



Payment Year 2024 Alternative Payment Model (APM) Incentive Payment Fact Sheet

CMS will begin paying the Qualifying Alternative Payment Model (APM) Participant (QP) Incentive Payment for the CY 2022 performance period of the Quality Payment Program starting in June 2024.

Who Is Eligible to Receive an APM Incentive Payment in 2024?

A clinician may be eligible for an incentive payment in 2024 if, during the 2022 QP Performance Period, if they:

- Were an eligible clinician participating in one or more Advanced APMs; AND
- Met or exceeded **one** of the following Medicare option thresholds¹:
 - Received at least 50% of payments for professional services through an Advanced APM; OR
 - Provided covered professional services through an Advanced APM to at least 35% of patients.

Determining Your 2024 APM Incentive Payment

In accordance with the Medicare Access and CHIP Reauthorization Act of 2015, which established the QPP, for payment years 2019 through 2024, the amount of the APM Incentive Payment is equal to 5% of the estimated aggregate payments for Medicare Part B covered professional services furnished by the QP during the calendar year immediately preceding the payment year (the “base period”).² In determining the estimated aggregate payments, CMS will consider covered professional services

¹ The QP payment amount and patient count thresholds for participation in Advanced APMs will remain frozen at 50% and 35%, respectively, through the CY 2024 performance year/2026 payment year before increasing to 75% and 50%, respectively, in the CY 2025 performance year/2027 payment year.

² For the CY 2019-2022 performance periods, Advanced APM participants who achieved Qualifying APM Participant (QP) status were excluded from MIPS and eligible for a 5% APM Incentive Payment. However, in December 2022, Congress announced it included a value-based care incentive in its year-end spending bill and changed the APM Incentive Payment to 3.5% for the 2023 performance period/2025 payment year. In March 2024, Congress announced another update, and established a 1.88% APM Incentive Payment for QPs for the 2024 performance period/payment year 2026, as well as a 0.75 percent adjustment to the QP conversion factor that will be applied to Medicare payments for covered professional services beginning in 2026.

furnished by the QP across all Taxpayer Identification Number/National Provider Identifier combinations during the base period. For eligible clinicians determined to be QPS in the CY 2024 performance period, and eligible to receive an APM Incentive Payment in 2026, the base period is 2025.

Note that the APM Incentive Payment is based only on Part B covered professional services (services paid under the Medicare physician fee schedule as well as certain payments noted below that are associated with payment under the Advanced APM; not all Part B items and services are considered.

Timeframe of Claims

In calculating the APM Incentive Payment amount, CMS uses claims for covered professional services submitted with dates of service from January 1 through December 31 of the base period and with processing dates of January 1 of the base period through March 1 of the payment year to allow 60 days for claims run out.

For example, to calculate the 2024 APM Incentive Payment, CMS captured claims submitted with dates of service from January 1, 2023, through December 31, 2023, and processing dates of January 1, 2023, through March 1, 2024. We believe that 60 days of claims run-out is sufficient to conduct the APM Incentive Payment calculations in an accurate and timely manner.

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

Many APMs use incentive payments and financial arrangements that differ from usual Medicare physician fee schedule (PFS) payments. The statute required CMS to establish policies for calculating the APM Incentive Payment when payment for covered professional services 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 shared savings payments made to accountable care organizations in all tracks of the Medicare Shared Savings Program to be financial risk payments. We would also consider as examples of 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). 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.

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.

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 PFS. 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 professional covered 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 professional 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) in the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model or Direct Contracting Models. 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 2024 APM Incentive Payment?

A: 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: What happens if I was a QP in performance year 2022 but I did not furnish covered professional services in the base year 2023?

A: Providers who have no services associated with the base year will not receive an APM Incentive Payment.

Q: How do I get help or more information?

For questions related to the 2024 APM Incentive Payment, contact the Quality Payment Program at 1-866-288-8292, available Monday through Friday 8:00 a.m.-8:00 p.m. Eastern Time, or via e-mail at QPP@cms.hhs.gov.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Version History

Date	Change Description
08/21/2024	Updated footnote 1 on page 1.
07/12/2024	Updated years included in the example under “Timeframe of Claims” section on page 2.
06/27/2024	Original version.