CMS Web Interface Support Call #1: 2024 Data
January 8, 2025

>>Ketchum: Hello everyone. Thank you for joining today's Web Interface Support Call. This presentation will be followed by a Q&A session where attendees will have an opportunity to ask questions via the phone and question box and CMS subject matter experts will address as many questions as time allows. Also to note, a recording and the slide deck from today's call will be posted on the QPP Webinar Library within the next two weeks.

Now I'll turn it over to Sandra Slaughter at CMS to begin. Sandra?

>>Sandra Slaughter, CMS: Thank you, Hallie. Welcome everyone and thank you for joining us today as Shared Savings Program ACOs prepare for quality reporting. I'm Sandra Slaughter from CMS. Joining me on the call today are other CMS experts and contractors who will share helpful information on CMS Web Interface quality reporting and answer your questions following today's presentation.

Today's call will only focus on the 2024 CMS Web Interface quality reporting. You can contact the Quality Payment Program Service Center with any of your other questions regarding cost, Promoting Interoperability, MIPS, or quality reporting in general. Today's slide deck recording, and transcript will be available on the QPP Webinar Library within the next two weeks.

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This is a disclaimer slide about this presentation. Information in the presentation is current at the time it is published, but I urge you to please be sure you're using source documents and links that are provided throughout the presentation.

Next slide please. And next slide.

The CMS Web Interface will close at 8 p.m. Eastern Time on March 31, 2025. Your submission will automatically be accepted at submission close. As a reminder, the CMS Web Interface is accessible using the “Sign In’ link on the Quality Payment Program website.

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This is a schedule of upcoming CMS Web Interface Support Calls. And please note that the dates for the upcoming biweekly Support Calls are listed on the slide. More information and registration links can be found in the 2024 CMS Web Interface Support Flyer.

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The 2024 CMS Web Interface Measure Specifications for the APM Performance Pathway, the CMS Web Interface Measure Specifications and Supporting Documents for ACOs were published on the QPP Resource Library, in December of 2023. These documents include Submission Release Notes and Coding Release Notes, which outline any changes that were made to the specifications from the 2023 performance period to 2024 performance period.

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The CMS Web Interface Application Programming Interface, or API, is available all year for testing in the Developer Preview Environment. There's narrative documentation and swagger documentation for users reporting the CMS Web Interface measures via API.

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This slide is about the Extreme and Uncontrollable Circumstances exception.

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The Public Health Emergency for COVID-19 expired on May 11, 2023. Medicare Shared Savings Program ACOs are no longer affected by the COVID-19 PHE and will therefore not receive the program's quality EUC policy for COVID-19 PHE related to circumstances for performance year 2024. ACOs may still have the quality EUC applied for non-COVID-19 PHE related circumstances like natural disasters. Affected ACOs that report quality data via the APP and the MIPS data completeness and case minimum requirements will receive the higher of their health equity adjusted quality performance score or the 40th percentile MIPS quality performance category score for purposes of determining shared savings. Review the 2024 APM Performance Pathway Scoring Guide within the APP Toolkit for more detailed information on scoring.

And now I'll hand things over to Debra Kaldenberg to cover other CMS approved reason request and frequently asked measure questions.

>>Deb Kaldenberg, PIMMS: Thanks Sandra. And welcome once again to the first 2024 CMS Web Interface Support Call. My name is Debra Kaldenberg, and I will be reviewing the next couple of topics starting with the Other CMS Approved Reason request process.

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For those on the line that have submitted using the CMS Web Interface in the past, the process for submitting requests to skip patients has not been changed. As a general overview, each individual measure displays specific reasons why a patient may not qualify for the measure. Those exclusions and/or exceptions should be used when available and appropriate at the measure level. An "Other CMS Approved Reason" to skip is not needed and therefore should not be requested in those situations. Requesting an "Other CMS Approved Reason" is a way to skip a patient attributed to a measure during denominator confirmation. It is reserved for circumstances that are unique, unusual, or not covered by any of the denominator exclusions or denominator exceptions identified in the measure specifications.

In order to submit a request for a CMS Approved Reason to skip, it must be submitted through the CMS Web Interface. And we request that you provide detailed information about why the patient should be skipped. This is necessary to ensure that we can get you a response as quickly as possible.

Some things to keep in mind, it isn't necessary to request an "Other CMS Approved Reason" to skip if there is an applicable denominator exclusion, if there's an applicable denominator exception, if the patient is “Not Qualified for the Sample.” For example, if the patient is deceased, in hospice, moved out of the country, or didn't have Fee-For-Service Medicare as their primary payer. Something else to note is prepopulated demographic information that isn't accurate can be updated within the CMS Web Interface. For example, if the date of birth is incorrect or the gender is incorrect, and when that is updated in the Web Interface, if it removes that patient from denominator eligibility, they will automatically be skipped and replaced.

