Quality Payment
PROGRAM

2017 CMS Web Interface Quality Reporting

Questions & Answers

January 2018

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Quality Reporting for Calendar Year 2017: Overview

Activity	Estimated* Timeline
Accountable Care Organizations (ACOs) and MIPS group practices provide care to patients during the reporting period	January 1, 2017–December 31, 2017
CMS assigns beneficiaries to the ACO or MIPS group practice, samples them into the CMS Web Interface for data collection, and prefills some beneficiary information.	November 2017–January 2018
CMS Web Interface opens so that Beneficiary Sample files can be downloaded	January 8–January 19, 2018
CMS Web Interface training environment available	January 9–January 13, 2018
Data entered into CMS Web Interface training environment erased	January 20-January 21, 2018
CMS Web Interface opens for data entry by ACOs and applicable MIPS group practices	**January 22, 2018**
ACOs and MIPS group practices attend weekly Q&A sessions	January 22–March 16, 2018
CMS Web Interface closes to data abstraction by ACOs and applicable MIPS group practices; no more abstraction possible	**March 16, 2018** ***Closes at 8:00pm ET / 7:00pm CT / 6:00pm MT / 5:00pm PT***
Continued access to CMS Web Interface to generate, view, and print reports (all other functionality disabled)	Through spring of 2021
ACOs selected for audit are notified by CMS	April 2018
ACOs' audit materials due to CMS	May 2018
Quality scores reported to ACOs	Late Summer/Early Fall 2018

*Dates may be subject to change.

Beneficiary Sample Without Data File

ID	Question	Answer
1.	What information will be provided in the Beneficiary Sample file that will be available in the CMS Web Interface in early January?	The file will include: • Medicare ID, also known as the 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 • Clinic ID, which will be the Taxpayer Identification Number (TIN) or CMS Certification Number (CCN) that provided the patient with the most primary care service visits • Provider Names/National Provider Identifiers (NPIs): NPIs, first names, and last names of the 3 providers within the ACO or MIPS 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 MIPS group practices a list of the assigned beneficiaries who have been sampled for CMS 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 MIPS 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 MIPS group practice should make every effort to locate the patient's record in order to collect data on this patient.

Sampling and Pre-population

ID	Question	Answer
1.	Will all of our assigned/ aligned beneficiaries be populated into the CMS Web Interface?	No. Patients will be sampled randomly (for ACOs it is based on third quarter assignment/ alignment) into the CMS Web Interface using the specifications in the 2017 Web Interface Sampling Methodology document, posted in the QPP Resource Library.
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 PREV-13), 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 MIPS 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 and Next Generation ACO Model 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 14 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 2017 measurement period this is the patient's age as of January 1, 2017. 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, 2017). In other words, a patient must be in the age range on both the first and last day of the measurement period.

ID	Question	Answer
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 MIPS group practice should report on all eligible patients.
6.	Can patients receiving comfort care be excluded from quality reporting?	Yes. In the Patient Confirmation section of each measure specification, 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 CMS Web Interface will be removed from the sample(s) and replaced.
7.	What will be populated into the CMS 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 (2017). • Medicare Number (also known as the HICNO) 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 • NPIs/Provider Names of 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) • Discharge Dates for CARE 1.

ID	Question	Answer
8.	What if prepopulated demographic information is not accurate?	While the end-user can modify the demographic information prefilled into the CMS Web Interface, we expect little need for ACOs and MIPS group practices to modify this information. However, if the patient's demographic information in your records and in the CMS Web Interface do not match, then the abstractor may need to correct the information in the CMS Web Interface. For example, Medicare claims may not have the accurate date of birth for a patient. Your ACO or MIPS 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 CMS 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, 2017 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 CMS Web Interface with the appropriate reason indicated.

