

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 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)(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.

(2) *Medicaid Medical Home Model financial risk standard.* For an APM Entity 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 following standard applies. The APM Entity participates in a Medicaid 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 Medicaid program;
- (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) *Other Payer Advanced APM nominal amount standard.* (i) Except for risk arrangements described under paragraph (d)(2) of this section, the total amount an APM Entity potentially owes us or foregoes under an Other Payer Advanced APM is at least be equal to 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) A marginal risk rate of at least 30 percent; and
- (B) Total potential risk of at least 4 percent of expected expenditures.

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

(i) For QP Performance Period 2019, 4 percent of the estimated average total revenue of participating APM Entities from the payer.

(ii) For QP Performance Period 2020 and later, 5 percent of the estimated average total revenue of participating APM Entities for 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 APM.

(i) In the event that the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the lowest marginal risk rate across all possible levels of actual expenditures would be used for comparison to the marginal risk rate specified in paragraph (d)(3)(ii)(A) 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)(A) 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 Advanced APM 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)(A) 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 Advanced APM benchmark, except for episode payment models, for which it is defined as the episode target price.

(7) *Capitation.* A capitation arrangement meets this Other Payer Advanced APM criterion. For purposes of paragraph (d)(3) of this section, 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 for the purpose of reconciling or sharing losses incurred or savings earned by the APM Entity. Arrangements made directly 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.

§414.1425 Qualifying APM participant determination: In general.

(a) *List used for QP determination.* (1) For Advanced APMs with Advanced APM Entities that include eligible clinicians on a Participation List, the Participation List defines the APM Entity group, regardless of whether the Advanced APM Entity also has eligible clinicians on an Affiliated Practitioner List.

(2) For Advanced APMs with Advanced APM Entities that do not include eligible clinicians on a Participation List but do include eligible clinicians on an Affiliated Practitioner List, the Affiliated Practitioner List defines the eligible clinicians who will be assessed to become QPs.

(3) For Advanced APMs with some Advanced APM Entities that include eligible clinicians on a Participation List and other Advanced APM Entities that only include eligible clinicians on an Affiliated Practitioner List, paragraph (a)(1) applies to APM Entities that include eligible clinicians on a Participation List, and paragraph (a)(2) applies to APM Entities that only include eligible clinicians on an Affiliated Practitioner List.

(b) *Group or individual determination—*

(1) *APM Entity group determination.* Except for §414.1445 and paragraph (b)(2) of this section, 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 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 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.* When the Affiliated Practitioner List defines the eligible clinicians to be assessed, for purposes of the QP determinations for a year, those eligible clinicians are assessed individually. 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 that 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.