Moderator: Hello, everyone. Thank you for joining today's Web Interface Support Call Webinar. This series of webinars are for Accountable Care Organizations, ACOs, and groups that are reporting data for the Quality Performance Category of the Quality Payment Program through the CMS Web Interface for the 2017 performance period. These webinars will highlight important information and updates about reporting quality data and provide ACOs and groups with an opportunity to ask CMS subject-matter experts their questions. Please note that these calls will only focus on reporting data for the Quality Performance Category. We will not cover reporting data for the other performance categories during these calls. Now we'll turn it over to Lisa Marie Gomez from the Center for Clinical Standards and Quality at CMS.

Lisa Marie Gomez/Moderator: Thank you. Welcome, everyone, and I want to thank you for joining us today as ACOs and MIPS Groups preparing for the CMS Web Interface Quality Reporting. As Paula mentioned, I'm Lisa Marie Gomez from CMS, the Quality Measurement and Value-Based Incentives Group and an expert on the CMS Web Interface. Joining me on this call today are other CMS experts and contractors who will share helpful information on CMS Web Interface Quality Reporting and answer your questions during the question-and-answer session after today's brief presentation. As noted earlier, today's focus is on Quality Reporting, but if you have any Advancing Care Information Questions, the Quality Payment Program will be providing more information in upcoming weeks. Also, you can contact the Quality Payment Program Service Center with any of your questions regarding Advancing Care Information, MIPS, or Quality Reporting in general. Next slide, please.

So, information in this presentation was current at the time of its publishing, but I urge you to please be sure that you're using the source documents and links that are provided throughout the presentation and please stay tuned to any communication from the Quality Payment Program, [Indistinct] Program, or Next Generation Program regarding any updated information. Next slide, please.

First, I'd like to go over some announcements regarding the CMS Web Interface. So, some updated new documentation, including the measure specification and supporting documents, EIDM User Guides and the Excel Templates are now available on the QPP Resource Library. Also, the script, presentation, and recording from December 13th CMS Web Interface Kickoff Webinar are now available on the QPP Webinar and Events page. So please check out those resources. Next slide, please.

Also, several new video tutorials have been posted on the QPP Resource Library. We posted these to be able to help you have resources available to you at any point in time, so please check out those videos. All right, next slide, please. Now I'm going to talk about upcoming webinar dates. So please mark your calendars. The next CMS Web Interface Webinar will be held on Wednesday, January 24th, from 1:00 to 2:00 Eastern Standard Time, and this will also include a Q&A session. Next slide, please.

I just want to note that the CMS Web Interface opened this past Monday, or actually last week on Monday to allow for testing. The test period runs through this Friday, January 19th. During this time, you can use the CMS Web Interface to test reporting, which includes logging into the Web Interface, downloading your sample, reviewing your sample, working on filling out your data in Excel Template offline, testing the upload function and your ability to upload the data to the Web Interface. You may also go in and manually

enter data by beneficiary or by measure, review the reports that are available through the CMS Web Interface, and test any data you upload or you'll be removing, and, also, I just want to note that anything that you upload during the testing period, it will be removed at the close of the test period.

From January 20th through the 21st, the CMS Web Interface will not be available at all for testing or uploading. It will actually be closed at that time, and anything uploaded, as I mentioned, at that time will be removed. The eight-week submission period starts Monday, so it's next week, on January 22nd, and runs through 8:00 P.M. Eastern Daylight Time on Friday, March 16th. You'll be able to save your progress in the system at each step. Please note you do not have to hit a "Submit to CMS" button as we've done in previous years. Instead, CMS will automatically take the data that is entered at the end of the submission period. So, whatever is entered as of 8:00 P.M. Eastern Daylight Time on March 16th is what will be accepted as your data submission for the CMS Web Interface Quality Reporting. So, again, we just want to iterate that there is no "Submit" button that you have to click, so whatever is uploaded as of 8:00 P.M. on March 16th, that is what will be accepted to CMS and what will be included as your reporting for Quality. Now I'm going to turn it over to Ralph to discuss Excel Template and Manual Reporting for MH-1 and PREV-13. Ralph.

Ralph: Okay. Thank you very much. We were asked to provide a little more information on MH-1 and PREV-13. Next slide.

