Health Industry Forum

Key Policy Issues in the Evolution of Medicare ACO Programs

June 3, 2014
7 ACO Policy Issues

1. Assignment
2. Financial Benchmarks
3. Minimum Savings Rate
4. Pathway to Higher Risk
5. Risk Adjustment
6. Quality Measures
7. Data
MSSP Issue #1: Assignment

- ACO defined as a collection of Medicare-enrolled tax ID numbers (TINs) practicing as a group practice arrangement or network.

- **Two step assignment process**, first step based on **plurality** of primary care services (allowed charges) provided by primary care physicians, second step based on primary care services provided by other ACO professionals, including specialists, NPs, PAs, and CNSs.

- **Preliminary prospective determination with final assignment determined at year-end.**

- **Primary care physicians** defined as family practice, general practice, geriatrics and internal medicine.
  
  - **Primary care codes** include: 99201-99215, 99304-99340, 99341-99350, G0438, G0439 and G0402, as well as FQHC/RHC revenue codes 0521, 0522, 0524, and 0525

- ACO participant TINs upon which beneficiary assignment is dependent (not just primary care physicians) must be **exclusive to one ACO**. Other ACO participants (e.g., hospitals) could participate in multiple ACOs. Or physicians billing under separate TINs.
MSSP Issue #1: Assignment

Problems:

• Use of assignment methodology results in significant beneficiary “turnover” in and out of an ACO’s assigned population
• Estimates of 20-30% per year (some reported higher)
• Prospective attribution only modestly improves the stability of the population
• Beneficiaries often come and go from the data stream due to tentative assignment to different ACOs throughout the year
• No-utilizers always churned out

Solutions:

• Use of a beneficiary enrollment model
• Use of a hybrid beneficiary “attestation” and assignment model
• Once attributed, cannot drop out unless assigned to another ACO
• Allow beneficiaries to stay in the data feeds for the whole year once they have tentatively assigned (so may be in more than 1 feed)
• Allow ACOs to waive Part B primary care copays
MSSP Issue #2: Financial Benchmarks

- Start with most recent 3 years of per-capita Medicare Parts A and B FFS expenditures for attributed beneficiaries during that period.
  - 3-month claims “run-out” period to calculate the benchmark.

- Spending truncated at 99th percentile of per capita spending.

- Beneficiary risk and growth trend adjusted across 3 base years, with full risk adjustment for newly assigned beneficiaries.

- Excludes incentive payments for Physician Quality Reporting System, eRx, and EHR “meaningful use” program, even those for hospitals.

- Excludes teaching and disproportionate share payments.

- Updates the benchmark by absolute dollar growth in national per capita FFS Parts A and B spending.
MSSP Issue #2: Financial Benchmarks

**Problems:**
- Setting trend based on all beneficiaries nationally
- Instability of the benchmarks from attribution churn
- Harder to find savings in low-cost areas
- Trending is national but really varies by region

**Solutions:**
- Address the assignment issues
- Set the trend based on an attributable population
- Adopt regional trending model
- Prospectively set the targets
- Minimize policy change adjustments
- Remove renormalization
Medicare Issue #3: Payment Model – Minimum Savings Rate

**Track 1**
- One-sided (shared savings only) risk model
- Caps savings at 10% of benchmark
- Threshold of 2%-3.9% depending on size of population
- Once MSR met, share up to 50% of first dollar savings depending on quality scores

**Track 2**
- Two-sided risk (shared savings and losses)
- Up to 60% shared savings
- First dollar savings/loss after 2% MSR surpassed
- Caps savings at 15% of benchmark
- Caps losses at 5% in year 1, 7.5% in year 2, and 10% in year 3
Minimum Savings Rate (MSR) by number of aligned beneficiaries

<table>
<thead>
<tr>
<th>Number of Aligned Beneficiaries</th>
<th>Minimum Savings Rate (low end)</th>
<th>Minimum Savings Rate (high end)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000 – 5,999</td>
<td>1.5</td>
<td>2.0</td>
</tr>
<tr>
<td>6,000 – 6,999</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>7,000 – 7,999</td>
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<td>8,000 – 8,999</td>
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<td>3.5</td>
</tr>
<tr>
<td>9,000 – 9,999</td>
<td>3.5</td>
<td>4.0</td>
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<td>10,000 – 14,999</td>
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<td>50,000 – 59,999</td>
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<tr>
<td>60,000</td>
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</tbody>
</table>

