Quality Payment
PROGRAM

2019 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 10 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 or a virtual group utilizing the CMS Web Interface. In this document, ACOs, groups, and virtual groups are collectively referred to as organizations. Each organization will be required to report on the same 10 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 Medicare Shared Savings Program and the Next Generation ACO Model have additional quality reporting requirements beyond the measures included in the CMS Web Interface.

Section 2

CMS Web Interface Quality Measures

For the 2019 performance year, organizations will use the CMS Web Interface to collect and submit clinical data on the following 10 individual measures. These measures span five measure categories: (Care Coordination and Patient Safety (CARE), Preventive Health (PREV), Mental Health (MH), Diabetes (DM), and Hypertension (HTN). Each measure is listed in the table below.

Table 1. CMS Web Interface Measures

Measure #	ACO #	NQF #	Measure Title
CARE-2	ACO-13	0101	Falls: Screening for Future Falls
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-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
DM-2	ACO-27	0059	Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%)
HTN-2	ACO-28	0018	Hypertension: Controlling High Blood Pressure
MH-1	ACO-40	0710	Depression Remission at Twelve Months

Note: N/A = Not Applicable.

For further information regarding any of the CMS Web Interface measures, please refer to the following:

The *2019 CMS Web Interface Measure Specifications and Supporting Documents*—located on the Quality Payment Program Resource Library webpage under the title 2019 CMS Web Interface Measure Specifications and Supporting Documents. 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 pre-populated with beneficiaries that have been assigned to each organization and will include demographic information for those beneficiaries. Using data located in CMS claims other CMS sources, beneficiaries will be selected for each measure sample who meet the denominator criteria and beneficiary eligibility. Beneficiaries 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 beneficiary's "rank," which indicates the order in which they were 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 beneficiaries for each measure. However, if the pool of eligible sampled beneficiaries is less than 248, then an organization is required to 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 2019 performance year (January 1, 2019 through December 31, 2019), 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 2018.

If possible, an "oversample" will be provided for each measure. This means that each sample will include more beneficiaries than are needed to meet the reporting requirement of 248. For the 2019 performance year, nine of the 10 measures may have an oversample of 616 beneficiaries. The PREV-13—Statin Therapy for the Prevention and Treatment of Cardiovascular Disease measure may have an oversample of 750 beneficiaries. Please note that the reporting requirement for consecutively ranked and confirmed Medicare beneficiaries remains at 248 for PREV-13 despite the larger sample size. If the sampling target of 616 or 750 beneficiaries cannot be met for any measure, it will have a smaller sample size that includes all beneficiaries 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 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, group, or virtual group based on current program rules. For ACOs, CMS will use beneficiaries assigned using the ACO assignment/alignment methodology.[1,2] For groups and virtual groups, CMS will use beneficiaries assigned using the MIPS assignment methodology.[3]

Using Medicare administrative data (e.g., claims data) from January 1, 2019, through October 31, 2019, CMS will exclude the following beneficiaries from quality measurement eligibility:

- Beneficiaries with fewer than two primary care services[4] within the organization, during the performance year.[5,6]
- 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 who are identified as eligible for quality measurement, we determine if they are eligible for any of the specific quality measures based on the denominator criteria as outlined in

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[1] The Shared Savings Program uses beneficiaries assigned in the third quarter of 2019. 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.

[2] 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-benchmarkmethodology-py4.pdf

[3] 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.

[4] As defined by the Healthcare Common Procedure Coding System (HCPCS) codes. See Appendices A and B for ACOs and Appendix A for MIPS group

[5] For the NGACO model and Shared Savings Program model, all claims billed on FQHC or RHC are considered primary care claims and will be included.

[6] In order to exclude services that were provided in a nursing home, al associated with designated HCPCS codes will be excluded from quality measurement eligibility. For the Next Generation ACO model and MIPS, Part B claims with designated HCPCS codes (see Appendix A) with a POS31 will be excluded. For the Shared Savings Program, these claims are excluded if they have a corresponding SNF stay.

the 2019 CMS Web Interface Measure Specifications and Supporting Documents. Due to limitations in the Medicare claims data, certain denominator exclusion and exception criteria must be applied to 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 measure specifications. It is recommended that your organization review the measure specifications and supporting documents for each measure.

Table 2. CMS Web Interface Sampling Methodology

Measure	Sampling Criteria
CARE-2 Falls: Screening for Future Falls	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 to74 years. 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 Place of Service (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 years. 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, group, or virtual group during the measurement period and at least one encounter between October 1, 2018 and March 31, 2019 (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 two eligible encounters during the measurement period.

Measure	Sampling Criteria
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.
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 Atherosclerotic Cardiovascular Disease (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.
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.
HTN-2: Hypertension: 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 End-Stage Renal Disease (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.
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, 2017 to October 31, 2018). 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

A random sample of 900 beneficiaries is selected for quality measurement (as defined in Section 4.1) and populated into the samples for measures for which they are eligible until a sample size of 616 (or 750 for PREV-13) (illustrated in Figure 1) is reached for each measure.

If a measure has fewer than 616 beneficiaries (or 750 for PREV-13) after this step, CMS will select additional eligible beneficiaries until the measure has the required 616 (or 750 for PREV-13) or until there are no additional eligible beneficiaries available. When the beneficiary is eligible for multiple measures, they will be included in multiple measures. Although this sampling methodology does not guarantee that beneficiaries will have the same numeric 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, groups, and virtual groups.

