2022 CMS Web Interface Sampling Methodology for the Merit-based Incentive Payment System (MIPS) and Medicare Shared Savings Program

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SECTION 1

Introduction

This document outlines the sampling methodology for the 10 clinical quality measures reported via the Centers for Medicare & Medicaid Services (CMS) Web Interface. The sampling methodology applies to Alternative Payment Model (APM) Entities, specifically Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs), meeting reporting requirements for the APM Performance Pathway[1] (APP) via the CMS Web Interface; and groups, virtual groups, and other APM Entities meeting the quality performance category reporting requirements for the traditional Merit-based Incentive Payment System (MIPS) via the CMS Web Interface. In this document, APM Entities, groups, and virtual groups are collectively referred to as organizations.

SECTION 2

CMS Web Interface Quality Measures

For the 2022 performance year, organizations reporting quality data via the CMS Web Interface are required to collect and submit clinical data on all 10 CMS Web Interface measures. The measures span 5 measure categories: Care Coordination and Patient Safety (CARE), Preventive Health (PREV), Mental Health (MH), Diabetes (DM), and Hypertension (HTN). Each measure is listed in Table 1 as shown below.

Table 1. CMS Web Interface Measures

Measure #	Quality ID #	NQF #	Measure Title
CARE-2	318	0101	Falls: Screening for Future Fall Risk
DM-2	001	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
HTN-2	236	0018	Controlling High Blood Pressure
MH-1	370	0710	Depression Remission at Twelve Months
PREV-5	112	2372	Breast Cancer Screening
PREV-6	113	0034	Colorectal Cancer Screening
PREV-7	110	0041	Preventive Care and Screening: Influenza Immunization
PREV-10	226	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PREV-12	134	0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
PREV-13	438	N/A	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

NOTE: N/A = Not Applicable

[1] Under the APP, there are other reporting requirements in addition to the reporting of the 10 CMS Web Interface measures. Please review the 2022 APM Performance Pathway Toolkit (ZIP) for information regarding the APP reporting requirements.

For further information regarding any of the CMS Web Interface measures, please refer to the 2022 CMS Web Interface Measure Specifications and Supporting Documents (PDF). The supporting documents 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 organization will report on each of the 10 clinical quality measures via the CMS Web Interface. The CMS Web Interface will be prepopulated with patients that have been assigned to each organization and will include demographic information for those patients. Using data from CMS claims and CMS Medicare enrollment and demographics, patients who meet the denominator criteria and patient eligibility will be selected for each measure sample. Patients are sampled into at least one measure, but may be sampled into more than one measure, and will be assigned a number (referred to as the patient's "rank," which indicates the order in which the patient was sampled into that measure).

All organizations, regardless of size, are required to completely and accurately report on a minimum of 248 consecutively ranked and confirmed Medicare patients for each measure. However, if the pool of eligible sampled patients is less than 248, then an organization is required to report on all sampled patients. Each organization will be required to complete data fields in the CMS Web Interface that capture quality data for each patient with respect to services rendered during the 2022 performance year (January 1, 2022, through December 31, 2022), unless otherwise specified by the measure. For example, the PREV-7: Preventive Care and Screening: Influenza Immunization measure requires the collection of certain quality data that spans the influenza season, which includes a few months from 2021.

If possible, an "oversample" will be provided for each measure. This means that each sample will include more patients than are needed to meet the reporting requirement of 248. For the 2022 performance year, 9 of the 10 measures may have an oversample of 616 patients. The PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure may have an oversample of 750 patients. Please note that the reporting requirement for consecutively ranked and confirmed Medicare patients remains at 248 for PREV-13 despite the larger sample size. If the sampling target of 616 or 750 patients can't be met for any measure, it will have a smaller sample size that includes all patients who meet measure eligibility. There are denominator exclusion and exception criteria for certain measures that could prevent an organization from meeting the sampling target for a measure.

SECTION 4

CMS Web Interface Quality Measure Sampling Methodology

Organizations will use the CMS Web Interface to submit data on samples of the organization's fee-for-service (FFS) Medicare patients. Each organization's samples will be determined using the following process.

