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healthpolicybrief

Understanding the Medicare ACO and Its Potential Impact on Ohio and the Nation: Considerations of CMS Draft Rules

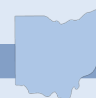
Introduction

The Patient Protection and Affordable Care Act (ACA) requires that the Secretary of the Department of Health & Human Services (HHS) establish a Medicare Shared Savings Program (MSSP) by January 1, 2012. The MSSP encourages physicians, hospitals, and certain other types of providers and suppliers to form accountable care organizations (ACOs) to provide cost-effective, coordinated care to Medicare fee-for-service beneficiaries. An ACO that meets certain requirements may share in savings achieved in Medicare expenditures for assigned beneficiaries. CMS estimates that up to 5 million Medicare beneficiaries will benefit from the MSSP.[1]

Under the ACA, HHS is authorized to determine the details of the MSSP through rulemaking. On April 7, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a notice in the Federal Register for public comment on a Proposed Rule detailing the Medicare Shared Savings Program (MSSP).[2] The proposed rule addresses policy and operational issues associated with the formation of an ACO, including beneficiary assignment, quality standards, incentive payments, and monitoring procedures. Public comment on the Proposed Rule is due by **June 6, 2011**. A CMS listening session will be scheduled for later this summer, the details of which will be issued by CMS by June 11, 2011.

Federal authorities have also published guidance in the Federal Register as to how ACOs formed under the MSSP can stay in compliance with federal anti-trust, self-referral, anti-kickback and civil monetary penalties (CMT) laws.[3] This guidance applies to ACOs even if they also serve Medicaid and commercially insured patients, and provides a legal zone of safety for ACOs to operate under federal law.

This paper summarizes the MSSP Proposed Rules, highlights considerations surrounding key components, and presents reactions from several Ohio-based health systems that are already implementing some form of accountable care.



How is the Medicare Shared Savings Program relevant to Ohio policymakers?

Although Medicare, unlike Medicaid, is a federally funded program, 1.3 million Ohioans receive coverage through Medicare and may benefit from the Shared Savings Program. In addition, throughout its history, Medicare has been a forerunner for new health care reimbursement strategies. Typically, when Medicare adopts a change to its payment policies, private health plans and state Medicaid programs follow. Federal authorities have also given guidance that ACOs formed under the Shared Savings Program will be in compliance with federal anti-trust, self-referral and anti-kickback laws even if they also serve Medicaid and commercially insured patients. This would suggest that the outcomes-based pay and shared savings mechanisms that are part of the proposed Medicare Shared Savings Program could be adopted by other insurers as well.

In addition, some experts believe that ACOs have the potential to improve quality of care while controlling costs and improving population health. The system reform concepts in the Shared Savings Program may provide Ohio policymakers with valuable insight into quality-improvement and cost-containment strategies that have the potential to improve the health of Ohioans.

Author

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What are Accountable Care Organizations?

Generally speaking, an accountable care organization is an integrated network of providers that are collectively held accountable for delivering coordinated, high-quality, cost-effective care to a group of patients. Elliott Fisher, MD, "the father of accountable care organizations," cites four goals that ACOs must meet to be accountable: clearly defined aims, detailed performance measurement (i.e. focus on patient health outcomes), true integration (coordinated care across patient conditions, settings, and services), and financial incentives that reward better care, not more care.

In a number of communities and regions, hospitals, physicians and other health care providers have invested resources in adopting some form of an accountable care organization. While the operational details may vary across ACOs, all of them share a system of health care delivery that ties provider reimbursements to quality metrics and reductions in the total cost of care to a set of patients.

What is Medicare?

Medicare is the federal health insurance program for most seniors over the age of 65, as well as some people with disabilities under age 65. Medicare is funded through payroll deductions, and most citizens are eligible for Medicare coverage when they turn 65, regardless of income. In Ohio, there are more than 1.3 million Medicare beneficiaries. The federal government runs Medicare, as opposed to Medicaid which is a federal-state partnership. Medicare covers primary and acute care services. Some Medicare beneficiaries chose to enroll in managed care plans, while others are covered on a fee-for-service basis. Because Medicare is the largest single payer of health services nationally (accounting for approximately 23% of all spending on personal health care), changes in how Medicare pays for services are often followed by other payers, including Medicaid.

Medicare Physician Group Practice Demonstration Project

In order to test the effectiveness of the ACO model, CMS implemented the Medicare Physician Group Practice Demonstration Project (PGP) in 2005. From 2005 to 2009, 10 large physician practice groups participated in PGP.[5] The participants received fee-for-service payments, and were also eligible for performance payments if they achieved quality and savings goals. Four years into the five year project, all of the practices met most of the quality goals, and five of the practices earned performance payments totaling $31.7 million.[6]

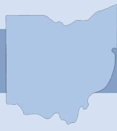
Although some of the results of PGP were positive, other results suggested that start up costs for an ACO may make the ACO model a poor fit for some physician practices groups.[7] In addition, the time frame for achieving a return-on-investment was longer than expected.[8] The provider groups that participated in PGP incurred an average of $1.7 million in start-up costs and did not recoup their investment during the first three years of the program. In addition, not all ACOs were successful in achieving savings. In fact, only two received shared saving in year one, six received shared savings in year two and eight received shared saving in year three.[9]

In announcing the results of PGP in December, 2010, CMS Administrator Don Berwick made reference to the upcoming MSSP Rules: "Now we want to raise the bar. We want to support these practices to demonstrate just how much American medicine can achieve if we put the right incentives in place."[10]

It is important to note that none of the 10 physician practice groups that participated in the PGP plan to participate in the MSSP if significant changes are not made to the proposed rules. In a joint letter to CMS on May 13, 2011, the groups wrote that they "all have serious reservations about the economics and the complexity" of the proposed MSSP.[11]

What is the Significance of the Medicare Shared Savings Program (MSSP) for ACOs?

There is little doubt the MSSP will have significant impact on provider groups seeking to form ACOs. It is the first federal initiative (beyond demonstration projects) with financial support for ACOs tied to incentives for clinical integration and uniform standards for ACO accountability. In addition, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) concurrently issued a "Proposed Statement of Antitrust Policy" to clarify antitrust



Summa Health System
Akron, Ohio

While hospital systems across the county are weighing the merits of creating an ACO as part of the Medicare Shared Savings Program, Akron-based Summa is considering whether to adjust the ACO system it already has in place to meet the new federal regulations.

Summa's ACO, New Health Collaborative, became operational on Jan. 1, 2011, and, according to leaders at the health system, will provide services to 11,000 Medicare Advantage enrollees in Northeast Ohio who are associated with SummaCare, Summa's provider-sponsored health plan.

Summa began considering adopting accountable care practices in late 2008 and last year began participating in an Accountable Care Implementation Collaborative organized by Premeire health care alliance. The national Collaborative involves 26 hospitals, included University Hospitals in Cleveland. It was through its work with the collaborative that Summa set up its ACO pilot.

Although Summa's ACO initiative will only provide service to Medicare enrollees, Charles Vignos, Chief Operating Officer of the New Health Collaborative, said the benefits of accountable care will eventually be realized by all patients served by the health system.

"Our lessons learned with the Medicare population will be used to shape care delivery and quality improvement processes with other patient populations," Vignos said. "If our model demonstrates a reduction in costs, improvements in quality, and patient engagement, we can expect other payers to partner with our organization to advance their respective population health improvement goals."

