



The Physicians Advocacy Institute's
Medicare Quality Payment Program (QPP)
Physician Education Initiative

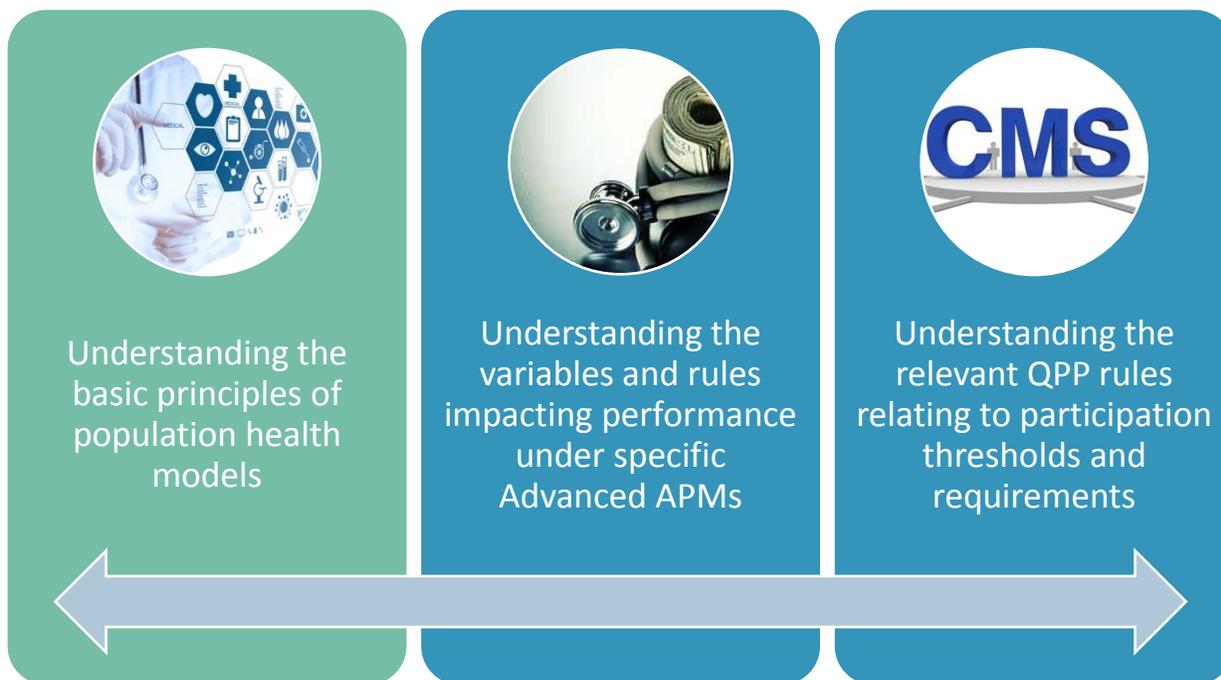
Building Blocks for Success:
Key Considerations for Advanced
Alternative Payment Model (APM)
Participation



MEDICARE QPP PHYSICIAN EDUCATION INITIATIVE

Building Blocks for Success: Key Considerations for Advanced Alternative Payment Model (APM) Participation

An Advanced Alternative Payment Model (APM) is one of two pathways physicians can choose under the Quality Payment Program (QPP), which was established as part of the Medicare Access and CHIP Reauthorization Act (MACRA). Under the Advanced APM pathway, physicians may be exempt from participation in the Merit-based Incentive Payment System (MIPS) and be eligible to receive a 5% incentive payment. For successful participation in an Advanced APM, physicians need to consider three core building blocks:



This resource focuses on the first of these three building blocks and highlights the types of variables and rules to be attuned to for specific Advanced APMs. Specifically, this resource will provide an overview of the interactions between core care management techniques, data insights, and what it means to take risk. Resources addressing the other two building blocks, with detailed information and specific Advanced APMs and relevant QPP rules related to the QPP's Advanced APM track, are available on [PAI's website](#) under the Advanced APM Pathway page.