ID	Question	Answer
10.	Is the ACO or MIPS group practice responsible for validating the data that is prepopulated into the CMS Web Interface?	Yes. The ACO or MIPS 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 CMS Web Interface is for informational purposes only, so validation of these data are at the discretion of the ACO or MIPS 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 MIPS group practice does not need to validate that data. If the ACO or MIPS group practice is selected for an audit, the ACO or MIPS 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 MIPS 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 CMS 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-1 will have inpatient discharge dates pre-populated. The ACO or MIPS group practice will be responsible for validating the inpatient discharge dates and that a visit occurred within the MIPS group practice or ACO within 30 days of the inpatient discharge date.

Abstraction into the CMS Web Interface

ID	Question	Answer
1.	For disease modules and patient care measures in the CMS 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 MIPS 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.

ID	Question	Answer
3.	How many unique patients should we expect we will need to abstract?	There are 14 patient samples provided to each organization as follows: • One patient sample for each of the two Care Coordination/Patient Safety measures (CARE-1 and CARE-2) • One patient sample for each of the 5 disease modules (CAD, HTN, IVD, MH, and the Diabetes Composite) • One patient for each of the 7 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 9,300 (14 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 2017. The sampling methodology is described in the 2017 Web Interface Sampling Methodology document available for download from the QPP Resource Library. ACOs and MIPS 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 MIPS group practice has confirmed and completely reported on 248 (or all, if there are fewer than 248) consecutively ranked patients.
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 CMS 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.

ID	Question	Answer
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. ***MIPS Group Practices*:** MIPS group practices are responsible for the beneficiaries assigned to them, and claims data indicate that beneficiaries assigned to a MIPS group practice have claims evidence of at least two primary care services during the measurement year from the group practice. Please refer to the CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology available in the QPP Resource Library for more details. The MIPS 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 MIPS group practice (e.g., patient moved or the provider is no longer with the ACO participant TIN or MIPS group practice)?	By the assignment/alignment algorithm, the patient was assigned/aligned to your ACO or MIPS group practice because they were deemed to have the plurality of their Medicare services with your ACO or MIPS group practice. Further, patients sampled into the CMS Web Interface had at least 2 Evaluation & Management (E&M) visits with your ACO or group practice between January 1 and October 28, 2017 therefore your ACO or MIPS 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 CMS Web Interface.
7.	Some of our beneficiaries have declined to share their data. Will they be eligible for sampling into the CMS Web Interface?	**Applicable to Shared Savings Program ACOs and Next Generation ACO Model 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 • MIPS Group Practices: CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology • 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 if we are an ACO in our first year of our first agreement period and are under pay- for-reporting? What if we are an ACO beyond the first year of our first agreement period?	**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. ACOs only: In order for ACOs beyond the first year of their first agreement period to be eligible for any shared savings earned, they must completely and accurately report and meet minimum attainment on at least one measure in each domain. Minimum attainment is complete reporting for measures that are pay-for-reporting and meeting the 30th percentile benchmark for measures that are pay-for-performance.

ID	Question	Answer
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 2017 CMS Web Interface measure specification documents and Release Notes, which are available for download from the Quality Payment Program Resource Library in the "Web Interface Measures" zip file: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html.
13.	Can we use NQF or HEDIS specifications for a measure when they are available?	No. Please follow the CMS Web Interface measure specifications as these specifications have been developed specifically for the CMS Web Interface reporting mechanism, which are available for download on the Quality Payment Program Resource Library in the "Web Interface Measures" zip file https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html. Additionally, these specifications are approved by the measure developer for use in the CMS Web Interface and reflect the intention of the NQF or HEDIS measures.
14.	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.
15.	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 CMS 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 QPP Service Center ticket should be submitted to qpp@cms.hhs.gov 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 QPP Service Center inquiry. You should retain this documentation and enter the QPP Service Center resolution number in the CMS Web Interface. You are not to select this option without prior approval from CMS.

