Hello, everyone. Thank you for joining today's Web Interface Support webinar. These webinars are for Accountable Care Organizations, ACO's, in 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. CMS will highlight important information and updates about reporting quality data, and provide ACO's and groups with an opportunity to ask their questions. Please note that these calls will only focus on reporting data for the quality-performance category. We will not cover reporting data for the other performance categories during these calls. Now I'll turn it over to Terri Ing from the Center for Medicare and Medicaid Innovation at CMS.

Thank you, Sandra. Welcome, everyone, and thank you for joining out support call on quality reporting through the CMS Web Interface for the 2017 performance year. As mentioned earlier, I'm Terri Ing, with the Next Generation ACO Model at Center for Medicare and Medicaid Innovation center. Joining me on this call today are other CMS Web Interface experts who will share helpful information and answer your questions during the Q&A session after today's brief presentation. Next slide. Disclaimer. This slide is a disclaimer and reminder that information in these slides are current at the time of this support call. We encourage everyone to use and reference the source documents that are cited and provided throughout the presentation. Announcements and updates will be shared at this support call. All your program-specific communication methods. So we urge you to please stay tuned to any communication from the Quality Payment Program, Share Savings Program, or the Next Generation program for updates. Next slide. So, announcements. We do have some announcements for today's call. We understand some users might still experience some problems getting access to Web Interface. Please contact the QPP Service Center. If you are a Shared Savings Program ACO or Next Generation ACO and have an outstanding ticket related to this, please send this to your original coordinator so we can assist you with resolving the issue. Previous CMS Interface support core materials are now available at the QPP Webinar & Events page. And the FAQ's, the Frequently Asked Questions, are now posted on the Web Interface, where the link where the QPP Webinar & Events page is. And for reminders, I'd like to go over some helpful reminders. As you know, the Web Interface admission window has been open since January 22nd. It will close Friday, March 16th, at 8:00 p.m. Eastern Daylight Time. There are ACO's and groups who have completed 100% reporting. And just want to remind everyone -- there's no submit data to CMS, but in the Web Interface this year we will automatically receive data that you enter in the Web Interface at the closing of the reporting period. Again, whatever data you enter into the Web Interface as of 8:00 p.m. Eastern Daylight Time on March 16th will be automatically submitted to CMS. I recommend that you check your reports and keep record of your progress and complete reporting. Also, we'll continue to have our weekly support calls from 1:00 p.m. to 2:00 p.m. Eastern Time each Wednesday. The last call will be on March 14th at 1:00 p.m. Eastern Time. So please do not wait until the last week, because these S.S. issues do require team assistance and resolution. And also, another reminder -- If you have questions for QPP, please send it to qpp@cms.hhs.gov only. Thank you. Now I'll turn it over to the next speaker.

If you would please go to slide six. Hello, everyone. My name is Sarah Grallert, and over the next handful of slides, I'll be walking through the process that we follow to select the beneficiaries that are populated into

