

(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 foregoes 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

losses incurred or savings earned by the participant. Arrangements made directly 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.

(8) *Aligned Other Payer Medical Home Model and Medicaid Medical Home Model 50 eligible clinician limit.* Beginning with the 2023 QP Performance Period, notwithstanding paragraphs (d)(2) and (4) of this section, if an APM Entity participating in an Aligned Other Payer Medical Home Model or Medicaid Medical Home Model is comprised of 50 or more eligible clinicians is comprised of more than 50 eligible clinicians, as determined by the information submitted for any of the three QP determination dates (March 31, June 30, and August 31 of the QP Performance Period) as specified in § 414.1440(e), the requirements of paragraphs (d)(1) and (3) of this section apply.

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§ 414.1425 Qualifying APM participant determination: In general.

(a) *List used for QP determination.* (1) For Advanced APMs in which all APM Entities may include eligible clinicians on a Participation List, the Participation List is used to identify the APM Entity group for purposes of QP determinations, regardless of whether the APM Entity may also include eligible clinicians on an Affiliated Practitioner List.

(2) For Advanced APMs in which APM Entities do not include eligible clinicians on a Participation List but do include eligible clinicians on an Affiliated Practitioner List, the Affiliated Practitioner List is used to identify the eligible clinicians for purposes of QP determinations.

(3) For Advanced APMs in which some APM Entities may include eligible clinicians on a Participation List and other APM Entities may only include eligible clinicians on an Affiliated Practitioner List depending on the type of APM Entity, paragraph

(a)(1) of this section applies to APM Entities that may include eligible clinicians on a Participation List, and paragraph (a)(2) of this section applies to APM Entities that may only include eligible clinicians on an Affiliated Practitioner List.

(b) *Group or individual determination under the Medicare Option.* (1) *APM Entity group determination.* Except for paragraphs (b)(2) and (3) of this section and as set forth in § 414.1440, for purposes of the QP determinations for a year, eligible clinicians are grouped and assessed through their collective participation in an APM Entity group that is in an Advanced APM. To be included in the APM Entity group for purposes of the QP determination, an eligible clinician's APM participant identifier must be present on a Participation List of an APM Entity group on one of the dates: March 31, June 30, or August 31 of the QP Performance Period. An eligible clinician included on a Participation List on any one of these dates is included in the APM Entity group even if that eligible clinician is not included on that Participation List at one of the prior or later listed dates. CMS performs QP determinations for the eligible clinicians in an APM entity group three times during the QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination dates: March 31, June 30, and August 31. An eligible clinician can only be determined to be a QP if the eligible clinician appears on the Participation List on a date (March 31, June 30, or August 31) CMS uses to determine the APM Entity group and to make QP determinations collectively for the APM Entity group based on participation in the Advanced APM.

(2) *Affiliated practitioner individual determination under the Medicare Option.* For Advanced APMs to which paragraph (a)(2) of this section applies, QP determinations are made individually for each eligible clinician. To be assessed as an Affiliated Practitioner, an eligible clinician must be identified on an Affiliated Practitioner List on one of the dates: March 31, June 30, or August 31 of the QP Performance Period. An eligible clinician included on an Affiliated Practitioner List on any one of

these dates is assessed as an Affiliated Practitioner even if that eligible clinician is not included on the Affiliated Practitioner List at one of the prior or later listed dates. For such eligible clinicians, CMS performs QP determinations during the QP Performance Period using claims data for services furnished from January 1 through each of the respective QP determination dates that the eligible clinician is on the Affiliated Practitioner List: March 31, June 30, and August 31.

(c) *QP determination.* (1) CMS makes QP determinations as set forth in §§414.1435 and 414.1440.

(2) An eligible clinician cannot be both a QP and a Partial QP for a year. A determination that an eligible clinician is a QP means that the eligible clinician is not a Partial QP.

(3) An eligible clinician is a QP for a year under the Medicare Option if the eligible clinician is in an APM Entity group that achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold for that QP Performance Period as described in §414.1430(a)(1) and (3). An eligible clinician is a QP for the year under the All-Payer Combination Option if the eligible clinician individually, or as part of an APM Entity group, achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold for that QP Performance Period as described in §414.1430(b)(1) and (3).

