

based focus and to be reliable and valid; and

(ii) For QP Performance Periods beginning on or after January 1, 2020, be:

(A) Finalized on the MIPS final list of measures, as described in § 414.1330;

(B) Endorsed by a consensus-based entity; or

(C) Determined by CMS to be evidenced-based, reliable, and valid.

(3) The quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must include at least one measure that is an outcome measure unless CMS determines that there are no available or applicable outcome measures included in the MIPS final quality measures list for the Advanced APM's first QP Performance Period. Beginning January 1, 2020, the included outcome measure must satisfy the criteria in paragraph (b)(2) of this section.

(4) A single quality measure that meets the criteria under both paragraphs (b)(2) and (3) of this section may be used to satisfy the requirements of paragraph (b)(1) of this section.

(c) *Financial risk.* To be an Advanced APM, except as described in paragraph (c)(6) of this section, an APM must either meet the financial risk standard under paragraph (c)(1) or (2) of this section and the nominal amount standard under paragraph (c)(3) or (4) of this section or be an expanded Medical Home Model under section 1115A(c) of the Act.

(1) *Generally applicable financial risk standard.* Except for paragraph (c)(2) of this section, to be an Advanced APM, an APM must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified QP Performance Period, do one or more of the following:

(i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(iii) Require the APM Entity to owe payment(s) to CMS.

(2) *Medical Home Model financial risk standard.* The APM Entity participates in a Medical Home Model that, based

on the APM Entity's failure to meet or exceed one or more specified performance standards, which may include expected expenditures, does one or more of the following:

(i) Withholds payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Reduces payment rates to the APM Entity or the APM Entity's eligible clinicians;

(iii) Requires the APM Entity to owe payment(s) to CMS; or

(iv) Causes the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

(3) *Generally applicable nominal amount standard.* (i) Except as provided in paragraph (c)(4) of this section, the total amount an APM Entity potentially owes CMS or foregoes under an APM must be at least equal to either:

(A) For QP Performance Periods beginning in 2023, 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities; or

(B) 3 percent of the expected expenditures for which an APM Entity is responsible under the APM.

(ii) [Reserved]

(4) *Medical Home Model nominal amount standard.* (i) For a Medical Home Model to meet the Medical Home Model nominal amount standard, the total annual amount that an APM Entity potentially owes CMS or foregoes must be at least the following amounts:

(A) For QP Performance Period 2017, 2.5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(B) For QP Performance Period 2018, 2.5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(C) For QP Performance Period 2019, 3 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(D) For QP Performance Period 2020, 4 percent of the average estimated total Medicare Parts A and B revenue

of all providers and suppliers in participating APM Entities.

(E) For QP Performance Periods 2021 and later, 5 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities.

(ii) [Reserved]

(5) For the purposes of this section, expected expenditures means the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures means the episode target price. For purposes of assessing financial risk for Advanced APM determinations, the expected expenditures under the terms of the APM should not exceed the Medicare Part A and Part B expenditures for a participant in the absence of the APM. If the expected expenditures under the APM exceed the Medicare Part A and Part B expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for purposes of Advanced APM determinations.

(6) *Capitation*. A full capitation arrangement meets this Advanced APM criterion. For purposes of this part, a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the APM for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed to reconcile or share losses incurred or savings earned by the APM Entity. Arrangements between CMS and Medicare Advantage Organizations under the Medicare Advantage program (part 422 of this title) are not considered capitation arrangements for purposes of this paragraph (c)(6).

(7) *Medical Home Model 50 eligible clinician limit*. Beginning in the 2023 QP Performance Period, notwithstanding paragraphs (c)(2) and (4) of this section, if an APM Entity participating in a Medical Home Model is comprised of more than 50 eligible clinicians, as determined by that APM Entity's Participation List on any of the three QP determination dates (March 31, June 30, and August 31 of the QP Performance Period), the requirements of para-

graphs (c)(1) and (3) of this section apply.

[81 FR 77537, Nov. 4, 2016, as amended at 82 FR 53960, Nov. 16, 2017; 83 FR 60090, Nov. 23, 2018; 84 FR 540, Jan. 31, 2019; 84 FR 63200, Nov. 15, 2019; 87 FR 70229, Nov. 18, 2022; 88 FR 79538, Nov. 16, 2023]

§414.1420 Other payer advanced APM criteria.

(a) *Other Payer Advanced APM criteria*. A payment arrangement with a payer other than Medicare is an Other Payer Advanced APM for a QP Performance Period if CMS determines that the arrangement meets the following criteria during the QP Performance Period:

(1) Use of CEHRT, as described in paragraph (b) of this section;

(2) Quality measures comparable to measures under the MIPS quality performance category apply, as described in paragraph (c) of this section; and

(3) Either:

(i) Requires APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures as described in paragraph (d) of this section; or

(ii) Is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act as described in paragraph (d) of this section.

(b) *Use of CEHRT*. To be an Other Payer Advanced APM:

(1) CEHRT must be used, for QP Performance Periods ending with 2019, by at least 50 percent; and for QP Performance Periods for 2020 through 2024, by at least 75 percent, of participants in each participating APM Entity group, or each hospital if hospitals are the APM Entities, in the other payer arrangement to document and communicate clinical care; and

(2) For QP Performance Periods beginning on or after January 1, 2024, use of CEHRT (as defined in §414.1305, paragraph (3) in the definition of "Certified Electronic Health Record Technology (CEHRT)"), must be a requirement of participation in the APM.

(c) *Use of quality measures*. (1) To be an Other Payer Advanced APM, a payment arrangement must apply quality measures comparable to measures

under the MIPS quality performance category, as described in paragraph (c)(2) of this section.