each measure in the Web Interface. Essentially, there are three steps that we follow to accomplish this. First, beneficiaries are assigned to an organization. Second, they are assessed for their quality eligibility and denominator eligibility. And third, they are selected into the applicable measures and loaded into the Web Interface. Next slide, please. Assignment is the first step of this process. It uses a pre-determined algorithm to establish which beneficiaries should be attributed to an organization. A beneficiary assigned to an organization in one year may or may not be assigned to the same organization in the years that follow. For purposes of sampling into the Web Interface, and for the Shared Savings Program, we used third-quarter assigned beneficiaries. For the next-generation ACO program, we used aligned beneficiaries updated for exclusions off of the second quarter. And for MIPS Group Practices, we used assigned beneficiaries as of October 31st of 2017. If you'd like any further information regarding the assignments and alignment methodologies, please refer to the specifications that are linked on the SSP, NGACO, and QPP websites. Next slide, please. So, after beneficiaries have been assigned to an organization, we can begin our sampling process. The first thing that we do as part of that process is to determine if the beneficiary is eligible for quality reporting. And this includes looking for beneficiaries that have had at least two primary-care services provided within the ACO or the group, beneficiaries who have a full year of Part A and Part B Medicare eligibility, beneficiaries that are not in hospice, beneficiaries that have not passed away, and beneficiaries that live in the U.S. After determining their quality eligibility, we will look to see if these beneficiaries are denominator eligible. And this includes looking at denominator-specific criteria, such as age, diagnosis if applicable, and any visit requirements for that measure. Lastly, we will select a sample of denominator-eligible beneficiaries for each measure. Next slide, please. Each measure will have its own beneficiary sample. In other words, each organization will have 13 samples of 616 beneficiaries and one sample of 750 beneficiaries for the statin therapy measure. If we're unable to find 616 or 750 eligible beneficiaries, we will select all eligible beneficiaries for that measure. Each beneficiary will be assigned a rank in every sample into which they are selected. This is the beneficiary's place in the sample. Each organization is required to confirm and complete data entry on 248 consecutive beneficiaries for each measure, or 100% of the beneficiaries that have been selected into that measure if it's less than 248. If you'd like more information on how this process works, please refer to the Sample Methodology document that is available in the QPP Resource Library and is linked in this presentation. Thank you.

Hello. This is Angie Stevenson with the PIMS Measures team, and we'd like to share some of the frequent measures questions we've received through the Quality Payment Program Service Desk with you. Could we go to slide 11, please? Thank you. Question one is, May we disqualify a patient if they had a palliative-care consult but no follow-up for palliative care is scheduled? The answer is you may select hospice during patient confirmation if the patient is in hospice care at any time during the measurement period. This includes non-hospice patients receiving palliative goals or comfort care. If you question whether or not the patient is receiving palliative or comfort care, we recommend you reach out to the group or the clinician to determine the meaning of the notes in the medical records. Patients for whom "In Hospice" is selected in the CMS Web Interface will be removed from the sample and replaced. Question two is in regard to the CARE-2 measure. Will the statements "normal gait" or "no gait disturbance" in a medical record meet the intent of CARE-2? Medical-record documentation that indicates a gait or balance assessment was performed will count for meeting the extent

of the measure. Could we go to slide 12, please? Thank you. Question three is a clarification to the previous answer that was given at the webinar held last week on February 14th. The answer was correct and in accordance with the PREV-12 measure specification, however since the webinar, we have had discussions with the audit team and would like to provide some additional information that you may find useful in the event of an audit. Question is, If the patient was screened for clinical depression with the PHQ-9 and had a score of zero but the provider did not document a separate statement with the results as negative for depression, may we answer yes for the screening being performed and then to assume negative results because of the zero score? The additional answer is, in the event of an audit, it would be acceptable to select "Yes" for screening being performed and "No" for "Patient had a positive screen" if the medical-record documentation indicates that the PH-9 score was zero. You may only count the PH-9 score of zero if there's no notation indicating otherwise. And please note that if the medical-record documentation indicates that the PH-9 score is zero but the notation indicates that the provider believes the patient has depression, then you must take that notation into account over PH-9 score of zero. We'd also like to note, this is the only instance where it is acceptable to count the assessment score without medical-record documentation of provider's interpretation of the assessment as positive or negative. And if there's any notation in the medical record at the encounter of another screening score or that the patient is depressed, that information should be used over a score of zero. Our last question is for the MH-1 measure. If the medical-record documentation indicates depression instead of major depression, may we exclude them? The Diagnostic and Statistical Manual of Mental Disorders, DSM, published by the American Psychiatric Association, provides comprehensive criteria for mental-health disorders. In the DSM are several different diagnoses related to depression, one of which is Major Depressive Disorder. ICD-10 codes, that's 32 through 33. Therefore, the medical-record notation of depression is not indicative of Major Depressive Disorder. In order to exclude a patient from MH-1, there must be medical-record documentation of major depression. That concludes the Frequent Measures questions. I will now turn it over to Ralph Trautwein for CMS Web Interface Updates and Helpful Tips. Thank you.

