

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS'S MONITORING ACTIVITIES FOR
ENSURING THAT MEDICARE
ACCOUNTABLE CARE ORGANIZATIONS
REPORT COMPLETE AND ACCURATE
DATA ON QUALITY MEASURES
WERE GENERALLY EFFECTIVE,
BUT THERE WERE WEAKNESSES
THAT COULD BE IMPROVED**

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Office of Inspector General

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Report in Brief

Date: September 2020
Report No. A-09-18-03033

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if the ACOs reduce health care costs and satisfy the MSSP quality performance standard for their assigned beneficiaries. As part of the standard, ACOs must report to CMS complete and accurate data on all quality measures. For performance year (PY) 2017, ACOs were required to report data on 31 quality measures through 3 methods of submission: a patient survey, claims and administrative data, and the designated CMS web portal. If ACOs do not report complete and accurate data, shared savings payments could be affected. Previous OIG audits of two selected ACOs assessed whether they reported complete and accurate data on selected quality measures.

Our objective was to determine whether CMS's monitoring activities were effective for ensuring that ACOs report complete and accurate data on quality measures.

How OIG Did This Audit

For PY 2017, we reviewed CMS's procedures and documentation. We also reviewed the Statements of Work, which included specific monitoring tasks for CMS's contractors to perform on behalf of CMS. In addition, we obtained information from the survey vendors on CMS's monitoring activities for the patient survey.

CMS's Monitoring Activities for Ensuring That Medicare Accountable Care Organizations Report Complete and Accurate Data on Quality Measures Were Generally Effective, but There Were Weaknesses That Could Be Improved

What OIG Found

CMS's monitoring activities were generally effective for ensuring that ACOs report complete and accurate data on quality measures through claims and administrative data and the CMS web portal. (For example, ACOs report data through the web portal on whether beneficiaries received preventive care, such as depression screenings.) However, we identified weaknesses in CMS's monitoring activities that could lead to ACOs reporting incomplete or inaccurate data through the patient survey. Specifically, CMS did not ensure that its contractor: (1) verified survey vendors' correction of identified issues even though the issues were directly related to the collection or reporting of data and (2) provided feedback reports in time for survey vendors to include in their Quality Assurance Plans (QAPs) all of the changes implemented to address identified issues. (A QAP describes a survey vendor's process for performing the patient survey and complying with the CMS Quality Assurance Guidelines.) In addition, CMS did not ensure that its contractor reviewed survey instruments (e.g., mail survey packages) translated into other languages. As a result of these weaknesses, ACOs may not report complete and accurate data on quality measures, which could affect the ACOs' overall quality performance scores and ultimately the shared savings payments.

What OIG Recommends and CMS Comments

To improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, we recommend that CMS update the Statement of Work to require its contractor to: (1) verify that survey vendors have corrected identified issues that directly relate to the collection or reporting of data; (2) confirm that all implemented changes to address the identified issues are included in QAPs before they are approved; and (3) review the translated survey templates, mail survey packages, and telephone survey scripts to ensure that they are consistent with the English versions.

CMS concurred with our recommendations and described actions that it had taken or planned to take to address our recommendations. For each recommendation, CMS stated that it will review current contractor requirements and incorporate updates within the scope of the contract as needed to address the related finding.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare providers and suppliers may voluntarily participate in the Medicare Shared Savings Program (MSSP) by creating or joining an Accountable Care Organization (ACO).¹ (These providers and suppliers are referred to as “ACO participants.”) ACOs may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if the ACOs reduce health care costs and satisfy the quality performance standard (MSSP standard) for their assigned beneficiaries. As part of the MSSP standard, ACOs are required to report to CMS complete and accurate data on all quality measures. CMS uses these measures to assess the quality of care furnished by an ACO and to determine the ACO’s overall quality performance score, which is used to calculate the ACO’s shared savings payments or, if applicable, the amount of shared losses. If ACOs do not report complete and accurate data, the shared savings payments could be affected. This vulnerability led us to perform assessments related to ACOs’ reporting of data on quality measures.

Previous Office of Inspector General (OIG) audits of two selected ACOs assessed whether the ACOs reported complete and accurate data on selected quality measures. Those audits found that West Florida ACO, LLC, and Sunshine ACO, LLC, generally reported complete and accurate data on quality measures through the CMS web portal, but there were a few reporting deficiencies that did not affect the overall quality performance score. This audit assessed the effectiveness of CMS’s monitoring of ACOs’ reporting of the data on quality measures and is part of the OIG’s body of work examining various aspects of ACOs under the MSSP. (Appendix B lists related OIG reports.)

OBJECTIVE

Our objective was to determine whether CMS’s monitoring activities were effective for ensuring that ACOs report complete and accurate data on quality measures.

BACKGROUND

Medicare Shared Savings Program and Accountable Care Organizations

For each performance year (PY),² CMS assigns Medicare fee-for-service beneficiaries to an ACO based on where the beneficiary receives a plurality of primary care services as determined by

¹ ACOs are groups of doctors, hospitals, and other providers that come together to give coordinated high-quality care to Medicare beneficiaries.

