

Quality Payment Program

**2020 All-Payer Combination Option & Other Payer Advanced Alternative Payment Models
Frequently Asked Questions**



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Note: The QP thresholds for payment years 2023 and 2024 are frozen at 50% for the payment amount threshold and 35% for the patient count threshold (note that the applicable performance years will be 2021 and 2022). The partial QP thresholds have also been frozen at the same levels used for the 2022 payment year and 2020 performance year.



Introduction

This Frequently Asked Questions (FAQ) document answers questions regarding the All-Payer Combination Option and Other Payer Advanced Alternative Payment Models (APMs) under the Quality Payment Program. For detailed, payer-specific information on the All-Payer Combination Option, please visit the [All-Payer Advanced APMs](#) webpage.

What's the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended Medicare's Sustainable Growth Rate, a formula for updating Medicare Physician Fee Schedule payment rates that threatened clinicians with potential payment cliffs, and replaced it with fixed annual updates that can be modified for individual clinicians based on a Quality Payment Program. There are 2 paths in the Quality Payment Program:

1. The [Merit-based Incentive Payment System \(MIPS\)](#), which adjusts Medicare payments based on combined performance on measures of Quality, Cost, Improvement Activities, and Promoting Interoperability), or
2. [Advanced APMs](#) with Medicare, under which an eligible clinician who meets threshold participation levels in their Advanced APM is determined to be a Qualifying Participant (QP) and thereby earns an incentive payment.

If an eligible clinician does not meet the threshold levels of participation to become a Qualifying APM Participant (QP) and earn the incentive payment based only on participation in Advanced APMs with Medicare, they can also count their participation in Other Payer Advanced APMs to potentially become a QP for the year. Other Payer Advanced APMs include certain payment arrangements with payers other than Medicare Fee-For-Service (FFS), such as Medicaid, Medicare Health Plans (Medicare Advantage), and commercial payers.

What's the All-Payer Combination Option?

The Advanced APM path under the Quality Payment Program provides 2 ways for eligible clinicians to become QPs: the Medicare Option, which takes into account the clinician's participation solely in Medicare Advanced APMs, and the [All-Payer Combination Option](#), which takes into account the clinician's participation in Advanced APMs both with Medicare and other payers. The Other Payer Advanced APMs are payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans (including Medicare Advantage plans), payers in CMS Multi-Payer Models, and other commercial payers. The Medicare Option allows eligible clinicians to become QPs through Advanced APM participation. The All-Payer Combination Option allows eligible clinicians to become QPs through participation in a combination of Advanced APMs and Other Payer Advanced APMs.



An eligible clinician's QP status is determined on the basis of 2 thresholds for applicable Advanced APM participation, one for patient count and one for payment amounts, described elsewhere in this document. Eligible clinicians who do not meet either threshold under the Medicare Option, but who still meet a minimum threshold under the Medicare Option, may request a QP determination under the All-Payer Combination Option. Eligible clinicians who are determined to be QPs through either option will receive a 5% APM incentive payment in the payment year (2 years after the QP Performance Period year) and will not be subject to the MIPS reporting requirements or payment adjustments.

What's an Other Payer Advanced APM?

Other Payer Advanced APMs are non-Medicare Fee For Service (FFS) payment arrangements with other payers such as Medicaid, Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans), payers with payment arrangements in Aligned Other Payer Models, and other commercial and private payer arrangements that meet the criteria to be an Other Payer Advanced APM.

By statute, the criteria for payment arrangements to be Other Payer Advanced APMs are similar, but not identical, to the criteria for Advanced APMs under Medicare.

To be an Other Payer Advanced APM, payment arrangements must meet the following three criteria:

- 1. Require use of certified EHR technology (CEHRT).** The other payer payment arrangement must require at least 75% of eligible clinicians in each participating APM Entity Group to use CEHRT to document and communicate clinical care information.
- 2. Base payments for covered professional services on quality measures that are comparable to those used in the MIPS Quality performance category.** The payment arrangement must base payment on quality measures that are evidence-based, reliable, and valid, at least one of which must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.
- 3. Require participants to bear a certain amount of financial risk.** A payment arrangement meets the financial risk if actual expenditures exceed expected aggregate expenditures, or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Social Security Act.

What's the Generally Applicable Nominal Amount Standard for Other Payer Advanced APMs?

We assess whether a payment arrangement meets the generally applicable nominal amount standard to be an Other Payer Advanced APM in one of two ways depending on how the payment arrangement defines risk.

