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**Medicare Shared Savings Program and
Physician Quality Reporting System
Group Practice Reporting Option Web
Interface Sampling Methodology**

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Guide to Quality Measurement: Group Practice Reporting Option Web Interface Sampling Methodology

Introduction

The purpose of this document is to provide clarification on the sampling methodology for the 22 clinical quality measures that will be reported via the Group Practice Reporting Option (GPRO) Web Interface. This guidance applies to all Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (SSP) with a 2012 or 2013 agreement period start date and all Physician Quality Reporting System (PQRS) GPROs that choose to report clinical quality data through the Web Interface for 2013.

Background

The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). The PQRI was further modified as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

In 2010, CMS created a new group practice reporting option (GPRO) for PQRI. In 2011, the program name was changed to Physician Quality Reporting System (PQRS). Group practices that satisfactorily report data on PQRS measures for a particular reporting period are eligible to earn a PQRS incentive payment equal to a specified percentage of the group practice's total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the reporting period. To earn an incentive for the 2013 PQRS program year, group practices may self-nominate or register to participate in GPRO via web interface or registry reporting or through other programs such as the Shared Savings Program.

On November 2, 2011, the Centers for Medicare & Medicaid Services (CMS) finalized new rules¹ under the Patient Protection and Affordable Care Act (Affordable Care Act) under which doctors, hospitals, and other health care providers may work together to better coordinate care for Medicare patients through an ACO. The Shared Savings Program will reward ACOs that lower their growth in health care costs for assigned Medicare beneficiaries while meeting performance standards on quality of care. Meeting these performance standards on quality of care will also allow the SSP ACO's PQRS-eligible providers to earn that performance year's PQRS incentive payment.

Starting with calendar year 2013 reporting, the 22 nationally recognized measures used in PQRS GPRO Web Interface reporting align with the ACO GPRO measures used in SSP and span three key domains:

¹ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 Fed. Reg. 67802. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

- Care coordination/patient safety (2 GPRO measures)
- Preventive health (8 GPRO measures)
- At-risk population:
 - Diabetes (6 GPRO measures)
 - Hypertension (1 GPRO measure)
 - Ischemic Vascular Disease (2 GPRO measures)
 - Heart Failure (1 GPRO measure)
 - Coronary Artery Disease (2 GPRO measures)

Narrative Measure Specifications and supporting documents for the GPRO measures are posted on the CMS web site^{2,3}.

GPRO Web Interface

Each SSP ACO or PQRS GPRO will report the 22 clinical quality measures in 15 modules via a web-based interface modeled after tools used in the Physician Group Practice (PGP) and the Medicare Care Management Performance (MCMP) Demonstrations. The Web Interface will be partially pre-populated with an assigned sample of beneficiaries and those beneficiaries' demographic and utilization information. Beneficiaries will be assigned a rank based on the order in which they were sampled into the module. Whenever possible each module of the Web Interface will be populated with a 50 percent oversample of the target reporting sample.

For all SSP ACOs and PQRS GPROs with 100 or more eligible professionals each module of the Web Interface will be prepopulated with 616 beneficiaries. For PQRS GPROs with 25-99 eligible professionals each module of the Web Interface will be prepopulated with 327 beneficiaries. If fewer than 616 or 327 beneficiaries are available for a given module then all available beneficiaries will be populated into the Web Interface for that module.

The organization will then be required to populate data fields in the Web Interface necessary for capturing quality measure information on the required number of consecutively ranked assigned Medicare beneficiaries with respect to services furnished during the 2013 reporting period (January 1, 2013 through December 31, 2013). PQRS GPROs with 100 or more eligible professionals and SSP ACOs are required to completely report on 411 consecutively ranked beneficiaries. PQRS GPROs with 25-99 eligible professionals are required to completely report on 218 consecutively ranked beneficiaries. Denominator inclusion and exclusion criteria for some modules may mean that reaching the target sample size is not possible for an organization. If fewer than the target number of eligible beneficiaries are available for a given measure, the organization must complete abstraction on 100 percent of the sample for each disease module and patient care measure.

