Hello, everyone. Thank you for joining today's web interface support webinar. These 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. CMS will highlight important information and updates about reporting Quality data and provide ACOs and groups with the opportunity to ask their questions. Please note that these calls will only focus on reporting data from the Quality Performance category. We will not cover reporting data for the other performance categories during these calls. Now, I will turn it over to Aruna Jasi (sp) from the Center for Medicare and Medicaid Innovation at CMS. Please go ahead.

Thank you, Stephanie. Welcome, everyone, and thank you for joining our support call on Quality reporting through the CMS web interface for the for the 2017 performance year. I am Aruna Jasi, and I am with the Next Generation ACO Model from the CMS Innovation Center. Also joining me on this call today are other CMS web interface experts who will share helpful information and answer your questions during our Q&A session. Next slide, please.

This slide is a disclaimer and is a reminder that information on these slides are current at the time of the support call. We encourage everyone to use and reference the source documents that are cited and provided throughout the presentation. Announcements or updates will be shared on these support calls or your program's specific communication methods. So we urge you to please stay tuned to any communications from the Quality Payment Program, Shared Savings Program, and the Next Generation ACO Model for updates. Next slide, please.

Some quick reminders. The eight-week CMS web interface submission window opened on Monday, January 22nd, and will close Friday, March 16, at 8:00 p. m. Eastern Daylight Time. We want to remind everyone that there is no Submit Data to CMS button in the web interface this year. We will automatically receive data that you have entered into the web interface at the closing of the reporting period. Again, whatever data you have entered into the web interface as of 8:00 p. m. Eastern Daylight Time on March 16th is automatically submitted to CMS. If you are experiencing issues trying to access the CMS web interface, please contact the QPP Service Center for support. Also, we will continue to have our weekly support call from 1:00 to 2:00 p. m. Eastern Time each Wednesday. And the last web interface support call will be on March 14th. Next slide, please. And now I'll turn this over to our next speaker, Jessica.

Thank you, Aruna. Those of you who are familiar with these webinars may notice that we don't have any additional slides to cover today. We're going to go straight into resources, and then we're going to spend the bulk of today going through questions and answers because we'd really like to address as many questions as possible today. So starting with Resources on slide five. You'll see the familiar Quality Payment Program Resources starting with the QPP Help and Support website. The second bullet is the QPP Resource Library. Now this website contains several resources that are very important and should still be utilize at this point in submission. A lot of the tickets that the Measures Team is seeing at this time can be answered with the measure specification and the supporting document. That's the first link there underneath the QPP Resource Library bullet. And for those of you

who say, hey, I don't have the PowerPoint, how do I get there, we did send a link to the QPP Resource Library through the webinar. So if you'll please look at the lower right-hand side of your screen there should be pop out box. And in the pop out box you'll be able to find the link that will send you to the QPP Resource Library so that you can access these materials. And the last bullet on slide five is for the QPP Webinar and Events page. And this page lists all of the webinar and events that CMS has been posting for QPP this year. And we want to draw your attention first to the questions and answers document, the FAQ document. This is posted on that page, and it is posted under the January 24th webinar materials. And this document contains a host of several frequently asked questions about assignment and sampling, and the measures, and how to report via the web interface. So if you have questions that you know it's been on previous webinars, and you know it might be something you asked last year, please do check out the question-and-answers document because it might be one of those frequent questions that we pushed to this document. And secondly, on the QPP Webinar and Events page, we just want to let you know that the webinar materials from last year - or last year - last week's webinar, which was February 14th, they are now available on the QPP Webinar and Event page. So please go to the QPP Webinar and Event page. And the link as well is provided in that pop out on the lower right-hand screen of the webinar so that you can access those materials. Next slide.

Slide six shows the instructional videos that CMS has developed to help - help you guys maneuver through the web interface. So if you have any questions about, you know, what will the screen look like when I'm submitting data, what will it look like, you know, as I'm - I'm going through the steps of the web interface. Please double check - or please check out these videos so that you can have a visual walk through and tutorial of how to use the web interface. Next slide. Slide seven is the list of resources for ACOs. Medicare Shared Data program ACOs, please visit the website. Also, there is a link provided in the second sub-bullet for program guidance and specifications. And also a reminder, many of you are probably well familiar with the ACO portal. Please go to the portal if you would like to see the 2017 Quality Measurement Reporting Guide, the Quality Reporting Resource Map, and the Quality Reporting Checklist. And also please keep an eye out for your weekly ACO Spotlight newsletter. This newsletter does contain important announcements and information regarding web interface submission. And also Next Generation ACOs, please reference your website and the connect site for information specific to your ACO model. Also please keep an eye out for your weekly newsletter for, again, important announcements and information regarding submission. Next slide.

