

## Quality Payment Program's (QPP) Intersection with BPCI Advanced Webinar Series Part I

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**Webinar Transcript**

Operator: Hello and thank you for joining the Quality Payment Program's (QPP's) Intersection with BPCI Advanced Webinar. To hear today's presentation please turn on your computer speakers or you can dial into the audio conference line via your phone at (800) 832-0736 and enter the room number 6523769 pound when prompted. To avoid any audio issues relating to an echo, please connect your audio using only one of these options. Note, today's webinar is being recorded. During today's presentation, all Participants will be in a listen only mode. Please feel free to enter any questions you may have throughout today's presentation in the Q&A pod displayed on the bottom right hand corner of the meeting room window. A short survey will also be available at the end of the presentation. It is now my pleasure to turn the webinar over to our facilitator for today. Beth, please go ahead.

Beth Chalick-Kaplan: Thanks Patricia. Hi everybody, thanks for joining us. I'm Beth Chalick-Kaplan, a member of the Model team, the BPCI Advanced Model Team, here at the CMS Innovation Center and I'm thrilled to have you join us today for this discussion, which is a two-part series. This is part one on the Quality Payment Programs, QPP Intersection with BPCI Advanced. This first session will provide an overview of the Advanced APM including Model requirements and timeline thresholds for achieving APM Participant or QP status. The second session scheduled for later this summer will detail how Physician Group Practices (PGPs), participating practitioners, and clinicians in BPCI Advanced achieve QP status under the Model. I'm joined today by Corey Henderson who will walk through today's materials, and after his presentation we will have time to answer some questions. Feel free to submit your questions throughout the presentation into the Q&A box. At the end of the webinar we ask you to take a moment to complete a survey that we'll automatically display on your screen. It's only nine questions, so again, please help us out and complete that. It helps us get a sense of how

we can help you to improve and provide events that are important to you and meaningful.

Now I'd like to shift gears and tell you a little bit about my friend and our fabulous presenter today, Corey Henderson. Corey is a Doctor of Public Health. He loves learning and teaching, and he really does love helping people overcome any hurdle that limits mental emancipation. Dr. Henderson's background intersects information technology, qualitative research, health policy, and public health. He's worked in the private and public sector on community advocacy, health policy, and health equity issues for over 15 years. His research interests include historical trauma, health care policy, qualitative research, and human-centered design. With that, I turn it over to my friend and colleague, Corey Henderson.

Corey Henderson: Good afternoon everyone. Thank you, Beth, for the great introduction and thank you to the BPCI Advanced Team. Let's jump right into the presentation. Today we're going to do things a little different. We're going to try to make sure that we're more interactive, that we are providing you with a platform that you want to learn and that you're happy to ask questions in our question and answer box. Please feel free to jump right in. If you hear anything that causes any pause, please feel free to ask the question and we'll do what we can to make sure we clarify this information. To begin, the Quality Payment Program really comes from the 2015 Medicare Access and CHIP Reauthorization Act. What the MACRA law really did was look at how we implement incentive programs, specifically the Quality Payment Program that provides the two participation tracks. They are the Merit-Based Incentive Payment System (MIPS) and the track that you're in, the Advanced Alternative Payment Model (APM) track for Advanced APMs.

Well, on the next slide we talk a little bit about what does it mean to be an Alternative Payment Model. Well, Alternative Payment Models are new approaches to paying for medical care through Medicare that often not only incentivize quality, but also value. One of the keys that Congress has looked at here was how do we look at not only the Affordable Care Act and other legislation, but also understand what a demonstration is that we're conducting here at CMS. MACRA really applies the Alternative Payment Models to include CMS Innovation Center models under section 1115A of the Social Security Act other than the Health Care Innovation Awards, the Shared Savings Program is also considered an APM, demonstrations under the Health Care

Quality Demonstration Program and further the demonstrations required by Federal Law.

With that overview, let me give you a little bit more detail of what we mean by an APM. That was the legislative understanding, but here let's talk about the payment approach that provides the added incentives to clinicians that provide the high quality and cost-efficient care. Now, APMs can apply to specific conditions, care episodes, or populations. What we mean by populations are not only populations of individuals, but populations meaning those beneficiaries that are under the care of a group or a clinician. Also, MIPS APMs may offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs but give you a little more benefit than just being in MIPS.

