[Classical music playing]

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 to 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 providing ACOs and groups with the 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 will turn it over to Rabia Khan from the Center for Medicare at CMS. Please go ahead.

Thank you. And welcome, everyone, and thank you all for joining our support call today on Quality Reporting through the CMS Web Interface for the 2017 performance year. As mentioned earlier, I'm Rabia Khan, and I'm with the Medicare Shared Savings Program. Joining me on this call today are other CMS Web Interface experts who will share helpful information and...your questions during our Q&A session after our brief presentation. Next slide, please. This is a disclaimer slide, and it's a reminder that information in 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. Announcement or updates will be shared at these support calls or your program-specific communication method. So, we urge you to please stay tuned to any communications from the Quality Payment Program, Shared Savings Program, or Next Generation ACO programs for updates. Next slide, please. We do have some announcements for today's call. We understand some users are experiencing issues trying to access the CMS Web Interface, and it's due to their username including an invalid symbol. We've updated our EIDM User Guides to communicate that you should not use the @ symbol in your username when you're creating it. If you currently have the @ symbol in your username and are experiencing these log-in issues, please contact the Quality Payment Program Service Center immediately. If you are a Shared Savings Program ACO and have an outstanding ticket related to this, please send this to your regional coordinator so we can assist you with resolving the issue. Previous CMS Web Interface Support Call Materials are also now available on the QPP Webinars & Events page. We're also working on posting the FAQs...the Web Interface on the QPP Webinars and Events page. Each program will announce when the FAQs are available publicly, but please continue to access them in the Web Interface. Next slide, please. Thanks. Now I'd like to go over some helpful reminders. So, as a reminder, the eight-week Web Interface submission window opened on Monday, January 22nd, and will close Friday, March 16th, at 8:00 p.m. Eastern Daylight Time. You can only access the CMS Web Interface from the Quality Payment Program website, and click "Sign In." If you have not tried to sign in yet, we strongly encourage you make the attempt to ensure you have access and are not experiencing issues. If you have the correct EIDM roles and cannot sign in, please reach out to the Quality Payment Program Service Center for support. There are ACOs and groups that have completed 100% reporting. And I just want to remind everyone that there is no "Submit data to CMS" button in the Web Interface this year. We'll automatically receive data that you've entered into the Web Interface the closing of the reporting period. Again, whatever data you've entered into the Web Interface as of 8:00 p.m. Eastern Daylight Time on March 16th is automatically submitted to CMS. I recommend that you check your reports and keep record of your progress and complete reporting. Also, we will continue to have our weekly support calls from 1:00 to 2:00 p.m. Eastern Time each Wednesday, so please mark your calendars with

the dates and information. Next slide, please. And I think we can skip to the next one. Thanks. So, as I mentioned earlier, some users are experiencing issues accessing the Web Interface due to their username, including the @ symbol. So, we have updated our EIDM user guides to communicate that you should not use the @ symbol when you're creating your username. If you have that symbol in your username currently and are experiencing issues, please contact the QPP Service Center immediately. And just as a reminder again, if you're a Shared Savings Program ACO and have any outstanding tickets related to access, really, that you should send that to your regional coordinator so we can assist with resolving the issue. I strongly encourage everyone who is reporting to log in to the Web Interface to ensure you don't have any access issues. So, if you haven't logged in yet, please do so. And please do not wait until the last week because these access issues do require a team for assistance and resolution. All right, next slide, please. And now I'm gonna turn it over to Angie Stevenson for frequently asked measure questions.

