Quality Payment
PROGRAM

ALL-PAYER COMBINATION OPTION & OTHER PAYER ADVANCED APMs

Topics

- Overview of Alternative Payment Models (APMs)
- Basics of Advanced APMs
- All-Payer Combination Option and Other Payer Advanced APMs
- Determination of Other Payer Advanced APMs
- QP Determinations
- Resources

ALTERNATIVE PAYMENT MODELS (APMS)

What is an APM?

Alternative Payment Models (APMs) are new approaches to paying for medical care through Medicare that incentivize quality and value. 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.

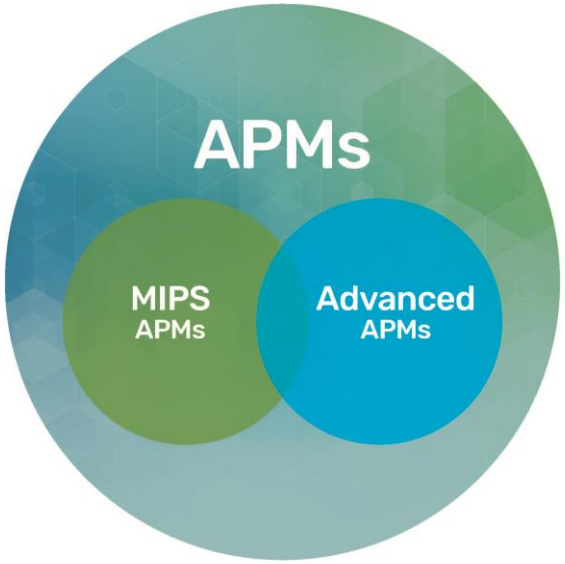
As defined by MACRA, **APMs include:**

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

APMs Overview

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- Can apply to a specific condition, care episode or population.
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of APMs



ADVANCED APMS

Advanced APMs

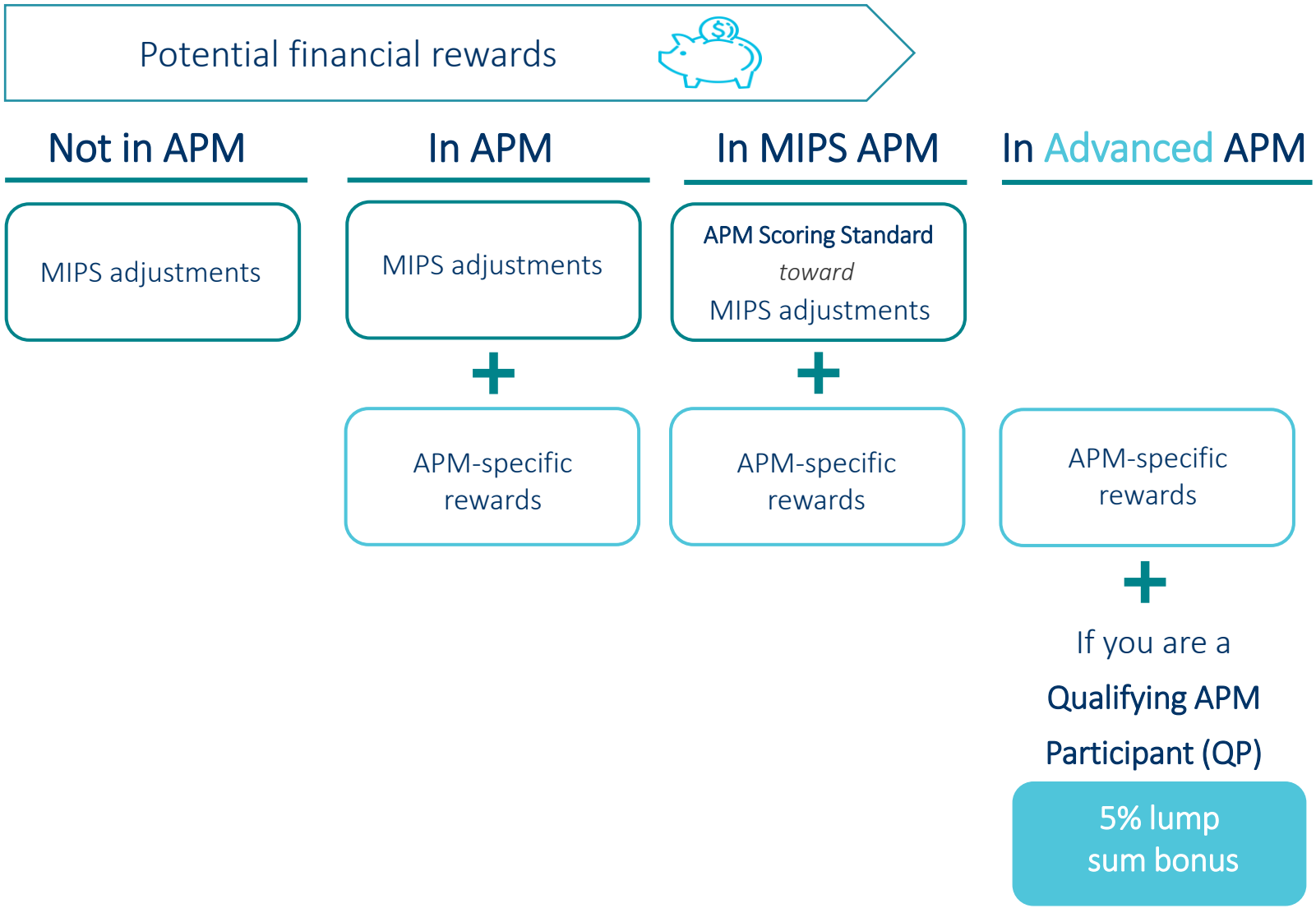
Clinicians and practices can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates **extra incentives** for a sufficient degree of participation in Advanced APMs.

