Section 5.1 Maintain

Quality Scores Monitoring and Reporting

This tool describes potential quality measurement and performance requirements for a community-based care coordination (CCC) program, the process of quality measure reporting, and ongoing monitoring of quality scores.

Time needed: 2 hours

Suggested other tools: Setting and Monitoring Goals for CCC; Technology Tools and Optimization for CCC; Patient Care Coordination Variance Reporting; CCC Program Evaluation; Workflow and Process Analysis/Redesign/Optimization tool suite;

Table of Contents

How to Use

1. **Determine** the quality measurement and performance requirements of the CCC program in which your community is engaged. If none is required currently, consider adopting federal standards and performance requirements for an internal assessment of the program.
2. **Review** and understand the process of quality measure reporting required for a CCC program. Identify the frequency, timeliness, and nature of reporting requirements, and how such results will be used.
3. **Continuously monitor** quality measurement results for accuracy, and quality scores to determine CCC program risk. Celebrate success and/or correct course as necessary.

Quality Measures and Performance Requirements

If the CCC program is established as an accountable care organization (ACO) or other health reform initiative under CMS and/or another payer, quality measures and performance standards will have been established for the program to meet in order to continue participation and reap the financial benefits that accrue with participation. The specific initiative will provide quality measure specifications in programmatic materials, statements of work (SOWs), participation agreements or other documentation.

The initiative will also likely have established performance standards such as a scoring system. Participants in the initiative will be expected to achieve a certain level of performance, or score, in order to continue participation in the initiative. There may be different levels of performance which define levels of reimbursement, incentives, savings, other impacts on payments, and/or other benefits from participation.

If a community has created a CCC program on its own, ideally specific goals have been established. These should be specific, measurable, achievable, realistic, and time-based (SMART) goals with documentation to support how the goals will be measured, who will conduct the measurement, how results will be shared among the participants (and with the public), and what the various levels of results mean in terms of continued participation and financial benefits. If such a CCC program is just getting started, a review of the CMS quality measures and performance standards and/or payer requirements may help the CCC program establish its own measures and performance standards.

Quality Measure Reporting Process and Support

Once quality measures and performance standards are identified, the CCC program will need to establish a means to capture the data required in the measures, and a process to report the results to CMS, other payer(s), and/or the CCC program governance body.

A vendor is commonly used for this purpose, similar to how hospitals, physician offices, and other providers (and payers) have support for collection and reporting of quality data for CMS Hospital Compare, Physician Quality Reporting System, The Joint Commission, state-sponsored reporting programs, and the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS). In fact, so many different reporting requirements have emerged over the years that the vast majority of healthcare organizations use a vendor to collect or receive all the applicable data and prepare reports specific to each requiring organizations' specifications.

In some cases, the organization collects the data manually, electronically, or use a combination of both and sends the data in batches to the vendor for processing and reporting. In other cases, the vendor supplies a tool for the organization to use in abstracting the necessary data. These tools vary in sophistication with respect to their Help features. In other cases, the vendor is able to extract the necessary data from automated systems directly. If data must also be obtained from patients or family members (such as for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or other sources, a vendor is generally used to assure anonymity of respondents.

The nature of processing data and additional reporting that the vendor supplies depend on the level of service acquired. With respect to reporting, a number of vendors offer detailed reports so the organization knows what is being reported. These reports may be in various forms, including

dashboard form for organizational leadership. Historical tracking allows the organization the ability to analyze, benchmark, and trend data over time. Supplemental data may also be tracked to highlight internal relationships, such as unit-specific or physician-specific data. Periodically, the vendor may aggregate data across organizations and prepare benchmarking reports for its customers and/or the public.

CCC programs should assess their data needs, identify which vendors are currently being used in the community, and determine how to either coordinate with one or more of those vendors or use a vendor specifically focused on CCC programs that may have additional services, such as risk stratification, care coordination tracking tools, etc.

Use the following Requirements Specifications to assess the CCC program's needs and approach vendors.

