Quality Payment PROGRAM

CMS Web Interface Sampling Methodology for the Merit-Based Incentive Payment System, the Medicare Shared Savings Program, and the Next Generation ACO Model

October 31, 2017

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SECTION 1
INTRODUCTION

The purpose of this document is to explain the sampling methodology for the 15 clinical quality measures reported via the Centers for Medicare & Medicaid Services (CMS) Web Interface. This guidance applies to all Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program and the Next Generation ACO Model, and all groups participating in the Merit-based Incentive Payment System (MIPS) program who elected and registered to report as a group utilizing the CMS Web Interface. In this document, ACOs and groups are collectively referred to as organizations. Each organization will be required to report on the same 15 nationally recognized measures.

This document provides background information regarding the number of beneficiaries each organization is expected to report on for purposes of the CMS Web Interface and how those beneficiaries are selected.

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SECTION 2
CMS WEB INTERFACE QUALITY MEASURES

For the 2017 performance period, ACOs and groups will use the CMS Web Interface to collect and submit clinical data on the following 15 measures (14 individual measures, and 1 composite measure composed of 2 component measures).[1,2] These measures span six measure categories: (Care Coordination and Patient Safety (CARE), Preventive Health (PREV), Mental Health (MH), Diabetes (DM), Hypertension (HTN), and Ischemic Vascular Disease (IVD)).[3]

Measure #	ACO #	NQF #	Measure Title
CARE-1	ACO 12	0097	Medication Reconciliation Post Discharge
CARE-2	ACO 13	0101	Falls: Screening for Future Fall Risk
PREV-5	ACO 20	2372	Breast Cancer Screening
PREV-6	ACO 19	0034	Colorectal Cancer Screening
PREV-7	ACO 14	0041	Preventive Care and Screening: Influenza Immunization
PREV-8	ACO 15	0043	Pneumococcal Vaccination Status for Older Adults
PREV-9	ACO 16	0421	Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan
PREV-10	ACO 17	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PREV-12	ACO 18	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan

1 Composite performance measures combine information on multiple individual performance measures into one single measure. National Quality Forum. (2013). Composite performance measure evaluation guidance. Washington, DC: Author. Retrieved from http://www.qualityforum.org/Publications/2013/04/ Composite_Performance_Measure_Evaluation_Guidance.aspx.

2 Note that the Shared Savings Program and the Next Generation ACO Model have additional quality reporting requirements beyond the measures included in the CMS Web Interface.

3 Categories may be referred to as modules in the CMS Web Interface and in some supporting documents. Note that the concept of “category” in the CMS Web Interface is distinct from the concept of “domain” that is used in the ACO program.

Measure #	ACO #	NQF #	Measure Title
PREV-13	ACO 42	N/A	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
DM-2*	ACO 27	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
DM-7*	ACO 41	0055	DM: Eye Exam
HTN-2	ACO 28	0018	Controlling High Blood Pressure
IVD-2	ACO 30	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
MH-1	ACO 40	0710	Depression Remission at Twelve Months

* These two Diabetes measures are the components of the one composite Diabetes measure.
Note: N/A = Not Applicable.

For further information on any of these measures, please refer to the following:

- *The 2017 CMS Web Interface Measure Specifications,* available in the "Quality Measure Specifications" zip file on the QPP Resource Library on CMS.gov.
- *The 2017 CMS Web Interface Supporting Documents*, available in the "Quality Measure Specifications Supporting Documents" zip file on the QPP Resource Library on CMS.gov. These files contain the following for each measure in Excel format: patient confirmation; data guidance; and downloadable resource tables, which include coding for each measure.

SECTION 3
CMS WEB INTERFACE QUALITY MEASURE REPORTING AND SAMPLE SIZE REQUIREMENTS

Each ACO and group will report on each of the 15 clinical quality measures via the CMS Web Interface. Each measure has its own specific denominator requirements, and thus its own specific beneficiary sample.[4] The CMS Web Interface will be prepopulated with a sample of beneficiaries specifically assigned to each organization and will include demographic information for those beneficiaries. Each beneficiary in the CMS Web Interface must be sampled into at least one measure, but may be sampled for more than one measure, and beneficiaries will be assigned a rank based on the order in which they were sampled into a measure. Each measure will be partially pre-populated with beneficiary and clinical information, as applicable.