Hi. This is Angie Stevenson from the PIMMS Measures Team, and we'd like to share some of the frequent measures questions that we have received through the Quality Payment Program Service Desk. Slide 8, please. First question is regarding the MH-1 measure. If a patient has a negative PH-2, then we don't do a PH-9. Can we count the PH-2 as a negative depression screen to satisfy the measure, or does it have to be a PQ-9? And, no, confirmation was received from the measure developer that a PHQ-2 screen, regardless of the PHQ-2 results, cannot be used to submit remission for the MH-1 measure. Question 2 is regarding CARE-1. Our patients are discharged from the hospital to the office setting in the same EMR, so the discharge medication that is in the record at the time of the follow-up visit is the same as the active medication list in the patient's outpatient chart. Would reviewing this one list after discharge meet the measure? Answer is -- review the medication reconciliation criteria -- it's on page 5 of the measure specification -- to confirm that your system meets the criteria for number 2, "Documentation of the patient's current medications with a notation that the discharge medications were reviewed." The date the provider reviewed the medications must also be documented. In the event of an audit, there must be a documented policy in place that outlines exactly what the provider was attesting to when checking the box to show that it supports the medication reconciliation criteria. Next slide, please. Next slide, please. Slide 9. Okay, question 3 is regarding CARE-1. We have patients discharged with follow-up visits occurring in settings other than the provider office. Why are they in our sample? For sampling in the CARE-1 measure, the following sets of codes are included by the measure steward, NCQA, in addition to office visits. Domiciliary, rest home, or custodial care services, codes 99324 through 99328, home services codes 99341 through 99350 -- you would expected to complete medication reconciliation for these patients' care coordination since these patients have been assigned to your organization. The rationale for this is to capture that segment of the population that does not or is not able to present to the physician office. The intent of the measure is to assure that the medication reconciliation is performed consistently on the patient population. These codes were also included in the 2014 Web Interface specifications when the measure was last used in the Web Interface. And please note that the 30-day post-discharge visit does not include the following nursing home codes of 99304 through 99318. Next slide, please. Slide 10, please. If we could switch to slide 10, please. Thank you. Question 4 is for IVD-2 measure. We are finding that the exclusion data set provided in the IVD-2 Coding support document includes several Heparin solution products. The typical use of these products is within an in-patient

or surgical environment as a one-time dose -- for example, a prophylactic to prevent blood clots in high-risk surgical patients. Was it the intent of the measure to include Heparin given as part of an in-patient stay, surgery, or other invasive procedure as a denominator exclusion? We have confirmed with NCQA, the measure owner, that, yes, patients receiving anticoagulants are removed as a denominator exclusion to prevent physicians from being penalized for using anticoagulants when they are clinically necessary. A patient may receive Heparin and later be put on an antiplatelet. A patient who happens to fall into the measure at the end of the year may only be on an anticoagulant appropriately and would otherwise count as a numerator fail if the exclusion was not in place. The exclusion allows the measure to focus solely on the use of aspirin or antiplatelets. Slide 11, please. Slide 11, please.

Hi. Deidra, are you able to advance to the next slide?

I'm on slide 11.

I'm sorry. Mine's still showing slide 10. So, it would be for question 5. Can you advance to the next one?

One moment, please. Let me know when you see it.

Okay, I'm sorry. Maybe slide 11.

I think we're having a lag.

Maybe we're having a lag in time. There we go. Thank you so much. Okay, question 5 is also for IVD-2. Our EHR lists billed diagnoses in each patient chart as far back as we have had the EHR. We have one column for problem list, chronic conditions, and one for diagnosis filled. In our billed diagnoses, there is an ability to resolve these or mark them as chronic. If the diagnosis is left unresolved, but also not marked chronic, would the patient qualify for the measure? Billed diagnosis codes alone do not meet the intent of the measure. Beneficiaries are sampled based on the diagnosis codes found in the claims. But medical record documentation needs to confirm that the patient does indeed have a particularly active diagnosis. Question 6. For the IVD-2 measure, we have a member that has an allergy to products. Would we have to answer "no" to documented use of aspirin or another antiplatelet, or would we be able to get a CMS-approved reason? The IVD-2 measure allows for medications other than Plavix. You would need to answer "no" for numerator reporting if the patient did not have the documented use of aspirin or other antiplatelet during the measure period. CMS has denied CMS-approved reason requests in both 2016 and 2017 that are asking to skip patients allergic to aspirin or a particular antiplatelet drug. Patients who have documentation of use of an anticoagulant drug during the measurement period would qualify for the denominator exclusion. Next slide, please. And I will turn it over to Ralph Trautwein for Reporting Tips and Guidance.