Thank you very much. My name is Ralph Trautwein, and I'm going to go over helpful information that may help you in your reporting using the CMS Web Interface. Next slide, please. During the slides you're about to see, you will not see any protected health information or personally-identifiable information. All the data you're about to see is test data. So there are no real beneficiaries, there are no real Medicare I.D.'s, and the organizations are fake. Next slide, please. In one of the webinars, one of the folks asked if they could print the FAQ's, and at that time, we did not have printing capabilities available in the CMS Web Interface for the FAQ's. Since that time, we've added that capability. You can now print the FAQ's using the browser's print function. We do recommend that you observe the online and use the online version frequently, because FAQ's are subject to change, but you now have the capability of printing. Next slide. And here you see what it looks like when you go to print. So if you select your browser's print capability, you'll see that it formats the FAQ's, and it basically will print all of them for you. Next slide, please. So, contextual help. There are often questions about the answers that you want to place into a particular cell or value. Within the CMS Web Interface, there is contextual help. So if you're using the online Web Interface, you can get to that contextual help. It's usually to the right of the area that you're about to enter data in for. And you'll see a little "Show More." Not all of the

contextual help is displayed because there may be extensive contextual help there. So if you pick on the "Show More" -- next slide -- you may see a pop-up modal like this with additional contextual help information that will help you to understand what the answers to this question are looking for. Next slide, please. We've gotten some help-desk tickets around, "How do I fix an issue with one of my beneficiaries?" For example, if you're looking in your medical records and you notice that you got the right beneficiary but the gender does not match, or you've got the right beneficiary but there's a mismatch on the birth date, or you've got the right beneficiary and they've gotten married and they've changed their name, and you want to get the name accurate in the records, you can make changes in the CMS Web Interface user interface to these types of data. Next slide, please. So, here, within the "Edit Info" feature of the beneficiary, you can see there is a place to correct the name, correct the gender, and correct the date of birth. Next slide, please. Notice, however, that you may not do this using the Excel template. All of those fields are in a slightly gray color, meaning fields that are in a slightly gray color, like the Medicare I.D., the name, the gender, the date of birth, the ranks of measures, those cannot be changed through the template. Anything that's in this light-gray template color cannot be changed using an Excel upload. So if you want to change any of those values, do so within the CMS Web Interface. Please note that you can't change ranks anywhere, and you can't change the Medicare I.D. anywhere either in the system or with the Excel template. Those remain constant for your beneficiary throughout the reporting period. Next slide. Okay. I'm going to hand it over to Jessica.

Thank you, Ralph. So, real quick, before we go into the Q&A session, we're going to walk through some resources for the CMS Web Interface. Next slide. And these are the same slides that we've been showing the last couple of weeks, but we really want to reiterate that these resources are available, and for you or those that you're working with, if you could please review these resources to collect the full and complete information regarding these measures while you're abstracting. Beginning at the top of slide 23, we have the QPP Help and Support site. We also have the QPP Resource Library, which provides the CMS version of the 2017 Web Interface Measures specifications and supporting documents. And supporting documents mean the coding documents, which is that spreadsheet that has all the codes listed for exceptions, exclusions, and so forth. So we strongly encourage you to review those measures' specs and supporting documents while you're abstracting. Also, on the QPP Resource Library, we have the Assignment and Sampling fact sheet. We know that there are a lot of questions coming regarding Assignment and Sampling, so if you have any questions, please do visit those sheets for information on, "Why is this patient in my Web Interface?" Also, we encourage you to look at the QPP Webinar & Events site for the 2017 CMS Web Interface webinar materials. And posted under the January 24, 2018 webinar is the Questions & Answers document. And this is a document that's been provided. It contains frequently asked questions from groups throughout the years, and if you have a frequent question, we certainly recommend that you go there to see -- maybe it's been asked before, and CMS has provided an answer through this document. And for those of you who have not accessed these resources yet, we went ahead and sent a message to the chat box of the webinar platform with direct links to the QPP Resource Library and the QPP Webinar & Events page. If you have any questions about how to access this information, I'm not sure if we'll have time today to go through that, but please contact the QPP Service Center, and they can definitely walk those steps it takes to find this information. Next slide. Slide 24 has a list of Web Interface instructional videos. These videos were developed this year.