And one example of this is something we've already seen come through is a skip request and that is to skip a patient who was identified as a female in the PREV-5 Breast Cancer Screening measure, but that patient is actually male. In that regard your skip request is not accurate. You should just update the demographic information and the patient will be skipped and replaced.

Also, an example of a request that will be denied due to measure specification requirements is included and that is CARE-2 Falls: Screening for Future Fall Risk. Any request to skip a patient due to non-ambulatory status will be denied as the measure specification expects that a falls screen will occur for those patients.

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Once submitted, additional information may be requested from the submitter via email from CMS-WISupport@gdit.com. The email from this mailbox will be sent to the address entered by the submitter in the skip request. Please reply with the information requested as soon as possible. Again, this helps to expedite your request. Contact QPP@cms.hhs.gov for questions and include the skip request number in your inquiry. If multiple requests for additional detail

are unanswered, the request will move forward in the review process using the information available. Once a decision has been issued, the request can't be reopened. If an "Other CMS Approved Reason" request is approved, the patient will be skipped and another patient must be reported in their place for the measure, if available. If an "Other CMS Approved Reason" request is denied, the patient will remain incomplete until you complete reporting on the patient. Please note that submitting your request for an "Other CMS Approved Reason" during the last days of the submission period could cause your request to not be processed. So, submit your request as soon as possible. More information on how to submit an "Other Approved Reason" request can be found starting on page 45 of the 2024 CMS Web Interface User Guide.

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And for today we will be reviewing how to access the patient's age for the Frailty and Advanced Illness denominator exclusions, as well as some questions and responses for PREV-7 Influenza Immunization, PREV-12 Depression Screening, and MH-1 Depression Remission at 12 Months.

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For the Frailty and Advanced Illness denominator exclusions, these can be found in the posted DM-2 Diabetes: Hemoglobin A1c Poor Control, Hypertension-2, Controlling High Blood Pressure, PREV-5 Breast Cancer Screening, and PREV-6 Colorectal Cancer Screening measure specifications. The measure specifications state “to assess the age for exclusions, the patient's age on the date of the encounter should be used.” So which encounter should be used to make this determination?

The measure specifications don't define which encounter to use when determining a patient's age for the Frailty and Advanced Illness denominator exclusions. For this reason, the patient's age at the end of the measurement period should be used. The sampling process will account for this denominator exclusion through October 31 of 2024. The patient must be at least age 66 at the end of the measurement period and meet criteria to be excluded. The patient doesn't have to

be age 66 when they meet criteria, they could be 65. Allowing the age to continue to be assessed based on the patient's age on the last day of the measurement period aligns with the 2024 sampling process and is consistent with 2023 and prior years.

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Before we review the PREV-7 information, I'll be handing it off to Alex for a PREV-7 announcement. Alex?

>>Alex Schotz, PIMMS: Hey, good afternoon. Just doing a quick sound check. Can you hear me?

>>Deb Kaldenberg, PIMMS: Yes, we can.

>>Alex Schotz, PIMMS: Okay, just real quick, I am one of the contractors that supports the Web Interface application. We wanted to let you all know that we are aware that there is an issue that's affecting some people with the Excel upload for PREV-7. It might not necessarily affect everyone, but right now some users are not able to upload the Excel document. They're getting an error related to PREV-7 answers.

So the team is aware of that issue. We have a fix in place. We're hoping that we'll be in the production environment later this afternoon. And once that happens, you guys should be unblocked and able to upload that Excel document.

And I'll push that back to Deb.

>>Deb Kaldenberg, PIMMS: All right, thanks Alex.

All right. Now we'll dive in a little bit deeper into PREV-7. So just to start with a general overview. If you've read the specifications, none of this will be new. The intent of this measure is for patients age six months and older seen for a visit during the measurement period to

receive an influenza immunization. Or you can report previous receipt of an influenza immunization. Again, this is defined in the posted measure specification. If you're looking at the Use of Telehealth for this measure, you can report previous receipt of an influenza immunization during the flu season that was done during a telehealth encounter. Obviously, the influenza immunization itself can't be completed during the telehealth encounter.

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So for performance year 2024, the CMS Web Interface Patient Sample Excel files, and this is kind of a review of this information. On December 19, 2024, CMS delivered a CMS Web Interface Patient Sample Excel file to each ACO reporting quality for performance year 24. The file contains the same patient sample that's available through the CMS Web Interface at the start of the CMS Web Interface reporting period that began on January 2, 2025. There are two variables used to identify which flu season or seasons that patients had an eligible encounter for the 2024 CMS Web Interface PREV-7 measure. Those include the PREV7_23_24FLU corresponding to the flu encounter timeframe of January 1, 2024 to March 31, 2024 that overlaps with the 2023-2024 flu season. And the PREV7_24_25FLU, which corresponds to the flu encounter timeframe of October 1, 2024 to December 31, 2024 that overlaps with the 2024-2025 flu season.

