|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Page** | **Line** | **Action Type** | **What has been inserted or deleted** | **Reason for change** |
| 1 | 7 | Inserted | Welcome to the QPP All-Payer Submission Form. |   |
| Addition to improve instructions. |
|   |
| 1 | 11 | Deleted | by State Medicaid programs, Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans), or commercial or other private payers with payment arrangements in a CMS Multi-Payer Model | Edit to clarify submission process. |
| 1 | 21 | Deleted | Deadlines | Edit to clarify submission process. |
| Submission Deadlines are specific to payer type.  | Edit to clarify submission process. |
|   |   |
| State Medicaid programs | Edit to clarify submission process. |
| 1 | 24 | Inserted | [Title XIX only] | Addition to improve instructions. |
| Payment arrangement determination requests for all Medicaid payment models (including Medicaid FFS and Medicaid Managed Care Plans) may only be submitted by State Medicaid Agencies. State Medicaid agencies | Addition to improve instructions. |
| 1 | 29 | Deleted | 30 | Edit to clarify submission process. |
| 1 | 29 | Inserted | 1 | Edit to clarify submission process. |
| 1 | 29 | Deleted | All-Payer  | Edit to clarify submission process. |
| 1 | 32 | Inserted |   |   |
| [Medicare Health Plans only] | Addition to improve instructions. |
|  |   |
| 1 | 40 | Deleted | 30 |   |
| 1 | 40 | Inserted | 1 | Addition to improve instructions. |
| 1 | 43 | Inserted |   |   |
| [All submitters] | Addition to improve instructions. |
|   |   |
| 2 | 2 | Inserted | [ | Correction to punctuation. |
| 2 | 2 | Deleted |  or  | Edit to clarify submission process. |
| 2 | 2 | Inserted | / | Correction to punctuation. |
| 2 | 2 | Inserted | ] | Correction to punctuation. |
| 2 | 3 | Inserted | [ | Correction to punctuation. |
| 2 | 3 | Deleted |  and states | Edit to clarify submission process. |
| 2 | 3 | Inserted | /States] | Addition to improve instructions. |
| 2 | 10 | Inserted | [ | Correction to punctuation. |
| 2 | 10 | Deleted |  or  | Edit to clarify submission process. |
| 2 | 11 | Inserted | / | Correction to punctuation. |
| 2 | 11 | Inserted | ] | Correction to punctuation. |
| 2 | 12 | Inserted | [ | Correction to punctuation. |
| 2 | 12 | Deleted |  or  | Edit to clarify submission process. |
| 2 | 12 | Inserted | / | Correction to punctuation. |
| 2 | 12 | Inserted | ] | Correction to punctuation. |
| 2 | 12 | Inserted | [ | Correction to punctuation. |
| 2 | 12 | Deleted |  and states | Edit to clarify submission process. |
| 2 | 13 | Inserted | /States] | Addition to improve instructions. |
| 2 | 13 | Deleted | 10 | Edit to clarify submission process. |
| 2 | 13 | Inserted | 15 | Addition to improve instructions. |
| 2 | 14 | Inserted | [ | Correction to punctuation. |
| 2 | 14 | Deleted |  or  | Edit to clarify submission process. |
| 2 | 14 | Inserted | / | Correction to punctuation. |
| 2 | 14 | Inserted | ] | Correction to punctuation. |
| 2 | 21 | Inserted | [ | Correction to punctuation. |
| 2 | 21 | Deleted |  or  | Edit to clarify submission process. |
| 2 | 21 | Inserted | / | Correction to punctuation. |
| 2 | 21 | Inserted | ] | Correction to punctuation. |
| 2 | 25 | Deleted | Instructions for Completing and Submitting this Form | Edit to clarify submission process. |
|   |
| 2 | 26 | Inserted |   |   |
| NOTE: Please be sure to save your work before navigating away from each page as any unsaved work will be lost. Additionally, the application times out after 30 minutes of inactivity. | Edit to clarify submission process. |
|   |   |
| A separate submission must be completed for each payment arrangement the [payer/state] is submitting. | Edit to clarify submission process. |
|   |   |
| Helpful Links: | Addition to improve instructions. |
| - QPP All-Payer Submission Form User Guide | Addition to improve instructions. |
| - QPP All-Payer FAQs | Addition to improve instructions. |
| - Glossary |   |
|   |   |
| 4 | 27 | Inserted | - | Correction to punctuation. |
| 4 | 27 | Deleted | : \_\_\_\_\_\_\_\_\_\_\_ | Edit to clarify submission process. |
| 4 | 28 | Inserted | - | Correction to punctuation. |
| 4 | 28 | Inserted | First | Addition to improve instructions. |
| 4 | 28 | Deleted | : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Edit to clarify submission process. |
| 4 | 29 | Inserted | - State Medicaid Director Last Name | Addition to improve instructions. |
