

PLEASE STAND BY FOR REALTIME CAPTIONS.

Speaker: Brian Willis

Hello everyone and thank you for attending today's webinar. Before we begin, we want to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget by clicking on the maximized icon on the top right of the widget or by simply dragging the bottom right corner of the widget panel. This webinar is being recorded. The recording will be available one day after the webcast, as the audience use for this webcast. If you have any questions for the presenters during the webcast, you can click on the Q&A widget on the bottom and submit your questions. Or you can try to address as many questions as possible during this event. If a fuller answer is required or we will run out of time, your question will be answered later via email. We do capture all questions. If you have any technical difficulties, please click on the health widget. It has a question mark icon and covers most common technical issues. You can use the Q&A widget for technical issues. Now, I would like to pass it over to Susan. You now have the floor.

Speaker: Susan Arday

Thank you very much. I really appreciate that. Good afternoon, everyone. Thank you and I would like to welcome everyone to today's webinar. This is on electronic clinical quality measures. It is titled Eligible Clinician eCQM Preventive Care and Screening Measures. This is the second in our eCQM series of webinars for eligible clinicians. As mentioned, my name is Susan. I am the CMS contracting officer representative for this particular action. I am the core for the CMS contract task of maintaining the electronic what -- clinical quality measures, or the eCQMs used in the incentive payment system, or MIPS. I will be presenting along with two others. There is also Beth and Jamie. We will present three measures. The first is quality I.D. 317, CMS22. It is Screening for High Blood Pressure and Follow-Up Documented. The second will be quality I.D. 110, Eligible Clinician eCQM Preventive Care and Screening Measures 11 - - CMS147, Influenza Immunization. The final will be CMS138, Tobacco Use Screening and Cessation Intervention. All three of these measures are in the top 10 issues for MIPS. There are many questions that come in. Today, our speakers will view the specifications and address the most common questions that are received. As you can see on the slide, at the end of today's session, you will be familiar with the top reported preventive care in screening eCQM. Two, you will better understand the most frequently asked questions for each of these eCQMs and how to follow ongoing information about these measures. You will also know how to go to the tragic -- packing system. You can go through MIPS, including the new CQL updates.

I would like to state that that's I want to make note of this that the staff and speakers have no financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or that may be referenced in this activity. At this time, I will hand the presentation over to Katie and Gary from quality insights, who will discuss CMS22, Screening for High Blood Pressure and Follow-Up Documented. You have the floor, Katie.

QUALITY ID 317/CMS22: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW-UP DOCUMENTED

Speaker: Katie Magoulick

Thanks, Susan. My name is Katie and I'll first review the measure populations for CMS22, preventive care and screening. And then we will address the most frequently asked questions on this issue. Gary will also provide us changes from 2019 reporting for this measure. We will field any questions at that time.

First, a review of the measure description. Mathematica Policy Research assesses the percentage of patients aged 18 years and older in the reporting period who were screened for high blood pressure and the recommended follow-up plan that was documented from the current blood pressure reading as indicated. The nominator includes all patients aged 18 years and older at the beginning of the measurement period. That leaves one eligible encounter during the measurement period. Nominator exclusions include any patient who has an active diagnosis of hypertension.

The numerator includes patients who were screened for high blood pressure and have a recommended follow-up plan documented. As indicated, the blood pressure is the hypertensive or hypertensive. There are two classifications of denominator exceptions for this measure. First, if the patient refuses to participate either in the blood pressure measurement or follow-up for medical reasons. If a patient is in an urgent medical situation where time is of the essence and delayed treatment will jeopardize the patient's health the status. This includes but is not limited to severe Allen blade -- elevated blood pressure where medical treatment is needed.

