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GPRO Web Interface Sampling Methodology for the Physician Quality Reporting System and the Medicare Shared Savings Program

Report

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SECTION 1
INTRODUCTION

The purpose of this document is to explain the sampling methodology for the 22 clinical quality measures that will be reported via the Group Practice Reporting Option (GPRO) Web Interface (WI). This guidance applies to all Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program with a 2012, 2013, or 2014 agreement period start date, all ACOs in the Pioneer ACO Model (referred to throughout as ACOs), and all group practices participating in Physician Quality Reporting System (PQRS) program using the WI for the 2014 performance year (referred to throughout as group practices), with ACOs and group practices collectively referred to as organizations. Each organization will be required to report on the same 22 nationally recognized measures, based on services rendered in 2014.

This document provides background information on the specific quality measures to be reported on using the WI, the number of beneficiaries each organization is expected to report on, and how those beneficiaries are selected.

SECTION 2
WEB INTERFACE QUALITY MEASURES

For the 2014 reporting period, ACOs and group practices that choose the WI reporting method will use the WI to collect and submit clinical data on the following 17 measures (15 individual measures, and 2 composite measures comprising 5 or 2 component measures, respectively). These measures span 15 modules (made up of 5 disease modules and 10 individual measure modules, each with its own specific population, or denominator, of interest):

- CARE-1 (NQF 0097): Medication Reconciliation
- CARE-2 (NQF 0101): Falls: Screening for Future Fall Risk
- PREV-5 (NQF N/A): Breast Cancer Screening
- PREV-6 (NQF 0034): Colorectal Cancer Screening
- PREV-7 (NQF 0041): Preventive Care and Screening: Influenza Immunization
- PREV-8 (NQF 0043): Pneumonia Vaccination Status for Older Adults
- PREV-9 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- PREV-10 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- PREV-11 (NQF N/A): Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

- PREV-12 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

- Diabetes Mellitus (DM) module (one individual measure plus five components of one component measure)

  - DM-2 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control

  - DM-13 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control

  - DM-14 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control

  - DM-15 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (<8%)

  - 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

  - DM-17 (NQF 0729): Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Tobacco Non-Use

- Hypertension (HTN) module (one measure)

  - HTN-2 (NQF 0018): Controlling High Blood Pressure

- Ischemic Vascular Disease (IVD) module (two measures)

  - IVD-1 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

  - IVD-2 (0068): Ischemic Vascular Disease IVD): Use of Aspirin or Another Antithrombotic

- Heart Failure (HF) module (one measure)

  - HF-6 (NQF 0083): Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- Coronary Artery Disease module (CAD): Composite (All or Nothing Scoring) (two components of one composite measure)

  - CAD-2 (NQF 0074): Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control

- CAD-7 (NQF 0066): Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

Appendix A provides a summary table of the measure information presented here.

For further information on any of these measures, please refer to the following documents, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html:

- The 2014 GPRO WI Disease Modules, Care Coordination/Patient Safety Measures, and Preventive Care Measures List document, which consists of the (22) 2014 GPRO WI reporting method measures.

- The 2014 GPRO WI Narrative Measure Specifications, which provides a description of each of the 22 measures.

- The 2014 GPRO WI Narrative Specification Release Notes, which provides a list of changes to existing measures made since the release of the 2013 GPRO Narrative Measure Specifications, Version 4.1.

- The 2014 GPRO WI Supporting Documents have been posted in Microsoft Excel format by module for program year 2014. Each document contains the following: Patient Confirmation, Data Guidance, and Downloadable Resource Tables, which include coding for each measure. Additionally, the "2014 Group Practice Reporting Option Web Interface Supporting Documentation Release Notes" are posted, documenting changes between program year 2013 and program year 2014.

- The 2014 Measure Flows for GPRO WI Users, containing performance rate calculation algorithms for the 22 WI measures, can be found in the associated zip file.

SECTION 3
WEB INTERFACE QUALITY MEASURE REPORTING AND SAMPLE SIZE REQUIREMENTS

Each ACO and group practice will report the 22 clinical quality measures via the WI, categorized into 15 modules (i.e., samples for 5 disease modules and 10 individual measure modules, each with its own specific population/disease, or denominator, requirement). The required reporting sample for each module is 411 for all ACOs (regardless of size) and group practices with 100 or more eligible professionals (EPs), and 218 for group practices with 25–99 EPs that choose the GPRO WI reporting method. The WI will use a sample of beneficiaries specifically assigned to each organization, and will include demographic and utilization information for those beneficiaries. Each beneficiary may be sampled into at least one module and assigned a rank based on the order in which they were sampled into a module. Each module will be partially prepopulated with beneficiary and clinical information, as applicable.

