Guide to Quality Performance Scoring Methods for Accountable Care Organizations

Introduction

The purpose of this document is to provide guidance on quality performance scoring in the Medicare Shared Savings Program (Shared Savings Program) for all Accountable Care Organizations (ACOs).

Background

On November 2, 2011, the Centers for Medicare & Medicaid Services (CMS) finalized new rules[1] under the Affordable Care Act establishing the Shared Savings Program, under which doctors, hospitals, and other health care providers may work together to better coordinate care for Medicare patients through ACOs. The Shared Savings Program will reward ACOs that lower their growth in health care costs for assigned Medicare beneficiaries while meeting performance standards on quality of care.

As required by the Affordable Care Act, before an ACO can share in any savings generated, it must demonstrate that it met the quality performance standard for that year. The CMS will measure quality of care using 33 nationally recognized measures in four key domains:

- Patient/caregiver experience (7 measures)
- Care coordination/patient safety (6 measures)
- Preventive health (8 measures)
- At-risk population:
    - Diabetes (6 measures)
    - Hypertension (1 measure)
    - Ischemic vascular disease (2 measures)
    - Heart failure (1 measure)
    - Coronary artery disease (CAD) (2 measures)

ACOs are required to completely and accurately report on all 33 measures for all quality measurement reporting periods in each performance year of their agreement period. For Shared Savings Program ACOs beginning their agreement period in April or July, 2012, there will be two reporting periods in the first performance year, CY 2012 and 2013. For ACOs beginning their agreement periods in 2013 or later, each performance year and reporting period will correspond to the calendar year. Narrative and technical measure specifications for the ACO quality measures are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Quality Performance Scoring

The 33 quality measures will be reported through a combination of a Web interface designed for clinical quality measure reporting, patient/caregiver experience surveys, claims data, and Medicare and Medicaid electronic health records (EHR) Incentive Program data.

[1] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 Fed. Reg. 67802.

The Final Rule establishing the Shared Savings Program requires the administration of a standardized survey of patient/caregiver experience of care that is based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS). In 2012 and 2013, CMS will administer and pay for the survey on behalf of ACOs participating in the Shared Savings Program. This corresponds with the first performance year for ACOs that enter the program in 2012 or 2013. Beginning in 2014, Shared Savings Program ACOs will be responsible for selecting and paying for a CMS-certified vendor to administer the survey.

The Final Rule states that the 33 quality measures will be scored as 23 measures. CMS will consider the individual CAHPS measures (excluding the health status/functional status measure) together as one measure for scoring purposes. In addition, CMS will score the two finalized CAD measures as one composite and the five optimal diabetes care measures as one composite. Of note, in the care coordination domain, the EHR measure is double weighted both for scoring purposes and for purposes of determining poor performance.

Pay for Performance

The performance year and the reporting period for quality measurement purposes will be the 12-month period beginning on January 1 of each year during the agreement period (the term of the participation agreement, which begins at the start of the first performance year and concludes at the end of the final performance year)[2]. For an ACO with a start date of April 1, 2012, or July 1, 2012, the ACO's first performance year is defined as 21 months or 18 months, respectively. For quality measurement purposes, ACOs with a start date of April or July 2012 have two reporting periods (CY 2012 and CY 2013) in their first performance year, as stated in 42 CFR 425.608(c)(8). Pay for performance will be phased in over the ACO's first agreement period as follows:

- Performance Year 1: Pay for reporting applies to all 33 measures.
- Performance Year 2: Pay for performance applies to 25 measures and pay for reporting applies to 8 measures.
- Performance Year 3: Pay for performance applies to 32 measures and pay for reporting applies to 1 measure.

As we phase in pay for performance, we will establish benchmarks for quality measures using a national sample of Medicare fee-for-service (FFS) claims data, Medicare Advantage (MA) quality data, or a flat percentage if FFS claims or MA quality data are not available.

Minimum Attainment Level for Quality Measures

For the first performance year, reporting periods 1 and 2 for Shared Savings Program ACOs with a 2012 start date (CY 2012 and 2013) "minimum attainment level" is defined in the Final Rule as complete and accurate reporting. Pay for performance is phased in beginning in Performance Year 2, reporting period 3 (CY 2014). For pay-for-performance measures, we defined the minimum attainment level at 30 percent or the 30th percentile, depending on what performance data are available. Below this level, the ACO would score zero points for the measure

An ACO may earn points for meeting the minimum attainment level on each measure. If the ACO crosses the minimum attainment level on at least one measure in each of the four domains, it will earn

[2] Unless otherwise noted in the ACO agreement.

points and therefore be eligible to share in a portion of the savings it generates. The ACO must also meet the cost savings criteria to be eligible for shared savings payments.

