2016 Physician Quality Reporting System (PQRS) Group Practice and ACO Web Interface Reporting Mechanism

Web Interface Q&A Session Support Call
Program Year 2016

Moderator: Ashley Burrell
March 2, 2017
1:00 p.m. ET

<u>Note: This transcript was current at the time it was published or uploaded onto the web.</u>

Ashley Burrell: Good afternoon everyone. I am Ashley Burrell from the PQPMI team and I'm your moderator today. I would like to welcome everyone to our Group Practice and ACO Web Interface Question and Answer Session. Today's call will feature brief reminders about Web Interface reporting requirements and helpful hints that can assist during submission. This call will be recorded and made available on the PQRS Web Interface webpage and the ACO Portal. Questions will be accepted through the Q&A feature on the right-hand side of your screen and will be addressed at the end of the session, as time permits. At this time I would like to turn this call over to Rabia Khan of the Division of Shared Savings Program at CMS. Rabia, over to you.

Rabia Khan: Thank you Ashley. And as Ashley noted, I'm Rabia Khan from the CMS Division of Shared Savings Program, and I welcome yo- all of you to our CMS support call for 2016 PQRS Group Practice and ACO GPRO Web Interface reporting. As Ashley mentioned earlier today's slides will be made available on the GPRO Web Interface webpage, they are currently not posted but they will be made available shortly. The slides are available on the Shared Savings Program ACO Portal, under the program announcement titled "2017 Web Interface Q&A Support Call Slides and Recordings." In addition, the slides are available on the Next Generation and Pioneer Connect sites.

Next slide please: **Slide 3**

Rabia Khan: During this support call, Pioneer, Next Generation and Shared Savings Program ACOs, as well as PQRS group practices will all be collectively referred to as organizations.

The Web Interface measure specifications and supporting documents are located on the GPRO Web Interface page of the CMS website. We strongly recommend that you use the measure specifications and supporting documents as a re-resource when you're reporting your quality data. Please use the 2016 measure documents for 2016 reporting.

Slide 4

The attestation deadline for providers participating in the Medicare EHR Incentive Program has been extended to Monday, March 13th at 11:59 PM Eastern Time. So, providers who are

participating and must attest to the Medicare EHR Incentive Program have to do so for the 2016 program requirements by March 13th to avoid that, twenty-eight, their 2018 payment adjustment. If you are participating in the Medicaid EHR Incentive program, please refer to your state's website for attestation information and deadlines.

Next slide please: **Slide 5**

As you know, the Web Interface is open for data entry and submission, and you may access the Web Interface through the PQRS portal. The Web Interface closes *[Laughs]* shortly, actually in a few weeks on March 17th at 8:00 PM- 8:00 PM Eastern time. We strongly encourage your organization not wait until the last day to submit data and to do so well before the 8:00 PM Eastern Time deadline on the 17th. That way, it'll ensure that you've fully submitted before the Web Interface closes.

Next slide please: **Slide 6**

So we do have a couple of more weekly Web Interface Data Submission support calls coming up, so please mark your calendars with the dates and times for our two remaining calls which are on March 9th and March 14th. Um, after that we will be hosting a Web Interface Lessons Learned session, where we'll go over your feedback on the 2016 Web Interface Reporting. We will provide more information to you as we get closer to uh, the end and the close of the Web Interface so, please stay tuned for that information.

Next slide please: **Slide 7**

There are some scheduled outages and maintenance weekends for PQR- for the PQRS portal which means, the Web Interface will not be accessible during the- these dates and times. Uh, so the Web Interface will not be accessible:
• Every Tuesday at 8:00PM Eastern Time through Wednesday at 6:00AM Eastern Time
• And then again on Thursdays from 8:00PM Eastern time through Friday at 6:00AM Eastern Time

Next slide please: **Slide 8**

As a reminder, to meet the satisfactory reporting requirements, all organizations must completely report a minimum of 248 consecutively confirmed and completed beneficiaries in each module OR 100 percent of beneficiaries if your organization has fewer than 248 available in the sample.

Satisfactorily reporting all 18 of the Web Interface measures will allow PQRS group practices and eligible professionals, participating in an ACO, to avoid the 2018 PQRS payment adjustment.

Next slide please: **Slide 9**

In addition, EPs participating in an ACO or PQRS group practice can satisfy their CQM reporting for the Medicare EHR Incentive Program, if they use certified EHR technology to abstract the data for reporting through the Web Interface.

PQRS group practices are required to use EHR technology, certified to the 2014 Edition, to populate the Web Interface.

EPs participating in an ACO must be using certified EHR technology and abstracting the data to report to the ACO, in the form and manner specified by the ACO. The ACO must then satisfactorily report the Web Interface measures.

