

## CMS Quality Payment Program

### Submission Form for Eligible Clinician and APM Entity Requests for Other Payer Advanced 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 (or their authorized representatives) that participate in other payer arrangements to request that CMS determine whether a payment arrangement is an Other Payer Advanced 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, and Programs of All Inclusive Care for the Elderly (PACE) plans), CMS Multi-Payer Models, or other commercial or private payer 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/>.

Note: This Form should only be used when a clinician's payment arrangement does not already appear on the CMS list of approved Other Payer Advanced APMs on the QPP website (<https://qpp.cms.gov/about/resource-library>). If a payment arrangement in which a clinician participates has already been approved by CMS, the clinician does not need to complete this form. Additionally, this form is different from the QPP clinician data submission process, whereby clinicians submit their actual payment and patient data for purposes of Qualified APM Participant (QP) determination. That process occurs near the end of the calendar year in which a clinician participates in a payment arrangement.

#### **Deadlines**

This form and the current Eligible Clinician Initiated Process pertain to payment arrangements implemented in calendar year 2020.

The Form Submission Deadline for all non-Medicaid payment arrangements is December 1 of the relevant QP Performance Period (*e.g.* December 1, 2020 for the 2020 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 2019 for the 2020 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 APM criteria. If an APM Entity or eligible clinician submits incomplete information and/or more information is required to make a determination, CMS will notify the APM Entity or eligible clinician and request the additional information that is needed. APM Entities or eligible clinicians must return the requested information no later than 15 business days from the notification date. 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 Submitting and Completing this Form**

In addition to APM Entities and Eligible Clinicians, those authorized to report on behalf of APM Entities and Eligible Clinicians may complete 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.

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: Supporting Documentation

Section 3: Payment Arrangement Information

Section 3.1: Title XIX (Medicaid)

Section 3.2: Non-Medicaid (Medicare Health Plans, CMS Multi-Payer Models, and Commercial and Other Private Payers)

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 payment arrangements). Medicare Health Plans include Medicare Advantage, Medicare-Medicaid Plans, Cost Plans under sections 1876 and 1833, 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.

Select "Start a New Submission Form" to begin.

## SECTION 1: APM Entity or Eligible Clinician 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 Information

1. APM Entity or Eligible Clinician Legal Name: \_\_\_\_\_
2. List the first name(s), last name(s),
3. NPI(s) of each clinician [TEXT BOX FOR EACH NPI]
4. Taxpayer Identification Number (TIN) (optional): [TEXT BOX FOR EACH TIN]
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 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: Supporting Documentation

Please attach documentation that supports responses to the questions asked in Information for Other Payer Advanced APM Sect of this Form. Supporting documents may include contracts or excerpts of contracts between you and the health plan, or alternative comparable documentation that supports responses to the questions asked in sections below.

Note: Please upload all documents that you will reference when completing this submission to the Supporting Document section of this Form, and label each document for reference for reference throughout the form.

*For Medicaid submissions, CMS will use existing Medicaid documentation in the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process as applicable. The following question will also be asked:*

*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]

[Upload Document button asking for File Name and Description]

## SECTION 3: Payment Arrangement Information

### SECTION 3.1: 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. Payment Arrangement Information**

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.

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:  
If questions about the payment arrangement arise during the processing of this request, CMS may contact the health plan or state for clarification.

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

3. Who participates in this payment arrangement (e.g., primary care physicians, specialty group practices)? [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. Is this payment arrangement available through other lines of business? [Y/N]
6. Is this payment arrangement in place for multiple years: [Yes/No]

*If yes, submit dates for start and finish [Start MONTH/YEAR DROP-DOWN] [Finish MONTH/YEAR DROP-DOWN]*

7. Are you requesting that CMS make a multi-year determination for this payment arrangement? [Yes/No]

*If yes, state the last performance year through which you are requesting the multi-year determination. [YEAR– include up to 5 years]*

*If no, the payment arrangement determination will be made for the upcoming performance year.*

8. In what county do you see the greatest number of patients? [TEXT BOX]
9. Payment arrangement documentation is required to support the answers provided above. Please note the attached document(s) and page number(s) that contain this information. [TEXT BOX]

## **B. Availability of Payment Arrangement**

1. Is this payment arrangement available through:[Medicaid FFS/Medicaid managed care plan]

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

2. Locations where this payment arrangement will be available:
  - Statewide (all counties) [CHECK BOX]
  - Counties (if not statewide) [DROP DOWN LIST]
  - I don't know [CHECK BOX]
3. In what county do you see the greatest number of patients? [TEXT BOX]

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

Medicaid Medical Home Model means a payment arrangement under Title XIX that CMS determined by the following characteristics.

