

QUALITY  
PAYMENT PROGRAM  
**All-Payer  
Combination  
Option**



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## **When and where do I submit comments?**

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-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
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- For additional information, please go to:  
<http://go.cms.gov/QualityPaymentProgram>


## **KEY TOPICS:**

- 1) The Quality Payment Program and HHS Secretary's Goals**
- 2) The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs)**
- 3) Medicaid and Private Payers**
- 4) Next Steps**

# The Quality Payment Program is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

## Medicare Fee-for-Service

**GOAL 1:** **30%** 

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

**GOAL 2:** **85%** 

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018



## STAKEHOLDERS:

Consumers | Businesses  
Payers | Providers  
State Partners



Set **internal goals** for HHS



Invite **private sector payers** to match or exceed HHS goals

# Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**



**The Merit-based  
Incentive  
Payment System  
(MIPS)**

**or**

**Advanced  
Alternative  
Payment Models  
(APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

# **MERIT-BASED INCENTIVE PAYMENT SYSTEM**

# MIPS: First Step to a Fresh Start

✓ **MIPS is a new program**

- **Streamlines 3 currently independent programs** to work as one and to ease clinician burden.
- Adds a fourth component to **promote ongoing improvement and innovation to clinical activities.**



Quality



Resource use



Clinical practice  
improvement  
activities



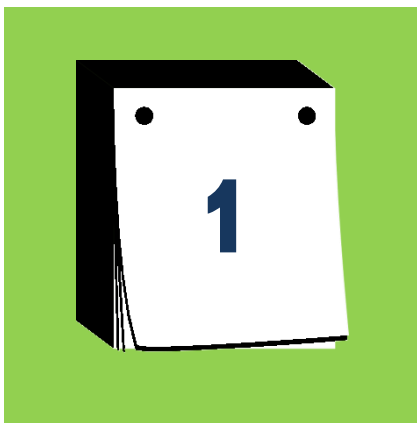
Advancing care  
information

- ✓ MIPS provides **clinicians the flexibility to choose the activities and measures** that are most meaningful to their practice to demonstrate performance.

