Medicare Shared Savings Program

QUALITY MEASUREMENT METHODOLOGY AND RESOURCES

Specifications

December 2020
Version 2020
Applicable for Performance Year 2020

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
MEDICARE SHARED SAVINGS PROGRAM

Revision History

Version	Major Revisions Description	Affected area
2020	Removed additional information on CAHPS for ACOs sampling methodology	Appendix A, Section 3.1
2020	Added section on Extreme and Uncontrollable Circumstances	Section 4.5
2020	Updated list of informational measures	Table 2-5
2020	Updated benchmarks for 2020/21	Section 4.1
2020	Updated performance year references to 2020	All
2020	Removed additional information regarding participation scenarios specific to 2019.	Section 1.2, Section 1.3
2020	Revised Patient/Caregiver Experience Survey section to reflect waiver of survey requirement for 2020.	Section 3.2

Table of Contents

1 Introduction 4
1.1 Quality Measure Structure and Data Collection Methods Overview 4
1.2 Quality Reporting for a Performance Year 4
1.3 Quality Standard and ACO Transition from Pay-for-reporting to Pay-for-performance 6
1.4 Relationship Between Quality Performance and Financial Performance 6
1.5 Quality Measure Resources 7
2 Quality Domains and Measures 8
2.1 Patient/Caregiver Experience Measures 9
2.2 Care Coordination/Patient Safety Measures 10
2.3 Preventive Health Measures 11
2.4 At-Risk Population Measures 12
2.5 Informational Measures 12
3 Quality Measure Data Collection and Performance Rate Calculations 13
3.1 Beneficiary Selection for Quality Measurement 14
3.2 Claims-Based Data 16
3.3 CMS Web Interface Data 16
3.3.1 Accessing and Reporting Data through the CMS Web Interface 16
3.3.2 CMS Web Interface Measures Samples 17
3.3.3 CMS Web Interface Measures Performance Rates 17
4 Quality Performance Scoring 17
4.1 Quality Measure Benchmarks 18
4.1.1 Benchmark Data Sources 18
4.2 Quality Measure Scoring 19
4.3 Quality Measure Domain Scoring 20
4.3.1 Quality Improvement Reward Scoring 20
4.3.2 Domain Score 23
4.4 Quality Score 24
4.5 Extreme and Uncontrollable Circumstances 26
4.6 Quality Measures Validation Audit 26
4.7 Compliance Actions 27
5 Alignment with the Quality Payment Program 27
List of Acronyms 28

List of Tables

Table 1-1. One-sided Models and Two-sided Models 7
Table 1-2. Sources of Measure Documentation by Measure Type and Links for 2020 Documentation 8
Table 2-1. Patient/Caregiver Experience Measures (2020) 10
Table 2-2. Care Coordination/Patient Safety Measures (2020) 11
Table 2-3. Preventive Health Measures (2020) 11
Table 2-4. At-Risk Population Measures (2020) 12
Table 2-5. Informational Measures (2020) 12
Table 4-1. Points Associated with Meeting or Passing Each Benchmark Level 19
Table 4-2. Crosswalk between Improvement Measure Score and Quality Improvement Points 23
Table 4-3. Total Points for Each Domain Within the Quality Performance Standard (2020) 23
Table 4-4. Example of Domain Scores for an ACO in Performance Year 1 that Completely Reported 25
Table 4-5. Example of Domain Scores for an ACO Beyond Performance Year 1 25

List of Figures

Figure 1-1. Timeline of Quality Reporting and Performance Assessment Activities 5

1.0 Introduction

Under the Medicare Shared Savings Program (Shared Savings Program), Accountable Care Organizations (ACOs) may earn 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. Examples in the sections that follow focus on Performance Year 2020. This document is subject to periodic change and will be updated to reflect the policies applicable for each subsequent reporting year.

Due to the Public Health Emergency (PHE) for the COVID-19 pandemic, modifications were made to the Shared Savings Program for impacted performance years including Performance Year 2020. Those modifications are noted in this document where applicable, while information regarding the quality measurement methodology, reporting and scoring are retained in this document for reference purposes.