All patients, regardless of whether they're ranked for the 2024 CMS Web Interface PREV-7 measure as provided within your ACO's patient sample file, have both of the two variables coded as “1 = patient does have a qualifying encounter”, or “0 patient does not have a qualifying encounter”. However, for purposes of reporting the 2024 CMS Web Interface PREV-7 measure via the CMS Web Interface, ACOs should concentrate on their ranked patients for PREV-7.

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For performance year 2024, the 2024 CMS Web Interface PREV-7 measure captures two flu seasons during the measurement period. Those flu seasons are the 2023-2024 flu season and the 2024-2025 flu season. A CMS Web Interface measure is sampled and scored at the patient level. So performance on a measure is therefore either met, not met, or a denominator exception applies for each patient in the sample. In the case of the 2024 CMS Web Interface PREV-7 measure, a patient is counted only once in the denominator and once in the numerator. Whether the patient has a qualifying encounter for a single flu season or both flu seasons. The patient's sample file contains two indicators that correspond to the two separate flu seasons. One for the 2023-2024 flu season and one for the 2024-2025 flu season. The indicator or indicators are checked if the beneficiary qualifies for the sample based on that timeframe. If the beneficiary qualifies based on both timeframes, then both indicators will be checked.

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When a patient is sampled into only one flu season, performance will be evaluated based on the administration of the influenza immunization during that specific flu season. When a patient is sampled into both flu seasons, performance will be evaluated based on the administration of the immunization during both flu seasons.

So I'm going to go through a breakdown here in text and then we'll also see it visually in the next slide. Performance met will occur, this will be the outcome, if the patient has documentation showing receipt of the immunization for the 2023-2024 flu season and the 2024-2025 flu season. Or if performance is met for one flu season. If the patient has a documented denominator exception for one flu season and they've received the vaccine for the other flu season. A denominator exception will be the outcome if there's a documented denominator exception for both flu seasons. Denominator exceptions must be documented during the measurement period and be specific to the flu season being reported. Performance will not be met when the patient hasn't received the influenza immunization for one or both flu seasons or if the patient qualified for a denominator exception for one flu season and didn't receive the influenza immunization for the other flu season, this would be considered a performance not

met. For example, the immunization wasn't administered in the 2023-2024 flu season and a denominator exception was documented for the 2024-2025 flu season.

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When a patient is sampled into both flu seasons as previously stated, performance will be evaluated based on the administration of the immunization during both flu seasons. New for 2024, a denominator exclusion may be reported when a patient experiences anaphylaxis due to the vaccine administration during or before the measurement period. If a denominator exclusion is reported, the patient will be skipped and another patient must be submitted in their place, if available. The patient will only be removed from the PREV-7 measure when a denominator exclusion is selected.

And then this follows with a visual of what we previously went over and I'll go over it again, “2023-2024 Flu Season” is across the top and the “2024-2025 Flu Season” is along the side or vertical. So as you can see, if I was administered the influenza immunization in 2023-2024 and also 2024-2025, that meets performance. If the immunization was administered in 2023-2024 flu season and not administered in the 2024-2025, performance is not met. Again, if I have the immunization administered in 2023-2024 flu season, but a denominator exception is documented for 2024-2025, I will meet performance. The middle column, “Immunization not Administered,” this would be a performance not met. Anytime you have the immunization not administered in one flu season and you have anything else documented in the other flu season, this results in a performance not met. For your denominator exception in the 2023-2024 flu season, if you have influenza administered, the vaccine administered in 2024-2025 you will meet performance. If the 2024-2025 immunization is not administered and you have an exception in 2023-2024, it is a performance not met. If you have two denominator exceptions, one for each flu season, again, that is a denominator exception.

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And now we will begin going over the PREV-7 frequently asked questions. The one thing I will say, we do have a posted 2024 CMS Web Interface FAQ document. You will see some of these same questions in that document as well as some others. So I would recommend downloading that resource as you're working through the Web Interface as well.

So for PREV-7, our first question: For the 2024 CMS Web Interface PREV-7 preventive care and screening influenza immunization measure. Are we required to report a patient's influenza immunization status for two separate flu seasons or do we have the option of reporting for only one of the flu seasons?

You must report immunization status specific to the flu season or seasons for which the patient had a qualifying encounter. The flu season in which the patient had a qualifying encounter will be noted in the CMS Web Interface. If the patient had a qualifying encounter during both flu seasons, you must report the patient's immunization status for both flu seasons.

Question two: How does the new denominator exclusion for anaphylaxis due to the influenza vaccine impact patients that are sampled into both flu seasons for the 2024 CMS Web Interface PREV-7 measure?

To account for all possible clinical scenarios, CMS has implemented the use of a Denominator Exclusion or the option to report a “Denominator Exception – Medical Reason,” when necessary for patients sampled into both flu seasons. Each of these options offers two reporting pathways for patients with documented anaphylaxis. A Denominator Exclusion may be reported when a patient experiences anaphylaxis due to the vaccine administration during or before the measurement period. If a denominator exclusion is reported, the patient will be skipped and another patient must be submitted in their place if available. The patient will only be removed from the 2024 CMS Web Interface PREV-7 measure when a denominator exclusion is selected. There must be medical record documentation supporting the use of the denominator exclusion if reported.

