Hello, everyone. Thank you for joining today's Web Interface Support Call Webinar. This series of webinars are the Accountable Care Organizations and for groups that are reporting data to 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 the reporting data for the quality performance category. We will not cover reporting data for the other performance categories during these calls. Now, I will turn the call over to Rabia Khan from the Center for Medicare at CMS. Please, go ahead.

All right, thank you. And welcome, everyone. And thank you all for joining us today for our support call on Quality Reporting through the CMS Web Interface. I'm Rabia Khan from the CMS Medicare Shared Savings Program. And joining me today on this call are other CMS Web Interface experts and contractors who will share helpful information and help answer your questions during our Q&A session after today's brief presentation. Just as a reminder, today's support call is focused on quality reporting through the CMS Web Interface. If you have other questions regarding other aspects of reporting and reporting for MIPS, we urge you to please contact the Quality Payment Program Service Center to see if -- to submit your questions when you have a resolution. Next slide, please. All right. This is a disclaimer slide about today's presentation. Information on these slides are current at the time of this presentation, but we ask that you use and reference the source documents that are provided throughout the slides. Please stay tuned for any communications from the Quality Payment Program, Shared Savings Program, or Next Generation Program for any updates and information. Next slide, please. So, as a reminder, the CMS Web Interface Submission window opened on Monday, January 22 and will close on March 16 at 8:00 P.M., Eastern Daylight Time. It will remain open for eight weeks and we just want to add another reminder that, from prior experience from reporting, you may have previously, when you submitted data, hit a "click to submit data to CMS" button, just as a reminder, at the time, at 8:00 P.M., Eastern Daylight Time is when we'll take all of your submissions to date. There are no buttons for you to click to send or submit data to CMS this year. Next slide, please. Okay. So, we have some updates and announcements we would like to share with everyone. We do have some new documents that are now available in the QPP Resource Library. They include a data dictionary, which is a document appendage to further assist users as they prepare to report data using the CMS Web Interface Excel template. The information contained in the data dictionary reflects elements from the Web Interface Excel template. In addition, we've also posted an Excel to XML Crosswalk. So, under PQRS, users who previously reported through the Web Interface using XML, this document is pretty similar and provides a mapping of the CMS Web Interface Excel template field to the XML specifications under PQRS to assist those who are trying to report through the Web Interface and the previously used XML specifications. So, we hope that these two new resources that are available to you will be really helpful. And we urge you to take a look and refer to them as you're developing, you're sampling your data for reporting. And also, just as a reminder, we do have support calls each week during the submission period. They occur Wednesdays, from 1:00 P.M. to 2:00 P.M., Eastern Time. So, please join us for our remaining calls, where we'll do our best to answer the questions that you present to us. But again, if we do not get to your questions in today's call or any of the upcoming support calls, please send them to the Quality Payment Program Service Center. All right, next slide, please. All right, now I'll turn it over to Angie Stevenson to go over some helpful measure questions.

Angie, I don't think we can hear you.

