NAACOS
National Association of ACOs

# The ACO Quality Reporting Guide

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# Introduction and Overview

ACOs participating in the Medicare Shared Savings Program (MSSP) must report quality data to the Centers for Medicare and Medicaid Services (CMS) after the close of every performance year. This performance data is assessed annually to determine if an ACO will be eligible to share in any savings generated or to establish the amount of shared losses the ACO will be responsible for, if applicable. If an ACO fails to meet the established quality performance standards, it will be ineligible to share in any savings generated. Additionally, for ACOs participating under a risk-based model, failure to meet the quality performance standard will result in application of the highest loss sharing rate.

CMS measures every ACO's quality performance using standard methods, established through rulemaking annually. Quality measures span four equally weighted domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations. Quality data collection will take place following the close of the performance year. Typically, the quality data reporting period takes place in January to March of the year following the performance year. CMS will communicate to ACOs when the testing period for data submission has begun as well as the annual submission deadlines through the ACO-Management System (ACO-MS) and ACO Spotlight Newsletter.

This resource summarizes key considerations for ACO quality reporting. This resource is only intended as a guide and is current as of the date of publication. ACOs should consult the CMS website and) ACO-MS for complete and up-to-date information.

**Overview of the ACO Quality Performance Standard**

The quality performance standard is the criteria CMS has established in order for ACOs to be eligible to share in savings earned. This standard also determines, if applicable, the magnitude of shared losses an ACO may be liable for under risk-bearing ACO models. The quality performance standard is defined as follows:

- For ACOs in the first year of the first agreement period: All measures are scored as pay-for-reporting. Therefore, ACOs must completely and accurately report all quality data in order to meet the quality performance standard. If an ACO fails to meet the quality performance standard, it will be determined to be ineligible to share in any savings generated. Additionally, for ACOs participating under a risk-based model, failure to meet the quality performance standard will result in application of the highest loss sharing rate.

- For ACOs in the second or third year of the first agreement period, and all years of any subsequent agreement periods: Measures are scored as pay-for-performance, according to a phase-in schedule established by CMS that is specific to measures and the ACO's performance year in the MSSP. ACOs must continue to completely and accurately report all quality data used to assess quality performance. In pay-for-performance years, CMS establishes a performance benchmark for each measure, which corresponds to a point scale for the measure. Measure specific scores are then used to calculate an overall quality score for the ACO. ACOs must meet minimum attainment, defined as the 30$^{th}$ percentile benchmark, on at least one measure in each domain to be eligible to share in any savings generated. If an ACO fails to meet the quality performance standard, it will be determined to be ineligible to share in any savings generated. Additionally, for ACOs participating under a risk-based model, failure to meet the quality performance standard will result in application of the highest loss sharing rate.

The final sharing rate for an ACO will be the product of the ACO's final quality score and the maximum sharing rate specific to the particular financial model the ACO participates in. More information on the scoring process is available in the "Quality Scoring and Projecting Performance" chapter of this resource, and more detailed information on the quality scoring methodology is available in the CMS Quality Measurement and Methodology resource.

**Measure Requirements**
For each performance year, measure documentation is made available by CMS on both the MSSP guidance and specifications website (see "Quality Measures and Reporting Specifications") as well as the Quality Payment Program (QPP) website (search "Web Interface Quality Measure Specifications"). CMS also makes previous performance year specifications and information available on the MSSP website. NAACOS also provides updates and information related to ACO quality measurement on the NAACOS quality webpage.

For Performance Year 2019, CMS will measure ACOs on 23 quality measures, covering four equally weighted domains:

1. Patient/Caregiver Experience (10 measures)
2. Care Coordination/Patient Safety (4 measures)
3. Preventive Health (6 measures)
4. At-Risk Population (3 measures) – Mental Health, Diabetes, and Hypertension

CMS calculates measures using Medicare claims data, by data reported by ACOs through the CMS Web Interface using patient medical record data from within and outside the ACO and via survey (Clinician and Group Consumer Assessment of Healthcare Providers and Systems Assessment). The CMS Web Interface is a secure, internet-based application for submitting a specific set of pre-populated quality measures. Quality data may be reported manually by the ACO or using a vendor's support. This process is described in more detail in the "Quality Data Collection and Reporting" chapter.

ACOs must invest significant time and resources into quality reporting. Therefore, it is important to develop a project plan in advance of quality data submission and ideally prior to beginning a new performance year. Project planning will also provide assistance in determining the resources needed to complete quality reporting. We hope this guide serves as a resource to assist your ACO in understanding the ACO quality reporting process.

## Quality Reporting Guide Table of Contents

# Chapter One: Quality Data Collection and Reporting

The CMS Web Interface Quality Reporting Period for the Shared Saving Program or Next Generation ACO runs from January 2 through to March 31 of each year to report on quality performance for the previous calendar year. The quality reporting period is a great opportunity for ACOs to identify areas of strength and opportunities for improvement in primary care management of chronic conditions and preventive services.

In this chapter, we will review the most common challenges in the data collection process, tools used by abstractors to guide their work, and pros and cons of using manual versus vendor abstraction.

**Data Collection**

Most Common Challenges in the Data Collection Process

Collecting data from multiple electronic health records (EHR) can be a challenge, particularly for large ACOs with many practice sites. Staff must have system access and be knowledgeable regarding EHR system configuration and documentation standards for each provider practice in order to locate data at multiple locations through multiple EHRs.

Lack of standardized documentation across providers and EHRs can also present a challenge. Generally, every provider documents patient data differently, and it is not always found in the preferred location. Searching requires the reading of medical notes and determining measure qualification. The opportunity exists for standardization of clinical and documentation workflows across provider and practice settings to reduce variation.

There are several challenges for ACOs collecting quality information across multiple locations. The logistical challenges include the need to travel to multiple provider office site locations to gather data due to lack of remote system access for all EHRs, among others. There may be an unwillingness for some providers inside and outside the ACO network to share quality data. This can be addressed through review of network and payer participation agreements as well as requests from patients to share medical records between providers.

Support Tools for Web Interface Abstraction

The strongest tool for Web Interface abstraction is to have a team of leaders, abstractors and auditors educated on every quality measure. Ideally, those individuals are working year-round on population health quality improvement activities, such as patient engagement in annual wellness visits and gap closure for preventive health and chronic diseases. To successfully support this team in Web Interface abstraction, it can be helpful for the ACO to use a variety of educational materials and supporting documents available for quick reference to those involved in this process.

