2024 CMS Web Interface Sampling Methodology for the 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 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.

SECTION 2

CMS Web Interface Quality Measures

For the 2024 performance year, ACOs 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 #	Measure Title
CARE-2	318	Falls: Screening for Future Fall Risk
DM-2	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
HTN-2	236	Controlling High Blood Pressure
MH-1	370	Depression Remission at Twelve Months
PREV-5	112	Breast Cancer Screening
PREV-6	113	Colorectal Cancer Screening
PREV-7	110	Preventive Care and Screening: Influenza Immunization
PREV-10	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PREV-12	134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
PREV-13	438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

For further information regarding any of the CMS Web Interface measures, please refer to the 2024 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.

[1] Under the APP, there are other reporting requirements in addition to the reporting of the 10 CMS Web Interface measures. Please review the 2024 APM Performance Pathway Toolkit (ZIP) for information regarding the APP reporting requirements.

SECTION 3

CMS Web Interface Quality Measure Reporting and Sample Size Requirements

An ACO electing to report via the CMS Web Interface will report on each of the 10 clinical quality measures. The CMS Web Interface will be prepopulated with patients who have been assigned to each ACO and will include demographic information for those patients. Using data from CMS claims and CMS Medicare enrollment and demographics, patients who meet the denominator and patient eligibility criteria will be selected for each measure sample. Selected patients are sampled into at least 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 ACOs, 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 ACO is required to report on all sampled patients. Each ACO 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 2024 performance year (January 1, 2024, through December 31, 2024), unless otherwise specified by the measure. For example, the PREV-7: Preventive Care and Screening: Influenza Immunization Measure collects data from the two discrete influenza seasons that occur over a given performance year.

If possible, an "oversample" will be provided for each measure. The CMS Web Interface allows an organization to remove ("skip") a beneficiary from the sample if he/she does not meet one or more of the quality sampling and/or measure-specific criteria. Therefore, oversampling is conducted so that each sample will include more patients than are needed to meet the reporting requirement of 248. For the 2024 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. There are denominator exclusion and exception criteria for certain measures that could prevent an ACO from meeting the sampling target for a measure. If the sampling target of 616 or 750 patients can't be met for a specific measure, then the sample for that measure will be smaller and will reflect all patients that meet the measure eligibility.

SECTION 4

CMS Web Interface Quality Measure Sampling Methodology

ACOs will use the CMS Web Interface to submit data on samples of the ACO's fee-for-service (FFS) Medicare patients. Each ACO'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 ACO based on the Shared Savings Program ACO assignment methodology.[2]

Using Medicare administrative data (i.e., claims data) from January 1, 2024, through October 31, 2024, CMS will exclude the following patients from quality measurement eligibility:

- Patients with fewer than 2 primary care services[3] within the ACO during the performance year.[4] [5]
- Patients with part-year eligibility in Medicare FFS Part A and Part B.
- Patients in hospice.
- Patients who are deceased.
- Patients who no longer reside in / moved out of 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, CMS determines if they are eligible for any of the specific quality measures based on the denominator criteria as outlined in the 2024 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 ACOs using medical record data via the CMS Web Interface.

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 your ACO review the measure specifications and supporting documents for each measure.

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[2] For the purpose of generating the CMS Web Interface Sample, the Shared Savings Program uses patients assigned in the third quarter of 2024. For information regarding Shared Savings Program patient assignment methodology, please review the Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications .

[3] 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 included in the definition of primary care services under the Shared Savings Program.

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

[5] 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 the Shared Savings Program, these claims are excluded if they have a corresponding Skilled Nursing Facility (SNF) stay.

Table 2. CMS Web Interface Sampling Methodology

Measure	Sampling Criteria[6]
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:[7] • Patients 66 years of age and older residing in a long-term care facility 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.
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 starting before and continuing into, or starting during the first six months of the measurement period. 3. Doesn't meet any of the following exclusion criteria:[7] • 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 a long-term care facility 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.

[6] 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. Note that this approach is consistent across measures for sampling purposes; while some measure specifications refer to using age on the date of the encounter, the sampling methodology still only accounts for age range eligibility at the measurement period level. 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 2024 measurement period, this is the patient's age as of January 1, 2024 (or in the case of the MH-1 measure, November 1, 2023). 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, 2024).

[7] 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[6]
MH-1: Depression Remission at Twelve Months	1. Ages 12 years and older. 2. Have an eligible encounter during the denominator identification period (November 1, 2022 to October 31, 2023). 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 41 to 74 years 2. Have at least one eligible encounter during the measurement period. 3. Doesn't meet the following exclusion criteria:[7] • Bilateral mastectomy • Patients age 66 and older residing in a long-term care facility 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/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.
PREV-6: Colorectal Cancer Screening	1. Ages 45 to 75 years 2. Have at least one eligible encounter during the measurement period. 3. Doesn't meet the following exclusion criteria:[7] • Patients with a diagnosis or past history of total colectomy or colorectal cancer. • Patients age 66 and older residing in a long-term care facility 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/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.
PREV-7: Preventive Care and Screening: Influenza Immunization	1. Ages 6 months and older. 2. Have at least one eligible encounter in the ACO during the measurement period and at least one encounter between January 1, 2024 and March 31, 2024 and/or between October 1, 2024 through December 31, 2024.
PREV-10: Preventive Care and Screening: Tobacco Use: Screening and	1. Ages 12 years and older. 2. Have at least 2 eligible encounters during the measurement period.

Measure	Sampling Criteria[6]
Cessation Intervention	
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 bipolar disorder.
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 diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD), including an ASCVD procedure. 3. For Population 2, patients aged 20 to 75 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 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

For 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 size of 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 ACOs.

