at the additional performance threshold and an additional adjustment factor of 10 percent is assigned for a final score of 100, subject to the application of a scaling factor as determined by CMS, such that the estimated aggregate increase in payments resulting from the application of the additional MIPS payment adjustment factors for the MIPS payment year shall not exceed $500,000,000 for each of the MIPS payment years 2019 through 2024.

(2) [Reserved]

(e) *Application of adjustments to payments.* For each MIPS payment year, the MIPS payment adjustment factor, and if applicable the additional MIPS payment adjustment factor, are applied to Medicare Part B payments for items and services furnished by the MIPS eligible clinician during the year.

§414.1410 Advanced APM determination.

(a) *General.* An APM is an Advanced APM for a payment year if CMS determines that it meets the criteria in §414.1415 during the QP Performance Period.

(b) *Advanced APM and Other Payer Advanced APM determination process.* CMS identifies Advanced APMs and Other Payer Advanced APMs in the following manner:

(1) *Advanced APM determination.* (i) No later than January 1, 2017, CMS will post on its Web site a list of all Advanced APMs for the first QP Performance Period.

(ii) CMS updates the Advanced APM list on its Web site at intervals no less than annually.

(iii) CMS will include notice of whether a new APM is an Advanced APM in the first public notice of the new APM.

(2) *Other Payer Advanced APM determination.* (i) CMS identifies Other Payer Advanced APMs following conclusion of the QP Performance Period using information submitted to CMS according to §414.1445. CMS will not make determinations for other payer arrangements for which insufficient information is submitted.

(ii) CMS makes Other Payer Advanced APM determinations prior to QP determinations under §414.1440.

(iii) CMS makes final Other Payer Advanced APM determinations and notifies Advanced APM Entities and eligible clinicians of such determinations as soon as practicable.

§414.1415 Advanced APM criteria.

(a) *Use of certified electronic health record technology (CEHRT)*—(1) *Required use of CEHRT.* To be an Advanced APM, an APM must:

(i) Require at least 50 percent of eligible clinicians in each participating APM Entity group, or, for APMs in which hospitals are the APM Entities, each hospital, to use CEHRT to document and communicate clinical care to their patients or other health care providers; or

(ii) For the Shared Savings Program, apply a penalty or reward to an APM Entity based on the degree of the use of CEHRT of the eligible clinicians in the APM Entity.

(b) *Payment based on quality measures.* (1) To be an Advanced APM, an APM must include quality measure results as a factor when determining payment to participants under the terms of the APM.

(2) At least one of the quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

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

(ii) Endorsed by a consensus-based entity;

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

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

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

(3) In addition to the quality measure requirements under paragraph (b)(2) of this section, the quality measures upon which an Advanced APM bases the payment in paragraph (b)(1) of this section must include at least one outcome measure. This requirement does not apply if CMS determines that there are no available or applicable outcome

measures included in the MIPS quality measures list for the Advanced APM's first QP Performance Period.

(c) *Financial risk.* To be an Advanced APM, an APM must either meet 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 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 following standard applies only for APM Entities that are participating in Medical Home Models, and, starting in the 2018 QP Performance Period, such APM Entities must be owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities. 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 2017 and 2018, 8 percent of the estimated average total Medicare Parts A and B revenues of 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 be an Advanced APM, the total annual amount that an Advanced 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 estimated average total Medicare Parts A and B revenues of participating APM Entities.

(B) For QP Performance Period 2018, 3 percent of the estimated average total Medicare Parts A and B revenues of participating APM Entities;

(C) For QP Performance Period 2019, 4 percent of the estimated average total Medicare Parts A and B revenues of participating APM Entities.

(D) For QP Performance Period 2020 and later, 5 percent of the estimated average total Medicare Parts A and B revenues of participating APM Entities.

(5) *Expected expenditures.* For the purposes of this section, expected expenditures is defined as the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures mean the episode target price.

(6) *Capitation.* A full capitation arrangement meets this Advanced APM criterion. For purposes of this part, a 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 for which payment is made through the APM furnished to a population of beneficiaries, 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 (42 U.S.C. 422) are not considered capitation arrangements for purposes of this paragraph.

§ 414.1420 Other payer advanced APMs.

(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 bears 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)(3) of this section.

(b) *Use of CEHRT.* To be an Other Payer Advanced APM, an other payer arrangement must require participants to use CEHRT as defined in § 414.1305. The other payer arrangement must require at least 50 percent of eligible clinicians in each participating APM Entity group, or each hospital if hospitals are the APM Entities, to use CEHRT to document and communicate clinical care.

(c) *Quality measure use.* (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 with an APM Entity must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:

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

(ii) Endorsed by a consensus-based entity;

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

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

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

(3) To meet the quality measure use criterion, an other payment arrangement must use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list. If an Other Payer Advanced APM has no outcome measure, the Advanced APM Entity must attest that there is no applicable outcome measure on the MIPS list.

(d) *Other Payer Advanced APM financial risk.* To be an Other Payer Advanced APM, an other payer arrangement must meet either the financial risk standard under paragraph (d)(1) or (2) of this section and the nominal risk standard under paragraph (d)(3) or (4) of this section, make payment using a full capitation arrangement under paragraph (d)(6) of this section, or be a Medicaid Medical Home Model that meets criteria comparable to an expanded Medical Home Model under section 1115A(c) of the Act.

(1) *Other Payer Advanced APM 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 APM exceed expected expenditures during a specified 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 direct payment by the APM Entity to the payer.