

# Quality Payment PROGRAM

## QCDR MEASURE DEVELOPMENT FOR THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROGRAM

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# Agenda



- Introduction
  - Kickoff and Announcements
  - Presentation Objectives
  - QCDR Requirements
- Measure Structure and Analytics
  - Composite
  - Multi-strata
  - Patient Reported Outcome (PRO)
  - Measure Type
  - Measure Analytics
- QCDR Measure Review Considerations
- Resources
- Q & A

# KICKOFF AND ANNOUNCEMENTS

Presenter: Dr. Daniel Green, Medical Officer, CMS, CCSQ

# CMS Strategic Vision – Measure Development Priorities



- CMS supports measure alignment across federal, state, and private programs.
- CMS is interested in promoting efficient data collection of measure-related data and in improving population health.
- CMS also continues to balance individual and shared provider accountability.
- Measures should address critical clinical gaps in care, support evidence-based medicine, and should engage patients as well as clinicians in care delivery.
- Additionally, measures should promote healthy living, assist in a better understanding of a patient's overall health, promote coordinated care, and help in reducing disparities in healthcare.
- When publicly reported, these measures help consumers make informed decisions regarding their healthcare and choice of clinician, facility, and services.

# CMS Meaningful Measures Initiative



- Meaningful Measures assess core issues that CMS considers most vital to providing high-quality care and improving patient outcomes.
- CMS intends to prioritize outcome-based measures and reduce the focus on process measures.
- Meaningful Measures include those that focus on one or more of the following areas:
  - Address high impact measure areas that safeguard public health.
  - Patient-centered and meaningful to patients
  - Outcome-based where possible
  - Relevant for and meaningful to providers
  - Minimize level of burden for providers
    - Remove measures where performance is already very high and that are low value
  - Significant opportunity for improvement
  - Address measure needs for population-based payment through alternative payment models
  - Align across programs and/or with other payers(Medicaid, commercial payers)



# CMS Meaningful Measures Initiative



## ● Promote Effective Communication & Coordination of Care

### Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

## ● Promote Effective Prevention & Treatment of Chronic Disease

### Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

## ● Work with Communities to Promote Best Practices of Healthy Living

### Meaningful Measure Areas:

- Equity of Care
- Community Engagement

## ● Make Care Affordable

### Meaningful Measure Areas:

- 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

### Meaningful Measure Areas:

- Healthcare-associated Infections
- Preventable Healthcare Harm

## ● Strengthen Person & Family Engagement as Partners in their Care

### Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Patient Reported Functional Outcomes

# Importance of QCDR Measures



## QCDR Measures:

- Are clinically relevant measures that address gaps in care for specialties, preventive care, and/or disease management.
- Are measures that aren't contained in the annual list of MIPS quality measures for the applicable performance period.
- Can be a measure in the annual list of MIPS quality measures that has substantive differences in the denominator or the manner it's collected.



# INTRODUCTION

Presenter: Robin Williams, PIMMS

## Presentation Objectives

- Review general requirements to be a QCDR
- Review QCDR measure requirements
- Describe QDCR measure types and analytics
  - Composite
  - Multi-strata
  - Patient reported outcomes (PRO)

# QCDR Requirements



- Participants
  - Have at least 25 participants by January 1, 2019.
  - A participant is a clinician submitting data to the QCDR for the purpose of quality improvement.
  - Not all participants have to use the QCDR to submit MIPS data to CMS.
- Attestation statement
  - Provide a statement during the data submission period to certify that to the best of your knowledge, all the data (quality measures, improvement activities, and advancing care information measures and objectives, if applicable) and results are true, accurate and complete.
- Data submission
  - Submit data through one of CMS approved secure data submission methods, such as a Quality Reporting Document Architecture (QRDA) III or Quality Payment Program data format (JSON, XML).
- Data validation plan and report
  - Provide a data validation plan describing how data for individual MIPS-eligible clinicians, groups and virtual groups will be validated.
  - Submit the results of data validation by May 31 of the year after the performance period.

