Instructions for populating the 2021 Merit-Based Incentive Payment System (MIPS) Performance Period Self-Nomination Qualified Clinical Data Registries (QCDR) Measure Submission Template

Disclaimer: The information is subject to change based upon what is finalized in the Calender Year 2021 Physician Fee Schedule Final Rule for the Quality Payment Program. If needed, this document will be updated to what is finalized in the final rule and reposted accordingly.

The QCDR Measure Submission Template should ONLY be filled out by QCDRs who meet the 2020 definition of a QCDR, are self-nominating as a QCDR for 2021, and wish to submit QCDR measures for CMS consideration.

A QCDR may submit a maximum of 30 QCDR measures for review and approval by CMS consideration for reporting.

Complete the fields for each proposed 2021 MIPS Performance Period QCDR Measure. (Note: If you do not own the measure, please provide your information in all unshaded columns.) **Please ensure that the QCDR measure specifications are checked for grammar and typographical errors before submission.**

Please follow these steps when completing the QCDR Measure Submission Template:

1. Open the QCDR Measure Submission Template and save it with your organization's name (i.e., 2021 QCDR Measure Submission_QCDRName_vX). Please update the version number, when an updated QCDR Measure Submission Template is uploaded or attached.

2. Navigate to the "QCDR Information" tab. For existing QCDRs in good standing, please update row 5 (Self-Nomination ticket #) and row 6 (Expected number of QCDR measures to be submitted (to be entered by QCDR)). For new QCDRs, enter information for all the rows except for row 4 (QCDR Vendor ID (if applicable)). Your organization will be assigned a QCDR Vendor ID upon approval.

3. Navigate to the "2021 QCDR Measure Subm Template" tab. Complete all required fields denoted with an asterisk (*). The table below shows which columns are required or optional. (If you do not own or co-own the QCDR measure, please provide your information in all unshaded columns.

4. Upload or attach the 2021 QCDR Measure Submission Template to your organization's 2021 Self-Nomination form. Please note that the 2021 QCDR Measure Submission Template does not need to include all of the proposed QCDR measures to be uploaded or attached to your organization's 2021 Self-Nomination form. You may upload or attach an updated 2021 QCDR Measure Submission Template with additional QCDR measures prior to the end of the 2021 Self-Nomination period which ends at **8 p.m. Eastern Time (ET) on September 1st.**