The non-profit taxable entity is governed by a board of directors comprised mostly of community-based primary care physicans, but also specialists and Summa representatives. The Summa ACO also includes a management team that directs work related to information technology (IT), delivery network, care delivery models and finance.

Having recently gone through the process of setting up an ACO, Vignos said, Summa has already learned lessons that could be useful for other health systems.

"ACOs require capital investment, diverse provider network capabilities, sophisticated management, as well as integrated IT systems to be successful," Vignos said. "Many organizations currently do not have these assets or resources in place to advance the principles of accountable care.

"Our lessons learned with the Medicare population will be used to shape care delivery and quality improvement processes with other patient populations."

— Charles Vignos, Chief Operating Officer of the New Health Collaborative, Summa

"Educating and engaging physicians as well as other care providers to design and implement this new model of care may also serve as a challenge in advancing accountable care," he added. "There are also a number of legal challenges that prevent providers from working more closely together in coordinating care and services for patients by participating in an accountable care program."

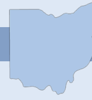
Summa's leadership has expressed interest in the Medicare Shared Savings Program, but is awaiting the final rules before making a definitive decision on whether to participate. "We have a dedicated board and management team assigned to explore these issues and create action plans to ensure we are competitive for the demonstration program," Vignos said.

As those leaders continue to evaluate the proposed rules, there are several areas of concern, most notably the data collection and reporting requirements.

"Medicare is requesting that an ACO entity be able to collect data on 65 measures to participate in the program," Vignos said. "The reality is there are very few entities in the country that could fulfill that request today given where physicians and hospitals are in their data collection and IT processes and capabilities. We request that Medicare scale back its data requirements to a select group of measures that the majority of providers collect today to participate in the Medicare program.

In spite of those concerns, Summa's leaders are optimistic that the system will participate in the Medicare Shared Savings Program. They point to its existing ACO pilot, and its position as an integrated health care delivery system (it is both a provider of, and payer for, health services).

"We are well positioned to advance the vision and principles of the Medicare Shared Savings Program," Vignos said.



Questions Ohio policymakers may be asked

Although federal officials have taken the lead on setting up a framework for ACOs in Medicare program, there are a number of issues that could potentially be addressed by Ohio policymakers. Stakeholders and constituents might ask state policymakers to provide the following:

- Leadership and funding to support the collection and analysis of health care data (e.g., multi-payer claims databases, health information exchanges) in support of ACOs.
- Support and funding for regional or community-based pilots that test various ACO payment models
- Leadership in the development and adoption of statewide health care performance measures and reporting standards for ACOs
- Support for the development of patient-centered medical homes as an important complement to the ACO principle of coordinated care
- Help in leveraging the state's health care purchasing power to develop performance-based contracts for ACOs

Note: Adapted from On the Road to Better Value: State Roles in Promoting Accountable Care Organizations, NASHP/Commonwealth Fund by Kitty Purington, Anne Gauthier, Shivani Patel, and Christina Miller, February 2011

issues that may discourage providers from joining ACO's.[12] At the same time, CMS and the Office of Inspector General (OIG) issued a request for public comment on possible federal waivers from application of the federal physician self-referral laws, the anti-kickback laws, and certain civil monetary penalties to specified financial arrangements involving ACOs.[13] Therefore, ACOs established under the MSSP may use the same organizational structure and clinical processes to serve not only Medicare beneficiaries but also patients covered by Medicaid, private insurance and self-insured employer plans.

What is an ACO under the Medicare Shared Savings Program?

Under the MSSP Proposed Rules, an ACO is a group of health care providers that may include hospitals, physicians and other providers that agree to work together to manage, coordinate and become accountable for the care of Medicare fee-for-service beneficiaries under a system of shared governance.[14] Providers that participate in an ACO, called "ACO participants," must be Medicare-enrolled providers or suppliers.[15]

If the ACO meets certain MSSP requirements, the ACO and its participants may share in the saving achieved in Medicare expenditures for assigned beneficiaries.[16] Beneficiaries are assigned to an ACO retrospectively based on utilization of primary care services during the performance year.[17] Assignment of a beneficiary to an ACO does not restrict a beneficiary's choice to receive health care services outside of the ACO.[18] However, the ACO is still responsible for the beneficiary's care and outcomes.

Who Can Form a Medicare ACO?

ACOs may be formed by professionals in practice group arrangements, networks of individual practices, multi-specialty group practices, independent practice associations, partnerships or joint ventures between hospitals and providers, and also integrated hospital systems.[19] The MSSP proposed Rules allow other types of Medicare enrolled entities to form ACOs provided they meet the requirements of the Rules.[20]

Notably, Federal Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and certain Critical Access Hospitals (CAHs) may not form their own ACOs under the proposed Rules without significant changes in the way they submit claims and report information.[21] However, the Rules include incentives for ACOs to include FQHCs, RHCs and CAHs as ACO participants. These incentives are discussed below.

How Does an ACO Apply to Participate in the Medicare Shared Savings Program (MSSP)?

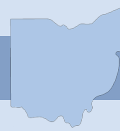
To participate in the MSSP, an ACO must commit to a three-year agreement in which the ACO participants agree to be accountable for the care of beneficiaries assigned to it.[22] An ACO must have at least 5,000 assigned

beneficiaries, and enough primary care providers to serve that population.[23]

Notably, when an ACO applies to participate in the MSSP, it may choose whether or not to place itself at risk for any losses during the first two years.[24] If an ACO chooses "Track 1", known as the "one sided approach", it will share in savings for the first two years, but not in losses. If an ACO chooses "Track 2", known as the "two sided approach", it will share in both savings and losses at the outset. The benefit of choosing "the two sided approach" is that an ACO will receive larger savings payments if savings are achieved.[25] ACOs that are more advanced with respect to care coordination and clinical integration are expected to choose Track 2 to take advantage of the larger rewards.

What Are the Organizational and Operational Requirements for Medicare ACOs?

Solid corporate governance, a commitment to efficient care and outcomes, and a strong technology infrastructure are the hallmarks of the MSSP. The ACO must have a governing body controlled by ACO participants (at least seventy five percent) and with beneficiary representation.[26] An ACO must also have a leadership team able to influence clinical practice to improve outcomes, a full-time senior level medical director, a commitment to clinical integration, quality assurance and improvement programs, compliance programs, and evidence-based practice guidelines.[27] The ACO must also have an infrastructure to collect and evaluate data and provide feedback to ACO participants.[28] By year



Ohio ACO case study

Catholic Health Partners
Cincinnati, Ohio

Over the past couple of years, Cincinnati-based Catholic Health Partners (CHP) has embraced the concept of accountable care in the six Ohio markets it serves.

The health system, which is the largest in Ohio, has, for example, begun transitioning its primary care practices into medical homes and is implementing a system-wide electronic medical record system.

"The changes we are making and the systems we are developing will benefit all patients regardless of their insurer, including those that have no insurance at all," Fishpaw said.

However, CHP, which has operations in Cincinnati, Lima, Lorain, Springfield, Toledo and Youngstown, has yet to decide whether its efforts fit with the type of ACO outlined in the Medicare Shared Savings Program.

