2016 GPRO Web Interface Quality Reporting

Questions & Answers

November 21, 2016

7500 Security Blvd., Baltimore, MD 21244-1850

Table of Contents

Quality Reporting for Calendar Year 2016: Overview

Activity	Estimated* Timeline
ACOs and PQRS group practices provide care to patients during the reporting period	January 1, 2016–December 31, 2016
CMS assigns beneficiaries to the ACO or PQRS group practice, samples them into the GPRO Web Interface for data collection, and prefills some beneficiary information.	November 2016–January 2017
GPRO Web Interface opens so that patient ranking files can be downloaded	January 3–January 6, 2017
GPRO Web Interface training environment available (with masked, dummy data)	January 9–January 13, 2017
GPRO Web Interface opens for data entry by ACOs and applicable PQRS group practices	**January 17, 2017**
ACOs and PQRS group practices attend weekly Q&A sessions	January 19–March 14, 2017
GPRO Web Interface closes to data abstraction by ACOs and applicable PQRS group practices; no more abstraction possible	**March 17, 2017** ***Closes at 8:00pm ET / 7:00pm CT / 6:00pm MT / 5:00pm PT***
Continued access to GPRO Web Interface to generate, view, and print reports (all other functionality disabled)	March 20–April 21, 2017
ACOs selected for audit are notified by CMS	April 2017
ACOs' audit materials due to CMS	May 2017
Quality scores reported to ACOs	Late Summer/Early Fall 2017

*Dates subject to change.

GPRO Web Interface

ID	Question	Answer
1.	Can you please clarify what the term “for analysis” means? Why is the “complete” patients higher than the “for analysis” count?	The **For Analysis** count reflects patients that are consecutively confirmed and completed starting with the patient ranked #1 in the disease module or patient care measure. The **Complete** count is the number of completed patients in any order in the disease module or patient care measure. If some of your patients have not been consecutively confirmed and completed, you may see a higher count of **Complete** patients than the **For Analysis** count. The For Analysis line is on the Home page in the Group Status section. 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 **For Analysis** count is the count used to determine if you have met the minimum reporting requirements.
2.	When should we click the “Submit Data to CMS” button?	After you have completed reporting and all of your files have been uploaded, you will need to go to the Submit screen and press the “Submit Data to CMS” button. This will indicate to CMS that your data collection is complete. If you need to enter additional data after you have pressed “Submit Data to CMS,” you may do so, but will need to press “Submit Data to CMS” again once you have finished data collection so that all data entered is transmitted to CMS. The Submit screen is accessed by clicking the “Submit” link at the top of the Web Interface. After you submit data, you may wish to print a “Totals Report” to ensure you have met reporting requirements for your data submission (see question #8 below).
3.	Where is the link in the Portal to access the GPRO Web Interface?	The link is https://qnpapp.qualitynet.org/pqrs/home.html . Click on the “Sign In” button. After signing into the QualityNet Secure Portal, select the “Quality Reporting” dropdown menu within the navigation bar. Then select the “Physician Quality Reporting system” link. Finally, select “GPRO Submission” on the tray page.
4.	Do you lose data when the system logs you out after a period of inactivity?	Yes, if the user is manually entering data and has not saved the information. The system will also lock the patient with the user account that last updated the information. If you are uploading an Extensible Markup Language (XML) file and get timed out the data will not be lost. In order not to lose data, it is recommended that you save your information frequently.
5.	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. However, only updates made prior to pressing the “Submit Data to CMS” button will be transmitted to CMS.
6.	Can we provide the data for all disease modules or patient care measures for a given patient even if the patient is not ranked in all disease module or patient care measures?	The XML file will pass format validation. However, only the patients ranked in the disease modules or patient care measures containing the measure data will be updated. The data will be discarded for patients not ranked in the disease modules or patient care measures containing the data.

ID	Question	Answer
7.	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 for that measure. Percentages are calculated only on the consecutively confirmed and completed patients. The final percentage will not be reported until all required consecutive patients have been entered.
8.	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 "The data you have submitted has been received by CMS and MEETS the requirements for ACO GPRO Web Interface satisfactory reporting," or "The data you have submitted has been received by CMS and MEETS the requirements for PQRS GPRO Web Interface satisfactory reporting. Please note: Some group practices are required to complete CAHPS for PQRS. If your group is required to do so, successful completion of CAHPS for PQRS is required to avoid the negative PQRS Payment Adjustment," then you have successfully consecutively completed all necessary patients. The For Analysis line on the Home page will indicate the number of patients meeting the reporting requirements. If you have met the minimum number of consecutively confirmed and completed patients, there will be a green checkmark next to the For Analysis count in each disease module and patient care measure. If all disease modules or patient care measures (15 individual measures and the diabetes composite comprised of 2 individual component measures) have a green checkmark, then you have met the reporting requirements. The Submit screen and "Submit Status Report" will indicate that the disease module or patient care measure "is complete" for each disease module or patient care measure that has been satisfactorily reported. If you see this message for each of the disease modules and patient care measures, then you have met the satisfactory reporting requirements. The Submit Screen and the Submit Status Report will also have text indicating if you have or have not met the reporting requirements.
9.	How do we export all prepopulated patient information?	The Patient file contains all patient information populated in the GPRO Web Interface with the exception of the CARE-3 data. To export Patient files, you must select one or more disease module or patient care measure to be reported. The Patient Medications file contains the CARE-3 information needed for medication documentation and disease modules or patient care measures need to be selected when exporting this file.
10.	Which reports do you recommend we print and keep?	Though this is not required, you may want to print the Measure Rates Report, which shows performance on each of the disease modules and patient care measures, and the Totals Report, which will give you the number of patients that were complete, skipped, etc. for each disease module and patient care measure. The Submit Status Report gives you a record of the disease modules or patient care measures completed at the time you pushed the "Submit Data to CMS" button on the Submit screen.

ID	Question	Answer
11.	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, this can be via electronic upload using XML or manual abstraction. More detailed resources regarding XML reporting are included in the XML section of this document, the XML specifications, and a recorded demonstration regarding electronic upload of data using XML will be posted on the GPRO Web Interface page of the CMS website.

System Requirements and Users

ID	Question	Answer
1.	Where do I go to access the Web interface?	The link is https://qnpapp.qualitynet.org/pqrs/home.html . Click on the "Sign In" button. After signing into the QualityNet Secure Portal, select the "Quality Reporting" dropdown menu within the navigation bar. Then select the "Physician Quality Reporting system" link. Finally, select "GPRO Submission" on the tray page.
2.	Do security officials have GPRO Web Interface access or only the Web Interface submitters?	Security officials (SOs) and ACO SOs do not have access to the GPRO Web Interface and cannot submit data for your ACO or group practice in the GPRO Web Interface. SOs and ACO SOs approve the Web Interface submitter roles in Enterprise Identity Management (EIDM). The SO or ACO SO must be from the ACO or group practice and may not be a vendor.
3.	How long does it take to get access to the Web Interface after completing the security official on-line registration?	The SO/ACO SO role approval should occur within a couple days. Once approved, the SO can immediately approve any Web Interface submitter roles for their organization. All submitter should be able to immediately access the Web Interface.
4.	Are organizations limited in the number of Web Interface submitters they can have?	No, organizations are not limited in the number of submitters they can have. We do recommend no more than 15 users per organization.
5.	When I log into the PQRS portal, my profile indicates that I am a PQRS Representative and a PQRS Submitter, however I do not see the GPRO submission link. Why is this?	In order to gain access to the GPRO submission link, you will need to request the Web Interface Submitter role. For more information, please see the recording of the EIDM demonstration, which is available on the GPRO Web Interface web site. ***Applicable to Shared Savings Program (Shared Savings Program) ACOs only:*** The 2016 EIDM Guidance document is posted on the Shared Savings Program Portal (located in the Program Announcement titled, *2016 Quality Measurement and Reporting Guides).*
6.	Can we use the GPRO Web Interface with Internet Explorer 7 or Google Chrome?	Internet Explorer 11 (IE11) is the browser officially supported by CMS and is the recommended version. Minimal testing of the GPRO Web Interface has been done with Google Chrome 38.0.2125.111m, Firefox 20.0.1, and Safari 5.1.7. These browsers can be used, but you will see minor changes on the screens.

ID	Question	Answer
7.	I have access to multiple organizations through my QualityNet account. What do I need to do to navigate from one organization to another in the system?	Once logged into the QualityNet Secure Portal, click on "User Profile" in the upper right hand corner of the screen. Select "User Preferences" from the dropdown. Then, click on the "Organization Switch" tab. Select the PQRS Program and the Organization to which you would like to switch. Click the update button and navigate back to the GPRO Web Interface using the "Quality Programs" dropdown menu.

XML Specifications

ID	Question	Answer
1.	Where can we find documentation on use of XML to load data into the GPRO Web Interface?	The 2016 GPRO XML Specifications and Release Notes is available on the GPRO Web Interface web site.
2.	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. After uploading an XML file, the data will be available to export once the status of the upload indicated processing is complete.
3.	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, the XML file does not contain a tag or contains an empty tag for the data that was manually entered, the data will not be overwritten or erased. For example, one user is manually entering information in the heart failure disease module and you are uploading data for the CAD disease module. As long as you do not enter values in the diabetes tags when uploading the CAD XML file your upload of CAD data would not overwrite the previously-entered diabetes data.
4.	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 the entire sample at one time.
5.	If a data field is not applicable to a patient, do we leave the field blank or enter a -1?	If a data field is not applicable (for example patient does not have LVSD so you do not need to enter the beta blocker data), the tag may be left blank in the XML or the tag may be left out of the XML file. The -1 was removed as an available option in 2014 to prevent accidental erasure of data.
6.	Does the XML upload automatically "save" the patient's information?	Yes. Uploading of the XML automatically updates and saves the patient's information, however, uploading the XML does not submit the data to CMS.

Patient Ranking File

ID	Question	Answer
1.	What information will be provided in the patient ranking file that will be available in the GPRO Web Interface in early January?	The file will include: • Health Insurance Claim Number (HICNO) • Patient first name • Patient last name • Sex • Birth Date • Patient Rank for each of the disease modules and patient care measures into which the patient was sampled • The Taxpayer Identification Number (TIN) or CMS Certification Number (CCN) that provided the patient with the most primary care service visits • National Provider Identifiers (NPIs), first names, and last names of the 3 providers within the ACO or PQRS group practice who provided the highest number of primary care services to the patient
2.	What are we supposed to do with the patient ranking data?	The patient ranking gives the ACOs and PQRS group practices a list of the assigned beneficiaries who have been sampled for GPRO Web Interface 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 and PQRS group practices 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 or PQRS group practice should make every effort to locate the patient's record in order to collect data on this patient.

