Hello, everyone. Thank you for joining today's 2018 QCDR Measure Workgroup webinar. CMS will provide an overview of the development, criteria, and evaluation of QCDR measures. After the webinar, CMS will take questions as time allows. Now I will turn the call over to Robin Williams, a CMS contractor specializing in QCDR measure development. Please go ahead.

Thank you. And thanks to all of you for joining this QCDR Measure Development for the Merit-based Incentive Program (MIPS) Program webinar. I'm Robin Williams from Practice Improvement and Measures Management Support, or PIMMS, team. And I'll be one of today's presenters.

Next slide, please. The disclaimer for today's webinar. Medicare policies change frequently. The information provided during this presentation is intended to be a general summary. It doesn't take the place of written laws or regulations. We encourage you to review specific statutes, regulations, and other interpretive materials. Next slide, please. Here's the webinar agenda. The intent of this webinar is to provide opportunities to learn what kind of QCDR measures will likely be approved for MIPS. With me is Dr. Green from CMS' Center for Clinical Standards and Quality, and Jocelyn Meyer, also from MIPS. We'll be your presenters today. Dr. Green will get us started, then Jocelyn and I will tag team through the presentation concluding with a question and answer. Dr. Green, would you get us started, please?

Thanks, Robin. Okay, I think we can go on to slide four and then slide five. Just want to welcome everybody today. Thank you all for dialing in for this call. We thought that in an effort to improve stakeholder experience their self-nomination and particularly try to prevent some of the frustration that understandably occurred on the part of the QCDRs as they were submitting their measures for consideration, we thought we would have this program, which I believe we will repeat again in April, to help the QCDRs better understand things we're looking for in measures and certain challenges that we face when we actually evaluate the measure sets and consider them for inclusion as a QCDR measure in this program. So we'll go over some of that today, and fortunately there will be some time at the end for some questions. And, again, I just want to welcome everybody and thank them for their interest and for their time.

So on slide five, this basically goes over our strategic vision and measure development priorities. We are looking to try to certainly support measure alignment across different payers, which would, of course, include other federal programs, state programs, and, of course, with private payers. We have participated in the AHIP standardization process that did come up with certain measure sets covering particular specialties. We will look for venues in the future that we can continue that effort. We are interested in reducing burden and promoting efficient collection of data, as well as, of course, improving patient care and population health. We do try to balance the individual and the shared provider accountability. We realize that clinicians are obviously very busy taking care of their patients, which, of course, is their primary purpose and function. But at the same time, we are in the process of trying to transition Medicare from solely pay for perform - I'm sorry, pay for service. We do think that measures should address critical clinical gaps in care and support evidence medicine, particularly when it exists. And should also engage patients as well as clinicians in care delivery. So, you know, measures where there is not a demonstrated gap in care, not really good or suitable for our program. Similarly measures

that are - I'm air quoting here since you can't see me - that are topped out, were relatively never events are not the best measures for the program. While we would all agree it's important to track certain - certain things like perioperative death and stuff like that, thank goodness it occurs so infrequently it doesn't lend itself well to distinguishing one clinician's care, necessarily, from another clinician's care. And as such, it's not a, as an example, a great measure for our program. We do look at measures that promote healthy living. That assist patients in understanding their overall health. Certainly coordination of care is important. We are very interested in reducing disparities in healthcare. We also look for measures that are understood by patients. So when we publicly report these measures, we hope that our - our beneficiaries can use that information to assist them as they select a clinician or facility for their healthcare services.

Next slide, please. So I'm sure many of you are familiar with our Meaningful Measure initiative. And Meaningful Measures assess core issues that CMS thinks are very important to providing high-quality care and to improve outcomes. We are prioritizing our outcome measures and trying to reduce the focus, if you will, on process measures. Now we recognize that we can't completely eliminate process measures, but you can imagine the outcome - you could do everything right, and if you have a bad outcome, yeah, not as terrific, of course, as having a good outcome. So we are trying to prioritize outcome measures. And we think the clinicians will agree that in the end that is the most important - the most important consideration, particularly for the patient. So Meaningful Measures would include high-impact measures that help to protect public health. Again, measures that are meaningful to patients. We talked about outcomes - measures that are relevant to providers. So we do want the measures to be meaningful for the providers in as much as they are - would be more willing to, if you will, participate and measure these things if they think it is something that's useful for their - their practice. We are, of course, trying to remove burden for providers. So toward that end we're trying to remove measures that are already, again, opt out. So if somebody is doing something 97% of the time, it's not really great for them to necessarily measure, hey, I'm doing this 97% of the time. We could argue, well, yeah, that would be great if you could do it 100% of the time assuming higher performance is better. But realistically, when we get to a certain level, measures would be considered topped out, and at that point patients - I'm sorry, physicians are just collecting information for the sake of the program. And we are trying to move away from that. We are looking at measures that have significant, again, opportunity for improvement. Population health and population-based payment through alternative payment models would be - and measures that help us achieve that - would be also important to us. And then, again, we talked about aligning across other programs with other payers.

