§414.1430 Qualifying APM participant determination: QP and partial QP thresholds.

(a) *Medicare Option*—(1) *QP payment amount threshold.* The QP payment amount thresholds are the following values for the indicated payment years:
(i) 2019 and 2020: 25 percent.
(ii) 2021 and 2022: 50 percent.
(iii) 2023 and later: 75 percent.
(2) *Partial QP payment amount threshold.* The Partial QP payment amount thresholds are the following values for the indicated payment years:
(i) 2019 and 2020: 20 percent.
(ii) 2021 and 2022: 40 percent.
(ii) 2023 and later: 50 percent.
(3) *QP patient count threshold.* The QP patient count thresholds are the following values for the indicated payment years:
(i) 2019 and 2020: 20 percent
(ii) 2021 and 2022: 35 percent
(ii) 2023 and later: 50 percent
(4) *Partial QP patient count threshold.* The Partial QP patient count thresholds are the following values for the indicated payment years:
(i) 2019 and 2020: 10 percent
(ii) 2021 and 2022: 25 percent
(iii) 2023 and later: 35 percent
(b) *All-Payer Combination Option*—(1) *QP payment amount threshold.*
(i) The QP payment amount thresholds are the following values for the indicated payment years:
(A) 2021 and 2022: 50 percent.
(B) 2023 and later: 75 percent.
(ii) To meet the QP payment amount threshold under this option, the eligible clinician must also meet a 25 percent QP payment amount threshold under the Medicare Option.
(2) *Partial QP payment amount threshold.* (i) The Partial QP payment amount thresholds are the following values for the indicated payment years:
(A) 2021 and 2022: 40 percent.
(B) 2023 and later: 50 percent.
(ii) To meet the QP payment amount threshold under this option, the eligible clinician must also meet a 20 percent Partial QP payment amount threshold under the Medicare Option.
(3) *QP patient count threshold.* (i) The QP patient count thresholds are the following values for the indicated payment years:
(A) 2021 and 2022: 35 percent.
(B) 2023 and later: 50 percent.
(ii) To meet the QP patient count threshold under this option, the eligible clinician must also meet a 20 percent QP patient count threshold under the Medicare Option.
(4) *Partial QP patient count threshold.* (i) The Partial QP patient count thresholds are the following values for the indicated payment years:
(A) 2021 and 2022: 25 percent.
(B) 2023 and later: 35 percent.
(ii) To meet the Partial QP patient count threshold under this option, the eligible clinician group or eligible clinician must also meet a 10 percent QP patient count threshold under the Medicare Option.

§414.1435 Qualifying APM participant determination: Medicare option.

(a) *Payment amount method.* The Threshold Score for an Advanced APM Entity group or eligible clinician is calculated as a percent by dividing the value described under paragraph (a)(1) of this section by the value described under paragraph (a)(2) of this section.
(1) *Numerator.* The aggregate of payments for Medicare Part B covered professional services furnished by the Advanced APM Entity group to attributed beneficiaries during the QP Performance Period.
(2) *Denominator.* The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity group to all attribution-eligible beneficiaries during the QP Performance Period.
(3) *Claims and adjustments.* In the calculations under paragraphs (a)(1) and (2) of this section, CMS compiles claims and treats claims adjustments, 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 Advanced 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 Advanced 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 Advanced APM Entity groups.

(c) *Attribution.* (1) Attributed beneficiaries are determined from Advanced APM attributed beneficiary lists generated by each Advanced APM's specific attribution methodology.

(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 Advanced APM Entity under both the payment amount and patient count methods for each QP Performance Period. CMS then assigns the score to the eligible clinicians included in the Advanced APM Entity that results in the greater QP status. QP status is greater than a Partial QP status, which is greater than no QP status.

§ 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 Medical Home Model or APM is available.

(2) Title XIX payments will only be included in the numerator and denominator as specified in paragraphs (b)(2) and (3) of this section for an Advanced APM Entity if:

(i) A State has at least one Medicaid Medical Home Model or Medicaid APM in operation that is determined to be an Other Payer Advanced APM; and

(ii) The Advanced APM Entity is eligible to participate in at least one of such Other Payer Advanced APMs during the QP Performance Period, regardless of whether the Advanced APM Entity actually participates in such Other Payer Advanced APMs. This will apply to both the payment amount and patient count methods.

(b) *Payment amount method*—(1) *In general.* The Threshold Score for an Advanced 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, to the Advanced APM Entity group or eligible clinician under the terms of Other Payer Advanced APMs during the QP Performance Period. CMS calculates Medicare Part B covered professional services under the All-Payer Combination Option in the same manner as it is calculated under the Medicare Option.

(3) *Denominator.* The aggregate amount of all payments from all payers, except those excluded under paragraph (a) of this section, to the Advanced APM Entity group during the QP Performance Period. The portion of this amount that relates to Medicare Part B covered professional services is