"We expect to make the decision to participate in the (Medicare) ACO program market by market," said Jon Fishpaw, vice president, advocacy and government relations at CHP. "We already know that participation does not make sense everywhere.

"Where we do decide to participate, we will have to make a significant investment to build infrastructure," he added. "For example, a separate legal entity, management team and governing board will be required. We will not make any final decision until the final rules are issued later in the year."

Of particular concern for CHP, Fishpaw said, is determining exactly how shared savings payments will be calculated.

"One big issue is whether the proposed shared savings mechanism will allow us to recoup the large investment that will be required to participate," he said.

Regardless of whether it participates in the Medicare ACO program, CHP plans to continue working on efforts to adopt many of the underlying concepts that are promoted through the Shared Savings Program.

"No matter what Medicare does or whether we participate in the ACO program, we intend to proceed with reforming the way care is delivered in our health system," Fishpaw said. "We will align and integrate with other providers, we will improve the flow of information and we will improve access to primary care, for example. The ACO program presents an opportunity to accelerate those efforts."

The greatest challenge to adoption of a more complete accountable care model, Fishpaw said, is the need to restructure the payment system.

"Today the financing mechanisms (e.g. insurance) pay for care on a fee-for-service basis," Fishpaw said. "The volume of care provided is rewarded, versus the value of the care provided. Many services that can help patients stay well and out of the hospital are not covered at all by insurance. Changing these payment systems is one of the greatest challenges and is in part what Medicare is attempting to do through ACOs."

"Today ... The volume of care provided is rewarded, versus the value of the care provided. Many services that can help patients stay well and out of the hospital are not covered at all by insurance. Changing these payment systems is one of the greatest challenges and is in part what Medicare is attempting to do through ACOs."
– Jon Fishpaw, vice president, advocacy and government relations at CHP

Cleveland Clinic, other high-profile systems may not participate in the MSSP

Although the Cleveland Clinic is one of the models for the MSSP ACO proposal, it and similar health care centers have so many concerns about the proposed rule that they may not participate in the MSSP unless significant changes are made to the Rule, according to an article titled "Model ACO Health Centers Skeptical of Proposed Rule," in the May 6, 2011 edition of Congressional Quarterly.

Leaders at health systems such as the Cleveland Clinic, the Mayo Clinic, Intermountain Healthcare and the Geisinger Health System have all expressed concern that while they support the ACO concept, the proposed rules do not offer enough incentive for them to consider participating in the MSSP.

Oliver "Pudge" Henkle, the chief government relations officer at the Cleveland Clinic, told Congressional Quarterly that "The assumption has been that Cleveland Clinics of the world are ideally suited for this. We are very supportive of the idea. It's clearly the right way to go and the journey is a good one. But it's a matter of recommending ways in which we think CMS can make the ACO model and its structure better."

two of the three-year agreement, fifty percent of ACO participants must be meaningful electronic health records (EHR) users with certified EHR technology.[29]
Transparency must also be a priority, with ACOs making available to beneficiaries and the public information about ACO participants, participants in joint ventures, representation on the governing board, quality performance standard scores, and shared savings and losses.[30]

What Clinical Requirements must a Medicare ACO meet?

To participate in the MSSP, an ACO must meet the process and clinical improvement standards of the Rules. For example, an ACO must show CMS that it plans to (1) promote evidence-based medicine, (2) support beneficiary engagement, (3) report internally on quality and cost metrics, and (4) coordinate care.[31] ACOs can choose to meet these requirements in a variety of ways by employing tools tailored to the ACO's circumstances.[32]

An ACO must also focus on patient-centered care. To meet this requirement, an ACO must do all of the following:

- Use an experience of care survey -- specifically, the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey -- to improve care over time
- Involve patients in ACO governance
- Evaluate the health needs of beneficiaries and develop plans to address those needs
- Identify high-risk individuals and develop individualized plans for targeted populations
- Coordinate care via use of enabling technologies or care coordinators
- Communicate clinical information to patients
- Adopt processes for beneficiary engagement and shared decision making
- Develop written standards for access to medical records
- Use internal processes to measure performance and improve care.[33]

An ACO must also meet threshold requirements for 65 quality performance standards. In year one, the ACO must submit data to CMS on each standard, and in year two the ACO must begin to meet performance benchmarks.[34] For purposes of determining how much an ACO should share in any savings, CMS will annually award points to an ACO that does well on the quality standards and use the resulting score to determine the amount of savings an ACO should receive.[35]

These 65 performance standards are broken down into five domains:

1. Patient/Caregiver Experience
2. Care Coordination
3. Patient Safety
4. Preventive Health
5. At Risk Population/Frail Elderly Health

A chart detailing all 65 ACO quality measures can be found at the end of this publication. It can also be downloaded at:

http://bit.ly/jU2oEF

CMS Announces Three New ACO Initiatives

On May 17, 2011, The Centers for Medicare & Medicaid Services (CMS) announced three initiatives that will provide more options and incentives for providers to participate in ACOs.

1. The Center for Medicare and Medicaid Innovation (Innovation Center) will support a new Pioneer ACO model, available to providers this summer, which is designed for organizations that have already adopted significant care-coordination processes and are ready to participate in shared savings. It is projected to save Medicare up to $430 million over three years.
2. The Innovation Center is seeking comment on the idea of an Advance Payment ACO Model that would provide additional up-front funding to providers to support the formation of new ACOs.
3. CMS will host free "accelerated development learning sessions" for providers who want to learn more about the necessary steps in becoming an ACO

How Can An ACO Share in Medicare Savings?

ACO participants are paid for services provided to beneficiaries on a fee-for-service basis just like any other Medicare provider. However, if an ACO meets the MSSP requirements, it can receive additional payments for savings achieved in Medicare expenditures for beneficiaries assigned to the ACO. The ACO then distributes these additional savings to its ACO participants.

To receive a savings payment, the ACO must meet the minimum requirements of the 65 quality performance standards.[36] In year one, reporting of data is all that is required. In year two, not only must the ACO report data, but it must meet a "minimum attainment level" for each of the standards.[37] Beginning in year two, if the ACO does not meet the "minimum attainment level" for each standard, it will not receive a payment.

To receive a payment, the ACO must experience a reduction in Medicare expenditures as compared to a yearly benchmark established by CMS.[38] The benchmark is a surrogate measure of what the Medicare expenditures would have been in the absence of the ACO.[39] The savings must exceed not only the benchmark but an additional margin "to account for normal variation in expenditures" which is called the "minimum savings rate" or "MSR."[40] The MSR differs for Track 1 and Track 2 ACOs. For an ACO to share in any savings, the savings must exceed the MSR.

How Are Savings and Losses Shared?

The amount an ACO can receive in shared savings depends on a number of factors including the amount of the savings, whether the ACO is Track 1 or Track 2, how well the ACO has performed on the quality reporting standards, and whether the ACO has expanded into rural areas or included FQHCs and RHCs as participants.[41] In short, ACOs that save more, choose to share in losses, do better on the quality standards, expand into rural areas, and include FQHCs and RHCs as participants will receive more in savings. For example, a Track 1 ACO can share in up to 52.5 percent of savings that exceed the benchmark. Track 2 ACOs can share in up to 65 percent of savings that exceed the benchmark. If, however, an ACO's performance on the quality standards is less than ideal, or it does not expand into rural areas or include FQHCs or RHCs, its share of savings can be reduced significantly.

