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Explanation of CMS Proposed Performance Measurement Framework for ACOs and Comparison with IHA P4P Measure Set April 2011

This briefing outlines Section II E (Quality and Other Reporting Requirements) of the Medicare Shared Savings (ACO) Program proposed regulations released on March 31, 2011. It was prepared by the Integrated Healthcare Association (IHA) to explain the regulations' parameters around performance measurement. It will also relate them to the IHA P4P Program and comment on the alignment of the measure sets, data submission processes, and quality performance standards that will be used for calculating payments, as well as for determining eligibility for continued enrollment in the program.

Under these regulations, CMS will enter into three-year contracts with ACOs, who will receive shared savings bonuses based on their ability to manage costs and performance on 65 measures of quality. In year one, ACOs will only be required to report measures, but in years two and three, they will be subject to scoring based on to-be-determined performance benchmarks.

CMS is seeking input on its performance measurement framework for ACOs, and there are still some aspects that remain unclear. Although CMS has set out the 65 measures it plans to use to assess quality that are largely endorsed by NQF or included in the EHR Incentive Program, the final measure specifications have not been set out in the proposed rule.

A. ACO Performance Measures

The 65 included measures – listed in Appendix One – are divided into five domains: (1) patient/caregiver experience; (2) care coordination; (3) patient safety; (4) preventive health; and (5) at-risk population/frail elderly health. To the extent possible, CMS sought to align these measures with measurement requirements across its existing public reporting and payment systems. The measures were also chosen to minimize collection and reporting burdens on providers; to have a high impact in terms of cost and accountability; to allow for consistency across ACOs, regardless of composition; and to offer opportunities to improve care.

Where feasible, CMS has chosen measures that are nationally endorsed by a multi-stakeholder organization. However, a number of the measures chosen were not originally designed for ACO measurement, and will have to be refined in order to be used for this purpose. The refinement parameters are not laid out in the proposed regulations, but will be posted prior to the beginning of the program. Risk adjustment and adjustments for patient and provider characteristics will be made where practical and appropriate, although these parameters are also not outlined.

Of CMS's proposed ACO measures, eighteen are in IHA's P4P measure set for Measurement Year (MY) 2011, and three are being tested at this time. These are highlighted in Appendix One, which also sets out the source of each of the measures, as well as how the ACO proposed measure set overlaps with the

Medicare Advantage Star Rating and HEDIS measures. The proposed measure set includes an additional twelve measures that the P4P Program has considered or tested, but not adopted due to the unavailability of data or small sample sizes in the commercial population. For the most part, these concerns are resolved in the Medicare population because of age and disease burden differences (Appendix One provides an explanation for why these measures were not adopted). There are also two hospital measures that are not applicable to the organizations measured by the IHA P4P program, and eleven measures that IHA has not considered because they are generally inappropriate for commercial populations, but are more appropriate for Medicare populations (e.g. screening for fall risk for elderly frail patients).

B. Data Submission Processes

For the first year, CMS specifies three primary data submission methods that are similar to the self-report, health plan report, and survey methods used by the P4P Program:

1. **Self-reported data** will be gathered using the Group Practice Reporting Option data collection tool (GPRO; a new tool currently used in the Physician Quality Reporting System that will allow ACOs to submit clinical information from EHRs, registries, and administrative data sources). For most measures, a random sample of at least 411 beneficiaries will be drawn from GPRO data.¹ 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 eleven 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 or eight of the proposed measures (one may be submitted by using either the GPRO or survey methods). These measures primarily capture patient and caregiver experience of care through the CG-CAHPS survey.

In subsequent years, modes of reporting will be expanded, and will leverage the infrastructure created under the EHR incentive program. Table One outlines the number of measures that will be collected from each of the data sources specified by CMS.

Table One: Number of Measures by Method of Data Submission

Method of Data Submission	Number of Measures
GPRO Tool	46
Group Practice Reporting Option (GPRO) Data Tool	42
GPRO Data Tool/EHR Incentive Program Reporting	3
GPRO Data Tool/eRx Incentive Program Reporting	1
Claims Data	11
Claims only	9
Claims or CDC National Healthcare Safety Network	2
Survey Data	8
Survey only	7
Survey or GPRO Data Tool	1
Total	65

¹ 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.