| . | Correction to punctuation. |
|   |   |
| 4 | 33 | Deleted | Telephone | Edit to clarify submission process. |
| 4 | 33 | Inserted | - Business Phone | Addition to improve instructions. |
| 4 | 33 | Deleted | : \_\_\_\_  | Edit to clarify submission process. |
| 4 | 33 | Inserted |  - Ext.\_  | Addition to improve instructions. |
|   |
| 4 | 37 | Deleted | /Town | Edit to clarify submission process. |
| 4 | 39 | Inserted | Confirm Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Addition to improve instructions. |
|   |
| 5 | N/A | Deleted | Middle Initial | Edit to clarify submission process. |
| 5 | 6 | Inserted |  Ext:\_\_\_ | Addition to improve instructions. |
| 5 | 9 | Deleted | /Town | Edit to clarify submission process. |
| 5 | 11 | Inserted | Confirm Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Addition to improve instructions. |
|   |   |
| D. | Addition to improve instructions. |
| - Are you submitting a form for an Other Payer Advanced APM? | Addition to improve instructions. |
|  Yes | Addition to improve instructions. |
|  No | Addition to improve instructions. |
| 5 | 29 | Deleted | [State Name] ACO Model), or terminology used to refer to the payment arrangement: [TEXT BOX] | Edit to clarify submission process. |
|   |   |
| Describe the participant eligibility criteria for this payment arrangement. | Edit to clarify submission process. |
| 5  | N/A | Deleted | Upload all documents to the Supporting Documents section of this Form, and label each document for reference throughout the Form. | Edit to clarify submission process. |
| 5 | N/A | Deleted | CMS will use existing Medicaid documentation in the Payer Initiated Other Payer Advanced APM Determination Process as applicable. | Edit to clarify submission process. |
| 5 | 40 | Deleted | Select the All-Payer QP Performance Period for which this payment arrangement determination is being requested. :  | Edit to clarify submission process. |
| 6 | 43 | Deleted | documentation is required to support the answers provided above. Please note the attached document(s) and page number(s) that contain this information. [TEXT BOX] | Edit to clarify submission process. |
| Availability of Payment Arrangement  | Edit to clarify submission process. |
| 6 | 7 | Deleted | Counties, if not statewide [DROP DOWN LIST] | Edit to clarify submission process. |
|   |   |
| Is this payment arrangement available through Medicaid Fee-For-Service? [Y/N] | Edit to clarify submission process. |
|   |   |
| Is this payment arrangement available through a Medicaid managed care plan? [Y/N] | Edit to clarify submission process. |
| 6 | N/A | Deleted  | General  | Edit to clarify submission process. |
| 6 | N/A | Inserted | Payment Arrangement | Addition to improve instructions. |
| 6 | 30 | Inserted | 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. | Addition to improve instructions. |
|   |
|   |
| 6 | 37 | Deleted | [Y/N] | Edit to clarify submission process. |
| 6 | 37 | Inserted | If so, please paste a link to the location of the document here or upload with other pertinent information [Y/N] | Addition to improve instructions. |
| 6 | 43 | Inserted | ] | Correction to punctuation. |
|   |
|   |
| 7 | 1 | Deleted | If | Edit to clarify submission process. |
| 7 | 1 | Inserted | Coordinated Care ACO Model), , or terminology used to refer to | Addition to improve instructions. |
| 7 | 2 | Deleted | information needed to answer the questions | Edit to clarify submission process. |
| 7 | 2 | Inserted | payment arrangement: [TEXT BOX] | Addition to improve instructions. |
|   |   |
| Who participates | Addition to improve instructions. |
| 7 | 5 | Deleted | Sections D and E of  | Edit to clarify submission process. |
| 7 | 5 | Inserted | payment arrangement (e.g. primary care physicians, specialty group practices, etc.)? . | Addition to improve instructions. |
| 7 | 14 | Inserted | Select the QP Performance Period for which this payment arrangement determination is being requested. | Addition to improve instructions. |
| 7 | 17 | Deleted | Form is not available in the aforementioned Medicaid  | Edit to clarify submission process. |
| 7 | 18 | Deleted | , | Correction to punctuation. |
| 7 | 18 | Inserted |  is required to support the answers provided above. Please | Addition to improve instructions. |
| 7 | 19 | Deleted | supporting documentation | Edit to clarify submission process. |
