

## CMS Quality Payment Program

### Submission Form for Eligible Clinician and APM Entity Requests for Other Payer Advanced ~~APM~~ Alternative Payment Model Determinations (Eligible Clinician Initiated Submission Form)

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#### Purpose

The Eligible Clinician Initiated Submission Form (Form) may be used by Eligible Clinicians and APM Entities that participate in other payer arrangements to request that CMS determine whether a payment arrangement is an Other Payer Advanced ~~APM~~ Alternative Payment Model (APM) under the Quality Payment Program as set forth in 42 CFR 414.1420. This process is called the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process (Eligible Clinician Initiated Process). The Eligible Clinician Process may be used for payment arrangements under Title XIX (Medicaid), Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid Plans, Cost Plans under sections 1876 and 1833 ~~Cost Plans~~, and Programs of All Inclusive Care for the Elderly (PACE) plans), CMS Multi-Payer Models, or other commercial or private payer ~~plans~~ payment arrangements.

The Eligible Clinician Initiated Process occurs following the relevant All-Payer QP Performance Period, except in the case of Title XIX (Medicaid) payment arrangements ~~including Medicaid FFS and Medicaid Managed Care Plans~~, which must be submitted during the year prior to the relevant performance period. More information about the Quality Payment Program is available at <http://qpp.cms.gov/>.

#### Deadlines

The Form Submission Deadline for all non-Medicaid payment arrangements is December 1 ~~of the relevant QP Performance Period (e.g. December 1, 2019 for the 2019 performance period)~~. Forms may be submitted starting in August. CMS intends to review and provide determinations for Forms submitted by September 1 prior to the December 1 Submission Deadline for payment arrangement participation data for QP determination purposes. CMS will provide determinations for Forms submitted between September 2 and December 1 as soon as practicable after the Submission Deadline.

Forms for payment arrangements authorized under Title XIX (Medicaid) must be submitted prior to the relevant All-Payer QP Performance Period. The deadline for these submissions is November 1 of the calendar year prior to the relevant All-Payer QP Performance Period. CMS intends to make determinations for these payment arrangements prior to the relevant All-Payer QP Performance Period ~~(e.g., in 2018 for the 2019 performance period)~~.

Different payment arrangements must be submitted separately. You must submit the required information pertaining to each payment arrangement you wish to have reviewed.

## Additional Information

CMS will review the payment arrangement information in this Form to determine whether the payment arrangement meets the Other Payer Advanced ~~Alternative Payment Model (APM)~~ criteria. If ~~you submit~~ [an APM Entity or eligible clinician submits](#) incomplete information and/or more information is required to make a determination, CMS will notify ~~you~~ [the APM Entity or eligible clinician](#) and request the additional information that is needed. ~~You~~ [APM Entities or eligible clinicians](#) must return the requested information no later than ~~40~~ [15](#) business days from the notification date. ~~If you~~ [If APM Entities or eligible clinician](#) do 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. These determinations are final and not subject to reconsideration.

## Notification

For non-Medicaid payment arrangements, CMS intends to notify [the](#) APM Entities and Eligible Clinicians of determination decisions by December 1 for Forms submitted by September 1, and as soon as practicable after the Submission Deadline for Forms submitted by December 1. For Medicaid payment arrangements, CMS intends to notify APM Entities and Eligible Clinicians of determination decisions prior to the relevant All-Payer QP Performance Period. CMS will also post a list of all the payment arrangements determined to be Other Payer Advanced APMs on a CMS website.

## ~~Instructions for Completing and Submitting this Form~~

~~NOTE: Please be sure to save your work before navigating away from each page as any unsaved work will be lost. Additionally, the application times out after 30 minutes of inactivity.~~

~~A separate submission must be completed for each payment arrangement the APM Entity or eligible clinician is submitting.~~

## Helpful Links:

[- QPP All-Payer Submission Form User Guide](#)

[- QPP All-Payer FAQs](#)

[- Glossary](#)

All Forms must be completed and submitted electronically through the CMS website. Additional information regarding electronic Form access and submission process will be available following publication of the 2018 Quality Payment Program Final Rule.

In addition to APM Entities and Eligible Clinicians, we allow those authorized to report on behalf of APM Entities or Eligible Clinicians to complete this Form.