Importantly, a Track 2 ACO also agrees to share in losses at the outset. If the ACO's Medicare expenditures for assigned beneficiaries are above the benchmark by more than 2 percent, the ACO must make a loss payment to CMS.[42] The amount of the loss payment may be reduced if the ACO does well on the quality standards or if it includes FQHCs and RHCs as participants.

What Are the Incentives for Medicare ACOs to Form in Rural Areas?

The Proposed MSSP Rules include incentives to encourage ACOs to include FQHCs and RHCs as participants. According to CMS, such incentives reflect the critical role FQHCs and RHCs play in the nation's health care delivery system, serving as safety net providers of primary care in rural and underserved areas and for low-income beneficiaries.[43]

The first incentive raises the shared savings rate by up to 5 percent for ACOs that include FQHCs and RHCs as participants. The second incentive exempts small, physician-driven Track 1 ACOs that include FQHCs, RHCs and CAHs from the 2 percent minimum savings rate (MSR) and instead allows the ACO to share in first dollar savings above the benchmark. Specifically, this provision applies to Track 1 ACOs with less than 10,000 assigned beneficiaries in the most recent year for which CMS has complete claims data that also meets one of the following criteria: (1) all of the ACO's participants are physicians or physician groups, (2) 75 percent of the assigned beneficiaries reside in counties outside Metropolitan Statistical Areas (MSAs), (c) 50 percent or more of the assigned beneficiaries received services from "Method II Critical Access Hospitals" or (4) at least 50 percent of the ACO's assigned beneficiaries had at least one encounter with a participating FQHC or RHC.[44]

How Can Medicare ACOs Avoid Potential Problems with the federal Antitrust, Self-referral, Anti-kickback, and Civil Monetary Penalties Laws?

Antitrust concerns have been at the heart of some of the criticism directed to the ACO model since it was included in Affordable Care Act. As a result, CMS, FTC, DOJ and OIG have recognized the need to clarify antitrust issues that may discourage providers from joining ACO's. Thus, at the same time CMS issued the Proposed Rules, the FTC and DOJ issued for public comment a Proposed Policy Statement to clarify how antitrust laws apply to ACOs formed under the MSSP.[45] Notably, the Rules and Policy Statement work together such that an ACO that complies with the Rules will satisfy the requirements of the Policy Statement, and vice versa. Public comments to the FTC/DOJ Proposed Statement of Antitrust Policy are due May 31, 2011.

ACOs give rise to antitrust concerns because joint-price agreements among competing health care providers may have anti-competitive effects which outweigh pro-competitive effects, and thus may be illegal under the antitrust "rule of reason."[46] These concerns become greater when ACO participants have greater market share.[47] To provide clear guidance, the Policy Statement establishes a "zone of safety." If an ACO falls within the "zone," it will not be challenged under the antitrust laws absent extraordinary circumstances.[48]

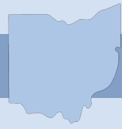
Although the criteria for the "zone of safety" are detailed, ACOs generally falls within the "zone" if (1) their participants that provide the same service have a market share of 30 percent or less for each common service in the ACO's primary service areas and (2) hospitals and ambulatory service centers that participate in an ACO are non-exclusive to the ACO.[49] There are also exceptions to the 30 percent market share rule for rural areas because many rural physicians have limited competition and thus greater market share.[50] ACOs with market share above 30 percent can seek review from the FTC and DOJ and obtain assurance that they will not be challenged on antitrust grounds.

Under the Policy Statement and Rules, an ACO may not participate in the MSSP if its participants have a greater than 50 percent market share for any common services, unless the ACO first obtains a letter from the FTC or DOJ stating those agencies have no intention to challenge the ACO under the antitrust laws.[51] ACOs can seek review and obtain letters from the FTC and DOJ on an expedited basis.

The Affordable Care Act also authorizes the Secretary to waive certain federal fraud and abuse laws as necessary to carry out the provisions of the MSSP.[52] On April 7, 2011, CMS published in the Federal Register a notice for public comment regarding possible waivers of the application of the physician self-referral law, the federal anti-kickback statute, and certain civil monetary penalties (CMP) laws to specified financial arrangements involving ACOs under the MSSP.[53] The notice also seeks public comment on similar waivers that may be issued in connection with Section 1115(a) of the Affordable Care Act with respect to the testing of certain innovative payment and service delivery models by the Center for Medicare and Medicaid Innovation. Public comment on the possible waivers is due by June 6, 2011 and CMS expects that any waivers will be issued concurrently with the Shared Savings Program Final Rules.[54]

How Do the Shared Saving Program Rules Relate to Medicaid?

Because Medicare is the largest single payer of health services nationally (accounting for approximately 23% of all spending on personal health care), changes in how Medicare pays for services are often followed by other payers, including Medicaid. In



Pediatric ACOs: Federal, state and regional progress

While the federal government has not yet issued draft rules related to pediatric ACOs, state policymakers are taking steps in that direction through the state budget process.

As discussions continue regarding the details of an Ohio pediatric ACO model, policymakers are working with Medicaid managed care plans and children's hospitals, as well as considering the existing models of accountable care, such as Columbus-based **Partners for Kids.**

"The pediatric ACO demo provision in the ACA was not funded and therefore is not being pursued at this time," said Barbara Edwards, director of the Disabled and Elderly Health Programs Group at CMS. "However, we are currently working with children's hospitals (individually and at national association level) to explore how other…Medicaid authorities might accommodate care integration models for children ([for example], health homes, global budgets, other payment reforms)."

Partners for Kids (PFK), an organization owned equally by Columbus-based Nationwide Children's Hospital and community pediatricians, has pursued accountable care efforts since its founding in 1994.

The organization began contracting with Medicaid Managed Care plan CareSource in Franklin County in 1996 and have since expanded the agreement to additional counties and have added similar agreements with Molina and Unison to coordinate care for children in central and southeastern Ohio. It now covers 290,000 children on Medicaid in 37 counties.

"CareSource's relationship with Partners for Kids has aligned the incentives of both organizations for improved clinical outcomes and cost effectiveness," said Janet Grant, Executive Vice President at CareSource. "To the member, it is a seamless integrated approach providing the comprehensive benefits of care coordination. We have accomplished mutually beneficial goals leveraging the health plan infrastructure and the clinical expertise and services of the Nationwide system."

According to Pam Carr,Executive Director of Partners for Kids, at the heart of the organization's work is a payment arrangement that PFK officials say aligns incentives among hospitals and doctors and rewards quality outcomes.

The arrangement starts with the managed care plans taking a capitation payment, or a fixed amount for each person served for a given time regardless of the services provided. The plans then set aside their enrollees who are 18 or younger and give most of the capitation payments for those children to PFK, which uses the funds to pay traditional fee-for-service payments for the children's care. At the end of each month, any remaining capitation dollars are kept by PFK, which divides the funds between Nationwide Children's and the physicians who are part of PFK.

PFK and local hospitals identify mothers who have a history of pre-term births and provides them with 17P Alpha Hydroxy Progesterone injections. The result is an increase in average gestational age from 28.4 weeks to 36.8 weeks among that population.

Another key component of the arrangement is that it provides quarterly incentive payments to physicians who are not employed by the hospital (hospital-employed doctors are already paid on a capitated basis and already receive quality incentives).