Overview

A decision to seek participation in an Advanced APM is best taken based on a broad assessment of the potential costs, risks, and rewards.

- **Costs** include the potential for expenses to improve practice performance (which may or may not exceed those necessary for MIPS preparation).
- **Rewards** include not just the potential for the 5% incentive payment under the QPP for Advanced APM participation, but also the potential for shared savings and the concomitant opportunity to use the APM as a means of supporting desired changes in the way care is delivered—which is the ultimate goal of these models.
- **“Risk”** properly understood means not just recognizing the likelihood and magnitude of financial losses, but also a broader understanding of the factors and their year-to-year variability that can positively or negatively impact performance under an Advanced APM.

A thoughtful assessment of the following considerations is a useful guide in determining whether an Advanced APM is the appropriate path:

- 1) [Understanding How Performance is Measured under a Specific Advanced APM in Relation to What You Can Control and Impact](#)
- 2) [Evaluating Your Care Model & Ability to Access & Analyze Data](#)
- 3) [Understanding Your Patient Population](#)
- 4) [What it Means to Take on Financial Risk](#)
- 5) [Risk Adjustment](#)
- 6) [Financial Infrastructure and Licensure Requirements](#)



Understanding How Performance is Measured under a Specific Advanced APM in Relation to What You Can Control and Impact

What is being measured?

A helpful starting point for considering whether to participate in an Advanced APM is to understand “what” is being measured. Many Advanced APMs build on the concept of population health payments, under which physicians and other clinicians receive a set payment amount to provide a set of services to a defined population, for a given period.¹ Under Advanced APMs, an APM Entity’s performance is measured based on its total cost and quality of care for patients in a defined population. This focus on measuring the total quality and cost of care is intended to align incentives so the APM Entity, and its affiliated physicians and other eligible clinicians, are concerned not just with the care they directly provide but also with all other aspects of a patient’s care and health.² The core task of participating in an Advanced APM is to help better manage a patient’s care in ways that improve quality (or at least allow strong performance on specified quality measures) and reduce total costs.

How is performance measured?

In addition to understanding “what” is measured under an Advanced APM, it is equally important to understand “how” this performance is measured. The general approach for measuring performance is comparing an APM Entity’s actual spending for a defined “performance period” against either the APM Entity’s spending in a previous period using an “*historical benchmark*” or the APM Entity’s actuarially predicted “*spending target*” set in relation to estimated costs of a defined population measured at some geographically adjusted level.

What Can You Control and Impact?

The next key consideration for participation in an Advanced APM is understanding the factors and annual variability in these factors that impact the historical benchmark or spending target, and the adjustments made over time between these measures and the APM’s performance population. Since the historical benchmark or spending target is set to reflect average spending in a prior period, there are some core elements that you can control under an Advanced APM:

- ✓ Knowing who your patients are from a risk profile perspective;
- ✓ Knowing how they are enrolled or “attributed;”

¹ See Alternative Payment Model (APM) Framework Final White Paper, HCP LAN, <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

² Ideally, from a health care system perspective, this encourages a focus on where referrals for other care are made (including *e.g.*, for specialist, post-acute and even end of life care), opportunities for helping patients access supportive non-clinical, social services, and encouraging and helping patients gain access to care in the setting that is most appropriate to their needs at the right time.



- ✓ Documenting through proper diagnostic coding your patients' conditions accurately; and
- ✓ Using data to identify care improvement opportunities.

Evaluating the potential of the payment model (how the model pays and rewards physicians and others for providing quality care that aligns with the APM's goals) to help a physician improve care (e.g., does the model provide for an upfront care management fee), the potential for upside shared savings and downside sharing of losses, and the potential for year-to-year fluctuations are core elements to considering what, if any, Advanced APM model is right for a practice or group of physicians and other eligible clinicians working together under an APM Entity.

Evaluating Your Care Model & Ability to Access & Analyze Data

The care model is a key consideration for participation in an Advanced APM as it reflects the core part of an Advanced APM that physicians can control. You need to evaluate your care management capabilities as a means of being able to manage performance year costs. For the reasons described above, it is important to evaluate your ability to identify and manage key points of variability impacting performance under the model.