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Question number three: Is the denominator exception still available to report for the 2024 CMS Web Interface PREV-7 measure?

Yes. The denominator exception option is available within the CMS Web Interface and should be reported when there is documentation of an appropriate exception reason as defined in the measure specification. It would also be acceptable to confirm a patient with anaphylaxis and the denominator, rather than reporting a denominator exclusion, and report a denominator exception if the influenza immunization was administered for the 2023-2024 flu season, but the patient experienced anaphylaxis during the 2024-2025 flu season. In this case, you would report the anaphylaxis in 2023 -- let me rephrase that. You would report receipt in the 2023-2024 flu season exception in the 2024-2025 flu season and that would allow you to meet the requirements of influenza immunization for that particular patient. Also, the denominator exception in the 2023-2024 flu season is due to patient or system reasons and anaphylaxis occurred during 2024-2025 to be reported as an exception. This will allow you to report the numerator outcome for the 2023-2024 flu season and a denominator exception medical reason due to anaphylaxis for the 2024-2025 flu season. And we know this is a little bit difficult and new. So please, if you have any questions and we aren't able to answer them on the call today or this definition did not assist, you are welcome to open up a ServiceNow case and we will also provide you a written response.

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Question number four: Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the 2024 CMS Web Interface PREV-7 measure?

Any available medical record documentation, including immunization registry data, can be used to confirm the quality action.

Question five: Is a documented history of an egg allergy sufficient documentation to use the denominator exception for a medical reason for the CMS Web Interface PREV-7 measure?

No. A documented history of an egg allergy in the patient's medical record alone doesn't meet the intent of the denominator exception for the 2024 performance period. Documentation of an egg allergy must be during the measurement period and support that the allergy is still active during the appropriate timeframe. Denominator Exceptions must be documented during the measurement period and be specific to the flu season being reported.

Question six: What are the documentation timing requirements for the numerator for the 2024 CMS Web Interface PREV-7 measure?

The medical records should support that the refusal, exception, or receipt occurred during the appropriate timeframe for the flu season being reported. The 2024 CMS Web Interface PREV-7 documentation should be during the measurement period and be specific to the flu season being reported. If the medical record documentation supports that the quality action or exception submitted is relevant to the flu season being measured, it would be considered acceptable.

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Next, we'll move into the PREV-12 preventive care and screening; screening for depression and follow-up plan. The intent of this measure is for patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool. And if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

In regards to the telehealth, screening for depression may be completed during a telehealth encounter. Documentation of recommended follow-up plan for a positive depression screen may be completed during a telehealth encounter.

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So here are frequently asked questions for the PREV-12 measure.

Question number one: Previously a follow-up plan had to be documented on the date of the encounter, but the 2024 CMS Web Interface PREV-12 Measure Specifications state that it may be documented up to two days after the date of the qualifying encounter. Is that correct?

Yes. For the 2024 CMS Web Interface PREV-12 measure, a follow-up plan must be documented within two calendar days after the qualifying encounter, either telehealth or office visit. However, the follow-up plan must still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator.

Question two: Can documentation of a follow-up plan be used to infer a depression screening was positive if no results were documented?

No. The depression screening results must be reviewed, verified, and documented in the medical record by the eligible professional to meet the screening portion of this measure.

Question three: Should patients with any history of bipolar disorder be excluded from the measure?

Yes. The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of bipolar disorder prior to the qualifying encounter used to evaluate the numerator. To implement this guidance, the qualifying encounter is the equivalent to the most recent depression screening. A patient should be excluded if they've ever been diagnosed with bipolar disorder prior to the qualifying encounter used to evaluate the numerator.

Question four: Does a certain condition such as intellectual disability, impairment, Alzheimer's, dementia, or autism qualify a patient for a denominator exception?

The specification doesn't define denominator exceptions by specific diagnosis. If the patient qualifies for the measure and there's medical record documentation that the patient wasn't screened for depression due to a medical reason, i.e. cognitive, functional, or motivational

limitations that may impact accuracy of results, or patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status, then it would be appropriate to select the denominator exception. Another way to think about this is if you have a patient, let's say that has Alzheimer's and it is documented in the medical record that the patient was not screened, due to the Alzheimer's, for depression, this would meet that medical exception. But again, if you have additional questions, we'll either try and get to them during this presentation or you are welcome to open up a ServiceNow Help Desk case.

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Question number five for PREV-12: Does conducting a PHQ-9 after a positive PHQ-2 count as appropriate follow-up for the measure as it has in the past?

And the response here is no. Per the 2024 CMS Web Interface PREV-12 Measure Specification, additional screening and assessment during the qualifying encounter doesn't qualify as a follow-up plan.

Question six: Can we confirm the numerator if the medical record only contains the name of the tool and interpretation by the clinician?

