Quality Payment PROGRAM

CMS Quality Payment Program

Guide for Managed Care Organizations Providing State Medicaid Agencies with Information and Documentation for Submitting Medicaid Requests for Other Payer Advanced APM Determinations

Purpose

Through the Payer Initiated Submission Form, the Centers for Medicare & Medicaid Services (CMS) will collect information and documentation to determine whether payment arrangements will qualify as Other Payer Advanced Alternative Payment Models (APMs) under the Quality Payment Program (QPP). This process is called the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process). More information about QPP is available at http://qpp.cms.gov/.

While Other Payer Advanced APM determination requests for all Medicaid payment arrangements may *only* be submitted by State Medicaid Agencies ("States"), Managed Care Organizations ("MCOs") (including entities such as prepaid health plans) may have important details of the information needed to fill out the Payer Initiated Submission Form (the "Form"), as well as access to documentation that will need to be attached to the form. In this guide, we are referring to payment arrangements between the MCO and APM Entities or eligible clinicians. The purpose of this document is to inform MCOs of the submission process, which will be conducted by the States, and to provide an outline to the States of information they may need to collect from MCOs. Please use this document together with the:

- Glossary for additional definitions,
- Medicaid Fact Sheet, and
- QPP All-Payer Frequently Asked Questions sheet.

States must submit all requests by April 1 of the year prior to the relevant Qualifying APM Participant (QP) Performance Period (e.g., by April 1, 2018 for the 2019 QP Performance Period).

For a complete Form, the State will need explanations and documentation for the criteria specified below. States are required to be specific (e.g., include page numbers or document sections) when referring to supporting documentation. States are not required to upload separate documentation for each topic. If one contract covers all relevant information needed for CMS to make an Other Payer Advanced APM determination, a State only needs to submit that one contract. Each file can be up to 25MB in size. If there are multiple documents, or multiple excerpts of documents, they should be named logically so they can be referred to throughout the Form. For example, to support the requirement that at least 50 percent of participating eligible clinicians use CEHRT, name the document where the requirement is specified

"STATE_APM_CEHRT" and provide page numbers. Document names can be up to 100 characters long.

Each different Medicaid payment arrangement ("payment arrangement"), even if operating in a single state, must be submitted through a separate Form with its own supporting documentation. Forms will be submitted electronically by the State through an electronic portal, Salesforce, so all supporting documentation must also be submitted electronically. If the supporting documentation is publicly available (e.g., included in a State Plan Amendment (SPA) or Section 1115 demonstration waiver application), the State can provide a link to the online location of the document rather than uploading the PDF. Examples of relevant documentation include contracts, excerpts of contracts, and participant agreements.

The information that the State will need to provide consists of:

Payment Arrangement Information

Payment Arrangement Name

The State will need to submit the name of the payment arrangement. If there is potential uncertainty over the name, include any terms that can help to identify the payment arrangement. Payment arrangement names or terminology used to refer to payment arrangements should be consistent across contracts that include this payment arrangement. The purpose of this information is to allow CMS and eligible clinicians to correctly identify the payment arrangement when evaluating clinician participation in Other Payer Advanced APMs.

Payment Arrangement Participants

The State will need to list the type of clinicians that may participate in the Medicaid payment arrangement; examples might include primary care physicians, nurse practitioners, or hospitalists. Note any limitations on the types of physician or other practitioner specialties that may participate. The purpose of this information is to allow CMS to identify the types of the eligible clinicians who could potentially become Qualifying APM Participants (QPs), in part, through their participation in the payment arrangement.

Availability of Payment Arrangement

The State will need to list the counties where the payment arrangement is available, or else note that the payment arrangement is available statewide.

Other Lines of Business

Is the same payment arrangement available through other lines of business, such as Medicare Advantage or to a commercial payer? If so, those payers may submit a separate Submission Form to request that CMS make an Other Payer Advanced APM determination. The purpose of this information is for CMS to identify whether this payment arrangement is available through other payers outside of the Medicaid context. CMS may be in contact with the MCO.

Information for Medicaid Medical Home Model Determination

Any Medicaid payment arrangement can be an Other Payer Advanced APM if CMS determines that it meets the criteria. A Medicaid Medical Home Model[1] is a specific type of Medicaid payment arrangement that focus specifically on primary care. A Medicaid Medical Home Model is not automatically an Other Payer Advanced APM. Like other Medicaid payment arrangements, the same CEHRT and quality measure requirements apply. But, the financial risk requirements that a Medicaid Medical Home Model needs to meet in order to be an Other Payer Advanced APM are different.

