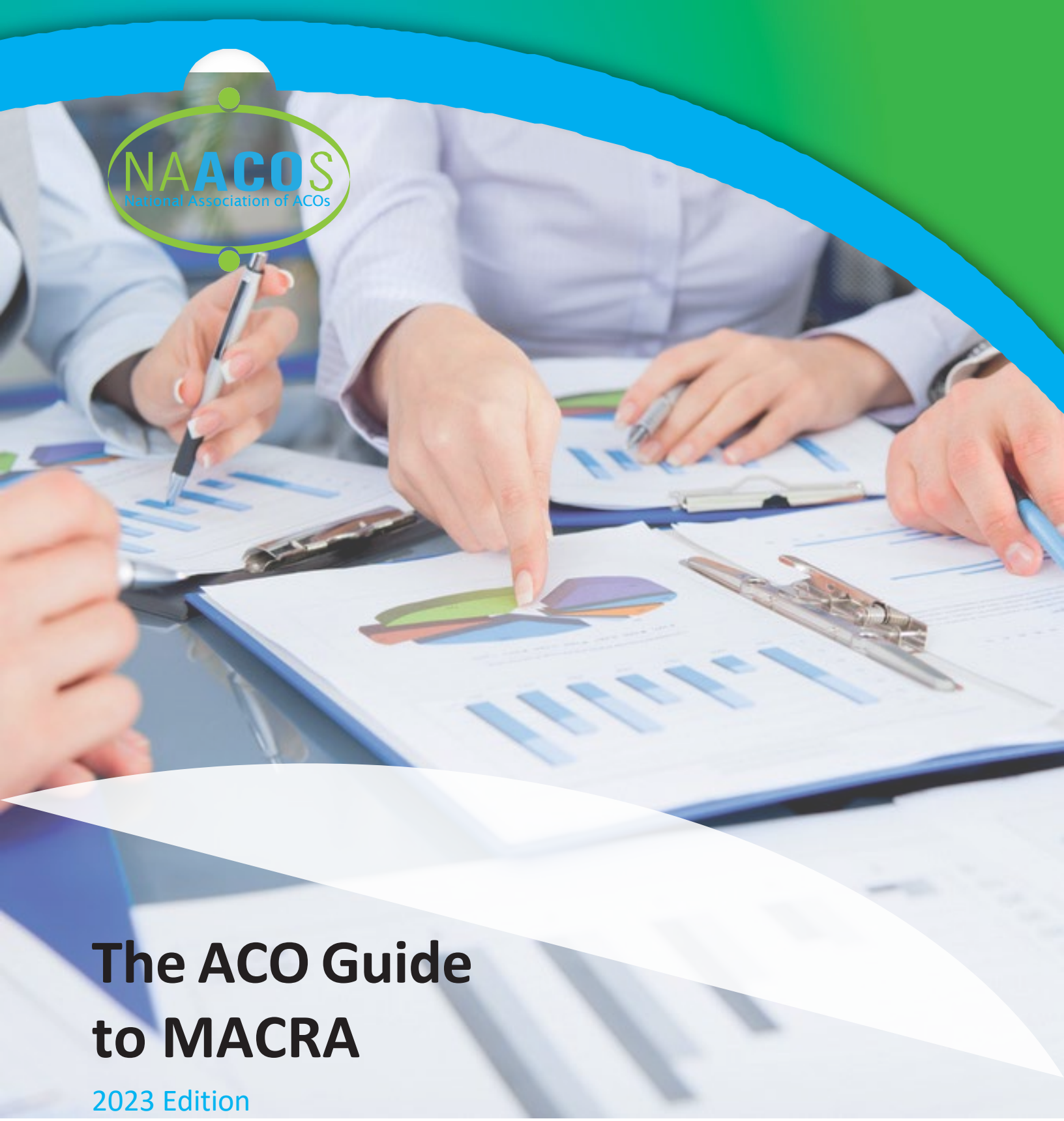

The ACO Guide to MACRA

2023 Edition

Updated February 2023

www.naacos.com

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Acronyms

ACI— Advancing Care Information
ACO — Accountable Care Organization
AMI— Acute Myocardial Infarction
API— Application Programming Interface
APM— Alternative Payment Model
APP— APM Performance Pathway
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
ECQM— Electronic Clinical Quality Measure
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
MIPS CQM— Merit-Based Incentive Payment System Clinical Quality Measure
MLR— Minimum Loss Rate
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 APM Participant
QPP— Quality Payment Program
QRDA— Quality Reporting Document Architecture
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 2023 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