Quality Scoring Points System

As illustrated in Table 1, a maximum of 2 points could be earned for each quality measure, with one exception. Because CMS believes that EHR adoption is important for ACOs to be successful in the Shared Savings Program, the EHR measure will be double weighted and will be worth up to 4 points to provide incentive for greater levels of EHR adoption. Note that for scoring purposes in Table 1, each of the three composite measures (patient/caregiver experience, diabetes, and CAD) have been collapsed into a maximum of two points.

Table 1. Total Points for Each Domain within the Quality Performance Standard

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible 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, plus the electronic health records measure double-weighted (4 points)	14	25%
Preventive Health	8	8 measures	16	25%
At-Risk Population	12	7 measures, including 5-component diabetes composite measure and 2-component coronary artery disease composite measure	14	25%
Total	33	23	48	100%

Quality Scoring Sliding Scale

While Table 1 shows the possible maximum points that may be earned by an ACO, quality scoring will be based on the ACO's actual level of performance on each measure. As detailed in the final rule, an ACO will earn quality points on a sliding scale based on level of performance. The higher the level of performance, the higher the corresponding number of quality points, as outlined in Table 2. The total points earned for measures in each domain will be summed and divided by the total points available for that domain to produce an overall domain score of the percentage of points earned versus points available.Table 2.Sliding Scale Measure Scoring Approach

ACO Performance Level	Quality Points (all measures except EHR)	EHR Measure Quality Points
90+ percentile FFS/MA or 90+ percent	2 points	4 points
80+ percentile FFS/MA or 80+ percent	1.85 points	3.7 points
70+ percentile FFS/MA or 70+ percent	1.7 points	3.4 points
60+ percentile FFS/MA or 60+ percent	1.55 points	3.1 points
50+ percentile FFS/MA or 50+ percent	1.4 points	2.8 points

ACO Performance Level	Quality Points (all measures except EHR)	EHR Measure Quality Points
40+ percentile FFS/MA or 40+ percent	1.25 points	2.5 points
30+ percentile FFS/MA or 30+ percent	1.10 points	2.2 points
<30 percentile or <30 percent	No points	No points

NOTE: ACO = Accountable Care Organization; EHR = electronic health records; FFS= fee for service; MA = Medicare Advantage.

Financial Reconciliation Accounting for Quality Performance

CMS is implementing both a one-sided model (sharing savings, but not losses, for the entire term of the first agreement) and a two-sided model (sharing both savings and losses for the entire term of the agreement), allowing ACOs to opt for one or the other model for their first agreement period. The maximum potential shared savings based on quality performance is 60 percent of the savings generated, under the two-sided model and 50 percent of the savings generated, under the one-sided model. Therefore, 100 percent complete and accurate reporting of the quality measures in the first performance year for ACOs with a 2012 start date (CYs 2012 and 2013), in the Shared Savings Program will result in an ACO's earning 50 or 60 percent of shareable savings, depending on whether the ACO is in the one-sided or two-sided model. For future performance periods, the percentage of shared savings will vary based on the ACO's performance on the measures as compared with the measure benchmarks as we phase in pay for performance. Actual shared savings payments may be eligible to an annual cap.

As shown in Table 1, each domain will be weighted equally. Accordingly, the percentage score for each domain, calculated using the methodology described previously, will be summed and divided by 4 to reflect the equal weighting of the domains. The resulting percentage will then be applied to the maximum sharing rate under either the one-sided or two-sided model to determine the ACO's final sharing rate for purposes of determining its shared savings payment.

Minimum Attainment Level for Each Domain of Care

As stated in 42 CFR 425.502, ACOs must meet the minimum attainment on at least 70 percent of the measures in each domain. If an ACO fails to achieve the minimum attainment level on at least 70 percent of the measures in a domain, CMS may give the ACO a warning, ask the ACO to develop a corrective action plan, or put the ACO in a special monitoring plan. Failure to meet the quality standard may result in termination. An ACO that has been terminated from the program is disqualified from sharing in savings.