² A PY is generally a 12-month period beginning on January 1 of each year during an ACO’s agreement period in the MSSP.

the highest Medicare allowed amount for those services.³ Medicare continues to pay ACO participants under the fee-for-service program. (CMS administers Medicare’s fee-for-service program, which provides hospital and supplementary medical insurance to eligible beneficiaries.) ACOs may be eligible to receive shared savings payments if the ACOs reduce health care costs and satisfy the MSSP standard for their assigned beneficiaries. ACOs may also be liable for any shared losses if the ACOs fail to reduce health care costs.

For PY 2017, 472 ACOs served approximately 9 million beneficiaries under the MSSP. Of the 472 ACOs, 159 were eligible for shared savings payments and received approximately \$799 million in shared savings payments.⁴

Quality Measures

In addition to reducing health care costs, ACOs must meet the MSSP standard to be eligible to receive shared savings payments. As part of the MSSP standard, ACOs are required to report to CMS complete and accurate data on all quality measures for each PY (42 CFR § 425.502(a)). CMS establishes quality measures to assess the quality of care furnished by ACOs (42 CFR § 425.500(a)). ACOs must report data on quality measures according to the method of submission established by CMS (42 CFR § 425.500(c)). Further, CMS publishes guidance for ACOs to use when reporting data on quality measures for each PY (such as the *Accountable Care Organization 2017 Quality Measure Narrative Specifications*).

For PY 2017, CMS measured quality of care using 31 nationally recognized quality measures,⁵ focusing on areas such as preventive care and high-cost chronic conditions.

Methods of Reporting Data on Quality Measures

ACOs were required to report data on the 31 quality measures through 3 methods of submission: (1) a patient experience-of-care survey (patient survey) (8 measures), (2) claims and administrative data (8 measures), and (3) the designated CMS web portal (15 measures).⁶

³ Starting in PY 2018, a beneficiary can be assigned to an ACO based on the primary care practitioner (e.g., a primary care physician or one of certain specialists) that the beneficiary selects (42 CFR §§ 425.402(b) and (e)).

⁴ Of the remaining 313 ACOs, 11 were liable for shared losses, and 302 were neither eligible to receive shared savings payments nor liable for shared losses because they generally did not reduce health care costs or they chose to participate by sharing in potential savings while not being liable for shared losses.

⁵ These measures have generally been tested, validated, and clinically accepted by a nationally recognized, multiple-stakeholder, consensus-based entity, such as the National Quality Forum. Beginning in PY 2019, CMS reduced the number of quality measures from 31 to 23.

⁶ CMS refers to the web portal as the “CMS Web Interface,” which is a secure internet-based application that CMS makes available for ACOs to report data on quality measures.

Patient Survey (8 Measures)

CMS required each ACO to select a CMS-certified survey vendor to administer the patient survey and report the data on eight quality measures to CMS on the ACO's behalf. For example, these data included beneficiaries' ratings of their health care providers and experiences, such as whether the beneficiaries received care, appointments, and information in a timely manner. The survey vendor collected the data through mail and telephone surveys from a sample of the ACO's assigned beneficiaries. To collect the data, the survey vendor first sent to each sampled beneficiary a mail survey, which contained a questionnaire that focused on a beneficiary's experience of care received from a provider who participated in an ACO. If a beneficiary did not respond to the mail survey, the survey vendor called the beneficiary to collect the data by telephone, using a script with the same questions as the mail survey.

For PY 2017, 12 survey vendors administered the patient survey to approximately 400,000 beneficiaries and reported patient survey data for those beneficiaries who responded.⁷

Claims and Administrative Data (8 Measures)

CMS used a contractor to obtain quality measure data on seven of the eight quality measures from ACOs' Medicare fee-for-service claims data.⁸ Using these claims data, the contractor calculated statistics related to these measures. For example, the contractor calculated the percentage of beneficiaries readmitted into an acute-care hospital for inpatient medical care for a quality measure named "Risk-Standardized All Condition Readmission." A high readmission rate for beneficiaries who were discharged within 30 days from an acute-care hospital could indicate a quality-of-care issue.

For the remaining quality measure, the contractor obtained the quality measure data by collecting administrative data on the ACO participants' use of certified electronic health record (EHR) technology. According to CMS's quality measure specifications,⁹ ACOs' use of certified EHR technology gives assurance that it includes the necessary functionality and security to facilitate good coordination of care and high quality of care for beneficiaries.

⁷ Survey vendors are organizations that have facilities, project experience, and staff expertise to administer the patient surveys. For PY 2017, of the 17 CMS-approved survey vendors, the ACOs selected 12.

⁸ The Medicare fee-for-service claims were for services provided to ACOs' assigned beneficiaries.

⁹ CMS, *Accountable Care Organization 2017 Quality Measure Narrative Specifications*. Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications>. Accessed on April 21, 2020.

CMS Web Portal (15 Measures)

ACOs reported data to CMS on 15 quality measures through the CMS web portal. For example, these data included an assessment of whether beneficiaries received preventive care, such as depression screenings, from ACO participants.

Calculation of the Overall Quality Performance Score for Shared Savings Payments

To calculate an ACO's overall quality performance score, CMS used the data on the 31 quality measures that were reported through the patient survey, claims and administrative data, and the CMS web portal. This score was used, in part, to calculate the shared savings payments or, if applicable, the amount of shared losses.

