

## Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

### Submission Form for Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration Qualifying Payment Arrangements (Qualifying Payment Arrangement Submission Form)

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#### **Purpose**

The Qualifying Payment Arrangement Submission Form (Form) may be used by MAQI participants that participate in payment arrangements with Medicare Advantage Health Plans to request that CMS determine whether a payment arrangement is a Qualifying Payment Arrangement under the MAQI Demonstration, authorized under Section 402 of the Social Security Amendments of 1967 (as amended). This process is called the MAQI Qualifying Payment Arrangement Determination Process (Qualifying Payment Arrangement Process). The Qualifying Payment Arrangement Process may be used for payment arrangements under Medicare Advantage Health Plans.

The Qualifying Payment Arrangement Process occurs following the relevant MAQI Demonstration Performance Period.

A federally mandated independent evaluation will be conducted of the MAQI demonstration. Evaluation activities are aimed at understanding the effects of the MAQI Demonstration. You may be contacted to provide additional information.

#### **Deadlines**

For 2019, the submission period for the Qualifying Payment Arrangement Process is projected to be from August 1, 2019 through October 2, 2019. CMS is projecting 60 days for the submission period. CMS intends to review and provide determinations for submitted Forms in December/January 2020.

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 Qualifying Payment Arrangement criteria under the MAQI Demonstration. If you submit incomplete information and/or more information is required to make a determination, CMS will notify you and request the additional information that is needed. You must return the requested information no later than 3 business days from the notification

date. If you 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 a Qualifying Payment Arrangement for the year. These determinations are final and not subject to reconsideration.

## **Notification**

CMS intends to notify MAQI participants of determination decisions in the December/January timeframe for Forms submitted during each submission period.

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

All Forms must be completed and submitted electronically through the CMS website.

In addition to MAQI participants, CMS will allow those authorized to report on behalf of MAQI participants to complete this Form.

This Form contains the following sections:

Section 1: MAQI Participant Identifying Information

Section 2: Payment Arrangement Information

Section 3: Supporting Documentation

Section 4: Certification Statement

MAQI participants must complete all four sections.

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

## **SECTION 1: MAQI Participant Identifying Information**

### **A. Point of Contact for this Form**

1. Name of contact or authorized representative: \_\_\_\_\_
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**

**[If Eligible Clinician or Authorized Representative submitting for the Eligible Clinician.]** [NOTE: If the NPIs have reassigned their billing to the TIN please complete the TIN Level Entity section below.]

1. List the first name(s), last name(s), and NPI(s) of the eligible clinician participating in the payment arrangement. [Drop down for authorized representatives that are submitting for more than one eligible clinician].

2. Taxpayer Identification Number (TIN): \_\_\_\_\_ under which Eligible Clinician bills. [Drop down if they are billing under more than one TIN.]

3. Contact Information of Eligible Clinician or Authorized Representative:

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: \_\_\_\_\_

### **[If TIN Level Entity submitting]**

[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): \_\_\_\_\_

## **SECTION 2: Payment Arrangement Information**

### **A. General Information**

List all payment arrangements [name, contract number, health insurance company, and whether the payment arrangement has already received approval for PY 2019]. [TEXT BOX or

FILLABLE TABLE with functionality to add new records for each payment arrangement].  
[NOTE: Please check the following website (<https://qpp.cms.gov/about/resource-library>) to see if the payment arrangement has been approved for 2019. For 2019, this information is contained in the document entitled, “2019 QPP Multi-Payer Other Payer Advanced APMs.” You will need the contract number to check on this.]

1. [For Eligible Clinicians and Authorized Representatives only] Is the payment arrangement information the same for all eligible clinicians that you have listed?  
[Yes/No]  
If no, you will need to let us know which eligible clinicians NPI this applies to. [drop down to add additional lines]

2. Payer Contact Person for this payment arrangement:

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

3. Describe the participant eligibility criteria for this payment arrangement. [TEXT BOX]  
[additional text boxes for more than one payment arrangement]
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]*

## **B. Payment Arrangement Documentation**

Please attach documentation for each plan that you believe is a Qualifying Payment Arrangement and supports responses to the questions asked in Section C (Information for Qualifying Payment Arrangement 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. It is strongly recommended that you upload the most current signed (and dated) contract with a MAO. The documentation should contain all the information in Section C, and it is preferred that a signed contract between a clinician and a MAO (or an independent physician association (IPA) and an MAO) be provided. [NOTE: YOU WILL NEED TO PROVIDE THE FOLLOWING INFORMATION FOR EACH PLAN THAT YOU BELIEVE IS A QUALIFYING PAYMENT ARRANGMENT].

Upload all documents to the Supporting Documentation section of this Form, and label each document for reference throughout the Form. Please provide contract number for each document you upload.

**C. Information for Qualifying Payment Arrangement Determination [this section will need to be completed for each Qualifying Payment Arrangement 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 clinicians participating in the payment arrangement to use CEHRT as defined in 42 CFR 414.1305 to document and communicate clinical care? [Y/N]

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 described 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:
    - 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*
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]*

Past Payment Arrangements (for informational purposes only)

In 2018 did you participate in any Medicare Advantage plan with requirements similar to those described above? [Y/N] (This information will not be used to determine eligibility for the MAQI demonstration.)

Generally Applicable Financial Risk Standard [this section will need to be completed for each contract]

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 participants in the Qualifying Payment Arrangement.
  - Payer reduces payment rates to participants in the Qualifying Payment Arrangement.
  - Payer requires direct payments by the participants in the Qualifying Payment Arrangement 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] [for each payment arrangement this question will need to be answered]

*A capitation arrangement for purposes of Qualifying Payment Arrangement 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 [this section will need to be completed for each contract]

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

### **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]

### **Qualifying Payment Arrangement Submission Form Privacy Act Statement**

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this Form by Section 402 of the Social Security Amendments of 1967 (as amended).

The purpose of collecting this information is to determine whether the submitted payment arrangement is a Qualifying Payment Arrangement as defined in the MAQI Demonstration for the relevant 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.

### **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 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 John Amoh at [john.amoh@cms.hhs.gov](mailto:john.amoh@cms.hhs.gov).**