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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 annual exclusions from the Merit-Based Incentive Payment System ("MIPS") reporting requirements, payment adjustments, and performance feedback (collectively, the "MIPS exclusions") under the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration. This process is called the MIPS exclusion determination process.

The MAQI Demonstration will allow participating eligible clinicians to have the opportunity to receive the MIPS exclusions for a given year if they participate to a sufficient degree in Qualifying Payment Arrangements with Medicare Advantage Organizations (MAOs) (combined with participation in Advanced Alternative Payment Models (APMs) with Medicare Fee-for-Service (FFS), if any) during the performance period for that year, without meeting the criteria to be Qualifying APM Participants (QPs) or Partial QPs, or otherwise being excluded from MIPS.

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 Threshold1	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 2 of the year of the Performance Period. CMS will not review Forms submitted after the Submission Deadline.

Additional Information

CMS will review the Payment Arrangement information provided in this Form, in conjunction with information reported on the Qualifying Payment Arrangement Form, to determine whether the MAQI participant meets the conditions to receive the MIPS exclusions. 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 whether they have met the requirements for the MIPS exclusion as soon as possible after determinations are made.

Instructions for Completing and Submitting this Form

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:

Section 1: MAQI Participant Identifying Information
Section 2: Payment Arrangement Data
Section 3: Certification Statement

MAQI participants must complete all sections. 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: ____________

Are you an Eligible Clinician, or an Authorized Representative, submitting this information on behalf of an individual clinician(s)? [check box].

Are you submitting on behalf of your clinicians at the TIN Level Entity? [check box]. [NOTE: This check box should only be completed at the TIN Level Entity when NPIs that bill through the TIN have reassigned their billing to that TIN].

B. MAQI Participant Information

[Eligible Clinician and information submitted by the Authorized Representative]

1. List the first name(s), last name(s), and NPI(s) of the eligible clinician(s). [Text box; Add button for more than one Eligible Clinician that the Authorized Representative is submitting for]
2. Taxpayer Identification Number (TIN): _______________under which Eligible Clinician bills. [Drop down if they are billing under more than one TIN.]

[TIN Level Entity]

[NOTE: This form should only be completed at the TIN Level Entity when NPIs that bill through the TIN have reassigned their billing to that TIN.]

1. List the TIN Level Entity Legal Name participating in the payment arrangement: ____

2. Taxpayer Identification Number (TIN):________________________

C. Advanced APM(s)

1. Advanced APM(s) in which MAQI participant participates [DROP DOWN LIST, allow multiple selections]

   1a. [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.]*

   2b. [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: Payment Arrangement Data

Information for <u>all Medicare Advantage plans</u> through which the MAQI participant furnished services ***must be included.*** *[Eligible Clinician/Authorized Representative or TIN Level Entity] 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.*

<u>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.</u>

Please note that CMS may validate your Qualifying Payment Arrangement participation information with the Medicare Advantage 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:___________________________ [Add button for additional plan name]

B. Did the [Eligible Clinician or TIN Level Entity] participate in a Payment Arrangement with this plan during the Performance Period (January 1 – August 31)? [Y/N] [Must answer these questions for each plan listed]

B1. [If yes, Name(s) of Payment Arrangement(s)]: *Note: the name listed here must match the name that the [Eligible Clinician or TIN Level Entity] participant used when submitting the Payment Arrangement determination request to CMS. You may select more than one Payment Arrangement per plan.* [free text]:_______________________

B2. [If yes, for each 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 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 Payment Arrangement.]*

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

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

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

C. What is the number of Medicare beneficiaries to whom the MAQI PARTICIPANT or, in the case of a MAQI PARTICIPANT that is a TIN Level Entity, the MAQI PARTICIPANT's Eligible Clinicians furnished services under each MAO contract during the Determination Period(s)?
[Eligible Clinician/Authorized Representative or TIN Level Entity] 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):_____________

***D.* What are the aggregate payments made to the MAQI PARTICIPANT under the terms of each MAO contract during the Determination Period(s)?**

[Eligible Clinician/Authorized Representative or TIN Level Entity] *participants may enter information for any or all of the snapshot periods.*

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

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to bind the [Eligible Clinician/Authorized Representative or TIN Level Entity]. 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]

AUTHORIZED INDIVIDUAL NAME, TITLE, [ELIGIBLE CLINICIAN/TIN/TIN Level Entity]

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.

PRA Disclosure Statement

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 **0938-1354 (Expires 10/31/2021)**. The time required to complete this information collection is estimated to average 5 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 John Amoh at john.amoh@cms.hhs.gov**