2013 Group Practice Reporting Option (GPRO) Web Interface Support Call

Q&A Sessions

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Purpose

This document is intended for group practices who self-nominated/registered and are participating in the 2013 Physician Quality Reporting System (PQRS) through the group practice reporting option (GPRO) and for Medicare Accountable Care Organization (ACO), including the Medicare Shared Savings Program (Shared Savings Program or SSP) and the Pioneer ACO Model.

The Centers for Medicare and Medicaid Services (CMS) will invite group practices participating through the 2013 PQRS GPRO, SSP ACO and Pioneer ACO programs to attend a series of support calls via webinar to provide educational support on various GPRO Web Interface-related topics. During the 2013 GPRO Support Calls, CMS will provide groups the opportunity to submit questions during the Question & Answer (Q&A) session, allowing CMS to answer the questions during the meeting. This document provides cumulative questions and answers from all of the 2013 GPRO Support Call Q&A sessions with CMS in addition to frequently asked questions (FAQs) from the 2012 submission period that are relevant to the 2013 PQRS submission. This document should be used for reference by group practices participating in the 2013 PQRS GPRO, SSP ACO and Pioneer ACO programs.

This document contains questions and answers from the Q&A sessions of the following 2013 GPRO Support Calls:

11/7/2013 – Topic: GPRO Measures Specifications / Supporting Documents
12/5/2013 – Topic: Web Interface Support Call
12/12/2013 – Topic: XML Training
1/9/2014 – Topic: Web Interface Training
1/16/2014 – Topic: Questions and Answers Session

Pre-recorded webinars about the following GPRO topics can be accessed any time on the CMS YouTube site, http://go.cms.gov/GPROPlaylist:

- 2013 PQRS GPRO 101 Part 1
- 2013 PQRS GPRO 101 Part 2
- 2013 PQRS GPRO Which Reporting Method? Part 1
- 2013 PQRS GPRO Which Reporting Method? Part 2
- 2013 PQRS GPRO Value-Based Payment Modifier
- 2013 PQRS Group Practice Measures Overview
- 2013 PQRS GPRO Public Reporting
- 2013 PQRS GPRO and ACO Web Interface Submission -- IACS
- 2013 PQRS GPRO and ACO Web Interface Measure Specifications/ Supporting Documents Part 1
- 2013 PQRS GPRO and ACO Web Interface Measure Specifications/ Supporting Documents Part 2
- 2013 PQRS GPRO and ACO Web Interface Measure Specifications/ Supporting Documents Part 3
- 2013 PQRS GPRO and ACO Web Interface Assignment and Sampling
- 2013 PQRS GPRO and ACO CAHPS Overview
- 2013 ACO/PQRS GPRO Web Interface Overview

User guides for the Web Interface are available on the **Physician and Other Health Care Professionals Quality Reporting Portal** (Portal), direct link http://www.qualitynet.org/pqrs:

- 2013 PQRS/ACO GPRO Web Interface User Manual
    - This guide provides information on how to access the Web Interface, how to set accessibility preferences, and how to customize the Web Interface by selecting the default page and modules.

    - The Introduction page for the 2013 PQRS/ACO GPRO Web Interface User Manual contains a link to a PDF version of the Quick Start User Guide
    - The Introduction page for the 2013 PQRS/ACO GPRO Web Interface User Manual also contains and a link to the GPRO Web Interface Online Help

- The GPRO Web Interface Online Help provides information on using the Web Interface including how to enter measure data, generating reports, and submitting data to CMS.
    - The Welcome page for the GPRO Web Interface Online Help contains a link for a PDF version of the GPRO Web Interface Online Help.
    - The online help may also be accessed during the submission period from the Web Interface.

2013 GPRO SUPPORT CALLS Q&A AND FAQ

IACS

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	Can the individual who has PQRS security official role also have a submitter role? I am a team of one person.	No – Security Official cannot have PQRS Submitter role. It is possible to transfer Security Official role to another person in your organization.	X	X	X
2	11/7/2013	When will authorization roles be available?	Once your Organization's Security Official and your account with the PQRS Submitter role is setup within IACS, you can request your application role of GPRO Submission 2013 role /ACO Submission 2013 within the PQRS Portal at https://qualitynet.org/pqrs. The GPRO Submission 2013 and ACO Submission 2013 application roles will be available on November 18, 2013.	X	X	X
3	11/7/2013	What is the difference between a PQRS Submitter and an ACO Submission 2013 role? Can they be the same person?	Yes, they need to be the same person. Need both roles in order to login to the Web Interface. The PQRS Submitter role is requested in IACS. Once that role is obtained and it is 11/18/2013 or later the QRMS role of ACO Submission 2013 may be requested. The ACO Submission 2013 role is requested in the PQRS Portal Roles Management application.	X	X	X
4	11/7/2013	I have a PQRS Submitter role but need to request the GPRO Submission 2013 Role (GPRO). However, when I log into my account, I do not see that role in the drop-down list to choose. Where do I go to request the GPRO Submission 2013 role?	You don't login to the IACS link for the GPRO submission role. The GPRO Submission 2013 role is requested in the PQRS Portal Roles Management application (https://qualitynet.org/pqrs) in the PQRS Portal. Please see the YouTube video on IACS accounts for more information.	X	NA	NA
5	11/7/2013	I utilize temp staff for this project and they will not be identified by Dec 2 to be able to initiate their IACS account request. Is that an issue?	As long as you have your Security Official set up by **December 2, 2013**, when you bring in temp staff, you should be able to get them on board quickly.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
6	11/7/2013	In addition to an IACS account, do we need to get a QualityNet account?	No, you do not need a QualityNet account. You just need an IACS account with the PQRS Submitter role and the ACO or GPRO Submission 2013 role.	X	X	X
7	11/7/2013	Is the PV-PQRS role the same as the GPRO submission 2013 role?	No, the PV-PQRS role used during registration or to pull your QRUR reports is not the same as the GPRO Submission role. You will need to request a new role for GPRO Submission. Also, if the Security Officer for your group only has a PV-PQRS role, they will need to go through additional step and verification to have the PQRS Security Official role. This is outlined in the IACS presentation on the CMS YouTube site: http://go.cms.gov/GPROPlaylist. Please contact the QualityNet Help Desk if you have any additional questions on obtaining IACS accounts at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org.**	X	NA	NA
8	11/7/2013	Can we find out which individuals in my ACO group have the PQRS submitter role active? We are unsure of this due to staff turnover.	Yes, please contact the QualityNet Help Desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org**. They will be able to provide this information.	NA	X	X
9	11/7/2013	What is the role\responsibility of the Security Official in IACS?	The Security Official's primary responsibility is to first set-up your organization in the IACS system and then act in an approval role to approve the PQRS Submitter role requests in IACS and the ACO or GPRO Submission 2013 role in the Portal.	X	X	X
10	11/7/2013	We have two ACOs, one that participated last year and one new one. I have an IACS account under the existing ACO. How do I set up an IACS account for the new ACO?	You can have the new ACO added to your current IACS account under the ACO primary TIN. If you have issues adding the new ACO to your existing account, please contact the QualityNet Help Desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org**.	NA	X	X
11	11/7/2013	If we had a PQRS submitter role last year (2012) and have maintained our IACS account by updating our password when requested, do we need to request it again for 2013?	No, you should be set as long as your password has been updated when requested.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
12	11/7/2013	Will we login to GPRO via IACS or QNET? Last year we used our IACS credentials to login to QNET and access the GPRO [Web Interface].	You use your IACS account to login to the QualityNet PQRS Portal at https://www.qualitynet.org/pqrs so you will be using your IACS credentials to access GPRO Web Interface.	X	X	X
13	11/7/2013	Regarding the GPRO Submission 2013 role on the submission portal: I set up my role last week and received confirmation that it was approved. When I look at the "Manage My Roles" nothing shows up. Is there some way (besides the emails) that I confirm what I did is correct?	Contact the QualityNet Help Desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org**. GPRO Submission roles are not available until **November 18, 2013**.	X	NA	NA
14	11/7/2013	Is there any flexibility with the limit of 10 IACS users for an ACO? Our ACO has 79 different organizations. Could the limit of users be raised for us?	We are limiting IACS to 15 users so please contact the Shared Savings Program to discuss your situation.	X	X	X
15	11/7/2013	If someone is a submitter for 2 organizations, can they do so with one IACS? If so how will they access one ACO versus the other's sample?	The ACO reporting goes by the ACO Primary TIN. Yes, if the submitter needs a role for two different ACO Primary TINs they would use the same IACS account and request to add the additional role/TIN to the existing IACS account.	NA	X	X
16	11/7/2013	To manually enter data in the Web Interface do we need to have a submitter or end user role?	The user must have the PQRS Submitter role within IACS and the ACO or GPRO Submission 2013 role within the PQRS Portal Roles Management Application. The PQRS Submitter role and the appropriate QRMS role are needed for utilizing the Web Interface.	X	X	X
17	11/7/2013	Has the issue of logging into multiple TINs been corrected?	2012 GPROs and ACOs were able to log in to multiple TINs, and users will be able to do so again in 2013. If additional information is needed, or if you have a particular concern, please contact the QualityNet Help Desk.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
18	11/7/2013	Can we create generic IACS accounts for our submitters? (We will be hiring temps and will not have all of them hired by December 12, 2013.)	No, each IACS account may only be requested and accessed by the person who will use the account. The Security Official account is the only account that must be started by December 2. If the Security Official account is obtained by December 2, 2013, the process to have each additional or temp employee register for their account should be completed quickly, and can be started after December 2. Contact the QualityNet Help Desk for further assistance.	X	X	X
19	11/7/2013	I am the IACS Security Official for the PQRS GPRO submission using my IACS account from last year. This year, I will also be the Security Official for a Shared Savings Program ACO submission. Do I modify my account to add the ACO?	Yes, since you already have existing account, you will need to modify your existing account if you want to add an additional TIN. IACS accounts for ACOs need to be associated to the Primary ACOs TIN. Contact the QualityNet Help Desk at 1-866-288-8912 or qnetsupport@sdps.org for further assistance.	X	X	X
20	11/7/2013	Is it possible to create an ACO account December 15-31? (The reason is our new resources will be onboard on 3rd week of December)	Please do not wait to set-up your ACO's IACS account. Account set-up is a multiple-step process and if you wait until late December you risk not having the account in place for quality reporting. Please see the IACS Account set-up and Maintenance document on the ACO portal. If you need to defer set-up the dual PQRS Submitter role within IACS, and ACO Submission 2013 role within QualityNet Roles Management System (QRMS) for the newly added staff that is preferred to waiting to set-up your account. The Security Official account is the only account that must be started by December 2. If the Security Official account is obtained by December 2, 2013, the process to have each additional or temp employee register for their account should be completed quickly, and can be started after December 2. Contact the QualityNet Help Desk for further assistance.	X	X	X
21	12/5/2013	Do submitter roles require a CMS user ID?	To obtain the submitter role you need to obtain an IACS account. The IACS account is sometimes called CMS ID but you do need an IACS account that will give you access to a PQRS Submitter Role and the Web Interface. You will have an IACS User ID for the IACS account that will be needed for logging into the PQRS Portal to submit data.	X	X	X

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22	12/5/2013	If I had the Submitter role last year, do I have to request it again this year?	No, as long as you kept your account active by changing your password when notified, your submitter role from 2012 will carry over to 2013.	X	X	X
23	12/5/2013	We submit for 2 GPROs. Do we need to request the GPRO Submission 2013 role in the portal for each TIN? When I tried to request the role for both TINs, I was not presented with the role for the second TIN after requesting it for the first.	The user will need to have the IACS PQRS Submitter role for each TIN. After the IACS PQRS Submitter role is obtained for a specific TIN, the user should be able to have the Portal QRMS role of GPRO Submission 2013 added for the same TIN. The GPRO Submission 2013 role will need added for each of the PQRS Submitter TIN(s) the user has in order to be able to access the web interface for each of the TIN(s). If you are having trouble adding the role for another TIN, please contact the QualityNet Help Desk for assistance.	X	X	X
24	12/5/2013	Does the GPRO Submission 2013 role in the portal require Security Official approval?	Yes, it does if the submitter requests this role. However, the Security Official can also just manually add and approve this role to PQRS Submitter account.	X	NA	NA
25	12/5/2013	Can someone with an existing IACS account associated with one ACO, also associate with a second ACO?	Yes, you can associate a second ACO with same IACS account. Please remember that ACO reporting goes by the ACO primary TIN, so the IACS account must be associated with the ACO primary TIN.	NA	X	X
26	12/5/2013	We have had an issue with QualityNet and approving the ACO submitter role. Is this issue being investigated?	Yes, we are researching the issue but have identified a resolution. We will follow-up individually on this incident.	NA	X	X
27	12/5/2013	If you have a security official in one ACO, what is the process for requesting security official for the second ACO?	If you are using the same Security Official, you just modify the account in IACS to request that the additional TIN be added. Note that for ACO reporting, your IACS account needs to be registered for the primary TIN and not a child TIN.	NA	X	X
28	12/5/2013	Does every submitter need an IACS account to access the Portal?	When you register for an IACS, you receive a user ID, which is the user ID you will need to log in to the Portal. Staff who are submitting data will need an IACS account, which will be used to log-in to the portal. The Security Official will have their own user ID.	X	X	X
29	12/5/2013	If I am the Security Official for our account, can I also be the submitter role? And if not, how do I change someone else to the Security role?	You cannot be both the Security Official and the submitter for the same tax ID. Please give the Quality Net Help Desk a call to go over the steps on how to add a Security Official.	X	X	X

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30	12/5/2013	If an IACS account has not been kept active, how do we re-apply?	Go to portalapplication.cms.hhs.gov. Then navigate to the new user registration link. If you need additional assistance, please contact the QualityNet Help Desk, who can walk you through the steps.	X	X	X
31	12/5/2013	I have the PQRS Submitter role from last year, but when I try to request roles, I don't have the option to request the ACO submission 2013 role.	If you had the PQRS Submitter role last year and you obtained the ACO Submitter role last year, you will be able to use what you already have to submit data this year. If you did not have the ACO Submitter role last year, please contact the QualityNet Help Desk and we can walk you through how to request that.	NA	X	X
32	12/5/2013	After IACS access is obtained, are additional steps required to make the Web Interface available?	Yes, you will need to access the submitter role. The PQRS Submitter needs to go to PQRS portal under manage roles and request the QRMS role of ACO submission 2013 or GPRO submission 2013 and the SO will need to approve that role. Alternatively, the SO can manually add the submission role and approve for the role for the PQRS Submitter.	X	X	X
33	12/5/2013	To access GPRO Web Interface, will we login from the QNET webpage using our IACS login?	Yes, you will login to the QNet Portal using your IACS User ID. The Web Interface is not accessible at this time, but the Portal is available if you want to test your login and see what the Portal looks like. The QNet Portal can be accessed at https://www.qualitynet.org.	X	X	X
34	12/5/2013	To submit data for an ACO, do all PQRS submitters need to also have the QRMS ACO Submission 2013 role? Or, should only one PQRS submitter have the QRMS ACO Submission 2013 role?	Each submitter that wants to report ACO data in the Web Interface will need their own ACO Submission 2013 role.	NA	X	X
35	12/5/2013	What is the web link to access QRMS	To have the Portal QRMS role added to an IACS PQRS Submitter account, go to https://www.qualitynet.org/pqrs and login there. Once logged in, utilize the manage roles link. Please contact the QualityNet Help Desk for assistance if needed.	X	X	X
36	12/5/2013	What prompted CMS to change the submitter role from 10 to 15? Have you seen that most ACOs are having to perform more manual entry?	CMS increased the number of submitter roles in response to requests from the ACOs. We hope this will enable ACOs with multiple TINs to submit data efficiently while also maintaining internal controls to ensure data accuracy.	X	X	X

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37	12/5/2013	What if the previous IACS account is not linked to the ACO TIN? Do we have to create a new account?	If the IACS account is not linked to the ACO primary TIN, then either the IACS user needs to request an SO role and register the primary TIN on the existing account or a new user who wants to be the SO needs to register for the SO role under the ACO primary TIN as a new user. Please contact the QualityNet Help Desk if any assistance is needed.	X	X	X
38	12/12/2013	If submitters are not changing from the 2012 Quality Reporting Submission, does the Security Official need to re-approve anything?	As long as everyone still has their active accounts that they had last year, and you have all of the submitters you want with active accounts, then no, there is no need for the Security Official to re-approve anything. There could be certification approvals coming in as IACS accounts need to be recertified every year in order to keep them active.	X	X	X
39	12/12/2013	Does each submitter require an IACS account? OR is the IACS account specific to the organization?	Yes to both. Each submitter will need an IACS account and each role you have with an IACS is specific to that organization. For example, your PQRS Submitter Role must be linked to the correct organization you wish you submit for. If you are submitting for two organizations, you would need PQRS submitter role associated to each of those organizations.	X	X	X
40	12/12/2013	Do the IT folks who will be doing the XML uploads need an IACS account?	Yes, anyone who needs to submit the data will need a PQRS Submitter IACS account of their own associated to the organization. You must have an IACS account to log into the Web Interface.	X	X	X
41	12/12/2013	We are an organization with multiple TINs. Please provide more information regarding the "QRMS" role.	Once an organization has a Security Official with two-factor in place, the next step is to have each submitter gain access to the PQRS Submitter role. In order to submit data and access Web Interface there is an additional role - the QRMS role. For ACO that's the ACO Submission 2013 role for GPRO that's the GPRO Submission 2013 role.	X	X	X
42	12/12/2013	Last year we had issues with submitting for multiple TINs. We submitted numerous tickets and it was never resolved, we ended up having to have one person register for one TIN and another person register for the other TIN. Will this happen to us again this year?	There shouldn't be an issue submitting for multiple TINs. You can test when the Web Interface opens on January 27th.	X	X	X

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43	12/12/2013	Where do we find the Portal role in IACS?	That role is not in the IACS application. That role is in the PQRS portal itself. That's at www.qualitynet.org/pqrs. If you log in there with your IACS credentials, you will be able to request or add that role.	X	X	X
44	12/12/2013	Is there an impact to QRMS and PQRS Submitter roles at the current time being displayed?	No, both the PQRS Submitter role and QRMS role are available now.	X	X	X
45	12/12/2013	We are having problems with changing passwords for our initial IACS account roles.	Please contact the QualityNet Help Desk.	X	X	X
46	12/12/2013	Can you elaborate on how we obtain the additional submitter role for the Web Interface?	At this point, it would be helpful to contact the QualityNet Help Desk and we will walk you through it.	X	X	X
47	12/12/2013	If submitting for more than one TIN, do I need to request the PORTAL GPRO Submission 2013 role for each TIN?	If you are submitting for multiple TINs, you need an IACS PQRS Submitter role for each of the TINs. Each of those PQRS Submitter roles under those TINs need the QRMS role attached to them.	X	X	X
48	12/12/2013	The QRMS role is not currently available on QualityNet.org	The QRMS role should be available. Please use the PQRS Portal link: qualitynet.org/PQRS. If you encounter issues adding the QRMS role, please contact the QualityNet Help Desk.	X	X	X
49	12/12/2013	What's the difference between the submitter role and the GPRO role?	The PQRS Submitter role is a role in IACS, which gives you access to the PQRS Portal. The ACO/GPRO Submission 2013 role is a role in the PQRS Portal and gives you access to the Web Interface.	X	X	X
50	12/12/2013	How many submitter roles would you recommend for a PQRS GPRO with 25-99 EPs that is new to the system?	We have a limit of 15 accounts per TIN submitting data to the system. It depends on your organization's structure and personnel, as well as if you're doing manual abstraction or using XML.	X	X	X
51	12/12/2013	What kind of role do we need to be able to import and export from the Web Interface?	In order to access the Web Interface, a person needs the IACS PQRS Submitter role and you will also need the portal role for that PQRS Submitter. After you get your PQRS Submitter role, you will need to go to the PQRS Portal and request a specific QRMS role. If you're a PQRS GPRO it will be the GPRO Submission 2013 Role **OR** if you're an ACO it will be the ACO Submission 2013. You can either request this role and your SO can approve it, or your SO can request it and approve the role all in one shot.	X	X	X

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52	12/12/2013	What was the logic for CMS increasing the submitter roles from 10 to 15? Did you find that 2012 submissions were using this many resources? How many ACOs used the XML methodology?	The reason of the increase is because of user requests. Most of the GPROs and ACOs used a mixture of both XML and manual entry. There were a handful that used strictly XML or strictly manual entry.	X	X	X
53	1/9/2014	Please verify if the submitters must register for IACS access by January 27th.	The Web Interface is open January 27, 2014 through March 21, 2014. You must have an IACS account in order to log into the Web Interface.	X	X	X
54	1/9/2014	Will all users be able to run reports in the Web Interface?	Any user logged into the Web Interface will be able to run reports in the Web Interface. Reports are only available during the submission period of January 27, 2014 through March 21, 2014.	X	X	X
55	1/9/2014	Will we get a new password daily or just one for login into the web interface?	The password does not change daily. When you log in you will receive a "User Authentication Challenge" screen which requires a one-time pass code. The pass code is received by the method selected in your IACS profile. If you check the box below Pass Code entry field, you may log in without receiving the User Authentication Challenge for 12 hours.	X	X	X
56	1/16/2014	Can more than 1 person access the Web Interface at the same time and do all who access need a separate IACS ID and login?	You may only have one person at a time working on a patient but more than 1 person can be in the web interface working on the same module. However, everyone entering data in Web Interface must have their own IACS account with the appropriate role.	X	X	X
57	1/16/2014	We have asked to add the QRMS submitter role to our IACS accounts and have received a confirmation saying your request has been submitted, but my Security Officer is not receiving these requests. She has received other request that have been sent through.	Please contact the QualityNet Help Desk.	X	X	X

MEASURES

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	Please clarify how a zero percent performance will work. Is a zero percent not allowed for any of the measures' performance calculations or is it for each individual patient/beneficiary?	A 2013 GPRO reporting individual measures via a registry needs to be concerned with a 0% performance. A 0% performance indicates all denominator-eligible patient events were reported as performance not met (8P modifiers or equivalent) or a combination of performance not met and exclusions. Measures reported with a 0% performance are not considered successful reporting. The 0% performance threshold doesn't apply to reporting through the GPRO Web Interface. The criteria for satisfactorily reporting PQRS via the GPRO Web Interface is outlined in the following manner: Report on all PQRS GPRO measures included in the Web Interface; AND Populate data fields for the first 218 (groups of 25-99) or 411 (ACOs or GPRO groups of 100+) consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or patient care measures. If the pool of eligible assigned beneficiaries is less than 218 (groups of 25-99) or 411 (ACOs of GPRO groups of 100+), then report on 100 percent of assigned beneficiaries.	X	X	X
2	11/7/2013	Calculation of the measures when part of a composite: Will we submit the measures separately and CMS will calculate the performance for the composite **OR** Will we provide the Pass/Fail result directly to CMS?	GPRO/ACO will enter in data that is relevant to individual measures that comprise the composite. Web Interface will calculate the composite calculation.	X	X	X

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3	11/7/2013	In several of the quality measures, "patient declined/patient refuses" is an acceptable exclusion reason. Can we apply this exclusion generally to other measures? Is there a list of measures where this exclusion would apply?	No, the "patient declined/patient refuses" exclusion cannot be applied across all measures, as not all measures include a patient reason exclusion. Thoroughly review the Narrative Specifications for applicable exclusions. Also, use the Data Guidance within the Supporting Documents to help determine exclusions available for a measure in the Web Interface. The Data Guidance will let you know whether or not there is an exclusion for a measure, and if there's an exclusion, it will show if "patient declined/patient refuses" is an acceptable exclusion. If a measure has an exclusion, the pull-down menu on the Web Interface will list allowable exclusions. If a measure has an exclusion, the XML Specification will list the corresponding values for the exclusion in the allowable values for the XML tag.	X	X	X
4	11/7/2013	Is the Supporting Documentation clear in where only codes listed in Resource Tables can be used as opposed to where the codes and medication lists are simply references to help those with EMRs (i.e. where the lists are not all inclusive)?	The coding provided is there to assist you and is based on measure owner recommendations. However, you will notice in the Narrative Specifications as well as the Supporting Documents, there are instances where specific direction is provided. For example, the heart failure measure only allows use of the three generic medications listed within the Narrative Specifications. Although not specifically listed, the brand name equivalents to the 3 generics also meet the numerator. Please use all of the documentation provided when entering data into the Web Interface.	X	X	X
5	11/7/2013	Can any claims data be used to report on the preventive measures or do we need to find the information in the patient's record?	You need information documented in your patient's record showing whether or not the service was provided. There are some measures that have pre-populated data from claims. In some instances, you don't have to have this information in the patient's record. For example, if influenza immunization information is pre-populated into the Web Interface, you do not need to check to see that this information is contained within your patient's medical record. However, if you have a patient that has a mammogram, you will need to be able to document the date of the mammogram and the results from the medical record. It depends on the measures that you are referencing so it is important that you seek direction from the Data Guidance contained in the Supporting Documents.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
6	11/7/2013	Will there be "paper tools" available for the measures?	It is recommended that you utilize all documents CMS has provided, such as the flows, the data guidance, the different tabs in the supporting documents and the other specifications. Everything has been provided for the process that the ACOs/GPROs will be going through. You may find that there are certain tools that you can create that will help you specifically as each entity may be different.	X	X	X
7	11/7/2013	Several measures note exclusions including "terminal illness" or "receiving palliative care." Can we apply this exclusion generally to other quality measures?	If you go to patient confirmation tab in supporting documents, there is a way to remove patients from the Web Interface if they are labeled as being in hospice. Definition of this says: select option if patient is not qualified for sample due to being in hospice care at any time during the measurement period. This includes non-hospice patients if receiving palliative or comfort care.	X	X	X
8	11/7/2013	Can you please define "hospice?" Does this include patients who are located in a nursing home?	Patients in a nursing home would be included if they are receiving palliative care or comfort care, but it would need to be specifically stated in the record that they are receiving either palliative or comfort care.	X	X	X
9	11/7/2013	Previously the speaker mentioned mammogram measure as it relates to patient reporting. Is it acceptable if the patient reports the date and the results and it's recorded in the medical record, but there is no report?	The measure owner requires both the date of the mammogram and the results be documented. The Data Guidance for PREV-5 includes the following NOTE: Documentation in the medical record must include both of the following: A note indicating the date the breast cancer screening was performed AND The result of the findings	X	X	X
10	11/7/2013	There is a lot of dialogue concerning physical health measures of the identified patients (diabetes, etc). Are there quality measures specific for outpatient mental health clinics (like major depression etc)?	Review the 2013 PQRS GPRO Measures List posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. Please call the QualityNet Help Desk if you have specific questions.	X	X	X
11	11/7/2013	Are we able to take documentation from the entire calendar year including November - December or only for the first 10 months of the year?	You are able to use documentation available for the entire measurement year (January 1 - December 31, 2013).	X	X	X

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12	11/7/2013	Do you know which measures, or portion of measures, that groups in general, were able to do auto downloads via XML back in GPRO (vs. manual collection and entry?) Labs, other?	All measure data in the Web Interface may be updated with an XML upload. The XML Specs provide the tags and valid values for each of the measure components. For the 2012 Program Year, some of the GPROs and ACOs updated all their measure data using XML uploads and others updated all their measure data using manual entry. The majority of the GPROs and ACOs used a mix of XML uploads and manual entry for all measures.	X	X	X
13	11/7/2013	Will the reported QM through claims be included in the numerator?	Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your ACO is selected for audit following the data collection period. This is not the case if the WI has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: • A note indicating the date the breast cancer screening was performed AND • The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the ACO be selected for audit.	X	X	X