² 2013 ACO GPRO Narrative Specifications: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

³ 2013 PQRS GPRO Narrative Specifications and 2013 Supporting Documents, Release Notes, and Measure Flows for ACO and PQRS GPRO Web Interface Users: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

Organizations will be provided access to the pre-populated Web Interface for data submission in the first quarter of 2014.

GPRO Web Interface Quality Measures

As previously stated, SSP ACOs and PQRS GPROs who choose to report through the Web Interface will use the GPRO Web Interface to collect and submit clinical data on the 22 GPRO quality measures, which span three domains and 15 modules:

- Care coordination/patient safety (2 GPRO measures, each its own module)
 - GPRO CARE-1 (NQF 0097): Medication Reconciliation
 - GPRO CARE-2 (NQF 0101): Falls: Screening for Future Fall Risk
- Preventive Care and Screening (8 GPRO measures, each its own module)
 - GPRO PREV-5 (NQF 0031): Preventive Care and Screening: Breast Cancer Screening
 - GPRO PREV-6 (NQF 0034): Preventive Care and Screening: Colorectal Cancer Screening
 - GPRO PREV-7 (NQF 0041): Preventive Care and Screening: Influenza Immunization
 - GPRO PREV-8 (NQF 0043): Preventive Care and Screening: Pneumococcal Vaccination for Patients 65 Years and Older
 - GPRO PREV-9 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
 - GPRO PREV-10 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
 - GPRO PREV-11 (CMS): Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
 - GPRO PREV-12 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- At-Risk Population:
 - Diabetes Module (1 individual measure + 1 five-component composite measure)
 - GPRO DM-2 (NQF 0059): Diabetes Mellitus: Hemoglobin A1c Poor Control
 - GPRO DM-13 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control
 - GPRO DM-14 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control
 - GPRO DM-15 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (<8%)

- GPRO DM-16 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease
- GPRO DM-17 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Tobacco Non Use
- Hypertension Module (1 measure)
 - GPRO HTN-2 (NQF 0018): Hypertension: Controlling High Blood Pressure
- Ischemic Vascular Disease Module (2 measures)
 - GPRO IVD-1 (NQF 0075): Ischemic Vascular Disease: Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control
 - GPRO IVD-2 (0068): Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic
- Heart Failure Module (1 measure)
 - GPRO HF-6 (NQF 0083): Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Coronary Artery Disease Module: Composite (All or Nothing Scoring) (1 two-component composite measure)
 - GPRO CAD-2 (NQF 0074): Coronary Artery Disease (CAD): Lipid Control
 - GPRO CAD-7 (NQF 0066): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

GPRO Web Interface Quality Measure Sampling Methodology

Medicare Shared Savings Program ACOs and PQRS GPROs who choose to report through the Web Interface will use the GPRO Web Interface to submit data on samples of the organization's Medicare beneficiaries. Each organization's samples will be determined using the following process:

Step 1: Identify beneficiaries eligible for quality measurement. CMS will assign a Medicare beneficiary to an SSP ACO or PQRS GPRO based on current program rules. For SSP ACOs, CMS will use beneficiaries assigned using the SSP ACO assignment algorithm^{4,5} for the 3rd

⁴ Available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

⁵ Available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html>

quarter of 2013. For PQRS GPROs, CMS will use beneficiaries assigned using the PQRS GPRO assignment algorithm for the 3rd quarter of 2013⁶.

Using Medicare administrative claims from January 1, 2013 through October 31, 2013, CMS will exclude beneficiaries with fewer than two primary care services⁷ during the reporting period, beneficiaries with part-year eligibility in Medicare FFS Part A and Part B, and beneficiaries who entered hospice during the measurement period. The remaining beneficiaries will be considered eligible for quality measurement.

Step 2: Identify beneficiaries eligible for sampling into each module. The beneficiaries identified as eligible for quality measurement will then be assessed for eligibility for each of the 15 modules, based on the denominator criteria outlined below.

