



Performance Year 2026 Guide to Submitting Medicaid Requests for Other Payer Advanced APM Determinations (Managed Care Organizations Providing State Medicaid Agencies with Information and Documentation)

Purpose

Through the Payer Initiated Submission Form, the Centers for Medicare & Medicaid Services (CMS) will collect information and documentation to determine whether certain Medicaid payment arrangements qualify as Other Payer Advanced Alternative Payment Models (APMs) under the Advanced APM track of 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 Medicaid payment arrangements may only be submitted by State Medicaid Agencies (“States”), Medicaid Managed Care Organizations (“MCOs”) (including entities such as prepaid health plans) may have important details of the information needed to complete the Payer Initiated Submission Form (the “Form”), as well as access to documentation that will need to be attached to the Form. The purpose of this document is to educate Medicaid MCOs about the submission process, which will be conducted by the respective States, and to provide an outline to the States of the information they may need to collect from Medicaid MCOs. Please use this document together with the:

- [Salesforce Portal](#)
- [All-Payer Advanced Alternative Payment Models \(APM\) Option](#)

Please note that in this guide, “payment arrangement” refers to payment arrangements between a Medicaid MCO and APM Entities, groups of eligible clinicians, or eligible clinicians.

States must submit all requests for an Other Payer Advanced APM determination between **January 1 and April 1** of the year prior to the relevant Qualifying APM Participant (QP) Performance Period (e.g., by April 1, 2025, for the 2026 QP Performance Period).

For a complete Form, the State must provide written explanations and supporting documentation, as applicable, 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 domain but may do so if that is the most efficient manner in which to submit information. 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, each document should be named logically so that the documents are easily identified and can be referenced throughout the Form. For example, to support the requirement that the payment arrangement requires as a condition of participation the use of CEHRT (as defined in 42 CFR 1305, paragraph (3) in the definition of “Certified Electronic Health Record Technology” (CEHRT), name the document where the requirement is specified “STATE_CONTRACT” or “STATE_RISKMODEL” and provide page numbers. Document names can be up to 100 characters long.

A separate Form, along with supporting documentation, is required for each Medicaid payment arrangement (“payment arrangement”) operating within a state. Forms and supporting documentation will be submitted electronically by the State through the Salesforce portal. If the supporting documentation is publicly available (e.g., included in a State Plan Amendment (SPA) or an approved Section 1115 demonstration waiver), the State may 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 state agreements/participation agreements with the CMS Innovation Center.

The State will need to provide the following types of information, which are described in more detail in the sections below:

- Payment arrangement information (types of participants, availability, etc.); and
- Information for Medicaid Medical Home Model determination (if applicable, including activities required by the payment arrangement); or
- Information for Other Payer Advanced APM determination (quality measures, financial risk, etc.)

Medicaid Payment Arrangement Information

Payment Arrangement Name

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

Payment Arrangement Participants

The State must list the type of clinicians that may participate in the Medicaid payment arrangement; examples might include primary care providers including physicians, physician assistants, and nurse practitioners, or hospitalists. The State also must cite any limitations on the types of clinicians or clinician specialties that may participate. The purpose of this information is to allow CMS to identify the eligible clinicians who could potentially become QPs, in part, through their participation in the payment arrangement.

Availability of Payment Arrangement

The State must note whether a payment arrangement is available statewide, or if operating in a substate region, list the counties where the payment arrangement is available.

Other Lines of Business

If the same payment arrangement is available through other lines of business (such as Medicare Advantage or a commercial health plan), the payer may submit a separate Submission Form to request an Other Payer Advanced APM determination for each line of business. In such cases, CMS may be in contact with the Medicaid MCO to verify the information.

Information for Medicaid Medical Home Model Determination

A Medicaid Medical Home Model¹ is a specific type of Medicaid payment arrangement that focuses specifically on primary care. In order to be an Other Payer Advanced APM, the Medicaid Medical Home Model must meet the same CEHRT use and quality measure requirements as other Medicaid payment arrangements, but the financial risk requirements are slightly different.

A State may request that CMS determine whether a Medicaid payment arrangement is a Medicaid Medical Home Model by providing the following information in this section:

- The State will identify the physician and non-physician practitioner specialty codes for all eligible clinicians who may participate in the payment arrangement. CMS will provide a list of physician and non-physician practitioner specialty codes from which to choose in the electronic portal.
- The State will identify whether the payment arrangement requires that beneficiaries be assigned to an individual clinician (empanelment).
- The State will identify whether the payment arrangement requires at least 4 of the following 7 activities and explain/provide citations to supporting documentation for each reported activity:
 - 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 State will respond to the following questions about financial risk:
 - Under the terms of the payment arrangement, does the failure of the participant to meet specific performance standards require any of the following actions?:
 - Payer (i.e., Medicaid MCO) withholds payment for services,
 - Payer reduces payment rates,
 - Payer requires the participant to owe payment(s), or
 - The participant 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) potentially owes or foregoes under the payment arrangement at least 5 percent of the APM Entity’s total revenue under the Medicaid MCO? If the answer is “Yes”, please explain 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, group of eligible clinicians, 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.

