Quality Payment PROGRAM

CMS Web Interface Data Submission Frequently Asked Questions

Quality Reporting for Performance Year 2018: Overview

Activity	Estimated* Timeline
ACOs and MIPS groups provide care to patients during the performance period	January 1, 2018–December 31, 2018
API available for testing in the production preview environment	September 2018- January 4, 2019
CMS assigns beneficiaries to the ACO or MIPS group, samples them into the CMS Web Interface for data collection, and prefills some beneficiary information	November 2018–January 2019
CMS Web Interface opens so that Beneficiary Sample files can be downloaded	January 7–January 18, 2019
CMS Web Interface training environment available	January 7–January 18, 2019
Data entered into CMS Web Interface training environment erased	January 19-January 20, 2019
CMS Web Interface opens for data entry by ACOs and applicable MIPS groups	**January 22, 2019** @ 10 AM (EST)
ACOs and MIPS groups attend weekly Q&A sessions	January 22–March 22, 2019
CMS Web Interface closes to data abstraction by ACOs and applicable MIPS groups; no more abstraction possible	**March 22, 2019** ***Closes at 8:00pm EDT / 7:00pm CDT / 6:00pm MDT / 5:00pm PT***

Activity	Estimated* Timeline
Continued access to CMS Web Interface to generate, view, and print reports (all other functionality disabled)	Through spring of 2022
ACOs selected for audit are notified by CMS**	April 2019
ACOs' audit materials due to CMS	May 2019
Quality scores reported to ACOs	Late Summer/Early Fall 2019

*Dates may be subject to change.
** Applicable to Shared Savings Program ACOs only. All Next Generation ACO Model ACOs are selected for the audit.

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 (either the Health Insurance Claim Number (HICN) or the Medicare Beneficiary Identifier (MBI)) • Beneficiary first name • Beneficiary last name • Sex • Birth Date • Beneficiary rank for each of the CMS Web Interface 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 up to 3 providers within and outside of the ACO or MIPS group who provided the highest number of primary care services to the patient

ID	Question	Answer
2.	What are we supposed to do with the beneficiary ranking data?	The beneficiary ranking gives the ACOs and MIPS groups 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 up to three providers who provided the plurality of primary care services visits to the beneficiary—all based on Medicare claims data from within and outside of the ACO or MIPS group. The purpose of this list is to assist the ACOs and MIPS groups in finding beneficiary records. It is possible, however, that the beneficiary's record is located with none of these providers. If that is the case, the ACO or MIPS group should make every effort to locate the beneficiary's record to collect data on this beneficiary.

Sampling and Pre-population

ID	Question	Answer
1.	Will all of our assigned/aligned beneficiaries be populated into the CMS Web Interface?	No. Beneficiaries will be sampled randomly (for ACOs it is based on third quarter assignment/ alignment) into the CMS Web Interface using the specifications in the 2018 Web Interface Sampling Methodology document, posted in the QPP Resource Library.

ID	Question	Answer
2.	What is the significance of a beneficiary's rank?	Each sampled beneficiary in a CMS Web Interface measure is randomly assigned a rank order number for that measure. Beneficiaries 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 measure. ACOs and MIPS groups must report on at least 248 consecutively ranked beneficiaries or all eligible beneficiaries available if there are less than 248 beneficiaries in the sample in order to complete reporting a measure. Additional beneficiaries (the oversample) are included in the sample in the event some need to be skipped (i.e., 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: Consecutively Confirmed and Completed Requirement.
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 (one for each measure and/or composite measure) drawn for the entire ACO, not for each participant TIN in the ACO.
4.	Many of the measures have age restrictions. What is the point in time a beneficiary's age is calculated?	For lower age limits, beneficiaries are sampled based on their age on the first day of the measurement period. For the 2018 measurement period, this is the beneficiary's age as of January 1, 2018. For upper age limits, where applicable, beneficiaries are sampled based on their age as of last day of the measurement period (i.e., the beneficiary's age as of December 31, 2018). In other words, a beneficiary 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 CMS Web Interface measures contain fewer than 248 ranked beneficiaries?	Not every CMS Web Interface measure may have a sample of 248 patients; this is particularly true in measures for diseases that have low prevalence rates. If CMS was unable to identify a minimum of 248 beneficiaries who met the sampling criteria, then all beneficiaries who meet the criteria will be sampled. If fewer than 248 beneficiaries are found eligible for a CMS Web Interface measure, then the ACO or MIPS group should report on all eligible beneficiaries.
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 prepopulated by CMS using Medicare claims, enrollment, and provider information available in the Integrated Data Repository (IDR) between January 1, 2018 to October 31, 2018. • Medicare Number (either the HICN or MBI) of the beneficiary • First and last name of the beneficiary • Gender • Beneficiary date of birth • Beneficiary rank in each CMS Web Interface measure, if applicable • NPIs/Provider Names of up to 3 providers that provided the most primary care services to the patient • TIN at which the beneficiary received the most primary care services • Whether the influenza vaccine was received (PREV-7) • Discharge Dates for CARE 1

