Quality Payment PROGRAM

Performance Year 2023 Guide to Submitting Medicaid Requests for Other Payer Advanced APM Determinations (Payer Initiated Submission Form)

Purpose

Through the Payer Initiated Submission Form (the "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/.

The purpose of this document is to guide States through the Form for ease of submission and to facilitate accurate determinations by CMS. Please use this document together with the:

- **Salesforce Portal**
- **All-Payer Advanced Alternative Payment Models (APM) Option**

Overview of Payer Initiated Process

Only States can submit requests for Medicaid payment arrangements (both Medicaid fee-for-service [FFS] and for Medicaid managed care). Each unique payment arrangement in a single state must be submitted through a separate Form.

Forms for all Medicaid payment arrangements ("payment arrangement") submitted by a State, including payment arrangements aligned with a CMS Multi-Payer Model, must be submitted by **April 1** of the year prior to the relevant Qualifying APM Participant (QP) Performance Period. For the **2023 QP Performance Period,** states may submit requests between **January 1 and April 1, 2022.** CMS will not make Other Payer Advanced APM determinations until after the Submission Deadline.

CMS will review the payment arrangement information submitted in this Form to determine whether the payment arrangement meets the Other Payer Advanced APM criteria. If a State submits incomplete information and/or more information is required to make a determination, CMS will notify the State and request the additional information that is needed. States must return the requested information no later than **15 business days** from the notification date for CMS to make a determination. If the State does not submit sufficient information within this time period, CMS will not make a determination regarding the payment arrangement. As a result, the payment arrangement would not be considered an Other Payer Advanced APM for the year.

CMS makes determinations on an annual basis. These determinations are final and not subject to reconsideration.

In making QP determinations under the All-Payer Combination Option, which includes Medicaid payments arrangements that are Other Payer Advanced APMs, CMS has to exclude Medicaid payment arrangements for eligible clinicians for whom there is no Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria available. To carry out this exclusion, CMS needs to determine which states and counties do, or do not, have Other Payer Advanced APMs with Medicaid as a payer. As a result, States that are requesting determinations regarding specific payment arrangements are encouraged to fill out the Form, but also States that are not submitting any requests are encouraged to notify CMS through the Form.

CMS will post a list of Medicaid payment arrangements that are determined to be Other Payer Advanced APMs to the QPP resource library in September 2022. Eligible clinicians will be able to review this list beginning in September 2022, before the 2023 QP Performance Period. If CMS has not already determined that a Medicaid payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or APM Entities on their behalf) have the option to submit information about their Medicaid payment arrangement(s). The submission period will open on September 1 of the calendar year prior to the relevant QP Performance Period, and the submission deadline will be November 1 of that year.

The Form

The Payer Initiated Submission Form will be submitted electronically through an electronic portal, Salesforce. All relevant documentation should be electronically attached to the submission and thoroughly referenced. Examples of relevant documentation include contracts, excerpts of contracts, and participant agreements. Each different payment arrangement, even if operating in a single state, must be submitted through a separate Form with its own documentation.

The first step is to register for a CMS QPP All-Payer Submission Form login. To do so, you will need to create a password. The password must be at least 8 characters, use a mix of numbers, uppercase and lowercase letters, and include at least one of the following special characters: ! # $ % - _ = + < >.

Save all work in Salesforce before navigating away from each page, as any unsaved work will be lost. Additionally, the application will time out after 30 minutes of inactivity. If you do not have access to Salesforce, or if you have questions using the interface, please contact the Salesforce help desk (CMMIForceSupport@cms.hhs.gov).

The Form contains the following sections:

- Payer Identifying Information – The purpose of this section is to collect information about the submitting State and identifying information about the payment arrangement. The information for this section will be used to distinguish each unique payment arrangement submitted and identify the payment arrangement for the purpose of making QP determinations for eligible clinicians.
- Supporting Documentation – The purpose of this section is to allow the submitting State to upload supporting documentation and make sure that naming conventions are established and clear in referenced sources throughout the Form.
- Payment Arrangement Information – The purpose of this section is to collect the details of the payment arrangement. References to supporting documentation are required.
- Availability of Payment Arrangement – The purpose of this section is to inform CMS of the availability of the payment arrangement to eligible clinicians in the State, including in what locations it is offered, and if it is offered through Medicaid fee-for-service or by a Medicaid managed care plan (providing Medicaid services under a Medicaid managed care contract). In addition, this section requests information on whether the same payment arrangement is available through other types of payers, such as employer or individual plans.
- Information for Medicaid Medical Home Model Determination – The purpose of this section is to collect information needed to make a determination as to whether the payment arrangement meets the criteria to be a Medicaid Medical Home Model. This section is only required when a State requests that CMS determine whether the payment arrangement is a Medicaid Medical Home Model.
- Information for Other Payer Advanced APM Determination – The purpose of this section is to collect information needed for CMS to determine whether the payment arrangement is an Other Payer Advanced APM. The parts of this section that collect information on Certified Electronic Health Record Technology (CEHRT) and quality measures are relevant for both Medicaid Medical Home Models and other Medicaid payment arrangements, while the financial risk sections are not relevant for Medicaid Medical Home Models (information to assess whether a payment arrangement meets the Medicaid Medical Home Model financial risk criteria is collected in the previous section). A State may submit information for both the Medicaid Medical Home Model and the financial risk section if it wishes to seek a determination under both the Medicaid Medical Home Model and generally applicable financial risk criteria.
- Certification Statement – This section requires the authorized individual submitting information to certify to the best of his or her knowledge that all information submitted to CMS is true, accurate, and complete.

If you have any questions about the Form, please contact the QPP All Payer help desk (QPP_APM_AllPayer@cms.hhs.gov).

