



**Department  
of Health**

Medicaid  
Redesign Team

# **Medicare Access and Children's Health Improvement Program Reauthorization Act (MACRA) Education Session**

June 2018

# Purpose

- Present an overview of key requirements of the Centers for Medicare and Medicaid (CMS) Services Quality Payment Program (QPP) established under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).
- Compare criteria for contracting New York State (NYS) Value Based Payment (VBP) Arrangements to program requirements under the CMS Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) Track of the QPP.
- Provide an overview of how providers can address burden associated with the implementation of disparate value based program criteria by contracting VBP arrangements aligned with MIPS and Advanced APM criteria.

# Agenda

- I. Introduction**
- II. MACRA and the Quality Payment Program**
- III. NYS Medicaid VBP Alignment with Requirements of the QPP**
- IV. Contracting Example**
- V. More to Come!**

# MACRA establishes the Quality Payment Program

**Under MACRA<sup>1</sup>, CMS introduced a new Medicare Merit-Based Incentive Payment System and put into place processes for developing, evaluating, and adopting alternative payment models (APMs).**

## MACRA Title I

- Consolidates several quality programs
- Offers bonus payments for participation in certain alternative payment models
- Repeals the Medicare Sustainable Growth Rate (SGR) for physician reimbursement
- Creates a new Physician Fee Schedule

### The Quality Payment Program<sup>2</sup>

This QPP reformed Medicare Part B payments for more than 600,000 clinicians across the country. The program aims to:

- 1) Support care improvement by focusing on better outcomes for patients
- 2) Promote the adoption of APMs
- 3) Advance existing delivery system reform efforts

<sup>1</sup> Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub.L. No. 114–10, 129 Stat. 87, codified as amended at 42 U.S.C. 1305 (2015).

<sup>2</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P, CMS-5522-FC, CMS-5522-IFC), 82 Fed. Reg. 53568 (Nov. 16, 2017)

# The Quality Payment Program

Under the Medicare QPP, eligible clinicians (those subject to participation in the program) will participate via one of two tracks:

## Merit-based Incentive Payment System (MIPS)

*MIPS participants will earn a performance-based payment adjustment determined by scoring across 4 performance categories.*

**OR**

## Advanced Alternative Payment Models (Advanced APMs)

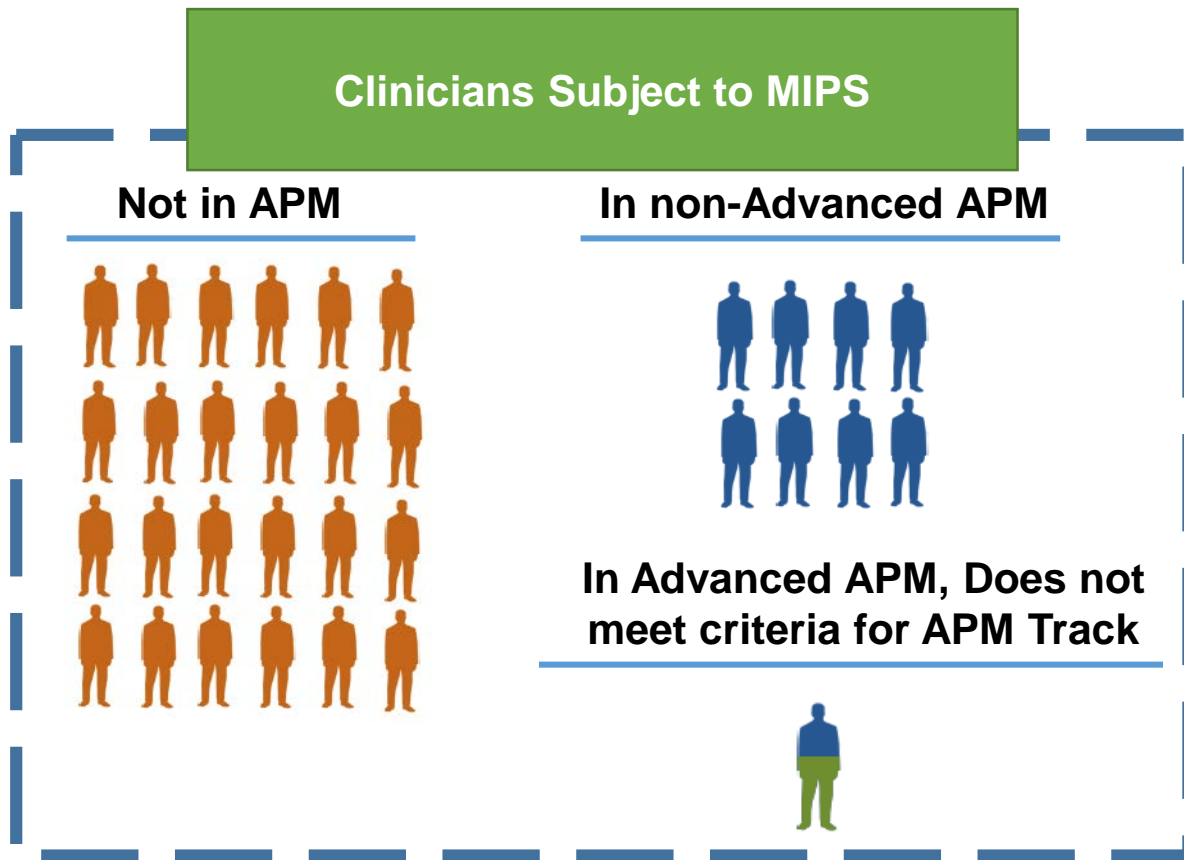
*Advanced APM track participants will be excluded from MIPS reporting requirements and receive a bonus on Medicare Part B payments*