Next slide, please. So this is our Meaningful Measure Initiative diagram. And you can see that we are - some of the things that we talked about that we are trying to improve. Reducing burden. Eliminating disparities. Track to measurable outcomes. Safeguarding the public health. Achieving cost savings. And improving access in rural communities. Sorry, something just popped up on my screen. In the end, we're trying to improve the CMS customer experience. And support innovative approaches to healthcare reform. And at the same time empowering doctors and - and patients. So, hopefully, you can see in the right-hand column - I'm not going to read through the - the different bullet points, but we do think that Meaningful Measures should promote effective communication, promote prevention and treatment of chronic

disease, work with community for best practices and healthy living, make care more affordable, make care safer by reducing harm. So acrogenic harm, obviously. And then strengthen person and family engagement as partners in their care.

Next slide, please. Okay, so the importance of QCDR measures. They are clinically-relevant measures that address gaps in care for specialties, preventive care, and/or disease management. So you guys have the benefit of not having to go currently through our rule-making process. And for better or for worse, that also enables you to be more nimble in your - with your measures in general. And by that I mean since it's not publish - publishing specifications that have to go through rule making, if there are tweaks that need to be made to improve the measure, fortunately those things can occur. We've had suggestions that we have the same criteria for measures that go in the program for - when we evaluate the QCDR measures. We have tried to resist that a little bit because the bar would be considerably higher as far as testing, for one thing, which would be - which would be difficult for some of the measures that we've evaluated. And in addition to that, most of the measures in our MIPS program are actually NQF endorsed. And we don't require that for our QCDR measures. We do look, however, that the measures that the QCDR has put forward are not contained in our annual list of MIPS measures. Or - when I say not contained, I don't mean just literally the same measure, but pretty much the exact concept. No sense having two very clinically similar measures in the same program because, obviously, each would have their own benchmark, and now we're parsing clinicians into much smaller groups and they are compared only against themselves - or each other, I should say - for that particular measure. Better we have one large group that we are able to compare multiple clinicians to one another. We do allow, however, measures that are in the MIPS program that have substantive or large differences in the denominator or the manner in which the measure is collected. So we do consider those. I think, Robin, I think that's it for my few talking points and introduction. I'll turn it back to you and Jocelyn for more specifics.

Thanks, Dr. Green. Do you want to go ahead and advance onto slide ten? Here are some goals or objectives for the webinar. Things we hope you'll understand at the end of the call. We want you to know that CMS and the PIMMS team are here to support you in developing QCDR quality measures and getting them through the QCDR self-nomination process.

The next slide, please. Slide 11. The next few slides are general requirements for a CMS-approved QCDR. The first bullet is about participants. By January 1st of 2019, had at least 25 clinicians submitting data to the QCDR for the purposes of quality improvement. Note: this doesn't mean that all the participants have to use QCDR to submit MIPS data to CMS for attestation. During data submission, attest that the results being submitted are true, accurate, and complete. Data submission. Use a CMS-approved method to submit your data. And data validation. Provide a written plan describing how data will be validated, and submit the results of data validation by May 31st of the year after the performance period.

Next slide, please. The QCDR requirement for quality measure are that you must support at least six MIPS quality measures or a specialty measure set. The six MIPS quality measures must include at least one outcome measure, or at least one high-priority measure. The high-priority measures are defined in the Final Rule and include outcome measures as well as appropriate use,

patient safety, efficiency, patient experience, and care coordination measures.

Next slide, please. In addition to the six MIPS quality measures or specialty measures set, QCDRs may support more of the MIPS quality measures and or up to 30 QCDR measures. So at least six MIPS quality measures or a specialty measures set, and no more than 30 QCDR measures. This slide references three categories from which QCDR measures can originate. QCDR measures may be NQF endorsed measures. They can be current MIPS quality measures with substantive differences, as Dr. Green just indicated. And there will be more - more on substantive differences later in this presentation. Or QCDR measures may be measures developed by boards, specialty societies, quality collaboratives, and/or large healthcare organizations. Regardless of the category of origin, all QCDR measures must be submitted during the self-nomination period, and all QCDR measures will be reviewed by CMS for potential inclusion in MIPS. Later in this presentation, I'll provide scenarios pointing out items considered when the QCDR measures are reviewed. The 2019 self-nomination period is September 1st through November 1st of 2018. We encourage you to submit your self-nomination, including QCDR measures, early to allow time for iteration should additional information be requested during the measure review phase.

Next slide, please. I'll now hand the presentation over to Jocelyn, who will describe measure structure and analytics.