Requirements Specifications for CCC Program Reporting Needs				
Potential Requirements	**Priority for Service**	**Vendor A Offering**	**Vendor B Offering**	**Vendor C Offering**
Process data file for reporting to CMS as approved vendor				
Process data file for reporting to <specify> as approved vendor				
Supply data abstraction tool				
Supply data element definitions				
Supply data abstraction tips				
Extract data from EHR for reporting to CMS as approved vendor				
Extract data from EHR for reporting to <specify> as approved vendor				
Conduct patient surveys for CMS as approved vendor				
Conduct patient surveys for <specify> as approved vendor				
Provide report of data reported within one day of filing report				
Provide historical tracking of data reported				
Collect and report supplemental data on <specify>				
Provide analytics on data reported for cost performance				
Provide analytics on data reported for risk				
Provide analytics on data reported for productivity				
Provide benchmarking over time				
Provide benchmarking with other CCC programs				
Provide benchmarking in dashboard format				
Transmit data using <specify security requirements>				
Access CMS data to risk stratify patients in CCC program's population				
Provide registry functionality for care coordination, including tracking patient care plan content				
Provide registry functionality for care coordination, including tracking medication reminders				

Requirements Specifications for CCC Program Reporting Needs				
Potential Requirements	**Priority for Service**	**Vendor A Offering**	**Vendor B Offering**	**Vendor C Offering**
Provide registry functionality for care coordination, including tracking preventive visit reminders				
Provide registry functionality for care coordination, including tracking <specify>				
Supply care management information using predictive modeling				
Provide provider resource directory functionality				
Provide community resource directory functionality				
Provide health information exchange functionality for care coordination				
Provide consultative services for set up				
Provide consultative services for evaluating results				
Other <specify>				
Other <specify>				

Continually Monitor Quality Measurement Results and Scores

Although the CCC program will collect and report data on various quality measures, it is very important to continuously monitor the reports and resultant performance scores.

Regular monitoring of reports should be done to:

1. **Assess the accuracy of reports.** If data are "off" in a given reporting period in comparison to previous reporting periods, the reason should be investigated. The following are possibilities to consider:

    a. *Issues during the reporting period may have caused inconsistency in trends*.

    Issues should be identifiable from administrative issues logs and patient variance reports. For example, the care coordinator could have had an extended sick leave and no one was available to substitute. Alternatively, the reporting period may have included holidays or other activities where patients routinely did not follow their patient action plans. Depending on the cause, take corrective action so that trending returns to normal or future similar issues can be mitigated with extra effort.

    b. *Data themselves may be incorrect.*

    If there is no apparent cause for results to trend differently, work with the reporting vendor to determine if there are missing data, redundancies in data or other data errors. Correct these immediately and file a corrected report. Data errors may also arise from local CCC program issues that were not previously detected. These may not be easy to detect, but tend to be focused on particular measures, not data overall. For example, a provider may have a new staff member who is consistently documenting a particular data element incorrectly.

Seek this out and take corrective action. Determine whether it is feasible to file a corrected report.

c. *Reporting errors may occur with accurate data.*

Although this is the least likely cause of inaccurate reports, it is possible that results are skewed because the vendor has applied an incorrect analytics process. It is also possible that the vendor has corrected an analytics process and the reports are now correct where previous reports were in error. Determine whether it is feasible to file corrected reports.

2. **Celebrate positive results.** If reports demonstrate positive trending in any or all measures, ensure that not only the results get shared with all stakeholders, but that some form of special commendation is made for a "job well done." Healthcare organizations have a tendency not to celebrate success, yet everyone benefits from a "pat on the back." The level of change required of all stakeholders (including patients) to CCC is huge. Knowing that progress is being made is very important and motivational. The celebratory process can take various forms, but should be sincere and unique to the nature of the findings.

3. **Take corrective action.** Any program of any type will not "make the mark" on every measure all the time. But when performance is scored and directly impacts the quality, cost and experience of care provided in a community, it is critical to continuously monitor results and quickly determine a root cause that can be addressed. Delaying corrective action within the timeframes given for CCC programs to demonstrate their value is generally not an option. Issues will generally not work themselves out and may actually worsen. However, it is equally important to not jump to conclusions. A root cause analysis is essential. Some organizations use Lean/Six Sigma, Balanced Scorecard, or other continuous process improvement strategies to determine root cause(s) and take corrective action.