Payer Identifying Information

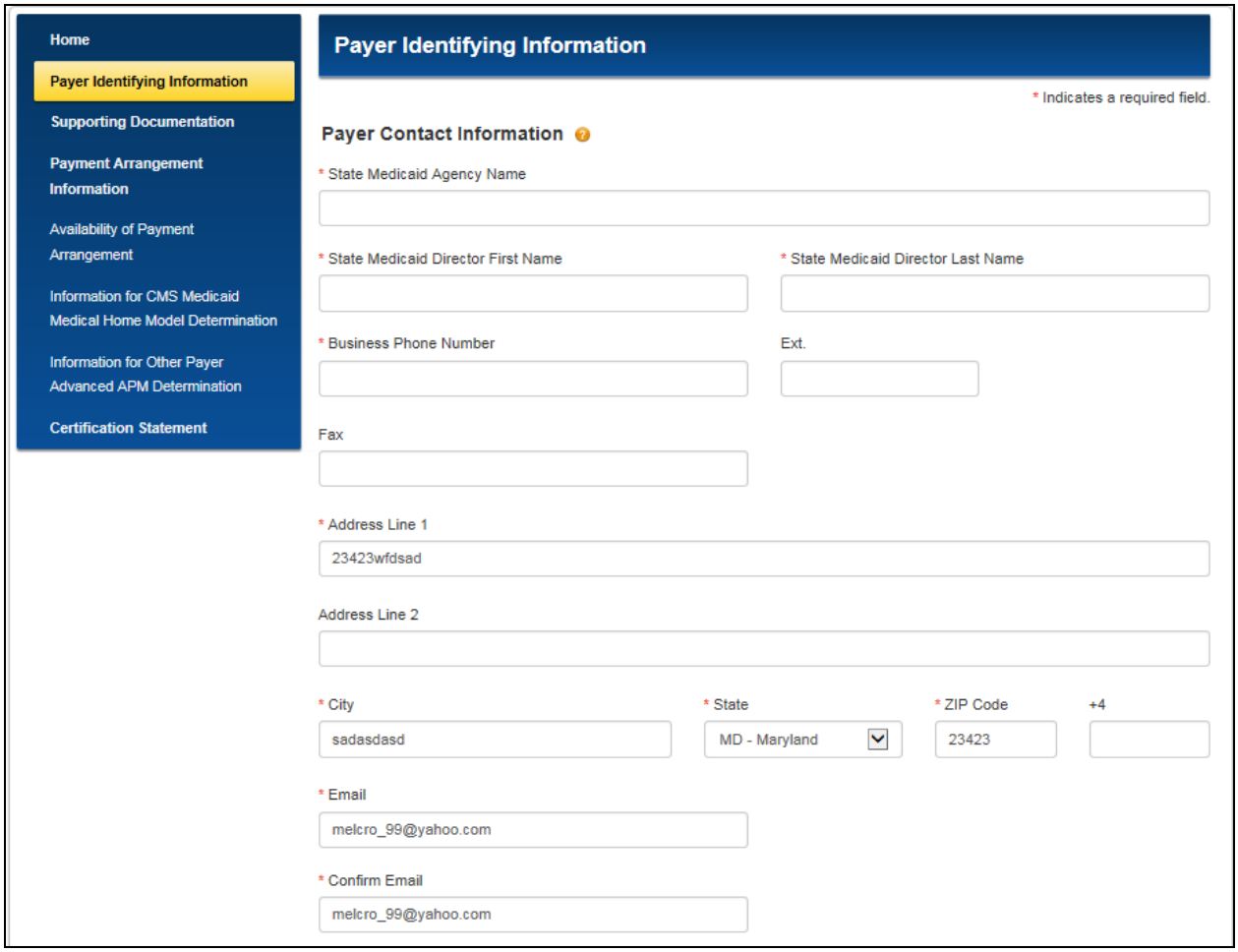
The purpose of this section is to collect information about the submitting State and identifying information about the payment arrangement. The information for this section will be used to distinguish each unique payment arrangement submitted and identify the payment arrangement for the purpose of QP determinations for eligible clinicians.

Payer Type

Select “State Medicaid Program” from the drop-down list. This selection includes payment arrangements that the state uses in Medicaid FFS, payment arrangements the state requires of Medicaid Managed Care plans, payment arrangements that Medicaid Managed Care Plans and health care providers voluntarily enter without state mandate, and arrangements that may align with a CMS Multi-Payer Model.

Payer Contact Information

Please complete all contact information for this particular Medicaid payment arrangement. For Medicaid payment arrangements, “Payer Contact Information” refers to contact information for the State Medicaid Agency and Agency Director.



The “Contact Person” is the individual CMS will reach out to with any questions about the payment arrangement and its operations – this person may be someone other than the State Medicaid Agency Director, but should be a state employee. If the appropriate contact person for the model differs from the State Medicaid Agency Director, add that person’s contact information here.

Contact Person

* Is the contact person the State Medicaid Director?

No

*First Name

*Last Name

*Business Phone Number

Ext.

Fax

*Address Line 1

Address Line 2

*City

*State

--None--

*ZIP Code

+4

*Email

*Confirm Email

* Are you submitting a form for an Other Payer Advanced APM?

Yes

Save | Save & Continue | Cancel

Are you submitting a form for an Other Payer Advanced APM?

The question is asking whether this form is being completed with the intention that a payment arrangement be reviewed as an Other Payer Advanced APM. CMS is required to confirm the availability or absence of a Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria in each State and, as such, has asked all State Medicaid programs to create a Salesforce entry, regardless of whether they have a payment arrangement for consideration. We strongly encourage all states to log into Salesforce and answer this question to announce whether the state has a payment arrangement that CMS could determine is an Other Payer Advanced APM or not.

If the State has a payment arrangement that it believes could qualify as a Medicaid Medical Home or Medicaid APM that meets the criteria to be an Other Payer Advanced APM, then check "Yes" here and continue to follow this guide as you reference and upload relevant information. If you are unsure of whether a payment arrangement will qualify as a Medicaid Medical Home Model or Medicaid APM that is an Other Payer Advanced APM, then proceed with the form to help clarify. If you select no to this question, the form will navigate to the Certification Statement followed by the end of the submission.

Save your progress

Supporting Documentation

The purpose of this section is for the submitting State to upload all relevant information and make sure naming conventions are clear for referenced sources throughout the form.

Upload all relevant documentation, such as contracts, participant agreements, waiver applications, etc. If you have multiple documents, or multiple excerpts of documents, you may want to name them intuitively for ease of reference throughout the form. For example, if you upload the specific section of the contract regarding CEHRT use, name the document "STATE_APM_CEHRT" so as not to confuse it with the document referencing risk arrangements. Names can be up to 100 characters long.

It is not required to upload separate documentation for each topic. If one contract covers all relevant information needed to support an Other Payer Advanced APM determination for the payment arrangement, it can be uploaded in full. Each file can be up to 25MB in size. To facilitate accurate evaluation, please be specific in your citations, directing CMS to the location of the information intended to be referenced in your response to each question.

If the supporting documentation is publicly available (e.g., included in a State Plan Amendment (SPA) or Section 1115 demonstration waiver application), you can cite the information using a link to the online location of the document rather than uploading the PDF.

