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Proposed Quality Measures for ACOs

The fifth advisory in our series on the newly proposed ACO regulations implementing Section 3022 of the PPACA

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Next year brings the possibility of accountable care organizations and the Centers for Medicare and Medicaid Services sharing savings that result from more efficient use of resources. CMS cites better care for individuals and better health for populations as two of its highest priorities. In pursuit of those goals, it proposed quality standards that ACOs must meet in order to be eligible for shared savings. The proposed rule addresses the following:

1. Measures CMS will use to assess quality of care;
2. Data relating to the measures that ACOs must provide to CMS;
3. Quality standards that an ACO must meet;
4. An opportunity to receive an additional 0.5 percent bonus of physician payments based on a virtual group practice; and
5. Public reporting by ACOs.

The proposed rule identifies 65 quality performance standard measures that CMS grouped into five domains. The domains and associated quality measures are set forth below:

1. Patient/Caregiver Experience	1-7 (7 measures)
2. Care Coordination	8-23 (16 measures)
3. Patient Safety	24-25 (2 measures)
4. Preventive Health	26-34 (9 measures)
5. At-Risk Population/Frail Elderly Health	35-65 (31 measures, including: Diabetes, Heart Failure, Coronary Artery Disease, Hypertension, Chronic Obstructive Pulmonary Disorder)

In addition, the ACO requirements focus on four less-frequently reported measures, including readmissions (4 measures), ambulatory sensitive conditions admissions (7 measures), meaningful use measures under the Health Information Technology for Economic and Clinical Health (HITECH) Act (5 measures), and new composite measures (3 measures).

Before an ACO can share in any savings created, it must demonstrate that it is delivering high-quality care by meeting the quality performance standards. To that end, each ACO must have a physician-directed quality assurance and process improvement committee. For the first year, an ACO will be deemed to have met the quality performance standards if it reports accurately on each of the measures.

It should be noted, however, that CMS has proposed to score quality during the first year for informational purposes, as a tool to help define future benchmarks. During the second and third years, to qualify for shared savings an ACO must satisfy the quality performance standards as measured by the applicable performance criteria and accurately report the quality measures.

Although grading of the measures in years two and three is discussed in the proposed regulation, CMS elected to defer defining the benchmarks for those years to future rulemaking. CMS proposes setting benchmarks for each measure at a minimum attainment level. ACOs will be evaluated against both national norms and their own prior scores. To accomplish its goal, CMS will analyze Medicare fee-for-service claims data, Medicare Advantage quality performance rates, and in some instances, the corresponding percent performance rates that an ACO must demonstrate. ACOs that do not meet the quality performance thresholds for all proposed measures will not be eligible for shared savings, regardless of how successful they were in reducing per capita costs.

Ultimately, CMS envisions that an ACO will be given a total performance score. Measures will be organized by domain, and a score between zero and two will be assigned for each measure. If an ACO scores low on one or more domain(s), the ACO would be put on probation. If the low scores continue, then CMS may terminate the ACO. Two measures—diabetes and coronary artery disease—will receive an “all or nothing” score. Thus, the ACO will receive either a “2” or a zero. The message is that failing to perform any element of a process is unacceptable.

Given 65 quality measures, a perfect score would be 130. With the ACO’s total score as the numerator and 130 as the denominator, the ACO will be given a quality percentage. That percentage will be multiplied by shared savings (if they exist) to determine the ACO’s eligibility for shared savings payments. In other words, if an ACO achieves 90 percent of the potential 60 percent of shared savings it can earn under the two-sided model, the ACO could earn 54 percent of the total savings generated.

CMS will use claims data, survey tools, and the Centers for Disease Control’s National Healthcare Safety Network (NHSN) database to gather data on the measures, as well as data submission through the HITECH program for meaningful use measures. CMS

also indicated that in future rulemaking it will align the shared savings program with the Electronic Health Records (EHR) Incentive Program.

Although some data is available via claims analysis, much of what CMS wants to evaluate must come from the ACOs. As an example, CMS cannot consider lab test results by looking at claims data. CMS proposes that a Group Practice Reporting Option (GPRO) tool, which it developed in 2010, be "built out, refined and upgraded" to provide more data. The burden of responding will, in theory, be minimized by having CMS' computers talk to the ACOs' computers.

To audit compliance, CMS plans to rely on a statistical sampling process, with three possible phases. First, each ACO must provide GPRO data for at least 411 randomly selected assigned beneficiaries or 100 percent of eligible beneficiaries (whichever is less), from each of the five quality "domains." CMS will then abstract a random sample of 30 beneficiaries per domain, although only the first eight beneficiaries' medical records will be audited. If no "discrepancies" are found, then the audit for that domain is finished.

If a discrepancy exists, then CMS will begin its second phase of audits and analyze the remaining 22 records. If that audit shows that 10 percent of the medical records contain discrepancies, CMS will provide education to the ACO on the correct specification process and provide the opportunity to correct and resubmit the measure in question. If at the end of this third audit the discrepancies are still more than 10 percent, the ACO will not be given credit for meeting the quality target.

Eligible professionals that are ACO providers/suppliers would be treated as a group practice for purposes of qualifying for a Physician Quality Reporting System incentive. If an ACO reports accurately on all measures included in the GPRO, then the ACO could receive a bonus equal to 0.5 percent of the ACO's eligible professionals' total estimated Medicare Part B PFS allowed charges. ACO providers/suppliers who meet the quality performance standards but do not generate shared savings would still be eligible for an incentive payment. However, in year two of the program, at least 50 percent of an ACO's eligible professionals must be meaningful users of EHR software.

The proposed regulations also demonstrate the agency's concerns about transparency. CMS plans to make the following information available about each ACO:

- Name and location.
- Primary contact.
- Organizational information including:

  ACO participants;

  Identification of ACO participants in joint ventures between ACO professionals and hospitals;

Identification of ACO participant representatives on its governing body; and

Associated committees and committee leadership.

- Shared savings information including:

  Shared savings performance payments received by ACOs or shared losses payable to CMS; and

  Total proportion of shared savings invested in infrastructure, redesigned care processes, and other resources required to support the three-part target goals of better health for populations, better care for individuals, and lower growth in expenditures, including the proportion distributed among ACO participants.

- Quality performance standard scores.

In summary, the proposed ACO regulations impose formidable challenges on any organization that seeks to participate in the model. Although CMS seeks to minimize the burdens by drawing upon prior initiatives (e.g., earlier physician and hospital quality reporting, incentives to adopt electronic health records), many of those initiatives are in the process of developing and expanding (e.g., the GPRO tool). Despite the tsunami of details included in the proposed regulation, one message is crystal clear: No demonstration of quality care, no savings to share.

In our ongoing series, we will be issuing a number of separate advisories focusing on specific topics raised by the new regulations and the affiliated guidance and requests for comments including:

- Beneficiary attributions and safeguards
- Shared savings calculations
- State law restrictions
- When things go wrong or circumstances change

Please also see our past installments in this series:

" The New ACO Regs: They're Here (Well, Sort of ...)" (04. 05.11)

"Antitrust Enforcement Agencies Issue Proposed Guidance on ACOs" (04.06.11)

"What the Proposed ACO Regulations Say About Legal Structures and Governance" (04.11.11)

"ACOs: The Fraud & Abuse Waivers – Finding a Path Through the Maze" (04.15.11)

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Stay tuned … and in the meantime, if you have any questions, please contact us.