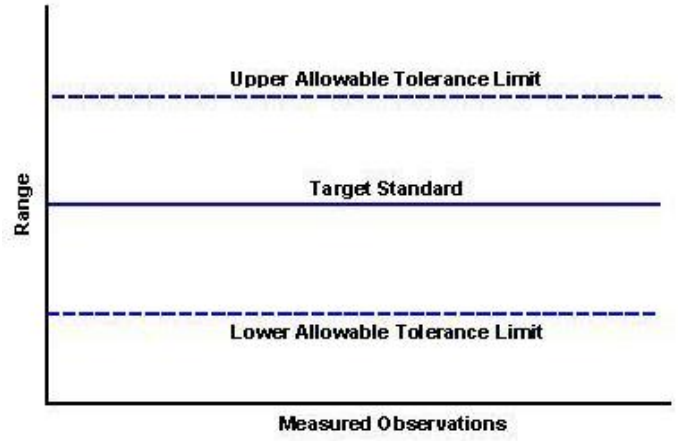
4. **Monitor performance scores.** Performance scores are derived from aggregating the measurement results. However, both should be monitored because measures may be weighted differently when they are aggregated to derive the performance score. Overall performance may also require minimum attainment of measure results. For example, in the 2013 Medicare Shared Saving Program for ACOs, the opportunity to earn a percentage of cost savings included a total of 23 measures across four domains. Each domain has a different number of measures, but each domain in total is weighted equally for the overall score. In addition, an ACO must have met at least 70% of the measures in each domain or be at risk for participating in the savings distribution. Hence, a high score in one domain will not compensate for a low score in another domain.

   See the appendix in this tool to review *CMS' Guide to Quality Performance Scoring Methods for Accountable Care Organizations*. Within this guide is a link to the quality measures standards. Note that new measures and scoring methods may be published toward the end of each calendar year.

5. **Understand the timing of the required reporting and monitor results more frequently.** This will ensure that any measure or measures that appear to be trending away from the desired result should be able to be identified in time for some corrective action to take place.

Display of Data Analysis

A variety of statistical tools are available to help monitor and display results. Personal preference or cost of tools may determine which are used. Control charts are one of the most commonly used tools to monitor quality. A basic control chart is illustrated below:



If sophisticated software is not available to the CCC program, a control chart can be generated easily from data in a spreadsheet. A key value of the control chart is that a target standard with upper and lower allowable tolerance limits can display data to show whether the data should desirably trend upward (quality) or downward (cost). Any result outside of the target range requires investigation. However, it should also be noted that non-randomness within the range should also be investigated. For example, if the target standard is 10, an upper allowable tolerance limit is 12, a lower allowable tolerance limit is 8, and for several weeks all scores are falling at approximately 11 and then suddenly drop to 9, then the sudden change (up or down) should be investigated.

The National Institute of Standards and Technology (NIST) is the federal government's standards-setting body. Additional information about control charts is available from NIST at: http://www.itl.nist.gov/div898/handbook/pmc/section3/pmc31.htm

Appendix: CMS Guide to Quality Performance Scoring Methods for Accountable Care Organizations

This Appendix provides guidance on quality performance scoring in the Medicare Shared Savings Program (Shared Savings Program) for all Accountable Care Organizations (ACOs).

Background

On November 2, 2011, the Centers for Medicare & Medicaid Services (CMS) finalized new rules[1] under the Affordable Care Act establishing the Shared Savings Program, under which doctors, hospitals, and other health care providers may work together to better coordinate care for Medicare patients through ACOs. The Shared Savings Program will reward ACOs that lower their growth in health care costs for assigned Medicare beneficiaries while meeting performance standards on quality of care.

As required by the Affordable Care Act, before an ACO can share in any savings generated it must demonstrate that it met the quality performance standards for that year. CMS will measure quality of care using 33 nationally recognized measures in four key domains:

1. Patient/caregiver experience (7 measures)
2. Care coordination/patient safety (6 measures)
3. Preventive health (8 measures)
4. At-risk population:
    a. Diabetes (6 measures)
    b. Hypertension (1 measure)
    c. Ischemic vascular disease (2 measures)
    d. Heart failure (1 measure)
    e. Coronary artery disease (CAD) (2 measures)

ACOs are required to completely and accurately report on all 33 measures for all quality measurement reporting periods in each performance year of their agreement period. For the Shared Savings Program, ACOs beginning their agreement period in April or July, 2012, there were two reporting periods in the first performance year, CY 2012 and 2013. For ACOs beginning their agreement periods in 2013 or later, each performance year and reporting period will correspond to the calendar year. Narrative and technical measure specifications for the ACO quality measures are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Quality Performance Scoring

The 33 quality measures will be reported through a combination of a Web interface designed for clinical quality measure reporting, patient/caregiver experience surveys, claims data, and Medicare and Medicaid electronic health records (EHR) Incentive Program data.