And the last slide is just a quick list of where to go if you need help. Please contact the QPP Service Center at qpp@cms. hhs. gov if you have any questions about the web interface measures, how to report for a specific encounter, or if you are having trouble navigating through the web interface system. And that is the end of the presentation, next slide, so I will hand it over for the Q&A session.

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, please dial 1-866-452-7887. If prompted, please provide the conference ID number, 72087469. So this first question pertains to the Care One measure. And it says, if at the patient's follow-up visit to discharge only certain medications are addressed during the visit, but the doctor says at the end of the note that medications were reviewed, does he have to specify that discharge meds and

current meds were both reviewed in order to meet the reconciliation criteria?

This is Jessica from the PIMMS Measures Team. And on page five of the Care One measurespecification, under the Definitions section, there is a definition for a medication reconciliation. And in that definition it includes five different criteria, one of which needs to be met in order to meet the intent of medication reconciliation. And based on this scenario, we believe it meet criteria number two, which states that documentation of the patient's current medication, with a notation that the discharge medications were reviewed. If you're looking at the medical record, and you're saying, well, I don't know if it's quite that - that one, there might not be current medications, then please take a look at page five of the measure spec. There's a couple other scenarios where that may work, for example, the first criteria is documentation of current medications with a notation that references the discharge medications. And I'm assuming you are going to be working with an EMR. If your EMR is set up in a way that displays this information, then that, too, would be met for - for this criteria. And a third criteria - another item - a documentation that the provider reconciled the current and discharge meds. The fourth criteria would be documentation of a current medication list, a discharge medication list, and notation that the appropriate practitioner type reviewed both lists on the same date of service. That's another criteria. So, again, if - if you're having trouble getting your specific scenario to fit one of these criteria, please submit a QPP Service Center request, and we can work with you offline for this specific event. Thank you.

Thank you. This next question is, for an ACO besides the three attributed providers that CMS provides in the spreadsheet, can you obtain information for any of the measures from other sources? And they listed skilled nursing facility or home healthcare as examples.

This is Olivia (Inaudible) from PIMMS, and (inaudible) if they are measure-specific exclusions let us know. But a general rule of thumb is that you can use data that you have available to you, whether it's within or outside of the ACO. PIMMS doesn't vary by measure in some cases.

And this is Deb from PIMMS. In some cases it may, for example, the hypertension measure, you will probably not want to use, say, an emergency department visit because of the fact that that particular blood pressure, emergency department visits aren't included in the encounter codes. It would have been considered denominator eligible. If you have a question about a specific measure, it may be best to ask that question through the Service Now Help Desk just because we can answer for specific measures. But, as Olivia said, as long as it is documented in the medical recorded and can be provided in the event of an audit, it really is okay wherever it comes from.

This is Sherry Grund from the ACO PAC Team. And I would also add that the specifications do outline for each measure whether or not a telehealth encounter can be used - or documentation from a telehealth encounter can be used for that specific measure. So that's another thing you can look at if you are considering using documentation from a telehealth encounter. Absolutely. And in keeping in mind with telehealth, we don't mean that it was a telehealth-billed encounter for the purposes of being reimbursed by Medicare. It could simply be a phone call - most of the times with the telehealth and the web interface measures, we're looking at the Numerator

Quality Action, and so we're really talking about phone calls, emails, that type of thing. It's not specific to a reimbursed telehealth encounter.

Correct.

Great. Thank you. This next question is about PREV-9. If BMI at the most recent visit is in November 2017, and the weight was taken then but the height was taken in February of 2017, which would make those two six months apart, can this BMI be counted? If not, can you look for the next most recent BMI in the measurement year with a height and weight that are within six months of each other?

So this Deb. The feedback we received from the measure developer on that particular question is that the height and the weight can be taken separately, however, they must be within six months of each other. So if you have a weight at your most recent encounter, you can look back six months, and only six months, for the height for the 2017 submission period. If it falls outside that six months, then it would be a performance fail because you don't have the height and weight from starting with your most recent visit within a six-month look back. Hopefully that answers the question. I think there was a second part to it, but the key here is that height and weight must be within the same six-month period of time. They don't have to be for the same encounter.