4.1 Step 1: Identify Patients Eligible for Quality Measurement

CMS will assign a Medicare patient to an APM Entity (including a Shared Savings Program ACO), group, or virtual group based on current program rules. For APM Entities, specifically Shared Savings Program ACOs, CMS will use patients assigned using the Shared Savings Program ACO assignment methodology.[2] For groups, virtual groups, and other APM Entities, CMS will assign patients using the MIPS assignment methodology.[3]

Using Medicare administrative data (i.e., claims data) from January 1, 2022, through October 31, 2022, CMS will exclude the following patients from quality measurement eligibility:

- Patients with fewer than 2 primary care services[4] within the organization during the performance year.[5] [6]
- Patients with part-year eligibility in Medicare FFS Part A and Part B.
- Patients in hospice.
- Patients who died.
- Patients who didn't reside in the United States.

The remaining assigned patients will be considered eligible for quality measurement.

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

For patients who are identified as eligible for quality measurement, we determine if they're eligible for any of the specific quality measures based on the denominator criteria as outlined in the 2022 CMS Web Interface Measure Specifications and Supporting Documents (PDF). Due to limitations in the Medicare claims data, certain denominator exclusion and exception criteria must be applied by organizations using medical record data via the CMS Web Interface.

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[2] The Shared Savings Program uses patients assigned in the third quarter of 2022. For information regarding Shared Savings Program patient assignment methodology, please review the Shared Savings Program Financial and BeneficiaryAssignment Specifications.

[3] For information regarding the MIPS assignment methodology, please review the 2022 MIPS Assignment Methodology Specifications for the CMS Web Interface and CAHPS for MIPS Survey (PDF).

[4] Primary care services are defined by the inclusion of certain Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT©) codes. See the Appendix for HCPCS and CPT codes that are includedin the definition of primary care services under the Shared Savings Program and MIPS.

[5] For the Shared Savings Program, all claims billed by a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) are considered primary care claims and will be included.

[6] In order to exclude services that were provided in a nursing home, all services billed with designated CPT codes (see Appendix) will be excluded from quality measurement eligibility. For MIPS, Part B claims billed with one of these designatedCPT codes and a Place of Service (POS) code 31 will be excluded. For the Shared Savings Program, these claims are excluded if they have a corresponding Skilled Nursing Facility (SNF) stay.

The sampling criteria for each measure is outlined in Table 2 below. Please note that the sampling criteria outlined in Table 2 shouldn't be used as a substitute for the measure specifications. We recommend that your organization review the measure specifications and supporting documents for each measure.

Table 2. CMS Web Interface Sampling Methodology

Measure	Sampling Criteria[7]
CARE-2: Falls: Screening for Future Fall Risk	1. Ages 65 years and older. 2. Have at least one eligible encounter during the measurement period.
DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1. Ages 18 to 75 years. 2. Have at least one eligible encounter with a documented diagnosis of diabetes in an office or outpatient setting during the measurement period or during the year prior to the measurement period. 3. Doesn't meet the following exclusion criteria:[8] • Patients 66 years of age and older residing in long-term care with a Place of Service (POS) code 32, 33, 34, 54, or 56 on an eligible claim during the measurement period; OR • Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, emergency department (ED), or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.

[7] For all measures that include an age range in the sampling criteria, a patient must be in the age range on both the first and last day of the measurement period. For lower age limits, patients are sampled based on their age on the first day of the measurement period (or in the case of the MH-1 measure, the denominator identification period). For the 2022 measurement period, this is the patient's age as of January 1, 2022 (or in the case of the MH-1 measure, November 1, 2021). For upper age limits, where applicable, patients are sampled based on their age as of the last day of the measurement period (i.e., the patient's age as of December 31, 2022).

[8] For measures with a denominator exclusion for patients age 66 and older who also have an indication of frailty for any part of the measurement period, patients are assessed on the exclusion criteria based on their age at the end (last day) of the measurement period.