All eligible clinicians (ECs) are subject to reporting under MIPS unless the clinician:

- Is a low volume Medicare Part B provider, or
- Qualifies to participate in the Advanced APM Track by sufficiently participating in Medicare and Other Payer Advanced APMs, meeting specific thresholds for percentage of patients seen or payments received under Advanced APM arrangements.

# How will NY providers participate in the Medicare QPP?

Most clinicians will be subject to MIPS requirements, including quality measure reporting and the adoption and use of 2015 Edition Certified Electronic Health Record Technology (CEHRT).



**Qualified Participants (QP) for Advanced APM Track; Excluded from MIPS**

**In Advanced APM, Meets criteria for APM Track**



Clinicians may be able to qualify for the Advanced APM track by counting a combination of Medicare beneficiaries along with patients seen under 'Other Payer Advanced APMs' – including Medicaid patients under Medicaid VBP arrangements.

# Medicare QPP MIPS Track Reporting and Participation in NYS Medicaid Programs

Eligible clinicians participating in MIPS are assessed against **four performance categories**.

## MIPS Reporting Requirements\*

Quality	Promoting Interoperability <sup>1</sup>	Improvement Activities	Cost
<ul style="list-style-type: none"> <li>•This performance category replaces PQRS.</li> <li>•<b>Clinicians choose six measures to report to CMS that best reflect their practice.</b> One of these measures must be an outcome measure or a high-priority measure and one must be a crosscutting measure.</li> </ul>	<ul style="list-style-type: none"> <li>•This program replaces the Medicare EHR Incentive Program, commonly known as Meaningful Use.</li> <li>•<b>Clinicians will report key measures of interoperability and information exchange.</b></li> </ul>	<ul style="list-style-type: none"> <li>•This is a <b>new category</b> that includes activities that assess how providers improve their care processes, enhance patient engagement in care, and increase access to care.</li> <li>•<b>Providers will report on activities from categories such as enhancing care coordination, patient and clinician shared decision-making, and expansion of practice access.</b></li> </ul>	<ul style="list-style-type: none"> <li>•This performance category replaces the Value Based Physician Modifier (VBM).</li> <li>•MIPS uses cost measures to gauge the total cost of care during the year or during a hospital stay.</li> <li>•<b>CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</b></li> </ul>

## Opportunities for Alignment with NYS Medicaid Programs

Advanced Primary Care (APC)/ VBP Arrangement Quality Measure Sets

SHIN-NY participation/ usage supports some of the required activities

NYS Patient Centered Medical Home (PCMH) completion satisfies requirement

<sup>1</sup>Formerly the “Advancing Care Information” performance category.

