Moderator: Hello, everyone. Thank you for joining today's Web Interface Support Kickoff Webinar. This series of webinars are for Accountable Care Organizations 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 the opportunity to ask CMS subject matter experts their questions. Please note that these calls will only focus on reporting data for quality performance category. We will not cover reporting data for the other performance categories during these calls. The presentation will be available on the CMS website after today's webinar. Now, I will turn the call over to Rabia Khan from the Division for Shared Savings Program, Performance-Based Payment Policy Group at CMS. Please go ahead.

Rabia Khan: Thank you and welcome, everyone, and thank you for joining us today as we kick off our support calls for ACOs and group practices who are reporting quality data to the CMS Web Interface. As Stephanie shared, I'm Rabia Khan from the CMS Department of Performance Based Payment Policy Group and an expert on our Shared Savings Program quality approach. We also have numerous CMS experts and contractors with us today to share helpful information on CMS Web Interface quality reporting and answer your questions during the question and answer session after today's presentation. As noted earlier, today is focused on quality reporting. But if you have ACI, advancing care information questions, the Quality Payment Program will be providing more information in the coming weeks. If you have questions, you can still contact Quality Payment Program service center with any of your questions regarding advancing care information or MIPS or quality reporting in general. Next slide, please.

Just really quickly, this is a disclaimer slide about this presentation. I just 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 Programs, your Shared Savings Program or next generation program regarding an update and information. Next slide, please.

Before going through the rest of the presentation, I'd like to go over some announcements regarding the web interface. So, please mark your calendars because on January 8th, the CMS web interface will be accessible through the Quality Payment Program portal. And you'll be able to use a test environment of the updated CMS web interface. From January 8th to 19th, you can use the web interface to test out your reporting, which includes logging into the web interface, downloading your sample, reviewing your sample, working on filling out your data in the Excel template offline, testing the upload functions, 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 web interface, and test any data you upload, or you'll be removing at the close of the test period. So, what will happen at the end of the test period is that, all of the data that you've inputted during the test period will be removed from the web interface. So it's not going to be available from January 20th to the 21st. Next slide, please.

And then the actual submission period is going to begin on January 22nd, and it will end on March 16th at 8:00 p.m. Eastern Time. So just to note that the submission period is an eight-week period. You will be able to save your progress in the system at each step. You do not have to hit a "submit to

CMS" button as was done in previous years. However, but what is different is that for this year, CMS will take the data that is submitted at the end of the submission period. So whatever is entered as of 8:00 p.m. Eastern Time on March 16th is what will be accepted as your data submission for web interface quality reporting. Next slide, please.

So, I just want to go over some resources that are available to you. The 2017 CMS web interface measure specifications are available in the QPP resource library. There was a revision to include updates to the prev five, six, and hypertension two measures. These are related to excluding institutionalized bennies. And that information can be accessible now through the website, and the link that's provided. We do have some instructional videos that are available for the web interface, including the user demonstration that was covered on November 29th, as well as the Excel template introduction. The other demonstration videos that are listed here will be available in the coming weeks. Next slide, please.

And just again, reviewing that we have weekly support calls throughout the submission period, and they will actually be kicking off on January 17th. And they are occurring on Wednesdays from 1:00 to 2:00 p.m. Eastern Time. So if you have questions, our CMS experts will be on those calls to answer questions that you have during the time period. Next slide, please.

We can skip to the next slide.

And just really quickly, I'd also like to review the reporting requirements for the various programs. So, organizations which include group practices and ACOs must completely report the required number of beneficiaries in order to satisfactorily report, which is the minimum of 248 consecutively confirmed and completed beneficiaries in each module, or 100 percent of beneficiaries if they're fewer than 248 available in your sample. Satisfactorily reporting all 15 CMS web interface measures will allow groups and eligible clinicians participating in an ACO to avoid the 2019 MIPS negative payment adjustment. Next slide, please.

For Shared Savings Program and next generation ACOs, if the ACO fails to satisfactorily report all measures, it will not meet the quality performance standards and will be ineligible to share in savings earned. And more specifically for TINs participating in a shared saved program ACO that fails to satisfactorily report the CMS web interface measures, you'll get a payment -- you'll get a MIPS quality performance for zero unless they report separately from the ACO either as a group or solo practitioner TIN. There are more -- there's a lot more information provided in the Shared Savings Program and MIPS interactions guide that's available on the Quality Payment Program research library, and the link directly to the guide is available on this slide. I urge anyone who has questions regarding the interactions between the Shared Savings Program and MIPS to review the guide. Next slide, please.

All right, and now I'll turn it over to Ken Howard, who's going to review some information on EIDM and access.

Kenneth Howard: Good morning and afternoon. I'll be presenting, thank you. So I wanted to touch base at a high level first. Anyone who has participated in PQRS or previous years' programs will be very familiar with the process in which to get your credentials, and we'll board your organization for participation and web interface. We're using the same process flow, so a lot

of the terminology is related on the previous quality programs. We'll be using EIDM, so going through this, each organization will have to establish a security official or an organization, so your primary TIN that you will be reporting under. For ACOs, it will be your ACO I guess registered TIN. And for group practices, it will be whatever TIN is representing the group practice as a whole. This should be the same information as related to your registration that you did last year. The organization as you define it, if you're an ACO, you will go through the dropdown menus once you choose the provider approval role. You will select the ACO security official role. Register your TIN and go through the approval process. If the information that you fill out on that approval process is not accurate as to our records, you will be kicked to a manual process. In which case, we will have help desk personnel verify the information that you're entering and try and approve you through a manual process going forward. So please fill out those forms as best you can and accurately as you have shared with us in the past. For the group practice organization, it's a very similar process. You're required to register your group if you're new or verify that you have an active account as a security official. If you're an existing, using your TIN -- combinations of your group crisis. Somebody's speaker is on. Anyway, if this information matches, you'll be automatically approved as an organization and establish your first security official role. That is the path of least resistance. If you fail that combination three times, you will again be moved to the manual process for onboarding. Again, we'll verify the information with you and have the help desk reach out and establish your role. Next slide, please.