So, for MH-1, the Depression Remission at Twelve Months Measure, if you select Denominator Exclusion or No Confirmed-Diagnosis, at that point in time, you don't have to enter any other information in the Excel Template for that beneficiary that you selected either one of those choices for. The conditional formatting will help you understand that and will actually keep the cells to the right of that black for the MH-1 Measure. Next slide.

And what does this look like in the CMS Web Interface itself? If you picked Denominator Exclusion, as shown here, then it will mark that beneficiary skipped for that measure, as indicated to the left in the Skipped Indicator. Next slide. Here you see the same thing with Not Confirmed-Diagnosis, and what does this look like in the CMS Web Interface itself? If you picked Denominator Exclusion, as shown here, then it will mark that beneficiary skipped for that measure, as indicated to the left in the Skipped Indicator. Next slide.

Here you see the same thing with Not Confirmed-Diagnosis. If you select that in the Manual Reporting option for MH-1, then it will also mark the beneficiary as “Skipped” next to it in the left. Next slide.

So, for PREV-13, the CMS Web Interface will not automatically skip ineligible beneficiaries based on the age for all the Risk Categories. So, when you get to Risk Category 3, you have to make a manual selection as to whether they're outside of the age range of 40-75 for Risk Category 3, and we're going to show you what that looks like both in the Excel Template and in the Manual Reporting in the CMS Web Interface. Next slide.

So, here's sort of an outline of how that reporting would go. If you're reporting PREV-13, and for Risk Category 1, you select No Diagnosis. Then you move on to Risk Category 2 and select No Diagnosis. When you get to Risk

Category 3, you're going to have to make an explicit selection -- No Diagnosis or Not Age 40-75 Years. Next slide.

Here's what it looks like in the Excel Template. You can see in the first column No Diagnosis has been selected for a particular beneficiary for Risk Category 1. In the next column that's filled in, No Diagnosis is selected for Risk Category 2, and then under the question, "Is the patient age 45-75 years of age and has a diagnosis of Type 1 or Type 2 diabetes?" here in Risk Category 3, we selected No Diagnosis or Not Age 40-75 Years if the patient is outside of that age range. Next slide.

Here's the same sequence of events in the CMS Web Interface Manual Reporting Stream. So here you see Risk Category 1, and it's asking, Does the patient have a diagnosis of atherosclerotic cardiovascular disease (ASCVD) -- active or history of at any time up through December 31, 2017? In this case, they've picked No Diagnosis, and you see the beneficiary is still marked Incomplete. Next slide.

For Risk Category 2, the second question, Has the patient ever had a fasting or direct laboratory test result of LDL greater than or equal to 190 milligrams or were previously diagnosed or currently have an active diagnosis of familial or pure hypercholesterolemia? And here they've picked No Diagnosis, and you see the patient is still marked as Incomplete. Next slide.

Finally, we're at Risk Category 3, and the question is, Is the patient age 40-75 years of age and has a diagnosis of Type 1 or Type 2 diabetes? The choice gives you a No Diagnosis or Not Aged 40-75 Years. So, if the patient is outside of that age range of 40-75 years, he picked No Diagnosis or Not Age 40 to 75 Years, and on the left, you see the patient beneficiary is marked as Skipped. So, at that point, the CMS Web Interface based on your manual selection will skip the beneficiary. Next slide. Okay, I'm going to hand it off to Jessica.

Deb Kaldenberg: And, actually, this is Deb Kaldenberg. I will be presenting for Jessica today. Next slide, please. So, some of the frequently asked Measure Questions we've been receiving through ServiceNow include some PREV-9 questions for the BMI Screening and Follow-Up Plan, and you will find that we have two different questions that really are answered by the same answer. So, our first question is, "If a patient is wheelchair-bound and cannot be weighed, can that be documented as denominator exception (medical reason), or do we have to select, 'No,' the patient did not have their BMI calculated?" And the second question is, "If a patient comes in that weighs more than what our scale can hold, should that be documented as a denominator exclusion (medical reason), or do we have to select 'No,' the patient did not have their BMI calculated?" And in this case, I believe the question should have really been written as denominator exception -- a little bit different than denominator exclusions. The answer for both of these questions as to whether the patient is wheelchair-bound or if the scale cannot get an accurate weight for a particular patient, if a BMI was not performed, the patient would not meet the measure criteria. The denominator exception applies to the date of the encounter or within the six-month look-back period, but in the case of the 2017 medical exception, it only applies to the follow-up, not to the BMI performance. So, in both of these cases, if you do not have a BMI calculated, you would have to select, "No, the patient did not have a BMI calculated" regardless of if they were

in a wheelchair or you did not have a scale that could accommodate the patient. Next slide, please.