This Form contains the following sections:

Section 1: Eligible Clinician or APM Entity Identifying Information

## Section 2: Payment Arrangement Information

Section 2.1: Title XIX (Medicaid)

Section 2.2: Non-Medicaid (Medicare Health Plans, CMS Multi-Payer Models, and Commercial and Other Private Payers)

## Section 3: Supporting Documentation

## Section 4: Certification Statement

An APM Entity or eligible clinician (submitter) will complete all four sections, but will only complete one of the two subsection in Section 2. Section 2.1 should be completed for any payment arrangement that is a Medicaid plan. Section 2.2 should be completed for any other type of payment arrangements (including Medicare Health Plans, CMS Multi-Payer Models, and Commercial and ~~Other Private Payer~~[other private payer](#) payment arrangements). Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, [Cost Plans under sections 1876 and 1833](#)~~Cost Plans~~, and Programs of All Inclusive Care for the Elderly (PACE) plans.

All required supporting documentation must be uploaded as attachments in the Supporting Documentation section of the Form.

## SECTION 1: APM Entity or Eligible Clinician ~~or APM Entity~~ Identifying Information

### A. Submitter Type

1. Select one of the following: [DROP-DOWN LIST]

- APM Entity

*APM Entity means an entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.*

- Eligible Clinician

*Eligible clinician means “eligible professional” as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following:*

- *A physician.*
- *A practitioner described in section 1842(b)(18)(C) of the Act.*
- *A physical or occupational therapist or a qualified speech-language pathologist.*
- *A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).*

### B. APM Entity or Eligible Clinician ~~or APM Entity~~ Information

1. Are you reporting on behalf of more than one Eligible Clinician (but not an APM Entity)? [Y/N]

*If yes, complete this section for each Eligible Clinician for whom you are reporting.*

2. APM Entity or Eligible Clinician ~~or APM Entity~~ Legal Name: \_\_\_\_\_

3. List the first name(s), last name(s), and NPI(s) of each clinician participating in the payment arrangement. [TEXT BOX FOR EACH NPI]

4. Taxpayer Identification Number (TIN) (optional): \_\_\_\_\_

5. DBA Name (if applicable): \_\_\_\_\_

6. Parent Company or Organization (if applicable): \_\_\_\_\_

7. Contact Information:

Telephone Number: \_\_\_\_ Fax Number: \_\_\_\_\_

Address Line 1 (Street Name and Number): \_\_\_\_\_

Address Line 2 (Suite, Room, etc.): \_\_\_\_\_

City/Town: \_\_\_\_ State: \_\_\_\_ Zip Code +4: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### C. APM Entity Contact Person (Optional)

Section only required for APM Entity submissions. Please complete only if person is different than the person listed above. For Eligible Clinician submissions, the Eligible Clinician is the contact person.

1. If questions arise during the processing of this request, CMS or its contractor will contact the individual shown/named below.

First Name: \_\_\_\_ Middle Initial: \_\_\_\_ Last Name: \_\_\_\_\_  
 Telephone Number: \_\_\_\_ Fax Number: \_\_\_\_\_  
 Address Line 1 (Street Name and Number): \_\_\_\_\_  
 Address Line 2 (Suite, Room, etc.): \_\_\_\_\_  
 City/Town: \_\_\_\_ State: \_\_\_\_ Zip Code +4: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

## SECTION 2: Payment Arrangement Information

### SECTION 2.1: Title XIX (Medicaid)

*This section includes payment arrangements that the State uses in Medicaid Fee-For-Service, payment arrangements the State requires Medicaid managed care plans to effectuate, and payment arrangements that Medicaid managed care plans and providers voluntarily enter without State involvement.*

#### A. General Information

~~1. Payment Arrangement Name (e.g. [State Name] ACO Model), or terminology used to refer to the payment arrangement: [TEXT BOX]~~

~~2. Select the All Payer QP Performance Period for which this payment arrangement determination is being requested: [YEAR DROP-DOWN]~~

~~*If questions about the payment arrangement arise during the processing of this request, CMS may contact the Health Plan or State for clarification.*~~