**Legend:**
- Minimum Savings Rate (low end of aligned beneficiaries (percent))
- Minimum Savings Rate (high end of aligned beneficiaries (percent))
MSSP Issue #3: Payment Model – Minimum Savings Rate

Problem:
- MSR resulted in 25% of ACOs with savings not receiving any payment
- Considered unfair that CMS keeps all those savings
- Minimum Savings Rate very high for some ACOs, especially small ACOs in low-cost areas

Solution:
- Eliminate MSR for 1-sided ACOs
- Reduce MSR for 1-sided ACOs
- Modify MSR for low/high cost areas
Background:

- Less than 5% of ACOs elected 2-sided risk track, thus 95% will be required to shift to 2-sided risk in second ACO contract (year 4).
- 2-sided risk requires insurance license and reserves in some states.
- ACOs are investing $1-3 million per year in infrastructure.
- Due to delays in claims run-out and reconciliation, ACOs may have to decide about their second contract with only PY1 results.
- Surveys show less than a third will stay in program.

### ACO Performance

<table>
<thead>
<tr>
<th>ACO Performance * Interim 2012 results</th>
<th>Total Savings as a Percent of the Target</th>
<th>Total Savings per Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOs Generating Shared Savings (N=29)</td>
<td>5.90%</td>
<td>$660</td>
</tr>
<tr>
<td>ACOs Positive but within Corridor (N = 25)</td>
<td>1.30%</td>
<td>$134</td>
</tr>
<tr>
<td>ACOs Negative but within Corridor (N = 29)</td>
<td>-1.10%</td>
<td>-$95</td>
</tr>
<tr>
<td>ACOs Negative outside Corridor (N = 31)</td>
<td>-5.30%</td>
<td>-$536</td>
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</tbody>
</table>
MSSP Issue #4: Payment Model - Pathway to Higher Risk

Problems:

- How to avoid significant contraction of the ACO program
- How to give ACOs more time to recoup their investments
- Capital intensive state licensure requirements
- Risk of violating bond conveniences

Solutions:

- Delay or remove requirement to shift to 2-sided track
- Improve the savings model so more recoup their investments
  - Sharing rate
  - Alter quality benchmarking system
  - Reduce or remove MSR
MSSP Issue #5: Risk Adjustment

MSSP uses the Hierarchical Condition Categories (HCC) to risk adjust the MSSP payments.

The scores are calculated separately for 4 groups:
- Aged, non-disabled
- Disabled
- Dual eligibles
- ESRD

Newly enrolled beneficiaries can cause the ACO’s risk score to increase.

Only demographic shifts can increase the risk score of the continuously enrolled population.

Both demographics and acuity shifts can decrease the risk of the continuously enrolled population.
MSSP Issue #5: Risk Adjustment

Problem:

- Unfair application of risk adjustment that allows all factors to decrease risk, but only certain factors to increase

Solution:

- Allow risk scores to grow for continuously assigned beneficiaries
- Use demographics only
- Research new methods
MSSP Issue #6: Quality—Measures

Pay for performance will be phased in over the ACO's first agreement period as follows:
- Year 1: Pay for reporting applies to all 33 measures.
- Year 2: Pay for performance applies to 25 measures. Pay for reporting applies to eight measures.
- Year 3: Pay for performance applies to 32 measures. Pay for reporting applies to one measure that is a survey measure of functional status. Measure for percentage of PCP meeting EHR certification is weighted double.

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Number of Measures</th>
<th>Measure Steward (Owner)</th>
<th>Data Collection Mode</th>
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<tbody>
<tr>
<td>Preventive Health</td>
<td>8 Measures</td>
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<tr>
<td></td>
<td>3</td>
<td>NCQA (2 HEDIS measures)</td>
<td>GPRO Data Collection Tool</td>
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<tr>
<td></td>
<td>2</td>
<td>AHRQ</td>
<td>GPRO Data Collection Tool</td>
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<td>2</td>
<td>AMA-PCPI</td>
<td>GPRO Data Collection Tool</td>
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<td>1</td>
<td>CMS</td>
<td>GPRO Data Collection Tool</td>
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<td>At Risk Population</td>
<td>12 Measures</td>
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<td>MN – Community Measurement</td>
<td>GPRO Data Collection Tool</td>
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<tr>
<td></td>
<td>4</td>
<td>NCQA (2 HEDIS measures)</td>
<td>GPRO Data Collection Tool</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>CMS / AMA-PCPI</td>
<td>GPRO Data Collection Tool</td>
</tr>
<tr>
<td>Patient/Care Giver Exp</td>
<td>7 Measures</td>
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<td>7</td>
<td>AHRQ</td>
<td>Clinician Group CAHPS Survey</td>
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<td>2</td>
<td>AHRQ ACSC</td>
<td>Claims</td>
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<td>Care Coordination / Patient Safety</td>
<td>6 Measures</td>
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<td>CMS</td>
<td>EHR Incentive Program Reporting (Meaningful Use)</td>
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<td>CMS</td>
<td>Claims</td>
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<tr>
<td></td>
<td>1</td>
<td>NCQA (not a HEDIS measure)</td>
<td>GPRO Data Collection Tool</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>AMA-PCPI/ NCQA</td>
<td>GPRO Data Collection Tool</td>
</tr>
</tbody>
</table>

