



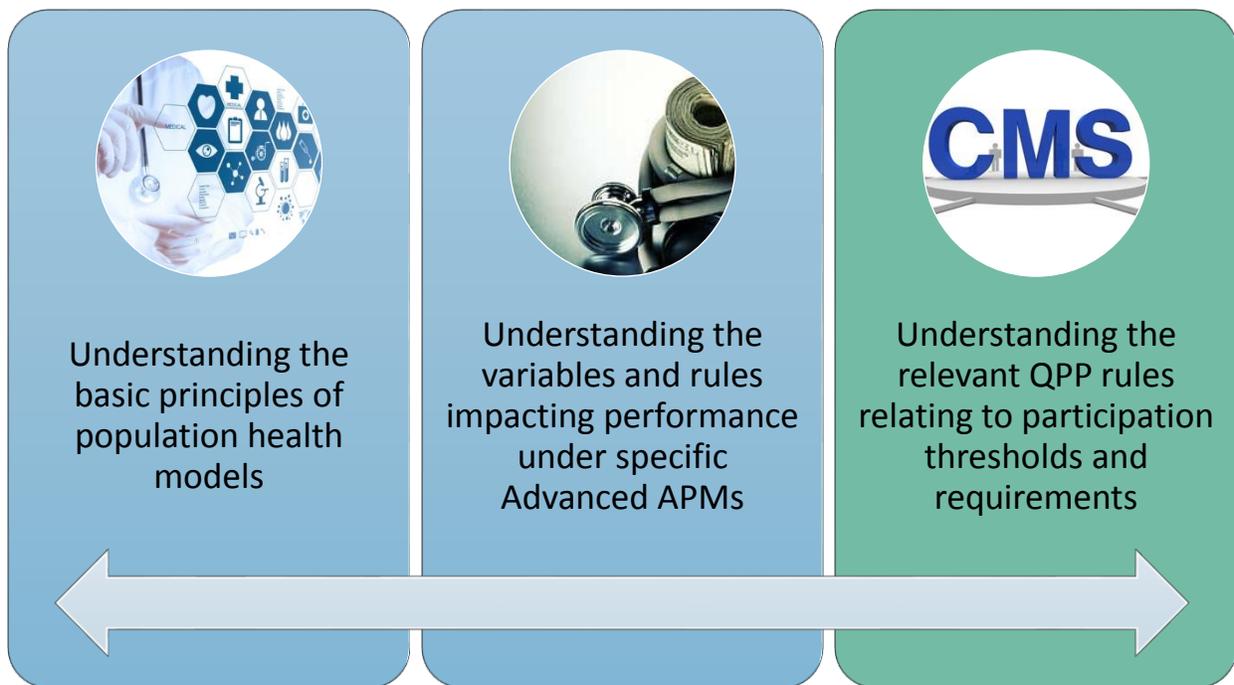
The Physicians Advocacy Institute's
Medicare Quality Payment Program (QPP)
Physician Education Initiative

QPP Advanced Alternative Payment
Model (APM) Overview

MEDICARE QPP PHYSICIAN EDUCATION INITIATIVE

QPP Advanced Alternative Payment Model Overview

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:

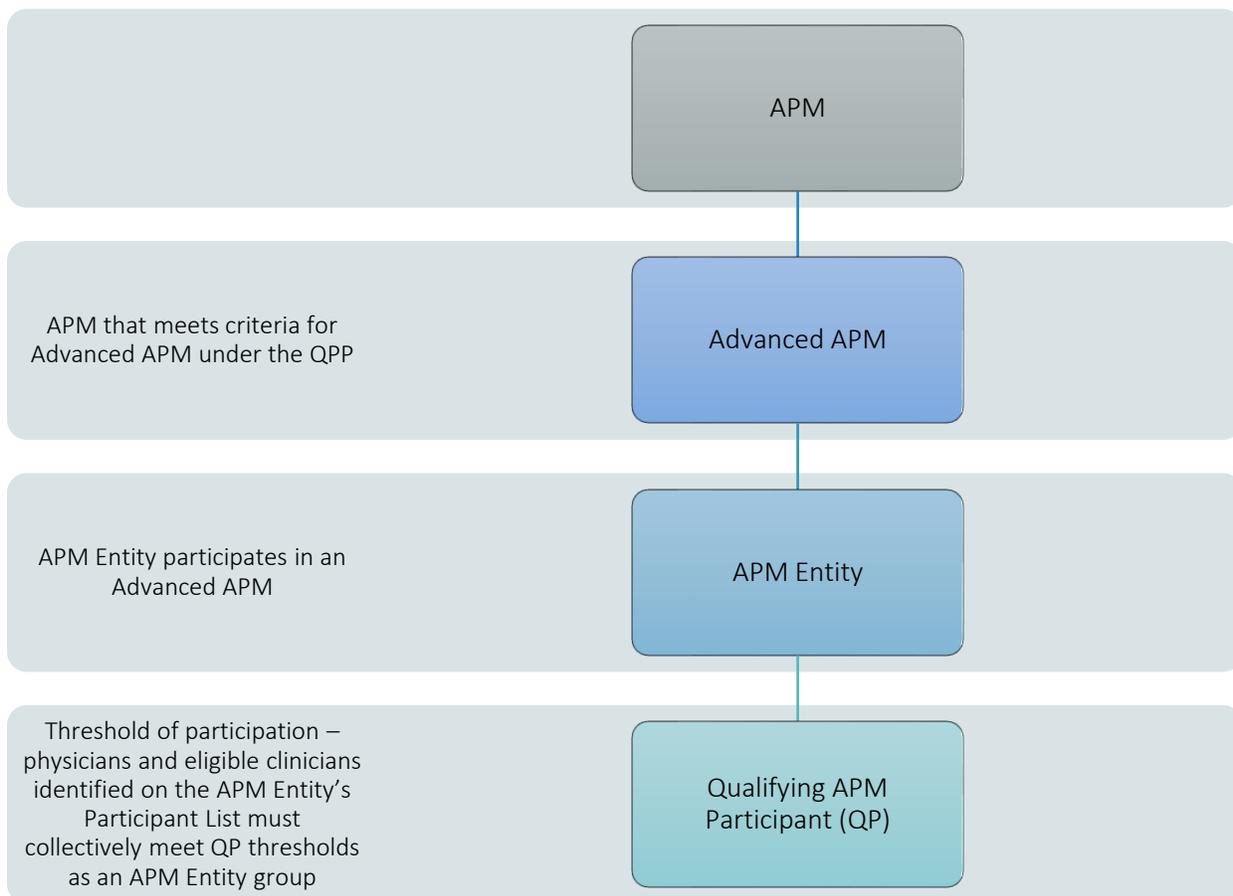


This resource focuses on the third of these three building blocks: understanding the relevant QPP rules for Advanced APM participation thresholds and requirements.

Advanced APMs are payment models that allow physicians and practices to be eligible to earn a 5% incentive payment for taking on some financial risk related to patients’ quality outcomes and costs. Physicians and other eligible clinicians¹ who participate in an Advanced APM will receive payments for their services through the Advanced APM payment structure, which must base payments for services on quality measures comparable to those in the MIPS program.

The 5% incentive payment physicians are eligible to receive under the QPP would be separate and distinct from the payments for services they receive through the Advanced APM. Additionally, under the QPP, there is a two-year gap between the participation year and the incentive payment year, therefore, successful participation in an Advanced APM in 2017 would result in a 5% incentive payment in 2019.

Elements Required for Receiving the Advanced APM 5% Incentive Payment



¹ For 2017, eligible clinicians are defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists.

What are the requirements for Advanced APMs?

It is important to note that the following specific criteria for Advanced APMs are only applicable for QPP purposes. CMS uses the following criteria to determine which existing APMs qualify for the Advanced APM pathway under the QPP that would allow physicians participating through an APM Entity to be eligible for the 5% incentive payment.

