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 it over to Robin Williams, the CMS contractor specializing in QCDR measure development.

Thank you, and thanks to you all for joining this QCDR measure development webinar for the MIPS program. I'm Robin Williams from the Practice Improvement and Measures Management Support, or PIMMS, team, and will be one of today's presenters. Next slide, please.

Our disclaimer. Medicare policy changes frequently. The information provided during this presentation is intended to be a general summary. It does not take the place of written law or regulations. We encourage you to review the specific statutes, regulations, and other interpretive material.

Next slide, please. Here's the agenda for our webinar. The intent of the webinar is to provide opportunity 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, Steven Szeliga, from the Quality Payment Program, Jocelyn Meyer, who's a colleague of mine on the PIMMS team. We'll be your presenters today. Dr. Green will get us stared, then Jocelyn, Steven, and I will tag-team through the rest of the presentation, concluding with Q&A. Dr. Green, would you get us started, please?

Yes. Thank you, Robin. Folks, can you hear me okay?

We can hear you.

Hello? Okay. Great. Well, welcome everybody. So glad you all could join in. Looks like we have quite a few folks on the call. I'm glad that there's this level of interest, certainly, in the measures. I'll say this is an updated encore of our earlier Measures Workgroup webinar. We have met with several QCDRs to this point, and between the Measures Workgroup, as well as the individual meetings we've had, so far, the feedback has been good. We're encouraged by that to try to make this process better and easier for the QCDRs as we move forward.

Next slide, please. Okay, so, this is just going over our strategic vision and measure-development priorities. We do seek alignment across federal and state and private programs, certainly, where we're able to do that. We are trying to promote efficient data collection. We realize that, in some instances, in some methods of collection, there can be burden associated with this, and we're trying to minimize and reduce the burden as much as possible. We're also trying to balance the individual, as well as group-provider accountability. We do think that the measure should, of course, address clinical gaps in care and support evidence-based medicine, as well as engaging patients and their clinicians in care delivery. So, clearly, there's no good reason to measure something that is already being done 100% of the time. We're looking at this program as an opportunity, one, to confirm a clinician's good practice, or in some instances where there are opportunities to provide better care and have better outcomes for their patients. We do look at preventative measures, and measures that promote healthy living that assist in better understanding of patients' overall health. Obviously care coordination is critical for efficient care, better

care, certainly for the most economical way to deliver care. Of course, we're very interested in trying to reduce the disparities that currently exist in health care. These measures may or may not be publicly reported, but if they are publicly reported, we are looking to help consumers make informed decisions regarding the health care choice of their clinician or facility. So, we do have a Physician Compare website, as you guys are aware, and we are posting more and more measures on the Physician Compare website. Although, we do not post first-year measures, so if it's a brand-new measure being collected for the first time, we would not report those results in the subsequent year.

Next slide, please. So, you guys have probably heard the term "the Meaningful Measures initiative." We're looking at meaningful measures to assess core issues that we as an agency consider most vital to providing high-quality care and improving patient outcomes. We do intend to prioritize the outcome-based measures. We're trying to reduce the focus, if you will, on process measures. I'm not saying we're eliminating process measures completely, but we certainly prefer outcome measures, or at least process measures that are strongly tied to an outcome. So, we define Meaningful Measures that focus on one or more of the following areas -- high-impact measures that safeguard public health, patient-centered and meaningful-to-patient type measures, outcome-based measures, again, where possible. We're looking for measures that are relevant to providers. We want the measures to be something that represents the work and care that they provide, again, so it can confirm their good care or give them an opportunity for improvement. We are trying to minimize the burden for providers. I mean, obviously a provider needs to take care of their patient first and foremost. We have started to trim measures that have very high performance rates and/or that are low-value. We do prefer measures where, again, there's a significant opportunity for improvement. So if it's an important process or outcome -- and let's say the average is 60% -- clearly there's an opportunity for improvement as compared to something where the average performance rate might be 97%. It's hard to move that needle from 97 to 98 or 99, and it may not be clinically significant to do that as it would be, let's say, in another metric, going from 60% to 80%. We are looking at population-based payment through Alternative Payment Models. So we're looking at measures potentially suitable for that. And again, as I mentioned, we are trying to align with other payers, including Medicare here at CMS, but also the commercial payers. We've been involved with The Core Collaborative in the past, and have adopted many of their measure sets.

Next slide, please. So, this is a pictorial of some of what we just went over. You guys have probably seen this slide already. Again, just at a high level, promoting effective communication and coordination of care that we just talked about, prevention and treatment of chronic disease, looking at communities to promote best practices of healthy living -- things like smoking cessation, trying to make care affordable. So, at the same time, looking at reducing wasted health care dollars. So, treatments that are not recommended -- over utilization, if you will, of certain tests or medications. Making care safer by reducing harm during the delivery of care, and strengthening the personal family engagement. So, those of you that are clinicians on the call, the communication with patients is critical. You could be the best doc, but if you can't communicate with your patient and have them understand what they need to do, and their caregiver, it gives new meaning to "falling on deaf ears."

Next slide, please. So, the importance of QCDR measures. We're looking, of course, for them to be clinically-relevant measures addressing gaps, as we already talked about, whether it be for specialties, preventative care, or disease management. Typically, these measures are not contained in the annual list of MIPS quality measures. There's no sense in having a measure that is either very similar or identical to a measure in the MIPS program. Better off just reporting the MIPS measure itself. And that way, you'll have a larger cohort of clinicians that your clinicians can be compared to, and thus a better opportunity for more of your physicians to score better. You can imagine, again, and you've heard me say this before, that if your docs are the only ones reporting a particular measure, by definition some are going to be higher performers, and other are going to be lower performers. Whereas if your QCDR and five registries are reporting the same, then sure. Save one in the MIPS program. All of your docs could be the superstars, because there are other docs to which they're compared. Let's see. So, QCDR measure can be a measure in our annual list, but if there's substantive differences in the denominator or the manner it's collected. So we may have a measure in MIPS that's only available for claims and registry reporting. However, if you specify that measure, obviously the measure itself would be different, and that could be a measure that we use. Again, EHR measure would, of course, have a different benchmark. I believe that's it for my opening remarks. Robin, I'm going to flip it back to you, if that's all right.

All right. Thanks, Dr. Green.

Thank you.

Go ahead and move to slide 10, please. Here are some goals and objectives for this 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 your developing QCDR quality measures and getting them through the QCDR self-nomination process.

Next slide, please. In the next two slides are general requirements for CMS-approved QCDR. The first bullet: Participants, by January 1st of the performance period, had at least 25 clinicians submitting data to the QCDR for the purpose of quality improvement. That means, for the 2019 performance period, you need 25 participants enrolled and submitting data to you by January of 2019. For 2018, the year we're in now, you needed those 25 participants by January 1st of this year. This does not mean that all participants have to use the QCDR to submit MIPS data to CMS.

The attestation statement: During data submission, attest that the results being submitted are true, accurate, and complete to the best of your abilities.

Data submission: Using a CMS-approved method to submit the data. For 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 requirements for quality measures are that you must submit at least six MIPS quality measures or a MIPS-approved specialty-measure set. The six MIPS quality measures must include at least one outcome measure, or at least one high-priority measure. High-priority measures are

defined as an outcome measure, 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 MIPS-approved specialty-measure set, QCDRs may submit more of the MIPS quality measures, and up to 30 QCDR measures. So, at least six MIPS quality measures or a MIPS-approved specialty-measure set, and no more than 30 QCDR measures. This slide references three categories from which QCDR measures can originate. QCDR measure may be NQF-endorsed measures. They may be current MIPS quality measures with substantive differences, as Dr. Green just mentioned -- and we'll get into more about substantive differences later in the presentation. Or QCDR measures can be measures developed by boards, specialty societies, collaboratives, or large health care systems. Regardless of the category of origin, all QCDR measures must be submitted during the self-nomination period, and all QCDR measure will be reviewed by CMS for potential inclusion in the MIPS. Later in this presentation, I'll provide some 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 your QCDR measures, early, to allow time for interaction should additional information be requested during the measure-review phase.

