Quality Measurement and Reporting Kickoff

All Shared Savings Program ACOs

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Agenda

- Introduction
- 2017 Quality Measurement: Domains and Measures
- 2017 Quality Reporting: Methods and Requirements of Data Submission
- Quality Performance Scoring
- Alignment with the Quality Payment Program
- Public Reporting
- Timeline, Resources, and Assistance

Introduction

- Accessing Slides
- Overview of Quality Measurement Approach

Accessing Slides

- Please login to the ACO Portal (https://portal.cms.gov) and click on today's event
  - ACO contacts maintained in the Health Plan Management System (HPMS) have access to the SSP Portal and receive the ACO Spotlight newsletter.
  - If you do not have access to the Portal, please work with your ACO to obtain the quality webinar slides and the ACO Spotlight newsletter for quality updates and webinar announcements.

Overview of Quality Measurement Approach

- The quality measurement approach in the Shared Savings Program is intended to:
  - Improve individual and population health
  - Address quality aims such as prevention, care of chronic illness, high prevalence conditions, patient safety, patient and caregiver engagement, and care coordination
  - Support the Shared Savings Program goals of better care, better health, and lower growth in expenditures
  - Align with the Quality Payment Program

2017 Quality Measurement Domains and Measures

- Quality Measurement: Domains
- Quality Measures: Aim 1: Better Care for Individuals
- Quality Measures: Aim 2: Better Health for Populations

Quality Measurement: Domains

- 31 quality measures are separated into the following four key domains that will serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance:
  - Better Care for Individuals
    - Patient/Caregiver Experience
    - Care Coordination/Patient Safety
  - Better Health for Populations
    - Preventive Health
    - Clinical Care for At Risk Populations

Quality Measures

Aim 1: Better Care for Individuals

1. Patient/Caregiver Experience Clinician/Group CAHPS
ACO-1 CAHPS: Getting Timely Care, Appointments, and Information
ACO-2 CAHPS: How Well Your Providers Communicate
ACO-3 CAHPS: Patients' Rating of Provider
ACO-4 CAHPS: Access to Specialists
ACO-5 CAHPS: Health Promotion and Education
ACO-6 CAHPS: Shared Decision Making
ACO-7 CAHPS: Health Status/Functional Status*
ACO-34 CAHPS: Stewardship of Patient Resources

*Measure is pay for reporting all years of the agreement period

Quality Measures

Aim 1: Better Care for Individuals (cont.)

2. Care Coordination/Patient Safety
ACO-8 Risk-Standardized, All Condition Readmission
ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure
ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)
ACO-11 Use of Certified EHR Technology
ACO-12 Medication Reconciliation Post-Discharge
ACO-13 Falls: Screening for Future Fall Risk
ACO-44 Use of Imaging Studies for Low Back Pain*

*Measure is pay for reporting all years of the agreement period

Quality Measures

Aim 2: Better Health for Populations

3. Preventive Health
ACO-14 Preventive Care and Screening: Influenza Immunization
ACO-15 Pneumonia Vaccination Status for Older Adults
ACO-16 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
ACO-18 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
ACO-19 Colorectal Cancer Screening
ACO-20 Breast Cancer Screening
ACO-42 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*

*Measure is pay for reporting all years of the agreement period

Quality Measures

Aim 2: Better Health for Populations (cont.)

4. Clinical Care for At-Risk Populations
Depression
ACO-40 Depression Remission at Twelve Months*
Diabetes ('all-or-nothing' Composite)**
ACO-27 Diabetes Mellitus: Hemoglobin A1c Poor Control
ACO-41 Diabetes: Eye Exam
Hypertension
ACO-28 Hypertension (HTN): Controlling High Blood Pressure
Ischemic Vascular Disease
ACO-30 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

*Measure is pay for reporting all years of the agreement period
**The diabetes composite (with two component measures) is scored as one quality measure.

