
# Overview of Value-Based Payment Methods and the Role of Quality Scorecards

## CT SIM Quality Council

## April 1, 2015

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| 1. Value-Based Payments in Healthcare: an Overview | 20 min |
| 2. Quality Scorecards: Methods and Uses | 20 min |
| 3. Design Choices and Potential Implications for CT | 20 min |
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# Value-Based Payment Models: Overview

Major categories of value-based payment models include the following:

| Payment Model | Description |
|---|---|
| **A. Pay for Performance** | Umbrella term for models that tie a portion of provider reimbursement to performance on specific quality measures, typically on top of a FFS base. May be structured as a bonus or a withhold or penalty. |
| **B. Shared Savings** | Providers and payors share in the savings achieved on total healthcare expenditures for a defined patient population over a given time period as a result of care being provided in a more efficient manner. |
| **C. Bundled or Episode-based payment** | A specified payment is established for a grouping of services, for which a provider takes responsibility for the costs of those services. Bundle can be established either for a discrete episode of acute care over a defined period of time, or for treatment of a chronic condition over a defined period of time. |
| **D. Capitation** | Provider groups receive prospective fixed payment and take responsibility for managing some or all healthcare services. |
| **E. Management Payments** | Additional payments are made (often a per member per month or per member per year) in order to compensate for non-billable services such as care management. Typically found in a "patient-centered medical home" arrangement. Less commonly, may be in the form of enhanced fees. |
| **F. Infrastructure Grant** | Additional funding received from the payor for general or specified infrastructural investments, often to support an agreed upon initiative(s) |

# Shared Savings: Methodology

Shared savings contracts typically include the following components:

| Shared Savings | Description |
|---|---|
| **Overview** | Cost of care incentive where the provider org and payor share in the savings achieved over a given time period from more efficient care being provided<br>➢ One-sided or asymmetric: Providers have no downside risk – i.e., are not accountable if spending exceeds budget benchmarks<br>➢ Two-sided or symmetric; In addition to shared savings potential, providers are at risk for losses if spending exceeds projected benchmarks |
| **Components** | ▪ FFS base reimbursement<br>▪ Shared savings: if actual spending below target spending level, and savings are above a minimum savings requirement, providers and payors will split savings pool according to predetermined percentage, up to a cap<br>▪ Shared downside (two-sided model only): if actual spending is above a target spending level, and losses are greater than a minimum loss rate, providers and payors will split loss pool according to predetermined percentage, up to a cap |
| **Patient Attribution** | ▪ Beneficiaries may be assigned prospectively or retrospectively<br>▪ Generally based on where they received most of their primary care services over a given period, referred to as a "plurality" of services |
| **Payment Mechanics** | ▪ Providers receive FFS base reimbursement, with reconciliation at end of a defined period (typically annually) |

# Payment Design Features: Mechanics & Terminology

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## Shared Savings Payment Design Features

***Determine Which Patients "Belong" to Which Providers***

***Determine Expected Annual Total Cost of Care for Attributed Patient Population***

***Determine How Much Each ACO and Provider Earns in Incentive Payments***

***1. Patient Attribution***
Patients are assigned to a provider based on where they receive primary care or other secondary factors

***2A. Cost Calculation - Benchmark***
Total cost of care is estimated for patient panel attributed to provider


***2B. Cost Calculation - Risk Adjustment***
Estimated costs for population attributed to a provider are adjusted based on clinical and other risk factors

***3A. Payment Calculation-Shared Savings***
Amount of savings eligible to be paid to provider based on minimum savings rate. In downside risk arrangement, money owed back to payer if costs are above benchmark

***3B. Payment Calculation-Performance Component***
Clinical quality and patient experience metrics are used to qualify for shared savings payment and/or additional incentive payments

***3C. Payment Distribution***
Shared savings and other incentive payments are distributed amongst providers

*Note: This illustration refers to payment methods often referred to as "shared savings programs" or "total cost and quality contracts" A variety of other types of value-based contracts exist in the US marketplace.*

# Patient Attribution

| *1. Patient Attribution*  | **Method used to assign a patient to a provider in a shared savings model** |
|---|---|

## Overview of Prospective vs Retrospective Attribution Methodologies

**Shared Savings Program Contract Start Jan 1**

**End of First Performance Year Dec 31**

***Performance Year 1***

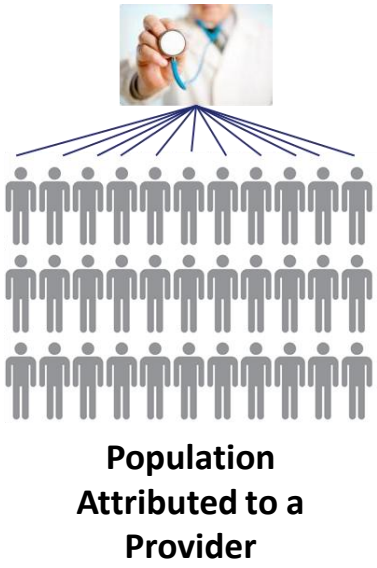
***When Are Patients Assigned?***

***How does it work?***

| ***Prospective Assignment*** | ***Retrospective Assignment*** |
|---|---|
| Patients assigned to providers at outset of performance year | Patients assigned to providers at end of performance year |
| **Methods Include:**<br>• Where the patient received care in prior year(s) (plurality of visits)<br>• Patient designates provider<br>• Insurer designates provider<br>• Geographic area dictates provider | **Methods Include:**<br>• Where the patient actually received care during the performance year (plurality of visits) |

