

## Performance Year 2022 Guide to Submitting Medicare Health Plan Requests for Other Payer Advanced APM Determinations (Payer Initiated Submission Form)

### Purpose

This is a guide on how Medicare Health Plans, including Medicare Advantage, may make a request for an Other Payer Advanced Alternative Payment Model (APM) Determination as part of the Quality Payment Program (QPP) through the Health Plan Management System (HPMS). A module for this purpose is contained within this year's HPMS Plan Bids at the site noted below. Through the Payer Initiated Submission Form (the "Form") as submitted by the Medicare Health Plan, the Centers for Medicare & Medicaid Services (CMS) will collect information and documentation to determine whether payment arrangements will qualify as Other Payer Advanced APMs under the QPP. This process is called the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process). More information about the 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:


- [Health Plan Management System \(HPMS\)](#)
- [All-Payer Advanced Alternative Payment Models \(APM\) Option](#)

### **Overview of Payer Initiated Process**

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 75 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 Medicare Health Plan payment arrangements, including Medicare Advantage and those 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. Medicare Health Plan payment arrangements must be submitted through the HPMS process as part of the annual bid cycle. HPMS will contain a special module for Other Payer Advanced APMs this year. Bid packages go out in early April and will be due back the first Monday in June in the year prior to the relevant QP Performance Period. For the 2022 QP Performance Period, payers may submit requests through HPMS and they will be due **June 4, 2021**.

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.

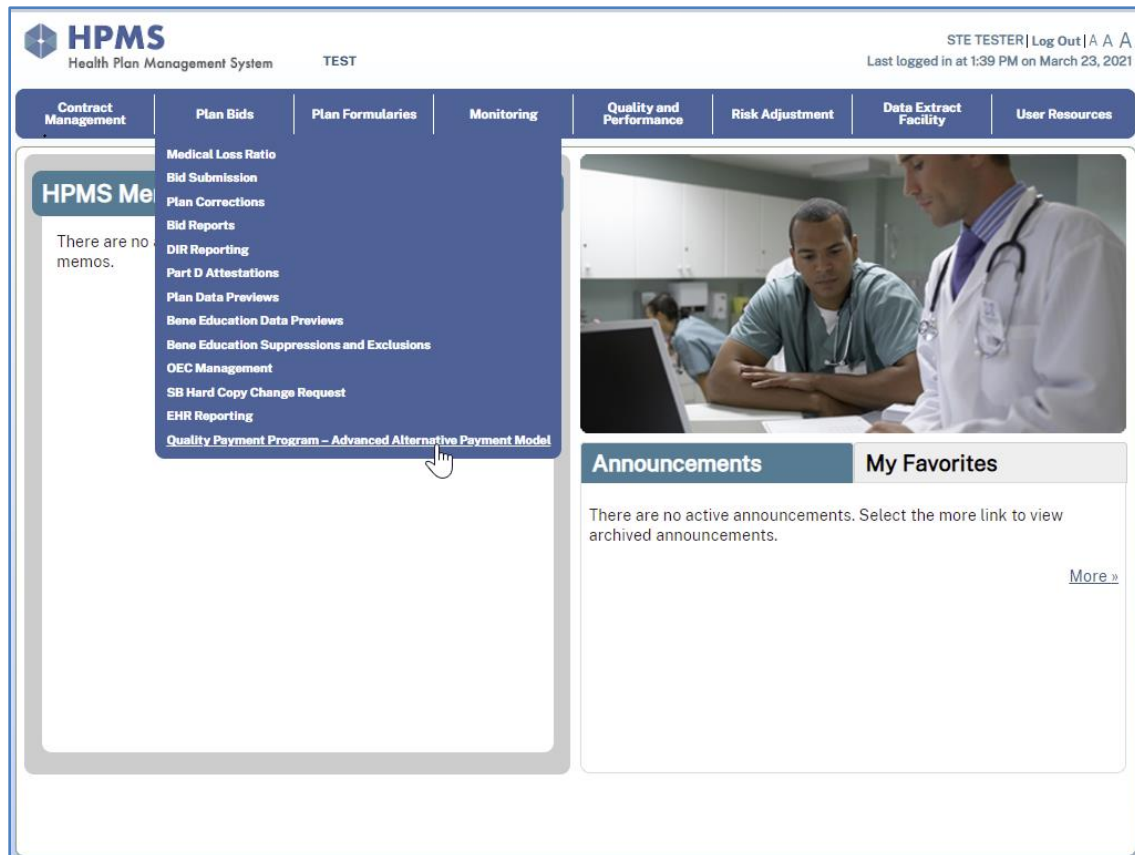
CMS anticipates posting a list of payment arrangements submitted through the Payer Initiated Process that are determined to be Other Payer Advanced APMs for the 2022 QP Performance Period on the CMS web site by September 2021. Eligible clinicians may refer to this list beginning in late 2021, before the 2022 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 Medicare Health Plan 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 of 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 is contained in the QPP Advanced Alternative Payment Models module within HPMS. The information will be submitted electronically through HPMS. Similar to Bid Submissions, the Form can be accessed through the QPP link under Plan Bids (listed above). The Form can be accessed through the same login used for Bid Submissions. The QPP Application will be specific to the QP Performance Period. After selecting the QP Performance Period, the payer will first update all application data; upload all relevant supporting documentation; submit the completed application; and have access to QPP user manuals. Each unique payment arrangement must be submitted separately on its own Form, along with its supporting documentation.

