Medicare Shared Savings Program

QUALITY MEASUREMENT METHODOLOGY AND RESOURCES

Specifications

October 2018
Version 2018
Applicable for Performance Year 2018

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICARE SHARED SAVINGS PROGRAM

Revision History

VERSION	MAJOR REVISIONS DESCRIPTION	AFFECTED AREA
2018	Updated year-specific references to 2018	Section 1 intro, Section 1.3, Figure 1, Section 1.6, Section 3 intro, Table 3-2, Table 3-3, Table 3-4, Section 4-5, Section 5 intro, Section 5-4, Table 5-7, Table 5-8, Table 5-9,
2018	Incorporated Track 1+ information	Section 1.5
2018	Updated links to point to new address of Shared Savings Program website, including new location of Measure Information Forms	Table 1-3, Section 2 intro, Section 4.3, Section 4.4, Section 4.5
2018	Revised location of Quality Payment Program Resource Library	Table 1-3
2018	Updated CAHPS for ACO survey information, including removal of references to ACO 9 and ACO 12	Section 3.1, Table 3-1
2018	Updated link to sampling specifications	Section 4.1
2018	Updated notification process description and description of sampling and non-response rates	Section 4.2
2018	Added information on Quality Measures Validation Audit and its impact on the Final Quality Score	Section 4.5, Section 5.5
2018	Updated information benchmarking	Section 5.2, Table 5-4, Table 5-7, Table 5-10, Appendix A

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1 Introduction

Within the Medicare Shared Savings Program (Shared Savings Program), the Centers for Medicare & Medicaid Services (CMS) enters into agreements with Accountable Care Organizations (ACOs). CMS rewards ACOs with shared savings when they are able to lower growth in Medicare Parts A and B fee-for-service (FFS) costs while also meeting performance standards on quality of care. Before an ACO can share in any savings, 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 if owed (for ACOs participating under a two-sided shared savings/losses model).

This document reviews the quality performance standard and scoring methodology for ACOs participating in the Shared Savings Program and describes the Shared Savings Program's quality measurement and reporting methodology. It also contains the 2018/2019 Quality Measure Benchmarks (Appendix A). Examples in the sections to follow focus on Performance Year 2018. This document is subject to periodic change and will be updated to reflect the policies applicable for each subsequent reporting year.

1.1 QUALITY MEASURE STRUCTURE AND DATA COLLECTION METHODS OVERVIEW

CMS develops Shared Savings Program policies with an emphasis on achieving better care for individuals, better health for populations, and lower growth in healthcare expenditures.

Similarly, CMS focuses ACO quality performance and improvement activity on four key domains (refer to Figure 1-1) 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.

To determine an ACO's quality performance score, CMS weights each of the four measure domains equally, at 25 percent, to encourage ACOs to focus on all domains to maximize their sharing rate (refer to 76 FR 67900).

Figure 1-1. Quality Domains

The number of measures within the four key domains has changed over time to reflect changes in clinical practice and to align with other quality reporting programs and to reduce burden. However, the structure of the measure domains and their equal weighting has remained consistent in determining an ACO's quality score.

1.2 QUALITY REPORTING FOR A PERFORMANCE YEAR

Quality data collection for a performance year occurs after the end of the calendar year, during the "quality data reporting period." For example, for the 2018 performance year, the data collection period for ACO submission of the performance year 2017 data through the CMS Web Interface occurred between January 22, 2018 and March 22, 2018.

Figure 1-2 below provides a timeline of quality reporting and performance assessment activities.

