Medicare Shared Savings Program Quality Measure Benchmarks for the 2016 and 2017 Reporting Years

This document was updated December 2016 to reflect benchmarks for measures introduced in 2015 and 2017 Physician Fee Schedule final rule updates.

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 2016 and 2017 quality reporting years.[1] This document also reviews the quality performance benchmarks and scoring methodology, as described in the Shared Savings Program regulations.[2]

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 sharing rate. In subsequent performance years, quality performance 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.

Both attainment and improvement in performance are taken into account when calculating the 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, the ACO becomes increasingly responsible for attaining high quality performance and improving performance over time. When an ACO renews its participation in the program for a second or subsequent agreement

[1] There are 34 quality measures for the 2016 performance year and 31 quality measures for the 2017 performance year. Measures retired for the 2017 performance year are noted in the table in Appendix A.

[2] Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 Fed. Reg. 67802 (Nov. 2, 2011). 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; Final Rule, 81 Fed. Reg. 80483 (Nov. 15, 2016).

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 2 years.[3] This document defines and sets the quality performance benchmarks that will be used for the 2016 and 2017 reporting periods. These benchmarks will apply to Shared Savings Program ACOs reporting quality data in these periods.

For the 2016 reporting year, CMS will measure quality of care using 34 quality measures (32 individual measures and 1 composite measure that includes 2 individual component measures). For the 2017 reporting year, CMS will measure quality of care using 31 quality measures (29 individual measures and 1 composite that includes 2 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 2 years before phasing into performance[4] and updates were made to the quality measure set in the 2017 Physician Fee Schedule (PFS) Final rule,[5] this document has been updated to include benchmarks for measures that phased into performance for the 2017 reporting year and notes new measures for the 2017 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.[6] Should CMS need to make such a modification, CMS will alert the ACOs through the Spotlight newsletter.

Benchmark Data Sources

We established 2016/2017 benchmarks using all available and applicable 2012, 2013, 2014, and 2015 Medicare fee-for-service (FFS) data.[7,8] This includes:

[3] §425.502(b)(4)(i) ("CMS will update the quality performance benchmarks every 2 years."); see also 79 Fed Reg.at 67926–67927.

[4] §425.502(a)(4) ("The quality performance standard for a newly introduced measure is set at the level of complete and accurate reporting for the first two reporting periods for which reporting of the measure is required. For subsequent reporting periods, the quality performance standard for the measure will be assessed according to the phase-in schedule for the measure."); *see also* 79 Fed. Reg. at 67920–67921.

[5] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Final Rule, 81 Fed. Reg. 80483 (Nov. 15, 2016).

[6] §425.502(a)(5) ("CMS reserves the right to redesignate a measure as pay for reporting when the measure owner determines the measure no longer aligns with clinical practice or causes patient harm."); *see also* 80 Fed. Reg. 71263.

[7] §425.502(b)(2)(i) ("CMS will define the quality benchmarks using fee-for-service Medicare data.")

[8] §425.502(b)(4)(iii) ("CMS will use up to three years of data, as available, to set the benchmark for each quality measure.")

- Quality data reported through the Physician Quality Reporting System (PQRS) by physicians and groups of physicians through the Web Interface, claims, or a registry for the 2012, 2013, 2014, and 2015 performance years;[9]
- Quality data reported by Shared Savings Program and Pioneer Model ACOs through the Web Interface for the 2012, 2013, 2014, and 2015 performance years;
- Quality measure data collected from the **Consumer Assessment of Healthcare Providers and Systems** (CAHPS) for ACOs, CAHPS for PQRS and Medicare FFS CAHPS surveys for the 2012, 2013, 2014, and 2015 performance years;[10]
- Attestation, hardship, and Meaningful Use data collected through the Electronic Health Record (EHR) Incentive Program for 2013 and 2014.

All of the quality measure benchmarks were calculated using ACO, group practice and individual physician data aggregated to the TIN level and included if there were at least 20 cases. 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.

Benchmarks for ACO Quality Measures

Benchmarks for quality measures that are pay for performance for the 2016 and/or 2017 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 3 in Appendix A. The following 6 measure benchmarks have been added to this document, because they phased into performance in 2017:

- ACO-34 CAHPS Stewardship of Patient Resources
- 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
- Diabetes Composite (includes 2 component measures)

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 C.F.R. §425.502, there are circumstances when we set benchmarks using flat percentages. The use of flat percentages addresses issues with measures that have an overall high level of performance and allows ACOs with high scores to be recognized for their performance and earn maximum or near maximum quality points. For 15 measures, we set benchmarks using flat percentages

[9] CMS did not use data submitted via the PQRS Qualified Clinical Data Registry (QCDR) and electronic reporting options due to data integrity issues.

