MIPS Quality Performance Category for Year 2 Overview Webinar
August 6, 2018

Hello, everyone. Thank you for joining today's "MIPS Quality Performance Category for Year 2" overview webinar. The purpose of this webinar is to provide information about the Quality Performance Category of Merit-based Incentive Payment System in Year 2 of the Quality Payment Program. Now I will turn it over to Adam Richards, health insurance specialist in the Center for Clinical Standards and Quality at CMS. Please go ahead.

Great. Thank you. And hello, everyone. And thank you all for joining us for today's webinar on the Quality performance category for Year 2 of the Quality Payment Program. We've got what I think will be a great discussion planned for you all today. This event will wrap up our recent MIPS Performance Category webinar series. We've previously covered the Cost, Promoting Interoperability, and Improvement Activities performance categories. And just so you all know, the Promoting Interoperability reporting and slide deck are available within our Quality Payment Program Resource Library on cms.gov. And I'll think we'll start pushing out that link in just a few minutes. We're also in the midst of posting the Cost performance category webinar materials. And we'll soon have the Improvement Activity webinar materials available to you, as well. So, I encourage each of you to sign up for our Quality Payment Program LISTSERV at qpp.cms.gov, as we'll be sending out updates and reminders when these materials are posted, if you are interested in checking them out. Of course, this isn't the end of our educational road together. We'll continue releasing additional resources and hosting events. So, this is really another good reason to sign up for the listserv, to stay up to date on all things Quality Payment Program. So, for today's events, I'm pleased to be joined by Sophia Sugumar, Dr. Dan Green -- both leading experts in the Quality Payment Category -- as well as Dr. David Nilasena, our MIPS scoring expert. I want to thank each of them for taking the time today to walk through this performance category with you all. We'll take the opportunity today to cover all things that you should know about the Quality performance category and then, hopefully, have some time for discussion and questions at the end. Now, before we get rolling with the content today, I do want to make it clear that we are covering the Year 2, the 2018 policies for the Quality performance category, that were finalized in last year's final rule. Please understand that even though we currently have proposals for Year 3 available for review and comment, we will not be discussing those proposals here today. So, for those who are interested in learning more about our proposals, I highly encourage you to review our comparison fact sheet, as well as our webinar recording from about two or three weeks ago on all aspects of the Year 3 proposed rule. All of those resources are available within the Quality Payment Program Resource Library on cms.gov. We'll also have some information, a little later in the event, on where you can find the actual proposed rule and how to formally comment. So, just a flag for you all as we move through our discussion today. So, let's jump onto Slide 3. We have quite a bit of ground to cover today as the Quality performance category contains quite a few elements. So, as we get that on the screen, I'll just go over some of the things -- some of the topics for today. We'll start with a general overview of the Quality Payment Program. We'll talk a little bit about the Merit-based Incentive Payment System and the requirements within. Just a basic, high-level information, just to kind of bring everyone up to speed and make sure we'll talking the same language as we go on. We'll then have an overview of the Quality performance category. We'll talk about some of the performance category requirements within. And

we'll move on to talking about how to submit data. We won't get into too much depth with how to submit the quality data, but just, again, a little bit of an overview. And then we'll wrap things up. We'll wrap our discussion up with a discussion on performance category scoring. It just came to my attention -- so I do want to flag this for everyone -- I think we are having some technical difficulties with advancing the slides. So, bear with us for just a second. We're going to try to get them going. Okay, I think we've got them now. So, I think we're in better shape now. So, as you can see, these are the topics that I just mentioned, that we'll go through. Again, a lot of high-level information. We'll try to deep-dive, where possible, to give you some of the more nuanced information. And then, of course, at the end, like we always do, we will talk about some of our health and supports, our no-cost assistance that is available to clinicians, really to help you with the Quality performance category. But it's not just that performance category. All things -- MIPS, Advanced APMs, Quality Payment Program in general. So, we'll talk about that a little bit later. Okay, so, let's move into the start of our discussion. I'm on Slide 4. I think this is always helpful to start with a bit of background, especially for those who are newer to the program. And, again, folks, we are trying to push these slides forward. So, if there's a bit of a delay, just bear with us. We're working out the kinks on our end, too. I'm just going to continue on. That way, we can get to the bulk of our discussion. But, anyway, I think it's helpful to start with a bit of background. So, the main takeaway with the Quality Payment Program is that this stems from the Medicare Access and CHIP Reauthorization Act of 2015. And this law required us, as in CMS, to implement the Quality Payment Program. So, this was really the program that's ultimately the solution to the problematic Sustainable Growth Rate formula. Of course, as a part of implementing this program, we've developed two tracks from which clinicians may participate. And we'll try to get that on-screen momentarily. But as we've been talking about, that's the Merit-based Incentive Payment System, also what we'll call MIPS throughout the remainder of our discussion today. And there's also the Advanced Alternative Payment Models track of the Quality Payment Program. And that's really for clinicians who are interested in earning additional incentives for taking on additional risk related to patient outcomes. There won't be a major focus on the Advanced APM side of the program today, but there are quite a few valuable resources available within the Quality Payment Program Resource Library if you are interested in this topic. So, again, folks, we are trying to work through some of our technical difficulties with getting the slides moving. So, this is the slide we were just talking about. It's also come to our attention that there is a bit of an audio challenge right now. So, we are going to work through that on the back end, and we'll try to get that resolved, as well. So, we're going to move on just temporarily to kind of keep things going. We're going to be on Slide 6 at this point. And I think -- there we go. Perfect. Oh, I think we're backtracking now. We want to go to Slide 6. So, as we work through that, we're going to talk just at a high level about the Merit-based Incentive Payment System. I do just want to give you all just a quick overview of MIPS. I think it's helpful context as we start talking about the performance categories, especially the Quality performance category. So, as I mentioned, we are on Slide 6. We're trying to get to that screen right now. But many of you may be familiar with where we started before the Quality Payment Program. A number of clinicians participated in what were known at that point as our legacy programs. So, we had the Physician Quality Reporting System, which we called PQRS, and that dealt with primarily quality. We had the Value-based Payment Modifier, which dealt with the measurement of quality and cost. And we also had the Medicare EHR Incentive Program for Eligible Professionals, which focused on the use of CEHRT. So,

