HIMSS MACRA Fact Sheet

Combination All-Payer and Medicare Payment Threshold Option –

Pt 2. Other Payer APMs and Other Payer Advanced APMs

HIMSS North America

Key Themes

This Fact Sheet addresses how the eligible clinicians can participate in arrangements with non-Medicare payers, and the criteria how a payment arrangement with a non-Medicare payer can become an Other Payer Advanced APM.

FOR MORE INFORMATION

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Beginning in 2021, there will be two avenues for eligible clinicians to become a Qualifying Alternative Payment Model (APM) Participant (QP) –

a. Medicare Option &
b. All-Payer Combination Option

The All-Payer Combination Option allows eligible clinicians with lower levels of participation in **Advanced APMs** to become QPs through sufficient participation in **Other Payer Advanced APMs** with payers such as State Medicaid programs and commercial payers, including Medicare Advantage plans.

Parallel to the relationship between **APMs** and **Advanced APMs**, the All-Payer Combination Option provides an incentive for eligible clinicians to participate in arrangements with non-Medicare payers (i.e., **Other Payer APMs**) that have payment designs similar to those in Advanced APMs (i.e., **Other Payer Advanced APMs**).

Regulatory Approach

The All-Payer Combination Option uses both the methods described in the Medicare Option and methods that calculate payments for all services from all payers, with certain exceptions, that are attributable to participation in both **Advanced APMs** and **Other Payer Advanced APMs**.

A payment arrangement with a non-Medicare payer (i.e., **Other Payer APM**) – including Medicaid APMs, Medicaid Medical Home Models, Medicare Advantage and other Medicare-funded private plans – can become an **Other Payer Advanced APM** if the arrangement meets three criteria:

(1) Certified Electronic Health Record technology (CEHRT) is used;
(2) Quality measures comparable to measures under the MIPS quality performance category apply; and
(3) The APM Entity either:
   a. bears more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures; or
   b. is a medical home in a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under this law.*

Additional Information

(1) Other Payer Advanced APM: Use of CEHRT

To be an **Other Payer Advanced APM**, payments must be made under arrangements in which certified EHR technology is used. This is slightly different than the requirement for Advanced APMs that "requires participants in such model to use certified EHR technology." Although the statutory requirements are phrased slightly differently, CMS is finalizing the two standards – for Advanced APMs and Other Payer Advanced APMs – to be as similar as possible.

This definition for Other Payer Advanced APMs is identical to the definition for use by eligible hospitals and CAHs and Medicaid eligible clinicians in the EHR Incentive Programs.†

The final rule amends the CEHRT requirements. In response to comments suggesting CMS relax the requirement that 75 percent of the clinicians use CEHRT to instead allow for glide paths that are tailored to each Other Payer Advanced APM's particular needs and capabilities, and as part of the alignment with CEHRT requirements across the Quality Payment Program, CMS is reducing the level of CEHRT use that an Other Payer Advanced APM must require of eligible clinicians in each APM Entity from 75 percent to 50 percent.

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* See HIMSS MACRA NPRM Fact Sheet: Medical Home
† See CHERT definition in Glossary of Terms and Definitions

(2) Other Payer Advanced APM: Application of Quality Measures

Another of the criteria to meet in order to be considered an Other Payer Advanced APM is on quality measures comparable to those under MIPS quality performance category. These quality measures apply under the **Other Payer APM**.

Of note, not all quality measures in an APM are required to be "comparable," and not all payments under the APM must be based on comparable measures. This approach is for **Other Payer Advanced APMs** is similar to the requirement for **Advanced APMs**.

Under this proposal, **Other Payer APMs** retain sufficient freedom to innovate in paying for services and measuring quality. For instance, an Other Payer APM may have incentive payments related to quality, total cost of care, participation in learning activities, and adoption of health IT.

The existence of all of the payments associated with non-quality aspects does not preclude the Other Payer APM from meeting this **Other Payer Advanced APM** criterion. In other words, this criterion only sets standards for payments tied to quality measurement, not other methods of payment.

Conversely, an **Other Payer APM** may test new quality measures that do not fall into the MIPS-comparable standard. So long as the Other Payer APM meets the requirements set forth in this Other Payer Advanced APM criterion, there is no additional prescription for how the Other Payer APM tests additional measures that may or may not meet the standards under this criterion.