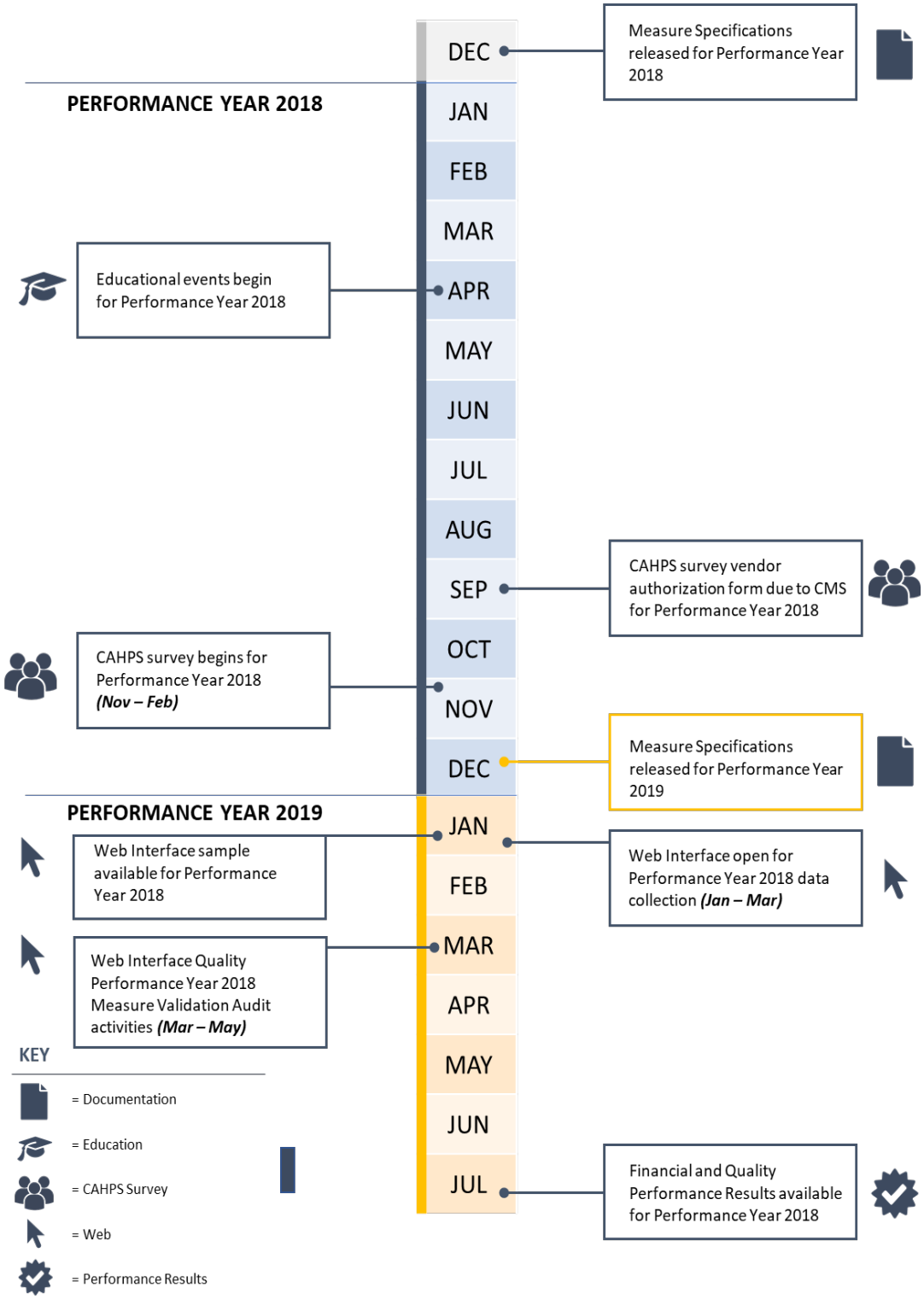

Figure 1-2. Timeline of Quality Reporting and Performance Assessment Activities

1.3 QUALITY STANDARD AND ACO TRANSITION FROM PAY-FOR-REPORTING TO PAY-FOR-PERFORMANCE

The quality performance standard is the specific 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).

CMS designates the quality performance standard for ACOs based on performance year rather than financial track. 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:

- In the first year of the first agreement period, all measures are scored as pay-for-reporting (P4R): ACOs must completely and accurately report all quality data used to calculate and assess their quality performance.
- In the second or third year of the first agreement period and all years of subsequent agreement periods, 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 Shared Savings Program:
  - ACOs must continue to completely and accurately report all quality data used to calculate and assess their quality performance.
  - CMS designates a performance benchmark and minimum attainment level for each P4P measure and establishes a point scale for the measure. An ACO's quality performance for a measure is evaluated using the appropriate point scale, and these measure-specific scores are used to calculate a 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.

Whether an ACO's performance on quality measures is scored as P4R or P4P for a particular year depends on the ACO's performance year and agreement start date. ACOs begin to phase in to P4P in the second performance year of their first agreement period and continue to phase in to P4P during the third performance year of an ACO's first agreement period. ACOs that renew their agreement for a second or subsequent agreement period continue under P4P for the length of the agreement period. There is also a phase-in process for measures added to the Shared Savings Program. For more information on the phase-in of measures from P4R to P4P, please refer to Section 4.1.

1.4 RELATIONSHIP BETWEEN QUALITY PERFORMANCE AND FINANCIAL PERFORMANCE

An ACO's final sharing rate, which is based on quality performance, is used to determine the ACO's eligibility for shared savings and liability for shared losses for ACOs under two-sided tracks.

- The final sharing rate is equal to the product of the ACO's final quality score and the maximum sharing rate specific to the financial model under which the ACO participates (e.g., 50 percent for Track 1 and Track 1+ Model, 60 percent for Track 2, 75 percent for Track 3).

$$Final\ Sharing\ Rate = Final\ Quality\ Score\ \times Max\ Sharing\ Rate$$

An ACO under a two-sided shared savings/losses model will also share losses, if applicable.

- For Track 1+ ACOs, the shared loss rate is 30 percent.
- For Tracks 2 and 3, the shared loss rate is one minus its final sharing rate.
  - For Track 2, the shared loss rate may not be less than 40 percent or exceed 60 percent.
  - For Track 3, the shared loss rate may not be less than 40 percent or exceed 75 percent.

An ACO that fails to meet the quality performance standard for the reporting period will be ineligible for a shared savings payment for the associated performance year. For ACOs participating under a two-sided shared savings/losses model (Track 2, Track 3, and Track 1+ Model), 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 if under a two-sided track, compared to ACOs with lower quality scores.

For information on the calculation and amount of savings an ACO may receive or losses for which an ACO may be liable, refer to the Shared Savings and Losses and Assignment Methodology Specifications.

1.5 QUALITY MEASURE RESOURCES

For each performance year, measure documentation is made available through the Shared Savings Program website and the Quality Payment Program Resource Library, and documentation for prior reporting years remains accessible through the CMS website in an archived format. As summarized in Table 1-1 below, CMS maintains a variety of publicly available sources of technical documentation on quality measures, including documentation for reporting year 2018.

Table 1-1. Sources of Measure Documentation by Measure Type and Links for 2018 Documentation

DOCUMENT NAME	MEASURE TYPE	DESCRIPTION	2018 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 2018 Quality Narrative Specifications
Web Interface Measures & supporting documents	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.	Visit the Quality Payment Program Resource Library for CMS Web Interface measure documentation
Measure Information Forms (MIFs)	Quality Payment Program data and claims-based measures	Detailed descriptive information on each measure.	Shared Savings Program website, under "2018 Measure Information Forms"
CAHPS for ACOs	Patient/care-giver experience measures	The CAHPS for ACOs survey include questions from the CG-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.	Refer to Appendix A

**Resources are updated for each performance year. The links provided, or related content, may change.*

2 Quality Domains and Measures

For Performance Year 2018, CMS will measure quality of care using 31 nationally recognized quality measures that span 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)
   - Mental Health (1 measure)
   - Diabetes (2 measures scored as 1 composite measure)
   - Hypertension (1 measure)
   - Ischemic Vascular Disease (1 measure)

More information regarding data collection for these measures is available in Section 3.

