

A Guide to Submitting Participation Data for Qualifying Alternative Payment Model Participant (QP) Determinations under the All-Payer Combination Option

2021 All-Payer Data Submission Form

Purpose

The Advanced Alternative Payment Model (APM) Program gives eligible clinicians two ways to become Qualifying Alternative Payment Model Participants (QPs):

- 1) the Medicare APM Option, which takes into consideration their participation in Medicare APMs; and
- 2) the All-Payer Combination Option, which takes into consideration their participation in Other Payer Advanced APMs as well as Medicare Advanced APMs.

Eligible clinicians can become QPs through the All-Payer Combination Option (the second of these options) during performance year 2021 (January 1, 2021 to December 31, 2021). To attain QP status under the All-Payer Combination Option, eligible clinicians must:

- 1) participate in a combination of Advanced APMs via Medicare fee-for-service (FFS) as well as Other-Payer Advanced APMs to a sufficient extent; and
- 2) submit required payment amount and patient count information to the Centers for Medicare & Medicaid Services (CMS).


The purpose of this document is to guide APM entities and eligible clinicians through the process of submitting payment amount and patient count data (requirement 2) for consideration under the All-Payer Combination Option of the QPP program (as set forth in 42 CFR 414.1425).

Please use this document in combination with the following resources:

- [Salesforce Portal](#)
- [All-Payer Advanced Alternative Payment Models \(APM\) Option](#)

A determination of the Other Payer Advanced APMs' eligibility is performed by CMS under a separate review process. For Other Payer Advanced APM determinations, CMS accepts submissions from both payers (Payer Initiated Process) and eligible clinicians (Eligible Clinician Initiated Process). CMS will review the contractual arrangements submitted by potential Other





Payer Advanced APMs and will determine if they meet the required criteria. These reviews are conducted separately from the QP determination process.¹

Overview of the All-Payer Data Submission Process

The All-Payer Combination Option data submission process allows eligible clinicians, TINs, and APM Entities to submit data on their participation in Other Payer Advanced APMs. As noted above, CMS will make determinations regarding which other payer payment arrangements qualify as Other Payer Advanced APMs based on the submission of payers prior to each QP performance period (January 1, 2021 through August 31, 2021). Once those determinations have been made, CMS will post a list of Other Payer Advanced APMs on the [QPP website](#). Similarly, CMS will also make determinations regarding Other Payer Advanced APMs based on submissions from APM Entities and eligible clinicians after each QP Performance Period.

In order to be considered for the All-Payer Combination Option, the eligible clinician, APM Entity, or TIN must:

- Have Medicare fee-for-service (FFS) QP threshold scores under the Medicare Advanced APM Option that meet or exceed the required minimum;
- But not meet or exceed the threshold scores required to achieve QP status under the Medicare Advanced APM Option.

See Tables 1 and 2 below for QPP All-Payer Combination Option QP thresholds and required Medicare minimum thresholds.

If these criteria are met, the submitter will be considered for QP status under the All-Payer Combination Option. This data submission system, provided through the “All Payer Data Submission Form – 2021” (“Form”) link on the Welcome page, collects payment amount and patient count information from the payment arrangements with payers other than Medicare FFS, for purposes of calculating payment amount and patient count threshold scores under the All Payer Combination Option.² All submitters requesting QP determinations must submit this form/data **no later than December 1** of the year of the QP Performance Period. CMS will not review Forms submitted after the submission deadline.

¹ For additional information regarding how to submit for an Other Payer Advanced APM determination, please refer to the following guidance documents: <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/0/All%20Payer%20Eligible%20Clinician%20Submission%20Form.pdf>


² More information on the Medicare and Other Payer thresholds can be found on page 10-11 of this document at this link: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/133/QPP%20All-Payer%20External%20FAQ_Remediated_2018%2004%2020.pdf

Table 1: QP Payment Amount Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method																
Performance Year	2017	2018	2019		2020		2021		2022		2023		2024		2025 and later	
Payment Year	2019	2020	2021		2022		2023		2024		2025		2026		2027 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	50%	25%	50%	25%	50%	25%	50%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Table 2: QP Patient Count Thresholds – All-Payer Combination Option