C. Quality Performance Standards

CMS proposes that ACOs be required to report quality measures and meet applicable performance criteria for all three years of the agreement period to be considered as having met the performance standard. For year one, the criteria will be full and accurate measures reporting, but for subsequent years, there will be performance benchmarks set. ACOs that do not meet the quality performance thresholds will not be eligible for shared savings, regardless of per capita cost reductions. It is unclear from the text of the proposed regulations whether the standards are set at the individual measure level or at the measure domain level.² Failure to report measures may result in contract termination.³

CMS considered two alternative options for establishing quality standards, and will use a ‘performance score approach’ that rewards higher-quality ACOs with higher percentages of shared savings. This approach is consistent with the recommended shared savings methodology that will be incorporated into IHA P4P Performance Based Contracting, where a multiplier based on a physician organization’s quality performance will be applied to the shared savings amount. CMS is also considering the use of a threshold approach, where ACOs would receive full shared savings if they met a minimum standard of care, and are currently seeking comments on this.

The performance score for each measure will be calculated by setting benchmarks using the most currently available data from Medicare FFS and Medicare Advantage⁴ (and later, data from the ACOs themselves). ACOs will be scored on a sliding scale for each measure using the benchmarks and thresholds defined in Table Two.

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

ACO Performance Level	Quality Points
90+ percentile FFS/MA Rate or 90+ percent	2 points
80+ percentile FFS/MA Rate or 80+ percent	1.8 points
70+ percentile FFS/MA Rate or 70+ percent	1.7 points
60+ percentile FFS/MA Rate or 60+ percent	1.55 points
50+ percentile FFS/MA Rate or 50+ percent	1.4 points
40+ percentile FFS/MA Rate or 40+ percent	1.25 points
30+ percentile FFS/MA Rate or 30+ percent	1.10 points
<30 percentile FFS/MA Rate or <30 percent	No points

There are three measures that will be scored differently owing to the nature of the measures. Measures number 35 (Diabetes Composite that includes five separate measures) and number 52 (Coronary Artery Disease composite that includes five separate measures) will be scored on an ‘all or nothing’ basis. Each individual sub measure will also be scored individually, although how this factors into the scoring is not explicit. Measure 24 (HAC composite with ten components and eight subcomponents) will be scored by summing the events included and evaluating the rate using the scale in the table above. More detail on these measures is provided in Appendix One.

² Page 204 specifies domain level, whereas page 171 specifies measure level.

³ If an ACO fails to report one or more measures, CMS will send a written request for submission, as well as an explanation for the delay. If the ACO does not comply with this request, its contract will be terminated.

⁴ 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.

Once all measure scores have been calculated, all measures in a domain will be summed to the domain level, and then scores will be averaged across all domains to provide a single quality metric. The final score will be used to determine the quality sharing for up to 50% of the shared savings generated by the ACO for a one-sided risk model and up to 60% for a two-sided risk model. Performance standards will be ramped up after two years to encourage performance improvement.

Example of Performance Calculation for a One-Sided ACO Model⁵

For illustrative purposes, we will use a fictional ACO called “California ACO, Inc.” California ACO receives a performance score on each measure; for example, its performance on Mammography Screening (measure number 28 in the preventive health domain) is above the 90th percentile, thus it receives two points, which is the maximum number of points per measure. Its points on each measure are then summed to the domain level, which will yield five domain scores. These domain scores are then divided by the total of points available for each domain to yield a domain score, as outlined in Table Three.

Table Three: California ACO Inc.’s Performance

Domain and Total Number of Measures	Total Points Available for One-Sided Model	Total Points for California ACO, Inc.	Domain Score
Patient/Caregiver Experience (7 measures)	14	12.95	92.5%
Care Coordination (16 measures)	32	29.6	92.5%
Patient Safety (2 measures)	4	3.4	85.0%
Preventive Health (9 measures)	18	12.6	70.0%
At-Risk Populations (31 measures)	62	48.05	77.5%
Total	130	106.6	83.5%

The domain scores are then averaged to yield an overall score⁶ - in California ACO’s case, this is 83.5%. This score is then multiplied by the percentage of shared savings available – 50% - to yield California ACO’s portion of shared savings, which is 41.75%. If California ACO saved a total of \$1million over the measurement year, it would receive \$417,500 from CMS in shared savings.

D. The Incorporation of Performance Requirements under s.1848 of the Act for Physician Quality Reporting System

The proposed rules also outline how current CMS incentive programs will be incorporated into ACO measurement and incentive payments. CMS proposes to incorporate certain requirements and payments related to the Physician Quality Reporting System (PQRS; a voluntary pay-for-reporting program in Medicare) into the Shared Savings program for eligible professionals within an ACO. The eligible professionals that are ACO participants would constitute a group practice for the purpose of qualifying for PQRS incentives under the Shared Savings Program, as opposed to qualifying as individuals. CMS is not proposing to incorporate payments for the EHR Incentive Program or the Electronic Prescribing Incentive Program – professionals can still participate separately in those programs, although there will be some overlap with the ACO measures.