The most reliable and accurate measure descriptions come from CMS. ACOs should absolutely rely on the CMS measure specifications as the source of truth for measure definition, numerator, denominator, and abstraction workflow. This information is shared by CMS through the ACO Management System (for webinars directed at ACOs specifically), the MSSP quality measures reporting specifications and guidance materials (found toward the bottom of this page) as well as the Quality Payment Program website.

However, CMS reference material is not easy to interpret and is lengthy reading. Some organizations developed their own guides to facilitate data abstraction. For example, Central New York Accountable Integrated Medicine, part of Trinity Health Integrated ACO, created what they call "the GIANT Guide" and the "Quick Guide for Abstractors," which include all of this information in one row for each measure and patient eligibility as well as measure time-frame specifications. This involves several columns but is a 'one stop' resource. Please see an example of such a resource here.

To make it easier for abstractors, it is appropriate to simplify information from CMS to educate your abstractors. It is also recommended to start reviewing measures and patient examples in October during the performance year through an internal interrater reliability audit process. This will allow you to identify areas of improvement and education.

It can be beneficial for the abstractors to use an FAQ document and discuss it weekly during the Web Interface Period. Quality leaders and abstractors should participate in CMS weekly meetings and webinars on quality. CMS also produces coding documents for each measure which include visit codes, procedure codes, ICD9 codes, ICD10 codes and medications. These lists include exclusions and exceptions to each measure. It is recommended to produce a document with a single row for each measure and various columns for coding information. This is especially valuable for abstractors during the reporting process.

Finally, ACOs may also choose to create a supplemental claims file including relevant diagnosis, services performed, and providers seen in order to guide chart abstraction to the appropriate EHR. This is valuable in larger networks or in instances where patients may have had services performed outside of the network.

Manual Versus Vendor Abstraction

There are two options for data abstraction to support the Web Interface process; manually at the practice level or through a vendor. There are multiple vendors and the experience can be different depending on the vendor chosen. Below are some benefits and challenges to consider when selecting your Web Interface abstraction method. It is advised that ACO administrators look at their own available internal personnel and financial resources when considering whether to use a vendor for the Web Interface process. There is no clear right or wrong path, and the decision is the discretion of administration after performing cost and resource analysis for collecting and transmitting data for Web Interface submission.

Benefits of Using Vendor Support:

- Vendors can provide support and alleviate burden on staff, particularly if an ACO does not have the personnel available to take on the added task of data collection and submission.
- If the ACO has multiple EHRs, using a vendor's support can assist with logistical challenges associated with collecting data across multiple EHRs.
- Some vendors will have application programming interface (API) links to various EHRs, making data extraction easier.
- Similarly, some vendors will have various means of data extraction (e.g., HL7 or C-CDA) that can help speed up the process of data collection.

Challenges Associated with Using Vendor Support:

- Vendors do not always abstract and submit data to the Web Interface on a specific timeline and may not have the same quality check standards in place that the manual review requires, such as a second review on every patient that does not meet the numerator criteria or where a chart or diagnosis is not found.
- Additionally, when strapped for resources, vendors may conduct telephonic chart audits versus in person data abstraction. Some ACOs have found higher rates of second review for abstractions that were not conducted onsite in the provider office. As such, some ACOs prefer that sites use internal staff who are familiar with provider documentation and EHRs to complete abstraction.
- Costs associated with vendor services can be prohibitive to some ACOs.
- There are legal considerations (e.g., securing personal health information or PHI, establishing Data Use Agreements) and contractual considerations which can add burden to ACOs using the vendor supported method.

**Data Reporting**

Web Interface Process: Prior to Data Reporting

- Request access to the CMS Web Interface platform and credentials for security officials and Web Interface submitters. The Web Interface submitter logs into the ACO Web Interface and uploads the CMS ACO Quality Reporting Web Interface Excel file template.
- Train ACO quality leads on each of the measure specifications ACOs are accountable to report. ACO quality leads can be made responsible for identifying and training all of their abstraction team members.
- Conduct an internal interrater reliability audit for a sample of patient charts for each measure, for each abstractor to ensure abstraction accuracy. This can be beneficial in preparing for a potential audit and increase success and should be done by each quality lead.
- Work on gap closure during the performance year for targeted ACO beneficiaries. To assess which beneficiaries to include in each sample, CMS reviews the Medicare claims submitted by the ACO during the performance period to create a sample of beneficiaries for each measure based on the measure criteria[1].

Web Interface Process: During Data Reporting

- Not all selected beneficiaries qualify for every single measure. Some beneficiaries may be skipped if they don't qualify for a particular measure, as determined by CMS.
- The interface includes alerts if there are errors or data irregularities in the data upload and multiple reporting options to understand submission progress.
- Abstractors should be held accountable in submitting data weekly and monitor numerator failures, including medical records not found, and diagnoses not found. Those charts should be assigned for secondary review by the quality lead. The abstraction should be scheduled to end two-to-three weeks prior to the deadline to ensure sufficient time to complete all secondary reviews. Weekly goals can be made in terms of the sample size, which is dependent on the ACO size. For example, a large organization should aim to complete 150-200 charts per week.

[1] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/397/2018%20CMS%20Web%20Interface%20User%20Guide.PDF

- There should be communication with affiliate providers early in the process to ensure sufficient time to resolve problems, such as issues getting access to the office to abstract the data. Running into these issues late in the process can cause delays if it takes additional time to obtain the clinical data.
- For the abstraction process, it's preferable to abstract on a patient by patient basis, instead of using a measure by measure process. This allows you to complete all measures the patient is eligible for versus having to go back to abstract the chart multiple times. Additionally, this may allow you to close out multiple measures early if you are in the 90th percentile and in compliance with consecutive and complete patients.
- If responsible for multiple TINs, once you receive the sample patient list, organize your list by TIN numbers and distribute to your abstractors in each TIN.
- During the reporting process, ensure the secondary reviewer is not the initial abstractor. Auditors should be assigned by software knowledge and should be required to audit all 'no' answers submitted in initial abstraction.
- Use the comment portion of the survey form to identify where data was found to assist in future location of the data for any secondary review or in the event of a CMS Quality Measures Validation (QMV) audit. This will save time and eliminate duplication of effort.

Coordinating Reporting Data in Your ACO

Web Interface data entry can be completed manually or via Excel upload. Excel upload allows the opportunity to maximize bonus points and reduce errors of manual submission into the Web Interface. If your organization has multiple participants across the nation, it is preferable to have a central team in charge of data submission. Teams in local organizations can send data in an Excel file to a central team to download on the weekly basis. It is advised that ACOs attempt to avoid skipping a patient; all patients that need to be skipped should have a secondary review.