Thank you very much. This is Ralph Trautwein. Before we step through the slides, I want to give you one easy tip, and that is please do not password-protect your file if you're doing an Excel upload. We have seen some cases where folks have submitted a password-protected file. If you get a parsing error and you've submitted a password-protected file, that's why you got that error. On the slide that's being shown, I want to talk about continuous reporting and how that affects your reporting in the CMS Web Interface. We do have a requirement to enforce continuous reporting, and the CMS Web

Interface does enforce continuous reporting. And I'm gonna show you what that means through a series of steps here in the slides. If you look at the snippet from the Excel template for CARE-2, you'll notice that there are several beneficiaries shown. The first one is completely blacked out because in the Patient Confirmation section, they were disqualified from the sample. And patient number 2, 3, 4, 5, 6, 7 have data in them, but if you notice, beneficiary number 5 in the list is not complete, meaning there's an answer missing in the column that says, "Was the patient screened for future fall risk?" The answer is missing for that beneficiary. But the answers are complete for those ranked in 2, 3, and 4. Notice 2 and 4 have answers in them of "yes" for both questions, and the beneficiary ranked in number 3 is not qualified for the sample for a CMS-approved reason. Next slide. So, when that file was submitted, this is what the results were in the CMS Web Interface. Notice there's two in the numerator, two in the denominator. Why were there only two in the numerator and only two in the denominator and the beneficiaries beyond that point were not scored in the performance rate? It's because the continuous reporting requirement had not been met. Next slide. So, let's go back to that same example and fill in an answer, the answer for this particular beneficiary. In this case, we're gonna say, yes, the patient was screened for future fall risk. And then we're gonna submit this. And you can go to the next slide. And notice the performance rate jumped. Now there are 25 in the numerator and 25 in the denominator. That's because all the beneficiaries that we had data for beyond that fifth beneficiary in that measure were also now included in the performance rate because continuous reporting was met. Next slide. Okay, another helpful tip is to make sure you're filling in the Patient Confirmation section of the Excel spreadsheet when you're doing bulk reporting. Notice in this little snippet from the spreadsheet that there's a "yes" for some of the patients, but some do not have an answer. So, for example, the beneficiary third down from the top has no answer to the Patient Confirmation question in regards to, "Can you locate the patient's medical record?" and, "Is the patient qualified for the sample?" Next slide. So, here we have a snippet from the PREV-6 measure, colorectal cancer screening. And you'll notice that those same beneficiaries all have data. They have "yeses" and "nos," and all the questions are answered. Next slide. But when we submit this spreadsheet, notice there's only one in the numerator and two in the denominator. So, why is that? It's because the Patient Confirmation section had not been completed for beneficiaries in that list that we were looking at. So, it took the first few that had answers and then did not do the rest of them because the Patient Confirmation section had not been answered for those beneficiaries. Next slide. So, let's move back to that Patient Confirmation section. And we see that, yes, yes, yes, and then there's some blank ones. Next slide. Okay, so, skipping beneficiaries in a measure. Notice that in this case there are four skipped beneficiaries, but the minimum only moved by one beneficiary. So, it moved from 248 to 249. So, why is that? That's because only one of the beneficiaries that we skipped was in the minimum reporting requirement. Where were the other three? They were in the oversample. So, although they were skipped, they did not move the minimum. Only the beneficiary that was in the minimum reporting requirement when it was skipped moved the minimum reporting requirement by one more beneficiary. Next slide. So, I'm gonna hand it over to Jessica.

Hi. This is Jessica Schumacher from the PIMMS Measures Team, and we'll run through the resources real quick, starting on slide 23. We have contact information -- or we have the resources for the QPP website, beginning with the QPP Help and Support webpage. And also on the bottom of slide 23, we have several resources that our presenters and CMS and contractors will be

referring to as we answer questions during the Q&A session. So, we strongly encourage you to please review the materials that are posted on slide 23. And also we encourage you to only use those materials that are provided by CMS, as we understand there are several other materials available out there to try to help facilitate submission. But, again, CMS's materials are the original resource that you should be referring to if you need guidance when submitting the quality measures. Next slide. On slide 24, we have the list of our new instructional videos that provide detailed instructions and step-by-step walk-through information on how to submit data -- or how to populate the Web Interface with data and how to plan your work and participate in 2017 submission. Next slide. Slide 25 has our resources for ACOs, beginning with Medicare Shared Savings Program. Again, I'll refer ACOs to the website Program Guidance & Specifications and the ACO Portal, and also there's the weekly ACO Spotlight Newsletter. And, Next Generation ACO models, please refer to the websites and the Connect site and your weekly newsletter for information regarding 2017 submissions. Next slide. And lastly, if you do need help, please contact QPP, and the e-mail and phone number is available on slide 26. If you have questions regarding your Medicare Shared Savings ACO or your Next Generation ACO, the e-mail contact is available on slide 26. And also if you have questions regarding Physician Compare, that e-mail address is provided on slide 26, as well. Next slide. Okay, so, that's the end of the presentation, and we'll hand it over to start 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 I.D. number, 72087466. So, for our first question, this person says, "We have less than 10 providers that started with our practice after August 31st of 2017. We looked for them under "individual reporting" and could not find them to report on. They are registered to our group through PECOS. I called QPP last week and was advised that we will not report on those providers individually. Is that correct? And if this is the case, will they receive a reduction and reimbursement in calendar year 2019?"

