Medicare Shared Savings Program

QUALITY MEASUREMENT METHODOLOGY AND RESOURCES

Specifications

April 2017
Version #2
Applicable for Reporting Year 2017

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

Revision History

VERSION	DATE	REVISION/CHANGE DESCRIPTION	AFFECTED AREA
1	09/01/2016	Initial release of document	
2	04/27/2017	Updated references and resources to reflect applicable performance year	Section 1 Intro, 1.3, 1.4, Table 1-3, Section 2 Intro, Section 3 Intro, Section 4.5, Section 5 Intro, Section 5.4
2	04/27/2017	Removed references to PQRS, VM, and EHR Incentive Programs and replaced with references to the Quality Payment Program	Section 1 Intro, Table 1-1, Section 4.4, Section 6, List of Abbreviations
2	04/27/2017	Added references to the 2017 Physician Fee Schedule Final Rule	Section 1.2, Section 2 Intro
2	04/27/2017	Revised minimum attainment definition to reflect update made in 2017 Physician Fee Schedule	Section 1.4, Section 5.6, Section 5.7
2	04/27/2017	Removed references to resetting ACO's overall quality score to 0	Section 1.4
2	04/27/2017	Revised measure set, counts, and names to reflect 2017 Physician Fee Schedule Final Rule	Section 3 intro, Table 3-2, Table 3-3, Table 3-4, Section 4.1, Section 4.3, Table 5-2, Section 5.3, Table 5-3, Table 5-6, Section 5.4, Table 5-7, Section 5.5, Table 5-8, Table 5-9, Appendix A
2	04/27/2017	Added footnote regarding ACO-9 vs. ACO-12 surveys	Table 3-1
2	04/27/2017	Changed references from GPRO Web Interface to CMS Web Interface	Table 3-2, Table 3-3, Table 3-4, Section 4 Intro, Section 4.5, Section 5.1, Section 5.3, Section 5.4, Section 5.5, List of Abbreviations
2	04/27/2017	Clarified language around CAHPS requirement	Section 4.2
2	04/27/2017	Added information on Quality Measures Validation Audit process and implications	Section 4.5, Section 5.5
2	04/27/2017	Removed columns for Reporting Years 2012 and 2013	Table 5-1
2	04/27/2017	Revised benchmarks sources to include 2015 Medicare FFS data (used for 2017 benchmarks)	Section 5.2
2	04/27/2017	Added note to clarify that ACO-11 is double-weighted in certain steps of the Quality Improvement Reward calculation	Section 5.4
2	04/27/2017	Added benchmarks for measures introduced in the 2015 Physician Fee Schedule that phase in to P4P for some ACOs in 2017	Appendix A

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1 Introduction

This document reviews the quality performance standard and scoring methodology for Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (Shared Savings Program), and describes the Program's quality measurement and reporting methodology. While this version of the document includes references to quality measures and documentation relevant to reporting years 2012 through 2017, examples in the sections below focus on reporting year 2017. This document is subject to periodic change and will be updated to reflect the policies applicable for each subsequent reporting year.

Quality data reporting and collection support quality measurement is an important part of the Shared Savings Program. Within the Shared Savings Program, the Centers for Medicare & Medicaid Services (CMS) enters into three-year agreements with ACOs. CMS rewards ACOs when they are able to lower growth in Medicare Parts A and B fee-for-service (FFS) costs (relative to their unique target) while also meeting performance standards on quality of care. Before an ACO can share in any savings generated, it must demonstrate that it met the quality performance standard for that year. The quality performance standard determines an ACO's eligibility to share in savings, if earned, and the extent of an ACO's liability for sharing losses (for ACOs participating under a two-sided shared savings/losses model). ACO quality reporting also interacts with the Quality Payment Program.[1]

1.1 STATUTORY AND REGULATORY BACKGROUND

Section 1899 of the Social Security Act (the Act) established the Medicare Shared Savings Program.[2] Pursuant to this statutory authority, CMS established regulations for the Shared Savings Program, through notice and comment rulemaking, including policies specific to the quality reporting requirements and quality performance standards. CMS published an initial notice of proposed rulemaking for the program in April 2011 followed by a public comment period. The final rule was published in November 2011,[3] amending 42 CFR Chapter IV by adding part 425. CMS periodically engages in notice and comment rulemaking to revise the Shared Savings Program regulations. Given the dynamic nature of quality measures, such as reflecting the developments in clinical care, changes to the Program's quality measures and quality

[1] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77008 (Nov. 4, 2016).
[2] The Shared Savings Program was mandated by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. These public laws are collectively known as the Affordable Care Act. Section 3022 of the Affordable Care Act amended Title XVIII of the Act (42 U.S.C. 1395 et seq.) by adding section 1899 to the Act to establish a Shared Savings Program.
[3] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802 (Nov. 2, 2011).

performance standards have been addressed through the annual Physician Fee Schedule rulemaking cycle.[4]

1.2 QUALITY MEASURE STRUCTURE AND DATA COLLECTION METHODS

In establishing the program, CMS focused on developing policies aimed at achieving the three-part aim consisting of:

1. Better care for individuals
2. Better health for populations
3. Lower growth in expenditure

CMS focused ACO quality improvement activity on four key domains (outlined below) within the dimensions of improved care for individuals and improved health for populations to serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance.

- Better Care for Individuals
  a. Patient/Caregiver Experience
  b. Care Coordination/Patient Safety
- Better Health for Populations
  a. Preventive Health
  b. At-Risk Population

To determine an ACO's overall quality performance score, CMS weighs each of the four measure domains equally at 25 percent to signal the equal importance of each of these areas and to encourage ACOs to focus on all domains in order to maximize their sharing rate (see 76 FR 67900).

The number of measures within the four key domains has changed over time, including

[4] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule, 78 Fed. Reg. 74230 (Dec. 10, 2013). Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2015; Final Rule, 79 Fed. Reg. 67907 (Nov. 13, 2014). Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2016; Final Rule, 80 Fed. Reg. 71263 (Nov. 16, 2015). Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements; Final Rule, 81 Fed. Reg 80483 (Nov. 15, 2016).

the addition and removal of measures to reflect changes in clinical practice and for other program needs, such as alignment with other quality reporting efforts. However, the structure of the measure domains has remained consistent, as has the equal weighting of the domains in determining the ACO's quality score.

Table 1-1 details the four methods of data collection are used within the Shared Savings Program approach to quality measurement.

Table 1-1. Data Collection Methods

QUALITY MEASURE TYPE	DATA USED	WHO WILL GATHER THE QUALITY INFORMATION?
Patient/caregiver experience measures	Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey includes CAHPS Clinicians & Group (CG-CAHPS) core measures, supplemental items, and program specific items	ACOs contract with CMS-approved survey vendors to administer the survey
Claims-based measures	Medicare beneficiaries' demographic information and claims data	CMS
Administrative measure: Use of Certified EHR Technology (CEHRT)	Quality Payment Program (QPP) eligible clinician and Advancing Care Information (ACI) data	CMS
ACO-reported clinical quality measures; data reported by ACOs through the CMS Web Interface	Medicare beneficiaries' demographic information and claims data files. Patient medical records (paper/Electronic Health Record (EHR)/registry) from within and outside of the ACO	CMS will provide patient samples with selected patient information ACOs must enter and submit data for sampled patients in the CMS Web Interface

1.3 PERFORMANCE YEAR AND CORRESPONDING QUALITY REPORTING YEAR

The reporting year for quality measurement relates to determining an ACO's quality performance for a specific performance year under an ACO's three-year agreement period. For each performance year, CMS determines the ACO's eligibility for shared savings and accountability for shared losses (in the case of ACOs participating under a

two-sided risk model) based on the ACO's financial and quality performance.

A performance year and quality reporting year typically correspond to the 12-month calendar year. However, quality data collection for a reporting year concludes following the end of the calendar year. ACOs that entered the Program in April 2012 and July 2012 had a protracted first performance year, spanning 21 or 18 months, respectively. The first performance year for 2012 starters spanned two quality reporting years: 2012 and 2013.

The term "reporting period" is most commonly used to refer to the actual data collection period. The data collection period for ACO-reported measures, for example, follows the conclusion of the performance year to which the data collection relates for purposes of quality performance measurement. For example, for the 2016 reporting year (quality measurement for the 2016 performance year), the reporting period for ACOs' submission of the data through the CMS Web Interface occurs between January 2017 and March 2017.

Quality reporting and quality performance assessment activities are cyclical. ACOs will likely be preparing to report quality data for the upcoming reporting year while preparing for and engaging in reporting for the current reporting year. Figure 1-1 provides an illustration based on select activities that occur.