Yeah, no, this is Deb. Her phone apparently just died, so let me go ahead. I'll do the frequently asked questions. This is Deb from the PIMMS contracts. If you'd do the next slide, please. So, the first frequently asked measure question that we want to cover today has to do with DM-7, the Diabetes eye exam. Here on the screen, we do have information that you will find in the posted measure document, including the description. Also included in the measure document is the fact that the eye exam must be performed or reviewed by an ophthalmologist or optometrist. However, be aware that, you know, if PCP happens to do the eye exam, as long as it was reviewed by the optometrist or ophthalmologist, that would be sufficient. This measure does permit the use of retinal imaging provided it includes the date when the fundus photography was performed and evidence that an eye care professional, again, the optometrist or ophthalmologist, reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. The eye exam may be patient reported, but in this case, it would require documentation of the year of the exam and the results or the findings and again, of course, you would have to somehow identify if it was an eye care professional that did the eye exam or reviewed the eye exam. Next slide, please. And so, for our first two questions on the eye exam, if a diabetic patient had a dilated eye exam in 2017, but the documentation does not mention diabetic retinopathy, is this acceptable? And in this case, the answer is yes, as long as the eye exam is documented as a retinal or dilated eye exam and it was completed in 2017, it would be accepted. You would also need to show the eye exam was performed by an ophthalmologist or optometrist, or results were reviewed by an optometrist or ophthalmologist. For the second question, for DM-7, we understand we can accept a patient reported exam as long as the patient reports the year of the exam and the results or the findings. In the case of an audit, does the medical record documentation of the patient's report suffice, or would an organization have to provide the actual report from the eye care professional? When utilizing the patient reported requirement, you would need to have the date, in this case, the year, and the result. When utilizing documentation in the patient record other than patient reported, you would need the date of the exam and the findings of a negative exam for exams performed in 2016 or the date of the exam if performed in 2017. The actual report from the eye care professional is not required. The medical record needs to support the exam was performed and reviewed by the eye care professional. The exam was a dilated or retinal exam, and if performed in the year prior to the performance period, the exam was negative for diabetic retinopathy. Next slide, please. And a third question on the eye exam. I'm writing regarding the diabetes composite Web Interface Measure. Composite confirmation guidance in the template that CMS provides states: "Does the patient have a documented history or active diagnosis of diabetes between January 1, 2016 and December 31, 2017?" Does this mean that documentation of history of diabetes or documentation of active diagnosis of diabetes must be found within the two-year time frame for the patient to be confirmed for the measure? If the only evidence of diabetes is before January 1, 2016, would we still include the patient in the measure? And the answer for this question is a diagnosis of Type I or Type 2 diabetes would need to be documented on the patient's problem list, be a diagnosis code listed on the encounter, or documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the measurement period or the year prior to the measurement period. If there is not medical record documentation of diabetes during 2016 or 2017 for the 2017 performance period, you should not confirm the diagnosis. Please refer to the denominator guidance for the Composite Confirmation on page 9 of the measure document. Next slide, please. And question number 4, we have a patient who qualifies for the diabetic measure. They are congenitally blind, so a retinal eye exam would not be warranted. What should we do with this patient? Mark the patient as NA? The 2017 DM-7 does not include denominator exclusions or denominator exceptions. According to the measure steward, in this case, NCQA, patients who are blind would often still require an eye exam. If you feel the patient should be disqualified from the denominator, you would need to request a CMS Approved Reason to skip the patient. Other CMS Approved Reasons should only be selected when approved by CMS. To request a CMS Approved Reason to Skip, submit a Quality Payment Program Service Desk inquiry providing the patient rank, the measure in question, and the reason for the request. A CMS decision will be provided in the resolution of the inquiry. Patients for whom a CMS Approved Reason is selected will be skipped and another patient must be reported in their place, if available. Next slide, please. And I will hand it over to Jessica Schumacher for resources and where to go for help. Thank you.

Thanks, Deb. Next slide. On slide 11, we have a list of resources that provides support and helpful information regarding the CMS Web Interface. Please visit the QPP Help and Support website. This is a stand-alone page that's available through the QPP website. And this help and support page provides support videos, webinars, online courses, learning networks, and more. Also, we strongly encourage that you visit the QPP Resource Library, which contains several CMS Web Interface materials. We understand that other organizations or companies may provide materials, as well, for support, but we strongly encourage you only to use those that are provided by CMS through the QPP website or through the ACO portals, as well, and we'll get to that in the next slide. But again, please visit the QPP website for Web Interface measure specs and the supporting documents, which are the coding documents and those coding documents contain the list of denominator, numerator, and exclusion codes and exceptions. And also, there's the Web Interface Support Webinars flyer, which provides the registration link to attend these webinars, Excel templates and so forth. At the end of this slide, on the bottom of slide 11, you'll see links to several new instructional videos that provide a walk-though of several features of the Web Interface. So, as you guys are becoming more familiar with the Web Interface and uploading data, if you have any questions along the way, please, please take a look at these videos, because they do provide a lot of helpful information. Next slide. And then on slide 12, we have resources for ACOs. Starting out with Medicare Shared Savings Program ACOs, there's the website link. Also, we strongly encourage you to review the program guidance specifications, and also the ACO Portal, and that provides resources, including the 2017 Quality Measures and Reporting Guides, the 2017 Quality Reporting Resource Map, and the 2017 Quality Reporting Checklist. And also, please keep an eye out for the weekly ACO Spotlight Newsletter, which includes a lot of updates and important information. Next Generation ACO Models, please visit your website and the Connect Site for any updates and additional information regarding Web Interface Reporting. Next slide. And on slide 13, as always, we just want to provide contact information for our help centers, starting with the QPP Service Center. Please contact the service center if you have any questions regarding measures, EIDM log in, functionality within the Web Interface. Also, we have the Medicare Shared Savings Program ACO, email contact on slide 13. If you have any questions about participation in ACO, please reach out to the Shared Savings Program email. Also, the Next Generation ACO Model email. If you have any questions, please contact them. And then also Physician Compare. If you have any questions about public reporting, please contact Physician Compare. Next slide. All right, and at this point, I believe we're ready to hand it over for the Q&A session. Thank you.