# QCDR Requirements



- Quality measures
  - Support at least 6 measures including
    - At least 1 outcome measure; OR if an outcome measure is not available, use at least 1 high-priority measure.
  - OR a MIPS-approved specialty measure set
- High priority is defined as an
  - Outcome
  - Appropriate use
  - Patient safety
  - Efficiency
  - Patient experience
  - Care coordination

# QCDR Requirements



- QCDR may host any MIPS quality measures and/or up to 30 QCDR measures from one or more of the following categories:
  - National Quality Forum (NQF) endorsed measures.
  - Current 2018 MIPS quality measures that are specified for a different submission method (i.e., QCDR submits an eCQM version of a MIPS quality measure).
  - QCDR measures developed for or used by boards, specialty societies, regional quality collaboratives, or large healthcare systems.
- All QCDR measures must be submitted for consideration during the self-nomination period for CMS review and approval for potential inclusion in MIPS.

NOTE: 2019 self nomination will be September 1 through November 1, 2018.

- Information will be available on the CMS web site



# MEASURE STRUCTURE AND ANALYTICS

Jocelyn Meyer, PIMMS

# QCDR Measure Basics



- QCDR Measures must have:
  - An evidence base (guideline based)
  - Intuitive appeal (high face validity)
  - Potential for improvement (not topped out)
  - Variation across Eligible Clinicians (ECs)
  - Responsiveness to improvement activities
  - Targets a meaningful measure/measurement gap
  - Prefer limited reporting burden

# QCDR Measure Basics



- Evidence Based
  - Cite clinical guidelines or recommendations from reputable sources.
  - Most recent or within the past 3 years.
- Measuring performance of a quality action with a known variation and gap in performance
  - Quantify the performance gap and variation in performance to demonstrate that there is room for improvement.
    - Cite recent Literature (most recent or within the past 3 years) or QCDR performance data.
- Measuring a meaningful quality action (numerator)
  - Quality actions are the focus of the quality measure.
  - The quality action details the clinical action expected for the population identified in the denominator.
  - Focuses on outcomes - the health status or change in health status of a patient as a result of care – desirable or adverse, rather than processes.
- Not duplicative of existing MIPS quality measures or QCDR measures.
- Beyond the conceptual state
  - Ideally, has been tested for implementation and reporting feasibility.
  - Has complete specifications.

# Composite Measure



- A combination of two or more individual performance measures that results in a single score.
- Composite measures can provide a broader assessment of quality care.
- Examples:
  - All-or-none Measures - Only those patients who received all indicated quality actions will be considered numerator compliant.
  - 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 1 adverse outcome from a list of 2 or more adverse outcomes.
  - Linear combinations – May be simple average or weighted average of individual measure scores.
  - Regression-based composite performance measures - The weight assigned to each item is directly related to its reliability and the strength of its association with the gold standard end point.
- Appropriate denominator exceptions should be evaluated for the quality action being measured.
- Advantages: Promotes a high standard of excellence of comprehensive care.

# Composite Measure



- **MIPS quality measure example:**
- Quality ID #441: Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
  - Most recent blood pressure (BP) measurement is less than 140/90 mm Hg -- And
  - Most recent tobacco status is Tobacco Free -- And
  - Daily Aspirin or Other Antiplatelet Unless Contraindicated -- And
  - Statin Use Unless Contraindicated
- Quality ID # 394: Immunizations for Adolescents
  - Patients who had one dose of meningococcal vaccine on or between the patient's 11th and 13th birthdays.
  - Patients who had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the patient's 10th and 13th birthdays.
  - Patients who have completed the HPV vaccine series with different dates of service on or between the patient's 9<sup>th</sup> and 13<sup>th</sup> birthdays.
  - All patients who are compliant for Meningococcal, Tdap and HPV during the specified timeframes.



# Multi-Strata Measure



- Multi-strata measure: multiple denominator options to reduce the number of measures addressing a similar condition, quality action or topic.
  - Reasons for stratification: age groupings, specific condition, specific location, different complications of the same procedure, vaccinations, etc.