Great. Thank you, Robin. Good afternoon. In this next portion of the webinar, we are going to take a deeper dive into the measure structure and analytics. Our goal is to help everyone understand some of the requests we have made in previous review cycles as well as provide information and guidance as you get ready for the next self-nomination. This knowledge may improve the process efficiency, reduce the back-and-forth communication during that self-nomination, and increase the likelihood of getting your measure approved. To get things started, we first want to establish the basics of a good measure. And we'll be taking a closer look in the next slides. First, measures must be evidence based and have an intuitive appeal or high face validity. It should make immediate sense to the eligible clinician utilizing the measure. The next two items are related to performance data. Measures must have an opportunity for improvement and show variation across eligible clinicians. And we'll discuss this in detail at the next slide. Next is responsiveness to improvement activities. This is an aspect of quality measurement that is not often talked about, but it is important. If we are holding these eligible clinicians accountable for quality measures, there should be some evidence-based improvement activities that would improve performance if implemented. As you are all aware, the Quality Payment Program now requires eligible clinicians to attest to improvement activities. We encourage corresponding evidence-based tools, strategies, care processes and systems that we can offer eligible clinicians to improve care. It's not enough just to measure. We also should be driving care - quality care as well. As measures are developed, we should be also thinking about related improvement activities to support the quality measures, which they could be developed in parallel. Moving on to the limiting of the burden of reporting. The measure should not be burdensome, meaning it should not be so complex or paperwork heavy that it deters eligible clinicians from submitting the measure. And lastly, as Dr. Green mentioned earlier as he kicked off the meeting, measures should fulfill a meaningful measurement and perform - or measurement gap.

Next slide. As we touched on in the previous slide, measures should be based on clinical guidelines or on the current scientific literature but should not be based on controversial or new treatment methodologies. We ask that clinical guidelines are submitted and come from reputable sources which reflect the most recent guidelines. A measure submitted in the self-nomination process should also assess a quality action with a known variation or performance gap. We request that any performance gap information and variation be quantified and able to demonstrate there was room for improvement. If citing data from literature, it should reflect in the most recent data or within the past three years. We have actually included - or encountered submissions with literature and data dating back to the eighties. So for QCDR measures, CMS has been considering measures topped out by the average performance rate of 90% or above. Or ten percent if the measure is inverse. Measures with high performance rates do not allow you room for quality improvement, and these measures will likely not be approved. A measure should also support variation across providers. A measure - if a measure has a very narrow performance rate, it may be considered topped out due to the lack of variation. For example, let's say we have a hundred eligible clinicians submitting a measure that had a performance rate between 71 and 72%. It would be difficult to create a meaningful benchmark. It would be hard to justify rewarding a clinician submitting a 71.6% performance rate compared to a 71.1 when they are only really separated by that half a percentage point. This is a prime example of the importance of harmonization of similar measures between QCDRs. So that a larger cohort can be compared to one another. This allows ample opportunity for meaningful benchmark creation. Moving on to the meaningful quality action, the numerator, or quality action, should be considered meaningful and appropriate to the patient population. Measures that are non-meaningful are, or we call them checkbox, would not be approved. CMS requests that measures be focused on outcomes, which we'll discuss later in the presentation as well. Next, measures should not be duplicative of MIPS or QCDR measures. We are excited to announce the QCDR measure specifications have been posted to the CMS website in the Resource Library. This is a new feature for 2018. And we encourage all of you to review the specifications prior to self-nominating a new measure. If submitted, like a similar measure, we will likely ask you to use the established measure unless your measure is more robust. It may be advantageous to go review this sooner rather than later just to allow ample time for collaboration and/or harmonization with other QCDRs. And lastly, we ask that the measure is beyond the conceptual state and have complete specifications. Ideally this would include testing for validity and feasibility, although it is not required for QCDR measures at this time.

Next slide. We will now transition over to measure construction. In the last review cycle, you may have - some of the established QCDRs - you may have received feedback from the team to form a composite measure. Composite measures are considered more robust as it requires multiple quality actions to occur. this allows assessment of a broader spectrum of quality care. And a composite measure is a combination of two or more measures that result in a single score. This was a concern of many QCDRs – that footprint data of the individual components would be lost in the shuffle. As a QCDR, you are still able to gather and maintain separate performance rates in order to provide that valuable feedback to the eligible clinician. The feedback would allow identification - identification of areas to improve. For program purposes, CMS will score based on the overall (inaudible) for the performance score indicated. Next we'll go through a few of the different composite measure constructions. First, all or none. This would require that