Yes. At a minimum you must document the tool's name and results of the screening with a score or a clinical interpretation of positive or negative for depression.

Question seven: For patients with a depression diagnosis, does the clinician have to track or complete the recommended follow-up with the patient, changing the medication dose or other approved intervention, to meet the numerator? Or does the existence of an active medication pre-screening suffice as a follow-up to the screening?

No. The 2024 CMS Web Interface PREV-12 Measure Specification doesn't require the clinician who performed the depression screening to track or complete the recommended follow-up. However, if the clinician determines that the results of the depression screening is positive,

there must be documentation of a recommended follow-up plan in the medical record. Documentation of ongoing pharmacological intervention or continuation of another approved intervention would be considered an appropriate follow-up plan. Noting that documentation of the follow up plan, for example, continuation of depression medication, must be in relation to the positive depression screening.

Question eight: The 2024 CMS Web Interface PREV-12 Measure Specification states that the results must be reviewed, verified, and documented by the eligible professional in the medical record on the date of the encounter to meet the screening portion of the measure. What is the definition of an eligible professional?

The intent of the statement is to clarify that the quality action must be completed by an eligible clinician. However, others within the organization may complete the action. The quality action can be completed by anyone the organization considers qualified.

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And now we're going to cover MH-1 depression remission at 12 months. And one thing to highlight is that these measures have very different purposes. And I'm referring to the PREV-12 in the MH-1, and they are stewarded by different measure developers. Therefore, you will see differences between these measures. Please note those are intentional based on feedback from the measure developers.

So for MH-1 depression remission at 12 months, the intent is for adolescent patients 12 to 17 years of age and adults, patients aged 18 years of age or older with major depression or dysthymia who reach remission 12 months, plus or minus 60 days, after an index date. Regarding use of telehealth, documentation of a follow-up PHQ-9 or PHQ-9M result less than 5 may be determined during a telehealth encounter.

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And for the frequently asked questions for MH-1 question one: For 2024 CMS Web Interface MH-1: Depression Remission at 12 Months, a PHQ-9 has been completed for the patient on a paper form and scanned into the medical record, but the score wasn't totaled. Is it acceptable to calculate the score during abstraction?

No. If the score isn't totaled in the medical record documentation, you must select no when asked if the patient had one or more PHQ-9s or PHQ-9Ms administered during the denominator identification. Documentation of a follow-up PHQ-9 or PHQ-9M with a score less than 5 is also required to determine the patient achieved remission for the numerator.

Question two: If a patient answers the first two questions of the PHQ-9 or PHQ-9M “not at all,” and the rest of the questions are blank, is the depression screening considered numerator compliant?

No. All nine questions must be answered to have a valid summary score for a follow-up PHQ-9 or PHQ-9M. There must be medical record documentation of the score and the date the PHQ-9 or PHQ-9M was completed.

Question three: Since the age range 2024 CMS Web Interface MH-1 measure is 12-17 years old and 18 and older, can we use the PHQ-9 for all of our patients?

Yes. You may use either the PHQ-9 or PHQ-9M tool to meet the intent of the 2024 CMS Web Interface MH-1 measure.

Question four: Can the PHQ-9 or PHQ-9M be performed inpatient or should it be performed during outpatient encounters only?

The 2024 CMS Web Interface MH-1 Measure Specification doesn't limit the PHQ-9 or PHQ-9M screening to a specific setting.

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Question five: Can the PHQ-9 or PHQ-9M be performed during a telehealth visit?

Yes. The PHQ-9 or PHQ-9M may be performed using telehealth. PHQ-9 or PHQ-9M administration doesn't require a face-to-face visit. Multiple modes of administration are acceptable: Telephone, mail, e-visit, email, patient portal, iPad, tablet, or patient kiosk.

Question six: Can you please clarify the timing used to identify denominator exclusions?

For denominator exclusions that require a specific diagnosis, the diagnosis must be active any time prior to the end of the patient's measure assessment period. The index event date marks the start of the measurement assessment period for each patient, which is 14 months, 12 months plus or minus 60 days.

Question seven: Can you explain how to determine the index event date?

First, verify the patient has an active diagnosis of major depression or dysthymia during the denominator identification period. That would be 11/1/2022 to 10/31/2023. And then two, the first instance of a PHQ-9 or PHQ-9M greater than 9 during this same time period is the index date. Please refer to the step-by-step Submission Guidance and Measure Confirmation Flow in the 2024 CMS Web Interface MH-1 Measure Specification.

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And now I'll hand it back over to Sandra for the resources and where to go for help. Thank you.

>>Sandra Slaughter, CMS: Thank you, Deb. These next few slides will outline the available CMS Web Interface resources.

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Please note that the 2024 submission resources are available on the Quality Payment Program Resource Library. Direct links to these resources will be distributed in the ACO Spotlight Newsletter. We encourage you to review these documents if you have questions on quality requirements and the measures.

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If you need additional assistance, please refer to the contact information listed on this slide. And now I'll hand things over to Hallie to begin the Q&A session.

