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 at 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 the 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 the call over Aruna Jhasti from the Centers 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 2017 performance year. I am Aruna Justi, 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 after today's presentation. Next slide, please. This slide is a disclaimer and is a reminder that information on these slides are current at this time of this support call. We encourage everyone to use and reprint 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 for 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 16th at 8:00 p.m. Eastern Daylight Time. We want to remind everyone that there is no submit data as a CMS option 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, an important reminder. Our next weekly support call is on March 14th at 1:00 p.m. Eastern Time. This is the last support call before the CMS web interface closes on March 16th. Next slide, please. We have a few announcements for you today. As a CMS web interface user, you may have been recently contacted by the Quality Payment Program to address and resolve an issue with the CMS web interface beneficiary sample file that you may have downloaded from the CMS web interface. If a Quality Payment Program Service Center representative was able to reach you, they had you access previously-downloaded files and re-save them to ensure the files were fixed. If you were not able – sorry – if you were not available, the Quality Payment Program representative left a voicemail callback number and ticket number you could use to call the QPP and complete the process. In order to reduce any concerns from CMS web interface users that these phone calls may be phishing scams, we wanted to assure you of the authenticity of these calls. If you received a message and have not yet been in contact with a QPP program representative, we urge you to contact us via the callback number and to get information left in this voicemail. Please note that this issue with the beneficiary sample download does not affect your ability to report data in the CMS web interface. CMS (inaudible) is used to continue Quality reporting. If you no longer have the information left via voicemail, or if you have questions regarding the CMS web interface or the Quality Payment Program, please

contact the Quality Payment Program. And a quick reminder. The webinar materials from the CMS web interface support calls are now available on the QPP Webinar and Events page. Next slide, please. I'll turn the presentation over to the next speaker, (inaudible).

Thank you. Next slide, please. So we're just going to quickly review the CMS Approved Reasons. Just a reminder that the CMS Approved Reasons are reserved for cases that are truly unique. So once we have reviewed, if it's determined that the request is not unique or an unusual circumstance, it's likely the request will be denied. Your CMS Approved Reason Request should be submitted as soon as possible. The longer you wait to submit a request, the higher the chances are it will not be reviewed before submission closes. In order to request a CMS Approved Reason, you should submit an email to the Quality Payment Program Service Center, and include the patient rank, the measure, and a detailed reason for your request. Please only submit one request for each unique scenario. And remember to never include any PII or PHI. In some cases, the Service Center may ask you for more information, so please be prepared to respond to any follow-up inquiries. Next slide, please. And now I will go ahead and hand things over to Ralph Trautwein. Thank you.

Thank you very much. We're going to provide you some helpful information at this point based off of some of the Help Desk tickets we've received and the observations we have from submissions. Next slide. In the screens you're about to see, I'm reminding you that there is no protected health information, PHI, or personally identifiable information, PII, present. Everything you're about to see is all test data and test organizations. There is no real organizations or real beneficiaries in these slides. Next slide. So, some Excel file guidance. One of the things we've observed, and this is not everybody, this is just a few users, but I'm warning you against doing this, and that's that some folks are copying the patient list – the Beneficiary tab – to multiple tabs in the spreadsheet. I don't know if they're doing it for version control purposes, or why they're doing that, but we're seeing some bloated Excel files where they copied their beneficiary list multiple times to additional tabs in the Excel file. We only process the first worksheet. And any additional worksheets are not processed in the file. And it slows down your file transfer. So we recommend that you not use that as a way to store supplemental beneficiary information or version control your information. You can at any time download, with data, a copy of everything that the system has accepted to date and keep that as a separate Excel template. But, please, do not copy multiple worksheets within your Excel file. Next slide. Another thing that we've observed, and this is only a few people, and we're not even sure how they managed to do this, but they've extended the Excel formatting to the maximum number of rows that Excel accepts, which is 1,048,576 rows. By default, the spreadsheet only has a little over 8,000 rows formatted, which covers everybody's (inaudible) sample capabilities. If you've extended the row count in Excel to the maximum 1,048,576 rows, the system has to go through each one of those rows looking for data and can slow down your Excel processings. So please don't add extra blank rows at the end of your spreadsheet when you're submitting it. Next slide, please. So, we've had a number of Help Desk tickets around skipping large numbers of beneficiaries. And I'm using MH-1 as an example because that seems to be a measure where a significant number of skips occur. In this example, I'm showing you what – how the system reacts if you skipped every beneficiary in MH-1. In this example, notice that you've reported on every beneficiary, but the minimum still indicates that it's not met, and the measure count is still not incremented. So if you skipped every beneficiary in the measure, but the measure count will not increase and the minimum met