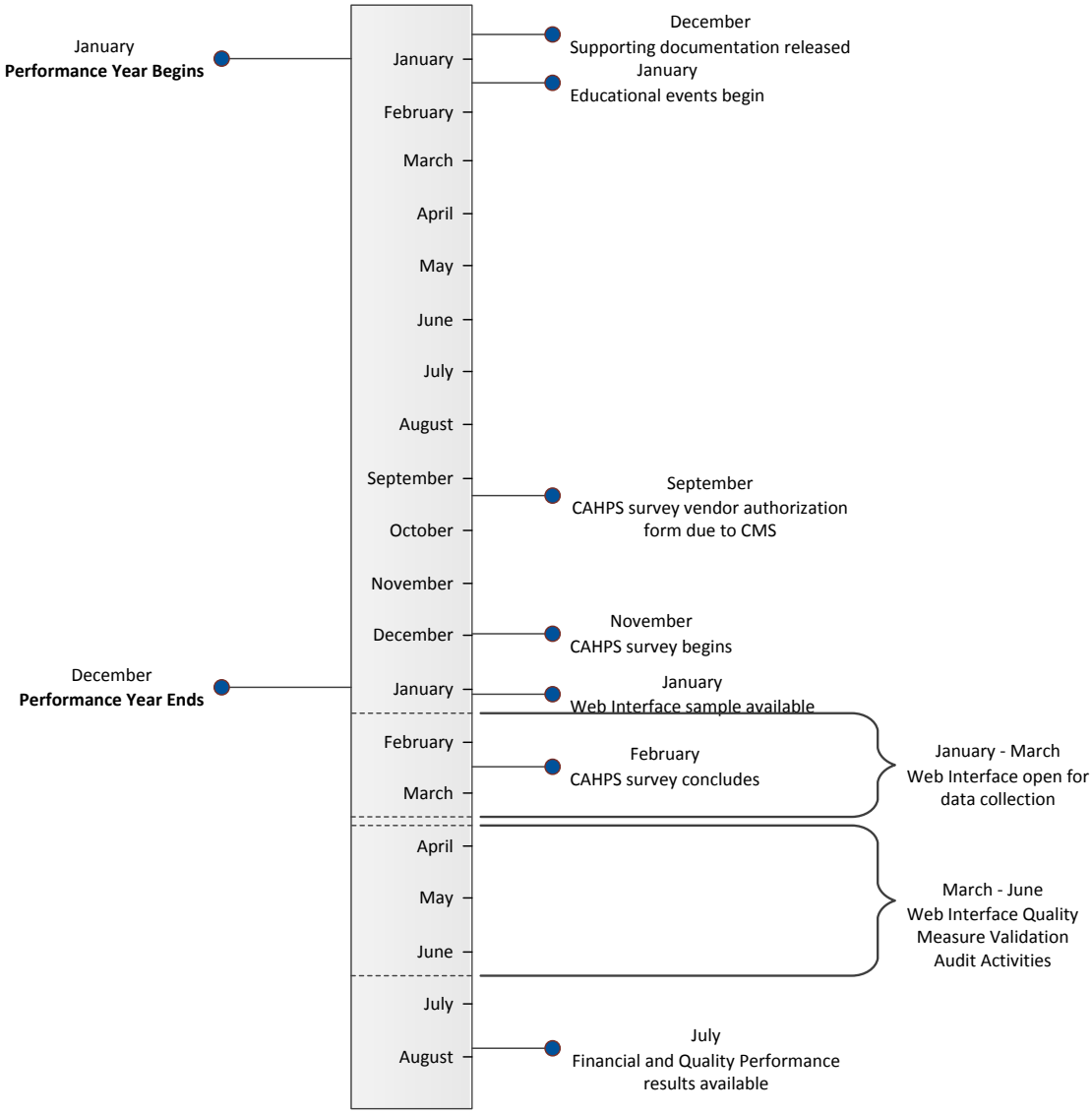

Figure 1-1. Illustrative Timeline of Select Quality Reporting and Performance Assessment Activities for One Performance Year

1.4 TRANSITION FROM PAY FOR REPORTING TO PAY FOR PERFORMANCE

The quality performance standard is the criteria that an ACO must meet in order to be eligible to share in any savings earned, and also determines the magnitude of losses for which an ACO may be liable (under a two-sided shared savings/losses model).

The quality performance standard is the same regardless of the ACO's financial track.

CMS designates the quality performance standard for ACOs based on performance year. The quality performance standard for ACOs in the first year of their first agreement period differs from the quality performance standard applied in later performance years, as indicated in the following outline:

- First year of first agreement period all measures are scored as pay-for-reporting (P4R): ACOs must completely and accurately report all quality data that are used to calculate and assess their quality performance.
- Second or third year of the first agreement period and all years of subsequent agreement periods some measures are scored as pay-for-performance (P4P) according to a phase-in schedule that is specific to measures and the ACO's performance year in the program:
  - ACOs must continue to completely and accurately report all quality data that are used to calculate and assess their quality performance.
  - CMS designates a performance benchmark and minimum attainment level for the P4P measure, and establishes a point scale for the measure. An ACO's quality performance on the measure is evaluated using the point scale for the measure, and these measure-specific scores are used to calculate an overall quality score for the ACO.
  - ACOs must meet minimum attainment (defined as the 30th percentile benchmark for P4P measures and complete reporting for P4R measures) on at least one measure in each domain to be eligible to share in any savings generated.

Table 1-2 summarizes the transition from P4R to P4P over the course of the ACO's first agreement period (and subsequent agreement periods) in the Shared Savings Program.

Table 1-2. Phase-In to Pay-for-Performance

PERFORMANCE YEAR	PAY FOR REPORTING (P4R) OR PAY FOR PERFORMANCE (P4P)	TO BE ELIGIBLE TO SHARE IN SAVINGS, IF EARNED, THE ACO MUST:
One	P4R	Completely and accurately report all quality measures.
Two and Three, and subsequent agreement periods	P4P	Completely and accurately report all quality measures and meet minimum attainment on at least one measure in each domain.

The table specifying the measure-specific benchmarks for each reporting year will indicate the P4P phase-in of measures for performance years one through three of an ACO's first agreement period. For example, see Appendix A containing the measure

benchmarks for the 2017 reporting year, illustrating that seven of eight measures in the Patient/Caregiver Experience domain transition to P4P in performance year 2 (PY2), with the Health Status/Functional Status measure (ACO-7) remaining P4R in all performance years.

1.5 RELATIONSHIP BETWEEN QUALITY PERFORMANCE AND FINANCIAL PERFORMANCE

An ACO's final sharing rate based on quality performance is used to determine the ACO's eligibility for shared savings and liability for shared losses. The final sharing rate is equal to the product of the ACO's final overall quality score and the maximum sharing rate specific to the financial model under which the ACO participates (e.g., 50 percent for Track 1, 60 percent for Track 2, 75 percent for Track 3). An ACO under a two-sided shared savings/losses model will share losses at a rate of one minus its final sharing rate. Under Track 2, the shared loss rate may not be less than 40 percent or exceed 60 percent. Under Track 3, the shared loss rate may not be less than 40 percent or exceed 75 percent. Additional factors determine the amount of savings an ACO may receive or losses for which an ACO may be liable. For detailed descriptions of the Shared Savings Program's financial models, see the Shared Savings and Losses and Assignment Methodology Specifications.

An ACO that fails to meet the quality performance standard for the reporting period will be ineligible for a shared savings payment for the related performance year. For ACOs participating under a two-sided shared savings/losses model (Track 2 and Track 3), failure to complete reporting will result in application of the highest sharing rate for losses for the performance year. ACOs with relatively higher quality scores will be eligible to share in a larger amount of savings, or be liable for a smaller amount of losses, compared to ACOs with lower quality scores.

1.6 QUALITY MEASURE RESOURCES

For each reporting year, measure documentation is made available through the CMS website, and documentation for prior reporting years also remains accessible through the CMS website in an archived format.[5] As summarized in Table 1-3, CMS maintains a variety of publicly available sources of technical documentation on quality measures, including documentation for reporting year 2017.

[5] See Shared Savings Program Quality Measures, Reporting and Performance Standards website; some documentation for prior reporting years also remains accessible through the CMS website in an archived format.