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. If prompted, provide the conference ID number 7-2-0-8-7-4-6-5. All right, so our first question is relating to PREV-12, depression screening. "If a patient has a positive PHQ-2 during the measurement year, does a negative PHQ-9 screening done after the allotted time count as a follow-up plan?"

Hi, this is Jessica Schumacher from the PIMMS Measures Team. And to address this, the measure specs states that the patient screened for depression on the date of the encounter using age-appropriate standardized tool, and if it's followed, there must be a follow-up plan documented on the date of the positive screen. So, first, we just want to make sure that for this encounter, that when the patient had the positive PHQ-2 during the measurement period, that on that same date as the positive PHQ-2, there was also documentation of a follow-up plan. And page 6 of the measure specification defines the follow-up plan and provides the following supporting information. The follow-up plan must be related to a positive depression screening. For example, the patient was referred to psychiatric evaluation due to positive depression screening. And some examples of a follow-up plan would be documentation that the patient -- And again, documentation on the date of the positive screening, that there will be additional evaluation for depression. There will be a suicide risk assessment, there will be a referral to a practitioner who is qualified to diagnose or treat depression. There will be a pharmacological intervention or other interventions or follow-up for the diagnosis of treatment of depression.

Thank you. And I'd just like to add something. This is Deb. In reading that question, if you did a PHQ-2 and then you later did a PHQ-9 and it's not on the same day of the encounter, as Jessica was discussing, that PHQ-9 would become your most recent screen. So, in that case, if it's positive, then all of the stuff that Jessica just spoke about needs to be true. If it is negative, then the intent of the measure has been met, because that PHQ-9 was a negative screen. If those two tools were used on the same encounter, you do a PHQ-2, followed by a PHQ-9, you've done a positive screen with your PHQ-2, your PHQ-9 then is your recommended follow-up and the intent of the measure has been met. But that would only be the case if those were done on the same encounter, the 2 followed by the 9. Thank you.

Great. Thank you both. This next question also pertains to PREV-12, depression screening. "Does the actual test name, ie, PHQ-2, need to be visible on the document to be accepted as as a screening? The questions are listed in the note."

Hi, this is Jessica from the PIMMS Measures Team. The measure specification indicates that the name of the age-appropriate standardized depression screening tool must be documented in the medical record. Now, based on this question, the last comment, that the questions are listed in the notes, we understand that there are instances where an EMR may have the PHQ-2 built in -- where the questions are built into the EMR system. And if that's the case, um, that would count. However, we do need -- we do need written policy in place at your office in case of an audit, just so that you can confirm that the provider using the EMR page, which had these questions is, in fact, matched back to the name of -- of the screen that they used. Thank you.

Thank you. The next question, "What are the auditable measures for the 2017 performance year?"

Hi, this is Rabia Khan from the Shared Savings Program. So, if your ACO is selected for audit following Web Interface reporting, any of the Web Interface measures could be selected for the audit, we will inform you if you are selected at that time, which measures we're auditing you for. And I think the same goes for Next Generation, except that all ACOs under Next Generation are audited.

Thank you.

All right, next question. "How do you remove data from the Web Interface system if it was mistakenly put in?"

Hi. So, if you upload it with your Excel template or you've entered data through the Web Interface via manual entry, there is one way to remove that data and that's with the Excel upload and putting an NA in the cell to wipe out that data that you've entered. So, if you put an NA in the cell corresponding to the data field that you want to remove entirely, to blank out, that will remove that data.

