

CMS Quality Payment Program

Submission Form for Requests for Qualifying Alternative Payment Model Participant (QP) Determinations under the All-Payer Combination Option (All- Payer QP Submission Form)

Welcome to the All-Payer QP Submission Form

Purpose

The All-Payer QP Submission Form (Form) may be used to request that CMS determine whether Eligible Clinicians are QPs under the All-Payer Combination Option of the Quality Payment Program (QPP) as set forth in 42 CFR 414.1425. This process is called the QP Determination Process. More information about QPP is available at <http://qpp.cms.gov/>.

The All-Payer Combination Option covers Eligible Clinicians, TINs, and APM Entities whose Medicare fee-for-service (FFS) QP threshold scores under the Medicare Option meet or exceed a certain minimum, but do not meet or exceed the threshold scores required to achieve QP status under the Medicare Option for a given year. This Form collects payment amount and patient count information on payers other than Medicare FFS, for purposes of calculating payment amount and patient count threshold scores under the All Payer Combination Option.

The charts below display the minimum Medicare FFS QP threshold scores and All-Payer Combination Option threshold scores that would make an Eligible Clinician, TIN, or APM Entity a QP or Partial QP under the All-Payer Combination Option.

Payment Amount Threshold Scores

Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

Patient Count Threshold Scores

Payment Year	2019	2020	2021		2022		2023		2024 and later	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

Eligible Clinicians, APM Entities, and TINs that meet neither the minimum payment amount nor the minimum patient count Medicare FFS threshold scores will not be evaluated for QP status under the All-Payer Combination Option. Clinicians who meet or exceed the Medicare FFS QP threshold scores using either the payment amount or the patient count methodology do not need the All-Payer Combination Option, as they are already QPs under the Medicare Option.

Which entity is submitting the Form? [dropdown: Eligible Clinician, TIN, or APM Entity]
This form should only be submitted at the TIN level if all NPIs that bill through the TIN participate in an Advanced APM through the TIN.

[If submitted by Eligible Clinician]

Eligible Clinicians requesting QP determinations must submit this Form no later than December 1 of the year of the QP Performance Period. CMS will not review Forms submitted after the Submission Deadline.

[If submitted by TIN]

TINs requesting QP determinations must submit this Form no later than December 1 of the year of the QP Performance Period. CMS will not review Forms submitted after the Submission Deadline.

[If submitted by APM Entity]

APM Entities requesting QP determinations must submit this Form no later than December 1 of the year of the QP Performance Period. CMS will not review Forms submitted after the Submission Deadline.

Additional Information

Because CMS has access to Medicare FFS claims data, [Eligible Clinicians/ TINs/ APM Entities] should not include Medicare FFS payments or patients in this Form. **Information must be submitted for each other payer from which the [Eligible Clinician/Eligible Clinicians participating in the TIN/Eligible Clinicians participating in the APM Entity] received payments for services provided during the Performance Period**, with the exception of the following payers:

- 1) The Secretary of Defense for the costs of Department of Defense health care programs;
- 2) The Secretary of Veterans Affairs for the cost of Department of Veterans Affairs health care programs; and
- 3) Title XIX, if the [Eligible Clinician/ TIN/ APM Entity] meets the criteria to have Title XIX payments and patients excluded from threshold score calculations. To determine whether the [Eligible Clinician/ TIN/ APM Entity] meets the criteria for Title XIX exclusion, please refer to the look-up tool at [hyperlink]. **If the [Eligible Clinician/TIN/APM Entity] does not meet the Title XIX exclusion criteria listed in the look-up tool, Title XIX data must be included in this Form.**

A single patient may be included under the numerator and/or denominator for multiple payers. For example, a patient whose primary insurance is a Medicare Advantage plan and whose secondary insurance is Medicaid should be included under both the Medicare Advantage plan and the Medicaid plan.

[Eligible Clinicians/TINs/APM Entities] may submit information on any or all of the three Snapshot Periods: January 1 through March 31, January 1 through June 30, or January 1 through August 31. Complete information for all relevant payers must be included for whichever Snapshot Period(s) the [Eligible Clinician/TIN/APM Entity] chooses to submit.

[If submitted by the Eligible Clinician]

The Eligible Clinician or an authorized agent of the Eligible Clinician may submit the Form on behalf of the Eligible Clinician. In submitting the Form, the submitter attests that he or she is qualified to make the assertions contained herein as the Eligible Clinician or an agent of the Eligible Clinician and that the assertions contained herein are true and accurate with respect to this Form.