| 7 | 19 | Inserted | document(s) | Addition to improve instructions. |
| 7 | 19 | Deleted | numbers | Edit to clarify submission process. |
| 7 | 19 | Inserted | number(s) | Addition to improve instructions. |
| 7 | 20 | Inserted | . | Correction to punctuation. |
| 7 | 20 | Deleted | ].  | Correction to punctuation. |
| 7 | 20 | Inserted | ] | Correction to punctuation. |
|  |  |  | Availability of Payment Arrangement | Addition to improve instructions. |
|   |   |
|   |   |
| 7 | 27 | Inserted | [Medicaid Only] Counties, if not statewide [DROP DOWN LIST] | Addition to improve instructions. |
|   |   |
| [Medicaid Only] Is this payment arrangement available through: | Addition to improve instructions. |
| - Medicaid Fee-For-Service | Addition to improve instructions. |
| - Medicaid Manage Care Plan | Addition to improve instructions. |
| - Other [Commercial and Medicare Health Plans] Is this payment arrangement available through other lines of business?  | Addition to improve instructions. |
| - Yes | Addition to improve instructions. |
| - No | Addition to improve instructions. |
| 7 | 41 | Inserted | Medicaid Medical Home Model means a payment arrangement under title XIX that CMS determines by the following characteristics. | Addition to improve instructions. |
|   |
| 8 | 12 | Deleted | If yes, list | Edit to clarify submission process. |
| 8 | 12 | Inserted | [If yes] List | Addition to improve instructions. |
| 8 | 12 | Deleted | contain | Edit to clarify submission process. |
| 8 | 12 | Inserted | provide evidence of | Addition to improve instructions. |
| 8 | 13 | Deleted | . | Correction to punctuation. |
| 8 | 13 | Inserted | .. | Correction to punctuation. |
| 8 | 24 | Deleted | , and cite the supporting document(s) and page number(s) that contain this information regarding each requirement. Briefly explain how each criterion is satisfied in the payment arrangement.  | Edit to clarify submission process. |
| 8 | 27 | Inserted | . | Correction to punctuation. |
| 8 | 29 | Inserted | cite supporting documentation and page numbers. | Addition to improve instructions. |
| 8 | 42 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 9 | 1 | Inserted | Medicaid Medical Home Model require that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, at least one of the following occurs: | Addition to improve instructions. |
|   |   |
| • -- Payer withholds | Addition to improve instructions. |
| 9 | 5 | Deleted | arrangement require  | Edit to clarify submission process. |
| 9 | 5 | Inserted | of services to | Addition to improve instructions. |
| 9 | 5 | Deleted | participating  | Edit to clarify submission process. |
| 9 | 6 | Deleted | to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures (i.e. benchmark amount)? [Y/N]  | Edit to clarify submission process. |
| 9 | 7 | Inserted | and/or the APM Entity’s eligible clinicians | Addition to improve instructions. |
| 9 | 8 | Deleted |   |   |
| If yes, which | Edit to clarify submission process. |
| 9 | 9 | Inserted | • -- Payer requires direct payments by the APM Entity to the payer | Addition to improve instructions. |
| • -- Payer reduces payment rates to APM Entity and/or the APM Entity’s eligible clinicians | Addition to improve instructions. |
| • -- Payer requires the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments | Addition to improve instructions. |
| Yes/No | Addition to improve instructions. |
|   |   |
| Which | Addition to improve instructions. |
| 9 | 9 | Inserted | the APM Entity's fails to meet or exceed one or more specified performance standards | Addition to improve instructions. |
|  | 9 | Deleted | actual aggregate expenditures exceed expected aggregate expenditures | Edit to clarify submission process. |
|  | 20 | Inserted | the APM Entity's fails to meet or exceed one or more specified performance standards | Addition to improve instructions. |
|  | 20 | Deleted | actual aggregate expenditures exceed expected aggregate expenditures | Edit to clarify submission process. |
| 9 | 29 | Inserted | Please describe how the amount that an APM entity owes or forgoes is calculated. [text box] | Addition to improve instructions. |
|   |   |
|   |   |
| List the attached document(s) and page numbers that provide evidence of the information required in this section. | Addition to improve instructions. |
|   |   |
| 9 | 38 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