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14	11/7/2013	Will GPRO have any pre-filled values for measures such as Influenza Immunization?	For the module that includes pre-filled fields the following will be pre-filled: Diabetes Module, Ischemic Vascular Disease Module, and Preventive Care Module (mammogram, colorectal screening, flu shot and pneumonia shot) in addition to the discharges for the GPRO CARE-1 medication reconciliation measure. As previously mentioned, the medication reconciliation measure is at **every** discharge so for sample patients we will provide the discharge date for each discharge that we can associate with an office visit up to 30 days following the discharge. For some measures, such as colorectal screening, flu and pneumonia shot, we will look in the claims but we may not find for some measures where the time period acceptable for screening is longer than claims we are analyzing.	X	X	X
15	11/7/2013	If our ACO can prove via claims data that breast cancer screening or colorectal cancer screening was performed but the results are not in the medical record, will this count as a numerator hit? For example, another provider outside the ACO ordered the test.	For PREV-5 Breast Cancer Screening, you have to have the date and result in the medical record. Even if it is pre-populated from claims in the Web Interface, you need to ensure that this information is also included in the medical record. For PREV-6, Colorectal Cancer Screening, the Data Guidance says that you need to have documentation in the medical record that screening is up to date or current.	X	X	X
16	11/7/2013	We have a question regarding the depression screening measure. Does the denominator include all patients or only those who were screened for depression? Is the goal to be screening all patients 12 and older for depression?	The denominator for NQF #0418 (PREV-12) does include all patients 12 years and older. Yes, this measure does comply with the latest guidance from the US Preventative Services Task Force which does recommend depression screening for those 12 years old and older.	X	X	X
17	11/7/2013	If a patient completes the depression screening questionnaire on the patient portal a day or more before the office visit and the provider reviews and follows up at the visit (days later), can this scenario be counted for the numerator of this measure?	According to the Inclusions/Synonyms tab of the PREV-12 Data Guidance, screening includes the following statement: This measure requires the screening to be completed in the office of the provider filing the code.	X	X	X
18	11/7/2013	Please clarify the definition for Former Smoker that is addressed in ACO Measure 17 (PREV-10) and 25 (DM-17).	If you can show documentation that they are not a current smoker, you can mark them as "nonsmoker" regardless of former smoker status.	X	X	X

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19	11/7/2013	Further clarification on the former smoker issue, there is no time frame associated with determining if they are non-smoker? That is, only if they are not smoking at the time of visit/assessment.	Specific to the DM-17 smoking measure – that screening means an identification during the measurement period so as long as you ask the question during that measurement period you're fine.	X	X	X
20	11/7/2013	Tobacco use: If you look at an EHR and notice that the patient is listed as "non-user" but there is no date listed is that acceptable or do we need to find office notes to make sure that the patient was questioned within the appropriate time period?	PREV-10: Tobacco Use Screening and Cessation Intervention and DM-17: Tobacco Non-Use both require that the patient was screened for tobacco use within a specific time period, therefore a screening date would be required.	X	X	X
21	11/7/2013	On the documentation for proving a beneficiary is no longer a smoker... Please define "documentation" - lab test?	If the lab test somehow identifies that the beneficiary is no longer a smoker that's fine. All that is really required is that the provider asks the patient if they're a smoker and they write it down to document that the patient is not a smoker.	X	X	X
22	11/7/2013	For medication reconciliation, what exactly needs to be stated in the note for a post acute care visit?	Guidance is provided in the Narrative Specification, Supporting Documents and CARE-1 performance calculation flow. There is not an exact note required, however the medical record must indicate the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications. Also, if someone besides the PCP (physician PA, NP) or a clinical pharmacist performs the medication reconciliation there must be documentation that the PCP or clinical pharmacist is aware of the review.	X	X	X
23	11/7/2013	In Medication Reconciliation, I think you need to clarify the documentation needed as we just had validation audit and auditors were very specific about what is needed.	For 2013 reporting of CARE-1, within the Supporting Documents under Inclusions / Synonyms column it reads: Medical records must indicate the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications **or** change the inpatient facility discharge medications **or** the dosage of the inpatient facility discharge medications. The medical record must show that the medications were reviewed from discharge to follow-up.	X	X	X

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24	11/7/2013	GPRO CARE-1, ACO Measure 12: We have implemented a process by pharmacists to ensure that a patient's medication list is reconciled on the day of discharge. Is this acceptable?	In addition to having the reconciliation at discharge, you would also need to follow-up with a discharge or office visit reconciliation within 30 days of the discharge. When CMS looks for patients who are eligible for this measure we look in the claims data for the office visit to have occurred at least one day after and within 30 days of the discharge.	X	X	X
25	11/7/2013	The description for ACO-31 (GPRO HF-6) states within a 12-month period when seen in an outpatient setting OR at EACH hospital discharge. Will the GPRO Web Interface be configured like CARE-1, i.e. there is a discharge date where we could have many to one person encounters?	HF-6 is not configured like CARE-1. The Web Interface will not list all of the patients' discharges for the measurement period. This measure, the question has a yes/no answer unless the patient is excluded for medical, patient or system reasons.	X	X	X
26	11/7/2013	For medication reconciliation, in order to be counted in the denominator do the following three criteria need to be met: 65 or older AND Discharged from an inpatient facility AND seen within 30 days? Or is this also measuring the compliance of following up within 30 days?	For 2013 GPRO Web Interface reporting of CARE-1, if a patient is not seen within 30 days following an inpatient facility discharge, mark appropriately for completion and stop abstraction. This removes this particular discharge from the performance calculation.	X	X	X
27	11/7/2013	For ACO 32 (GPRO CAD-2) (NQF #0074): Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control, if the patient has been prescribed a statin but does not have a plan of care, does that still satisfy the measure?	According to measure owner, AMA, yes it would satisfy. According to the definition of a documented plan of care, found in the Narrative Specification for CAD-2, a plan of care includes the prescription of a statin. In other words, a statin is the minimum requirement for a plan of care.	X	X	X
28	11/7/2013	For GPRO CAD-2, the supporting documents do not state the LDL-c test had to come from 2013, does this mean if the LDL-c test was performed in 2012 and was less than 100, we answer YES?	No, the LDL-C test must be performed during the measurement year (12-mo period per specification) for the GPRO Web Interface reporting year. This is outlined in the Narrative Specifications and the Data Guidance. Within the instructions, we realize that "during the measurement period" is not stated directly after the < 100, but it is when it is referring to > 100 and we will review this language for 2014 reporting period to clarify.	X	X	X

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29	11/7/2013	There is a 2013 GPRO CAD Data Guidance document and a 2013 ACO GPRO CAD Data Guidance document. Which should we be looking at? We are a Pioneer ACO.	All ACO GPRO Data Guidance documents are now aligned with PQRS GPRO documents, and can be found here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html or simply follow the "GPRO Web Interface Page" link on the ACO Quality Measures and Performance Standards page. The document you need to reference is the first document located in the download section at the bottom of this page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
30	11/7/2013	For the diabetes measures, will patients only be pulled into the denominator if they have a diagnosis of diabetes during the measurement year, or will they be included if they have a prior diagnosis but no diagnosis in the measurement year?	This is a measure where CMS does look back to the prior year for a diagnosis in the administrative claims in addition to the measurement year.	X	X	X
31	11/7/2013	Regarding the Diabetes Composite measure for LDL control. If the chart documentation reveals that the LDL has been controlled < 100 mg/gL throughout the last 12-24 months, but the "most recent" LDL is > 100, has the measure been met?	You must answer using the most recent test in the measurement period and provide the date and value.	X	X	X
32	11/7/2013	Regarding Measure #1 (NQF 0059): Diabetes Mellitus: Hemoglobin A1c Poor Control, which is considered satisfactory reporting: 1) patients with DM HgbA1c <20.9 or 2) patients with DM HgbA1c >9.	This measure is an inverse measure. To pass the measure, the patient would need to have HgbA1c > 9. Please reference the measure flows to better understand passing performance, especially in complex cases such as inverse measures.	X	X	X
33	11/7/2013	Regarding DM-2 and DM-15, patients aren't allows to have a HbA1c value of >8 and <9 to succeed in either measure. They fail performance on both measures. Is that correct?	Yes, that's correct. They would fail performance on both measures. The 2013 performance calculation flows will be helpful in clarifying passing and failure in performance for these measures.	X	X	X

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34	11/7/2013	In relation to the measures that diabetes – non-tobacco use and Prevention – screening for tobacco use, how are we to answer these questions in relation to electronic cigarettes?	The measure owner does not consider e-cigarettes tobacco use.	X	X	X
35	11/7/2013	The Diabetes composite measures specify that patients must have "Two or more face-to face visits for diabetes" to qualify for the denominator. Can CMS provide any guidance on what qualifies as a visit for diabetes?	This is available in the Downloadable resources online. In the excel files that list the codes, there is a set of codes in a section that is grayed out and these are the codes CMS uses to identify the sample for the Diabetes module.	X	X	X
36	11/7/2013	Follow up question regarding Diabetes Composite measure and the most recent" LDL > 100. If the documentation shows that patient is non-compliant with the plan of care, is there an exception or exclusion available?	There is no requirement for a plan of care based on an elevated LDL-C and there are **NO** exclusions available for this measure	X	X	X
37	11/7/2013	HbA1c in DM-2 and DM-15 do not allow MBs with a value of >8 and <9 to succeed in either measure. They fail performance on both measures. Is that correct?	Yes, that's correct. Take a look at the measure calculation flows for clarification on what meets performance requirements for those instances.	X	X	X
38	11/7/2013	The data guidance states DM pts need 2 face to face visits for the denominator but the supplemental documents for GPRO do not ask for this information. Are 2 face to face visits necessary for the GPRO submission?	The required 2 face to face visits are addressed during the sampling process. The Assignment and Sampling documents are located on the cms.gov website; http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. These documents are specifically located in the Downloads section at the bottom of the page.	X	X	X
39	11/7/2013	Is CMS considering a change to HbA1c to include the MBs with value >8 and <9 so that they can meet performance on DM 15 or DM 2?	The GPRO Web Interface measures are reviewed on a regular basis and can be updated yearly based on measure owner edits. 2014 PQRS measures are in the last stage of finalization based on the PFS Final Rule due for posting November 2013.	X	X	X

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40	11/7/2013	Can you verify the IVD dx codes? The IVD (ACO#s29 & 30) code includes 414.00-414.9 but the DM/IVD (ACO#26) code only has 414.01-414.9. Is that intentional?	Yes, each measure owner includes coding they feel is appropriate for the measure.	X	X	X
41	11/7/2013	For GPRO PREV-6 Colorectal Cancer Screening--Is the FIT (Fecal immunochemical test) considered to be an FOBT in your definitions. It is not listed in the Data Guidance information under Inclusions/Synonyms.	No, that information is not provided by the measure owner. Anything you do not see in the Inclusions or Synonyms column would not be acceptable. **UPDATE:** Post support call, PMBR contacted NCQA (measure steward for PREV-6). The Fecal Immunochemical Test (FIT) would be considered an FOBT. The FIT will be included in the 2014 PREV-6 Data Guidance, inclusions/synonyms tab.	X	X	X
42	11/7/2013	Measure # 16- For the follow-up plan; is the documentation of a future visit enough to satisfy the measure? Does is have to be a specific type of visit?	It doesn't have to be a specific type of visit - it just has to be linked to the BMI. Documentation of a future visit does satisfy the 2013 measure.	X	X	X
43	11/7/2013	Back to the BMI follow-up visit - how does this need to be linked?	The follow up visit needs to be linked in some manner to the abnormal BMI visit. It would be anticipated that documentation would be available to establish the required link.	X	X	X
44	11/7/2013	For the Fall Screening- Is documentation of "No Walking or Balance Issue" or "has walking or balance issues" in measurement year sufficient for screening for future fall risk or just answering "Have you had a fall in the past 12 months"?	In the Data Guidance for CARE-2 a fall is defined as screening for future fall risk can include documentation of no falls within the last year **OR** documentation of one fall without injury in the past year **OR** documentation of two or more falls in the past year **OR** any fall with injury in the past year.	X	X	X
45	11/7/2013	For the influenza vaccine exclusion what qualifies as an "other system reason" and "vaccine not available"?	For example, if you went to a place that didn't have the supplies for the flu vaccine - that would be a system reason.	X	X	X
46	11/7/2013	Will the CPT codes for few of the quality measures like influenza, smoking status etc, sent through claims satisfy some of the quality measures for GPRO?	This is specified in the Data Guidance by measure.	X	X	X

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47	11/7/2013	For the pneumonia vaccination measure, does the eligible exclusion need to be noted in the measurement period in order to exclude the patient from the measure, or can the exclusion be noted anywhere in the patient's history?	That can be noted anywhere in the patient's history.	X	X	X
48	11/7/2013	For pneumococcal vaccination, the specs do not mention patient reported data. Since it is unlikely the pt received the vaccination during the Measurement Year, we assume we should be counting patient reported data? Is this acceptable?	Yes, for PREV-8 it would be acceptable to count patient reported data assuming it is documented.	X	X	X
49	11/7/2013	Are the release notes in the GPRO Web Interface supporting documents new this year?	No, they are not new for this year.	X	X	X
50	11/7/2013	Is the prefilled data elements list posted on the website?	The prefilled data elements list is not currently available but will be shared before the submission period begins.	X	X	X
51	12/5/2013	What is the proper age calculation for PREV-5: Breast Cancer Screening? The NQF specification has notes that imply it starts at 42 because of the two-year look back period. I thought the rule is the age is 40 on January 1st of the measurement year.	The 2013 denominator age requirement for PREV-5, Breast Cancer Screening, is 40 years of age as of the first day of the measurement period or Jan 1, 2013. Please do not refer to the NQF specifications for purposes of 2013 GPRO Web Interface reporting. Instead, please use the specifications specifically created for the GPRO Web Interface program.	X	X	X
52	12/5/2013	Regarding CARE-1: Medication Reconciliation, how are we to handle instances when a patient is re-admitted before their required 30-day follow-up? How is the provider able to reconcile medications from the first hospitalization when those medications would likely be changed within 30 days?	The 30-day follow-up office visit is part of the sampling process for 2013 CARE-1. Therefore, if a patient has two discharges, medication reconciliation will be based on the follow-up visit in an office within 30 days of discharge. If both hospitalizations are pre-filled in your Web Interface and the office visit is within 30 days of both hospital discharge dates you may use this follow up visit to determine medication reconciliation for both discharges.	X	X	X

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53	12/5/2013	If a patient is in the hospital for rehabilitation, is that considered an inpatient status?	Yes, a rehabilitation stay is considered an acute stay or inpatient status.	X	X	X
54	12/5/2013	For ACO14, Influenza Immunization, please explain the reference to Previous Receipt in the 2013 specification manual.	2013 PREV-7: Influenza Immunization - As long as the patient reports they previously received a flu shot, that would be acceptable. Accurate and complete information would indicate the vaccine occurred during the flu season dating back to August 1, 2013.	X	X	X
55	12/5/2013	For ACO18 (GPRO PREV-12) please advise who may perform the depression screening (i.e. who is considered qualified to perform it)	The depression screening for PREV-12 must be completed in the office of the provider filing the code.	X	X	X
56	12/5/2013	For ACO13 (GPRO CARE-2) please advise who may perform the fall screening (who is considered qualified).	The 2013 GPRO Web Interface Falls Assessment screening in CARE-2 must be completed at least once within 12 months but does not have to be completed in the office. The Falls Assessment can be completed over the phone, at a home health visit or a PT visit.	X	X	X
57	12/5/2013	In the measurement specifications, unless otherwise specified, is the "within measurement period" referring to the 12-month reporting period or an 18-month reporting period?	"Within measurement period" refers to the 12-month measurement period unless otherwise specified. For GPRO Web Interface submission in 2014 for program year 2013, within the measurement period would specifically be in reference to Jan 1, 2013 to Dec 31, 2013.	X	X	X
58	12/5/2013	Regarding Care-1: Medication Reconciliation, we understand that this needs to be linked to a specific discharge date; Is the implied date or timeframe acceptable for reporting?	When confirming the discharge date for 2013 reporting of CARE-1, the date used for verification can be plus or minus two days on either side of the pre-filled discharge date. The office visit where medication reconciliation was accomplished must be within 30 days of the discharge date.	X	X	X
59	12/5/2013	For the 2013 quality specifications, for the tobacco measure (PREV-10) when it says screening should be at least once within 24 months would it be accurate to tell our abstractors that screening must be in the record either in 2012 or 2013?	Yes, this is correct. The 2013 PREV-10 Data Guidance defines Within 24 months as: The 24-month look-back period of time from the measurement end date.	X	X	X

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60	12/5/2013	If patient received an influenza immunization at an outside facility such as a CVS, does the documentation in the EP's medical record only need to indicate that the patient said they received outside, or does it also need to include exact date that patient indicated that they received it?	The exact date of receipt of the influenza immunization reported in PREV-7 is not needed. You will need to document that the immunization was received during the current flu season, which is August 1, 2012 through March 31, 2013 for the 2013 measurement period.	X	X	X
61	12/5/2013	We have a number of independent providers. How does our group know if the Meaningful Use measure is satisfied by them in the required timeframe?	This is related to the ACO measure based on administrative claims that is the percentage of primary care providers that are incentive eligible under the EHR incentive program. The measure requires that screening be completed in the office of the provider filing the code. For the 2013 reporting year, the measure is run by April 2014. We suggest that you provide education and outreach to providers letting them know that they should attest as close to the end of the measurement period (December 31, 2013) as possible.	NA	X	X
62	12/5/2013	For Measure ACO 31 (GPRO HF-6) Heart Failure Beta-Blocker Therapy, supporting documents list metoprolol tartrate as one of the acceptable beta blockers. However, the narrative specifications list metoprolol succinate. Is either one acceptable?	For this Heart Failure beta-Blocker measure, there are three generic beta blockers that are allowable to meet the measures numerator criteria. The medication that was just listed is not recognizable as one of those medications. We went to the measure steward, the AMA, and asked for clarification. The medications are coded in RxNorm which is the standard clinical terminology used to report medications. Within the RxNorm terminology, metoprolol succinate extended release is identified as metoprolol tartrate extended release. Metoprolol tartrate alone, meaning not the extended release form, is not included on the medication list. In order to meet the measure, it needs to be the extended release form. The AMA has been assured by their pharmacy experts who helped them develop the value sets of the allowed medications that the metoprolol tartrate extended release maps to the metoprolol succinate extended release. Brand names that map to these three generic medications are acceptable to use to satisfy the numerator for this measure. We will be posting this answer on CMS's website as part of the frequently asked questions shortly.	X	X	X

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63	12/5/2013	For IVD measures, if our supporting chart documentation does not contain any of the SSP codes for IVD how can we be certain to include or exclude a patient? Chart notes may sometimes use the verbiage 'CAD' 'stroke' 'CABG.'	The codes are provided in order to facilitate use of creating a XML directly from your EHR if that's your chosen method. If you are supplementing with some manual review, you can certainly utilize any verbiage that is written in the chart. That language would be appropriate to use as synonym for the IVD.	X	X	X
64	12/5/2013	Regarding the measures requiring the use of aspirin (ex. DM-16), does aspirin need to be on the medication list or does the aspirin actually have to be prescribed in 2013?	As long as there is evidence in the medical record that the patient is taking daily aspirin, that is sufficient.	X	X	X
65	12/5/2013	If we are not billing a code for depression screening and fall screening, can the screening be done over the telephone?	Depression screening required for PREV-12 cannot be performed over the phone. The depression screening must be completed in the office of the provider filing the code. However, for further clarification the falls screening required for CARE-2 can be accomplished over the phone.	X	X	X
66	12/5/2013	Related to falls screening, does it need to be done in a provider office, or could it be a physical therapy office? Is a screening during a home care evaluation not acceptable?	The falls screening required for CARE-2 can be accomplished during a home care evaluation. You need to make sure to document in the medical record the results as well as the date of the screening.	X	X	X
67	12/5/2013	For the Heart Failure measure regarding the LVEF (HF-6), it states that if the ejection fraction is ever less than 40, how far back do we reasonably need to go to find this information?	You may go back as far as necessary in the patient's medical record to determine if the patient ever had an LVEF <40% or documentation of moderate or severe left ventricular systolic dysfunction.	X	X	X
68	12/5/2013	For ACO-21 (GPRO PREV-11), are all patients with an active diagnosis of hypertension excluded as a no for medical reason for this measure even if a BP is taken at the visit?	Yes, that's correct. The patient would be excluded from PREV-11 for medical reasons if there is an active diagnosis of hypertension.	X	X	X

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69	12/5/2013	For the PREV-9: Body Mass Index (BMI) Screening and Follow-Up, does it require recording of BMI on the most recent office visit or any time in the 6 month preceding the most recent visit?	Yes, that's correct. The patient's BMI can be recorded at the most recent visit or any time within 6 months prior to the most recent visit.	X	X	X
70	12/5/2013	I thought there were 22 ACO measures to report via GPRO but you mention 15 modules. How do these match up?	There are 22 GPRO quality measures that span 3 of the domains of care and 15 modules. Modules are defined by the shared denominator criteria for the measure or measure groups (e.g., all patients with diabetes in the DM module; all patients with discharge + office visit within 30 days in CARE-1, etc.) Following are the GPRO measures: CARE - 2 measures that are their own module PREV - 8 measures that are their own module At Risk Population - 1 module for each disease category DM – 1individual measure, DM-2 and 1 composite made up of 5 component measures scored as one composite measure, DM-13-DM-17 HTN - 1 measure IVD – 2 measures HF – 1 measure CAD - 2 component measures scored as one composite measure	X	X	X
71	12/5/2013	When you say at the beginning of the measurement period, say the parameter is 18 or older, should we exclude someone that turned 18 during measurement period?	The age of a patient is determined on Jan 1, 2013 for 2013 GPRO Web Interface reporting. A patient who is not the correct age for a measure or module should not be pulled into the sample to begin with if they are not the age required for denominator inclusion.	X	X	X
72	12/5/2013	Has there been any further work done on creating some sort of further education on "lessons learned" related to Care 1: Medication Reconciliation measure?	To better understand the question being asked, we would like the group to submit this question to the QualityNet Help Desk. We make updates to the measure specifications and relief notes based not only on measure owner updates but also on feedback we receive from the groups and ACOs. We would like to know which aspect of the measure you are referring to.	X	X	X
73	12/5/2013	Are we going to get the list of NPIs that you count towards the EHR incentive payment measure, given there were perceived discrepancies in the calculated percentage?	We are looking into providing that information in future years.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
74	12/5/2013	Are there implications for a "0" numerator for one or more modules?	When participating via the 2013 GPRO Web Interface, a 0% performance rate will not affect incentive eligibility. The implications of 0% performance may affect Physician Compare percentages for a group practice. Also, if quality tiering was elected, a 0% performance may affect the group.	X	X	X
75	12/5/2013	According to the Data Guidance sheets, there is an "HMO Enrollment" option for indicating a patient is not qualified for the sample. Does this mean that any patient who has an HMO supplement is required to be excluded from our sample?	Beneficiaries enrolled in a group health plan as their primary payer—including beneficiaries enrolled in Medicare Advantage (MA) plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly (PACE) programs under section 1894—are not eligible for assignment. If an ACO/GPRO has more recent confirmation that a beneficiary was enrolled in an MA plan during the reporting year, they may exclude the beneficiary in the WI. Note that Medicare Secondary Payer (MSP) status doesn't exclude a beneficiary from assignment to an ACO/GPRO.	X	X	X
76	12/5/2013	Our entity performs all manual chart review (no EHR). How can we confirm a patient diagnosis to include or exclude from a measure if we do not have codes in the medical record? Does verbiage of DM, CAD, etc suffice or is there something else to confirm?	If you are performing manual abstraction it would be acceptable to confirm the patient's diagnosis by locating the verbiage of DM, CAD, etc. within the medical records. Please utilize all of the documentation provided to assist group practices reporting via the 2013 GPRO Web Interface. These documents include the 2013 GPRO Narrative Specifications, 2013 GPRO Web Interface Flows, 2013 GPRO Measures List, and the 2013 Supporting Documents.	X	X	X
77	12/5/2013	Regarding the Fall Risk Assessment, earlier it was stated that this must be done within the primary care setting, and then later it was stated that it's ok to do over the phone. Which is correct?	The falls screening required for CARE-2 can be accomplished over the phone. It can also be accomplished during a home care evaluation. Documentation needs to include the results of the screening as well as the date of the screening. From the Data Guidance "Inclusions/Synonyms" column Note: Screening for fall risk may include: -Documentation of no falls in the past year or only one fall without injury in the past year or -Documentation of two or more falls in the past year or any fall with injury in the past year	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
78	12/12/2013	For ACO-16/PREV-9: Body Mass Index (BMI) Screening and Follow-Up, if the patient has no visits with our organization during the calendar year, are they automatically part of the numerator? Or can we look at that most recent visit and see if BMI was charted then or 6 months prior?	If the patient has no visits in the reporting year, then the patient should not be included in your group's sample. If you find a patient that did not have an office visit at your group in the reporting year, please contact the QualityNet Help Desk.	X	X	X
79	12/12/2013	What are the measure values for CARE-1 and CARE-2?	Please refer to the CARE supporting documents posted on the GPRO Web Interface page of the CMS website for the criteria to confirm a patient. The allowable values for these measures are included in the XML specifications.	X	X	X
80	12/12/2013	For ACO-31/HF-6 (Beta blocker): If the patient is allergic to one of the beta blockers, are they excluded for medical reasons, or do we have to show allergies to all three medications (carvedilol, bisoprolol fumarate, metoprolol)?	It would be acceptable to medically exclude a patient based on an allergy to any beta-blocker.	X	X	X
81	12/12/2013	For ACO-31/HF-6 (Beta blocker): We don't currently capture LVEF discretely, and we're finding only a handful of patients where anyone has ever charted the relevant HCPCS code. Thus our denominator is extremely small. Is this okay?	Yes, this is acceptable. If you have confirmed a diagnosis of heart failure but cannot determine if the patient has LVSD (LVEF < 40% or documented as moderate or severe) you will select "No: Select this option if the patient does not have LVSD".	X	X	X
82	12/12/2013	Will you be changing any of the measure specifications prior to the Web Interface opening?	No, the measures specifications will not change prior to the opening of the Web Interface.	X	X	X
83	1/9/2014	For CARE-1: Medication Reconciliation, can you please define clinician. Physician, PA, NP?	There is a note within the data guidance that says the intent of this measure is to ensure that the PCP (Physician, Physician Assistant, Nurse Practitioner) or a clinical pharmacist (pharmacist who has the authority to prescribe medications) reviewed the discharge medications from the inpatient facility. If others, such as a nurse, perform the medication reconciliation there must be documentation that the primary care physician or clinical pharmacist is aware of the review.	X	X	X

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84	1/9/2014	Is there a list of GPRO measures that are pre-populated and of those can you tell us which we will have to verify the medical record?	Please refer to the Web Interface Overview slides on the CMS YouTube site for a screenshot of the pre-filled data report: http://go.cms.gov/GPROPlaylist. As a general rule, all information that is pre-populated should be verified against the patient's medical record. The exceptions to this are where immunization claims (PREV-7 and PREV-8) and colorectal cancer screening claims (PREV-6) have been pre-populated for you.	X	X	X
85	1/9/2014	Is there a reason that the diagnosis list for IVD confirmation is different for the DM module than the IVD module?	There is a difference, because the measures are developed by different measure owners. The measure owner for IVD is National Committee for Quality Assurance (NCQA) and the measure owner for DM is Minnesota Community Measurement (MNCM).	X	X	X
86	1/9/2014	The XML specifications do not indicate that the LDL date has to be during the measurement period. Is there a limit to the date range for that LDL?	All dates that are recorded in the Web Interface, other than date of birth, must be between January 1, 2013 and December 31, 2013. The XML Specification indicates the date must be in 2013, which is the measurement period. In the directions for DM-14, Determine Date Blood Was Drawn for the LDL-C Test and the directions for IVD-1Determine Date Blood was Drawn for the Lipid Profile, the available values indicate “Valid date between 01/01/2013 and 12/31/2013 in format MM/DD/YYYY”. Appendix A for the <dm-ldlc-date> and the <ivd-lipid-date> tags the Valid Values column indicates “Must be a valid date in 2013”	X	X	X
87	1/9/2014	For DM-2 and DM-15, if an A1c is pre-populated from an unknown source, and you cannot find evidence within your system, you don't have to change this to "No". There is a claim for the test-- you just didn't provide it. You would not get credit for the value.	Yes, that's correct. If you have a prefilled value and you didn't want to change it to “No” you can leave it as “Yes” and fill in a “0”. However, essentially they are the same answer if you don't perform the test or if there is a 0 for your performance.	X	X	X
88	1/9/2014	If we answer "No" to medical record found, but we don't know the exact date that a patient moved out of the country, for example, what date do we enter?	Please use 12/31/13. You can refer to the “Patient Confirmation” tab GPRO supporting documents for this information.	X	X	X