1.1 QUALITY MEASURE STRUCTURE AND DATA COLLECTION METHODS OVERVIEW

CMS focuses ACO quality performance and improvement activity on four key domains, Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population 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.

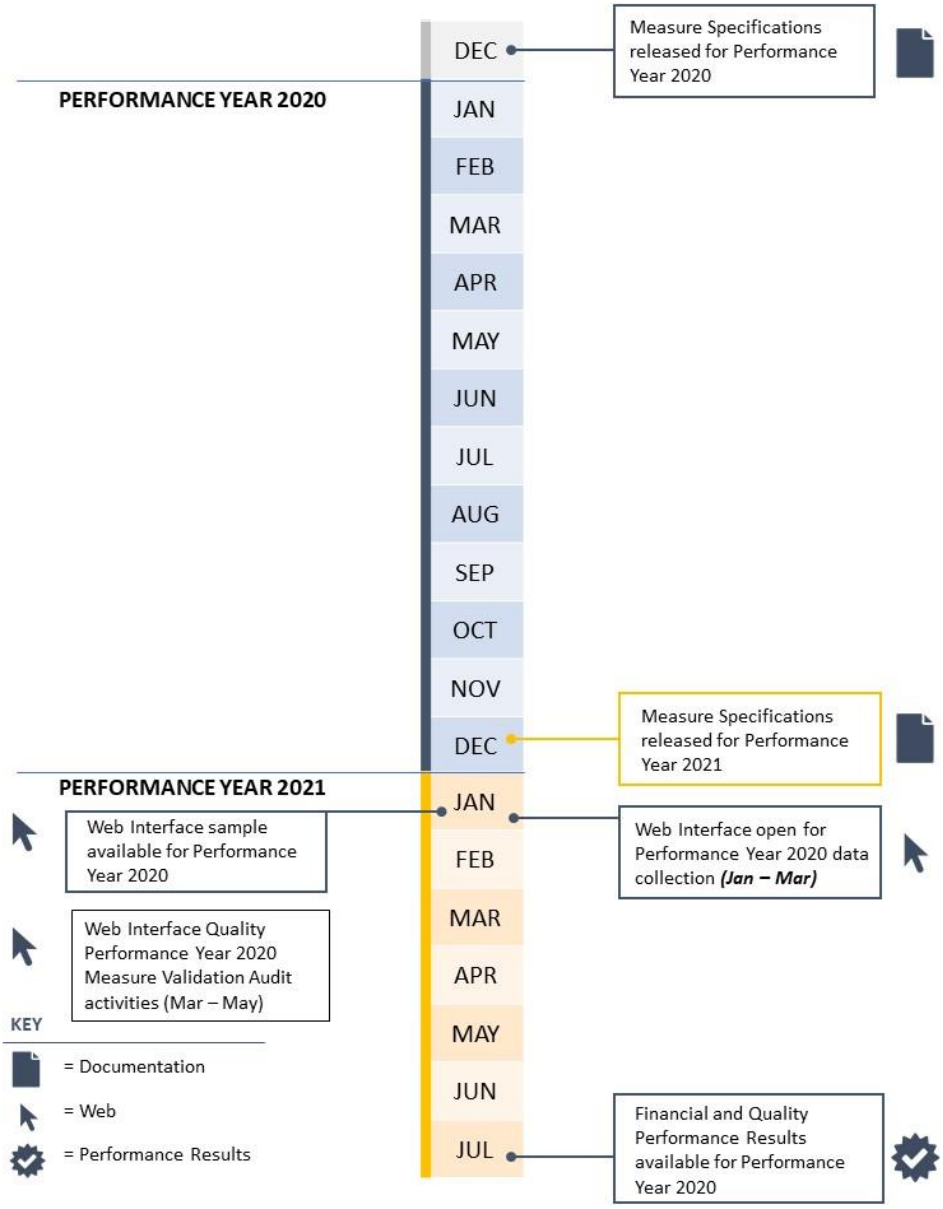
The number of measures within the four key domains has changed over time to reflect changes in clinical practice, to move toward more outcome-based measures, and to align with other quality reporting programs and reduce burden. Currently, there are 23 measures across the four domains, and all measures are equally weighted within each domain.