|   |
| 10 | 1 | Inserted | 2. List the attached document(s) and page numbers that provide evidence of the information required in this section. [Text box] | Addition to improve instructions. |
|   |
| 10 | 9 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 10 | 21 | Inserted | 2. List the attached document(s) and page numbers that provide evidence of the information required in this section. | Addition to improve instructions. |
|   |
|   |
|   |
|   |
|   |
| 10 | 32 | Deleted | apply any | Edit to clarify submission process. |
| 10 | 32 | Inserted | tie payments to one or more | Addition to improve instructions. |
| 10 | 32 | Deleted |  that are comparable to MIPS quality measures as required by 42 CFR 414.1420(c)? [Y/N] | Edit to clarify submission process. |
|   |   |
| If yes, does at least one quality measure have an evidence-based focus, is it reliable and valid, and does it meet | Edit to clarify submission process. |
| 10 | 36 | Inserted | , | Correction to punctuation. |
| 10 | 36 | Inserted | which meets one or more of | Addition to improve instructions. |
| 10 | 45 | Inserted |  (If so, please upload supporting documentation below) | Addition to improve instructions. |
| 11 | 2 | Deleted | A minimum of one quality measure that meets the above criteria and is an outcome measure is required in order to satisfy the Quality Measure Use criterion. Please provide the following information for each quality measure included in the payment arrangement that you wish for CMS to consider for purposes of satisfying this criterion. [TEXT BOX FOR EACH MEASURE] | Edit to clarify submission process. |
|   |
|   |
| 11 | 8 | Inserted | 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. | Addition to improve instructions. |
|   |   |
| Please upload a document using "Upload Document" or provide measure information in the text box below. [Upload document button and text box] | Addition to improve instructions. |
|   |   |
| 2. Does the arrangement tie payments to one or more quality measures that is an outcome measure? | Addition to improve instructions. |
| - Yes | Addition to improve instructions. |
| - No | Addition to improve instructions. |
|   |   |
| [Button] Add Measure | Addition to improve instructions. |
|   |   |
|   |   |
| A. | Addition to improve instructions. |
| 11 | 22 | Inserted |  [Text box] | Addition to improve instructions. |
| 11 | 23 | Deleted | MIPS measure identification number (if applicable) | Edit to clarify submission process. |
| National Quality Forum (NQF) number (if applicable) | Edit to clarify submission process. |
| If the measure is neither a MIPS measure nor a currently endorsed NQF measure, cite the scientific evidence and/or clinical practice guidelines that support the use of the measure. | Edit to clarify submission process. |
|   |   |
| 11 | 28 | Inserted | B. | Addition to improve instructions. |
| 11 | 28 | Inserted |  [y/n] | Addition to improve instructions. |
| 11 | 31 | Inserted |   |   |
| C. | Addition to improve instructions. |
| 11 | 43 | Deleted |   |   |
| Are | Edit to clarify submission process. |
| 12 | 44 | Inserted | 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. [Text box] | Edit to clarify submission process. |
| This is an outcomes measure that does not meet | Addition to improve instructions. |
| 12 | 1 | Deleted | measures outcome measures? [Y/N | Edit to clarify submission process. |
| 12 | 2 | Inserted | criteria [Checkbox | Addition to improve instructions. |
| 12 | 7 | Inserted | Describe how the measure has an evidence-based focus, is reliable and valid, by meeting criteria selected above. [Text box] | Addition to improve instructions. |
|   |   |
|  - D. National Quality Forum (NQF) number (if applicable) [Text box] | Addition to improve instructions. |
|  - E. MIPS measure identification number (if applicable) [Text box] | Addition to improve instructions. |
| 12 | 20 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] |   |
| Edit to clarify submission process. |
|   |
| 12 | 40 | Deleted | A | Edit to clarify submission process. |
| 12 | 40 | Inserted | For purposes of Other Payer Advanced APM determination, a | Addition to improve instructions. |
| 13 | 8 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 12 | N/A | Reinserted | List the attached document(s) and page numbers that provide evidence of the information required in this section. | Addition to improve instructions. |