Column	Column Header	Required/Optional?	Instructions/Notes
A	PIMMS Tracking ID (PIMMS USE ONLY)	N/A	This is a unique ID that is used for PIMMS tracking purposes and internal use only.
B	Input Row Completeness	N/A	Provides the status of "Complete" or "Incomplete" for each row. "Incomplete" will display if all of the REQUIRED fields have not been populated for a given entry.
C	Error Messages for Required Fields	N/A	Provides the user with an error message(s) regarding missing REQUIRED information for each entry. Also, missing REQUIRED information for each entry will have the cell highlighted in red after five REQUIRED fields have been populated in the template for the specific proposed measure.
D	Measure ID: Measure Title (Reference only)	N/A	This is a locked autofilled cell that gives a reference point of Measure ID and Measure Title.
E	Measure Ready for PIMMS Review?	Required	Indicate if the given entry is "Ready for PIMMS Team Review", a "Work in Progress" or "Withdrawn". Entries with a "Work in Progress" status will not be reviewed until the status is updated to "Ready for PIMMS Team Review".
F	Do you own this measure?	Required	Enter "Yes", "No" or "Co-owned by 2 or more QCDRs" for this field. By selecting "No" you are attesting that you do not own or co-own the measure and currently have the appropriate documentation (i.e., email, letter) giving your organization permission from the QCDR measure owner/steward to use the QCDR measure. Documentation to support permission will be verified. Please provide information in all unshaded columns. **Please note that the QCDR who owns the measure must be an active and approved QCDR for the given self-nomination period.**
G	If you answered "No" or "Co-owned by 2 or more QCDRs", please indicate the approved owner or co-owners	Optional	Provide the name of the active and approved QCDR(s) that own or co-own the QCDR measure. **Example:** XXX QCDR
H	Program Submission Status	Required	Select the measure submission status from the drop down list that describes the measure submitted for review. (New or existing measure with/without changes). If you select 'Existing Approved QCDR Measure With No Changes', all cells that should not be changed will be shaded. **Please ONLY update the cells that are unshaded.**
I	If this is a previously CMS approved measure, please provide the CMS assigned measure ID	Required	Please enter the **most recent** CMS assigned QCDR measure ID if the QCDR measure was included in any MIPS performance period as an approved measure. Enter "N/A" if not applicable. **Please do NOT self-assign a QCDR measure ID. CMS is responsible for assigning QCDR measure IDs.**
J	If existing measure with changes, please indicate what has changed to the existing measure	Optional	Provide a detailed explanation of what changes were made to the measure. **Example:** Denominator exclusion added
K	Can the measure be benchmarked against the previous performance period data?	Optional	Enter "Yes" or "No" to indicate if the benchmark from prior years is able to be used for comparison.
L	If applicable, please provide details why the previous benchmark can or cannot be used	Optional	Provide details regarding why the previous benchmark can or cannot be used in response to the changes to the existing measure. **Example:** The improvement addition to the numerator will make this measure an Outcome measure and therefore cannot be compared to the measure from last year.
M	Measure Title	Required	Provide the measure title, which should begin with a clinical condition of focus, followed by a brief description of action. **Example:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan.
N	Measure Description	Required	Describe the measure in full detail. **Example:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
O	Denominator	Required	Describe the eligible patient population to be counted to meet the measures' inclusion requirements. **Example:** All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.
P	Numerator	Required	The clinical action that meets the requirements of the measure. **Example:** Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.
Q	Denominator Exclusions	Required	An exclusion is anything that would remove the patient, procedure, or unit of measurement from the denominator. Enter "N/A" if not applicable. **Example:** Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.
R	Denominator Exceptions	Required	Allow for the exercise of clinical judgement. Applied after the numerator calculation and only if the numerator conditions are not met. Enter "N/A" if not applicable. **Example:** Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. **OR** Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.
S	Numerator Exclusions	Required	An exclusion is anything that would remove the patient, procedure, or unit of measurement from the numerator, typically used in ratio or inverse proportional measures. Applied before the numerator calculation. Enter "N/A" if not applicable. **Example:** If the number of central line blood stream infections per 1,000 catheter days were to exclude infections with a specific bacterium, that bacterium would be listed as a numerator exclusion.
T	Primary Data Source Used for Abstraction	Required	Indicate the primary data source used for the measure. This may include but is not limited to administrative claims data, facility discharge data, chronic condition data warehouse (CCW), claims, CROWNWeb, EHR (enter relevant parts), Hybrid, IRF-PAI, LTCH CARE data set, National Healthcare Safety Network (NHSN), OASIS-C1, paper medical record, Prescription Drug Event Data Elements, PROMIS, record review, Registry (enter which Registry), Survey, Other (describe source).
U	If applicable, please enter additional information regarding the data source used	Optional	Provide additional information when "Registry" and/or "Other" is selected. **Example:** ABC Registry You may list additional data sources used in addition to the primary data source.
V	NQF ID Number (if applicable)	Optional	Provide the assigned NQF ID number, if the submitted QCDR measure fully aligns with the NQF endorsed version of the measure. If no NQF ID number, enter 0000. **Example:** 0418
W	High Priority Measure?	Required	Enter "Yes" or "No" to indicate if the measure is a high priority measure.
X	High Priority Type	Required	Indicate the high priority measure type.
Y	Measure Type	Required	Select which measure type applies to the measure.
Z	NQS Domain	Required	Select which NQS domain applies to the measure.
AA	Care Setting	Required	Select which care setting is included within the measure. If multiple care settings apply, select the option "Multiple Care Settings" and enter them in the next cell.
AB	If Multiple Care Settings selected, list Care Settings here	Optional	If "Multiple Care Settings" was selected, enter all Care Settings that apply.
AC	Includes Telehealth?	Required	Please answer "Yes" or "No" if the QCDR measure's denominator includes services provided via telehealth. (Please review the quality action to ensure that it is appropriate via telehealth.)
AD	Which Meaningful Measure Area applies to this measure?	Required	Select ONLY one Meaningful Measure Area that best applies to the measure.
AE	Meaningful Measure Area Rationale	Required	Provide a rationale for the selected Meaningful Measure Area for the QCDR measure. **Example:** This measure identifies patients with depression and an appropriate follow-up treatment plan.

