Hello, everyone. Thank you for joining today's Web Interface Support Webinar. This series of webinars is for Accountable Care Organizations, (ACOs) and groups that are reporting data from the Quality Performance Category of the Quality Payment Program through the CMS Web Interface for the 2018 performance period. These webinars will highlight important information and updates about reporting quality data and provide ACOs and groups with the opportunity to ask CMS subject-matter experts their questions. During today's webinar, we will also share links for various resources and other information that will appear as announcements on your screen. 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'll turn it over to Sandra Adams from the Center for Medicare at CMS. Please go ahead.

Thank you, Stephanie. Good afternoon, everyone. Thank you for joining our webinar. Next slide, please.

This is our disclaimer slide. If you have any questions about the disclaimer, please contact the Quality Payment Program help desk. Next slide, please.

And here are some announcements. Please see this slide for links for the slides, recording, and transcripts for the webinar that was held on January 9, 2019. Next slide, please.

This slide provides you with reminders about the Web Interface submission period. The submission period is now open. It will close on March 22, 2019 at 8:00 p.m., Eastern Daylight Time. The Web Interface is accessible via the sign-in link on the Quality Payment Program website that you can access for this slide. And CMS Web Interface will save your progress with each step, so you do not have to click a "submit" button at the end of submission. And, again, the Web Interface will automatically accept your submission at the end of the submission period. Next slide, please.

Here's some more reminders about being timely and submitting any CMS approved reasons if early in the submission period as soon as possible. Next slide, please.

Here are some more reminders about submitting a request for a CMS Approved Reason. This slide goes through the process for submitting any requests for CMS approved reasons. Next slide, please.

And this slide provides the dates for the Web Interface support calls. And our next support call will be on February 6th, and it will include the topics of frequent reporting questions, frequent measure question, and a question-and-answer question to follow those topics. Next slide, please.

And now Ozlem Tasel from the Web Interface development team will provide some tips about reporting using Excel.

Thank you, Sandra. Hi, this is Ozlem Tasel. Today, I'd like to go over some tips and guidance on reporting in Excel. Next slide, please. Okay, the first tip -- do not upload password-protected Excel files. If you do so, you will get an error message that your upload failed. Ensure that the files are in .xlsx format. If you try to upload a file in a different format, again, you will get an error message that your upload failed. Do not alter or add CARE-1 discharge dates. CARE-1 discharge dates are part of your prefilled

beneficiary central data and cannot be changed. Your file will be uploaded and processed. However, any changes to the discharge dates in the Excel file will result in Excel errors. Beneficiary rank cannot be altered or added. Any changes to a beneficiary prefilled rank will be ignored during the upload. Any new rank added to beneficiaries will result in Excel errors that display the beneficiary is not assigned to the given measure. You can upload Excel files as many times as you'd like. Also, you can upload partially complete Excel files one measure at a time or one beneficiary at a time. Note that only the data that you have specifically entered into the Excel template will be overwritten in the system. Any fields that are left blank will not change any data in the system. Any fields for which "N/A" is selected will be specifically overwritten with an empty value in the CMS Web Interface. Next slide.

You can add a new column or delete an existing column in the Excel template without affecting your upload. Be sure to add any new columns outside of the table to avoid increasing the size of your Excel file. As you can see in the screenshot below, the table ends with the column HC. You can add a new column anywhere after this column, start with the HD column. A column added by you will not be saved into the system, and a deleted column will not impact any data already in the system for that measure. And lastly, do not edit existing column headers that you see in the first two rows. They need to be unchanged in order for your file to be processed properly. Next slide, please. Okay, I will now pass it off to Amy Mills for the next portion.

Hi. This is Amy Mills. And I will review the frequent assignment and sampling questions. Next slide, please. The first question asked, "My organization has less than 248 beneficiaries ranked in some measures. Can my organization still meet the reporting requirement for those measures?" And the answer is yes. Not every CMS Web Interface measure will have a sample of 248 patients. This is particularly true in measures for diseases that have low prevalences. If fewer than 248 beneficiaries are found eligible for a measure, then the ACO or MIPS group should report on all eligible beneficiaries. The next question is about measure age restrictions: "At what point in time is a beneficiary's age calculated?" For sampling, the lower age limits are calculated on the first day of the measurement period. For 2018, that is as of January 1, 2018. The upper age limits are sampled based on their age as of the last day of the measurement period. For this year, it's December 31, 2018. Next slide, please.