Measure	Sampling Criteria[7]
HTN-2: Controlling High Blood Pressure	1. Ages 18 to 85 years. 2. Have at least one eligible encounter with a diagnosis of essential hypertension one year prior to the measurement period or during the first 6 months of the measurement period. 3. Doesn't meet any of the following exclusion criteria:[8] • Evidence of End-Stage Renal Disease (ESRD), dialysis, or renal transplant before or during the measurement period. • Patients 66-80 years of age residing in long-term care or with a POS code of 32, 33, 34, 54, or 56 on an eligible claim during the measurement period. • Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, ED, or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. • Patients 81 years of age and older with at least one claim/encounter for frailty during the measurement period.
MH-1: Depression Remission at TwelveMonths	1. Ages 12 years and older. 2. Have an eligible encounter during the denominator identification period (November 1, 2021 to October 31, 2022). 3. Have a diagnosis of major depression or dysthymia. 4. Doesn't meet any of the following exclusion criteria during the denominator identification period: Have a diagnosis of bipolar or select personality disorders, schizophrenia or psychotic disorder, pervasive developmental disorder, or personality disorder emotionally labile.
PREV- 5: Breast Cancer Screening	1. Women ages 51 to 74 years. 2. Have at least one eligible encounter during the measurement period. 3. Doesn't meet the following exclusion criteria:[8] • Bilateral mastectomy • Patients age 66 and older residing in long-term care or with aPOS code of 32, 33, 34, 54, or 56 on an eligible claim during the measurement period. Patients age 66 and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, ED, or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.

Measure	Sampling Criteria[7]
PREV-6: Colorectal Cancer Screening	1. Ages 50 to 75 years. 2. Have at least one eligible encounter during the measurement period. 3. Doesn't meet the following exclusion criteria:[8] • Patients with a diagnosis or past history of total colectomy or colorectal cancer. • Patients age 66 and older residing in long-term care or with a POS code of 32, 33, 34, 54, or 56 on an eligible claim during the measurement period. • Patients age 66 and older with at least one claim/encounterfor frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, ED, or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.
PREV-7: Preventive Care and Screening: Influenza Immunization	1. Ages 6 months and older. 2. Have at least one eligible encounter in the organization duringthe measurement period and at least one encounter between October 1, 2021, and March 31, 2022 (the flu season).
PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	1. Ages 18 years and older. 2. Have at least 2 eligible encounters during the measurement period.
PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	1. Ages 12 years and older. 2. Have at least one eligible encounter during the measurement period. 3. Doesn't meet the following exclusion criteria: • Patients who have been diagnosed with depression or with bipolar disorder.

Measure	Sampling Criteria[7]
PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	1. Have at least one eligible encounter during the measurement period. 2. For Population 1, a previous or current active diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD), including an ASCVD procedure. 3. For Population 2, patients aged ≥ 20 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia. 4. For Population 3, patients aged 40 to 75 years at the beginning of the measurement period with type 1 or type 2 diabetes. 5. Doesn't meet the following exclusion criteria: • Diagnosis of rhabdomyolysis at any time during the measurement period.

4.3 Step 3: Randomly Sample Patients into Each Measure

A random sample of 900 patients is selected for quality measurement (as defined in Section 4.1) and populated into the samples for measures for which they're eligible until a sample sizeof 616 (or 750 for PREV-13) is reached for each measure.

If a measure has fewer than 616 patients (or 750 for PREV-13) after this step, CMS will select additional eligible patients until the measure has the required 616 (or 750 for PREV-13) or until there are no additional eligible patients available. When the patient is eligible for multiple measures, they'll be included in multiple measures. Although this sampling methodology doesn't guarantee that patients will have the same numeric rank across measures, it does increase the likelihood that a patient will have a similar rank across measures. Therefore, a patient with a low rank in one measure will likely have a low rank in other measures for which he or she is eligible. The intent of this approach is to reduce the reporting burden for organizations.

For all measures, patients will be assigned a rank number between 1 and 616 (or 750 for PREV-13) based on the order they're populated into each measure sample. Identifying patients for the PREV-13 measure requires additional steps as a result of the 3 distinct risk categories used to determine denominator eligibility. To begin the sampling for PREV-13, each risk category is considered separately, and patients are assigned a rank between 1 and 250 for that risk category (in the same manner as the other measures). After each risk category has reached 250, the 3 categories will be combined into a single sample of 750. This process allows each risk category to have equal representation, to the extent possible, in the sample.

