Medicare Shared Savings Program

QUALITY MEASURE BENCHMARKS FOR THE 2018 AND 2019 REPORTING YEARS

Guidance Document

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

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1 Introduction

This document describes methods for calculating the quality performance benchmarks for Accountable Care Organizations (ACOs) that are participating in the Medicare Shared Savings Program (Shared Savings Program) and presents the benchmarks for the quality measures for the 2018 and 2019 quality reporting years. This document also reviews the quality scoring methodology as described in the Shared Savings Program regulations.

Annually, ACOs are required to completely and accurately report quality data that are used to calculate and assess their quality performance. In order to be eligible to share in any savings generated, an ACO must meet the established quality performance standard that corresponds to its performance year. In the first performance year of their first agreement period, ACOs satisfy the quality performance standard when they completely and accurately report on all quality measures (pay-for-reporting). Complete and accurate reporting in the ACO's first performance year qualifies the ACO for the maximum quality score and sharing rate. In subsequent performance years, quality measures are phased in to pay-for-performance and national performance benchmarks are used to calculate the ACO's quality score and final sharing rate.

Both attainment and improvement in performance are taken into account when calculating an ACO's quality score and final sharing rate for ACOs in their second and subsequent performance years. ACOs are rewarded up to four additional points in each domain, if they demonstrate quality improvement. In this way, ACOs are recognized and rewarded for attaining high quality performance as well as improving performance over time. When ACOs renew their participation in the program for a second or subsequent agreement period, the quality performance of ACOs is assessed in the same manner as ACOs in the third performance year of their first agreement period.

Quality performance benchmarks are established by the Centers for Medicare & Medicaid Services (CMS) prior to the reporting period for which they apply and are set for two years. This document defines and sets the quality performance benchmarks that will be used for the 2018 and 2019 reporting years. These benchmarks will apply to Shared Savings Program ACOs reporting quality data in these years.

For the 2018 and 2019 reporting years, CMS will measure quality of care using 31 quality measures (29 individual measures and one composite that includes two individual component measures). The quality measures span four quality domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population. Because new quality measures introduced to the Shared Savings Program are set at the level of complete and accurate reporting for the first two years before phasing into performance, this document will be updated to include benchmarks for measures that phase into performance for the 2019 reporting year. The benchmarks for each measure, along with the phase-in schedule for pay-for-performance and applicable reporting year for each measure, are displayed in Appendix A.

It is also important to note that CMS maintains the authority to revert measures from pay-for-performance to pay-for-reporting when the measure owner determines the measure causes patient harm or no longer aligns with clinical practice, or when there is a determination under the Quality Payment Program that the measure has undergone a substantive change. Should CMS need to make such a modification, CMS will alert the ACOs through the ACO Spotlight Newsletter.

2 Benchmark Data Sources

We established 2018/2019 benchmarks using all available and applicable 2014, 2015, and 2016 Medicare fee-for-service (FFS) data. This includes:

- 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 performance years.
- Quality data reported by Shared Savings Program, Next Generation Model, and Pioneer Model ACOs through the CMS Web Interface for the 2014, 2015, and 2016 performance years.
- Quality measure data collected from the Consumer Assessment of Healthcare Providers and Systems (CAHPS©) for ACOs and CAHPS for PQRS for the 2014, 2015, and 2016 performance years.

Quality measure benchmarks were calculated using data from ACOs, group practices, and individual physicians that successfully met the Shared Savings Program or PQRS quality reporting requirements and had at least 20 cases. In addition, for claims-based measures, data were limited to organizations with at least one eligible professional and one assigned beneficiary using the Shared Savings Program assignment methodology, and that had at least 20 cases in the denominator. For PQRS-reported data, individually reported data was aggregated and averaged to the TIN level.

3 Benchmarks for ACO Quality Measures

Benchmarks for quality measures that are pay-for-performance for the 2018 and/or 2019 reporting years are specified in Appendix A. ACOs should refer to their applicable performance year of their first agreement period to determine if the measure is pay-for-reporting or performance. ACOs in a second agreement period should refer to Performance Year (PY3) in Appendix A.

A quality performance benchmark is the performance rate an ACO must achieve to earn the corresponding quality points for each measure. We show the benchmark for each percentile, starting with the 30th percentile (corresponding to the minimum attainment level) and ending with the 90th percentile (corresponding to the maximum attainment level). Under the Shared Savings Program's regulation at 42 CFR § 425.502, there are circumstances when we set benchmarks using flat percentages. We use flat

percentages to address measures where performance is highly clustered, and it allows ACOs with high scores to be recognized for their performance and earn maximum or near-maximum quality points. For 12 measures, we set benchmarks using flat percentages when the 90th percentile was equal to or greater than 95 percent and/or the 60th percentile was equal to or greater than 80 percent.

4 Quality Scoring Points System

Table 1 shows the maximum possible points that may be earned by an ACO in each domain and overall in 2018 and 2019. An ACO achieves the maximum points for all measures designated as pay-for-reporting when the ACO completely and accurately reports. For measures that are pay-for-performance, quality scoring will be based on the ACO's level of performance on each measure.

Table 1. Total Points for Each Domain within the Quality Performance Standard

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

After the first performance year of its first agreement period, an ACO will earn quality points for each measure on a sliding scale based on level of performance. As shown in Table 2, performance below the minimum attainment level (the 30th percentile) for a measure will receive zero points for that measure; performance at or above the 90th percentile of the quality performance benchmark earns the maximum points available for the measure. For measures that are pay-for-reporting, ACOs will receive full points when the ACO completely and accurately reports on all measures.