## Getting Started: Access the Quality Payment Program Start Page for a Contract Year

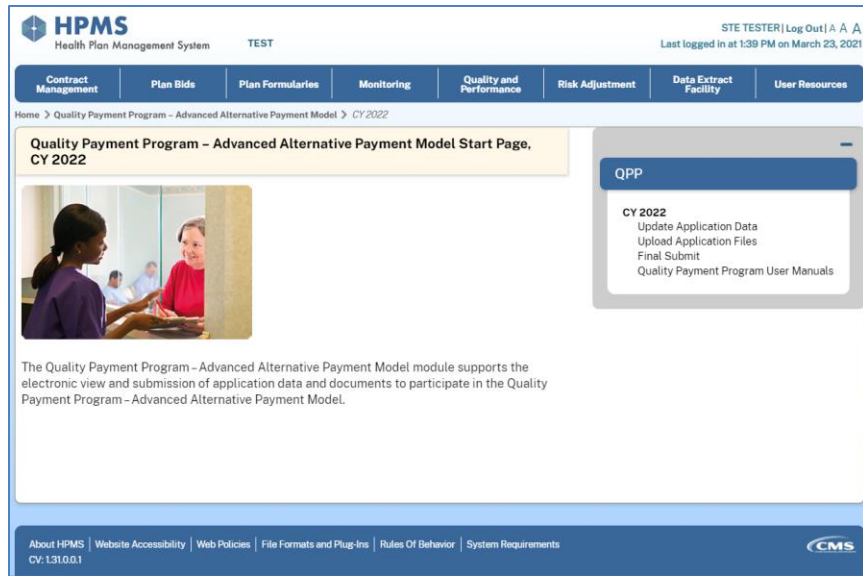
On the HPMS Home Page, select **Plan Bids** in the top green navigation bar. Then, click **Quality Payment Program – Advanced Alternative Payment Model** in the flyout menu.



On the **Quality Payment Program** start page, select the applicable contract year in the QPP Application menu.


The menu expands to show additional links for the selected contract year.

To expand/contract the QPP Application menu, click the QPP Application menu bar from within the module:



On the **Quality Payment Program** start page for the selected contract year, click **Update Application Data** in the menu.

From the Select a Contract/Plan page, enter a Contract ID in the **Search Contract** field. The contract is highlighted in the Select a Contract window. **Select a Plan** within the Plan window. Click **Submit**.