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89	1/9/2014	For DM-16, if a patient has IVD, we are only able to select "Yes" or "No" for daily ASPIRIN use. If the patient is on another antiplatelet medication, does it qualify?	Please refer to the DM drug code list in the supporting documents. The measure looks for Aspirin or another Antithrombotic, which includes: Aspirin, clopidogrel, or a combination of Aspirin and extended release Dipyridamole	X	X	X
90	1/9/2014	Can you please show us PREV-11: Screening for High Blood Pressure and Follow-Up Documented (ACO #21)? This is a complicated measure with various follow-up options.	Please refer to the 2013 GPRO measure flows and 2013 Supporting Documents found under the Downloads section on the GPRO Web Interface page of the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html There is also a video in the Quick Start Guide that will go into more the available answers for this measure. The Quick Start Guide is accessible via the PQRS Portal: www.qualitynet.org/PQRS.	X	X	X
91	1/9/2014	What are we confirming for the PREV measures? Since most of these are not gender specific, would we just be confirming they are the correct age?	For every patient you confirm the existence of their medical record and verify the date of birth is correct. We only remove a patient if they are not qualified for a specific PREV measure.	X	X	X
92	1/9/2014	Are there duplicate fields in the different modules? Like BPs - if you enter in one module - does it populate the others?	There are measures that similar fields in multiple modules. Because the measures can have different owners, coding, or exclusions, the Web Interface does not populate values entered in one module into another module.	X	X	X
93	1/9/2014	Should we only Answer Yes or NO based on the drugs listed in the supporting document?	Because of the complexity of the GPRO program, it is difficult to answer generalized questions. In many instances, you will answer questions within the Web Interface measures with medications listed based on the Drug List provided within the Supporting Documentation; keeping in mind, certain measures only allow for the specific medications provided to be used (for example, HF-6) and certain measures allow for medications outside of those listed in the Drug List. Be sure to review all documents thoroughly, as medication guidance is provided within the Narrative Specifications and Data Guidance. If you have a question regarding a specific medication for a certain measure, please contact the QualityNet Help Desk.	X	X	X

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94	1/9/2014	Can you provide a clarification about "Medical Record Not Found"? When we went live with our EHR we created a patient record for patients who had ever been seen by our organization going back many years. There is no clinical/encounter data for some of these.	If the medical record cannot be found, then you would answer "No: Select this option if you are unable to find the patient's medical record" in the Patient Confirmation section of the Web Interface.	X	X	X
95	1/9/2014	Could you provide us an example of where in the supporting documentation that will indicate if a measure that is prefilled needs to be verified in the medical chart?	Pre-filled value information is not located within the supporting documents, but in the Online Help, which will be available to all groups upon logging in to the Web Interface.	X	X	X
96	1/9/2014	Do we have to update the patient measures in GPRO by March 21st?	The Web Interface is open between January 27, 2014 and March 21, 2014. All patient data must be updated in the Web Interface between these dates. Once the submission period closes, you will not be able to access the Web Interface to update data, view data, upload or generate XML, run or view reports. These activities are only available while the Web Interface is open during the submission period.	X	X	X
97	1/9/2014	For Care-1 measure, patient rank in patient ranking file and in patient discharge file are going to be same?	The patient's rank in a module is a fixed value and will be the same in all XML files. It will also be the same value displayed in the Web Interface on the Patient List, in the Patient Status, and any reports in which the patient appears.	X	X	X
98	1/9/2014	I thought there were some prefilled measures we could accept based on claims, like influenza vaccination? Can you please specifically address that one as an example?	Yes, certain measures contain pre-filled values, the majority of which a group or ACO may edit or change. For the influenza immunization measure if a claim for influenza immunization was processed by Medicare it will be pre-filled with "Yes". The GPRO doesn't need to add or verify any additional information for patients that are pre-filled with "Yes". Note: This is also true for PREV-6 and PREV-8. A document will be provided to assist abstractors with pre-filled elements.	X	X	X

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99	1/9/2014	If mammogram or colon cancer screening has been done, do we need to report results?	PREV-5: Breast Cancer Screening and PREV-6 Colorectal Cancer Screening do not require results of the screening be documented in the GPRO Web Interface. The date of and the mammography results are required documentation. The colorectal cancer screening measure only requires the records indicate the screening is considered current.	X	X	X
100	1/9/2014	If the patient is given a drug (for e.g. - anti-platelet) but is not listed on the drug choices listed in the supporting document. Would we choose the answer as a Yes or No.	Because of the complexity of the GPRO program, it is difficult to answer generalized questions. If you have a question regarding a specific medication for a certain measure, please contact the QualityNet Help Desk.	X	X	X
101	1/9/2014	Is it correct that the HTN confirmation diagnosis was expanded from the 2012 list than the 2013 spec list?	Please use only 2013 documents when abstracting for program year 2013. Refer to the Release Notes for areas in the specification documents that were changed.	X	X	X
102	1/9/2014	Just to clarify the expectation that is if they are on Coumadin for IVD/DM then they should also be on aspirin?	For DM-16: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease - Warfarin is listed as an exclusion. Warfarin and enoxaparin are considered anticoagulant antithrombotics while aspirin and clopidogrel are considered antiplatelet antithrombotics. Please refer to the Exclusions column within the Data Guidance for details relating to drug exclusions located within the 2013 GPRO Supporting Documents found under the Downloads section on the GPRO Web Interface page of the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
103	1/9/2014	On the exclusions tab it only specifies for the CPT's and not the diagnosis? Please advise.	CPT is not the only type of code you will find within the Exclusion Tab for each module; you will find different code nomenclatures (e.g., ICD-9, ICD-10, SNOMED, etc.). If you have a more specific question, please contact the QualityNet Help Desk.	X	X	X
104	1/9/2014	On the specs it does not specify if you can take inpatient data for measures that have BP example Preventive BP, HTN and diabetes. Can we take a BP from inpatient records?	The diabetes blood pressure measure (DM-13) and Hypertension (HTN-2) requires that the BP be obtained during a visit to the practitioner's office or other non-emergency outpatient facility. The blood pressure can be taken from any setting when reporting PREV-11.	X	X	X

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105	1/9/2014	Panelist just stated dates had to be from the current program year. How does that apply to measures such as influenza vaccine (2012 influenza season) and pneumococcal vaccine?	The dates referenced were in regards to measures requiring dates be added within the Web Interface. For the influenza and pneumococcal measures, you are not required to add a date, you need to confirm that the vaccines were received within the specified time period if they were not pre-populated for you from claims data. The dates entered in the Web Interface where a date value is required must be for the program year.	X	X	X
106	1/9/2014	Please clarify which narrative measure specs we are to use for Pioneer ACO 2013 reporting. There are significant differences in the logic of several measures in QMAT NARRATIVE specs versus the PQRS GPRO narr CQM specs. Do we use PQRS GPRO narr specs now?	Pioneer ACOs are reporting 2013 clinical quality measures via the GPRO Web Interface. Please refer to the "2013 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes" zip file available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	NA	NA	X
107	1/9/2014	Please confirm the tobacco use measures: On DM tobacco use - "yes" means tobacco non-user; in PREV 10 does yes mean tobacco user?	DM-17 "yes" means tobacco non-user. PREV-10 "yes" means tobacco user.	X	X	X
108	1/9/2014	So if a person had a flu shot elsewhere, that person will be a Fail?	Please refer to question #60 & FAQ #232: The exact date or location of receipt of the influenza immunization reported in PREV-7 is not needed. You will need to document that the immunization was received during the current flu season (even if the immunization was received from a local pharmacy), which is August 1, 2012 through March 31, 2013 for the 2013 measurement period.	X	X	X
109	1/9/2014	We have RxNorm codes for statins not in the list provided in the measure specifications for CAD. Must we limit our results to only the statin RxNorm codes in the specs?	Please see the Data Guidance for CAD-2. Within the Inclusions/Synonyms column you will see the following: "See CAD Drug Code tab for a list of lipid-lowering medications (list may not be all inclusive)" In other words, you may use RxNorm codes representing statins included on your list that are not on the list included in the downloadable resource. In addition, please read the note included in this section regarding prescribed statins.	X	X	X

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110	1/9/2014	Will we need to actually enter the patients calculated BMI into the portal? Or do we need to say yes a BMI was completed or no a BMI was not completed?	You do not need to enter the calculated BMI into the Web Interface. Please see the Supporting Documents, the GPRO Online Help, the videos imbedded in the GPRO online help, or the GPRO XML Specifications for the allowable answers for this measure. The allowable answers for all measures can be found in these documents or videos.	X	X	X
111	1/16/2014	Tobacco Assessment and Cessation: If a patient is assessed and identified as a smoker at the current visit, does smoking cessation counseling done at a previous visit within the 24 month look-back period count?	While that is correct, please also note that the 24 month look-back period is measured from the measurement period end date, per the Data Guidance note.	X	X	X
112	1/16/2014	Are the IVD codes for the DM measure and for the IVD measure itself different? I cannot find specific IVD codes for the DM measures	Yes, the codes for these measures are different, as the measures are owned by different measure stewards. Please use the codes that are available in the Downloadable Resource for each measure.	X	X	X
113	1/16/2014	For HTN-2, DM-3 and PREV-11: Is the most recent blood pressure taken during an outpatient procedure the data to report, or should we report on the last non-procedure/Emergency Department visit blood pressure?	For both HTN-2 and DM-13 the most recent blood pressure (BP) obtained during a visit to the practitioner's office or other non-emergency outpatient facility should be utilized. For PREV-11, data from the most recent BP in the patients' medical record should be utilized regardless of setting.	X	X	X
114	1/16/2014	BMI: Can we use a reported BMI that is in a specialty note but without a height and weight noted?	No, the measure requires the height and weight be measured by an eligible professional or their staff (see Data Guidance). Height and weight alone are not sufficient and the BMI needs to have been calculated based on this height and weight.	X	X	X
115	1/16/2014	BMI: If the only office visit was March 2013 and there was no BMI recorded, can we look back 6 months into 2012 to a visit where the BMI is recorded? Or is this a failed measure?	Yes, if the most recent office visit was March 2013 PREV-9 allows a 6 month look back from the most recent visit to determine if a BMI was calculated, or in this case October 2012.	X	X	X
116	1/16/2014	BMI: please clarify what "calculated within the past six months or during the current visit" means when auditing this measure.	If there was documentation on weight and height in a patient's medical record without an actual calculation of a BMI that would not be sufficient. We need to see in the medical record that those numbers were used to calculate the BMI and the plan that came from that result if it was abnormal.	X	X	X

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117	1/16/2014	BMI: Can you please clarify again what types of visits count for assessing whether the BMI was recorded at the most recent visit? (i.e. all outpatient visits including specialists, ED, urgent care, hospital stay?)	PREV-9 does not specify what type of visit, only that an eligible professional or their staff needs to have measured the patient's height and weight that is used for the calculation of the BMI.	X	X	X
118	1/16/2014	BMI: For a patient with a BMI out of range, does a previous visit's follow-up plan count within 6 months? Or do we need to document a follow-up plan at each visit with an abnormal BMI?	The numerator is met when the BMI is calculated at the most recent visit or within the past 6 months of this visit and a follow-up plan is documented within the last 6 months or during the current visit if the BMI is outside normal parameters (see Narrative Specifications).	X	X	X
119	1/16/2014	CAD-7: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%), it appears that some statins that should qualify for the measure aren't covered by the RxNorm codes provided in the specifications. Are we limited to just the RxNorm codes in the specifications?	No, you are not limited to the medications listed in the specifications. For this measure, the data guidance says that the medication list may not be all inclusive.	X	X	X
120	1/16/2014	Can an LDL done in an acute care hospital count?	Yes it can. Any documentation the provider has at the point of care may be used for CAD-2.	X	X	X
121	1/16/2014	Can we confirm diagnosis based on our own claims analysis or must the information be documented in the chart? Can we confirm a diagnosis from one physician and obtain the supplemental data questions from another physician? Does it matter from whom we collect the patient?	The information must be documented within the medical record. A listing of the diagnosis in the exclusions tab within the Downloadable Resource is sufficient. It does not matter which provider has documented the information; only that the information is available to all at the point of care.	X	X	X

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122	1/16/2014	PREV-9: Can we exclude a patient for PREV-9: Body Mass Index (BMI) Screening and Follow-Up for medical reasons if the patient is in a wheelchair?	Yes, you may exclude a patient in a wheelchair.	X	X	X
123	1/16/2014	Can we give guidance to all of our Practices to use the most recent available dates in the Medical record for where the specific values are asked?	We would prefer that you look at this on a measure by measure basis. If the measure you are reporting for requires the most recent quality action then you are correct. However, for GPRO measures it's hard for us to answer generic questions such as this one. Again, please look at the documentation for each measure.	X	X	X
124	1/16/2014	Can we use ambulatory blood pressure monitor readings for the screening blood pressure?	Ambulatory blood pressure monitor readings from the patient are not acceptable. Eligible professionals who report this measure must perform the blood pressure screening at the time of the qualifying visit and may not obtain measurements from external sources.	X	X	X
125	1/16/2014	Can you confirm that "last 12 months" refers to the 2013 calendar year for purposes of current reporting?	The statement “within the last 12 months” in the Data Guidance typically refers to the current 12 month measurement period. However, some measures allow look back periods. Use the 2013 GPRO Web Interface documents provided by CMS to determine the specific requirements for each measure/module.	X	X	X
126	1/16/2014	CARE-1 Medication Reconciliation: Do we meet the measure if the EP went over discharge meds with patient and recommends discontinuing (name of drug) or continuing all meds as documented on med list? Or, do we have to have the actual d/c sheet with meds listed in chart?	Numerator compliance for CARE-1 is met if the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications.	X	X	X
127	1/16/2014	CARE-1: Does it include all discharges in 2013 or only until a certain date in 2013?	The claims data used for sampling is provided to CMS’ contractor at the end of October. Any claims noting discharges processed by that date are included that also have office visits within 30 days of the inpatient facility discharge.	X	X	X

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128	1/16/2014	CARE-1: If the hospital discharge follow-up visit provider note documents end of visit medications and the provider has signed the note would this count as discharge medication reconciliation, or does the note specifically need to state discharge medications reconciled?	Documentation for CARE-1 needs to include: • A note indicating the physician, PA, NP or clinical pharmacist is aware of the patient's discharge medications. • A note reconciling discharge medications with current medications (including dosage) in the outpatient record • A note outlining whether medications are remaining status quo or changing (discontinuation, adding new, changing dosage)	X	X	X
129	1/16/2014	CARE-1 Med Reconciliation: When looking for a hospital discharge should we only be looking at inpatient admissions, or would observation admissions also be included?	CARE-1 discharges are identified by inpatient discharge day management codes found in Physician claims. Observation admissions should not use these discharge codes and therefore should not be included in this measure.	X	X	X
130	1/16/2014	CARE-1 Medication Reconciliation: Will the discharge dates be included in our exported patient list?	The Medication Reconciliation dates are exported separately from the patient list. There are 5 files you may export in the XML. Please reference the XML specs for details. The XML Specs are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
131	1/16/2014	CARE-1 Medication Reconciliation: Will CMS provide all discharge dates the ACO is responsible for verifying within the Web Interface?	Yes, that's correct.	X	X	X
132	1/16/2014	CARE-1 Medication Reconciliation: How do we handle patients who are discharged from an acute care hospital to a skilled nursing facility? Is the skilled nursing facility physician visit the office visit?	No, if the patient is also discharged from the skilled nursing facility and has a single office visit within 30 days of the discharge from the inpatient facility, the office visit medication reconciliation will count as the office visit for both the inpatient and skilled nursing facility discharges. If there is no office visit found in claims within 30 days after an inpatient discharge (inpatient facility and skilled stays) there will not be a pairing (inpatient discharge and office visit dates) to populate in the Web Interface.	X	X	X
133	1/16/2014	CARE-1 Medication Reconciliation: Does the reconciliation process from the provider need to include medications such as eye drops (Over-the-counter as well as prescription) or milk of magnesia, etc.?	Yes, all medications whether prescription or over-the-counter should be reconciled.	X	X	X

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134	1/16/2014	CARE-1 Medication Reconciliation: If a member is discharged from an inpatient facility during the measurement period but were not seen within 30 days following the discharge, are they removed from the denominator of the measure?	When we identify patients that are eligible for CARE-1, we first look for the discharge and then look for a discharge visit with a primary care physician visit associated with your ACO/GPRO within 30 days. On the Web Interface, you will have a table with your discharge dates and the confirmation that the patient was discharged on this date. (+/- 2 days). If you confirmed the discharge date, then you must confirm they had an office visit within 30 days. If they had an office visit within 30 days, then you need to answer the medication reconciliation question. They are not included in the denominator if you cannot confirm the discharge date and that an office visit occurred.	X	X	X
135	1/16/2014	CARE-1: Medication Reconciliation, if the hospital discharge follow-up visit provider note documents the end of visit medications and the provider has signed the note, would this count as discharge medication reconciliation, or does the note specifically need to state discharge reconciliation?	Yes, this would count as medication reconciliation as long as the following information is included per the data guidance : "Medical record must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications".	X	X	X
136	1/16/2014	CARE-2: Falls: Screening for Future Fall Risk, can we count screenings for future fall risk regardless of the setting where they were performed, outpatient or inpatient?	Yes, that is correct.	X	X	X
137	1/16/2014	CARE-2: Falls: Screening for Future Fall Risk, if a patient were screened for fall risk while hospitalized, can this be included as a "yes" if it were within the reporting period within our care continuum?	Yes, as long as the screening is within the measurement period. Refer to the Data Guidance for further clarification of fall risk screening documentation.	X	X	X
138	1/16/2014	CARE-2: Falls: Screening for Future Fall Risk, if we cannot find any 2013 encounters for a ranked patient, can we assume no fall screening was performed?	In order for a patient to be attributed to your GPRO or ACO, the patient must have had 2 primary care visits with your GPRO or ACO during 2013. Use all available information to determine if the medical record can be found and if fall screening occurred.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
139	1/16/2014	CARE-2: Screening for Future Fall Risk, can you clarify that falls risk period is calendar year 2013 or is the 12-month period 12 months prior to the visit?	The 12-month period is calendar year2013 (January 1, 2013 - December 31, 2013).	X	X	X
140	1/16/2014	Claims data from the CCLF files should not be used for ANY measures. Only data documented in the medical records should be used, correct?	Correct. CMS will use claims data when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your ACO is selected for audit following the data collection period. This is not the case if the WI has been pre-filled with claims information.	X	X	X
141	1/16/2014	Clinical Depression Screening: If a completed PHQ-9 form is in the medical record, does that count?	PHQ-9 is an acceptable screening tool for PREV-12. The Data Guidance states, "Examples of depression screening tools include but are not limited to" in reference to the screening tools. The critical element to remember is that the screening tool must be age appropriate and standardized.	X	X	X
142	1/16/2014	Colon Cancer Screening: Is one FOBT ok for reporting or do you need 3 FOBT results?	If you look within the Data Guidance it tells you what test and what timing would be acceptable so yes, one FOBT would be acceptable for the purposes of this measure.	X	X	X
143	1/16/2014	Colon Cancer screening: Must there be documentation of procedure or is physician notation in the chart sufficient?	The physician notation within the medical chart would be sufficient.	X	X	X
144	1/16/2014	Colorectal Cancer Screening: Does the FIT test qualify for the colorectal screening measure?	Yes it does. This clarification has been received from the measure steward.	X	X	X

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145	1/16/2014	Depression Screening: If they have a positive screen, does the follow-up plan need to be documented on the same day that the positive test was documented?	If there is a positive screen documented during the measurement period a follow up plan must also be documented on the date of the positive screen (see Narrative Specifications).	X	X	X
146	1/16/2014	DM-13: High Blood Pressure Control, if the patient has multiple Systolic and Diastolic blood pressure values for their most recent date, are we permitted to take the lowest Diastolic and lowest Systolic as outlined in HEDIS specifications?	The DM data guidance states, "Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP." Please use GPRO Web Interface measure specifications that are located on the CMS website.	X	X	X
147	1/16/2014	DM-14, how does a result of 0 (zero) for "unable to calculate LDL-C due to high triglyceride affect the performance calculation?	For this measure you would fail performance if you enter 0. For questions such as this we recommend you take a look at the measure flows that are available on the CMS website. These measure flows can help you determine performance rates for all the measures.	X	X	X
148	1/16/2014	DM-14: Low Density Lipoprotein (LDL-C) Control, the eligible age range is 18-75 years old. However, the average age of our population is much higher (i.e. 80-90 years old) and would be excluded. What should we do?	When sampling patients for the diabetes modules, we only sample patients within the eligible age range. So you should not find patients outside of the age range. Depending on the age range of your patient population, your sample for this measure may not include 616 patients if you are an ACO or a PQRS GPRO with 100 or more EPs. The maximum sample size for a PQRS GPRO with 25-99 EPs is 327.	X	X	X
149	1/16/2014	DM-16: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease, ASA or antiplatlet use includes exclusions of Coumadin or Lovenox use. It does not state the newer anticoagulants: Eliquis (apixaban), Pradaxa (dabigatran), and Xarelto (rivaroxaban). Are these appropriate exclusions?	The newer medications are also appropriate exclusions. We have received additional measure owner clarification regarding the exclusion of the newer medications listed: Eliquis (apixaban), Pradaxa (dabigatran), and Xarelto (rivaroxaban) are all appropriate exclusions.	X	X	X

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150	1/16/2014	Does a hypertension diagnosis need to be documented in 2013? The technical specifications state any time in patient's history; the same is true for all at-risk measures other than diabetes.	For HTN-2: Controlling High Blood Pressure, the diagnosis can be anytime documented in the patient's medical record up through the last day of the measurement period (December 31, 2013). Please refer to the data guidance for other measures.	X	X	X
151	1/16/2014	For ACO-11 measure regarding EHR use, how can we obtain a list of the physicians who were included in the numerator determination? Also, if there is a discrepancy that a physician should be included, how can we update the list and/or corrected?	This list is not available for this year. Based on feedback, we will consider it for next year. For ACOs that have questions outside of their GPRO measures, please contact the QualityNet Help Desk.	X	X	X
152	1/16/2014	For an A1c or Blood Sugar result, does the entry into the interface need to be a "draw" from a lab or may a Point of Care result be used for reporting?	The requirements for this element do not include a specific location for the drawn sample. The A1c result should be included in the medical record or be available to the practitioner at the point of care.	X	X	X
153	1/16/2014	For the most recent blood pressure documentation, does the data need to be pulled from a Primary Care Visit or would a Specialty office visit be ok to use for the data?	As long as the blood pressure is documented in the medical record, it can be either a primary care visit or a specialty office visit.	X	X	X
154	1/16/2014	GPRO HF-6: Does the reason for not prescribing beta-blocker therapy need to be documented during the measurement period to count or does it count if it was documented anytime in the patient's history?	You may find documentation of a medical reason for not prescribing beta-blocker therapy at any time in the patient's history.	X	X	X
155	1/16/2014	HF measure: Is a clinical diagnosis sufficient to confirm the diagnosis? If not, what are acceptable methods for confirmation of diagnosis.	Yes, clinical diagnosis is sufficient as long as it is documented in the records. For acceptable diagnosis, please refer to the Data Guidance Inclusions/Synonyms and the downloadable evaluations tab for this measure.	X	X	X
156	1/16/2014	HF-6: When will we receive the brand names that map to the 3 generic medications acceptable to use as noted in the Q&A?	Brand name medications are provided by measure stewards at their discretion.	X	X	X

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157	1/16/2014	How will you identify denominator patients for the Heart Failure measure who have LVEF<40% as you only have claims data only	When sampling patients for heart failure, we do use claims to identify those with a diagnosis of heart failure. When you go into the web interface you have an option to indicate whether the patient has LVSD and if they do, continuing to determine if a beta-blocker has been prescribed.	X	X	X
158	1/16/2014	HTN: Regarding the medical reason for not including BP. Is this a pregnancy any time in 2013, or only if still pregnant at last office visit?	This is referencing anytime within 2013.	X	X	X
159	1/16/2014	HTN-2: Controlling High Blood Pressure, can BPs from ED and Urgent Care visits be excluded as well as inpatient BPs?	For HTN-2 the most recent blood pressure (BP) obtained during a visit to the practitioner's office or other non-emergency outpatient facility should be utilized.	X	X	X
160	1/16/2014	HTN-2: Controlling High Blood Pressure, should we use encounters related to the following specialties: Cardiology, Internal Medicine, Family Medicine, Geriatrics, Nephrology, Endocrinology?	You should take the most recent blood pressure reading of the measurement period regardless of provider type, as long as the blood pressure isn't taken in an emergent or emergency or surgical setting.	X	X	X
161	1/16/2014	If a claim for a service (such as flu vaccine) can be identified in claims data but it is not in the patient record because the vaccine was given at a location other than the ACO (such as Walgreens) can the ACO enter this in GPRO and receive credit?	If a claim for an influenza immunization was pre-filled in the Web Interface (a "Yes" answer) you do not need to have supporting documentation in the patient's medical record. If the influenza immunization field is blank (null) when you look in your Web Interface you can select the "Yes" option if you have supporting documentation in your patient's medical record indicating their receipt of the immunization during the flu season (October 1, 2012 – March 31, 2013) or "Prior receipt" (back to August 1, 2012). You are able to take patient report of this immunization being received.	X	X	X
162	1/16/2014	If a patient does not have diabetes but is in the sample and meets other measures, do we include this patient, or do we add an additional diabetic patient to the numerator?	The first thing you'll need to do is confirm the diagnosis of diabetes. If you cannot do that, you'll select no and move on to the next patient.	X	X	X

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163	1/16/2014	If a patient is recorded as deceased before the end of the year, are we reporting data for them through the date of their death, or are we considering them disqualified for the entire 2013 measurement period?	That patient would be disqualified for the 2013 measurement period. Use the Medical Record Found answer to mark the patient as Not Qualified for Sample, the select Deceased as the reason and provide the date. For additional information, please see the Patient Confirmation tab in the Supporting documents available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
164	1/16/2014	If a patient's EF was less than 40% in the past, but now better. How should we report this patient? LVSD, yes or no?	From HF-6 Data Guidance instructions: If the patient has ever had an LVEF < 40% or has had a documented LVEF as moderate or severe answer "Yes"	X	X	X
165	1/16/2014	If a physician puts a patient on a diet for high BMI, and they also have high BP. Does physician have to say that the plan for diet is to reduce BP specifically, or is it acceptable to just have diet documented?	We would expect if you're putting a patient on a specific diet, that this part of the follow-up plan should reference the elevated BMI or high blood pressure. We would expect it to be documented for that physician's knowledge in the future.	X	X	X
166	1/16/2014	If the medical note states the medications were reconciled at a post discharge office visit but it does not specify if the medications were changed, kept, or discontinued, does this count as medication reconciliation?	The CARE-1 data guidance states that the "Medical record must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications."	X	X	X
167	1/16/2014	If the patient is listed under specialty but most data is available in the primary care physician records do records have to be transferred to the specialist to include in their record or is the primary care physician record acceptable?	GPROs and ACOs should follow their specific documentation policies. For PQRS reporting, as long as records are available to the specialist the records do not need to be transferred from the primary care provider to the specialist.	X	X	X
168	1/16/2014	If the physician has documented for the patient questions on the patient's environment (rugs, etc.) does that satisfy the measure, or does history of past falls or injury have to be used?	Documentation of patient environment does not satisfy CARE-2. The following is taken directly from the CARE Data Guidance: Screening for future fall risk may include: Documentation of no falls in the past year or only one fall without injury in the past year or documentation of two or more falls in the past year or any fall with injury in the past year.	X	X	X

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169	1/16/2014	If there is prefilled data in any measure but we have no documentation in the patient medical record, can we use the prefilled data as confirmation?	This depends on what additional information is required for the measure. Some measures require additional information to confirm the patient and if you cannot provide this information, you wouldn't be able to confirm the patient.	X	X	X
170	1/16/2014	In the Part D table, the NDC Code is 11 digits long, whereas the standard NDC Code is 10 digits. Is there a cross reference table to tie the 11 digit NDC Codes back to the standard NDC codes?	CMS does not have a recommendation for a cross-reference or website to map the codes. Utilize appropriate staff or a Google search to map the codes.	X	X	X
171	1/16/2014	Influenza: Confirm that an influenza vaccine received Sept 2013 meets PREV-7 measure.	No, September 2013 would be the flu season for 2014. You may look back to 2012 for the 2013 reporting. Please review the data guidance those dates are specified. For 2013 reporting, the flu season would be from October 2012 - March 2013 with a look back to August 1, 2012.	X	X	X
172	1/16/2014	IVD-2: Use of Aspirin or Another Antithrombotic, is Pradaxa considered an antithrombic	No, Pradaxa (dabigatrin) is not considered an antithrombotic and would be excluded. Prasurel (Effient) however is on the medication list in the data guidance for IVD-2 as an antithrombotic.	X	X	X
173	1/16/2014	PREV-11" The specs state to select no medical reason if the patient has an active diagnosis of HTN. How do you define "active"? Documented in 2013?	Patient is under medical management for hypertension. Documentation of medical management should be indicated in the medical records during 2013.	X	X	X
174	1/16/2014	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the immunization measures?	If that information is available at the point of care, then that information can be used.	X	X	X
175	1/16/2014	Please clarify if you mean to say the BMI look back is from 12/31/2013 and that 2014 services / visits should not be included for data abstraction.	Correct. 2014 Services/visits should not be included for data abstraction for the 2013 GPRO Web Interface submission. However, if the most recent BMI is abnormal it is acceptable to show a note in the chart for a recommended follow up visit within 6 months, which could be a follow up scheduled in 2014.	X	X	X

