2017 CMS Web Interface Reporting

Keys to Successful Reporting Part 1 – Measures Refresher

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Medicare Shared Savings Program and Next Generation ACO Model

DISCLAIMER

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Accessing Slides

- Shared Savings Program ACOs:
  - Please login to the ACO Portal (https://portal.cms.gov) and click on today's event.
    - ACO contacts maintained in the Health Plan Management System (HPMS) have access to the SSP Portal and receive the ACO Spotlight newsletter.
    - If you do not have access to the Portal, please work with your ACO to obtain the quality webinar slides and the ACO Spotlight newsletter for quality updates and webinar announcements.

- Next Generation ACOs:
  - Connect site: https://app.innovation.cms.gov/NGACOConnect

Agenda

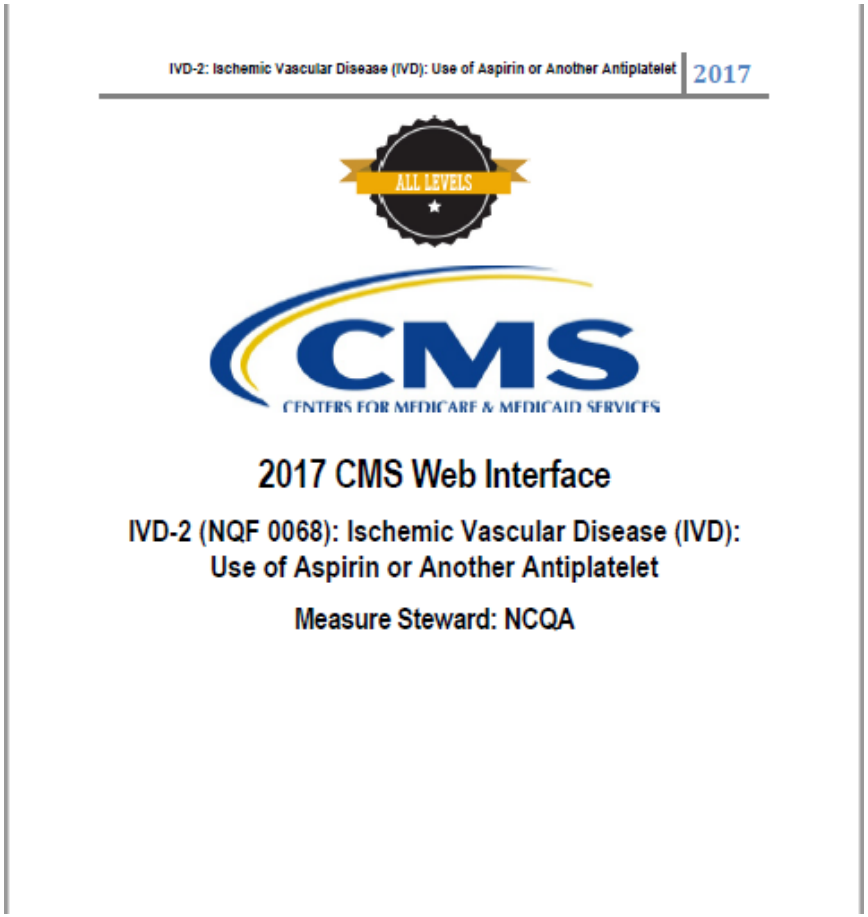
- Measure Documents
- Performance Year (PY) 2017

  CMS Web Interface Measures
  - CARE-1
  - CARE-2
  - DM-2
  - DM-7
  - HTN-2
  - IVD-2
  - MH-1
- Quality Measures Validation Audit
- Resources
- Questions

Measure Documents

- Measure Specification Document
- Coding Document

Measure Specification Document



IVD-2: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet 2017

ALL LEVELS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2017 CMS Web Interface

IVD-2 (NQF 0068): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Measure Steward: NCQA

Coding Document

2017 CMS WEB INTERFACE DOWNLOADABLE RESOURCE
IVD Encounter Codes

Module Type	Module Indicator GPRO	Variable Name	Code System	Code	Code Description
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99201	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99202	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99203	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99204	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99205	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99212	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99213	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99214	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99215	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99341	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99342	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99343	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99344	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99345	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99347	For CMS sampling use only
IVD	IVDConfirm	ENCOUNTER_CODE	C4	99348	For CMS sampling use only