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

Thank you, Robin. Good afternoon. In this next portion of the webinar, we're going to take a deeper dive into the measure structure in analytics. The goal is to help everyone understand some of the requests that we've made in the previous self-nomination cycles, as well as provide information and guidance as you get ready for this upcoming self-nomination. Hopefully this knowledge will improve the process and efficiency, and reduce that back-and-forth communication during the self-nomination period, and hopefully get your measure approved.

So, next slide. That's the right slide right there. Thank you. So, to get things started, we want to first establish the basics of a good measure. And we'll definitely be taking a closer look in the coming slides. First, measures must be evidence-based and have an intuitive appeal, or high face validity. It should make immediate sense to the eligible clinicians utilizing the measure. And, of course, as Dr. Green mentioned, if publicly reported, it should make sense to the public, as well. The next two items are related to performance data. It should have an opportunity for improvement, and show variation across eligible clinicians, which we'll discuss in detail later. Next is responsiveness to improvement activities. This aspect of quality improvement is not often talked about, but it is definitely important. If we're holding those eligible clinicians accountable for quality measures, there should be some sort of evidence-based improvement activities that would lead to improved quality. As you're all aware, MIPS requires eligible clinicians to attest to improvement activities, and we had encouraged these corresponding evidence-based tools and strategies to improve quality. It's not just enough to measure quality, but we should actually drive quality care, as well. As measures are developed, we should also be thinking about related improvement activities to support the quality measures, which ultimately should be developed in parallel. As Dr. Green mentioned earlier, as we kicked off the meeting, measures should fulfill the meaningful-measurement criteria or measurement gap. And then, moving on, lastly is limiting the burden of reporting. The

measures should not be so complex or paperwork-heavy that it deters eligible clinicians from submitting a measure.

And then next slide, please. As we touched on the previous slide, measures should be based on clinical guidelines and current scientific literature, but should not be based on controversial or new treatment methodologies. We do ask that any clinical guidelines are submitted within your self-nomination. And we really encourage that they be from a reputable source, and be the most recent -- typically, in the past three years. A measure submitted in the self-nomination process should also assess a quality action with a known variation of performance gap. Again, any applicable performance data is appreciated when submitting your self-nomination. It helps us with the review process. There should be enough gap to demonstrate there is room for improvement. If citing data from literature, it should reflect the most recent data, or within the past three years. We actually have encountered submissions with literature and data provided back from the '80s, so it's just important that it's relevant. For QCDR measures, CMS has been considering topped-out measures of 95 or above. This isn't defined in concrete, but it's just sort of a consistent rule of thumb that we've been going by. Measures with high performance rates do not allow for real room for improvement for the quality, so these measures will likely not be approved. And lastly, in regards to variation -- performance variation allows deciles to be assigned based on the performance range. In performance-measurement terms, a very high standard deviation or variation may indicate data-collection issues, or it could be an opportunity for improvement. And we're hoping to address the opportunity for improvement. If a measure has a very narrow performance range, it may be considered tapped out due to that lack of variation. For example, if 100 clinicians submitted the measure, and all had a performance rate between that 71% to 72% performance range, it'd be difficult to create a very meaningful benchmark. It would be hard to justify rewarding a clinician submitting a 71.6% compared to a 71.1% because it's only separated by that 0.5%. And this is a very important example to point out, is, we commonly suggest that measures should be harmonized with other QCDRs so that a larger cohort can be compared to one another. And this may create a larger range for those meaningful benchmarks to be established.

Hey, Jocelyn, what slide are you on?

I'm on this slide.

Slide 16. Okay. Just wanted to make sure. Thank you.

Yep. 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 or check-box will not be approved. CMS requests that measures be focused on an outcome, which we'll discuss later in the presentation. Next, measures should not be duplicative of existing MIPS or QCDR measures. We have published or posted the QCDR specification on the CMS website on the Resource Library. This is something new for 2018, and we encourage all of you to review the specifications prior to self-nominating for next year or a new measure. If you're submitting and we determine that it's duplicative or very similar to an already-approved measure, we will likely ask you to go reach out to that steward and ask for permission to use that measure. And so it may be advantageous to go review that sooner or later, to allow that ample time to start collaborating with those other QCDRs. We are excited to announce -- and you may have already

heard -- that we are going to be launching a Google group for QCDRs to sort of collaborate, and an open forum of new-measure concepts. So, you'll find more information on the coming days on that. Lastly, measures should be beyond the conceptual state and have complete specifications. Ideally, this would include testing for validity, reliability, and feasibility. But this is not required for QCDR measures.

Next slide. There we go. We'll now transition over to the measure construction. In the last review cycle, you may have received feedback from the team to form a composite measure. Composite measures are considered to be more robust, as it requires multiple quality actions to occur. This allows the sustenance of a broader spectrum of quality care. A composite measure is a combination of two or more measures that result in a single score. This is a concern of a lot of the QCDRs, that performance data of the individual components would be lost in the shuffle. As a QCDR, you're still able to gather and maintain separate performance rates to provide that feedback to the eligible clinicians. And this would allow the identification for areas to improve upon. But for program purposes, CMS will be basing the score on that overall indicated performance rate. Composite measure may be constructed in multiple ways. First, we have the all-or-none. This would require the eligible patients to receive all of the quality actions to be numerator-compliant. But on the flip side, there's also an any-or-none, which is similar, but it is used for adverse events. A patient is counted a failing if a patient experiences at least one of the adverse outcomes. For example, a surgical measure that assesses a rate of infection, re-admission, and re-operation -- if all of those adverse events were avoided, then that's when the eligible clinician would meet the intent of the measure. Next is the linear combination. This will calculate performance based on a simple or weighted average of the scores of each of the components. Lastly, regression composite measures will weight components based on the reliability and the strength to support or drive to that gold standard.

Next slide, please. Within MIPS, we have a number of composite measures. For example, 441 is IVD All or None Outcome Measure, or we have the Immunizations for Adolescents. Both are measures that require all components to be in compliance in order for the 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 within 441 is to assess the most recent blood-pressure measurement. However if the blood pressure is derived from the urgent-care setting, this would be considered a denominator exception, and would not be the blood pressure they'd use to determine for the performance. The same denominator exception would not be appropriate for the other components, therefore it's only a numerator option for that first component.

The Immunization measure is a measure that ensures that all adolescents receive the appropriate vaccinations. The numerators are specific to the vaccine, the number of doses, and the appropriate timing. This particular measure requires for performance rate, but CMS will score the eligible clinician based on the fourth bullet: All patients who are compliant for Meningococcal, Tdap, and HPV during the specified time frames. This would allow the eligible clinicians to evaluate their performance, or lack thereof, in each of the areas. For instance, if most patients were receiving the Meningococcal and the Tdap, but the eligible clinician or group was falling short of providing that HPV, they could take a peek at their internal processes to ensure that more of their patients were receiving that HPV vaccine.

So, next slide. Moving on to multiple-strata measures. The goal of multi-strata measures is to reduce the number of measures addressing a similar condition or quality action. These measures contain multiple denominators but address similar clinical intent. We are really wanting to have the same measures with similar concepts be combined. An extreme example was having two pain-improvement measures. I think Dr. Green always says, "One for their pinky toe, and one for their big toe." That's not a clear indication of quality, or that shouldn't be separated into two different measures. We would definitely suggest those concepts be combined. And then each measure, each denominator can be limited to the appropriate patient population, and the numerator can be adjusted for the denominator-eligible population.