2017 Quality Reporting: Methods and Requirements of Data Submission

- Quality Reporting Methods
- Quality Reporting Methods: Patient Experience Survey
- Quality Reporting Methods: Claims Data
- Quality Reporting Methods: Quality Payment Program Data
- Quality Reporting Methods: CMS Web Interface

Quality Reporting Methods

- Quality data collected via:
  - Patient Survey
  - Claims
  - Quality Payment Program data
  - CMS Web Interface

Quality Reporting Methods: Patient Experience Survey

Measure	Data used	Who will gather this quality information?	Timelines/ Key Dates
ACO-1 CAHPS: Getting Timely Care, Appointments, and Information	CAHPS for ACOs Survey includes Clinician and Group Consumer Assessment of Healthcare Providers & Systems (CG-CAHPS) core measures, supplemental items, and program specific items	ACOs select CMS-approved Survey Vendors to administer the survey	• ACOs select approved vendor for CAHPS in the fall of 2017 • Survey will be administered beginning in November 2017
ACO-2 CAHPS: How Well Your Providers Communicate			
ACO-3 CAHPS: Patients' Rating of Provider			
ACO-4 CAHPS: Access to Specialists			
ACO-5 CAHPS: Health Promotion and Education			
ACO-6 CAHPS: Shared Decision Making			
ACO-7 CAHPS: Health Status/Functional Status			
ACO-34 CAHPS: Stewardship of Patient Resources			

Quality Reporting Methods: Claims Data

Measure	Data used	Who will gather this quality information?	Timelines/ Key Dates
ACO-8 Risk-Standardized, All Condition Readmission	Medicare beneficiaries' demographic information and claims data	CMS	No ACO action needed
ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure			
ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes			
ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure			
ACO-38 All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions			
ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)			
ACO-44 Imaging Studies for Low Back Pain			

Quality Reporting Methods: Quality Payment Program Data

Measure	Data used	Who will gather this quality information?	Timelines/ Key Dates
ACO-11 Use of Certified EHR Technology	Information on Participation and Advancing Care Information category from Quality Payment Program	CMS	Each ACO participant TIN is responsible for submitting data on the MIPS Advancing Care Information category on behalf of its eligible clinicians in the form and manner specified by MIPS.

Detailed specifications for this measure will be available in a Measure Information Form (MIF) posted on the Shared Savings Program website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html

Quality Reporting Methods: CMS Web Interface Data

Measure	Data used	Who will gather this quality information?	Timelines/ Key Dates
Care Coordination/Patient Safety ACO-12 Medication Reconciliation Post-Discharge ACO-13 Falls: Screening for Future Fall Risk **Preventive Health** ACO-14 through ACO-20 and ACO-42 (all measures in this domain) **Clinical Care for At Risk Populations**	1. Medicare beneficiaries' demographic information and claims data files 2. Patient medical records (paper/EHR/ registry) *from within and outside of the ACO*	1. CMS will provide patient samples (with the same patient in multiple samples when possible) with selected patient information. 2. ACOs must enter and submit data into the CMS Web Interface for at least 248 consecutively ranked beneficiaries (or 100 percent of beneficiaries if there are fewer than 248 beneficiaries available) in each sample.	• ACOs set up necessary accounts and roles to access the CMS Web Interface by the end of December 2017. • ACOs download patient ranking file in early January 2018. • ACOs enter clinical information into the CMS Web Interface (manually or via XML) from mid-January to mid-March (8 weeks) each year, following the performance year.

Quality Reporting Methods: CMS Web Interface

- The CMS Web Interface is the system ACOs must access and use to report quality data to CMS.
  - ACOs do not need to register for Web Interface reporting. However, ACOs must get the necessary accounts and roles to access the CMS Web Interface
  - Guidance on accessing the CMS Web Interface will be provided later this year
- Using 2017 3rd Quarter assignment, we will identify assigned beneficiaries eligible for quality reporting. A sample of these beneficiaries will be populated into the CMS Web Interface for quality reporting.
  - More information on this process can be found in the 2017 Sampling Methodology document, which will be posted to the Quality Payment Program web page during the summer

Quality Reporting Methods: CMS Web Interface

- Approximately 2 weeks prior to the opening of the CMS Web Interface submission period, ACOs will be able to download their Patient Ranking file (i.e., the list of beneficiaries sampled and their ranks) and supporting information, which includes:
  - 14 patient samples, each patient's rank order number in each module, the TIN or CCN at which the patient received the most care, and 3 NPIs from whom the patient received the most care.
- To prepare for reporting, ACOs will have an opportunity to access a training version of the CMS Web Interface prior to the submission period.
- Beginning in January 2018, ACOs will have approximately 8 weeks to complete quality reporting for their patient sample for 2017 reporting.
- ACOs must completely report on a minimum of 248 beneficiaries in each module or 100 percent of consecutively ranked beneficiaries if they have fewer than 248 beneficiaries available in the sample.

