2020 Qualified Clinical Data Registry (QCDR) Fact Sheet

Overview

To become a QCDR for the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program, you must self-nominate and successfully complete a qualification process.

When is the self-nomination period?

You can self-nominate from:

July 1 – September 3 of the year prior to the applicable performance period. The Self-Nomination period will promptly close at **8:00 pm ET** on September 3rd. Self-Nominations submitted after the deadline will not be considered.

Tips for Successful Self-Nomination:

1. To become qualified for a given performance period, the vendor must have at least 25 participants by January 1 of the year prior to the applicable performance period. These participants do not need to use the QCDR to report MIPS data to us; rather, they need to submit data to the QCDR for purposes of quality improvement.

2. You must provide all required information at the time of self-nomination, and before the close of the self-nomination period via the CMS Quality Payment Program portal (https://qpp.cms.gov/login) for CMS consideration.

3. Self-nomination is an annual process. If you want to qualify as a QCDR for a given performance period, you will need to self-nominate for that performance period. Qualification and participation in a prior program year does not automatically qualify a vendor for subsequent MIPS performance periods.

   A simplified self-nomination form is available to reduce the burden of self-nomination for those existing QCDRs that have previously participated in MIPS and are in good standing (CMS did not take remedial action against or terminate the QCDR as a third party intermediaries).

   The simplified form is available **only** for existing QCDRs in good standing.

4. Take advantage of QCDR measure concept preview calls available until June 28th. These collaborative preview calls include CMS, MIPS QCDR/Registry Support Team, and the QCDR to discuss and provide feedback regarding the QCDR measure prior to self-nomination. This may also provide an opportunity to discuss current provisionally approved QCDR measures. CMS may provide direction or suggestions to revise the QCDR measure. Please note,

decisions are not considered final during the call. To schedule a meeting, contact the QCDRVendorSupport@gdit.com by 5:00 pm ET on June 15, 2019. QCDR measure concepts and specifications to be discussed at the meeting must be sent at least one week prior to the scheduled meeting in a single Word or Excel document. If information is not received at least one week prior to the scheduled meeting, the meeting is subject to be rescheduled. In addition, a QCDR measure concept preview call does not qualify a QCDR as meeting the QCDR definition for a given self-nomination period.

The list of vendors that have been approved to submit data to CMS as a QCDR for the 2020 performance period of MIPS will be posted in the Resource Library of the CMS Quality Payment Program website.

What is a QCDR?

A QCDR is defined as an entity that demonstrates clinical expertise in medicine and quality measurement development that collect medical or clinical data on behalf of MIPS eligible clinicians to track patients and diseases and foster improvement in the quality of care provided to patients. A QCDR may include:

- An entity with clinical expertise in medicine. Clinicians must be on staff with the organization and lend their clinical expertise in the work carried out by the organization as a QCDR.
- An entity with stand-alone quality measurement development.
- An entity that collects medical or clinical data on behalf of a MIPS eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.
- An entity that uses an external organization for purposes of data collection, calculation, or transmission may meet the definition of a QCDR as long as the entity has a signed, written agreement that specifically details the relationship, roles and responsibilities of the entity with the external organization effective as of September 1 the year prior to the year for which the entity seeks to become a QCDR.

Entities without clinical expertise in medicine and quality measure development that want to become a QCDR, may collaborate with entities with such expertise.

As described in the CY 2018 Quality Payment Program final rule (82 FR 53809), changes to the QCDR's organizational structure (for example, if a specialty society wishes to partner with a different data submission platform vendor) are considered substantive and would need to be updated at the time of self-nomination. The roles of each organization should be specifically detailed within the self-nomination form.

Alternatively, entities may seek to qualify as another type of third-party intermediary, such as a Qualified Registry. Becoming a Qualified Registry does not require the level of measure development expertise that is needed to be a QCDR that develops measures.

The QCDR reporting option is different from a Qualified Registry because QCDRs are not limited to reporting only MIPS Quality Measures. A QCDR may also submit a maximum of 30 QCDR measures for CMS consideration for the 2020 performance period of MIPS.