The Advanced APM, as we look at this circle, the APM is the larger overarching buckets of APMs, so that's the Alternative Payment Model. But within that bucket there's a smaller subset of Alternative Payment Models that we call the MIPS APMs. Then the circle that touches that is the Advanced APMs, and the reason why that is, is because you have Advanced APMs that also have Participants that are operating under the MIPS APM structure and all of them are considered Alternative Payment Models. Here the Advanced APM meets these three criteria. One, that we require Participants to use certified EHR technology. That would be the APM structure itself. That we base payment for covered professional services on quality measures comparable to those in MIPS. That also that we require entities to bear more than nominal financial risk or that the APM is a Medical Home Model expanded under Innovation Center authority.

Further describing what we mean by the financial risk, the work, or the participation that a clinician does. We're looking at the Qualifying Advanced APM Participants or what we call the QP. You will often see it referenced here as the Qualifying APM Participants and that determination is done at two levels. One, we look at two thresholds, the patient counts or the payment amounts. The reason why I say or is because if you exceed the patient counts or you exceed the payment amounts, then you will be qualified as the qualifying Advanced APM Participant. We're putting Advanced here because we want to make sure you understand that the Advanced really is because you're a Participant in an Advanced APM.

What's the benefit of being in an Advanced APM? I'm glad you asked. Well, clinicians and practices can receive greater rewards for taking on some risk related to patient outcomes. In addition, Participants that achieve QP status receive these three benefits. One, a 5 percent incentive payment, or what we called the APM Incentive Payment of 5 percent per payment year through 2024. In addition, you will be excluded from MIPS participation, again reducing burden there. Then finally a higher physician fee schedule update started in 2026.

Now that we've talked about the benefits of being an APM Participant in an Advanced APM, let's talk a little bit about what it means to be a QP as we talk about the payments and the patient threshold. We do a calculation and in that calculation, we use the QP methodology. You can find that paper on [qpp.cms.gov](http://qpp.cms.gov) that describes the QP methodology. The 2018 paper is also available in a predictive QP methodology and we're using both those papers now to combine into one that we will hopefully be releasing soon, but the methodology is still the same. What are we doing? We are looking at understanding how your incentive payment will be based on either your participation in percentages of payments through your Advanced APM that would be through BPCI Advanced, or the percentage of patients that you've seen through the Advanced APM BPCI Advanced.

The 2018, let's just go back one year so you understand. What we did was we said in 2018 did you have 25 percent of your payments come through BPCI Advanced? If you did and you met or exceeded that number, then you became a qualifying APM Participant or a QP. Let's go back to 2018 and look at your patients. Did you see 20 percent of all your patients through the work you did in BPCI Advanced? If you did meet or exceed that number, you would have received the QP status or the Qualifying APM Participant Status. For 2019 the number increased to 50 percent of your payments must come through the Advanced APM of BPCI Advanced or 35 percent of your patients must come through BPCI Advanced or your Advanced APM.

Why is that important for you to see the juxtaposition between 2018 to 2019? I think it's important because of this slide here. When you look at the All-Payer Combination Option, which we will be discussing in more detail, you'll get to see that in 2018 that 25 percent and 20 percent was really the base for this also 2019 year. What do I mean by that? Underneath this slide in the section where 2019 is highlighted, you'll see that it says Medicare. The 25 percent is the threshold that

you must minimally meet under your QPP Payment amount threshold. Again, 25 percent of your payments must come through your Medicare Advanced APM participation, or 20 percent of your patients must be met through your Medicare Advanced APM participation. Again, we're talking about BPCI Advanced here, so if 25 percent of your patients that you -- 20 percent of your patients that you've seen came through BPCI Advanced, then the other 15 percent could be met using the All-Payer Combination Option. If, for instance, we talk about the payment amount, in order to reach QP through payment amount, you would have to have 50 percent total with a minimum of 25 percent coming through your participation in BPCI Advanced. The important thing here is if you've met the 50 percent just through your BPCI Advanced or the 35 percent through your BPCI Advanced, then you do not need to add in any other work done outside of Medicare payment arrangements, which would be the BPCI Advanced APM.

You say, well I don't think I've done that much work potentially, but I've done work, I'm a Participant in BPCI Advanced. While I'm here, let me talk a little bit about what that means. If you're in BPCI Advanced, once you're determined to be and selected by your entity and your organization as a member of BPCI Advanced, the structure is you are a member now of BPCI Advanced. Simply, once we determined that BPCI became an Advanced APM, then you went through the process of deciding you wanted to participate and we made a determination that you are now in the Model. That model then qualifies you for these QP performance designations, which then qualify you for the 5 percent APM incentive and the other benefits. Let's talk about this partial QP. You've done some work but it's a little lower threshold that you've done the work at, and you still don't want the burden of having to do any work in MIPS, so having to compare your thresholds with MIPS. We're going to still look at your patient count and your payment amount as your base.

