



# Understanding the QPP All-Payer Combination Option



The webinar will begin at 2:00 pm ET.

January 29, 2021

# Housekeeping

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1. Speakers will present for about 45 minutes
2. Q&A will take the remainder of the time
  - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
  - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question. Please make sure you have dialed in on the telephone and used your audio pin to connect.
3. Webinar is being recorded
  - Slides and recording will be available on the NAACOS website within 24 hours.

# Speakers



**Allison Brennan**

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# MACRA Resources

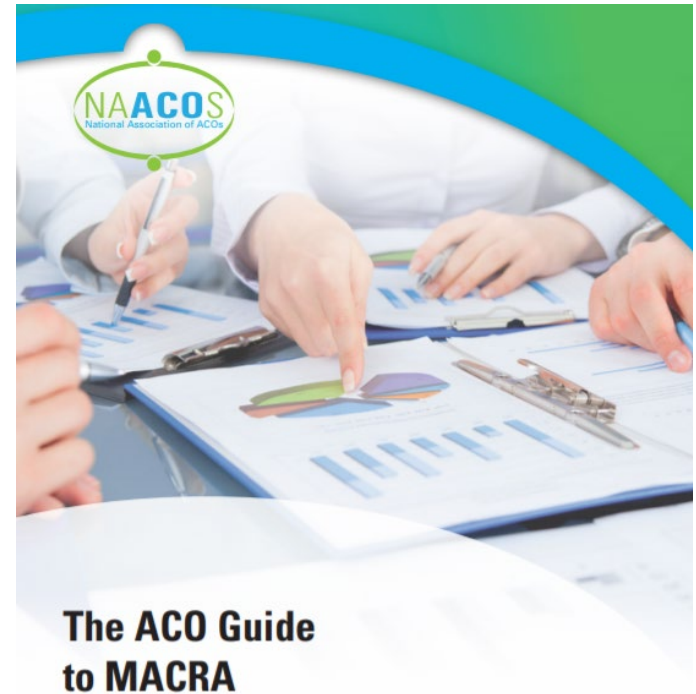
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NAACOS' [resource](#) *The ACO Guide to MACRA* is an in-depth guide that reviews everything that ACOs need to know about MACRA implementation

NAACOS [resource](#) details Advanced APM QP calculations compared to ACO data and calculations

Other NAACOS and CMS MACRA resources, updates and comment letters available on our [MACRA page](#)



Quality Payment  
PROGRAM

**2021 ALL-PAYER  
COMBINATION  
OPTION WEBINAR**



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*This publication is a general summary that explains certain aspects of the Medicare Program, but 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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# Presentation Overview



- Overview of Alternative Payment Models (APMs) and Advanced APMs
- All-Payer Combination Option Basics
- Other Payer Advanced APMs
- All-Payer Combination Option Eligibility
- QP Determination Process
- Help and Support
- Question & Answer