Table 1-3. Sources of Measure Documentation by Measure Type & Links for 2017 Documentation

DOCUMENT NAME	MEASURE TYPE	DESCRIPTION	2017 DOCUMENTATION*
Narrative specifications	All measures addressed in a single document	Descriptions of each measure including patient sampling criteria, measure calculation information (description of numerator and denominator and any exceptions or exclusions), and additional information provided by the measure owner (such as notes, rationale, and clinical recommendations).	Accountable Care Organization 2017 Quality Measure Narrative Specifications
Supporting documents and measure flows	ACO-reported measures	Detailed information to support data collection and reporting through the CMS Web Interface. Supporting documents provide reporting instructions for each measure. Measure flows contain performance rate calculation algorithms. The measures, and related documentation, are grouped into eight categories, or "modules."	Visit the Quality Payment Program Education & Tools website for the CMS Web Interface measure documentation. The specifications are located in the Quality Measures Specifications zip file under the Documents and Download heading, "For Registries, Qualified Clinical Data Registries, and EHR Vendors."
Measure Information Forms (MIFs)	Administrative and claims-based measures	Detailed descriptive information on each measure.	Shared Savings Program website, under "2017 Reporting Year Documentation"
Release notes	Any measure for which there has been change in specifications/ documentation	Specify changes to the measures documentation in relation to prior reporting years.	Available (as applicable) in the other referenced documentation

DOCUMENT NAME	MEASURE TYPE	DESCRIPTION	2017 DOCUMENTATION*
CAHPS for ACOs	Patient/care-giver experience measures	ACO-9 and ACO-12 Surveys. Both versions include questions from the Clinician & Group-CAHPS, supplemental items, and program-specific items.	CAHPS for ACOs Survey website
Benchmarks	All measures	Basis for determining an ACO's performance on a measure as used for quality measure scoring under P4P.	See Appendix A

**Resources are periodically updated. The links provided, or related content, may change.*

2 Quality Measures for Reporting Year 2017 and Prior Years

Since the publication of the November 2011 Shared Savings Program Final Rule, updates to the quality measures have been proposed and finalized in the Physician Fee Schedule rules. For details on the development of the measures used in each reporting year, please see the following:

- Measures used in reporting years 2012, 2013, and 2014: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; November 2011 Final Rule
- Measures used in reporting year 2015: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule
- Measures used in reporting year 2016: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rule
- Measures used in reporting year 2017: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements; Final Rule

Tables listing the measures relevant for prior reporting years and phase-in schedules for P4P are included in these referenced final rules, as well as the documentation specific to the reporting year, such as the quality measure benchmark guidance, accessible through the Shared Savings Program Quality Measures, Reporting and Performance Standards website. Note that the phase-in schedule indicated in these resources applies to a measure after it has been P4R for the first two reporting periods of its use.

3 Quality Domains and Measures

For PY 2017, and the corresponding quality reporting year 2017, CMS will measure quality of care using 31 nationally recognized quality measures in four key domains:

1. Patient/Caregiver Experience (8 measures)
2. Care Coordination/Patient Safety (10 measures)
3. Preventive Health (8 measures)
4. At-Risk Population (5 measures)
    - Depression[6] (1 measure)
    - Diabetes (2 measures scored as 1 composite measure)
    - Hypertension (1 measure)
    - Ischemic Vascular Disease (1 measure)

The 31 quality measures will be reported through a combination of a patient/caregiver experience of care survey (8 measures), CMS claims and administrative (Use of Certified Electronic Health Record Technology (CEHRT)) data (8 measures), and ACO-reported clinical quality measure data (15 measures). This section of the document reviews the measures included in each domain and identifies the method of data submission for each measure. More information on how data for these measures are collected is available in Section 4.

3.1 PATIENT/CAREGIVER EXPERIENCE MEASURES

Measures in the Patient/Caregiver Experience domain are collected via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey. The CAHPS for ACOs Survey is based on the CAHPS Clinician & Group Survey (CG-CAHPS)[7] and includes additional content relevant to patient/caregiver experience with care delivered by an ACO. The survey was developed from the CG-CAHPS core survey, CG-CAHPS supplemental items,[8] as well as program-specific items (measure sources are indicated in Table 3-1 below). The measures are referred to as summary survey measures (SSM) because the survey includes multiple questions in most of the measures. ACOs may choose between administering two different versions of the

[6] This is referred to as the Mental Health module in the CMS Web Interface documents, but it reflects the same quality measure.
[7] The CG-CAHPS Survey is maintained by the Agency for Healthcare Research and Quality (AHRQ), and used by CMS for measuring quality performance of ACOs on patient and caregiver experience of care.
[8] CG-CAHPS supplemental items were developed specifically in the context of and to supplement the CG-CAHPS items (e.g., Patient Centered Medical Home). CAHPS supplemental items refers to items within the CAHPS tool kit that may be used to supplement more than one version of the CAHPS survey, such as items that may be added to the Health Plan Survey or CG-CAHPS.

CAHPS for ACOs Survey: ACO-9 and ACO-12. (These survey names do not bear a relationship to similarly enumerated measures in other domains). The differences between the measures included in the surveys are outlined in Table 3-1, indicating that ACO-12 includes additional, optional content that is not used in calculating the ACO's quality score.

Table 3-1. Patient/Caregiver Experience Measures (2017)

ACO MEASURE #	SUMMARY SURVEY MEASURE	METHOD OF DATA SUBMISSION/SURVEY NUMBER	SOURCE	USED TO CALCULATE QUALITY SCORE?
ACO-1	Getting Timely Care, Appointments, and Information	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes
ACO-2	How Well Your Providers Communicate	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes
ACO-3	Patients' Rating of Provider	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes
ACO-4	Access to Specialists	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes
ACO-5	Health Promotion and Education	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes

ACO MEASURE #	SUMMARY SURVEY MEASURE	METHOD OF DATA SUBMISSION/SURVEY NUMBER	SOURCE	USED TO CALCULATE QUALITY SCORE?
ACO-6	Shared Decision Making	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes
ACO-7	Health Status & Functional Status	Survey/ACO-9	CG-CAHPS core; CG-CAHPS supplemental; program specific items	Yes
ACO-34	Stewardship of Patient Resources	Survey/ACO-9	CAHPS supplemental	Yes
N/A (CG-CAHPS required content)	Courteous & Helpful Office Staff	Survey/ACO-9 and ACO-12	CG-CAHPS core	No
N/A (Optional Content)	Care Coordination Between Visit Communication Helping You Take Medications as Directed	Survey/ACO-12	CAHPS supplemental; program specific items	No

Note: The ACO-9 version contains required content and the ACO-12 version contains required and optional content.

The survey also includes questions to collect information on English proficiency, disability, and self-reported race and ethnicity categories. CMS has translated the survey into Cantonese, Mandarin, Korean, Russian, Spanish, Vietnamese, and Portuguese.

3.2 CARE COORDINATION/PATIENT SAFETY MEASURES

The measures in the Care Coordination/Patient Safety domain are listed in Table 3-2 below. Measures in this domain are collected via Medicare claims data, EHR Incentive

Programs data, and the CMS Web Interface.

Table 3-2. Care Coordination/Patient Safety Measures (2017)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-8	Risk-Standardized, All Condition Readmission	Claims
ACO-35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Claims
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	Claims
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	Claims
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	Claims
ACO-43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)	Claims
ACO-11	Use of Certified EHR Technology	QPP Advancing Care Information Data
ACO-12 (CARE-1)	Medical Reconciliation Post-Discharge	CMS Web Interface
ACO-13 (CARE-2)	Falls: Screening for Future Fall Risk	CMS Web Interface
ACO-44	Use of Imaging Studies for Low Back Pain	Claims

Note: Text in parentheses is the equivalent CMS Web Interface measure identifier.

3.3 PREVENTIVE HEALTH MEASURES

The measures in the Preventive Health domain are listed in Table 3-3 below. Measures in this domain are collected via the CMS Web Interface.

Table 3-3. Preventive Health Measures (2017)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-14 (PREV-7)	Preventive Care and Screening: Influenza Immunization	CMS Web Interface
ACO-15 (PREV-8)	Pneumonia Vaccination Status for Older Adults	CMS Web Interface
ACO-16 (PREV-9)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	CMS Web Interface

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-17 (PREV-10)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface
ACO-18 (PREV-12)	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	CMS Web Interface
ACO-19 (PREV-6)	Colorectal Cancer Screening	CMS Web Interface
ACO-20 (PREV-5)	Breast Cancer Screening	CMS Web Interface
ACO-42 (PREV-13)	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS Web Interface

Note: Text in parentheses is the equivalent CMS Web Interface measure identifier.

3.4 AT-RISK POPULATION MEASURES

The measures in the At-Risk Population domain are listed in Table 3-4 below. Measures in this domain are collected via the CMS Web Interface.

Table 3-4. At-Risk Population Measures (2017)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-40 (MH-1)	Depression Remission at Twelve Months	CMS Web Interface
Diabetes Composite ACO-27 (DM-2)	Diabetes: Hemoglobin A1c Poor Control	CMS Web Interface
Diabetes Composite ACO-41 (DM-7)	Diabetes: Eye Exam	CMS Web Interface
ACO-28 (HTN-2)	Controlling High Blood Pressure	CMS Web Interface
ACO-30 (IVD-2)	Ischemic Vascular Disease: Use of Aspirin of Another Antithrombotic	CMS Web Interface

Note: Text in parentheses is the equivalent CMS Web Interface measure identifier.

