

Measuring and Paying for Quality Under the Proposed ACO Rule and Lessons Learned from a Past Demonstration

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Overview

- Quality Measurement under the Medicare Shared Savings Program (“MSSP”)
- Impact of Quality Performance on Opportunity for Shared Savings
- Other Quality-Related Requirements
- Relevant Lessons from the Medicare Physician Group Practice Demonstration



Quality Measurement under the Medicare Shared Savings Program

MSSP - Quality Performance Assessment

- CMS stated three primary goals for ACOs under the proposed regulations:
 - Better care for individuals,
 - Better health for populations, and
 - Lower growth in expenditures
- The quality assessment methodology proposed by CMS is designed to determine whether an ACO has achieved the former two goals
- Under the proposed quality assessment methodology, an ACO is eligible for shared savings if it meets the “quality performance standard”

MSSP - Quality Performance Measures

- CMS has proposed the use of 65 “quality performance measures” to assess whether, and to what extent, an ACO has met the quality performance standard
- Proposed measures fall within five domains:
 - Patient/caregiver experience
 - Care coordination (including care transitions and information systems)
 - Patient safety
 - Preventive health
 - At-risk population and frail elderly health

MSSP - Quality Performance Measures (cont.)

Domain	Category	Total Number of Measures
1. Patient/Caregiver Experience		7 measures
2. Care Coordination (including Transitions and Information Systems)		16 measures
3. Patient Safety		2 measures
4. Preventive Health		9 measures
5. At-Risk Population/Frail Elderly Health	<ul style="list-style-type: none"> - Diabetes - Heart Failure - Coronary Artery Disease - Hypertension - Chronic Obstructive Pulmonary Disorder - Frail Elderly 	31 measures

MSSP - Quality Performance Measures (cont.)

- Measures assess ACO improvement compared with past performance as well as ACO achievement relative to national or other benchmarks
- These 65 measures are proposed for the first performance year
- Measures to be used during latter performance years will be proposed in future rulemaking
 - CMS plans to refine and expand the measures
- Over time, CMS plans to use scoring methodologies that are weighted towards outcome, patient experience and functional status measures

MSSP - Quality Performance Measures (cont.)

- CMS tried to use measures that were already being used under other programs to reduce the administrative burden of quality reporting
- Most of the proposed measures can be derived from existing CMS programs and resources such as:
 - Physician Quality Reporting System (“PQRS”)
 - eRx Incentive Program
 - HITECH
 - Hospital Compare, and
 - CDC National Healthcare Safety Network
- ACO professionals may earn the PQRS incentive under the MSSP

MSSP - Quality Performance Measures (cont.)