**HPMS**  
Health Plan Management System

TEST

STE TESTER | [Log Out](#) | [A](#) [A](#) [A](#)  
Last logged in at 1:39 PM on March 23, 2021

[Contract Management](#) | [Plan Bids](#) | [Plan Formularies](#) | [Monitoring](#) | [Quality and Performance](#) | [Risk Adjustment](#) | [Data Extract Facility](#) | [User Resources](#)

[Home](#) > [Quality Payment Program - Advanced Alternative Payment Model](#) > [CY 2022](#) > [Update Application Data](#)

Select a Contract/Plan

QPP

+

Search Contract:

Select a Contract:

XXXX - Sample Contract Name


Select a Plan:

XXX - Sample Plan Name

[Back](#) [Submit](#)

[About HPMS](#) | [Website Accessibility](#) | [Web Policies](#) | [File Formats and Plug-Ins](#) | [Rules Of Behavior](#) | [System Requirements](#)

CV-1310.01





1. Select the applicable application from the **Select an Application** drop-down list:

**HPMS**  
Health Plan Management System

TEST

STE TESTER | Log Out | A A A  
Last logged in at 1:39 PM on March 23, 2021

Contract Management | Plan Info | Plan Formularies | Monitoring | Quality and Performance | Risk Adjustment | Data Extract Facility | User Resources

Home > Quality Payment Program - Advanced Alternative Payment Model > CY 2022 > Update Application Data

**Update for XXXX, Plan 000** QPP +

Select an Application:  
Initial (for 2022) ▾

Application Attestation Section:

Section	Description	Status	Data
1	Section 1-Payer Identifying Information	Complete	<a href="#">Update</a> <a href="#">View</a>
2.A	Section 2.A-Medicare Health Plans -General Information	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.B	Section 2.B-Medicare Health Plans -Availability of Payment Arrangement	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.C	Section 2.C-Medicare Health Plans -Payment Arrangement Documentation	Upload Only	<a href="#">View</a>
2.D	Section 2.D-Medicare Health Plans -Information for Aligned Other Payer Medical Home Model Determination	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E1-CEHRT	Section 2.E1-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Certified Electronic Health Record Technology (CEHRT)	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E2-Quality Measure Use	Section 2.E2-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Quality Measure Use	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E3-Financial Risk Standard	Section 2.E3-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Generally Applicable Financial Risk Standard	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E4-Nominal Amount Standard	Section 2.E4-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Generally Applicable Nominal Amount Standard	Incomplete	<a href="#">Update</a> <a href="#">View</a>
3	Section 3-Supporting Documentation	Upload Only	<a href="#">View</a>
4	Section 4-Certification Statement	Incomplete	<a href="#">Update</a> <a href="#">View</a>

[Back](#)

About HPMS | Website Accessibility | Web Policies | File Formats and Plug-Ins | Rules Of Behavior | System Requirements  
CY.131.0.01

CMS

**HPMS**

Health Plan Management System

TEST

STE TESTER | Log Out | A A A

Last logged in at 1:39 PM on March 23, 2021

Contract  
Management

Plan Bids

Plan Formularies

Monitoring

Quality and  
Performance

Risk Adjustment

Data Extract  
Facility

User Resources

[Home](#) > [Quality Payment Program - Advanced Alternative Payment Model](#) > [CY 2022](#) > [Update Application Data](#)**Update for XXXX, Plan 000**

QPP




Select an Application:

Initial (for 2022) ▾

Application Attestation Section:

Section	Description	Status	Data
1	Section 1-Payer Identifying Information	Complete	<a href="#">Update</a> <a href="#">View</a>
2.A	Section 2.A-Medicare Health Plans -General Information	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.B	Section 2.B-Medicare Health Plans -Availability of Payment Arrangement	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.C	Section 2.C-Medicare Health Plans -Payment Arrangement Documentation	Upload Only	<a href="#">View</a>
2.D	Section 2.D-Medicare Health Plans -Information for Aligned Other Payer Medical Home Model Determination	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E.1-CEHRT	Section 2.E.1-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Certified Electronic Health Record Technology (CEHRT)	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E.2-Quality Measure Use	Section 2.E.2-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Quality Measure Use	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E.3-Financial Risk Standard	Section 2.E.3-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Generally Applicable Financial Risk Standard	Incomplete	<a href="#">Update</a> <a href="#">View</a>
2.E.4-Nominal Amount Standard	Section 2.E.4-Medicare Health Plans -Information for Other Payer Advanced APM Determination -Generally Applicable Nominal Amount Standard	Incomplete	<a href="#">Update</a> <a href="#">View</a>
3	Section 3-Supporting Documentation	Upload Only	<a href="#">View</a>
4	Section 4-Certification Statement	Incomplete	<a href="#">Update</a> <a href="#">View</a>

[Back](#)



To begin the application, click the Update link in the Data column for an Attestation Section.

The user advances to an Attestation data-entry page.

The user can complete the Attestation Sections in any order.

All Attestation Sections with an initial status of “Incomplete” must display a “Complete” status before the user can Final Submit the application.

Attestation Sections with the status “Upload Only” require file uploads that are performed and validated elsewhere in the QPP Application module. During data entry, a user is advised if an upload is required. The user cannot Final Submit an application if required uploads have not been completed.

The user can use the “Check if section is complete” function at the bottom of each application section to identify any incomplete data entry.

If a county is removed from the Plan service area, then the county will automatically be removed from the QPP application. If a county is added to the Plan service area, the user needs to manually add the county to the applicable QPP application, if necessary.

On the Attestation Section information page, enter the applicable data. Required data is flagged with an asterisk (\*) in the first column.

After each section has been submitted and all supporting documentation has been uploaded, the submitter should proceed to submit using the Final Submit link. Here the Submitter will be asked to “agree” with the Application Certification and then HPMS will review the application for missing or incomplete fields; if any are found the submitter will have to revisit those sections before the final submission. Upon final submission, the submitter will receive confirmation of submission and a submission number.

## **Completing the Form**

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.
- **Medicare Health Plans**
  - **General Information** – The purpose of this section is to collect the details of the payment arrangement.



- 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 a CMS multi-payer model.
- Payment Arrangement Documentation - References to supporting documentation are required.
- Information for Other Payer Advanced APM Determination – The purpose of these sections is to collect information needed for CMS to determine whether the payment arrangement is an Other Payer Advanced APM.
- 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.
- 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.

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.

## **Section 1. 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

Medicare Health Plan will already be selected as these are the only types of payers completing the Form in HPMS.

### Payer Contact Information

Please complete all contact information for this particular Medicare Health Plan payment arrangement.

Required	Item #	Description	Response	Upload May Be Required (*)
		<b>Section 1: Payer Identifying Information</b>		
		<i>When available, Payer Identifying Information will pre-populate for payers that already have HPMS accounts.</i>		
	1.A	<b>A. Payer Type</b>		
	1.A.1	1. Payer Type can only be Medicare Health Plan in HPMS.	Medicare Health Plan	
	1.B	<b>B. Payer Contact Information</b>		
	1.B.1	1. Non-Medicaid : (These fields will be read-only)		
	1.B.1.a	Legal Entity Name:	CHA HMO, INC.	
	1.B.1.b	DBA Name (if applicable):		
	1.B.1.c	Parent Company or Organization (if applicable):	Humana Inc.	
	1.B.2	2. All Payers:		
*	1.B.2.a	Business Phone Number:	3232299676	
	1.B.2.b	Ext.:		
	1.B.2.c	Fax Number:		
*	1.B.2.d	Address Line 1 (Street Name and Number):	7979 Lord Baltimore Drive	
	1.B.2.e	Address Line 2 (Suite, Room, etc.):		
*	1.B.2.f	City:	Owings Mills	
*	1.B.2.g	State:	Maryland	
*	1.B.2.h	Zip Code *4:	21117	
*	1.B.2.i	Email Address:	abc@gmail.com Confirm Email Address: abc@gmail.com	

Question 1.C. "Contact Person" is the individual CMS will reach out to with any questions about the payment arrangement and its operations. This section will be auto-populated with the information for the Bid Primary contact in HPMS, but changes can be made.