Next slide. This is an example: Measure 7. It's assessing the beta-blocker for CAD based on the history of MI, or myocardial infarction, or their compromised LVEF. Each of the strata considers different risks, deeming it appropriate for that beta-blocker therapy. Another option would alter both numerator and denominator, but are measuring similar concepts. For example, a measure developed to ensure diagnostic tests are read and communicated in an appropriate amount of time. Each of the denominators can be grouped by the diagnostic test based on an urgency, but each of the numerators can be adjusted to align with the denominator. The numerator action criteria for criteria one may be four hours, whereas criteria two is more urgent, and only allows for 30 minutes to elapse before that communication should occur. If eligible clinicians submit a multi-strata measure, it would be anticipated that they would submit all of the strata that they have denominator-eligible encounters.

Next slide, please. Now that we've discussed the composite and the multi-strata measures, we will discuss the ways to crunch the numbers. For multiple-strata measures and composite measures, we request that you indicate a method in which you determine the overall performance rate. This is the rate that we'll use for scoring purposes. It may be derived by a weighted average, simple average, or indication of a particular performance rate. First, weighted average is determined by summing the numerator counts of each sub-measure and dividing by the sum of the denominator counts of each sub-measure. So, back to Measure 7. Combines the two criteria into one weighted average by adding the numerator-compliant instances from both criteria, and dividing it by all the eligible instances found in the denominator criteria. And, of course, subtracting the denominator exceptions from the denominator when appropriate. Next is a simple average. It's determined by adding the percentages for each of the sub-measures and dividing by the total number of components within each sub-measure. MIPS Measure 305 is an example of a simple average where the performance rates from each of the strata are added together and divided by the number of strata to create that simple average.

Next slide, please. There may be instances where a weighted average or simple average is not the appropriate overall performance rate, but rather an indicated performance rate would be best representation. For example, MIPS Measure 238 is a measure that assesses high-risk medication use within the elderly population. One numerator evaluates the use of one high-risk medication, and the second numerator evaluates if two orders of the same high-risk medication were prescribed during the performance period. The overall performance rate used for scoring is actually based on that first criteria over the first numerator, because that is the 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. And, now, I did just mention inverse, so before we move on, for inverse measures, a lower calculated performance rate indicates better clinical care or quality or control. The performance-not-met numerator option is actually the representation of better clinical quality or control, and submitting that numerator option will produce a performance rate that is closer to zero. We do ask that all QCDRs designate which measures are inverse, and it is very important to capture this accurately. We could be unfairly scoring eligible clinicians if we don't have that appropriately designated. So, just keep that in mind when submitting. And if you do have questions, please feel free to ask more about that.

So now we can move on to the next slide. And we'll do a deeper dive into the measure analytics. And next slide, please. Measures may include circumstances where they may need to remove a patient from an evaluation of the quality action. The timing of their removal would be dependent on whether it is an exclusion or an exception. Exclusions are more absolute, where the quality action is not applicable, and would not be considered for a particular population. However, on the other hand, a denominator exception permits the exercise of clinical judgment, and implies that the treatment was at least considered for the eligible patient. These are typically classified under a medical patient or system reasons. For example, Measure 318, this is a hypertension-screening measure, therefore it would not be appropriate to include those patients that have already been diagnosed with hypertension. This patient population would be removed prior to the evaluation of the quality action, and this would be considered that denominator exclusion. However, there may be instances where the patient would be eligible for the measure, but circumstances may remove them from the evaluation of the quality action. For example, if the patient refuses or is in an emergent situation, the patient is appropriate for screening, but there's a reason documented for not completing that quality action, and that would be considered the denominator exception in this scenario. And there are also numerator exclusions, which, these typically apply to ration and proportion measures that are inverse, and define instances that should not be included within the numerator data. And 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. For the proportional measures, numerator exclusions are typically used only in inverse measures, where lower score indicates better quality.

Next slide, please. Risk adjustment. You may choose to risk-adjust your measures. This is a statistical process that is used to adjust for different patient characteristics before determining the outcome. This allows a more accurate comparison, or evens out the playing field, if you will. There is also an option to risk stratify. This is different from risk adjustment. This separates the outcomes within different groups. For example, we have a statin-therapy measure, 438 within MIPS, that creates different strata based on different risk factors, it'll take in consideration lab values, your age, additional diagnoses. So, it's just important to know the difference there, between risk adjustment and risk stratification.

All right. Next slide. Okay. Electronically-derived measure requirements. We would like to bring attention to the electronically-derived registry measures. While this may ease the burden on abstracting the data, it's imperative that vendors, our QCDRs collaborate with the measure steward prior to creating an eCQM version. This is to ensure that work has not already begun on creating an eCQM, and so the appropriate coding is maintained. This specification must be a true representation of the

measure's intent, and produce valid data. This may have unintended consequences to the eligible clinician where the eCQM has a considerably lower performance rate because it was not completely capturing the numerator data. CMS would like all parties to be respectful of copyrights and intellectual property when attempting to adapt the measure to meet their needs of abstraction. We're not trying to reduce the number of EHR data mining, as this is definitely a valuable resource, but cautioning the creation of eCQMs that may not truly represent the measure's intent. We have received e-mails from concerned measure stewards that performance data is not aligning when abstracting manually versus eCQM. So, just wanted everyone to keep that in mind.

Next slide. Measures may be constructed as proportional, continuous variable, or ratio. Proportional measures are most prevalent in MIPS. Proportional measures have a clear numerator and denominator. The numerator captures the quality action, and is divided by the denominator-eligible population. For example, we have Measure 128 of the population, which would be the denominator, how many of those patients have received a documented BMI with a follow-up plan if required?

Next slide, please. Continuous-variable measures do not have your traditional numerator-versus-denominator format, but are evaluated on a continuous scale. MIPS has implemented a few continuous variables recently. For example, 461 -- Average Change in Leg Pain prior to Lumbar Discectomy or Laminotomy. Performance is determined by the degree of improvement of the leg pain following surgical intervention. The measure does not have a set level of improvement required to meet performance, but rather an average. CMS recommends that measures within this construct show enough variability to support benchmarking. If the majority of eligible clinicians all show the same average change of one point, this would not support that variability to establish those meaningful benchmarks, and it may be more appropriate to assign a threshold in order to meet performance. In this scenario, the numerator may be revised to state number of patients that reported a 2.3-point improvement following surgery, and it would create a proportional measure at that point.

Next slide. The last example we wanted to review was ratio measures. This score may have a value of zero or greater that is derived by diving a count of one type of data by another type of data. We see a lot of confusion between ratio and proportional, and they're not interchangeable. One element of the ratio is that the numerator is not in the denominator. For example, the number of patients with central lines who develop an infection, divided by the number of days of central lines. When determining performance, performance rates closer to one represent that expected outcome. In our example here today, we have the average length of stay for heart failure. The expected -- and we just threw out numbers here, so this is not backed by any clinical guidelines. The expected outcome, length of stay would be 4.5 days. When assessing this patient's stay, it was actually 5.5, which exceeded that expectation and produced a ratio of 1.2.

Next slide. And I will actually be turning it over to Steven, and he's going to just sort of walk through some of the challenges in those non-proportional measures, and how they relate to scoring. So, take it away, Steven.

