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Explanation of Performance Measurement and Payment Framework for the Medicare Shared Savings Program October 2011

On October 20, 2011, CMS released the final rule for ACOs in the Medicare Shared Savings Program (MSSP). The MSSP is scheduled to begin in 2012, with rolling start dates of April and July of that year, and the first measurement and payment year will begin on January 1, 2013. This memo outlines the final parameters around quality measurement, cost measurement, and the calculation of shared savings for ACOs.

A. ACO Performance Measures

Based on feedback, CMS removed a number of the 65 measures contained in the proposed rule that were perceived as redundant, operationally complex, or burdensome, and retained 33 measures that focus on areas of high prevalence and cost for the Medicare program. Some of the initial measures were also moved out of the quality performance domain into CMS's monitoring program to prevent ACOs from manipulating or avoiding at-risk patients. The monitoring program requires no additional action from ACO providers, and will use CMS claims data.

The final measures, listed in the Appendix, focus predominantly on ambulatory care, given the primary care focus of the MSSP and the method of beneficiary attribution. The measures are divided into four domains to better align with other CMS value based purchasing initiatives: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At Risk Populations, which focuses on diabetes, hypertension, ischemic vascular disease, heart failure, and coronary artery disease.

The final measure set is comprised primarily of NQF-endorsed measures, but CMS has also included non-endorsed measures that it feels will have high-impact on the quality of care delivered. Measures cover care that assigned beneficiaries will receive from *both* ACO and non-ACO providers. Some of the measures are not yet specified for ACO-level measurement, and will need to be refined; the specifications and reporting methodologies for non-CAHPS measures will be available on CMS's website prior to the start of the MSSP in 2012. CAHPS measure specifications will be available during 2012. A number of measures will be risk-adjusted, but this will generally be limited to age and gender; the risk adjustment specifications will be outlined in sub-regulatory guidance.

The 33 measures will be scored as 23, since six of the seven patient experience measures are scored as one, as are the all-or-nothing diabetes and CAD measures. As outlined in the Appendix, IHA's current measure set has 13 of the 33 measures,¹ and there is also overlap between the MSSP measures and the 2012 Medicare Advantage Health Plan Star Rating measures, as well as health plan HEDIS measures.

Despite feedback, the final measures are quality-only, and do not focus explicitly on resource use or reducing costs. CMS believes that specific measures addressing utilization or high-cost services are unnecessary to incentivize ACOs to address costs, and that the incentives offered by shared savings will be sufficient to engender lower cost

¹ There are also four measures that IHA is considering adopting for the purpose of Medicare Stars measurement, two measures that overlap, but are not fully aligned with IHA's Meaningful Use of HIT domain, and one measure that CMS has yet to specify which may align with IHA's measure set (see Appendix for more details).

growth. They do, however, state that they may consider such measures in the future. The specifications for benchmark and actual cost – which will be the basis for shared savings calculations – are outlined below.

B. Aligning ACO Quality Measures with other Laws and Regulations

The MSSP is closely aligned with the National Quality Strategy. The final rule also incorporates certain performance requirements and payments related to the Physician Quality Reporting System (PQRS; a voluntary pay-for-reporting program in Medicare) for eligible professionals within an ACO. The eligible professionals that are ACO participants will constitute a group practice for the purpose of qualifying for PQRS incentives under the Shared Savings Program. In the future, the MSSP will seek to align more closely with the EHR Incentive Programs as EHR use becomes more widespread.

C. Data Submission Processes

CMS has specified four data submission methods in the final rule:

1. **Self-reported data** will be gathered using the Group Practice Reporting Option data collection tool (GPRO; a tool currently used in the Physician Quality Reporting System that will allow ACOs to submit clinical information from EHRs, registries, and administrative data sources). 22 measures will be collected using the GPRO web interface. For most measures, a random sample of at least 411 beneficiaries will be drawn from GPRO data.² For some measures, data submission will be in the form of ‘attestation’ that will be validated by cross-checking with measures captured by CMS’s EHR or eRx Incentive Programs. CMS specifies that it may audit these data for accuracy.
2. **Claims data** submitted to CMS will be used to calculate three of the performance measures. This will not require any additional reporting on the part of ACO professionals, who already provide these data to CMS for the purposes of payment.
3. **Survey data** will be used for seven of the measures. These measures capture patient and caregiver experience of care through the CG-CAHPS survey. CMS will pay for the administration of the CG-CAHPS survey in 2012 and 2013.
4. **EHR Incentive Program:** one measure will be based on data already reported to the EHR Incentive Program, and no additional reporting will be required on behalf of ACO participants.