## 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.

# Multi-Strata Measure



- **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%)
  - Patients who are 18 years and older with a diagnosis of CAD or history of cardiac surgery who have a current or prior LVEF < 40%
  - Patients who are 18 years and older with a diagnosis of CAD or history of cardiac surgery who have a prior myocardial infarction

# Multiple Performance Rate Calculation



- Multiple Performance Rates
  - Weighted Average:
    - Add the numerator counts of each submeasure and divide by the sum of the denominator counts of each submeasure
    - **MIPS quality measure example:** Quality ID #7: Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=80 visits)} = 80 \text{ visits}}{\text{Data Completeness Numerator (140 visits) – Denominator Exception (b}^1\text{+b}^2\text{=20 visits)} = 120 \text{ visits}} = 66.67\%$$

- Simple Average:
  - Add the percentages for each submeasure and divide by the total number of component submeasures
  - **MIPS quality measure example:** Quality ID #9: Anti-Depressant Medication Management

# Multiple Performance Rate Calculation



- Multiple Performance Rates
  - Indicated Performance Rate:
    - The measure steward will indicate performance rate used for the overall performance rate.
    - **MIPS quality measure example:** Quality ID #238: Use of High-Risk Medications in the Elderly



# MEASURE ANALYTICS

Jocelyn Meyer, PIMMS  
Steven Szeliga, QPP



- **Denominator exclusion** refers to criteria that remove the encounter/patient from the denominator before determining if the quality action was completed. Exclusions are more absolute where the quality action is not applicable and would not be considered for a population.
- **Denominator exception** permits the exercise of clinical judgment and implies that the treatment was at least considered for the each eligible patient such as medical, patient or system reason.
- **Numerator exclusions** apply to ratio and proportion measures to define instances that should not be included in the numerator data.
  - Ratio: If the number of central line blood stream infections per 1000 catheter days were to exclude infections with a specific bacterium, that bacterium would be listed as a numerator exclusion.
  - Proportion: Typically used in inverse measures where a “lower score indicates better quality.”

# Measure Analytics



- **Risk Adjustment:** Risk adjustment is the statistical process used to identify and adjust for differences in patient characteristics (or risk factors) before examining outcomes of care.
- The purpose of risk adjustment is to allow for more accurate comparison of outcomes of care across healthcare organizations.
- Statistical risk models should not include factors associated with disparities of care as these factors will obscure quality problems related to disparities.
- **Risk Stratification:** Separates reporting outcomes for different groups, unadjusted by a risk model.

# Electronically Derived Measure Requirements



- When measures are being e-specified:
  - Collaborate with measure steward prior to creating an eCQM version of the measure
    - For example, identifying SNOMED and/or ICD-10 codes
  - Must be tested and produce valid data
  - Maintain the measure's intent
  - Be respectful of copyright protected intellectual property
  - EHR data mining is permitted without eCQM designation

# Measure Analytics



- **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) where 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

# Measure Analytics



- **Continuous Variable:** A measure score in which each individual value for the measure can fall anywhere along a continuous scale (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



- **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
  - Average Length of Stay for Heart Failure
    - Actual: 5.5
    - Expected: 4.5 days
    - Ratio: 1.2

# Non-Proportional Scoring Implications

i.e. continuous variable and ratio measures



- Non-Proportional measures include a variety of different data elements that are captured as the numerator information. The variability in these data points would make decile creation based on a mathematical analysis very unpredictable. Some examples of the variability can be seen below:
  - Average Time (in minutes)
  - Average Time (in hours)
  - Change in Outcome (related to improvement tests)
  - Length of Stay
  - Ratio
- In addition to the variability above, we would be unable to determine if the numbers are truly reflective of the clinician's practice/quality. Outliers can have a large impact in modeling if not realized and adjusted.
  - We would be unable to equate for and normalize the data based on:
    - practice size
    - physical location
    - general patient pop (which we do not have)
    - risk-adjustment factors

# Non-Proportional Scoring Implications



- We consider you to be the experts within your medical communities and believe that you will have greater insights into the benchmarks related to these measures.
- Solution: Revise the numerators to establish an expected benchmark based on guidelines or national performance data. By comparing the observed data to the benchmark, this would allow for these measures to be converted into a proportional measure.
- Utilize performance data to determine performance met or performance not met criteria
- Allow creation of a dataset that is easier to analyze and produce reliable scoring benchmarks
  - Example: Door to Balloon time
    - Continuous variable: Mean time from arrival to balloon
    - Proportional: Balloon time under two hours