1.2 QUALITY REPORTING FOR A PERFORMANCE YEAR

Quality data collection for a calendar performance year occurs after the end of the calendar year, during the "quality data reporting period." For example, for Performance Year 2019, the data collection period for ACO submission of the Performance Year 2019

data through the CMS Web Interface occurred between January 2, 2020 and April 30, 2020.[1] For an overall timeline of data submission, calculation, and performance assessment for the Performance Year, please refer to Figure 1-1.

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



[1] For Performance Year 2019, the reporting deadline was extended from March 31 to April 30 due to the public health emergency, https://www.federalregister.gov/d/2020-06990/p-445.

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. 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 (42 CFR § 425.502(a)):

- 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 (i.e., CMS Web Interface, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey) [2] 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 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) on at least one measure in each domain to be eligible to share in any savings generated or avoid owing the maximum share of losses incurred for ACOs under a two-sided model.

1.4 RELATIONSHIP BETWEEN QUALITY PERFORMANCE AND FINANCIAL PERFORMANCE

An ACO's quality performance influences an ACO's eligibility to share in savings as well as the amount of shared savings for which it may be eligible. For some ACOs

[2] For Performance year 2020, ACOs will not be required to field a CAHPS for ACOs survey and will receive automatic credit for summary survey measures in the Patient/Caregiver Experience domain, (https://www.federalregister.gov/d/2020-26815).

participating in a two-sided shared savings and losses model, quality performance can influence the amount of shared losses owed, if applicable. In general, ACOs with relatively higher quality scores will be eligible to share in a larger amount of savings and owe a smaller amount of shared losses.

Table 1-1. One-sided Models and Two-sided Models

AGREEMENT START DATE	ONE-SIDED MODEL	TWO-SIDED MODEL
Agreement start date January 1, 2018	Track 1	Track 2, Track 3*, Track 1+ Model
Agreement start date July 1, 2019 and beyond	Level A and Level B of the BASIC track	Level C, Level D, and Level E of the BASIC track; ENHANCED track

**One Track 3 ACO has an agreement start date of January 1, 2019.*

For an ACO that has met the quality performance standard, the final shared savings 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 (40 percent for Levels A and B of the BASIC track, 50 percent for Track 1, the Track 1+ Model, and Levels C through E of the BASIC Track, 60 percent for Track 2, and 75 percent for the ENHANCED track). An ACO will not qualify to share in savings in any year it fails to report accurately, completely, and timely on the quality performance measures (42 CFR § 425.100(b)).

For an ACO participating in Track 2 or the ENHANCED track (formerly Track 3), the final shared loss rate is equal to one minus the final shared savings rate but may not be less than 40 percent and may not exceed 60 percent for Track 2 or 75 percent for the ENHANCED track. An ACO in Track 2 or the ENHANCED track that fails to meet the quality performance standard will face the maximum final shared loss rate for that model. For ACOs participating in a two-sided model under the BASIC track or the Track 1+ model, the final shared loss rate is fixed at 30 percent (42 CFR § 425.605(C)).

For more 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 1-2. below, CMS maintains a variety of publicly available sources of technical documentation on quality measures, including documentation for Performance Year 2020.

Table 1-2. Sources of Measure Documentation by Measure Type and Links for 2020 Documentation

DOCUMENT NAME	MEASURE TYPE	DESCRIPTION	2020 DOCUMENTATION*
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 "2020 Measure Information Forms"
CAHPS for ACOs	Patient/care-giver experience measures	The CAHPS for ACOs Survey includes 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 used for quality measure scoring under P4P.	Refer to 2020/2021 Quality Measure Benchmarks

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

2.0 Quality Domains and Measures

For Performance Year 2020, CMS will measure quality of care using 23 nationally recognized quality measures that span four key domains:

1. Patient/Caregiver Experience (10 measures)
2. Care Coordination/Patient Safety (4 measures)
3. Preventive Health (6 measures)
4. At-Risk Population (3 measures)
   - Mental Health (1 measure)

- Diabetes (1 measure)
- Hypertension (1 measure)

Quality measures are calculated via several avenues:

- CAHPS for ACOs Survey, which includes CAHPS Clinicians & Group (CG-CAHPS) core measures, supplemental items, and program-specific items
- Medicare claims data and Medicare beneficiaries' demographic data
- Data reported by ACOs through the CMS Web Interface using patient medical record data from within and outside the ACO

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[3] and includes additional content relevant to patient/caregiver experience of care delivered by ACOs. The survey includes the CG-CAHPS core survey, CG-CAHPS supplemental items, 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.