Currently, incentives to non-hospital employed doctors are tied to access, namely whether a provider accepts Medicaid patients. However, PFK is working to tie incentives to Healthcare Effectiveness Data and Information Set (HEDIS) quality measures. Those incentive changes are expected next year.

As part of its move toward incentivizing quality of care, PFK has adopted a wellness strategy around asthma, diabetes, obesity and premature births. The ultimate goal of those efforts is to spread success to the community outside the partnership.

One early success from PFK's efforts involves reducing premature births. The organization, in collaboration with local hospitals lead by Nationwide Children's Hospital, identifies mothers who have a history of pre-term births and provides them with 17P Alpha Hydroxy Progesterone injections. The result is an increase in average gestational age from 28.4 weeks to 36.8 weeks among that population.

PFK officials say a key to the program's success is that the organization is able to use Medicaid's robust data to measure the effectiveness of its effort.

Edwards said that several states have asked CMS for assistance in exploring how they might structure contracts and reimbursement strategies for a variety of populations. She said that, "CMS is at present examining reimbursement models and care integration options, and working with states one-on-one through technical assistance to help states achieve their reform goals."

Key questions, concerns and considerations about the MSSP

Issue	ACO Proposed Regulations
Open provider network/ preservation of patient choice	Medicare beneficiaries will be able to seek care from any provider, even if the provider is outside of their assigned ACO
Quality measures/ reporting requirements	• Measures quality of care using 65 nationally-recognized measures in five domains: care coordination, patient safety, preventive health, patient experience and care of at-risk and frail elderly populations • Outlines a monitoring and reporting plan that includes analyzing claims and specific financial and quality data, producing quarterly and annual aggregated reports, performing site visits, and conducting beneficiary surveys
Shared Savings methodology	• If an ACO chooses "Track 1" (one sided approach), it will share in savings for the first two years, but not in losses. If an ACO chooses "Track 2" (two sided approach), it will share in both savings and losses at the outset. In year 3, all ACOS share in both cost and savings. • The amount an ACO can receive in savings depends on the amount of the savings, the track chosen, performance on quality reporting standards, and whether the ACO has expanded into rural areas or included FQHCs and RHCs as participants
Retroactive assignment of beneficiaries/ primary care	• Beneficiaries are assigned to an ACO retrospectively based on utilization of primary care services - by only primary care physicians - during the previous year. • The ACO must include sufficient numbers of primary care providers to serve the assigned beneficiaries.
Timeline and uncertainty	The public comment period closes on June 6, 2011; ACO operations are to begin January 1, 2012
Start-up costs and operational requirements	• CMS assumes ACO start up costs equal to the average start-up costs of the Medicare Physician Group Practice (PGP) demonstration of $1.76 million. • Requires that 50% of ACO primary care providers in year 2 be meaningful electronic health record users. • Imposes a significant financial surety requirement on ACOs formed by primary care physicians • Requires that CMS withhold 25% of each year's saving share until the end of the contract period (less any losses) to ensure ACOs participate for the full three years

Considerations

- May limit an ACO's ability to control the cost and quality of care delivered to their assigned beneficiaries
- May increase risk to an ACO because it is still financially and statistically responsible for the care and outcomes of an assigned beneficiary that receives care elsewhere
- Recognizes and preserves the patient's right to choose his or her own provider already allowed under fee-for-service

- Such reporting requirements may pose a significant administrative burden and cost to ACOs.
- Only 11 of the 65 quality measures can be met using claims data. The others require the resource-intensive process of culling data from medical records and /or surveys. Would it be better to focus instead on quality improvement in a limited number of high impact areas?
- Will focusing on so many measures detract and/or prohibit targeted clinical improvement efforts?
- Performance-based payment model holds providers accountable for care quality and patient outcomes

- Track 2's added risk may outweigh potential benefits. Since the percentage that determines downside losses exceeds the percentage that determines upside gains, there may not be an adequate level of shared savings to incentivize ACOs to transform their care practices.
- Track 1's intent was to offer newly formed ACOs time to learn from the first 2 years before shared losses would begin. Realistically, given the time it would take for CMS to collect and analyze first year claims and performance data, the feedback would not even be available before the start of year 3; thus, the ACO would have to assume the risk before it had any idea of how it performed and how to address deficiencies.
- Track 2 may favor ACOs operating in low-cost or high growth rate regions because CMS will use (higher) national growth rates to set budget targets; inflated budget targets lessen the risk of losing money.
- ACOs will individually have to decide how to distribute shared savings across participating providers. The proposed regulations offer no guidance on this issue.
- Encourages providers to render services that increase efficiency of care and improve patient health rather than on services for which they are routinely paid under the fee for service model.

- Designing explicit performance targets is difficult for an ACO if it does not know in advance who its assigned patients are.
- Since an ACO will not know which beneficiaries are assigned to it until the year has ended, the ACO has an incentive to implement care coordination strategies for all beneficiaries, not just for those on whom it will be evaluated.
- Non-primary care physicians, mainly specialists, provide 60% of all primary care services to Medicare beneficiaries, many of whom have multiple chronic conditions. To exclude their services from the assignment decision underestimates the level of primary care services needed by the ACO's pool of beneficiaries.

- The timeline for implementation is very aggressive for such a complex process of change that will require a fundamental change in provider culture.
- The ability to measure financial and quality performance is constrained by the time it takes to collect and analyze claims and other data (6 months after the close of the year to collect claims, plus time for analysis.) If results in year 1 are not known until year 3, an ACO faces substantial operational uncertainty and risk that may be a deterrent to participation in the shared savings program.
- The potential for significant cost savings and improved health quality and outcomes makes ACO implementation a matter of urgency.

- Eight of the ten PGP sites already had electronic health records in place. Start-up costs for ACOs lacking EHRs would be significantly higher and, in some cases, prohibitive.
- The EHR requirement may also disqualify a lot of potential ACOs.
- The ACO must fund initial operating expenses for a year before any savings are received. The 25% savings withhold may further hamper cash flow and reduce savings distribution payments to providers.
- Newly created physician ACOs are not likely to have sizeable capital reserves or access to letters of credit necessary to meet the financial surety requirements.

SOURCES listed at end of publication

fact, the Affordable Care Act established the Pediatric Accountable Care Demonstration Project to allow pediatric medical providers to form ACOs and receive incentive payments from Medicaid in the same manner as provided for under the Medicare Shared Savings Program.[55] Although the pediatric ACO demonstration project had been scheduled to begin on January 1, 2012 and end on December 31, 2016, the project was not funded in the current federal budget. However, according to Barbara Edwards, director of the Disabled and Elderly Health Programs Group at CMS, "…we [CMS] are currently working with children's hospitals (individually and at national association level) to explore how other…Medicaid authorities might accommodate care integration models for children ([for example], health homes, global budgets, other payment reforms)."

Conclusion

Now that the MSSP draft rules have been issued, hospitals, physicians and other health care providers are preparing comments to submit to CMS. In addition, they are assessing whether it is feasible and/or desirable to transform their practices to meet the requirements of the MSSP. Organizations that already have moved forward some form of an accountable care organization will need to assess their operations, processes and metrics to determine what changes would be needed to participate in the MSSP and whether such participation aligns with corporate goals. These transformations will take time because of the complexity and potential cost of meeting the proposed requirements. The Proposed Rules are intended to become effective by January 1, 2012, so only those systems that have already started to integrate will likely be able to take advantage of the shared savings immediately.