Sampling and Prepopulation

ID	Question	Answer
1.	Will all of our assigned/ aligned beneficiaries be populated into the GPRO Web Interface?	No. Patients will be sampled randomly (for ACOs it is based on third quarter assignment/ alignment) into the GPRO Web Interface using the specifications in the 2016 Web Interface Sampling Document, posted on the GPRO Web Interface webpage.
2.	What is the significance of a patient's rank?	Each sampled patient in a disease module or patient care measure is randomly assigned a rank order number for that disease module or patient care measure. Patients will be ranked 1-616 (or 750 for PREV13), or to the maximum number of eligible beneficiaries if fewer than 616 (or 750) are eligible for a given disease module or patient care measure. ACOs and PQRS Group Practices must report on at least 248 consecutively ranked beneficiaries or the maximum number of eligible beneficiaries available, should 248 not be available to completely report a disease module or patient care measure. Additional patients (the oversample) are included in the sample in the event some need to be skipped (e.g., medical record not found, not qualified for sample, etc.). In this case, the skipped beneficiary will be replaced with the next ranked beneficiary in the sample to facilitate completion of reporting on 248 cases in consecutive order. For more information on consecutive completion, please see Appendix A.
3.	Will each ACO (participant) TIN receive its own set of samples?	**Applicable to** Shared Savings Program **ACOs, Pioneer ACOs, and Next Generation ACOs only**: No. Quality data collection, measurement, and reporting in the ACO program are conducted at the ACO-level. The samples on which ACOs will need to submit clinical quality data will be drawn from all assigned/aligned beneficiaries across the entire ACO, that is, all participant TINs. More specifically, samples will be drawn from third quarter assignment/alignment. In other words, there will be one set of 16 samples drawn for the entire ACO, not for each participant TIN in the ACO.
4.	Many of the measures have age restrictions. As of when is a patient's age calculated?	For lower age limits, patients are sampled based on their age on the first day of the measurement period. For the 2016 measurement period this is the patient's age as of January 1, 2016. For upper age limits, where applicable, patients are sampled based on their age as of last day of the measurement period (i.e., the patient's age as of December 31, 2016).
5.	What if one or more of our disease module/patient care measures contain fewer than 248 ranked patients?	Not every disease module or patient care measure may have a sample of 248 patients; this is particularly true in disease modules for diseases that have low prevalence rates. If CMS' contractor was unable to identify 248 patients who met the sampling criteria, then all patients who meet the criteria will be sampled. If fewer than 248 patients are found eligible for a disease module or patient care measure, then the ACO or PQRS group practice should report on all eligible patients. For example, we have historically seen low numbers of patients sampled into the Heart Failure disease module.

ID	Question	Answer
6.	Can patients receiving comfort care be excluded from quality reporting?	Yes. In the Patient Confirmation tab in the Supporting Documents, hospice is defined as "hospice care at any time in the measurement period and includes non-hospice patients receiving palliative goals or comfort care". Patients for whom "In Hospice" is selected in the GPRO Web Interface will be removed from the sample(s).
7.	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 28 of the measurement year (2016). • Medicare HIC Number of the patient • First and last name of the patient • Gender • Patient date of birth • Patient rank in each disease module or patient care measure, if applicable • The 3 providers that provided the most primary care services to the patient • TIN at which the patient received the most primary care services • If the influenza vaccine was received (PREV-7) • Visits Dates that must be reported on for CARE-3
8.	What if prepopulated 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 PQRS group practices to modify this information. However, if the patient's demographic information in your records and in the GPRO Web Interface do not match, then the abstractor may need to correct the information in the GPRO Web Interface. For example, Medicare claims may not have the accurate date of birth for a patient. Your ACO or PQRS group practice should correct this information because it may affect that patient's denominator eligibility for certain measures. Note that any demographic information you change in the GPRO Web Interface does not get reported back to the CMS claims system. You should urge your patient to contact the Social Security Administration directly to have that information updated.
9.	Is CMS able to exclude from sampling patients who were enrolled in an HMO at some point during the measurement period, who entered hospice, or who died during the measurement period?	Yes. If Medicare claims as of October 28, 2016 indicate that the patient had HMO coverage as a primary payer, died, or entered hospice at any time during the measurement period, then CMS will exclude them from the quality sample. However, the claims we pull in October may not have the most up-to-date information (same for 'deceased' or 'hospice'.) If the abstractor finds additional or more recent information indicating that the beneficiary was enrolled in an HMO (as primary payer), entered hospice, or died at some point during the measurement period, then it would be appropriate to select "Not Qualified for Sample" in the GPRO Web Interface with the appropriate reason indicated.

ID	Question	Answer
10.	Is the ACO or PQRS group practice responsible for validating the data that is prepopulated into the GPRO Web Interface?	Yes. The ACO or PQRS group practice should validate each patient's demographic information, as changes to age and gender may affect a patient's denominator eligibility. Provider information populated in the GPRO Web Interface is for informational purposes only, so validation of this data are at the discretion of the ACO or PQRS group practice. PREV-7 (flu shot) is the only instance where numerator-specific data are prepopulated. Note that influenza immunization data are not prepopulated for all beneficiaries ranked in PREV-7, but only those for whom an immunization could be identified in the claims data. If influenza immunization data has been prepopulated for a patient, the ACO or PQRS group practice does not need to validate that data. If the ACO or PQRS group practice is selected for an audit, the ACO or PQRS group practice will not have to provide medical record documentation for prepopulated influenza immunization data. However, if influenza immunization data are not prepopulated, the ACO or PQRS group practice should refer to the patient's medical record to determine if an influenza immunization was administered in accordance with the measure specifications, and should document their findings in the GPRO Web Interface. Influenza immunization data obtained from the medical record (i.e., not prepopulated from claims data) is subject to provision of supporting documentation should your organization be selected for an audit. CARE-3 will have up to 12 visits pre-populated. The ACO or PQRS group practice will be responsible for validating that these visits occurred within the group practice or ACO.

Abstraction into the GPRO Web Interface

ID	Question	Answer
1.	For disease modules and patient care measures in the GPRO Web Interface, what makes the patient "confirmed and complete"?	Confirmed and complete means that for disease modules, you have confirmed the disease diagnosis and provided all the required information under that disease module (e.g., for a DM patient, that includes HbA1c value and an eye exam); or, for patient care measures, which do not require confirmation of a diagnosis (CARE and PREV), indicate whether or not you have found the medical record, confirmed the patient is qualified for the measure, and provided all the required information (e.g., indicate whether or not the patient received a mammography screening).
2.	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, by the end of the submission period the ACO or PQRS group practice must have completely reported on at least the first 248 confirmed, consecutively ranked beneficiaries (or all sampled beneficiaries if fewer than 248 are ranked) and submitted the data to CMS in order to satisfy the reporting requirement for each measure.
3.	How many unique patients should we expect we will need to abstract?	There are 17 patient samples provided to each organization as follows: • One patient sample for each of the two Care Coordination/Patient Safety measures (CARE-2 and CARE-3) • One patient sample for each of the 6 disease modules (CAD, HF, HTN, IVD, MH, and the Diabetes Composite) • One patient for each of the 9 Preventive Health measures (PREV-5 through PREV-13). Each of these samples will have no more than 616 (or 750 for PREV-13) beneficiaries. Patients are sampled using a method that increases the likelihood that they will be sampled into multiple disease modules or patient care measures (if they were eligible for multiple disease modules or patient care measures). Although there is potential to see over 10,600 (16 samples x 616 beneficiaries and 1 sample x 750 beneficiaries), we typically see sample sizes between 4,000 and 6,000 unique patients. We would expect similar sample sizes in 2016. The sampling methodology is described in the 2016 Web Interface Sampling Document available for download from the GPRO Web Interface website. ACOs and PQRS group practices are required to confirm and completely report on the first 248 consecutively ranked patients in each disease module and patient care measure. 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 PQRS group practice has confirmed and completely reported on 248 (or all, if there are fewer than 248) consecutively ranked patients.

ID	Question	Answer
4.	What does “consecutively complete” mean?	Patients are numbered 1-616 or 1-750 for PREV-13 (or 1 to the maximum number available if less than 616 or 750), and 248 of these patients, in consecutive order, need to be confirmed and 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, the final completed patient should be ranked 249 instead of 248. For several examples, see Appendix A.
5.	What if one of our sampled patients was not seen at our facility during the measurement period?	***ACOs*:** Though the patient may not have been seen at your facility, due to how patients are chosen for inclusion in a disease module or patient care measure sample, the patient was seen at least twice by participant TINs affiliated with your ACO during the measurement period. Specifically, beneficiaries were assigned to your ACO and must have had two or more primary care services within the ACO to be sampled into the disease module or patient care measure. Since your organization is deemed accountable for such a case, you may not select ‘not qualified for sample’ under this circumstance. ***PQRS Group Practices*:** PQRS group practices are responsible for the beneficiaries assigned to them, and claims data indicate that beneficiaries assigned to a PQRS group practice have claims evidence of at least two primary care services during the measurement year from the group practice. Please refer to the PQRS GPRO CAHPS for PQRS and Web Interface 2016 Assignment Methodology Specifications for more details. The PQRS group practice must use best efforts to obtain required quality data for such patients.
6.	What if one of our sampled patients is no longer being seen at one of the ACO’s participant TINs, or at the PQRS group practice (e.g., patient moved or the provider is no longer with the ACO participant TIN or PQRS group practice)?	By the assignment/alignment algorithm, the patient was assigned/aligned to your ACO or PQRS group practice because they were deemed to have the plurality of their Medicare services with your ACO or PQRS group practice. Further, patients sampled into the GPRO Web Interface had at least 2 Evaluation & Management (E&M) visits with your ACO or group practice between January 1 and October 28, 2016 therefore your ACO or PQRS group practice is considered accountable for this patient’s care, and you should do your best to obtain the needed quality of care information to complete the GPRO Web Interface.
7.	Some of our beneficiaries have declined to share their data. Will they be eligible for sampling into the GPRO Web Interface?	**Applicable to Shared Savings Program ACOs, Next Generation ACOs, and Pioneer ACOs only**: Quality data collection is not related to the data sharing processes that have been established for the Claims and Claims Line Feed (CCLF) data. A beneficiary who declines to share their data is not exempt from quality reporting.

