

*Combination Option.* (1) An APM Entity or eligible clinician may request as set forth in §414.1445(b)(2) that CMS determine whether a payment arrangement in which they participate meets the Other Payer Advanced APM criteria and may demonstrate participation in an Other Payer Advanced APM determined as a result of a request made in §414.1445(a)(1) or (b)(1) in a form and manner specified by CMS.

(2) To request a QP determination under the All-Payer Combination Option, for each payment arrangement submitted as set forth in paragraph (e)(1) of this section, the APM Entity or eligible clinician must include:

(i) The amount of revenue for services furnished through the payment arrangement, the total revenue received from all payers except those excluded as provided in paragraph (a)(2) of this section, the number of patients furnished any service through the arrangement, and the total number of patients furnished any services, except those excluded as provided in paragraph (a)(2) of this section; and

(ii) In the case of an APM Entity or eligible clinician requesting a QP determination under either a Medicaid Medical Home Model or Aligned Other Payer Medical Home Model pursuant to the criteria in §414.1420, information specified by CMS for purposes of compliance with the 50 eligible clinician limit specified at §414.1420(d)(8).

(3) An APM Entity or eligible clinician must submit the information specified in paragraph (e)(2) of this section in a form and manner specified by CMS. An APM Entity or eligible clinician may submit the information specified in paragraph (e)(2) of this section for the following periods of time in the relevant QP Performance Period: January 1 through March 31, January 1 through June 30, and January 1 through August 31.

(4) To request a QP determination under the All-Payer Combination Option, an APM Entity or eligible clinician must submit this information to CMS no later than the QP Determination Submission Deadline, which is December 1 of the calendar year that is 2 years prior to the payment year.

(f) *Requirement to submit sufficient information—(1) Sufficient Information.*

CMS makes a QP determination with respect to the eligible clinician under the All-Payer Combination Option only if the APM Entity or eligible clinician submits the information required under paragraph (e) of this section sufficient for CMS to assess the eligible clinician under either the payment amount or patient count as described in paragraphs (b) and (c) of this section.

(2) *Certification.* The APM Entity or eligible clinician who submits information to request a QP determination under the All-Payer Combination Option must certify that the information submitted to CMS is true, accurate, and complete. Such certification must accompany the submission and be made at the time of submission. In the case of information submitted by an APM Entity, the certification must be made by an individual with the authority to bind the APM Entity.

(g) *Notification of QP determination.* CMS notifies eligible clinicians determined to be QPs or Partial QPs for a year as soon as practicable after QP calculations are conducted.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53963, Nov. 16, 2017; 83 FR 60091, Nov. 23, 2018; 87 FR 70230, Nov. 18, 2022]

#### **§414.1445 Determination of other payer advanced APMs.**

(a) *Determination of Medicaid APMs.* Beginning in 2018, and each year thereafter, at a time determined by CMS, a state, APM Entity, or eligible clinician may request, in a form and manner specified by CMS, that CMS determine whether a payment arrangement authorized under Title XIX is either a Medicaid APM or a Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria as set forth in §414.1420. A state must submit its request by April 1 of the year prior to the relevant QP Performance Period, and an APM Entity or eligible clinician must submit its request by November 1 of the year prior to the relevant QP Performance Period. CMS will not determine that a payment arrangement is a Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria as set forth in §414.1420 for a year

after the relevant QP Performance Period.

(b) *Determination of Other Payer Advanced APMs*—(1) *Payer initiated Other Payer Advanced APM determination process.* Beginning in 2018, and each year thereafter, at a time determined by CMS a payer with a Medicare Health Plan payment arrangement may request, in a form and manner specified by CMS, that CMS determine whether a Medicare Health Plan payment arrangement meets the Other Payer Advanced APM criteria set forth in § 414.1420. A payer with a Medicare Health Plan payment arrangement must submit its requests by the annual Medicare Advantage bid deadline of the year prior to the relevant QP Performance Period. A Medicare Health Plan is a Medicare Advantage plan, a section 1876 cost plan, a PACE organization operated under section 1894, and any similar plan which provides Medicare benefits under demonstration or waiver authority (other than an APM as defined in section 1833(z)(3)(C) of the Act).

(2) *Eligible clinician initiated Other Payer Advanced APM determination process.* Except as provided by paragraph (a) of this section, at a time specified by CMS, an APM Entity or eligible clinician may request that CMS determine whether a payment arrangement meets the Other Payer Advanced APM criteria as set forth in § 414.1420 in a form and manner specified by CMS. An APM Entity or eligible clinician must submit requests by December 1 of the calendar year of the relevant QP Performance Period.

(c) *Information required for Other Payer Advanced APM determinations.* (1) In order to make an Other Payer Advanced APM determination as set forth in paragraphs (a) and (b) of this section, a payer, APM Entity, or eligible clinician must submit the information specified by CMS in a form and manner specified by CMS. If a payer, APM Entity, or eligible clinician fails to submit the information required, CMS will not make a determination as to whether a payment arrangement meets the Other Payer Advanced APM criteria as set forth in § 414.1420.

(2) If an eligible clinician submits information showing that a payment arrangement requires that the eligible

clinician must use CEHRT as defined in § 414.1305 to document and communicate clinical care, CMS will presume that the CEHRT criterion in § 414.1420(b) is satisfied for that payment arrangement.

(i) Based on the submission by an eligible clinician or payer of evidence that CMS determines sufficiently demonstrates that CEHRT is used as specified in § 414.1420(b) by participants in the payment arrangement, CMS will consider the CEHRT criterion in § 414.1420(b) is satisfied for that payment arrangement.

(ii) [Reserved]

(3) If a payment arrangement has no outcome measure, the payer, APM Entity, or eligible clinician requesting a determination of whether a payment arrangement meets the Other Payer Advanced APM criteria must certify that there is no available or applicable outcome measure on the MIPS measure list.

(d) *Certification.* A payer, APM Entity, or eligible clinician that submits information pursuant to paragraph (c) of this section must certify that the information it submitted to CMS is true, accurate, and complete. Such certification must accompany the submission and be made at the time of submission. In the case of information submitted by a payer or an APM Entity, the certification must be made by an individual with the authority to bind the payer or the APM Entity.

(e) *Timing of Other Payer Advanced APM determinations.* CMS makes Other Payer Advanced APM determinations prior to making QP determinations under § 414.1440.

(f) *Notification of Other Payer Advanced APM determinations.* CMS makes Other Payer Advanced APM determinations and notifies the requesting payer, APM Entity, or eligible clinician of such determinations as soon as practicable following the relevant submission deadline.

[82 FR 53964, Nov. 16, 2017, as amended at 83 FR 60091, Nov. 23, 2018]

**§ 414.1450 APM incentive payment.**

(a) *In general.* (1) CMS makes a lump sum payment to QPs in the amount described in paragraph (b) of this section