Our highest volume of questions are around exception criteria. For quick review, let's discuss the addition -- difference. The nominator exclusions criteria are evaluated before checking if the patient meets the numerator criteria. The patient who qualifies for the denominator exclusion will be excluded from the denominator. In this instance, a patient with an active diagnosis of hypertension would be excluded. The denominator exception criteria are only evaluated if the patient does not meet this numerator criteria. Patients who do not meet this numerator criteria also meet the exception criteria for the denominator, such as nonperforming screenings being pre-removed from the denominator. The way to think about exclusions versus exception logic is the order of operation. When you go through the logic, you first review for measure inclusion in the initial population. And then you do the denominator, the denominator exception, and so on. This is how we evaluate the order of population. So if they are excluded, they'll never get to the nominator exception criteria. The patient will only be removed from the denominator if the patient did not meet the numerator criteria. The measure logic accounts for every reason -- does not account for every reason of why they are excluded.

An example of the patient that qualifies as a nominator exception is a patient who receives a blood pressure screening during an eligible encounter. It is their first documented hypertensive reading, before the follow-up. The patient did receive their screen, but does not receive a follow-up. This patient would be removed from the denominator exception.

Moving into our frequently asked questions. Our frequently most asked question asked for clarifications on what constitutes a denominator exception. Can the denominator exception criteria be documented outside an eligible encounter? The answer is no. Denominator exception criteria, once in documented within the measurement period, for example, a patient came in to see you last year and refused to have their blood pressure taken. This was documented. When the patient returns the following year and happens to receive it again, this would need to be documented again to qualify as an exception. The denominator exception criteria must be documented for each measurement period.

We receive questions involving the blood pressure screening timing. The question was, do we need verification of the blood pressure screening occurred during a qualifying encounter? The answer, the blood pressure screening must occur at the time of the qualifying encounter. The measure used to promote recent blood pressure reading from the last eligible encounter during the measurement period. For example, if the patient has four eligible encounters during the measurement period and the blood pressure was taken at the first, second, and third encounters, but not the fourth, the measure will look at the third encounter. Again, the most recent eligible encounter with the blood pressure screening results is what is considered to be measured.

Our final most frequently asked question regards blood pressure follow-up timing. Can the recommended follow-up for pre-hypertensive or hypertensive readings occur before the blood pressure screening encounter? The answer is no. The follow-up must begin concurrently with or start after the eligible blood pressure screening encounter. It cannot occur prior to the eligible encounter. That follow-up must be ordered within 24 hours after the start of the encounter.

As we discussed, blood pressure follow-up from the previous slide, we will talk about follow-up interventions for this measure. A follow-up plan based on low pressure meeting must be documented. With hypertensive versus pre-hypertensive and second hypertensive readings require follow-up intervention orders within the specified time frames. Eligible follow-up intervention orders include any of the following: life recommendations, weight reduction recommendations, dietary recommendations, physical activity recommendations, moderation of alcohol consumption, or referral to an alternate provider. Three hypertensive readings require a follow-up visit to be ordered within one year of the eligible encounter. First hypertensive reading documentations require follow-up visits be ordered within four weeks of the eligible encounter. Specifically, for second three hypertensive blood pressure readings, follow-up must include one or more of the following as indicated. Antihypertensive phonological therapy, laboratory tests, or electrocardiograms.

Next, Gary will go ahead and report on the 2019 reporting changes with you.

Speaker: Gary Rezek

Thanks. I want to talk about some of the coding updates that impacts CMS22. That is along with the conversion to CQL, specifications can now use are called direct reference codes. These are used in instances where a value set of a single code can be replaced with a direct reference to that single code, instead of what identifies a value set. For the 2019 reporting year, single codes link value sets have been's transitioned to direct reference codes, with other opportunities optional. For CMS22, what was used to define blood pressure have been transitioned to direct

reference codes. To show you how this will appear in the new specifications, first I will show you a snippet of the 2018 specs and how the blood pressure values appeared. In the day tear -- data criterion section, you can see this along with a reference to the value sets named. Each of these value sets contained only one code. In the 2019 specs, there is a bit of a subtle change here. You no longer see this OID. You see the same datatype. Instead of a value set, you see the direct reference to the link code. There is four description of a code terminology and version, which is linked to the code that. The way this appears in the CQL logic, the data element is referred to by the code description, as highlighted in the CQL definition, which is taken from measurements.