ID	Question	Answer
16.	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 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, the Controlling High Blood Pressure measure (HTN-2), excludes patients who have end-stage renal disease, chronic kidney disease stage 5, are on dialysis, or have had a kidney transplant. By virtue of having one or more of these, the patient is no longer eligible for the denominator An example of an exception would be the patient's refusal of an influenza immunization. Because the patient met denominator criteria, but then refused the immunization, they will be removed from the denominator of the measure due to the exception.

Care Coordination/Patient Safety

ID	Question	Answer
1.	Can we add discharges to the pre-populated discharges in CARE-1?	No, only report on the inpatient discharges that are pre-populated in the CMS Web Interface.
2.	What if our records indicate the patient's inpatient discharge happened a few days after the date pre-populated into the CMS Web Interface?	You can confirm the discharge in the CMS Web Interface if the discharge date in your records is within 2 calendar days (before or after) the pre-populated discharge date noted in the CMS Web Interface.
3.	What if the patient did not have an office visit within 30 days of the pre-populated inpatient discharge date?	Patients are sampled into this measure only if Medicare claims indicate an office visit within 30 days of the inpatient discharge occurred. However, if you are unable to confirm an office visit, you would select "No" under "Office Visit" in the CMS Web Interface. If "No" is selected the discharge would not be included in the denominator of the measure.
4.	Are patients only counted as numerator compliant for medication reconciliation if, after each discharge, their medications were reconciled?	Each of the patient's inpatient discharges is counted as a single observation. For each discharge/office visit combination in the CMS Web Interface, you will need to confirm the discharge, confirm an office visit within 30 days, and confirm that medication reconciliation was done. For example, if a patient has two discharges (each with an office visit within 30 days), but medication reconciliation was only done at one office visit after the first discharge, then the patient will contribute two observations to the denominator, but only one to the numerator.

ID	Question	Answer
5.	What documentation is required to confirm that medication reconciliation was performed?	Your documentation needs to cover the following: • A note indicating the physician, PA, NP, registered nurse, or clinical pharmacist is aware of the patient's discharge medications • A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. Documentation in the outpatient medical record must include evidence of medication reconciliation and the date on which it was performed. Any of the following evidence meets criteria: ✓ Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in meds since discharge, same meds at discharge, discontinue all discharge meds), ✓ Documentation of the patient's current medications with a notation that the discharge medications were reviewed, ✓ Documentation that the provider "reconciled the current and discharge meds," ✓ Documentation of a current medication list, a discharge medication list and notation that the appropriate practitioner type reviewed both lists on the same date of service, Notation that no medications were prescribed or ordered upon discharge.
6.	If a patient is discharged once and has three office visits within 30 days, will the patient appear in the denominator three times?	No. The patient would appear in the denominator once (for one discharge). In order to meet the numerator criteria, medication reconciliation would need to have been performed at only one of the office visits.
7.	For CARE-1, are we to use the first office visit after discharge to answer the medication reconciliation question, or, can we use any office visit within the 30 days?	You can use any office visit within 30 days of the discharge date during which medication reconciliation was accomplished.
8.	If the patient is in the hospital for rehabilitation, is that considered an inpatient status?	Yes, as noted in the CARE-1 measure specification, inpatient rehabilitation, inpatient psychiatric, skilled nursing facility, or acute hospital discharges are considered inpatient facility discharges for the purposes of this measure.
9.	Can the inpatient facility discharge occur outside the group practice?	Yes, the inpatient facility discharge may have occurred under a non-ACO/MIPS group practice provider.