So when EPs must- well, please note EPs must still individually attest separately to the EHR Incentive Program for other program requirements. So, when EPs go to the attestation system and reach the screens for reporting CQM's, they should select option 1, since they're reporting through an eReporting option. EPs can also choose to submit their CQM data separately, instead of selecting that eReporting option when they go in to attest. And that as a- again as a reminder that deadline is March 13th.

And then finally, Shared Savings Programs ACOs who fail to satisfactorily report Web Interface measures will not meet the quality performance standard and will not be eligible, then, to share in savings, if earned.

Next slide please: **Slide 10**

And now I am going to turn it over to Sue Hanlon to go over some helpful information on the Web Interface.

Sue Hanlon: Thank you, and good afternoon.

Um, today we're going to go over two topics. We're going to review the Totals Reports, which provides completeness information, and we're also going to review submission information, which includes using the Submit screen and knowing what your submission status is.

Next slide please: **Slide 11**

Okay, the Totals Report. The Totals Report provides a status of your patient abstraction as of the date and time the report was generated. It contains a Summary Level, as well as a Detail Level, which displays a drilldown of the selected row from the Summary Level. And the totals are reported by measure.

Next slide please**: Slide 12**

Okay. Here is a sample of the report. It's the Summary Level report and as you can see, it's for CARE-2 only. So, there will be a screen that looks like this for every measure. So we'll just kind of review what's on this, um, to give you a good idea of the Summary Report.

The first thing is, you're going to see All Ranked Patients. And then, there's a breakout within All Ranked Patients. And the first thing I wanted to remind you of is that, All Confirmed and Complete, that's not consecutively confirmed and complete; that is just a total of confirmed and complete. Um, the second portion is Consecutively Completed or Skipped, and then within that category is a breakout of information. And the last line at the very bottom where it says For Analysis, that is the consecutively confirmed and complete total.

Um, another thing I'd like to point out on the screen is, to get to the detail level, it's- look at the- in the center of the screen there's a Details Column, that's your link to the detail level for that row on the report. If you click on that, it will give you a new uh, report layout, it's the details and that is the listing of all the patients that meet that criteria.

Okay, next slide please: **Slide 13**

Some additional helpful hints on the Totals Report; some of which I just reviewed but I'll go over it again. The All Confirmed and Complete row, shows the count of all patients confirmed and complete regardless of the order. The For Analysis row, contains the total number of patients, starting with Rank #1 where the record is confirmed and complete in consecutive order. The Comments column, is a system generated field which um, provides further information about what that count is- is providing you.

And, this is just a reminder to pay attention to the Report Generation date and time. If you have added or changed data since the last time you re- you um, generated that report, you probably should regenerate or create a new report for yourself.

And finally, the Web Interface User Guide contains a lot of detailed information in how to understand what data is provided on the report.

Next slide: **Slide 14**

Okay, so now we're going to review um, submitting your data to CMS.

The final action you must take to ensure that all patient data is available to CMS is on the Submit screen. Your data will be submitted by checking the authorization box, and there's a picture of what it looks like, **[refers to screenshot on slide]** and by clicking the Submit Data to CMS button. And remember, that the patient data entered or saved on the Home page, or uploaded via XML file is saved, but it is not available to CMS until you submit.

Our next slide is a picture of the Submit screen.

Next slide please: **Slide 15**

Thanks.

Okay, so this is the Submit screen, and you can see, at the very top are some instructions and some information um, helpful to using the screen. There's a message here in red, which we're going to review in a minute, but below that, there's the authorization box that you need to click and then followed by the Submit Data to CMS button.

When you first go on the screen, you're going to receive a message. And in this example, you can see the message is in red, and it says: "The data you have submitted does not meet the requirements for reporting. Please continue to update patients." And then it says: "See table below for completion details." So at the very bottom of the screen it gives you your module by module status, and that's in the Comments field.

Um, next screen please, or slide: **Slide 16**

Um, these are the three different messages that you're going to see on that Submit screen. One, we- we previously reviewed, which is the- the- the middle um, message, but the first message that we're displaying here, is if you've not submitted any data at all. It shows up in red type, so that should be um, a notification to you that you need to do something; and it just says "Your final data has not been submitted to CMS, please use the Submit button," um, et cetera. The middle message is the one we've already reviewed, which is also in red, which is also an

indication to you that you need to take action: "The data you have submitted does not meet the requirements." Um, and finally, the last message in green, says: "The data you have submitted meets the requirements for PQRS GPRO web-based satisfactory reporting." And that's what you want to see there.

Um, next slide please: **Slide 16**

Here are, some additional um, data submission hints.

You can use both the Submit screen and the Submission Status Report to view the status of your submission.

Each module is listed with a comment indicating if the module has met the requirements for satisfactory reporting. And that's at the bottom of the um, the screen and also at the bottom of the report.

