Quality Payment PROGRAM

# 2017 MIPS Quality Performance Category

## Fact Sheet

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) streamlines a patchwork collection of programs into a single system that rewards doctors and other clinicians for better care. Doctors and other clinicians will be able to practice as they always have, but may receive higher Medicare payments based on their performance and engagement in key activities. There are two paths in this program:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

Under MIPS, there are four performance categories that will affect Medicare payments:

- Quality
- Improvement Activities
- Advancing Care Information
- Cost

## Focusing on Quality

Quality measures are tools that help the Centers for Medicare & Medicaid Services (CMS) measure health care processes, outcomes, and patient perceptions related to the ability to provide high-quality health care. Quality measures also help CMS link outcomes that relate to one or more health care quality goals such as effective, safe, efficient, patient-centered, equitable, and timely care.

The MIPS Quality performance category replaces and incorporates components of the Physician Quality Reporting System (PQRS) and the Physician Value-based Payment Modifier (VM). There are 271 quality measures in the Quality Payment Program. Some of these measures are process measures, and some are outcome measures; among these measures, some have been identified as high priority measures. Please note:

- MIPS eligible clinicians reporting through a Qualified Clinical Data Registry (QCDR) may submit approved QCDR (non-MIPS) measures as developed by their QCDRs.
- Clinicians in MIPS APMs have an additional set of measures required by the APM that the APM submits on their behalf.

| Classifications of Quality Measures | | |
|---|---|---|
| ***Process measures*** | ***Outcome measures*** | ***High priority measures*** |
| Process measures show what doctors and other clinicians do to maintain or improve health, either for healthy people or those diagnosed with a given condition or disease. These measures usually reflect generally accepted recommendations for clinical practice. For example:<br>• The percentage of people getting preventive services (such as mammograms or immunizations).<br>Process measures can tell consumers about medical care they should receive for a given condition or disease, and can help improve health outcomes. | Outcome measures show how a health care service or intervention influences the health status of patients. For example:<br>• The percentage of patients who died because of surgery (surgical mortality rates).<br>• The rate of surgical complications or hospital-acquired infections.<br>Outcome measures may seem to represent the "gold standard" in measuring quality, but an outcome is the result of many factors, some of which may be out of a clinician's control. | High priority measures include the following categories of measures:<br>• Outcome<br>• Appropriate use<br>• Patient experience<br>• Patient safety<br>• Efficiency measures<br>• Care coordination |

Under MIPS (including MIPS APMs), the Quality performance category is the most heavily weighted and the most flexible performance category. This performance category provides a wide variety of options for participation, including:

- Offering clinician specialty-specific measure sets, which allows clinicians to use measures that are meaningful to them;
- Providing 6 ways to submit data; and
- Providing flexible participation options for data collection during the transition year also known as *Pick Your Pace.*