There are nine types of denominator inclusion criteria, as outlined below:

1. To be included in the PREV-6 and PREV-8 through PREV-12 and CARE-2 denominators, a beneficiary must:
 - a) Meet age criteria⁸; AND
 - b) Have two face-to-face encounters⁹ occurring during the measurement period
2. To be included in the CARE-1 denominator, a beneficiary must:
 - a) Meet age criteria; AND
 - b) Have a discharge from an inpatient facility during the first 305 days of the measurement period followed by a face-to-face encounter with a primary care physician (as defined by the specialty codes in **Appendix C**) within 30 days of the inpatient discharge.
3. To be included in the PREV-5 denominator, a beneficiary must:
 - a) Meet gender criteria; AND
 - b) Meet age criteria; AND
 - c) Have two face-to-face encounters occurring during the measurement period

⁶ Available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

⁷ As defined by the Healthcare Common Procedure Coding System (HCPCS) codes in **Appendices A and B** for SSP ACOs and **Appendix A** for PQRS GPROs

⁸ Age criteria for this and all measures are provided in the Narrative Measure Specifications Manual (see Footnotes 2 and 3).

⁹ Detailed specifications on the qualifying HCPCS or Current Procedural Terminology (CPT) codes for this and all measures are provided in the 2013 Supporting Documents (available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html)

4. To be included in the PREV-7 denominator; a beneficiary must:
 - a) Meet age criteria; AND
 - b) Have one face-to-face encounter occurring between October 1 (of the year prior to the measurement period) through March 31 of the measurement period
5. To be included in the diabetes mellitus (DM) denominator, a beneficiary must:
 - a) Meet age criteria; AND
 - b) Have
 - i. two face-to-face encounters with different dates of service in an outpatient setting or non-acute inpatient setting occurring during the measurement period or the year prior with a documented diagnosis of diabetes mellitus (DM) (type 1 or type 2); OR
 - ii. one face-to-face encounter in an acute inpatient or emergency department setting during the measurement period or the year (services that occur over both periods may be counted) with a documented diagnosis of diabetes mellitus (type 1 or type 2)
6. To be included in the ischemic vascular disease (IVD) denominator, a beneficiary must:
 - a) Meet age criteria; AND
 - b) Have
 - i. two face-to-face encounters occurring during the measurement period with a documented diagnosis of ischemic vascular disease (IVD); OR
 - ii. an alive discharge for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) at any time in the patient's history up through the last day of the measurement period
7. To be included in the coronary artery disease (CAD) denominator, a beneficiary must:
 - a) Meet age criteria; AND
 - b) Have two face-to-face encounters occurring during the measurement period with a documented diagnosis of coronary artery disease
8. To be included in the hypertension (HTN) denominator, a beneficiary must:
 - a) Meet age criteria; AND

- b) Have two face-to-face encounters occurring during the measurement period with a documented diagnosis of hypertension
9. To be included in the heart failure (HF) denominator, a beneficiary must:
- a) Meet age criteria; AND
 - b) Have two face-to-face encounters occurring during the measurement period with a documented diagnosis of heart failure