And then finally, our last uh, slide please: **Slide 17**

In addition to the Submit screen and the- the report, there's also a submission status message that appears at the top of your screen. Um, it's- it's right underneath th- the organization name, and there are two basic messages. One, which shows up in green, and it's telling you that there's no un-submitted data changes; and the other message, which appears in red will say: "You have un-submitted data changes. Please submit." And in addition to that, it's also telling you the last submission date, and the last update date. So that information, which is always going to be showing to you as you navigate through the user interface, um, is giving you, um, your status, your submission status.

And that concludes my slides for today.

Next slide please: **Slide 18**

We'll turn this over to Deb.

Deb Kaldenberg: Good afternoon everyone, this is Deb Kaldenberg from the PQMM team.

Next slide please: **Slide 19**

And, we will be going over, actually five measures questions, um, three of them you'll see here on this slide. The other two that we go over um, we've actually added, we'll just go over them verbally um, and that's due to the increased number of inquiries we've received in the last week.

Um, the first question is in regards to PREV-10. If a patient has been screened several times within the reporting period and received cessation intervention, but not at the most recent screening, does this patient qualify for the numerator? And, is this patient compliant with the measure?

And the answer to this is, if at the most recent screening, the patient is identified as a tobacco user, then you may look within the 24-month period for documentation of cessation intervention. Within 24 months is defined as the 24-month lookback from the measurement period end date. So you'd be able to look from January 1st of 2015, through December 31st of 2016.

The next question is also in regards to PREV-10. Do I meet the intent of the measure, as long as the patient is asked about their smoking status?

And in this case, the answer is no. The measure intent is that the patient is screened for tobacco use. Tobacco use includes both smoking and smokeless tobacco, at this time though, e-cigs are not considered tobacco use.

The third question is in regards to CARE-3. Do you have to list all four parts: name, dosage, route, and frequency of a medication on your med list to count?

So every medication should include the medication's name, dosage, frequency, and administered route to the best of the provider's ability on the date of the encounter. For example, much of the information may be reliant on what the patient or patient's caregiver knows and can share with the provider. This could be especially true when knowing the necessary components for over the counters, herbals and vitamins. It is more likely all components will be available for prescription medications. If there are components missing, there should be documentation that supports that the provider was able to provide a complete list, based on available information on the date of the encounter.

The fourth question that we're going to- to go over is in regards to MH-1, the depression remission at 12 months. We're receiving quite a number of questions about requests for a CMS approved reason to skip, if the patient was not seen during the index period. And in this case, this isn't a reason to request a skip. You would just, if you're unable to confirm diagnosis of major depression or dysthymia, you would select no- or you would select "not confirmed diagnosis". And in reality this works the same way as if you requested a CMS approved reason to skip, in that the patient is skipped and replaced with another patient. Um, it's completely taken out of your denominator.

Also within the MH-1 measure keep in mind, that the only screening tool that can be used both, for denominator eligibility and to show remission, is the PHQ-9.

The other question we wanted to go over, is in regards to PREV-13, the statin measure. We have a lot of questions coming in where the patient's triglycerides are too high to confirm that the LDL-C value meets risk category 1, or risk category 2 or risk category-3 um, criteria; and yet the patient is on a statin and they want to go ahead and select, yes and then yes to statin. And, this is not something that can be done. You have to confirm the LDL-C value meets the intent of risk category 2 or risk category 3. If you don't have an LDL-C value because of high triglycerides, you would just end up answering in- in that way that, you know, no that value is not there, um, and that patient would be skipped and replaced.

So those are our questions um, that we'll go over today and then of course any as we start to go through the Q&A session. But at this time I will hand it over to, I believe, Michael.

Slide 21

Michael Kerachsky: Great, thank you very much Deb. Um, my name is Michael Kerachsky from the PQPMI Team, and I'm going to present on uh, the available educational as well as help desk resources.

Uh, next slide please: **Slide 22**

Okay, uh slide 22 contains a list of educational resources. This includes, the website and portal links specific to PQRS group practices and each of the ACO models. Um, the Web Interface support page includes the following:

- Links to Web Interface support call transcripts, as well as presentations
- Assignment Methodology, as well as Sampling document.
- XML and Measures Specifications, as well as supporting documentation and data guidance.
- Also, there's a Question and Answer document posted to the webpage.

In addition, there are three educational demonstrations. Uh,

- The Web Interface Overview
- Web Interface Measures and,
- EIDM for Web Interface

All three of these are posted on the Web Interface webpage. Ah, we strongly encourage your organizations review these step-by-step instructions and then included are instructions on how to access the Web Interface as well as how to utilize the documentation that is listed on this slide.

Next slide please: **Slide 23**

Okay, slide 23 includes a list of help desk contacts, uh, for the PQRS group practice and ACO models. Uh, for any PQR- PQRS EIDM Web Interface questions, please contact the QualityNet Help Desk. Uh, also note that the CAHPS for PQRS Survey Project Team help desk, is applicable to PQRS group practices only.