The next questions we have are related to the PREV-13 Measure, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. And, again, in this case, the answer will apply to both of the questions that are asked. The first question was, "How does the measure steward define the diagnosis of pure hypercholesterolemia?" And "What do we report if ICD-10 Code E7800 hypercholesterolemia is noted, but without pure or familial?" And in this case, hypercholesterolemia alone would not meet the description provided for utilization within the 2017 CMS Web Interface. In this case where the description or documentation only states "hypercholesterolemia," you would select "No Diagnosis" and continue to Risk Category 3. The measure owner confirmed that the intent of this category and code is specific to pure hypercholesterolemia to identify the genetic component versus the broader term and interpretation of elevated or high cholesterol, which might be impacted by lifestyle. Next slide, please.

And the third question for PREV-13 -- "Would the following terms qualify the patient for denominator inclusion -- hyperlipidemia, dyslipidemia, and high cholesterol?" And the answer to this question is, no, these terms would not be considered confirmation of denominator eligibility for the PREV-13 Measure with 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, there must be medical-record documentation of an LDL-C value greater than or equal to 190, or the patient was previously diagnosed with or currently has an active diagnosis of familial or pure hypercholesterolemia. Next slide, please.

The next set of questions is specific to the MH-1 Depression Remission at Twelve Months. "If a patient has a diagnosis of bipolar disorder, in May of 2016, can they be excluded from the MH-1 Measure?" In order to use the denominator exclusion, an active diagnosis of bipolar disorder must be documented in the medical record during the denominator identification measurement period, which for the 2017 submission period falls between the dates of 12/1/2015 and 11/30/2016, or the measurement assessment period, which would be determined 12 months, plus or minus 30 days, from the index date. So in the case of an active diagnosis of bipolar disorder in May of 2016, this would be a denominator exclusion if it falls within the denominator identification measurement period. For the second question, "If the patient was diagnosed with a personality disorder in May of 2016, but the abstractor finds no evidence of this in October of 2016, the index date --" So, apparently, this is the date where there was a PHQ-9 greater than 9 -- "and forward --" So they're not finding the personality disorder on October 2016 -- "and forward when the first active diagnosis of major depression is found, would it count as an exclusion?" And the answer to this question is, a personality disorder noted in the medical record in May of 2016 would qualify as an exclusion since it is documented during the denominator identification measurement period. The diagnosis of personality disorder would have to be considered an active diagnosis during the denominator identification measurement period in order to count as a denominator exclusion. Active diagnosis is defined as the diagnosis that is either on the patient's problem list, a diagnosis code listed on the encounter, or is documented on a progress note indicating that the patient is being treated or managed for the disease or condition during the measurement period. Next slide, please.

And then we're going to the next couple of slides -- going to be kind of going through some scenarios and examples, as well as providing some definitions and some clarity of definitions for the MH-1 Measure. So, the denominator identification measurement period, as previously stated for the 2017 submission period -- or 2017 program year, 2018 submission, is 12/1/2015 to 11/30/2016. The index date is the first instance of an elevated PHQ-9 greater than nine, along with a diagnosis of depression or dysthymia. This index date will occur during the denominator identification measurement period. So, in this case, you'll see we have a May 1 index date. This would be our first instance of a PHQ-9 greater than nine during the denominator identification measurement period. Next slide, please.

The measurement assessment period starts at the index date and looks forward 12 months, plus or minus 30 days. Twelve Months is defined as the point in time from the date that a patient meets the initial population-inclusion criteria, a diagnosis, and a PHQ-9 score greater than nine extending out 12 months, and then allowing a grace period of 30 days prior to and 30 days after this date. Remission is defined as a PHQ-9 score of less than five at 12 months, plus or minus 30 days, from the index date. The most recent PHQ-9 score less than five obtained during this two-month period is deemed as remission at 12 months. Values obtained prior to or after this date are not counted as numerator-compliant or as remission. So, we have a May 1, 2016 index date falls within the denominator identification measurement period, and a case where we're showing a remission on May 10th, which would be our most recent PHQ-9 score less than five, and this does fall within the measurement assessment period. We can use a PHQ-9 less than five on May 10 when our index date was May 1. Next slide, please.