Expenditure-based Nominal Amount Standard	Revenue-based Nominal Amount Standard**
Nominal amount of risk must be: • Marginal Risk of at least 30 percent; • Minimum loss rate of no more than 4 percent; and • Total Risk of at least 3 percent of the expected expenditures the APM Entity is responsible for under the APM <i>Note: In the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, we will compare the average marginal risk rate across all possible levels of actual expenditures to the marginal risk rate.</i>	Nominal amount of risk must be: • Marginal Risk of at least 30 percent; • Minimum loss rate of no more than 4 percent; and • Total Risk of at least 8 percent of average estimated total combined revenues from the payer to providers and other entities under the payment arrangement

**Note that total combined revenues from a payer include any financial risk payments or supplemental service payments including but not limited to payments comparable to care management fee payments, shared savings payments, or other types of performance-based incentive payments typically used in APMs and Advanced APMs with Medicare.

The revenue-based standard will apply only to models in which risk for APM Entities is expressly defined in terms of revenue and is an alternative option to the expenditure-based nominal amount standard.



Is there an All-Payer QP Performance Period?

The performance period is the same for both the Medicare Option and the All-Payer Combination Option, and is January 1 through August 31 of the calendar year that is two years prior to the payment year. Just as we do in the Medicare Option, we will make QP determinations using the data submitted by eligible clinicians or APM Entities for 1 of 3 snapshot dates: March 31, June 30, and August 31.

What's the Other Payer Advanced APM Determination Process?

To collect the necessary information and determine whether an Other Payer payment arrangement meets the criteria to be an Other Payer Advanced APM, we will use the following two processes:

1. Payer Initiated Other Payer Advanced APM Determination Process; (Payer Initiated Process); and
2. Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process)

What's the Payer Initiated Process?

CMS will allow certain payers—State Medicaid Agencies,¹ Medicare Advantage and other Medicare Health Plans, and payers participating in CMS Multi-Payer Models²—to voluntarily submit information to CMS about their payment arrangements with eligible clinicians. This Payer Initiated Process is designed to reduce reporting burden for APM Entities and eligible clinicians, while allowing CMS to collect the information it needs to make Other Payer Advanced APM determinations. Payers that choose to participate would assist their networks of clinicians by carrying out the task of sending the information regarding the payment arrangement to CMS.

If a payer chooses not to submit their payment arrangement information to CMS (or isn't eligible to do so), then eligible clinicians or APM Entities participating in the payment arrangement would be able to do so instead. That process, known as the Eligible Clinician Initiated Process, is explained in more detail on the following pages.

¹ State Medicaid Agencies can also submit information for Medicaid Managed Care health plans.

² Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) Plans.

How does the Payer Initiated Process work?

Under the Payer Initiated Process, payers would submit payment arrangement information such as:

- Name of Payer and payment arrangement;
- Description of how the payment arrangement meets the Other Payer Advanced APM criteria (CEHRT use, quality measure use, and financial risk); and
- Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation)

We'll review the submitted payment arrangement information to determine whether the payment arrangement meets the Other Payer Advanced APM criteria. If payers don't send in all the information we need, we'll let them know and ask that they send us more information. Once we have what we need and review it, we'll post the results of Other Payer Advanced APM determinations in the [2020 and 2019 Comprehensive List of APMs](#). For arrangements submitted under the Payer Initiated Process, this would happen prior to the beginning of the QP Performance Period. Payers will be able to request review of multiple payment arrangements they have through the Payer Initiated Process, though CMS will make separate determinations for each of those arrangements.

What's the Eligible Clinician Initiated Process?

The Eligible Clinician Initiated Process is designed to provide eligible clinicians and APM Entities with an opportunity to submit information to CMS about any payment arrangements they are participating in when their payer does not do so (or isn't eligible to).

A major difference between the Payer Initiated and Eligible Clinician Initiated Processes is that the Payer Initiated Process happens before the QP Performance Period, and the Eligible Clinician Initiated Process generally happens afterward (except for Medicaid payment arrangements, where both the Payer Initiated Process and the Eligible Clinician Initiated Process happen before the QP Performance Period).

After the QP Performance Period, if we haven't already determined that a payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or their APM Entities) have the option to submit their information and ask for a determination.

How does the Eligible Clinician Initiated Process work?

Like payers, eligible clinicians would submit payment arrangement information:

- Name of Payer and Payment Arrangement;
- Description of how the payment arrangement meets the Other Payer Advanced APM criteria (CEHRT use, quality measure use, and financial risk); and
- Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation).