\* Source: CMS, CMS *Quality Payment Program MIPS Overview*, <https://qpp.cms.gov/mips>

# Participation in the Medicare QPP Advanced APM Track

## Eligible clinicians benefits include:



Exclusion from MIPS reporting requirements



5% lump sum bonus on Medicare Part B services through 2025



A higher physician fee schedule update beginning in 2026.

The QPP defines two pathways for eligible clinicians to qualify the Advanced APM Track:

### Medicare Only Option

For those providers with >50% of payments (or >35% of patients) through Medicare Advanced APMs

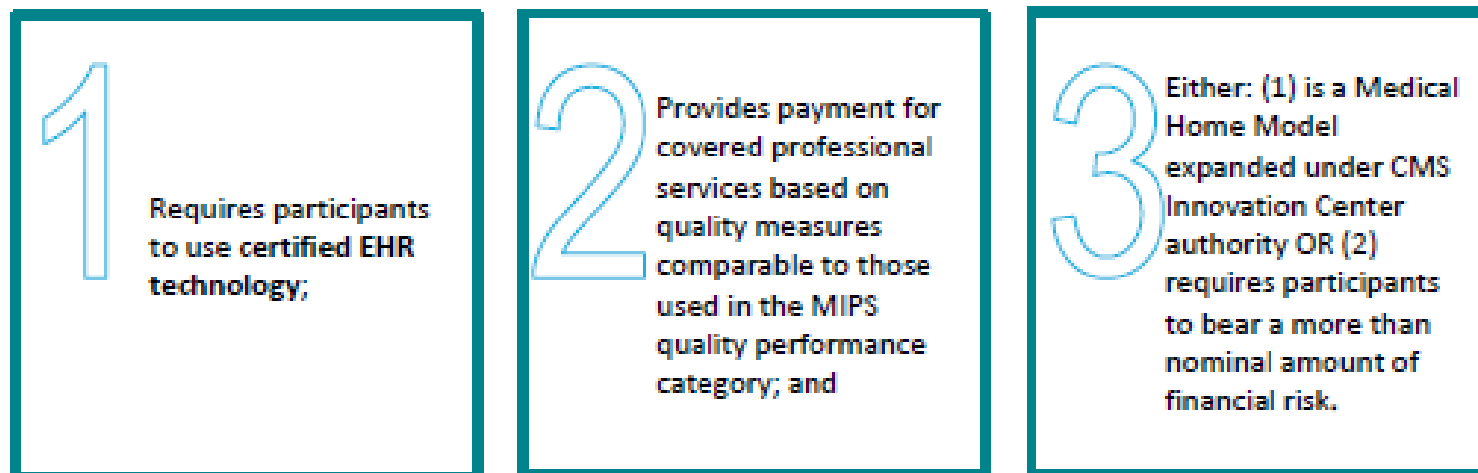
### All-Payer Combination Option

For those providers who have at least 25% of payments (or 20% of patients) through Medicare Advanced APMs. Providers can qualify by meeting specified thresholds based on participation in a both Medicare and Other Payer Advanced APMs.



## Contracts for Medicaid VBP Arrangements must meet specific criteria to be deemed an Other Payer Advanced APM

- **Clinicians can qualify for the Advanced APM track for their Medicaid population through the All-Payer Combination Option**, based on participation in Medicare and Other Payer Advanced APMs.
- Other Payer Advanced APMs are non-Medicare payment arrangements that meet the following criteria:



- Payer types that may have payment arrangements that qualify as Other Payer APMs include:
  - **Title XIX (Medicaid and Medicaid Medical Home Models)**
  - Medicare Health Plans
  - CMS Multi-Payer Models (including CPC+ Payer Partners)
  - Other Commercial and Private Payers

# Section in Review

## QPP Participation Tracks

- Eligible clinicians include Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists.
- MIPS Participants report of 4 performance categories to determine their payment adjustment

**Quality Payment Program Eligible Clinicians**

- Includes Medicare Part B eligible clinicians billing more than \$90,000 a year AND providing care for more than 200 Medicare patients a year.

**MIPS**

**Advanced APM**

- Eligible clinicians who qualify for the Advanced APM Track will receive a 5% bonus incentive payment and will be exempted from MIPS reporting and payment adjustments.

