

# 2019 Qualified Clinical Data Registry (QCDR) Measure Development Handbook

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## Introduction

Qualified Clinical Data Registries (QCDRs) have the opportunity to submit QCDR measures for consideration during the self-nomination period. All submitted QCDR measures are reviewed by CMS for potential inclusion as QCDR measures in the Merit-based Incentive Payment System (MIPS) program. This document provides guidance and suggestions to QCDR measure developers on QCDR measure structure, analytics and types as well as a QCDR measure development check list, resources for QCDR measure development and definitions used by CMS to communicate QCDR measure review decisions.

**Disclaimer:** This QCDR Measurement Development Handbook is subject to change based upon what is finalized for inclusion and removal in the CY 2019 Physician Fee Schedule proposed rule for the Quality Payment Program.

## QCDR Measure Development Checklist

Prior to nominating a QCDR measure, the following checklist should be reviewed to increase the likelihood of approval of the QCDR measure. CMS and their contractors use a similar checklist during the QCDR measure review process.

### QCDR measures should:

- Be clinically relevant and evidence based (summary of current clinical guidelines).
- Include evidence of a performance gap and/or eligible clinician performance variation.
- Include requests made by CMS during the previous program year (Provisionally Approved Measures) or documentation of why the request is not clinically appropriate.
- Focus on a quality action instead of documentation.
- Focus on an outcome rather than a clinical process.
- Preferably fall within clinical workflows so data collection is not burdensome.
- Address one or more meaningful measure areas and National Quality Strategy domains.
- Be fully developed and not just in the concept development phase.
- Include accurate measure classification (inverse, risk-adjusted, ratio, proportional, or continuous variable).
- Include proper spelling and grammar throughout the specification.
- If approved for previous performance period, identify changes to the specification. Measures that undergo substantive changes will have a new QCDR measure ID assigned. Substantive changes alter the intent of the QCDR measure and may impact the performance score. In this instance, QCDR measure data would not be comparable across performance periods.

### QCDR measures should not:

- Duplicate an existing or proposed MIPS quality measure.
- Duplicate an existing QCDR measure (unless the new measure is a dramatic improvement over the existing measure).

- Duplicate a retired PQRS measure.
- Split a single or related clinical process or outcome into several QCDR measures. *For example: The results of 3 different tests are required for a standard of care. Each test should not be a single measure, but all included in one measure.*
- Have the potential of unintended consequences. *For example: the measure disqualifies a patient from receiving oxygen therapy or other comfort measures.*
- Focus on the elimination of serious, preventable, and costly medical errors - “Never Events.” *For example: Surgery performed on the wrong patient or a fire in the operating room.*

## QCDR Measure Development

This section provides information on methods of constructing or structuring measures, the parts of a measure needed for analytics, methods of measure analytics and measure types.

### Measure Specification Components

Critical to the construction of a quality measure is the identification of the measure’s target population and numerator, including any applicable exclusions or exceptions. The measure specifications should precisely define the measure’s denominator, numerator, denominator or numerator exclusions, and denominator exceptions. The following components are used to create quality measures and include the analytic attributes used to calculate a measure.

**Measure Description:** This is a high-level summary of the target population and the quality action. The measure description should briefly describe the type of score (e.g., percentage, percentage rate, proportion, number), the target population, and the focus of measurement. *For example, “Percentage of patients 65 years of age and older who were screened for future fall risk during the performance period.”*

- **Denominator statement:** The lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator statement must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age ranges, condition or diagnosis, procedures, setting, and timeframe (when applicable) or other qualifying events. *For example, “Patients aged 18 through 75 years with a diagnosis of diabetes.”*
- **Denominator exclusion:** Criteria that remove the encounter/patient from the denominator before determining if the quality action was completed. Denominator exclusions are more absolute where the quality action is not applicable and would not be considered for the population. *For example, “Patients with bilateral lower extremity amputations would be listed as a denominator exclusion for a measure requiring foot exams.”*
  - For registry data submissions, denominator exclusions are not considered denominator eligible and should not be included in the data completeness and performance rate calculations.