A State may (but is not required) to request that CMS determine whether a Medicaid payment arrangement is a Medicaid Medical Home Model by submitting the following information in the Form:

The State will identify the physician specialty codes of all categories of eligible clinicians who may participate in the Medicaid payment arrangement. CMS will provide a list of physician specialty codes to choose from in the electronic portal.

Does the payment arrangement require patients to be assigned to individual clinicians (empanelment)?

Select all the following elements that the Medicaid payment arrangement requires. Please explain and provide citations to supporting documentation for each "Yes" response.

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g. shared savings or population-based payments).

The questions for the Medicaid Medical Home Model financial risk and nominal amount standards are:

Under the terms of the Medicaid payment arrangement, does failure to meet specific performance standards trigger any of the following actions:

- Payer (i.e., MCO) withholds payment for services,
- Payer requires direct payments by the APM Entity,

[1] The definition of Medicaid Medical Home Model is at 42 CFR § 414.1305.

- Payer reduces payment rates, or
- APM Entity loses the right to all or part of an otherwise guaranteed payment or payments?

Please explain and provide citations to supporting documentation for any "Yes" responses. Please provide details about which actions are taken, how withholds and payments are triggered, and the specific amounts at risk.

Is the total amount an APM Entity (e.g., an ACO, or group practice) potentially owes or foregoes under the payment arrangement at least 3 percent of the APM Entity's total revenue under the payer? If the answer is "Yes", please explain specifically how total revenue and the percentage potentially owed are calculated, and provide citations to documentation that supports the answer.

- "Potentially owes or foregoes" refers to the consequences to the eligible clinician or APM Entity for failure to meet specific performance standards, and "total revenue" is the total combined revenue from the payer to providers and suppliers participating in the APM Entity.

CMS may determine that the payment arrangement is not a Medicaid Medical Home Model, but it could still be an Other Payer Advanced APM. Because of this, a State may also submit answers to the generally applicable financial risk standards that are discussed below.

Information for Other Payer Advanced APM Determination

Certified Electronic Health Record Technology (CEHRT)[2]

This section is applicable to all Medicaid payment arrangements

Does the Medicaid payment arrangement require either at least 50 percent of participating eligible clinicians in each APM Entity group to use CEHRT or each hospital if the hospital is the APM Entity? Please provide a reference to the requirement in the documentation you are submitting alongside the Form (e.g., document name and relevant page numbers).

- Prior to 2019, CEHRT means either the 2014 or 2015 Base EHR Edition that has been certified. Beginning in 2019, the 2015 Base EHR Edition will be required to meet this criterion.[3]

Quality Measures[4]

This section is applicable to all Medicaid payment arrangements

[2] The CEHRT Other Payer Advanced APM criterion is located at 42 CFR § 414.1420(b).
[3] For purposes of this Form, CEHRT is defined at 42 CFR § 414.1305.
[4] The quality measure Other Payer Advanced APM criterion is at 42 CFR § 414.1420(c).

Does the Medicaid payment arrangement apply quality measures that are comparable to the MIPS quality performance category?

To be MIPS comparable, measures must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

- Included on the annual MIPS list of measures (https://qpp.cms.gov/mips/quality-measures),
- Endorsed by a "consensus-based entity" (i.e. the National Quality Forum [NQF]),
- Developed under section 1848(s) - Priorities and Funding for Measure Development - of the Social Security Act (the "Act")[5],
- Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act, or
- Other support for measure validation.

Please explain and provide citations to supporting documentation to support the answer.

- Does the Medicaid payment arrangement use an outcome measure that is on the MIPS quality measure list? An outcome measure assesses healthcare results experienced by patients. They include endpoints like well-being, ability to perform daily activities, or death. An intermediate outcome measure assesses a factor or short-term result that contributes to an ultimate outcome, such as having an appropriate cholesterol level.

Provide the following information on at least one measure tied to payments. You must include at least one outcome measure on the MIPS quality measure list and one quality measure that is MIPS-comparable; these may be the same measure if the outcome measure also has an evidence-based focus and is reliable and valid.