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176	1/16/2014	Please confirm that documentation for data pre-populated by claims is not required.	With pre-populated data, some of the measures will require additional information. For example, on PREV-5: Breast Cancer Screening, a Yes/No for whether a mammogram was performed will be pre-populated but you need to provide the date and results of the screening. We will be distributing a document in the near future regarding pre-filled elements that will be helpful during submission.	X	X	X
177	1/16/2014	PREV-11 screening for high BP: is a patient reported BP acceptable for BP rescreen if the one taken at the office was elevated?	No, patient reporting for this measure is not acceptable.	X	X	X
178	1/16/2014	PREV-12: Can it be a talk with provider about the feelings to screen for depression?	The provider must substantiate the quality action being reported. Talking with the patient about their general mood is not considered a depression screening using a standardized age appropriate tool. The following is provided in the PREV Data Guidance: Standardized Clinical Depression Screening Tool: A normalized and validated depression screening tool developed for the patient population where it is being utilized.	X	X	X
179	1/16/2014	PREV-10: Tobacco Use: Screening and Cessation Intervention would a note by the physician in the plan section of the chart "Quit Smoking" satisfy the follow-up requirement?	Yes it would.	X	X	X
180	1/16/2014	PREV-11, should we really exclude patients who already have a diagnosis of hypertension? We are worried this will lead to too many skipped patients for this module.	Yes you should remove patients who have a current diagnosis of hypertension. We are aware that this may make your denominator smaller and we are prepared to see this, although the majority of hypertensive patients should be remove during assignment and sampling.	X	X	X
181	1/16/2014	PREV-11, to qualify as a second hypertensive reading, must the readings be consecutive and within the measurement period?	They do not have to be consecutive readings; however, both reading should occur during a 12 month period to be considered a second hypertensive reading for purposes of recommending appropriate follow-up.	X	X	X
182	1/16/2014	PREV-11: Screening for High Blood Pressure and Follow-Up Documented, what type of follow up plan for hypertension should be reported for the out-of-range patient?	The data guidance outlines the different information that should be documented depending on whether the patient is pre-hypertensive; the first hypertensive blood pressure reading is recorded, or if there has already been a second hypertensive blood pressure reading.	X	X	X

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183	1/16/2014	PREV-12 (Screening for Clinical Depression and Follow-Up Plan), the specifications state "no medical reason" can be selected if the patient has an active diagnosis of Depression or Bipolar Disorder diagnosed prior to the first day of the measurement period. How far back prior to 2012 can we look for the diagnosis to be considered active?	There is no requirement for this measure. The active diagnosis must occur prior to the first day of the measurement period.	X	X	X
184	1/16/2014	PREV-12: Screening for Clinical Depression and Follow-Up Plan, does the depression screening have to be done in a face-to-face encounter?	Yes it does. Please see the Inclusion/Synonym column of the Data Guidance for this measure which states, “This measure requires the screening to be completed in the office of the provider filing the code.”	X	X	X
185	1/16/2014	PREV-5: Breast Cancer Screening, are we only going to see females within the correct age range?	Yes, based on the assignment and sampling process, you should only see females. If you see otherwise, please open a help desk ticket and we will work will CMS for a "CMS approved reason to exclude the patient.	X	X	X
186	1/162014	PREV-5: Breast Cancer Screening, how should we answer if the patient refused the screening?	In this instance you will have to select "no" in the Web Interface and it would be a performance failure for the measure.	X	X	X
187	1/16/2014	PREV-5: Breast Cancer Screening, is the period of 24-month look back period January 1, 2012 - December 31, 2013?	Yes, that's correct. If you cannot locate a screening in 2013, you may look back to the previous year, which would be 2012. For this measure, you should have both the date and results of the screening documented.	X	X	X
188	1/16/2014	PREV-5: We have noticed there are a few patients that are eligible for this measure who were 70 years old on 1/1/13 - would we answer "no - other CMS approved reason"?	If you believe a patient is attributed to your sample mistakenly you can open a QualityNet Help Desk Incident to request an “other CMS approved reason”. Please make sure you include the patient rank, module/measure, and reason for request. CMS will approve or deny the request in the resolution of the incident.	X	X	X
189	1/16/2014	PREV-6: Colorectal Cancer Screening, is it true that if a patient refused a colo-rectal screen that this is now considered a "not done" response?	Within the data guidance, the only acceptable reason for exclusion is medical reason. The patient record would fail the measure if the patient refused the screening.	X	X	X
190	1/16/2014	PREV-7: Influenza Immunization, does an influence vaccine given in September 2012 count?	Yes you may look back as far as August 2012 for the influenza vaccine.	X	X	X

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191	1/16/2014	PREV-9, can a measured BMI in the patient's record from an encounter in any setting be used (e.g. outpatient, inpatient, ED, etc)?	As long as you can find the most recent BMI you can use that. In the narrative specification for the BMI measure there is a numerator note that indicates the calculated BMI or follow up plan for BMI outside of normal parameters that is documented outside of the medical record may be reported if done in the providers office or facility or if obtained by the provider from outside medical records within six months.	X	X	X
192	1/16/2014	PREV-9: Body Mass Index (BMI) Screening and Follow-Up, please clarify what "calculated within the past six months or during the current visit" means when auditing this measure.	If the BMI was not calculated at the most recent visit, then BMI needs to be documented within 6 months from the most recent visit. If the BMI is out of normal range, a follow-up plan must also be documented at that current visit or within the past 6 months.	X	X	X
193	1/16/2014	PREV-9: Body Mass Index (BMI) Screening and Follow-Up, when should BMI follow up plan provided: one the date of the encounter which has out-of-range BMI or should we look back 6 months from the most recent out-of-range BMI encounter?	If the patient has an abnormal BMI, a follow-up plan at that current visit or within the past 6 months of the visit should be documented.	X	X	X
194	1/16/2014	The HTN guidance is really difficult to follow and understand can you please take a minute to explain it.	This question is very generic. Please review the documents provided by CMS for the GPRO Web Interface, including the 2013 Narrative Specification, the 2013 Supporting Documents, and the 2013 GPRO Web Interface Flows. If you have further questions please open a QualityNet Help Desk inquiry so we can address your questions/concerns in a more complete manner.	X	X	X
195	1/16/2014	We have patients sampled for which we know their primary care provider is out of network. If we can gain access to those charts, can we report that data?	If you can access those charts at the time of care, then yes you can report that data.	X	X	X
196	1/16/2014	What if a patient recovers from previous LVSD?	For the HF-6 measure the data guidance refers to verification of LVSD if the patient ever had an LVEF less than 40% or has had a documented LVEF as moderate or severe.	X	X	X

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197	1/16/2014	What type of follow up plan for hypertension should be reported for the out of range patient?	HTN-2 does not require documentation or reporting of a follow up plan.PREV-11 requires a follow-up plan and recommendations for the appropriate follow-up plan are included in the PREV Data Guidance. The follow-up plan required for PREV-11 should be documented in the medical records.	X	X	X
198	1/16/2014	When a measure states that screening tools include, but aren't limited to (such as PREV-12: Depression & Follow Up), how do we know what screening tools other than those mentioned will be allowed?	For the PREV-12 measure a standardized and age-appropriate depression screening tool is acceptable.	X	X	X
199	1/16/2014	When using an EHR, can you use the answer to tobacco use listed in social history as an appropriate answer? It is listed in an office visit, has a date but can we use this as a screening since it might be an on-going response from previous office visits.	PREV-10: Determine if the patient was screened for tobacco use at least once within 24 months AND identified as a tobacco user. The response you use must meet the time parameters specified in the PREV-10 Data Guidance and Narrative Specification. If audited, it should be determined that the quality action can be substantiated.	X	X	X
200	1/16/2014	Will PREV-5: Breast Cancer Screening and PREV-6: Colorectal Cancer Screening measures be among those prefilled in GPRO?	Yes, this will be pre-populated when available in the claims. We won't pre-populate the date. Please note, it's only pre-populated if the answer is yes for mammogram screening.	X	X	X
201	1/16/2014	For the collection of the Care data - where must the assessment need to happen? PCP office, hospital, nursing home, over the phone, etc.?	Assuming this question is regarding Care 1 and where the medical record information is coming from, the medical record must indicate that the clinician is aware of the inpatient facility discharge medication and they will either keep the inpatient facility discharge medication or change the inpatient facility discharge medication. All locations mentioned are appropriate as long as the medication reconciliation was reviewed by a PCP, PA, NP or clinical pharmacist.	X	X	X
202	1/16/2014	Do I need to confirm the diagnosis for each patient or just use the provided patient list as the denominator?	You must use information documented within the medical record to confirm a diagnosis. A listing of the diagnosis in the exclusions tab within the Downloadable Resource is sufficient. It does not matter which provider has documented the information; only that the information is available to all at the point of care.	X	X	X

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203	FAQ	Can we use NQF's specifications for a measure when they are available?	On rare occasions, the NQF specifications will differ from the GPRO measure specifications (generally for logistic reasons). Please follow the GPRO specifications, which will reflect the intention of the NQF measure.	X	X	X
204	FAQ	Can we use the claims data we received from CMS to confirm a diagnosis?	No, you may not use the CMS data to confirm a diagnosis. The confirmation is meant to be a confirmation by the ACO or GPRO based on information **in the patient's medical record**. We would like to know that you have a record of what you are trying to confirm. The confirmation can be from documentation anytime in the patient's history up through the last day of the measurement period (the exception being the diabetes modules, where documentation must be from the measurement period or the year prior to the measurement period).	X	X	X
205	FAQ	Are abstractors responsible for reporting actual values (e.g., HbA1c) or will CPT II codes that correspond to the measures suffice?	If the measure specifications indicate that a value must be entered (e.g., HbA1c), then the ACO or GPRO is expected to enter the value (e.g., 8.0). A CPT II code would not suffice. If you can confirm that the prefilled service date is correct, but you do not have the results from that (or any other) test done during the measurement period, then you should enter a "0" in the result field. This patient would be considered complete, but would not count toward the numerator of the performance rate.	X	X	X
206	FAQ	Can we add discharges to the pre-populated discharges in CARE-1?	No. You are only required to report on the discharges that are pre-populated in the GPRO Web Interface.	X	X	X
207	FAQ	What if our records indicate the patient's discharge happened a few days after the date pre-populated into the GPRO Web Interface?	You can confirm the discharge in the GPRO Web Interface if the discharge date in your records is within 2 days (before or after) the discharge date noted in the GPRO Web Interface.	X	X	X
208	FAQ	What if the patient did not have an office visit within 30 days of discharge?	Patients are sampled into this measure only if Medicare claims indicate an office visit within 30 days. If, however, you are unable to confirm an office visit, you would answer "no" under "Office Visit" in the GPRO Web Interface. This discharge will not be included in the denominator of the measure.	X	X	X

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209	FAQ	If we do not have access to our patient's discharge information (e.g., no information at all or only the date of admission), how do we validate the discharge date that is prefilled in the GPRO Web Interface?	It is the ACO's or GPRO's responsibility to obtain this information to the best of its ability to account for the patient's care. If the documentation in the patient's medical record, registry, or other information (e.g., a list received from the hospital) does not reflect an inpatient hospital discharge on this date, **or within 2 days prior or after this date**, then you would need to answer "No". This will disable the medication reconciliation question. If the medical record documentation reflects a different discharge date, again answer "No".	X	X	X
210	FAQ	If a patient is discharged once and has three office visits within 30 days, will the patient appear in the denominator three times?	No. The patient would appear in the denominator once (for one discharge). In order to meet the numerator criteria, medication reconciliation would need to have been performed at one or more of the office visits.	X	X	X
211	FAQ	If a patient is discharged from a hospital to a skilled nursing facility (med rec performed) and then to a long term care facility (med rec performed), what should we report?	Patients who were sampled into this measure had evidence of a primary care visit within 30 days of their discharge. In these cases, a primary care encounter in the SNF or LTC setting can be considered an outpatient encounter.	X	X	X
212	FAQ	When the discharge dates pre-populated are a discharge from hospital to SNF and then back to hospital, is it correct to mark "No" for these discharges until the patient actually leaves the inpatient setting?	For each discharge that is pre-populated in the GPRO Web Interface, the abstractor is required to confirm whether or not a discharge occurred on that date and if so, whether or not a visit occurred within 30 days. In the situation you describe, where you are able to confirm both discharges occurred, you would mark "Yes" under "Discharge" and then move on to confirm whether or not a visit occurred within 30 days.	X	X	X
213	FAQ	Are patients only counted as numerator compliant for medication reconciliation if, after each discharge, their medications were reconciled?	Each of the patient's discharges is counted as a single observation. For each patient/discharge combination in the GPRO Web Interface, you will need to confirm the discharge, confirm an office visit within 30 days, and confirm that medication reconciliation was done. For example, if a patient has two discharges (each with an office visit within 30 days), but medication reconciliation was only done at one office visit after the first discharge, then the patient will contribute two observations to the denominator, but only one to the numerator.	X	X	X
214	FAQ	Can medication reconciliation be performed over the phone?	As long as all of the criteria are met, the reconciliation does not need to be a traditional encounter. For example, telephone encounters are acceptable.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
215	FAQ	For screening for Future Fall risk, should we look for a screening during the 12-month measurement period, or 12 months from the last visit?	The screening must be done during the measurement period in order to be included in the numerator.	X	X	X
216	FAQ	Do we only include vaccinations administered between January and March 2013? Or can we look back into 2012 for documentation of an influenza immunization?	The influenza immunization measure is one of the measures that allow you to look back to before 1/1/2013. If your medical record contains documentation that the patient was administered the influenza immunization between October 1, 2012 and March 31, 2013 OR if there is documentation that the immunization was done prior to October 1, 2012 (by a provider or at another setting), then you can select "Yes" to indicate that an influenza immunization was received. You do not have to verify that patient received influenza vaccine if this information is pre-populated into the Web Interface.	X	X	X
217	FAQ	For immunization measures, if our documentation only includes the month and year of the vaccination, should we fill in a default day of the month?	Neither of the immunization measures (Influenza and Pneumonia) require that a date be included as part of the abstraction. You need only indicate whether or not the vaccination was given during the timeframe specified in the measurement specifications.	X	X	X
218	FAQ	If the medical record does not indicate that the patient has been vaccinated for influenza and/or pneumonia and the patient is unable to recall, how would you recommend answering PREV-7 and PREV-8?	In this situation, you would answer "No" for both, unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.	X	X	X
219	FAQ	For the BMI Screening measure, the description reads "Percentage of patients aged 18 and older with a calculated BMI in the past six months or during the current visit…" What does this mean in context of the measurement year?	For this measure, you are asked to look at calendar year 2013 (the measurement period) and find the last visit for that patient. You should then determine if a BMI was calculated at this visit. If a BMI was not calculated at this visit, then you should look back 6 months (from the most recent visit) to determine if a BMI was calculated. When you find a visit where the BMI was calculated, you will need to determine if it is normal or abnormal. If it was normal, then no further abstraction is necessary. If it was abnormal, then there needs to be documentation that a plan of care was in place. If you are unable to find a visit and recorded BMI within the 6 months preceding the most recent visit, you would indicate that a BMI was not calculated.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
220	FAQ	If a patient's medical record contains height and weight but not BMI, would we need to indicate that a BMI was not calculated? Similarly, what if the weight was measured during the measurement year, but the height was measured in February 2012?	This would not meet the BMI measurement requirements, which requires that both components of the BMI be measured during the measurement year.	X	X	X
221	FAQ	Does the calculated BMI need to be recorded in the GPRO Web Interface?	No. There is not a field in the GPRO Web Interface to record the actual BMI, so ACOs and GPROs do not need to record it.	X	X	X
222	FAQ	Is there any exclusion for patients whose BMI cannot be calculated (e.g., paraplegia)?	Paraplegia would be considered a medical reason for not calculating a BMI.	X	X	X
223	FAQ	One of our terminally ill patients has a BMI outside of normal parameters, but there was no follow-up plan. How do we complete this patient?	Terminal patients are excluded from this measure. The BMI measurement screen of the Web Interface is where you are able to indicate Not Screened for Medical Reason. Because you will have completed available fields for this patient for this measure, you will have completely reported on this patient for this measure.	X	X	X
224	FAQ	If the medical record only indicates "smoking", will that patient be numerator compliant for PREV-10?	We can deduce from this entry in the medical record that the patient was asked that they were a smoker and they answered positively. However, in order to be numerator compliant, there also needs to be indication that the patient received tobacco cessation counseling. In this case, there is no indication of tobacco cessation counseling, so the patient would not be numerator compliant.	X	X	X
225	FAQ	If a patient quit smoking in the last 3 months, will the patient be considered to be a non tobacco user?	Yes, they would be identified as a non-user of tobacco if they quit smoking in the last 3 months of the measurement period.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
226	FAQ	Many of our patients have prescriptions for Bupropion SR 150 mg Extended Release and for Bupropion SR 200 mg Extended Release. The PREV Drug Code list of tobacco cessation agents includes Bupropion SR 150 mg Extended Release but NOT Bupropion SR 200 mg Extended Release. Could we answer "Yes" to the question determine if intervention was received when they are taking the 200 mg one?	Yes, this would be acceptable.	X	X	X
227	FAQ	What documentation is needed for depression screening?	The screening component of the measure is looking at whether or not an age-appropriate standardized screening tool was used. Although the specification provides examples of tools that can be used, use of a specific standardized tool is not required. If the tool used indicates a potential diagnosis of depression, the second part of the measure will require documentation of a follow-up plan. Please note that documentation from the provider that the patient does not have depression is not sufficient evidence of a screening. Note that the medical record does not need to include a copy of the standardized tool that was used.	X	X	X
228	FAQ	If there is a notation in the patient record (in 2013) that the patient is under care of a mental health professional sufficient to exclude the patient from the depression measure?	If there is an indication that treatment by a mental health professional **for depression or bipolar disorder** began or a diagnosis was made prior to the measurement period, then yes, the patient may be excluded from the measure.	X	X	X
229	FAQ	If we have documentation that a colonoscopy was performed in 2009, would that count toward the numerator of the colorectal cancer screening measure?	Yes. You will need to indicate that there is documentation in the medical record of a colonoscopy being performed during the measurement year or during the nine years preceding the measurement year. Note that patient reported testing is allowable.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
230	FAQ	If the physician recommends a colonoscopy, but the patient states they wish to receive the test elsewhere, can that be counted as a "yes"? What if the patient fails to follow up?	In neither of those cases will the patient "count" toward the numerator. The patient needs to have had the colonoscopy during the measurement period or during the 9 years prior to the measurement period, or a flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period, or an FOBT during the measurement period.	X	X	X
231	FAQ	Why do we need to have the mammogram and colon cancer screening reports in our medical records in order to satisfy the screening components of these measures?	To clarify, the measure steward requires that the date of the mammography and findings be present in the medical record for the Mammography Screening measure, but you need only have enough documentation to support that FOBT, flexible sigmoidoscopy or colonoscopy was performed within the respective timeframes as noted in the PREV Data Guidance.	X	X	X
232	FAQ	What dates for a mammography will be counted toward the numerator of PREV-5?	For this data collection period (reporting year 2013), a mammography performed between January 1, 2012 through December 31, 2013 (24 months) will be included in the numerator.	X	X	X
233	FAQ	If we are unable to find the *result* of a mammogram in the patient record, do we need to change the response to "No"? What if we can't find documentation of any mammogram in the past two years?	That is correct. The measure steward's specifications indicate that a mammogram must be accompanied by the results/findings of the mammogram. Because the record of the mammogram was not accompanied by the results/findings of the mammogram, then this case would not be included in the numerator and you would need to answer "No" in the GPRO Web Interface.	X	X	X
234	FAQ	For the mammogram measure, will an MRI count for patients with implants? Will a sonogram count for patients with dense breast tissue?	The measure steward has not included any provision for including MRI or ultrasound testing as a substitute for mammography. We will share your comments with the measure owner for future evaluation.	X	X	X
235	FAQ	Are breast implants an approved medical reason for not having a mammography? What about terminal illness? What if the patient is currently undergoing treatment for breast cancer?	No. None of the above are currently approved medical reasons for not having a mammography. We will bring these suggestions to the measure steward for consideration.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
236	FAQ	For documenting the follow-up visit for the Screening for High Blood Pressure measure, is a future appointment sufficient to satisfy the documentation follow-up?	In order for a future appointment to satisfy the follow-up requirement, there would need to be documentation that links the appointment to the fact that the patient has an elevated blood pressure and requires monitoring of this elevation. In addition, recommended lifestyle modifications, referrals to alternative/primary care provider, anti-hypertensive pharmacological therapy, laboratory tests, or an electrocardiogram are considered recommended follow-up depending on the BP reading. Specific direction is provided in the 2013 GPRO Preventive Care Data Guidance document.	X	X	X
237	FAQ	For Screening for High Blood Pressure measure, if a patient is screened by a specialist, does the specialist need to document a follow up or does this measure only apply to PCPs?	This measure applies to anyone who provides care to the patient. If the specialist notes an elevated blood pressure, then there should be a follow-up plan documented in the record in order to satisfy the numerator requirement.	X	X	X
238	FAQ	Are blood pressure readings done during a stress test acceptable?	A blood pressure taken under more normal circumstances would be more clinically appropriate.	X	X	X

