

DELIVERING VALUE

How Value-Based Purchasing Improves Quality and Lowers Costs

ISSUED BY BUYING VALUE

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This purchasing guide is intended to assist private purchasers of health care coverage to switch from the traditional health care purchasing model of paying based on volume to the rapidly emerging model of paying based on value. Paying based on value is a proven technique of improving quality and lowering costs. It emphasizes purchasing strategies that a) use alternative payment models that motivate and reward quality and efficiency and b) support delivery system reform. This guide describes the need for payment and delivery system reform, highlights the most promising reform ideas and then describes some steps health care purchasers can take to switch to purchasing on value.

Improving Quality and Lowering Costs in Health Care through Value-Based Purchasing

Changing from paying for health care services based on volume to paying for health care based on value has long been a major goal for leading private health care purchasers and is becoming a spotlight issue for smaller purchasers. Resistance from providers, who largely benefit from being paid based on volume, has been a historical barrier to such reform.

Now, however, new Medicare payment reforms required by the 2010 Affordable Care Act (ACA), have paved the way to convincing providers to embrace value-based payment methodologies and to transform their processes for delivering care. By 2017, the Centers for Medicare and Medicaid Services (CMS) will attach nine percent of Medicare payments to some form of value purchasing. Another element of the ACA, “The Partnership for Patients,” challenges private purchasers to use payments in support of ambitious safety improvement goals set by HHS. Private purchasers, both large and small, will need to capitalize on this opportunity to pay on value and to avoid the cost-shifting that providers often claim accompanies Medicare payment.

Fee-for-Service Payments and Siloed Care Are Bad Business

In the current fee-for-service-based health care system, providers are paid for each service performed, without regard to whether the service improves the health status of the patient. In fact, providers are paid the same amount—if not more—for services performed when the patient is *harmed* by treatment or if no change in health status occurs as the result of a service. Simply put, the more services provided, the more the provider is paid. In virtually no other field do we purchase without any regard for value. Aside from being a costly way to pay for care and one that does not safeguard the patient or consumer, this payment model results in overtreatment which is often harmful to the patient.¹ While patients often believe that more care is better care, there is extensive evidence that this simply is often not true.²

In addition, the fee-for-service payment model provides neither motivation nor support for providers to coordinate care, leaving it up to patients to navigate through various “silos” of care where providers focus on just one aspect of a patient’s health, often with no one clinician treating the patient as a whole person. This lack of integration and coordination leads to poor quality and is also a contributing factor to higher costs.

What Does it Mean to “Pay for Value”?

Partnership for Patients

Two goals of the Partnership for Patients:

- Keep patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
- Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

For more information or to join the Partnership for Patients go to:

www.healthcare.gov/compare/partnership-for-patients/index.html

If rewarding health care providers for simply delivering more (and more expensive) services yields higher costs and care that is not always better and sometimes harmful, how else might purchasers design their health benefit purchasing strategies?

Paying for value entails buying health benefits through new mechanisms for payment, which in turn will motivate and reward providers for better ways of delivering health care services. In simple terms, require your insurer or administrator to change provider payment incentives and delivery models, and the delivery system will deliver more efficient and effective care.

Paying for value is not a new idea.³ It is one that has evolved over time, however. First generation efforts introduced the idea of offering providers bonuses for superior quality with respect to preventive care measures. Second generation efforts, such as CMS’ new Hospital Value-Based Purchasing initiative, place provider payments at risk, so that providers can experience lower payments if their performance is sub-par, and higher payments if their quality is strong.⁴

The third generation of paying-for-value strategies seeks more fundamental, structural reforms in the way care is delivered—away from traditional fee-for-service models and toward integrated systems of care.

The unceasing rise of health benefit costs has caused employers, governments and insurers to take more aggressive action to drive change and support these more fundamental reforms. At a time of economic challenge, health care benefits can no longer be an annual employer budget buster.

The sections that follow describe paying-for-value strategies that address *payment reform* and *delivery system reform*. The ACA calls for widespread use of these two reform strategies in Medicare, Medicaid and extending them to private health care coverage.

What is Payment Reform?

