Medicare Shared Savings Program

QUALITY MEASUREMENT METHODOLOGY AND RESOURCES

Specifications

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Version 2019
Applicable for Performance Year 2019

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

Revision History

VERSION	MAJOR REVISIONS DESCRIPTION	AFFECTED AREA
2019	Updated performance year references to 2019	All
2019	Added and edited text to reflect 2019 participation scenarios	Section 1.2, Section 1.3, Table 1-1, Section 1.4, Section 3.1
2019	Updated list of measures for the 2019 performance year, including removal of section on ACO-11.	Section 2 Intro, Section 2.1, Table 2-1, Table 2-2, Table 2-3, Table 2-4, Table 4-1, Table 4-3, Section 4.3, Table 4-4, Table 4-5,
2019	Provided list of informational measures	Table 2-5
2019	Updated selected benchmarks for 2019	Section 4.1
2019	Added section on CEHRT attestation requirement	Section 5.1
2019 – April	Added additional information on CAHPS for ACOs sampling methodology	Appendix A, Section 3.1

Table of Contents

List of Tables

List of Figures

1 Introduction

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

This document reviews the quality performance standard and scoring methodology for ACOs participating in the Shared Savings Program and describes the Shared Savings Program's quality measurement and reporting methodology. Examples in the sections to follow focus on Performance Year 2019. This document is subject to periodic change and will be updated to reflect the policies applicable for each subsequent reporting year.

1.1 QUALITY MEASURE STRUCTURE AND DATA COLLECTION METHODS OVERVIEW

CMS focuses ACO quality performance and improvement activity on four key domains (refer to Figure 1-1) to serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance.

To determine an ACO's quality performance score, CMS weights each of the four measure domains equally, at 25 percent, to encourage ACOs to focus on all domains

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

1.2 QUALITY REPORTING FOR A PERFORMANCE YEAR

Quality data collection for a performance year occurs after the end of the calendar year, during the "quality data reporting period." For example, for performance year 2018, the data collection period for ACO submission of the performance year 2018 data through the CMS Web Interface will occur between January 22, 2019 and March 22, 2019.

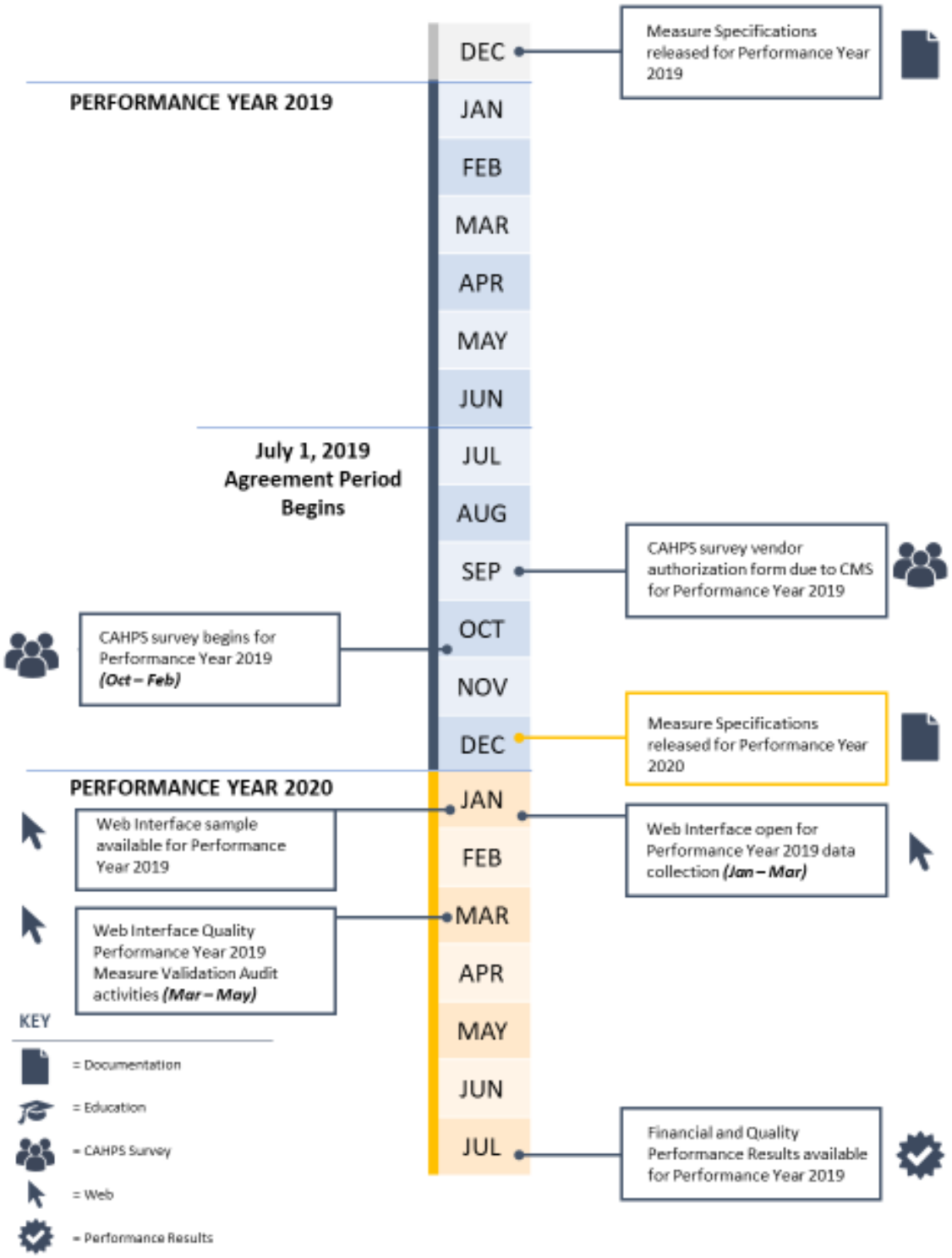
Note that in 2019, some ACOs will participate in one or two 6-month performance years (or performance period) and others will participate in one 12-month performance year. Specifically, the following scenarios may occur:

- An ACO enters a 12-month performance year on January 1, 2019

- An ACO extends their agreement by 6 months from January 1, 2019, through June 30, 2019
- An ACO begins an agreement on July 1, 2019 (including ACOs that early renewed their prior agreement, and ACOs that extended their agreements by 6 months and renew for a new agreement period, and ACOs entering the program).

A single quality data reporting period covering all of calendar year 2019 will be used to assess quality in all of these scenarios (see 83 FR 59953 through 59955, 83 FR 67959 through 67961).

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



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

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

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

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

Whether an ACO's performance on quality measures is scored as P4R or P4P for a particular year depends on the ACO's performance year and agreement start date. ACOs begin to phase in to P4P in the second performance year of their first agreement period and continue to phase into P4P during the third performance year of an ACO's first agreement period. ACOs in a second or subsequent agreement period continue under P4P for the length of their agreement period. As noted in the 2019 Shared Savings Program Final Rule and in Table 1-1 below, we defined the following participation options, as we believed it was appropriate to consider an ACO's experience with the Program for the purposes of applying policies that phase-in over the course of an ACO's agreement, such as the phase-in of measures from P4R to P4P:

Table 1-1. Phase-in of Policies by Applicant Type

APPLICANT TYPE	AGREEMENT PERIOD FOR POLICIES THAT PHASE-IN OVER TIME (PHASE IN OF PAY-FOR-PERFORMANCE)
New ACO legal entity	First agreement period. These ACOs should refer to "PY1" of the phase-in schedule.
ACOs re-entering the program	Either: (1) The next consecutive agreement period if the ACO's prior agreement expired, or if new legal entity is identified as a re-entering ACO because more than 50% of its ACO participants recently participated in an ACO whose agreement period expired. These ACOs should refer to "PY3" of the phase-in schedule. (2) The first performance year of the same agreement period in which the ACO was participating at the time of termination, if the ACO's prior agreement was terminated, or if new legal entity is identified as a re-entering ACO because more than 50% of its ACO participants recently participated in an ACO whose agreement period was terminated. ACOs that terminated in their first agreement period should refer to "PY1" of the phase-in schedule. ACOs that terminated in a subsequent agreement period should refer to "PY3" of the phase-in schedule. (3) If new legal entity is identified as re-entering ACO because more than 50% of its ACO participants recently participated in an ACO that is currently in the Shared Savings Program, the new ACO would be considered to be entering into the same agreement period in which this other ACO is currently participating, beginning with the first performance year of that agreement period. If the ACO is in their first agreement period, ACOs should refer to "PY1" of the phase-in schedule. If the ACO is in a subsequent agreement period, ACOs should refer to "PY3" of the phase-in schedule.
ACOs renewing their agreement	Next consecutive agreement period. These ACOs should refer to "PY3" of the phase-in schedule.

There is also a phase-in process for measures added to the Shared Savings Program. For more information on the phase-in of measures from P4R to P4P, please refer to Section 4.1.

1.4 RELATIONSHIP BETWEEN QUALITY PERFORMANCE AND FINANCIAL PERFORMANCE

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

Table 1-2. One-sided Models and Two-sided Models

AGREEMENT START DATE	ONE-SIDED MODEL	TWO-SIDED MODEL
Agreement start date January 1, 2019 and prior	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

The final sharing rate is equal to the product of the ACO's final quality score and the maximum sharing rate specific to the financial model under which the ACO participates. An ACO under a two-sided shared savings/losses model will also share losses, if applicable.

