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Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

Submission Form for Requests for MIPS Exclusion Determinations under the MAQI Demonstration (Threshold Data Submission Form)

Welcome to the Threshold Data Submission Form

Purpose

The Threshold Data Submission Form (Form) may be used to request that CMS determine whether participants in the MAQI Demonstration are to receive waivers from Merit-based Incentive Payment System (MIPS) reporting and payment consequences. This process is called the MIPS waiver determination process.

The MAQI Demonstration will allow participating clinicians to have the opportunity to be eligible for waivers that will exempt them from the MIPS reporting requirements and payment adjustment for a given year if they participate to a sufficient degree in Qualifying Payment Arrangements with MAOs (combined with participation in Advanced APMs with Medicare FFS, if any) during the performance period for that year, without requiring them to be QPs or Partial QPs, or to otherwise meet MIPS exclusion criteria.

Demonstration participants who meet either the payment amount threshold or the patient count threshold shown below for at least one of three snapshots (January 1 – March 31, January 1 – June 30, or January 1 – August 31) during the performance period for a given year of the Quality Payment Program (QPP) will receive waivers from MIPS reporting and payment consequences for that year of QPP.

Performance Period Year	Payment Amount Threshold[1]	Patient Count Threshold[2]
2018	25%	20%
2019	50%	35%
2020	50%	35%
2021	75%	50%
2022	75%	50%

Notes: [1] Equals percent of total Medicare FFS and MA payments that are under the terms of Advanced APMs/Qualifying Payment Arrangements.
[2] Equals percent of total Medicare FFS and MA patients that are under the terms of Advanced APMs/Qualifying Payment Arrangements.

This Form collects Medicare Advantage payment and patient count information, for purposes of calculating payment amount and patient count threshold scores. Because CMS has access to Medicare FFS payment amount and patient count information internally, MAQI participants do not need to submit Medicare FFS data in this Form.

MAQI participants requesting MIPS exclusion determinations must submit this Form no later than October 31 of the year of the Performance Period (except in the first performance year where CMS anticipates this date to be in November 2018). CMS will not review Forms submitted after the Submission Deadline.

Additional Information

CMS will review the Qualifying Payment Arrangement participation information in this Form to determine whether the MAQI participant meets the conditions to receive waivers from MIPS reporting and payment consequences. If incomplete information is submitted and/or more information is required to make a determination, CMS will notify the MAQI participant and request the additional information that is needed. MAQI participants must return the requested information no later than 3 business days from the notification date. If the MAQI participant does not submit sufficient information within this time period, the MAQI participant will not be excluded from MIPS for that year. These determinations are final and not subject to reconsideration.

Notification

CMS will notify MAQI participants of whether they met the MIPS exclusion criteria as soon as possible after determinations are made.

MAQI participants may submit information on any or all of the three snapshot periods: January 1 through March 31, January 1 through June 30, or January 1 through August 31. Complete information for all MA plans must be included for whichever snapshot period(s) the MAQI participant chooses to submit.

The MAQI participant or an authorized agent of the MAQI participant may submit the Form on behalf of the MAQI participant. In submitting the Form, the submitter attests that he or she is qualified to make the assertions contained herein as the MAQI participant or an agent of the MAQI participant and that the assertions contained herein are true and accurate with respect to this Form.

All Forms must be completed and submitted electronically.

This Form contains the following sections:

MAQI participants must complete Sections 1 and 3 in their entirety. Section 2 include options for submitting data for any of the three snapshot periods. MAQI participants may submit information for any or all of the three snapshot periods. It is strongly recommended, though not required, that MAQI participants submit both patient count and payment amount information for whichever snapshot period(s) they choose.

SECTION 1: MAQI Participant Identifying Information

A. Point of Contact for this Form

1. Name:_____
2. Job Title:_____
3. Organization Name:_____
4. Email:_____
5. Confirm Email:_____
6. Phone Number:_____ Ext:_____
7. Address Line 1 (Street Name and Number): _____
   Address Line 2 (Suite, Room, etc.): _____
   City: _____ State: _____ Zip Code +4: _____

B. MAQI Participant Information

1. Name of MAQI participant: _____
2. MAQI participant's NPI:_____
3. Advanced APM(s) in which MAQI participant participates [DROP DOWN LIST, allow multiple selections]

   3a. [For each Advanced APM selected] Model participation ID:_____
   [*Help bubble text: This refers to the unique identifier that the Advanced APM has assigned to the APM Entity through which the MAQI participant participates. It is most often a short combination of letters and numbers (for example, V### or E#####). If you are unsure of your Model participation ID, please reach out to the point of contact for your Advanced APM.]*

   3b. [For each Advanced APM selected] TIN through which MAQI participant participates in the Advanced APM:_____

   3c. [For each Advanced APM selected] Name of the point of contact for the APM Entity at CMS (optional):_____

SECTION 2: Qualifying Payment Arrangement Participation Data

Information for <u>all MA plans</u> through which the MAQI participant furnished services ***must be included.*** *MAQI participants may choose to submit information for any or all of the snapshot periods; you are not required to submit information for all three snapshot periods. In order to have a MIPS exclusion determination made for a snapshot period, you must enter information for every MA plan for that snapshot period.*

Please note that CMS may validate your Qualifying Payment Arrangement participation information with the MA plans you include in this Form.