The principle goal of payment reform is to move away from the current payment system that pays providers for each service performed, toward a payment system that encourages the delivery of care consistent with scientific findings about what works, rewards improved health status and incentivizes providers to spend health benefit purchaser dollars wisely. While aligning payment incentives with desired performance is essential if a purchaser is to pay for value, it requires a degree of technical expertise. The operational details of any new payment model must be worked out with insurers (or plan administrators) and plans, but purchasers need to be clear at the start on what they want and expect from each party. Here are examples of several alternative payment models being employed by insurers and providers in a variety of care settings.

- **Shared Savings.** Shared savings is a payment strategy that offers incentives for providers to reduce health care spending for a defined patient population (e.g., a group of employees) by offering the providers a percentage of net savings realized as a result of their efforts.³ Under this payment model, providers are rewarded if they can manage health care services to come in below a “budget.” The budget represents expected costs related to a comprehensive set of covered services for a group of patients who receive their primary care from the provider organization. The budget can be defined prospectively. This involves forecasting using past claims experience information. Alternatively, the budget can be defined retrospectively by comparing provider performance in managing cost to the experience of all other providers contracted with the payer. In this latter scenario, a provider who performs better than the average for all of the other providers is viewed as coming in “below budget”, and thus generating savings.

Shared savings models are attractive to employer purchasers and to insurers because they introduce an incentive to manage costs within a budget that simply does not exist in traditional volume-incenting payment arrangements. This incentive can cause providers to reconsider their test-ordering patterns, their referral patterns, and steps they can take to make themselves more accessible (to prevent avoidable emergency department visits and hospital admissions) and to improve coordination of care (to prevent avoidable hospital readmissions).

Shared savings models are also attractive to providers who are currently only contracted with payers under fee-for-service arrangements. Shared savings arrangements offer an opportunity for the provider to share with the payer (or self-insured employer) in any savings generated through the provider’s efforts, without the provider assuming any financial risk should expenditures come in above the budget.

Case Study: Shared Savings

A cooperative multi-payer, multi-provider medical home initiative in the Northeast region of Pennsylvania involves a shared savings opportunity for participating primary care practices with two regional insurers: Blue Cross of Northeastern Pennsylvania and Geisinger Health Plan. During the first 15 months of implementation in 2009 and 2010, practices were eligible for up to 50% of the savings that they generated relative to prospectively defined budgets established independently by each insurer for their commercial and Medicare Advantage lines of business. The savings were calculated with risk adjustment and net of supplemental payments that the practices received during the time period

to support their medical home operations. In order to share in the savings, practices were contractually obligated to meet at least nine of 14 performance criteria, including measures such as improvement in the percentage of total population diabetic patients with HbA1c (blood sugar) below 9%, improvement in the percentage of hypertensive patients with blood pressure <140/90 and the percentage reduction in the practice’s 30-day hospital readmission rate. The insurers concluded their evaluations in 2011 and made savings payments to those practices that generated net savings and performed well relative to the performance criteria.

The four types of bundled payments:

1. Inpatient procedure-based (e.g., hip replacement)
2. Outpatient procedure-based (e.g., colonoscopy)
3. Inpatient acute medical care (e.g., treatment of a heart attack)
4. Chronic care (e.g., annual treatment for a patient with diabetes)

Shared savings payment models are in use by a variety of insurers and providers but are still too new to draw definitive conclusions about their results. This payment model is common among key delivery reform efforts like the “accountable care organization” (ACO) and the medical home.⁶

- **Bundled Payment.**⁷ Sometimes referred to as “episode-based payment,” a bundled payment is a payment for all of the services needed by a patient, across multiple care providers and possibly multiple care settings, for a procedure or chronic condition for a defined time period. Participating providers may include hospitals, physicians and other providers who have responsibility for an inpatient care episode that is defined as extending through a post-discharge rehabilitation phase. If a contracted provider(s) (e.g., a hospital and its affiliated professionals) can manage cost and quality by reducing avoidable complications, it can retain the difference between the bundled payment and what the costs incurred for service delivery. However, if the provider(s) fail to reduce avoidable complications, it runs the risk of the payments being less than the costs incurred to deliver the services.