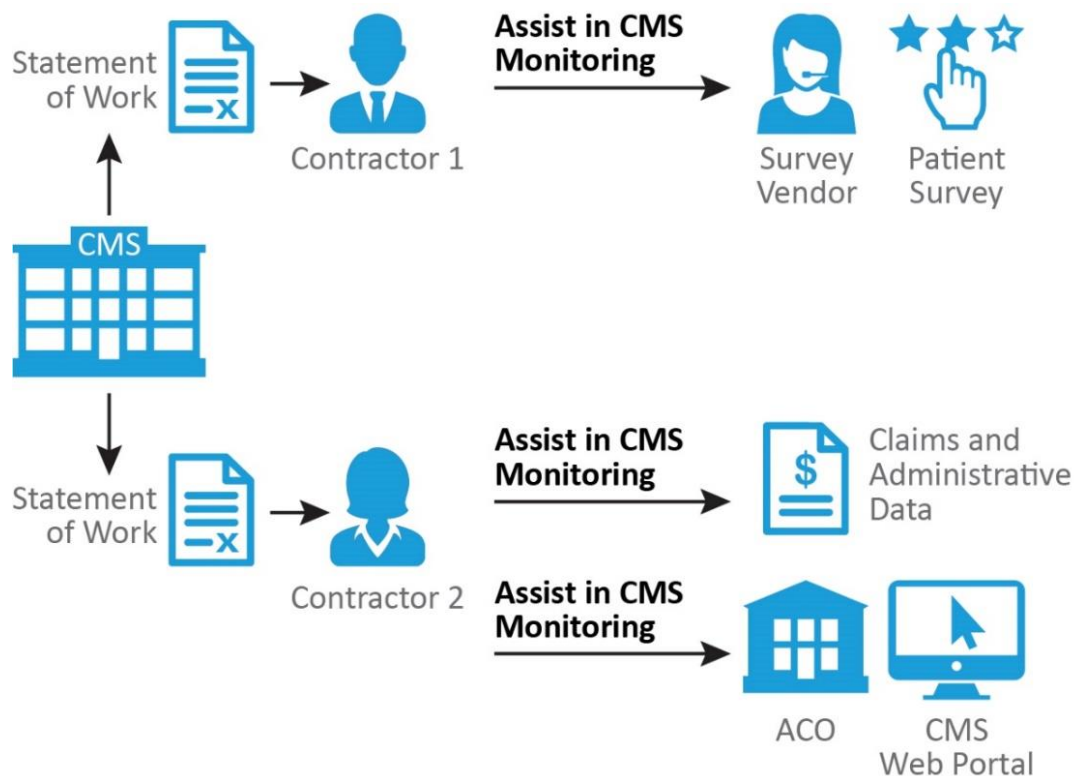
CMS's Monitoring Activities Related to Reporting Data on Quality Measures

According to Federal regulations, CMS monitors and assesses the performance of ACOs to ensure that they continue to satisfy the program requirements (e.g., report complete and accurate data on quality measures) (42 CFR § 425.316(a)(1)). CMS employs a range of methods to monitor ACOs, such as audits, which include onsite reviews (42 CFR § 425.316(a)(2)).

Further, the Federal regulations identify CMS as having the ultimate responsibility to monitor and assess the performance of ACOs. CMS used two contractors to assist in these monitoring activities. CMS provided direction and guidance to the contractors through Statements of Work, which laid out the contractors' tasks.

Figure 1 on the following page illustrates how the two contractors assisted with CMS's monitoring activities. Specifically, Contractor 1 assisted with CMS's monitoring activities related to the patient survey, and Contractor 2 assisted with CMS's monitoring activities related to claims and administrative data and the CMS web portal.

Figure 1: CMS Used Two Contractors To Assist in Its Monitoring Activities for PY 2017



Patient Survey Monitoring

CMS used one contractor to monitor survey vendors' compliance with survey procedures and to analyze the data the vendors reported. In addition, CMS issued the CMS Quality Assurance Guidelines, which described the survey procedures that survey vendors should follow and the contractor's monitoring activities.

As part of its monitoring activities for PY 2017, the CMS contractor (i.e., Contractor 1) performed the following activities:

- **Review and approval of survey vendors' quality assurance plans (QAPs):** The CMS contractor reviewed and approved QAPs submitted by survey vendors. The QAP describes the survey vendor's process for performing the survey and complying with the CMS Quality Assurance Guidelines. Each survey vendor annually updated and submitted a QAP to the CMS contractor.
- **Onsite reviews and remote telephone reviews:** The CMS contractor performed comprehensive onsite reviews of 5 of the 12 vendors' survey processes. These reviews covered overall processes and quality controls for performing the mail and telephone surveys and submitting data. The contractor also performed remote telephone reviews by listening to telephone surveys of beneficiaries conducted by survey

vendors. Following onsite reviews (i.e., site visits) and remote telephone reviews, the contractor provided the survey vendors with feedback reports, which included identified issues and action items to correct those issues.

- **Review of reported data:** The CMS contractor assessed the data that survey vendors reported to CMS. This assessment included steps to ensure that the reported data were complete and accurate. The contractor reported the results of its data review to CMS.
- **Other:** The CMS contractor was responsible for analyzing, evaluating, and refining the survey instruments used to collect data. For example, the contractor was responsible for updating and monitoring the use of survey templates, mail survey packages, and telephone survey scripts translated into other languages.