They provide a live walk-through demonstration on how to access and upload data into the CMS Web Interface. They are quick videos, so if you need a quick walk-through to learn about what you're doing and the final steps of getting data uploaded, please definitely take a look at these videos, as well. Next slide. On slide 25 are the resources for ACO's. And Medicare Shared Savings Program ACO's, starting at the top of slide 25, the information for you includes the websites and the program guides and specifications. Also, the ACO Portal, which provides the 2017 Quality Measurement and Reporting guides, the Reporting Resource Map, and the Reporting Checklist. We also strongly encourage you to keep an eye out for the ACO Spotlight Newsletter, which provides up-to-date announcements and important reminders. And same thing for Next Generation ACO's -- please check your websites and the Connect site and your weekly newsletters for important updates. Next slide. And slide 26 is going to be the last slide for today's presentation, and it lists contacts. If you do have questions, please reach out to QPP through the Service Center. The e-mail is qpp@cms.hhs.gov, or call 866-288-8292. And that concludes the presentation. Thank you.

Thank you. If we can turn it over to the next slide, please. We are now going to start the Q&A portion of the webinar. You can ask questions via chat or via phone. To ask a question via phone, please dial 1-866-452-7887, and if prompted please provide the conference I.D. number 72087468. So, our first question here is, "Is the BMI follow-up plan for values outside of normal parameters the same as a care plan? I.E. does nutrition counseling, diet, and exercise count as a BMI follow-up plan?"

Hello. This is Angie Stevenson. I'm sorry. The definition of the follow-up plan can be found on page six of the measure specs. Exercise counseling or nutrition counseling does count as a follow-up plan. Thank you.

Thank you. Our next question is, "Our practice only asks about tobacco use in the form, 'Do you smoke?' or 'Do you smoke tobacco?' with answers like 'Current,' 'Every day,' 'former,' 'never smoker.' Does this satisfy the tobacco-screen measure?

Hi. This is Ngozi with the Business team. No, this will not, because the intent of the PREV-10 Measure is to screen for smoking and smokeless-tobacco use. By asking "Do you smoke?" you're only really screening for smoking tobacco use only and not for the other type of tobacco use. Thank you.

And this is Deb. I would just add, if you screen and the individual answers that they are a smoker and you provide cessation intervention or counseling, that would be acceptable. But as Ngozi just said, if you are only screening for smoking and the answer is no, then you haven't screened for other types of tobacco, and therefore the intent of the measure would not be met.

Thank you. Our next question is, "Has it been decided which measures will be audited this year?"

Hi. This is Ravia. I come from CMS. So, no. For the Shared Savings Program and Next Generation ACO's, if you are selected for a Quality Measures Validation Audit following the Web Interface submission period, any of the measures that you're reporting on could be selected for that audit. When we do the Shared Savings Program, only a subset of ACO's are selected, whereas Next Generation all ACO's are audited.

Yep.

And when we communicate with you regarding the audit, we will identify which measures and include in there the process for how to provide us with the medical-record documentation and the timeline for that for our audit.

Thank you. This next question is about HTN-2. And this person is asking, if they had a patient with an office visit with a primary care provider at the beginning of one month, and then later that month saw a specialist, and blood pressure was documented on that first visit with the primary care provider but not documented with the specialist, are they to report the blood pressure based upon the primary care provider visit or the specialist visit? I think they're asking, too, about how the measure's specs say that they should use the most recent blood pressure.

Hi. This is Ngozi with the Business team. So, the Hypertension 2 measure, as long as the blood pressure is documented in the medical records, you may use the most recent blood pressure obtained during a visit to the practitioners office or other non-emergent outpatient facilities. Thank you.

Thank you. And, Sandra, I think we can take a question from the phone.

Yes. And our first question comes from the line of Jonathan Manquist with Elliot Hospital. Your line is now open.