"What if the pre-populated demographic information is not accurate?" The CMS Web Interface user can modify the demographic information that is pre-populated into the CMS Web Interface. If the beneficiary's demographic information in your records and in the CMS Web Interface do not match, then you can correct this information and you should correct this information because it may affect the beneficiary's denominator eligibility for certain measures. And next I'll hand it off to Jessica for the measure questions.

Thanks, Amy. So, the Web Interface measures team has been receiving a lot of questions about MH-1 depression remission at 12 months, so I just wanted to provide an overview of the definitions and help provide some visuals and examples of the timelines and hope to answer some of your questions. So, if you have MH-1 questions today, if you could please wait to enter them in the Q&A box for a couple minutes because I am hoping that the next couple slides are going to answer all of your questions. But if not, let us know.

So, on slide 15, we have some definitions regarding; they're kind of around the denominator identification period. And just as a reminder, the intent of MH-1 is to measure the number of patients, 18 years of age or older, who have an active diagnosis of major depression. And that also includes depression in remission. If you look at the coding document, you'll see those codes in there. So, major depression or dysthymia who reach remission within 12 months, plus or minus 30 days after the index date. So, if you're interested in knowing the rationale behind the measure, we've been having a lot of questions about "What am I doing? What am I trying to do with this measure?" Please take a look at the back of the measure spec. There's a clinical recommendation statement that begins on page 24. And that section notes that clinicians should establish and maintain follow-up with these patients and that appropriate, reliable follow-up is highly correlated with improved response and remission scores. And it's also correlated with the improved safety and efficacy of medications and helps prevent relapse. So, in a nutshell, that's the point of this measure. It's designed to first identify appropriate patients who have that diagnosis of major depression or dysthymia, and that takes place during a look-back period. And then, the measure has you determine whether or not the patient reached remission during the follow-up, which is 12 months, plus or minus 30 days later.

So, with that said, the definitions kind of set up that framework, and the first definition that you need to start with is that denominator identification period. And that is a 12-month period that looks back from December 1st of 2016 to November 30th of 2017. And that period is used to identify and index dates for denominator confirmation. And an index date is then defined as the date in which the first instance, which is the keyword there -- the first instance of an elevated PHQ-9 greater than 9 and -- which is another key word here -- an active diagnosis of major depression or dysthymia occurring during that denominator identification period. So, before we move on to the example, I just kind of want to explore that index date definition because this is where we get a lot of questions. So, the first comment I want to make about index dates is that, as noted in the measure specification, all nine questions in that PHQ-9 must be answered to have a valid summary score. Also, as stated in the measure specification, an active diagnosis of major depression or dysthymia is defined as a diagnosis that is either on the patient's problem list, a diagnosis code description list on the encounter, or is documented in a progress note indicating that the patient is being treated or managed for the disease or condition at some point during that denominator identification period. That active diagnosis -- In the spec, you'll notice this year the "and" is bolded and underlined because the active diagnosis must be associated with the encounter in which the PHQ-9 score was greater than nine. If you do not have a diagnosis, then what you'll be doing is you'll be measuring and holding this provider accountable for the patient's remission when there wasn't a diagnosis. Therefore, you must look for the first instance of an elevated PHQ-9 greater than nine and active diagnosis of major depression or dysthymia during that denominator I.D. period. And my last friendly note to take home today is that, for 2018 MH-1, we understand that when you're looking through these notes, there might be different types of documentation. So, for 2018, we recommend that you need to have documentation of major depression or dysthymia. That would be acceptable. If you have documentation of just depression and if it's paired with eligible diagnosis code, such as S32.9, then that would be acceptable.

Now, moving on to the example for denominator I.D. period, so if that medical record has documentation at the first instance in which the patient

has an elevated PHQ-9 score greater than 9 and an active diagnosis of major depression. Back on slide 15, we had noted that was May 1st of 2017. So, I'll write down that May 1st of 2017 -- thanks, guys -- as my index date, and you can see that. There's a graphic at the bottom of the screen. This graphic is going to be used in our examples across the next couple slides. So, I hope this helps. If you guys need any other information that might help out with this timeline, just please let us know. So, next slide.

