



Introduction

This guide is intended to serve as a quick resource for identifying key aspects of participation under the Advanced Alternative Payment Model (Advanced APM) track of the Medicare Quality Payment Program (QPP); additional policies also apply to the Advanced APM Track that are not included here.¹ Terms in **bold and underlined** include links for further explanation.

As a reminder, clinicians must meet the following two criteria in order to qualify as **Qualifying APM Participants (QPs)** who participate under the Advanced APM track of the QPP. Qualification for this track entitles them to exemption from MIPS for payment years 2019 through 2024 (qualification determined annually); for those eligible clinicians who qualify as QPs, a 5 percent lump sum incentive payment based on Medicare payments for covered professional services in the year previous to the payment year will be paid to the Tax Identification Number (TIN) in which the eligible clinician participates that is affiliated with the **APM Entity**, to be distributed as agreed upon between the TIN and its participating eligible clinicians.

- Criterion 1: Must be on a **Participation List** or, if a Participation List does not include eligible clinicians, an **Affiliated Practitioner List** for a CMS APM² that is determined to be an **Advanced APM** or for an Other Payer Arrangement³ that is determined to be an **Other Payer Advanced APM**.
- Criterion 2: Must have threshold levels of participation through one or more Advanced APMs or Other Payer Advanced APMs, based on either a Percent of Payments Threshold or a Percent of Patients Threshold (see **Table 2**).
 - The thresholds may be applied to participation in Advanced APMs only (**Medicare Only Option**), or – beginning with 2019 participation – to participation in both Advanced APMs and Other Payer Advanced APMs (**All Payer Combination Option**).
 - Clinicians who qualify as **Partial Qualifying APM Participants (Partial QPs)** by meeting somewhat lower participation thresholds may also be exempt from MIPS unless they actively elect to report under that program, but they will not be eligible to receive the QP bonus.⁴

The following tables provide additional detail to better understand how qualification under the Advanced APM Track of the QPP is determined:

- **Table 1**: Criteria for APMs or Other Payer Arrangements to Qualify as Advanced APMs or Other Payer Advanced APMs
- **Table 2**: Final QP Thresholds and Partial QP Thresholds
- **Table 3**: Key Variables in the QP Determination Process
- **Table 4**: Key Concepts and Terms under the Advanced APM Track of the QPP

¹ The information in this document reflects Hart Health Strategies' understanding of final policies based on available information and may be subject to change.

² Note: For the purposes of this Resource Guide, the term "CMS APM" refers to those models that fall under MACRA's statutory definition for Alternative Payment Model (APM). These include: Centers for Medicare and Medicaid Services (CMS) Innovation Center models other than a Health Care Innovation Award; the Medicare Shared Savings Program; a Health Care Quality Demonstration under section 1866 of the Social Security Act; or a demonstration required by federal law.

³ The term "Other Payer Arrangements" means a payment arrangement with any payer that is not a CMS APM.

⁴ New for 2019, a Partial QP must submit an affirmative election if he or she wishes to be evaluated under the MIPS program. Previously CMS used the Partial QP's actual MIPS reporting activity to determine whether to exclude Partial QPs from MIPS.

Table 1: Criteria for APMs or Other Payer Arrangements to Qualify as Advanced APMs or Other Payer Advanced APMs

Policy	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
<p>Criterion 1: Use of certified electronic health record technology (CEHRT)</p>	<p>A CMS APM must require at least 75 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.</p> <p><u>For Other Payer Arrangements</u>, the same requirement for a CMS APM above applies to Other Payer Arrangements. However, CMS is offering flexibility by stating that a payer or eligible clinician must provide documentation to CMS that CEHRT is used to document and communicate clinical care under the payment arrangement, regardless of whether such CEHRT use is explicitly required under the terms of the payment arrangement.</p>
<p>Criterion 2: Payment based on quality measures</p>	<p><u>A CMS APM</u> must include quality measure results as a factor when determining payment to participants under the terms of the APM, and at least one of the measures upon which payment is based must meet the below criteria.</p> <p><u>For Other Payer Arrangements</u>, the payment arrangement must apply quality measures that meet the below criteria.</p> <p><u>Criteria</u>⁵:</p> <p>At least one of the quality measures must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:</p> <ol style="list-style-type: none"> 1. Used in the MIPS quality performance category 2. Endorsed by a consensus-based entity; 3. Developed under section 1848(s) of the Act, which provides priorities and funding for measure development; 4. Submitted in response to the MIPS Call for Quality Measures; or 5. Any other quality measures that CMS determines to have an evidence- based focus and to be reliable and valid.