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- **Numerator statement:** The upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator statement must clearly detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (patients who received a particular service or clinicians that completed a specific outcome/process). *For example, "Patients whose most recent HbA1c level resulted during the performance period is well controlled."*
- **Numerator exclusion:** Applies to ratio and inverse proportion measures to define instances that should not be included in the numerator data.
  - *Ratio Example: If the number of central line blood stream infections per 1,000 catheter days were to exclude infections with a specific bacterium, that bacterium would be listed as a numerator exclusion.*
- **Denominator exception:** Used only in proportion measures to remove a patient, procedure, or unit of measurement from the denominator only if the numerator criteria are not met. This permits the exercise of clinical judgment and implies that the treatment was at least considered for each eligible patient. Denominator exceptions may be classified into medical, patient or system reasons.

## Measure Structure

There are several methods for structuring quality measures. The following are common measure structures with examples for constructing a more robust measure through creation of a composite or stratified quality measure.

- **Simple measure structure (non-stratified/non-composite measure):** This is the most common measure structure within MIPS. It contains a single target population with a single numerator. This produces one performance rate.
  - **MIPS quality measure example:** Quality ID #130 (NQF 0419): Documentation of Current Medications in the Medical Record.
- **Composite measure:** A combination of two or more individual performance measures, each of which individually reflects quality of care, into a single performance measure with a single score. Appropriate denominator exceptions should be included for the quality action being measured. Composite measures promote a high standard of excellence of comprehensive care.
  - *Composite measures can provide a broader assessment of quality care.*  
Examples:
    - All-or-none - Only those patients who received all indicated quality actions will be considered numerator compliant.



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- Any-or-none - Similar to all-or-none but is used for events that should not occur. A patient is counted as failing if he or she experiences at least one adverse outcome from a list of two or more adverse outcomes.
  - Linear combinations – May be a simple average or a weighted average of individual measure scores.
  - Regression-based composite - The weight assigned to each item is directly related to its reliability and the strength of its association with the gold standard endpoint.
- **MIPS quality measure example (All-or-none):** Quality ID #441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal control); Quality ID #394: Immunizations for Adolescents.
- **Multi-strata measure:** Multiple denominator options to reduce the number of measures addressing a similar condition, quality action or topic. Reasons for stratification include but not limited to: age groupings, specific condition, specific location, different complications of the same procedure, and vaccinations.
  - **Measure construction:**
    - Each denominator (patient population) can be limited to the appropriate patient population.
    - Each numerator (quality action) can be adjusted for the denominator eligible patient population.
    - **MIPS quality measure example:** Quality ID #7: Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%).
- **Multiple performance rate calculation:** CMS requires one performance rate be identified that will be submitted for scoring purposes. QCDRs still have the opportunity to provide stratified performance data to the eligible clinicians to provide meaningful feedback. CMS will utilize the overall or indicated performance rate for the scoring of quality measures. Options to determine the scored performance rate include but not limited to:
  - Weighted Average:
    - Add the numerator counts of each sub-measure and divide by the sum of the denominator counts of each sub-measure.
    - **MIPS quality measure example:** Quality ID #7: Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%).
  - Simple Average:
    - Add the percentages for each sub-measure and divide by the total number of component sub-measures.
    - **MIPS quality measure example:** Quality ID #9: Anti-Depressant Medication Management.



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- Indicated Performance Rate
  - Identify one of the performance rates that should be used for benchmarking/scoring purposes. This is often the more robust quality action.
  - **MIPS quality measure example:** Quality ID #238: Use of High-Risk Medications in the Elderly.

## Measure Types

Measures can be classified into the following measure types:

- **Process Measure:** A measure that focuses on a process which may lead to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.
  - Process measures are supported by evidence that the clinical process—that is the focus of the measure—has led to improved outcomes.
  - CMS recognizes that process measures contribute to improving the clinical process to achieve the clinical outcome, but the intent is to prioritize outcome-based measures and move away from process based measures.
  - **MIPS quality measure example:** Quality ID #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.
- **Outcome Measure:** A measure that assesses the results of healthcare that are experienced by patients: clinical events, recovery and health status, experiences in the health system, and efficiency/cost.
  - **MIPS quality measure example:** Quality ID #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery.
- **Intermediate Outcome Measure:** A measure that assesses the most recent assessment of quantity, quality, and consistency of the body of evidence that the measured intermediate clinical outcome leads to a desired health outcome.
  - An intermediate outcome is a (measured) change in physiologic state that leads to a longer-term health outcome.
  - **MIPS quality measure example:** Quality ID #236: Controlling High Blood Pressure.
- **Patient Reported Outcome (PRO) Measure:** A type of outcome measure where the patient directly self-reports the status of a health condition, health behavior, or experience with healthcare without interpretation of the patient's response by a clinician or anyone else.
  - **MIPS quality measure example:** Patient-Reported Pain and Function Improvement after one-year post <procedure/treatment>.
    - Numerator: Patients whose pain or function scores improved by at least 10% (e.g., 10 points on a 100-point scale) after one year.