2.1 PATIENT/CAREGIVER EXPERIENCE MEASURES

The 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 Clinician and Group (CG)-CAHPS Survey[1] 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,[2] and program-specific items (measure sources are indicated in Table 2-1 below). The measures are referred to as summary survey measures (SSM) because the survey includes multiple questions for most of the measures.

For 2018, CMS will provide a single version of the CAHPS for ACOs Survey, which has been streamlined to 58 items. This survey includes 10 SSMs. The 2018 survey was pilot tested during the 2016 survey administration to inform CMS adoption of the survey. CMS is implementing this updated and streamlined survey for 2018 in response to stakeholder feedback and to reflect the Agency for Healthcare Research and Quality

[1] 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.
[2] 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 toolkit 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.

(AHRQ) version 3.0 update to CG-CAHPS. The summary survey measures included in the 2018 survey are outlined in Table 2-1 below.

Table 2-1. Patient/Caregiver Experience Measures (2018)

ACO MEASURE #	SUMMARY SURVEY MEASURE	METHOD OF DATA SUBMISSION	SOURCE	USED TO CALCULATE QUALITY SCORE?
ACO-1	Getting Timely Care, Appointments, and Information	Survey	core items	Yes
ACO-2	How Well Your Providers Communicate	Survey	core items	Yes
ACO-3	Patients' Rating of Provider	Survey	core item	Yes
ACO-4	Access to Specialists	Survey	supplemental item	Yes
ACO-5	Health Promotion and Education	Survey	supplemental items	Yes
ACO-6	Shared Decision Making	Survey	supplemental items	Yes
ACO-7	Health Status & Functional Status	Survey	core and supplemental items	Yes*
ACO-34	Stewardship of Patient Resources	Survey	supplemental items	Yes
N/A (CG-CAHPS required content)	Courteous & Helpful Office Staff	Survey	core items	No
N/A (CG-CAHPS required content)	Care Coordination	Survey	core items	No

**ACO-7 is pay-for-performance in all years of an ACO's agreement. ACOs will receive 2 points on this measure in quality scoring (see Section 4) if the ACO completely reports the CAHPS measures.*

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, Korean, Mandarin, Portuguese, Russian, Spanish, and Vietnamese.

2.2 CARE COORDINATION/PATIENT SAFETY MEASURES

The measures scored in the Care Coordination/Patient Safety domain are listed in Table 2-2 below. Measures in this domain are collected via Medicare claims data, Quality Payment Program data, and the CMS Web Interface.

Table 2-2. Care Coordination/Patient Safety Measures (2018)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-8	Risk-Standardized, All Condition Readmission	CMS calculates from claims
ACO-35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	CMS calculates from claims
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	CMS calculates from claims
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	CMS calculates from claims
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	CMS calculates from claims
ACO-43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)	CMS calculates from claims
ACO-11	Use of Certified EHR Technology	Quality Payment Program Promoting Interoperability (previously called Advancing Are 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	CMS calculates from claims

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

2.3 PREVENTIVE HEALTH MEASURES

The measures scored in the Preventive Health domain are listed in Table 2-3 below. Measures in this domain are collected via the CMS Web Interface.

Table 2-3. Preventive Health Measures (2018)

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-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.

2.4 AT-RISK POPULATION MEASURES

The measures scored in the At-Risk Population domain are listed in Table 2-4 below. Measures in this domain are collected via the CMS Web Interface.

Table 2-4. At-Risk Population Measures (2018)

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.

3 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. Using the quality measure data collected using Quality Payment Program data, Medicare claims data (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 measure specifications (refer to Section 1.5).

Performance rates are used to determine the points an ACO earned on each measure according to the Shared Savings Program's quality benchmarks, which are described in Section 4.1. ACOs will receive performance results for all quality measures as part of their annual 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.

Table 3-1 below details four categories of measures, used in the Shared Savings Program, by data collection method.

Table 3-1. Quality Measures by Data Collection Method

QUALITY MEASURE TYPE	DATA USED	WHO WILL GATHER THE QUALITY INFORMATION?
Survey 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 calculates measures from Medicare claims data.
Quality Payment Program data measure: Use of Certified EHR Technology (CEHRT)	Quality Payment Program-eligible clinician and Promoting Interoperability (PI) data	CMS calculates measure using administrative data.

QUALITY MEASURE TYPE	DATA USED	WHO WILL GATHER THE QUALITY INFORMATION?
ACO-reported clinical quality measures	Medicare beneficiaries' demographic information and claims data files Data reported by ACOs through the CMS Web Interface using 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 clinical data for sampled patients in the CMS Web Interface. CMS Web Interface calculates preliminary performance rates

3.1 BENEFICIARY SELECTION FOR QUALITY MEASUREMENT

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

Criteria 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 and Track 1+ model ACOs:
  - Prospectively assigned beneficiaries maintaining eligibility as of the second quarter will be used for the CAHPS for ACOs Survey sample.
  - Prospectively assigned beneficiaries maintaining eligibility as of the third quarter will be used for CMS Web Interface sampling.
  - Prospectively assigned beneficiaries maintaining eligibility as of the fourth quarter will be used for claims-based measure calculations.