[If submitted by the TIN]

The representative who submits the Form for the TIN must be an authorized agent of the TIN. In submitting the Form, the submitter attests that he or she is qualified to make the assertions contained herein as an agent of the TIN and that the assertions contained herein are true and accurate with respect to this Form.

[If submitted by the APM Entity]

The representative who submits the Form for the APM Entity must be an authorized agent of the APM Entity. In submitting the Form, the submitter attests that he or she is qualified to make the assertions contained herein as an agent of the APM Entity and that the assertions contained herein are true and accurate with respect to this Form.

[If determination is requested at the Eligible Clinician level]

CMS will review the Other Payer Advanced APM participation information in this Form to determine whether the Eligible Clinician meets the QP thresholds. If incomplete information is submitted and/or more information is required to make a determination, CMS will notify the Eligible Clinician and request the additional information that is needed. Eligible Clinicians must

return the requested information no later than 5 business days from the notification date. If the Eligible Clinician does not submit sufficient information within this time period, the Eligible Clinician will not be assessed for QP status through the All Payer Combination Option for that Performance Period. These determinations are final and not subject to reconsideration.

[If determination is requested at the TIN level]

CMS will review the Other Payer Advanced APM participation information in this Form to determine whether the Eligible Clinicians billing under the TIN meet the QP thresholds. If incomplete information is submitted and/or more information is required to make a determination, CMS will notify the TIN point of contact and request the additional information that is needed. The TIN point of contact must return the requested information no later than 5 business days from the notification date. If the TIN point of contact does not submit sufficient information within this time period, Eligible Clinicians participating in the TIN will not be assessed for QP status through the All Payer Combination Option for that Performance Period. These determinations are final and not subject to reconsideration.

[If determination is requested at the APM Entity level]

CMS will review the Other Payer Advanced APM participation information in this Form to determine whether the Eligible Clinicians participating in the APM Entity meet the QP thresholds. If incomplete information is submitted and/or more information is required to make a determination, CMS will notify the APM Entity and request the additional information that is needed. APM Entities must return the requested information no later than 5 business days from the notification date. If the APM Entity does not submit sufficient information within this time period, the Eligible Clinicians participating in the APM Entity would not be assessed for QP status through the All Payer Combination Option for that Performance Period. These determinations are final and not subject to reconsideration.

Notification

CMS will include the list of all Eligible Clinicians determined to be QPs for the QP Performance Period in a look-up tool on a CMS website.

Helpful Links:

- **QPP All-Payer QP Submission Form User Guide**
- **QPP All-Payer FAQs**
- **Glossary**

All Forms must be completed and submitted electronically.

This Form contains the following sections:

Section 1: [Eligible Clinician/TIN/APM Entity] Identifying Information

Section 2: Other Payer Advanced APM Participation Data

Section 3: Certification Statement

[Eligible Clinicians/TINs/APM Entities] must complete Sections 1 and 3. Section 2 includes options for submitting data for any of the three Snapshot Periods. [Eligible Clinicians/TINs/APM Entities] may submit information for any or all of the three Snapshot Periods. It is strongly recommended, though not required, that [Eligible Clinicians/TINs/APM Entities] submit both patient count and payment amount information for whichever Snapshot Period(s) they choose.

SECTION 1: [Eligible Clinician/TIN/APM Entity] Identifying Information

A. Point of Contact for this Form

1. Name: _____
2. Job Title: _____
3. Organization Name: _____
4. Email: _____
5. Confirm Email: _____
6. Phone Number: _____ Ext: _____
7. Address Line 1 (Street Name and Number): _____
 Address Line 2 (Suite, Room, etc.): _____
 City: _____ State: _____ Zip Code +4: _____

B. [If Eligible Clinician] Eligible Clinician Information

If an authorized representative is submitting information on behalf of multiple Eligible Clinicians, that authorized representative must complete this form separately for each Eligible Clinician.