Next slide: **Slide 24**

Okay, slide 24 includes a list of acronyms which you may find useful as you report. Uh, this is included in all of the presentations.

Next slide please: **Slide 25**

Okay, at this time we will begin the Question and Answer portion of today's support call.

Couple of, ah, requests for attendees today. Please submit your question in writing, via the Q&A box located at the top of the webinar screen. You may need to click the Q&A tab at the top of the screen to access this feature.

Upon submitting questions please identify if you are a PQRS group practice, or the type of ACO model you participate in. If your question concerns measures please identify the measures number.

User specific questions must be sent to the QualityNet Help Desk so a representative may research your organization's unique questions, on a case by case basis and provide an appropriate resolution.

As a reminder, today, we will not be responding to MIPS policy questions.

And finally, in an effort to read as many questions as possible, we will not read repeat questions.

Question and Answers

Question Moderator: Michael Kerachsky

Michael Kerachsky: Okay, our first question today; for HTN-2, would a hypertensive disorder diagnosis confirm a patient, even if the SNOMED code doesn't match up with the data guidance?

Carol Noyes: Hi, this is Carol. Um, SNOMED coding or, the coding that is provided within this measure is what is applicable for the condition for hypertension. If you have documentation that does not match, then you cannot use that. Um, if you have documentation within your medical record that just says essential hypertension, you may use that, um, documentation. Otherwise, I would say refer to the evaluation coding, um, to ensure that your conditions are meet- meeting the intent of the measure.

Michael Kerachsky: Thank you.

Next question, also regarding hypertension. Would HTN in a diagnosis section of a medical note, be enough to confirm a patient with hypertension?

Carol Noyes: Hi, this is Carol again, and as previou- previously um, yes that would. If it says essential hypertension, or the conditions that are in the evaluations coding tab of the supporting documentation then, this would be acceptable.

Michael Kerachsky: Okay, next question regards a PREV-10.

If an EMR has smokeless user options incorporated into a tobacco template, but there is not a no smokeless option when the patient denies; so that the results in the record are silent on smokeless when patient denies, is this okay?

Deb Kaldenberg: This is Deb from the PQMM Team. Um, I'm not a hundred percent sure I understand the question, but basically what you will have to show is documentation that the patient has been screened for both um, smokeless or smoking or just tobacco use in general. Um, and if the patient was not a tobacco user and you have documentation they've been screened then you would meet the intent of the measure.

If I'm not answering your question, you can certainly open up a QualityNet Help Desk ticket, um for further clarification. Or, possibly if someone else on the call understands this question a bit more than- than I do at this time, please feel free to jump in.

[Pause]

Michael Kerachsky: Okay, I guess we'll continue on.

Um, if you- sorry if, if you are able to look at most, but not all, medical records in a MSSP ACO to confirm diagnosis for IVD, TED, Heart Failure, etc. is it appropriate to confirm and answer, not compliant for that patient? Or, is it OK to not confirm and skip to the next beneficiary?

Olivia Berzin: This is Olivia Berzin, I can take a first stab at that. So I would say if you truly cannot find um, kind of medical record documentation of these diagnoses, then you should

absolutely um, not confirm the patient as opposed to confirming them and making them not compliant in the measure.

Sherry Grund: I- I think- this is Sherry from ACO PAC team and I think this is question is just a little bit hard to understand. Um, I'm not certain if that is the only question that's being asked, uh, about the confirmation of diagnosis here, or if there's, uh, a second part to that that's wondering about um, skipping based on non-compliance. Um, so if there's more to this, um, based on both Olivia's and my um, comments, um, please, um expound on your question a little bit so that we um, can answer more fully for you.

[Pause]

Michael Kerachsky: Okay, the next question is regarding CARE-2.

Does asking the patient this question qualify as performing a fall screening: "Has patient received treatment previous- previously for a fall?"

Carol Noyes: Um, so this is Carol again, and this is a partial, I suppose, um, question. So, I guess the main question would be, has the patient fallen? So, during the measurement period there would need to be a question asked about the patient's status of the fall. Um, so have they- do you have documentation of whether the patient has been assessed for- assessed for a history of falls or any falls with injury? And so a documentation of no falls would also be sufficient.

So you're looking for an assessment of the screening for fall risk, at least once during the measurement period.

Michael Kerachsky: Thank you.

Um, next question regards MH-1. A patient wasn't seen at our office until 2016. If the provider entered a qualifying depression diagnosis in the problem list as chronic in 2016, would this qualify the patient? There is no documentation of depression during the index period.

Deb Kaldenberg: This is Deb. If there- if you cannot confirm depression of- or diagnosis of major depression or dysthymia during the index period, then you would select the not confirmed. Um, that diagnosis needs to be considered active during the index period. Um, it's certainly possible if they have that diagnosis in 2016, they may be attributed in 2017. But it would not be a confirmation for 2016.