ID	Question	Answer
8.	Will the CMS Web Interface use a Health Insurance Claim Number (HICN) or a Medicare Beneficiary Identifiers (MBI)?	The 2018 beneficiary samples include either a HICN or a MBI. The CMS Web Interface and Excel template contain tips that indicate whether a beneficiary has an HICN or MBI, so that you can locate the beneficiary records correctly and efficiently. Likewise, the API contains the same beneficiary sample using the HICN and MBI. It is important that you use the same beneficiary identifier included in the sample when uploading data to the CMS Web Interface via Excel or API.
9.	What if prepopulated demographic information is not accurate?	While the CMS Web Interface user can modify the demographic information that is prepopulated into the CMS Web Interface from the Medicare beneficiary enrollment database, it is anticipated that there will be little need for ACOs and MIPS groups to modify this information. However, if the beneficiary's demographic information in your records and in the CMS Web Interface does not match, then the CMS Web Interface user may need to correct the information. For example, Medicare claims may not have the accurate date of birth for a beneficiary. Your ACO or MIPS group should correct this information because it may affect that beneficiary's denominator eligibility for certain measures. Note that any demographic information you changed in the CMS Web Interface does not get reported back to the Medicare beneficiary enrollment database. You should encourage your patient to contact the Social Security Administration directly to have such information updated.

ID	Question	Answer
10.	Is CMS able to exclude beneficiaries from sampling who did not have Fee-For-Service (FFS) Medicare as their primary payer at some point during the measurement period, who entered hospice, or who died during the measurement period?	Yes. If Medicare data as of October 31, 2018 indicate that the beneficiary did not have Fee- for-Service (FFS) Medicare as their 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 data we pulled in October may not have the most up-to-date information (same for ‘deceased’ or ‘hospice’). If the CMS Web Interface user finds additional or more recent information indicating that the beneficiary did not have FFS Medicare as their 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
11.	Is the ACO or MIPS group responsible for validating the data that is prepopulated into the CMS Web Interface?	Yes. The ACO or MIPS group should validate each patient's demographic information, as changes to age and gender may affect a beneficiary'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. Additionally, the Web Interface will include the inpatient discharge dates for the CARE-1 measure. The ACO or MIPS group will be responsible for validating the inpatient discharge dates and that a visit occurred within the MIPS group or ACO within 30 days of the inpatient discharge date. 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 does not need to validate that data. If the ACO or MIPS group is selected for an audit, the ACO or MIPS group 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 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. Should your organization be selected for an audit, the influenza immunization data that is obtained from the medical record (i.e., not prepopulated from claims data) is subject to provision of supporting documentation.

Skipping Beneficiaries

ID	Question	Answer
1.	When is it appropriate to skip reporting on a beneficiary?	Each measure in the CMS Web Interface has a sample of beneficiaries that is chosen from the pool of beneficiaries assigned to the organization.[1] Medicare claims data are used to determine if a beneficiary meets the criteria to be included in a given CMS Web Interface 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 measure-specific criteria.

[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/Downloads/Shared-Savings-Losses-Assignment-Spec-V6.pdf
For Next Generation ACO model, please refer to: https://innovation.cms.gov/Files/x/nextgenaco-methodology.pdf.
For MIPS, refer to the CMS Web Interface Assignment Methodology Specifications. Available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-CMS-Web-Interface-and-CAHPS-for-MIPS-Survey-assignment-methodology.pdf
[2] Refer to the CMS Web Interface Sampling Methodology, available at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

ID	Question	Answer
		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. Some skip reasons remove a beneficiary from all CMS Web Interface measures, and other skip reasons only remove the beneficiary from that specific 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.
2.	If we skip a lot of beneficiaries in our sample, will we still be able to completely report?	Beneficiaries for whom the ACO or MIPS group has selected “No - Medical Record Not Found”, “Diagnosis Not Confirmed”, or “Not Qualified for the Sample” (for CMS approved reasons, deceased, entered hospice, Non-FFS Medicare, moved out of the country) are considered “skips”. As long as you have met the minimum requirement of 248 consecutively completed beneficiaries (or 100% of the sample if fewer than 248 are available), then you will have completely reported on the CMS Web Interface measure. If you do not meet the minimum requirement, then you will not have completely reported.

