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 the important information and updates about reporting quality data and provide ACOs in 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. Please also note that today is a final webinar in a series for 2017 reporting. Now I will turn the call over to Sandra Adams from the Center for Medicare and CMS.

Thank you very much. Welcome, everyone, and thank you for joining our webinar on Quality Reporting via the CMS Web Interface. I'm Sandra Adams with the Division of Shared Savings Program. Joining me on this call today are other CMS Web Interface subject-matter experts and contractors who will share information and answer your questions during our question-and-answer session after today's brief presentation. Next slide, please. Thank you.

This slide is a disclaimer slide about this presentation. Information on these slides is current at the time of the webinar, but we ask that you use and reference the source documents that are provided throughout the presentation. Next slide, please. Thank you.

The Web Interface will close on Friday, March 16th. Please remember your organization has until March 31st to complete your improvement activities and your Advancing Care Information reporting. Please remember that you do not have to click any "Submit" button to submit the data in the Web Interface to CMS. CMS will automatically receive data that you've entered into the Web Interface at the closing of the reporting period. Again, whatever data you've entered into the Web Interface is automatically submitted to CMS for Performance Year 2017. And, also, the CMS Approved Reason -- to request a CMS Approved Reason, please submit an e-mail to the Quality Payment Program Service Center and include the patient rank, measure, and a detailed reason for the request. Any CMS Approved Reason Request should be submitted as soon as possible, and when submitting a request, please do not include PII or PHI. Next slide, please. And now Jessica Schumacher, a CMS Contractor, will address some Frequent Measures Questions.

Thanks, Sandra. So, next slide.

On Slide 5, we'll start out with a Frequent Question that we've been receiving regarding IVD-2, and we just wanted to clarify from last week's webinar the response for this question. The question reads, "If we find an anticoagulant for IVD-2, are we supposed to still look for an active diagnosis of IVD or can we stop since the patient will be excluded at this point anyway?" And just to confirm, the answer is, you would confirm the diagnosis first as the patient must have had an AMI, CABG, or PCI during the 12 months prior to the measurement year, or had a diagnosis of IVD during the measurement year to be included in the initial population. If you are unable to confirm this, select "Not Confirmed-Diagnosis." If you confirmed the diagnosis, but the patient had documentation of use of anticoagulant medication during the measurement year, select "Denominator Exclusion." Either way, the patient will be "skipped," and another patient must be reported in their place, if available. And the second Frequent IVD-2

Question that we've been receiving is, "For the IVD measure, if you have a patient who was on aspirin at the beginning of the measurement period, but was on an excluded medication later in the year, do I submit 'Yes' for the Numerator? Or do I submit as a Denominator Exclusion?" And the answer is, you would submit "Denominator Exclusion." Patients who have documented use of anticoagulant medications during the measurement year are excluded from the measure whether they had been on aspirin or antiplatelets during the year or not. Next slide.

On Slide 6, we'll start with our third Frequent Asked Measures questions, and this is regarding PREV-7. "For PREV-7, what dates are included when looking at visits?" For 2017 reporting, the Denominator includes patients seen for a visit within the ACO or group between October 1, 2016 and March 31, 2017. You would answer "Yes" for the Numerator when the patient received an influenza immunization or reported previous receipts of an influenza immunization between August 1, 2016 through March 31, 2017. And the fourth Frequent Question is regarding MH-1, and this is also a clarification from last week's webinar, and this is regarding question, "Would documentation of PHQ-9 score in a progress note be enough to pass the measure and an audit?" And the answer is, "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 the question, "Was the patient screened for depression using an age-appropriate standardized tool during the measurement period?" Next slide. And now I'll hand it over to Ralph Trautwein to talk about Web Interface Helpful Guidance. Thank you.

Thank you very much. Next slide, please.

So in the following screens that you're about to see, there is no Protected Health Information and no Personally Identifiable Information. All of this data that you're about to see in any of the screenshots is from test data. There are no real beneficiaries, no real Medicare IDs, and no real organizations. Next slide, please.

Okay. Excel File Guidance. We've noticed in some of our help-desk tickets that some people are including blank rows between the headers and the first rows of data in your spreadsheet. Here's an example where I've taken the spreadsheet, and I have four blank rows -- Excel rows between the end of the header and the beginning of the first row of data. Next slide, please.

