Quality Payment PROGRAM

A Guide to Submitting CMS Multi-Payer Model Requests for Other Payer Advanced APM Determinations – Commercial Payers (Payer Initiated Submission Form)

Purpose

Through the Payer Initiated Submission Form (the "Form"), the Centers for Medicare & Medicaid Services (CMS) will collect information and documentation to determine whether payment arrangements will qualify as Other Payer Advanced Alternative Payment Models (APMs) under the Quality Payment Program (QPP). This process is called the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process). More information about QPP is available at http://qpp.cms.gov/.

The purpose of this document is to guide payers through the Form for ease of submission and to facilitate accurate determinations by CMS. Please use this document together with the:

- **Salesforce Portal,** https://app1.innovation.cms.gov/qpp/qppLogin
- **Glossary for additional definitions**, https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html.
- **CMS Multi-Payer Models Fact Sheet**, https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-CMS-Multi-Payer-Models-APMs.pdf, and
- **QPP All-Payer Frequently Asked Questions sheet**, https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html**.**

Overview of Payer Initiated Process

A CMS Multi-Payer Model is an Advanced APM in which CMS partners with other payers (such as Medicaid, Medicare Health Plans, and commercial payers) to create aligned incentives for health care providers across both Medicare and other payer populations. Examples of CMS Multi-Payer Models include the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model.

Other Payer Advanced APMs are alternative payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans, payers in CMS Multi-Payer Models, and other commercial payers.

To be an Other Payer Advanced APM, payment arrangements must meet the following three criteria:

1. Require use of certified EHR technology (CEHRT). The other payer payment arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity Group to use CEHRT to document and communicate clinical care information.
2. Base payments for covered professional services on quality measures that are comparable to those used in the MIPS quality performance category. The payment arrangement must base payment on quality measures that are evidence-based, reliable, and valid, at least one of which must be an outcome measure if an appropriate outcome measure is available on the MIPS measure list.
3. Require participants to bear a certain amount of financial risk. A payment arrangement meets the financial risk if actual expenditures exceed expected aggregate expenditures, or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Social Security Act.

Payers with payment arrangements in CMS Multi-Payer Models may submit Other Payer Advanced APM determination requests for those payment arrangements. Each different payment arrangement from a single payer must be submitted through a separate Form.

Payers must use the submission channel and deadline that corresponds with the line of business of the payment arrangement being submitted.

- Payers with Medicaid payment arrangements in CMS Multi-Payer Models should use the Medicaid submission process. All Medicaid payment arrangements must be submitted by states. The Submission Deadline for Medicaid payment arrangements is **April 1** of the year prior to the relevant QP Performance Period. For the 2019 QP Performance Period, states may submit requests between **January 1 and April 1, 2018.** Guidance on Medicaid payment arrangement submission is available here.
- If a payer (e.g., an MAO) has payment arrangements that are under a Medicare Health Plan (MA, PACE, or cost plan) and are part of a CMS Multi-Payer Model, the request for an "Other Payer Advanced APM" determination for those payment arrangements should be made as part of the annual Medicare Health Plan bid submission process through HPMS. HPMS will contain a special module for Other Payer Advanced APMs this year. Bid packages will go out in early April and be due back the first Monday in June in the year prior to the relevant QP Performance Period. For the 2019 QP Performance Period, payers may submit requests though HPMS and they will be due **June 4, 2018**. Guidance on Medicare Health Plan payment arrangement submission will be made available at a later date.
- Payers with commercial payment arrangements in CMS Multi-Payer Models should use the commercial submission process. *Note: the only commercial payment arrangements that may be submitted in 2018 for Other Payer Advanced APM determinations are those in CMS Multi-Payer Models*. Commercial payment arrangements must be submitted by June 1 in the year prior to the relevant QP Performance Period. For the 2019 QP Performance Period, payers may submit requests between **January 1 and June 1, 2018.**

The remainder of this guidance document pertains only to submissions for commercial payment arrangements that are aligned with a CMS Multi-Payer Model . For guidance on Medicaid payment arrangement submission, go here. Guidance on Medicare Health Plan payment arrangement submissions will be made available at a later date.

CMS will review the payment arrangement information submitted in this Form to determine whether the payment arrangement meets the Other Payer Advanced APM criteria. If a payer submits incomplete information and/or more information is required to make a determination, CMS will notify the payer and request the additional information that is needed. Payers must return the requested information no later than **15 business days** from the notification date for CMS to make a determination. If the payer 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. CMS makes determinations on an annual basis. These determinations are final and not subject to reconsideration.

CMS expects to post a list of payment arrangements submitted through the payer-initiated process that are determined to be Other Payer Advanced APMs for the 2019 QP Performance Period on the CMS web site by September 2018. Eligible clinicians may refer to this list beginning in late 2018, before the 2019 QP Performance Period begins. If CMS has not already determined that a payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or APM Entities on their behalf) have the option to submit information about their CMS Multi-Payer Model payment arrangement(s), as well as any Other Payer Advanced APMs in which they participate. The submission period for eligible clinicians will open on September 1 of the calendar year prior to the relevant QP Performance Period, and the Submission Deadline will be December 1 of the calendar year. of the relevant QP Performance Period.

The Form

The Payer Initiated Submission Form will be submitted electronically through an online Salesforce portal. All relevant documentation should be electronically attached to the submission and thoroughly referenced. Examples of relevant documentation include contracts, excerpts of contracts, CMS Memoranda of Understanding, and participant agreements. Each unique payment arrangement must be submitted separately on its own Form, along with its supporting documentation.

For commercial payment arrangement submissions through Salesforce, the first step is to register for a CMS QPP All-Payer Submission Form login. To do so, you will need to create a password. The password must be at least 8 characters, use a mix of numbers, uppercase and lowercase letters, and include at least one of the following special characters:! # $ % - _ = + < >

Save all work in Salesforce before navigating away from each page, as any unsaved work will be lost. Note that the application will time out after 30 minutes of inactivity. Please contact the

Salesforce help desk (CMMIForceSupport@cms.hhs.gov) for assistance with access or use issues.

The Form contains the following sections, which are described in detail in the following pages:

- Payer Identifying Information – The purpose of this section is to collect information about the submitting payer and identifying information about the payment arrangement. The information for this section will be used to distinguish each unique payment arrangement submitted and identify the payment arrangement for the purpose of making Qualifying APM Participant (QP) determinations for eligible clinicians.
- Supporting Documentation – The purpose of this section is to allow the submitting payer to upload supporting documentation and make sure that naming conventions are established and clear in referenced sources throughout the Form.
- Payment Arrangement Information – The purpose of this section is to collect the details of the payment arrangement. References to supporting documentation are required.
- Availability of Payment Arrangement – The purpose of this section is for the submitting payer to identify the locations where the payment arrangement is available. This section also requests information on whether the same payment arrangement is available through other lines of business.
- Information for Other Payer Advanced APM Determination – The purpose of this section is to collect information needed for CMS to determine whether the payment arrangement is an Other Payer Advanced APM.
- Certification Statement – This section requires an individual who is authorized to bind the payer to certify that all information submitted to CMS is true, accurate and complete.