Sure. Good afternoon, everybody. So, I think, as we were walking through with Jocelyn, you could kind of see how the delineation between these

proportion measures and continuous-variable measures becomes increasingly more difficult. So just wanted to walk through a few different items today as we look at it from a statistical nature, as opposed from a clinical nature. So, we can see that non-proportion measures include a variety of different data elements that are captured within the numerator. Because of this, the variability in the day becomes increasingly more complex, and makes it very difficult to create any type of statistical model that would be able to give a relative outcome on the benchmarks. Below are a few listed items that we've seen within the measures. So we have an average time in minutes, an average time in hours, change in outcome related to improvement tests, length of stay, or ratio. In addition to the variability, we would also be unable to determine if the numbers are truly reflective of the clinician's practice or quality. Outliers can have a large impact in modeling if not realized and adjusted. We would be unable to equate for and normalize the data based on practice size, physical location, general population, or risk-adjustment factors that are outside of the actual measures themselves.

Next slide, please. So, based on this information, we consider you to be the experts within your medical communities, and believe that you will have greater insights into the benchmarks related to these measures. As Jocelyn mentioned earlier, if we can revive the numerators to establish a benchmark based on guidelines or national performance data, this would actually create a proportion measure that will make it easier to not only track improvement, but also will give us a more standard guideline for creating statistical modeling related to benchmarks. We can utilize performance data to determine performance-met or performance-not-met criteria. And this also makes it more reliable when we talk about the ability to see, if there are outliers within the data, that could potentially be normalized prior to creating the benchmark. So, we can see that an example would be the Door to Balloon time. A continuous variable would just be a mean time from arrival to balloon, whereas if we have a proportion measure, we can say, "balloon time under two hours," and this would allow for the QCDRs to be more involved with the quality standards set by the measures that are being created. That's pretty high-level, trying to explain the complexities from our end, trying to make sure that we accommodate all of the measures that are becoming available within the program, especially as we move towards more of a quality-performance program, where we're trying to assess better performance and better quality are the outcome for the measures. Next slide.

Okay, thanks, Steven. Yeah, thank you so much. In this next section, we'll be moving away from the analytics, and briefly touch on classifications of measure types and whatnot.

So we can go ahead and go to the next slide. A process measure is promoting a certain process or quality action that may lead to an outcome. Within the process measure, the outcome is not absolute, but supported by evidence that that clinical process may lead to an outcome. For example, 226, the Preventative Care and Screening Tobacco Use: Screening and Cessation Intervention. This is a process measure that promotes a specific screening and cessation intervention for tobacco users. If the process is followed, it may lead to decreased tobacco use. However, if the measure is altered to require that the patient stopped tobacco use within a period of time, this would be considered an outcome. The outcome would actually be the cease of tobacco use. So, next slide, please. As I mentioned, an outcome is a measure that is such that the results are an outcome of a process. This could include clinical events, recovery health status, patient experiences,

efficiency, or cost. CMS promotes the use of outcome over the process measures, and encourages QCDRs to explore opportunities to create more outcome-based measures. For example, we have MIPS Measure 181. This measures the success of cataract surgery, and requires a specific level of visual acuity to determine if the cataract surgery was a success.

Next slide, please. And, next, we have efficiency and cost/resource use. Efficiency is broadly defined as the costs 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 the processes that are required to achieve the outcome. This measure, in our example, addresses both cost/resource for low-risk prostate cancers, but also improves the quality of care, as it addresses patient safety and effective testing.

Next slide, please. And, also, there are a number of measures that utilize patient-reported assessment tools. These may include pain or functional assessments to measure the success of a treatment or therapy. Please do keep in mind that measures only capture that a survey was completed. We won't approve those. We expect that there should be some sort of improvement or positive outcome to demonstrate the quality action. This may include improved pain score, increased function, or the patients were satisfied with their care. I know we've held previous webinars addressing the functional-outcome measures, or the many functional-outcome measures within QCDRs. So we're just looking to get those harmonized. And then that is all I have. But before I turn it over to Robin, I want to mention, we are nearing the end of the presentation, and we encourage you to submit questions for the Q&A portion of the webinar. So, I will turn it over to Robin. Thank you.

Thanks, Jocelyn. I'm going to share with you some of the items that are considered when we do the QCDR reviews.

Go ahead to the next slide, please, slide 38. One of the first things considered -- and this won't come as a surprise. It's been mentioned several times -- is the QCDR measure evidence based? So, are guidelines summarized and cited in the self-nomination submission, and does the measure submission include summarized and cited evidence of a performance gap. If these items are missing, you'll likely be asked to submit them in order for the measure review to be completed. Another thing considered is, does the QCDR measure address one or more of the six National Quality Strategy Priorities? They're listed here on the slide, in a list of Meaningful Measures Initiative that Dr. Green spoke of.

Next slide, please. Slide 39. More things considered, and not in any particular order. I'm waiting for that slide to come up. In addition to being evidence-based and showing room for improvement, does the measure submission include evidence of variance in performance across the clinicians? That was also mentioned a couple times. It's not. We may ask you to provide that, also, so we are aware of what that information is. If there's a high-performance rate and minimal variation across clinicians, the measure will likely not be approved. As has been mentioned, measures with high performance rates don't provide meaningful measurement or benefit to the patients or the clinicians. Also considered is, if implemented, could there be potential harm to patients due to an unwanted, unintended consequence? If so, the measure will not be approved. Likewise, if the measure's focus is for a topic that should never occur, those "never" events, the QCDR measure will not be approved.

Next slide, please. Slide 40. Those are some more general things considered during the measure review. In the next two slides, we'll go over some more specific scenarios to kind of orient you to the format of the next two slides. And each bullet represents a scenario, and then the typical CMS reaction or response. 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 as standard of care, the measure will likely not be approved. In this next scenario, the QCDR measure submitted includes an NQF measure ID. Include the NQF ID only if submitting the exact measure specification as endorsed by NQF. If the specification is not exact, it won't be considered the NQF-endorsed measure. And the last scenario on this slide, if the QCDR measure submitted is similar to measure submitted by another QCDR, meaning the intent of the measure is similar to that of other QCDR measure submitted, CMS may ask you to work with the other QCDRs to harmonize those similar measures into a single measure that can be used to process QCDRs. Measure harmonization between the QCDRs provides eligible clinicians a bigger cohort to be compared against for performance, scoring, and benchmarking. Measure should be harmonized, unless there is a compelling reason for not doing so. QCDRs will be asked to provide detailed justification for having separate measures.

Next slide, please. Some more scenarios, on slide 41. If the QCDR measure submitted is identical to measure submitted by other QCDRs, CMS may ask you to get permission to use the other QCDRs measure. If the QCDR measure submitted is similar or related to measures submitted by the same QCDR, meaning you submit QCDR measures that are similar to each other, CMS may ask you to combine those similar measures into a broader denominator, multi-strata or composite measure, as mentioned by Jocelyn a few minutes ago. If the QCDR measure is similar to a measure that was previously rejected, the measure will not be approved unless it has been modified to require a more meaningful quality action. If the QCDR measure submitted is an assessment measure, meaning the action is that the clinician completed an assessment, CMS will request that the measure be modified to identify the standardized assessment tool, and that the treatment plan reflect the results of these assessments. Similarly, if the QCDR measure submitted is a patient-survey measure, meaning the action is that the patient completes the survey, CMS will request that the measure be modified to be about the patient's satisfaction, or improvement in the patient condition. And as Jocelyn mentioned a few minutes ago, CMS will not approve patient-survey measures that only measure whether the survey was distributed or completed.

Next slide, please. This is my last slide 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 into several QCDR measures -- the QCDR will be asked to consolidate the related measures into a single composite measure. By consolidating the similar measures into a single composite measure, clinicians in groups are likely to have more meaningful data on which to improve the quality of care they provide. If the QCDR measure submitted is a continuous variable rate, while these measures are acceptable, as Steven mentioned, they are difficult to work with for comparative purposes. The QCDR will be asked if a quality threshold can be set. If so, they may be asked to transform that 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 improvement? Additionally, we will likely ask for variation in performance rates among the providers reporting a given 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 previous performance data, if approved, the measure will be identified as a new QCDR measure, and assigned a different measure ID.