'age | Copyright&Disclaimer | EncounterCodes | DenominatorExclusionDrugCodes | DenominatorCodes | NumeratorDrugCodes | ⊕

PY 2017 CMS Web Interface Measures

- List of Measures
- Review of:
  - CARE-1
  - CARE-2
  - DM-2
  - DM-7
  - HTN-2
  - IVD-2
  - MH-1

2017 CMS Web Interface Measures (1 of 2)

List of Measures
CARE-1 (ACO-12): Medication Reconciliation Post- Discharge
CARE-2 (ACO-13): Falls: Screening for Future Fall Risk
DM-2 (ACO-27): Diabetes: Hemoglobin A1c Poor Control (>9%)*
DM-7 (ACO-41): Diabetes: Eye Exam*
HTN-2 (ACO-28): Controlling High Blood Pressure
IVD-2 (ACO-30): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
MH-1 (ACO-40): Depression Remission at Twelve Months

* DM composite (all or nothing scoring)

2017 CMS Web Interface Measures (2 of 2)

List of Measures
PREV-5 (ACO-20): Breast Cancer Screening
PREV-6 (ACO-19): Colorectal Cancer Screening
PREV-7 (ACO-14): Preventive Care and Screening: Influenza Immunization
PREV-8 (ACO-15): Pneumococcal Vaccination Status for Older Adults
PREV-9 (ACO-16): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
PREV-10 (ACO-17): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PREV-12 (ACO-18): Preventive Care and Screening: Screening for Depression and Follow-Up Plan
PREV-13 (ACO-42): Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Definitions of Time Periods

Performance Year: Calendar Year 2017 (January 1 – December 31, 2017)

Measurement Period: Calendar Year 2017

Look-back Periods:

- DM-7: Calendar Year 2016 (stated as “performed the year prior to the measurement period”)
- IVD-2: Calendar Year 2016 (AMI, CABG or PCI in twelve months prior to measurement period)
- MH-1: December 1, 2015 – November 30, 2016 (Index Date for the PHQ-9 greater than 9); eleven to thirteen month window (PHQ-9 less than 5) dependent on the Index Date

CARE-1

Measure Description: The percentage of discharges from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record.

Denominator Exclusions: None
Denominator Exceptions: None

This is a new measure for PY 2017 reporting (previously used for reporting in 2014).

CARE-1 Documentation

- Verification of each prefilled discharge date (+/- 2 days)
- Evidence of medication reconciliation and the date on which it was performed (within 30 days of the prefilled inpatient discharge date). Documentation of any of the following evidence meets the medication reconciliation criteria:
  - current medications with a reference to the discharge medications (e.g., no changes in meds since discharge, same meds at discharge, discontinue all discharge meds);
  - patient's current medications with a notation that the discharge medications were reviewed;
  - evidence the provider "reconciled the current and discharge meds";
  - current medication list, a discharge medication list, and notation that the appropriate practitioner type reviewed both lists on the same date of service; or
  - notation that no medications were prescribed or ordered upon discharge.

CARE-1 Audit Example

Beneficiary Information	Discharge Date	Discharge Date Confirmed +/- 2 days	Office Visit in 30 Days	Medication Reconciliation
Patient 1	08/08/2017	Yes	Yes	Yes
Patient 1	06/02/2017	~~No~~	-	-
Patient 1	03/15/2017	~~Yes~~	~~No~~	-
Patient 2	07/14/2017	~~Yes~~	~~No~~	-
Patient 2	10/02/2017	Yes	Yes	Yes

CARE-1 Measure Logic

Confirm Patient Qualified Options

- **Yes** (continue to Each Discharge from Inpatient Facility Options)
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from CARE-1 sample (skipped) and replaced with another patient]

Each Discharge from Inpatient Facility Options

- **No** (discharge not included in the denominator)
- **Yes** (continue to Seen Within 30 Days of Each Discharge Options)

Seen Within 30 Days of Each Discharge Options

- **No** (discharge not included in the denominator)
- **Yes** (discharge included in the denominator – continue to Medications Reconciled Each Discharge Options)

Medications Reconciled Each Discharge Options

- **No** (discharge not included in numerator)
- **Yes** (discharge included in numerator)

CARE-2

Measure Description: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Denominator Exclusions: None

Denominator Exceptions: Medical reasons

Changes: Added gait or balance assessment as meeting the numerator in addition to screening for history of falls.