For questions about Form content or Other Payer Advanced APM policy, please contact the QPP All Payer help desk (QPP_APM_AllPayer@cms.hhs.gov). For technical questions about Salesforce, please contact the Salesforce help desk (CMMIForceSupport@cms.hhs.gov).

Payer Identifying Information

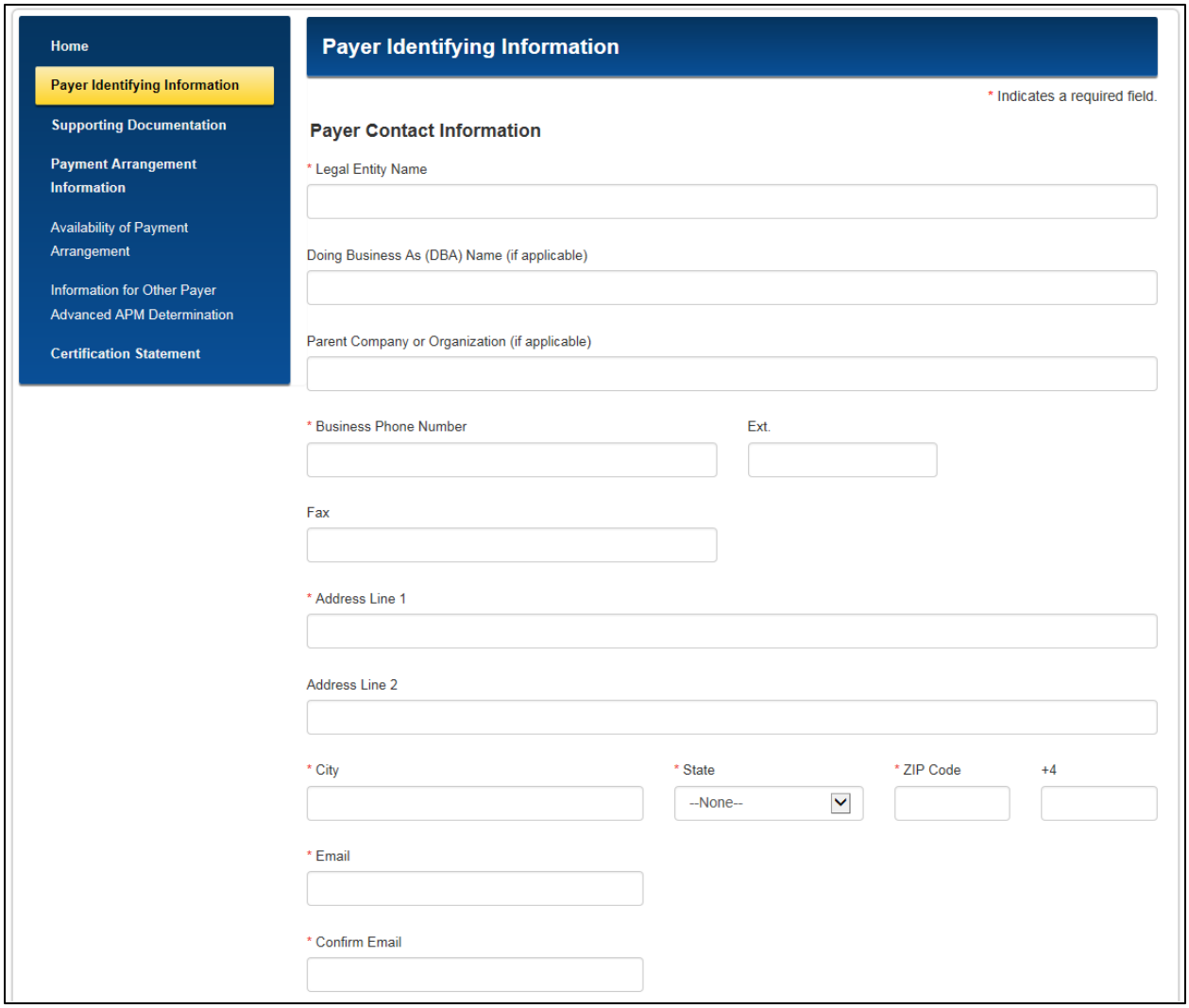
The purpose of this section is to collect information about the submitting payer and identifying information about the payment arrangement. The information for this section will be used to distinguish each unique payment arrangement submitted and identify the payment arrangement going forward for the purpose of QP determinations for eligible clinicians.

Payer Type

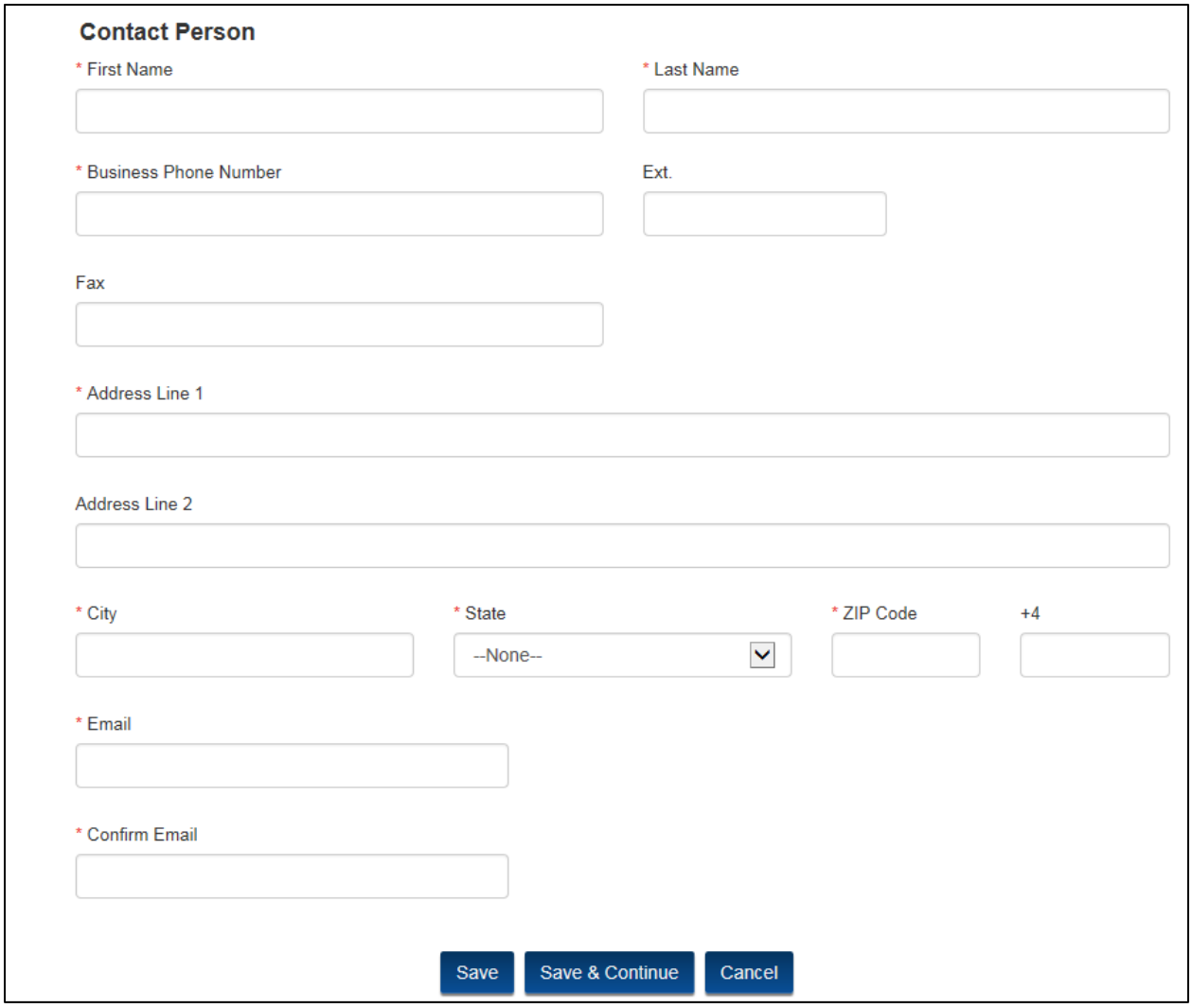
Select “Commercial” from the drop-down list. This selection includes all commercial payment arrangements that may align with a CMS Multi-Payer Model.