Measures submitted by a QCDR <u>may</u> be from one or more of the following categories:

- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS), which must be reported via CAHPS certified vendor. Although the CAHPS for MIPS survey is included in the MIPS measure set, the changes needed for reporting by individual eligible clinicians are significant enough to treat it as a QCDR measure for the purposes of reporting via a QCDR. Please note that submitting a subset of CAHPS survey measures as a QCDR measure will not count for credit towards completing the CAHPS for MIPS Survey.
- National Quality Forum (NQF) endorsed measures.
- Current 2020 MIPS Clinical Quality Measures.
- QCDR measures developed by boards or specialty societies with the appropriate documented permission to the QCDR measure.
- QCDR measures developed by regional quality collaborative with the appropriate documented permission to the QCDR measure.

What are the requirements to become a QCDR?

1. **Participants:** You must have at least 25 participants by January 1 of the year prior to the applicable performance period (January 1, 2019). These participants are not required to use the QCDR to report MIPS data to CMS, but they must submit data to the QCDR for quality improvement. Please note that your system must be implemented and able to accept data from a clinician, group or virtual group should they wish to submit data on MIPS Quality Measures and QCDR measures starting on January 1, 2020.

2. **Certification Statement:** During the data submission period, you must certify that data submissions are true, accurate, and complete to the best of your knowledge. This certification includes the acceptance of data exports directly from an EHR or other data sources. If you become aware that any submitted information is not true, accurate, and complete, you will correct such issues promptly prior to submission, and understand that the knowing omission, misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

3. **Data Submission:** You must submit data via a CMS-specified secure method for data submission, such as a defined Quality Payment Program data format. Additional information regarding data submission methodologies can be found in the Developer Tools section of the Resource Library of the Quality Payment Program website: https://qpp.cms.gov/developers.

4. **Data Validation Plan:** During self-nomination, you must thoroughly explain your **process** for validation of data submitted on behalf of individual MIPS eligible clinicians, groups and virtual

groups through the development of a Data Validation Plan. You are required to provide the following as a part of your Data Validation Plan:

- Name of QCDR
- Process of verifying Quality Payment Program eligibility of MIPS eligible clinicians, groups, and virtual groups.
- Process of verifying accuracy of TIN/NPIs.
- Process of calculating reporting and performance rates.
- Process of verifying that your system will only accept data (for purposes of MIPS) on 2020 MIPS Clinical Quality Measures, electronic Clinical Quality Measures and/or QCDR measures (as applicable) during submission.
- Process used for completion of randomized audit.
- Process used for completion of detailed audit.

Your Data Validation Plan will be reviewed by CMS as a part of your self-nomination application and will need CMS approval prior to its implementation for the performance period.

5. **Data Validation Execution Report:** You must execute your 2020 Data Validation Plan and provide us with the **results** (i.e., Results of the randomized/detailed audits? Were there any calculation issues? If so, why did they occur and what was done to remediate?). **Execution of your Data Validation Plan must be completed prior to the 2020 performance period data submission period so errors can be corrected prior to data submission.**

- The 2020 Data Validation Execution Report that includes the results of our audit must be submitted to CMS by May 31, 2021.
- The following items should be addressed in the 2020 Data Validation Execution Report:

  - Name of QCDR
  - Results of verifying MIPS eligibility of clinicians, groups, and virtual groups (i.e., were any issues identified when determining if clinicians, groups, and virtual groups meet the MIPS eligibility requirements? If so, please provide details and examples regarding the identified issues and how they were resolved).
  - Results of verifying the accuracy of Taxpayer Identification Number (TIN)/National Provider Identifier (NPI) (i.e., were any issues identified when verifying TINs/NPIs? If so, please provide details and examples regarding the identified issues and how they were resolved).
  - Results of verifying that 2020 MIPS Quality Measure specifications and/or QCDR measure specifications are utilized for submission (i.e., were any issues identified when verifying that only 2020 MIPS Clinical Quality Measures and/or QCDR measures (as applicable) were submitted? If so, please provide details and examples regarding the identified issues and how they were resolved).
  - Results of calculating data completeness and performance rates (i.e., were any issues identified with how the MIPS quality measure specifications and/or QCDR

measure specifications (as applicable) were implemented in the system? If so, please provide details and examples regarding the identified issues and how they were resolved).
- o Results of the randomized audit (i.e., were there any data issues identified? If so, please provide details and examples regarding the identified issues).
- o Results of the detailed audit (i.e., provide details and examples regarding how the identified data issues were resolved (*Note: The detailed audit is required if errors are found through the randomized audit*).

