Quality Payment
PROGRAM

Qualifying Alternative Payment Model Participants (QPs) Methodology Fact Sheet

Overview

This methodology fact sheet describes the process and methodology that the Centers for Medicare & Medicaid Services (CMS) will use to identify eligible clinicians who, through their participation in Advanced Alternative Payment Models (APMs), are Qualifying APM Participants (QPs) for a year and will be eligible to receive the 5% APM Incentive Payment.

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.

- **Identify eligible clinicians participating in Advanced APMs.** Obtain lists of eligible clinicians participating in Advanced APMs.
- **Identify attribution-eligible beneficiaries**. Using Medicare Parts A and B administrative claims data and Medicare beneficiary enrollment information, identify attribution-eligible beneficiaries.
- **Identify beneficiaries attributed to Advanced APM Entities.** Obtain lists of beneficiaries attributed to Advanced APM Entities.
- **Calculate payment amount Threshold Scores.** Calculate the payment amount Threshold Score at the APM Entity level.
- **Calculate patient count Threshold Scores.** Calculate the patient count Threshold Score at the APM Entity level.
- **Determine QP status.** 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 QP Status to the eligible clinicians in the APM Entity.)
- **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. This step will only occur after the Final QP determination for a calendar year.

QP Performance Period

The QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for 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.

QP Determinations During the QP Performance Period

During a given QP Performance Period, CMS will make QP determinations using each Advanced APM Entity's Participation List as of three points in time, or "snapshot" dates: March 31, June 30, and August 31. For each of the three QP determination dates, CMS will use the APM Entity group'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 group's Threshold Scores. CMS will allow for 90 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:

1. **First QP determination.** 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 group meets or exceeds the QP threshold based on the APM Entity group's data from January 1 through March 31, then all eligible clinicians in the Advanced APM Entity group will be QPs 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]

2. **Second QP determination.** If the Advanced APM Entity group did not meet the QP threshold under the initial QP determination, or if the Advanced APM Entity group includes eligible clinicians who were not part of the Advanced APM Entity group at the initial QP determination, 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 group meets the QP threshold based on the APM Entity group's data from January 1 through June 30, then all eligible clinicians in the Advanced APM Entity group will be QPs, 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. If the Advanced APM Entity group does not meet the QP threshold at the second QP determination but did meet the QP threshold at the initial determination, CMS will not revise the QP status of the eligible clinicians who were previously determined to be QPs. If an Advanced APM Entity group meets the threshold in both the first and second determinations, but some eligible

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

clinicians no longer remain on the Participation List for the second determination, those eligible clinicians will still be considered QPs for that QP Performance Period.

3. **Third QP determination.** 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.

Identify Eligible Clinicians Participating in Advanced APMs

CMS will identify eligible clinicians participating in Advanced APMs using (1) an APM Entity's Participation List and/or (2) an Affiliated Practitioner List. These lists will identify eligible clinicians 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 Comprehensive Primary Care Plus (CPC+) Model, the Comprehensive ESRD Care (CEC) Model, the Medicare Shared Savings Program – Tracks 2 and 3, and the Next Generation Accountable Care Organization (ACO) model, CMS will use the Participation List to define the Advanced APM Entity group, regardless of whether there is also an Affiliated Practitioner List or other list of eligible clinicians associated with the Advanced APM Entity. CMS will assess the eligible clinicians on the Participation List as a group 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 group.

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. If the APM Entity does not identify eligible clinicians on a Participation List, CMS will use the APM Entity's Affiliated Practitioner List (making determinations at the individual eligible clinician level).

Each APM program team at CMS is responsible for the 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 group for purposes of QP determinations if an eligible clinician's APM participant identifier is present on a Participation List of an APM Entity

group 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]
6. Has a minimum of one claim for evaluation and management services furnished by an eligible clinician or group of eligible clinicians within an APM Entity during the QP determination period.[4] Healthcare Common Procedure Coding System codes 99201–99499, G0402, G0438, G0439[5] and G0463[6] indicate evaluation and management services.

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[2] Next Generation ACOs also have an opportunity to designate Preferred Providers. However, Preferred Providers are not eligible to be assessed as QPs as part of the Next Generation ACO APM Entity group. For further information on Next Generation ACO Model Preferred Providers, please refer to: https://innovation.cms.gov/Files/x/nextgenacofaq.pdf

[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.

[4] To better align the attribution eligibility criteria with each APM's attribution methodology, CMS may modify the attribution basis to use other criteria in addition to, or instead of, the criteria based on evaluation and management services. We modify the attribution eligibility criteria if attributed beneficiaries would not be a subset of the attribution-eligible population because the Advanced APM does not use evaluation and management services as a criterion for identifying attributed beneficiaries.

[5] See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.

[6] See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm8572.pdf (page 3).