now we -- Well, we were up to the screen. Now we've backtracked. But those were our legacy programs prior to the Quality Payment Program coming along. Those three programs have now been sunset, and we have combined elements of all of those three previous programs into what we now know as MIPS, the Merit-based Incentive Payment System. Yet even though all of those programs have sunsets, I believe there are a number of similarities that you'll notice within the current MIPS performance categories. So, for example -- Thank you. We're back on the right slide now. For example, some of the similarities with the Quality performance category, it's very similar to PQRS. And we'll talk about this category in-depth today. Cost is similar to the Value-based Modifier. And the Promoting Interoperability performance category is analogous to the EHR Incentive Program. So, that gives you a little bit of context around MIPS and how we've sunset these various legacy programs into MIPS. If we can move on to Slide 7. And we're going to try to move on to Slide 7, just to talk a little bit about the makeup of the Merit-based Incentive Payment System and our performance categories for Year 2. I think we have a little bit of a lag, again, so I'm just going to charge forward. I think we're on the right slide now. So, as you can see on-screen, MIPS is comprised of four performance categories. That's Quality, Cost, Improvement Activities, and Promoting Interoperability. All four of those performance categories add up to 100 final points. And I always like to call this out because we will assign a final score to each eligible clinician, and that final score can range from zero to 100 points. Now, of course, that final is compared to what we call the performance threshold, which is essentially the minimum amount of points a clinician must receive in order to avoid a negative payment adjustment. In comparing the final score to the performance threshold, it will help us determine if a clinician receives a positive, negative, or neutral payment adjustment in payment year 2020, which is the corresponding payment year to the 2018 performance period. And it's important to remember that we are on that two-year cycle. And we'll talk a little bit about the timeline in just a few moments. So, I'm going to jump into some of the participation basics under MIPS. I'm going to jump over to Slide 9, if we could, please. I want to start, again, kind of a refresher here, with MIPS, about just talking a little bit of the high level on who is included. Always think this is a nice, important refresher for us. So, on Slide 9, if we've got this on to that slide by this point, what we're talking about here are those who are included in MIPS. So, our MIPS eligible clinician types, as we like to call them. So, ultimately, between Year 1 and 2, we didn't change the types of clinicians who are eligible to participate in 2018. So, for those keeping track at home, that still includes physicians, physician assistants, nurse practitioners, and clinical nurse specialists, as well as certified registered nurse anesthetists. So, those are our five major clinician types for both Year 1 and Year 2 of the program. So, that's 2017 and 2018. One thing I do want to note, that I want to call out, you'll see on these slides, during our presentation today and then in following up afterward, we say, in certain places, "no change" or "change." That's simply to help you identify which policies have remained the same from Year 1 to Year 2, as well as to call out those policies that we may have changed. Just to give you a bit of insight, we tried as much as possible to maintain a gradual implementation as we went from Year 1 to 2. So, you'll see a lot of similarities. But we also wanted to make sure that you're all comfortable with the changes and know what those changes are, as we're working through Year 2, the 2018 performance period. So, jumping on and moving on to Slide 10, just want to talk a little bit at a high level about the low-volume threshold. So, we did change the low-volume threshold for 2018. It now includes MIPS eligible clinicians who are billing more than $90,000 a year in allowed charges for covered professional services, under

the Medicare Physician Fee Schedule, and -- that's the key word -- furnishing covering professional services to more than 200 Medicare beneficiaries a year. So, the key takeaway here is that you have to have both to be included in the program. So, you have to exceed the billing and the number of Medicare beneficiaries per year. I do want to call something out that I think is very important. So, in order for us to be compliant with the Bipartisan Budget Act of 2018, which passed a little bit earlier this year, it actually helps us continue our gradual implementation of the program. So, in order to be compliant, we've had to change the criteria for the low-volume threshold determination. So, as I mentioned and as you see on-screen, those determinations will only be made on covered professional services under the Physician Fee Schedule. This is different from the 2017 transition year, where the low-volume threshold determinations were made on all Medicare Part "B" charges. So please take note of that, that we are only basing these on allowed charges per covered professional services, under the Medicare Physician Fee Schedule for Performance Year 2, which is 2018. So, moving on to Slide 11, we talked a little bit about those who were included in the program at a fairly high level. Again, these are the folks who are exempt. And we haven't changed out exemption criteria. Again, that remains three major categories here. Those who are newly enrolled to Medicare are exempt. Those who are below the low-volume threshold. So, as we talked about earlier, you have to have both of those components to be included in MIPS for the performance period. If you don't have both of those, you will be excluded. And those who are significantly participating in Advanced APMs. So, those who are meeting the thresholds to become what we call a Qualifying APM Participant, or a QP. Those would be our three exemption criteria. And just a note for those who excluded, there is still the option to voluntarily participate. So, you'll receive performance feedback, but you will not receive a MIPS payment adjustment. I think this is helpful in the sense of gaining some experience for future program years for those who may be included in future years. So, always helpful to voluntarily participate if you have the means to do so and you're excluded from the program. So, moving on to Slide 12. Just quickly, at a high level, want to talk about the performance period for Year 2. I think this is important to call out. We did make a change to the performance periods for Year 2, as you can see on-screen, hopefully, for the Quality performance category. For Year 1, we did finalize it. It was a 90-day minimum. However, we did provide the full year, full 12 months, as an option. For Year 2, it is a full 12 months of reporting for Quality. And we'll talk a little bit more about this as we go through our discussion today. The other thing on-screen that I think is really important is the Cost performance category. So, for Year 1, that wasn't included. We didn't assess clinicians on Cost. It was feedback only. For Year 2, we are assessing clinicians on Cost, and it's a full 12 months. Improvement Activities and Promoting Interoperability will both remain the same, at a minimum of 90-day reporting.