ID	Question	Answer
10.	Can the post-discharge medication reconciliation be performed over the phone prior to the office/clinic visit within 30 days of discharge, or must medication reconciliation be performed at the office/clinic visit?	As identified in the Numerator Guidance note in the measure specification (page 9), medication reconciliation post discharge may be completed during a telehealth encounter, and, therefore, can be performed over the phone within 30 days of discharge. There must be documentation in the outpatient medical record that includes evidence of medication reconciliation and the date on which it was performed.
11.	For Care-2, does gait and balance assessment meet the intent (numerator) of the measure?	Yes, assessment of whether an individual has experienced a fall or problems with gait or balance allow you to answer "Yes" to the falls screening question.
12.	For CARE-2, who can perform the falls screening?	Any clinician with appropriate skills and experience may perform the fall risk screening.
12.	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 or assessment of gait or balance.
14.	For CARE-2, is a specific screening tool required for this measure?	No, any query of future fall risk or assessment of the patient's gait or balance is acceptable.
15.	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.

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. In instances where you cannot confirm diabetes, please select “Not Confirmed-Diagnosis”.
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 looks for an encounter with diagnosis of diabetes in the administrative claims during 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.
5.	If the practitioner documents that he/she 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 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: 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 measure specification and coding documents).
2.	For the most recent blood pressure documentation, does the data need to be pulled from a primary care visit or would a specialty office visit be 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.
3.	To use pregnancy as a medical reason for not including blood pressure, is this a pregnancy anytime in 2017, or only if the patient is still pregnant at the last office visit?	This is referencing a pregnancy at any time within 2017.
4.	Should we exclude institutionalized beneficiaries?	Yes, the Denominator Exclusion now includes Patients age 65 and older in Institutional Special Needs Plans (SNP) or Residing in Long-Term Care with a POS code 32, 33, 34, 54, or 56 any time during the measurement period. The intent of the exclusion for individuals age 65 and older residing in long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy. This update was made to the measure specifications in September 2017.

At Risk Populations: Ischemic Vascular Disease

ID	Question	Answer
1.	Is a diagnosis of peripheral vascular disease or peripheral arterial disease considered confirmation of a diagnosis of ischemic vascular disease?	No, neither would be considered confirmation.
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).
3.	Can we exclude a patient from the denominator if they are prescribed warfarin?	Yes, patients receiving warfarin should be excluded from this measure by selecting the “Denominator Exclusion” option.

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 active during the denominator identification period (12/1/2015 through 11/30/2016).
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 the measurement assessment period. The measurement assessment period is the 13 months that occur after the patient's index visit 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 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 2017 MH-1 measure specification (which includes a calculation flow) for additional information on reporting the measure.
6.	The 2017 MH-1 measure specification states that we report the index PHQ-9 score that is greater than 9, is this correct? Should it actually be reporting the follow-up PHQ-9 score and date from the Measurement Assessment Period?	Correct, you should report the most recent follow-up PHQ-9 score that is less than 5 and the date of administration that was 12 months (+/- 30 days, or 11 to 13 months) after the initial PHQ-9 that had a score greater than 9 was administered (index date). Please know that the numerator instructions in the specification have been updated for the 2017 performance year.

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 CMS Web Interface and it would be a performance failure as there is no patient exception option for this measure.
3.	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 an inquiry to the QPP Service Center to request approval and more details may be required.
4.	For PREV-5, should we exclude institutionalized beneficiaries?	Yes, the Denominator Exclusion for this measure now includes Patients age 65 and older in Institutional Special Needs Plans (SNP) or Residing in Long-Term Care with a POS code 32, 33, 34, 54, or 56 any time during the measurement period. The intent of the exclusion for individuals age 65 and older residing in long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy. This update was made to the measure specifications in September 2017.
5.	For PREV-5, does digital breast tomosythesis (3D) mammography count as meeting the numerator criteria?	Yes, digital breast tomosynthesis (3D) mammography is now included in the numerator guidance as meeting the numerator criteria. The following codes to represent this addition are now listed in the PREV Coding document: 77061, 77062, and 77063. This update was made to the measure specifications posted in the "Web Interface Measures" zip file here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html.