(4) Notwithstanding paragraph (c)(3) of this section, an eligible clinician is a QP for a year if:

(i) The eligible clinician is included in more than one APM Entity group and none of the APM Entity groups in which the eligible clinician is included meets the QP payment amount threshold or the QP patient count threshold, or the eligible clinician is an Affiliated Practitioner; and

(ii) CMS determines that the eligible clinician individually achieves a Threshold Score that meets or exceeds the QP payment amount threshold or the QP patient count threshold.

(5) Beginning in the 2020 QP Performance Period, an eligible clinician in an APM Entity is not a QP for a year if:

(i) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or

(ii) The APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk for that QP performance period under the terms of the Advanced APM, even if such termination date occurs within such QP Performance Period.

(6) Beginning in the 2020 QP Performance Period, an eligible clinician is not a QP for a year if:

(i) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities; or

(ii) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities.

(7) Advanced APMs that start or end during the QP Performance Period:

(i) Notwithstanding paragraph (a) of this section and §§414.1435 and 414.1440, CMS makes QP determinations and Partial QP determinations for the APM Entity group or individual eligible clinician under §414.1425(b) for Advanced APMs that start or end during the QP Performance Period and that are actively tested for 60 or more continuous days during the QP Performance Period using claims data for services furnished during those dates on which the Advanced APM is actively tested. For Advanced APMs that start active testing during the QP Performance Period,

CMS performs QP and Partial QP determinations during the QP Performance Period using claims data for services furnished from the start of active testing of the Advanced APM through each of the QP determination dates that occur on or after the Advanced APM has been actively tested for 60 or more continuous days: March 31, June 30, and August 31. For Advanced APMs that end active testing during the QP Performance Period, CMS performs QP and Partial QP determinations using claims data for services furnished from January 1 or the start of active testing, whichever occurs later, through the final day of active testing of the Advanced APM for each of the QP determination dates that occur on or after the Advanced APM has been actively tested for 60 or more continuous days during that QP Performance Period: March 31, June 30, and August 31.

(ii) For QP determinations specified under paragraph (c)(4) of this section and Partial QP determinations under paragraph (d)(2) of this section, QP determinations are made using claims data for the full QP Performance Period even if the eligible clinician participates in one or more Advanced APMs that start or end during the QP Performance Period.

(d) *Partial QP determination.* (1) An eligible clinician is a Partial QP for a year under the Medicare Option if the eligible clinician is in an APM Entity group that achieves Threshold Score that meets or exceeds the corresponding Partial QP payment amount threshold or Partial QP patient count threshold for that QP Performance Period as described in § 414.1430(a)(2) and (4). An eligible clinician is a Partial QP for the year under the All-Payer Combination Option if the eligible clinician achieves individually, or as part of an APM Entity group, a Threshold Score that meets or exceeds the corresponding Partial QP payment amount threshold or Partial QP patient count threshold for that QP Performance Period as described in § 414.1430(b)(2) and (4).

(2) Notwithstanding paragraph (d)(1) of this section, an eligible clinician is a Partial QP for a year if:

(i) The eligible clinician is included in more than one APM Entity group

and none of the APM Entity groups in which the eligible clinician is included meets the corresponding QP or Partial QP threshold, or the eligible clinician is an Affiliated Practitioner; and

(ii) CMS determines that the eligible clinician individually achieves a Threshold Score that meets or exceeds the corresponding Partial QP Threshold.

(3) Beginning in the 2020 QP Performance Period, an eligible clinician is not a Partial QP for a year if:

(i) The APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or

(ii) The APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk for that performance period under the terms of the Advanced APM.

(4) Beginning in the 2020 QP Performance Period, an eligible clinician is not a Partial QP for a year if:

(i) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities; or

(ii) One or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM, and the eligible clinician does not achieve a Threshold Score that meets or exceeds the Partial QP payment amount threshold or Partial QP patient count threshold based on participation in the remaining non-terminating APM Entities.

(e) *Notification of QP determination.* CMS notifies eligible clinicians determined to be QPs or Partial QPs for a year as soon as practicable following each QP determination date in the QP Performance Period.