If there isn't anyone -- This is Deb from the PIMMS team. If there isn't anyone on that can address this question at this time, I would recommend to the caller you go ahead and open up a Quality Payment Program Service Now Help Desk question, and they'll be able to route it to the individuals that could answer this for you.

All right. So, moving on to the next question, "Is there a place in the portal where we need to submit results, or do they all get submitted on March 16th?"

So, this is Rabia. I'll start, and, Ralph, if you could share some information on the reports that are helpful. But, right, there is no "Submit" button. We will take all the data as it is entered as of 8:00 p.m. Eastern Daylight Time on March 16th. There are helpful reports. I would recommend looking at your measures report and your total report, but there is a completion report that becomes available after the close at 8:00 p.m. that confirms your submission.

Just to add to what Rabia said, as you're submitting, look at the "View Progress" screen frequently, and that will help you to see exactly where you stand in the data that you've reported. It gives a summary for each of the measures. And some of the screens that I was showing today in the slide deck

were from "View Progress." As Rabia mentioned, there are also other reports. The measure rates report will give you further details about the reporting that you've completed. And once the submission window closes, the confirmation report, the data confirmation report, will become available, which will summarize what has been submitted to CMS, based on the data reporting that you completed at the time the submission window closed.

All right, next question -- "We received this error message -- 'Beneficiary is not assigned to the PREV-8 measure' -- but the beneficiary is ranked number 277 and did have a pneumonia vaccine in claims. How can we fix this error?"

We would have to see exactly what happened in your situation. If you could please open up a Help Desk ticket and provide the details about your submission and the issue that you had, then we can look individually at your particular issue.

Great. Thank you. Next question -- "On measure PREV-7, are you looking for an office visit during the measurement period 2017 or a visit in the date range October 1, 2016, through March 31, 2017, in order to qualify?"

Hi. This is...

Hi. This is Angie.

Go ahead. This is...

I'm sorry. It's Angie. Go ahead.

Thank you. We're actually looking for -- In order for a beneficiary to be eligible for the denominator, they need to have had at least two encounters during the measurement period, as well as one encounter in the ACO or group practice during the flu season. And that flu season is defined as October 1, 2016, through March 31st of 2017.

All right. Thank you. Next question -- "If we have already uploaded some data, but then found we had a mistake on some patient, if we correct that on the Excel spreadsheet, will it automatically correct? Or will it overwrite the previous uploaded data?"

Ralph, I'm wondering if you could...with that one?

Sure. If you change some values, either via the CMS Web Interface manual, U.I. screens, or if you change them by the Excel bulk upload, the latest data that you've submitted is the data that counts. So, you can change one particular answer through Excel, or you can change one particular answer through the Web Interface. Whatever that answer is that you submitted last is the answer that counts. Now, if you leave cells blank, meaning there's no data at all in that cell in the Excel spreadsheet, it's ignored. So, say you didn't do a download with data, but you're using a template that you've just put some additional data in and those cells are blank in some columns that you previously reported data in. That data will not be overwritten with blanks. The only way to erase data is by selecting "N.A." in a cell in the Excel spreadsheet. That will erase data. If you've selected "N.A." in a particular cell, it will take that data that you reported before and remove it.

Great. Thank you. And, Stephanie, I think we can take the next question from the phones.

We have a question from Jonathan Menkes.

Hi. I actually have two questions having to do with the flu shot -- flu immunization, rather. Does it have to -- For the office visits, can they be from a specialist or a PCP? Does it matter?

This is...

Hi.

Go ahead. Go ahead.

I was just gonna say, no, it doesn't matter. It could be either. They are not limited.

Okay. Then the second question -- Thank you for that. The second question would be, if there was a visit somewhere else in the ACO that reflected immunization or flu that we could get through claims, could we count that? Say they went to another...

They already went through that one.

Thanks. Yes. That would be -- The actual flu shot -- if you are able to identify it through claims, you do not need -- it doesn't need to occur within the ACO or the group practice.