[Pause]

Michael Kerachsky: Patients that have a diagnosis of heart failure but also have an exclusion exception, for example, permanent pacemaker Z95, how do you enter these into the Web Interface? No selection for exclusion- no selection for exclusion exception.

Carol Noyes: Hi, this is Carol. Um, so for Heart Failure 6, the presence of a permanent pacemaker alone is not an exception for this measure. However, if the physician- if you find physician documentation that the patient is not taking a beta blocker because they have a pacemaker then you can utilize the medical—re- reason exception for that patient. So there would need to be documentation of this, as just a permanent pacemaker presence alone is not an exception.

A patient would have to have an AV block without a permanent pacemaker to qualify for that.

Michael Kerachsky: Thank you. Next question.

If patient has abnormal BMI, abnormal blood pressure, and positive for depression, would this be acceptable to pass PREV-7, PREV-11 and PREV-12? Follow-up in 3 months for abnormal BMI, abnormal blood pressure and positive depression screen? Or, does it need to be separate as such – follow-up in 3 months for abnormal BMI, follow-up in 3 months for abnormal blood pressure and follow-up in 3 months for positive depression?

Deb Kaldenberg: And this is Deb. The first thing that I would suggest that you do is um, utilize the supporting document Data Guidance tab for the PREV um, set of measures. And the reason is- is you really want to look at PREV-9, PREV-11 and PREV-12 to determine if your recommended follow-up is meeting each of those conditions.

So, you know, without knowing in this case, what the blood pressure value was, that may or may not meet the recommended follow-up needed for the elevated blood pressure. Um, you certainly can have just one recommended follow-up, if at that encounter, more than one condition is going on, say there's an abnormal BMI and an elevated blood pressure, if that recommended follow-up is occurring on the same encounter as those two situations, and it's relevant to both those situations, then it would be acceptable. Um, but- but you definitely want to look at what your recommended follow-up is, and ensure that it's meeting what's going on for-for each of those 3 measures.

Michael Kerachsky: Okay, the fol- following question pertains to PREV-9.

Data guidance states: "A follow-up plan must be documented during the encounter, or during the previous 6 months of the current encounter." Can you clarify if the encounter refers to the date of the abnormal BMI or the date of the most recent visit?

Deb Kaldenberg: And that would be the date of the most recent visit. So if at your most recent encounter, there is not a calculated BMI, you can look back six months to find um, a calculated BMI documented.

Michael Kerachsky: Okay. Next question concerns IVD.

There are four drugs that are acceptable for anti-thrombotic therapy. However, it was my understanding from a previous support call that I could request a CMS approved – other reason for those patients on Warfarin. Is this correct?

Carol Noyes: Hi this is Carol, and yes. You may sel- you may um, send in a CMS approved reason request. And I think we had that on um, one of the slides, maybe a couple of them ago. Um, but you could actually send in a CMS approved reason, you'll need to send in the rank, and the reason um, and those patients may be listed in one email or file, and sent to CMS for review.

Michael Kerachsky: Okay, we are a GPRO and have been reporting since 2011. Are there any known impacts to the CAD-7 rate, due to the attribution issue this year that caused a high skip threshold? We had to skip roughly 250 patients. Our measure rate dropped 12 points from previous years.

Olivia Berzin: This is Olivia. Um, I mean at this point we haven't heard of any widespread issues. Um, but we'll certainly be monitoring, um, any impact on the performance rate.

Rabia or Lisa Marie, feel free to jump in with anything else.

Rabia Khan: Thank you Olivia. This is Rabia. Yes, um, so we are continuing to monitor things and so and for ACOs we'll provide more information at a later time um, if we do see there is a significant impact. Um, but at this time, please continue reporting so that way you can complete reporting by the 17th.

Lisa Marie Gomez: This is Lisa Marie, also if we hear there's any issues related to GPROs, we'll also um, send out notifications. But I think as of now we'll just continue to monitor. Thanks, Olivia.

Michael Kerachsky: Okay, thank you.

Is a performance rate of zero percent acceptable for successfully reporting a measure in the GPRO Web Interface?

Olivia Berzin: This is Olivia. As long as you've completely reported, um, you know you'll still be able to- still be able to successfully report even if your performance rate on one or more measures is zero percent.

Michael Kerachsky: Is there anything we can do, if we have a greater than ten percent skip rate, and abstracting more charts is not mitigating this? For example, MH-1 or other measures like CAD where the patient diagnosis is not confirmed or measure specific exclusions are high.

[Pause]

Rabia Khan: So this is Rabia. And, other folks feel free to sort of jump in here, but, um, we do understand that for some measures, uh, like MH-1, um, you may have a higher than normal skip rate. Um, and we had previously noted that for CAD-7 that may also be possible this year given that we did um, identify an issue with the sampling for that measure; so you may have more than ten percent skip rates for those measures and may- possibly other measures but as long as you um, consecutively confirm and try to report um two hundred and four- well, report 248 or if you have less than that, um, the rest of your sample, then you will meet the com- the complete reporting requirements. I don't know if others had anything to add.

