NAACOS
National Association of ACOs

The ACO Guide to MACRA

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Table of Contents

Acronyms 2
Executive Summary 3
- Overview of MACRA 3
- MACRA Resources 5
- Benefits to ACOs under MACRA 5

Advanced Alternative Payment Models 7
- Overview 7
- APM Definitions 7
- Advanced APM Criteria 8

2019 Advanced APMs 11
Qualifying APM Participant (QP) Thresholds 11
QP Calculation 12
Partial QPs 13
Advanced APM ECs Who Don't Meet QP the Threshold 13
QP Performance Period and Timing of QP Determination 13
All-Payer Combination Option 14
Advanced APM Payments 18
Advanced APM FAQs 19
- Overview 23

MIPS APM Scoring Standard: ACO Considerations 24
MIPS Eligible Clinicians 24
Providers Excluded from MIPS 25
MIPS Performance Categories 25
Performance Category Evaluations for MIPS APMs 26
- Quality 26
- Clinical Practice Improvement Activities 28
- Promoting Interoperability 29
- Resource Use/Cost 31
- Performance Category Scoring 32

MIPS Payment Adjustments 33
- Exceptional Performance Bonuses 35
- MIPS Payment Adjustments and ACO Benchmarks 36
- Application and Notification of MIPS Payment Adjustment 36

MIPS Performance Feedback Reports 36
MIPS Performance Review, Audits and Public Reporting 36
MIPS FAQs 37

Acronyms

ACI— Advancing Care Information
ACO — Accountable Care Organization
AMI— Acute Myocardial Infarction
APM— Alternative Payment Model
CABG— Coronary Artery Bypass Graft
CAH— Critical Access Hospital
CDS— Clinical Decision Support
CHERT— Certified Electronic Health Record Technology
CMS— Centers for Medicare & Medicaid Services
CPIA— Clinical Practice Improvement Activities
CPC+— Comprehensive Primary Care Plus Model
CPOE— Computerized Physician Order Entry
CPS— Composite Performance Score
CAHPS — Consumer Assessment of Healthcare Providers and Systems
CMMI — Center for Medicare and Medicaid Innovation
DO— Doctor of Osteopathic Medicine
EC— Eligible Clinician
EHR— Electronic Health Record
ESRD — End-Stage Renal Disease
FFS— Fee for Service
FQHC— Federally Qualified Health Center
HCC — Hierarchical Condition Category
LDO— Large Dialysis Organization
MA— Medicare Advantage
MACRA— The Medicare Access and CHIP [Children's Health Insurance Program] Reauthorization Act of 2015
MD— Medical Doctor
Meaningful Use— The Electronic Health Record Incentive Program
MIPS— Merit-Based Incentive Payment System
MLR— Medical Loss Ratio
MMA — Medicare Modernization Act
MSSP— Medicare Shared Savings Program
NPI— National Provider Identifier
PCI— Percutaneous Coronary Intervention
PECOS — Provider Enrollment, Chain, and Ownership System
PFS — Physician Fee Schedule
PQRS— Physician Quality Reporting System
PY— Performance Year
QP— Qualifying Advanced APM Professional
QPP— Quality Payment Program
RHC— Rural Health Clinic
TIN— Tax Identification Number
VM— Value-Based Payment Modifier
WI — Web Interface

Executive Summary

This guide is intended to educate Accountable Care Organizations (ACOs) on the ACO-specific information they need to understand MACRA's 2020 Quality Payment Program (QPP) requirements. We continue to update this resource as more information becomes available from CMS. If you wish to share feedback with us on this resource or pose questions about MACRA implementation, please contact us at advocacy@naacos.com

Background: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law April 16, 2015 and is one of the most significant laws affecting Medicare since the program's inception in 1965. MACRA was a bipartisan effort that repealed the sustainable growth rate formula and set Medicare physician payment on a new course. MACRA is designed to shift Medicare physician payments from a system based on fee for service (FFS) to one based on value and quality, a transition that will take time and will be implemented for years to come. The first MACRA payment update went into effect in July 2015, with a 0.5 percent payment update for Medicare Physician Fee Schedule (PFS) items and services. There are annual 0.5 percent updates each year through 2019, after which point the automatic payment updates will be flat until 2026.

Since MACRA's passage, the Centers for Medicare & Medicaid Services (CMS) has been working to implement the law. In October 2016 CMS released a final rule implementing the key details of MACRA for the performance year (PY) 2017. For more information on QPP policies governing PY 2017 through 2019, please refer to previous annual editions of this guide available on our website. In this guide for PY 2020, NAACOS staff has summarized the main ACO-related provisions applicable to ACOs.

Overview of MACRA

MACRA created two payment paths for Medicare Part B providers: participation in an Advanced Alternative Payment Model (APM) or in the Merit-Based Incentive Payment System (MIPS). Together, these two pathways make up the QPP. Both Advanced APM and MIPS participation rely on a two-year lag between performance/reporting years and payment adjustment years. For example, performance in 2020 corresponds to payment adjustments in 2022. MACRA rewards providers in Advanced APMs, which includes a number of benefits for certain ACOs. While Medicare ACO models are considered APMs, not all are considered Advanced APMs. Eligible clinicians (ECs), who participate in Advanced APMs and meet other requirements, will earn a 5 percent bonus from 2019 through 2024. Further, beginning in 2026, clinicians in Advanced APMs will receive an annual update of 0.75 percent compared to those not in Advanced APMs, who will receive annual updates of 0.25 percent. These payment adjustments are separate from bonuses/penalties from the APM itself, such as shared savings or loss payments for ACOs.

CMS estimates the number of providers qualifying for Advanced APM bonuses will remain steady in the fourth year of the program. The agency estimates that between 210,000 and 270,000 clinicians will earn Advanced APM bonuses. Overall, CMS projects the agency will pay aggregate 2022 Advanced APM bonuses totaling between $535 million and $685 million.

To be considered an Advanced APM, a payment model has to meet certain criteria such as requiring use of Certified Electronic Health Record Technology (CEHRT) and basing payments in part on quality measures comparable to those used in MIPS. Advanced APMs also have to meet certain risk criteria. Organizations, such as ACOs that participate in an Advanced APM, are also required to have a certain proportion of payments made "through" the APM, or they could meet this requirement based on

patient counts through the APM. These thresholds are referred to as the Qualifying APM Participant (QP) thresholds, and only Advanced APM participants who meet the QP threshold will receive the 5 percent bonus and/or higher annual update. Providers in Advanced APMs who meet QP thresholds are exempt from reporting requirements and payment adjustments under MIPS.

CMS's comprehensive list of Advanced APMs is available on this webpage and, among others, includes:

- MSSP Tracks 1+, 2 and 3, Basic Level E and Enhanced Tracks
- Next Generation ACO Model,
- Comprehensive End-Stage Renal Disease (ESRD) Care Model (Large Dialysis Organization (LDO) arrangement and non-LDO two-sided risk arrangement),
- CPC+,
- Oncology Care Model (two-sided risk arrangement),
- Vermont All-Payer ACO Model Initiative
- Bundled Payments for Care Improvement Advanced (BPCI Advanced)

NAACOS has repeatedly advocated that CMS use an inclusive approach when identifying which APMs qualify as "Advanced." We are very pleased that the MSSP Tracks 1+, 2 and 3, the Next Generation ACO and Direct Contracting Models are on the 2020 Advanced APM list, but we are disappointed MSSP Track 1 is not included. We advocate that CMS include all Medicare ACOs as Advanced APMs.

Providers who are not QPs will participate in MIPS, which is the default program for Medicare Part B. MIPS consolidated three legacy Medicare Part B quality reporting programs: the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the eligible professional Medicare EHR Incentive Program (Meaningful Use). MIPS evaluates ECs based on performance categories including quality, cost, use of certified EHR technology (i.e., Promoting Interoperability, formerly Advancing Care Information), and clinical practice improvement activities (CPIA).

To recognize ACOs' commitment to advancing value-based healthcare, Medicare ACOs in MIPS are considered MIPS APMs and are given favorable benefits. This means reporting criteria and performance evaluations for ACOs differ from the general MIPS requirements. NAACOS advocacy has repeatedly called for CMS to reward ACOs under MIPS and to ease and streamline reporting burdens, and we are pleased to see many of the provisions CMS finalized for ACOs in MIPS. The list of MIPS APMs includes those listed as Advanced APMs above as well as other models, shown on this CMS webpage.

MACRA Resources

Resources from CMS

- The final 2020 Medicare Physician Fee Schedule (MPFS)/QPP rule and CMS QPP education page
- CMS QPP resource library
- CMS Final 2020 QPP FAQs

NAACOS Resources

- MACRA webpage includes information and updates as well as resources on MACRA implementation
- Final 2020 MPFS/QPP rule summary
- NAACOS Webinars available on-demand here
    - NAACOS Review of 2020 Final Physician Fee Schedule and QPP Rule

Benefits to ACOs under MACRA

ACOs are recognized as one of Medicare's premier APMs, and as such, providers in ACOs receive many benefits under the QPP as outlined below.

Key Benefits for ACOs in MIPS (Track 1 ACOs, Basic Levels A, B, C and D and Advanced APMs who do not meet QP thresholds)

Please refer to the MIPS section of this guide for more specific details on the following benefits.

- ACOs in MIPS receive advantages by being scored under the MIPS APM Scoring Standard, which gives ACOs favorable treatment for their commitment to value-base care.
- Given ACOs historically high performance, ACOs should easily avoid penalties under MIPS and will be eligible for MIPS bonuses and exceptional performance bonuses.
- ACOs are given full credit for the CPIA performance category based on their ACO participation.
- ACOs do not have additional quality reporting requirements under MIPS since the MSSP quality reporting is used for the MIPS quality performance category.
- CMS will use MSSP Web Interface (WI) quality reporting to set the MIPS benchmarks for group practices and ACOs in MIPS that report quality via the WI. For quality, ACOs will only be compared to those reporting through the WI.
- ACOs are not evaluated on cost. This exception allows ACOs to avoid an evaluation of their resource use that would be different from their MSSP evaluation, using an approach and benchmarks that conflict with the MSSP.
- The significant investments ACOs have made in quality, care coordination, data analytics and health IT will be an advantage for ACOs that are evaluated under MIPS and will favorably position ACOs compared to other providers who have not made these investments.
- CMS evaluates an ACO as one cohesive entity and will apply the same MIPS score to all ECs who are part of the ACO, thus reinforcing the role of the ACO.
- In addition to bonuses under MIPS, ACOs are still eligible for shared savings under the MSSP.

Key Benefits for Advanced APM ACOs

There are a number of benefits for Advanced APM ACOs, which are listed below and further explained in the Advanced APM section of this Guide.

- Advanced APM ACOs that meet the QP thresholds earn a 5 percent bonus annually from 2019 through 2024. This bonus is in addition to shared savings the ACO can earn through MSSP or the Next Generation ACO model.
- Beginning in 2026, clinicians in Advanced APM ACOs that meet QP thresholds will have higher automatic annual payment increases of 0.75 percent, as opposed to the annual increases of 0.25 percent for providers not in Advanced APMs.
- ACOs will know as early as July during the performance year if they meet the QP thresholds.
- Those who fall short of the QP thresholds, known as Partial QPs, have the option of whether to report MIPS and receive any related MIPS payment adjustments.
- Advanced APM bonuses are excluded from expenditure calculations used in the ACO model.
- Advanced APMs are given credit for APM participation with payers other than Medicare beginning with 2019 performance/2021 payment.
- Being a QP in an Advanced APM means the ACO's participants avoid MIPS, thus allowing them to concentrate on the goals of the ACO and to avoid distractions from other CMS requirements.
- Participating in an Advanced APM ACO offers the opportunity for providers to be on the cutting edge of innovation in healthcare delivery.