ID	Question	Answer
3.	When can I use "No - Medical Record Not Found?"	The "No - Medical Record Not Found" option should be used only if there is truly an inability to locate and access the beneficiary's medical record. By virtue of being sampled into the CMS Web Interface, CMS has identified claims for this beneficiary submitted by your organization. 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. 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) 2. At least 2 primary care office or other outpatient visits billed by the organization[3] during the reporting period. "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 CMS Web Interface measure samples: • In hospice[4] • Moved out of the U.S. • Deceased • Non Fee-for-Service (FFS) Medicare[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, 2018). Refer to Appendix B, Table B-2 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
5.	When can I use "Not Confirmed - Diagnosis?"	For CMS Web Interface 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 composite measure, 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.
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 beneficiary. 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. 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.

ID	Question	Answer
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 CMS Web Interface 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 beneficiaries selected for MH-1?	MH-1 requires that a PHQ-9 be confirmed. Thus, if your MIPS group or ACO does not use the PHQ-9, you may find yourself needing to skip a large number of beneficiaries. Again, as long as you replace these beneficiaries with other beneficiaries until 248 records are consecutively confirmed and completed - or until you exhaust your sample - you can still completely report.

Abstraction into the CMS Web Interface

ID	Question	Answer
1.	For measures in the CMS Web Interface, what makes the patient “confirmed and complete”?	Confirmed and complete means that for each measure or composite measure, you have confirmed the disease diagnosis and provided all the required information (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 (e.g., CARE and PREV), indicated 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., indicated whether or not the beneficiary received a mammography screening).
2.	Do we have to enter our data in rank order? Or can we abstract information on beneficiaries 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 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 beneficiaries 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 4 disease measures (HTN, IVD, MH, and the Diabetes Composite) • One patient sample for each of the 8 Preventive Health measures (PREV-5 through PREV-13). Each of these samples will have no more than 616 (or 750 for PREV-13) beneficiaries. Beneficiaries are sampled using a method that increases the likelihood that they will be sampled into multiple measures (if they were eligible for multiple 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 beneficiaries. We would expect similar sample sizes in 2018. The sampling methodology is described in the 2018 Web Interface Sampling Methodology document available for download from the Quality Payment Program (QPP) Resource Library. ACOs and MIPS groups are required to confirm and completely report on the first 248 consecutively ranked beneficiaries in each CMS Web Interface measure. The additional sampled beneficiaries allow for cases in which some lower ranked beneficiaries may not be eligible for quality reporting. In such cases, the beneficiary may be “skipped” and an additional consecutively ranked beneficiary must be reported for each “skipped” beneficiary until the ACO or MIPS group has confirmed and completely reported on 248 (or all, if there are fewer than 248) consecutively ranked beneficiaries.

ID	Question	Answer
4.	What does "consecutively complete" mean?	Beneficiaries are ranked 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 beneficiaries- in consecutive order- need to be confirmed and completed in the CMS Web Interface. If you need to skip a beneficiary (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 beneficiary, the final completed beneficiary should be ranked 249 instead of 248. For several examples, see Appendix A.
5.	What if one of our sampled beneficiaries was not seen at our MIPS group or ACO during the measurement period?	Applicable to Shared Savings Program ACOs and Next Generation ACO Model ACOs only: Though the beneficiary may not have been seen at your specific facility or practice, the beneficiary was assigned to your ACO or MIPS group and must have been seen at least twice by participant TINs affiliated with your ACO or MIPS group during the measurement period to be chosen for inclusion in a CMS Web Interface measure samples. Since your organization is deemed accountable for such a case, you may not select 'not qualified for sample' under this circumstance. Please refer to the CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology available in the QPP Resource Library for more details. Your ACO or MIPS group must use best efforts to obtain required quality data for such beneficiaries.