Okay. Thank you. This next question is, if a patient is transferred from one hospital to another hospital as an inpatient in both cases, but the transfer date is listed in Care One as the discharge date, should this patient be reported or should he or she be skipped as discharge not confirmed?

This is Jessica from the Measures Team. And this patient should be reported. The Care One measure specification indicates that - that the measure should be reported for each discharge. So for this patient, their first discharge will count and - and will be a line item in the web interface. So for that line item you will need to look in your medical records and see if there was an outpatient visit within 30 days of that initial discharge, and then review the medical record to see if medications were reconciled during the outpatient visit. If their second hospitalization is longer than 30 days and takes up that window so there was no outpatient visit 30 days following the initial discharge, then you would select no, and that patient will be skipped. And then, I hope not to confuse things, but the second discharge then should be another line item - another encounter - that was pulled into the web interface. So then you would report on the second - so you would have to report medication reconciliation within 30 days post-discharge for both discharges. Thank you.

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

Our first question is from Jessica Hahn.

Hi. My name is Jessica, and I am calling from the Near Quality Care ACO. And the question I had was around PREV-12. And I know there is a denominator exclusion for active diagnosis of depression. And so my question is, if we have in our medical record documentation that the clinician noted the patient had depression, is that sufficient enough to exclude the patient in the denominator? And is there anything else that needs to be added?

This is Sherry Grund from ACO PAC. And you will want to note whether or not the patient has depression. And we need - just one second. I am thinking of another measure. Go ahead, Jessica.

I'm pulling it up, too, Sherry. I'm sorry.

Okay.

Sorry, Jessica. So, um, so exclusion, active diagnosis of depression or bipolar. And I'm pulling up the coding document just to refresh my memory. So the claim document under the denominator exclusion code, that sheet lists all of the diagnoses that were approved by the measure steward for the exclusion. And so are you saying in your chart there's no code, there's just the mention of depression?

Yeah. Well, I'm looking at the note specifications, but I just wanted clarity on this one. In the notes it just says the patient is depressed, or something along those lines. And in your -

Okay.

Is it an active diagnosis? I'm sorry.

Yeah. I mean, I think we're assuming that it's active just because it says patient is currently depressed. So would that count?

So just to clarify. This is Devon, and again, this is information that came from the measure steward because there has been a change with Pres 12, that that diagnosis of depression prior to 2017 had to occur in the year before the measurement period. Starting in 2017, that parameter is no longer in place. That diagnosis of depression could have happened after 12/31 of 2016. But we did receive the following from them, and if you want this in writing, I would suggest opening up a Service Now Help Desk ticket so that it can be provided to you. The patient can be excluded if the diagnosis precedes any eligible encounter even if the screening had occurred in an earlier encounter. If the diagnosis occurs during but not prior to the most recent encounter of the measurement period, the patient would not be excluded. It would be accepted - it would be expected that a screening occurred at the encounter or the previous eligible encounter. If such a screening has been done with appropriate follow up, the patient would be in the numerator. So you're not only looking for is this an actual diagnosis of depression where, if you have documentation that says the patient has an active diagnosis of depression, that is an exception for exclusion. But you also need to ensure that that is occurring prior to the first eligible encounter you have. Does that help?

Okay. Yeah, no it does. Thank you for clarifying.

Yeah.

The measure owner is just trying to make sure that you remove people from the denominator that already have an active diagnosis of depression. But aren't diagnosed with that with your screening that day. So, um, just stated a different way than Deb did in case - because it can get confusing when you try to explain that.

Yeah. Thank you.

All right. Our next question is for the HTN measure. Can the blood pressure be taken from a VNA home visit if the patient is unable to leave their home?

Hi. This is Ngozi with the PIMMS team. For the hypertension two measure, only blood pressure readings performed by a clinician in the provider's office are acceptable for numerator compliance of this measure. Thank you.

Thank you. Our next question is, if CMS audits our ACO, will skips or denominator exclusions be reviewed or is the review only measures that were answered? Do they review only measures that were answered?

So this is Rebecca.

Go ahead Rebecca.

Sorry. CMS reviews both measure-level skips as well as medical record not found. Sorry to talk over you. Go ahead, Sherry.