So, this is a slide document sending you to where the proper onboard documentation is located. This information again has not changed from last year. So if you're an existing group practice or ACO, it'll be very familiar to you. If you're a new organization, this'll give you detailed screen prints of the process you need to follow if you have a question at any point in the process. Once your organization has been registered through using this documented process, you will then have to have your individual people who will be uploading your bennie sample information and manipulated data within the web interface. Acquire the web interface submitter role. The SO that registered your organization will be the one who approves those requests. So I just want to be clear about that. It's two steps. Again, any question about these processes, you can either send e-mails to the support desk, or call them directly, they will be more than happy to walk you through any complications that you have. Next slide, please.

Okay, so I'm sorry. This is just additional documentation. Again, very detailed information about the onboarding process system establishment of roles. They've been very useful in the past. I highly encourage anyone, especially the new participants, to go out and look at this documentation as it's pretty accurate as to what you need to follow. Next slide, please.

And here is that contact information. So the QPP support center, if you have difficulties or have specific questions that you need addressed, please do not hesitate to reach out in any one of these manners in order to get your questions answered. Next slide. And I passed the ball to Ralph.

Ralph Trautwein: Good afternoon. I'm Ralph Trautwein. You can go to the next slide.

The steps I'm about to walk you through are included in the recorded CMS web interface demonstration. We have slides here to show you step by step the

process for entering the CMS web interface. The red arrows on these images are just to direct your attention to locations that you're going to click on or enter data. So to get into the CMS web interface, you're going to have to first sign in. So you'll select sign in on the Quality Payment Program screen. Next slide.

And here you'll enter your EIDM credentials. There'll be a place for your ID and password, and then you'll select the sign-in button. Next slide.

Entry requires two-factor authentication. And a second factor will be sent, a code will be sent to your cellphone. You'll have to enter that code here. And then once you've entered it, press submit code. Next slide.

Now if you're an ACO, when you reach the account dashboard, you'll see something that looks like this. There'll be a list of APM entities, and you'll have a start reporting button. You're one click away from entering the CMS web interface. Hit start reporting. Next slide.

And here you see the landing page, the initial landing page for the CMS web interface. On the left-hand side, there's an area of navigation that includes a variety of menu choices like viewing your progress, reporting data, viewing reports, managing your group, and frequently asked questions. And there's a timeline that helps you understand where you are during the test and submission periods. Next slide, please.

If you're a MIPS group, then you have a few extra steps. You're going to, on your account dashboard, select report as a group. Next slide.

Okay, once you've reached this quality scoring screen, you're going to pick quality measures, and then start reporting. Next slide.

And then from this screen, once you're into the quality scoring areas, you're going to pick "go to the CMS web interface." Only users that are groups that are registered for the CMS web interface will have this selection. It's actually doing a look up against the registered groups for the CMS web interface to supply this button. So if you're not registered for the CMS web interface as a group, you will not have this button. If you are, you will have this button. Select go to the CMS web interface. Next slide.

And here you reach the same type of landing page that we saw for ACOs for the CMS web interface. It has the same left-hand navigation, the same timeline, and the same choices. But you'll be in for your group that you registered for. Next slide.

There's some additional CMS web interface resources that are available to you. They're on the resource center. Next slide.

And I'm going to hand this off to Catherine.

Catherine Hersey: Thanks, Ralph. Next slide.

So I'm going to talk a little bit about the assignment and sampling process as it pertains to the web interface. Next slide.

Next.

So, the CMS web interface allows MIPS groups and ACOs to report data on a predetermined population of patients. So this section, we're going to talk a little bit about how we determine that population of patients. Sorry, back to the slide before this one. So, there's three main components to this. And this slide represents the broad strokes of that process. And you can think of it kind of like a funnel, right? So the first thing that we're doing is we're looking for beneficiaries that are assigned to your organization. And we'll talk in more detail about that in the next slide.

And once we figure out who's assigned to your organization, we're going to look at those beneficiaries and see if they're eligible for quality reporting. And that includes things like, are they eligible for the measure that we're asking you to report on. And then once we figure out who is both assigned and eligible for quality reporting, we'll then take that remaining universe of beneficiaries, and we'll pull a sample of them into the applicable measures. And those are the beneficiaries that get loaded into the web interface for quality reporting. Next slide.

Next slide, please.

So, assignment is a process of determining which beneficiaries are attributed to an organization. And we do this using a predetermined algorithm. It's a little bit different depending on the particular program that you're in. But generally speaking, they all use some flavor of plurality of primary care services. One thing to note is, in many cases, a beneficiary who is assigned to an organization in one reporting year may or may not be assigned to that same organization in following reporting years. So if you've done this multiple years in a row, you won't necessarily see the same beneficiaries that you saw in a previous year. And for CMS web interface purposes, if you're a Shared Savings Program, we're very specifically using the beneficiaries that were assigned to your ACO as of the third quarter. So we're using the third-quarter assignment file. If you're a next generation ACO, we are using alliance beneficiaries updated for exclusions as of the second quarter. And if you're a MIPS group practice, we run assignments for you, and we use claims data through the end of October. Next slide.

Slide 29, please. So this page gives you links to the different assignment methodologies. As I mentioned, it's a little bit different depending on your program. So if you're a MIPS group practice, you can go to the QPP website. If you're a next generation ACO model, you'd want to go to the innovation center. And if you're a Shared Savings Program ACO, you would want to look at them, the Shared Savings Program website. For the specific details on how assignment works for your particular organization. Next slide, please.

Next.

So, now we're going to -- we talked about assignment. Now we're going to go into a little bit of detail of assignment. I'm sorry, of sampling. So, we just talked about how we figure out who to assign to your organization. And now that we know who those assigned beneficiaries are, we need to figure out which one of those are going to be sampled into the web interface. So, assignment beneficiaries may be sampled into one or more CMS web interface measures. We do this using a three-step sampling process. So the first step in sampling is we have your assignment beneficiaries, and we figure out if they're eligible for quality reporting. And in this context, it specifically means, are they alive? Right cause we don't want any beneficiaries who have

died in the sample. Were they in hospice care? Because that would make them ineligible for the sample. Did they move out of the country? Because that would make them ineligible for the sample. And lastly, anyone who's enrolled in an HMO is not eligible for the sample. So the first step in sampling is to pull out all of those beneficiaries who don't meet that basic criteria. The next step is with whoever's left. We figure out which of those beneficiaries are eligible for the different denominators. So there's 13 this year. We'll go through and figure out which of the beneficiaries meets criteria for which of these measures. And what we're left with is a pool of beneficiaries who have been assigned that we know meet general eligibility criteria, and we know which measures those beneficiaries are eligible for. And then from there, we pull a sample of beneficiaries for each measure. Next slide, please.