4 Quality Measure Data Collection and Performance Rate Calculations

This section describes the approach for determining the patient sample and the procedures for collecting/reporting data, as well as the approach for calculating performance rates, grouped by the four methods the measures data are collected. Using the quality measure data that is collected by CMS (administrative and claims-based measures), or submitted by ACOs (CMS Web Interface measures) and survey vendors (CAHPS for ACOs Survey measures), CMS calculates performance rates for each measure for each ACO based on the algorithms specified in the measures documentation (see Section 1.6). Performance rates are used to determine the points an ACO earned on each measure according to the Program's quality benchmarks, described in Section 5. ACOs will receive performance results for all quality measures as part of their yearly quality performance reports. ACOs will also receive a CAHPS for ACOs detailed report with additional data related to their performance on the patient/caregiver experience of care measures.

4.1 BENEFICIARY AND PROVIDER ELIGIBILITY FOR QUALITY MEASUREMENT

A subset of an ACO's assigned beneficiaries are used in quality measurement for the Shared Savings Program, for the CAHPS for ACOs, CMS Web Interface measures, and claims-based measures. A beneficiary may be used in quality measurement if they meet the criteria outlined in the following steps.

Step 1. Beneficiary is assigned to an ACO.

- For Track 1 and 2 ACOs:
  - Second quarter preliminary prospectively assigned beneficiaries will be used for the CAHPS for ACOs Survey sample.
  - Third quarter preliminary prospectively assigned beneficiaries will be used for CMS Web Interface sampling.
  - Fourth quarter preliminary prospectively assigned beneficiaries will be used for claims-based measure calculations.
- For Track 3 ACOs, prospectively assigned beneficiaries will be used:
  - With exclusions through the second quarter for the CAHPS for ACOs Survey sample.
  - With exclusions through the third quarter for CMS Web Interface sampling.
  - With exclusions through the fourth quarter for claims-based measure

calculations.

Step 2. The beneficiary is eligible for use in quality measurement.

- For the CAHPS for ACOs Survey, CMS will include in the survey sample assigned beneficiaries (as identified in Step 1 above) who are 18 years or older and not excluded for one of the following reasons: received fewer than two primary care service visits within the ACO during the performance year (beneficiaries receiving care only from hospitalists are excluded); part-year eligibility in Medicare FFS Part A and Part B; entered hospice during the performance year; died during the performance year; did not reside in the United States. Institutionalized beneficiaries (individuals residing in a group home or institution such as a hospice or nursing home) are not eligible for selection, and are excluded from the survey if identified as such.[9]
- For the CMS Web Interface measures, CMS will include in the measure samples assigned beneficiaries (as identified in Step 1 above) who are not excluded for one of the following reasons: measure-specific age criteria;[10] received fewer than two primary care services within the ACO during the performance year; part-year eligibility in Medicare FFS Part A and Part B; entered hospice during the performance year; died during the performance year; did not reside in the United States.[11] Eligibility for a given measure is determined based on the criteria for each measure as described in the measure documentation (see Section 1.6).
- For claims-based measures, CMS determines if a beneficiary is eligible for the quality measure on the basis of the criteria for each measure as described in the measures documentation (see Section 1.6).

For the administrative measure (Use of CEHRT), providers eligible for inclusion in denominator are described in the narrative specifications and Measure Information Forms (MIFs).

4.2 PATIENT/CAREGIVER EXPERIENCE SURVEY DATA

4.2.1 SURVEY ADMINISTRATION

ACOs are responsible for selecting and paying for a CMS-approved vendor to administer the CAHPS for ACOs Survey to a random sample of FFS beneficiaries assigned to the ACO for the reporting year. CMS-approved CAHPS for ACOs vendors

[9] See e.g., CAHPS® Survey for ACOs Participating in Medicare Initiatives: Quality Assurance Guidelines, version 4 (July 2016).
[10] Patient age is determined during the sampling process, and patients must meet age criteria for the measure on the first and last day of the measurement period.
[11] See the annual "Web Interface Sampling Document" that is made available through the Quality Payment Program Education & Tools webpage each year.

will collect data between November and February, and deliver results to CMS.

ACOs must have a contract in place with a CMS-approved CAHPS for ACOs Survey vendor for each reporting year. CMS maintains a list of approved and conditionally approved CAHPS survey vendors, accessible through the CAHPS for ACOs website. Each year, ACOs are required to authorize a CMS-approved vendor using a web-based vendor authorization tool, identifying the ACO's survey vendor, according to a timeline specified by CMS.

If an ACO fails to select a survey vendor, or if the vendor fails to administer the survey, the ACO will be considered to have failed to meet the quality performance standard for the reporting period.

4.2.2 SURVEY SAMPLE AND SURVEY PROCEDURES

CMS randomly samples 860 FFS Medicare beneficiaries assigned to the ACO who are eligible for the survey sample as described in Section 4.1. Further, 25 percent of each ACO's sample will be drawn from "high users of care." High users of care are beneficiaries with the top 10 percent of primary care claims within the ACO. CMS will deliver the beneficiary sample to each ACO's selected vendor. High utilizers are oversampled to increase the likelihood that survey questions measuring less common experiences garner an adequate number of responses. Oversampling of high utilizers provides greater ability to study the experience of this group.

The CAHPS for ACOs Survey is collected using mixed-mode data collection procedures. The procedures start with a prenotification letter followed by a mail survey. After several weeks, sampled beneficiaries who do not respond by mail are contacted by telephone and invited to answer the survey via an interview. Beneficiaries may receive up to six telephone calls.

4.2.3 SURVEY SCALE AND PERFORMANCE RATE DETERMINATIONS

The response scales of the CAHPS for ACOs Survey measures reflect the CAHPS suite of surveys maintained by AHRQ. An ACO's performance rates on patient/caregiver experience measures are calculated using survey results submitted by an ACO's survey vendor. Each of the scored SSMs gets a 0-100 score. The process of developing the 0-100 scores for each SSM consists of the following steps:

Step 1. Assign points for individual question responses.

The first step in scoring is to assign a numeric value to each response option in the response scale for the survey measure. For example, the question "In the past six months, how often did your provider explain things in a way that was easy to understand?" has the following response scale:

- 1 – Never

- 2 – Sometimes
- 3 – Usually
- 4 – Always

For Yes/No responses, CMS assigns a value of one (1) for “Yes” and zero (0) for “No.”

Step 2. Apply sample and non-response weights.

Sampling and non-response weights are applied after assigning a numeric value to each response. These weights are applied so that statistics computed from the survey data are representative of an ACO’s population of FFS beneficiaries. Sampling weights compensate for oversampling of high utilizers of care (previously described). Non-response weights compensate for the fact that not all sampled beneficiaries respond to the survey.

Step 3. Perform case mix adjustment.

Case mix adjustment is applied to ensure that comparisons across ACOs reflect differences in performance rather than differences in beneficiary characteristics (‘case-mix’). These adjustments are based on linear regression models that describe responses on a particular survey question (the dependent variable) as a linear function of respondent characteristics (“case-mix adjustors”, or independent variables).

Case-mix adjustment is a multi-step process. The first step is identification of respondent characteristics that are significantly associated with reports and ratings of care. The next step is determination of which of these potential adjustors vary in their distribution across ACOs. Scores are adjusted for the following respondent characteristics: age, education, self-reported health status, self-reported mental health status, Medicaid dual eligibility, low-income subsidy eligibility, survey completion in an Asian language, and whether another person helped the respondent complete the survey (“proxy assistance”).

All variables are used to adjust scores for all measures, with the exception of the Health Status and Functional Status measure, which is not adjusted for self-rated health, self-rated mental health and proxy assistance, and the Sharing Your Health Information questions within the Shared Decision Making measure, which is not adjusted for proxy assistance.

The ACO’s mean score after case-mix adjustment represents the mean that would be obtained for a given ACO if the average of the case-mix variables for that ACO were equal to the national average across all participating ACOs. In other words, the case-mix adjusted score is what CMS would expect the ACO mean score to be if its patient population was the same as the national average.

Step 4. Transform scores to 0-100 scale.

Finally, weighted, case-mix adjusted numerical responses are converted to a 0-100 scale, where zero represents the poorest performance and 100 represents the best performance. Scores are converted to this scale using the following approach. First, the weighted, adjusted responses for each question in the SSM are averaged to produce the overall SSM score on the original survey response scale.