So, on Slide 13, moving on, this is to kind of round out this section and move on. I think this is a good illustration of the two-year cycle that I mentioned earlier. Again, so, we are currently in the midst of the 2018 performance year. We're open. Clinicians have the opportunity to capture data and report on measures at this point. Beginning next year, 2019, we'll open the data-submission period, which many of you may be familiar with from this year. So, clinicians will be able to submit their data to us. We'll also have a feedback period, which is actually what we're in the midst of, right now, for Performance Year 1. And so, I think this is a good plug, if you haven't checked your Performance Feedback Report yet, please do so by signing in to qpp.cms.gov, using your EIDM credentials. And you'll be able

to access your performance feedback from 2017. And then, of course, we will get into the payment year, which is 2020 for the 2018 performance year, where clinicians will receive their MIPS payment adjustments. So, that's the two-year cycle for MIPS. I hope that was kind of helpful -- a helpful visualization -- just to kind of wrap your head around how all of the Merit-based Incentive Payment System works. So, at this point, I'm going to move on to Slide 14. We're going to start talking about the Quality performance category in some depth. And I'm going to turn it over to Dr. Dan Green to take you through this next section.

Thanks very much, Adam. Welcome, everybody. Glad you could dial in. Sorry -- I know this is kind of silly, because if you can't hear us, you can't hear my apology, but sorry that we're having audio problems and there's a little bit of a lag with the advancement of the slides. We are on Slide 15 now. And I know this is a review for most of you -- "What are Quality measures?" So, quality measures are metrics or tools that allow us to measure how a clinician is performing on a particular process of care, an outcome, or to get information on how their patients perceive the care that they receive. So, outcomes relate to one or more of the Quality goals. And the link to the outcomes would be either -- the categories -- I'm sorry -- for the measures would include effective care, safe care, efficient care, patient-centered care, equitable, and timely care intervention. And it's important for clinicians to actually measure the care that they're providing to their patient. As a physician, I can tell you, I never once went to work thinking I was only going to provide so-so care today. We all think we're providing the best care possible. And certainly, it's each clinician's intention to do so, but sometimes when we actually see the results of different metrics, we see we're not doing as well as we thought we were doing. And this can be helpful to help us improve quality, whether it's a process like what percentage of our patients that should be getting mammograms are getting mammograms, or whether it's an outcome in terms of, "How is my patient doing after having their total hip replacement done?" Are they actually showing not just that they have a total hip, but they're having decreased pain or increased function? So, these are important things for clinicians to be aware of, because, obviously, if we're doing all this surgery and our patients aren't doing any better, well, the question is "Why?" Or if we're missing a lot of patients that haven't had mammograms, we may be subjecting our patients to undue risk, in terms of development of breast disease. So, the Quality performance category, if you're a MIPS eligible clinician, has over 270 Quality measures in the 2018 performance period. Additionally, we have an opportunity to report through something called a Qualified Clinical Data Registry, and these are measures that are developed by, in some instances, by specialty societies, regional health collaboratives, large health institutions. And they can report, or request to be able to report, up to 30 of their own measures. And we have -- with the number of QCDRs that we have in the program, we have an additional over 800 measures that can be reported through a QCDR. Next slide, please. So, let's just briefly talk about the Quality measure classification. We have process measures, and those show what doctors and other clinicians do to maintain or improve the health of their patient. And so, a process measure was like the example I gave before, with mammography -- you did or didn't do the mammogram. Or influenza vaccination -- you gave the shot or you didn't give the shot. Or, again, the patient already had the shot, and it's ensuring that he or she already received the vaccination. So, these are process measures. Colonoscopy is another example of a process measure. And there are quite a few process measures in our program. Then the outcome measure is basically -- in some instances, are based off of processes that clinicians do. And