It is important to look at the current model in place and identify opportunities for improvement that would help you be more successful in the model of interest. For example, you should consider how the approaches in the Advanced APM could lead to improved patient outcomes and lower costs, allowing you to be able to share in the savings that you help create. Improvements to the care model could be made by optimizing clinical workflows, the technology infrastructure and streamlining operations, or adapting policies and processes that help with better population health management. Lastly, consider if any waivers, beneficiary incentives/enhancements, and/or network tools are available under the model of interest, as well as how you could use one or more of these to your advantage to further enhance your care model and performance.

Example of Next Generation Accountable Care Organization (ACO) model Waivers

Waivers	Next Gen ACO
<u>SNF 3-day Rule Waiver</u> ³	Allows beneficiaries to be admitted directly to a SNF from their home, a physician's office, an observation status of the ER, or when they have been in the hospital for fewer than three days. SNF must have a quality rating of 3+ stars.

³ <https://innovation.cms.gov/Files/x/pioneeraco-snfwaiver.pdf>



Waivers	Next Gen ACO
<u>Telehealth Waiver</u> ⁴	Waiver of the requirement that beneficiaries must be located in a rural area, and at a specified type of originating site, when telehealth services are provided by providers/suppliers or preferred providers to beneficiaries assigned to the Next Gen ACO, in specific facilities or at their residence.
<u>Post-Discharge Home Visit Waiver</u> ⁵	Waiver permits "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision of providers/suppliers or preferred providers, following discharge from an inpatient facility. Benefit limited to one visit in the first 10 days following discharge and one additional visit in the subsequent 20 days.
Coordinated Care Reward	CMS will make a \$25 payment as a Coordinated Care Reward when a beneficiary receives an Annual Wellness Visit from their Next Gen ACO doctor.

Understanding Your Patient Population

Another important element of participating in an Advanced APM is understanding the patient population that you will be considered as caring for (i.e., that will be attributed to you) under the Advanced APM, and your ability to manage that population's health care costs. Do you tend to have a healthy patient population, with low health care costs? Or do you generally see patients who are sicker, with higher health care costs? Moreover, based on the attribution method (e.g., prospective, retrospective, or hybrid—discussed in detail below) do you have enough information in advance to know which patients are assigned to you for purposes of accountability under the Advanced APM? If not, consider how this impacts your ability to succeed under the model.

Patient Attribution

You will need to consider how and which patients would be attributed to you under the model of interest. There are several types of attributions that can be used: patient-based, episode-based, single and multiple attribution, and an allocation method.

⁴ <https://innovation.cms.gov/Files/x/nextgenaco-telehealthwaiver.pdf>

⁵ <https://innovation.cms.gov/Files/x/nextgenaco-pdhomevisitwaiver.pdf>



Patient-Based

- Assigns the costs of each patient to a provider or providers
- Holds providers accountable for the total cost of care for the patient
- Commonly used in ACO performance measurement

Episode-Based

- Each episode of care is assigned to a provider or providers
- An episode is defined as all the clinical services for a patient from onset of symptoms until treatment is complete
- Holds providers accountable for discrete episodes of care

Single v. Multiple Attribution

- Single attribution assigns the patient or episode to the provider with the highest percentage of services or total cost
 - Usually a minimum threshold to ensure the provider has been sufficiently involved in the patient's care to be held accountable
- Multiple attribution is designed to allocate the patient or episode to more than one provider as it may not be equitable to assume one provider is accountable for the entirety of a patient's care
 - Multiple attribution will result in more patients/episodes being assigned to providers than under a single attribution methodology in order to reach minimum threshold requirements

Allocation Method

- Can be based on visits or provider payments
- Can include evaluation and management payments only or all physician claims

Furthermore, the attribution of patients could be *prospective* or *retrospective*, or reflect a hybrid of the two. Understanding which of these methods the Advanced APM employs will help you gain a better sense of which patients and what costs you will be responsible for managing under the model.