~~3.1. Health Plan or State Contact Person for this payment arrangement:~~

~~Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_~~

~~4.1. Describe the participant eligibility criteria for this payment arrangement. [TEXT BOX]~~

~~5.1. Is this payment arrangement open to all provider types or limited to certain specialties? [SELECT ONE]~~

~~If the payment arrangement is limited to certain specialties, select the provider specialties that may participate in the payment arrangement. [DROP-DOWN]~~

~~6.1. In what county do you see the greatest number of patients? [TEXT BOX]~~

### ~~B.A. Availability of Payment Arrangement~~

~~1. Is this payment arrangement available through Medicaid Fee-For-Service? [Y/N]~~

~~2.1. Is this payment arrangement available through a Medicaid managed care plan? [Y/N]~~

~~If yes, state the health insurance company and plan name under which this payment arrangement was implemented. [TEXT BOX]~~

~~3.1. Locations where this payment arrangement will be available:~~

- ~~I don't know [CHECK BOX]~~
- ~~Statewide (all counties) [CHECK BOX]~~
- ~~Counties (if not statewide) [DROP-DOWN LIST]~~

### ~~C.A. Payment Arrangement Documentation~~

Please attach documentation that supports responses to the questions asked in Sections D (CMS Medicaid Medical Home Model Determination) and E (Information for Other Payer Advanced APM Determination) of this Form. Supporting documents may include contracts or excerpts of contracts between you and the Medicaid managed care plan, contracts or excerpts of contracts between you and the State Medicaid agency, or alternative comparable documentation that supports responses to the questions asked in Sections [CD](#) and [DE](#) below.

~~Upload~~*Note: Please upload all documents [that you will reference when completing this submission](#) to the Supporting Documentation section of this Form, and label each document for reference throughout the Form.*

*CMS will use existing Medicaid documentation in the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process as applicable.*

*[Optional](#): Is information about this payment arrangement included in a State Plan Amendment (SPA), Section 1115 demonstration waiver application, Special Terms and Conditions document, implementation protocol document, or other document describing the 1115 demonstration arrangement approved by CMS? [Y/N/Don't Know]*

### B. Payment Arrangement Information

1. Payment Arrangement Name (e.g. [State Name] ACO Model), or terminology used to refer to the payment arrangement: [TEXT BOX]

2. Health Plan or State Contact Person for this payment arrangement:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

*If questions about the payment arrangement arise during the processing of this request, CMS may contact the Health Plan or State for clarification.*

3. Describe the participant eligibility criteria for this payment arrangement. [TEXT BOX]

4. Is this payment arrangement open to all provider types or limited to certain specialties? [SELECT ONE]

*If the payment arrangement is limited to certain specialties, select the provider specialties that may participate in the payment arrangement. [DROP-DOWN]*

5. In what county do you see the greatest number of patients? [TEXT BOX]

~~7-6. please attach the relevant~~ [Payment arrangement](#) documentation. ~~Note the~~ [is required to support the answers provided above. Please note the attached](#) document ~~name(s)~~ and page number(s) that contain [this](#) information ~~regarding this payment arrangement.~~ [TEXT BOX]

### **C. Availability of Payment Arrangement**

1. Is this payment arrangement available through Medicaid Fee-For-Service? [Y/N]

2. Is this payment arrangement available through a Medicaid managed care plan? [Y/N]

*If yes, state the health insurance company and plan name under which this payment arrangement was implemented. [TEXT BOX]*

3. Locations where this payment arrangement will be available:

— I don't know [CHECK BOX]

- Statewide (all counties) [CHECK BOX]

- Counties (if not statewide) [DROP DOWN LIST]

- I don't know [CHECK BOX]

### **D. Information for CMS Medicaid Medical Home Model Determination**

1. Do you request that CMS make a determination regarding whether this payment arrangement is a Medicaid Medical Home Model as defined in 42 CFR 414.1305? [Y/N]