Michael Kerachsky: Okay, we have a CARE-3 question.

A provider sees a patient in a nursing home. A pre-typed visit note from state- uh, a sorry a pre-typed visit note states- pre-typed visit note form states that meds are reviewed with pharmacists and are correct. No list of meds are on the note. Do we mark "no" because we can't see the med list, or "yes" because the form states, "reviewed"?

Olivia Berzin: For this particular one, I think you might need to open a ticket for that. Um, might need additional details**.**

[Pause]

Michael Kerachsky: Okay, as long as we report on 248 members, then technically we have completed reporting, correct?

Olivia Berzin: Uh, as long as you are saying 248 beneficiaries per module or, 100 percent of the module if 248 are not available, then yes. So not a total of 248 beneficiaries across all of your samples. 248 in each sample.

Rabia Khan: And this is Rabia. Just to add to that, they must be consecutively confirmed.

Olivia Berzin: Mm-hmm.

Rabia Khan: Um, Sue can- which report, could you go over which report would be helpful to check to be sure that you've completed reporting?

Speaker: I think it's the Totals Report, which we reviewed today.

Sue Hanlon: Yes, definitely. The Totals Report will help you know exactly where you're at and which record if you are not complete. If there's a record that is causing you to um, have an incomplete record that allows you not to take credit for all those records following that incomplete record that you may have completed. Um, it will show up on that Totals Report in the Details tab, so that you'll know which one you need to go to, um, to take care of that and uh, be able to make them all consecutively completed.

Michael Kerachsky: Okay, we have a Web Interface question.

How can we pull a comprehensive status report, which includes all of the patient's names, so that we may identify measures errors for each patient?

[Pause]

Rabia Khan: Sue, are you available for that one?

Sue Hanlon: Can you repeat the question please?

Michael Kerachsky: Absolutely. So the question is, how can we pull a comprehensive status report which includes all of the patient's names, so that we may identify measure errors for each patient?

Sue Hanlon: That would be the Check Entries Report.

Rabia Khan: So, more information on each of the reports is available in the Web Interface User Guide that's on the PQRS Portal. Um, so for more information about what each report can provide you, uh, I would suggest taking a look at that guide.

Michael Kerachsky: Can we um, go back one slide?

Okay, next question: I am receiving error messages regarding XML mapping. I have verified information against the provided references. How can I get additional assistance?

Sue Hanlon: Um, please go ahead and enter a help desk ticket for that issue.

Michael Kerachsky: Okay. We uploaded an XML file and the denominator exceptions measure rate were captured correctly; but the total complete indicates- indicated all patients, which is not correct in most of the measures. I'm not sure why yet. Must it indicate the actual completed counts?

Sue Hanlon: Um, I- I think you'd be best to create a help desk ticket. And we can look at that, um, individually.

[Pause]

Michael Kerachsky: Okay, next two questions here and, first, can you submit one measure at a time? Second, does it hurt to report on all 616 patients, instead of just 248?

Sue Hanlon: You can submit one measure at a time. Um, I-I don't think it hurts, but it doesn't help you to add, you know, to include all 616 patients…so-

Olivia Berzin: *[Interjects]* So, I'm going to jump in; this is Olivia. It actually depends on um, with those additional patients, if they meet the numerator criteria or not. So, I would recommend um, for kind of fuller discussion of this um, uh, check out page 12 of 46 of our Q&A document, which has a kind of lengthy example on this.

Rabia Khan: Right, and this is Rabia just to add. Um, you can submit the data to CMS multiple times as you're in the system. Just please note that um, once you've completed everything, your final submission is what we're- we'll be seeing once the Web Interface closes. So, even after if you've, let's say you've completed 100 percent, um and you've submitted the data and you go back into the system, and you decide to make some updates please ur- I urge you to double check your Totals Reports again to make sure that you're still complete. And I would suggest hitting Submit again. So, and the- like I said, you can hit the- submit the data to CMS as much as you want.

Michael Kerachsky: Okay uh, next question.

We have nearly all our measures completely reported, including many measures that we reported on 100 percent of the sample patients due to denominator exclusions and skips. But after submission all measures are showing – not meeting requirements. How do we proceed?

Sue Hanlon: It- it seems like you must have an incomplete patient before you've reached your 248 consecutively confirmed and completed patients. But if you-

Rabia Khan: *[Interjects]* So…

Sue Hanlon: If you- oh, go ahead.

Rabia Khan: Oh, this is Rabia just to add um, and please, Sue, feel free. Um, I would urge you to check your Totals Report like we mentioned earlier. That may help you identify the issue.