>>Ketchum: Thanks Sandra. So we're now going to start the Q&A portion of the webinar. You can ask questions via the Q&A box or through the webinar audio. If you want to ask a question through the webinar audio, please raise your hand and we'll unmute your line so that you can speak. To submit a question via the Q&A box, please click send -- to submit a question anonymously via the Q&A box, please click send anonymously, otherwise all attendees will be able to view your question. And just a note that if you want to ask a question over the phone, you need to have a working microphone.

So we have a couple of questions on the line. The first one's from Antoinette. Antoinette, we've unmuted your line if you'd like to unmute yourself.

Antoinette, are you there? All right, we will come back to you.

Our next question on the line is from Sheila. Sheila, we have unmuted your line if you would like to unmute yourself.

>>Attendee: Yes, thank you. I also put it in the chat box, but I believe there is a programming error for measure PREV-13, the statin? In that Population 1 is defined as all patients with ASCVD according to the measure specification. But 118 of the patients are marked in my ACO as not eligible due to age. And there is no age restriction on Population 1. Meanwhile,

Population 2 is defined as patients age 20 to 75 with an LDLC above 190 or pure hypercholesterolemia, which does have an age limitation. And zero of my patients are marked. And when I go into the Web Interface itself, it's set that way as well. So either the downloaded spreadsheet or in the computer online access, I cannot change it on population 1 from not eligible to the actual answer. And the restriction is not being applied where it should be. So it's reversed. And when I send in a ticket, the response I received was, oh, it doesn't say that in the narrative, but we'll ignore anybody age 20 to 75. But it's not Population 1, it's Population 2.

>>Deb Kaldenberg, PIMMS: This is Deb from the measures team. I do just want, because I happen to see one of the ServiceNow cases and I can confirm that there is no age requirement for that first population. I think this is going to require multiple folks on the call to either be able to address. So I'm not sure if there's others on the call that would like us to kind of come back to this through a ServiceNow case to work it out or if there's any additional information we can provide today.

>>Attendee: Okay. And I will note that I have spoken with a colleague. This is not just me; this is systemwide.

>>Deb Kaldenberg, PIMMS: Yes. I appreciate that. And like I said, if you still have an open case, I would say let's work through that case. And one of the things we can do is we can make sure that PREV-13 is the measure that we, go ahead, one of the measures that we cover at the next support call. I'm sure that you'll probably be able to get an answer prior to that, but we can make sure that anybody on this call also has this information kind of covered at the next Support Call as well. But I don't know if there's anyone else on the call currently, if there's any additional information that we can provide this caller at this time or if we just want to go ahead and continue to work through the ServiceNow case.

>>Alex Schotz, PIMMS: Yeah, I think we want to move ahead and we'll discuss this after.

>>Deb Kaldenberg, PIMMS: Sounds great. Thank you.

>>Ketchum: All right. Thank you for that question. The next question we have is from the Q&A box for Deb. And Deb, the question reads, “Specific to PREV-5 patient confirmation, are we required to use the CMS provided responses of “not confirmed age” if we determine otherwise?”

>>Deb Kaldenberg, PIMMS: And for this one, again, it may require some additional folks to be able to fill in. I do want to say that for PREV-5, I don't think you should be required to say “not confirmed age” if you're able to determine that that patient is qualified for the sample or for that measure, I'm sorry, but if there's additional information that can be provided to this caller, that would be great.

>>Alex Schotz, PIMMS: Sure. So through the user interface you can go in and update the date of birth. If it's incorrect that would recalculate the age. And if the date of birth makes it so that they are eligible for that measure, then that automated sort of response “not confirmed for age” will disappear and you'll be able to respond.

>>Ketchum: Okay. Thank you. The next question we have on the line is from Jason. Jason, we have unmuted your line if you'd like to unmute yourself.

>>Attendee: Can you hear me?

>>Ketchum: Yes.

>>Attendee: Yes. If you could go back to slide, I think it's 25, please. Yes, thank you. It's number six. I just want to be crystal clear about this, because there was much discussion last year. So am I correct that as long as a depression screening was given, responded to and that the score was verified, that would meet the numerator regardless of any clinician interpretation? Is that correct?

>>Deb Kaldenberg, PIMMS: Jason, I'm having problems for some reason seeing the actual slide, but I do think in regards to this, there has to be -- you don't have to have a score, but you

do have to be able to identify whether or not the results of that screening were positive or negative.

>>Attendee: Okay. So that's not what it says on the screen. It says “you must document the tool's name and results of the screening with a score or a clinician interpretation, a positive or negative.”

>>Deb Kaldenberg, PIMMS: So if you have the score, you know, that is directly from the measure specification, I believe. If you have a score and you have moved forward based on the fact that that verification from the clinician is based on the score you have documented a follow up is necessary or you don't need a follow up because that has been determined to be negative, that would fix the ball.