| 14 | 9 | Deleted | Describe the participant eligibility criteria for | Edit to clarify submission process. |
| 14 | 9 | Inserted | Who participates in | Addition to improve instructions. |
| 14 | 10 | Deleted | . |   |
| 14 | 18 | Inserted |  (e.g. primary care physicians, specialty group practices, etc.)? | Addition to improve instructions. |
| 14 | 26 | Deleted |  All-Payer | Edit to clarify submission process. |
| 15 | 12 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 15 | 29 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 15 | 32 | Deleted | apply any | Edit to clarify submission process. |
| 15 | 32 | Inserted | tie payments to one or more | Addition to improve instructions. |
| 15 | 32 | Deleted |  that are comparable to MIPS quality measures as required by 42 CFR 414.1420(c)? [Y/N] | Edit to clarify submission process. |
|   |   |
| If yes, does at least one quality measure have an evidence-based focus, is it reliable and valid, and does it meet | Edit to clarify submission process. |
| 15 | 36 | Inserted | , | Correction to punctuation. |
| 15 | 36 | Inserted | which meets one or more of | Addition to improve instructions. |
| 15 | 45 | Inserted |  (If so, please upload supporting documentation below) | Addition to improve instructions. |
| 16 | 1 | Deleted | A minimum of one quality measure that meets the above criteria and is an outcome measure is required in order to satisfy the Quality Measure Use criterion. Please provide the following information for each quality measure included in the payment arrangement that you wish for CMS to consider for purposes of satisfying this criterion. [TEXT BOX FOR EACH MEASURE] | Edit to clarify submission process. |
|   |   |
| Measure  | Edit to clarify submission process. |
| 16 | 7 | Inserted | 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. | Addition to improve instructions. |
|   |   |
| Please upload a document using "Upload Document" or provide measure information in the text box below. [Upload document button and text box] | Addition to improve instructions. |
|   |   |
| 2. Does the arrangement tie payments to one or more quality measures that is an outcome measure? | Addition to improve instructions. |
| - Yes | Addition to improve instructions. |
| - No | Addition to improve instructions. |
|   |   |
|   |   |
|   |   |
| A. Measure | Addition to improve instructions. |
| 16 | 20 | Inserted |  [Text box] | Addition to improve instructions. |
| 16 | 21 | Deleted | MIPS measure identification number (if applicable) | Edit to clarify submission process. |
| National Quality Forum (NQF) number (if applicable) | Edit to clarify submission process. |
| If the measure is neither a MIPS measure nor a currently endorsed NQF measure, cite | Edit to clarify submission process. |
| 16 | 24 | Inserted | B. | Addition to improve instructions. |
| 16 | 24 | Inserted |  [y/n] | Addition to improve instructions. |
|   |
| 16 | 28 | Inserted | C. | Addition to improve instructions. |
| 16 | 40 | Inserted |   |   |
| Cite | Addition to improve instructions. |
| 16 | 42 | Deleted | . |   |
| 16 | 42 | Inserted |  in order for CMS to make a determination about the evidence base for this measure. [Text box] | Addition to improve instructions. |
| 17 | 44 | Inserted |   |   |
| This is an outcomes measure that does not meet any of the above criteria [Checkbox] | Addition to improve instructions. |
| 17 | 4 | Deleted | one the following  | Edit to clarify submission process. |
| 17 | 4 | Deleted | :  |   |
| 17 | 4 | Inserted |  selected above. [Text box] | Addition to improve instructions. |
| 17 | 16 | Deleted | Are any of the above measures outcome measures? [Y/N] |   |
| Edit to clarify submission process. |
|   |
| 17 | 18 | Inserted |  - D. National Quality Forum (NQF) number (if applicable) [Text box] | Addition to improve instructions. |
|  - E. MIPS measure identification number (if applicable) [Text box] | Addition to improve instructions. |
|   |   |
| 17 | 25 | Deleted |   |   |
| List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
| 18 | 1 | Inserted | For purposes of Other Payer Advanced APM determination, a | Addition to improve instructions. |
| 18 | 13 | Deleted | A | Edit to clarify submission process. |
| 18 | 24 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 19 | 18 | Deleted | Describe the participant eligibility criteria for | Edit to clarify submission process. |
