

## Calculating Advanced APM Participation for 2017

Under MACRA, clinicians are exempt from the Merit-based Payment System (MIPS) and receive payment incentives if they exceed certain thresholds of participation in certain risk-bearing alternative payment models (APMs), known as “advanced APMs.” For 2017, qualifying advanced APMs are Tracks 2 and 3 of the Medicare Shared Savings Program, the Next Generation Accountable Care Organization (ACO) program, the Comprehensive Care for Joint Replacement program, and the two-sided risk tracks of the Oncology Care Model and the Comprehensive End-stage Renal Disease program. A comprehensive list of Medicare APMs – including which ones qualify as advanced APMs – is available on CMS’s QPP [website](#).

CMS will measure advanced APM participation by calculating a “threshold score” using both the amount of Medicare Part B professional services attributable to an advanced APM and the percentage of patients cared for through the advanced APM. In most circumstances, CMS will calculate collective participation at the level of the advanced APM entity, which is the entity that has contracted with CMS to accept risk for financial and quality outcomes (e.g., an ACO). The agency will calculate a “threshold score” by aggregating payment amounts and patient counts among all clinicians who are listed on the Participation List the advanced APM entity is required to submit to CMS.

### Methodology to Calculate Threshold Score

CMS will use the following calculations to determine clinicians’ threshold scores and use the more advantageous threshold score to determine clinicians’ eligibility for incentives.

**Payment Amounts = X ÷ y**  
**THRESHOLD SCORE**

**x** = Aggregate of all payments for Medicare Part B professional services furnished by eligible clinicians in the advanced APM entity to attributed beneficiaries

**y** = Aggregate of all payments for Medicare Part B professional services furnished by eligible clinicians in the advanced APM entity to attribution-eligible beneficiaries<sup>[1]</sup>

**Patient Counts = X ÷ y**  
**THRESHOLD SCORE**

**x** = Number of unique attributed beneficiaries to whom eligible clinicians in the advanced APM entity furnish Medicare Part B professional services

**y** = Number of attribution-eligible beneficiaries to whom eligible clinicians in the advanced APM entity furnish Medicare Part B professional services

[1] For purposes of these calculations, CMS defines attribution-eligible beneficiaries as those who:

- Are not enrolled in an MA or Medicare cost plan;
- Do not have Medicare as a secondary payer;
- Are enrolled in both Medicare Parts A and B;
- Are at least 18 years of age;
- Are U.S. residents, and
- Have a minimum of one claim for evaluation and management services by an eligible clinician or group of clinicians within the APM entity during the performance period.

## **Qualifying Participants (QPs) and Partial QPs**

CMS will compare clinicians' threshold scores to pre-determined participation thresholds for payment amounts and patient counts, as follows:

- If clinicians' threshold score for 2017 advanced APM participation meets or exceeds either 25 percent of Medicare payments or 20 percent of Medicare patients, the clinicians are deemed to be "qualifying participants" (QPs). QPs are exempt from reporting under the MIPS and earn an advanced APM incentive payment in calendar year 2019.
- If clinicians' threshold score falls short of the QP thresholds but exceeds either 20 percent of Medicare payments or 10 percent of Medicare patients, the clinicians are deemed to be "partial QPs." Partial QPs do not earn an advanced APM incentive payment, but can choose whether to participate in MIPS.
- Clinicians who do not qualify as either QPs or Partial QPs must participate in the MIPS. However, those clinicians may receive advantageous MIPS scoring for their APM participation.

All clinicians on an APM entity's Participation List will receive the same designation (QP, Partial QP or MIPS-eligible) for purposes of the advanced APM incentives.

### **Timing of QP Determinations**

CMS will make group QP determinations based on a snapshot of an APM entity's Participation List at three points during 2017 – March 31, June 30 and Aug. 31. Once a clinician is included in an APM entity's determination, the clinician will continue to be included for the rest of the year, even if the clinician later is removed from the APM entity's Participation List. However, clinicians who are added to an APM entity's Participation List mid-year will be included in the group determination at the next snapshot.

If an APM entity meets the participation threshold under the first assessment based on March 31 data, all of the APM's eligible clinicians will be deemed QPs for the rest of the year. If the APM entity does not meet the threshold, or if it adds clinicians to its Participant List, it will be reassessed during the next assessment period based on data from Jan. 1 through June 30. If the entity does not meet the threshold at that point, it will receive one final assessment using data from Jan. 1 through Aug. 31. For each of the determinations, CMS will allow for three months' claims run-out before calculating threshold scores. Eligible clinicians will know their QP status approximately four months after the end of the determination time period.