CMS utilizes a single version of the CAHPS for ACOs Survey, which was streamlined in 2018 to 58 questions. The survey includes 10 SSMs.

For Performance Year 2020, ACOs will not be required to field a CAHPS for ACOs survey and will receive automatic credit for measures in the Patient/Caregiver Experience domain, (https://www.federalregister.gov/d/2020-26815).

The SSMs included in the 2020 survey are outlined in Table 2-1 below.

[3] 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.

Table 2-1. Patient/Caregiver Experience Measures (2020)

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	Patient's Rating of Provider	Survey	Core Items	Yes
ACO-4	Access to Specialists	Survey	Supplemental Items	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
ACO-45	Courteous & Helpful Office Staff	Survey	Core Items	Yes
ACO-46	Care Coordination	Survey	Core Items	Yes

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, and the CMS Web Interface.

Table 2-2. Care Coordination/Patient Safety Measures (2020)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-8	Risk-Standardized, All Condition Readmission	CMS calculates from claims
ACO-38	Risk-Standardized Acute Admission Rates 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-13 (CARE-2)	Falls: Screening for Future Fall Risk	CMS Web Interface

Note: Text in parentheses is the equivalent CMS Web Interface measure identifier.
** Due to a specification change in the measure by the measure steward, ACO-43 was reverted back to pay-for-reporting for all ACOs in 2020 and 2021.*

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 (2020)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-14 (PREV-7)	Preventive Care and Screening: Influenza Immunization	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 MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
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 (2020)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-40 (MH-1)	Depression Remission at Twelve Months	CMS Web Interface
ACO-27 (DM-2)	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS Web Interface
ACO-28 (HTN-2)	Hypertension: Controlling High Blood Pressure	CMS Web Interface

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

2.5 INFORMATIONAL MEASURES

CMS also provides a set of measures derived from Medicare claims data for informational purposes only on a quarterly basis throughout the performance year. These measures are listed in Table 2-5.

Table 2-5. Informational Measures (2020)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION	REPORT PROVIDED IN
ACO-35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure	CMS calculates from claims	Quarterly Quality Report
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	CMS calculates from claims	Quarterly Quality Report

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION	REPORT PROVIDED IN
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	CMS calculates from claims	Quarterly Quality Report
N/A	Overutilization Monitoring System	CMS calculates from claims	Quarterly Opioid Report
N/A	Use of Opioids at High Dosage in Persons Without Cancer	CMS calculates from claims	Quarterly Opioid Report
N/A	Use of Opioids from Multiple Providers in Persons Without Cancer	CMS calculates from claims	Quarterly Opioid Report
N/A	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	CMS calculates from claims	Quarterly Opioid Report

3.0 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 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. Typically, 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. However, this report will not be provided for Performance Year 2020 as CMS is waiving the requirement for ACOs to field a CAHPS for ACOs survey.

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[4], CMS Web Interface measures, and claims-based measures.[5]

Criteria 1. Beneficiary is assigned to an ACO.