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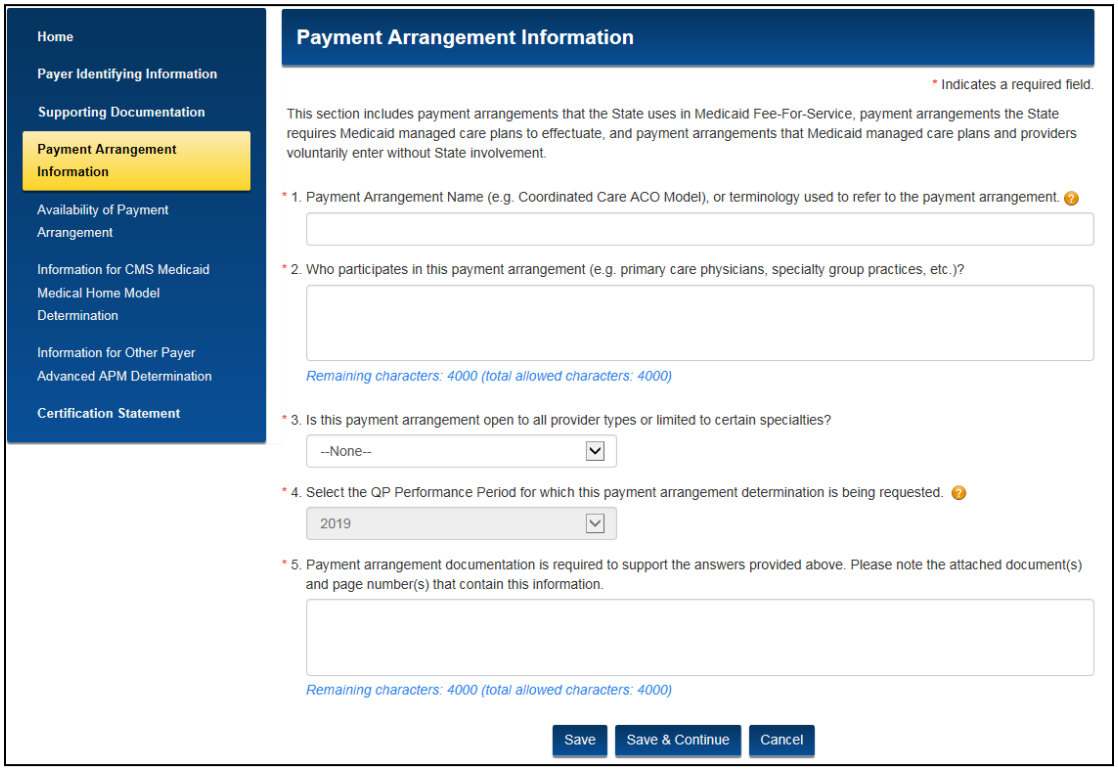
Payment Arrangement Information

The purpose of this section is to report the details of the payment arrangement. References to supporting documentation are required.



In Question 1, please provide the name of the payment arrangement. If there is potential uncertainty over the name, include any terms that can help identify the payment arrangement. Payment arrangement name or terminology used to refer to the payment arrangement should be consistent across contracts that include the payment arrangement. The purpose of this information is to allow CMS and eligible clinicians to correctly identify the payment arrangement when evaluating eligible clinicians' participation in Other Payer Advanced APMs.

Using the free text box for Question 2, describe who participates in this payment arrangement.

In Question 3, use the dropdown menu to note if there are any limitations on the types of physician or practitioner specialties that may participate. If yes, there will be a list of pre-specified options; please select all physician and practitioner specialties that may participate in the payment arrangement. This selection should describe the eligible clinicians who could potentially become QPs based on their participation in the payment arrangement.

Question 4 asks for the relevant performance period. This is the period for which the requestor is seeking Other Payer Advanced APM status for the payment arrangement. Other Payer Advanced APM determinations are made for the calendar year or years that include the QP Performance Period. Submissions may indicate a multi-year determination.

Question 5 requests citations to documentation (uploaded in the “Supporting Documentation” section, as described above) to support the answers provided above. When referencing documents, please cite the specific sections/pages to which CMS should refer when evaluating this information.

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Availability of Payment Arrangement

The purpose of this section is to collect information to determine availability of the payment arrangement to eligible clinicians in the State, including the locations where it is offered, and whether the payment arrangement is offered through Medicaid FFS or Medicaid managed care. In addition, this section requests information on whether the same payment arrangement is available through other types of payers, such as employer or individual plans.

In Question 1, please provide the counties where the payment arrangement is available for participation by eligible clinicians, or note that the payment arrangement is available statewide.

In Question 2, report whether the payment arrangement is available through Medicaid FFS or managed care. There is an “other” option if needed; if selected, you will be asked for clarification.

In Question 3, answer “Yes” if the payment arrangement is available through other lines of business. “Other lines of business” refers to payment arrangements that are also offered by another type of payer (e.g., a payment arrangement being offered by both Medicaid and a commercial payer as part of a CMS Multi-Payer model).

Is the same payment arrangement available through other lines of business, such as Medicare Advantage or a commercial payer? If so, those payers may submit a separate Submission Form to seek 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 Managed Care Organization (MCO).