CARE-2 Documentation

- The date on which the screening occurred

  and

- Documentation of whether the patient has been assessed for a history of falls or any fall with injury. Documentation of no falls is sufficient. Gait or balance assessment meets the intent of the measure;

  or

- Documentation of the reason why the Quality Action is not performed due to a medical reason exception. The exception for this measure is when the patient is non-ambulatory (count as non-ambulatory only if patient is non-ambulatory at the most recent encounter during the measurement period).

CARE-2 Audit Example

Beneficiary Information	Fall Risk Screen
Patient 1	Yes
Patient 2	Yes
Patient 3	Medical Reason

CARE-2 Measure Logic

Confirm Patient Qualified Options

- **Yes** (patient included in the denominator – continue to Screening for Future Fall Risk)
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from CARE-2 sample (skipped) and replaced with another patient]

Screening for Future Fall Risk Options

- **No** (patient does not meet numerator criteria)
- **Yes** (patient meets numerator criteria)
- **No - Denominator Exception - Medical Reasons** (patient removed from denominator)

Diabetes Composite

- Components of the Composite Measure
  - DM-2 (ACO-27): Diabetes: Hemoglobin A1c Poor Control (>9%)
  - DM-7 (ACO-41): Diabetes: Eye Exam

- All or Nothing Scoring
  - For a detailed description of the calculation of this measure see Appendix I of the Diabetes Composite measure specification

DM-2

Measure Description: Percentage of patients 18 – 75 years of age with diabetes who had hemoglobin A1c greater than 9.0% during the measurement period.

Denominator Exclusions: None

Denominator Exceptions: None

Changes: None

DM-7

Measure Description: Percentage of patients 18 – 75 years of age with diabetes who had retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

Denominator Exclusions: None

Denominator Exceptions: None

Changes: None

Diabetes Composite Documentation

- A diagnosis of diabetes (active or history of) during the measurement period or year prior to the measurement period;

  and

- The date and value of the most recent HbA1c test performed during the measurement period;

  and

- Evidence that a retinal or dilated eye exam was performed by an eye care processional and the date it was performed during the measurement period. If a retinal or dilated eye exam was not performed during the measurement period but was performed the year prior to the measurement period and the results were negative, the date and result of that eye exam;

  or

- If retinal imaging was performed, the date imaging was performed and evidence that it was reviewed by an eye care professional.

Diabetes Composite Audit Example

Beneficiary Information	Denominator Confirmation	HbA1c Test	Date HbA1c Test	HbA1c Value	Retinal Eye Exam
Patient 1	Yes	Yes	06/24/2017	7.5	Yes
Patient 2	Yes	Yes	05/14/2017	9.1	Yes
Patient 3	Yes	Yes	09/09/2017	8.0	~~No~~

DM-2 Measure Logic

Confirm History or Active Diagnosis of Diabetes Options

- **Yes** (patient included in the denominator – continue to HbA1c Test)
- **Not Confirmed-Diagnosis** [stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]

HbA1c Test Options

- **No** (patient meets numerator criteria)
- **Yes**
  - enter most recent HbA1c date
  - enter most recent HbA1c value

NOTE: Patient with value greater than 9.0% OR no test performed OR missing value meets numerator criteria. Patient with value equal to or less than 9.0% does not meet numerator criteria.

DM-7 Measure Logic

Confirm History or Active Diagnosis of Diabetes Options

- **Yes** (patient included in the denominator – continue to Eye Exam)
- **Not Confirmed-Diagnosis** [stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from DM sample (skipped) and replaced with another patient]

Eye Exam Options

- **No** (patient does not meet numerator criteria)
- **Yes** (patient meets numerator criteria)

HTN-2 (1 of 2)

Measure Description: Percentage of patients 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement period.