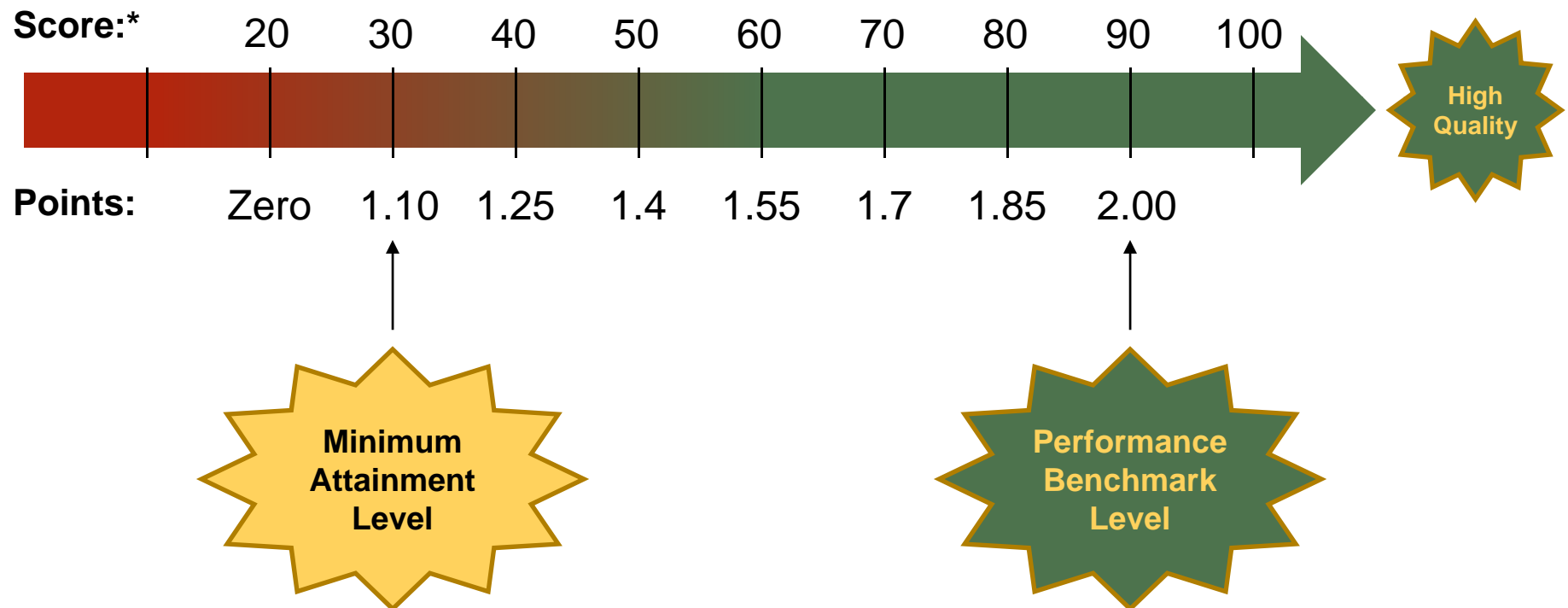
- CMS has not yet determined the specifications for the proposed measures
 - Many of the measures have National Quality Forum endorsement or are in use by other CMS programs, but the specifications may need to be revised in order to apply to ACOs
 - CMS will make the specifications available on its website “prior to the start” of the MSSP
- Results for the 65 measures would be calculated through claims data, survey data and a new data collection tool called the Group Practice Reporting Option (“GPRO”)
 - CMS would retain the right to audit data input into the GPRO tool by reviewing beneficiary medical records

MSSP - Calculation of Quality Performance Score

- In the first year, the program would operate as a “pay for reporting” program
 - ACOs would achieve the maximum quality performance score by submitting quality data for all 65 quality measures
- In subsequent years, CMS proposes to use a sliding scale quality performance measurement methodology
 - ACOs that achieve higher scores on the individual measures would be rewarded with higher overall quality scores and in turn, higher percentages of shared savings

MSSP - Calculation of Quality Score for Each Measure

Scoring for a Single Measure



* Score is measured as a percentile of FFS/MA rate or as a percentage, depending on the measure.

MSSP - Calculation of Quality Score for Each Measure (cont.)

- Performance benchmarks and minimum attainment levels for each of the measures will be provided to ACOs “prior to the start” of each performance period
- Scores for the diabetes composite measure and the coronary artery disease composite measure would be awarded on an “all or nothing” basis
 - An ACO receives zero points for these measures if one of the criteria is not met
 - CMS is signaling to providers that failing to perform any element of a process for the diabetes composite measure or the coronary artery disease composite measure is unacceptable
 - But, sub measures within these composite measures will also be scored individually