Next slide, please. Slide 43. We'll spend a little bit on substantive changes. Substantive changes. This is specific to QCDR measures that were approved from the previous program year and are re-submitted during the soft nomination for the next program year with changes that may not allow comparison to previous performance data. Here are some examples of substantive changes. The care setting that was originally identified with general E&M codes has now been changed to include anesthesia procedural codes. Or maybe the quality action was changed from the number of patients who had an assessment two months post-procedure to the number of patients who showed greater than 10% improvement in functional ability two months post-procedure. And the last example is, analytic designation have been changed. So, if the measure designation hasn't changed -- it was an inverse, and now it's not, or proportional or ration or continuous-variable and/or risk-adjusted, and those have changed from the prior year to the next submission, that may impact the comparison of the previous performance data. CMS may ask about the measure designation if it is submitted differently from the prior or previous year to confirm that the QCDR measure has indeed been 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.

Next slide, please. Let's talk a little bit about provisionally-approved measures. Some QCDR measures are provisionally approved, meaning they can be used for the performance period, but CMS is requesting performance data or modifications to the measure for the next self-nomination period. If you have provisionally-approved measures for the 2018 performance period, the JIRA notification informing you of the provisional approval included a comment with the CMS request that's to be completed when you submit the QCDR for the 2019 self-nomination period. Here are the most common reasons for provisional approval. CMS wants to quantify the performance gap and room for improvement. With the notification that the measure was provisionally approved for 2018, we ask for a summary of data, of performance data and clinician variance, to be included with the 2019 self-nomination. Another reason could be that CMS requests measures be combined into composite or multi-strata measure. Again, in that notification of the provisional approval for 2018, we identified the measures that should be combined for the 2019 self-nomination submission. CMS could be wanting to request collaboration with another QCDR to harmonize measures. And we talked about this before, being that similar measures are coming in. Again, in that notification of the provisional approval for the 2018 period, we identified the QCDR measures to work with before the 2019 self-nomination submission. And, lastly, CMS requests the measure be modified. Again, in that notification of provisional approval, we provided an example or suggestions of ways to revise the measure, to be made before the 2019 self-nomination submission. If the QCDR measure that was provisionally approved is resubmitted during the next self-nomination period, part of the measure review is to determine if the request has been completed, or if there is detailed justification as to why it was not completed. If the CMS request was completed and there is evidence of a performance gap or variation, the

QCDR measure will likely be approved. If the CMS request was not completed, the QCDR measure will likely not be approved.

Next slide, please. Slide 45. You've seen this checklist before. It's been revised a little bit as we interact with the QCDRs to get more and more detail onto it. But prior to nominating a QCDR measure, this checklist could be reviewed. CMS and the PIMMS team uses similar checklists during our review process. This first slide -- I'm not going to read it to you, and there won't be any surprises, because these will all have been covered during this presentation. This first slide is what the QCDR measures should do, and the next slide is the list of things that the QCDR measures should not do.

And we can go ahead and move on to slide 47. Here's the ones they should not do. And then the next slide. 47, please. In summary, for QCDR measures to be meaningful, they must not only address gaps in care for specialities, preventative 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 and performance variation across clinicians provide meaningful measurement in benefit to the patients and clinicians. CMS welcomes the opportunity to meet with QCDRs to review measure concepts and provide feedback prior to self-nomination.

The next slide, please. Got a few slides left, just with some resources, before we move to the Q&A session. Go ahead on to slide 49. As has been mentioned a couple times, CMS welcomes the opportunity to meet with QCDR to review measure concepts and provide feedback prior to self-nomination. To request a measures concept call, contact the QCDRVendorSupport@gdit.com site by September 1st. That's when the self-nomination period begins. Provide availability at the time of the request so we can get something scheduled, and then, about at least a week prior to that call, please send the concepts that you'd like to review so that CMS and the PIMMS team can be prepared when we do have the call.

Next slide, please. This slide, slide 50, has some more resources that can be used. Please note, as Jocelyn mentioned, the fourth bullet is the 2018 QCDR Measure Specification file. This is posted in the Resource Library. These are the QCDR measures for the 2018 performance period. And it's a good resource as you plan for your 2019 self-nomination. The resource library has additional reference material, and it will be updated this summer in preparation for that 2019 performance period. Again, that starts September 1st.

Next slide, please. Also, I want you to be aware of the eCQI Resource Center. Those specific to Electronic Clinical Quality Measures, or eCQMs, has many resources on measure development and implementation that may be of use as you develop and implement your QCDR measures. And finally, I want to call out the same thing Jocelyn did, that we announced recently the QCDR Measure Development Google group forum as a space for the QCDRs to collaborate on the QCDR measures. Look for announcements that it will be going live soon. Thank you for your time and attention, and I'll now turn the call back over to our moderator for the Q&A portion.

Thank you. We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, please dial 1-866-452-7887. If prompted, please provide the conference ID number, which is 2889118. Please note that we will not be answering questions related to 2018

participation in the Merit-based Incentive Payment System. We will only be able to answer questions related to the development of QCDR measures. Also, we may not be able to answer all the questions submitted via chat. If your question is not answered, please contact the Quality Payment Program Service Center.

So it looks like our first question here is from a hospital-based radiology practice. And they say there are some challenges meeting the volume when there are not enough measures to work with, so they're wondering when the list of measures will be expanded.

This is Sophia Sugumar from CMS, and I can take a stab at that question. So, in addition to the MIPS quality measure that are available in the program, QCDRs have the ability to create measures that are more specialty-based. We find that a lot of specialties have developed their own QCDRs, which are Qualified Clinical Data Registries, in which they've come together and kind of developed their measures based off the needs of their physicians that they support. And those measures are what they put forth during self-nomination, which occurs between September and November of a given year prior to the actual performance period. So, for 2019, it would be September 1 of 2018. So, the QCDR measures are an alternate to the MIPS quality measures, and the purpose of those measures are to kind of act as a supplement for clinicians who believe that there aren't measures in the MIPS Quality Measures set that are available or applicable to them. So we encourage the use of QCDRs if there are measures that you find are not available, and then this quality-measure list. I would suggest, if you would like to have an idea of what's available for 2018, to visit the QPP Resource Library, and under the 2018 page, there is a list of MIPS Quality Measures, but then there's also a list of measures supported by QCDRs that are currently approved for the 2018 performance period, and those are broken down by clinical topic. If you have any questions in terms of how to reach out to a QCDR, if you're possibly interested in using their measures, we have a qualified posting that's also available on the Resource Library, which will provide contact information for all our approved vendors for the 2018 performance period.

All right. Thank you. Our next question, this person's asking, "To be able to submit QCDR measures, are we supposed to nominate ourselves?"

Yes. Only QCDRs can develop and submit for CMS consideration QCDR measures, so that would occur during the self-nomination period. I would just like to flag that we are going to have a public-facing webinar on self-nomination. That would be later this summer. Self-nomination will occur between September 1 and November 1, and it's between that time period where you will be required, as you submit your application to be considered as a QCDR, that you would submit your measure concepts, as well, for CMS review.

Great, thank you. And this next question is, "How does QCDR fit into the IQR program and measures?"

I'm not sure that's --

It doesn't. It does not at this point.

Great. Thank you. For this next question, this person says, "If a hospital owns several practices with varying numbers of physicians in each practice, does the hospital report this information for the practices? And if they

report this information, is it reported as one practice, or broken down by physical addresses and/or specialties?"