Denominator Exclusions. Denominator exclusions for MH-1 can be selected any time during the denominator identification measurement period or the measurement assessment period. So, if you find an applicable denominator exclusion during the denominator identification measurement period, the 12/01/2015 to 11/30/2016, you can select the denominator exclusion. However, you can also select the denominator exclusion if it occurs during the measurement assessment period. This would mean you would need to know when your index date is so that you can look forward 12 months, plus or minus 30 days. Next slide, please.

And on Slide 25, we have a couple of scenarios that we can walk through. Scenario one, we have an index date, PHQ-9 greater than nine on 05/01/2016. We have a remission date of 5/10/2017, where the remission PHQ-9 score was less than five. In this case, the numerator reporting would be, yes, the patient has achieved remission. The second scenario, same index date, we have a PHQ-9 greater than nine, and, of course, these are all assuming that we have an active diagnosis of major depression or dysthymia. We have an index date, PHQ-9 greater than nine on May 1st. We have a remission date with a PHQ-9 less than five on 9/1/17. In this case, you would have to code "No" because the PHQ-9 less than five occurred outside the measurement assessment period. In other words, it occurred outside of the 12 months, plus or minus 30 days, that was established based on the 5/1/2016 index date. The third scenario, again with an index date PHQ-9 greater than nine of 5/1/2016. We have a remission date on 4/30/2017. This is within our 12 months, plus or minus 30 days. However, we do not have a PHQ-9 score of less than five. So, in this case, you would also code "No" because the score was not less than five. Next slide, please.

And the next set of slides are slides that are resources and where to go for help. Several of the resources here on Slide 2017 are resources on the QPP website. Next slide.

There are also resources listed out for ACOs, specifically listed out for the Medicare Shared Savings Program ACO, as well as the Next Generation ACO Model. Next slide, please.

And also, resources on where to get help from CMS. These are both all the ServiceNow Help Desk contact information, as well as the Medicare Share Savings Program ACO, Next Gen ACO Model, and Physician Compare e-mail addresses. Next slide, please. And I will hand it back over. Thank you very much.

Moderator: Okay. We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, dial 1-866-452-7887, and if prompted, please provide a conference I.D. number, which is 78689865. So, I guess to start, Paula, do we have anyone on the line?

Paula: And also for those that would like to ask an audio question, you may press Star 1 to enter the question queue. For your first question, your name did not record. Please announce yourself. If you have pressed Star 1 to ask a question, please announce your name. Okay, we'll move along. You have a question from Angie Massey.

Angie Massey: Hi. This is Angie Massey. We have done test uploads within the past two weeks, and we've noticed that if we make modification to the column headers that it doesn't necessarily pick up the column header has been changed, and I thought in the last webinar that you guys gave to us that it was reading those column headers. So, could you expand upon whether or not the column headers are being read, and, also, second part of that question is, if the columns are changed in order, what happens? Does the test actually default or error out?

Ralph: The column headers should remain as they are in the template. It actually looks for those column headers to associate the answers that are in the spreadsheet. So, we recommend that you don't change the wording in the column headers. They should remain exactly as they are in the template.

Angie Massey: And so, if they're modified in order, will there be an issue with uploading?

Ralph: When you say "modified in order," you mean shuffled around so that the columns are in a different order?

Angie Massey: Yes.

Ralph: We also recommend that you keep them in the order that they're in. We haven't tested shuffling the columns around in whatever random order or different order that you might have selected. We have tested narrowing down the spreadsheet to just, for example, a single measure. So, for example, if you include the beneficiary demographics, the patient confirmation information and then just CARE-2 column, that does work. We did test that. We haven't really verified and don't recommend shuffling the column orders around.

Angie Massey: Okay, and like we said, we modified the header nomenclature by putting in spaces, removing a word or two just to see if it would still upload, and it did still upload. So, I just wanted to give you that feedback that it doesn't error out, and then additional feedback. If we did have files error out, is there some kind of prompt or somewhere we can check to see what the errors are when the file does not upload?

Ralph: Yes. In the CMS Web Interface, if you have errors on your upload, an errors column will appear in the report-data area, and it will list the individual errors that are found in the file, and will also, when possible, give you pointers to the row and column that the error occurred.

Angie Massey: Right. That's only if the file actually uploads. What I'm concerned about is when the file itself doesn't upload. When you upload it and it gives you an error that the file did not upload, all it says is, "Error. Did not upload." It doesn't tell you why.