For some measures and exclusions, CMS has applied exclusion criteria during the sampling process. However, exclusions aren't always applied during sampling, because sometimes, it isn't possible to do with claims data. If an organization is unable to report data on a patient at the time of abstraction, the organization must indicate a reason the data can't be reported. The organization must not skip a patient without providing a valid reason, which is defined as an exclusion in the CMS Web Interface measure specifications. The acceptable reasons will be available for selection within the CMS Web Interface.

Appendix: Primary Care Service Codes Used for Determining Quality Eligibility

Code	Description	Programs (SSP and MIPS) Using Codes
Office or Other Outpatient Services		
99201	New patient, brief	SSP, MIPS
99202	New patient, limited	SSP, MIPS
99203	New patient, moderate	SSP, MIPS
99204	New patient, comprehensive	SSP, MIPS
99205	New patient, extensive	SSP, MIPS
99211	Established patient, brief	SSP, MIPS
99212	Established patient, limited	SSP, MIPS
99213	Established patient, moderate	SSP, MIPS
99214	Established patient, comprehensive	SSP, MIPS
99215	Established patient, extensive	SSP, MIPS
G2212	Prolonged Office or other Outpatient Evaluation and Management (E/M) Service**	SSP
Initial Nursing Facility Care		
99304	New or established patient, brief (use except when provided in a SNF)†	SSP, MIPS
99305	New or established patient, moderate (use except when provided in a SNF)†	SSP, MIPS
99306	New or established patient, comprehensive (use except when provided in a SNF)†	SSP, MIPS
Subsequent Nursing Facility Care		
99307	New or established patient, brief (use except when provided in a SNF)†	SSP, MIPS
99308	New or established patient, limited (use except when provided in a SNF)†	SSP, MIPS
99309	New or established patient, comprehensive (use except when provided in a SNF)†	SSP, MIPS
99310	New or established patient, extensive (use except when provided in a SNF)†	SSP, MIPS

Code	Description	Programs (SSP and MIPS) Using Codes
Nursing Facility Discharge Services		
99315	New or established patient, brief (use except when provided in a SNF)†	SSP, MIPS
99316	New or established patient, comprehensive (use except when provided in a SNF)†	SSP, MIPS
Other Nursing Facility Services		
99318	New or established patient (use except when provided in a SNF)†	SSP, MIPS
Domiciliary, Rest Home, or Custodial Care Services		
99324	New patient, brief	SSP, MIPS
99325	New patient, limited	SSP, MIPS
99326	New patient, moderate	SSP, MIPS
99327	New patient, comprehensive	SSP, MIPS
99328	New patient, extensive	SSP, MIPS
99334	Established patient, brief	SSP, MIPS
99335	Established patient, moderate	SSP, MIPS
99336	Established patient, comprehensive	SSP, MIPS
99337	Established patient, extensive	SSP, MIPS
Domiciliary, Rest Home, or Home Care Plan Oversight Services		
99339	Brief	SSP, MIPS
99340	Comprehensive	SSP, MIPS
Home Services		
99341	New patient, brief	SSP, MIPS
99342	New patient, limited	SSP, MIPS
99343	New patient, moderate	SSP, MIPS
99344	New patient, comprehensive	SSP, MIPS
99345	New patient, extensive	SSP, MIPS
99347	Established patient, brief	SSP, MIPS
99348	Established patient, moderate	SSP, MIPS