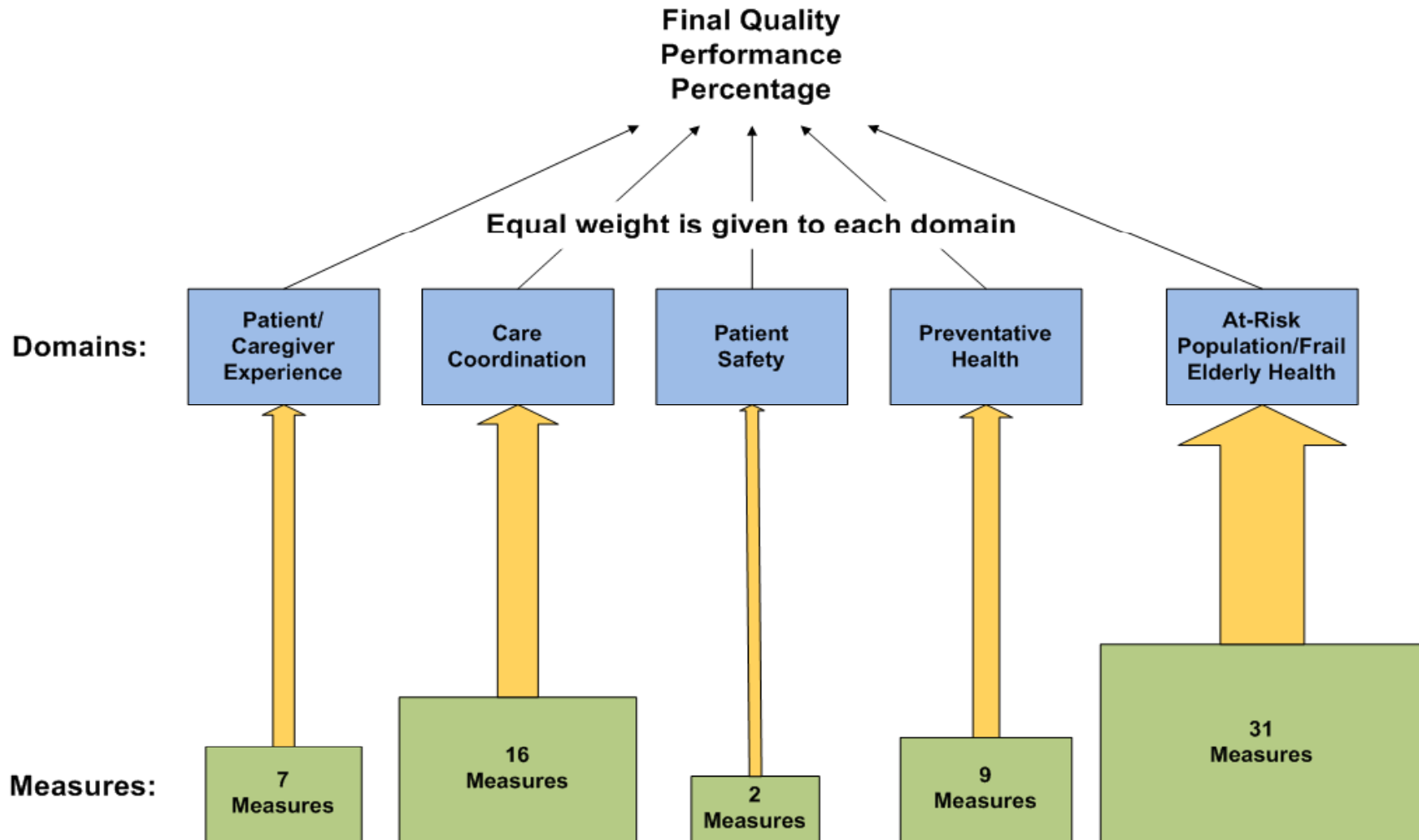
MSSP - Calculation of Quality Score for a Domain

- Scores for individual measures are converted into a quality performance score for a domain by comparing:
 - The total number of points earned by the ACO for the measures in that domain to
 - The total number of points that could have been earned by the ACO on the measures in that domain
- For example, if an ACO earned 10 total points for a domain with 20 measures, the ACO's score for that domain would be 25%
- Regulations state “All measures within a domain must have a score above the minimum attainment level . . . in order for the domain to be eligible for shared savings.”

MSSP - Calculation of Quality Score Across all Domains

- The quality performance score percentages on the five domains are then combined, **giving equal weight to each domain**, to determine the total quality performance score percentage across all domains and measures
 - Giving equal weight to each domain emphasizes the measures within a domain with few measures and deemphasizes the measures within a domain with many measures
 - For example, the Patient Safety domain, which has only 2 measures, would get the same weight as the At Risk Population and Frail Elderly Health domain, which has 31 measures

MSSP - Calculation of Quality Score Across all Domains (cont.)