Add a Plan + [Button] [Users will enter the below information for each plan, and there is no limit on the number of plans for which they may enter information. After the information below has been entered for each plan, display a chart summarizing the plans entered so far, and allow users to press this button again to add another payer]

A. Plan Name:_____

B. Did the MAQI participant participate in a Qualifying Payment Arrangement with this plan during the Performance Period (January 1 – August 31)? [Y/N]

B1. [If yes] Name(s) of Qualifying Payment Arrangement(s): *Note: the name listed here must match the name that the MAQI participant used when submitting the Qualifying Payment Arrangement determination request to CMS. You may select more than one Qualifying Payment Arrangement per plan.* [free text]:_____

B2. [If yes, for each Qualifying Payment Arrangement] Contract # (if applicable):_____ [*Help bubble text: This refers to the unique identifier that the Qualifying Payment Arrangement has assigned to the entity through which the MAQI participant participates in the Qualifying Payment Arrangement. It is most often a short combination of letters and numbers (for example, H####, E#### or R####). If you are unsure of your Contract #, please reach out to the point of contact for your Qualifying Payment Arrangement.]*

B3. [If yes, for each Qualifying Payment Arrangement] Name of the payer point of contact for the Qualifying Payment Arrangement (if available):_____

B4. [If yes, for each Qualifying Payment Arrangement] Phone number of the payer point of contact for the Qualifying Payment Arrangement: (if available)_____

B5. [If yes, for each Qualifying Payment Arrangement] Email address of the payer point of contact for the Qualifying Payment Arrangement: (if available)_____

C. What is the number of unique patients to whom the MAQI participant furnished services that are under the terms of Qualifying Payment Arrangements under this MA plan during this Snapshot Period?

Services are considered to be under the terms of a Qualifying Payment Arrangement if they are included in the measures of aggregate expenditures used by the Qualifying Payment Arrangement. MAQI participants may enter information for any or all of the snapshot periods. A unique patient may be included in multiple snapshot periods; in other words, a patient who is included in the first snapshot period should also be included in the second and third snapshot periods.

C1. First snapshot period (January 1 – March 31):_____

C2. Second snapshot period (January 1 – June 30):_____

C3. Third snapshot period (January 1 – August 31):_____

D. What is the total number of unique patients to whom the MAQI participant furnished services under this MA plan during the snapshot period?
MAQI participants may enter information for any or all of the snapshot periods. The total number of unique patients submitted for a snapshot period in this section (D) should meet or exceed the number of unique patients submitted for the same snapshot period in the previous section (C).

D1. First snapshot period (January 1 – March 31):_____

D2. Second snapshot period (January 1 – June 30):_____

D3. Third snapshot period (January 1 – August 31):_____

E. What is the aggregate amount of all payments attributable to the MAQI participant under the terms of Qualifying Payment Arrangement(s) under this MA plan during the snapshot period?
MAQI participants may enter information for any or all of the snapshot periods.

C1. First snapshot period (January 1 – March 31):_____

C2. Second snapshot period (January 1 – June 30):_____

C3. Third snapshot period (January 1 – August 31):_____

F. What is the aggregate amount of all payments from this MA plan to the MAQI participant during the snapshot period?
MAQI participants may enter information for any or all of the snapshot periods. The total amount of payments submitted for a snapshot period in this section (F) should meet or exceed the amount of payments submitted for the same snapshot period in the previous section (E).

D1. First snapshot period (January 1 – March 31):_____

D2. Second snapshot period (January 1 – June 30):_____

D3. Third snapshot period (January 1 – August 31):_____

SECTION 3: Certification Statement

MAQI Participant
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.

[DATE, MAQI participant]

Third Party Submitting on Behalf of MAQI Participant
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 MAQI participant specified in the MAQI Participant Identifying Information section 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.

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

For a third party submitting on behalf of a MAQI participant, that third party must also submit as supporting documentation the following certification from each MAQI participant that the third party is reporting on behalf of:

I have read the contents of this submission. I am authorized to submit this form on behalf of the MAQI participant. 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, MAQI participant]

Data Threshold 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 MAQI participant is to be excluded from MIPS.

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.