basically, it's the ultimate, "Well, how did the patient do, once they had all these process interventions or the condition was treated?" So, basically, if you treat a person for a particular condition, did he or she get better or not get worse, depending on what you're trying to treat? And so, what was the outcome of the intervention provided by the clinician? Now, in our program, we have what we call high-priority measures, and these are particular measures that we value a little bit more highly than other measures. Obviously, you can do everything right, but if you have a bad outcome, the patient, in the end, isn't really necessarily helped. So, you can imagine, obviously, the outcome is more important than kind of how you get there or the process, necessarily. At the same time, we know, in medicine -- antibiotics is a perfect example -- there's overuse of certain treatment modalities, be it medication -- in the case of antibiotics sometimes, be it overordering or overutilization of certain tests -- lab tests or bloodwork -- or radiographic or radiology measures sometimes are inappropriately used -- people are just doing repeated imaging studies when not indicated. The patient's experience of care is important. Did the patient feel like he or she was included in the decision-making and clearly understood all of his or her options to treat their particular ailment. Obviously, patient safety is important. Did the patient receive the right medication at the right time, through the right route? Efficiency measures also are considered high-priority measures. And then care coordination. And one of the things -- one of the main benefits of electronic health records, currently, but will get even better over time -- is the sharing of information. First of all, it will reduce the duplication of, or repetition of, certain tests, which, in the case of radiology tests, will reduce exposure of X-ray to the patient. It will reduce costs, but more importantly, it will be more convenient and allow for more timely care if we can coordinate the care that our patients receive with the specialists to whom we are referring these folks when needed. Next slide, please. All right, so, in 2018, in the MIPS program, Quality will comprise 50% of the final MIPS score. And you may recall, Adam had the four categories listed. And total possible points, if you will, were 100 points. And we're looking, ultimately, not just at the Quality category -- today we're focusing on Quality, of course -- but we're looking to see what the clinician's ultimate total score is, which would be the total points from the Quality section, the Improvement Activity section, Cost section, and the Interoperability section. So, to participate, you have to submit collected data for at least six months for the 12-month reporting period. I'm sorry. For six months -- I meant six measures for the 12-month performance period. Excuse me. So, the performance period is January 1 through December 31 of 2018. And again, we would look for clinicians to report on six measures, one of which should be an outcome measure. Or if there is not an outcome measure that pertains to that clinician's scope of practice, they should select a high-priority measure, and we just reviewed those on the previous slide. A clinician could also select a specialty specific set of measures, and we have those measures for, I believe, over 20 different specialties. Some include cardiology, dentistry, emergency medicine, general surgery. And there are instances where some of these specialty sets have fewer than six measures. So, if a clinician reports on all of the measures in the specialty set when there are fewer than six measures, if they report and exceed our reporting threshold of 60% of the eligible patients, they would be satisfactory reporting. You can review the 2018 Quality measures, including the specialty sets, by visiting the "Explore Measures" section of our Quality Payment Program website. And the link for that will be actually in the slides. So, that's a -- Well, actually, we've got one more slide. I'm sorry. We're on 18 now. Do want to make one other mention here of the Web Interface. So, the Web

Interface is designed for groups and Virtual Groups with 25 or more clinicians who are participating in MIPS and who register and choose to submit data using the Web Interface. Now there are 15 required Quality measures. Clinicians have to report for the full-year patients. And what happens is, we select patients for these groups to report, and we send them a list of the patients, for example, that had diabetes. And they have to report on the patients that we send them. And they have to report on over 200 patients for each of these 15 Quality measures. I believe the number is 248. And in certain instances -- if the patient dies, the patients left the practice -- they can skip a patient and then they go on to the next patient in the sequence. But, all in all, when all is said and done, assuming they have enough patients, we do ask that they report on the, I believe, 248 patients. So, interesting concept in that the patients are provided to you for you to be able to report. It is, again, another optional method for these groups to participate. Do want to make one last mention about bonus points. We do offer bonus points for some of the Quality metrics. If a clinician submits two or more outcome or high-priority measures, they will receive bonus points. Now, the first outcome measure, since it's a requirement, you don't get a bonus point for that. But if you submit two outcome measures -- again, or two high-priority measures -- while your first one is required, you will receive a bonus point for your second one. There's also an opportunity to earn additional points for reporting through end-to-end electronic reporting. So, if you're using a registry or Qualified Clinical Data Registry to submit your data, and they're able to get all of the data from your certified electronic health record, without any human intervention in between, collect that data, calculate the results, and then send it to us. They can indicate end-to-end electronic reporting for that measure, and the clinician may be eligible for an additional bonus point. So, I believe that is it for my part of the presentation. I thank you for your attention. And I will turn it over to Dr. David Nilasena for the scoring portion.

Okay, thanks, Dan. And so, I'll be covering some details about how the Quality category will be scored in Year 2 of QPP. So, in this slide, we have kind of a recap of what you just heard. So, the requirements for the category -- generally, you pick six of over 270 available MIPS measures to report. One of those measures needs to be an outcome measure, or if an outcome measure is not available, another high-priority measure. You can report the CAHPS survey as one of your MIPS measures, and that would count as one of your six. It's also a high-priority measure. Or you can, instead of picking six measures, you could report an entire specialty measure set. You could use the CMS Web Interface that Dan just talked about, which has 15 quality measures. Or you could work with a QCDR, a Qualified Clinical Data Registry, and report six of their measures. One of them would need to also be an outcome measure or a high-priority measure. And then, if you are in a group or Virtual Group, and you have 16 or more clinicians, then we may calculate a claims-based measure called the all-cause readmission measure. So, if you meet the case minimum of 200 patients for that measure, then we would score that measure for your group or your Virtual Group, and that would contribute to your Quality category score. Next slide. All right, so, for each of the measures that are submitted or scored, you will receive between 3 and 10 points, based on performance against established benchmarks. If you fail to submit a required measure, you will get zero points for that measure. And as Dan mentioned, we do have bonus points available if you submit more than the one required outcome or high-priority measure, or if you use end-to-end electronic reporting in your submission of your measures. For both of these two bonus-point types, you're capped at 10%