Payer Contact Information

Please complete all contact information for this particular Commercial payment arrangement.



The “Contact Person” is the individual CMS will reach out to with any questions about the payment arrangement and its operations.



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Supporting Documentation

The purpose of this section is for the payer to upload all relevant information and ensure naming conventions are clear for referenced sources throughout the Form. All documentation supporting answers provided in the Form must be uploaded to this section.

Upload all relevant documentation, such as contracts, participant agreements, CMS Memoranda of Understanding, etc. If you have multiple documents, or multiple excerpts of documents, you may want to name them intuitively for ease of reference throughout the form.

For example, if you upload the specific section of the contract regarding CEHRT use, name the document “PAYER_APM_CEHRT” so as not to confuse it with the document referencing risk arrangements. Document file names can be up to 100 characters long.

You are not required to upload separate documentation for each topic. If one contract covers all relevant information needed to support an Other Payer Advanced APM determination for the payment arrangement, it can be uploaded in full. Each file can be up to 25MB in size. To facilitate accurate evaluation, please be specific in your citations, directing CMS to the location of the information intended to be referenced in your response to each question.

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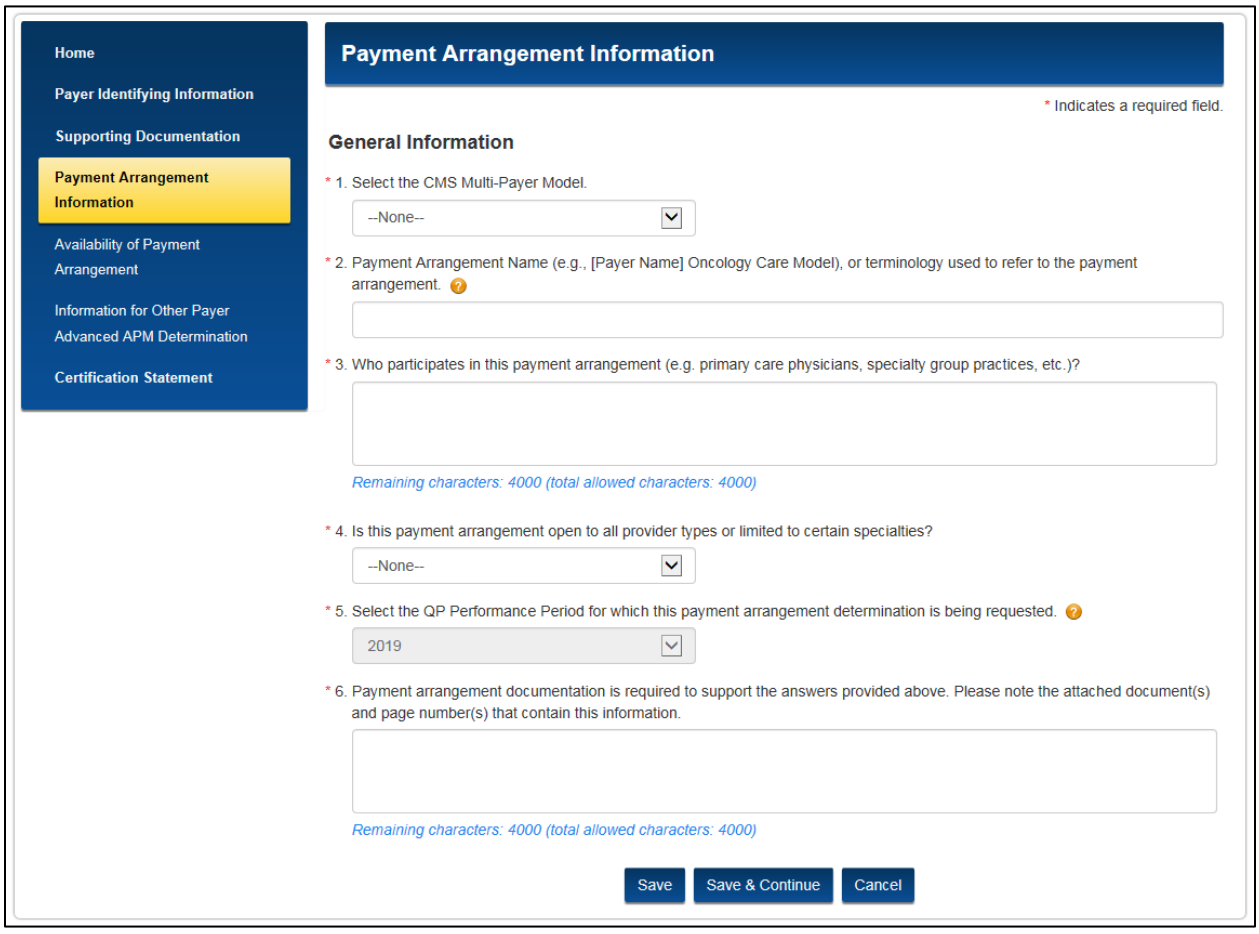
Payment Arrangement Information

The purpose of this section is to report the details of the payment arrangement. References to supporting documentation are required.