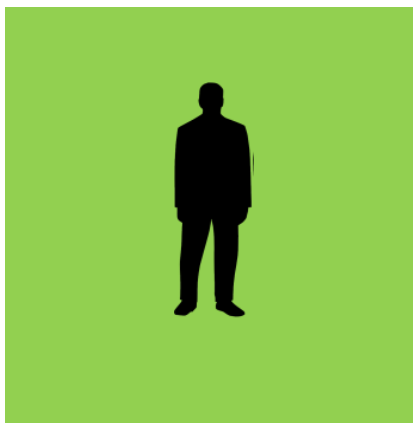


# Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



**FIRST** year of Medicare  
Part B participation



Below **low patient**  
**volume** threshold



Certain participants in  
**ADVANCED** Alternative  
Payment Models

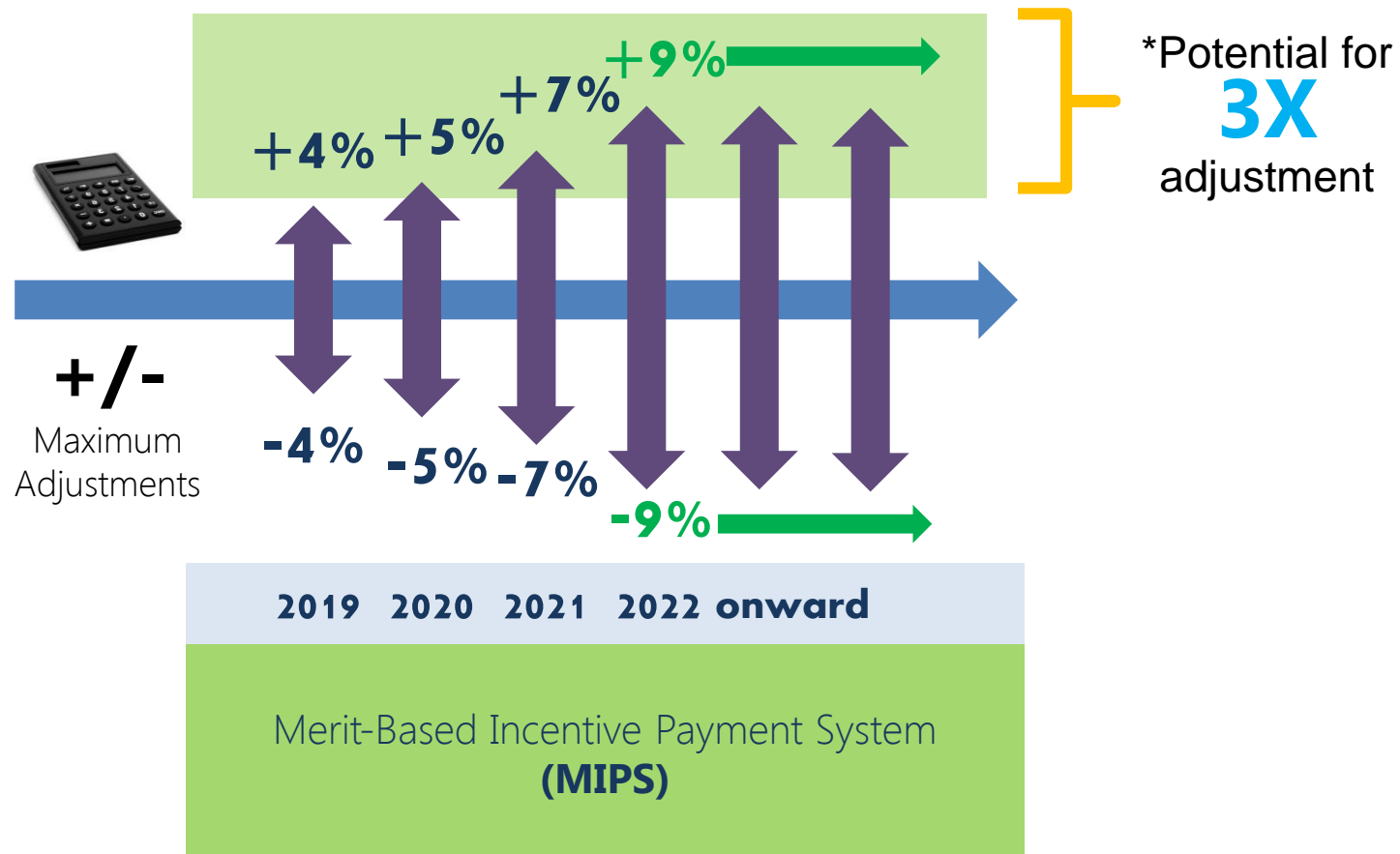


Medicare billing charges less than or equal to  
\$10,000 and provides care for 100 or fewer Medicare  
patients in one year

Note: MIPS **does not** apply to hospitals or facilities

# How much can MIPS adjust payments?

**Note:** MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



# **INCENTIVES FOR ADVANCED APM PARTICIPATION**

# What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

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

## Advanced APMs meet certain criteria.

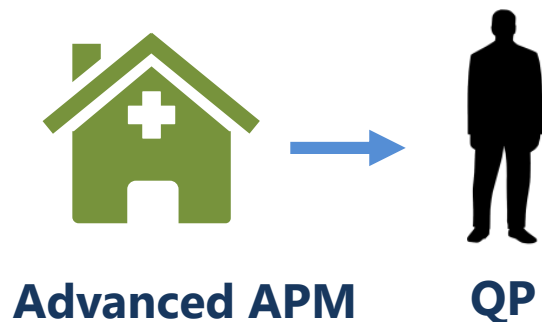


As defined by MACRA,  
Advanced APMs **must meet  
the following criteria:**

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

**NOTE:** MACRA **does NOT** change how any particular APM functions or rewards value. Instead, it **creates extra incentives** for APM participation.

# How do I become a **Qualifying APM Participant (QP)**?



You must have a **certain %** of your patients or payments through an **Advanced APM**.



Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

## PROPOSED RULE

# How do Eligible Clinicians become QPs?

### Eligible Clinicians to QP in 4 STEPS



Eligible Clinicians

QP

1. QP determinations are made at the **Advanced APM Entity level**.
2. CMS calculates a **“Threshold Score”** for each Advanced APM Entity.
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2017 performance for 2019 payment).
- ✓ Aligns with the MIPS performance period.