Column	Column Header	Required/Optional?	Instructions/Notes
AF	Inverse Measure	Required	Indicate if the measure is an inverse measure. This is a measure where a lower calculated performance rate for this type of measure would indicate better clinical care or control. The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases.
AG	Proportional Measure	Required	Indicate if the measure is a proportional measure. This is a measure where the score is derived by dividing the number of cases that meet a criterion for quality (the numerator) by the number of eligible cases within a given time frame (the denominator). The numerator cases are a subset of the denominator cases (e.g., percentage of eligible women with a mammogram performed in the last year).
AH	Continuous Variable Measure	Required	Indicate if the measure is a continuous variable measure. This is a measure where a measure score in which each individual value for the measure can fall anywhere along a continuous scale and can be aggregated using a variety of methods such as the calculation of a mean or median (e.g., mean time to thrombolytics, which aggregates the time in minutes from a case presenting with chest pain to the time of administration of thrombolytics). CMS encourages QCDRs to construct the numerators to be proportional by establishing an expected benchmark based on guidelines or national performance data. Applying MIPS scoring methodology has proven to be challenging for non-proportional measures because variability in the data points makes decile creation based on a mathematical analysis very unpredictable.
AI	Ratio Measure	Required	Indicate if the measure is a ratio measure. This is a measure where 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.
AJ	If Continuous Variable and/or Ratio is chosen, what is the range of the score(s)?	Optional	Please provide a defined range of performance. If it is not a continuous variable and/or ratio measure, enter "N/A". **Example**: 0-250 minutes
AK	Number of performance rates to be calculated and submitted	Required	Indicate the number of performance rates submitted for the measure. If only one is calculated, enter '1'.
AL	Performance Rate Description(s)	Optional	Provide a brief description for each performance rate to be calculated and submitted. **Example:** This measure will be calculated with 7 performance rates: 1) Overall Percentage for patients (aged 5-50 years) with well-controlled asthma, without elevated risk of exacerbation 2) Percentage of pediatric patients (aged 5-17 years) with well-controlled asthma, without elevated risk of exacerbation 3) Percentage of adult patients (aged 18-50 years) with well-controlled asthma, without elevated risk of exacerbation 4) Asthma well-controlled (submit the most recent specified asthma control tool result) for patients 5 to 17 with Asthma 5) Asthma well-controlled (submit the most recent specified asthma control tool result) for patients 18 to 50 with Asthma 6) Patient not at elevated risk of exacerbation for patients 5 to 17 with Asthma 7) Patient not at elevated risk of exacerbation for patients 18 to 50 with Asthma
AM	Indicate an Overall Performance Rate	Required	Specify which of the submitted rates will represent an overall performance rate for the measure or how an overall performance rate could be calculated based on the data submitted (for example, simple average of the performance rates submitted) or weighted average (sum of the numerators divided by the sum of the denominators), etc. **If only 1 performance rate is being submitted, enter 1st performance rate.**
AN	Risk-Adjusted Status?	Required	Indicate if the measure is risk-adjusted.
AO	If risk-adjusted, indicate which score is risk-adjusted	Required	Indicate the score that is risk-adjusted for the measure.
AP	Is the QCDR Measure able to be abstracted?	Required	Please attest that the measure element can be abstracted and is feasible. **If borrowing the measure, it is expected that the ability to abstract the data according to the QCDR measure owner's specifications is a condition of self-nominating the QCDR measure. Withdrawing of the QCDR measure during an active performance period is not acceptable.**
AQ	Was the QCDR measure tested at the individual clinician level?	Optional	Enter "Yes" or "No" to indicate if the QCDR measure was tested at the individual clinician level.
AR	Validity Testing Summary	Optional	Provide validity testing summary if available.
AS	Feasibility Testing Summary	Optional	Provide feasibility testing summary if available.
AT	Reliability Testing Summary	Optional	Provide reliability testing summary if available.
AU	Describe Link to Cost Measure/Improvement Activity	Required	Describe the link between the QCDR measure, cost measure, and an improvement activity. Please document "no link identified", if there is no link to a cost measure or an improvement activity. In cases where a QCDR measure does not have a clear link to a cost measure and an improvement activity, we would consider exceptions if the potential QCDR measure otherwise meets the QCDR measure requirements and considerations.
AV	Clinical Recommendation Statement	Required	Provide a concise statement regarding the clinical recommendation for this QCDR measure including the current clinical guideline from which the measure is derived. **Example:** Adolescent Recommendation (12-18 years) "The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360).
AW	Provide the rationale for the QCDR measure	Required	Provide a concise statement regarding the rationale for the QCDR measure. **Example:** Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt, Brody 2014). 2014 U.S. survey data indicate that 2.8 million (11.4%) adolescents aged 12 to 17 had a major depressive episode (MDE) in the past year and that 15.7 million (6.6%) adults aged 18 or older had at least one MDE in the past year, with 10.2 million adults (4.3%) having one MDE with severe impairment in the past year (Center for Behavioral Health Statistics and Quality, 2015).
AX	Provide measure performance data (# months data collected, average performance rate, performance range, and number of clinicians or groups)	Optional	Please provide the # of months the data was collected, average performance rate, performance range and the number of eligible clinicians and/or TINs submitting the measure within your self-nomination. **Example:** 12 months, Average performance rate 75%, range 52-89%, 112 Clinicians submitting data
AY	If applicable, provide the study citation to support performance gap for the measure	Optional	Provide the study citation for the measure to support the performance gap. Citations should be the most current available or within 5 years. **Example:** Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, 2010, p. 948)
AZ	If applicable, provide a Participation Plan if QCDR measure has low adoption by clinicians	Optional	If a QCDR measure fails to meet benchmarking thresholds for 2 consecutive performance periods (i.e. the data submitted is insufficient in meeting the case minimum and volume thresholds required for benchmarking), the QCDR may submit a participation plan for CMS consideration if is believed that the measure is important and relevant to a specialist's practice. **Participation Plan requirements**: Detailed plan and methods to encourage eligible clinicians and groups to increase QCDR measure adoption. As examples, a QCDR measure participation plan could include one or more of the following: Development of an education and communication plan; update the QCDR measure's specification with changes to encourage broader participation; require reporting on the QCDR measure as a condition of reporting through the QCDR.
BA	Please indicate applicable specialty/specialties	Required	Indicate the specialty/specialties the measure applies to. **Example:** Anesthesiology, Neurology, and Urology
BB	Preferred measure published clinical category	Required	Please provide a preferred clinical or specialty category. Please note that if a preferred measure published clinical category is not provided, one will be assigned to the measure by CMS. **Example:** Diabetes and Substance Use/Management
BC	QCDR Notes	Optional	Provide any additional notes that would assist in the review or clarification of the QCDR measure.
BD	CMS QCDR Measure Feedback	N/A	QCDR measure review feedback will be entered in this column. Feedback will be dated with the most current feedback at the top of the cell. Please note that the column will be locked until CMS has provided their feedback.
BE	Vendor QCDR Measure Response	N/A	Vendor provides their response to the QCDR measure review feedback provided by CMS. Response(s) should be dated with the most current feedback at the top of the cell. Please note that this column will be locked until CMS has provided their feedback.
BF	QCDR Measure Reconsideration Meeting Summary	N/A	This column will be populated for each QCDR measure that is discussed during the resolution meeting between CMS, PIMMS MIPS Team and the vendor.
BG	Final CMS Measure Decision	N/A	This column will be populated or updated for each QCDR measure that is discussed during the resolution meeting between CMS, PIMMS MIPS Team and the vendor.