# 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

# Alternative Payment Models (APMs)



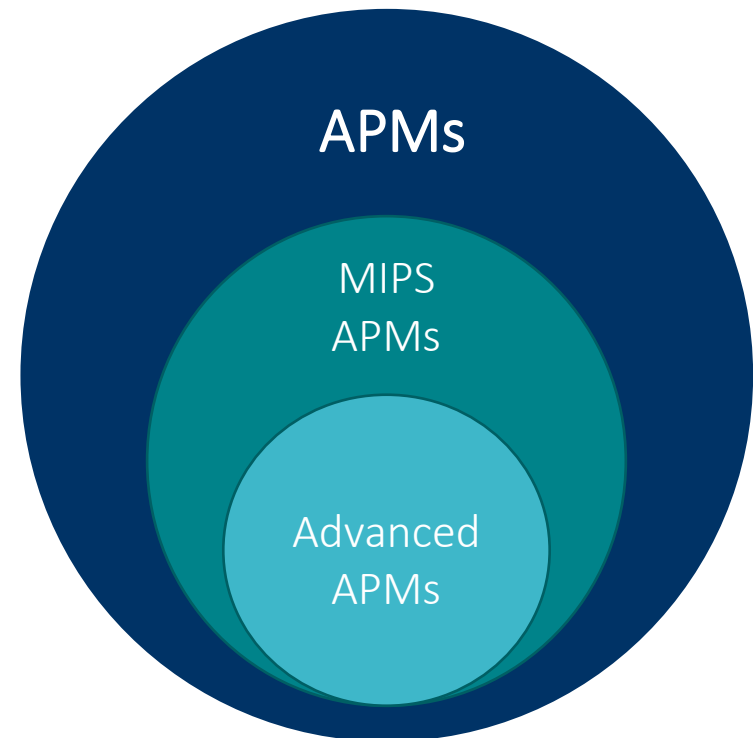
## Overview

- APMs reward healthcare providers for delivering value-based care. They can apply to a specific:
  - Health condition, like end-stage renal disease
  - Care episode, like joint replacement
  - Population, like primary care providers in Maryland

### *Types of APMs*

- APMs
- MIPS APMs
- Advanced APMs

**Please note:** The designation of the APM does not affect a clinician's eligibility for MIPS. APM participants will still need to participate in MIPS unless they receive QP status or are otherwise exempt.





# ADVANCED APMs

# Advanced APMs

Clinicians and practices can:

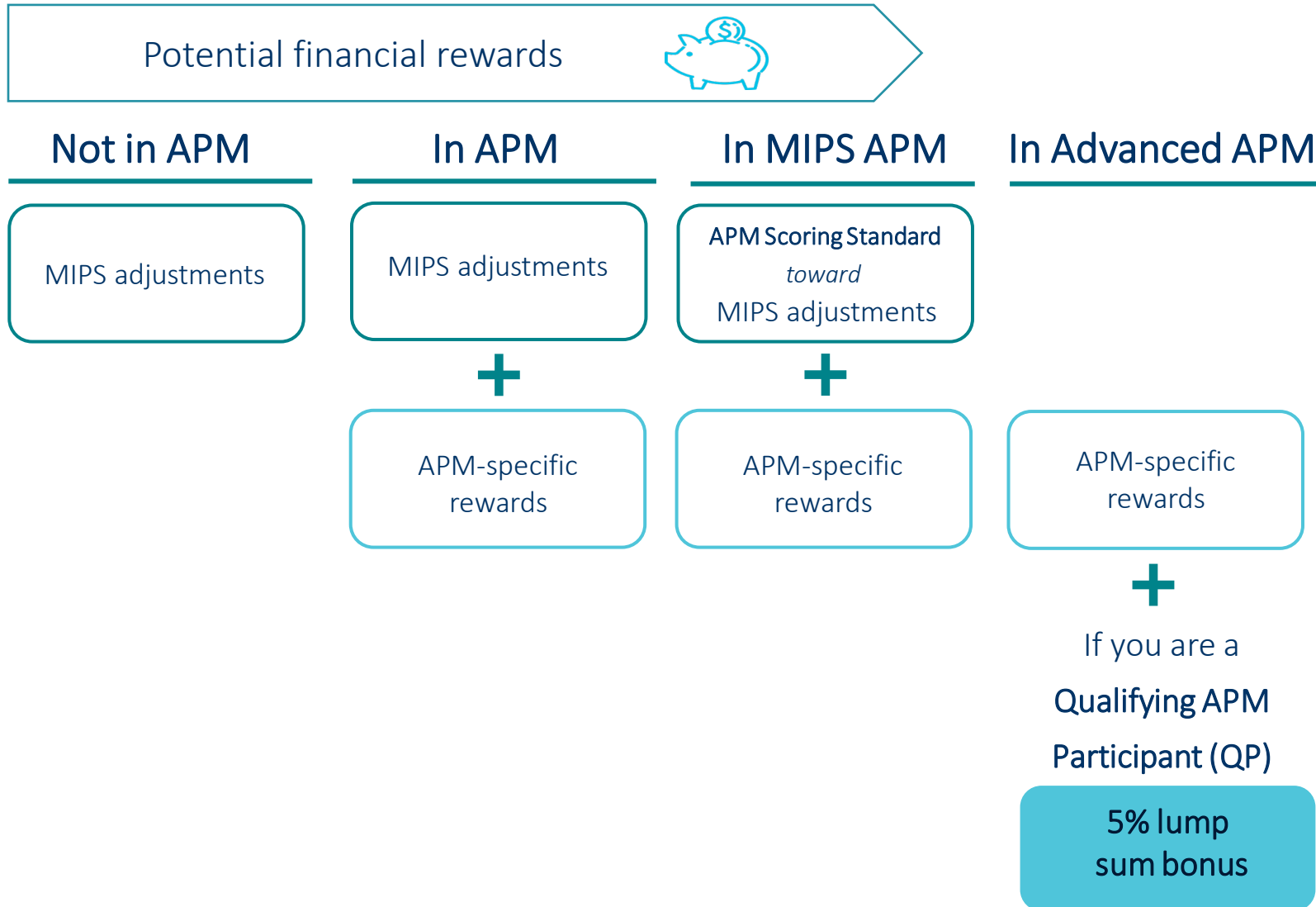
- Receive **greater rewards** for taking on some risk related to patient outcomes.