of the total available points in the Quality category. So, you could get up to 10% for end-to-end electronic reporting and an additional up to 10% for high-priority and outcome measures. We'll also, for Year 2, be doing something different in scoring improvement in the category, and I'll be talking in some more detail about that in a few slides. Next slide. All right, so, I mentioned you generally will get between 3 and 10 points for a measure, based on comparing it to benchmarks. If a measure has a benchmark -- Sorry -- if a measure does not have a benchmark or it does not meet the case minimum, which is generally 20 cases for the measure, then we would not be able to score that measure against a benchmark, and you would get just a flat 3 points for submitting that measure. You must also meet the data completeness requirements for the measure, which, for Year 2, is 60% of the available cases for that measure. If you don't meet that data completeness, you would only receive 1 point for submitting the measure. The exception to that is, if you are in a small practice of 15 or fewer clinicians, we would still give you 3 points for the measure, similar to what we did in Year 1, and that is taking into consideration some of the unique challenges of small practices. Each data submission mechanism requires a minimum amount of data to meet data completeness requirements. And so, for example, if a registry is in QCDRs and for electronic health records, we look at All-Payer data, and you have to get 60% of the cases using All-Payer data. For claims-based submission, we only look at Medicare cases. And then, for things like CAHPS and the Web Interface, they have special sampling requirements that have to be met, in order to meet the data completeness for those two. Next slide. All right, so, we talked about benchmarks. For the Quality category for 2018, we established benchmarks using data that was derived from the Physician Quality Reporting System, or PQRS, from 2016. So, that's two years prior to the current performance period. So, we did this for all of the mechanisms that were available under PQRS, so that includes qualified registries, QCDRs, claims-based measures, and EHR. So, for all of those where we potentially had PQRS data, we attempt to create historical benchmarks. And we would use those for scoring in the Quality category. For the CAHPS measure, the patient experience survey measure, for the first year of the program, we were able to use historical CAHPS data from the 2015 CAHPS for PQRS and the CAHPS for ACO surveys. However, for Year 2, there have been some changes to the CAHPS survey, and so we are unable to create a historical benchmark for Year 2. So, we will be using performance period data for Year 2 to establish those benchmarks for the CAHPS survey, using 2018 data. For the CMS Web Interface, according to our final rule policy, we will continue to use the benchmarks that have been established for the Shared Savings Program, in order to take advantage of the overlap and the synergies between those two programs. Next slide. All right, so, we create separate benchmarks for each unique submission mechanism. And so, this is basically measures that have different specifications for different submitters. They would each get their own unique benchmarks. So, for claims measures, they have one set of benchmarks. For QCDRs and registries, they have a second set of benchmarks. For electronic health records and eCQMs, they have their own benchmark. And this is to take into consideration some differences in the specifications between those submission types. In creating the benchmarks, we use data from all reporters, either individuals or groups. So, in PQRS, we combine all the individual and group data and use those to create the benchmarks. And we need to have at least 20 reporters for the measure, in order to create a benchmark that is usable for scoring. And these 20 reporters have to meet the data completeness criteria, the case minimum, and also have a performance rate greater than zero before we would use their data. The reason this is important is that if a measure does not have an established benchmark, the most you can get for that measure is 3

points, regardless of your performance. Next slide. All right, so, we use the benchmarks to convert each measure performance rate into points. So, we take each measure you submit, and we compare it, based on the submission mechanism you're using, to the specific benchmark created for that mechanism. We have a decile scoring system, so we create decile benchmarks for each measure, and then we compare your performance to those deciles, and that gets you a point between -- gets you a score -- between 3 and 10 points for each measure. Now for Year 2, we have a few measures where the scoring is slightly different because they have been identified as extremely topped out measures. These are measures that have uniform performance near the maximum possible score, and there's really very little, if any, variation among the scores of those who submitted those measures. So, we have six measures that have been identified as extremely topped out for Year 2, and the most that they could get is 7 points under our scoring system. But, basically, for all the other measures, the points you earn are based on where your performance falls within the decile range that we've established for the benchmarks. Next slide. All right, and these are the six extremely topped out measures that we identified for Year 2. These will be capped at 7 points for 2018. And you can see the six measures listed on this slide. So, if you submit one of these measures, even if your score fell within the top three deciles, the most you could get is 7 points for the measure. If you fell below that, you could get between 3 and 7 points. Next slide. All right, the other component to the category score is the denominator that we use. And this is basically the total available points, based on the number of measures that you are expected to submit. So, for most submitters, since you're required to have six measures, and the most you can get for each measure is 10 points, then your category denominator would be 60 points. If you happen to be in a group or Virtual Group and we are able to calculate the all-cause readmission measure, that would add one measure to your denominator, and that would get you up to 70 points. And then, for the Web Interface, since they have a unique fixed set of measures, actually their maximum denominator, or their expected denominator, is 110 for 11 measures that we score. If they are scored on the readmission measure in addition, that would bump them up to 120 points for the denominator. And then, for some groups, if they also submitted the CAHPS survey, they could actually get up to 130 points. So, we basically determine how many measures that you are trying to submit or required to submit, multiply that by 10, and that gets you your denominator for the category. For those who submit fewer than six measures, we do have a process where we look to see if there were other measures that you should have submitted, based on the clinical relation to the ones you did submit. And it's possible that your denominator could be reduced if you succeed in that validation process. Next slide. All right, there is a possibility that there would be no measures relevant to your practice or available for you to report, and in that case, we could not give you a score for the Quality category. We think this will be exceedingly rare that this happens, but if it does happen, then the Quality category would be reweighted to 0% of your final score and the points would be redistributed such that the Improvement Activities and the Promoting Interoperability category would each account for 45% of your total score. We would leave the Cost category at 10% of your score. But, again, this will be an incredibly rare situation. Probably the only way that this would happen is if you had a unique hardship exemption from a natural disaster or something like that, where you weren't able to submit Quality. Next slide. All right, we talked about the bonus points a little while ago. And, again, there are two types. One is the end-to-end reporting bonus. And you can get this bonus if you submit the measure directly from your certified EHR, using a process that involves no manual intervention. And so, it basically makes it from your EHR