If you do that, you will see a series of errors that look like this, where the system complains that no Medicare I.D. is found. The solution for this is just to delete the blank rows of data that are between the end of the header and the first row of beneficiary data in your file. And here you can see I've got one error for each blank row in the file. Next slide.

Also, we've noticed that some people have deleted the top portion of the header. The header is actually a two-row header, and the upper row -- here I've deleted it -- in this example has been removed. We need both headers. The system that's parsing this Excel spreadsheet requires both rows of the header to be there. So please do not delete the first row of the header and just use the second row of the header. You need both rows.

If you do, on the next slide, when you go to submit your file, you'll get this "Upload Error." So if you're seeing this upload error, please check to

make sure that you haven't removed any of the rows of header information in the Excel template. Next slide.

So what's going to happen when the submission window closes? You'll see some behavioral changes in the application automatically occur at the moment the submission window closes. There are some items in the left-hand navigation that will no longer be allowed to be selected. They will be grayed-out. For example, you won't be able to pick "Report Data" anymore. So all the functionality in "Report Data" is disabled in the application. It will not allow you to report any data after the submission window closes. Also, "Manage Group" will be disabled in the application. It will not allow you to make any changes to clinics or providers in the system after the submission window closes. Next slide, please.

The View Progress screen will also change quite a bit. You're going to see that you're done reporting. You'll see that you've gotten to submission due date and the milestone timeline, and it's going to give you a summary list of where you stand with the measure completion. So in this case, I've blanked out the submission due date because we made it an earlier date in our test environment to trigger this scenario, and I didn't want to confuse anybody, so I've blanked over, blacked out the due date that we've set in our test environment. In your case, you'll see the actual submission end date. Okay, next slide.

All right. Also on the View Progress screen, you'll notice that we've added a couple of selections to download your 2017 reporting data and to view your measure rates report. So while you're on View Progress, if you pick that link, download your 2017 reporting data, it will automatically give you an Excel spreadsheet -- it will open up the download file, give you an Excel spreadsheet with all of the data in it that you've reported. So this will be available to you after this initial window closes. Also, you can download it at any time from Report Data Now, and after the submission window closes and Report Data is disabled, you can pick this link off of View Progress and still download the Excel spreadsheet with everything that you're reporting. Next slide.

Another change that's going to occur in the application is that when you go to View Reports now, you'll see that the Data Confirmation Report is disabled. After the submission window closes, the Data Confirmation Report will automatically enable, and you will be able to select this report from the View Reports screen. Next slide.

And you'll see a report that looks like the report that I'm showing here, where the report indicates that they've completed their submissions, and it will give a list of every measure and where you stood on reporting your data for that measure -- whether the minimum was met or the minimum was not met, and you can also download this report and print this report. So this report will be available to you. It will also be available for several years, so you can still get to it later, but it is enabled after the submission window closes. Next slide.

And these are some helpful reminders. Let's just mention at the beginning of the slide show, there's no "Submit" button to worry about pressing. Everything regarding your submission of your data happens automatically. So as soon as this behavior starts to happen in the application after closing the submission window, your data is ready and available and is all saved and will be submitted as is to CMS. One note is that if -- And we don't

recommend that you wait this long, but if you have a file in the middle of being processed, at the moment the submission window closes, that file will continue processing until complete. The reason we don't recommend you wait that long is the ability to see errors or see how that affected your submission will be gone. The Report Data screens will all be disabled, including the error list. So don't wait till the last minute, but if you do have a file in progress, it will be processed completely. All right, next slide.

I'm going to hand it over to Jessica.

Thank you, Ralph. So, real quick, we'll go through the resources and where to go for help. Next slide.

On Slide 20, again, please see the QPP Help and Support website for information regarding support videos and online courses. We added a couple of additional links under the QPP Resource Library. The bottom of that list, you'll see a link to the Medicare Shared Savings Program and MIPS Interactions. That's the Scoring document for MIPS Group, and then the last bullet is the Scoring Guide for Medicare Shared Savings Programs and Next Generation ACOs. If you have any questions about scoring for the program, please reference the appropriate document. Also, under QPP Webinar & Events, please note that's where we post materials from these webinars, and also the Questions & Answers documents, which contain frequent questions and answers. Next slide.

On Slide 21 is a list of instructional videos, and last slide, please.

