

## A Guide to Submitting Commercial Model Requests for Other Payer Advanced APM Determinations (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](#)
- [Glossary for additional definitions](#)
- [QPP All-Payer Frequently Asked Questions](#)

### Overview of Payer Initiated Process


Payers with commercial payment arrangements 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.

Commercial payment arrangements must be submitted by June 1 in the year prior to the relevant Qualifying APM Participant (QP)<sup>1</sup> Performance Period. For the 2020 QP Performance Period, payers may submit requests between **January 1 and June 1, 2019**.

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.

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<sup>1</sup> Qualifying APM Participant is an eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity including participation in Other Payer Advanced APMs.



CMS makes determinations on an annual basis. These determinations are final and not subject to reconsideration.

For the 2020 QP Performance Period, CMS will post a list of payment arrangements that are determined to be Other Payer Advanced APMs on the QPP website (<http://qpp.cms.gov/>) in September 2019. Eligible clinicians may view this list beginning September 2019, before the 2020 QP Performance Period. If CMS has not already determined that a payment arrangement is or is not 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 Commercial payment arrangement(s). The submission period for eligible clinicians will open on August 1 of the relevant QP Performance Period (e.g. August 1, 2019 for Performance Period 2019), and the Submission Deadline will be November 1 of that year.

## The Form

The Payer Initiated Submission Form (the 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 different payment arrangement must be submitted through a separate Form with its own 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](mailto: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 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 to inform CMS of 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 qualifies as an Other Payer Advanced APM.
- Certification Statement – This section requires the authorized individual submitting information to certify to the best of his or her knowledge 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](mailto:QPP_APM_AllPayer@cms.hhs.gov)). For technical questions about Salesforce, please contact the Salesforce help desk ([CMMIForceSupport@cms.hhs.gov](mailto: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.

Payer Contact Information

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



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### Payer Identifying Information

\* Indicates a required field.

#### Payer Contact Information

\* Legal Entity Name

Doing Business As (DBA) Name (if applicable)

Parent Company or Organization (if applicable)

\* Business Phone Number  Ext.

Fax

\* Address Line 1

Address Line 2

\* City  \* State  \* ZIP Code  +4

\* Email

\* Confirm Email

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



### Contact Person

\* First Name

\* Last Name

\* Business Phone Number

Ext.

Fax

\* Address Line 1

Address Line 2

\* City

\* State

\* ZIP Code

+4

\* Email

\* Confirm Email

Save

Save & Continue

Cancel

\*\*\*Save your progress\*\*\*

## 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.

The screenshot shows a web interface for uploading supporting documentation. On the left is a navigation menu with the following items: Home, Payer Identifying Information, Supporting Documentation (highlighted in yellow), Payment Arrangement Information, Availability of Payment Arrangement, Information for Other Payer Advanced APM Determination, and Certification Statement. The main content area is titled "Supporting Documentation" and contains the following text: "Please attach documentation that supports responses to the questions asked in the Information for Other Payer Advanced APM Determination section 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 the Information for Other Payer Advanced APM Determination section." Below this is a note: "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." There is an "Upload Document" button. Below the button is a table with columns "File Name", "Description", and "Action". The table is currently empty, displaying "No uploaded documents". At the bottom of the table area, it says "Showing 0 to 0 of 0 entries" and has "Previous" and "Next" navigation links. A "Continue" button is located at the bottom of the main content area.

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. 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.

\*\*\*Save your progress\*\*\*



## Payment Arrangement Information

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

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### Payment Arrangement Information

\* Indicates a required field.

#### General Information

\* 1. Select the CMS Multi-Payer Model.

--None--

\* 2. Payment Arrangement Name (e.g., [Payer Name] Oncology Care Model), or terminology used to refer to the payment arrangement. ?

\* 3. Who participates in this payment arrangement (e.g. primary care physicians, specialty group practices, etc.)?

Remaining characters: 4000 (total allowed characters: 4000)

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

--None--

\* 5. Is this payment arrangement in place for multiple years?

--None--

\* 6. Does the payer request that CMS make a multi-year determination for this payment arrangement?

--None--

Save Save & Continue Cancel

For Question 1, if applicable, please select the CMS Multi-Payer Model with which the payment arrangement is aligned. If you are not part of a CMS Multi-Payer Model please select "None."

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.

\* 3. Is this payment arrangement open to all provider types or limited to certain specialties?

Limited to certain specialties

If the payment arrangement is limited to certain specialties, select the provider specialties that may participate in the payment arrangement.

Ambulatory Surgical Center  
Anesthesiology Assistant  
Audiologist  
Certified Clinical Nurse Specialist  
Certified Nurse Midwife  
Certified Registered Nurse Anesthetist (CRNA)  
Chiropractic  
Clinic or Group Practice  
Clinical Cardiac Electrophysiology  
Clinical Laboratory

↓ ↑

Advance Diagnostic Imaging  
All Other Suppliers  
Ambulance Service Provider

Question 5 asks for the years your payment arrangement will be in place.

Question 6 asks if it is requested that CMS make a multi-year determination for your payment arrangement.

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

*\*\*\*Save your progress\*\*\**

### **Availability of Payment Arrangement**

The purpose of this section is to collect information to inform CMS of where the payment arrangement is available. This section also requests information on whether the same payment arrangement is available through other lines of business.



**Availability of Payment Arrangement**

\* Indicates a required field.

\* 1. Select locations where this payment arrangement will be available.