[10] 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.

when the 60th percentile was equal to or greater than 80.00 percent.[11] For 3 measures, we set benchmarks using flat percentages when the 90th percentile was equal to or greater than 95.00 percent.[12]

For ACO-9 and ACO-10, we converted observed to expected ratios to percentages by multiplying the observed to expected ratio percentiles by the national performance rate to examine whether the use of flat percentages would be invoked. As a result, ACO-9, Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5) is now a flat percentage. ACO-10, Ambulatory Sensitive Condition Admissions: Heart Failure (AHRQ PQI #8) measure benchmarks are not set to flat percentages.

In efforts to maintain consistency across benchmarks, we displayed the ACO-10 observed to expected ratio percentiles as percentages. ACOs can compare their previous annual performance scores for ACO-9 and ACO-10 by multiplying their observed/expected ratio performance rates with the following national means:

- ACO-9 national mean performance rate: 6.86%
- ACO-10 national mean performance rate: 18.19%

Please note, ACO-9 and ACO-10 were retired in the 2017 PFS final rule and will not be used in the Shared Savings Program quality measurement approach beginning with the 2017 performance year.

Quality Scoring Points System

Table 1 and **Table 2** show the maximum possible points that may be earned by an ACO in each domain and overall in 2016 and 2017, respectively. 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
2016 Reporting Year: 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	9	9 measures	18	25%
At-Risk Population	7	5 individual measures and a 2-component diabetes composite measure	12	25%
Total in all Domains	34	33	68	100%

[11] *See* 78 Fed. Reg. at 74759–74763.

[12] *See* 79 Fed. Reg. at 67925.

Table 2
2017 Reporting Year: 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: 3 individual measures and a 2-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 their 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 3**, 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 nine 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-9: Ambulatory Sensitive Conditions Admissions: for COPD or Asthma in Older Adults (AHRQ PQI #5).
- ACO-10: Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ PQI #8).
- 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 incentive for greater levels of EHR adoption.

Table 3 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. Because the EHR measure (ACO-11) is double weighted, an ACO's performance rate of 78 percent on that measure would earn 3.40 points.

Table 3
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:

- 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

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 domain score of the percentage of points earned relative to points available. 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.

Quality Measures Validation Audit

In the 2017 PFS final rule, CMS finalized updates to the annual Quality Measures Validation (QMV) audit of web interface measures.[13] Results of the QMV audit may impact an ACO's overall quality score. If an ACO fails the audit (that is, has an overall audit match rate of less than 90 percent), then the ACO's

[13] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Final Rule, 81 Fed. Reg. 80489-80492 (Nov. 15, 2016).

overall quality score may be adjusted proportional to its audit performance.[14] The audit-adjusted quality score will be calculated by multiplying the ACO's quality score by the ACO's match rate. For example, if an ACO's quality score is 75 percent and the ACO's audit match rate is 80 percent, the ACO's audit-adjusted quality score would be 60 percent. 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.

[14] 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: 2016/2017 Reporting Year ACO Quality Measure Benchmarks

Domain	Measure	Description	Performance Year(s) When Measure is in Effect		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.
			2016	2017	PY1	PY2	PY3							
Patient/Caregiver Experience	ACO-1	CAHPS: Getting Timely Care, Appointments, and Information	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes*	Yes	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	Yes	Yes	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)	Yes*	Yes	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	Yes*	Yes	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	Yes*	Yes	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	Yes*	Yes	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)	No**	Yes	R	P	P	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care Coordination/Patient Safety	ACO-9	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)	Yes	No^	R	P	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00
Care Coordination/Patient Safety	ACO-10	Ambulatory Sensitive Conditions Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8)	Yes	No^	R	P	P	25.04	22.16	19.67	17.28	14.95	12.01	8.31

Domain	Measure	Description	Performance Year(s) When Measure is in Effect		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.
			2016	2017	PY1	PY2	PY3							
Care Coordination/Patient Safety	ACO-11	Percent of PCPs who Successfully Meet Meaningful Use Requirements	Yes	Yes$^{\vee}$	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Care Coordination/Patient Safety	ACO-39	Documentation of Current Medications in the Medical Record	Yes*	No^	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	No**	Yes	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	Yes	Yes	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	No**	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	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	Yes	Yes	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO-19	Colorectal Cancer Screening	Yes	Yes	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO-20	Breast Cancer Screening	Yes	Yes	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO-21	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented	Yes	No^	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	Yes	Yes	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	Yes	Yes	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Domain	Measure	Description	Performance Year(s) When Measure is in Effect		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.
			2016	2017	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	Yes*	Yes	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	Yes	Yes	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	Yes	Yes	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population HF	ACO-31	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Yes	No^	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population CAD	ACO-33	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and Diabetes or Left Ventricular Systolic Dysfunction (LVEF<40%)	Yes	No^	R	R	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 that phase into Pay for Performance in 2017. Benchmarks for these measures do not apply to the 2016 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 was retired in the 2017 PFS final rule. Measure will no longer be reported beginning with the 2017 performance year.

ᵛMeasure 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. Benchmarks displayed for this measure do not apply in 2017.