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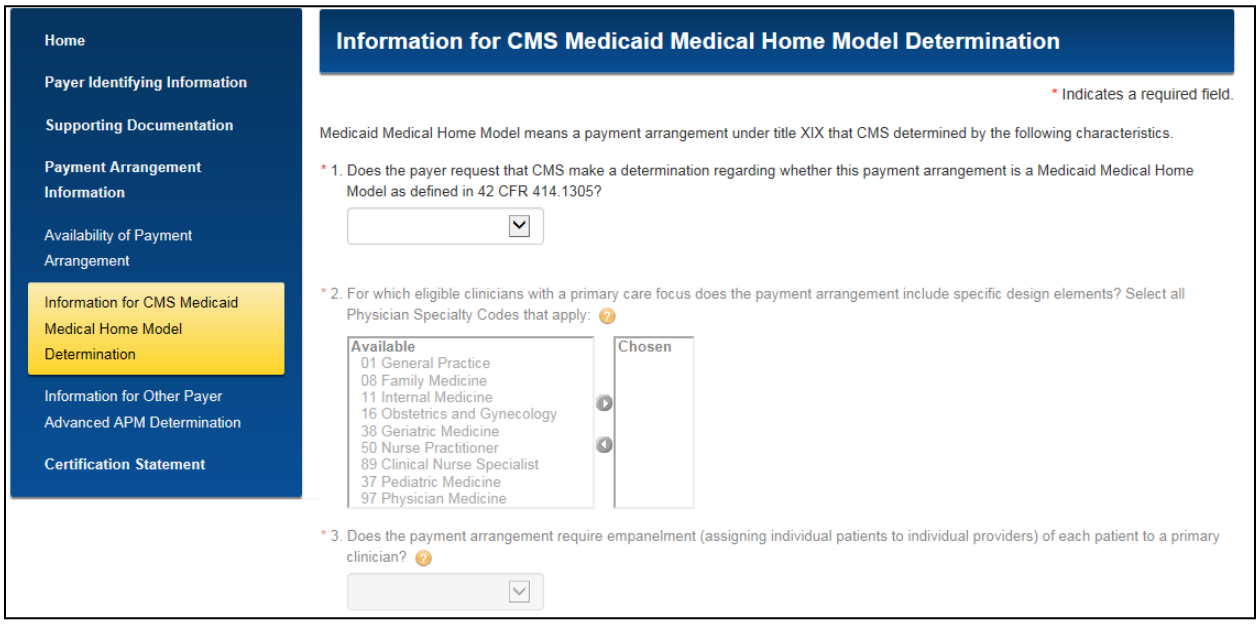
Information for Medicaid Medical Home Model Determination

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. However, 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 information discussed here.

The purpose of this section is to collect information needed to make a determination as to whether the payment arrangement meets the criteria to be a Medicaid Medical Home Model. This section requires information on primary care specialties participating in the model, empanelment of patients, documented actions such as shared decision making, care coordination, and financial risk standards.

This section is only relevant for Medicaid payment arrangements that are Medicaid Medical Home Models. If the payment arrangement being submitted is to be considered a Medicaid Medical Home Model, answer "Yes" to Question 1 to continue with this section. Otherwise answer "No" and this section will be skipped.



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

In Question 2, using the table provided, identify the physician specialty codes of eligible clinicians who may participate in the payment arrangement.

In Question 3, check “Yes” or “No” to state whether the payment arrangement requires patients to be assigned to individual providers (empanelment). If you select “No” to this question, the payment arrangement will not be considered a Medicaid Medical Home Model.

Medicaid Medical Home Models are required to include 4 of the 7 elements listed in Question 4. Please check “Yes” for all activities that are included under the payment arrangement and can be verified by the submitted documentation (e.g., contract language), and use page numbers or document references to support each statement. If you do not select 4 or more of these elements, the payment arrangement may not be considered a Medicaid Medical Home Model.

* 4. Select all elements from the following list that are required by the payment arrangement.

a. Planned coordination of chronic and preventive care

Yes

Cite supporting documentation and page numbers.

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b. Patient access and continuity of care

--None--

c. Risk-stratified care management

--None--

d. Coordination of care across the medical neighborhood

--None--

e. Patient and caregiver engagement

--None--

f. Shared decision-making

--None--

g. Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g., shared savings or population-based payments).

--None--

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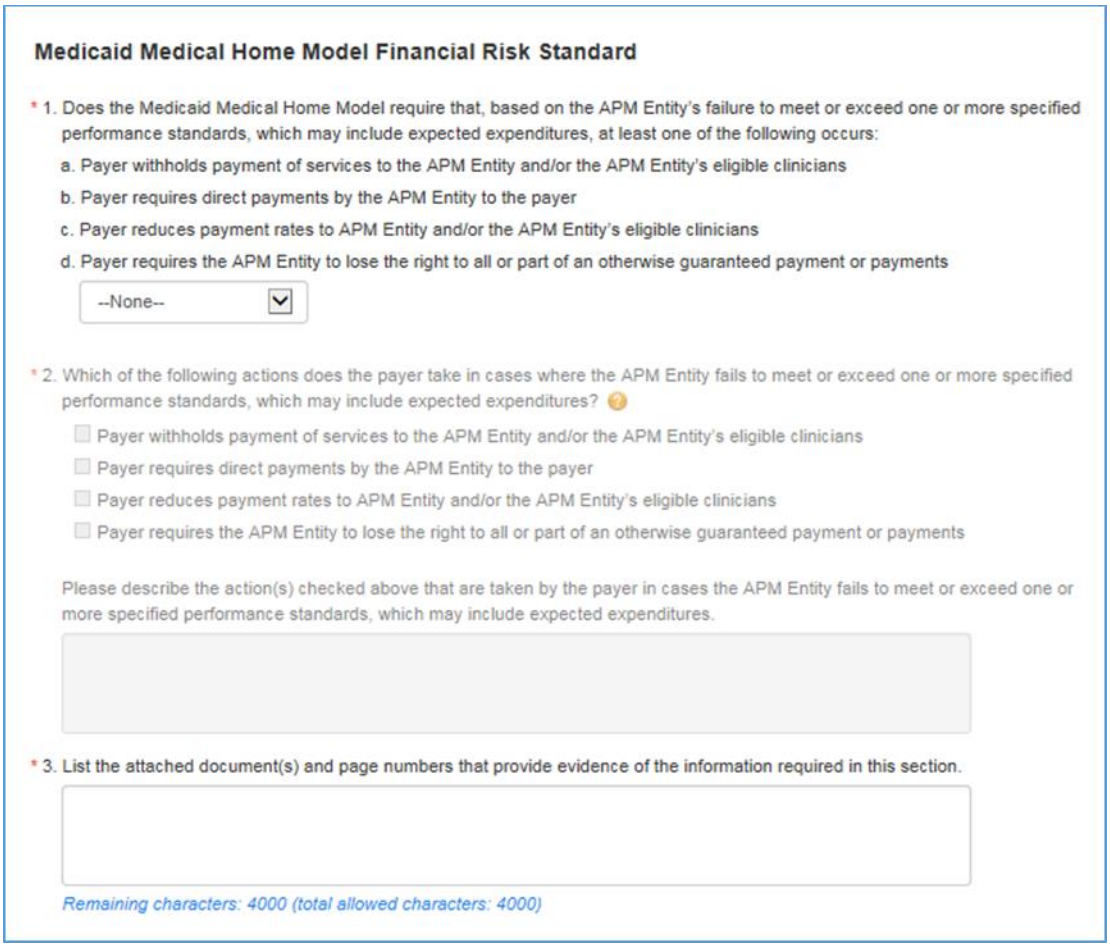
Medicaid Medical Home Model Financial Risk Standard

The purpose of this section is to collect information needed to determine whether the payment arrangement meets the Medical Home Model financial risk standard. Note, this section only appears if you requested that CMS make a determination of whether this payment arrangement is a Medicaid Medical Home Model. In order to support this determination, this section requests information regarding payment withholds or repayment requirements for APM Entities under the payment arrangement. For purposes of this form, the APM Entity is the practitioner or group of practitioners that participates in the payment arrangement. This section is relevant only for Medicaid Medical Home Models. Other sections of this Form will collect information on financial risk and nominal amount information for other Medicaid payment arrangements.