Other coding updates which have impacted this measure include the addition of new codes and the denominator coding. These codes allow for the inclusion of some nursing homes and other assisted-living encounters. Lastly, in the antihypertensive medication value set, several codes have been removed to reflect specific drug formulations that have been discontinued.

Q & A

Thank you, Katie and Gary. At this time, I would like to turn it over to Anita to see if there are questions that have come in through the chat.

Thank you, Susan. Yes, we have received several questions. The first question that we have is, how would we show an exception?

This is Gary.

Can the questioner clarify how would they show an exception? Are they talking about encoding or in documentation?

It came from a practice. Charlotte Rogers from the cardiac and vascular Institute. I would imagine how are they submitted to show an exception.

This is Gary. I will try to answer that. I can answer that in broad terms. If the questioner wants to drill down, please follow up. All the exception criteria are defined in value sets, so those would need to be documented in the medical record as a reason why either the blood pressure was not taken or that the follow-up was not performed.

Thank you. The next one asks, when we are being audited to check the specific quality measure, can the auditor take any blood pressure measure reported during the reporting period, or do they have to take the last reported blood pressure?

This is Gary again. Let me speak to the measure specification and maybe not specifically to auditing. The intent of the measure is, you look at the most recent encounter where the blood pressure was taken in the measurement period.

Thanks, Gary. The next question is, if the patient has four encounters and only three of the four yield a measurement, the patient would fail one of the four encounters?

No, that is incorrect. We would only look at the most recent encounter where the blood pressure was taken. That is the index encounter and that is what the measure logic flows from. You can have subsequent encounters where no blood pressure was taken. You can have previous encounters where the numerator criteria are not met. As long as the most recent encounter with the blood pressure taken passes the numerator criteria, they would pass.

Thanks. The next question says if a provider stops taking blood pressure meetings midway through the year, we just take that last blood pressure. That would seem to encourage not taking blood pressure's after you get one controlled reading. >> Again, I cannot speak to some unintended consequences. Yes, the way the measure logic currently works is that we only look at the most recent one taken. There can be subsequent encounters where blood pressure readings are not.

The next question was a follow-up. Is the blood pressure the most recent blood pressure or the blood pressure on the most recent encounter?

The most recent blood pressure during an eligible encounter. That would happen during the measurement period.

The next one is, could you please provide clarification on how a nurse visit encounter would qualify?

We need to follow up on that. That is if the encounter coding meets the denominator criteria, which has been defined in the value sets provided with the measure. It is an eligible encounter and would be counted, I think, regardless of who takes the blood pressure. Questions of attribution and who that performance measure is assigned to is something I cannot address at this time. Please follow up and I am sure we will be talking later about how to submit follow-up questions that you may still have after the presentation.

Similar to that one, it was asking can the follow-up be counted as a nurse visit? So it seems like they want to know if they come back for a nurse visit to have the blood pressure checked, can that count as a follow-up?

Let me think about that. With that information only, and again, I would encourage the person asking this question to maybe submit this with some more detail to us -- a follow-up at a later time with a nurse, I don't think that is one of the codified follow-up measures. You can have a referral to an alternate provider. There are certain requirements to address, to order a follow-up at the time the blood pressure is taken. A nurse follow-up at a later date is not currently a valid intervention or follow-up plan for this measure.

The next one is, if hypertension is a visit diagnosis in an office or emergency department visit and is the only record of that diagnosis, should the patient still be in the denominator?

I think that would depend on how it is documented in the patient record in the outpatient setting. If there is a record of that patient having a diagnosis of hypertension and it is documented in their record, they would be excluded.

Great. We are running tight on time. We promise all of these questions will get answered. We will get these out to you. If there is still time at the end, we can come back. Right now, I need to turn it back over to Susan for our next presenter.

Thank you, Anita. I would like to introduce Beth. She is going to present CMS147 , preventive care and screening for Influenza Immunization. Take it away, Beth.