We require QCDRs to utilize auditing processes to ensure the accuracy of all data submissions under all performance categories. QCDRs would have certified at the time of submission that the data submitted (for all performance categories) is true, accurate, and complete to the best of their knowledge.

Please note, a late submission of your Data Validation Execution Report from your QCDR will be seen as non-compliance with program requirements and may result in remedial action or termination of the QCDR in future program years.

Please note: CMS will provide a sample Data Validation Execution Report template, which will be posted on the [CMS Quality Payment Program Resource Library.](#)

6. **Performance Category Feedback Reports:** QCDRs are required to provide performance category feedback at least four times a year to all MIPS eligible clinicians, groups and virtual groups they are reporting for. Please note:

- CMS does not provide a template for the performance feedback reports.
- If a real-time feedback dashboard is available to clinicians, CMS asks that the QCDR e-mail clinicians, groups and virtual groups at least four times a year, to remind them the feedback is available.

What information is required to self-nominate?

You must provide the following when you self-nominate:
- What is your QCDR's Vendor Name?
- Are you a new or existing QCDR (approved in a previous year of MIPS and/or Physician Quality Reporting System [PQRS])?
- Did you submit QCDR Measure Specifications (if submitting QCDR Measures)?
- Are you supporting MIPS Clinical Quality Measures? Please note that the MIPS clinical quality measure must be used as specified. Measure specification changes are not permitted.
- Are you supporting MIPS electronic Clinical Quality Measures (eCQMs)? Please note that the MIPS eCQM must be used as specified. Measure specification changes are not permitted.

- Which MIPS performance categories do you intend to support? Please note QCDRs are required to support the Quality performance category.
- Which Improvement Activities are you supporting?
- Are you supporting the Promoting Interoperability Objectives and Measures set?
- Vendor Type (i.e., Collaborative, Health Information Exchange/Regional Health Information Organization, Health IT vendor, Regional Health Collaborative, Specialty Society, Other)
- Which data collection method(s) do you intend to support?
- Data Validation Plan
- Confirm you will provide your 2020 performance period Data Validation Plan results by May 31, 2021 (the Data Validation Execution Report)
- Available Performance Data
- Risk Adjustment Method for QCDR Measures (if applicable)
- Which reporting options do you intend to support (i.e., Individual MIPS eligible clinician, Group, Virtual Groups)?
- Specify the Cost (frequency (monthly, annual, per submission) and if the Cost is per provider/practice and Services Included in Cost
- Detailed information on quality measure development experience and clinical expertise

What are the QCDR measure specification requirements?

You must provide specifications for each QCDR measure that you would like to nominate for CMS consideration:

- Provide QCDR measure descriptions and narrative specifications for each QCDR measure with your submitted self-nomination application no later than the last day of the applicable self-nomination period (September 3), utilizing the QCDR measure submission template.
- Publicly post the QCDR measure specifications for each QCDR measure no later than 15 calendar days following CMS's approval of these QCDR measure specifications and provide CMS with the link to the posted information (via a comment in your approved self-nomination form).

QCDR Measures	MIPS Quality Measures
For QCDR Measures, QCDR measure specifications must include: • Measure Title and Description • Denominator and numerator statements • Descriptions of the denominator exceptions, denominator exclusions, and numerator exclusions • National Quality Strategy (NQS) domain • Care setting • Meaningful measure area • Meaningful measure area rationale • Measure type • If the QCDR measure is a high priority measure and priority type (if applicable) • Data source used for the measure • Concise summary of evidence to support performance gap • Performance data on the QCDR measure, average performance rate, and number of clinicians reporting the QCDR measure • Measure owner, please note that permission to use another QCDR's measure should be obtained prior to the QCDR measure being submitted for CMS consideration. • National Quality Forum (NQF) number, if applicable • Number of performance rates required for QCDR measure • Overall performance rate information, if more than one is required • Clinical recommendation statements which summarize the clinical recommendation based on best practices • QCDR measure rationale which provides a brief statement describing the evidence base and/or intent for the measure • Traditional vs Inverse measure • Proportional, continuous variable, ratio measure indicator • If the QCDR measure is risk-adjusted • Risk adjustment variables, and risk adjustment algorithms, when applicable • Indicate which specialty/specialties apply to the QCDR measure • Preferred measure clinical category • Attestation of the feasibility of the QCDR measure at the time of self-nomination	**For MIPS Clinical Quality Measures**, only the MIPS Clinical Quality Measure IDs for individual measures and/or the specialty-measure set measures must be submitted.