eligible patients would receive all of the quality actions to be considered numerator compliant. On the flip side, we have any or none, which is similar to all or none, but it is used for events that should not occur. A patient is counted as failing if the patient experiences at least one adverse outcome from the list of two or more adverse outcomes. For example, a surgical measure that assesses the rate of infection, readmission, and reapparition. If all adverse events were avoided, the eligible clinician would meet the intent of the measure. Linear combinations will calculate the performance based on a simple or weighted average of all the scores within a component. And lastly, a regression composite performance measure will weight the component based on the reliability and strength to support a drive to the gold-standard end point. Next slide. The Quality Payment Program has a number of composite measures implemented. Measure 441 (IVD), All or None Outcome Measure, and Measure 394, Immunization for Adolescents. Both measures require all components to be in compliance in order for an eligible clinician to be considered numerator compliant. For each of the quality actions, appropriate denominator exceptions should be evaluated unique to the quality action. For example, the first component of 441 is to assess the most recent blood pressure measurement. However, if the blood pressure measure is derived from an urgent care setting, this would be considered a denominator exception. The same exception would not be appropriate for the other components within the - within the measure, therefore it is not a numerator option. The immunization measure ensures that all adolescents receive the appropriate vaccination. The numerators are specific to the vaccine, number of doses, and appropriate timing. This particular measure requires four performance rates. But CMS will score the eligible clinician based on the fourth bullet. All patients who are compliant for the Meningococcal, Tdap, and HPV during the specified timeframe. This would allow the eligible clinician to evaluate the performance, or lack thereof, in areas that they may be struggling. For instance, if most patients were receiving the Meningococcal and Tdap vaccinations, but the eligible clinician or group was falling short on the HPV, they may institute an initiative to ensure that the adolescents were at least educated and offered and potentially given that HPV vaccination. We agree with the QCDRs that this is very valuable data and are still able to glean this information with the composite measures.

Next slide. Moving on to multiple strata measures. The goal of multiple strata measures is to reduce the number of measures addressing a similar condition or quality action. These are measures that contain multiple denominator options but address a similar clinical intent. You may want to explore stratification of a measure if you would like to delineate between - based on age, specific condition, or perhaps location. We are really wanting to have measures that have similar concepts be combined. An extreme example, having two pain improvement measures. One for their pinky toe and one for their big toe. Or perhaps a blood pressure measure separated into multiple measures based on the diagnosis. We require those measures to be combined in order to be considered.

Next slide. An example within MIPS is 438, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. Each strata considers a different risk factor, whether it be age, lab value, diabetes, each deeming they are appropriate for statin therapy. This is an example of adjusting the denominator for the appropriate population. Another example would be altering both the numerator and the denominator but they are measuring a similar concept. For example, a measure developed to ensure diagnostic testing is read and communicated in the appropriate amount of time. Each

denominator can be constructed and grouped based on the diagnostic test urgency, but the numerators can be adjusted to align with the denominator. The numerator for criteria one may be four hours, where criteria two only allows 30 minutes for communication to occur based on that urgency. If a - keeping in mind, if a clinician submits on a multiple strata measure, it would anticipated that they submit all strata that they have denominator eligibility. You can't just choose one - one or two of the strata and leave out the third. Again, QCDRs are still able to provide this feedback for each stratification to eligible clinicians. However, scoring will be based on the overall performance rate.

Now - again, next slide. Slide 21, please. Yep. Okay. Now that we've been discussing the composite and multiple straters - multiple strata measures, we should discuss ways that can crunch the numbers. For multiple strata and composite measures, we request that you indicate the method in which you determined the overall performance rate. This rate will be used for scoring purposes. It may fall under a weighted, or average, simple average, or indication of a particular performance rate. We also touched on the linear combination and regression-based composites, but we'll stick to the basics here. Weighted average is determined by summing the numerator count of each sub-measure and dividing the sum of the denominator counts of each sub-measure. MIPS measure - measure seven is an example of a weighted average where you add the numerator-compliant instances for both criteria and divide by the eligible instances in both criteria with, of course, tracking the appropriate denominator exceptions. Next is the simple average is determined by adding the percentages of each of the sub-measures and divided by the - the total number of components. So say if you have two measures - or two strata - you would take both of your performance rates and divide - or add them together and then divide by two. MIPS Measure 305 is an example of a simple average. And lastly - next slide. There may be instances where weighed or simple average is not the appropriate overall performance rate but rather an indicated performance rate would best represent performance. MIPS Measure 238 assesses high-risk medication use within the elderly population. One numerator evaluates the use of one high-risk medication, and the second numerator evaluates two high-risk medications during the measurement period. The overall performance rate used for scoring would be that first, more robust, quality action. Keeping in mind this is an inverse measure, and the intent of the measure is to limit the number of high risk medications to the elderly population. Before we move on to the next section, I just mentioned inverse measures. For inverse measures, a lower calculated performance rate indicates better control. The performance not met numeration action is actually the representation of the better quality or clinical control. Submitting that option will produce a performance rate closer to zero percent of quality increases. We do ask that QCDRs designate which measures are inverse. It is imperative to capture this designation accurately. If not, it may - if not obstructed appropriately, the eligible clinician adhering more closely to the clinical intent will score lower than that eligible clinician who is not in compliance.