ID	Question	Answer
6.	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.
7.	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.
8.	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 2017 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.
9.	For PREV-6, should we exclude institutionalized beneficiaries?	Yes, the Denominator Exclusion for this measure now includes Patients age 65 and older in Institutional Special Needs Plans (SNP) or Residing in Long-Term Care with a POS code 32, 33, 34, 54, or 56 any time during the measurement period. The intent of the exclusion for individuals age 65 and older residing in long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy. This update was made to the measure specifications in September 2017.

ID	Question	Answer
10.	The measure specification states that code 81528 is CT Colonography and should be reported every 5 years. I believe the 81528 code may be mislabeled and should be the COLOGUARD code and be included in the FIT_DNA_time period of 3 years. I heard this was a mistaken variable name and we could report 81528 as FIT DNA and use the 3 year period. Can you confirm this 3 year logic is correct?	Yes, the variable name should be FIT_DNA_CODE not CT_COLONOGRAPHY_CODE for CPT 81528. The variable name and code for CT colonography (74263) are correct in the PREV coding supporting document. Please utilize the appropriate timeframes for the test being submitted. The numerator codes sheet in the PREV coding document has been updated for the 2017 performance year.
11.	For PREV-6, is it true that if a patient refused a colorectal screen, that this is 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.
12.	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).
13.	Do we only include vaccinations administered between January and March 2017? Or can we look back into 2016 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, 2017. If your medical record contains documentation that the patient was administered the influenza immunization between August 1, 2016 and March 31, 2017, 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 CMS Web Interface. However, if influenza immunization data are not pre-populated, 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 audit.
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.

ID	Question	Answer
15.	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 the information can be used.
16.	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.
17.	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.
18.	When the patient reported pneumococcal vaccination prior to the availability of PCV13 (2010), is the type of vaccine required to meet the measure?	The medical record documentation should state the year (up through the last day of the measurement period) and type of pneumococcal vaccine provided • If patient reported prior to 2015, documentation indicating receipt of a pneumococcal vaccine is sufficient • If patient reported in 2015, 2016 or 2017, documentation indicating the year of the vaccination and confirmation of the type as PPSV23 or PCV13 is required
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? How do we report the BMI measurement if it occurs before the beginning of the measurement period?	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. Example: if the most recent office visit was March 2017, PREV-9 allows a 6- month look back from the most recent visit to determine if a BMI was calculated. In this case, the provider would be able to look back to October 2016 to check if BMI was measured. This would be considered numerator compliant as long as the BMI was within normal parameters or outside normal parameters with a documented follow-up plan addressing the variance.
20.	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, however, it must be linked to the out of range BMI. Documentation of a future visit does satisfy the 2017 measure.

ID	Question	Answer
21.	We noticed that changes were made in the exclusions and exceptions for PREV-9, the BMI Screening measure. Can you explain?	Denominator exclusions (where, if present the patient is skipped and replaced with another patient) are pregnancy, patients who refuse to have their height or weight measured or refuse follow-up). The medical reason exceptions for this measure's follow-up plan (i.e., patient is removed from the denominator) are elderly patients (65 years or older) for whom weight reduction/weight gain would complicate other underlying health conditions. Also, patients in an urgent or emergent medical situation are considered medical reason exceptions.
22.	What is the timing associated with the denominator exclusions and exceptions for PREV-9? Can you explain?	Denominator exclusions: • pregnancy-may occur any time overlapping the measurement period • patients who refuse to have their height or weight measured or refuse follow-up-any time during the measurement period Denominator exceptions (applies to follow-up plan): Medical reason-at the most recent encounter or within the 6-month look-back of the most recent encounter
23.	Why is there only one set of normal parameters for Body Mass Index (BMI) instead of the two we have had in prior years?	The Measure Owner has removed the upper age parameter based on variation noted in studies exploring optimal BMI ranges in the elderly. However, it may be appropriate to except certain patients from the follow-up plan. Please see the measure specification document for additional information under the Narrative Measure Specification Guidance section.
24.	For PREV-10, if the medical record only indicates "smoking", will that patient be numerator compliant?	We can deduce from this entry in the medical record that the patient was asked if they were a smoker and they answered positively. However, to be numerator compliant, there also needs to be indication that the patient received tobacco cessation intervention. In this case, there is no indication of tobacco cessation intervention, so the patient would not be numerator compliant.
25.	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.
26.	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.