Denominator Exclusions:

- Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period
- Patients with a diagnosis of pregnancy during the measurement period
- Patients 65 and older in SNP or residing in LTC with POS codes 32, 33, 34, 54 or 56 any time during the measurement period

Denominator Exceptions: None

HTN-2 (2 of 2)

Changes: The measure owner, NCQA added an exclusion to this measure after the measure specification was posted. A revised measure specification will be posted.

- The **exclusion is for patients age 65 and older in Institutional Special Needs Plans or residing in Long-Term Care** with a Place of Service Code 32, 33, 34, 54 or 56 any time during the measurement period
- The intent of the exclusion for individuals age 65 and older residing in long-term care facilities, including nursing homes, is to **exclude individuals who may have limited life expectancy and increased frailty** where the benefits of the process may not exceed the risks
- This exclusion is **not intended as a clinical recommendation** regarding whether the measures process is inappropriate for specific populations, instead the exclusions **allows clinicians to engage in shared decision making with patients** about the benefits and risks of screening when an individual has limited life expectancy

HTN-2 Documentation

- A diagnosis of essential hypertension within the first six months of the measurement period or at any time prior to the measurement period (prior to 6/30/2017);

  and

- The date and value of the most recent systolic and diastolic blood pressure readings during the measurement period. If there are multiple blood pressure readings on the same date of service, use the lowest systolic and lowest diastolic reading as the most recent blood pressure reading;

  or

- Documentation of exclusion criteria.

HTN-2 Audit Example

Beneficiary Information	Denominator Confirmation	BP Documented	BP Date	Systolic BP	Diastolic BP
Patient 1	Yes	Yes	08/08/2017	128	66
Patient 2	Denominator Exclusion	-	-	-	-
Patient 3	Yes	Yes	10/11/2017	152	96

HTN-2 Measure Logic

Confirm Diagnosis of Essential Hypertension Options

- **Yes** (patient included in the denominator – continue to Blood Pressure Measurement)
- **Not Confirmed - Diagnosis** [stop abstraction – patient removed from HTN sample (skipped) and replaced with another patient]
- **Denominator Exclusion** [stop abstraction – patient removed from HTN sample (skipped) and replaced with another patient]
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from HTN sample (skipped) and replaced with another patient]

Blood Pressure Documented Options

- **No** (patient does not meet numerator criteria)
- **Yes**
  - enter most recent systolic and diastolic blood pressure date
  - enter most recent systolic and diastolic blood pressure values

NOTE: Patient with values less than 140 and less than 90 meets numerator criteria. Patient with values greater than or equal to 140 or greater than or equal to 90 does not meet numerator criteria.

IVD-2 (1 of 2)

Measure Description: Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.

Denominator Exclusions: Patients who had documentation of use of anticoagulant medications overlapping the measurement year

Denominator Exceptions: None

IVD-2 (2 of 2)

Changes: The measure's title changed from "Use of Aspirin or Another Antithrombotic" to "Use of Aspirin or Another Antiplatelet."

An exclusion for anticoagulant use has also been included in the measure. This use needs to occur at some point in the measurement year.

IVD-2 Documentation

- An active diagnosis of ischemic vascular disease during the measurement period or diagnosed with AMI, CABG or PCI during the 12 months prior to the measurement period;

  and

- An active prescription for aspirin or another antiplatelet anytime during the measurement period;

  or

- Documentation of exclusion criteria.

IVD-2 Audit Example

Beneficiary Information	Denominator Confirmation	Aspirin/Antiplatelet Therapy
Patient 1	Denominator Exclusion	-
Patient 2	Yes	Yes
Patient 3	Yes	Yes

IVD-2 Measure Logic

Confirm Active Diagnosis of Ischemic Vascular Disease or Patient Diagnosed with AMI, CABG or PCI Options

- **Yes** (patient included in the denominator – continue to Aspirin/Antiplatelet Therapy)
- **Not Confirmed-Diagnosis** [stop abstraction – patient removed from IVD sample (skipped) and replaced with another patient]
- **Denominator Exclusion** [stop abstraction – patient removed from IVD sample (skipped) and replaced with another patient]
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from IVD sample (skipped) and replaced with another patient]

Aspirin/Antiplatelet Therapy Options

- **No** (patient does not meet numerator criteria)
- **Yes** (patient meets numerator criteria)

MH-1

Measure Description: Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

Denominator Exclusions: Permanent nursing home residents or active diagnosis of bipolar or personality disorder (can occur anytime during the denominator identification measurement period or the measurement assessment period).