Next, this average score is transformed to the 0-100 scale using the following formula:

$$Y = \frac{(X - a)}{(b - a)} \times 100$$

"Y" is the 0-100 score, "X" is an ACO's CAHPS score on its original scale, "a" is the minimum possible score on the original scale, and "b" is the maximum possible score on the original scale. For SSMs composed of items with different response scales, the transformation from the original response scale to the 0-100 scale is performed before taking the average across scales. For example, the Health Status and Functional Status SSM is comprised of nine questions. One of these questions uses a "Never/Sometimes/Usually/Always" response scale, one uses a "Poor/Fair/Good/Very Good/Excellent scale," and seven use a "Yes/No" response scale. Because these items have different response scales, they cannot be directly averaged and are first transformed to a common 0-100 scale and then these 0-100 responses are averaged.

Table 4-1. Example of Scoring Transformation for Patients' Rating of Provider Measure (ACO-3) below shows an example of how the case-mix adjusted mean for the CAHPS for ACOs SSM Patients' Rating of Provider would be converted from the original scale to the 0-100 scale for three hypothetical ACOs. The Patients' Rating of Provider SSM is a single-question SSM, meaning there is only one question that contributes to the overall measure. The one question is as follows: "Using any number from zero to 10, where zero is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?"

Table 4-1. Example of Scoring Transformation for Patients' Rating of Provider Measure (ACO-3)

HYPOTHETICAL ACO	CASE-MIX ADJUSTED MEAN SCORE	CALCULATION OF 0-100 SCORE	CONVERTED SCORE
ACO A	7.5	(7.5-0)/(10-0) x 100	75
ACO B	8.0	(8.0-0)/(10-0) x 100	80
ACO C	9.0	(9.0-0)/(10-0) x 100	90

4.3 CLAIMS-BASED DATA

CMS obtains the necessary Medicare claims files (including Part B Carrier, Part A Inpatient, Part A Outpatient, and Part A Skilled Nursing Facility (SNF)) from the CMS

Integrated Data Repository (IDR) and calculates the rates for these measures for each ACO, based on the algorithms specified in the MIFs, which is posted on the Shared Savings Program website. Calculations for each of these measures are conducted on the ACO's assigned beneficiaries who are eligible for the measures (see Section 4.1 for additional information on which assigned beneficiaries are used). For the claims-based measures, ACOs do not need to collect or submit additional data aside from normal billing activities. Each of these measures, with the exception of ACO-44 (Imaging for Low Back Pain), are expressed in such a way that lower performance rate indicates better quality (lower calculated results are desired).

4.4 QUALITY PAYMENT PROGRAM ADVANCING CARE INFORMATION DATA

For the Use of Certified EHR Technology measure, claims and administrative data are used to calculate the performance rate for each ACO, following the algorithm specified in the MIF that will be posted on the Shared Savings Program website. Unlike all of the other ACO measures, where the unit of analysis is an ACO beneficiary or admissions, this measure focuses on the ACO provider.

Once the National Provider Identification (NPI) numbers of eligible clinicians (ECs) are identified by the Merit-Based Incentive Payment System (MIPS) program[12] for the denominator, providers are then compared with the Advancing Care Information (ACI) data to identify providers who meet the numerator. The performance rate for this measure, then, is the sum of the total number of NPIs in the numerator divided by the total number of NPIs in the denominator, multiplied by 100 percent.

Each ACO participant taxpayer identification number (TIN) is responsible for submitting data on the MIPS ACI category on behalf of its ECs in the form and manner specified by MIPS. For more information on how participating TINs must report ACI data, please visit the Quality Payment Program webpage or contact the QPP Service Center.

4.5 CMS WEB INTERFACE DATA

Shared Savings Program ACOs will use the CMS Web Interface, pre-populated with a sample of the ACO's beneficiaries, as the mechanism for collecting and submitting clinical data to CMS. ACO-reported measures are aligned with the measure requirements for non-ACO group practices that select the CMS Web Interface as a group practice reporting mechanism for MIPS. As such, narrative descriptions and supplementary documents, which provide additional guidance related to the measures

[12] If you decide to participate in traditional Medicare, rather than an Advanced APM, then you will participate in MIPS. In MIPS, you earn a payment adjustment based on evidence-based and practice-specific quality data. The Medicare Access and Children's Health Insurance Program (CHIP) Authorization Act (MACRA) defined four performance categories for MIPS, linked by their connection to quality and value of patient care: Quality, Improvement Activities, Advancing Care Information, and Cost.

reported through the CMS Web Interface, are available on the Quality Payment Program webpage.

4.5.1 ACCESSING AND REPORTING DATA THROUGH THE CMS WEB INTERFACE

ACOs are responsible for entering data into the CMS Web Interface during an eight-week data submission period that occurs just after the close of the performance year (typically spanning January – March of the calendar year following the performance year to which reporting relates). ACOs will report data based on services furnished during the calendar year (January 1 through December 31) reporting year, unless otherwise noted in the supporting documents.

CMS will not grant extensions to the reporting deadline. It is imperative that ACOs complete the data reporting and submission requirements in the CMS Web Interface by the deadline specified by CMS.

ACOs will have the opportunity to export their data from the CMS Web Interface and download reports from the system during the reporting period and following the end of the data collection period. These extracts may include:

- Patient Summary Report: maintains all the information provided for the selected patient.
- Totals Report: composed of several reports for each module. It shows the total number of completed and incomplete records per module and determines if the minimum requirement is met.
- Measure Rates Report: provides the performance rates of the clinical quality measures for your ACO Primary TIN.
- Activity Logs Report: provides a list of activities performed by anyone who has logged into the CMS Web Interface for your ACO during the submission period. The report helps to determine when patient data was updated or track user activities.

More information on the reports that are available for download as well as on how to export data is made available during the reporting period.

4.5.2 CMS WEB INTERFACE MEASURES SAMPLES

The CMS Web Interface is pre-populated with measure-specific beneficiary samples and beneficiary demographic information. For certain measures, additional data are also pre-populated in the CMS Web Interface, such as visit dates and flu shot receipt (if available in claims data).

Since each CMS Web Interface measure has specific denominator requirements, each

measure has its own beneficiary sample.[13] CMS makes reasonable efforts to include the same beneficiary in multiple measures. The measure samples are grouped into eight categories, or disease-related "modules."[14] Each beneficiary pre-populated in the CMS Web Interface will be assigned a rank based on the order in which they are sampled into a given measure module.

For the 2017 reporting year, all ACOs are required to consecutively confirm and complete a minimum of 248 beneficiaries for each measure module or all sampled beneficiaries if fewer than 248 are qualified for a module. Denominator inclusion and exclusion criteria for some measures may result in a sample of fewer than 248 beneficiaries. In this case, the ACO must report on 100 percent of the eligible beneficiaries for that measure. Whenever possible an oversample will be provided, to include more beneficiaries than are needed to meet the reporting requirement of 248.

4.5.3 CMS WEB INTERFACE MEASURE PERFORMANCE RATES

Once the submission period closes for the CMS Web Interface for each measurement period, CMS checks for complete reporting of these measures for each ACO and determines the performance rates for each measure. An ACO that fails to complete reporting by the deadline specified by CMS will be considered to have failed to meet the quality performance standard for the reporting year.

4.5.4 QUALITY MEASURES VALIDATION AUDIT

Each year, at the discretion of CMS, a subset of ACOs are selected for a Quality Measures Validation (QMV) audit. During the QMV audit, the ACO will be asked to substantiate, using information from the beneficiaries' medical record, what was entered into the CMS Web Interface for a sample of beneficiaries and a sample of measures. Beginning with 2016, CMS will calculate an overall QMV audit match rate for each audited ACO. The overall QMV audit match rate will be equal to the total number of audited records that match the information reported in the Web Interface divided by the total number of records audited.

[13] For more information see the Web Interface Sampling Document, which will be made available on the Quality Payment Program Education & Tools webpage each year.
[14] Eight modules for 2017: CAD, CARE, DM, HF, HTN, IVD, MH, PREV.

5 Quality Performance Scoring

This section describes the phase-in to P4P, data sources, methods for calculating the quality measure benchmarks for ACOs, and how the benchmarks are applied to measures that are P4P. This section also discusses how the ACO's overall quality score is derived and how CMS determines an ACO's eligibility for shared savings as part of performance year financial reconciliation. Examples included in this section are based on the quality measure benchmarks for the 2017 reporting year.

5.1 PAY FOR PERFORMANCE PHASE-IN SCHEDULE & QUALITY MEASURE BENCHMARKS

Whether measures are in P4R or P4P for a particular year depends on the timing of the ACO's agreement start date. Measures begin to phase in to P4P in PY2 of an ACO's first agreement period and continue to be phased in to P4P during PY3 of an ACO's first agreement period as illustrated in Table 5-1.