And out last slide, 22, is the list of -- I'm sorry. We have resources for ACOs. If you have any questions, please refer to the appropriate ACO website. We have them both listed here for Shared Savings Program and for Next Generation ACOs. Also, please keep an eye out for your Spotlight Newsletters or weekly newsletters, as those do contain important announcements and information regarding submission. Next slide.

Our last slide, Slide 23, is a list of resources -- where to go for help. If you have any questions, or if you want to submit that very last-minute CMS-approved reason, please contact the QPP Service Center at QPP@cms.hhs.gov, or at (866) 288-8292. And that is the end of the presentation. Thank you.

All right. Next slide, please.

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, 72087471. Okay, so this first question comes from an ACO of 25-plus providers, and it's about PREV-8. "Can a state-immunization portal, such as I-CARE, be utilized to obtain pneumonia-vaccine information, and if yes, is the vaccine type required?"

Hi. This is Ngozi with the PIMMS Team. So, regarding the immunization registry data, if the information is available at the point of care, then, yes, the information can be used for the purposes of confirming your Numerator. The required medical-record documentation should state the year all through the last day of the measurement period and type of the pneumococcal vaccine. However, if the patient reported prior to 2015, all you really need is documentation indicating that the patient received a

vaccine and the date of the vaccine. Now, if the patient reported in 2015, 2016, or 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 patient is ranked in multiple measures, and we report data on any measure they are ranked in, are we expected to report data for all measures they are ranked in?"

This is Olivia. I can take that. It's not necessarily the case that you need to report on the beneficiary in every measure in which he or she is ranked. However, you do need to report on that if they are "in the minimum" of a given measure.

Thank you. This next question is, "On the QPP website, we currently have 13 out of 14 measures complete, but the reporting minimum is met, and there are no errors. Did we successfully submit our quality reporting even with the 13 out of 14 measures complete?"

This is Rabia from CMS, and then, Ralph, please jump in if I missed anything, but so to clarify that the complete count in the CMS Web Interface that shows up under progress summary only reflects measures that meets the MIPS Quality Measure Scoring Requirement. So MIPS will only score measures with 20 or more beneficiaries in the Denominator. For measures with fewer than 20 beneficiaries in the Denominator will not be included in the MIPS scoring and will not appear in the complete count. So you're saying 13 out of 14 because one of your measures has a Denominator of less than 20. Now, for MIPS ECs participating in ACOs and for groups, you won't lose points in the MIPS Quality Category because there are fewer than 20 beneficiaries in the Denominator for a measure, but you still must completely report each measure, and for purposes of the Shared Savings Program and Next Generation ACO Model, we will be using all data submitted by ACOs for scoring purposes under our quality-measurement approaches. So, for measures in which there are zero beneficiaries, or less than 20, it won't reflect a green complete status in the complete count or in a measure-progress card. To ensure your ACO or group has met the complete reporting requirements for measures with a Denominator less than 20, we recommend confirming. You can consecutively report it on each beneficiary in your sample and the number of beneficiaries skipped using the measure progress cards and measure rates report. So, specifically, the measure progress cards break down to ACOs group progress per measure, and you can see the total kind of beneficiary sample for the measure, as well as those that are incomplete, complete, and skipped. So, each card shows how many beneficiaries were consecutively completed and will note if you've met the reporting requirements for that measure. So, in cases where you've skipped all beneficiaries in the sample, you will completely report it if the measure card notes the 6/16 beneficiaries have been skipped, or the entire size of your initial sample that's left in 6/16. So I suggest reviewing Page 64 in the Measure Rates section of the CMS Web Interface User Guide, and please download your reports for your internal records. The Data Confirmation Report will be available at the end of the submission period, and that will serve as your receipt for your final submission, and it gives a high-level overview for each measure that you've met the minimum. So, again, measures of fewer than 20, beneficiaries and the Denominator will be noted in yellow as not meeting the minimum requirement. So please keep your records and ensure you've consecutively reported on everyone for the Shared Savings Program, and for Next Generation ACO Model, we'll definitely review your submissions, and I can speak for the Shared

Savings Program that we will confirm for your ACO that you've completed reporting. So we will share that confirmation with you.

All right. For this next question, this person says, "For MH-1, we have no patients eligible for the Denominator. The Web Interface shows performance as 0%, but we have reported on everyone that we can. Can you advise on what to do?"

This is Rabia. Could you repeat that again? I apologize.