For 2019 if you've minimally met a percentage of payments of 20 percent through your Advanced APM and that's on the Medicare side, then we will then call you a Partial QP or Partial Qualifying APM Participants. That means that you are exempt from having to do any work in MIPS unless you choose to. So, you have a choice, you can choose to participate in MIPS or you don't have to. Then if we look at the percentage of patients, if you've minimally seen 10 percent of all your patients through BPCI Advanced, then that percentage would allow for you also to make a choice whether you want to participate in

MIPS or not. If you choose not to participate in MIPS, then you will just receive a neutral adjustment and there will be no penalty.

Moving on, let's talk a little bit about these snapshots. We often hear this term snapshot, snapshot, snapshot date. If you go to [qpp.cms.gov](http://qpp.cms.gov) and look up the participation tool, you'll see where we described based on this time period. This is what we know about you. These snapshots are only our way of giving you updates throughout the year. What we do is we take a 90-day snapshot. January 1st through March 31st we look, and we see, did you do the work necessary for us to tell you that you're a QP at that point in time? If you have done that work, then your QP status remains. If we then go back and we look at January 1st through June 30th if you've met QP status there, we give you a designation that we let you know that you've met QP status and you are now eligible for the 5 percent incentive payment. If we then go back and look at January 1st through August 31st, which August 31st is the end of the QP Performance Period, then we look back and we say January 1st through August 31st you did not meet the QP status on the March 31st snapshot date, you did not meet it on the June 30th snapshot date, but now that we have these three quarters of a year's worth of data we can see that you've done the work, you get QP status there. QP status appends, meaning that you don't lose it, we add to it. Once you meet that percentage of patients or payments and we've done that calculation, then we use these snapshots to help you see throughout the year different points in time. Nothing for you to do there but continue doing the work that you're doing.

How does all of this relate to timeframes, payments, and incentive determination? Let's start with this year being the Performance Period or the performance year. In 2019 if we took this as the Performance Period, we would then take a QP status based on the Advanced APM Participation. As I just mentioned, we'd look at January 1st through August 31st looking at different snapshots in time throughout the year. We then, if you have QP status, take a look at that status to say, okay, whatever work you do next year (2020) that would be your incentive determination year. We will add up your payments for Part B covered professional services furnished by your QP. Then we would make a payment in 2021, which is two years after you've been determined to be a QP, to pay out the 5 percent lump sum payment. That payment will be made to the TIN or the billing organization.

Let's talk a little bit about the Alternative Payment Model just so -- I just talked about the TIN and the structure. The APM Entity or the TIN, or what we would call the Tax Identification Number, is nothing more than the billing organization that the NPIs, the National Provider Identifiers or the clinicians under the Eligible Clinician List, would then receive or bill on your behalf. It's just nothing more than an APM Entity or a payment arrangement with a non-Medicare provider through a direct agreement or through federal or state law regulations. If you decide to assign your billing over to a group, we would call that the APM Entity or the TIN.

Here we have some questions, one of the questions that we're going to pose, and this question is just a great question for you to check in and see, am I doing a good enough job to move slow enough but break the information down enough that you've learned something? We ask that you look at the question on the screen and then we want to know what you think, "if Participants achieve QP status do they receive a MIPS payment adjustment?" Based on the responses that we're seeing here, let me just explain a little bit to you what we want to clarify as the answer. With the poll just closing, we have that some believe that there is a MIPS payment adjustment under QP status if it's achieved.

Let me explain to you why the answer is that you do not receive a MIPS payment adjustment. Earlier we talked about the MIPS side and the Alternative Payment side. If you are QP that is the highest level of participation, so as a QP you're in an Advanced APM, at that highest level of participation you do not have to do any work in MIPS, specifically your TIN organizations do its reporting through the APM. At this point, we then can look and say that we're going to give you a 5 percent APM incentive payment. Just like the MIPS payment adjustment, the 5 percent incentive payment is a payment, so we do not pay twice, so we will not pay for both. What we want to do is understand a little bit more about why that is true. The MIPS payment adjustment is a payment adjustment towards your fee, your physician fee schedule, where the 5 percent APM incentive is based on the amount added up off that 5 percent from the added amount. The answer is no, just to clarify that you're either an Advanced APM and receive QP status or you are doing some participation in MIPS, which makes you eligible if you are participating in MIPS for a MIPS payment adjustment. Hopefully that clarifies.