Claims and Administrative Data Monitoring

CMS used a second contractor (i.e., Contractor 2) to analyze the claims and administrative data for eight quality measures. Specifically, the contractor's analyses included comparing an ACO's performance results for the current year and the prior year to determine whether there was a significant difference.

CMS Web Portal Monitoring

To monitor the data for the 15 quality measures reported through the web portal, CMS used the same contractor (i.e., Contractor 2) as the one that analyzed claims and administrative data. As part of its monitoring activities for PY 2017, the contractor performed validation audits of the reported data on quality measures. Specifically, the contractor reviewed beneficiaries' medical record documentation to determine whether it adequately supported the data that each ACO had previously reported on selected quality measures. The results of such audits may be used to adjust an ACO's overall quality performance score and ultimately the shared savings payment or, if applicable, the amount of shared losses.

HOW WE CONDUCTED THIS AUDIT

For PY 2017, we evaluated CMS's monitoring activities to determine whether they were effective for ensuring that ACOs report complete and accurate data on quality measures.¹⁰ Specifically, we reviewed CMS's procedures and documentation related to monitoring activities. We also reviewed the Statements of Work, which included specific monitoring tasks for CMS's contractors to perform on behalf of CMS. In addition, we used questionnaires to obtain information from 8 of the 12 survey vendors about CMS's monitoring activities and the survey

¹⁰ We did not review ACOs' reported data on quality measures to verify that they were complete and accurate.

vendors' interactions with CMS and the CMS contractor for the patient survey, but we did not verify the accuracy of that information.¹¹

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

For PY 2017, CMS's monitoring activities were generally effective for ensuring that ACOs report complete and accurate data on quality measures through claims and administrative data and the CMS web portal. However, we identified weaknesses in CMS's monitoring activities that could lead to ACOs reporting incomplete or inaccurate data through the patient survey. Specifically, CMS did not ensure that its contractor:

- verified survey vendors' correction of identified issues even though the issues were directly related to the collection or reporting of data;
- provided feedback reports in time for survey vendors to include in their QAPs all of the changes implemented to address identified issues; and
- reviewed survey instruments (i.e., survey templates, mail survey packages, and telephone survey scripts) translated into other languages, such as Mandarin.

These weaknesses occurred because: (1) CMS did not require its contractor to verify survey vendors' correction of identified issues, (2) the timeline that CMS and its contractor developed for the QAPs and feedback reports did not allow survey vendors enough time to include in their QAPs all changes implemented to address the issues included in the feedback reports, and (3) CMS did not require its contractor to review the translated survey templates.

As a result of these weaknesses in CMS's monitoring activities, ACOs may not report complete and accurate data on quality measures, which could affect the ACOs' overall quality performance scores and ultimately the shared savings payments.

¹¹ We did not contact two of the survey vendors because they were acquired by other companies after PY 2017. In addition, two survey vendors did not respond to our request for information.

FEDERAL REQUIREMENTS

As part of the MSSP standard, ACOs are required to report to CMS complete and accurate data on all quality measures (42 CFR § 425.502(a)). Further, to ensure that ACOs continue to satisfy the eligibility and program requirements, CMS monitors and assesses the performance of ACOs, including ACO participants (42 CFR § 425.316(a)(1)). CMS employs a range of methods to monitor and assess an ACO's performance, including but not limited to any of the following, as appropriate: (1) analysis of specific financial and quality measurement data reported by the ACO, as well as aggregate annual and quarterly reports; (2) analysis of beneficiary and provider complaints; and (3) audits (including analysis of claims, chart review (the medical record), beneficiary survey reviews, coding audits, and onsite compliance reviews) (42 CFR § 425.316(a)(2)).

CMS DID NOT ENSURE THAT ITS CONTRACTOR VERIFIED SURVEY VENDORS' CORRECTION OF IDENTIFIED ISSUES

According to the Statement of Work, after the CMS contractor's site visit to a survey vendor, the vendor is given a defined period in which to correct any problems and to provide followup documentation of corrections for review or be subject to a followup site visit or both.¹²

The CMS contractor performed site visits and other types of monitoring of survey vendors as required in the Statement of Work; however, the contractor did not request documentation from the survey vendors to verify that issues directly related to the collection or reporting of data were corrected.¹³ The contractor requested that vendors provide only written responses that included a summary of the corrections. Further, when the contractor performed subsequent reviews of these vendors in the following PY, the reviews did not always follow up on the issues identified in the prior PY's feedback reports.

Monitoring Activities That the Contractor Performed

The CMS contractor performed site visits at 5 of the 12 survey vendors. For the remaining seven vendors, the CMS contractor performed other types of monitoring activities, such as remote telephone reviews and validating survey data submitted by the vendors. The contractor identified 50 issues (e.g., the need to update a survey management system). After completing these monitoring activities, the CMS contractor provided the survey vendors with feedback reports, which included identified issues and actions needed to correct them. The contractor required written responses from the vendors to address these issues and action items.

¹² CMS, *Implementation of the CAHPS [Consumer Assessment of Healthcare Providers and Systems] Surveys for the Medicare Shared Savings Program, Physician Quality Reporting System and Other Physician Quality Programs*; Statement of Work for Contract No. GS-10F-0275P, task 5.19, page 12.

¹³ In the Statement of Work, CMS did not require the contractor to request documentation to verify survey vendors' correction of issues.