No, that's the general thing that CMS is going to look at anomalies that they find in the data, which would include exactly what Rebecca just mentioned. But when we actually look at medical records, we're looking at whether or not if you selected a numerator, a hit or a quality action occurred, we're going to look at those answers and ask you to provide some supporting documentation if you're an ACO that is selected for audit or if you are a Next Generation ACO. And we're going want you to provide that supporting documentation. Or, if you selected an exclusion or an exception that caused the patient not to be in the denominator, we'll ask for supporting documentation that shows or supports why you made that selection, in the web interface. So those are the kinds of things that we'll actually end up reviewing. And the other thing that we would look at would be things that would support why you were able to answer yes to those questions that put that patient in the denominator to start with.

Right. And this is Rabia, just to add to that. So it's more about, you know, when we conduct our audit, we're matching whether what you've entered - we're looking at whether what you've entered in the web interface matches the documentation that you submit to us. And that's what we're confirming as a part of that audit. And to help clarify since I do see some other questions that have come up about being selected for audit. So all Next Generation ACOs will participate in a Quality Measures Validation Audit following the submission period. A subset of Shared Savings Program ACOs will be selected, and that's exactly what Rebecca and Sherry were noting. We are going to look at data anomalies and further investigate those anomalies as well as that would be a clear indicator as to whether you are selected for the audit or not as a part of our requirement. But in terms of notification, Shared Savings Program ACOs, the ones who are selected to participate in our audit, will be notified directly from the Shared Savings Program. And we'll be notifying your point of contact for your ACO. It will occur after the submission period. I don't know, Sherry, if there is more information, but -

It will be, I believe, within a month of the submission period ending.

Thanks.

All right. This next question is, will final - final results for individual performance measures be rounded at all? And they listed as an example, will the final result for pneumonia of 79. 94% be rounded to 80% thus putting it into the 80th percentile?

I mean I can answer from the Shared Savings Program perspective. This is Olivia, and I'm hoping Lisa Marie can answer from a scoring perspective. But no, we do not round beyond the hundredth place when comparing your performance rate to the Shared Savings Program benchmark.

This is Lisa Marie. Same thing. The scores aren't rounded up. It's whatever is provided is what is given as the score. Just as Olivia noted for - so the same thing as for ACOs, it also applies to Group.

Great. Thank you both. This next question is, are we able to directly enter data into the web interface as well as submit data via the upload button?

Hi. So this is Lisa Marie. So with submitting data, whatever is uploaded into the web interface is what is actually provided to CMS. Unlike previous years, there has been a button that had to be clicked in order to submit the data to CMS. That button no longer exists. Whatever is submitted or uploaded by 8:00 p. m. Eastern Daylight Time on March 30 - March 16th, will be the data that will be submitted to CMS. So whatever is uploaded is what CMS receives.

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

I'm sorry. Our next question is from Christine Tomaselli.

Hello. My question is about IBD. I noticed that in the narrative specification - or the PDF document, that Aggrenox is listed as numerator compliant. But in the PDF - I'm sorry, in the Excel spreadsheet with the numerator drug codes, it's not listed. Can you confirm if that is still an approved formula?

Hi. This is Angie Stevenson with the PIMMS Team. And yes, it is there - I believe the generic name, you'll find that in the coding document. And generic or brand name are acceptable as long as you have that documented in the medical record.

Thank you.

All right. Our next question is about PREV-9, BMI. If the patient is wheelchair bound and cannot safely stand on a scale, can they be excluded from the measure?

This is Deb from the PIMMS Team. And - and the answer to that is they can't be excluded. Basically wheelchair-bound patients, amputees, those patients are - there are ways to get a BMI on those patients, and the measure developers intended that there would be a way to do the BMI. So they do not fit within that criteria of an exclusion or an exception.

Thank you. This next question is, if you uploaded data multiple times to the web interface, will all the data be overwritten with the new data submitted and not just the fields that were left blank from the last upload?

So this is Ralph Trautwein. If you submitted multiple times, and you have different data for the various submissions for the beneficiaries, the last set of data will be the data that counts. So you - you could have an answer of yes the first submission, an answer of no the second submission, and an answer of yes for the third submission for a particular beneficiary question. The last yes is the one that will count for you.

Thank you. And this next question is about PREV-9. Can the BMI taken from a TCM visit and/or an ED visit be used for this metric?

