



Qualifying Alternative Payment Model Participants (QPs) Methodology Fact Sheet: Medicare Option 2024 Performance Period / Payment Year 2026

This methodology fact sheet describes the process and methodology that the Centers for Medicare & Medicaid Services (CMS) will use to identify eligible clinicians, through their participation in Medicare Advanced Alternative Payment Models (Advanced APMs), who are Qualifying APM Participants (QPs) for the 2024 Performance Period. QPs are excluded from MIPS and may be eligible to receive a 1.88% APM Incentive Payment in Payment Year 2026 as well as a higher conversion factor update on their claims for covered professional services furnished in 2026. This fact sheet is applicable only to the Medicare only QP determination. Information on the All-payer Combination Option is available on the [All-Payer Advanced APM Option webpage](#) on the [QPP website](#).

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Determination of QPs and Partial QPs

We will take the following steps to determine QPs and Partial QPs. Please note each step is outlined in more detail in the subsequent sections.

- **Step 1. Identify eligible clinicians participating in Advanced APMs.** Obtain lists of eligible clinicians participating in Advanced APMs.
- **Step 2. Identify attribution-eligible beneficiaries.** Use Medicare Parts A and B administrative claims data and Medicare beneficiary enrollment information.
- **Step 3. Identify beneficiaries attributed to Advanced APM Entities.** Use CMS administrative records and attribution-eligible beneficiaries identified in Step 2.
- **Step 4. Calculate payment amount Threshold Scores.** Calculate the payment amount Threshold Score at the APM Entity level.
- **Step 5. Calculate patient count Threshold Scores.** Calculate the patient count Threshold Score at the APM Entity level.
- **Step 6. Determine QP status and Partial QP status for eligible clinicians at the APM Entity level.** Determine whether the eligible clinicians in an APM Entity achieve QP status, based on either the payment amount or patient count method. (CMS will apply the more advantageous Threshold Score to the eligible clinicians in the APM Entity to determine whether eligible clinicians achieved QP status or Partial QP status.)
- **Step 7. Determine QP and Partial QP status for certain individual eligible clinicians.** Calculate Threshold Scores based on the payment amount and patient count methods for eligible clinicians who are assessed individually. Eligible clinicians are assessed individually only when the Advanced APM includes eligible clinicians only on an Affiliated Practitioner List, or when the eligible clinicians participate in multiple Advanced APMs and do not achieve QP Status at the APM Entity level during the first two QP determinations in a MIPS performance period. This step will only occur after the third (final) QP determination for a calendar year.
- **Step 8. Other Payer Advanced APMs QP status.** If an eligible clinician does not meet the threshold levels of participation to become a QP and earn the incentive payment based only on participation in Advanced APMs with Medicare Fee-for-Service (FFS), such clinician can also count their participation in Other Payer Advanced APMs to potentially become a QP for the year. Other Payer Advanced APMs include certain payment arrangements with payers other than Medicare FFS, such as Medicaid, Medicare Health Plans (Medicare Advantage), and commercial payers. Additional information may be found in the [All-Payer Combination Option & Other Payer Advanced Alternative Payment Models Frequently Asked Questions](#).

QP Performance Period

The QP Performance Period is the time period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they achieve QP status and are eligible to receive an APM Incentive Payment in the corresponding payment year. The QP Performance Period runs from January 1 through August 31 of the calendar year that is two years prior to the payment year. In other words, the 2024 QP performance period corresponds to the 2026 Payment Year.