Example of Not Verifying Correction of Identified Issues

For PY 2017, the CMS contractor identified nine issues during a site visit of a survey vendor and provided a feedback report to the vendor containing those issues and action items to correct them. For one action item, the contractor recommended that the survey vendor create a checklist to document data preparation activities it performed before submitting survey data to the contractor. The vendor responded that it had created such a checklist and provided a description of the checklist, but the contractor did not request a copy of the checklist to verify the data preparation activities and to ensure that the vendor submits complete and accurate data. In the following PY, the contractor performed a remote telephone review of the survey vendor, but this review did not verify correction of most of the issues identified in the prior PY, such as the need to create a checklist to document data preparation activities.

These issues occurred in part because, in the Statement of Work, CMS did not require the contractor to verify survey vendors' correction of issues identified in the feedback reports.

If CMS does not ensure that its contractor verifies survey vendors' correction of all identified issues, survey vendors may continue to have the same issues. Further, CMS would not be able to verify that survey vendors followed the survey protocols for collecting and reporting complete and accurate data. As a result, survey vendors may not report complete and accurate data on quality measures on behalf of an ACO, which could affect an ACO's overall quality performance score and ultimately the shared savings payments.

CMS DID NOT ENSURE THAT ITS CONTRACTOR PROVIDED FEEDBACK REPORTS IN TIME TO ENABLE SURVEY VENDORS TO INCLUDE IN QUALITY ASSURANCE PLANS ALL OF THE CHANGES IMPLEMENTED TO ADDRESS IDENTIFIED ISSUES

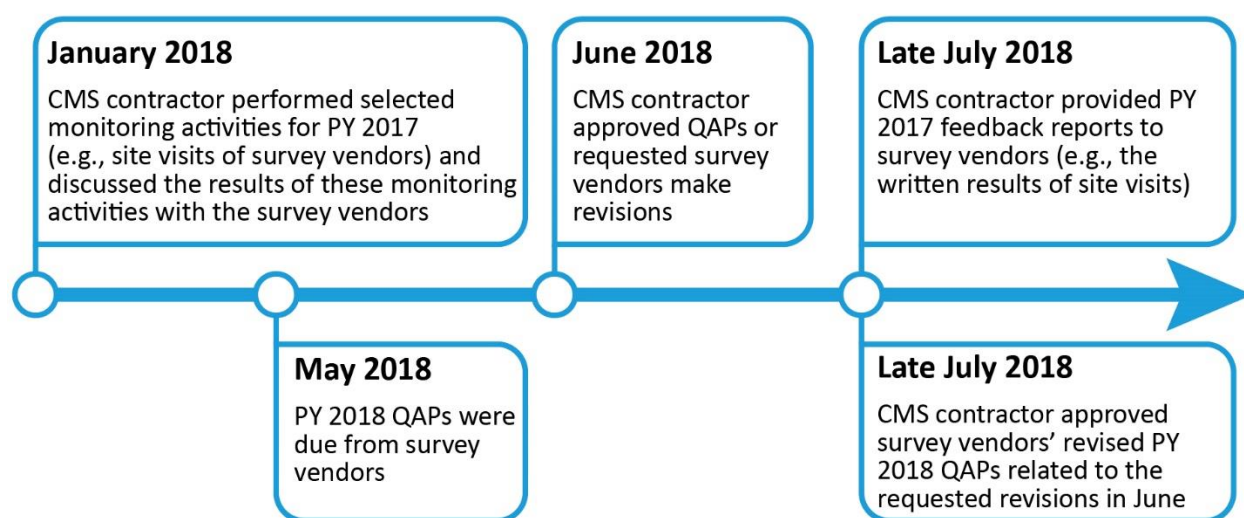
According to the Statement of Work, the CMS contractor shall review the survey vendor's QAP.¹⁴ Further, CMS's Quality Assurance Guidelines require each survey vendor to develop and annually update a QAP, which is a comprehensive working document that describes the survey vendor's implementation of and compliance with all required protocols to administer the patient survey. The QAP must include a description of the survey vendor's quality control processes and procedures and a summary outlining the results of the CMS contractor's monitoring activities (e.g., the results included in feedback reports). Depending on the issues

¹⁴ CMS, *Implementation of the CAHPS Surveys for the Medicare Shared Savings Program, Physician Quality Reporting System and Other Physician Quality Programs*; Statement of Work for Contract No. GS-10F-0275P, tasks 5.14 and 5.18, pages 11–12.

that the CMS contractor identified, the vendor may be required to submit a revised QAP for review and final approval.¹⁵

Figure 2 shows the timeline for the CMS contractor to provide the results of monitoring activities (including feedback reports) to survey vendors for PY 2017 and for those vendors to submit their QAPs to the CMS contractor for PY 2018.

Figure 2: Timeline for CMS Contractor’s Providing Results of PY 2017 Monitoring Activities and for Survey Vendors Submitting PY 2018 Quality Assurance Plans



The contractor did not provide feedback reports in time for survey vendors to include in their QAPs all of the changes that were implemented to address identified issues included in the feedback reports. Specifically, although the CMS contractor performed monitoring activities for PY 2017 and discussed the results of these monitoring activities with the survey vendors in January 2018, it did not provide the vendors with the feedback reports (i.e., written results of the monitoring activities) until late July 2018. This date was after the due date (May 2018) for survey vendors to submit their PY 2018 QAPs and after the contractor had approved these QAPs (June 2018). As a result, the survey vendors were not always able to include in their PY 2018 QAPs all the changes that were implemented to address issues identified during the contractor’s monitoring activities for PY 2017.¹⁶ The contractor approved the PY 2018 QAPs without requiring the survey vendors to include this information.

