Quality Payment PROGRAM

Alternative Payment Model (APM) 2019 Incentive Payment Fact Sheet

CMS will begin paying the Qualifying Alternative Payment Model (APM) Participant (QP) Incentive Payment for the 2017 performance year of the Quality Payment Program starting in September 2019.

Who Is Eligible to Receive an APM Incentive Payment in 2019?

A clinician is eligible for an incentive payment in 2019 if, during the 2017 QP Performance Period, they:

- Were an eligible clinician participating in one or more Advanced APMs; AND
- Met or exceeded **one** of the following thresholds:
  - Provided professional services through an Advanced APM to at least 20 percent of their patients; OR
  - Received at least 25 percent of their payments for professional services through an Advanced APM.

Determining Your 2019 Incentive Payment

In accordance with the statute, APM Incentive Payments will be made in each of payment years 2019 through 2024 for eligible clinicians who were determined to be QPs in performance years 2017 through 2022, respectively. The APM Incentive Payment is equal to 5 percent of the estimated aggregate payment amounts for Medicare Part B covered professional services furnished by the QP during the "base period," which is the calendar year preceding the payment year, across all billing TINs associated with the QP's NPI.

The APM Incentive Payment is based on the paid amounts for Medicare Part B covered professional services furnished by the QP across all of their TIN/NPI combinations during the base period, which for purposes of 2017 QPs is calendar year 2018. Note that the APM Incentive Payment is based only on Part B covered professional services (services paid under the Part B physician fee schedule as well as certain payments noted below associated with payment under the Advanced APM), not all Part B items and services.

Timeframe of Claims

In calculating the APM Incentive Payment amount, CMS uses claims submitted with dates of service from January 1 through December 31 of the base period and processing dates of January 1 of the base period through March 31 of the subsequent payment year to allow for claims run-out.

For example, to calculate the 2019 APM Incentive Payment, CMS captured claims submitted with dates of service from January 1, 2018, through December 31, 2018, and processing dates of January 1, 2018, through March 31, 2019. We believe that 3 months of claims run-out is sufficient to conduct the APM Incentive Payment calculations in an accurate and timely

manner. This methodology is consistent with the claims run-out timeframes used for reconciliation payments in several current APMs, such as the Shared Savings Program, the Next Generation Accountable Care Organizations (ACO) Models, and the Comprehensive ESRD Care Model.

Treatment of Payments for Services Paid on a Basis Other Than Fee-For-Service

Many APMs use incentives and financial arrangements that differ from usual fee schedule payments. The statute required CMS to establish policies for calculating the APM Incentive Payment when payment is made on a basis other than fee-for-service. In the Calendar Year (CY) 2017 Quality Payment Program final rule, we divided such payments into three categories: financial risk payments, supplemental service payments, and cash flow mechanisms.

Financial Risk Payments

Financial risk payments are non-claims-based payments based on performance in an APM when an APM Entity assumes responsibility for the cost of a beneficiary's care, whether it be for an entire performance year, or for a shorter duration of time, such as over the course of a defined episode of care. For instance, we would consider the shared savings payments made to ACOs in all tracks of the Shared Savings Program to be financial risk payments. We also would consider as examples of be financial risk payments reconciliation payments from us to a participant hospital or repayment amounts from a participant hospital to us under the Comprehensive Care for Joint Replacement model, as well net payment reconciliation amounts from us to an Awardee (or vice versa) under the Bundled Payments for Care Improvement (BPCI) Initiative (although we note that BPCI was not an Advanced APM in 2017).

We note that in the context of categorizing these types of payments as "financial risk payments," we refer to payments that may be based on the cost of a beneficiary's care and do not necessarily limit these payments to financial arrangements that would require an APM Entity to accept downside risk.

When calculating the estimated aggregate payment amount for covered professional services upon which to base the APM Incentive Payment amount CMS will exclude financial risk payments.

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 paid under the physician fee schedule. Often these are per-beneficiary per-month (PBPM) payments that are made for care management services or separately billable services that share the goal of improving quality of care overall, enabling investments in care improvement, and reducing Medicare expenditures for services that could be avoided through care coordination.

When calculating the APM Incentive Payment, in cases where payments are for covered services that are in lieu of services paid under the PFS, those payments would be considered covered professional services and would be included in the APM Incentive Payment amounts.

CMS will determine whether certain supplemental service payments are in lieu of covered services that are paid under the PFS using the following criteria:

1. Payment is for services that constitute physicians' services authorized under section 1832(a) of the Act and defined under section 1861(s) of the Act;
2. Payment is made for only Part B services under the first criterion above, that is, payment is not for a mix of Part A and Part B services;
3. Payment is directly attributable to services furnished to an individual beneficiary; and
4. Payment is directly attributable to an eligible clinician.

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. In themselves, 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. An example of a cash flow mechanism is the population-based payment (PBP) available in the Next Generation ACO Model. A PBP is a monthly lump sum payment in exchange for a percentage reduction in Medicare fee-for-service payments to certain ACO providers and suppliers.

When calculating the estimated aggregate payment amount for covered professional services upon which to base the APM Incentive Payment amount, CMS will use the payment amount that would have been made for Part B covered professional services if the cash flow mechanism had not been in place.

Treatment of Payment Adjustments in Calculating the Amount of APM Incentive

When calculating the APM Incentive Payment amount, CMS excludes MIPS, Value Modifier, Meaningful Use, and Physician Quality Reporting System payment adjustments. This allows CMS to assess all eligible clinicians on the same merits when calculating the APM Incentive Payment, and does not enhance or negate the amount of APM Incentive Payment a QP receives, based on factors that are extraneous to Advanced APM participation.

Treatment of Other Incentive Payments in Calculating the Amount of APM Incentive Payments

As specified in the statute, the calculation of the incentive payment will not include incentive payments made under the health professional shortage area (HPSA) Physician Bonus Program, the Primary Care Incentive Payment program, or the HPSA Surgical Incentive Payment.

Accounting for Services Furnished Through CAHs, RHCs, and FQHCs

Critical Access Hospitals (CAHs)

Eligible clinicians who furnish services at Critical Access Hospitals (CAHs) that have elected to be paid for outpatient services under Method II will be eligible to become QPs and receive the APM Incentive Payment if they are part of an APM Entity in an Advanced APM. Professional services furnished at a Method II CAH are considered "covered professional services" because they are furnished by an eligible clinician and payments are based on the Medicare Physician Fee Schedule. Therefore, the APM Incentive Payment would be based on the amounts paid for those services attributed to the eligible clinician, as identified using the attending NPI included on a submitted claim, in the same manner as all other covered professional services.

CMS will make the APM Incentive Payment for an eligible clinician who becomes a QP based on covered professional services furnished at a Method II CAH to the CAH TIN that is affiliated with the Advanced APM Entity.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Payment for services furnished by eligible clinicians in RHCs and FQHCs is not made under or based on the PFS. Therefore, professional services furnished in those settings would not constitute covered professional services under section 1848(k)(3)(A) of the Act and would not be considered part of the estimated aggregate payment amount upon which the APM Incentive Payment is calculated.

Frequently Asked Questions & Answers

Q: How can I verify the amount of my 2019 APM Incentive Payment?

A: Later this fall you will be able to verify your information by going to the QPP portal where you will see the incentive payment amount and the billing NPI for both the NPI and the organization. Visit qpp.cms.gov for this information.

Q: How do I get help or more information?

You can reach the Quality Payment Program at 1-866-288-8292 (TTY 1-877-715-6222), Monday through Friday, 8:00 AM-8:00 PM ET or by e-mail at: QPP@cms.hhs.gov.