

## CMS Quality Payment Program

### Submission Form for Other Payer Requests for Other Payer Advanced Alternative Payment Model Determinations (Payer Initiated Submission Form)

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#### **Welcome to the QPP All-Payer Submission Form.**

#### **Purpose**

The Payer Initiated Submission Form (Form) may be used to request that CMS determine whether such payment arrangements are Other Payer Advanced Alternative Payment Models (APMs) under the Quality Payment Program as set forth in 42 CFR § 414.1420. This process is called the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process). More information about the Quality Payment Program is available at <http://qpp.cms.gov/>.

#### **[Title XIX only]**

Payment arrangement determination requests for all Medicaid payment models (including Medicaid fee-for-service [FFS] and Medicaid Managed Care Plans) may be submitted only by State Medicaid Agencies. A State Medicaid Agency requesting a determination for any payment arrangement under Title XIX of the Social Security Act, including payment arrangements aligned with a CMS Multi-Payer Model, must submit this Form by April 1 of the year prior to relevant QP Performance Period (*e.g.*, in 2023 for the 2024 performance period).

#### **[Medicare Health Plans only]**

A Medicare Health Plan requesting a determination for a payment arrangement, including one aligned with a CMS Multi-Payer Model, must submit this Form by the annual Medicare Advantage bid submission deadline of the year prior to relevant All-Payer QP Performance Period (*e.g.*, in 2023 for the 2024 performance period).

#### **[Commercial or private payers only]**

A commercial or other private payers (non-Medicaid, non-Medicare) requesting a determination for a payment arrangement must submit this Form by **June 1** of the year prior to relevant All-Payer QP Performance Period (*e.g.*, in 2023 for the 2024 performance period).

#### **[All submitters]**

CMS will not review Forms submitted after the applicable Submission Deadline.

Different payment arrangements under the same [payer/state] must be submitted separately. [Payers/States] must submit the required information pertaining to each payment arrangement they 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 a [payer/state] submits incomplete information and/or more information is required to make a determination, CMS will notify the [payer/state] and request the additional information that is needed. [Payers/States] must return the requested information no later than 15 business days from the notification date. If the [payer/state] does 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**

CMS will notify the [payer/state] regarding determinations as soon as practicable after applicable Submission Deadline. CMS will also post a list of all the payment arrangements determined to be Other Payer Advanced APMs on a CMS website.

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 [payer/state] is submitting.

## **Helpful Links:**

- **QPP All-Payer Submission Form User Guide**
- **QPP All-Payer FAQs**
- **Glossary**

All Forms must be completed and submitted electronically. Additional information for submission by each payer type is available on the CMS website.

This Form contains the following sections:

### Section 1: Payer Identifying Information

### Section 2: Payment Arrangement Information

Section 2.1: Title XIX (Medicaid)

Section 2.2: Medicare Health Plans

Section 2.3: Commercial or Private Payer Plans

### Section 3: Supporting Documentation

### Section 4: Certification Statement

Payers will complete all four sections, but will only complete the subsection in Section 2 that applies to their payer type. For example, a Medicaid Managed Care Plan will complete Section 2.1, but not Sections 2.2 or 2.3.

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

## SECTION 1: Payer Identifying Information

Medicare Health Plans will complete this Form through the Health Plan Management System (HPMS). When available, Payer Identifying Information will pre-populate for payers that already have HPMS accounts.

### A. Payer Type

1. Select one of the following: [DROP DOWN LIST]
  - State Medicaid Program
  - Medicare Health Plan (including Local Coordinated Care Plans, Regional Coordinated Care Plans, Medicare Private Fee-for-Service Plans, Medicare Medical Savings Account Plans, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans)
  - Commercial or Private Payer

### B. Payer Contact Information

1. Non-Medicaid:
  - Legal Entity Name: \_\_\_\_\_
  - DBA Name (if applicable): \_\_\_\_\_
  - Parent Company or Organization (if applicable): \_\_\_\_\_
2. Medicaid:
  - State Medicaid Agency Name
  - State Medicaid Director First Name
  - State Medicaid Director Last Name
3. All Payers:
  - Business Phone Number - Ext. \_\_\_\_\_
  - Fax Number: \_\_\_\_\_
  - Address Line 1 (Street Name and Number): \_\_\_\_\_
  - Address Line 2 (Suite, Room, etc.): \_\_\_\_\_
  - City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code +4: \_\_\_\_\_
  - E-mail Address: \_\_\_\_\_
  - Confirm Email Address: \_\_\_\_\_

### C. Contact Person

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

1. Is the contact person the State Medicaid Director? [Y/N]  
If yes, skip to Section 2.

## 2. Contact Information:

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

**D. Medicaid Only**

1. Are you submitting a form for an Other Payer Advanced APM determination? [Y/N]

**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. 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 Medicaid managed care plans and providers, contracts or excerpts of contracts between Medicaid managed care plans and the State, contracts or excerpts of contracts between the State Medicaid agency and providers, or alternative comparable documentation that supports responses to the questions asked in Sections D and E below.