*If no, skip to section E.*

*If yes, list the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]*

2. For which eligible clinicians with a primary care focus does the payment arrangement include specific design elements? Select all Physician Specialty Codes that apply: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant. [CHECK BOX]
3. Does the payment arrangement require empanelment (assigning individual patients to individual providers) of each patient to a primary clinician? [Y/N]
4. Select all elements from the following list that are required by the payment arrangement, and cite the supporting document(s) and page number(s) that contain this information regarding each requirement. Briefly explain how each criterion is satisfied in the payment arrangement.
  - Planned coordination of chronic and preventive care. [Y/N] If yes, [TEXT BOX]
  - Patient access and continuity of care. [Y/N] If yes, [TEXT BOX]
  - Risk-stratified care management. [Y/N] If yes, [TEXT BOX]
  - Coordination of care across the medical neighborhood. [Y/N] If yes, [TEXT BOX]
  - Patient and caregiver engagement. [Y/N] If yes, [TEXT BOX]
  - Shared decision-making. [Y/N] If yes, [TEXT BOX]
  - Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g. shared savings or population-based payments). [Y/N] If yes, [TEXT BOX]

#### Medicaid Medical Home Model Financial Risk Standard

~~10. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]~~

1. Does the payment arrangement Medicaid Medical Home Model require ~~you~~that, based on the APM Entity's failure to bear financial risk if actual aggregate expenditures meet or exceed expected aggregate expenditures (i.e. benchmark amount)? [Y/N] one or more specified performance standards, at least one of the following occurs:

- If yes, which 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

[Yes/No]

2. Which of the following actions does the payer take in cases where ~~actual aggregate expenditures~~ the APM Entity's fails to meet or exceed expected aggregate expenditures one or more specified performance standards? [CHECK BOX]
  - Payer withholds payment of services
  - Payer reduces payment rates
  - Payer requires direct payments.
  - Payer requires you 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 where ~~actual aggregate expenditures exceed expected aggregate expenditures~~ the APM Entity fails to meet or exceed one or more specified performance standards. [TEXT BOX]*

*Please describe how the amount that an APM entity owes or forgoes is calculated. [text box]*

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

#### Medicaid Medical Home Model Nominal Amount Standard

- ~~1. List the attached document(s) and page numbers that contain the information required in this section. For performance year 201920, is [TEXT BOX]~~

1. ~~Is~~ the total amount that ~~you~~ your participating entity potentially owes or foregoes under the payment arrangement at least 3 percent of ~~your~~ the average estimated total revenue of all the participating providers or other entities under the payer.? [Y/N]

*If yes, please describe how the amount that ~~you owe~~ an APM entity owes or foregoes is calculated. [~~TEXT BOX~~Text Box]*

2. List the attached document(s) and page numbers that contain the information required in this section. [Text Box]

#### **E. Information for Other Payer Advanced APM Determination**

See CY 2017 and CY 2018 Quality Payment Program Final Rules for further information regarding CMS Medicaid Medical Home Model designation.

Certified Electronic Health Record Technology (CEHRT)

1. ~~List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]~~ Does the payment arrangement require at least 50 percent of participating eligible clinicians in each APM Entity (or each hospital if hospitals are the APM participants) to use CEHRT as defined in 42 CFR 414.1305 ~~to document and communicate clinical care?~~ [Yes/No/I don't know]
2. Does this payment arrangement require you to use CEHRT as defined in §414.1305 to document and communicate clinical care. [Y/N]
- ~~1. If the submitter type is Eligible Clinician, please describe how the CEHRT requirement applies at the individual level. [TEXT BOX]~~
3. List the attached document(s) and page numbers that contain the information required in this section. [Text Box]

### Quality Measure Use

1. Does the payment arrangement apply any quality measures that are comparable to MIPS quality measures as required by 42 CFR 414.1420(c)? [Y/N]
2. If yes, does at least one quality measure have an evidence-based focus, is it reliable and valid, and does it meet at least one of the following criteria: [Y/N]
  - Any of the quality measures included on the proposed annual list of MIPS quality measures;
  - Quality measures that are endorsed by a consensus-based entity;
  - Quality measures developed under section 1848(s) of the Act;
  - Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act or
  - Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid.
3. Please provide the following information for each quality measure included in the payment arrangement that you wish for CMS to consider for purposes of satisfying this criterion. [TEXT BOX FOR EACH MEASURE]
  - Measure title
  - MIPS measure identification number (if applicable)
  - National Quality Forum (NQF) number (if applicable)
  - If the measure is neither a MIPS measure nor a currently endorsed NQF measure, cite the scientific evidence and/or clinical practice guidelines that support the use of the measure.
  - Is the measure an outcome measure?

- Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one the following criteria:
  - o Any of the quality measures included on the proposed annual list of MIPS quality measures;
  - o Quality measures that are endorsed by a consensus-based entity;
  - o Quality measures developed under section 1848(s) of the Act;
  - o Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act or
  - o Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid

4. Are any of the above measures outcome measures? [A minimum of one quality measure that meets the above criteria and is an outcome measure is required in order to satisfy the Quality Measure Use criterion.](#) [Y/N]

*If no, check here if no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure list. [CHECK BOX]*

5. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]

#### Generally Applicable Financial Risk Standard

#### Section not applicable for Medicaid Medical Home Models

*If no, check here if no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure list. [CHECK BOX]*

#### Generally Applicable Financial Risk Standard

#### Section not applicable for Medicaid Medical Home Models

- ~~1. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]~~
1. Does the payment arrangement require you [or your participating entity](#) to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures (i.e. benchmark amount)? [Y/N]
  2. If yes, [which of the following actions does the payer take in cases where the APM Entity's fails to meet or exceed one or more specified performance standards,](#) ~~which of the following actions does the payer take in cases where actual aggregate expenditures exceed expected aggregate expenditures?~~ [\[CHECK BOX\]](#) ~~Check Box~~
    - Payer withholds payment of services to the APM Entity and/or the APM Entity's eligible clinicians.

- Payer reduces payment rates to APM Entity and/or the APM Entity's eligible clinicians.
- Payer requires direct payments by the APM Entity to the payer.

*Please describe the action(s) checked above that are taken by the payer in cases where actual aggregate expenditures exceed expected aggregate expenditures. [TEXT BOX]*

3. Is this payment arrangement a full capitation arrangement? [Y/N]

*A full capitation arrangement for purposes of Other Payer Advanced APM determinations is a payment arrangement in which a per capita or otherwise predetermined payment is made under the payment arrangement for all items and services ~~for which payment is made through the payment arrangement~~ furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed for reconciling or sharing losses incurred or savings earned.*

*If yes, describe how this payment arrangement is a full capitation arrangement. [TEXT BOX]*

4. List the attached document(s) and page numbers that contain the information required in this section. [Text Box]

#### Generally Applicable Nominal Amount Standard

*Section not applicable for Medicaid Medical Home Models*

#### ~~Generally Applicable Nominal Amount Standard~~

~~*Section not applicable for Medicaid Medical Home Models*~~

- ~~2. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]~~

- 3.1. Please briefly describe the payment arrangement's risk methodology. Note the risk rate(s), expenditures that are included in risk calculations, circumstances under which you are required to repay or forego payment, and any other key components of the risk methodology. [TEXT BOX]

- 4.2. Is the marginal risk that you or your participating entity potentially owe or forego under the payment arrangement at least 30 percent? [Y/N]  
*If yes, please describe the marginal risk rate(s) and the actions required (e.g., repayment or forfeit of future payment) under the payment arrangement. [TEXT BOX]*

5.3. Is the minimum loss rate with which you or your participating entity operate under the payment arrangement no more than 4 percent? [Y/N]

*If yes, please describe the minimum loss rate. [TEXT BOX]*

6.4. Is the total amount that you or your participating entity owe or forgo under the payment arrangement at least:

- 8 percent of the total revenue from the payer of ~~your~~all providers and suppliers in ~~the payment arrangement~~your participating entity if financial risk is expressly defined in terms of revenue [Y/N]

*If yes, please explain how risk is expressly defined in terms of revenue. [TEXT BOX]*

- 3 percent of the expected expenditures for which you or your participating entity are responsible under the payment arrangement? [CHECK BOX]

*If yes, please describe how the amount that you owe or forego is calculated. [TEXT BOX]*

5. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]

## **SECTION 2.2: Non-Medicaid (Medicare Health Plans, CMS Multi-Payer Models, and Commercial and Other Private Payer Payment Arrangements)**

### **A. General Information**

1. Payment Arrangement Name (e.g. [Payer Name] Oncology Care Model), or terminology used to refer to the payment arrangement: [TEXT BOX]