MSSP – Warnings, Terminations and Appeals

- An ACO's failure to meet the minimum attainment level for one or more of the five domains would result in the issuance of a warning
- Continued underperformance in the subsequent year would result in termination of the ACO's MSSP agreement
- There is no administrative or judicial review of:
 - The quality performance standards established by CMS,
 - CMS's assessment of the quality of care furnished by an ACO, or
 - CMS's termination of an ACO for failure to meet quality performance standards



Impact of Quality Performance on Opportunity for Shared Savings

Quality and Shared Savings

- Must timely and accurately report on quality measures in order to be eligible for shared savings
- CMS proposes to reward ACOs that achieve higher quality performance percentages
 - Higher percentages of shared savings
 - Lower percentages of shared losses

Overall Calculation of Shared Savings Rate

- CMS proposes to calculate a Shared Savings Rate for each ACO to determine the ACO's portion of any savings achieved each year
- Shared Savings Rate = Quality Performance Sharing Rate + Potential Increase for FQHC/RHC participation (subject to a total cap)
- Maximum Quality Performance Savings Rate
 - 50% in year in which ACO not at risk
 - 60% in year in which ACO at risk

Summary of Shared Savings Calculation (Track 1 and Track 2)

	ACO Not At Risk (Track 1, CYs 1 &2)	ACO At Risk (Track 1, CY3; Track 2, all yrs)
Minimum Savings Rate	2% to 3.9% of benchmark	2% of benchmark
Shared Savings	Amount is net of MSR	First dollar savings
Shared Savings Rate		
Quality Performance Sharing Rate	Maximum 50%	Maximum 60%
FQHC/RHC	Maximum 2.5%	Maximum 5%
Shared Savings Cap	7.5% of benchmark	10% of benchmark
Shared Savings Withhold	25%	25%

Calculating an ACO's Quality Performance Sharing Rate

- CMS will apply the ACO's Quality Performance Percentage to the maximum Quality Performance Sharing Rate
 - One-sided model: $50\% * [\text{quality performance percentage}]$
 - Two-sided model: $60\% * [\text{quality performance percentage}]$
- In the first year, ACOs achieve 100% quality performance percentage by reporting on all measures
- In subsequent years, based on percentage of points earned across the five domains based on performance
 - In order for the domain to be eligible for shared savings, must report all measures and have a score above the minimum attainment level for all measures

Example Calculation After First Year

Domain	Patient/ Caregiver Experience	Care Coordination	Patient Safety	Preventative Health	At-Risk Population/Frail Elderly Health
Measures <i>(CMS may revise)</i>	7 Measures	16 Measures	2 Measures	9 Measures	31 Measures
Total Possible Points	14 points	32 points	4 points	18 points	62 points
Domain Score	$11.2/14=$ 80%	$29/32=$ 90%	$4/4=$ 100%	$16.2/18=$ 90%	0% (not minimum attainment for all measures)
Quality Performance Score Percentage	Average (80%, 90%, 100%, 90%, 0%)= 72%				
Quality Performance Savings Rate	72% * 50% two-sided maximum= 36%				
	72% * 60% two-sided maximum= 43%				

Impact of Quality Performance on Calculation of Shared Loss Rate

- For two-sided models, CMS proposes to calculate ACO's share of losses and 1 minus the shared savings rate (subject to a cap)
- ACO with a higher shared savings rate, due to quality performance, will have a correspondingly lower loss rate
 - ACO 1 has a quality performance percentage of 90%
 - Shared Savings Rate= $90\% * 60\% = 54\%$
 - Shared Loss Rate= $100\% - 54\% = 46\%$
 - ACO 2 has a quality performance percentage of 75%
 - Shared Savings Rate= $75\% * 60\% = 45\%$
 - Shared Loss Rate= $100\% - 45\% = 55\%$