Detailed instructions on each of these methods will be provided in sub-regulatory guidance.

D. Quality Performance Standards

For year one, the requirement to receive shared savings is complete and accurate reporting on all 33 measures; pay for performance will be phased in over years two and three. In year two, performance will be calculated on a total of 25 measures, and 8 will be reporting-only, and in year three, 32 will be scored with only one reporting-only measure (see the table in Appendix for measures phase-in timeline). ACOs must completely and accurately report on all measures, and if an ACO fails to report one or more measure in the specified time frame without explanation, it may face expulsion from the program.

The “sliding scale” approach to scoring individual measures, which is outlined in Table One, has been retained in the final rule. Under this approach, each measure’s performance score is calculated by comparing the ACO’s performance against benchmarks based on the most currently available data from Medicare FFS and Medicare Advantage.³ A minimum performance threshold of the national 30th percentile of performance for Medicare Advantage or FFS, or a rate of 30%, has been finalized. The values of the percentiles will be published in sub-regulatory guidance at the start of the second performance year. The minimal attainment level will rise gradually over time in order to encourage improvement.

² There are some exceptions to the 411 threshold, such as when an ACO has fewer than 411 beneficiaries who qualify for the measure, in which case the total population of qualifying patients is used.

³ The Medicare FFS rates will be determined by pulling a sample of data and modeling; Medicare Advantage rates will be determined by looking at annual MA quality performance data.

All measures within a domain are given equal weighting with the exception of the Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment measure in the Care Coordination/Patient Safety domain, which is double-weighted in an effort to signal the importance of EHR adoption (see Table One).

Table One: CMS’s “Sliding Scale Measure Scoring Approach”

| ACO Performance Level | Quality Points (All Measures Except EHR) | EHR Measure Points |
|---|--|--------------------|
| 90+ percentile FFS/MA rate or 90+ percent | 2 points | 4 points |
| 80+ percentile FFS/MA rate or 80+ percent | 1.85 points | 3.7 points |
| 70+ percentile FFS/MA rate or 70+ percent | 1.7 points | 3.4 points |
| 60+ percentile FFS/MA rate or 60+ percent | 1.55 points | 3.1 points |
| 50+ percentile FFS/MA rate or 50+ percent | 1.4 points | 2.8 points |
| 40+ percentile FFS/MA rate or 40+ percent | 1.25 points | 2.5 points |
| 30+ percentile FFS/MA rate or 30+ percent | 1.1 points | 2.2 points |
| <30 percentile FFS/MA rate or <30 percent | 0 points | 0 points |

Reproduced from final rule, available at <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

In the proposed rule, any ACO not meeting the 30th percentile cut-off on any one measure would not qualify for shared savings, and could face program expulsion. In the final rule, this standard has been relaxed such that ACOs may qualify for shared savings if they meet the minimum quality performance standard on at least 70% of measures in each domain.

E. Overall Scoring for Shared Savings Determination

Once individual measures in each domain are scored based on the approach outlined in Table One, these scores are summed and divided by the total potential points per domain to obtain a domain score. These domain scores, each weighted equally at 25%, are summed to get the final performance score. Table Two outlines the potential points per domain, and the number of measures for the purposes of calculating performance scores.

Table Two: Total Points for Each Domain

| Domain | Total Individual Measures (see appendix) | Total Measures for Scoring Purposes | Total Potential Points per Domain | Domain Weight |
|-----------------------------------|--|---|-----------------------------------|---------------|
| Patient/ Caregiver Experience | 7 | 1 measure with 6 survey module measures combined, plus 1 individual measure | 4 | 25% |
| Care Coordination/ Patient Safety | 6 | 6 measures, with the EHR measure double-weighted (see table above) | 14 | 25% |
| Preventive Health | 8 | 8 measures | 16 | 25% |
| At-Risk Populations | 12 | 7 measures, two of which are composites (diabetes composite has 5 separate measures, CAD composite has 2) | 14 | 25% |
| TOTAL | 33 | 23 | 48 | 100% |

Reproduced from final rule, available at <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

This method of scoring rewards higher performance with a higher percentage of shared savings. Unlike some other value based purchasing initiatives that CMS has adopted, such as the hospital VBP program, this method does not explicitly reward improvement, although CMS states in the rule that improvement over time is rewarded with a higher portion of shared savings.