Table 5-1. Transition to Pay-for-Performance by Agreement Start Date

IF YOUR ACO STARTED IN…	REPORTING YEAR 2014	REPORTING YEAR 2015	REPORTING YEAR 2016	REPORTING YEAR 2017
2012	P4P (PY2)	P4P (PY3)	P4P (PY4)**	P4P (PY5)**
2013	P4P (PY2)	P4P (PY3)	P4P (PY4)**	P4P (PY5)**
2014	P4R (PY1)	P4P (PY2)	P4P (PY3)	P4P (PY4)**
2015	—	P4R (PY1)	P4P (PY2)	P4P (PY3)
2016	—	—	P4R (PY1)	P4P (PY2)
2017	—	—	—	P4R (PY1)

Note: — = not applicable

** For most Shared Savings Program ACOs, each performance year corresponds to one reporting period. The exception is the Shared Savings Program ACOs that have a 2012 start date. Their first performance year was 18 or 21 months and included both the 2012 and 2013 reporting periods.*

*** For purposes of this table: PY4 = first year of second agreement period; PY5 = second year of second agreement period.*

In the first performance year of their first agreement period, ACOs qualify for the maximum sharing rate when they completely and accurately report on all quality

measures (P4R). As indicated in Section 4, this requires that the ACO complete data reporting and submission through the CMS Web Interface and that the ACO's CAHPS survey vendor complete administration of the CAHPS survey for the patient/caregiver experience measures. In subsequent performance years, quality measure benchmarks are phased in for performance measures and the quality performance standard requires ACOs to continue to completely and accurately report quality data on all measures, but the ACO's final sharing rate is determined based on its performance compared to national benchmarks. When an ACO renews its participation in the Program for a second or subsequent agreement period, the quality performance of the ACO is assessed in the same manner as ACOs in the third performance year of their first agreement period.

Quality measure benchmarks are established by CMS prior to the reporting year for which they apply and are set for two years.[15] As shown in Table 5-2, each new measure will be P4R for its first two reporting years in use.[16] In other words, the transition schedule indicated in the published benchmark documents applies to a measure after it has been P4R for the first two reporting years it is in use. It is also important to note that CMS maintains the authority to revert measures from P4P to P4R when the measure owner determines the measure causes patient harm or no longer aligns with clinical practice.[17]

Table 5-2. Pay-for-Performance Schedule for New Measures

MEASURE	INTRODUCED IN…	PAY FOR PERFORMANCE SCHEDULE
ACO-34, ACO-25, ACO-36, ACO-37, ACO-38, ACO-40, ACO-41 (and thus the Diabetes Composite)	2015	In 2017 and beyond, the phase-in schedule applies.
ACO-42	2016	P4R for all ACOs, regardless of start date, in 2016 and 2017. In 2018 and beyond, the phase-in schedule applies.
ACO-43, ACO-11, ACO-12, ACO-44	2017	P4R for all ACOs, regardless of start date, in 2017 and 2018. In 2019 and beyond, the phase-in schedule applies.

[15] § 425.502(b)(4)(i) ("CMS will update the quality performance benchmarks every 2 years."); see also 79 Fed Reg.at 67926–67927.
[16] See Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule Other Revisions to Part B for CY 2015; Final Rule, 79 Fed. Reg. 67907 (Nov. 13, 2014).
[17] § 425.502(a)(5) ("CMS reserves the right to redesignate a measure as reporting when the measure owner determines the measure no longer aligns with clinical practice or causes patient harm."); *see also* 80 Fed. Reg. 71263.

See Section 2 for references to documentation showing the benchmarks and P4P phase-in schedules for each reporting year.

5.2 BENCHMARK DATA SOURCES

CMS established benchmarks for the 2016 and 2017 reporting years (Appendix A) using all available and applicable 2012, 2013, 2014, and 2015 Medicare FFS data.[18,19] These data include:

- Quality data reported through the Physician Quality Reporting System (PQRS) by physicians and groups of physicians through the CMS Web Interface, claims, or a registry for the 2012, 2013, 2014, and 2015 reporting years;[20]
- Quality data reported by Shared Savings Program and Pioneer Model ACOs through the CMS Web Interface for 2012, 2013, 2014 and 2015 performance years;
- Quality measure data collected from the CAHPS for ACOs, CAHPS for PQRS and Medicare FFS CAHPS surveys administered for the 2012, 2013, 2014, and 2015 reporting years;[21] and
- Attestation and meaningful use data collected through the EHR Incentive Programs for 2013 and 2014.

The quality measure benchmarks were calculated using ACO, group practice, and individual physician data aggregated to the TIN level. (These calculations include a TIN's data if it had at least 20 cases in the denominator for the measure). Quality data for ACOs, providers or group practices that did not satisfy the reporting requirements of the Shared Savings Program or PQRS were not included in calculation of the benchmarks.

5.3 QUALITY MEASURE SCORING

Once ACO-specific measure data has been collected and the measure performance rates are calculated, CMS determines whether all measures have been completely reported. CMS then determines how many points an ACO earned on each measure. An ACO can earn a maximum of two points on each measure, with the exception of measure ACO-11 (Use of Certified EHR Technology), which is double-weighted and

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[18] § 425.502(b)(2)(i) ("CMS will define the quality benchmarks using fee-for-service Medicare data.")
[19] § 425.502(b)(4)(iii) ("CMS will use up to three years of data, as available, to set the benchmark for each quality measure.")
[20] CMS did not use data submitted via the PQRS Qualified Clinical Data Registry (QCDR) and electronic reporting options due to data integrity issues.
[21] CMS' Medicare FFS CAHPS Survey data is only included for the Patients' Rating of Provider measure (ACO-3) due to alignment of survey questions with the CAHPS for ACOs Survey.

worth up to four points.

- Measures in P4R: Maximum points will be earned on all measures if all measures reported through the CMS Web Interface are completely reported and a CMS-approved vendor administers the CAHPS for ACOs Survey on behalf of the ACO and transmits the data to CMS. Incomplete reporting on any CMS Web Interface measure will result in zero points being earned on all CMS Web Interface measures. Similarly, if a CAHPS for ACOs Survey is not administered and no data is transmitted to CMS, zero points will be earned on all Patient/Caregiver Experience measures.
- Measures in P4P: Points are earned for each measure based on the ACO's performance compared to measure-specific benchmarks, as shown in Table 5-3. If no beneficiaries (or in the case of ACO-11, providers) are eligible for a measure's denominator, the ACO will earn full points on the measure. Incomplete reporting on any CMS Web Interface measure will result in zero points being earned on all CMS Web Interface measures. Similarly, if a CAHPS for ACOs Survey is not administered and no data is transmitted to CMS, zero points will be earned on all Patient/Caregiver Experience measures.

Table 5-3. Points Associated with Meeting or Passing Each Benchmark Level

BENCHMARK	POINTS ASSOCIATED WITH MEETING OR PASSING BENCHMARK	POINTS ASSOCIATED WITH MEETING OR PASSING ACO-11 BENCHMARK*
< 30th percentile	No points	0
30th percentile	1.10	2.20
40th percentile	1.25	2.50
50th percentile	1.40	2.80
60th percentile	1.55	3.10
70th percentile	1.70	3.40
80th percentile	1.85	3.70
90th percentile	2.00	4.00

Note: ACO-11, Use of CEHRT is double-weighted for scoring purposes.

For example, an ACO has a performance rate of 71.75 percent on ACO-13 (Falls: Screening for Falls Risk). Because ACO-13 is P4P in PY2 and PY3, CMS compares this performance rate to the benchmark for ACO-13. A rate of 71.75 percent is higher than the 80th percentile benchmark of 67.64 percent, but is lower than the 90th percentile benchmark of 82.30 percent, as shown in Table 5-4. Therefore, on ACO-13,

the ACO will receive the 1.85 points associated with surpassing the 80th percentile benchmark. Note this example is based on quality measure benchmarks for the 2016/2017 reporting years.

Table 5-4. Example of Points Assigned to Measure ACO-13 Based on 2016/2017 Measure Benchmarks

ACO-13 BENCHMARK	POINTS ASSOCIATED WITH MEETING OR PASSING THIS BENCHMARK
< 30th percentile	0
30th percentile = 25.26%	1.10
40th percentile = 32.36%	1.25
50th percentile = 40.02%	1.40
60th percentile = 47.62%	1.55
70th percentile = 57.70%	1.70
80th percentile = 67.64%	1.85
90th percentile = 82.30%	2.00

For most of the measures, the higher the level of performance, the higher the corresponding number of quality points. However, it is important to note that for some ACO quality measures, a lower score represents better performance - specifically, ACO-8, ACO-27, ACO-35, ACO-36, ACO-37, ACO-38, and ACO-43.

5.4 QUALITY MEASURE DOMAIN SCORING

5.4.1 QUALITY IMPROVEMENT REWARD SCORING

Starting with the 2015 performance year, CMS introduced a Quality Improvement Reward that will allow ACOs to earn up to four additional points in each domain if they show statistically significant improvement (based on z-scores) in their performance on quality measures from one year to the next. CMS will not deduct any points from an ACO's quality score if the ACO did not improve on a quality measure. The Quality Improvement Reward, introduced in the 2015 Physician Fee Schedule Final Rule,[22] is adapted from the Medicare Advantage Five-Star Rating program, which has developed and implemented a methodology for measuring quality improvement.[23] The Quality

[22] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2015; Final Rule, 79 Fed. Reg. 67907 (Nov. 13, 2014).