indicator does not change. Next slide. So here's an example where they reported on 18 beneficiaries and skipped all the rest. Until you reach 20 beneficiaries that have actual real results that aren't skipped, then the measure increment count does not increment. It stays un – for example, in this case, zero out of 14 measures are complete. So I have submitted 18 beneficiaries and it now flipped to meet the minimum because I've skipped all the rest. So the met minimum flag flipped because I reported on all the beneficiaries I had to report. But the measure did not increment. So it remains at zero out of 14. Next slide. So, in this example, we finally reached 20 beneficiaries that have been reported on for MH-1. And here you see the minimum met flag is flipped. It shows you met the minimum. And the measure count incremented by one. So once you have reached that number of 20 beneficiaries that you've actually reported data on and not skipped, the flag will flip from zero to one as a complete measure. When all the rest of the beneficiaries have been skipped. If you're not skipping beneficiaries, you still need to meet the minimum requirement for reporting before that flag will increment. Next slide. So, this is specific to groups to see the performance points. In measures with benchmarks, and here you see this particular measure has a benchmark, you will receive performance points. And here you can see that this measure – that's the minimum reporting requirement. And in this particular case, they've gotten seven performance points for this particular measure. Next slide. For groups who see performance points, measures without benchmarks will not receive performance points in the interface. So, here in this example, Prev-13 does not have a benchmark, and therefore the performance points are not shown. We have gotten quite a few Help Desk tickets around this issue, where for measures without benchmarks, they've met the minimum, they've reported all their data, but don't see performance points. That is expected behavior in the application. Again, this is only for groups who see performance points. Next slide. Okay, I'm going to hand it over to Jessica now.

All right. Thank you, Ralph. So the next section, we'll quickly go through Resources and Where to Go for Help, and then we'll jump into our Q&A session. Next slide. On slide 17, you'll see the list of CMS resources that are available on the QPP Help and Support website and also on the QPP Resource Library. At the bottom of the page is a link to the QPP Webinar and Events page. And as a reminder, that is where the Questions-and-Answers document and the webinars and transcripts materials, that's where they are also posted is on the QPP Webinar and Events page. Next slide. On slide 18, you'll see the list of the CMS web interface instructional videos. If you are having some trouble or if you just want to know what next steps are in the web interface, please take a look at these videos. They provide a nice walk through of the system and provide step-by-step instructions on what to expect as you report. Next slide. Slide 19, our resources for the ACOs. Starting with the Shared Savings Program ACOs. Please reference your website and the Program Guidance and Specifications. Also please keep an eye out for the ACO Spotlight newsletter. That newsletter does provide useful information and important announcements regarding website reporting. And same for Next Generation ACOs. Please reference materials on your website and the Connect site. And keep an eye out for that weekly newsletter for important announcements. Next slide. Slide 20 lists our contact information for the QPP Service Center if you have any questions. And, again, if you want to submit a Request for CMS Approved Reasons, please contact the QPP Service Center at qpp@cms.hhs.gov. And I believe that's it for our resource slide. Next slide. I will hand it over for the Q&A session. Thank you.

We are now going to start the Q&A portion of the webinar. You can ask questions via Chat or phone. To ask a question via phone, dial 1-866-452-7887. If prompted, please provide the conference ID number, 72087470. So this first question comes from a Care Two ACO organization with over 25 providers. And they are asking, would an encounter for a fall meet the intent of the measure, either by our provider or in the ER or for imaging? And they say, also if the ER consistently does a fall risk assessment in order to tell if the patient needs fall risk band, rails up on the bed, etc., would this count?

Hi. This is Jessica from the PIMMS team. So any medical record documentation that describe – or not describe. So any medical record documentation that indicates that the patient had a fall would count as a screening, therefore, in this instance, it would count as long as you have that medical record documentation. If the patient – if the documents just indicate the patient was there because of a fall, that doesn't meet – that doesn't meet the intent of the measure. There has to be that documentation stating the patient's fall history, or that there is an injury due to a fall, or a case assessment. Thank you.

