

All-Payer Clinician Initiated Submission Form 2019 Finalized vs 2020 Finalized

Burden Impact: There are no impacts to burden as a result of any changes to this form from the previous version.

Page	Line	Final Rule 2019	Final Rule 2020	Reason for Change
1	11		(or their authorized representatives)	Edited for clarity.
1	25		Note: This Form should only be used when a clinician's payment arrangement does not already appear on the CMS list of approved Other Payer Advanced APMs on the QPP website (https://qpp.cms.gov/about/resource-library). If a payment arrangement in which a clinician participates has already been approved by CMS, the clinician does not need to complete this form. Additionally, this form is different from the QPP clinician data submission process, whereby clinicians submit their actual payment and patient data for purposes of Qualified APM Participant (QP) determination. That process occurs near the end of the calendar year in which a clinician participates in a payment arrangement.	Edited for alignment with finalized requirement.
1	38		This form and the current Eligible Clinician Initiated Process pertain to payment arrangements implemented in calendar year 2019.	Alignment with current year.
2	36		Instructions for Submitting and Completing this Form In addition to APM Entities and Eligible Clinicians, those authorized to report on behalf of APM Entities and Eligible Clinicians may complete this form.	Edited for clarity.
2	45	e	E	Edited for clarity.
2	45	c	C	Edited for clarity.
3	15	3	2	Edited for clarity.

3	16	2	3	Edited for clarity.
3	17	2	3	Edited for clarity.
3	18	2	3	Edited for clarity.
3	33	.	Select "Start a New Submission Form" to begin	Edited for clarity.
4	22	Are you reporting on behalf of more than one Eligible Clinician (but not an APM Entity)? [Y/N] If yes, complete this section for each Eligible Clinician for whom you are reporting.		Alignment with current year.
4	28	and		Edited for clarity.
4	30	participating in the payment arrangement.		Edited for clarity.
4	33		[TEXT BOX FOR EACH TIN]	Alignment with current year.
4	34	_____		Edited for clarity.
5	19		SECTION 2: Supporting Documentation Please attach documentation that supports responses to the questions asked in Information for Other Payer Advanced APM Sect of this Form. Supporting documents may include contracts or excerpts of contracts between you and the health plan, or alternative comparable documentation that supports responses to the questions asked in sections below. Note: Please upload all documents that you will reference when completing this submission to the Supporting Document section of this Form, and label each document for reference for reference throughout the form.	Edited for clarity.

			<p>For Medicaid submissions, CMS will use existing Medicaid documentation in the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process as applicable. The following question will also be asked:</p> <p>Optional: Is information about this payment arrangement included in a State Plan Amendment (SPA), Section 1115 demonstration waiver application, Special Terms and Conditions document, implementation protocol document, or other document describing the 1115 demonstration arrangement approved by CMS? [Y/N/Don't Know]</p> <p>[Upload Document button asking for File Name and Description]</p>	
5	41	2	3	Edited for clarity.
5	43	2	3	Edited for clarity.
6	6	<p>Payment Arrangement Documentation</p> <p>Please attach documentation that supports responses to the questions asked in Sections D (CMS Medicaid Medical Home Model Determination) and E (Information for Other Payer Advanced APM Determination) of this Form. Supporting documents may include contracts or excerpts of contracts between you and the Medicaid managed care plan, contracts or excerpts of contracts between you and the State Medicaid agency, or alternative comparable documentation that supports responses to the questions asked in Sections</p>		Edited for clarity.

		<p>D and E below.</p> <p>Note: Please upload all documents that you will reference when completing this submission to the Supporting Documentation section of this Form, and label each document for reference throughout the Form.</p> <p>CMS will use existing Medicaid documentation in the APM Entity or Eligible Clinician Initiated Other Payer Advanced APM Determination Process as applicable.</p> <p>Optional: Is information about this payment arrangement included in a State Plan Amendment (SPA), Section 1115 demonstration waiver application, Special Terms and Conditions document, implementation protocol document, or other document describing the 1115 demonstration arrangement approved by CMS? [Y/N/Don't Know]</p>		
6	29		<p>This section includes payment arrangements that the State uses in Medicaid Fee-For-Service, payment arrangements the State requires Medicaid managed care plans to effectuate, and payment arrangements that Medicaid managed care plans and providers voluntarily enter without State involvement.</p>	<p>Edited for clarity.</p>
6	38		<p>If questions about the payment arrangement arise during the processing of this request, CMS may contact the health plan or state for clarification.</p>	<p>Edited for clarity.</p>
7	1	<p>If questions about the payment arrangement arise during the processing of this request,</p>		<p>Edited for clarity.</p>