# Cost Benchmark Calculation Overview

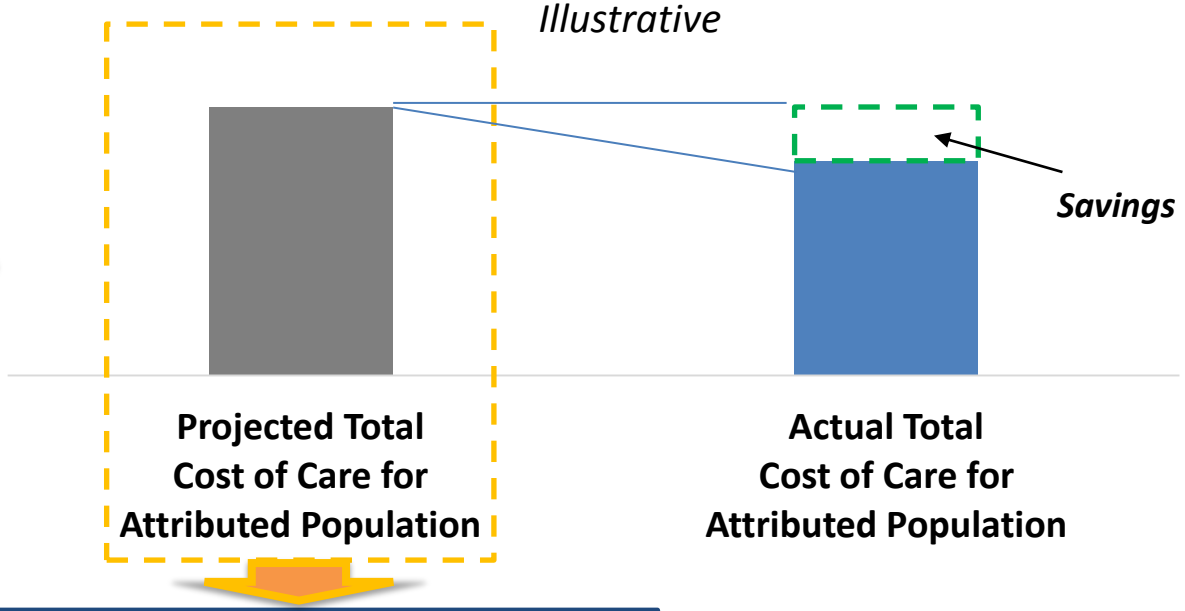
| *2. Cost Calculation (cost benchmark & risk adjustment)* | **Future cost estimation for population of patients attributed to a provider, from which shared savings calculations are determined** |
|---|---|



**Population Attributed to a Provider**

**How Shared Savings Are Calculated**

*Illustrative*




***How is the projected cost for the attributed population determined?***

*Step 1:* Define population used to determine cost benchmark

*Step 2:* Risk adjust cost benchmark

# Cost Benchmark Calculation Overview

| 2B. Cost Calculation (cost benchmark) | Population of patients used to determine cost benchmark for shared savings program |
|---|---|

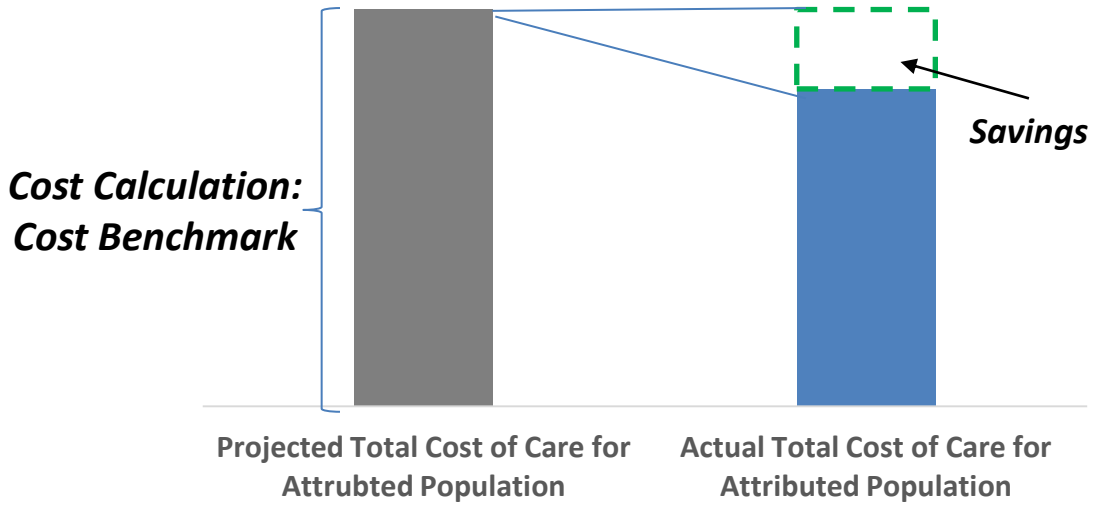
***Step 1:*** **Define population used to determine cost benchmark**

**1 Historical Costs:**
Uses past patient experiences of population attributed a provider to project future expenses for that population.

**2 Control Group Costs:**
A comparator group that ***is not*** based on the past experiences of the patients in the shared savings program. Control groups can be based on:

- What is considered to be best practice in the region
- The broader regional provider network, or
- A comparator group that is deemed to be similar