⁵ A one-sided ACO model is eligible for up to 50% of its shared savings, whereas a two-sided model is eligible for up to 60% of its shared savings, although the same calculation is used to determine the total quality points available.

⁶ CMS is treating all domains equally, regardless of the number of measures, which is based on a judgment that all domains are equally important (see pages 208 to 209 of the proposed rule).

E. Requirements for Public Reporting by ACOs

Although the Affordable Care Act did not include public reporting requirements for the Shared Savings Program, CMS believes that it would be desirable and consistent with the Act. They propose that the following be publicly reported by all ACOs on a mandatory basis:⁷

1. Name, location, and primary contact
2. Organizational information:
 - a. ACO participants
 - b. Identification of ACO participants in joint ventures between ACO professionals and hospitals
 - c. Members of governing body, associated committees, and committee leadership
3. Shared savings information:
 - a. Shared savings payment received or shared losses incurred
 - b. Total proportion of shared savings invested in infrastructure, redesigned care processes, and other resources required to support the aims of better population health, better cares for individuals, and lower growth in expenditures
4. Quality performance scores

F. Aligning ACO Quality Measures with other Laws and Regulations

These quality measures are amongst the first promulgated under the Affordable Care Act, which has many separate quality measurement and reporting programs. CMS is seeking comments about harmonization, specifically whether quality standards under the Act's many quality initiatives should use the same definitions of domains, categories, specific measures, and performance rewards.

G. Comments

We are encouraged by the overlap between the current P4P measures and reporting processes and the proposed ACO regulations. This overlap, as well as the experience that physician organizations that participate in IHA's P4P program have with measurement and reporting, make them well-qualified to adopt this measurement framework if they decide to participate in the Shared Savings Program. However, in their current configuration, these ACO measurement and reporting requirements represent a significant burden. IHA is preparing a response to the proposed regulations that states our support for standardized measurement, to the extent possible, across programs, as well as our recommendations for reducing the burden of ACO performance measurement and reporting in Year One. This includes starting with only previously-specified measures that have been tested and validated, and adding more measures in years two and three once these have been fully specified.

⁷ CMS will provide ACOs with a standardized reporting format through sub-regulatory guidance, and will build reporting requirements into the three-year contracts it signs with ACOs.

Appendix One: Comparison of ACO Measure Set and IHA, Medicare Advantage Star Rating, and HEDIS Measure Sets

Legend

Grey: measures that overlap with IHA measure set

PQRS: Physician Quality Reporting System

EHR: CMS EHR Incentive Program

NQF: National Quality Forum

Measures		Measure Source				Alignment with IHA, Medicare Advantage Star Rating, and HEDIS Measures			
ACO Measure #	Measure Description	PQRS	EHR	NQF	Other	IHA P4P Measure	Comments about alignment with IHA measure set	Medicare Advantage Health Plan Star Rating Measure	HEDIS Measure
Patient/Caregiver Experience									
1	CG-CAHPS: Getting Timely Care, Appointments, and Information			5		Patient Assessment Survey (PAS) Timely Care and Service	IHA PAS measures based on CG-CAHPS	Getting Appointments and Care Quickly (CAHPS)	CAHPS Health Plan Survey 4.0H (CPA) Getting Care Quickly
2	CG-CAHPS: How Well Your Doctors Communicate			5		PAS Doctor-Patient Communication		Doctors Who Communicate Well (CAHPS)	How Well Doctors Communicate
3	CG-CAHPS: Helpful, Courteous, Respectful Office Staff			5		PAS Office Staff		Customer Service	Customer Service
4	CG-CAHPS: Patients' Rating of Doctor			5		PAS Overall Ratings of Care			Rating of Personal Doctor
5	CG-CAHPS: Health Promotion and Education			5		PAS Health Promotion			Health Promotion and Education
6	CG-CAHPS: Shared Decision Making			5					Shared Decision Making
7	Medicare Advantage CAHPS: Health Status/Functional Status			6			Considering testing in PAS		
Care Coordination/ Transitions									
8	Rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population				CMS	Inpatient Readmissions Within 30 Days (NQF #329)	IHA's 30 day all- cause readmission measure may not be exactly same		Plan All-Cause Readmissions (PCR)
9	30 Day Post Discharge Physician Visit				CMS				
10	Reconciliation After Discharge from an Inpatient facility. Percentage of patients aged 65 years and older d/c from any inpatient facility and seen within 60 days			554					Medication Reconciliation Post-Discharge (MRP)
11	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions			228 or alternate					