We're going to focus on denominator exclusions. That's our probably second biggest set of questions we're getting is, "How do I find an exclusion?" We have a lot of questions about the timing and also the requirements. So, let's talk about denominator exclusions. It's an active diagnosis of bipolar or personality disorder anytime during that denominator I.D. period through the measurement assessment period. Quick side note -- an active diagnosis, again for bipolar or personality disorder -- is going to be a diagnosis that's on the patient's problem list, a code description listed on the encounter, or documentation in progress notes stating that the patient is being treated for the disease or condition. Please see the coding document for a complete list of acceptable ICD-10 codes for bipolar and personality disorder. And then moving on to the second bullet on slide 16. The measure assessment period is unique to each patient, as it starts on the patient's index date and will extend out 12 months. From that 12 months, then you add and subtract 30 days to get that window for remission. In the example at the bottom of the slide, you can see that the index date is, again, May 21, 2017. So, I go out 12 months, which is May 1st of 2018. Then I count out 30 days to establish the end of the measure assessment period. So, add 30 days. That's May 31st of 2018. Now, note there are 31 days in May, so I added 30 days rather than adding one month. So, that 30 days takes us to May 31st. Now, in the example below, you can see there's still that index date. We added in a bar on that timeline to show you the denominator exclusion window, and that window is then going to run from December 1, 2016, which is the first day in the denominator I.D. period, through the last day of the patient's measure assessment period, which is May 31st of 2018. Okay. I'm sorry. All right, next slide, please. Thank you. I'm sorry.

On slide 17, we're going to focus on some of the definitions around the quality action, and that's when we start looking for remission. So, as stated in the measure specification in the clinical recommendation section, responding to treatment and achieving remission takes time. So, we want to be sure that we give the patient and provider enough time before measuring for remission. Therefore, remission is defined as the most recent PHQ-9 score less than 5 during that measurement assessment period of 12 months, then adding and subtracting 30 days. Now, as a quick side note, you want to establish the farther spread for the patient between their diagnosis and then remission in order to allow time for the patient and provider to identify the best treatment approach. That's why, when establishing the index date, you use the first instance of that PHQ-9 score greater than 9. And then when establishing remission, you look for the most recent PHQ-9 less than 5. So, you want to make sure you give them a nice spread to work together to try to find an acceptable treatment. So, using that same example on the bottom of slide 17, we have our index dates. And now I count out 12 months, and I subtract 30 days from the index date to get the start of that window. So, that gives me April 1st of 2018. So, remission must occur on or between April 1st of 2018 through May 31st of 2018. And I begin at May 31, 2018, and I start looking back for that most recent PHQ-9 with a score less than 5. Next slide.

And slide 18 is going to show some examples based on frequent questions. We use the same index date of May 1, 2017, throughout all the three scenarios here just to make it easier to follow. The scenarios do -- they'll have different dates for the most recent PHQ-9 less than five. So, scenario 1 is someone that we followed through the previous slides. It shows the patient had medical record document confirmation of a PHQ-9 greater than nine during the measurement I.D. period and then a PHQ-9 less than five during the measurement assessment period, which is that 12-month, plus or minus 30-day, window. Scenario 2, though, shows that the patient only had a follow-up PHQ-9 less than five on September 1st of 2018, which is outside of the measurement assessment window of that 12 months, plus or minus 30 days. So, in this case, you would have to select "no" because it's outside of the remission window. For scenario 3, it shows that the most recent PHQ-9 was on April 30th of 2018. So, it was within the measurement period of that 12 months, plus or minus 30 days. However, the score was not less than five, so for this you would have to select "no." And that is all that I have on MH-1, so I hope I was able to help you guys. If not, please let us know what other questions you have. And at this time, I'll hand it over to Angie. Thank you.