2. Is this payment arrangement part of a CMS Multi-Payer Model? [Y/N]

*If yes, select the CMS Multi-Payer Model. [DROP-DOWN LIST]*

3. Select the All-Payer QP Performance Period for which this payment arrangement determination is being requested: [YEAR DROP-DOWN]

4. State the health insurance company and plan name under which this payment arrangement was implemented. [TEXT BOX]

5. Payer Contact Person for this payment arrangement:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

6. Describe the participant eligibility criteria for this payment arrangement. [TEXT BOX]

7. Is this payment arrangement open to all provider types or limited to certain specialties?  
[SELECT ONE]

*If the payment arrangement is limited to certain specialties, select the provider specialties that may participate in the payment arrangement. [DROP-DOWN]*

## **B. Payment Arrangement Documentation**

Please attach documentation that supports responses to the questions asked in Section C (Information for Other Payer Advanced APM Determination) of this Form. Supporting documents may include contracts or excerpts of contracts between you and the payer, or alternative comparable documentation that supports responses to the questions asked in Section C below.

Upload all documents to the Supporting Documentation section of this Form, and label each document for reference throughout the Form.

*For CMS Multi-Payer Models, please include your CMS Multi-Payer Model Participation Agreement in Supporting Documentation.*

## **C. Information for Other Payer Advanced APM Determination**

### Certified Electronic Health Record Technology (CEHRT)

1. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]
2. Does the payment arrangement require at least 50 percent of participating eligible clinicians in each APM Entity (or each hospital if hospitals are the APM participants) to use CEHRT as defined in 42 CFR 414.1305 to document and communicate clinical care? [Y/N]
3. If the submitter type is Eligible Clinician, please describe how the CEHRT requirement applies at the individual level. [TEXT BOX]

### Quality Measure Use

1. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]
2. Does the payment arrangement apply any quality measures that are comparable to MIPS quality measures as required by 42 CFR 414.1420(c)? [Y/N]
3. If yes, does at least one quality measure have an evidence-based focus, is it reliable and valid, and does it meet at least one of the following criteria: [Y/N]

- Any of the quality measures included on the proposed annual list of MIPS quality measures;
  - Quality measures that are endorsed by a consensus-based entity;
  - Quality measures developed under section 1848(s) of the Act;
  - Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act or
  - Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid.
4. A minimum of one quality measure that meets the above criteria and is an outcome measure is required in order to satisfy the Quality Measure Use criterion. Please provide the following information for each quality measure included in the payment arrangement that you wish for CMS to consider for purposes of satisfying this criterion. [TEXT BOX FOR EACH MEASURE]

- Measure title
- MIPS measure identification number (if applicable)
- National Quality Forum (NQF) number (if applicable)
- If the measure is neither a MIPS measure nor a currently endorsed NQF measure, cite the scientific evidence and/or clinical practice guidelines that support the use of the measure.
- Is the measure an outcome measure?
- Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one the following criteria:
  - *Any of the quality measures included on the proposed annual list of MIPS quality measures;*
  - *Quality measures that are endorsed by a consensus-based entity;*
  - *Quality measures developed under section 1848(s) of the Act;*
  - *Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act or*
  - *Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid*

5. Are any of the above measures outcome measures? [Y/N]

*If no, check here if no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure list. [CHECK BOX]*

#### Generally Applicable Financial Risk Standard

1. List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]
2. Does the payment arrangement require you to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures (i.e. benchmark amount)? [Y/N]

3. If yes, which of the following actions does the payer take in cases where actual aggregate expenditures exceed expected aggregate expenditures? [CHECK BOX]
- Payer withholds payment of services to the APM Entity and/or the APM Entity's eligible clinicians.
  - Payer reduces payment rates to APM Entity and/or the APM Entity's eligible clinicians.
  - Payer requires direct payments by the APM Entity to the payer.