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

In general, ACOs with relatively higher quality scores will be eligible to share in a larger amount of savings. ACOs in Track 2 and the ENHANCED track (Track 3) with relatively higher quality scores will be liable for a smaller amount of losses compared to ACOs with lower quality scores, because the loss sharing rate is determined based on quality performance. However, ACOs under the Track 1+ Model and the BASIC track's two-sided models have a fixed loss sharing rate of 30% that is not adjusted for the final quality score. For information on the calculation and amount of savings an ACO may receive or losses for which an ACO may be liable, refer to the Shared Savings and Losses and Assignment Methodology Specifications.

An ACO that fails to meet the quality performance standard (complete reporting for ACOs in their first performance year of their first agreement period, complete reporting and meeting minimum attainment on at least one measure in each domain for all other ACOs) for the performance year will be ineligible for a shared savings payment for the associated performance year. For ACOs participating under a two-sided shared savings/losses model, failure to meet the quality performance standard will result in application of the highest sharing rate for losses for the performance year.

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 1-3 below, CMS maintains a variety of publicly available sources of technical documentation on quality measures, including documentation for reporting year 2019. As shown in Table 1-3 below, CMS maintains a variety of publicly available sources of technical documentation on quality measures, including documentation for reporting year 2019.

Table 1-3. Sources of Measure Documentation by Measure Type and Links for 2019 Documentation

DOCUMENT NAME	MEASURE TYPE	DESCRIPTION	2019 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
CMS Web Interface documentation guides	ACO-reported measures	Detailed information regarding the documentation that will be needed to substantiate data elements for each measure in the event of an audit	Forthcoming
Measure Information Forms (MIFs)	Quality Payment Program data and claims-based measures	Detailed descriptive information on each measure.	Shared Savings Program website, under "2019 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 2019 Quality Measure Benchmarks

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

2 Quality Domains and Measures

For Performance Year 2019, 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 measures)
   - Hypertension (1 measure)

These measures are calculated via several means:

- 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[1] and includes additional content relevant to patient/caregiver experience with care delivered by an ACO. 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.

For 2019, CMS will continue to provide a single version of the CAHPS for ACOs Survey, which was streamlined in 2018 to 58 items and implemented for performance year 2018. The survey includes 10 SSMs. ACO-45 (Courteous and Helpful Office Staff) and

[1] The CG-CAHPS Survey is maintained by the Agency for Healthcare Research and Quality (AHRQ) and used by CMS for measuring quality performance of ACOs on patient and caregiver experience of care.

ACO-46 (Care Coordination) were previously provided for informational purposes, but starting in performance year 2019 they will be scored as part of the Shared Savings Program quality measure set. The SSMs included in the 2019 survey are outlined in Table 2-1 below.

Table 2-1. Patient/Caregiver Experience Measures (2019)

ACO MEASURE #	SUMMARY SURVEY MEASURE	METHOD OF DATA SUBMISSION	SOURCE	USED TO CALCULATE QUALITY SCORE?
ACO-1	Getting Timely Care, Appointments, and Information	Survey	core items	Yes
ACO-2	How Well Your Providers Communicate	Survey	core items	Yes
ACO-3	Patients' Rating of Provider	Survey	core item	Yes
ACO-4	Access to Specialists	Survey	supplemental item	Yes
ACO-5	Health Promotion and Education	Survey	supplemental items	Yes
ACO-6	Shared Decision Making	Survey	supplemental items	Yes
ACO-7	Health Status & Functional Status	Survey	core and supplemental items	Yes*
ACO-34	Stewardship of Patient Resources	Survey	supplemental items	Yes
ACO-45	Courteous & Helpful Office Staff	Survey	core items	Yes
ACO-46	Care Coordination	Survey	core items	Yes

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

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

2.2 CARE COORDINATION/PATIENT SAFETY MEASURES

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

Table 2-2. Care Coordination/Patient Safety Measures (2019)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-8	Risk-Standardized, All Condition Readmission	CMS calculates from claims
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	CMS calculates from claims
ACO-43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91)	CMS calculates from claims
ACO-13 (CARE-2)	Falls: Screening for Future Fall Risk	CMS Web Interface

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

2.3 PREVENTIVE HEALTH MEASURES

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

Table 2-3. Preventive Health Measures (2019)

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-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 (2019)

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 Poor Control	CMS Web Interface
ACO-28 (HTN-2)	Controlling High Blood Pressure	CMS Web Interface

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

2.5 INFORMATIONAL MEASURES

Some measures are provided to ACOs in a Quarterly Quality Report for informational purposes only and are not part of the official Shared Savings Program quality measure set. These measures are listed in Table 2-5.