ID	Question	Answer
8.	Can we exclude a sampled patient if they were only seen by a specialist at our facility?	No, this patient was assigned to your organization and has received the plurality of his or her primary care services at your organization so your organization is considered accountable for his/her care. Please refer to your program's assignment/alignment specifications for more information on how beneficiaries are assigned/aligned: • Shared Savings Program ACOs: Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications • Group Practices: PQRS GPRO CAHPS for PQRS and Web Interface 2016 Assignment Methodology Specifications • Pioneer ACOs: Pioneer ACO Benchmark Methodology for Performance Years 4-5 • Next Generation ACOs: Please refer to your Participation Agreement
9.	Is there any benefit or harm to abstracting additional ranks in the disease module or patient care measure than what is required?	Some organizations may choose to report data for more than the minimum number of beneficiaries for their own quality tracking or quality improvement efforts. If you enter the beneficiaries consecutively, the first 248 consecutively confirmed and completed patients will be used in the completeness determination, but all consecutively confirmed and completed beneficiaries reported on will be used in the measure rate calculations (i.e., if you complete 310 consecutively confirmed beneficiaries, then all 310 will be used in the measure rate calculations.) Whether or not this is advantageous depends on whether or not those additional beneficiaries meet the numerator criteria of the measure. For instance, if you have consecutively confirmed and completed exactly 248 beneficiaries, 200 of whom meet the numerator criteria, then you would have a performance rate of 80.65%. If you consecutively confirm and complete an additional beneficiary who meets the numerator criteria, then your new rate would be 80.72% (201/249). If that additional beneficiary instead does not meet the numerator criteria, then your new rate would be 80.32% (200/249).
10.	What do we have to do in order to be eligible for shared savings under pay for reporting?	**ACOs only**: If you completely and accurately reported on the minimum 248 beneficiaries for each of the disease modules and patient care measures, or all sampled beneficiaries if <248 were included in the sample you would have satisfactorily reported under pay for reporting.
12.	Where can we find a list of diagnosis, procedure, and exclusion/exception codes (e.g., denominator exclusions and reasons for denominator exceptions for "medical reason" or "patient reason") that can be used for reporting?	This information can be found in the 2016 GPRO Web Interface Supporting Documents and Release Notes, which is available for download from the GPRO Web Interface Website.
13.	Can we use NQF or HEDIS specifications for a measure when they are available?	Please follow the GPRO Web Interface specifications as these specifications have been developed specifically for the GPRO Web Interface reporting mechanism. Additionally, the GPRO Web Interface Narrative specifications are approved by the measure developer for use in the GPRO Web Interface and reflect the intention of the NQF or HEDIS measure.

ID	Question	Answer
14.	Different measures define the same condition differently. Why is that? Do we use just one of them?	We acknowledge there are differences in the coding for similar elements provided when that element is used in multiple measures, e.g., the diagnosis of hypertension is defined differently for HTN-2 to determine the initial population and PREV-11 where it is used as a denominator exclusion. CMS encourages alignment of measures especially in regards to the coding used to represent various measure elements; however, these two measures were developed and are maintained by different measure stewards. You are to follow the individual code list for each measure as they are listed for that measure when using codes to extract the data from your EHR or another data source.
15.	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.
16.	Is there a list of Other CMS Approved Reasons to remove patients from any of disease modules or patient care measures? How do you get approval to select Other CMS Approved Reason in the GPRO Web Interface?	There is no list of Other CMS Approved Reasons, requesting and approving removal of patients for an Other CMS approved reason is done on a case-by-case basis. To gain CMS approval, a QualityNet Help Desk ticket should be submitted to qnetsupport@hcqis.org that includes: • the beneficiary rank (never any protected health information, "PHI"), • the disease module or patient care measure, and • an explanation of why you think it is appropriate to skip the beneficiary. CMS will either approve or deny the request and will identify appropriate next steps (if any) that need to be taken. This information will be provided in the resolution of the QualityNet Help Desk inquiry. You should retain this documentation and enter the QualityNet Help Desk resolution number in the GPRO Web Interface. You are not to select this option without prior approval from CMS.
17.	Please define exclusion and exception.	Exclusions are a removal of the patient from the denominator prior to looking for the numerator criteria (or Quality Action). Exceptions are looked at as a way to exclude the patient from the denominator when they do not meet the numerator. Not all measures have exclusions and/or exceptions. They are only to be used when the measure owner allows. For example, under the Screening for High Blood Pressure measure (PREV-11), an example of an exclusion would be patients who have an active diagnosis of hypertension. This is an exclusion because by virtue of having this prior diagnosis, they are no longer eligible for the denominator. An example of an exception would be patient refusal of screening for high blood pressure or patient refusal of a follow-up plan. Because the patient met denominator criteria, but then refused screening or treatment, they will be removed from the sample of patients as an exception.

Care Coordination/Patient Safety

ID	Question	Answer
1.	For CARE-2, if a patient had a fall with resulting fracture within the measurement period, had physical therapy (PT) at home, and was evaluated for safety by PT, would this count as a fall screening?	Yes, this would count as long as the documentation includes whether the patient had been assessed for a history of falls or any fall with injury. Documentation of no falls is sufficient in those instances where that is the case.
2.	For CARE-2, who can perform the falls screening?	Any clinician with appropriate skills and experience may perform the fall risk screening.
3.	For CARE-2, we have many skilled nursing facility patients. The skilled nursing facility uses a quarterly MDS that are signed by nurses. Do these satisfy the fall risk measure?	This would be appropriate as long as it addresses the patient's fall history.
4.	For CARE-2, is the "Timed Up and Go" (TUG) test (used to assess patient mobility) acceptable as a fall risk screening?	It would count as a future fall risk screening if it includes documentation of the patient's fall history. The TUG tests that have been shared with us do not.
5.	Does the CARE-2 fall screen apply to all patients, or only patients having had a previous fall?	This screen applies to all patients in your CARE-2 sample.
6.	For CARE-2, can we use the Morse Fall Screen?	The Morse Fall Screen is an acceptable screening because it addresses the question of past history of falls.
7.	For CARE-3, can we add visits to the pre-populated visits in the GPRO Web Interface?	No. You may only report on the visit dates that are pre-populated in the GPRO Web Interface.
8.	What if our records indicate the patient's visit date happened a few days before or after the pre-populated date in the GPRO Web Interface?	You can confirm the visit date in the GPRO Web Interface if the date in the patient record is within 2 calendar days (before or after) of the pre-populated date. If your records indicate the patient's visit happened more than 2 calendar days before or after the pre-populated visit, it would be appropriate to indicate that you cannot confirm the visit.
9.	CMS has given us a date of 7/1/16 and 7/2/16 – We have attestation of the meds from the physician for 7/1/16; can we say "Yes" to the 7/2/16 date of service due to the +/- two calendar day criteria? Basically we are using the one attestation for two different dates of service.	No, you cannot use one attestation for two different dates of service. This measure is to be reported once for each visit.

ID	Question	Answer
10.	Are only PCPs responsible for documentation of current medications? We have several prefilled dates where the visits were with specialists.	The CARE-3 measure is not intended to be limited to providers listed in the three PCP locations in the Web Interface (NPI1, NPI2, and NPI3), so you should abstract those patients seen by other providers. Keep in mind, all populated visits were taken from claims billed by one of your group's participant TINs (i.e., these visits are considered 'within the ACO') or at your group practice.
11.	When a patient has multiple office visits listed for CARE-3, and there is confirmation of the med list and review of meds for all of the dates except one, is the measure scored as a fail for all the dates, or are the passed dates scored as passed and only the one date scored as a fail?	The performance for this measure is scored on a visit basis. The denominator for an organization, ACO or PQRS group practice, would include the total number of visits that are confirmed as having occurred on the dates (+/- 2 days), not the total number of patients that meet the denominator criteria. The calculation flows for each measure collected in the Web Interface are provided for you on the GPRO Web Interface Webpage. The calculation sample at the bottom of each flow is an example of how performance is calculated for that measure.

At Risk Populations: Coronary Artery Disease

ID	Question	Answer
1.	For CAD-7, does the ejection fraction have to be recorded during the measurement period?	No. The ejection fraction that is used to confirm the patient has left ventricular systolic dysfunction (LVSD) may have been performed at any time in the patient's history up through the last day of the measurement period. The result of the LVEF may be expressed quantitatively as < 40% or qualitatively as moderate or severe dysfunction.
2.	For CAD-7, to confirm whether a CAD patient also has DM, what is the timeframe of the DM diagnosis? Does the DM diagnosis need to be present in 2016 or anytime in the history?	The patient should have an 'active' diagnosis of diabetes during the measurement period.
3.	For CAD-7, does Amlodipine alone (not mixed with another drug) count as an ACE/ARB?	No, Amlodipine alone does not count as an ACE/ARB. Review the CAD Drug Codes tab of the 2016 GPRO Web Interface CAD Supporting Document for Amlodipine combinations acceptable for CAD-7.
4.	For CAD-7, can the acceptable diagnoses for "No-Medical Reasons" be documented anytime in the patient's history? Would this meet criteria to answer "No-Medical Reasons?"	A medical reason used to exclude a patient from CAD-7, e.g., chronic kidney disease (CKD), needs to be documented in the patient's medical record and occur anytime in the patient's history up through the last day of the measurement period. If the medical exception is due to pregnancy complications, the beneficiary must be pregnant for at least 1 day of the measurement period (2016).
5.	For CAD-7, if a patient has LVSD but they have chronic kidney disease and are not on an ACE/ARB do we select "No-Medical Reasons?"	• Select "Yes" to LVSD • Select "No—Denominator Exception—Medical Reasons" (if the medical record has documentation of CKD as a medical reason for not prescribing ACE/ARB)

ID	Question	Answer
6.	For CAD-7, what are other medical reasons that would count for not prescribing ACE inhibitor or ARB therapy aside from allergy, intolerance?	As noted in the Denominator Exceptions in the CAD Data Guidance tab, Other medical reasons include any medical reasons documented by the provider for not prescribing ACE/ARB therapy.
7.	For CAD-7, medications were stopped due to symptoms, but a plan of care to start on a lower dose was noted. Do we answer "No—Denominator Exception—Medical Reasons" or "Yes?"	If the medication was started anytime during the measurement period, then you would select "Yes" because the patient was prescribed an ACE inhibitor or ARB therapy at some time during the measurement period.