What is considered a QCDR measure?

QCDR Measures may include:

- A measure that is not contained in the annual list of MIPS Quality Measures for the applicable performance period.
- A measure that may be in the annual list of MIPS Quality Measures but has substantive differences in the manner it is submitted by the QCDR.
- The CAHPS for MIPS survey, which can only be submitted using a CMS-approved survey vendor. Although the CAHPS for MIPS survey is included in the MIPS measure set, the changes needed for reporting by individual eligible clinicians are significant enough to treat it as a QCDR measure for the purposes of reporting via a QCDR. CMS will not approve patient survey measures that only measure whether the survey was distributed and/or completed. In addition, QCDRs will not receive CAHPS for MIPS survey credit for CAHPS for MIPS survey measures submitted as QCDR measures.

What are the QCDR measure consideration criteria?

Prior to self-nomination of a QCDR measure, the following checklist should be reviewed to increase the likelihood of approval of the QCDR measure. CMS and the contractor team use a similar checklist during the review of QCDR measures.

QCDR measures should:

- Be developed using the measure development processes as defined in the CMS Blueprint.
- Be clinically relevant and evidence based (align with current clinical guidelines).
- Include evidence of a performance gap either by providing performance data or the most recent study citation supporting a performance gap.
- Address requested revisions made by CMS during the previous performance period of MIPS (Provisionally Approved measures) or provide rationale of why the CMS request is not clinically appropriate.
- Focus on a quality action instead of documentation.
- Focus on an outcome rather than a clinical process.
- Have opportunity for adequate patient population and measure adoption for the QCDR measure to have a more significant impact on quality improvement.
- Clearly define the quality action and population in the description for eligible clinician ease of understanding.
- Address one or more Meaningful Measure Areas and National Quality Strategy domains.
- Be fully developed and not just in the concept development phase. End to end testing or process validation should be performed to ensure data can be collected or extracted, received and calculations can occur.
- Indicate accurate measure analytics (inverse, risk-adjusted, ratio, proportional, or continuous variable)

- Be thoroughly proofread by the QCDR to ensure proper spelling and grammar throughout the QCDR measure specification.
- Identify whether there are changes to the QCDR measure specification for the upcoming performance period of MIPS, if approved from a previous performance period of MIPS. Please note, substantive changes that alter the intent of the QCDR measure, and may impact the performance score and benchmarking may result in a new measure ID being assigned.

QCDR measures should **not**:

- Duplicate an existing or proposed MIPS clinical quality measure (CQM/eCQM).
- Duplicate an existing QCDR measure (unless the new measure is a substantial improvement over the existing measure).
    - o To reduce the number of duplicative QCDR measures in MIPS, CMS encourages QCDRs to share and/or harmonize QCDR measures that are similar in topic and/or concept.
- Duplicate a retired Physician Quality Reporting System (PQRS) or quality measure.
- Include measures that are considered topped out with performance rates. Topped out non-process measures means a measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. Topped out process measures mean a measure with a median performance rate of 95 percent or higher.
- Split a single or related clinical process or outcome into several QCDR measures. For example: the results of three different tests are required for a standard of care. Each test should not be a single measure but all three should be combined into one comprehensive measure.
- Have the potential of unintended consequences. For example, a measure that discourages an oncology patient from receiving oxygen therapy or other comfort measures.
- Focus on the elimination of serious, preventable, and costly medical errors that are highly unlikely to occur, so-called "Never Events". For example: Surgery performed on the wrong patient or a fire in the operating room.
- Be overly burdensome to the MIPS eligible clinician.
- Be a standard of care with the expectation it is performed consistently (low bar).
- Be incidence measures - measures that count the occurrence of new or newly diagnosed cases of a specified disease, illness, or injury within the indicated timeframe.
- Have a quality action that is not attributable to the submitting eligible clinician.
- Be documentation/check box measures.

CMS recommends that QCDRs utilize the following when developing and self-nominating QCDR measures:

- Measure Development Plan
- QCDR Measure Development Handbook

- **CMS Blueprint**

What data submission functions must an approved QCDR perform?

Following the self-nomination and QCDR measure process, an approved QCDR must perform the following data submission functions:

1. **Indicate:**
   - Whether the QCDR is using CEHRT data source
   - End-to-end electronic reporting, if applicable.
   - Performance period start and end dates.
   - Report data on Promoting Interoperability objectives and measures and objectives or Improvement Activities, as applicable, to the standards and requirements of the respective performance categories.