# **MEDICAID AND PRIVATE PAYERS**

# What about **Medicaid or private payers APMs**? Can they help me qualify to be a QP?

Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP.

**“All-Payer  
Combination  
Option”**

**IF** the “Other Payer APMs” meet criteria similar to those for Advanced APMs, CMS will consider them “Other Payer Advanced APMs”:



**Certified  
EHR use**



**Quality  
Measures**



**Financial  
Risk**

## PROPOSED RULE

# Medicaid Medical Home Models

### Medicaid Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Other Payer Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category**.



A **Medicaid Medical Home Model** is an **Other Payer APM** 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:
  - 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.

## PROPOSED RULE

### Other Payer Advanced APM Criterion 1: Requires use of CEHRT



Certified  
EHR use

**Example:** An Advanced APM has a provision in its participation agreement that at least 75% of an APM Entity's eligible clinicians must use CEHRT.



APM  
Entity



Eligible  
Clinicians

- ✓ An Other Payer Advanced APM must **require at least 75% of the eligible clinicians in each APM Entity to use CEHRT** to document and communicate clinical care.

## PROPOSED RULE

# Other Payer Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures



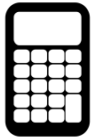
Quality  
Measures

- ✓ An Other Payer Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Other Payer Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

- ✓ **Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:
  - Quality measures that are endorsed by a consensus-based entity; or
  - Quality measures submitted in response to the MIPS Call for Quality Measures; or
  - **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**

## PROPOSED RULE

# Other Payer Advanced APM Criterion 3: Requires APM Entities to Bear More than Nominal Financial Risk



### Financial Risk

An Other Payer Advanced APM must meet **two standards**:

### Financial Risk Standard

APM Entities must  
bear risk for  
monetary losses.

&

### Nominal Amount Standard

The risk APM Entities  
bear must be of a  
certain magnitude.

- ✓ The Other Payer Advanced APM financial risk criterion is **completely met** if the APM is a **Medicaid Medical Home Model** that meets criteria comparable to Medical Home Models **expanded under CMS Innovation Center Authority**
- ✓ Medicaid Medical Home Models that **have not meet the standard above** will have **unique financial risk and nominal amount standards**.

PROPOSED RULE

## Other Payer Advanced APM Criterion 3: Financial Risk Criterion

The Other Payer  
Advanced APM  
**requires** one or  
more of the  
following **if actual  
expenditures  
exceed expected  
expenditures:**

### Financial Risk Standard

✓ **Direct payment** from the APM Entity

OR

✓ **Reduction in payment rates** to the APM  
Entity or eligible clinicians

OR

✓ **Withhold of payment** to the APM Entity  
or eligible clinicians

## PROPOSED RULE

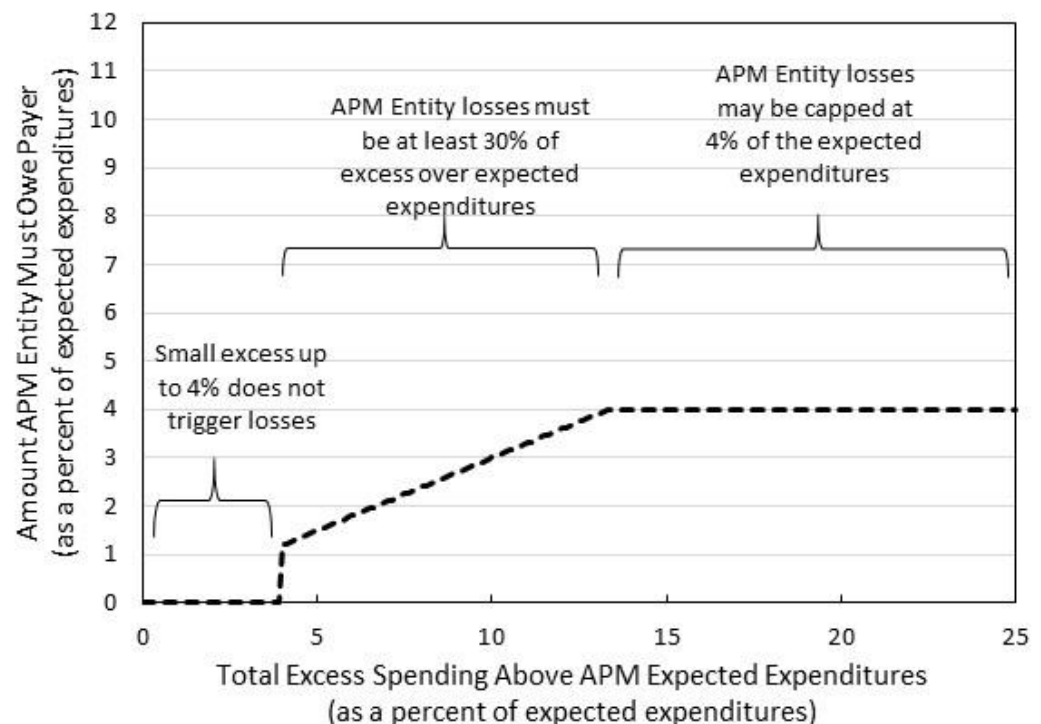
### Other Payer Advanced APM Criterion 3: Financial Risk Criterion