⁵ In the 2019 final rule, CMS finalized separate criteria that will apply for 2020 performance, specifically that: at least one of the quality measures upon which an Advanced APM bases payment must be finalized on the MIPS final list of measures; be endorsed by a consensus-based entity; or otherwise determined by CMS to be evidence-based, reliable, and valid.

Policy	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
	<p><u>Additional outcome measure requirement for CMS APMs⁶</u>: In addition, the quality measures upon which an Advanced APM bases the payment 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.</p> <p><u>Additional outcome measure requirement for Other Payer Arrangements⁷</u>: The arrangement must use an outcome measure if there is an applicable outcome measure on the MIPS quality measure list. Otherwise, the payer, APM Entity, or eligible clinician requesting a determination must certify that there is no available or applicable outcome measure on the MIPS measure list.</p>
Criterion 3: Financial Risk Overview	<p><u>A CMS APM must meet:</u></p> <ol style="list-style-type: none"> 1. The generally applicable financial risk standard OR the Medical Home Model financial risk standard; AND 2. The generally applicable nominal amount standard OR the Medical Home Model nominal amount standard. <p>Alternatively, the model can be a Medical Home Model expanded under CMS Innovation Center authority.⁸</p> <p><u>An Other Payer Arrangement must meet:</u></p> <ol style="list-style-type: none"> 1. The generally applicable financial risk standard that applies for Other Payer Arrangements OR the Medicaid Medical Home Model financial risk standard; AND 2. The generally applicable nominal amount standard that applies for Other Payer Arrangements OR the Medicaid Medical Home Model nominal amount standard. <p>Alternatively, the arrangement can:</p> <ol style="list-style-type: none"> 1. Make payment using a full capitation arrangement or 2. Be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Model expanded under CMS Innovation Center authority.⁹

⁶ In the 2019 final rule, CMS finalized that the outcome measure on which an Advanced APM must base payment must be evidence-based, reliable, and valid unless there is no available or applicable outcome measure.

⁷ In the 2019 final rule, CMS finalized that the outcome measure on which an Other Payer Advanced APM must base payment must be evidence-based, reliable, and valid unless there is no available or applicable outcome measure.

⁸ No such models exist at this time.

⁹ No such models exist at this time.

Policy	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
<p><i>Financial risk</i> Generally applicable standard</p>	<p>The following requirements apply based on whether an APM Entity’s actual expenditures for which the APM Entity is responsible exceed expected expenditures during a specified QP Performance Period. If actual expenditures exceed expected expenditures, then one or more of the following must apply.</p> <p>The CMS or Other Payer Arrangement must:</p> <ol style="list-style-type: none"> 1. Withhold payment for services to the APM Entity or the APM Entity’s eligible clinicians; 2. Reduce payment rates to the APM Entity or the APM Entity’s eligible clinicians; or 3. One of the following: <ol style="list-style-type: none"> a. <u>For a CMS APM:</u> Require the APM Entity to owe payment(s) to CMS. b. <u>For an Other Payer Arrangement:</u> Require direct payment by the APM Entity to the payer.
<p><i>Financial risk</i> Medical Home Model standard/ Medicaid Medical Home Model standard</p>	<p>This standard only applies for APM Entities that are participating in CMS Medical Home Models or Medicaid Medical Home Models. Note that, except for the 2017 QP Performance Period, and except for APM Entities participating in Round 1 of the Comprehensive Primary Care Plus (CPC+) Model, 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 (or its subsidiaries) in order for this standard to apply.</p> <p>Specifically, if an APM Entity fails to meet or exceed one or more specified performance standards (which may, but do not have to include, expected expenditures), the CMS APM or Other Payer Arrangement must do one or more of the following:</p> <ol style="list-style-type: none"> 1. Withhold payment for services to the APM Entity or the APM Entity’s eligible clinicians; 2. Reduce payment rates to the APM Entity or the APM Entity’s eligible clinicians; 3. Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments; OR 4. One of the following: <ol style="list-style-type: none"> a. <u>For a CMS APM:</u> Require the APM Entity to owe payment(s) to CMS; or b. <u>For an Other Payer Medicaid Medical Home Model:</u> Require direct payment by the APM Entity to the Medicaid program.