QP Determinations During the QP Performance Period

During the QP performance period, CMS will make QP determinations using each Advanced APM Entity's Participation List as of three determination, or "snapshot" dates. For each of the three QP determination dates, CMS will use the APM Entity's Medicare administrative claims data for dates of service from January 1 of the same calendar year through the snapshot date to calculate the APM Entity's Threshold Scores. CMS will allow for 60 days of claims run out before calculating the Threshold Scores, so the QP determinations will be made approximately four months after the end of each QP determination period. The three QP determinations are the following:

- **First QP determination – March 31.** The first QP determination during the QP performance period will be made for all eligible clinicians that are identified as being participants in Advanced APMs as of the first snapshot date of March 31. If the APM Entity meets or exceeds either QP threshold based on the APM Entity's data from January 1 through March 31, then all eligible clinicians in the Advanced APM Entity will be QPs for the performance period unless the Advanced APM Entity's participation in the Advanced APM is voluntarily or involuntarily terminated prior to the end of the QP Performance Period.¹
- **Second QP determination – June 30.** If the Advanced APM Entity did not meet the QP threshold at the second QP determination date, or if the Advanced APM Entity includes eligible clinicians who were not part of the Advanced APM Entity at the initial QP snapshot date, CMS will make a second QP determination that will include all eligible clinicians associated with an Advanced APM Entity at the initial QP determination plus any additional eligible clinicians who are on the Participation List as of the second snapshot date of June 30.

If the Advanced APM Entity meets or exceeds either QP threshold based on the APM Entity's data from January 1 through June 30, then all eligible clinicians in the Advanced APM Entity will be QPs for the performance period, unless the Advanced APM Entity's participation in the Advanced APM is voluntarily or involuntarily terminated prior to the end of the QP Performance Period.

- **Third QP determination – August 31.** CMS will follow the same process used for the second QP determination for the final QP determination of the QP Performance Period, which will include all eligible clinicians associated with an Advanced APM Entity at the second QP determination plus any additional eligible clinicians who are on the Participation List as of August 31 unless the Advanced APM Entity's participation in the Advanced APM is voluntarily or involuntarily terminated prior to the end of the QP Performance Period.

Identify Eligible Clinicians Participating in Advanced APMs

CMS will identify eligible clinicians participating in Advanced APMs using (1) the APM Entity's Participation List and/or (2) the Affiliated Practitioner List. These lists will identify each eligible clinician participating in each Advanced APM Entity using a unique combination of Taxpayer Identification Number (TIN) and National Provider Identifier (NPI). The process that CMS will use to determine QP status will differ depending on whether a Participation List and/or an Affiliated Practitioner List is available for the Advanced APM Entity.

- **Advanced APM Entities with a Participation List.** For Advanced APM Entities with a Participation List such as the Primary Care First Model, the Medicare Shared Savings Program, the ACO REACH Model, the Maryland Total Cost of Care (TCOC) Primary Care Program (PCP), and the Kidney Care Choices (KCC) models, CMS will use the Participation List to define the Advanced APM Entity, regardless of whether there is also an Affiliated Practitioner List or other list of eligible

¹ Eligible clinicians may also be denied QP status for program integrity violations.

clinicians associated with the Advanced APM Entity. CMS will assess the eligible clinicians on the Participation List collectively at the APM Entity level for purposes of QP determination.

- **Advanced APM Entities with an Affiliated Practitioner List.** For Advanced APM Entities with an Affiliated Practitioner List but no Participation List, such as the Comprehensive Care for Joint Replacement (CJR) Model, CMS will use the Affiliated Practitioner List to identify eligible clinicians for purposes of QP determinations, and CMS will assess the QP status of those eligible clinicians individually rather than together as an APM Entity.

Some APM Entities participating in Advanced APMs—such as those participating in certain episode-based payment models—may use either a Participation List or an Affiliated Practitioner List. In this case, CMS will identify eligible clinicians for QP determinations using the APM Entity's Participation List (making determinations at the APM Entity level), when available.

Each APM program team at CMS is responsible for the creation and management of Participation Lists and Affiliated Practitioner Lists. For purposes of QP determinations, CMS will use the most recent lists available on CMS-maintained systems at the time of the QP determinations. CMS will then identify eligible clinicians in the APM Entity for purposes of QP determinations if an eligible clinician's APM participant identifier is present on a Participation List of an APM Entity on one of the snapshot dates during the QP Performance Period.² This ensures that the list is limited to eligible clinicians who have not terminated their participation in an APM on or before a given snapshot date.