Advanced APMs

Incentive Structure



Advanced APMs

Current List of Advanced APMs

- Bundled Payments for Care Improvement (BPCI) Advanced Model*
- Comprehensive Care for Joint Replacement Model
- Comprehensive ESRD Care Model (LDO Arrangement)
- Comprehensive ESRD Care Model (non-LDO Two-sided Risk Arrangement)
- Comprehensive Primary Care Plus (CPC+) Model
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Maryland Total Cost of Care Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Primary Care Program)
- Next Generation ACO Model
- Shared Savings Program – Track 2
- Shared Savings Program – Track 3
- Oncology Care Model (OCM) – Two-Sided Risk
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

*BPCI Advanced is scheduled to begin in October 2018, and participants will have an opportunity to achieve QP status, or be scored under the APM scoring standard for MIPS, starting in performance year 2019.

ALL-PAYER COMBINATION OPTION & OTHER PAYER ADVANCED APMS

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.

All-Payer Combination Option

All-Payer Combination Option & Other Payer Advanced APMs

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

All-Payer Combination Option

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.**

All-Payer Combination Option

Other Payer Advanced APM Criteria

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.

All-Payer Combination Option

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.

All-Payer Combination Option

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.

ALL PAYER COMBINATION OPTION: DETERMINATION OF OTHER PAYER ADVANCED APMs

All-Payer Combination Option

Determinations 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.

All-Payer Combination Option

Determinations 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.

All-Payer Combination Option

Determinations 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.

All-Payer Combination Option

Timeline for Determinations of Other Payer Advanced APMs

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

All-Payer Combination Option

Medicaid Eligible Clinicians

Eligible Clinician Initiated Process -- Medicaid

- A list of Medicaid Other Payer Advanced APMs determined for the 2019 QP Performance Period through the Payer Initiated Process was posted September 1, 2018.
  - https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Medicaid-Other-Payer-Advanced-APM-determination-list.pdf
- Submission period for Eligible Clinicians to submit Medicaid payment arrangement is open from September 1, 2018 to November 1, 2018.
  - Submission forms can be found at: https://qpp.cms.gov/apms/overview?py=2019#
- CMS will make determinations based on these submissions, and post an updated list of Medicaid Other Payer Advanced APMs in December 2018.