All ACOs and groups, regardless of size, are required to report a minimum of 248 consecutive Medicare beneficiaries for each measure. However, if the pool of eligible sampled beneficiaries is less than 248, then an ACO or group would report on all sampled beneficiaries. Each organization will be required to complete data fields in the CMS Web Interface that capture quality data for each beneficiary with respect to services rendered during the 2017 performance period (January 1, 2017, through December 31, 2017), unless otherwise specified by the measure.[5] These data must be completely and accurately reported for 248 consecutively ranked and confirmed Medicare beneficiaries. Denominator inclusion and exclusion criteria for some measures may mean that reaching the target sample size is not possible for an organization.

Whenever possible, each measure-specific sample will include more beneficiaries than are needed to meet the reporting requirement of 248 (i.e., an oversample will be provided). For the 2017 performance year, each measure will have a sample of 616 beneficiaries (or as many beneficiaries who meet the quality and measure eligibility criteria if the total is less than 616) to achieve this oversample, with the exception of PREV-13, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease.[6] PREV-13 will have a sample of 750 beneficiaries (or as many beneficiaries who meet the quality and eligibility criteria if the total is less than 750).[7] Note that the reporting requirement for consecutively ranked and confirmed Medicare beneficiaries remains at 248 for PREV-13 despite the larger sample size.

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4 Because the Diabetes measures are components of a composite measure, the denominators are the same. Thus, there is a single sample for the Diabetes component measures.

5 For example, PREV-7, Preventive Care and Screening: Influenza Immunization, specifies that quality data is with respect to the influenza season, which includes some dates in 2016.

6 This is equivalent to a 148 percent oversample.

7 This is equivalent to a 201 percent oversample.

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SECTION 4
CMS WEB INTERFACE QUALITY MEASURE SAMPLING METHODOLOGY

ACOs and groups will use the CMS Web Interface 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

CMS will assign a Medicare beneficiary to an ACO or group based on current program rules. For ACOs, CMS will use beneficiaries assigned using the ACO assignment/alignment algorithm.[8,9] For groups, CMS will use beneficiaries assigned using the MIPS assignment algorithm.[10]

Using Medicare administrative data from January 1, 2017, through October 27, 2017, CMS will exclude the following beneficiaries from eligibility:

- Beneficiaries with fewer than two primary care services[11] within the ACO or group, as applicable, during the performance period.
- Beneficiaries with part-year eligibility in Medicare FFS Part A and Part B.
- Beneficiaries in hospice.
- Beneficiaries who died.
- Beneficiaries who did not reside in the United States.

The remaining beneficiaries will be considered eligible for quality measurement.

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8 The Shared Savings Program uses beneficiaries assigned in the third quarter of 2017. The Shared Savings Program beneficiary assignment methodology can be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html

9 For Next Generation ACOs, the most recent exclusions are applied to aligned beneficiaries. The Next Generation ACO Model methodology can be found at https://innovation.cms.gov/Files/x/nextgenaco-methodology.pdf.

10 The MIPS assignment methodology for the CMS Web Interface and CAHPS for MIPS Survey document can be found on the CMS website at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html.

11 As defined by the Healthcare Common Procedure Coding System (HCPCS) codes. See Appendices A and B for ACOs and Appendix A for MIPS groups.

4.2 Step 2: Identify Beneficiaries Eligible for Sampling into Each Measure

For beneficiaries identified as eligible for quality measurement, we further determine if they are eligible for any of the specific quality measures on the basis of the denominator criteria for each measure. Denominator criteria use is outlined below.