At Risk Populations: Diabetes

ID	Question	Answer
1.	Is a diagnosis of impaired fasting glucose, pre-diabetes, or hyperglycemia considered a diagnosis of diabetes?	These diagnoses are not synonymous with diabetes mellitus. In instances where you cannot confirm diabetes, please select "Not Confirmed: Select this option if you are unable to confirm the diagnosis of DM for this patient."
2.	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?	CMS does look back to the prior year for a diagnosis of diabetes in the administrative claims in addition to the measurement year when populating the patient sample. When confirming the diagnosis, organizations should also look at the measurement year and one year prior.
3.	For DM-2, (Diabetes Poor Control), the flow charts indicate that patients with a value greater than 9.0 or missing (0 value) will count in the numerator. Why is this?	DM-2 is considered an inverse measure which means a lower rate indicates better clinical care or control. The patient is numerator compliant if their most recent HbA1c level is greater than 9%, the HbA1c result is missing, or if there are no HbA1c tests performed with a documented result during the measurement year.
4.	For DM-2, regarding HbA1c, the data guidance says there must be a note in the record. Does the actual lab report showing the date and value count as the note, or is a specific progress note entry required?	The date and the value are the two components needed. They can either be in a dated note or be present as part of the dated laboratory report.

ID	Question	Answer
7.	If the practitioner documents that he instructs the patient to have an eye exam performed but the patient does not follow through; this will be entered as a 'No' response. Is this appropriate since the practitioner did refer the patient?	There must be clear documentation that the dilated eye exam was performed in order to enter a 'Yes' response. Documentation noting a referral for a dilated eye exam was made is not sufficient to pass the measure.

At Risk Populations: Heart Failure

ID	Question	Answer
1.	Does the diagnosis of heart failure have to include documentation in the medical record of current or prior LVEF less than 40%?	The measure steward requires that in order to be eligible for the denominator, the patient must have a diagnosis of heart failure confirmed in the medical record AND also have a current or prior LVEF less than 40% or one referred to as moderate or severe.
2.	If a patient had an EF less than 40% in 2005 but then in 2014 has an EF of 45%, would he or she be included in the denominator of the HF-6 measure?	In the scenario you describe, you would select "Yes" for the LVSD element because the measure specifies that the patient has had, at any time in their history, an ejection fraction less than 40%.
3.	In 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.
4.	For HF-6, 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, and metoprolol succinate extended release)?	It would be acceptable to select "No—Denominator Exception—Medical Reasons" when documentation in the medical record reflects the patient has an allergy to any beta-blocker.
5.	For HF-6, the exceptions include pleural effusions. Can we only use an exception for a patient if it is an active problem during 2016?	Yes. Transient conditions that are listed in the "HF EXCLUSION EXCEPTION CODES" tab in the supporting documents that may be due to causes other than heart failure should be restricted to documentation within the measurement period.
6.	For HF-6, if there is an echo report showing moderate LV dysfunction AND an ejection fraction of 40-45%, does the patient meet the measure?	Yes. You would use the most severe result in the patient's history (moderate LV dysfunction) and select "Yes" under LVSD.

ID	Question	Answer
7.	Where can we find the most current list of beta blockers acceptable for use in HF-6?	The 2016 GPRO Supporting Documents contain the list of-beta blockers for the HF-6 measure. Bisoprolol, carvedilol, or sustained release metoprolol succinate are the ONLY beta-blockers allowed for this measure. Within the RxNorm terminology, "metoprolol succinate extended release" is identified as "metoprolol tartrate extended release." You will note that metoprolol tartrate alone, meaning not the extended release form, is not included in the medication list. The measure developer, the AMA Physician Consortium for Performance Improvement, has been assured by their pharmacy experts who helped them develop the value set of allowable medications that the "metoprolol tartrate extended release" as specified in RxNorm maps to the "metoprolol succinate extended release." Brand names that map to these three generic medicines are appropriate to use to satisfy the numerator.
8.	Pacemaker (V4501) is an exception for HF-6: Beta Blocker for LVSD. If the patient has a Biventricular ACID which is a Defibrillator (V4502), is this considered an exception for beta-blockers?	Yes. If documentation in the medical record indicates the patient is not prescribed a beta-blocker due to a Biventricular ACID, this would be considered acceptable as a medical exception.
9.	For HF-6, if a patient is on a beta blocker, but it is not one of the beta blockers in the list provided by CMS, how would we answer the question?	You would select "No" if the beta blocker is not one of the three generic beta-blockers listed for this measure or one of the brand name beta-blockers equivalent to one of the three generics.
10.	For HF-6, Beta Blocker, "Fibrillation" was listed as an exception for beta blockers. Is it referring to atrial fibrillation, ventricular fibrillation, or both?	Coding provided in the "HF EXCLUSION EXCEPTION CODES" tab of the HF Supporting Document includes both atrial fibrillation and ventricular fibrillation codes.

ID	Question	Answer
11.	Should we be concerned if we skip large numbers of patients selected for HF-6 and CAD-7?	Both HF-6 and CAD-7 include denominator criteria beyond their respective diagnoses (heart failure and coronary artery disease) requiring confirmation in the GPRO Web Interface. For HF-6, left ventricular systolic dysfunction (LVSD) must also be confirmed. If it cannot be, "No" is to be selected to complete that record and it is to be replaced with the next patient record in sequence. For CAD-7, if LVSD and diabetes cannot be confirmed "No" is selected to complete that record and it is replaced with the next patient record in sequence. The patient records that were answered "No" for these denominator criteria in each measure will be removed from the performance calculations for the measures as they are skipped and replaced by other patient records until 248 records are consecutively confirmed and completed or you exhaust the number in your same that you can consecutively confirm and complete by following the specifications provided. Because of these additional denominator criteria you may find somewhat higher rates of "skip" use on measures with less denominator inclusion criteria.

At Risk Populations: Hypertension

ID	Question	Answer
1.	If a sampled patient for HTN-2 did not have a blood pressure reading, will the patient be excluded from the denominator and not included in the performance calculation?	If a blood pressure reading was not taken, the patient will not be excluded from the denominator or performance calculation unless there is a valid medical reason for the blood pressure measurement not being done (see the HTN Supporting Documents).
2.	For the hypertension measure, if we confirmed the diagnosis but do not have a blood pressure recorded within the measurement period, should we answer "No"?	That is correct. If you have no blood pressure measurement within the measurement period you should select "No."
3.	For HTN-2, is the patient's position during the blood pressure reading taken into account? Would we use the lowest systolic and lowest diastolic reading regardless of sitting, standing, or lying down?	You would use the lowest systolic and lowest diastolic values regardless of position if there are multiple blood pressures on the same date of service.

ID	Question	Answer
4.	For the most recent blood pressure documentation, does the data need to be pulled from a primary care visit or would a specialty office be okay to use?	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. If you question the applicability of a particular visit when reporting the most recent BP for HTN-2, please review the coding provided to assist in determining whether or not a particular visit is considered eligible. Please use the code list provided in the Evaluation Codes tab of the HTN Supporting Document to extract the data from your EHR or another data source.
5.	For the hypertension and blood pressure screening measures, if the provider only documents "HBP" (high blood pressure) can we accept this abbreviation as confirming the diagnosis of hypertension, or, does the note have to say "Hypertension?"	"HBP" is an accepted abbreviation for high blood pressure; however, further documentation to support hypertension must be present to confirm the hypertension diagnosis. As noted in the HTN Supporting Document: Determine if the patient has a documented diagnosis of essential HTN within the first six months of the measurement period or any time prior to the measurement period but does not end before the start of the measurement period
6.	To use pregnancy as a medical reason for not including blood pressure, is this a pregnancy anytime in 2016, or only if the patient is still pregnant at the last office visit?	This is referencing a pregnancy at any time within 2016.

At Risk Populations: Ischemic Vascular Disease

ID	Question	Answer
1.	Will a diagnosis of CAD be considered sufficient to confirm a diagnosis of IVD?	You would need to look at the codes in the Supporting Documentation to determine which CAD codes are used to represent IVD.
2.	For IVD-2, how do we handle the situation where the provider indicates the patient is allergic to aspirin? Are there any medical reasons we can use to explain why a patient is not on medications? Does patient refusal count?	There are no exceptions for this measure, so you would have to select "No" (i.e., the quality action was not performed).

At-Risk Populations: Mental Health

ID	Question	Answer
1.	What timeframe should be used to determine if the patient has a diagnosis of major depression disorder or dysthymia?	The diagnosis of depression/dysthymia needs to be documented as newly diagnosed or existing within the patient's history during the INDEX measurement identification period (12/1/2014 through 11/30/2015).
2.	Is the timeframe that should be used for the Denominator Exclusions the same as the diagnosis of depression or dysthymia?	Exclusions can occur during the denominator identification period and during the denominator assessment period. The assessment period is the 13 months that occur after the patient's index date.
3.	Can I use any PHQ-9 less than 5 obtained during the 11-13 month remission window?	No, confirmation has been received from the measure developer (MNCM) that the most recent PHQ-9 result must be used during the 11-13 month remission window.
4.	Please define "permanent nursing home resident" for the purposes of reporting a Denominator Exclusion for MH-1.	Permanent Nursing Home Resident is defined as a patient who is residing in a skilled nursing facility on a long term basis. It does not include patients who are receiving short term rehabilitative services following a hospital stay, nor does it include patients residing in assisted living or group home settings.
5.	What happens if the group does not use the PHQ-9 tool? Would they be marked as a negative? Would the patient not quality for the measure?	The patient would not meet denominator eligibility. This specific measure looks for those patients with an appropriate diagnosis and an elevated PHQ-9 greater than 9 during a specific time period to establish denominator eligibility. Please review the posted 2016 MH-1 Supporting Document, Data Guidance tab and/or the 2016 MH-1 Performance Calculation flow for additional information on reporting the measure.
6.	Our EMR has cross-walked ICD-9 311 to ICD-10 F32.9. We noticed that the ICD-9 311 code is not part of the GPRO Web Interface code set for program year 2016. Can we use ICD-9 311 to confirm diagnosis of major depression when reporting MH-1: Depression Remission at Twelve Month via the GPRO Web Interface reporting mechanism?	No, you cannot use ICD-9 code 311 to confirm that a patient has a diagnosis of major depression for the purposes of GPRO Web Interface measure MH-1: Depression Remission at Twelve Months. The list of diagnosis codes provided in the detailed measure specifications for MH-1 is considered to be all-inclusive and reflects guidance from the measure developer, Minnesota Community Measurement (MNCM). MNCM has indicated that ICD-9 311 is not a denominator eligible diagnosis. If your ICD-9 to ICD-10 crosswalk equated ICD-9 311 to ICD-10 F32.9, medical record documentation should be used to confirm the diagnosis meets the definition of ICD-10 F32.9 ("major depressive disorder, single episode, unspecified") in order for the patient to be included in the measure. Please note that this definition is different than that of ICD-9 311 ("depressive disorder not elsewhere classified").