>>Attendee: So this is still unclear to me. Again, so like, let's say the patient's scores -- takes the PHQ-9 and scores a three and it's determined that there's no action needed based on our, you know, healthcare policy. And that is recorded in the medical record, does that meet the numerator requirements? Because the score was written and the screening was given.

>>Deb Kaldenberg, PIMMS: Okay. I just finally and I am so sorry, Jason, I just got back to that slide. I was having some technical difficulties. I'm going to ask if you don't mind going ahead and submitting a ServiceNow case so that we can make sure that we give one answer that is clear to you. And then we will also again come back to this group in the next Support Call and confirm that this particular question. Could you give me the number of the question that's causing confusion?

>>Attendee: Yeah, it's number six.

>>Deb Kaldenberg, PIMMS: Okay, thank you. And that way we can also redo question six to confirm that everybody has the same understanding. If you don't mind doing that, that would be great.

>>Attendee: Sure.

>>Deb Kaldenberg, PIMMS: Thank you.

>>Ketchum: Our next question on the line is from Lisa. Lisa, we have unmuted your line if you'd like to unmute yourself.

All right, Lisa, I see you have lowered your hand.

The next question we have in the chat box is also for Deb and the question reads, "For depression screening can we use score, or negative, or positive?"

>>Deb Kaldenberg, PIMMS: So I think this is going to be the similar one to what Jason was just saying was causing some confusion. And I want to make sure that I don't create any additional confusion. So we will ensure that this is answered on the next Support Call, but if this particular caller also wants it in writing, if you open up a ServiceNow case, we'll be able to get you the same answer we will provide Jason. Thank you.

>>Ketchum: Thanks Deb. Our next question on the line is from Hannah. Hannah, we've unmuted your line if you would like to unmute yourself.

Okay. And I see you've put your hand down as well. That takes us to the end of our question queue for right now. So we would just like to take a second to encourage anyone who may have a question to go ahead and type your question in the Q&A box or take advantage of the opportunity to ask your question over the phone by using the raised hand function and we can get your question answered out loud.

>>Deb Kaldenberg, PIMMS: Hallie, I went ahead and marked one question to respond to. I don't know if that's come through and if I can find it again, I'll read it out loud, but it does have something to do with explaining why for MH-1. I think I found it. "Can you clarify why we

can't score a validated, reliable evidence-based scale like the PHQ-9 to determine a number for MH-1?"

And the reason for that is based on feedback we received from the measure developer of that particular measure. Their purposes in order for that PHQ-9 score to count it would be validated and scored by the eligible clinician. It wouldn't be done at abstraction. So if that didn't answer your question, please feel free to re-ask and I'll try and explain that a little bit better.

>>Ketchum: Thanks Deb.

>>Deb Kaldenberg, PIMMS: And then also Hallie, somebody is asking for a link to submit the ServiceNow ticket. I know that there's information on how to do that but didn't know if that was something you'd be able to share.

>>Ketchum: Yeah, we can definitely get, excuse me, that information out to folks.

>>Deb Kaldenberg, PIMMS: Thank you.

>>Ketchum: Just wanted to do another call to see if anyone else had a question they would like to ask over the line. Or a question you would like to type into the chat box. If you would like to keep it anonymous, you are welcome to mark as anonymous and it will be done as such.

We do have another question in the box for Deb, "For MH-1 where everything is marked zero, so clinicians didn't actually score because of how we give guidance on other depression measures."

>>Deb Kaldenberg, PIMMS: So the one thing I would recommend here is to make sure that you're following the measure specification. If you're saying that that patient met denominator criteria and they have an index date where they met all that information, you're trying to determine if the patient has achieved remission within the proper time period. You would be redoing that PHQ-9 or PHQ-9M and having a score and documentation. Obviously if there is a

zero, that to me is indicative of a score, but I would ensure that you're kind of working through that MH-1 measure as it's one of the more complicated just ensuring that you are following all of the steps and the timeframes associated, because you're looking during the performance period for a remission that the depression itself and that higher score occurred outside the 2024 year. So if you have additional questions, please feel free to ask.

>>Ketchum: Thank you. We have another question on the line from Sidney. Sidney, we've unmuted your line if you'd like to unmute yourself.

>>Attendee: Oh, can you hear me?

>>Ketchum: Yes.

>>Attendee: Okay. The question is because CMS we are using Web Interface reporting, right? So there's another option is that CMS generate an Excel file so that you can, you know, figure out the answers there. I noticed that it looks like the flu vaccination description, the day range looks like is not entirely correct. So I wonder whether CMS noticed that or whether they have any like corrective actions that would be done on that.

>>Deb Kaldenberg, PIMMS: I believe this is something that was covered earlier. Alex, I don't know if this was the issue you were talking about or if there was something different going on, but I believe this is something that has been corrected and if you find that you have still some things that are not lining up correctly, it would probably be best for your specific situation to kind of open up a ServiceNow case to ensure that the right people are able to take a look at that and confirm that everything has been corrected or what your next steps would be.