Thank you. And, Stephanie, I think we can take one question from the phone at the time.

Our first question is from Jason Shardshire.

Hi. Can you hear me?

Yes.

Yes, I have a question about the BMI measure, PREV-9. So, my question is, our EMR automatically calculate the BMI, even if the height and weight or both, are not taken on the same encounter and sometimes can go back like, even within a year. So, how do we treat cases where the BMI was calculated automatically, so it's present, but maybe the height was not calculated -- let's say, it was calculated nine months ago?

So, this is Deb from the PIMMS Team. The direction we have received in the past from the measure developer is it's okay if the height and weight are not done on the same encounter, but the height and weight do need to be done within the same six months. So, you know, your six months look back that you have, that height and weight has to be done within that same period of time. They understand they're not done at -- So, if you're nine months out, that would be a fail if you don't have an updated height and weight.

Okay. Thanks.

You bet.

All right, our next question, "How do you print a complete FAQ document in the Web Interface Portal? There is no 'print' icon and clicks does not work."

We apologize, but a print feature for the FAQs is not available in the CMS Web Interface.

All right, thank you. Next question is about Care-2, fall screening. "Does the verbiage in the note gait or no gait, count as fall screening?

Hi, this is Jessica Schumacher from the PIMMS Measures Team. So, in order to pass this order, the patient must either be screened for future falls or have a history of falls noted, or they must undergo a gait or balance assessment. If the verbiage gait or no gait is just descriptive of the patient's condition, then that statement alone does not indicate whether the future falls assessment was performed, whether there's a history of falls or whether a gait or balance assessment was performed. If the medical record documentation indicates that a screening or gait assessment was performed in addition to these statements, then that would meet the intent of the measure and you code yes. But if the medical record documentation does not indicate again, whether a future fall screening or gait assessment was conducted and does not indicate no falls, it would not meet the intent of the measure and you should code no. Thank you.

Thank you. Next question, "For med reqs for transitional care management, does the actual note need to say 'Medications were reconciled,' or something similar?"

Hi, this is Jessica from PIMMS. So, in the measure specification for Care-1, there's a list of the five criteria that would meet -- that would define a medication reconciliation. And there is the third option, would -- could apply. The documentation needs to say that the provider reconciled the current and discharge medications in order to meet the intent of medication reconciliation. There has to be documentation in that out-patient medical record that includes some type of evidence that the discharge medications were reconciled with the out-patient medications. And so, just based on this description that was provided in that chat box, I'm not able to provide it more guidance. There might be other situations that might apply if there's more language in the medical record. Also, if your organization has an EMR setup, that has, for example, uh, a medication list with headers and one header says "discharge medication," or the header says, "out-patient medication," and maybe there's a checked box that would indicate that the provider reviewed both lists, or if the EMR displays like current medications and the provider can indicate that they reconciled against the out-patient, if there's a setup in your EMR format that matches one of the five criteria that's listed in the measure specification for medication reconciliation, then those situations would fit the intent of the measure. So, if you have any more information about what's included in your medical record, please let me know or feel free to open up a help desk ticket. Thank you.

Thank you. Our next question is about PREV-8, pneumonia immunization. "Is it sufficient to have the type and date recorded in medical record if received outside of our clinic, where we would not have paper record and/or lot number, et cetera?"

Hi, this is Allison from the PIMMS Team. Yes, it is acceptable to have the date and the type of vaccine recorded. When the vaccination is given outside of the clinic, as well as when it's patient reported and it also can be reported via a telehealth encounter.

Great. Thank you. Stephanie, I think we can take a question from the phone.

Our next question comes from the line. Melissa Koonz.

Yes, I've got two questions. One is about the statin measure. We have found that a lot of our patients in the sampling have the diagnosis of just hyperlipidemia and not pure or familial. That are on statins, but we are doing a denominator exclusion, because the pure hyperlipidemia or the familial is not listed. Is that correct?