QUALITY ID 110/CMS147: PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION

Speaker: Susan Arday

Thanks, Susan. This is Beth from -- today we will be walking through the details and descriptions for quality I.D. 110, CMS147, preventive care and screening, Influenza Immunization. Similar to last presentation, we will walk through some frequently -- frequently asked questions and values that change the measure.

As you can see on the screen, the measure description is a percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization or who reported previous receipt of an influenza immunization. The initial population is out patients aged six months and older seen for a visit during the measurement period. The denominator equals initial population and patients also seen for a visit between October 1 and March 31. There are no denominator exclusions. For the numerator, the numerator statement is patients who received an influenza immunization or who reported previous receipt of an influenza immunization. For the denominator exceptions, they are as followed. Documentations of medical reasons for not receiving the immunization, such as a patient allergy or other medical reasons, documentation of patient reasons for not receiving an immunization such as a patient declined , and finally a documentation of system reasons for not receiving the influenza immunization, such as the vaccine was not available or other system reasons.

Moving into the frequently asked questions for this measure, the first that we would like to start with is as follows. How many encounters are needed to meet the measure requirements? The answer is you may only need one encounter to satisfy the initial population and denominator criteria. However, you could need two separate encounters depending on the timing on those encounters. Let's walk through a few scenarios to further demonstrate this point.

Let's assume that 2018 is a measurement period. As you can see on the screen, the initial population logic is that the birth date of the patient must be greater than or equal to six months at the start of the measurement period. There must also be the following list of encounters. The initial qualifying encounter during the measurement period or dialysis during the measurement period or another dialysis during the measurement period. This means the encounter must be

placed between January 1 and December 31, 2018. For the denominator, the requirements are as follows. It is the initial population, as well as an encounter during the influenza season or chemo analysis or peritoneal dialysis. That encounter must take place between October thirteenth -- October 1, 2018 and March 31. Again, moving forward with this scenario, continuing 2018 being our measurement period, but take a look at scenario number one. In this scenario, on January 5, 2018, there is an office visit. This single visit meets both the initial population and the denominator criteria, since it falls within the measurement period and the flu season. Moving forward to scenario two, let's assume there was an office visit on October 2, 2018, and an office visit on June 1, 2018. The first visit satisfies the denominator requirement, as this falls within the flu season. The patient is not pulled into the initial population until June 1, because this satisfies the initial population requirement. For scenario three, it's assume that there is an office visit on June 1, 2018 and an office visit on October 3, 2018. Although the patient has a visit that meets the population, there is no visit during the current flu season. This situation may be counted towards the following reporting year.

This leads us into our next frequently asked question. What is the timeframe in which the influenza immunization must be administered to meet the measure? The answer is that the immunization must be administered between August 1 through March 31 of the current flu season. For the purposes of this measure, the flu season begins on October 1 of the year prior to the measurement period and ends on March 31 during the measurement period. The measurement period corresponds to a calendar year, which is January 1 through December 31, as indicated in the measurement period field in this header. For an eCQM, the information is aggregated at the end of the measurement period, December 31, in accordance with the reporting program guidelines. The measurement period serves as a timing anchor for clearing data for the specific flu season, including data from the previous year. In order to meet the measure, the influenza immunization must be administered between August 1 and March 31 of the current flu season. Within the measures specifications, the influenza season definition is defined as the start of the measurement period -90 days and from the start of measurement period +90 days. The -90 days accounts for October through December of the current flu season. The +90 days accounts for January through March of the current influenza season. The numerator of the measure may also be met if the influenza vaccination is administered between August 1 through December 31 of the current flu season. That is within the specifications, and the logic may be found in the numerator definition titled influenza season including August and September of the prior year. This accounts for influenza vaccinations administered -153 days from the start of the measurement period to +90 days from the start of the measurement period. Or, from August through March of the current influenza season. The eCQM only assesses the flu season that ends during the measurement period. This is noted within the measures guidance field, but it is important to note that the guidance field is as follows. To enable reporting of this year's measure at the close of the reporting period, this measure will only affect the influenza season that ends in March of the reporting period. The subsequent influenza season and the March of the following year will be measured and reported in the following year. As an example, if the measurement period is January 1, 2018 through March 31, 2018, the influenza season included in the measure will be from August 1, 2017 through March 31, 2018.