**Authors and Contributors:**
Jennifer Bailey, MSN, RN, Director of Ambulatory Clinical Operations, Trinity Health
Adriana Quiroga-Garcia, MPH, Quality Improvement Performance Manger, Central New York Accountable Integrated Network part of Trinity Health Integrated Care ACO
Joseph Bartman, ACO/CIN Operations Specialist, Trinity Health
Teri Bruno, Network Liaison, Central New York Accountable Integrated Network part of Trinity Health Integrated Care ACO
Rob Fields, CMO, Mount Saini Health System

# Chapter Two: CAHPS Assessments for ACOs

CMS assesses ACOs on the Consumer Assessment of Healthcare Providers and Systems (CAHPS). This component of quality performance and reporting is critical to an ACO's success. The Medicare ACO CAHPS Webpage includes links to the most recent surveys which must be used in the performance year and must be made available in multiple languages. The multiple language presurvey letters and survey tools provided by CMS are available here. The CMS survey tool in English is available here. Participation in CAHPS is mandatory for ACOs; however, survey recipients are randomly chosen by your CMS-approved vendor and beneficiary response is voluntary.

CMS will make announcements and link to resources including the CAHPS Ambulatory Care Improvement Guide, podcasts, and other resources on this webpage.

**Vendor Selection Process**

An ACO may choose a vendor that already completes other surveys for its office or health system as long as they are using the CAHPS Survey for ACOs approved vendor and on the list found here. They may provide the best pricing as part of the current contract with your organization. If you do not have a vendor, there are many choices on the CMS approved vendor list. ACOs must assess the CMS-approved vendors to determine the best fit for your organization.

If an ACO works with multiple TINs, it may be advantageous to look for a vendor with the ability to break down final data at the TIN level. This level data will help in identifying areas of opportunity and focus of education.

In July of each year, the ACO's ATS (Authorized to Sign) will be sent a link to the vendor authorization tool, and the selected vendor must be chosen from the list provided. A final list of approved vendors is listed on the CAHPS for ACOs webpage prior to this selection process.

**Key Deadlines**

There are several key deadlines to be aware of for CHAPS assessments. The CAHPS Survey Timeline is available here. The last date to choose a vendor for CAHPS is provided each year by CMS and has historically fallen in the August/September timeframe. Deadline for vendor selection for the 2019 surveys was September 18, 2019.

Generally, in October of each year, pre-notification letters are mailed to chosen beneficiaries approximately one week before the actual CAHPS survey is sent. Repeat mailings and telephone calls will be made to non-responders. CAHPS vendors will conclude their final data submissions by a date established by CMS. This is generally an end of January/February timeframe.

Some vendors may be able to provide the ACO with preliminary results after the submission period closes; however, CAHPS and quality reports are not considered final until they are provided by CMS. Final results are historically made available by CMS in the August/September timeframe each year.

Many vendors will provide a comparison of your ACO results to the CAHPS benchmarks provided by CMS and to other ACOs for which they have data. The results are a good indicator as to how you have done, but they are not final until provided by CMS and do not include all ACO data or risk adjustment for your

beneficiary cohort. In particular, risk adjustment can be a big consideration in final performance. Current CMS guidance states the following on page 48:

*Certain respondent characteristics, such as age and education, aren't under the control of the organization, but are related to the sampled beneficiary's survey responses. To make sure comparisons between organizations reflect differences in performance rather than differences in case-mix, CMS adjusts for such respondent characteristics when comparing organizations.*

*In general, individuals who are older, those with less education, and those in better overall and mental health give more positive ratings and reports of care. The case-mix model used for analyzing CAHPS for ACOs survey data includes these four self-reported characteristics, together with indicators of Medicaid dual eligibility/eligibility for low-income subsidy status, Asian language of survey completion (Cantonese/Korean/Mandarin/Vietnamese), and information indicating whether another person helped the respondent complete the survey. Although proxy reporting contributes weakly to differences in organization means, it's been retained as an adjustor to address concerns occasionally voiced about the effects of proxy responses on scores.*

*Case-mix adjustment is implemented via linear regression models predicting CAHPS measures from case-mix adjustors and organization indicators. In these models, missing case-mix adjustors are imputed as the organization mean. Adjusted means represent the mean that would be obtained for a given organization if the average of the case-mix variables for that organization were equal to the national average across all participating organizations.*

*Beneficiaries were sampled for the survey such that one quarter of the sample represented beneficiaries with high utilization of services. Survey responses are weighted to account for this sampling method so that survey results represent the general population of an organization's beneficiaries.*

**Executing the CAHPS Survey**

Prior to the start of the CAHPS survey process, the vendor will reach out to confirm beneficiary's language and telephone numbers. This is done through a template provide by the vendor. Accurate telephone numbers will assist in follow up calls of non-responders, and verification of language ensures your beneficiaries will receives in a format understandable to them. Communication from the vendor and requested completion has historically been the mid-October timeframe. CMS provides the following link to its CAHPS FAQ: https://acocahps.cms.gov/en/faqs/faqs-for-acos/

**Provider Education**

Each year, CMS provides the CAHPS Quality Measures including the survey questions that can be utilized as presurvey education for your providers. Improvement planning guidance is also available from some vendors and AHRQ if there are areas of needed improvement.

At the beginning of each year, plan to educate providers regarding CAHPS measures that will be included in the survey process beginning in October. Remember, beneficiaries are asked in the survey process to think back over the last six months, so it is important to start the education early to allow time for providers to make an impact. It may be beneficial to share the actual survey that beneficiaries receive with the providers so they can understand the types of questions that patients are being asked.

It is beneficial to review the previous year's survey results or the current year's preliminary results for areas of opportunity, as well as to identify areas where providers excelled. ACO CAHPS surveys can be

compared to those of other payers to find trends for improvement across payers. This also provides consistency when educating providers and reducing confusion.

It can be helpful to create education that is simple and to the point to present to the providers, but always have the details handy for those providers who would like to engage in higher-level conversations. Other helpful improvement activities can include:

- Creating an improvement plan that is agreed upon by the participants and educate the office staff and provider what the plan is and why it needs to be done.
- Assisting with implementation of the plan or training key people within the practices regarding implementation.
- Providing final CAHPS results in the third quarter timeframe and as a reminder that the surveys will be sent out in October.
- Providing tips and tricks to the office staff and providers to emphasize using terminology consistent with survey questions, as this may help beneficiaries recall conversations when completing their surveys. Example: "Mr. Jones, here is a copy of your education the doctor reviewed with you today." This language should be consistent with the phrases used in the survey questions so patients can clearly identify what has been shared with them.