So if you happen to have a BMI, and it is at your most recent encounter, and if the BMI is abnormal, you have a recommended follow up, you can certainly use that. If you question whether or not a visit from - whether or not those visits would be typically considered denominator eligible, maybe because you don't have a recommended follow up, you can certainly review the coding that has been provided. And if those visits are not what is considered a denominator-eligible encounter, you don't have to use it, and you can look for the next most-recent visit. But if you have medical record documentation of a BMI that's been calculated, you can certainly use it. And if it's abnormal, the expectation would be there would also be a recommended follow up documented.

Okay. Thank you. This next question also relates to BMI follow up. And it says, does the follow-up plan have to be tied to the most recent BMI? So if the most BMI is out of the normal range with no follow- up plan but there is another out-of-normal-range BMI documented a week prior that did have the follow- up plan, can this meet the intent of PREV-9?

And yes, your scenario would meet the intent of PREV-9. If it's the most recent encounter, you have an abnormal BMI but no recommended follow up. But you look back in your medical record, and a week prior there was also a calculated BMI that was abnormal, and at that encounter there is documentation of a recommended follow up, that would be acceptable.

Great. Thank you. And we can take a question from the phone at this time, Stephanie.

Our next question is from Diana Amity.

Hi there. Thank you very much. I'm talking - a question about PREV 13, the statin therapy. And I'm specifically looking at page 12 of the narrative measure sets. And where it says on the (inaudible) category number three, that the patient - the range of the LDL is 70 - between 70 and 189 during the measurement period or two years prior. And then when you go to page 20 of the same document, it talks about the highest fasting. So there is some confusion with our EMR developer with reporting out this measure, which we do electronically. Are we to look for a range of 70 to 189 as it states on page 12, or are we looking at in the three years, what is the highest LDL and is that between 70 to 189. And if it's no, then we stop and move to the next patient.

So this is Deb. And I'm going to try and follow. If you've gotten to the denominator population three, and you're looking for the LDL result of 70 to 189. And - and the second - what - what page?

So on page 12 it gives you the question of, determine if the patient has an LDL of 70 to 189 during the measurement period or two years prior. Then it goes through the yes or no algorithm.

Okay.

Very clear on that. But if you go to page 20, it says check to determine if highest LDL is 70 to 189 in the measurement period or two years prior. So it's a little misleading. Are you looking for the highest regardless of the range, or are you looking for the highest within that range of 70 to 189?

Okay. I would say it's anywhere between - if that LDL falls within the 70 to 189, I can see what you're saying about that first sentence where we - and this is just for the flow piece - to define - check to determine if the highest fasting or direct is between 70 to 189. So you are just looking for an LDLC between the range of 70 to 189 and that diagnosis of diabetes.

So if there is a value of 70 - if there is a value between 70 and 189, but there is also a value of 245 -

Okay.

We are not to look to the 245 because the question is looking at 70 to 189, right?

Yes. Well, you can - if they have any LDLC between that 70 to 189.

Right. But if there is one that's higher, then that is not used because it's specifically looking to that range of 70 to 189, correct?

I would say that's accurate. I would also ask, though, and we can certainly add this unless somebody else can clarify, because I'm scrolling through the measure pretty quick looking at these pages with you, I would be more comfortable if you would open up a Quality - or a Quality Payment Program Service Now Help Desk ticket so that we can step through this with a little more time. That does seem accurate to me unless there is someone else on the call who feels pretty comfortable about answering this without looking at it in more detail.

I think it depends on the age of the patient, so I would agree -

Right. Taking all of that into consideration, I'm just talking about is it - are we looking at the highest within the three years? Or are we looking at the highest within that range? Taking out - taking into consideration that there are factors that have to be met to even get to risk category three.

Right. Because you have to go through risk category one and two first. So, I'm with Deb. I think we need to go back to the drawing board and take a look at this. Make sure we're giving you an accurate answer.

Okay. Thank you.

Thanks, Sherry.

All right. This next question is about using the Excel template. If we have to reenter a question, what are the typical problems we should look for if it appears we have lost the previous data?

Samantha, can you jump in and answer this?

This is Nadya. Could you repeat that question? I think we're really trying to understand so we could give an appropriate response.

Yes. So this question is about re-answering a question on the Excel template. And so this person is asking, if they do have to re-answer a question, are there any typical problems they should look for if it appears that they have lost the previous data?

Could you submit a ticket for that inquiry? We want to be sure - like we just - I think we need to confirm what it is that you are seeing and experiencing so we can troubleshoot that directly.