Medicare Advanced APM Only Option

All Payer Combination Option

**AND**

Medicare Advanced APMs

Other Payer Advanced APMs

- Medicare Advanced APMs include:
  - Medicare CPC+
  - MSSP Track 2/3
  - Next Gen ACO
  - More...

- Title XIX (Medicaid and Medicaid Medical Home Models)
- Medicare Health Plans
- CMS Multi-Payer Models (including CPC+ Payer Partners)
- Other Commercial and Private Payers

# NYS Medicaid VBP Alignment with QPP Requirements

# VBP Alignment with QPP CEHRT Requirements

- **QPP Requirements:** CMS is phasing in required use of EHR systems with specific requirements
  - The MIPS Track: Includes measures focusing on patient engagement and electronic exchange of health information using CEHRT.
  - The Advanced APM Track: In order to be deemed an Advanced APM, **the contractual arrangement must require the use of 2015 Edition CEHRT to document and communicate clinical information by at least 50% of contracted providers.**
- **How do the requirements in the State's VBP Roadmap align?**
  - ***The VBP Roadmap does not include requirements for use of CEHRT.***
  - Increased provider utilization of 2015 Edition CEHRT under QPP requirements may support NYS Health IT initiatives, as the 2015 Edition CEHRT<sup>1</sup>:
    - Focuses on health IT components necessary to establish an interoperable nationwide health information infrastructure;
    - Incorporates changes designed to foster innovation, open new market opportunities, and provide more provider and patient choices in electronic health information access and exchange;
    - Addresses information blocking and the continued reliability of certified health IT.

<sup>1</sup> The Office of the National Coordinator for Health IT. (2015). *2015 Edition Final Rule: Overview of the 2015 Edition Health IT Certification Criteria & ONC Health IT Certification Program Provisions*. [https://www.healthit.gov/sites/default/files/onc\\_2015\\_edition\\_final\\_rule\\_presentation\\_10-28-15.pdf](https://www.healthit.gov/sites/default/files/onc_2015_edition_final_rule_presentation_10-28-15.pdf)

# VBP Alignment with QPP Quality Measure Requirements

- **QPP Requirements**

- The MIPS Track: Eligible clinicians must select and report on 6 quality performance measures from the MIPS quality measure list, **including 1 outcome measure** or another high-priority measure if there is no applicable outcome measure.
- The Advanced APM Track: In order to be deemed an Advanced APM, **the contractual arrangement must include MIPS-comparable\* quality measures tied to payment, including 1 outcome measure on the MIPS Measure List.**

- **How do the State's VBP Quality Measure sets align?**

NYS Medicaid VBP Arrangements*			
	Total Measures	Cat 1*	Cat 2*
TCGP/IPC	53	37	16
HARP	42	33	9
HIV/AIDS	44	28	16
Maternity Care	18	9	9

Category 1 VBP Measures included on the 2018 MIPS Measure List		
Total Cat 1 Measures in MIPS Measure List	Process Measures	Outcome Measures
20	18	2
15	12	3
16	13	3
1	1	0

\*See Appendix A for more detail.

# Other Payer Advanced APM Financial Risk Requirements

In order to be deemed an Other Payer Advanced APM, the VBP contractual arrangement must require participants to bear more than a nominal amount of financial risk defined through:

## Marginal Risk

Marginal risk defines the percentage for which the contracted provider entity is liable for if actual expenditures are higher than expected (higher than the benchmark).

## Minimum Loss Rate

A percentage by which actual expenditures may exceed expected expenditures without triggering financial risk.

## Total Risk

Defined as the maximum potential payment for which an APM Entity could be liable under a payment. Total risk can be defined as a percentage of expected expenditures or as a percentage of revenues paid to the contracted provider(s).

***Population-Based Payments and Capitation\* Arrangements:*** Per capita or otherwise predetermined payment made for all items and services paid through the payment arrangement are considered to meet the Other Payer Advanced APM criteria for financial risk.

\* For the purposes of determination, a capitation is not one where settlement is performed to reconcile or share losses incurred or savings earned.