Thank you. This next question is about IBD-2. If we find an anticoagulant for IBD-2, are we supposed to still look for an active diagnosis of IBD or can we stop since the patient will be excluded at this point?

Hi. This is Angie from the PIMMS Measures team. That is correct. You would exclude the patient from the denominator because they had documentation of use of an anticoagulant medication during the measurement year. And the diagnosis, as I'm looking at the spec, you – I think that you are verifying that kind of all at once on the template, but I would have to have Ralph confirm that. So, the answer would be that it is a denominator exclusion. Sorry.

Thank you. This next question is, for Prev-7, what dates are included when looking at visits?

Hi. This is Angie again from PIMMS. For 2017 reporting, the sampling process identifies the patients – the eligible patient sample. And verifies that they have at least two visits or one preventative visit during the measurement year. They also verify that the patient had a visit between October and March, and that is a requirement for the measure. But you are not responsible for confirming that. So you would only need to determine if the patient received or reported previous receipt of the influenza immunization between August 1, 2017 and March 31, 2017. And that has already –

Angie, I hate to correct you, but it is August 1, 2016.

I'm sorry. Thank you so much. I don't know why that always –

Didn't want to confuse someone.

And here we are in 2018. I apologize. That's correct. So you're looking for the immunization between August 1, 2016, and March 31, 2017. Thank you.

Thank you. This next question is for Prev-13 statin. If the patient is a diabetic and the LDL is less than 70 and not on a statin spec that says they can be an exception, how does this fit in the web interface when the answer

for the question is diabetes LDL 70, 189, you answer no and can't get to the statin question to enter medical reason exception.

Hi. This is (inaudible) with the PIMMS team. So, when you're looking at the Excel document, you document use a denominator exclusion in Column CT and Column CR of the Excel document. All exclusions should be captured in this – these columns. Denominator exceptions will be captured in Column CW, which is titled, Was the patient taking a prescribed statin therapy between January 1st and December 31st 2017? It's a conditional field that opens when you say yes. If you say no, then it really doesn't open the next question, was it asking if the patient was on statin because it's not necessary. Thank you.

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

Our first question is from Jason Shopshire.

Hi. Can you hear me?

Go ahead.

Hello?

Yes.

Yes. I have a couple questions. So my first question is, can you please confirm, because I can't find anything on the website, what are the total possible points for groups and ACOs?

Hi. This is Robia (inaudible) CMS. I don't believe we have anyone on the line for MIPS scoring, so I don't think - . I know for ACOs I can pull up, there is a Quality Category Scoring Guide that's available on the Quality Payment Program 2017 Resource Library that walks through for ACOs how the Quality category will be scored under MIPS. But – and I apologize – if you would like to send that to the Quality Payment Program Service Center, we'll make sure that someone on the scoring side can respond to that.

Okay, this is Tim. Can you hear me?

Okay. (Inaudible) someone from the scoring is there at the next – next Wednesday, that would be very beneficial.

Absolutely. I'm sure other people are interested.

Yes.

And Robia –

Okay.

This is Tim. Can you hear me?

Oh, Tim is on. Great. Thank you. Yes.

Yeah. So the – if you just go to Google and type in, uh, MIPS Quality Performance Category Scoring for MSSP and Next Gen ACOs, it will take you to the 2017 Resource Library page. And you select that file, and it pulls up a

PDF document, which lays out the Performance category scoring for MSSP and the web interface groups. It's a side by side. And you scroll all the way down to the third page, it shows you your totals. And it does a side-by-side comparison on which ACO measure and measure title are applicable. I'm trying to figure out how to send that to the group. We'll figure out how to do that and post that with the notes for today. But that should answer your question. Thanks so much.

Okay. Our next question is, we are experiencing an issue with the web interface upload not recognizing the CMS ticket numbers for the EF-30 patients. Is this a known issue?

This is Robia. If you're a Shared Savings Program ACO with ticket numbers associated with the CEC skip – the CMS (inaudible) skip request, can you please escalate your tickets with our regional coordinators? That will help us identify and be sure that we can pull those tickets to address them. Olivia, I don't know if you want to add anything else.