Sorry, guys. I think I'm having a little bit of a lag with my slides. So, a little more information on sampling. As I mentioned, each measure is going to have its own sample of beneficiaries. In other words, each organization is going to have 13 samples of 616 beneficiaries. It's also going to have a sample of 750 beneficiaries for the statin therapy measure. That one measure gets a sample that's a little bit larger. Sometimes you'll hear us refer to a beneficiary's rank. And all that is, is a beneficiary's place in the sample. The person ranked first happens to be the first beneficiary we pulled into the sample of that measure. It has no other significance from a sampling perspective. Each organization is required to confirm and complete data entry on 248 consecutive beneficiaries for each measure. One thing I will note is there will always be some cases where a given measure, there just aren't 616 beneficiaries to fill up your sample. In those cases, we'll give you as many as we can find. Similarly, there'll be some cases where there just aren't enough beneficiaries that hit 248. In those cases, your obligation would be to report on as many as are available to you. For more information on the details of the CMS sampling methodology, you can go to the resources library on the QPP page, and there is a sampling methodology document available there that provides all of the additional details. So, now I'm going to pass it off to another CMS colleague to talk about beneficiary download and Excel upload.

Ralph Trautwein: Hello. I'm Ralph Trautwein again. You can go to the next slide.

So once you're in the CMS web interface, it's very easy to work with the Excel bulk download and upload process. On the left-hand side, there's a report data area, the left-hand navigation. Select report data. Next slide.

And you'll see an area on the report data screen for downloading your sample and for uploading your dad. On the left-hand side, you're going to pick download. Next slide.

And you'll be offered two choices of download. The first choice is beneficiary sample without data. This choice always gets you back to your original sample without change. So if you ever want to see your original sample without any data changes made to it, you'd select that. Most often, you're going to pick beneficiary sample with data, which will include not only your beneficiary sample, but all the data that you've submitted to the CMS web interface to date. Select that. Next slide.

It'll ask for a confirmation. Do I want to proceed with the download? Hit download. Next slide.

Okay. Next, you're going to populate the spreadsheet that it provides you with data. Your beneficiary sample will be included in the spreadsheet, and things that you can't override through the spreadsheet will be a slightly grey color. Things like the beneficiary's name, their Medicare ID, things of that nature. You won't be able to change through the bulk upload process. For values that you can change, the cells will be available to you. There will be frequently, for those cells, dropdowns that help you to populate those cells with the correct values. There will also be helpful tips in the spreadsheet. Once you've entered your data, and it doesn't have to be fully populated to submit. You can submit any amount of data at any time through the Excel upload process, and you can submit as often as you like through this Excel upload process. Once you populate it, the data that you want to submit, next slide.

You are going to next either drag and drop it to this Excel upload area, or pick browse, and find the file that you want to submit to the CMS web interface. Next slide. It'll ask you to confirm that you want to perform this upload. Click upload. Next slide.

And then a progress pill will pop up to show you where you stand with the upload process. All of the data that's included in your Excel spreadsheet is processed real-time during the upload process. So the file is transferred to the CMS web interface. And the progress of processing that data is shown to you in this little progress pill. Next slide.

Once you've completed the upload, you can check for errors. And there will be an errors column on the report data page. But if you've encountered any errors, it'll show you exactly what they are. So in this case, I created an error. I overrode something that I shouldn't have touched. I typed over a Medicare ID and put something else in there. And created an error in my spreadsheet so that you can see what errors look like. Once you've corrected those errors -- and the errors will help you. It'll give you rows or columns to help guide you to exactly where the issues is. Once you've corrected the errors, then you can go back and upload the spreadsheet again. Next slide.

Okay, I'm going to pass it off now to Jessica.

Jessica Schumacher: Thank you, Ralph. This is Jessica Schumacher. I'm a CMS contractor with the PIMMS contract team. And in this next section, we would like to review the measures resources that are available on the QPP resource library website. And we'd also like to go over some frequent questions that have been coming in through the QPP service center. Next slide.

So first on slide 43, we'd like to go over the 2017 web interface measures and supporting documents. Again, all of which are available on the QPP resource library through a hyperlink that's entitled Web Interface Measures and Supporting Documents. And this link is located about halfway down the page on the resource library. The first document that we have listed on this slide is the 2017 CMS web interface measures list. And this list provides the following information for the CMS web interface measures, including measure number, measure title, alternative measure numbers for other programs and the measure owner. The next resource that we have listed is the narrative measures specifications which include the performance flows. And the measure specifications is a PDF document. There's going to be one PDF for each measure, and one for the DM composite. These measure specifications include the measure ID, NQF number if applicable, description, improvement

notation, initial patient population information, the denominator, denominator exclusions and exceptions, the numerator, numerator exclusions, definitions, and the measure guidance. It also includes the measure rationale, clinical recommendation, and the visual flow with performance rate calculation algorithms. The next bullet is the CMS web interface coding documents. The coding documents are Excel workbooks. And there's one document for each module. So for example, you'll see one workbook for PROV, and another one for care and so forth. The coding documents list codes related to the denominator, including exception, exclusion, and exclusion drug codes if applicable. It also lists encounter and numerator codes, including exclusion drug codes if applicable. And real quick, we wanted to know that the coding documents do provide a lot of information that support the measure specifications. So we strongly recommend that you have them available during abstraction. Just for a quick example, if you're extracting data for IVD 2, which is use of aspirin or other anti-platelets and want to know if Coumadin is an appropriate exclusion, then you would open up the IVD coding document. And then you would click on the denominator exclusion drug codes tab at the bottom of the document. And you would search through the list of drugs, and you would see the generic brand for Coumadin which is Warfarin. And you would be able to count that, then, as an exclusion. Also, we want to note that in previous years, the coding document used to contain more information. In an effort to streamline the documentation, the measure document, which is the PDF that we talked about before, now includes the specification, submission guidance, and the flow. So the coding document, which is the Excel document, only provides the coding lists. So we just want to call out that new change. The last item on slide 43 is the release notes. And this provides a list of existing measures and changes to the measures that have been made since last year, which they were -- the 2016 GPro web interface narrative measure specification. Next slide.

