IAC Institute for Accountable Care

ACO Quality in the Medicare Shared Savings Program

Quality measurement is an integral part of the Medicare Shared Savings Program (MSSP) to ensure that care quality stays high as ACOs manage total health spending. Over time, CMS has refined its approach and the number of MSSP quality metrics collected has declined from 27 in 2012 to 6 in 2021.[1,2] In 2020, the most recent year data are available, MSSP Total Quality Scores were based on 13 measures covering four quality domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population health.[3] Each ACO reported measures for a random sample of at least 248 ACO-assigned beneficiaries.[2] In 2021, the Center for Medicare and Medicaid Services program introduced a new quality measurement approach for the MSSP's 2021 performance year (described in Appendix 1), but the results are not currently available.[2] This paper analyzes the change in MSSP quality scores over time, focusing on the 10 measures that have appeared consistently in the MSSP performance results since 2016.

Summary of Findings

- MSSP ACO total quality scores are consistently high.
- MSSP ACOs scored higher on quality than MIPS Group Practices
- ACO quality improved over time for nine of the ten measures analyzed.
- Performance improved dramatically on certain measures like fall risk screening, depression screening, and depression remission at 12 months.

ACO Quality Performance is Consistently High and Has Improved Over Time

The vast majority of ACOs earned Total Quality Scores of at least 85 out of 100 total points in each year of the MSSP program (Exhibit 1). In their first performance year, each ACO receives a quality score of 100% as long as they completely and accurately report all measures. In subsequent years, ACOs are scored based on their performance relative to established benchmarks and on quality improvement.[3] The total quality scores reported in 2019 and 2020 are artificially high, however, because CMS set a floor equal to the year's MSSP average score of 92 points in 2019 and 97 points in 2020 to mitigate the impact of COVID-19.[4] However, each ACO's *individual quality scores* were reported as measured and were not affected by the total quality floors. Therefore, this paper uses ten individual measures to assess how ACO quality has changed over time.

ACOs Outperformed MIPS Group Practices on Quality in 2020

The Merit-Based Incentive Payment System (MIPS) is a national Medicare pay-for-performance program that most Medicare physician participate in. CMS adjusts future payments to their physicians based on their individual or group performance.[5] Data recently published in the New England Journal of Medicine compared the average quality scores earned by MIPS group practices to those earned by MSSP ACOs. It found that the ACO outperformed the MIPS group practices on all 10 quality scores shown (Table 1)[6]

Exhibit 1: Percentage of MSSP ACOs With Total Quality Scores Above 85%: 2013 – 2020

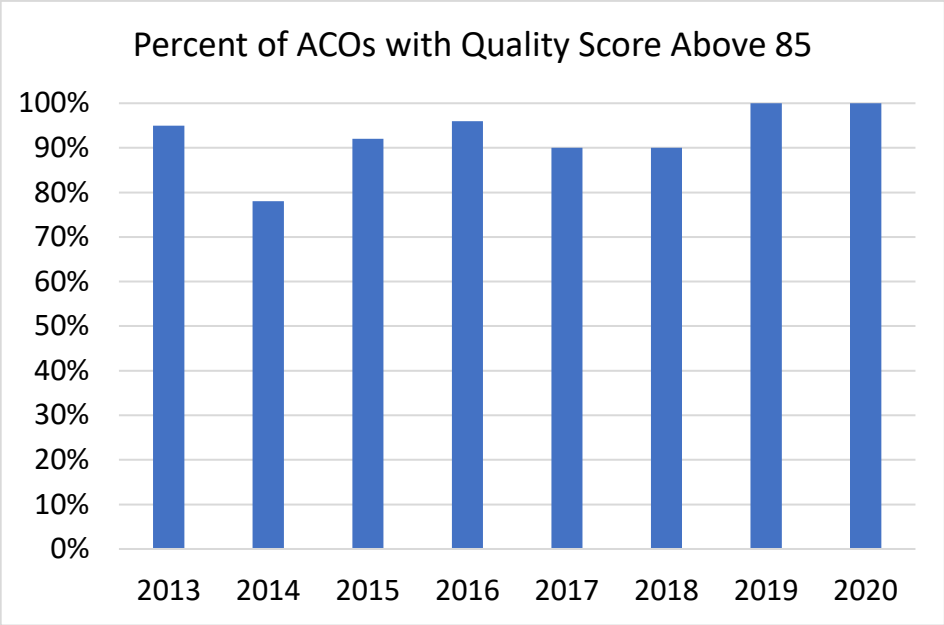

Table 1: Mean Performance for MIPS Group Practices compared to MSSP ACOs in 2020.[6]