1. Name of Eligible Clinician: _____
2. TIN(s) under which Eligible Clinician bills : _____
3. Eligible Clinician's NPI: _____
4. Advanced APM(s) in which Eligible Clinician participates [DROP DOWN LIST, allow multiple selections]
 - 4a. [For each Advanced APM selected] Model participation ID (if applicable): _____
[Help bubble text: This refers to the unique identifier that the Advanced APM has assigned to the APM Entity through which the Eligible Clinician participates. It is most often a short combination of letters and numbers (for example, V### or E#####). If you are unsure of your Model participation ID, please reach out to the point of contact for your Advanced APM.]
 - 4b. [For each Advanced APM selected] TIN through which Eligible Clinician participates in the Advanced APM: _____

4c. [For each Advanced APM selected] Name of the point of contact (e.g. Project Officer) for the APM Entity at CMS (optional):_____

[If TIN] TIN Information

1. TIN:_____

2. NPIs that bill through the TIN: _____
This form should only be completed at the TIN level if all NPIs that bill through the TIN participate in an Advanced APM through the TIN.

3. Advanced APM(s) in which the TIN participates [DROP DOWN LIST, allow multiple selections]

3a. [For each Advanced APM selected] Model participation ID:_____ *[Help bubble text: This refers to the unique identifier that the Advanced APM has assigned to the APM Entity through which the TIN participates. It is most often a short combination of letters and numbers (for example, V### or E#####). If you are unsure of your Model participation ID, please reach out to the point of contact for your Advanced APM.]*

3b. [For each Advanced APM selected] Name of the point of contact (e.g. Project Officer) for the APM Entity at CMS (optional):_____

[If APM Entity] APM Entity Information

1. Name of APM Entity:_____

2. All TIN(s) through which all NPIs in the APM Entity bill:_____

3. Advanced APM(s) in which the APM Entity participates [DROP DOWN LIST, allow multiple selections]

3a. Model participation ID:_____ *[Help bubble text: This refers to the unique identifier that the Advanced APM has assigned to the APM Entity. It is most often a short combination of letters and numbers (for example, V### or E#####). If you are unsure of your Model participation ID, please reach out to the point of contact for your Advanced APM.]*

3b. [For each Advanced APM selected] Name of the point of contact (e.g. Project Officer) for the APM Entity at CMS (optional):_____

[Note to include at the bottom of this section for APM Entities] CMS will use its internal records to determine the list of NPIs that participated in this APM Entity during the Performance Period.

SECTION 2: Other Payer Advanced APM Participation Data

Per statute, information for all payers through which the [Eligible Clinician/TIN/Eligible Clinicians participating in the APM Entity] bills/bill must be included, with the exceptions of Department of Defense health care programs, Department of Veterans Affairs health care programs and Title XIX if the [Eligible Clinician/ TIN/ APM Entity] meets Title XIX exclusion criteria.

*To determine whether the [Eligible Clinician/ TIN/ APM Entity] meets the criteria for Title XIX exclusion, please refer to the look-up tool at [hyperlink]. **If the [Eligible Clinician/TIN/APM Entity] does not meet the Title XIX exclusion criteria listed in the look-up tool, Title XIX data must be included in this Form.***

[Eligible Clinicians/TINs/APM Entities] may choose to submit information for any or all of the Snapshot Periods; you are not required to submit information for all three Snapshot Periods. In order to have a QP determination made for a Snapshot Period, you must enter information for every payer for that Snapshot Period.

Please note that CMS may validate your Other Payer Advanced APM participation information with the payers you include in this Form.

Add a Payer + [Button] [Users will enter the below information for each payer (or each discrete plan), and there is no limit on the number of payers (plans) for which they may enter information. After the information below has been entered for each payer, display a chart summarizing the payers entered so far, and allow users to press this button again to add another payer]

A. Payer Name: _____

B. Type of Payer [drop-down: Medicare health plan, Medicaid, Commercial, Other]

C. Did the [Eligible Clinician/TIN/APM Entity] participate in an Other Payer Advanced APM with this plan during the Performance Period (January 1 – August 31)? [Y/N]

C1. [If yes] Name of Other Payer Advanced APM:

Note: In order to select a payment arrangement as an Other Payer Advanced APM in this Form, that payment arrangement must have been submitted for an Other Payer Advanced APM determination through either the Payer- or Eligible Clinician-Initiated Processes. If your payment arrangement is not in this list, please submit an Other Payer Advanced APM determination request using the Eligible Clinician-Initiated Process. The deadline to submit Other Payer Advanced APMs through the Eligible Clinician-Initiated Process is November 1; you may not submit additional determination requests after that date. Upon submitting the Other Payer Advanced APM determination request for a payment arrangement, that payment arrangement will appear in this list. Please note that inclusion in this list does not indicate that a payment arrangement has been determined to be an Other Payer Advanced APM; it

merely indicates that it has been submitted for an Other Payer Advanced APM determination.