No. I mean the ticket num – ticket numbers we provide are the ones from the QPP Service Center, so I – yeah, if we could escalate those to the web interface developer, that would be great.

Thank you. This next question is, for Prev-6, does the format of the date of the colonoscopy matter? Is the year acceptable, or the month and year?

Hi. This is Jessica from the PIMMS team. There is no specific requirement for the format of the date. So – so any type of date would be acceptable. But please note on page eight of the measure specification, if the patient is reporting their screening, then there must be – the date must be the year, or more. If there is the day and the month, that would be great. But for patient-reported, at least – at least there has to be the year. Thank you.

Thank you. This next question is, if the patient self-reports Prev-8, what are the guidelines for passing them? I know if it is before 2015, the guidelines are slightly different.

Hi. This is (inaudible) with the PIMMS team. So if the patient reported for the Prev-8 measure, what's required is the date, meaning the year, and the type of vaccine. However, if the patient reported prior to 2015, documentation indicating receipt of the vaccine and the date and year will be sufficient. If they reported in 2015, 2016, 2017, documentation indicating the year of the vaccine and confirmation of the type is required. Thank you.

Thank you. This next question is, if a member has been attributed to our ACO due to specialist, but the primary care provider is not part of the ACO, what are we to do to complete the measures?

Hi. This is Sarah (inaudible) from ACO (inaudible). I'll take a stab at this one. So there's a couple of ways that a beneficiary needs to come to the sample after they are assigned or aligned to the ACO or group. And the first thing that we look for is that that beneficiary has two visits where primary service – primary care services were provided during the measurement year. So that's the first step that we're looking at. It's not necessarily with a primary care provider. How they're selected into a specific sample also isn't necessarily related to whether or not that visit occurred with a primary care provider. So the expectation would be that you would continue to report on that beneficiary.

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

Our next question is from Andy Runandi.

Hello. My question is about Care Two. Care One, sorry. When we were uploading Care One to an Excel file, we received an error message that said the provider was not found to be associated with our organization. I confirmed it, and that provider is associated with our organization. And she has had more than 1,500 Medicare-billed encounters in 2017, so I'm not sure why this error is showing up. Also, I want to know what we can do to rectify this.

So we would have to take a look at the Excel upload that you performed. If you could open a ticket with the details, including your organization and which beneficiary you're having problems with, we can take a look at that Excel file and help you with resolving that issue.

Okay. I've already opened a ticket, but I just wanted to ask this question anyway just in case. I have one more question also.

But one other thing to ask about that is make sure that they are on your – in Managed Providers, if you go under Managed Groups within the web interface and click on Managed Providers, and make sure that they are in that list.

Yeah, they are.

Okay. Okay.

They are in that list. They are in that list –

Okay.

And the NPI numbers match. The last name does not match exactly, but the first name and the NPI numbers match exactly.

And so we are doing a check on first name and last name, so they would need to match within the Managed Providers. And in the Excel spreadsheet. So that's what we do the name – if a check is on the name in that case.

Okay. Okay. My other question was regarding the mental health issue that we just discussed. For us, we also skipped a, you know, a huge number of the 216 patients. But our consecutively completed ones are – it's exactly at 19. So according to the previous, you know, what you just said previously on the webinar, we need to reach 20 before it will count towards our total measures complete. Now, what actions should I take right now to ensure that that happens because we have completed everything, and we can't get one more.

This is Robia. I'll jump – I'll start, and then Ralph, please jump in. And, I apologize, are you a group practice or are you an –

Group practice.

You're a group practice, okay. Yeah, to help clarify. So the complete count, those – those totals that show up on that about measures completed is very specific to MIPS scoring purposes. So for MIPS scoring, you need to have at least 20 cases in your denominator for that measure to be eligible for MIPS

scoring. So, if it's less than 20, that's why it's not appearing on that count in the upper right corner for the complete count. .. Okay.

However, you still need to complete the 248 consecutive complete reporting. And if you have a denominator after you've completed, and all of your reporting, and you, you know, and it's still less than 20, I think ultimately that's okay. It's just it's not going to show up on that complete count list and will not be included as a part of your MIPS score for Quality for that – that measure may not be included, then, in that score. And so, I would recommend confirming, you know, that, you know, you've met the minimum reporting requirement on the measure, I think like the sheet.

Got it. Okay. Yeah, I think we have met the minimum.