Ralph: If you encounter that, could you enter a Help Desk ticket and provide a screenshot of what you're seeing? And we'll try to help you individually with that error.

Angie Massey: Sure.

Moderator: And now we'll read a question from the chat. Someone says, "MSSP, Track 1, CARE-1 -- if evident that visit is post-discharge and med reconciliation is documented, but does not specifically state 'reconciled with discharge meds,' is this considered sufficient to meet the measure?"

Jessica Schumacher: Hi. This is Jessica Schumacher from the PIMMS Measures Team, and I'm really glad this is one of the first questions out of the gate because the QPP Service Center has received several questions related to this, and we're even starting to receive screenshots of specific examples, and, of course, you cannot send in PII or PHI, and it does take us a while to kind of wade through all the different scenarios and help provide guidance. So, we might upset a couple people because the measures investigation is very straightforward.

On Page 5, there's a list of requirements. One of them has to be met in order to be considered a medication reconciliation, and so [since this is] the first time answering this question today, I'm going to go through that list, and I'm going to provide just a couple of comments at the end. So, again, as long as the medical-record documentation meets one of the following requirements, it will be considered a medication reconciliation. And, again, this is from Page 5 of the Measures Specification. "Documentation of the current medication with a notation that references the discharge medication, documentation of the patient's current medication with a notation that the discharge meds were reviewed, or documentation that the provider reconciled the current and discharge meds, or 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, or the last option is that there needs to be notation that no medications were prescribed or ordered upon discharge. So, again, if you come across this scenario where you're looking at your medical record, and you're not sure if an item fits into one of these, just remind yourself if I'm not sure, what proof do I have in case it does come up for an audit? Is there enough documents or is my EMR -- Is the way my EMR pages set up, does it provide these points of data to meet one of these five requirements so

that if I were audited, I would say, "Well, here's my documentation. This is what I understand," and if you also have questions, maybe, for example, I think this specific question is geared towards Item Number 3, which is documentation the provider reconciled the current and discharge meds? Is the requirement, or if the medical record just says reconciled medications, that's not a complete comment that is required for this measure, but if later, there might be a second sentence or another paragraph that would confirm that both the current and the discharge meds were reconciled. If there is any indication that both the current and discharge meds were reconciled, then that would count, but if it's just a blank statement saying Med Recs or Medication Reconciled, then that wouldn't meet that Number 3 requirement -- both the current and discharge meds being reconciled. Thank you.

Moderator: All right. So, the next chat question, "Can you submit just the demographic information and one measure, or do you have to submit all columns?"

Ralph: Could you repeat the question on more time?

Moderator: Yes. So, it's, "Can you submit just the demographic information and one measure, or do you have to submit all columns?"

Ralph: Oh, excellent question. So, you do not have to enter all columns. The bulk upload mechanism will take whatever data that you provided and apply it to your submission in the CMS Web Interface. If columns are left blank where data's not reported, it just skips those, those cells. So, you can enter what data you have and upload, and then if you collect more data, enter that additional data and upload, you can upload as many times as you want to build up and accumulate the total submission.

Moderator: Okay, great. Thank you. So, next question -- An ACO has a question regarding the numerator for PREV-10, Preventative Care and Screening Tobacco Use. "Would legal marijuana be considered as part of tobacco use under this measure?"

Deb Kaldenberg: This is Deb Kaldenberg from the PIMMS Team, and the answer to that is, no. Marijuana is not considered for the 2017 program year tobacco and would not be part of this measure. I will say, as I've seen some other questions come in for the PREV-10 Measure, tobacco screening is both smoking and smokeless tobacco. So, ensure that your screening does include those. Simply asking if a patient is a smoker does not cover the intent of the measure as the measure intends to cover both smokeless and smoking tobacco. Thank you.

Moderator: Thank you, Deb. So, next question. "I have a low score for the DM Composite. Shouldn't the performance score be higher for the lower numbers since DM HbA1c is an inverse measure?"

Angie Stevenson: Hi. This is Angie Stevenson. The lower performance score would indicate the better quality on this measure. And, yes, it is an inverse measure.

Deb Kaldenberg: And this is Deb. The only thing I would add to that is if you are looking at your composite score, you want to ensure you're going to have a lower score for DM2, but in order to pass the composite, it is going

to mean that you receive the lower score for DM2 and the higher score for DM7.

Moderator: All right. Thank you both. The next question, "Do we need to send all patients just the minimum or can we send consecutive number between the minimum and the maximum?"

