

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Office of Media Affairs

MEDICARE FACT SHEET

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Improving Quality of Care for Medicare Patients: Accountable Care Organizations

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

This fact sheet describes the proposals to ensure that ACOs provide high quality care, including proposed quality measures, and a proposed method for scoring the performance of the ACO for purposes of the Shared Savings Program. There will be a 60 day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as it develops final regulations on the program.

Background:

The Medicare Shared Savings Program, which is to be implemented on January 1, 2012, is intended to encourage providers of services and suppliers (e.g., physicians, hospitals and others involved in patient care) to coordinate patient care and improve communications with each other to get each beneficiary the right care at the right time, and see that the care is provided right the first time. To accomplish this, the Act allows providers to create ACOs that will be held accountable for improving the health and experience of care for individuals, improving the health

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of populations, and reducing the rate of growth in health care spending. Studies show that better care often costs less, because coordinated care helps avoid unnecessary duplication of services and preventing medical errors.

Proposals For Assessing Quality Included in the ACO Proposed Rule:

Proposed Quality Measures: For 2012, CMS proposes to use a number of quality measures to establish the quality performance standard ACOs must meet in order to share in savings, provided they also meet the program's cost savings requirement. These 65 measures span five quality domains: Patient Experience of Care, Care Coordination, Patient Safety, Preventive Health, and At-Risk Population/Frail Elderly Health. The list of proposed measures is included in the appendix to this fact sheet.

CMS considered a broad array of process and outcome measures would help in assessing an ACO's success in delivering high-quality health care at both the individual and population levels. Several of the proposed quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System, the Electronic Health Record (EHR) Incentive Program, and the Hospital Inpatient Quality Reporting Program. CMS also sought to align the proposed ACO quality measures with the National Quality Strategy and other Department of Health and Human Services priorities. CMS proposes that the measures would be reported to CMS through a combination of claims submission, data collection using a tool designed for clinical quality measure reporting, and surveys.

CMS is proposing to define the first quality performance period as beginning January 1, 2012 and ending December 31, 2012.

Proposed Quality Performance Scoring: As required by the Affordable Care Act, before an ACO can share in any savings created, it must demonstrate that it is delivering high quality care. Thus, a calculation of the quality performance standard will indicate whether an ACO has met the quality performance goals that would allow it to be considered eligible for shared savings. The proposed method for scoring the measures and determining the performance level that must be achieved to share in savings under the Shared Savings Program is described in the proposed rule.

CMS proposes that the performance on each measure will be scored on a linear points scale and roll up into 5 scores for each of the 5 domains. The percentage of points earned for each domain will be aggregated using an equal weighting method to arrive at a single percentage that will be applied to the maximum sharing rate for which the ACO is eligible.

For the first year of the Shared Savings Program, CMS proposes to set the quality performance standard at the reporting level. This means that during the first performance period, ACOs will be required to report the quality measures completely and accurately in order to share in savings. However, CMS proposes to still score quality in the first year for informational purposes and to help define the benchmarks for future program years. CMS proposes to set the quality performance standard at a higher level in subsequent years.

Proposed Incorporation of the Physician Quality Reporting System into the Shared Savings Program: The Affordable Care Act allows CMS to incorporate the Physician Quality Reporting System reporting requirements and incentive payments into the Shared Savings Program. ACO participant providers/suppliers who are also Physician Quality Reporting System eligible professionals may earn the Physician Quality Reporting System incentive as a group practice under the Shared Savings Program, by meeting its quality performance standard

The Shared Savings Program NPRM will appear in the XX, 2011 issue of the *Federal Register*. CMS will accept comments on the proposed rule until XX, and will respond to them in a final rule to be issued later this year. The Shared Savings Program will begin operating on January 1, 2012.

For more information, please see:

www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

**Proposed Quality Measures for Accountable Care Organizations
For First Year Of The Medicare Shared Savings Program**

Patient/Caregiver Experience Domain:

<u>1.</u>	<u>Clinician/Group CAHPS: Getting Timely Care, Appointments, and Information</u>
<u>2.</u>	<u>Clinician/Group CAHPS: How Well Your Doctors Communicate</u>
<u>3.</u>	<u>Clinician/Group CAHPS: Helpful, Courteous, Respectful Office Staff</u>
<u>4.</u>	<u>Clinician/Group CAHPS: Patients' Rating of Doctor</u>
<u>5.</u>	<u>Clinician/Group CAHPS: Health Promotion and Education</u>
<u>6.</u>	<u>Clinician/Group CAHPS: Shared Decision Making</u>
<u>7.</u>	<u>Medicare Advantage CAHPS: Health Status/Functional Status</u>

Care Coordination Domain:

<u>8.</u>	<u>Risk-Standardized, All Condition Readmission</u>
<u>9.</u>	<u>30 Day Post Discharge Physician Visit</u>
<u>10.</u>	<u>Medication Reconciliation</u>
<u>11.</u>	<u>Care Transition Measure:</u>