So on slide 44, you will see a list of measures that were recently updated. And these updated measures and supporting documents are currently available on the QPP resource library website. And they were posed on November 28 of 2017. As mentioned in the announcements at the beginning of today's webinar, the current posting -- I'm sorry, the current posting from November 28th includes changes to prev-5, prev-6, and HTN2. So first we want to talk about changes that were made to prev-5. This measure was updated to include 3-D mammography, so now the following codes are listed in the prev coding document. And that includes codes 77061, 77062, and 77063. Prev-5 was also updated to include the place of service exclusions, which we'll talk about more in detail on slides 45 through 47. The second measure that's listed that was updated is prev-6. And this measure was updated to correct the coding document. As numerator code 81528 for fit DNA was inadvertently mislabeled as CT colonography. The place of service exclusion, which we will discuss next, was also added to this measure. The third measure that was updated is HTN2, and that was updated to also include the place of service exclusion. And lastly, MH1 is being updated to correct the numerator instruction to indicate that you should report the most recent PHQ9 score that is less than 5. And we will talk about this update in more detail on slide 50. Please note that the revised measure specification will be made available on the QPP resource library in the next couple of weeks. We're estimating around December 22nd, but this might change a day or two. So, please be sure before abstracting to make sure you reference the most recent measure specs that are available on the QPP resource library. Next slide.

So starting with slide 45, we'd like to talk about the 2017 place of service codes that were recently updated. And we're going to go through this in a

little more detail, and we're going to base it off a question that came in through the QPP service center, just to highlight how this change might affect those of you who are currently looking through medical records and starting to get ready to abstract. So a recent question was, please provide information about the exclusion for patients 65 and older whom are residing in long-term care facilities or special needs plans, SNPs, in the below guidance. And the guidance reads, "The national community for quality assurance, NCQA, has informed CMS of updates to the following CMS web interface measures. ACO 20, which is prev-5, ACO 19, which is prev-6, and ACO 28, which is HTN2, we will apply an exclusion for patients aged 65 or older, in institutional SNPs or residing in a long-term care facility for each of these measures. Next slide.

And the answer to this request is, the following codes have been provided by the measure steward for use with the measure. And the first code is place of service 32 for nursing facility. And the definition of a nursing facility is a facility with -- I'm sorry. A facility that primarily provides residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities. The next place of service code is 33 per custodial care facility. And this is a facility which provides room, board, and other personal assistance services generally on a long-term basis. And which does not include a medical component. The third place of service code is 34 for hospice. A facility other than a patient's home in which palliative and supportive care for terminally ill patients and their families are provided. The fourth and final code is 54 for intermediate care facilities, intellectuals with difficulties. And that's a facility which primarily provides health-related care and services above the level of custodial care to individuals, but not does not provide the level of care or treatment available in a hospital or CMS. Next slide.

And slide 47, I'm sorry, continues on to the final code which is place of service 56. Psychiatric residential treatment center. And that's defined as a facility or distinct part of a facility or psychiatric care which provides a total 24-hour, therapeutically planned and professionally staffed group living and learning environment. And just to note that this coding will be utilized during the sampling process of patients into the CMS web interface. Plain lines where the place of service code is equal to any of the above values will not be used in the process to identify beneficiaries for those measure samples. If a patient is noted to have medical record documentation of being institutionalized and is in your sample, then you may exclude the patient. If the patient turns age 65 at any time during the measurement year and in SNP or residing in long-term care with a place of service code of 32, 33, 34, 54, or 56, any time during the measurement period, they would be excluded from the denominator for the measures. Next slide.

So next question that we've been seeing a lot coming through the help desk a lot is regarding ACO 12 Care One, which is medication reconciliation, post discharge. And the question that we see coming in reads, "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? And the answer is identified in the numerator guidance of the measure spec, which is on page nine. Medication reconciliation post discharge may be completed during the telehealth encounter, and therefore, can be performed over the phone within 30 days of discharge. There must be documentation in the outpatient medical

records that includes evidences of medication reconciliation and the date on which it was performed. Medication reconciliation is defined as a type of review in which the discharged medications are reconciled with the most recent medications in the outpatient medical record. Next slide.

And continuing on that, any of the following evidence meets the criteria. There could be documentation of the current medications in a notation that references the discharge medication, such as no changes in meds since discharge, same meds at discharge, or discontinue all discharge meds. Or there could be documentation of the patient's current medication with a notation that the discharge medications 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 reviewed both lists at the same date of service. Or there could be notation that no medications were prescribed or ordered upon discharge. And just a quick note, at this time, NCQA considers physicians, prescribing practitioners, registered nurses, and clinical pharmacists as eligible professionals for Care One data submission, as long as these providers take responsibility for the documentation of the medication reconciliation. CMS does not dictate their internal processes for gathering this information. Next slide.

The next question that we see a lot is regarding MH1, ACO 40, depression remission at 12 months. And a typical question will read, "the 2017 MH1 measure specification states that we report the index PHQ9 score that is greater than 9 is as correct? Should actually be reporting the follow-up PHQ score and date from the measurement assessment period." And this person is correct, that you should report the most recent follow-up PHQ9 score that is less than 5, which indicates remission, and the date of administration that was 12 months plus or minus 30 days, which is roughly 11 to 13 months after the initial PHQ9 that had a score greater than 9 which sets that index date. Please know that the numerator instructions in the specification have been updated for the 2017 performance year. And again, that update measure spec is in the process of being posted and will be made public in the next couple weeks. Next slide.

