TABLE Group D: Measures with Substantive Changes Finalized for the 2021 MIPS Payment Year and Future Years

D.1. Medication Reconciliation Post-Discharge

Category	Description
NQF #:	0097
Quality#:	046
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	Medicare Part B Claims Measure Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	The percentage of discharges from any inpatient facility (for example hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Submission Criteria 1: 18-64 years of age • Submission Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older
Substantive Change:	**Modified collection type**: Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Steward:	National Committee for Quality Assurance
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We removed the CMS Web Interface Measure Specifications collection type. This is a process measure, which promotes care coordination when transitioning from an inpatient facility to outpatient care. Removal of this measure from the CMS Web Interface supports our effort to move towards outcome and more meaningful measures within the CMS Web Interface. In addition, since clinicians are required to report all available CMS Web Interface measures, removing this measure from the CMS Web Interface will reduce the burden of the number of measures a clinician is required to report under the CMS Web Interface. This measure is broadly applicable to eligible clinicians participating in the MIPS program using the collection types of Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications. Retaining this measure through the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types allows clinicians to choose this measure as one of the six measures clinicians are generally required to report to meet the quality performance category requirements.

Comment: Commenters indicated that CMS should retain this measure because ensuring clinicians are reconciling patient medications limits the occurrence of adverse drug events for elderly patients with multiple co-morbidities and prescription medications.

Response: This is a process measure that promotes care coordination when transitioning from an inpatient facility to outpatient care. While we agree that medication reconciliation is an important aspect of care coordination and avoiding adverse drug events, we believe a more broadly applicable measure that does not just focus on medication reconciliation post discharge would more effectively promote care coordination. In addition, since clinicians are required to report all available CMS Web Interface measures, removing this measure from the CMS Web Interface will reduce the burden of the number of measures a clinician is required to report under the CMS Web Interface. We do not believe removing this measure from one collection type, CMS Web Interface, will increase the occurrence of adverse drug events because eligible clinicians have the opportunity to report this measure as a Medicare Part B Claims Measure Specification or MIPS CQMs Specification.

Comment: In addition, several commenters expressed general concerns that the measures we proposed to remove from the CMS Web Interface would continue to be used in other programs or that they would remain available to report to MIPS via other reporting mechanisms, creating inconsistency in the available measure set by reporting mechanism. One commenter expressed concerns about removal of the CMS Web Interface and its impact on the Medicare Shared Savings Program and ACO participants that utilize this data collection method for this measure.

Response: We acknowledge that measures proposed for removal from the CMS Web Interface may continue to be required by other programs and available by other collection types. However, removing them from the CMS Web Interface would reduce burden on MIPS groups and ACO participants by removing the requirement that they actively submit the measure performance data through the CMS Web Interface. For MIPS groups, we are removing this measure to reduce burden of reporting the required measure set. However, we are retaining this measure through the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types to allow clinicians an opportunity to report this measure as one of the six measures to meet the quality performance category requirements.

FINAL ACTION: We are finalizing the changes to measure Q046 as proposed for the 2019 Performance Period and future years.

D.2. Pneumococcal Vaccination Status for Older Adults

Category	Description
NQF #:	N/A
Quality#:	111
CMS eCQM ID:	CMS127v7
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine
Substantive Change:	**Modified collection type:** Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We removed the CMS Web Interface Measure Specifications collection type. This measure has lost NQF endorsement and no longer reflects the current guidelines. A new measure is under development to reflect current guidelines and may be proposed in the future. In addition, since clinicians are required to report all available CMS Web Interface measures, removing this measure from the CMS Web Interface will reduce the burden of the number of measures a clinician is required to report under the CMS Web Interface. This measure is broadly applicable to eligible clinicians participating in the MIPS program using the collection types of Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications, and eCQM specifications. Retaining this measure through the Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications, and eCQM specification collection types allows clinicians to choose this measure as one of the six measures clinicians are generally required to report to meet the quality performance category requirements. We encourage stakeholders to submit a replacement measure for future consideration that is in alignment with the most current clinical guidelines.

Comment: Several commenters opposed the removal of the CMS Web Interface Measure Specifications collection type for this measure. The commenter recommended that CMS works toward immediately replacing the measure with another similar (and endorsed) measure which will lead to the capture of comprehensive care of elderly patients. They noted that complete removal and no replacement of this measure will lessen the incentive and urgency for ACOs to administer this life saving vaccination, resulting in fewer patients vaccinated, and leading to worsened outcomes and higher costs.