**How Shared Savings Are Calculated**
*Illustrative*



# Cost Benchmark Calculation Overview

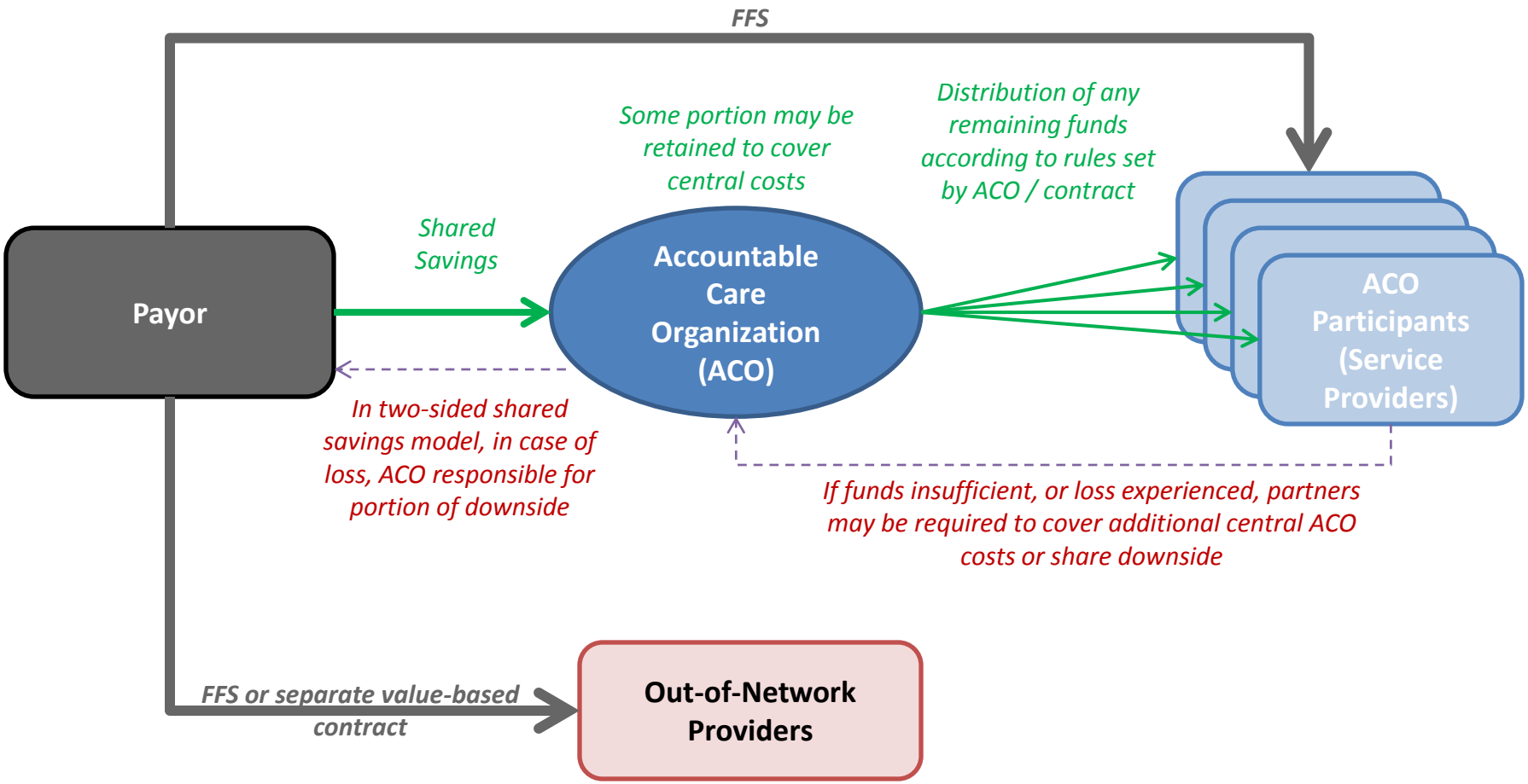
| | |
|---|---|
|  *2B. Cost Calculation (risk adjustment)* | **Additional method used to adjust future shared savings cost projections that accounts for the overall risk of the population as part of the cost projection. Risk adjustment takes into consideration demographics and the diagnoses of the population.** |

## ***Step 2:*** Risk adjust the cost benchmark

| Cost Benchmark Method | Role of Risk Adjustment |
|---|---|
| ***Historical Costs*** | • A historical cost benchmark will inherently account for risk as it is based on the actual prior care experiences of the attributed population.<br>• However, adjustment can be valuable as a way to more accurately predict how future costs are likely to vary from the historical snapshot. |
| ***Control Group Costs*** | • Unlike the historical cost benchmark, the control benchmark is based off of a population that is ***not part*** of the shared savings program and will not inherently account for the attributed population's level of risk.<br>• Risk adjustment provides an essential method to reflect the impact of risk on the cost benchmark, providing for an "apples to apples" comparison. |

# Shared Savings: Funds Flow Overview

## High-Level Overview of Funds Flow in a Shared Savings Contract



# Shared Savings Payment Calculation & Distribution

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**1 Payment Calculation**
How payers pay ACOs

**2 Payment Distribution**
How ACOs pay provider groups and providers

*Flow of Funds*

## Payer


*Enters into contracts with ACOs*

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## Accountable Care Organization (ACO)


*Enters into contracts with payers and distributes funds to provider organizations*

- Portion of Shared Savings
- Quality Bonus
- Care Coordination Fee (PMPM)

## Provider Group

MDs, PC

*Contracts with ACOs, pays its employed providers, and distributes earnings to owners*

- Fee For Service
- Portion of Shared Savings
- Quality Bonus
- Care Coordination Fee (PMPM)

## Provider

*Employed by and/or holds ownership interest in provider group*

- Base Salary + Productivity Incentive
- Portion of Shared Savings
- Quality Bonus

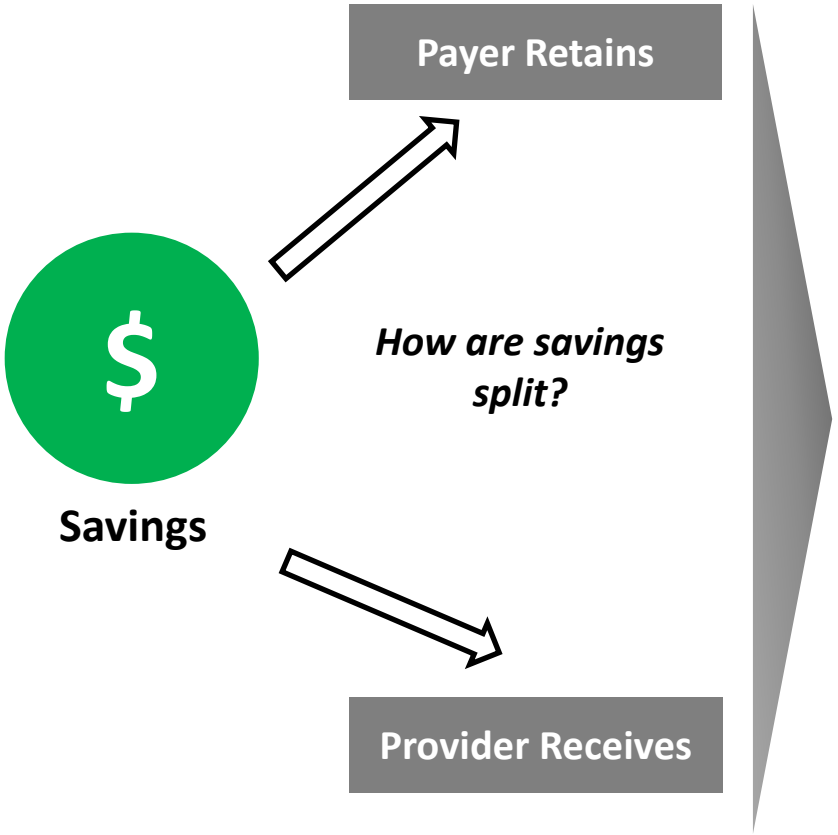
*Components of provider comp may or may not be directly funded by the group's shared savings or quality bonus pools*

