

Predictive Qualifying Alternative Payment Model (APM) Participants (QPs) Methodology Fact Sheet

What is the Predictive QP status analysis?

One of the Quality Payment Program's goals is to be clear about your Qualifying APM Participant (QP) or Partial QP status. We said we'd look at your claims history and give you, as a 2017 Advanced APM eligible clinician, our best estimate about your QP or Partial QP status. For the 2017 Predictive QP analysis, this is how we determined if you, from your participation in one of the following Advanced APMs, are predicted to be a QP for the 2017 performance year and are likely to be eligible for the 5% APM Incentive Payment in the 2019 payment year.

These calculations are predictive in nature, meaning they are a prediction of your QP status in performance year 2017, if you participate in at least one of these Advanced APMs in performance year 2017:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation Accountable Care Organization (ACO) Model
- Medicare Shared Savings Program - Track 2
- Medicare Shared Savings Program - Track 3

For this analysis, we used administrative claims with dates of service between 1/1/16 and 8/31/16 that were processed between 1/1/16 and 11/30/16. Actual QP determinations will use claims data from the relevant performance year as of three points in time, or "snapshot" dates: March 31, June 30, and August 31.

If you are a participant in the Comprehensive Care for Joint Replacement Model (CJR)—CEHRT Track, we did not make predictions about your QP status for performance year 2017. The CJR-CEHRT Track did not begin until 2017 so there are no historical claims data available. We also did not make predictions for the Oncology Care Model (OCM)—Two-Sided Risk Arrangement as there are no OCM practices currently participating in this arrangement.

What were the Predictive QP & Partial QP determination steps?

We took the following steps to estimate QPs and Partial QPs in our 2017 predictive analysis.

Please note each step is outlined in more detail in the subsequent questions and answers.

- **Identified eligible clinicians participating in Advanced APMs** using the APM Entity participation lists.
- **Identified attribution-eligible beneficiaries** from Medicare Parts A and B administrative claims data and Medicare beneficiary enrollment information.
- **Identified beneficiaries attributed to Advanced APM Entities.**
- **Calculated payment amount Threshold Scores.**
- **Calculated patient count Threshold Scores.**
- **Determined predictive QP or Partial QP status** for an APM Entity group based on the payment amount or patient count. We applied the more advantageous QP Status to the eligible clinicians participating in the APM Entity.

How did we identify eligible clinicians participating in Advanced APMs?

In order to perform the QP determination estimate for eligible clinicians, we used the participation list for each APM. Each of our APM teams manages Participation Lists. Every APM's participation list includes Taxpayer Identification Numbers (TINs) and/or National Provider Identifiers (NPIs). These identifiers were used to identify eligible clinicians participating in Advanced APMs. All of the Advanced APM Entities included in the Predictive QP analysis had a Participation List and we assessed the eligible clinicians on the Participation List as a group at the APM Entity level for predictive QP determination.

How did we identify attribution-eligible beneficiaries?

We found beneficiaries to be attribution-eligible to an APM Entity if during the historical assessment period they:

- Weren't enrolled in Medicare Advantage or a Medicare cost plan.

- Didn't have Medicare as a secondary payer.
- Were enrolled in both Medicare Parts A and B for the entire QP performance period.
- Were at least 18 years of age on January 1.
- Were a United States resident¹.
- Had a minimum of 1 claim for evaluation and management services furnished by one or a group of eligible clinicians used in assignment in an APM Entity during the historical assessment period.²

To match the attribution eligibility criteria with each APM's attribution methodology, we may apply exceptions to the evaluation and management requirement for attribution-eligible beneficiaries. Such an exception will be applied in 2017 to the [CEC model, including the predictive QP analysis](#).

How did we identify beneficiaries attributed to Advanced APM Entities?

Each Advanced APM maintains a list of beneficiaries attributed to an APM Entity based on the APM's attribution rules. We used the latest lists available for the predictive QP determination. You can learn more about the APM-specific attribution methodologies at: qpp.cms.gov/learn/apms.

What did we include in our threshold calculations?

Claims methodology and timeframe. We used Medicare Part B claims with dates of service from 1/1/16-8/31/16 that were processed between 1/1/16 and 11/30/16 to calculate the denominator and numerator for the Predictive QP analysis.