Quality Reporting Methods: CMS Web Interface

- ACOs may enter data manually or import data via an Extensible Mark-up Language (XML) interface.
- ACOs should use the supporting documents and other materials provided for 2017 to make the most of your valuable resources:
  - Visit the Quality Payment Program Education & Tools website for the CMS Web Interface measure documentation. The specifications are located in the Quality Measures Specifications zip file under the Documents and Download heading, “For Registries, Qualified Clinical Data Registries, and EHR Vendors.”
- Following the 8-week submission period, ACOs may be selected for the 2017 Quality Measures Validation Audit.

Quality Performance Scoring

- Quality Performance
- Pay for Performance Phase-In
- Pay for Performance
- Implications for ACO Compliance

Quality Performance

- CMS designates the quality performance standard for each ACO based on its performance year.*
  - The quality performance standard is the criteria that an ACO must meet in order to be eligible to share in any savings earned.
- An ACO's final sharing rate based on quality performance is used to determine the ACO's eligibility for shared savings and liability for shared losses.

Performance Year	Pay for Reporting or Pay for Performance	To be eligible to share in savings, if earned, the ACO must:
1	Pay for Reporting (P4R)	Completely and accurately **report** all ACO quality measures. This qualifies the ACO to share in the **maximum** available sharing rate for payment.
2 and 3, and subsequent agreement periods	Pay for Performance (P4P)	Completely and accurately report all quality measures and meet minimum attainment on at least one measure in each domain.

*Quality Performance Standard is the same regardless of ACO track

Pay for Performance Phase-In

- Under Pay for Performance (i.e., ACO's second and subsequent performance years/agreement periods):
  - Increasing number of measures are phased into pay for performance each year
  - ACOs must meet minimum attainment level (30th percentile benchmark) to receive points for pay for performance measures
  - Shared savings payments are linked to quality performance by comparing performance to benchmarks and awarding points based on a sliding scale
  - High performing ACOs receive higher sharing rates for earned shared savings

	2015 starters and ACOs in their 2nd Agreement	2016 starters	2017 starters
Pay for Performance Measures in 2017	24	17	0
Pay for Reporting Measures in 2017	7	14	31
Total Measures in 2017	31	31	31

*Note: New measures introduced to the Shared Savings Program will be set at pay for reporting for 2 years before the phase-in schedule applies, unless the measure was finalized as pay for reporting all years.

Pay for Performance Phase-In

- Determining if a measure is P4R vs. P4P for your ACO
  - Using the 2016 and 2017 Benchmark Guide, you can look at the column of the phase-in schedule associated with your performance year and determine if the measure is in P4R or P4P. However, there are several exceptions, because new measures are P4R for 2 years before transitioning to P4P.
- Helpful hints for understanding the new measure phase-in:
  - If the 2016 column of the benchmarking document displays "**Yes***", this means that the measure was introduced in 2015. The measure will be P4R for all ACOs in 2016. The phase-in schedule displayed does not apply until 2017.
  - If the 2016 column of the benchmarking document displays "**No****", this means that the measure was introduced in 2017. The measure will be P4R for all ACOs in 2017. The phase-in schedule displayed does not apply until 2019.

Domain	Measure	Description	Performance Year(s) When Measure is in Effect		First Agreement Period Pay for Performance Phase In† R=Reporting P=Performance		
			2016	2017	PY1	PY2	PY3
At-Risk Population Diabetes	Diabetes Composite ACO-27 and – 41	ACO-27: Diabetes Mellitus: Hemoglobin A1c Poor Control ACO-41: Diabetes: Eye Exam	Yes*	Yes	R	P	P

Pay for Performance

- ACOs performance on each pay for performance measure is compared to the measure's benchmark (which is the same across all ACOs). ACOs earn points for each measure based on a sliding scale (see next slide)
  - For more information on the benchmarks, please refer to the Quality Measure Benchmarks for the 2016 and 2017 Reporting Years, available on the Shared Savings Program website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html
  - Performance, for measures identified as pay for performance, below the minimum attainment level (i.e., below 30% or below 30th percentile benchmark) would earn zero points for that measure

Quality Performance Scoring: Part 1: Measure Scoring

ACO Performance Level	Quality Points (all measures except ACO-11)	ACO-11 points
90th percentile benchmark	2 points	4 points
80th percentile benchmark	1.85 points	3.7 points
70th percentile benchmark	1.7 points	3.4 points
60th percentile benchmark	1.55 points	3.1 points
50th percentile benchmark	1.4 points	2.8 points
40th percentile benchmark	1.25 points	2.5 points
30th percentile benchmark	1.10 point	2.2 points
<30th percentile benchmark	No points	No points

Quality Performance Scoring: Part 2: Quality Improvement (QI) Reward

- ACOs in PY2 and beyond may also earn up to 4 Quality Improvement Reward points in each domain.
- Methodology used to determine Quality Improvement Reward points mirrors Medicare Advantage's Five Star Rating Program*
- Domain Improvement Score = Net Improvement ÷ number of eligible measures
  - Net improvement = Number of significantly improved measures minus number of significantly declined measures.
  - Eligible Measures = Measures in use in the previous performance year and the current performance year.
  - In cases where the ACO shows a statistically significant decline on a measure, but in both years, the ACO's performance rate on the measure is above 90% (or, in the case of certain measures, above the 90th percentile benchmark), the change will be considered "no change".

