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Summary of 2014 CMS Proposed Changes to the ACO Quality Measures

The CMS Notice of Proposed Rule Making (NPRM) released on July 3, with comments due September 2, alters the quality reporting for MSSP ACOs in a number of ways. These include changes to the measures, the number of measures to be reported, and the quality benchmarks.

Proposed Quality Measure Changes
In sum, CMS proposes to add 12 measures and drop eight for a new total of 37 ACO quality measures. These would become effective for the 2015 reporting period, or reported by ACOs in early 2016. (ACOs with 2015 start dates would only be responsible in 2015 for complete and accurate reporting of all measures.) Generally, CMS wishes to increase the number of outcome based measures over time and retire measures (moreover process-oriented measures) as appropriate.

The proposed new quality measures are:

- CAHPS stewardship of patient resources. This measure determines whether the ACO provider talked with their patient about prescription costs. It would be added to the patient experience domain. (This presently is an unscored measure that's currently shared with ACOs for information purposes only.)
- A 30-day all cause SNF readmission measure. This measure would be calculated from claims data.
- All-cause unplanned admissions for patients with diabetes, heart failure, and multiple chronic conditions. These measures would fall under the care coordination/patient safety domains.
- Depression remission at 12 months. This measure would fall under the preventive health domain and aligns with PQRS. CMS is also seeking comments on additional behavioral health measures such as substance abuse and mental health measures.
- Diabetes measures for foot exam and eye exams. These measures would fall under the clinical care for at-risk populations – diabetes domain. These would align with the PQRS and EHR incentive program measures.
- Coronary artery disease (CAD) symptom management. This would measure whether CAD patients are seen within 12 months for anginal symptoms, present or absent. It would be added to the CAD composite measures and would align with PQRS and the ENR incentive program.
- CAD beta blocker therapy prior to MI or LVEF. This would measure whether patients with CAD who've had prior MI or LVEF (left ventricular systolic dysfunction less than 40 percent) are prescribed a beta blocker. It would be added to the clinical care for at-risk population – CAD and included in the CAD composite measure.
- CAD antiplatelet therapy. This would measure whether patients 18 or older with a CAD diagnosis seen within 12 months were prescribed aspirin or clopidogrel. It would be

added to the clinical care for at-risk population – CAD and included in the CAD composite measure. This measure would replace the existing ACO measure #30.

- Documentation of current medications in the medical record. This would measure whether medication reconciliation was performed during every office visit. It would replace ACO measure #12 and aligns with PQRS and the EHR incentive program.
- Percent of PCPs who successfully meet meaningful use requirements. This would modify ACO measure #11.

CMS proposes to retire these eight measures:

- ACO #12: medication reconciliation after discharge from an inpatient facility
- ACO #22: diabetes composite: hemoglobin A1c
- ACO #23: diabetes composite: low density lipoprotein
- ACO #24: diabetes composite: blood pressure
- ACO #25: diabetes composite: tobacco non-use
- ACO #29: ischemic vascular disease: complete lipid profile and LDL control
- ACO #30: ischemic vascular disease: use of aspirin or other antithrombotic
- ACO #32: coronary artery disease composite: drug therapy for lowering LDL cholesterol

CMS also proposes to update and revise the diabetes and CAD composites to include the following eight measures:

- ACO #26: diabetes: daily aspirin or antiplatelet medication use for diabetes and ischemic vascular disease
- ACO #27: diabetes: hemoglobin A1c poor control
- ACO #41: diabetes: foot exam
- ACO #42: diabetes: eye exam
- ACO #33: CAD: ACE inhibitor or ARB therapy for diabetes or LVEF
- ACO #43: antiplatelet therapy
- ACO #44: symptom management
- ACO #45: beta-blocker therapy - poor MI or LVEF

In sum, the five component diabetes measures would drop to four and the two CAD component measures would grow from two to four. CMS also seeks comments on how they combine and incorporate component measure scoring for the composite. (For an overview of these proposed changes see the tables, pages 404-409.)