And I think in your case –

I see your point.

Right.

Right. And I think in your case, you've actually reported on every beneficiary.

Yes.

It's just that your reporting was such that a majority of them fell into the skipped categorization. So, you've reported on every beneficiary that you can. You just ended up – your reporting ended up skipping a lot of beneficiaries.

That's correct, yes. Okay. Thank you.

Great. This next question is, if a patient has a PHQ-9 but the clinician does not indicate whether the score was positive or negative, how do I answer the question of, was the screen positive for depression between January 1st and December 31st, 2017?

Hi. This is Jessica from the PIMMS team. So you aren't able to answer it, so you would need to select no. The rationale is that the clinician provides their – their results – their interpretation of the screening so that the rest of the care team is crystal clear understanding that whether or not that patient has depression. So – so for that you would need to select no. Thank you.

Thank you. This next question is, for Prev-6. Is a patient-reported colonoscopy with results acceptable?

This is Jessica from the MIPS team. Yes. Patient-reported colonoscopy is acceptable. Please make sure that you have medical record documentation that indicates the date of the colonoscopy, the type of the test, obviously a colonoscopy, and also the results and findings from that test. Thank you.

Thank you. For this next question, this person says that Care One CPT codes 99496 and 99495, Transitional Care Management Visits, are not listed in the Prev coding document as an acceptable encounter code for that metric. Will these still count as a visit within 30 days of discharge?

This is Jessica from the PIMMS Measures team. And yes, transitional care management visits will count when they are performed in outpatient settings. If the TCM was conducted during an outpatient within 30 days, then it definitely counts. So do make sure that it's within those 30 days. Thank you.

Thank you. This next question is, why are there 750 statin patients in our sample?

Hi, this is Sarah from ACO (inaudible). As you may recall, this was a new measure last year, performance year 2016. And it's a bit of a complicated measure with three different risk categories. And the decision was made to provide a larger sample for this measure in anticipation of a high (inaudible) rate.

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

Our next question is from Jody (Inaudible). Jody, please go ahead.

Hello?

Go ahead.

Oh, shoot. Hello? Hello? I'm sorry. Hello?

Jody, (inaudible) hear you?

Jody, can you hear us? It looks like she may have lost her line. When you like to go to the next question in queue?

Yes, please, Stephanie.

The next question in queue is Rebecca (Inaudible).

Hi. Thank you for taking my call. I noticed that the skip thresholds are a little higher than in the past because the skip reasons are lumped into one bucket whereas in the past our reports showed each skip reason segregated from the other. For example, not qualified for sample had a separate skip threshold percentage compared to medical record not found. So, I'd like to know, how will CMS view skip thresholds going forward considering that skip thresholds are used as flags for audit, and we may have skips due to CEC beneficiaries that shouldn't have been attributed or we had beneficiaries that died and are required to be excluded.

This is Robia, and speaking for, you know, the Shared Savings Program. Right. So, the data that we'll be receiving for our Quality Measures Validation Audit, we will break down the types of skips and take a look at anomalies based on specific skip rates. So like medical record not found, like you noted. Moving forward, I think that's a great – that's great feedback for us to hear. We're planning to do a lessons learned as well with this reporting cycle, and we'll take that as feedback for improvements for next year, I think, as well, because that's helpful to know that you guys also want the breakdown of each skip rate. And I completely understand.

Yeah. It is helpful, so – but thank you for answering that and understanding, you know, where our – where the ACO population is coming from in that regard. So, thank you very much.

Absolutely. Thank you.

All right. Our next question is, how do we clear previously-entered data through the web interface? For example, change the content to null.

Ralph, did you want to address that question?

This is Robia. Could you repeat the question real quick? Sorry.

Yes. So the question is, how do we clear previously-entered data through the web interface? For example, change the content to null.

Okay. So, there's one way to do that, and that's do an Excel upload. So, if you find the piece of data that you want to remove altogether, I mean to null it out, enter NA in that cell in the spreadsheet, and upload it, and it will remove your data entry for that particular answer or particular piece of data.

Thank you. This next question is, if a BMI is obtained and abnormal, is it acceptable for the follow-up plan to be completed on a separate date as long as it is within the previous six months? Would a handout with the after-visit summary on appropriate diet or exercise be sufficient to count as a follow-up plan?