ID	Question	Answer
6.	What if one of our sampled beneficiaries is no longer being seen at one of the ACO's participant TINs, or at the MIPS group (e.g., beneficiary moved or the provider is no longer with the ACO participant TIN or MIPS group)?	By the assignment/alignment algorithm, the beneficiary was assigned/aligned to your ACO or MIPS group because they were deemed to have the plurality of their Medicare services with your ACO or MIPS group. Further, beneficiaries sampled into the CMS Web Interface had at least 2 Evaluation & Management (E&M) visits with your ACO or MIPS group between January 1 and October 31, 2018. Therefore, your ACO or MIPS group is considered accountable for this beneficiary's care, and you should do your best to obtain the necessary 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.
8.	Can we exclude a sampled beneficiary if they were only seen by a specialist at our facility?	No, this beneficiary 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 : CMS Web Interface & CAHPS for MIPS Survey Assignment Methodology • Next Generation Model ACOs: Please refer to your Participation Agreement

ID	Question	Answer
9.	Is there any benefit or harm to abstracting additional ranks in the CMS Web Interface 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 beneficiaries 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 have consecutively confirmed and completed an additional beneficiary who meets the numerator criteria, then you would have a new rate of 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).

ID	Question	Answer
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?	Applicable to Shared Savings Program ACOs and Next Generation ACO Model ACOs only: If you completely and accurately reported on the minimum 248 beneficiaries for each of the CMS Web Interface measures, or all sampled beneficiaries if fewer than 248 were included in the sample, you would have satisfactorily reported under pay-for-reporting. Applicable to Shared Savings Program ACOs and Next Generation ACO Model 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.
11.	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 2018 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.

ID	Question	Answer
12.	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. They 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.
13.	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. Clinical point of care is the point in time when clinicians deliver healthcare products and services to beneficiaries.

ID	Question	Answer
14.	Is there a list of Other CMS Approved Reasons to remove beneficiaries from any of the CMS Web Interface 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 beneficiaries 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: • Email Subject: CMS Approved Reason Request • The beneficiary rank (never any protected health information, “PHI”), • The associated measure • A detailed explanation of why you think it is appropriate to skip the beneficiary. CMS will either approve or deny the request and will identify in the resolution of the QPP Service Center Case (previously Service Center ticket or inquiry number). You should retain this documentation and enter the QPP Service Center case number in the CMS Web Interface. You are not to select this option without prior approval from CMS. Please do not include any PHI or sensitive data (e.g., HICNs, MBIs, birth dates, names, etc.) in your case. A detailed explanation with the measure and rank is sufficient to process the request.

ID	Question	Answer
15.	Please define exclusion and exception.	Exclusions are a removal of the beneficiary from the denominator prior to looking for the numerator criteria. Exceptions are a way to exclude the beneficiary from the denominator when they do not meet the numerator criteria for specified reasons. Not all measures have exclusions and/or exceptions. The exclusions and exceptions are only to be used as defined in the measure specifications. For example, the Controlling High Blood Pressure measure (HTN-2), excludes beneficiaries 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 beneficiary is no longer eligible for the denominator. An example of an exception would be the beneficiary's refusal of an influenza immunization. Because the beneficiary 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 prepopulated discharges in CARE-1?	No, only report on the inpatient discharges that are prepopulated in the CMS Web Interface.

ID	Question	Answer
2.	What if our records indicate the beneficiary's inpatient discharge happened a few days after the date prepopulated into the CMS Web Interface in CARE-1?	You can confirm the discharge (i.e., select "Yes") in the CMS Web Interface if the discharge date in your records is within 2 calendar days before or 2 calendar days after the prepopulated discharge date in the CMS Web Interface, but you cannot change the prepopulated date.
3.	What if the beneficiary did not have an office visit within 30 days of the prepopulated inpatient discharge date in CARE-1?	Beneficiaries are sampled into this measure only if Medicare claims indicate an office visit within 30 days of the inpatient discharge occurred within the ACO or MIPS group . 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.	For CARE-1, are beneficiaries only counted as numerator compliant for medication reconciliation if, after each discharge, their medications were reconciled?	Each of the beneficiary'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 occurred within 30 days, and confirm that medication reconciliation was done. For example, if a beneficiary 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 beneficiary will contribute two observations to the denominator, but only one to the numerator.