I think this question is one we would defer to the Service Center. It's not related to QCDR measure development. It's related to submissions and participation. So if we can provide the user with that contact information, that would be great.

Great. We can certainly provide that. So, for this next question, "If a measure is for a clinician to make a referral to an intervention or a program, does the clinician have to recommend to a specific site and document which one, follow up, and determine if the patient is actually enrolled? Please describe how such a measure should be operationalized."

This is Jocelyn. I can take this one, I think. So, I think it's dependent on the measure and how it's developed. So, there are some measures that actually require that referral loop to be closed, but then there's also other measures where it's a referral to cardiac rehab or evaluation of some sort. But it just depends on how that measure is constructed.

Great. Thank you. And, Tammy, are there any questions on the phone at this time?

There are no audio questions at this time.

Okay. Great. So, the next chat question says, "Is there a difference between inverse and inverted?"

This is Jocelyn again. Not that I am aware of. I just would say, if the clinical action is where your performance is trending towards 0%, that would be considered inverse. I'm not really familiar with the inverted term, but assuming that that lower performance rate would be higher clinical control, then yes.

Yeah, and just to kind of tag onto what Jocelyn just said. I'm not aware of any inverted measures within the program. Everything that I've seen refers to them as inverse. So it would be difficult to actually give an answer without truly understanding what the question is.

All right. Our next question is, "Does CMS require risk adjustment for QCDR measures?"

We certainly would prefer risk adjustment, to have the ability for you to risk-adjust. That will probably be becoming more important in the future, especially for outcome measures.

All right. Thank you. This next question is, "Is the numerator typically defined by the measure steward? For example, NQF or NCQA?"

So, typically, yes, the measure numerator is defined by the steward. But, again, with QCDR measures, the QCDR is considered the steward most of the time. So, I guess it depends on the situation. If the QCDR is using a measure that is owned by someone else and has received the appropriate permissions, they would have to use the numerator as it was included in the original specification. If the measure is their own, then they are responsible for coming up with that numerator.

Thank you. This next question is, "What is the difference between a registry submission and a QCDR registry submission?"

So, if an eligible clinician or a group uses a qualified registry, which is different from a QCDR in the sense where, qualified registries are limited to only supporting either MIPS-quality measures that have proposed and finalized through rule-making, improvement activities, or promoting interoperability measures. QCDRs are different in the sense where they are able to develop their own measures for CMS consideration, so that provides them with an opportunity to develop measures that address specialty concerns that their specialists want to be measured on that might not be reflective of the measures that are in the MIPS Quality Measure set.

Thank you. For this next question, this person says that they are concerned that their Physician Policy Committee won't be able to schedule a CMS call before September 1st because they do not meet until August 10th through 11th. So they were wondering, will CMS take pre-submission measure reviews and discussions once the application period opens?

To request a preview, we just ask that that request come in prior to the opening of September 1st of the self-nomination process. So just make sure that you make that request, and we'll probably want to get that scheduled soon after, just because it will start to get quite busy during the self-nominations. So we just want to make sure we provide the opportunity to review and time with you. So, just before that September 1st deadline.

Yeah, the other thing to remember is, the closer we get to the deadline, the less of an opportunity the entity will have to make any revisions that may be required.

All right. Thank you. This next question, this person says they're a dermatology practice with one full-time M.D., one part-time M.D., and one full-time physician assistant, and they reported MIPS through their EMR system last year. Does QCDR apply to them?

So, they would not be able to qualify, based off the way you described, to be a QCDR themselves. However, we do have dermatology-based QCDRs available if they are using a QCDR to report. We suggest they visit the Resource Library and look at our qualified posting to see what vendors are approved for 2018.

Great. Thank you. And kind of a related question, someone asked, "Does this apply to practices that do not have 25 providers?"

So, the requirements to become a QCDR, the eligibility requirements, we specifically don't look to approve individual practices or individual clinicians as QCDRs. We're looking at larger entities, whether they be specialty societies, regional collaboratives, or larger health care systems. If there's a larger health care system that manages multiple smaller practices, that might be something we also consider. But stand-alone practices are not ones we would typically approve to be a QCDR.

Great. Thank you. This next question, this person says, "At the kickoff meeting, you indicated that we can start to work with you on new measures. Who at CMS should we communicate with as we work on developing these new measures?”

So, as Jocelyn and Robin have indicated earlier, we do have these measure-concept preview calls that are ongoing now, and we've been meeting with QCDRs as they've come and approached us. So you can e-mail the QCDR Vendor Support e-mail address -- I think it's in an earlier slide. It's QCDRVendorSupport@gdit.com -- and provide them with your availability so we can schedule a call. They will ask that you provide measure concepts a week before the call for us to review.

Great. Thank you. This next question says, "Most of these measures appear to be focused on primary care. How are specialists able to qualify?"

I guess the question is more of how specialty societies can qualify to be a QCDR? That's what I'm going to interpret it as. Because a specialist, as in an individual clinician, wouldn't qualify to be a QCDR. So, if a specialty society is interested in becoming a QCDR, I would encourage you to visit our Resource Library, which would have a self-nomination fact sheet as to our requirements of what you should have, and our expectations of your qualifications prior to self-nomination. We will post additional resources for 2019 as to how to self-nominate, a user guide that will give you screenshots and step-by-step steps that will show you how to complete the form and submit that. If you are interested in also developing measure concepts and submitting those, we will provide you with templates, and ask that you complete all that and submit all that information by the November 1st deadline for consideration for the 2019 performance period.

Great. Thank you. This next question is, "When CMS is reviewing measures, how much time do CMS staff give measure stewards to make revision and/or attempt harmonization?"

Some of that's dependent on when we receive the measures. Certainly, if it's submitted the last day -- I mean, we do try to give you as much time as possible. Jocelyn, if they're looking for an exact number of days, maybe you have that.

Yeah. I think we do five days. And that's why we're trying to do some preemptive harmonization, and giving you guys tools to review current QCDR measures, providing that Google group forum to discuss new measure concepts with other QCDRs. So we're trying to get all the avenues to get that done prior to self-nomination, but typically, when we make a request to revise, depending on the timing of it, it's three or five days.

But also, to add to Jocelyn's point, that all is dependent on how major the harmonization is. So, if it's something minor, where it's just an age range, and we feel that it could be something that could be done within the time frame that Jocelyn specified, then that's one thing. If it's something larger, we also provisionally approve and then ask for harmonization by the next self-nomination period. So it really depends on the situation.

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

We do have a question, from the line of Julie Marhalik-Helms with NAPA Anesthesia.

Hi. Thank you for taking my question. I was just curious as to whether or not a single-specialty group with multiple TINs can create their own QCDR.

So, we are generally looking for a QCDR to be either a regional health collaborative, a large hospital institution or health system, or a specialty society. We'll be happy to consider other folks, but that's in keeping with, I think, how we've defined QCDRs. We won't have a single-practice, if you will, QCDR. So, I don't know if that answers your question or helps you.

To add to Dan's point, we do have specialty societies that are anesthesia-based that have their own QCDRs that are available for reporting. I think the concern with having smaller practices developing their own QCDR comes to the volume of operational requirements that we have in the program, and whether those can be met, and the registry and technical submission requirements that we have, and whether those aspects can also be met. So, our preference is to typically go with the larger for those reasons, because they have the means and the resources to meet all our requirements, and participate and kind of meet those program requirements that are required throughout the year.

So, just to make sure I'm clear, if there's, say, 2,000 providers that would be reporting, does that meet that threshold, or would that still be considered single-practice even though there's multiple -- 10, 11, 12 -- TINs reporting.

Mm-hmm.

Well, we wouldn't consider it necessarily a single practice, but would you be submitting your own measure suggestions, for example?