*Note: Please upload all documents that you will reference when completing this submission. All sections of this form require documentation to verify the information provided in those sections. Documentation that will be referenced in any and all sections should be uploaded here.*

1. 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 section 1115 demonstration arrangement approved by CMS? If so, please paste a link to the location of the document here or upload with other pertinent information [Y/N]

## B. Payment Arrangement Information

1. Payment Arrangement Name (e.g. Coordinated Care ACO Model), or terminology used to refer to the payment arrangement: [TEXT BOX]
2. [OPTIONAL] Select the CMS Multi-Payer Model with which this payment arrangement is aligned, if applicable: [DROP DOWN LIST]
3. 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]*

4. Does the payer request that CMS make a multi-year determination for this payment arrangement? [Yes/No]

*If yes, state the last performance year through which the payer is 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.*

5. Who participates in this payment arrangement (e.g. primary care physicians, specialty group practices, etc.)? . [TEXT BOX]
6. 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]*

7. 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]

## C. Availability of Payment Arrangement

1. Locations where this Payment Arrangement will be available:
  - States [DROP DOWN LIST]
  - [Medicaid Only] Counties, if not statewide [DROP DOWN LIST]
2. [Medicaid Only] Is this payment arrangement available through:
  - Medicaid Fee-For-Service
  - Medicaid Managed Care Plan

3. [Commercial and Medicare Health Plans only] Is this payment arrangement available through other lines of business? [Y/N]

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

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

1. Does the payer 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 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. [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.
  - Planned coordination of chronic and preventive care. [Y/N] If yes, cite supporting documentation and page numbers. [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 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.
  - 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.*  
[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. Is the total amount an APM Entity potentially owes or foregoes under the payment arrangement at least 5 percent of the average estimated total revenue of the participating providers or other entities under the payer? [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 provide evidence of the information required in this section. [Text box]

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

##### 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 to document and communicate clinical care, as required by 42 CFR 414.1420(b)? [Y/N]



*For purposes of this Form, the APM Entity is the practitioner or group of practitioners that participates in the payment arrangement.*

2. List the attached document(s) and page numbers that provide evidence of 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]

- 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

*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 upload any supporting documents using "Upload Document" or provide measure information in the text box below. [Upload document button and text box]*

2. Does the arrangement tie payments to one or more quality measures that is an outcome measure? [Y/N]

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

3. [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

Cite the scientific evidence and/or clinical practice guidelines that support the use of the measure in order for CMS to make a determination about the evidence base for this measure. [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]

### Generally Applicable Financial Risk Standard

*Section not applicable for Medicaid Medical Home Models*

1. Does the payment arrangement require the participating APM 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]

*For purposes of Other Payer Advanced APM determination, 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 provide evidence of the information required in this section.

## 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 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 an APM Entity potentially owes or foregoes 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 operates 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 an APM Entity potentially owes or foregoes under the payment arrangement at least:
  - 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity 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 an APM Entity is responsible under the payment arrangement? [CHECK BOX]  
*If yes, please describe how the amount that an APM Entity owes or foregoes is calculated. [TEXT BOX]*
5. List the attached document(s) and page numbers that provide evidence of the information required in this section. [TEXT BOX]

## **SECTION 2.2: Medicare Health Plans**

*This section is applicable for Medicare Health Plans, including: Medicare Advantage, Medicare-Medicaid Plans, and Cost Plans under sections 1876 and 1833, and Programs of All Inclusive Care for the Elderly (PACE) plans.*

## A. Payment Arrangement Information

*CMS will collect this information through HPMS.*

1. Please select the type of Medicare Health Plan that includes this payment arrangement. [DROP-DOWN]
2. [OPTIONAL] Select the CMS Multi-Payer Model with which this payment arrangement is aligned, if applicable: [DROP DOWN LIST]
3. 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]*

4. Does the payer request that CMS make a multi-year determination for this payment arrangement? [Yes/No]

*If yes, state the last performance year through which the payer is 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.*

5. Who participates in this payment arrangement (e.g. primary care physicians, specialty group practices, etc.)? [TEXT BOX]
6. 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]*

7. 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

*CMS will collect contract service area information through HPMS.*

1. Through which plans and in what locations is this payment arrangement offered? [SELECT OR ENTER PLAN NAMES AND LOCATIONS]

### C. Payment Arrangement Documentation

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

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

### D. Information for Aligned Other Payer Medical Home Model Determination

Aligned Other Payer Medical Home Model means an other payer payment arrangement (not including Medicaid) that is formally aligned with a CMS Multi-Payer Model that is a Medical Home Model and that CMS determines by the following characteristics.