There are some other bundled payment efforts under way beyond those using the PROMETHEUS Payment model. For example, CMS announced in August 2011 the Bundled Payments for Care Improvement initiative. Applicants for these models were invited to define the episode of care as the acute care hospital stay only (Model 1), the acute care hospital stay plus post-acute care associated with the stay (Model 2), or just the post-acute care, beginning with the initiation of post-acute care services after discharge from an acute inpatient stay (Model 3). Under the fourth model, CMS would make a single, prospective bundled payment that would encompass all services furnished during an inpatient stay by the hospital, physicians and other practitioners.⁹ In addition, private insurers have launched bundled payment efforts as have the Medicaid programs in Arkansas and Massachusetts.

Case Study: Bundled Payments

PROMETHEUS Payment[®] model is a new form of bundled payment being tested among many purchasers across the country. The PROMETHEUS Payment system assigns a dollar value or an “evidence-informed case rate” (ECR) to an entire episode of care for a condition or a procedure. The episode of care includes treatments and tests that are usually recommended as clinical guidelines for the condition or procedure. The provider(s) who treat the patient are eligible to receive the ECR as payment in addition to a quality bonus based on patient outcomes and the avoidance of common, yet preventable complications. PROMETHEUS Payment currently has available ECRs for 20 different episodes of care.⁸

PROMETHEUS has been implemented in three pilot programs and is currently being put into place in additional sites. The first pilot was implemented by HealthPartners, a Minnesota non-profit

HMO that also operates multi-payer clinics. The pilot included only services related to acute myocardial infarction and ran in four of HealthPartners’s provider networks in 2009. The second pilot was implemented beginning in 2010 by the Employers’ Coalition on Health (ECOH), a non-profit employer coalition-based PPO headquartered in Rockford, Illinois and is intended to run through 2012. This pilot is at least initially focused on services related to diabetes, hypertension and coronary artery disease. The third pilot began in Pennsylvania in the first quarter of 2010 through the collaborative efforts of Independence Blue Cross and Crozer-Keystone, the latter a non-profit integrated provider. This pilot has initially focused on hip and knee replacement procedures. While still being tested, early results of the PROMETHEUS Payment model are proving to be promising. To obtain more information on the PROMETHEUS Payment model, visit: www.hci3.org.

- **Global Payment.**¹⁰ A global payment is a comprehensive payment to a group of providers that is intended to account for most or all of the expected cost of care for a group of patients for a defined time period. While generally synonymous with the term “capitation,” advocates of the concept use the term “global payment” to distinguish its design and application from early capitation models which were less sophisticated and under which some providers suffered financial losses. Today, global payment design and implementation strategies are improved over earlier efforts. For example, many insurers have added forms of risk-adjustment (to account for the relative illness burden of the population) and risk sharing (to protect the provider if costs are higher than expected) so that providers don’t face potential catastrophic financial loss and the incentive to skimp on care, which was a common concern with early forms of capitation arrangements.

Many other global payment pilots and broad-based implementations have been occurring and will occur across the country in the coming months.¹⁴ Of special note is the CMS Pioneer ACO model involving 32 organizations, all being paid using a global payment arrangement in lieu of traditional fee-for-service payment beginning in 2012.¹⁵ For more information about Pioneer ACOs, see the inset below.

Case Study: Global Payment

Recent evaluations of new global payment arrangements have yielded encouraging results, including for CalPERS, the California Public Employees’ Retirement System. Through Blue Shield of California, CalPERS offered its Sacramento-area employees and their families a limited-network HMO comprised of a large physician group and a multi-hospital system. The limited-network HMO was created with a promise of no cost increase for one year, and an insurer/provider target of a \$32 per member, per month cost *decrease*. The insurer and two provider groups

agreed to accept the global payment risk jointly, and to share in any savings. Over 41,000 employees and dependents enrolled.¹¹ Through October 2010, the organizations’ combined efforts led to a 17 percent reduction in patient re-admissions; a half-day reduction in the average patient length of stay; a nearly 14 percent drop in the total number of days patients spend in a facility; and a 50 percent reduction in the number of patients who stay in a hospital 20 or more days.¹² The final result of the effort was \$20 million in savings for the care of 41,500 patients.¹³

What is Delivery System Reform?

The principal goal of delivery system reform is to move away from a system where individual providers care for patients in “silos” to a more coordinated and evidence-based approach where providers collaborate on the patient’s behalf to recommend and provide care that is known to improve the health status of a patient. Delivery system reform and payment system reform go hand-in-hand, but can be advocated for separately.

