

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.

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(2) CMS provides notice of the amount of the APM Incentive Payment to QPs as soon as practicable following the calculation and validation of the APM Incentive Payment amount, but in any event no later than 1 year after the incentive payment base period.

(b) *APM Incentive Payment amount.* (1) The amount of the APM Incentive Payment is equal to 5 percent of the estimated aggregate payments for covered professional services as defined in section 1848(k)(3)(A) of the Act furnished during the calendar year immediately preceding the payment year.

(2) The estimated aggregate payment amount for covered professional services includes all such payments to any and all of the TIN/NPI combinations associated with the NPI of the QP.

(3) In calculating the estimated aggregate payment amount for a QP, CMS uses claims submitted with dates of service from January 1 through December 31 of the incentive payment base period, and processing dates of January 1 of the base period through March 31 of the subsequent payment year.

(4) The payment adjustment amounts, negative or positive, as described in sections 1848(m), (o), (p), and (q) of the Act are not included in calculating the APM Incentive Payment amount.

(5) Incentive payments made to eligible clinicians under sections 1833(m), (x), and (y) of the Act are not included in calculating the APM Incentive Payment amount.

(6) Financial risk payments such as shared savings payments or net reconciliation payments are excluded from the amount of covered professional services in calculating the APM Incentive Payment amount.

(7) Supplemental service payments in the amount of covered professional services are included in calculating the APM Incentive Payment amount according to this paragraph (b). Supplemental service payments are included in the amount of covered professional services when calculating the APM Incentive Payment amount when the supplemental service payment meets the following four criteria:

(i) Is payment for services that constitute physicians services authorized

under section 1832(a) and defined under section 1861(s) of the Act.

(ii) Is made for only Part B services under the criterion in paragraph (b)(9)(i) of this section.

(iii) Is directly attributable to services furnished to an individual beneficiary.

(iv) Is directly attributable to an eligible clinician, including an eligible clinician that is a group of individual eligible clinicians.

(8) For payment amounts that are affected by a cash flow mechanism, the payment amounts that would have occurred if the cash flow mechanism were not in place are used in calculating the APM Incentive Payment amount.

(c) *APM Incentive Payment recipient.* (1) CMS pays the entire APM Incentive Payment amount to the TIN associated with the QP's participation in the Advanced APM entity that met the applicable QP threshold during the QP Performance Period.

(2) In the event that an eligible clinician is no longer affiliated with the TIN associated with the QP's participation in the Advanced APM Entity that met the applicable QP threshold during the QP Performance Period at the time of the APM Incentive Payment distribution, CMS makes the APM Incentive Payment to the TIN listed on the eligible clinician's CMS-588 EFT Application form on the date that the APM Incentive Payment is distributed.

(3) In the event that an eligible clinician becomes a QP through participation in multiple Advanced APMs, CMS divides the APM Incentive Payment amount between the TINs associated with the QP's participation in each Advanced APM during the QP Performance Period. Such payments will be divided in proportion to the amount of payments associated with each TIN that the eligible clinician received for covered professional services during the QP Performance Period.

(d) *Timing of the APM Incentive Payment.* APM Incentive Payments made under this section are made as soon as practicable following the calculation and validation of the APM Incentive Payment amount, but in any event no later than 1 year after the incentive payment base period.

(e) *Treatment of APM Incentive Payment amount in APMs.* (1) APM Incentive Payments made under this section are not included in determining actual expenditures under an APM.

(2) APM Incentive Payments made under this section are not included in calculations for the purposes of re-basing benchmarks in an APM.

(f) *Treatment of APM Incentive Payment for other Medicare incentive payments and payment adjustments.* APM Incentive Payments made under this section will not be included in determining the amount of incentive payment made to eligible clinicians under section 1833(m), (x), and (y) of the Act.

**§ 414.1455 Limitation on review.**

There is no administrative or judicial review under sections 1869, 1878, or otherwise, of the Act of the following:

(a) The determination that an eligible clinician is a QP or Partial QP under § 414.1425 and the determination that an APM Entity is an Advanced APM Entity under § 414.1410.

(b) The determination of the amount of the APM Incentive Payment under § 414.1450, including any estimation as part of such determination.

**§ 414.1460 Monitoring and program integrity.**

(a) *Vetting eligible clinicians prior to payment of the APM Incentive Payment.* Prior to payment of the APM Incentive Payment, CMS determines if eligible clinicians were in compliance with all Medicare conditions of participation and the terms of the relevant Advanced APMs in which they participate during the QP Performance Period. For QPs not meeting these standards there may be a reduction or denial of the APM Incentive Payment. A determination under this provision is not binding for other purposes.

(b) *Termination by Advanced APMs.* CMS may reduce or deny an APM Incentive Payment to eligible clinicians who are terminated by APMs or whose Advanced APM Entities are terminated by APMs for non-compliance with all Medicare conditions of participation or the terms of the relevant Advanced APMs in which they participate during the QP Performance Periods.

(c) *Information submitted for All-Payer Combination Option.* Information submitted by eligible clinicians or Advanced APM Entities to meet the requirements of the All-Payer Combination Option may be subject to audit by CMS. Eligible clinicians and Advanced APM Entities must maintain copies of any supporting documentation related to All-Payer Combination Option for at least 10 years and must attest to the accuracy and completeness of the data submitted.

(d) *Recoupment of APM Incentive Payment.* For any QPs who are terminated from an Advanced APM or found to be in violation of any Federal, State, or tribal statute, regulation, or other binding guidance during the QP Performance Period or Incentive Payment Base Period or terminated after these periods as a result of a violation occurring during either period, CMS may rescind such eligible clinicians' QP determinations and, if necessary, recoup part or all of any such eligible clinicians' APM Incentive Payment or deduct such amount from future payments to such individuals. CMS may reopen and recoup any payments that were made in error in accordance with procedures similar to those set forth at 42 CFR 405.980 and 42 CFR 405.370 through 405.379 or established under the relevant APM. The APM Incentive Payment will be recouped if an audit reveals a lack of support for attested statements provided by eligible clinicians and Advanced APM Entities.

(e) *Maintenance of records.* An Advanced APM Entity or eligible clinician that submits information to CMS under § 414.1445 for assessment under the All-Payer Combination Option must maintain such books contracts, records, documents, and other evidence for a period of 10 years from the final date of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection, whichever is later, unless:

(1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the Advanced APM Entity of eligible clinician at least 30 days before the formal disposition date; or

(2) There has been a termination, dispute, or allegation of fraud or similar