Medicaid Medical Home Model Financial Risk Standard

* 1. Does the Medicaid Medical Home Model require that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, which may include expected expenditures, at least one of the following occurs:

a. Payer withholds payment of services to the APM Entity and/or the APM Entity's eligible clinicians

b. Payer requires direct payments by the APM Entity to the payer

c. Payer reduces payment rates to APM Entity and/or the APM Entity's eligible clinicians

d. Payer requires the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments

--None--

* 2. Which of the following actions does the payer take in cases where the APM Entity fails to meet or exceed one or more specified performance standards, which may include expected expenditures?

- Payer withholds payment of services to the APM Entity and/or the APM Entity's eligible clinicians
- Payer requires direct payments by the APM Entity to the payer
- Payer reduces payment rates to APM Entity and/or the APM Entity's eligible clinicians
- Payer requires the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments

Please describe the action(s) checked above that are taken by the payer in cases the APM Entity fails to meet or exceed one or more specified performance standards, which may include expected expenditures.

* 3. List the attached document(s) and page numbers that provide evidence of the information required in this section.

Remaining characters: 4000 (total allowed characters: 4000)

In Question 1, answer “Yes” if, under the payment arrangement, failure to meet specific performance standards triggers any of the following actions:

- Payer withholds payment for services;
- Payer requires direct payments by the APM Entity;
- Payer reduces payment rates; or
- APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

This question is asking if payments under the payment arrangement are tied to measures of performance. If so, answer yes to the action (or actions) that is the best fit for the model. There will be room to explain under Question 2.

Question 2 specifically asks, “Which of the following actions does the payer take in cases where the APM Entity fails to meet or exceed one or more specified standards, which may include expected expenditures?” Here, “expected expenditures” means the beneficiary or patient expenditures for which an APM Entity is responsible under the payment arrangement. If you have answered “Yes,” to Question 1, Question 2 requests an explanation of how withholds, payments, and payment reductions are operationalized. Please provide details about which actions are taken, how withholds and payment consequences are triggered, and the specific amounts at risk. Be specific in your descriptions and cite all relevant documentation.

Medicaid Medical Home Model Nominal Amount Standard

For the next part of Question 2, you will need to explain details regarding the level of risk in the payment arrangement. In Question 1, answer “Yes” if “the total amount an APM Entity potentially owes or foregoes under the payment arrangement is at least 5 percent of the APM Entity’s total revenue under the payer.” “Potentially owes or foregoes” refers to the actions 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. If the answer is “Yes,” explain specifically how total revenue and the percentage potentially owed are calculated.

Provide references to all relevant documentation, noting specific pages or sections.

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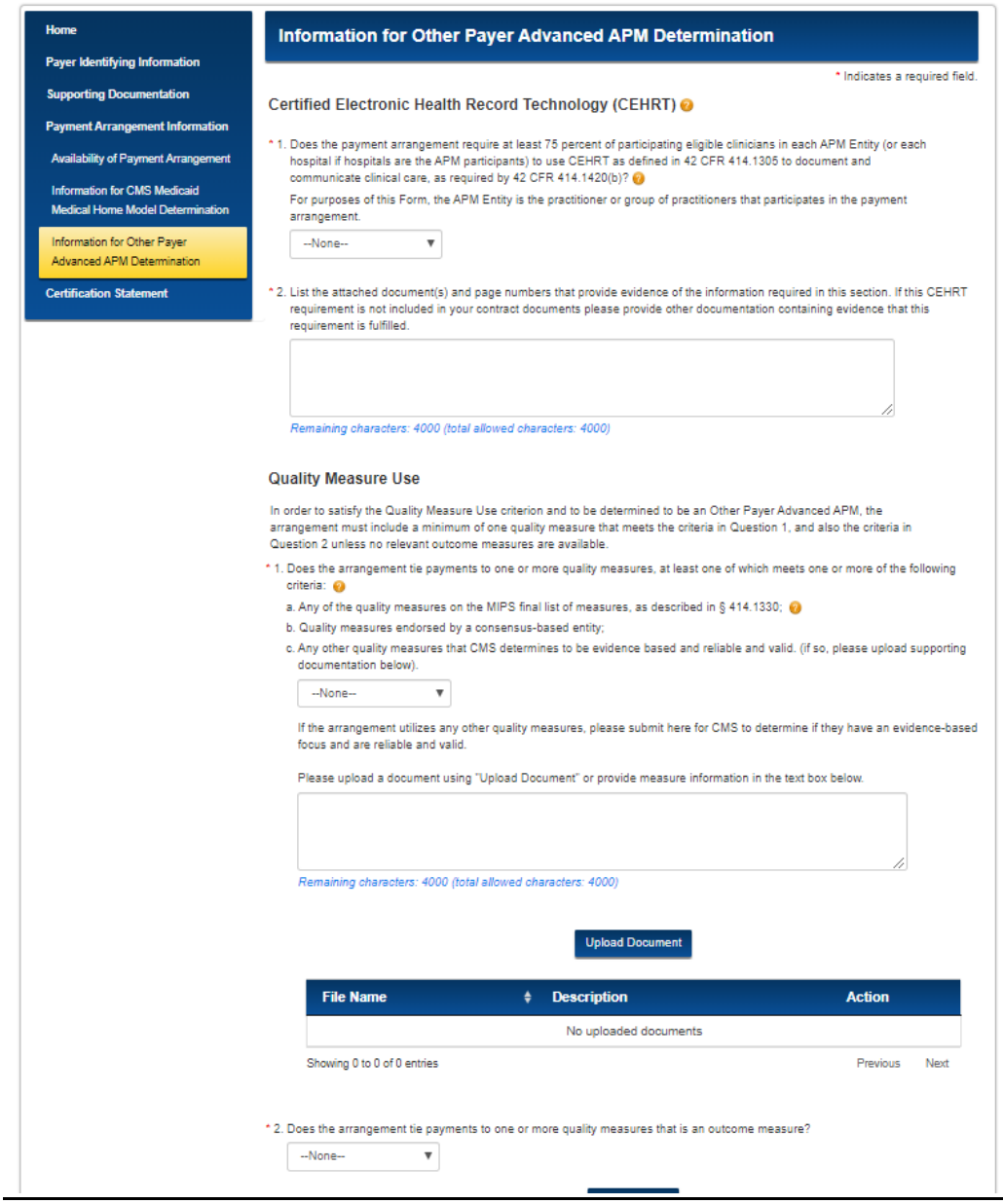
Information for Other Payer Advanced APM Determination