- Measures that only capture the distribution of survey assessments will not be approved.
  - PRO measures should require positive outcome (Improved pain score, Improved functional status, Patients are satisfied).
- **Efficiency and Cost/Resource Use:** Measures of cost and resource use can be used to assess the variability of the cost of healthcare and to direct efforts to make healthcare more affordable.
  - **MIPS quality measure example:** Quality ID #102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.
- **Patient Engagement/Experience:** Patient engagement measures the involvement and strengthens person and family engagement as partners in their healthcare. The measure should address the experience of each person and their family and the extent to which they are engaged as partners in their care.
  - **MIPS quality measure example:** Quality ID #321: CAHPS for MIPS Clinician/Group Survey.
- **Structure:** Measures healthcare organizations or clinicians on a use of a feature as it relates to the capacity to provide high-quality healthcare. These measures require evidence that the specific structural elements are linked to improved care and improved health outcomes.
  - **MIPS quality measure example:** Quality ID #225: Radiology: Reminder System for Screening Mammograms.

## Measure Analytics

Measures can be described as proportion, continuous variable, or ratio depending upon the methodology used to analyze the measure. The construction of the patient population and assessment of the quality action would determine the methodology.

- **Proportion:** A score derived by dividing the number of cases that meet a criterion for quality (the numerator) by the number of eligible cases within a given time frame (the denominator). The numerator cases are a subset of the denominator cases (e.g., percentage of eligible women with a mammogram performed in the last year).
  - The performance rate of a proportion measure is defined as the number of patients meeting the quality action divided by the denominator eligible population.
    - **MIPS quality measure example:** Quality ID #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: 321 patients received appropriate BMI screening and follow-up out of 401. The performance rate would be 80 percent.
- **Continuous Variable:** A measure score in which each individual value for the measure





can fall anywhere along a continuous scale and can be aggregated using a variety of methods such as the calculation of a mean or median (e.g., mean time to thrombolytics, which aggregates the time in minutes from a case presenting with chest pain to the time of administration of thrombolytics).

- Aggregate scores for continuous variable measures are more complex than for proportion measures in that they are more than just the counts of individuals in each population.
- **MIPS quality measure example:** Quality ID #461: Average Change in Leg Pain Following Lumbar Discectomy and/or Laminotomy: An eligible clinician performed 127 laminotomies. Patients reported an average change in leg pain of 1.7 points.
- **Ratio:** A score that may have a value of zero or greater that is derived by dividing a count of one type of data by a count of another type of data. The key to the definition of a ratio is that the numerator is not in the denominator (e.g., the number of patients with central lines who develop infection divided by the number of central line days).
  - Rates closer to 1 represent the expected outcome.
  - **Example:** Actual/Expected.
    - Length of Stay for Heart Failure
      - Actual: 5.5
      - Expected: 4.5 days
      - Ratio: 1.2
- **Inverse:** A lower calculated performance rate for this type of measure would indicate better clinical care or control. The “Performance Not Met” numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases.
  - **MIPS quality measure example:** Quality ID #1: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Goal is to have a lower percentage of patients with diabetes with poor control.

## Measure Classification

- **National Quality Strategy (NQS) domains:** The National Quality Strategy provides a focus for addressing the abundance of clinical quality measures currently used in national programs. The goal is to have measures that address the most common health concerns that Americans face and minimize provider burden.
  - Patient Safety
  - Person and Caregiver Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction



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- **Meaningful Measures:** Meaningful Measures identify high priority areas for quality measurement and improvement that CMS considers most vital to providing high-quality care and improving patient outcomes. CMS intends to prioritize outcome-based measures and move away from process based measures. Meaningful Measures include those that focus on one or more of the following areas:
  - Promoting Effective Communication & Coordination of Care
    - Medication Management
    - Admissions and Readmissions to Hospitals
    - Transfer of Health Information and Interoperability
  - Promote Effective Prevention & Treatment of Chronic Diseases
    - Preventive Care
    - Management of Chronic Conditions
    - Prevention, Treatment, and Management of Mental Health
    - Prevention and Treatment of Opioid Substance Use Disorders
    - Risk Adjusted Mortality
  - Work with Communities to Promote Best Practices of Healthy Living
    - Equity of Care
    - Community Engagement
  - Make Care Affordable
    - Appropriate Use of Healthcare
    - Patient-focused Episode of Care
    - Risk Adjusted Total Cost of Care
  - Make Care Safer by Reducing Harm Caused in the Delivery of Care
    - Healthcare-associated Infections
    - Preventable Healthcare Harm
  - Strengthen Person & Family Engagement as Partners in Their Care
    - Care is Personalized and Aligned with Patient's Goals
    - End of Life Care according to Preferences
    - Patient's Experiences of Care
    - Patient Reported Functional Outcomes
- **High Priority Measure:** Measures that meet the definition of high-priority should be flagged as such during self-nomination. CMS identifies the following as high priority:
  - **Outcome measures:** Outcome measures show how a health care service or intervention influences the health status of patients. (Outcome measures include outcome, intermediate outcome, and patient reported outcome).
  - **Appropriate Use:** CMS wants to specifically focus on appropriate use measures. This means that the measure must address appropriate use of services, including measures of over-use.
  - **Patient Safety:** This means that the measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process; and harm caused in the delivery of care.



This means that the structure, process or outcome must occur as a part of or as a result of the delivery of care.

- **Efficiency/Cost Reduction:** This means that the measure must address the affordability of health care including unnecessary health services, inefficiencies in health care delivery, high prices, or fraud. Measures should cause change in efficiency and reward value over volume.
- **Person and caregiver-centered Experience and Outcomes:** Should address the experience of each person and their family; and the extent to which they are engaged as partners in their care. CMS wants to specifically focus on patient reported outcome measures (PROMs). Person or family-reported experiences of being engaged as active members of the health care team and in collaborative partnerships with providers and provider organizations.
- **Communication and Care Coordination:** This means that the measure must address the promotion of effective communication and coordination of care; and coordination of care and treatment with other providers.
- **Opioid Related measures:** Opioid-related measures that measure opioid use, overuse, risks, monitoring, and education<sup>1</sup>.

## QCDR Measure review process

### Communication between CMS, Contractors, and QCDRs

- CMS welcomes the opportunity to meet with the QCDRs to review measure concepts and provide feedback prior to self-nomination.
- During QCDR measure review process, contractors may reach out for additional information related to the submitted specification (Performance data, supporting clinical guidelines, consideration of a denominator exclusion/exception).
- QCDR measure status notifications (Approved, Provisionally Approved, Rejected) as defined in section 3.2.
- The QCDR/Registry Google Calendar will be used to share CMS availability for QCDR measure reconsideration calls (after the self-nomination period ends) and to track and highlight key milestones and activities for the annual self-nomination period.

### QCDR Measure Status Notifications:

QCDR measures are reviewed by CMS and contractors. The QCDR measure status is assigned to indicate whether the measure has been approved, provisionally approved or rejected.

- *Approved* – The QCDR measure is approved for the given performance period.
- *Provisionally Approved* – The QCDR measure is approved for the given performance period however, CMS is requesting additional information or action if the measure is resubmitted for subsequent performance periods. CMS will provide a rationale for the provisional status based on the definitions outlined below. This may include performance

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<sup>1</sup> This is a proposal in the CY 2019 Physician Fee Schedule proposed rule for the Quality Payment Program. This Handbook will be updated in accordance to the final rule.

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data to assess performance gaps, revision or harmonization of the measure if it is to be submitted during the next QCDR self-nomination.

- **Rejected** – The QCDR measure is not approved for the given performance period. CMS will provide a rationale for the rejection based on the definitions outlined below.