Advanced Alternative Payment Models

Overview

MACRA is designed to shift Medicare physician payments to be increasingly based on value and rewards providers in Advanced APMs. ECs who participate in Advanced APMs and meet other criteria will earn a 5 percent bonus from 2019 through 2024. Further, beginning in 2026, clinicians in Advanced APMs will receive an annual update of 0.75 percent compared to those not in Advanced APMs, which will receive an annual update of 0.25 percent. These payment adjustments are separate from an ACO's shared savings or losses from the MSSP or Next Generation ACO model. CMS uses a two-year lag between Advanced APM participation and payment adjustment years with 2020 participation corresponding to 2022 payments, 2021 participation corresponding to 2023 payments, and so on.

To be considered an Advanced APM, a payment model has to meet criteria such as requiring use of certified EHR technology, basing payments in part on quality measures comparable to those in MIPS and requiring Advanced APMs to meet certain financial and nominal risk criteria. Organizations such as ACOs that participate in an Advanced APM must have a certain proportion of payments made "through" the APM or they can achieve this based on patient counts through the APM. Meeting these QP thresholds is necessary to earn the 5 percent bonus or higher annual update.

For 2019, the list of Advanced APMs includes:

- MSSP Tracks 1+, 2 and 3, Basic Level E and Enhanced Track,
- Next Generation ACO model,
- Comprehensive ESRD Care Model (LDO arrangement and non-LDO two-sided risk arrangement),
- CPC +, and
- Oncology Care Model (two-sided risk arrangement).

The complete list of Advanced APMs is available on this CMS webpage.

Providers in Advanced APMs that meet QP thresholds are exempt from reporting requirements and payment adjustments under MIPS. Advanced APM ACOs which don't meet QP thresholds but do meet a lower bar (i.e., the Partial QP threshold), have the option of participating in MIPS. Advanced APM determinations are made each year independent of past year's performance. NAACOS has repeatedly advocated for CMS to use an inclusive approach when identifying which APMs qualify as "advanced." We are very pleased that the MSSP Tracks 1+, 2 and 3 and the Next Generation ACO model are on the Advanced APM list, but we are disappointed all ACO models are not included. We advocate that CMS include all Medicare ACOs models as Advanced APMs.

APM Definitions

MACRA introduces a number of new terms that are important to understand as they refer to different requirements for APMs and Advanced APMs.

- **APM (e.g. Track 1 ACO)**
    - A Medicare payment/delivery model which is designed to improve care delivery and meets several criteria. An APM could be any of the following:
        (1) A model under the CMS Innovation Center (other than a health care innovation award)
        (2) MSSP

(3) A demonstration under section 1866C of the Social Security Act
(4) A demonstration required by Federal law

- **APM Entity (e.g. a specific MSSP ACO)**
  - An entity that participates in an APM through an agreement with CMS or an Other Payer
- **Advanced APM (e.g. MSSP Track 3)**
  - An APM that meets specific requirements to qualify as Advanced
- **APM Entity Group (collective group of ECs across an ACO)**
  - The group of ECs participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, Taxpayer Identification Number (TIN), and National Provider Identifier (NPI) for participating ECs.

Advanced APM Criteria

MACRA includes requirements for an APM to be considered "advanced," and these criteria must be met in the design of the APM. Therefore, the criteria must be for a specific ACO model or ACO track, such as the Next Generation model and each track within the MSSP.

Specifically, to be an Advanced APM, an APM must meet the following three criteria:

1. Require participants to use certified EHR technology;
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the MIPS; and
3. Either: (1) require APM Entities to bear more than a nominal amount of financial risk for monetary losses or (2) be a Medical Home Model expanded under Innovation Center authority.

All MSSP tracks and the Next Generation ACO Model meet the first two criteria, but the financial risk requirement is the key component of CMS's determination for which ACO tracks/models qualify as Advanced APMs. NAACOS has repeatedly urged CMS to set the required risk at a reasonable level and to account for the significant investments ACOs make to participate in the program. There are separate standards for APMs evaluated under the Medical Home Model standard, which includes APMs that have been expanded using the authority under section 1115A(c) of the Social Security Act and meet the criteria detailed below. ACOs are evaluated under the "Generally Applicable" standards.

Use of Certified EHR Technology

CMS policy is that, beginning with PY 2019, an Advanced APM must require at least 75 percent of ECs in an APM Entity, or for APMs in which hospitals are the APM Entities then each hospital would be required, to use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care to their patients or other health care providers. Specifically, for the MSSP, CMS must apply a penalty or reward to an APM Entity based on the degree of the use of CEHRT of the ECs in the APM Entity. NAACOS expects CMS to provide more information to ACOs in the future regarding how this will apply to ACO contracts specifically. The CEHRT threshold increased from 50 percent to 75 percent beginning with PY 2019, despite NAACOS objections to this increase. A penalty or reward must be applied to an APM Entity based on the degree of the use of CEHRT of the ACO's ECs. In 2019, CMS requires MSSP ACOs to provide an annual attestation that 75 percent (for Advanced APM models) of eligible clinicians are utilizing CEHRT. Based on this attestation requirement, Track 2, 3 and MSSP ACOs in Basic Level E or Enhanced Track meet the Advanced APM CEHRT requirement as well as the Next Generation model.

The definition of CEHRT is the same across MIPS and APMs and can be met by using an EHR certified by the Office of the National Coordinator for Health Information Technology Certification Program. Specifically, for 2019 performance the CEHRT must be certified to 2015 Edition certification criteria.

In order for Next Generation ACOs to demonstrate their required use of CEHRT to meet Advanced APM requirements, the Center for Medicare and Medicare Innovation (Innovation Center) amended the Next Generation ACO Model Participation Agreement. The agreement states, "Beginning in 2017, the ACO and its Next Generation Participants shall use certified (electronic health record) technology (as defined in section 1848(o)(4) of the Act) in a manner sufficient to meet the requirements for an 'eligible alternative payment entity' under section 1833(z)(3)(D)(i)(I) of the Act (added by section 101(e)(2) of the Medicare Access and CHIP Reauthorization Act of 2015) as prescribed through future regulation."

Beginning in September 2017, CMS performed CEHRT Compliance Reviews to confirm Next Generation ACO compliance with MACRA and the updated Participation Agreement. The CEHRT Compliance Review is conducted at the entity (Next Generation ACO) level. ACOs must attest to whether their ACO is in compliance with Participation Agreement and CEHRT requirements with a "Next Generation ACO CEHRT Compliance Attestation Form." Instructions on completing the attestation form are provided to ACOs during the CEHRT Compliance Review period. Next Generation ACOs have approximately three weeks to complete and return the form.

Quality Measures Comparable to MIPS

CMS requires that Advanced APM payments for covered services must be based on quality measures comparable to MIPS and must include at least one of five types of measures: (1) any quality measures included on the annual list of MIPS measures (must include at least one outcome measure); (2) quality measures endorsed by a consensus-based entity; (3) quality measures developed under section 1848(s) of the Social Security Act; (4) quality measures submitted in response to the MIPS Call for Quality Measures; and (5) quality measures that CMS determines to have an evidence-based focus, be reliable, and be valid. Medicare ACOs meet the Advanced APM quality requirements through the MSSP or Next Generation ACO Model, which both require quality reporting via the Web Interface.

Financial Risk Standard

Generally Applicable Risk Standard

Under the generally applicable risk standard, which applies to ACOs, an Advanced APM must require that if actual expenditures for which an APM Entity is responsible exceed expected expenditures during a specified performance period, CMS will:

- Withhold payment for services to the APM Entity or the APM Entity's ECs;
- Reduce payment rates to the APM Entity or the APM Entity's ECs; or
- Require the APM Entity to owe payment(s) to CMS.

Medical Home Model Risk Standard

The Medical Home Model risk standard includes more flexibility for what is required to meet financial risk standards. Specifically, this risk standard includes the three criteria for the generally applicable risk standard listed above plus an additional standard which causes the APM entity to lose the right to all or part of an otherwise guaranteed payment(s). This would apply for a performance period if either:

- Actual expenditures for which the APM Entity is responsible exceed expected expenditures; or
- APM Entity performance on specified measures does not meet or exceed expected performance.

Nominal Risk Standard

In addition to meeting the financial risk standard, MACRA requires APMs to meet a nominal risk standard. Under CMS policy, full capitation arrangements automatically meet this Advanced APM criteria and all other payment arrangements are assessed against the applicable nominal amount standards. Similar to the financial risk standard, there is one set of nominal risk criteria that is generally applicable to APMs (including ACOs) and another set of criteria for Medical Home Models, which establishes a lower bar for those in the latter category.

Generally Applicable Nominal Risk Standard (Applicable to ACOs)

To meet this criterion the total amount an APM Entity potentially owes CMS or foregoes under an APM must be at least equal to either:

- 8 percent of the average estimated total Medicare Parts A and B revenues of a participating APM Entity (the revenue-based standard); or
- 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the benchmark-based standard).

NAACOS has repeatedly advocated for CMS to simplify risk requirements and minimize the level of risk for Advanced APMs. We are pleased that in the 2019 QPP rule CMS finalized a policy to maintain the revenue-based standard at 8 percent through PY 2024. CMS does not include a mechanism through which the agency accounts for an APM Entity's investments or costs in order to count those towards an APM Entity meeting the nominal risk criterion, though this is something for which NAACOS continues to strongly advocate. It's important to note that the nominal risk standards set minimum thresholds and the actual risk an APM Entity bears is defined through the APM itself according to the specific APM's terms. Therefore, these standards do not change any existing ACO risk criteria, and MSSP Tracks 1+, 2 and 3 and Basic Level E and Enhanced Tracks, as well as the Next Generation ACO Model all meet or exceed the risk criteria.

Medical Home Model Nominal Risk Standard (not applicable to ACOs)

The nominal risk standard for APMs evaluated as Medical Home Models is different than that used to for other APMs. Under the Medical Home Model standard, an APM meets the nominal risk requirement if the total annual amount that an Advanced APM Entity potentially owes CMS or foregoes is at least:

- In 2017, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue,
- In 2018, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue,
- In 2019, 3 percent of the APM Entity's total Medicare Parts A and B revenue,
- In 2020, 4 percent of the APM Entity's total Medicare Parts A and B revenue, or
- In 2021 and beyond, 5 percent of the APM Entity's total Medicare Parts A and B revenue.

Medical Home Model Size Restrictions

Beginning in 2018 Medical Home Model APM Entities must also meet size restrictions. Specifically, the APM Entity must be owned and operated by an organization with fewer than 50 ECs whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities. Starting in 2018, the Medical Home Model Advanced APM financial risk standard would not apply for APM Entities that do not meet this criterion. While this policy is in effect generally, CMS allows an exception for entities participating in the CPC+ Model as of January 1, 2017. Therefore, organizations in CPC+ Round 1 remain eligible for the Advanced APM bonus regardless of their practice size or relationship to a parent organization. Unfortunately, and despite repeated requests from

NAACOS to do so, CMS has not modified its policy that MSSP Track 1 ACO primary care practices are not eligible for Advanced APM bonuses based on their Track 1 or CPC+ participation. More information on the overlap of ACO and CPC+ programs is available in this NAACOS resource.

2019 Advanced APMs

Based on APM evaluations explained in the preceding sections, CMS's Advanced APM list includes:

- MSSP Tracks 1+, 2 and 3,
- MSSP Basic Track Level E and Enhanced Track,
- Next Generation ACO Model,
- Comprehensive ESRD Care Model (LDO arrangement and non-LDO two-sided risk arrangement),
- CPC+, and
- Oncology Care Model (two-sided risk arrangement).

The complete list of Advanced APMs is available on this CMS webpage.