#### Nominal Amount Standard

The **amount of risk** under an Other Payer Advanced APM must at least meet the following components:

- ✓ **Total risk** of at least 4% of expected expenditures
- ✓ **Marginal risk** of at least 30%
- ✓ **Minimum loss ratio** (MLR) of no more than 4%.

#### Illustration of the amount of risk an APM Entity must bear in an Other Payer Advanced APM:





## PROPOSED RULE

### Other Payer Advanced APM Criterion 3: Example

The following is an example of a risk arrangement that would **meet the Other Payer Advanced APM financial risk criterion**:

An APM consists of a **two-sided** shared savings arrangement:

- ✓ If the APM Entity's actual expenditures exceed expected expenditures (the "benchmark"), then the APM Entity **must pay CMS 60% of the amount that expenditures that exceed the benchmark**.
- ✓ The APM Entity **does not have to make any payments** if actual expenditures exceed the benchmark by **less than 2%** of the benchmark amount.
- ✓ There is a **stop-loss provision** so that the APM Entity could pay up to but no more than a **total amount equal to 10%** of the benchmark.

## PROPOSED RULE

# Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Financial Risk Criterion

The Medicaid Medical Home Model **requires** one or more of the following **if actual expenditures exceed expected expenditures**:

## Medicaid Medical Home Model Financial Risk Standard

✓ **Direct payment** from the APM Entity

**OR**

✓ **Reduction in payment rates** to the APM Entity or eligible clinicians

**OR**

✓ **Withhold of payment** to the APM Entity or eligible clinicians

**OR**

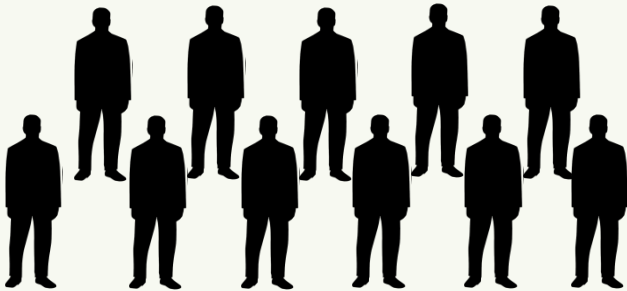
✓ **Reduces** an **otherwise guaranteed** payment or payments

## PROPOSED RULE

# Other Payer Advanced APM Criterion 3: Medicaid Medical Home Model Nominal Amount Standard

## Medicaid Medical Home Model Nominal Amount Standard:

Subject to Size Limit



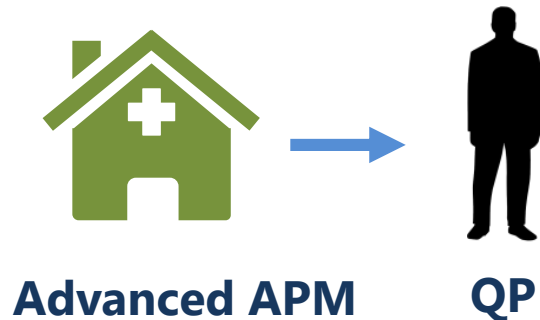
The Medicaid Medical Home Model standards only apply to APM Entities with  $\leq 50$  eligible clinicians in the APM Entity's parent organization