Policy	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
<p><i>Financial risk – nominal amount</i> Generally applicable standard</p>	<p><u>For CMS APMs</u>: The total amount an APM Entity potentially owes to CMS or foregoes under an Advanced APM must be at least equal to:</p> <ol style="list-style-type: none"> 1. For QP Performance Periods 2017 through 2024: 8 percent of the estimated average total Medicare Parts A and B revenues of the participating APM Entities; OR 2. 3 percent of expected expenditures for which an APM Entity is responsible under the APM. <p><u>For Other Payer Arrangements</u>: The total amount an APM Entity potentially owes or foregoes under an Other Payer Advanced APM is at least:</p> <ol style="list-style-type: none"> 1. 8 percent of the total revenue from the payer of providers and suppliers participating in each APM Entity in the payment arrangement if financial risk is expressly defined in terms of revenue; OR 2. At least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.¹⁰ <p>Additionally, under this standard for Other Payer Arrangements, the risk arrangements must have:</p> <ol style="list-style-type: none"> 1. A marginal risk rate of at least 30 percent;¹¹ and 2. A minimum loss rate (MLR) of no greater than 4 percent of expected expenditures.

¹⁰ While regulatory text at 42 CFR 414.1420(d)(3)(ii)(B) states that total potential risk must be at least 4 percent of expected expenditures, CMS policies finalized at 81 FR 77471 state that CMS is “finalizing that a payment arrangement must require APM Entities to bear financial risk for at least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement.” CMS has since also engaged in public outreach referring to the 3 percent requirement; see this [slide deck](#) as an example.

¹¹ Additional requirements and exceptions apply regarding the marginal risk rate, which is the percentage of actual expenditures that exceed expected expenditures for which an APM Entity is responsible under an Other Payer Arrangement.

Policy	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
<p><i>Financial risk – nominal amount</i> Medical Home Model standard/ Medicaid Medical Home Model standard</p>	<p>This standard applies to the same APM Entities as the Financial Risk Medical Home Model Standard.</p> <p><u>For CMS APMs:</u> The total amount an APM Entity potentially owes to CMS or foregoes under an APM must be at least equal to:</p> <ol style="list-style-type: none"> 1. For QP Performance Period 2017, 2.5 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities. 2. For QP Performance Period 2018, 2.5 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities. 3. For QP Performance Period 2019, 3 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities. 4. For QP Performance Period 2020, 4 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities. 5. For QP Performance Period 2021 and later, 5 percent of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating APM Entities. <p><u>For Other Payer Medicaid Medical Home Models:</u> The total annual amount that an APM Entity potentially owes or foregoes must be at least the following amounts:</p> <ol style="list-style-type: none"> 1. For QP Performance Period 2019, 3 percent of the APM Entity’s total revenue under the payer. 2. For QP Performance Period 2020, 4 percent of the APM Entity’s total revenue under the payer. 3. For QP Performance Period 2021, 5 percent of the APM Entity’s total revenue under the payer.

Table 2: Final Qualifying APM Participant (QP) Thresholds and Partial Qualifying APM Participant (Partial QP) Thresholds

Note: The percentages included in this table were finalized in the CY 2017 QPP Final Rule for all applicable years, and CMS did not propose or finalize any policies to update these percentages in the CY 2018 or CY 2019 QPP Rule.