ID	Question	Answer
27.	If a patient quit smoking in the last 3 months, will the patient be considered a non-tobacco user?	Yes. If a patient indicates that they are a non-smoker during the most recent inquiry regarding their smoking status, they are considered a non-tobacco user for the purposes of this measure.
28.	For PREV-12, what documentation is needed for depression screening?	Although the specification provides examples of tools that can be used, use of a specific standardized tool is not required. Please note that the first screening part of the measure looks for documentation of the use of a standardized age-appropriate screening tool., In addition, the second part of the measure looks for documentation of a follow up plan if the tool indicates a potential diagnosis of depression. 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. Please see the measure specification for more information and guidance regarding collection of the data elements for this measure.
29.	If there is a notation in the patient record (in 2017) 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 any encounter during the measurement period are to be excluded from the measure.
30.	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 name of the age appropriate standardized screening tool that was used.
31.	Do we need 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. In order to complete reporting on a patient, simply the name of the tool used and the result (positive or negative for depression) is required.

ID	Question	Answer
32.	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.
33.	What denotes a positive depression screen?	The 2017 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 by the clinician reviewing the screening results. 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 clinician administering and reviewing the standardized tool based on their knowledge of the patient and the tool being used.
34.	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.
35.	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 2017 CMS Web Interface measure specifications.
36.	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).
37.	Can you please explain the change to the denominator for Risk Category #2?	Patients who were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, in conjunction with those patients with a laboratory result of an LDL-C greater than or equal to 190 mg/dL, were added to the denominator of this Risk Category in conjunction with those patients. In the past, the only criteria for Risk Category 2 was a laboratory result of an LDL-C greater than or equal to 190 mg/dL.

ID	Question	Answer
38.	Would the following terms qualify the patient for denominator inclusion: hyperlipidemia, dyslipidemia and high cholesterol?	No, these terms would not be considered confirmation of denominator eligibility for the PREV-13 measure, risk category 2. The coding provided is specific to familial or pure hypercholesterolemia and this coding is considered to be all inclusive. In order to be considered denominator eligible for risk category 2, it must be documented as an LDL-C value greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia.

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 CMS 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 CMS Web Interface allows an organization to remove ("skip") a beneficiary from the sample if he/she does not meet one or more of the quality sampling and/or disease module or patient care measure-specific criteria. Organizations can skip beneficiaries in the CMS 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: No - Medical Record Not Found, Not Qualified for Sample, Not confirmed - Diagnosis, measure-specific exclusion criteria, and No - 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 Next Generation ACO model, please refer to your Participation Agreement.

For MIPS, refer to the GPRO Web Interface Assignment Methodology Specifications. Available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/CMS-Web-Interface-and-CAHPS-for-MIPS-Survey-Assignment-Methodology.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 MIPS 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 CMS Web Interface will provide feedback when 5% of a given sample has been skipped and 50% of the beneficiaries have been completed. However, this is only a system warning and the system will continue to allow you to skip 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. ***Applicable to Shared Savings Program 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.*

[2] Refer to the CMS Web Interface Sampling Methodology, available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/CMS-Web-Interface-Sampling-Methodology-2.pdf

ID	Question	Answer
3.	When can I use “No - 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 CMS 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 CMS 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 menu provided (which matches the above stated list). The CMS 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, 2017). Refer to Appendix B, Table B-2 for examples.
5.	When can I use “Not Confirmed - Diagnosis?”	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.