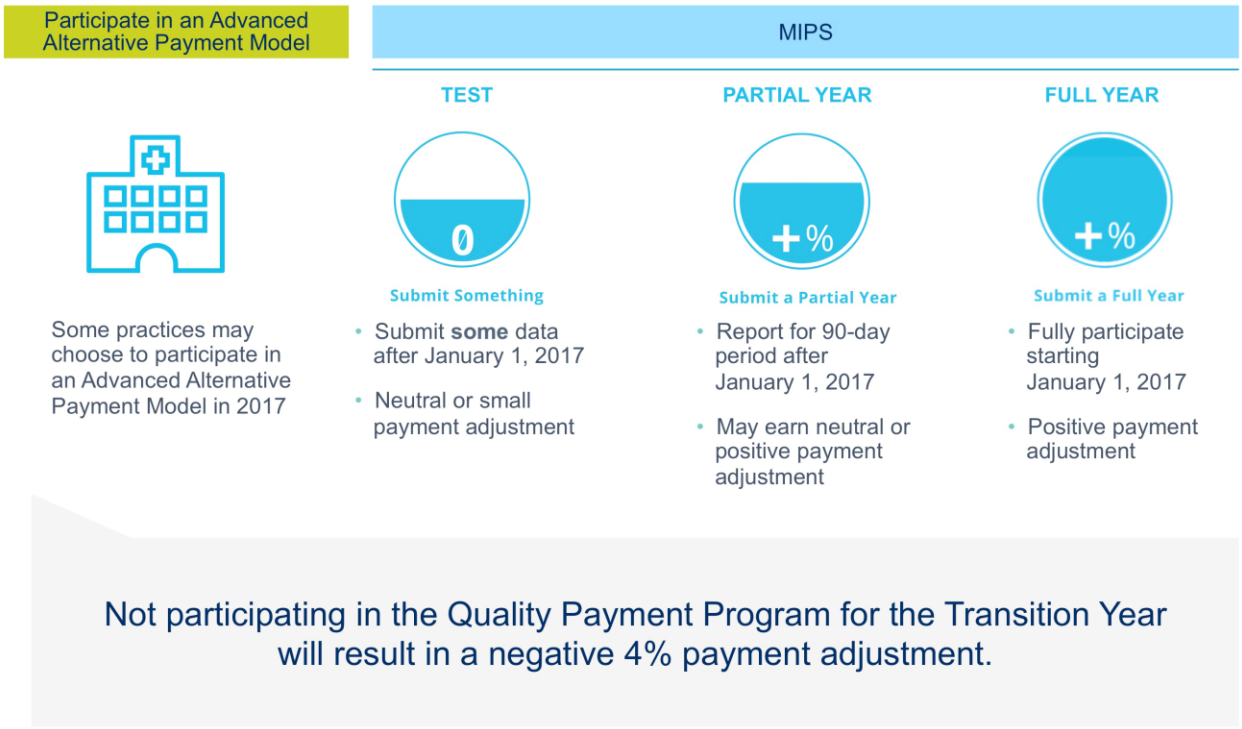
## Quality in the Transition Year

For the 2017 transition year, MIPS eligible doctors and other clinicians have different options for submitting on the Quality performance category, including (1) deciding to participate individually or as a group, (2) choosing how much data to submit, also known as "Pick Your Pace" and, (3) choosing which data submission mechanism to use.

**Test:** Choosing the test option means that clinicians submit the minimally required data of one quality measure, for one patient for one day. This will let clinicians become familiar with the program while making sure they avoid the negative payment adjustment.

**Partial:** Submitting at least six quality measures, including at least one outcome measure, for 90 days or up to a full year. Under partial participation, CMS will analyze performance data, and clinicians have the chance to earn a modest positive payment adjustment. See more on 90 data submission below.

**Full**: Full participation requires submitting data for the full year (Jan 1-Dec 31, 2017). Participating fully gives clinicians a greater chance to receive a higher positive payment adjustment.




## More on Partial Participation: 90-Day Performance Period/Data Submission

The 90-day performance period is an option, for eligible clinicians participating via claims, electronic health records (EHR), qualified registries, and QCDRs, offered to reduce submission burden. It allows you to submit performance data for 90 days as opposed to submitting data for the entire 12-month performance period.

The difference between the 90-day and 12-month performance period is the amount of time to determine a denominator eligible sample for the measure(s) eligible clinicians choose to submit. A 12-month performance period requires submitting measure data from January 1 through December 31 of the performance period. The 90-day performance period is based on any 90 consecutive days an eligible clinician chooses to submit data from within the January 1 through December 31 performance period. Once this timeframe is chosen, then the eligible clinician would need to submit data on at least 50% of denominator eligible encounters within that timeframe for each of the measure(s) being submitted. Please note that measures that do not meet the 20 case minimum threshold will not receive more than 3 points for that measure.

Most quality measures can be used for 90-day performance period. There are some measures, though, that by design, are hard to align with a 90-day performance period and some are not feasible for certain timeframes in which the measure may be analyzed.

For example, some measures are based on observation periods after an event such as a surgery or discharge from acute care. MIPS Quality ID: 191, CMS133: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery, has a 90-day look forward period of observation after the denominator qualifying event of cataract surgery. This is accommodated in the measure specification by including only cataract surgeries in the first 270 days of the year (January 1 through September 30) allowing for follow-up assessment within 90-days post-surgery (October 1 through December 31) before the end of the calendar year.