Table 2-5. Informational Measures (2019)

ACO MEASURE #	MEASURE TITLE	METHOD OF DATA SUBMISSION
ACO-35	Skilled Nursing Facility 30—Day All-Cause Readmission Measure	CMS calculates from claims
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	CMS calculates from claims
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	CMS calculates from claims
ACO-44	Use of Imaging Studies for Low Back Pain	CMS calculates from claims

3 Quality Measure Data Collection and Performance Rate Calculations

This section describes the approach for determining the patient sample and the procedures for collecting/reporting data, as well as the approach for calculating performance rates. Using the quality measure data collected using Medicare claims data (claims-based measures), or submitted by ACOs (CMS Web Interface measures) and survey vendors (CAHPS for ACOs Survey measures), CMS calculates performance rates for each measure for each ACO based on the measure specifications (refer to Section 1.5).

Performance rates are used to determine the points an ACO earned on each measure according to the Shared Savings Program's quality benchmarks, which are described in Section 4.1. ACOs will receive performance results for all quality measures as part of their annual quality performance reports. ACOs will also receive a CAHPS for ACOs detailed report with additional data related to their performance on the patient/caregiver experience of care measures.

3.1 BENEFICIARY SELECTION FOR QUALITY MEASUREMENT

A subset of an ACO's assigned beneficiaries will be used in quality measurement for the Shared Savings Program—including the CAHPS for ACOs Survey, CMS Web Interface measures, and claims-based measures—if they meet the criteria outlined below, which apply to ACOs in a 6-month performance year (or performance period) and ACOs in a 12-month performance year. As previously noted, a single quality data reporting period covering all of calendar year 2019 will be used to assess quality in all of these scenarios. Appendix A presents a more detailed description of the sampling specifications for the CAHPS for ACOs Survey.

Criteria 1. Beneficiary is assigned to an ACO.

- For ACOs under preliminary prospective assignment with retrospective assignment (i.e., Track 1 and Track 2 ACOs and ACOs selecting retrospective assignment in the BASIC track or ENHANCED track):
  - Second quarter of calendar year preliminary prospectively assigned beneficiaries will be used for the CAHPS for ACOs Survey sample. However, the sample for the CAHPS for ACOs Survey will be determined based on the initial preliminary prospective assignment list for the 6-month performance year beginning on July 1, 2019.
  - 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., Track 3, and Track 1+ Model ACOs and 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. However, the sample for the CAHPS for ACOs Survey will be determined based on the initial prospective assignment list for the 6-month performance year beginning on July 1, 2019.
  - 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:
  - CMS will include in the survey sample assigned beneficiaries (as identified in Step 1 above) who are 18 years or older, excluding those who:
    - Received fewer than two primary care service visits within the ACO during the performance year (beneficiaries receiving care only from hospitalists are excluded);
    - Entered hospice during the performance year;
    - Died during the performance year;
    - Were sampled for the spring administration of the In-Center Hemodialysis CAHPS Survey;
    - Were institutionalized (all primary care services 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).[2]
    - Resided outside the United States, Puerto Rico, or the U.S. Virgin Islands
- For the CMS Web Interface measures:
  - CMS will include in the measure samples assigned beneficiaries (as identified in Step 1 above), excluding those who:

[2] Refer to CAHPS® Survey for ACOs Survey Quality Assurance Guidelines, version 6 (June 2018).

- Do not meet measure-specific age criteria;[3]
- 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).

3.2 PATIENT/CAREGIVER EXPERIENCE SURVEY DATA

3.2.1 SURVEY ADMINISTRATION

ACOs are responsible for selecting and paying for CMS-approved vendors to administer the CAHPS for ACOs Survey to a random sample of FFS beneficiaries assigned to the ACO for the reporting year. CMS-approved CAHPS for ACOs Survey vendors collect data between October and January and deliver responses to CMS.

ACOs must have a contract in place with a CMS-approved CAHPS for ACOs Survey vendor for each reporting year. CMS maintains a list of approved CAHPS for ACOs Survey vendors, which is accessible through the CAHPS for ACOs website. ACOs are required to authorize a CMS-approved vendor using a web-based vendor authorization tool—which identifies the ACO's survey vendor. The window for completion of vendor authorization closes in September.