# NYS Medicaid VBP Alignment with Other Payer Advanced APM Financial Risk Requirements

## Other Payer Advanced APM Criteria

## How do the State's VBP Financial Risk requirements align?

<b>Marginal Risk</b> of $\geq 30\%$
<b>Minimum Loss Rate</b> of $\leq 4\%$
<b>Total Risk Rate</b> based on one of the following: <b>Expenditure Based</b> $\geq 3\%$ of expected expenditures
<b>Revenue Based</b> $\geq 8\%$ of total revenues paid to the participating provider
<b>Population-based or capitation arrangements</b> where per capita or otherwise predetermined payment made for all items and services paid through the payment arrangement.

Level 1 VBP	Level 2 VBP	Level 3 VBP
None, upside only	Minimum percentage of potential losses to be allocated to the provider with a low quality score is 20%. <b><i>In order to meeting QPP requirements VBP Contractors will have to increase the amount of downside risk to 30%</i></b>	
	No equivalent term included in the VBP Roadmap	
	Cap of $\geq 3\%$ of the target budget in the first year and $\geq 5\%$ from the second year on.	
	The VBP Roadmap does not currently include a revenue based definition.	
		Prospective per member per month (PMPM) and/or prospective bundled payments. VBP contractor will provide all covered services and is at financial risk for costs that exceed capitation.

## Contracting VBP Arrangements to Meet Both NYS Medicaid VBP and CMS Other Payer Advanced APM Criteria\*

Domain	VBP Level 1 Arrangement	VBP Level 2 Arrangement	VBP Level 3 Arrangement	Key Takeaways
<b>Use of Certified EHR Technology</b>	No requirements.	No requirements.	No requirements.	To meet Other Payer Advanced APM criteria, VBP contractors will need to include additional terms outside of the state's criteria to address use of CEHRT.
<b>Quality Measurement Tied to Payment</b>	Quality measures must be incorporated into the payment arrangement and used to determine the amount of shared savings for which VBP contractors are eligible. State will not define or enforce what quality measures are selected or the approach used to evaluate performance/reward providers.			To meet Other Payer Advanced APM criteria, VBP contractors must select and incorporate MIPS comparable quality measures into the VBP contract.
<b>Financial Risk</b>	None, upside only.	Minimum percentage of potential losses to be allocated to the provider with a low quality score is 20%, with a maximum cap of 3% of the target budget in the first year and 5% from the second year.	Prospective PMPM and/or prospective bundled payments. VBP contractor will provide all covered services and is at financial risk for costs that exceed capitation.	To meet Other Payer Advanced APM requirements, VBP contractors must define financial risk in VBP contracts to meet both state and CMS defined criteria (marginal risk, minimum loss rate, and total risk or population-based payment criteria).

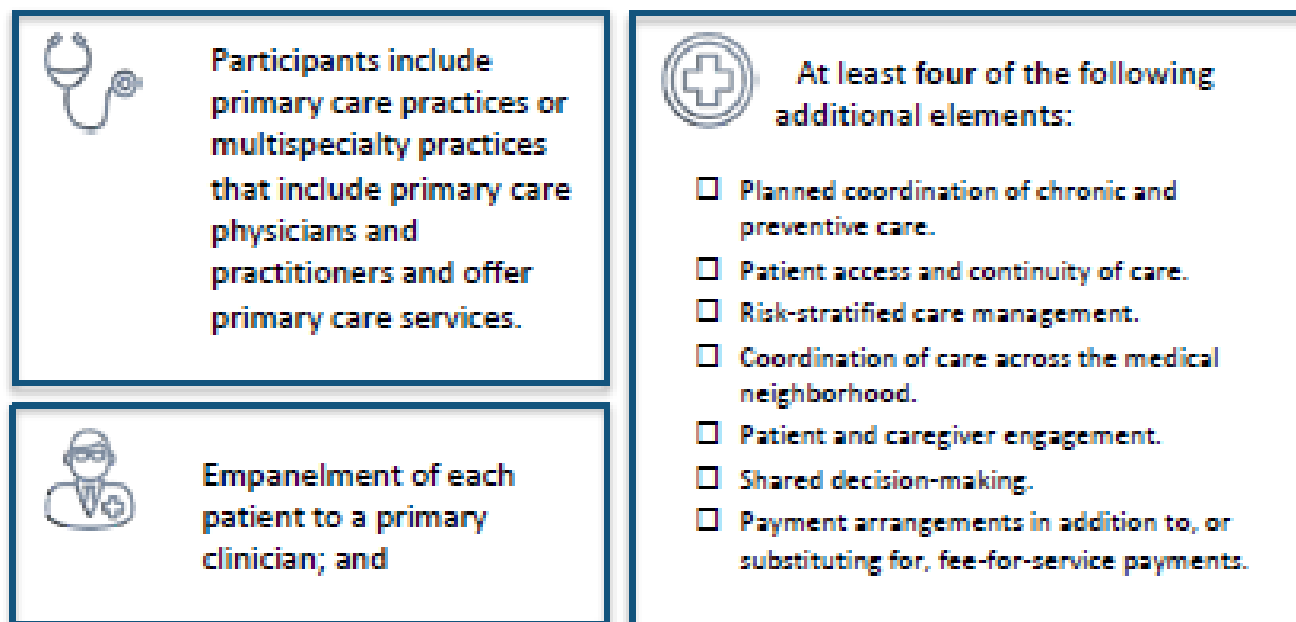
\*See Appendix B for detailed requirement list.