Question 1.D. The question is asking whether this form is being completed with the intention that a payment arrangement be reviewed as an Other Payer Advanced APM.

## Section 2. Medicare Health Plans

### Section 2.A. General Information

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

Section 2: Payment Arrangement Information - Medicare Health Plans			
Section 2.A: General Information			
	2.A.1	1. Type of Medicare Health Plan that includes this payment arrangement:	HMO/HMOPOS
*	2.A.2	2. Payment Arrangement Name (e.g. [Payer Name] Oncology Care Model), or terminology used to refer to the payment arrangement:	<input type="text" value="Example Payment Arrangement Name"/>
*	2.A.3	3. Who participates in this payment arrangement (e.g. primary care physicians, specialty group practices, etc.)?	<input type="text" value="Example Participants"/>
*	2.A.4	4. Is this payment arrangement open to all provider types or limited to certain specialties?	<div>All provider types Limited to certain specialties</div>
	2.A.4.a	a. If the payment arrangement is limited to certain specialties, select the provider specialties that may participate in the payment arrangement.	<div>Clinical Laboratory Community Mental Health Center Comprehensive Outpatient Rehabilitation Facility Critical Access Hospital Department Store End-Stage Renal Disease Facility Federally Qualified Health Center</div>
	2.A.5	5. QP Performance Period for which this payment arrangement determination is being requested.	2019
*	2.A.6	6. 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.  Upload documentation using the Upload Application Files link for section 3.	<div><input type="text" value="Example Documentation Notes"/></div>

☐ Check if section is complete.



For Question 1, please identify the type of Medicare Health Plan that includes this payment arrangement. Examples include HMOs and PPOs.

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 names and 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 submitter 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.

## Section 2.B. 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 counties where the payment arrangement is available for participation by eligible clinicians.

Section 2: Payment Arrangement Information - Medicare Health Plans		
Section 2.B: Availability of Payment Arrangement		
*	<p>2.B.1</p> <p>1. In what locations is this payment arrangement offered?</p> <p>Note: If a county is removed from the plan service area, then the county will automatically be removed from the QPP application. If a county is added to the plan service area, the applicant will need to manually add the county to the applicable QPP application, if necessary.</p>	<p>Service Area Not Included (at least one must be included)</p> <p>Include All   Include Selected</p> <p>VA, 49288 (Fairfax City) VA, 49290 (Fairfax) VA, 49291 (Falls Church City) VA, 49530 (Loudoun) GU, 65010 (Agana) GU, 65020 (Agana Heights) GU, 65030 (Agat) GU, 65040 (Asan) GU, 65050 (Barrigada) GU, 65060 (Chalan Pago)</p> <p>Service Area To Include</p> <p>Remove All   Remove Selected</p>
*	<p>2.B.2</p> <p>2. Is this payment arrangement part of one of the following CMS multi-payer models? Note: Payer must have a signed Memorandum of Understanding (MOU) with CMS for partnership in a multi-payer model.</p>	<p>Payment arrangement is not part of a CMS multi-payer model Oncology Care Model (OCM) Comprehensive Primary Care Plus (CPC+) Vermont All-Payer Model</p>

In Question 2, if the payment arrangement is part of a CMS multi-payer model, select the appropriate model. As of the posting of this fact sheet, the CMS multi-payer model options are: the Oncology Care Model, the Comprehensive Primary Care Plus Model, and the Vermont All-Payer Model. If the model is not part of a CMS multi-payer model, select "Payment arrangement is not part of a CMS multi-payer model."



## **Section 2.C. Payment Arrangement Documentation**

### **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.

### **Section 2.D.1. 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.

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 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).

### **Section 2.D.2. Quality Measure Use<sup>1</sup>**


This section requests information regarding the quality measures used in the payment arrangement. Documentation and references are required. Upload documentation in Section 3.

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.

