[Classical music plays]

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 for 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 the call over to Sandra Adams from the Center for Medicare at CMS. Please go ahead.

Thank you, Stephanie. Welcome, everyone, and thank you for joining our webinar on quality reporting through the CMS Web Interface. I'm Sandra Adams with the CMS Division of Shared Savings Program. Joining me today on this call are other CMS subject-matter experts and contractors who will share helpful information and answer your questions during our question-and-answer session after today's presentation. Our webinar today is focused on quality reporting through the CMS Web Interface. If you have questions related to the Quality Payment Program, reporting ACI, or other questions, you can submit a ticket through the Quality Payment Program Service Center. If you submit a ticket to the Quality Payment Program Service Center requesting a CMS approved reason, please provide the measure number, the patient rank, and the reason you are requesting a CMS approved reason. You do not need to provide the beneficiary's name or any PII to request a CMS approved reason. Today, we are aware there are technical issues with the uploading and downloading function in the CMS Web Interface. We are working to resolve these issues. Thank you for your patience. Also, this issue with the upload and download function does not impact your ability to manually enter data or access reports. Next slide, please.

This disclaimer slide is about this presentation. Information on the slides are current at the time of the webinar, but we ask that you use and reference the source documents that are provided throughout the presentation. Please stay tuned to any communication from the Quality Payment Program, the Shared Savings Program, or the Next Generation ACO Model for updated information. Next slide, please.

Just a reminder that the CMS Web Interface window opened on Monday, January 22, and will remain open for eight weeks. And CMS Web Interface materials are now available on the Quality Payment Program Webinars & Events page. Next slide, please.

Okay. The next CMS webinar will be held on Wednesday, February 21, at 1:00 to 2:00 p.m. Eastern time. The webinar will include a brief presentation and question and answers afterwards. And now Amy Mills from the ACO program analysis contractor will review some frequent assignment, sampling, and pre-population questions.

Good afternoon. I'll be covering assignment, sampling, and pre-population of data into the CMS Web Interface. The first question is about PREV-7. The question says, "I have a patient that was only seen once during the flu season of October 1, 2016, through March 31, 2017. Would this make them not qualified for the sample?" And the answer is that according to Medicare claims, all beneficiaries sampled into the CMS Web Interface have had at

least two visits with a provider in your organization during 2017. Additionally, CMS ensures that the beneficiary had at least one visit with the encounter codes listed in the supporting documents for PREV-7 at the organization during the flu season, which is October 1, 2016, through March 31, 2017. Please note, users are not responsible for confirming that the qualifying encounters occurred. You would only need to determine if the patient received or reported previous receipt of the influenza immunization (if not pre-filled) between August 1, 2016, and March 31, 2017. Next slide, please.

This question is about when to mark "medical Record Not Found." The question says, "We are finding a small number of patients in our beneficiary sample have not been seen by any of our organization's providers in the past three years. When we find a patient whom our providers haven't seen, should we mark "Medical Record Not Found" since a medical record is unavailable for the reporting period? Or should we mark something else?" The answer is that by the assignment algorithm, the patient was assigned to your organization because they were deemed to have the plurality of their Medicare services with your organization (per claims submitted by your organization's participants to Medicare). Further, patients sampled into the CMS Web Interface had at least two Evaluation & Management visits with your organization between January 1 and October 27, 2017. Therefore, your organization is considered accountable for this patient's care, and you should do your best to obtain the needed quality of care information to complete the CMS Web Interface. Next slide.

The next question is about the Medicare IDs in the CMS Web Interface. The question says, "Some of the Medicare IDs, or Health Insurance Claim Numbers, that were provided in the CMS Web Interface are different than what we have on file for the patient. What should we do?" The answer is that a patient's Medicare ID or HICN may change over time as eligibility reasons change, for example, if the patient's eligibility status changes from spouse to widow or if a patient changes eligibility from self to dependent status. Please also note that HICNs with brackets are not necessarily incorrect; they are used for beneficiaries who are eligible for Medicare through the Railroad Retiree Board. Whenever possible, you should confirm the patient based on other criteria, for example, name, gender, and date of birth. The HICN cannot be edited in the CMS Web Interface, although you can make note of this in the Comments field for your reference. And now I'll pass it on to Jessica for frequently asked measures questions.