Attribution Method

- Can be based on a majority or plurality methodology
- Can limit assignment to primary care physicians (PCPs), or allow assignment to any physician specialty
- Majority - assigns beneficiary to the provider that accounts for 50% or more of the visits or costs. If no provider meets that 50% threshold, the beneficiary is not attributed
- Plurality - assigns beneficiaries to the provider with the highest proportion of visits or costs, usually subject to a minimum threshold

Prospective Attribution

- Assigns beneficiaries based on historical claims data, typically from the prior year
- Allows patient and physician notification
- Assumption that most patients will use the same providers in the future as they have in the past
 - Advantage: quality and cost reports available on a timely basis
 - Disadvantage: if something occurs that substantially changes the mix of patients served by clinicians affiliated with the model from one year to the next there can be a material mis-match between the patients actually cared for and those assumed under the model

Retrospective Attribution

- Assigns beneficiaries based on their actual utilization during the performance period
 - Advantage: Could increase efficiency
 - Disadvantage: Inability to provide timely reporting to providers. Timely reporting could allow for adjustments that increase likelihood of model success

Hybrid Attribution

- Preliminarily assigns beneficiaries based on prior year's data, but reconciles the patient attribution list based on performance year data to arrive at final attribution
- Hybrid approach seeks to strike a balance between purely prospective and retrospective attribution approaches



Benchmarks & Spending Targets

As discussed above, you will need to understand the model's overarching approach to calculating a benchmark or spending target. For example, is it based on an actuarial model that estimates costs for a defined population, or is it based on historical, adjusted costs of the entities participating in the model?

Many Advanced APMs use your historical patient population and related costs to establish future performance and cost benchmarks. For example, all of the Medicare Shared Savings Program (MSSP) ACOs and the Next Generation ACO model operate using a "historical benchmark" based on past performance of the ACO participants in relation to attributed beneficiaries. These benchmarks are then updated each year to recognize (to some degree) underlying medical cost trends and changes in patient risk and demographic characteristics for attributed beneficiaries. This stands in contrast to more actuarially driven models that estimate costs for a defined population at a more general level (in contrast to a set of provider's actual historical experience with a population) and then make adjustments to reflect the population a practice or other organization actually serves.

There are pros and cons to both the historical benchmark and actuarial model approaches. A practice that can identify significant opportunities under an APM for improving or maintaining quality while at the same time reducing total cost of care could benefit from a historical model given a potentially higher starting point in its benchmark relative to being measured against an actuarially determined benchmark for the patient population as a whole. Over time, however, these advantages can fade as the practice improves year over year. For example, in MSSP, an ACO that chooses to continue in the program beyond the first 3-year agreement period will have its historical benchmark reset in conjunction with its renewal in the program. Thus, reductions in expenditures achieved in the first agreement period will be captured in the reset benchmark making it potentially more difficult to continue to achieve savings.

Another important factor in this regard is how the historical benchmark is "trended," that is, how is the historical benchmark adjusted for growth in underlying medical costs. In MSSP, beginning in 2017, benchmarks are trended based on regional considerations as opposed to a nationally determined trend rate. Whether this is positive or negative for the ACO's performance then depends on how the trend for a particular region compares to the national average. Similarly, an ACO that maintains health spending growth below that of the trend (whether national or regional) being applied can still achieve savings because its actual spending (which may reflect a high degree of continued efficiency) is measured as a benchmark growing at a higher assumed rate for purposes of calculating shared savings (or losses).

For some practices (e.g., those that start at a relatively efficient level) there may be advantages of having actual spending compared against an actuarially determined spending target. This is because the spending is then compared to an average for the population overall. Thus, if a practice