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. For example, clinical information needed to apply exclusions may

not be available in claims data but need to be abstracted from the medical record. If an ACO is unable to report data on a patient at the time of abstraction, the ACO must indicate a reason the data can't be reported. The ACO 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
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
G2211	Complex Evaluation and Management Services Add-on*
G2212	Prolonged Office or other Outpatient Evaluation and Management (E/M) Service
Office-Based Opioid User Disorder Services	
G2086	Office-Based Opioid User Disorder Services, at least 70 minutes in the first calendar month*
G2087	Office-Based Opioid User Disorder Services, at least 60 minutes in a subsequent calendar month*
G2088	Office-Based Opioid User Disorder Services, each additional 30 min above 120 minutes*
Initial Nursing Facility Care	
99304	New or Established Patient, brief (use except when provided in a SNF)
99305	New or Established Patient, moderate (use except when provided in a SNF)
99306	New or Established Patient, comprehensive (use except when provided in a SNF)
Subsequent Nursing Facility Care	
99307	New or Established Patient, brief (use except when provided in a SNF)
99308	New or Established Patient, limited (use except when provided in a SNF)
99309	New or Established Patient, comprehensive (use except when provided in a SNF)

Code	Description
99310	New or Established Patient, extensive (use except when provided in a SNF)
Nursing Facility Discharge Services	
99315	New or Established Patient, brief (use except when provided in a SNF)
99316	New or Established Patient, comprehensive (use except when provided in a SNF)
Other Nursing Facility Services	
99318	New or Established Patient (use except when provided in a SNF)
G0317	Prolonged Nursing Facility Evaluation and Management Service
G0318	Prolonged Home or Residence Evaluation and Management Service
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

Code	Description
99350	Established Patient, extensive
Prolonged Services with Direct Patient Contact	
99354	Prolonged Services with Direct Patient Contact
99355	Prolonged Services with Direct Patient Contact
Health and Behavior Assessment/Intervention Procedure	
96160	Administration of Health Risk Assessment
96161	Administration of Health Risk Assessment
Caregiver Training	
96202	Caregiver Behavior Management Training*
96203	Caregiver Behavior Management Training*
97550	Caregiver Training Services*
97551	Caregiver Training Services*
97552	Caregiver Training Services*
Behavioral Health Integration and Care Management	
99484	General Behavioral Health Integration Care Management
Chronic Care Management	
99483	Assessment of and Care Planning for Patients with Cognitive Impairment
99424	Principal Care Management Service
99425	Principal Care Management Service
99426	Principal Care Management Service
99427	Principal Care Management Service
99437	Chronic Care Management Service
99439	Non-Complex Chronic Care Management Service
99487	Complex Chronic Care Management Service
99489	Complex Chronic Care Management Service
99490	Non-Complex Chronic Care Management Service
99491	Non-Complex Chronic Care Management Service
G2058	Non-Complex Chronic Care Management Service
G2064	Principal Care Management Service
G2065	Principal Care Management Service

Code	Description
G3002	Chronic Pain Management and Treatment
G3003	Chronic Pain Management and Treatment (additional 15 minutes)
Psychiatric Collaborative Care Management Services	
99492	Behavioral Health Integration Service
99493	Behavioral Health Integration Service
99494	Behavioral Health Integration Service
G2214	**Psychiatric Collaborative Care Model**
Transitional Care Management	
99495	Transitional Care Management Services
99496	Transitional Care Management Services
Advance Care Planning	
99497	Advance Care Planning (services identified by this code furnished in an inpatient setting are excluded)
99498	Advance Care Planning (services identified by this code furnished in an inpatient setting are excluded)
Community Health Integration Services	
G0019	Community Health Integration Services*
G0022	Community Health Integration Services*
Principal Illness Navigation Services	
G0023	Principal Illness Navigation Services*
G0024	Principal Illness Navigation Services*
Wellness Visits and Screenings	
G0402	Welcome to Medicare Visit
G0438	Annual Wellness Visit
G0439	Annual Wellness Visit
G0442	Annual Alcohol Misuse Screening Service
G0443	Annual Alcohol Misuse Counseling Service
G0444	Annual Depression Screening Service
G0101	Cervical or Vaginal Cancer Screening*
G0136	Social Determinants of Health Risk Assessment*

Code	Description
99406	Smoking and tobacco use cessation counseling visit: intermediate, greater than 3 minutes up to 10 minutes*
99407	Smoking and tobacco use cessation counseling visit: intensive, greater than 10 minutes*
Outpatient Services	
G0463	Hospital Outpatient Clinic Visit (for services furnished in ETA hospitals)
G0506	Chronic Care Management
Virtual Communication	
G2010	Remote Evaluation of Patient Video/Images
G2012	Virtual Check-In
Non-Face-to-Face On-Line Digital Evaluation and Management Services	
99421	Online Digital Evaluation and Management Service, 5-10 minutes
99422	Online Digital Evaluation and Management Service, 11-20 minutes
99423	Online Digital Evaluation and Management Service, 21 or more minutes
Primary Care Codes and Services	
99441	Telephone Evaluation and Management Services, 5-10 minutes (telephone evaluation and management) – while payable under Medicare Fee for Service payment policies
99442	Telephone Evaluation and Management Services, 11-20 minutes (telephone evaluation and management) – while payable under Medicare Fee for Service payment policies
99443	Telephone Evaluation and Management Services, 21-30 minutes (telephone evaluation and management) – while payable under Medicare Fee for Service payment policies
G2252	Communication Technology-Based Service (CTBS)

* New or modified HCPCS and CPT codes included in the definition of primary care services starting with the 2024 performance year.