3.2.2 SURVEY SAMPLE AND SURVEY PROCEDURES

CMS randomly samples 860 Medicare FFS beneficiaries assigned to an ACO who are eligible for the survey sample as described in Section 3.1. Furthermore, 25 percent of each ACO's sample will be drawn from "high users of care." High users of care are beneficiaries with the top 10 percent of primary care claim charges within the ACO. CMS will deliver the beneficiary sample to each ACO's selected vendor. High users of care are oversampled to increase the likelihood that survey questions measuring less common experiences garner an adequate number of responses.

The CAHPS for ACOs Survey is collected using mixed-mode data collection procedures. Sampled beneficiaries are mailed a pre-notification letter, followed by up to two survey mailings. After several weeks, sampled beneficiaries who do not respond by

[3] 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.

mail are contacted by telephone and invited to answer the survey via an interview. Beneficiaries may receive up to six telephone calls.

3.2.3 SURVEY SCALE AND PERFORMANCE RATE DETERMINATIONS

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

Step 1. Assign points for individual question responses.

The first step in scoring is to convert survey respondents' descriptive responses into numerical values using the response scale for the survey question. For example, the question "In the past six months, how often did your provider explain things in a way that was easy to understand?" has the following response scale:

- 1 – Never
- 2 – Sometimes
- 3 – Usually
- 4 – Always

For Yes/No response scales, CMS assigns a value of one (1) for "Yes" and zero (0) for "No." The numeric response values of the separate Yes/No and Never/Always response scales indicate the ordinal ranking of responses within each scale. If we were to compare the response values to the two response scales, the equivalent comparison for raw numeric values is "Yes = 1" and "Always = 4" as both are the top response value for their respective response scales. In scoring, no direct comparisons are made across raw response values (that is, we don't equate "Yes = 1" to "Always = 4").

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

Step 2. Perform case mix adjustment.

Case mix adjustment is a multi-step process and is applied to adjust for differences in beneficiary characteristics ('case mix'). These adjustments are based on linear regression models that describe responses on a particular survey question (the dependent variable) as a linear function of respondent characteristics ("case-mix adjustors," or independent variables).

Scores are adjusted for the following respondent characteristics: age, education, self-reported health status, self-reported mental health status, Medicaid dual eligibility, low-

income subsidy eligibility, survey completion in an Asian language, and whether another person helped the respondent complete the survey ("proxy assistance").

All variables are used to adjust scores for all measures, with the exception of the Health Status and Functional Status SSM and the sharing health information question within the Shared Decision-Making SSM.[4]

An ACO's mean score after case-mix adjustment represents the ACO's estimated mean score after adjustment for differences between the case mix of their assigned beneficiaries and the case mix of the national average of beneficiaries assigned to all participating ACOs. In other words, the case-mix adjusted score is the mean that would be obtained for a given ACO if the average case mix variables for that ACO were equal to the national average across all participating ACOs. The ACO's actual mean score will be adjusted upward or downward for a given measure depending on how different the patient population of the ACO is, relative to the national average case mix.

Step 3. Transform scores to 0-100 scale.

Finally, weighted, case-mix adjusted numerical responses are converted to a 0-100 scale, where zero represents the poorest performance and 100 represents the best performance. Scores are converted to this scale using the following approach.

- First, the weighted, adjusted responses for each question of a given SSM are averaged to produce the overall SSM score on the original survey response scale.
- Next, this average score is transformed to the 0-100 scale using the following formula:

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

  - Y = 0-100 score
  - X = ACO's CAHPS score on its original scale
  - a = minimum possible score on the original scale
  - b = maximum possible score on the original scale

For SSMs composed of items with different response scales, the transformation from the original response scale to the 0-100 scale is performed before taking the average across scales.

Table 3-2 below provides an example of how the case-mix adjusted mean for the Access to Specialists SSM would be converted from its original scale to the 0-100 scale for three hypothetical ACOs. The Access to Specialists SSM is a single-question SSM,

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

which means there is only one question that contributes to the overall measure. The one question is as follows: "In the last 6 months, how often was it easy to get appointments with specialists?" The response scale is as follows, with 1 as the minimum possible score (i.e., a) and 4 as the maximum possible score (i.e., b) on the 4-point original scale:

- 1 – Never
- 2 – Sometimes
- 3 – Usually
- 4 – Always

Table 3-2. Example of Scoring Transformation for Access to Specialists Measure (ACO-4)

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

3.3 CLAIMS-BASED DATA

CMS obtains the necessary Medicare Part A and Part B claims files from the CMS Integrated Data Repository (IDR) and calculates the performance rates for these measures for each ACO based on the algorithms specified in the MIFs, which are posted on the Shared Savings Program website. Calculations for each of these measures are conducted using the ACO's assigned beneficiaries who are eligible for the measures (refer to Section 3.1 for additional information on assigned beneficiary eligibility). For claims-based measures, ACOs do not need to collect or submit additional data beyond normal billing activities. Each of these measures are expressed in such a way that a lower performance rate indicates better quality (lower calculated results are desired).