Advanced APM Beneficiary Attribution Eligibility Criteria

Models Below Follow QPP's Standard Attribution Eligibility Criteria

Medicare Accountable Care Organization (ACO) Track 1+ Model

Medicare Shared Savings Program (SSP) Track 2

SSP Track 3

Next Generation ACO

Oncology Care Model (OCM)

CPC+

Eligibility Criteria

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

and

At least one claim with evaluation and management services HCPCS code (99201 - 99499), G0402, G0438, G0439 or G0463

Models Below Utilize the Flexibility in the Sixth Criterion

Comprehensive Care for Joint Replacement Model

Maryland All-Payer Care Redesign Program

Bundled Payments for Care Improvement Advanced (BCPI Advanced Model) - Affiliated Practitioners:
Hospital Participants

Bundled Payments for Care Improvement Advanced (BCPI Advanced Model) - Affiliated Practitioners:
Physician group practice participants

Eligibility Criteria

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 or FQHC claim (claim type 40 and the type of bill 71x or 77x)

Comprehensive End- Stage Renal Disease Care Model

Eligibility Criteria

At least one maintenance dialysis service claim (claim type 40 and type of bill 72x)

and

No claim for acute kidney injury (condition code 84) on the outpatient claim (claim type 40)

and

At least one professional claim (claim type 71, 72) for services furnished by an eligible clinician or group of eligible clinicians participating in the APM

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. Similar to the approach for identifying eligible clinicians participating in Advanced APMs, once a beneficiary is present on the attribution list of an APM Entity group 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 the APM-specific attribution methodologies is available at: https://qpp.cms.gov/learn/apms. 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.

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 as follows:

Threshold score based on the payment amount method

$$\frac{\text{\$\$\$ for Part B professional services to attributed beneficiaries}}{\text{\$\$\$ for Part B professional services to attribution-eligible beneficiaries}} = \text{Threshold Score \%}$$

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 at least 90 days of 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 Medicare Part B claims for 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 numerator of the Threshold Score as the aggregate of all payments for Medicare Part B 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 method used in 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 Medicare Part B 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 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. Part B covered professional services under the Medicare Physician Fee Schedule (PFS) are currently subject to several statutory provisions geared toward improving quality and efficiency in service delivery. Eligible professionals are subject to payment adjustments under the Medicare Electronic Health Record (EHR) Incentive Program, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier through calendar year 2018, and, beginning with calendar year 2019, the MIPS payment adjustment will replace the three payment adjustments. These payment adjustments directly adjust the payment amount that eligible professionals receive under the PFS or that MIPS eligible clinicians receive under Part B, as applicable, during the relevant payment year. CMS will exclude the Merit-Based Incentive Payment System (MIPS), EHR Incentive Program, PQRS, and Value-Based Payment Modifier payment adjustments when calculating payment amounts for covered professional services for the numerator and denominator of the QP Payment Amount Threshold Score.

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 incentives 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 within an APM when an APM Entity assumes responsibility for the cost of a beneficiary's care. For example, the shared savings payments made to ACOs in the Shared Savings Program are financial risk payments. CMS will not include financial risk payments when calculating payment amounts for covered professional services in the numerator and denominator of the Threshold Score under the QP payment amount approach.

B. Supplemental service payments

Supplemental service payments are Medicare Part B 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 of the QP payment amount Threshold Score calculation.

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 of the QP payment amount Threshold Score calculation is posted at qpp.cms.gov in the Resource Library.

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 Part B 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 the QP status determinations. CMS will calculate the patient count Threshold Score for all eligible clinicians in the Advanced APM Entity group as follows:

Threshold Score based on the patient count method

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

Counting unique beneficiaries. CMS will count any beneficiary for whom eligible clinicians within an Advanced APM Entity received payments for Part B 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.

Denominator for the Patient Count Method. The denominator of the Threshold Score under the QP patient count method 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. The numerator of the Threshold Score for the QP patient count method 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 Status and Partial QP Status for Eligible Clinicians in APM Entity groups

If the Threshold Score calculated during a QP determination period for the APM Entity group based on the payment amount or patient count method meets or exceeds the relevant QP threshold for the payment amount or patient count method, CMS will consider all eligible clinicians in the APM Entity group 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 of 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 group-level determination process. First, if an individual eligible clinician participates in more than one Advanced APM Entity and none of the eligible clinician's Advanced APM Entity groups achieve 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 individual eligible clinicians for QP or Partial QP status, CMS will use claims data for services furnished by the eligible clinician (as identified by NPI) through all of the eligible clinician's Advanced APM Entities during the QP Performance Period. Under the payment amount approach, CMS will compute 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, (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, and (3) multiplying the result by 100. The patient count approach will be 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.

Participation in Multiple Advanced APMs

Although QP status generally is determined at the APM Entity group level, an eligible clinician who participates in multiple Advanced APMs but does not become a QP based on the QP determinations made at the APM Entity group level for any of the Advanced APM Entities in which they participate will be assessed at the individual clinician level. Eligible clinicians in multiple Advanced APMs are assessed individually only when the clinician does not achieve QP

Status at the APM Entity level for any of their APM Entities during the first two QP determinations, and this assessment will only occur after the final QP determination for a QP Performance Period.