Everyone, this is Angie Stevenson with the PIMMS measures team. Today I'd like to review some frequently asked questions for the PREV-7, -8, and -9 measures. I want to remind you that you can find the 2018 CMS Web Interface frequently asked questions document in the Quality Payment Program resource library. And that link's included in the resource slides in the last section of this presentation and, I think, all of our presentations. So, I wanted to remind you of that. Next slide, please. Okay, you're on it. I'm sorry.

Okay, so, PREV-7, the influenza immunization measure. Question one -- "What is the cut-off date for the receipt of an influenza immunization for PREV-7?" And the answer is “for 2018 reporting, the denominator includes patients seen from October 1, 2017, through March 31, 2018. You would determine if the patient received the influenza immunization or reported previous receipt of the immunization between August 1, 2017, through March 31, 2018, to report the numerator.” Question two is "do we need to verify the patient had an encounter during October 1, 2017, and March 31, 2018?" No, you do not. “Users are not responsible for confirming that the qualifying encounters occurred for PREV-7. All beneficiaries sampled into the Web Interface have had at least two visits with a provider in your organization during 2018. And additionally, CMS ensures using Medicare claims billed by your organization that the beneficiary had at least one visit with the encounter codes listed in the PREV Coding Document for PREV-7 during that flu season of October 1, 2017, through March 2018.” Next slide, please.

Question three -- "Do we need to verify the patient received an influenza immunization if the answer is prefilled in our sample?" And aside from confirming that the patient is qualified for sample during your patient confirmation -- I just wanted to mention -- not in hospice, deceased, moved out of the country, or where Medicare is not the primary payer -- then they are qualified for the sample. But for the measure, the Web Interface has been prefilled with "yes" based on claims data, and no further action is required. You would only need to determine if the patient received or reported the influenza immunization between August 1, 2017, and March 31, 2018, if the answer is not prefilled. Question four is "if the patient reports they received the influenza immunization but cannot remember the exact date, what should we document?" And “documentation of patient reported previous receipt of the influenza immunization is acceptable during the flu season. The month and the year the immunization was received would need to

be included in the medical record documentation" to meet the numerator. Next slide, please.

PREV-8 is the pneumonia vaccine Status for Older Adults measure. Question five is "when the beneficiary reported the pneumococcal -- I'm sorry, I can't say that very well -- vaccine prior to the availability of PCV13, is the type of vaccine required to meet the measure?" The answer is that "the medical record documentation should state the year up through the last day of the measure period and the type of vaccine provided. If the beneficiary reported prior to 2015, documentation indicating receipt of the of the pneumonia vaccine is sufficient. If the beneficiary reported during 2015 or after, then documentation indicating the year of the vaccination and confirmation of the type as PPSV23 or PCV13 is required." Question six -- "Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the immunization measure?" The answer is, yes, if the immunization registry information is available at the point of care, then the information may be used. Next slide, please.

These questions are for the PREV-9 Body Mass Index Screening and Follow-Up Plan measure. Question seven -- "If a patient is wheelchair-bound or nonambulatory and cannot be weighed, can that be documented as a denominator exclusion medical reason, or do we have to select, 'no,' the patient did not have their BMI calculated?" And question eight -- my answer is also going to apply to question eight, which is, "If a patient comes in that weighs more than what a scale can hold, should that be documented as a denominator exclusion medical reason, or do we have to select 'no,' that the patient did not have their BMI calculated?" The answer for both of those is that "if a BMI was not performed and documented, the patient would not meet the measure criteria, and you would select "no." The timing component for the denominator exclusion is the date of the encounter with the calculated BMI or within the previous 12 months of the current encounter. And medical reason denominator exceptions only apply to the follow-up plans, not to the BMI performance." Next slide, please.

Question nine -- "If a patient has been in the office multiple times within the measure period or 12 months prior to the measure period and they have more than one encounter where their BMI was abnormal, can a follow-up plan that was linked to an abnormal BMI from a previous visit be sufficient for the measure?" The answer is "yes, starting with the most recent visit, look for medical record documentation of a calculated BMI. And to your question, if at the most recent visit there was medical record documentation of an abnormal BMI but no documentation of a recommended follow-up, then you look back 12 months from the most recent visit for a recommended follow-up that is linked to an encounter with a documented abnormal BMI. The calculated BMI and the recommended follow-up must be documented at the same encounter within 12 months of the most recent visit" in order to be considered linked. And that is all I have today, and I will turn this over to Sandra Adams. Thank you.