Criteria 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, excluding those who:
    - Received fewer than two primary care service visits within the ACO during the performance year (beneficiaries receiving care only from hospitalists are excluded);
    - Entered hospice during the performance year;
    - Died during the performance year;
    - Were institutionalized (resided in a group home or institution such as a hospice or nursing home).[3]
- For the CMS Web Interface measures:
  - CMS will include in the measure samples assigned beneficiaries (as identified in Step 1 above), excluding those who:
    - Do not meet measure-specific age criteria;[4]
    - Received fewer than two primary care services within the ACO during the performance year;
    - Entered hospice during the performance year;
    - Died during the performance year;
    - Do not meet measure-specific eligibility criteria as described in the measure specifications (refer to Section 1.5).
- For claims-based measures, CMS determines if a beneficiary is eligible for the quality measure based on the criteria for each measure as described in the measures documentation (refer to Section 1.5).
- For ACO-11 (Use of CEHRT), providers eligible for inclusion in denominator are described in the narrative specifications and MIFs.

[3] Refer to CAHPS® Survey for ACOs Survey Quality Assurance Guidelines, version 6 (June 2018).
[4] Patient age is determined during the sampling process, and patients must meet age criteria for the measure on the first and last days of the measurement period.

3.2 PATIENT/CAREGIVER EXPERIENCE SURVEY DATA

3.2.1 SURVEY ADMINISTRATION

ACOs are responsible for selecting and paying for CMS-approved vendors 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 Survey vendors 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 CAHPS for ACOs Survey vendors, which is 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—which identifies the ACO's survey vendor—according to a timeline specified by CMS.

3.2.2 SURVEY SAMPLE AND SURVEY PROCEDURES

CMS randomly samples 860 Medicare FFS beneficiaries assigned to an ACO who are eligible for the survey sample as described in Section 3.1. Furthermore, 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 users of care are oversampled to increase the likelihood that survey questions measuring less common experiences garner an adequate number of responses. Oversampling of high users of care provides greater opportunity to study the experience of this group.

The CAHPS for ACOs Survey is collected using mixed-mode data collection procedures. Sampled beneficiaries are mailed a pre-notification letter, followed by two survey mailings. 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.

3.2.3 SURVEY SCALE AND PERFORMANCE RATE DETERMINATIONS

The response scales of the CAHPS for ACOs Survey SSMs reflect the CAHPS suite of surveys maintained by AHRQ. The response scale is the list of response options for one item. An ACO's performance rates on patient/caregiver experience SSMs 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 convert survey respondents' descriptive responses into numerical values using the response scale for the survey question. 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 response scales, CMS assigns a value of one (1) for “Yes” and zero (0) for “No.”

After assigning a numeric value to each response apply, CMS applies sampling weights that compensate for oversampling of high users of care (previously described).

Step 2. Perform case mix adjustment.

Case mix adjustment is a multi-step process and refers to the use of statistical procedures to permit comparison of quality performance between ACOs with differing assigned beneficiary populations. It 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).

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 SSM and the sharing health information question within the Shared Decision Making SSM.[5]

An ACO’s mean score after case-mix adjustment represents the ACO’s estimated mean score after adjustment for differences between the case mix of their assigned beneficiaries and the case mix of the national average of beneficiaries assigned to all participating ACOs. In other words, the case-mix adjusted score is the mean that would be obtained for a given ACO if the average case mix variables for that ACO were equal to the national average across all participating ACOs. The ACO’s actual mean score will

[5] The Health Status and Functional Status summary survey measure is not adjusted for self-rated health, self-rated mental health, and proxy assistance. The question on sharing your health information within the Shared Decision making measure is not adjusted for proxy assistance.

be adjusted upward or downward for a given measure depending on how different the patient population of the ACO is, relative to the national average case-mix.

Step 3. 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 of a given 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* = 0-100 score
- *X* = ACO's CAHPS score on its original scale
- *a* = minimum possible score on the original scale
- *b* = 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.

Table 3-2 below provides an example of how the case-mix adjusted mean for the Patients' Rating of Provider SSM would be converted from its original scale to the 0-100 scale for three hypothetical ACOs. The Patients' Rating of Provider SSM is a single-question SSM, which means 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 3-2. Example of Scoring Transformation for Access to Specialists Measure (ACO-4)

HYPOTHETICAL ACO	CASE-MIX ADJUSTED MEAN SCORE	CALCULATION OF 0-100 SCORE	CONVERTED SCORE
ACO A	3.75	$\frac{(3.75 - 1)}{(4 - 1)} \times 100$	91.67
ACO B	3.5	$\frac{(3.5 - 1)}{(4 - 1)} \times 100$	83.33
ACO C	3.25	$\frac{(3.25 - 1)}{(4 - 1)} \times 100$	75.00

3.3 CLAIMS-BASED DATA

CMS obtains the necessary Medicare Part A and Part B claims files from the CMS Integrated Data Repository (IDR) and calculates the performance rates for these measures for each ACO based on the algorithms specified in the MIFs, which are posted on the Shared Savings Program website. Calculations for each of these measures are conducted using the ACO's assigned beneficiaries who are eligible for the measures (refer to Section 4.1 for additional information on assigned beneficiary eligibility). For claims-based measures, ACOs do not need to collect or submit additional data beyond 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).

3.4 QUALITY PAYMENT PROGRAM PROMOTING INTEROPERABILITY DATA

For the Use of CEHRT measure (ACO-11), data from the Quality Payment Program Promoting Interoperability category (formerly Advancing Care Information) are used.

Specifically, the denominator of this measure is a list of MIPS eligible clinicians in all Shared Savings Program ACOs, regardless of track. Unlike the other ACO measures, where the unit of analysis is an ACO beneficiary, this measure focuses on the ACO provider. The numerator of this measure is the number of MIPS-eligible clinicians in the ACO met the Promoting Interoperability base score. The measure performance rate is that quotient, multiplied by 100 percent (100.0%).