Response: We agree on the importance of a pneumonia vaccination measure. However, we believe the burden to submit this measure via the CMS Web Interface and the loss of NQF endorsement aligns with our goal to be less burdensome for clinicians and ensure measures are still supported by the current clinical guidelines. Furthermore, we acknowledge that pneumonia vaccination is an important preventive clinical intervention, but measure Q111 does not address current pneumonia vaccination guidelines. We believe maintaining the measure under other collection types to provide an option to select a measure that addresses important population health matter. However, until this measure can be replaced with a measure promoting pneumococcal vaccination, we believe it should not be required to be submitted via the CMS Web Interface. Eligible clinicians submitting Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications are able to select quality measures that are applicable to their specialty that are meaningful to their practice. In the CMS Web Interface, all measures are required; therefore, some eligible clinicians may believe the measure to be burdensome since it does not fully align with the current pneumococcal vaccination schedule.

Comment: A few commenters expressed concern that the measures we proposed to remove from the CMS Web Interface would continue to be used in other programs or that they would remain available to report to MIPS via other reporting mechanisms, creating inconsistency in the available measure set by reporting mechanism.

Response: We acknowledge that measures proposed for removal from the CMS Web Interface may continue to be required by other programs and available by other collection types. However, removing them from the CMS Web Interface would reduce burden on MIPS groups and ACO participants by removing the requirement that they actively submit the measure performance data through the CMS Web Interface. Specific to ACO participants, ACOs can track these additional metrics in order to participate in the Shared Savings Program and potentially earn shared savings. We note, however, that one of the advantages of clinician participation in a Shared Savings Program ACO is that the ACO reports quality on the clinicians' behalf, reducing clinician burden. We believe that this streamlined approach benefits ACOs in reducing program complexity and enables CMS to make meaningful comparisons on a consistent measure set, across ACOs who are eligible to share in any earned savings or may be responsible for any owed losses, based on that performance. For MIPS groups, we are removing this measure to reduce burden of reporting the required measure set. However, we are retaining this measure through the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types to allow clinicians an opportunity to report this measure as one of the six measures to meet the quality performance category requirements.

Comment: One commenter stated that measure Q111: Pneumococcal Vaccination Status for Older Adults is aligned with the CMS Meaningful Measures Framework and is a high-impact measure. The commenter did not agree with CMS' concern that the measure is not aligned with ACIP pneumococcal vaccination recommendations. The commenter requested that CMS retain the current pneumococcal vaccination measure until such time as it can be updated with new measure(s).

Response: We agree that the measure addresses an important population health matter and encourage measure developers to submit an updated measure through the Call for Measures process. Please note that we are retaining this measure in the MIPS program and this substantive change only relates to the removal of the CMS Web Interface data collection method. The removal of the CMS Web Interface was proposed to reduce burden on MIPS groups and ACO participants by removing the requirement that they actively submit the measure performance data through the CMS Web Interface. We maintain the concern that it is not in complete alignment with the ACIP recommendations. The measure specification only requires one dose ever documented, either the PCV13 or PPSV23 vaccine (or both). According to ACIP recommendations, patients should receive both vaccines. The order and timing of the vaccinations depends on certain patient characteristics, and are described in more detail in the ACIP recommendations.

Category	Description
FINAL ACTION: We are finalizing the changes to measure Q111 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure: The CMS eCQM ID changed from "CMS127v6" to "CMS127v7." The NQF# changed from "0043" to "N/A" due to loss of NQF endorsement. These changes were also applied to specialty measure sets in Table Group B where this measure was included.	

D.3. Diabetes: Eye Exam

Category	Description
NQF #:	0055
Quality #:	117
CMS eCQM ID:	CMS131v7
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period
Substantive Change:	**Modified collection type**: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications
Steward:	National Committee for Quality Assurance
High Priority Measure:	No
Measure Type:	Process
Rationale:	We removed the CMS Web Interface Measure Specifications collection type. This measure evaluates a process in the care for the patient. Removal of this measure from the CMS Web Interface Measure Specifications supports our effort to move towards outcome and meaningful measures. In addition, since clinicians are required to report all available CMS Web Interface measures, removing this measure from the CMS Web Interface will reduce the burden of the number of measures a clinician is required to report under the CMS Web Interface. This measure is broadly applicable to eligible clinicians participating in the MIPS program using the collection types of Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications, and eCQM specifications. Retaining this measure through the Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications, and eCQM specification collection types allows clinicians to choose this measure as one of the six measures clinicians are generally required to report to meet the quality performance category requirements

Comment: One commenter opposed the elimination the CMS Web Interface Measure Specifications collection type for this measure as regular exams are vital to preventing unnecessary vision loss.

