

**§ 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

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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 in the manner described in paragraphs (d) and (e) of this section.

(i) For payment years 2019 through 2025, CMS makes a lump sum payment to QPs in the amount described in paragraph (b) of this section in the manner described in paragraphs (d) and (e) of this section.

(ii) [Reserved]

(2) CMS provides notice of the amount of the APM Incentive Payment to QPs as soon as practicable following the calculation and validation of the APM Incentive Payment amount, but in any event no later than 1 year after the incentive payment base period.

(b) *APM Incentive Payment amount.*

(1) For payment years 2019 through 2024, the amount of the APM Incentive Payment is equal to 5 percent or, with respect to payment year 2025, 3.5 percent of the estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during the calendar year immediately preceding the payment year. CMS uses the paid amounts on claims for covered professional services to calculate the estimated aggregate payments on which CMS will calculate the APM Incentive Payment.

(2) The estimated aggregate payment amount for covered professional services includes all such payments to any

and all of the TIN/NPI combinations associated with the NPI of the QP.

(3) In calculating the estimated aggregate payment amount for a QP, CMS uses claims submitted with dates of service from January 1 through December 31 of the incentive payment base period, and processing dates of January 1 of the base period through March 31 of the subsequent payment year.

(4) The payment adjustment amounts, negative or positive, as described in sections 1848(m), (o), (p), and (q) of the Act are not included in calculating the APM Incentive Payment amount.

(5) Incentive payments made to eligible clinicians under sections 1833(m), (x), and (y) of the Act are not included in calculating the APM Incentive Payment amount.

(6) Financial risk payments such as shared savings payments or net reconciliation payments are excluded from the amount of covered professional services in calculating the APM Incentive Payment amount.

(7) Supplemental service payments in the amount of covered professional services are included in calculating the APM Incentive Payment amount according to this paragraph (b). Supplemental service payments are included in the amount of covered professional services when calculating the APM Incentive Payment amount when the supplemental service payment meets the following four criteria:

(i) Is payment for services that constitute physicians services authorized under section 1832(a) and defined under section 1861(s) of the Act.

(ii) Is made for only Part B services under the criterion in paragraph (b)(9)(i) of this section.

(iii) Is directly attributable to services furnished to an individual beneficiary.

(iv) Is directly attributable to an eligible clinician, including an eligible clinician that is a group of individual eligible clinicians.

(8) For payment amounts that are affected by a cash flow mechanism, the payment amounts that would have occurred if the cash flow mechanism were not in place are used in calculating the APM Incentive Payment amount.