Shared Savings
MSSP Issue #6: Quality—Scoring

• Benchmarks based on PQRS and ACO data

• Performance below the minimum attainment level for a measure will receive zero points for that measure.

• Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance.

• Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.

• Performance at or above 90 percent or the 90th percentile of the performance benchmark earns the maximum points available for the measure.

• The overall score is applied to the savings potential to determine an ACO’s share of the savings (e.g. 80% overall score x 50% = 40% of savings).
| MSSP Measure | MSSP Benchmark 90th percentile PY 2014-2015 | MSSP Summary Statistic 90th percentile PY 2012 | NCQA HEDIS Medicare HMO 90th percentile MY 2012 | NCQA HEDIS Medicaid HMO 90th percentile MY 2012 | CDC’s Healthy People Goal 2020

#9 – ASC Admissions: COPD or Asthma in Older Adults | 0.0% | 0.76% | No reasonable comparison publicly available, given CMS’ customization

#14 - Influenza Immunization [6mos.+] | 100.00% | 70.62% | 78.70% (MY 2011) | n/a (child only) | 6mos-17yr: 80.00% 18yr.+: 90.00%

#15 - Pneumococcal Vaccination [65+] | 100.00% | 81.05% | 83.10% (MY 2011) | n/a (child only) | 65yr.+: 90.00%

#16 - Adult Weight Screening and F/U [18+] | 100.00% | 75.80% | 95.40% | 84.40% | Adults: 53.60%

#19 - Colorectal Cancer Screening [50-75] | 100.00% | 86.53% | 77.00% | n/a | 50-75yr.: 70.50%

#20 - Mammography Screening [40-69] | 99.56% | 76.03% | 82.20% | 62.90% | 50-74yr.: 81.10%
MSSP Issue #6: Quality—Benchmarks

Problems:

- Assumes a level of precision with measurement that supports ranking of providers
- Unrealistic benchmarks biased toward large, experienced medical groups in PQRS
- ACOs are included in the database for calculating the benchmarks so by definition some portion will not achieve full savings
- Quality scores reduces savings rather than triggering bonuses
- Submission process extremely burdensome
- Major confusion around the measure definitions

Solutions:

- Reset the benchmark expectations
  » Remove arbitrary flat percentage benchmarks
  » Use additional data sources for benchmarks
- Allow improvement in quality scores to count equally to achieving the benchmarks
MSSP Issue #7: Data

- Part A and B data drive benchmark and reconciliation.
- Application – CMS provides estimated attribution list to determine # of lives and benchmark
- Quarterly ACO requests and receives claims data and attribution at that point in time
- At end of P1, after claims run-out, ACO receives who was finally attributed to ACO and their final benchmark
- Using the claims data they retrospectively try to explain what patients contributed to the over/under and why their denominator changed by 30-50% over the year
- No data is real-time to help manage patient care
MSSP Issue #7: Data—included information

1. Cost and utilization
   • Aggregate data reports on quality and utilization at the start of the agreement period based on the historical beneficiaries used to calculate the benchmark, and quarterly thereafter (most recent 12-mo).

2. Attribution
   • ACO can request a list of attributed beneficiaries included in the benchmark and at the end of each performance period:
     » Name,
     » Date of Birth,
     » Sex,
     » Health Insurance Claim Number (HIC)

3. Claim Feeds
   • Subject to a beneficiary “opt-out”, an ACO can request monthly Part A, B and D claims data for potentially assigned beneficiaries for purposes of evaluating performance, quality, and population-based activities.