ASSIGNMENT & SAMPLING

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	How is patient age determined for who is in the measures? For example, is it age on Jan 1 of the measurement year?	Yes, age is calculated on the first day of the measurement year. For this measurement period, it is January 1, 2013.	X	X	X
2	11/7/2013	If patient is enrolled in SSP from Jan-Oct 2013 and expires Nov 2013, can the patient be sampled for the quality measures?	We are using data through the end of October 2013; it is possible that the patient would be sampled if they died after that date or if their date of death was not updated in CMS' enrollment database prior to sampling. However, you do have an option in the Web Interface to indicate that the patient is not actually qualified for the sample because the patient is in hospice, has moved out of the country, is deceased, enrolled in an HMO, or for another CMS approved reason. See the 2013 Supporting Documents and Release Notes for ACO and PQRS GPRO Web Interface Users posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	NA	X	X
3	11/7/2013	What is the definition of a primary care service visit? Is the definition a visit by a Primary care physician or any physician (including a specialist) that may use primary care service codes?	There is more information on the primary care service visit on the CMS website and the YouTube videos. A list of primary service codes is available in the 2013 GPRO Sampling Supplement posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
4	11/7/2013	We have had a couple of PCP's resign from our ACO and HPMS shows this will be effective 12/31/2013. However, your attribution methodology of using Q3 2013 will still include these physicians. It will be difficult to get info from these docs.	From the point of care coordination, the Medicare beneficiaries assigned to your ACO did have the plurality of visits at your ACO, albeit the physicians may have left your practice. Additionally, we do have documentation on the SSP website about the affects of dropped or added TINs. Those providers that are participated, but left their ACO will receive a PQRS incentive if the ACO satisfactorily reports quality measures. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Updating-ACO-Participant-List.html for more information.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
5	11/7/2013	Please confirm the following eligibility rule for sampling: Patient must have claims for 2 primary care encounters at our ACO?	Yes, this is correct. The list of HCPCS codes used to identify claims for primary care encounters are presented in Appendices A and B in the 2013 GPRO Sampling Supplement posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
6	11/7/2013	Should there be patients attributed on our sampled patient file who by CMS are attributed to physicians outside of our ACO, can you provide us with the physician/practice name for the minimum of two visits they had within the network so we can chase the data	ACOs will receive the list of beneficiaries prior to the Web Interface opening. The list will include top TIN or CCN and up to three top NPIs based on the number of visits to each provider.	NA	X	X
7	11/7/2013	Are mental health providers exempt from PQRS reporting given the criteria for assigning and sampling patients is two primary care services?	In both the 2013 PQRS GPRO Assignment Specifications and the Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology documents posted on the CMS website, tables 2, 3, and 4 provide list of specialties that are included in each assignment methodology. Mental health professional are included in the list of specialties used for assignment and sampling purposes, in particular geriatric and general psychiatry.	X	X	X
8	11/7/2013	Where could I find a physician specialty breakdown for GPROs? Are surgeons included?	Most surgical specialties included in the assignment methodology as well. Refer to tables 2, 3, and 4 in both the 2013 PQRS GPRO Assignment Specifications and the Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology documents.	X	X	X
9	11/7/2013	How do we handle a patient who is sampled, but we can't identify an office visit during the reporting period?	If this happens to your group during abstraction, please submit ticket to the QualityNet Help Desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org**.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
10	11/7/2013	How will the 218 patients be chosen? Will it be the first 218 claims submitted or just a random 218 patients?	Patients are randomly sampled - see the Assignment and Sampling slide presentation at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. We initially sample from the universe of quality-eligible beneficiaries. PQRS GPROs with 25-99 EPs who are required to consecutively complete 218 patients will provide a sample whenever possible of 327. We do that first by identifying 500 beneficiaries who are eligible for the Preventive Care Modules in general. This random sample will then be populated into the each of the modules whenever possible and for those modules where we are not able to assign 327 particularly for the disease module then we will then randomly sample additional beneficiaries. See the Assignment and Sampling YouTube video at http://go.cms.gov/GPROPlaylist.	X	NA	NA
11	11/7/2013	Where can we find the encounter codes used for "primary care" visits?	There is more information on the primary care service visit on the CMS website and the YouTube videos. A list of primary service codes is available in the 2013 GPRO Sampling Supplement posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
12	11/7/2013	Why won't the Web Interface patient list for PQRS GPROs be released until January 27th?	ACOs receive the patient list prior the opening of submission because they are multi-TIN organizations, meaning that one ACO is made up of multiple group practices from multiple TINs across a wide variety of practice areas. They are given their patient sample in advance so they can gather the information needed for submission. PQRS GPROs are group practices comprised of only one TIN. Additionally, the ACO program has separate contracts with their groups and is able to provide this information securely whereas PQRS GPRO is not set up in the same way.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
13	11/7/2013	In the list of patients that we will receive prior to the opening of the Web Interface (ACOs only), can you please confirm that the following information will be provided: Health Insurance Claim (HIC) number, date of birth, first name, and last name?	This is an ACO only related question. CMS will provide information to identify a patient including the patient's HIC number, date of birth, first name and last name. We will also provide which measures/modules the patient is sampled into and their rank in the measures/modules as well as their top providers. We plan to provide this approximately two weeks prior to the opening of the Web Interface.	NA	X	X
14	12/5/2013	What was the logic behind choosing 411 patients for submission?	A sample size 411 has been used historically in other programs such as HEDIS and the Physician Group Practice (PGP) Demonstration. It yields a 95% confidence interval, which is why we have continued to use it. To account for cases in which a patient must be skipped for a valid skip reason, whenever possible CMS will provide a 50% oversample. Therefore 616 patients will be populated into each module, or all eligible patients if fewer than 616 are available.	X	X	X
15	12/5/2013	What happens if we can't find a beneficiary that's assigned to us in any of our medical record systems?	You are able to skip patients if you cannot find them in the medical records as long as you completely report on 411 consecutively ranked patients in total per module. For example, if you skip one patient, you will need to report on an additional patient, patient 412.	X	X	X
16	12/5/2013	What is meant by "consecutively ranked" in relation to PQRS GPROs with 100 or more EPs reporting via the GPRO WI who must complete 411 consecutively ranked patients in each GPRO module?	When patients are sampled into a module, they are assigned a rank based on the order in which they were sampled. Consecutive means you start at the patient with rank #1 in that module and complete all the patients in the module ranked from 1-411. If you must skip a patient for one of the valid skip reason, you must complete additional patients on a one-to-one basis for each skipped patient. Each module will have a patient with a rank, and you will complete the patients ranked 1-411 in that module. It is possible that each patient will have a different rank throughout different modules. However, the sampling methodology that CMS will use increases the likelihood of a patient having a similar rank in each module into which they are sampled. In other words, a low ranked patient in one module is likely to have a low (though not identical) rank in other modules.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
17	12/5/2013	If we do not participate in the elective ranking, do we need to include rank in our submission?	Patients are ranked automatically as they are sampled into each module in the Web Interface for your group. They will already be ranked when you log into the Web Interface and you cannot change the rank order. In one module, the patient may be ranked #1 but in another module, they may be ranked something differently (though in most cases, we expect a similar rank in other modules). You do not need to enter data in the order the patient is ranked. For example, you may complete the data for a patient ranked #200 in the module before you complete the data for a patient ranked #1 in that module. As long as you complete the first 411 eligible patients for an ACO or PQRS GPRO with 100 or more EPs, or the first 218 eligible patients for a PQRS GPRO with 25-99 EPs, the order in which they are completed is your choice. If you are referring to the elective quality tiering under the Physician Value Program, please submit your question to the QualityNet helpdesk.	X	X	X
18	12/5/2013	Is a "not-eligible beneficiary" considered a "skipped" beneficiary?	Yes, this is correct. You must enter all required information to confirm that a patient is not eligible for a particular module or measure.	X	X	X
19	12/5/2013	Can you explain the 10% skip rate? For example, if we have a 10% rate of those beneficiaries that are deceased, will we still have a successful submission?	If you find patients that you are unable to find medical records for or the proper diagnosis or another appropriate reason for skipping, you need to skip the patient and report on another patient. Once you run a report, you will see the skip rate in addition to how many patients you skipped and the reason. You will still have a successful submission as long as you complete additional patients. If you exhaust your list of eligible patients and report on 100%, you will be considered complete.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
20	12/5/2013	We have 6,000 patients aligned with our ACO. What if the first 411 hit only one EP? How do we ensure that all EPs are sampled?	The sampling is not done at an EP level. The sampling is completed for the entire ACO. There could potentially be EPs in your organization who do not have patients attributed to them in the sample. For SSP ACOs, all of the EPs under an ACO participant TIN satisfy PQRS requirements by virtue of the ACO successfully reporting ACO GPRO Web Interface measures. "Full" Pioneer participant TINs (participant TINs under which all providers participate in the ACO) will satisfy PQRS requirements by virtue of the ACO successfully reporting ACO-GPRO Web Interface measures.	NA	X	X
21	12/5/2013	We have two TINs registered under our ACO. Will the submission of data on the 411 satisfy reporting requirements for all providers, including those without specifically attributed patients?	Yes, it's 411 patients for each of the 15 measure modules. Sampling is completed for the entire ACO, so it is possible that an EP doesn't have any patients attributed in the Web Interface.	NA	X	X
22	12/5/2013	Will the CMS patient sample for GPRO include the confirmed/not confirmed for the disease modules? As an example, would we have to attest someone is diabetic, or is it pre-populated by CMS?	The sample will have been received from claims data submitted with the appropriate G-code. For example, the sample for diabetes would be pulled using claims data with diabetes G-code included on the claim. We ask that you then confirm that the patient does have diabetes documented in the medical record to complete the remaining data.	X	X	X
23	12/5/2013	Are ACOs encouraged to search providers outside of the given TIN and NPIs for quality measures on assigned beneficiaries?	Yes, the information CMS provides on the top TIN and top NPIs is to guide you in looking for patient records; however, as an ACO you have agreed to be accountable for you assigned beneficiaries. You will need to do your due diligence to find records.	NA	X	X
24	12/5/2013	If we have a patient in our sample for ACO GPRO reporting that was attributed by a physician who was rounding in a skilled nursing facility but who left and has provider outside of our ACO, do we use the SNF records for the data and is this acceptable?	In order for the patients who have been assigned to your ACO, the plurality of their primary care services would have been attributed to your ACO. When we identify your patients as eligible for quality sampling we look for two visits within the measurement period with one of the ACO participant TINs. Claims data provides record of patients being seen by an ACO provider during the measurement period; therefore, you should look for medical records for that patient.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
25	12/5/2013	Are the GPRO patients provided from CMS determined by encounter claims submissions so we would be able to find a patient by encounter for the measures?	Yes, patients are initially identified and assigned to the ACO or GPRO based on primary care service encounters provided by the organization. For GPROs, it is for primary care services under their specific TIN and for ACOs; it's for services under their participating TINs. We require a minimum of 2 visits at the TIN during the measurement year to be identified as eligible for quality sampling. Encounter codes for individual measure denominator criteria are available in the measure supporting documents.	X	X	X
26	12/5/2013	Would patients who have only seen an Urgent Care provider within our TIN still be required to report on, or would this be an eligible skip?	Based on assignment and sampling methodology the patient was assigned to your TIN. If you have the patient's medical record you would be required to report.	X	X	X
27	12/12/2013	If a provider leaves the ACO, what selection would be the appropriate choice for a patient?	If you still have access to the patient record, you should report data for the patient.	X	X	X
28	12/12/2013	Will beneficiaries who decline to share data be included in the random sampling?	Yes, they would be included in your sample.	NA	X	X
29	12/12/2013	If a provider is listed under an ACO, they are covered under the GPRO incentive. Do they still have to report on their non-ranked Medicare patients through PQRS?	The ACO should only report on the assigned patients in each module. You will need to populate the data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or patient care measures. If the pool of eligible assigned beneficiaries is less than 411, then you will need to report on 100% of assigned beneficiaries.	NA	X	X
30	12/12/2013	How are we going to know if a patient/beneficiary is a HMO Medicare enrollee for the previous year (measurement year)?	When we are sampling, if we find HMO enrollment as a primary payer, we will not sample those patients. However, if you find this information, then you can indicate that as a reason the patient is Not Qualified for Sample and provide a Reason of HMO Enrollment with a Date.	X	X	X
31	1/9/2014	What is the format of the beneficiary file that will be sent to ACO's on January 13th (i.e. xml, csv, xlsx, etc.)	The beneficiary file that will be sent to ACOs only will be delivered via your ESP or MSP mailbox as an Excel file (.xlsx).	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
32	1/9/2014	Can you confirm that the Sample Beneficiary List will be downloaded from the GPRO site?	The Patient Ranking XML file will contain your Beneficiary List. This file contains the patients Demographic information and the modules in which the patient is ranked. See the GPRO XML Specifications for all the values contained in this file.	X	X	X
33	1/9/2014	If an ACO has not requested claims data for a beneficiary because the person did not want CMS to share the data to the ACO, will that beneficiary be excluded from PQRS?	No. Quality data collection is not related to the data sharing processes that have been established for the Claims and Claims Line Feed data. A beneficiary opting out of data sharing does not exempt them from quality reporting.	NA	X	X
34	1/9/2014	If selected medical record found "NO" will skip patient from all the modules and measures correct?	Yes, Selecting "No" will skip the patient in all modules and measures. If the Medical Record Found is set to "Not Qualified for Sample" and a valid Reason and Date are provided, the patient will also be skipped in all modules. You will need to complete data for an additional patient in each skipped module. See the Patient Confirmation tab in each of the Supporting Documents as well as the Medical Record Found video imbedded in the GPRO Online help for more information on skipping a patient.	X	X	X
35	1/9/2014	In terms of consecutive ranking, let's say we are doing the XML with all the patients listed. The ranking for each measure will be in a different order due to the sample taken. Do we do 411 consecutive patients for the aggregate list or by module?	You need to complete data for 411 consecutive patients in each module.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
36	1/9/2014	When the beneficiary list is provided, will it be in the format of the measures as well? If not, for those ACOs who are uploading data via XML, is there a specific format that we need to have it in?	The beneficiary file that will be sent to ACOs only will be delivered via your MFT mailbox as an Excel file (.xlsx). If you are uploading XML files you must use the format specified in the GPRO XML Specifications. The XML Specifications are available on the CMS GPRO Web Interface page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. If you export your patient data or patient discharge data in an XML file from the Web Interface it will be in the same format that is required for an XML upload.	NA	X	X
37	1/9/2014	Will the random sample be available in the MFT 1/13/14 in the morning?	Each ACO received a Beneficiary-Provider Supplemental Information File on 1/13/14 as planned. The file was delivered to each ACO's MFT mailbox, and will be available for download until February 11, 2014. Groups will be able to access the beneficiary information when the Web Interface opens on 1/27/14.	NA	X	X
38	1/16/2014	How should the three primary care physician names be used? Do we abstract any and all data from any or all patient records from any/all of the three provided names?	The physician name is provided to help you as a point of reference to help you find patient medical records, however the physician list is not exhaustive and you should look for all data on the patient.	NA	X	X
39	1/16/2014	How should we then handle discrepancies in HIC#s when the CMS file has one HIC# and our charts reflect a different number? How should this be documented in GPRO?	The Railroad Retiree Board or the Social Security Administration assign patient Health Insurance Identification Numbers (HIC#). Patient's HIC#s may change over time as eligibility reasons change (for example, the last two digits of a patient's HIC# may change if the patient's eligibility status changes from spouse to widow or the entire HIC# may change if a patient changes eligibility from self to dependent status). Whenever possible you should confirm the patient based on other criteria (e.g., name, gender, date of birth).	NA	X	X
40	1/16/2014	If a patient turned 76 in 2013 and is ranked for cancer screening should we answer the question as they were within the age range for part of 2013?	Yes they should. For the GPRO program we look at the patients' age as of January 1 of the program year.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
41	1/16/2014	If any sampled patients were to die after your Q3 sampling but before the end of the measurement period I would mark the patient as deceased and skip them. What if the patient became deceased during the data submission period in 2014 (thru March 21)?	If the patient was alive for the entirety of the measurement period (calendar year 2013) then you are responsible for reporting on that patient. Therefore, you should report on patients that died in 2014.	X	X	X
42	1/16/2014	If dates provided for the Med Rec measure for discharges do not match any dates in our medical records for a discharge, should we exclude the patient or use the CMS provided discharge date for denominator inclusion?	When confirming the discharge date for 2013 reporting of CARE-1, the date used for verification can be plus or minus two days on either side of the pre-filled discharge date. The office visit where medication reconciliation was accomplished must be within 30 days of the discharge date.	X	X	X
43	1/16/2014	If the ACO reports on a deceased, HMO, or hospice patient unintentionally does this count against the ACO completely reporting on 411 beneficiaries?	If you reported on a patient as deceased, HMO, or hospice, you would be able to go back into the Web Interface and fix it. If you unintentionally provided measure data, then determined that the patient is no longer qualified for the sample, you should use the Medical Record Found section to mark the Patient as Not Qualified for the Sample and provide the reason and Date. The patient will not count toward the minimum number of patients required for the module(s) in which the patient is ranked. The measure data for patients marked as not qualified for the sample will not be used in completeness or performance calculations.	X	X	X
44	1/16/2014	If the patient is attributed to a psychiatrist and does not have any other office visits with a Primary Care Physician, can we exclude this patient as we cannot go through these charts?	No, if you have a situation such as this, please open a Help Desk ticket. We will work with you to find the visits that attributed the patient to your group. As needed, we will work with CMS to provide a "CMS approved reason". Please note that the assignment and sampling process is at the TIN level, not the provider level.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
45	1/16/2014	In addition to the 3 physician names we receive 1 TIN in the sample file set, will the Web Interface show us 3 TINs for the 3 physicians when it opens on Jan 27?	Yes, these will be available in the Web Interface. We populated up to 3 providers if that many were found in claims for the primary care HCPCS codes. If only one or two providers are populated for a given patient, those were the only NPIs we found in the relevant claims. For clinics, we only populate a single value for each patient. This is usually a TIN but may be a CCN for ACOs with FQHCs and RHCs. For GPROs, the TIN will be the GPRO TIN for all sampled patients.	X	X	X
46	1/16/2014	In our PQRS patient list, there patients that are not part of the ACO, i.e not in the latest assignment list. Do we need to provide PQRS info for those patients?	All patient samples for the GPRO WI were based on a third quarter assignment for MSSP ACOs. For Pioneer ACOs we use data available as of the third quarter which was exclusions through the second quarter.	NA	X	X
47	1/16/2014	Last year, we had some patients attributed to our ACO that had not activity in record for more than 4 years. Would we be able to say could not find medical record since there is absolutely no activity?	Due to differences in the patient attribution methodologies for Pioneer ACO's and MSSP ACO's it may be possible that an assigned or aligned beneficiary was not treated within the medical year. To address the situation we require two visits at one of the ACO participant TINs during the measurement year. According to the claims, we have found the patients to be associated with your ACO during the measurement year so this should not be an issue.	NA	X	X
48	1/16/2014	The patient list we received is missing some information such as patient discharges, dates. When can we expect that data?	The patient discharge dates will be available when you log in to the Web Interface.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
49	1/16/2014	To clarify, if the mammogram, colorectal screen or flu shot is prefilled we do not need to confirm it is located in the chart?	Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your ACO is selected for audit following the data collection period. This is not the case if the WI has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: • A note indicating the date the breast cancer screening was performed AND • The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the ACO be selected for audit.	X	X	X
50	1/16/2014	We dropped a provider end of December, 2013. We noticed that there are several patients from that provider. What do we need to about these patients?	You are responsible for reporting on this patient to the best of your ability. If necessary, you should contact the provider in order to gather the required information to completely and accurately report on that patient. If you no longer have access to the patient's medical record and are unable to access it through the dropped provider, then you should indicate "Medical Record Not Found". However, if you have the medical record you may not select that option, even if some documentation is missing from the patient's record.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
51	1/16/2014	We found over 30 PQRS patients that are not in our 3rd Quarter, 2013 assignment list. Please advise what we need to do about these patients.	All patients entered into the Web Interface were taken from the 3rd Quarter 2013 assignment list. So, this should not happen. If you encounter this, please open a Help Desk ticket.	NA	X	X
52	1/16/2014	We have beneficiaries that have been sampled but are still in the 30-day waiting period for data sharing. Will the pre-populated data provided include information on patients who have opted out of sharing information or have not yet responded?	This question is specific ACOs only. Data sharing is separate from quality reporting. So even if a patient has opted out of data sharing, they could still potentially be included in your samples and you would need to report on those patients.	NA	X	X
53	1/16/2014	We received the beneficiary sample file, however we saw three beneficiaries with different HIC# than what was provided in the IIIQ beneficiary files (first/last name and DOB are same for these beneficiaries). What should our best course of action? Which HIC# should we use?	HIC numbers do change for beneficiaries over time. If you can match on other variables such as first/last name, DOB, that should be fine. Otherwise, I would reach out to the patient.	NA	X	X
54	1/16/2014	Will the discharge date file (Medication Reconciliation) be available before 1/27/2014?	No that file will not be available before 1/27/2014.	X	X	X
55	FAQ	What is the significance of a patient's rank?	Each sampled patient in the module/measure is randomly assigned a rank order number for that module/measure. Patients will be ranked 1-616 for an ACO or PQRS GPRO with 100 or more EPs, or the maximum number of eligible beneficiaries if fewer than 616 are eligible for a given module. The purpose is to facilitate completion of 411 cases in consecutive order. For PQRS GPROs with 25–99 EPs, patients will be ranked 1–327 to facilitate completion of 218 cases in consecutive order.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
56	FAQ	Will each ACO child (participant) TIN receive its own set of samples?	No. Quality data collection, measurement and reporting in the ACO program are conducted at the ACO-level. The 15 samples on which ACOs will need to submit clinical quality data will be drawn across all assigned/aligned beneficiaries across all the child TINs of the ACO. In other words, there will be one set of 15 samples drawn for the entire ACO, not for each TIN in the ACO. The patients will be assigned to a clinic during the sampling. The Clinic IDs for an ACO will map to the participating ACO TINs. The Patient List can be sorted or filtered by the Clinic Name or ID to refine the list.	NA	X	X
57	FAQ	What if one or more of our modules contains fewer than 411 (for ACOs and PQRS GPROs with 100 or more Eligible Professionals (EPs)) or 218 (for PQRS GPROs with 25-99 EPs) ranked patients?	Not every module or measure will have a sample of 616 patients (or even 411 patients) for ACOs and PQRS GPROs with 100 or more EPs or 327 (or even 218) for PQRS GPROs with 25-99 EPs; this is particularly true in modules with diseases that have low disease prevalence rates. If CMS' contractor was unable to identify 616/327 patients that met the module sampling criteria, then all patients who meet the criteria will be sampled. In past experience, we have seen low numbers of patients sampled into the Heart Failure module. If you have fewer than the minimum number of patients in a module, you must confirm and complete or provide a valid skip reason for all the patients in the module.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
58	FAQ	What will be populated into the GPRO Web Interface?	The following information will be pre-populated by CMS using Medicare claims, enrollment, and provider information available in the Integrated Data Repository (IDR) as of October 31 of the measurement year. Medicare HIC ID of the patient. First and last name of the patient. Gender Patient Date of birth Patient Rank in each module, if applicable The 3 Providers that provided the most primary care services to the patient Clinic at which the patient received the most primary care services Date of HbA1c test (DM module) Date of LDL-C test (DM module) Date of LDL-C test (IVD module) Mammogram (PREV-5) Colorectal Screening (PREV-6) Flu Shot (PREV-7) Pneumococcal Vaccination (PREV-8) Discharge dates (CARE-1)	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
59	FAQ	What if pre-populated demographic information is not accurate?	While the end-user can modify the demographic information prefilled into the GPRO Web Interface, we expect little need for ACOs and GPROs to modify this information. However, if the patient's demographic information in your records and in the GPRO Web Interface does not match, then the abstractor may need to correct the information in the GPRO Web Interface. The most common issue may be a patient's date of birth. Medicare claims may not have the accurate date of birth for a patient, and your ACO or GPRO should correct this information since all measures have an age criteria for which the patient may be affected (e.g., patient may be removed from the denominator). If any changes to demographic information (such as age or sex) result in the patient no longer being qualified for the measure, you should select "Other CMS Approved Reason". Note that any demographic information you change in the GPRO Web Interface cannot be fed back into the CMS claims system. You should urge your patient to contact the Social Security Administration directly to have that information	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
60	FAQ	Is the ACO or GPRO responsible for validating the data that is pre-populated into the Web Interface?	You will need to look at the data guidance for specific measures to answer this question. For example, if an HbA1c lab test date is prefilled for a particular patient, the ACO or GPRO will need to identify the HbA1c value from that test. If, in your medical records, you do not find documentation of an HbA1c test performed on that date or cannot find an associated HbA1c value, you can then change the date to one that is within the measurement period for which you do have the HbA1c value. Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your organization is selected for audit following the data collection period. This is not the case if the WI has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: A note indicating the date the breast cancer screening was performed AND The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the organization be selected for audit.	X	X	X

PAYMENT ADJUSTMENT

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	We are a group of more than 100 providers. We understand that we can submit one measure through the Web Interface for all our providers and that will satisfy the requirement for the PQRS and also the value based modifier to avoid the penalty. Is that correct?	There are two sets of criteria for reporting 2013 PQRS Web Interface reporting to avoid the 2015 PQRS and Value-based Payment Modifier (VM) adjustment: 1.) Meet the criteria to avoid payment adjustment. To avoid the PQRS payment adjustment, your group must submit one valid measure through the GPRO Web Interface. Please note, if your group registered for the Value-based Payment Modifier (VM) quality tiering, then reporting only one valid measure may subject the TIN to a downward VM adjustment in 2015. Please also note that certain data for 2013 Web Interface reporting will be posted on Physician Compare. Additionally, CMS encourages all groups to learn how to satisfactorily report during the 2013 reporting period in order to prepare for participation in future program years. 2.) Satisfactory report to earn the 2013 PQRS incentive by reporting on all measures included in the Web Interface and populate data for the first 218 consecutively ranked and assigned beneficiaries if you are a group of 25-99EPs or on the first 411 consecutively ranked and assigned beneficiaries if you are a group of 100+ EPs, or if there are less than that number, to report on 100% of assigned beneficiaries.	X	NA	NA
2	11/7/2013	Do ACO TINs still need to report one measure to avoid the PQRS payment adjustment or does all reporting for the ACO take care of that requirement?	The PQRS payment adjustment is applied to ACOs in the same way as for PQRS GPROs. In order to earn the PQRS incentive, you would still have to meet minimum Web Interface ACO requirements for PQRS reporting.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
3	11/7/2013	Is there another way that we can use to report one measure for one patient in order to avoid the 2015 PQRS payment adjustment? For example, is submitting via claims an acceptable way to report the one measure for one patient to avoid the PQRS payment adjustment?	There is no opportunity to change reporting methods since the registration period has closed. So, if you selected the GPRO Web Interface as your reporting mechanism, you must submit one valid measure for one patient in the Web Interface to avoid the payment adjustment. In order to earn the PQRS incentive in 2013 (and if applicable, to meet the Shared Savings Program Requirements), you must report on all measures/modules for your patient threshold (411 patients for ACOs and PQRS GPROs with 100 or more EPs, and 216 patients for PQRS GPROs with 25-99 EPs per measure/module). If you're a group practice, you cannot report via claims. Claims reporting is only for individual PQRS reporters.	X	X	X
4	11/7/2013	Please clarify the criteria to avoid the PQRS payment adjustment for 2013 claims. Is it correct that the group must report on one measure successfully, for each NPI associated with that tax identification number (TIN)?	If your group is reporting as individuals (i.e., each EP in your group is reporting individually), they can submit one measure via a G-Code on their claim to avoid the payment adjustment.	X	X	X
5	11/7/2013	We need clarification on this other piece [payment adjustment], if the complete ACO reporting also takes care of avoiding the PQRS pay adjustment, for all participating TINS with the ACO. Please clarify. Thanks.	That does count for all participating TINs within and ACO if the ACO satisfactorily reports on behalf of the participating TINs.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
6	11/7/2013	So if I have 300 providers, I merely need to submit a successful Web Interface measure for just one beneficiary in the sample?	There are two sets of criteria for reporting 2013 PQRS Web Interface reporting to avoid the 2015 PQRS and Value-based Payment Modifier (VM) adjustment: 1.) Meet the criteria to avoid payment adjustment. To avoid the PQRS payment adjustment, your group must submit one valid measure through the GPRO Web Interface. Please note, if your group registered for the Value-based Payment Modifier (VM) quality tiering, then reporting only one valid measure may subject the TIN to a downward VM adjustment in 2015. Please also note that certain data for 2013 Web Interface reporting will be posted on Physician Compare. Additionally, CMS encourages all groups to learn how to satisfactorily report during the 2013 reporting period in order to prepare for participation in future program years. 2.) Satisfactory report to earn the 2013 PQRS incentive by reporting on all measures included in the Web Interface and populate data for the first 218 consecutively ranked and assigned beneficiaries if you are a group of 25-99 EPs or on the first 411 consecutively ranked and assigned beneficiaries if you are a group of 100+ EPs, or if there are less than that number, to report on 100% of assigned beneficiaries.	X	X	X
7	11/7/2013	While the ACO Quality Measures are Primary Care related, all participant TINs including Behavioral Health and Specialists who are in our ACO are eligible for the PQRS incentive and avoidance of penalty, right?	When the ACO satisfactorily reports quality measures, the ACO participant TINs with PQRS eligible professionals receive credit for PQRS reporting on behalf of all eligible professionals that are part of the TIN, PCPs and specialists. Please see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf for a list of EPs.	NA	X	X
8	11/7/2013	Are ACOs provided with the amount of PQRS bonus money paid to every TIN, by TIN, in their ACO?	Incentive payments are paid to the participant TIN not primary TIN.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
9	11/7/2013	How does the participant TIN within an ACO get the PQRS incentive bonus amount by individual NPI? We are a participant TIN and cannot locate a report that delineates the bonus distribution.	ACOs do not get PQRS feedback reports which provide the NPI break down.	NA	X	X
10	12/5/2013	To avoid the payment adjustment, do you have to select one measure and complete 411 beneficiaries?	You must report on one patient for one measure to avoid the PQRS Payment Adjustment through the Web Interface.	X	X	X
11	12/12/2013	To avoid the PQRS payment adjustment, it is required that at least one measure is reported via the Web Interface. If our group reports only 1 measure, will we receive error messages because not all measures are submitted?	Yes, the Web Interface will show errors because it is missing data. However, if you are only submitting one patient for one measure to avoid the payment adjustment, this is acceptable. You must go to the Submit Screen on the Web Interface and click the Submit button to notify CMS that your submission is complete.	X	X	X
12	12/12/2013	If our organization did not choose quality tiering, is it still possible for our organization to incur CMS penalties if our organization still submits everything required on the Web Interface?	For PQRS and Value-based Modifier (VM) purposes, if you submit satisfactorily in the GPRO Web Interface, your group will not be subject to a payment adjustment.	X	NA	NA

TIMELINE

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	I noticed on the email that the Web Interface is scheduled to open January 27-March 21, 2014. I would like to point out that the deadline for submission of data for the EHR Incentive program for the 2013 program year is February 28, 2014. My group, like many others, is tasked with submitting data for both of these programs. Providers beyond their first year of demonstrating meaningful use have to report data for the entire 2013 calendar year. We will not be able to begin compiling their data (~400 eligible providers) until after January 1, 2014. It is time consuming to pull the data and submit via the attestation system.	We understand and agree with your concerns. We are working to align the program timelines where possible, and while we understand compiling data can be burdensome, we need to receive quality data as close to the end of the reporting period as possible in order to perform calculations and provide timely feedback. Please note submitting data for EHR incentive pilot is done through the PQRS data warehouse.	X	X	X
2	11/7/2013	When will Web Interface open?	January 27, 2014 – March 21, 2014	X	X	X
3	11/7/2013	Will ACOs be provided the beneficiary list (sample of patients selected) for quality reporting prior to January 27th?	Yes, two weeks prior to the opening of the Web Interface, the ACOs will be provided with an excel spreadsheet containing this information.	NA	X	X
4	11/7/2013	To clarify, will the beneficiary lists be provided 2 weeks in advance of 1/27 to both ACOs and GPRO Web Interface participants? How will the lists be distributed? When will the exact date these lists will be available be announced?	The target date for distributing the list is January 13, 2014 and it will be available on MFT and the ACO portal. GPROs will receive their participant list when the Web Interface opens on January 27, 2014.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
5	11/7/2013	When will the measure specs (not XML) and Web Interface User Manual for 2013 be posted?	There are a couple different user manuals, the one that is posted on the portal (https://www.qualitynet.org/portal/pqrs Physician and Other Health Care Professionals Quality Reporting Portal) will be available after January 9, 2014 [we do not have the exact date]. This manual will show you how to login to the Web Interface. The online help within the Web Interface has information on using the Web Interface. This manual will be available when the Web Interface is open. Measure specs were posted in December 2012.	X	X	X
6	12/5/2013	When will the Shared Savings payments be made to an ACO for the 2013 year (i.e. for an ACO starting 1/1/2013)?	For an ACO with a January 2013 start date, the financial reconciliation results will be available in the spring/summer of 2014.	NA	X	X
7	12/5/2013	In a past Webinar, we were made aware that ACO GPRO files will be available 1/13/2014. What files can we expect to receive on 1/13/2014? How will these be delivered?	The file that will be delivered on 1/13/2014 is a file that identifies all beneficiaries that are ranked and sampled into the Web Interface for your ACO. The file consists of the patient's HIC number, first name, last name, birth date, gender, the patient's rank in each of the modules into which they are sampled, the TIN that provided the patients with the most primary care services in 2013, and the NPI, first name, and last name of the three EPs that provided the most primary care services for the patient. The goal is to help you get started ahead of time in identifying patient records both in terms of which patients and where you might look for them. These will be delivered via your MFT or EFT mailboxes.	NA	X	X
8	12/5/2013	Last year, we received a file on 2/4/2013 that appears to be a key file. This is a supplemental file that was received 11 days before the portal was open. When can we expect to receive this file for 2014?	This is the file that will be delivered via your MFT or EFT mailboxes on 1/13/2014.	NA	X	X
9	12/5/2013	When will physicians receive their PQRS payments?	For 2013, the payments will go out by summer or fall of 2014.	X	X	X
10	12/5/2013	When will we receive our retrospective year end assignment list?	ACOs participating in SSP will receive your retrospective list at the time you receive your financial reconciliation. We anticipate that ACOs with Program Year 1 ending 12/31/2013 receive these reports in summer of 2014.	NA	X	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
11	12/5/2013	Will the file sent on 1/13/2014 include date of which Medication Reconciliation date is needed?	No, it won't. The file will not contain measure specific information. It will contain only patient identifiers and patient rank in each module.	NA	X	X
12	12/5/2013	Is the only file we will not receive on 1/13 the Discharge file?	The only file you will receive is the basic information identifying the patient and their rank in each module. The rest of the information, including all measure-specific information, will be available on the Web Interface when it is opened on 1/27/2014.	NA	X	X
13	12/12/2013	Are the sample files available January 9th?	The XML sample files are currently available on the GPRO Web Interface page of the CMS website under the Downloads section	X	X	X
14	12/12/2013	Will the sample lists be available 2 weeks prior to GPRO opening?	For the ACOs, your patient sample will be available on January 13, 2014 and can be accessed through your MSP or ESP mailbox. For PQRS GPROs, your patient sample will be available on January 27, 2014, when the Web Interface opens.	NA	X	X
15	12/12/2013	What is the final deadline for submission of the XML?	The final deadline for submission is March 21, 2014. When you are finished updating your data in the Web Interface, please ensure that you press the Submit button on the Submit screen of the Web Interface. This notifies CMS that the data submission is complete. We are encouraging groups to begin submission as early as possible.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
16	1/9/2014	Is there a section that tells the sequence of flow - When we get the claim files, activity on web interface, submitting XML?	You do not get claim files, your claims submitted to CMS are used to select a sample of your eligible patients, which are loaded into the Web Interface before the submission period begins. The Web Interface submission period is January 27 through March 21, 2014. You will be able to log into the Web Interface starting January 27, 2014. During the submission period you will be able to see the patients selected for your sample. You may update the measure data for your patients either by manually entering the data or uploading an XML file containing the data between January 27 and March 21, 2014. You may also run reports during they submission period. You must complete the data for the minimum number of patients required by the ACO Program or by your GPRO size in each of the 15 modules during the submission period. After you complete the data for the required number of patients, you must Submit your data to CMS by selecting the Submit button on the Submit page on the Web Interface. After the end of the submission period on March 21, 2014 you will not be able to access the Web Interface. This means you must update all data, submit your data, run any desired reports, or export any XML files before March 21.	X	X	X
17	1/9/2014	Can you please clarify what will be available on January 13th as stated earlier?	ACOs will receive a file on 1/13/14 with information about the patients sampled for GPRO Web Interface reporting. The file will include the following information about each sampled patient: • HICNO • Patient first name • Patient last name • Sex • Birth Date • Patient Rank for each of the samples • The TIN or CCN that provided the patient with the most primary care service visits NPIs, first names, and last names of the 3 providers who provided the highest number of primary care services to the patient	NA	X	X