On slide 51, we're going to go over ACO 20 prev-5, breast cancer screening. Again, this is a measure that has been recently updated. And a frequent question that we're seeing is, what needs to be taken into account, a 3D or 2D mammography? And we just want to reiterate that either a 3D or 2D mammography will count for this measure. The intent of this measure is that starting at age 50, women should have one or more mammograms every 24 months with a 3-month grace period. And as stated by the submission guidance on page 8 of the measure spec, those screenings includes breast x-ray, diagnostic mammography, mammography, or screening mammography. Please note that the numerator guidance in this specification has been updated for 2017 for performance year. And that updated specification is currently available on the QPP resource library. Next slide.

And we just have a couple left, you guys. On slide 52, real quick, a frequent question regarding colorectal cancer screening. The question reads, the measure specification states that code 81528 is CT colonography and should be reported every five years. I believe the 81528 code may be mislabeled and should be the color guard code and be included in the fit DNA time period of three years. I heard this was a mistake in variable name, and we could report 81528 as fit DNA and use the three-year period. Can you confirm this three-year logic is correct? Yes, the variable name should be

fit DNA code, not CT colonography code for CPT 81528. The variable name and code for CT colonography, which is 74263 are correct in the prev coding supporting document. Please utilize the appropriate time frames for the testing submitted. And this numerator code has been corrected in the coding document for prev and is currently available on the QPP resource library. Next slide.

On slide 53, we have a common question regarding prev-8, ACO 15. Pneumococcal vaccination status for older adults. And the typical question goes, "when the patient reported pneumococcal vaccination prior to the availability of PCV 13 from 2010, is the type of vaccine required to meet the measure?" And the answer is, the medical record documentation should state the year up to the last day of the measurement period. And the type of pneumococcal vaccine provided. If the patient reported prior to 2015 documentation indicating receipt of a pneumococcal vaccine is sufficient. If patient reported in 2015, 2016, or 2017, documentation indicating the year of the vaccination and confirmation of the type as PPSB23 or PCV13 is required. Next slide.

And this is our last example. It's regarding ACO 42, prev-13, statin therapy for the prevention and treatment of cardiovascular disease. The question reads, "would the following terms qualify the patients for denominator inclusion? Hyperlipidemia, dyslipidemia, and high cholesterol?" And the answer is no. These terms would not be considered confirmation of denominator eligibility for prev-13, risk category 2. The coding provided is specific to familial or pure hyper cholesterol Imia. And this coding is considered to be all-inclusive. In order to be considered denominator eligible based on the LDL-c value in category 2, it must be documented as an LDL-c value greater than or equal to 190. And before we move on, before I close out my section, we just wanted to have one more note. For prev-13, we just want you to know that the 2017 CMS web interface will not automatically skip an ineligible beneficiary for this measure. So this means that you must manually verify that the beneficiary is within age range and LDL-c range for risk category three as specified in the denominator section of the measure, which is page six. And I believe that's the end of my section. Next slide.

Oh, I think I have one more, you guys. I'm so sorry. No, I think I'm done. Great, I'm all done. So I'm going to hand it over to my colleague, Allison Peel.

Allison Peel: Thanks, Jessica. We wanted to be able to put kind of in one section of the presentation where you could go for resources for help. So we've listed some of those here. And you'll notice that some of these may be a repeat of what you've seen previously in the webinar slides today. Next slide.

So, slide 56 talks about general resources. Of course, we have the QPP help and support page where you can find a wide variety of information. The website includes videos and webinars, online courses, developer tools, and in-person assistance tools. The QPP website also has the resource library or a link to the resource library which contains all of our measure specification documents, our supported documents, user guides, the Excel spreadsheet template, assignment methodology guides, sampling methodology guides, as well as other instructional videos. Next slide.

If you're a Shared Savings Program ACO, there are specific areas and resources in which you can go for help. We have those listed here, including

the website, program guidance and specifications, as well as the ACO portal link. If you're a next generation ACO model, we also have the links available here for you to the website as well as to the portal. Next slide.

There are a variety of e-mail addresses in which you can reach out to get questions answered. There's always the QPP service center. E-mail and phone number here for Medicare Shared Savings Program ACOs. There's a specific e-mail address and same with next generation. For questions regarding physician compare, we've also listed the e-mail address for you there. And I think that that's it. I believe we're at the end of the presentation.

Jessica Schumacher: Stephanie, we'll go ahead and close out the presentation. We'll hand it back to you for the Q&A session. Thank you.

Moderator: We are now going to start the Q&A portion of the webinar. Please focus your question on the topics reviewed on today's webinar. You can ask questions via chat or phone. To ask a question via phone, dial 1-866-452-7887. Again, the number is 1-866-452-7887. If you are prompted, please enter your ID number of 72086432. Please hold for your first question.

Moderator: While we wait for people to dial in via the phone, we'll take one quick chat question first.

This question has come in a couple times. Where can we find information on the top ten and top NPIs for each beneficiary?

Sarah Grallert: Hi, this is Sarah Grallert from RTI. I can take this one. So, there's a couple places you can find that information for the ACOs, we will be transferring over their beneficiaries ranking files on January 8th. That will include detail on both all of the top NPIs and provide information and top TINs. That information is also available right directly within the web interface.

Moderator: Okay, great. Do we have anyone on the phone lines yet?

Our first audio question comes from Jason Shropshire.

Jason Shropshire: Hi, can you hear me?

Moderator: Go ahead.

Jason Shropshire: Yes, I have just a couple of quick questions. So my first question is, for those of us who did GPRO web interface submissions in the past, there was a numerology that went along with exclusions, numerator confirmations, exceptions, like, 17s, 4s, 2s, 1s. How is that going to work with the new Excel template? And when can we get a copy of that numerology?

Ralph Trautwein: So there isn't really a numerology that corresponds to what you've used in the past. The questions and answers are in the Excel template. And so you'll be able to pull down the selection that's available to you in terms of answers to the various measure questions in the Excel template itself.

Jason Shropshire: Okay. Basically you're saying that that numerology doesn't apply now. It's just a yes/no?