4. Reconciliation Reports
   • Annually 6-9 months after the end of the each performance period
MSSP Issue #7: Data—Problems

Problems:

- No single report tells an ACO if they are above or below target.
- Quarterly financial and utilization reports ($/pmpm, hosp days, etc) do not breakdown by patient and are for rolling year with no quarter breakdowns yet attribution and claims are quarterly.
- Quarterly Claims (CCLF) are on a different time cycle and incomplete and have no population (denominator).
- Big gaps in claims data (eg substance abuse, opt-outs), sometimes 20% of costs.
- No report helps with real-time care yet CMS has the eligibility “ping” data that would tell ACOs real-time when major event is occurring.
MSSP Issue #7: Data—Solutions

Solutions:

- Greater ability to disaggregate the utilization/cost statistics
  » (e.g., allow readmission rate drill down to the patient ID or NPI)
- Break rolling 12 month utilization/cost reports into discrete quarters
- Provide additional data fields in attribution report:
  » Address, institutional status, NPI, HHC markers, plus 10 others.
- Fill in $ gaps for missing claims by providing de-identified claims or at least total dollar value so total claims $ = expenditures in other reports and reconciliation
- Provide denominator with claims data so rates can be calculated
- Provide provider-specific de-identified claims at the start of program so ACOs can start working with providers
- Make available CMS beneficiary eligibility “ping” data to ACOs
- Reconciliation- Improve transparency and auditability by including samples of individual beneficiary cost data that are used in determining performance benchmark and results
Questions?
APPENDIX
Medicare Issue #3: Payment Model

- Actual spending
- Shared losses
  - Minimum Loss Rate (Track2)
- Projected spending
- Minimum Savings Rate
- Shared savings
  - Actual spending

ACO Launched
More About the Measures (Annual Measurement)

- Data sources for the measures range from Medicare’s payor claims data, medical record data and beneficiary survey data.
- Most of the non-survey measures will rely on CMS’ Group Practice Reporting Option (GPRO) web-based tool to submit results for samples of eligible beneficiaries:
  - Pre-populated with data available from claims
  - ACO would need to enter supplemental data from medical records
- Additionally, CMS is committing in their final rule to do additional quality monitoring on an on-going basis, using their claims to identify:
  - Patterns of avoiding at-risk beneficiaries
  - Misuse / underuse or overuse of services over time
- CMS finalized the use of the Clinical Group CAHPS and will administer and pay for the data collection on behalf of contracted ACOs for first two years.
- All measures will be reported on calendar year cycles, and measures for CY2012 are required for ACOs electing interim payment; for CY2013 for others starting in 2012.
Scoring of Quality Performance

Performance Scoring (for Years 2 and 3; mock for Year 1)