*“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

## Advanced APM Criteria



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**.

# Advanced APMs

## Terms to Know



- **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** – Advanced APMs must meet three specific criteria: Require CEHRT use, base payment on MIPS-comparable quality measures, and either be a Medicare Medical Home or require participants to bear a more than nominal amount of risk.
- **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** – APMs that meet these criteria: 1) APM entities that participate in the APM under an agreement with CMS; 2) APM bases payment incentives on performance (either at the APM entity or eligible clinician level), on cost/utilization, and quality measures.
- **Participation List** - The list of participants in an APM Entity that is participating in an Advanced APM, 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.

# Advanced APMs



## Current List of Advanced APM

Bundled Payments for Care Improvement (BPCI) Advanced Model
Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
Comprehensive Primary Care Plus (CPC+) Model
Comprehensive ESRD Care (CEC) Model (LDO arrangement and Non LDO Two-Sided Risk Arrangement)
Direct Contracting (DC) Model - Professional PBP and Global PBP
Kidney Care Choices Model: Comprehensive Kidney Care Contracting (CKCC) Graduated, Professional, and Global Options
Kidney Care Choices Model: Kidney Care First (KCF)
Maryland Total Cost of Care Model (Care Redesign Program and Primary Care Program)
Medicare Accountable Care Organization (ACO) Track 1+ Model
Medicare Shared Savings Program – Track 2, Track 3, Level E of the BASIC track, the ENHANCED track
Next Generation ACO Model
Oncology Care Model (OCM) – Two-Sided Risk
Primary Care First (PCF) General Option, Seriously Ill Population (SIP) Option (CEHRT)
Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)



# ALL-PAYER COMBINATION OPTION

Basics

# All-Payer Combination Option

## Overview



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



### Medicare Option

- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs with Medicare.