Next slide. Great. So now we can move over to the measure analytics. Measures may include circumstances that will need to remove the patient from evaluation of the quality actions. The timing of the removal is dependent on whether it's an exclusion versus an exception. Exclusions are more absolute, where the quality actions not applicable would not be considered for that particular population. On the other hand, denominator exceptions permit the exercise of clinical judgment and implies better treatment was at least considered for each of the eligible patients. These are typically classified

as medical, patient, or system reasons. Let's look at Measure 317 within the Quality Payment Program, Preventative Care and Screening, Screening for Blood Pressure, High Blood Pressure, and Follow Up Plan Documented. This is a hypertension screening measure, therefore it would not be appropriate to include patients that are - have already been diagnosed with hypertension. This patient population would be moved prior to the evaluation of the quality action via denominator exclusion. However, there may be instances where a patient would be eligible for the measure, but circumstances may remove them from the evaluation of the quality action. For instance, let's say a patient refuses or is in an emergent - urgent situation. This patient is appropriate for the screening, but there is a reason documented for not completing that quality action. There are also numerator exclusions that typically apply to ratio and proportional measures to define instances that should not be included within the numerator data. In a ratio measure, an example of a numerator exclusion would be infections with a specific bacterium and a measure that assesses central line bloodstream infections. So the use of a numerator exclusion within proportional measures, it's typically within an inverse measure where the lower score indicates better quality. And next slide. Okay. Proportional - or measures can be constructed as proportional, continuous, variable, or ratio. Proportional measures are the most prevalent type of measures within the Quality Payment Program. Proportional measures have a clear numerator and denominator. The numerator captures the quality action and is divided by the numerator - or the denominator of eligible population. For example, we have Measure 128. Of the patient population, the denominator, how many patients have a documented BMI with a follow-up plan if indicated, which we consider the numerator.

Next slide. Okay. Continuous variable measures do not have a traditional numerator/denominator format but are evaluated on a continuous scale. The Quality Payment has implemented a few continuous variable measures recently. For example, Measure 461, Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy. Performance is determined by the degree of improvement of leg pain following surgical intervention. The measure does not have that level of improvement required to meet performance, but rather is evaluated on average improvement. CMS recommends that measures within this construct show enough variability to support a benchmark. If the majority of eligible clinicians all show an average change of one point, this would not support variability to make that meaningful benchmark. In this instance, it may be more appropriate to determine a threshold of pain improvement to meet performance, so the numerator may be revised to state number of patients that reported a two point, three point improvement in pain following surgery. So re-establish a threshold instead. And then that would, in turn, make it a proportional measure.

Next slide. And the last example we wanted to review was ratio measures. This score may have a value of zero or greater that is derived by dividing a count of one type of data by the count of another type of data. We see a lot of confusion between ratio and proportional. They are not interchangeable. One element of a ratio measure is that the numerator is not in the denominator. For example, the number of patients with central lines who develop infection divided by the number of days within - of central line days. When determining performance, performance rates closer to one represent the expected outcome. An example would be your actual divided by your expected outcome.

And next slide. We also would like to bring attention to electronically-specified registry measures. While this may ease the burden of extracting

data, it is imperative that vendors collaborate with the measure steward prior to this eCQM creation. This is to ensure that work has not already started and the appropriate coding is maintained. The specification must be a true representation of the measure's intent and produce valid data. CMS would like all parties to be respectful of copyright and intellectual property when attempting to adapt measures to meet their abstraction needs. We are definitely not trying to reduce EHR data mining as this is a valuable resource, but cautioning the creation of eCQMs that may not truly represent the measure's intent. We did - we have received a few emails from concerned stewards that performance data is not aligning when abstracted manually versus the e-specification on eCQM. This may have unintended consequences to eligible clinicians where the e-spec may have considerably lower performance rates because maybe that eCQM didn't completely capture that numerator data. So just wanted to put that caution or that red flag out there. In this next section we'll be removing - or moving away from analytics and briefly touching on (inaudible) process and outcomes and other measure types.

So next slide. We can go to slide 30. All right. A process measure. A process measure is promoting a certain process of quality action that may lead to an outcome. Within a process measure, an outcome is not absolute but supported by evidence that clinical process may lead to the outcome. So let's take a peek at 226. Preventative Care and Screening Tobacco Use, Screening, and Cessation Intervention. This is a process measure that promotes specific screening and cessation intervention counseling for tobacco users. If the process is followed, this may lead to decreased tobacco use. If you wanted to take this measure and transform it into an outcome measure, the difference would be if you required the patients to actually report that they stopped tobacco use in order to be numerator compliant. This would then meet the definition of an outcome measure where the outcome is absolute and tobacco use has ceased.