Notes

1. CMS Medicare Shared Savings Program, Supplementary Information, 76 Fed. Reg. at 19534.
2. Medicare Shared Savings Program, 76 Fed. Reg. 19528 et seq. (proposed April 7, 2011); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §3022 (2010).
3. Medicare Shared Savings Waiver Designs, 76 Fed. Reg. 19655 et seq. (proposed April 7, 2011); Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program ("Proposed Statement of Antitrust Policy"), 75 Fed. Reg. 21894 et seq. (proposed April 19, 2010)
4. Medicare Shared Savings Waiver Designs, 76 Fed. Reg. 19655 et seq. (proposed April 7, 2011).
5. John Iglehart, Assessing an ACO Prototype – Medicare's Physician Group Practice Demonstration, 364 N. Eng. J. of Med. 198-200 (Jan. 20, 2011).
6. Id.
7. Haywood and Kosel, The ACO Model – A Three-Year Financial Loss?, The New England Journal of Medicine, Health Policy and Reform (March 23, 2011).
8. Id.
9. Victoria Elliott, Most ACOs May Lose Money Initially, American Medical News (April 7, 2011).
10. Iglehart, 364 N. Eng. J. of Med. 198-200.
11. Evans, Melanie. Proposed ACO Rules Too Risky, Demo Group Participants Say. Modern Healthcare.com, May 13, 2011.
12. Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program ("Proposed Statement of Antitrust Policy"), 75 Fed. Reg. 21894 et seq. (proposed April 19, 2010)
13. Medicare Shared Savings Waiver Designs, 76 Fed. Reg. 19655 et seq. (proposed April 7, 2011).
14. Medicare Shared Savings Program, 76 Fed. Reg. at 19641 (proposed April 7, 2011) (to be codified at 42 C.F.R. §§425.4 and 425.5(a)).
15. Medicare Shared Savings Program, 76 Fed. Reg. at 19641 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.4).
16. Medicare Shared Savings Program, 76 Fed. Reg. at 19641 (proposed April 7, 2011) (to be codified at 42 C.F.R. § 425.5(a)(2)).
17. Medicare Shared Savings Program, 76 Fed. Reg. at 19645 (proposed April 7, 2011) (to be codified at 42 CFR§425.6(a)).
18. Medicare Shared Savings Program, 76 Fed. Reg. at 19645 (proposed April 7, 2011) (to be codified at 42 C.F.R.§425.6(a)(2)).
19. Medicare Shared Savings Program, 76 Fed. Reg. at 19641-19642 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(b)).
20. Medicare Shared Savings Program, 76 Fed. Reg. at 19641-19642 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(b)(5)); See also, Supplementary Information, 76 Fed. Reg. at 19539.
21. See, Medicare Shared Savings Program, Supplementary Information, 69 Fed. Reg. at 19538.
22. 42 U.S.C. §1395jjj(b)(2)(B); Medicare Shared Savings Program, 76 Fed. Reg. at 19642 and 19651-19652 (proposed April 7, 2011) (to be codified at 42 C.F.R. §§425.5(d)(3) and 425.18).
23. 42 U.S.C. §1395jjj (b)(2)(D); Medicare Shared Savings Program, 76 Fed. Reg. at 19645 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(d)(13)).
24. Medicare Shared Savings Program, 76 Fed. Reg. at 19643 (proposed April 7, 2011) (to be codified at 42 C.F.R. 425.5(d)(6)).
25. Medicare Shared Savings Program, 76 Fed. Reg. at 19646-7 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.7(c-d)).
26. Medicare Shared Savings Program, 76 Fed. Reg. at 19643 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(b)(8)).
27. Medicare Shared Savings Program, 76 Fed. Reg. at 19643-19644 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(b)(9-10)).
28. Medicare Shared Savings Program, 76 Fed. Reg. at 19643-19644 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(b)(9)(viii)).
29. Medicare Shared Savings Program, 76 Fed. Reg. at 19648 (proposed April 7, 2011) (to be codified a t42 C.F.R. 425.11(b)).
30. Medicare Shared Savings Program, 76 Fed. Reg. at 19653-19654 (proposed April 7, 2011) (to be codified at 42 C.F.R. 425.23).
31. Medicare Shared Savings Program, 76 Fed. Reg. at 19645 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.5(d)(15)(i)); See also, Supplementary Information, 76 Fed. Reg. at 19546-19547.
32. Medicare Shared Savings Program, Supplementary Information, 76 Fed Reg. at 19546.
33. Medicare Shared Savings Program, 76 Fed. Reg. at 19645 (proposed April 7, 2011) (to be codified at 42 C.F.R. 425.5(d)(15)(ii)).
34. Medicare Shared Savings Program, 76 Fed. Reg. at 19648 (proposed April 7, 2011) (to be codified at 42 C.F.R. §§425.9 and 425.10).
35. Medicare Shared Savings Program, 76 Fed. Reg. at 19646-19647 (proposed April 7, 2011) (to be codified at 42 C.F.R. §§425.7(c-d) and 425.10(b-d)).
36. Medicare Shared Savings Program, 76 Fed. Reg. at 19646-19647 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.7(c)(3) and (d)(3)).
37. Medicare Shared Savings Program, 76 Fed. Reg. at 19648 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.10(b)(2)).
38. 42 USC §1395jjj(d)(1)(B); Medicare Shared Savings Program, 76 Fed. Reg. at 19645-19646 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.7(a)).
39. See, Medicare Shared Savings Program, Supplementary Information, 76 Fed Reg. at 19604.
40. Medicare Shared Savings Program, 76 Fed. Reg. at 19646-19647 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.7(c)(2-3) and (d)(2-3)).
41. Medicare Shared Savings Program, 76 Fed. Reg. at 19646-19647 (proposed April 7, 2011) (to be codified a 42 C.F.R. §425.7(c-d)).
42. Medicare Shared Savings Program, 76 Fed. Reg. at 19647 (proposed April 7, 2011) (to be codified at 42 C.F.R. §425.7(d)).
43. See Medicare Shared Savings Program, Supplementary Information 76 Fed. Reg. at 19538.
44. Medicare Shared Savings Program, 76 Fed. Reg. at 19646-19647 (proposed April 7, 2011) (to be codified at 42 CFR §425.7(c)(4)).
45. Proposed Statement of Antitrust Policy. 76 Fed. Reg. 21894.
46. Proposed Statement of Antitrust Policy, 76 Fed. Reg. 21894.
47. Proposed Statement of Antitrust Policy, 76 Fed. Reg. at 21897.
48. Proposed Statement of Antitrust Policy, 76 Fed. Reg. at 21897.
49. Proposed Statement of Antitrust Policy, 76 Fed. Reg. at 21897.
50. Proposed Statement of Antitrust Policy, 76 Fed. Reg. at 21897.
51. Medicare Shared Savings Program, 76 Fed. Reg. at 19642 (proposed April 7, 2011) (to be codified at 42 CFR §425.5(d)(2)); Proposed Policy Antitrust Statement, 76 Fed. Reg. at 21897-21898.
52. 42 U.S.C. §1395jjj(f).
53. Medicare Shared Savings Waiver Designs, 76 Fed. Reg. 19655 et seq. (proposed April 7, 2011).
54. Medicare Shared Savings Waiver Designs, 76 Fed. Reg. 19655 et seq. (proposed April 7, 2011).
55. 42 U.S.C. §1396a.

