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)

Purpose

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

Title XIX (Medicaid) Only

Payment arrangement determination requests for all Medicaid payment models (including Medicaid FFS and Medicaid Managed Care Plans) may only be submitted by APM Entities or eligible clinicians participating in State Medicaid payment arrangements. APM Entities or eligible clinicians 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 November 1 of the year prior to relevant QP Performance Period.

CMS will not review Submission Forms for Medicaid payment models submitted after November 1, 2018. Submission forms from APM Entities and eligible clinicians participating in other non-Medicare payment arrangements may be submitted in 2019.

Additional Information

CMS will review the payment arrangement information in this Form to determine whether the payment arrangement meets the Other Payer Advanced Alternative Payment Model (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 the APM Entity or eligible clinician 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.

Different payment arrangements must be submitted separately. Eligible clinicians or APM Entities must submit the required information pertaining to each payment arrangement they wish to have reviewed.

In addition to APM Entities and eligible clinicians, we allow those authorized to report on behalf of APM Entities or eligible clinicians to complete this Form.

Notification

CMS will notify the APM Entity or eligible clinician 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.

Helpful Links

- QPP All-Payer FAQs
- Glossary

All Forms must be completed electronically using this fillable PDF, and submitted by email to the QPP All-Payer inbox: qpp_apm_allpayer@cms.hhs.gov.

This Form contains the following sections:

Section 1: Eligible Clinician or APM Entity Identifying Information

Section 2: Payment Arrangement Information – Title XIX (Medicaid)

Section 3: Supporting Documentation

Section 4: Certification Statement

APM Entity or eligible clinician (submitter) must complete all four sections. All fields outlined in red are required and must be completed.

All required supporting documentation must be included as attachments in the email submission of this Form.

The Eligible Clinician Initiated Process in 2018 is only available for Title XIX (Medicaid) payment arrangements for QPP performance year 2019.

SECTION 1: APM Entity or Eligible Clinician Identifying Information

A. Submitter Type

- Select one of the following:

  ○ 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. Are you reporting on behalf of more than one Eligible Clinician (but not an APM Entity)?
   If you are reporting on behalf of more than one group of clinicians who practice under multiple TINs, use a separate submission form for each group.
3. List the first name(s), last name(s), and NPI(s) of each clinician participating in the payment arrangement.
4. Taxpayer Identification Number (TIN) (optional):
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:

Address Line 1 (Street Name and Number):

Address Line 2 (Suite, Room, etc.):

City/Town: State: Zip Code +4:

E-mail Address:

SECTION 2: Payment Arrangement Information – 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 you and the Medicaid managed care plan, contracts or excerpts of contracts between you and the State Medicaid agency, or alternative comparable documentation that supports responses to the questions asked in Sections D and E below.

Note: Please include all documents that you will reference when completing this submission as attachments when submitting this PDF form. Label each document, for reference throughout the Form.

CMS will use existing Medicaid documentation in the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process as applicable.

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?

B. Payment Arrangement Information

1. Payment Arrangement Name (e.g. [State Name] ACO Model), or terminology used to refer to the payment arrangement:
2. Health Plan or State Contact Person for this payment arrangement:

Name:

Title:

Telephone Number:

E-mail Address:

If questions about the payment arrangement arise during the processing of this request, CMS may contact the Health Plan or State for clarification.

3. Describe the participant eligibility criteria for this payment arrangement.

4. Is this payment arrangement open to all provider types or limited to certain specialties?

If the payment arrangement is limited to certain specialties, select the provider specialties that may participate in the payment arrangement. Use CTRL key for multiple selections.

Advance Diagnostic Imaging
All Other Suppliers
Ambulance Service Provider
Ambulatory Surgical Center
Anesthesiology Assistant

5. 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.

C. Availability of Payment Agreement

1. Is this payment arrangement available through Medicaid Fee-For-Service?
2. Is this payment arrangement available through a Medicaid managed care plan?

   If yes, state the health insurance company and plan name under which this payment arrangement was implemented.

3. Locations where this payment arrangement will be available:

   i. Statewide (all counties)

   ii. Counties (if not statewide)

   iii. I don't know ☐

4. In what county do you see the greatest number of patients?

D. Information for CMS Medicaid Medical Home Model Demonstration

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?