Whenever possible, each module of the WI will include a 50% oversample of the required reporting sample. For all ACOs (regardless of size) and group practices with 100 or more eligible professionals, each module of the WI will be prepopulated with 616 beneficiaries to obtain this 50% oversample. Likewise, for group practices with 25–99 eligible professionals, each module of the WI will be prepopulated with 327 beneficiaries. If the number of beneficiaries eligible for a given module is fewer than the required minimum reporting sample of 411 or 218, then all eligible beneficiaries will be populated into the WI for that module, and the ACO or group practice would need to report on 100% of the beneficiaries provided.

The organization will then be required to complete data fields in the WI that capture quality measure information with respect to rendered services applicable to the 2014 reporting period (January 1, 2014, through December 31, 2014). These data must be completed accurately for the required number of consecutively ranked and confirmed assigned Medicare beneficiaries. Group practices with 100 or more EPs and ACOs are required to completely report on 411 consecutively ranked beneficiaries. Group practices with 25–99 EPs 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 numbers of eligible beneficiaries are available for a given module, the organization must report on 100 percent of the eligible beneficiaries provided for that disease module or individual measure module.

SECTION 4
WEB INTERFACE QUALITY MEASURE SAMPLING METHODOLOGY

ACOs and group practices will use the WI to submit data on samples of the organization's fee-for-service (FFS) Medicare beneficiaries. Each organization's samples will be determined using the following process:

4.1 Step 1: Identify Beneficiaries Eligible for Quality Measurement

The Centers for Medicare & Medicaid Services (CMS) will assign a Medicare beneficiary to an ACO or group practice based on current program rules. For ACOs, CMS will use beneficiaries assigned using the ACO assignment algorithm[1] for the third quarter of 2014. For group practices, CMS will use beneficiaries assigned using the PQRS assignment algorithm[2] for the third quarter of 2014.

Using Medicare administrative claims from January 1, 2014, through October 31, 2014, CMS will exclude from the above:

- beneficiaries with fewer than two primary care services[3] 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.

4.2 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 modules. Eligibility based on denominator criteria is outlined below:

1. To be included in the any of the following denominators:
   - Colorectal Cancer Screening (PREV-6),
   - Pneumonia Vaccination Status for Older Adults (PREV-8),
   - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (PREV-9),

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[1] The Shared Savings Program beneficiary assignment methodology can be found here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf

[2] The PQRS assignment methodology document and training presentation can be found on this page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

[3] As defined by the Healthcare Common Procedure Coding System (HCPCS) codes in **Appendices B** and **C** for ACOs and **Appendix B** for PQRS group practices.

- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (PREV-10),
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (PREV-11),
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (PREV-12), or
- Falls: Screening for Future Fall Risk (CARE-2)

A beneficiary must:

a. Meet age criteria[4]; AND

b. Have at least one face-to-face encounter[5] occurring during the measurement period.

2. To be included in the Medication Reconciliation (CARE-1) denominator, a beneficiary must:

   a. Meet age criteria; AND

   b. Have a discharge from an inpatient facility and a subsequent face-to-face encounter with a primary care physician[6] in the organization within 30 days of the discharge date. Both the discharge and the follow-up visit must occur within the measurement year.

3. To be included in the Breast Cancer Screening (PREV-5) denominator, a beneficiary must:

   a. Meet gender criteria; AND

   b. Meet age criteria; AND

   c. Have at least one face-to-face encounter occurring during the measurement period.

4. To be included in the Preventive Care and Screening: Influenza Immunization (PREV-7) denominator; a beneficiary must:

   a. Meet age criteria; AND

   b. Have at least one face-to-face encounter during the influenza season. The influenza season is defined at October 1, 2013, through March 31, 2014, for the 2014 measurement period.

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[4] Age criteria for this and all measures are provided in the Narrative Measure Specifications and the Measure Flows available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.

[5] Detailed specifications on the qualifying HCPCS or Current Procedural Terminology codes for this and all measures are provided in the 2014 Supporting Documents (available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html).

[6] As defined by the specialty codes in **Appendix D.**

5. To be included in a DM denominator, a beneficiary must:
    a. Meet age criteria; AND
    b. Have at least two face-to-face encounters with a documented diagnosis of DM (type 1 or type 2) in an office or outpatient setting. The visits must be on different dates of service, and may occur either during the measurement period or the year prior to the measurement period.
6. To be included in the ischemic vascular disease (IVD) denominator, a beneficiary must:
    a. Meet age criteria; AND
    b. Have at least:
    c. Two face-to-face encounters during the measurement period with a documented diagnosis of IVD in an office or outpatient setting; OR
        i. One inpatient procedure for IVD during the year prior to the measurement year. Procedures include coronary artery bypass graft and percutaneous coronary intervention; OR
        ii. One inpatient discharge for an acute myocardial infarction during the year prior to the measurement year.
7. To be included in the coronary artery disease (CAD) denominator, a beneficiary must:
    a. Meet age criteria; AND
    b. Have at least two face-to-face encounters occurring during the measurement period with a documented diagnosis of or procedure related to CAD.
8. To be included in the hypertension (HTN) denominator, a beneficiary must:
    a. Meet age criteria; AND
    b. Have two face-to-face encounters with a documented diagnosis of hypertension, occurring during the first 6 months of the measurement period or the year prior to the measurement period.
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 HF.