Payment Year	Payment Amount Threshold			Patient Threshold		
	Medicare Only Option	All Payer Combination Option		Medicare Only Option	All Payer Combination Option	
		Medicare Payments	All Payer Payments		Medicare Patients	All Payer Patients
QP Thresholds						
2019 and 2020	25%	N/A	N/A	20%	N/A	N/A
2021 and 2022	50%	25%	50%	35%	20%	35%
2023 onward	75%	25%	75%	50%	20%	50%
Partial QP Thresholds						
2019 and 2020	20%	N/A	N/A	10%	N/A	N/A
2021 and 2022	40%	20%	40%	25%	10%	25%
2023 onward	50%	20%	50%	35%	10%	35%

Note that the following numerators and denominators apply under CY 2018 QPP Final Rule policies, and that they continue to apply for 2019.^{12,13} See the discussion on [Level of Threshold Analysis for QP Determinations](#) for additional information on when CMS makes QP determinations on a collective basis (for an APM Entity Group) versus on an individual basis.

- Percent of Payments (Medicare Payments)
 - Numerator: The aggregate of payments for Medicare Part B covered professional services furnished by the APM Entity Group to [attributed beneficiaries](#) during the QP performance period.
 - 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.
- Percent of Payments (All Payer Combination Option)

¹² Numerator and denominator descriptions are generally pulled from finalized regulation text as amended under the CY 2018 QPP Final Rule. In such text, CMS did not clearly identify how the descriptions would apply for individual-level determinations (versus determinations for an APM Entity Group). Based on a QP Methodology Fact Sheet released on October 4, 2017, CMS will make individual-level determinations as follows: *Under the payment amount approach, CMS will compute the eligible clinician’s Threshold Score by (1) summing the eligible clinician’s payments for all services furnished to beneficiaries that were attributed to the eligible clinician’s Advanced APM Entities, (2) dividing that sum by the eligible clinician’s payments for all services furnished to beneficiaries who were attribution-eligible for one or more of the eligible clinician’s Advanced APM Entities, and (3) multiplying the result by 100. The patient count approach will be analogous, with each beneficiary counted only once in the numerator and denominator even if the eligible clinician treated that beneficiary through more than one Advanced APM Entity during the QP Performance Period.*

¹³ For the purposes of the All-Payer Combination Option, CMS also finalized for 2018 a special methodology for determining individual level threshold score in cases where an eligible clinician’s threshold score at the individual level is a lower percentage than the one calculated at the APM Entity Group level.

- Numerator: The aggregate amount of all payments from all payers, except excluded payments,¹⁴ to the APM Entity Group or eligible clinician under the terms of all Advanced APMs and Other Payer Advanced APMs during 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.
- Denominator: The aggregate amount of all payments from all payers, except excluded payments, to the APM Entity Group or eligible clinician 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.
- Percent of Patients (Medicare Patients)
 - Numerator: The number of attributed beneficiaries to whom the 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.
 - Denominator: The number of attribution-eligible beneficiaries to whom the APM Entity Group or eligible clinician furnishes Medicare Part B covered professional services or services by an RHC or FQHC during the QP performance period.
- Percent of Patients (All Payer Combination Option)
 - Numerator: The number of unique patients to whom the APM Entity Group or eligible clinician furnishes services that are included in the measures of aggregate expenditures used under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP performance period.
 - Denominator: The number of unique patients to whom the APM Entity Group or eligible clinician furnishes services under all non-excluded payers during the QP performance period.

¹⁴ Excluded payments include payments made by:

- the Secretary of Defense for the costs of Department of Defense health care programs;
- the Secretary of Veterans Affairs for the cost of Department of Veterans Affairs health care programs; and
- Under Title XIX in a State in which no Medicaid Medical Home Model or APM is available – that is, if 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. Medicaid payments and patient are included in the QP determinations if CMS determines that there is at least one Medicaid APM or Medicaid Medical Home Model that is an Other Payer Advanced APM available in the county where the eligible clinician sees the most patients during the QP Performance Period, and that the eligible clinician is not ineligible to participate in the Other Payer Advanced APM based on their specialty.