States

- AK - Alaska
- AL - Alabama
- AR - Arkansas
- AS - American Samoa
- AZ - Arizona
- CA - California
- CO - Colorado
- CT - Connecticut
- DC - District of Columbia
- DE - Delaware

\* 2. Is this payment arrangement available through other lines of business?

--None--

Save Save & Continue Cancel

In question 1, please select 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.

\*\*\*Save your progress\*\*\*

### 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. \* Note that a payment arrangement must include this CEHRT element in order to be considered an Other Payer Advanced APM.\*

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### Information for Other Payer Advanced APM Determination

\* Indicates a required field.

#### 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)? 🔗

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

No

NOTE: A payment arrangement must include this element in order to be considered an Other Payer Advanced APM.

\* 2. List the attached document(s) and page numbers that provide evidence of the information required in this section. If this CEHRT requirement is not included in your contract documents please provide other documentation containing evidence that this requirement is fulfilled.

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Prior to 2019, CEHRT means either the 2014 or the 2015 Base EHR Edition that has been certified. Beginning in 2019, the 2015 Base EHR Edition that has been certified will be required to meet this criterion.<sup>2</sup>

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 75 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<sup>3</sup>

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.

<sup>2</sup> For purposes of this Form, CEHRT is defined at 42 CFR § 414.1305.

<sup>3</sup> The quality measure Other Payer Advanced APM criterion is at 42 CFR § 414.1420(c).

## Quality Measure Use

In order to satisfy the Quality Measure Use criterion and to be determined to be an Other Payer Advanced APM, the arrangement must include a minimum of one quality measure that meets the criteria in Question 1, and also the criteria in Question 2 unless no relevant outcome measures are available.

- \* 1. Does the arrangement tie payments to one or more quality measures, at least one of which meets one or more of the following criteria: ?
- a. Any of the quality measures on the MIPS final list of measures, as described in § 414.1330; ?
  - b. Quality measures endorsed by a consensus-based entity;
  - c. Any other quality measures that CMS determines to be evidence based and reliable and valid. (if so, please upload supporting documentation below).

If the arrangement utilizes any other quality measures, please submit here for CMS to determine if they have an evidence-based focus and are reliable and valid.

Please upload a document using "Upload Document" or provide measure information in the text box below.

Remaining characters: 4000 (total allowed characters: 4000)

Upload Document

File Name	Description	Action
No uploaded documents		

Showing 0 to 0 of 0 entries

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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" (e.g., the National Quality Forum [NQF]), 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. An outcome measure assesses healthcare results experienced by patients. They include endpoints like well-being, ability to perform daily activities, or death. An intermediate outcome measure assesses a factor or short-term result that contributes to an ultimate outcome, such as having an appropriate cholesterol level. 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.

\* 2. Does the arrangement tie payments to one or more quality measures that is an outcome measure?

--None--

Add Measure

Measure Title	Outcome Measure	Action
No measures have been added		

Showing 0 to 0 of 0 entries

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### Add Measure

\* Indicates a required field.

\* a. Measure Title

\* b. Is the measure an outcome measure? ?

--None--

\* c. Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one of the following criteria:

- Any of the quality measures on the MIPS final list of measures, as described in § 414.1330;
- Quality measures endorsed by a consensus-based entity;
- Any other quality measures that CMS determines to be evidence based and 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.

- This is an outcome measure that does not meet any of the above criteria.

*For payment arrangements beginning in performance year 2020 or later, there must be at least one outcome measure that meets one of the criteria selected above.*

d. National Quality Forum (NQF) number (if applicable)

e. MIPS measure identification number (if applicable)

Save

Save & New

Close

If there is no applicable outcome measure, respond “No,” and also respond to the pop-up box asking if there are any outcomes measures.<sup>4</sup>

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.

Provide the following information on at least one measure tied to payments. 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.

*\*\*\*Save your progress\*\*\**

### 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.

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<sup>4</sup> 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).




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 arrangement, is a yes or no question that requires documentation. “Is this payment arrangement a full capitation arrangement?” Full capitation is defined as 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 the purpose of reconciling or sharing losses incurred or savings earned by the participant. For purposes of Other Payer Advanced APM determinations, payment arrangements directly between CMS and Medicare Advantage Organizations under the Medicare Advantage program (42 U.S.C. 422) are not considered capitation arrangements. Provide citations to all relevant documentation, noting specific pages or sections.

**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)? 


\* 2. Is this payment arrangement a full capitation arrangement? 

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

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### 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 least:

- 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity, 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 suppliers participating in the APM Entity.

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

## 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 forgo payment, and any other key components of the risk methodology.

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- \* 2. Is the marginal risk an APM Entity potentially owes or forgoes under the payment arrangement at least 30 percent? 

- \* 3. Is the minimum loss rate with which an APM Entity operates under the payment arrangement no more than 4 percent? 

- \* 4. Is the total amount an APM Entity potentially owes or forgoes under the payment arrangement at least:

a. 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.

b. 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement?

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

Remaining characters: 4000 (total allowed characters: 4000)

\*\*\*Save your progress\*\*\*

## Certification Statement

The authorized individual submitting information on behalf of the payer is certifying to the best of his or her knowledge that the information submitted to CMS is true, accurate and complete.

Please contact the QPP All-Payer help desk ([QPP\\_APM\\_AllPayer@cms.hhs.gov](mailto:QPP_APM_AllPayer@cms.hhs.gov)) with any questions prior to submission.

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**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 immediately notify CMS and provide the relevant additional or corrected information. Additionally, I will review the arrangement on an annual basis. If changes to the arrangement render the information in this Form not true, accurate, or complete, I will immediately notify CMS and provide the relevant additional or corrected information. 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