All-Payer Combination Option – Patient Count Method																
Performance Year	2017	2018	2019		2020		2021		2022		2023		2024		2025 and later	
Payment Year	2019	2020	2021		2022		2023		2024		2025		2026		2027 and later	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	35%	35%	20%	35%	20%	35%	20%	35%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	25%	25%	10%	25%	10%	25%	10%	25%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Total	Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare



On December 27, 2020, the Consolidated Appropriations Act, 2021 was signed into law. Under this law, the QP thresholds for performance years 2021 and 2022/payment years 2023 and 2024 were frozen at 50% for the payment amount threshold and 35% for the patient count threshold. The partial QP thresholds were also frozen at the same levels used for the 2020 performance year/2022 payment year. In December 2022 and March 2024, Congress announced additional updates and froze the QP payment amount and patient count thresholds for participation in Advanced APMs at 50% and 35%, respectively, through performance year 2024/payment year 2026.

The Form

The All-Payer Data Submission Form (the Form) will be submitted electronically through an online Salesforce portal. APM entities, TINs, and eligible clinicians begin by clicking on the “Other-Payer Advanced APM Determination request” link on the All-Payer Advanced Alternative Payment Models (APMs) Option [webpage](#). Upon clicking this link, first time users will be prompted to register. To do so, the users will need to create a password. The password must be at least 8 characters, use a mix of numbers, uppercase and lowercase letters, and include at least one of the following special characters: ! # \$ % - _ = + < >.


Save all work in Salesforce before navigating away from each page, as any unsaved work will be lost. Note that the application will time out after 30 minutes of inactivity. Please contact the Salesforce help desk (CMMIForceSupport@cms.hhs.gov) for assistance with access or use issues.

The screenshot shows the CMS.gov logo at the top, with the text "Centers for Medicare & Medicaid Services" below it. The main heading is "CMS Quality Payment Program (QPP) All-Payer Submission Form". Below this is a "Login" section with a user icon. The form includes fields for "Username" and "Password", with an example username "John.Doe@cms.hhs.gov.qpp". A blue "Login" button is present, along with links for "Register Here!" and "Forgot Password?". A security notice states: "Per CMS security protocol, passwords can only be reset once within a 24 hour timeframe." Below this, contact information for technical support is provided: "If you need Help Desk support for Technical issues, please contact: CMMIForceSupport@cms.hhs.gov or call 1-888-734-6433, option 5." For program issues, the contact is: "If you need Help Desk support for Program issues, please contact: QPP@cms.hhs.gov". At the bottom, a section titled "The Information System:" contains a privacy and security notice and a disclaimer: "Unauthorized or improper use of this system is prohibited and may result in disciplinary action and/or civil and criminal penalties."

Once inside the CMS Portal, submitters must complete Sections 1 through 4.

The form contains the following sections, which are described in detail in the following pages:

- [Section 1: Welcome Page – Home \(Submitter type\)](#): The purpose of this section is to provide basic information on the All-Payer QP calculation process, initiate the data submission process, and identify the type of submitter (i.e. APM Entity, TIN, or individual clinician).
- [Section 2: Participant Identifying Information](#): The purpose of this section is to obtain identify information on the submitter, including names and identifying provider numbers (e.g., NPI).
- [Section 3: Other Payer Advanced APM Participation Data](#): The purpose of this section is for the submitter to provide all relevant data for the All-Payer QP calculation. This would include patient count and/or payment amount from all other



payers with whom the submitter has contracts. The submitter will also select the QP snapshot period for which they will be submitting data.

- [Section 4: Certification Statement](#): This section requires the authorized individual who is submitting information to certify to the best of his or her knowledge that all information submitted to CMS is true, accurate, and complete.

Section 1: Welcome Page – Home

Decision Tree

The “All-Payer Eligibility Decision Tree” helps submitters determine their eligibility for this option. Follow the prompts on the decision tree to determine if the All-Payer QPP data submission form is right for you.

1. Are you a Medicare provider?

- a. If you answer No, you are not eligible to participate in the CMS Quality Payment Program.
- b. If you answer Yes, you can move on to the next question.

2. Are you a Medicare Advanced Alternative Payment Model participant?

The decision tree diagram then provides a list of all qualifying models.