We probably would apply for maybe two or three QCDR measures, but then also Reporting MIPS Measures and some of the other specialty QCDR measures. So, for example, some of the QCDR measures that are already approved by CMS, we would just ask permission to report some of those, as well.

Okay. Just out of curiosity, why wouldn't you just go with an existing QCDR that's already reporting that?

Right now, we are just assessing the feasibility. So it's just really kind of a research period for us. But cost and ease.

Yeah, I mean, part of what we're looking for is, we're looking for QCDRs to have the medical expertise, certainly, for their measure development. At this point, we're not requiring NQF endorsement, for example, for the measures. But we are trying to raise the bar on the measures that we consider for QCDRs so that they become a bit more comparable to the measures that we approve in the actual program.

So, we've been reporting through one of the QCDRs in our specialty. We were just assessing the feasibility of starting our own.

No, no. I understand. I'm letting you know -- you can imagine, for example, a specialty society, I mean, they, generally speaking, are staffed with care experts that may or may not have the time where they can convene the right people to actually develop the measures. I guess what I'm getting at is, we're looking for the measures to, again, be more robust and, I'll say, higher-bar. More meaningful and appropriate. And often that requires a certain level of measure expertise. And I guess one of the concerns I would have, from what you're describing, is, would you all have that?

Okay. So, maybe a separate discussion offline.

Sounds like a plan. Thank you.

Thank you.

All right. Our next question is, "Are we able to offer a measure pending approval to other QCDRs for submission with their application?"

Yes, you can do that. So, if it's pending approval, it hasn't been assigned a measure ID yet, so those other QCDRs would have to note in their QCDR Measure template that the measure belongs to you, and that they've received the appropriate permissions. Now, CMS doesn't get involved in terms of the process of seeking permission. We leave that to the QCDR legal teams, and what you feel is appropriate in order to give and receive that permission. We just ask that it be done by the time of self-nomination.

Thank you. Our next question is, "What about measures that gather treatment and outcome data when there is a gap? The measure is designed to measure outcomes of treatments for development of clinical guidelines."

That would be more of a research or experimental use. And while, certainly, data-collection vendors and registries certainly can do that, that's not necessarily something that we would include in our QCDR measure collection for a host of reasons. Some of them have to do with, I imagine, again, if there are different treatment modalities looking at outcomes, some of that would probably need to go through an IRB institution. And at the same time, we're looking for best practices, not so much for experimental measures.

Okay. Thank you. Our next question is, "If we don't submit any new measures for QCDR, but will be leveraging existing NQF and HEDIS measures, do we still need to self-register for these specific measures to be certified?"

Sophia?

Yeah, no problem. If you want to support measures that are not included in the MIPS Quality Measure list that is finalized through rule-making, then, yes, you would have to self-nominate those measures. So if they're NQF-endorsed, we need the NQF ID numbers. If they're not NQF-endorsed, that's not needed. If the measures do not belong to you, we need to know who they belong to. As appropriate, you should get permission from those stewards. We do not want there to be copyright issues, and you might have stewards that are not too happy if you don't seek their permission prior to using the measure. So, that is something we would ask you to consider before you self-nominate measures, that you take the appropriate steps to make sure you are able to use them.

But if you're not planning to submit any of your own measures, you may consider trying to become just a registry. The requirements would be a little easier for you. And then, as a registry, you could report any measures in the MIPS program. As Sophia was discussing, if you're talking about reporting other QCDRs measures, then you would need to be a QCDR -- again, as Sophia said.

Great. Thank you. And I think for this next question, we'll go back to slide 38. Deirdre, if you could move back to that slide for us. So, this person would like some elaboration on cost reduction.

Cost reduction? Could you repeat?

Go ahead.

No, if you understand...

I think they just wanted some clarification on what we're meaning when we want to measure cost reduction. And so let's say, for instance, like, repeating the same MRI three times, that's going to be very costly. And so measures that reduce that or address overuse would be considered cost-reduction measures.

Great. Thank you. And this next question is, "If you are requested to consolidate measures into a composite measure, will that measure now only count for one measure?"

Yes.

All right. And, Tammy, do we have anyone on the line with phone questions?

There are no audio questions at this time.

All right. Thank you. Our next chat question is, "When will the new blueprint be released?"

I think that's something we'd have to follow up on, because that's not a publication that we manage.

Yeah, and I think, Sophia, to add to that, we will be publishing a handbook. It's not a replacement for the blueprint, but definitely will give a lot of additional feedback and information when creating your measures.

Yes. And that handbook is specific to only QCDR measures.

All right. Thank you. this next question is, "Do you envision any changes to the QCDR vetting process due to the upcoming CMS MACRA Measure Development Cooperative Agreement awards?" And this person's asking specifically how far along a concept or measure needs to be in order to be submitted for consideration.

I don't know that we're anticipating any change. The requirements of QCDR measures would be as they are finalized in the final rule. So, if it's not in there, we couldn't hold them to more stringent standards.

Thank you. This next question says, "We are advised not to submit documentation/check-box as a QCDR measure. What does this mean, and can you give an example of this?"

Yeah. So, when we say it's a check-box measure -- say, for example, it would be, the patient was assessed for depression. The depression screening tool indicates the patient is depressed. But then just doing that quality action and no follow-up, no plan of care, that would be considered a check-box, where you're just doing the assessment. There's no quality action associated.

All right. Thank you. For this next question, this person says, "There are a number of MIPS measures -- for example, MIPS 431, Alcohol Screening and Intervention -- that have only outpatient E&M codes that would also be highly relevant and meaningful for inpatient encounters providers. Is it possible to submit these measures as QCDR measures with the relevant inpatient codes? And if not, do you have a recommendation?"

I'm sorry. Can you repeat the question one more time?

Yes. So, this person says, "There are a number of MIPS measures" -- and lists MIPS 431, Alcohol Screening and Intervention, as one example -- "that have only outpatient E&M codes that would also be highly relevant and meaningful for inpatient encounters providers. Is it possible to submit these measures as QCDR measures with the relevant inpatient codes? And if not, do you have a recommendation?"

I can take this one, if you'd like.

Go for it.

So, if you're wanting to expand the clinical setting that's not found within the MIPS, by all means, you can definitely submit that. We do, however, try to take that feedback back to the measure steward. So, for instance, if it was Measure 431, we might go back to the measure steward and request that they add those in a subsequent performance period so that clinical setting is represented within the MIPS Measures, as well. So, you can still do that. It is important for us, because when we look at that measure, we're going to say, "Well, this is duplicative." So when you self-nominate, I would definitely include that within your denominator, or some sort of indication that this is not a duplication of the MIPS measure, but expanding the clinical, because then we will probably come back and be like, "Well, what's your coding?" and whatnot. So have that extra information would be helpful.

All right. This next question is, "Does CMS provide guidance on risk adjustment to assist measure developers?"

I believe that there are some. I think in either the blueprint or another measure-related resource on our CMS website, there is a section about risk adjustment of measures, but I'm not sure if the level of detail there will cater to the person's question. Dan, what were you saying? Sorry.

I was going to say, I think that NCQA also has some information. But if you have difficulty after checking those places, you can certainly let us know, and we'll try to find some other places to get you information.

Okay. This next question is, "What is the process of requesting to use a measure from another QCDR? Is the decision to approve solely on the other QCDR?"

So, let's say for 2019 you're interested in one of the existing QCDR measures that have been approved. Those QCDR organization names, and through the qualified posting of the points of contact with their contact information is available for you to start that. Reach out early and be proactive. If, for some reason, and if it's not posted in measures but is in the process of being submitted, and it's one you are also interested in submitting, we would ask that you include that measure in your template, recognize who the steward is or the QCDR is that's the original owner of the

measure, and that you've gotten the appropriate permissions. If for some reason we reject the measure in the original submission from the original vendor who owns that measure, the same rejection would apply across the board. So it would not be available for anyone to report if the owner of the measure cannot report it.