Payments through [Method II Critical Access Hospitals \(CAHs\)](#). We included covered professional services furnished by CAHs billing under Method II (Method II CAHs) in the Predictive QP analysis.

Treatment of payment adjustments. Many statutes apply to Medicare Physician Fee Schedule Part B covered professional services to help improve service delivery, quality, and efficiency. Your payments may be adjusted under the Medicare EHR Incentive Program, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier through payment adjustment year 2018. For years after 2018, payment

¹ 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.

² For some Advanced APMs that do not use evaluation and management services to determine attribution, and for which attributed beneficiaries are not a subset of the attribution-eligible beneficiary population (based on an evaluation and management service criterion), CMS may modify this criterion to better align with the Advanced APM's methodology for identifying attributed beneficiaries. The modified criterion may include a combination of evaluation and management and/or other services.

adjustments under those three programs will expire and be replaced by any applicable Merit-based Incentive Payment System (MIPS) payment adjustments that directly change the amounts you're paid under the Physician Fee Schedule for the payment year. We excluded the Medicare EHR Incentive Program, PQRS, and Value-Based Payment Modifier payment adjustments in the Predictive QP analysis.

How did we calculate payment amount Threshold Scores?

Denominator for the payment amount method. We calculated the denominator for the payment amount method as the total 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 historical analysis period. We used the combinations of TINs or TINs and NPIs listed on the Advanced APM Entity's Participation List to get all claims billed for covered professional services furnished to attribution eligible beneficiaries through the Advanced APM Entity during the historical analysis period.

Numerator for the payment amount method. We calculated the numerator for the payment amount method as the total of all Medicare part B claims for covered professional services furnished by eligible clinicians in the Advanced APM Entity to attributed beneficiaries during the historical analysis period. Like the method we used for the denominator, we used the combinations of TINs or TINs and NPIs for eligible clinicians listed on a Participation List to find Medicare Part B claims for covered professional services furnished to attributed beneficiaries through the Advanced APM Entity during the historical analysis period.

Threshold Score for the payment amount method. We calculated the payment amount Threshold Score for an Advanced APM Entity as a percentage by dividing the numerator value by the denominator value.

How did we calculate patient count Threshold Scores?

Denominator for the patient count method. We calculated the denominator for the patient count method as the number of attribution eligible beneficiaries that received Medicare Part B covered professional service furnished by eligible clinicians in the Advanced APM Entity to attribution-eligible beneficiaries during the historical analysis period. We used the combinations of TINs and NPIs listed on the Advanced APM Entity's Participation List to get all claims billed for covered professional services

Threshold score based on the payment amount method

\$\$\$ for Part B professional services to attributed beneficiaries

= Threshold Score %

\$\$\$ for Part B professional services to attribution-eligible beneficiaries

furnished to attribution eligible beneficiaries through the Advanced APM Entity during the historical analysis period. This included Medicare Part B covered professional services delivered in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that were on an APM Entity Participation List. We counted attribution-eligible beneficiaries once for each APM Entity for the denominator.

Numerator for the patient count method. We calculated the numerator for the patient count method as the number of attributed beneficiaries that received Medicare Part B covered professional service furnished by eligible clinicians in the Advanced APM Entity to attributed beneficiaries during the historical analysis period. We used the combinations of TINs or TINs and NPIs listed on the Advanced APM Entity's Participation List to get all claims billed for covered professional services furnished to attributed beneficiaries through the Advanced APM Entity during the historical analysis period. This included Medicare Part B covered professional services delivered in RHCs and FQHCs that were on an APM Entity participation list. We counted an attributed beneficiary once for each eligible clinician for the numerator.

Threshold Score for the patient count method. We calculated the patient count Threshold Score for an Advanced APM Entity as a percentage by dividing the numerator value by the denominator value.

Threshold score based on the patient count method

$$\frac{\text{\# of patients given services under Advanced APMs and Other Payer Advanced APMs}}{\text{\# of patients given services under all payers}} = \text{Threshold Score \%}$$

of patients given services under all payers

Participation in multiple Advanced APMs

Because our 2017 predictive analysis only examines QP status at the APM Entity group level, we did not calculate predictive QP assessments for eligible clinicians in multiple Advanced APM Entities.

Although QP status generally is determined at the APM Entity group level, an exception exists for eligible clinicians participating in multiple Advanced APMs. If 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 for QP status after the final QP snapshot date during the performance year.