Hi. This is Angie from the PIMMS team. As for the BMI completed on a separate date, yes, as long as the recommendations for diet or exercise was as a result of the abnormal BMI – or of an abnormal BMI – at the visit or in the six months prior, and it was discussed with the patient and documented in the medical record, that would count. You can find the definition on page six of the measure specs about follow-up plans. And you can also find some follow-up plan guidance with an example of what needs to be documented in the medical record.

And this is Deb from the PIMMS team. I just want to clarify that you can use a follow-up plan from a previous visit, but you can't use a follow-up plan that is not linked to an abnormal BMI within that six-month period. So you have to have both the abnormal BMI and a follow-up plan linked. And – and the rest of what Angie shared is absolutely correct. You can certainly hand out a document that provides the patient with some information on what you're recommending as a follow up to an abnormal BMI. But you would want to have that information documented in your medical records in the event of an audit.

Great. Thank you. This next question is, for the IBD measure, if you have a patient that was on aspirin at the beginning of the measurement period but was on an excluded medication later in the year, should this be marked as confirmed, yes on aspirin, or excluded based on the excluded medication?

Hi. This is Angie with PIMMS. That would be a denominator exclusion for patients who had documentation of use of an anticoagulant during the measurement year. Thank you.

Thank you. For this next question, this person says, our patient sample contains patients who belong to a physician who has retired and so we do not have access to the patients' charts. In this situation, do we have to indicate that the physician has retired or should we just select medical record not found?

This is Olivia from ACO (Inaudible). I can take a quick stab at that. I'll just remind you that patients and beneficiaries are assigned to your ACO as a whole, not to particular providers within the ACO. And we do expect ACOs to make a concerted effort, you know, to obtain the information they need for Quality reporting. That said, if you are really unable to access the patients' medical records, then it would be appropriate to select medical record not found.

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

Our next question is from Jody.

Ah, am I here again? Hello?

You may go ahead with your question, Jody.

(Inaudible)

Are you on speakers?

Hello? Hello?

Jody, go ahead with your question.

Okay. So for the MH-1, our question, because we have less than 20, we went through all the beneficiaries and skipped all 119 beneficiaries. So we had to skip all of them because we don't do the PHQ-9 here. So – but that's going to show up as incomplete, and it doesn't change – I understand it won't change the number of measures, but the measure is remaining incomplete. Don't all measures have to be submitted to have that you've successfully participated in a web interface?

Yes, this is Robia, and, Ralph, jump in again (inaudible). So, right. The complete tab that shows up on that screen, and I'm wondering if we can go back a couple of slides to show – what slide number that is – I wonder if we can go back a couple of slides so we can get to the screen that had the complete count in the upper right corner. But essentially, the complete count indicates to you which measures meet the MIPS criteria for scoring. So those are the measures that will be eligible for scoring. So you have to have a denominator of at least 20 (inaudible) cases.

Yeah. One more back. Back one more.

Ah, one more. Thank you.

There you go.

Slide 13? So if – if – yes, here we are. Sorry. Slide 13. So, yes, so in the upper right where it says one over 14, that's in relation to the measures that are eligible for MIPS scoring. So if you – like I said, if you have less than 20 cases – so for your instance you've skipped all of the beneficiaries in your sample. So you've completed that consecutive reporting requirement, but because you don't use the PHQ-9 you've skipped everyone. You have a denominator of zero. So they're not going to show up in that upper right complete count because it's not – because it's not meeting the criteria for MIPS scoring. And it won't be in your MIPS score. However, you should check your measure progress like it showed on the screen to ensure that you – it

says, minimum met, so to ensure that you've met the complete reporting requirement to be – to meet the criteria for complete reporting.

Robia, I think she's referring to maybe what was on an earlier slide. I don't know if it's the one directly before this one or –

Because it still shows that it's incomplete. That the measure itself is incomplete.

Eleven they said.

We were under the impression that for web interface reporting, that all measures had to be completed.

Yes.

Right. Because it still says minimum not met.

I mean that is still correct.

So –

So on the slide they were on in this example, the user has skipped every single beneficiary in the measure. And so if, in that case, the application indicates that the minimum is not met for this measure because there are no beneficiaries that have data reported against them. And the measure count does not increment. As soon as you start to have one or more beneficiaries that you've reported that are not in the skipped category, on the next slide –

There's no more beneficiaries –

(Inaudible.)