5.	What documentation is required to confirm that medication reconciliation was performed for CARE-1?	Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. Your documentation needs to cover the following: • Verification of each prepopulated discharge date (+/- 2 days) • A note indicating the physician, PA, NP, registered nurse, or clinical pharmacist performed the medication reconciliation, or if others perform the medication reconciliation, a note indicating the physician, PA, NP, registered nurse, or clinical pharmacist is aware of the review • Evidence of medication reconciliation and the date on which it was performed (within 30 days of the prepopulated inpatient discharge date). 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 beneficiary'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 ✓ Documentation that beneficiary was seen for post-discharge follow-up with evidence of medication reconciliation or review ✓ Documentation in the discharge summary that the discharge medications were reconciled with the current medications; the discharge summary must be in the outpatient chart

ID	Question	Answer
6.	If a beneficiary is discharged once and has three office visits within 30 days, will the beneficiary appear in the CARE-1 denominator three times?	No. The beneficiary 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.	Fore CARE-1, if the beneficiary 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.	For CARE-1, can the inpatient facility discharge occur outside the MIPS group?	Yes, the inpatient facility discharge may have occurred under a non-ACO/MIPS group provider.
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 for CARE-1?	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 can therefore 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.

ID	Question	Answer
13.	For CARE-2, we have many skilled nursing facility beneficiaries. 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 beneficiary’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 regarding the beneficiary’s fall history or assessment of gait or balance is acceptable.
15.	Does the CARE-2 fall screen apply to all beneficiaries, or only beneficiaries having had a previous fall?	This screen applies to all beneficiaries in your CARE-2 sample.
16.	We noticed the medical reason exception was removed for CARE-2. Please explain what the change entails?	The ‘medical reason denominator exception was removed because a denominator exclusion was added to account for removal of non-ambulatory beneficiaries that may be included in your CARE-2 sample.

At Risk Populations: Diabetes

ID	Question	Answer
1.	For the diabetes composite measure, 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”.

ID	Question	Answer
2.	For the diabetes composite measure, will beneficiaries only be sampled into the measure 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 Medicare claims during the measurement year when populating the beneficiary 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 beneficiaries 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 beneficiary is included in the numerator (which would increase the measure performance rate, resulting in poorer measure performance) 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 present as part of the dated laboratory report.

ID	Question	Answer
5.	For DM-7, if the practitioner documents that he/she instructs the beneficiary to have an eye exam performed, but the beneficiary does not follow through; this will be entered as a 'No' response. Is this appropriate since the practitioner did refer the beneficiary?	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 beneficiary for HTN-2 did not have a blood pressure reading, will the beneficiary be excluded from the denominator and not included in the performance calculation?	If a blood pressure reading was not taken, the beneficiary will not be excluded from the denominator or performance calculation unless there is a valid medical reason the blood pressure measurement was not 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 for HTN-2?	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 codes in the WI measure coding documents to assist in determining whether or not a particular visit is considered eligible.

ID	Question	Answer
3.	To use pregnancy as a medical reason for not including blood pressure for HTN-2, is this a pregnancy anytime in 2018, or only if the beneficiary is still pregnant at the last office visit?	This is referencing a pregnancy at any time within 2018.
4.	Should we exclude institutionalized beneficiaries for HTN-2?	Yes, the Denominator Exclusion now includes beneficiaries 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. Please note these beneficiaries are removed from this measure during sampling when identified in claims.

At Risk Populations: Ischemic Vascular Disease

ID	Question	Answer
1.	For IVD-2, 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 beneficiary is allergic to aspirin? Are there any medical reasons we can use to explain why a beneficiary 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).

ID	Question	Answer
3.	Can we exclude a beneficiary from the IVD-2 denominator if they are prescribed Warfarin?	Yes, beneficiaries receiving warfarin should be excluded from this measure by selecting the “Denominator Exclusion” option.

At-Risk Populations: Mental Health

ID	Question	Answer
1.	For MH-1, what timeframe should be used to determine if the beneficiary 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 (12/1/2016 through 11/30/2017).
2.	For MH-1, is the timeframe that should be used for the Denominator Exclusions the same as the diagnosis of depression or dysthymia?	Yes, exclusions can occur during the denominator identification period. Exclusions can also be identified during the measurement assessment period, which is the 13 months that occur after the beneficiary’s index visit date.
3.	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 beneficiary who is residing in a long term residential facility any time during the denominator identification period or before the end of the measurement assessment period. It does not include beneficiaries who are receiving short term rehabilitative services following a hospital stay, nor does it include beneficiaries residing in assisted living or group home settings.