So, this is Deb from the PIMMS Team. Um, no, that wouldn't be correct, basically, in that situation. So, to take a step back. Make sure you're going through those three risk categories in order, confirming the ASCVD for risk category one. If the answer is no, looking at the LDLC value or the familial or pure hypercholesterolemia. And if the answer to that is no, you would move on to risk category three. And in that case, if you're answering all three risk categories no, that patient will actually be skipped and replaced. It's not a denominator exclusion in that case and we would not want you to confirm the diagnosis if you can't confirm that it's the pure or familial hypercholesterolemia.

Okay. And so, I probably misspoke when saying denominator exclusion. So, if we go through all of those and then get to the point where can't -- if it's not pure or familial, it's just in there as hyperlipidemia, it would end up being a skip?

It would be a skip if you can't confirm the LDLC values for the risk category two or the LDLC value, the age and the diagnosis, the diabetes for risk category three. So, yes, if you're saying no to all three risk categories and there's just the one piece you're wanting to make sure that, you know, I've looked at the LDLC value, I've looked at the diagnosis. I can't confirm it's pure or familial. Do I move on to risk category three? And that answer would be yes.

Okay. And then the other question is on the mental health one, the depression remission. We really started implementing using the PHQ nonconsistently in 2017. So, because it's a remission measure, we end up having to skip, because we answered no, that there's not a PHQ-9 on file. In the Web Interface, it's saying, you know, you have an oddly high number of skips, but have claims documentation that these people have depression. And we're not saying that they don't have the MDD, it's just that they don't have the PHQ-9. So, then it goes on to the next question. Is that a red flag there for any reason? I mean, we're just going to score low on it. It's in the reporting year. We've got plans implemented to improve that.

So, this is Deb. In regards to MH-1, basically, you know, you are skipping and replacing what you're identifying if you don't have a PHQ-9 greater than 9 during the denominator identification measurement period, is that they're not considered denominator eligible for that measure. I'm not sure if anyone else on the call wants to speak to whether or not this raises any kind of flags when you have high skips for MH-1.

CMS, did you want to make a comment on that or...?

Um, sure, could you just sort of repeat the question? I apologize.

Sure. The questioner was wondering if, because on MH-1, they've started now to use the PHQ-9, but much of their period of time that this tool covers has caused them to skip a lot of patients on MH-1, because for the whole year, they were not using the PHQ-9 and so they're skipping a lot of patients. So, they're getting that alert that indicates that they have a high number of skips for MH-1. And want to know if that's alerting us to anything or putting up a red flag?

Yeah, so, for the MH-1 measure, we are aware from previous years, as well, there are frequent skips related to not using necessarily the PHQ-9, but possibly other assessment tools. And do we understand under the Shared Savings Program and I think Next Generation ACO, the measure is pay for reporting, so as long as you complete reporting, you will get full points on that measure. But, yes, we do understand there are -- you may have higher skip rates than normal or as compared to other measures for this one. But, we do urge providers to be using appropriate assessment -- screening and assessment tools for people with depression.

All right, thank you. Next question relates to PREV-9, BMI. "Is a non-ambulatory patient excluded from BMI measurements?"

Hi, this is Angie Stevenson from PIMMS Team. Um, no, they aren't. Wheelchair-bound or amputees, non-ambulatory patients are not excluded. Um, if they would refuse the measurement of height and weight or refuse follow-ups, then they could be qualified for a denominator exclusion.

All right, thank you, Angie. Next question, "If a patient has a primary insurance of PPO and secondary Medicare, Part B, should they remain in the sample?"

Sure. This is Olivia Berzin from ACO PAC. So, the HMO enrolled exclusion is really intended to capture folks for whom Medicare is not the primary payer. So, in the situation you describe, it sounds like Medicare is not the primary payer and so you should select, "not qualified for sample," and the reason being "HMO enrolled."

OK. Thank you. Next question, "If you submit more than the required number of beneficiaries, consecutively and confirmed for a measure, can your MIPS quality score be improved?"

This is Olivia Berzin. And I can answer part of that and I'll defer to Lisa Marie for the scoring piece. But essentially, your performance rate for each measure will be calculated using all consecutively confirmed and completed beneficiaries, you know, to the extent that that improves or declines your performance rate actually depends on, you know, whether those additional beneficiaries were numerator hits, of course. But Lisa Marie, to the extent that they can increase their performance rate, how does that impact their MIPS scoring?

