Quality Payment
PROGRAM

2018 CMS Web Interface Sampling Methodology for the Merit-Based Incentive Payment System, the Medicare Shared Savings Program, and the Next Generation ACO Model

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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) that 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. Please 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.

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SECTION 2

CMS WEB INTERFACE QUALITY MEASURES

For the 2018 performance year, organizations will use the CMS Web Interface to collect and submit clinical data on the following 15 measures (13 individual measures, and 1 composite measure composed of 2 component measures).[1] 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)) and each measure is listed in the table below.

Table 1. CMS Web Interface Measures

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	N/A	Pneumococcal Vaccination Status for Older Adults
PREV-9	ACO-16	0421	Preventive Care and Screening: Body Mass Index (BMI) 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
PREV-13	ACO-42	N/A	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

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.

Measure #	ACO #	NQF #	Measure Title
DM-2*	ACO-27	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
DM-7*	ACO-41	0055	Diabetes: 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 the CMS Web Interface measures, please refer to the following:

- *The 2018 CMS Web Interface Measure Specifications,* available in the "Quality Measure Specifications" zip file on the QPP Resource Library on CMS.gov.
- *The 2018 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 organization will report on each of the 15 clinical quality measures via the CMS Web Interface. Each measure (including the composite measure) has specific denominator requirements and specific beneficiary sample. The CMS Web Interface will be pre-populated with a sample of the beneficiaries assigned to each organization and include demographic information for those beneficiaries. Each beneficiary in the CMS Web Interface is sampled into at least one measure, but may be sampled for more than one measure. Beneficiaries will be assigned a rank based on the order in which they were sampled into a measure.

All organizations, regardless of size, are required to confirm and complete a minimum of 248 consecutively ranked Medicare beneficiaries for each measure. However, if the pool of eligible sampled beneficiaries is less than 248, then an organization 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 2018 performance year (January 1, 2018, through December 31, 2018), unless otherwise specified by the measure. For example, for the PREV-7, Preventive Care and Screening: Influenza Immunization measure, some of the quality data that needs to be collected might span the influenza season, which includes some months of 2017. Data must be completely and accurately reported for 248 consecutively ranked and confirmed Medicare beneficiaries.

When it is 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 2018 performance year, each measure (with the exception of PREV-13, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease) will have a sample of 616 beneficiaries. PREV-13 will have a sample of 750 beneficiaries. Note that the reporting requirement for consecutively ranked and confirmed Medicare beneficiaries remains at 248 for PREV-13 despite the larger sample size. For any measure that is not able to meet the sampling threshold of 616 or 750 beneficiaries, such measure will have a smaller sample size that includes all beneficiaries who meet measure eligibility. There are denominator exclusion and exception criteria for some measures that might prevent an organization from meeting the sampling threshold 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 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 methodology.[2,3] For groups, CMS will use beneficiaries assigned using the MIPS assignment methodology.[4]

Using Medicare administrative data from January 1, 2018, through October 31, 2018, CMS will exclude the following beneficiaries from quality measurement eligibility:

- Beneficiaries with fewer than two primary care services[5] 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 assigned beneficiaries will be considered eligible for quality measurement.

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 using the 2018 CMS Web Interface Measure Specifications and Supporting Documents. Due to limitations in the Medicare claims data, some denominator exclusion and exception criteria must be applied by organizations using medical record data.

The sampling criteria for each measure is outlined in the below table. Please note that the sampling criteria outlined in Table 2 should not be used as a substitute for the measures specifications. It is recommended that your organization review the measure specifications and supporting documents for each measure.

2 The Shared Savings Program uses beneficiaries assigned in the third quarter of 2018. 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.

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

4 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.