**Key** = Typical contractual provision; = Less typical contractual provision

Note: an ACO can include one or multiple provider groups

# Share Savings Payment Calculation

***Additional considerations for how payment calculation is determined include:***

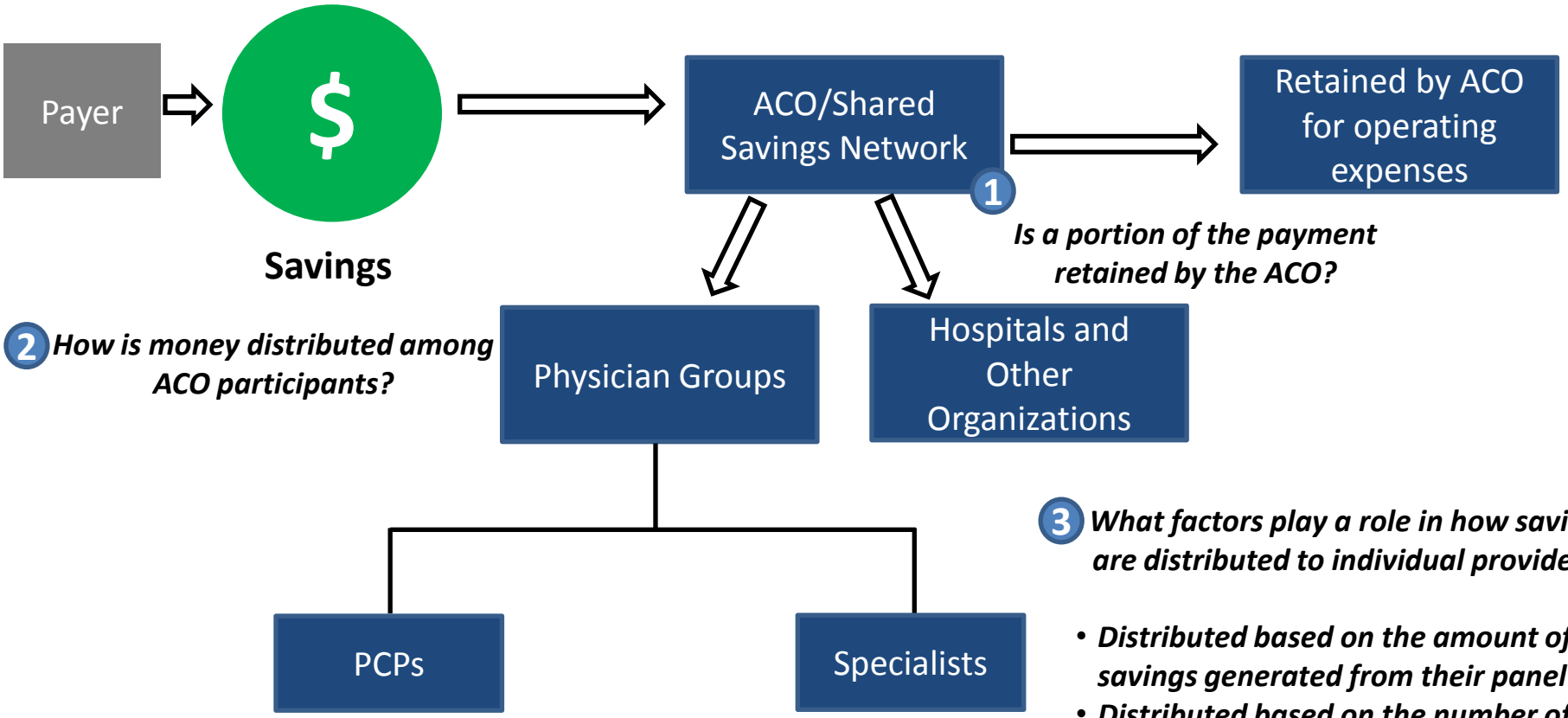



**Decision Points (*all assume quality thresholds are met*):**

| | |
|---|---|
| ***Is the savings amount fixed or varied?*** | **Fixed**: the % of savings will be the same as long as threshold quality targets are met, but will not increase with improved performance.<br>**Varied:** the % of savings the ACO receives will increase with quality performance that exceeds the quality threshold targets. |
| ***How is quality performance assessed?*** | **Benchmark:** Based on performance relative to others (i.e.; %ile rank).<br>**Improvement:** Based on the ACO's prior performance.<br>**Combined:** Blend of the benchmark and the improvement methods. Improvement helps to bring along lower performers while benchmark rewards high performers. |

# Shared Savings Payment Distribution

***Decisions about how payments are distributed within an ACO include:***




**3** ***What factors play a role in how savings are distributed to individual providers?***

- ***Distributed based on the amount of savings generated from their panel?***
- ***Distributed based on the number of attributed lives provider is managing?***
- ***Distributed based on reaching quality and patient experience targets?***
- ***A combination of all three?***

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| 2. Quality Scorecards: Methods and Uses | 20 min |
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# Quality Scorecards: Methods and Uses

The following steps are typically employed to derive and utilize quality scores in value-based contracts.