Rabia: So, this is Rabia, and I'll just please jump in. So, you're required to report on 248 consecutive beneficiaries. If you want to report on additional, that's fine. If you have less than 248, you must report on all that are available. I don't know if, Olivia, if you want to add anything else.

Olivia: Sure, yeah. It wasn't clear to me whether they were asking about actually submitting the data, like whether you could submit on a subset of the beneficiaries at a given time by uploading the Excel, but, yeah. As long as you complete every one who marked as in the minimum in the Web Interface for each measure, then you're all set.

Moderator: Great. Thank you. So, next question, "Do we have to submit data on all ranks for a measure? Specifically, can we submit 400 consecutive patients starting at Rank 1, or do we have to submit the entire ranked population for that measure?"

Olivia: This is Olivia, and basically the same answer that we just gave, because a previous question, which is as long as you kind of met the -- or completed -- all the patients that are ranked in the minimum in the Web Interface and marked as such in the Web Interface for each measure, then you'll have completely reported. One thing to note is that to the extent that you go beyond that and complete more patients, consecutively confirming and complete more patients than the minimum, those additional patients will also be used in calculating your performance rate.

Moderator: Okay. And, Paula, I think we can take one more question from the phone.

Paula: You have a question from Pamela Macks.

Pamela Macks: Hi. Can you hear me?

Moderator: Yes, we can hear you.

Pamela Macks: Oh, okay. Awesome. So, this has to do with IVD and denominator exclusion. So, the patients who have documentation of use of the anticoagulant medication overlapping the measurement year. So, you're in hospital, and you're on Heparin for a couple of days. Is that what overlap the measurement period means, or overlap means the whole year?

Angie Stevenson: Hi. This is Angie Stevenson from the PIMMS Group, and it would be during the measurement, during the whole measurement year, or any time during the measurement year.

Pamela Macks: So, any time. So, I'm in the hospital for a period of time. They put me on Heparin for those days that I'm in there, and that would then qualify as an exclusion. Is that true in that example?

Angie Stevenson: If it is Heparin during a hospital stay, and it was prescribed, it would meet the denominator exclusion. If it were used for the I.V. line, it wouldn't meet the definition, but it if it was actually prescribed, and they were on it for a time, but if it is just to heparinize an I.V. line, then that would not really mean.

Pamela Macks: Oh, okay. All right. So, there is a difference between those two. Okay. Thank you.

Moderator: All right. So, we have some more questions on chat. An ACO has a question regarding the numerator for PREV-6, colorectal cancer screening. "Would Cologuard count as a FIT DNA test?"

Jessica Schumacher: Hi. This is Jessica from the PIMMS Measures Team, and the 2017 narrative measure specification for PREV-6 identifies the following as an applicable test -- fecal immunochemical DNA test, which is FIT DNA. That is allowed during the measurement period, or the two years prior to the measurement period. And, yes, Cologuard is considered to be a FIT DNA testing. Thank you.

Moderator: Great. Thank you. The next question, "For CARE-1 Module, it showed an error on upload -- 'An internal error has occurred. Please see server logs.' When does that happen?"

Ralph: If you could just enter a Help Desk ticket with that information, we'll look into that issue.

Moderator: Okay. Next question, "When there was a 'Submit' button, we received a submission report. How is that going to be generated now that there is no 'Submit' button?"

Ralph: When the submission period closes on March 16th, that report will automatically become available to you, and it will be available for three years. So you can go back to the CMS Web Interface, and then the grayed-out button that wasn't available to you during the submission period will become available, and you can pick on that and see the report.

Moderator: Okay. Next question, "On several measures, N.A. is listed as an option in the Excel document, but the Web portal fails on these patients. The Web portal doesn't have N.A. as an option. Please advise."

Ralph: It's hard for me to diagnose that with the information provided. N.A. is a special -- Let me speak to it this way. N.A. is a special value available on the Excel Template to remove data that you've previously reported via the bulk upload. So if you've got -- For example, you put in an answer for beneficiary on a measure, and you no longer want to have that answer at all, you want to blank it out and all of that, then in the Excel Template use N.A. to remove a previously reported answer. N.A. is not a selection in the CMS Web Interface user interface because you simply would remove the answer using the user interface if you no longer wanted it.

Moderator: Okay. Thank you. Next question, "I downloaded the test data, made some changes, and then tried to upload. I got an error on the CMS portal that the format wasn't correct, but I hadn't changed the format from the download. Will this be an issue with live data?"