4.3 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, as applicable.

CMS will select an initial random sample of quality eligible beneficiaries (as defined in section 4.1) and populate them into the five disease modules and 10 individually sampled patient care measures for which they are eligible until the required number of beneficiaries plus a 50% oversample for the modules/measures are reached. This is equivalent to 616 beneficiaries for ACOs and groups practices with 100 or more EPs, and 327 beneficiaries for group practices with

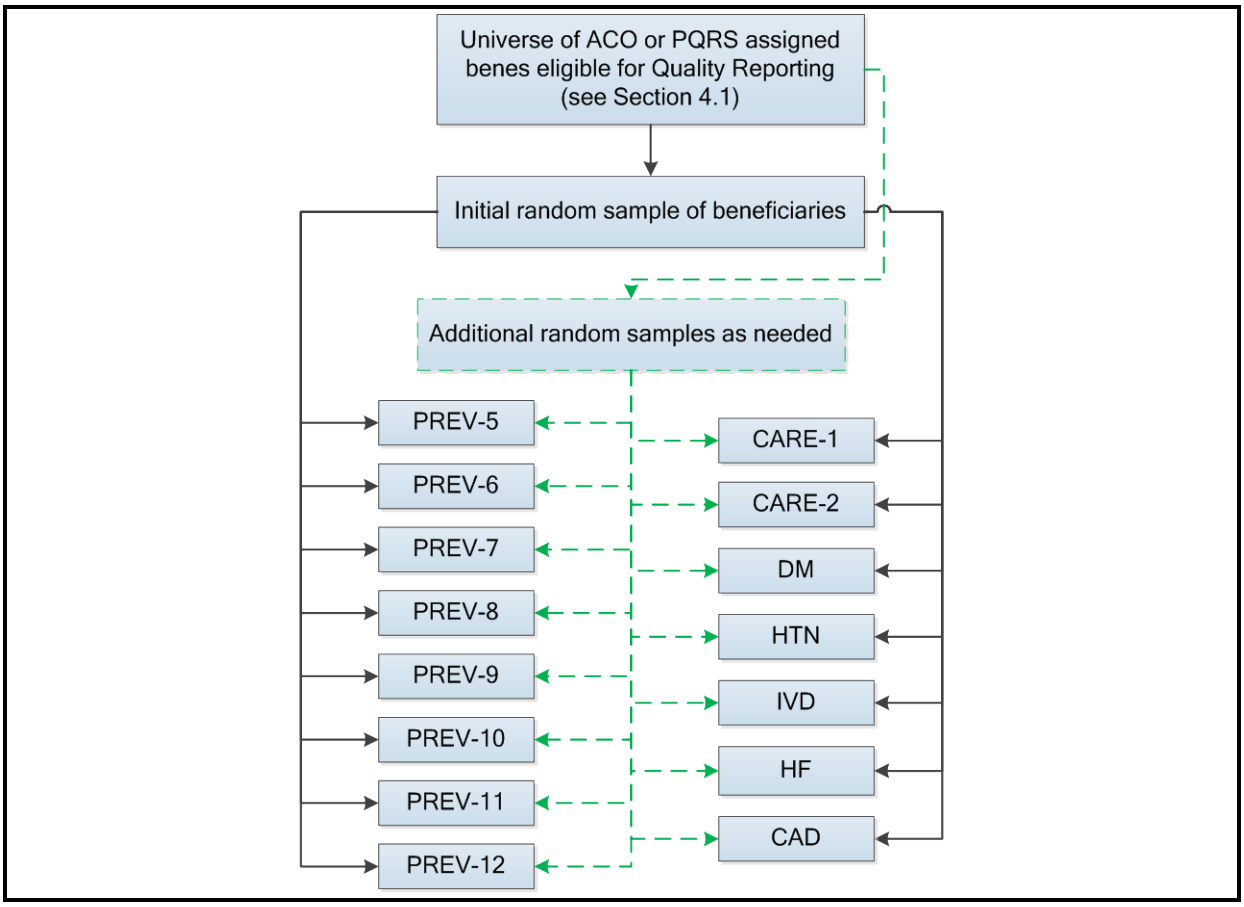
25-99 EPs (illustrated in ***Figure 1***). CMS will use an initial sample of 900 beneficiaries for ACOs and group practices with 100 or more EPs. For group practices with 25–99 EPs an initial sample of 500 beneficiaries will be used.