¹⁵ CMS, *Medicare Shared Savings Program and Next Generation ACO Model CAHPS Survey for Accountable Care Organizations Participating in Medicare Initiatives, Quality Assurance Guidelines*; version 5, July 2017. Available at <https://acocahps.cms.gov/en/quality-assurance-guidelines/>. Accessed on April 21, 2020.

¹⁶ The CMS contractor discussed the results of the monitoring activities (including identified issues and actions needed to correct them) with the survey vendors when these activities were performed. Therefore, before the contractor provided the PY 2017 feedback reports, the survey vendors were able to include in their PY 2018 QAPs some of the changes that were implemented to address issues identified during the contractor’s monitoring activities for PY 2017.

These issues occurred because the timeline that CMS and its contractor developed for the QAPs and feedback reports did not allow survey vendors enough time to include in their QAPs all of the changes implemented to address the issues identified in the feedback reports.¹⁷

If CMS does not ensure that its contractor provides feedback reports in time for survey vendors to include in their QAPs all of the changes implemented to address identified issues, survey vendors may continue to have the same issues. Further, CMS would not be able to verify that survey vendors followed the survey procedures for collecting and reporting complete and accurate data. As a result, survey vendors may not report complete and accurate data on quality measures on behalf of an ACO, which could affect an ACO's overall quality performance score and ultimately the shared savings payments.

CMS DID NOT ENSURE THAT ITS CONTRACTOR REVIEWED SURVEY INSTRUMENTS TRANSLATED INTO OTHER LANGUAGES

According to the Statement of Work, the CMS contractor shall update survey translations, monitor the use of survey translations, and make recommendations for adding or dropping translations based on need.¹⁸ The translated survey instruments are the materials used to perform the patient survey. These include templates for mail and telephone surveys, mail survey packages (i.e., the cover letter and questionnaire), and telephone survey scripts for collecting data.

Monitoring Activities That the Contractor Performed

The CMS contractor translated the survey questions into other languages, formatted the survey templates, and posted both English and translated survey templates on the patient survey website. Survey vendors used these templates to prepare mail survey packages and telephone survey scripts and to collect data from beneficiaries.

Although the CMS contractor updated the survey translations as required in the Statement of Work, it did not review the survey templates to ensure that the translated questions were correct before posting them to the website.¹⁹ As a result, there was an error in which the same question was repeated twice in a mail survey questionnaire translated into Mandarin. (A beneficiary detected the error and called the survey vendor about it.) Although the contractor reviewed the English versions of mail survey packages and telephone survey scripts that survey vendors prepared, the contractor did not review the translated versions that the contractor updated to verify that they were consistent with the English versions.

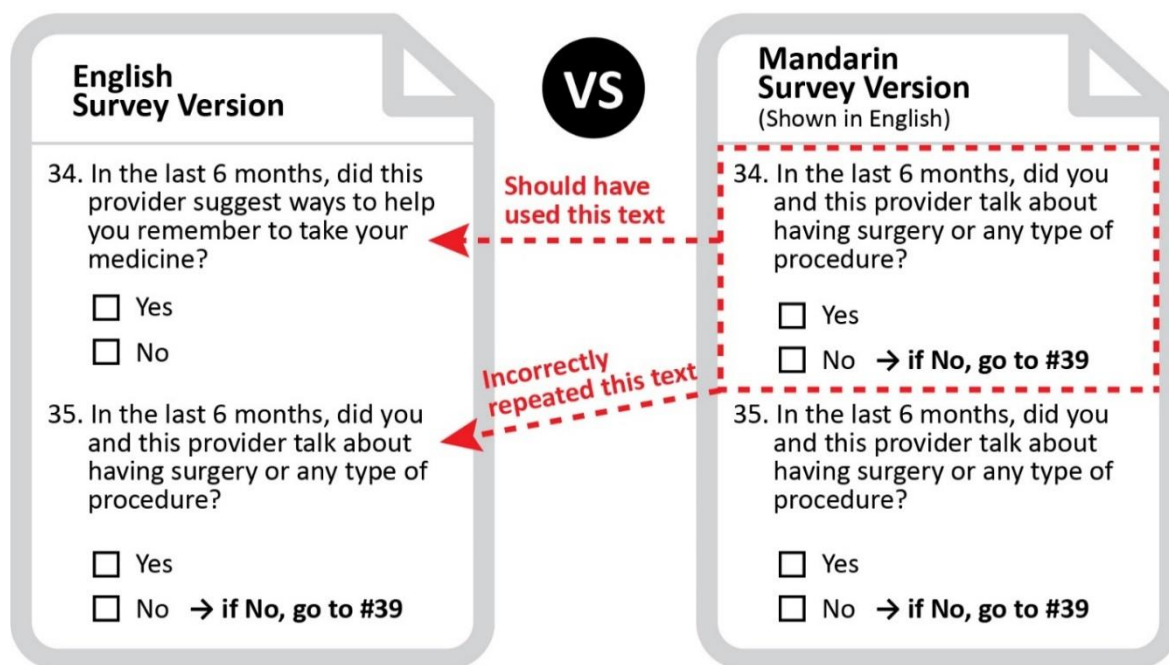
¹⁷ According to CMS, the timeline was later revised so that survey vendors received the written results of PY 2018 monitoring activities before submitting their PY 2019 QAPs. However, we did not verify that this change was implemented. Further, the change to the timeline may not ensure that all implemented changes to address the identified issues are included in the QAPs.