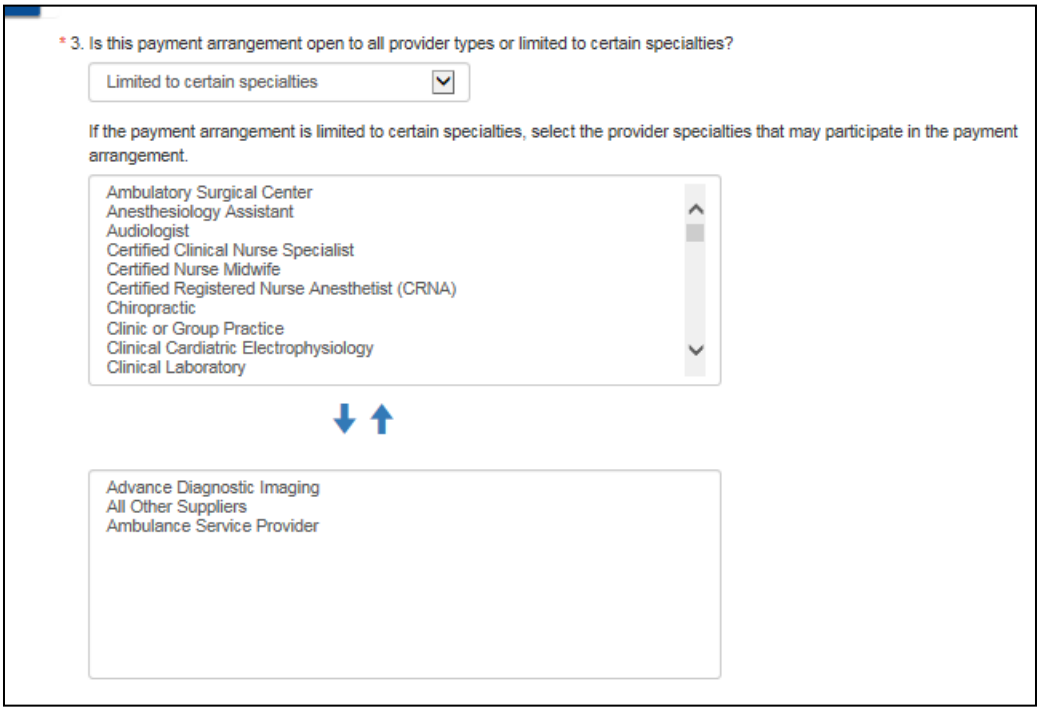


For Question 1, please select the CMS Multi-Payer Model with which the payment arrangement is aligned.

In question 2, please provide the name of the payment arrangement. If there is potential uncertainty over the name, include any terms that can help identify the payment arrangement. Payment arrangement name or terminology used to refer to the payment arrangement should be consistent across contracts that include the payment arrangement. The purpose of this information is to allow CMS and eligible clinicians to correctly identify the payment arrangement when evaluating eligible clinicians' participation in Other Payer Advanced APMs.

Using the free text box for question 3, describe who participates in this payment arrangement.

In question 4, use the dropdown menu to note if there are any limitations on the types of physician or practitioner specialties that may participate. If yes, there will be a list of pre-specified options, please select all physician and practitioner specialties that may participate in the payment arrangement. This should describe the eligible clinicians who could potentially become QPs based on their participation in the payment arrangement.



Question 5 asks for the relevant performance period, this is the period for which the requestor is seeking Other Payer Advanced APM status for the payment arrangement. Other Payer Advanced APM determinations are made for the calendar year that includes the QP Performance Period. Each submission is only valid for one calendar year.

Question 6 requests citations to documentation (uploaded in the "Supporting Documentation" section, as described above) to support the answers provided above. When referencing

documents, please cite the specific sections/pages CMS should refer to when evaluating this information.

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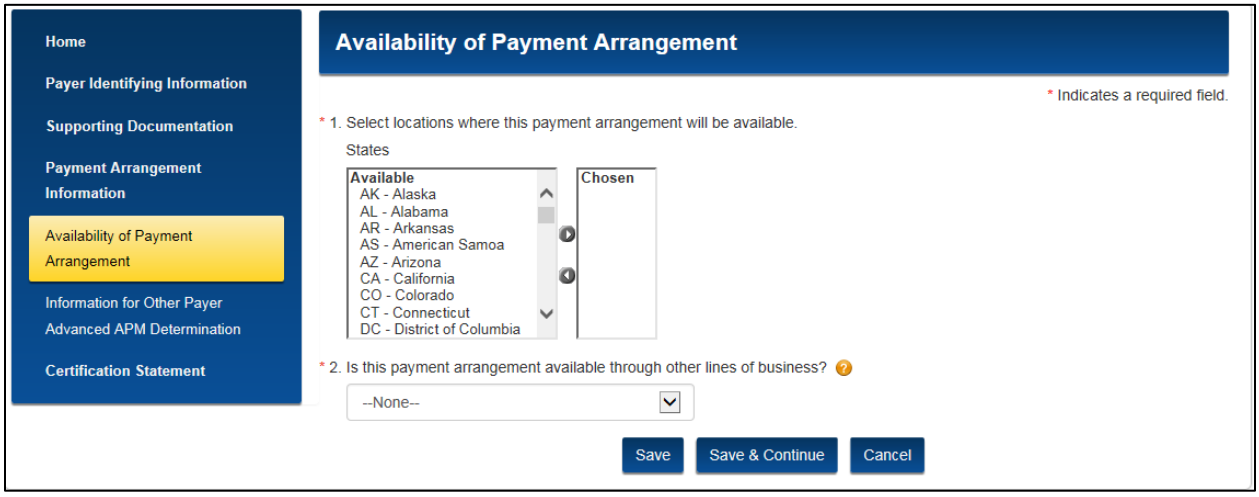
Availability of Payment Arrangement

The purpose of this section is to collect information to identify the location(s) where the payment arrangement is available. This section also requests information on whether the same payment arrangement is available through other lines of business.



In question 1, please provide the states where the payment arrangement is available for participation by eligible clinicians.

In question 2 answer “Yes” if the payment arrangement is available through other lines of business. “Other lines of business” refers to payment arrangements that are also offered by another type of payer (e.g., a payment arrangement being offered by both Medicaid and a commercial payer as part of a CMS Multi-Payer model).

Is the same payment arrangement available through other lines of business, such as Medicare Advantage or to a commercial payer? If so, those payers may submit a separate Submission Form to seek an Other Payer Advanced APM determination. The purpose of this information is for CMS to identify whether this payment arrangement is available through other lines of business.

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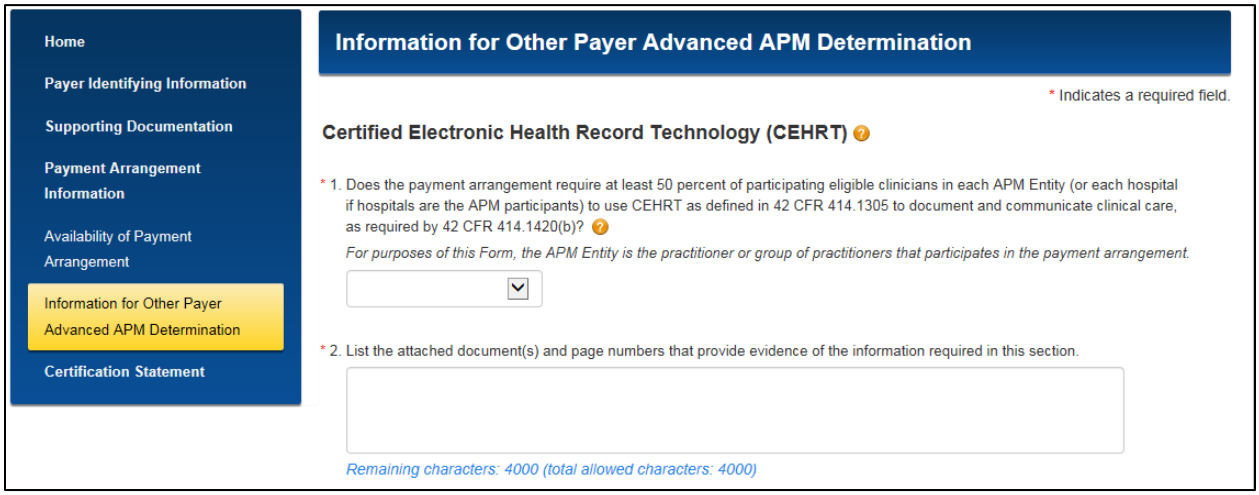
Information for Other Payer Advanced APM Determination

The purpose of this section is to collect information needed to determine whether a payment arrangement is an Other Payer Advanced APM.