2. **Submit:**
   - The data and results for all supported MIPS performance categories.
     - ✓ The data must include **all-payer data**, and not just Medicare Part B patients, as applicable.
   - Results for at least six Quality Measures (claims, MIPS CQMs, eCQMs, and/or QCDR measures), including one outcome measure, as applicable.
     - ✓ If an outcome measure is not available, use at least one other high priority measure.
     - ✓ Give entire distribution of measure results by decile, if available.
       - ▪ Additional information about benchmarks can be found in the Quality Benchmarks zip file.
   - Appropriate measure and activity IDs for Quality Measures, Promoting Interoperability measures and objectives, and Improvement Activities.
   - Measure-level data completeness rates by TIN/NPI and/or TIN.
   - Measure-level performance rates by TIN/NPI and/or TIN.
   - The sampling methodology used for data validation.
   - Risk-adjusted results for any risk-adjusted measures.
   - Additional details for QCDR Measures:
     - ✓ Data elements and QCDR measure specifications.
     - ✓ Risk-adjusted results for QCDR quality data.
     - ✓ Comparison of quality of care by measure, by clinician or group.

3. **Report on the number of:**
   - Eligible instances (the eligible patient population).
   - Instances a quality action is performed (performance met).
   - Instances the applicable quality action was not met (performance not met).
   - Instances a performance exception/exclusion occurred (denominator exceptions/numerator exclusions).

4. **Verify and maintain eligible clinician information:**
- Signed verification of clinician names, contact information, services provided, costs charged to clinicians, Quality Measures (MIPS Clinical Quality Measures and/or QCDR Measures), and specialty-specific measure sets (if applicable).
- Business agreement(s) with clinicians, groups or virtual groups who provide patient-specific data.
  - ✓ A practice administrator may give consent on behalf of a group or virtual group reporting as a group, but not for an individual MIPS-eligible clinician reporting as an individual
  - ✓ Business associate agreements must comply with HIPAA Privacy and Security Rules.
  - ✓ Include disclosure of MIPS quality measure results and data on Medicare and non-Medicare beneficiaries.
- Signed NPI-holder authorization to:
  - ✓ Submit data and results to CMS for MIPS.
- Certification statement that all data and results are true, accurate and complete to the best of your knowledge.

5. **Comply with:**
- Any CMS request to review your submitted data.
- Requirement to participate in the mandatory QCDR kick-off meeting and monthly support calls.
- Participation requirements (Data Validation Execution Report, performance feedback to eligible clinicians, QCDR must be up and running by January 1 of the given performance period, etc.).
- A CMS-approved secure method for data submission.

What are the thresholds for data inaccuracies? What are considered data inaccuracies?

Data inaccuracies that affect MIPS eligible clinicians, may result in:

- Remedial action may be taken against your QCDR due to the low data quality rating.
- Will have the QCDR Qualified Posting updated for the performance period of MIPS to indicate the QCDR's data error rate on the CMS website until the data error rate falls below 3 percent and that remedial action has been taken against the QCDR.

Data inaccuracies affecting **more than 5%** of your total MIPS eligible clinicians may lead to termination of the QCDR for future program year(s).

CMS will evaluate each quality measure for data completeness and accuracy. The vendor will also attest that the data (quality measures, improvement activities, and promoting interoperability objectives and measures) results submitted are true, accurate, and complete to the best of their knowledge.
CMS will determine error rates calculated on data submitted to CMS for MIPS eligible clinicians.

CMS will evaluate data inaccuracies including, but not limited to:

- TIN/NPI Issues – Incorrect Tax Identification Numbers (TINs), Incorrect National Provider Identifiers (NPIs), Submission of Group NPIs.
- Formatting Issues – Submitting files with incorrect file formats, Submitting files with incorrect element formats, Failure to update and resubmit rejected files.
- Calculation Issues – Incorrect qualities for measure elements, performance rates, and/or data completeness rates; Numerators larger than denominators.
- Data Audit Discrepancies – Since data audits are required to occur prior to data submission, QCDRs should correct all identified errors prior to submitting the data to CMS. QCDR acknowledgement of data discrepancies found post submission from clinician feedback reports.

What may cause remedial action to be taken or termination of third party intermediaries from the program?

