to add this option in future years.

August 2019
Submission form available for ECs

December 2019
CMS updates list of Other Payer Advanced APMs for PY 2019

Deadline for EC submissions

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018)

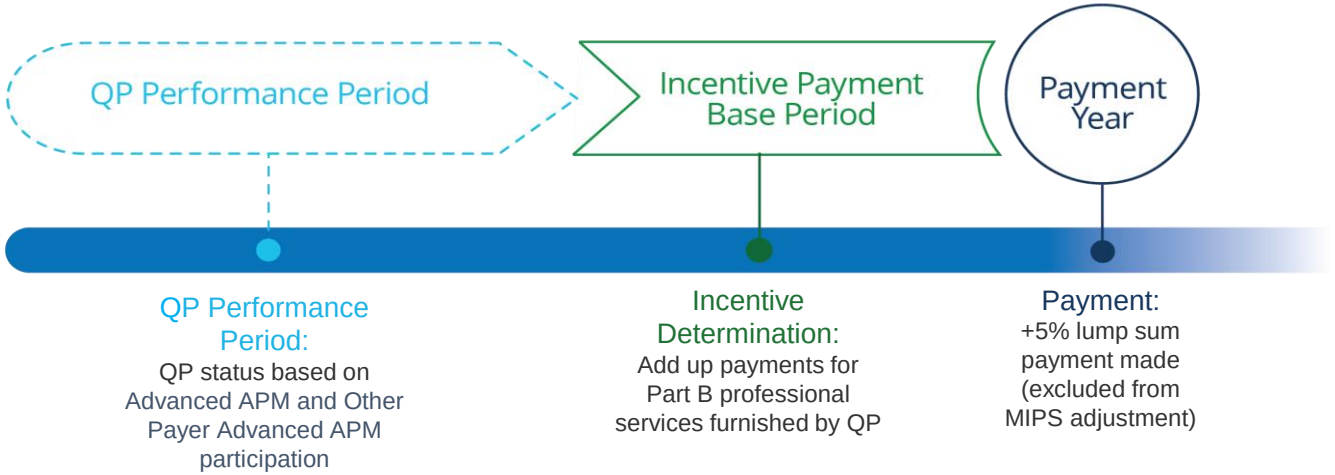
All-Payer Combination Option: QP Determinations

Final Rule with Comment Period for Year 2

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 2019 QP Performance Period.

- CMS will assess eligible clinicians' participation in Advanced APMs with Medicare and – where applicable – Other Payer Advanced APMs to determine if they will be QPs for the payment year (this is explained in more detail in the next slide.



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

1

- An Eligible Clinician or APM Entity needs to participate in an Advanced APM with Medicare to a sufficient extent to qualify for the All-Payer Combination Option.
- For performance year 2019, based on the payment amount method, sufficient means:

<25%	• Eligible Clinician or APM Entity does not qualify to participate in All-Payer Combination Option.
25% - 50%*	• Eligible Clinician or APM Entity does qualify to participate in the All-Payer Combination Option.
≥50%	• Eligible Clinician or APM Entity attains QP status 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).

Final Rule with Comment Period for Year 2

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

2

Under the All-Payer Combination Option, an Eligible Clinician or APM Entity needs to be in at least one Other Payer Advanced APM during the relevant QP Performance Period.

Eligible clinicians or APM Entities seeking a QP Determination under the All-Payer Combination Option will**:

1. Inform CMS that they are in a payment arrangement that CMS has determined is an Other Payer Advanced APM; and

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 QP Performance Period.

Final Rule with Comment Period for Year 2

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

3

Between August 1 and December 1 after the close of the QP Performance Period, eligible clinicians or APM Entities 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, January 1 – June 30, and January 1 – August 31.
- All other payments and patients through other payers except those excluded, aggregated between January 1 – March 31, January 1 – June 30, and January 1 – August 31.

Eligible clinicians 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.

Final Rule with Comment Period for Year 2

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

4

QP Determinations under the All-Payer Combination Option:

Eligible clinicians and APM Entities will have the option to request All-Payer QP determinations. Eligible clinicians can request at either the individual level, and APM Entities can request at the APM Entity level.

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

Payment Amount Method

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

Patient Count Method

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

Final Rule with Comment Period 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.

In the case where the Medicaid APM is implemented at the sub-state level, Title XIX (Medicaid) payments and associated patients 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.