***Methods***

1. Define quality metrics
2. Calculate an ACO's raw scores for a given performance period
3. Convert raw scores to "points"
   - Assign directionality
   - Assign value of performance relative to a benchmark
   - Group and assign relative weight

***Uses***

4. Use points to:
   - Calculate payments for which the ACO is eligible
   - Provide performance feedback to providers
   - Provide performance data to consumers

# Quality Scorecards: Methods

1. Define quality metrics
2. Calculate an ACO's raw scores for a given performance period

For each metric, parameters include:

- Data source type(s)
- Pool of data to utilize
- Unit of measurement
- Measurement period
- Denominator definition and exclusions
- Numerator definition and exclusions
- Risk adjustment or stratification

Raw score expressed as a percentage (numerator over denominator) that can be interpreted as "observed" as a percent of "expected."

# Quality Scorecards: Methods

## 3 Convert raw scores to "points"

For each metric:

| Step | Key Questions |
|---|---|
| Assign directionality | Does a higher percentage indicate better or worse performance? |
| Assign value of performance relative to a benchmark | Against what pool of data will performance be benchmarked? E.g.:<br>• Own ACO prior performance or performance of others?<br>• All-provider or ACO-only?<br>• All-payer or single-payer?<br>• National or regional? |
| Group and assign relative weight | • Does the metric belong to a group of metrics related to a single topic?<br>• Will the metric be combined with other(s) to form a composite score?<br>• How much will the metric be worth relative to others? |

# Quality Scorecards: Methods

**3** Convert raw scores to "points": directionality and relative value

**MSSP 2014 Reporting Year ACO Quality Measure Benchmarks (Excerpt)**

| Domain | Measure | Description | Pay-for-Performance Phase In R= Reporting P= Performance | | | 30th perc. | 40th perc. | 50th perc. | 60th perc. | 70th perc. | 80th perc. | 90th perc. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | PY1 | PY2 | PY3* | | | | | | | |
| Preventive Health | ACO #21 | Proportion of Adults who had blood pressure screened in past 2 years | R | R | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| At-Risk Population Diabetes | Diabetes Composite ACO #22–26 | ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent)<br>ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL)<br>ACO #24. Blood Pressure (BP) < 140/90<br>ACO #25. Tobacco Non Use<br>ACO #26. Aspirin Use | R | R | P | 17.39 | 21.20 | 23.48 | 25.78 | 28.17 | 31.37 | 36.50 |
| At-Risk Population Diabetes | ACO #27 | Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) | R | P | P | 70.00 | 60.00 | 50.00 | 40.00 | 30.00 | 20.00 | 10.00 |
| At-Risk Population Hypertension | ACO #28 | Percent of beneficiaries with hypertension whose BP < 140/90 | R | P | P | 60.00 | 63.16 | 65.69 | 68.03 | 70.89 | 74.07 | 79.65 |
| At-Risk Population IVD | ACO #29 | Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl | R | R | P | 35.00 | 42.86 | 51.41 | 57.14 | 61.60 | 67.29 | 78.81 |
| At-Risk Population IVD | ACO #30 | Percent of beneficiaries with IVD who use Aspirin or other antithrombotic | R | P | P | 45.44 | 56.88 | 68.25 | 78.77 | 85.00 | 91.48 | 97.91 |
| At-Risk Population HF | ACO #31 | Beta-Blocker Therapy for LVSD | R | R | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| At-Risk Population CAD | CAD Composite ACO #32–33 | ACO #32. Drug Therapy for Lowering LDL Cholesterol<br>ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD | R | R | P | 54.08 | 61.44 | 66.11 | 69.96 | 72.32 | 76.40 | 79.84 |

*No Shared Savings Program ACO is in Performance Year 3 for the 2014 reporting year.

Source: CMS, Medicare Shared Savings Program Quality Measure Benchmarks for the 2014 Reporting Year, Feb 2015

# Quality Scorecards: Methods

**3** Convert raw scores to "points": group and assign weight

**MSSP 2014 Reporting Year: Total Points for Each Domain within the Quality Performance Standard**

| Domain | Number of Individual Measures | Total Measures for Scoring Purposes | Total Possible Points | Domain Weight |
|---|---|---|---|---|
| Patient/Caregiver Experience | 7 | 7 individual survey module measures | 14 | 25% |
| Care Coordination/ Patient Safety | 6 | 6 measures, the EHR measure is 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 in all Domains | 33 | 28 | 58 | 100% |

**MSSP Sliding Scale Measure Scoring Approach**

| ACO Performance Level | Quality points |
|---|---|
| 90+ percentile FFS data or 90+ percent | 2.00 points |
| 80+ percentile FFS data or 80+ percent | 1.85 points |
| 70+ percentile FFS data or 70+ percent | 1.70 points |
| 60+ percentile FFS data or 60+ percent | 1.55 points |
| 50+ percentile FFS data or 50+ percent | 1.40 points |
| 40+ percentile FFS data or 40+ percent | 1.25 points |
| 30+ percentile FFS data or 30+ percent | 1.10 point |
| <30 percentile FFS data or <30+ percent | No points |

Source: CMS, Medicare Shared Savings Program Quality Measure Benchmarks for the 2014 Reporting Year, Feb 2015

# Quality Scorecards: Uses

4 Use points to:

- Calculate payments for which the ACO is eligible
- Provide performance feedback to providers
- Provide performance data to consumers

Ways in which an ACO's quality performance typically translates into payments:

1. **Discrete P4P.** ACOs are paid directly for quality performance, instead of or in addition to cost performance.

2. **Binary Shared Savings Threshold.** ACOs are paid a fixed share of savings achieved provided that they hit a certain quality threshold or "gate."

3. **Shared Savings Escalator.** ACOs are paid an amount of shared savings that varies with quality performance (i.e. higher quality scores allow the ACO to keep a greater percentage of shared savings, up to a cap)

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# Design Choices and Implications

The following steps are typically employed to derive and utilize quality scores in value-based contracts.