To be an Other Payer Advanced APM, the **amount of risk** under a Medicaid Medical Home Model must be at least the following amounts:

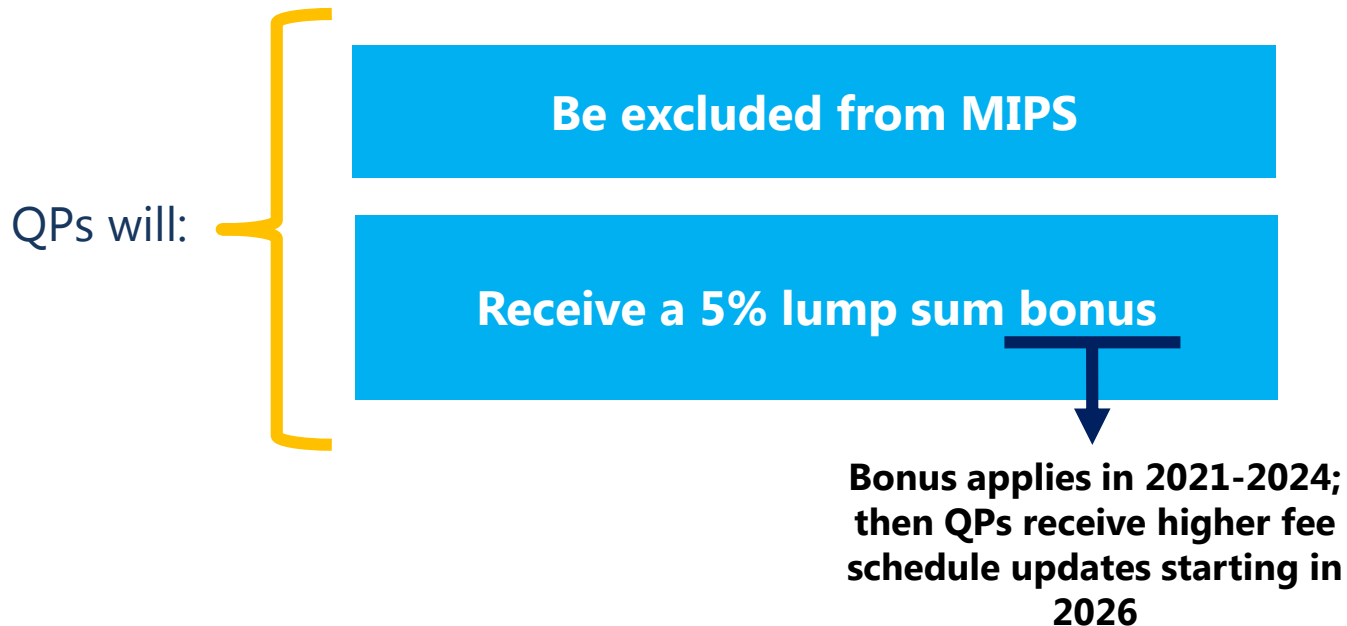
- ✓ **4% of payer revenue (2019)**
- ✓ **5% of payer revenue (2020 and later)**

# All-Payer Combination Option

## How do I become a **Qualifying APM Participant (QP)**?



You must have a **certain %** of your patients or payments through an **Advanced APMs and Other Payer Advanced APMs**.

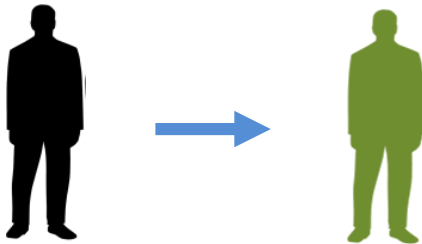


# PROPOSED RULE

## All-Payer Combination Option

### How do Eligible Clinicians become QPs?

#### Eligible Clinicians to QP in 4 STEPS



Eligible Clinicians

QP

1. Eligible clinicians submit information to CMS regarding their participation in **Other Payer Advanced APMs**.
2. CMS calculates a **“Threshold Score”** for each Advanced APM Entity, including Medicare and All-Payers (**2 stages**).
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2019 performance for 2021 payment).
- ✓ Aligns with the MIPS performance period.

