Quality Payment
PROGRAM

Medicaid Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019

Under the Quality Payment Program's All-Payer Combination Option, State Medicaid Agencies, Medicare Advantage and other Medicare Health Plans, as well as commercial and private payers participating in CMS-sponsored Multi-Payer payment arrangements (CMS Multi-Payer Models), may submit information to CMS about their payment arrangements with eligible clinicians. CMS will determine whether each submitted payment arrangement constitutes an Other Payer Advanced Alternative Payment Model (APM) for a given Performance Year. If a payer chooses not to (or is not eligible to) submit its arrangements to CMS, eligible clinicians or APM Entities participating in the payment arrangement may do so.

Table 1 below provides a list of Medicaid payment arrangements that CMS has determined to be Other Payer Advanced APMs for the Calendar Year (CY) 2019 QP Performance Period, based on submissions from payers made earlier this year through the Payer Initiated Process. Except as noted otherwise, this table contains our Medicaid Other Payer Advanced APM determinations based on the criteria in effect for CY 2018 and on information that states submitted to CMS on the listed payment arrangements. We will update this list later this year after we consider the additional requests for Medicaid Other Payer Advanced APM determinations submitted by November 1 through the Eligible Clinician Initiated Process.

In addition to this list, we will soon be posting lists of Medicare Advantage and CMS Multi-payer payment arrangements that CMS determines to be Other Payer Advanced APMs before the beginning of the CY 2019 QP Performance Period based on submissions through the Payer Initiated Process earlier this year. Those lists will be revised at the end of CY 2019 after we make additional Other Payer Advanced APM determinations based on submissions by eligible clinicians who participate in other payer payment arrangements.

The criteria for payment arrangements to meet the requirements of Other Payer Advanced APMs are similar, but not identical, to the criteria used for Advanced APMs under Medicare. To be an Other Payer Advanced APM, payment arrangements must currently meet each of the following criteria, as specified in our regulation at 42 CFR 414.1420:

1. **Require use of certified EHR technology (CEHRT).** The other payer payment arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity Group to use CEHRT to document and communicate clinical care information. However, CMS has proposed to increase this criterion to be 75 percent as of January 1, 2020.

2. **Base payments for covered professional services on quality measures that are comparable to those used in the MIPS quality performance category.** To be an Other Payer Advanced APM, at least one of the quality measures used in the payment arrangement must be comparable to measures under the MIPS quality performance category, have an

evidence-based focus, and be reliable and valid. A payment arrangement must also use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list.

3. **Require participants to bear a certain amount of financial risk.** A payment arrangement meets the financial risk criterion if (1) the payment arrangement is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Social Security Act, or (2) when actual expenditures for which the APM Entity is responsible under the payment arrangement exceed expected expenditures, the payer withholds payment for services, reduces payment rates, or requires direct payment by the APM Entity to the payer. The total amount an APM Entity potentially owes a payer or foregoes under a payment arrangement must be at least eight percent of the total combined revenues from the payer if financial risk is expressly defined in terms of revenue; or, three percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.

For more information on CMS's policies regarding the All-Payer Combination Option and Other Payer Advanced APMs, as well as how to submit information to CMS for an Other Payer Advanced APM determination, see our fact sheets and guidance documents located in the QPP Resource Library.

Medicaid Other Payer Advanced APMs QP Performance Period 2019			
State	**Payment Arrangement Name**	**Medicaid Fee-for-Service (FFS) or Managed Care**	**Availability/Location**
Massachusetts	Accountable Care Partnership Plan	Manage Care	Statewide
Ohio	Episode-based payments Model**	FFS/Managed Care	Statewide
Tennessee	Retrospective Episodes of Care Model**	Managed Care	Statewide
Washington	Community Health Network of Washington Population-Based Payment Model Option B (ABD)	Managed Care	Statewide
Washington	Community Health Network of Washington Population-Based Payment Model Option B (F/S)	Managed Care	Statewide

Washington	Community Health Network of Washington Population-Based Payment Model Option C (F/S)	Managed Care	Statewide

**The Other Payer Advanced APM determination for this payment arrangement is based on the proposed changes to the CEHRT criterion included in the CY 2019 Physician Fee Schedule proposed rule at 83 FR 35996. As such, this determination is conditional pending publication of the CY 2019 Physician Fee Schedule final rule, and will become final only to the extent it is consistent with that final rule. The current CEHRT use criterion requires is that the Other Payer Advanced APM must require at least 50 percent of eligible clinicians in each participating APM Entity, or each hospital if hospitals are the APM Entities, to use CEHRT to document and communicate clinical care. One proposed change would require a payer or eligible clinician to provide documentation to CMS that, for CY 2019, CEHRT is used to document and communicate clinical care under the payment arrangement by at least 50 percent of eligible clinicians.