F. Measuring Benchmark and Actual Expenditures

The quality performance score is used alongside cost performance in order to determine shared savings. The actual and projected cost of care delivered are implicit measures in the MSSP, as the base shared savings amount will be the difference between *actual* and *benchmark* expenditures under Parts A and B for assigned Medicare FFS patients.

For the actual cost in a given year, the patient population will be the beneficiaries assigned to the ACO, but for the initial benchmark, the patient population will include Medicare FFS beneficiaries who would have been assigned to the ACO in each of the three years prior to the start of the agreement period.⁴ Beneficiaries will be categorized into one of four cost categories (in this order): ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non dual Medicare beneficiaries. Total annual Parts A and B per capita expenditures will be truncated at the 99th percentile of national Medicare FFS expenditure in each benchmark and performance year in order to account for high-cost outliers. For the benchmark calculation, the three years are weighted such that the most recent year accounts for 60%, the second most recent for 30%, and the first year for 10%. Benchmark years one and two will be trended forward to year three using the growth rate in per beneficiary expenditures for Parts A and B, separately for each of the cost categories identified above.

A number of adjustments will be made to both benchmark and performance year costs. The benchmark will be adjusted to account for national growth rates in Parts A and B expenditures for FFS beneficiaries in each of these four categories listed above. Both benchmark and performance year costs will be adjusted to account for health status and demographic characteristics based on the CMS-HCC model. In a performance year, the costs of newly-assigned beneficiaries will be adjusted using the CMS-HCC model, and the costs of continuously-assigned beneficiaries will be adjusted using demographic factors alone unless CMS-HCC risk adjustment results in a lower risk score. Finally, Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments will be excluded from both benchmark and performance year expenditures, as will Graduate Medical Education (GME), PQRS, Electronic Prescribing (eRx), and EHR incentive payments for eligible professionals, and EHR incentive payments for hospitals.

G. Calculating Shared Savings

Actual Part A and B expenditures for assigned beneficiaries during a performance year will be compared to benchmark expenditures in order to calculate the base amount of shared savings for which an ACO is eligible. Shared savings will be calculated differently for model one ACOs (one-sided risk) and model two ACOs (two-sided risk).

For one-sided risk ACOs, an entity is eligible to share up to 50% of savings based on quality performance. There is a minimum shared savings rate of between 2.0% and 3.9%, depending upon the number of assigned beneficiaries. After this rate is met, an ACO is eligible to participate in first-dollar sharing. In other words, once an ACO has met the minimum shared savings rate, the performance score is multiplied by 50% of the *total amount* of shared savings in order to calculate the ACO's share. This amount is limited to 10% of the benchmark expenditures. The transition to two-sided risk in year three for ACOs in model one was removed in the final rule.

For two-sided risk ACOs, an entity is eligible to share up to 60% of savings based on quality performance. There is a flat 2% minimum shared savings rate, after which an ACO can share in first-dollar sharing. There is also a 2.0% minimum loss rate after which an ACO will be required to pay back a portion of shared losses; the shared loss rate will be one minus the final sharing rate applied to first-dollar losses, and will not exceed 60%. Once an ACO has met the shared savings or loss rate, the performance score will be multiplied by 60% of the total in order to calculate the ACO's share; this amount will not exceed 15% of benchmark expenditures.

