

CMS does not perform a QP determination for such eligible clinician(s) under the All-Payer Combination Option.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53961, Nov. 16, 2017; 84 FR 63201, Nov. 15, 2019]

§ 414.1430 Qualifying APM participant determination: QP and partial QP thresholds.

(a) *Medicare Option*—(1) *QP payment amount threshold*. The QP payment amount thresholds are the following values for the indicated payment years:

- (i) 2019 and 2020: 25 percent.
- (ii) 2021 and 2022: 50 percent.
- (iii) 2023 and 2024: 50 percent.
- (iv) 2025 and later: 75 percent.

(2) *Partial QP payment amount threshold*. The Partial QP payment amount thresholds are the following values for the indicated payment years:

- (i) 2019 and 2020: 20 percent.
- (ii) 2021 and 2022: 40 percent.
- (iii) 2023 and 2024: 40 percent.
- (iv) 2025 and later: 75 percent.

(3) *QP patient count threshold*. The QP patient count thresholds are the following values for the indicated payment years:

- (i) 2019 and 2020: 20 percent
- (ii) 2021 and 2022: 35 percent
- (iii) 2023 and 2024: 35 percent.
- (iv) 2025 and later: 50 percent.

(4) *Partial QP patient count threshold*. The Partial QP patient count thresholds are the following values for the indicated payment years:

- (i) 2019 and 2020: 10 percent
- (ii) 2021 and 2022: 25 percent
- (iii) 2023 and 2024: 25 percent.
- (iv) 2025 and later: 35 percent.

(b) *All-Payer Combination Option*—(1) *QP payment amount threshold*.

(i) The QP payment amount thresholds are the following values for the indicated payment years:

- (A) 2021 through 2024: 50 percent.
- (B) 2025 and later: 75 percent.

(ii) To meet the QP payment amount threshold under this option, the eligible clinician must also meet a 25 percent QP payment amount threshold under the Medicare Option.

(2) *Partial QP payment amount threshold*. (i) The Partial QP payment amount thresholds are the following values for the indicated payment years:

- (A) 2021 through 2024: 35 percent.

(B) 2025 and later: 50 percent.

(ii) To meet the QP payment amount threshold under this option, the eligible clinician must also meet a 20 percent Partial QP payment amount threshold under the Medicare Option.

(3) *QP patient count threshold*. (i) The QP patient count thresholds are the following values for the indicated payment years:

- (A) 2021 through 2024: 35 percent.
- (B) 2025 and later: 50 percent.

(ii) To meet the QP patient count threshold under this option, the eligible clinician must also meet a 20 percent QP patient count threshold under the Medicare Option.

(4) *Partial QP patient count threshold*.

(i) The Partial QP patient count thresholds are the following values for the indicated payment years:

- (A) 2021 through 2024: 25 percent.
- (B) 2025 and later: 35 percent.

(ii) To meet the Partial QP patient count threshold under this option, the eligible clinician group or eligible clinician must also meet a 10 percent QP patient count threshold under the Medicare Option.

[81 FR 77537, Nov. 4, 2016, as amended at 86 FR 65681, Nov. 19, 2021; 87 FR 70230, Nov. 18, 2022]

§ 414.1435 Qualifying APM participant determination: Medicare option.

(a) *Payment amount method*. The Threshold Score for an APM Entity or eligible clinician is calculated as a percent by dividing the value described under paragraph (a)(1) of this section by the value described under paragraph (a)(2) of this section.

(1) *Numerator*. The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to attributed beneficiaries during the QP Performance Period.

(2) *Denominator*. The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to all attribution-eligible beneficiaries during the QP Performance Period.

(3) *Claims and adjustments*. In the calculations under paragraphs (a)(1) and (2) of this section, CMS compiles claims and treats claims adjustments,

supplemental service payments, and alternative payment methods in the same manner as described in §414.1450.

(b) *Patient count method.* The Threshold Score for each eligible clinician in an APM Entity group is calculated as a percent under the patient count method by dividing the value described under paragraph (b)(1) of this section by the value described under paragraph (b)(2) of this section.

(1) *Numerator.* The number of attributed beneficiaries to whom the APM Entity group furnishes Medicare Part B covered professional services or services by a Rural Health Clinic (RHC) or Federally-Qualified Health Center (FQHC) during the QP Performance Period.

(2) *Denominator.* The number of attribution-eligible beneficiaries to whom the APM Entity group or eligible clinician furnish Medicare Part B covered professional services or services by a Rural Health Clinic (RHC) or Federally-Qualified Health Center (FQHC) during the QP Performance Period.

(3) *Unique beneficiaries.* For each APM Entity group, a unique Medicare beneficiary is counted no more than one time for the numerator and no more than one time for the denominator.

(4) *Beneficiaries count multiple times.* Based on attribution under the terms of an Advanced APM, a single Medicare beneficiary may be counted in the numerator or denominator for multiple different APM Entity groups.

(c) *Attribution.*

(1) Attributed beneficiaries are determined from each Advanced APM Entity's attributed beneficiary lists generated by each Advanced APM's specific attribution methodology except as set forth in this paragraph (c)(1)(i). Beneficiaries who have been prospectively attributed to an APM Entity for a QP Performance Period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity's attributed beneficiary list.

(ii) [Reserved]

(2) When operationally feasible, this attributed beneficiary list will be the final beneficiary list used for reconciliation purposes in the Advanced APM.

(3) When it is not operationally feasible to use the final attributed beneficiary list, the attributed beneficiary list will be taken from the Advanced APM's most recently available attributed beneficiary list at the end of the QP Performance Period.

(d) *Use of methods.* CMS calculates Threshold Scores for an APM Entity or eligible clinician as provided by §414.1425(b) under both the payment amount and patient count methods for each QP Performance Period. CMS then assigns to the eligible clinicians included in the APM Entity group or to the eligible clinician the score that results in the greater QP status. QP status is greater than Partial QP status, and Partial QP status is greater than no QP status.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53963, Nov. 16, 2017; 85 FR 85035, Dec. 28, 2020]

§414.1440 Qualifying APM participant determination: All-payer combination option.

(a) *Payments excluded from calculations.* (1) These calculations include a combination of both Medicare payments for Part B covered professional services and all other payments for all other payers, except for payments made by:

(i) The Secretary of Defense for the costs of Department of Defense health care programs;

(ii) The Secretary of Veterans Affairs for the cost of Department of Veterans Affairs health care programs; and

(iii) Under Title XIX in a State in which no Medicaid APM or Medicaid Medical Home Model that is an Other Payer Advanced APM is available.

(2) Payments and associated patient counts under paragraph (a)(1)(iii) of this section are included in the numerator and denominator as specified in paragraphs (b)(2) and (3) and paragraphs (c)(2) and (3) of this section for an eligible clinician if CMS determines that there is at least one Medicaid APM or Medicaid Medical Home Model that is an Other Payer Advanced APM available in the county where the eligible clinician sees the most patients during the QP Performance Period, and that the eligible clinician is not ineligible to participate in the Other Payer