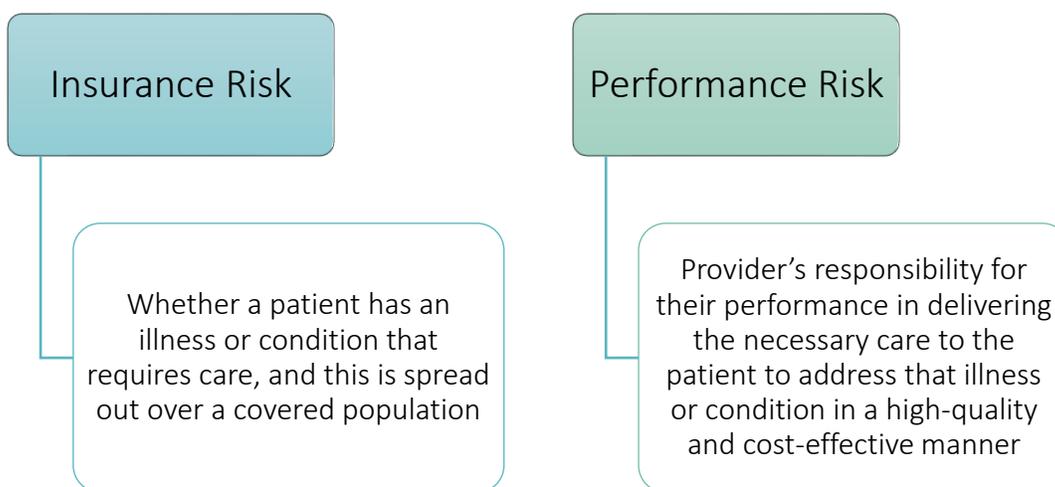


is relatively efficient it lessens the risk that the practice could be “penalized” for its own above average performance prior to beginning in an APM given that it will be compared to a population average.

For these reasons, recognition of benchmark process and how the benchmark is adjusted over time is important to think about your practice’s participation in any given model.

What it Means to Take on Financial Risk

There are generally two types of financial risk: 1) insurance risk and 2) performance risk.



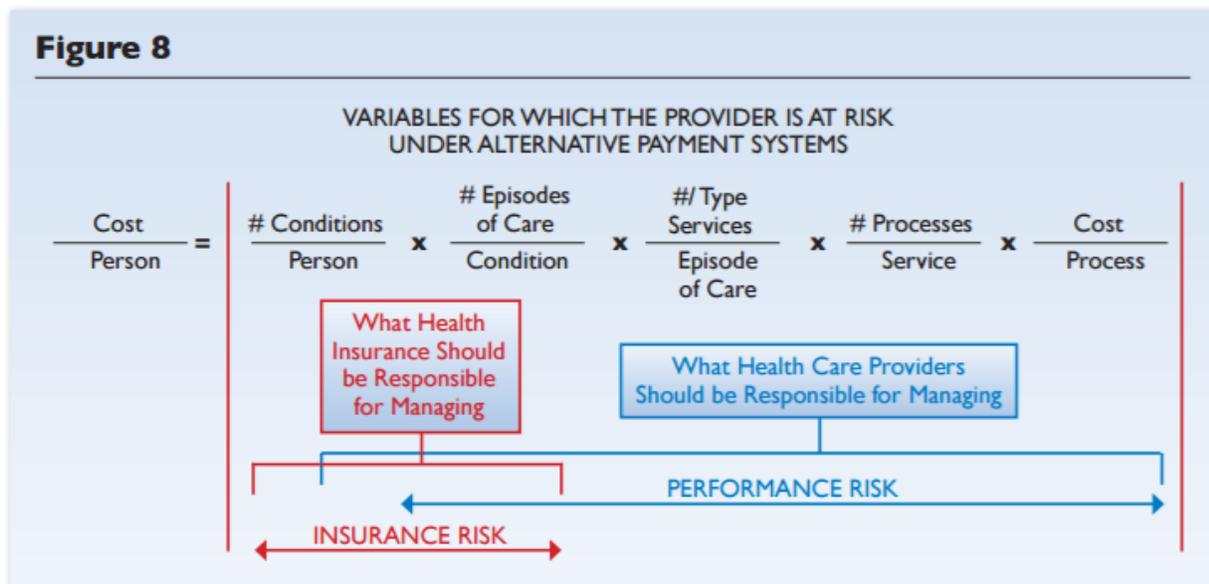
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The following chart from a Robert Wood Johnson Foundation report illustratively identifies the elements that fall under insurance risk, and those that fall under performance risk.