All-Payer Combination Option

Timeline for Determinations of Other Payer Advanced APMs

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

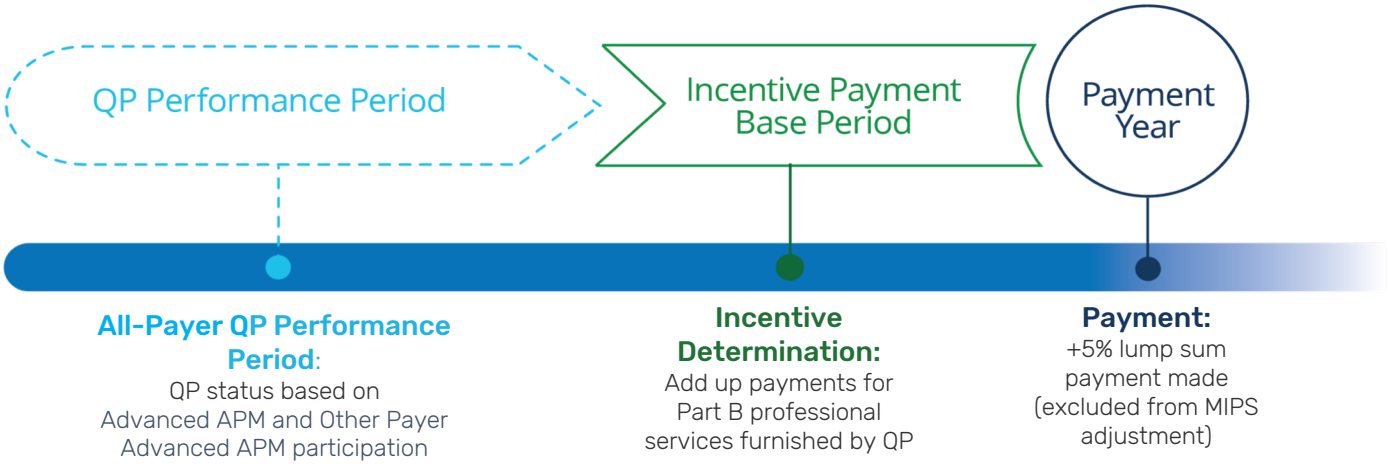
ALL PAYER COMBINATION OPTION: QP DETERMINATIONS

All-Payer Combination Option

QP Performance Period

- The All-Payer 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 will be QPs for the payment year.

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



All-Payer Combination Option

QP Determination Process

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).

All-Payer Combination Option

QP Determination Process

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.

All-Payer Combination Option

QP Determination Process

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.