Identify Attribution-Eligible Beneficiaries

CMS will identify beneficiaries as attribution-eligible to an Advanced APM Entity if during the QP determination period the beneficiary:

1. Is not enrolled in Medicare Advantage or a Medicare cost plan;
2. Does not have Medicare as a secondary payer;
3. Is enrolled in both Medicare Parts A and B for the entire QP determination period;
4. Is at least 18 years of age on January 1 of the QP Performance Period;
5. Is a United States resident;³

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 for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population based on the requirement to have at least 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, the attribution basis determined by CMS based upon the methodology the Advanced APM uses for attribution, which may include a combination of evaluation and management and/or other services.

³ A beneficiary is considered to be a resident of the United States if the state code in the Medicare beneficiary enrollment file is a US state or territory code.

Table 1. Evaluation & Management Codes Used for Beneficiary Attribution				
96160	G0081	G0444	G2004	G2211
96161	G0082	G0463	G2005	G2212
96202	G0083	G0466	G2006	G2214
96203	G0084	G0467	G2007	G2252
97550	G0085	G0468	G2008	G3002
97551	G0086	G0469	G2009	G3003
97552	G0087	G0470	G2010	G9481
99201 - 99499	G0101	G0502	G2012	G9482
G0019	G0136	G0503	G2013	G9483
G0022	G0316	G0504	G2014	G9484
G0023	G0317	G0505	G2015	G9485
G0024	G0318	G0506	G2025	G9486
G0071	G0323	G0507	G2058	G9487
G0076	G0402	G0511	G2064	G9488
G0077	G0438	G0512	G2065	G9489
G0078	G0439	G2001	G2086	
G0079	G0442	G2002	G2087	
G0080	G0443	G2003	G2088	

Standard Attribution Eligibility Criteria

For up-to-date information about participation in a specific model, including alternative attribution-eligible beneficiary criteria, please visit the respective model webpage at innovation.cms.gov.

The Alternative Payment Models below follow QPP's Standard Attribution Eligibility Criteria:

- Shared Savings Program (SSP): Basic Level E and Enhanced
- Vermont All-Payer Accountable Care Organization (ACO) Model
- Bundled Payment for Care Improvement Advanced (BPCI Advanced) Model
- Maryland Total Cost of Care (MDTCOC) Primary Care Program (PCP)
- Primary Care First Model
- ACO REACH Model
- Enhancing Oncology Model (EOM)
- Kidney Care Choices Model
- ACO PC Flex Model

The eligibility criteria are:

- Professional services claim (claim type 71 or 72)
OR
- Method II CAH claim (claim type 40, type of bill 85x, and revenue center code 096x, 097x, or 098x)
OR

- RHC FQHC (claim type 40 and type of bill 71x, or 77x)

AND

- Has a minimum of one claim for evaluation and management services furnished by and eligible clinician or group of eligible clinicians within an APM Entity during the QP determination period. Healthcare Common Procedure Coding System codes can be found in Table 1 above.

To ensure the attribution eligibility definition is appropriate for each APM's attribution methodology, CMS may apply exceptions to the evaluation and management requirement for attribution-eligible beneficiaries and develop an alternative attribution-eligible definition for specific APMs.

Note: The standard definition of an attribution-eligible beneficiary would exclude certain attributed beneficiaries who do not necessarily receive any evaluation and management services from eligible clinicians who are participants in certain Alternative Payment Models. Because attributed beneficiaries are not a subset of the standard definition of the attribution-eligible beneficiary population, an alternative definition of an attribution-eligible beneficiary for purposes of the Quality Payment Program is appropriate.

Alternative Attribution-Eligible Criteria

The models with Alternative Attribution-Eligible Criteria are:

- [Bundled Payments for Care Improvement Advanced Model](#)
- [Comprehensive Care for Joint Replacement Model](#)
- [Maryland Total Cost of Care Model: Care Redesign Program](#)

Identify Beneficiaries Attributed to Advanced APM Entities

CMS will obtain lists of attributed beneficiaries from CMS-maintained systems and will use the latest attribution lists available at the time of each QP determination. Like the approach used for identifying eligible clinicians participating in Advanced APMs, once a beneficiary is present on the attribution list of an APM Entity on one of the snapshot dates during the QP Performance Period — March 31, June 30, or August 31 — the beneficiary will be included as an attributed beneficiary for that and subsequent QP determinations during the QP Performance Period.