Okay. Thank you.

All right, our next question -- this person says their previously submitted data has disappeared from the Web Interface, so they want to know, why has this happened, and are there any known system issues on that?

We're not aware of any case where data has been lost. If you can open a ticket up, we'd be happy to look at your particular situation and what you're seeing. If you had seen the data show in the performance rate report -- or the measure rates report or seeing the data show up in your "View Progress" screen, then it should still be there. We're not aware of any case where data has been lost.

Great. Thank you. Next question -- "Is dementia a valid medical reason for not performing a depression screen?"

Hi. This is Jessica from the PIMMS team. If you have medical-record documentation that the patient was not screened for depression due to dementia or Alzheimer's, then you could select no denominator exception for a medical reason. Please note, though, that patients with dementia and Alzheimer's may undergo routine depression screening unless there is documentation that, due to their diagnosis, they're unable to be screened. Medical-record documentation must indicate that the reason the patient was not screened was due to the patient's diagnosis in order for the visit to be claimed as an exclusion. Thank you.

Thank you. This next question says, "For PREV-12, it says PHQ-9 is a screening tool. However, it says that if it is positive, a follow-up plan must be documented. What number on a PHQ-9 test is considered positive?"

Hi. This is Jessica again from PIMMS. And the measure spec indicates that the measure does not require documentation of a specific score. It's whether the results of the normalized and validated depression screening tool used are considered positive or negative. And in order to know if it's positive or negative, you only need to review the medical record documentation for notations of the results from the test. Thank you.

Thank you. Next question. This person says that their co-worker had the @ symbol in her username and still does not have access to the tool. She submitted the issue before the tool opened for submission. Are there any updates on when these will be resolved?

This is Rabia. Yes, so, we are working through these issues, and we have been escalating tickets. So, if you could share your ticket number, if you're a Shared Savings Program ACO, if you could send it through your regional coordinator. If you could reach out to me directly, we'll escalate your ticket and find out what's happening.

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

Our next question is from Jordan Ellis.

Hi. My question is regarding medication reconciliation. For a patient who has been selected multiple times for the medication reconciliation measure, let's use the example January 1st and January 10th. If they are not seen between those two hospitalizations, what is the proper response for the first discharge that we are reconciling?

Hi. This is Jessica from the PIMMS team. So, each discharge is going to count as a unique event. So, if the beneficiary is discharged January 1st, then you would look for an outpatient visit within 30 days of that discharge. And if there is one, then that outpatient visit would also count for the January 10th discharge. So, if you have multiple discharges and there's an outpatient visit that falls within 30 days of both of those discharges, then that outpatient visit, if medication reconciliation occurred, would count for both of those discharges. Does that make sense?

Yes. So, let me clarify. If the medication reconciliation was completed on January 21st, that medication reconciliation could be used for both the admission on January 1st and January 10th.

Are January 1st and 10th admissions or discharges?

I'm sorry. So, both discharge dates.

Good. Okay. Yep. Then you're correct. It will count for both.

Thank you for clarifying.

Thank you.

All right, our next question is about MH-1. "If follow-up PHQ-9 is 5, is that considered a fail? Does it have to be less than 5, 4, 3, 2, and 1?

Hi. This is Jessica from PIMMS. It has to be less than 5. So, it has to be a score of 4, 3, 2, or 1 to be considered a pass. If you have a score of 5, that would be considered a fail. Thank you.

Great. Thank you. Next question -- "Do we have to set up an EIDM account for each ACO TIN?"

This is Rabia. So, if you are a Shared Savings Program ACO or a Next Generation ACO -- and, Kerry Ann, please chime in here for Next Gen -- but if you're reporting quality data through the CMS Web Interface, no, you are going to use your ACO information and follow the EIDM registration guide to create the accounts and the roles. Now, if you are trying to report ACI, I would like to clarify that ACO participant TINs will need to report ACI through the QPP website. So, that may be the reason why some ACOs, I think, are looking as they sign in for the option to be able to report ACI. Now, that needs to be reported at a TIN level, and there are resources available on the 2017 QPP resource library regarding ACI reporting. And there is a YouTube video included. For Shared Savings Program ACOs, we do have on our portal a resource map that links directly to all of these resources to help you with the interactions between the Shared Savings Program and MIPS. But if you are continuing to experience EIDM issues, if you've created the correct roles per our registration guide, then please reach out to the Quality Payment Program Service Center. And if you already have an open ticket, please reach out to your regional coordinator and share your tickets with them because they will work directly with us to escalate these issues. I don't know, Terry, if anyone else wants to...anything.