Measures		Measure Source				Alignment with IHA, Medicare Advantage Star Rating, and HEDIS Measures			
ACO Measure #	Measure Description	PQRS	EHR	NQF	Other	IHA P4P Measure	Comments about alignment with IHA measure set	Medicare Advantage Health Plan Star Rating Measure	HEDIS Measure
12	Diabetes, short-term complications (AHRQ PQI #1)			272			Tried, but commercial populations too small; AHRQ software is publicly available without risk-adjustment tools		
13	Uncontrolled Diabetes (AHRQ PQI #14)			638					
14	Chronic obstructive pulmonary disease (AHRQ PQI #5)			275					
15	Congestive Heart Failure (AHRQ PQI #8)			277					
16	Dehydration (AHRQ PQI #10)			280					
17	Bacterial pneumonia (AHRQ PQI #11)			279					
18	Urinary infections (AHRQ PQI #12)			281					
Care Coordination/Information Systems									
19	% All Physicians Meetings Stage 1 HITECH Meaningful Use Requirements				CMS		Could do if MDs to be included were clearly defined		
20	% of PCPs Meeting Stage 1 HITECH Meaningful Use Requirements				CMS	No specific measure, but IHA P4P has adopted all Stage One Meaningful Use measures, and can calculate this from the data we collect			
21	% of PCPs Using Clinical Decision Support		Core		CMS	Implement one clinical decision support rule			
22	% of PCPs who are Successful Electronic Prescribers Under the eRx Incentive Program		Core		CMS	Generate and transmit permissible prescriptions electronically (eRx)			
23	Patient Registry Use		Menu Set		CMS	Generate patient lists by specific conditions; Send patient reminders per patient preference			
Patient Safety									
24	Health Acquired Conditions Composite			531	CMS (HACs)		Hospital measure		
25	Health Care Acquired Conditions: CLASBI Bundle			298			Hospital measure		
Preventive Health									
26	Influenza Immunization	110	Clinical Quality	41			Tested on PAS, and it worked, but was not adopted due to vaccine availability issues at the time; could easily be added to PAS	Annual Flu Vaccine (CAHPS)	Flu Shots for Older Adults Ages 50 – 54 (FSA) Flu Shots for Older Adults (FSO)
27	Pneumococcal Vaccination	111	Clinical	44			Never tested, but could	Pneumonia	Pneumonia

Measures		Measure Source				Alignment with IHA, Medicare Advantage Star Rating, and HEDIS Measures			
ACO Measure #	Measure Description	PQRS	EHR	NQF	Other	IHA P4P Measure	Comments about alignment with IHA measure set	Medicare Advantage Health Plan Star Rating Measure	HEDIS Measure
			Quality				potentially be integrated into PAS	Vaccine (CAHPS)	Vaccination Status for Older Adults (PNU)
28	Mammography Screening	112	Clinical Quality	31		Breast Cancer Screening (NQF #31)		Breast Cancer Screening	Breast Cancer Screening (BCS)
29	Colorectal Cancer Screening	113	Clinical Quality	34		Colorectal Cancer Screening (NQF #34)		Colorectal Cancer Screening	Colorectal Cancer Screening (COL)
30	Cholesterol Management for Patients with Cardiovascular Conditions		Clinical Quality	75		Cholesterol Management LDL Screening and Control < 100 (NQF # 75)		Cholesterol Screening for Patients with Heart Disease	Cholesterol Management for Patients with Cardiovascular Conditions (CMC)
31	Adult Weight Screening and Follow-up	128	Clinical Quality	421		MY11 testing measure (NCQA adult BMI assessment)	No follow-up plan required; need EHR to do		Adult BMI Assessment (ABA)
32	Blood Pressure Measurement	TBD	Clinical Quality	13			Once EHR use is widespread, could be added easily (challenge is ID'ing population with hypertension)		
33	Tobacco Use Assessment and Tobacco Cessation Intervention	TBD	Clinical Quality	28			Once EHR use is widespread, could be added easily		Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
34	Depression Screening	134		418			Implemented depression Care Management first; could be added easily once EHR use is widespread		
At-Risk Populations: Diabetes									
35	Diabetes Composite (All or Nothing Scoring)			575, 64, 61, 28, TBD			IHA P4P has an all-or-nothing score for diabetes, which has 3 out of the 5 components specified in proposed regulations (the last two are only available with EHR)		HEDIS has a Comprehensive Diabetes Care (CDC) measure that has 3 out of the 5 components specified in proposed regulations
36	Hemoglobin A1c Control (<8%)		Clinical Quality	575		Diabetes care: HbA1c Control <8% (NQF # 575)		Plan Members with Diabetes whose blood	Comprehensive Diabetes Care (CDC)