⁶ See, Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs; Network for Regional Healthcare Improvement, Robert Wood Johnson Foundation; January 2009; available at: <http://www.rwjf.org/content/dam/web-assets/2009/01/better-ways-to-pay-for-health-care>.



Figure 8



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When you take on performance risk under Advanced APMs, your performance is being measured against the established benchmark for target costs. Generally, if your actual costs come in below that benchmark, you or the APM Entity will be able to share in the savings you help generate (shared savings); if your actual costs come in above that benchmark, you or the APM Entity taking risk under the APM will likely be responsible for some of the excess costs typically up to a cap (shared losses). In this regard, important in assessing the level of “financial risk” you may be taking on is to take account of your maximum exposure under the APM. Often the limitation on risk is expressed as a proportion of revenue derived by the practice (and other organizations that may be participating with the practice in an APM) or a percentage of the total expenditures of patients attributed to the APM (to include expenditures not under the direct control of the practice).

For example, to qualify as an Advanced APM, CMS requires under the QPP that the total amount an APM Entity (the entity technically participating in the Advanced APM) must ultimately place at risk is either: “8% of the average estimated total Medicare Parts A and B *revenues* of the APM Entity,” or “3% of the expected total Parts A and B *expenditures* for which the APM Entity is responsible for under the Advanced APM” (*emphasis added*).⁸

If you are considering participation in an Advanced APM or other APM involving financial risk, you should also consider whether there are state-based requirements pertaining to physician or other clinician risk bearing. As discussed later in the “Financial Infrastructure and Licensure Requirements” section, CMS’s provisions generally do not preempt any such state requirements.

⁷ <http://www.rwjf.org/content/dam/web-assets/2009/01/better-ways-to-pay-for-health-care>

⁸ See 42 CFR §414.1415(c)(3).



The following chart provides an example of the different sharing rates available under the MSSP Tracks and Next Gen ACOs (note risk adjustment is discussed in more detail below).

	MSSP Track 1	MSSP Track 2	MSSP Track 3	MSSP Track 1+	Next Gen ACO
Benchmark	<p>Established based on three years of historical ACO data, using risk-adjusted average per capita expenditures for Parts A and B Medicare FFS beneficiaries for these enrollment types: end-stage renal disease (ESRD), disabled, aged/dual eligible and aged/non-dual eligible</p> <p>CMS applies a national average growth rate, and beginning in 2017 a regionally adjusted growth rate, to trend forward benchmark years and account for underlying growth in medical costs. Benchmarks are also adjusted annually to reflect the risk scores of newly assigned beneficiaries (diagnosis-based risk scores for continuously assigned beneficiaries can only decrease year-to-year).</p> <p>Benchmarks may be adjusted during a performance period due to ACO participant TIN changes.</p>				<p>Established prior to each performance year and uses a hybrid approach to incorporate historical and regional costs</p> <p>Initially, the prospective benchmark is established through the following steps:</p> <ul style="list-style-type: none"> • Determine the ACO's historic baseline expenditures; • Apply regional projected trend; • Risk adjust using the CMS Hierarchical Condition Category (HCC) model; • Apply the discount, which is derived from one quality adjustment and two efficiency adjustments
Shared Savings	<p>Shared savings once a minimum savings rate (MSR) is met or exceeded</p> <ul style="list-style-type: none"> • Up to 50% for Track 1 and 1+, not to exceed 10% of ACO benchmark; • Up to 60% for Track 2, not to exceed 15% of ACO benchmark; • Up to 70% for Track 3, not to exceed 20% of ACO benchmark 				<p>Shared savings are determined by comparing Total Medicare Parts A and B spending for beneficiaries compared to the benchmark</p> <p>Two Risk Arrangements:</p> <ul style="list-style-type: none"> • Arrangement A – shared savings of up to 80% • Arrangement B – shared savings of up to 100% <p>First dollar shared savings for spending below the benchmark. CMS caps aggregate savings up to 15% of the benchmark in both arrangements.</p>