Denominator Exceptions: None

Changes: None

MH-1 Documentation

- A diagnosis of major depression or dysthymia;

  and

- A PHQ-9 score *greater than* 9 between 12/1/2015 and 11/30/2016;

  and

- A follow-up PHQ-9 score *less than* 5 at 12 months (+/- 30 days) after the initial PHQ-9 score *greater than* 9. If there is more than one PHQ-9 score obtained between the 11 and 13 month window, select the most recent PHQ-9 date and score within that window;

  or

- Documentation of exclusion criteria.

MH-1 Audit Example

Beneficiary Information	Denominator Confirmation	Index PHQ-9 Performed (12/1/2015-11/30/2016)	PHQ-9 Score > 9	Date
Patient 1	Yes	Yes	Yes	12/02/2015
Patient 2	Yes	Yes	Yes	07/30/2016
Patient 3	Yes	Yes	Yes	10/10/2016

Value	Assessment PHQ-9 Performed (11-13 Months from Index PHQ-9)	PHQ-9 Score < 5	Date	Value
15	Yes	Yes	12/22/2016	3
11	Yes	Yes	07/01/2017	4
18	Yes	Yes	11/01/2017	4

MH-1 Measure Logic (1 of 2)

Confirm Active Diagnosis of Major Depression or Dysthymia Options

- **Yes** (continue to Index PHQ-9 administered)
- **Not Confirmed - Diagnosis** [stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]
- **Denominator Exclusion** [stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]
- **No - Other CMS Approved Reason** [requested through help desk ticket – if CMS approval received, stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]

Index PHQ-9 Administered Options

- **No** [stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]
- **Yes** (continue to PHQ-9 Score >9)

MH-1 Measure Logic (2 of 2)

Index PHQ-9 Score >9 Options

- **No** [stop abstraction – patient removed from MH-1 sample (skipped) and replaced with another patient]
- **Yes** (patient included in the denominator – continue to Assessment PHQ-9 administered)
  - enter the date of the first PHQ-9 score greater than 9
  - enter the score of the first PHQ-9

Assessment PHQ-9 Administered Options

- **No** (patient does not meet numerator criteria)
- **Yes** (continue to Assessment PHQ-9 <5)

Assessment PHQ-9 <5 Options

- **No** (patient does not meet numerator criteria)
- **Yes** (patient meets numerator criteria)
  - enter the date of the most recent PHQ-9 score less than 5
  - enter the score of the most recent PHQ-9

Quality Measures Validation Audit

Quality Measures Validation Audit (1 of 7)

Shared Savings Program Only:

- The Quality Measures Validation (QMV) audit
  - Provides an opportunity to identify areas that need education and outreach
  - Ensures ACOs are fulfilling their obligation to completely and accurately report clinical quality information
- CMS Regulatory Authority
  - In the November 2011 final rule, the Shared Savings Program finalized a proposal to retain the right to validate the data ACOs enter into the Web Interface (76 FR 67893 through 67894).
  - Refinements to the audit methodology were made in the 2017 and 2018 Physician Fee Schedule (PFS) final rules.

Quality Measures Validation Audit (2 of 7)

Shared Savings Program Only:

- A subset of Shared Savings Program ACOs will be selected for the QMV audit and will be notified after the CMS Web Interface submission period ends. If your ACO is selected…
  - CMS will provide a sample of 200 beneficiaries
  - You must submit medical record documentation that corresponds with the data entered into the Web Interface; and if applicable, written explanations of any anomalous data entry patterns identified by CMS
  - You will be audited on 4 or 5 CMS Web Interface measures, as determined by CMS
- Results of the audit may impact the quality score if the ACO's match rate is below 80% for the audit

Quality Measures Validation Audit (3 of 7)

Shared Savings Program Only:

- CMS will calculate a "match rate" for each selected Shared Savings Program ACO
- A "match" is when the medical record documentation adequately supports the Web Interface data

$$Match\ Rate = 100 * \frac{Number\ of\ Matches}{Number\ of\ Audited\ Records}$$

  - Match Rate ≥ 80% = Audit Pass
  - Match Rate < 80% = Audit Fail

Quality Measures Validation Audit (4 of 7)

Next Generation ACO Model Only:

- All Next Generation ACOs will be audited.
  - 2016 cohort: Results for the audit may impact the quality score for 2017 if the ACO's match rate is below the match rate considered passing for the audit.
  - 2017 cohort: Results of the audit will NOT impact the quality score for 2017. Results will be used for education and outreach.
- **Sample:** CMS will provide a sample of 200 beneficiaries
- **Measures:** You will be audited on 4 or 5 CMS Web Interface measures, as determined by CMS
- **Webinar:** 2017 NGACO Audit Methodology webinar will be offered in early December. The webinar will focus on the 2017 audit methodology for the Next Generation ACOs.

Quality Measures Validation Audit (5 of 7)

- What is a data anomaly?
  - Data anomalies are patterns of data entry exhibited by an ACO that are considered outliers from the patterns we see across all ACOs.
  - For example, an ACO is selecting “Medical Record Not Found” at a rate that is significantly higher than the rate of that selection across all ACOs.
- If CMS identifies anomalous data entry patterns, overall or for specific measures, your ACO may be required to submit a written explanation.
- A written explanation helps CMS (1) understand the unique circumstances of your ACO, and (2) identify opportunities for CMS to provide additional education and support.

Quality Measures Validation Audit (6 of 7)

- The following documentation requirements are generally applicable:

Documentation Requirements Applicable to All Measures	
Not Qualified for Sample	Specific reason a patient is not eligible for the sample (i.e., death, hospice, non-US resident, or HMO enrollment) in the medical record.
Other CMS Approved Reason	The Quality Payment Program Service Desk Inquiry Number with Response

Quality Measures Validation Audit (7 of 7)

For each measure audited:

- Documentation provided for the audit should be consistent with the documentation used to support the CMS Web Interface data submission
- Documentation should substantiate the following for each record, as applicable:
  - Denominator criteria, including confirmation of a diagnosis, if applicable (CMS does identify diagnoses with claims data, but ultimately the diagnosis must be confirmed with medical record documentation.

  Exclusions
  - Numerator criteria (i.e., that the beneficiary met the measure)
  - Exceptions (i.e., medical, patient or system reasons for removing the beneficiary from the denominator)

Resources

- Newsletters
- Specifications
- Websites and Portals
- Mailboxes and Help Desks

Newsletters

- **Newsletters provide announcements for:**
  - Important program information
  - Upcoming deadlines
  - Upcoming webinars

- **Spotlight Newsletter for Shared Savings Program ACOs**
  - Sent to contacts listed in HPMS

- **Next Generation ACO Newsletter**
  - Sent to ACO Executives, Primary Contacts, and any other ACO-designated Newsletter/Briefing contacts

Specifications

2017 Reporting Year Documentation

- 2017 Reporting Year Narrative Specifications [PDF, 476KB] . This document contains the 2017 narrative specifications for the 31 quality measures.
- CMS Web Interface Measures
  - Visit the Quality Payment Program Resource Library for the CMS Web Interface measure documentation. The "Web Interface Measures" zip file is located in the Quality section, under "2017 Quality Measure Specifications".

Websites and Portals

- **Shared Savings Program website**
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html
- **Shared Savings Program ACO Portal**
  - https://portal.cms.gov
- **Next Generation ACO Model Website**
  - https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
- **Next Generation ACO Connect Site**
  - https://app.innovation.cms.gov/NGACOConnect

Mailboxes and Help Desks

- Medicare Shared Savings Program
  - E-mail: SharedSavingsProgram@cms.hhs.gov

- For questions related to the Quality Payment Program, CMS Web Interface, Measures, and EIDM
  - Email: qpp@cms.hhs.gov
  - Phone: (866) 288-8292
  - Monday – Friday, 8 a.m. – 8 p.m. ET

- Next Generation Model
  - Email: NextGenerationACOModel@cms.hhs.gov

QUESTIONS?

Thank you for your participation!