ID	Question	Answer
4.	What happens if the organization does not use the PHQ-9 tool? Would they be marked as a “not confirmed—diagnosis”? Would the beneficiary not qualify for the denominator of the measure?	The beneficiary would not meet denominator eligibility (patients age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during the index visit). In other words, if the patient did not have a PHQ-9 greater than 9, you must select “No” and the patient will be removed from the measure.
5.	The 2018 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 also 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).
6.	For MH-1, can I use any PHQ-9 with a score less than 5 obtained during the 11-13 month remission window?	No, the measure specifications state that the most recent PHQ-9 result must be used during the 11-13 month remission window.

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 for PREV-5?	No, documentation of results is required in order to report numerator compliance.

ID	Question	Answer
2.	For PREV-5, Breast Cancer Screening, how should we answer if the beneficiary 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 beneficiary exception option for this measure.
3.	For PREV-5, what if a beneficiary had a unilateral mastectomy and has metastatic disease and, therefore, receives PET scans and CTs rather than a mammogram?	If the beneficiary 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 beneficiary. However, approval should not be considered automatic.
4.	For PREV-5, should we exclude institutionalized beneficiaries?	Yes, the Denominator Exclusion for this measure now includes beneficiaries 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. Please note these beneficiaries are removed from this measure during sampling when identified in claims.
5.	For PREV-5, does digital breast tomosynthesis (3D) mammography count as meeting the numerator criteria?	Yes, digital breast tomosynthesis (3D) mammography is included in the numerator guidance as meeting the numerator criteria.
6.	For PREV-6, is it true that if a beneficiary refused a colorectal screen, that this is considered a “No” response?	There is no patient reason exception for this measure. Please select “No”.

ID	Question	Answer
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 (fecal occult blood test) 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. The type of test, results and the date on which the testing was performed needs to be documented in the medical record.
8.	For PREV-6, what if the beneficiary meets sampling criteria for the measure and is not yet 50, e.g., 45 years of age, when they had a colonoscopy? Is this beneficiary numerator compliant if we have the date and results in the medical record?	Yes, a beneficiary who met the denominator criteria for the Colorectal Cancer Screening measure in the 2018 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 beneficiaries 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. Please note these beneficiaries are removed from this measure during sampling when identified in claims.
10.	For PREV-7, will immunizations found in claims be included in the numerator?	Claims data is used when available to prepopulate the CMS Web Interface field used in the numerator for PREV-7 (influenza immunization).

ID	Question	Answer
11.	For Prev-7, do we only include vaccinations administered between January and March 2018? Or can we look back into 2017 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, 2018. If your medical record contains documentation that the patient was administered the influenza immunization between August 1, 2017 and March 31, 2018, then you can select "Yes" to indicate that an influenza immunization was received. You do not have to verify that the beneficiary 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 beneficiary'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 beneficiary, the organization should maintain documentation of the immunization, should your organization be selected for an audit.
12.	If the medical record does not indicate that the beneficiary has been vaccinated for influenza and the beneficiary 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 beneficiary.
13.	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the immunization measures (PREV-7 and PREV-8)?	If that information is available at the point of care, then the information can be used.
14.	For the influenza vaccine exception in PREV-7, what qualifies as a "system reason"?	A vaccine shortage is an example of a system reason.

ID	Question	Answer
15.	If the medical record does not indicate that the beneficiary has been vaccinated for pneumonia and the beneficiary 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 beneficiary.
16.	When the beneficiary reported pneumococcal vaccination prior to the availability of PCV13 (2010), is the type of vaccine required to meet PREV-8?	The medical record documentation should state the year (up through the last day of the measurement period) and type of pneumococcal vaccine provided. • If beneficiary reported prior to 2015, documentation indicating receipt of a pneumococcal vaccine is sufficient. • If beneficiary reported after or during 2015, documentation indicating the year of the vaccination and confirmation of the type as PPSV23 or PCV13 is required.