Alternative Considered: Minimum Quality Threshold

- ACOs would receive maximum quality performance sharing rate (i.e., 50% or 60%) if they perform at or above 50th percentile in all domains
 - Higher than minimum attainment level of 30th percentile under proposed sliding scale methodology
- Potential Benefits
 - Would require minimum quality attainment in *all* domains
 - Would not reward ACOs for random variability
 - Shared savings percentage fixed and certain once threshold met
- Potential Drawbacks
 - No incentive to improve quality once threshold met



Other Quality-Related Requirements

Other Quality-Related Requirements

- ACO must certify the accuracy, completeness and truthfulness of submitted quality data
- At least 50% of an ACO's PCPs must be meaningful EHR users by the start of the second performance year in order to continue participating or CMS may terminate the agreement
- ACOs must publicly report quality performance standard scores in a standardized format to be specified by CMS

Other Quality-Related Requirements (cont.)

- Must have a physician-directed quality assurance and process improvement committee
 - Oversee ongoing quality assurance and improvement program
- Must implement evidence-based medical practice or clinical guidelines and processes for delivering care
 - Cover diagnoses with significant potential for the ACO to achieve quality and cost improvements
- ACO participants and providers/ suppliers must agree to be subject to performance evaluations and potential remedial actions
 - ACO must have policies and procedures for expulsion of ACO participants and ACO provider/suppliers
- ACO must have infrastructure (e.g., HIT) to collect and evaluate data
 - Must provide feedback to ACO participants and providers/suppliers across entire ACO



Relevant Lessons from the Medicare Physician Group Practice Demonstration

Medicare Physician Group Practice Demonstration – Background

- The MSSP is modeled on Medicare’s Physician Group Practice (“PGP”) Demonstration which operated from April 2005 through March 2010
- The PGP demonstration had three primary goals:
 - Promote coordination of care between providers of Medicare Part A (hospital insurance) services and Medicare Part B (medical insurance) services
 - Improve efficiency and effectiveness of care by supporting care management strategies, process redesign, and physician and care team tools
 - Reward improvements in health outcomes

Medicare PGP Demonstration – Background (cont.)

- The PGP demonstration focused on Medicare beneficiaries who had chronic illnesses or multiple co-morbidities or were transitioning care settings
- PGPs in the PGP demonstration could earn up to 80% of the financial savings that they produced
 - In contrast, as discussed earlier, ACOs in the MSSP may earn up to 50% or 60% of the savings
- PGPs received payments under their existing Medicare fee schedules
- The PGP demonstration had a 5-year term

Medicare PGP Demonstration – Determining Market Growth Rate

- PGPs were eligible for shared savings if their Medicare spending growth rate for assigned beneficiaries was more than 2% lower than the growth rate for a comparison group of beneficiaries
 - Comparison group consisted of Medicare beneficiaries in the local market area who did not have an office visit at the PGP during the performance year
 - Growth rate for comparison group was calculated by comparing the per capita spending for these Medicare beneficiaries in the performance year with the spending in a base year period

Medicare PGP Demonstration – Risk Adjustment

- The PGP's expenditures were risk adjusted to consider the health status of the PGP's beneficiaries
- The PGP demonstration used the CMS hierarchical condition categories (CMS-HCC) risk adjustment model currently used by CMS to adjust Medicare capitation payments to Medicare Advantage health plans
- CMS used beneficiaries' current year diagnoses to adjust current year expenditures
- Thus, PGPs with a sicker patient population were not disadvantaged

Medicare PGP Demonstration – Assignment of Beneficiaries

- Medicare beneficiaries were assigned to a participating PGP if they received the plurality of their physician office and outpatient services at that PGP during the performance year
- On average, Medicare beneficiaries visited the PGP to which they were assigned five times per performance year

Medicare PGP Demonstration – Performance Measurement

- Quality was assessed using 32 quality measures which were phased in over the first three performance years
- By the third performance year:
 - 50% of shared savings payments were based on cost efficiency and
 - 50% of shared savings payments were based on performance on quality measures
- For example, in the third performance year, 50% of the maximum shared savings was earned regardless of quality performance and 50% depended on the quality performance score

Medicare PGP Demonstration – Performance Measurement (cont.)