Certified Electronic Health Record Technology (CEHRT)

There is one question on use of CEHRT; this response requires supporting documentation to verify the yes or no response.



Prior to 2019, CEHRT means EHR technology that meets either the 2014 or 2015 Edition Base EHR definition and has been certified to the certification criteria specified under 42 CFR §414.1305. Beginning in 2019, CEHRT means EHR technology that meets the 2015 Edition Base EHR definition and has been certified to the certification criteria specified under 42 CFR §414.1305.

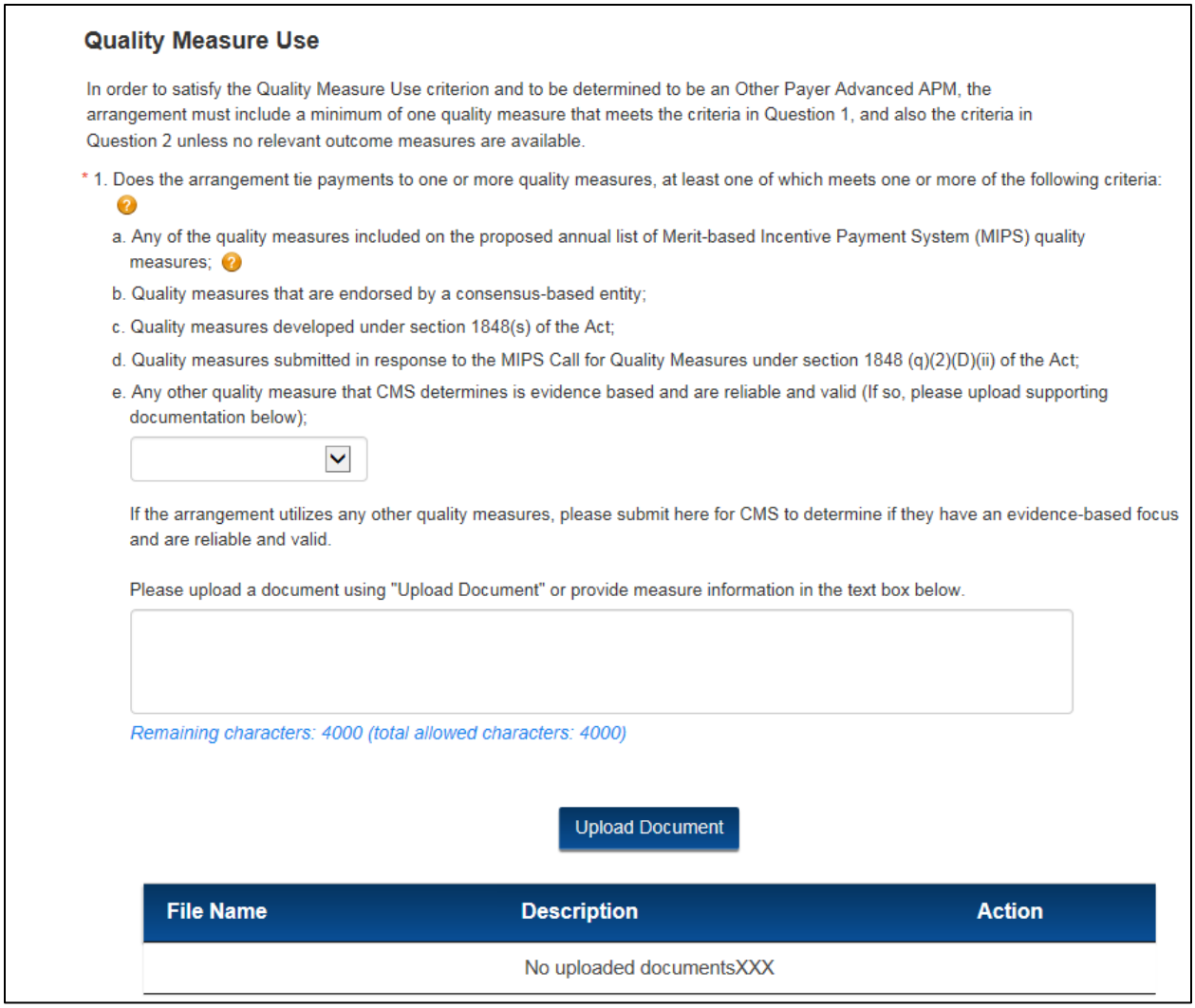
Answer “Yes” or “No” to indicate whether the payment arrangement meets the CEHRT use criterion. To meet this criterion, the payment arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity group (or each hospital if hospitals are the APM Entities) to use CEHRT to document and communicate clinical care.

Please provide a reference to the requirement in the documentation (e.g., document name and relevant page numbers).

Quality Measure Use[1]

This section requests information regarding the quality measures used in the payment arrangement. The questions pertain to measures that are used and ask for measure details. Documentation and references are required.

[1] *The quality measure Other Payer Advanced APM criterion is at 42 CFR § 414.1420(c).*



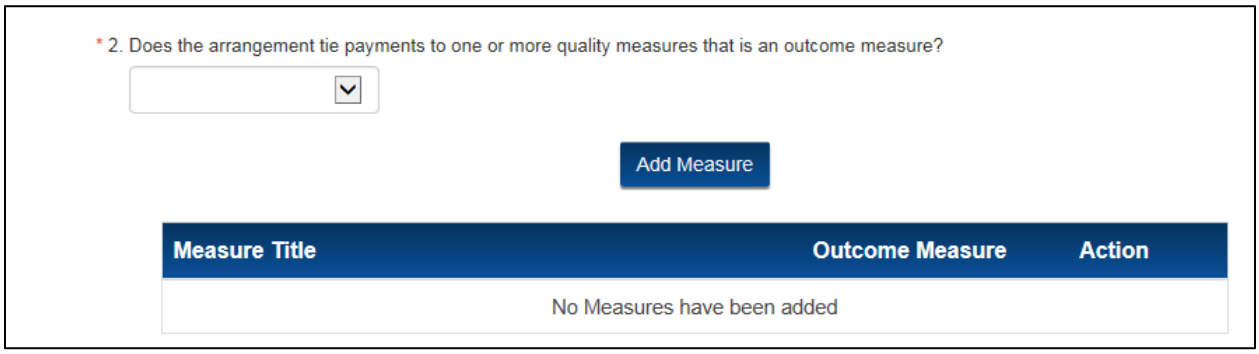
Question 1 is a “Yes” or “No” response to whether MIPS comparable quality measures are used in the payment arrangement. To be MIPS comparable, measures must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

- Included on the annual MIPS list of measures (https://qpp.cms.gov/mips/quality-measures),
- Endorsed by a “consensus-based entity” (i.e. the National Quality Forum [NQF]),
- Quality measures developed under section 1848(s) - Priorities and Funding for Measure Development -- of the Social Security Act (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
- Other support for measure validation.