Measures		Measure Source				Alignment with IHA, Medicare Advantage Star Rating, and HEDIS Measures			
ACO Measure #	Measure Description	PQRS	EHR	NQF	Other	IHA P4P Measure	Comments about alignment with IHA measure set	Medicare Advantage Health Plan Star Rating Measure	HEDIS Measure
								sugar is under control	
37	Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	2	Clinical Quality	64		Diabetes care: LDL Control < 100 (NQF # 64)		Cholesterol Screening for Patients with Diabetes	
38	Tobacco Non Use	TBD	Clinical Quality	28			Once EHR use is widespread, could be added easily		
39	Aspirin Use			TBD			Once EHR use is widespread, could be added easily		
40	Hemoglobin A1c Poor Control (>9%)	1	Clinical Quality	59		Diabetes care: HbA1c Poor Control <9% (NQF # 59)			Comprehensive Diabetes Care (CDC)
41	High Blood Pressure Control in Diabetes Mellitus	3	Clinical Quality	61		Diabetes care: Blood Pressure Control for People with Diabetes <140/90 (NQF # 61)	IHA P4P uses 140/90, whereas this measure specifies 140/80		
42	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	119	Clinical Quality	62		Diabetes care: Nephropathy Monitoring (NQF # 62)		Kidney function testing for members with diabetes	
43	Dilated Eye Exam in Diabetic Patients	117	Clinical Quality	55			Tested previously, but data issues at the time; may be possible now	Eye exam to check for damage from diabetes (HEDIS)	Comprehensive Diabetes Care (CDC)
44	Foot Exam	63	Clinical Quality	56			This is not something that has been billed separately from an office visit (data issues)		
At-Risk Populations: Heart Failure									
45	Left Ventricular Function (LVF) Assessment	198		79			There is generally not sufficient population size to collect heart failure measures in the commercial population, although these conditions are more prevalent in the Medicare population		
46	Left Ventricular Function (LVF) Testing	228			CMS				
47	Weight Management	227		85					
48	Patient Education	199		82					
49	Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	8	Clinical Quality	83					

Measures		Measure Source				Alignment with IHA, Medicare Advantage Star Rating, and HEDIS Measures			
ACO Measure #	Measure Description	PQRS	EHR	NQF	Other	IHA P4P Measure	Comments about alignment with IHA measure set	Medicare Advantage Health Plan Star Rating Measure	HEDIS Measure
50	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	5	Clinical Quality	81					
51	Warfarin Therapy for Patients with Atrial Fibrillation	200	Clinical Quality	84					
At-Risk Populations: Coronary Artery Disease									
52	Composite: All or Nothing Scoring			67, 74, 70, 64, 66					
53	Oral Antiplatelet Therapy Prescribed for Patients with CAD	63	Clinical Quality	67					
54	Drug Therapy for Lowering LDL-Cholesterol	197	Clinical Quality	74					
55	Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infection (MI)	7	Clinical Quality	70					Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
56	LDL level < 100 mg/dl			64	CMS				
57	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetics and/or Left Ventricular Systolic Dysfunction (LVSD)	118		66					
At-Risk Populations: Hypertension									
58	Blood Pressure Control	TBD	Clinical Quality	18		MY2011 testing (NQF # 18)		Controlling Blood Pressure	Controlling High Blood Pressure (CBP)
59	Plan of Care	TBD		17					
At-Risk Populations: Chronic Obstructive Pulmonary Disease									
60	Spirometry Evaluation	51		91		MY2011 testing	IHA P4P uses the HEDIS measure for this	Testing to Confirm Chronic Obstructive Pulmonary Disorder (HEDIS)	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
61	Smoking Cessation Counseling Received				CMS		Once EHR use is widespread, could be added easily		
62	Bronchodilator Therapy based on FEV1	52		102					

Measures		Measure Source				Alignment with IHA, Medicare Advantage Star Rating, and HEDIS Measures			
ACO Measure #	Measure Description	PQRS	EHR	NQF	Other	IHA P4P Measure	Comments about alignment with IHA measure set	Medicare Advantage Health Plan Star Rating Measure	HEDIS Measure
At-Risk Populations: Frail Elderly									
63	Screening for Fall Risk			101			Not applicable to commercial population (although applicable to Medicare population)	Reducing the Risk of Falling (HOS)	Fall Risk Management (FRM)
64	Osteoporosis Management in Women Who had a Fracture			53				Osteoporosis Management (HOS)	Osteoporosis Management in Women Who Had a Fracture (OMW)
65	Monthly INR for Beneficiaries on Warfarin			555					