## QCDR Measure Review Terminology and Definitions:

Below are the definitions for communications from CMS regarding QCDR measure feedback after review:

- **Standard of Care:** Standard of care is based on the typical practice of an average or below average physician, e.g., what basic care would be expected of any physician under similar circumstances. This includes the minimum that would be expected of any physician treating a given patient related to the concept/recommendation/care dictated by the measure. *For example: obtaining informed consent prior to surgery.*
- **Low Bar:** The measure evaluates basic healthcare that should be done on a routine basis.
- **Topped out:** Measures with a high-performance rate, where there is little to no room for quality improvement.
- **Performance Gap:** Data that shows the quality action is not being performed as frequently as it should. This data is based on recent and relevant scientific evidence, reputable studies or data from the QCDR.
- **Performance Variance:** Variance in performance allows for a range of deciles to be developed based on performance range. With regard to performance measurement, a high standard deviation or variance may indicate erratic data collection or an opportunity for performance improvement. CMS is requesting that performance data be assessed to determine if the variance is due to data collection (e.g. workflow, method of data abstraction, etc.) or actual performance differences. CMS does anticipate performance variance and would like to ensure it reflects opportunity for performance improvement, not data imperfections.
- **Harmonization:** CMS encourages QCDRs to share and/or harmonize QCDR measures that are similar in topic and/or concept. CMS will not likely approve measures that are duplicative or very similar to one another, as harmonized measures allow for a larger cohort on which clinicians can be compared.
- **Combine measure concepts:** Measures that split a similar or related clinical outcome or process into individual measures should be combined. *For example: Improvement in toe pain-not pain in the 5<sup>th</sup> toe and a separate measure for the 2<sup>nd</sup> toe.*
- **Documentation, checkbox, or no quality action:** The focus of these measures is not about providing quality care and improving outcomes.
  - For example, the quality action, as defined by the numerator statement is the completion of an assessment or a survey but offers no follow-up or plan of care to address abnormal/unusual findings or the survey does not account for patient satisfaction with the care received.





- Measure developers should avoid selecting or constructing measures that can be met primarily through documentation without evaluating the clinical quality of the activity—often satisfied with a checkbox, date, or code. *For example, a completed assessment, care plan, or delivered instruction.*
- **Eligible clinician attribution issue:** The quality action is not under the direct control of the reporting clinician. The quality action is completed or dependent on others.

## Scenarios

The following are common scenarios CMS and the contracting team have encountered during the self-nomination process. CMS asks that QCDRs review the scenarios below and consider the likely CMS response prior to self-nominating a QCDR measure.

- **Action:** A QCDR submits a QCDR measure similar or identical to an existing MIPS quality measure:
  - **Likely CMS Response:** CMS will ask you to report the MIPS quality measure for that clinical area.
- **Action:** A QCDR submits a QCDR measure similar or identical to retired PQRS/MIPS or QCDR measures identified as topped out or standard of care:
  - **Likely CMS Response:** Measure will likely not be approved.
- **Action:** A QCDR submits a QCDR measure including the NQF measure ID:
  - **Likely CMS Response:** Include the NQF ID only if submitting the exact measure specification as endorsed by NQF. If the specifications are not exact, it will not be considered NQF endorsed and an NQF ID should not be included.
- **Action:** A QCDR submits a QCDR measure similar (same clinical topic and/or quality action) to QCDR measures submitted by other QCDRs:
  - **Likely CMS Response:** CMS may ask you to work with other QCDRs to harmonize the similar QCDR measures into a single measure that could be used across all QCDRs.
    - Measure harmonization between QCDRs provides eligible clinicians a bigger cohort to be compared against for performance scoring and benchmarking.
    - Measures should be harmonized, unless there is a compelling reason for not doing so that would justify a separate measure. QCDRs will be asked to provide a detailed justification.
- **Action:** A QCDR submits a QCDR measure identical to measures submitted by other QCDRs:
  - **Likely CMS Response:** CMS may ask you to get permission to use the other QCDR's measure.
- **Action:** A QCDR submits one QCDR measure that is similar to or related to other QCDR measures submitted by the same QCDR:
  - **Likely CMS Response:** CMS may ask you to combine similar or related QCDR measures into a broader denominator or multi-strata/composite measure.