CG-CAHPS SURVEY

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	In the videos, it states a video will be shared soon on CG-CAHPS. When can we expect that information to be available? Will this be a requirement in 2014, and will CMS administer the survey?	The video will be posted shortly and we will send a notice when it is available. CG-CAHPS survey is a 2013 requirement and CMS will administer that survey to those groups that 100 or more. The 2014 PFS final rule has not been posted so CMS cannot comment on 2014 requirements.	X	X	X
2	11/7/2013	Is the CAHPS survey going to count for or against quality tiering? What are the results like, i.e. are they presented as patient names or just percentages? Is there a sample of the survey available?	The CG-CAHPS will not count for purposes of quality tiering based on 2013 performance (2015 payment adjustment period). The results are provided by the survey vendor. No patient names are given. This is an anonymous survey, so only percentages are released. There is a copy of the survey on the website (http://acocahps.cms.gov/) that was set up for vendors that will be administering the survey.	X	X	X
3	11/7/2013	What happens if you plan to report through GPRO and already have implemented the CG-CAHPS survey? Can CMS take the data from our survey vendor?	For this year, CMS cannot take data from your survey vendor. For 2013, CMS will administer the survey for ACOs and PQRS GPROs with 100 or more EPs. You can view the CAHPS survey at this address: http://acocahps.cms.gov/. The survey is the same for both ACOs and PQRS GPROs with 100 or more EPs.	X	X	X

2012 GPRO REPORTING

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
4	11/7/2013	We are an ACO who successfully reported all quality measures via the GPRO Web Interface for 2012. We are trying to identify the PQRS incentive amount for each of our physicians' NPI, but cannot locate the QRUR report on the Portal. Please advise.	For ACOs, the PQRS incentive payment is made at the participating TIN level. There is no report available which defines the amount of PQRS incentive per NPI for ACOs.	NA	X	X
5	11/7/2013	Is there a way to find out which of our providers did not meet the EHR measure?	Please send your question to the ACO help desk.	NA	X	X
6	11/7/2013	We cannot find a report to identify the PQRS incentive bonus amount for each NPI under the participating TINs in our ACO, either via the ACO portal or the PQRS feedback reports. How do I get this info?	ACOs do not get PQRS feedback reports which provide the NPI break down.	NA	X	X
7	11/7/2013	We submitted as a GPRO in 2012. We will know you received data because we received confirmation of transmission, and we have a QRUR report based on 2012 data, but we have no PQRS feedback report for 2012. Please explain.	The 2012 PQRS GPRO feedback on reporting information is combined in the 2012 QRUR report.	X	X	X
8	11/7/2013	Can you tell us how many ACOs used the XML Upload versus the Web Portal?	Based on our experience last year, we found that most of the ACOs and PQRS GPROs used a mixture of both XML upload and manual entry in the Web Interface. There are situations where it is possible to extract a date from an electronic health records system, but they might have to look up the value and we've heard examples of that. The majority of the patient updates were done with XML last year.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
9	12/5/2013	I was able to see last year's QRUR report and noticed that there are inclusions/exclusions with the disease modules. Will these automatically be included in the patient sample, or would we identify them as null value?	Questions related to QRUR reports should be directed to the QualityNet Help Desk.	X	X	X
10	1/09/2014	For the 2012 Program Year ACOs were required to confirm all pre-populated fields for Breast Cancer Screening (per Q&A). Will that apply to the 2013 Program Year? And can you confirm which measures will have prepopulated values?	Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your organization is selected for audit following the data collection period. This is not the case if the WI has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: • A note indicating the date the breast cancer screening was performed AND • The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the organization be selected for audit.	NA	X	X

REPORTING REQUIREMENTS

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	We have 20 out of our 105 EPs participating in the CPC Initiative; can we still qualify for the 0.5% incentive payment if we submit data on all required metrics via the Web Interface?	If your group satisfactorily reports via Web Interface you will receive 0.5% PQRS incentive, but CPC providers in your group must also be sure to submit their data to the CPC program.	X	X	X
2	11/7/2013	What is the definition of a large ACO? What is the definition of a medium ACO?	ACOs are not designated as medium or large. All ACOs are required to report on 411 consecutively ranked beneficiaries in each module. "Medium" and "large" refer to group practices participating in PQRS GPRO. Medium GPROs are those with 25-99 eligible professionals. Large GPROs are those with 100 or more eligible professionals.	X	X	X
3	11/7/2013	For GPRO submission, do you recommend only completing data for the 411 consecutive patients required or should we submit data for all eligible patients?	This is a personal preference for your group. For satisfactory reporting, we require that your group report 411 consecutive patients (for ACOs and PQRS GPROs with 100 or more EPs) or 218 consecutive patients (for PQRS GPROs with 25-99 EPs) for each of the 15 measures/modules. Some groups do choose to report on all patients eligible for their measures/modules. This could be for internal use for quality checking or for other group reasons. All of the patients that are consecutively confirmed and completed will be included in your performance data.	X	X	X
4	11/7/2013	If many of our locales do not perform primary care does this mean this particular location needs to complete all measures on 100% of their patients for Web Interface GPRO over 100 providers?	Each ACO needs to complete reporting on the first 411 consecutive patients in each of the 15 measures/modules. We have links to ACO GPRO reporting resources on the SSP website; this includes information on assignment and sampling.	NA	X	X
5	11/7/2013	We are July 2012 starters and we have participants who will become effective January 1, 2014. Do these participants need to report through GPRO for 2013?	Contact the QualityNet Help Desk **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org**. Participant TINs that become part of the ACO effective 2014 will need to report PQRS by another option for 2013 reporting period.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
6	12/5/2013	Are physician specialists in an SSP ACO deemed to meet PQRS reporting by the SSP submission of GPRO measures?	It doesn't matter if EP is a specialist or a primary care provider. If an ACO satisfactorily reports, all EPS within the ACO will qualify for PQRS reporting.	NA	X	X
7	12/5/2013	When do we sign up as a GPRO for the 2014 program year? Since we are an ACO for 2014, do we need to submit any additional paperwork?	If you are an SSP ACO in 2014, you cannot participate in PQRS GPRO in 2014. You must report through your SSP ACO	NA	X	X
8	12/5/2013	Our ACO went live in January 2013. Do we report on GPRO for the 2013 period? We were told we do not report as an ACO on GPRO until Program Year 2 which in our case would be 2014 to be reported January - March 2015.	Any ACOs that began their agreement period starting on 1/1/2013 will report for the 2013 reporting period. This reporting period begins on January 27, 2014. ACOs that started after 1/1/2014 will begin reporting as an ACO in early 2015.	X	X	X
9	12/5/2013	How do we verify which of our providers are covered in GPRO? We had several acquisitions this year and all of our GPROs are under the same Tax ID?	For the PQRS GPRO we assess at the Tax ID level. As long as all providers report under your Tax ID, they are covered. The same goes for ACOs.	X	X	X
10	12/5/2013	What happens if a participating physician reports PQRS outside of the ACO if he/she belongs to the ACO?	If an EP from a SSP ACO reports PQRS individually via claims or other method, we will not evaluate them separately from their SSP ACO PQRS participation. However, if a Pioneer ACO is part of a split TIN, then the group can participate as an entire group (both ACO and non-ACO participating providers) by reporting as a group in PQRS GPRO or the non-participating ACO EPs within the group can report PQRS individually via claims, registry or EHR reporting.	NA	X	X
11	12/5/2013	On slide 13, you state that PQRS GPROs with less than 24 EPs are not eligible for reporting. Can you clarify?	PQRS GPROs with 2-24 EPs cannot report via the Web Interface. They can however report via registry for the 2013 program year.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
12	12/5/2013	Can you clarify the definition and impact of the GPRO sizes? If an SSP ACO has fewer than 100 TINS or fewer than 100 participants, are they only to report 218 patients per module?	The "medium" and "large" GPRO size does not apply to SSP or Pioneer ACOs. GPRO size only applies to PQRS GPROs. An ACO will report on 411 consecutively ranked patients per module to satisfactorily report PQRS.	NA	X	X
13	12/5/2013	If an EP joins a single-TIN ACO after the participant list has been confirmed, does the ACO still need to report PQRS for the new EP even though he/she is currently affiliated with the ACO TIN?	Any participant TIN that was on the ACO participant list at the beginning of the reporting year will be included in quality reporting and eligible for the PQRS incentive if the TIN satisfactorily reports. If an EP joins a participant TIN and is billing under that TIN, then that EP will be part of reporting for those claims that were submitted under the ACO participant TIN.	NA	X	X
14	12/5/2013	What if a participant group or individual ACO EP pulls out of the ACO and we no longer have access to the patient record, would we still have to report GPRO results on these patients?	Yes, if possible you would want to report GPRO results on any patient that is in your sample. The participants will be eligible for the PQRS incentive and avoid the Payment Adjustment if the ACO satisfactory reports. It is to their benefit to cooperate with ACO quality reporting. If there is no way to locate the medical records, there is a mechanism in the Web Interface to skip that patient and move on the next patient.	NA	X	X
15	12/5/2013	We have several TINs within our ACO. Will reporting in GPRO on all measures satisfy reporting requirements for all participating TINs in order for them to receive incentive payments regardless of the number of patients associated with the respective TINs?	ACO participate as a group for quality reporting. The ACO as an entire group will be successful and report satisfactorily or not. All providers and participant TINs will receive the PQRS incentive if the ACO satisfactorily reports. If the ACO does not satisfactorily report, the subject to the PA if the ACO does not satisfactorily report.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
16	12/5/2013	If we have not elected quality tiering for 2013 reporting, can we choose one measures group and report on that completely for the year? Are there any particular measures that are required for 2013?	There are two sets of criteria for reporting 2013 PQRS Web Interface reporting to avoid the 2015 PQRS and Value-based Payment Modifier (VM) adjustment: 1.) Meet the criteria to avoid payment adjustment. To avoid the PQRS payment adjustment, your group must submit one valid measure through the GPRO Web Interface. Please note, if your group registered for the Value-based Payment Modifier (VM) quality tiering, then reporting only one valid measure may subject the TIN to a downward VM adjustment in 2015. Please also note that certain data for 2013 Web Interface reporting will be posted on Physician Compare. Additionally, CMS encourages all groups to learn how to satisfactorily report during the 2013 reporting period in order to prepare for participation in future program years. 2.) Satisfactory report to earn the 2013 PQRS incentive by reporting on all measures included in the Web Interface and populate data for the first 218 consecutively ranked and assigned beneficiaries if you are a group of 25-99 EPs or on the first 411 consecutively ranked and assigned beneficiaries if you are a group of 100+ EPs, or if there are less than that number, to report on 100% of assigned beneficiaries.	X	X	X
17	12/5/2013	For a GPRO, if an EP reports via claims and the GPRO does not meet the incentive through the Web Interface, will the EP be eligible for an individual incentive?	No, PQRS GPRO will only be analyzed at the TIN-level for Web Interface reporting. If the GPRO doesn't meet the reporting requirements for incentive eligibility, even though the EP may have satisfactorily reporting via claims they will not receive that incentive.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
18	12/5/2013	Will MU PQRS Measures need to be reported for 2013 if the group is reporting through GPRO? If so, will GPRO eventually take the place of all PQRS reporting?	For 2013, PQRS GPRO reporting will get you PQRS GPRO credit. There are additional steps the individuals NPIs within the group practice will need to take to meet all the requirements for MU. Web Interface reporting is not the same as reporting with Certified Electronic Health Record Technology (CEHRT). See the EHR Incentive Program website for information about Meaningful Use requirements at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MLN_MedicareEHRProgram_PQRS_eRXComparison.pdf.	X	NA	NA
19	12/5/2013	When the physician receives the incentive payment for PQRS, will it state PQRS payment on it?	To clarify all payment are made at the TIN level. For PQRS GPROs the group will receive the payment. For ACOs each participant TIN under the ACO will receive the payment for the providers within that group. It will be one lump-sum payment made at the TIN level. Yes, it should state that it is a PQRS payment on the Remittance Advice with indicator of LE ("Levy") to indicate an incentive payment, along with PQ13 to identify that payment as the 2013 PQRS incentive payment.	X	X	X
20	12/5/2013	We have 29 PCP in our ACO and just completed PY 2012. The PCP who "get it" are already reporting on PQRS. Does this mean that their patients will not appear in the list of 411?	Since they have enrolled in ACO, they can only participate through the ACO if we are talking about a SSP ACO. Therefore, any reporting they have been doing as individuals through other methods (claims, registry, EHR) will not count for PQRS incentive or avoiding the payment adjustment. They must report through the ACO.	NA	X	X
21	12/5/2013	Do we report on exactly 411 patients per module or greater than or equal to 411 patients per module?	It is greater than or equal to 411 patients per module. 411 consecutively confirmed and complete patients per module (or 100% if fewer than 411 patients are available in a module) is the minimum to report to receive the incentive but you can report more than 411 as well. Skipped patients do not count toward the 411 count. When a patient is skipped for a valid reason, an additional consecutively ranked patient must be completed.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
22	12/5/2013	Are we required to report on 411 patients per module? How many modules are there?	There are 15 modules and you are required to report on 411 consecutively ranked patients or if you have less than 411 patients sampled, then you will report on 100% of your patients for each module. If your group practice has 25-99 EPs they would be required to report on 218 consecutively ranked patients for each module or 100% of your patients if there are less than 218 patients sampled.	X	X	X
23	12/12/2013	As an ACO, will more than 411 patients be included in the denominator of the measures?	All patients who are consecutively confirmed and completed will be included in the measure denominator for performance rate calculation.	NA	X	X
24	1/9/2014	How would you be able to confirm that you have met the requirements to avoid the 2015 PQRS Payment Adjustment?	In order to avoid the 2015 PQRS Payment Adjustment, you would need to complete one patient for one measure and click the Submit button on the Submit screen in the Web Interface.	X	NA	NA
25	1/9/2014	Can you define a small, medium and large GPRO?	A small GPRO has between 2 and 24 eligible professionals (EPs) and is not able to report via the Web Interface. A medium GPRO has been 25 and 99 EPs. Medium GPROs must populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 327) for each module or patient care measures. Large GPROs have greater than 100 EPs. Large GPROs must populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each module or patient care measures.	X	NA	NA
26	1/9/2014	How do we enter non-Medicare patients?	Only Medicare beneficiaries are entered into the web interface.	X	X	X
27	1/9/2014	I thought you only need to select one measure group to report - it appears in this demo that all need to be completed for the patients - is this correct?	Measures Group reporting is not a reporting option available to GPROs. The Measures Groups reporting option is only available to individual eligible professionals (EPs). This presentation was created for group practices that self-nominated to participate as a group via the Web Interface. Please contact the QualityNet Help Desk if you need additional assistance.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
28	1/9/2014	Our ACO submission will count for PQRS submission for our participant TINs for 2013. Will this be the same for 2014?	Yes, for Shared Savings Program ACOs the ACO GPRO Web Interface submission will satisfy PQRS reporting requirements.	NA	X	NA
29	1/16/2014	Are Providers participating in and reporting through an ACO exempt from reporting claimed based measures for PQRS?	If an EP from a SSP ACO reports PQRS individually via claims or other method, we will not evaluate them separately from their SSP ACO PQRS participation.	NA	X	NA
30	1/16/2014	For groups that will be submitting only one measure this year, is there any requirement as to which measure needs to be chosen?	No, the 2013 PQRS final rule did not specify which one measure would need to be reported in order to avoid the 2015 PQRS payment adjustment.	X	X	X
31	1/16/2014	We're ACO approved on December 2013. Do we have to submit 2013 measures as ACO ?	This submission period for 2013 would be for those ACOs that started their agreements at the beginning of 2013. ACOs that were just approved in December 2013 will need to report on 2014 data.	NA	X	X
32	1/16/2014	What do we with the 94 patients selected for audit from a TIN that left our ACO mid-year 2013?	As an ACO your contract should be accountable for those patients' care. You should do your due diligence to find those medical records of those patients and answer those questions in the Web Interface as required. If however you are unable to find their medical records you have the option to select that and removing them.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
33	FAQ	How many unique patients should we expect to need to abstract?	There are 15 GPRO Web Interface modules, but many modules have similar criteria. For ACOs and GPROs with 100 or more EPs, CMS will sample no more than 616 patients for each of the 15 modules. For GPROs with 25-99 EPs, CMS will sample no more than 327 patients for each of the 15 modules. In 2012, patients were sampled using a method that would increase the likelihood that they would be sampled into multiple modules (if they were eligible for multiple modules). Typically we saw sample sizes between 4,000 and 6,000 unique patients, but ACOs or GPROs could potentially see over 9,000 (15 samples x 616 beneficiaries). We would expect a smaller number of unique beneficiaries for GPROs with 25-99 EPs. A similar sampling methodology will be used for 2013. The methodology is described in the 2013 GPRO Sampling Supplement available for download from the GPRO Web Interface Website. ACOs and GPROs with 100 or more EPs are required to completely report on the first 411 consecutively ranked patients in each module. GPROs with 25-99 EPs are required to completely report on the first 218 consecutively ranked patients in each module. The additional sampled patients allow for cases in which some lower ranked patients may not be eligible for quality reporting. In such cases, the patient may be "skipped" and an additional consecutively ranked patient must be reported for each "skipped" patient until the ACO or GPRO has completely reported on 411 (or all, if there are fewer than 411) consecutively ranked patients.	X	X	X
34	FAQ	For modules and measures in the Web Interface, what makes the patient "complete"?	Complete means that you have found the medical record, confirmed the disease diagnosis (for CAD, DM, HF, HTN, IVD samples) and provided all the required information under that module/measure (e.g., for a DM patient, that includes but is not limited to HbA1c value, most recent BP, tobacco use, etc.); or, for those measures that do not require confirmation of a diagnosis (CARE and PREV), that you have found the medical record, confirmed the patient is eligible for the measure, and provided all the required information (e.g., indicate whether or not the patient received a mammography screening).	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
35	FAQ	What does "consecutively complete" mean?	Patients are numbered 1-616 (or 1 to the maximum number available if less than 616), and 411 of these patients need to be completed in the GPRO Web Interface. If you need to skip a patient (e.g., due to "medical record not found", or the diagnosis could not be confirmed), you must complete the next record that follows consecutively. For example, if you had to skip one patient your final completed patient should be ranked 412 instead of 411. For several examples, see Appendix A. These numbers are for an ACO or PQRS GPROs with 100 or more EPs. See the examples for the number of patients for PQRS GPROs with 25-99 EPs.	X	X	X

WEB INTERFACE

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	If we upload data from the EMR into the portal, do we still need to go into the portal and choose the drop-down menu to select whether patient was eligible for the measure?	You must confirm whether the patient is eligible for the measure either on the screen using the drop-down menu or by including the confirmation value in the uploaded XML file. The XML specs define the tag and allowable values to confirm whether the patient was eligible for the measure. You may upload all required information using the XML files, which means you do not need to go into the portal and choose the drop-down menu. Any measure data that can be entered using the drop-down menu or text fields on the screen may also be uploaded in the XML file. You would only need to choose a value from the drop-down menu or enter data in a text field if you do not include the information in the XML file.	X	X	X
2	11/7/2013	Is there a user manual online for help with the GPRO Web Interface system? This will be the first year we report using the GPRO Web Interface System and we have no idea how to use it.	Currently, there is no user manual available online. When you get into the system there will be full information along with videos on how to use the Web Interface. On the PQRS portal (https://www.qualitynet.org/pqrs) there is a quick start guide that will show you how to login to the Web Interface. We will be putting more information into the built-in online help feature of the Web Interface.	X	X	X
3	11/7/2013	I understand that if one uploads data via an XML, the report or status screen will show which measures are still incomplete. At this point, one can go into the GPRO Web Interface and update the information, is that correct?	Yes, that is correct. Anything you upload, you will be able to view in the Web Interface and you can do additional entry if needed.	X	X	X
4	11/7/2013	Is there a PDF version of the XML specifications? the version online is not easily exported	Yes, if you go to the introduction in the XML spec there is a link to download a PDF version of the spec. However, this PDF version is not 508 compliant, but the online version is 508 compliant.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
5	11/7/2013	Is there currently a template available for viewing in the GPRO Web Interface?	There will not be a test period for Web Interface reporting. There will be a high-level overview of the Web Interface, which will be a future YouTube video. There will also be a detailed training as we approach submission. These will give you insight in terms of what submission will be like and what the screens will look like. The Supporting Documents provide additional information on each of the measures and the required data that can be entered in the Web Interface.	X	X	X
6	11/7/2013	We are creating an information collection sheet for each measure. Will there be an opportunity to preview the Web Interface prior to the opening of submission?	Yes, there will be a high-level overview webinar that will be posted on the CMS YouTube website the next month. This will give a preview of how all of the data entry screens look. The Supporting Documents describe each of the measures and the measure components with the values that can be entered in the Web Interface. The Supporting Documents can aid in setting up the information collection sheet.	X	X	X
7	11/7/2013	Do the IT staff who are uploading our XML files need an IACS account?	Yes, you need to login to the Web Interface to perform the upload so you will need an IACS account. If you're gathering the information offline and compiling a single XML file, only the person uploading the file would need an IACS account.	X	X	X
8	11/7/2013	Will the GPRO allow us to export the reports this year in either XML or CSV?	No, CMS security does not allow exporting the reports because they contain PHI and PII.	X	X	X
9	11/7/2013	Can the abstractors be in the tool entering data at the same time as our IT people are uploading data?	You could have two people working at the same time, but you want to be careful if someone is uploading XML data for a patient that is being abstracted manually. They could overwrite one or another so you'll want to exercise caution when doing this. We recommend that if you are uploading an XML, which should only take a few minutes, you would not want to have people extracting at the same time.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
10	11/7/2013	In prior years, there was an option in GPRO to export patient list with clinical data into XML, there was then instructions to convert the XML into Excel, we fill out the Excel and there was instruction to convert the Excel to XML for upload. Is this option available this year?	Yes, this option is available this year. You can export patient data from Web Interface into an XML file and then you can use excel. We included instructions in the XML specification on how you would do this using Excel 2013, 2010, and 2007. These instructions are available in the XML specification – you will see the link to the XML XSD files on the left-hand side of the specification. Everything you need is posted on the CMS PQRS website under the GPRO Web Interface page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
11	11/7/2013	When will the ACO GPRO Web Interface user manual for Program Year 2013 be released? Last year's was released on Jan 18, 2013	There are a couple different user manuals, the one that is posted on the portal (https://www.qualitynet.org/portal/pqrs Physician and Other Health Care Professionals Quality Reporting Portal) will be available after January 9, 2014 [we do not have the exact date]. This manual will show you how to login to the Web Interface. The online help within the Web Interface has information on using the Web Interface. This manual will be available when the Web Interface is open.	X	X	X
12	11/7/2013	Is there any possibility that the GPRO specs will be modified between now and the 2014 reporting period beginning January 27th?	No, the 2013 documents that include 2013 Narrative Specifications, Flows, and Supporting Documents, will not be modified between now and the submission period	X	X	X
13	11/7/2013	Will the test files in January be specific for each module and disease, so they will be a true test?	The file that will be provided in January prior to the Web Interface opening is the file of beneficiaries sampled into the ACO GPRO Web Interface and the top three TIN/NPI combinations where the beneficiary received care. It is not a test file.	X	X	X
14	11/7/2013	Want to confirm that if we use the Web Interface do we still need to submit the QRDA XML files?	If you're submitting in the Web Interface, CMS allows manual entering of data in the Web Interface and XML uploads using the Web Interface XML format. If your question about QRDA relates to the EHR Incentive Program- Meaningful Use submission you will need to submit a QRDA file. QRDA submission is not related to Web Interface reporting. Contact the QualityNet Help Desk if you have additional questions.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
15	12/5/2013	It was stated the PQRS GPROs with 100 or more EPs have to report on all measures and all patients to meet requirements. In the 2013 Physician Fee Service final rule, it states you must report at least one measure. Which is the correct answer?	There are 2 criteria for PQRS reporting in the Web Interface: 1) In order to avoid the payment adjustment, the GPRO must report one patient on one measure and click "submit" in the Web Interface. 2) In order to receive the PQRS incentive, you must successfully report on greater than or equal to 411 consecutively ranked patients within the Web Interface for each module.	X	X	X
16	12/5/2013	Are you going to have a test system to practice in for a week before go live?	No, there will not be a test system before going live.	X	X	X
17	12/5/2013	In the GPRO XML sample files posted, there were a number of null values included. Is a group penalized for including null values?	There were two sets of sample files provided; one was exported from a group that hadn't completed any abstraction. This shows how your XML file will look the first time you log into the Web Interface. It will have your patients, the patient's demographic information and any pre-filled data. There will be null values because no abstraction has been performed yet. When you upload a file, if it should have a null value for something, it is ignored in the Web Interface, and you will still need to enter the value into the Web Interface after you upload the file.	X	X	X
18	12/5/2013	Will we be able to pull ranked patients out of GPRO into an xml file, convert it to an Excel file, update the file and convert back to an xml file and upload in GPRO?	Yes, you can do this. On 12/12/2013 we will be hosting XML training. In addition, the XML specs posted on the CMS website has details on how to convert XML to Excel and create XML files from Excel.	X	X	X
19	12/5/2013	Is there going to be an instruction document with screen shots from PQRS that we will have in advance of the go live date?	A high-level Web Interface training including screenshots has been posted on the CMS YouTube site: http://www.youtube.com/watch?v=LFOIw4S7NnI&feature=share&list=UUhHTRPxz8awulGaTMh3SAkA&index=4.	X	X	X
20	12/5/2013	When will the XML be provided by CMS to the GPRO submitters?	If you are referencing the XML sample files or XML specs, they are available and posted on the CMS website. They are located on the GPRO Web Interface page. This page can be located by typing in "GPRO Web Interface" into the search box on the CMS website or by referencing the link on slide 16 of this presentation. When the submission period is open, you will be able to export the XML files for your TIN's patients.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
21	12/5/2013	Do we need to make null the prefilled data if we are unable to complete the measure, or can we leave it? For instance, if an A1c is prefilled with yes, and the date, but we have no record of an A1c, we will change the taken to no, do we null the date?	You do not need to null the date. When we look at the data to determine whether it's needed or not to complete the measure, if you answer "no, the test was not performed" then we are going to ignore the date it was taken. Otherwise, you can leave the pre-filled "Yes", but put a "0" in the field that is asking for the value of that lab test. This will be reviewed during the ACO / PQRS GPRO Web Interface XML training on 12/12/2013.	X	X	X
22	12/5/2013	Was it just said that there is no option to export from GPRO? I believe this option was available last year.	XML files for the patient ranking, patient measure data, discharge data, clinics, and providers can be exported from the Web Interface.	X	X	X
23	12/5/2013	To whom do the modules get sent when there are numerous submitters?	If your IACS account is tied to the TIN, you will be able to see that TIN when you log in to the Web Interface and you'll be able to see all modules and measures. When they log in to portal they will have access to all modules and patients for the TIN.	X	X	X
24	12/5/2013	We only have to report on 411 consecutive patients in each module. We manually abstract 100% of the patients so it's hard to carve out just the applicable ones (and we end up doing 100% of the sample, 616 patients). Are there any analysis implications for just doing the 411 as opposed to completing oversample too?	The Web Interface automatically consecutively ranks the first 411 patients of the total 616 patients. As you complete patients into the Web Interface, you can look at the Totals Report, which will tell which patients are completed for a module and the rank of the completed patients in that module. If you are doing Manual extraction, the patient list can be sorted by patients in rank order so you can easily identify the first 411 ranked patients in each module. As far as an impact on an analysis, it will not matter. When you complete 411 patients, you are finished in terms of satisfactorily reporting for PQRS.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
25	12/5/2013	For pre-populated field data from CMS, can we update those fields with current information?	You should use the most recent data for the patient. The patient sampling goes through the end of October so if you have more recent data, you will want to update the Web Interface with that information. The supporting documents will provide additional information indicating when you should use the latest result for the patient. Any information documented in the patient's medical record should be used to update the Web Interface. The only exception to this will be CARE-1: Medication Reconciliation, where the information for this measure is pre-filled with the discharge date of any inpatient hospital stay for the patient who also had a visit within 30 days, so you do not add additional discharges that would have occurred late in 2013.	X	X	X
26	12/5/2013	Is it possible that an ACO would be asked to respond to a data request for a patient who is in our ACO but got the services in question from a provider who is not in our ACO?	Yes. Patients are assigned to an ACO or GPRO if they received the plurality of their primary care services from that ACO or GPRO during the measurement period. Further, each patient who is sampled into the GPRO Web Interface was found to have at least 2 primary care service visits with an ACO or GPRO provider during the measurement period. However, particular services related to individual quality measures may have been obtained at an outside organization. In those cases, it may be necessary to look for information with providers outside of the ACO or GPRO.	X	X	X
27	12/12/2013	What version of Java is supported in the Web Interface?	The Web Interface is not Java dependent, so your Java version does not matter for the purposes of submitting your GPRO data.	X	X	X
28	12/12/2013	Did you experience technical issues last year with the Web Interface?	There were a few short and unplanned outages in addition to planned maintenance weekends. If an unplanned outage occurs, we will notify the ACOs and GPROs as soon as possible. There is a maintenance weekend planned during submission, February 21, 2014 beginning at 8:00 pm ET through February 24, 2014 ending at 6:00 am ET.	X	X	X
29	12/12/2013	Can you please repeat the URL for GPRO Web Interface?	The GPRO Web Interface will be accessible via the PQRS Portal: https://www.qualitynet.org/pqrs.	X	X	X
30	12/12/2013	Is IE 8.0 still a requirement? Or can IE 9.0 and above be used?	This year we are recommending you use Internet Explorer (IE) 9.0. Although we have done some testing in IE 8.0, most of our testing and development tests have been done in IE 9.0.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
31	12/12/2013	What data may be prefilled? Where can we find a list of prefilled elements?	We had a slide in the presentation that had a list of the prefilled elements. This information is also in Q&A and in the Web Interface presentation that is posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
32	12/12/2013	Are there any implications if our organization uses multiple versions of Internet Explorer?	I don't know of any implications of using different versions. We have tested using IE8 and IE9, but do not support other browsers.	X	X	X
33	12/12/2013	If the Medicare ID does not match for a patient but we confirm the patient based on date of birth and name, do we skip the patient? If not, are we required to update the Medicare ID manually in the Web Interface?	The Medicare ID cannot be changed in the Web Interface. The Medicare ID is the linking field for the patient. If you can't find the patient in your medical records systems then we would say medical record not found and proceed to the next ranked patient.	X	X	X
34	12/12/2013	Will any of the GPROs who are on Internet Explorer 8 be given an opportunity to test the portal before the submission period opens?	No, there is not a test period for the Web Interface prior to the start of submission on January 27, 2013. The Web Interface was fully tested with IE8 and well as the recommended IE9.	X	X	X
35	12/12/2013	Will there be any testing of the portal and/or uploading of XML files to the portal before the submission period begins?	No, there is not a test period for the Web Interface prior to the start of submission on January 27, 2013.	X	X	X
36	1/9/2014	Can you please repeat what to search for at CMS.gov to find the detailed GPRO specifications?	If you are looking for the 2013 GPRO measure specifications, you can go to the PQRS GPRO page on the CMS website under the Downloads section: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html If you at looking for the 2013 GPRO Web Interface Quick Start Guide, it will be available on January 13th on the PQRS Portal: www.qualitynet.org/PQRI	X	X	X
37	1/9/2014	Will we be able to sort beneficiaries by TIN/EIN within the GPRO Web Interface?	For ACO the clinic ID is going to be your TIN/EIN.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
38	1/9/2014	If a subset of GPRO measures are submitted for a patient by XML file, say on Feb 2, and then a few more measures are submitted for same patient on Feb 12 by XML file (and not the Web Interface), would the first file get overwritten or updated?	The first XML file would be overwritten by the second upload. However, if there are no tags or the tags are empty in the second XML file for the data uploaded in the first file, the new upload won't overwrite your previously uploaded data.	X	X	X
39	1/9/2014	When we receive the beneficiary list to abstract, will it include the patient's rank or will we only be able to see that in the Web Interface itself?	Yes, you will be able to see the patient's rank. The patient will have a "0" in the Web Interface if he or she isn't ranked in the module. If the patient is not ranked in a module, the module data is not provided in the XML file. If he or she is ranked, there will be a "1" through "616" associated with the patient in both the Web Interface and in the XML file	NA	X	X
40	1/9/2014	Is the patient's medical record number from our system going to display in the Web Interface?	No, the medical record number is not included on claims, so it will not be pre-populated in the Web Interface. However, you can add it to the Web Interface using an XML upload or entering it manually in the Web Interface.	X	X	X
41	1/9/2014	Is the patient list the same for all 22 measures?	You will have one overall patient list for your GPRO or Primary ACO; however a patient may or may not be ranked in each of the 15 modules. It is unlikely that a patient will be ranked for every module The list of patients included in each module will be different.	X	X	X