For all measures, beneficiaries will be assigned a rank number between 1 and 616 (or 750 for PREV 13) based on the order they are populated into each measure sample. Identifying beneficiaries for the PREV 13 measure requires additional steps as a result of the three distinct risk categories used to determine denominator eligibility. To begin the sampling for PREV-13, each risk category is considered separately, and beneficiaries 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 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.

For some measures and for some exclusions, CMS has applied exclusion criteria during the sampling process. However, exclusions are not always applied during sampling, because sometimes, it is not possible to do with claims data. If an organization is unable to report data on a beneficiary at the time of abstraction, the organization must indicate a reason the data cannot be reported. The organization must not skip a beneficiary 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 as well.

APPENDIX A.

PRIMARY CARE CODES USED FOR DETERMINING QUALITY ELIGIBILITY

Code	Description	Programs Using this Code
Office or other outpatient services		
99201	New patient, brief	SSP, NGACO, MIPS
99202	New patient, limited	SSP, NGACO, MIPS
99203	New patient, moderate	SSP, NGACO, MIPS
99204	New patient, comprehensive	SSP, NGACO, MIPS
99205	New patient, extensive	SSP, NGACO, MIPS
99211	Established patient, brief	SSP, NGACO, MIPS
99212	Established patient, limited	SSP, NGACO, MIPS
99213	Established patient, moderate	SSP, NGACO, MIPS
99214	Established patient, comprehensive	SSP, NGACO, MIPS
99215	Established patient, extensive	SSP, NGACO, MIPS
Initial nursing facility care		
99304	New or established patient, brief (use except when provided in a SNF)*†	SSP, NGACO, MIPS
99305	New or established patient, moderate (use except when provided in a SNF)* †	SSP, NGACO, MIPS
99306	New or established patient, comprehensive (use except when provided in a SNF)* †	SSP, NGACO, MIPS
Subsequent nursing facility care		
99307	New or established patient, brief (use except when provided in a SNF)* †	SSP, NGACO, MIPS
99308	New or established patient, limited (use except when provided in a SNF)* †	SSP, NGACO, MIPS
99309	New or established patient, comprehensive (use except when provided in a SNF)* †	SSP, NGACO, MIPS
99310	New or established patient, extensive (use except when provided in a SNF)* †	SSP, NGACO, MIPS

Code	Description	Programs Using this Code
Nursing facility discharge services		
99315	New or established patient, brief (use except when provided in a SNF)* †	SSP, NGACO, MIPS
99316	New or established patient, comprehensive (use except when provided in a SNF)* †	SSP, NGACO, MIPS
Other nursing facility services		
99318	New or established patient (use except when provided in a SNF)* †	SSP, NGACO, MIPS
Domiciliary, rest home, or custodial care services		
99324	New patient, brief	SSP, NGACO, MIPS
99325	New patient, limited	SSP, NGACO, MIPS
99326	New patient, moderate	SSP, NGACO, MIPS
99327	New patient, comprehensive	SSP, NGACO, MIPS
99328	New patient, extensive	SSP, NGACO, MIPS
99334	Established patient, brief	SSP, NGACO, MIPS
99335	Established patient, moderate	SSP, NGACO, MIPS
99336	Established patient, comprehensive	SSP, NGACO, MIPS
99337	Established patient, extensive	SSP, NGACO, MIPS
Domiciliary, rest home, or home care plan oversight services		
99339	Brief	SSP, NGACO, MIPS
99340	Comprehensive	SSP, NGACO, MIPS
Home services		
99341	New patient, brief	SSP, NGACO, MIPS
99342	New patient, limited	SSP, NGACO, MIPS
99343	New patient, moderate	SSP, NGACO, MIPS
99344	New patient, comprehensive	SSP, NGACO, MIPS
99345	New patient, extensive	SSP, NGACO, MIPS
99347	Established patient, brief	SSP, NGACO, MIPS
99348	Established patient, moderate	SSP, NGACO, MIPS

Code	Description	Programs Using this Code
99349	Established patient, comprehensive	SSP, NGACO, MIPS
99350	Established patient, extensive	SSP, NGACO, MIPS
99354	Prolonged Services with Direct Patient Contact*	SSP, NGACO
99355	Prolonged Services with Direct Patient Contact*	SSP, NGACO
96160	Administration of Health Risk Assessment (Telehealth)*	SSP
96161	Administration of Health Risk Assessment (Telehealth)*	SSP
99484	General Behavioral Health Integration 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, NGACO, MIPS
99492	Behavioral Health Integration*	SSP
99493	Behavioral Health Integration*	SSP
99494	Behavioral Health Integration*	SSP
99495	Transitional Care Management Services within 14 days of discharge	SSP, NGACO, MIPS
99496	Transitional Care Management Services within 7 days of discharge	SSP, NGACO, MIPS
99497	Advance Care Planning*	SSP, NGACO
99498	Advance Care Planning*	SSP, NGACO
Wellness visits		
G0402	Welcome to Medicare visit	SSP, NGACO, MIPS
G0438	Annual wellness visit	SSP, NGACO, MIPS
G0439	Annual wellness visit	SSP, NGACO, MIPS
G0442	Annual Alcohol Misuse Screening*	SSP, NGACO
G0443	Annual Alcohol Misuse Counseling*	SSP
G0444	Annual Depression Screening*	SSP, NGACO

Code	Description	Programs Using this Code
New G code for outpatient hospital claims		
G0463	Hospital Outpatient Clinic Visit (refer to note below)	SSP, MIPS
G0506	Chronic Care Management*	SSP, NGACO

*For SSP, Indicates new or modified CPT codes included in the definition of primary care services starting in PY19

†For MIPS and the NGACO model, Part B claims will not be used if these codes are in the claim with POS code 31.