- For ACOs under preliminary prospective assignment with retrospective reconciliation (i.e., ACOs selecting retrospective assignment in the BASIC track or ENHANCED track):
  - Second quarter of calendar year preliminary prospectively assigned beneficiaries is historically used for the CAHPS for ACOs Survey sample.
  - Third quarter of calendar year preliminary prospectively assigned beneficiaries will be used for CMS Web Interface sampling.
  - Fourth quarter of calendar year preliminary prospectively assigned beneficiaries will be used for claims-based measure calculations.
- For ACOs with prospective assignment (i.e., ACOs selecting prospective assignment in the BASIC track or ENHANCED track):
  - Prospectively assigned beneficiaries maintaining eligibility as of the second quarter of the calendar year will be used for the CAHPS for ACOs Survey sample.
  - Prospectively assigned beneficiaries maintaining eligibility as of the third quarter of the calendar year will be used for CMS Web Interface sampling.
  - Prospectively assigned beneficiaries maintaining eligibility as of the fourth quarter of the calendar year 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 sample:
  - CMS historically includes assigned beneficiaries (as identified in Criteria1 above) who are 18 years or older, excluding those who:

[4] As noted in Footnote 2, for Performance Year 2020 ACOs will not be required to field a CAHPS for ACOs survey and will receive automatic credit for summary survey measures in the Patient/Caregiver Experience domain.

[5] The criteria for beneficiary selection for sampling eligibility are inclusive of new telehealth and telemedicine codes added to the 2020 CMS assignment methodology in response to the public health emergency. For detail on how these codes may impact beneficiary selection for quality measures, please refer to the Telehealth Guidance for CMS Web Interface Quality Measures for 2020 Quality Reporting on the Quality Payment Program Resource Library webpage.

- Received fewer than two primary care service visits within the ACO during the performance year;
- Beneficiaries receiving 90% or more of their care from hospitalists (defined by place of service codes 21 and 23) are excluded;
- Entered hospice during the performance year;
- Died during the performance year;
- Were sampled for the spring administration of the In-Center Hemodialysis CAHPS Survey;
- Resided in an institutional setting (all primary care charges were received in institutional settings or the most recent primary care visit during the sampling period occurred in an institutional setting, based on claims data).[6]
- Resided outside the United States, Puerto Rico, and the U.S. Virgin Islands

▪ For the CMS Web Interface measures:

– CMS will include in the measure samples assigned beneficiaries (as identified in Criteria1 above), excluding those who:

- Do not meet measure-specific age criteria;[7]
- 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 an assigned 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 performance year 2020, CMS waived the requirement for ACOs to field the survey. ACOs will receive automatic full points for each summary survey measure in the Patient/Caregiver Experience domain (insert final rule reference when available). Detail on survey administration and scoring methodology is therefore not included in this document but can be referenced in prior year versions on the Shared Savings Program website.

[6] Refer to CAHPS® Survey for ACOs Survey Quality Assurance Guidelines, version 7 (April 2019).
[7] 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 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 specifications 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 3.1 for additional information on assigned beneficiary eligibility). For claims-based measures, ACOs do not need to collect or submit additional data. Each of these measures are expressed in such a way that a lower performance rate indicates better quality (lower calculated results are desired).

3.3 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 Merit-Based Incentive Payment System (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.[8]

3.3.1 ACCESSING AND REPORTING DATA THROUGH THE CMS WEB INTERFACE

ACOs are responsible for entering data into the CMS Web Interface during a twelve-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). ACO clinical data can be imported into the CMS Web Interface using health information technology, via APIs, Excel upload, or manually. 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 individual ACOs 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.

[8] 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.

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

3.3.2 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 up to the three clinicians in the ACO that provided the most care to the beneficiaries.

Since each CMS Web Interface measure has specific denominator requirements, each measure has its own beneficiary sample.[9] CMS makes reasonable efforts to include the same beneficiary in multiple measures in order to reduce reporting burden. The measure samples are grouped into five categories, or disease-related "modules."[10] 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 2020 performance 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 (e.g., up to 616 beneficiaries or 750 beneficiaries for PREV-13) than are needed to meet the reporting requirement of 248.