Preventive Health

ID	Question	Answer
1.	If our ACO can prove via claims data that breast cancer screening was performed, but the results are not in the medical record, will this count as a numerator hit?	No, documentation of results are required in order to report numerator compliance.
2.	For PREV-5, Breast Cancer Screening, how should we answer if the patient refused the screening?	In this instance, you will have to select "No" (the quality action was not performed) in the GPRO Web Interface and it would be a performance failure as there is no patient exception option for this measure.
3.	For PREV-5, does thermal gram count?	No, this does not count toward numerator compliance.
4.	For PREV-5, what if a patient had a unilateral mastectomy and has metastatic disease and, therefore, receives PET scans and CTs rather than a mammogram?	If the patient had a unilateral mastectomy and has metastatic disease and now a screening mammography is no longer performed, it would be appropriate to request "Other CMS Approved Reason" to exclude the patient. However, approval should not be considered automatic. You must submit a QualityNet Help Desk ticket to request approval and more details may be required.
5.	Is a 3D Mammography considered numerator compliant for PREV-5?	A 3D Mammography is not considered numerator compliant. If the patient received a 3D mammography and you would like to skip that patient, you may request an "Other CMS Approved Reason" to skip. CMS will review your request and provide a resolution in the inquiry response.
6.	In PREV-6, Colorectal Cancer Screening, will ColoGuard qualify for the Colorectal screening quality measure?	Yes, based on the updated USPSTF guidelines (June 2016), the 2016 PREV-6: Colorectal Cancer Screening measure will allow for FIT-DNA screening such as Cologuard as well as Computed tomography (CT) colonography to be considered numerator compliant when reporting via the 2016 GPRO Web Interface. Documented performance of Fecal Immunochemical DNA Testing during the measurement period or two years prior to the measurement period will be numerator compliant. Documented performance of Computed tomography (CT) colonography during the measurement period or the four years prior to the measurement period will be numerator compliant.
7.	For PREV-6, is it true that if a patient refused a colorectal screen, that this is now considered a "No" response?	There is no patient reason exception for this measure therefore you would fail the measure if the patient refused the screening.
8.	For PREV-6, if we have documentation in the medical record indicating colorectal screening is "up-to-date" or "current", is this enough to select "Yes?" Do we need to have evidence that the screening was FOBT, Flex Sigmoidoscopy or Colonoscopy for "Yes?"	You need to select "No" if there is documentation in the medical record indicating the colorectal screening is up-to-date or current without further detail. Results of the testing and the date on which the testing was performed needs to be documented in the medical record.

ID	Question	Answer
9.	What if the patient meets sampling criteria for the measure and is not yet 50, e.g., 45 years of age, when they had a colonoscopy. Do we get to count that patient as compliant if we have the date and results in the medical record?	Yes, a patient who met the denominator criteria for the Colorectal Cancer Screening measure in the 2016 performance year and had a colonoscopy at age 45 during the nine year look back period would meet numerator criteria for the measure as long as the dated results are available.
10.	For PREV-7, will immunizations found in claims be included in the numerator?	Claims data is used when available to pre-populate the field used in the numerator for PREV-7 (influenza immunization).
11.	Do we only include vaccinations administered between January and March 2016? Or can we look back into 2015 for documentation of an influenza immunization?	The influenza immunization measure is one of the measures that allow you to look back to before January 1, 2016. If your medical record contains documentation that the patient was administered the influenza immunization between August 1, 2015 and March 31, 2016, then you can select "Yes" to indicate that an influenza immunization was received. You do not have to verify that the patient received the influenza vaccine if this information is pre-populated into the GPRO Web Interface. However, if influenza immunization data are not prepopulated, the organization should refer to the patient's medical record to determine if an influenza immunization was administered in accordance with the specifications. If the immunization data was not pre-populated as "Yes" for the patient, the organization should maintain documentation of the immunization, should your organization be selected for an ACO Quality Measure Validation audit.

ID	Question	Answer
12.	The following statement is included in the Guidance heading of the PREV-7 Narrative measure specification: “To account for the majority of reporting years' appropriate flu season duration, the measure logic will look at the first 89 days of the measurement period for the appropriate criteria and actions to be present/performed (January 1 through March 31). The measure developer believes it is best to keep the logic as static as possible from one reporting year to the next. Therefore, during leap years, only encounters that occur through March 30 will be counted in the denominator.” Since 2016 is a leap year, are we to only include influenza immunizations received through March 30 or can we include immunizations that were received through March 31 as stated in the instructions of the Data guidance for this measure?	If your medical record contains documentation that the patient was administered the influenza immunization between August 1, 2015 and March 31, 2016, then you can select “Yes” to indicate that an influenza immunization was received. This would be the same for program year 2016 even though it is a leap year.
13.	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 measure specifications. Should you be selected for an audit of your GPRO Web Interface submitted quality data, you will need to provide a dated note that references the vaccination was provided in the appropriate timeframe. If your GPRO Web Interface was prefilled with influenza immunization data when your organization accessed the GPRO Web Interface this requirement (to supply supporting documentation) does not apply.
14.	If the medical record does not indicate that the patient has been vaccinated for influenza and the patient is unable to recall, how would you recommend answering PREV-7?	In this situation, you would select “No,” unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.
15.	For the influenza vaccinations, we have patients with vaccinations, but the CVX code associated is 88, which is the non-specific vaccination code. This is not listed as an acceptable code in the Data Guidance. Is this acceptable?	A generic code would not be acceptable. Documentation in the medical record should confirm that influenza vaccination was received.

ID	Question	Answer
16.	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.
17.	For the influenza vaccine exception, what qualifies as a "system reason"?	An example of a system reason is if there were a vaccine shortage like we had a few years ago.
18.	If the medical record does not indicate that the patient has been vaccinated for pneumonia and the patient is unable to recall, how would you recommend answering PREV-8?	In this situation, you would select "No," unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.
19.	For PREV-9, 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…" If you are not excluding the patient and the BMI was not measured at the last visit in the measurement period, is there another way to report the performance of a BMI?	If a BMI was not calculated at this visit, you should look back 6 months (from the most recent visit) to determine if a BMI was calculated. 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 and answer "No". Please refer to the Data Guidance for a list of exclusions for this measure.
20.	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 PQRS group practices do not need to provide the BMI value in the GPRO Web Interface. Should your organization be selected for an audit, this documentation may be requested.
21.	For the BMI follow-up plan; is the documentation of a future visit enough to satisfy the measure? Does it 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 out of range BMI. Documentation of a future visit does satisfy the 2016 measure.
22.	For BMI, if the only office visit was March 2016 and there was no BMI recorded, can we look back 6 months into 2015 to a visit where the BMI is recorded?	Yes, if the most recent office visit was March 2016, 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 2015. In your scenario this would be numerator compliant as long as the BMI was within normal parameters or outside normal parameters with a documented follow-up plan addressing the variance.

ID	Question	Answer
23.	Please clarify 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.
24.	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. A follow-up plan must be documented within the last 6 months or during the current visit if the BMI is outside normal parameters (see Narrative Specifications).
24.	For PREV-9, if a patient has a BMI value below the accepted parameters, but is described as "well-nourished" within the visit note, would this be an acceptable explanation as to why the patient is "Not Eligible/Not Appropriate for BMI Follow-Up"?	No. If the BMI value is below acceptable parameters the provider must indicate in the medical records why the patient was not eligible or not appropriate for a BMI follow-up. Stating that the patient is "well-nourished" alone is not sufficient reasoning for that determination.
25.	The provider documented an elevated blood pressure as well as an abnormal BMI. In the section for follow-up plan, he documented that he counseled the patient to reduce salt and to diet to lose weight. Does this meet the follow-up for both measures?	If the provider documented an abnormal blood pressure as well as an abnormal BMI on the same patient encounter, and these are considered most recent for both PREV-9; Body Mass Index Screening and Follow-Up and PREV-11, Screening for High Blood Pressure and Follow-Up Documented, recommending lower sodium intake and weight loss would address follow-up for both BP and BMI.
26.	For BMI, if a patient is over 65 years old and has a BMI lower than normal parameters, what should be selected for follow-up?	A follow-up is required when the BMI is outside of normal parameters whether it is below or above these parameters. The follow-up plan for a BMI lower than the parameters listed may include education, such as referral to a nutritionist; documentation of a future follow-up appointment related to BMI, referral to a registered dietician, or referral to online resources, among others that the physician may determine appropriate for that individual.
27.	For PREV-10, if the medical record only indicates "smoking", will that patient be numerator compliant?	We can deduct from this entry in the medical record that the patient was asked if 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.

ID	Question	Answer
28.	For PREV-10, the patient was screened for tobacco use during a telephonic outreach and is identified as a tobacco user. If they accept instructions and educational materials on smoking cessation, will this count as meeting the measure?	Yes, this would meet the measure assuming that all required documentation is in the medical record.
29.	For PREV-10, does Chantix (Varenicline Tartrate) count as a medication for Tobacco use intervention for patients identified as smokers? This medication was not listed on the med list.	Yes, Chantix (Varenicline Tartrate) is acceptable.
30.	For PREV-10, does tobacco screening at a hospital count?	If that information is available at the point of care, it may be used in determining your answer. The setting is not specified for this measure.
31.	For PREV-10, if the notes state "Status Unknown" and the beneficiary has Alzheimer's, would this be a medical reason for exception?	Yes, as long as there is documentation from the provider linking this diagnosis to the reason the patient was not screened.
32.	If a patient quit smoking in the last 3 months, will the patient be considered to be a non-tobacco user?	Yes. If a patient indicates that they are a non-smoker during the most recent inquiry regarding their smoking status, then they are considered a non-tobacco user for the purposes of this measure.
33.	For PREV-11, when 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 plans for a future appointment to satisfy the follow-up requirement, there would need to be documentation (at the appointment where the elevated BP occurred) that links the future 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 PREV Data Guidance tab of the 2016 PREV Supporting Documents.
34.	For the Screening for High Blood Pressure measure (PREV-11), 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.