## Potential Design Choices for CT

- Use of regional vs statewide vs national data to define benchmarks
- Use of single-payer vs multi-payer or all-payer benchmarks
- Use of ACO improvement over time vs single-year performance against benchmark to calculate ACO's quality points earned
- Weighting of different metric types

## Potential Implications

- Degree of provider participation in shared savings programs
- Reduction of disparities in access and outcomes
- Ability to incent and monitor continuous provider performance improvement
- Ease of implementation
- Ability of consumers to interpret and utilize information

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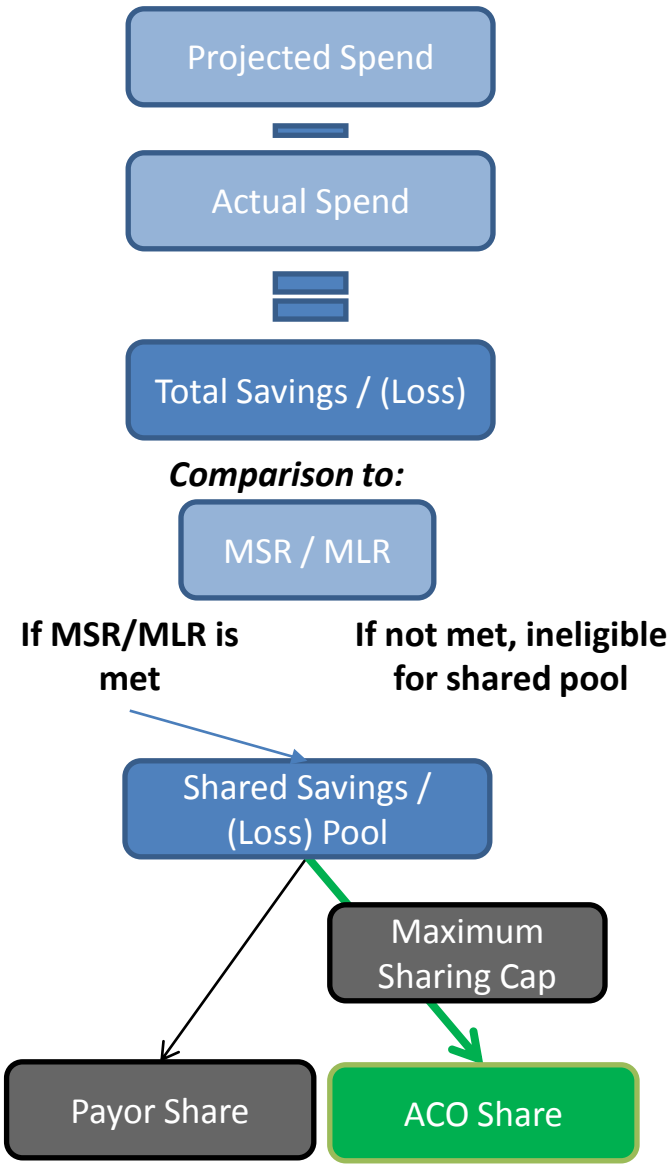
# Shared Savings Calculation Methodology




*Established using a **baseline** and an **inflator** , typically based on provider's historical or market's actual increase, plus in some cases a risk adjustment factor. In future years the baseline may be **rebased,** creating a potentially more difficult target.*

*Actual cost of year for attributed population for the time period*

*Total available savings or loss*

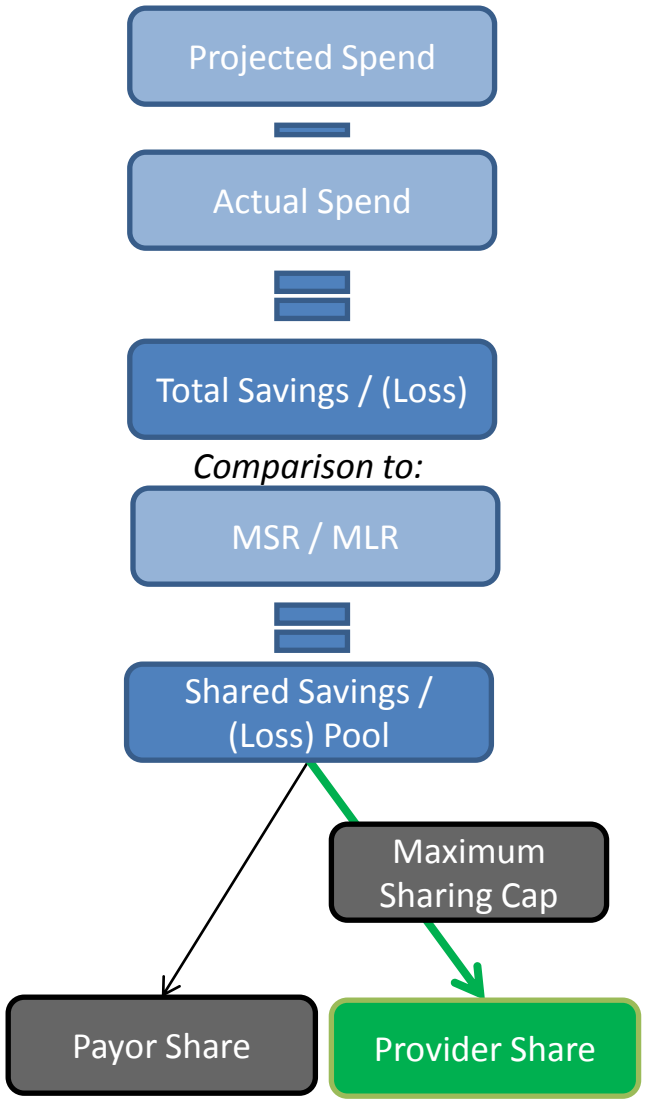
*Minimum savings requirement (MSR) percentage that must be achieved before savings can be shared (e.g., MSSP MSR ~2-3% based on size of population) or minimum loss rate (MLR) percentage in two-sided model only (e.g., MSSP MLR =2%)*

*Pool available for shared savings / loss after MSR/MLR have been hit. Note that in MSSP, participants are eligible for 1st dollar savings (i.e., % of total pool). In other models, eligible pool is only that above MSR/MLR. In most models, participants must also hit a threshold quality score, and the amount of savings is also related to quality performance.*

*Maximum sharing cap percentage for provider which limits upside and protects provider against downside (in two-sided)*