Moving forward to our next question, if a patient says they have already received a flu shot, how is this documented? If a patient has already received a flu shot during the current influenza

season, the patient must still meet the numerator using the quality data model datatype, communication from patients to provider, and captured using the previous receipt of influenza vaccine value sets. The previous receipt of influenza vaccine value sets contain several concepts. Positionally, if the provider reporting on the measure is the one who administered the flu shot before the official start of the flu season on October 1, that information may be pulled into the numerator to meet the measure as immunizations administered in August and September of the prior influenza season and will also qualify to meet the numerator.

Another question that we also receive is, why are there these datatypes to measure the influenza vaccine, both procedure performed with influence and vaccination, and administered the recruit -- included in the measure. The answer is that the PCP I adheres to the terminology standards put forth in the CNS measures management system blueprint. It specifies the measure using the immunization administered, the datatype, and the influenza vaccine value set, which includes various codes. We have heard feedback from providers and implementers that it is commonly used to document the administration of a flu shot. To allow for greater flexibility, we have included the procedure performed in the datatype and the influenza vaccination value set, which includes PCP codes.

Finally, another question that we receive is if the measurement period is 2018 and the patient has an allergy to eggs that starts on July 1, 2018 and ends on February 1, 2019, does this qualify as a valid exception? The answer is that this does not qualify for a valid exception. In order for a patient to qualify as an exception, the allergy must be active for the entire current flu season. The allergy noted in the question starts on July 1, 2018 and ends on February 1, 2019. This is after the end of the flu season, which is October 1, 2017 through March 31, 2018 being reported on for the 2018 measurement period. Because of this, the allergy would not be an applicable exception for that reporting year. This is reflected within the specifications and the diagnosis of allergy to eggs definition. The allergy diagnosis must overlap after the influenza season, meaning that any allergy that ends before the flu season ends were not qualified as a valid exception.

Lastly, I would like to walk you through some coding updates for 2019. Below are a couple of value sets that we have updated as a part of annual maintenance, including our patient reason value set. We also updated the influenza vaccine value set based on updates as a part of the annual maintenance. We also updated the influenza vaccination value set as a part of annual maintenance.

Moving along, as a part of the annual update process, the interaction value set was -- which was stewarded -- was removed from the program. Because of this, value sets or encounters were replaced with a face-to-face value set being created. They are as follows. We have a case-by-case interaction and we added the following value sets. We had care services in a long-term residential facility, a home healthcare services extension value set, a nursing facility visit value set, an office visit value set, and an outpatient visit value set. As I mentioned, because face-to-face interaction value set was removed from the program, accounting for the codes and the value set, PCPI kept the encounter influence a grouping value set and added the following extensional value sets as displayed on the screen to account for the encounters which would meet the measures.

Q & A

Thank you, Beth. At this time, I would like to turn it over to Anita to see if there any questions that have come in through the chat.

We once again have a lot of interest in this measure. The first question is, do you get dinged if the patient refuses this vaccine?

The way that we were accounting for a patient refusing the vaccine, this would be accounted for in an exception. That is -- I will go back to slide 22 for the measure exception. The documentation of patient reason. This would be accounted for with the patient reason value set and documenting a valid exception if the patient does decline.

Thank you. The next question is, if a provider does not immunize, is the shot record the best way to satisfy this measure?

In order to -- and maybe we can follow up off-line about this as it is a more detailed question -- within the measure specification, a patient could report previous receipt if they already had an influenza immunization administered within the influenza season. Otherwise, ideally, that provider would administer the influenza immunization during that visit. If the provider would never immunize, this is not a measure that would be appropriate for them to report on.

Thank you. The next question is, are we expected to be giving influenza vaccines for emergency department visits? I am not sure if you showed the codes or not there, whether the codes include emergency department.

Let me go to that slide. I don't believe we include emergency department visits. That should not qualify as an encounter that would meet this measure. So no, that would not. Emergency department visits would not count in this measure.