*For more information on the Medicare Advantage 5 Star Rating Methodology, see: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2015-Part-C-and-D-Medicare-Star-Ratings-Data-v4-16-2015.zip

Quality Performance Scoring: Part 2: Quality Improvement (QI) Reward

- Quality Improvement Points are determined by taking the Domain Improvement Score and comparing it to the following table:

Domain Improvement Score	Quality Improvement Points
90+ percent	4.0 points
80+ percent	3.56 points
70+ percent	3.12 points
60+ percent	2.68 points
50+ percent	2.24 points
40+ percent	1.8 points
30+ percent	1.36 point
20+ percent	0.92 point
10+ percent	0.48 point
< 10 percent	No points

- Total points earned in a domain cannot exceed the total possible points in the domain.

Quality Performance Scoring: Part 3: Domain Score

- To calculate each domain score, the number of points earned by the ACO across all measures in the domain, including any quality improvement points earned, is divided by the number of possible points in the domain and multiplied by 100 to create a percentage. This results in a domain score for each of the four domains.

Quality Performance Scoring: Part 3: Domain Score

Measure	Performance Rate	Highest Benchmark Passed	Points Earned	Total Possible
ACO-14	76.68%	70th percentile benchmark of 75.93%	1.70	2
ACO-15	91.82%	70th percentile benchmark of 84.55%	1.70	2
ACO-16	67.17%	60th percentile benchmark of 66.35%	1.55	2
ACO-17	90.68%	90th percentile benchmark of 90.00%	2.0	2
ACO-18	46.51%	80th percentile benchmark of 39.97%	1.85	2
ACO-19	81.40%	Satisfactorily Reported—P4R	2.0	2
ACO-20	80.53%	Satisfactorily Reported—P4R	2.0	2
ACO-21	85.90%	Satisfactorily Reported—P4R	2.0	2
ACO-42	82.10%	Satisfactorily Reported—P4R	2.0	2
Subtotal from measures	—	—	16.80	18
Quality Improvement Reward	55%	>50 percent improvement	2.24	4
Total	—	—	18 (not 19.04)*	18

NOTE: The Preventive Health Domain is used in this example and assumes ACO is in PY2 of first agreement period

*Quality improvement points earned is capped at the possible points earned in the domain based on the number of measures in the domain. In this case, there are 9 measures in the domain, each worth 2 possible points, totaling 18 points.

Quality Performance Scoring: Part 4: Overall Quality Score

- After a score has been calculated for each domain, the four domain scores are averaged to calculate a final overall quality score.

Domain	Points Earned	Total Possible Points	Domain Score
Patient/Caregiver Experience	14.80	16	92.50%
Care Coordination/Patient Safety	20.50	22	93.18%
Preventive Health	18.00	18	100%
At-Risk Population	7.85	8	98.13%
Overall Quality Score			95.95%

$$Overall\ Quality\ Score = \frac{(92.5\% + 93.18\% + 100\% + 98.13\%)}{4} = \mathbf{95.95\%}$$

- The final overall quality score is used to calculate each ACO's sharing rate.

Implications for ACO Compliance

- ACOs who do not meet the quality performance standard will not be eligible to share in savings, if earned.
- Failing to meet the quality performance standard may also result in a compliance action such as a corrective action or termination.

Alignment with the Quality Payment Program

- Overview
- MIPS APM Scoring
- Advanced APMs

Overview of Alignment

- The Quality Payment Program has identified the Shared Savings Program as an Alternative Payment Model (APM).
  - ACOs in Track 1 of the Shared Savings Program do not meet the Advanced APM definition.
  - ACOs in Tracks 2 and 3 are Advanced APMs.
- Eligible clinicians (ECs) in Track 1 ACOs will be assessed under MIPS using the APM scoring standard.
- When ECs participating in Shared Savings Program Track 2 or 3 ACOs meet the Qualifying Participant (QP) threshold for the year, they are excluded from the MIPS reporting requirements and payment adjustment.
  - If ACOs do not meet the QP threshold, then ECs will be assessed under MIPS using the APM scoring standard.