Code	Description	Programs (SSP and MIPS) Using Codes
99349	Established patient, comprehensive	SSP, MIPS
99350	Established patient, extensive	SSP, MIPS
Prolonged Services with Direct Patient Contact		
99354	Prolonged Services with Direct Patient Contact, first hour	SSP
99355	Prolonged Services with Direct Patient Contact, each additional 30 minutes	SSP
Health and Behavior Assessment/Intervention Procedure		
96160	Administration of patient-focused health risk assessment instrument	SSP, MIPS
96161	Administration of caregiver-focused health risk assessment instrument	SSP, MIPS
General Behavioral Health Integration and Care Management		
99484	General Behavioral Health Integration Care Management	SSP
Chronic Care Management		
99437	Chronic Care Management**	SSP
99487	Chronic Care Management Service	SSP, MIPS
99489	Chronic Care Management Service	SSP, MIPS
99490	Chronic Care Management Service, 20 minutes	SSP, MIPS
99491	Chronic Care Management Service, 30 minutes**	SSP
Psychiatric Collaborative Care Management Services		
99492	Behavioral Health Integration	SSP
99493	Behavioral Health Integration	SSP
99494	Behavioral Health Integration	SSP
Transitional Care Management		
99495	Transitional Care Management Services within 14 days of discharge	SSP, MIPS
99496	Transitional Care Management Services within 7 days of discharge	SSP, MIPS

Code	Description	Programs (SSP and MIPS) Using Codes
Advance Care Planning		
99497	Advance Care Planning	SSP
99498	Advance Care Planning	SSP
Wellness Visits		
G0402	Welcome to Medicare visit	SSP, MIPS
G0438	Annual wellness visit	SSP, MIPS
G0439	Annual wellness visit	SSP, MIPS
G0442	Annual Alcohol Misuse Screening	SSP
G0443	Annual Alcohol Misuse Counseling	SSP
G0444	Annual Depression Screening*	SSP
New G Codes for Outpatient Hospital Claims		
G0463	Hospital Outpatient Clinic Visit	SSP
G0506	Chronic Care Management	SSP
Virtual Communication		
G2010	Remote Evaluation of Patient Video/Images*	SSP, MIPS
G2012	Virtual Check-In*	SSP, MIPS
Non-Face-to-Face On-Line Digital Evaluation and Management Services		
99421	Online Digital Evaluation and Management Service (e-visit), 5-10 minutes*	SSP, MIPS
99422	Online Digital Evaluation and Management Service (e-visit), 11-20 minutes*	SSP, MIPS
99423	Online Digital Evaluation and Management Service (e-visit), 21+ minutes*	SSP, MIPS
Primary Care Codes and Services		
99441	Telephone Evaluation and Management Services, 5-10 minutes of Medical Discussion*	SSP, MIPS
99442	Telephone Evaluation and Management Services, 11-20 minutes of Medical Discussion*	SSP, MIPS
99443	Telephone Evaluation and Management Services, 21-30 minutes of Medical Discussion*	SSP, MIPS
G2252	Communication Technology-Based Service (CTBS)**	SSP

Code	Description	Programs (SSP and MIPS) Using Codes
Care Planning for Patients with Cognitive Impairment		
99483	Cognitive assessment and care plan services	SSP
Non-complex Chronic Care Management		
G2058	Chronic care management services, additional 20 min clinical staff time	SSP
99439	Chronic care management services, each additional 20 minutes	SSP
Principal Care Management		
99424	Principal Care Management**	SSP
99425	Principal Care Management**	SSP
99426	Principal Care Management**	SSP
99427	Principal Care Management**	SSP
G2064	Comprehensive Care Management Service (principal care management services)	SSP
G2065	Comprehensive Care Management Service (principal care management services)	SSP
Psychiatric Collaborative Care Model		
G2214	Psychiatric Collaborative Care Model	SSP

† For MIPS, Part B claims won't be used if these codes are in the claim with POS code 31.
* New or modified HCPCS and CPT codes included in the definition of primary care services for the 2020 performance year as finalized in the May 8, 2020 COVID-19 Interim Final Rule with Comment Period (IFC) (85 FR 27583) for the purposes of patient assignment under the Shared Savings Program and in the September 2, 2020 COVID-19 Interim Final Rule with Comment Period (IFC) (85 FR 54847) for the purposes of patient assignment under MIPS, and such codes continue to be applied for the 2022 performance year due to the COVID-19 public health emergency.
** New or modified HCPCS and CPT codes included in the definition of primary care services starting with the 2022 performance year.