Now let's talk about the All-Payer Combination Option, Other Payer Advanced APMs, and the reason why we're going to talk about this is because you recall earlier I mentioned to you that there is a QP status and the QP status is based on your APM payment or patient count. That threshold will help you to understand how you get to QP status. Here, let me explain the two different sides. One, I talk about the Medicare option. BPCI Advanced is a Medicare Based Payment Arrangement that you have with us under the Alternative Payment Model of BPCI Advanced. One, it's available for all performance years because it is Medicare, but two, eligible clinicians achieve QP status exclusively based on their participation in the Advanced APM or BPCI Advanced with Medicare. On the All-Payer Combination Option side starting in 2019, and that's where you saw the numbers increase to 50 percent and 35 percent, eligible clinicians can achieve QP status based on the combination, that's why we call it the All-Payer Combination Option, of participation in both. With Advanced APMs with Medicare you must be an Advanced APM and you add in Other Payer Advanced APMs offered by other payers. All would be Medicare plus the Other Payer Advanced APMs. Next slide.

Here are the Other Payer Advanced APMs, what do I mean by that? Well by definition the Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria similar to Advanced APMs under Medicare. But if I talk about how we define them by title, you're probably familiar with Medicaid, you're probably familiar with Medicare Advantage or what we call it Medicare Health Plans including Medicare Advantage. You are also familiar with the Payment Arrangements aligned with CMS Multi-Payer Models or other commercial and private payers.

When we describe what we mean by the Other Payer Advanced APM, they are similar but not identical to comparable criteria used for Advanced APMs under Medicare. Well what do I mean by that in detail? Number one, we do require that at least 50 percent of eligible clinicians use certified EHR technology to document and communicate with clinical care information. This is the Other Payer Advanced APM criteria, which means that if you have Other Payer model that we're going to use that criteria to define whether or not it's considered the Other Payer Advanced APM meeting these qualifications. Again, that Other Payer Advanced APM must also require that clinicians, at least 50 percent of them use certified EHR technology to document and communicate clinical care information. Two, that they base payments

on quality measures that are comparable to those used in the MIPS quality performance category. Three, that either they are a Medicaid Medical Home Model that meets criteria that are comparable to a Medical Home Model expanded under CMS Innovation Center authority or that they require Participants to bear more than a nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures.

A little more detail for you about what we mean by the expenditures and the different ways that we look at the applicable nominal amounts standard for Other Payer Advanced APMs. We applied it in one of two ways and this again helps with the understanding of what we mean by the risk, expenditure based in nominal amounts standard. Then we're looking at the nominal amount of risk must be a 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. Under the revenue base nominal amount standard, the nominal amount of risks must be a marginal risk of at least 30 percent, a minimum loss rate of no more than 4 percent. But also, for QP Performance Periods 2019 and 2020 a total risk of at least 8 percent of combined revenues from the payer or providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue. This is all a part of the arrangement you would have with your payer.

The Medicaid Medical Home Model is nothing more than a payment arrangement under Medicaid or Title 19 that has the following features. One that Participants include primary care practices or multispecialty practices that include Primary Care Physicians and practitioners and offer primary care services. Two, that there must be an empowerment of each patient to a primary clinician. Finally, at least four of the following additional elements. One, that there is plan coordination of chronic and preventative care that patient access and continuity of care is included, risk stratify care management, coordination of care across the medical neighborhood, patient and caregiver engagement, shared decision making, and finally payment arrangements in addition to or substitute in for fee-for-service payments. Again, at least four of these must be included in the elements. For the Medicaid Medical Home Model, we also have a nominal amount standard. The nominal amount standard must require that the total annual amount that an APM Entity potentially owes a payer or foregoes under the Medicaid Medical Home Model is at least

3 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2019, 4 percent for 2020, and then going forward in 2021 and later 5 percent.

A little bit about the determination of how Other Payer Advanced APMs are made. Here, we talked a little bit about, again, the Payer Initiated or the Eligible Clinician Initiating Process. I want to take my time here to help you understand this without going too fast and too far. There are two different pathways in which we look at how we make determinations to be Other Payer Advanced APM. The first way is the Payer Initiated process. There is a voluntary and a deadline is before the QP Performance Period and this Payer Initiated process is voluntary because we allow for the payer to submit the information. We can't force them but we're creating a voluntary process that payers want to provide specific information about the payer in the arrangement. There are specific deadlines and mechanisms for submitting that payment arrangement information, and they do vary by the payer type in order to align with preexisting processes and also to meet statutory requirements.