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

3.5 CMS WEB INTERFACE DATA

An ACO will use the CMS Web Interface, which is 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 reported through the CMS Web Interface, are available on the Quality Payment Program webpage.[6]

[6] Please note that while the CMS Web Interface measure specifications note that three rates will be reported for ACO-17 (PREV-10), the Shared Savings Program will use only the second rate for Shared Savings Program quality scoring.

3.5.1 ACCESSING AND REPORTING DATA THROUGH THE CMS WEB INTERFACE

ACOs are responsible for entering data into the CMS Web Interface during an eight-week quality data reporting period that occurs just after the close of the performance year (typically January through March of the calendar year following the performance year). ACOs will report data based on services furnished during the performance year (January 1 through December 31), 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.

More information on these reports, as well as information on how to export data, will be available during the reporting period.

3.5.2 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), and the three providers in the ACO who provided the most care to the beneficiaries.

Since each CMS Web Interface measure has specific denominator requirements, each measure has its own beneficiary sample.[7] CMS makes reasonable efforts to include the same beneficiary in multiple measures in order to reduce reporting burden. The measure samples are grouped into eight categories, or disease-related "modules."[8] Beneficiaries pre-populated in the CMS Web Interface will be assigned ranks based on the order in which they are sampled into a given measure module.

For the 2018 reporting year, all ACOs are required to confirm and complete a minimum of 248 consecutive beneficiaries for each measure module, or confirm and complete 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. Oversampling is conducted to include more beneficiaries

[7] For more information, refer to the CMS Web Interface Sampling Document, which will be available on the Quality Payment Program Resource Library webpage each year.
[8] Eight modules for 2018: CARE, DM, HTN, IVD, MH, PREV.

(e.g. up to 616 beneficiaries or 750 for PREV-13) than are needed to meet the reporting requirement of 248.

3.5.3 CMS WEB INTERFACE MEASURE PERFORMANCE RATES

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

4 Quality Performance Scoring

This section describes the phase-in to P4P, data sources, methods for calculating the quality measure benchmarks for ACOs, and how these benchmarks are applied to P4P measures. This section also discusses how an ACO's quality score is calculated 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 2018/2019 performance years.

4.1 QUALITY MEASURE BENCHMARKS

Quality measure benchmarks are set for two years and are established by CMS prior to the first performance year for which they apply. The benchmarks are used to score measure performance, domain performance and calculate each ACO's quality score.

When a measure is added to the ACO quality measure set, it will be P4R for its first two performance years 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.

4.1.1 BENCHMARK DATA SOURCES

CMS established benchmarks for the 2018 and 2019 reporting years (Appendix A) using all available and applicable 2014, 2015, and 2016 Medicare FFS data. This includes:

- Quality data reported by Shared Savings Program, Pioneer Model ACOs, and Next Generation Model ACOs through the CMS Web Interface for the 2014, 2015, and 2016 performance years; and
- Quality measure data collected from the CAHPS for ACOs and CAHPS for PQRS surveys administered for the 2014, 2015, and 2016 reporting years.

- 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 2014, 2015, and 2016 reporting years;[9, 10]

The quality measure benchmarks were calculated using ACO, group practice, and individual physician data aggregated to the practice or TIN level. (These calculations only include a practice or 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.

4.2 QUALITY MEASURE SCORING

Once ACO-specific measure data is collected and 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 worth up to four points.

- P4R measures: 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 for all CMS Web Interface measures and failure to meet the quality standard for the performance year. Similarly, if a CAHPS for ACOs Survey is not administered and no data is transmitted to CMS, zero points will be earned for all Patient/Caregiver Experience measures and the ACO will fail to meet the quality standard for the performance year.
- P4P measures: Points are earned for each measure based on the ACO's performance compared to measure-specific benchmarks, as shown in Table 4-1 below. 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 for all CMS Web Interface measures and the ACO will fail to meet the quality standard for the performance year. Similarly, if a CAHPS for ACOs Survey is not administered and

[9] CMS did not use data submitted in 2014 via the PQRS Qualified Clinical Data Registry (QCDR) and electronic reporting options due to data integrity issues. Other measure-specific mechanism exclusions were also made on a case-by-case basis.
[10] ACO-17 was respecified in 2018. As a result, we recalculated the measure using patient-level data submitted by ACOs and group practices through the CMS Web Interface in 2014, 2015, and 2016 and created benchmarks using solely that data.

no data is transmitted to CMS, zero points will be earned for all Patient/Caregiver Experience measures and the ACO will fail to meet the quality standard for the performance year.

Table 4-1. Points Associated with Meeting or Passing Each Benchmark Level

BENCHMARK	POINTS ASSOCIATED WITH MEETING OR PASSING BENCHMARK, ALL MEASURES OTHER THAN ACO-11	POINTS ASSOCIATED WITH MEETING OR PASSING ACO-11 USE OF CEHRT BENCHMARK*
< 30th percentile	No points	No points
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

Example

An ACO earns a performance rate score of 82.75 on measure ACO-13 (Falls: Screening for Future Fall Risk). The performance rate score of 82.75 is at or above the 80th percentile and below the 90th percentile, so the ACO will receive 1.85 points (Refer to table above).

Measure	Description	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
	Points	1.1	1.25	1.4	1.55	1.7	1.85	2.00
ACO-13	Falls: Screening for Future Fall Risk	43.42	50.42	58.45	66	73.39	81.79	90.73

Please note that this example is based on quality measure benchmarks for the 2018/2019 performance years.