### All-Payer Combination Option

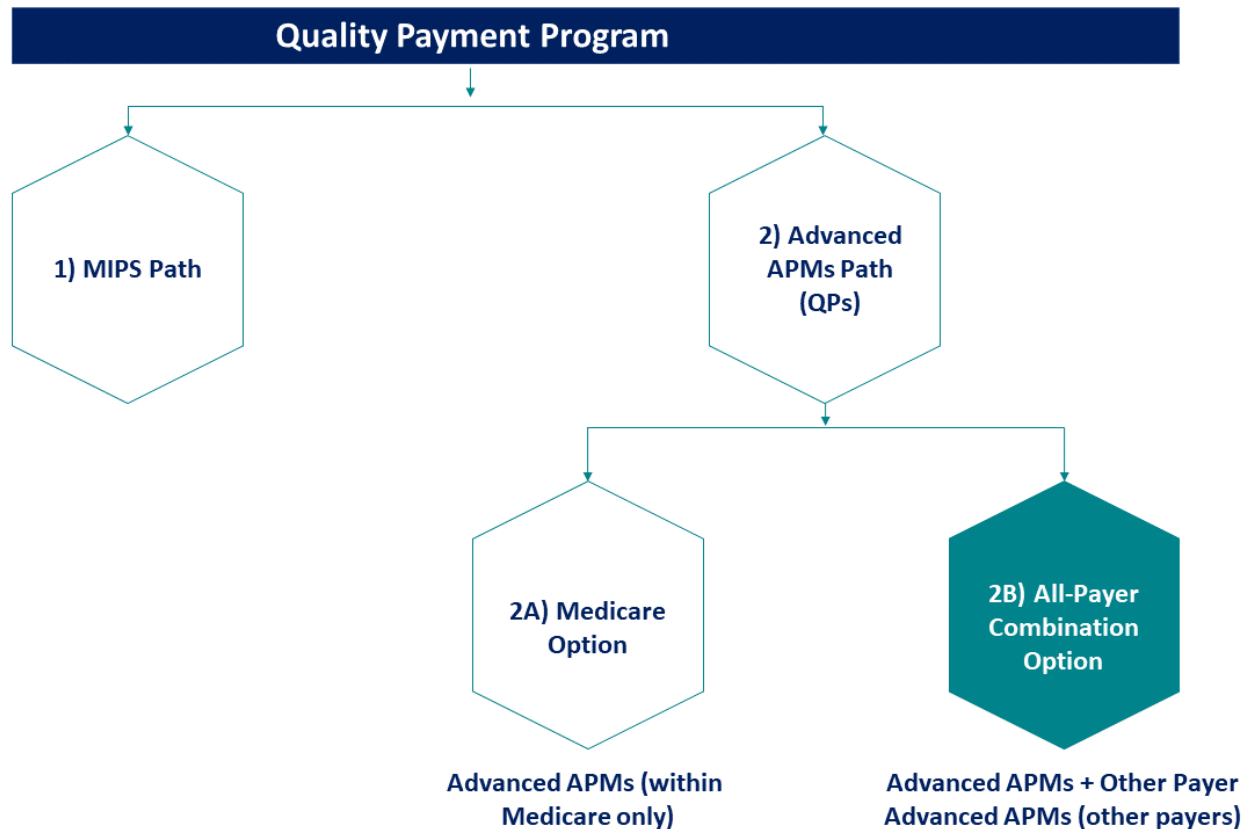
- Eligible clinicians achieve QP status based on a combination of participation in:
  - Advanced APMs with Medicare; and
  - Other Payer Advanced APMs offered by other payers.

# All-Payer Combination Option



## Basics

- The Medicare Advanced APM option has been available since 2017 and the All-Payer Combination Option was new for the 2019 performance year. 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.





# OTHER PAYER ADVANCED APMS

# Other Payer Advanced APMs



## Basics

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 APMs



## 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:

Medicare Advanced APMs	Other Payer Advanced APMs
Requires at least 75 percent of eligible clinicians to <b>use Certified Electronic Health Record Technology (CEHRT)</b> to document and communicate clinical care information.	Requires at least 75 percent of eligible clinicians to <b>use CEHRT</b> to document and communicate clinical care information
Provides payment for covered professional services based on <b>quality measures comparable to those used in the Merit-based Incentive Payment System (MIPS)</b> Quality performance category	Provides payment for covered professional services based on <b>quality measures comparable to those used in the MIPS</b> Quality performance category
Either: (1) is a <b>Medical Home Model</b> expanded under <a href="#">CMS Innovation Center</a> authority OR (2) requires participants to <b>bear a significant financial risk</b>	Either: (1) is a Medicaid Medical Home Model that meets criteria that are comparable to a <b>Medical Home Model expanded</b> under CMS Innovation Center authority, OR (2) requires participants to bear <b>more than nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures</b>

# Other Payer Advanced APMs

## Financial Risk Standard



For payment arrangements other than Medicaid Medical Home Models, to be an Other Payer Advanced APM, an APM Entity must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the payment arrangement exceed expected expenditures during a specified period of performance do one or more of the following:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians;  
or
- Require direct payment by the APM Entity to the payer. For this risk standard, it is not sufficient for the payment arrangement to require reductions in otherwise guaranteed payments.