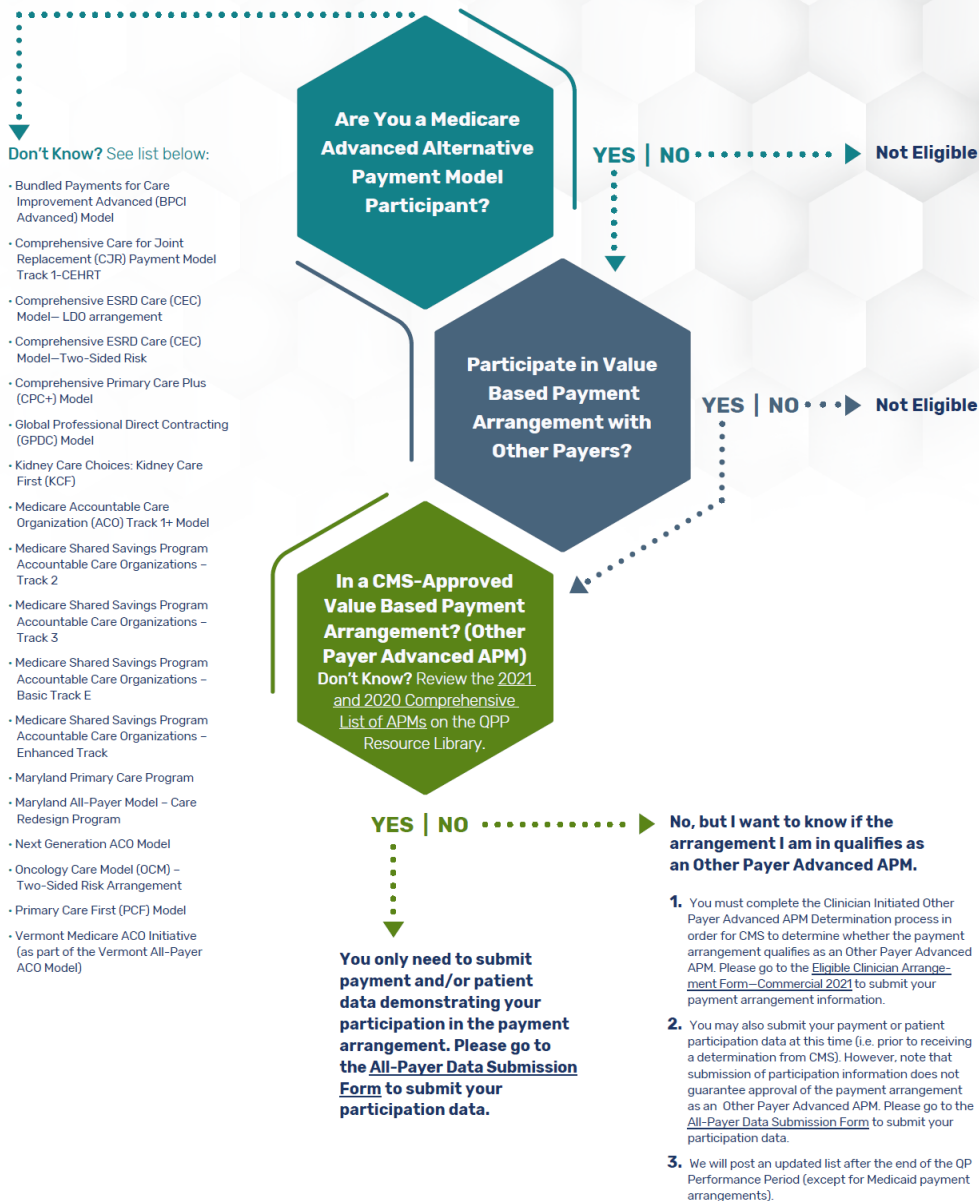
- a. If your model does not fall into one of the listed model types, answer **No**. You are not eligible to participate in the CMS Quality Payment Program.
- b. If your model falls into one of the listed model types, answer **Yes** and move on to the next question.