So, depending on, you know, what you report and also if you get bonus points, you'll -- you know, you can maximize your -- you know, the amount of points you get for quality, under quality. But essentially, if you meet end-to-end testing and you're able to meet all the different criteria, you're able to maximize your points. But again, you want to make sure you meet all the reporting requirements for each measure and then, like I said, to increase your points further is to get bonus points. But I think with Web Interface, those people who are just reporting through Web Interface, you're going to be getting, you know, a lot points compared to folks reporting via different submission mechanisms. So, I just want folks to be aware of that. But I think with Web Interface, you're actually able to maximize your points.

Great. Thank you both. Next question, "Can we upload the data in batches, i.e., multiple Excel uploads? Also, is it possible to edit the uploaded data?"

So, if I understand the question correctly, you're asking, can you put more than one spreadsheet together and the answer to that is, no, you should not do that. You should use the spreadsheet and the beneficiary list that's supplied. And if you are reporting for more than one organization, you have to select that organization and work within that organization's Excel template and beneficiary list to upload those beneficiaries. So, for example, if you have two organizations that you're working with, you enter the CMS Web Interface for one of those two and you work with the Excel spreadsheet that belongs to one of those two organizations. If you want to submit data for the second organization, then you have to reenter the CMS Web Interface with the second organization.

Right. Thank you. Stephanie, we can take one phone question at this time.

Our next question is from Samantha Brensickel.

Hi, I'm wondering for the BMI measure, if I have a patient that is a paraplegic and there's no weight found in the progress notes, can that patient be excluded from the measure?

Hi, this is Angie Stevenson from PIMMS. No, the patient cannot be excluded. If there is not a BMI calculated, documented in the medical record, then that would not meet the intent of the measure.

So, I guess I'm confused, because if a patient refuses to be weighed, that does count as an exclusion, though?

Yes.

Okay. All right, thank you.

You're welcome.

All right, our next questions is on PREV-7, influenza vaccine. "What is the measurement period for the two office visits or one preventative visit?"

Hi, this is Angie, again, from PIMMS. For 20-7 reporting, the measurement period for the two office visits or the one preventative visit, is during the measurement year. But the denominator includes only those patients with a visit October 1, 2016 through March 31st of 2017. That answer your question?

Okay. Thank you. Next question. I think so. Next question. "Our EMR has an immunization section. If the pneumonia vaccination is documented in this section of the EMR, will this meet the measure?"

His, this is Allison from the PIMMS Team. Yes, that will meet the measure. The documentation should be available at the point of care. But it can be, you know, in various places throughout the medical records.

Thank you, next question. "If dates of birth in the file initially provided by CMS are incorrect and abstraction has already begun, would the incorrect birth dates be corrected upon upload to the Web Interface or would the file be rejected?"

During a file upload, the areas in the Excel template that are marked in a light-gray color, are not changeable or are ignored by the CMS Web Interface if they are changed. The change is not applied. So, if you're using an old sample from the beginning of the test period when the date of births were incorrect, you can upload that sample. It will not change the date of births to the incorrect date of birth, 'cause you cannot change it by the Excel upload process. But we do recommend that you download the current sample so that you have the correct date of births associated with your beneficiaries in the Excel spreadsheet.

Thank you. Next question. "When uploading a file into the CMS Web Interface, does the file, the upload, have to have a specific naming protocol?"

There is not a naming convention. You have to use a valid file name for your Windows or Mac system when you create the file. But you can name it something that's meaningful to you. So, if you want to have several copies of the file, one for each clinic, you can name them as such when you do a "Save As," and the system will accept those files when you upload them.

Thank you. Stephanie, I think we can take one question from the phone.

Our next question is from Angela Farley.

Yes, ma'am, can you hear me?

Yes.

My question is on PREV-13. I'm getting a lot of kick-back from my auditors and my providers when they're looking at this measure in the third risk category for the diabetic patients who are between 40 and 75, having an LDL of less than 70, but they're on a statin. And they feel like if they mark that the patient does not qualify for that risk category, that that's going to be a skip that flags against them. Is that correct?

