

As detailed in CMS 5522-FC, beginning in Quality Payment Program Year 3, the All-Payer Combination Option will be an available pathway to QP status for eligible clinicians participating sufficiently in Advanced APMs and Other Payer Advanced APMs. The All-Payer Combination Option allows for eligible clinicians to achieve QP status through their participation in both Advanced APMs and Other Payer Advanced APMs. In order to include an eligible clinician's participation in Other Payer Advanced APMs in their QP threshold score, we will need to determine if certain payment arrangements with other payers meet the criteria to be Other Payer Advanced APMs.

To provide eligible clinicians with advanced notice prior to the start of the 2019 performance period, and to allow other payers to be involved prospectively in the process, we finalized that a payer initiated identification process for identifying payment arrangements that qualify as Other Payer Advanced APMs. However, to appropriately implement the Title XIX exclusions, we determined it was not feasible to allow APM Entities and eligible clinicians to request determinations for Title XIX payment arrangements after the conclusion of the All-Payer QP. To do so would mean that a single clinician requesting a determination for a previously unknown Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria could unexpectedly affect QP threshold calculations for every other clinician in that state (or county). Thus, we also finalized that APM Entities and eligible clinicians may request determinations for any Medicaid payment arrangements in which they are participating at an earlier point, prior to the start of the 2019 performance period. This would allow all clinicians in a given state or county to know before the beginning of the performance period whether their Title XIX payments and patients would be excluded from the all-payer calculations that are used for QP determinations for the year under the All-Payer Combination Option.

CMS is making revisions to Appendix D, used for the Medicaid Specific Eligible Clinician-Initiated Determination Process, to reflect formatting changes, reordering of questions, and minor edits made to improve clarity of questions for clinician respondents. These changes result from continued work with our IT contractor to develop the electronic data collection tool (Salesforce) based on Appendix D that was cleared November 16, 2017 for the data collection that begins on September 1, 2018. These changes are technical in nature and don't substantively alter the type or amount of data we are collecting via the electronic version of the Appendix D form.