Qualifying APM Participant (QP) Thresholds

APM Entities (e.g., a Next Generation ACO) that participate in an Advanced APM are also required to have a certain proportion of payments or patients "through" the APM. Only ACOs that meet these QP thresholds will receive the 5 percent bonus or higher annual update in 2026 and beyond. The QP determination is made separately for each performance year, and the thresholds gradually increase over time. In the first two years, CMS only evaluated traditional Medicare payment/patients in making the QP determination. Starting with PY 2019 (2021 payment year) CMS will also factor in an Advanced APM Entity's participation with payers outside of traditional Medicare. It's important to note that Medicare Advantage is not included in the evaluation for traditional Medicare but will be included in the evaluations of payers outside of traditional Medicare. CMS will make QP determinations collectively using the group of ECs in an Advanced APM Entity. Therefore, an ACO as a whole will be evaluated in the QP determination using the collective group of ECs associated with the ACO's participant list. Affiliated practitioners, such as Next Generation ACO preferred providers, or providers with a contractual relationship with the ACO will not be included in the ACO's QP determination but could meet the QP thresholds as individuals. The QP payment thresholds were established in MACRA and CMS defines the patient count thresholds. CMS calculates both the payment and patient count thresholds and uses the more advantageous QP result.

Payment and Patient Count Threshold for Meeting QP Determination

Payment Year	2019	2020	2021	2022	2023	2024+
QP Payment Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Threshold	20%	20%	40%	40%	50%	50%
QP Patient Count Threshold	20%	20%	35%	35%	50%	50%
Partial QP Patient Count Threshold	10%	10%	25%	25%	35%	35%

QP Calculation

Payment Approach

CMS generally interprets payments "through" an Advanced APM Entity to mean payments made by CMS for services furnished to attributed beneficiaries, who are the beneficiaries for whose costs and quality of care an Advanced APM Entity is responsible. To calculate the QP payment threshold, CMS specifically focuses on payments for Medicare Part B covered professional services, which include services for which payment is made under, or based on, the Medicare Physician Fee Schedule. The numerator of the QP calculation includes the aggregate of payments for Medicare Part B covered professional services furnished by ECs in the Advanced APM Entity to attributed beneficiaries during the timeframe used for the QP determination. To identify attributed beneficiaries, CMS uses the attribution methodology of the specific APM. For ACOs the agency uses either the MSSP or Next Generation ACO attribution rules, as appropriate, and relies on the latest available attribution list at the time of a QP determination. Specifically, the QP evaluations will rely on an ACO's preliminary prospective assignment list or prospective assignment list. Therefore, there may be discrepancies between beneficiaries who are ultimately attributed to an ACO and those used to make the QP determination. The denominator includes the aggregate of payments for Medicare Part B covered professional services furnished by the ECs in the Advanced APM Entity to attribution-eligible beneficiaries during the timeframe used for QP determination. The definition of attribution-eligible is a beneficiary who:

- Is not enrolled in Medicare Advantage or a Medicare cost plan,
- Does not have Medicare as a secondary payer,
- Is enrolled in both Medicare Parts A and B,
- Is at least 18 years of age,
- Is a United States resident, and
- Has a minimum of one claim for evaluation and management services by an EC or group of ECs within an APM Entity for any period during the QP Performance Period.

Patient Count Approach

The patient count method is similar to the payment amount approach. The numerator is the number of unique attributed beneficiaries to whom ECs in the Advanced APM Entity furnish Medicare Part B covered professional services or professional services by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) as described below, during the QP performance period. The denominator is the number of attribution-eligible beneficiaries to whom ECs in the Advanced APM Entity furnish Medicare Part B covered professional services or (as detailed below) services by a RHC or FQHC during the QP performance period. A specific beneficiary may be counted in the numerator and denominator for multiple Advanced APM Entities or ECs, but an individual beneficiary is not counted more than once in the numerator and once in the denominator per ACO or APM Entity.

CMS counts a beneficiary in the numerator of the Threshold Score for the patient count method if the beneficiary receives Method II Critical Access Hospital (CAH) professional services furnished by ECs in an Advanced APM Entity. The agency also counts professional services furnished by ECs in an Advanced APM Entity at RHCs and FQHCs. Specifically, professional services furnished at RHCs and FQHCs that participate in an ACO and are reimbursed under the RHC All-Inclusive Rate System or FQHC Prospective Payment System (respectively) are counted towards the QP determination calculations under the patient count method but not under the payment amount method. This only applies to ACOs that allow RHC and FQHC services to be counted for purposes of attributing beneficiaries to an ACO. Therefore, in these instances CMS includes beneficiaries attributed to an ACO in full or in part because of services

furnished by RHCs or FQHCs in the patient counts used for QP calculations. This is only for clinicians in RHCs or FQHCs who meet the MACRA definition of "eligible clinician" and are included as ACO participants. In this case, these ECs are considered for an ACO's QP determination along with all the other ECs in the ACO.

Partial QPs

Advanced APM Entities that fall short of the QP threshold but meet the Partial QP threshold are not eligible for the Advanced APM bonuses or the higher annual updates starting in 2026. Partial QPs have the option of whether to participate in MIPS. If they elect to do so, they are evaluated under the MIPS APM standard and receive payment adjustments based on their participation. An Advanced APM Entity will know if it is a Partial QP by the beginning of the MIPS submission period and does not need to make MIPS decisions as Partial QPs prior to that time. If the Advanced APM Entity elects not to report under MIPS, all ECs/TINs in the APM Entity group will be excluded from MIPS reporting and payment adjustments.

Advanced APM ECs Who Don't Meet QP the Threshold

If an EC participates in multiple Advanced APM Entities during a QP performance period and is not determined to be a QP based on participation in any of those Advanced APM Entities, then CMS will assess the EC individually using combined information for services associated with that individual's NPI and furnished through all the EC's Advanced APM Entities during the QP performance period. This is designed to help those participating in multiple Advanced APM Entities that do not meet QP thresholds through their APM Entity's QP evaluation. If determined to be a Partial QP, the EC will elect whether to report under MIPS and subsequently be subject to MIPS payment adjustments.

QP Performance Period and Timing of QP Determination

The QP performance period runs from January 1 through August 31 of the calendar year two years prior to the payment year. During that QP Performance Period, CMS will make QP determinations at three separate times based on the ECs billing Medicare through MSSP ACO Participant TINs. Should an ACO meet the QP threshold the first time, those ECs are considered QPs for the year. CMS also makes the QP determination two additional times, each time based on the ECs who are part of the MSSP ACO Participant TINs (i.e., those who reassign their Medicare billing rights to an ACO Participant TIN). New clinicians added after the first calculation thus have an opportunity to become QPs based on the second or third QP determination. This is an additive process, so if an ACO achieves QP status based on the first determination, those clinicians retain their QP status even if the ACO doesn't meet the QP status in subsequent determinations. The QP determination is made three times: January through March, January through June, and January through August.

The process of identifying specific ECs in a Next Generation ACO is different because ACOs in that model are not required to have full TIN participation as is required under MSSP. Under the Next Generation ACO model, not all providers within a TIN must participate in the ACO so CMS will identify ECs in Next Generation ACOs based on the TIN/NPI combinations from the Participant List finalized prior to the performance year. Below is a visual example of the timing of the QP determinations, and as of PY 2019 each evaluation includes a four-month claims run out.

The QP policy provides certainty of an ACO's QP status during the performance year and allows flexibility for new clinicians who join an MSSP ACO during the performance period to become a QP for that year. CMS periodically updates its QPP look up tool to reflect results from recent QP determinations. While QP determinations made during the QP Performance Period are considered final, they may be rescinded in the event that an Advanced APM Entity is terminated from an Advanced APM, voluntarily or involuntarily, prior to August 31, or in the event of EC or Advanced APM Entity program integrity violations.

All-Payer Combination Option

Overview

While QP determinations are only based on traditional Medicare Advanced APM participation in the early years of the QPP, beginning with PY 2019 CMS will give credit for qualifying APM participation with payers outside of Medicare, including Medicare Advantage (MA), Medicaid and eventually other commercial plans. Please note that under this All-Payer Option CMS still requires Medicare Advanced APM participation, and this option is for those that do not meet QP thresholds based on their Medicare Advanced APM participation alone. CMS has a separate process for evaluating and approving "Other Payer" Advanced APMs. Developing a robust All-Payer Option will be especially important as the QP thresholds become increasingly challenging in future years.

Criteria for Other Payer Advanced APMs

In order for CMS to evaluate and subsequently give credit for participation with Other Payer Advanced APMs, the agency must first determine whether a specific Other Payer APM meets the required criteria. Other Payer APMs have to meet similar criteria as a Medicare Advanced APM, and the specific requirements are that an Other Payer APM must:

- Provide for payment for services based on quality measures comparable to those under MIPS.
- Require at least 50 percent of ECs in an APM Entity, or each hospital if hospitals are the APM Entities, to use CEHRT to document and communicate clinical care in PY 2019 and 75 percent beginning in PY 2020
- Include financial risk such that the APM arrangement uses full capitation or:
    - If APM Entity's actual expenditures for which it is responsible under the APM exceed expected expenditures, the Other Payer must modify payment to the APM Entity or its clinicians by: withholding payment for services, reducing payment rates, or requiring direct payment by the APM Entity to the payer.
    - Be a Medicaid Medical Home Model, which meets the financial risk criteria through the options in the bullet above or by requiring the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments.
- Bear more than nominal risk or be a Medicaid Medical Home Model:
    - An Other Payer APM Entity must potentially owe or forego at least: 3 percent of the expected expenditures for which the APM Entity is responsible under the payment arrangement (benchmark-based standard) OR 8 percent of the total combined revenues from the payer to the providers/entities under the payment arrangement (revenue-based standard). The risk arrangements must also have a marginal risk rate of at least 30 percent and a minimum loss rate (MLR) at or below 4 percent.
    - For Medicaid Medical Home Models, the nominal risk standard requires that the minimum total annual amount that an Advanced APM Entity must potentially owe or

forego is at least 3 percent of the APM Entity's total revenue under the payer in 2019, 4 percent in 2020 and 5 percent in 2021 and beyond.

As a reminder, the MLR is the threshold beyond which point the ACO must repay losses and is based on a percent by which an ACO's actual expenditures differ from the benchmark. Therefore, the lower the MLR the more likely an ACO would be to have to repay losses and the higher the MLR, the less likely the ACO would be to have to repay losses. Once it is determined that an ACO met or exceeded the MLR and has to repay losses, the marginal loss rate determines what portion of the losses the ACO has to pay back. The higher the marginal risk rate, the larger the share of losses that the ACO must repay.

CMS Review of Other Payer APMs

CMS will approve Other Payer APMs based on those submitted for review by the agency. Requests are voluntary and can be submitted by payers or providers. Under the Payer Initiated Process, payers, including Medicaid, MA and those involved in CMS Multi-Payer Models can request review of their payment arrangements. Through the Eligible Clinician Initiated Process, ECs or APM Entities such as ACOs can request a review of their payment arrangements. CMS begins to review requests submitted by payers as early as the year prior to the performance year and plans to make determinations under the Payer Initiated Process before the QP Performance Period. CMS will post approved Other Payer Advanced APMs on a public website. Submission for the EC Initiated Process will take place from August 1 to December 1 the year before the QP Performance Period, though information would be submitted earlier for Medicaid APMs. This sequential approach of the Payer Initiated Process followed by the EC Initiated Process aims to alleviate burdens on providers who would not need to submit information for payment arrangements approved through the Payer Initiated Process. CMS will update the website to include additional payment arrangements approved through the EC Initiated Process. Please refer to *Table 42: Timeline for Other Payer Advanced APM Determination Process for the 2019 QP Performance Period by Payer Type* on page 53868 of the final 2018 QPP rule for PY 2019 submission timeframes and for PY 2020 submission timelines please refer to *Table 59: Finalized Other Payer Advanced APM Determination Process for Medicaid, Medicare Health Plans, and Remaining Other Payers for QP Performance Period 202*0 on page 1148 in the final 2019 Medicare Physician Fee Schedule rule.

CMS will share determinations about Other Payer arrangements "as soon as practicable." For each process, CMS will use forms detailing what information and supporting documentation is required. Under the EC Initiated Process, CMS will presume an Other Payer APM meets the CEHRT use requirement if the agency receives documentation showing the APM requires the ECs to use CEHRT.

