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

Performance Year	**2023 and beyond Total**	**2023 and beyond Medicare Minimum**
QP Payment Amount Threshold	75%	25%
Partial QP Payment Amount Threshold	50%	20%

Patient Count Threshold Scores

Performance Year	**2023 and beyond Total**	**2023 and beyond Medicare Minimum**
QP Patient Count Threshold	50%	20%
Partial QP Patient Count Threshold	35%	10%

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.

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, or APM Entity meets the criteria to have Title XIX payments and patients excluded from threshold score calculations. Eligible Clinicians, TINs, or APM Entities whose primary practice is in any of the following locations, are required to submit their Title XIX payments and patient data. Eligible Clinicians, TINs, and APM Entities may exclude their Title XIX payment and patient data.

XIX Table:

State of Primary Practice	County of Primary Practice
Massachusetts	All Counties
Ohio	All Counties
Tennessee	All Counties
Washington	All Counties

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.

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

- Glossary

All Forms must be completed and submitted electronically.

This Form contains the following sections:

Section 1: Submitter Type
Section 2: Participant Identifying Information
Section 3: Other Payer Advanced APM Participation Data
Section 4: Certification Statement

SECTION 1: Submitter Type

Select one of the following:

1. **APM Entity** [CHECK BOX]
   APM Entity means an entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.

2. **Eligible Clinician(s)** [CHECK BOX]
   Eligible clinician means "eligible professional" as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following:
   ---I. A physician.
   ---ii. A practitioner described in section 1842(b)(18)(C) of the Act.
   ---iii. A physical or occupational therapist or a qualified speech-language pathologist.
   ---iv. A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

3. **TIN Level** [CHECK BOX]
   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.

SECTION 2: Participant [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. Business 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. Confirm NPI: _____

[If TIN] TIN Information

1. TIN Legal Entity Name:_____
2. Tax Identification Number: _____
3. Retype TIN:_____

[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. Retype TINs:_____

Note: CMS will use its internal records to determine the list of NPIs that participated in this APM Entity during the Performance Period.

SECTION 3: Other Payer Advanced APM Participation Data

Per statute, information for <u>all payers</u> 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. Information on Medicare FFS or participation in Medicare Advanced APMs should not be submitted.

Eligible Clinicians, TINs, and APM Entities must choose a specific Snapshot Period for submitting data. This period must match the same timeframe for the Medicare Advanced APM in which you participate. 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.

Snapshot Period

Please select the Snapshot Period for which you are submitting data for the 2024 QP Performance Period. Note, this Snapshot Period should be the same as the Medicare FFS Snapshot Period data you choose to be used in the All-Payer QP Calculation. If you have not achieved QP status based on any Medicare snapshot, we will assess your performance using the All-Payer Combination Option base on the snapshot you select:

[Drop down menu]

1. January – March
2. January – June
3. January – August

Work Sheet for Data Submission

[Instructions provided for downloading and uploading an Excel Spreadsheet for entering required data. Users will enter the information for each payment arrangement with each payer or discreate plan from which they have received payment for serviced during the snapshot period selected.]

*In the **Participant Identification** section of the QPP All Payer Submission Form, you selected whether your submission is at the APM Entity, Eligible Clinician, or TIN level. In Section [#], you indicated the **"Snapshot Period"** for which you are submitting data. Data reported in this worksheet MUST be reported at the level you indicated in the "Submitter Type" field and for the "Snapshot Period" you indicated in Section [#]. For example, if you selected "TIN level" as your submitter type and the "Second Snapshot" as the period for which you are submitting data, please enter in all payment arrangements under which your TIN received payments during the Second Snapshot (January 1, 2024-June 30, 2024).*

This form may be completed by [the eligible clinician/an eligible clinician in your TIN/an eligible clinician in your APM Entity] or by an authorized individual on behalf of the [eligible clinician/TIN/APM Entity. Examples of authorized individuals include (but are not limited to) practice manager, financial analyst/ manager, and accountant.

Note: The TIN reporting option may only be used by TINs participating in the Medicare Shared Savings Program.

The following information must be submitted in each row of the worksheet for which an entry is made:

A. Payment Arrangement Name [Drop down list of previously determined Other Payer Advanced APMs; or free text]:_____

B. Payment Arrangement Identifier [drop-down: Identifiers of previously determined Other Payer Advanced APMs; or free text] _____

C. Payer Name:_____

D. Type of Payer (e.g., Medicare Advantage, Medicaid):_____

E. Payment Arrangement Point of Contact Name:_____

F. Payment Arrangement Point of Contact Phone: _____

G. Total Payments:_____

Enter the total payments received (in dollars) under the terms of the payment arrangement you entered in column A. The data entered into this field should be based on the "Snapshot Period" you selected in Section [#] of the QPP All Payer Submission Form and at the same level as the Participant Identification you selected in the QPP All Payer Submission Form. For example, if you indicated in the QPP All Payer Submission Form that your submission was for the Second Snapshot and your Submitter Type was "TIN level," the dollar amount you enter in this field should be the total payments that the TIN received under the payment arrangement during the Second Snapshot (January 1, 2024-June 30, 2024).

Drug costs should be included in the reported total payments IF the payment arrangement includes drug costs. If drug costs are not included in the payment arrangement, drug costs should not be reported as part of total payments.

H. Total Patients:_____

On the Data Collection Worksheet tab, enter the number of unique patients furnished services under the terms of the payment arrangement you entered in column A. The data entered into this field should be based on the "Snapshot Period" you selected in Section [#] of the QPP All Payer Submission Form and at the same level as the "Submitter Type" you selected in the QPP All Payer Submission Form. For example, if you indicated in the QPP All Payer Submission Form that your submission was for the Second Snapshot and your Submitter Type was "TIN level," the number you enter in this field should be the total number of unique patients to whom the TIN furnished services under the payment arrangement during the Second Snapshot (January 1, 2024-June 30, 2024).

To determine which patients should be counted, please include only those that are included in the measure of total payments you reported for the payment arrangement. Note that this is a count of unique patients NOT a count of unique visits (i.e., one patient with two visits under the same payment arrangement will be counted only once.)

SECTION 4: 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 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.

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 0938-1314 (Expiration date: 01/31/2025). 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 at qpp@cms.hhs.gov.