**Authors and Contributors:**
Melody Danko-Holsomback, CRNP, MSN, Director of Operations, (Keystone ACO)
Contributing Authors: Cindy Yeager, Care Gaps and Quality Manger (Keystone ACO)
Ginna Bodycot, Director of Quality Improvement (Delaware Valley ACO)

# Chapter Three: Quality Scoring and Projecting Performance

Using quality reporting to predict your performance can maximize your success in the Medicare Shared Savings Program (MSSP).Not only is it important to understand how your potential score will affect that performance year and any potential financial savings, but it also helps to identify any areas for improvement. The pay-for-reporting years are crucial years to set up infrastructure and educate clinicians and support staff to perform optimally when the measure switches to pay-for-performance. Projecting your performance can also help identify your baseline performance, and if done in real time, can help you adjust any deficiencies before the reporting period begins.

A best practice is to partner with your electronic health record (EHR) vendors and utilize their quality reporting tools for MSSP. Many EHR vendors can help create dashboards to identify areas of opportunity —in addition to helping with your quality submission. This is key if an operational issue is identified early and can be corrected, such as a clinician documenting free text versus a standard smart form that can be measured and reported. Drops in scores or low performance can often be attributed to process issues rather than the clinician not providing quality care. It is recommended to assess your quality performance at least quarterly, if not monthly or in real time. However, please note that EHR reporting tools typically only pertain to the Web Interface measures, which are only a part of the MSSP Quality score. If your ACO does not have EHR MSSP reporting tools available, you can use other sources to help predict performance such as the previous year's performance or other internal registry reporting.

**CMS Quality Score Calculation**

In order to project your performance, it is important to understand how CMS calculates your score. It is recommended to familiarize yourself with the performance year's quality measure guidance.

In the first performance year of an ACO's first agreement period, ACOs satisfy the quality performance standard when they completely and accurately report on all quality measures (pay-for-reporting). Pay-for-reporting qualifies the ACO for the maximum quality score and sharing rate. In subsequent performance years, quality measures are phased-in to pay-for-performance. In pay-for-performance years, national performance benchmarks are used to calculate the ACO's quality score and final sharing rate based on the ACO's performance in comparison to the benchmark level of performance. When predicting your quality performance, it is important to pay attention to the quality guidance and determine if a quality measure is pay-for-reporting or pay-for-performance for your ACO in the performance year.

CMS will measure quality by using the predetermined quality measures, as finalized in the Medicare Physician Fee Schedule rule, across four domains with equal weighting: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population. Domain scoring is important to understand as the ACO Quality score depends more on how the overall domains perform versus a particular quality measure. This can be helpful if an ACO is struggling with a particular measure. Remedial action is not taken for just one measure if the other measures in the domain are performing above the minimum attainment. Minimum attainment is defined for pay-for-performance measures as meeting the 30th percentile benchmark and for pay-for-reporting measures as complete and accurate reporting. In order for ACOs to achieve minimum attainment, at least 70 percent of the measures in each domain must meet the 30th percentile. For example, using the table below, from the 2018/2019

quality guidance, six of the eight Patient/Caregiver Experience measures must meet the 30th percentile. If only five measures meet the 30th percentile, the domain would not meet the minimum attainment and the ACO may be subject to a Corrective Action Plan (CAP).

| DOMAIN | NUMBER OF INDIVIDUAL MEASURES | TOTAL MEASURES FOR SCORING PURPOSES | TOTAL POSSIBLE POINTS | DOMAIN WEIGHT |
|---|---|---|---|---|
| Patient/Caregiver Experience | 8 | 8 individual survey module measures | 16 | 25% |
| Care Coordination/ Patient Safety | 10 | 10 measures, including the EHR measure, which is double-weighted (4 points) | 22 | 25% |
| Preventive Health | 8 | 8 measures | 16 | 25% |
| At-Risk Population | 5 | 4 measures: three individual measures and a two-component diabetes composite measure that is scored as one measure | 8 | 25% |
| Total in all Domains | 31 | 30 | 62 | 100% |

Within the domains, an ACO will earn quality points for each measure on a sliding scale based on level of performance. Performance below the minimum attainment level or the 30th percentile for a measure will receive zero points for that measure; performance at or above the 90th percentile of the quality performance benchmark earns the maximum points available for the measure. For measures that are pay-for-reporting, ACOs will receive full points if the ACO completely and accurately reports for that measure. Please see the table below for the sliding scale scoring. These points roll up to the maximum points allowed for each domain.

| ACO PERFORMANCE LEVEL | QUALITY POINTS |
|---|---|
| 90+ percentile benchmark or 90+ percent | 2.00 points |
| 80+ percentile benchmark or 80+ percent | 1.85 points |
| 70+ percentile benchmark or 70+ percent | 1.70 points |
| 60+ percentile benchmark or 60+ percent | 1.55 points |
| 50+ percentile benchmark or 50+ percent | 1.40 points |
| 40+ percentile benchmark or 40+ percent | 1.25 points |
| 30+ percentile benchmark or 30+ percent | 1.10 point |
| <30+ percentile benchmark or <30+ percent | No points |

Additionally, CMS will reward ACOs with improvement points, up to four points in a given domain not to exceed the maximum domain points, if the ACO demonstrates significant improvement in that domain. This is an important concept to understand, especially if initial quality performance is high. Subsequent years can show lower overall quality scores with very little, if any, change in actual quality performance. CMS then calculates a percent score for each domain (sum of points earned and improvement points divided by the total available quality points for that domain). ACOs receive an overall quality score (sum of all domain percent scores divided by four domains) used to determine the amount of shared savings or losses based on its track.

## Quality Performance Projection Tool

Click here for a quality performance projection tool example for ACOs.