This is Deb from the PIMMS Team. Risk category three, if you have confirmed the patient has diabetes and you've confirmed the age and you've confirmed the LDLC value required for that risk category and I believe that LDLC value is greater than or equal to 190, so you've determined -- Oh, no, I'm in risk category two, sorry. Risk category three is the LDLC between 70 and 189. You've now confirmed the patient is denominator eligible. If you are also finding that that patient has a most recent fasting or direct LDLC value of less than 70, that could be used as a denominator exception. However, if that patient is on a statin, you do not have to select a denominator exception. You may select that the patient is on a statin. They're denominator eligible, they're on a statin. You don't have to worry about that denominator exception. That denominator exception is there for the patients that fall into risk category three as denominator eligible and they're not on a statin.

Okay. Thank you so much.

You're welcome. And if you need to have the information to kind of go back and reference for those that are questioning you, a lot of that information is on page 14 of the posted statin measure document, so the PREV-13 measure document.

Well, and I did read that and then the updates, it was in the spotlight, but it neglected to say anything about the patients who were below that LDL value and were on a statin. So, it's looking like that these patients are being excluded and my provider selector being penalized for having patients on statin, who are under good control. So, if we use that as an exclusion, then that would make them count as a skip, so I wanted to make sure that that was correct. But you're saying, if they're diabetic, in that age range, and they're LDL is less than the perimeters set and they're on a a statin, we can still select that?

Okay, no, I need to go back just a little bit. So, first, you're determining the denominator population and let's say, you've gotten to that risk category three, you're confirming they're between the ages of 40 and 75, a Type 1, Type 2 diabetic, with an LDLC result of 70 to 189, as the highest fasting or direct laboratory test in the measurement year two years prior. So, you have to have confirmed the 70 to 189 LDLC value. If the answer for that is no, that is a skip, even if they are on a statin. If the answer to that is yes, what we have then on page 11, that I was referring to, is a denominator exception, which, if a patient was not on a statin and they're most recent LDL was less than 70, then you can select the denominator exclusion -- denominator exception -- and that patient will be considered complete. So, that's one of the things that works a little different between those exclusions and the exceptions. An exclusion, you end up skipping and replacing, an exception, you are -- you've completed that patient.

Okay. Oh. All right. Well, that clarifies it. Thank you.

You're welcome.

All right, our next question is related to HTN-2. "The specification states, if there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading." And this person says they just want to clarify, "Does that mean that we are to use the lowest, even if they come from different readings? For example, 180/60 and 160/90, we would use 160 and 60?"

So, this is Deb from the PIMMS Team and that would be correct. You can "mix and match the systolic and the diastolic blood pressure readings from the same encounter.

All right. Thank you, Deb. And the next question relates to PREV-7 and PREV-8. "If flu and pneumonia vaccinations are recorded in the state immunization registry information system, is documentation in the EHR required? Is the registry considered an extension of the EHR if the registry is available to providers at the point of service?"

So, this is Deb from the PIMMS Team. Go ahead.

Go ahead, Deb.

I was just going to say, as long as you have access to that information at the point of care, you can use it. Basically, that would be the information that will be requested of you if you are audited for some reason. So, you have to have access to that information. But that's the main requirement, in that case. And, Allison, I don't know if you had something to add.

Uh, no. Thanks, Deb.

All right, thank you. The next question relates to Care-1. "My system has the hospital and ambulatory medications in the same list. If my visit type is hospital discharge follow-up and my provider states they have reviewed the medication list, is this compliant with the measure?"

Hi, this is Jessica from PIMMS. So, this would be compliant, as long as, the provider's stating that they reviewed the medication list, as long as whether it's a check mark or if it's a notation, as long as there's a policy in place that clearly states that the doctor checking that box indicates that the provider reviewed both lists on the same date of service, then that would meet the intent of the measure. And please note that that policy is going to be needed in the event of an audit. Thank you.

Right. Thank you, Jessica. Next question. "If I signed a patient whose name shows abbreviated in their CMS report, for example, Jackie instead of Jacqueline, that shows in our EMR, do we have to update it in the CMS website? Is an update a requirement or an option?"