3.4 CMS WEB INTERFACE DATA

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

which provide additional guidance related to the measures reported through the CMS Web Interface, are available on the Quality Payment Program webpage.[5]

3.4.1 ACCESSING AND REPORTING DATA THROUGH THE CMS WEB INTERFACE

ACOs are responsible for entering data into the CMS Web Interface during a nine-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 the reporting deadline. It is imperative that ACOs complete the data reporting and submission requirements in the CMS Web Interface by the deadline specified by CMS.

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

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

3.4.2 CMS WEB INTERFACE MEASURES SAMPLES

The CMS Web Interface is pre-populated with measure-specific beneficiary samples and beneficiary demographic information. For certain measures, additional data are also pre-populated in the CMS Web Interface, such as visit dates and flu shot receipt (if available in claims data), and the three 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.[6] CMS makes reasonable efforts to include the same beneficiary in multiple measures in order to reduce reporting burden. The measure samples are grouped into eight categories, or disease-related "modules."[7] 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.

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[5] 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.

[6] 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.

[7] Eight modules for 2018: CARE, DM, HTN, MH, PREV.

For the 2019 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 for PREV-13) than are needed to meet the reporting requirement of 248.

3.4.3 CMS WEB INTERFACE MEASURE PERFORMANCE RATES

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

4 Quality Performance Scoring

This section describes the phase-in to P4P, data sources, methods for calculating the quality measure benchmarks for ACOs, and how these benchmarks are applied to P4P measures. This section also discusses how an ACO's quality score is calculated and how CMS determines an ACO's eligibility for shared savings as part of performance year financial reconciliation. Examples included in this section are based on the quality measure benchmarks for the 2019 performance year.

4.1 QUALITY MEASURE BENCHMARKS

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

When a measure is added to the ACO quality measure set, it will be P4R for its first two performance years in use. It is also important to note that CMS maintains the authority to revert measures from P4P to P4R when the measure owner determines the measure causes patient harm or no longer aligns with clinical practice.

4.1.1 BENCHMARK DATA SOURCES

CMS established benchmarks for the 2018 and 2019 reporting years using all available and applicable 2014, 2015, and 2016 Medicare FFS data (2015, 2016, and 2017 for measures where benchmarks were set in the 2019 update). This includes:

- Quality data reported by Shared Savings Program, Pioneer Model ACOs, and Next Generation Model ACOs through the CMS Web Interface for the 2014, 2015, and 2016 performance years (2015, 2016, and 2017 for ACO-27); and

- Quality measure data collected from the CAHPS for ACOs and CAHPS for PQRS surveys administered for the 2014, 2015, and 2016 reporting years.
- Quality data reported through the Physician Quality Reporting System (PQRS) or MIPS by physicians and groups of physicians through the CMS Web Interface, claims, or a registry for the 2014, 2015, and 2016 performance years (2015, 2016, and 2017 for ACO-27);[8, 9]

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

4.2 QUALITY MEASURE SCORING

Once ACO-specific measure data is collected and measure performance rates are calculated, CMS determines whether all measures have been completely reported. CMS then determines how many points an ACO earned on each measure. An ACO can earn a maximum of two points on each measure.

- P4R measures: Maximum points will be earned on all measures if all measures reported through the CMS Web Interface are completely reported and a CMS-approved vendor administers the CAHPS for ACOs Survey on behalf of the ACO and transmits the data to CMS. Incomplete reporting on any CMS Web Interface measure will result in zero points for all CMS Web Interface measures and failure to meet the quality standard for the performance year. Similarly, if a CAHPS for ACOs Survey is not administered and no data is transmitted to CMS, zero points will be earned for all Patient/Caregiver Experience measures and the ACO will fail to meet the quality standard for the performance year.
- P4P measures: Points are earned for each measure based on the ACO's performance compared to measure-specific benchmarks, as shown in Table 4-1 below. If no beneficiaries 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

[8] CMS did not use data submitted in 2014 via the PQRS Qualified Clinical Data Registry (QCDR) and electronic reporting options due to data integrity issues. Other measure-specific mechanism exclusions were also made on a case-by-case basis.

[9] ACO-17 was respecified in 2018. As a result, we recalculated the measure using patient-level data submitted by ACOs and group practices through the CMS Web Interface in 2014, 2015, and 2016 and created benchmarks using solely that data.