Therefore, a 90-day performance period that included dates in October, November, or December would not be feasible for submission purposes and an alternative to the 4th quarter 90-day submission period should be selected for this measure.

There are 43 quality measures that may not be ideal if implemented within the 90-day performance period; the limitations and rationale associated with these measures are indicated in the table, located in the appendix.

## Submitting Quality Data

In general, MIPS eligible doctors and other clinicians may participate in MIPS individually or as a group and there are six data submission mechanisms available, five of which are available to groups.

| ***Participate as an individual*** | ***Participate with a group*** |
|---|---|
| If a MIPS eligible clinician participates as an individual, their payment adjustment will be based on their individual performance.<br><br>An individual is defined as a single clinician, identified by a single National Provider | Each MIPS eligible clinician participating in MIPS with a group will receive a payment adjustment based on the group's performance.<br><br>Under MIPS, a group is defined as a single Taxpayer Identification Number (TIN) with |

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|---|---|
| Identifier (NPI) number tied to a Taxpayer Identification Number (TIN). | two or more MIPS eligible clinicians as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN. |

## Choosing a Way to Submit Quality Data

We urge clinicians to review each option carefully and choose the one that works best for them or their group. Please note that several options use third party intermediaries.

| Data Submission Mechanism | How does it work? |
|---|---|
| **Qualified Clinical Data Registry (QCDR)** (available to individual MIPS eligible clinicians and groups) | A QCDR is a CMS-approved entity that collects medical and/or clinical data to track patients and disease. Each QCDR usually gives tailored instructions about how to submit data. For MIPS, if clinicians choose this option, they'll need to participate with a QCDR CMS has approved.<br>List of 2017 CMS-Approved Qualified Clinical Data Registries (QCDRs) |
| **Qualified Registry** (available to individual MIPS eligible clinicians and groups) | A qualified registry collects clinical data and submits it to CMS on behalf of MIPS eligible clinicians. For MIPS, if clinicians choose this option, they'll need to participate with a Qualified Registry CMS has approved.<br>List of 2017 CMS-approved Qualified Registries |
| **Electronic Health Record (EHR)** (available to individual MIPS eligible clinicians and groups) | Clinicians submit data to CMS directly through their EHR system. Or, they can work with a qualified health IT vendor who'll submit the data for them. |
| **Claims**<br>(available only to individual MIPS eligible clinicians) | Clinicians pick measures and report through their routine billing processes. If they choose this option, they'll need to add certain billing codes to denominator eligible claims to show that the required quality action or exclusion happened. |
| **CMS Web Interface**<br>(only available to groups with 25 or more MIPS eligible doctors and other clinicians) | A secure internet-based application available to pre-registered groups of 25 or more MIPS eligible clinicians. CMS partially pre-populates the CMS Web Interface with claims data from the group's Medicare Part A and Part B |

| Data Submission Mechanism | How does it work? |
|---|---|
| | beneficiaries who have been assigned to the group. Then, the group completes the clinical data for the pre-populated Medicare patients.<br><br>For the transition year, registration was April 1 through June 30, 2017. Groups who wanted to participate via the CMS Web Interface registered here. |
| **CAHPS for MIPS Survey Vendors** | For the transition year, registration was April 1 through June 30, 2017. Groups who wanted to administer the CAHPS for MIPS Survey registered here.<br><br>List of 2017 CMS-Approved CAHPS for MIPS Survey Vendors |
| **Note**:<br><br>The Quality performance category has one measure that is an administrative claims measure, the All-Cause Hospital Readmission measure. Groups of 16 or more clinicians are subject to the All-Cause Hospital Readmission measure if 200 patients are attributed. If 200 patients are not attributed, the All-Cause Hospital Readmission measure will not be calculated, and clinicians will only be scored on the reported 6 measures, for a total possible score of 60 points.<br><br>No data submission action is required for administrative claims. | |

## Getting Started

After a clinician has chosen how they'll participate and selected their submission mechanism, they're ready to start. Here are some steps that can help them get started:

### *1. Determine if you're a MIPS eligible clinician*

- MIPS eligible clinicians are one of the following "clinician types" who bill $30,000 or more in Medicare Part B allowed charges and provide care for 100 or more Part B-enrolled Medicare beneficiaries:
    - Physicians, which includes doctors of medicine, doctors of osteopathy (including osteopathic practitioners), doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors;
    - Physician assistants (PAs);
    - Nurse practitioners (NPs);
    - Clinical nurse specialists;
    - Certified registered nurse anesthetists; and
    - Any clinician group that includes one of the professionals listed above.
- Click here to determine if you're a MIPS eligible clinician using the MIPS Participation Status Look-up tool.