Thank you, Angela. Next slide, please. So, we will go over some of the resources available now, and this slide has hyperlinks to resources that are available at the Quality Payment Program Resource Library. Next slide, please.

So, a continuation of resources -- this slide lists instructional videos that are available, again, at the Quality Payment Program Resource Library. Next slide, please. And here are some websites that will be helpful for

support, and, in addition, some CMS Web Interface webinar materials are now available at the Quality Payment Program Resource Library for our prior webinars that we have held. Links are here on this slide. Next slide, please.

And here's contact information for the Medicare Shared Savings Program ACO webpage and Quality Measures Reporting and Performance Standards and the ACO Portal and also resources for the Next Generation ACO Model. Next slide, please.

And here are some e-mail and telephone numbers for additional assistance, should you need help from CMS. Next slide, please. And here is a slide with instructions for how to ask a question during the question-and-answer period that will begin now.

All right. Yeah. So, we are now going to start the Q&A portion of the webinar. You can ask your questions via chat or via phone. To ask a question via phone, please dial 1-866-452-7887. And if prompted, please provide the conference I.D. number, which is 4448869. And you'll need to press star 1 to be added to the question queue. And please note, as well, if you do have any follow-up questions or a clarification that you want to share during this portion of the call in the chat, please do type "follow-up question" at the beginning of your chat, and that way we can keep an eye out for those.

All right, so, our first question is relating to PREV-6: “If we have a patient report the date and year, the type of test, and the result findings, but the patient was only able to give the year and they can't recall the month or the day, should we be using January 1st of that year? And also, would this apply for PREV-5 in the same scenario?”

Hi. This is Jessica from the measures team. So, the Web Interface requires you just to enter yes or no. You do not have to enter the dates in the actual tool. In the event of an audit for PREV-6, if it's patient-reported, you just need to have the year and the type of test and the results and findings of that test. And for PREV-5, the short response would be you have to know the year if it's within that full-year look-back period. If you're getting into that 30-month grace period, then you would need to be able to also identify the month. If others have more to add or need to correct me, please jump in. Thank you.

This is Deb just to say that it's the three-month look-back and not 30 months, and that's just to be able to show that you are falling within that look-back period, which is why that month would be needed.

Great. Thank you. And this next question is on PREV-12. “If a patient had an active diagnosis of depression at any time during the period, should it be a denominator exclusion, or does the diagnosis need to be active at the time of the screening in order to qualify for an exclusion?”

That is a great question. And the patient can only be excluded if there's an active diagnosis of depression or bipolar prior to that encounter with the most recent depression screening. So, it has to be before that numerator event. If the diagnosis occurs during that encounter with the most recent depression screening, then that patient would be excluded. Thank you.

Thank you. This next question says, "Can you please clarify if providing a patient identified as a tobacco user with educational materials on the

dangers of tobacco use and the benefits of cessation -- can you please clarify if that meets the measure?"

Hi. This is Angie with PIMMS. The tobacco cessation intervention includes brief counseling, three minutes or less, and/or pharmacotherapy. You can look on page 6 of the measure specifications for the definition of follow-up plans. And that does note that concepts - such as written self-help materials, brochures, and pamphlets, or complementary alternative therapies - are not included in the PREV coding document and do not qualify for the numerator. Thank you.

Thank you. This next question says, "For MRPD, if a patient was discharged from a hospital into a skilled nursing facility, should that patient be showing up as ranked, particularly if the patient was in the skilled nursing facility for the entire 30-day duration of the post-initial discharge?"

This is Jessica from the measures team. So, for CARE-1 medication reconciliation post-discharge, beneficiaries are sampled into the measure only if Medicare claims indicate an office visit within 30 days of that in-patient discharge occurring within the group. So, if you're unable to confirm an office visit, you would select "no" under office visit within the Web Interface. And when "no" is selected, then the discharge would not be included in the denominator of the measure. Thank you.

Thank you. And, Stephanie, do we have anyone on the phone with questions?

We do have a question, from Elizabeth Layden.