ID	Question	Answer
35.	For PREV-11, if the patient's blood pressure has fluctuated during the year, but the last blood pressure is within normal levels, can we select "Yes" that screening was performed?	Yes, this is acceptable because you are using the most recent BP. We do not expect to see a follow-up plan if the most recent blood pressure is normal. Normal blood pressure parameters for this measure are systolic blood pressure less than (<) 120 AND diastolic blood pressure less than (<) 80.
36.	When a patient has a reason for exclusion that is listed in the GPRO supporting documents, such as having a diagnosis of hypertension, should that be marked as "No—Other CMS Approved Reason"?	No, the patient would be excluded based on meeting a specified denominator exclusion for this measure. You would select "Denominator Exclusion" and stop abstraction on that patient for this measure.
37.	For PREV-11, in the Data Guidance, it states "use the most recent BP." What does this mean if the measure only needs to be done "at least once per measurement period?"	The measure only has to be reported once, but the most recent BP should be used if there is more than one reading documented during the measurement period. For more information, please refer to the PREV Supporting Document.
38.	For PREV-11, if we are looking at the most recent blood pressure, what is meant by the second hypertensive reading?	The Hypertensive BP Readings included in the Inclusions/Synonyms column of the Data Guidance tab are to assist in determining the most appropriate follow-up. The most recent BP is used, but the medical records might indicate the most recent reading is a second consecutive reading in the hypertensive range, and, therefore, the follow-up documented should be based on a second hypertensive reading because it is the most recent.
39.	For PREV-11, can you please clarify the exclusion for "Active Hypertension?"	If a patient has an active diagnosis of hypertension on the date you are using for their most recent blood pressure reading, they can be excluded from PREV-11. This would indicate the patient is already being medically managed for hypertension. During the sampling process, patients with a submitted claim with the hypertension diagnosis prior to the measurement period are not included in the sample. However, the sample is created prior to the end of the year so some patients may need to be excluded by you during the GPRO Web Interface data collection process.
40.	For PREV-11, if a physician directed the patient to increase exercise for a reason other than BP management and plan for a return visit in a year, but there was no correlation to the elevated BP, would the patient fail as a follow-up plan was not directly linked?	Correct. The follow-up recommended should be appropriately linked to blood pressure management within the medical record documentation when reporting PREV-11.
41.	Can we use ambulatory blood pressure monitor readings from the patient 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.

ID	Question	Answer
42.	The most recent BP reading was from the ED. Should we use the latest BP reading from the last office visit?	As long as the BP from the ED visit ends up in the office medical records, it is acceptable. PREV-11 includes inpatient, outpatient, nursing home, urgent care, emergency room, etc. visits. Please review the 2016 PREV Supporting Document, PREV Evaluation Codes tab for encounters used to attribute patients and for eligible visits for the PREV-11 measure.
43.	What documentation is needed for depression screening?	The use of a standardized screening tool must be documented and, if the tool used indicates a potential diagnosis of depression, the second part of the measure will require documentation of a follow-up plan. 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. Please note that documentation from the provider that the patient does not have depression is not sufficient evidence of a screening. The medical record does not need to include a copy of the standardized tool that was used.
44.	If there is a notation in the patient record (in 2016) that the patient is under care of a mental health professional, is that sufficient to exclude the patient from the depression measure?	Patients with a diagnosis of depression or bipolar disorder prior to the first day of the measurement period are to be excluded from the measure. If documentation reflects that treatment by a mental health professional for depression or bipolar disorder began or a diagnosis was made prior to the measurement period, then the exclusion requirement has been fulfilled.
45.	If the documentation states that a depression screening was performed, and then states the patient is not depressed, does that qualify for the measure?	This would qualify as a depression screen as long as dated documentation indicates the age appropriate standardized screening tool that was used.
46.	If a patient was administered a PHQ-9 during the measurement year, but also had a documented diagnosis of depression prior to the measurement year, do we indicate "Yes" for clinical depression screening, or, do we indicate "No-Medical Reasons?"	In this situation you would not select "Yes" for clinical depression screening nor would you indicate "No Medical Reason" as a denominator exception. Instead, if the patient has an active diagnosis of depression, diagnosed before the first day of the measurement period, you would select "Denominator Exclusion." Please refer to the PREV supporting documents, data guidance tab for PREV 12.
47.	If the patient has a negative screen for depression, what is the appropriate answer since "No" is not a listed option?	Select "Yes" indicating that the patient was documented as being screened. Then select "No," patient's screen was not positive for clinical depression using an age appropriate standardized tool. If you selected "No" (the patient's screen is not positive), then you do not answer the follow-up plan questions.
48.	Please confirm whether we have to confirm the use of PHQ2-9 for depression screening. If PHQ2-9 is not required to be in the medical record, how would we confirm that it is being used?	PREV-12 requires a standardized age appropriate screening tool be used during the measurement period for depression screening (not limited to PHQ-2 or PHQ-9). You need to have documentation that the age appropriate standardized depression screening tool was used, but the actual screening tool does not need to be present in its entirety, just the result (positive or negative for depression).

ID	Question	Answer
49.	Is traumatic brain injury an exclusion for PREV-12, depression screening?	If the physician decides this is a situation in which the patient's functional capacity or motivation to improve may impact the accuracy of the results of the standardized depression assessment tool, then you would select "No – Denominator Exception – Medical Reasons" . It depends on the functionality of the patient and the extent of the patient's injury and that would be up to the physician's discretion. The patient's medical record should contain this information.
50.	For the Depression Screen, does there have to be evidence in the EMR of a valid depression screening tool used, and not just a diagnosis of depression?	If no age appropriate standardized depression screening tools are documented, then you would have to select "No" to whether or not the patient was screened for depression. To exclude the patient from this measure, the diagnosis of depression would have to be made prior to 2016. If the diagnosis of depression occurred on or after January 1, 2016, there needs to be evidence of a depression screen using an age appropriate standardized tool during the measurement period, January 1, 2016 to December 31, 2016.
51.	For Depression screening, we have the capability to push out the questionnaires through our email portal. If the patient answers positive, we will have them come in for follow-up. Would this count?	From the measure owner: We agree this is an innovative approach. In order to meet the current measure, the results of the depression screening and follow-up plan (if positive depression screen) must be documented at the time of the encounter (i.e., the appointment with the provider). Although the patient may have access to the depression screening tool in advance of the appointment, the depression screening results need to be documented on the date of the encounter (date of the appointment). If it is evident the eligible provider documented/verified the results of the depression screen in the medical record on the date of the encounter, this would meet the screening portion of this measure. But please note; if the depression screening was positive, a follow-up plan must also be documented.
52.	For PREV-12, 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 PREV-12 includes all patients 12 years and older. This measure complies with the latest guidance from the US Preventive Services Task Force which recommends depression screening for those 12 years old and older.
53.	What denotes a positive depression screen?	The 2016 PREV-12 measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score may be considered positive for depression. Whether or not a PHQ-2 or PHQ-9 (or other standardized screening tool) screening score is considered positive would be determined by the eligible professional administering and reviewing the standardized tool based on their knowledge of the patient and the tool being used.

ID	Question	Answer
54.	For Risk Category #3 in PREV-13, can the diagnosis of diabetes be at any time or is it active diagnosis during the measurement period?	Diabetes history is defined as any history of diabetes prior to or during the measurement period.
55.	Are the medical reason exceptions listed in the Data Guidance for PREV-13 the only reasons we can use for not having a patient on a statin?	The denominator exceptions were based on the evidence reviewed by the measure owner. They can be found in the 2016 GPRO Web Interface Narrative Specifications and the Data Guidance tab of the PREV Supporting Document and are all inclusive.
56.	Can you confirm whether PCSK9 meets the intent of PREV-13 (not a statin, but used for like purposes).	Only statin medications meet the intent of this measure (PREV-13).
57.	There seems to be a conflict between source documents for one of the exceptions. The Data Guidance tab in the 2016 Supporting documents indicate the following: a. most recent fasting or direct LDL-C lab test <70 mg/dL for diabetes diagnosis currently receiving statin medication therapy. While GPRO specification document states the following: b. Patients with diabetes who have a fasting or direct LDL-C laboratory test result <70 mg/dl and are not taking statin therapy. I've also found several documents on-line, including PQRS specification document that indicate diabetic patients with LDL <70 and are NOT taking statins.	This was an error in the Data Guidance. If a patient is prescribed statin therapy they would be considered numerator compliant. The word "Not" was inadvertently left out of the Data Guidance. It is correctly annotated in the posted narrative measure specification. The denominator exception is "most recent fasting LDL for diabetes diagnosis currently not receiving statin medication therapy".

Skipping Beneficiaries

ID	Question	Answer
1.	When is it appropriate to skip reporting on a beneficiary?	Each disease module or patient care measure in the GPRO Web Interface has a sample of beneficiaries to be reported on that is chosen from the pool of beneficiaries assigned to the organization.[1] CMS claims data are used to determine if a beneficiary meets the criteria to be included in a given disease module/patient care measure's sample.[2] However, due to the timing of quality sampling, a full 12 months of claims are not available for analysis when the quality samples are created. The result is that a beneficiary may lose eligibility for the quality sample in general, or a particular measure denominator, between the time the sample is generated and the end of the performance year. It is also possible that data derived from the claims cannot be substantiated by information in the medical record. For these reasons, as well as the possibility that a medical record cannot be located, the GPRO Web Interface allows an organization to remove ("skip") a beneficiary from the sample if he/she does not meet one or more of the quality sampling and/or disease module or patient care measure-specific criteria. Organizations can skip beneficiaries in the GPRO Web Interface using one of several options. If an appropriate skip reason is entered for a sampled beneficiary, that beneficiary is considered completed, but not confirmed. This means the beneficiary will not be counted towards the reporting requirement of 248 consecutively confirmed and completed beneficiaries, and will be replaced with the next consecutively ranked beneficiary who in turn must be reported on, or, if they do not meet criteria for quality reporting, skipped. Some skip reasons remove a beneficiary from all disease modules and patient care measures, and other skip reasons only remove the beneficiary from that specific disease module or patient care measure. Specific skip reasons are discussed in this document. They include: Medical Record Not Found, Not Qualified for Sample, Diagnosis Not Confirmed, measure-specific exclusion criteria, and Other CMS Approved Reason.

[1] For the Shared Savings Program, refer to the Shared Savings and Losses Assignment Methodology Specifications. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html

For the Pioneer ACO model, refer to the Alignment and Financial Reconciliation Methods. Available at: http://innovation.cms.gov/Files/x/PioneerACOBmarkMeghodology4to5.pdf

For Next Generation ACO model, please refer to your Participation Agreement.