Yes. So this person says, "For MH-1, we have no patients eligible for the Denominator. The Web Interface shows performance as 0%, but we have reported on everyone we can. Can you advise on what to do?"

Right. So this is Rabia again. I just provided a response that applies to this scenario, and we completely understand that you may have a high skip rate for MH-1, but, again, that complete measure count reflects only measures that meet the MIPS scoring requirements and what MIPS is going to use for the Quality Category. So --

Rabia, I think they're asking about the performance rate, though. Their performance rate is showing 0%...

Oh, so you won't --

...even though they have zero beneficiaries eligible for the Denominator.

And that's fine. For the Shared Savings Program, that measure is pay-for-reporting all year, so you will not be penalized as long as you just complete reporting, and if you have your beneficiaries, then, fine. I don't know if there is anyone from the MIPS side who has anything to add. Thanks, Olivia.

Olivia, this is Tim. Can you restate the question again? I'm sorry. I'm trying to get back on to the actual display.

Sure. I might be able to rephrase it. The question is, they have zero beneficiaries that are eligible for the Denominator of MH-1, and their performance rate is showing 0%.

Okay. So...yeah. We do have an element from the MIPS side that is going to be implemented, but I'll have to get back with the inquirer to make sure we give them the appropriate response. This is about MH-1, right? So we do have an update coming that will account for that similar to the shared-savings logic, but I don't have that right in front of me, so we'll have to readdress it outside of this call. Thanks.

Okay. This next question is, "For PREV-9 BMI screening with the look-back period of six months, does the six months include the whole month, or is it exactly six months from the recent BMI date?" And, for example, they say, "If the BMI was abnormal on December 20th, and the follow-up was done June 1st, will this qualify as 'Yes' for a follow-up look-back?"

Hi. This is Angie Stevenson from the PIMMS Measures Team. It's anything that is less than seven months from the most recent BMI that can be used. The number of days is going to vary since the number of days in a month vary. So, your example is, BMI was abnormal on 12/20, you would not go back clear

to the first of June. You would just go back as far as June 20th or whatever is less than seven months. Sherry or Mary, do you have anything to add to that? Would it --

No, that was very complete. Thank you.

Thank you.

Thank you. This next question is, "How long will the reports be available on the QPP website after the submission is closed?"

They're available for a period of three years.

Great. Thank you. And, Stephanie, we can take a question from the phone at this time. We have a question from Ann Thu Tham.

Good afternoon. Thank you for taking my call. I just have a quick clarification on PREV-12. If, for the Denominator exclusion, if the diagnosis of depression or bipolar, if this is diagnosed, it's supposed to be active during calendar year 2017 or a note during a calendar year 2017 visit on past medical history of depression or bipolar is considered as a Denominator exclusion for this measure?

Hi. This is Jessica from the PIMMS Measures Team, and the diagnosis have to be active during 2017 in order for it to count.

Okay, so a past medical history of depression inside a visit note during 2017 would not work?

Correct. So when you're looking at the 2017 records, it has to be an active diagnosis.

Okay.

It has to be in the Problem List.

Right. So I would also like to clarify about PHQ-2 and PHQ-9, which are considered to be the screening tool -- allowable screening tool for this measure. So we have those two built in or embedded in our EMR flow sheet, and what the submission does is that they just filled out that flow sheet, but not necessarily much about it in the -- or some of them don't say much about it in the progress note of a visit, but we have it documented in the EMR flow sheet, and I would like to seek clarification whether it is Numerator-compliant if PHQ-9 or PHQ-2 score was documented, along with the date of assessment, would that be Numerator-compliant?

No. So for PREV-12, we need the provider to document the results from that screening, whether or not the patient has or does not have depression based on the screening.

Right, but --

Feel free to -- Mm-hmm? Go ahead.

I'm sorry. Go ahead. So, what about throughout that calendar year, 2017, we have multiple screening, but some of it, like the score zero -- or, actually, all of them are score zero.

Okay. So that's a great point. So you would use the most recent, and, Sherry, feel free to jump in. If it's a score of zero for PHQ-2 or PHQ-9, then that would be acceptable. That would indicate a negative for depression. Yeah.

Okay, perfect. So it's normal to say "zero," but not necessarily negative or positive, that would still be okay?