[23] For more information on the Medicare Advantage 5 Star Rating Methodology, see: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2015-Part-C-and-D-Medicare-Star-Ratings-Data-v4-16-2015.zip

Improvement Reward methodology complements and reinforces the current quality performance scoring approach by explicitly rewarding statistically significant improvements in performance on quality measures from one year to the next. ACOs in PY2 of their first agreement period and beyond will be eligible to earn a Quality Improvement Reward. The steps used to calculate the Quality Improvement Reward for each domain are outlined below.

Step 1.

For each ACO, CMS looks at the ***change in performance*** for each measure.

$$\text{Change in Performance} = Performance_{Current\ Year} - Performance_{Prior\ Year}.$$

Step 2.

CMS determines whether the change in performance was ***statistically significant*** at a 95 percent confidence level for each measure.

Step 3.

Within each domain, CMS sums the number of measures with a statistically significant improvement and subtracts the number of measures with a statistically significant decline to determine the ***Net Improvement***.[24]

Net Improvement = # of significantly improved measures - # of significantly declined measures

Step 4.

CMS next divides the Net Improvement in each domain by the number of eligible measures in the domain to calculate the ***Domain Improvement Score*** for the reward.

$$Domain\ Improvement\ Score = \frac{Net\ Improvement}{Number\ of\ Eligible\ Measures} * 100$$

- In the event that an ACO shows a statistically significant decline in a measure from one year to the next, but still scores above 90 percent (or above the 90th percentile benchmark in the case of certain claims-based measures) in both years, CMS will consider this change as a "no change" in performance instead of a significant decline in performance when calculating the Domain Improvement Score. This aligns with Medicare Advantage's "hold harmless" provision in the five-star rating methodology. Furthermore, ACOs will be "held harmless" (i.e., changes between years will neither be considered a significant improvement or a significant decline) in

[24] Note that ACO-11 is double-weighted in Step 3 and Step 4.

the following situations:

- If the ACO did not completely report measures through the CMS Web Interface in either the current year or the previous year, none of the CMS Web Interface measures will be considered a significant improvement or a significant decline (i.e., ACO will be "held harmless" on these measures).
- If the ACO did not field a CAHPS for ACO Survey in either the current year or previous year, none of the CAHPS for ACO Survey measures will be considered a significant improvement or a significant decline (i.e., ACO will be "held harmless" on these measures).
- If the ACO has a denominator of zero on a measure in either the current year or the previous year, the change in performance will neither be considered a significant improvement or a significant decline (i.e., ACO will be "held harmless" on this measure).

Note that only measures that are not new to the ACO program in a given year are used in this calculation. For example, only measures collected in both 2016 and 2017 performance years are included in the Domain Improvement Score calculation for 2017.

Step 5.

CMS assigns ***Quality Improvement Points*** to the Domain Improvement Score according to the point system listed in Table 5-5.

Table 5-5. Crosswalk between Improvement Measure Score and Quality Improvement Points

IMPROVEMENT MEASURE SCORE	QUALITY IMPROVEMENT POINTS
90+ percent	4.0 points
80+ percent	3.56 points
70+ percent	3.12 points
60+ percent	2.68 points
50+ percent	2.24 points
40+ percent	1.8 points
30+ percent	1.36 point
20+ percent	0.92 point
10+ percent	0.48 point
< 10 percent	No points

5.4.2 DOMAIN SCORE

Table 5-6 shows the maximum possible points that may be earned by an ACO in each domain and overall.

Table 5-6. Total Points for Each Domain Within the Quality Performance Standard (2017)

DOMAIN	NUMBER OF INDIVIDUAL MEASURES	TOTAL MEASURES FOR SCORING PURPOSES	TOTAL POSSIBLE POINTS	DOMAIN WEIGHT
Patient/Caregiver Experience	8	8 individual summary survey measures	16	25%
Care Coordination/ Patient Safety	10	10 measures, the EHR measure is double-weighted (4 points)	22	25%
Preventive Health	8	8 measures	16	25%
At-Risk Population	5	3 individual measures and a 2-component diabetes composite measure (scored as 1 measures)	8	25%
Total in all Domains	31	30	62	100%

The Quality Improvement Reward points (discussed in Section 5.4.1, not available for ACOs in PY1 of their first agreement period) are added to the total points earned in a domain for measure performance (discussed in Section 5.3), and this combined total of points in each domain cannot exceed the maximum points that are possible in that domain, as identified in Table 5-6. For each domain, the combined total points earned is divided by the number of possible points in the domain and multiplied by 100 to create a percentage. This results in a domain score for each of the four domains.

For example, as shown in Table 5-7**,** if an ACO earns a total of 14.80 points in the Preventive Heath domain based on their measure performance and earns an additional 2.24 Quality Improvement Reward points in the domain, they will earn 16 out of a possible 16 points and their Preventive Health domain score will be 100 percent. Note that although the total adds up to 17.04, the total points earned cannot exceed the maximum possible points in the domain (in this example, 16 points).

Table 5-7. Example of How a Domain is Scored for an ACO in Performance Year 2 (2017)

MEASURE	PERFORMANCE RATE	HIGHEST BENCHMARK PASSED	POINTS EARNED	TOTAL POSSIBLE POINTS
ACO-14	76.68%	70th percentile benchmark of 75.93%	1.70	2
ACO-15	91.82%	70th percentile benchmark of 84.55%	1.70	2
ACO-16	67.17%	60th percentile benchmark of 66.35%	1.55	2
ACO-17	90.68%	90th percentile benchmark of 90.00%	2.0	2
ACO-18	46.51%	80th percentile benchmark of 39.97%	1.85	2
ACO-19	81.40%	*Satisfactorily Reported - Pay for Reporting*	2.0	2
ACO-20	80.53%	*Satisfactorily Reported - Pay for Reporting*	2.0	2
ACO-42	71.62%	*Satisfactorily Reported - Pay for Reporting*	2.0	2
Subtotal from measures	**—**	**—**	**14.80**	**16**
Quality Improvement	55%	*>50 percent Domain Improvement Score*	2.24	4
Total	**—**	**—**	**16 (not 17.04)***	**16**

Note: The Preventive Health Domain is used in this example. — = not applicable

**Points earned is capped at the possible points earned in the domain based on the number of measures in the domain. In this case, there are 8 preventive health measures, each worth two possible points, totaling 16 points.*

5.5 OVERALL QUALITY SCORE

After a domain score has been calculated for each domain using the methodologies described above, the four domain scores are weighted equally to calculate one overall quality score.[25] Table 5-8 shows an example of an ACO in the first year of their first agreement period who completely and accurately reports on all measures collected via the CMS Web Interface and administers the CAHPS for ACOs Survey through a CMS approved vendor. As a result, the ACO earns full points on all measures and earns domain scores of 100 percent in each domain.

$$Overall\ Quality\ Score = 100\% \times 0.25 + 100\% \times 0.25 + 100\% \times 0.25 + 100 \times 0.25 = 100\%$$

Table 5-8. Example of Domain Scores for an ACO in Performance Year 1 that Completely Reported

DOMAIN	POINTS EARNED/TOTAL POSSIBLE POINTS	COMPLETE REPORTING BY DOMAIN	DOMAIN SCORE
Patient/Caregiver Experience	16/16	Completely reported on all measures	100%
Care Coordination/Patient Safety	22/22	Completely reported on all measures	100%
Preventive Health	16/16	Completely reported on all measures	100%
At-Risk Population	8/8	Completely reported on all measures	100%
Overall Quality Score	**—**	**—**	**100%**

Note: Based on quality measures in effect in 2017. — = not applicable

As shown in Table 5-9, for an ACO (in P4P) that earned a domain score of 100 percent on the Preventive Health domain, 92.50 percent on the Patient/Caregiver Experience domain, 93.18 percent on the Care Coordination/Patient Safety domain, and 85.00 percent on the At-Risk Population Domain, the overall quality score is 92.67 percent.

[25] Although the domain scores are shown rounded to the hundredths place, unrounded domain scores are used to calculate the overall quality score.