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 seven ACO quality measures have a reverse scoring structure, which means that a lower rate represents better performance, and a higher rate represents worse performance.

A lower rate is indicative of better performance on the following measures:

- ACO 8: Risk Standardized, all condition readmissions.
- ACO 27: Diabetes Mellitus: Hemoglobin A1c poor control.
- ACO 35: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM).
- 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.
- ACO 43: Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91).

A maximum of 2 points can be earned for each scored individual or composite measure, except for the ACO 11 quality measure. The ACO 11 measure is double weighted and is worth up to 4 points to provide an incentive for greater levels of EHR adoption.

Table 2 shows the points earned for each pay-for-performance measure at the corresponding decile value. For example, if an ACO's performance rate for the Influenza Immunization measure (ACO 14) is 72 percent, it would earn 1.70 points for that measure.

Table 2. Sliding-Scale Measure: Scoring Approach

ACO PERFORMANCE LEVEL	QUALITY POINTS
90+ percentile benchmark or 90+ percent	2.00 points
80+ percentile benchmark or 80+ percent	1.85 points
70+ percentile benchmark or 70+ percent	1.70 points
60+ percentile benchmark or 60+ percent	1.55 points
50+ percentile benchmark or 50+ percent	1.40 points
40+ percentile benchmark or 40+ percent	1.25 points
30+ percentile benchmark or 30+ percent	1.10 point
<30+ percentile benchmark or <30+ percent	No points

Currently, certain measures are pay-for-reporting in all years; therefore, benchmarks are not provided for these measures at this time:

- ACO 7: CAHPS: Health Status/Functional Status.
- ACO 40: Depression Remission at Twelve Months.
- ACO 42: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease.

- ACO 44: Use of Imaging Studies for Low Back Pain.

5 Quality Improvement Reward

Additionally, CMS will reward ACOs that demonstrate significant improvement in their quality measure performance by adding up to 4.00 points to the number of points earned in each domain. The total points in each domain cannot exceed the maximum points that are possible in that domain, as identified in Table 1. For instance, an ACO may receive 4.00 additional points in the Patient/Caregiver Experience domain by demonstrating quality improvement; however, the ACO's total points for the domain cannot exceed the maximum 16 possible points that can be earned for the Patient/Caregiver Experience domain.

The total points earned for measures in each domain, including any quality improvement points, will be summed and divided by the total points available for that domain to produce a percentage score equal to points earned relative to points available in each domain. The percentage score for each domain will be averaged together to generate a final overall quality score for each ACO that will be used to determine the amount of savings it shares or, if applicable, the amount of losses it owes.

6 Quality Measures Validation Audit

Annually, 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. Results of the QMV audit may impact an ACO's overall quality score. ACOs with an overall audit match rate of less than 80 percent may have its overall quality score adjusted proportional to its audit performance.[1] For each percentage point difference between the ACO's match rate and the 80 percent audit match rate considered passing the audit, the ACO's overall quality score will be adjusted downward by 1 percent. The formula for this adjustment is as follows:

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

For example, if an ACO's quality score is 90 percent and the ACO's audit match rate is 75 percent (i.e., 5 percentage points below the passing rate of 80 percent), then the ACO's audit-adjusted quality score would be 85.50 percent, that is, (90 – (90 x 0.05)) = 85.50. The audit-adjusted quality score will be the quality score that is used to determine the final sharing rate of any savings that the ACO may share or the percentage of any losses for which the ACO is accountable.

[1] CMS retains discretion not to apply this adjustment to the ACO's score in certain unusual circumstances where it would be inappropriate to apply the adjustment. See 81 Fed. Reg. 80491-80492.

Appendix A

Table 3. 2018/2019 Reporting Year ACO Quality Measure Benchmarks

DOMAIN	MEASURE	DESCRIPTION	FIRST AGREEMENT PERIOD PAY-FOR-PERFORMANCE PHASE-IN† R=Reporting P=Performance			30TH PERC.	40TH PERC.	50TH PERC.	60TH PERC.	70TH PERC.	80TH PERC.	90TH PERC.
			PY1	PY2	PY3							
Patient/Caregiver Experience	ACO-1	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
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

DOMAIN	MEASURE	DESCRIPTION	FIRST AGREEMENT PERIOD PAY-FOR-PERFORMANCE PHASE-IN† R=Reporting P=Performance			30TH PERC.	40TH PERC.	50TH PERC.	60TH PERC.	70TH PERC.	80TH PERC.	90TH PERC.
			PY1	PY2	PY3							
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
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

DOMAIN	MEASURE	DESCRIPTION	FIRST AGREEMENT PERIOD PAY-FOR-PERFORMANCE PHASE-IN† R=Reporting P=Performance			30TH PERC.	40TH PERC.	50TH PERC.	60TH PERC.	70TH PERC.	80TH PERC.	90TH PERC.
			PY1	PY2	PY3							
Preventive Health	ACO-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
At-Risk Population Diabetes	Diabetes Composite ACO-27 & ACO-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

**Measures introduced in the 2017 PFS final rule for which the phase-in schedule applies beginning with Performance Year (PY) 2019. Benchmarks for measures that phase in-to pay-for-performance in 2019 will be published before the start of PY 2019.*

†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.

ᵛMeasure was updated for PY 2017 to align with the Quality Payment Program and is set at pay-for-reporting for all ACOs for PY 2018. Benchmarks will be provided for PY 2019.