	MSSP Track 1	MSSP Track 2	MSSP Track 3	MSSP Track 1+	Next Gen ACO
Shared Losses	N/A	<p>Shared losses once minimum loss rate (MLR) is met or exceeded Capped at 5% for Track 2 Year 1</p> <p>Capped at 7.5% for Track 2 Year 2, and</p> <p>Capped at 10% for Track 2 Year 3</p>	<p>Shared losses once MLR is met or exceed, capped at 15%</p>	<p>ACO must repay 30% of losses, regardless of quality performance, once MLR met or exceeded.</p> <p>Revenue-based loss sharing limit: 8% of ACO participant FFS revenue in 2018.</p> <p>Benchmark-based loss sharing limit: 4% of ACO's updated historical benchmark.</p>	<p>Shared losses once minimum loss rate (MLR) is met or exceeded Capped at 5% for Track 2 Year 1</p> <p>Capped at 7.5% for Track 2 Year 2, and</p> <p>Capped at 10% for Track 2 Year 3</p>

The costs for which you are responsible varies under the different models. It is important to review the details of the model to determine what exactly you are accountable for. For example, determining whether you are only accountable for your direct costs for providing care to a patient, or if other clinicians' costs for the services they provide to the patient are also factored into your accountability in some way. You will need to evaluate how and if you can manage these costs in a way that would allow you to be successful under the model by achieving savings.

If you are uncertain about your performance or ability to achieve savings, and are concerned about taking on risk for shared losses, a good starting point is to consider easing into lower risk models by first starting in a shared savings only model (upside risk), like an MSSP Track 1 ACO, and then transitioning to Tracks 1+, 2, or 3, which also incorporate shared losses (downside risk). While participation in an upside only model will not meet the requirements for an Advanced APM (since it does not entail undertaking more than a "nominal amount of risk" as required by the QPP),



participation in such a model can constitute participation in a “MIPS APM” under the QPP and can positively impact a physician’s participation under MIPS. Most importantly, participation in an upside only model can yield important information and lessons on whether participation in an Advanced APM is feasible and desirable for any given set of physicians or other clinicians seeking to work together.

For additional information on MIPS APMs, please see PAI’s QPP Tutorial # 5 on MIPS APMs, available on [PAI’s website](#) under the video library page.

Risk Adjustment

Risk adjustment under an Advanced APM generally describes the process by which costs for the “average” patient included in the model’s defined population are adjusted to reflect the predicted increase or decrease in costs associated with a particular patient’s diagnosis or demographic (essentially age and gender) based factors. There are generally two types of risk adjustment models: prospective risk adjustment and concurrent risk adjustment.

Prospective Risk Adjustment	Concurrent Risk Adjustment
<ul style="list-style-type: none"> • Previous year's diagnoses are used to predict the current year's risk scores • Potential draw-back: concern, particularly with a chronically ill population, that a patient's diagnoses and health care experience in the prior year maybe a poor predictor of risk and cost in the current year 	<ul style="list-style-type: none"> • Risk scores are based on current year diagnoses • Potential draw-back: there is less certainty in the current year over the risk scores of the patient population since the full scope of their diagnoses are not known until well after the end of the current year

Virtually all Advanced APMs under the QPP currently utilize the prospectively based CMS Hierarchical Condition Category (HCC) model used for Medicare Advantage (known as the CMS-HCC model). Under this model, each diagnosis abstracted from claims or medical record documentation is mapped into available HCC’s that are assigned different risk scores reflective of the predicted impact of a particular condition (or set of conditions) on spending. A patient’s overall HCC score is a sum of all the factors associated with the individual HCC categories applicable to the patient’s diagnoses.

Note: the HCC model relies on medical diagnoses taken from claims data only. As such, it does not include indications imputed or inferred from prescription drug use or clinical information contained in electronic medical records.