Hi, there. Thank you. I had a question regarding, there's a common question, I think it's in row "L" most of the time. "Is the patient qualified for this measure?" And the way it came up is, PREV-7, you have to have two visits or one preventative visit, and we had sometimes now found no visits, and we were told that it was asked and answered in a previous webinar that this column should be pretty much all yeses based on the fact that CMS has already qualified the sample based on the number of visits they have and claims and everything. Is that true? Because we didn't know how to answer "No" when we found no office visits in our EHR.

This is Olivia from ECO. I can take a first stab at this. Essentially, yes, we agree that the previous response given is still correct. So, because there is claims evidence submitted by your organization of the qualifying visits, we don't think it's appropriate to skip patients because you were unable to confirm the visits took place since they were billed for. So, I don't know, CMS, if you want to weigh in on that, as well.

Yeah, this is Ravia. I just want to add, yeah, Olivia, you're correct. So, during our process for sampling, as we've noted earlier, we do identify, if you're a part of the Shared Savings Program or Next Gen ACO, we pull beneficiaries from your assigned-beneficiary population, and then beyond that, like Olivia said, we do identify eligible beneficiaries based on visits. So they have received care from your ACO participants, and we apply this visit rule, as well, for groups. So, we are, in our claims, identifying that these beneficiaries have been seen by these providers, and we do expect that, since they've been seen, that medical-record documentation is available.

So, I guess I'm just thinking audit readiness. If we don't find in our EHR, should we worry?

Well, I mean, for audit purposes -- and, Sherry Grund, please jump in here -- what we're going to look at is, we're confirming and matching what you've reported in the Web Interface with what you have documented, essentially.

Ravia, I'll help you out here a little bit.

Sure.

For Preventive Care 7, which is the Influenza measure, we're only going to be auditing -- and this is only if that information wasn't pre-filled as an immunization that was given and billed for from some source, which doesn't necessarily have to be from your ACO -- that one was given. So we're not going to audit that, because that could be out of your control, because it could have been given at a church, at a Walgreens, a different institution altogether that's not associated with you.

I'm breathing again. Thank you.

I'd have documentation of that in your records. But what we will look at are any "Yes" answers to that variable that were not pre-filled, and you determined through your medical-record documentation, or maybe from an immunization registry that you have access to, that that patient did receive an immunization. And those would be the subset of beneficiaries that we would want to have you send us some supporting documentation for in case they were a beneficiary that was selected, and you were selected for audit, and that measure was selected for you to be audited on.

That's fair. Thank you.

Yeah. And this is Ravia. Just to also add, for Shared Savings Program ACO's, we do select a subset of our ACO's for the Quality Measures Validation Audit, and some of our considerations are high anomalies, are high rates of, like, skips, for instance. So, high "Medical Record Not Found" skip rates could trigger your selection for being a part of our audit.

Yeah.

I apologize. I believe Jonathan's line was disconnected.

All right. Well, we will move on to the next question, then. So, the next question for PREV-13, "If a patient is allergic to a statin, they are a denominator exception, correct?"

This is Deb from the PIMS team. Yes, if you look at, I believe, page 24 of the PREV-13 measure document, within the table you have a statin-allergy code. So if you were finding that the patient is allergic to a statin medication, you can do the denominator exception, however there also needs to be the documented reason for not receiving statin therapy is due to that statin allergy.

All right. Thank you.

Thank you. This next question is about PREV-5. And they say they have a patient that indicates that her mammograms in the past have been done in Arizona while she stayed there over the winter months. And they said that they did call that imaging location and were able to verify that those

mammograms were done on the day reported, however they were not able to get a copy of the mammogram report unless they had a signed release from the patient. So they're asking, "Is it sufficient documentation to state that we verified the mammogram via telephone contact, and that the provider would not release a copy of the mammogram report?"

This is Deb from the PIMS team. The one thing it sounds like is missing is the results of the mammogram. You don't actually have to have the report itself. However, along with the date of the mammogram, you do need the results documented. This could be patient-reported. So if the patient reported that the results were normal and that's documented in the medical record, that would be acceptable. Again, the actual mammogram report is not a requirement.

