OMB control number: 0938-134
Expiration Date: 02/28/2027

2024 Qualifying APM Participant (QP) Performance Period Partial QP Election Form

Dear [APM_Entity_Name]:

Based on CMS' QP threshold calculations for performance year 2024 (payment adjustment year 2026), there are eligible clinicians in «APM_Entity_Name» that are Partial QPs. Accordingly, [APM_Entity_Name] is to elect whether to report to MIPS. If [APM_Entity_Name] elects to report to MIPS, all MIPS eligible clinicians in [APM_Entity_Name] that are Partial QPs will be subject to the MIPS reporting requirements and payment adjustments for that year. To elect to report or not report to MIPS, [APM_Entity_Name] is to complete and submit this election form accordingly to QualityPaymentProgramAPMHelpdesk@cms.hhs.gov no later than March 31, 2025.

In the absence of making an explicit election, the MIPS eligible clinicians in [APM_Entity_Name] will not participate in MIPS. Therefore, the Partial QPs in [APM_Entity_Name] will participate in MIPS and receive a corresponding MIPS payment adjustment only if the APM Entity elects for the eligible clinicians to participate in MIPS.

If [APM_Entity_Name] elects not to report to MIPS, the clinicians can still report to MIPS though they will not be subject to the MIPS payment adjustment. This election is only applicable to performance year 2024 (payment adjustment year 2026). If you have questions, please contact QualityPaymentProgramAPMHelpdesk@cms.hhs.gov.

Election Form

Please indicate whether [APM_Entity_Name] elects to report to MIPS by putting an "X" by one of the options listed below:

☐ [APM_Entity_Name] **elects** to report to MIPS.
☐ [APM_Entity_Name] **elects not** to report to MIPS.

Signature

I certify that I am legally authorized to bind [APME] to this election.

Signature: _____ **Print Name:** _____
Title: _____ **Date:** _____

Please email the selected and signed form to QualityPaymentProgramAPMHelpdesk@cms.hhs.gov by March 31, 2025.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), 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: 2/28/2027). This information collection is the tool to be used to request that CMS determine whether Eligible Clinicians are partial QPs under the All-Payer Combination Option of the Quality Payment Program (QPP) as set forth in 42 CFR 414.1425. The time required to complete this information collection is estimated to average .25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is voluntary and all information collected will be kept private in accordance with regulations at 45 CFR 155.260, Privacy and Security of Personally Identifiable Information. Pursuant to this regulation, CMS may only use or disclose personally identifiable information to the extent that such information is necessary to carry out their statutory and regulatory mandated functions. 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, MD 21244-1850. If you have questions or concerns regarding where to submit your documents, please contact QPP at qpp@cms.hhs.gov.

Under the Privacy Act of 1974 (5 U.S.C. 552a) any personally identifying information obtained will be kept private to the extent of the law.