Yes, I'm just wondering, if a patient is legally blind, if they are still required to have the diabetic eye exam.

Hi. This is Deb from the measures team, and the answer to that is, yes, they do. And this is something that has been confirmed by NCQA.

Okay. Thank you.

Thank you.

All right, this next question is on IVD-2. If a patient has a documented allergy to aspirin, how should I submit that?

Hi. This is Angie. You would have to select "no." There are other anti-platelet drugs besides aspirin that could be used to meet the measure. Thank you.

Thank you. This next question is on PREV-10. “Our denominator for Population 2 is less than 20. Will this measure be used in our performance score? And since the PREV-10 measure was re-specified this year, what data was used for calculating the PREV-10 Population 2 benchmark?”

This is Kristin. If this is an ACO, it would be scored, but I can just answer for ACOs. And as far as the benchmark, this year Population 2, previously, it was not explicitly calculated in the Web Interface, but the data elements that were necessary to calculate it were. So, the benchmark was set using those data elements from previous years and simulating the rate for Population 2 to set the benchmark for this year.

And this is Lisa Marie. With regard to benchmarks for, like, groups, for groups we actually follow the same benchmark established under the ACO model.

Great. Thank you. This next question says, "During an earlier webinar, there was mention of bonus points awarded for measures submitted through an electronic upload. Can you confirm that?"

Hi. This is Ozlem. Yes, you can earn one in 10 bonus points for each measure updated via APIs or Excel upload. But please note that you can only get one bonus point per measure, even if you use combination of API and Excel to update that measure. Thank you.

Thank you, and this next question says, "Would you be able to clarify whether the Medicare supplemental plans from a commercial payer count as a disqualification reason for the non-FFS Medicare?"

Hi. This is -- This is Amy. Go ahead. Go ahead.

It's true if that supplemental payer is the primary payer that the beneficiary would be disqualified. Medicare Fee-For-Service needs to be the primary payer in order for the beneficiary to be qualified for reporting.

All right. Thank you. And, Stephanie, do we have any question on the phone?

Our next question is from Beth Cianis.

Hi. My question is regarding PREV-12 for depression screen. If we are not able to confirm that the patient had an eligible encounter during the measurement period, is the patient able to be marked as not qualified for the measure at all?

Hi. This is Jessica. Oh. Sorry. Go ahead. Go ahead, Jessica. No, no. Go ahead.

Oh, I'm just flipping to that spot in the spec, Deb. If you know off the top of your head, go right ahead.

This is Sarah from RTI, and I was just going to say that, based on our claims evidence from what we have in our system, it does, in fact, show that a beneficiary would have had two encounters during the measurement year in order to be eligible for quality reporting. And then, Jessica, if you wanted to answer specific to the measure, that's fine, too.

Sure. So, after reviewing records, only if you're not able to find an encounter then could you select that "not qualified for sample." But thank you.

Thank you. So, this next question is on PREV-12. If a provider uses at PHQ-2 tool to assess depression and includes the tool in the note, but does not comment on the results, and the score is greater than zero but less than three, can the abstractor answer, "Yes, the patient has been screened, and, no, the patient is not depressed"?

This is Jessica from the PIMMS team. So, no, no, if the score is greater than zero, then the eligible clinician must document the interpretation of their results, just so the rest of the care team has clear communication as

to that patient's current condition, which then would impact their treatment outcomes. So, thank you.

Thank you. And this next question is on PREV-5 for breast cancer screening. And they're referencing in the last webinar the age was discussed. If a patient had a breast cancer screening done within the last 27 months and the screening occurred before the patient was 50, can that be used?

Hi. This is Angie with PIMMS. This measure does have an age difference in the description of the measure and the denominator statement in the measure. The patient must be 51 to be in the denominator. But the patient is not considered eligible for the denominator until age 51. But mammograms that are received beginning at age 50 are allowed for the numerator. And due to that grace period, yes, the patient might have even been 49, and that would meet the intent. The initial population includes women 50 to 74 years of age with a visit during the measurement period, and that is so the patient sample maintains the proper age criteria within the performance period. Therefore, women ages 50 to 52 are included in the measure if they had a visit and a mammogram since age 50. But the look-back only applies to patients 52 to 74. Thank you.