If the submitted information isn't complete, we'll let the eligible clinician or APM Entity know and ask them to send in the information we need. Once we have all the information we need, we'll post the results of Other Payer Advanced APM determinations on the [Quality Payment Program Resource Library](#). For payment arrangements submitted under the Eligible Clinician Initiated Process, we'll post an updated list after the end of the QP Performance Period (except for Medicaid payment arrangements).

How will CMS calculate the payment amounts and patient counts under the All-Payer Combination Option?

Calculation of the Threshold Score under the All-Payer Combination Option is based on participation in both Advanced APMs and Other Payer Advanced APMs. We'll calculate these threshold Scores in two stages – first under the Medicare Option and second, if requested, under the All-Payer Combination Option, applying the most advantageous result to eligible clinicians.

The Threshold Scores calculated based on payment amounts and patient counts under the All-Payer Combination Option will be compared to the QP Thresholds in the tables below to determine whether eligible clinicians are QPs for the year. The eligible clinicians are then notified of their QP status. The payment amount and patient threshold counts are displayed in Tables 1 and 2 below.

Table 1: All-Payer Combination Option – Payment Amount Method

Payment Year	2020	2021	2022	2023	2024
QP Payment Amount Threshold					
Medicare Minimum	N/A	25%	25%	25%	25%
Total	N/A	50%	50%	50%	50%
Partial QP Payment Amount Threshold					
Medicare Minimum	N/A	20%	20%	20%	20%
Total	N/A	40%	40%	40%	40%

*Total includes Advanced APM (Medicare FFS) and Other Payer Advanced APM (Medicaid and other payers) participation

Table 2: All-Payer Combination Option – Patient Count Method

Payment Year	2020	2021	2022	2023	2024
QP Patient Count Threshold					
Medicare Minimum	N/A	20%	20%	20%	20%
Total	N/A	35%	35%	35%	35%
Partial QP Patient Count Threshold					
Medicare Minimum	N/A	10%	10%	10%	10%
Total	N/A	25%	25%	25%	25%

*Total includes Advanced APM (Medicare FFS) and Other Payer Advanced APM (Medicaid and other payers) participation