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

Measure	Description	30th Perc.	40th Perc.	50th Perc.	60th Perc.	70th Perc.	80th Perc.	90th Perc.
	Points	1.1	1.25	1.4	1.55	1.7	1.85	2
ACO-13	Falls: Screening for Future Fall Risk	43.42	50.42	58.45	66	73.39	81.79	90.73

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

For most measures, the higher the level of performance, the higher the corresponding number of quality points. However, it is important to note that for some ACO quality measures assessing the occurrence of undesirable outcomes, a lower score represents better performance. Specifically,

- ACO-8 (Risk-Standardized All-Condition Readmission) and ACO-38 (All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions) capture admissions and readmissions that are preventable events

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

4.3 QUALITY MEASURE DOMAIN SCORING

4.3.1 QUALITY IMPROVEMENT REWARD SCORING

Starting with Performance Year 2015, CMS introduced a Quality Improvement Reward that allows ACOs to earn up to four additional points in each domain if they show statistically significant improvement in their performance on quality measures from one year to the next. CMS will not deduct any points from an ACO's quality score if the ACO did not improve on a quality measure. The Quality Improvement Reward is adapted from the Medicare Advantage Five-Star Rating program, which has developed and implemented a methodology for measuring quality improvement.[10] 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***.

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

[10] 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

Step 4.

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

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

In the event that an ACO demonstrates a statistically significant decline in a measure from one year to the next, but still scores above 90 percent (or above the 90th percentile benchmark in the case of certain claims-based measures) in both years, CMS will consider this "no change" in performance (instead of a significant decline) when calculating the domain improvement score. This aligns with the Medicare Advantage "hold harmless" provision in the five-star rating methodology. Furthermore, ACOs will be "held harmless" (i.e., changes between years will neither be considered a significant improvement nor a significant decline) in the following situations:

- If the ACO did not completely report measures through the CMS Web Interface in 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.
- If the ACO has a denominator of zero on a measure in either the current year or the previous year, the change in performance will neither be considered a significant improvement nor a significant decline.

Note that only measures that are not new to the Shared Savings Program in a given year are used in this calculation. For example, only measures collected in both Performance Year 2018 and Performance Year 2019 are included in the domain improvement score calculation for 2019.

Step 5.

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

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

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 (2019)

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:

$$11.55\ Performance\ Measure\ Points + 2.24\ Quality\ Improvment\ Points\ = 13.79$$

$$Domain\ Score = \frac{Total\ Points\ Earned}{Total\ Possible\ Points} \times 100\% = \frac{13.79}{12} \times 100\% = 100\%$$

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.[11] 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.

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

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 2019. — = not applicable

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

As shown in Table 4-5 below, for an ACO beyond the first year of their first agreement period that earned a domain score of 100 percent on the Preventive Health domain, 94.00 percent on the Patient/Caregiver Experience domain, 92.50 percent on the Care Coordination/Patient Safety domain, and 90.00 percent on the At-Risk Population Domain, the quality score is 94.13 percent.

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

DOMAIN	POINTS EARNED FOR ACO BEYOND PERFORMANCE YEAR 1	TOTAL POSSIBLE POINTS	DOMAIN SCORE
Patient/Caregiver Experience	18.80	20	94.00%
Care Coordination/Patient Safety	7.40	8	92.50%
Preventive Health	12	12	100.00%
At-Risk Population	5.40	6	90.00%
Quality score			**94.13%**

Note: Example uses 2019 performance year quality measures.

Quality Score = 94.0% x 0.25 + 92.50% x 0.25 + 100% x 0.25 + 90.0% x 0.25 = 94.13%

4.5 QUALITY MEASURES VALIDATION AUDIT

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

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

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

4.6 COMPLIANCE

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

5 Alignment with the Quality Payment Program

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

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

5.1 CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY (CEHRT) USE

Beginning Performance Year 2019, ACOs will be required to certify annually, in the form and manner specified by CMS, that:

- at least 50 percent of the ECs use the version of CEHRT required by the Quality Payment Program (2015 Edition for Performance Year 2019) for ACOs in Track 1 and BASIC track Levels A-D (i.e., MIPS APMs)
- at least 75 percent of the ECs use the version of CEHRT required by the Quality Payment Program (2015 Edition for Performance Year 2019) for ACOs in Track 2, Track 3, Track 1+ Model and BASIC track Level E and ENHANCED track (i.e., Advanced APMs), which is the threshold established under the Quality Payment Program) for Advanced APMs.

This certification is not a measure that is used to calculate the ACO's annual quality score.

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 2019 Quality Performance Category Scoring Web Interface Reporters under the APM Scoring Standard
- Scores for Improvement Activities in MIPS APMs in the 2019 Performance Period

Appendix A: 2019 Sampling Methodology for the Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) Survey for Accountable Care Organizations (ACOs) Participating in Medicare Initiatives

The purpose of this appendix is to explain the sampling methodology for the CAHPS for ACOs Survey in Performance Year 2019. It describes beneficiaries eligible for the CAHPS for ACOs Survey, sample size requirements, and the survey procedure.