>>Alex Schotz, PIMMS: Yeah, I am sorry, I was just typing in the chat as well. So there were a few individuals who I think there were like 12 different organizations who downloaded the Excel template and it had incorrect dates on it. That was resolved within a couple hours of the submission window opening. So you might -- I don't know if you've tried to redownload the template and you're still seeing those incorrect dates.

>>Deb Kaldenberg, PIMMS: I don't know, Halle, if you can unmute Sidney. I think that was -- Alex was asking him to confirm or if we just want to move on.

>>Attendee: Yes, this is Sidney. Yeah, thanks for the answer. Actually Jamie put in a response in the chat box. I think that what I have not done is that I have not really because we downloaded the file and have not looked into the whether there's an update or anything like that. So what I would do is just to follow up and whether they have a revised or a corrected version there so that, you know. And we say that if it's still the issue have not resolved, then probably I will put in a ticket or something. Yeah. Thank you.

>>Deb Kaldenberg, PIMMS: That's great. Thank you.

>>Ketchum: Yes. All right. Thank you both. Wanted to do another call to see if anyone had a question they would like to ask over the phone. In the meantime, we do have another question in the chat for Deb. And the question reads, “Is there additional information you can provide regarding the new statin requirement below, patients aged 40 to 75 at the beginning of the measurement period with a 10 year ASCVD risk score of greater than or equal to 20%? Where should we look in the patient's medical record for this information?”

>>Deb Kaldenberg, PIMMS: So I can't tell you where to look for the information. I can provide and maybe you've already fully reviewed the measure specification and that's why you're asking the question. I will say a lot of times the coding document can be of assistance if for no other reason that it can help you find in the medical record what you're looking for. Unfortunately where to find it is not something that I can provide. I can only help with understanding the intent of the measure itself.

What I did want to ensure to communicate is that we will have an overview of PREV-13 at the next call, but if there are some very specific questions about the PREV-13 measure itself, I can try and answer those today or others that have that experience that are on the call with me will also try and do that as well. But that's kind of what I wanted to communicate. We will ensure

that PREV-13 is covered at the next Support Call. If you happen to have a specific question and can't wait until that call and you don't come up with a question during today's call, you're welcome to send that through the ServiceNow Help Desk as well. Thank you.

>>Ketchum: Thanks Deb. Our next question in the queue is for Margaret or sorry it's for Jamie. And the question reads, “Is there a nice summary of differences between the 2023 and 2024 metrics specs that we can download?”

>>Jamie Welch, PIMMS: Yep. Hello Margaret, this is Jamie. If you go out to the QPP or the Quality Payment Program Resource Library and open up the file that contains the specifications for web interface and the coding documentation for web interface, there are two documents. They're both, they're called release notes. There's release notes for the coding documents and there is a release notes for the specifications themselves. And hopefully that gives you a nice overview and helps out with any changes made between the 2023 and 2024 program or performance years. Thanks.

>>Ketchum: Thank you. We once again want to invite you to ask any questions you may have by raising your hand or by entering your question into the Q&A box. As a reminder, you do need a work microphone to ask your question over the phone and then you can also click ask anonymously in the Q&A box if you would like your answer to or your question to remain anonymous. Also, as a reminder, we will be posting all of the materials from today's webinar on the QPP library in the next two weeks.

>>Deb Kaldenberg, PIMMS: Hey Hallie, I think there's a couple of CARE-2 questions that we should be able to cover. If you just give us a couple of seconds. We're just double checking some information. One of them is the very last question that has come in. And I believe we do have Aroush has identified that to answer live.

>>Aroush Anis, PIMMS: Thank you, Deb. So a clinician with appropriate skills and experience may perform the screening.

>>Ketchum: And to clarify that question was for CARE-2, can you please clarify who is qualified to close this quality action?

>>Aroush Anis, PIMMS: Correct.

>>Ketchum: Thank you. All right, we are going to do one last call to see if anyone would like to ask a question. There's one more question in the queue for Jamie. The question reads, "Does documentation of fall precaution meet the fall measure." Jamie?

>>Jamie Welch, PIMMS: Yep. Thank you so much for this question. We had to review the specification real quick. Within the specification and we don't normally comment on how to specifically document these types of assessments within your medical record. And what we do generally is we point back to the specification itself. And within the specification it says documentation of no falls is sufficient, or a gait, or balance assessment meets the intent of the measure. But for any reason, if you still need clarity on this particular question or guidance, please reach out and provide a ServiceNow inquiry. We'll help you. Thanks.

>>Ketchum: All right, thank you, Jamie. That takes us to the end of our question queue. So we are going to go ahead and wrap up the Q&A portion for today's webinar. I'll turn it back to Sandra to conclude the call. Sandra?

>>Sandra Slaughter, CMS: Thank you, Hallie. And thank you everyone for joining us today. As a reminder, the slide deck recording and transcript from today's call will be available in the QPP Webinar Library in the next two weeks. The next CMS Web Interface Support Call will occur on January 22, 2025. Thank you.