---

<sup>1</sup> The quality measure Other Payer Advanced APM criterion is at 42 CFR § 414.1420(c).




Please provide citations to supporting documentation to support the answer. Also provide all relevant evidence-base for the measure, measure calculation, and any support for measure validation. Cite and explain in detail all documentation. Upload documentation in Section 3.

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 tied to payment, then answer “Yes” and provide more information about the outcome measure in 2.D.2.Q1.A-2.D.2.Q1.E. If there is no applicable outcome measure, respond “No,” and note this in 2.D.2.Q1.B.a.<sup>2</sup>

---

<sup>2</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).

*	2.D.2.2	2. Does the arrangement tie payments to one or more quality measures that is an outcome measure?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
		Enter the detail for each quality measure below.		
		<b>Quality Measure 1</b>	Select group option: <input type="button" value="Add"/> <input type="button" value="Drop"/>	
*	2.D.2.Q1.A	A. Measure title	<input type="text" value="Example Measure Title"/>	
*	2.D.2.Q1.B	B. Is the measure an outcome measure?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
	2.D.2.Q1.B.a	a. If no, check here if no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure list.	<input type="checkbox"/>	
*	2.D.2.Q1.C	C. Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one the following criteria:		
	2.D.2.Q1.C.i	i. Any of the quality measures included on the proposed annual list of Merit-based Incentive Payment System (MIPS) quality measures;	<input type="checkbox"/>	
	2.D.2.Q1.C.ii	ii. Quality measures that are endorsed by a consensus-based entity;	<input type="checkbox"/>	
	2.D.2.Q1.C.iii	iii. Quality measures developed under section 1848(s) of the Act;	<input type="checkbox"/>	
	2.D.2.Q1.C.iv	iv. Quality measures submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act or;	<input type="checkbox"/>	
	2.D.2.Q1.C.v	v. Any other quality measures that CMS determines to have an evidence-based focus and are reliable and valid.	<input checked="" type="checkbox"/>	
	2.D.2.Q1.C.v.a	a. 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.	<input type="text" value="Example Citation"/>	
	2.D.2.Q1.C.vi	vi. This is an outcomes measure that does not meet any of the above criteria.	<input type="checkbox"/>	
	2.D.2.Q1.C.vi.a	a. Describe how the measure has an evidence-based focus, is reliable and valid, by meeting criteria selected above.	<input type="text"/>	
	2.D.2.Q1.D	D. National Quality Forum (NQF) number (if applicable)	<input type="text"/>	
	2.D.2.Q1.E	E. MIPS measure identification number (if applicable)	<input type="text"/>	



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. Information can be added for up to 20 measures.

- 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 the response and provide citations to uploaded documentation in support of the response. Upload documentation in Section 3.

### **Section 2.4.3. 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 boxes in Question 2 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.


		Section 2: Payment Arrangement Information - Medicare Health Plans		
		Section 2.D: Information for Other Payer Advanced APM Determination		
		<u>Generally Applicable Financial Risk Standard</u>		
*	2.D.3.1	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)?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
	2.D.3.2	2. If yes, which of the following actions does the payer take in cases where actual aggregate expenditures exceed expected aggregate expenditures?		
	2.D.3.2.a	a. Payer withholds payment of services to the APM Entity and/or the APM Entity's eligible clinicians.	<input type="checkbox"/>	
	2.D.3.2.b	b. Payer reduces payment rates to APM Entity and/or the APM Entity's eligible clinicians.	<input type="checkbox"/>	
	2.D.3.2.c	c. Payer requires direct payments by the APM Entity to the payer.	<input checked="" type="checkbox"/>	
	2.D.3.2.d	d. Please describe the action(s) checked above that are taken by the payer in cases where actual aggregate expenditures exceed expected aggregate expenditures.	<div>Example Action Description</div>	

Question 3, 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. If the answer to Question 3 is yes, please describe the capitated payment arrangement. Provide citations to all relevant documentation, noting specific pages or sections.