Please explain and provide citations to supporting documentation to support the answer.

Please explain the evidence-base for the measure, measure calculation, and any support for measure validation. Upload, cite, and explain in detail all relevant documentation.

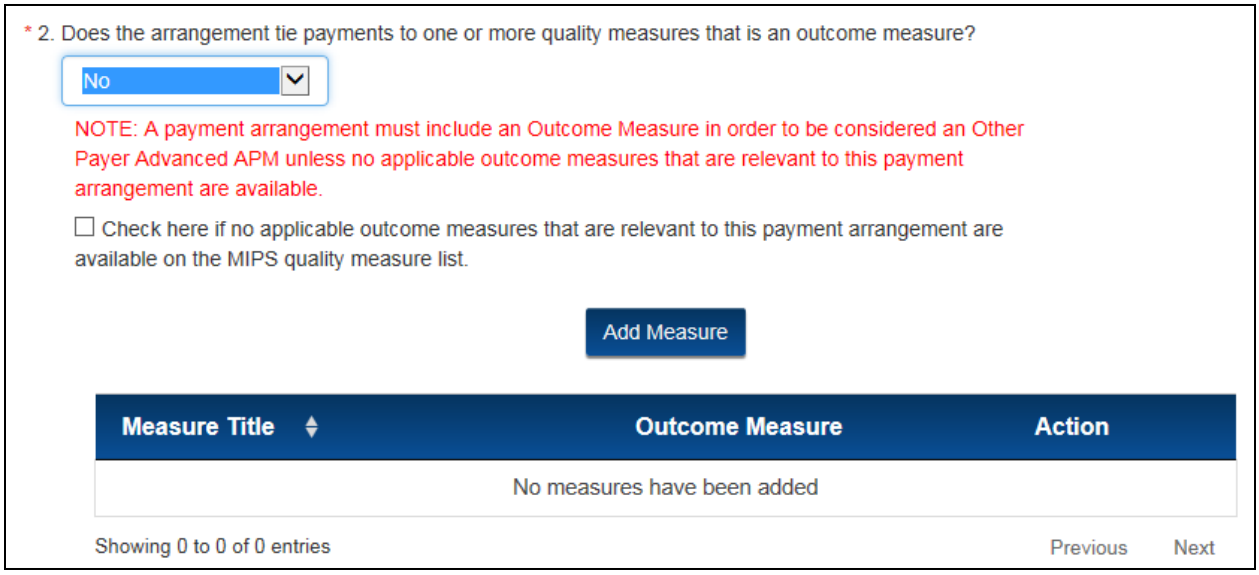
Question 2 asks if one of the measures used under the payment arrangement is an outcome measure. Examples of outcome measure used in MIPS include “Rate of Post Operative Stroke or Death in Asymptomatic Patients Undergoing Corotical Artery Stenting,” or “Improvement in Patient Visual Function with 90 days Following Cataract Surgery.” Either outcome measures or intermediate outcome measures can be used. If there is at least one outcome measure used under the payment arrangement, then answer “Yes” and then click the “Add Measure” button to provide more information about the outcome measure.



If there is no applicable outcome measure, respond “No,” and also respond to the pop-up box asking whether there are any outcome measures included on the MIPS quality measure list that are applicable for the arrangement.[2]

Information on MIPS comparable quality measures should also be entered by selecting the “Add Measure” button. Information can be added for as many measures as are used in the payment arrangement.

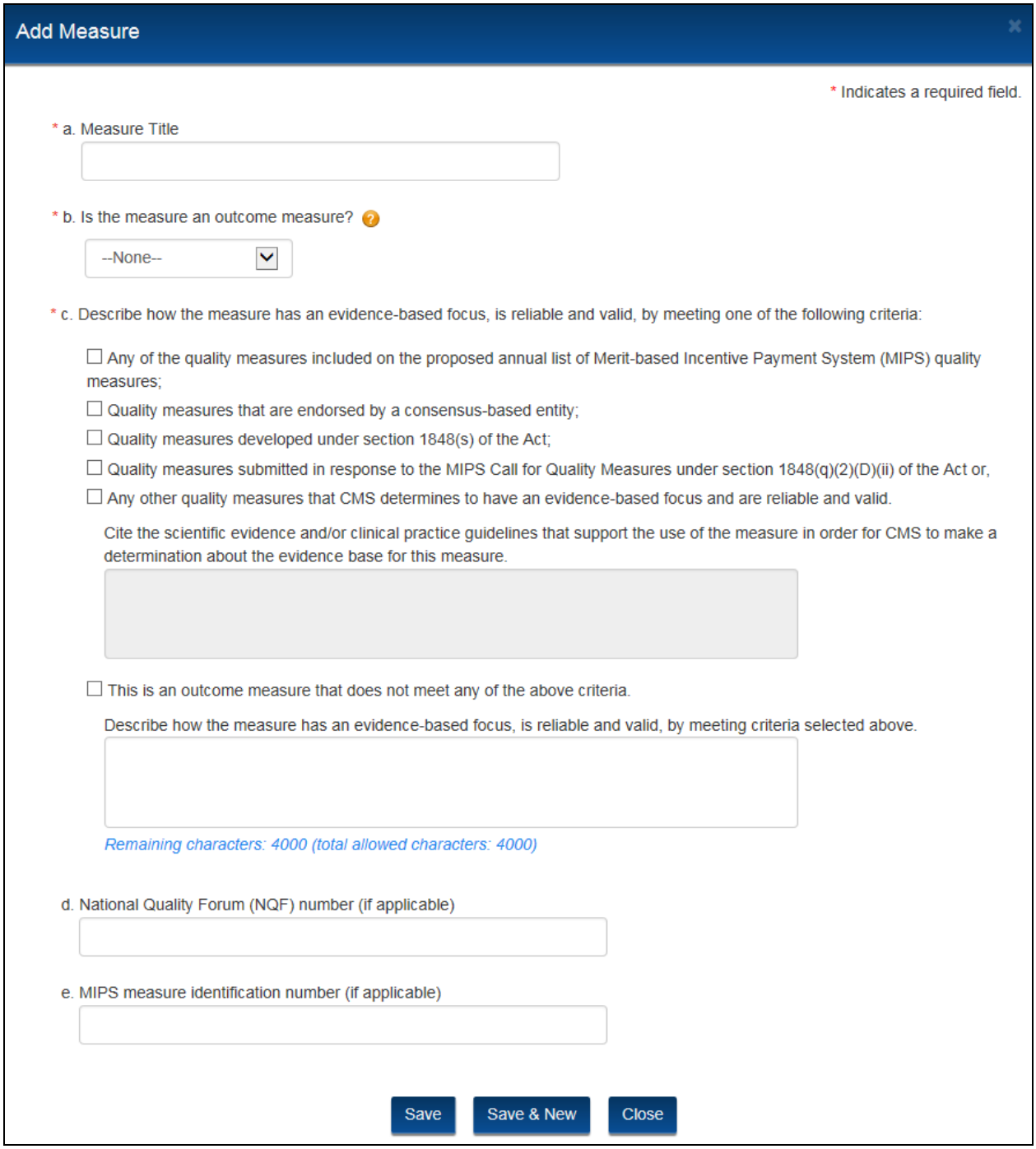
[2] *Please note that if there is no available or applicable outcome measure on the MIPS measure list, the payer must certify that there is no available or applicable outcome measure on the MIPS measure list per 42 CFR § 414.1445(c)(3).*



Provide the following information on at least one measure that is used in the payment arrangement. You must include at least one outcome measure on the MIPS quality measure list and one quality measure that is MIPS-comparable; these may be the same measure if the outcome measure also has an evidence-based focus and is reliable and valid.