This is Sherry again. We do not require, as Deb indicated, that report be there if you should be audited on that measure. Just the results. Okay. Thank you. This next question says, "For PREV-9, if a patient has an abnormal BMI, does the follow-up have to come from the same encounter, or can it be addressed in a different encounter during six months from the most recent abnormal BMI?"

Hi. This is Angie with PIMS. If, at the most recent visit, there is documentation of an abnormal BMI but no documentation of a recommended follow-up, you can look back six months for a recommended follow-up that is as result of another BMI. So you're going to look back six months for another abnormal BMI with a follow-up a that visit. And then that would meet the intent. Thank you.

Thank you. The next question is, "Which fall-risk tools are acceptable?"

Hi. This is Jessica from the PIMS Measures team. And this is regarding CARE-2. The measure's specification states on page five that there is no specific tool required for this measure. However, it does indicate that some tools that could be used are the Morse Fall Scale or the Timed Get Up and Go Test, but those are just examples. You don't have to have documentation of a specific tool. So when you're abstracting, please look for documentation that indicates whether the patient has been assessed for a history of falls or any fall with injury, or you can look for documentation of no falls, and those instances will all count for this measure. And then, Sherry, is there anything to add from the audit side?

Certainly agree with what you just said for documentation requirement, and, again, what we already covered in the slide earlier with the question that was in regards to gait assessment, because that is also something that can be documented and indicate that it is a numerator-compliant patient, then, if that gait was assessed.

All right. Thank you. And we can take a question from the phone at this time.

Thank you. And this question comes from René with Health Choice Care. Your line is now open.

Hi. Can you hear me? Hello?

Yes.

We can hear you.

Okay, perfect. Thank you. I've actually got two questions, if that's okay. The first one is, when working with the Excel file, it's my understanding that we can place N/A in a field value in order to nullify it on the actual Web Interface. However, that doesn't work for date or numerical values. So how would we, absent of having to go into each individual element within the Web Interface, how would we be able to remove those values using the Excel file?

Hi. This is Ralph Trautwein. The N/A for dates should work in removing those dates. If it's not, please open a ticket. We did build it so that N/A, if you put N/A in a date, it will remove the date that you reported. And will that also include numerical values? So, let's say HbA1c values, or systolic or diastolic blood-pressure values, as well.

Yes.

Okay, perfect. And then my second question, if I'm allowed, is, for the MH-1 measure, would a follow-up PHQ-2 with a score of zero meet the intent of a follow-up within the 11- to 13-month time window?

Hi. This is Jessica from the PIMS Measures team. And unfortunately, no, it does not. That measure owner specifically wants the PHQ-9 to be used, and justification for that is included in the rationale of the measure specification. Thank you.

All right. Perfect. Thank you so much.

All right. Our next question is from an MSSP Track 1 ACO. They say they have a patient screened for BMI with an abnormal result of 27.57, and there is no plan, however it's well-documented that this is a lung-cancer patient undergoing chemo and radiation treatments, so this person says it's evident that the physician was encouraged by an increase in appetite, and can this be a medical exception, or must it state 'No BMI plan because...'?"

Hi. This is Angie with PIMS. Yes, this could be a denominator exception for a medical reason if the healthcare provider feels that weight loss or weight gain would complicate the underlying health conditions. So if that is the case, you would want to select a denominator exception. If not, then you could request a CMS-approved reason to skip the patient. Thank you.

Thank you. This next question relates to the PREV-12 medical exclusion. "Does the diagnosis have to be prior to the start of the measurement period -- prior to January 1st, 2017 -- or can it also be during the measurement period -- prior to December 31st, 2017?

Hi. This is Jessica from the PIMS Measures team. And guidance from the Measures steward indicates that the patient can be excluded if the diagnosis precedes any eligible encounter, even if a screening had occurred at an earlier encounter. So if the diagnosis occurred during but not prior to the most recent encounter of the measurement period, the patient would not be excluded. It would be expected that a screening occur at the encounter or a previous eligible encounter. If such a screening has not been done with appropriate follow up, the patient would be in the numerator. Thank you.