Yeah. This is Teri Ings. So, for the Next Generation ACO, you would be reporting on the ACO primary TIN for this one TIN. But if you're a user of the EIDM account and you also happen to report on behalf of other organizations or entities other than the ACO, then you'll be mapping to that specific, separate EIDM -- separate TIN. So, for the ACO, there's only one single TIN you'll be using to enter into the Web Interface on behalf of the ACO. So, it would be the ACO primary TIN.

All right, our next question -- for the HMO enrolled that disqualifies them from a measure, if Medicare is secondary and a commercial plan is primary, is that considered HMO-enrolled?

This is from Olivia from ACO PAC. Yeah, the intent is to exclude the...Medicare Fee-for-Services services, not the primary care. So, in this scenario that you describe, a commercial insurer is the primary care, and, thus, it would be appropriate to select HMO enrollment there.

Great. Thank you. Next question -- "When submitting for mental health, I got an error on one patient that said, 'An internal error has occurred. Please see server logs.' Can you tell me what I need to do to resolve this issue?"

Please enter a Help Desk ticket for that, and we'll look at that issue. I don't know what's causing that particular error in your case, but we would be happy to investigate and let you know exactly what's causing it.

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

Our next question from Tony Nanchez.

Hi. I have a question about PREV-13...Medicare Shared Savings Program. We did write the question in, and it was answered by Jessica Schumacher. I think you're on the call today, so thank you for your response, but I would like some clarification about Zetia and Trilipix. So, the response was that they are listed in the numerator codes of the supporting document, but they are listed as combination drugs, the ezetimibe and fenofibrate, combination with simvastatin. So, I'd just like to confirm that we can count those alone. And then I also have a question about the quantity of patients we report on.

So, this is Deb from the PIMMS team. What I would ask you to do with a question that you received a response that you need some additional clarification -- it may be best for us to pull up that inquiry and go back and provide you some additional guidance. So, if you would either re-open that inquiry or, if it has been completely closed out and you can't do that, open up a new inquiry and reference the original case number, and that will give us the opportunity to dig further into not only the response that we provided, but provide additional information. Would that be acceptable to you?

Yeah, that's fine. I'll re-open then. Thank you very much.

No, thank you.

Can you tell me if there's any bonus for reporting on more than the minimum required number of patients for the ACO? I understand the quality score may vary depending on how many of them were numerator-compliant. I understand that part. But just for the actual number of patients reported on, is there any incentive?

This is Olivia again. I think I can try to help address that. I think to the extent completing additional beneficiaries is helpful or hurtful actually depends on what those beneficiaries look like. So, if they're all numerator-compliant, that could help your performance rate potentially, but if they're perhaps not at all numerator-compliant, then that could potentially hurt your performance rate. So, I think it's a case-by-case basis.

All right, so there are no bonus points then for reporting on all patients for all measures.

Correct.

Thank you very much.

All right. Thank you. And for our next question, I think we're going to revisit that PREV-7 question, if Sarah wants to jump in.

Hi. This is --

Oh, go ahead, Sarah.

Sherri, but please chime in. I just wanted to -- I think I gave a confusing answer to the question regarding populating the PREV-7 flu shot numerator. I think I should clarify by saying that if the flu shot data is pre-populated, you don't need to substantiate those data with claims data. However, if you are populating those data, you would need to substantiate it with the medical records. And, Sherri, please provide additional clarification...

No, I think you hit the nail on the head, the documentation that we will look for in a case like that. And the caller's question may be a way that, through claims, you can identify where you might look for that documentation, what office might have written some documentation for you. But the actual support for the fact that the influenza immunization was given needs to come from medical-record documentation if it has not been pre-filled by the ACO PAC team when you go into your Web Interface.

All right. Thank you. So, for our next question, this person says that in the January 31st webinar, it was said that on the CARE-1 medication post D/C that if provider has in their note that medications were reconciled, that would suffice. But per the protocol, it says it has to be one of the five criteria, which just medications reconciled would not qualify. So, I guess they're looking to see if you can please clarify this and if this answer would affect their submissions.