Please enter QCDR information in cells B3 through B6.

QCDR Information Fields	QCDR Information Entries	Instructions/Notes
QCDR Organization Name:		To be completed by the QCDR.
QCDR Vendor ID (if applicable):		To be completed by the QCDR, if a Vendor ID has been assigned.
Self-Nomination ticket #:		To be completed by the QCDR, once a self-nomination ticket is available in the QPP Self-Nomination Portal.
Expected number of QCDR measures to be submitted (to be entered by QCDR):		To be completed by the QCDR. Should include the number of QCDR measures the QCDR plans to submit for the 2021 self-nomination period.
Total number of QCDR measures entered in 2021 QCDR Measure Submission Template:	0	For reference only. Count allows check against expected number of QCDR measures to be submitted.
Total number of QCDR measures "Ready for PIMMS Review" status in 2021 QCDR Measure Submission Template:	0	For reference only. Allows confirmation that all expected QCDR measures are ready for PIMMS review at time of submission.
Total number of QCDR measures in "Work in Progress" status in 2021 QCDR Measure Submission Template:	0	For reference only. Allows confirmation that all expected QCDR measures are no longer in a work in progress status at time of submission.
Total number of QCDR measures in missing required information:	0	For reference only. Allows confirmation of the number of QCDR measures missing required information.