The purpose of this section is to collect information needed to determine whether a payment arrangement is an Other Advanced APM. The parts of this section that solicit information on CEHRT and quality measures are relevant for both Medicaid Medical Home Models and other Medicaid payment arrangements. The financial risk sections under “Information for Other Payer Advanced APM Determination” contain different information than the sections for Medicaid Medical Home Models. If the State is submitting a payment arrangement for consideration as a

Medicaid Medical Home Model, this section is not required, as relevant information for that determination is collected in the previous section.



Certified Electronic Health Record Technology (CEHRT) Use

There is one question on use of CEHRT; this response requires supporting documentation to verify the yes or no response. *Note that a payment arrangement must include this CEHRT element in order to be considered an Other Payer Advanced APM.*

Answer "Yes" or "No" to indicate whether the payment arrangement meets the CEHRT use criterion. To meet this criterion, the payment arrangement must require at least 75 percent of eligible clinicians in each participating APM Entity group (or each hospital if hospitals are the APM Entities) to use CEHRT to document and communicate clinical care.

Please provide a reference to the requirement in the documentation (e.g., document name and relevant page numbers).

Quality Measure Use[2]

This section pertains to the quality measures used in the payment arrangement. The questions pertain to measures that are used and ask for measure details. Documentation and references are required.

Question 1 is a "Yes" or "No" response to whether Merit-based Incentive Payment System (MIPS) comparable quality measures are used in the payment arrangement. 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]), or
- Other measure with support for measure validation.

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

Please explain the evidence-base for the measure, measure calculation, and any support for measure validation. Upload, cite, and explain in detail all relevant documentation.

Question 2 asks if one or more of the measures used under the payment arrangement is an outcome measure. An outcome measure assesses healthcare results experienced by patients. They include endpoints such as 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. If there is at least one outcome measure used under the payment arrangement, then answer "Yes" and then click the "Add Measure" button to provide more information about the outcome measure.

[2] The quality measure Other Payer Advanced APM criterion is at 42 CFR § 414.1420(c).

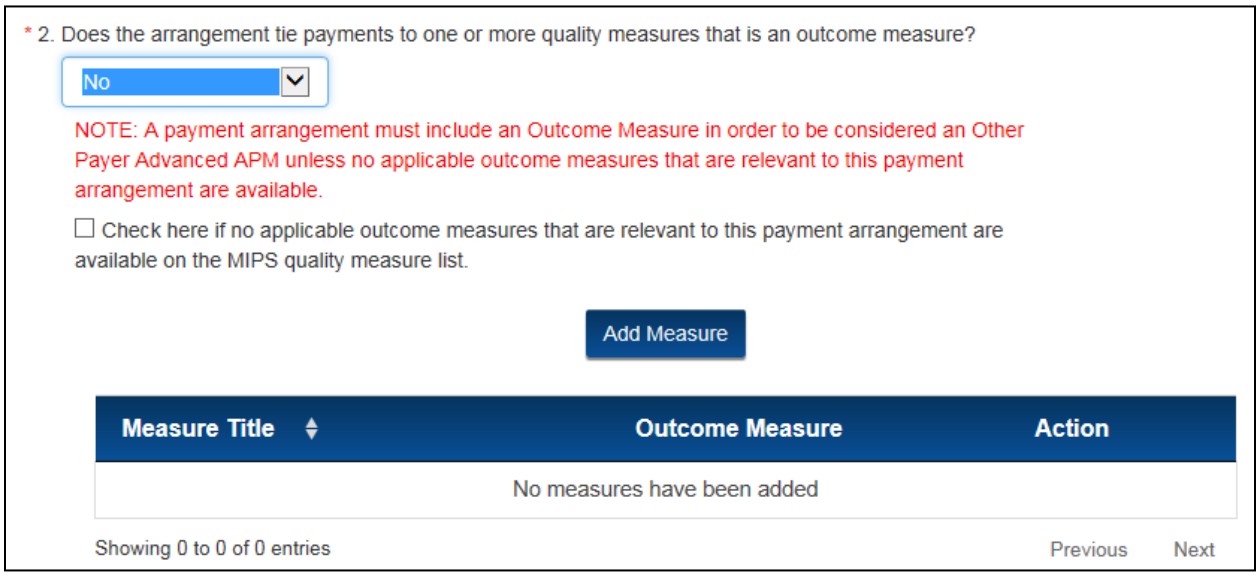
If there is no applicable outcome measure, respond “No,” and also respond to the pop-up box asking if there are any outcomes measures.[3]

Information on MIPS comparable quality measures should also be entered by selecting the “Add Measure” button. Information can be added for as many measures as are used in the payment arrangement.

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.