ID	Question	Answer
17.	For PREV-9, the BMI Screening measure, the description reads “Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months…” If you are not excluding the beneficiary 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 12 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 12 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 15, 2018, PREV-9 allows a 12 - month look back (less than 13 months) from the most recent visit to determine if a BMI was calculated. In this case, the provider would be able to look back to February 16, 2017 to check if BMI was measured. As long as the BMI was calculated and documented at an encounter that was less than 13 months from the current encounter it would be acceptable. 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.
18.	Please explain how exclusions and exceptions are to be reported for PREV-9, the BMI Screening measure.	Denominator exclusions (where, if present the beneficiary is skipped and replaced with another beneficiary) are pregnancy, or beneficiaries 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., beneficiary is removed from the denominator) are elderly beneficiaries (65 years or older) for whom weight reduction/weight gain would complicate other underlying health conditions. Also, beneficiaries in an urgent or emergency medical situation are considered medical reason exceptions.

ID	Question	Answer
19.	What is the timing associated with the denominator exclusions and exceptions for PREV-9?	Denominator exclusions: • Pregnancy- may occur any time overlapping the measurement period • Beneficiaries 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 12-month look-back of the most recent encounter
20.	Why is there only one set of normal parameters for Body Mass Index (BMI) instead of the two we had for performance years prior to 2017?	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 beneficiaries from the follow-up plan. Please see the measure specification document for additional information under the Narrative Measure Specification Guidance section.
21.	We noticed that the PREV- 10 tobacco use measure was changed since last year; can you please explain the changes made?	Three measure rates are now being calculated for this measure. Medical reason exceptions vary by rate. The three rates are: • Percentage of patients aged 18 years and older who were screened for tobacco use one or more times in 24 months • Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention • Percentage of patients aged 18 years and older who were screened for tobacco use one or more times in 24 months AND who received tobacco cessation intervention if identified as a tobacco user

ID	Question	Answer
22.	For PREV-10, if the medical record only indicates “smoking”, will that beneficiary meet the screening requirements of the measure?	We can deduce from this entry in the medical record that the beneficiary was asked if they were a smoker and they answered positively. However, to meet the screening requirement of the measure, the beneficiary needs to be queried regarding all forms of tobacco use.
23.	For PREV-10, the beneficiary 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.
24.	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.
25.	If a beneficiary quit smoking in the last 3 months, will the beneficiary be considered a non-tobacco user for PREV-10?	Yes. If a beneficiary 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.
26.	Does screening for tobacco use and cessation intervention have to occur during the same encounter for PREV-10?	No, they do not. However, they do need to occur during the 24 month look-back period and the cessation intervention must occur after the most recent tobacco user status is documented.

ID	Question	Answer
27.	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 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 stating that the beneficiary 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; a note indicating the name of the tool that was used to screen the beneficiary and whether they interpret the screen as positive or negative is sufficient. Please see the measure specification for more information and guidance regarding collection of the data elements for this measure.
28.	If there is a notation in the patient record (in 2018) that the patient is under care of a mental health professional, is that sufficient to exclude the beneficiary from PREV12?	Beneficiaries with a documented active diagnosis of depression or a bipolar disorder prior to any encounter during the measurement period are to be excluded from the measure. The beneficiary is removed from the denominator by selecting the denominator exclusion option in the CMS Web Interface. You may not exclude beneficiaries who were diagnosed with depression or bipolar disorder based on a screening that occurred during a visit within the measurement period.
29.	If the documentation states that a depression screening was performed, and then states the beneficiary is not depressed, does that qualify for PREV-12?	This documentation would qualify as a depression screen as long as the dated documentation indicates the name of the age appropriate standardized screening tool that was used.

ID	Question	Answer
30.	Is traumatic brain injury an exclusion for PREV-12, depression screening?	If the physician determines this is a situation in which the beneficiary'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 beneficiary and the extent of the beneficiary's injury, which would be up to the physician's discretion.
31.	For PREV-12, what denotes a positive depression screen?	The 2018 PREV-12 measure does not require documentation of a specific score; whether results of the normalized and validated depression screening tool are considered positive or negative by the clinician reviewing the screening results is sufficient. 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 beneficiary and the tool being used.
32.	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.
33.	Are the medical reason exceptions listed in the Data Guidance for PREV-13 the only reasons we can use for not having a beneficiary on a statin?	Yes, the denominator exceptions are based on the medical evidence reviewed by the measure owner. They can be found on pages 6 and 7 of the 2018 CMS Web Interface measure specifications.
34.	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).

