

The ACO Guide to MACRA

Updated September 2017

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Executive Summary

This guide is intended to educate ACOs on the ACO-specific information they need to understand MACRA's 2017 Quality Payment Program (QPP) requirements. We continue to update this resource as more information becomes available from CMS. Additionally, we have created a [summary](#) of the proposed 2018 MACRA QPP requirements. If you wish to share feedback with us on this resource or pose questions about MACRA implementation, please contact us at advocacy@naacos.com

Background: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law April 16, 2015 and is one of the most significant laws affecting Medicare since the program's inception in 1965. MACRA was a bipartisan effort that repealed the sustainable growth rate formula and sets Medicare physician payment on a new course.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 items and services. There are annual 0.5 percent updates each year through 2019, after which point the automatic payment updates will be flat until 2026.

Since MACRA's passage, the Centers for Medicare & Medicaid Services (CMS) has been working to implement the law. In October, 2016 CMS released a comprehensive final rule implementing the key details of MACRA for the 2017 performance year, and this guide summarizes the main ACO-related provisions of that rule. For more information on the proposed 2018 requirements, please access our [summary](#) of the CMS proposed 2018 Quality Payment Program (QPP) rule.

Overview of MACRA

MACRA creates two paths for Medicare Part B providers: participation in an Advanced Alternative Payment Model (APM) or in the Merit-Based Incentive Payment System (MIPS). Both Advanced APM and MIPS participation rely on a two-year lag between performance/reporting years and payment adjustment years. Reporting begins in 2017 which corresponds to payment adjustments in 2019. CMS will continue to use a two-year lag between performance and payment adjustment years moving forward, with 2018 performance corresponding to 2020 payment adjustments, 2019 performance corresponding to 2021 payments, and so on.

MACRA rewards providers in eligible APMs, which CMS refers to as Advanced APMs and includes a number of benefits for ACOs. While Medicare ACO models are considered APMs, some ACOs won't qualify as Advanced APMs based on whether their ACO takes on risk through the Medicare Shared Savings Program (MSSP) Tracks 2, 3, or the Next Generation model, or meets other criteria. Eligible clinicians, who participate in Advanced APMs and meet other requirements, will earn a 5 percent bonus from 2019 through 2024. Further, beginning in 2026, clinicians in Advanced APMs will receive an annual update of 0.75 percent compared to those not in Advanced APMs, who will receive annual updates of 0.25 percent. These payment adjustments are separate from bonuses/penalties from the APM itself, such as shared savings or loss payments for ACOs.

To be considered an Advanced APM, a payment model has to meet certain criteria such as requiring use of an Electronic Health Record (EHR) 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. The thresholds are referred to as the Qualifying APM Professional (QP) thresholds, and only Advanced APM participants who meet the QP threshold will receive the 5 percent bonus or higher annual update. Providers in Advanced APMs who meet QP thresholds are exempt from reporting requirements and payment adjustments under MIPS.

For 2017, CMS finalized a list of Advanced APMs including:

- MSSP Tracks 2 and 3
- Next Generation ACO model
- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement and non-LDO two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC +)
- Oncology Care Model (two-sided risk arrangement)

The complete list of Advanced APMs is available on this CMS [webpage](#).

NAACOS has repeatedly advocated that CMS use an inclusive approach when identifying which APMs qualify as “Advanced.” We are very pleased that the MSSP Tracks 2 and 3 and the Next Generation ACO model are on the 2017 Advanced APM list, but we are disappointed MSSP Track 1 is not included. We strongly advocate that CMS include all Medicare ACOs, including MSSP Track 1 ACOs as Advanced APMs. While MSSP Track 1 is not included, we are pleased that CMS is creating a new ACO model, Track 1+, which begins in 2018 and qualifies as an Advanced APM. We have been strongly urging CMS to create this new option for ACOs and are working closely with the agency on its development.

Providers who are not in an Advanced APM will participate in MIPS, which is the default program for Medicare Part B. MIPS consolidates three existing Medicare Part B quality reporting programs: the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the eligible professional Medicare EHR Incentive Program (Meaningful Use). Reporting for these programs ends December 31, 2016, and providers transition to reporting under MIPS beginning in 2017. One of the goals of MACRA was to streamline reporting requirements under these three disparate programs to alleviate administrative burdens on providers. MIPS evaluates eligible clinicians based on performance categories including quality, cost, use of certified EHR technology (i.e., 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 population. NAACOS advocacy has repeatedly called for CMS to reward ACOs under MIPS and to ease and streamline reporting burdens, and we are pleased to see many of the provisions CMS finalized for ACOs in MIPS.

Among others, CMS’s final list of 2017 MIPS APMs includes:

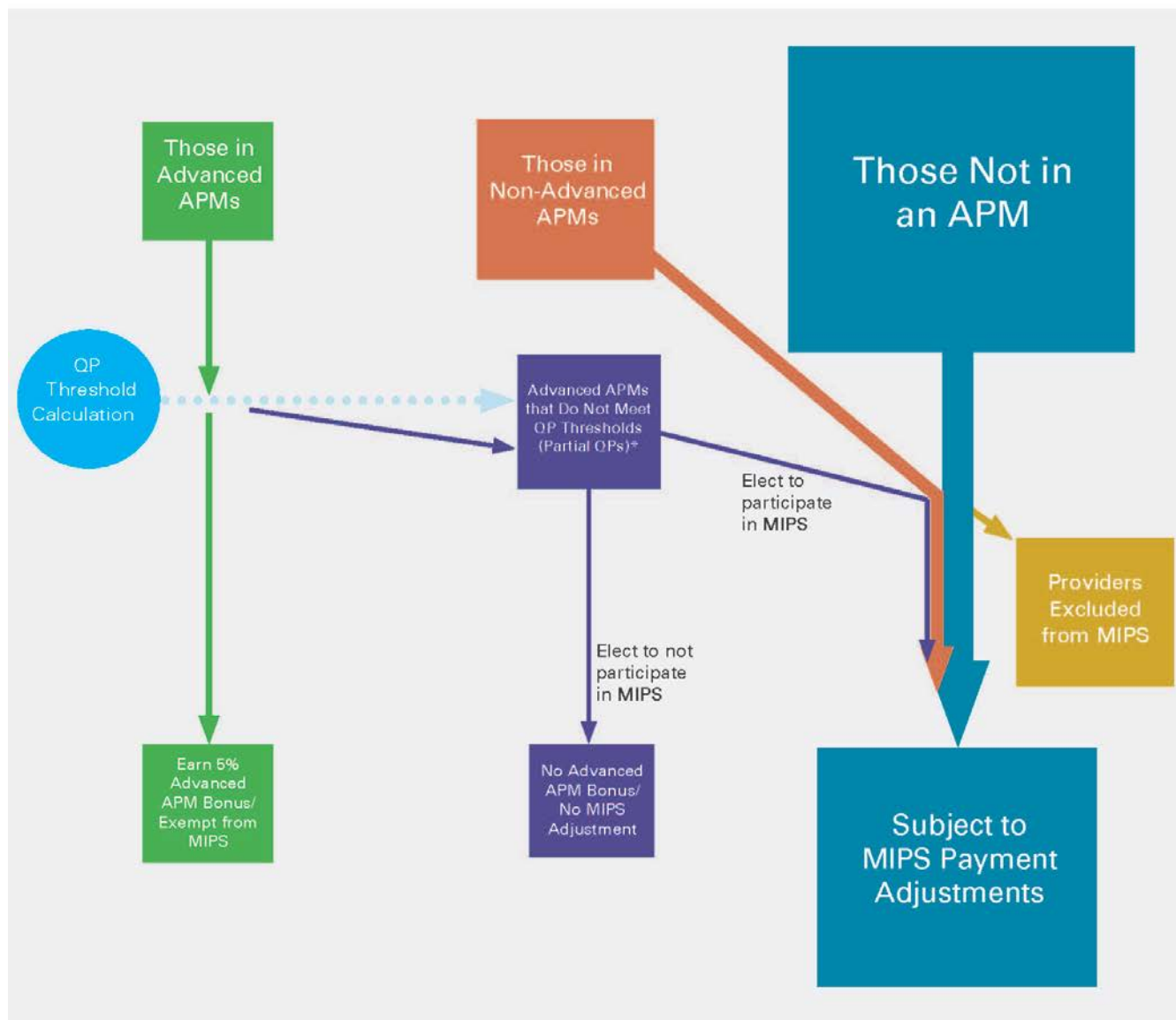
- MSSP Tracks 1, 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- Oncology Care Model (all arrangements)
- CPC+ Model

MACRA

Medicare Part B Eligible Clinicians

The boxes in this graphic represent the approximate sizes of the respective populations for the first year of the program, 2017 performance which corresponds to 2019 payment adjustments.

Acronyms: **APM** is an Alternative Payment Model, **QP** refers to Qualifying APM Professional, and **MIPS** is the Merit-Based Incentive Payment System



**CMS estimates that few if any Advanced APM Entities would fail to meet QP thresholds in early years of the program.*



MACRA Resources

Resources from CMS

- The Final MACRA [Rule](#) and CMS's main QPP education [page](#)
- Information about 2017 APMs, including those CMS considers MIPS APMs, is available in this [CMS resource](#).
- CMS Executive [Summary](#) of the final MACRA Rule and CMS Quality Payment Program [Factsheet](#)

NAACOS Resources

- MACRA [webpage](#) includes information and comment letters on MACRA implementation.
- NAACOS Webinars available on-demand [here](#).

Summer, 2017

- **MACRA Advanced APMs: Update and Proposals for 2018**
In June 2017, CMS released a proposed rule with detailed proposals affecting MACRA QPP. This webinar reviews the 2018 proposals for Advanced APMs and provides an update on 2017 Advanced APMs and frequently asked questions.
- **Understanding CMS Proposed Changes to the Merit-Based Incentive Payment System (MIPS) for 2018**
This webinar reviews key changes to MIPS proposed for 2018 and is tailored to ACOs specifically, outlining the requirements of the APM Scoring Standard applicable to ACOs in MIPS.

Fall 2016, following release of the final MACRA rule

- **Overview of Final MACRA Rule: Implications for ACOs**
This webinar reviews the main structure of the Quality Payment Program and its two paths: MIPS and Advanced APMs, with a particular emphasis on the ACO-specific details under the final rule.
- **MACRA Advanced Alternative Payment Models: Deep Dive for ACOs**
This webinar reviews the key components of CMS's evaluation and determination of Advanced APMs and walks through what ACO Advanced APMs need to know about payment adjustments. We also discuss CMS's plans to develop a new ACO model, Track 1+.
- **MACRA Merit-Based Incentive Payment System: Deep Dive for ACOs**
This webinar walks through the MIPS program and discusses what ACOs need to do for 2017 reporting, which corresponds to 2019 payment adjustments. We review each of the performance categories, CMS's reporting requirements, how ACOs in MIPS are evaluated and what to expect for the first MIPS payment adjustments.
- **ACO Reactions to MACRA Final Rule: Discussion and Planning for the Future**
This final webinar includes reactions from ACOs on the MACRA final rule and a discussion of how they are preparing for the transition to MACRA. We review popular audience questions from previous MACRA webinars, take additional questions and discuss audience polling questions.

Benefits to ACOs under MACRA

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

Key Benefits for ACOs in MIPS (Track 1 ACOs)

Please refer to the MIPS section of this guide for more specific details on the following benefits. Also, readers should carefully review the section on MIPS payment adjustments since the expectations for 2019 MIPS bonuses have significantly decreased as a result of CMS easing program criteria to allow the vast majority of providers to avoid penalties in 2017.

- ACOs in MIPS receive advantages by being scored under the MIPS APM Scoring Standard, which gives ACOs favorable treatment for their commitment to value-based care.
- Based on the low bar set for 2017 reporting in MIPS, ACOs should easily avoid penalties under MIPS and will be eligible for MIPS bonuses and exceptional performance bonuses.
- ACOs are given full credit for the CPIA performance category based on their ACO participation.
- ACOs do not have additional quality reporting requirements under MIPS since the MSSP quality reporting is used for the MIPS quality performance category.
- CMS will use MSSP Web Interface quality reporting to set the MIPS benchmarks for group practices and ACOs in MIPS that report quality via the Web Interface. For quality, ACOs will only be compared to those reporting through the Web Interface.
- CMS aligned reporting of the Advancing Care Information performance category and MSSP reporting of Measure 11
- ACOs are not evaluated on cost (non-ACO providers are evaluated on cost beginning in 2018). This exception allows ACOs to avoid an evaluation of their resource use that would be different from their MSSP evaluation, using an approach and benchmarks that conflict with the MSSP.
- The significant investments ACOs have made in quality, care coordination, data analytics and health IT will be an advantage for ACOs that are evaluated under MIPS and will favorably position ACOs compared to other providers who have not made these investments.
- CMS evaluates an ACO as one cohesive entity and will apply the same MIPS score to all eligible clinicians 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.
- Track 1 ACOs will be eligible to participate in the new Track 1+ when that model becomes available in 2018 and Track 1+ ACOs will qualify as Advanced APMs.

Key Benefits for Advanced APM ACOs (ex. MSSP Track 2, 3 and Next Generation ACOs)

Please refer to the Advanced APM section of this Guide for more information on the benefits below. Readers should note that ACOs must meet the Qualifying APM Professional (QP) thresholds to be Advanced APMs that earn the 5 percent bonus or higher annual updates. These benefits are for ACOs in MSSP Tracks 2, 3, and the Next Generation model and will be applicable to ACOs in Track 1+, which will be available in 2018 and will qualify as an Advanced APM.

- Advanced APM ACOs that meet the QP thresholds earn a 5 percent bonus annually from 2019 through 2024. This bonus is in addition to shared savings the ACO can earn through MSSP or the Next Generation ACO model.

- Beginning in 2026, Advanced APM ACOs that meet QP thresholds will have higher guaranteed annual payment increases of 0.75 percent, as opposed to the annual increases of 0.25 percent for providers not in Advanced APMs.
- Based on the policies finalized by CMS regarding QP determinations, ACOs will know as early as August during the performance year if they meet the QP thresholds. CMS estimates that in early program years, the vast majority of Advanced APM ACOs will meet the QP thresholds.
- Those who fall short of the QP thresholds, known as Partial QPs, have the option of whether to report MIPS.
- Advanced APMs are given credit for APM participation with payers other than Medicare beginning with 2019 performance/2021 payment.
- Being a part of an Advanced APM means the ACO's participants avoid MIPS, thus allowing them to concentrate on achieving the goals of the ACO and avoiding distractions from other CMS requirements.
- Participating in an Advanced APM ACO offers the opportunity for providers to be on the cutting edge of innovation in healthcare delivery.

Track 1+

NAACOS has long advocated for a glide path to risk through a new lower risk ACO model. With growing calls for ACOs to take on risk and time limits to Track 1 participation, it's important to recognize that the other Medicare ACO models with downside risk require too much risk for most ACOs. The final MACRA rule included CMS's plans to introduce a new ACO risk model, Track 1+, which requires a lower level of risk, should losses occur. We are very pleased that CMS recognizes the need for a new model and is introducing Track 1+, which will be available starting in 2018 and will qualify as an Advanced APM. CMS took important steps to develop Track 1+ and the model is detailed in this CMS [factsheet](#). NAACOS continues to advocate for changes on Track 1+, which is a top advocacy priority that we are working on with the administration and leaders in Congress.

In the factsheet, CMS explains that Track 1+:

- Requires downside risk with two possible risk arrangements that include either a revenue- or benchmark-based loss sharing limit. CMS determines which risk arrangement applies for a particular ACO after evaluating the following criteria:
 - The ACO includes an ACO participant (as identified by Taxpayer Identification Numbers / CMS Certification Numbers) that is an inpatient prospective payment system (IPPS) hospital, cancer center, or a rural hospital with more than 100 beds, or is owned or operated by, in whole or in part, such a hospital or by an organization that owns or operates such a hospital.

If at least one of these criteria are met, the ACO's loss sharing limit will be 4 percent of the ACO's updated historical benchmark.

If none of these criteria are met, the ACO's loss sharing limit would be 8 percent of ACO participant Medicare fee-for-service (FFS) revenue (which would include total Parts A and B FFS revenue for ACO participants that are rural hospitals with 100 or fewer beds) in year 1 (2018). In years 2 and 3 (2019 and 2020), if the nominal risk requirement revenue standard for Advanced APMs under the Quality Payment Program increases above 8 percent of APM Entity revenues, ACOs in the Track 1+ Model with a revenue-based loss sharing limit would be offered the option to accept higher risk in order to continue to be considered participants in an Advanced APM. In subsequent years of the Model, the loss sharing limit will be aligned with the required nominal amount for Advanced APMs. If the loss limit, as a percentage of ACO participants' FFS revenue exceeds the amount that is 4 percent of the ACO's updated historical benchmark, then the loss limit would be capped and set at 4 percent of the updated historical benchmark.

Other Track 1+ details include that it will:

- Qualify as an Advanced APM, allowing Track 1+ eligible clinicians to earn the 5 percent Advanced APM bonus provided other criteria are met.
- Limit how long an ACO can participate in this model
 - New ACOs are permitted to participate for one three-year agreement period.
 - Current Track 1 ACOs that transition to Track 1+ during their existing agreement period have the opportunity to renew for a subsequent three-year agreement period in Track 1+.
- Include the same rebased benchmarking [methodology](#) CMS finalized in 2016 regulations for all MSSP ACOs. Note: because CMS considers a Track 1 ACO that moves into Track 1+ to be

continuing in its same agreement period, the new rebasing methodology would not apply until the start of a subsequent agreement period.

- Be available for participation beginning in 2018 with an application cycle that aligns with the normal MSSP application cycle
- Include a maximum sharing rate of 50 percent and a marginal loss rate of 30 percent
- Utilize prospective beneficiary assignment
- Allow choice of symmetrical minimum savings and minimum loss rates
- Include the option to elect the SNF 3-Day Rule Waiver

For more information on how Track 1+ compares to other MSSP tracks and the Next Generation ACO model, please refer to the NAACOS ACO Comparison [Chart](#).

2017 Transition Year

Many providers voiced concern about the transition to MIPS reporting in 2017, with specific concerns about program complexity, not having sufficient time to understand the program before being measured, and potentially receiving negative MIPS payment adjustments. CMS considered this feedback and responded by easing program requirements for 2017 MIPS reporting. CMS finalized a “pick your pace” approach for 2017 that includes three options for providers required to report under the MIPS and a fourth option for those in Advanced APMs.

The three MIPS options below provide flexibility but do not change existing ACO program requirements, which would have to be modified through the MSSP or Next Generation program. Therefore, ACOs are still required to follow MSSP/Next Generation program requirements including full year quality reporting. MIPS eligible clinicians who don't send any data in 2017 will receive an automatic 4 percent penalty in 2019. CMS reiterates that providers in Advanced APMs who meet QP thresholds in 2017 are exempt from MIPS reporting and would earn a 5 percent bonus in 2019. It's important to note that CMS's final policy, which allows the majority of providers to avoid MIPS penalties, also means there will be less money available to fund MIPS bonuses. Readers should refer to the [MIPS Payment Adjustment section](#) for more information.

First Option: Test

Providers must submit a minimum amount of data to Medicare (e.g., one quality measure or one clinical practice improvement activity) to ensure adequate system capabilities prior to broader participation in 2018 and 2019. This approach allows providers to avoid penalties but would not qualify them for bonuses.

For the second and third options, the size of a specific MIPS payment adjustment will depend on how much data is submitted and the quality results.

Second Option: Continuous 90-day reporting

Eligible clinicians may choose to submit MIPS information for a continuous 90-day period rather than the full-year reporting CMS proposed, thus allowing more time for preparation. Reporting would have to begin by October 2, 2017 at the latest. This option allows eligible clinicians to qualify for a neutral or small positive payment adjustment.

Third Option: Participate for the full calendar year

For those ready to report on January 1, 2017, they may choose to submit MIPS information for a full calendar year. Submitting information for the entire calendar allow these providers to qualify for a moderate positive payment adjustment.

Fourth Option: Participate in an Advanced APM

Providers participating in Advanced APMs that meet the QP threshold avoid MIPS reporting and qualify for a 5 percent in 2019.

Advanced Alternative Payment Models

Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is designed to shift Medicare physician payments from a system based on fee for service (FFS) to one based on value. MACRA rewards providers in eligible Alternative Payment Models (APMs), which the Centers for Medicare and Medicaid Services (CMS) refers to as Advanced APMs. Eligible clinicians who participate in Advanced APMs and meet other criteria will earn a 5 percent bonus from 2019 through 2024. Further, beginning in 2026, clinicians in Advanced APMs will receive an annual update of 0.75 percent compared to those not in Advanced APMs, which will receive an annual update of 0.25 percent. These payment adjustments are separate from an ACO's shared savings or losses from the MSSP or Next Generation ACO model. CMS uses a two-year lag between Advanced APM participation and payment adjustment years with 2017 participation corresponding to 2019 payments, 2018 participation corresponding to 2020 payments, and so on.

To be considered an Advanced APM, a payment model has to meet certain criteria such as requiring use of an EHR and basing payments in part on quality measures comparable to those used in Merit-based Incentive Payment System (MIPS). Advanced APMs also have to meet certain risk criteria, and CMS made significant changes to the required levels and structure of risk in the final rule, which is explained in more detail below. 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. The thresholds are referred to as the Qualifying APM Professional (QP) thresholds, and only Advanced APM Entities, such as an ACO, that meet the QP threshold will receive the 5 percent bonus or higher annual update.

For 2017, CMS finalized a list of Advanced APMs including:

- MSSP Tracks 2 and 3
- Next Generation ACO model
- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement and non-LDO two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC +)
- Oncology Care Model (two-sided risk arrangement)

The complete list of Advanced APMs is available on this CMS [webpage](#).

Providers in Advanced APMs that meet QP thresholds are exempt from reporting requirements and payment adjustments under MIPS. Advanced APMs, including ACOs in MSSP Tracks 2 and 3 and Next Generation ACOs, which don't meet QP thresholds but do meet a lower bar (i.e., the Partial QP threshold), have the option of participating in MIPS. Advanced APM determinations are made each year independent of past year's performance.

NAACOS has repeatedly advocated for CMS to use an inclusive approach when identifying which APMs qualify as "advanced." We are very pleased that the MSSP Tracks 2 and 3 and the Next Generation ACO model are on the 2017 Advanced APM list, but we are disappointed MSSP Track 1 was not included. We strongly advocate that CMS include all Medicare ACOs, including MSSP Track 1 ACOs as Advanced APMs. While MSSP Track 1 is not included, CMS created Track 1+ which begins in 2018 and qualifies as an

Advanced APM. NAACOS has strongly supported and been instrumental in developing the Track 1+ ACO model.

APM Definitions

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

- **APM (e.g. MSSP Track 1)**
 - A Medicare payment and/or delivery model 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) The Medicare Shared Savings Program (MSSP)
 - (3) A demonstration under section 1866C of the Social Security Act
 - (4) A demonstration required by Federal law
- **Advanced APM (e.g. MSSP Track 3)**
 - An APM that meets specific requirements to qualify as Advanced, outlined in the following section
- **APM Entity (e.g. a specific MSSP ACO)**
 - An entity that participates in an APM through an agreement with CMS (and/or in later years participates with a non-Medicare payer)
- **APM Entity Group (e.g. ACO Participant TIN)**
 - The group of eligible clinicians 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 eligible clinicians.

Advanced APM Criteria

MACRA includes requirements for an APM to be considered an “eligible” APM, or as CMS refers to it as an “Advanced” APM. These criteria must be met in the design of the APM, so for an ACO, the criteria must be for a specific ACO model or ACO track, including the Next Generation model and each track within the MSSP.

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

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

All MSSP tracks and the Next Generation ACO model meet the first two criteria, but the financial risk requirement is the key component of CMS’s determination for which ACO tracks/models qualify as Advanced APMs. NAACOS has repeatedly urged CMS to set the required risk at a reasonable level and to account for the significant investments ACOs make to participate in the program and provide high quality, coordinated care to beneficiaries. 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 finalized a general policy that an Advanced APM require at least 50 percent of eligible clinicians use certified health IT functions as outlined in the definition of Certified EHR Technology (CEHRT). There is a slight modification for ACOs that acknowledges the existing MSSP requirements for CEHRT through reporting ACO measure 11 (Use of Certified EHR Technology). Through the alternative criteria finalized for ACOs, they will meet the CEHRT use requirement if the APM Entity applies a financial penalty or reward based on the degree of their eligible clinicians’ use of CEHRT, and MSSP ACOs currently meet this requirement through ACO measure 11. The definition of CEHRT is the same across MIPS and APMs and can be met by using an EHR certified by the ONC Health IT Certification Program. Specifically, for 2017 performance the CEHRT must be certified to either the 2014 or 2015 Edition certification criteria and in 2018 providers may continue to use either 2014 or 2015 Edition CEHRT.

Quality Measures Comparable to MIPS

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

Financial Risk Standard

Generally Applicable Risk Standard

CMS finalized its proposal that 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 and/or the APM Entity’s eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians; or
- Require the APM Entity to owe payment(s) to CMS.

ACOs are evaluated under this risk standard, but it does not apply APMs considered under the Medical Home Model standard.

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 under which the APM Entity could lose the right to all or part of an otherwise guaranteed payment or payments. This would apply if either:

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

Nominal Risk Standard

In addition to meeting the financial risk standard, MACRA requires APMs to meet a nominal risk standard. This is designed to ensure APMs have enough at risk to qualify them as Advanced APMs eligible to earn the 5 percent bonus and higher 0.75 percent annual update. CMS finalized a policy that full capitation arrangements would automatically meet the Advanced APM financial risk criterion and all other payment arrangements would be assessed against the applicable nominal amount standards set forth in the final rule. Similar to the financial risk standard, CMS finalized one set of nominal risk criteria that is generally applicable to APMs (including ACOs) and another set of criteria for Medical Home Models, which sets a lower bar for those in the latter category.

Generally Applicable Nominal Risk Standard (Applicable to ACOs)

NAACOS strongly urged CMS to reduce the proposed levels of risk the agency included in its MACRA Notice of Proposed Rule Making (NPRM), and we are very pleased to see the agency made significant changes to both simplify and reduce the generally applicable nominal risk standard.

Specifically, 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:

- For 2017 and 2018 performance periods, 8 percent of the average estimated total Medicare Parts A and B revenues of a participating APM Entity (the revenue-based standard); or
- For all performance periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the benchmark-based standard)

CMS did not finalize required thresholds for marginal risk or minimum loss rates. If an APM's financial design meets either of the two nominal amount standards, CMS would consider the nominal amount standard to be met. The 8 percent revenue-based standard will be available for the first two performance periods in 2017 and 2018, but the agency states its intent to increase the standard in 2019 and later years. CMS will weigh public comments to assess the impact of the standard before establishing a revised nominal amount standard for 2019 and later, and NAACOS will be closely engaged in this process. These thresholds also provide a guide for new APMs that may be developed in the future, such as MSSP Track 1+, which CMS states would be designed to meet the criteria enabling Track 1+ to qualify as an Advanced APM. Please refer to the MSSP [Track 1+ section](#) of this guide for more details on that model.

CMS did not finalize a mechanism through which the agency would account for an APM Entity's investments or costs and count those towards an APM Entity meeting the nominal risk criterion. 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. As a reminder, current limits on the maximum amount of losses to be shared by an ACO include:

- **MSSP Track 2:** Phases in over three years, starting at 5 percent in year 1; 7.5 percent in year two; and 10 percent in year three and any subsequent year.
- **MSSP Track 3:** 15 percent
- **Next Generation ACO model:** 5 to 15 percent

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

The nominal risk standard for APMs evaluated as Medical Home Models, such as CPC+, is different than that used to evaluate other APMs. Under the Medical Home Model standard, an APM is considered to meet the nominal risk standard 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, 3 percent of the APM Entity's total Medicare Parts A and B revenue
- In 2019, 4 percent of the APM Entity's total Medicare Parts A and B revenue
- In 2020 and later, 5 percent of the APM Entity's total Medicare Parts A and B revenue

Medical Home Model Size Restrictions

As required by MACRA and finalized by CMS, the Medical Home Model standards are more flexible. APMs evaluated under this standard must meet the financial and nominal risk criteria, and beginning in 2018 they must also meet size restrictions for the APM Entities within a Medical Home Model APM. Specifically, starting with the 2018 performance period, such APM Entities must be owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities. Starting in 2018, the Medical Home Model Advanced APM financial risk standard would not apply for APM Entities that are owned and operated by organizations with greater than 50 eligible clinicians. This information may be important to share if, for example, a Track 1 ACO has a primary care practice that is considering leaving the ACO to pursue CPC+ on their own in order to qualify for the Advanced APM bonus. More information on the overlap of ACO and CPC+ programs is available in this NAACOS [resource](#).

2017 Advanced APMs

Based on APM evaluations explained in the preceding sections, CMS finalized a list of 2017 Advanced APMs including:

- MSSP Tracks 2 and 3
- Next Generation ACO model
- Comprehensive ESRD Care Model (LDO arrangement and non-LDO two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (two-sided risk arrangement)

The complete list of Advanced APMs is available in this [CMS resource](#).

CMS Plans for More Advanced APMs in the Future

CMS plans to develop new APMs that could be Advanced APMs and will reopen certain APMs for additional application rounds, such as CPC+ and the Next Generation ACO model in 2018. Further, CMS plans to amend the design of certain APMs so that they meet the Advanced APM criteria.

Qualifying APM Professional Thresholds

APM Entities (e.g., a Next Generation ACO) that participate in an Advanced APM are also required to have a certain proportion of payments made “through” the APM. They can also meet this requirement based on patient counts through the APM. These thresholds are referred to as the Qualifying APM Professional (QP) thresholds, and only Advanced APM Entities that meet the QP threshold will receive the 5 percent bonus or higher annual update in 2026 and beyond.

The QP determination is made separately for each performance year, and the thresholds are lower in the beginning of the program and gradually increase over time. In the first two years of the program, CMS will only evaluate traditional Medicare payment/patients in making the QP determination. But starting with 2019 performance which corresponds to 2021 payments, CMS will also factor in an Advanced APM Entity’s participation with payers outside of traditional Medicare. It’s important to note that Medicare Advantage is not included in the evaluation for traditional Medicare but would be included in the evaluations of payers outside of traditional Medicare beginning with 2019 performance. Please refer to the section on the All-Payer Combination Option for more information. CMS will make QP determinations collectively using the group of eligible clinicians in an Advanced APM Entity. Therefore, an ACO as a whole will be evaluated in the QP determination using the ACO’s Participation List. Affiliated practitioners, such as with Next Generation ACOs, or providers with a contractual relationship with the ACO will not be included in the QP determination.

The QP payment thresholds were established in MACRA and CMS finalized the patient count thresholds below. CMS will calculate the QP threshold scores using both the payment and patient count approaches and will apply the more advantageous QP result.

Payment and Patient Count Threshold for Meeting QP Determination

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

QP Calculation

Payment Approach

CMS generally interprets payments “through” an Advanced APM Entity to mean payments made by CMS for services furnished to attributed beneficiaries, who are the beneficiaries for whose costs and quality

of care an Advanced APM Entity is responsible under the Advanced APM. To calculate the QP payment threshold, CMS specifically focuses on payments for Medicare Part B covered professional services, which include services for which payment is made under, or based on, the Medicare Physician Fee Schedule (PFS). The numerator of the QP calculation includes the aggregate of all payments for Medicare Part B covered professional services furnished by eligible clinicians in the Advanced APM Entity to attributed beneficiaries during the timeframe used for the QP determination. For the purposes of identifying attributed beneficiaries, CMS uses the attribution methodology of the specific APM, so for ACOs the agency would identify attributed beneficiaries using either the MSSP or Next Generation ACO attribution rules, as appropriate. CMS will identify the attributed beneficiaries for an Advanced APM Entity based on the latest available attribution list at the time of a QP determination. Specifically, the QP evaluations done during the performance year will rely on a Track 2 ACO's preliminary prospective assignment list, or for Track 3 and Next Generation ACOs, will rely on their prospective assignment lists. Therefore, there may be discrepancies between beneficiaries who are ultimately attributed to an ACO and those used during the performance period to make the QP determination.

The denominator includes the aggregate of all payments for Medicare Part B covered professional services furnished by the eligible clinicians in the Advanced APM Entity to attribution-eligible beneficiaries during the timeframe used for QP determination. (Please refer to the section on the QP Performance Period to better understand specifically which clinicians would be used in the QP calculation.) CMS finalized the definition of attribution-eligible to mean 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
- Has a minimum of one claim for evaluation and management services by an eligible clinician or group of eligible clinicians within an APM Entity for any period during the QP Performance Period.

Patient Count Approach

As an alternative to calculating whether an ACO or Advanced APM Entity meets the payment thresholds above, CMS will use a patient count method which is similar to the payment approach. The patient count threshold numerator is the number of unique attributed beneficiaries to whom eligible clinicians in the Advanced APM Entity furnish Medicare Part B covered professional services or professional services at an RHC or FQHC as described below, during the QP determination timeframe.

The denominator is the number of attribution-eligible beneficiaries to whom eligible clinicians in the Advanced APM Entity furnish Medicare Part B covered professional services or (as detailed below) services by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) during the timeframe used for QP determination. A specific beneficiary may be counted in the numerator and denominator for multiple Advanced APM Entities or eligible clinicians, but an individual beneficiary will not be counted more than once in the numerator and once in the denominator per ACO or APM Entity.

CMS will count 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 eligible

clinicians in an Advanced APM Entity. The agency will also count professional services furnished by eligible clinicians 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) will be 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 will include 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 definition of “eligible clinician” under MACRA and are included as ACO participants. In this case, these eligible clinicians will be considered for an ACO’s QP determination along with all the other eligible clinicians in the ACO.

Partial QPs

Advanced APM Entities that fall short of the QP threshold but meet the Partial QP threshold are not eligible for the Advanced APM bonuses or higher annual updates starting in 2026. Partial QPs have the option of whether to participate in MIPS. If they elect to do so, they would be evaluated under the MIPS APM standard and would receive payment adjustments based on their participation. Please refer to the [MIPS section](#) of this guide for more information. An Advanced APM Entity will know if it is a Partial QP by the beginning of the MIPS submission period and will not need to make MIPS decisions as Partial QPs prior to that point in time. If the Advanced APM Entity elects not to report under MIPS, all eligible clinicians/TINs in the APM Entity group will be excluded from MIPS reporting and payment adjustments. Decisions cannot be made on a TIN by TIN basis.

Advanced APM Eligible Clinicians Who Don’t Meet QP the Threshold

If an eligible clinician participates in multiple Advanced APM Entities during a QP performance period and is not determined to be a QP based on participation in any of those Advanced APM Entities, then CMS will assess the eligible clinician individually using combined information for services associated with that individual’s NPI and furnished through all the eligible clinician’s Advanced APM Entities during the QP performance period. This exception to making the QP determination at the APM Entity level is designed to help eligible clinicians participating in multiple Advanced APM Entities, who would otherwise not qualify for the Advanced APM bonuses or higher annual updates starting in 2026. In the cases where the QP determination is made at the individual eligible clinician level, if the eligible clinician is determined to be a Partial QP the eligible clinician will make the election whether to report to MIPS and then be subject to MIPS reporting requirements and payment adjustments.

QP Performance Period and Timing of QP Determination

CMS proposed that the QP Performance Period would be a full year and would be two years prior to the Advanced APM payment year (e.g., 2017 performance for 2019 payment). This would have resulted in CMS making the QP determination after the close of the performance period, thus notifying Advanced

APMs of their QP status after the MIPS reporting period. Because this would be unfair to APM Entities that would find out they needed to participate in MIPS *after* the MIPS reporting period, NAACOS urged CMS to modify this timing so that ACOs would not feel the need to report under MIPS based on the off-chance that they would not meet the QP thresholds. We are very pleased that in the final rule CMS made considerable changes to the QP performance period and timing of the QP notification.

Under the modified process that CMS finalized, a QP performance period runs from January 1 through August 31 of the calendar year that is two years prior to the payment year. During that QP Performance Period, CMS will make QP determinations at three separate times based on the eligible clinicians who are billing Medicare through MSSP ACO Participant TINs. Should an ACO meet the QP threshold the first time, those clinicians would be considered QPs for the year. CMS will also make the QP determination two additional times, each time based on the eligible clinicians who are part of the MSSP ACO Participant TINs (i.e., those who reassign their Medicare billing rights to an ACO Participant TIN). New clinicians added after the first calculation thus have an opportunity to become QPs based on the second or third QP determination. This is an additive process, so if an MSSP ACO achieves QP status based on the first determination, the individual clinicians will retain their QP status even if the ACO doesn't meet the QP status in subsequent QP determinations during that performance period. Therefore, if an ACO meets the QP threshold once, the QP status is achieved for the year but it would only apply to the eligible clinicians who reassign their Medicare billing rights to an MSSP ACO Participant TIN on the specific dates when CMS accesses the Medicare enrollment information from the Provider Enrollment, Chain, and Ownership System (PECOS).

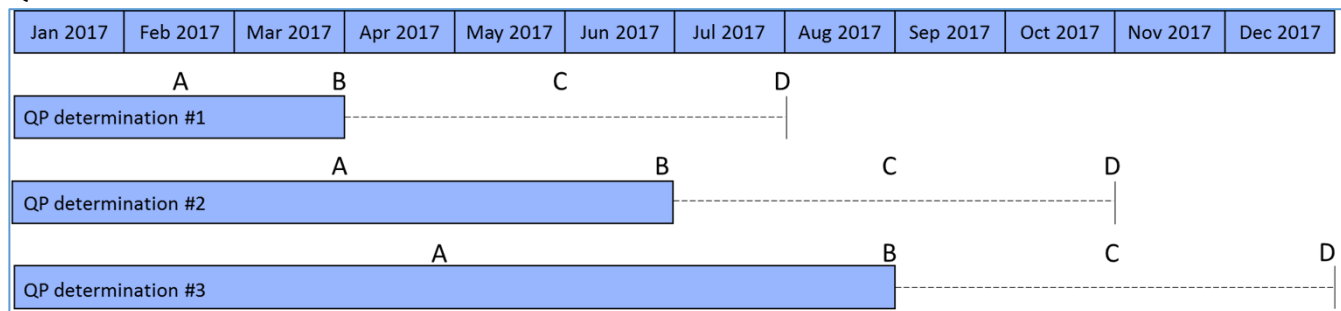
Those dates are:

- March 31
- June 30
- August 31

The process of identifying specific eligible clinicians in a Next Generation ACO is different because ACOs in that model are not required to have full TIN participation as is required under MSSP. Under the Next Generation ACO model, not all providers within a TIN must participate in the ACO so CMS will identify eligible clinicians in Next Generation ACOs based on the TIN/NPI combinations from the Participant List finalized during the summer prior to the start of the performance year.

Below is a visual example from the final rule of when QP evaluations will occur, and each will include a four month claims run out.

QP Performance Period



The finalized policy allows for greater certainty of an ACO's QP status at an earlier point in time and flexibility for new clinicians who join an ACO during the performance period to become a QP for that year. CMS will notify Advanced APM Entities and eligible clinicians of their QP or Partial QP status as soon as the agency has made the determination and performed all necessary validation of the results. While QP determinations made during the QP Performance Period are considered final, they may be rescinded in the event that an Advanced APM Entity is terminated from an Advanced APM, voluntarily or involuntarily, prior to August 31 of the QP Performance Period, or in the event of eligible clinician or Advanced APM Entity program integrity violations.

All-Payer Combination Option

For performance years 2017 (2019 payment adjustment) and 2018 (2020 payment adjustment), CMS will only evaluate QP thresholds based on participation in traditional Medicare Advanced APMs. However, beginning with 2019 performance (2021 payment adjustment), eligible clinicians may become QPs through the All-Payer Combination Option. This provides credit for Advanced APM Entities that participate in qualifying payment arrangements with payers outside traditional Medicare Part B that have payment designs similar to Medicare Advanced APMs. The All-Payer Combination Option was included in MACRA to incentivize APMs to pursue these types of payment arrangements outside Medicare and to give credit to Advanced APMs for their efforts to move from FFS to APM arrangements with all their payers. The All-Payer Combination Option will not replace or supersede the Medicare Option. Instead, it will allow Advanced APM Entities to become QPs by meeting a lower threshold based on Medicare Part B covered professional services through Advanced APMs and an overall threshold based on services through both Medicare Advanced APMs and Other Payer Advanced APMs.

CMS will conduct the QP determination sequentially so that the Medicare Option is applied before the All-Payer Combination Option. As part of the All-Payer Option, an Advanced APM Entity still has to meet a certain Medicare threshold but it's lower than the required threshold under the Medicare Option. This additional opportunity for Advanced APM Entities to meet the QP threshold will be particularly helpful in later years when the QP thresholds increase and are more difficult to achieve. In order for an APM outside of Medicare to count towards the under the All-Payer Combination Option, the arrangement has to meet similar criteria as a Medicare Advanced APM: provide for payment for services based on quality measures comparable to those under MIPS, require use of certified EHRs technology, and bear more than nominal financial risk or be a medical home model.

CMS sets financial and nominal risk criteria for Other Payer APMs, requiring the amount an APM Entity potentially owes or foregoes under an Other Payer Advanced APM is at least 3 percent of the expected expenditures for which an APM Entity is responsible under the payment arrangement. CMS did not finalize a revenue-based nominal risk standard for Other Payer APMs in this rule but notes the agency plans to establish this in future rulemaking. For Medicaid Medical Home Models, CMS finalized a nominal risk standard requiring that the minimum total annual amount that a Medicaid Medical Home Model must require an Advanced APM Entity to potentially owe or forego must be at least 4 percent of the APM Entity's total revenue under the payer in 2019 and 5 percent in 2020 and later.

Further, except for Medicaid Medical Home Models, the risk arrangement must have:

- A marginal risk rate of at least 30 percent of losses in excess of expected expenditures; and

- A minimum loss rate at or below 4 percent

The minimum loss rate is the threshold beyond which point the ACO must repay losses and it 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.

In order to achieve QP status using the All-Payer Combination Option, the following would have to occur:

- (1) APM Entity submits to CMS sufficient information on all relevant payment arrangements with other payers;
- (2) Based upon that information, CMS determines that at least one of those payment arrangements is an Other Payer Advanced APM;
- (3) The APM Entity meets the relevant QP thresholds by having sufficient payments or patients attributed to a combination of participation in Other Payer Advanced APMs and Medicare Advanced APMs.

It's important to note that Advanced APM Entities participating in Other Payer APMs would still undergo the QP determination process that includes calculating payments or determining patient counts that go "through" the Other Payer APM. The charts below from the final rule reflect the QP payment and patient count thresholds under the All-Payer Combination Option. There is still a Medicare Advanced APM threshold as part of this evaluation.

TABLE 36: QP Payment Amount Thresholds – All-Payer Combination Option

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

TABLE 37: QP Patient Count Thresholds – All-Payer Combination Option

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

Under the All-Payer Combination, provided the Advanced APM Entity meets the required Medicare thresholds, CMS will combine the final calculation across payers to determine if the QP threshold is met. Table 39 from the final MACRA rule includes an example of an Advanced APM that meets the Medicare threshold and would be evaluated under the All-Payer Combination Option. In this example, the APM Entity exceeds the QP threshold and would attain QP status.

TABLE 39: All-Payer Combination Option Example 2

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

*For Medicare Part B payments, the amount used for the All-Payer Combination Option will be the same as the amount tied to attribution-eligible beneficiaries used in the denominator of the calculation under the Medicare Option.

CMS will provide more details and guidance in the future on the specific information and submission process for APM Entities to utilize the All-Payer Combination Option. CMS will also consider creating an option for states to seek a determination from CMS on whether a specific Medicaid payment arrangement would qualify under this option. CMS notes that Medicare Advantage APM participation could count towards the All-Payer Combination Option, but that CMS is not permitted by statute to give credit for Medicare Advantage APM participation when calculating the Medicare Option.

Advanced APM Payments

For payment years 2019 through 2024, Advanced APM Entities that meet QP thresholds will receive a lump sum payment equal to 5 percent of the estimated aggregate payment amounts for Medicare Part B covered professional services for the prior year (base year). As an example, CMS will evaluate QP status based on performance and information from 2017, will base the 5 percent bonus on 2018 Medicare Part B covered professional services, and will make the 5 percent bonus payment in 2019. CMS expects to issue Advanced APM bonuses midway through the payment year.

In calculating the estimated aggregate payment amount for a QP, CMS uses claims submitted with dates of service from January 1 through December 31 of the incentive payment base period and processing dates of January 1 of the base period through March 31 of the subsequent payment year. 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 entire APM Incentive Payment amount to the TIN associated with the QP's participation in the Advanced APM entity that met the applicable QP threshold during the QP Performance Period. NAACOS urged CMS to make this payment to the APM Entity (i.e., the ACO) and is disappointed CMS finalized its proposal to make the payment at the TIN level. We will continue to advocate that CMS change this policy. If at the time of the APM Incentive Payment distribution, an eligible clinician is no longer affiliated with the TIN associated with the Advanced APM QP participation, CMS will make the APM Incentive Payment to the new TIN listed on the eligible clinician's CMS-855R (Reassignment of Medicare Benefits form) on the date that the APM Incentive Payment is distributed. Should an eligible clinician become a QP through participation in multiple Advanced APMs, CMS will divide the APM Incentive Payment amount between the TINs associated with the QP's participation in each Advanced APM during the QP Performance Period. Such payments will be divided in proportion to the amount of payments associated with each TIN that the eligible clinician received for covered professional services during the QP Performance Period.

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

How likely is my ACO to meet the QP threshold?

CMS did an evaluation following the methodologies for determination of QP status and found that all participants in Advanced APMs that were in operation in 2014 and 2015 would have met the QP threshold. Based on that information, CMS assumes that during the early QP Performance Periods the vast majority of eligible clinicians participating in Advanced APM would be QPs.

How will my ACO know if we would meet the QP threshold?

CMS conducted a Predictive QP Status [Analyses](#) in late spring of 2017, which was based on 2016 data for Advanced APM Entities that participated in 2016. This predictive analyses is designed to help Advanced APM Entities estimate whether they are likely to meet the QP thresholds for the performance year. Based on CMS Analysis, all 2016 Advanced APM Entities would have met QP thresholds during that performance year.

If my ACO is determined to be a Partial QP, how do we alert CMS that we do not want to participate in MIPS?

An ACO that is a Partial QP would have to elect to participate in MIPS and CMS will have a process for this election. Partial QPs will not participate in MIPS unless the APM Entity opts the group into MIPS participation so that no actions other than the APM Entity's election for the group to participate in MIPS would result in MIPS participation. Should a Partial QP ACO not want to participate in MIPS, no action is necessary.

What CEHRT does an Advanced APM have to use?

CMS maintains the same definition of certified EHR technology (CEHRT) for Advanced APMs as it does for the MIPS Advancing Care Information (ACI) performance category. Specifically, for 2017 performance, the CEHRT must be certified to either the 2014 or 2015 Edition certification criteria to submit Quality measures, ACI, and Improvement Activities data for MIPS. In 2018 providers may continue to use either 2014 or 2015 Edition CEHRT. However, those who are in MIPS and voluntarily use 2015 Edition CEHRT in 2018 will receive a 10 percent ACI bonus for doing so to incentivize the movement to 2015 CEHRT.

Is the 5 percent Advanced APM bonus based on the Medicare paid amount of allowed amount?

When calculating the 5 percent Advanced APM bonus, and determining the payment approach to the QP determination, CMS will use the Medicare allowed amount rather than the Medicare paid amount, which reflects any reductions from the Medicare physician fee schedule amount for beneficiary cost sharing, or payment adjustments from Medicare quality reporting programs that affect payments in 2018, such as the Physician Quality Reporting System or the Value-Based Payment Modifier.

Does CMS consider an ACO's participation in multiple Advanced APMs when calculating whether the ACO meets the QP threshold in order to qualify for the Advanced APM bonus?

No. CMS proposed to combine the numerators of Advanced APM Entities that participate in multiple Advanced APMs with substantially similar Participation Lists, but the agency did not finalize this policy. Based on perceived implementation difficulties, CMS will only evaluate an ACO, or other Advanced APM Entity, based on participation in one specific Advanced APM. However, CMS will assess individual eligible clinicians who are in multiple Advanced APMs at the individual level if they do not meet the QP threshold as part of the Advanced APM Entity.

How is the 5 percent bonus calculated for an individual provider who practices at an ACO and at another organization that is not part of an Advanced APM Entity?

The 5 percent bonus looks at each QP's NPI individually and aggregates all the NPI's billing across TINs. So if a physician bills through four different TINs, CMS will capture billing from all of the clinician's practices and use that total amount as the basis of the bonus.

What specific clinician types are used in the QP calculations?

In order to define the group for QP determinations, CMS pulls all Medicare-enrolled Eligible Clinicians 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 bonus in 2019, are we ineligible for the bonus in future years?

CMS determines MIPS and Advanced APM payment adjustments/bonuses on an annual basis. If an ACO is in MSSP Track 1 in 2017 and thus ineligible for the Advanced APM bonus in 2019, this has no bearing on future years. If that ACO moves into MSSP Track 3, or another qualifying ACO track/model in future years and meets the QP threshold that ACO would qualify for the 5 percent bonus for that particular year and CMS would make separate determinations for subsequent years.

Merit-Based Incentive Payment System

Overview

The Merit-Based Incentive Payment System (MIPS) is the default program for Medicare Part B providers and evaluates them based on criteria such as quality, cost, use of certified Electronic Health Record (EHR) technology and practice improvement activities. MIPS reporting begins in 2017, which corresponds to payment adjustments in 2019. CMS will continue to use a two-year lag between performance and payment adjustment years, with 2018 performance corresponding to 2020 payment adjustments, 2019 performance corresponding to 2021 payments and so on. MIPS consolidates components of three existing Medicare Part B quality reporting programs: the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the eligible professional Medicare EHR Incentive Program (Meaningful Use). Reporting for these programs ends December 31, 2016 and providers transition to reporting under MIPS beginning in 2017.

While MIPS is the default program for Medicare Part B providers, MSSP Track 2 and 3 and Next Generation ACOs that meet Qualifying APM Participant (QP) thresholds in a given performance year are exempt from MIPS. MACRA requires the QP threshold determination, which is evaluated based on the proportion of payments that made “through” the APM Entity (i.e., an individual ACO) in order to qualify as an Advanced APM. To learn more about how CMS will calculate the QP threshold, please refer to the [Advanced APM section](#) of this guide.

Advanced APM Entities including ACOs in MSSP Tracks 2 and 3 and Next Generation ACOs that don’t meet QP thresholds but do meet a lower bar, the Partial QP threshold, have the option of whether to participate in MIPS. Therefore, the following ACOs are required to participate in MIPS:

- MSSP Track 1 ACOs
- MSSP Track 2 and 3 and Next Generation ACOs that do not meet QP or Partial QP thresholds

MIPS participation determinations are made each year independent of past years and MIPS performance is evaluated separately each year. To recognize the commitment of ACOs to advancing value-based healthcare, Medicare ACOs in MIPS are considered MIPS APMs and are given favorable benefits in MIPS. This means reporting criteria and performance evaluations for ACOs differ from the general MIPS population. NAACOS advocacy has repeatedly called for CMS to reward ACOs under MIPS and ease and streamline reporting burdens. We are pleased to see many of the provisions CMS finalized for ACOs in MIPS.

Among others, CMS’s final list of 2017 MIPS APMs includes:

- MSSP Tracks 1, 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care Model (all arrangements)
- OCM (all arrangements)
- CPC+ Model

More information about 2017 APMs, including those CMS considers MIPS APMs, is available in this [CMS resource](#).

MIPS APM Scoring Standard: ACO Considerations

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

To identify eligible clinicians who are part of MIPS APM, CMS uses the same approach as identifying eligible clinicians who are part of an Advanced APM Entity. This includes the use of three snapshot dates (March 31, June 30 and August 31), which establish and then add eligible clinicians to the MIPS APM during the performance year. For MSSP ACOs in MIPS, this means that CMS will identify eligible clinicians who reassign their Medicare billing rights to an ACO Participant TIN on the snapshot dates; the reassignment data is exported from PECOS. This allows new clinicians who join an ACO TIN from January 1 through August 31 to be considered under the MIPS APM scoring standard. If an eligible clinician joins an MSSP ACO after August 31 of the performance year, he or she will need to submit data to MIPS and adhere to all generally applicable MIPS data submission requirements. Should a Next Generation ACO be required to participate in MIPS, which is unlikely in early years but would occur if the ACO didn't meet the QP or Partial QP threshold, the clinicians identified as part of the Next Generation ACO would be based on the TIN/NPI combinations submitted to CMS as the final Participation List for the performance year.

MIPS Eligible Clinicians

The definition of a MIPS eligible clinician for payment years 2019 and 2020 includes the following providers as well as groups that include such professionals.

- Physicians (MD and DO)
- Nurse Practitioners
- Physician Assistants
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Clinicians are identified by a unique billing TIN and NPI combination and more clinician types, such as physical and occupational therapists, clinical social workers, and others may be included in future years. Clinicians who are not required to participate in MIPS in the first two years 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 eligible clinicians, including those who voluntarily report on applicable measures and activities specified under MIPS.

Providers Excluded from MIPS

In addition to CMS excluding providers in Advanced APMs that meet QP thresholds or Partial QPs who choose not to report under MIPS, the providers below would be excluded from MIPS. CMS modified the exclusion criteria in the final MACRA rule resulting in exclusion of more clinicians than originally anticipated. In fact, based on these criteria CMS estimates that 32.5 percent of eligible clinicians will be excluded from MIPS reporting in 2017.

- Those with less than or equal to \$30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients
- 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.

CMS is not excluding providers based on specialty nor is the agency automatically excluding hospital-based clinicians. Additionally, CMS notes that while non-patient facing eligible clinicians are not exempt from MIPS, CMS is establishing a process that applies alternative measures or activities that fulfill the goals of the applicable performance category. Some clinicians who may not be formally excluded from MIPS may have limited reporting requirements if there are not applicable measures for those providers. CMS may also re-weight performance categories if there are not sufficient applicable measures available. CMS aims to ensure that MIPS eligible clinicians who do not have sufficient alternative measures/activities are scored appropriately.

MIPS APM Performance Period

The MIPS APM performance period is the same as the regular MIPS performance period (i.e., 2017 reporting for 2019 payment adjustments). However, solely for the 2017 performance period, CMS finalized a transition approach that eases reporting burdens and includes an option for a shorter reporting period. This transition approach is explained in more detail in the [2017 Transition Year](#) section of this document. However, it is important to note that while the 2017 MIPS performance periods can be less than a full year, CMS has not shortened the performance or quality reporting periods for the MSSP or Next Generation ACO model. Therefore, ACOs must still meet reporting requirements under these ACO programs, which require full year reporting. The upside is that successful full-year reporting under the ACO programs allows ACOs to be eligible for the maximum bonuses under MIPS. Further, any providers reporting quality through the Web Interface, which is the required quality reporting mechanism for ACOs, are required to participate in full-year reporting.

MIPS Performance Categories

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

performance in the following categories:

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

CMS finalized that it will not evaluate any providers on the cost category for the 2017 performance year. Further, because MSSP and Next Generations ACOs participating in MIPS are considered “MIPS APMs”, they are evaluated in a different manner via the MIPS APM Scoring Standard. The performance categories and relative weights are detailed below. While CMS finalized performance weights that change over time for eligible clinicians 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 APMs (including ACOs)

MIPS Reporting Year and Corresponding Payment Adjustment Year	2017 Reporting/ 2019 Payment
Performance Category	ACO Weights
Quality	50%
Advancing Care Information	30%
Cost*	0%
Clinical Practice Improvement Activities	20%

**CMS notes that the agency may consider evaluating ACOs on cost in the future but is finalizing a 0 weight for 2017 and future years unless modified through rulemaking.*

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

Performance Category	2017 Reporting/ 2019 Payment	2018 Reporting/ 2020 Payment	2019 Reporting/ 2021 Payment
Quality	60%	50%	30%
Advancing Care Information	25%	25%	25%
Cost	0%	10%	30%
Clinical Practice Improvement Activities	15%	15%	15%

Performance Category Evaluations for MIPS APMs



Quality

NAACOS urged CMS not to require duplicative quality reporting for ACOs in MIPS, and we are pleased that CMS finalized a policy under which an ACO will only need to submit their quality measures to CMS once. That data will be evaluated for the MSSP/Next Generation model and for MIPS, thus avoiding additional reporting requirements. As with other MIPS performance categories, an ACO's MIPS quality performance will be evaluated at the ACO level. For the MIPS APM Scoring Standard, ACOs will submit CMS Web Interface measures on behalf of their participating MIPS eligible clinicians as they currently do in the MSSP and/or Next Generation Models. ACO quality performance data that is not submitted to the CMS Web Interface, for example the CAHPS survey and claims-based measures, will not be included in the MIPS APM quality performance category score. MIPS population health measures will not be included in the quality performance category score for eligible clinicians in ACOs that are evaluated under the MIPS APM scoring standard.

CMS will use MIPS quality performance category requirements and benchmarks to determine the MIPS quality performance score. MSSP quality benchmarks will be used not only for ACOs, but also for all eligible clinicians in groups reporting through the Web Interface. These benchmarks will be determined based on the corresponding MSSP reporting year, so 2017 MSSP reporting will set the benchmarks for 2017 MIPS quality Web Interface performance. CMS will post the MIPS CMS Web Interface benchmarks in the same manner as the other MIPS benchmarks. CMS will apply the MIPS scoring methodology to each measure. Measures below the 30th percentile will be assigned a value of three points during the 2017 transition year to be consistent with the global floor established in this rule for other measures. CMS notes that the agency will revisit this global floor for future years.

ACOs and groups of 25 or more MIPS eligible clinicians reporting via the Web Interface must report on all measures included in the CMS Web Interface. They must report on the first 248 consecutively ranked beneficiaries in the sample for each measure or module. If the sample of eligible assigned beneficiaries is less than 248, then the group must report on 100 percent of assigned beneficiaries. In some instances, the sampling methodology will not be able to assign at least 248 patients on which a group reports, particularly for smaller groups or ACOs. Those reporting via the Web Interface are generally required to report on all of the measures in the set.

CMS finalized its proposal to award two bonus points for each outcome or patient experience measure and one bonus point for each other high priority measure that is reported in addition to the one high priority measure that is already required to be reported under the quality performance category submission criteria. The agency defines high priority measures as those based on the following criteria: outcomes, patient experience, patient safety, care coordination, cost, and appropriate use. For the CMS Web Interface, CMS will apply bonus points based on the finalized set of measures reportable through that submission mechanism. MIPS eligible clinicians will only receive bonus points if they submit a high priority measure with a performance rate that is greater than zero, provided that the measure meets the case minimum and data completeness requirements. While bonus points are available, there is a cap set at 10 percent of the denominator (total possible points the MIPS eligible clinician could receive in the quality performance category) of the quality performance category for the first two years. ACOs will automatically be eligible for bonus points in

the quality performance category for reporting high priority measures that are already included in the Web Interface measure set.

In the event that an ACO does not report on quality measures as required by the MSSP or Next Generation model, the ACO participant TINs must report data for the MIPS quality performance category according to the MIPS submission and reporting requirements.



Clinical Practice Improvement Activities

MACRA introduces a new area of evaluating providers through the Clinical Practice Improvement Activities (CPIA) portion of MIPS. As explained below, ACOs will not have to report any CPIA information in 2017 and will receive full credit for this performance category.

The subcategories of CPIA include the following:

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

CMS proposed to give ACOs half the amount of credit under this category and then require additional reporting. Specifically, they proposed that all MIPS eligible clinicians in an ACO participant TIN would submit CPIAs according to the MIPS requirements, meaning that every MIPS eligible clinician in the ACO would report on one-to-three approved CPIAs for the 2017 performance year to

receive full credit in this category. NAACOS urged CMS against requiring any additional reporting from ACOs and their clinicians and requested they receive full credit under CPIA since practice improvement is an inherent goal of the MSSP and Next Generation Models and ACOs should not be burdened with an additional reporting requirement.

We are very pleased that in the final rule, CMS made very beneficial changes to CPIA reporting for ACOs which will reward ACOs for their existing efforts without requiring additional reporting from the ACO or its clinicians. Specifically, CMS finalized a policy to provide half credit to MIPS APMs including ACOs and to also evaluate MIPS APMs to determine if they should be further rewarded and granted additional credit above that. Specifically, CMS evaluates documented requirements under the terms of the APM, as set forth in the model's participation agreement. In the event that a MIPS APM incorporates sufficient improvement activities to receive the maximum score, APM Entity groups (e.g., ACOs) and/or their constituent MIPS eligible clinicians (or TINs) participating in the MIPS APM will not need to submit data for the improvement activities performance category in order to receive that maximum improvement activities score. In the event that a MIPS APM does not incorporate sufficient improvement activities to receive the maximum potential score, APM Entities will have the opportunity to report and add points to the baseline MIPS APM-level score on behalf of all MIPS eligible clinicians in the APM Entity group for additional improvement activities that would apply to the APM Entity level improvement activities performance category score. The approach outlined in the paragraph above explains how CMS will evaluate and reward all APMs, and the agency has already completed that evaluation. These details are outlined in this CMS [resource](#).

We are very pleased that through this evaluation CMS determined that MSSP and Next Generation ACOs will receive a full score for the clinical practice improvement activities performance category and therefore will not need to submit additional improvement activity information for MIPS. This applies to all ACOs in MIPS. Should the CPIAs or ACO program criteria change in future years, CMS may reevaluate this decision and that would be addressed in future CMS guidance.



Advancing Care Information

The Advancing Care Information (ACI) performance category replaces the EHR Incentive Program (Meaningful Use), and CMS changes many requirements in the transition from Meaningful Use to ACI. Eligible clinicians are still required to utilize Certified EHR technology (CEHRT) to meet the ACI criteria. CMS finalized a shortened ACI reporting period of 90 days in 2017, which is a reduction from the proposed full year reporting. CMS also eased requirements and eliminated certain measures, including those related to Clinical Decision Support (CDS) and Computerized Physician Order Entry (CPOE).

The ACI performance score is comprised of a base score and a performance score. To earn points toward the base score, a MIPS eligible clinician must report “yes” for yes/no measures or must report a one in the numerator for measures with a numerator/denominator. Reporting on all measures in the base score is required, so CMS retains its “all or nothing” approach to part of ACI. CMS significantly reduced the number of measures in the base score from the proposed 11 measures to 4 in 2017 and 5 in 2018. The base score accounts for 50 percent of the overall ACI score and includes measures related to:

- Security Risk Analysis
- e-Prescribing

- Provide Patient Access
- Health Information Exchange
 - Send Summary of Care
 - Request/Accept Summary of Care

In addition to measures for the base score, eligible clinicians choose to report on up to nine measures for a performance score and bonus points are available on top of that. Overall, MIPS eligible clinicians have the ability to earn an ACI score of up to 155 percentage points, which will be capped at 100 percent when the base score, performance score and bonus score are all added together.

MIPS also requires that as part of ACI, 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 certified EHR technology, that they are compliant with all standards applicable to the exchange of information, and that their system implementation allows for timely access by patients to their electronic health information and allows for timely exchange of electronic health information with other healthcare providers.

ACO Reporting for ACI

- **MSSP Reporting of ACI information:** MSSP ACO Participant TINs submit ACI data using a MIPS data submission mechanism. All of the ACO Participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one ACO score.
- **Next Generation ACO Reporting of ACI information:** Next Generation ACOs submit data at either the individual level or at the TIN level using a MIPS data submission mechanism. CMS will attribute one score to each MIPS eligible clinician. This score will be the highest score attributable to the TIN/NPI combination of each MIPS eligible clinician, which may be derived from either group or individual reporting. The scores attributed to each MIPS eligible clinicians will be averaged to yield a single ACO.

The ACI requirements finalized align with ACO reporting requirements that CMS finalized in the 2017 Medicare Physician Fee Schedule, released November 2, 2016. In that rule, CMS changed the title and specifications of ACO Measure 11 to align with MIPS. Specifically, CMS changed the title of ACO measure 11 to “Use of Certified EHR Technology” and the specifications to assess the ACO on the degree of CEHRT use by all providers and suppliers designated as MACRA eligible clinicians participating in the ACO. This increases the reporting burden for ACOs as the measure previously focused solely on primary care physicians’ use of CEHRT.

Due to these changes, this measure will be phased into pay for performance after two years (2017 and 2018) as a pay-for-reporting measure for all ACOs. During years in which this measure is designated as a pay-for-reporting measure, in order for CMS to determine that an ACO has met requirements for complete and accurate reporting, at least one eligible clinician participating in the ACO must meet the reporting requirements under the ACI performance category. Beginning in the 2019 performance year, this measure will be assessed according to the following phase-in schedule: Performance Year (PY) 1 –

Reporting; PY 2 – Performance; and PY 3 – Performance. During pay-for-performance years, the assessment of EHR adoption will be measured based on a sliding scale.



Resource Use/Cost

In the proposed rule CMS referred to this category as “resource use” but in the final rule changes the category label to “cost.” CMS finalized its proposal not to calculate a cost performance score for MIPS APMs under the APM Scoring Standard. This is due to the fact that ACOs are already being measured on cost in their respective MSSP and Next Generation ACO Models. Specifically, CMS explains, “Because ACOs in the Shared Savings Program are assessed through particular attribution and benchmarking methodologies for purposes of earning shared savings payments, we believe that adding additional and separate MIPS incentives around cost would be redundant, potentially confusing, and could undermine the incentives built into the Shared Savings Program.” (p. 77258) By not evaluating ACOs on cost under MIPS, it allows ACOs to continue to focus on one set of cost measures and not be subject to additional cost measures with different specifications and benchmarks.

CMS notes that it may continue to consider how the agency might incorporate an assessment of the MIPS cost performance category into the APM scoring standard for ACOs. However, CMS explains that the zero weight for the cost performance category for ACOs will remain in place for subsequent years unless CMS modifies it through future notice and comment rulemaking.

CMS had proposed to evaluate MIPS eligible clinicians who are not in APMs on cost, but the agency is not going to do so in 2017. Rather, the agency finalized a weight of zero for all MIPS eligible clinicians during the 2017 transition year. The agency will introduce cost performance evaluation in the future and finalized a 10 percent weight for the cost performance category for eligible clinicians not scored under the MIPS APM scoring standard.

Performance Category Scoring

Below is an outline of how each performance category will be scored under the MIPS APM Scoring Standard.

Performance Category	Action Required	Max Possible Points	Percentage of Overall MIPS Score
Quality	<p>MSSP Web Interface measures reported through the ACO, using MSSP quality benchmarks. Earn up to 10 points per measure based on performance vs. benchmark. Bonus points are awarded for reporting high priority measures contained in the Web Interface measure set. Measures are averaged to compile a score for this category.</p> <p>(xv) A MIPS eligible clinician's quality performance category score is the sum of all the points assigned for the measures required for the quality performance category criteria plus the bonus points in paragraph (b)(1)(xiii) and bonus points in paragraph (b)(1)(xiv) of this section. The sum is divided by the sum of total possible points. The quality performance category score</p>	80 points	50%
Advancing Care Information	<p>Total score = Base Score Plus Performance Score and Bonus Points</p> <p>Base score: Achieved by meeting the Protect Patient Health Information objective and reporting the numerator (of at least one) and denominator or yes/no statement as applicable (only a yes statement would qualify for credit under the base score) for each required measure.</p> <p>Performance score: Between zero and 10 or 20 percent per measure (as designated by CMS) based upon measure reporting rate,</p> <p>Bonus points: up to 15 percent for bonus score for reporting on things such as Public Health and Clinical Data Registry</p> <p>Any total score over 100 points earns full credit in this category.</p>	100 points (Base Score= 50 points Performance Score= 90 points)	30%
Clinical Practice Improvement Activities	CMS evaluated details of the MSSP and Next Generation ACO model to determine how these models meet the CPIA criteria and goals. Based on this evaluation, at least for 2017 performance, CMS is rewarding ACOs with full credit in this category. No ACO reporting is required.	40 points	20%
Cost	CMS will not calculate a cost score for ACOs under the MIPS APM Scoring Standard	N/A	0%

MIPS Payment Adjustments

For each performance year, CMS will evaluate ACOs and other providers compared to the MIPS performance threshold and will make additional adjustments to ensure the overall program remains in budget and will then apply payment adjustments during the applicable payment adjustment year.

Calculating a MIPS Composite Performance Score (CPS)

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

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

MIPS Performance Thresholds

CMS had proposed to set the 2017 performance threshold at the mean or median of all MIPS eligible clinicians' CPSs, but the agency made a significant change to this in the final rule. As part of CMS's efforts to ease the transition into MIPS, the agency is setting the 2017 MIPS performance threshold at three points. This is significantly lower than expected and means ACOs will avoid penalties in MIPS since they automatically earn full credit under CPIA. Therefore, ACOs are well positioned to be high performers in MIPS. However, setting the performance threshold at such a low level means that many providers will avoid penalties under MIPS.

The program is, for the most part, designed as a budget-neutral program, meaning that MIPS penalties are collected and distributed among those who perform well enough to qualify for bonuses. By mitigating the penalties, CMS also significantly reduces opportunities for bonuses. Unlike some current Medicare quality reporting programs, which have a flat rate bonus or penalty, MIPS payment adjustments can range within the corridors established by MACRA.

The range of bonuses and penalties is detailed in the table below, but it is likely that the 2019 bonuses will not reach 4 percent for those who perform well in MIPS in 2017. CMS acknowledges the reduced bonus opportunity stating, "We also note that with our transition policies that we anticipate most MIPS eligible clinicians that submit data will receive a neutral to small positive MIPS payment adjustment in the transition year. We anticipate the slope of the positive MIPS payment adjustment due to budget neutrality to be relatively flat, which will minimize differences based on the adjustment factor, although there will be more MIPS payment adjustments for the additional adjustment factor for exceptional performance." (p. 77337)

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

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

Scaling Factor

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

Providers at and Below the Performance Threshold

For 2017, providers who don’t report any measures will receive an automatic 4 percent MIPS penalty. MIPS eligible clinicians with a final score below the performance threshold of three 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. MIPS eligible clinicians with a final score between 0 and 0.75 will also receive the 4 percent penalty in 2019 based on 2017 reporting. Those with CPSs at the performance threshold will receive a neutral payment adjustment.

Providers Above the Performance Threshold

Eligible clinicians with CPSs above the performance threshold are eligible for bonuses and will be evaluated using the linear sliding scale and the scaling factor which can increase or decrease bonuses in order to keep the program budget-neutral. As noted above, based on CMS finalizing a low performance threshold, the scaling factor is likely to be lower than 1.0, which will reduce bonus opportunities for those with CPSs above the performance threshold. It is unclear at this point what the scaling factor will be and thus what the potential bonuses will be.

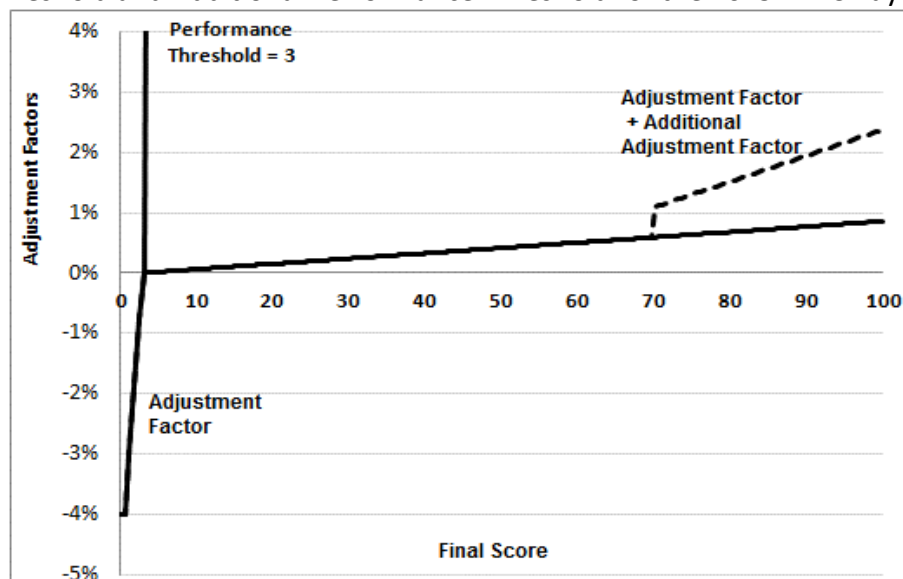
TABLE 31: Illustration of Point System and Associated Adjustments in Transition Year

Final Score Points	MIPS Adjustment
0-0.75	Negative 4 percent (Note: We anticipate that this range will comprise mostly of MIPS eligible clinicians with a final score of 0.)
0.76-2.9	Negative MIPS payment adjustment greater than negative 4 percent and less than 0 percent on a linear sliding scale. (Note: We do not anticipate many MIPS eligible clinicians to fall into this range.)
3.0	0 percent adjustment
3.1-69.9	Positive MIPS payment adjustment ranging from greater than 0 percent to 4 percent \times a scaling factor to preserve budget neutrality, on a linear sliding scale
70.0-100	Positive MIPS payment adjustment AND additional MIPS payment adjustment for exceptional performance. (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor.)

Exceptional Performance Bonuses

While MIPS is designed to be budget neutral, there is an additional \$500 million per year from 2019 through 2024 for “exceptional performers.” CMS finalized an exceptional performance threshold of 70 points for the first year of the program, so eligible clinicians with a final CPS of 70 or higher will be eligible for the exceptional performance adjustment. The figure below illustrates how the additional performance threshold would be applied.

Figure A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Final Performance Threshold and Additional Performance Threshold for the 2019 MIPS Payment Year



The exceptional performance bonus could range from 0.5 percent to 10 percent, which would be added to the bonus determined under the main part of the program. Therefore, MIPS eligible clinicians with a final score at or above the additional performance threshold, which is set at 70 for 2017 reporting, will receive an additional MIPS payment adjustment factor for exceptional performance. Similar to the regular MIPS payment adjustment, this will be based on a linear sliding scale such that an additional adjustment factor of 0.5 percent is assigned for a final score at the additional performance threshold and an additional adjustment factor of up to 10 percent is assigned for a final score of 100, subject to the application of a scaling factor. The scaling factor for the exceptional performance bonuses will be calculated by CMS and ensures that the agency does not spend more than the \$500 million it has annually for these bonuses. Therefore, similar to the regular MIPS payment adjustments, it is unclear how many providers will be eligible for the exceptional performance bonus or what those specific amounts will be.

MIPS Payment Adjustments and ACO Benchmarks

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

Application and Notification of MIPS Payment Adjustment

For each applicable year the MIPS payment adjustments will be applied to Medicare Part B payments for items and services furnished by the MIPS eligible clinician 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 shall notify providers of applicable MIPS payment adjustments by December 1 of the year preceding the payment adjustment year, so December 1, 2018 for 2019 payment adjustments. As discussed below, CMS may notify eligible clinicians 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. Therefore, all MIPS eligible clinicians, including those scored under the APM scoring standard will receive performance feedback to the extent applicable. CMS plans to distribute the first round of MIPS performance feedback reports beginning in July 2018. In the meantime, CMS will continue to provide Quality Resource Use Reports (QRURs) and CMS expects to release a round of QRURs in fall 2017, which would reflect 2016 performance and would be the last

QRURs issued before CMS transitions to new MIPS performance feedback reports in 2018. The 2016 annual QRUR will show how groups and solo practitioners performed in 2016 on the quality and cost measures used to calculate the 2018 Value Modifier (VM) as well as their 2018 VM payment adjustment. The VM payment adjustments end in 2018, and there will be a transition from feedback and payment adjustments under existing Medicare quality reporting programs to MIPS. CMS explains that the agency hopes the 2016 annual QRURs will still be valuable and will support the transition to MIPS.

For the MIPS performance feedback reports released in 2018, CMS plans to provide performance feedback for MIPS data collected in 2017. This data could potentially include all applicable data reflecting 2017 performance, including data on the quality and cost performance categories, as well as data regarding the final score and payment adjustment. CMS will work with stakeholders on the best way to include all four performance categories in performance feedback.

If technically feasible CMS will include the MIPS payment adjustment factors in the performance feedback, and if that is not feasible, CMS will notify MIPS eligible clinicians through guidance documents or other program communication channels as to when and how this information will be announced prior to the statutory deadline of December 1, 2018. In future years of the program, CMS plans to make performance feedback available via a CMS designated system, which they intend to be a web-based application.

MIPS Performance Review, Audits and Public Reporting

MIPS Performance Review

MIPS eligible clinicians or groups may request a targeted review of the calculation of the MIPS payment adjustment factor for a given year. MIPS eligible clinicians 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 eligible clinicians or groups may include additional information in support of their request for targeted review at the time the request is submitted. If CMS requests additional information from the MIPS eligible clinician or group, it must be provided and received by CMS within 30 days of the request. Non-responsiveness to the request for additional information may result in the closure of the targeted review request, although the MIPS eligible clinician or group may submit another request for targeted review before the deadline. 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 eligible clinicians and groups for data validation, auditing, program integrity issues, and instances of non-compliance with MIPS requirements. If a MIPS eligible clinician 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.

At least initially, CMS plans to use data validation and audits as an educational opportunity for MIPS eligible clinicians and groups. Therefore, during the 2017 transition year the data validation and audit process will include education and support for MIPS eligible clinicians and groups selected for an audit.

Lastly, CMS finalized that all MIPS eligible clinicians and groups that submit data electronically must attest to the best of their knowledge that the data submitted is accurate and complete.

Public Reporting on Physician Compare

MACRA requires CMS to continue to expand the amount of information it shares with the public on the Medicare Physician Compare [website](#), which currently has web pages for individual physicians, group practices and ACOs. At this time, if a clinician or group submits quality data as part of an ACO, there is an indicator on the clinician's or group's profile page, thus identifying which clinicians and groups took part in an ACO. Also, currently, all ACOs have a dedicated page on the Physician Compare website to showcase their data. If technically feasible, CMS plans to use this model as a guide for adding APM data to Physician Compare. Specifically, CMS explains that it views the MACRA requirement to report MIPS performance publicly as a way to build on public reporting currently done, including public reporting on Physician Compare for ACOs.

CMS finalized its proposals to indicate on eligible clinician and group profile pages when the eligible clinician or group is participating in an ACO or other APM. CMS also plans to link eligible clinicians and groups to their ACO's data through Physician Compare. CMS will coordinate efforts between Physician Compare and the four performance categories of MIPS in terms of targeted review and any relevant data resubmission or correction. All data available for public reporting —measure rates, scores, and attestations —will be available for review and correction during the targeted review process, and CMS finalized a 30-day preview period in advance of the publication of data on Physician Compare. MACRA also requires that aggregate information on MIPS be periodically posted on the Physician Compare website, including the range of final scores for all MIPS eligible clinicians and the range of performance for all MIPS eligible clinicians for each performance category.

CMS states its intent to integrate APM data gradually into Physician Compare as informed by consumer testing. It's important to note that CMS will post information on Physician Compare for both Advanced APMs and APMs that participate in MIPS.



MIPS FAQs

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

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

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

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

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

What happens if an ACO is unsuccessful with quality reporting?

Should an ACO fail to report quality through the MSSP or Next Generation ACO program, the ACO participant TINs would be evaluated at the TIN level for MIPS. CMS would still use the MIPS APM scoring standard for the ACO TINs and each of the ACO Participant TINs would receive its own TIN-level final score instead of an ACO-level final score. 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.

What if an ACO drops out of the ACO program during the performance year?

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

If we perform well under MIPS, when in 2019 would we receive our MIPS bonus?

MIPS payments will not be made in a lump sum but will be applied as an adjustment on a per claim basis for claims with dates of service during the payment adjustment year.

Certain providers that are currently required to report under programs such as PQRS aren't required to report under MIPS. Does that mean they can stop reporting in 2017?

MACRA specifies the clinicians included in the first two years of the program, and this definition is different than who is or is not required to report under existing Medicare quality reporting programs such as PQRS, Meaningful Use, and the VM. Starting in year three of MIPS (2021 reporting for 2023 payment adjustments), CMS may expand the definition of MIPS eligible clinicians to include other providers. However, if clinicians who are not required to participate in MIPS in the first two years want to voluntarily report, they may do so. CMS states that it intends to provide informative performance feedback to clinicians who voluntarily report to MIPS, which would include the same performance category and final score rules that apply to all MIPS eligible clinicians.

Will FQHCs and RHCs that are part of an ACO participate in MIPS?

FQHCs and RHCs may voluntarily report to MIPS, however no adjustments to payments will be made unless billing Medicare Part B.

Will the MIPS 'test' option for 2017 be applicable/available for ACOs?

No. For MIPS, ACOs will be evaluated on quality, ACI and CPIA performance categories. The MIPS quality performance category will be evaluated using MSSP/Next Gen ACO quality reporting, which requires a 12-month reporting period. Full credit for CPIA will automatically be given to ACOs with no additional reporting required. ACI reporting for 2017 is a minimum 90-day reporting period.

How will ACOs report ACI requirements? Will ACI be reported by the TINs or will the ACO be responsible for reporting this information on behalf of the TINs?

MSSP ACOs will report ACI at the TIN level. TIN-level scores will then be aggregated as a weighted average to come up with one ACO entity-level score. Next Gen ACOs will report ACI at either the individual or TIN levels, these scores will then be aggregated and averaged to come up with one ACO entity-level score.

How will CMS handle exemptions for certain providers in the ACI performance category if those ECs are part of an ACO?

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

How will ACO TINs report ACI measures to CMS? Will the attestation process be the same as is currently used for Meaningful Use?

ACO TINs will report ACI measures to CMS using a group reporting option. Using this option, the group (TIN) will need to aggregate data for all the individual MIPS ECs within the group for whom they have data in the CEHRT. Measures will be reported and evaluated at the group level. CMS states that the group calculation of the numerators and denominators for each measure must reflect all of the data from all individual MIPS ECs that have been captured in the CEHRT for the given ACI measure. According to CMS, for ACI group reporting, everyone in a TIN reports on the same measures because the data is aggregated by the TIN before it reports.

If the group's CEHRT is capable of submitting the data as a group, they will submit the aggregated data that is produced by the CEHRT. If the group's CEHRT is not capable of this level of reporting, the group will aggregate the data by adding together the numerators and denominators for each MIPS EC within the group for whom the group has data captured in their CEHRT. If one individual meets the criteria to exclude a particular ACI measure, that individual's data can be excluded from the aggregate calculation of that particular measure only.

CMS notes that there may be difficulty identifying unique patients across a group for the purposes of aggregating performance on the ACI measures in this manner, particularly when a group is using multiple CEHRT systems (or systems certified to different editions). CMS states that they will consider unique patients to be individual patients treated by the group who would typically be counted as one patient in the denominator of an ACI measure. This patient may see multiple MIPS ECs within the group, or see ECs at multiple group locations. When aggregating performance for group reporting, CMS will not require that the group determines that a patient seen by one MIPS EC, or at one location, is not also seen by another EC in the group or captured in a different CEHRT system. CMS notes this may result in the same patient appearing more than once in the denominator. Accordingly, CMS states their final policy will allow groups some flexibility as to the method for counting unique patients in the denominators to accommodate these situations. CMS anticipates releasing additional guidance and resources further describing this process in the near future.

Does MIPS require ACOs report any quality measures outside of the ACO Web Interface reporting?

No, ACOs will continue to report Web Interface measures as it does currently for the MSSP and Next Gen programs. CMS made certain changes to the ACO quality measure set for the 2017 performance year in the final 2017 Medicare Physician Fee Schedule rule. Be sure to access the updated measure specifications for 2017. However, note that clinicians who do not appear on the ACO participant list at one of three snapshot dates (March 31, June 30 and August 31) will be required to report information on quality, ACI and CPIA according to the MIPS requirements separately from the ACO.

Will CMS count MIPS payment adjustments as ACO expenditures?

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.

Why did CMS exclude Track 1 ACOs from MIPS eligibility notifications?

According to CMS, Track 1 ACOs were excluded from MIPS eligibility notifications sent to clinicians in late April through May of 2017 due to the fact that CMS anticipates Track 1 ACOs will not meet low volume threshold exemptions as this calculation is made at the group level for Track 1 ACOs. More information on the CMS MIPS eligibility notifications can be found on the CMS [website](#) (under “MIPS Participation Status Letter” tab). Alternatively, CMS also launched an online MIPS participation status lookup [tool](#). To use this tool, simply enter an NPI number under “check your participation status.”

Do ACOs need to register for the Web Interface by the MIPS registration deadline of June 30, 2017?

No. ACOs do not need to register for the MIPS Web Interface reporting mechanism. ACOs will continue to report quality information via the MSSP or Next Gen ACO program.



NAACOS is a 501 (c) 6 non-profit organization that allows ACOs to work together to increase quality of care, lower costs and improve the health of the communities. Determined to create an environment for advocacy and shared learning, organizations representing over 250 Accountable Care Organizations (ACO) from more than 48 states have formed the National Association of ACOs.

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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