Advanced APMs under the QPP must:

- Be a certain Center for Medicare & Medicaid Innovation Model (CMMI), Shared Savings Program track, or certain federal demonstration program;
- Require participants to use certified electronic health record technology (CEHRT);
- Base payments for services on quality measures comparable to those in MIPS; and
- Is a Medical Home Model expanded under CMMI, or requires the APM Entity to bear more than nominal financial risk for losses.

Note: each APM will have its own participation requirements that specify the level of CEHRT use, risk arrangement under that APM, shared savings/losses under that model, etc. The QPP does not affect or change these arrangements. To learn about specific APM participation requirements, please see the overview resources available on [PAI's website](#)² under the Advanced APM Pathway page, as well as the [CMMI website](#).³

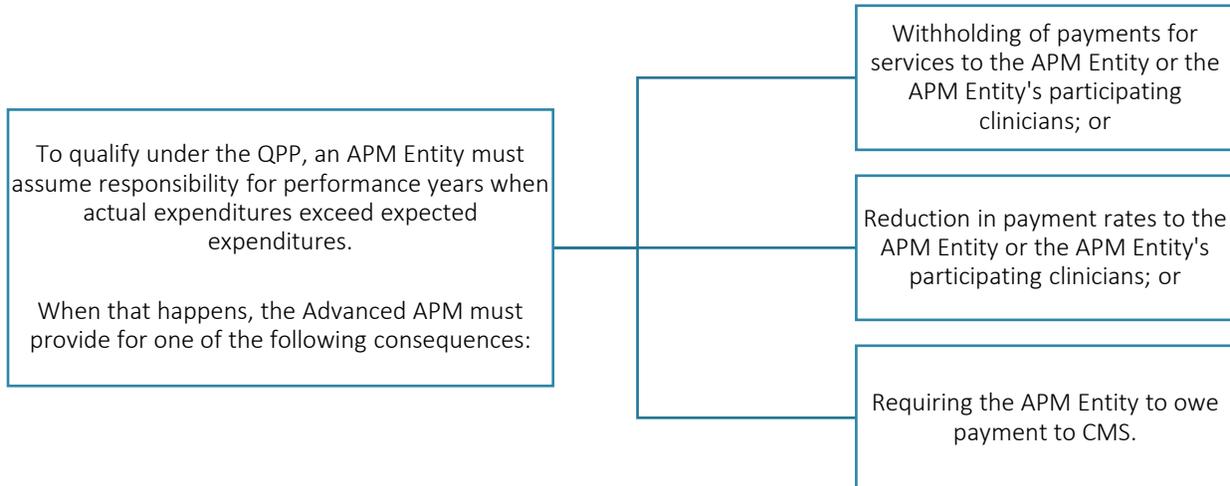
What is risk and “more than nominal financial risk?”

CMS requires APM Entities to take on some level of risk to help ensure that they have a vested interest in the cost and quality of services being provided. While the specific risk arrangement is determined under each specific APM, generally, the risk is determined by identifying a target for expected expenditures (costs) that the APM Entity is responsible for if its actual expenditures exceed that target. Generally, if the APM Entity's actual costs come in below that benchmark, it will be able to share in the savings (“shared savings”); if the APM Entity's actual costs come in above that benchmark, it may be responsible for some or all of the excess costs (“shared losses”).