3. Do you participate in value-based payment arrangements with other payers?

- a. If yes, then check to see if your payment arrangement is a **CMS-approved value-based payment arrangement**. If you are **in a CMS-approved value-based payment arrangement**, you only need to submit payment and/or patient data demonstrating your participation in the payment arrangement (as well as payment amount and patient count information from other payment arrangements with payers other than Medicare FFS).
 - i. You can then click the “**All Payer Data Submission Form – 2021**” link at the bottom of the page.
- b. If you’re not sure, you can click the provided links under the question to see if your payment arrangement has been approved.
- c. If you are not in a CMS-approved value-based payment arrangement, you can follow the instructions at the bottom of the diagram for next steps.
 - i. You can still submit your payment or participant data using the “All Payer Data Submission Form,” but submission of this data does not guarantee approval of the payment arrangement as an Other-Payer Advanced APM.

- ii. CMS will post an updated list of approved value-based payment arrangements at the end of the QP performance period.

2021 All-Payer Eligibility Decision Tree



Welcome to the QPP All-Payer Data Submission Form

On the data submission form home page, two charts will outline the criteria to meet the payment amount and patient count threshold scores, respectively. The Other Payer Advanced APM determination will be made based on the resulting threshold scores. Any data submissions not meeting these minimum criteria listed in the charts will not be accepted as an Other Payer Advanced APM. Only one set of threshold data need meet the determination criteria, meaning if you submit both payment amount and patient threshold scores, CMS will accept the submission as an Other Payer Advanced APM if one or both of the threshold scores meets the determination criteria.

APM Entities, eligible clinicians, 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. To start a new data submission, press the “Start a New Data Submission” button at the bottom of the page.

Note, when submissions are completed, a table will appear at the bottom of the page, with the identifying Submission Form ID and Submitter Type information. Submitters will be able to view the PDF of the entries.

QPP Forms Table Populated: Submitter Type

Once you’ve opted to start a new data submission, this screen will appear. Select one of the boxes, depending on your submitter type, and then click “Continue”.

Submitter Type

Select one of the following:

☐ APM Entity

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.

☐ Eligible Clinician(s)

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(l)(3)(B) of the Act).

☐ TIN Level

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.

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 the APM Entity does not submit sufficient information within this time period, the eligible clinicians participating in the APM Entity 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 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.

CMS will review the Other Payer Advanced APM participation information in this Form to determine whether the eligible clinician (identified by the National Provider Identifier, or NPI) meets the QP thresholds. 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 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.

CMS will review the Other Payer Advanced APM participation information in this Form to determine whether eligible clinicians (NPIs) that are under the TIN meet the QP thresholds. 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.



Section 2: Participant Identifying Information

This section provides screenshots where the APM Entity/eligible clinician/TIN will enter their identifying information. Simply fill out the identifying information for your respective form, and then click either the “Save & Continue” button or the “Save” button. The “Save” button allows you to save your progress and return to the form later.

Participant Identifying Information, if Submitter is an APM Entity:

1. First, fill in all the required fields under “**Point of Contact.**”
2. Select the Medicare Advanced APM in which eligible clinicians participate. This question, under the “**APM Entity**” header, contains a drop-down menu which allows you to select your particular Medicare Advanced APM.
3. Type the name of your APM Entity in the appropriate field.

Home

Participant Identifying Information

Other Payer Advanced APM

Participation Data

Certification Statement

Participant Identifying Information

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Point of Contact

* First Name

John

* Last Name

Doe

* Job Title

APM Entity

* Organization Name

John Doe APM

* Email Address

john.doe@apm.com

* Confirm Email Address

john.doe@apm.com

* Business Phone Number

555-555-5555

Ext.

* Address Line 1 (Street Name and Number)

123 Any Street

Address Line 2 (Suite, Room, etc.)

* City

AnyTown

* State

MD - Maryland

* Zip Code

55555

+4

APM Entity

* 1. Medicare Advanced APM in which Eligible Clinician participates:

Bundled Payment for Care Improvement Advanced Model

* 2. Name of APM Entity

John Doe APM

3. Name of the point of contact (e.g. Project Officer) for the APM Entity at CMS

First Name

John

Last Name

Doe

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

Save

Save & Continue

Cancel

Participant Identifying Information, if Submitter is an Eligible Clinician:

1. Fill in all the required fields under “**Point of Contact.**”
2. Fill out the eligible clinician’s National Provider Identifier (NPI) number. The NPI must have 10 digits. Check this field carefully for accuracy.