*Please describe the action(s) checked above that are taken by the payer in cases where actual aggregate expenditures exceed expected aggregate expenditures. [TEXT BOX]*

4. Is this payment arrangement a capitation arrangement? [Y/N]

*A capitation arrangement for purposes of Other Payer Advanced APM determinations is a payment arrangement in which a per capita or otherwise predetermined payment is made under the payment arrangement for all items and services for which payment is made through the payment arrangement furnished to a population of beneficiaries, and no settlement is performed for reconciling or sharing losses incurred or savings earned.*

*If yes, describe how this payment arrangement is a capitation arrangement. [TEXT BOX]*

#### Generally Applicable Nominal Amount Standard

- 2.1.** List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX]

- 3.2.** Please briefly describe the payment arrangement's risk methodology. Note the risk rate(s), expenditures that are included in risk calculations, circumstances under which you are required to repay or forego payment, and any other key components of the risk methodology. [TEXT BOX]

- 4.3.** Is the marginal risk that you potentially owe or forego under the payment arrangement at least 30 percent? [Y/N]

*If yes, please describe the marginal risk rate(s) and the actions required (e.g., repayment or forfeit of future payment) under the payment arrangement. [TEXT BOX]*

- 5.4.** Is the minimum loss rate with which you operate under the payment arrangement no more than 4 percent? [Y/N]

*If yes, please describe the minimum loss rate. [TEXT BOX]*

- 6.5.** Is the total amount that you owe or forego under the payment arrangement at least:

- 8 percent of the total revenue from the payer of your providers and suppliers in the payment arrangement if financial risk is expressly defined in terms of revenue [Y/N]
- If yes, please explain how risk is expressly defined in terms of revenue. [TEXT BOX]*

- 3 percent of the expected expenditures for which you are responsible under the payment arrangement? [CHECK BOX]  
*If yes, please describe the amount that you owe or forego is calculated. [TEXT BOX]*

### **SECTION 3: Supporting Documentation**

*Please upload all supporting documentation here. Documents should be labeled for reference use throughout the Form.*

### **SECTION 4: Certification Statement**

*The Submitter will only complete the Certification Statement relevant to his or her submitter type.*

#### **APM Entity**

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to bind the APM Entity submitting this Form. I further certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this Form is not true, accurate, or complete, I will notify CMS of this fact immediately. I understand that the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

[I agree \[Check box\]](#)

[DATE, AUTHORIZED INDIVIDUAL NAME, TITLE, APM ENTITY NAME]

#### **Eligible Clinician**

I have read the contents of this submission. By submitting this Form, I certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this Form is not true, accurate, or complete, I will notify CMS of this fact immediately. I understand that the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

[I agree \[Check box\]](#)

[DATE, ELIGIBLE CLINICIAN]

#### **Third Party Submitting on Behalf of Eligible Clinician**

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to submit this Form on behalf of each EC specified in section 1.B of this Form. I further certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this Form is not true, accurate, or complete, I will notify CMS of this fact immediately. I understand that the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

[I agree \[Check box\]](#)

[DATE, AUTHORIZED INDIVIDUAL NAME, TITLE, NAME OF THIRD PARTY ENTITY  
(if applicable)]

For a third party submitting on behalf of an eligible clinician(s), that third party must also submit as supporting documentation the following certification from each eligible clinician that the third party is reporting on behalf of:

I have read the contents of this submission. I authorize [insert Third Party Name] to submit this Form on my behalf. I certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this Form is not true, accurate, or complete, I will notify CMS of this fact immediately. I understand that the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

[DATE, ELIGIBLE CLINICIAN]

## **Eligible Clinician Initiated Submission Form Privacy Act Statement**

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this Form by sections 1833(z)(2)(B)(ii) and (z)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395l).

The purpose of collecting this information is to determine whether the submitted payment arrangement is an Other Payer Advanced APM as set forth in 42 C.F.R. 414.1420 for the relevant All-Payer QP Performance Period.

The information in this request will be disclosed according to the routine uses described below. Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud and abuse;
2. A congressional office in response to a subpoena;
3. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
4. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached.

### **Protection of Proprietary Information**

Privileged or confidential commercial or financial information collected in this Form is protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

### **Protection of Confidential Commercial and/or Sensitive Personal Information**

If any information within this request (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. 552(b)(4) and/or (b)(6), respectively.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1314 (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **\*\*\*CMS Disclosure\*\*\*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QPP@cms.hhs.gov.