IDENTIFY ELIGIBLE BENEFICIARIES

For the CAHPS for ACOs Survey, CMS will include in the survey sample assigned beneficiaries (as identified in Section 3.1) who are 18 years or older, excluding those who:

- Received fewer than two primary care service visits within the ACO during the performance year (beneficiaries receiving care only from hospitalists are excluded);
- Entered hospice during the performance year;
- Died during the performance year;
- Were sampled for the Spring administration of the In-Center Hemodialysis CAHPS Survey;
- Were institutionalized (all primary care services 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).[12]
- Resided outside the United States, Puerto Rico, or the U.S. Virgin Islands;

The remaining assigned beneficiaries will be considered the sample frame of eligible beneficiaries from which a sample is drawn. The performance year 2019 CAHPS for ACOs survey uses the same instrument as the CAHPS for the Merit-based Incentive Payment System (MIPS) Survey. The sample frames of these two surveys are de-duplicated to ensure that Medicare fee-for-service beneficiaries only receive one of the two surveys. If a beneficiary is assigned to both sample frames, the beneficiary is maintained on the CAHPS for MIPS frame (to preserve sample size for MIPS groups, which tend to be smaller than ACOs). The CAHPS for ACOs contract team works with other CMS programs and de-duplicate sample frames as needed.

[12] Refer to CAHPS® Survey for ACOs Survey Quality Assurance Guidelines, version 6 (June 2018).

The CAHPS for ACOs Survey names a focal provider for each eligible beneficiary to anchor responses. The approach to assigning a focal provider involves the following principles: (1) the focal provider is the provider delivering the plurality of primary care services, defined as the greatest number of visits; (2) the focal provider is an ACO provider used in assignment; (3) primary care providers are prioritized as focal providers over specialty providers, consistent with the central importance of primary care in ACOs; (4) providers of specialties that are not covered by Clinician and Group CAHPS (e.g., dentists) cannot be named as focal providers; and (5) the focal provider may be a physician, physician assistant, nurse practitioner, certified nurse midwife, or certified clinical nurse specialist. Beneficiaries for whom a focal provider cannot be identified are excluded from the sample frame.

SAMPLE SIZE

The CAHPS for ACOs Survey data coordination team randomly samples 860 Medicare FFS beneficiaries assigned to an ACO who are eligible for the survey sample as described above. This sample size requirement aims to reach the target of 425 completed surveys per ACO. Twenty-five percent of each ACO's sample will be randomly selected from "high users of care;" the remaining 75 percent of the sample is randomly selected from the other survey eligible beneficiaries. High users of care are beneficiaries with the top 10 percent of primary care claims within the ACO. Scoring and analysis of data apply weights that appropriately compensate for the oversampling of high users of care. Hence, the high users of care, who may account for 25 percent of the sampled beneficiaries within each ACO, would represent 10 percent of the sample after weighting, reflecting the composition of the underlying beneficiary population. If an ACO has fewer than 860 eligible beneficiaries, the sample draw is 100 percent of survey eligible beneficiaries. Sampling procedures prevent the selection of multiple beneficiaries within the same household.

SURVEY PROCEDURE

CMS will deliver the beneficiary sample to each ACO's selected vendor. ACOs are responsible for selecting and paying for CMS-approved vendors to administer the CAHPS for ACOs Survey. CMS will provide the most up-to-date contact information available as of September 2019, including an address for all sampled beneficiaries and a phone number for most sampled beneficiaries.

Survey vendors will download their sample files and undertake their data collection activities, which begins in October 2019 and ends in January 2020.

The CAHPS for ACOs Survey is collected using mixed-mode data collection procedures. Vendors administer the survey using procedures and processes specified by CMS. Sampled beneficiaries are mailed a pre-notification letter, followed by up to two survey mailings. After several weeks, sampled beneficiaries who do not respond by mail are contacted by telephone and invited to answer the survey via phone interview.

Beneficiaries may receive up to six telephone calls. CMS is exploring the appropriateness and applicability of web administration for future performance years.

List of Acronyms

Acronym	Definition
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Model
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	corrective action plan
CEHRT	Certified EHR Technology
CG-CAHPS	CAHPS Clinician & Group Survey
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ECs	eligible clinicians
EHR	Electronic Health Record
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
PI	Promoting Interoperability
PQI	Prevention Quality Indicator
PQRS	Physician Quality Reporting System
PY	performance year
QMV	Quality Measures Validation
SSM	summary survey measure
TIN	taxpayer identification number