# MEASURE TYPES

Jocelyn Meyer, PIMMS

# Measure Type



- **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.
- **MIP quality measure example:** Quality ID #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

# Measure Type



- **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.
- Outcome measures are supported by evidence that the measure has been used to detect the impact of one or more clinical interventions.
- **MIPS quality measure example:** Quality ID #191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

# Measure Type



- **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 Reported Outcome (PRO) 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





# QCDR MEASURE REVIEW CONSIDERATIONS

Robin Williams, PIMMS

# QCDR Measure Review Considerations



- Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure, when implemented, can lead to the desired outcomes and/or more affordable care (i.e., NQF's Importance criteria).
- Measure addresses one or more of the six National Quality Strategy (NQS) domains.
  - Patient Safety
  - Person and Caregiver Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction

# QCDR Measure Review Considerations Continued



- Measures should have provider performance variation.
- Measures that have high performance rates or lack a performance gap in clinical care, do not provide meaningful measurement or benefit to the patient or clinician.
- Potential use of the measure in a program does not result in unwanted unintended consequences (e.g., depriving patients of oxygen therapy or other comfort measures).
- Measures that are “never events” will not be approved.
- Measure is responsive to specific program goals and statutory requirements.

# QCDR Measure Review Considerations



- Action: QCDR submits a QCDR measure similar or identical to an existing MIPS quality measure
  - **Typical Reaction:** CMS will ask you to report the MIPS quality measure for that clinical area.
- Action: QCDR submits a QCDR measure similar or identical to retired PQRS/MIPS or QCDR measures identified as topped out or standard of care
  - **Typical Reaction:** Measure will likely not be approved.
- Action: QCDR submits a QCDR measure including the NQF measure ID
  - **Typical Reaction:** 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.
- Action: QCDR submits a QCDR measure similar (same clinical topic and/or quality action) to measures submitted by other QCDRs
  - **Typical Reaction:** CMS may ask you to collaborate with other QCDRs to harmonize the similar measures into a single measure that could be used across all QCDRs.
    - Measure harmonization between QCDRs provides eligible clinicians a bigger cohort 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.

# QCDR Measure Review Considerations



- Action: QCDR submits a QCDR measure identical to measures submitted by other QCDRs
  - **Typical Reaction:** CMS may ask you to get permission to use the other QCDR's measure.
- Action: QCDR submits a QCDR measure similar to or related to measures submitted by the same QCDRs
  - **Typical Reaction:** CMS may ask you to combine QCDR measures into a broader denominator or multi-strata/composite measure.
- Action: QCDR submits a QCDR measure similar to a measure that was previously rejected
  - **Typical Reaction:** Measure will not be approved, unless it has been modified to require a more meaningful quality action.
- Action: QCDR submits a QCDR measure that is an assessment measure (the provider completed an assessment [i.e. BMI])
  - **Typical Reaction:** 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: QCDR submits a QCDR measure that is a patient survey measure (the patient completed a survey)
  - **Typical Reaction:** CMS will request that the measure be modified to be about patient satisfaction and/or demonstrate a quality action (improvement in the patient's problem or condition)—not that the survey was completed.

# QCDR Measure Review Considerations



- Action: QCDR submits QCDR measure that qualify individual steps for a single quality action **OR** delineate individual complications or outcomes of care associated with a specific procedure
  - **Typical Reaction:** 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: QCDR submits a QCDR measure that is a continuous variable rate
  - These measures are difficult to work with for comparative purposes.
  - **Typical Reaction:** 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.
- Action: QCDR submits a QCDR measure that does not demonstrate room for quality improvement (topped out)
  - **Typical Reaction:** CMS will request performance data from the QCDR to understand the analytic value of the measure. Specifically, is there room for quality improvement? Additionally, we will likely ask for variation in performance rates among providers reporting a given measure.
- Action: QCDR resubmits their QCDR measure, that was approved for the previous year, with substantive changes that may not allow comparison to previous performance data
  - **Reaction:** The measure will be identified as a new measure and assigned a different measure ID for benchmarking purposes.