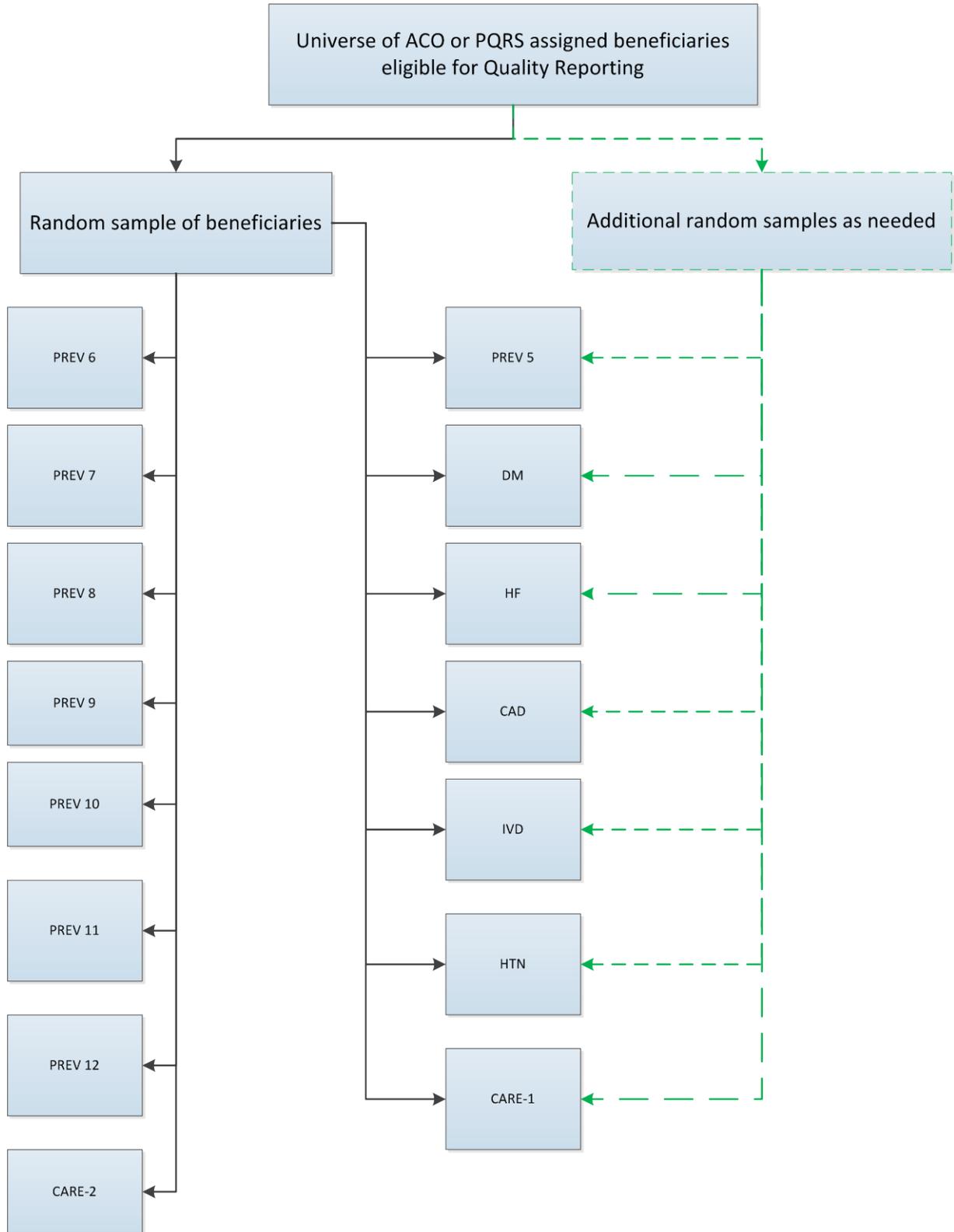
Step 3: Randomly sample beneficiaries into each module. To reduce the burden on practices, CMS will use a methodology to generate samples that would enable one beneficiary to qualify for multiple modules.

CMS will utilize a base sample of beneficiaries that qualify for the Preventive Care and Screening domain and “carry over” those beneficiaries that also qualify for other modules. Specifically, CMS will select a random sample of beneficiaries who were identified as eligible for the Preventive Care and Screening domain¹⁰ and randomly sample them into each of the 15 modules until each module has the target number of beneficiaries (illustrated in **Figure 1**). CMS will use an initial sample of 900 beneficiaries for SSP ACOs and PQRS GPROs with 100 or more eligible professionals. For PQRS GPROs with 25-99 eligible professionals an initial sample of 500 beneficiaries will be used. Note that this initial sample of beneficiaries will be used for PREV-6, PREV-7, PREV-8, PREV-9, PREV-10, PREV-11, PREV-12, and CARE-2.

If, after this step, a module has fewer than 616 beneficiaries (for SSP ACOs and PQRS GPROs with 100 or more eligible professionals) or 327 beneficiaries (for PQRS GPROs with 25-99 eligible professionals), CMS will randomly sample additional eligible beneficiaries until the module has 616 or 327 beneficiaries or until there are no additional eligible beneficiaries available. This sampling methodology reduces administrative burden for SSP ACOs and PQRS GPROs.