This is Olivia Berzin. I can take that one. I would say, that's completely optional. If you're able to confer that it's the same beneficiary based on other things, like last name, date of birth, their Medicare ID, then there's no particular need for you to update it, unless that would be helpful for you.

Right. Thank you, Olivia. And, Stephanie, I think we can take one question from the phone.

Our next question is from Abram S. [Inaudible] Abram, your line is open.

Hello? Can you hear me?

Yeah, we can hear you.

Yeah. Can we upload the data in batches that is 100 patients at a time? Can we do that like multiple times? And once after we uploading it, can be edit it? Will there be option to edit it, because I'm saving it as an auto save to one? Can I repeat my question?

You don't have to complete all the data to submit data in an Excel bulk upload. You can partially complete data in the spreadsheet and still upload it. The system will accumulate the data that you've uploaded. So, if you report for 100 beneficiaries an upload and then report for the next 100 beneficiaries, then you upload, you'll have data for 200 beneficiaries in the CMS Web Interface. You can also go in and manually correct data. Or if you change something on your upload, the latest version of the data is the one that it counts. So, if you, for example, change the answer to a measure question for a particular beneficiary and a second upload, the system will use the second answer as the answer for that beneficiary.

Okay. Thank you so much.

All right, our next question is, "Are all the patients we are submitting data on all payers or just Medicare?"

This is Olivia. I can take that. I don't know if anyone else wants to weigh in, but these are just Medicare beneficiaries.

Okay. Thanks, Olivia. Next question, "Our hospital and out-patient offices are on the same EMR. We found two patients that had labs drawn at hospitals, but have not seen the provider. Is it appropriate then, to mark 'no medical record was found'?"

Hi, this is Jessica from the PIMMS Team. So, this is regarding Care-1. And thank you for this question. I'm going to assume, since they're on the same EMR, that you're able to confirm the in-patient facility discharge, so looking at the flow in the measure spec on page 13, after you confirm the in-patient facility discharge date is listed two more days before or after the prefill date, then you move on to whether the patient was seen within 30 days following this in-patient facility discharge. If you don't have an out-patient visit within 30 days following discharge, then you would code no to that question. And the discharge will be removed from the performance calculation for that measure. Thank you.

Thank you. Our next question is, "How do you earn bonus points?"

Hi, this is Lisa Marie. So, there's some ways to earn bonus points. One is like with end-to-end testing, which is an Excel upload. And then there's also ways, so like, for groups, also administering the CAPs from its survey. So, those are different ways. For ACOs, you're already required to do a CAP survey or Rabia, do you want to take that portion? But at least for groups, it's through end-to-end testing and also through your measuring CAPs.

Yeah, and this is Rabia. So, for the Shared Savings Program and for Next Generation, there's nothing really to the program to add bonus points. I mean, we do have, as a part of our process, looking at quality improvement and rewarding those who've improved performance from last year to this year. But in terms of bonus points, they're really applicable to MIPS, and so if you are subject to MIPS and you're participating in an ACO, our understanding is -- and Lisa Marie, correct me if I'm wrong here, but -- you are eligible to get the end-to-end reporting bonus if you are using Excel uploading for reporting.

Yes, Rabia, that is correct. The end-to-end bonus points that are obtained, which is through the Excel upload.

All right, our next question is relating to Care-1. "With medical records we have in our possession, what if we cannot confirm the in-patient encounter or discharge date? Do we select no when asked to confirm discharge date?"

This is Jessica from PIMMS. If the provider is not able to obtain the discharge date, then to the question, "Was the patient discharged from an in-patient facility on the discharge date listed, plus or minus two calendar days?", that's the question that you would code no to. And that patient then will be removed from the performance calculation. Thank you.

All right, Thank you. And I think that's all the time we have today for the Q&A session. So, I will now pass it off to Rabia to close it out.

Thank you. And thank you all for joining us today and asking such wonderful questions during our call. We do understand that we may not have gotten to every question that was sent to us during this call, but if we did not get to it, we urge you to please sent that to the Quality Payment Program Service Center and we'll be sure that we address your question. And I do want to remind folks, we do have a support call again next week. It's Wednesdays, from 1:00 P.M. to 2:00 P.M., Eastern Time. So, thank you all for joining today and have a wonderful day.

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