**PROPOSED RULE**

# **All-Payer Combination Option**

## **How do Eligible Clinicians become QPs?**

### **STEP 1**

- ✓ **QP determinations are made at the Other Payer Advanced APM Entity level.**
- ✓ **All participating eligible clinicians are assessed together.**

**Other Payer Advanced APM**



**Other Payer Advanced APM Entities**



**Eligible Clinicians**



## PROPOSED RULE

# All-Payer Combination Option

## How do Eligible Clinicians become QPs?

### STEP 2

- ✓ CMS will calculate a percentage “Threshold Score” for each Advanced APM Entity using two methods (payment amount and patient count).
- ✓ All-Payer Combination Option is based on the sum of payments for Medicare Part B and payments from all other payers, with exceptions.
- ✓ Methods are based on professional services and beneficiaries attributed to Advanced APM Entities.
- ✓ CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.

**These definitions  
are used for  
calculating  
Threshold Scores  
under both  
methods.**

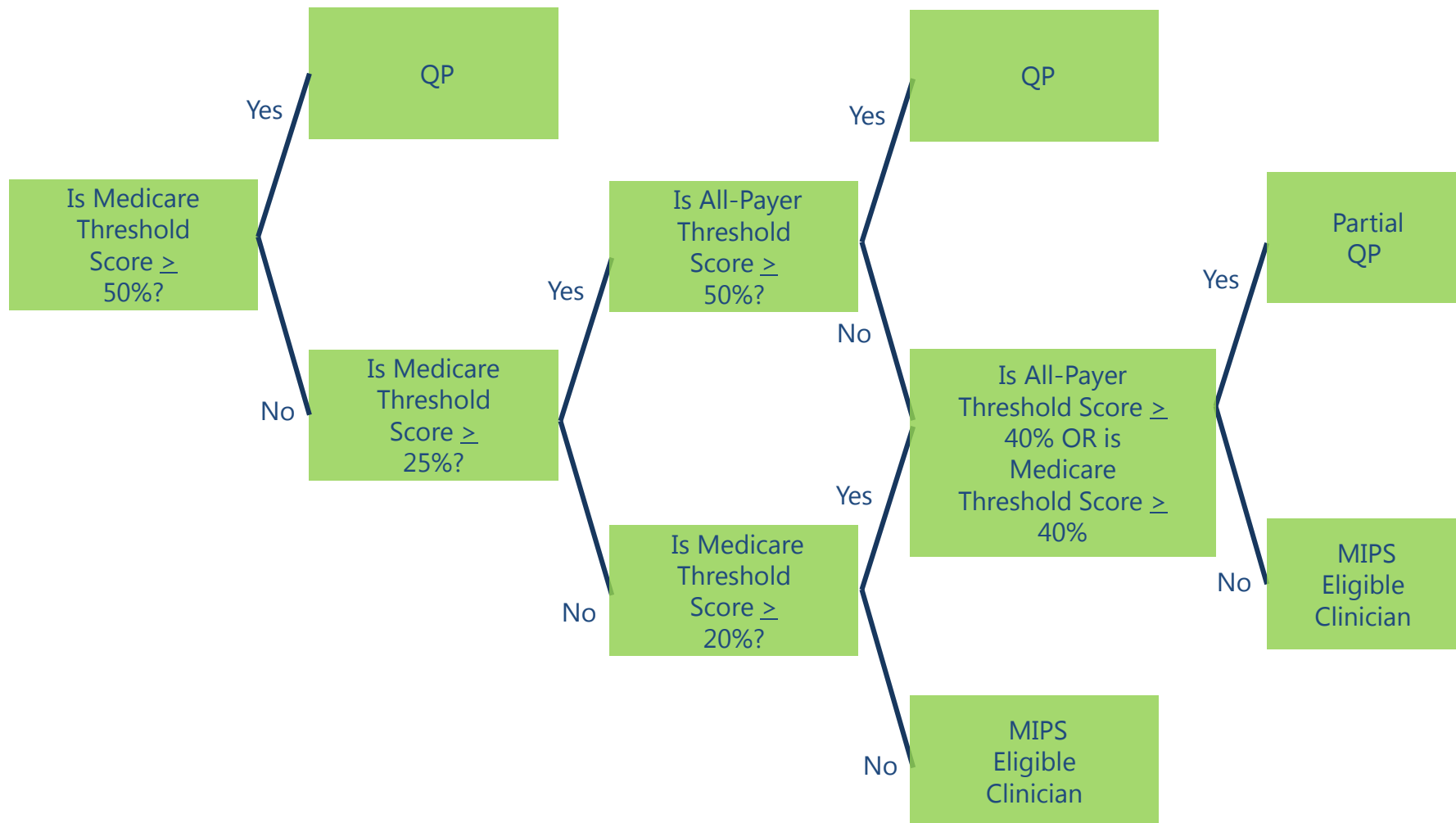
**Attributed** (beneficiaries for whose cost and quality of care the APM Entity is responsible)