¹⁰ A beneficiary will be considered eligible for the Preventive Health domain if he or she has two face-to-face office visits (as defined by the HCPCS codes for the Preventive Health Supporting Documents) during the measurement period.

Figure 1. Sampling Process



Beneficiaries will be assigned a rank between 1 and 616 (for SSP ACOs and PQRS GPROs with 100 or more eligible professionals) or 1 and 327 (for PQRS GPROs with 25-99 eligible professionals) based on the order in which they are populated into each denominator sample. If fewer beneficiaries are eligible for a module then all of the beneficiaries in the sample will be assigned a rank. SSP ACOs and PQRS GPROs with 100 or more eligible professionals will be required to consecutively complete a minimum of 411 beneficiaries (or all beneficiaries in the sample if there are fewer than 411). PQRS GPROs with 25-99 eligible professionals will be required to consecutively complete a minimum of 218 beneficiaries. If the organization is unable to provide data on a particular beneficiary, the organization must indicate a reason why the data cannot be provided. The organization cannot skip a beneficiary without providing a valid reason as to why data on that beneficiary cannot be provided. The valid reasons will be available as options in the GPRO Web Interface. For each beneficiary that is skipped the organization must completely report on the next consecutively ranked beneficiary until the target sample of 411 or 218 is reached.

While this sampling methodology does not guarantee that beneficiaries will have the same rank across modules, it does increase the likelihood that a beneficiary will have a similar rank across modules. Therefore, a low-ranked beneficiary in one module will likely have a low rank in the other modules for which he or she qualifies.

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Appendix A:*
**Primary care codes used in beneficiary assignment criteria
and in the two-visit rule for SSP ACOs and PQRS GPROs**

Office or other outpatient services

- 99201 New Patient, brief
- 99202 New Patient, limited
- 99203 New patient, moderate
- 99204 new Patient, comprehensive
- 99205 New Patient, extensive
- 99211 Established Patient, brief
- 99212 Established Patient, limited
- 99213 Established Patient, moderate
- 99214 Established Patient, comprehensive
- 99215 Established Patient, extensive

Initial nursing facility care

- 99304 New or Established Patient, brief
- 99305 New or Established Patient, moderate
- 99306 New or Established Patient, comprehensive

Subsequent nursing facility care

- 99307 New or Established Patient, brief
- 99308 New or Established Patient, limited
- 99309 New or Established Patient, comprehensive
- 99310 New or Established Patient, extensive

Nursing facility discharge services

- 99315 New or Established Patient, brief
- 99316 New or Established Patient, comprehensive

Other nursing facility services

- 99318 New or Established Patient

Domiciliary, rest home, or custodial care services

- 99324 New Patient, brief
- 99325 New Patient, limited

(continued)

Appendix A:*
**Primary care codes used in beneficiary assignment criteria
and in the two-visit rule for SSP ACOs and PQRS GPROs**

99326 New Patient, moderate
99327 New Patient, comprehensive
99328 New Patient, extensive
99334 Established Patient, brief
99335 Established Patient, moderate
99336 Established Patient, comprehensive
99337 Established Patient, extensive

Domiciliary, rest home, or home care plan oversight services

99339, brief
99340, comprehensive

Home services

99341 New Patient, brief
99342 New Patient, limited
99343 New Patient, moderate
99344 New Patient, comprehensive
99345 New Patient, extensive
99347 Established Patient, brief
99348 Established Patient, moderate
99349 Established Patient, comprehensive
99350 Established Patient, extensive

Wellness visits

G0402 Welcome to Medicare visit
G0438 Annual wellness visit
G0439 Annual wellness visit

* <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

Appendix B:*

**Additional primary care codes used in beneficiary
assignment criteria and in the two-visit rule for SSP ACOs**

For FQHC or RHC services

0521 Clinic visit by member to RHC/FQHC

0522 Home visit by RHC/FQHC practitioner

0524 Visit by RHC/FQHC practitioner to a member, in a covered Part A stay at the SNF

0525 Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility

* <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

Appendix C:

Primary care provider specialty codes used in the CARE-1 denominator criteria

Primary care physician specialty codes

1 General Practice

8 Family Practice

11 Internal Medicine

38 Geriatric Medicine