#### Section 2.D.4. Generally Applicable Nominal Amount Standard

Question 1 requires a detailed description of the payment arrangement’s risk methodology. Include all relevant 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 average 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**. Marginal risk may be below 30 percent in some instances as long as the average marginal risk at all levels of losses up to the total risk is above 30 percent. 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. If marginal risk is less than 30 percent but the average marginal risk is equal to or above 30 percent, describe and cite the marginal risk amounts required 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. If no minimum loss rate is in place, in other words losses start when actual expenditures exceed expected expenditures please describe if a minimum loss rate is not applicable.

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 combined revenues from the payer to providers and suppliers 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 suppliers participating in the APM Entity.

Provide references to all relevant documentation, noting specific pages or sections. Upload documentation in Section 3.

		Section 2: Payment Arrangement Information - Medicare Health Plans		
		Section 2.D: Information for Other Payer Advanced APM Determination		
		<u>Generally Applicable Nominal Amount Standard</u>		
*	2.D.4.1	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.	Example Description	
*	2.D.4.2	2. Is the marginal risk an APM Entity potentially owes or foregoes under the payment arrangement at least 30 percent?	<input checked="" type="radio"/> Yes	
*	2.D.4.2.a	a. Please describe the marginal risk rate(s) and the actions required (e.g., repayment or forfeit of future payment) under the payment arrangement.	Example Description	
*	2.D.4.3	3. Is the minimum loss rate with which an APM Entity operates under the payment arrangement no more than 4 percent?	<input checked="" type="radio"/> Yes	
*	2.D.4.3.a	a. Please describe the minimum loss rate.	Example Description	
	2.D.4.4	4. Is the total amount an APM Entity potentially owes or foregoes under the payment arrangement at least:		
*	2.D.4.4.a	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.	<input type="radio"/> Yes <input checked="" type="radio"/> No	
	2.D.4.4.a.i	i. If yes, please explain how risk is expressly defined in terms of revenue.		
*	2.D.4.4.b	b. 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
	2.D.4.4.b.i	i. If yes, please describe how the amount that an APM Entity owes or foregoes is calculated.	Example Description	
*	2.D.4.5	5. List the attached documents and page numbers that provide evidence of the information required in this section.  Upload documentation using the Upload Application Files link for section 3.	Example Document Notes	



### **Section 3. 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. 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.

## Final Submit an Application

After all Section Attestations show a “Complete” status on the **Application Attestation** status page and any required supporting documentation file has been uploaded, the user is ready to Final Submit the application.

1. On the **Quality Payment Program Start Page**, click **Final Submit** in the menu. (To access the Start Page for a contract year, see the “Getting Started” section.)
2. On the **Select Contract/Plan** page, select a contract and a plan in the picklists. Click **Submit**.

The screenshot displays the HPMS (Health Plan Management System) interface. At the top, there's a header with the HPMS logo and navigation tabs: Contract Management, Plan Bids, Plan Formularies, Monitoring, Quality and Performance, Risk Adjustment, Data Extract Facility, and User Resources. Below the header, a breadcrumb trail reads: Home > Quality Payment Program - Advanced Alternative Payment Model > CY 2022 > Final Submit. The main content area is titled 'Select a Contract/Plan/Application' and features a 'QPP' button with a plus sign. There's a 'Search Contract:' input field. Below it, a 'Select a Contract:' dropdown menu is open, showing three options: 'Z0001 - Example Contract 1', 'Z0002 - Example Contract 2', and 'Z0003 - Example Contract 3'. Underneath, a 'Select a Plan:' dropdown menu shows one option: '000 - Plan Example 1'. At the bottom of the form area are 'Back' and 'Submit' buttons. The footer contains links for 'About HPMS', 'Website Accessibility', 'Web Policies', 'File Formats and Plug-Ins', 'Rules Of Behavior', 'System Requirements', and the CMS logo.

3. On the **Final Submit Detail** page, review the data and click the link for the last uploaded application file to review supporting documentation. Click **Submit**.



## Version History

Date	Change Description
8/20/2021	Original version.