Next slide. All right. An outcome measure is - is a measure that assesses the results or an outcome of healthcare. This would include clinical events, recovery, health status, patient experiences, efficiency, or costs. CMS, as Dr. Green had mentioned when he kicked off, that we were really looking for more outcome-based measures over the process. We're encouraging vendors to explore any opportunity to create more outcome-based measures. An example within our program - or within the Quality Payment Program is Measure 191. This measure gauges the success of cataract surgery and requires a specific level of visual acuity in order to meet performance.

Next slide. Is the efficiency and cost reduction - or resource use. Efficiency is broadly defined as the cost associated with a specific level of performance with respect to the quality of safety, timeliness, effectiveness, equity, and patient centeredness. The measure should be linked to a quality outcome as well as practices that are required to achieve this outcome within the Quality Payment Program. Measure 102, the Prostate Cancer Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients. This measure addresses both the cost and resource use for low-risk prostate cancer patients, but also improves the quality of care for this patient population in regards to patient safety, effective testing.

And next slide. And lastly, we will touch on patient-reported outcome measures. There are a number of measures that utilize patient-reported assessment tools. These may include your pain, your functional to gauge the success of treatment or therapy. But please keep in mind that these measures

- just handing out that survey or assessment will not be approved. The patient-reported outcome measures are required to incorporate some sort of positive outcome in order to be considered. So this may include improved pain, increase function, or just that the patient was satisfied with their care.

And next slide. All right. And now I will turn it over to Robin, and she'll review some of those specific QCR requests and later we'll enter into some Q&A. So thank you guys.

Thanks, Jocelyn. That's great information. This is a good time to let everyone know that this webinar will be repeated in June. an announcement with the date and details will go out a few weeks before the presentation, and you're more than welcome to attend again. There's been a lot of information provided. Now I'll share with you some of the items considered when reviewing QCDR measures.

Next slide, please. Slide 35. It won't come to - as a surprise to you that one of the first things considered during measure review is, is the QCDR measure evidence based? Are guidelines summarized and cited in the self-nomination measure submission, and does the measure submission include summarized and cited evidence of a performance gap. If these items are missing, you will likely be asked to submit them in order for the measure review to be completed. Another thing considered: does the measure address one or more of the six national quality strategy priorities? They are listed on this slide and align to the Meaningful Measure Initiative that Dr. Green spoke about.

Next slide, please. Slide 36. More things considered, but not in any particular order. In addition to being evidence based and showing room for improvement, does the measure submission include evidence of variation in performance across clinicians? If not, you may be asked to provide it. If there is a high performance rates and minimal variance across clinicians, the measures will likely not be approved. Measures with high performance rates do not provide meaningful measurement or benefit to patients or clinicians. You've heard that a couple of times now from all of us speaking. Also considered is, if implemented, could there be potential harm to the patient due to negative, unintended consequences? If so, the measure will not be approved. Likewise, if the measure's focus is for a topic that never occur, those never events, the measure will not be approved.

Next slide, please. Those were more general things considered QCDR measure review. In the next few slides, I'll go over some specific scenarios. Each bullet represents a scenario or an action and the likely reaction. In the first scenario, if the QCDR measure submitted is similar or identical to an existing MIPS quality measure, CMS will ask you to report the MIPS quality measure. If the QCDR measure submitted is similar or identical to a retired PQRS, MIPS, or QCDR measure that was identified as topped out or is a standard care, the measure will likely not be approved. In this next scenario, the QCDR measure submission includes an NQF measure ID. Only include the NQF ID if it is the exact measure. If the submission includes an NQF ID, and the QCDR measure is not the exact specification, we will likely seek additional information in order to complete the measure review. And the last scenario on this slide. If the QCDR measure submitted is similar to measures submitted by another QCDR, the intent of the measure is the same, CMS may ask you to collaborate with other QCDR measures to harmonize the measure into a single measure that could be used across all QCDRs. This was

brought up by Jocelyn also. Measure harmonization between QCDRs provides eligible clinicians a bigger cohort for performance and bench scoring - benchmarking. Measures should be harmonized unless there is a compelling reason for not doing so that would justify separate reasons.