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

Table 2. CMS Web Interface Sampling Methodology

Measure	Sampling Criteria
CARE-1: Medication Reconciliation Post-Discharge	1. Ages 18 and older 2. Had a follow-up visit within the ACO or group within 30 days of an identifiable discharge
CARE-2 Falls: Screening for Future Fall Risk	1. Ages 65 years and older 2. Have at least one encounter during the measurement period
PREV- 5: Breast Cancer Screening	1. Women ages 51-74 2. Have at least one encounter during the measurement period 3. Does not meet the following exclusion criteria: bilateral mastectomy or evidence of right and left unilateral mastectomy. Or ages 65 and older with a POS code 32, 33, 34, 54 or 56 on an eligible claim at any time during the measurement period
PREV-6: Colorectal Cancer Screening	1. Ages 50 to 75 2. Have at least one eligible encounter during the measurement period. 3. Does not meet the following exclusion criteria: patients with a diagnosis or past history of total colectomy or colorectal cancer. Or patients ages 65 and older with a POS code 32, 33, 34, 54 or 56 on an eligible claim at any time during 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 ACO or group during the measurement period and at least one encounter between October 1 and March 31 (the flu season)

Prev-8: Pneumococcal Vaccination Status for Older Adults	1. Ages 65 years and older 2. Have at least one eligible encounter during the measurement period
Prev-9: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	1. Ages 18 years and older 2. Have at least one eligible encounter during the measurement period
Prev-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	1. Ages 18 years and older 2. Have at least two eligible encounters during the measurement year
Prev-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	1. Ages 12 and older 2. Have at least one eligible encounter during the measurement year
Prev-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	1. Ages 21 years and older 2. Have at least one eligible encounter during the measurement period 3. For risk category 1, a diagnosis of ASCVD 4. For risk category 2, a previous diagnosis or currently an active diagnosis of familial or pure hypercholesterolemia 5. For risk category 3, type 1 or type 2 diabetes 6. Does not meet the following exclusion criteria: diagnosis of rhabdomyolysis
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and Diabetes: Eye Exam	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
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 year or during the first 6 months of the measurement year

	3. Does not meet any of the following exclusion criteria: evidence of ESRD, dialysis, or renal transplant before or during the measurement period, or patients ages 65 and older with a POS code 32, 33, 34, 54 or 56 on an eligible claim at any time during the measurement period
IVD-2: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	1. Ages 18 and older 2. Have an eligible encounter during the measurement period 3. Have an acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) during the 12 months prior to the measurement period (as defined in coding documents), or have a diagnosis of ischemic vascular disease (IVD) during the measurement year
MH-1: Depression Remission at Twelve Months	1. Ages 19 and older 2. Have an eligible encounter during the denominator identification period (12/1/2016 to 11/30/2017) 3. Have a diagnosis of major depression or dysthymia 4. Does not meet any of the following exclusion criteria in the year prior to the measurement period: have a diagnosis of bipolar or personality disorder

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 (or 750 for PREV-13) (illustrated in Figure 1).

If, after this step, a measure has less than 616 beneficiaries (or 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 will rank the same beneficiary across measures when the beneficiary is eligible for multiple measures. Therefore, when it is possible, the beneficiaries in each sample will not be unique. This reduces the administrative burden for organizations by minimizing the total number of beneficiaries for whom data need to be collected.