Delivery system reform is on display in two integrated care models now under way in nearly every state. “Medical home” is an innovation focused on the transformation of primary care that has been in ever-growing implementation since 2008. Accountable care organizations represent a more far-reaching delivery system innovation that began to spread in 2010, spurred by the ACA. Each is described below.

- **Medical Home.** A medical home (alternatively, “Patient-Centered Medical Home”) is a primary care practice that organizes and delivers care in a fundamentally different manner than is currently commonplace.¹⁶ Medical homes are required to master core competencies, including a focus on care coordination and care management of chronic conditions using a team-based approach to manage all care for a patient. Medical homes commit to enhancing access to care

(e.g., seeing patients during non-traditional hours), engaging the patient in self-management, practicing evidence-based care and using data to test and assess improvements in care delivery.

In order to transform how they operate, primary care practices often are provided some form of technical assistance. The assistance can range from the provision of external certification standards from an organization such as NCQA or JCAHO, to more intensive supports such as coaching by an expert in medical home transformation and/or participating in a learning collaborative with other practices. Many payers require that practices obtain recognition from an external accreditation organization, although the impact that such recognition has on practice medical home performance remains uncertain.

Medical homes often receive supplemental payments to cover the costs of traditionally non-reimbursed medical home services in addition to traditional fee-for-service payment. In increasing instances, medical homes are also afforded the opportunity to share in any savings that they generate, such as in the Northeast Pennsylvania example cited earlier. Incentives for high quality and efficiency are often also part of the payment model, either as a stand-alone bonus incentive or integrated into the shared savings methodology, as has been the case in Northeast Pennsylvania.

Case Study: Medical Home

One medical home initiative is the Ambulatory Intensive Caring Unit (A-ICU) in Atlantic City, New Jersey. The A-ICU is a medical home-type model that focuses on the most chronically ill patients. The union, UNITE HERE, and the local health care system partnered with foundation and consulting resources to form these intensive primary care clinics. To encourage participation in the A-ICU, the union members with the highest health care costs were given free access to physicians and prescriptions. Within the first year, the union experienced a 25 percent drop in costs.¹⁸

Similar programs exist for casino workers in Las Vegas and for Boeing employees in Seattle and are now being established in several other states after the results of the UNITE HERE experience and those of Boeing became public. The nature of the Boeing A-ICU has been described as follows:

“Each [A-ICU]-enrolled patient received a comprehensive intake interview, physical exam, and diagnostic testing. A care plan was developed in partnership with the patient. The plan was executed through intensive in-person, telephonic and email contacts – including frequent proactive outreach by an RN, education in self-management of chronic conditions, rapid access to and care

coordination by the [A-ICU] team, daily team planning huddles to plan patient interactions, and direct involvement of specialists in primary care contacts, including behavioral health when feasible. Mercer and Renaissance provided administrative and clinical support, respectively, including weekly telephone check-ins with the RN care managers for joint problem solving. Quarterly collaborative meetings were held with all teams and organizational partners to share learnings. Qualitatively observed gains included refinement of care managers’ patient engagement skills, more proactive care and care coordination, and easier patient access to care providers.”¹⁹

Most medical home initiatives, however, are *not* focused only on care for the most chronically ill patients. Instead, they seek to affect total practice transformation for *all* patients, balancing the need for intensive care management for the most ill patients in the practice with attention to preventive care and risk prevention with the balance of a practice’s patient population. Medical home initiatives that focus on the sickest patients are most likely to generate a short-term ROI, but are unlikely to avoid other future costs that will be generated through avoidable lifestyle-induced chronic illness that has yet to develop or to become severe.

There are over two-dozen multi-stakeholder medical home initiatives alone across the country,¹⁷ with many others that are single-payer-based. Most of these practice efforts are supported with enhanced payments from commercial and/or public payers. The multi-stakeholder initiatives are the result of the collaborative efforts of payers, providers, employers and other interested stakeholders. Payers participating in multi-payer initiatives on a pilot basis have sometimes decided to implement their own broader initiative following successful pilot experiences.

To learn if there is a medical home pilot in your area or for more information, see: www.pcpcc.net/.