Measure names	Denominator criteria
(All of the following measures share the same denominator criteria) 1. PREV-8: Pneumococcal Vaccination Status for Older Adults 2. PREV-9: Preventive Care and Screening: BMI Screening and Follow-Up 3. PREV-10: Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention 4. CARE-2: Falls: Screening for Future Fall Risk	1. Meet Age Criteria 2. Have at least one face-to-face encounter during the measurement period[12]
5. CARE-1: Medication Reconciliation Post-Discharge	1. Meet Age Criteria 2. Have at least one face-to-face encounter during the measurement period 3. Had a follow-up visit within the ACO within 30 days of an identifiable discharge
6. PREV-5: Breast Cancer Screening	1. Meet gender criteria 2. Meet age criteria 3. Have at least one face-to-face encounter during the measurement period 4. Does not meet any exclusion criteria[13]
7. PREV-6: Colorectal Cancer Screening	1. Meet age criteria 2. Have at least one face-to-face encounter during the measurement period 3. Does not meet any exclusion criteria[14]

12 Please note that in some cases, CMS will use a shorter look back period than is specified by the measure. This is due to the fact that CMS does not use claims more than 2 years old for purposes of sampling.

13 Beneficiaries that are 65 years of age and older and are in Institutional Special Needs Plans or are residents of a long-term care facility will be excluded from these measures (PREV-5, PREV-6, and HTN), per revised measure specifications from NCQA.

14 Beneficiaries that are 65 years of age and older and are in Institutional Special Needs Plans or are residents of a long-term care facility will be excluded from these measures (PREV-5, PREV-6, and HTN), per revised measure specifications from NCQA.

Measure names	Denominator criteria
8. PREV-7: Influenza Immunization	1. Meet age criteria 2. Have at least two face-to-face encounters during the measurement period 3. Have at least one face-to-face encounter within the ACO or group during the influenza season. The influenza season is defined as October 1, 2016, through March 31, 2017
9. PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	1. Meet age criteria 2. Have at least one face-to-face encounter during the measurement period 3. Does not meet exclusion criteria
10. DM-2 or DM-7: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) or Eye Exam	1. Meet age criteria 2. Have at least one face-to-face encounter with a documented diagnosis of Diabetes (type 1 or type 2) in an office or outpatient setting
11. IVD-2: Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet	1. Meet age criteria 2. Have one of the following: o At least one face-to-face encounter during the measurement period with a documented diagnosis of IVD in an office or outpatient setting. o One inpatient procedure for IVD during the year before the measurement year (i.e., January 1 through December 31, 2016). o One inpatient discharge for an acute myocardial infarction during the year before the measurement year (i.e., January 1 through December 31, 2016).
12. HTN-2: Controlling High Blood Pressure	1. Meet age criteria 2. Have at least two face-to-face encounters with a documented diagnosis of essential hypertension during the first 6 months of the measurement period or the year prior to the measurement period (i.e., January 1, 2016, through June 30, 2017)

Measure names	Denominator criteria
	3. Does not meet exclusion criteria.[15]
13. MH-1: Depression Remission at 12 Months	1. Meet age criteria 2. Have at least one face-to-face encounter during the denominator identification period (i.e., December 1, 2015 through November 30, 2016). 3. Have a diagnosis of major depression or dysthymia. 4. Does not meet exclusion criteria.
14. PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	1. Meet age criteria.[16] 2. Have at least one face-to-face encounter during the measurement period. 3. Have a diagnosis of atherosclerotic cardiovascular disease, hypercholesterolemia, or a diagnosis of Diabetes.[17] 4. Does not meet exclusion criteria.

15 Beneficiaries that are 65 years of age and older and are in Institutional Special Needs Plans or are residents of a long-term care facility will be excluded from these measures (PREV-5, PREV-6, and HTN), per revised measure specifications from NCQA.

16 Note that the PREV-13 denominator is a single denominator that represents three risk categories. Age criteria will vary depending on the specific risk category for which the beneficiary qualifies.

17 Diagnosis of atherosclerotic cardiovascular disease represents risk category 1, diagnosis of hypercholesterolemia represents risk category 2, and diagnosis of Diabetes represents risk category 3.