1. Does the payer request that CMS make a determination regarding whether this payment arrangement is an Aligned Other Payer 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 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. [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.
  - Planned coordination of chronic and preventive care. [Y/N] If yes, cite supporting documentation and page numbers. [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]

Aligned Other Payer Medical Home Model Financial Risk Standard

1. Does the Aligned Other Payer 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 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.
  - 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.*  
[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]

Aligned Other Payer Medical Home Model Nominal Amount Standard

1. Is the total amount an APM Entity potentially owes or foregoes under the payment arrangement at least 5 percent of the average estimated total revenue of the participating providers or other entities under the payer? [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 provide evidence of the information required in this section. [Text box]

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

#### 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 to document and communicate clinical care, as required by 42 CFR 414.1420(b)? [Y/N]

*For purposes of this Form, the APM Entity is the practitioner or group of practitioners that participates in the payment arrangement.*

2. 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]
  - 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

*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 upload any supporting documents using "Upload Document" or provide measure information in the text box below. [Upload document button and text box]*

2. Does the arrangement tie payments to one or more quality measures that is an outcome measure? [Y/N]

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

## 3. [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

Cite the scientific evidence and/or clinical practice guidelines that support the use of the measure in order for CMS to make a determination about the evidence base for this measure. [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]

#### Generally Applicable Financial Risk Standard

1. Does the payment arrangement require the participating APM 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]

*For purposes of Other Payer Advanced APM determination, 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

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 an APM Entity potentially owes or foregoes 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 operates 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 an APM Entity potentially owes or foregoes under the payment arrangement at least:
  - 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity 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 an APM Entity is responsible under the payment arrangement? [CHECK BOX]  
*If yes, please describe how the amount that an APM Entity owes or foregoes is calculated. [TEXT BOX]*
5. List the attached document(s) and page numbers that provide evidence of the information required in this section.

## SECTION 2.3: Commercial and Private Payers (non-Medicare, non-Medicaid)

### 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. [OPTIONAL] Select the CMS Multi-Payer Model with which this payment arrangement is aligned, if applicable: [DROP DOWN LIST]
3. 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]*

4. Does the payer request that CMS make a multi-year determination for this payment arrangement? [Yes/No]

*If yes, state the last performance year through which the payer is 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.*

5. Who participates in this payment arrangement (e.g. primary care physicians, specialty group practices, etc.)? [TEXT BOX]
6. 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]*

7. 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. Select locations where this payment arrangement will be available:
  - States [DROP DOWN LIST]
2. Is this payment arrangement available through other lines of business?

### **C. Payment Arrangement Documentation**

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

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

*Note: Please upload all documents that you will reference when completing this submission. All sections of this form require documentation to verify the information provided in those sections. Documentation that will be referenced in any and all sections should be uploaded here.*

### **D. Information for Aligned Other Payer Medical Home Model Determination**

Aligned Other Payer Medical Home Model means an other payer payment arrangement (not including Medicaid) that is formally aligned with a CMS Multi-Payer Model that is a Medical Home Model and that CMS determines by the following characteristics.

1. Does the payer request that CMS make a determination regarding whether this payment arrangement is an Aligned Other Payer 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 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. [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.
  - Planned coordination of chronic and preventive care. [Y/N] If yes, cite supporting documentation and page numbers. [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]

Aligned Other Payer Medical Home Model Financial Risk Standard

1. Does the Aligned Other Payer 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 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.
  - 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.*  
[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]

Aligned Other Payer Medical Home Model Nominal Amount Standard

1. Is the total amount an APM Entity potentially owes or foregoes under the payment arrangement at least 5 percent of the average estimated total revenue of the participating providers or other entities under the payer? [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 provide evidence of the information required in this section. [Text box]

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

Certified Electronic Health Record Technology (CEHRT)

4. 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 to document and communicate clinical care, as required by 42 CFR 414.1420(b)? [Y/N]

*For purposes of this Form, the APM Entity is the practitioner or group of practitioners that participates in the payment arrangement.*

2. List the attached document(s) and page numbers that provide evidence of the information required in this section.

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]
  - 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

*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 upload any supporting documents using "Upload Document" or provide measure information in the text box below. [Upload document button and text box]*

2. Does the arrangement tie payments to one or more quality measures that is an outcome measure? [Y/N]

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

3. [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

Cite the scientific evidence and/or clinical practice guidelines that support the use of the measure in order for CMS to make a determination about the evidence base for this measure. [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]

#### Generally Applicable Financial Risk Standard

1. Does the payment arrangement require the participating APM 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]

*For purposes of Other Payer Advanced APM determination, 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 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 capitation arrangement. [TEXT BOX]*

4. List the attached document(s) and page numbers that provide evidence of the information required in this section.

#### 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 an APM Entity potentially owes or foregoes 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 operates 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 an APM Entity potentially owes or foregoes under the payment arrangement at least:

- 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity 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 an APM Entity is responsible under the payment arrangement? [CHECK BOX]

*If yes, please describe how the amount that an APM Entity owes or foregoes is calculated. [TEXT BOX]*

5. List the attached document(s) and page numbers that provide evidence of the information required in this section.

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

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

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

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, PAYER NAME]

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, PAYER NAME]



## **Payer 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: 01/31/2025). 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].