# Resubmitted QCDR Measures with Substantive Changes



- The QCDR measure was approved for the previous program year
- QCDR Measure has substantive changes that may not allow comparison to the previous performance data
  - **Examples of substantive changes:**
    - Revised care setting
      - 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
      - Is no longer an inverse measure,
      - Is now a proportion, ratio or continuous variable measure
      - Is now risk adjusted
- CMS will consider the resubmitted QCDR measure with substantive changes to be a new QCDR measure and assign a different measure ID.

# Provisionally Approved QCDR Measures



- The QCDR measure was provisionally approved for the previous reporting year
  - Possible Reasons:
    - Quantify the performance gap and room for improvement
    - Combine measures into a composite or multi-strata measure
    - Collaborate with another QCDR to harmonize measures
    - Modify the measure (i.e., the quality action)
- If the CMS request for measure revision was completed, the measure will be reviewed and likely approved if the performance and/or variance data submitted provides evidence of a gap or variation
- CMS request was not completed
  - Measure will likely not be approved



# QCDR Measure Checklist



- **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 previously approved for an earlier program year but the measure has changed, clearly identify changes to the specification.

# QCDR Measure Checklist



- **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.
- Have the potential of negative unintended consequences
- Focus on “Never Events”.

# Summary



- QCDR measures must be clinically relevant, harmonized, should be aligned with public and private payers, and minimally burdensome to report.
- Ensure that the measures selected for the MIPS program reflect the best available science, and that may require retiring or revising measures so that they reflect the latest clinical guidelines and align with the MIPS program.
- QCDR measures that have low performance rates or a performance gap in clinical care provide meaningful measurement, and benefit to the patient and/or clinician.
- CMS welcomes the opportunity to meet with QCDRs to review measure concepts and provide feedback prior to self-nomination.

# RESOURCES

Robin Williams, PIMMS

- CMS and the PIMMS MIPS team welcome the opportunity to review measure concepts and provide feedback prior to self-nomination
  - Request a measures concept call by contacting: [QCDRVendorSupport@gdit.com](mailto:QCDRVendorSupport@gdit.com)
    - Make the request by September 1<sup>st</sup> (self-nomination period begins)
    - Provide availability at the time of the request
    - Send measure concepts at least one week prior to the scheduled meeting
- 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>

## Resources and Who to contact for Assistance

- Blueprint for the CMS Measures Management System
  - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint-130.pdf>
- National Quality Forum Measure Evaluation Criteria
  - [http://www.qualityforum.org/Measuring\\_Performance/Submitting\\_Standards/2015\\_Measure\\_Evaluation\\_Criteria.aspx](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards/2015_Measure_Evaluation_Criteria.aspx)
- Measure Development Plan
  - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>
- 2018 QCDR Measure Specification file
  - <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Qualified-Clinical-Data-Registry-QCDR-Measure-Specifications.xlsx>
- CMS and the PIMMS MIPS team welcomes the opportunity to review measure concepts and provide feedback prior to self-nomination
  - Schedule a call at: [QCDRVendorSupport@gdit.com](mailto:QCDRVendorSupport@gdit.com)
- The resource library has additional reference material and they will be updated in the summer for the 2019 performance period.

# Resources



The one-stop shop for the most current resources to support **Electronic Clinical Quality Improvement**

- eCQI Resource Center – Home page
  - <https://ecqi.healthit.gov/>
- eCQI Resource Center – Tools
  - <https://ecqi.healthit.gov/ecqm-tools-key-resources>
- eCQI Resource Center - eCQM Education
  - <https://ecqi.healthit.gov/ecqm-education>
- eCQI Resource Center – Implementers
  - <https://ecqi.healthit.gov/ecqms/ecqi-implementers>

- To ask a question, please dial:  
**1-866-452-7887**
- Press \*1 to be added to the question queue.
- You may also submit questions via the chat box.
- Speakers will answer as many questions as time allows.
- Ask most important questions first.