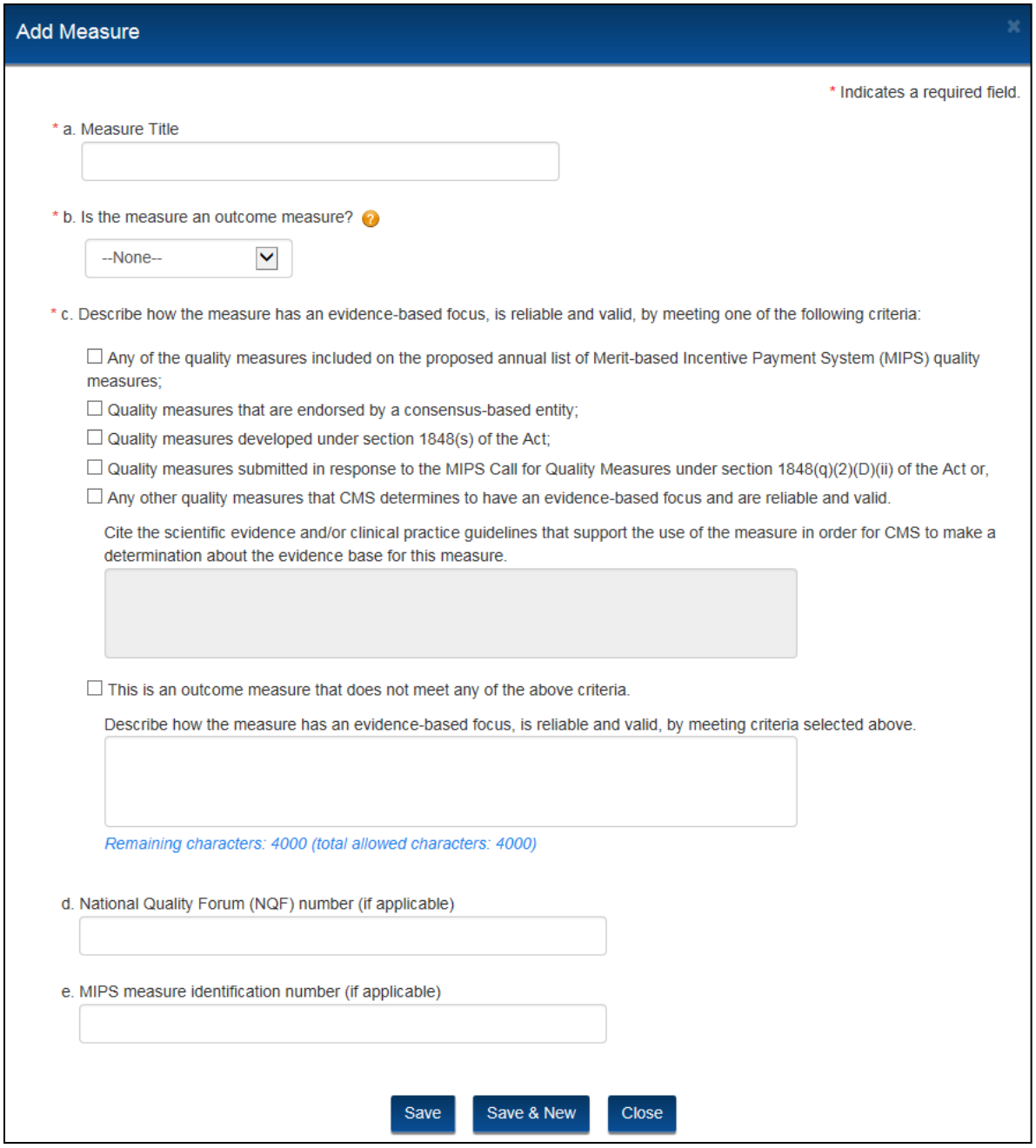
Please explain and provide citations to supporting documentation to support the answer.



[3] Please note that if there is no available or applicable outcome measure on the MIPS measure list, the payer (in this 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).

Add Measure Information:

A. Measure title
B. Is the measure an outcome measure (yes or no)?
C. Please explain how the measure is reliable and valid by checking the appropriate box. If you check the last box, “Any other quality measures that CMS determines…,” then cite all relevant evidence and/or clinical practice guidelines in support of the measure. In the second text box, please provide a description of how the measure has an evidence-based focus, is reliable and valid. The entry can simply be a reference to supporting documentation.
D. If applicable, enter the National Quality Forum (NQF) number.
E. If applicable, provide the MIPS measure identification number.



Provide references to all relevant documentation, noting specific pages or sections.

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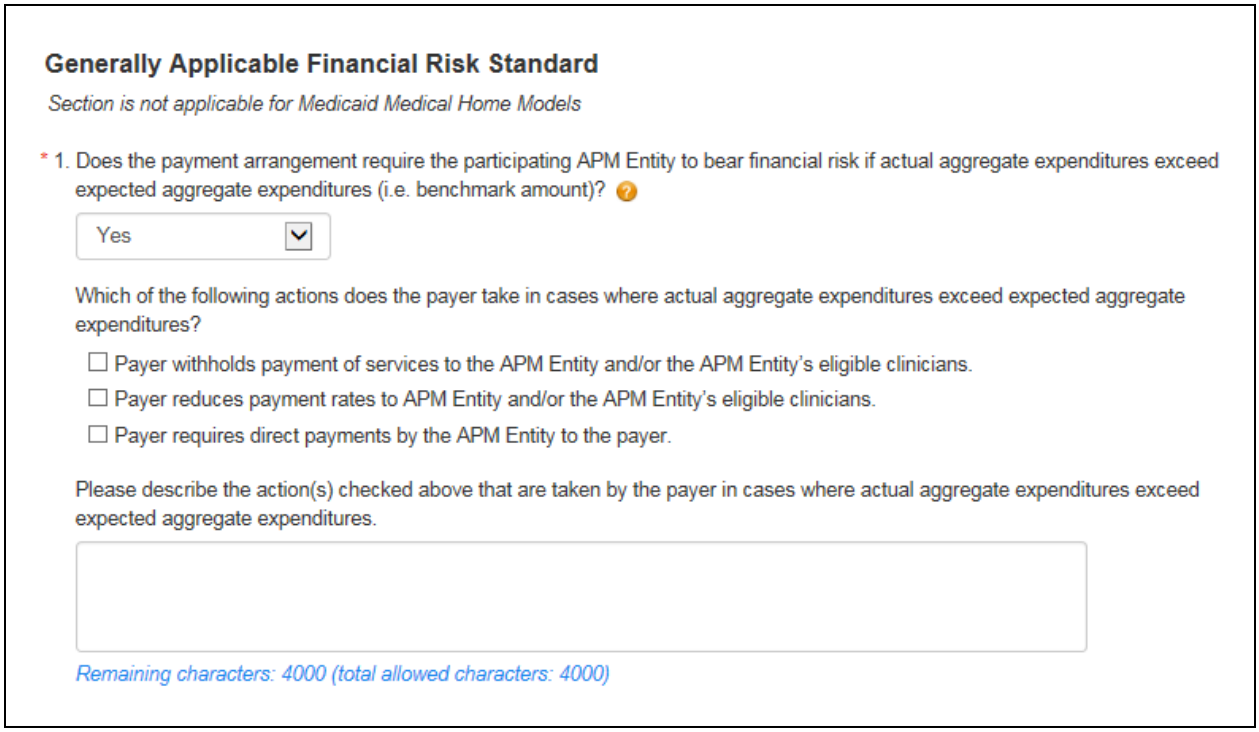
Generally Applicable Financial Risk Standard[4]

The purpose of this section is to collect information needed to determine whether the payment arrangement meets the generally applicable financial risk standard. To support this determination, this section requests information about payment withholds or repayment requirements for APM Entities under the payment arrangement. For purposes of this form, the APM Entity is the practitioner or group of practitioners that participates in the payment arrangement. 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.

