public payer, such as CMS, needs in order to consider and determine whether a payer arrangement satisfies the Other Payer Advanced APM criteria. Furthermore, data submission by a smaller number of private payers, rather than a large amount of physicians would ease CMS' burden to assess whether other payer arrangements meet the Other Payer Advanced APM criteria by the nature of lower volume and more congruent data. For example:

- The AAFP has a membership containing over 69,000 active/practicing family physicians, with 61 percent reporting submitting claims to 7-10 payers. Assuming the average number of payers with whom family physicians have relationships with is seven, then CMS will receive 483,000-plus disparate submissions from family physicians. Add to that total the number of submissions from other physicians, specialists, and APM entities, and the danger of CMS receiving duplicative, flawed, and otherwise accurate data is too great for CMS to require submission from APM Entities and/or eligible clinicians.
- The flipside of the calculation reveals a more manageable number for CMS. According to a recent National Association of Insurance Commissioners report card, in 2014, there were 366,089 direct health and medical insurance carriers. That means CMS would be required to process no more than that amount each year when assessing whether other payer arrangements meet the Other Payer Advanced APM criteria.

The burden on private payers to make submissions to CMS on payer arrangements would be minimal. On November 17, 2015 a national payer sent response to CMS' RFI on MACRA, it stated, "As a committed participant in the move to value-based payment, is willing and able to support providers in documenting non-Medicare, APM revenue. In establishing documentation requirements for the all-payer model, we encourage CMS to minimize the administrative burden on providers and on the other entities implementing APMs."
Another national payer's letter from November 17, 2015 expressed a similar statement: "EPs will need to obtain data and information from the private payers to submit qualifying information to CMS. This invariably raises concerns about the administrative burden of providing data and information in general, the risks of revealing proprietary information, and the potential for CMS to audit or judge private payers' APMs."

The AAFP offers an alternative to CMS for receiving data to assess whether other payer arrangements meets the Other Payer Advanced APM criteria—similar to CMS' proposal for Medicaid. In the interest of public and payer alignment and convergence on APM frameworks, payers should be required to submit: (1) the payment amounts and/or number of patients furnished any service through each Advanced APM; (2) the sum of their total payment amounts and/or number of patients furnished any service; and (3) any additional, relevant information the payer believes would help CMS gain a better understanding of the mechanics of APM frameworks. The information should be submitted at least 60 days before the beginning of the QP Performance Period. CMS should, to the extent permitted by federal law, maintain confidentiality of certain information that the Advanced APM Entities and/or eligible clinicians submit regarding Other Payer Advanced APM status in order to avoid dissemination of potentially sensitive contractual information or trade secrets. Other payers are in a better position to deliver the necessary and relevant information to CMS on their own payer arrangements and they would be able to submit "batch" reports on their arrangements, which could include the corresponding clinicians. CMS would then have more accurate and granular data on which clinicians are participating in what payer arrangement with whichever payer, thereby allowing for an increase in program integrity. In addition, it would remove the second-step attestation requirement CMS is proposing for payers to confirm the accuracy of all