### *2. Shop for your measures*

- There are about 271 quality measures in MIPS. Clinicians can start looking at the measures to find what will work best for them or their group. They can sort measures by how they plan to submit data, by specialty, or by measure type.
- If the clinician plans to participate beyond the "test" participation option, they'll have to submit at least six quality measures, including at least one outcome measure, for 90 days or up to a full year.

### *3. Understand your quality measures*

- Once the clinician has found the measures that work for them, they'll need to look at the measure specifications that go with them. Measure specifications describe each measure and outline each measure's elements.
- If the clinician chooses the CMS Web Interface as their data submission mechanism, they're expected to report on all measures included in the CMS Web Interface for a full year.

### *4. Data collection*

- For the transition year, clinicians can start collecting their quality data as early as January 1, 2017 or as late as December 31, 2017, depending on their chosen Pick Your Pace participation. CMS urges clinicians to submit as much data as soon as possible.

Tips:

- The test option requires that clinicians submit data for at least one patient, for at least one day. That means a clinician could collect this data up to **December 31, 2017.**
- The partial option requires at least 90 days of data, therefore, **October 2, 2017** would be the last day to begin data collection.
- The full option requires clinicians to start data collection on **January 1, 2017.**
- Clinicians in MIPS APMs should work with their APM entity on timelines and required activities for the transition year.

### *5. Submission of data*

- The period for data submission for QCDRs, qualified registries, and EHR is between January 1, 2018 and March 31, 2018. The CMS Web Interface submission period is between January 22, 2018 and March 16, 2018. For the claims submission mechanism, which is available only to individuals, data is submitted at the same time that claims are submitted. A submission timeline, with due dates, will be available on https://qpp.cms.gov. Performance will be assessed based on the data submitted. Clinicians will meet the minimum MIPS program requirement if one quality measure (for at least one patient for at least one day) is submitted. Again, this is considered the test participation option.
- For the transition year, only one data submission mechanism can be used for the quality performance category with the exception of the CAHPS for MIPS survey. Clinicians that choose to report their patient experience data via the CAHPS for MIPS survey, will need to select an additional data submission mechanism to submit quality measures, if they are planning to participate beyond the test option for the transition year.

### *6. Post submission*

- After data is submitted, CMS will begin analyzing it.
- Eligible clinicians submitting via claims or a qualified registry who submit less than six measures or no outcome or high priority measure, CMS will use what is called the Eligibility Measure Applicability (EMA) process to determine if additional clinically related measures could have been submitted. If CMS finds that there are no applicable measures for the clinician, they won't be held accountable for not submitting those measures. If CMS discovers that additional clinically related measures could have been submitted and were not, it will impact the Quality performance category final score. However, in this first year, under the Pick Your Pace option, submission of only one measure will assure that clinicians do not receive a negative payment adjustment.

***EMA is:***

- Based on evaluation of submitted measures and determination of clinically related measures aligned with specialty measure sets
- Specific to the submission mechanism (i.e., EMA will not determine that a claims submitter had a registry measure available)
- Not applicable for EHR, QCDR, and Web Interface data submission mechanisms

- EMA is an enhanced version of the Measure-Applicability Validation (MAV) process that CMS used for the Physician Quality Reporting System (PQRS). EMA allows clinicians to succeed by evaluating measures appropriate for the clinician and adjusting their performance in the quality performance category of MIPS, when appropriate.

## Quality Scoring

The Quality performance category is worth 60% of the overall MIPS final score. For the transition year, clinicians will automatically receive a minimum of three points for completing and submitting at least one quality measure. If they report fully and submit six measures, or a specialty measure set, they will be scored on all the measures. If they are in a group of 16 or more clinicians, they will also be scored on a population-based measure, known as the All-Cause Hospital Readmissions measure, if they exceed a case volume of more than 200 Medicare patients. CMS will use national benchmarks as the basis for scoring.