Okay, thank you. Has any thought been given to changing the October 1 date, since the recommendations to start getting the vaccine has changed to August and September?

That is a good question. As a part of our annual maintenance process, we convene a technical expert panel that reviews the updated guidance and recommendations. I will say that, although, within the specifications, the influenza season is October through March, you do still meet the measure and that is accounted for August through September of the influenza season -- they are accounted for and would meet the numerator for this measure.

Great. The next one, is there an interpreter to easily convert CQL to SQL? Otherwise, everyone will need to rewrite all this logic to rerun in a database and variance will ensue.

That is a good question that I may have to circle back with CMS on. Susan, I am not sure if you have any other thoughts on that.

This is Susan. Thanks, Beth. I was thinking about the same thing. CQL to SQL. On the top of my head, I am not aware of any. I do not believe our tool does that. That is a great question. A good place to send that in so we can make sure we answer your question fully and appropriately, if the questioner would send that into QPP at CMS.HMS.gov.

Again, we will be taking all these questions and going through them one by one to make sure that they get answered and consulted with as a.

The next question is can you satisfy both the numerator and denominator during a single visit?

That is a great question. I'll go back to one of my frequently asked questions. I will go to slide 25. -- Actually, I will go to slide 24. You could beat both the initial population and denominator. It depends on the timing of the visit. If the timing of the encounter, like we mentioned -- actually, I will go forward one slide -- in the first scenario, 2018 was the measurement period. Say you had an office visit on January 5, that means the initial population and the denominator are within the measurement period and the current flu season. It all depends on the timing of the visit. In some instances, the initial population and the denominator could be satisfied by one visit.

Okay. What is meant by the denominator exception requirements stating, for example, patient has allergy to eggs whose prevalence must start after influenza season? What does this mean?

I think they are referring to the specifications themselves. Would you mind repeating that one more time, Anita? I just pulled up the specification documentation.

Sure. What is meant by the denominator exception requirements stating patient has allergy to eggs whose prevalence must start after influenza season? What does this mean?

That all refers to the timing of the diagnosis of allergy to eggs. Within the specifications themselves, the diagnosis of allergy to eggs must overlap after, but it would not start after. Is overlapped after. It must be active through the end of the influenza season. I am not sure that helps clarify things a bit. Otherwise, you may have to call up after. >> Once again, we need to get onto our final presentation. I am going to turn it back over to Susan. I just want to emphasize that we will get all of your questions answered.

Thank you, Anita. I would advance forward very quickly. There with me. I am moving to slide 47 here. 34, I am sorry. We will next hear from Jamie of PCPI. She is going to go over quality I.D. to 26, otherwise known as CMS138, Preventive Care and Screening, Tobacco Use Screening and Cessation Intervention. Jamie, you have the floor.

QUALITY ID 226/CMS138: PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION

Speaker: Jamie Lehner

Thank you, Susan. This is a very commonly known measure. We are going to go through several questions that we have gotten frequently, especially with respect to the change from a single reporting rate to multiple. Hopefully, if you have any questions, we will get through those in the next slides.

Just to review, the measure description for CMS138, quality I.D. to 26, it is the percentage of patients aged 18 years and older who are screened for tobacco use one or more times within 24 months and who received intervention if identified as a tobacco user. We do have three different reporting rates are population criteria. The first is a percentage of patients aged 18 years or older who were screened for tobacco use one or more times within 24 months. The second is patients age 18 years and older who are screened for tobacco use and identified as a tobacco user who received intervention. The third is essentially a combination of those clinical actions where we look for those patients aged 18 and older who were screened for tobacco use one or more times and who received tobacco cessation intervention if identified as a tobacco user. Will take these next few slides to go through the individual populations and give them a closer look.