to CMS, using only verifiable electronic means. This could be through a third party, such as a qualified registry or a QCDR. It could be directly from your certified EHR uploaded to CMS. But, basically, as long as there's no manual human intervention, you could qualify for these bonus points. And you can get one bonus point per measure submitted under these requirements. You can also get bonus points for submitting additional outcome or high-priority measures beyond the one required outcome measure. For each additional outcome or patient experience measure, you can get 2 bonus points. And for all other high-priority measures, you can get 1 bonus point. Now, both of these types, as I mentioned before, are capped at 10% of the category denominator. So, generally, as I mentioned on the earlier slide, if your denominator is 60 points for six measures, then you could only get a maximum of 6 bonus points of each of these types. Next slide. All right, so, a new thing in scoring for the Quality category for Year 2 is scoring based on improvement. So, we're doing this only for the Quality category in 2018. And we will be looking at your score in 2018 compared to 2017, which is the only other year of QPP that we have to compare to. You do need to participate fully in the Quality performance category for this year, and that means submitting six measures for a complete specialty set and at least one in one outcome measure. Or if an outcome measure is not available, another high-priority measure. And you also need to meet the data completeness for the measures that you submit, as that would constitute participating fully in the Quality category. You also need to be submitting data under the same identifier for Year 1 and Year 2, or at least an identifier that we can link to another identifier in the two years, so that we can make the comparison. Next slide. So, to calculate improvement, we're doing it at the category level. And we will look at only the achievement points that you garnered for the Quality category in the two years. So, this means we won't be taking into account the bonus points that you may have earned for the Quality category. So, we will take your achievement points, and the increase in achievement points between Year 1 and Year 2, and we will divide that by the achievement what you had in Year 1, giving you sort of a relative improvement over Year 1, and then we'll multiply that by 10% to get your improvement percent score. Next slide. All right, so, this slide just gives an example of the way that this improvement scoring will work. So, in this case, a clinician submitted six measures using CEHRT. She earned 33 measure achievement points and 6 measure bonus points for end-to-end reporting. And in the transition year, the same eligible clinician earned 25 measure achievement points and 2 measure bonus points for reporting an additional outcome measure. And just as a reminder, for outcome and patient experience measures, you get 2 bonus points. For the other types of high-priority measures, you just get 1. So, in this example for 2017, her Quality Payment Category achievement percent score was 42%, which is 25 points divided by the 60 possible points. For Year 2, the score was 55%, which was 33 achievement points divided by the 60 possible points. The increase from Year 1 to Year 2, you get by subtracting 55% minus 42%. That's 13%. And then you divide that by the achievement score in Year 1, which was 42%, and that gets you, after you take 10%, a total of 3.1%, and that would be the improvement percent score that would be added to their final score. If we're not able to compare data between the two performance periods, or if there is no improvements -- if you went down -- then your improvement score would be zero, so we won't give you a negative score. Next slide. Now, as most of you know, in Year 1, we had a transition year policy called Pick Your Pace, and so the submission requirements, particularly for Quality, were much lower than we have in Year 2. And so, we didn't want to sort of overly weight the improvement for those who may have been participating under Pick Your Pace. And so, in our Year 2 rule, we finalized that if your Year 1 achievement

score was less than 30%, we would sort of treat it as if it was 30% for the purposes of calculating improvement. And we did this by figuring out, or determining, the minimum score you would get if you had submitted all six measures and met data completeness in Year 1, regardless of your performance, and that would be 30%. So, this allows you to still get a score on improvement, even if you were doing Pick Your Pace, but it doesn't sort of overly weight the amount of improvement that we observed for your data. Now, again, the improvement percent score cannot be negative and it is capped at 10% of your total score. Next slide. Alright, so, once we have all of the things we've just talked about, we will take your total measure achievement points, we will add any measure bonus points that you got from end-to-end reporting or high-priority measures, we'll divide that by the total available measure achievement points -- again, that's normally 60 or 70 -- and then we will add to that the improvement percent score that we just talked about. And those together will give you your Quality performance category percent score. Next slide. And this just continues the example we were just talking about. So, the clinician had six measures in 2018, using CEHRT. And so, we already talked about her measure achievement points and the improvement percent score. So, since her Quality performance category percent score was 68.1% -- and this is taking into account not only her achievement points, but also the bonus points that she garnered -- and then we add to that the 3.1% for the improvement percent score, that gets her a total of 68.1%. So, she had 65% for the submitted measures and bonus points, plus 3.1% for the improvement percent score, for a total for the category of 68.1%. We would then multiply that by the weight for the category, which is 50% in Year 2, and so the total number of points contributing to the final score would be 34.05 points. Next slide.

Alright.

Okay, so that's the end of the scoring. And I think I'll now turn it over to Sophia to continue on.

Thanks, Dr. Nilasena. Okay, let's move to Slide 37, please. Alright, as you prepare to... As you prepare for Quality reporting, we suggest that you visit the QPP website to check your participation status to see if you're eligible for MIPS. In addition to that, we strongly suggest that you utilize the Explore Measures tool on the QPP website to see what measures are available and out there for you to report. In addition to the 270-plus QPP MIPS Quality measures we have in MIPS, there is additional QCDR measures that are available for reporting, should you choose to work through a QCDR. Those QCDR measures on the list of approved QCDRs are available, as well, through the QPP Resource Library. So, we suggest you also utilize those resource tools to determine what measures you would report on for Quality. Next slide, please. All right, as you are collecting your measures, as I believe Dr. Green and Dr. Nilasena have emphasized, please make sure you take a look at the measure specifications, which are updated to reflect the performance period. And we ask that you use that as you narrow down your selection of measures that you choose from. The measure specifications will describe each of the measures and outline the specific data elements that are required of the measure for reporting. Those specific measure specifications are located on the QPP resource website and can be downloaded for your reference. We strongly suggest that you have started already to collect your data for the 2018 performance period. You should have started to collect this data starting on January 1, since 2018 requires a full year of performance data, in order to meet the data completeness requirements and in order to possibly receive a higher positive payment adjustment. And a