Table 5-9. Example of Domain Scores for an ACO Beyond Performance Year 1

DOMAIN	POINTS EARNED	TOTAL POSSIBLE POINTS	DOMAIN SCORE
Patient/Caregiver Experience	14.80	16	92.50%
Care Coordination/Patient Safety	20.50	22	*93.18%*
Preventive Health	16.00	16	100.00%
At-Risk Population	6.80	8	85.00%
Overall quality score	**—**	**—**	**92. 67%**

Note: Example uses 2017 reporting year quality measures. — = not applicable

$$Overall\ Quality\ Score = 92.5\% \times 0.25 + 93.18\% \times 0.25 + 100\% \times 0.25 + 85.0\% \times 0.25 = 92.67\%$$

The ACO's final overall quality score is used in determining the ACO's final sharing rate for savings and loss as described in Section 1.5.

5.6 MINIMUM ATTAINMENT REQUIREMENT

In performance years where measures are scored P4P, the quality performance standard includes a requirement that the ACO meet the minimum attainment requirements (defined as meeting the 30th percentile benchmark for P4P measures and complete reporting for P4R measures) on at least one measure in each domain. For example, as shown in Table 5-10, the ACO achieved minimum attainment on 100 percent of measures in the At-Risk Population domain by passing the 30th percentile benchmark on three out of the three P4P measures and by completely reporting on the P4R measure. Assuming the ACO has also achieved minimum attainment on at least one measure in the Patient/Caregiver Experience domain, Coordination/Patient Safety domain and the Preventive Health domain, the ACO will meet the quality performance standard.

Table 5-10. Minimum Attainment in At-Risk Population Domain for an ACO in Performance Year 2

MEASURE	PERFORMANCE RATE	HIGHEST BENCHMARK PASSED	POINTS EARNED	MINIMUM ATTAINMENT MET?
ACO-40	35.00%	Not applicable: P4R	2.00	Yes

MEASURE	PERFORMANCE RATE	HIGHEST BENCHMARK PASSED	POINTS EARNED	MINIMUM ATTAINMENT MET?
Diabetes Composite (ACO-27, 41)	43.92%	60th percentile benchmark of 41.54%	1.55	Yes
ACO-28	85.65%	80th percentile benchmark of 80.00%	1.85	Yes
ACO-30	52.32%	50th percentile benchmark of 50.00%	1.40	Yes

5.7 CONSEQUENCES OF FAILING TO MEET THE QUALITY PERFORMANCE STANDARD AND MINIMUM ATTAINMENT

CMS monitors ACO compliance with the quality performance standard and meeting minimum attainment. A compliance action may be taken if:

- An ACO does not completely and accurately report on all measures; or
- An ACO in a performance year under P4P fails to achieve the minimum attainment level (defined as meeting the 30th percentile benchmark for P4P measures and complete reporting for P4R measures) for at least 70 percent of measures in each domain.

Compliance action may include being subject to a corrective action plan (CAP); or termination of the ACO's participation agreement.

6 Alignment with the Quality Payment Program

Medicare-enrolled providers and suppliers are subject to a number of CMS quality reporting requirements and initiatives. In an effort to reduce provider quality reporting burden, CMS aligned quality reporting requirements for the Shared Savings Program with the Quality Payment Program (QPP).

6.1 QUALITY PAYMENT PROGRAM

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) of 2015 advances a coordinated framework for health care providers to successfully take part in the CMS QPP that rewards value and outcomes in one of two ways: Merit-Based Incentive Payment System (MIPS); Advanced Alternative Payment Models (APMs).

You can learn more about the QPP policies on the CMS website: https://qpp.cms.gov/.

List of Abbreviations

Acronym	Definition
ACI	Advancing Care Information
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Model
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	corrective action plan
CEHRT	Certified EHR Technology
CG-CAHPS	CAHPS Clinician & Group Survey
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CY	calendar year
ECs	eligible clinicians
EHR	Electronic Health Record
FFS	fee-for-service
GPRO	Group Practice Reporting Option
HTN	hypertension
IDR	Integrated Data Repository
IVD	Ischemic Vascular Disease
MACRA	Medicare Access and Children's Health Insurance Program Reauthorization Act
MIF	Measure Information Form
MIPS	Merit-Based Incentive Payment System
NPI	National Provider Identifier
P4P	pay-for-performance
P4R	pay-for-reporting
PFS	Physician Fee Schedule
PQI	Prevention Quality Indicator

Acronym	Definition
PQRS	Physician Quality Reporting System
PY	performance year
QMV	Quality Measures Validation
QPP	Quality Payment Program
SNF	Skilled Nursing Facility
SNFRM	Skilled Nursing Facility 30-Day All-Cause Readmission Measure
SSM	summary survey measure
TIN	taxpayer identification number

Appendix A: 2016 Reporting Year ACO Quality Measure Benchmarks

DOMAIN	MEASURE	DESCRIPTION	PAY-FOR-PERFORMANCE PHASE IN R= REPORTING P= PERFORMANCE			30TH PER C.	40TH PER C.	50TH PER C.	60TH PER C.	70TH PER C.	80TH PER C.	90TH PER C.
			PY1	PY2	PY3							
Patient/Caregiver Experience	ACO - 1	CAHPS: 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	CAHPS: How Well Your Providers Communicate	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Patient/Caregiver Experience	ACO - 3	CAHPS: Patients' Rating of Provider	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Patient/Caregiver Experience	ACO - 4	CAHPS: 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	CAHPS: Health Promotion and Education	R	P	P	56.27	57.44	58.27	59.23	60.17	61.37	63.41
Patient/Caregiver Experience	ACO - 6	CAHPS: Shared Decision Making	R	P	P	73.45	74.06	74.57	75.16	75.84	76.6	77.66
Patient/Caregiver Experience	ACO - 7	CAHPS: Health Status/Functional Status	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Patient/Caregiver Experience	ACO - 34	CAHPS: Stewardship of Patient Resources*	R	P	P	24.38	25.67	26.97	28.21	29.53	31.13	33.46
Care Coordination/Patient Safety	ACO - 8	Risk-Standardized, All Condition Readmission	R	R	P	15.32	15.19	15.07	14.97	14.87	14.74	14.54
Care Coordination/Patient Safety	ACO - 35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)*	R	R	P	19.34	18.93	18.57	18.25	17.89	17.49	16.92
Care Coordination/Patient Safety	ACO - 36	All-Cause Unplanned Admissions for Patients with Diabetes*	R	R	P	59.31	54.95	51.43	48.22	45.12	41.81	37.78
Care Coordination/Patient Safety	ACO - 37	All-Cause Unplanned Admissions for Patients with Heart Failure*	R	R	P	83.83	77.61	72.59	67.87	63.43	58.61	52.48
Care Coordination/Patient Safety	ACO - 38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	R	R	P	68.35	63.48	59.40	55.79	52.21	48.46	43.67
Care Coordination/Patient Safety	ACO - 43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)**	R	P	P	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care Coordination/Patient Safety	ACO - 11	Use of Certified EHR Technology^	R	P	P	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care Coordination/Patient Safety	ACO - 12	Medication Reconciliation Post-Discharge**	R	P	P	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care Coordination/Patient Safety	ACO - 13	Falls: Screening for Future Fall Risk	R	P	P	25.26	32.36	40.02	47.62	57.70	67.64	82.30
Care Coordination/Patient Safety	ACO - 44	Use of Imaging Studies for Low Back Pain**	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Preventive Health	ACO - 14	Preventive Care and Screening: Influenza Immunization	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00

DOMAIN	MEASURE	DESCRIPTION	PAY-FOR-PERFORMANCE PHASE IN R= REPORTING P= PERFORMANCE			30TH PER C.	40TH PER C.	50TH PER C.	60TH PER C.	70TH PER C.	80TH PER C.	90TH PER C.
			PY1	PY2	PY3							
Preventive Health	ACO - 15	Pneumonia Vaccination Status for Older Adults	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO - 16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO - 18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO - 19	Colorectal Cancer Screening	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO - 20	Breast Cancer Screening	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A
At-Risk Population Depression	ACO - 40	Depression Remission at Twelve Months	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A
At-Risk Population Diabetes	Diabetes Composite ACO - 27 and - 41	ACO-27: Diabetes Mellitus: Hemoglobin A1c Poor Control* ACO-41: Diabetes: Eye Exam*	R	P	P	27.81	32.30	37.13	41.54	46.93	52.41	60.30
At-Risk Population Hypertension	ACO - 28	Hypertension (HTN): Controlling High Blood Pressure	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population IVD	ACO - 30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00

**Measures introduced in the 2015 Physician Fee Schedule (PFS) final rule for which the phase-in schedule applies beginning with the 2018 performance year*

***Measures introduced in the 2017 PFS final rule for which the phase-in schedule applies beginning with the 2019 performance year. These measures do not have 2016 and 2017 benchmarks.*

†ACOs in their second agreement period will be assessed using the same Pay for Performance Phase In schedule as a PY3 ACO in its first agreement period.

^Measure title has changed for the 2017 performance year. The 2017 measure title is Use of Certified EHR Technology and is set at pay for reporting for all ACOs for the 2017 performance year.