Thank you. So, next slide, please. Starting on slide 10. We just want to begin by covering PREV-9, the BMI Screening and Follow-Up Plan Measure. The Measures team received a lot of questions about the measure, and we just want to highlight information that's currently available in the measure specification to help answer some frequent questions that folks might be having at this point in time. Before we begin, I just want to encourage you guys to please be sure that you have access to the 2017 CMS Web Interface measure specifications that are currently posted on the QPP resource library. As the specifications were last updated December 20 of 2017, that's the posting stamp that's marked next to the zipped file that's on the QPP resource library. We want to be sure that you have the most recent version.

Now, starting on slide 10, we note that the denominator confirmation indicates that the denominator includes the initial patient population minus any denominator exclusions. And denominator exclusions apply to patients with either of the following: patients who are pregnant any time during the

measurement period; patients who refuse measurement of height or weight or refuse follow-up at any encounter during the measurement period. And we definitely want to call out that patients who are wheelchair bound or if they're amputees, those patients are not excluded from the measure. If a BMI was not performed, the patient would not meet the intent of the measure, and you would code "no" to fail the measure. Next slide.

Slide 11, we list the denominator exceptions, and those only apply to the follow-up plan, not medical record documentation of the calculated BMI. The medical record denominator exception could include, but it's not limited to, the following patients as deemed appropriate by the health care provider, starting with elderly patients who are 65 or older, for whom weight reduction or weight gain would complicate other underlying health conditions; also, patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. Please note that just having a medical condition does not qualify the patient for a denominator exception. Weight loss/weight gain must complicate such underlying medical conditions to be considered an exception. Slide 12.

On slide 12, we just want to restate the numerator reporting. Start with the most recent visit in the measurement period. If a calculated BMI is documented in the medical record at that visit and if the BMI is abnormal and a recommended follow-up plan is also documented at the visit, the intent of the measure has been met. If at the most recent encounter in the measurement period, there is no medical record documentation of a calculated BMI, or there is a BMI but no follow-up documented, then you may look back six months from the encounter for a calculated BMI, and if abnormal, a recommended follow-up must be tied to the abnormal BMI. And lastly, if there is no BMI documented in the medical record for the patient at the most recent visit during the measurement period or in the six months prior to the visit, then you must code "no" for the numerator. Now, please note, if you would like to see a visual graphic that explains how you walk through these steps, please see the measures flow on page 15 of the PREV-9 Measure Spec. Thank you. Next slide.

So, on to some frequent questions that we've received. The first one applies to all measure types, and the question is, "Why wasn't my CMS approved reason request approved?" We've been with CMS to review many situations and guidance that's received from CMS that's related to them through the QPP service now incident. And if you requested a CMS approved reason, it was not approved, that's because a CMS medical officer who reviewed the 2017 CMS approved reason request made a final determination to not approve your request. Generally, if the measure developer did not include an applicable exclusion or exception for this measure and it does not appear the request presents a unique circumstance, then the request will be denied. In these cases, you will report this measure in the same fashion it is reported using other submission mechanisms, as providers will be held to the same standard and data would likely be consistent and compared across ACOs and MIPS groups. We are unable to accept requests for CMS approved reason on the weekly Web interface webinars. You must have a CMS approved reason "approved" response from the QPP Service Center in writing in e-mail in order to appropriately place the case number into the Web interface, which will allow you then to skip the patient. Next slide.

And starting on slide 14, number 2 is for PREV-6. "Is the new FDA Approved Epi proColon blood test acceptable?" No, the Epi proColon test (Septin 9

serology test) is not acceptable for the colorectal cancer screening measure. While the FDA has approved the Epi proColon test for use, this is separate from a clinical practice guideline. The colorectal cancer screening measure is based on the U.S. Preventive Services Task Force Guidelines and expert consensus. The USPSTF stated there is limited evidence evaluating the use of Septin 9 serology test.

