

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

Advanced APM based on their specialty.

(b) *Payment amount method*—(1) *In general.* The Threshold Score for either an APM Entity group or eligible clinician will be calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (b)(2) and (3) of this section.

(2) *Numerator.* The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, attributable to the eligible clinician or to the APM Entity group under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period.

(3) *Denominator.* The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, made to the eligible clinician or to the APM Entity group during the QP Performance Period.

(c) *Patient count method*—(1) *In general.* The Threshold Score for either an APM Entity group or eligible clinician is calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (c)(2) and (3) of this section.

(2) *Numerator.* The number of unique patients to whom an APM Entity group or eligible clinician furnishes services that are included in the measures of aggregate expenditures used under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period.

(3) *Denominator.* The number of unique patients to whom the APM Entity group or eligible clinician furnishes services under all non-excluded payers during the QP Performance Period.

(4) *Unique patients.* CMS may count a single patient in the numerator and/or denominator for multiple different payers.

(d) *QP Determinations under the All-Payer Combination Option.* (1) CMS performs QP determinations following the QP Performance Period using payment amount and/or patient count information submitted from January 1 through each of the respective QP determina-

tion dates: March 31, June 30, and August 31. CMS will use data for the same time periods for the Medicare and other payer portions of Threshold Score calculations under the All-Payer Combination Option. CMS will use the payment amount or patient count method, applying the more advantageous of the two for both the Medicare and other payer portions of the Threshold score calculation, regardless of the method used for the Medicare Threshold Score calculation.

(2) An APM Entity may request that CMS make QP determinations at the APM Entity level, an eligible clinician may request that CMS make QP determinations at the eligible clinician level, and an eligible clinician or an APM Entity may request that CMS makes QP determinations at the TIN-level in instances where all clinicians who reassigned billing rights to the TIN are participating in a single APM Entity. CMS makes QP determinations at either the APM Entity, eligible clinician, or TIN level. Eligible clinicians assessed at the eligible clinician level under the Medicare Option at § 414.1425(b)(2) will be assessed at the eligible clinician level only under the All-Payer Combination Option. Eligible Clinicians may meet the Medicare and the All-Payer Combination Option thresholds using the payment amount method for both thresholds, the patient account method for both thresholds, or the payment amount method for one threshold and the patient account method for the other threshold.

(3) CMS uses data at the same level for the Medicare and other payer portions of Threshold Score calculations under the All-Payer Combination Option. When QP determinations are made at the eligible clinician or, at the TIN level when all clinicians who have reassigned billing rights to the TIN are included in a single APM Entity; and if the Medicare Threshold score for the APM Entity group is higher than when calculated for the eligible clinician or TIN, CMS makes QP determinations using a weighted Medicare Threshold Score that is factored into an All-Payer Combination Option Threshold Score.

(e) *Information used to calculate Threshold Scores under the All-Payer*

Combination Option. (1) An APM Entity or eligible clinician may request as set forth in §414.1445(b)(2) that CMS determine whether a payment arrangement in which they participate meets the Other Payer Advanced APM criteria and may demonstrate participation in an Other Payer Advanced APM determined as a result of a request made in §414.1445(a)(1) or (b)(1) in a form and manner specified by CMS.

(2) To request a QP determination under the All-Payer Combination Option, for each payment arrangement submitted as set forth in paragraph (e)(1) of this section, the APM Entity or eligible clinician must include:

(i) The amount of revenue for services furnished through the payment arrangement, the total revenue received from all payers except those excluded as provided in paragraph (a)(2) of this section, the number of patients furnished any service through the arrangement, and the total number of patients furnished any services, except those excluded as provided in paragraph (a)(2) of this section; and

(ii) In the case of an APM Entity or eligible clinician requesting a QP determination under either a Medicaid Medical Home Model or Aligned Other Payer Medical Home Model pursuant to the criteria in §414.1420, information specified by CMS for purposes of compliance with the 50 eligible clinician limit specified at §414.1420(d)(8).

(3) An APM Entity or eligible clinician must submit the information specified in paragraph (e)(2) of this section in a form and manner specified by CMS. An APM Entity or eligible clinician may submit the information specified in paragraph (e)(2) of this section for the following periods of time in the relevant QP Performance Period: January 1 through March 31, January 1 through June 30, and January 1 through August 31.

(4) To request a QP determination under the All-Payer Combination Option, an APM Entity or eligible clinician must submit this information to CMS no later than the QP Determination Submission Deadline, which is December 1 of the calendar year that is 2 years prior to the payment year.

(f) *Requirement to submit sufficient information—(1) Sufficient Information.*

CMS makes a QP determination with respect to the eligible clinician under the All-Payer Combination Option only if the APM Entity or eligible clinician submits the information required under paragraph (e) of this section sufficient for CMS to assess the eligible clinician under either the payment amount or patient count as described in paragraphs (b) and (c) of this section.

(2) *Certification.* The APM Entity or eligible clinician who submits information to request a QP determination under the All-Payer Combination Option must certify that the information submitted to CMS is true, accurate, and complete. Such certification must accompany the submission and be made at the time of submission. In the case of information submitted by an APM Entity, the certification must be made by an individual with the authority to bind the APM Entity.

(g) *Notification of QP determination.* CMS notifies eligible clinicians determined to be QPs or Partial QPs for a year as soon as practicable after QP calculations are conducted.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53963, Nov. 16, 2017; 83 FR 60091, Nov. 23, 2018; 87 FR 70230, Nov. 18, 2022]

§414.1445 Determination of other payer advanced APMs.

(a) *Determination of Medicaid APMs.* Beginning in 2018, and each year thereafter, at a time determined by CMS, a state, APM Entity, or eligible clinician may request, in a form and manner specified by CMS, that CMS determine whether a payment arrangement authorized under Title XIX is either a Medicaid APM or a Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria as set forth in §414.1420. A state must submit its request by April 1 of the year prior to the relevant QP Performance Period, and an APM Entity or eligible clinician must submit its request by November 1 of the year prior to the relevant QP Performance Period. CMS will not determine that a payment arrangement is a Medicaid APM or Medicaid Medical Home Model that meets the Other Payer Advanced APM criteria as set forth in §414.1420 for a year