All-Payer Combination Option

QP Determination Process

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

$$$ 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 %

All-Payer Combination Option

QP Determination Process

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

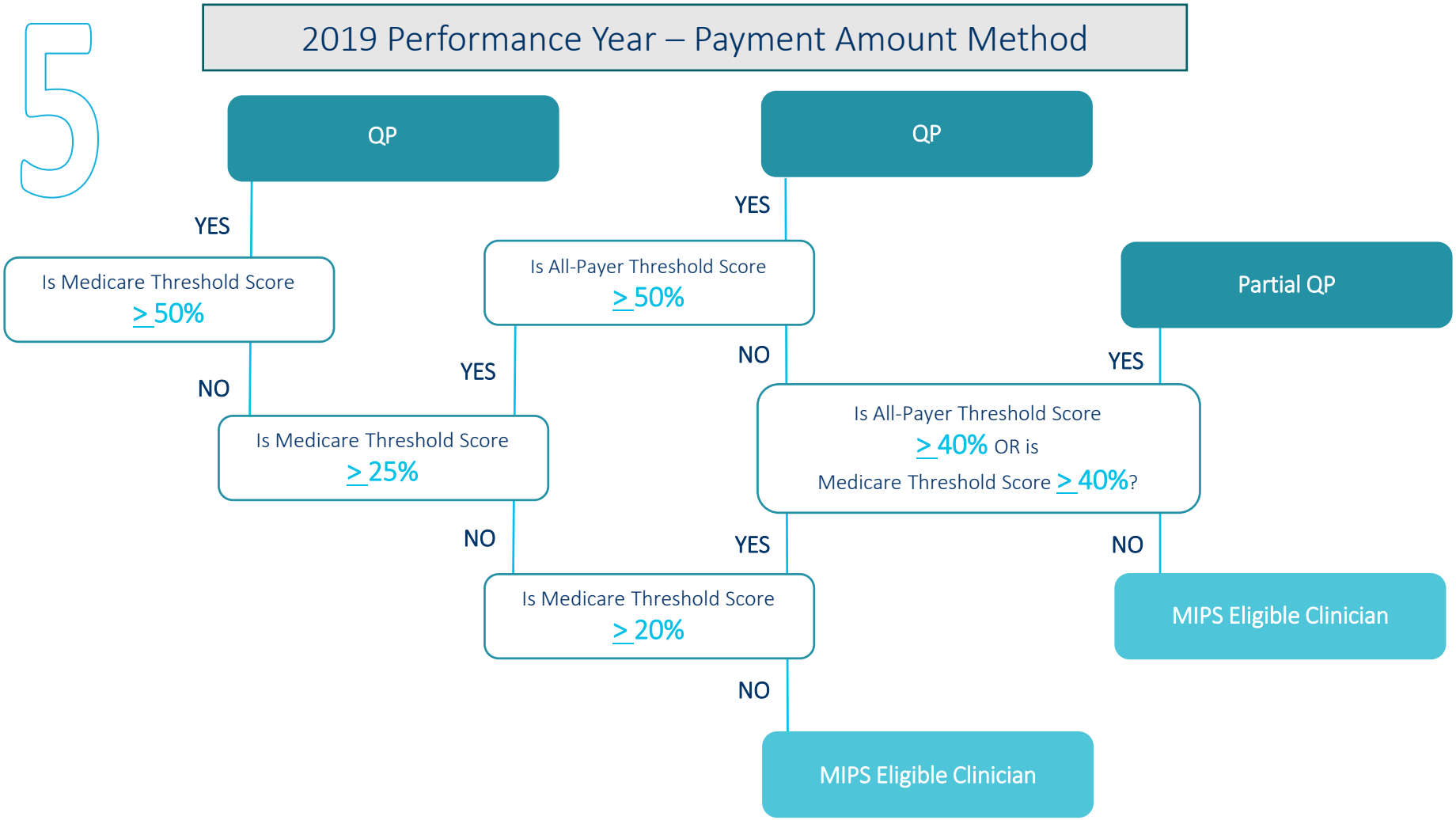
Specifically, that list of excluded payments includes, but is not limited to, Title XIX (Medicaid) payments where no Medicaid APM (which includes a Medicaid Medical Home Model that is an Other Payer Advanced APM) is available under that state program.

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.