For most 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 assessing the occurrence of undesirable outcomes, a lower score represents better performance. Specifically,

- ACO-8 (Risk-Standardized All-Condition Readmission), ACO-35 (Skilled Nursing Facility 30-Day All-Cause Readmission Measure), ACO-36 (All-Cause Unplanned

Admissions for Patients with Diabetes), ACO-37 (All-Cause Unplanned Admissions for Patients with Heart Failure), ACO-38 (All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions) capture admissions and readmissions that are preventable events

- ACO-27 (Diabetes Mellitus: Hemoglobin A1c Poor Control) captures beneficiaries whose HbA1c is not in control, and
- ACO-43 (Ambulatory Sensitive Condition Acute Composite) captures the ratio of observed admissions to expected admissions.

4.3 QUALITY MEASURE DOMAIN SCORING

4.3.1 QUALITY IMPROVEMENT REWARD SCORING

Starting with Performance Year 2015, CMS introduced a Quality Improvement Reward that allows ACOs to earn up to four additional points in each domain if they show statistically significant improvement 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 is adapted from the Medicare Advantage Five-Star Rating program, which has developed and implemented a methodology for measuring quality improvement.[11] ACOs in Performance Year 2 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.

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

Step 2.

CMS determines whether the change in performance was ***statistically significant*** (either improved or declined) 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 ***net improvement***.

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

$$Net\ Improvement = \#\ of\ Singificantly\ improved\ measures - \#\ of\ significantly\ declined\ measures$$

Step 4.

CMS divides the net improvement in each domain by the number of eligible measures in the domain to calculate the ***domain improvement score***. This score is used to determine the Quality Improvement Reward.

$$Domain\ Improvement\ Score = \frac{Net\ Improvment}{\#\ of\ Eligible\ Measures} \times 100\%$$

In the event that an ACO demonstrates 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 "no change" in performance (instead of a significant decline) when calculating the domain improvement score. This aligns with the Medicare Advantage "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 nor a significant decline) in 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.
- 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.
- 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 nor a significant decline.

Note that only measures that are not new to the Shared Savings Program in a given year are used in this calculation. For example, only measures collected in both Performance Year 2017 and Performance Year 2018 are included in the domain improvement score calculation for 2018.

Step 5.

CMS assigns ***quality improvement points*** to the domain improvement score according to the point system listed in Table 4-2 below.

Table 4-2. 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

4.3.2 DOMAIN SCORE

Table 4-3 below shows the maximum possible points that may be earned by an ACO in each domain and overall.

Table 4-3. Total Points for Each Domain Within the Quality Performance Standard (2018)

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 measure)	8	25%
Total in all Domains	31	30	62	100%

The quality improvement reward points (discussed in Section 4.3.1) are added to the total points earned in a domain for measure performance (discussed in Section 4.2), and this combined total of points cannot exceed the maximum points that are possible in that domain, as identified in Table 4-3. For each domain, the combined total of points is divided by the number of possible points for the domain and multiplied by 100 to create a percentage. This results in a domain score for each of the four domains.

Example:

There are 16 possible points in the Preventive Health domain. If an ACO earns:

$$14.8\ Performance\ Measure\ Points + 2.24\ Quality\ Improvment\ Points\ = 17.04$$

$$Domain\ Score = \frac{Total\ Points\ Earned}{Total\ Possible\ Points} \times 100\% = \frac{17.04}{16} \times 100\% = 100\%$$

The total 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.

	Description	P / R	Performance Rate	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	Points Earned
	Points			1.40	1.55	1.70	1.85	2.00	
ACO-14	Preventive Care and Screening: Influenza Immunization	P	76.68%	50	60	70	80	90	1.70
ACO-15	Pneumonia Vaccination Status for Older Adults	P	71.82%	50	60	70	80	90	1.70
ACO-16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	P	67.17%	50	60	70	80	90	1.55
ACO-17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	P	93.68%	68.18	73.85	79.55	85.67	92.31	2.0
ACO-18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	P	86.51%	50	60	70	80	90	1.85
ACO-19	Colorectal Cancer Screening	R	81.40%	50	60	70	80	90	2.0
ACO-20	Breast Cancer Screening	R	80.53%	50	60	70	80	90	2.0
ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	R	71.62%	N/A	N/A	N/A	N/A	N/A	2.0
Total									**14.80**
	Points			2.24	2.68	3.12	3.56	4.0	
	Quality Improvement		55%	50	60	70	80	90	2.24
Total									**17.04**

**Points earned are capped at the maximum possible points that can be earned in the domain. In this case, there are 8 preventive health measures, each worth 2 possible points, for a total of 16 points.*

4.4 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 quality score.[12] Table 4-4 below shows an example of an ACO in the first year of their first agreement period (P4R) that completely and accurately reported on all measures collected via the CMS Web Interface and administered the CAHPS for ACOs Survey

[12] Although domain scores are shown rounded to the hundredths place in this document, unrounded domain scores are used to calculate the quality score.

through a CMS-approved vendor. As a result, the ACO earns full points on all measures and earns domain scores of 100 percent for each domain.

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

Table 4-4. Example of Domain Scores for an ACO in Performance Year 1 that Completely Reported

DOMAIN	POINTS EARNED/TOTAL POSSIBLE POINTS FOR ACO IN FIRST PERFORMANCE YEAR	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%
Quality Score	**—**	**—**	**100%**

Note: Based on quality measures in effect in 2018. — = not applicable

As shown in Table 4-5 below, for an ACO beyond the first year of their first agreement period 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 quality score is 92.67 percent.

Table 4-5. Example of Domain Scores for an ACO Beyond Performance Year 1

DOMAIN	POINTS EARNED FOR ACO BEYOND PERFORMANCE YEAR 1	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%
Quality score			**92.67%**

Note: Example uses 2018 reporting year quality measures.