		CMS may contact the Health Plan or State for clarification.		
7	4	[OPTIONAL] Select the CMS Multi-Payer Model with which this payment arrangement is aligned, if applicable: [DROP DOWN LIST]	Who participates in this payment arrangement (e.g., primary care physicians, specialty group practices)? [TEXT BOX]	Edited for clarity.
7	17		Is this payment arrangement available through other lines of business? [Y/N]	Alignment with current year.
7	33	Describe the participant eligibility criteria for this payment arrangement. [TEXT BOX]		Alignment with current year.
8	3	Medicaid Fee-For-Service? [Y/N]		Alignment with current year.
8	6	Is this payment arrangement available through a Medicaid managed care plan? [Y/N]	[Medicaid FFS/Medicaid managed care plan]	Edited for clarity.
8	8		to Medicaid managed care plan	Edited for clarity.
8	15		In what county do you see the greatest number of patients? [TEXT BOX]	Alignment with current year.
8	20	Medicaid Medical Home Model means a payment arrangement under Title XIX that CMS determined by the following characteristics.		Edited for clarity.
8	26	E	D	Edited for clarity.
8	28	contain	provide evidence of	Edited for clarity.
8	35	CHECK	Menu Selection	Edited for clarity.
9	29	you	the APM Entity	Edited for clarity.

9	33		, which many include expected expenditures	Edited for clarity.
10	25		For the purposes of this form, the APM Entity is the practitioner, or group of practitioners, that participates in this payment arrangement.	Edited for clarity.
10	27		/Don't Know	Edited for clarity.
10	29	If the submitter type is Eligible Clinician, please describe how the CEHRT requirement applies at the individual level. [Text Box]	Does the payment arrangement require you use CEHRT as defined in 42 CFR 414.1305?	Edited for alignment with finalized requirement.
10	31		[Y/N]	
10	40	the payment arrangement apply any quality measures that are comparable to MIPS quality measures as required by 42 CFR 414.1420(c),	Does the payment arrangement tie payments to one or more quality measures, at least one of which meets the following criteria (42 CFR 414.1420(c))? [Y/N] the quality measures have an evidence base focus, is it reliable and valid, and does it	Edited for alignment with finalized requirement.
10	42	which		Edited for clarity.
10	42	s		Edited for clarity.
11	3	If the arrangement uses any other quality measures not already meeting the criteria above, add those measures using the Add Measure button below and cite the relevant scientific evidence and/or clinical practice guidelines that support the use of the measure in order for CMS to determine if they have an evidence-based focus and are reliable and valid	Please provide the following information for each quality measure included in the payment that you wish for CMS to consider for purposes of satisfying this criteria.	Edited for alignment with finalized requirement.
11	9	Please upload any supporting documents using "Upload Document" or provide measure information in the text box below. [Upload document button and text box]		Edited for clarity.
11	15	Does the arrangement tie payments to one or more quality measures that is an outcome measure? [Y/N]	Are any of the above outcome measure? 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 criteria. [Y/N]	Edited for alignment with finalized requirement.

		If no, check here if no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure final list. [Check Box]	If no, check here to confirm no outcomes measures that are relevant to this payment arrangement are available on the MIPS quality measure list. [Check Box] List the attached document(s) and page numbers that contained the information required in this section. [TEXT BOX]	
11	33	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.		Edited for clarity.
13	21	all	in each APM Entity or Eligible Clinician in the payment arrangement	Edited for clarity.
13	23	entity		Edited for clarity.
13	25		OR	Edited for clarity.
13	27	you or your participating entity are	an APM Entity or Eligible Clinician	Edited for clarity.
13	27	is		Edited for clarity.
13	36	2	3	Edited for clarity.
14	10	[OPTIONAL] Select the CMS Multi-Payer Model with which this payment arrangement is aligned, if applicable: [DROP DOWN LIST]		Edited for alignment with finalized requirement.
14	13		Locations where this payment arrangement will be available: [Drop down menu of States] Is this payment arrangement available through other lines of business? [Yes, No, Don't know]	Edited for alignment with finalized requirement.
14	31	select the QP performance periods		