| 19 | 18 | Inserted | Who participates in | Addition to improve instructions. |
| 19 | 19 | Deleted | . | C |
| 19 | 19 | Inserted |  (e.g. primary care physicians, specialty group practices, etc.)? | Addition to improve instructions. |
| 19 | 28 | Deleted |  All-Payer | Edit to clarify submission process. |
| 19 | 39 | Deleted | Nationwide [Y/N] | Edit to clarify submission process. |
|   |
| 16 | N/A | Inserted | Is this payment arrangement available through other lines of business? [Y/N] | Addition to improve instructions. |
| 17 | N/A | Deleted | Note that CMS will access the payer’s CMS Memorandum of Understanding or other relevant documentation for participation in the CMS Multi-Payer Model. | Edit to clarify submission process. |
| 20 | 11 | Inserted | 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. | Addition to improve instructions. |
|   |
|   |
| 20 | 20 | Deleted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
|   |
| 20 | 31 | Inserted | 2 | Addition to improve instructions. |
| 20 | 34 | Deleted | contain | Edit to clarify submission process. |
| 20 | 34 | Inserted | provide evidence of | Addition to improve instructions. |
| 20 | 35 | Deleted |  [TEXT BOX] | Edit to clarify submission process. |
| 20 | 36 | Inserted |   |   |
|   |
| 20 | 41 | Deleted | apply any | Edit to clarify submission process. |
| 20 | 41 | Inserted | tie payments to one or more | Addition to improve instructions. |
| 20 | 41 | Deleted |  that are comparable to MIPS quality measures as required by 42 CFR 414.1420(c)? [Y/N] | Edit to clarify submission process. |
|   |   |
| If yes, does | Edit to clarify submission process. |
| 20 | 44 | Inserted | , | Addition to improve instructions. |
| 20 | 44 | Deleted | quality measure have an evidence-based focus, is it reliable and valid, and does it meet at least one | Edit to clarify submission process. |
| 20 | 45 | Inserted | of which meets one or more | Addition to improve instructions. |
| 21 | 8 | Inserted |  (If so, please upload supporting documentation below) | Addition to improve instructions. |
| 21 | 10 | Deleted | A minimum of one  | Edit to clarify submission process. |
| 21 | 10 | Inserted | If the arrangement utilizes any other | Addition to improve instructions. |
| 21 | 10 | Inserted | measures, please submit here for CMS to determine if they have an evidence-based focus and are reliable and valid. | Addition to improve instructions. |
|   |   |
| Please upload a document using "Upload Document" or provide | Addition to improve instructions. |
| 21 | 14 | Inserted | information in the text box below. | Addition to improve instructions. |
|   |   |
| 2. Does the arrangement tie payments to one or more quality measures | Addition to improve instructions. |
| 21 | 17 | Deleted | meets the above criteria and  | Edit to clarify submission process. |
| 21 | 18 | Deleted |  is required in order to satisfy the Quality | Edit to clarify submission process. |
| 21 | 18 | Inserted | ? | Addition to improve instructions. |
| - Yes | Addition to improve instructions. |
| - No | Addition to improve instructions. |
|   |   |
| Add | Addition to improve instructions. |
| 21 | 22 | Deleted | Use criterion. Please provide the following information for each quality measure included in | Edit to clarify submission process. |
| 21 | 23 | Inserted | [“Add Measure” may be used as many times as | Addition to improve instructions. |
| 21 | 23 | Deleted | payment arrangement that you wish for CMS to consider for purposes of satisfying this criterion. [TEXT BOX FOR EACH MEASURE | Edit to clarify submission process. |
| 21 | 25 | Inserted | submitter wishes | Addition to improve instructions. |
| 21 | 27 | Inserted | A. | Addition to improve instructions. |
| 21 | 30 | Inserted |  [Text box] | Addition to improve instructions. |
| 21 | 31 | Deleted | MIPS measure identification number (if applicable) | Edit to clarify submission process. |
| National Quality Forum (NQF) number (if applicable) | Edit to clarify submission process. |
| If the measure is neither a MIPS measure nor a currently endorsed NQF measure, cite the scientific evidence and/or clinical practice guidelines that support the use of the measure. | Edit to clarify submission process. |
|   |   |
| 21 | 36 | Inserted | B. | Addition to improve instructions. |
| 21 | 36 | Inserted |  [y/n] | Addition to improve instructions. |