Sources for key questions table (pages 10-11)

Accountable Care News Special Edition: Expert Commentary on the CMS, FTC/DOJ, IRS, and OIG ACO Regulations/Guidnace. April, 2011. http://www.accountablecarenews.com/issues/acnewsspecial0411.pdf

Iglehart, John K. The ACO Regulations – Some Answers, More Questions. New England Journal of Medicine. April 13, 2011. http://healthpolicyandreform.nejm.org/?p=14218&cpage=1

Klar, Ron. Overweight and Out of Shape: ACO Regs Need a Major Makeover, Health Affairs blog, April 7, 2011. http://healthaffairs.org/blog/2011/04/07/overweight-and-out-of-shape-aco-regs-need-a-major-makeover/

Lieberman, Steven. Proposed CMS Regulation Kills ACOs Softly. Health Affairs Blog, April 6, 2011. http://healthaffairs.org/blog/2011/04/06/proposed-cms-regulation-kills-acos-softly/

McClellan, Mark and Fisher, Elliott. Accountable Care Organizations: A Framework for Evaluating Proposed Rules. Health Affairs blog, March 31, 2011. http://healthaffairs.org/blog/2011/03/31/accountable-care-organizations-a-framework-for-evaluating-proposed-rules/

Proposed Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings

Patient/Care Giver Experience

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
1	**Clinician/Group CAHPS:** Getting Timely Care, Appointments, and Information	NQF #5	Survey	Patient Experience of Care
2	**Clinician/Group CAHPS:** How Well Your Doctors Communicate	NQF #5	Survey	Patient Experience of Care
3	**Clinician/Group CAHPS:** Helpful, Courteous, Respectful Office Staff	NQF #5	Survey	Patient Experience of Care
4	**Clinician/Group CAHPS:** Patients' Rating of Doctor	NQF #5	Survey	Patient Experience of Care
5	**Clinician/Group CAHPS:** Health Promotion and Education	NQF #5	Survey	Patient Experience of Care
6	**Clinician/Group CAHPS:** Shared Decision Making	NQF #5	Survey	Patient Experience of Care
7	**Clinician/Group CAHPS:** Shared Decision Making	NQF #6	Survey	Patient Experience of Care

Care Coordination/Transitions

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
8	**Risk-Standardized, All Condition Readmission:** The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.	CMS	Claims	Claims
9	**30 Day Post Discharge Physician Visit**	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
10	**Medication Reconciliation:** Reconciliation After Discharge from an Inpatient Facility Percentage of patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NQF #554	NQF #554	Process
11	**Care Transition Measure:** Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan	NQF #228 or alternate	Survey or Group Practice Reporting Option (GPRO) Data Collection Tool	Patient Experience of Care

Care Coordination

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
12	**Ambulatory Sensitive Conditions Admissions: Diabetes, short-term complications** (AHRQ Prevention Quality Indicator (PQI) #1) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma), per 100,000 population.	NQF #272	Claims	Outcome

Care Coordination (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
13	**Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes** (AHRQ Prevention Quality Indicator (PQI) #14) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication, per 100,000 population.	NQF # 638	Claims	Outcome
14	**Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease** (AHRQ Prevention Quality Indicator (PQI) #5) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD, per 100,000 population.	NQF #275	Claims	Outcome
15	**Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure** (AHRQ Prevention Quality Indicator (PQI) #8) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF, per 100,000 population.	NQF #277	Claims	Outcome
16	**Ambulatory Sensitive Conditions Admissions: Dehydration** (AHRQ Prevention Quality Indicator (PQI) #10) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypovolemia, per 100,000 population.	NQF # 280	Claims	Outcome
17	**Ambulatory Sensitive Conditions Admissions: Bacterial pneumonia** (AHRQ Prevention Quality Indicator (PQI) #11) All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for bacterial pneumonia, per 100,000 population.	NQF # 279	Claims	Outcome
18	**Ambulatory Sensitive Conditions Admissions: Urinary infections** (AHRQ Prevention Quality Indicator (PQI) #12) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code of urinary tract infection, per 100,000 population.	NQF # 281	Claims	Claims

Care Coordination/Information Systems

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
19	**% All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements**	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool / EHR Incentive Program Reporting	Process
20	**% of PCPs Meeting Stage 1HITECH Meaningful Use Requirements**	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool / EHR Incentive Program Reporting	Process

Care Coordination/Information Systems (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
21	**% of PCPs Using Clinical Decision Support**	CMS EHR Incentive Program – Core Measure	Group Practice Reporting Option (GPRO) Data Collection Tool/ EHR Incentive Program Reporting	Process
22	**% of PCPs who are Successful Electronic Prescribers Under the eRx Incentive Program**	CMS EHR Incentive Program – Core Measure	Group Practice Reporting Option (GPRO) Data Collection Tool / eRx Incentive Program Reporting	Process
23	**Patient Registry Use**	CMS EHR Incentive Program – Menu Set Measure	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

Patient Safety

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
24	**Health Care Acquired Conditions Composite:** • Foreign Object Retained After Surgery • Air Embolism • Blood Incompatibility • Pressure Ulcer, Stages III and IV • Falls and Trauma • Catheter-Associated UTI • Manifestations of Poor Glycemic Control • Central Line Associated Blood Stream Infection (CLABSI) • Surgical Site Infection • AHRQ Patient Safety Indicator (PSI) 90 Complication/Patient • Safety for Selected Indicators (composite) ◦ Accidental puncture or laceration ◦ Iatrogenic pneumothorax ◦ Postoperative DVT or PE ◦ Postoperative wound dehiscence ◦ Decubitus ulcer ◦ Selected infections due to medical care (PSI 07: Central Venus Catheter-related Bloodstream Infection) ◦ Postoperative hip fracture ◦ Postoperative sepsis	CMS (HACs), NQF #531 (AHRQ PSI)	Claims or CDC National Healthcare Safety Network	Outcome
25	**Health Care Acquired Conditions: CLABSI Bundle**	NQF #298	Claims or CDC National Healthcare Safety Network	Process

Preventive Health

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
26	**Influenza Immunization:** Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	Physician Quality Reporting System Measure #110 EHR Incentive Program – Clinical Quality Measure NQF #41	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

Preventive Health (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
27	**Pneumococcal Vaccination:** Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine.	Physician Quality Reporting System Measure #111 EHR Incentive Program – Clinical Quality Measure NQF #44	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
28	**Mammography Screening:** Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months.	Physician Quality Reporting System Measure #112 EHR Incentive Program – Clinical Quality Measure NQF #31	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
29	**Colorectal Cancer Screening:** Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening.	Physician Quality Reporting System Measure #113 EHR Incentive Program – Clinical Quality Measure NQF #34	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
30	**Cholesterol Management for Patients with Cardiovascular Conditions:** • The percentage of members 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year.LDL-C screening • LDL-C control (<100 mg/dL)	EHR Incentive Program – Clinical Quality Measure NQF # 75	Group Practice Reporting Option (GPRO) Data Collection Tool	Process & Outcome
31	**Adult Weight Screening and Followup:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. Parameters: Age 65 and older BMI ≥ 30 or < 22; Age 18-64 BMI ≥ 25 or < 18.5	Physician Quality Reporting System Measure #128 EHR Incentive Program – Clinical Quality Measure NQF #421	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
32	**Blood Pressure Measurement:** Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged > 18 years with diagnosed hypertension.	Physician Quality Reporting System #TBD EHR Incentive Program – Clinical Quality Measure NQF #13	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