reminder with regard to the submission period -- the submission period for the 2018 performance period will begin on January 1, 2019, and will end on April 2, 2019. Now, if you're submitting Quality data via claims, your claims must be processed via MACs by March 2nd of 2019. There will be an eight-week submission period between January 2nd and March 31st for the CMS Web Interface, should you choose to use that as your reporting method. Right now, you can sign in to the QPP website to review your data throughout the performance period. You do need to sign up for an EIDM account -- an Enterprise Identity Data Management account. There are instructions as to how to create one. You would follow the portal website there to create that EIDM account. Next slide, please. And I'll turn the call over to Adam for additional information.

Okay, thank you, Sophia, and thank you to Dr. Green, Dr. Nilasena. Before moving on, I want to again apologize for the technical difficulties that we experienced today. Thank you for those who stuck with us. We will have the recording and slide deck available in the next two-ish weeks for additional review, and we'll make sure that we get these resources out to you. I'm going to move fairly quickly through the remaining sections so that we can get to your questions. We did extend the call a bit so we can take some of those questions, so please hang on with us for a few more minutes. I'm on Slide 40, so just quickly, again, just to touch on some of the resources we have available. Sophia mentioned the Explore Measures page on qpp.cms.gov. I did see a lot of questions in the chat on where to find measures, as well as those that are denoted high-priority or outcome. So please take a look at the Explore Measures feature on qpp.cms.gov. You'll find all of that information there. We also have a number of resources in our resource library on cms.gov, fact sheets specific to the Quality performance category, our measure specifications, our supporting documentation guide, the Quality benchmarks, all types of supporting documentation related to the CMS web interface, QCDR Measure Specifications, so on and so forth. I did also see quite a few questions on improvement scoring. That is also contained within the Quality performance category fact sheet, so if you are interested in the Quality improvement scoring, please take a look at that fact sheet because there is some very good information within. So, if we move on to the next slide, please, just to note quickly that we do have free resources available to help you with the Quality Payment Program. These are not just specific to the Quality performance category, but all of the Quality Payment Program. So, again, specialized and customized assistance depending on your practice size, your preferences, whether you're interested in transitioning into an Alternative Payment Model. There are all types of forms of support available to you, and it's all at absolutely no cost. I also encourage you to, again, visit qpp.cms.gov for additional information, and of course, if you do have a question, please feel free to reach out to our Quality Payment Program service center. You can see in the bottom right-hand quadrant you can either contact the service center via phone or through e-mail, qpp@cms.hhs.gov, for additional help and support. Moving on to Slide 42. I just wanted to note this is kind of circling back from earlier where we were talking about our proposals for Year 3 of the Quality Payment Program. Our proposals are available on the federal register, so I encourage you, if you are interested in those proposals, to take a look at them. We are also in the official comment submission period, so we do have a 60-day comment period on all of our proposals that's open right now. Please note the date, September 10, 2018. That is when our comment period closes. So, if you are interested in submitting comment to us on our Year 3 proposals, there are a number of ways to do so. They are listed on screen. There's also official guidance included in the federal register, so please take a look at

those proposals if you are interested in helping us shape the future years of the Quality Payment Program. Okay, with that, I think we're going to jump into our Q&A session. As I mentioned, we did extend a bit, so I'm going to -- perfect. Slide 44. We did extend a bit to take some calls from you also. If I could turn it over to the moderator just to walk through how to get in line into the phone line, and then we'll circle back in just a minute. Moderator?

At this time, if you would like to ask a question, you may do so by dialing in at 1-866-452-7887. When prompted, enter ID 9984704. If at this time you're already online and you would like to ask a question, please press "star" then number 1 on your telephone keypad. Again, that's "star," then the number 1 on your telephone keypad to ask your question. Our first question comes from the line of Lisa Gall.

Hi. Thank you for taking my call and question. I have a question regarding multiple strata measures, Quality measures, and if and when the guidance will be available on how to score Quality Measures with multiple answers. Thank you.

Hi, this is David. Yeah, so similar to Year 1, we will be posting the benchmarks in which strata we will be using for the benchmarks for those measures, and that will be the one that we use for the actual scoring of the measure. I'm not sure the timing of that, when that will be posted, but we are planning to post that document similar to what we did for Year 1.

Yeah, absolutely, and just to kind of piggyback on that, David, we are working through that right now and we'll make sure to announce and update through the QPP listserv. So again, a good plug. If you haven't done so already, please join our listerv at qpp.cms.gov.

Again, if you would like to ask a question, please press "star" then the number 1 on your telephone keypad. Again, that's "star" 1 to ask your question. Our next question comes from the line of Marie Hooper.

Hi, Marie.

Hi, thank you for taking my call, my question. I'm confused a bit regarding when I'm reading some of the Q&As. ACOs are expected for the category, and our submission is -- we are to have a patient satisfaction with a qualified vendor. If a practice is not part of an ACO in understanding the quality session of practice or one of the virtual groups, then can go, and I'm assuming use a qualified vendor by CMS to do their own patient satisfaction survey, correct? Because unless they're part of the ACO, Medicare wouldn't have a way to tie them to the ACO patient satisfaction measure, and I was confused by the answer on the Q&A.