# Other Payer Advanced APMs



## Nominal Risk 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
  - 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.



# OTHER PAYER ADVANCED APMS DETERMINATIONS

# Other Payer Advanced APM Determinations

## Payment Arrangement Options



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.

Eligible clinicians who are QPs for a year under the All-Payer Combination Option are not subject to the MIPS reporting requirements and qualify for the 5 percent APM incentive bonus in the 2023 payment year.

# Other Payer Advanced APM Determinations

## Payment Arrangement Options



### 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 is available for Medicaid, Medicare Health Plans (e.g., Medicare Advantage, PACE plans, etc.) and Other commercial payers including those participating in CMS Multi-Payer Models.
- Guidance materials and the Payer Initiated Submission Form will be made available on our website 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.

# Other Payer Advanced APM Determinations

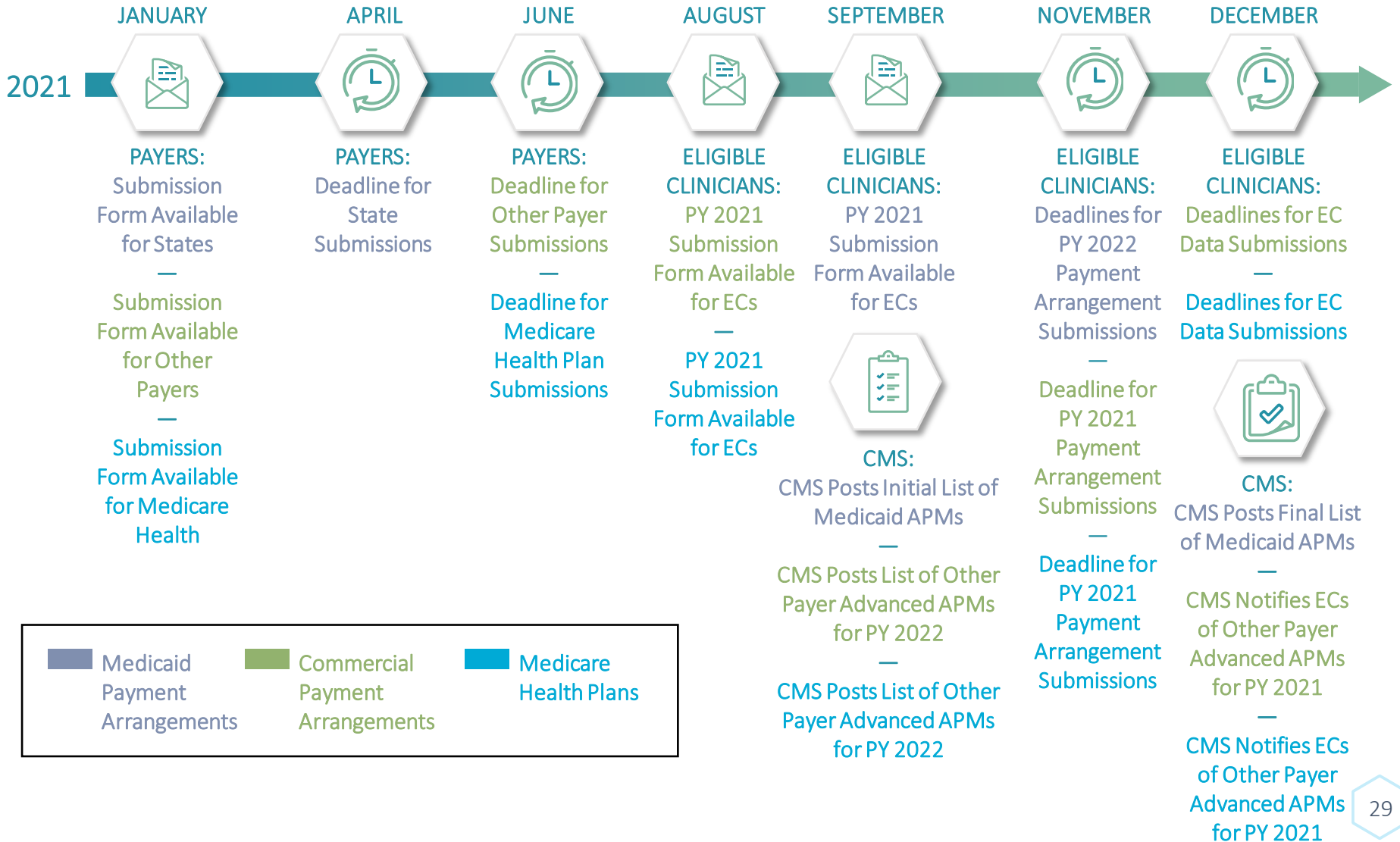
## Payment Arrangement Options



### 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.
- Submission forms can be found at: <https://app1.innovation.cms.gov/qpp>

# Complete Timeline





# ALL-PAYER COMBINATION OPTION ELIGIBILITY

# Qualifying APM Participant (QP) Determinations



QP thresholds are frozen for the next two years. They will be the same as they were in 2020.



Performance Year	2020	2021	2022
Payment Year	2022	2023	2024
QP Payment Amount Threshold	50%	50%	50%
QP Patient Count Threshold	35%	35%	35%

If you are not determined to be a QP or a Partial QP, you will be required to participate in MIPS and will be subject to a MIPS Final Score and payment adjustment, unless you are otherwise excluded. Visit [qpp.cms.gov](https://qpp.cms.gov) to learn more about MIPS.