Next slide, please. That will be slide 38. More scenarios. If the QCDR measure submitted is identical to measures submitted by other QCDRs, CMS may ask you to get permission to use the other QCDR's measure. If the QCDR measure submitted is similar to or related to measures submitted by the same QCDR, meaning you submitted QCDR measures that are similar to each other, CMS may ask you to combine QCDR measures into a broader denominator or multistrata or composite measure. You see the examples that Jocelyn provided. If the QCDR measure submitted is similar to a measure that was previously rejected, the measure will not be approved unless it has been modified to require more a meaningful quality action. The QCDR measure submitted is an assessment measure, meaning that the clinician completes an assessment. CMS will request that the measure be modified to identify the standardized assessment tool to be used and the measure modified that the treatment plan will be modified based on the results of the assessment. Again, this is - these are some examples that Jocelyn provided. Similarly, if the QCDR measure submitted is a patient survey measure, meaning the patient completes a survey, CMS will request that the measure be modified to be more about patient satisfaction and not just that the survey was completed.

Next slide, please. Slide 39. And the last side of scenarios. If the QCDR measures submitted quantify individual steps for a single quality action or delineate individual pieces of a specific procedure, meaning a single process or outcome is divided up in several QCDR measures, the QCDR will be asked to consolidate the related measures into a single composite measure. By consolidating similar measures into a single composite measure, clinicians in groups are likely to have more meaningful data on which to improve the quality care they provide. If the QCDR measure submitted is a continuous variable rate, and because these measures are difficult to work with for comparative purposes, the QCDR will be asked if a quality threshold could be set. If so, it will be asked to transform the measure into a percentage rate. If the QCDR measure submitted does not demonstrate room for improvement, CMS will request performance data from the QCDR to understand the analytic value of the measure. Specifically, is there room for quality improvement or does the measure have a very high performance rate already? Additionally, we will likely ask for variation in performance rates among providers reporting the measure. And the last scenario. If the QCDR measure submitted was approved the previous year and now has substantive changes that may not allow comparison to the previous performance data, if approved, the resubmitted measure will be identified as a new measure and assigned a different measure ID. We'll talk a little bit more about this on the next slide.

Next slide, please. So let's spend a few minutes on the resubmitted QCDR measure with substantive change. This is specific to QCDR measures that are approved for the previous program year and resubmitted during the self-nomination for the next program year with changes that may not allow comparison to the previous performance data. Here are some examples of substantial changes. The care setting was originally identified by general ENM codes and changed to include anesthesia procedural codes. It was broadened. In the next example, the quality action was changed from the number of patients who had an assessment to two-month post-procedure to the

number of patients who showed greater than ten percent improvement in functionable ability two months post-procedure. And the last example. The analytic designation has been changed. If any of the measure designations have changed, inverse, proportion, ratio, continuous variable and/or risk adjusted, this may impact the comparison to the previous performance data. CMS may ask about the measure designation if it is submitted differently from the previous year to confirm that the QCDR measure has, indeed, changed. If approved, CMS will consider the resubmitted QCDR measure with substantive changes to be a new QCDR measure and assign it a different measure ID.

Now let's move on to slide 41, please. Some QCDR measures are provisionally approved, meaning they can be used for the program year, but CMS needs additional information or is requesting modifications be made to the measure before it is resubmitted during the next self-nomination period. When a QCDR measure is provisionally approved, along with the notification of the measure's status is a request for information or suggested revisions needed for the next self-nomination period. Here are the main reasons and requests for provisionally-approved QCDR measures. CMS wants to quantify the performance gap and room for improvement. With the notification that the measure is provisionally approved, we'll ask for a summary of QCDR performance and clinician variance data be submitted during the next self-nomination period. CMS requests measures be combined into a composite or multistrata measure. In the notification that the measure is provisionally approved, we will identify the measures to be combined for the next self-nomination period. CMS requests collaboration with other QCDRs to harmonize the measures. We'll identify the QCDRs to collaborate with in the notification that the measure is provisionally approved. CMS requests the measure be modified, for example, changes to the quality action. We'll suggest revision in the notification when we let you know that the measure is provisionally approved. If the QCDR measure that was provisionally approved is resubmitted during the self-nomination period, part of the measure review is to determine if the request has been completed or that there is information as to why it was not completed. If the CMS request is not completed and there is not a compelling reason as to why, the measure will likely not be accepted. To summarize, if you have provisionally-approved measures in the 2018 program year, the notification that the measure was provisionally approved included the CMS request or recommendation for the 2019 self-nomination submission.

Slide 42, please. Here is a QCDR measure checklist that may be useful. You don't need me to read the list, and there won't be any surprises in as much as it has been covered during the presentation. However, I would like to call out the last two items as they may help reduce the back-and-forth that occurs after measures have been approved and final specifications are being prepared. Please spell and grammar check the specifications and confirm the measure classification and designations are accurate.

Next slide, please. In summary, for QCDR measures to be meaningful and not - they not only must address gaps in care for specialties, provide preventive care and/or disease management, they must also be clinically relevant, harmonized, and minimally burdensome to report. QCDR measures that are evidence based with low performance rates in performance variance across clinicians provide meaningful measurement and benefit to patients and clinicians. CMS welcomes the opportunity to meet with QCDRs to review measure concepts and provide feedback prior to self-nomination.