**Attribution-eligible** (all beneficiaries who could potentially be attributed)

# PROPOSED RULE

## All-Payer Combination Option

2021 - 2022





# PROPOSED RULE

## All-Payer Combination Option

### How do Eligible Clinicians become QPs?

#### STEP 2 Exclusions

##### Excluded Payments and Patients:

- ✓ **Department of Defense health care programs**
- ✓ **Department of Veterans Affairs health care programs**
- ✓ **Title XIX in a state with no Medicaid Medical Home Model or APM.** In order not to adversely impact physicians who have no opportunity to participate, Title XIX payments or patients would be excluded *unless*:
  - (1) a state had at least one Medicaid Medical Home Model or APM in operation that is determined to be an Other Payer Advanced APM; and
  - (2) the relevant Advanced APM Entity is eligible to participate in at least one such Other Payer Advanced APM, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs.

# PROPOSED RULE

## All-Payer Combination Option

### How do you calculate the Medicare Threshold Score?

#### STEP 2 – STAGE 1

- ✓ The two methods for calculation are Payment Amount Method and Patient Count Method.
- ✓ The two stages for calculating are Medicare first, then all-payers.

#### Payment Amount Method

$$\frac{\text{\$ \$ \$ for Part B professional services to attributed beneficiaries}}{\text{\$ \$ \$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$



**Payments**

#### Patient Count Method

$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score \%}$$



**Patients**

# PROPOSED RULE

## All-Payer Combination Option

### How do you calculate the All-Payer Threshold Score?

#### STEP 2 – STAGE 2

- ✓ If the Medicare Threshold Score is not above the QP threshold, then calculate the All-Payer Threshold Score.

Payment Amount Threshold Score		Patient Count Threshold Score	
<div> <div> <div>\$\$\$ for Part B professional services to <b>attributed beneficiaries</b></div> <hr/> <div>\$\$\$ for Part B professional services to <b>attribution-eligible beneficiaries</b></div> </div> <div>+</div> <div> <div>\$\$\$ under the terms of <b>Other Payer Advanced APMs</b></div> <hr/> <div>\$\$\$ for from <b>all other payers*</b></div> </div> </div>		<div> <div># of <b>attributed beneficiaries</b> given Part B professional services</div> <hr/> <div># of <b>attribution-eligible beneficiaries</b> given Part B professional services</div> </div> <div>+</div> <div> <div># of <b>patients</b> given services under <b>Other Payer Advanced APMs</b></div> <hr/> <div># of <b>patients</b> given services under <b>all other payers*</b></div> </div>	


# PROPOSED RULE

## All-Payer Combination Option


### How do Eligible Clinicians become QPs?

#### STEP 3

- ✓ The All-Payer Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.

All-Payer Combination Option – Payment Amount Method										Payments 
Payment Year	2019	2020	2021		2022		2023		2024+	
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%

All-Payer Combination Option – Patient Count Method										Patients 
Payment Year	2019	2020	2021		2022		2023		2024+	
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	35%	50%	35%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	25%	35%	25%

# PROPOSED RULE

## All-Payer Combination Option

### How do Eligible Clinicians become QPs?

#### STEP 4

- ✓ **All the eligible clinicians** in the Other Payer Advanced APM Entity **become QPs** for the payment year.



Find additional information about the Quality Payment Program, including fact sheets, upcoming webinars and more at:  
<http://go.cms.gov/QualityPaymentProgram>

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