## The Other Payer Advanced APM Financial Risk Standards are Unique for Medicaid Medical Home Payment Arrangements\*

For the purposes of Advanced APM determination only, CMS defines a Medicaid Medical Home Model payment arrangement as including, at a minimum, the elements listed in the figure below.

- Note that PCMH certification is not required and will not be considered a substitute for these elements.



### Nominal Amount Standard for Medicaid Medical Home Payment Arrangements

Nominal amount of risk must be:

- At least 3% of **total estimated revenue** of the participating providers under the payer in 2019.
- Total risk required increases from  $\geq 3\%$  to  $\geq 4\%$  in 2020 and to  $\geq 5\%$  in 2021.

*Other Payer Advanced APM criteria for use of CEHRT and MIPS comparable quality measures tied to payment still apply.*

\*This option is only available to a contracting provider entity that participates in a CMS defined Medicaid Medical Home Payment Arrangement and is **owned and operated by an organization with 50 or fewer clinicians** whose billing rights have been reassigned to the tax identification number (TIN) of the organization or any of the organization's subsidiary entities.

# VBP Contracting Example




*Contracting VBP Arrangements to Meet Both NYS and CMS Other Payer Advanced APM Criteria*

## VBP Contracting Example:

*Defining Total Care for the General Population (TCGP) arrangement financial risk terms to meet both the Level 2 VBP and Other Payer Advanced APM criteria.*

- Based on a prior year’s data, the **expected expenditures** for the attributed population under the arrangement total \$10,000,000.
- The Provider and Managed Care Organization (MCO) agree to include the following financial risk terms defining shared losses for the first contract year as:

*“30% of the losses with a cap of 3% of the target budget \$10,000,000. Actual expenditures must exceed the target budget by 2% to trigger the shared loss repayment requirements.”*

	VBP Arrangement Terms	How does this meet the Other Payer Advanced APM Criteria? <sup>1</sup>	How does this meet NYS Medicaid VBP Criteria for Level 2 Arrangements? <sup>2</sup>
	<b>Marginal Risk</b> <ul style="list-style-type: none"> <li>▪ 30% of the losses <i>(amount exceeding the target budget)</i></li> </ul>	This meets the <b>marginal risk</b> requirement of $\geq 30\%$ of the amount by which actual expenditures exceed expected expenditures or the target budget.	This meets the State’s criteria, exceeding the requirement for a “minimum <b>percentage of potential losses to be allocated</b> to the provider with a low quality score is 20%”
	<b>Total Risk</b> <ul style="list-style-type: none"> <li>▪ with a cap of 3% of the target budget</li> </ul>	This meets the <b>expected expenditure based definition of Total Risk</b> which requires that the maximum potential payment for which the contracting provider could be liable for is $\geq 3\%$ of expected expenditures (the target budget)	This meets the State’s criteria, which requires a <b>cap</b> of $\geq 3\%$ of the target budget in the first year.
	<b>Minimum Loss Rate</b> <ul style="list-style-type: none"> <li>▪ 2% minimum loss rate</li> </ul>	This meets the <b>Minimum Loss Rate</b> requirement of $\leq 4\%$ . as The contracted terms require that the actual expenditures exceed 2% of the expected expenditures before financial risk terms are applied.	<i>The State does not include requirements for, or prohibit inclusion of a Minimum Loss Rate in the VBP Roadmap.</i>