In response to NAACOS advocacy, CMS finalized a more flexible policy related to the previous requirement for annual submission and determination of whether an Other Payer APM qualifies as Advanced. Specifically, CMS will no longer require annual submission of all the information related to making this determination and will instead permit a requestor (i.e., payer, APM Entity or EC) to submit information about a multi-year payment arrangement that is determined to qualify as an Other Payer Advanced APM. Following the initial submission and approval, in subsequent years the requestor would only need to submit information on any relevant changes to the payment arrangement. For multi-year payment arrangements submissions, CMS will require that the requestor's certifying official agree to review the submission at least annually to assess whether there have been any changes and to submit updated information notifying CMS of any changes relevant to the Other Payer Advanced APM criteria for each successive year of the arrangement. Absent a submission of updated information, CMS will continue to apply the original Other Payer Advanced APM determination until the arrangement ends or

expires or it has been five years since the determination was made. NAACOS is pleased with this increased flexibility which minimizes burdens on providers and ACOs.

All-Payer QP Performance Period and QP Calculation

The QP performance period for the All-Payer Option will match that for the Medicare, beginning January 1 and ending August 31 of the calendar year two years prior to the payment year. As with the Medicare Option, CMS will make QP determinations based on three snapshot dates: March 31, June 30 and August 31, and an EC or APM Entity will need to meet the relevant QP threshold under the All-Payer Option for at least one of these. Data for QP determinations does not need to be submitted for all three time periods. If information for only the first two periods is provided, CMS will make the QP determination without any disadvantage for not submitting data for the final period.

In response to NAACOS advocacy, CMS did not finalize its proposal to only make All-Payer QP determinations at the individual clinician level. This reversal lessens administrative burdens and reinforces the role of the ACO in the All-Payer Option. CMS will still allow ECs to request a QP determination at the EC level, but the agency will also allow a TIN, ACO or APM Entity to request a QP determination at the TIN or APM Entity level. CMS notes that in cases where QP determinations are requested at the APM Entity level, the agency expects that the composition of the APM Entity will be "generally consistent" across the Medicare Advanced APM and Other Payer Advanced APM. Should that not be the case, CMS expects the QP determination request to be at the EC or TIN level. In the event that CMS receives a request for QP determination from an individual EC and also separately receives a QP determination request from that EC's TIN or APM Entity, CMS will make a determination at multiple levels, and the EC could become a QP on the basis of any of the determinations. CMS states that QP status notifications under the All-Payer Option would be provided "as soon as practicable" after the submission deadline.

All-Payer QP Calculations

QP determinations are based on the more favorable calculation when evaluating payment amounts and patient counts. In order for CMS to make QP determinations based on payers other than Medicare, detailed information must be provided to the agency about payments and patients for Other Payer APM arrangements. Payment and patient information can be submitted at the individual EC, TIN or APM Entity level, and this information is to be submitted using a CMS form by December 1 of the performance year.

CMS will calculate the payment amount approach by dividing the numerator (defined as the aggregate amount of all payments from all payers, except those excluded, attributable to the EC or to the APM Entity under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period) by the denominator (defined as the aggregate amount of all payments from all payers, except those excluded, made to the EC or to the APM Entity's providers during the QP Performance Period). CMS will use a similar method with the patient count approach. Specifically, the agency would divide the numerator (defined as the number of unique patients to whom an APM Entity's providers or an EC furnishes services that are included in the measures of aggregate expenditures used under the terms of all Advanced APMs and Other Payer Advanced APMs during the QP Performance Period) by the denominator (defined as the number of unique patients to whom the APM Entity or EC furnishes services under all non-excluded payers during the QP Performance Period). The only payment arrangements excluded from the QP calculation are: Department of Defense health care programs, Department of Veterans Affairs health care programs and Medicaid programs where there is no APM/Medicaid Medical Home Model available in the ACO's area.

Those who do not meet the QP thresholds under the Medicare or the All-Payer Option but who do meet the lower Partial QP thresholds, can elect whether they want to report on MIPS and receive any resulting payment adjustments under that program. As a reminder, Partial QPs are not eligible for the Advanced APM bonuses. For ECs or APM Entities, CMS requires that documentation pertaining to Other Payer determinations must be retained for a period of six years from the end of the QP performance period or the date of completion of evaluation, inspection or audit (whichever is latest). Also, when an APM Entity submits information to request an Other Payer Advanced APM determination, the certification must be made by an individual with the authority to bind the payer or APM Entity.

QP Payment Amount Thresholds – All-Payer Combination Option

All-Payer Combination Option – Payment Amount Method										
Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024+**	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
Partial QP Payment Amount Threshold	N/A	N/A	40%	20%	40%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

QP Patient Count Thresholds – All-Payer Combination Option

All-Payer Combination Option – Patient Count Method										
Payment Year	**2019**	**2020**	**2021**		**2022**		**2023**		**2024+**	
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
Partial QP Patient Count Threshold	N/A	N/A	25%	10%	25%	10%	35%	10%	35%	10%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

Under the All-Payer Option, provided the Advanced APM Entity meets the required Medicare thresholds, CMS will combine the calculation across payers to determine if the QP threshold is met. Table 39 from the final 2017 QPP rule includes an example of an APM Entity evaluated under the All-Payer Option, showing how this APM Entity would attain QP status and earn the bonus.

All-Payer Combination Option Example 2

Payer	Payments through ACO	Total Payments Applicable	Threshold Score
Medicare*	200,000	500,000	40%
Commercial	400,000	500,000	80%
Medicaid	100,000	150,000	67%
Total	700,000	1,150,000	61%

*For Medicare Part B payments, the amount used for the All-Payer Option will be the same as that used in the denominator of the calculation under the Medicare Option.

Advanced APM Payments

For payment years 2019 through 2024, eligible clinicians in Advanced APM Entities that meet QP thresholds will receive a lump sum payment equal to 5 percent of the estimated aggregate payment amounts for Medicare Part B covered professional services for the prior year (base year). As an example, CMS will evaluate QP status based on 2019, will base the 5 percent bonus on paid 2020 Medicare Part B covered professional services, and will make the 5 percent bonus payment in 2021. CMS expects to issue Advanced APM bonuses midway through the payment year. In calculating the estimated aggregate payment amount for a QP, CMS uses claims submitted with dates of service from January 1 through December 31 of the incentive payment base period and includes a three-month claims runout. ACO shared savings payments or net reconciliation payments are excluded from the amount of covered professional services in calculating the APM Incentive Payment amount.

CMS pays the bonus to the TIN associated with the QP's participation in the Advanced APM entity. NAACOS has repeatedly urged CMS to make this payment to the APM Entity (i.e., the ACO) and is disappointed in the policy to make the payment at the TIN level. We will continue to advocate that CMS change this policy. If at the time of the APM Incentive Payment distribution, an EC is no longer affiliated with the TIN associated with the Advanced APM QP participation, CMS will make the APM Incentive Payment to the new TIN listed on the EC's CMS-855R (Reassignment of Medicare Benefits form) on the date that the APM Incentive Payment is distributed. Should an EC become a QP through participation in multiple Advanced APMs, CMS will divide the APM Incentive Payment amount between the TINs associated with the QP's participation in each Advanced APM during the QP Performance Period. Such payments will be divided in proportion to the amount of payments associated with each TIN that the EC received for covered professional services during the QP Performance Period.

It's important to note that the 5 percent Advanced APM Incentive Payments are not included in calculations for the purposes of rebasing ACO benchmarks nor are they counted as expenditures for the ACO. For payment years 2026 and later, payment rates under the Medicare PFS for services furnished by the EC will be updated by the 0.75 percent qualifying APM conversion factor.

Advanced APM FAQs

Do you have a question that is not addressed in this Guide? If so, please submit it to us at advocacy@naacos.com. We will do our best to find an answer and may include the FAQ (without any submitter information) in a future iteration of this Guide.

How will my ACO know if we meet the QP threshold?
Following the claims run out after the snapshot date, CMS will conduct the QP calculations and ACOs can check the status for their QPs for that particular timeframe by going to the CMS QP Lookup Tool.

If my ACO is a Partial QP, how do we alert CMS that we do not want to participate in MIPS?
An ACO that is a Partial QP has to elect to participate in MIPS and CMS has a process for this election. Partials QPs will not participate in MIPS unless the APM Entity opts into MIPS, so no action is necessary. The election is made at the APM Entity (i.e., ACO) level.

What CEHRT does an Advanced APM have to use?
CMS maintains the same definition of CEHRT for Advanced APMs as it does for the MIPS PI performance category. Specifically, for 2017 and 2018 performance, the CEHRT must be certified to either the 2014 or 2015 Edition certification criteria to submit Quality measures, PI, and Improvement Activities data for MIPS. Providers in MIPS who voluntarily use 2015 Edition CEHRT in 2018 receive a 10 percent PI bonus for doing so to incentivize the movement to 2015 CEHRT. 2015 CEHRT is required beginning with PY 2019.

Do Next Generation ACOs have to report any PI measures?
No. In order for Next Generation ACOs to demonstrate they meet the Advanced APM CEHRT use requirements, the Innovation Center amended the Next Generation ACO Model Participation Agreement and requires the ACO attest that at least 75 percent of ECs in PY 2019 use CEHRT to document and communicate clinical care to their patients or other health care providers.

What is the basis of the 5 percent Advanced APM bonus – are things like Part B drugs and MIPS adjustments included?
The APM Incentive Payment is equal to 5 percent of the estimated aggregate payments for PFS covered professional services only, furnished during the calendar year immediately preceding the payment year. The estimated aggregate payment amount for covered professional services includes all such payments to all of the TIN/NPI combinations associated with the NPI of the QP. In calculating the estimated aggregate payment amount for a QP, CMS uses claims submitted with dates of service from January 1 through December 31 of the incentive payment base period, and processing dates of January 1 of the base period through March 31 of the subsequent payment year. MIPS payment adjustment, previous incentive payments, and financial risk payments such as shared savings payments or net reconciliation payments are excluded from the amount of covered professional services in calculating the APM Incentive Payment amount. Supplemental service payments are included in the amount of covered professional services when they meet specific criteria. Part B drugs are not included in the APM incentive payment calculations. The technical components of imaging and other diagnostic services is only included if they are paid for under the physician fee schedule and furnished by an eligible clinician.

For the QP calculation, does CMS factor in patients seen by an ACO physician at locations that are not part of the ACO?
The purpose of the attribution-eligible denominator is to ensure that the denominator of QP determination calculations only includes payments for services furnished to patients who could potentially be attributed to an APM Entity, and thus could also appear in the numerator of the QP determination calculations. Assume that a physician practices at two different locations, only one of which is part of an Advanced APM ACO (ex. TIN A is a participant in a Track 3 ACO and TIN B that is not part of an ACO). When making the QP calculation, CMS will only use the TIN/NPI combination associated with the ACO when determining which beneficiaries are attribution eligible. So, in this example, only patients seen by the physician in TIN A would be included in the denominator and patient's seen by the physician in TIN B would not be factored into the denominator.

Under the All-Payer Option, is data included in the denominator for commercial payers that do not offer APMs?
Data from all payers, except those that are specifically excluded, is included in the denominator of the All-Payer Option. Excluded payment arrangements are those related to Department of Defense health care programs, Department of Veterans Affairs health care programs and Medicaid programs where there is no APM/Medicaid Medical Home Model available in the ACO's area. NAACOS advocates for CMS to only include payers with whom the APM Entity contracts with for an APM in the denominator.

Is the 5 percent Advanced APM bonus based on the Medicare paid amount or allowed amount?
When calculating the 5 percent Advanced APM bonus, and determining the payment approach to the QP determination, CMS uses the Medicare allowed amount rather than the Medicare paid amount, which reflects any reductions from the Medicare physician fee schedule amount for beneficiary cost sharing.

Under the All-Payer Option, can we submit QP information at the APM Entity level if the providers who make up our Medicare ACO are not exactly the same group involved in the Other Payer APM?
In cases where QP determinations are requested at the APM Entity level, CMS expects that the composition of the APM Entity will be "generally consistent" across the Medicare Advanced APM and Other Payer Advanced APM. CMS does not define "generally consistent." Should that not be the case, CMS expects the QP determination request to be at the EC or TIN level.