Risk adjustment's main role in Advanced APM models is to attempt to better align the patient characteristics and predicted spending as between the patient population accounted for in a historical benchmark or spending target. For example, under MSSP, new patients are attributed to the ACO on a year-to-year basis, and each patient is assigned a risk score based on their previous year's diagnoses as documented in the medical record information. This information is then used to adjust the ACO's historical benchmark. The idea is that the new assignees may have characteristics that differ from those reflected in the historical benchmark such that assigning a risk score and adjusting the historical benchmark is intended to account for any differences.

Each Advanced APM, however, has specific rules that are important to be aware of as it concerns risk adjustment. For example, in the Next Generation ACO model, any increase or decrease in risk scores between the baseline and performance year is capped at 3%. In MSSP ACOs, the risk scores for patients that remain continuously assigned to the ACO and patients can only have their individual risk scores adjusted downward for diagnoses from the previous year (other than for increases in age, the risk scores for a continuously assigned patient are not adjusted upward even if their diagnoses from the previous year would suggest otherwise). According to CMS, the reason for this is to address a concern that the model would otherwise reward potential efforts to increase a continuously assigned patient's risk scores through more intensive coding.

Risk adjustment's reliance on diagnosis-based information underlies the importance of accurate medical record documentation, diagnostic coding, and building appropriate processes to support documentation as part of the workflow. In the same vein, it is important to understand some limitations of the CMS-HCC model, particularly in relation to factors does not take into account, but which are also thought to help explain variation in costs across patients. Socioeconomic factors, such as those at issue for disadvantaged populations, for example, are not accounted for in the CMS-HCC model even though such factors might contribute to different levels of spending in patients that otherwise have the same characteristics in relation to age/gender and clinical conditions.⁹ Functional status, such as in relation to activities of daily living, provides a further example of another factor that might explain differences in costs between patients but which is not accounted for in the CMS-HCC model (presumably in part because this information is not captured in claims data). Depending on the nature of the APM and the patient population covered by the model, failure to account for functional status could be more or less consequential (for example, it would be a more consequential issue for a frail population).

Finally, empirical studies of risk adjustment's effectiveness (including the CMS-HCC model) typically find that risk adjustment models under predict costs for patients with serious illnesses. Thus, an APM or practice model that was likely to enroll or have attributed to it a high proportion of very sick individuals might find that adjustments made to its benchmark or spending target to

⁹ While it is beyond the scope of this resource to go into these issues in depth, one reason for this is a lack of reliable data on which modelers say they need to make a credible adjustment.



account for differences in risk might not be sufficient to offset the true additional costs associated with caring for such populations.

For all these reasons in evaluating an APM, it makes sense to consider whether the APM assumes that participating physicians and other clinicians will be caring for a general population (e.g., the average Medicare patient) or whether it assumes a much sicker overall population. If the assumption is that physicians and other clinicians will be caring for a sicker population, then determine whether the model has features, as part of risk adjustment or through another mechanism, that seek to properly account for the additional risk and related increased costs in the APM's benchmark or spending target.

Financial Infrastructure and Licensure Requirements

Lastly, there may be other financial and infrastructure insurance requirements that you must satisfy under the model or state requirements to ensure that you are capable of taking on the financial responsibility and associated risk under an Advanced APM. Although the QPP is a federal program, CMS's operation of an Advanced APM does not generally preempt state law. Therefore, for example, as part of an organization's application to participate in the Next Generation ACO program, an ACO must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities unless it provides a written attestation to CMS that it is exempt from such state laws.

Although according to CMS most states do not have laws that specifically address provider organizations bearing substantial financial risk (California being a notable exception) or distributing savings, CMS makes clear that it is the ACO's responsibility to determine and meet all applicable licensure requirements.

Toward this end, CMS also typically requires in the case of risk-based models that an APM Entity have in place a financial guarantee sufficient to cover potential losses (with the specifics set forth in the model's participation agreement).

Where can I go for more information?

For additional information on the QPP requirements for Advanced APM participation please see the QPP Advanced APM Overview resource, available on [PAI's website](#) under the Advanced APM Pathway page, as well as PAI QPP Tutorial #4 on Advanced APMs available on the video library page.

Additional resources are available on CMS's QPP website: <https://qpp.cms.gov/learn/apms>.