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[Participant Identifying Information](#)
[Other Payer Advanced APM Participation Data](#)
[Certification Statement](#)

Participant Identifying Information

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Point of Contact

* First Name John	* Last Name Doe
* Job Title Eligible Clinician	* Organization Name John Doe Clinic
* Email Address [redacted].com	* Confirm Email Address [redacted]@il.com
* Business Phone Number 555-555-5555	Ext.
* Address Line 1 (Street Name and Number) 123 Any Street	Address Line 2 (Suite, Room, etc.)
* City AnyTown	* State MD - Maryland
	* Zip Code 55555
	+4

Eligible Clinician Information

Note: 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. Eligible Clinician First Name Jane	* 2. Eligible Clinician Last Name Doe
* 3. Eligible Clinician's NPI [redacted]	* 4. Re-Type Eligible Clinician's NPI [redacted]

[Save](#) [Save & Continue](#) [Cancel](#)

Participant Identifying Information, if Submitter is Entering at the TIN Level:

1. Fill in all the required fields under “**Point of Contact.**”
2. Fill out the taxpayer identification number (TIN) legal entity name. The TIN must have 9 digits. Check this field carefully for accuracy.

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[Other Payer Advanced APM](#)
[Participation Data](#)
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Participant Identifying Information

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Point of Contact

* First Name John	* Last Name Doe
* Job Title TIN Level Entity	* Organization Name John Doe TIN
* Email Address [redacted].com	* Confirm Email Address [redacted].com
* Business Phone Number 555-555-5555	Ext.
* Address Line 1 (Street Name and Number) 123 Any Street	Address Line 2 (Suite, Room, etc.)
* City AnyTown	* State MD - Maryland
	* Zip Code 22222
	+4

TIN Level Entity Information

* 1. TIN Legal Entity Name John Doe TIN, LLC	
* 2. Tax Identification Number (TIN) [redacted]	* 3. Re-Type Tax Identification Number (TIN) [redacted]

[Save](#) [Save & Continue](#) [Cancel](#)

Section 3: Other Payer Advanced APM Participation Data

This page presents information on how to submit data regarding participation in Other-Payer Advanced APMs. Please read the “Instructions for uploading a document” section carefully, as it contains instructions explaining how to download the data collection spreadsheet and then upload the updated spreadsheet once the required information is filled out.

Other Payer Advanced APM Participation Data (Initial Access):

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[Participant Identifying Information](#)
[Other Payer Advanced APM Participation Data](#)
[Certification Statement](#)

Other Payer Advanced APM Participation Data

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Per statute, information for all payers through which the Eligible Clinician, TIN, or Eligible Clinicians participating in the APM Entity bills 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, and 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.

Instructions for uploading a document:

1. Select download in the Action column.
2. Save the document to your local drive and complete the spreadsheet as instructed.
3. Delete the currently uploaded document from the Portal by selecting Delete in the Action column.
4. Confirm that you would want to delete the document.
5. Refresh the page, if necessary, to display the enabled Upload Document button.
6. Upload the updated spreadsheet file.

Template Name	Action
TBD	Download

Upload Document

File Name	Snapshot Period	Action
No uploaded documents		

Showing 0 to 0 of 0 entries

PreviousNext



Continue


Instructions for Filling out Data Collection Worksheet:

Once you download the spreadsheet template from the portal, please review the “instructions” tab for detailed information regarding how to populate the required data fields.³ The actual data will be filled out in the “Data Collection Worksheet” tab. Also, feel free to refer to the “Glossary” tab to look up any key terms or definitions.