Ralph: We did have an issue around the providers that was impacting some users where if the provider's name had two parts to it, and there was a space in it, that was causing some problems. That fix was put out into the production environment and should no longer be impacting folks, so I suggest you try again, and if you still have the problem, then enter a Help Desk ticket, and we'll look into your specific issue.

Moderator: Great. Thank you. Paula, I think we can take another question from the phone.

Paula: Okay. You have a question from Rebecca Eastman.

Rebecca Eastman: Yes, hi. I was wondering whether or not there was going to be an official document like there has been before in years past that was the Q&As that they put out like in December or January?

Rabia: So, this is Rabia. So, the Q&As that we've previously produced in a separate document have been incorporated into the webinar space under the FAQ section.

Rebecca Eastman: Mm-hmm.

Rabia: I don't know, Ralph, if you could share anything further about that.

Ralph: Yeah. So, we do have the ability to add throughout the submission period additional information if additional Frequently Asked Questions come up, but our starting FAQs are loaded into the system, and if you go to the left-hand navigation towards the bottom, you'll see a choice that says "Frequently Asked Questions." When you select that, you'll get a list of topics, along with the information provided for those topics. So, you can scroll up and down and pick a topic and navigate directly to the relevant information for that topic.

Rebecca Eastman: Thank you.

Moderator: Okay. And we have some more questions in the chat. "Is there a way to delete an entry in Web Interface when working manually? It seems that you can only make another selection and fields can't go back to being blank."

Kim: This is Kim, and I can answer that one. So, in the webinar [Indistinct], if it's an input field where you would enter in the date or a value, then those can be deleted and saved as an empty value, but if it's a [Indistinct], there is no way within the Web Interface Data Entry to delete those, but if we don't need that [Indistinct], then we just ignore it. So, let's say you had chosen, like, a numerator answer, and then you change it that that patient is now skipped, then we would just ignore the numerator value that you had previously entered and would go with whatever question would make it stop and be skipped or whatever was needed for that question to be completed or skipped. However, with the Excel upload, you can use N.A. to clear out any values.

Moderator: All right. Thank you. Next question, "Does the discharge date need to be documented in the provider's EHR for CARE-1?"

Jessica Schumacher: Hi. This is Jessica Schumacher from the PIMMS Measure Team. Yes, the medical-record documentation must include the discharge date,

and it must be within two calendar days before or after the pre-filled discharge date. Thank you.

Moderator: Thank you, Jessica. Next question, "Will our beneficiary sample be the same as the one was in the testing phase?"

Sarah Grallert: Hi. This is Sarah Grallert from RTI. Yes, it is the same.

Moderator: All right. Thank you. "For PREV-9 for BMI, if you want to answer follow-up is not medically indicated, would that be considered a denominator exception even if it is not age-related?"

Deb Kaldenberg: Can you go ahead and come back to that one, and I will pull up that measure document?

Moderator: Yes. We can come back to that one. So, next question, "I have a Web submitter Interface role and am not able to see any test data in the QPP site. Is the test period limited for any particular role?"

Rabia: This is Rabia. No, it is not. If you could send that to the Quality Payment Program Service Center, we can look into that issue.

Moderator: Okay. And I think we can take the next question from the phone, Paula.

Paula: You have a question from the line of Nancy Adler.

Nancy Adler: Hi. Thank you. On CARE-1, we've noticed some of our discharge patients who were discharged from the hospital were admitted to our transitional care unit, which is a subacute rehab, so that's actually they were not discharged home, so then they would not qualify for that measure because they go to rehab maybe for two weeks? Do you hear me on that?

Jessica Schumacher: Yes, we hear you. I'm guessing they're trying to open up the CARE-1 document because there is some information in there that tries to speak to that, but, yes, we can hear you.

Nancy Adler: Okay. All right. Because we have a lot of that where then they'll go for maybe two weeks to rehab, and then they go home. So, the discharge statement there is not really an officially discharge date because then it's a subacute rehab.

Jessica Schumacher: Right. Hi. This is Jessica Schumacher from the PIMMS Measures Team, and I am looking into that right now. I'm sorry for the pause. If you want, you can come back to this, and I'll answer it in a little bit. Thank you.

Nancy Adler: Thank you.

Moderator: All right. So, another chat question. "Where are the details on end-to-end reporting documented? In the QPP Program, you can get bonus points for each measure you do end-to-end. Correct?"