Physician Group Practice Demonstration Quality Measures			
Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Preventive Care
HbA1c Management	Left Ventricular Function Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	Left Ventricular Ejection Fraction Testing	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Beta-Blocker Therapy – Prior MI	Blood Pressure Control Plan of Care
Lipid Measurement	Blood Pressure Screening	Blood Pressure	Breast Cancer Screening
LDL Cholesterol Level	Patient Education	Lipid Profile	Colorectal Cancer Screening
Urine Protein Testing	Beta-Blocker Therapy	LDL Cholesterol Level	
Eye Exam	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy for Patients HF		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

* Source: Centers for Medicare and Medicaid Services, *Medicare Physician Group Practice Demonstration: Physician Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration* (December 2010).

Medicare PGP Demonstration – Performance Measurement (cont.)

- Performance measures were developed by CMS in coordination with the American Medical Association and the National Committee for Quality Assurance (NCQA)
- Performance measures were phased in to reduce administrative burden of collecting and reporting data for all measures
 - During the first performance year, only diabetes performance measures were used
 - Congestive heart failure and coronary artery disease measures were phased in during performance year two
 - Hypertension and colorectal and breast cancer screening measures were phased in during performance year three

Medicare PGP Demonstration – Performance Measurement (cont.)

- Quality improvement targets for the performance measures were based on both:
 - Improvement of quality as compared to the PGP's prior performance
 - Quality achievement as compared to national benchmarks

Medicare PGP Demonstration – Participants

- Ten PGPs participated in the PGP demonstration, including:
 - Freestanding multi-specialty physician group practices
 - Faculty group practices
 - Physician groups within an integrated health care system
 - Physician groups part of physician network organizations
- Participating PGPs ranged from 232 to 1291 physicians
- In total, participating PGPs represented 5,000 physicians and 220,000 Medicare fee-for-service beneficiaries

Medicare PGP Demonstration – Results after Fourth Performance Year

Participant	Quality Percentage				Shared Savings Payments			
	PY1	PY2	PY3	PY4	PY1	PY2	PY3	PY4
Academic Medical Centers								
Dartmouth-Hitchcock Clinic	95.45%	97.78%	92.45%	94.34%	0	6,689,879	3,570,173	328,798
University of Michigan Faculty Group Practice	95.45%	100.00%	94.34%	96.23%	2,758,370	1,239,294	2,798,005	5,222,852
Freestanding Group Practices								
Marshfield Clinic	81.82%	100.00%	98.11%	100.00%	4,565,327	5,781,573	13,816,922	16,154,242
The Everett Clinic	86.36%	95.56%	94.34%	94.34%	0	129,268	0	0
Integrated Delivery Systems								
Billings Clinic	90.91%	97.78%	98.11%	92.45%	0	0	0	0
Geisinger Clinic	72.73%	100.00%	100.00%	100.00%	0	0	1,950,649	1,788,196
Forsyth Medical Group	100.00%	100.00%	96.23%	96.23%	0	0	0	0
Park Nicollet Clinic	95.45%	97.78%	100.00%	100.00%	0	0	0	0
St. John's Clinic	100.00%	100.00%	96.23%	98.11%	0	0	3,143,044	8,185,757
Network Model								
Middlesex Health System	86.36%	95.56%	92.45%	94.34%	0	0	0	0

* Source: Data from RTI International (under contract with CMS).

Medicare PGP Demonstration – Results after Fourth Performance Year (cont.)

- The data in the table on the preceding slide is from the CMS website
 - Only includes data from the first four performance years
- PGPs within integrated delivery systems began performing better by the third performance year
- Trends as of the fourth performance year:
 - PGPs that are part of academic medical centers appear to outperform others
 - The impressive performance of Marshfield Clinic suggests that freestanding PGPs may also have an advantage
 - Almost half of the PGPs received no performance payments at all

Medicare PGP Demonstration – Characteristics of Success

- Results from the fourth performance year suggest that academic medical centers and freestanding PGPs were able to reduce costs better than integrated delivery systems and networked PGPs
 - But, it is not clear why
- RTI International (under contract with CMS) came to the following conclusions based on the second performance year data:
 - “Because the Demonstration was not structured to test specific interventions, and the beneficiaries are assigned retroactively, it is difficult to identify a specific protocol or action that explains performance.”