After the Payer Initiated process, we then have Eligible Clinician Initiated process. The deadline is after the QP Performance Period, so again after August 31st and except for eligible clinicians participating in Medicaid payment arrangements, there is an overall process which is similar to eligible clinicians for all payer types. What I mean by that, if you have a Payer Initiated process in which the payers submit the information, the process for eligible clinicians is very similar, and we do have submission deadlines too, but they are different than those of the payers. The Payer Initiated process, these are some of the key takeaways. Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based upon information voluntarily submitted by payers. This Payer Initiated process will be available for Medicaid, Medicare Health Plans, i.e., Medicare Advantage or Pace Plans and payers participate in CMS Multi-Payer Models beginning in 2018.

For the 2019 QP Performance Period in which we're in, we intent to add remaining payer types in future years. There're also guidance materials in the payer-initiated submission form that is made available so that you could, through this time prior to the QP Performance Period, make a submission. CMS will review the payment arrangement information submitted by each payer to determine whether the

arrangement meets the Other Payer Advanced APM criteria. Finally we do, CMS, will post a list of Other Payer Advanced APMs on a CMS website prior to the QP Performance Period, and much of this information you can find by going to [www.qpp.cms.gov](http://www.qpp.cms.gov) as an additional resource.

What about this Eligible Clinician Initiated Process? Well, let's do the overview for that too. If CMS has not already determined that a payment arrangement is Other Payer Advanced APM under the Payer Initiated Process, then the Eligible Clinicians or the 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, and that link is also available on [www.qpp.cms.gov](http://www.qpp.cms.gov). Note eligible clinicians or APM Entities participating in Medicaid Payment Arrangements will be required to submit information for Other Payer Advanced APM determination for those Medicaid Payment Arrangement only prior to the QP Performance Period. CMS will review the payment arrangement information submitted by an APM Entity or the eligible clinicians to determine whether the payment arrangement meets the Other Payer Advanced APM criteria.

Here's a timeline that talks about the different payer types. For Medicaid in January 2019, the submission form was available for states. April 2019 that was the deadline for state submissions. September 2019, the submission form is available for eligible clinicians and CMS will post the initial list of Medicaid APMs. November 2019, we close out that form with a deadline for eligible clinicians' submissions and in December 2019, we post the final list of Medicaid APMs. For CMS Multi-Payer Models, in January 2019 the submission form opens for other payers. June 2019, there's a deadline for other payer submissions. Then September 2019, we will post that list that we've made based off the other payer's submissions. Then August 2019, we have the submission form made available for those eligible clinicians to start their process. In December we will then finally post the list of Other Payer Advanced APMs for performance year 2019 and the deadline for eligible clinicians ends.

The Medicaid Eligible Clinician Initiated process is a list of payer and clinician submitted Medicaid Other Payer Advanced APMs determined for the 2019 QP Performance Period through the Payer Initiated process and it was posted on September 1st, 2018. You can find that too on [www.gpp.cms.gov](http://www.gpp.cms.gov) under the Advanced APM drop down or the APM drop down. Two, the period for eligible clinicians to submit Medicaid Payment Arrangements for 2020 QP Performance Period is open from September 1st, 2019 to November 1st, 2019 and that also is available under the All-Payer, once you hit the APM drop down on [www.gpp.cms.gov](http://www.gpp.cms.gov). As always, CMS will post an updated list of Medicaid Other Payer Advanced APM in December 2019.

Here's a timeline for the Other Payer Advanced APMs that are Medicare Health Plans and the remaining Other Payer Payment Arrangements. April 2019, we opened the submission form for Medicare Health Plans. June 2019 is the deadline for that submission for Medicare Health Plan submissions. September 2019, we post a list based on those payer submissions. August 2020, the submission form is available for eligible clinicians, and December 2020, we will post the final list. For the remaining Other Payer types, we will be making available the list, but Other Payer Advanced APM determinations will not be made for performance year 2019. But we do intend to add this as an option for future years; but for August 2020, we will have a submission form available for eligible clinicians. In December 2020, we will post that list for the remaining Other Payer Payment Arrangements.

QP determinations under the All-Payer Combination Option. Here, again you'll take note that we have these different time periods throughout the year. The All-Payer QP Performance Period is the period during which CMS will assess eligible clinicians' participation and Advanced APMs and Other Payer Advanced APMs. It's important for me to note here that you must be in an Advanced APM that is approved by CMS first in order for you to add Other Payer Advanced APMs to determine if you are a QP for that payment year. The All-Payer QP Performance Period will be from January 1st through June 30th of the year that is, again, two years prior to the payment year. Under this proposal, CMS will make QP determinations under the All-Payer Combination Option from either January 1st through March 31st, January 1st through June 30th, or January 1st through August 31st aligning those timeframes with the snapshots.