A. Measure title.
B. Outcome measure (Yes/No)?
C. How was this measure validated? Cite all relevant evidence and/or clinical practice guidelines in support of the measure.
D. National Quality Forum (NQF) number, if applicable.
E. MIPS measure identification number, if applicable.

Please explain and provide citations to supporting documentation to support the answer.

If there is no applicable outcome measure, respond accordingly.[6]

[5] We note that the two options tied to Title XVIII of the Act may be relatively unlikely to be applicable to Medicaid payment arrangements.

[6] Please note that if there is no available or applicable outcome measure on the MIPS measure list, the payer (in case the State) must certify that there is no available or applicable outcome measure on the MIPS measure list per 42 CFR § 414.1445(c)(3).

Generally Applicable Financial Risk Standard[7]

Medicaid Medical Home Models are subject to the different Medicaid Medical Home Model Financial Risk Standard discussed above. A State requesting a determination that a payment arrangement is a Medicaid Medical Home Model may also submit information pertaining to the Generally Applicable Financial Risk Standard in case CMS determines that the Medicaid payment arrangement is not a Medicaid Medical Home Model.

If an APM Entity's actual expenditures are higher than expected expenditures, does the Medicaid payment arrangement state that at least one of the following happens?[8] Please explain and provide citations to supporting documentation for each "Yes" response.

- Payer (i.e., MCO) withholds payment for services
- Payer reduces payment rates; or
- Payer requires direct payment.
- Expected expenditures refers to the beneficiary or patient expenditures for which an APM Entity is responsible during a specified period of time. For episode payment arrangements, episode expenditures refers to the episode target price.

Generally Applicable Nominal Amount Standard[9]

Medicaid Medical Home Models are subject to the Medicaid Medical Home Model Nominal Amount Standard, which is discussed above. A State requesting a determination that a payment arrangement is a Medicaid Medical Home Model may also submit information pertaining to the Generally Applicable Financial Risk Standard in case CMS determines that the Medicaid payment arrangement is not a Medicaid Medical Home Model.

The State will be asked to provide a detailed description of the Medicaid payment arrangement's risk methodology. As a reminder, this refers to the payment arrangement between the MCO and the APM Entity or eligible clinicians. Include all information needed to explain what the payment arrangement requires of the APM Entity in terms of risk. Relevant details include risk rates, expenditures that are included in risk calculations, circumstances under which an APM Entity is required to repay or forego payment, and any other key components of the risk methodology. Cite all relevant documentation in support of the description.

Is the marginal risk rate at least 30 percent?

[7] The generally applicable financial risk standard Other Payer Advanced APM criterion is located at 42 CFR § 414.1420(d)(1).
[8] Please note that Medicaid managed care plans must comply with 42 CFR § 438.3(i) when designing and implementing physician incentive plans that put participating physicians at financial risk.
[9] The generally applicable nominal amount standard Other Payer Advanced APM criterion is located at 42 CFR § 414.1420(d)(3).

- Marginal risk means the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the payment arrangement. In the case where actual expenditures are higher than expected (higher than the benchmark), the APM Entity may only be liable for a percentage of the difference. The percentage they are liable for is the marginal risk.

Is the minimum loss rate no more than 4 percent? Describe, and cite, the minimum loss rate and any consequential action the payment arrangement requires.

- In the case where actual expenditures are higher than expected, the APM Entity may not be subject to financial risk if the difference is small. The minimum loss rate is the percentage by which actual expenditures may exceed expected expenditures without triggering consequential actions.

Is the total amount at risk for the APM Entity at least 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity? Please support with explanations of how risk is defined in terms of revenue.

- Total revenue means the total combined revenue from the payer to providers and suppliers participating in the APM Entity.

Is the total amount at risk for the APM Entity at least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement? Expected expenditures means the beneficiary or patient expenditures for which an APM Entity is responsible under an APM. Please support with explanations of how expected expenditures are calculated.

Capitation[10]

- Capitation is defined as a per capita or otherwise predetermined payment made for all items and services paid through the payment arrangement. For purposes of Other Payer Advanced APM determinations, a capitation arrangement is not one where settlement is performed to reconcile or share losses incurred or savings earned. Provide citations to any relevant documentation.

[10] The regulation pertaining to capitation is located at 42 CFR § 414.1420(d)(7).