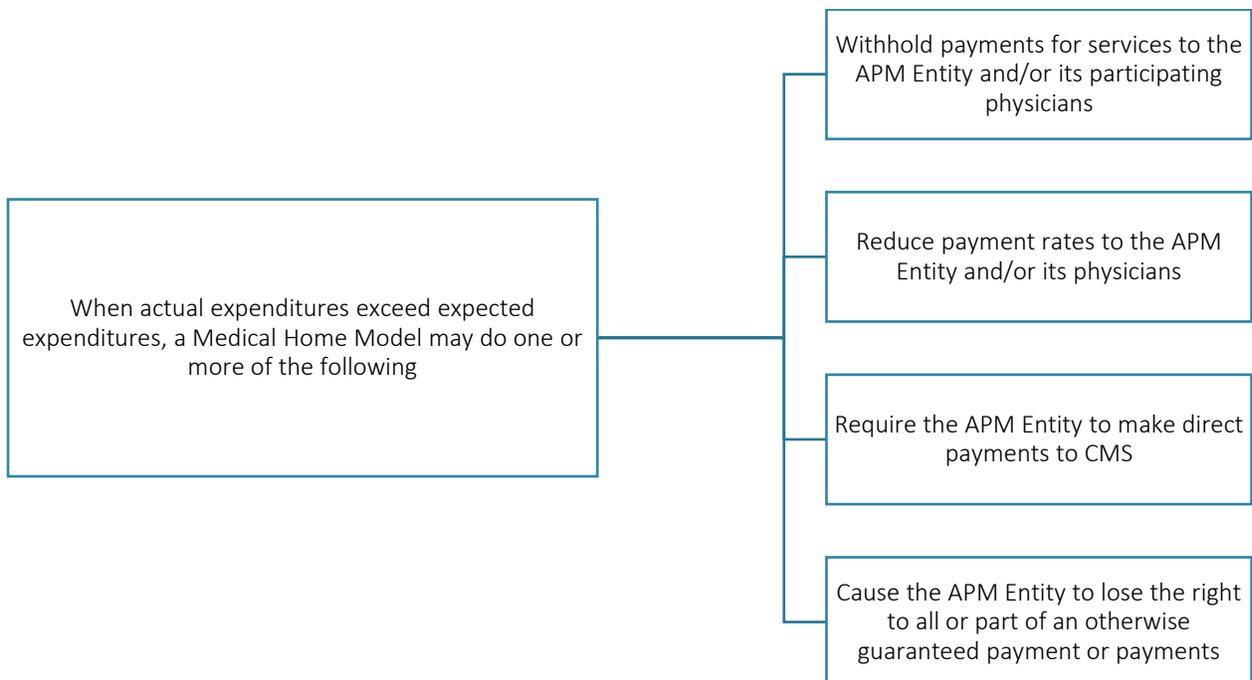
² <http://www.physiciansadvocacyinstitute.org/>

³ <https://innovation.cms.gov/initiatives/index.html#views=models>

Financial Risk Standard for an APM Entity Participating in an Advanced APM

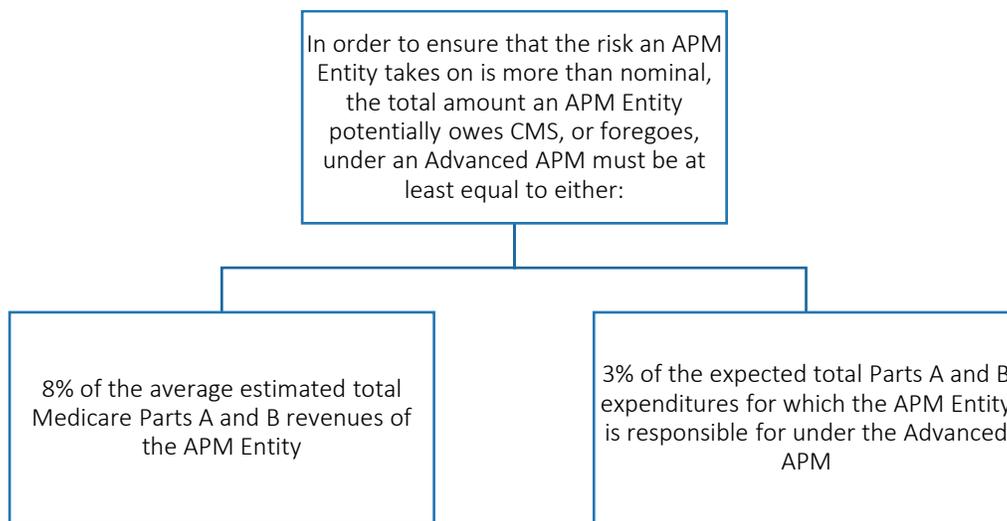


Financial Risk Standard for an APM Entity Participating in a Medical Home Model Advanced APM



An APM Entity must take on more than nominal payment risks for years when the APM Entity’s actual expenditures under the Advanced APM exceed its expected expenditures. By “more than nominal risk,” CMS sets the minimum total amount that the APM Entity potentially owes CMS or foregoes for exceeding the target. CMS has determined that the minimum total amount an APM Entity puts at risk must be at least 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.