And the last question that we've been receiving a lot, number 3, is for MH-1, and folks asking if there's a way to exclude patients who have Alzheimer's or dementia. And a denominator exclusion only applies if the patient has died, received hospice or palliative care service, has a permanent nursing home residence, or has an active diagnosis of bipolar disorder or personality disorder. Assuming the patient has an active diagnosis of depression, including remission, or dysthymia during the denominator identification measurement period, you should look to see if the patient has one or more PHQ-9s administered or, if a PHQ-9 greater than 9 is not present during that denominator identification period. If none are found, then the patient will be skipped and replaced. And that is the end of the measure questions. So now I'll hand it over to Ralph Trautwein.

Thank you very much. Next slide, please. So, in the screens I'm about to show you, you will not see any PHI or PII. All the screenshots that we've taken is utilizing test data, so if you see patient names or beneficiary names, don't worry. They're not real names. Next slide.

There have been some questions recently about the end-to-end bonus credit. The end-to-end bonus credit is only displayed in the CMS Web Interface for groups. It's not displayed for APOs, although APOs can earn the end-to-end bonus credit. How you would see the end-to-end bonus credit if you're a group is pointed out in this screenshot here from the "View Progress" screen. Here you see a CARE-2 measure in which an Excel upload has been performed and earned the one-point end-to-end bonus credit. And then there's a brief explanation below that end-to-end bonus credit of why you're receiving the credit. Again, only groups will see the end-to-end bonus credit within the CMS Web Interface. Next slide.

So, I want to highlight the Measure Rates Report. We get a lot of questions about some of the information that is available via the Measure Rates Report. If you enter the CMS Web Interface and go to the reports, the first report is the Measure Rates Report. And here I'm displaying a measure card directly on that report. Please note that those blue numbers are drill down. So you can get additional information by picking on them. For example, if you wanted to see exactly which beneficiaries were counted as complete, which beneficiaries were counted as incomplete, which beneficiaries are skipped, you can pick any one of those numbers, and it will drill down and provide you exactly the information you're seeking. Next slide.

So, here I've picked the skipped number. You can see in the drill down for the measure rates report, skipped, it's highlighted. And the exact list of the beneficiaries that are skipped is displayed below that. So, it's an easy way to find information regarding the beneficiary reporting that you've done so far within the CMS Web Interface. Next slide.

So, we often get questions about consecutively reported beneficiaries. We only score based off of consecutive reporting. And the Measure Rates Report helps you with the visibility of what it means to be consecutively reported.

If you pick on the number here in this case, we've got 249 consecutively complete beneficiaries.

If you pick on that number -- next slide -- it will show you the list of the beneficiaries that compose what it means to be consecutively complete. Next slide.

Also available within the Measure Rates Report is a treasure trove of data that you can get to by downloading an Excel spreadsheet of all the information that's available to you through the Measure Rates Report. Just pick on the Download Report button that you see here in this screenshot. Next slide.

And you'll get a very thorough spreadsheet containing all of that type of information sorted in order, so if you wanted to see the complete beneficiaries, they're all on the spreadsheet in a list. The incomplete, they're all on the spreadsheet in a list. So, this can also help you understand the reporting that you've done to date and understand where you have holes or where you have gaps or where you need to go back and do some more reporting. There is a tab for each measure in this spreadsheet. So, CARE-2, the one that I'm on now, is specific to that measure. Next slide.

We've noticed that folks are often -- or some, not often, but some folks are reporting extra data that they don't need to report. And the spreadsheet with conditional formatting helps you to have some visibility as to when you're reporting extra data. If you do a download with data and you see data showing up in these blacked-out cells, then you're reporting data that doesn't match with the questions that you've answered. So, for example, in this example, I've picked "Not confirmed diagnosis," and there's extra data here that doesn't go with that answer. "Not confirmed age" -- there's also extra data here that doesn't go with that answer. So, if you uploaded it without conditional formatting enabled or ignored the conditional formatting, you may be reporting data that you do not need to report. Next slide.

