Quality Payment PROGRAM

Quality Payment Program – Final Rule for Year 2 Other Payer Advanced APM Determination Process – Medicaid

On November 2, 2017, the Department of Health and Human Services (HHS) issued a final rule with comment period continuing to implement policies for Calendar Year (CY) 2018 of the Quality Payment Program. This fact sheet provides a brief overview of the Centers for Medicare and Medicaid Services' (CMS) process for determining whether payment arrangements with payers other than Medicare meet the criteria for Other Payer Advanced Alternative Payment Models (APMs) under the All-Payer Combination Option. It then provides detail on how the Other Payer Advanced APM Determination process is unique for payment arrangements authorized under Medicaid (Title XIX).

What's the All-Payer Combination Option?

The Advanced APM path under the Quality Payment Program provides two ways for Eligible Clinicians to become Qualifying APM Participants (QPs): the Medicare Option, which only takes participation in Advanced APMs with Medicare into account, and the All-Payer Combination Option, which takes participation in both Advanced APMs with Medicare and Other Payer Advanced APMs into account. Other Payer Advanced APMs are alternative payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans, payers in CMS Multi-Payer Models, and other commercial payers. The Medicare Option allows Eligible Clinicians to become QPs through Advanced APM participation starting in the 2017 QP Performance Period. The All-Payer Combination Option allows Eligible Clinicians to become QPs through participation in a combination of Advanced APMs and Other Payer Advanced APMs starting in the 2019 QP Performance Period.

Eligible clinicians who do not meet either the patient count or payment amount QP threshold to become QPs under the Medicare Option, but still meet a lower threshold under the Medicare Option, may request a QP determination under the All-Payer Combination Option. Eligible clinicians who become QPs through either option will receive a 5% APM incentive bonus payment in the payment year (two years after the QP Performance Period year) and will not be subject to the MIPS reporting requirements or payment adjustments.[1]

[1] Eligible Clinicians may become Partial QPs under the Medicare Option, which allows the clinician to elect whether to report to MIPS and receive a MIPS payment adjustment, or not to report and be excluded from MIPS Partial QP status does not confer a 5% APM incentive payment.

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).

In 2018, prior to the 2019 QP Performance Period, CMS will allow certain payers – State Medicaid Agencies, Medicare Advantage and other Medicare Health Plans, and payers participating in CMS-sponsored Multi-Payer payment arrangements (CMS Multi-Payer Models) [2] – to voluntarily submit information to CMS about their payment arrangements with eligible clinicians. By encouraging payers to submit this information on a voluntary basis, the 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 who 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 a payment arrangement information to CMS (or isn't eligible to), then eligible clinicians or APM Entities participating in the payment arrangement would be able to do so instead through the Eligible Clinician Initiated Process.

We explain how the Payer Initiated and Eligible Clinician Initiated Processes specifically apply to Medicaid below.

What's the Medicaid Exclusion?

If no Medicaid APM or Medicaid Medical Home Model [3] is available in a given state, then Medicaid patients and associated payments are excluded from the threshold score calculations for eligible clinicians in that state. This exclusion, which is required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), ensures that Medicaid payments/patients are only included in QP determinations if eligible clinicians have a meaningful opportunity to participate in a Medicaid APM or Medicaid Medical Home Model.

If a Medicaid APM or Medicaid Medical Home Model is only available in certain counties, CMS will exclude Medicaid payments and patients from QP calculations for eligible clinicians who practice in counties where the Other Payer Advanced APM is unavailable. Similarly, Medicaid

[2] Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans.
[3] Medicaid Medical Home Models here refers to those that CMS determines meets the Other Payer Advanced APM criteria.

payment amounts and patient counts will be excluded when an eligible clinician is ineligible to participate in all existing Medicaid APMs due to his or her specialty.

In order to provide eligible clinicians with clarity about whether their Medicaid payments and patients will be excluded from QP determinations under the All Payer Combination Option in advance of the relevant QP Performance Period, CMS will develop and post a final list of Medicaid APMs prior to the start of a QP Performance Period. To provide this clarity, CMS needs to receive information regarding Medicaid APMs and Medical Home Models earlier than information from other payers.

How Does the Payer Initiated Process Work for Medicaid?

In 2018, prior to the 2019 QP Performance Period, State Medicaid Agencies can voluntarily submit Medicaid payment arrangements to CMS and request a determination of whether those payment arrangements qualify as Other Payer Advanced APMs. Specifically, the submission period will open on January 1 of the calendar year prior to the relevant QP Performance Period with a Submission Deadline of April 1 of the year prior to the QP Performance Period (see Table 1 for more information).