Does CMS consider an ACO's participation in multiple Advanced APMs when calculating whether the ACO meets the QP threshold in order to qualify for the Advanced APM bonus?
No. CMS originally considered combining the numerators of Advanced APM Entities that participate in multiple Advanced APMs with substantially similar Participation Lists, but the agency did not finalize this policy based on operational complexity. Therefore, CMS only evaluates an ACO based on participation in one specific Advanced APM. However, CMS will assess individual ECs who are in multiple Advanced APMs at the individual level if they do not meet the QP threshold as part of the Advanced APM Entity.

How is the 5 percent bonus calculated for an individual provider who practices at an ACO and at another organization that is not part of an Advanced APM Entity?
The 5 percent bonus looks at each QP's NPI individually and aggregates all the NPI's billing across TINs. Therefore, if a physician bills through four different TINs, CMS will capture Medicare billings from all of the clinician's practices and use that total amount as the basis of the bonus.

Is the Advanced APM bonus for participating in the All-Payer Option the same as or in addition to participating in Medicare Advanced APMs?
The 5 percent bonus for achieving QP status is one bonus, which can be earned via participation in Medicare Advanced APMs or in Other Payer APMs through the All-Payer Combination Option (which still retains a requirement for Medicare APM participation, though is lower than what is required under the Medicare option). There is no additional bonus for achieving QP status through the All-Payer Option.

What specific clinician types are used in the QP calculations?
In order to define the collective group of ECs for QP determinations, CMS pulls all Medicare-enrolled ECs of the types listed below who have reassigned their billing to an ACO TIN as of the applicable QP snapshot date (March 31, June 30, or August 31).

Provider types referenced in the definition of Eligible Clinician: Physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, physical or occupational therapist, qualified speech-language pathologist or qualified audiologist.

Initially, CMS provided QP status information at the clinician level but not at the ACO level – will they provide the QP threshold details to ACOs at the ACO level?
CMS initially provided QP status information at the individual clinician level. However, NAACOS requested that the agency provide the QP determination, including the ACO's specific QP threshold score, at the ACO level. CMS responded by saying they plan to provide the QP results at the ACO level but did not indicate when they would do so.

If my ACO does not earn an Advanced APM bonus in 2021, are we eligible in future years?
Yes. CMS determines MIPS and Advanced APM payment adjustments/bonuses on an annual basis. If an ACO is in MSSP Track 1 in 2019 and thus ineligible for the Advanced APM bonus in 2021, this has no bearing on future years. If that ACO moves into MSSP Track 3, or another qualifying ACO track/model in future years and meets the QP threshold that ACO would qualify for the 5 percent bonus for that particular year and CMS would make separate determinations for subsequent years.

If an ACO terminates from their qualifying Advanced APM model/track during the performance year, are the providers in that ACO still eligible for the 5 percent Advanced APM bonus?
QP determinations are made at three points during the QP performance period, which is January 1 through August 31 of the QPP performance year. The three snapshot dates are March 31, June 30 and August 31. If ECs meet the QP thresholds based on any of those periods, they retain their QP status which qualifies them for the Advanced APM bonus. If an ACO terminates from its program, voluntarily or involuntarily, during the QP performance period, that ACO's clinicians are not eligible for the bonus. If an ACO terminates after August 31, the clinicians that attained QP status can still receive the bonus during the payment adjustment year. However, CMS will deny, reduce, or recoup APM Incentive Payments made to ECs if an APM Entity or EC is either out of compliance with the APM's program requirements or if the APM Entity or EC is terminated from participating in the APM for program integrity reasons.

If an Eligible Clinician meets the QP criteria, is that clinician exempt from MIPS reporting requirements and MIPS payment adjustments for each practice TIN the clinician bills under?
Yes, CMS staff have confirmed with NAACOS that once an NPI is determined to be a QP, then the NPI will be exempt from MIPS through all TIN/NPI combinations associated with the NPI. An NPI that is a QP will not receive a MIPS payment adjustment but will receive the 5% APM incentive payment as a result of their QP status.

Will ACOs that enter in Basic Track Level E or the Enhanced Track in July 2019 be considered Advanced APMs under the Quality Payment Program in 2019? Will its participants be exempt from MIPS for 2019?
ACOs that move to Basic Level E or the Enhanced Track on July 1 will have one snapshot date (August 31) in which CMS will conduct calculations for Qualifying APM Participant threshold to determine if the ACO is eligible to receive the 5 percent Advanced APM bonus under the QPP. CMS clarified in the final rule it will still use the entire QP performance period (January 1, 2019, through August 31, 2019) rather than conducting QP determinations from July 1, 2019, through August 31, 2019. To qualify as an Advanced APM in 2019, 50 percent of Medicare payments must be made "through" or 35 percent patients must receive are under an Advanced APM.

If an ACO obtains Qualifying APM Participant (QP) status, it will be exempt from MIPS reporting for the entire calendar year 2019. As stated in the final 2019 Physician Fee Schedule rule, ACOs that reach QP status in under either snapshot in the first six months of the year (March 31, 2019 or June 30, 2019) will also receive a 5 percent MACRA bonus and be exempt from MIPS reporting. More information about the QPP how it applies to ACOs can be found in NAACOS's ACO Guide to MACRA. ACOs can check the status for their QPs via the CMS QP Lookup Tool.

Merit-Based Incentive Payment System

Overview

MIPS is the default program for Medicare Part B providers and evaluates them based on criteria such as quality, cost, use of certified EHR technology and practice improvement activities. MIPS performance in 2020 corresponds to 2022 payment adjustments. MIPS consolidates components of three legacy Medicare Part B quality reporting programs: PQRS, the VM, and Meaningful Use. Reporting for these programs ended December 31, 2016 and providers transitioned to reporting under MIPS beginning with the PY 2017.

While MIPS is the default program for Medicare Part B providers, MSSP Track 1+, 2 and 3, Basic Level E and Enhanced Track, and Next Generation ACOs that meet QP thresholds in a given performance year are exempt from MIPS. MACRA requires the QP determination, which is evaluated based on the proportion of payments or patients "through" the APM Entity (i.e., an individual ACO) in order to qualify as an Advanced APM. To learn more about the QP threshold and calculation, please refer to the Advanced Alternative Payment Models of this guide.

Advanced APM Entities that don't meet QP thresholds but do meet a lower bar, the Partial QP threshold, have the option of whether to participate in MIPS. Therefore, the following ACOs are required to participate in MIPS:

- MSSP Track 1 ACOs
- MSSP Basic Track Levels A, B, C and D
- MSSP Track 1+, 2 and 3 and Next Generation ACOs that do not meet QP or Partial QP thresholds
- MSSP Basic Level E and Enhanced Track ACOs that do not meet QP or Partial QP thresholds

To recognize the commitment of ACOs to advancing value-based healthcare, Medicare ACOs in MIPS are considered MIPS APMs and are given favorable benefits in MIPS. This means reporting criteria and performance evaluations for ACOs differ from the general MIPS requirements. NAACOS advocacy has repeatedly called for CMS to reward ACOs under MIPS and ease and streamline reporting burdens.

Among others, CMS's final list of 2020 MIPS APMs includes:

- MSSP Tracks 1, 1+, 2 and 3,
- MSSP Basic Track Levels A, B, C, D and E and Enhanced Track,
- Next Generation ACO Model,
- Comprehensive ESRD Care Model (all arrangements),
- Oncology Care Model (all arrangements), and
- CPC+ Model.

Finally, beginning in 2021 CMS anticipates introducing a new MIPS Value Pathways or MVP approach to streamline reporting for certain specialties. Proposals for this approach are anticipated to be released in the summer of 2020. NAACOS is closely following these changes to determine what impact, if any, there may be on ACOs.

MIPS APM Scoring Standard: ACO Considerations

NAACOS strongly advocated for CMS to exempt ACOs from MIPS reporting, or if required to participate in MIPS, then to ease program requirements for ACOs and account for their commitment to enhancing care through their participation in the ACO model. We are very pleased that CMS responded by providing a number of advantages for ACOs in MIPS, including certain elements of the APM scoring standard. The MIPS APM scoring standard is the scoring methodology applicable for ECs identified on the Participation List for the performance period of an APM Entity participating in a MIPS APM, including ACOs.

To identify ECs who are part of a MIPS APM, CMS uses four snapshot dates (March 31, June 30, August 31 and December 31), which establish and then add ECs to the MIPS APM during the PY. For MSSP ACOs in MIPS, this means that CMS will identify ECs who reassign their Medicare billing rights to an ACO Participant TIN on the snapshot dates; the reassignment data is exported from the Provider Enrollment, Chain, and Ownership System (PECOS). This allows new clinicians who join an ACO TIN from January 1 through December 31 to be considered under the MIPS APM scoring standard. Should a Next Generation ACO be required to participate in MIPS, the clinicians identified as part of the Next Generation ACO would be based on the TIN/NPI combinations submitted to CMS as the final Participation List for the performance year. The MIPS APM performance period is the same as the generally applicable MIPS performance period. Therefore, 2020 performance will dictate 2022 payment adjustments.

MIPS Eligible Clinicians

The definition of a MIPS eligible clinician for PY 2020 includes the following providers as well as groups that include such professionals.

- Physicians (MD and DO)
- Nurse Practitioners
- Physician Assistants
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Physical Therapists
- Occupational Therapists
- Qualified Speech Language Pathologists
- Qualified Audiologists
- Clinical Psychologists
- Registered Dieticians

CMS added a number of clinician types for PY 2019 as represented in the list above. Clinicians are identified by a unique billing TIN and NPI combination. Clinicians who are not required to participate in MIPS may voluntarily report but would not have any MIPS-related payment adjustments (positive or negative). In no case will a MIPS payment adjustment apply to the items and services furnished by practitioners who are not MIPS ECs, including those who voluntarily report on applicable measures and activities specified under MIPS.

Providers Excluded from MIPS

In addition to CMS excluding QPs or Partial QPs who do not elect to participate in MIPS, the providers below would be excluded from MIPS:

- Those with less than or equal to $90,000 in Medicare Part B allowed charges or less than or equal to 200 covered professional services to Part B enrolled individuals.
- Those who provide 200 or fewer covered professional services to Part B enrolled individuals.
- New Medicare-enrolled MIPS eligible clinicians, which means those who first become enrolled in Medicare during the MIPS performance period. This exclusion is for those who have not previously submitted claims under Medicare as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier.

It is important to note that an ACO would only be excluded using this criterion if the entire ACO entity met such exclusion criteria, which is highly unlikely. CMS does not exclude providers from MIPS based on specialty nor does the agency automatically exclude hospital-based clinicians. Additionally, CMS notes that while non-patient facing ECs are not exempt from MIPS, CMS has established a process that applies alternative measures or activities that fulfill the goals of the applicable performance category for these types of clinicians. CMS may also re-weight certain performance categories if there are not sufficient applicable measures available, however this does not apply to ACOs in all cases since the ACO entity is scored as a whole. More information is available in the FAQ section of this resource.

The MIPS determination period is a 24-month assessment period including a two-segment analysis of claims data consisting of: (1) an initial 12-month segment beginning on October 1 of the calendar year two years prior to the applicable performance period and ending on September 30 of the calendar year preceding the applicable performance period; and (2) a second 12-month segment beginning on October 1 of the calendar year preceding the applicable performance period and ending on September 30 of the calendar year in which the applicable performance period occurs. The first segment includes a 30-day claims run out. The second segment does not include a claims run out, but includes quarterly snapshots for informational use only, if technically feasible. This timeframe will also be used to determine those that meet the definition of non-patient facing clinicians, hospital-based clinicians, ambulatory surgical center-based clinicians, and those determined to be a small practice. Finally, CMS offers an “opt-in option” that allows those who meet or exceed at least one, but not all of the low volume threshold criteria, to choose to opt-in and participate in MIPS.