Also within the CMS Web Interface there are lots of helpful tips and pieces of information to help you understand where you are in the reporting and how far you have to go, when the reporting ends, so for example, in the left-hand navigation, it shows you exactly how many days are left for you to report, and in the View Progress screen, it shows you exactly how many measures you've completed. If you've reported data, and the measure is not yet marked "complete," make sure that you're checking things like the Patient Confirmation section if you're doing Excel uploads. This is a frequently missed item, where folks fill out all the information for the beneficiary in the Measures section but miss the Patient Confirmation section and fail to get their complete measure because those beneficiaries are not yet complete. Next slide. I'm going to turn it over to Jessica.

Thank you, Ralph. So now, real quick, we'll walk through our resources and where to go for help. Next slide. And slide 27 lists the resources available on the QPP website, again, starting with the QPP Help and Support website. There are tools available to help -- videos, webinars, online courses, and so forth to help you understand the QPP program and system. On the QPP Resource Library, there are several resources available to help provide information regarding the measure specifications and how to use the Web Interface system. On the QPP Webinar & Events page, there are transcripts and presentations from these webinars. Also, we want to announce that the

Questions & Answers document is available on that page as well. And it's posted with the webinar materials from January 24 of 2018. Next slide.

Slide 28 is a list of videos that are available. These videos cover several topics regarding how to access and use the CMS Web Interface. If you would like to know how to navigate the system, please check out these videos for information. Next slide.

Slide 29 provides resources for ACOs starting with Medicare Shared Savings Program ACOs. We have the link to your website and also to your program guidance and specifications. Also, the ACO Portal is available to provide resources, including the Measure and Reporting Guides, the Reporting Resource Map, the Quality Reporting Checklist, and also please keep an eye out for the ACO Spotlight Newsletter, which contains announcements. And Next Generation ACOs, again, we provide your website and the link to your Connect site. And also please keep an eye out for the weekly newsletters for important announcements.

And our last slide, number 30, again, please contact QPP at QPP@cms.hhs.gov or via phone at 866-288-8292 if you have any questions related to your EIDM and login, how to use the system, how to report measures. We look forward to helping you. And that is the end of the presentation. I'll hand it back over for the Q&A session. Thank you.

We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, dial 1-866-452-7887. If prompted, provide the conference ID number 72087467. So, this first question is "For depression screening measure, the provider did PHQ-2 in the EHR with a "no" answer for both questions, with a Documents in Progress note "negative." Will this pass?

Hi. This is Jessica from PIMMS. This will pass, and if you look at the measure specification, you would code that "yes," a screening was performed, and that "no," the screening was not positive. Thank you.

Thank you, Jessica. This next question is about the CARE-2 measure. So this person says, for that measure, if it is documented that a patient ambulates without gait abnormalities, or the mention of gait status is given by a physical therapist, is this sufficient to meet the measure, or does the documentation have to use the verbiage "gait assessment" along with results?

Hi. This is Jessica from PIMMS. So, in order to meet the intent of CARE-2 and have adequate documentation in the event of an audit, there must be medical record documentation that states that an assessment of gait or balance was performed. I understand for this scenario if it's coming from a physical therapist, that might be an indication that an assessment was performed; however, there does need to be that supporting documentation that indicates an assessment was performed. If, after reviewing the medical record, if you do find supporting documentation that meets that criteria, then you can code "yes," and it would meet the intent of the measure. If you do not find additional supporting information in the medical record, then you may follow up with the provider to see if there's a process in place for their notation. Thank you.

Thank you. This next question is "For CARE-1, if the patient expired during the year, is that patient then removed for all of the supplied discharge

dates? Or do we still report data for the discharge dates where the patient was alive through the 30-day post-discharge period?"

Hi. This is Jessica from PIMMS. So, information regarding patients who are deceased during the measurement period is available in the Measures Specification. Starting on page 6 of the CARE-1 Measures Spec, information related to patients who pass away during the measurement period, which is January 1 through December 31 of 2017, is that during the patient confirmation, you would indicate that the patient had passed away during the year. And in doing so, that will remove that patient from all of the measures. Thank you.