⁴ For more information on the assignment process, please see the final rule, available here: <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

APPENDIX: ACO Measure Descriptions and Comparison with IHA, Medicare Stars, and HEDIS

GREY: MSSP measure is contained in IHA measure set; see “Alignment with IHA Measure Set” column for notes on measures that are similar, or that IHA is planning on adopting

| Measure Title | | NQF Measure #, Measure Steward | Method of Data Submission | P4P Phase-In R = Reporting P = Performance | Alignment with IHA Measure Set | Medicare Advantage Health Plan Star Rating Measure | HEDIS Measure |
|---|---|-----------------------------------|---------------------------|--|--|--|--|
| Patient/Caregiver Experience | | | | | | | |
| 1 | CAHPS: Getting Timely Care, Appointments, and Information | NQF#5, AHRQ | Survey | Yr 1: R Yr 2: P Yr 3: P | PAS Timely Care and Service | C27: Getting Appointments and Care Quickly (CAHPS) | CAHPS Health Plan Survey 4.0H (CPA) Getting Care Quickly |
| 2 | CAHPS: How Well Your Doctors Communicate | NQF#5, AHRQ | Survey | Yr 1: R Yr 2: P Yr 3: P | PAS Doctor-Patient Communication | | How Well Doctors Communicate |
| 3 | CAHPS: Patients’ Rating of Doctor | NQF#5, AHRQ | Survey | Yr 1: R Yr 2: P Yr 3: P | PAS Overall Ratings of Care | | Rating of Personal Doctor |
| 4 | CAHPS: Access to Specialists | NQF#5, AHRQ | Survey | Yr 1: R Yr 2: P Yr 3: P | Timely Care and Service for Specialists | | |
| 5 | CAHPS: Health Promotion and Education | NQF#5, AHRQ | Survey | Yr 1: R Yr 2: P Yr 3: P | PAS Health Promotion | | Health Promotion and Education |
| 6 | CAHPS: Shared Decision-Making | NQF#5, AHRQ | Survey | Yr 1: R Yr 2: P Yr 3: P | | | Shared Decision Making |
| 7 | CAHPS: Health Status/ Functional Status | NQF #6, AHRQ | Survey | Yr 1: R Yr 2: R Yr 3: R | | | |
| Care Coordination/Patient Safety | | | | | | | |
| 8 | Risk-Standardized, All Condition Readmission* | NQF #TBD, CMS | Claims | Yr 1: R Yr 2: R Yr 3: P | NQF # 0329 All Cause Readmissions (may not be the same, ACO measure TBD) | | |

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|--------------------------|---|------------------------|---------------------------------|-------------------------------|---|--|--|
| 9 | Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ PQI #8) | NQF #275, AHRQ | Claims | Yr 1: R Yr 2: P Yr 3: P | | | |
| 10 | Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ PQI #8) | NQF #277, AHRQ | Claims | Yr 1: R Yr 2: P Yr 3: P | | | |
| 11 | Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment | CMS | EHR Incentive Program Reporting | Yr 1: R Yr 2: P Yr 3: P | IHA has adopted all Stage One Meaningful Use measures | | |
| 12 | Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility | NQF #97, AMA-PCPI/NCQA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | IHA has adopted all Stage One Meaningful Use measures , including selecting any 5 menu set measures | C13: Care for Older Adults Medication Review (not post-discharge specific) | Medication Reconciliation Post-Discharge (MRP) |
| 13 | Falls: Screening for Fall Risk | NQF #101, NCQA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Considering adoption for Medicare Advantage measurement and reporting | C24: Reducing the Risk of Fall | Fall Risk Management (FRM) |
| Preventive Health | | | | | | | |
| 14 | Influenza Immunization | NQF #41, AMA- PCPI | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Considering adoption for Medicare Advantage measurement and reporting | C06: Annual Flu Vaccine (CAHPS) | Flu Shots for Older Adults Ages 50-54 (FSA) Flu Shots for Older Adults (FSO) |
| 15 | Pneumococcal Vaccination | NQF #43, NCQA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Considering adoption for Medicare Advantage measurement and reporting | C07: Pneumonia Vaccine (CAHPS) | Pneumonia Vaccination for Older Adults (PNU) |
| 16 | Adult Weight Screening and Follow-Up | NQF #421, CMS | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Considering adoption for Medicare | C12: Adult BMI Assessment | Adult BMI Assessment (ABA) (does not |