Pioneer ACO Model

The CMS Innovation Center launched a pilot to test the quality and financial impact of payment arrangements of ACOs. There are 32 integrated care organizations from across the country from large organizations such as the University of Michigan and Partners Health to smaller organizations like Gensys PHO in southeastern Michigan. These 32 organizations will test global payment models over three years and will be held to strict quality measures. For more information on the three year model and a list of the 32 organizations, see:

http://innovations.cms.gov/documents/pdf/PioneerACO-General_Fact_Sheet_2_Compliant_2.pdf

- **Accountable Care Organization (ACO).**²⁰ The accountable care organization concept was conceived relatively recently,²¹ but builds upon years of past experience with medical groups contracting with health insurers to care for populations of patients on a global payment basis. The idea received a significant boost in 2010 when the ACA created a new Medicare ACO program that began January 1, 2012. This ACA provision prompted frenzied activity among many providers to position themselves to become ACOs, even before the rules of the Medicare ACO program were defined. (For more information on Pioneer ACOs, see inset.)

An accountable care organization is a local provider entity that agrees to assume responsibility for all of the health care and most if not all of the related expenditures for a defined population of patients, with payment typically linked in some fashion to performance on resource management and quality. The provider entity can take many different forms, including a physician group practice, a physician independent practice association and an integrated delivery system comprised of hospitals, physicians and other professionals. Payment is typically in the form of a shared savings or a global payment arrangement.

The accountable care organization concept builds upon that of a medical home. In fact, many believe that an ACO cannot clinically or financially succeed without a foundation comprised of medical homes.²² The ACO concept extends beyond the medical home in that it formally links the full continuum of care to the medical home, and provides an opportunity for collaboration and improved continuity as a patient moves throughout the delivery system.

Case Study: Accountable Care Organization²³

The largest insurer in Massachusetts, Blue Cross Blue Shield of Massachusetts (BCBSMA), implemented its Alternative Quality Contract (AQC) with provider groups beginning in 2009 to reward high quality, appropriate and efficient care by supporting transformation to a health care system in which financial and clinical goals are aligned. Like many global payment arrangements, the “upside” and “downside” risk (i.e., potential gains and losses, respectively) is shared to protect both parties.

BCBSMA established the AQC as an alternative voluntary model of payment for provider organizations. The strategy has four central components:

- 1. Integration across the continuum of care.** Contracted providers assume clinical and financial responsibility for all care required by a patient, and organizing and coordinating that care whether it is delivered by the contracted provider or another entity.
- 2. Accountability for performance measures (ambulatory and inpatient).** The ability of a contracted provider to financially succeed under the AQC is linked to the ability to earn incentives worth up to 10% of the global payment. These incentives are tied to inpatient and outpatient performance measures. This potential incentive payment is in addition to earnings that can result from reduction of overuse and misuse and safeguards against the possibility of under-treatment, thus encouraging physicians to deliver the best care possible.

- 3. Global payment for all medical services (health status-adjusted).** Contracted providers are paid a PMPM amount to cover all medically needed services. The base payment is determined based upon historical health care cost expenditure levels, and is adjusted for health status. The global budget is adjusted annually for a negotiated inflation factor. The level of risk can vary by provider group, but within a group, the upside risk is always equal to the downside risk.

- 4. Sustained partnerships (five-year contract).** Because BCBSMA seeks long-term, redefined relationships through the AQC, providers must commit to a five-year agreement.

BCBSMA reported that providers were eager to contract with BCBSMA in this manner, believing that that it would be advantageous to participate in a reform initiative on a smaller scale before facing broader changes in payment and expectations regarding care delivery.

The first published independent evaluation of the AQC contract reported that with regard to spending on health care services, there was a 1.9% savings in Year 1 relative to a control group, an increase of 2.6 percentage points in the percentage of patients meeting chronic care quality thresholds, an increase of 0.7 percentage points in the percentage of patients meeting pediatric care thresholds, and no significant improvement in adult preventive care. Because BCBSMA provided infrastructure support and paid quality bonus payments, overall spending exceeded the value of the 1.9% savings.²⁴

How Private Purchasers Can Switch to Paying on Value²⁵

Moving from paying for volume to paying for value requires changes for purchasers, payers and providers. These changes are often coupled with incentives for consumers and patients to use higher value providers, like those within medical homes or ACOs. The following five steps are suggestions payers can use to help facilitate the switch to paying on value.²⁶

- 1. Make payment and delivery system reform a requirement with contracted insurers, plans and providers.** a.) Find out what the insurer (or plan administrator) is already doing or planning through the Catalyst for Payment Reform Request for Information (see inset), National Business Coalition on Health eValue8 Survey or simple direct inquiry. b.) Specify the payment and/or delivery model(s) of greatest interest, and negotiate into contracts with insurers and plans (see Catalyst for Payment Reform model contract language at www.catalyzepaymentreform.org/Model_Contract_Language.html). c.) Specify the measures of quality performance and cost effectiveness you want, considering alignment with those established by Medicare, and require timely reports of data. d.) Require a rigorous process for evaluating cost and clinical effectiveness, as well as assessing lessons learned and applying them in both payment and delivery system model refinement.

Catalyst for Payment Reform (CPR)

CPR's health plan Request for Information (RFI) on payment reform allows employers and other health care purchasers to query health plans about their current provider payment practices and plans for future reforms. Specifically, the RFI will help purchasers gather information on the amount of total physician and hospital compensation that is tied to performance through various value-based purchasing programs. The RFI embodies a strategic menu of reform areas that gives health care purchasers and insurers the capacity to plan, implement and evaluate payment policies that promote high-quality and cost-effective care.

www.catalystpaymentreform.org/RFI.html

2. *Team up.* It is a large task to drive change in health care payment and delivery systems. Individual purchasers would be well served by trying to advance change with other individual purchasers or with coalitions such as those comprising the National Business Coalition on Health, or with multi-stakeholder coalitions that exist in some regions, representing the voices of employers, consumers, providers and insurers. Catalyst for Payment Reform is developing two new important resources for purchasers — a National Compendium on Payment Reform and a National Scorecard on Payment Reform — that are projected to be available in March 2013. The National Business Group on Health, Catalyst for Payment Reform, and the Pacific Business Group on Health are other key organizations for purchasers to consider joining. While some purchasers should be aware of anti-trust law when working in concert with other purchasers, effective value-based purchasing can be implemented well within the law. (See anti-trust guidelines in toolkit [here](#).)
3. *Encourage members to choose less costly providers and models of insurance.* Large health care purchasers can advocate for the use of less costly, but high quality, models of insurance that favorably structure cost-sharing arrangements of insurer products so consumer out-of-pocket costs are limited. For example, purchasers can eliminate or lower co-payments for preventive health care and care within a medical home. Union leaders can encourage their membership to participate in health benefit programs that influence consumer use of costly care to ensure adequate enrollment and sustainability of the model.
4. *Serve as a vocal advocate for reform.* Value-based purchasers need to be vocal advocates for reform to help encourage change throughout the marketplace. The Partnership for Patients, a public-private partnership that encourages delivery system reform to improve patient-safety, is being supported by many value-based purchasers. For more information on the Partnership for Patients and how to join, see inset. In addition, some state legislatures play a significant role in facilitating and shaping payment and delivery system reform. Legislators need to hear the voice of purchasers and will respond if the voice is insistent, multiplied and repeated.
5. *Be patient.* Payment and delivery reform will take time to be properly implemented, and initial efforts won't all be effective. Excessive zeal on the parts of health care purchasers, insurers and providers will likely result in early failure. Patience and caution will be necessary to implement, test, and perfect the payment and delivery system model changes.

Conclusion

Pay-for-value strategies, like those identified in this guide, help purchasers use their influence to improve health care access and quality and reduce costs. There is no “one-size-fits-all” approach, but with the basic knowledge of delivery system and payment system reform efforts, purchasers can better understand which models will work best for the health care needs of their members and within their local health care marketplace. Purchasers can then apply sound and proven strategies to improve the value that they receive for their benefit dollars.

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- ²⁶ Purchasers with an understanding of their population characteristics can specify certain improvement expectations, but to get started on paying on value, it is not necessary to have a full analysis of a purchaser’s population.
- ²⁷ For many of Medicare’s new payment initiatives (Shared Savings and Pioneer ACO) a common set of performance measures have been identified. For more information go to: www.cms.gov/sharesavingsprogram/37e_Quality_Measures_Standards.asp#TopOfPage.