Okay. This next question says, "For CARE-1 MRPD measure, if my patient does a follow-up visit with their specialist, not an urgent visit, just an office visit, and med reconciliation is completed, including mention of the discharge medications, may I use this as a 'yes' for the measure?"

This is Jessica from PIMMS. You may use any outpatient visit within 30 days of the discharge and...I'm sorry. I'm reading through the question again. And in order to code "yes," you need to make sure that during that outpatient visit, one of the five criteria for medication reconciliation is met. If there's documentation that the current and discharge medications were reconciled together and the doctor indicated the date that it was reconciled, then that would count, and you would code "yes." Thank you.

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

Our first question is from Abhishek Deshwal.

Hi. Thank you for taking my question. My question is regarding the Measure Rates Report, which was shown today. Where can we find a guide to know the whole process, right, what patients are skipped and what patients are considered as [Indistinct] conformed and not conformed? So, do we have a guide where we can refer all this information for every given measure?

There is a user guide available on the resource library. Actually, somebody asked that question here in the Q&A, and I gave the link out for where the resource library is located. So, yes, there is a user guide, and it describes the Measure Rates Report and the information available on it.

Oh, okay. Thanks for that.

All right. For this next question, this person says, "We are having issues with the Web Interface logging users out. There was a period of about 15 minutes where no one could log in."

We did have an outage between 11:00 a.m. and 12:00 p.m. Eastern time today, which affected all users of the CMS Web Interface. If your issue occurred during that time, the reason is that we had an outage. If it's outside of that window of time, please put a ticket in, and we'll investigate your issue.

All right. Thank you. This next question says, "Does the CMS MIPS GPRO Web Interface Quality Measures Report section have a total calculated quality score similar to what is available for ACI? And is there any area in the

reports or maybe other sections of the Web Interface that indicates that abstraction is completed and what the anticipated quality score will be?"

Ralph, did you want to address that question?

Yeah, I'm not sure I completely understand the question. So, if I'm getting what the user is trying to ask, we do show scoring information in the CMS Web Interface for groups. There is no scoring information displayed for ACOs within the CMS Web Interface. For groups, you can see that both on the Measure Rates Report and in the View Progress screen. For ACOs, scoring information will be supplied to them at a later date.

This is Rabia. To clarify for ACOs, the MIPS score for quality is applicable to your participants who are subject to MIPS if they are. So your ACRs are reporting. You're not going to see the MIPS score because that's going to be calculated on the back end using the MIPS APM scoring standard for your participant. So, participants should be able to view their MIPS scores when they are available.

Thank you. This next question is "So, end-to-end bonus points are not displayed for ACO submissions, only displayed for groups? It is still applicable to ACOs, correct?"

This is Rabia again. So, yes, ACOs can earn end-to-end bonus points just like groups, but it doesn't appear on your screen because it's factored into the MIPS quality category score that's calculated for the ECs participating in your ACO. So your participants will see the bonus points when they receive their MIPS score from the Quality Payment Program. So, your ACO won't be able to see it, but you can get those points for them following the same process as groups.

Thank you. This next question is "For our measures that minimum have been met, the measures score is not visible. Do all measures have to have the minimum met before any will be visible?"

So, for the groups that see scoring, the score is available as a measure is completed. So, you can see the score individually per measure. You don't have to fill out all the measures to see the scores. If you're not seeing that, please open a ticket, and we'll look into your particular situation.

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

Our next question is from Jonathan Minkus.

Hello. Thanks for taking my question. On PREV-12, we got some documentation that with a code G8433, and we're wondering if that qualified as an exception. It's a HCPCS code "Screening for depression not completed, documented reason."

Hi. This is Jessica from the PIMMS team. I'm looking up G8433. So, for PREV-12, the only exclusions from PREV-12 are listed on page 5 of the Measures Specification, mm-hmm, and the exclusion is a diagnosis of depression or bipolar disorder. So only those diagnoses will be allowable.

Okay.

Is there any documentation as to why it wasn't completed?

I'd have to ask my colleague, who's on the webinar, but I think they're not live on the phone now.

