§ 425.502 Calculating the ACO quality performance score for performance years (or a performance period) beginning on or before January 1, 2020.

(a) *Establishing a quality performance standard.* 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.

(1) For the first performance year of an ACO's first agreement period, CMS defines the quality performance standard at the level of complete and accurate reporting for all quality measures.

(2) During subsequent performance years of the ACO's first agreement period, the quality performance standard will be phased in such that the ACO must continue to report all measures but the ACO will be assessed on performance based on the quality performance benchmark and minimum attainment level of all measures.

(3) Under the quality performance standard for each performance year of an ACO's subsequent agreement period, the ACO must continue to report on all measures but the ACO will be assessed on performance based on the quality performance benchmark and minimum attainment level of all measures.

(4) A newly introduced measure is set at the level of complete and accurate reporting for the first two reporting periods, the measure is required. For subsequent reporting periods, the quality performance standard for the measure will be assessed according to the phase-in schedule for the measure.

(5) CMS reserves the right to redesignate a measure as pay for reporting when the measure owner determines the measure no longer aligns with clinical practice or causes patient harm, or when there is a determination under the Quality Payment Program that the measure has undergone a substantive change.

(b) *Establishing a performance benchmark and minimum attainment level for measures.* (1) CMS designates a performance benchmark and minimum attainment level for each measure, and establishes a point scale for the measures.

(2)(i) CMS will define the quality benchmarks using fee-for-service Medicare data.

(ii) CMS will set benchmarks using flat percentages when the 60th percentile is equal to or greater than 80.00 percent, or when the 90th percentile is equal to or greater than 95 percent.

(iii) CMS reserves the right to use flat percentages for other measures when CMS determines that fee-for-service Medicare data are unavailable, inadequate, or unreliable to set the quality benchmarks.

(3) The minimum attainment level for pay for performance measures is set at 30 percent or the 30th percentile of the performance benchmark. The minimum attainment level for pay for reporting measures is set at the level of complete and accurate reporting.

(4)(i) CMS will update the quality performance benchmarks every 2 years.

(ii) For newly introduced measures that transition to pay for performance in the second year of the 2-year benchmarking cycle, the benchmark will be established for that year and updated along with the other measures at the start of the next 2-year benchmarking cycle.

(iii) CMS will use up to three years of data, as available, to set the benchmark for each quality measure.

(c) *Methodology for calculating a performance score for each measure.* (1) Performance below the minimum attainment level for a measure will receive zero points for that measure.

(2) Performance equal to or greater than the minimum attainment level for a pay-for-performance measure will receive points on a sliding scale based on the level of performance.

(3) Those measures designated as all or nothing measures will receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met.

(4) Performance at or above 90 percent or the 90th percentile of the performance benchmark earns the maximum points available for the measure.

(5) Performance equal to or greater than the minimum attainment level for pay-for-reporting measures will receive the maximum available points.

(d) *Establishing quality requirements for domains.* (1) CMS groups individual measures into four domains:

(i) Patient/care giver experience.

(ii) Care coordination/Patient safety.

(iii) Preventative health.

(iv) At-risk population.

(2) To satisfy quality requirements for a domain:

(i) The ACO must report all measures within a domain.

(ii) CMS may take the compliance actions described in § 425.216 for ACOs exhibiting poor performance on a domain, as determined by CMS under § 425.316.

(iii)(A) If the ACO achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings under subpart G of this part, the ACO may receive the proportion of those shared savings for which it qualifies.

(B) If an ACO fails to achieve the minimum attainment level on all measures in a domain, it will not be eligible to share in any savings generated.

(e) *Methodology for calculating the ACO's overall performance score.* (1) CMS scores individual measures and determines the corresponding number of points that may be earned based on the ACO's performance.

(2) CMS adds the points earned for the individual measures within the domain and divides by the total points available for the domain to determine the domain score.

(3) Domains are weighted equally and scores averaged to determine the ACO's overall performance score and sharing rate.

(4)(i) ACOs that demonstrate quality improvement on established quality measures from year to year will be eligible for up to 4 bonus points per domain.

(ii) Bonus points are awarded based on an ACO's net improvement in measures within a domain, which is calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures.

(iii) Up to four bonus points are awarded based on a comparison of the ACO's net improvement in performance on the measures for the domain to the total number of individual measures in the domain.

(iv) When bonus points are added to points earned for the quality measures in the domain, the total points received for the domain may not exceed the maximum total points for the domain in the absence of the quality improvement measure.

(v) If an ACO renews its participation agreement for a subsequent agreement period, quality improvement will be measured based on a comparison between performance in the first year of the new agreement period and performance in the last year of the previous agreement period.