The QP status is based on the Advanced APM participation during the QP Performance Period. We then take a look at the incentive determination, which is the following year based on if you receive QP status. That's when you will become eligible for the 5 percent APM Incentive Payment based on your Medicare participation. Then the following year, which is two years after the Performance Period, you have your payment year.

Here's another great poll question for you. I'm going to open up for your responses here. What benefits do Participants receive in an Advanced APM? Is it (A) A 5 percent incentive payment per payment year to 2024? (B) A higher physician fee schedule updated starting in 2026? (C) Are excluded from MIPS or (D) All of the above? The answer is (D) All of the above. I feel like an amazing teacher right now. I mean, honestly, if I could just shake every one of your hands, will be a lot of shaking, but I would be glad to turn this in to the superintendent of the school district to say that over 87 percent got the answer right. Really if anyone clicked on any of these, you would have been right, but the correct answer is "all of the above."

The QP Determination Process. An eligible clinician or APM Entity needs to participate in Advanced APM. We keep saying that because we get questions: Do I need to be in an Advanced APM with Medicare? Do I need to be in an Advanced APM in order to get the 5 percent bonus? Yes, because we can't make a payment for participation in something that you're not in. It sounds a little out there, but we want to try to make sure we clarify. Now, since you're in that Medicare model then to that sufficient extent we want to qualify you for the All-Payer Combination Option. How do we do that? For performance year 2019, we based the payment amount method under sufficient means. If you have less than 25 percent, the eligible clinician or APM Entity does not qualify to add the All-Payer Combination Option. If you have 25 percent to 50 percent, then the eligible clinician or the APM Entity does qualify to participate in the All-Payer Combination Option. If you have greater than 50 percent, then the eligible clinician or APM Entity attains QP status based on their Medicare option alone, and participation in the All-Payer Combination Option is not necessary. Reducing burden there by, just letting you know upfront, if you hit QP status, you do not have to submit for the All-Payer. You already have it.

Eligible clinicians must have greater than or equal to 25 percent, and less than 50 percent of payments through an Advanced APM, in order to be eligible to add to their participation in the Medicare option Advanced APM of BPCI Advanced and all Advanced APMs for that seat.

The QP Determination Process. Under the All-Payer Combination Option, an eligible clinician or APM Entity need to be in at least one Other Payer Advanced APM during the relevant QP Performance Period - needs to be in at least one. Eligible clinicians or APM Entity seeking a QP determination under the All-Payer Combination Option will inform CMS that they are in a payment arrangement that CMS has determined is an Other Payer Advanced APM and submit information to CMS on a payment arrangement where CMS will make an Other Payer Advanced APM determination. Now, note that the eligible clinicians in Medicaid payment arrangements will only have the option to submit their payment arrangement information prior to the relevant QP Performance Period.

Three, QP determinations under the All-Payer Combination Option. Between August 1st and December 1st, 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 1st through March 31st, January 1st through June 30th, and June 1st through August 31st. Again, that matches the snapshot dates. All other payments and patients through other payers, except those excluded, aggregated between January 1st through March 31st, January 1st through June 30th, and January 1st through August 31st, again, aligning with the three snapshot periods. Just for purposes of clarification, you can submit that data at the individual or the group, what we would call the TIN or the APM Entity level.

Four, 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 or the APM Entity level (as determined and submitted by the APM Entity). What are we going to do? We're going to take a calculation of your threshold scores under both the payment amount and patient count methods, applying the more advantageous of the two. For the payment amount method, we're going to take a look at your dollars or your spending or the total billing through Advance APMs

and Other Payer Advanced APMs. We're going to divide that by the dollars from all payers, except the excluded dollars, and that's how we get to a threshold score. For the patient count method, the number of patient's furnished services under Advanced APMs and Other Payer Advanced APMs divided by the number of patients furnished services under All-Payers, except excluded patients. That's how we get to a threshold score for patient count.

The MACRA statute directs us to exclude certain types of payments and we will for associated patients. Specifically, the list of excluded payments includes, but is not limited to, Medicaid payments, or Title 19, 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 19, or 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.

Here again is the breakdown, we're just drilling it in. If you meet or exceed the percentages, that's how you get to a place to be able to add in Other Payer Advanced APM participation. For this QP Determination Process, you pretty much walk through this step-down. Is Medicare threshold greater than 50 percent? If the answer is no, then you go and look and say is it greater than 25 percent? If the answer is no, then you're going to go look and see if it's greater than 20 percent? If the answer's no, then you're a MIPS Eligible Clinician. If the All-Payer Threshold Score is greater than 50 percent, if the answer is no, then again, you're going to look at is the All-Payer Threshold Score greater than 40 percent? So on and so forth. I don't want to bore you with this, but we do have a great question coming in.