A. Measure title
B. Outcome measure (Yes/No)?
C. How was this measure validated? Cite all relevant evidence and/or clinical practice guidelines in support of the measure.
D. National Quality Forum (NQF) number, if applicable.
E. MIPS measure identification number, if applicable.

Please explain and provide citations to supporting documentation to support the answer. Provide references to all relevant documentation, noting specific pages or sections.



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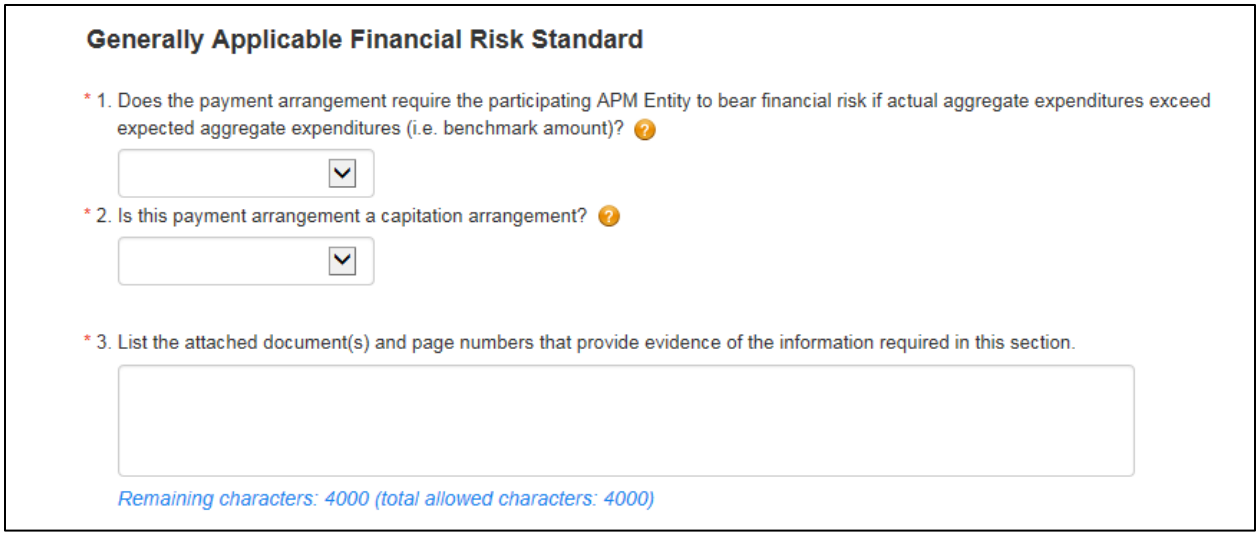
Generally Applicable Financial Risk Standard

The purpose of this section is to collect information needed to determine whether the payment arrangement meets the generally applicable financial risk standard. To support this determination, this section requests information about payment withholds or repayment requirements for APM Entities under the payment arrangement. For purposes of this form, the APM Entity is the practitioner or group of practitioners that participates in the payment arrangement.

In question 1, answer "Yes" if the payment arrangement requires participating eligible clinicians (or groups of eligible clinicians) to bear financial risk if actual expenditures are higher than expected expenditures (i.e., a benchmark amount). Expected expenditures refers to the beneficiary or patient expenditures for which an APM Entity is responsible under the payment arrangement. For episode payment models, expected expenditures typically refers to the episode target price.

If the answer to question 1 is "Yes," then provide more detail on any consequential actions that will be taken by the payer if actual expenditures exceed expected expenditures. Check the box next to each of the actions the payment arrangement employs and then describe the actions that are taken under the payment arrangement in detail in the text box. Use direct citations to uploaded documentation.

Question 2 regarding capitation arrangements is a yes or no question that requires documentation. "Is this payment arrangement a capitation arrangement?" A capitation risk arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made to an APM Entity for all items and services furnished to a population of beneficiaries, and no settlement is performed for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity. Because of the inclusion of all items and services, it may also be referred to as "full capitation." For purposes of Other Payer Advanced APM determinations, a capitation arrangement is not one where settlement is performed to reconcile or share losses incurred or savings earned. Provide citations to all relevant documentation, noting specific pages or sections.



Generally Applicable Nominal Amount Standard

Question 1 requires a detailed description of the payment arrangement's risk methodology. Include all information to explain what the payment arrangement requires of the APM Entity in terms of risk. Relevant details include risk rates, 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. Cite all relevant documentation in support of the description.

On question 2, answer "Yes" if the marginal risk rate is at least 30 percent. Marginal risk means the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the payment arrangement. If actual expenditures are higher than expected (higher than the benchmark), the APM Entity may only be liable for a percentage of the difference. The percentage they are liable for is the marginal risk. If marginal risk is equal to or above 30 percent, describe and cite documentation to show the marginal risk rate and the consequential action the payment arrangement requires if actual expenditures are higher than expected.

On question 3, answer "Yes" if the minimum loss rate is no more than 4 percent. In the case where actual expenditures are higher than expected, the APM Entity may not be subject to financial risk if the difference is small. The minimum loss rate is the percentage by which actual expenditures may exceed expected expenditures without triggering consequential actions. Describe and cite documentation to show the minimum loss rate and any consequential action the payment arrangement requires.