For PQRS, refer to the GPRO Web Interface Assignment Methodology Specifications. Available at: https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016_PQRS_Assignment-.pdf

[2] Refer to the GPRO Web Interface Sampling Methodology, available at: https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016_WebInterface_Sampling-.pdf

ID	Question	Answer
2.	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 whom the ACO or PQRS group practice 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 is only a system warning and the system will continue to allow you to skip patients. ACOs and group practices will not be penalized for skipping 10% of a given disease module or patient care measure's sampled patients. As long as you have met the minimum requirement of 248 consecutively completed patients (or 100% of the sample if fewer than 248 are available), then you will have completely reported on the disease module/patient care measure. ***ACOs only**: If you skip reporting on a large percentage of beneficiaries you may be selected for the quality audit and/or for targeted education with your ACO.*
3.	When can I use "Medical Record Not Found?"	The Medical Record Not Found option should be used only if there is truly an inability to locate and access the beneficiary's medical record after concerted effort is put forth. CMS expects that beneficiary medical care is being coordinated, that the organization make every effort to locate and obtain access to the medical record, and that providers share the necessary records for the purposes of coordinating care and reporting quality data. CMS encourages organizations to put systems and processes in place so that patient care is more coordinated for the dual purposes of patient safety and quality improvement. It is likely that data for sampled patients are available from medical records maintained by the organization's providers because sampled patients are those with: 1. the largest share of their primary care services provided by the organization (i.e., they have been assigned to the organization), and 2. at least 2 primary care office or other outpatient visits billed by the organization[3] during the reporting period. CMS expects organizations to make a **concerted effort** to obtain medical records for their assigned and sampled beneficiaries. This includes collaborating with physicians and/or other clinic staff both inside and outside the organization (including but not limited to the three NPIs provided in the GPRO Web Interface), as well as facilities both inside and outside the organization, with such collaboration attempts being repeated throughout the course of the data collection period, if needed. Medical Record Not Found is not an appropriate response when you are able to locate and access a medical record, but are unable to locate certain data within it. Refer to Appendix B, Table B-1 for examples.

[3] For ACOs, the ACO's participants would have billed for these services.

ID	Question	Answer
4.	When can I use "Not Qualified for Sample?"	CMS makes efforts to exclude beneficiaries that are not qualified for the sample, but because there are limitations in the claims data used to identify the sample, the GPRO Web Interface allows a beneficiary to be skipped because they are not qualified for the sample. The beneficiary must meet one of the following criteria to be considered not qualified for the sample and will be removed from all disease module and patient care measure samples: • In hospice[4] • Moved out of the U.S. • Deceased • HMO enrolled[5] If any of the above are true for a sampled beneficiary, at any time during the measurement period, that beneficiary is not qualified for the sample. If Not Qualified for Sample is selected, you must also select the specific reason from the drop down menu provided (which matches the above stated list). The GPRO Web Interface will also ask for a date that corresponds with the reason a beneficiary is not qualified for the sample. If the exact date is unknown (e.g., beneficiary date of death), you may enter the last day of the measurement period (i.e., December 31, 2016). Refer to Appendix B, Table B-2 for examples.
5.	When can I use "Diagnosis Not Confirmed?"	For disease modules and patient care measures that evaluate quality of care as it pertains to a specific medical condition, relevant diagnoses will be identified using claims data as part of the sampling process. However, organizations will be asked to confirm that the sampled beneficiary has documentation of that medical condition in the medical record. For example, before entering data for the diabetes disease module, organizations will be asked to confirm if the beneficiary has an active diagnosis of diabetes. If the diagnosis cannot be confirmed with the information the organization has access to in the beneficiary's medical record, then the organization should skip that beneficiary and "diagnosis not confirmed" should be the reason chosen as the skip reason. Refer to Appendix B, Table B-3 for examples.

[4] Hospice includes non-hospice beneficiaries receiving palliative goals or comfort care.

[5] The beneficiary was enrolled in a group health plan as their primary payer, including beneficiaries enrolled in Medicare Advantage plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly programs under section 1894.

6.	How do I know if a beneficiary meets measure-specific exclusion criteria?	Measure owners may specify a certain category of patient that should be excluded from a particular measure. The most common reason for this type of exclusion is that the quality intervention would not be appropriate for that patient population. For example, it would not be appropriate to provide follow-up for an out of range BMI for a pregnant patient therefore, the measure owner has specified pregnancy as an exclusion for the BMI Assessment and Follow-up measure (ACO-19/PREV-9). Exclusions for a given measure are determined by the measure owner and not all measures have exclusions. For measures where the measure owner has identified an appropriate exclusion category, this will be specified in the Narrative Specifications and the Supporting Documents and an option will be made available in the GPRO Web Interface that allows organizations to indicate that a given beneficiary meets the exclusion criteria for a measure. Refer to Appendix B, Table B-4 for examples.
7.	When can I select "Other CMS Approved Reason?"	Other CMS approved reason is reserved for cases that are unique, unusual, and not covered by any of the above stated skip reasons. Though this option is available as a drop down, it may not be used without prior approval from CMS. To gain CMS approval, a QualityNet Help Desk ticket should be submitted to qnetsupport@hcqis.org with: • the disease module or patient care measure, • beneficiary rank number (never any protected health information, "PHI"), and • an explanation of why you think it is appropriate to skip the beneficiary. CMS will either approve or deny the request and will identify appropriate next steps (if any) that need to be taken. This information will be provided in the resolution of the QualityNet Help Desk ticket. You should retain this documentation and enter the QualityNet Help Desk resolution number in the GPRO Web Interface. Refer to Table B-5 for examples.

PQRS and Value Modifier Payment Adjustments

ID	Question	Answer
1.	How do ACOs use the Web Interface to meet 2016 PQRS reporting requirements and avoid the 2018 PQRS adjustment and Value Modifier automatic downward adjustment for failure to satisfactorily report quality data?	**Applicable to Shared Savings Program ACOs only**: If the ACO satisfactorily reports all of the GPRO Web Interface quality measures for the performance year, its ACO participant TINs and the eligible professionals billing through those TINs will avoid the PQRS downward payment adjustment, the automatic downward adjustment under the Value Modifier for failure to satisfactorily report quality data, and will qualify for an upward, neutral, or downward adjustment based on the ACO's quality performance under the Value Modifier. Shared Savings Program Participant TINs are now able to report to the PQRS program separately from what the ACO reports. As finalized in the 2017 Physician Fee Schedule final rule, EPs billing through an ACO TIN can report via registry, Qualified Clinical Data Registry (QCDR), and EHR as an individual or group. For more information on Shared Savings Program interactions with PQRS and the Value Modifier, please review guidance available on the Shared Savings Program quality webpage under Supplemental Documents and the CMS How to Report Once for Medicare Quality Programs guide. **Applicable to Pioneer and Next Generation ACOs only:** The PQRS-eligible professionals (regardless of specialty) will avoid the PQRS payment adjustment by reporting quality measures via the GPRO Web Interface and by fielding the CAHPS survey as a participant of their Pioneer Model ACO. Note that both the TIN and the NPI must be documented as part of the ACO to receive PQRS credit as a result of the successful ACO reporting. Pioneer and Next Generation Model ACO participant TINs may separately register for the PQRS Group Practice Reporting Option (GPRO).
2.	My TIN joined an ACO as an ACO participant in the middle of 2016. Will the eligible professionals that bill through this TIN avoid the 2018 PQRS payment adjustment and Value Modifier automatic downward adjustment for failure to report satisfactorily report quality data through ACO reporting under the Shared Savings Program for this reporting period?	**Applicable to Shared Savings Program ACOs only**: No. In order for your TIN to avoid the PQRS payment adjustment and Value Modifier automatic downward adjustment through ACO reporting under the Shared Savings Program, their ACO participant TIN must appear on the certified list of ACO participants that the ACO submits to CMS at the beginning of each performance year (i.e., at the beginning of 2016). TINs that are not on the ACO's certified participant list at that time must satisfy PQRS reporting requirements separately. For more information, please refer to the following guide: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PQRS-FAQs.pdf

Quality Measures Validation Audit (Applicable to ACOs only)

ID	Question	Answer
1.	When would an ACO know whether it has been selected for auditing?	ACOs participating in Performance year 2016 quality reporting will be notified in the spring of 2017, after the close of the reporting period, if they have been selected for audit.
2.	What kind of documentation do we have to send in if we are chosen for audit?	You need to have medical record documentation for every option you choose in the GPRO Web Interface that results in numerator compliance or a denominator exclusion. In addition, rationale for your use of confirmation options that remove the patient from all measures (i.e., medical record not found, other CMS approved reason, etc.) should be documented. Quick Reference Guides containing guidance on documentation requirements for each measure is available on the Shared Savings Program ACO Portal under the Program Announcement, "Quality Measurement and Reporting", as well as on the Pioneer Connect site and Next Generation ACO Model Connect site.

Performance Scoring and Benchmarks

ID	Question	Answer
1.	For ACOs that joined the Shared Savings Program before 2016 or are in the Pioneer ACO Model, a number of measures are Pay for Performance in 2016. Where can we find the benchmarks for the quality measures that are in Pay for Performance?	**Applicable to Shared Savings Program ACOs and Pioneer ACOs only**: The quality measure benchmarks for the 2016 reporting year are available on the Shared Savings Program website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html) and on the Pioneer Connect site.
2.	Where can I find more information on how the benchmarks are used to determine our overall quality score?	**Applicable to Shared Savings Program ACOs and Pioneer ACOs only**: *Shared Savings Program ACOs*: This information is presented in the benchmarking document https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf. Additional information is also available in the Quality Measurement Methodology and Resources document on the Shared Savings Program Portal. *Pioneer ACOs:* This information is presented in the Quality Measurement Methodology and Resources document posted on the Pioneer ACO Connect site.
3.	Regarding calculation of measures that are part of a composite, will we submit the measures separately and will CMS calculate the performance for the composite OR will we provide the Pass/Fail result directly to CMS?	The ACO or PQRS group practice will enter data that is relevant to the individual measures (component measures) that comprise the composite. The GPRO Web Interface will calculate the composite rate as well as the rates for each component measure. The component measure results are generally valuable for targeting areas for quality improvement but the ACO or PQRS group practice will be scored on the overall composite measure.

General

ID	Question	Answer
1.	You often reference the "Measures Steward" and "Measures Owner." Can you explain who they are and what their roles are in quality measures reporting?	These terms refer to the organizations that create, test, and maintain quality measures. When more than one organization is involved, they must designate a *measure steward* during the NQF endorsement process. The measure stewards for each measure are listed alongside the measure name in *Table 1* of the 2016 Quality Performance Standards Narrative Specifications document for ACOs and the 2016 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes file for group practices and ACOs reporting via the Web Interface.