3.3.3 CMS WEB INTERFACE MEASURES 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 (42 CFR § 425.500(f)).

4.0 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 to share in savings or be responsible for shared

[9] 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.
[10] Five modules for 2020: CARE, DM, HTN, MH, PREV.

savings as part of performance year financial reconciliation. Examples included in this section are based on the quality measure benchmarks for the 2020/2021 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 2020 and 2021 reporting years using all available and applicable 2016, 2017, and 2018 Medicare FFS data. This includes:

- Quality data reported by Shared Savings Program, Pioneer Model ACOs (for 2016 only), and Next Generation Model ACOs through the CMS Web Interface for the 2016, 2017, and 2018 performance years; and
- Quality measure data collected from the CAHPS for ACOs and CAHPS for Physician Quality Reporting System (PQRS, for 2016 only) or the CAHPS for Merit-based Incentive Payment System (MIPS) surveys administered for the 2017 and 2018 performance years.
- Quality data reported through the PQRS by physicians and groups of physicians through the CMS Web Interface, claims, or a registry for the 2016 performance year or reported through MIPS by physicians and groups of physicians through the CMS Web Interface or claims for the 2017 and 2018 performance years.

The quality measure benchmarks were calculated using ACO, group practice, and individual physician data aggregated to the practice or taxpayer identification number (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/MIPS were not included in calculation of the benchmarks.

For more information on benchmarking, refer to the 2020/2021 Quality Measure Benchmarks.

4.2 QUALITY MEASURE SCORING

CMS designates the quality performance standard in each performance year. The quality performance standard is the overall standard the ACO must meet in order to be eligible for shared savings (42 CFR § 425.502(a)). 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.

- 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. [11] 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 (as defined in Section 1.3) 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 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/or 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
< 30th percentile	No points
30th percentile	1.10
40th percentile	1.25

[11] As noted in Footnote 2, for Performance Year 2020 ACOs will not be required to field a CAHPS for ACOs survey and will receive automatic credit for summary survey measures in the Patient/Caregiver Experience domain.

BENCHMARK	POINTS ASSOCIATED WITH MEETING OR PASSING BENCHMARK
50th percentile	1.40
60th percentile	1.55
70th percentile	1.70
80th percentile	1.85
90th percentile	2.00

Example

An ACO earns a performance rate score 82.75 percent on ACO-13 (Falls: Screening for Falls 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 (see Table 4.1).

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
ACO-13	Falls: Screening for Future Fall Risk	30.00	40.00	50.00	60.00	70.00	80.00	90.00

Please note that this example is based on quality measure benchmarks for the Performance Year 2020.

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) and ACO-38 (Risk-Standardized Acute Admission Rates 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.

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.[12] Under this methodology, the classification of significant improvement or significant decline is used to calculate the net improvement of the domain score. 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.

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***.

$$Net\ Improvement = \#\ of\ Significantly\ improved\ measures - \#\ of\ Significantly\ declined\ measures$$

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*** as a percentage. This score is used to determine the Quality Improvement Reward.

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

In the event that an ACO demonstrates a statistically significant decline in measure performance from one year to the next, but still scores above 90 percent (or above the 90th

[12] 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

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 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 the previous year, none of the CAHPS for ACO Survey measures will be considered a significant improvement or a significant decline.[13]
- If the ACO has a denominator of zero on a measure in either the current year or the previous year, the change in performance on that measure will neither be considered a significant improvement nor a significant decline.

Note that, only measures collected in both Performance Year 2019 and Performance Year 2020 are included in the domain improvement score calculation for 2020.

Step 5.

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

[13] As CMS waived the requirement for ACOs to field a CAHPS for ACOs survey, all ACOs will receive automatic full credit for measures in the patient/caregiver experience domain and there will not be quality improvement points applied to this domain for Performance Year 2020 scoring.

Table 4-2. Crosswalk between Improvement Measure Score and Quality Improvement Points

DOMAIN IMPROVEMENT 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 (2020)

DOMAIN	NUMBER OF INDIVIDUAL MEASURES	TOTAL MEASURES FOR SCORING PURPOSES	TOTAL POSSIBLE POINTS	DOMAIN WEIGHT
Patient/Caregiver Experience	10	10 individual summary survey measures	20	25%
Care Coordination/ Patient Safety	4	4 measures	8	25%
Preventive Health	6	6 measures	12	25%
At-Risk Population	3	3 individual measures	6	25%
Total in all Domains	23	23	46	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 12 possible points in the Preventive Health domain. If an ACO earns:

$$11.55\ \textit{Performance Measure Points} + 2.24\ \textit{Quality Improvement Points} = 13.79$$

$$\frac{\textit{Total Points Earned}}{\textit{Total Possible Points}} \times 100 = \textit{Domain Score}$$

$$\frac{13.79}{12}\ \textit{converts to}\ \frac{12}{12} \times 100 = 100\%$$

The total score will be 100 percent. Note that although the total adds up to 13.79, the total points earned cannot exceed the maximum possible points in the domain.