This is Sherry. Just to give a little bit more background on that. We have gotten that question before, and we determined because zero is such an emphatic result, that is why we're accepting it just as a numeric negative for this test, but I just want to make sure that you're clear that any other score, we do want that physician interpretation of the result as either negative or positive, but zero you can count as a negative result.

Okay. So, also, I just want to clarify further, that for PHQ-2, if it was filled out with a score indicating a positive screen -- like it'd say positive, and then we also have documentation of PHQ-9 flow sheet completed on the same day, then would that be Numerator-compliant if we had both of those two pieces, but not necessarily it said in the note about it?

I think you have several pieces to that question. The PHQ -- and maybe Jessica will follow up after I make a comment or two. The PHQ-9 in follow-up would definitely be considered a follow-up if that's on that same [Indistinct] as the PHQ-2 positive result.

Yes, Ma'am -- Mm-hmm.

So that is Numerator-compliant as far as a follow-up is concerned. The only piece that I didn't quite catch is whether or not you have documentation to support the PHQ positive result.

So, on the flow, it has three lines -- like the date of the assessment, the score, and then underneath it, it would say positive or negative.

Oh, okay. Okay.

Yeah.

Then I would agree that that would be documentation that would be sufficient for an audit.

But if the PHQ-9 also had the same date as the PHQ-2, and then also have the score, but may not have an interpretation of negative or positive, would that still be measure-compliant or Numerator-compliant?

Because it's being used as the follow-up, it would still be Numerator-compliant -- not the best practice because you want to encourage them to make sure that their documentation is reflective of what they're thinking about that patient, so they're communicating that with their fellow caregivers, but definitely still would be Numerator-compliant in that instance that you're describing.

All right. Our next question says, "Currently PREV-5, PREV-6, and HTN-2 can have long-term-care exclusions. Can we use claims data to validate? What are the requirements to use the long-term-care exclusion?"

Hi. This is Ngozi with the PIMMS Team again. So, for the PREV-5, PREV-6, and HTN measure -- unfortunately, no. You cannot use claims data alone. We would require medical-record documentation at a minimum to support a long-term-care exclusion. Thank you.

Thank you. This next question is about the PREV-9 measure. "The six-month prior to the most recent visit refers to the exact six months --" I apologize. This looks like a repeat question. So I'll move on here. "We finished our abstraction several weeks ago for the majority of our facilities. Last week our total quality scores ranged from 56 to 58. We made no abstraction changes. This week our total quality scores were 60 out of 60. What are the correct total quality scores?" And this person said they did submit this on Monday.

Yeah. So this is sent to the QPP Service Center, and I apologize. This looks like group practice. Are we aware? So if you incurred -- If you're an ACO, if you could escalate your ticket to your Regional Coordinator, we can review that. But if you're group practice, I don't know if Tim or Cindy, if there's anything you want to add.

Yeah, this is Tim. I don't have anything at this time, but Cindy is not with us. I wasn't sure if we needed anything else. Katie is with us, but please go ahead otherwise.

Yeah, so I apologize. I think this is a specific use case, but I think maybe it should be reviewed. So if you have -- You're saying that if you provide your ticket number in the Q&A box, we will review it.

That's correct. Let's do that.

All right. Our next question is, "Are we able to remove a file from the Web Interface?"

This is Rabia. Could you repeat that one again? I apologize.

Yes. So this person asked if they're able to remove a file from the Web Interface? And just for background, they said they would like to test performance scores by submitting the minimum 248 versus the larger sample, but they want to know how to remove the file if they decide not to use it.

So the CMS Web Interface always uses the latest data reported. There isn't a concept of removing a file. There's a concept of continuing to report until you get to the data set that you want and are satisfied with. So if you reported an answer of "Yes" to a question in a previous file, and now want an answer of "No," then simply resubmit the second answer, and the last answer will be used. So there isn't a concept of deleting a previous file. There's a concept of updating your submission with the latest data that you want to be your submission for the year.

All right. Thank you. This next question is, "When I sign into QPP, if I have two duplicate entities under APM entities, I should only have this one. Is this normal to have two? How can I fix this?"

This is Rabia. So, I see we've gotten this question a couple of times here. So if you are seeing duplicates of your organization, whether you're an ACO or group on the account dashboard--so for groups, please confirm that your

TIN is correct, and for ACOs, please confirm that the organization name is correct on the dashboard, because if that is correct and just you can choose any of the options for that organization on the dashboard and continue to use Web Interface to report your data, the duplication of the QRUR because of a recent system update, it will not affect your submission. There will only be one submission at the end of the window. So, as long as you can confirm the names are correct and you're selecting the correct organization to report on, it will be fine, whichever selection you choose.