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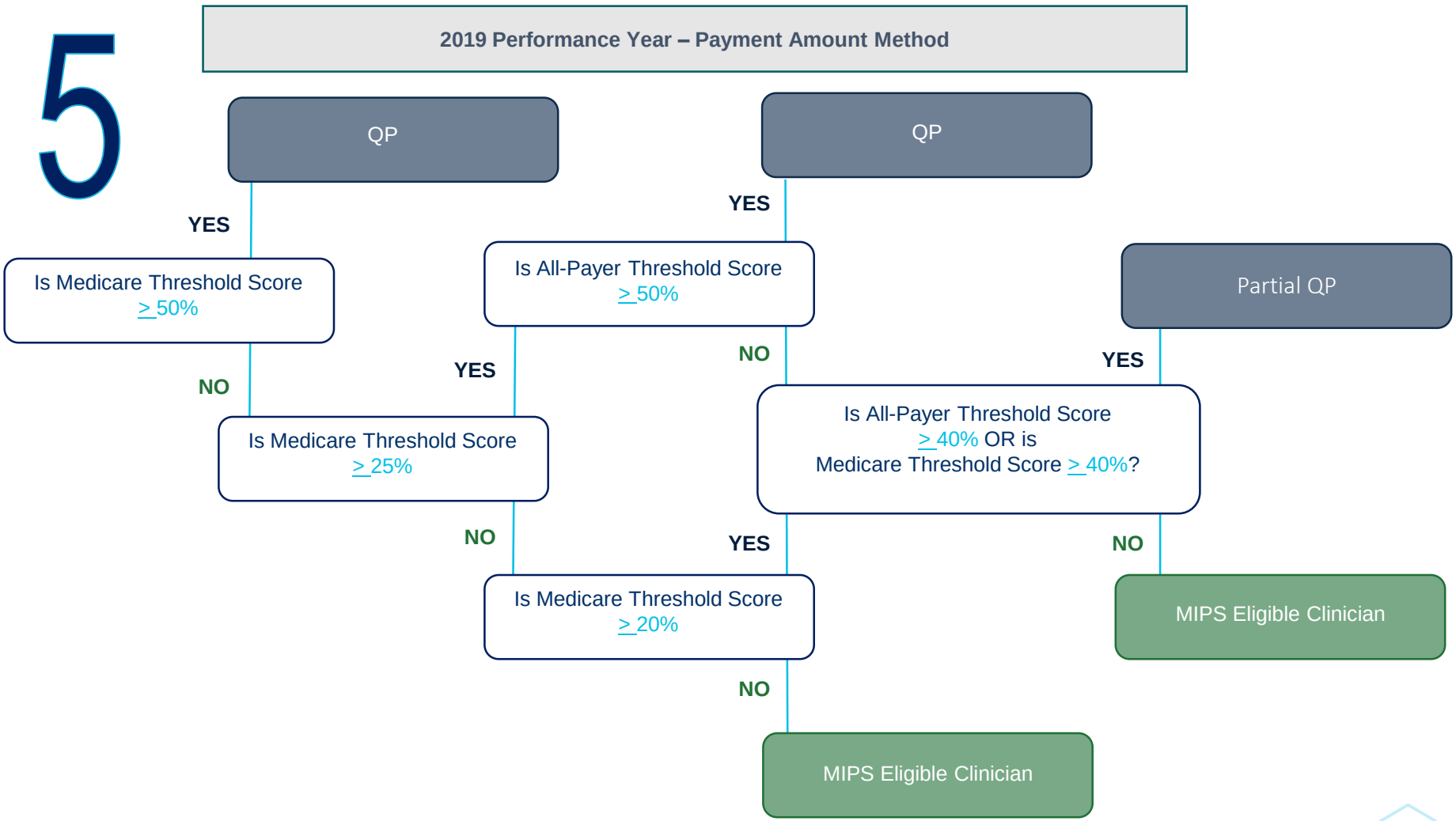
All-Payer Combination Option: How do Eligible Clinicians become QPs?
Step 5: Notification of QP Status and Next Steps



Final Rule with Comment Period for Year 2

Requests for Comment

- In this final rule with comment period, we seek comment on the following policies that pertain to the All-Payer Combination Option:
  - **Other Payer Medical Home Models:** We seek comment on whether to establish a definition for Other Payer Medical Home Models.
  - **Marginal Risk and Minimum Loss Rate Requirements:** We seek comment on whether we should continue these requirements and also on whether there are alternative approaches.
  - **Other Payer Advanced APM Determinations:** We seek comment on whether to establish a multi-year determination for Other Payer Advanced APMs that do not change from one year to the next and on what kind of information should be submitted annually after the first year to update an Other Payer Advanced APM determination.
  - **CEHRT:** We seek comment on whether we should consider revising the 50 percent CEHRT use requirement and instead use some other standard to identify other payer arrangements that meet the criterion to require CEHRT use.
  - **Calculations:** We seek comment on whether we should add an alternative to allow QP determinations at the TIN level when all clinicians who have reassigned billing to the TIN are included in a single APM Entity.

QUALITY PAYMENT PROGRAM

Resources

Technical Assistance

Available Resources

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included 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.ISCMail@us.ibm.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://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

Final Rule with Comment Period: Comments Due January 2, 2018

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Q&A Session

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