Sue Hanlon: I- if you can't figure that out, please go ahead and open a help desk ticket.

Michael Kerachsky: Thank you. Uh, next question. If a patient is "diabetes confirmed" in the diabetes measure, can we con- can they be considered, um, "diabetes confirmed" in CAD and Statin measures?

Deb Kaldenberg: This is Deb, from the measures team. So from the perspective of the measures, um, certainly if you have the documentation to confirm diabetes for the diabetes composite, that same confirmation could be used to confirm diabetes in the other measures. But if you're asking something more specific, like does that confirmation populate- or I'm not sure if there's- I'm assuming there's more to it because as far as the documentation piece is concerned, documentation of diabetes could be used um, for any of the measures that require confirmation of diabetes.

Michael Kerachsky: What are the documentation requirements for PREV-11: Blood pressure screening?

Deb Kaldenberg: So, for PREV-11, you know, one of the first things again that I would suggest is going ahead and looking at the data guidance tab of the supporting document. Um, of course PREV-11 specifically. You're going to want to have documentation of what the blood pressure value is to show that; and if the blood pressure value is considered abnormal, whether It falls within the pre-hypertensive, first hypertensive or second hypertensive reading, that you have documentation of the appropriate follow-up. Um, and then keeping in mind that for the pre-hypertensive values, if the provider is considered the primary care provider, then the pre-hypertensive follow-up is considered completed and- and you can report as such.

Um, if you have a specific scenario you have a question about, please feel free to open up a help desk ticket. Um, but I would assume that as long as you are following what is required within the measure and you have documentation to support that, that would be what you would need.

Sherry Grund: And this is uh, Sherry. And if you're an ACO um, remember that you can get that information in the QRGs um, on the second page of that particular um, QRG.

Um, the only additional thing that um, Deb um, didn't cover I don't believe was um, documentations of exclusion or exception criteria. Or I- or I missed it Deb, sorry if- if I did. Um, you would want to be sure to have documentation of that as well. Um, because that would be necessary if you were selected for audit.

Rabia Khan: Right, and this is Rabia just to add um, so the ah, Quick Reference Guides that um, Sherry just mentioned. We have our Audit Quick Reference Guide for SS- a Shared Savings Program ACOs on uh, our portal as well as the measure Quick Reference Guides. They're all located uh, under the program announcement 2016 Quality Measurement and Reporting Guides.

Michael Kerachsky: Okay. I received permission to use, Other CMS approved reasons for PREV-5: 3D Mammogram; I entered the ticket number. Why does the Check Entries Report show these entries as errors?

Sue Hanlon: Um, the Check Entries al- also provides informational messages, which doesn't mean it's an error. But if it- if you think there's still a problem please enter a help desk ticket.

Michael Kerachsky: When will the 2016 Mean Performance Rate be posted?

Olivia Berzin: Eh, this looks like an ACO specific question so if you could send it to the Shared Savings Program Help Desk, or the Next Generation um, ACO mailbox or the Pioneer ACO mailbox um, we can answer it there.

Rabia Khan: Right and this is Rabia, just to help. So, um, when we- for the Shared Savings Program we provide the 2016 Mean Performance Rates for our quality measures when you receive your qu- Performance for 2016 Quality Report. Um, and that will be provided to you with the financial reconciliation later this summer.

Michael Kerachsky: For the MH-1 measure, are we able to use a PHQ-2 of zero to count as remission at the 12-month window?

Deb Kaldenberg: This is Deb. Um, no. The only PHQ tool that can be used is the PHQ-9. If you have documentation um, you confirmed the major depression or dysthymia diagnosis, and you have a PHQ-9 greater than 9 during the index period, the only way to show remission is um, a PHQ-9 less than 5 uh, that happened at 12 months, plus or minus 30 days. So the PHQ-2 cannot be used to report the MH-1: Depression remission at 12 months.

Michael Kerachsky: Okay, next question.

Are all Medicare Advantage replacement plans eligible for exclusion, not qualified for sample, or only specific types of Medicare Advantage replacement plans?

Olivia Berzin: This is Olivia. I can take first stab at that, um if the beneficiary was enrolled in a group health plan as their primary care, um, including beneficiaries enrolled in a Medicare Advantage plan under part C, um, then that would be an appropriate use of the HMO exclusion.

[Pause]

Michael Kerachsky: Okay, move to the next question. Um, MH-1, if "yes" to confirm the diagnosis; and the PHQ-9 was not done in 2015, just in 2016, then the answer would be "no" on the PHQ-9, and the patient is skipped. What happens if there is not 248 confirmed, and all patients used?