Clinicians in MIPS APMs are subject to a special scoring standard, which can be found here.

### National Benchmarks

#### *What are benchmarks?*

For quality measures, CMS used data that was reported via PQRS in 2015, two years before the transition year of MIPS. For the CAHPS for MIPS survey, benchmarks are based on two previous surveys: the 2015 CAHPS for PQRS and the 2015 CAHPS for ACOs. For the CMS Web Interface, benchmarks are used from the Medicare Shared Savings Program.

#### *How do benchmarks convert to points?*

Each quality measure is converted into a 10-point scoring system. Performance on quality measures is broken down into 10 “deciles,” with each decile having a value of between one and 10 points. The deciles will be based on stratified levels of national performance (benchmarks) within that baseline period. A clinician’s performance on a quality measure will be compared to the performance levels in the national deciles. The points received are based on the decile range that matches their performance level.

For inverse measures (like the diabetic HgA1c measure), the order’s reversed—decile one starts with the highest value and decile 10 has the lowest value.

If a measure can be reliably scored against a benchmark, then clinicians can receive 3-10 points. Reliably scored means that:

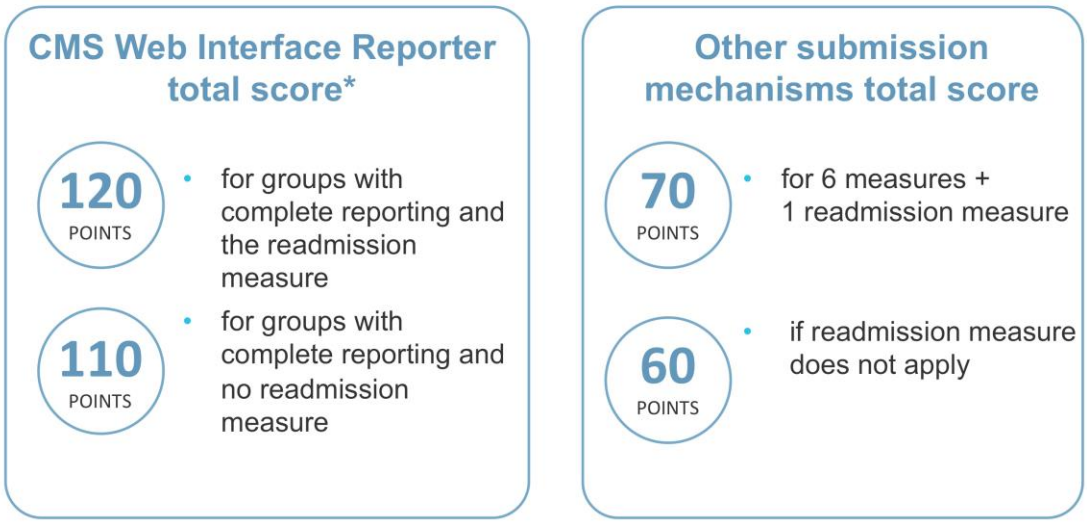
- A national benchmark exists
- The sufficient case volume has been met (>20 cases for most measures; >200 cases for readmissions)
- The data completeness criteria has been met (meaning at least 50 percent of possible data is submitted)

### *What if a measure I chose doesn't have a national benchmark?*

Quality measures that can't be reliably scored against a benchmark, or quality measures without a benchmark, will receive three points.

Please note that the requirements for establishing a national benchmark may occur based on the submissions from the performance year if data completeness and case minimum reporting requirements are satisfied.

## Maximum Number of Points by Submission Mechanism




**Also applies to MIPS APMs that submit data via the CMS Web Interface*

Note: There are 130 available points for clinicians participating via the CMS Web Interface and administering the CAHPS for MIPS survey.