CMS states it does not anticipate these changes would increase an ACO's reporting burden since the total number of measures ACOs would need to directly report through the CMS website interface would actually decrease by one since the increased number of reporting measures would be calculated by CMS using administrative claims or patient survey data.

CMS also notes it is proposing "to reduce GPRO minimum reporting requirements for PQRS reporting from 411 to 248 consecutively ranked and assigned patients for each measure or 100 percent of the sample for each measure if there are less than 248 patients in a given sample" (pg. 410).

Concerning future quality measures, CMS is seeking comment on the following issues:

- gaps in measures and additional specific measures, for example, related to care coordination in the post-acute setting and quality or care in post-acute including skilled nursing and home health
- caregiver experience of care
- alignment with value-based payment modifier (VM) measures, in part since CMS is proposing to start applying the VM to physicians participating in ACOs beginning in 2017 – there may be synergies that can be created by aligning ACO and VM measures
- specific measures to assess care in the frail elderly population
- utilization, or should utilization measures be included to encourage more efficient care and what measures would be most appropriate and how to risk adjust such measures
- health outcomes, that is when would it be appropriate to include a self-reported health and functional status measures
- measures for retirement or what measures have "topped out"
- additional public health measures such as preventive care and screening for unhealthy alcohol use, a NQF measure (#2152) that CMS is considering adding

HIT Meaningful Use and EHR Quality Reporting

In order to better align the ACOs with Medicare meaningful use, CMS is proposing to allow ACOs to satisfy the CQM (Clinical Quality Measures) reporting component of the EHR incentive program if/when the ACO extracts data necessary for the ACO to satisfy its GPRO quality reporting requirements from CEHRT (Certified EHR Technology) and when the ACO satisfactorily reports the ACO GPRO measures through a CMS web interface. Though CMS is not proposing any new ACO requirements regarding EHR reporting, it is soliciting for comments and suggestions concerning most generally opportunities and barriers to ACO EHR quality measure reporting, ways of overcoming any barriers, and ways of implementing EHR-based reporting of quality measures such as directly from EHRs via data submission vendors.

Quality Performance Benchmarks

First, CMS is proposing to use flat percentages to set benchmarks so that ACOs with high performance on measures are not penalized. CMS states "… we will now use all available FFS data to calculate benchmarks, including ACO data, except where performance at the 60th percentile is equal to or greater than 80 percent for individual measures. In these cases, a flat percentage will be used to set the benchmark for the measure" (pg. 423).

Also, where measures are topped out, or for example where 80th or 90th percentiles approach 100 percent performance, CMS proposes when national FFS data results in the 90th percentile for a measure are greater than or equal to 95 percent, they will use flat percentages for the measure.

For second, three-year contract ACOs, CMS proposes to clarify existing regulations such that in the first year of the second three-year contract, ACOs will continue to be assessed on its performance on each measure. In other words, an ACO will not receive another one-year transition period.

CMS proposes to update measures every two years. For example, data submitted in 2013 for the 2012 reporting period would apply for a total of two performance years, or 2014 and 2015. After which CMS would reset the benchmarks for all ACOs based on data for the 2014 reporting

period that is reported during 2015. These updated benchmarks would then apply for 2016 and 2017. CMS seeks comments on the appropriate number of years a benchmark should remain stable before being updated.

Finally, concerning awarding quality improvement, CMS recognizes that ACOs should be awarded for both attainment and improvement, or explicitly awarding ACOs for year-over-year improvement. CMS is proposing to borrow from the MA program such that ACOs be allowed to score bonus points towards achieving shared savings. For each quality measure domain, ACOs would be eligible for up to two additional bonus points (though they could not exceed the current maximum total points achievable within the domain) if they achieve statistically significant levels (using the MA program's t-testing method) of quality improvement for the measures within the domain. Generally, CMS would use the MA formula, which is the score for a measure in the performance year minus the score in the previous year. (The proposal would exclude ACOs in their first year.) CMS is seeking comments both on this bonus point scoring proposal as well as comments on any alternative approaches to reward explicitly quality improvement for ACOs.