* Source: Department of Health and Human Services, *Report to Congress: Physician Group Practice Demonstration Evaluation Report* (2009).

Medicare PGP Demonstration – Characteristics of Success (cont.)

- RTI International conclusions (cont.):*
 - The most distinguishing factors between the PGPs that earned and did not earn performance payments were the pre-existing expenditure trends and the organizational structures.
 - Various analyses could not determine the precise reasons for the difference in financial performance.”

* Source: Department of Health and Human Services, *Report to Congress: Physician Group Practice Demonstration Evaluation Report* (2009).

Medicare PGP Demonstration – Characteristics of Success (cont.)

- Successful PGPs attributed their success to some of the following factors:
 - Organizational structure and prior investments
 - New investments in care management programs and redesigned care processes
 - More intensive diagnostic coding
 - Health information technology
 - Educating providers and providing feedback to providers about certain conditions and populations of patients

Medicare PGP Demonstration – Comparing Savings with Investments

- An extrapolation of the results of the PGP demonstration published in *The New England Journal of Medicine* suggests that most ACOs that participate in the MSSP will lose money during the first three years of the program*
- On average, participants in the PGP demonstration invested \$1.7 million in the first year
- Half of the PGPs in the PGP demonstration are unlikely to break even on this initial investment

* Source: Trent T. Haywood & Keith C. Kosel, *The ACO Model – A Three-Year Financial Loss?*, *New Eng. J. Med.* 364:e27 (Apr. 7 2011).

Medicare PGP Demonstration – Comparing Savings with Investments (cont.)

- While limited, this analysis of the PGP demonstration concluded that, assuming a demonstration program term of five years and an investment per PGP provider of \$737, PGPs in the PGP demonstration would need a 13% margin to break even*
- Given these assumptions and the fact that the proposed MSSP would have a three year term, ACOs participating in the MSSP would need a 20% margin to break even

* Source: Trent T. Haywood & Keith C. Kosel, *The ACO Model – A Three-Year Financial Loss?*, New Eng. J. Med. 364:e27 (Apr. 7 2011).

Medicare PGP Demonstration – Takeaways

- Before committing to participate in the MSSP, providers should do their due diligence to assess whether they are likely to come out ahead financially
- Academic medical centers and freestanding PGPs may be more likely to succeed
- Providers who have invested significantly in clinical and operational integration, care management programs and care processes, intensive diagnostic coding and health information technology may be more likely to recover the additional initial investments necessary to participate
- Under MSSP, ACOs may benefit from the fact that the first performance year is pay-for-reporting year

General Quality Related Considerations for Potential Participants in the MSSP

- Even if you do not participate in the MSSP, the quality measures in the proposed regulations are likely to be part of CMS payment policies in the future
- Will you have capacity to collect and share data across all providers in or contracted with the ACO? Will CMS data be sufficient to assist in quality performance tracking?
- Consider the status of HIT implementation among potential ACO participants (both for your ability to successfully track quality and for your eligibility to continue participating the second year)

General Quality Related Considerations for Potential Participants in the MSSP (cont.)

- Are there particular domains on which you may not perform as well, or on which it would be easy to improve in order to increase your portion of shared savings?
- How will you incentivize quality performance among individual participants? Will you split up savings based on individual participant performance?
- Be mindful of potential legal barriers to performance-based credentialing

Further Information

- Stay up-to-date on developments by checking the Ropes & Gray Health Reform Resource Center website at www.healthreformresourcecenter.ropesgray.com
- The proposed regulations are available through the Ropes & Gray Health Reform Resource Center website
- Comments on the proposed regulations are due by June 6, 2011

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