Hi. This is Jessica from the PIMMS team. Thank you for asking for additional informa-- or for clarification, I guess. So, to start with CARE-1, you're correct in that, in order to meet the intent of the measure, there must be medical record documentation that shows that discharge medications were reconciled with current active medications during an outpatient visit. With that said, to meet the intent of the measure, you must meet one of the five criteria that's listed in the measure spec. And based on the example that's given in this question, it appears -- if it's a post-discharge visit and the note indicates that medications were reconciled, as stated on previous calls, if that means that there's a current medication list and a discharge medication list and the provider reviewed the two lists, then that would meet the intent of the measure. Alternatively, to help folks out who have an EMR, CMS is agreeing that if you have an EMR set up that has the discharge medications and whether it's displayed on the same page as the outpatient medications or if the discharge medications roll over and then become the active medication lists for the first outpatient visit -- if your system is set up in a way that supports one of the five criteria that's listed in the measure spec under the definition of medication reconciliation, then you will meet the intent of that measure. Thank you.

Thank you. Next question -- "What happens if we do not get a CMS-approved reason and end up reporting on patients who should have been excluded since they are in this CEC/ESRD program? Will they get skipped automatically by CMS, or will the data be counted in measure performance rates?

Hi. This is Olivia Berzin from ACO PAC. And, Raina, I think I just answered your question via text, as well, but the answer is, it's really important for you to submit a CMS-approved reason to skip those patients. They will not be automatically excluded from the measure, so you need to do so on your end. And the only way to do that is to get a CMS-approved reason to skip. And so make sure the...everyone submit the measure and ranks numbers that are affected by this comprehensive ESDR care exclusion, and we will get that resolved as quickly as possible.

And this is Rabia. Just to add to that, I do want to clarify that specific contacts within your ACO are not required to submit that request for the CMS-approved skip for that. So, anyone, really, within your ACO who is working on quality reporting can make that request, but as Olivia said, you must provide the rank and information for that.

All right. Thank you. So, for this next question, this person says they've been experiencing issues with the Web Interface in the past few days. For example, data entry has not been saved, there's been a freezing screen, they've been booted off. So they're asking if other submitters have experienced these issues or if they should try entering in a different browser or during a different time of day.

So, I don't want to speak for the whole user community, but we have not had those types of reports occurring. And we have not seen Help Desk tickets to that effect. So, if you're continuing to have an issue, please contact the Help Desk, and we'll be happy to work with you to see what's happening in your case.

All right. Thank you. This next question is, "What about if a patient has a commercial insurance as their primary insurance and Medicare as secondary?"

Hi. This is Olivia, and I think we covered a similar question a few minutes ago, but the key here is that a commercial payer is primary. In other words, Medicare is not primary. And so if that is the case, then it is appropriate to select HMO enrollment to skip this beneficiary.

All right. Thank you. Next question -- "When I downloaded our sample data, what does the clinic I.D. represent?"

Hi. This is Sarah Graller from RTI. The clinic I.D. would represent the tax I.D. or the CCM for that clinic.

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

Again, if you would like to ask a question, please press star, then the number 1.

All right, and I think we have time for just one more question. So, in regards to PREV-12, depression and follow-up, if the physician remarks in the exam psychiatric negative for depression/anxiety, no suicidal ideas, does this meet the intent of the measure?

Hi. This is Jessica from the PIMMS measures team. And this would meet the intentions of the measure as long as there is medical-record documentation of the name of the screening tool. The measure specification requires that the name of the screening tool be included in the medical-record documentation. We understand there's scenarios where you might have an EMR setup that has questions from the PHQ-2 and PHQ-9 built in to your EMR. If that's the scenario, that would be acceptable. However, we have to warn you that, in the event of an audit, you would need to have documentation indicating what screen tool is being referenced within your EMR. Thank you.

Thank you, and that concludes our Q&A portion of the webinar. So, with that, I'll pass it off to Rabia for the closing.

Thank you, and thank you all for joining us today and asking great questions. We understand that time didn't allow for us to get through all the question, so if we did not get to yours, I ask that you please send it to the Quality Payment Program Service Center. And I do just want to sort of reiterate that if you're a Shared Savings Program ACO and you have outstanding tickets that need resolution or support, please reach out to your regional coordinator and share that information with them. And as a reminder, we do have our next support call next Wednesday from 1:00 to 2:00 p.m. Eastern Standard Time. But do not wait till then to ask your question. So, again, please send it to the Quality Payment Program Service Center. But thank you all for joining again, and have a great afternoon.

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