Ralph Trautwein: Correct.

Jason Shropshire: Okay. So my second question is an assignment question. So I have a tax ID who is part of a next generation ACO. And some of the providers within the next generation ACO are participating, and some are not. We will be reporting MIPS as a group TIM for those providers who are not participating. However, those participating providers will be in that TIN. Because again, it's just one TIN. So my question is, can you be assigned patients that are part of the next gen ACO, and they would also be part of our regular tax ID since we have this hybrid providers who are participating and not participating in the ACO?

Catherine Hersey: So, this is Catherine Hersey from RTI. And I have a question for you. What you were describing, you are certainly not the only person in this situation. When we do assignment and sampling, we look specifically at the TIN NPI combinations in your ACOs participant list. We see your point. If that TIN also shows up as a MIPS group practice, then it's very possible, you might have some claims overlap, and you could very well see the same beneficiary in both samples.

Jason Shropshire: Okay, great, thank you.

Moderator: Your next call to your question comes from Kate Kilroy.

Kate Kilroy: Hi, this is Kate. Can you hear me?

Moderator: Go ahead.

Kate Kilroy: Okay, great. Can you please explain the parameter for the bonus points for uploading data to the web interface via the Excel template? I believe that it was previously communicated that bonus points were only available for EHR data that was directly extracted from an EHR and not modified.

Ralph Trautwein: So, there are a variety of ways of getting data into the Excel template. You can do so programmatically. If you have IT resources who can orchestrate such capabilities. Or you can enter it manually into the Excel template based off of your electronic health records. And the information you have there. But it gives you the capability to do all reporting. So you can gather your information offline, populate it into the Excel template, and then upload it all at one time for all the information that you've gathered. Either by programmatic population, or by manual population into the template.

Kate Kilroy: Great. Regardless of how we gather, we can earn the bonus.

Correct.

Kate Kilroy: Awesome, thank you.

Moderator: Your next question comes from --

Questioner: Hi, this is -- Thank you for taking my question. Can you hear me?

Moderator: Go ahead.

Yeah, so my question is, regarding the Excel template, like as one of the gentlemen just mentioned, we can populate the Excel template automatically. So I would like to know that, do we need to honor the merging of the column? And the rules which are available on the Excel sheet. Or we can just make sure that we populate the right data in the right column, and the system will still accept the file.

Ralph Trautwein: You will need to preserve in your Excel template the headers and columns that are present. If you want to divide up the rows of data. Say for example, you want to order the data by rank, what's ranked in care one and take all those beneficiary rows and give them to somebody in the template to work on, and then order by care two. And then give those rows in the Excel spreadsheet to another person to work on, you can do that. They can submit those data sets separately. But the template itself cannot be changed. You can't change the columns, and you can't change the headers.

Questioner: Okay, yeah. I have another follow-up question. The clinic ID column, right. So when we download the files, right, where does the clinic ID column will be populated with the proper TIN when we download this file from the CMS web interface.

Ralph Trautwein: So the information that's included in the beneficiary sample for the clinic ID will be supplied if it's included in the beneficiary sample.

Questioner: I didn't follow that, please. Hello?

Ralph Trautwein: Hi, so I don't believe that the clinic ID is a TIN. It's not a TIN. It's not an NPI, but it's a unique identifier assigned to that clinic.

Sarah Grallert: Hi, this is Sarah. Go ahead.

Questioner: I'm sorry, go ahead, yeah, please.

Sarah Grallert: This is Sarah Grallert from RTI. The clinic ID can be a TIN. It often is, and it can also be a CPM.

Questioner: Okay, yeah. Like last time, we had capability to download a file based on the measure ID -- sorry, based on just a measure or based on a TIN. So this time, like whenever we download, we will get everything at once. We don't have that option for now on this new tool.

Ralph Trautwein: If I'm understanding your question right, you're asking, can I limit what comes into the download? And the answer to that is no. You get everything. You get your whole beneficiary sample in the download. If you want to get your beneficiary sample without any data that you've supplied to date, you can do so. There is a choice for that. But it is your entire beneficiary sample that's downloaded. If you want to get the download with everything you reported to date, there's a choice for that, as well.

Questioner: Okay, thank you. Thank you for that information, yeah.

Moderator: Your next question comes from Amy Allred.

Amy Allred: Hi, can you hear me?

Moderator: Go ahead.

Amy Allred: Thank you for taking my question. We developed software application to complete the GPRO process internally. We're in a rush this year to revamp our application to convert all the formal XML tags to the appropriate Excel headers. Also converting all the numeric answers that we used last year to the alphabet text options that are in the Excel template. Last year, we were able to just simply push the XML format straight out of our database. And this year, they're going to have to change to that the Excel process. So my question was, the headers that are in the Excel format, there's also a grouping above each header. Does that have to be uploaded, as well, or can just the header such as Medicare ID, clinic ID, et cetera, be uploaded?

Ralph Trautwein: Both headers, it's a dual header, will need to be in the template. The first row, which groups the information, and the second row, which are the individual columns will both need to be in the template.

Amy Allred: Okay, thank you very much.

Moderator: Your next question comes from the line as Steve Daniels.

Steve Daniels: Hello. Similar to a couple of the last callers. I'm a software vendor that is programmatically generating this file. And I have a couple of questions similar to the previous callers. So the first is, can software vendors get access to a demo or a test environment to be testing the file format? And that would be an environment that's not tied to a participating TIN or ACO.

Sarah Grallert: So no. Only users who have the correct EIDM accounts and roles can get into the web interface and be able to access the test environment. The security official or ACO security official has to be someone from the organization. Which means the group practice or the ACO. Now, the web interface submitter role is approved by the person from the organization. That security official. And that may be a vendor, but it has to be associated with that organization. So no, you can't –

Steve Daniels: So there's no alternate demo environment that's not tied to a civilian group.

Sarah Grallert: Right.

Steve Daniels: Okay. My second question, I noticed in the demonstration videos that when a user indicates an exclusion or an exception or contests a denominator inclusion, there's a support ticket column. Can you explain what that is about? Is that about submitting evidence via support ticket or something like that?