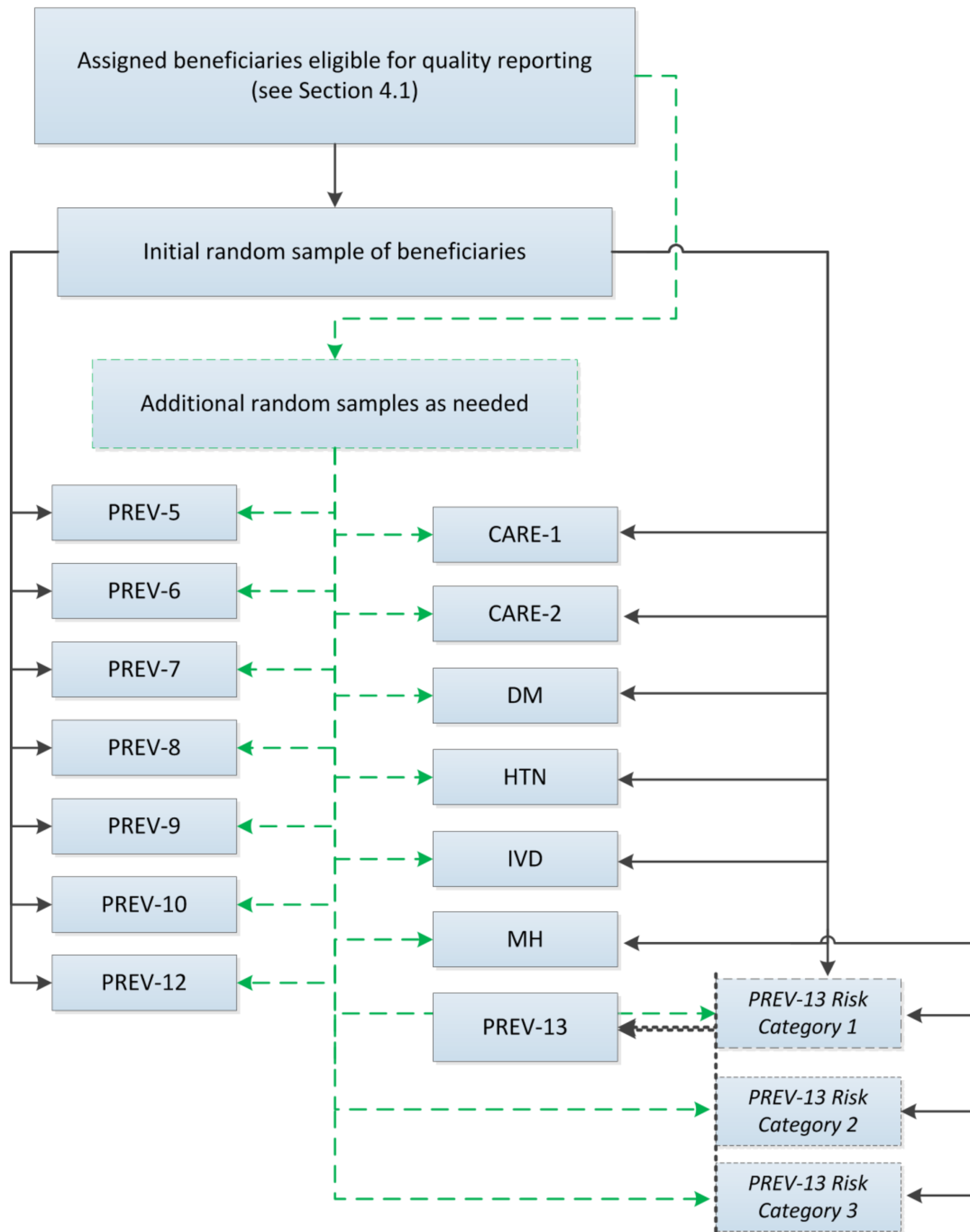
4.3 Step 3: Randomly Sample Beneficiaries into Each Measure