• CMS sets benchmarks at beginning of each reporting year using FFS and ACO data
• Points are assigned to each measure (and summed by domain) based on performance related to the MSSP benchmark
• The minimum attainment level is set at 30% or the 30th percentile of the performance benchmark (must achieve this for one measure per domain)
  » If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated
  » ACOs must score above the minimum attainment level determined by CMS on 70% of the measures in each domain
• Domain scores are determined by dividing the actual points by the maximum potential points to determine a % of performance
• The overall score is applied to the savings potential to determine an ACO’s share of the savings (e.g. 80% overall score x 50% = 40% of savings)
# CMS 33 Quality measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure # Measure Steward</th>
<th>Method of Data Submission</th>
<th>Pay for Performance Phase In</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM: Better Care for Individuals</td>
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<td></td>
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</tr>
<tr>
<td>1. Patient/Caregiver Experience</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
<td>R</td>
</tr>
<tr>
<td>2. Patient/Caregiver Experience</td>
<td>CAHPS: How Well Your Doctors Communicate</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
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<tr>
<td>3. Patient/Caregiver Experience</td>
<td>CAHPS: Patients' Rating of Doctor</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
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<tr>
<td>4. Patient/Caregiver Experience</td>
<td>CAHPS: Access to Specialists</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
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<tr>
<td>5. Patient/Caregiver Experience</td>
<td>CAHPS: Health Promotion and Education</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
<td>R</td>
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<tr>
<td>6. Patient/Caregiver Experience</td>
<td>CAHPS: Shared Decision Making</td>
<td>NQF #5 AHRQ</td>
<td>Survey</td>
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<td>7. Patient/Caregiver Experience</td>
<td>CAHPS: Health Status/Functional Status</td>
<td>NQF #6 AHRQ</td>
<td>Survey</td>
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<td>8. Care Coordination/ Patient Safety</td>
<td>Risk Standardized, All Condition Readmission*</td>
<td>NQF #TBD CMS</td>
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<tr>
<td>9. Care Coordination/ Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator (PQI) #5)</td>
<td>NQF #275 AHRQ</td>
<td>Claims</td>
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<tr>
<td>10. Care Coordination/ Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)</td>
<td>NQF #277 AHRQ</td>
<td>Claims</td>
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<tr>
<td>11. Care Coordination/ Patient Safety</td>
<td>Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment</td>
<td>CMS</td>
<td>EHR Incentive Program Reporting</td>
<td>R</td>
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<td>12. Care Coordination/ Patient Safety</td>
<td>Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility</td>
<td>NQF #97 AMA-PCPI/NCQA</td>
<td>GPRO Web Interface</td>
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<td>13. Care Coordination/ Patient Safety</td>
<td>Falls: Screening for Fall Risk</td>
<td>NQF #101 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>AIM: Better Health for Populations</td>
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<td>14. Preventive Health</td>
<td>Influenza Immunization</td>
<td>NQF #41 AMA-PCPI</td>
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### CMS 33 Quality measures (Continued)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure #</th>
<th>Measure Steward</th>
<th>Method of Data Submission</th>
<th>Pay for Performance Phase In</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Preventive Health</td>
<td>Pneumococcal Vaccination</td>
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<td>NCQA</td>
<td>GPRO Web Interface</td>
<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
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<td>16. Preventive Health</td>
<td>Adult Weight Screening and Follow-up</td>
<td>NQF #421</td>
<td>CMS</td>
<td>GPRO Web Interface</td>
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<td>17. Preventive Health</td>
<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
<td>NQF #28</td>
<td>AMA-PCPI</td>
<td>GPRO Web Interface</td>
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<td>18. Preventive Health</td>
<td>Depression Screening</td>
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<td>19. Preventive Health</td>
<td>Colorectal Cancer Screening</td>
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<td>20. Preventive Health</td>
<td>Mammography Screening</td>
<td>NQF #31</td>
<td>NCQA</td>
<td>GPRO Web Interface</td>
<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
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<td>21. Preventive Health</td>
<td>Proportion of Adults 18 – who had their Blood Pressure Measured within the preceding 2 years</td>
<td>CMS</td>
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<td>GPRO Web Interface</td>
<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
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<tr>
<td>22. At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (&lt;8 percent)</td>
<td>NQF #0729</td>
<td>MN Community Measurement</td>
<td>GPRO Web Interface</td>
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<td>23. At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (&lt;100)</td>
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<td>GPRO Web Interface</td>
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<td>25. At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Tobacco Non Use</td>
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<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
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<td>26. At Risk Population - Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Aspirin Use</td>
<td>NQF #0729</td>
<td>MN Community Measurement</td>
<td>GPRO Web Interface</td>
<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
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<tr>
<td>27. At Risk Population - Diabetes</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control (&lt;9 percent)</td>
<td>NQF #59</td>
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<td>GPRO Web Interface</td>
<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
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<tr>
<td>28. At Risk Population - Hypertension</td>
<td>Hypertension (HTN): Blood Pressure Control</td>
<td>NQF #18</td>
<td>NCQA</td>
<td>GPRO Web Interface</td>
<td>R → Reporting Performance Year 1: P → Performance Year 2: P</td>
</tr>
</tbody>
</table>
## CMS 33 Quality measures (Continued)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure #/ Measure Steward</th>
<th>Method of Data Submission</th>
<th>Pay for Performance Phase In Performance Year 1</th>
<th>Pay for Performance Phase In Performance Year 2</th>
<th>Pay for Performance Phase In Performance Year 3</th>
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<tbody>
<tr>
<td>At Risk Population – Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control ≤100 mg/dl</td>
<td>NQF #75 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>At Risk Population – Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>NQF #68 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>At Risk Population - Heart Failure</td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>NQF #83 AMA-PCPI</td>
<td>GPRO Web Interface</td>
<td>R</td>
<td>R</td>
<td>P</td>
</tr>
<tr>
<td>At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol</td>
<td>NQF #74 CMS (composite) / AMA-PCPI (individual component)</td>
<td>GPRO Web Interface</td>
<td>R</td>
<td>R</td>
<td>P</td>
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<tr>
<td>At Risk Population – Coronary Artery Disease</td>
<td>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)</td>
<td>NQF #86 CMS (composite) / AMA-PCPI (individual component)</td>
<td>GPRO Web Interface</td>
<td>R</td>
<td>R</td>
<td>P</td>
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</table>

*We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.*