<p>Populate the rows for every payment arrangement under which the APM Entity's eligible clinicians/eligible clinician/TIN's eligible clinicians received payment during the snapshot period, by selecting from the drop-down menu the payer, payment arrangement name, type of payer, and (if applicable), the payment arrangement identifier. If the payment arrangement and/or payer and/or payment arrangement identifier do not appear in the drop-down menu, please manually enter the name of the payment arrangement, payer, and (if applicable) payment arrangement identifier into the cell.</p> <p>Please note that you should submit data for each payment arrangement for all applicable payers for the snapshot period, such as commercial and Medicare Health Plan. If the APM Entity/eligible clinician/TIN participated in more than one payment arrangement with a single payer, you should report data for each payment arrangement with the payer in separate rows. <u>Medicaid payment arrangements should ONLY be reported in some cases (see the "Payment Arrangement" definition in the "Instructions" tab).</u> You do NOT need to submit data for Medicare Fee-for-Service or for payment arrangements associated with payments from the Secretary of Defense for Department of Defense health care programs (e.g., TRICARE) or from the Secretary of Veterans Affairs for Veterans Affairs health care programs.</p>				<p>Enter the name, phone number, and email of the payer point of contact for the payment arrangement you indicated in the payment arrangement column (column A).</p>		<p>Enter the total payments (in dollars) the APM Entity's eligible clinicians/eligible clinician/TIN's eligible clinicians received through the payment arrangement during the snapshot period (based on date of service).</p> <p><u>To be evaluated under the Payment Amount Threshold, you must complete this field for every applicable payment arrangement.</u></p>		<p>Enter the total number of unique patients to whom the APM Entity's eligible clinicians/eligible clinician/TIN's eligible clinicians furnished services during the snapshot period (based on date of service).</p> <p><u>To be evaluated under the Patient Count Threshold, you must complete this field for every applicable payment arrangement.</u></p>	
Example Data Submission Entries (you will likely have more than four entries)									
Payment Arrangement	Payment Arrangement Identifier	Payer	Type of Payer	Payment Arrangement Point of Contact Name	Payment Arrangement Point of Contact Phone (no spaces or dashes--i.e., #####)	Payment Arrangement Point of Contact Email	Total Payments (\$#.##)	Total Patients (#)	
Payment Arrangement 1	4321	Commercial Insurance Payer 1	Commercial	Joe Insurer	2025555555	email@insurer1.com	\$10,382.27	45	
Payment Arrangement 2	5432	Commercial Insurance Payer 1	Commercial	Joe Insurer	2025555555	email@insurer1.com	\$27,045.33	70	
Payment Arrangement 3	1234	Commercial Insurance Payer 2	Commercial	Sally Insurer	7815555555	email@insurer2.com	\$45,037,526.50	17,032	
Payment Arrangement 4	H0000	Medicare Advantage Payer	Medicare Health Plan	M.A. Insurer	9195555555	email@insurer3.com	\$16,526,890.86	57,107	
Record your data below - for more information on each field, see "Instructions" tab									
Payment Arrangement	Payment Arrangement Identifier	Payer	Type of Payer	Payment Arrangement Point of Contact Name	Payment Arrangement Point of Contact Phone (no spaces or dashes--i.e., #####)	Payment Arrangement Point of Contact Email	Total Payments (\$#.##)	Total Patients (#)	

³ There are separate templates for APM entities, eligible clinicians, and TINs. Although this screenshot asks the submitter to “populate the rows for every payment arrangement in which the [APM Entity/TIN/eligible clinician] participated...”, the actual templates will only list a singular submitter type. Salesforce will automatically provide the correct template based on which submitter type is chosen.


- 
- 1) On the Data Collection Worksheet tab, enter the Payment Arrangement in column A by selecting it from the drop-down menu (if the payment arrangement appears in this list) OR by typing in the name. Note that any applicable payment arrangements that do not appear in the drop-down menu must still be entered in the worksheet (by typing in the payment arrangement name).
 - 2) All payment arrangements for all payers must be entered in this worksheet, except Medicare Fee-For-Service, payment arrangements associated with the Secretary of Defense for Department of Defense health care programs (e.g., TRICARE), and payment arrangements from the Secretary of Veterans Affairs for Veterans Affairs health care programs.
 1. Please note that Medicaid payment arrangements are excluded from these calculations. However, if you/eligible clinicians in your TIN/eligible clinicians in your APM Entity saw most of your patients in any of the following counties between January 1, 2021, and August 31, 2021, please include those data:
 - i. Any counties in Massachusetts, Ohio, Tennessee, Washington
 - ii. The following counties in Oregon: Benton, Lincoln, Linn
 2. Do NOT submit Medicaid payment arrangements if you/eligible clinicians in your TIN/eligible clinicians in your APM Entity saw the most of your patients outside of these counties between January 1, 2021, and August 31, 2021.
 - 3) In column B, the payment arrangement identifier, please enter the payment arrangement identifier (e.g., contract number, Medicaid identifier) corresponding to the payment arrangement you entered in column A (if available).
 - 4) In column C, please enter the payer name corresponding to the payment arrangement you entered in column A.
 - 5) In column D, please select the type of payer (Medicare Advantage, Commercial, etc.) from the drop-down menu, corresponding to the payment arrangement you entered in column A.
 - 6) In column E, provide the point of contact name corresponding to the payment arrangement you entered in column A. The “Point of Contact Name” is the individual whom CMS will contact with any questions about the payment arrangement and its operations.
 - 7) In column F, provide the point of contact phone number corresponding to the payment arrangement you entered in column A.
 - 8) In column G, provide the point of contact email address corresponding to the payment arrangement you entered in column A.
- 