The Final Rule establishing the Shared Savings Program requires the administration of a standardized survey of patient/caregiver experience of care that is based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS). In 2012 and 2013, CMS administered and paid for the survey on behalf of ACOs participating in the Shared Savings

Program. This corresponds with the first performance year for ACOs that entered the program in 2012 or 2013. Beginning in 2014, Shared Savings Program ACOs will be responsible for selecting and paying for a CMS-certified vendor to administer the survey.

The Final Rules states that the 33 quality measure will be scored as 23 measures. CMS will consider the individual CAHPS measures (excluding the health status/functional status measure) together as one measure for scoring purposes. In addition, CMS will score the two finalized CAD measures as one composite and the five optimal diabetes care measures as one composite. Of note, in the care coordination domain, the EHR measure is double weighted both for scoring purposes and for purposes of determining poor performance.

Pay for Performance

The performance year and the reporting period for quality measurement purposes will be the 12-month period beginning on January 1 of each year during the agreement period (the term of the participation agreement, which begins at the start of the first performance year and concludes at the end of the final performance year).[2] For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO's first performance year is defined as 21 months or 18 months respectively. For quality measurement purposes, ACOs with a start date of April or July 2012 have two reporting periods (CY 2012 and CY 2013) in their first performance year, as stated in 42 CFR 425.608(c)(8). Pay for performance will be phased in over the ACO's first agreement period as follows:

- **Performance Year 1:** Pay for reporting applies to all 33 measures.
- **Performance Year 2:** Pay for performance applies to 25 measures and pay for reporting applies to 8 measures.
- **Performance Year 3:** Pay for performance applies to 32 measures and pay for reporting applies to 1 measure.

As pay-for-performance is phased in, benchmarks will be established for quality measures using a national sample of Medicare fee-for-service (FFS) claims data, Medicare Advantage (MA) quality data, or a flat percentage if FFS claims or MA quality data are not available.

Minimum Attainment Level for Quality Measures

For the first performance year, reporting periods 1 and 2 for Shared Savings Program ACOs with a 2012 start date (CY 2012 and 2013) "minimum attainment level" is defined in the Final Rule as complete and accurate reporting. Pay-for-performance is phased in beginning in Performance Year 2, reporting period 3 (CY 2014). For pay-for-performance measures, minimum attainment level is defined as 30 percent or the 30th percentile, depending on what performance data are available. Below this level, the ACO would score zero points for the measure.

An ACO may earn points for meeting the minimum attainment level on each measure. If the ACO crosses the minimum attainment level on at least one measure in each of the four domains, it will earn points and therefore be eligible to share in a portion of the savings it generates. The ACO must also meet the cost savings criteria to be eligible for shared savings payments.

Quality Scoring Points System

As illustrated in Table 1 below, a maximum of 2 points could be earned for each quality measure with one exception. Because CMS believes that EHR adoption is important for ACOs to be

successful in the Shared Savings Program, the EHR measure will be double weighted and will be worth up to 4 points to provide incentive for greater levels of EHR adoption.

Note that for scoring purposes in Table 1, each of the three composite measures (patient/caregiver experience, diabetes, and CAD) have been collapsed into a maximum of two points.

Table 1: Quality Scoring Points System

Total Points for Each Domain within the Quality Performance Standard Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points Per Domain	Domain Weight
Patient/Caregiver Experience	7	1 measure with 6 survey module measures combined, plus 1 individual measure	4	25%
Care Coordination/ Patient Safety	6	6 measures, plus the electronic health records measure double-weighted (4 points)	14	25%
Preventive Health	8	8 measures	16	25%
At-Risk Population	12	7 measures, including 5-component diabetes composite measure and 2-component coronary artery disease composite measure	14	25%
Total	**33**	**23**	**48**	**100%**

References

[1] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 Fed. Reg. 67802.

[2] Unless otherwise noted in the ACO agreement.

 Updated 01/07/2015

Produced under contract with The Office of the National Coordinator for Health Information Technology (ONC)

For support using the toolkit

Stratis Health • Health Information Technology Services

952-854-3306 • info@stratishealth.org

www.stratishealth.org

Key Health Alliance
Regional Extension Assistance Center for HIT

StratisHealth