Trevey Davis: We have a couple of questions, thanks Corey, on that are germane to the slide. The first question has to do with the sort of top box here. When will we be posting our Medicare thresholds for QP status? When can people expect to see their first QP status?

Corey Henderson: You can see your first QP status right now for predictive QP. The actual first snapshot is not available, as of yet. That will be coming later this summer, but we do have the predictive QP that is out there.

Trevey Davis: Then as a follow-up to that question, Corey, do you expect right now the predicted QP is at the APM Entity level? Do you expect to provide any information for individual providers going forward?

Corey Henderson: Yes. Those individual determinations are made after the QP determination period of August 31st, in which we're able to then make determinations and calculations at the individual level after that date.

Trevey Davis: Thank you.

Corey Henderson: Next slide.

Here are some resources for you as we move into the question and answer section here, Q&A. There's technical assistance available to everyone and being CMS and an entity that focuses on not only keeping you educated but keeping you informed, we have free resources and organizations on the ground to help provide eligible clinicians included in the Quality Payment Program with the most resources. Primary care and specialty physicians, we have something for you. Small and solo practices, we have something for you. Large practices, we have something for you, and there's always technical support for those who participate in our Advanced APMs through our APM learning system. And, you'll also have your dynamic BPCI events team available for your questions, emails, or calls. I'm going to pass it back over to our moderator.

Beth Chalick-Kaplan: Thanks Corey. Just to let everyone know, we do have a few other subject matter experts in the room with us. You heard from Trevey Davis already, and I'd like to let you all know that Sacha Wolfe and Erin Hagenbrok are also here with us. Let's switch over to some of our questions. A lot of them came through and I hope that we have answers, and we'll get to as many as we can. The first question, "If we plan to sign the amendment which requires QPP list submission, but our QPP list is currently blank, how do we proceed?" Sacha, do you want to take that one?

Sacha Wolf: Yeah. I'll take that one, Beth. The amendment to the BPCI Advanced participation agreement will become effective on the date that it's signed by the last party to sign it. Any blank QPP list submissions from previous quarters will not be considered "not compliant" since the amendment wasn't offered after the deadline for those submissions. However, for Participants who signed the amendment, blank QPP list will not be accepted.

Beth Chalick-Kaplan: Okay, how about, "I have a multi-specialty orthopedic group. We report to MIPS as a group rather than as individuals. Under CJR or BPCI Advanced, not every provider will directly participate in the bundle. Can we still qualify the group as APM, and if so what are the criteria?"

Sacha Wolf: May I take this one?

Beth Chalick-Kaplan: Sure.

Sacha Wolf: I'll take it. BPCI Advanced the Model is an Advanced Alternative Payment Model for all Participants. For purposes of QP determinations, the APM Entity is either the Convener Participant or the Non-Convener Participant, who submits the QPP list that includes all eligible clinicians. The structure of the Participants, either Convener or Non-Convener, and the type of Episode Initiators they have will dictate whether the eligible clinicians will be assessed as a group or assessed individually.

Beth Chalick-Kaplan: You know Sacha I think a lot of these questions are really in your wheelhouse, so I'm going to stick with you for a little if you don't mind.

Sacha Wolf: Sure.

Beth Chalick-Kaplan: If we plan to sign the amendment, which requires QPP list submission, but our QPP list is currently blank, how do we proceed?

Sacha Wolf: That one, very similar to the first question. We're not going to really be looking at blank QPP list submissions from the previous quarters. But, for this upcoming Q3 2019 submission that's due on June 1st, we would need anyone signing that amendment to make sure that they sign or submit a QPP list. We will not accept any blank submission.

Beth Chalick-Kaplan: If a Convener Participant has multiple Downstream Episode Initiators, what is the difference between combining them into one BPID for QPP purposes versus restructuring them into multiple BPIDs. How does it affect QPP determination? It would be helpful to have numerical examples, if possible.

Sacha Wolf: That's a great question, Beth. I definitely have a long-winded response for this one. But, to sort of go through what it means to restructure and how that might affect QPP: For Convener Participants, it really depends on the type of Episode Initiators they have under a single participation and agreement. If a Convener Participant has only hospital Episode Initiators, eligible clinicians listed on the affiliated

practitioner list tab for the QPP list will be assessed individually for purposes of QP determination. Now if that same Convener Participant with only hospital Episode Initiators restructures, eligible clinicians would still be assessed individually. There's really less of an impact on QP determination for Convener Participants with only hospital Episode Initiators.