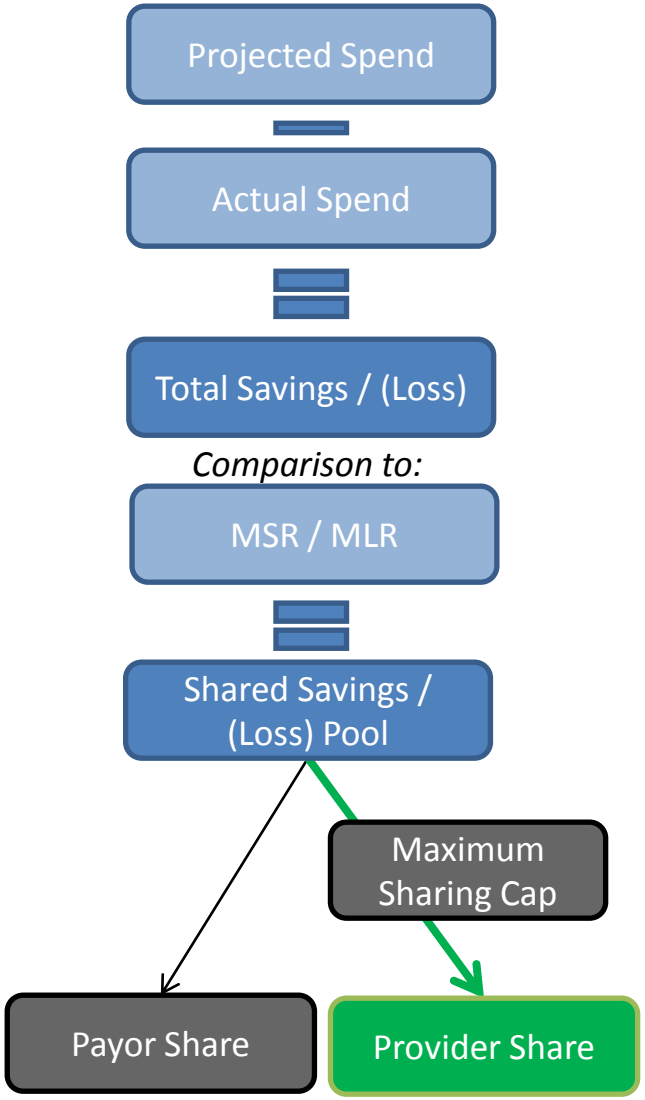
*Payor / Provider maximum percentage-based split of shared savings or loss (in two-sided). Typically provider share % of upside is higher in two-sided model because they also are sharing in risk. Usually providers must also meet a quality performance target to get full share.*

# Shared Savings Calculation Example




| | One-Sided | Two-Sided |
|---|---|---|
| Projected Spend | $500 | $500 |
| Actual Spend | $480 | $480 |
| Total Savings / (Loss) | $20 | $20 |
| MSR / MLR | MSR: 2% = $10 | MSR: 2% = $10 |
| | *Savings is above MSR; Eligible for 1st dollar savings* | |
| Shared Savings / (Loss) Pool | $20 | $20 |
| Maximum Sharing Cap | Cap: 10%. Savings is below cap so entirety of savings can be shared. | Cap:15%. Savings is below cap so entirety of savings can be shared. |
| Payor Share / Provider Share | Provider: 50% = $10<br>Payor: 50% = $10 | Provider: 60% = $12<br>Payor: 40% = $8 |

# Shared Savings Calculation Example




| | One-Sided | Two-Sided |
|---|---|---|
| Projected Spend | $500 | $500 |
| Actual Spend | $495 | $495 |
| Total Savings / (Loss) | $5 | $5 |
| MSR / MLR | MSR: 2% = $10 | MSR: 2% = $10 |
| Shared Savings / (Loss) Pool | $0 | $0 |
| Maximum Sharing Cap | Cap: N/A because savings is less than MSR | Cap: N/A because savings is less than MSR |
| Payor Share / Provider Share | Provider: 50% = $0<br>Payor: 50% = $0 | Provider: 60% = $0<br>Payor: 40% = $0 |

*Even though spend below projection, savings achieved is below MSR*

# MSSP Benchmark Sources

We established the benchmarks using all available and applicable 2012 Medicare fee-for-service (FFS) data. This includes:

- Quality data reported through the Physician Quality Reporting System (PQRS) by physicians and groups of physicians
- Quality measure data calculated from Medicare claims data submitted by physicians and groups of physicians
- Quality data reported by ACOs, including ACOs participating in the Pioneer ACO Model
- Quality measure data collected from surveys administered to the larger Medicare FFS population including under pay-for-performance demonstrations.

Benchmarks for most measures in the Care Coordination / Patient Safety, Preventive Health and At-Risk Population domains were established using all available FFS data from calendar year 2012. These data were collected under the PQRS and include:

- Data collected from ACOs participating in the Shared Saving Program and the Pioneer ACO Model, and other groups that satisfactorily reported data through the PQRS Group Practice Reporting Option (GPRO) Web Interface.
- Data collected from eligible professionals (EPs) and group practices eligible for the PQRS incentive payment reporting through all available submission mechanisms for the PQRS, including, for example: claims, registry, Electronic Health Records (EHR), and measures group.

The benchmarks for the all-condition readmission measure (ACO #8) and the ambulatory sensitive condition admissions measures for chronic obstructive pulmonary disease (COPD) or asthma in older adults (ACO #9) and heart failure (ACO #10) are calculated using 2012 Medicare FFS claims data. We calculated these benchmarks using data at the TIN level for all physicians and groups of physicians who had at least 20 cases in the denominator.

For the EHR measure (ACO #11), we used results from Shared Savings Program and Pioneer ACO Model ACOs for 2012 to establish the performance benchmark. Benchmarks for the Patient / Caregiver Experience measures were developed based on survey data collected from beneficiaries with FFS Medicare in 2013 regarding their care experiences during calendar year 2012. These data include:

- Responses to CMS' CAHPS Survey for Accountable Care Organizations Participating in Medicare Initiatives by beneficiaries assigned to ACOs participating in the Shared Savings Program or the Pioneer ACO Model
- Responses to CMS' Medicare FFS CAHPS Survey by beneficiaries with FFS Medicare, including beneficiaries receiving services under FFS demonstrations.