Thus, CMS proposes that the quality measures on which the **Other Payer Advanced APM** bases payment must include at least one of the following types of measures provided that they have an evidence-based focus and are reliable and valid:

(1) Any of the quality measures included on the proposed annual list of MIPS quality measures;
(2) Quality measures that are endorsed by a consensus-based entity;
(3) Quality measures developed under section 1848(s) of the Act;
(4) Quality measures submitted in response to the MIPS Call for Quality Measures; or
(5) Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid.

Similar to APMs, CMS encourages the use of outcome measures by proposing **Other Payer Advanced APM** must include at least one outcome measure if an appropriate measure (i.e., the measure addresses the specific patient population and is specified for the APM participant setting) is available on the Merit-Based Incentive Payment System (MIPS) list of measures for that specific QP Performance Period.

The final rule makes no changes in this section.

(3) Other Payer Advanced APM: Financial Risk for Monetary Losses

The third criterion that an Other Payer APM must meet to be an Other Payer Advanced APM is that under the arrangement, the APM Entity must either

- bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures or
- be a Medicaid Medical Home Model that meets criteria comparable to expanded Medical Home Models.

The financial risk standard under this criterion is similar to that proposed for the **Advanced APM** criterion. As with all the Advanced APM criteria, this requirement pertains to the payment arrangement structure, not of the performance of the participants within the payment arrangement.

Financial Risk Standard. Under the generally applicable financial risk standard for Other Payer Advanced APMs, a payment arrangement must, if APM Entity actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period:

- 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 payments by the APM Entity to the payer.

The final rule makes no changes in this section.

Nominal Amount of Risk Standard. After an Other Payer Advanced APM risk arrangement meets the previously discussed proposed financial risk standard, it must meet measures for the following nominal risk standard:

(1) ***marginal risk***, which is a common component of risk arrangements – particularly those that involve shared savings – that refers to the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under an Other Payer APM; and

(2) ***minimum loss rate (MLR)*****,** which is a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk.

Table 40 from the preamble at Section II.F.7(a) in the NPRM summarizes the generally applicable nominal amount standard. The final rule finalizes both the marginal risk and the MLR as proposed.

Table 40: Amounts of Risk Sufficient for Other Payer Advanced APMs to Meet the Nominal Amount Standard

Marginal Risk	Maximum Potential Risk Must at Least Be the Following
<30%	N/A
% of spending in excess of expected expenditures	4% of Other Payer expected expenditures

The proposed rule also included a requirement to meet measures for ***total potential risk***, which refers to the maximum potential payment for which an APM Entity could be liable under an Other Payer APM. The final rule does not adopt these criteria. Instead, CMS seeks comment on:

- setting the revenue-based standard for 2019 and later at up to 15 percent of revenue; or
- setting the revenue-based standard at 10 percent so long as risk is at least equal to 1.5 percent of expected expenditures for which an APM Entity is responsible under an APM.

CMS expects to apply the same percentage standards for Other Payer Advanced APMs as for Advanced APMs; however, they are seeking comment on how and why this standard could differ for Medicaid APMs relative to the generally applicable Other Payer Advanced APM standard.

Capitation. CMS proposes that full capitation risk arrangements would meet this Other Payer Advanced APM financial risk criterion.

For purposes of this rulemaking, a capitation risk arrangement is defined as “a payment arrangement in which a per capita or otherwise predetermined payment is made to an APM Entity for services furnished to a population of beneficiaries, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity.”

Capitation arrangements qualifying under this financial risk standard must be structured to directly hold the provider – or the entity to which the provider has assigned their billing – accountable.

The final rule makes no changes in this section.

Implications for Health IT

The use of Health IT and data analytics are either embedded in or critical to meeting the three criteria for Other Payer Advanced APM.

1. **Use of CEHRT**. Meaningful users will already have an advantage in becoming a QP under this section.
2. **Comparable quality measures**. As discussed in the HIMSS Fact sheets on MIPS quality measures,‡ the CMS Web Interface was known as the GPRO Web Interface under the PQRS Program. QPs that have used GRPO for PQRS and Shared Savings Program ACOs have used the CMS Web Interface for submitting their quality measures since the program's inception, making this a familiar data submission process
3. **Financial risk for monetary losses**. Many of the risk modeling and management, contract management, and clinical and business intelligence tools utilized in population health management programs will be useful for QPs to meet the risk component of Other Payer Advanced APMs.

Resources

MACRA Resource Center
MACRA Final Rule Executive Summary
HIMSS MACRA NPRM Fact Sheets

‡ See HIMSS Fact Sheets on Proposed MIPs Quality Performance Categories: Large Groups (25 or more Eligible Clinicians); Small Groups (25 or less Eligible Clinicians); Specialists