Yes. In addition to that, anytime you do a download with data, that will have your most recent answer. Changing the Excel file and uploading will update any of your answer that you had previously entered. And if that doesn't answer your question, please do submit a ticket so we can look into y our specific issue.

Okay. Thank you both.

And this is Deb. Before we move on, I want to backtrack a little bit, if that's okay. Would that be okay?

Yeah.

That's fine.

Okay. And this is thanks to one of the folks on the call. Sometimes, you know, you can't see something that's right in front of your face, and Sherry weigh in if you think this is accurate. So with -

I found it, too!

Yeah. With the PREV-13 question, you have to walk through this measure step by step. So you are first looking at that age range and the (inaudible) diagnosis. If the answer to that is no, you're going to risk category two. Well risk category two, is going to meet that same age range from category three, and a piece of that requirement, or the denominator eligibility in this case, is if they have ever had a fasting or direct LDLC of 190. So - greater than or equal to 190. So in your scenario, when they have an LDLC of 224, you're going to be eligible for this measure based on risk category two, which is why that is not addressed in risk category three. Because you're already going to be in based on risk category two. So I hope that answers the question that we weren't able to answer before. That should save you the need to open up an inquiry.

Then you'll proceed to answering the numerator question, whether or not the patient had - was on a statin.

All right. This next question is about PREV-13. If a patient has a diagnosis of hyperlipidemia or hypercholesterolemia reported, but not peer or familial, should we include them in the denominator? And this person says that they have a lot of these patients that are otherwise skipped. And they have codes like E78.5 or 2, not E78.

Hi. This is Ngozi with the Payment - PIMMS Team. So we recommend that you utilize the diagnosis of hypercholesterolemia in the medical records for the purposes of this measure. If there is no supporting documentation within the medical records for the diagnosis of familial or peer hypercholesterolemia, you shouldn't confirm the diagnosis in the web interference. Also, per the measure developer, hyperlipidemia is not included as a diagnosis to confirm denominator eligibility for risk two in the PREV-13 measure. Thank you.

Thank you. This next question is, is the depression remission measure still pay for reporting?

Sure. This is Olivia. I can answer that. ACO40 or MH1 is pay for reporting on all years.

Olivia, I think you might have cut out.

I'm sorry. I gave an answer, but apparently nobody heard it. MH1 or ACO40 is pay for reporting in all years.

Great. Thank you. For this next question, this person says, on the web interface, I have three measures that are marked as, you have skipped an unusual number of beneficiaries for whom you filed claims on this measure. For example, IBD-2 has many patients that had an anticoagulant in the hospital, therefore they were excluded. So this person is asking, did I do something wrong with my reporting on this measure?

So this is Deb. From the PIMMS Team, from the measure perspective, we will say that there are certain measures that we see through Help Desk tickets and past history that will be high-skip measures. And this comes from the fact for IBD-2 in 2017, this is due to the fact that we have that additional denominator exclusion that is now skipping all of those patients that happened to be on one of those medications. MH-1 would be another measure that you would see a high skip, more than likely, and that would be either because you can't confirm the diagnosis, you don't use a PHQ-9 screening tool, or you're not finding a PHQ-9 greater than nine. So for that particular measure, any one of those situations not being present would create a situation where the patient is not denominator eligible and you'll skip them. So there are certainly measures where you - you may see higher skip. And as long as you are, you know, looking for the documentation, measure by measure, that you can confirm that they belong in the measure, and you just can't find it, then you're not doing anything wrong. There may be some additional information from one of the other team members from a different perspective that would be good to add.

This is Sherry from ACO PAC. If you are an ACO, Shared Savings Program or Next Generation model, the information that you will need to have will just be documentation that you would want to have to support the answer that you are providing. So nothing special to do, but what you are basing your decision on to skip that patient is all you would want to be sure that you maintain.

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

Our next question is from David Richardson.

Hello. I'm currently working on the PREV-6 measure, and I'm wondering, does it matter where the - if a patient has a colonoscopy, where the colonoscopy was performed?

This is Sherry again. No it will not. As far as documentation of that, remember that you'll need to have documentation for when it was done and the results of the colonoscopy.

Okay. Thank you.

That doesn't have to be, necessarily, the colonoscopy report if you have general documentation of the result, that is fine also.

Okay. Thank you very much.