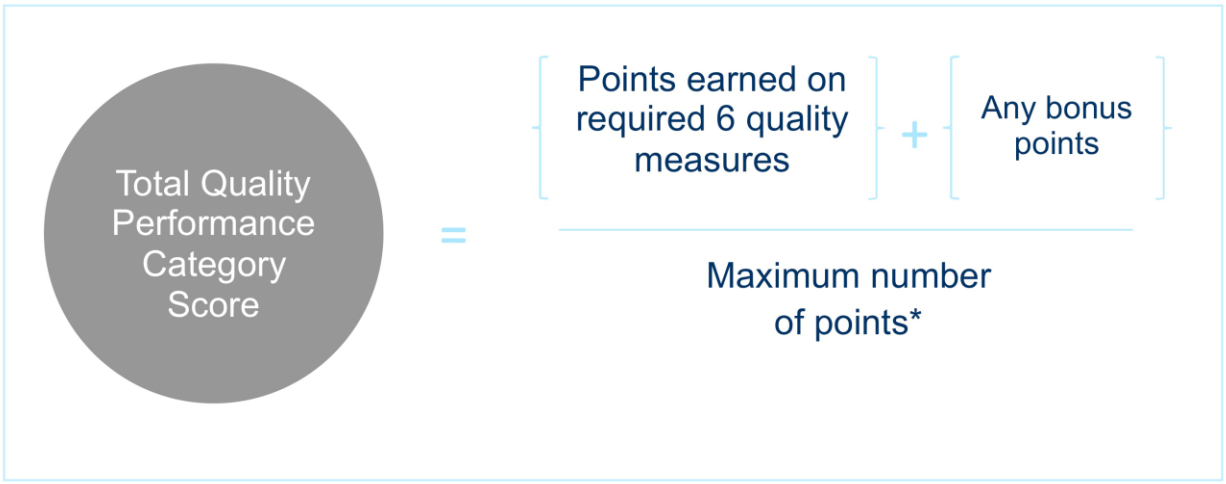
## Bonus Points

### *Bonus for end-to-end reporting*

Clinicians will receive one bonus point if they report their quality data directly from their EHR to a qualified registry, QCDR, or via the CMS Web Interface. That bonus point will be added to the quality performance category points.

### *Bonus for submitting additional measures*

There are bonus points for submitting additional measures including one bonus point for each high priority measure and two bonus points for each additional outcome and patient experience measure. Bonus points will be added to a clinician's overall quality performance category points.




*Maximum number of points = # of required measures x 10

## Data Accuracy

In the Quality Payment Program Final Rule with comment, CMS states that it will address the details of a process for auditing measures and activities under MIPS for the Quality, Advancing Care Information, and Improvement Activities performance categories through sub-regulatory guidance.

CMS believes it is important to ensure the Quality Payment Program is based on accurate and reliable data. Under MIPS, CMS will validate data on an ongoing basis. Clinicians could also get a request from us for an audit, which will require them to respond within 45 calendar days.

## Shaping the Future of Quality

### *Quality measure development and inclusion*

In choosing future quality measures, based on stakeholder feedback, CMS looks for measures that are:

- Applicable
- Feasible
- Scientifically defensible (quality measures only)
- Reliable
- Valid at the individual MIPS eligible clinician level
- Not duplicative of existing measures and activities for notice and comment rulemaking

This means that a recommended list of new measures and activities will be publicly available for comment for a period of time. CMS will evaluate the comments we get through the rulemaking process before making a final selection. Every year, a final list of measures and activities for

MIPS eligible clinicians will be published in the **Federal Register** no later than November 1 of the year, before the first day of a performance period.

The quality performance category focuses on measures in the following six domains for future measure thought and selection:

- Patient safety
- Person and caregiver-centered experience and outcomes
- Communication and care coordination
- Effective clinical care
- Community/population health
- Efficiency and cost reduction

### *Annual call for quality measures*

Each year, CMS will hold a Call for Measures that lets clinicians and organizations, including but not limited to those representing MIPS eligible clinicians (professional associations and medical societies) and other stakeholders (researchers and consumer groups) submit quality measures for consideration.