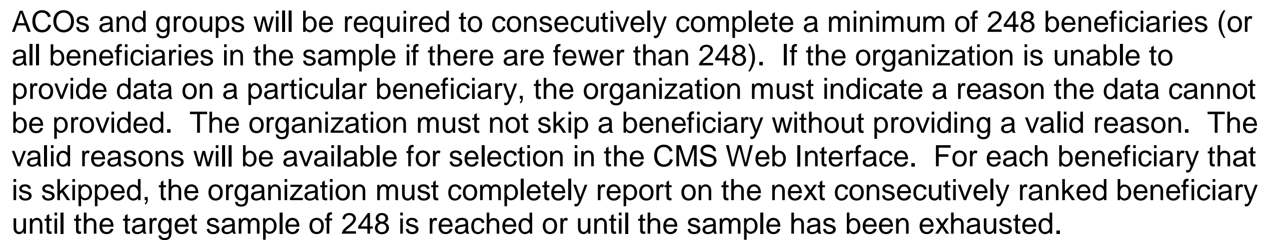
CMS will select an initial random sample of 900 beneficiaries eligible for quality measurement (as defined in Section 4.1) and populate them into the measures for which they are eligible until a sample size of 616 is reached (750 for PREV-13) (illustrated in Figure 1).

If, after this step, a measure has fewer than 616 beneficiaries (750 for PREV-13), CMS will randomly sample additional eligible beneficiaries until the measure has the required 616 (or 750 for PREV-13) or until there are no additional eligible beneficiaries available. Note that CMS uses the same beneficiary across measures, where possible. This reduces the administrative burden for ACOs and groups by minimizing the total number of beneficiaries for which data need to be collected. Thus, to the extent possible, the beneficiaries in each measure sample will not be unique.

For all measures except PREV-13, beneficiaries will be assigned a rank between 1 and 616 based on the order in which they are populated into each measure-specific sample. Because PREV-13 has three distinct risk categories, sampling for that measure requires additional steps. In the first stage of sampling, each risk category will be represented separately, and beneficiaries will be assigned a rank between 1 and 250 for each PREV-13 risk category in the same manner as the other measures. After each sample has been completed, the three PREV-13 risk categories will be combined into a single sample of 750. This allows each risk category to have equal representation in the sample to the extent possible. We will also distribute each risk category throughout the sample to the extent possible.

Figure 1
Sampling Process





ACOs and groups will be required to consecutively complete a minimum of 248 beneficiaries (or all beneficiaries in the sample if there are fewer than 248). 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 must not skip a beneficiary without providing a valid reason. The valid reasons will be available for selection in the CMS Web Interface. For each beneficiary that is skipped, the organization must completely report on the next consecutively ranked beneficiary until the target sample of 248 is reached or until the sample has been exhausted.

Although this sampling methodology does not guarantee that beneficiaries will have the same rank across measures, it does increase the likelihood that a beneficiary will have a similar rank across measures. This approach provides for beneficiaries to have the same or similar rank across measures, which may reduce reporting burden for the ACOs and groups. Therefore, a low-ranked beneficiary in one measure will likely have a low rank in the other measures for which he or she qualifies.

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APPENDIX A.
PRIMARY CARE CODES USED FOR DETERMINING QUALITY ELIGIBILITY

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 (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)	
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 (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)	
99315	New or established patient, brief
99316	New or established patient, comprehensive

Other nursing facility services (services that take place in a skilled nursing facility (i.e., on claims with a POS 31 indicator) are excluded)	
99318	New or established patient
Domiciliary, rest home, or custodial care services	
99324	New patient, brief
99325	New patient, limited
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
Care management services	
99490	Chronic care management service
99495	Transitional care management services within 14 days of discharge

99496	Transitional care management services within 7 days of discharge
Wellness visits	
G0402	Welcome to Medicare visit
G0438	Annual wellness visit
G0439	Annual wellness visit

APPENDIX B.
ADDITIONAL PRIMARY CARE CODES[18] USED FOR DETERMINING QUALITY ELIGIBILITY (ACO ONLY)

Applicable to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) 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), nursing facility, intermediate care facility for individuals with mental retardation, or other residential facility

18 42 Code of Federal Regulations (CFR) Part 425 defines primary care services as the set of services identified by the following revenue center codes: 0521, 0522, 0524, and 0525. Appendix C contains all codes in that range that are currently in use.