Understanding QP Calculations for ACOs

Executive Summary: To qualify for the Advanced APM bonus under MACRA, an ACO participating in an Advanced APM (e.g., the Next Generation ACO Model or MSSP Tracks 1+, 2, 3, Basic Level E, or Enhanced Track) must meet QP thresholds by having a certain proportion of payments or patients "through" the ACO. Only ACOs that meet the QP thresholds will receive the 5 percent bonus available through 2024 or higher annual update in 2026 and beyond. This resource answers questions about the QP calculations and how QP numerators and denominators compare to data ACOs receive from their MSSP or Next Gen participation. While there are similarities between QP attribution and attribution-eligible data and MSSP/Next Gen assigned and assignable data, there are notable differences detailed below. NAACOS continues to advocate for CMS to apply QP policies that are advantageous to ACOs and to simplify QP calculations by aligning the data and definitions used with existing ACO data and definitions.

QP Calculation Background: The QP determination is made separately for each performance year, and the thresholds gradually increase over time. The QP thresholds are set at 50 percent of payments and 35 percent of patients for PY 2019 and PY 2020. In PY 2017 and 2018, CMS only evaluated traditional Medicare payment/patients in making QP determinations. Starting with PY 2019 (2021 payment year) CMS also factors in participation with payers outside of traditional Medicare for ACOs who submit data under the All-Payer Combination Option. CMS makes QP determinations collectively using the group of ECs in an Advanced APM Entity. Therefore, an ACO as a whole is evaluated using the group of ECs associated with the ACO's participant list. Affiliated practitioners, such as Next Gen ACO preferred providers, or providers with a contractual relationship with the ACO are not included in the ACO's QP determination. The QP payment amount thresholds were established in MACRA and CMS defines the patient count thresholds. CMS calculates both the payment amount and patient count thresholds and uses the more advantageous result. ACOs have three chances to meet QP thresholds during a performance year (January 1 through March 31; January 1 through June 30; and January 1 through August 31). ACOs only need to meet the threshold one time. Those that do not meet the QP threshold but meet a lower threshold, the Partial QP threshold, are not eligible for Advanced APM bonuses and have an option to participate in the MIPS. More details on the QP calculations and thresholds are included in NAACOS' ACO Guide to MACRA, available to NAACOS members here.

Acronyms

APM: Alternative Payment Model
AYs: Alignment Years
CCLFs: Claim and Claim Line Feeds
ECs: Eligible Clinicians
E/M: Evaluation and Management
ETA: Electing Teaching Amendment
FQHC: Federally Qualified Health Center
MACRA: Medicare Access and CHIP Reauthorization Act of 2015
MIPS: Merit-based Incentive Payment System
MSSP: Medicare Shared Savings Program
NPP: Non-physician Practitioner
PY: Performance Year
QEM: Qualifying Evaluation and Management
QP: Qualifying APM Participant
RHC: Rural Health Center

Predictive QP Status Analysis: To give Advanced APM Entities a sense of whether they would likely meet QP thresholds in PY 2019, CMS conducted a predictive QP status analysis. This was done for those participating in an Advanced APM in PY 2019 and was based on claims from January 1 through August 31, 2018, which were processed from January 1 through November 29, 2018. The predictive analysis is meant to give ACOs a sense of where they stand relative to the QP thresholds. However, this analysis has no bearing on whether ACOs will actually meet the QP thresholds in PY 2019 as those determinations are made based on 2019 data during the snapshot periods.

Key MACRA Resources

- CMS Factsheet: *Qualifying Alternative Payment Model Participants Methodology Fact Sheet: Medicare Option 2019 Performance Period*
- CMS Advanced APM webpage
- NAACOS resource: *The ACO Guide to MACRA*
- NAACOS MACRA webpage with numerous MACRA-related updates, resources and advocacy initiatives

Are MSSP "assignable" beneficiaries the same group of beneficiaries that are "attribution-eligible" for QPP?

No. While there is likely a notable overlap between these two populations, there are meaningful differences between them based on a variety of factors, including using different primary care codes and different providers to identify the beneficiary populations. For example, an attribution-eligible beneficiary for the QP calculation includes a beneficiary who receives certain primary care services from an EC in the ACO, regardless of specialty. ECs under MACRA also include more than just physicians, so receiving a qualifying service from a NPP identified in the table below causes a beneficiary to be counted as attribution-eligible for QP calculations. CMS examines ECs' professional, Critical Access Hospitals billed under Method II (CAH II), FQHC and RHC claims to determine attribution-eligible beneficiaries. This is different from the MSSP definition of assignable, which includes beneficiaries who received at least one primary care service from a Medicare-enrolled physician who is a primary care physician or who has one of the specialty designations included in §425.402(c). If a beneficiary only receives a service from a physician not used in MSSP assignment (i.e., a specialty not included in assignment) OR only sees an NPP and there has been no qualifying physician visit during the most recent 12 months included in the quarterly report, the beneficiary would not be included as an assignable beneficiary in the quarterly report.

The timeframes are also different, with CMS looking at certain snapshot periods for QP determinations and focusing on dates of service during a specified 12-month window for ACO assignment. The list of primary care services also differs across QP determinations and ACO assignment. The specific primary care codes and timeframes are shown in the table on the following page.

To be included in the numerator or denominator of the QP calculation, a beneficiary must have received a Part B covered professional service during the QP determination period in question. If the beneficiary did not receive a Part B covered professional service during the determination period, that beneficiary would not be included in the QP calculation. In contrast, for the purposes of MSSP assignment, if a beneficiary does not receive any service during a quarter from the ACO, he or she still shows up as an assigned beneficiary on the ACO's quarterly report for an ACO with prospective assignment. For ACOs with preliminary prospective assignment with retrospective reconciliation, Medicare assigns beneficiaries in a preliminary manner at the beginning of a performance year based on most recent data available and provides updated quarterly data based on the most recent 12 months of data. Therefore, a beneficiary would need to receive the plurality of care from the ACO during the most recent 12 months of data included in the quarterly report, but a beneficiary may not have received a service during the quarter.

In summary, there are key differences between the populations used in the QP calculation (attributed beneficiaries / attribution-eligible beneficiaries) as compared to a calculation of ACO assigned/assignable beneficiaries.

Table A: Comparison of QP and ACO Calculations

Issue	QP Calculation	MSSP Assignment	Next Gen Assignment
Clinicians	Eligible clinicians for the purposes of QP calculations include those on the ACO's participant list at a given time. CMS uses the most recent list available on CMS-maintained systems at the time of the QP determinations. Provider types referenced in the definition of eligible clinician include: physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, anesthesiologist assistant, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, physical or occupational therapist, and qualified speech-language pathologist or qualified audiologist. *Note: QP calculations do not factor in Next Gen Affiliated Practitioners.*	MSSP uses full TIN participation but not all providers are included in the MSSP assignment methodology. MSSP assignment requires a visit from a physician. Assignment focuses on physicians (primary care and select specialties identified in regulations) and considers select NPPs. An overview of MSSP assignment is available here.	Next Gen uses TIN-NPI level assignment, so individual NPIs are identified as Next Gen Participants. Next Gen also includes Preferred Providers who are not used for alignment.
Attributed or Assigned beneficiaries	Attributed beneficiaries during the QP performance period: number of unique beneficiaries attributed to the ACO for the patient count method and aggregate payments for Part B covered professional services furnished to attributed beneficiaries for the payment amount method.	Assigned beneficiaries are determined for each ACO based on the plurality of primary care services provided by an ACO's clinicians to beneficiaries meeting certain criteria. ACOs can select from preliminary prospective assignment with retrospective reconciliation (often referred to as retrospective reconciliation) or prospective assignment. Beneficiaries are also assigned via voluntary alignment. Specific rules and timeframes related to MSSP assignment are available in this CMS resource.	Assigned beneficiaries are determined for each ACO based on the plurality of primary care services provided by an ACO's Participants to beneficiaries meeting certain criteria. Beneficiaries are also assigned via voluntary alignment. Assignment is prospective.

Attribution-eligible / Assignable Beneficiaries	QP calculations use attribution-eligible beneficiaries for the denominator. An attribution-eligible beneficiary includes a beneficiary who receives certain primary care services (identified below) from an EC in the ACO (see details above) during a snapshot period.	Assignable beneficiaries are noted in MSSP quarterly and annual assignment reports and CCLFs. Assignable beneficiaries include those who received at least one primary care service (identified below) from a Medicare-enrolled physician who is a primary care physician or who has one of the specialty designations included in §425.402(c).	Beneficiaries included in the Next Gen ACO Initial Alignment Report are beneficiaries identified as having at least one paid claim for a qualifying E/M service during the two-year alignment period.
Primary care services to identify beneficiaries	Beginning with PY 2018, beneficiaries are attribution-eligible if they receive one of the following services during the QP determination HCPCS codes 99201 – 99499 or G-codes G0402, G0438, G0439, G0463, G0466, G0467, G0469, G0470, G0511 or G0512.	MSSP assignment focuses on the following primary care services, CPT codes/G-codes: 99201 through 99215; 99304 through 99318 (codes for professional services furnished in a nursing facility; services identified by these codes furnished in a SNF are excluded). 99319 through 99340; 99341 through 99350 (codes for E/M services furnished in a patients' home for claims identified by place of service modifier 12); 99487, 99489 and 99490; 99495 through 99498; 96160 and 96161; 99354 and 99355; 99484, 99492, 99493 and 99494. G0402, G0438, G0439, G0463 for services furnished in ETA hospitals, G0506, G0444, G0442, and G0443.	Assignment is based on QEM services. QEMs are identified by the following CPT codes/G-codes: 94201-215, 99324-337, 99339-99340, 99341-99345, 99347-99350, 99495-99496, 99490, G0402, G0438, G0439.
Timeframes	QP determinations are made based on the information (pulled from the group of clinicians and beneficiaries) during a snapshot period during the performance period, of which there are three: January 1 through March 30 January 1 through June 30 January 1 through August 31	MSSP identifies beneficiaries for assignment based on a 12-month assignment window (January through December for those with retrospective assignment and October 1 through September 30 for those with prospective assignment). For identifying assignable beneficiaries in quarterly reports, CMS evaluates data from the most recent 12-month window.	Each PY is associated with two AYs. The first AY for a PY is the 12-month period ending 18 months prior to the start of the PY. The second AY is the 12-month period ending 6 months prior to the start of the PY. E.g., AYs for PY 2016 were 07/01/2013-06/30/2014 and 07/01/2014-06/30/2015.