Thank you. This next question is "if the smoking status in the chart reads 'former smoker' or 'nonsmoker,' will this be accepted for the PREV-10 measure?"

Hi. This is Angie again. "Former smoker" or "nonsmoker" would suffice for a smoking tobacco status. However, there must be documentation that the patient was screened for both smoking and smokeless tobacco and the status for each of those in order to meet the intent of the measure. Thanks.

Thank you. This next question says, "If the patient's birthday does not match with CMS Web Interface information, should we correct the birthday and continue on answering the measure questions?"

Hi. This is Ozlem. If the patient's birth date is incorrect in the Web Interface, it can be updated in the data entry pages. You cannot update the patient's birthday via Excel, but you can manually update it in the Web Interface. You will need to go to the patient's list and select a beneficiary, and under the "beneficiary demographic" section, click the "edit info" link and update their birth date or correct the birth date and click on "save." That should correct the data form for your beneficiary. Thank you.

Thank you. And, Stephanie, do we have anyone on the line with questions?

Our next question is from Hannah Park.

Oh, hi. I have a question related to hypertension. Our provider took multiple blood pressure on the same day. However, the blood pressures were coming from two different encounters, but, again, it's on the same day. Can we still mix the blood pressure to find and record the lowest systolic blood pressure and diastolic blood pressure?

This is Deb. I need to go back and review the measure specification, but I can certainly answer your question later on within the call. I know there's a couple of other hypertension questions that will be asked.

Okay. Thank you.

Thank you.

All right, so, this next question is "does CKD stage 3 or CKD stage 4 count an exclusion for the HTN-2 Controlling High Blood Pressure measure?

And this is Deb again. And that was a really quick hypertension question, so I haven't researched the other one quite yet. But, no, CKD stage 3 and stage 4 are not denominator exclusions for the hypertension measure. Both the verbiage within that specification as well as the coding that's associated with it do identify only CKD stage 5 as CKDs that should be used as denominator exclusions. Thank you.

Great. So, this next question says, "The denominator exclusion for active diagnosis of bipolar disorder states that any time prior to the end of the performance period, the only exclusion of the permanent nursing home resident exclusion states that during the identification period or before the end of the measurement assessment period and performance period means any time prior to December 31, 2018, correct?"

This is Jessica from the measures team. So, on page 9 of the measures specification -- First of all, the language in the spec is aligned with the eCQMs. But if you look at page 9 of the measures specification, which is where this step takes place, this step begins with a denominator I.D. period. So, the denominator confirmation begins on December 1st of 2016. That's your start date for denominator exclusions. And then you'll notice in the definition of denominator exclusions, it says an active diagnosis of bipolar or personality disorder -- that extends through the performance period. So, MH-1 has a performance period outside of the MIPS measure period. The MIPS measure period is January 1st through December 31st of 2018. But the performance period for MH-1 is that first day of that denominator I.D. period. So, December 1st of 2016 is the first day of the performance period, and the last day of the performance period is going to be unique for each patient, depending on their index date because that then is the first step in fleshing out their measurement assessment period. So, the language is a little different on page 9. It's for alignment with eCQMs. The guidance from the measure owner is that denominator exclusions for active diagnosis of bipolar disorder or personality disorder can be claimed if you have an active diagnosis either on that first day of the denominator I.D. period, December 1, 2016, to the last day of that patient's unique measurement assessment period because that's the performance period for that patient for this measure. Thank you.

Thank you. Our next question is on the DM-7, the diabetes eye exam. If the patient had a retinal eye exam done in 2018 and the result was negative retinopathy in the left eye, but for the right eye the clinical note says, "image not readable," can we answer "yes" to the DM-7 eye exam question based on this evidence?

So, this is Deb from the measures team, and based on your scenario, yes, you could answer that there was a retinal eye exam done in 2018. As a follow-on to the hypertension question that was asked previously, I was able to find on page 5 of the measures specifications that if there are multiple blood pressure readings on the same day, you can use the lowest systolic and lowest diastolic reading as the most recent blood pressure reading. So, therefore, they are not requiring that the mixing and matching of the

systolic and diastolic values are from the same encounter, but rather on the same day. Thank you.