Advanced APM Incentive Update: On December 23, Congress passed an omnibus funding bill that included a partial extension of Advanced APM incentive payments. NAACOS is encouraged that the legislation includes a one-year extension of these incentives, although at a lower 3.5 percent. Importantly, it also maintains current qualifying thresholds for an additional 12 months. Although the extension does not maintain the full 5 percent incentive, this temporary extension ensures value-based care providers will be eligible to qualify for incentives in performance year 2023 (payment year 2025). This will help maintain momentum on the movement to value and gives stakeholders more time to work with the next Congress on long-term solutions that improve value-based care. A NAACOS press release is available.

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. CMS provided annual 0.5 percent updates each year through 2019, and thereafter automatic payment updates are flat until 2026, when payment rates will differ based on whether clinicians are participating in certain Alternative Payment Models (APMs).

Since MACRA's passage, the Centers for Medicare & Medicaid Services (CMS) has been working to implement the law. For information on QPP policies governing performance years (PY) 2017 through 2022, please refer to previous annual editions of this guide available on our website. In this guide for PY 2023, NAACOS has summarized the main provisions applicable to ACOs.

Overview of MACRA

MACRA created two payment paths for Medicare Part B providers: participation in an Advanced 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 2022 corresponds to payment adjustments in 2024. MACRA rewards providers in Advanced APMs, which benefits 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 an annual 5 percent incentive payment from 2019 through 2024. In December 2022, Congress passed legislation that provides a 3.5 percent incentive payment for performance year 2023 (payment year 2025). 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.

To be considered an Advanced APM, a payment model must 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 incentive payments or higher annual updates beginning in payment year 2026. 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 for the 2023 QP performance period includes:

- Medicare Shared Savings Program (Basic Level E and Enhanced)
- ACO REACH (formerly Global and Professional Direct Contracting Model)
- Bundled Payments for Care Improvement Advanced Model
- Comprehensive Care for Joint Replacement Payment Model (CEHRT Track)
- Kidney Care Choices Model (Kidney Care First; Professional and Global Options)
- Maryland Total Cost of Care Model (Care Redesign Program)
- Primary Care First Model
- Vermont All-Payer ACO Model

NAACOS has repeatedly advocated that CMS use an inclusive approach when identifying which APMs qualify as "Advanced." We are very pleased with the ACO models included on the 2023 Advanced APM list, but NAACOS has also advocated that all MSSP levels be deemed Advanced APMs by having CMS account for start-up and ongoing operational costs as risk.

Providers who are not QPs participate in MIPS, which is the default program for Medicare Part B. 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. The list of MIPS APMs includes those listed as Advanced APMs above as well as other models, shown on this CMS webpage. In 2021, CMS introduced a new APM Performance Pathway (APP), which evaluates all MIPS APMs, including ACOs using a new, reduced quality measure set that will be used for evaluation in both the MIPS and MSSP programs using one unified quality assessment methodology.

MACRA Resources

Resources from CMS

- The final 2023 Medicare Physician Fee Schedule (MPFS)/QPP rule and CMS factsheet
- CMS QPP resource library and fact sheet
- QPP webpage on the APM Performance Pathway (APP)
- CMS electronic clinical quality measure (eCQM) Resource Center

NAACOS Resources

- MACRA webpage includes information and updates as well as resources on MACRA implementation
- Final 2023 MPFS/QPP rule analysis
- NAACOS webinars available on-demand here

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 (MSSP Basic Levels A, B, C and D and Advanced APM Entities that 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 APP, 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 are 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.
- 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 are an advantage for ACOs that are evaluated under MIPS and favorably position ACOs compared to other providers who have not made these investments.
- CMS evaluates an ACO as one cohesive entity and applies 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 incentive payment from 2019 through 2024, which is in addition to shared savings the ACO can earn through their ACO participation.
- In 2025, Advanced APM ACOs can earn a 3.5 percent incentive payment.

- 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 incentive payments 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 payment and 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 incentive payment from 2019 through 2024. In December 2022, Congress passed legislation that provides a 3.5 percent incentive payment for payment year 2025. 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 ACO REACH model. CMS uses a two-year lag between Advanced APM participation and payment adjustment years with 2021 participation corresponding to 2023 payments, 2022 participation corresponding to 2024 payments, and so on.