MIPS Performance Categories

There are four performance categories under MIPS, which are listed below. For MIPS scoring, each provider will receive a composite performance score (CPS) between zero and 100 based on performance in the following categories:

1. Quality
2. Promoting Interoperability (formerly Advancing Care Information)
3. Cost
4. Clinical Practice Improvement Activities

Because MSSP and Next Generation ACOs participating in MIPS are considered “MIPS APMs,” they are evaluated in a different manner, using the MIPS APM Scoring Standard. The performance categories and

relative weights for the MIPS APM Scoring Standard are detailed below. While CMS finalized performance weights that change over time for ECs not in ACOs, for ACOs the weights will not change unless CMS decides to do so in future rulemaking.

MIPS Performance Categories and Weights for MIPS APM Scoring Standard (ACOs)

MIPS Reporting Year and Corresponding Payment Adjustment Year	2020 Reporting/ 2022 Payment
Performance Category	**ACO Weights**
Quality	**50%**
Promoting Interoperability	**30%**
Cost	**0%**
Clinical Practice Improvement Activities	**20%**

Generally Applicable Weights for MIPS ECs/groups (not applicable to ACOs)

Performance Category	2020 Performance/2022 Payments
Quality	45%
Promoting Interoperability	25%
Cost	15%
Clinical Practice Improvement Activities	15%

Performance Category Evaluations for MIPS APMs

Quality

ACOs only need to submit their quality measures to CMS per the MSSP or Next Generation program requirements. That data will then also be used by CMS to calculate a MIPS quality score, thus avoiding additional reporting requirements in MIPS for ACOs. As with other MIPS performance categories, an ACO's MIPS quality performance will be evaluated at the ACO entity level. ACOs will submit CMS WI measures on behalf of their participating MIPS ECs as they currently do in the MSSP and/or Next Generation Models. ACO program claims-based measures will not be included in the MIPS APM quality performance category score for ACOs. Likewise, MIPS population health measures will not be included in the quality performance category score for ECs in ACOs that are evaluated under the MIPS APM scoring standard. In the rare event that an ACO does not report on quality measures as required by the MSSP or Next Generation Model, the ACO participant TINs must report data for the MIPS quality performance category according to the MIPS submission and reporting requirements. When an ACO fails to report quality measures, CMS will allow an individual clinician who is also a solo practitioner to report on any available MIPS measures, including individual quality measures.

MIPS quality measures and scores

For 2020, ACOs will be scored on a total of 9 quality measures in MIPS and up to 10 points can be earned for each measure. CMS will score performance using a percentile distribution separated by decile categories. For each benchmark, CMS will calculate the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls. CMS uses a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile. For example, a raw score of 55 percent would fall within the sixth decile of 41.0 percent to 61.9 percent and would receive between 6.0 and 6.9 points. Table 11 in the final 2018 QPP rule provides an outline of the benchmark decile distribution (p. 53699).

ACO Quality Measures Scored Under the MIPS Quality Performance Category for 2020

ACO Quality Measure	Measure Description	MIPS High Priority Designation
ACO-13	Screening for Falls Risk	Yes
ACO-14	Influenza Immunization	No
ACO-17	Tobacco Use: Screening and Cessation Intervention	No
ACO-18	Screening for Depression and Follow-up Plan	No
ACO-19	Colorectal Cancer Screening	No
ACO-20	Breast Cancer Screening	No
ACO-27	Diabetes Measure	Yes
ACO-28	Controlling High Blood Pressure	Yes
ACO-1 through ACO-7, ACO-34, 45, 46	CAHPS for ACOs	Yes

Benchmarks

CMS will use MIPS quality performance category scoring requirements and benchmarks to determine the MIPS quality performance score for ACOs. MSSP quality benchmarks will be used not only for ACOs, but also for all ECs in groups reporting through the WI. These benchmarks will be determined based on the corresponding MSSP reporting year. CMS will post the MIPS CMS WI benchmarks in the same manner as the other MIPS benchmarks. CMS will apply the MIPS scoring methodology to each measure.

Bonus Points

Previously, CMS provided ACOs with bonus points for reporting Web Interface measures categorized as "high priority" by MIPS. Despite NAACOS objections, starting in 2019, CMS no longer awards ACOs with these bonus points. CMS noted it may remove bonus opportunities for high priority measures altogether in future program years. CMS did not eliminate bonus points awarded to those who report quality using end-to-end electronic reporting.

Improvement Points

Additional points may be earned for quality improvement year over year in MIPS, which will also be applicable to ACOs scored under the APM Scoring Standard. This will compare quality scores from the prior performance period and will be measured at the performance category level (rather than at the measure level). Up to 10 percentage points are available in this performance category. Specifically, CMS

finalized that the improvement percent score will be calculated by dividing the increase in the quality performance category achievement percent score of an individual MIPS EC or group (calculated by comparing the quality performance category achievement percent score from the prior performance period to the current performance period) by the prior performance period's quality performance category achievement percent score, and multiplying by 10 percent. For an example, please see Table 24 in the final 2018 QPP rule, which was the first year these bonus points were made available (p. 53746).

Clinical Practice Improvement Activities

MACRA introduces a new area of evaluating providers through the CPIA portion of MIPS. As explained below, ACOs will not have to report any CPIA information in 2020 and will receive full credit for this performance category automatically.

The subcategories of CPIA include the following:

(1) Expanded practice access, such as same day appointments for urgent needs and after-hours access to clinician advice.
(2) Population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a Qualified Clinical Data Registry.
(3) Care coordination, such as timely communication of test results, timely exchange of clinical information to patients or other clinicians, and use of remote monitoring or telehealth.
(4) Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.
(5) Patient safety and practice assessment, such as via the use of clinical or surgical checklists and practice assessments related to maintaining certification.
(6) Participation in an APM.
(7) Achieving health equity, such as for MIPS eligible clinicians that achieve high quality for underserved populations, including persons with behavioral health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in rural areas, and people in geographic Health Professional Shortage Areas.
(8) Emergency preparedness and response, such as measuring MIPS eligible clinician participation in the Medical Reserve Corps, measuring registration in the Emergency System for Advance Registration of Volunteer Health Professionals, measuring relevant reserve and active duty uniformed services MIPS eligible clinician activities, and measuring MIPS eligible clinician volunteer participation in domestic or international humanitarian medical relief work.
(9) Integrated behavioral and mental health, such as measuring or evaluating such practices as: co-location of behavioral health and primary care services; shared/integrated behavioral health and primary care records; cross-training of MIPS eligible clinicians, and integrating behavioral health with primary care to address substance use disorders or other behavioral health conditions, as well as integrating mental health with primary care.

We are pleased that CMS provides ACOs with full credit for this performance category automatically. To acknowledge the work ACOs inherently are engaged in for improvement, CMS requires no attestations or registrations/reporting to earn the full credit in this performance category. These details are outlined in this CMS resource. CMS states that the agency will continue to post an evaluation annually to determine what credit is provided automatically to each APM. As of the date

of publication, the 2020 resource has not yet been provided by CMS. ACOs were awarded with full credit in this performance category in previous years.

Promoting Interoperability

The Promoting Interoperability (formerly Advancing Care Information) performance category replaces the legacy EHR Incentive Program (Meaningful Use). ECs are still required to utilize Certified EHR Technology (CEHRT) to meet the PI criteria. CMS finalized a shortened PI reporting period of 90 days in 2019 and requires use of 2015 CEHRT. In 2020, CMS continues to require the use of 2015 certified EHR technology in PY 2020 for a 90-day continuous reporting period. As a reminder, beginning in 2019 and for subsequent years, CMS allows clinicians in ACOs to report PI measures either as an individual or as a group (i.e., TIN). In 2020, CMS makes a change to the exclusion criteria for hospital-based clinicians for the PI performance category. Specifically, 75 percent or more of NPIs in a TIN must meet the definition of hospital-based in order to be excluded from this performance category. Previously, CMS required 100 percent of clinicians in a TIN to meet this criterion to be excluded. As a reminder, CMS does not include providers excluded from PI in an ACO's weighted average PI score. Table 48 on page 62998 of the final 2020 MPFS/QPP rule reviews the final objectives and measures for the PI performance category in 2020. Lastly, although in 2019 CMS removed the ACO program quality measure 11, Use of CEHRT, all ACOs subject to MIPS must still report Promoting Interoperability for purposes of MIPS.

ACOs and PI

Beginning in 2019, CMS will allow clinicians in ACOs to report PI measures either as an individual or as a group (i.e., Taxpayer Identification Number (TIN)). Therefore, ACOs are no longer restricted to group/TIN level reporting for PI. As a reminder, beginning in 2019 CMS removed the ACO Quality Measure ACO-11, Use of CEHRT, instead requiring an annual attestation regarding the ACO's CEHRT use for purposes of the ACO program. However, all ACOs subject to MIPS will be required to report PI for purposes of the MIPS program.

Moving to Performance-based Measurement

CMS uses a performance-based measurement for this category. ECs must report at least six measures across four objectives including: e-prescribing, health information exchange, provider to patient exchange, and public health/clinical data exchange. Clinicians will be scored based on their performance on each measure, worth up to 40 points each. The scores for each of the individual measures will be added together to calculate the final performance category score of up to 100 possible points. CMS also finalized the Security Risk Analysis measure as a required measure; though no points will be awarded for this measure it remains a non-optional requirement. Table 49 on page 63003 of the final 2020 MPFS/QPP rule reviews the final scoring methodology for the PI performance category in 2020.

TABLE 49: Scoring Methodology for the Performance Period in 2020

Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing*	10 points
	Query of PDMP	5 points (*bonus*)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information*	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information*	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting* Electronic Case Reporting* Public Health Registry Reporting* Clinical Data Registry Reporting* Syndromic Surveillance Reporting*	10 points

* Exclusion available.

Table 48 on page 62998 of the final 2020 MPFS/QPP rule reviews the final objectives and measures for the PI performance category in 2020.

Objective	Measure	Numerator	Denominator	Exclusion
e-Prescribing: Generate and transmit permissible prescriptions electronically	e-Prescribing: At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.	Number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period.	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
e-Prescribing: Generate and transmit permissible prescriptions electronically	Query of PDMP (bonus): For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.	N/A (measure is Y/N)	N/A (measure is Y/N)	N/A
Health Information Exchange: The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of CEHRT.	Support Electronic Referral Loops by Sending Health Information: For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care of health care provider (1) creates a summary of care using CEHRT; and (2) electronically exchanges the summary of care record	Number of transitions of care and referrals in the denominator where the summary of care record was created using CEHRT and exchanged electronically.	Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

Provider to Patient Exchange: The MIPS eligible clinician provides patients (or patient-authorized representative) with timely electronic access to their health information.	Provide Patients Electronic Access to Their Health Information: For at least one unique patient seen by the MIPS eligible clinician: 1. The patient (or patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and 2. The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's CEHRT	Number of patients in the denominator (or patient-authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the MIPS eligible clinician's CEHRT	Number of unique patients seen by the MIPS eligible clinician during the performance period.	N/A

Finally, MIPS also requires that as part of PI, providers must attest to CMS that they support the exchange of health information and are not engaging in information blocking. For example, providers will attest that they are not knowingly and willfully taking action (such as disabling functionality) to limit or restrict the compatibility or interoperability of CEHRT, that they are compliant with all standards applicable to the exchange of information, and that their system implementation allows for timely access by patients to their electronic health information and allows for timely exchange of electronic health information with other healthcare providers.

Resource Use/Cost

CMS finalized a policy to not calculate a cost performance score for MIPS APMs under the APM Scoring Standard. This is due to the fact that ACOs are already being measured on cost in their respective MSSP and Next Generation ACO Models. By not evaluating ACOs on cost under MIPS, it allows ACOs to continue to focus on one set of cost measures and not be subject to additional cost measures with different specifications and benchmarks. CMS notes that it may continue to consider how the agency might incorporate an assessment of the MIPS cost performance category into the APM scoring standard for ACOs. However, CMS explains that the zero weight for the cost performance category for ACOs will remain in place for subsequent years unless CMS modifies it through future notice and comment rulemaking.