## Frequently Asked Questions

1. **How should vendors (Registry, QCDR, and EHR) analyze and submit the quality measure data for a 90-day performance period?**
   Vendors should submit quality measure data as specified within the measure specification used for data extraction or abstraction. CMS recommends the following abstraction methods for registry, QCDR, or EHR data submission methods. Please note claims data submission has slightly different guidance, which is addressed in the next question.
   - Select a 90-day performance period. Identify eligible encounters in that performance period using the quality measures' denominator requirements.
   - Use the 90-day performance period and any appropriate look-back periods to identify numerator-compliant actions consistent with measure requirements. Please note that if numerator compliance events are not pulled from the entire year for these measures it may under estimate the eligible clinician's true performance as numerator compliant events will be limited to occurring in the 90-day reporting window. Most MIPS measures only require one encounter with no look forward or look back periods and these measures are ideal for reporting during the shortened submission window of 90 days.
   - Submit all required denominator, numerator, and exclusion/exception data for encounters identified in step 1.

2. **How will CMS analyze claims data to know which 90-day performance period the eligible clinician or group chooses for claims-based submissions?**
   CMS will analyze claims data based on the first and last Quality Data Code (QDC) submitted by the eligible clinician during the performance period January 1-December 31 of 2017. This timeframe may include more time than 90 days if the first and last QDC are submitted for a

time window longer than a 90-day period. Analyzing claims data in this method may allow the best numerator outcome submitted to be calculated for the measure for a smaller denominator sample that is limited to a 90-day period.

3. **Which measure(s) are less optimal for 90 day performance?**
   See table in the appendix below.

## Resources

- Information regarding the Annual Call for Measures and Activities
- Reporting quality data via the CMS Web Interface and/or administering the CAHPS for MIPS Survey
- MIPS Data Validation Fact Sheet and Criteria
- The eCQI Resource Center contains information regarding electronic clinical quality measures (eCQMs)
- Medicare Shared Savings Program Benchmarks (Applicable for CMS Web Interface users)
- MIPS APMs in the Quality Payment Program
- For questions, contact the Quality Payment Program Service Center at 1-866-288-8292 (TTY 1-877-715- 6222), available Monday through Friday 8:00 AM-8:00 PM Eastern Time, or via e-mail at QPP@cms.hhs.gov