If, after this step, a disease module/patient care measure has fewer than 616 beneficiaries (for ACOs and group practices with 100 or more EPs) or 327 beneficiaries (for group practices with 25–99 EPs), CMS will randomly sample additional eligible beneficiaries until the module has the required 616 or 327 beneficiaries, or until there are no additional eligible beneficiaries available. Using the same beneficiary across modules where possible reduces the administrative or abstraction burden for ACOs and group practices by minimizing the total number of beneficiaries on which data need to be collected.

Beneficiaries will be assigned a rank between 1 and 616 (for ACOs and group practices with 100 or more EPs) or 1 and 327 (for group practices with 25–99 EPs) based on the order in which they are populated into each denominator sample. ACOs and group practices 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). Group practices with 25–99 EPs will be required to consecutively complete a minimum of 218 beneficiaries (or all beneficiaries in the sample if there are fewer than 218). If the organization is unable to provide data on a particular beneficiary, the organization must indicate a reason the data cannot be provided. The organization cannot skip a beneficiary without providing a valid reason. The valid reasons will be available as options in the WI. 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 or until the sample has been exhausted.

Although 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.

Figure 1
Sampling Process



APPENDIX A:
2014 WEB INTERFACE QUALITY MEASURES

Measure #	Measure Title	NQF #	ACO Domain	Disease Module/ Individual Measure Module
CARE-1	Medication Reconciliation	0097	Care coordination & patient safety	Medication Reconciliation
CARE-2	Falls: Screening For Future Fall Risk	0101	Care coordination & patient safety	Falls
PREV-5	Breast Cancer Screening	NA	Preventive health	Breast cancer screening
PREV-6	Colorectal Cancer Screening	0034	Preventive health	Colorectal cancer screening
PREV-7	Preventive Care and Screening: Influenza Immunization	0041	Preventive health	Influenza immunization
PREV-8	Pneumonia Vaccination Status For Older Adults	0043	Preventive health	Pneumonia vaccination
PREV-9	Preventive Care and Screening: Body Mass Index Screening and Follow-Up	0421	Preventive health	BMI screening
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028	Preventive health	Tobacco screening
PREV-11	Preventive Care and Screening: Screening For High Blood Pressure and Follow-Up Documented	NA	Preventive health	Blood pressure screening
PREV-12	Preventive Care and Screening: Screening For Clinical Depression and Follow-Up Plan	0418	Preventive health	Depression screening
DM-2	Diabetes: Hemoglobin A1c Poor Control	0059	At-risk population	DM
DM-13 through 17	Diabetes Composite (All or Nothing Scoring): ▪ Diabetes Mellitus: High Blood Pressure Control ▪ Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control ▪ Diabetes Mellitus: Hemoglobin A1c Control (<8%) ▪ Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use For Patients With Diabetes and Ischemic Vascular Disease ▪ Diabetes Mellitus: Tobacco Non-Use	0729	At-risk population	DM

(continued)

APPENDIX A:
2014 WEB INTERFACE QUALITY MEASURES

Measure #	Measure Title	NQF #	ACO Domain	Disease Module/ Individual Measure Module
HTN-2	Controlling High Blood Pressure	0018	At-risk population	HTN
IVD-1	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	0075	At-risk population	IVD
IVD-2	Ischemic Vascular Disease (IVD): Use of Aspirin of Another Antithrombotic	0068	At-risk population	IVD
HF-6	Heart Failure (HF): Beta-Blocker Therapy For Left Ventricular Systolic Dysfunction (LVSD)	0083	At-risk population	HF
CAD-2	Coronary Artery Disease Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control	0074	At-risk population	CAD
CAD-7	Coronary Artery Disease Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%))	0066	At-risk population	CAD

APPENDIX B:*
PRIMARY CARE CODES USED TO IDENTIFY QUALITY ELIGIBILITY BENEFICIARIES FOR ACOS AND GROUP PRACTICES REPORTING VIA WI

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 B:*
PRIMARY CARE CODES USED TO IDENTIFY QUALITY ELIGIBILITY BENEFICIARIES FOR ACOS AND GROUP PRACTICES REPORTING VIA WI

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 C
ADDITIONAL PRIMARY CARE CODES USED IN BENEFICIARY ASSIGNMENT CRITERIA AND IN QUALITY ELIGIBILITY FOR ACOS[7,8]

For federally qualified health center (FQHC) or rural health clinic (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 skilled nursing facility (SNF)
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or nursing facility or intermediate care facility for individuals with mental retardation or other residential facility

[7] http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf

[8] Note: not applicable to PQRS GPROs

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APPENDIX D
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

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