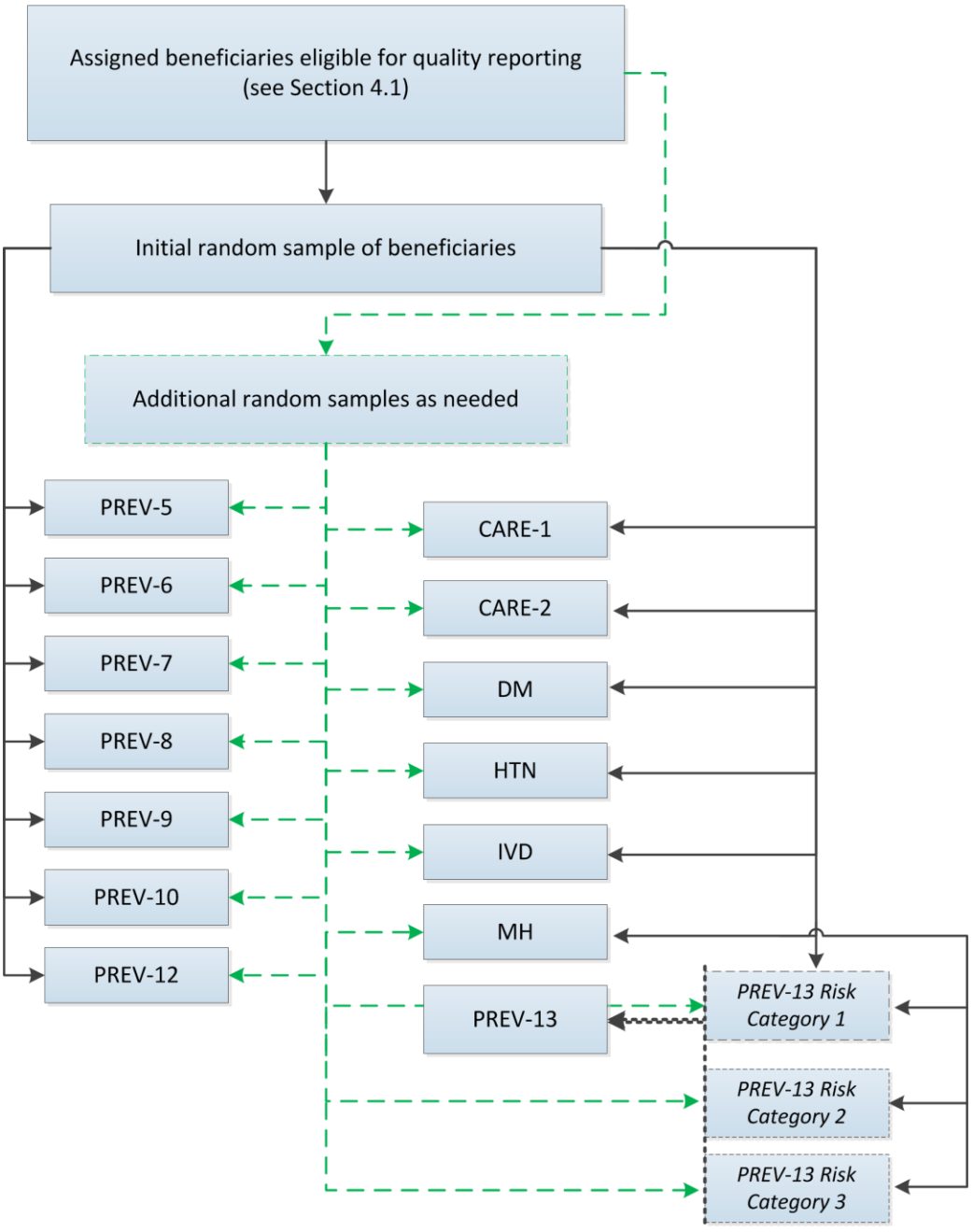
For all measures, beneficiaries will be assigned a rank between 1 and 616 (or 750 for PREV 13) based on the order in which they are populated in each measure-specific sample. Sampling for PREV 13 requires additional steps because the measure has three distinct risk categories that are used to determine denominator eligibility. To begin the sampling for PREV-13, each risk category will be represented separately, and beneficiaries will be assigned a rank between 1 and 250 for each risk category (in the same manner as the other measures). After each risk category has reached 250, the three 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. Additionally, CMS will attempt to evenly distribute the risk categories throughout the sample.

If an organization is unable to report data on a particular beneficiary, the organization must indicate a reason the data cannot be reported. The organization must not skip a beneficiary without providing a valid reason. The valid reasons are listed in the Web Interface measure specifications and 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. Therefore, a beneficiary with a low rank in one measure will likely have a low rank in other measures that he or she is eligible. The intent of this approach is to reduce reporting burden for the ACOs and groups.

Figure 1

Sampling Process



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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	
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
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[6] 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

6 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.