<u>12.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Diabetes, short-term complications</u>
<u>13.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Uncontrolled Diabetes</u>
<u>14.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Chronic obstructive pulmonary disease</u>
<u>15.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Congestive Heart Failure</u>
<u>16.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Dehydration</u>
<u>17.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Bacterial pneumonia</u>
<u>18.</u>	<u>Ambulatory Sensitive Conditions Admissions:</u> <u>Urinary infections</u>
<u>19.</u>	<u>% All Physicians Meeting Stage 1 HITECH</u> <u>Meaningful Use Requirements</u>
<u>20.</u>	<u>% of PCPs Meeting Stage 1 HITECH</u> <u>Meaningful Use Requirements</u>
<u>21.</u>	<u>% of PCPs Using Clinical Decision Support</u>
<u>22.</u>	<u>% of PCPs who are Successful Electronic</u> <u>Prescribers Under the eRx Incentive Program</u>
<u>23.</u>	<u>Patient Registry Use</u>

Patient Safety Domain:

24.	<u>Health Care Acquired Conditions Composite:</u> • <u>Foreign Object Retained After Surgery</u> • <u>Air Embolism</u> • <u>Blood Incompatibility</u> • <u>Pressure Ulcer, Stages III and IV</u> • <u>Falls and Trauma</u> • <u>Catheter-Associated UTI</u> • <u>Manifestations of Poor Glycemic Control</u> • <u>Central Line Associated Blood Stream Infection (CLABSI)</u> • <u>Surgical Site Infection</u> • <u>AHRQ Patient Safety Indicator (PSI) 90</u> <u>Complication/Patient Safety for Selected Indicators (composite)</u> ○ <u>Accidental puncture or laceration</u> ○ <u>Iatrogenic pneumothorax</u> ○ <u>Postoperative DVT or PE</u> ○ <u>Postoperative wound dehiscence</u> ○ <u>Decubitus ulcer</u> ○ <u>Selected infections due to medical care (PSI 07: Central Venous Catheter-related Bloodstream Infection)</u> ○ <u>Postoperative hip fracture</u> ○ <u>Postoperative sepsis</u>
25.	<u>Health Care Acquired Conditions: CLABSI Bundle</u>

Preventive Health Domain:

26.	<u>Influenza Immunization</u>
27.	<u>Pneumococcal Vaccination</u>
28.	<u>Mammography Screening</u>
29.	<u>Colorectal Cancer Screening</u>
30.	<u>Cholesterol Management for Patients with Cardiovascular Conditions</u> •
31.	<u>Adult Weight Screening and Follow-up</u>
32.	<u>Blood Pressure Measurement</u>
33.	<u>Tobacco Use Assessment and Tobacco Cessation Intervention</u>
34.	<u>Depression Screening</u>

At-Risk Population/Frail Elderly Domain:

35.	At Risk Population - Diabetes	Diabetes Composite (All or Nothing Scoring): • Hemoglobin A1c Control (<8%) • Low Density Lipoprotein (<100) • Blood Pressure <140/90 • Tobacco Non Use • Aspirin Use
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36.	At Risk Population – Diabetes	Diabetes Mellitus: Hemoglobin A1c Control (<8%)
37.	At Risk Population – Diabetes	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
38.	At Risk Population - Diabetes	Diabetes Mellitus: Tobacco Non Use
39.	At Risk Population - Diabetes	Diabetes Mellitus: Aspirin Use
40.	At Risk Population - Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)
41.	At Risk Population - Diabetes	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
42.	At Risk Population - Diabetes	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
43.	At Risk Population - Diabetes	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients
44.	At Risk Population - Diabetes	Diabetes Mellitus: Foot Exam
45.	At Risk Population - Heart Failure	Heart Failure: Left Ventricular Function (LVF) Assessment
46.	At Risk Population - Heart Failure	Heart Failure: Left Ventricular Function (LVF) Testing
47.	At Risk Population - Heart Failure	Heart Failure: Weight Measurement
48.	At Risk Population - Heart Failure	Heart Failure: Patient Education

49.	At Risk Population - Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
50.	At Risk Population - Heart Failure	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
51.	At Risk Population - Heart Failure	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation
52.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite: All or Nothing Scoring • Oral Antiplatelet Therapy Prescribed for Patients with CAD • Drug Therapy for Lowering LDL-Cholesterol • Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) • LDL Level <100 mg/dl • Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

53.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
54.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines). The LDL-C treatment goal is <100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDL-C 130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of non-lipid risk factors (National Cholesterol Education Program (NCEP)).
55.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

56.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD): LDL level < 100 mg/dl
57.	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
58.	At Risk Population – Hypertension	Hypertension (HTN): Blood Pressure Control
59.	At Risk Population – Hypertension	Hypertension (HTN): Plan of Care
60.	At Risk Population – COPD	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
61.	At Risk Population – COPD	Chronic Obstructive Pulmonary Disease (COPD): Smoking Cessation Counseling Received
62.	At Risk Population – COPD	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1
63.	At Risk Population – Frail Elderly	Falls: Screening for Fall Risk
64.	At Risk Population – Frail Elderly	Osteoporosis Management in Women Who had a Fracture
65.	At Risk Population – Frail Elderly	Monthly INR for Beneficiaries on Warfarin