Each Advanced APM generates the list of beneficiaries attributed to an APM Entity based on the APM's respective attribution rules. Further information on APM-specific attribution methodologies is available on the [QPP website](#).

Beneficiaries may be attributed to more than one APM

Entity. For purposes of QP determinations, CMS will include beneficiaries attributed to multiple APM Entities on the list of attributed beneficiaries for each Advanced APM Entity to which the beneficiary is attributed.

$$\frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution-eligible beneficiaries given Part B professional services}} = \text{Threshold Score \%}$$

Beneficiaries who have been prospectively attributed to an APM Entity for a QP Performance Period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity's attributed beneficiary list.

To ensure consistency of the beneficiary population in the numerator and denominator of the payment amount and patient count Threshold Score calculations, CMS will compare each APM Entity's attribution-eligible beneficiaries to the list of attributed beneficiaries extracted from CMS's systems. If a beneficiary appears on the attributed beneficiaries list, but not on the attribution-eligible beneficiaries list, CMS will not include that beneficiary in the QP determination.

Calculate Payment Amount Threshold Scores

For the payment amount method, CMS will calculate a Threshold Score for all eligible clinicians at the APM Entity-level as follows:

Claims methodology and timeframe. CMS will use professional claims (claim type codes 71 and 72) and a subset of outpatient claims (claim type 40) with a 60-day claims run-out after the end of the QP determination period to calculate the denominator and numerator of the payment amount method.

Denominator for the payment amount method. CMS will calculate the denominator for the payment amount method as the aggregate of all covered professional services furnished by eligible clinicians in the Advanced APM Entity to attribution-eligible beneficiaries during the QP determination period (with dates of service from January 1 of the QP Performance Period through the relevant snapshot date). CMS will use the combinations of TINs and NPIs listed on the Advanced APM Entity's Participation List or Affiliated Practitioner List (as applicable) to capture all claims billed for Covered Professional Services furnished to attributed beneficiaries through the Advanced APM Entity.

Numerator for the payment amount method. CMS will calculate the payment amount method as the aggregate of all payments for covered professional services furnished by eligible clinicians in the Advanced APM Entity to attributed beneficiaries during the QP determination period (with dates of service from January 1 of the QP Performance Period through the relevant snapshot date). Similar to the approach used for the denominator, CMS will use the combinations of TINs and NPIs for eligible clinicians listed on a Participation List or Affiliated Practitioner List to identify claims for covered professional services furnished to attributed beneficiaries through the Advanced APM Entity.

Threshold Score for the payment amount method. CMS will calculate the payment amount Threshold Score for an Advanced APM Entity as a percentage by dividing the numerator value by the denominator value and multiplying the result by 100.

Payments through Method II Critical Access Hospitals (CAHs). CMS will include Covered Professional Services billed by CAHs billing under Method II (Method II CAHs) in the payment amount numerator and denominator.

Treatment of payment adjustments. Covered Professional Services under the Medicare Physician Fee Schedule (PFS) are subject to MIPS payment adjustments. These payment adjustments directly adjust the payment amount that eligible clinicians receive under the PFS during the relevant payment year.

Threshold score based
on the payment amount method

\$\$\$ for Part B professional
services to attributed
beneficiaries

=

Threshold
Score %

\$\$\$ for Part B professional
services to attribution-
eligible beneficiaries

When determining QP and Partial QP status in 2024, CMS will exclude the Merit-Based Incentive Payment System (MIPS) payment adjustments when calculating payment amounts for Covered Professional Services for the numerator and denominator of the QP Payment Amount formula.