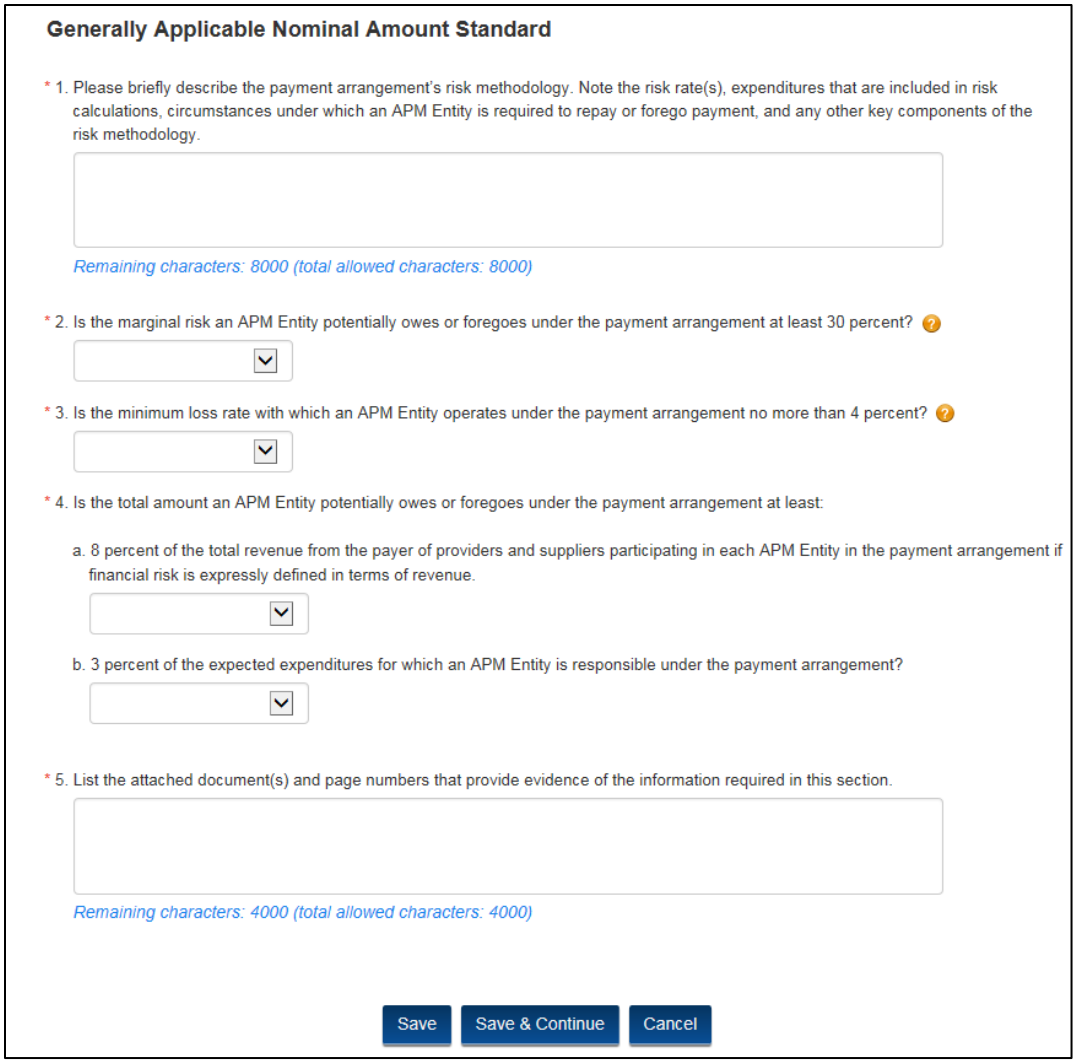
On question 4, answer "Yes" to the questions on total risk if the minimum percentages described below are met. The total risk can be expressed in terms

of revenue or expected expenditures, and either standard will fulfill the criteria so long as the minimum percentages are met. The total amount at risk for the APM Entity must be at least8 percent of the total combined revenues from the payer to providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue. or

- 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement. Expected expenditures means the beneficiary or patient expenditures for which an APM Entity is responsible under the payment arrangement.

Please support these answers with explanations of how risk is defined in terms of revenue or how expected expenditures are calculated. For these purposes, total revenue means the total combined revenue from the payer to providers and other entities under the payment arrangement.

Provide references to all relevant documentation, noting specific pages or sections.



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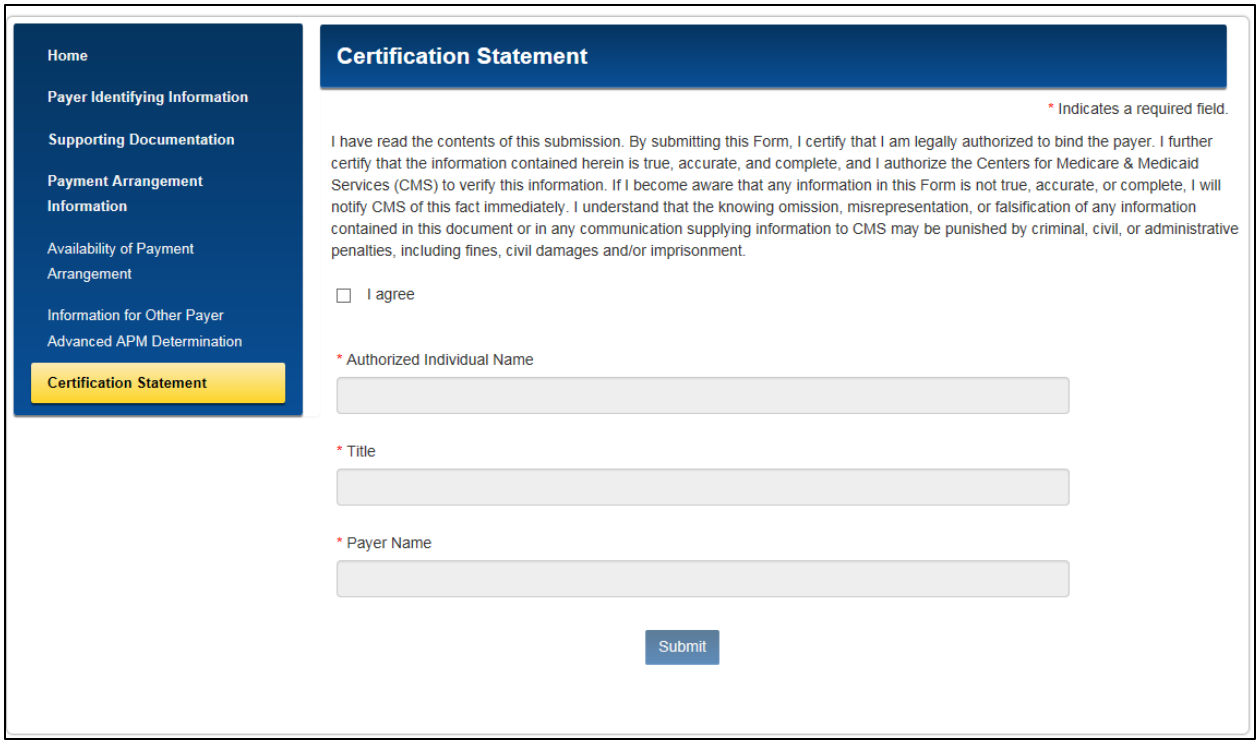
Certification Statement

The individual who is submitting information on behalf of the payer and authorized to bind the payer is certifying to the best of their knowledge that the information submitted to CMS is true, accurate and complete. Please contact the QPP help desk (qpp@cms.hhs.gov) with any questions prior to submission.


Home
Payer Identifying Information
Supporting Documentation
Payment Arrangement Information
Availability of Payment Arrangement
Information for Other Payer Advanced APM Determination
Certification Statement
Certification Statement
* Indicates a required field.
I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to bind the payer. 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
* Authorized Individual Name
* Title
* Payer Name
Submit