More than Nominal Financial Risk Standard for APM Entities Participating in Advanced APMs



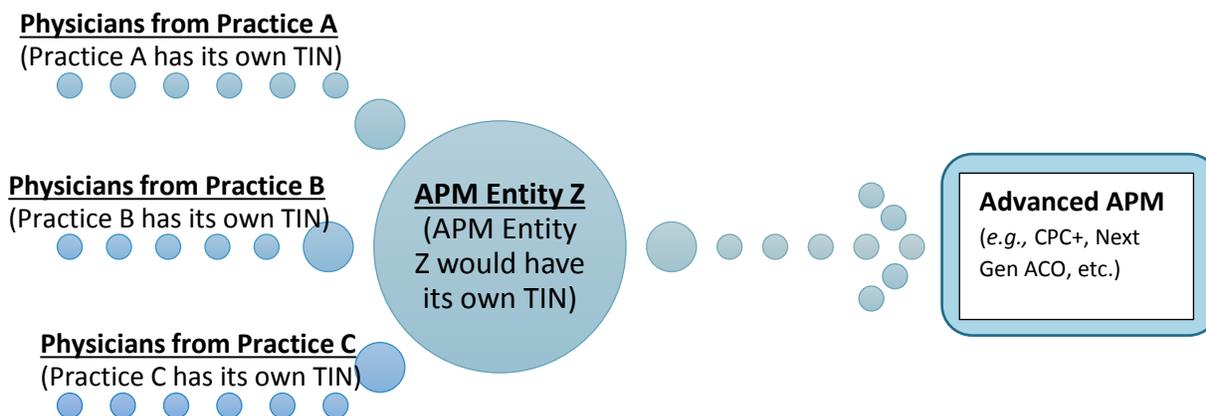
What is an APM Entity?

An APM Entity is an entity that participates in an Advanced APM or payment arrangement with CMS or another payer, respectively, through a direct agreement with CMS or other payer, or through a federal or state law or regulation. Physicians would participate in an Advanced APM through an APM Entity. There is flexibility in how an APM Entity could be formed. It could be comprised of:

- A sole physician or other eligible clinician
- A group practice of physicians and other eligible clinicians with a single tax identification number (TIN)
- A combination of physicians and other eligible clinicians from different practices and multiple TINs

Regardless of its makeup, each APM Entity would have its own TIN for participating in a specific Advanced APM.

Physicians Participate in Advanced APMs through an APM Entity



Does participation in an Advanced APM automatically exempt physicians from MIPS and qualify them for the 5% APM incentive payment?

