Quality Payment Program
All-Payer Combination Option Glossary

This table summarizes the definitions that are relevant specifically to the All-Payer Combination Option, and is provided solely for the convenience of individuals who are completing a Payer Initiated Submission Form for purposes of the All-Payer Combination Option under the Quality Payment Program. Readers should not rely on this information as a complete statement of CMS policy. For more detailed information, please refer to the calendar year (CY) 2017 Quality Payment Program Final Rule with Comment Period[1] and the CY 2018 Quality Payment Program Final Rule with Comment Period[2] and CMS' regulations from 42 CFR §§ 414.1305-414.1465.

Terms	Definition	Regulation
Qualifying APM Participant (QP) Performance Period	The term QP Performance Period is used for both the Medicare and All-Payer Combination Option; the QP Performance Period starts on January 1 and ends on August 31 of the calendar year that is 2 years prior to the payment year. For example, the 2019 QP Performance Period corresponds to the 2021 payment year.	*See* 42 CFR § 414.1305
Alternative Payment Model (APM) Entity	An APM Entity is an entity that participates in an APM or other payer arrangement through a direct agreement with The Centers for Medicare & Medicaid Services (CMS) or with an other payer or through Federal or State law or regulation.	*See* 42 CFR § 414.1305

[1] Begins at 81 FR 77008.
[2] Begins at 82 FR 53568.

Terms	Definition	Regulation
Capitation Arrangement	For purposes of the Other Payer Advanced APM financial risk criterion, 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 the Other Payer Advanced APM financial risk criterion. An other payer arrangement that makes payment using a capitation arrangement meets the Other Payer Advanced APM financial risk criterion.	*See* 42 CFR § 414.1420(d)(7)
Certified Electronic Health Record Technology (CEHRT)	For 2019 and subsequent years, CEHRT refers to EHR technology (which could include multiple technologies) certified under the ONC Health IT Certification Program that meets the 2015 Edition Base EHR definition (as defined at 45 CFR 170.102) and has been certified to the 2015 Edition health IT certification criteria that are listed in 42 CFR § 414.1305.	*See* 42 CFR § 414.1305
CMS Multi-Payer Model	A CMS Multi-Payer Model is an Advanced APM that CMS determines, per the terms of the Advanced APM, has at least one other payer arrangement that is designed to align with the terms of that Advanced APM.	*See* 42 CFR § 414.1305
Eligible Clinician	Eligible clinician means ‘‘eligible professional’’ as defined in section 1848(k)(3) of the Act, as identified by a unique TIN and NPI combination and, includes any of the following: (1) A physician. (2) A practitioner described in section 1842(b)(18)(C) of the Act.	42 CFR § 414.1305

Terms	Definition	Regulation
	(3) A physical or occupational therapist or a qualified speech-language pathologist. A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).	
Expected Expenditures	For the purposes of the Other Payer Advanced APM financial risk criterion, 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.	*See* 42 CFR § 414.1420(d)(6)
Generally Applicable Financial Risk Standard	For payment arrangements other than Medicaid Medical Home Models, 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 payment arrangement exceed expected expenditures during a specified period of performance do one or more of the following: • Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians; • Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians; or • Require direct payment by the APM Entity to the payer. For this risk standard, it is not sufficient for the payment arrangement to require reductions in otherwise guaranteed payments.	*See* 42 CFR 414.1420(d)(1)
Generally Applicable Nominal Amount Standard	For payment arrangements other than Medicaid Medical Home Models, the total amount an APM Entity potentially owes a payer or foregoes under a payment arrangement must be at least: • For the 2019 and 2020 QP Performance Periods, 8 percent of the total combined revenues from the payer to providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue; or be at least equal to 3% of the	*See* 42 CFR § 414.1420(d)(3)

Terms	Definition	Regulation
	expected expenditures for which an APM Entity is responsible under the payment arrangement; and • A marginal risk rate of at least 30 percent; and • Total potential risk of at least 4 percent of expected expenditures.	
Medicaid APM	A Medicaid APM is a payment arrangement authorized by a State Medicaid program that meets the Other Payer Advanced APM criteria set forth in § 414.1420.	*See* 42 CFR § 414.1305
Marginal Risk, Minimum Loss Rate, and Total Risk	• Marginal risk – the percentage of the amount by which actual expenditures exceed expected expenditures for which an APM Entity would be liable under the payment arrangement. • Minimum loss rate—a percentage by which actual expenditures may exceed expected expenditures without triggering financial risk. • Total risk—the maximum potential payment for which an APM Entity could be liable under a payment arrangement.	*See* discussion of these terms in the CY 2017 Quality Payment Program final rule with comment period (81 FR 77469 through 77471) and the CY 2018 Quality Payment Program final rule with comment period (82 FR 53848 through 53849).
Medicaid Medical Home Model	A Medicaid Medical Home Model is a payment arrangement under title XIX that CMS determines to have the following characteristics: • The payment arrangement 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	*See* 42 CFR § 414.1305

Terms	Definition	Regulation
	this provision, primary care focus means the inclusion of specific design elements related to eligible clinicians practicing under one or more of the following Physician Specialty Codes: 01 General Practice; 08 Family Medicine; 11 Internal Medicine; 16 Obstetrics and Gynecology; 37 Pediatric Medicine; 38 Geriatric Medicine; 50 Nurse Practitioner; 89 Clinical Nurse Specialist; and 97 Physician Assistant; • Empanelment of each patient to a primary clinician; and • At least four of the following: a. Planned coordination of chronic and preventive care. b. Patient access and continuity. c. Risk-stratified care management. d. Coordination of care across the medical neighborhood. e. Patient and caregiver engagement. f. Shared decision-making. Payment arrangements in addition to, or substituting for, fee-for service payments (for example, shared savings or population-based payments).	
Medicaid Medical Home Model Financial Risk Standard	For Medicaid Medical Home Models, based on the APM Entity's failure to meet or exceed one or more specified performance standards, the model does one or more of the following: • Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians; • Require direct payment by the APM Entity to the Medicaid program; • Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or • Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.	*See* 42 CFR § 414.1420(d)(2)

Terms	Definition	Regulation
Medicaid Medical Home Model Nominal Amount Standard	For Medicaid Medical Home Models, the total annual amount that an APM Entity potentially owes a payer or foregoes must be at least the following amounts: • For QP Performance Period 2019, 3 percent of the average estimated total revenue of the participating providers or other entities under the payer. • For QP Performance Period 2020, 4 percent of the average estimated total revenue of the participating providers or other entities under the payer. • For QP Performance Periods 2021 and later, 5 percent of the average estimated total revenue of the participating providers or other entities under the payer.	*See* 42 CFR § 414.1420(d)(4)
Other Payer Advanced APM	An Other Payer Advanced APM means an other payer arrangement that meets the Other Payer Advanced APM criteria set forth in § 414.1420.	*See* 42 CFR § 414.1305
Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process)	Beginning in CY 2018 prior to the 2019 QP Performance Period, certain other payers, including those with payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payment arrangements aligned with a CMS Multi-Payer Model, can use the Payer Initiated Other Payer Advanced APM Determination Process (Payer Initiated Process) to request that we determine whether one or more of their payment arrangements are Other Payer Advanced APMs.	*See* 42 CFR §414.1445(b)(1); and additional discussion in the CY 2018 Quality Payment Program final rule with comment period (82 FR 53854 through 53857).