ID	Question	Answer
35.	Can you please explain the change between performance year 2016 and performance year 2017 to the denominator for Risk Category #2?	Beneficiaries who were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia, in conjunction with those beneficiaries 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 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.
36.	Would the following terms qualify the beneficiary for denominator inclusion for PREV-13: 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, the beneficiary must have a documented LDL-C value greater than or equal to 190 mg/dL or have been previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia.

Performance Scoring and Benchmarks

ID	Question	Answer
1.	For ACOs that joined the Shared Savings Program or Next Generation ACO Model before 2018, a number of measures are Pay- for- Performance in 2018. 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 2018 reporting year are available on the Shared Savings Program website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-and-2019-quality-benchmarks-guidance.pdf) and on the Next Generation Model ACO Connect site.

ID	Question	Answer
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**. 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 available 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 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 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/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 document as well as in the CMS Web Interface Measures List, which are available in the Quality Payment Program Resource Library in the “Web Interface Measures & supporting documents” zip file.

Appendix A: Consecutively Confirmed and Completed Requirement

Question: How do organizations consecutively confirm and complete beneficiaries?
Answer: The minimum number of beneficiaries that must be confirmed and completed for satisfactory reporting via the CMS Web Interface is 248 for each CMS Web Interface measure (or the maximum number available to you if less than 248). This means that ACOs and MIPS groups 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 beneficiary is no longer qualified for the sample, (c) the beneficiary meets measure-specific exclusion criteria, (d) the diagnosis could not be confirmed, (e) the beneficiary 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 beneficiary must be completed for each beneficiary that was skipped until 248 beneficiaries have been consecutively confirmed and completed or until the sample has been exhausted. Please see the Appendix tables A-1 through A-4 for examples.

> **Confirmed** means that you have obtained the beneficiary’s medical record, confirmed the beneficiary 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 beneficiary for the measure for which they were sampled.

Consecutive means that you have completed the beneficiary 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 CMS Web Interface measure is considered complete and no additional abstraction required since 248 ranked beneficiaries were consecutively confirmed and completed.

Table A-1. Example 1

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary 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

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
4	Y	**N**	Y	No—Medical Record Not Found	Yes—“Medical Record Not Found” has been selected for this beneficiary	No—This beneficiary 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 beneficiary 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 beneficiary is not confirmed and must be replaced with another beneficiary from the sample

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
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 beneficiary available for abstraction. After patient rank #231, the CMS Web Interface measure is considered complete since all available ranked beneficiary have been consecutively confirmed and completed.

Table A-2. Example 2

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary 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

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
4	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—”Not Confirmed—Diagnosis” has been selected	No—This beneficiary 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 beneficiary is not confirmed and must be replaced with another beneficiary from the sample

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
7–230	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
231-232	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 beneficiary rank #2 was not provided and causes the count of consecutively completed ranks to stop at rank #1. The CMS Web Interface measure is considered incomplete until Rank #2 is completed.

Table A-3. Example 3

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary 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 beneficiary is not completed you will have only 1 beneficiary counting towards your reporting requirement.	No—this beneficiary 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

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
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 beneficiary 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 beneficiary 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.

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
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 beneficiary 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 beneficiary rank #250, the CMS Web Interface measure is considered complete since all available ranked beneficiaries have been consecutively completed.

Table A-4. Example 4

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary 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 beneficiary 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

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
6	Y	**N**	Y	No—the beneficiary 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 beneficiary 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 beneficiary 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

Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
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 “No - 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 “No - 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”. Please note, this beneficiary may be excluded from certain measures based on the measure specifications.

ID	Example	Should I 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 "No - Medical Record Not Found". Your organization is unable to access the medical records for affected sampled beneficiaries.
6.	Dr. Banks can find the beneficiary'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 “No - 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 “No - 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 2018.	Yes, this sampled beneficiary is not qualified for the sample because she did not have FFS Medicare as her primary payer during the measurement period.
2.	Mr. Bannister entered hospice care in December of 2018	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 2018	Yes, this sampled beneficiary now permanently outside of the United States.
4.	Ms. Smith died in April 2018	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 2017.	Yes, presumably Mr. Hughes remained deceased in 2018, and thus would not be qualified for the sample.

Table B-3: Diagnosis Not Confirmed Examples

ID	Example	Should I select "Not Confirmed – Diagnosis"?
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 "Denominator Exclusion"?
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 "No - 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.

[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 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

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 beneficiary 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 detailed question 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.