We haven't defined a benchmark for the health status/functional status measure (ACO #7) because the measure remains pay-for-reporting in all performance years of an ACO's agreement period.

Source: CMS, Medicare Shared Savings Program Quality Measure Benchmarks for the 2014 Reporting Year, Feb 2015

# Quality Scorecards: Methods

**3** Convert raw scores to "points": directionality and relative value

**MSSP 2014 Reporting Year ACO Quality Measure Benchmarks (Excerpt)**

| Domain | Measure | Description | Pay-for-Performance Phase In R= Reporting P= Performance | | | 30th perc. | 40th perc. | 50th perc. | 60th perc. | 70th perc. | 80th perc. | 90th perc. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | PY1 | PY2 | PY3* | | | | | | | |
| Patient/Caregiver Experience | ACO #1 | Getting Timely Care, Appointments, and Information | R | P | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| Patient/Caregiver Experience | ACO #2 | How Well Your Doctors Communicate | R | P | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| Patient/Caregiver Experience | ACO #3 | Patients' Rating of Doctor | R | P | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| Patient/Caregiver Experience | ACO #4 | Access to Specialists | R | P | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| Patient/Caregiver Experience | ACO #5 | Health Promotion and Education | R | P | P | 54.71 | 55.59 | 56.45 | 57.63 | 58.22 | 59.09 | 60.71 |
| Patient/Caregiver Experience | ACO #6 | Shared Decision Making | R | P | P | 72.87 | 73.37 | 73.91 | 74.51 | 75.25 | 75.82 | 76.71 |
| Patient/Caregiver Experience | ACO #7 | Health Status/Functional Status | R | R | R | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Care Coordination/Patient Safety | ACO #8 | Risk Standardized, All Condition Readmissions | R | R | P | 16.62 | 16.41 | 16.24 | 16.08 | 15.91 | 15.72 | 15.45 |
| Care Coordination/Patient Safety | ACO #9 | ASC Admissions: COPD or Asthma in Older Adults | R | P | P | 1.75 | 1.46 | 1.23 | 1.00 | 0.75 | 0.56 | 0.27 |
| Care Coordination/Patient Safety | ACO #10 | ASC Admission: Heart Failure | R | P | P | 1.33 | 1.17 | 1.04 | 0.90 | 0.76 | 0.59 | 0.38 |
| Care Coordination/Patient Safety | ACO #11 | Percent of PCPs who Qualified for EHR Incentive Payment | R | P | P | 51.35 | 59.70 | 65.38 | 70.20 | 76.15 | 84.85 | 90.91 |
| Care Coordination/Patient Safety | ACO #12 | Medication Reconciliation | R | P | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| Care Coordination/Patient Safety | ACO #13 | Falls: Screening for Fall Risk | R | P | P | 17.12 | 22.35 | 27.86 | 35.55 | 42.32 | 51.87 | 73.38 |
| Preventive Health | ACO #14 | Influenza Immunization | R | P | P | 29.41 | 39.04 | 48.29 | 58.60 | 75.93 | 97.30 | 100.00 |
| Preventive Health | ACO #15 | Pneumococcal Vaccination | R | P | P | 23.78 | 39.94 | 54.62 | 70.66 | 84.55 | 96.64 | 100.00 |
| Preventive Health | ACO #16 | Adult Weight Screening and Follow-up | R | P | P | 40.79 | 44.73 | 49.93 | 66.35 | 91.34 | 99.09 | 100.00 |
| Preventive Health | ACO #17 | Tobacco Use Assessment and Cessation Intervention | R | P | P | 30.00 | 40.00 | 50.00 | 60.00 | 70.00 | 80.00 | 90.00 |
| Preventive Health | ACO #18 | Depression Screening | R | P | P | 5.31 | 10.26 | 16.84 | 23.08 | 31.43 | 39.97 | 51.81 |
| Preventive Health | ACO #19 | Colorectal Cancer Screening | R | R | P | 19.81 | 33.93 | 48.49 | 63.29 | 78.13 | 94.73 | 100.00 |
| Preventive Health | ACO #20 | Mammography Screening | R | R | P | 28.59 | 42.86 | 54.64 | 65.66 | 76.43 | 88.31 | 99.56 |

Source: CMS, Medicare Shared Savings Program Quality Measure Benchmarks for the 2014 Reporting Year, Feb 2015

# Achievement vs Improvement Example

**ACO Performance Period 1 Score: 40%**
**ACO Performance Period 2 Score: 45%**

**Performance Period 2 %tiles**

| 30th %tile | 40th %tile | 50th %tile | 60th %tile | 70th %tile | 80th %tile |
|---|---|---|---|---|---|
| 20% | 30% | 35% | 40% | 45% | 55% |

**Achievement Approach**

**Improvement Approach**

## Sliding Scale

| Percentile | Points |
|---|---|
| < 30th ("minimum attainment threshold") | 0.0 |
| 30th - < 40th | 1.0 |
| 40th - < 50th | 1.2 |
| 50th - < 60th | 1.4 |
| 60th - < 70th | 1.6 |
| 70th - < 80th | 1.8 |
| ≥ 80th ("upper threshold") | 2.0 |

Calculation:
Performance Period 2 = 45%
45% = 70th percentile
**Achievement points earned = 1.8**

## Sliding Scale

| Percent (%) Relative Improvement | Points |
|---|---|
| < 5% | 0.0 |
| 5% - < 6% | 1.0 |
| 6% - < 7% | 1.2 |
| 7% - < 8% | 1.4 |
| 8% - < 9% | 1.6 |
| 9% - < 10% | 1.8 |

Calculation:
45% -40% = 5% absolute improvement
5%/40% = 12.5% relative improvement
**Improvement points earned = 2 points**

Source: Minnesota's Integrated Health Partnerships (IHP) via CMMI