Jessica Schumacher: Lisa Marie, is that something...?

Kim: Could you repeat the question?

Moderator: Yes. So, it's, "Where are the details on end-to-end reporting documented? In the QPP Program, you can get bonus points for each measure you do end-to-end. Correct?"

Kim: That is correct. That is correct you'll get end-to-end when reporting on Web Interface. If you could let me know which number that is, because we have, also, like, specific information relative to the rule. They want specific language. But you do get end-to-end bonus points when reporting to the Web Interface.

Moderator: All right. Thank you.

Deb Kaldenberg: And this is Deb. This is Deb. If you could go back to that PREV-9 question. I was finally able to get my computer to cooperate and open up that specification.

Moderator: Great. So, the question is, "For PREV-9 for BMI, if you want to answer follow-up is not medically indicated, would that be considered a denominator exception even if it is not age-related?"

Deb Kaldenberg: Okay. So, looking at the denominator exception, we have a recommended follow-up for an abnormal BMI is not documented for the medical reasons. And let me get back. We have our denominator exceptions. So basically, you have patients, elderly patients 65 years or older for whom weight reduction, weight gain would be complicated under other underlying health conditions such as, and then they provide examples. Those specific medical reasons are for the age population 65 or older, and then we also have the denominator exception for patients in an urgent or in an emergent medical situation where time is of the essence. So, it appears as if your question is really regarding that first set of reasons, and those reasons, illness or physical disability, mental health, dementia, confusion, nutritional deficiency are specific to elderly patients 65 years of age and older.

Moderator: All right. Thank you.

Jessica Schumacher: Hi. I'm sorry. This is Jessica Schumacher. I'm going to jump in again and just answer the live question that we just had regarding CARE-1, and I'm sorry it took me a while to pull that up. On Page 8 of the Measures Spec in the Denominator Guidance, the language does state that the measures be reported each time that a patient was discharged from an in-patient facility and had an office visit within 30 days of discharge. So if you have a patient who has multiple discharges or is discharged for a short period of time, but is coming back, the measure needs to be completed for each measure. Thank you. Or I'm sorry -- each discharge. Thank you.

Moderator: All right. Thank you both. So the next question, it looks like it's related to HTN-2. "If patients have a history of hypertension in medical record, but are unable to find an office visit during the measure period that patient was seen for hypertension, but the patient's current medications include an ACE, ARB, or beta-blocker. Since patients are on a medication that would treat blood pressure, would that be considered a current history of hypertension and quality for the measure?"

Deb Kaldenberg: So, for hypertension 2, you really do need to look for confirmation that the patient has a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to

the measurement period and basically where that essential hypertension does not end before the start of the measurement period. I believe on Page -- Looks like Page 7 of the Measures Specification, it will give you some additional information as far as if you're confirming that diagnosis or if you're looking for appropriate denominator exclusion. So, you would want to find not just documentation that the patient is on a medication, but that the patient does have an active diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period and that that diagnosis has not ended prior to 1/1/2017.

Sherry Grund: This is Sherry Grund with ACO PAC. The point that Deb just made is a very important one, and it's one we see confused quite a bit when we perform audit on your submission. So please heed her advice there.

Moderator: All right. Thank you all, and it looks like we have time to answer just one more question. So, the last question is, "Is it acceptable to change the clinician name if we find that the patient was actually seen by a different clinician?"

Olivia: This is Olivia. I can answer part of that. So, the provider names are solely provided to you all to help in kind of finding the medical records that might help you extract information on these cases. So, you are more than welcome to select another provider. Ralph, can you speak to how they would do that?

Ralph: I'm sorry. We were discussing another question here that was online. Can you repeat the question to me?

Olivia: Sure. Can you speak to how an organization could change the NPIs in the Web Interface? Is there a drop-down list, et cetera?

Ralph: Oh. So, there is a manage provider feature in the CMS Web Interface. If you got to the left-hand navigation, you'll see a selection that offers you the ability to manage your clinics and manage your providers. You can edit the providers that you have in the system. You can add new ones, and you can actually delete if you've gone through the steps to disassociate providers with the existing beneficiary list. So, you can manipulate your providers within the system.

Moderator: All right, and that concludes our Web Interface Support Webinar for today, so thank you, everyone, for joining.

Paula: Thank you, everyone. This concludes today's call. You may now disconnect. Speakers, please stand by.