# QP Through All-Payer Combination Option



1

Be a Medicare Provider

2

Be an Eligible Clinician in an Advanced APM Entity  
[List of Medicare Advanced APMs](#)

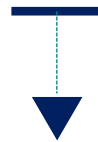
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Be an Eligible Clinician or APM Entity in an [Other Payer Advanced APM](#)

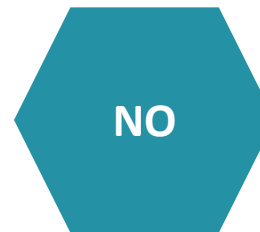
# All-Payer Eligibility Decision Tree



Are You a Medicare Provider?



Next Slide



Not Eligible

# All-Payer Eligibility Decision Tree



## Are You a Medicare Advanced Alternative Payment Model Participant?

### Don't Know? See List Below.

Bundled Payments for Care Improvement (BPCI) Advanced

Comprehensive ESRD Care (CEC) —Two-Sided Risk

Comprehensive Primary Care Plus (CPC+)

Medicare Accountable Care Organization (ACO) Track 1+ Model

Next Generation ACO Model

Kidney Care Choices Model: Comprehensive Kidney Care Contracting (CKCC) Graduated, Professional, and Global Options

Medicare Shared Savings Program —Track 2, Track 3, Level E of the BASIC track, the ENHANCED track

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Primary Care First (PCF) General Option, Seriously Ill Population (SIP) Option (CEHRT)

Oncology Care Model (OCM) —Two-Sided Risk

Maryland All-Payer Model (Care Redesign Program)

Maryland Total Cost of Care Model (Maryland Primary Care Program)

Maryland Total Cost of Care Model (Care Redesign Program)

Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

Direct Contracting (DC) Model - Professional PBP and Global PBP

Kidney Care Choices Model: Kidney Care First (KCF)

YES

NO

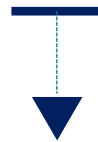
Not Eligible

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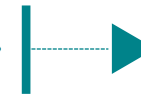
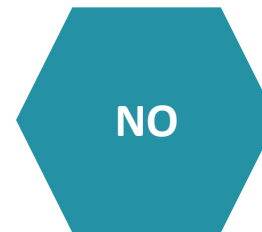
# All-Payer Eligibility Decision Tree



Participate in Value Based Payment Arrangement with Other Payers?