Appendix A: Consecutively Confirmed and Completed Requirement

The minimum number of patients that must be confirmed and completed for satisfactory reporting via the GPRO Web Interface is 248 for each disease module and patient care measure (or the maximum number available to you if less than 248). This means that ACOs and PQRS group practices must consecutively confirm and complete data for 248 patients, starting with the beneficiary ranked #1 in each measure's sample. If you skip a beneficiary because (a) the medical record was not found, (b) the patient is no longer qualified for the sample, (c) the beneficiary meets measure-specific exclusion criteria, (d) the diagnosis could not be confirmed, (e) the patient age or date of birth has changed such the patient is not eligible for the measure, or (f) an "Other CMS Approved Reason" then an additional patient must be completed for each beneficiary that was skipped.

Confirmed means that you have obtained the patient's medical record, confirmed the patient is eligible for quality sampling, confirmed the disease diagnosis if applicable (for CAD, DM, HF, HTN, IVD, MH), confirmed the beneficiary's age and sex, and confirmed that the beneficiary does not meet exclusion criteria for a given measure.

Complete means that you have provided all the information required for a given patient for the measure for which they were sampled.

Consecutive means that you have completed the patient that was ranked immediately after the previously completed patient.

In Example 1 (see Table A-1), three patient ranks need to be skipped and replaced. After patient rank #251, the disease module or patient care measure is considered complete and no additional abstraction required since 248 ranked patients were consecutively confirmed and completed.

Table A-1. Example 1

Patient Rank	Consecutiv	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
2	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
3	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
4	Y	**N**	Y	No—Medical Record Not Found	Yes—"Medical Record Not Found" has been selected for this beneficiary	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
5	Y	**N**	Y	No—Patient is not qualified for the sample because they meet measure specific exclusion criteria.	Yes—"Denominator Exclusion" has been selected for this beneficiary	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
6	Y	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
7–248	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
249–251	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—these additional beneficiaries replace skipped beneficiary #4, skipped beneficiary #5 and skipped beneficiary #6

No additional beneficiaries need to be abstracted.

In Example 2 (see **Table A-2**), two patient ranks need to be skipped, but there are fewer than 248 patients available for abstraction. After patient rank #231, the disease module or patient care measure is considered complete since all available ranked patients have been consecutively confirmed and completed.

Table A-2. Example 2

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
2	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
3	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
4	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—"Not Confirmed—Diagnosis" has been selected	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
5	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
6	Y	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
7–230	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
231	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—this additional beneficiary replaces skipped beneficiary #64

No additional beneficiaries are available for abstraction.

In Example 3 (see **Table A-3**), laboratory result data for patient rank #2 was not provided and causes the count of consecutively completed ranks to stop at rank #1. The disease module or patient care measure is considered incomplete until Rank #2 is completed.

Table A-3. Example 3

Patient Rank	Consecuti	Confirme	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
2	Y	Y	**N**	Yes—all relevant beneficiary data have been confirmed	No—Lab test data required for the numerator was not provided. If this patient is not completed you will have only 1 patient counting towards your reporting requirement.	No—this patient is incomplete
3	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed
4	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed
5	**N**	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample. This beneficiary is also not considered consecutive until rank #2 is completed.
6–248	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed
249	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed. Note this beneficiary must be completed to replace skipped rank #5

No additional beneficiaries need to be abstracted.

In Example 4 (see **Table A-4**), three patient ranks need to be skipped. While there are more than 248 beneficiaries in the original sample, there are not enough beneficiaries sampled to replace those that were skipped. After patient rank #250, the disease module or patient care measure is considered complete since all available ranked patients have been consecutively completed.

Table A-4. Example 4

Patient Rank	Consecuti	Confirme	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1-3	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
4	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—"Not Confirmed—Diagnosis" has been selected	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
5	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
6	Y	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample.
7–178	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
179	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—"Not Confirmed—Diagnosis" has been selected	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
180–248	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
249	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—this additional beneficiary replaces skipped beneficiary #4
250	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—this additional beneficiary replaces skipped beneficiary #6

No additional beneficiaries are available for abstraction.

Appendix B: Skipping Beneficiaries (Examples)

Table B-1: Medical Record Not Found Examples

ID	Example	Should I select Medical Record Not Found?
1.	Dr. Ruiz has Mrs. Liu's medical record, but there isn't a lot of information in it.	No. If you have a medical record you may not select medical record not found. You must complete reporting with the data available to you. If data are required that you cannot find either in the medical record you have, or through information obtained from other providers, you must answer the questions in the negative; e.g., that a diagnosis cannot be confirmed, or that a quality action was not performed.
2.	Ms. Jenkins sees one of our physicians, but her physician visits are at the nursing home she resides in, which also maintains her medical record onsite.	Maybe. This beneficiary has been assigned to your organization based on the professional services rendered by providers participating in your organization. You are expected to work with your participating providers and any facilities to obtain any medical record data you need. If after a concerted effort your organization cannot get the nursing home to share data, you may select Medical Record Not Found.
3.	Dr. Menlo left our practice in March, and took all his patients and their medical records with him. We have tried our best but he still refuses to provide us with data on his patients	Maybe. Your organization should have policies in place that address data sharing for quality reporting purposes, including for those providers that leave the organization mid-year. You are expected to work with all providers to obtain any medical record data you need. If after a concerted effort your organization is unable to obtain the record or its contents from Dr. Menlo, you may select Medical Record Not Found.
4.	Mr. Hyde sees Dr. Jones for routine care at our practice, but gets all of his diabetic care with Dr. Jekyll. Dr. Jekyll doesn't reliably share his data with us.	No. Mr. Hyde has been assigned your organization because your organization has provided the plurality of primary care services. You are expected to work with Dr. Jekyll to obtain any data you need. In the event you cannot get data from Dr. Jekyll, you must enter data based on what you can obtain from the medical record at your organization.
5.	Dr. Moriarty is currently under federal investigation, and all of his patient's records have been removed from our practice.	Yes, this would be appropriate use of medical record not found. Your organization is unable to access the medical records for affected sampled beneficiaries.
6.	Dr. Banks can find the patient's medical record, but can't find any of the information he needs in it.	No. A medical record is available. Dr. Banks is expected to use the data available to him, and coordinate with other providers for additional data where needed. If a specific piece of data needed to confirm a quality action was performed cannot be found, he must indicate that the quality action was not performed.
7.	There was a flood in our building just before the data collection period that destroyed many of our medical records.	Yes, this would be appropriate use of medical record not found. In this case your organization is unable to access the affected medical records.

Table B-2: Not Qualified for Sample Examples

ID	Example	Should I select Not Qualified for Sample?
1.	Ms. Alvarez had ABC Inc., a private insurer, as her primary payer through February of 2016.	Yes, this sampled beneficiary is not qualified for the sample because she was enrolled in an HMO during the measurement period.
2.	Mr. Bannister entered hospice care in December of 2016	Yes, this sample beneficiary is not qualified for the sample because he entered hospice care during the measurement period
3.	Mrs. Grey retired and moved to Argentina is November of 2016	Yes, this sampled beneficiary now permanently outside of the United States.
4.	Ms. Smith died in April 2016	Yes, this sampled beneficiary is deceased for part of the measurement period.
5.	Mr. Skywalker lives in New Jersey, but takes an extended vacation in Costa Rica every winter.	No, this sampled beneficiary has not changed his residence to outside the United States.
6.	Mr. Hughes died in 2013.	Yes, presumably Mr. Hughes remained deceased in 2016, and thus would not be qualified for the sample.

Table B-3: Diagnosis Not Confirmed Examples

ID	Example	Should I select Diagnosis Not Confirmed?
1.	Ms. Stackhouse has coronary artery disease (CAD) listed in her medical record, but she gets all her CAD treatment from her cardiologist.	No. The diagnosis is documented in the medical record. You are expected to coordinate care as needed to answer all coronary artery disease related questions
2.	Dr. Reeves is puzzled as to why Mr. Kent was sampled for the ischemic vascular disease measure, as Mr. Kent has no medical record documentation of any chronic medical condition.	Yes. CMS does identify diagnoses with claims data, but ultimately the diagnosis must be confirmed with medical record documentation. It is possible that claims-derived diagnosis data is inaccurate.

Table B-4: Meets Exclusion Criteria Examples

ID	Example	Should I select Meets Exclusion Criteria?
1.	Dr. Berzin does not believe any of his patients in a nursing home should receive BMI screenings, and does not screen or provide BMI follow-up to those patients.	No. Nursing home residence is not a specified exclusion for the BMI Screening and Follow-up measure. Exclusion criteria are determined by the measure owner and not all measures contain exclusion criteria. It is not appropriate to use this option for any reason other than those specified for the applicable measure by the measure owner.
2.	Dr. Beebe does not obtain a BMI for her pregnant patients.	Yes, pregnancy is a specific exclusion for the BMI screening measure.
3.	Mrs. Wagstaff is allergic to eggs and an influenza vaccination is contraindicated.	No. This allergy is specified as a measure exception—not a measure exclusion. You will be able to enter this data into the GPRO Web Interface further into the abstraction process. Exception criteria is also clearly defined in the Supporting Documents.

Table B-5: Other CMS Approved Reason Examples[6]

ID	Example	Should I select Other CMS Approved Reason?
1.	Dr. Lorusso can find the medical record, but he can't find documentation of Mr. Miyagi's colorectal cancer screening.	No. Dr. Lorusso cannot select Other CMS Approved Reason. He must indicate that Mr. Miyagi did not have a colorectal cancer screen.
2.	Ms. Lemon has located some beneficiaries that are outside of the age criteria for the measure they were sampled in.	No. You are able to correct a beneficiary's date of birth directly in the GPRO Web Interface. If doing so causes the patient to be outside of the age criteria for specific measures, the GPRO Web Interface will automatically skip those beneficiaries.
3.	Mr. McGrath has diabetes and history of traumatic eye injuries that have made him excessively fearful of eye exams. He has repeatedly refused to complete one due to his adverse physiological reaction.	No, you should submit a ticket to the QualityNet Help Desk (by emailing QNetSupport@hcqis.org or calling 1-866-288-8912; TTY: 1-877-715-6222). CMS will review the details of this specific situation and provide a written response with additional instructions.

[6] Other CMS approved reason is reserved for cases that are unique, unusual, and not covered by any other skip reasons. **It may not be used without prior approval from CMS which can be requested by submitting a QualityNet Help Desk ticket.** Please see the "Skipping Beneficiaries" section of this document for more information on obtaining CMS approval for using "Other CMS Approved Reason."