ID	Question	Answer
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 CMS 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 "No - 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 in the menu, it may not be used without prior approval from CMS. To gain CMS approval, an inquiry should be submitted to the Quality Payment Program Service Center (qpp@cms.hhs.gov) 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 QPP Service Center ticket. You should retain this documentation and enter the QPP Service Center case number in the CMS Web Interface. Refer to Table B-5 for examples.
8.	Should we be concerned if we skip large numbers of patients selected for MH-1?	MH-1 requires that a PHQ-9 be confirmed. Thus, if your practice or organization does not use the PHQ-9, you may find yourself needing to skip a large number of patients. Again, as long as you replace these patients with other patients until 248 records are consecutively confirmed and completed or until you exhaust your sample, you can still completely report.

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 2017 quality reporting will be notified in the spring of 2018, after the close of the reporting period, if they have been selected for audit. ***Applicable to Next Generation ACO Model ACOs only:*** All Next Generation ACO Model ACOs will be selected for the 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 CMS Web Interface that results in: • Denominator criteria, including confirmation of a diagnosis where applicable • Exclusions • Numerator criteria • Exceptions

Performance Scoring and Benchmarks

ID	Question	Answer
1.	For ACOs that joined the Shared Savings Program or Next Generation ACO Model before 2017, a number of measures are Pay- for- Performance in 2017. Where can we find the benchmarks for the quality measures that are in Pay- for- Performance?	**Applicable to Shared Savings Program ACOs and Next Generation Model ACOs only**: The quality measure benchmarks for the 2017 reporting year are available on the Shared Savings Program website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf) and on the Next Generation Model ACO Connect site.
2.	Where can I find more information on how the benchmarks are used to determine our overall quality score in the Shared Savings Program or Next Generation ACO Model?	**Applicable to Shared Savings Program ACOs and Next Generation ACO Model 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. *Next Generation ACO Model ACOs:* This information is presented in the Quality Measurement Methodology and Resources document posted on the Next Generation 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 MIPS group practice will enter data that is relevant to the individual measures (component measures) that comprise the composite. The CMS 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 MIPS group practice will be scored on the overall composite measure.

Interaction between CMS Web Interface and the Quality Payment Program

ID	Question	Answer
1.	How can I find out more information on the interaction between the Shared Savings Program and the Quality Payment Program?	For more information, please see: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Medicare-Shared-Savings-Program-and-MIPS-Interactions.pdf

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 on the cover page of each measure’s specification 2017 document as well as in the 2017 CMS Web Interface Measures List, which are available on the QPP website in the Quality Measure Specifications and Quality Measure Specifications Supporting Documents zip files: https://qpp.cms.gov/about/resource-library

Appendix A: Consecutively Confirmed and Completed Requirement

The minimum number of patients that must be confirmed and completed for satisfactory reporting via the CMS 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 MIPS 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 that 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 until 248 patients have been consecutively confirmed and completed or until the sample has been exhausted..

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 DM, 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	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—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

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
231-232	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—these two additional beneficiaries replace skipped beneficiaries #4 and #6

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	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	**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 **e been** consecutively completed.
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	Consecutive	Confirmed	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 No - 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 No - 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.

ID	Example	Should I select Medical Record Not Found?
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 2017.	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 2017	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 2017	Yes, this sampled beneficiary now permanently outside of the United States.
4.	Ms. Smith died in April 2017	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 2017, 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 diabetes listed in her medical record, but she gets all her diabetes treatment from her specialist.	No. The diagnosis is documented in the medical record. You are expected to coordinate care as needed to answer all diabetes 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 CMS 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 No - 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 CMS Web Interface. If doing so causes the patient to be outside of the age criteria for specific measures, the CMS 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 Quality Payment Program Service Center (by emailing qpp@cms.hhs.gov or calling 1-866-288-8292; 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 <u>not</u> be used without prior approval from CMS which can be requested by submitting an inquiry to the QPP Service Center.** Please see the "Skipping Beneficiaries" section of this document for more information on obtaining CMS approval for using "Other CMS Approved Reason."