Quality Payment Program – All Payer Combination Option/Other Payer Advanced APM Policy

November 15, 2017

Click here for CMS' final rule with comment period. Discussion of the All-Payer Combination Option is on pages 984-1147. QP Payment Amount Thresholds and QP Patient Count Thresholds are on page 985. The QP Determination Decision Tree is on page 986.

Other Payer Advanced APM Determinations

Starting in Performance Year 2019, payers can submit payment arrangements authorized under Title XIX Medicaid, Medicare Health Plan payment arrangements (including Medicare Advantage) and payment arrangements aligned with a CMS Multi-Payer Model and request that CMS make Other Payer Advanced APM determinations before the relevant QP performance period. Payer Initiated process is voluntary. CMS will make guidance available regarding the Payer Initiated process for each payer type.

If CMS hasn't already made the determinations through the Payer Initiated Process, eligible clinicians may submit information and data about their payment arrangements to CMS and ask CMS to make Other Payer Advanced APM determinations.

Other Payer Advanced APM determinations are in effect for one year. A list of Other Payer Advanced APMs will be posted on CMS' website prior to the start of the relevant QP performance period.

Remaining other payers, including commercial and other private payers that are not states, Medicare Health Plans or payers with arrangements that are aligned with a CMS Multi-Payer Model, may request that CMS determine whether they are Other Payer Advanced APMs starting prior to the 2020 QP Performance Period and each year thereafter.

QP Performance Period

QP performance period starts on January 1 and ends on August 31 of the calendar year that is two years prior to the payment year. CMS will make QP determinations based on 3 snapshot dates: January 1 - March 31, January 1- June 30 and January 1 -August 31. An eligible clinician needs to meet the relevant QP or Partial QP threshold under the All-Payer Combination Option on one of these dates and CMS will use data for the same time periods for Medicare and other payer payments or patients in making QP determinations. CMS will notify eligible clinicians of their QP Status under the All-Payer Combination Option as soon as practicable.

QP Determinations Under the All-Payer Combination Option

Eligible clinicians will have the option to be assessed at the individual or the APM Entity level. If the Medicare threshold score is higher for an eligible clinician when calculated for the APM Entity group than when calculated for the individual eligible clinician, then CMS will make the QP determination using a weighted Medicare threshold score that will be factored into the All-Payer Combination Option threshold score calculated at the individual eligible clinician level.

If CMS receives a request for QP determination from an individual eligible clinician and also separately receives a QP determination request from that individual eligible clinician's APM Entity, CMS will make a determination at both levels. The eligible clinician could become a QP on the basis of either of the two determinations. CMS is requesting comment on whether in future rulemaking it should also add a third 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.

Eligible clinicians who are Partial QPs for the year under the All-Payer Combination Option would make the election whether to report to MIPS and then be subject to the MIPS reporting requirements and payment adjustments.

For the payment amount method, CMS would first make a calculation under the Medicare Option. If the minimum threshold score for the Medicare Option were met so that the eligible clinician could become a QP under the All-Payer Combination Option, and did not become a QP under the Medicare Option, CMS would make calculations under the All-Payer Combination Option. The numerator would be the aggregate of all payments from all payers, except those excluded, that are made or attributable to the eligible clinician, under the terms of all Advanced APMs and Other Payer Advanced APMs. The denominator would be the aggregate of all payments from all payers, except those excluded, that are made or attributed to the eligible clinician.

For the patient count method, for each APM Entity CMS would count each unique patient one time in the numerator and one time in the denominator. The same patient could be counted separately in the numerator and denominator of two separate payers (for example, Medicare and Medicaid).

APM Entities or eligible clinicians must submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination, as well as the payment amount and patient count information for CMS to make QP determinations by December 1 of the calendar year that is 2 years prior to the payment year.

If you have any questions, please contact our General Counsel Diane Turpin at 202-266-2600.