14	31	state the last performance year through	for	Edited for alignment with finalized requirement.
14	32	you are requesting the multi-year determination	this payment arrangement determination is being made	Edited for clarity.
15	1	<p>Is this payment arrangement part of: {DROP DOWN LIST}</p> <p>Medicare Health Plan [including Local Coordinated Care Plans, Regional Coordinated Care Plans, Medicare Private Fee-for-Service Plans, Medicare Medical Savings Account Plans, Medicare-Medicaid Plans, 1876 and 1833 Cost Plans, and Programs of All Inclusive Care for the Elderly (PACE) plans]</p> <p>Commercial or Private Payer Plans</p>		Edited for alignment with finalized requirement.
15	14	<p>Payment Arrangement Documentation</p> <p>Please attach documentation that supports responses to the questions asked in Section C (Information for Other Payer Advanced APM Determination) of this Form. Supporting documents may include contracts or excerpts of contracts between you and the payer, or alternative comparable documentation that supports responses to the questions asked in Section C below.</p> <p>Upload all documents to the Supporting Documentation section of this Form, and label each document for reference throughout the Form.</p> <p>For CMS Multi-Payer Models, please include</p>		Edited for alignment with finalized requirement.

		your CMS Multi-Payer Model Participation Agreement in Supporting Documentation.		
15	34	to document and communicate clinical care as required by 42 CFR 414.1420(b)		Edited for alignment with finalized requirement.
15	37	the submitter type is Eligible Clinician, please describe how the	No, does this payment arrangement require you to use as defined in 42 CFR 414.1305 to document and communicate clinical care?	Edited for alignment with finalized requirement.
15	39	requirement applies at the individual level. [TEXT BOX]	[Y/N]	Edited for alignment with finalized requirement.
16	19	Please upload any supporting documents using "Upload Document" or provide measure information in the text box below. [Upload document button and text box]		Edited for alignment with finalized requirement.
16	27	Please provide the following information for each quality measure included in the payment that you wish for CMS to consider for purposes of satisfying this criteria.		Edited for alignment with finalized requirement.
17	1	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.		Edited for alignment with finalized requirement.
17	14	Does the arrangement tie payments to one or more quality measures that is an	Are any of the above 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 criteria.	Edited for clarity.
17	20	if	to confirm	Edited for clarity.
17	21	final		Edited for clarity.
17	23		List the attached document(s) and page numbers that contained the information required	Edited for clarity.

			in this section. [TEXT BOX]	
17	29	you or your participating entity	the participation APM Entity or Eligible Clinician	Edited for clarity.
18	8		Payment arrangement documentation is required to support the answers provided above.	Edited for clarity.
18	9	List the	Please note the	Edited for clarity.
18	9	e		Edited for clarity.
18	10	required in this section	is	Edited for clarity.
18	16	you are	an APM Entity	Edited for clarity.
18	16	is		Edited for clarity.
18	24	you or your participating entity	an APM Entity or Eligible Clinician	Edited for clarity.
18	32	all ...in your	in each APM Entity or Eligible Clinician	Edited for clarity.
18	33	entity	in the payment arrangement	Edited for clarity.
18	36		OR	Edited for clarity.
18	38	you or your participating entity are	an APM Entity or Eligible Clinician	Edited for clarity.
18	38		is	Edited for clarity.
18	40	you	an APM Entity or Eligible Clinician	Edited for clarity.
18	46	SECTION 3: Supporting Documentation		Edited for clarity.
19	2	Please upload all supporting documentation here. Documents should be labeled for reference use throughout the Form.		Edited for clarity.
19	18	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	I understand that any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil	Edited for alignment with finalized requirement.

		administrative penalties, including fines, civil damages and/or imprisonment.	penalties.	
20	5	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 understand that any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.	Edited for alignment with finalized requirement.
20	39	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 understand that any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.	Edited for alignment with finalized requirement.
21	15	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 understand that any person who knowingly files a statement of claim containing any false, incomplete, or misleading information, may be guilty of a criminal act punishable under Federal and state law and may be subject to civil penalties.	Edited for alignment with finalized requirement.