Thank you. This next question is, "Where is the Performance Results Report?"

So for the Shared Savings Program, and Next Generation ACO Model, we will be delivering your 2017 Performance Year results this summer. I don't know, Tim, if there's anything you wanted to add for MIPS Performance Results and when those will be available?

Yeah, thanks. This is Tim. So the performance feedback for MIPS groups will be available in July of 2018.

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

We have a question from Jordan Ellis.

Hi. My question is regarding the benchmarks on the Measure Rate Report. For example, on a particular score of 74%, can you advise on why this percentile would be very close to that top benchmark of 82.3%?

Could you share the rates again? I apologize. So you said the benchmark -- your performance rate is at what?

Yeah, so as an example, for one of the measures, it would be 74%, and then that score is very close to the benchmark line, which is 82% -- just trying to communicate this to my Leadership Team.

Right. So -- and I apologize. Are you part of an ACO or a group?

Yes. Track 1 ACO.

Track 1 ACO. Okay, so the benchmarks are -- All of the benchmarks of the Shared Savings Program calculated all Web Interface benchmarks. We do have a guidance document available on our Shared Savings Program website that sort of walks through how the scoring and the points associated with comparing your performance to the benchmarks. So -- And I don't know, Olivia, if you want to jump in here. The points are associated by each of the different percentiles. I'm not sure [Laughs] reading your question, but you have to exceed the percentile to get that percentile's points associated with it. So...

Sure. I think a clarifying question could be, is our score of 74%, is this real time, and is that placing us near the top of that second percentile?

So, for measures that are pay-for-performance, it will depend on -- Go ahead. Is that Olivia? Okay.

Oh, no. I --

[Laughs] For measures that are pay-for-performance, it will depend on which year of your agreement period per an ACO -- which measures are pay-for-performance versus which ones are pay-for-reporting. So when calculating your quality score under the Shared Savings Program, for measures that are pay-for-performance, we will compare it to the benchmarks and the fine points associated to our approach and including it in the guide. I'm wondering, Olivia, if you can provide the link in the Q&A box, but we also factor into your score quality-improvement points. We do have a reward associated with that, so it doesn't necessarily mean that is your score under the Shared Savings Program, but we will provide your final quality scores later this summer with the financial results, and you'll have a quality report that indicates the performance rates that you have within the Web Interface, but also factoring in improvement reward points when applicable, yeah. I hope that helps. If you have further questions, please send it to the Shared Savings Program mailbox, and we'll definitely direct you to the appropriate guide and can walk you though how to read it.

Okay. Our next question is, "Would a Denominator exception within, for example, in IVD, count towards the 248 reporting requirement, or would that be considered a patient skip, and we would need an additional patient?"

Hi. This is Angie from PIMMS. A Denominator exception is not a skip, so that patient would be considered complete. Thank you.

Thank you. This next question is, "Can the BMI six-month look-back include dates from 2016?"

Hi. This is Angie again. And, yes, as long as it's within the six months of the most recent BMI, and it is possible that it might be in 2016. Thank you.

Thank you. This next question is, "How do we reset a previous answer to empty if we are using the QPP website?" This person says, "I understand that by adding N/A on the spreadsheet, the answer could be reset, but how do we reset it on the website if we choose not to use the spreadsheet upload?"

So, if there isn't an N/A selection in the user interface, if you want to remove data, the only way to do that is via an Excel upload. You can always change your answer. So if you put in an answer into the Web Interface of "Yes," and you want to change it to "No," or a Denominator exception or whatever answer is available there, you can change it as many times as you want right up until the close of the submission window. But if you want to remove an answer altogether, the only way to do that is for the questions that are -- for example, radio buttons, is to do that via the Excel spreadsheet and select "N.A." and upload that.

Thank you. And it looks like we have some questions on Slide 7, so if we could move to that slide, please, Deirdre -- Slide 7, and I'll pass it off to Jessica.