All right. Thank you. This next question is, "Can you elaborate on the following measure review consideration? Measures that are "never" events will not be approved."

This is common. A "never" event example could be surgery performed on the wrong patient. Dr. Green, you probably have some more examples. But we certainly would never want those to occur, so we wouldn't want to be measuring those.

Things that occur too infrequently to really distinguish. "Doctor A is providing better care than Doctor B." Fires in the operating room should never happen. You may never have one in five years. Maybe the year you have it, it's terrible. But your numerator count or failure count at that point would be one, and somebody else would be zero. So we couldn't really compare or have deciles to assign points. We all agree it should never happen, and all precautions should take place to prevent it from happening. But it happens so infrequently, it's not a good quality measure for the program.

All right. Thank you. This next question is, "What are the options if a QCDR doesn't want to share a measure, and if we want to modify or harmonize and stratify the measure, do we need permission?"

So, as we indicated earlier, we definitely highly encourage harmonization and collaboration between the QCDRs. We would not approve duplicative measures that were just one off from one another. So, in any case, if you are reaching out to a QCDR and they're unwilling to work with you, we ask that you let us know so that we can kind of reach out and find out why. And we would then, as a part of our QCDR measure, we do process review both concepts, and would probably pick the better of the two.

Thank you. This next question is, "What's the best way to understand what provisionally-approved measures may undergo harmonization for the next performance period?"

This is Robin. If the question is that, how do you know which measures were identified as being requested to be harmonized, in the JIRA comment that provided the status that it was provisionally approved, for example, for 2018, it would request that you work with QCDR "X," "Y," or "Z" to harmonize the measure for the next performance period so the measure as well as the other vendor, the other QCDRs would be listed in that comment.

All right. Thank you. This next question is to please define "participants."

Do we know what they are referring to when they say participants? Is it the 25 participants in the registry? If we're referring to the 25 participants a QCDR must have, we're asking that the entity that's developing this QCDR, they should be able to submit and received data from eligible clinicians. So when we say participants, we're referring to the physicians or groups that you can actually accept and receive data, and have the ability to transmit data. This is more of showing that you have that technical experience, and you have experience with registry collection. You kind of have to

demonstrate that to us as a part of your self-nomination. We expect that vendors would have experience doing that.

Thank you. This next question is, "When does the nomination period open for QCDRs for 2019?"

The self-nomination period will open September 1, 2018, and will close at 5:00 p.m. November 1st. So, during that time, we will have it open. It's a web-based tool. Further instructions are forthcoming. We will probably release those instructions later in the summer, and we will have a webinar to go along with it that will be sometime in August.

All right. This next question is, "Can an electronic health record apply to become a QCDR?"

I guess I'd have to take a look at whether or not they met our requirements of QCDR participation, and we would kind of have to know why. I mean, because EHR is a submission method under MIPS, why they would actually want to be a QCDR instead.

All right. This next question is, when you self-nominate to become a QCDR, do you have to list out every already-approved measure you might potentially report on?

So, if this is a question from an existing vendor, yes. You have to, as a part of your self-nomination process, list all the ones you've been approved for. We do re-evaluate the measures on an annual basis.

Great. Thank you. And, Tammy, I just wanted to check in to see if we have any questions on the phone.

There are no other audio questions.

All right. Thank you. And as a reminder, if you would like to ask a question via phone, please dial 1-866-452-7887 and press star-1 to be added to the queue. So, this next chat question is, "Is a QCDR just the quality reporting measures for MIPS-eligible providers?"

QCDRs are used for the purposes of MIPS, yes. They can report on quality measures, develop their own QCDR measures, support improvement activity reporting, or support promoting interoperability measure reporting. So they can do either all of those or some of those. We do ask that they definitely support at least six quality measures, whether that be QCDR measures or MIPS quality measures or mix of both.

Thank you. This next question is, "How does the QCDR fit into the greater CMS landscape?"

So, QCDR is an organization that can report quality and, potentially, if they so choose, interoperability data as well as improvement activity data for purposes of the Quality Payment Program. Hopefully they're in the business of quality improvement independent of CMS. But in terms of a CMS landscape, we would expect them to partner with medical experts -- either a specialty society, again, regional health collaborative, or a large health organization -- so that the data and the metrics they're collecting fit our meaningful data, and are well-vetted in terms of their appropriateness.

Thank you. This next question is, "For our provisionally-approved measures, it was requested to provide performance data for consideration for the 2019 performance period. How is this done?"

Yeah, so, when you go to self-nominate this next year, we ask that it would be included within your self-nomination. Yes. And you're right, you probably don't remember seeing that field. Part of that self-nomination process for 2019 will be updated. We're continuing to try and improve our processes on our site, as well. So, as you submit your self-nomination, please include it. And that would include your performance range, as well as the number of eligible clinicians that are included within that data.

Great. Thank you. This next question is, "Composite measures are not required, correct? Only one high-priority or outcome measure?"

That's correct.

All right. And the next question, this person says, "Please remind me of the criteria that needs to be met to use a measure that is not in the MIPS list."

So, I believe we have a previous slide that kind of outlines what we're looking for in terms of QCDR -- that they not be standard of care, topped-out, meaning there's high, unvarying performance rates, that they don't reflect documentation or check-box, but they actually show or can measure quality improvements, not duplicative of any existing measures that are already in the program, not duplicative of existing approved QCDR measures. I'd refer back to those slides and our self-nomination fact sheets as they come out this summer to help you make sure you meet all the criteria as you prepare your measures for self-nomination.

All right. Thank you. And, Tammy, I just wanted to check in again to see if anyone was on the phone?

There are no phone questions at this time.

Great. Thank you. All right. So, this next question is, "Will there be notification of what measures may be harmonized?"

I believe that's a follow-up from a previous question regarding provisional approval in the request for harmonization. So, each self-nomination, if it is determined that the harmonization is too great, or that it's going to be too cumbersome to accomplish within the short amount of time within self-nomination, we may request -- we would give you feedback via JIRA that it's provisionally approved for the year, however during the next self-nomination, it would be expected or anticipated that the measure be harmonized with the other QCDRs that are submitting a very similar measure. But, yeah. There will be notification which measures should be harmonized.

Great. Thank you. And it looks like there are no longer any questions relating to this webinar in the chat box, so we will just pause for a couple minutes to allow for any last-minute questions. And just as a reminder, we are only able to answer questions related to the development of QCDR measures.

So, last call for questions, folks.

All right. I see we did just get one question. "If a QCDR resubmits a measure in 2018 that had been approved in prior years, would we need to submit new clinical documentation?"

Not necessarily, unless the information previously submitted has changed or is outdated. By outdated, we're thinking more than three or four years old.

All right. Thank you, Dr. Green. And, Tammy, do we have anyone on the line?

There are no audio questions.

Is that it, operator?

There are no audio questions at this time.

Okay.

And there are no more questions in the chat.

Okay. Well, timing is everything, guys. So, to our participants, kudos to you, because we're just about up on time, anyway. I do want to thank folks for dialing in, and I also want to thank them, also, for the thoughtful and good questions that were asked. We hope you found this helpful. As we mentioned early in the call, we have had kind of one-on-ones with QCDRs that are planning self-nomination or to re-self-nominate to review their measure concepts if they had concerns. And that is open to everybody. So, just wanted to reiterate that. For those of you that are already QCDRs or registries, we will look forward to speaking with you on our monthly support call, which will be coming up a little bit later this month. So thank you again, and have a great afternoon and a terrific summer. Good day.

This concludes today's conference call. You may now disconnect.