Okay, sure. And, Jonathan, there's also exceptions if patient reasons, for example, if the patient refused to participate or if there's a medical reason. The patient could be in an urgent or emergent situation, where time is of the essence, and a delay would jeopardize their health.

Sure.

Or there's situations where the patient's functional capacity might not be accommodating to having a screening. If there are other exceptions in the note, have them review the notes around that encounter to see if there's any other documentation that might support an exclusion or exception. And if they have any questions, please submit a QPP ticket.

Okay. And I have one other question.

Mm-hmm?

I put it in on the chat, too, but what is a preventive visit for PREV-7? How does CMS define a preventive visit?

For PREV-7?

Yeah.

Are you talking about in terms of --

I was thinking --

I'm sorry.

Sorry. This is Angie. I didn't know if that was maybe a question that someone from Sampling could answer because that's how they're sampling, making sure they have at least one preventative visit.

Hi. This is Sarah from RTI, and I can say from a sampling perspective, we would refer back to the coding documents for further clarification around what sort of defines that visit in PREV-7.

Okay, the supporting coding documentation?

Exactly. Yes.

All right. We have to double-check that. We haven't been diligent on that. Sorry.

[Chuckles]

Thank you.

Sure.

And just to add to that, just please note, Jonathan, that the coding documents were recently updated. So, please do pull the most recent document just to double-check those codes. Thanks.

Okay. This next question says, "IVD aspirin numerator inclusion drug code list does not include Aggrenox, but it includes on page 8 under 'oral platelet.' So, can you include Aggrenox as a numerator drug?"

Hi. This is Angie from PIMMS. Yes, the numerator drug codes in the IVD coding document are considered all-inclusive for the purpose of VHR mapping, but you may use the medical record documentations to meet the numerator. If there is documentation to support the patient was taking an antiplatelet during the measurement period, then the intent of the measure is met. Thank you.

Thank you. This next question is about PREV-9. What is the age group, if any, for exclusions or exceptions?

The age group is age 18 and older. And the denominator exclusions are not age specific. The denominator exceptions aren't necessarily, either. That would be a patient with a documented medical reason. The example given in the specs is that elderly patients 65 and older for whom weight reduction or weight gain would complicate perhaps another underlying health condition, and then it gives some examples. But if you feel that there is a medical condition, and weight gain or reduction would complicate that condition, then that would also be an exception.

All right. Thank you. This next question is "Will Medicare Shared Savings Program ACOs be able to view performance scores for 2017 claims data on the QPP website?"

Hi. This is Rabia. So, no, you will receive your Shared Savings Program quality results, which include the claims measures that are within our measure set this summer when you receive your Performance Year 2017 results. The claims measure data that is available in the QPP website is for groups who elected to report to MIPS via the claims reporting option.

All right. Thank you. This next question is "Can you please clarify the issue with IVD/ASA ACO 30 regarding whether or not a single episode of IV anticoagulants excludes a patient from the measure?" And they listed IV heparin during a onetime procedure as an example.

Hi. This is Angie from PIMMS. Yes, a onetime heparin use would exclude the patient from the measure. We did discuss this with the measure owner in CQA and received some guidance. The patients receiving anticoagulants are removed as a denominator exclusion in order to prevent clinicians from being penalized for using anticoagulants when they are clinically necessary. The example they gave was maybe a patient who happens to fall on the measure at the end of the year might only be on an anticoagulant appropriately and would otherwise count as a numerator fail without that exclusion in place. So they decided to remove patients who receive anticoagulants even one time, of any kind, during the measurement period, and that would allow them to focus solely on the use of aspirin or other antiplatelets. Thank you.

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

Our next question is from Alyssa Andres.

Hi. Thanks for taking my call. I just had a quick question about if data is uploaded into the Interface -- will it override any claims that have been already populated by CMS?

So, when you upload data, the CMS Web Interface accumulates your uploads. The only way data is overwritten is if you supply different answers for previously submitted data. So, if you leave an Excel template cell blank, it will not override an uploaded value that you've previously supplied to the CMS Web Interface. It will always use the last piece of data supplied for a particular value. So if you change your answer and upload, that changed answer will be the one that's used. If you leave it blank and have previously uploaded data, no change will be made to that data.