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

Information for Other Payer Advanced APM Determination

Certified Electronic Health Record Technology (CEHRT)²

This section is applicable to all Medicaid payment arrangements

In order to be an Other Payer Advanced APM, a payment arrangement must require as a condition of participation the use of CEHRT (as defined in 42 CFR 1305, paragraph (3) in the definition of “Certified Electronic Health Record Technology” (CEHRT). The State will indicate whether this requirement is met and will provide a reference to the requirement in the supporting documentation (e.g., document name and relevant page numbers).

Quality Measures³

This section is applicable to all Medicaid payment arrangements

In order to be an Other Payer Advanced APM, the payment arrangement must apply quality measures comparable to measures under the Merit-based Incentive Payment System (MIPS) quality performance category. In particular, the State will respond to the following questions about the quality measures used in the payment arrangement:

- Does the arrangement tie payment to one or more quality measures, at least one of which meets the following criteria?
 - Is a quality measures on the MIPS final list of measures, as described in § 414.1330
 - Is endorsed by a “consensus-based entity” or
 - Is determined by CMS to be evidence-based, reliable, and valid. (If so, please upload supporting documentation.)
- Does the payment arrangement tie payment to an outcome measure that is on the MIPS quality measure list?
 - Provide the following information on at least one outcome measure that is tied to payment. A single quality measure may be used to meet these criteria if the outcome measure also has an evidence-based focus and is reliable and valid.
 - Measure title.
 - Outcome measure (Yes/No)?
 - How was this measure validated? Cite all relevant evidence and/or clinical practice guidelines in support of the measure.
 - National Quality Forum (NQF) number, if applicable.
 - 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.⁴

An outcome measure assesses health care 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.

² The Other Payer Advanced APM CEHRT use criterion is located at 42 CFR § 414.1420(b).

³ The Other Payer Advanced APM use of quality measure criterion is located at 42 CFR § 414.1420(c).

⁴ 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).

Generally Applicable Financial Risk Standard⁵

Medicaid Medical Home Models are subject to a different Medical Home Model Financial Risk Standard as discussed above. A State that has requests an Other Payer Advanced APM determination for a Medicaid Medical Home Model may optionally choose to submit information to support the Generally Applicable Financial Risk Standard to be considered an Other Payer Advanced APM. This assessment will be performed if CMS determines that the Medical Home Model is not a Medicaid Medical Home Model.

States will respond to the following question pertaining to the Generally Applicable Financial Risk Standard for a an Other Payer Advanced APM determination:

- 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?⁶ Please explain and provide citations to supporting documentation for each "Yes" response.
 - Payer (i.e., Medicaid MCO) withholds payment for services,
 - Payer reduces payment rates, or
 - Payer requires the participant to owe payment(s).

Expected expenditures refers to the beneficiary or patient expenditures for which an APM Entity is responsible during a specified period of time. For episode-based payment arrangements, episode expenditures refer to the episode target price.

Generally Applicable Financial Risk Standard⁷

Medicaid Medical Home Models are subject to the Medicaid Medical Home Model nominal amount standard, which is discussed above. A State that requests an Other Payer Advanced APM determination for a payment arrangement that is a Medicaid Medical Home Model may also submit information to support the generally applicable financial risk standard. The generally applicable financial risk assessment will be performed if CMS determines that the Medicaid payment arrangement is not a Medicaid Medical Home Model.

The State will submit responses to the following questions regarding the generally applicable financial risk standard:

- Provide a detailed description of the payment arrangement's risk methodology. Please note that "payment arrangement" refers to the payment arrangement between the MCO and the APM Entity, group of eligible clinicians, or eligible clinicians.
 - This description will include all information needed to explain the risk requirements in the payment arrangement, including 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, as well as citations to all relevant documentation in support of the description.
- Is the average marginal risk rate at least 30 percent? Marginal risk is the percentage of overage (the amount the actual expenditures exceed expected expenditures) for which an APM Entity is at risk. In other words, in the case where actual expenditures are higher than expected (higher than the target price), the APM Entity may only be liable for a percentage of the difference. The percentage for which they are liable is the marginal

⁵ The generally applicable financial risk standard Other Payer Advanced APM criterion is located at 42 CFR § 414.1420(d)(1).

⁶ 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.

⁷ The Generally Applicable Nominal Amount Standard Other Payer Advanced APM criterion is located at 42 CFR § 414.1420(d)(3).

risk. 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.

- 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 (also called a risk corridor).

The payment arrangement must meet one of the following three criteria for which you will be prompted to provide detail:

1. Is the total amount at risk at least 8 percent of the APM Entity's total revenue?⁸ Please support with explanations of how risk is defined in terms of revenue and provide citations to any relevant documentation.
2. Is the total amount at risk at least 3 percent of the APM Entity's expected expenditures? Expected expenditures means the patient expenditures for which an APM Entity is responsible under an APM. Please support with explanations of how expected expenditures are calculated and provide citations to any relevant documentation.
3. Capitation⁹ The State will be asked to indicate whether the payment arrangement is a full capitation arrangement. 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 any relevant documentation.

Version History

Date	Change Description
02/24/2025	Original version

⁸ Total revenue means the total combined revenue from the payer to providers and suppliers participating in the APM Entity.

⁹ The regulation pertaining to capitation is located at 42 CFR § 414.1420(d)(7).