To be considered an Advanced APM, a payment model must 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 incentive payments or higher annual updates.

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.

APM Definitions

MACRA introduced new terms that are important to understand as they refer to different requirements for APMs and Advanced APMs.

- **APM (e.g., MSSP Basic Level A)**
  - 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 Enhanced Track)**
  - 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 accountable care model or track, such as each track within the MSSP or ACO REACH.

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 ACO REACH meet the first two criteria, but the financial risk requirement is the key to CMS's determination for qualifying 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. 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 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. 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. Starting with PY 2019, CMS requires MSSP ACOs to provide an annual attestation that 75 percent (for Advanced APM models) of ECs are utilizing CEHRT. Based on this attestation requirement, MSSP Basic Level E or Enhanced Track meet the Advanced APM CEHRT requirement.

Under the ACO REACH Model, ACOs are required to ensure that the percentage of Participant Providers that are ECs and that use CEHRT meets or exceeds the CEHRT use criterion (currently 75 percent). Preferred Providers are not subject to this requirement and not eligible for QP status under the ACO REACH 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 2022 performance the CEHRT must be certified to 2015 Edition certification criteria.

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 ACO REACH Model. CMS finalized a revision to the regulation in the 2023 Medicare physician fee schedule to clarify that the criterion for payment can be met through the use of a single quality measure.

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
    - CMS made this 8 percent revenue-based standard permanent as part of the 2023 Medicare physician fee schedule.
- 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. CMS does not include a mechanism through which the agency accounts for an APM Entity's start up or ongoing investments or costs as part of 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 ACO Advanced APMs 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 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
Starting with 2018, Medical Home Model APM Entities were required to 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. The Medical Home Model Advanced APM financial risk standard does not apply for APM Entities that do not meet this criterion. In the 2023 Medicare physician fee schedule, CMS finalized a policy to apply the 50 eligible clinician limit directly to the APM Entity participating in the mode, not the parent organization. CMS will make QP determinations on each of the three snapshot dates throughout the year (March 31, June 30, August 31). If the number of eligible clinicians is above 50 on any of the snapshots, no clinicians will achieve or retain QP status for the performance period. These changes will be effective beginning in performance year 2023.

Qualifying APM Participant (QP) Thresholds

APM Entities (e.g., an MSSP Enhanced 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 incentive payments or higher annual updates 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 introduced an option for ACOs to 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 is included in the evaluations of payers outside of traditional Medicare.

CMS makes QP determinations collectively using the group of ECs in an Advanced APM Entity. Therefore, an ACO as a whole is evaluated in the QP determination using the collective group of ECs associated with the ACO's participant list. Affiliated practitioners, such as ACO REACH preferred providers, or providers with a contractual relationship with the ACO are not included in the 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.

The QP thresholds were scheduled to rise significantly with performance year 2021 (payment year 2023). However, following a major advocacy campaign from NAACOS, ACOs and other leading stakeholders, Congress passed legislation on two occasions to keep the thresholds at attainable levels through at least performance year 2023.

Payment and Patient Count Threshold for Meeting QP Determination

Payment Year *(Note: performance years are two years prior)*	2019	2020	2021	2022	2023	2024	2025	2026
QP Payment Threshold	25%	25%	50%	50%	50%	50%	50%	75%
Partial QP Payment Threshold	20%	20%	40%	40%	40%	40%	40%	50%
QP Patient Count Threshold	20%	20%	35%	35%	35%	35%	35%	50%
Partial QP Patient Count Threshold	10%	10%	25%	25%	25%	25%	25%	35%

QP Calculation

Payment Approach

CMS generally interprets payments "through" an 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 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 PFS. 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 example, CMS uses the MSSP and ACO REACH Model attribution rules, relying on the latest available attribution list at the time of a QP determination. Specifically, the QP evaluations 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.

Under CMS QP calculations, a beneficiary may be counted only once in the numerator and denominator for a particular ACO but that beneficiary may be counted multiple times across the numerators and denominators for different ACOs or other APM Entities. In the final 2021 Medicare PFS rule, CMS acknowledged that when a beneficiary is prospectively assigned to an ACO or other APM Entity, and therefore could not possibly be assigned to other ACOs/APM Entities, it is unfair to include that beneficiary in those QP calculations. Therefore, CMS finalized a policy, which NAACOS supported, to exclude prospectively assigned beneficiaries from the denominators of other ACO/APM Entity QP calculations when that beneficiary is ineligible to be added to the ACO/APM Entity's list of assigned beneficiaries. This decreases the QP denominator, thus increasing the overall QP score. In response to NAACOS comments, in the final rule CMS clarified that the prospectively assigned beneficiaries will be removed from the denominator of other ACOs regardless of whether those other ACOs have retrospective or prospective assignment. This applies to the payment and patient count calculations.

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, aside from the exception noted above, 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 incentives or the higher annual updates starting in 2026. They 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, those clinicians are excluded from MIPS reporting and payment adjustments.

Advanced APM ECs Who Don't Meet QP/Partial QP Thresholds

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 assesses 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 elects 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 makes QP determinations at three separate times based on the collective ECs' billing Medicare through ACO REACH or 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 ACO REACH participants or 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. Each QP evaluation includes a 60-day claims run out.

The process of identifying specific ECs in ACO REACH is different because that model does not require full TIN participation as is required under MSSP. Therefore, CMS identifies ECs in ACO REACH based on the TIN/NPI combinations from the Participant List finalized for that performance year.

The QP policy provides certainty of 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 if 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. There is a limited opportunity to appeal QP determinations. There is a targeted review process for limited circumstances surrounding QP determinations, such as to review CMS clerical errors like omitting a clinician from a Participation List used for QP determinations. If CMS determines a clinician was missing due to CMS clerical error, the agency will assign the ACO or APM Entity's most favorable QP score from that performance year.

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 provides an option to 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. Having a robust All-Payer Option will be especially important as the QP thresholds become increasingly challenging in future years. Unfortunately, due to administrative burdens, this option has been unpopular.

Criteria for Other Payer Advanced APMs

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 75 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
- 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 an 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 approves 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 can request review of their payment arrangements and through the Eligible Clinician Initiated Process, ECs or APM Entities such as ACOs can request a review of their payment arrangements. The Payer Initiated process comes before the clinician-initiated process. More information on the timing for this process is available on this CMS webpage. The 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. For each process, CMS uses 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. CMS posts approved Other Payer Advanced APMs on a public website, which is updated as payment arrangements are approved.

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 no longer requires annual submission of all the information related to making this determination and instead permits 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 only needs to submit information on any relevant changes to the payment arrangement. For multi-year payment arrangements submissions, CMS requires 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 continues 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 makes 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.

CMS makes All-Payer QP determinations at the ACO or APM Entity level as well as at the TIN or Eligible Clinician level, providing flexibility to make the request at various levels. The agency 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. If 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 makes 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. That 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 calculates 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 uses a similar method with the patient count approach. Specifically, the agency divides 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 incentive payments. 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

Payment Year	2019/ 2020	2021	2022	2023	2024	2025
QP Payment Amount Threshold	N/A	50% Total 25% Medicare	50% Total 25% Medicare	50% Total 25% Medicare	50% Total 25% Medicare	50% Total 25% Medicare
Partial QP Payment Amount Threshold	N/A	40% Total 25% Medicare	40% Total 25% Medicare	40% Total 25% Medicare	40% Total 25% Medicare	40% Total 25% Medicare

QP Patient Count Thresholds – All-Payer Combination Option

Payment Year	2019/ 2020	2021	2022	2023	2024	2025
QP Patient Count Threshold	N/A	35% Total 20% Medicare	35% Total 20% Medicare	35% Total 20% Medicare	35% Total 20% Medicare	35% Total 20% Medicare
Partial QP Patient Count Threshold	N/A	25% Total 10% Medicare	25% Total 10% Medicare	25% Total 10% Medicare	25% Total 10% Medicare	25% Total 10% Medicare

Under the All-Payer Option, provided the Advanced APM Entity meets the required Medicare thresholds, CMS combines 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.

All-Payer Combination Option Example

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 is 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 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). In 2023 (payment year 2025) clinicians can qualify for a 3.5% incentive payment. As an example, CMS will evaluate QP status based on 2022 performance, will base the 5 percent incentive payment on paid 2023 Medicare Part B covered professional services, and will make the incentive payment in 2024. CMS expects to issue Advanced APM incentive payments 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 incentive payments 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 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 makes 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 divides 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 are 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 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 thresholds?
Following the claims run out after the snapshot date, CMS conducts 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 must 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.

Was the 5 percent Advanced APM incentive payment extended beyond 2024?
The 5 percent Advanced APM incentive payment was scheduled to expire after payment year 2024, performance year 2022, based on the MACRA statute. Congress passed a one-year 3.5 percent extension in December 2022 that will allow Advanced APMs to receive incentive payments in 2025.

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 Promoting Interoperability performance category. Specifically, 2015 CEHRT is required beginning with PY 2019.

Do ACO REACH entities have to report any PI measures?
No. ACO REACH entities are required to meet the Advanced APM CEHRT use requirements through their applications and Participation Agreement and are not required to report PI measures.

What is the basis of the Advanced APM incentive payment – are things like Part B drugs and MIPS adjustments included?
The APM Incentive Payment is equal to 5 percent (or 3.5 percent in 2025) 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. Payments for the technical components of imaging and other diagnostic services are only included if they are paid for under the PFS 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 QP denominator is to ensure calculations only include 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 an Enhanced ACO and TIN B that is not part of an ACO). When making the QP calculation, CMS only uses 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.

Are Advanced APM incentive payments based on the Medicare paid amount or allowed amount?

After a number of initial references from CMS about basing the Advanced APM incentive payment on the aggregate allowed amounts, the agency changed course and in 2019 stated that the incentive payment is based on the aggregate paid amounts. NAACOS is very disappointed with this reversal and advocated for a change, but the agency finalized their clarification about basing the incentive payment on paid amounts in the final 2021 Medicare PFS rule, summarized in this NAACOS resource.

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 incentive payment?
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 that policy based on operational complexity. Therefore, CMS only evaluates an ACO based on participation in one specific Advanced APM. However, CMS assesses individual ECs who are in multiple Advanced APMs at the individual level if they do not meet the QP threshold as part of the APM Entity.

How is the APM incentive payment calculated for an individual provider who practices at an ACO and at another organization that is not part of an Advanced APM Entity?
The incentive payment 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 captures Medicare billings from all of the clinician's practices and use that total amount as the basis of the incentive payment , even if one or more of those TINs are not participants in the ACO.

Is the Advanced APM incentive payment for participating in the All-Payer Option the same as, or in addition to, participating in Medicare Advanced APMs?
The incentive payment for achieving QP status is one payment, 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 payments 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.

If my ACO does not earn an Advanced APM incentive payments based on 2022 performance, are we eligible in future years?
CMS determines MIPS and Advanced APM payment adjustments/incentives on an annual basis. If an ACO was in MSSP Basic A in 2021 and thus ineligible for the Advanced APM incentive payment in 2023, this has no bearing on future years. If that ACO moves into MSSP Basic E, or another qualifying ACO track/model in 2023, and meets the QP threshold that ACO would qualify for the 3.5 percent incentive for that particular year.

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 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 APM incentive payment as a result of their QP status.

If an ACO terminates from their qualifying Advanced APM model/track during the performance year, are the providers in that ACO still eligible for Advanced APM incentive payments?
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 incentive payment. If an ACO terminates from its program, voluntarily or involuntarily, during the QP performance period, that ACO's clinicians are not eligible for the incentive payment.

Starting with PY 2020, ECs may not retain QP or Partial QP status if it stems from participation in an APM Entity that terminates its APM participation after the QP performance period ends (August 31) but before bearing financial risk under the APM. Additionally, 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.

The CMS QPP Portal shows some ECs having QP status while others have MIPS status within our same ACO. How is that possible?
For purposes of determining QP status versus MIPS status, CMS makes three determinations throughout the performance year at each of the three snapshot dates (March 31, June 30 and August 31). The ACO is evaluated at the ACO entity level for each snapshot date. CMS specifically looks at the group of ECs participating in an APM Entity as identified by a combination of the APM identifier, APM Entity identifier, TIN, and NPI.

Because of the numerous QP evaluations, there can be instances where some clinicians receive a different status than others within the same ACO. As an example, if an ACO is determined to have met QP status on snapshot date 1, all of the ECs included in that evaluation receive the QP status. However, if the ACO does not meet QP status on snapshot date 2, if there were ECs added to participant TINs from snapshot date 1 to snapshot date 2, the new ECs would not obtain QP status given the fact that the ACO did not meet the QP threshold on snapshot date 2. However, if the ACO goes on to meet the QP threshold on snapshot date 3, then the new ECs would at that time be given QP status. If the ACO did not meet the QP threshold on snapshot date 3 in this example, then the new ECs would not obtain QP status even though the rest of the ACO does retain the QP status it achieved during snapshot date 1.

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 (CEHRT) and practice improvement activities. MIPS performance in 2023 corresponds to 2025 payment adjustments. MIPS consolidated components of three legacy Medicare Part B quality reporting programs: Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the eligible professional Medicare EHR Incentive Program (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 Basic Level E and Enhanced Track, and DCEs/ACO Reach participants that meet QP thresholds in a given performance year are exempt from MIPS. MACRA requires clinicians meet the established QP thresholds for a particular year, which is evaluated based on the proportion of payments or patients "through" the APM Entity (i.e., an individual ACO) in order to qualify for Advanced APM incentive payments. To learn more about QP thresholds and calculations, please refer to the Advanced APM section 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 Basic Track Levels A, B, C and D
- MSSP Basic Level E and Enhanced Track ACOs that do not meet QP or Partial QP thresholds
- DCEs/ACO Reach participants that do not meet QP or Partial QP thresholds

Beginning in 2021, CMS introduced a new APM Performance Pathway (APP) to evaluate all MIPS APMs, including ACOs. The APP is designed to evaluate all MIPS APMs, including ACOs, using a new, reduced quality measure set that is used for evaluation in both the MIPS and MSSP programs using one unified quality assessment methodology. ACOs subject to MIPS will therefore continue to report quality measures as part of their quality obligations under the MSSP, and CMS will use the APP scoring methodology to provide a MIPS quality score and MSSP quality score using the same measures and methodologies. For more information on the changes to MSSP ACO quality assessments, please refer to our NAACOS resource detailing the quality changes for ACOs under the new APP scoring and reporting requirements.

MIPS APP: 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 subject to MIPS. The MIPS APP 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 APP. Should a DCE/REACH ACO be required to participate in MIPS, the clinicians identified as part of the DCE/REACH ACO would be based on the TIN/NPI combinations submitted to CMS for the performance year. The MIPS APP performance period is the same as the generally applicable MIPS performance period. Therefore, 2023 performance will dictate 2025 payment adjustments.

MIPS Eligible Clinicians

The definition of a MIPS eligible clinician for PY 2023 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
- Clinical Social Worker
- Certified Nurse Midwives

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 below and in the FAQ section of this resource.

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), or final MIPS score, 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 DCEs/ACO reach participants participating in MIPS are considered "MIPS APMs," they are evaluated in a different manner, using the MIPS APP. The performance categories and relative weights for the MIPS APP 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 APP (ACOs)

MIPS Reporting Year and Corresponding Payment Adjustment Year	2023 Reporting/ 2025 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	2023 Performance/2025 Payment
Quality	**30%**
Promoting Interoperability	**25%**
Cost	**30%**
Clinical Practice Improvement Activities	**15%**

Performance Category Evaluations for MIPS APMs

Quality

ACOs submit their quality measures to CMS per the MSSP, Direct Contracting or REACH Model program requirements. That data and resulting quality score will then also be used by CMS to award 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. In 2023, ACOs have a choice to submit either CMS WI measures on behalf of their participating MIPS ECs, or to submit the new, reduced APP clinical quality measure set. ACOs also have two administrative claims measures applied as part of their MIPS APP quality score. In the rare event that an ACO or DCE does not report on quality measures as required by the MSSP, Direct Contracting or REACH Model, the ACO/DCE/REACH participant TINs or clinicians 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. More information on the MSSP APP quality requirements is outlined in our NAACOS resource on APP for ACOs.

MIPS quality measures and scores

ACOs will be scored on a total of 10 measures if reporting Web Interface measures, or 3 measures if voluntarily reporting new APP measures via eCQM or MIPS CQM in MIPS. 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. QPP quality benchmarks are posted to the qpp.gov webpage annually. Tables 62 and 63 of the final 2023 MPFS rule lists the Web Interface and optional APP measures available to ACOs in 2023. More information on measure scoring, including annual changes to measures such as measure suppression policies, please refer to our quality resource.

Benchmarks

CMS will use MIPS APP quality benchmarks to assess performance. For 2023, benchmarks will vary based on the reporting method selected by the ACO (Web Interface, eCQM or MIPS CQM).

Bonus Points

Beginning in 2022, CMS removed the bonus opportunities for reporting high priority/outcomes measures as well as the end-to-end electronic reporting bonus. However, points can be added to the quality score for improvement (more information provided below). For 2023 and subsequent years, ACOs reporting eCQMs or MIPS CQMs who serve a large portion of underserved patients and provide high quality care may be eligible for a new equity bonus; more information is available in our quality resource.

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 APP. 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. 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). Note that any bonus points that might have been achieved in either year will be removed before CMS calculates this comparison.

Clinical Practice Improvement Activities

MACRA introduced a new area of evaluating providers through the CPIA portion of MIPS. 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.

Promoting Interoperability

The Promoting Interoperability (formerly Advancing Care Information) performance category replaces the legacy EHR Incentive Program (Meaningful Use). ECs are required to utilize Certified EHR Technology (CEHRT) to meet the PI criteria. In 2022, CMS continues to require the use of 2015 CEHRT in PY 2022 for a 90-day continuous reporting period. In 2023, the 2015 Edition Cures Update will be required to be used by eligible clinicians participating in the ACO. CMS notes that while duration of use is not specified, ACOs should attest to CEHRT use that is current as of the date of attestation. The MSSP's annual CEHRT attestation shares the same CEHRT edition functionality requirements used in the Promoting Interoperability program. To view a list of products that have been updated to the 2015 Edition Cures Update, visit the Certified Health IT Product List (CHPL).

CMS allows clinicians in ACOs to report PI measures either as an individual or as a group (i.e., TIN). Starting in 2020, 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. ACOs are given one score for this performance category, calculated as an average score of all the clinicians/groups PI score (weighted based on the size of the group). CMS does not incorporate scores for providers excluded from PI in an ACO's weighted average PI score. Table 95 in the 2023 final MPFS rule lists the objectives and measures for the Promoting Interoperability Category in 2023. 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.

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.

Resource Use/Cost

CMS does not calculate a cost performance score for MIPS APMs under the APP, including ACOs. This is due to the fact that ACOs are already being measured on cost in their respective 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.

Performance Category Scoring

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

Complex Patient Bonus

The complex patient bonus will be worth a maximum of ten points, and the bonus will be added to the final MIPS score. CMS assesses 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. CMS limits the bonus to clinicians who have a median or higher value for at least one of the two risk indicators (HCC and dual eligible proportion).

MIPS Scoring Overview

Performance Category	Action Required	Possible Points	Percentage of Overall MIPS Score
Quality	MSSP Web Interface measures reported through the ACO, using WI benchmarks OR voluntarily report new APP measures using MIPS benchmarks (vary based on reporting method selected). Earn up to 10 points per measure based on performance vs. benchmark. Measures are averaged to compile a score for this performance category. NOTE: If CMS determines there is no benchmark for a measure, that measure will be suppressed from the final quality category score Certain bonus points are also available to ACOs (added to final score)	WI = 100 points APP = 60 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 ACO model to determine how 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 established for the performance year, and will make additional adjustments to ensure the overall program remains budget neutral (bonuses awarded equal penalties applied). CMS applies resulting payment adjustments during the applicable payment adjustment year on claims as they are processed (not as a lump sum bonus).

Calculating a MIPS Score

CMS will combine the weighted scores of the performance categories to determine a MIPS final score. An ACO will have one score 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.

If the final MIPS CPS is above the performance threshold set by CMS for the performance year, ECs will receive a positive payment adjustment 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.

MIPS Performance Thresholds

CMS established a 75-point performance threshold for PY 2023 (no change from PY 2022). The program is designed as a budget-neutral program, meaning that MIPS penalties are collected and distributed among those who perform well enough to qualify for positive payment adjustments (bonuses). There is no exceptional performance threshold and additional funding provided for exceptional performers in PY 2023 (corresponding to 2025 payment adjustments). Therefore, there will be considerably less funding and therefore bonuses available in MIPS. From 2019 to 2024 Congress provided an additional $500 million in funding per year for exceptional performers.

The range of maximum bonuses and penalties permitted is detailed in the table below. CMS notes that they anticipate more clinicians will receive a positive adjustment than a negative adjustment, and therefore they expect the MIPS payment adjustment for ECs receiving a perfect MIPS score of 100 points to earn less than 9 percent. Historically, bonuses for those receiving a perfect score of 100 points have earned approximately a 2 percent bonus.

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. As an example, 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

Providers who don't report any information under MIPS will receive an automatic 9 percent MIPS penalty in the corresponding payment adjustment year. MIPS ECs with a final score below the performance threshold of 75 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 final scores 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. Table 99 in the final 2023 MPFS rule outlines an example of the point system and resulting MIPS payment adjustments.

Example of Point System and Resulting MIPS Payment Adjustments

Final Score Points	MIPS Adjustments
0-18.75	MIPS payment adjustment of -9%
18.76-74.99	Negative MIPS payment adjustment greater than -9% and less than 0%
75	Neutral MIPS payment adjustment (no adjustments to payments)
75.01-100	Positive MIPS payment adjustment greater than 0%
See Table 99 in the final 2023 MPFS rule for more information	

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 MIPS 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, 2024 for 2025 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 as well. NAACOS will continue to advocate for CMS to provide relevant, timely and transparent performance information to ACOs on their MIPS performance.

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 Care Compare

MACRA requires CMS to continue to expand the amount of information it shares with the public on

the Medicare Care Compare (formerly named 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.

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 Direct Contracting Model/REACH Model?
No. An ACO's final MIPS score is not used to evaluate ECs or the ACO/DCE/REACH participant for purposes of the MSSP, Direct Contracting or REACH Models and CMS does not foresee ACO programs using the final MIPS score for program evaluation purposes. However, please note starting in 2021 and subsequent years, CMS has transitioned to use of the APP which uses one single quality scoring method and measure set for use in both the MIPS and MSSP programs (for quality assessments specifically).

What happens if an ACO is unsuccessful with quality reporting?
Should an ACO fail to report quality through the MSSP, the ACO participant TINs would be evaluated at the TIN or individual EC level for MIPS. 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 APP. 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 APP.

If we perform well under MIPS, when in 2025 would we receive our MIPS bonus?
MIPS payments will not be made in a lump sum but will be applied as a payment 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?
Clinicians and 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. 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, 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.

Does MIPS require ACOs to report any quality measures outside of the ACO's MSSP quality reporting?
No, ACOs will report Web Interface or APP measures for the MSSP, in addition to the CAHPS for MIPS survey, and are not required to report any additional quality measures for purposes of MIPS. For more information on the changes to MSSP ACO quality assessments under the APP, please refer to our NAACOS resource on the quality requirements under the APP for ACOs.

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 published throughout the year?
No. ACOs do not need to register for the MIPS Web Interface reporting mechanism.

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.

Does the Virtual Group option for MIPS 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?
CMS finalized a policy in 2022 to modify the hierarchy used when multiple final MIPS scores exist for a clinician. Table 73 (p. 65537) of the final 2022 MPFS rule summarizes these changes. Specifically, in 2022 CMS updated the scoring hierarchy to include subgroups and to specify that the scoring hierarchy would apply with respect to any available final score that is associated with a TIN/NPI from MVPs, traditional MIPS, and/or the APP.

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 obtaining that 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.

Is the APP for MIPS the same as the APP for the MSSP?
Yes. Beginning in 2021 and for subsequent years, CMS created the APP to measure and assess quality for ACOs. This APP score will be used for both MSSP and MIPS. More information on how these quality changes impact MSSP shared savings calculations and other details is available in our NAACOS resource on quality requirements under the APP for ACOs.

Is the Web Interface being phased out?
Yes. Despite extensive NAACOS advocacy efforts to maintain this reporting mechanism and measures, beginning in 2025 the Web Interface will no longer be available as a reporting mechanism for ACOs.

Is the MIPS APM Scoring Standard still used for ACOs subject to MIPS?
No, beginning in 2021 and for subsequent years, the MIPS APM Scoring Standard was replaced with the new APP which will assess all APMs subject to MIPS, including ACOs.

The National Association of ACOs (NAACOS) represents more than 8 million beneficiary lives through Medicare's population health-focused payment and delivery models. NAACOS is a member-led and member-owned nonprofit of more than 400 ACOs in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost.

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.

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