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- **Action:** A QCDR submits a QCDR measure similar to a measure that was previously rejected:
  - **Likely CMS Response:** Measure will not be approved, unless it has been modified to require a more meaningful quality action.
- **Action:** A QCDR submits a QCDR measure that is an assessment measure (the provider completed an assessment [e.g. BMI]):
  - **Likely CMS Response:** CMS will request that the measure be modified to identify the standardized assessment tool and that the treatment plan be modified based on the assessment results.
- **Action:** A QCDR submits a QCDR measure that is a patient survey measure (the patient completed a survey):
  - **Likely CMS Response:** CMS will request that the measure be modified to measure patient satisfaction and/or demonstrate a quality action (improvement in the patient's problem or condition). CMS will not approve patient survey measures that only measure whether the survey was distributed and/or completed.
- **Action:** A QCDR submits a QCDR measure that splits a single or related clinical process or outcomes into several QCDR measures **OR** delineates individual complications or outcomes of care associated with a specific procedure:
  - **Likely CMS Response:** QCDRs will be asked to consolidate the related series of measures into a single composite measure. By consolidating multiple similar measures into a single composite measure, clinicians and groups are likely to have more meaningful data on which to improve the quality of care they provide.
- **Action:** A QCDR submits a QCDR measure that is a continuous variable rate:
  - These measures are acceptable but are difficult to work with for comparative purposes.
  - **Likely CMS Response:** QCDRs will be asked if a quality threshold could be set. If so, they will be asked to transform the measure into a percentage rate. If not, it will remain a continuous variable rate.
- **Action:** A QCDR submits a QCDR measure that does not demonstrate room for quality improvement (topped out):
  - **Likely CMS Response:** 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 providers reporting a given measure.
- **Action:** The QCDR measure was approved for the previous program year.
  - **Likely CMS Response:** If submitted, CMS will likely request performance rate data from the QCDR as evidence of a performance gap before consideration of continued approval.
- **Action:** QCDR resubmits a measure has substantive changes that may not allow comparison to the previous performance data.
  - **Examples of substantive changes:**
    - Revised care setting:

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- From: General Evaluation & Management codes
  - To: Add Anesthesia procedural coding
- The intent of the quality action has changed.
  - From: The number of patient who had an assessment two months post procedure.
  - To: The number of patient who showed > 10% improvement in functional ability two-month post procedure.
- The analytic designation has been changed
  - No longer an inverse measure.
  - Now is a proportion, ratio or continuous variable measure.
  - Now is risk-adjusted.
- **Likely CMS Response:** CMS will consider the resubmitted QCDR measure with substantive changes to be a new QCDR measure and assign a different measure ID.
- **Action:** The QCDR resubmits a measure that was provisionally approved from the previous performance period:
  - Possible Reasons for Provisional Approval:
    - Request data to quantify the performance gap and room for improvement.
    - Request to combine measures into a composite or multi-strata measure.
    - Request to work with another QCDR on measure harmonization efforts.
    - Request modifications to the measure (e.g., the quality action).
  - **Likely CMS Response:**
    - If the CMS request was completed by the QCDR, the QCDR measure will be reviewed and likely approved.
    - If the CMS request was *not* completed by the QCDR, the QCDR measure will likely not be approved.

## QCDR Measure Development Resources

- 2019 QCDR Measure Specification file
  - <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/430/2019%20QCDR%20Measure%20Specifications.xlsx>
- List of MIPS quality measures in the performance period are posted on the Quality Payment Program page of MIPS. MIPS quality measure for 2019, will be posted to the page once the final rule is public.
  - <https://qpp.cms.gov/about/resource-library>
- QCDR Measure Development Google Group. A space for QCDRs to collaborate on QCDR measures and share ideas throughout the QCDR measure development process.
  - <https://groups.google.com/forum/#!forum/qcdr-forum>
- The QCDR/Registry Google Calendar
  - <https://calendar.google.com/calendar?cid=cWNkcmZvcnVtQGdtYWlsLmNvbQ>



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- Blueprint for the CMS Measures Management System
  - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html>
- Measure Development Plan
  - <https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/Measure-development.html>
- CMS and the contracting team welcome the opportunity to review QCDR measure concepts and provide feedback prior to self-nomination.
  - Request a QCDR measure concepts review meeting by contacting: [QCDRVendorSupport@gdit.com](mailto:QCDRVendorSupport@gdit.com) by September 1st
  - Send QCDR measure concepts to the email address above, at least one week prior to the scheduled meeting
- The [Quality Payment Program Resource Library page](#) has additional reference material and they will be updated in the summer for the 2019 performance period.