Um hmm.

All right. This next question is, when reporting contiguous beneficiaries for a measure, do we need to start at beneficiary ranked number one for the measure? Or can we select a later rate as the start of the minimal number of contiguous needed?

This is Olivia. I can take a first stab at that. You do need to start at patient number one. The complete - the continuous count begins at patient number one. That said, you can throughout the data submission period, you can enter data kind of in whatever order you would like. But at the end of the day, you need to have started with patient number one.

Great. Thank you. This next question is about DBP measure. For the diagnosis of HTN, if the member was diagnosed several years ago but no longer has a current diagnosis of HTN, can we use the past diagnosis date we find in the record, or does the member have to have a current diagnosis?

So this is Deb from the PIMMS team. I believe you - if you were to review the measure document, the diagnosis has to be an active diagnosis not ending before the first day of the measurement year. And it needs to be a diagnosis that occurs at least within the first six months of the measurement year. Or any time prior, but again, it has to be considered active during the measurement year.

Thank you. For this next question, this person notes that in PREV-8, patients have to be 65 years and older to qualify for the measure. So does the pneumococcal vaccine count towards the numerator if it was given any time in the patient's history? Or does the vaccine also have to be administered after the patient has turned 65?

The intent of PREV-8 is that they have received the pneumococcal vaccine. It does not have to be a pneumococcal vaccine that they received at age 65 or after. It could have been received prior to. There are some additional details that may be of interest. Certainly if you got the Prevnar, I believe, seven, that is not intended for the elderly population. If you specifically know that's the vaccine that they received, that doesn't really meet the intent of the measure. Certainly NCQA intended that the vaccine being provided was for the patient population of 65 and older. But we are aware that there are times that that vaccine is given prior to the age of 65. So that would be acceptable.

Great. Thank you. This next question is, if we have two blood pressure readings on the same day, are we able to merge both? For example, if the first blood pressure is 139 over 90 and the second one is 142 over 60, are we able to state the blood pressure is 139 over 60?

Hi. This is Ngozi with the PIMMS Team. So if the blood pressure was taken on the same day during an applicable encounter, you may combine the lowest diastolic and the systolic number for reporting. So, yes, in this situation you can say 139 over 60. Thank you.

Thank you. And Stephanie, we can take a question from the phone at this time.

Our next question is from Sharon Baress.

Hi. I have another question with PREV-13 because I'm just - I see a lot of people using the codes interchangeably for the population two. And so is the intent there just to have people who are LDLC greater than 190 or some sort of familial hyperlipidemia or is it to have anybody who has an elevated LDL? And I'm just - I think this is a general feedback. This is way too complicated a measure, and you're going to get not very good data to work with if you are planning on using this. Because I see, in looking at providers' charts, that a lot of people - our codes in our charts are not as - I've sent in, actually, a Quality Measure ticket for this, but are not as definitive - even the answer I got back was a little bit confusing to include them if they are hypercholesterolemia but not include them and look at the chart. You know, the codes don't always match what the providers are doing. If that makes sense.

Sure. Um, this is Deb. So for PREV-13, and, again, thank you. I think you are the first one that got us looking at risk category two instead of hyper-focusing on risk category three in the previous question. I would say you're really - you're relying on your medical record documentation. We have heard that maybe some of these codes are not being used along with medical record documentation that is showing that it's the familial or peer hypercholesterolemia. But I would say it's, as you are doing that abstraction, if you've gone through that risk category one, you're not finding that the patient is eligible based on that, risk category two really is either that LDLC. If they've ever had the LDLC of greater than or equal to 1990. Or if they were previously diagnosed or currently have an active diagnosis of the peer hypercholesterolemia. If you are not finding that, then I wouldn't confirm them based on that risk category. If you think it's a matter of that the code is appropriate, and it's one of the codes that's identified in the code set, but the documentation might not be an exact match, I would say, you know, we have, and I - Sherry, I'd like you to kind of confirm this - I believe the conversations we've had is we are aware that sometimes the coding description is not going to be exact. But if you know it is - it is a match, and it's just not the exact verbiage, it would be appropriate to confirm in that case.