Table 3: Key Variables in the QP Determination Process

Key Variables	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
<p>Listing of Advanced APMs</p>	<p>CMS will make a list of Advanced APMs available before January 1, 2017, and will update the list no less frequently than annually. A current list of Advanced APMs for 2019 is available here. CMS will also provide information on approved Other Payer Advanced APMs via the QPP Resource Library.</p> <p>For new models announced within a Performance Period, CMS will announce the model’s Advanced APM status upon first public notice of the model.</p>
<p>Eligible Clinicians Who May Be Assessed for Potential QP or Partial QP Status</p>	<p><u>For CMS Advanced APMs:</u> Those clinicians who may be assessed for potential QP or Partial QP status include:</p> <ul style="list-style-type: none"> • Eligible clinicians on a Participation List if an APM Entity includes eligible clinicians on a Participation List. If an APM Entity includes eligible clinicians on a Participation List, clinicians on an Affiliated Practitioner List would not be assessed for potential QP or Partial QP status. • Eligible clinicians on an Affiliated Practitioner List if an APM Entity does not include eligible clinicians on a Participation List but does include eligible clinicians on an Affiliated Practitioner List <p>Individual eligible clinicians must be the Participation List or Affiliated Practitioner List on one of the following “snapshot” dates to be assessed for potential QP or Partial QP status: March 31, June 30, and August 31.</p> <p><u>For Other Payer Advanced APMs:</u> To be eligible for consideration under the All-Payer Combination Option, an eligible clinician must also be part of an APM Entity Group participating in an Other Payer Advanced APM.</p>
<p>Level of Threshold Analysis for QP Determinations</p>	<p><u>For CMS Advanced APMs:</u> For APM Entities with eligible clinicians on a Participation List, CMS will group eligible clinicians together and assess them through their collective participation in an APM Entity Group. CMS will make QP determinations collectively for the APM Entity Group based on participation in the Advanced APM. However, the APM Entity must remain in the Advanced APM through the end of the QP Performance Period.</p> <p>For APM Entities that do not include eligible clinicians on a Participation List but do include eligible clinicians on an Affiliated Practitioner List, CMS will assess each Affiliated Practitioner individually.</p> <p>If an eligible clinician does not achieve QP status based on collective participation on a Participation List in an APM Entity Group for a single Advanced APM, or the eligible clinician is an Affiliated Practitioner, CMS will determine whether the clinician individually meets or exceeds an applicable QP threshold.</p> <p><u>For Other Payer Advanced APMs:</u> In general, CMS will make a QP determination at the individual eligible clinician level if the eligible clinician requests a determination at the individual level. CMS will make a QP</p>

Key Variables	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
	<p>determination at the TIN level if the TIN requests a QP determination at the TIN level. CMS will make a QP determination at the APM Entity level if the APM Entity requests a QP determination at the APM Entity level. In general, if CMS receives requests to assess a clinician at multiple levels (individual, TIN-level, or APM Entity-level), CMS will assess on all levels, and QP status will be based on the level yielding the most advantageous result. However, if CMS assesses an eligible clinician at the individual level for the purposes of the Medicare Option, CMS will likewise conduct the assessment at the individual level for the purposes of the All Payer Combination Option.</p>
<p>QP Performance Period</p>	<p>The time period that CMS will use to assess the level of participation by an eligible clinician in Advanced APMs and Other Payer Advanced APMs for purposes of making a QP determination for the year. The QP Performance Period begins on January 1 and ends on August 31 of the calendar year that is 2 years prior to the payment year.</p> <p>While the full performance period is January 1 – August 31, in order to give participants more notice about whether they have met the QP thresholds, CMS will consider numerators and denominators from January 1 of the QP Performance Period to each “snapshot” date of March 31, June 30, or August 31, for the purposes of making the threshold determinations. Therefore, eligible clinicians could meet the QP thresholds based on a time period other than the January 1 through August 31 full performance period.</p> <p>In general, once a QP determination is made, that QP determination will continue to apply for the performance period. However, if one or more of the APM Entities in which an eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, the eligible clinician will not be considered a QP for that year unless the eligible clinician continues to meet QP thresholds based on participation in the remaining non-terminating APM Entities.</p> <p>Additionally, starting with 2018, CMS finalized that for Advanced APMs that start or end during the QP Period and that are actively tested for 60 or more continuous days during the QP Performance Period, CMS will make QP and Partial QP determinations using claims data for services furnished during those dates on which the Advanced APM is actively tested. However, for individual-level determinations (for eligible clinicians who are Affiliated Practitioners or who may achieve QP status based on participation across multiple Advanced APMs, CMS will consider data for the full QP Performance Period.</p>