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.[14] 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 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.

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

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

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	20/20	Completely reported on all measures	100%
Care Coordination/ Patient Safety	8/8	Completely reported on all measures	100%
Preventive Health	12/12	Completely reported on all measures	100%
At-Risk Population	6/6	Completely reported on all measures	100%
Quality Score	**—**	**—**	**100%**

Note: Based on quality measures in effect in 2020. — = 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 100.00 percent on the Patient/Caregiver Experience domain, 92.50 percent on the Care Coordination/Patient Safety domain, 100 percent on the Preventive Health domain, and 90.00 percent on the At-Risk Population Domain, the quality score is 95.63 percent.[15]

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	20	20	100.00%
Care Coordination/Patient Safety	7.40	8	92.50%
Preventive Health	12	12	100.00%
At-Risk Population	5.40	6	90.00%

[15] As noted in Footnote 2, for Performance Year 2020 ACOs will not be required to field a CAHPS for ACOs survey and will receive automatic credit for summary survey measures in the Patient/Caregiver Experience domain.

DOMAIN	POINTS EARNED FOR ACO BEYOND PERFORMANCE YEAR 1	TOTAL POSSIBLE POINTS	DOMAIN SCORE
Quality Score	**—**	**—**	**95.63**

Note: Example uses 2020 performance year quality measures. — = not applicable

Quality Score = 100.0% x 0.25 + 92.50% x 0.25 + 100% x 0.25 + 90.0% x 0.25 = 95.63%

4.5 EXTREME AND UNCONTROLLABLE CIRCUMSTANCES

The quality score will be adjusted for certain ACOs identified by the Extreme and Uncontrollable Circumstances (EUC) Policy. ACOs impacted by this policy are identified by the following criteria:

- 20% or more of the ACO's assigned beneficiaries reside in an area identified under the Quality Payment Program as being affected by an extreme and uncontrollable circumstance (42 CFR § 425.502(f)(1)(i))
- An ACO's legal entity is physically located in an area identified as being affected by an extreme and uncontrollable circumstance under the Quality Payment Program (42 CFR § 425.502(f)(1)(ii))

ACOs that meet one of the above criteria will have their quality performance score set equal to the mean quality performance score for all Shared Savings Program ACOs for the performance year. However, if the ACO completely and accurately reported all quality measures, the higher of the ACO's quality performance score or the mean quality performance score for all Shared Savings Program ACOs will be used (42 CFR §425.502(f)(2)(i-ii).

4.6 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

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 that have failed the audit will be adjusted downward 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 that 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)).

4.7 COMPLIANCE ACTIONS

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 (42 CFR §425.316(c)(1)).

5.0 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.

Participants of MIPS APMs and their ECs will also need to continue submitting MIPS Promoting Interoperability data, in the form and manner specified by MIPS, for MIPS APM scoring purposes. 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).

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

- Medicare Shared Savings Program & MIPS Interactions
- Performance Year 2020 Quality Performance Category Scoring Web Interface Reporters under the APM Scoring Standard
- Scores for Improvement Activities in MIPS APMs in the 2020 Performance Period

List of Acronyms

Acronym	Definition
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
API	Application Programming Interface
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
ECs	Eligible Clinicians
EHR	Electronic Health Record
EUC	Extreme and Uncontrollable Circumstances
FFS	Fee-for-service
HTN	Hypertension
IDR	Integrated Data Repository
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
PHE	Public Health Emergency
PI	Promoting Interoperability
PQI	Prevention Quality Indicator
PQRS	Physician Quality Reporting System
PY	Performance Year

Acronym	Definition
QMV	Quality Measures Validation
SSM	Summary Survey Measure
TIN	Taxpayer Identification Number