## Appendix

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 005 | CMS135 | eCQM, Registry | Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 007 | CMS145 | eCQM, Registry | Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%) | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 008 | CMS144 | eCQM, Registry | Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 110 | CMS147 | eCQM, Claims, Registry | Preventive Care and Screening: Influenza | 90-day period should not include any dates between April-September | Data should only be collected for the flu season |
| 138 | N/A | Registry | Melanoma: Coordination of Care | 90-day period should not cover the month of December | Measure looks for treatment plan within one month of diagnosis |
| 191 | CMS133 | eCQM, Registry | Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a cataract surgery to have taken place in the first 9 months of the calendar year with a 3 month look forward period |
| 217 | N/A | Registry | Functional Status Change for Patients with Knee Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 218 | N/A | Registry | Functional Status Change for Patients with Hip Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 219 | N/A | Registry | Functional Status Change for Patients with Foot or Ankle Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 220 | N/A | Registry | Functional Status Change for Patients with Lumbar Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 221 | N/A | Registry | Functional Status Change for Patients with Shoulder Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 222 | N/A | Registry | Functional Status Change for Patients with Elbow, Wrist or Hand Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 223 | N/A | Registry | Functional Status Change for Patients with General Orthopaedic Impairments | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 226 | CMS138 | eCQM | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |
| 281 | CMS149 | eCQM | Dementia: Cognitive Assessment | Two encounters required | Two encounters within the 90-day performance period is not feasible to align with the intent of the measure |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 303 | N/A | eCQM, Registry | Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a cataract surgery to have taken place in the first 9 months of the calendar year |
| 304 | N/A | eCQM, Registry | Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a cataract surgery to have taken place in the first 9 months of the calendar year |
| 305 | CMS137 | eCQM | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 312 | CMS166 | eCQM | Use of Imaging Studies for Low Back Pain | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 330 | N/A | eCQM, Registry | Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a hemodialysis catheter procedure to have taken place in the first 9 months of the calendar year |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 348 | N/A | eCQM, Registry | HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate | This measure has two submission criteria with restriction considerations:<br>1. 90-day period should not include December<br>2. 90-day period should not cover the 4th quarter (October-December) | 1. Measure looks for an encounter in the first 11 months of the calendar year<br>2. Measure looks for a defibrillator implant procedure to have taken place in the first 9 months of the calendar year |
| 355 | N/A | Registry | Unplanned Reoperation within the 30 Day Postoperative Period | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 356 | N/A | Registry | Unplanned Hospital Readmission within 30 Days of Principal Procedure | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 357 | N/A | Registry | Surgical Site Infection (SSI) | 90-day period should not cover the month of December | Measure looks for infection within one month of procedure |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 370 | CMS159 | eCQM, Registry | Depression Remission at Twelve Months | This method requires a denominator eligible encounter within the submission year | The PHQ-9 Tool would need to be evaluated in the chosen 90 Day submission period |
| 373 | CMS65 | eCQM | Hypertension: Improvement in Blood Pressure | 90-day period should not include July-December | Index event needs to take place within the first 6 months of the calendar year; follow-up action must be in the last 6 months of the performance year |
| 377 | CMS90 | eCQM | Functional Status Assessments for Patients with Congestive Heart Failure | Two encounters required | Two encounters within the 90-day performance period is not feasible since the first encounter should be within the first 6 months of the calendar year and the follow-up encounter at least 30 and no more than 180 days after the first encounter |
| 384 | N/A | Registry | Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a retinal detachment surgery to have taken place in the first 9 months of the calendar year |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 385 | N/A | Registry | Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a retinal detachment surgery to have taken place in the first 9 months of the calendar year |
| 389 | N/A | Registry | Cataract Surgery: Difference Between Planned and Final Refraction | 90-day period should not cover the 4th quarter (October-December) | Measure looks for a cataract surgery to have taken place in the first 9 months of the calendar year |
| 391 | N/A | Registry | Follow-Up After Hospitalization for Mental Illness (FUH) | This measure has two submission criteria with restriction considerations:<br>1. 30-day period should not include December<br>2. 7-day period should not cover the last week in December) | 1. Measure looks for a follow up within 30 days from mental health discharge<br>2. Measure looks for a discharge 7 days from mental health discharge |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 392 | N/A | Registry | HRS-12: Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 393 | N/A | Registry | HRS-9: Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision | 90-day period should not include July-December | Index event needs to take place within the first 6 months of the calendar year; follow-up action must be in the last 6 months of the performance year |
| 408 | N/A | Registry | Opioid Therapy Follow-up Evaluation | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 409 | N/A | Registry | Clinical Outcome Post Endovascular Stroke Treatment | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 411 | N/A | Registry | Depression Remission at Six Months | This method requires a denominator eligible encounter within the submission year | The PHQ-9 Tool would need to be evaluated in the chosen 90 Day Submission Period |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
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| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 418 | N/A | Registry | Osteoporosis Management in Women Who Had a Fracture | 90-day period should not include July-December | Index event needs to take place within the first 6 months of the calendar year; follow-up action must be in the last 6 months of the performance year |
| 421 | N/A | Registry | Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 432 | N/A | Registry | Proportion of Patients Sustaining a Bladder Injury at the Time of any Pelvic Organ Prolapse Repair | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 433 | N/A | Registry | Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |

| Measure with Less than Optimal Performance in a 90-Day Submission Period | | | | | |
|---|---|---|---|---|---|
| **Quality ID** | **CMS ID (if applicable)** | **Effected Submission Method(s)** | **Measure Title** | **Limitation** | **Rationale** |
| 434 | N/A | Registry | Proportion of Patients Sustaining a Ureter Injury at the Time of any Pelvic Organ Prolapse Repair | 90-day period should not include December | Measure looks for an encounter in the first 11 months of the calendar year |
| 435 | N/A | Registry | Quality of Life Assessment For Patients With Primary Headache Disorders | Two encounters required | Two encounters within the 90-day performance period is not feasible since the first encounter should be within the first 6 months of the calendar year and the follow-up encounter at least 30 and no more than 180 days after the first encounter |
| 442 | N/A | Registry | Persistence of Beta-Blocker Treatment After a Heart Attack | 90-day period should not include July-December | Index event needs to take place within the first 6 months of the calendar year; follow-up action must be in the last 6 months of the performance year |