Table 4: Key Concepts and Terms under the Advanced APM Track of the QPP

Key Concept or Term	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
Advanced Alternative Payment Model (Advanced APM)	An APM that CMS determines meets criteria detailed in Table 1 above for CMS APMs.
Affiliated Practitioner	An eligible clinician identified by a unique APM participant identifier on a CMS- maintained list who has a contractual relationship with the APM Entity for the purposes of supporting the APM Entity’s quality or cost goals under the Advanced APM
Affiliated Practitioner List	<p>The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list.</p> <p>In the final rule that cancelled the EPM model and reconfigured the CJR model, CMS finalized that individuals on a Clinician Engagement List would also be considered included in the Affiliated Practitioner List.</p>
All Payer Combination Option	The methodology for achieving QP status based on (1) a minimum level of participation in one or more Advanced APMs (i.e. Medicare Advanced APMs) AND (2) additional threshold levels of participation in one or more Other Payer Advanced APMs. This option is only available beginning with payment year 2021 (based on participation in 2019).
APM Entity	An entity that participates in an APM or other payment arrangement through a direct agreement with CMS or an other payer or through Federal or State law or regulation
APM Entity Group	The group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, Taxpayer Identification Number (TIN), and National Provider Identifier (NPI) for each participating eligible clinician.
Attributed beneficiary	A beneficiary attributed to the APM Entity under the terms of the CMS Advanced APM as indicated on the most recent available list of attributed beneficiaries at the time of a QP determination

Key Concept or Term	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
Attribution-eligible beneficiary	<p>A beneficiary who during the QP performance period:</p> <ol style="list-style-type: none"> 1. Is not enrolled in a Medicare Advantage or Medicare cost plan 2. Does not have Medicare as a secondary payer 3. Is enrolled in both Medicare Parts A and B 4. Is at least 18 years of age 5. Is a US resident 6. Has a minimum of one claim for evaluation and management services furnished by an eligible clinician who is in the APM Entity for any period during the QP performance period, OR for an Advanced APM that does not base attribution on evaluation and management services and meets other specified criteria, a separate criterion to be determined by CMS.
Medicaid APM	A payment arrangement authorized by a State Medicaid program that meets the Other Payer Advanced APM criteria
Medical Home Model	<p>An APM under section 1115A of the Act that is determined by CMS to have the following characteristics:</p> <ol style="list-style-type: none"> 1. The APM has a primary care focus with participants that primarily include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services. For the purposes of this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more designated specialty codes. 2. Empanelment of each patient to a primary clinician; and 3. At least four of the following: <ol style="list-style-type: none"> a. Planned coordination of chronic and preventive care. b. Patient access and continuity of care. c. Risk-stratified care management. d. Coordination of care across the medical neighborhood. e. Patient and caregiver engagement. f. Shared decision-making. 4. Payment arrangements in addition to, or substituting for, fee-for-service payments (for example, shared savings or population-based payments)
Medicaid Medical Home Model	A Medicaid payment arrangement that CMS determines to have characteristics that align with those required for Medical Home Models, except that such payment arrangement is made under title XIX

Key Concept or Term	Finalized Policies from the CY 2017, CY 2018, and CY 2019 QPP Final Rules
Medicare Only Option	The methodology for achieving QP status based only through achieving a threshold level of participation in one or more CMS Advanced APMs, without taking participation in an Other Payer Arrangement into account. This option is available beginning with payment year 2019 (based on 2017 participation).
Other Payer Advanced APM	An other payer arrangement that meets the Other Payer Advanced APM criteria
Partial Qualifying APM Participant (Partial QP)	An eligible clinician determined by CMS to have met the relevant Partial QP threshold for a year
Participation List	The list of participants in an APM Entity that is compiled from a CMS-maintained list
Qualifying APM Participant (QP)	An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity.