

Raise the bar: How to achieve QP status during a pandemic

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Accountable care organizations (ACOs) participating in Advanced Alternative Payment Models (Advanced APMs) are eligible to qualify for a payment bonus equal to 5% of Medicare Part B revenue and avoid Merit-based Incentive Payment System (MIPS) payment adjustments and reporting requirements.¹

ACO participants and providers—as identified by Taxpayer Identification Number (TIN)—are paid the bonus directly, two years after the ACO qualifies to receive the bonus. ACOs that do qualify to receive the bonus typically receive roughly \$4,400 a year from each physician, and as much as \$11,000 to \$13,000 for various specialists like ophthalmologists or cardiologists (see Figure 1 for more detail).² For typical ACOs comprised of hundreds (or thousands) of primary care physicians (PCPs) and specialists, the bonus can amount to millions of dollars annually—a substantial sum of money, and a major incentive for ACOs to participate in the Advanced APM program.

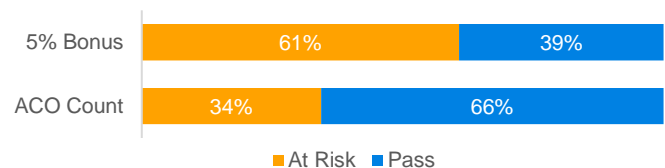
In order for ACOs to receive the 5% bonus, they must achieve Qualifying Advanced APM Participant status (QP status) by meeting the eligibility criteria outlined by the Centers for Medicare and Medicaid Services (CMS).³ In 2021, the requirements for an ACO to achieve QP status will increase significantly over 2020 requirements, making it substantially more difficult for many ACOs to qualify. In examining 99 Medicare Shared Savings Program (MSSP) ACOs that achieved QP status in 2019, 34 of them are at risk of losing QP status and forfeiting the bonus for the 2021 performance year (to be paid in 2023), equivalent to an estimated \$114 million of annual bonus payments in aggregate (see Figure 2).⁴ Additionally, COVID-19 will complicate achieving QP status for ACOs. In this paper, we explore QP status criteria and the actions ACOs can take to ensure they continue to qualify for the 5% bonus, even during a pandemic.

FIGURE 1: PART B REVENUE AND 5% BONUS BY PHYSICIAN SPECIALTY

Physician Specialty	Part B Revenue	5% Bonus
Ophthalmology	\$263,000	\$13,200
Cardiology	229,000	11,400
Nephrology	226,000	11,300
Pulmonary Disease	163,000	8,100
Diagnostic Radiology	115,000	5,700
Orthopedic Surgery	116,000	5,800
Internal Medicine	109,000	5,400
Gastroenterology	102,000	5,100
Family Practice	70,000	3,500
Emergency Medicine	66,000	3,300

FIGURE 2: HYPOTHETICAL MSSP ACO QP STATUS IN 2021

Assumes 2019 performance remains unchanged in 2021



QP requirements

To understand why many ACOs are at risk of failing the QP status criteria and losing the 5% bonus, it helps to understand the QP scoring methodology.

QP SCORE

ACOs participating in Advanced APMs achieve QP status if at least one of two criteria is met:

- Patient count:** The proportion of attribution-eligible Medicare fee-for-service (FFS) patients who are attributed to the ACO exceeds the minimum threshold (e.g., 35% in 2019).
- Payment amount:** The proportion of Part B physician claims for attribution-eligible Medicare FFS patients who are attributed to the ACO exceeds the minimum threshold (e.g., 50% in 2019).

¹ For more information on MIPS, see <https://qpp.cms.gov/mips/overview>.

² Based on the calendar year (CY) 2017 Medicare Provider Payment Public Use Files from CMS. Revenue eligible for Advanced APM bonus is trended to CY2022 at 2.5% annually. Figure 1 is limited to physicians participating in all MSSP ACOs.

³ For details on eligibility criteria, see <https://qpp.cms.gov/apms/advanced-apms?>

⁴ Based on the calendar year (CY) 2017 Medicare Provider Payment Public Use Files from CMS. Revenue eligible for Advanced APM bonus is trended to CY2022 at 2.5% annually. Figure 2 is limited to the 99 MSSP ACOs achieving 2019 QP status.

For both criteria, ACOs are scored and compared to the minimum threshold defined by statute. Both scores are expressed relative to the total attribution-eligible⁵ population seen by ACO participants.

$$\text{Patient Count Score} = \frac{\text{\# of attributed beneficiaries given Part B professional services}}{\text{\# of attribution eligible beneficiaries given Part B professional services}}$$

$$\text{Payment Amount Score} = \frac{\text{claims \$ for Part B professional services to attributed beneficiaries}}{\text{claims \$ for Part B professional services to attribution-eligible beneficiaries}}$$

See Figure 3 for an illustrative example of how these two scores are calculated for a single ACO. By comparing “ACO Patients Seen” to “Total Patients Seen” and “Part B Revenue in ACO” to “Total Part B Revenue,” Provider Group B seems to practice effective care coordination by retaining most of its patients seen within the ACO’s participant list. However, it also has the lowest “Total Patients Seen” count and claim volume of the participant list (and thus would contribute the least to the 5% bonus). Although Provider Group C detracts from this ACO’s QP scores, the ACO would qualify for QP status. It is important to note that the QP scores are calculated at the ACO level, and each eligible *participant* within the ACO is awarded QP status if either threshold is met. The QP thresholds each year are defined by statute and increase significantly in 2021 (see Figure 4).

ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

CMS instituted a Quality Payment Program (QPP) that provides financial incentives for participants to shift from fee-for-service (FFS) reimbursement to value-based reimbursement. One of the tracks under the QPP is the Advanced APM track. An Advanced APM ACO meets the following criteria:

- Requires participants to use certified electronic health record (EHR) technology.
- Provides payments for covered professional services based on quality measures comparable to those used in the MIPS quality performance category.
- Either (a) is a Medical Home Model expanded under CMS Innovation Center authority, or (b) requires participants to bear a significant financial risk.

ACOs that participate as Advanced APMs and meet prescribed proportions of patients or payments serviced by the ACO's participants become Qualifying APM Participants (QPs) and receive a bonus equivalent to 5% of all Part B physician revenue (not just revenue for ACO patients).

FIGURE 3: ILLUSTRATIVE QP SCORE CALCULATIONS

ACO Participant	Total Patients Seen ⁽¹⁾	ACO Patients Seen ⁽²⁾	Patient Count Score	Total Part B Revenue (millions) ⁽³⁾	Part B Revenue in ACO (millions) ⁽⁴⁾	Payment Amount Score	5% Bonus (millions)
Provider Group A	5,000	3,000		\$32.30	\$22.80		\$1.62
Provider Group B	3,500	3,000		17.99	13.49		0.90
Provider Group C	4,000	1,200		48.02	19.51		2.40
ACO Total	12,500	7,200	58%	\$98.30	\$55.79	57%	\$4.92

(1) All attribution-eligible patients seen by provider during performance period.

(2) All patients seen by provider during performance period that are attributed to a provider within the ACO. Each patient may only count once towards the numerator and denominator of the QP calculation. This example assumes that no patients overlap across ACO participants.

(3) All Part B revenue received for attribution-eligible patients.

(4) All Part B revenue received for patients attributed to a provider within the ACO.

⁵ For eligibility criteria, see page 10 here: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V7.pdf>.

QP SNAPSHOTS

At three distinct times each year, CMS measures each ACO's QP status based on all eligible participants in the ACO that year as of the snapshot date. If QP status is achieved at any of these snapshot dates,⁶ then all participants in the ACO at that point in time are QPs (even if they are not on the ACO's participant list during other snapshots). Once an ACO achieves QP status during one snapshot, its eligible participants during that snapshot period retain QP status for all future snapshots of the same year (see Figure 8 below).

Drivers of QP scores

There are several factors that are key drivers of QP status:

PCPS VS. SPECIALISTS

- Primary care physicians (PCPs) drive beneficiary attribution to ACOs under MSSP and Next Generation ACO. Many of the beneficiaries seen by PCPs participating in an ACO will be attributed to the ACO, increasing the ACO's QP scores (by driving up QP numerators).
- Specialists generally do *not* drive ACO attribution. Therefore, beneficiaries seen by specialists are often already attributed to the ACO (not affecting the QP score) or will not be attributed to the ACO (decreasing the QP score).
- The balance of PCPs and specialists within an ACO can have a material impact on its QP status. Figure 3 above shows a sample QP score calculation for an ACO that contains a higher proportion of PCP groups (Provider Groups A and B). Figure 5 shows an illustrative example of what the QP scores might look like for an ACO with a large proportion of specialist groups (Provider Groups X, Y, and Z). By comparing "ACO Patients Seen" to "Total Patients Seen" and "Part B Revenue in ACO" to "Total Part B Revenue," the majority of services for Provider Groups X and Z are for patients not attributed to the ACO. While the QP scores are lower for this illustrative ACO, it is important to recognize the substantial revenue specialists earn for the ACO. Once the QP score has been met, the revenue that specialists bring in can increase the bonus amount substantially.
- Participant list management decisions have trade-offs. Limiting the number of specialists in an ACO in an effort to achieve QP status can limit the size of the very bonus the ACO seeks to earn.

⁶ The QP snapshot dates are March 31, June 30, and August 31.

⁷ For more information on retrospective versus prospective attribution for MSSP ACOs, see <https://us.milliman.com/en/insight/prospective-and-retrospective-assignment-in-mssp-and-beyond>.

CARE COORDINATION

- ACOs with tightly coordinated PCPs and specialists will generally have higher QP scores, because the specialists have little or no impact on QP scores. Additionally, the specialists will still increase the Part B revenue underlying the 5% bonus.
- Specialists typically are an important component of overall care management and quality. Naturally, some specialists will receive referrals from outside the ACO, which detracts from the ACO's QP scores. However, coordination with PCPs on patient follow-up and meeting beneficiaries' care needs will improve beneficiary attribution and the ACO's QP scores.

ATTRIBUTION METHOD

- Under MSSP rules, Medicare beneficiaries in the same performance year (PY), i.e., claim measurement period, can be attributed to an ACO under two methods (see Figure 1 above):
 - Retrospective:** Beneficiary attribution and performance year are concurrent. Attribution is known by the end of the performance year.
 - Prospective:** Beneficiary attribution occurs 15 months prior to the start of the performance year. Attribution is known before the start of the performance year.
- ACOs have until September 22, 2020, to decide which attribution method will be used for PY2021 (see Figure 8 below).
- ACOs that expect evaluation and management visits (including telehealth visits) to be lower in 2020 than in 2021, due to COVID-19, may achieve higher QP scores in PY2021 under retrospective attribution than prospective attribution.
- Each ACO should carefully consider MSSP risk adjustment, reporting limitations, and other factors when selecting which assignment methodology will be best for its own situation.⁷

FIGURE 4: THRESHOLDS FOR QP STATUS

Full QP thresholds are shown below. Partial QP thresholds do not qualify an ACO for the 5% bonus and are not shown below.

Performance Year (PY)	Bonus Payment Year	QP Status	
		Patient Count	Payment Amount
2017	2019	20%	25%
2018	2020	20%	25%
2019	2021	35%	50%
2020	2022	35%	50%
2021+	2023+	50%	75%

FIGURE 5: ILLUSTRATIVE QP SCORE CALCULATIONS (SPECIALIST-HEAVY ACO)

ACO Participant	Total Patients Seen ⁽¹⁾	ACO Patients Seen ⁽²⁾	Patient Count Score	Total Part B Revenue (millions) ⁽³⁾	Part B Revenue in ACO (millions) ⁽⁴⁾	Payment Amount Score	5% Bonus (millions)
Provider Group X	11,200	2,750		\$77.79	\$21.96		\$3.89
Provider Group Y	5,000	3,000		27.63	17.22		1.38
Provider Group Z	10,000	2,000		71.44	17.84		3.57
ACO Total	26,200	7,750	30%	\$176.86	\$57.02	32%	\$8.84

(1) All attribution-eligible patients seen by provider during performance period.

(2) All patients seen by provider during performance period that are attributed to a provider within the ACO. Each patient may only count once towards the numerator and denominator of the QP calculation. This example assumes that no patients overlap across ACO participants.

(3) All Part B revenue received for attribution-eligible patients.

(4) All Part B revenue received for patients attributed to a provider within the ACO.

Future of QP status

ACOs need to consider a variety of challenges moving forward.

INCREASED QP SCORES IN PY2021+

Beginning in PY2021, both the patient count and payment amount thresholds will increase significantly (see Figure 4 above). COVID-19 aside, these thresholds will be difficult for many ACOs to reach; COVID-19 only further compounds the difficulty. Figure 6 and Figure 7 show the distribution of 2019 QP scores for the 99 MSSP ACOs. The dotted grey vertical line represents the 2019 QP threshold and the solid black line represents the 2021 QP threshold. ACOs that did not meet the 2019 payment amount threshold are identified by light grey bars (but all 99 ACOs did at least meet the patient count threshold and thus earned QP status), and ACOs with 2019 QP scores above the 2021 thresholds have blue bars. In between (in orange bars) are the ACOs at risk for achieving 2021 QP status (those that met the 2019 threshold but with QP scores below the 2021 threshold). If nothing is done to improve the QP scores of this group between 2019 and 2021, approximately \$114 million in bonus revenue could be forfeited for PY2021.

IMPACT OF COVID-19

The effects of the COVID-19 pandemic will be a challenge to MSSP ACOs for the foreseeable future, specifically in the area of attribution. COVID-19 is limiting in-person visits and affecting attribution and the numerator of the QP calculation. Additional changes including the expansion of telehealth (which can lead to beneficiary assignment), care deferral, quality reporting, extreme and uncontrollable circumstances contract adjustments, and other changes create new challenges and opportunities for ACOs.^{8,9}

FIGURE 6: 2019 ACOS AND 2021 PAYMENT AMOUNT THRESHOLD

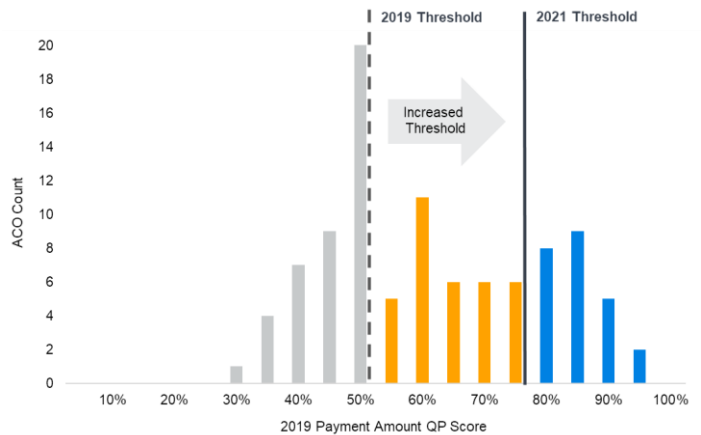
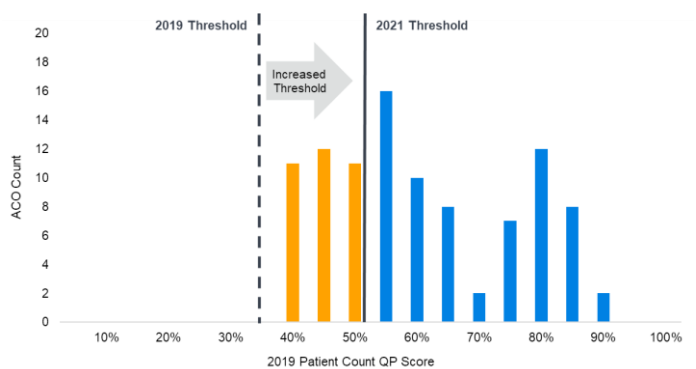


FIGURE 7: 2019 ACOS AND 2021 PATIENT COUNT THRESHOLD



⁸ For more information on how COVID-19 will impact MSSP ACOs, see <https://us.milliman.com/en/insight/eight-key-impacts-of-covid19-on-mssp-acos>.

⁹ For information from the National Association of ACOs (NAACOS) regarding COVID-19, see <https://www.naacos.com/covid-19-and-acos-fact-sheet>.

QP strategies

In light of the increased QP thresholds that will "raise the bar," we share four actions that may improve ACOs' QP scores for PY2021:

1. **Increase telehealth:** As a result of COVID-19, CMS has stated that telehealth may be counted as an attributable service.¹⁰ In order to increase beneficiary assignment (or maintain current beneficiaries), ACOs need to increase telehealth capacity. The sooner this is done, the better, to ensure beneficiaries are reached and attribution is bolstered.
2. **Optimize network composition:** Looking ahead to 2021, ACOs will more likely achieve the patient count threshold than the payment amount threshold (see blue regions in Figures 6 and 7 above). ACOs should consider how each participant affects the ACO's QP scores.¹¹ By increasing the proportion of PCPs, improving care coordination, or in some cases removing providers from the participant list, ACOs can boost attribution and increase QP scores. While doing this, ACOs need to weigh the benefits of the 5% bonus with the forgone revenue from having fewer specialists. Figure 1 above shows the average Part B revenue and associated 5% bonus of 10 highly utilized physician specialties. ACOs have until September 22, 2020, to finalize their participant lists.
3. **Evaluate attribution method:** As discussed earlier, switching from prospective attribution to retrospective attribution may help ACOs that expect lower volumes of primary care services (including telehealth) in 2020 than in 2021. ACOs have until September 22, 2020, to select the attribution method for PY2021.
4. **Outreach early:** Once an assigned beneficiary receives Part B services from the ACO during the performance year, that person becomes part of the numerator in the QP calculations. The beneficiary remains in the numerator for the rest of the performance year, improving the ACO's QP scores for all remaining QP snapshots. Therefore, it is important to see beneficiaries early on, so they can be part of the initial QP snapshot and all future QP snapshots in the performance year.

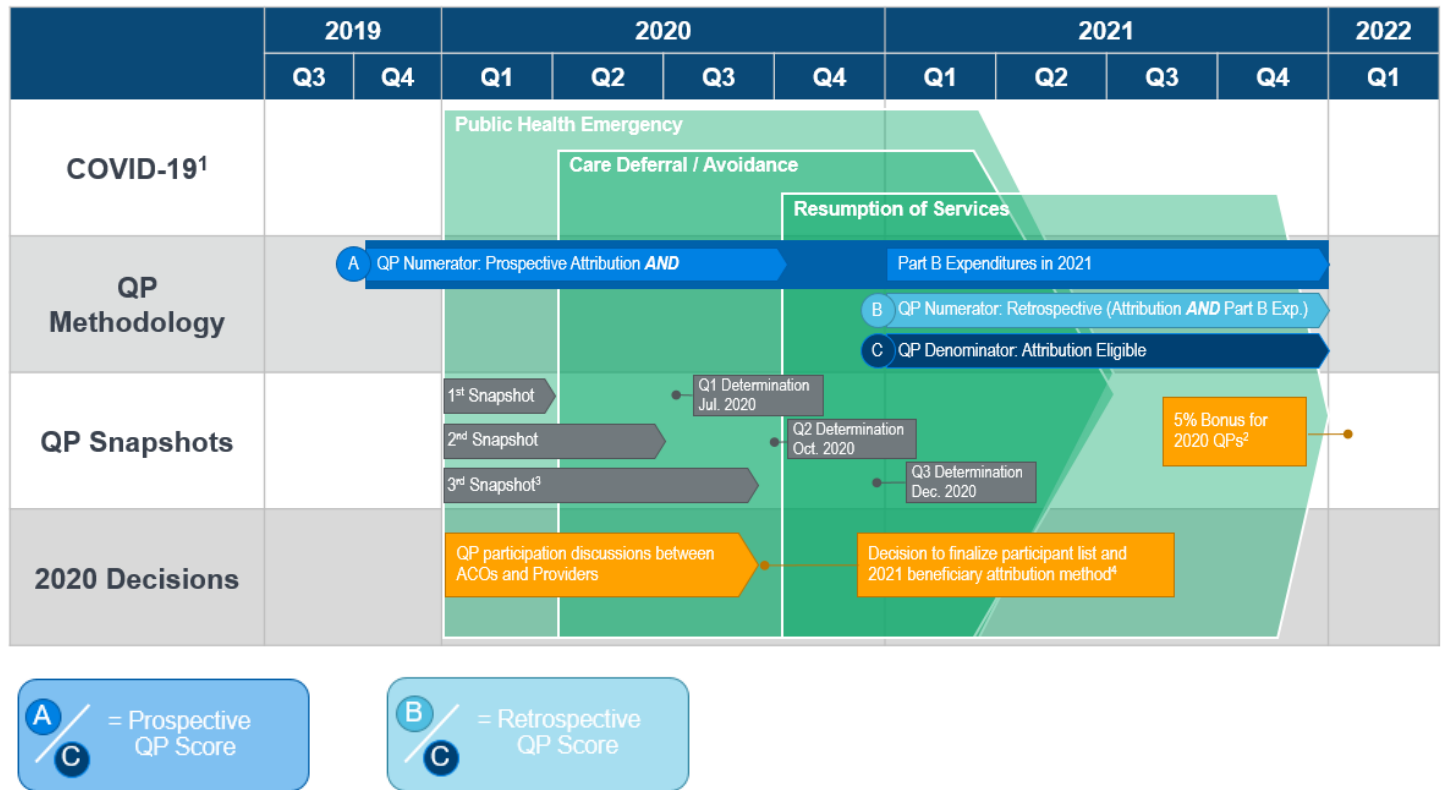
Conclusion

Among the 99 2019 MSSP ACOs studied, 34 are at risk for losing a combined estimated \$114 million in bonus for PY2021 (and thus become subject to MIPS payment adjustments and reporting requirements). To receive the bonus, ACOs must achieve QP status, which is influenced by factors such as care coordination, PCPs and specialists in the participant list, and beneficiary attribution method. Looking forward, higher QP thresholds and COVID-19 will make achieving QP status more difficult. ACOs need to take immediate action, especially given the COVID-19 pandemic (see Figure 8). By making deliberate efforts to reach beneficiaries early in the performance year, utilizing telehealth, selecting the most favorable attribution method, and carefully reviewing the ACO participant list, ACOs can "raise the bar" and set themselves up to achieve QP status for the 2021 performance year.

¹⁰ CPT codes approved for MSSP attribution: Remote evaluation of patient video/images (G2010), virtual check-ins (G2012), e-visits (99421-99423), telephone E/M (99441-99443), newly added codes during public health emergency (PHE) including nursing facility care (99304-99306), nursing facility discharges (99315-99316), domicile/rest-home visit new patient (993327-99328), domicile/rest-home visit established patient (99334-99337), home visit new patient (99341-99345), home visit established patient (99347-99350). MSSP risk adjustment requires telehealth to include "face-to-face encounter." For more information, see <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

¹¹ Milliman actuaries have created models to help MSSP ACOs evaluate TIN-level contributions to QP status and 5% bonus (and MSSP settlement).

FIGURE 8: QP TIMELINE PY2020+



¹ COVID-19 timeframes are provided as examples. “PHE” duration is based on a recent CBO study indicating that there is a strong possibility that the PHE may be in place through a portion of 2021, see: <https://www.cbo.gov/system/files/2020-04/HR6201.pdf> (p5). “Care Deferral/ Avoidance” and “Resumption of Services” are subjectively approximated and assumed to correlate with the PHE timeframe.

² QP Bonus based on performance year 2020 is scheduled to be paid in 2022.

³ QP 3rd Snapshot ends on 8/31/2020. See: <https://qpp.cms.gov/about/eligibility-determination-periods-and-snapshots>

⁴ Decision to add participants must be made by 8/24/2020 and to remove participants by 9/22/2020



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