				Column Title changed for 2021	If "NO", see instructions tab	Column Title changed for 2021	Column Title changed for 2021
PIMMS Tracking	Input Row Comp	Error Messages for Requi	Measure ID: Measure Title (Re	Measure Ready for PI	Do you own this meas	If you answered "No" or "Co-owned by 2	Program Submission Status*
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If this is a previously CMS approv	If existing measure with changes, please indicate what has	Can the measure be be	If applicable, please provide details why the previous bench

Measure Title*	Measure Description*	Denominator*	Numerator*

Column Title changed for 2021

Denominator Exclusions*	Denominator Exceptions*	Numerator Exclusions*	Primary Data Source Used for

New for 2021

If applicable, please enter additional information rega	NQF ID Number(if	High Priority M	High Priority Type*	Measure Type*	NQS Domain*	Care Setting*	If Multiple Care Settings selected, lis

New for 2021

Includes Telehealth?*	Which Meaningful Measure Area ap	Meaningful Measure Area Rationale*	Inverse Measu	Proportional M	Continuous Va	Ratio Measure*	If Continuous Variable and/or Ratio is c

		Column Title changed for 2021				New for 2021	New for 2021
Number of performan	Performance Rate Descriptio	Indicate an Overall Perfor	Risk-Adjusted St	If risk-adjusted, indicate which s	Is the QCDR Measure able t	Was the QCDR measure tes	Validity Testing Summary

New for 2021	New for 2021	New for 2021		
Feasibility Testing Summary	**Reliability Testing Summary**	**Describe Link to Cost Measure/Improvement**	**Clinical Recommendation Statement***	**Provide the rationale for the QCDR measure**

Column Title changed for 2021

New for 2021

Provide measure performance data (# months data collecte	**If applicable, provide the study citation to support performa**	**If applicable, provide a Participation Plan if QCDR measure**

Please indicate applicable specialty/s	Preferred measure published clinica	QCDR Notes

CMS QCDR Measure Feedback	Vendor QCDR Measure Response	QCDR Measure Reconsideration Meeting Summary	Final CMS Measure Decision

2021 Excel Template:

PIMMS Tracking ID (PIMMS USE ONLY)

Input Row Completeness

Error Messages for Required Fields

Measure ID: Measure Title (Reference only)

Measure Ready for PIMMS Review?*

Do you own this measure?*

If you answered "No" or "Co-owned by 2 or more QCDRs", please indicate the approved owner or co-owners

Program Submission Status*

If this is a previously CMS approved measure, please provide the CMS assigned measure ID*

If existing measure with changes, please indicate what has changed to the existing measure

Can the measure be benchmarked against the previous performance period data?

If applicable, please provide details why the previous benchmark can or cannot be used

Measure Title*

Measure Description*

Denominator*

Numerator*

Denominator Exclusions*

Denominator Exceptions*

Numerator Exclusions*

Primary Data Source Used for Abstraction*

If applicable, please enter additional information regarding the data source used

NQF ID Number
(if applicable)

High Priority Measure?*

High Priority Type*

Measure Type*

NQS Domain*

Care Setting*

If Multiple Care Settings selected, list Care Settings here

Includes Telehealth?*

Which Meaningful Measure Area applies to this measure?*

Meaningful Measure Area Rationale*

Inverse Measure*

Proportional Measure*

Continuous Variable Measure*

Ratio Measure*

If Continuous Variable and/or Ratio is chosen, what is the range of the score(s)?

Number of performance rates to be calculated and submitted*

Performance Rate Description(s)

Indicate an Overall Performance Rate*

Risk-Adjusted Status?*

If risk-adjusted, indicate which score is risk-adjusted

Is the QCDR Measure able to be abstracted?*

Was the QCDR measure tested at the individual clinician level?

Validity Testing Summary

Feasibility Testing Summary

Reliability Testing Summary

Describe Link to Cost Measure/Improvement Activity*

Clinical Recommendation Statement*

Provide the rationale for the QCDR measure*

Provide measure performance data (# months data collected, average performance rate, performance range, and number of clinicians or groups)

If applicable, provide the study citation to support performance gap for the measure

If applicable, provide a Participation Plan if QCDR measure has low adoption by clinicians

Please indicate applicable specialty/specialties*

Preferred measure published clinical category*

QCDR Notes

CMS QCDR Measure Feedback

Vendor QCDR Measure Response

QCDR Measure Reconsideration Meeting Summary

Final CMS Measure Decision

2022 Webform Template Value
N/A
N/A
N/A