<sup>1</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P, CMS-5522-FC, CMS-5522-IFC), 82 Fed. Reg. 53568 (Nov. 16, 2017)

<sup>2</sup> New York State Department of Health, Medicaid Redesign Team, A Path Toward Value Based Payment: Annual Update, June 2016.

# VBP Contracting Example:

*What dollars are at risk?*

Based on the established target budget, the contracting provider can expect the following:

	VBP Arrangement Terms	What does this mean?
<b>TARGET BUDGET</b>	<b>\$10,000,000</b>	The target budget is set based on total expected expenditures for the attributed population
<b>Marginal Risk</b>	<ul style="list-style-type: none"> <li>30% of the losses (<i>amount exceeding the target budget</i>)</li> </ul>	The contracting provider is at risk for 30% of the amount of actual expenditures exceeding \$10,000,000
<b>Total Risk</b>	<ul style="list-style-type: none"> <li>With a cap of 3% of the target budget</li> </ul>	The maximum amount the provider is liable for is 3% of the target budget or \$300,000. This means that if the actual expenditures exceed the expected, the provider will be responsible for 30% of the overage (marginal risk) up to \$400,000.
<b>Minimum Loss Rate</b>	<ul style="list-style-type: none"> <li>2% minimum loss rate</li> </ul>	A minimum loss rate of 2% of the target budget means that actual expenditures must exceed \$200,000 before the financial risk terms are applied. For example, if at the end of the year actual expenditures total \$10,100,000 (\$100,000 less than the MLR), then the provider will not be liable for the financial risk terms requiring repayment of 30% of the overage.

## VBP Contracting Example:

### *End of Year Reconciliation and Shared Losses to be Paid*

At the end of the contract year, **the actual expenditures total \$11,500,000** for the attributed patient population, exceeding the target budget by \$1,500,000.

	VBP Arrangement Terms	What does this mean?
<b>Target Budget</b>	\$10,000,000	<i>The target budget was set based on total expected expenditures for the attributed population</i>
<b>Marginal Risk</b>	<ul style="list-style-type: none"> <li>30% of the losses of \$1,500,000</li> </ul>	The provider is liable for \$450,000 which is 30% of the amount that actual expenditures exceed expected.
<b>Total Risk</b>	<ul style="list-style-type: none"> <li>With a cap of 3% of the target budget</li> </ul>	The amount the provider must repay is capped at \$300,000.
<b>Minimum Loss Rate</b>	<ul style="list-style-type: none"> <li>2% minimum loss rate</li> </ul>	The financial risk terms are triggered and the provider is liable for a percentage of the overage since the actual expenditures exceeded expected expenditures by an amount above the 2% minimum loss rate of \$200,000.

In this example, the total amount that the provider is liable for is \$450,000 which exceeds the capped amount of \$300,000 total risk. Therefore, based on the contracted financial risk terms, the provider will repay a total of \$300,000.

# More to come!

- Qualification for the Advanced APM track under the All Payer Option will begin with QPP performance year 2019.
- MACRA has the State's attention and we are looking for ways to align requirements in support of providers participating in both the NYS Medicaid VBP Program and the CMS Quality Payment Program.