You may select more than one Other Payer Advanced APM per plan.

[drop-down of Other Payer Advanced APMs]

C3. [If yes, for each Other Payer Advanced APM] Name of the payer point of contact for the Other Payer Advanced APM (if available): _____

C4. [If yes, for each Other Payer Advanced APM] Phone number of the payer point of contact for the Other Payer Advanced APM: (if available) _____

C5. [If yes, for each Other Payer Advanced APM] Email address of the payer point of contact for the Other Payer Advanced APM: (if available) _____

[If no: no follow-up question; skip question C and go straight to question E]

D. [If answer to C was yes] What is the number of unique patients to whom the [Eligible Clinician/TIN/APM Entity] furnished services that are under the terms of this Other Payer Advanced APM during the Snapshot Period?

Services are considered to be under the terms of the Other Payer Advanced APM if they are included in the measures of aggregate expenditures used by the Other Payer Advanced APM. [Eligible Clinicians/TINs/Advanced APMs] may enter information for any or all of the Snapshot Periods. A unique patient may be included in multiple Snapshot Periods; in other words, a patient who is included in the first Snapshot Period should also be included in the second and third Snapshot Periods.

D1. First Snapshot Period (January 1 – March 31): _____

D2. Second Snapshot Period (January 1 – June 30): _____

D3. Third Snapshot Period (January 1 – August 31): _____

E. What is the total number of unique patients to whom the [Eligible Clinician/TIN/APM Entity] furnished services under this payer during the Snapshot Period?

[Eligible Clinicians/TINs/Advanced APMs] may enter information for any or all of the Snapshot Periods. The total number of unique patients submitted for a Snapshot Period in this section (E) should meet or exceed the number of unique patients submitted for the same Snapshot Period in the previous section (D).

E1. First Snapshot Period (January 1 – March 31): _____

E2. Second Snapshot Period (January 1 – June 30): _____

E3. Third Snapshot Period (January 1 – August 31): _____

F. [If answer to C was yes] What is the aggregate amount of all payments from this payer attributable to the [Eligible Clinician/TIN/APM Entity] under the terms of the Other Payer Advanced APM during the Snapshot Period?

[Eligible Clinicians/Advanced APMs] may enter information for any or all of the Snapshot Periods]

F1. First Snapshot Period (January 1 – March 31): _____

F2. Second Snapshot Period (January 1 – June 30): _____

F3. Third Snapshot Period (January 1 – August 31): _____

G. What is the aggregate amount of all payments from this payer to the [Eligible Clinician/TIN/APM Entity] during the Snapshot Period?

[Eligible Clinicians/TINs/Advanced APMs] may enter information for any or all of the Snapshot Periods. The total amount of payments submitted for a Snapshot Period in this section (G) should meet or exceed the amount of payments submitted for the same Snapshot Period in the previous section (F)

G1. First Snapshot Period (January 1 – March 31): _____

G2. Second Snapshot Period (January 1 – June 30): _____

G3. Third Snapshot Period (January 1 – August 31): _____

SECTION 3: Certification Statement

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to bind the [Eligible Clinician/TIN/APM Entity]. I further certify that the information contained herein is true, accurate, and complete, and I authorize the Centers for Medicare & Medicaid Services (CMS) to verify this information. If I become aware that any information in this Form is not true, accurate, or complete, I will notify CMS of this fact immediately. I understand that the knowing omission, misrepresentation, or falsification of any information contained in this document or in any communication supplying information to CMS may be punished by criminal, civil, or administrative penalties, including fines, civil damages and/or imprisonment.

I agree [Check box]

AUTHORIZED INDIVIDUAL NAME, TITLE, [ELIGIBLE CLINICIAN/TIN/APM ENTITY NAME]

QP Submission Form Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) is authorized to collect the information requested on this Form by sections 1833(z)(2)(B)(ii) and (z)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395l).

The purpose of collecting this information is to determine whether the [Eligible Clinician/Eligible Clinicians participating in the Advanced APM] [is/are] [a QP/QPs] as set forth in 42 C.F.R. 414.1425 for the relevant All-Payer QP Performance Period.

The information in this request will be disclosed according to the routine uses described below. Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud and abuse;
2. A congressional office in response to a subpoena;
3. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
4. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this Form is protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this request (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. 552(b)(4) and/or (b)(6), respectively.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is XXXX-XXXX (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications,

claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QPP@cms.hhs.gov.