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42	1/9/2014	If multiple red "X"s are listed per beneficiary, do we need to respond to each measure or merely one?	You will need to complete the data for each red "X". An exception would be if the patient is ranked high in one measure and very low in another module. If they are ranked high enough, you may be able to complete the module before abstracting the patient for that module. ACO or Large GPRO example: a patient is ranked 415 in PREV-5 and ranked 400 in HTN, you will need to complete the patient's data in HTN, but you may not need to complete the patient's data in PREV-5 unless you have skipped four lower ranked patients in PREV-5 to meet the minimum of 411 consecutively confirmed and completed patients in the PREV-5 module. Medium GPRO example: a patient is ranked 222 in PREV-5 and ranked 200 in HTN, you will need to complete the patient's data in HTN, but you may not need to complete the patient's data in PREV-5 unless you have skipped four lower ranked patients I nPREV-5 to meet the minimum of 218 consecutively confirmed and completed patients in the PREV-5 module.	X	X	X
43	1/9/2014	Once we complete the medical record number, can we drag and drop that column so it's further to the left on the patient list?	Yes, you can move the columns for the Patient List on the Home page to be in any order that you prefer. Note that the order will not save between log-ins. So you will need to reorder the patient list columns each time you log into the Web Interface.	X	X	X
44	1/9/2014	Does the patient list include the provider's name or the provider's NPI?	The provider's name will be included in the Patient List displayed on the Home page of the Web Interface. However, both the provider's name and NPI will be listed in the Provider List displayed on the Edit Provider screen in the Web Interface. The provider's name and NPI are both listed in the XML file that can be exported from the Web Interface. See the GPRO XML Specifications for all fields included in the Provider XML file.	X	X	X
45	1/9/2014	Will CMS populate the clinic ID and the clinic name or is the ACO expected to populate these fields?	In most cases, the clinic ID and clinic name will be pre-populated; however if it is not pre-populated, you are able to add this information in the Web Interface.	NA	X	X

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46	1/9/2014	If we upload an XML file will we need to use the Web Interface and edit entries in order to get them complete?	We have thoroughly tested the Web Interface and have not found any issues. This situation occurred in previous years because of the way the Medical Record Found answer was recorded. In previous years, the Medical Record Confirmation was required in each module. If the patient had inconsistent answers in the modules, one of the modules would be marked as incomplete even when the data was provided. Since the Medical Record Found is only answered once for the patient, no matter how many modules the patient is ranked in, the situation where you needed to correct your answer to set all the Medical Record Found values to the same answer to complete the patient's data will not occur.	X	X	X
47	1/9/2014	Will the Web Interface be open prior to 1/27/14 for XML imports?	No, the Web Interface will not be accessible prior to 1/27/14.	X	X	X
48	1/9/2014	Once we have finished submission, are we able to retrieve a medical record number level report, listing all patients identified as a "1", "2", etc?	You can access this information in two ways prior to the close of submission (1/27/14): 1) Run the Detailed Totals report 2) Export your patients to an XML file and then follow the instructions in the XML specifications to import the data into Excel.	X	X	X
49	1/9/2014	Can you review again what the 10% threshold not exceeded means? Does it mean you haven't reported on enough patients?	The 10% threshold represents the percentage of patients that were skipped in a measure out of all of the patients that were consecutively completed.	X	X	X
50	1/9/2014	Can we only use the web interface to manually enter data and not use the xml upload at all? If yes, will we be penalized?	You may enter all your patient data manually. The XML uploads are an alternate method, so you will not be penalized if you do not use XML.	X	X	X
51	1/9/2014	Can you please confirm that GPRO Web submitters (NOT ACO) will not receive their reports this Monday, but will have to wait until 1/27 when the portal opens?	GPRO Web submitters will be able to access reports and patient data on January 27 when the submission period opens.	X	NA	NA

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52	1/9/2014	Does the 100% complete mean that data is ready for submission?	100% complete means you have completed the required number of consecutively ranked patients and you are ready to submit the data to CMS. To submit your data, open the Submit screen and click the Submit button. This will provide your completed data to CMS. See the video imbedded in the GPRO online help for more information.	X	X	X
53	1/9/2014	If prefilled data has a U or O, how would we verify that or do we need to say "No"?	Patients sampled into the Web Interface have had at least two primary care service visits at your practice or with an ACO participating provider. You should do your best to obtain the needed quality of care information to complete the GPRO Web Interface if it is not available in the patient's medical record.	X	X	X
54	1/9/2014	If we report null (-1) values for measures will this get credit as a complete patient? Or would we need to answer 1, 2, 4, 5, 15, etc...?	No, entering "-1" will clear out the value in the database so you need to provide an answer. The "-1" value should only be used with extreme care if you uploaded a file and it contained an error you wish to remove.	X	X	X
55	1/9/2014	In PREV-11 it says 500 are complete so why isn't it a green check?	In the scenario shown during training, 500 patients were complete, but the patients ranked 14, 15, and 259 were incomplete. The "Analysis" line shows the number of consecutively confirmed and complete patients, excluding skipped patients. The count of Analysis patients stops at the first incomplete patient. The "Complete" line shows the number of complete patients in any order. The complete line excludes skipped patients, but does not stop at an incomplete patient. Once the patients ranked 14, 15, and 259 are complete, the number of consecutively confirmed and complete patients will change to 411 and PREV-11 will be marked as complete. The information available to determine skipped or incomplete patients is available in the Totals Report. The specific patient with the patient's rank in the module is shown on the Details page of the Totals Report.	X	X	X

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56	1/9/2014	Is there a space to add multiple clinics for each patient? If 3 providers are listed, won't many patients have at least 3 clinic needs?	CMS provides information on the clinic and providers that provided the most care to each sampled patient. This information is provided to assist in the data collection process and help practices search more efficiently for patient medical records. In an effort to maintain user-friendly Web Interface we balance the amount of supplemental information such as this with the space available to provide that information. To that end we provide space for one clinic and up to 3 providers.	NA	X	X
57	1/9/2014	Of course we are only needing the value for control measures, but I feel it's better to keep the date and put in a '0' for value. If time allows, some groups might try to figure out where that A1C came from.	You may keep the pre-filled date, but provide a '0'. The performance will be calculated the same if you answer "No" or if you answer "Yes" and provide a '0'.	X	X	X
58	1/9/2014	Please explain the difference between the analysis column and the completed column	The "Analysis" line shows the number of consecutively confirmed and complete patients, excluding skipped patients. The count of Analysis patients stops at the first incomplete patient. The "Complete" line shows the number of complete patients in any order. The complete line excludes skipped patients, but does not stop at an incomplete patient.	X	X	X
59	1/9/2014	Will the clinic name be provided in the sample list?	If pre-filled, the Clinic ID will be provided in the Patient Ranking or Patient XML file exported from the Web Interface. The Clinic Name will not be included because Clinic Names may not be unique.	X	X	X
60	1/9/2014	Will the rates be calculated on the 411 sample or if we submit 616 will the rates be calculated on that?	Completeness is calculated in the first 411 consecutively confirmed and completed patients. Performance is calculated on all consecutively confirmed and completed patients. Skipped patients are not included, and the denominator count stops at the first incomplete patient. If you submit data for all 616 patients for an ACO or a Large GPRO all confirmed and complete patients will be used to calculate the performance rate. If you are a Medium GPRO and submit data on all 327 patients, all confirmed and complete patients will be used to calculate the performance rate.	X	X	X

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61	1/16/2014	As an ACO, are we able to use a database that contains beneficiary information outside the medical record? For example, if we have partnered with a company (as an ACO) and a third party database is created, can we use that data to enter information into the Web Interface?	CMS holds the ACO accountable for reporting quality data in the GPRO Web Interface. If the ACO chooses to partner with a vendor to submit quality data on its behalf, such arrangements are between the ACO and the vendor.	NA	X	X
62	1/16/2014	Can we use claims data to answer the question even if it was performed and submitted by a provider outside of our ACO?	You can use claims data as long the information is documented in the patient's medical record. When confirming the diagnosis, we prefer that you use medical record data instead of claims data.	NA	X	X
63	1/16/2014	Can you list the measures which will be pre-populated in GPRO and for which we will not need to look for the data in the patient's EMR?	Those measures include PREV-6: Colorectal Cancer Screening, PREV-7: Influenza Immunization and PREV-8: Pneumococcal Vaccination for Patients 65 Years and Older.	X	X	X
64	1/16/2014	Can you please explain in detail where the discharge dates will be located in the Web Interface and if we will be able to export them out of the Web Interface?	The discharge dates are located on the CARE tab. If the patient is ranked in CARE-1, you would go to the CARE tab to enter the discharge dates. There are videos located in the "2013 PQRS/ACO GPRO Web Interface User Manual" (which can be found at www.qualitynet.org/PQRS), that provide additional detail on discharge dates. On the Introduction page, there is a link to the online help, which contains all of the videos. Yes, you can export the discharge dates. The XML specifications, available on the GPRO Web Interface page of the CMS website, detail how you can export this data.	X	X	X
65	1/16/2014	For practices that left our ACO mid-year whose medical records we cannot obtain, What is the process for making a list of those practices/patients for removal? How would skipping these patients affect us?	If you are unable to obtain the medical records for patients in your sample, you have the option in the Web Interface to select that the patient is not eligible for the measure because the medical record cannot be found. If you cannot find a medical record for a patient, this patient would be skipped. You would need to complete additional patients to complete 411 patients (as an ACO or large GPRO) for the measure.	NA	X	X

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66	1/16/2014	For the medications, the downloadable resources has an RxNorm code; but we have NDC codes... can you direct how I might be able to map the NDC codes with the RxNorm codes?	CMS does not provide mapping to NDC codes.	X	X	X
67	1/16/2014	If I download my data, then add Medical Record Numbers to the file and upload it. Will a second download of data have those Medical Record Numbers in the file?	Yes.	X	X	X
68	1/16/2014	If we have access to hospital records with EF, should we use these as well as our outpatient record when looking for LVSD or should we only count a patient as confirmed if this information is in our outpatient chart.	You can use any source of information that is available at the point of care for the primary care provider.	X	X	X
69	1/16/2014	If we use multiple medical records sources (specialist and PCP), where is the best place to note the source in GPRO and to include the notes in our extract? Last year comments were cut off at 20 characters vs. 140.	Comments may be entered in the General Comments text box on the Demographics tab for a patient. Comments may also be entered in the Comments box located on each of the module tabs. Comments may also be entered in the XML file, which has tags corresponding to the General Comments or module Comments text boxes. The limit on comments is 250 characters for 2014, as it was in 2013. The Other ID field is limited to 20 characters, but this field was intended to hold IDs such as insurance numbers or other values used to identify the patient. Comments should go in the Comments fields.	X	X	X
70	1/16/2014	Is there a "tool" we could use to have our providers/staff enter measure information into as they abstract information from patients charts and information?	There is no “tool” but the XML files may be imported into Excel which could be used to record data.	X	X	X
71	1/16/2014	Is there a need to secure a copy of proof of evidence for every element of MSSP abstraction in case of an audit?	The MSSP and Pioneer ACO program do have quality audits so we recommend retaining a record of all data that is reported in the Web Interface.	NA	X	X

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72	1/16/2014	May we also report null values via XML if we intend to manually abstract the value after our initial XML upload?	If you intend to manually enter data after an XML upload, you can leave the tag for that data element out of the XML file or leave the tag as an empty tag in the XML file. A "missing" tag or empty tag will not result in a null value being saved in the database.	X	X	X
73	1/16/2014	On the Check Entries Report, can you explain warning versus error?	A warning is used when there is an inconsistency between similar elements and an error is used when there is missing or invalid data. You can find more information on the check entries report and the check entries button in the online help.	X	X	X
74	1/16/2014	We did not see pre-populated data in sample file (e.g. discharge date from inpatient facility). Would that be in a separate file?	Yes, the Patient XML file contains all data except the CARE-1 measure data. The Discharge Dates are in the Patient Discharge XML file. Please see the XML Specifications available on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html for the layout of these files. The XML Specs may also be downloaded from the Web Interface Online Help.	X	X	X
75	1/16/2014	What happens if we cannot confirm a diagnosis for a patient? Is this patient considered a "skipped" patient?	If that's the case, you wouldn't be able to confirm diagnosis and you would select "no" in the Web Interface or XML file for the module confirmation question. The patient would be skipped in the module but may be eligible in other modules in which they are ranked.	X	X	X
76	1/16/2014	What time will the web interface open on January 27th? When will XML export files be available for download?	The XML will be available as soon as the web interface opens. We don't have an exact time for when then Web Interface will open on 1/27/14 but we will announce that as soon as it becomes available.	X	X	X
77	1/16/2014	Where can we find a complete list of "CMS approved reasons" or "medical reasons" for patient exclusion?	There is not a complete list for either CMS approved reasons or medical reasons. These answers vary based on the measure. Within the data guidance, there is often an example provided for an acceptable medical reason. CMS approved reason is determined on a case-by-case basis.	X	X	X
78	1/16/2014	Where is the quick reference guide on QualityNet located?	Go to the following website: qualitynet.org/PQRS. On the left hand side, there is a User Manual blue box. The Web Interface quick reference guide is called "2013 PQRS/ACO GPRO Web Interface User Manual".	X	X	X

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79	1/16/2014	Why would "Unknown" be listed as the physician if attribution is based on paid claims?	It may be possible that the NPI is on the claim, but the provider name is not and the Web Interface couldn't identify the provider name. In this case, the physician name would be listed as unknown.	X	X	X
80	1/16/2014	Will sample files for each measure (not beneficiary information, just the column headers) be available prior to the 27th?	There are sample xml files on the CMS website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html). You can use these sample files and XSD's and import them into Excel. There are no files with just column headers unless you were to use Excel with the XSD files.	X	X	X
81	1/16/2014	Our MFT Beneficiary List did not contain any discharge dates or testing dates. Will we download those via the GPRO interface? Discharge dates are in the context of med rec and test dates in the context of lipid tests.	Yes. When available the Web Interface will be prepopulated with information on discharge dates and test dates found in Medicare claims. You can access those and download them from the Web Interface.	NA	X	NA
82	FAQ	Can you please clarify the terms "for analysis" means?	The **For Analysis** count on reports and screens reflects patients that are consecutively confirmed and completed. If some of your patients have not been consecutively confirmed and completed, you may see a different count of completed patients and For Analysis patients. The For Analysis line is on the Home page in the Group Status section. The Home is the initial page seen when logging on or when the "Home" option is selected from the global navigation. The For Analysis line also appears on the Totals Report. The line the question refers to is in the Totals Report, which has a comment indicating whether or not they have met the minimum requirement.	X	X	X
83	FAQ	When should we click the "submit" button?	In order to be marked as complete for reporting, you do need to go to the Submit screen and press the "Submit" button. This will indicate to CMS that your data collection is complete. If you need to enter additional data after you have pressed "Submit", you may do so, but you will need to press "Submit" again once you have finished data collection.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
84	FAQ	Do you lose data when the system logs you out after a period of inactivity?	Yes, if you are editing a patient and do not save the information, the edits on that patient will be lost if the system logs you out for inactivity. The system will also lock the patient with the user account that last updated the information. The Locked Records screen can be used to unlock a patient so any use can edit the patient.	X	X	X
85	FAQ	Can you edit information in the patient record after saving it?	Yes. The user can save the record multiple times and edit it at any time before the data collection period closes.	X	X	X
86	FAQ	Can we provide the data all modules for a given patient even if the patient is not ranked in all modules?	Yes, you could upload data for patients where it is not appropriate. Only the patients ranked in the module containing the measure will be updated. The data will be discarded for patients not ranked in the module containing the measure.	X	X	X
87	FAQ	One of our measure specific reports shows no data. Is this normal?	Yes, this report will be blank if you do not have any consecutively confirmed and completed patients. The final percentage is calculated on consecutively confirmed and completed patients who meet the measure criteria.	X	X	X
88	FAQ	How can we tell when we have completed data collection (i.e. satisfied the complete reporting requirements)?	The For Analysis line on the Totals Report reflects patients that have been consecutively confirmed and completed. If your report indicates that 411 or more patients for an ACO or PQRS GPROs with 100 or more EPs, or 218 or more patients for PQRS GPROs with 25-99 EPs, are considered "For Analysis", then you have successfully consecutively completed all necessary patients in the module. If you have fewer than the minimum number of eligible patients in the module and you have completed 100% of your sample, you also meet the reporting requirements. The comments on the For Analysis line will indicate "OK! Minimum Requirement Met". The Analysis line on the Group Status line on the Home page will have a green checkmark next to each module that satisfies the reporting requirements. Alternatively, the "Submit" screen and the "Submit Status Report" will indicate "OK! Minimum Requirement Met" for each module that has been satisfactorily reported. If you see this message for each of the 15 modules, then you have met the satisfactory reporting requirements.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
89	FAQ	How do we export all pre-populated patient information?	Downloading the Patient file and the Patient Discharge file will contain all information that was pre-populated into the GPRO Web Interface.	X	X	X
90	FAQ	Which reports do you recommend we print and keep?	Though this is not required, you may want to print the Measure Rates Report (shows performance on each of the measures and modules) and the Totals Report, which will give you a sense of how many patients were skipped, etc.	X	X	X
91	FAQ	Does reporting on the GPRO Web Interface measures require manual chart abstraction? Is there any alternate method of data submission?	GPRO Web Interface measures must be reported via the Web Interface. However, some data can be uploaded from your EHR using XML. Training on this process will be provided prior to the start of the GPRO Web Interface reporting period.	X	X	X
92	FAQ	Can we use the GPRO Web Interface with Internet Explorer 7 or Google Chrome?	No, we recommend Internet Explorer 9, but you may use Internet Explorer 8 in order to use the GPRO Web Interface.	X	X	X
93	FAQ	Is it possible to use data from multiple sources for abstraction?	Yes, any documentation the physician has available to them at the point of care is eligible for use in data collection.	X	X	X
94	FAQ	Do we have to enter our data in rank order? Or can we abstract information on patients out of rank order?	The actual order of data entry does not matter, however, the ACO or GPRO must consecutively report on at least the first 411 ranked beneficiaries (or all sampled beneficiaries if fewer than 411 are ranked) in order to satisfy the reporting requirement for each measure or module.	X	X	X
95	FAQ	What if one of our sampled patients was not seen at our facility during the measurement period?	Though the patient may not have been seen at your facility, the patient has to have been seen at least twice at one of the organizations (or facilities) affiliated with your ACO during the measurement period in order to be included in the samples. Specifically, beneficiaries were assigned to your ACO based on 3rd quarter 2013 assignment or alignment and must have had two or more primary care services visits at one of the ACO's Primary or Child TINs to be sampled into the module. Since your organization is deemed accountable for such a case, you may not select 'not qualified for sample' under this circumstance.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
96	FAQ	What if one of our sampled patients is no longer being seen at one of the ACO's organization (e.g. patient moved or the provider is no longer with the ACO participant TIN)?	By the assignment/alignment algorithm, the patient was assigned/aligned to your ACO as they were deemed to have the plurality of their Medicare services with your ACO. Further, patients sampled into the GPRO Web Interface had at least 2 E&M visits with your ACO between January 1 and October 31, 2013. As an ACO, you will need to be accountable for this patient's care, and should do your best to obtain the needed quality of care information to complete the GPRO Web Interface.	NA	X	X
97	FAQ	What are reasons to select "Not Qualified for Sample"?	An ACO or GPRO may select "Not Qualified for Sample" in the GPRO Web Interface if: • The patient was in hospice during the measurement period • The patient moved out of the country during the measurement period The patient was deceased during the measurement period (if patient died after the measurement period, you should still abstract information on them) • The patient had HMO Enrollment during the measurement period	X	X	X
98	FAQ	Some of our beneficiaries have opted out of data sharing. Will they be eligible for sampling into the GPRO Web Interface?	Quality data collection is not related to the data sharing processes that have been established for the Claims and Claims Line Feed data. A beneficiary opting out of data sharing does not exempt them from quality reporting.	NA	X	X
99	FAQ	Can we exclude a sampled patient if they were only seen by a specialist at our facility?	No, this patient was assigned to your ACO, so you will need to be accountable for his/her care. Please refer to the Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf) for more information on how beneficiaries are assigned to an SSP ACO. For Pioneer ACOs please see the Pioneer ACO Benchmarking Methodology.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
100	FAQ	Is there any benefit or harm to abstracting additional ranks in the module than what is required?	Some organizations may choose to upload more records for their own quality tracking or quality improvement efforts. If you enter the beneficiaries consecutively, only the first 411 patients will be used in the completeness determination, but all 616 beneficiaries will used in the measure rate calculations.	X	X	X
101	FAQ	Are there repercussions for skipping a lot of patients in our sample (i.e., if we are not able to locate their medical records)?	Patients for which the ACO or GPRO has selected no medical record found, diagnosis not confirmed or not qualified for the sample (for CMS approved reasons, deceased, entered hospice, enrolled in an HMO, moved out of the country) are considered "skips". The GPRO Web Interface will produce a warning when 10% of a given sample has been skipped. However, this warning is only a system warning. ACOs and GPROs will not be penalized for skipping 10% of a module's sampled patients and as long as you have met the minimum requirement of 411 consecutively completed patients (or 100% of the sample if fewer than 411 are available), then you will have completely reported on the module. However, if there seems to be a consistent unexplainable pattern that CMS observes in your skips, then it may raise a flag, and that may be one of the selection criteria for a targeted audit or for targeted education with your ACO or GPRO.	X	X	X
102	FAQ	For services where the date of a test has been pre-populated into the GPRO Web Interface, do we need to find the result of that day's test?	For each of the measures that require a test value, the latest test in the measurement period is the test to be extracted/abstracted. While CMS has identified to the best of its ability the latest test date captured in Medicare claims, it is possible that is not the most recent service date. If you have more updated information in the patient's medical record, you can insert the date of the latest test (in the reporting period) for which you have a value to collect in the date field.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
103	FAQ	Are there any requirements for who can enter data into the Web Interface?	While CMS does not require specific clinical backgrounds for clinical quality of care data abstraction, several factors should be considered when making this staffing decision. If information for certain measures is frequently stored in the same location and is a straightforward data collection, a non-clinical person is appropriate. An example of this would be the laboratory measures when you are looking for the most recent date and the corresponding value or result. If a measure has denominator exclusions that may require clinical knowledge to make the connection between the documentation and the reason for not providing a service or drug, then this needs to be considered as well, and a person with more solid clinical background may be better suited for abstracting this measure.	X	X	X