(vi) For performance year 2017 and subsequent performance years, if an ACO receives the mean Shared Savings Program ACO quality score based on the extreme and uncontrollable circumstances policies in paragraph (f) of this section, the ACO is not eligible for bonus points awarded based on quality improvement.

(vii) For performance year 2017 and subsequent performance years, if an ACO receives the mean Shared Savings Program ACO quality score under paragraph (f) of this section, in the next performance year for which the ACO receives a quality performance score based on its own quality reporting, quality improvement is measured based on a comparison between the performance in that year and the most recently available prior performance year in which the ACO reported quality.

(f) *Extreme and uncontrollable circumstances.* For performance year 2017 and subsequent performance years, including the applicable quality data reporting period for the performance year, CMS uses an alternative approach to calculating the quality score for ACOs affected by extreme and uncontrollable circumstances instead of the methodology specified in paragraphs (a) through (e) of this section as follows:

(1) CMS determines the ACO was affected by an extreme and uncontrollable circumstance based on either of the following:

(i) Twenty percent 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.

(A) Assignment is determined under subpart E of this part.

(B) In making this determination for performance year 2017, CMS uses the final list of beneficiaries assigned to the ACO for the performance year. For performance year 2018 and subsequent performance years, CMS uses the list of assigned beneficiaries used to generate the Web Interface quality reporting sample.

(ii) The ACO's legal entity is located in an area identified under the Quality Payment Program as being affected by an extreme and uncontrollable circumstance. An ACO's legal entity location is based on the address on file for the ACO in CMS' ACO application and management system.

(2) If CMS determines the ACO meets the requirements of paragraph (f)(1) of this section, CMS calculates the ACO's quality score as follows:

(i) The ACO's minimum quality performance score is set to equal the mean quality performance score for all Shared Savings Program ACOs for the relevant performance year.

(ii) If the ACO completely and accurately reports all quality measures, CMS uses the higher of the ACO's quality performance score or the mean quality performance score for all Shared Savings Program ACOs.

(3) CMS applies determinations made under the Quality Payment Program with respect to—

(i) Whether an extreme and uncontrollable circumstance has occurred; and

(ii) The affected areas.

(4) CMS has sole discretion to determine the time period during which an extreme and uncontrollable circumstance occurred, the percentage of the ACO's assigned beneficiaries residing in the affected areas, and the location of the ACO legal entity.

[76 FR 67973, Nov. 2, 2011, as amended at 78 FR 74823, Dec. 10, 2013; 79 FR 68008, Nov. 13, 2014; 80 FR 71386, Nov. 16, 2015; 81 FR 80560, Nov. 15, 2016; 82 FR 53370, Nov. 15, 2017; 82 FR 60918, Dec. 26, 2017; 83 FR 60093, Nov. 23, 2018; 83 FR 68069, Dec. 31, 2018; 85 FR 19291, Apr. 6, 2020; 85 FR 85040, Dec. 28, 2020]

§ 425.504 Incorporating reporting requirements related to the Physician Quality Reporting System Incentive and Payment Adjustment.

(a) *Physician quality reporting system.* (1) ACOs, on behalf of eligible professionals who bill under the TIN of an ACO participant, must submit the measures determined under § 425.500 using a CMS web interface, to qualify on behalf of their eligible professionals for the Physician Quality Reporting System incentive under the Shared Savings Program.

(2)(i) Eligible professionals who bill under the TIN of an ACO participant within an ACO may only participate under their ACO participant TIN as a group practice under the Physician Quality Reporting System Group Practice Reporting Option of the Shared Savings Program for purposes of receiving an incentive payment under the Physician Quality Reporting System.

(ii) Under the Shared Savings Program, an ACO, on behalf of eligible professionals who bill under the TIN of an ACO participant must satisfactorily report the measures determined under Subpart F of this part during the reporting period according to the method of submission established by CMS under the Shared Savings Program in order to receive a Physician Quality Reporting System incentive under the Shared Savings Program.

(3) If eligible professionals who bill under the TIN of an ACO participant within an ACO qualify for a Physician Quality Reporting System incentive payment, each ACO participant TIN, on behalf of its ACO supplier/provider participants who are eligible professionals, will receive an incentive, for those years an incentive is available, based on the allowed charges under the Physician Fee Schedule for that TIN.

(4) ACO participant TINs and individual eligible professionals who bill under the TIN of an ACO participant cannot earn a Physician Quality Reporting System incentive outside of the Medicare Shared Savings Program.

(5) The Physician Quality Reporting System incentive under the Medicare Shared Savings Program is equal to 0.5 percent of the Secretary's estimate of the ACO's eligible professionals' total