**Directions for ACO Projection Tool:**

1. Depending on your ACO's performance year, pay-for-reporting or pay-for-performance may need to be updated in the tool. CMS publishes this information in the quality measure guidance. Please review and populate this section of the ACO Projection Tool →Measure Thresholds Tab in Columns G and H.

| | | | G | H | I | J | K | L | M | N | O |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Measure | Measure in Effect for 2019 | P4R or P4P? 2019 | 30th per | 40th per | 50th per | 60th per | 70th per | 80th per | 90th per |
| Patient/ Caregiver Experience | ACO-1 | CAHPS: Getting Timely Care, Appointments, and Information | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-2 | CAHPS: How Well Your Doctors Communicate | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-3 | CAHPS: Patients' Rating of Doctor | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-4 | CAHPS: Access to Specialists | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-5 | CAHPS: Health Promotion and Education | Yes | P | 54.18 | 55.48 | 56.72 | 57.95 | 59.39 | 60.99 | 63.44 |
| | ACO-6 | CAHPS: Shared Decision Making | Yes | P | 54.75 | 55.97 | 57.05 | 58.1 | 59.27 | 60.58 | 62.76 |
| | ACO-7 | CAHPS: Health Status/Functional Status | Yes | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | ACO-34 | CAHPS: Stewardship of Patient Resources | Yes | P | 24.25 | 25.57 | 26.74 | 28.12 | 29.43 | 31.08 | 33.43 |
| | ACO 45 | CAHPS: Courteous and Helpful Office Staff | Yes | P | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | ACO 46 | CAHPS: Care Coordination | Yes | P | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Care Coordination/ | ACO-8 | Risk Standardized, All Condition Readmission | Yes | P | 15.18 | 15.04 | 14.91 | 14.79 | 14.65 | 14.5 | 14.27 |
| | ACO-38 | All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions | Yes | P | 65.99 | 61.21 | 57.25 | 53.51 | 50 | 46.16 | 41.39 |
| | ACO-43 | Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91) | Yes | P | 1.95 | 1.84 | 1.77 | 1.73 | 1.68 | 1.62 | 1.51 |
| | ACO-13 | Falls: Screening for Future Fall Risk | Yes | P | 43.42 | 50.42 | 58.45 | 66 | 73.39 | 81.79 | 90.73 |
| Preventive Health | ACO-14 | Preventive Care and Screening: Influenza Immunization | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-17 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Yes | P | 55.22 | 61.76 | 68.18 | 73.85 | 79.55 | 85.67 | 92.31 |
| | ACO-18 | Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-19 | Colorectal Cancer Screening | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-20 | Breast Cancer Screening | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| | ACO-42 | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | Yes | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| At-Risk Populat | ACO-40 | Depression Remission at Twelve Months | Yes | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | ACO 27 | Diabetes Mellitus: Hemoglobin A1c Poor Control | Yes | P | 70 | 60 | 50 | 40 | 30 | 20 | 10 |
| | ACO-28 | Hypertension (HTN): Controlling High Blood Pressure | Yes | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |

2. Input your ACO's quality performance based on the current year's benchmarks in the ACO Projection Tool→Scoring Input Tab → Column D. Utilize the drop-down feature to select performance: <30th, 30th, 40th, 50th, 60th, 70th, 80th, 90th. This information will automatically populated Column E, which are points associated with percentile performance.

| A | B | C | D | E |
|---|---|---|---|---|
| | | | 2019 Expected Performance | |
| Patient/ Caregiver Experience | ACO-1 | CAHPS: Getting Timely Care, Appointments, and Information | <30th | 0 |
| | ACO-2 | CAHPS: How Well Your Doctors Communicate | <30th | 0 |
| | ACO-3 | CAHPS: Patients' Rating of Doctor | <30th | 0 |
| | ACO-4 | CAHPS: Access to Specialists | 90th | 2 |
| | ACO-5 | CAHPS: Health Promotion and Education | 90th | 2 |
| | ACO-6 | CAHPS: Shared Decision Making | 90th | 2 |
| | ACO-7 | CAHPS: Health Status/Functional Status | 90th | 2 |
| | ACO-34 | CAHPS: Stewardship of Patient Resources | 90th | 2 |
| | ACO-45 | Couteous and Helpful Office Staff | 90th | 2 |
| | ACO-46 | Care Coordination | 90th | 2 |
| Care Coordinatio | ACO-8 | Risk Standardized, All Condition Readmission | 90th | 2 |
| | ACO-38 | All-Cause Unplanned Admissions for Patients with | 90th | 2 |
| | ACO-43 | Ambulatory Sensitive Condition Acute Composite | 90th | 2 |
| | ACO-13 | Falls: Screening for Future Fall Risk | 90th | 2 |
| Preventive Health | ACO-14 | Preventive Care and Screening: Influenza Immunization | <30th | 0 |
| | ACO-17 | Preventive Care and Screening: Tobacco Use: Screening | 90th | 2 |
| | ACO-18 | Preventive Care and Screening: Screening for Clinical | 90th | 2 |
| | ACO-19 | Colorectal Cancer Screening | <30th | 0 |
| | ACO-20 | Breast Cancer Screening | 90th | 2 |
| | ACO-42 | Statin Therapy for the Prevention and Treatment of | 90th | 2 |
| At-Risk Population | ACO-40 | Depression Remission at Twelve Months | 90th | 2 |
| | ACO-27 | Diabetes Mellitus: Hemoglobin A1c Poor Control | 90th | 2 |
| | ACO-28 | Hypertension (HTN): Controlling High Blood Pressure | 40th | 1.25 |

3. Your ACO's predicted quality score will populate in the ACO Projection Tool→2019 Projection Model in Column L. Please note this does not include any improvement points that CMS may award. The predicted amount of share savings your ACO is eligible for based on the predicted quality score is in Column B.

Instructions

1. Select expected performance from drop-downs within Column D of the Scoring Input Sheet.
2. Do not input data in any other fields within the model. All information will populate based on the inputs of Column D within the Scoring Input Sheet

**2019 MSSP ACO Quality Scoring System**

| Domain | Number of Individual Measures | Total Measures for Scoring Purposes | Total Possible Points | Domain Weight | # P4P Measures | Possible P4P Points | # P4R Measures | Possible P4R Points* | Expected P4R & P4P Points Earned | Domain Percentage |
|---|---|---|---|---|---|---|---|---|---|---|
| Patient/ Caregiver Experience Measures | 10 | 10 individual survey module measures | 20 | 25% | 9 | 18 | 1 | 2 | 14.0 | 70.00% |
| Care Coordination/ Patient Safety | 4 | 4 measures | 8 | 25% | 3 | 6 | 1 | 2 | 8.0 | 100.00% |
| Preventive Health | 6 | 6 measures | 12 | 25% | 5 | 10 | 1 | 2 | 8.0 | 66.67% |
| At-Risk Population | 3 | 3 individual measures | 6 | 25% | 2 | 4 | 1 | 2 | 5.3 | 87.50% |

Average percentage across four domains used to calculate final shared savings or losses ***(does not include improvement points)*** 81.04%

*Assumes that full scoring is reached for all-or-nothing measures.