| 22 | 4 | Deleted | Are any of the above measures outcome measures? [Y/N] | Edit to clarify submission process. |
|   |
|   |
| 22 | 9 | Inserted | C. Describe how the measure has an evidence-based focus, is reliable and valid, by meeting one the following criteria: | Addition to improve instructions. |
| [Checkboxes] | Addition to improve instructions. |
|   |   |
| 22 | 21 | Inserted | 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. [Text box] | Addition to improve instructions. |
|   |   |
| This is an outcomes measure that does not meet any of the above criteria [Checkbox] | Addition to improve instructions. |
|   |   |
| Describe how the measure has an evidence-based focus, is reliable and valid, by meeting criteria selected above. [Text box] | Addition to improve instructions. |
|   |   |
|  - D. National Quality Forum (NQF) number (if applicable) [Text box] | Addition to improve instructions. |
|  - E. MIPS measure identification number (if applicable) [Text box] | Addition to improve instructions. |
|   |   |
|   |   |
| 22 | 37 | Deleted | List | Edit to clarify submission process. |
| 22 | 37 | Inserted |   |   |
| Does | Addition to improve instructions. |
| 22 | 38 | Deleted | attached document | Edit to clarify submission process. |
| 23 | 38 | Inserted | payment arrangement require the participating APM Entity to bear financial risk if actual aggregate expenditures exceed expected aggregate expenditures (i.e. benchmark amount)? [Y/N] | Addition to improve instructions. |
|   |   |
| If yes, which of the following actions does the payer take in cases where actual aggregate expenditures exceed expected aggregate expenditures? [CHECK BOX] | Addition to improve instructions. |
| Payer withholds payment of services to the APM Entity and/or the APM Entity’s eligible clinicians. | Addition to improve instructions. |
| Payer reduces payment rates to APM Entity and/or the APM Entity’s eligible clinicians. | Addition to improve instructions. |
| Payer requires direct payments by the APM Entity to the payer. | Addition to improve instructions. |
|   |   |
| Please describe the action | Addition to improve instructions. |
| 23 | 5 | Deleted | and page numbers | Edit to clarify submission process. |
| 23 | 5 | Inserted | checked above | Addition to improve instructions. |
| 23 | 5 | Deleted | contain the information required in this section. | Edit to clarify submission process. |
| 23 | 6 | Inserted | are taken by the payer in cases where actual aggregate expenditures exceed expected aggregate expenditures. | Addition to improve instructions. |
| 23 | 9 | Deleted | 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)? [Y/N]  | Edit to clarify submission process. |
|   |   |
| If yes, which of the following actions does the payer take in cases where actual aggregate expenditures exceed expected aggregate expenditures? [CHECK BOX] | Edit to clarify submission process. |
| Payer withholds payment of services to the APM Entity and/or the APM Entity’s eligible clinicians. | Edit to clarify submission process. |
| Payer reduces payment rates to APM Entity and/or the APM Entity’s eligible clinicians. | Edit to clarify submission process. |
| Payer requires direct payments by the APM Entity to the payer.  | Edit to clarify submission process. |
|   |   |
| Please describe the action(s) checked above that are taken by the payer in cases where actual aggregate expenditures exceed expected aggregate expenditures. [TEXT BOX] | Edit to clarify submission process. |
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| 23 | 26 | Deleted | A | Edit to clarify submission process. |
| 23 | 26 | Inserted | For purposes of Other Payer Advanced APM determination, a | Addition to improve instructions. |
| 23 | 37 | Deleted |   |   |
| List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Edit to clarify submission process. |
| 20 | N/A | Reinserted | List the attached document(s) and page numbers that contain the information required in this section. [TEXT BOX] | Addition to improve instructions. |
| 21 | N/A | Deleted  | **SECTION 3: Supporting Documentation**Please upload all supporting documentation here. Documents should be labeled for reference use throughout the form. | Edit to clarify submission process. |
| 21 | N/A | Inserted | I agree [Check box] | Addition to improve instructions. |
| 21 | N/A | Deleted | DATE | Edit to clarify submission process. |