Population one, the initial population and denominator. We're looking for all patients aged 18 years and older in for at least two visits or at least one preventive visit during the measurement period. There two different buckets and types of encounters that you can have in order to satisfy this particular requirement. So pay attention to measure specifications, as it is important to note which types of encounters fall in one or two requirements. The numerator for population one is patients who are screened for tobacco use at least once within 24 months. That includes those measurement periods and the year prior to the measurement period. Finally, this population has a denominator exception for documentation of medical reason for not treating for tobacco use. That may include limited life expectancy diagnosis or other medical reasons to satisfy that valid exception.

Population two, we see things that are similar. What is important to note is that we have a smaller denominator for this population. We are looking for all patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period. We further constrain that denominator to patients were screened for tobacco use and identified as a tobacco user. This is actually taking a subset of the patients who met the numerator of population one and pulling that into the denominator for population two, which is how we further narrow that down. The numerator for population to back -- two is those who received cessation intervention. We have a denominator exception, a documented reason. That includes that limited life expectancy or another medical reason.

And population three, we get back to the initial or the same initial population and denominator as population one. All patients aged 18 years and older seen for these two visits or at least one preventive visit during the measurement period. Our numerator looks at both of the clinical actions. We determine if the patient was screened for tobacco use at least once within 24 months and who received tobacco cessation intervention if identified as a tobacco user. The denominator exception combines those from populations one and two. If the documentation of medical reasons for not treating for tobacco use or documentation of a medical reason for not providing tobacco cessation intervention, if the patient was identified as the user.

One of the most frequently asked questions is, why was this measure split into three populations? It seems very cumbersome and very challenging to understand that. The reason why is because, in order to see where improvement was needed or where a gapping care existed, the measure was split into these different populations. Based on the screening and the cessation intervention components, that occurred. Prior to that, we looked at the performance for a measure, for this measure, you could not necessarily see whether the provider was not performing the screenings clinical actions, or if that provider was screening okay but with that were not providing intervention that should be provided to a patient who is a tobacco user. Beginning last year with the implementation period, 2018, we can use the third, which is translating the measure into the way that it has previously been included in the program, to compare performance scores across program years. You can see a clinician is able to determine whether or not they have changed drastically in the overall rate. Again, looking more importantly at those various clinical actions independently to determine where they gapping care has been.

Another question is, what is the difference between the populations and can we just add the scores of populations one into in order to get -- one and two in order to get population three? No, we cannot do that together. Population two has a denominator, as I mentioned before, that is actually a subset of the denominator used in populations one and three. We're going to take a little bit of a closer look with an example, assuming that the performance period is 2018. We're going to assume that the sample size for this, or the reported sites for this patient population is 100.

And population one, looking at the far left, we are finding that we are looking for patients aged 18 years and older with one preventive visit. We have 100 patients meeting that criterion. The numerator for this population assesses whether or not the patients were screened for tobacco use. We have 80 patients who met that. There are 10 patients who meet the medical reasons for not screening. We go to the bottom, we look at the performance score, where we have 80 has the numerator divided by 100, which is the initial population, or the denominator, minus the valid exceptions overtime. We have $80/90$, which equals 88.9%.

Using very similar numbers and carrying this over to population two, we find that 100 patients to start with in the initial population. We recall that the denominator for population two is only a subset. Of those 80 patients who were screened for tobacco use, 50 of them are identified as tobacco users. It is that 50 number that is going to be used as the base denominator for eligible populations for population two. The numerator looks to see if those users have received tobacco cessation intervention. We have 20 meeting the criteria. We find that we have 10 patients with a medical reason for not providing cessation intervention. Our performance score is 20 divided by $50-10$, so $20/40$ equals 50%. If we were to add these two together, it would equate to something far above 100%. We know that we cannot do that. Taking a look at population three on the far right, we find 100 patients meet the age and encounter criteria. People screened for tobacco use were identified as nonusers are 30. Patients screened for tobacco use identified as users is 50. That is where that combines to create our 80 that we used in population one, you might recall for the numerator. The tobacco users who received cessation intervention is at 20. Combining those two valid medical exceptions, we have 20 patients who are going to be

removed from the eligible population. So we have our performance score of 30+20. So it is the nonusers plus the users who received tobacco cessation intervention, divided by our initial population, 100, minus the denominator exception of 20. We have 50/80 and 52.5%. -- 62.5%.