Thank you. This next question is on PREV-9. "If the patient's most recent encounter is October 25, 2018, and the most recent BMI assessment is May 25, 2018, and the BMI is abnormal, but follow-up occurred on October 25, 2018, does this follow-up count?"

Hi. This is Angie. No, I don't believe that example would count, not unless there was an abnormal BMI at the 10/25/18 visit. Thank you.

Thank you. And, Stephanie, do we have anyone on the phone at this time?

We have a question from Sandra St. D'Angelo.

Hi. Thank you for taking my call. The question I have is for both PREV-12 and MH-1, and it's really around, if there's a patient that has dementia or Alzheimer's. How are we supposed to handle that situation, when perhaps they can't answer any of the standardized question of PHQ-9 or any other depression screening form? I don't see them as exclusions unless I'm missing something.

Hi. This is Jessica from the measures team. Correct, they are no exclusions. And the premise of that is, for MH-1, if that patient -- in order to pull the patient to the denominator, they first must have that diagnosis of major depression or dysthymia. If they don't, then you would code "no," and they would be excluded and replaced. If they did have a diagnosis of depression or dysthymia, you would continue on in denominator confirmation to see if they that PHQ-9 score, and if they don't, then they'll be skipped and replaced. There is the exclusion for permanent nursing home residents. So, if it is a patient who's in a position in which they need to have care, then that patient would be able to be excluded. But otherwise, they would not meet the denominator confirmation steps. Regarding PREV-12, I'm just pulling that spec up because my brain is wrapped around MH-1 today. For PREV-12, exclusion, similar situation, if they don't have that depression screening, then they would be coded out. For PREV-12, if the patient does have depression which is associated with Alzheimer's and dementia, you would want to make sure the patient is being screened and that, if they are positive, that there would be a follow-up plan. So, you do want to follow the abstraction steps for PREV-12 with these patients, as well. If it gets to a point in which they are no longer eligible for this measure, then they would code out, as well. Does that help?

Okay. It does. So, we go through the process, and if they can't answer the questions, then we'll have to say, no, we couldn't complete the assessment, and that would skip them.

Correct. Pretty much.

Okay. Thank you so much. I appreciate that.

Hold on one second, though. This is Deb. I do want to clarify that, for PREV-12, PREV-12 doesn't require. You actually have to find medical record documentation that the depression screening was not completed due to the patient's functional capacity to complete that screening. So, if the only thing you're finding is that you have a denominator-eligible patient for PREV-12, you haven't done a screening, and you can find in the medical

records they have a diagnosis of depression or dysthymia, Alzheimer's, anything like that, you can't just automatically skip them. You will have to say that the screen was not completed. But if you can find medical record documentation that says the screening wasn't done based on this diagnosis, then it would be acceptable to select that denominator exclusion. For MH-1, the difference there is, if they're not completing that PHQ-9, they're not considered denominator-eligible. So, it's not like you're saying that they met or didn't meet the measure. They just weren't really intended to be within that measure population because there is no PHQ-9 greater than nine.

Okay. Thank you so much. I understand, and I appreciate the response.

Thank you, and it looks like we have time for one last question. So, this is on the PREV-13 section of the template, and they say that "in that template, each risk category contains an exclusion choice. However, the measure exclusion is not per risk category. Where would we enter the exclusion? Would we enter it into each risk category?"

I'm sorry. Could you repeat that?

Yes. So, this is for the PREV-13 section of the template. They say that "each risk category contains an exclusion choice. However, the measure exclusion is not per risk category. Where would we enter the exclusion? Would we enter it in each risk category?"

Oh, I just wanted to make sure it wasn't a measures question. Ozlem, would your team be able to answer that?

If we can either come back to that question, we'll look for the answer. Otherwise, please open a help-desk ticket, and we can look into it and answer that appropriately. Thank you.

All right, thank you. And that is all the time we have for today. If we could go to the next slide, please. And if we weren't able to answer your question, please do feel free to e-mail those addresses. They're listed here on the next slide, and we also sent them out earlier as an announcement that you should have seen pop up on your screen. And we do also encourage you to join us for our next webinar on February 6th.

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