Okay. And just sort of in terms of the data that you want and the questions that you want to ask, you know, I think the person asking at the last one with the third category, why that's very frustrating to look at is that you're basically having people skip people who are being treated well with the way that it's set up. So you're going to have a higher rate of people, you know, not having bad LDLs or something like that. With the way that it's set up that if a patient is on a statin, or my diabetic is on a statin,

you're not looking at them appropriate - sort of like looking at the negative. Because you're not going to see all of the patients who are diabetic or being treated appropriately when you knock them out of that last category by saying, yes, my patient's on a statin, but you made them a skip because they already got their LDL down to less than 70. Does that make sense?

You don't have to skip them. That makes sense, but if you've gotten to risk category three, so you've confirmed that they are eligible based on risk category three, knowing that they have had the highest - so this one is in the measurement year or two years prior, so three-year time period. If they meet that 70 to 189 within that three-year time period and they're eligible, you do not have to use that denominator exception just because of - I think it's the most recent LDL is less than 70. That's only if they're not on a statin.

No, but what happens in the website is I say, yes, I have a diabetic who I've been treating. I've been in practice for ten years. Yes, I have a diabetic. I've been treating them for ten years. Their diabetes is well controlled. I have them on a statin. And the last time I checked their cholesterol, the LDL was less than 70, which it's supposed to be. But on the web interface, what happens is I say yes, they're diabetic. They don't have a bad LDL. So then that counts as a skip, as opposed to - and it won't let me put in on the website whether or not they are on a statin.

Right. If they don't - if they don't meet that criteria of 70 to 189 in three years, then they're not considered eligible. And that is certainly something that can be, you know, every year the measure steward, in this case this is a CMS measure, they do review these. I know they spent a lot of time on this, but we can certainly provide this information if the - if PQMM isn't on the call right now, you know, kind of give them your feedback, and they can bring it up with the measure developer when they review it for 2019. I'm pretty sure it didn't change for 2018.

Okay.

You're doing an excellent job if you're getting people down below 70.

Well, that's what we're supposed to do. And that's why it's so frustrating that they're being knocked out because we're treating them well, and then we have - we get penalized and we have to put more people in there who, you know, are - for some reason or another don't have that. So it's going to skew your data and skew the way people's quality reporting is coming out. So, that's my two cents. Thanks.

All right. This next question is, are we required to skip beneficiaries who are taking an anticoagulant for the aspirin measure, or can we choose to report on those beneficiaries?

Hi, this is Angie with the PIMMS measures team. You would claim a denominator exclusion if - I'm sorry - if they took an anticoagulant during the measurement period at all. And the beneficiary will be skipped for that measure. But, you would use the denominator exclusion reason. Thank you.

Okay. Thank you. This next question is, how long after the submission window closes will we be able to access the data confirmation report?

Ralph, will you be able to answer that question?

Yes. The reports are available for three years following the close of the submission window. So you should be able to access the data submission report for the following three years.

Thank you. This next question is for the MH-1 measure. I have a patient who has Down's syndrome who is nonverbal and non-ambulatory. Can I ask for a CMS-approved reason for this patient?

Hi. This is Jessica from the PIMMS measures team. If you have a patient, and this goes for anyone on the phone, if you have a patient that doesn't - that you're having trouble fit the patient confirmation steps, one of the options is to request - or is to submit a request via the QPP Service Center for a CMS- approved reason. So for this example, you may definitely submit a request. Please note, we are coming to the end of submission in the next couple of weeks. So if you would like to submit it, we strongly encourage you to do it sooner rather than later as it will take a while for us to reach out to CMS and get review and then pass on their decision to you. So if you would like to, we strongly recommend you do it soon. Thank you.

Thank you. And it looks like we have time for one more question. So this last question is, if the patient provides the result of a previous colonoscopy, does that count for the measure? For example, the provider noted in February 2010 colonoscopy, patient said it was normal.

Hi, this is Jessica from the PIMMS measures team. So I am looking at the PREV-6 measure, and on page five you'll find guidance saying that - that - sorry, I'm just reading through it. (Inaudible) colonoscopies during the measurement - so within the previous nine years. During the measurement period or the nine years before. So it has to be done once every ten years. And I'm sorry, did you say it was complete in 2010?

Yes, that is correct.

Okay. So that - that would qualify. Please note, (inaudible) if you have more to add, documentation, you will need the date and the findings. In addition to the type of screening, but obviously it's colonoscopy. Thank you.

The findings expressed as normal would be sufficient as far as Audit is concerned.

Great. Thank you both. And thank you all for joining today's webinar. That concludes our session for today.

This concludes today's conference. You may now disconnect.