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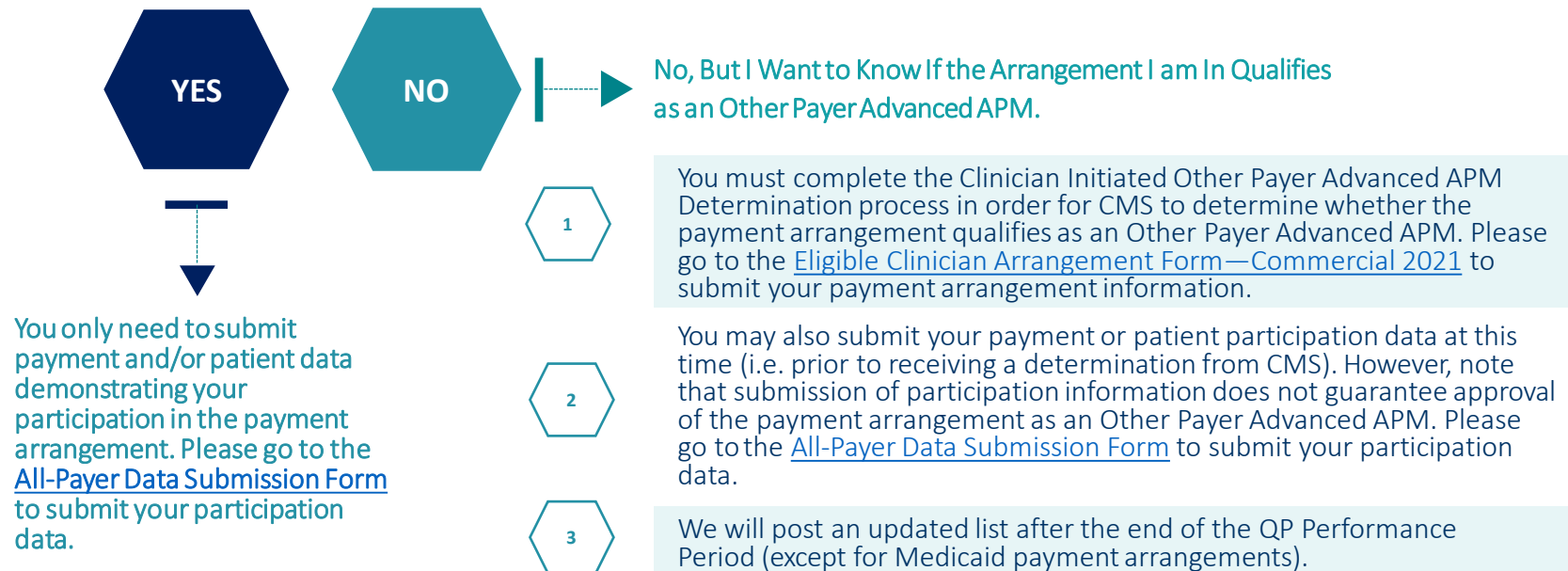