- 
- 9) In column H, enter the total payments billed (in dollars) under the terms of the payment arrangement you entered in column A (payments are based on date of service). The data entered into this field should be based on the “Snapshot Period” you selected in the QPP All Payer Submission Form and at the same level as the “Submitter Type” you selected in the QPP All Payer Submission Form.
 1. For Snapshot 1, enter data based on dates of service between January 1, 2021, and March 31, 2021.
 2. For Snapshot 2, enter data based on dates of service between January 1, 2021, and June 30, 2021.
 3. For Snapshot 3, enter data based on dates of service between January 1, 2021, and August 31, 2021.
 - 10) In column I, 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 the QPP All Payer Submission Form and at the same level as the “Submitter Type” you selected in the QPP All Payer Submission Form.
 1. For Snapshot 1, enter data based on dates of service between January 1, 2021 – March 31, 2021
 2. For Snapshot 2, enter data based on dates of service between January 1, 2021 – June 30, 2021
 3. For Snapshot 3, enter data based on dates of service between January 1, 2021 – August 31, 2021
 - 11) Once you have entered all the required information in the spreadsheet, save it, and follow the instructions on the Other Payer Advanced APM Participation Data screen for uploading the spreadsheet to the submission form.

File Upload - Select Snapshot:

This page will appear after you have uploaded your completed spreadsheet. The page asks you to select the snapshot period for which you are submitting data for the 2021 QP performance period. Remember, you may submit data from any of the three allowable snapshot periods listed in the drop-down menu on the following page.

You must choose which snapshot period you are selecting for submission of your other payer data. The choices are:

- Snapshot 1: January 1 through March 31;
 - Snapshot 2: January 1 through June 30; and
 - Snapshot 3: January 1 through August 31.
- 



Note, these are the same snapshot periods used under the Medicare Option for Advanced APM participation. Calculations will use the Medicare and other payer data from the same snapshot period to ensure the calculation of the QP threshold will have a common denominator. It is not required, but recommended that both patient count and payment amount data are submitted for the relevant snapshot period, as CMS will calculate the QP threshold using each and will use the outcome that is most advantageous for the submitter.

Click “Upload” once you have attached your completed spreadsheet and selected the applicable snapshot period.

File Upload Window Select Snapshot:



The screenshot shows a dropdown menu with the following options: --None-- (highlighted in blue), January - March, January - June, and January - August. Below the dropdown is a text input field and a "Browse..." button.

Note: There is 25MB limit on your file upload.

Upload

Close



Other Payer Advanced APM Participation Data (Example with Snapshot Period 3 Uploaded):

This screen mimics the screen shown earlier but includes Snapshot Period 3. It will appear once you have completed and uploaded your data collection spreadsheet and selected the snapshot period for which you are submitting. You should be able to see your file name and selected snapshot period listed at the bottom of the page. In this example the submitter selected Snapshot Period 3, but data submissions from any of the three snapshots are acceptable.

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Other Payer Advanced APM Participation Data

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Per statute, information for all payers through which the Eligible Clinician, TIN, or Eligible Clinicians participating in the APM Entity bills 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, and 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.

Instructions for uploading a document:

1. Select download in the Action column.
2. Save the document to your local drive and complete the spreadsheet as instructed.
3. Delete the currently uploaded document from the Portal by selecting Delete in the Action column.
4. Confirm that you would want to delete the document.
5. Refresh the page, if necessary, to display the enabled Upload Document button.
6. Upload the updated spreadsheet file.

Template Name	Action
TBD	Download

Upload Document

File Name	Snapshot Period	Action
Data-0257_3_QPP_All_Payer_Data_Submission_Worksheet_Sample.xls x	January - August	Delete

Showing 1 to 1 of 1 entries

Previous1Next

Continue

If everything looks correct, please click "Continue."