For non-ACOs, the cost performance category weight is 15 percent for PY 2020. CMS will increase the cost performance category weight by 5 percent each year until the cost category is worth 30 percent of a MIPS EC's overall score in 2024.

In addition to the Total Per Capita Cost and Medicare Spending Per Beneficiary measures, CMS assesses non-ACOs on 18 episode cost measures for MIPS ECs. In 2020, CMS makes slight modifications to the Total Per Capita Cost and Medicare Spending Per Beneficiary cost measure attribution methods for 2020

to improve validity; these measures are evaluated using administrative claims data and do not apply to ACOs. Table 47 on page 1350 in the final 2020 MPFS/QPP rule outlines the cost measures used to evaluate non-ACOs subject to MIPS.

Performance Category Scoring

Below is an outline of how each performance category will be scored under the MIPS APM Scoring Standard. In addition, those seeing a large proportion of high-risk patients could be eligible to earn up to five additional points through the complex patient bonus.

Complex Patient Bonus

CMS calculates the complex patient bonus for APM Entities and virtual groups by adding the beneficiary weighted average Hierarchical Condition Categories (HCC) risk score for all MIPS ECs (and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation such as the MSSP) within the APM Entity or virtual group to the average dual eligible ratio for all MIPS ECs (and if technically feasible, TINs for models and virtual groups which rely on complete TIN participation) within the APM Entity or virtual group, multiplied by five.

Under the HCC calculation for MIPS APMs, including ACOs, CMS will use the beneficiary weighted average HCC risk score for all MIPS ECs, and if technically feasible, TINs for models that rely on complete TIN participation such as the MSSP. CMS will calculate the weighted average by taking the sum of the individual EC's (or TIN's as appropriate) average HCC risk score multiplied by the number of unique beneficiaries cared for by the clinician and then divide by the sum of the beneficiaries cared for by each individual clinician (or TIN) in the APM Entity.

Under the dual eligible calculation, CMS will use the average dual eligible patient ratio for all MIPS ECs, and if technically feasible, TINs for models that rely on complete TIN participation. CMS will use data on dual-eligibility status sourced from the state Medicare Modernization Act (MMA) files, submitted by each state to CMS with monthly Medicaid eligibility information. The complex patient bonus will be worth a maximum of five points, and the bonus will be added to the final MIPS score. For examples of HCC and dual eligible status calculations, see Table 27 in the final 2018 rule (p. 53776). Note that in 2019, CMS altered the dates used to determine eligibility for the Complex Patient Bonus to align with changes to the MIPS eligibility determination timeframe. Starting in 2019 and thereafter, CMS will assess eligibility for this bonus by looking at claims October 1 of the calendar year preceding the applicable performance period and ending September 30 of the calendar year in which the applicable performance period occurs.

Performance Category	Action Required	Max Possible Points	Percentage of Overall MIPS Score
Quality	MSSP Web Interface measures reported through the ACO, using MSSP quality benchmarks. Earn up to 10 points per measure based on performance vs. benchmark. Measures are averaged to compile a score for this performance category. Nine total quality measures will be scored for ACOs for 2019. Bonus points: no bonus points available to ACOs.	90 points	50%

Promoting Interoperability	Evaluated on four objectives: 1. E-prescribing (10 points) and Query PDMP (5 bonus points) 2. Health Information Exchange (40 points) 3. Provider to Patient Exchange (40 points) 4. Public Health and Clinical Data Exchange (10 points) Total of 100 possible points available for this performance category.	100 points	30%
Clinical Practice Improvement Activities	CMS evaluated details of the MSSP and Next Generation ACO model to determine how these models meet the CPIA criteria and goals. Based on this evaluation, CMS rewards ACOs with full credit in this category. No ACO reporting is required.	40 points	20%
Cost	CMS will not calculate a cost score for ACOs under the MIPS APM Scoring Standard.	N/A	0%

MIPS Payment Adjustments

For each performance year, CMS will evaluate ACOs and other providers compared to the MIPS performance threshold and will make additional adjustments to ensure the overall program remains budget neutral (bonuses awarded equal penalties applied) and will then apply payment adjustments during the applicable payment adjustment year.

Calculating a MIPS (CPS)

CMS will combine the weighted scores of the performance categories to determine a MIPS CPS. An ACO will have one CPS that is applied to all ECs in the ACO for a particular year. MIPS payment adjustments will be applied at the unique TIN/NPI level for each MIPS EC in the ACO. In the event that an ACO does not report quality measures as required by the MSSP, the ACO participant TINs will each be considered a unique APM Entity for purposes of the APM scoring standard.

Overall, if the CPS is above the performance threshold set by CMS, ECs will receive a bonus during the payment adjustment year. A penalty will be applied if the CPS is below the threshold, and CPSs at the performance threshold receive a neutral MIPS adjustment factor. All MIPS ECs with the same final CPS will receive the same MIPS payment adjustment.

MIPS Performance Thresholds

CMS set a 45-point performance threshold for PY 2020. The exceptional performance threshold is 85 points for PY 2020. The program is, for the most part, designed as a budget-neutral program, meaning that MIPS penalties are collected and distributed among those who perform well enough to qualify for bonuses. The range of maximum bonuses and penalties is detailed in the table below. According to CMS estimates, an EC receiving a perfect score in MIPS for PY 2020 would earn a 6.25 percent bonus in 2022 payment adjustments. As a comparison, those earning a perfect score for PY 2017 earned a 1.88 percent bonus or positive payment adjustment in 2019.

Range of Penalties and Bonuses under MIPS (set by MACRA)

MIPS Payment Adjustment Year	Max Bonus/Penalty
2019	+/- 4%
2020	+/- 5%
2021	+/- 7%
2022 and beyond	+/- 9%

Scaling Factor

To adjust the scores so that the penalties balance the bonuses, CMS uses a linear sliding scale and a "scaling factor," which is essentially a multiplier that ensures budget neutrality. The scaling factor could result in bonuses above the maximum amounts listed above but could also cause bonuses to be lower than they would be without the application of a scaling factor. MACRA sets the maximum scaling factor at 3.0, meaning if the maximum scaling factor was used in a particular year bonuses could be tripled. Alternatively, if a lower scaling factor is used, it would reduce bonuses. Specifically, if the scaling factor is greater than zero and less than or equal to 1.0, then the adjustment factor for a final score of 100 in the first year of the program would be less than or equal to 4 percent. If the scaling factor is above 1.0, but less than or equal to 3.0, then the adjustment factor for a final score of 100 would be higher than 4 percent.

Providers at and Below the Performance Threshold

For 2020, providers who don't report any information under MIPS will receive an automatic 9 percent MIPS penalty. MIPS ECs with a final score below the performance threshold of 30 points receive a negative MIPS payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a final score at the performance threshold.

Providers Above the Performance Threshold

ECs with CPSs above the performance threshold are eligible for bonuses and will be evaluated using the linear sliding scale and the scaling factor which can increase or decrease bonuses in order to keep the program budget-neutral. Until final performance information is available, it is unclear what the scaling factor will be and thus what the potential bonuses will be.

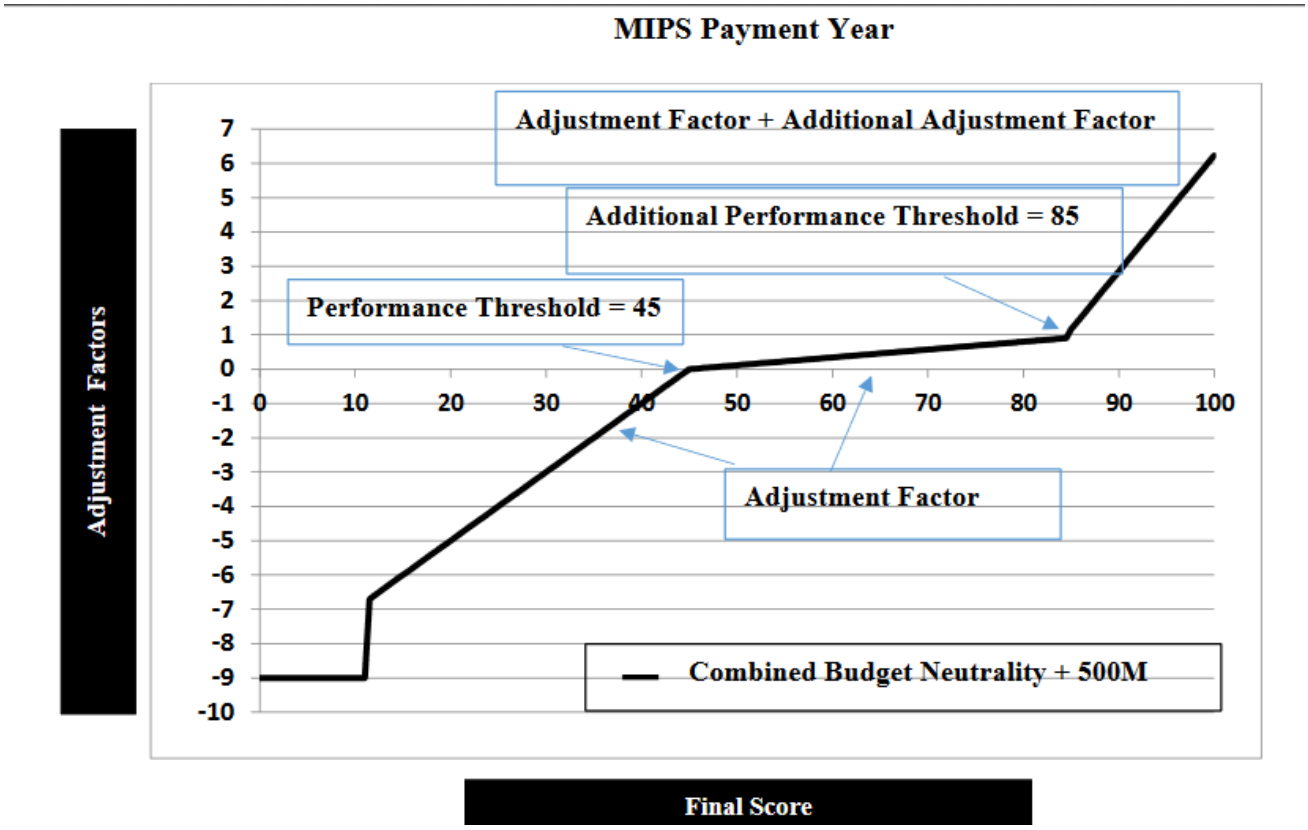
Example of Point System and Resulting MIPS Payment Adjustments

Final Score Points	MIPS Adjustment
0-29.99	Negative MIPS payment adjustment between 0-7 percent
30.0	0 percent adjustment
30.01-74.99	Positive MIPS payment adjustment ranging from greater than 0 percent to 7 percent × a scaling factor to preserve budget neutrality, on a linear sliding scale
75.0-100	Positive MIPS payment adjustment AND additional MIPS payment adjustment for exceptional performance. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.)

Exceptional Performance Bonuses

While MIPS is designed to be budget neutral, there is an additional $500 million per year from 2019 through 2024 for "exceptional performers." CMS finalized an exceptional performance threshold of 85 points for the 2020 PY, therefore ECs with a final CPS of 85 or greater will be eligible for the exceptional performance adjustment. The figure below from the final 2020 MPFS rule illustrates how the additional performance threshold would be applied.

Figure 1: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold for the 2022 MIPS Payment Year (page 63041 of the 2020 final MPFS/QPP rule)



The exceptional performance bonus could range from 0.5 percent to 10 percent, which would be added to the bonus determined under the main part of the program. Therefore, MIPS eligible clinicians with a final score at or above the additional performance threshold, which is set at 85 for 2020 performance/2022 payments, will receive an additional MIPS payment adjustment factor for exceptional performance. Similar to the regular MIPS payment adjustment, this will be based on a linear sliding scale such that an additional adjustment factor of 0.5 percent is assigned for a final score at the additional performance threshold and an additional adjustment factor of up to 10 percent is assigned for a final score of 100, subject to the application of a scaling factor. The scaling factor for the exceptional performance bonuses will be calculated by CMS and ensures that the agency does not spend more than the $500 million it has annually for these bonuses. Therefore, similar to the regular MIPS payment adjustments, it is unclear how many providers will be eligible for the exceptional performance bonus or what those specific amounts will be.