Thank you. This next question says, "For CARE-1, if a patient is discharged from an inpatient bed to a swing bed, which discharge date should be used? The discharge from the inpatient bed or discharge from the swing bed?

Hi. This is Jessica from the PIMS team. So, you would use the discharge that ranked for that patient in the CMS Web Interface. And if this patient has two discharges, one from the hospital and one from the swing bed, if both of those discharges are eligible for assignment sampling, then you will find both of those discharges listed in the Web Interface. So, please abstract data for the encounter that's pre-filled in the Web Interface. For this example, I'm going to go ahead and assume that you're working off the first discharge from the hospital, therefore you need to look out 30 days from that discharge to see if there's an outpatient visit, and then see if there's medication reconciliation during that outpatient visit. For example, if you have one outpatient visit that's within 30 days of both discharges, then you can use that outpatient visit for both of those discharges, assuming that all medications were reconciled during that outpatient visit. And, Sherry, did you need to add anything else from an auditing perspective?

I don't think so. I think that's good.

Great. Thank you both. This next question says, "For the HTN measure, can you advise if we are to use a blood pressure from ER and/or urgent-care locations?

Hi. This is Ngozi from the PIMS team. For the HTN measure, all you need to do is read a reading obtained from a visit to a practitioner's office or non-emergency outpatient facility. So, an ER is an emergency facility. Thank you.

Thank you. And, Sandra, if there's anyone on the phone, I think we can take a question there at this time.

And I have no further questions over the phone.

Great. Thank you. So, this next question is, "How do you define consecutive? If beneficiaries are skipped, does that count as consecutive?"

Yes. If you've reported on the beneficiary, it is counted in the consecutive reporting. If you haven't reported any data for the beneficiary, meaning you missed them in the Excel template when you did your upload, or you skipped over them, meaning you did not report anything for them in the CMS Web Interface when you were going through the list, then that does not count as consecutive reporting. If you're in the CMS Web Interface, you can see the rankings from 1 to the end of your ranking, in order, on the incomplete beneficiaries to get a really quick view of which ones you haven't completed yet for a particular measure. So you can select that measure, and you can go in and view the incomplete beneficiaries, and it will give them to you in rank, from 1 onward, and you can see which ones you've missed.

Thank you. Our next question is, "MH specs state you can use a progress note as a source of major depression. Is this true despite there not being a code that is included in the approved-code list?"

This is Jessica from the Measures team. Correct. Medical-record documentation should be used as the primary resource of information when

you're abstracting. If the patient has a documented diagnosis of major depression or dysania in the medical record, then you would select "Yes." Thank you.

Thank you. For this next question, this person says, "In the past, we were able to print the file rough-cut file upon submission of all of our quality measures. Will that file be available after March 16th? Is there any way to get the file prior to that date if you have completed all entries?

After March 16th, you will no longer be able to do any Excel uploads or downloads. If you want to preserve that data from what you've entered into the CMS Web Interface, we recommend you do a download with data, which will give you an Excel template of all of your beneficiaries and all the data that you submitted to that point in time and was accepted by the CMS Web Interface.

Great. Thank you. This next question says, "If you are manually submitting data, how do you fix data that entered and saved incorrectly -- for example removing a "No" answer and subsequent questions in PREV-13 if you need to change the answer to "Yes." I apologize, Ravia. Could you repeat the question?

Yes, of course. So, this person's asking, if you are manually submitting data, how do you fix data that entered and saved incorrectly? And they listed PREV-13 as an example, if you need to remove a "No" answer and subsequent questions and change that answer to "Yes."

That's a good question. You can change anything that you've entered in the CMS Web Interface at any time, right up until the close of the submission window. So, if you've completed a beneficiary, you can open that complete beneficiary and change any of the answers that you want to to a different value. If you skip the beneficiary, you can also change the answers so that it no longer skips the beneficiary. So you're not locked in with what you first reported during the submission window. You can change that right up until the end of the submission window.

Well, thank you. I think one other thing they may have been wondering about was, they'll have to go in and change the parent variable before they can answer those dependent variables underneath it in order to make those variables enabled to be entered. So, if I'm reading between the lines, that might have been one of their concerns.