The scenario is kind of different for Convener Participants that have only Physician Group Practice or PGP Episode Initiators. As the eligible clinicians listed on the participation list tab of the QPP list will be assessed as a group for QP determination. When eligible clinicians are assessed as a group, patient count and payment thresholds may be impacted positively or negatively by the eligible clinicians within that group. If a Convener Participant with only PGP Episode Initiators restructures, then the eligible clinicians will still be assessed as a group, but that group gets smaller since it will only contain eligible clinicians for that single PGP Episode Initiator and rather than that eligible clinicians for all the convening Participant Episode Initiators.

Lastly, it's a different scenario when you have a Convener Participant with both hospital and PGP Episode Initiators under a single participation agreement. In this case, only eligible clinicians participating under the PGP Episode Initiator will be assessed as a group for QP determinations. Eligible clinicians associated with the hospital Episode Initiators will not be assessed for QP determination. If a Convener person spent with both hospital and PGP Episode Initiators restructures, then the eligible clinicians under the PGP Episode Initiators will be assessed as a group for each PGP. Then the eligible clinicians under the hospital Episode Initiator will be assessed individually for purposes of QP determination.

Beth Chalick-Kaplan: That's a lot of information. Actually, here is a good one for Corey, a shorter one. When can we expect to see 2019 snapshot one QP status in the QPP participation look up tool?

Corey Henderson: I'm glad you asked that question, again. I think that this is a great way to provide more detail. Very quickly, what we do is we look at January 1 through March 31<sup>st</sup> and then we give a 60-day run-out period; it used to be 90 days. What that run-out period means is that we are doing reconciliation on the claim or the data and the information, so we can make sure the billing is correct. That run-out period allows us to get the right numbers at the right time with over 90 percent validity and

reliability of the data. Once we have the 60 days, then we do the calculation based on that information. We are looking at pretty much starting in April and then the 60 days that would be all of April, all of May, and we do our calculation. That's why we said snapshot one comes summer 2019 because we have to make sure that the information is correct to base our QP determination off.

Beth Chalick-Kaplan: Thanks Corey. How is it determined that 50 percent of physicians you see heard?

Trevey Davis: I'll take this question.

Beth Chalick-Kaplan: Thanks, Trevey.

Trevey Davis: Yeah. In the past, providers may be familiar with the process of submitting promoting interoperability data through their Alternate Payment Model to confirm that they're using current CERT. However, one thing that we've updated in the Quality Payment Program is that Participants in an Advanced Alternative Payment Model actually enter into participation agreement with their model that require CERT usage. We no longer have an actual submission requirement for that CERT usage, but rather it's part of your participation agreement with the Model. Actually, we also, in previous years, have been at 50 percent CERT usage, but we're now up to 75 percent CERT usage in the Model.

Corey Henderson: Let me clarify the 50 percent and 75 percent. The 75 percent is for the Advanced APM participation under Medicare, so the BPCI Advanced. The 50 percent will be moved into 75 percent for the Other Payer Advanced APM starting next year. There's still 50 percent threshold or percentage when you submit your payment arrangement, contract information or documentation that 50 percent of clinicians actually use CERT, was a requirement under the Other Payer Advanced APM determination, not specifically for BPCI Advanced which is at 75 percent.

Sacha Wolf: For BPCI Advanced, in the fall or late fall around November, we will be releasing a deliverable called a Care Redesign Plan. On that Care Redesign Plan, applicants and Participants will attest to using CERT on that deliverable.

Beth Chalick-Kaplan: Thanks for that. Since we're running a little short on time, I do want to shift gears right now and ask you to please complete the survey that you will momentarily see on your screen. Thanks for attending Part 1

of the Quality Payment Programs Intersection with BPCI Advanced Webinar Series. Again, we promise we're going to do a follow-up deeper dive in the summer. If you do have additional questions or your question were not answered today, feel free to first go visit the BPCI Advanced homepage and the address is on the slide behind the survey. As mentioned before, we have a number of helpful resources, and we'll continue to post new and updated materials. If you need additional assistance related to BPCI Advanced, you can always email the BPCI Advanced team at the mailbox [bpciadvanced@cms.hhs.gov](mailto:bpciadvanced@cms.hhs.gov). Thanks for spending time with us today.

Operator: Ladies and gentlemen, that concludes today's presentation. Thank you for your participation, and feel free to now disconnect.