Hi. Thank you. I just want to let attendees know that on Slide 7 we're going -- Oh, it must be Slide 6 -- the one before this. Yep. There. Thank you. On Slide 6, got MH-1, the Frequent Measures Question Number 4, it's labeled as an MH-1 item, and it should be PREV-12, and so we'll correct that before we post it. "So for PREV-12, if there's a PHQ Score 9 in the progress note, is that enough to pass?" And the answer is, no, because you need to have that positive or negative assessment result indicated in the medical record. Therefore, you would select a "No" to the question, "Was the patient

screened for depression using an age-appropriate tool during the measurement period?" And this is reflected in your measures specification on Page 9 under Numerator Reporting, and, again, on Page 14 of the Measures Flow. So if you don't have access to the presentation in time, and you need to see this today, please look at those two pages in the Measures Spec, and you'll be able to find that point in which you would select "No." Thank you.

Thank you. This next question is, "If I have errors, but have completed all required reporting, do I need to do anything about those errors?"

So you don't have to remove the errors from the CMS Web Interface if you're satisfied with the data that has been reported, and you've completed the minimum reporting for each measure. One easy way to clear errors out is to do a download with data from the CMS Web Interface, save that file, and then re-upload the exact same file again. That will clear out any errors because the data that you have in that file is all data that's been accepted by the CMS Web Interface.

Thank you. This next question is, "Will having less than 20 case minimums affect a group's ACO submission results?"

Could you please repeat the question?

Yes. "Will having less than 20 case minimums affect a group's ACO submission results?"

So -- This is Rabia. For the Shared Savings Program and Next Generation ACO Model, we will use all data that's submitted through the Web Interface. So if you have less than 20 beneficiaries in your Denominator, we'll still include that for scoring purposes. Now, as a reminder, when it comes to our quality-measurement approach, measures that are paid-for-reporting, you will get full points for completely reporting the measure. For measures that are pay-for-performance, we will compare those to the established benchmarks, and then -- I mean, we also factor in quality-improvement reward, as well, into your final quality score. I hope that helps.

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

We have a question from Sharon Barrett.

Just a quick one about Mental Health-1. If the patient can't talk, is that a Denominator exclusion, or if they have no diagnosis of depression on their chart, that does not confirm diagnosis?

Hi. This is Jessica from the PIMMS Measures Team. So, if they don't have a diagnosis, an active diagnosis of major depression or Dysthymia in their chart, then they're not confirmed.

Okay. So we shouldn't just say "excluded" because during that time nobody asked them, or...? See what I'm saying?

So, Sharon, this is Deb from the PIMMS Team. If the patient can't talk, I'm assuming then you don't have a PHQ-9 greater than 9 result during the Denominator identification measurement period. Is that correct?

Right. Yep.

Okay. Then you would select -- There's an option for that. If you can confirm the diagnosis, you would move on, and you would just select that there's not a PHQ-9 result because the PHQ-9 greater than 9 result during that specific time period is part of the Denominator eligibility.

Okay. All right. Well, one way or another, they're not going to be in the...

Right.

Okay.

Either way, you're going to end up skipping them. Yes, ma'am.

Okay. Thanks. All right. Bye.

All right. This next question is, "We have a measure that has zero beneficiaries, and, obviously, we didn't submit a blank file. Our status for this measure says, 'Reporting not started.' Do we need to do anything?"

So, I don't know what is your particular situation, but if you open a ticket with the details, then we'd be happy to look at that and try to help you. Some of the things that cause a measure beneficiary not to be completed is if you fill in all the information in the measure section, but forget to fill in the patient-conformation answer that goes with the beneficiaries in that measure section, then none of those beneficiaries will be complete because the patient-confirmation answer is part of the completion for the beneficiary in that data section. So if that's not the case for you, if you're still seeing a problem, please open a ticket, and we'll try to help you.

Thank you. And it looks like we have time for one last question. This question is, "Could you please clarify how skip rates are calculated? Is it based only on the number of skips within the consecutively completed ranked beneficiaries for a measure?"

Kim, are you on the call?

Sure, yes. This is Kim. I can answer that. Skips only show up once the minimum has been met, and it is calculated based off of the number of bennies skipped and consecutively complete over the total number you've consecutively reported.

Okay. Thank you. And that concludes the Q&A portion of this webinar, and now I'll pass it off to Sandra to get the closing.

Thank you. Thank you to everyone for attending today's webinar. Just as a reminder, you can report ACI and I.A. until March 31st, and if your question was not answered on today's webinar, please contact the Quality Payment Program Service Center and open up a ticket. Thank you for attending. Bye-bye.

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