   If no, skip to section E.

   If yes, list the attached document(s) and page numbers that contain the information required in this section.

2. For which eligible clinicians with a primary care focus does the payment arrangement include specific design elements? *Select all that apply. Use CTRL key for multiple selections.*

01 General Practice
08 Family Medicine
11 Internal Medicine
16 Obstetrics and Gynecology
37 Pediatric Medicine
38 Geriatric Medicine
50 Nurse Practitioner

3. Does the payment arrangement require empanelment (assigning individual patients to individual providers) of each patient to a primary clinician?
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. If yes,
   - Patient access and continuity of care. If yes,
   - Risk-stratified care management. If yes,
   - Coordination of care across the medical neighborhood. If yes,
   - Patient and caregiver engagement. If yes,
   - Shared decision-making. If yes,
   - Payment arrangements in addition to, or substituting for, fee-for-service payments (e.g. shared savings or population-based payments). If yes,

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

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? (select all that apply)

   ☐ Payer withholds payment of services
   ☐ Payer reduces payment rates
   ☐ Payer requires direct payments.
   ☐ Payer requires you 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.

Please describe how the amount that an APM entity owes or forgoes is calculated.

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

Medicaid Medical Home Model Nominal Amount Standard

1. For performance year 2019, is the total amount that your participating entity potentially owes or foregoes under the payment arrangement at least 3 percent of the average estimated total revenue of all the participating providers or other entities under the payer?

   If yes, please describe how the amount that an APM entity owes or foregoes is calculated.

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

E. 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 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?

2. Does this payment arrangement require you to use CEHRT as defined in §414.1305 to document and communicate clinical care?
3. List the attached document(s) and page numbers that contain 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)?
2. If yes, does at least one quality measure have an evidence-based focus, is it reliable and valid, and does it meet at least one of the following criteria:
    - 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 (e.g. NQF);
    - 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.
3. Please provide the following information for each quality measure included in the payment arrangement that you wish for CMS to consider for purposes of satisfying this criterion.
    - Measure title
    - MIPS measure identification number (if applicable)
    - National Quality Forum (NQF) number (if applicable)
    - Describe how the measure has an evidence-based focus, is reliable and valid, and meets one the following criteria:
        - *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 the measure is not a MIPS measure, a currently endorsed NQF measure, developed under section 1848(s), or submitted in response to the MIPS Call for Quality Measures, cite the scientific evidence and/or clinical practice guidelines that support the use of the measure.
- Is the measure an outcome measure?

4. Are any of the above measures outcome measures? A minimum of one quality measure that meets the above criteria and is an outcome measure is required in order to satisfy the Quality Measure Use criterion.

   If no, check here if no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure list. ☐

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

<u>Generally Applicable Financial Risk Standard</u>

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)?
2. If yes, 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?

☐ 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.

3. Is this payment arrangement a full capitation arrangement?

   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.

4. List the attached document(s) and page numbers that contain 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 you are required to repay or forgo payment, and any other key components of the risk methodology.

2. Is the marginal risk that you or your participating entity potentially owe or forgo under the payment arrangement at least 30 percent?
   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.

3. Is the minimum loss rate with which you or your participating entity operate under the payment arrangement no more than 4 percent?
   If yes, please describe the minimum loss rate.

4. Is the total amount that you or your participating entity owes or forgoes under the payment arrangement at least:

   - 8 percent of the total revenue from the payer of all providers and suppliers in your participating entity if financial risk is expressly defined in terms of revenue?
     If yes, please explain how risk is expressly defined in terms of revenue.

   - 3 percent of the expected expenditures for which you or your participating entity are responsible under the payment arrangement?
     If yes, please describe how the amount that you owe or forgo is calculated.

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

SECTION 3: Supporting Documentation

Please include all supporting documentation as attachments when submitting this PDF form. Documents should be labeled for reference use throughout the Form

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 the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

I agree ☐

[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 the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

I agree ☐

[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 the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

I agree ☐

[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 the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

[DATE, ELIGIBLE CLINICIAN]

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.

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: 03/31/2020). 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.