Not Eligible

# All-Payer Eligibility Decision Tree



## In a CMS-Approved Value Based Payment Arrangement? (Other Payer Advanced APM)





# QP DETERMINATION PROCESS

# 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 2021, 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



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

\$\$\$ 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



# 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.

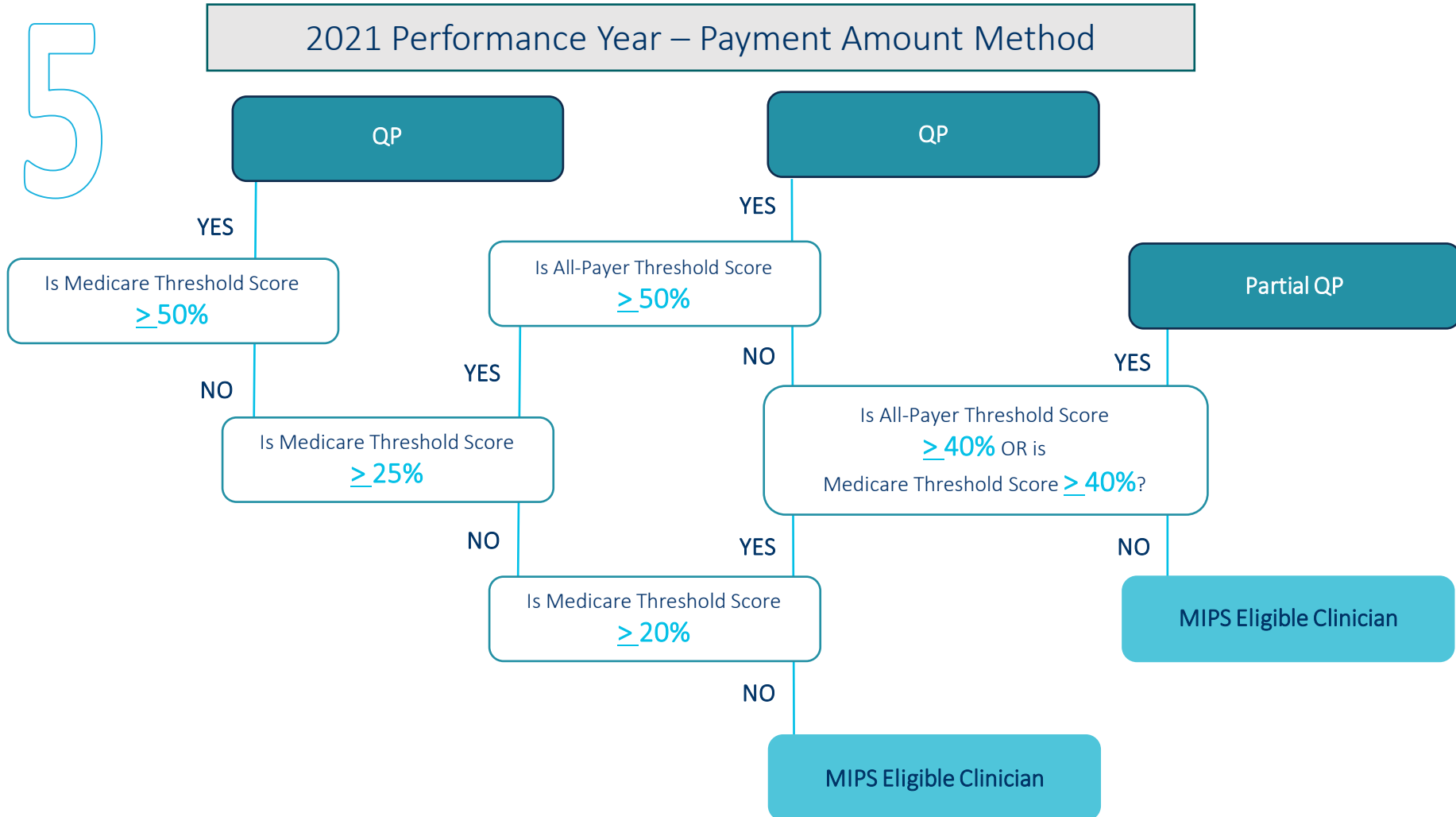
In the case where the Medicaid APM is implemented at the sub-state level, Title XIX (Medicaid) payments and associated patients will be excluded unless CMS determines that there is at least one Medicaid APM available in the county where the eligible clinician sees the most patients and that eligible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

# All-Payer Combination Option

## QP Determination Process



5





# HELP & SUPPORT

# All-Payer Combination Option

## Resources



- [Webpage](#)
- [FAQs](#)



# Q&A SESSION



**Thank you!**

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