Section 4: Certification Statement

This section will provide screenshots of the certification statement for data submissions for APM Entities, eligible clinicians, and TINs.

Certification Statement (if Submitted as an APM Entity):

For APM Entity submitters, please read the certification statement on this page, check the “I agree” box, and fill out the authorized individual name and Title information. Once completed, you can click the “Submit” button and your QP threshold data will be sent to CMS for review. More details on the CMS QP threshold review process can be found in the “Overview of the All-Payer data submission process” section beginning on the first page of this document.

The screenshot shows a web interface for the Certification Statement. On the left is a navigation menu with links: Home, Participant Identifying Information, Other Payer Advanced APM Participation Data, and Certification Statement (highlighted in yellow). The main content area has a blue header 'Certification Statement' and a warning: '***Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity***'. A legend indicates that an asterisk (*) denotes a required field. The 'APM Entity' section contains a paragraph of legal certification, a checked checkbox for 'I agree', and input fields for 'Authorized Individual Name' (filled with 'John Doe') and 'Title' (filled with 'APM Entity'). A blue 'Submit' button is at the bottom center.

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Certification Statement

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

APM Entity

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to bind the APM Entity submitting this Form. 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

* Authorized Individual Name

* Title

[Submit](#)

Do not forget to hit the “Submit” button. Your submission is now complete.

Certification Statement (if Submitted as an Eligible Clinician):

If you are an eligible clinician submitting for yourself, please fill out only the top portion of the page, check the “I agree” box, and then click submit at the bottom of the page. If you are a third party submitting data on behalf of an eligible clinician, please fill out only the bottom portion of the page, check the “I agree” box at the bottom of the page, and then hit submit. Once you click “Submit” your data will be sent to CMS for review. More details on the CMS QP threshold review process can be found in the “Overview of the All-Payer data submission process” section beginning on the first page of this document.

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Certification Statement

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Eligible Clinician

I have read the contents of this submission. By submitting this Form, I 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

* Authorized Individual Name
John Doe

* Title
Eligible Clinician

Third Party Submitting on Behalf of Eligible Clinician

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to submit this Form on behalf of each EC specified in APM Entity or Eligible Clinician Information of this Form. 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

* Authorized Individual Name

* Title

Submit

Do not forget to hit the “Submit” button. Your submission is now complete.

Certification Statement (Submitted on Behalf of an Eligible Clinician):

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Certification Statement

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

Eligible Clinician

I have read the contents of this submission. By submitting this Form, I 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

* Authorized Individual Name

* Title

Third Party Submitting on Behalf of Eligible Clinician

I have read the contents of this submission. By submitting this Form, I certify that I am legally authorized to submit this Form on behalf of each EC specified in APM Entity or Eligible Clinician Information of this Form. 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

* Authorized Individual Name

* Title

Do not forget to hit the "Submit" button. Your submission is now complete.

Certification Statement (if Submitted at the TIN Level):

For TIN submitters, please read the certification statement on this page, check the “I agree” box, and fill out the authorized individual name and Title information. Once completed, you can click the “Submit” button, and your QP threshold data will be sent to CMS for review. More details on the CMS QP threshold review process can be found in the “Overview of the All-Payer data submission process” section beginning on the first page of this document.

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Certification Statement

Please be sure to save your work before navigating away from this page as any unsaved work will be lost. Additionally, the application times-out after 30 minutes of inactivity

* Indicates a required field.

TIN Level

I have read the contents of this submission. By submitting this Form, I 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

* Authorized Individual Name

* Title

Do not forget to hit the “Submit” button. Your submission is now complete.

Note: When submissions are completed, this table will appear at the bottom of the page, with the identifying Submission Form ID and Submitter Type information. Submitters will be able to view the PDF of the entries.

QPP Forms Table Populated:

Start a New Data Submission			
Submission Form ID	Submitter Type	Status	Action
Data-0267	TIN Level	Submitted	View PDF
Data-0265	Eligible Clinician(s)	Submitted	View PDF
Data-0257	APM Entity	Submitted	View PDF

Version History

Date	Change Description
08/29/2024	Updated thresholds in the All-Payer Combination Option tables on page 3 and revised text explaining the QP thresholds on page 4.
08/20/2021	Original version.