Overview of Alignment

- For 2017, for MIPS ECs participating in Shared Savings Program ACOs, a final score is assessed across 4 performance categories for the APM entity group (the MIPS ECs participating in the ACO).
- The final score for the APM entity group is applied to each MIPS EC that bills under the TIN of an ACO participant in the ACO.

Quality Payment Program Resources

- Quality Payment Program Education & Tools webpage
  - https://qpp.cms.gov/resources/education
  - Quality Payment Program Fact Sheet
  - Advancing Care Information Fact Sheet
  - Scores for Improvement Activities in MIPS APMs in the 2017 Performance Period
    - https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf

- Quality Payment Program Events page:
  - "Medicare Shared Savings Program in the Quality Payment Program" webinar
    - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/APMs-in-The-Quality-Payment-Program-for-Shared-Savings-Program-SSP-webinar-slides.pdf

Public Reporting

- CMS
- ACO

CMS

- All ACO measures are available for public reporting.
- Performance year results, which include financial and quality results, are publicly reported on data.cms.gov.
- In late 2018, a subset of measures collected via the CMS Web Interface and CAHPS for ACOs Survey for the 2017 reporting period may be displayed on Physician Compare: https://www.medicare.gov/physiciancompare.

ACO

- ACOs must make the following available on the ACO's own website, on a designated web page for public reporting:
  - General and organizational information
  - Shared savings and losses information
  - Performance on quality measures
- ACO Public Reporting Guidance is posted on the Shared Savings Program website via the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes-Regulations-Guidance.html*

*The public reporting guidance document currently available online does not yet include 2016 and 2017 quality reporting.

Timeline, Resources, and Assistance

- Overview
- Education & Outreach Webinars
- Resources

Overview

Reporting Period	Summer/Fall 2017	Winter 2017 - 2018	Spring 2018	Summer 2018
2017 reporting period	• ACOs need to set up necessary accounts for quality reporting via the CMS Web Interface • ACOs need to select CMS approved vendor to administer the CAHPS for ACOs Survey	• Must have system access before CMS Web Interface opens • CMS Web Interface Patient ranking file is made available • CAHPS for ACOs Survey in field beginning in November • CMS Web Interface opens for Patient Ranking files, training, then 8 weeks for reporting and submission of data to CMS	• Quality measures validation audit in progress for select ACOs • CMS calculates claims-based and ACO-11 Use of Certified EHR Technology (send ACI performance data by March 31, 2018)	• 2017 ACO Quality Reports and quality measures validation audit results will be delivered • Quality measures validation audit lessons learned webinar

Education & Outreach Webinars

Reporting Period	Winter 2016	Spring/Summer 2017	Fall 2017	Winter 2017 - 2018	Spring 2018	Summer 2018
2017 reporting period	Measure Information Forms for claims-based measures made available	Webinar series in preparation for 2017 reporting and 2017 quality measures	Sampling methodology made available on the QPP website	CMS Web Interface data collection support calls during submission period	CMS Web Interface lessons learned webinar Audit Training webinar	2017 financial and quality results webinar (late summer) Lessons learned from audit findings webinar

- Please stay tuned to the ACO Spotlight Newsletter and the Quality Payment Program website for announcements.

Resources

- Shared Savings Program website
  - http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html
- Shared Savings Program ACO Portal
  - https://portal.cms.gov
  - Quality webinars (all are recorded and posted on the Shared Savings Program ACO Portal)
- Quality Payment Program website
  - https://qpp.cms.gov/education
    - CMS Web Interface documentation (located in the Quality Measures Specifications zip file under the Documents and Download heading, “For Registries, Qualified Clinical Data Registries, and EHR Vendors”)

Resources

- For questions related to the CMS Web Interface or quality measures
  - Contact the QualityNet Help Desk and identify yourself as a representative from an ACO.
    - E-mail: qnetsupport@hcqis.org
    - Phone: (866) 288-8912 | TTY: (877) 715-6222 | Fax: (888) 329-7377
    - Monday – Friday 7 a.m. - 7 p.m. CT
- Medicare Shared Savings Program
    - E-mail: SharedSavingsProgram@cms.hhs.gov
- For questions related to the Quality Payment Program, MIPS, MACRA, and APMs
    - Email: qpp@cms.hhs.gov
    - Phone: (866) 288-8292
    - Monday – Friday, 8 a.m. – 8 p.m. ET

QUESTION & ANSWER SESSION