Okay. Well, that's an excellent point. There is a relationship between the data and the answers that you provide in the CMS Web Interface. As you're entering answers to questions, you'll notice that sometimes subsequent questions are grayed out. You can't answer anything or enter data into them until you've answered the question in a way that unlocks those subsequent questions. If you go back and change the answer, you may see those subsequent questions gray out again. So if you've answered them, and you go back and pick a different answer to the question that preceded them, it may reinforce the grayed-out, that they don't apply based on your answer. The conditional formatting in the Excel template also helps you understand those relationships between the answers that you're giving and the subsequent columns of data that go with that answer. So, if the column is blacked out in the subsequent cell to your answer, then it's not seeking data for that cell for that beneficiary until you answer the question in such a way that it requires that extra data.

Great. Thank you. This next question is about DM-2 and DM-7 measures. "If documentation of diabetes is found in a specialist's note only and not the primary care provider, is that sufficient enough to confirm a diagnosis of diabetes?"

Hi. This is Angie with PIMS. As long as the diabetes diagnosis is active in the patient's medical records, it is sufficient. Just a reminder that only patients with a diagnosis of Type 1 or 2 diabetes should be included in the denominator for the measure, not those with a diagnosis of secondary diabetes due to another condition. Thank you.

Thank you. And for this next question, this person says they're seeing, for some of their groups, the number of completed measures in progress, the screen does not match the number of measures that are successfully submitted. Ralph, would you be able to address that question?

This is Ravia. I apologize. Could you repeat it?

Yes. So, this person says that for some of their groups, the number of completed measures in the progress screen does not match the number of measures that are successfully submitted.

Okay. I'm not sure what's causing that. The only issue that I know of where you may have a measure that doesn't show up as complete is when the beneficiary count is zero. So, if you have a measure that actually had no beneficiary sampled for it, or less than 20, then that doesn't count as a completed measure. So if you see that particular situation, then the Web Interface is operating as expected. If you're seeing something outside of those conditions, then please enter a ticket and we'll look into your specific situation.

Well, could they possibly have an incomplete record that is stopping the count?

So, for example, say you submitted 300 beneficiaries' worth of data, but you missed reporting on the first beneficiary in the ranked set for that measure, then that measure will not be complete, and your scoring will not be done because you haven't met consecutive reporting requirements. So you could have reported, for example, 300 beneficiaries, starting from 2 to 301, and missed number 1, and that measure will not be counted as complete, and you will not get a score.

Great. Thank you. And this next question says, "If we have a patient that was only seen by the hospitalist during hospital stays, is that patient qualified for these measures?"

Hi. This is Sarah Grallert from RTI. I think we addressed this topic a little bit earlier, Olivia answered a question. But, yes, we sample based on claims evidence that the beneficiary was seen twice for primary-care services at your ACO or group. So, yes, you should complete based on that assumption.

Great. Thank you. And it looks like we have time for one last question. So, our final question is, "If our ACO is chosen for an audit, how will we be notified, and who in our ACO will be notified?"

Hi. This is Ravia. For Shared Savings Program ACO's, when we identify who is selected to participate in our Quality Measures Validation Audit, we will directly contact the contacts identified by the ACO through our management system. And we will also interact with our regional coordinators to ensure that you guys are aware and have received the materials. And we'll also provide a training, a webinar training that will go over the process of the audit. I don't know, Terri, if you want to add anything for Next Gen.

Yeah. For Next Generation, the audit information will be sent to the primary contact that you gave us for your ACO.

All right. Great. And that wraps up our Q&A portion of today's webinar, so I'll now pass it off to Terri to do the closing.

Thank you, everyone, for joining webinar today and asking a lot of good questions. We understand the time didn't allow us to get to all of your questions, so we ask that you send in outstanding questions to the QPP Service Center. Thank you, everyone.

Ladies and gentlemen, thank you for participating in today's webinar. This does conclude the program, and you may all disconnect. Everyone, have a great day.