So, what if there are claims that are prepopulated for flu vaccine?

So, if there is prepopulated information in the flu vaccine, if you change the answer on whether or not they received that flu vaccine, it will change the answer in the CMS Web Interface.

Okay. Thank you.

All right. This next question is "Can a fall risk assessment count for a physical therapy progress note?"

Hi. This is Jessica from PIMMS. And I'm sorry. Can you please read that one more time?

Yes. So, it says, "Can a fall risk assessment count for a physical therapy progress note?"

Oh, thank you. Okay. So, I'm not sure what the second half of that question meant. If you have medical record documentation during the program year that indicates that a fall assessment was conducted or that indicates other items required for CARE-2, such as the patient's history of falls, a described fall, or a note stating "no falls," then that would meet the intent of the measure. Thank you.

Thank you. This next question relates to PREV-12, preventative depression. And this person says, "We have patients who were screened for clinical depression with a PHQ-9 score of zero, but the provider did not document a separate statement with the results as negative for depression. Can we answer 'yes' for the screening being performed and then to assume negative results because of the score of zero?"

That's a great question, and it's another frequent question that we do receive. Please note that on page 6 of the PREV-12 Measure Specification, the guidance indicates that the results and findings must be documented, and the reason being is that the score provides the provider with an indication of how that person is doing; however, other items might be taken into consideration in order to give a diagnosis of depression. So, for example, one person may... For example I might have a score of 5, and that's how I've functioned every day since I was born, so a score of 5 might be my baseline. However, another person -- a score of 5 might mean that they're clinically depressed. So, the score of 5 just provides the provider with the indication of how they're doing; however, there are other things that go into account.

Therefore, you have to have that medical record documentation of whether the screening was positive or negative for depression.[1] Thank you.

Thank you. This next question is "If a patient has a BMI that the physician considers normal for this patient's situation but is outside of the normal parameters as noted in the supporting documentation, can the physician still select BMI as normal?"

Hi. This is Angie with PIMMS. No, the clinician needs to report the measure based on the parameters in the measure specification. I guess that's it. Thank you.

Thank you. And this next question relates to MH-1, depression versus major depression. "If major was not documented or no office policy stated so, then the measure is not met. We are getting a lot of depression in our notes, so in the slide presented today," this person says that the word "major" is not in the answers. So, does that mean they can use a diagnosis of just depression?

Hi. This is Jessica from PIMMS. I strongly encourage you to review the MH-1 coding document. If you click on the Denominator Codes sheet, you will see a list of eligible denominator codes. And the depression codes range from F32 through F33. Yep, through F33. So, please take a look at those codes. And if you have any questions about a specific situation, for example, if there's just medical record documentation of depression but there's no other supporting evidence, please contact the help desk, and we can talk you through that situation based on the medical record documentation. Thank you.

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

Again, to ask a question, please press star, then the number one.

All right. So, our next question is "I have one provider with 58 records that has left the ACO." And this person says they have another provider with 92 records that refuses to cooperate in the quality submission. "Should I enter these as 'Record not found'? Or should I enter as 'Record found' and fail all of the measures for those patients?"

This is Olivia from ACO PAC. I can take a first stab at that, and maybe CMS can jump in as well. But CMS does expect organizations, in particular, ACOs, to make a concerted effort to obtain the necessary medical records for their assigned and sampled beneficiaries. Organizations that were part of your ACO according to the certified participant list at the start of the year are considered part of the ACO for the entire year, so we expect ACOs to collaborate with physicians and other clinic staff inside and outside the organization as well as facilities both inside and outside of the organization, with such collaboration attempts' being repeated throughout the course of data collection as needed. If you absolutely cannot access those medical records and don't have policies and procedures in place or kind of established agreements with those ACO participants, then yes, it would be appropriate to select "Medical Record not found."

Great. Thank you. And this next question is "If ACO reports GPRO for all member physicians, is there anything else that the physician needs to report?