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 D.*

*If yes, list the attached document(s) and page numbers that provide evidence of 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. [Menu Selection 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

1. Does the Medicaid Medical Home Model require that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, at least one of the following occurs:
- 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 the APM Entity's fails to meet or exceed one or more specified performance standards? [CHECK BOX]
- Payer withholds payment of services
  - Payer reduces payment rates
  - Payer requires direct payments.
  - Payer requires the APM Entity 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 the APM Entity fails to meet or exceed one or more specified performance standards, which may include expected expenditures. [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. For performance year 2021 and later, is the total amount that your participating entity potentially owes or foregoes under the payment arrangement at least at least 5 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2021? [Y/N]

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

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

#### **D. 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. Does the payment arrangement require at least 75 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? For the purposes of this form, the APM Entity is the practitioner, or group of practitioners, that participates in this payment arrangement. [Y/N/Don't Know]
2. Does the payment arrangement require you use CEHRT as defined in 42 CFR 414.1305? [Y/N]
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 tie payments to one or more quality measures, at least one of which meets the following criteria (42 CFR 414.1420(c))? [Y/N]
2. Does at least one of the quality measures have an evidence base focus, is it reliable and valid, and does it meet one or more of the following criteria? [Y/N]
  - Finalized on the MIPS final list of measures, as described in §414.1330;
  - Endorsed by a consensus-based entity; or
  - Determined by CMS to be evidenced-based, reliable, and valid

*Please provide the following information for each quality measure included in the payment that you wish for CMS to consider for purposes of satisfying this criteria.*

2. [Button] Add Measure

- A. Measure title [Text box]
- B. Is the measure an outcome measure? [Y/N]
- C. Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one the following criteria [Checkbox]:

- i.* Finalized on the MIPS final list of measures, as described in §414.1330
- ii.* Endorsed by a consensus-based entity
- iii.* Determined by CMS to be evidenced-based, reliable, and valid

[Text box]

- iv.* This is an *outcomes* measure that does not meet any of the above criteria [Checkbox]

Describe how the measure has an evidence-based focus, is reliable and valid, by meeting criteria selected above. [Text box]

- D. National Quality Forum (NQF) number (if applicable) [Text box, if (ii) above is checked]
  - E. MIPS measure identification number (if applicable) [Text box, if (i) above is checked]
3. Are any of the above outcome measure? 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 criteria. [Y/N]

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

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

Generally Applicable Financial Risk Standard

*Section not applicable for Medicaid Medical Home Models*

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 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]*

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 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*

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]
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]*
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]*

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 providers and suppliers in your participating in each APM Entity or Eligible Clinician 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]*

OR

  - 3 percent of the expected expenditures for which an APM Entity or Eligible Clinician is 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 3.2: Non-Medicaid (Medicare Health Plans, CMS Multi-Payer Models, and Commercial and Other Private Payer Payment Arrangements)**

#### **A. Payment Arrangement Information**

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

Name: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_
3. State the health insurance company and plan name under which this payment arrangement was implemented. [TEXT BOX]
4. Locations where this payment arrangement will be available: [Drop down menu of States]
5. Is this payment arrangement available through other lines of business? [Yes, No, Don't know]
6. Who participates in this payment arrangement (e.g. primary care physicians, specialty group practices, etc.)? [TEXT BOX]
7. Is this payment arrangement in place for multiple years: [Yes/No]

*If yes, submit dates for start and finish [Start MONTH/YEAR DROP-DOWN] [Finish MONTH/YEAR DROP-DOWN]*

8. Are you requesting that CMS make a multi-year determination for this payment arrangement? [Yes/No]

*If yes, select the QP performance periods for which this payment arrangement determination is being made. [YEAR– include up to 5 years]*

*If no, the payment arrangement determination will be made for the upcoming performance year.*

9. 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]*

10. Payment arrangement documentation is required to support the answers provided above. Please note the attached document(s) and page number(s) that contain this information. [TEXT BOX]

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

### Certified Electronic Health Record Technology (CEHRT)

1. 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? [Y/N]
2. If No, does this payment arrangement require you to use CEHRT as defined in 42 CFR 414.1305 to document and communicate clinical care? [Y/N]
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), at least one of which meets one or more 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. (If so, please upload supporting documentation below)

*If the arrangement uses any other quality measures not already meeting the criteria above, add those measures using the Add Measure button below and cite the relevant scientific evidence and/or clinical practice guidelines that support the use of the measure in order for CMS to determine if they have an evidence-based focus and are reliable and valid.*