Measure	Measure Name	Mean Performance MIPS Group Practices	Mean Performance MSSP ACOs
ACO-13	Falls: Screening for Future Fall Risk	82.4	85.0
ACO-14	Preventive Care and Screening: Influenza Immunization*	72.7	76.0
ACO-17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	79.0	81.7
ACO-18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	68.0	71.5
ACO-19	Colorectal Cancer Screening	68.3	72.6
ACO-20	Breast Cancer Screening*	69.7	74.0
ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*	83.1	83.4
ACO-40	Depression Remission at Twelve Months	9.6	14.0
ACO-27	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*	15.3	14.7
ACO-28	Controlling High Blood Pressure*	69.1	72.9

Source: Jacobs et al. Expanding Accountable Care's Reach Among Medicare Beneficiaries. New England Journal of Medicine. April 27, 2022.

ACO Performance Has Consistently Improved over Time

Exhibit 2 demonstrates how MSSP ACO performance has improved across the five years of available data for three measures: screening for fall risk (ACO-13), depression screening (ACO-18), and colorectal cancer screening (ACO-19). Nine of the ten individual MSSP quality metrics improved between 2016 and 2020 (Table 2).

Exhibit 2

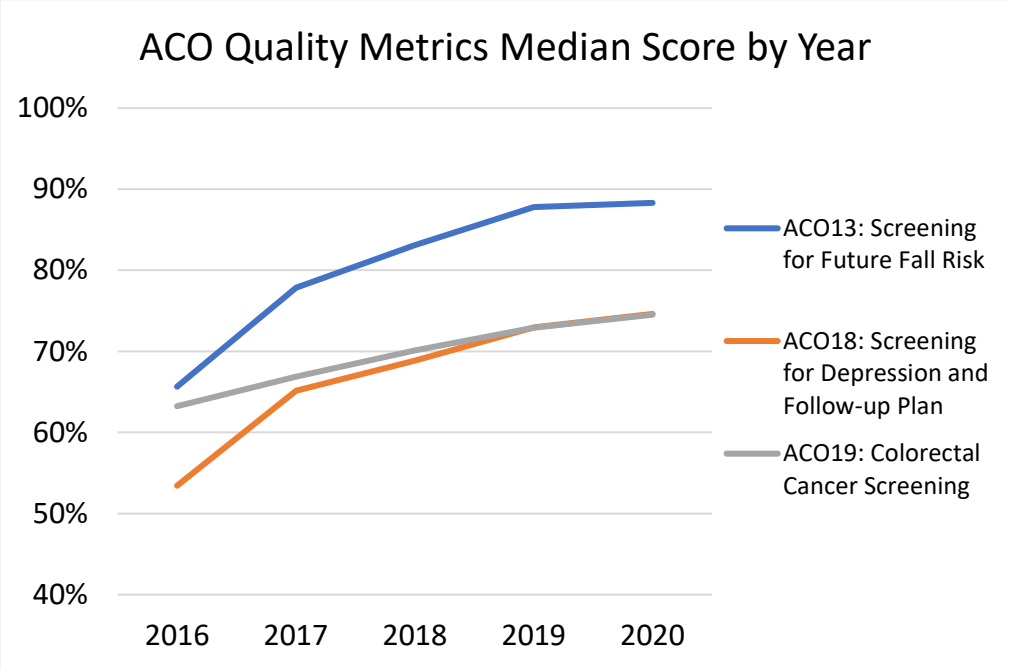

Table 2: Change in Mean MSSP ACO performance by Measures, 2016 and 2020.

Metric Number	Metric Name	**2016 Mean**	**2020 Mean**
ACO13	Falls: Screening for Future Fall Risk	64.0%	85.0%
ACO14	Preventive Care and Screening: Influenza Immunization*	68.3%	76.0%
ACO17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	91.0%	81.7%
ACO18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	53.6%	71.5%
ACO19	Colorectal Cancer Screening	61.5%	72.6%
ACO20	Breast Cancer Screening*	67.6%	74.0%
ACO42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*	77.7%	83.3%
ACO40	Depression Remission at Twelve Months	6.4%	14.0%
ACO27	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*	18.2%	14.7%
ACO28	Controlling High Blood Pressure*	70.5%	72.9%

Conclusion

Overall, MSSP ACO total quality scores are high and have improved over time for the vast majority of measures. However, the degree to which these measures have improved varies. Unfortunately, the existing measure offers only a limited picture of the clinical quality of care. It is essential that ACOs and CMS continue to promote high quality care for beneficiaries which is a vital element of Medicare's population health programs.