Right. There's no more beneficiaries showing up.

I mean, if there were, we wouldn't (inaudible).

Yeah.

Right. So this is how the application behaves. And we're trying to show you how it works. So if you have one to 19 beneficiaries that you had data for that you can report on, and they didn't count as skipped, then it will show minimum met with all the rest of them skipped. And it will not increment the measure count.

Right.

What if all 119 are skipped?

Okay. Because when we go to pull the report, it still shows that it's incomplete, and I think that's what's throwing us off.

So this is Robia. I think it would be best to always download your reports and take screenshots. And I think the other piece of that is just as long as you have completed reporting on your entire sample, then you have met that

requirement. And I understand the system is not apparently recognizing that once you've skipped everyone –

Right.

It doesn't recognize it as being complete. But if you've skipped everyone and you reported completely on that measure, please keep record of that, I would say, also, but we will – we will receive that data as is and accept it. Yeah.

Okay. Because that was our – that's what we were concerned about.

Yeah.

Exactly. The system is not recognizing that.

Absolutely.

Okay.

I completely understand. We will –

So should we – go ahead.

Oh no, please go ahead.

So if we've got the screenshot, should we send the screenshot in?

No. I think for your records, so long as you completed reporting, in general, I think I recommend for everyone to, you know, as you're reporting, download your reports and keep screenshots for your own purposes and records. We will – there is a report that is generated right after this deadline at 8:00 p.m. on March 16th that will confirm that we've received all the completed data. So that is definitely another form of confirmation for you. But, yes. So essentially the system, because you skipped everyone, is not recognizing it as complete. But you've reported on each of your beneficiaries and we understand.

Correct.

Yes.

Okay. Will do. Thank you.

All right. And before we move on to the next question, I think Jessica wants to jump in to clarify some info on Prev-12.

Thank you. This is Jessica. I just want to clarify a previous response I gave may not have been very clear. So regarding the question for Prev-12, if the clinician did not indicate whether the score was positive or negative for depression, then how do they answer the question, was the screen tool positive for depression during the measurement period? So I'm – when I am thinking through this, I am looking at page 14 of the measure spec. I'm looking at the measure flow for Prev-12. At the top of the flow, there is that question, patient was screened for depression using the standardized age-appropriate tool. Yes, they were screened based on this inquiry. The next question, patient had a positive screening for depression during the

measurement period. That's where you would select no, and that pulls you over to the performance met. The patient will be pulled into the numerator because you're not able to indicate whether – whether or not it was positive. If it is positive, then in the flow you get to move on to the follow-up questions about the follow-up plan. But in this – in this instance, if the patient does not have medical record documentation of a positive or negative score, then, unfortunately, it can't go much further in Prev-12. So you would – you would select no to that question.[1] Thank you.

Thank you. This next question is, after an ACO submits data, will the associated PIMMS be able to see the data on QPP if they log in with their own AIDM account?

I apologize (inaudible). Could you repeat that one? Yes. So, after an ACO submits data, will the associated PIMMS be able to see the data on QPP if they log in with their own AIDM account?

And Tim, please jump in here. So our understanding is unless the ACO completes reporting, the ACO-reported data on the back end is going to be used to calculate the Quality category for MIPS-eligible clinicians within each ACO who are subject to it. The MIPS scores will not be available right after the window – submission window closes. There will be a notification from the Quality Payment Program of when eligible clinicians can log in and locate their MIPS Quality category and other scores.

Yeah. This is Time. That's correct. And they'll also be available with the Performance feedback in July.

Great. Thank you both. And it looks like we have time for one last question, so this question is, what types of groups are able to see performance points?

So, all groups can see performance points when they've met the minimum of 20 beneficiaries or more for the – met the minimum reporting for the measure. So if – if you're in a group, not an ACO, then for the measures that you have that have benchmarks, once you've met your minimum reporting requirement, you will see the performance points.

Great. Thank you. And that concludes our Q&A and the webinar for the day. So thank you all for joining.

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

[1]*Addendum added 3/12/2018: If the medical record documentation does not include the provider's assessment of whether the patient is positive or negative for depression based on the screening, then you would select "NO" to question "Was the patient screened for depression using an age appropriate standardized tool during the measurement period".*