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

calculated under the All-Payer Combination Option in the same manner as it is calculated under the Medicare Option.

(c) *Patient count method*—(1) *In general.* The Threshold Score for an Advanced APM Entity group or eligible clinician is calculated by dividing the value described under the numerator by the value described under the denominator as specified in paragraphs (c)(2) and (3) of this section).

(2) *Numerator.* The number of unique patients to whom the Advanced APM Entity group or eligible clinician furnishes services that are included in the measures of aggregate expenditures used under the terms of all of their Other Payer Advanced APMs during the QP Performance Period, plus the patient count numerator specified in paragraph (a)(1) of this section.

(3) *Denominator.* The number of unique patients to whom eligible clinicians in the Advanced APM Entity group furnish services under all non-excluded payers during the QP Performance Period.

(d) *Participation in multiple Other Payer Advanced APMs.* (1) For each APM Entity group or eligible clinician, a unique patient is counted no more than one time for the numerator and no more than one time for the denominator for each payer.

(2) CMS may count a single patient in the numerator and/or denominator for multiple different Advanced APM Entities or eligible clinicians.

(3) For purposes of this section, Advanced APM Entities are considered the same entity across Other Payer Advanced APMs if CMS determines that the Participation Lists are substantially similar or if one entity is a subset of the other.

§414.1445 Identification of other payer advanced APMs.

(a) *Identification of Medicaid APMs.* CMS will make an annual determination prior to the QP Performance Period to identify Medicaid Medical Home Models and Medicaid APMs.

(b) *Data used to calculate the Threshold Score under the All-Payer Combination Option.* To be assessed under the All-Payer Combination Option, APM Entities or eligible clinicians must submit the following information for each other payment arrangement in a manner and by a date specified by CMS:

(1) Payment arrangement information necessary to assess the other payer arrangement on all Other Payer Advanced APM criteria under §414.1420;

(2) For each other payment arrangement, the amount of revenues for services furnished through the arrangement, the total revenues from the payer, the numbers of patients furnished any service through the arrangement, and the total numbers of patients furnished any service through the payer.

(3) An attestation from the payer that the submitted information is accurate.

(c) *Requirement to submit adequate information.* (1) CMS makes a QP determination with respect to the individual eligible clinician under the All-Payer Combination Option if:

(i) The eligible clinician's Advanced APM Entity submits the information required under this section for CMS to assess the APM Entity group under the All-Payer Combination Option; or

(ii) The eligible clinician submits adequate information under this section.

(2) If neither the Advanced APM Entity nor the eligible clinician submits all of the information required under this section, then CMS does not make a QP assessment for such eligible clinician under the All-Payer Combination Option.

(d) *Outcome measure.* An Other Payer Advanced APM must base payment on at least one outcome measure.

(1) *Exception.* If an Other Payer Advanced APM has no outcome measure, the Advanced APM Entity must submit an attestation in a manner and by a date determined by CMS that there is no available or applicable outcome measure on the MIPS list of quality measures.

(2) [Reserved]

§414.1450 APM incentive payment.

(a) *In general.* (1) CMS makes a lump sum payment to QPs in the amount described in paragraph (b) of this section in the manner described in paragraphs (d) and (e) of this section.