Another common question that we received with this measure is, do I need to screen the patient for every visit to meet this measure? No, you do not have to screen the patient on every single visit. The measure requires that patients have an encounter during the measurement period to satisfy one of the initial population or denominator requirements. That can be either the one or two types of encounter buckets. However, the screening must happen at least once within a 24 month period. This can be during the measurement period, or the year prior. The numerator of the measure looks at the most recent screening during that timeframe. So if the patient was screened multiple times, the measure is only going to look at the last one, the one that is close to the end of the measurement period.

Continuing for a little bit more of an example year, let's assume that the measurement period is 2018. In terms of looking for that 24 month period, we are looking at 2018 and 2017 for the clinical actions. In this patient example, we have four different visits, or four different screenings. Assuming that patient meets the initial population, age, and encounter criteria, we can see that the patient was screened on March 1, 2017, and they were identified as a nonuser of tobacco. Later in the year, December 20, the patient was screened again and was identified as a tobacco user. They received tobacco cessation intervention on December 20, 2017. During the measurement period, they were screened again on May 1 and identified as a tobacco nonuser. Right before the end of the year, on December 2, the patient was again screened and is identified as a tobacco user. However, it is important to note that there was no tobacco cessation given. There was no valid medical reason documented. If we are to take a look at whether or not this patient is -- these specific pieces meet or fail the measure for the population, we take a look at population one in which they passed. The patient was screened for tobacco use at least once within a 24 month period. Having on to population two, we will actually report this measure for this patient, because it is the most recent tobacco screening and they were identified as a tobacco user. We will satisfy that denominator criteria. However, they did not receive the cessation intervention and they did not have a valid denominator exception. This patient was -- would fail population two. In population three, we have initial population criteria met. Moving into the numerator, although the patient at the screening component, he did not meet the cessation intervention component. Therefore, this patient would fail in population three.

Finally, for our frequently asked questions, which population is being used for reporting purposes? According to documentation from CMS for 2018, it is the second population's performance score that is being used. However, we do recommend reviewing documentation each implementation year in order to make sure that you are getting the most up-to-date information and implementation for this particular measure.

This is just following up with what was presented for the other two measures. We have some coding changes for 2019 implementation. As mentioned before, face-to-face intervention value sets was removed. Those individual extensions have been added to the home healthcare services and office visit value sets for this measure. Finally, our value set for life expectancy that is

limited did have one new code added. That is based on some external requests that came through, requesting that we consider adding this particular process. It was determined that in that the intent of the value set. We have included it for this current year's implementation. That concludes the frequently asked questions and the significant changes to coding for 2019. I turn it back over to Susan.

Q & A

Thank you. Do we have any questions at this time? I would like to quickly turn it over to Anita.

We have several questions, but we are very limited on time, Susan. The first question was, isn't this measure topped out?

I can take that. No, not according to our most recent benchmarks. You may be thinking, when you think this measure is topped out, what the rate would look like for population three. Typically, that could be topped out. We benchmark all of population two. Clearly, in our most recent and historical analyses, they are not topped out on any of eCQM or CQM or registry type of specification for this measure.

I think really have time for one more. With the recent boom of patients converting to vaping, will these measures pertain to them? Specifically, if they achieve cessation through conversion, via conversion to vaping, will that count?

This is a great question. The measure provides guidance surrounding this. There is not a lot of evidence to support electronic nicotine devices as either tobacco use or as a method for using tobacco use and converting off of that, it has not been included. At least not within the measure specification. We continue to look at more recent guidance and publications available in order to see if there is -- if we can sway things one way or another and put them into one of the appropriate buckets. Because nothing finite exists, we have not done that. There is some issue with CMS138, I think guidance within the claims registry and that interface specification.

CONCLUSION

Thank you.

>> [Event Concluded]

We hope you will share the feedback on the survey. You can access this at any time by clicking on the widget. You have a lot of material to discuss today.

[Event Concluded]