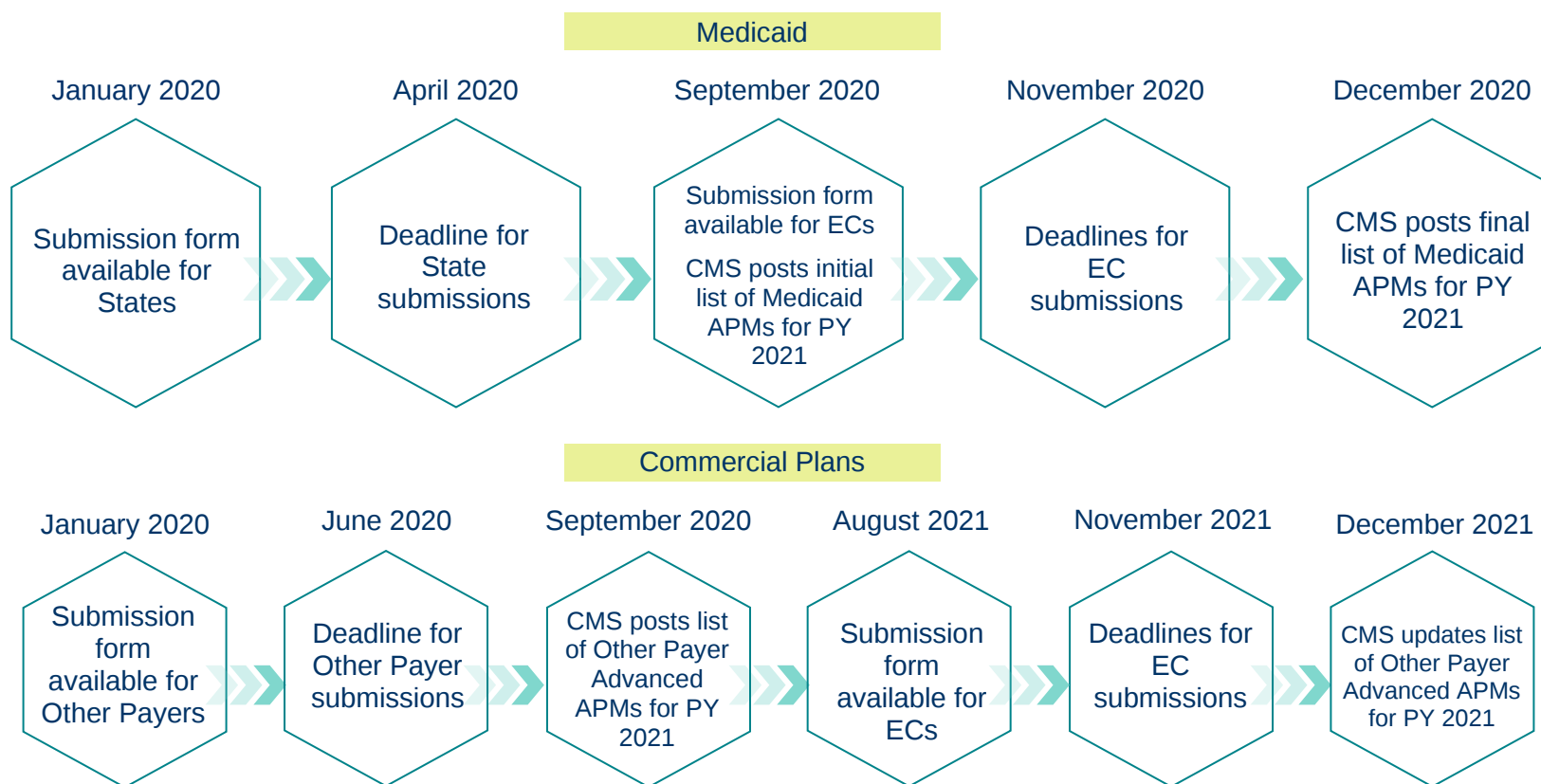


How do eligible clinicians become QPs under the All-Payer Combination Option? When would QP Determinations be made during the All-Payer Combination Option?

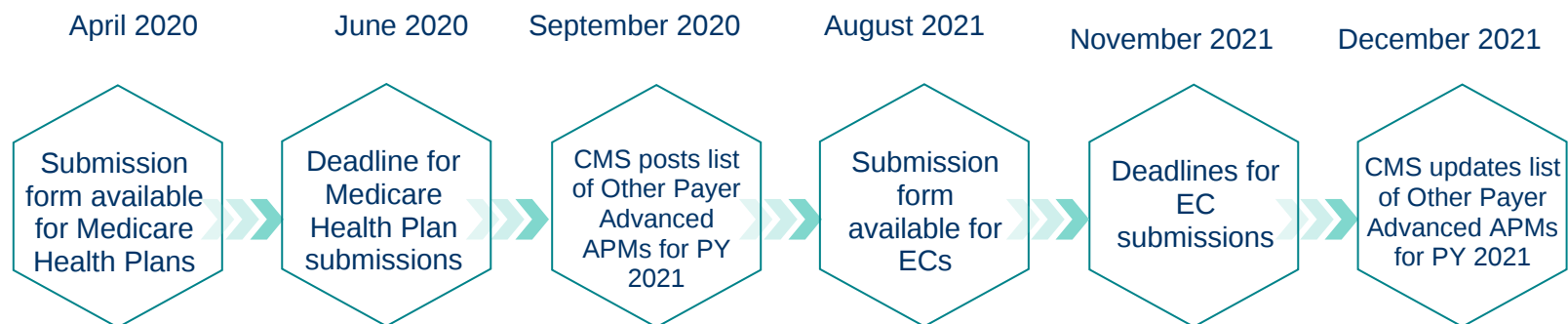
To attain QP status under the All-Payer Combination Option, eligible clinicians must: participate in a combination of Advanced APMs (Medicare FFS) and Other Payer Advanced APMs to a sufficient extent; and submit required payment amount and patient count information to CMS. Eligible clinicians will have the option to either be assessed at the individual level or at the APM Entity level.

The Performance Period for the All-Payer Combination Option will be that same as the Performance Period for the Medicare Option: January 1 through August 31. Eligible clinicians will be QPs if they meet the criteria for sufficient participation in any of 3 snapshot periods during the Performance Period: January 1 through March 31, January 1 through June 30, or January 1 through August 31. Eligible clinicians would submit QP determination requests to CMS between August 1 and December 1, after the end of the Performance Period. The Performance Year 2021 Timeline for Other Payer Advanced APM Determinations is displayed in Figure 1 on the following page.

Figure 1: Performance Year 2021 Timelines for Other Payer Advanced APM Determinations



Medicare Health Plans



Version History

If we need to update this document, changes will be identified here.

Date	Change Description
01/14/2021	Updated to reflect the freeze to QP thresholds for payment years 2023 and 2024 as a result of the Consolidated Appropriations Act, 2021.
08/28/2020	Original posting