¹⁸ CMS, *Implementation of the CAHPS Surveys for the Medicare Shared Savings Program, Physician Quality Reporting System and Other Physician Quality Programs*; Statement of Work for Contract No. GS-10F-0275P, task 8.3, page 14.

¹⁹ In the Statement of Work, CMS did not require the contractor to review the translated survey templates.

Figure 3 shows the error in a mail survey questionnaire translated into Mandarin. In the Mandarin version (shown translated into English on the right), question 34 repeated the text of question 35 rather than using the correct text shown in the English version of question 34 on the left.

Figure 3: Error in Translated Mail Survey Questionnaire



After identifying this error, CMS instructed the contractor to correct the error, which required a survey vendor to make additional phone calls to collect the missing data for 314 beneficiaries.²⁰

These issues occurred because, for PY 2017, CMS did not require its contractor to review the translated survey templates.²¹

If CMS does not ensure that its contractor reviews survey instruments translated into other languages, patient survey data may not be complete and accurate. As a result, survey vendors may not report complete and accurate data on quality measures on behalf of an ACO, which could affect an ACO's overall quality performance score and ultimately the shared savings payments.

²⁰ According to CMS, all templates in other languages were reviewed to check for similar errors, and no other errors were identified.

²¹ For PY 2018, although CMS and its contractor developed written procedures for translating the survey templates, these procedures did not include reviewing the translated survey templates after they had been translated and formatted to ensure that they were consistent with the English versions.

RECOMMENDATIONS

To improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, we recommend that the Centers for Medicare & Medicaid Services update the Statement of Work to require its contractor to:

- verify that survey vendors have corrected identified issues that directly relate to the collection or reporting of data;
- confirm that all implemented changes to address the identified issues are included in QAPs before they are approved; and
- review the translated survey templates, mail survey packages, and telephone survey scripts to ensure that they are consistent with the English versions.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it had taken or planned to take to address our recommendations. CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear as Appendix C.

CMS's comments on our recommendations are summarized below:

- Regarding our first and second recommendations, CMS stated that it will review current contractor requirements and incorporate updates within the scope of the contract as needed.
- Regarding our third recommendation, CMS stated that after the 2017 reporting year, CMS strengthened its quality assurance process by requiring translation service providers to have a minimum of two staff members review the translated survey templates, mail survey packages, and telephone survey scripts to ensure accuracy. CMS also stated that it will further review current contractor requirements and incorporate updates within the scope of the contract as needed.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For PY 2017, we evaluated CMS's monitoring activities to determine whether they were effective for ensuring that ACOs report complete and accurate data on quality measures.²² We also reviewed the Statements of Work, which included specific monitoring tasks for CMS's contractors to perform on behalf of CMS. In addition, we used questionnaires to obtain information from 8 of the 12 survey vendors about CMS's monitoring activities and the survey vendors' interactions with CMS and the CMS contractor for the patient survey, but we did not verify the accuracy of that information.²³

We did not review the overall internal control structure of CMS. Rather, we limited our review of internal controls to those that were significant to the objective of our audit.

We conducted our audit from August 2018 through July 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed CMS's procedures related to its monitoring activities;
- reviewed CMS's contracts with its contractors and Statements of Work (which included specific monitoring tasks for contractors to perform on behalf of CMS) to identify monitoring activities for each of the 3 submission methods of data reporting by ACOs;
- reviewed supporting documents for monitoring activities that CMS and its contractors performed, including:
 - a list of the ACOs that received warning letters, were placed on corrective action plans, or were terminated for PY 2017;
 - CMS's criteria and process for issuing warning letters, placing ACOs on corrective action plans, or terminating ACOs;

²² We did not review ACOs' reported data on quality measures to verify that they were complete and accurate.

²³ We did not contact two of the survey vendors because they were acquired by other companies after PY 2017. In addition, two survey vendors did not respond to our request for information.

- a description of the data validations that CMS or its contractors performed and the results of those validations;
- required reports and a memo from CMS contractors about ACOs' reported data on quality measures (e.g., monthly progress reports and the annual data validation memo);
- Quality Assurance Guidelines for ACOs;
- survey vendors' QAPs; and
- feedback reports;
- interviewed CMS officials and contractors about their monitoring activities (including any issues identified) and their interactions with each other, the survey vendors, and the ACOs;
- provided questionnaires to 10 survey vendors²⁴ to identify and evaluate CMS's monitoring activities (e.g., site visits); and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