[1] *Addendum, 2/21/2018: In the event of an audit, it would be acceptable to select "YES" for screening being performed and "NO" for patient had a positive screen if medical record documentation indicates that the PHQ-9 score was 0. You may only count the PHQ-9 score of 0 if there is no notation indicating otherwise. Please note, if medical record documentation indicates that the PHQ-9 score is 0, but notation indicates that the provider believes the patient has depression then you must take the notation into account over the PHQ-9 score.*

Hi. This is Rabia. And, Lisa Marie, please jump in here. So, first to clarify, if you're a Shared Savings Program ACO, and you are part of Track 1, which does not meet the Advanced APM definition, so you have ACO participants who are eligible clinicians in their subjects in MIPS who will be scored under the MIPS APM scoring standard. So the ACO will complete the Web Interface Quality Reporting, and that is what is used. So the ACO reported data is going to be used to calculate your quality category score for your participants who are subject to MIPS. For improvement activities, they will receive full credit by virtue of participation in the ACO. And then for costs, that's not applicable for this year. But then for the Advancing Care Information category, yes, your ECs who are subject to MIPS will still need to, if they are not exempt, I believe, under MIPS, will still need to report ACI. And I ask Lisa Marie to please clarify if there is anything I missed or misstated.

And for the question, it was relating to what an ACO needs to to report for the clinicians participating in the ACO, correct?

No, Lisa Marie, the question is about... The ACO completes quality reporting. Is there anything else their participants who are subject to MIPS need to do or report for MIPS?

Oh, okay. So, that's the question. So, as Rabia noted, what she outlined in terms of what would be required for each performance category, and as she noted, what would be the scoring methodology in terms of what they would be under, and as she noted, it would be under the APM scoring standard and that they would get full credit for the improvement activities and then how they would be scored under Advancing Care Information. So, I do want to outline one other element. And I believe this question was raised last week. I don't know the exact wording of the question from last week, but I want to highlight one other element that I think it's critical when we think about just clinicians in terms of [Indistinct] under ACO participant TIN. So, for the 2017 performance period, CMS conducted eligibility determinations based on two time frames -- Claims data ranging from September 1, 2015, through August 31, 2016, and September 1, 2016, through August 31, 2017. These eligibility determinations identify those clinicians that are eligible to participate in MIPS. So, clinicians who create new organizations and/or switch practices or TINs, so this means that having a new TIN/NPI combination after August 31 of 2017 -- they are not able to be identified to participate in MIPS and will therefore receive no neutral payment adjustment in 2019. So, I just want to highlight that that's an element we at CMS wanted to highlight for folks who had a question that they mentioned from last week. It also addresses another portion of the question that was just asked.

All right. Thank you both, and it looks like we have time for just one more question. So, this last question says, "Can you please repeat the location of the coding documents for the measures?"

Hi. This is Jessica from PIMMS. So, I think the easiest way to announce it on the call without having to read off a long URL is to first take you to the QPP website, which is https://qpp.cms.gov/. Once you get to the QPP website, the upper right-hand corner, you'll see a drop-down that says, "About." If you click on that, the second link is the Resource Library. And when you get to the Resource Library, you'll be taken to a white page that's a redirect, and you click on the first link, saying, "Resource Library to CMS.gov." And when you get to the Resource Library, that's where you can

access the 2017 and 2018 resources for QPP. Please be sure to click on "Find 2017 resources," and I use the first hyperlink, which says, "by provider type or topic." And you'll be taken to a web page that contains multiple links for all the resources related to QPP, and if you scroll down under the MIPS section, there's a section called Quality, and you'll see all the claims and registry measures. They take up kind of a chunk of the page. And under that is a sweet little sub-bullet that says, "Web Interface Measures & supporting documents." And it was last posted on December 20 of 2017. If you click on that hyperlink, you will be asked to open a file because the Web Interface Measures & supporting documents are zipped into a file, so you'll need to unzip the file. So, click "Open," and that will take you to the document. The coding documents are a spreadsheet, so you can filter for convenience. Thank you.

Thank you, and that concludes today's webinar. So, thank you all for joining.

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