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|-------------------------------------|---|-------------------------------------|--------------------|-------------------------------|-------------------------------------|---|---|
| | | | | | Advantage measurement and reporting | (does not include follow-up plan) | include follow-up plan) |
| 17 | Tobacco Use Assessment and Tobacco Cessation Intervention | NQF #28, AMA- PCPI | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | | | Medical Assistance with Smoking and Tobacco Use Cessation (MSC) |
| 18 | Depression Screening | NQF #418, CMS | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | | | |
| 19 | Colorectal Cancer Screening | NQF #34, NCQA | GPRO Web Interface | Yr 1: R Yr 2: R Yr 3: P | Colorectal Cancer Screening | C02: Colorectal Cancer Screening | Colorectal Cancer Screening |
| 20 | Mammography Screening | NQF #31, NCQA | GPRO Web Interface | Yr 1: R Yr 2: R Yr 3: P | Breast Cancer Screening | C01: Breast Cancer Screening | Breast Cancer Screening (BCS) |
| 21 | Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years | CMS | GPRO Web Interface | Yr 1: R Yr 2: R Yr 3: P | | | |
| At-Risk Population: Diabetes | | | | | | | |
| 22 | Diabetes Composite (All-Or-Nothing Scoring): HbA1c Control (<8%) | NQF #0729, MN Community Measurement | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Diabetes Care: HbA1c Control <8% | C19: Diabetes Care – Blood Sugar Controlled | Comprehensive Diabetes Care (CDC) |
| 23 | Diabetes Composite (All-Or-Nothing Scoring): LDL (<100) | NQF #0729, MN Community Measurement | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Diabetes Care: LDL Control <100 | C20: Diabetes Care – Cholesterol Controlled | Comprehensive Diabetes Care (CDC) |
| 24 | Diabetes Composite (All-Or-Nothing Scoring): Blood Pressure <140/90 | NQF #0729, MN Community Measurement | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Diabetes Care: BP Control <140/90 | C21: Controlling Blood Pressure | Comprehensive Diabetes Care (CDC) |
| 25 | Diabetes Composite (All-Or-Nothing Scoring): Tobacco Non-Use | NQF #0729, MN Community Measurement | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | | | |
| 26 | Diabetes Composite (All-Or- | NQF #0729, | GPRO Web | Yr 1: R | | | |

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|--|--|---|-----------------------|-------------------------------|--|--|--|
| | Nothing Scoring): Aspirin Use | MN Community Measurement | Interface | Yr 2: P Yr 3: P | | | |
| 27 | Diabetes Mellitus: HbA1c Poor Control (>9%) | NQF #59, NQCA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Diabetes Care: HbA1c Poor Control >9% | | Comprehensive Diabetes Care (CDC) |
| At-Risk Population: Hypertension | | | | | | | |
| 28 | HTN: Blood Pressure Control | NQF #18, NCQA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | | C21: Controlling Blood Pressure | Controlling High Blood Pressure (CBP) |
| At-Risk Population: Ischemic Vascular Disease | | | | | | | |
| 29 | IVD: Complete Lipid Profile and LDL Control <100 mg/dl | NQF #75, NCQA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | Cholesterol Management LDL Screening and Control <100 | C03: Cardiovascular disease – Cholesterol Screening (note: Stars measure does not include complete lipid profile) | Cholesterol Management for Patients with Cardiovascular Conditions (CMC) |
| 30 | IVD: Use of Aspirin or Another Antithrombotic | NQF #68, NCQA | GPRO Web Interface | Yr 1: R Yr 2: P Yr 3: P | | | Comprehensive Ischemic Vascular Disease Care (IVD) *Applies to physician-level measurement only |
| At-Risk Population: Heart Failure | | | | | | | |
| 31 | HF: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | NQF #83, AMA- PCPI | GPRO Web Interface | Yr 1: R Yr 2: R Yr 3: P | | | |
| At-Risk Population: CAD | | | | | | | |
| 32 | CAD Composite, All-Or-Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol | NQF #74, CMS (composite)/ AMA- PCPI (individual | GPRO Web Interface | Yr 1: R Yr 2: R Yr 3: P | | | |

| | | | | | | | |
|----|--|---|--------------------|-------------------------------|--|--|--|
| | | component) | | | | | |
| 33 | CAD Composite, All-Or-Nothing Scoring: ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD | NQF #66, CMS (composite)/AMA- PCPI (individual component) | GPRO Web Interface | Yr 1: R Yr 2: R Yr 3: P | | | |

*NOTE: measure is under development, and the use of it in the MSSP is contingent upon the availability of specifications before January 1, 2012.