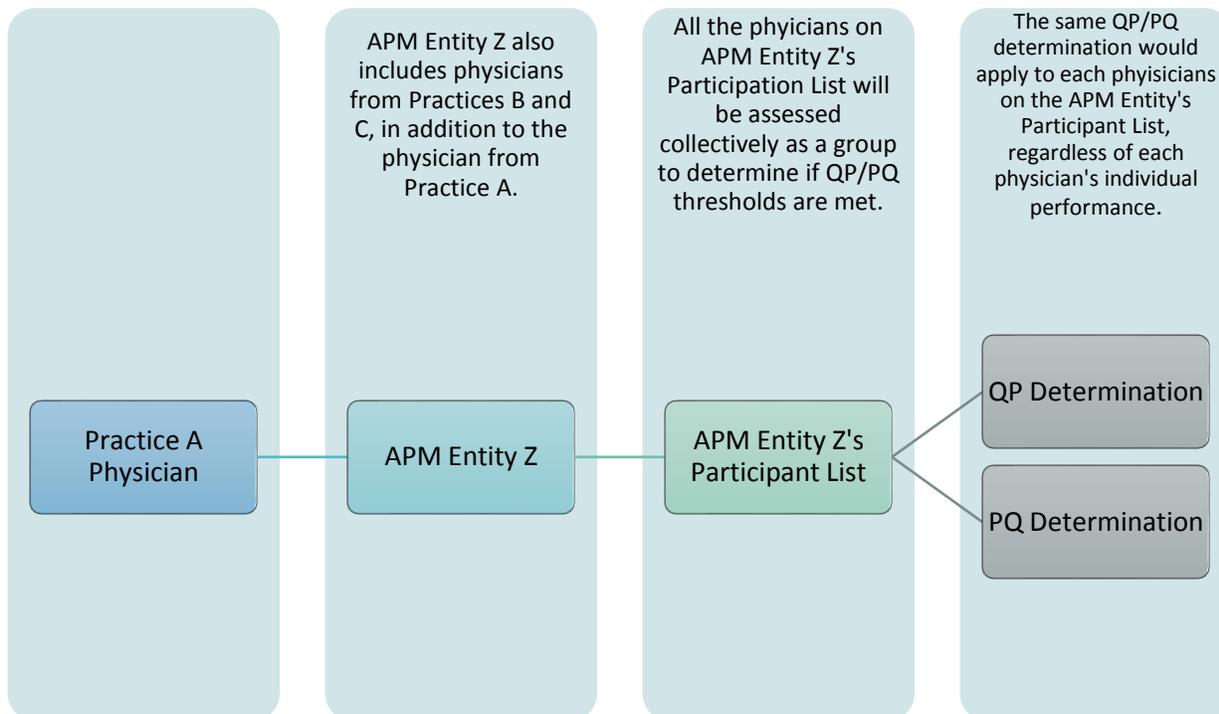
Physicians who participate in Advanced APMs and are determined to be Qualifying Advanced APM Participants (QPs) or Partial QPs (PQs) will be exempt from MIPS. However, the 5% incentive payment is dependent on whether the physician is determined to be a QP or PQ; only QPs are eligible to receive the 5% incentive payment.

Additionally, with a PQ determination, an APM Entity has the option to participate in MIPS using the MIPS APM scoring standard. If neither the QP or PQ threshold are met, then physicians are subject to the MIPS program and related reporting requirements.

Qualifying Advanced APM Participant (QP)	Partially Qualifying Advanced APM Participant (PQ)	Neither a QP or PQ
<ul style="list-style-type: none"> • Eligible to receive a 5% incentive payment • Exempt from MIPS 	<ul style="list-style-type: none"> • Not eligible to receive a 5% incentive payment • Exempt from MIPS (however, the APM Entity could elect to participate in MIPS using the MIPS APM scoring standard and be eligible to receive a positive payment adjustment) 	<ul style="list-style-type: none"> • Subject to MIPS participation using the MIPS APM scoring standard

Is Advanced APM participation determined at the individual physician level or practice level?

Participation in an Advanced APM is determined at the APM Entity level. Physicians and other eligible clinicians identified on the APM Entity’s Participant List must collectively meet the QP/PQ thresholds as an APM Entity group for each individual physician to receive credit for participation in an Advanced APM.



How do I become a QP or PQ?

As discussed above, QP and PQ thresholds are determined at the APM Entity level. CMS uses two methods to arrive at a QP or PQ determination: 1) Medicare Payment Count Method – based on the percentage of Medicare payments they receive through an Advanced APM, and 2) Medicare Patient Count Method – based on the percentage of Medicare patients they see through an Advanced APM.

	Medicare Payment Count Method	Medicare Patient Count Method
QP	25% of Medicare Part B payments are received through an Advanced APM	20% of Medicare Part B patients are seen through an Advanced APM
PQ	20% of Medicare Part B payments are received through an Advanced APM	10% of Medicare Part B patients are seen through an Advanced APM



All physicians and other eligible clinicians on the APM Entity’s Participant List collectively need to meet these thresholds. The APM Entity only meets **either the Medicare Payment Count Method or the Medicare Patient Count Method**; the APM Entity does not need to meet both to receive a QP or PQ determination.