²⁴ We provided questionnaires to 10 of the 12 survey vendors. We did not contact two of the survey vendors because they were acquired by other companies after PY 2017.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Sunshine ACO, LLC, Generally Reported Complete and Accurate Data on Quality Measures Through the CMS Web Portal, but There Were a Few Reporting Deficiencies That Did Not Affect the Overall Quality Performance Score</i>	<u>A-09-18-03019</u>	10/21/2019
<i>West Florida ACO, LLC, Generally Reported Complete and Accurate Data on Quality Measures Through the CMS Web Portal, but There Were a Few Reporting Deficiencies That Did Not Affect the Overall Quality Performance Score</i>	<u>A-09-18-03003</u>	8/29/2019
<i>ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program</i>	<u>OEI-02-15-00451</u>	7/19/2019
<i>Using Health IT for Care Coordination: Insights From Six Medicare Accountable Care Organizations</i>	<u>OEI-01-16-00180</u>	5/17/2019
<i>CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned: Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Programs</i>	<u>A-09-17-03010</u>	10/19/2017
<i>Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality</i>	<u>OEI-02-15-00450</u>	8/28/2017

APPENDIX C: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 31, 2020

TO: Amy J. Frontz
Deputy Inspector General for Audit Services

FROM: Seema Verma
Administrator 

SUBJECT: Office of Inspector General Draft Report: CMS's Monitoring Activities for Ensuring That Medicare Accountable Care Organizations Report Complete and Accurate Data on Quality Measures Were Generally Effective, but There Were Weaknesses That Could Be Improved, A-09-18-03033.

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

Through the Medicare Shared Savings Program (Shared Savings Program), CMS is committed to expanding value-based care and achieving better health for individuals, while lowering growth in expenditures. The Shared Savings Program offers an opportunity for providers and suppliers to create or join an Accountable Care Organization (ACO), which agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population, and in exchange can receive a portion of the savings they achieve or be held accountable for a portion of losses if costs increase. In 2018, CMS announced an overhaul of the Shared Savings Program known as "Pathways to Success" to strengthen the program and reward ACOs that take on greater risk with higher shared savings rates.

ACOs report on quality measures in four domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population. In performance year (PY) 2017, which OIG reviewed, ACOs were required to report data on 31 quality measures that are submitted by the ACO through the CMS Web Interface, collected by a vendor via a patient experience of care survey, and calculated by CMS for ACOs from administrative claims data. CMS identifies the sample of patients and provides each ACO with a list of the assigned beneficiaries on which they must report through the CMS Web Interface. Additionally, CMS provides the ACO's designated vendor a separate sample of the ACO's assigned beneficiaries to survey for patient experience of care measures.

CMS has a robust process to monitor and assess the performance of ACOs, including quality control and validation checks to ensure quality measure reporting is complete and accurate. For quality measures submitted through patient surveys, CMS monitors survey vendors' compliance with survey procedures and analyzes the data reported. CMS issues yearly Quality Assurance Guidelines to standardize the data collection process and to make sure the survey data collected across survey vendors are comparable. In the Quality Assurance Guidelines, CMS details our extensive oversight of participating survey vendors to ensure compliance with the survey protocols, which includes review and approval of survey vendors' Quality Assurance Plans,

analysis of vendor-submitted data, site visits and conference calls, and additional activities as needed.

For quality measures calculated by CMS from administrative claims data, CMS reviews claims submitted to Medicare through normal billing activities and calculates the rates for these measures for each ACO. CMS excludes beneficiaries who do not meet the eligibility criteria for assignment to the ACO and then compares ACO program measure performance rates with external data sources and historical ACO program performance to validate the data. OIG found no issues with CMS's monitoring activities to ensure complete and accurate data relating to quality measures submitted through claims and administrative data.

For quality measures submitted through the CMS Web Interface, a subset of ACOs are selected annually for a Quality Measure Validation (QMV) audit. During the QMV audit, the ACO will be asked to substantiate, using information from the beneficiaries' medical record, what was entered into the CMS Web Interface for a sample of beneficiaries and a sample of measures.

CMS provides extensive education and outreach to ACOs around the requirements for reporting quality measures through the CMS Web Interface, in addition to posting guidance and hosting regular calls with ACOs leading up to and throughout the data submission period. OIG found no issues with CMS's monitoring activities to ensure complete and accurate data relating to quality measures submitted through the CMS Web Interface.

OIG Recommendation

To improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, we recommend that the Centers for Medicare & Medicaid Services update the Statement of Work to require its contractor to verify that survey vendors have corrected identified issues that directly relate to the collection or reporting of data.

CMS Response

CMS concurs with OIG's recommendation. CMS will review current contractor requirements and incorporate updates within the scope of the contract as needed to address the finding related to the collection or reporting of data.

OIG Recommendation

To improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, we recommend that the Centers for Medicare & Medicaid Services update the Statement of Work to require its contractor to confirm that all implemented changes to address the identified issues are included in Quality Assurance Plans before they are approved.

CMS Response

CMS concurs with OIG's recommendation. CMS will review current contractor requirements and incorporate updates within the scope of the contract as needed to address the finding.

OIG Recommendation

To improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, we recommend that the Centers for Medicare & Medicaid Services update

the Statement of Work to require its contractor to review the translated survey templates, mail survey packages, and telephone survey scripts to ensure that they are consistent with the English version.

CMS Response

CMS concurs with OIG's recommendation. Subsequent to the 2017 reporting year, CMS has strengthened its quality assurance process by requiring translation service providers to have a minimum of two staff members review the translated survey templates, mail survey packages, and telephone survey scripts to ensure accuracy. However, CMS will further review current contractor requirements and incorporate updates within the scope of the contract as needed to address the finding.