Provider Resource

Medicare Shared Savings Program
(MSSP)
Quality Measures

Updated May 2, 2013

What you will find in this resource:

- A description of the Medicare Share Savings Program also called MSSP

- An explanation about why it is important to providers

- An overview of the 33 quality measures

- A description of the data collection process

- Recommendations for provider success in meeting the performance measures enabling payout of the incentive

Description of MSSP

The Medicare Shared Savings Program (MSSP) is a voluntary incentive program for Accountable Care Organizations (ACOs) to reward providers that work together to lower cost of care while meeting quality performance standards. The intent of the program is to encourage providers, suppliers, and others involved with care to create a new type of health care entity that agrees to be responsible and accountable for the care of its assigned beneficiaries. The goals of the program are congruent with the Institute of Healthcare Improvement's Triple Aim:

- Better population health management
- Better experience of care (satisfaction)
- Better management of cost of care

These goals will be achieved through better coordination of care across the continuum and implementing evidenced-based care that eliminates waste.

In order to participate in MSSP, the ACO must submit an application describing how they plan to meet the program goals. CMS sets benchmark goals for the ACO in both cost and quality areas. The ACO agrees to work to meet these benchmarks. If the ACO does not meet the cost and quality goals there are no shared savings.

Importance to Providers

Provider (also includes groups of providers) participation in the program is voluntary. A provider may be part of an ACO without participating in the MSSP program. All providers will continue to get paid by Medicare at the regular fee-for-service rates regardless of their participation. If a provider or group decides to participate, they will sign an agreement of participation with the ACO and be eligible to share in the savings. Savings are distributed once a year and are based on the entire ACO meeting the benchmarks. It is important for provider practices to be aware of the measures and to work collectively to meet the goals.

Quality Measures

The quality measures are designed to promote improved outcomes for patients. They are all clinically proven practices that promote prevention and better disease management. The measures are really a way to look at processes and care that should already be in place according to the evidence-based guidelines.

The MSSP program has a total of 33 measures. Only 22 of the measures are collected from medical records. The remaining 11 are collected directly from patient surveys and claims or administrative data. The measures are divided into four key domains:

- Patient/ Caregiver Experience (7 measures)

- Care Coordination and Patient Safety (6 measures)
- Preventive Health (8 measures)
- At-risk Populations / Disease Specific (12 measures)

The first year of data collection (2012 data) is used to help set the benchmarks for performance quality. For this year, the incentive pay will be based on reporting, not how well the ACO performed. In the following years, the incentive will be based on how well the ACO actually performs on the measures. See ***Table 1*** for a list of the specific measures.

During the data collection process for 2012, opportunities for improvement in adherence to the guidelines and more importantly documentation of data elements were identified. See ***Table 2*** for a summary of the measure specifications and opportunities identified.

Inconsistency in documentation processes and methods across the ACO create challenges in accurately gathering the data for the quality measures that have to be collected from the patient medical record. Creating consistent processes with clear documentation within each practice is vital to successfully reaching the benchmark goals for future incentive pay.

Data Collection Process

The data collection process takes place once a year and is scheduled in early spring by the Centers for Medicare and Medicaid (CMS). Each ACO receives a list of patient names from CMS to be included in the sample for data collection. CMS randomly selects 616 names for each measure from claims data that have been submitted during the measurement year. The ACO is required to report the measure results on 411 consecutive names in each measure list. There are exclusions for several of the measures which make the patient ineligible for that measure creating a “skip”. A skip requires that the next patient on the list be added to meet the 411 consecutive patient requirements. There may be one or more measures that have a smaller sample size of less than 411. In this case, all patients in the sample must be reported.

Once the data is collected, it is entered in the Group Practice Reporting Option (GPRO) web interface. This may be accomplished by direct data entry or data can be imported. AnewCare uses Health Endeavors, a third party software company to compile the MSSP data and upload it in the GPRO tool. This approach provides some advantages and process checking to ensure successful reporting.

After CMS receives the data, they analyze and will later send out official performance reports to the ACO.

Table 1: The ACO GPRO Quality Measures from the Medical Record 2012 Measurement Period					
ACO #	Domain	Measure Title	Pay for Performance Phase-In R= Reporting P= Performance		
			PY1	PY2	PY3
12	Care Coord./Pt Safety	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	R	P	P
13	Care Coord./Pt Safety	Falls: Screening for Fall Risk	R	P	P
14	Preventive Health	Influenza Immunization	R	P	P
15	Preventive Health	Pneumococcal Vaccination	R	P	P
16	Preventive Health	Adult Weight Screening and Follow-up	R	P	P
17	Preventive Health	Tobacco Use Assessment and Tobacco Cessation Intervention	R	P	P
18	Preventive Health	Depression Screening	R	P	P
19	Preventive Health	Colorectal Cancer Screening	R	R	P
20	Preventive Health	Mammography Screening	R	R	P
21	Preventive Health	Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years	R	R	P
22	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (<8%)	R	P	P
23	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (<100)	R	P	P
24	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Blood Pressure <140/90	R	P	P
25	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Tobacco Non Use	R	P	P
26	At Risk Population – Diabetes	Diabetes Composite (All or Nothing Scoring): Aspirin Use	R	P	P
27	At Risk Population – Diabetes	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	R	P	P
28	At Risk Population – Hypertension	Hypertension (HTN): Blood Pressure Control	R	P	P
29	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 mg/dl	R	P	P
30	At Risk Population – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	R	P	P
31	At Risk Population – Heart Failure	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	R	R	P
32	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Drug Therapy for Lowering LDL-Cholesterol	R	R	P
33	At Risk Population – Coronary Artery Disease	Coronary Artery Disease (CAD) Composite (All or Nothing Scoring): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	R	R	P