This is Claudia from CMS, and David, please feel free to jump in on this. So, for ACO participation, you must be on our ACO certified participant list for the performance year for those groups to receive not only the MIPS APM scoring standard, but also the ACO reported data to be scored under the Quality category, which would be the web interface measures and the CAHPS for ACO summary survey measures. So, that is correct that if they are not on -- if a practice is not on your certified ACO participant list for the year, then it is not going to be seen as part of the ACO.

Yeah, and this is David, maybe just to add to that. So, for Year 2 for ACOs, the CAHPS survey is required. For groups that are not in an ACO under regular MIPS, it's an option. They don't have to use CAHPS, but if they register by the deadline, which was the end of June, then they could use the CAHPS measure as one of their Quality category measures, and that would be done through a CMS certified vendor. You're not allowed to sort of use your own survey or your own vendor. That has to be the approved CAHPS survey and approved CAHPS vendor. But other groups outside of an ACO do have that option as long as they register by the deadline.

Very good. Thank you for that clarification.

Thank you.

Your next question is from Debbie.

Hi, Debbie.

Hi. Thank you for taking my question. My question is the new tobacco use number 226 where it has the three criteria that you have to meet. So, within our EHR, you've got three denominators, three numerators within a tobacco use. And the benchmarks, you only have -- there's just one set of the benchmarks. So how is that going to be measured for this year?

Yeah, this is David again. And this kind of relates to the first question. For multi-strata measures, we will work with the measure developer to select the strata that is sort of the one we will use for benchmarking and scoring, and we will make that information available through a posting on our QPP website.

But David.

Yeah, go ahead.

Sorry to interrupt. We will be using the second strata, which is a strata which is basically -- it'll be the patients that do answer affirmatively, aka, they do smoke, and the percentage of those that were counseled to quit. So, it is a new element, if you will, in the measure. I suspect we won't have a benchmark for that unless one can be calculated in the "real time" benchmarks.

So, is it going to be based on -- like last year, the measure last year and the benchmark that we have now?

Well, so David, please, you're the expert with benchmarks, so please correct me if I'm wrong, but this should be an easy measure to have at least 20 clinicians reporting on more than 20 instances. So, I would imagine we would be able to calculate a new benchmark for this performance period, but please correct me if I misspoke.

No, that's right. So, I didn't mention it in my section, but for those measures where we don't have sufficient data to create a historical benchmark, we will use data from the performance period of 2018 to try to create a benchmark if there are at least 20 submitters. And like Dan mentioned, it's likely that this measure will have more than enough data to create that. So, you won't know the benchmarks until after the performance

period, but it's likely you will have a benchmark so you can get up to 10 points on the measure.

Okay. But in the meantime, trying to monitor how a client -- how a provider is doing a group, it's going to be hard to tell since we don't really have the benchmark to compare against. I mean, you have three criteria. Let's say one is 70%, one's 90%, one's 89%. You don't know where you're comparing against the benchmark, so we won't know until the end of the year is what you're saying?

Yeah, that's correct.

Okay.

Your next question is from Margaret Krengel.

Hello?

Your line's open, Margaret.

Oh, hey. This is Marge. I'm actually an occupational therapist and I'm going to be presenting on this at our annual conference for the American Society of Hand Therapy. And I'm not going to go into great detail, but I want to make sure our physical therapists and occupational therapists qualify as participants in this at this point, or are we still kind of not there yet? Hello?

Yep, yep. Hi, this is David. I thought certainly somebody else would jump in on this one. Yeah, so for Year 1 and Year 2, occupational therapists and physical therapists are not MIPS eligible clinicians. We have proposed them to be added for Year 3, and we're currently in the comment period for that proposed rule. Comments are due by September 10th. But they are the two that we are considering adding.

Okay, so we did the PQRS at that time when it was available and required for our documentation, and I see that there's at least six qualifying measurements and questions that we need to be able to answer out of the several hundred. So many of them will not apply to our profession, particularly surgical things that we do, or cardiovascular things. So, I'm wondering, through the comments that you may be receiving from our various organizations, are we going to bring that down into something that's more practical for us to do, or are we going to stick with the PQRS questions, which were once used as part of our evaluation process?

So, this is Adam Richards. I'm just going to jump in here. Since we are in an open comment period, we can't necessarily comment on that. Again, when all the comments come in, we will kind of review everything that is submitted and take a look at our proposals at that point, but unfortunately right now, we can't comment until after the comment period is closed.

So, at this point, we can comment and say, "These are the Quality measure or outcome measures that we use that have been systematically used by the therapists in this profession," particularly in hand therapy, and that would be a comment that you would receive and review so that maybe we could get something in there that we've actually utilized? Is that safe to say that?

Yep, absolutely. We encourage you to submit those comments to us, and again, that information is available. I think it was on Slide 42 on how to get those comments over to us, but yes, we'd love to hear from you.

Okay, I've written that information down. Okay, well, I appreciate that. So, the answer is right now, we are not, but possibly in the third year, we will be involved. Okay. Well, thank you very much for your time. I appreciate this.

Okay, thank you.

And folks, we are past time, so we do have to wrap things up. A special thank you to our subject matter experts for being here with us today, and certainly a big thank you to all who joined and participated in today's webinar. We appreciated all the questions, certainly through the Q&A and through the phone line, and we also appreciate you kind of staying with us through our technical difficulties. We appreciate your interest in this topic, and as well as the Quality Payment Program. So again, we'll post the recording of this webinar and slide deck shortly, so please, if you haven't done so already, sign up for the Quality Payment Program listerv on qpp.cms.gov, and we'll give you an update when all of these resources are available. So again, we appreciate your time today. Thank you all so much, and we'll talk to you all again soon. Take care.

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