Endnotes:

1. Improving Quality of Care for Medicare Patients: Accountable Care Organizations. *Accountable Care Organ*.:8.
2. Understanding the APP for ACOs. Accessed March 31, 2022. https://naacos.memberclicks.net/assets/docs/pdf/2021/UnderstandingtheAPPforACOs121721.pdf
3. Medicare Shared Savings Program Quality Measurement Methodology and Resources. https://www.cms.gov/files/document/2020-quality-measurement-methodology-and-resources.pdf.
4. Performance Year Financial and Quality Results - Centers for Medicare & Medicaid Services Data. Accessed March 31, 2022. https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results
5. Traditional MIPS Overview - QPP. Accessed June 16, 2022. https://qpp.cms.gov/mips/traditional-mips
6. Jacobs D, Rawal P, Fowler L, Seshamani M. Expanding Accountable Care's Reach among Medicare Beneficiaries. *N Engl J Med*. Published online April 27, 2022. doi:10.1056/NEJMp2202991
7. Jennifer Perloff P, Sam Sobul MPA. Use of Electronic Health Record Systems in Accountable Care Organizations. *Am J Manag Care*. 2022;28(1). Accessed April 1, 2022. https://www.ajmc.com/view/use-of-electronic-health-record-systems-in-accountable-care-organizations

Appendix 1: Recent Changes in MSSP Quality Measurement

In 2021, CMS implemented a major shift in how quality data is collected and how quality scores are determined. The new system, known as the APM Performance Pathway (APP), will change how quality metrics are reported, how those metrics impact overall quality scores, and how those scores affect ACO savings.[2] Through 2020, ACOs reported quality data through a Web Interface, which pre-populates a reporting tool with a sample of the ACO's assigned beneficiaries.[3] Beginning in 2021, ACOs will have a choice of reporting through either the Web Interface, through electronic clinical quality measures (eCQMs)/Merit-Based Incentive Payment System (MIPS) CQMs, or both. ACOs that report data in both ways will receive the higher of the two scores. This option will continue through 2024 and beginning in 2025 all ACOs will be required to report eCQMs.[2]

While ACOs have choices in determining how to report their quality measures, the scoring system will switch to the APP method, rather than the current domain-based method, beginning in 2021 for all MSSP ACOs. This system presents a few notable changes from the current, Web Interface method. First, there are fewer measures, with just three clinical quality measures, two administrative claims measures, and one patient experience measure bringing the total down to six measures. Second, rather than the sampling required for the Web Interface, the APP measures require reporting on at least 70 percent of the patients who qualify for the measure, regardless of payer or whether the patient is assigned to the ACO. This change dramatically increases the number of patients ACOs must report on. Finally, because the APP has done away with the domain method of scoring, the quality measures that remain will be weighted differently than they were in prior years when determining the overall quality score.[2]

These changes present several potential issues for measuring ACO quality. eCQMs are derived from electronic medical records (EMRs), meaning that ACOs with multiple EMRs will have to aggregate data across all of their EMRs.[2] A recent study found that 77% of ACOs use at least six EMRs.[7] Expanding the volume of data ACOs must report combined with the need to aggregate the data across multiple EMRs will likely prove challenging for many ACOs and could create short term instability in quality scores due to the transition to the new system.

Appendix 2: Full Measure Descriptions for the Ten Metrics in Tables 1 and 2

Metric	Name	Description
ACO13	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.
ACO14	Preventive Care and Screening: Influenza Immunization	Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
ACO17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
ACO18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
ACO19	Colorectal Cancer Screening	Percentage of adults 50 - 75 years of age who had appropriate screening for colorectal cancer.
ACO20	Breast Cancer Screening	Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer.
ACO42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Percentage of the following patients—all considered at high risk of cardiovascular events— who were prescribed or were on statin therapy during the measurement period: · Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR · Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR · Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL
ACO40	Depression Remission at Twelve Months	The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.
ACO27	Diabetes: HbA1c Poor Control (>9%)	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. Note that a lower performance rate is indicative of better quality.
ACO28	Controlling High Blood Pressure	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.