**81%** **Amount of shared savings the ACO would be eligible to share (already accounting for CMS' cut)**

**Points to consider:**

- Benchmarks are subject to change year to year, update and populate this section of the ACO Projection Tool → Measure Thresholds Tab yearly.
- As mentioned in the previous section on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) section, many CAHPS vendors will provide ACO comparison scores to help predict performance. These tend to be directional. Therefore, ACOs can use the CAHPS vendor predictions or the previous year's CAHPS scores to predict CAHPS performance. However, this should not take away from the needed improvement efforts to improve scores.
- ACO quality claims measures, in the Care Coordination/Patient Safety Domain, that come with the financial quarterly results are risk adjusted accurate predictors of performance. These results do lag by a quarter and are therefore not the best real time actionable reports, but they are accurate predictors to determine the Care Coordination/Patient Safety Domain scores.

**Authors:**
Megan Reyna, VP of Government and Value Based Programs (Advocate Aurora Health)
Melanie Romero, Senior Director of Clinical Quality Improvement and Innovation (LTC ACO)

# Chapter Four: ACO Quality Audits

**Overview**

Each ACO that contracts with CMS under its Medicare Shared Savings Program (MSSP) is required to report patient medical record data via the CMS Web Interface to determine its quality performance. Quality data collection for a performance year occurs after the completion of the calendar year, during the quality data reporting period in the first several months of the following calendar year. An ACO's quality score may be affected if it is chosen for a Quality Measures Validation (QMV) audit. Each year, at the discretion of CMS, a subset of ACOs are selected for a QMV audit. During the QMV audit, an ACO will be asked to substantiate, using information from its beneficiaries' medical records, what was entered into the CMS Web Interface. The information contained in this section is meant to guide the ACO to maximize awareness and preparation regarding audit activities and to assist the ACO if it is selected for audit.

**Preparing for an Audit**

As ACOs create the organization's CMS Web Interface project plan and timeline, plan all activities with the possibility of a CMS audit in mind. Obtaining the needed information to report Web Interface measures to CMS is accomplished through a process known as chart abstraction. Individuals who have been specially educated and trained to review charts for the existence of documented care associated with Web Interface measures are often called abstractors. After abstraction, abstractors document certain information and attest whether the information needed is in the charts. After identifying if charts contain the needed information, abstractors identify if the information they found in the charts met the requirements of the measure's technical specification.

ACOs should include potential CMS audit activities in their ACO Web Interface abstraction project plan and timeline. In addition, identification of the potential audit team and the education of the internally developed audit processes should also be one of the outputs of the abstraction planning process. All ACO employees involved in Web Interface activities should have an advanced understanding of the CMS audit process, especially those employees involved in the abstraction process. Internal abstractor education should include how abstraction activities ultimately contribute to successful ACO audit activities should CMS identify the ACO for audit. The ACO's Web Interface annual plan, communication of the ACO audit plan and requirements to abstraction team(s) should include but not be limited to:

- Abstraction team accountability,
- Anticipation and communication of any specific ACO requirements to the internal team including any identified vacation black-out dates when access to data may be limited,
- Identification of the audit data collection team and information gathering process, and
- Communication of audit requirements to any ACO abstraction contracts/partners in advance of abstraction.

ACO internal/external partners and vendors and their activities should be identified in the ACO annual plan/timeline. The ACO should assure that any Web Interface contracts/agreements include:

- Timeframes when Web Interface audit may take place using annual CMS deadlines,
- Communication of cooperation needed from external partners, for example, the need for quick responses to any requests for information, and
- Communication of needed chart/EMR access/print capability.

**Abstraction Education for Audits**

The internal ACO education concerning the audit process should begin with the leader/owner of the ACO Web Interface submission process having a full understanding of the potential audit requirements. A review of the current CMS requirements can be found each year in the Medicare Physician Fee Schedule Final Rule and published CMS guidance and measure specification documents (found at the bottom of the page). The ACO Web Interface education team should include internal and any needed external team members that contribute to the Web Interface submission. Annual internal measure specification and abstraction education should include the complete audit process and the interdependence between data submitted to CMS and the information required, along with timelines to be aware of should CMS call for an audit. Major concepts to communicate include:

- Purpose and repercussions of an ACO audit and
- Identification and tracking of each abstraction back to the abstractor that viewed, abstracted and closed the measure for submission to CMS

During internal measure education within the ACO, it is necessary to impress upon abstractors to anticipate an audit as they are abstracting information. A measure should not be considered closed unless the information that they viewed meets the requirements of the measure according to the most recent CMS technical specifications. The documented information that the abstractor views will "stand alone" and will need to be produced and quickly sent to CMS in the case of an audit. The audit process does not allow explanation or interpretation of the information on the part of the ACO. Because of this, the ACO abstractors should use the CMS audit requirements as a guide regarding reaching out for assistance with abstraction decisions or if certain documentation/data can be used to close Web Interface measure(s). Specific education should include:

- The consequences of reporting inaccurate data. ACOs should reinforce any internal policies/procedures especially as they relate to compliance policies for inaccurate data.
- Assurance that all abstractions are signed-off by the person that is abstracting or is approving the data for use after the abstractions are reviewed for quality assurance.
- Warning that abstractors never use an unapproved substitute abstractor who has not been educated and approved to abstract according to the ACO methods (e.g., office staff/ACO staff).

In addition, the ACO may choose to consider some specific requirements for abstractors. For example, the ACO may assign abstractions and where only the assigned person may abstract for the measure/patients. ACOs may identify these practices with other organizational compliance requirements (e.g. password sharing). The ACO's process for inter-rater reliability (IRR) or post-abstraction education testing process should include audit questions. It is wise to also discuss the possibility and consequences of an audit with the abstraction team regularly throughout the season. An ACO may wish to consider a policy that makes the abstractor the data collection agent during audit activities for the patients/measure that was abstracted.

Education should also reinforce that time is of the essence after the ACO is notified that it has been chosen for the audit. All ACO team members should be aware of the possibility of an audit after Web Interface submission activities. The internal communication hierarchy should be established and understood at all levels of the organization because CMS could send the communication regarding the audit to anyone in the organization. Finally, the ACO should communicate and celebrate if the ACO is not chosen for audit. This will be an indication to the ACO and abstraction team that that the end of Web Interface submission process has officially concluded.