Note: these thresholds will change beginning in the 2019 performance year for the 2021 payment incentive year.

How are these thresholds calculated?

Medicare Payment Count Method

The threshold is calculated by taking the aggregate of all Medicare Part B payments for the attributed beneficiaries, and dividing it by the total Medicare Part B payments for all “attribution-eligible” beneficiaries

$$\frac{\text{Payments for Part B services to attributed beneficiaries}}{\text{Payments for Part B services to attribution-eligible beneficiaries}} \geq 25\% \text{ for QP; } 20\% \text{ for PQ}$$

Medicare Patient Count Method

The threshold is calculated by taking the number of unique beneficiaries who are attributed to the Advanced APM Entity, and dividing it by the total number of attribution-eligible beneficiaries

$$\frac{\text{Number of attributed beneficiaries provided Part B services}}{\text{Number of attribution-eligible beneficiaries provided Part B services}} \geq 20\% \text{ for QP; } 10\% \text{ for PQ}$$

Note: attribution under each method—payment and patient—is determined by each Advanced APM’s underlying attribution rules. For example, the Medicare Shared Savings Program (MSSP) attribution would apply to the APM Entities (i.e., Accountable Care Organizations (ACOs)) participating in an MSSP Advanced APM.

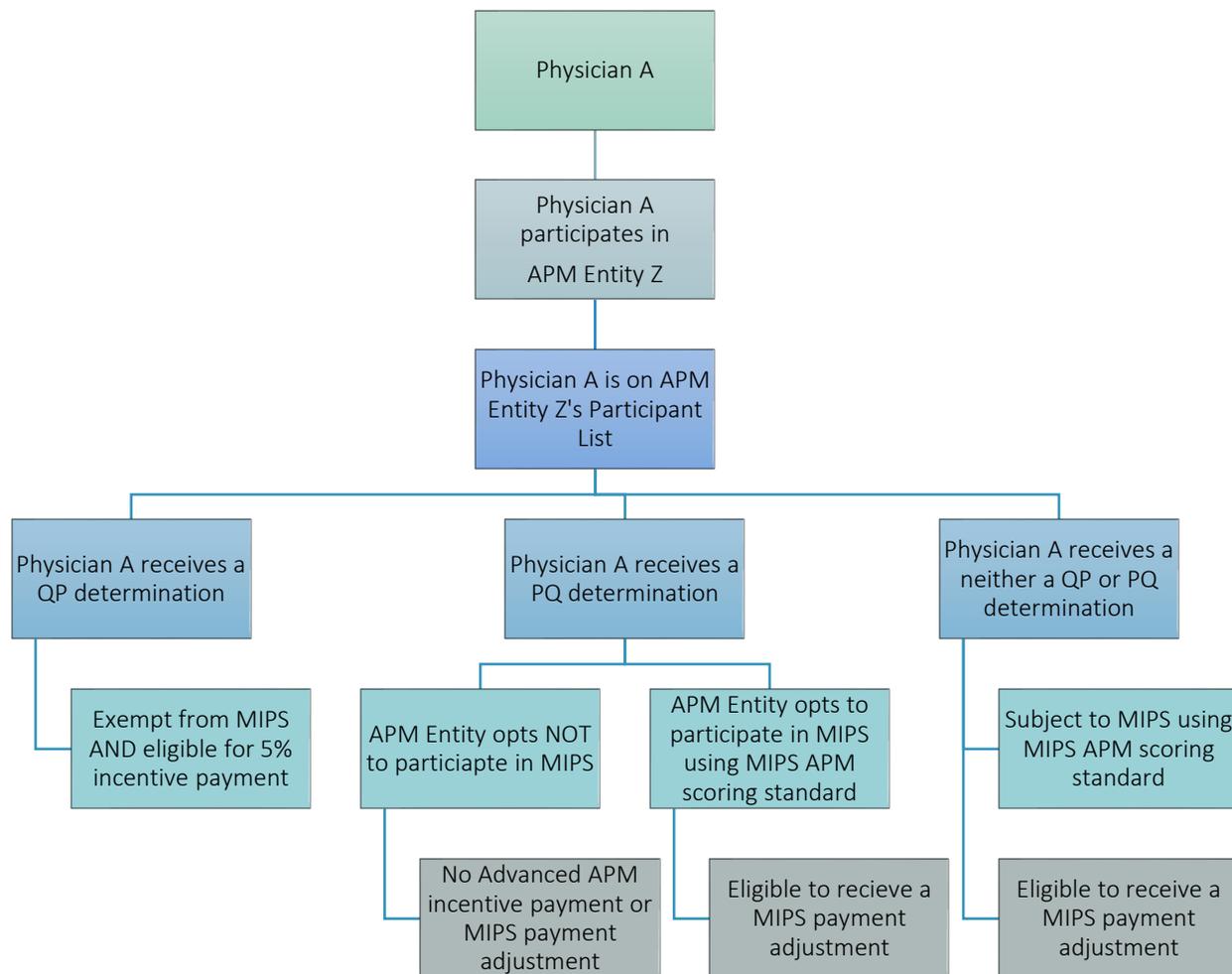
How do I know if I’ve met the QP/PQ thresholds?