State Medicaid Agencies will be responsible for submitting information both about payment arrangements in Medicaid fee-for-service and those offered by Medicaid Managed Care Plans or other health plans; Medicaid health plans may not submit payment arrangements directly to CMS.

A State Medicaid Agency may request review of multiple Medicaid payment arrangements through the Payer Initiated Process, though CMS would make separate determinations as to each other payer arrangement. For instance, a single State Medicaid Agency might request determinations for arrangements offered by several different managed care plans.

How Does the Eligible Clinician Initiated Process Work for Medicaid?

The Eligible Clinician Initiated Process was designed to provide eligible clinicians with an opportunity to submit their payment arrangement information to CMS in the event their payer does not do so. In the context of Medicaid, this provides an opportunity for clinicians to report a payment arrangement if their State Medicaid Agency does not.

Beginning in 2018, before the 2019 QP Performance Period, if CMS has not already determined that a Medicaid payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or APM Entities on their behalf) have the option to submit information about their Medicaid payment arrangement. The submission period will open on September 1 of the calendar year prior to the relevant QP Performance Period, and the Submission Deadline will be November 1 of that year. These determinations must be made before the 2019 QP Performance Period in order to implement the Medicaid exclusion described above.

Like states, eligible clinicians may request review of multiple Medicaid payment arrangements that have not already been determined to be Other Payer Advanced APMs, though CMS would make separate determinations as to each other payer arrangement.

The specific information and processes for Payers and Eligible Clinicians to submit payment arrangement information to CMS are outlined in Table 1 below.

Table 1: Steps for submitting Medicaid payment arrangement information to CMS for Other Payer Advanced APM Determinations

Payer Initiated Process	Eligible Clinician Initiated Process
Under the Payer Initiated Process, State Medicaid Agencies will submit 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).	**Like States, eligible clinicians 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).
The Payer Initiated Process follows these steps: • The State Medicaid agency should consult the Medicaid-specific guidance and would complete the Payer Initiated Submission Form for Medicaid payment arrangements.** As necessary, the State Medicaid Agency should consult with managed care plans or other Medicaid health plans in compiling and submitting this information. • CMS reviews the submitted payment arrangement information to determine whether the arrangement meets the Other Payer Advanced APM criteria. If the submitted information is incomplete, CMS will inform the State Medicaid Agency and request more information. • CMS will make Other Payer Advanced APM determinations prior to the beginning of the QP Performance Period and will post the results on our website at cms.gov (see Table 2 below for specific dates).	**The Eligible Clinician Initiated Process follows these steps:** • If a payer does not submit their payment arrangement information to CMS (or isn't eligible to), then eligible clinicians participating in the payment arrangement would be able to do so instead The eligible clinician should consult the Eligible Clinician Initiated Process guidance and would complete the Eligible Clinician Initiated Submission Form. *** • CMS reviews the payment arrangement information submitted to determine whether the arrangement meets the Other Payer Advanced APM criteria. If the submitted information is incomplete, CMS will inform the eligible clinician and the eligible clinician will be able to submit additional information. • CMS will make Other Payer Advanced APM determinations prior to the beginning of the QP Performance Period and will post the results on our website at cms.gov (see Table 2 below for specific dates).

**CMS will release guidance on Other Payer Advanced APM Determinations and the Payer Initiated and Eligible Clinician Initiated forms will be made available at a later date.

Public Posting and Timeline

Before the relevant QP Performance Period starts, we'll post on our website at cms.gov a list of payment arrangements determined to be Other Payer Advanced APMs through the Payer Initiated Process. In December 2018, we'll update this list to include payment arrangements determined to be Other Payer Advanced APMs based on submissions through the Eligible Clinician Initiated Process.

Table 2: Performance Year 2019 Timeline for Medicaid Other Payer Advanced APM Determinations

Payer Initiated Process		Eligible Clinician (EC) Initiated Process*	
Guidance sent to states; Submission Period Opens	**Jan. 2018**	Guidance made available to ECs; Submission Period Opens	**Sept. 2018**
Submission Period Closes	**April 2018**	Submission Period Closes	**Nov. 2018**
CMS contacts states and Posts Other Payer Advanced APM List	**Sept. 2018**	CMS contacts ECs and states and Posts Other Payer Advanced APM List	**Dec. 2018**

*Note that APM Entities or eligible clinicians may use the Eligible Clinician Initiated Process.

For more information on CMS's policies regarding the All-Payer Combination Option and how to become a Qualifying APM Participant under the All-Payer Combination Option, see the following fact sheet on the Quality Payment Program resource library:

"Quality Payment Program Year 2 Final Rule - All-Payer Combination Option & Other Payer Advanced APMs."