MISCELLANEOUS

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	11/7/2013	Will First year ACO 2013 Cohort scores be publically reported by individual ACOs?	ACO scores will be posted on Physician Compare by ACO.	NA	X	X
2	11/7/2013	I can't find videos when I go to YouTube ...are there any more specific variables I can search to find the videos?	You can access the videos at http://go.cms.gov/GPROPlaylist.	X	X	X
3	11/7/2013	Are there any plans for offering training on the GPRO interface and reporting on the measures in general outside of these Q/A's. More like an instructor led training class.	Yes, there will be trainings for the Web Interface in January 2014. During these sessions we will walk through the application and allow time for Q&A.	X	X	X
4	12/5/2013	My group chose Administrative Claims; does this protect us from the penalty? With this election, is it correct that we do not need to submit any special codes on claims? If our EPs want to earn the PQRS incentive, they can report individually, correct?	Yes, this is correct. However, these calls are for the GPROs reporting via the Web Interface; therefore you do not need to attend these calls.	X	NA	NA
5	12/5/2013	Is there a plan to have a Q&A session where we can actually ask questions as opposed to just typing them in?	No, this is the format that will be used moving forward.	X	X	X
6	12/5/2013	The 2012 GPRO reports for groups with more than 100 providers stratify groups into low, mid, or high quality and low, mid, or high efficiency categories. One standard deviation is used for the cut points. Yet, we see about half of the expected number of groups.	This group should contact the QualityNet Help Desk for more information on their 2012 reports.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
7	12/5/2013	Is this call for practices that are submitting by registry? If not, will any of the webinars address questions about registry reporting?	This support call is for GPROs submitting via the Web Interface only. If you are submitting via registry, please work directly with your registry. A list of qualified registries can be found on the Registry page of the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html.	X	NA	NA
8	12/5/2013	Is the calculated performance rate publicly reported? Does is impact anything for SSP? I am asking because it was stated that if we report on all 616 patients all are used to determine the performance rate and we are trying to determine our best course of action.	For ACOs that began their agreement start date in 2012, there will be public reporting on Physician Compare website in early 2014. The diabetes component measures and CAB measures will be reported.	NA	X	X
9	12/5/2013	Are we being judged on performance for each module? What implications are there for a measure where we have a "0" for the numerator	ACO will need to completely and accurately report for 2013. This is the quality standard for the 2013 reporting period. In 2014, we move to pay for performance and you can find which measures go to pay for performance both in the SSP rule and supplement documents that are on the ACO quality page on the CMS website.	NA	X	X
10	12/5/2013	Will a list of questions and answers from this program be available for future reference, as well as the slides?	Yes, we will post the Q&A document and slides on the GPRO Web Interface page of the CMS website within two weeks of support calls: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
11	12/5/2013	Regarding the Quality Tier Reporting option, can you go in depth regarding how the standard deviation is being used to determine the performance levels for quality and cost?	This is a Value-based Payment Modifier (VM) question, please contact the QualityNet Help Desk for information at 1-866-288-8912 (TTY: 1-877-715-6222) or Qnetsupport@sdps.org. Information about VM is available on the CMS Physician Feedback Program website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.	X	NA	NA
12	12/5/2013	What is the audit process after submission?	Additional information on the audit will be provided after the close of the reporting period to ACOs that are selected to participate in the Medicare Shared Savings Program quality measures validation audit.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
13	12/12/2013	We have users who still need to be added to the listserv for all these notifications and meetings; how do we add people to the PQRS GPRO listserv?	If you are a PQRS GPRO, please send your request to: PQRS_Vetting@mathematica-mpr.com. If you are an ACO, you can update your contacts in HPMS.	X	X	X
14	12/12/2013	Can you restate how we will receive these slides? Will they be sent to all invitees, or do we have to go to a CMS site to retrieve them?	The slides will be posted on the GPRO Web Interface page of the CMS website within two weeks of the call.	X	X	X
15	12/12/2013	By saying the PDF is "not 508 compliant" does that mean you would not recommend us printing them and using them to develop our XML?	No. You can still download the PDF and use it as a reference. However, a screen reader may not read the information accurately to a visually impaired user, and some of the built in navigational features (table of contents, bookmarks, and hyperlinks) may not be fully functional. If you click on the link, the online version is 508 compliant and the navigational features are fully functional.	X	X	X
16	1/9/2014	How do we access the EFT or MFT mailbox?	To access the MFT Internet Server, you must use the 4-character user ID and password assigned to you by the Center for Medicaid, CHIP and Survey & Certification (CMCS). For technical assistance, including issues with account passwords and the MFT web browser interface, contact the ACO Information Center at 1-888-734-6433, option 2. TTY/TDD: 1-888-734-6563.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
17	1/9/2014	What is the exact title of the Supporting Documents that is referred to? I want a list of "other CMS approved reasons" for skipping a particular measure.	The Supporting Documents can be located on the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. Scroll to the bottom of the page to the "Downloads" section and select the first option; "2013 Supporting Documents and Release Notes for ACO and PQRS GPRO Web Interface Users". The Supporting Documents are Excel documents and are divided into 7 separate modules. A list of "other CMS approved reasons" is not available. This option must be requested by opening a QualityNet Help Desk incident and must include the measure/module, patient rank, and reason for the request. An example of a reason approved by CMS in the past is when a male patient has been attributed to PREV-5: Breast Cancer Screening.	X	X	X
18	1/9/2014	Which of the you tube videos provides the list of prefilled data? What name?	The 2013 GPRO Web Interface Overview video on YouTube shows the Pre-filled Elements Report with the prefilled elements. The slides for this video, showing the Pre-filled Elements Report are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. The GPRO Online help available from a link in the 2013 GPRO Web Interface Quick Start Guide at qualitynet.org/pqrs. The Online Help will also be available from the application during the Submission period. See the information for the Online Help in the "Purpose" section of this document for details on how to access the Online Help outside the application.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
19	1/16/2014	The SSP Quality Measure Benchmarks for the 2014 and 2015 Reporting Years: Appendix A listed several measures 7, 8, 19, 20, 21, 31 and 23 and 33 as Pay for Reporting in program year 2. We began participating as an ACO effective 1/1/2013.	ACOs with 2012 and 2013 start dates are pay-for-reporting for the 2013 reporting period that ACOs are currently reporting on. The benchmarks do apply to 2014 and 2015 reporting periods with data entry in early 2015 and 2016 respectively. For 2014 reporting with data entry in early 2015, the benchmarks will apply to ACOs with 2012 and 2013 agreement start dates for the measures that are pay-for-performance as outlined in table 1 in the Shared Savings Program rule. ACOs with 2014 agreement start dates will be pay-for-reporting for 2014.	NA	X	NA
20	1/16/2014	We are an anesthesiologist group of 100+ and do some pain management. Can we opted out and continue to bill EP PQRS via claim?	ACO Participant TINS can only participate in PQRS by the ACO satisfactory reporting via the ACO GPRO web interface. If EPs bill through non-ACO participant TINs, they may participate in PQRS in another way for the non-ACO billed charges. For groups reporting in the web interface via the traditional PQRS GPRO, the time period for changing your registration option has already passed.	X	X	X
21	1/16/2014	We require clarification regarding which NARRATIVE specs should be used to report 2013 Pioneer ACO CQMs. Are we to now use the PQRS GPRO NARRATIVE SPECS?	Yes that's correct.	NA	NA	X
22	1/16/2014	What does a 'termed' beneficiary mean. Should that beneficiary still be managed through care manager?	When we are talking about beneficiaries in terms of the Web Interface we are talking about the Medicare patients that have been assigned to your group or ACO that you would need to report on.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
23	FAQ	What information will the Beneficiary Provider Supplemental File include?	The file will include: • HICNO • Patient first name • Patient last name • Sex • Birth Date • Patient Rank for each of the samples • The TIN or CCN that provided the patient with the most primary care service visits NPIs, first names, and last names of the 3 providers who provided the highest number of primary care services to the patient	NA	X	X
24	FAQ	What are we supposed to do with the Beneficiary Provider Supplemental File?	The purpose of the beneficiary-provider file is to give the ACOs a list of the assigned beneficiaries who have been sampled for GPRO data collection, the TIN or CCN at which the beneficiary received the most primary care services, and the names and NPIs of the three providers who provided the plurality of primary care services visits to the beneficiary – all based on Medicare claims data. The purpose of this list is to assist the ACOs in finding patient records. It is possible, however, that the patient's record is located with none of these providers. If that is the case, the ACO should make every effort to search your own systems of network of providers to locate the patient's record in order to collect data on this patient.	NA	X	X

XML

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	12/12/2013	From the file we receive from CMS, what if we believe the date of birth is wrong?	If you need to change the date of birth (DOB), you can do that from the Web Interface. You won't be able to do this in XML, but you can update the date in the Web Interface. The DOB is an alterable field that can be corrected manually in the Web Interface. In terms of patient status, you may want to consider what impact that would have on some of the measures that are age dependent.	X	X	X
2	12/12/2013	Can we provide updated NPI's in the XML, or do we have to use the NPI's provided by CMS?	No, if you choose to update the NPI you can use XML to do that. If you want to change the NPI to make it easier to either find a patient or correct an association you can do that on the Web Interface or you can do that in the XML. Just ensure that the NPI does exist in your database. You can do this by looking on your screen or by exporting your providers XML file. The Add/Edit Providers screen displays a list of all providers for your TIN. If you update the provider on the patient's demographics page in the Web Interface you can select the new provider from a pre-populated list.	X	X	X
3	12/12/2013	When was it mentioned that the XSD files were changed?	The XSD file that was changed is the patient ranking file which is embedded in the XML specification. We have the updated specification and they will be available 12/13/2013 on the CMS website. The other XSD files were not changed.	X	X	X
4	12/12/2013	Will CMS be providing an Excel to XML template like they did last year?	No, we are not going to give you a template as we have given you step-by-step instructions in the XML Specifications on to how to create your own template in Excel 2007, 2010, and 2013.	X	X	X
5	12/12/2013	If we enter some information in the Web Interface, then upload an XML file, will the XML information overwrite what was previously manually entered?	If you have a value in the XML tag, for example, if you entered "yes the patient had a mammography screening" in the Web Interface and then you upload an XML file that says "no the patient did not have a mammography screening," then yes, the XML file **will** overwrite what you originally entered into the Web Interface. If, however, you upload an XML file that does not contain the mammography screening tag or if you upload an empty mammography screening tag, then it will **not** overwrite what you have in the Web Interface.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
6	12/12/2013	If we are making our submission through an XML upload file is it only the complete patient XML file that we upload or are there multiple XML files that need to be created and uploaded?	It is entirely up to how your organization would like to upload the XML files. The data can be in one submission or in multiple files. As noted in the question above, if you upload multiple XML files, the latest file will overwrite any previously loaded files. But again, you can upload one module at a time, one office's patients at a time, one measure at a time, etc. It really depends on what is best for your workflow.	X	X	X
7	12/12/2013	If you upload a file, do you have the capability to back out that file in case you upload incorrect data by error?	You do have the opportunity to correct an error. Backing out incorrect data, would essentially either overwrite the data with the new correct value or if you just put it in the wrong place, you could use a "-1" in your XML value. This is described as one of the valid values in the XML specification. A "-1" will blank out as a null the value that is currently in the database for the patient. For example you were only uploading dates for HbA1c and you accidently put them under LDL-C dates. If you wanted to remove the HbA1c dates from the LDL-C dates, you could modify the uploaded file to replace the dates with "-1" upload the file again. All dates with a "-1" in the XML file will now have a null in the database. Please use extreme cautious while doing this because it will remove data from the database, however we did put this option in just to cover this situation.	X	X	X
8	12/12/2013	Can we test an upload with one patient?	Yes, once the Web Interface is open you may upload one patient as a test. Whatever data you enter will be saved for this patient.	X	X	X
9	12/12/2013	We were planning to use the Excel spreadsheet tool from last year to upload into the GPRO tool. Will this work or is there a new version, and if so, is it located on the above referenced cms.gov website?	If you used Excel last year, you can't use that same template this year because some of the measures and associated tags have changed for 2013. This especially goes for GPROs, as you will see significant changes in your measures. In addition, because the medical record found now applies to all of the modules in which the patient is ranked instead of being on a module by module basis, you can't use last year's template. We have given you instructions as to how to create a new template in Excel 2007, 2010, and 2013 with the supplied XSD files. The format for the template this year is not significantly differently from last year, but there are new and removed tags. Please use the format for this year or your tags will not be valid. The XML Spec contains a Release Notes section detailing the changes for this year.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
10	12/12/2013	Are the NPI and Clinic IDs optional?	Yes, they are optional. You will have a pre-populated clinic and up to three NPIs. If you're happy with what you've got and you don't want to change them, you don't need to include them in the XML file.	X	X	X
11	12/12/2013	Is there a test system for us to upload a test patient's XML file?	No there is not a test system.	X	X	X
12	12/12/2013	If you submit an NPI that was not on the list of NPIs that was originally given to us for that beneficiary will that be accepted?	An XML file containing an NPI that is not on the list of NPIs for your TIN will not be processed. Other valid NPIs will be processed. You will have a pre-populated list of NPIs and you can add NPIs in the Web Interface during the submission period. All NPIs associated to a patient will be pre-populated. All of the available NPI's will be available on a screen and drop down That will be demonstrated in January. If you want to use additional NPIs, you can go into the Web Interface and add new NPI's and then upload your XML files.	X	X	X
13	12/12/2013	If we change a patient's date of birth and the patient is no longer in age range for a measure, what do we do?	That may fall under other CMS approved reasons so we ask that you submit a QualityNet Help Desk ticket for this question.	X	X	X
14	12/12/2013	How will CMS notify users of XSD updates? Or is the user responsible for checking the website and dates on documents	If we find any need to update the XSD, there are different avenues for updating the users. Should we need to change one, we will notify you immediately. How you will be notified depends on your program. It will not be your responsibility to check, we will ensure you are notified.	X	X	X
15	12/12/2013	As a follow up question to the XSD file change, will the sample files be updated as well?	The sample files did not need to be updated. What was found was that the version in the header did not match what was in the sample file. The sample file was correct which pointed out the difference in the XSD.	X	X	X
16	12/12/2013	What is the purpose of the clinic file?	This file is more useful for ACOs as they have a number of participating TINs. The information in the clinic file will help the organization see which participating TIN or CCN is associated to a patient. It can help them filter out their patients by each participating TIN.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
17	12/12/2013	If you are new to the PQRS Web Interface, do you have to upload the HTML file in order to view the measures?	When the Web Interface opens, you will see the different measures. If you are new to the Web Interface, we suggest viewing the overview presentations that are available to you. These resources will show you what the different measures are. If you upload an XML file, the values that are uploaded will be visible in the Web Interface.	X	X	X
18	12/12/2013	When using the XML option, how can we ensure our patient sample stops at patient #411? In other words, if our file contains 616 patients, how can we ensure our performance is only tied to the first 411 patients via the file?	When you export your patients, either in the patient ranking or patient discharge file, the file will contain the patient's rank in all modules in which they were sampled. Depending on how you create your XML file, you would want to use that rank and only provide data for the first 411 patients. Just remember if you are uploading additional patients above 411, the count will stop at the first patient that is incomplete.	X	X	X
19	12/12/2013	If I am using XML and submit a different NPI, it sounds like from RTI's answer it would be accepted? What do the NPI's listed in the patient file represent?	As long as the NPI is already in the Web Interface when you upload the XML file you can submit a different NPI for a patient and it will be accepted. The NPIs for your TIN will be pre-populated and you can also add NPIs using the Web Interface. The top 3 NPIs for the patient are an additional way you can look up your patient, or filter your list of patients.	X	X	X
20	12/12/2013	Will prefilled elements be included in the download export file?	Yes, when you first log on to the Web Interface, if you were to do an export of the patient and the patient discharge data it will contain all of the prefilled elements for you as soon as you log in to the Web Interface.	X	X	X
21	12/12/2013	If you substitute an NPI that differs from the three NPI's supplied. Does that work for TIN as well? Is there any benefit in submitting NPI's?	If you are changing an NPI for a patients, that's just going to be changing the association to that single patient in the Web Interface. The top three NPIs for a patient were provided to help you find a patient. The Clinic TINs or CCNs are provided to help you find patients. It is for your use and will not be submitted to CMS. CMS will not use the clinics or providers associate to a patient for calculations or measurements.	X	X	X
22	12/12/2013	Can we generate one XML file per measure and upload data using one XML file per measure?	Yes, you can.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
23	12/12/2013	Is it acceptable if we don't include the "provider NPI", "patient first and last names", "gender", "birth-date", "clinic-identifier", "rank" in the XML file? Do we get an error by not using these elements?	No, you won't get an error for not including this information in the XML file. The first/last name, gender, birth-date, and rank will all be pre-populated in the Web Interface. If you need to change any of the fields, you cannot do so in your XML file; you must update them directly in the Web Interface.	X	X	X
24	12/12/2013	Is an Excel template of the XML file is posted on the CMS Web Interface website? I can't seem to find it under the Download section.	No, the XML specifications have been posted on the GPRO Web Interface page of the CMS website under the *2013 GPRO Web Interface XML Specification* header: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. There are step-by-step instructions in the XML specifications for creating an Excel to XML template. The XSD files used to create the Excel template are included in the XML specifications.	X	X	X
25	12/12/2013	Can you clarify if these slides and/or an online manual for GPRO can be accessed within the link you provided?	The slides will be posted on the GPRO Web Interface page of the CMS website within two weeks of the call. The XML specifications have been posted and can be also be found at this website.	X	X	X
26	12/12/2013	Can you provide a link to the most current XML GPRO specifications?	You can find the XML specifications and other documentation for the GPRO Web Interface on the GPRO Web Interface web site: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
27	12/12/2013	Do you have a recommended workflow for a new group, with 4-5 staff performing data abstraction? Should we abstract by patient or by modules?	It's a personal choice. You may want to consider staff with particular expertise to complete certain modules. In addition, for the sampling of the Preventive Care measures, we tried to reuse patients as much as possible. So, it would make sense to complete these together at the patient level.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
28	12/12/2013	Can you review again the process for removing a value from a prior submission with a subsequent file submission (i.e. “removing” vs. “modifying” the previously submitted value)	Backing out incorrect data, would essentially either overwrite the data with the new correct value or if you just put it in the wrong place, you could use a “-1” in your XML value. This is described as one of the valid values in the XML specification. A “-1” will blank out as a null the value that is currently in the database for the patient. For example you were only uploading dates for HbA1c and you accidently put them under LDL-C dates. If you wanted to remove the HbA1c dates from the LDL-C dates, you could modify the uploaded file to replace the dates with “-1” upload the file again. All dates with a “-1” in the XML file will now have a null in the database. Please use extreme cautious while doing this because it will remove data from the database, however we did put this option in just to cover this situation.	X	X	X
29	12/12/2013	Is this XML tag correct: <submission> tag has attribute xmlns="gov/cms/pqrs/patient/v1"? Should it be ACO instead of PQRS?	The tag as written is correct. The ACO and GPRO measures were aligned for 2013 so there is only one submission attribute for PQRS reporting in the Web Interface.	X	X	X
30	12/12/2013	Will you provide a checklist to ensure we don't miss anything on the Web Interface for submission?	If you are performing manual abstraction, when you save a patient, you will receive an errors/warnings message if applicable. If you are using XML, you can use the check entries report to check for inconsistencies and missing information. The Totals Report will also help you make sure everything is complete in the Web Interface. It includes detailed information on the completeness of data shown in the Group Status section of the Home page. This report helps you determine if the requirements for reporting have been met. If they have not been met, the report helps you determine which patients are missing and the data that is needed to qualify them for the reporting requirements.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
31	12/12/2013	There's a typo found in the XML Specification.	The available values and appropriate XML format for the **Not Qualified for Sample** date should be changed from <care-not-qualified-date> to <medical-not-qualified-date> in the body of the specification. Appendix A, which lists the valid tags and values, is correct. The XML specifications will be updated to correct the typo and you will be notified when the version is available.	X	X	X
32	12/12/2013	When an ACO has multiple participant TINs do we need to upload one set of results (patient, patient discharge) per TIN?	You can choose to combine all of your TINs into one upload or multiple uploads. Whatever works best for you is how you should upload your patients. The Web Interface will allow multiple uploads.	X	X	X
33	1/9/2014	For first time data submitters, is there a test XML file we can download to see what it looks like?	Sample XML files are available in the "Downloads" section of the CMS Web Interface page http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
34	1/9/2014	Is there any easy way of converting data captured in Excel using the patient xsd from cams into xml data? It has not been easy to achieve using Excel.	Answering this requires more information than is available here. Please open a QualityNet Help Desk ticket and describe the problem you are having so we can make a recommendation.	X	X	X
35	1/9/2014	Last time, when the fields were not in the same order as in the XML download with the tags intact, it gave us an error. So please confirm that the tags should be in the same order as the Upload file as in the Download file.	The tags must be in the order specified in the XML Specification. See sections 4.2.5and 4.2.16 in the XML Specification where this is called out and see Appendix A for the Patient tag order and Appendix B for the Patient Discharge tag order. The XML file that is exported from the Web Interface will contain the tags in the order indicated in the XML Specification.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
36	1/9/2014	We're uploading a file with multiple providers. Am I correct in stating that the <group-tin> should be populated with the TIN from the ACO, while the provider's TIN should be placed in the <clinic-identifier>?	The ACO Primary TIN must be used in the <group-tin> tag. The <clinic-identifier> will be pre-filled for most of the patients. If you need to add a clinic identifier or update a clinic identifier for the patient you must use a clinic identifier that exists in the Web Interface. To obtain a list of the clinic identifiers that exist in the system view the Add/Edit->Clinics screen in the Web Interface or export the Clinics XML file. The clinic identifiers in the system represent the participating TINs or CCNs for the Primary ACO TIN. The clinic identifiers will be prepopulated and you may also add clinics if needed.	X	X	X
37	1/9/2014	When will the XML file be available for download? Will this be the 27th or the 13th?	XML files may be downloaded from the Web Interface when they submission period opens on January 27. You will be able to download XML files at any time during the submission period. Once the submission period closes on March 21, you will be unable to access the Web Interface or download XML files.	X	X	X
38	1/16/2014	Does the XML file name need to be the same file name for uploading and downloading?	No it does not. When downloading file, the system will generate a name for it. You can choose to save it under a different name. When uploading a file you may provide a name that helps you identify the contents of the file as long as the name of the file, including the ".xml" extension does not exceed 35 characters. The file length limit is also listed on the Upload Data screen in the Web Interface.	X	X	X
39	1/16/2014	If an empty tag is used for some of the prefilled measures, would that throw an error during submission?	No empty tags do not throw errors in submission. The file will be accepted but empty tags will not be processed.	X	X	X
40	1/16/2014	What happens if an ACO reports on all 616 patients instead of 411? Will we see errors when uploading the XML document?	No, you will not get errors if you report in all your patients. This may be easier for ACOs/GPROs that are extracting data from EHRs than limiting the extracted data to just the first 411(ACO or Large GPRO) or 218(Medium GPRO) eligible patients.	X	X	X
41	1/16/2014	What modules do I need to choose when exporting the XML files so that I will have the fields that match with the sample patient only prefilled that was provided by CMS?	The measures which may be pre-filled are DM-2, DM-15, IVD-1, PREV-5, PREV-6, PREV-7, PREV-8. You should select the DM, IVD, PREV-5, PREV-6, PREV-7, PREV-8 modules to get patients with pre-filled data.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
42	1/16/2014	When would you have a null value in an XML file?	A null value means the answer has not yet been provided in the Web Interface. The only reason to use a null value in a XML file is if you entered a value in the XML file and you determined the value was an error.	X	X	X
43	1/16/2014	Where can I download the .xsd files for the XML import?	The .xsd files can be downloaded from the XML specs available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
44	FAQ	After entering some data into the GPRO Web Interface, will that data be available immediately for XML export?	Yes. When you request an XML file, it will contain all information that is currently saved in the GPRO Web Interface.	X	X	X
45	FAQ	If we upload data via XML, will it erase any data that was entered manually by another user?	If you have a value in the XML tag that is associated with data entered by another user, then yes, your XML upload would overwrite that value. However, if, for example, one user entered information in the diabetes module and you are uploaded data for the CAD module, then your upload of CAD data would not overwrite the previously-entered diabetes data.	X	X	X
46	FAQ	Can we upload all of our sampled patients in one XML file?	We would recommend you try the upload with a few patients to make sure that there are no errors, but you can also upload all of your sampled patients in one file.	X	X	X
47	FAQ	Does the XML upload automatically "save" the patient's information?	Yes. Uploading of the XML automatically saves the patient's information. Note that you still need to submit your data to CMS by going to the Submit screen and clicking the Submit button.	X	X	X

Additional Information

PQRS GPRO

- 2013 PQRS GPRO information is available on the CMS PQRS website under the "Group Practice Reporting Option" page, or directly at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Selected-Group_Practice_Reporting_Option.html.
- 2013 PQRS GPRO Web Interface reporting information is available on the CMS PQRS website under the "GPRO Web Interface" page, or directly at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.
- Any questions regarding this document, PQRS or participation in the PQRS GPRO should be referred to the **QualityNet Help Desk** at desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org.**

SSP

- 2013 SSP information is available on the SSP website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html.

PIONEER ACO

- Any questions regarding this document or participation in PQRS through the Pioneer ACO should contact the CMS at **PIONEERQUESTIONS@cms.hhs.gov**.

APPENDIX: CONSECUTIVE COMPLETION REQUIREMENT

Patients are numbered 1-616 (or 1 to the maximum number available if less than 616), and 411 of these patients need to be completed in the GPRO Web Interface by ACOs and PQRS GPROs with 100 or more EPs. For PQRS GPROs with 25-99 EPs, up to 327 patients will be ranked in a module and 218 must be completed. The 616 number represents a 50% oversampling to provide additional patients if you need to skip a patient in order to allow completion of 411 patients. Complete means that you have found the medical record, confirmed the disease diagnosis (for CAD, DM, HF, HTN, IVD), and provided all the required information; or, for those measures that do not require confirmation of a diagnosis (CARE and PREV), that you have found the medical record, confirmed the patient is eligible for the measure, and provided all the required information.

The minimum number for satisfactory reporting is 411 (ACO or PQRS GPRO with 100 or more EPs), or 218 (PQRS GPRO with 25-99 EPs) consecutively confirmed and completed patients, starting with the patient ranked #1 in the disease module or patient care/coordination measure. If you skip a patient because the medical record was not found, the patient is no longer qualified for the sample, the patient is not eligible for the disease module or patient care measure, **or** the diagnosis could not be confirmed then an additional patient, *on a one to one basis*, must be completed according to the criteria noted above. If the pool of eligible assigned beneficiaries is less than 411 for ACOs or for group practices participating in PQRS GPRO with 100 or more EPs, or less than 218 for group practices participating in PQRS GPRO with 25-99 EPs then report on 100% of assigned beneficiaries.

Following are three examples of completing patients in consecutive order in the Web Interface.

EXAMPLE #1

In this example, 2 patient ranks need to be skipped. An additional patient is eligible for a clinical exclusion per the measure specifications.

Patient Rank	Disease Confirmation (not applicable to all measures) or patient care eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes – confirmed	Yes – complete	Yes	
2	Yes – confirmed	Yes – complete	Yes	
3	Yes – confirmed	Yes – complete	Yes	
4	N/A	N/A	No	Medical Record not found
5	Yes – confirmed	Yes – complete	Yes	Patient was eligible for one of the clinical exclusions in the specifications.
6	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during 2013
7 through 411	Yes – confirmed	Yes – complete	Yes	
412	Yes – confirmed	Yes – complete	Yes	Must complete additional patient to make up for skipping Rank #4
413	Yes – confirmed	Yes – complete	Yes	Must complete additional patient to make up for skipping Rank #6

Note*:* No additional abstraction required: consecutively completed 411 ranked patients. Module considered complete.

EXAMPLE #2

In this example, 2 patient ranks need to be skipped, but there are fewer than 411 patients available for abstraction.

Patient Rank	Disease Confirmation (not applicable to all measures) or patient care eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes – confirmed	Yes – complete	Yes	
2	Yes – confirmed	Yes – complete	Yes	
3	Yes – confirmed	Yes – complete	Yes	
4	N/A	N/A	No	Medical Record not found
5	Yes – confirmed	Yes – complete	Yes	
6	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during 2013
7 through 386	Yes – confirmed	Yes – complete	Yes	
387	Yes – confirmed	Yes – complete	Yes	No additional patients available for abstraction.

Note: No additional patients available for abstraction: consecutively completed all available ranked patients. Module considered complete.

EXAMPLE #3

In this example, laboratory result data for patient rank #2 was not provided and causes the count of consecutively completed ranks to stop at rank #1.

Patient Rank	Disease Confirmation (not applicable to all measures) or patient care eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes – confirmed	Yes – complete	Yes	
2	Yes – confirmed	No – didn't abstract information on lab test	No	If this patient is not completed, you will have consecutively completed only 1 patient (Rank #1). Once Rank #2 is completed, it will be considered consecutively completed.
3	Yes – confirmed	Yes - complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
4	Yes – confirmed	Yes - complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
5	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during 2013
6 through 411	Yes – confirmed	Yes - complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
412	Yes – confirmed	Yes - complete	No	Must complete additional patient to make up for skipping Rank #5. Once Rank #2 is completed, this will be considered consecutively completed.

Note: Module considered incomplete until Rank #2 is completed.