Sarah Grallert: So, in the web interface, if an ACO or group practice is seeking a CMS approved skip, what is required for that skip is also the Quality Payment Program service center ticket number associated with that request and approval.

Steve Daniels: Mm-hmm, and can you give me an example of what might qualify as a skip?

Sarah Grallert: If Carol or Deb or someone from measures, give an example, like a CMS approved skip request?

Debra Kaldenberg: Sure, I can give you one that was used last year. Last year, we had a situation with the 3D mammography. And NCQA did not consider the 3D mammography numerator compliant for prev 5. So in the 2016 submission period, we would get requests to skip patients that had received a 3D mammography. And those were approved. Typically, it's very unusual circumstances where you might have a situation. Again, there was a period of time for prev-5 where the gender was inadvertently identified as female, but you found the patient was really male. In past years, you could not automatically update that within the system. So a skip was used for that. So it's just gonna be some unique circumstances that you may find were the quality action may not have occurred, but the patient is considered denominator eligible. We don't really know what those might be this year, as some of the frequently asked CMS approved reasons to skip have been kind of updated. So IDD 2. If a patient is on Warfarin in previous program years, that was either a skip or a fail. At this time, we now have a denominator exclusion, I believe, is how that's identified. So, a skip is no longer required for that.

Steve Daniels: Got it. Okay. Thank you very much. And my last question is related to error handling. So I saw a screen shot that showed examples of errors in the file. For example, beneficiary not found. And my question is, will the file still upload if there are errors found, or will just those rows be rejected?

Ralph Trautwein: So the file will still upload if there are errors in it. And the data that is good will be used. But if there are errors -- Anything that has an error will not apply during that upload, and you will have to correct that error and reupload to get that data to actually be applied to your beneficiary sample.

Steve Daniels: Right. Thank you very much.

Moderator: Your next question comes from the line of Christina Phares.

Christina Phares: Hi, good afternoon. Hello?

Moderator: Go ahead.

Christina Phares: Okay. My question is, last year, the flu vaccinations, they were prefilled with a yes based on claims data. Is that something that's going to be prefilled on the data spreadsheets? Or will it only be available through the web interface?

Sara Grallert: Hi, this is Sara Grallert from RTI. I'm actually looking that up as we speak. It is -- it will be available on the web interface if we have the data available to be prefilled. As far as what's downloadable from on the MFT file is not located there. And then as far as what's downloadable -- right.

Debra Kaldenberg: I'm sorry. I was just going to say, maybe Ralph can address what is available in the Excel download from the load interface.

Christina Phares: Yes, that would be great because I had a similar question for the post discharge medication dates.

Ralph Trautwein: So yes. When you're downloading your Excel template, populated with your beneficiary sample, if there are flu vaccine information available for the beneficiary, it will be pre-populated into Excel template.

Christina Phares: Wonderful. Will that work the same with a Care One measure for the post discharge medication reconciliation dates?

Ralph Trautwein: Correct. So with the discharge dates associated with Care One, we'll be pre-populated into the template. And you cannot alter those dates through the Excel upload process. You fill in the information associated with those dates, but the dates themselves can't be altered.

Christina Phares: Okay, wonderful. And my last question. For the ischemic vascular disease, is the diagnosis code that is considered as an active ischemic vascular disease for the current year? Is that limited to the cabbage MI and PCI, or is there a list of other diagnoses that could fall under that active ischemic vascular disease diagnosis?

Debra Kaldenberg: So this is Deb from the PIMMS team. I would recommend that you go ahead and look at the coding provided in the IVD coding document that's posted. The coding provided in those documents is considered all-inclusive for the purposes of mapping to your EHR. They will also give you an idea of what diagnoses are considered appropriate. And then if you find you have a specific question during submission, where you have a diagnosis, and you're not sure, at that point in time, you could request -- open up a QPP service now help desk question, and we'd be able to review the specific circumstances.

Christina Phares: Okay. But if they're on the coding document, it's safe to assume that that would be acceptable as an active ischemic vascular disease?

Debra Kaldenberg: As long as it's on that coding document, and it meets the parameters required for that particular measure, it would be okay. If they're saying that that active diagnosis needs to be during the measurement period, you'd want to ensure not only do you have that diagnosis code, but it's also documented in your medical records as active during the measurement period.

Christina Phares: Okay, all right, thank you so much.

Moderator: Your next question from the line of Tyler Moser.

Tyler Moser: Hi, I just had a question about transition year for the CMS web interface users. I know that, are we required to submit all 15 measures during the transition year for the full calendar year, or can you just do two or three measures to avoid the payment adjustment?

Lisa Marie Gomez: Hi, this is Lisa Marie. So if you're utilizing the web interface, use your office key measures for a 12-month period. Unlike the other submission mechanisms where you're able to select, as you call it, pick your pace. That does not apply to the web interface.

Tyler Moser: Okay, and my next question was, according to the specific web interface benchmarks, are there any benchmarks specific to web interface? Because when you look on the resource page, there are claims, EHR and

registry benchmarks, but there's nothing specific to benchmarks for web interface.

Lisa Marie Gomez: This is Lisa Marie. There are benchmarks. And Rabia, I know the benchmarks are outlined in a particular document. Do you want to identify the name of the document?

Rabia Khan; Right, so as finalized under the Quality Payment Program final rule for 2017. They'll be using the Shared Savings Program web interface benchmarks. The benchmarks of the Shared Savings Program are available on our Shared Savings Program webpage under program guidance and specifications. It does include all of the benchmarks that we have for the entire Shared Savings Program measure set. But what's limited for group practices as really just as web interface measures. You will see when you get into the web interface what is being provided in there are also the benchmarks. So you'll be able to also see them as you're working in the web interface.

Tyler Moser: Thank you.

Moderator: Your next question is from the line of Leslie Alabi.

Leslie Alabi: Hi, thanks for taking my question. I'll limit it to one. So, I understand that there are medical exceptions for the BMI with follow-up plan. I'd like to find out if a situation would qualify as such. I know that some of our providers will determine through clinical judgment that a patient who is over 65 with BMI above normal parameters may not warrant a follow-up plan due to their clinical judgment. That the idea that they're losing some weight would not be to their benefit. Not due to any underlying serious diagnosis, but the notion that a little extra weight has been shown to be protective for elderly. I'll be curious what the ruling would be on that as a medical exception.

