Quality Payment PROGRAM

Other Payer Advanced APM Determination Process: Medicare Health Plans Fact Sheet

Quality Payment Program Final Rule for Year 2

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 & Medicaid Services' (CMS) process for determining whether payment arrangements with payers other than Medicare Fee-For-Service (FFS) meet the criteria for Other Payer Advanced Alternative Payment Models (APMs) under the All-Payer Combination Option. It also discusses how the Other Payer Advanced APM Determination process is unique for payment arrangements offered through Medicare Health Plans, which include Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans.

What is 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.

How are Medicare Health Plans treated under the All-Payer Combination Option?

Under the Medicare Access and CHIP Reauthorization Act of 2015, Medicare Advantage and other Medicare Health Plan participation must be considered as part of the All-Payer Combination Option, rather than the Medicare Option. That is, payments and patients under Medicare Advantage and other Medicare Health Plans, do not count toward meeting the threshold levels of participation under the Medicare Option, which is explicitly limited to Medicare. However, CMS intends to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative alternative payment arrangements under Medicare Advantage that could qualify as Advanced APMs by allowing credit for participation in such Medicare Advantage arrangements prior to 2019 and incenting participation in such arrangements in 2018 through 2024. CMS intends to release additional details regarding a potential Medicare Advantage demonstration in the future.

What is 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)
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,[2] Medicare Advantage and other Medicare Health Plans,[3] and payers participating in CMS-sponsored Multi-Payer payment arrangements (CMS Multi-Payer Model Payers) – to voluntarily submit information to CMS about their payment arrangements. This Payer Initiated Process is designed to reduce reporting burden for APM Entities and eligible clinicians, while allowing CMS to collect the information needed to make Other Payer Advanced APM determinations. Payers that choose to participate would assist their networks of clinicians by sending the information regarding the payment arrangement to CMS.

If a payer chooses not to submit its payment arrangement information to CMS (or isn't eligible to), then eligible clinicians or APM Entities participating in the payment arrangement could do so instead. That process is known as the Eligible Clinician Initiated Process.

Explanations of how the Payer Initiated and Eligible Clinician Initiated Processes specifically apply to Medicare Health Plan payment arrangements are provided below.

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[2] State Medicaid Agencies can also submit information for Medicaid Managed Care health plans.
[3] Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, 1876 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans.

What is the Payer Initiated Process for Medicare Health Plans?

In 2018, prior to the 2019 QP Performance Period, Medicare Health Plans may voluntarily submit information on their payment arrangements to CMS and request determinations of whether those payment arrangements qualify as Other Payer Advanced APMs. To reduce burden and complexity, Medicare Health Plans will submit this information contemporaneously with the annual bidding process for Medicare Advantage contracts. Medicare Health Plan Payers will use the Health Plan Management System (HPMS) for this submission.

Medicare Health Plans will be responsible for submitting this information by the annual Medicare Advantage bid submission deadline in the year prior to the 2019 QP Performance Period. The submission period will open on April 6, 2018, prior to the 2019 QP Performance Period, and the submission deadline will be June 4, 2018. The timeline for payers to request a determination and submit information to CMS is outlined in Table 2.

If a Medicare Health Plan would like us to make determinations for multiple payment arrangements, it must complete a separate submission for each payment arrangement.

What is the Eligible Clinician Initiated Process for Medicare Health Plans?

The Eligible Clinician Initiated Process is designed to provide eligible clinicians with the opportunity to submit their payment arrangement information to CMS if their payer does not do so. For Medicare Health Plan payment arrangements, this provides the opportunity for eligible clinicians to report a payment arrangement if the Medicare Health Plan payer does not.

Starting in 2019, if CMS has not already determined that a Medicare Health Plan payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, eligible clinicians (or their APM Entities) paid by a Medicare Health Plan may submit information on their payment arrangements and request determinations between August 1 and December 1 of the same year as the relevant QP Performance Period.

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 Medicare Health Plan payment arrangement information to CMS for Other Payer Advanced APM Determinations

Payer Initiated Process	Eligible Clinician Initiated Process
Under the Payer Initiated Process, Medicare Health Plans will 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)	**Like Medicare Health Plans, 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 measures tied to payment, and financial risk); and • Payment arrangement documentation (e.g., contracts/excerpts from contracts, or comparable documentation).
The Payer Initiated Process follows these steps: • The Medicare Health Plan consults guidance from CMS specific to Medicare Health Plans • The Medicare Health Plan completes the payer-specific submission form contained in the new Quality Payment Program module within the Health Plan Management System (HPMS) contemporaneously with the annual bidding process for Medicare Advantage contracts. [4]This module will become available in April. • Generally, Other Payer Advanced APM determinations will be made at the plan level; a single Medicare Advantage or cost contract may cover multiple Medicare Advantage or cost plans offered by the organization. If there are multiple payment arrangements within a given plan, the	**The Eligible Clinician Initiated Process follows these steps:** • If a Medicare Health Plan does not submit its payment arrangement information to CMS, then eligible clinicians participating in the payment arrangement could do so instead. • The eligible clinician consults the Eligible Clinician Initiated Process guidance and completes 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 and will post the results on

[4] 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.

Medicare Health plan must submit a request for each payment arrangement. • This assumes the relevant payment arrangement criteria vary by plan across the contract. If, however, the payment arrangement criteria are identical across plans offered under a single contract, the Medicare Health Plan may submit one form for all plans covered by the applicable contract. • Note, organizations using HPMS may submit payment arrangements for Other Payer Advanced APM determinations even if they are not submitting an annual bid for a Medicare Advantage contract (e.g., Medicare-Medicaid Plans). • The deadline for completing submission forms within the Quality Payment Program module will be the same as the due date for Medicare Advantage bids, the first Monday in June (For the 2019 period, this date is June 4, 2018). • 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 Medicare Health Plan and request more information through HPMS. • 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.gov (see Table 2 below for specific dates).

Public Posting and Timeline

Before the relevant QP Performance Period starts, CMS will post on our website at cms.gov a list of payment arrangements determined to be Other Payer Advanced APMs through the Payer Initiated Process. After the QP Performance Period, CMS will 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 Medicare Health Plan Other Payer Advanced APM Determinations

	Payer Initiated Process	Date	Eligible Clinician (EC)* Initiated Process	Date
Medicare Health Plans	Guidance sent to Medicare Health Plans– Submission Period Opens	**April 2018**	Guidance made available to ECs– Submission Period Opens	**Aug. 2019**
	Submission Period Closes	**June 2018**	Submission Period Closes	**Dec. 2019**
	CMS contacts Medicare Health Plans and Posts Other Payer Advanced APM List	**Sept. 2018**	CMS contacts ECs and Posts Other Payer Advanced APM List	**Dec. 2019**

*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."