CMS may take remedial action for failing to meet applicable criteria for approval or submit data that is inaccurate, unusable, or otherwise compromised.

Failure to comply with the remedial action process may lead to termination of third party intermediaries for the current and/or subsequent performance year.

The QCDR Qualified Posting will be updated to reflect when remedial action has been taken and/or termination of third party intermediaries participating as a qualified QCDR.

What is the overall process to become an approved QCDR?

The overall process includes these steps:

- The QCDR completes and submits the self-nomination form, supported measures (MIPS Quality Measures and/or QCDR Measures), and Data Validation Plan through the Quality Payment Program portal for CMS consideration.
- If the self-nomination form, MIPS Quality Measures, and Data Validation Plan are approved, all submitted QCDR measures are reviewed (if applicable). CMS may approve, provisionally approve, or reject the QCDR measures. The QCDR measure statuses are defined as:
  - o Approved – The QCDR measure is approved for the given performance period.
  - o Provisionally Approved – The QCDR measure is approved for the given performance period however, CMS is requesting additional information or action if the QCDR measure is resubmitted for subsequent performance periods. CMS will provide a rationale for the provisional status. This may include performance data to assess performance gaps, revision or harmonization of the QCDR measure if it is to be submitted during the next self-nomination period.

- o Rejected – The QCDR measure is not approved for the given performance period. CMS will provide a rationale for the rejection.
- The Qualified Posting is developed for the approved QCDRs and include organization type, specialty, previous participation in MIPS (if applicable), program status (remedial action taken against the QCDR or terminated as a third part intermediary (if applicable)), contact information, last date to accept new clients, virtual groups specialty parameters (if applicable), the approved measures, performance categories supported, services offered, and costs incurred by clients. All approved QCDRs are included in the Qualified Posting that is posted on the CMS Quality Payment Program Resource Library.
- Approved QCDRs review and acknowledge the measure specifications for their approved QCDR measures.
- Approved QCDRs are required to support the performance categories and measures and activities listed on their Qualified Posting and meet all applicable approval criteria for the applicable performance period as a condition of participation in MIPS. Failure to do so may lead to remedial action or possible termination of the QCDR from future years of MIPS.

Resources

- **QCDR Support Calls -** CMS will hold mandatory support calls for QCDRs that are approved to participate in the 2020 performance period. These support calls will be held approximately once a month, with the kick-off meeting (in-person or virtually) being the first of the monthly calls. The support calls address reporting requirements, steps for successful submission, and allow for a question and answer session. The monthly support calls are limited to only approved 2020 performance period QCDRs. Each QCDR must attend both the webinar and audio portion via computer or phone to receive credit for attending the support call. One representative, from a vendor supporting multiple QCDRs, will **NOT** be counted as attendance for multiple QCDRs.
- **Quality Payment Program ListServ -** The Quality Payment Program ListServ will provide news and updates on new resources, website updates, upcoming milestones, deadlines, CMS trainings, and webinars. To subscribe, visit the Quality Payment Program website and select "Subscribe to Updates" at the bottom of the page or in the footer.
- **Quality Payment Program Website -** Educational documents for QCDR participation will be available on the website to help support you in your submission process.
- **Quality Payment Program -** If you have any questions, the Quality Payment Program is here to help and will be able to direct you to the appropriate staff to best meet your needs. You can reach the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292 or 1-877-715-6222 (TTY) Monday – Friday, 8:00 AM – 8:00 PM Eastern Time.
- **The Self-Nomination User Guide -** This guide provides step-by-step instructions for vendors looking to become an approved QCDR for the 2020 performance period of MIPS.
- **Blueprint for the CMS Measures Management System -** Provides a standardized system for developing and maintaining the Quality Measures used in CMS's various quality initiatives and programs. The primary goal is to provide guidance to measure developers to help them produce high-caliber healthcare Quality Measures and

documents the core set of business processes and decisions criteria when developing, implementing, and maintaining measures.

- **Measure Development Plan -** Is a focused framework to help CMS build and improve Quality Measures that clinicians could report under MIPS and as participants in Advanced Alternative Payment Models (collectively known as the Quality Payment Program).
- **QCDR Measure Development Handbook -** 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.
- **QCDR Measure Development Google Group -** Provides a space for QCDRs to collaborate on QCDR measures and share ideas throughout the QCDR measure development process.
- **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.