Next slide, please. Slide 44, and the next slide, please. Here's a couple of slides with resources. A lot of material has been presented. Remember, the webinar will be repeated in June. The announcement will go out a few weeks prior with the exact date and details. And please - please - please join us again. These are some resources that may be of use. Note that the fourth bullet is the 2018 QCDR Measure Specification file. This was recently posted to the Resource Library. These are QCDR measures for this reporting year and is a good resource as you plan for the next self-nomination. The fifth or second-to-last bullet includes how to schedule a call with CMS to review measure concepts prior to the self-nomination period. And finally, the Resource Library has additional information. Reference material will be updated this summer in preparation for the 2019 performance period. Slide 46 is resources that are on the eCQI Resource Center. Though that center is specific to the eCQMs, or the electronic Quality Clinical Quality Measures, there are many resources on there about measure development and implementation that may be of help as you develop and implement your QCDR measures. Thank you for your time and attention. I'll now turn the call over to our moderator for the Q&A portion.

Great. Next slide, please. We are now going to start the Q&A portion of the webinar. You can ask a question via Chat or phone. To ask a question via phone, dial 1-866-452-7887. If prompted, please provide the conference ID number, 9989237, and press star one to be added to the question queue.

And so our first question says, according to slide 11, one QCDR requirement is to have at least 25 participants by January 1, 2019. Do you mean that a QCDR vendor needs to have 25 participants, not an individual practice?

That's correct. The QCDR itself has to have 25 total participants. It could be 25 groups that each are solo practice practitioners. Or it could be five with five. I mean, it doesn't really matter. As long as there's at least 25 people using the QCDR.

Great. Thank you. This next question is, measures may have significant variation. However, only those who do well on the measures may choose to report on them. Does CMS use the benchmarks based on all participants in a registry or only those who choose to report a measure for MIPS purposes?

Um, only those who may choose to report on them. Yes, that's correct. So we can only use benchmarks based on measures - based on data that we receive. So you're right that some clinicians may not choose to report measure X because they may not do a good job on it. But the only way we can create a benchmark is from the cohort of folks that are reporting it. We can't assume that the people that aren't reporting it are doing a good job or a bad job.

Great. Thank you. This next question is, can a QCDR use any measures that are being used by other QCDRs or must they get permission to use them? And this person says that this refers to your statement that the specifications for QCDR measures are now on the CMS website, and QCDRs are being encouraged to use existing measures instead of requesting approval to use a different measure.

So, at this point, folks do have to get permission to use QCDR measures. We are looking into policies for the future in terms of whether or not a measure being approved for the program as a QCDR measure would allow other QCDRs to report it. Again, obviously not with modification the way it's written. We're looking into that now. But more important - I shouldn't say

more importantly, but it is important to realize, for the owner of the QCDR measure, you would want other people to use your measure rather than have their own measure. If QCDR A and B are basically doing the same measure, but each one is reporting just a one off, so one, let's say, uses an age of 18 to 65 and one uses 21 to 65. It doesn't behoove either QCDR's members because their members will be scored against one another. In other words, all the folks participating in QCDR A will be scored against other participants from QCDR A. So if everyone is doing a wonderful job and the average is 95%, you know, you could have folks that are scoring 93% look like poor performers and get, you know, fewer points. Whereas if all the - if A and B were both put together, maybe the average performance is only 85% because let's say the QCDR B folks aren't quite - doing quite the same job as QCDR A. Well now that 93% person, instead of being below the average, is now above the average and would likely get more points. So it's - it's in the best interests of the - of both QCDRs to be using the same measures of having, you know, a million one offs.

Okay. Thank you, Dr. Green. And Stephanie, I just wanted to check in and see if we have anyone dialed in to the phone line.

There are no questions at this time.

All right. Thank you, Stephanie. So I think that will conclude the Q&A portion of this webinar, and I'll now toss it back to Dr. Dan Green for the closing.

Well, we thought you guys might have some more questions, but I guess either we did a terrific job or people fell asleep because it was after lunch. Hopefully it's the former and not the later. As I mentioned, obviating correctly, I said we would repeat this in April and it's actually in June, so I apologize for that. But, in any case, we will have a free airing, if you will, so obviously it will have to wait until June if you do have questions about measures and QCDR measures. We'd be happy to answer them, and we are available if you are working on particular measure topics and you kind of want to run them by us before you get too deep into the development process and spend a lot of time and money in your effort. So that is an option for you, and feel free to dial in again if - feel free to dial in again if you want to June. as I said, we'd be also happy to help before then. Did we get - no, I think we got - I think we've answered all the questions. All right. With that I'm happy to give you guys back some of your day. Thanks again, and we will look forward to speaking with you on the next QCDR call. Have a great day and thank you.

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