Debra Kaldenberg: This is Deb from the PIMMS team. Within the 2017 prev-9 measure document, within the denominator exceptions, it does identify that elderly patients 65 or older for whom weight reduction or weight gain would complicate other underlying health conditions, they give some examples. Those examples are not considered all-inclusive. So as long as there is medical record documentation that the provider feels like, you know, a follow-up for either weight reduction or weight gain for this particular patient 65 years or older is not applicable, would not be conducive. Again, as long as it's documented within the medical record, you could select the denominator exception.

Leslie Alabi: Okay, thank you.

Debra Kaldenberg: You're welcome.

Moderator: Your next question comes the line of Neil Lennertz.

Neil Lennertz: Hi. Two quick questions. Last year, we were an MMSP ACO, and this year, we are now a next generation ACO. As the transition, we have to register the next generation ACO, the TIN and the -- with new information. As a security officer, do I need to submit a new request as the SO for the new ACO name? And complete the registration there, or -- cause I don't think I can reuse the existing registration for the previous TIN.

Do I register the new TIN when I request a new security officer role?

Kenneth Howard: Hi, this is Ken Howard. For your EIDM and setting up your organization, so my first thing is going to be call the QualityNet help desk and help them walk you through to make sure everything that we're telling you is one -- I'm sorry, the QPP service center. Just to make sure everything I'm telling you is 100 percent accurate. But if you have your -- if the next-gen ACO is the same TIN as what the previous entity was, there's nothing you need to do. You are set up. The TIN is the identifier of the organization. So if you're a security official of the reporting TIN, you should be good to go. If the TIN changes, then you need to set up a new organization with the new next gen TIN. But again, verify this through the QPP service center. I don't want to mislead you, but again, we lock things in via the TIN of the reporting TIN.

Neil Lennertz: Okay, and second quick question. There are a number of side discussions between the two different versions of the XL file. One coming from the web interface, and the one coming from the manage file transfer. Will there be a template file for the version coming from the managed file transfer since that one has the provider NPIs in it?

Sarah Grallert: No, this is Sarah Grallert. No, there will not be a template provided. It will largely look like what you received last year.

Neil Lennertz: Thank you.

Moderator: Your next question comes from the line of Kate Kilroy. Go ahead, Kate, with your follow-up. Your next question comes from the line of Pradiva Arawong.

Pradiva Arawong: Hello, can you hear me?

Moderator: Go ahead.

Pradiva Arawong: Thank you for taking my call and my question. Just wanted to verify this. We are a diverse organization where we have a section, one of our divisions I find under the ACO, and there'll also going to be pulling data under the MIPS. So, one of the gentleman had mentioned there would be an overlap between the beneficiaries who are part of the MIPS and the ACOs because of the NPIs. Our question is, should we still submit data for these overlapping patients?

Catherine Hersey: So, this is Catherine. I'll try to clarify that response. There are cases, as I mentioned before, where a TIN can be both in a next generation ACO and registered for group practice reporting. It may be the case that a beneficiary or more overlaps. It really varies so you might have none overlapping at all. You might have a handful. You might have a lot. It's really hard to tell. Everyone's circumstances are a little bit unique. but to the extent that you are reporting as an ACO, and you also have one of your practices reporting under the MIPS program, if that beneficiary shows up in both places, and you need to complete them to meet your minimum recording requirements, you need to complete them in both samples. Does that answer your question?

Pradiva Arawong: Yes, it did, thank you.

Catherine Hersey: Okay.

Pradiva Arawong May I have another question?

Moderator: Go ahead.

Moderator: Yes, go ahead.

Pradiva Arawong: Oh, thank you. The other question, we just signed up another division of our sunder the MIPS. Apart from an existing one. And we wanted to know as a data submitter one, can one person submit data for both, for MIPS?

Rabia Khan: Just to clarify, you're asking if the web interface, the user has a web interface submitter role, can they submit data for two different group practices?

Yes.

Kenneth Howard: So, I need to follow up on this. My initial answer is no, you can only represent one organization. Once you associate as a submitter -- I know that's -- I saw a couple people asking this particular question in Q&As. I'm gonna follow up with a response after I do a little bit of research. But please stand by.

Pradiva Arawong: Sure, perfect, thank you.

Moderator: Okay, great, we will take one more chat question because we do only have about four minutes left. So our last question will be, for Care One, if there are several post discharge office visits within the 30 days from discharge, do you have to use the first visit to satisfy the measure, or can it be done at any of the visit in that post 30 days?

Debra Kaldenberg: This is Deb from the PIMMS team. For the discharge measures, so for care one, what you're going to answer is all of the prefilled discharges. So you may have three prefilled discharges, and you'll confirm each of those discharge dates within plus or minus two calendar days of what's prefilled. And then report whether or not there was a medication reconciliation completed. Now, it is possible you'll have a medication reconciliation that is within 30 days of more than one discharge. And it would be acceptable to use that for both. As long as it meets that 30-day requirement. And of course, all the other requirements identified in the specification. Thank you.

Moderator: All right, great. Well, thank you so much. And Rabia, we will transfer over to you to close the call.

Rabia Khan: All right. Thank you, Stephanie. I just want to thank everyone who joined us today for today's kickoff webinar. If we did not get to your question, I think there are quite a few in the Q&A box that have come up. We urge you to please send it to the Quality Payment Program service center, where you will get a response from the subject matter experts. I just -- before closing out, I do want to remind folks that web interface reporting will begin January 22, 2018, and will end March 16th at 8:00 p.m. Eastern Time, but you will be able to use the web interface for a test period starting January 8th and ending January 19th. So in order to do so, you will need your EIDM accounts and rules set up. The resources are provided in the slides and available through the various program communication methods for

the portals or the QPP research library. The slides for today's presentation will be provided shortly on the Quality Payment Program resource library. Thank you all again for joining us, and have a great afternoon.

Moderator: Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.