*Please provide the following information for each quality measure included in the payment that you wish for CMS to consider for purposes of satisfying this criteria.*

2. [Button] Add Measure

- A. Measure title [Text Box]
- B. Is the measure an outcome measure? [Y/N]
- C. Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one the following criteria:
  - i. *Any of the quality measures included on the proposed annual list of MIPS quality measures;*
  - ii. *Quality measures that are endorsed by a consensus-based entity;*
  - iii. *Quality measures developed under section 1848(s) of the Act;*
  - iv. *Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act or*
  - v. *Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid*

[Text box]

- vi. This is an outcomes measure that does not meet any of the above criteria [Checkbox]

If applicable, describe how the measure has an evidence-based focus, is reliable and valid, by meeting criteria selected above. [Text box]

- D. National Quality Forum (NQF) number (if applicable) [Text box]
- E. MIPS measure identification number (if applicable) [Text box]

3. Are any of the above outcome measure? 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 criteria. [Y/N]

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

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

#### Generally Applicable Financial Risk Standard

1. Does the payment arrangement require the participation APM Entity or Eligible Clinician 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 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]*

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 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. Payment arrangement documentation is required to support the answers provided above. Please note the attached document(s) and page numbers that contain this information. [TEXT BOX]

#### Generally Applicable Nominal Amount Standard

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 an APM Entity is required to repay or forego payment, and any other key components of the risk methodology. [TEXT BOX]

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]*
3. Is the minimum loss rate with which an APM Entity or Eligible Clinician operate under the payment arrangement no more than 4 percent? [Y/N]  
*If yes, please describe the minimum loss rate. [TEXT BOX]*
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 providers and suppliers participating in each APM Entity or Eligible Clinician 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]*
  - OR
  - 3 percent of the expected expenditures for which an APM Entity or Eligible Clinician is responsible under the payment arrangement? [CHECK BOX]  
*If yes, please describe how the amount that an APM Entity or Eligible Clinician owes 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 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 any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.

I agree [Check box]

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



### Multi-Year Other Payer Advanced APM Determination

I have submitted information that this payment arrangement will be in place for multiple years. I certify that I will review the submission at least once annually, to assess whether there have been any changes to the information since it was submitted, and to submit updated information notifying CMS of any material changes to the payment arrangement that would be relevant to the Other Payer Advanced APM criteria and the determination of the arrangement as an Other Payer Advanced APM, for each successive year of the arrangement. Absent the submission of updated information to reflect material changes to the payment arrangement, I acknowledge that CMS would continue to apply the original Other Payer Advanced APM determination for each successive year of the payment arrangement through the earlier of the end of that multi-year payment arrangement or 5 years.

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 any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.

I agree [Check box]

[DATE, ELIGIBLE CLINICIAN]

### Multi-Year Other Payer Advanced APM Determination

I have submitted information that this payment arrangement will be in place for multiple years. I certify that I will review the submission at least once annually, to assess whether there have been any changes to the information since it was submitted, and to submit updated information notifying CMS of any material changes to the payment arrangement that would be relevant to the Other Payer Advanced APM criteria and the determination of the arrangement as an Other Payer Advanced APM, for each successive year of the arrangement. Absent the submission of updated information to reflect material changes to the payment arrangement, I acknowledge that CMS would continue to apply the original Other Payer Advanced APM determination for each successive year of the payment arrangement through the earlier of the end of that multi-year payment arrangement or 5 years.

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 any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.

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 any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.

[DATE, ELIGIBLE CLINICIAN]

Multi-Year Other Payer Advanced APM Determination (if applicable)

I have submitted information that this payment arrangement will be in place for multiple years. I certify that I will review the submission at least once annually, to assess whether there have been any changes to the information since it was submitted, and to submit updated information notifying CMS of any material changes to the payment arrangement that would be relevant to the Other Payer Advanced APM criteria and the determination of the arrangement as an Other Payer Advanced APM, for each successive year of the arrangement. Absent the submission of updated information to reflect material changes to the payment arrangement, I acknowledge that CMS would continue to apply the original Other Payer Advanced APM determination for each successive year of the payment arrangement through the earlier of the end of that multi-year payment arrangement or 5 years.

I agree [Check box]

[DATE, AUTHORIZED INDIVIDUAL NAME, TITLE, NAME OF THIRD PARTY ENTITY]

## **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.

### **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 0938-1314 (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 at [qpp@cms.hhs.gov](mailto:qpp@cms.hhs.gov)