All-Payer Combination Option

QP Determination Process

5

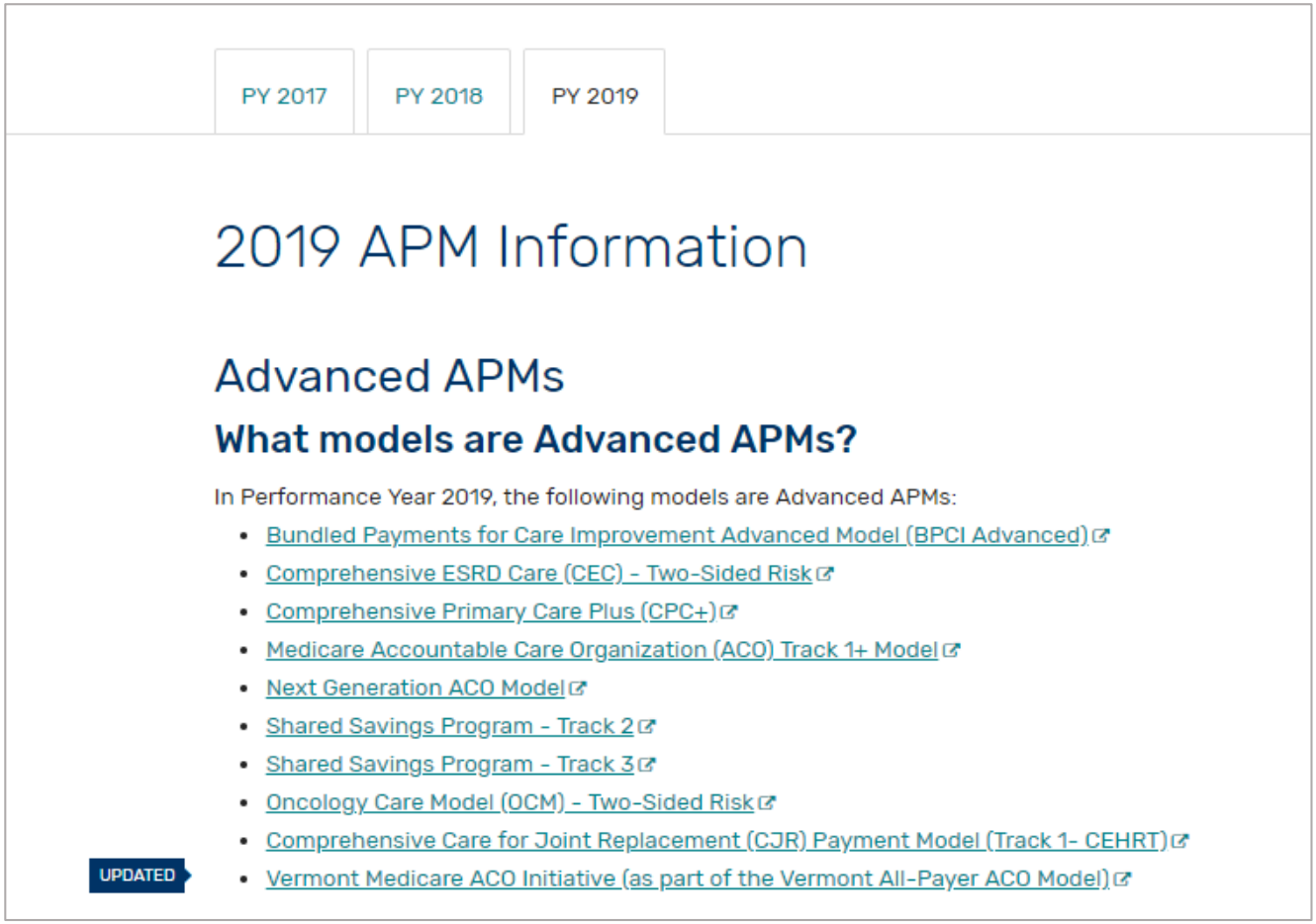


RESOURCES

APM Webpages

Advanced APMs and Links to Model Pages

Begin on **qpp.cms.gov** under the APM tab and 2019 performance year



APM Webpages

Advanced APM Policy

How do I join an Advanced APM?

1. Learn about specific Advanced APMs and how to apply.
2. Apply to an Advanced APM that fits your practice and is currently accepting applications.
3. This website will be updated as new information is available.

What happens if I am in an Advanced APM?

Once you're in an Advanced APM, you'll earn the 5 percent incentive payment in 2021 for Advanced APM participation in Performance Year 2019 if:

- You receive 50% of your Medicare Part B payments through an Advanced APM or
- See 35% of your Medicare patients through an Advanced APM

You'll need to send in the quality data required by your Advanced APM. Your model's website will tell you how to send in your Advanced APM's quality data.

If you leave the Advanced APM during Performance Year 2019, you should make sure you've seen enough patients or received enough payments through an Advanced APM to qualify for the 5% bonus. If you haven't met these thresholds, you may need to submit MIPS data to avoid a downward payment adjustment.

APM Webpages

All Payer – General Information

UPDATED

All-Payer Combination Option

Qualifying APM Participant (QP) of Other Payer Advanced APMs

Starting in the 2019 QP Performance Period, Eligible Clinicians will be able to become QPs through the All-Payer Combination Option. This Option is attainable through participation in a combination of Advanced APMs with Medicare and Other Payer Advanced APMs.

Medicaid Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019

Under the Quality Payment Program's All-Payer Combination Option, State Medicaid Agencies, Medicare Advantage and other Medicare Health Plans, as well as commercial and private payers participating in CMS-sponsored Multi-Payer payment arrangements (CMS Multi-Payer Models), may submit information to CMS about their payment arrangements with eligible clinicians.