MIPS Payment Adjustments and ACO Benchmarks

In late May 2017 CMS issued an updated factsheet on the Track 1+ ACO option which clarified that "MIPS payment adjustments would be included in ACO expenditures under the current Shared Savings Program's regulations for calculating benchmark and performance year expenditures just as other payment adjustments made on claims under other value based payment programs are incorporated." The agency notes that "advanced APM lump sum incentive payments to qualified participants (QPs) participating in Track 1+ Model ACOs will not be included in ACO expenditures because they are not beneficiary-identifiable payments and are lump sum payments to QPs made outside the claims payment system." NAACOS is disappointed in this policy decision by CMS and will continue to strongly advocate that these payments not be included as expenditures for ACO benchmark calculations.

Application and Notification of MIPS Payment Adjustment

For each applicable year the MIPS payment adjustments will be applied to Medicare Part B payments for items and services furnished by the MIPS EC during the year. Therefore, unlike bonuses in the MSSP that are paid in a lump sum, MIPS bonuses will be applied to affected Medicare Part B claims as they are processed. The same is true for MIPS penalties, which will be deducted from each claim (based on its date of service, not processing date) during the payment adjustment year. CMS will notify providers of applicable MIPS payment adjustments by December 1 of the year preceding the payment adjustment year, so December 1, 2021 for 2022 payment adjustments. As discussed below, CMS may notify ECs through MIPS performance feedback reports, if technically feasible.

MIPS Performance Feedback Reports

MACRA requires CMS to give feedback to providers to help them understand their performance on measures and criteria evaluated under MIPS. CMS distributed the first round of MIPS performance feedback reports beginning in July 2018 for 2017 performance via the QPP website. CMS shares this feedback via the Quality Payment Program portal. As a result of NAACOS advocacy, CMS now shares with ACOs how each TIN scores on the Promoting Interoperability performance category. NAACOS will continue to advocate for CMS to provide relevant, timely and transparent performance information to ACOs on their MIPS performance. If you have suggestions for how CMS can improve sharing performance information on MIPS with ACOs, please email us at advocacy@naacos.com.

MIPS Performance Review, Audits and Public Reporting

MIPS Performance Review

MIPS ECs or groups may request a targeted review of the calculation of the MIPS payment adjustment factor for a given year. MIPS ECs and groups will have a 60-day period to submit a request for targeted review, which begins on the day CMS makes available the MIPS payment adjustment factor. CMS will respond to each review request that is submitted by the deadline and the agency will determine whether a targeted review is warranted. MIPS ECs or groups may include additional information in support of their request for targeted review at the time the request is submitted. Decisions based on the targeted review are final, and there is no further review or appeal.

Data Validation and Audits

CMS will perform ongoing monitoring of MIPS ECs and groups for data validation, auditing, program integrity issues, and instances of non-compliance with MIPS requirements. If a MIPS EC or group is found

to have submitted inaccurate data for MIPS, CMS will reopen and revise the MIPS determination and would collect any overpayments due. CMS has the authority to re-open MIPS determinations at any time for fraud or similar fault. CMS notes that it will limit data validation and audit requests to the minimum data necessary to conduct validation.

Public Reporting on Physician Compare

MACRA requires CMS to continue to expand the amount of information it shares with the public on the Medicare Physician Compare website, which currently has web pages for individual physicians, group practices and ACOs. At this time, if a clinician or group submits quality data as part of an ACO, there is an indicator on the clinician's or group's profile page, thus identifying which clinicians and groups took part in an ACO. Also, currently, all ACOs have a dedicated page on the Physician Compare website to showcase their data. If technically feasible, CMS plans to use this model as a guide for adding APM data to Physician Compare. Specifically, CMS explains that it views the MACRA requirement to report MIPS performance publicly as a way to build on public reporting currently done, including public reporting on Physician Compare for ACOs. CMS states its intent to integrate APM data gradually into Physician Compare as informed by consumer testing. It's important to note that CMS will post information on Physician Compare for both Advanced APMs and APMs that participate in MIPS.

MIPS FAQs

Do you have a question that is not addressed in the materials above or the FAQs below? If so, please submit it to us at advocacy@naacos.com. We will do our best to find an answer and may include the FAQ (without any submitter information) in a future iteration of this Guide.

Does my ACO have to submit a list of clinicians for MIPS?

No. CMS will use the information based on ACO Participation Lists and PECOS (the Medicare enrollment system) to determine which MIPS eligible clinicians are in an ACO for purposes of the APM scoring standard. Therefore, ACOs do not need to submit additional lists to CMS.

Does the ACO's overall MIPS score have any bearing on quality or performance under the MSSP or Next Generation ACO program?

No**.** An ACO's MIPS score is not used to evaluate ECs or the ACO for purposes of the MSSP or Next Generation ACO program and CMS does not foresee ACO programs using the final MIPS score for program evaluation purposes.

What happens if an ACO is unsuccessful with quality reporting?

Should an ACO fail to report quality through the MSSP or Next Generation ACO program, the ACO participant TINs would be evaluated at the TIN level for MIPS. CMS would still use the MIPS APM scoring standard for the ACO TINs and each of the ACO Participant TINs would receive its own TIN-level final score instead of an ACO-level final score. An individual clinician can also report individual measures using this fallback option. This policy does not cancel or mitigate any of the negative consequences associated with non-reporting of quality as required under the MSSP, including ineligibility for shared savings payments and/or potential termination of the ACO from the program. Please note this is only a fallback option for the rare case when an ACO completely fails to report quality measures on behalf of its ECs through the MSSP or Next Generation ACO programs.

What if an ACO drops out of the ACO program during the performance year?
If an ACO drops out of their ACO program during the performance year prior to March 31, the MIPS eligible clinicians that are part of the ACO would not be considered part of an ACO and would not receive favorable benefits for ACOs under the MIPS APM scoring standard. These clinicians would have to report individually or as groups at the TIN level like other non-MIPS APM providers. If an ACO's participation is terminated on or after March 31 of a performance period, the MIPS eligible clinicians in the ACO would still be considered an ACO in a MIPS APM for the year, and they would report and be scored under the APM scoring standard.

If we perform well under MIPS, when in 2022 would we receive our MIPS bonus?
MIPS payments will not be made in a lump sum but will be applied as an adjustment on a per claim basis for claims with dates of service during the payment adjustment year.

Will FQHCs and RHCs that are part of an ACO participate in MIPS?
FQHCs and RHCs may report under MIPS, however no adjustments to payments will be made unless billing Medicare Part B.

How will ACOs report PI requirements? Will PI be reported by the practices or will the ACO be responsible for reporting this information on behalf of the practices/TINs?
Practices (TINs) are responsible for reporting PI data to CMS. All TIN scores will then be aggregated as a weighted average to come up with one ACO entity-level score for PI. Beginning in 2019 CMS allows such reporting of PI at either the individual or TIN levels, and these scores will then be aggregated and averaged to come up with one ACO entity-level score for the PI performance category.

How will CMS handle exemptions for certain providers in the PI performance category if those ECs are part of an ACO?
According to CMS staff, because each reporter (TIN or individual) is attributed a score based on standard MIPS rules for PI, certain groups of individuals will not be scored under PI (hospital-based, non-patient facing, etc.). Any individual attributed such a non-score/exclusion will be removed from the APM Entity group PI score. However, those individuals will still receive the same PI score and final overall composite performance score as everyone else in the APM Entity. NAACOS will continue to advocate for CMS to clarify this in a published ACO-specific MIPS education document.

Does MIPS require ACOs to report any quality measures outside of the ACO Web Interface reporting?
No, ACOs will continue to report Web Interface measures as they do currently for the MSSP and Next Generation Model programs.

Will CMS count MIPS payment adjustments as ACO expenditures?
Yes. In late May 2017 CMS issued an updated factsheet on the Track 1+ ACO option which clarified that "MIPS payment adjustments would be included in ACO expenditures under the current Shared Savings Program's regulations for calculating benchmark and performance year expenditures just as other payment adjustments made on claims under other value based payment programs are incorporated." They agency notes that "advanced APM lump sum incentive payments to qualified participants (QPs) participating in Track 1+ Model ACOs will not be included in ACO expenditures because they are not beneficiary-identifiable payments and are lump sum payments to QPs made outside the claims payment system." NAACOS is disappointed in this policy decision by CMS and will continue to strongly advocate that these payments not be included as expenditures for ACO benchmark calculations.

Do ACOs need to register for the Web Interface by the MIPS registration deadline of June 30, 2018?
No. ACOs do not need to register for the MIPS Web Interface reporting mechanism. ACOs will continue to report quality information via the MSSP or Next Gen ACO program.

Does each practice in the ACO need to report for the same 90-day period under PI requirements?
No. Each practice or individual clinician may select its own 90-day period to report PI Information data to CMS. As a reminder, beginning in 2019 CMS allows reporting of PI at either the individual or TIN levels for ECs in ACOs, and these scores will then be aggregated and averaged to come up with one ACO entity-level score for the PI performance category.

I heard there is a Virtual Group option for MIPS for 2019, does this apply to clinicians in ACOs?
No. While there is a Virtual Group option which was introduced beginning in 2018, this option does not apply to ACOs or the clinicians in ACOs. Instead, the Virtual Group option allows ECs in small practices that are not in an APM an opportunity to pool their resources with another small group(s) for reporting and scoring purposes under MIPS.

What happens if a clinician has multiple MIPS scores? Which score will apply for the clinician in the payment year?
Tables 30 and 31 in the final 2018 QPP rule illustrate the agency's policies for determining which final score will be used when more than one final score is associated with a TIN/NPI (Table 30) and the final policies that apply if there is no final score associated with a TIN/NPI from the performance period, such as when a MIPS eligible clinician starts working in a new practice or otherwise establishes a new TIN (Table 31), both found on page 53787. Please refer to this table for the hierarchy specific to your situation.

If an Eligible Clinician meets the QP criteria, is that clinician exempt from MIPS reporting requirements and MIPS payment adjustments for each practice TIN the clinician bills under?
Yes, CMS staff have confirmed with NAACOS that once an NPI is determined to be a QP, then the NPI will be exempt from MIPS through all TIN/NPI combinations associated with the NPI. An NPI that is a QP will not receive a MIPS payment adjustment but will receive the 5% APM incentive payment as a result of their QP status.

Does the MIPS payment adjustment apply to Part B drugs?
No. Payment adjustments will only apply to payments made for covered professional services for which payment is made under, or is based on, the Medicare Physician Fee Schedule and are furnished by a MIPS eligible clinician. The payment adjustment will not apply to Medicare Part B drugs or other items and services that are not covered professional services.

Is the MIPS payment adjustment applied to the Medicare paid amount?
Yes. The MIPS payment adjustment is applied to the Medicare paid amount, so it does not impact the portion of the payment that a beneficiary is responsible to pay.

About NAACOS. The National Association of ACOs (NAACOS) is a non-profit organization representing more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. Models include the Medicare Shared Savings Program (MSSP), Next Generation ACOs, and alternative payment models supported by a myriad of commercial health plans and Medicare Advantage. NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, outcomes, and healthcare cost efficiency.

Mission:

- Foster growth of ACO models of care;
- Participate with Federal Agencies in development & implementation of public policy;
- Provide industry-wide uniformity on quality and performance measures;
- Educate members in clinical and operational best practices;
- Collectively engage the vendor community, and
- Educate the public about the value of accountable care.

Contact Us:

Jennifer Gasperini
Senior Policy Advisor
NAACOS
jgasperini@naacos.com

Clif Gaus, Sc.D.
President and CEO
NAACOS
cgaus@naacos.com