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

4.5 QUALITY MEASURES VALIDATION AUDIT

An ACO's quality score may be impacted by the Quality Measures Validation (QMV) audit. The ACO's final quality score is used in determining the ACO's final sharing rate for savings and losses as described in Section 1.4.

Each year, at the discretion of CMS, a subset of ACOs are selected for a QMV audit. During the QMV audit, an ACO will be asked to substantiate, using information from its beneficiaries' medical records, what was entered into the CMS Web Interface for a sample of beneficiaries and a sample of measures. 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 CMS Web Interface divided by the total number of records audited. If the audit concludes that the overall audit match rate between the quality data reported through the CMS Web Interface and the medical records is less than 80 percent, absent unusual circumstances, CMS will adjust the ACO's quality score proportional to the ACO's audit performance (42 CFR § 425.500(e)(2)).

The quality score for ACOs who have failed the audit will be adjusted by one percent for each percentage point difference between the ACO's QMV Audit match rate and 80 percent. In other words, the final quality score for ACOs who have failed the audit will be calculated as follows:

$$Quality\ Score\ \times (100\% - [80\% - QMV\ Audit\ Match\ Rate])$$

If, at the conclusion of the audit process, CMS determines that the ACO has passed the audit (match rate of 80 percent or higher), but that there is an audit match rate of less than 90 percent, the ACO may be subject to compliance action such as being required to submit a corrective action plan (CAP) under 42 CFR § 425.216 for CMS approval (per 42 CFR § 425.500(e)(3)).

4.6 COMPLIANCE

CMS may take compliance action if the ACO fails to meet the minimum attainment level on at least 70 percent of measures in one or more domains Compliance actions may include receiving a warning letter or being subject to a CAP or a special monitoring plan. Also, failure to report quality measure data accurately, completely, and timely may subject the ACO to termination.

5 Alignment with the Quality Payment Program

The Quality Payment Program rewards value and outcomes in one of two ways through the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

CMS aligned quality reporting requirements for the Shared Savings Program with the Quality Payment Program in an effort to reduce reporting burden.

There are a number of resources available to Shared Savings Program ACOs, including the following guides:

- Medicare Shared Savings Program & MIPS Interactions (Appendix B)
- Performance Year 2018 Quality Performance Category Scoring Web Interface Reporters under the APM Scoring Standard
- Scores for Improvement Activities in MIPS APMs in the 2018 Performance Period

List of Acronyms

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
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
PQRS	Physician Quality Reporting System

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

Appendix A: 2018/2019 Performance Years ACO Quality Measure Benchmarks

Benchmarks for quality measures that are pay-for-performance for at least one cohort of ACOs in PY 2018 are specified below. The measures' phase-in schedules are also listed. These phase-in schedules assume that all measures have been in use for two or more years. So, if a measure description is marked with an asterisk (*) or caret (^), the measure is pay-for-reporting for all ACOs (regardless of the ACO's start date) in 2018 because the measure was introduced in 2017. This is the case regardless of what the phase-in schedules indicate.

Domain	Measure	Description	Pay-for-Performance Phase In†			30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
			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	54.18	55.48	56.72	57.95	59.39	60.99	63.44
Patient/ Caregiver Experience	ACO-6	CAHPS: Shared Decision Making	R	P	P	54.75	55.97	57.05	58.10	59.27	60.58	62.76

Domain	Measure	Description	Pay-for-Performance Phase In†			30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
			PY1	PY2	PY3							
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	24.25	25.57	26.74	28.12	29.43	31.08	33.43
Care Coordination/ Patient Safety	ACO-8	Risk-Standardized, All Condition Readmission	R	R	P	15.18	15.04	14.91	14.79	14.65	14.50	14.27
Care Coordination/ Patient Safety	ACO-35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	R	R	P	19.22	18.81	18.47	18.15	17.80	17.41	16.85
Care Coordination/ Patient Safety	ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	R	R	P	60.28	55.75	52.07	48.84	45.74	42.32	37.99
Care Coordination Patient Safety	ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	R	R	P	82.32	76.20	71.24	66.71	61.91	57.13	50.99
Care Coordination/ Patient Safety	ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	R	R	P	65.99	61.21	57.25	53.51	50.00	46.16	41.39
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 Technologyv	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

Domain	Measure	Description	Pay-for-Performance Phase In†			30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
			PY1	PY2	PY3							
Care Coordination/ Patient Safety	ACO-13	Falls: Screening for Future Fall Risk	R	P	P	43.42	50.42	58.45	66.00	73.39	81.79	90.73
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
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	55.22	61.76	68.18	73.85	79.55	85.67	92.31
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

Domain	Measure	Description	Pay-for-Performance Phase In†			30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
			PY1	PY2	PY3							
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	29.90	34.33	38.81	43.32	48.21	53.64	60.37
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

Note: R=Reporting; P=Performance

**Measures introduced in the 2017 PFS Final Rule for which the phase-in schedule applies beginning with Performance Year 2019. These measures do not have benchmarks for Performance Year 2018. This table will be updated in advance of Performance Year 2019 to include benchmarks for these measures.*

† Phase-In applies to an ACO's first agreement period. ACOs in their second agreement period will be assessed using the same pay-for-performance phase-in schedule as a Performance Year 3 ACO in its first agreement period.

^Measure title has changed for Performance Year 2017. The 2017 measure title is Use of Certified EHR Technology and is set at pay-for-reporting for all ACOs for Performance Year 2018.