In Question 1, answer "Yes" if the Medicaid payment arrangement requires participating eligible clinicians (or groups of eligible clinicians) to bear financial risk if actual expenditures are higher than expected expenditures (i.e., a benchmark amount). Expected expenditures refers to the beneficiary or patient expenditures for which an APM Entity is responsible under the payment arrangement. For episode payment models, expected expenditures typically refers to the episode target price.

If the answer to Question 1 is "Yes," then provide more detail on any consequential actions that will be taken by the payer if actual expenditures exceed expected expenditures. Check the box next to each of the actions the payment arrangement employs and then describe the actions that are taken under the payment arrangement in detail in the text box. Use direct citations to uploaded documentation.

[4] 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.



Question 2, regarding capitation arrangement, is a yes or no question that requires documentation. As a reminder, we are referring to the payment arrangement between the MCO and APM Entity. Full capitation is defined as a payment arrangement in which a per capita or otherwise predetermined payment is made under the payment arrangement for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the participant.

Provide citations to all relevant documentation, noting specific pages or sections.

<u>Generally Applicable Nominal Amount Standard</u>

Question 1 requires a detailed description of the payment arrangement's risk methodology. Include all information 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.

On Question 2, answer "Yes" if the average marginal risk rate is at least 30 percent. 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. If 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**. Marginal risk may be below 30 percent in some instances as long as the average marginal risk at all levels of losses up to the total risk is above 30 percent. If marginal risk is equal to or above 30 percent, describe and cite documentation to show the marginal risk rate and the consequential action the payment arrangement requires if actual expenditures are higher than expected. If marginal risk is less than 30 percent but the average marginal risk is equal to or above 30 percent, describe and cite the marginal risk amounts required if actual expenditures are higher than expected.

On Question 3, answer "Yes" if the minimum loss rate is no more than 4 percent. 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. Describe and cite documentation to show the minimum loss rate and any consequential action the payment arrangement requires. If no minimum loss rate is in place—in other words losses start when actual expenditures exceed expected expenditures—please describe if a minimum loss rate is not applicable.

On Question 4, answer "Yes" to the questions on total risk if the minimum percentages described below are met. The total risk can be expressed in terms of revenue or expected expenditures, and either standard will fulfill the criteria so long as the minimum percentages are met. The total amount at risk for the APM Entity must be at least:

- 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity, or
- 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 the payment arrangement.

Please support these answers with explanations of how risk is defined in terms of revenue or how expected expenditures are calculated. For these purposes, total revenue means the total combined revenue from the payer to providers and suppliers participating in the APM Entity.

Provide references to all relevant documentation, noting specific pages or sections.

We note that 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.

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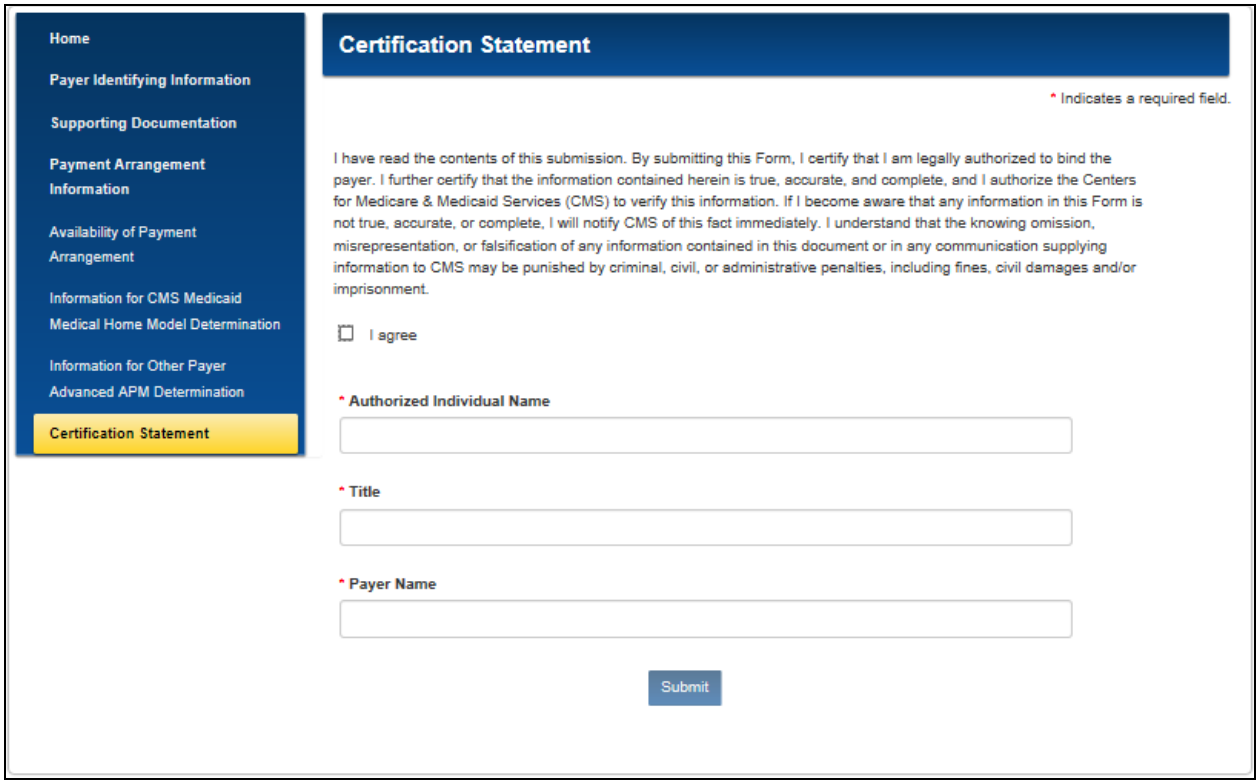
Certification Statement

The authorized individual submitting information on behalf of the payer is certifying to the best of their knowledge that the information submitted to CMS is true, accurate, and complete. Please contact the QPP help desk (QPP@cms.hhs.gov) with any questions prior to submission.



Version History

Date	Change Description
04/18/2022	Original version.