(2) At least one of the quality measures used in the payment arrangement as specified in paragraph (c)(1) of this section must:

(i) For QP Performance Period before January 1, 2020, have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

(A) Used in the MIPS quality performance category, as described in § 414.1330;

(B) Endorsed by a consensus-based entity;

(C) Developed under section 1848(s) of the Act;

(D) Submitted in response to the MIPS Call for Quality Measures under section 1848(q)(2)(D)(ii) of the Act; or

(E) Any other quality measures that CMS determines to have an evidence-based focus and to be reliable and valid; and

(ii) For QP Performance Periods beginning on or after January 1, 2020, be:

(A) Finalized on the MIPS final list of measures, as described in § 414.1330;

(B) Endorsed by a consensus-based entity; or

(C) Determined by CMS to be evidence-based, reliable, and valid.

(3) To meet the quality measure use criterion under paragraph (c)(1) of this section, a payment arrangement must:

(i) For QP Performance Periods before January 1, 2020, use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list. This criterion also applies for payment arrangements determined to be Other Payer Advanced APMs on or before January 1, 2020, but only for the Other Payer Advanced APM determination made with respect to the arrangement for the CY 2020 QP Performance Period (regardless of whether that determination is a single- or multi-year determination).

(ii) For QP Performance Periods on or after January 1, 2020, use at least one measure that is an outcome measure and meets the criteria in paragraph (c)(2)(ii) of this section if there is such an applicable outcome measure on the MIPS quality measure list.

(4) A single quality measure that meets the criteria under both para-

graphs (c)(2) and (3) of this section may be used to satisfy the requirements of paragraph (c)(1) of this section.

(d) *Financial risk.* To be an Other Payer Advanced APM, except as described in paragraph (d)(7) of this section, a payment arrangement must meet either the financial risk standard under paragraph (d)(1) or (2) of this section and the nominal amount standard under paragraph (d)(3) or (4) of this section, or be a Medicaid Medical Home Model with criteria comparable to an expanded Medical Home Model under section 1115A(c) of the Act.

(1) *Generally applicable financial risk standard.* Except for APM Entities to which paragraph (d)(2) of this section applies, to be an Other Payer Advanced APM, an APM Entity must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the payment arrangement exceed expected expenditures during a specified period of performance do one or more of the following:

(i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(iii) Require direct payment by the APM Entity to the payer.

(2) *Medicaid Medical Home Model and Aligned Other Payer Medical Home Model financial risk standard.* The APM Entity participates in a Medicaid Medical Home Model or an Aligned Other Payer Medical Home Model that, based on the APM Entity's failure to meet or exceed one or more specified performance standards, does one or more of the following:

(i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians;

(ii) Require direct payment by the APM Entity to the payer;

(iii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(iv) Require the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.

(3) *Generally applicable nominal amount standard.* Except for payment arrangements described in paragraph

(d)(2) of this section, the total amount an APM Entity potentially owes a payer or foregoes under a payment arrangement must be at least:

(i) For QP Performance Periods beginning in 2023, 8 percent of the total combined revenues from the payer to providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue; or, 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.

(ii) Except for risk arrangements described under paragraph (d)(2) of this section, the risk arrangement must have a marginal risk rate of at least 30 percent.

(4) *Medicaid Medical Home Model and Aligned Other Payer Medical Home Model nominal amount standard.* For a Medicaid Medical Home Model or an Aligned Other Payer Medical Home Model to meet the Medicaid Medical Home Model nominal amount standard, the total annual amount that an APM Entity potentially owes a payer or forgoes must be at least the following amounts:

(i) For QP Performance Period 2019, 3 percent of the average estimated total revenue of the participating providers or other entities under the payer.

(ii) For QP Performance Period 2020, 4 percent of the average estimated total revenue of the participating providers or other entities under the payer.

(iii) For QP Performance Periods 2021 and later, 5 percent of the average estimated total revenue of the participating providers or other entities under the payer.

(5) *Marginal risk rate.* For purposes of this section, the marginal risk rate is defined as the percentage of actual expenditures that exceed expected expenditures for which an APM Entity is responsible under an other payer payment arrangement.

(i) In the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the average marginal risk rate across all possible levels of actual expenditures would be used for comparison to the marginal risk rate specified in para-

graph (d)(3)(ii) of this section, with exceptions for large losses as described in paragraph (d)(5)(ii) of this section and small losses as described in paragraph (d)(5)(iii) of this section.

(ii) *Allowance for large losses.* The determination in paragraph (d)(3)(ii) of this section may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by an amount sufficient to require the APM Entity to make financial risk payments under the other payer payment arrangement greater than or equal to the total risk requirement under paragraph (d)(3)(i) of this section.

(iii) *Allowance for minimum loss rate.* The determination in paragraph (d)(3)(ii) of this section may disregard the marginal risk rates that apply in cases when actual expenditures exceed expected expenditures by less than 4 percent of expected expenditures.

(6) *Expected expenditures.* For the purposes of this section, expected expenditures is defined as the Other Payer APM benchmark. For episode payment models, expected expenditures means the episode target price. For purposes of assessing financial risk for Other Payer Advanced APM determinations, the expected expenditures under the payment arrangement should not exceed the expenditures for a participant in the absence of the payment arrangement. If expected expenditures under the payment arrangement exceed the expenditures that the participant would be expected to incur in the absence of the payment arrangement, such excess expenditures are not considered when assessing financial risk under the payment arrangement for Other Payer Advanced APM determinations.

(7) *Capitation.* A full capitation arrangement meets this Other Payer Advanced APM criterion. For purposes of paragraph (d)(3) of this section, a full capitation arrangement means a payment arrangement in which a per capita or otherwise predetermined payment is made under the payment arrangement for all items and services furnished to a population of beneficiaries during a fixed period of time, and no settlement is performed for the purposes of reconciling or sharing