Appendix B: 2018 Medicare Shared Savings Program and Merit-based Incentive Payment System (MIPS) Interactions

	MIPS PERFORMANCE CATEGORY, SCORING, AND ELIGIBILITY STATUS					
ACO STATUS	**QUALITY**	**IMPROVEMENT ACTIVITIES (IA)**	**PROMOTING INTEROPERABILITY (PI)**	**COST**	**LOW VOLUME THRESHOLD**	**ELIGIBLE FOR MIPS ALTERNATIVE PAYMENT MODEL (APM) SCORING STANDARD**
ACO successfully reports quality[13]	Eligible clinicians in the ACO[14] get a quality performance score based on the CMS Web Interface and CAHPS for ACO quality measures that are reported by the ACO.	Eligible clinicians in the ACO get full credit based on ACO participation. No additional reporting is necessary.	ACO participant TINs report at the group level or solo practice level for eligible clinicians subject to PI.[15] Data is aggregated and weighted to get a single ACO score that applies to all eligible clinicians.	N/A under the APM scoring standard.	Determined at the ACO level. This means that even if clinicians, or physician groups, are at or below the low volume threshold of $90,000 in covered professional services under the Medicare PFS, or furnishing covered professional services to less than or equal to 200 beneficiaries, if they bill through the TIN of an ACO participant or if the physician group is an ACO participant they will be subject to MIPS if the ACO exceeds the low volume threshold. It is rare that an ACO does not exceed the low volume threshold.	Yes, based on ACO performance on quality measures, IA full credit, and aggregated and weighted ACO performance on PI. Quality is weighted at 50%, IA at 20%, and PI at 30%.

[13] The ACO must successfully report the CMS Web Interface and CAHPS for ACO quality measures.
[14] For purposes of this table, the term “ACO” equates to an APM Entity—a defined term in the Quality Payment Program.
[15] More information on PI reporting and requirements are available in the PI Fact Sheet.

	MIPS PERFORMANCE CATEGORY, SCORING, AND ELIGIBILITY STATUS					
ACO STATUS	**QUALITY**	**IMPROVEMENT ACTIVITIES (IA)**	**PROMOTING INTEROPERABILITY (PI)**	**COST**	**LOW VOLUME THRESHOLD**	**ELIGIBLE FOR MIPS ALTERNATIVE PAYMENT MODEL (APM) SCORING STANDARD**
ACO doesn't successfully report quality	Eligible clinicians get a quality performance score of zero unless the ACO participant TIN reports separately from the ACO. ▪ Groups may report using registry, QCDR, EHR, CAHPS for MIPS or Web Interface (if the TIN registered for Web Interface or CAHPS for MIPS reporting) submission methods. ▪ Solo practices may report using QCDR, claims, EHR, and registry submission methods.[16]	Eligible clinicians in the ACO get full credit based on ACO participation. No additional reporting is necessary.	ACO participant TINs report and are scored at the group level or solo practice level for eligible clinicians subject to PI.	N/A under the APM scoring standard.	Determined at the ACO level. This means that even if clinicians, or physician groups, are at or below the low volume threshold of $90,000 in covered professional services under the Medicare PFS, or furnishing covered professional services to less than or equal to 200 beneficiaries, if they bill through the TIN of an ACO participant or if the physician group is an ACO participant, they will be subject to MIPS if the ACO exceeds the low volume threshold. It is rare that an ACO does not exceed the low volume threshold.	Yes, based on ACO participant TIN's performance on quality measures reported outside of the ACO, IA full credit, and ACO participant TIN's performance on PI. Quality is weighted at 50%, IA at 20%, and PI at 30%.

[16] More information regarding MIPS group reporting is available in the MIPS Group Participation Resource.

	MIPS PERFORMANCE CATEGORY, SCORING, AND ELIGIBILITY STATUS					
ACO STATUS	**QUALITY**	**IMPROVEMENT ACTIVITIES (IA)**	**PROMOTING INTEROPERABILITY (PI)**	**COST**	**LOW VOLUME THRESHOLD**	**ELIGIBLE FOR MIPS ALTERNATIVE PAYMENT MODEL (APM) SCORING STANDARD**
ACO's Medicare Shared Savings Program Agreement is Terminated	Agreement is terminated on or after March 31st of the performance year: Eligible clinicians in ACO participant TINs are subject to APM scoring standard rules for ACOs. The rules that apply for MIPS APM reporting and scoring depend on whether the ACO successfully reports as explained in the rows above. Please note that regardless of whether the ACO successfully reports quality, eligible clinicians will get full credit for IA, which is enough to earn at least a neutral MIPS adjustment in 2020. Agreement is terminated before March 31st of the performance year: Eligible clinicians in ACO participant TINs must participate in MIPS either at the group or individual level and will be subject to regular MIPS scoring rules. For more information on MIPS scoring rules for an individual or group, please visit: https://qpp.cms.gov/mips/overview.					
Qualifying APM Participant	Eligible clinicians who reassigned their billing rights to an ACO participant TIN in a Track 2, Track 3, or Track 1+ Model ACO and are identified in one of the first 3 performance year snapshots (March 31, June 30, and August 31) during the 2018 QP performance period may become Qualifying APM Participants (QPs)[17] for the year. If these eligible clinicians meet thresholds to become QPs for the year, they will receive an APM incentive payment and be excluded from MIPS. Note, if a Track 1+ Model ACO Track 2 or Track 3 ACO terminates its participation in the Shared Savings Program after March 31st and before August 31st, its eligible clinicians will lose QP status and become MIPS eligible. These clinicians should keep working with their ACO to report quality measures in order to benefit from the APM scoring standard. These clinicians will get full credit for IA and should also report PI at the group or solo practice level. While they will no longer be eligible to receive an APM incentive payment, the eligible clinicians will still be scored under the MIPS APM Scoring Standard and may earn a positive MIPS payment adjustment.					

[17] More information on QPs is available in the QPs Methodology Fact Sheet.