Deb Kaldenberg: So this is Deb. You are correct that if there is no PHQ-9 completed in 2015 that you would select "no" to the PHQ-9 and the patient will be skipped and replaced. And this is one of those cases, and why the MH-1 measure in particular um, you may have more skips than some of the other measures. You may, in fact, if you don't use the PHQ-9 in 2015 at all, you will have to go through your entire patient sample. So if you have 616 patients attributed, you would report um, on 100 percent of your sample as you won't get to the 248 confirmed patients.

[Pause]

And- and Michael, I can go ahead and, and read the next one if you'd like, and I can answer that one as well. I'm not sure we've had this one for MH-1 yet this year. If that's okay.

Michael Kerachsky: Absolutely, go ahead.

Deb Kaldenberg: Okay. For MH-1, if a patient reaches remission after 6 months, and the PHQ-9 score is recorded within the performance period, is this accessible? And- and I'm assuming you mean, can we use that score?

And the answer is no. You can only use the PHQ-9: 12 Months, plus or minus 30 days after the index date, and your index date is your first PHQ-9, greater than nine during your index period. Um, so anything that occurs prior to the 12 months, minus 30 days or anything that occurs after

the 12 months plus 30 days, would not be considered remission for this measure. And actually, within the Web Interface tool, it will not even let you put in, that date um, of that PHQ-9 score because it won't meet the time parameters.

Michael Kerachsky: Okay. If patient refuses screen for BC, how do we enter it into GPRO Web Interface?

Deb Kaldenberg: So we're not 100 percent sure which measure you are referring to, potentially this is PREV-5 the breast cancer screening measure. But regardless, if you have a situation where a patient refuses, and a measure does not have a denominator exception patient reason, or a patient refusal, um, you would either report "not compliant" or, if you want CMS to review the- the specifics around that situation, you can certainly open up a help- help desk ticket asking that CMS review, um, and they will provide a resolution in that- their their decision in the resolution of that inquiry.

Um, so hopefully we've answered your question. If not, this might be another case where you want to open up a help desk ticket.

Michael Kerachsky: Okay. For PREV-13, can you clarify the med exception for DM patients, whose most recent LDL was less than 70? Are these patients an exception when not on statin therapy or when receiving statin therapy**?** Data guidance and supporting documents, in narrative specs conflict.

Deb Kaldenberg: And this is Deb. And you're absolutely right and we did um, try and clarify this in a couple of different places. Um, anytime a patient is on a statin, you would not want to report the denominator exception, um, as that patient is compliant. Um, certainly in this case, the error Is in the data guidance. Um, your denominator exception medical reason would be if a patient was not on a statin.

Michael Kerachsky: Okay. For hypertension, if medical record has essential hypertension in the problem list, but a code that does not match up with the data guidance, might be a more specific SNOMED code than what the data guidance contains, is this okay?

Carol Noyes: I'm sorry, I'm reading that again. Hold on one second.

So, medical record documentation of essential hypertension um, *[Pause]* alone would be acceptable. Um, if you are finding coding that- or and you can use the coding, as a guide um, to locate that information. So if the information is present within your medical record, then it can be used.

Deb Kaldenberg: The- the point is, is whatever it is you're finding, should support the coding that that measure has included. Um, as that measure developer does intend that it's an essential hypertension diagnosis. So if you're looking at medical record documentation or you have other codes that that you're finding and- and you want to use this confirmation, what you need to have documentation of, is that that information you're using meets what that measure is looking for.

Um, so a-again, this is another situation if- if you have a concern about something very specific, it may be best to open up a help desk ticket for us to have a chance to look at that and provide you a response.

Michael Kerachsky: Okay, we'll take uh, one more question here.

Early in the reporting process, this call acknowledged that CAD had a bad patient sample set. Can CMS confirm this issue, and will this be adjusted for performance?

Rabia Khan: So this is Rabia, and just to clarify, um, so, we do recognize that organizations are skipping a higher than expected number of beneficiaries in the CAD-7 sample, um, due to not being able to confirm the diagnosis. Um, we determined that when we made uh, recent upgrades to our programming processes it inadvertently changed our sampling criteria for that measure. This resulted in more cases in which a CAD diagnosis cannot be confirmed. However, we do provide an over sample of 616 beneficiaries for reporting. So as with all measures uh, you are required to consecutively confirm and complete 248 beneficiaries, or as many or, as possible until the sample is exhausted. Um, in terms of performance in- under the program, I mean we just urge you to complete reporting and uh, we'll provide further information at a later time, once we've been able to take a look at the impact.

Michael Kerachsky: Okay, thank you. This concludes, portion um, today's question and answer portion of today's call. This uh, thank you for attending, and back to you Ashley.

Ashley Burrell: Thank you, Mike. And thank you to all of our panelists for that informative session. Thank you to our attendees for participating in today's Web Interface Support call.

If you would like further information, or feel your question was not addressed on today's call, please contact the QualityNet Help Desk and the appropriate team will be able to assist you. Everyone have a great day and presenters please hold for the sub-conference.

*Bolded Words – Non-spoken