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

QPP Advanced Alternative Payment Model (APM) 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:

- Understanding the basic principles of population health models
- Understanding the variables and rules impacting performance under specific Advanced APMs
- Understanding the relevant QPP rules relating to participation thresholds and requirements

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 clinicians (ECs)\(^1\) 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 received 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 2019 will result in a 5% incentive payment in 2021.

**Elements Required for Receiving the Advanced APM 5% Incentive Payment**

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\(^{1}\) For 2019, eligible clinicians are defined as Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Physical & Occupational Therapists, Qualified Speech-Language Pathologists, Qualified Audiologists, Clinical Psychologists, and Registered Dietitians or Nutrition Professionals.
What are the requirements for Advanced APMs?

Within the Advanced APM pathway, physicians can participate in Medicare Advanced APMs and, beginning with the 2019 performance year, in Other Payer Advanced APMs. Other Payer Advanced APMs are payment arrangements with any payer other than traditional Medicare. Other Payer Advanced APMs include payment arrangements with states (Medicaid payment arrangements, including Medicaid managed care organization arrangements), Medicare Health Plans, or payers with arrangements that are aligned with a CMS Multi-Payer Model.

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.

Generally, Medicare and Other Payer 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);
- Have at least one quality measure must be on the MIPS final list, be endorsed by a consensus-based entity, or otherwise be determined to be an evidence-based, reliable, and valid by CMS to considered MIPS-comparable; and
- Is either 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 Advanced APM Pathway page, as well as the CMMI website.

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”).

**Financial Risk Standard for an APM Entity Participating in a Medicare Advanced APM**

To qualify under the QPP, an APM Entity must assume responsibility for performance years when actual expenditures exceed expected expenditures.

When that happens, the Advanced APM must provide for one of the following consequences:

- Withhold payments for services to the APM Entity or the APM Entity’s participating clinicians; or
- Reduce payment rates to the APM Entity or the APM Entity’s participating clinicians; or
- Require the APM Entity to owe payment(s) to CMS.

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

When actual expenditures exceed expected expenditures, a Medical Home Model may do one or more of the following:

- Withhold payments for services to the APM Entity and/or its participating ECs
- Reduce payment rates to the APM Entity and/or its ECs
- Require the APM Entity to make direct payments to CMS
- Cause the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments
An APM Entity must take on more than nominal payment risks for years when the APM Entity’s actual expenditures under the Medicare or Other Payer 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 an Other Payer or foregoes for exceeding the target. For example, for Medicare Advanced APMs, 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 all providers and suppliers participating in the APM Entity, OR 3% of the expected 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

In order to ensure that the risk an APM Entity takes on is more than nominal, the total amount an APM Entity potentially owes CMS, or foregoes, under an Advanced APM must be at least equal to either:

- 8% of the average estimated total Medicare Parts A and B revenues of all providers and suppliers participating in the APM Entity
- 3% of the expected expenditures for which the APM Entity is responsible for under the Advanced APM

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

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

**Physicians Participate in Advanced APMs through an APM Entity**

Physicians from Practice A  
(Practice A has its own TIN)  

Physicians from Practice B  
(Practice B has its own TIN)  

Physicians from Practice C  
(Practice C has its own TIN)  

APM Entity Z  
(APM Entity Z would have its own TIN)

Advanced APM  
(e.g., CPC+, Next Gen ACO, etc.)

**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.

<table>
<thead>
<tr>
<th>Qualifying Advanced APM Participant (QP)</th>
<th>Partially Qualifying Advanced APM Participant (PQ)</th>
<th>Neither a QP or PQ</th>
</tr>
</thead>
</table>
| • Eligible to receive a 5% incentive payment  
• Exempt from MIPS  | • 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)  | • Subject to MIPS participation using the MIPS APM scoring standard |

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

Participation in a Medicare and/or Other Payer 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?

While for the 2017 and 2018 participation years, physicians could only receive credit for APM participation if they were participating in a “Medicare Advanced APM,” (i.e., an APM administered by CMS/CMMI under Medicare Part B), beginning in 2019, physicians who are participating in APM arrangements with other payers (e.g., Medicare Advantage plans), “Other Payer Advanced APMS,” can have that participation count towards the requirements for the QPP Advanced APM pathway.

There are four ways for physicians or other eligible clinicians to meet the QP and PQ thresholds.
Under the Medicare Option, only payments and patients from Medicare FFS patients are considered. All-Payer Combination Option, there is a minimum threshold for Medicare patients/payments that must be met before the All Payer options kick in. The All-Payer options, therefore, do not replace or supersede the Medicare Option, and instead utilize a pair of calculations using first the Medicare Part B patient/payment count method, and then the All-Payer patient/payment count method for services furnished through Other Payer APMs.