**Electronic and Physical Set Up to Support Audit Preparation**

To reduce the organizational stress and limited time associated with the CMS audit process, anticipating and completing any activities during abstraction that are associated with an audit will be welcomed in the case of an audit. ACOs should develop a standard procedure to document the location of abstracted information, where exception language (clinical rationale) is located, for quick identification, easy retrieval and reproduction for the CMS audit. Creating a specific physical space/area that allows for efficient audit preparation is advised, such as a locked file cabinet for hardcopy work.

ACOs should anticipate and identify needed administrative support in case of an audit and educate them in advance regarding the needed capabilities and anticipated audit activities. Additionally, equipment to support confidential fax/scanning activities should be available. It is also wise to gather and identify in advance, copies of all standing policies and procedures that the ACO and/or any providers use to satisfy specific measures. CMS will request these to support certain abstractions. The ACO should also establish electronic drives/folders or binders for documents to support audit readiness. These locations should be identified and communicated to the team. ACOs should consider proactive establishment of an ACO specific internal audit process and responsibility matrix, including access to any abstraction files or electronic health records (EHRs) accessed during the abstraction time period. Also, ACOs should remind remote access sites during abstraction that at the conclusion of the abstraction activities, the ACO may again need to access supporting documentation if the ACO is chosen by CMS for audit.

**Abstracting for an Audit**

ACO abstraction requires a full understanding by the ACO abstraction leadership regarding the CMS measure technical specifications which CMS distributes each year, usually in December prior to the performance year start. ACOs should carefully review and fully understand numerator, denominator, exclusion, and exception requirements. This includes a thorough understanding of the technical specifications and guidance documents provided by CMS. Those responsible to understand the technical specification should pay special attention to words such as, “if,” “or,” “and,” “either,” etc. These words are especially important to the measure interpretation. ACO interpretation can be enhanced by carefully reviewing current, and if available, previous CMS webinars, documents, and weekly meetings that took place during Web Interface reporting activities. Annually, CMS will indicate specific areas in measure where there has been inconsistency of focus and/or trends as the agency hosts weekly calls to clarify measures. It is recommended to download and review the questions and answers from CMS weekly calls from the previous year to remind staff and reinforce the nuances of technical specification interpretation. However, the ACO should be careful not to include information that is no longer relevant in its training materials.

CMS relies on the technical specification as the definitive source of truth for measure abstraction. Therefore, the ACO leadership should consult with others if needed and have a full understanding of the CMS measure flow described in the technical specification. ACOs can consider utilizing the CMS algorithms and calculations at the end of each algorithm in the technical specification for abstraction insights from CMS. The ACO should clearly understand that during an audit it is required to give CMS more source information during the audit than what was given to CMS on the Excel spreadsheet or what was abstracted directly into Web Interface software. Each year CMS produces a document containing what will be required in the case of an audit. Titles such as CMS *Web Interface Measure Documentation*: *Reference Guide for Performance Year 2019* have been used in previous years.

Finally, a crucial activity an ACO can invest in is to audit itself before CMS does by applying the CMS audit standards to the ACO submitted data during the Web Interface abstraction process. This should be

done as the ACO's own internal Quality Assurance (QA) process is completed. Identification and ongoing improvement of any internal QA deficiencies should be internally established by the ACO. An ACO analysis of data could include:

- Identification and development of the process to identify any abstraction inconsistencies,
- Identify a stringent internal abstraction documentation and QA process, and
- Consider year-round mock abstraction.

**Resources**

- CMS Quality Measures and Reporting Specifications
- NAACOS Member Resource: Preparing for a Quality Measures Validation Audit
- CMS Measure Documentation Resource

**Author:**
Ginna Bodycot, RN BSN (Delaware Valley ACO)

# Chapter Five: Promoting Interoperability and ACOs

For ACOs, the Promoting Interoperability (PI) performance category of the Merit-Based Incentive Payment System (MIPS) assesses Certified Electronic Health Record Technology Use (CEHRT). In addition to an annual CEHRT attestation, ACOs subject to MIPS are evaluated on the PI performance category. In 2019, CMS allows individual clinicians in ACOs to report PI measures to CMS at the National Provider Identifier (NPI) level. CMS also allows group practices in ACOs to report PI measures to CMS at the TIN level. CMS will then aggregate all the NIP and TIN PI scores to come up with one average score for the entire ACO entity. This is a weighted average based on the number of providers in each TIN. This final average score applies to the entire ACO. In MIPS, ACOs are given one MIPS final score based on the individual performance categories of the program which is applied to all MIPS eligible clinicians (ECs) in the ACO. For more information regarding how MIPS applies to ACOs specifically, please refer to our ACO Guide to MACRA.

For this reason, it is crucial for ACOs to familiarize themselves with the MIPS PI requirements and measures and to educate practices on the requirements and to support their reporting efforts. This should be done well in advance of the reporting process, which takes place in January to March of the year following the performance year. PI reporting is completed via the Quality Payment Program (QPP) web portal. Ensure the appropriate staff has proper credentials and access to this QPP web portal well in advance of the reporting process.

Items to Note:

- CMS educational materials are not tailored to ACOs or clinicians and groups in an ACO reporting PI. Therefore, it is crucial to refer to NAACOS materials and obtain CMS clarification where there is ambiguity regarding how a specific policy may impact ACOs.
- CMS has provided NAACOS and ACOs with conflicting guidance over the years regarding how PI exemptions apply to ACOs. At the time of publication, CMS staff has reported that TINs in ACOs may apply for PI hardship exemptions, including the exemption for small practices. This applies to the PI exemption specifically—not exemption from the entire MIPS program. This must be done in the last quarter of the performance year. CMS staff will notify the practice if it has been granted the hardship exemption.
- CMS has noted that when compiling the ACO average PI score, CMS will NOT include providers deemed exempt from the PI performance category (e.g., hospital-based clinicians). These providers will not be included in the denominator of this average ACO PI score, according to CMS.
- CMS will share performance feedback on the PI category via the QPP portal following the reporting period. This information will be displayed at the TIN level as well as the ACO level. You must have appropriate access to the QPP portal to view this performance information.