CMS has three evaluation periods during which it makes QP determinations. To be considered part of the APM Entity, physicians and other eligible clinicians must be on an APM Entity’s Participant List on one of the three following dates

- March 31
- June 30
- August 31

CMS will review the APM Entity’s Participant List and review the collective performance of all physicians and other eligible clinicians as a group to determine whether the QP/PQ thresholds have been met. As noted above, if a PQ determination is made for the APM Entity, the APM Entity has the option to participate in MIPS using the MIPS APM scoring standard.

Advanced APM Participation Outcomes



What if I participate in multiple Advanced APMs? Does each APM Entity I am a part of need to meet the QP/PQ thresholds?

Physicians who participate in multiple Advanced APMs are only required to meet the QP threshold as part of one APM Entity that they are part of. If a physician is participating in multiple APM Entities and is not determined to be a QP based on participation in any of those APM Entities, the

physician could still meet the QP threshold through the aggregation of his or her performance across all the APM Entities. CMS will use the claims analyses and attribution methodology it uses for the Advanced APM Entity group level for this determination.

Physician Participating in Multiple APM Entities



What Advanced APMs are available in 2017?

- [Comprehensive ESRD Care Model](#) (LDO and Non-LDO arrangements)
- [Comprehensive Primary Care Plus](#) (CPC+)
- [Medicare Shared Savings Program](#) (MSSP ACOs Track 2 and Track 3)
- [Next Generation ACO Model](#)
- [Oncology Care Model](#) (only two-sided risk arrangements)
- [Comprehensive Care for Joint Replacement \(CJR\) Payment Model](#) (Track 1 – CEHRT)

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- [Comprehensive Care for Joint Replacement \(CJR\) Payment Model](#) (Track 1 – CEHRT)
- [Vermont Medicare ACO Initiative](#) (as part of the Vermont All-Payer ACO Model)
- [Cardiac Rehabilitation \(CR\) Incentive Payment Model](#)
- [Acute Myocardial Infarction \(AMI\) Model](#) (Track 1 – CEHRT)
- [Coronary Artery Bypass Graft \(CABG\) Model](#) (Track 1 – CEHRT)
- [Medicare-Medicaid Accountable Care Organization Model \(MMACO Tracks 2 and 3\)](#)
- [Advancing Care Coordination through Episode Payment Models Tracks 1 and 2](#)
- [Medicare ACO Track 1+](#)
- [Surgical Hip/Femur Fracture Treatment \(SHFFT\) Model \(Track 1 – CEHRT\)](#)