*Thank you!*

***Please send questions and feedback to:***

**[vbp@health.ny.gov](mailto:vbp@health.ny.gov)**

# Appendix A

VBP Alignment with QPP Quality Measure Requirements:

*Additional Reference Slides*



# MIPS-Comparable Quality Measures

- To be MIPS comparable, measures must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:
  - Included on the annual MIPS list of measures,
  - Endorsed by a “consensus-based entity” (i.e. the National Quality Forum [NQF]),
  - Quality measures developed under section 1848(s) - Priorities and Funding for Measure Development -- of the Social Security Act (the “Act”)4,
  - Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act, or
  - Other support for measure validation.
- The full MIPS Quality Measure List can be accessed at <https://qpp.cms.gov/mips/quality-measures>

# 2018 NYS Medicaid VBP Arrangement Quality Measure Sets

- **NYS Medicaid VBP Quality Measure Sets**

The 2018 Quality Measure Sets for the NYS Medicaid Total Care for the General Population (TCGP), Integrated Primary Care (IPC), Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS), Health and Recovery Plan (HARP), and Maternity Care Arrangements can be accessed through the Delivery System Reform Incentive Payment (DSRIP) VBP Resource Library at [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm).

- **Measure Classification\***:

Each measure has been designated by the State as Category 1 or 2 with associated recommendations for implementation and testing for future use in VBP arrangements. Note that measure classification is a State recommendation and implementation is to be determined between the MCO and VBP Contractor.

- ***Category 1 Measures***

Category 1 measures are intended to be used to determine the amount of shared savings for which VBP contractors would be eligible.

- ***Category 2 Measures***

Category 2 measures have been accepted by the State based on agreement of measure importance, validity, and reliability, but flagged as presenting concerns regarding implementation feasibility.

# Appendix B

NYS Medicaid VBP Alignment with Other Payer Advanced APM Criteria

# Criteria for Use of CEHRT and Quality Measurement in the Payment Arrangement

## Other Payer Advanced APM Criteria<sup>1</sup>

## How do NYS Medicaid VBP requirements align?<sup>2</sup>

Other Payer Arrangement	Medicaid Medical Home Model Arrangement	Level 1 VBP	Level 2 VBP	Level 3 VBP
<p>The contractual arrangement must require the use of 2015 Edition CEHRT to document and communicate clinical information by at least 50% of contracted providers.</p>		<p>No Requirement</p>		
<p>The contractual arrangement must include MIPS-comparable quality measures tied to payment, including 1 outcome measure on the MIPS Measure List.</p>		<p>Quality measures must be incorporated into the payment arrangement and used to determine the amount of shared savings for which VBP contractors are eligible. State will not define or enforce what quality measures are selected or the approach used to evaluate performance/reward providers.</p>		

<sup>1</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P, CMS-5522-FC, CMS-5522-IFC), 82 Fed. Reg. 53568 (Nov. 16, 2017)

<sup>2</sup> New York State Department of Health, Medicaid Redesign Team, A Path Toward Value Based Payment: Annual Update, June 2016.

# Criteria for Financial Risk in the Payment Arrangement

## Other Payer Advanced APM Criteria<sup>1</sup>

## How do NYS Medicaid's VBP Financial Risk requirements align?<sup>2</sup>

Other Payer Arrangements		Medicaid Medical Home Model Arrangement	Level 1 VBP	Level 2 VBP	Level 3 VBP
<b>Marginal Risk</b> of $\geq 30\%$		No Requirement	None, upside only	Minimum percentage of potential losses to be allocated to the provider with a low quality score is 20%	
<b>Minimum Loss Rate</b> of $\leq 4\%$		No Requirement		No equivalent term included in the VBP Roadmap	
<b>Total Risk Rate</b> based on one of the following:				Cap of $\geq 3\%$ of the target budget in the first year and $\geq 5\%$ from the second year on.	
<b>Expenditure Based</b> $\geq 3\%$ of expected expenditures under the arrangement	<i>Does not include an expenditure-based definition of Total Risk.</i>			The VBP Roadmap does not currently include a revenue based definition.	
<b>Revenue Based</b> $\geq 8\%$ of total revenues paid to the participating provider under the arrangement	$>3\%$ of estimated total revenue paid to the participating providers under the arrangement				
<b>Population-based or capitation arrangements</b> where per capita or otherwise predetermined payment made for all items and services paid through the payment arrangement.					Prospective PMPM and/or prospective bundled payments. VBP contractor will provide all covered services and is at financial risk for costs that exceed capitation.

<sup>1</sup> Medicare Program; CY 2018 Updates to the Quality Payment Program (CMS-5522-P, CMS-5522-FC, CMS-5522-IFC), 82 Fed. Reg. 53568 (Nov. 16, 2017)

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