**Author:**
Jennifer Gasperini, Senior Policy Advisor, NAACOS

# Chapter Six: Using Internal Incentive Programs to Drive Quality Performance

**Introduction**

Incentive programs are a critical element of any value-based program. Since most physicians are reimbursed either directly by fee-for-service payments or via relative value unit (RVU) based compensation models, creating incentive programs that focus on quality and utilization can go a long way towards driving performance on value-based metrics. The basic structure of any incentive program should include a component based on quality performance as well as a component that defines the distribution of funds once shared savings and other risk revenues are received. The best performing incentive programs have several common features including simplicity in structure and administration, transparency in performance, and are linked to contract attribution and performance expectations.

**Physician Reimbursement and Funding**

One of the biggest challenges for any ACO is helping physicians bridge the gap between fee-for-service and value-based reimbursement models. While it is unlikely that revenues which today come from fee-for-service structures will suddenly transition to capitated or full risk models, incentive programs can supplement or ideally substitute some of the physicians' volume-based income to income that is based on quality and cost performance metrics. It is important to provide context for any incentive program, highlighting the reasons for its existence and how the metrics and funds are linked to contractual expectations. Funding for incentive programs is varied. In some instances, the convening entity (independent practice association, health system or management services organization) will provide the capital to fund the plan. In other instances, the funding comes purely from advanced payments from health plans in the form of care coordination payments. Some networks provide the structure for reporting quality throughout the year but only distribute funds if there are returns from their Medicare ACO or other risk contracts. While in this last example there is a delay between performance and payment, the link between the two is very direct.

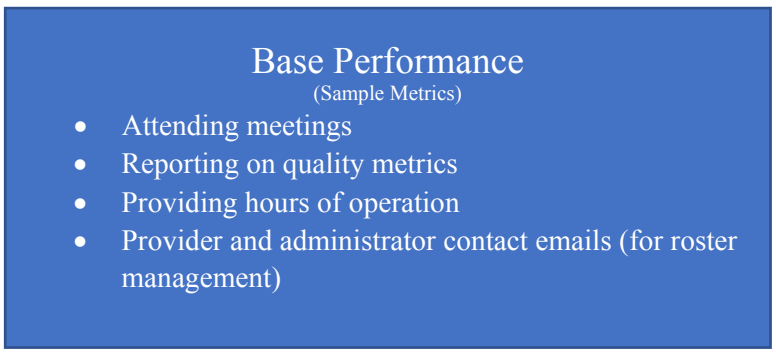
**Characteristics of Effective Incentive Plans**

Simplicity

In our collective experience, the best incentive plan models are the simplest, requiring minimal calculations to determine income at the physician level. While this resource discusses certain specific examples below, there are many different variations across the country, and ultimately internal culture and stakeholder input will drive the structure that works best for the network.

Tiered Structure

These models consist of two-to-three tiers of performance often including a base of participatory and operational elements with higher tiers consisting of clinical quality measures. The financial distribution can vary but in one example can include per member per month payments if targets are achieved at each tier.




Point-based Plans

Point-based models assign points to specific measures and set cut offs for minimum performance. Potential payments are calculated as a per member per month but then filtered by point achievement. For example, if a physician could have earned $1000 based on the number of lives attributed to her but only earned 80 out of 100 points (80 percent) then she would receive $800 as the final payment. Point systems can be structured in many ways and combined with tiered models. As a best practice, it is suggested to use foundational measures, such as providing contact information and office hours, as "gating" measures before any payments are received or as necessary activities of being part of the network, as they are essential expectations for a functional network.

Shared Savings and Risk-Based Payment Structures

There are networks across the country that pay distributions to providers only relative to any shared savings or risk-based payments received by payers. In most cases, the payments are determined by a combination of attribution and quality performance. Therefore, a structure for collecting quality performance information and providing performance reports is still very important to prevent confusion once payments are received and distributed.

Transparency

While transparency is important in describing the structure of any incentive plan, it is also important when it comes to displaying performance data. While financial incentives can be effective in driving performance, simply displaying quality data publicly can be very effective in driving improvement over time. Performance information can be displayed via websites, PDF or paper reports, and even smartphone apps that allow providers to see their performance compared to their peers within the network. While this can trigger many questions regarding data integrity and reliability, having a sound and transparent process from the beginning can help mitigate many of the data concerns and questions that physicians are likely to express.

Connection to Value-Based Contracts

Whatever the structure of the incentive plan, the chosen metrics should be tied to those contained in the various ACO and value-based contracts for which the network is accountable (e.g., Medicare Shared Savings Program Quality Measure Set or Medicare Stars Program Measures). While the list of metrics can become quite long based on that criteria alone, further filtering by removing metrics that are already performing at a high level (and therefore may not need reinforcement in the incentive plan) or by including metrics that are weighted at a higher level (like certain Stars Program metrics) may be reasonable.

**Other Considerations**

Utilization measures, such as inpatient admissions per 1000 or emergency room visits per 1000, are commonly discussed in the context of incentive plans. While utilization measures such as these are attractive given the direct link to contract performance and value-based goals, there are several issues to consider when including these in incentive programs. Physicians may have concerns regarding the ability to control utilization depending on existing supports to manage high risk patients, or even the ability to provide after-hours access which may help mitigate emergency room utilization. Ideally, inclusion of these measures would be done in the context of appropriate care management and other improvement efforts within the network. The second issue with utilization measures is that at the physician level the number of patients that utilize the hospital or emergency room can get quite low, making adequate statistical significance an issue for many physicians. Often these measures are evaluated at the site or group level if appropriate.

**Conclusion**

Incentive programs can be an important element in ACO and value-based strategy. It is important, however, to think about these programs strategically, linking performance at the physician level to performance at the contract level and keeping in mind simplicity in structure and transparency in funds flow and performance in order to extract the most from any internal incentive program.

**Author:**

Dr. Rob Fields, CMO, Mount Sinai Health System

The National Association of ACOs (NAACOS) represents more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. Models include the Medicare Shared Savings Program (MSSP), Next Generation ACOs, and alternative payment models supported by a myriad of commercial health plans and Medicare Advantage. NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, outcomes, and healthcare cost efficiency.

## Mission:

- Foster growth of ACO models of care;
- Participate with Federal Agencies in development & implementation of public policy;
- Provide industry-wide uniformity on quality and performance measures;
- Educate members in clinical and operational best practices;
- Collectively engage the vendor community, and
- Educate the public about the value of accountable care.

## Contact Us:

Jennifer Gasperini
Senior Policy Advisor
NAACOS
jgasperini@naacos.com

**National Association of ACOs**

www.naacos.com

601 13th Street, NW, Suite 900S, Washington, DC • 202.640.1985 • info@naacos.com