Treatment of services paid on a basis other than Fee-For-Service (FFS). CMS will include certain payments made on a basis other than FFS in the numerator and denominator prior to calculating the payment amount Threshold Scores. Some Advanced APMs may use incentive payments and financial arrangements other than, or in addition to, traditional fee-for-service payments. For purposes of the QP payment amount Threshold Score calculations, CMS classifies such payments in three categories: financial risk payments, supplemental service payments, and cash flow mechanisms.

A. Financial Risk Payments

Financial risk payments are non-claims-based payments based on performance in an APM when an APM Entity assumes responsibility for the cost of a beneficiary's care. For example, the shared savings payments made to accountable care organizations in the Medicare Shared Savings Program are financial risk payments. CMS will not include financial risk payments when in the numerator or denominator when calculating the Threshold Score for the payment amount method for QP determinations.

B. Supplemental Service Payments

Supplemental service payments are covered professional service payments for longitudinal management of a beneficiary's health or for services that are within the scope of medical and other health services under Medicare Part B that are not separately reimbursed through the PFS. CMS will use the TIN and NPI from the APM Entity Participation Lists and the beneficiary identifiers from the attributed beneficiaries list to link these payments to the appropriate Advanced APM Entity.

CMS then will add these payments to the numerator and the denominator when calculating the payment amount Threshold Score.

CMS will determine whether supplemental service payments made in lieu of covered professional services were paid under the PFS. More information about supplemental service payments and the list of supplemental service payments that would be included in the numerator and denominator when calculating the payment amount Threshold Score is posted at qpp.cms.gov in the [QPP Resource Library](#).

Supplemental Payments Paid on a Fee-for-Service Basis

Overview: Certain supplemental service payments and statutory payment adjustments must be included in the base payment amount for the purpose of calculating the APM Incentive Payment. This section of requirements describes each of the relevant payments and adjustments paid on an FFS basis.

Supplemental Payment	Included/Excluded
Monthly Enhanced Oncology Services (MEOS)	Included
Vermont ACO population-based payment (PBP) fee-for-service reductions	CMS will use the payment amount that would have been made for Covered Professional

	Services if the cash flow mechanism had not been in place
Global and Professional Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Capitation Payment Mechanism fee-for-service reductions	CMS will use the payment amount that would have been made for Covered Professional Services if the cash flow mechanism had not been in place
Comprehensive Kidney Care Contracting (CKCC), and Kidney Care First (KCF) Capitation Payment Mechanism fee-for-service reductions	CMS will use the payment amount that would have been made for Covered Professional Services if the cash flow mechanism had not been in place
Accountable Care Organization (ACO) Primary Care (PC) Flex Capitation Payment Mechanism fee-for-service reductions	CMS will use the payment amount that would have been made for Covered Professional Services if the cash flow mechanism had not been in place

Supplemental Payments for Services Paid other than Fee-for-Service

Overview: When calculating the APM Incentive Payment, we include supplemental service payments that are not paid through Medicare claims processing system but are instead made to APM Entities for providing care to attributed beneficiaries in an Advanced APM.

Supplemental Payment	Model
Care Management Fee (CMF) Payments	Maryland Primary Care Program
Comprehensive Primary Care Payments (CPCP)	Maryland Primary Care Program
Health Equity Advancement Resource and Transformation (HEART)	Maryland Primary Care Program
Professional Population-Based Payment (Professional PBP)	Primary Care First

C. Cash Flow Mechanisms

Cash flow mechanisms involve changes in the method of payment for services furnished by providers and suppliers participating in an APM Entity. Cash flow mechanisms do not change the overall amount of payments. Rather, they change cash flow by providing a different method of payment for services. For expenditures affected by cash flow mechanisms, CMS will calculate the estimated aggregate payment amount for Covered Professional Services using the payment amount that would have been made for those services if the cash flow mechanism had not been in place.