<table>
<thead>
<tr>
<th>Medicare Payment Count Method</th>
<th>Medicare Patient Count Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>• based on the percentage of Medicare payments received through a Medicare Advanced APM</td>
<td>• based on the percentage of Medicare patients seen through a Medicare Advanced APM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Payer Payment Count Method</th>
<th>All Payer Patient Count Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>• based on the percentage of payments received through a Medicare Advanced APM and Other Payer Advanced APM</td>
<td>• based on the percentage of patients seen through a Medicare Advanced APM and Other Payer Advanced APM</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Medicare Payment Count Method</th>
<th>Medicare Patient Count Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>QP 50% of Medicare Part B payments are received through a Medicare Advanced APM</td>
<td>35% of Medicare Part B patients are seen through a Medicare Advanced APM</td>
</tr>
<tr>
<td>PQ 40% of Medicare Part B payments are received through a Medicare Advanced APM</td>
<td>25% of Medicare Part B patients are seen through a Medicare Advanced APM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Payer Payment Count Method</th>
<th>All Payer Patient Count Method</th>
</tr>
</thead>
</table>
| Step 1: Receive 25% of Medicare Part B payments are received through a Medicare Advanced APM  
Step 2: 50% of all payments are received through a Medicare Advanced APM and Other Payer Advanced APM | Step 1: 20% of Medicare Part B patients are seen through a Medicare Advanced APM  
Step 2: 35% of all patients are seen through a Medicare Advanced APM and Other Payer Advanced APM |
| Step 1: Receive 20% of Medicare Part B payments are received through a Medicare Advanced APM  
Step 2: 40% of all payments are received through a Medicare Advanced APM and Other Payer Advanced APM | Step 1: 10% of Medicare Part B patients are seen through a Medicare Advanced APM  
Step 2: 25% of all patients are seen through a Medicare Advanced APM and Other Payer Advanced APM |
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

\[
\frac{\text{Payments for Part B services to attributed beneficiaries}}{\text{Payments for Part B services to attribution-eligible beneficiaries}} \geq 50\% \text{ for QP; } 40\% \text{ for PQ}
\]

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

\[
\frac{\text{Number of attributed beneficiaries provided Part B services}}{\text{Number of attribution-eligible beneficiaries provided Part B services}} \geq 35\% \text{ for QP; } 25\% \text{ for PQ}
\]

All Payer Payment/Patient Count Methods

A similar approach is used with the All Payer Count methods, but the numerators for step 2 of All Payer count method would also include payments/patients from the Other Payer Advanced APM. The All-Payer Combination payment count and patient count methods are determined similar to the Medicare methods, but using payment and patient information from Medicare Advanced APMs and Other Payer Advanced APMs. For example, the All Payer Combination payment count method is determined by taking the aggregate of all payments from all payers, except those excluded, that are made or attributable to the eligible clinician under the terms of all Medicare Advanced APMs and Other Payer Advanced APMs, and dividing it by the aggregate of all payments from all payers, except those excluded, that are made or attributed to the eligible clinician.

CMS has provided an example of how it would use the payment amount method under the All-Payer Combination Option to make a QP determination. In its example, CMS posits that an APM Entity is participating in a Medicare ACO, a commercial ACO arrangement, and a Medicaid APM, and receives the following payments outlined in the chart from each during the 2019 performance period.
All-Payer Combination Option Example

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payments through ACO</th>
<th>Total Payments from Applicable Payer</th>
<th>Threshold Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare*</td>
<td>200,000</td>
<td>500,000</td>
<td>40 percent</td>
</tr>
<tr>
<td>Commercial</td>
<td>400,000</td>
<td>500,000</td>
<td>80 percent</td>
</tr>
<tr>
<td>Medicaid</td>
<td>100,000</td>
<td>150,000</td>
<td>67 percent</td>
</tr>
<tr>
<td>Total</td>
<td>700,000</td>
<td>1,150,000</td>
<td>61 percent</td>
</tr>
</tbody>
</table>

* For Medicare Part B payments, the amount used for the All-Payer Combination Option will be the same as the amount used in the Medicare Option.

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.

Submission of Information for Other Payer Advanced APM Credit

CMS has finalized that APM Entities or eligible clinicians must submit all of the required information about the Other Payer Advanced APMs in which they participate, including those for which there is a pending request for an Other Payer Advanced APM determination (i.e., those that have been submitted through the Eligible Clinician Initiated Process during the QP Performance Period), as well as the payment amount and patient count information sufficient for CMS to make QP determinations by December 1, 2019.

If an APM Entity or eligible clinician submits sufficient information for either the payment amount or patient count method, but not for both, CMS will make a QP determination based on the one method that contains sufficient information.

An APM Entity or eligible clinician that submits information to request a QP determination under the All-Payer Combination Option must certify to the best of its knowledge that the information submitted is true, accurate and complete. In the case of information submitted by the APM Entity, the certification needs to be made by an individual with the authority to bind the APM Entity. This certification must accompany the form that APM Entities or eligible clinicians submit to CMS when requesting that they make QP determinations under the All-Payer Combination Option.

CMS has also finalized that an APM Entity or eligible clinician that submits information for QP determinations must maintain records to enable the audit of QP determinations and the accuracy
of APM Incentive Payments for 6 years from the end of the QP Performance Period or from the date of completion of any audit, evaluation, or inspection (whichever is later).

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 following dates:

- March 31
- June 30
- August 31
- December 31 – for full TIN APMs, which CMS has defined as an APM where participation is determined at the TIN level and where all eligible clinicians have assigned their billing rights to the TIN participating in the APM.

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. Use the CMS QP Lookup Tool to determine your QP/PQ status.

Advanced APM Participation Outcomes

**FIGURE 1: QP Determination Tree, Payment Years 2021-2022**

Source: CY 2018 QPP Final Rule
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 Participating in Medicare Advanced APMs

What Medicare Advanced APMs are available in 2019?

- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+, 2, 3, Basic Level E, and ENHANCED Track
- Next Generation ACO Model
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- Maryland All-Payer Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program and Care Redesign Program)

For a list of Other Payer Advanced APMs, please see the following resources:

- 2019 List of Medicare Health Plan Other Payer APMs
- 2019 QPP Multi-Payer Other Payer Advanced APMs
- 2019 Medicaid Other Payer Advanced APMs in the Quality Payment Program