CMS will determine whether each submitted payment arrangement constitutes an Other Payer Advanced Alternative Payment Model (APM) for a given Performance Year. If a payer chooses not to (or is not eligible to) submit its arrangements to CMS, eligible clinicians or APM Entities participating in the payment arrangement may do so. The list of determined Medicaid Other Payer Advanced APMs is available for your review, before electing to complete the Eligible Clinician Initiated Submission Form.

APM Webpages

All Payer – Eligible Clinician Initiated Submission Form

The Eligible Clinician Initiated Submission Form

The Eligible Clinician Initiated Submission Form is now available. The form may be used to request that CMS determine whether such payment arrangements are Other Payer Advanced APMs under the Quality Payment Program as set forth in 42 CFR § 414.1420. The process is called the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiation Process).

CMS will review the payment arrangement information in this form to determine whether the payment arrangement meets the Other Payer Advanced Alternative Payment Model (APM) criteria. Additional details and explanation about the submission process are available by selecting the Eligible Clinician Initiated Submission Form.

APM Webpages

All Payer – Additional Resources

- Medicare health plans (PDF 442KB)
- CMS multi-payer models (PDF 440KB)
- Guide to submitting Medicaid requests for other payer Advanced APM determinations (PDF 881KB)
- Guide for Managed Care Organizations providing State Medicaid Agencies information (PDF 378KB)
- All-Payer Combination Option & Other Payer Advanced APMs FAQs (PDF 867KB)
- All-Payer Combination Option glossary (PDF 382KB)
- Guide to Submitting CMS Multi-Payer Model Requests for Other Payer Advanced APM Determinations (PDF 1MB)
- Submitting Medicare health plan requests for determinations (PDF 1.7MB)

HELP & SUPPORT

Technical Assistance

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

Help CMS Improve the Quality Payment Program

Interested in providing feedback to CMS as we continue to improve the Quality Payment Program experience?

We're looking for participants to collaborate with us to provide feedback on all aspects related to qpp.cms.gov, including:

- Products
- Services
- Educational Materials
- Website Content

These feedback sessions typically range from 30-60 minutes and can be done over the phone, via video conference, or through email.

Email the QPP User Research Lead to participate in our feedback sessions!

Q&A

Q&A Session

To ask a question, please dial:

1-888-408-8176

If prompted, use passcode: 5457616

Press *1 to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.


DEPARTMENT OF HEALTH & HUMAN SERVICES · USA


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPENDIX

Relevant Terms

- **National Provider Identifier (NPI)** – 10-digit numeric identifier for individual clinicians.
- **Taxpayer Identification Number (TIN)** – Number used by the Internal Revenue Service to identify an organization/entity, such as a group or medical practice.
- **APM Name** – The APM in which you participate as part of your APM entity.
- **Subdivision Name (SD Name)** – the specific APM in which you participate, including track (if applicable).
- **APM Entity Name (APME)** – The name of the organization in which you participate.

NPI	APM Name	Subdivision Name	APME
1234567890	Comprehensive Primary Care Plus Model	CPC+ - Medical Home	Sample Family Practice

Additional Participation Terms

- **APM Entity** - An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.
- **Advanced APM** – A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- **Affiliated Practitioner** - An eligible clinician identified by a unique APM participant identifier on a CMS-maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.
- **Affiliated Practitioner List** - The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.
- **MIPS APM –** Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.
- **Participation List** - The list of participants in an APM Entity that is compiled from a CMS-maintained list.
- **Qualifying APM Participant (QP)** - An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity.

Illustrative Example of APMs

- Comprehensive list of APMs for 2018
- Includes the APM name, MIPS APM status, Advanced APM status, and criteria for being considered an Advanced APM.

APM	MIPS APM under the APM Scoring Standard	Medical Home Model	Use of CEHRT Criterion	Quality Measures Criterion	Financial Risk Criterion	Advanced APM
Comprehensive ESRD Care (CEC) Model (non-LDO arrangement one-sided risk arrangement)	YES	No	YES	YES	No	No
Comprehensive Primary Care Plus (CPC+) Model	YES	YES	YES	YES	YES	YES
Frontier Community Health Integration Project Demonstration (FCHIP)	No	No	No	No	No	No
Home Health Value-based Purchasing Model (HHVBP)	No	No	No	YES	No	No