Calculate Patient Count Threshold Scores

CMS will use a patient count method in parallel with the payment amount method when making QP status determinations. CMS will calculate the patient count Threshold Score for all eligible clinicians in the Advanced APM Entity as follows:

Counting unique beneficiaries. CMS will count any beneficiary for whom eligible clinicians within an Advanced APM Entity received payments for Covered Professional Services (including professional services furnished at a Method II CAHs), Rural Health Clinics (RHCs), or Federally Qualified Health Centers (FQHCs), using all available administrative claims information generated during the QP determination period. CMS will count a given beneficiary in the numerator and denominator for multiple Advanced APM Entities but will count a beneficiary no more than once in the numerator and denominator for any given APM Entity.

Threshold score based on the patient count method

of attributed beneficiaries given Part B professional services

=

of attribution-eligible beneficiaries given Part B professional services

Threshold Score %

Denominator for the patient count method. When calculating the Threshold Score under the QP patient count method, the denominator will be the number of attribution-eligible beneficiaries associated with the Advanced APM Entity during the QP determination period. CMS will count attribution-eligible beneficiaries once per APM Entity for the denominator.

Numerator for the patient count method. When calculating the Threshold Score for the QP patient count method, the numerator will be the number of unique beneficiaries who were attributed to the Advanced APM Entity during the QP determination period. CMS will count an attributed beneficiary once per APM Entity for the numerator.

Threshold Score for the patient count method. CMS will calculate the patient count Threshold Score for eligible clinicians in an Advanced APM Entity as a percentage by dividing the numerator value by the denominator value and multiplying by 100.

Determine QP and Partial QP Status for Eligible Clinicians in an APM Entity

If the Threshold Score calculated during a QP determination period for the APM Entity based on the payment amount or patient count method meets or exceeds the relevant QP, CMS will consider all eligible clinicians in the APM Entity to be QPs or Partial QPs (as applicable) for that performance year.

Determine QP and Partial QP Status for Individual Eligible Clinicians

CMS generally will make QP determinations at the APM Entity level so that all the eligible clinicians on the Participation List for an APM Entity will be assessed together as a group. There are, however, two exceptions to the APM Entity-level determination process. First, if an individual eligible clinician participates in more than one Advanced APM Entity and none of the Advanced APM Entities with which the eligible clinician participates achieves QP Status during any of the QP determination periods, then CMS will assess the performance of the eligible clinician individually after the third QP determination period is completed. Second, in cases where there is no Participation List for an Advanced APM Entity, but there is an Affiliated Practitioner List, CMS will assess eligible clinicians included on the Affiliated Practitioner List individually for each QP determination period.

To assess an individual eligible clinician for QP or Partial QP status, CMS will use claims data for services furnished by the eligible clinician (as identified by NPI) through all the eligible clinician's Advanced APM Entities during the QP Performance Period. Under the payment amount methodology, CMS will calculate 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 (the numerator), (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 (the denominator), and (3) multiplying the result by 100. The patient count methodology is 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.

All-Payer Combination Option Overview

The Advanced APM path under the Quality Payment Program provides two ways for eligible clinicians to become QPs: the **Medicare Option**, which considers eligible clinicians' participation solely in Medicare Advanced APMs, and the **All-Payer Combination Option**. The All-Payer Combination Option, which was new in 2019, considers the eligible clinicians' participation in Advanced APMs both with Medicare and other payers. Other Payer Advanced APMs are payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans (including Medicare Advantage plans), payers in CMS Multi-Payer Models, and other commercial payers.

An eligible clinician's QP status is determined by meeting or exceeding one of two thresholds for applicable Advanced APM participation, one for patient count and one for payment amounts. Eligible clinicians who do not meet either threshold under the Medicare Option, but who still meet a minimum threshold under the Medicare Option, may request a QP determination under the All-Payer Combination Option.

This document describes only the process for determining QP status and Partial QP status under the Medicare Option. If you'd like to learn more about the All-Payer Combination Option, please review the [All-Payer Advanced APM Option webpage](#) and the [All-Payer Combination Option & Other Payer Advanced Alternative Payment Models Frequently Asked Questions](#).

Version History

06/29/2026 Original posting