Preventive Health (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
33	**Tobacco Use Assessment and Tobacco Cessation Intervention:** Percentage of patients who were queried about tobacco use. Percentage of patients identified as tobacco users who received cessation intervention.	Physician Quality Reporting System #TBD EHR Incentive Program – Clinical Quality Measure NQF #28	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
34	**Depression Screening:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.	Physician Quality Reporting System #134 NQF #418	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – Diabetes

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
35	**Diabetes Composite (All or Nothing Scoring)**: • Hemoglobin A1c Control (<8%) • Low Density Lipoprotein (<100) • Blood Pressure <140/90 • Tobacco Non Use • Aspirin Use	NQF #575*, 64*, 61*, 28*, TBD	Group Practice Reporting Option (GPRO) Data Collection Tool	Process & Outcome
36	**Diabetes Mellitus: Hemoglobin A1c Control (<8%)** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%.	EHR Incentive Program – Clinical Quality Measure NQF #575	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
37	**Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl).	Physician Quality Reporting System Measure #2 EHR Incentive Program – Clinical Quality Measure NQF #64	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
38	**Diabetes Mellitus: Tobacco Non Use** Tobacco use assessment and cessation	Physician Quality Reporting System #TBD EHR Incentive Program – Clinical Quality Measure NQF #28	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
39	**Diabetes Mellitus: Aspirin Use:** Daily aspirin use for patients with diabetes & cardiovascular disease	NQF TBD	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
40	**Diabetes Mellitus: Hemoglobin A1c Poor Control(>9%):** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.	Physician Quality Reporting System Measure #1 EHR Incentive Program – Clinical Quality Measure NQF #59	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome

At Risk Population – Diabetes (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
41	**Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).	Physician Quality Reporting System Measure #3 EHR Incentive Program – Clinical Quality Measure NQF #61	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
42	**Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients:** Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months.	Physician Quality Reporting System Measure #119 EHR Incentive Program – Clinical Quality Measure NQF #62	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
43	**Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients:** Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam.	Physician Quality Reporting System Measure #117 EHR Incentive Program – Clinical Quality Measure NQF #55	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
44	**Diabetes Mellitus: Foot Exam:** The percentage of patients aged 18 through 75 years with diabetes who had a foot examination.	Physician Quality Reporting System Measure #163 EHR Incentive Program – Clinical Quality Measure NQF #56	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – Heart Failure

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
45	**Heart Failure: Left Ventricular Function (LVF) Assessment:** Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded.	Physician Quality Reporting System Measure #198 NQF # 79	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
46	**Heart Failure: Left Ventricular Function (LVF) Testing:** Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of heart failure (HF) during the measurement period.	Physician Quality Reporting System Measure #228 CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
47	**Heart Failure: Weight Measurement**: Percentage of patient visits for patients aged 18 years and older with a diagnosis of heart failure with weight measurement recorded.	Physician Quality Reporting System #227 NQF # 85	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
48	**Heart Failure: Patient Education**: Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months.	Physician Quality Reporting System #199 NQF # 82	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – Heart Failure (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
49	**Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic**: Dysfunction (LVSD) Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	Physician Quality Reporting System Measure # 8 EHR Incentive Program – Clinical Quality Measure NQF #83	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
50	**Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)**: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	Physician Quality Reporting System Measure #5 EHR Incentive Program – Clinical Quality Measure NQF #81	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
51	**Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation**: Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	Physician Quality Reporting System Measure #200 EHR Incentive Program – Clinical Quality Measure NQF #84	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – Coronary Artery Disease

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
52	**Coronary Artery Disease (CAD) Composite: All or Nothing Scoring** • Oral Antiplatelet Therapy Prescribed for Patients with CAD • Drug Therapy for Lowering LDLCholesterol • 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)	NQF #67, 74, 70, 64, 66	Group Practice Reporting Option (GPRO) Data Collection Tool	Process & Outcome
53	**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.	Physician Quality Reporting System Measure # 6 EHR Incentive Program – Clinical Quality Measure NQF #67	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – Coronary Artery Disease (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
54	**Coronary Artery Disease (CAD): Drug Therapy for Lowering LDLCholesterol:** 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 LDLC 130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program (NCEP).	Physician Quality Reporting System #197 EHR Incentive Program – Clinical Quality Measure NQF #74	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
55	**Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI):** Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	Physician Quality Reporting System Measure # 7 EHR Incentive Program – Clinical Quality Measure NQF #70	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
56	**Coronary Artery Disease (CAD): LDL level < 100 mg/dl**	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
57	**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):** Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	Physician Quality Reporting System Measure #118 NQF #66	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – Hypertension

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
58	**Hypertension (HTN): Blood Pressure Control:** Percentage of patients with last BP < 140/90 mmHg	Physician Quality Reporting System #TBD EHR Incentive Program – Clinical Quality Measure NQF #18	Group Practice Reporting Option (GPRO) Data Collection Tool	Outcome
59	**Hypertension (HTN): Plan of Care:** Percent-age of patient visits for patients aged 18 years and older with a diagnosis of HTN with either systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension.	Physician Quality Reporting System #TBD NQF # 17	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population – COPD

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
60	**Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented.	Physician Quality Reporting System Measure # 51 NQF #91	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
61	**Chronic Obstructive Pulmonary Disease (COPD): Smoking Cessation Counseling Received**	CMS	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population — COPD (cont.)

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
62	**Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1**: Percentage of patients aged 18 years and older with a diagnosis of COPD and who-have an FEV1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator.	Physician Quality Reporting System Measure # 52 NQF #102	Group Practice Reporting Option (GPRO) Data Collection Tool	Process

At Risk Population — Frail Elderly

	measure type & description	CMS program, NQF measure number, measure steward	method of data submission	measure type
63	**Falls: Screening for Fall Risk**: Percentage of patients aged 65 years and older who were screened for fall risk at least once within 12 months	NQF #101	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
64	**Osteoporosis Management in Women Who had a Fracture**: Percentage of women 65 years and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture	NQF #53	Group Practice Reporting Option (GPRO) Data Collection Tool	Process
65	**Monthly INR for Beneficiaries on Warfarin:** Average percentage of monthly intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period	NQF #555	Claims	Process

about hpio

The Health Policy Institute of Ohio is a 501(c)3 nonprofit organization that serves as Ohio's nonpartisan, independent source for forecasting health trends, analyzing key health issues, and communicating current research to policymakers, state agencies and other decision-makers.

HPIO informs health policy development through four strategic objectives:

- Achieving and Maintaining Health and Wellness for all Ohioans
- Ensuring Access to Care for all Ohioans
- Developing Tools for Improved Ohio Health System Data Transparency
- Aligning Public and Private Payments with Health Quality Outcomes

HPIO's recently redesigned website includes a multitude of resources for policymakers, analysts and researchers, including the recently released ***Ohio Medicaid Basics 2011***.

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