Response: We believe this measure would be burdensome to require all eligible clinicians using the CMS Web Interface to submit this measure. All measures included in the CMS Web Interface are required to be submitted even if the measure may not apply to a particular specialty. We are maintaining the measure under other collection types to provide an option to select a measure that addresses important process in diabetes care. Eligible clinicians submitting Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications are able to select quality measures that are applicable to their specialty that are meaningful to their practice. In the CMS Web Interface, all measures are required, therefore some eligible clinicians may believe the measure to be burdensome.

Comment: A few commenters expressed concern that the measures we proposed to remove from the CMS Web Interface would continue to be used in other programs or that they would remain available to report to MIPS via other reporting mechanisms, creating inconsistency in the available measure set by reporting mechanism.

Response: We acknowledge that measures proposed for removal from the CMS Web Interface may continue to be required by other programs and available by other collection types. However, removing them from the CMS Web Interface would reduce burden on MIPS groups and ACO participants by removing the requirement that they actively submit the measure performance data through the CMS Web Interface. Specific to ACO participants, ACOs can track these additional metrics in order to participate in the Shared Savings Program and potentially earn shared savings. We note, however, that one of the advantages of clinician participation in a Shared Savings Program ACO is that the ACO reports quality on the clinicians' behalf, reducing clinician burden. We believe that this streamlined approach benefits ACOs in reducing program complexity and enables CMS to make meaningful comparisons on a consistent measure set, across ACOs who are eligible to share in any earned savings or may be responsible for any owed losses, based on that performance. For MIPS groups, we are removing this measure to reduce burden of reporting the required measure set. However, we are retaining this measure through the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types to allow clinicians an opportunity to report this measure as one of the six measures to meet the quality performance category requirements.

FINAL ACTION: We are finalizing measure Q117: *Diabetes: Eye Exam* as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure: The CMS eCQM ID changed from "CMS131v6" to "CMS131v7." These changes were also applied to specialty measure sets in Table Group B where this measure was included.

D.4. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Category	Description
NQF #:	0421
Quality #:	128
CMS eCQM ID:	CMS69v7
National Quality Strategy Domain:	Community/Population Health
Current Collection Type:	Medicare Part B Claims Measure Specifications, eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.
Substantive Change:	**Modified collection type**: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications **Updated the denominator exception logic:** for the eCQM Specifications collection type to allow medical reasons for not obtaining the BMI.
Steward:	Centers for Medicare & Medicaid Services
High Priority Measure:	No
Measure Type:	Process
Rationale:	We removed the CMS Web Interface Measure Specifications collection type. This measure evaluates a process in the care for the patient. Removal of this measure from the CMS Web Interface Measure Specifications supports our effort to move towards outcome and meaningful measures. In addition, since clinicians are required to report all available CMS Web Interface measures, removing this measure from the CMS Web Interface will reduce the burden of the number of measures a clinician is required to report under the CMS Web Interface. This measure is broadly applicable to eligible clinicians participating in the MIPS program using the collection types of Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications, and eCQM specifications. Retaining this measure through the Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications, and eCQM specification collection types allows clinicians to choose this measure as one of the six measures clinicians are generally required to report to meet the quality performance category requirements. We updated the denominator exception logic for the eCQM Specifications collection type to allow medical reasons for not obtaining the BMI. The Technical Expert Panel (TEP) convened by the measure steward recommended adding a medical reason as there could be valid medical reasons for not obtaining the BMI. We agree with the TEP to add a medical exception. There are valid medical reasons that may inhibit the eligible clinicians from obtaining a BMI. Specifically, CMS69v6 has denominator exceptions for medical reasons for not providing the follow-up plan. These exceptions are currently expressed as "Intervention, Order not done" and "Medication, Order not done". The updated measure, CMS69v7, adds an exception to remove patients from the denominator who have a medical reason for not having a BMI performed. This exception was added to account for patients for whom it may be physically difficult to conduct a BMI, such as patients who are unable to stand or for whom their weight exceeds scale limits. This update will provide eligible clinicians the opportunity to exclude patients when there is an appropriate medical reason documented.

Comment: One commenter suggested that BMI screening and follow-up is an important metric since weight loss and gain are symptoms of some mental health disorders and patients with serious mental illness face increased risks for obesity and early death from medical co-morbidities as a side-effect of psychotropic medications. One commenter supported the updates to this measure. Another commenter suggested that elimination of this measure would impact the long-term importance of assessing clinician performance related to population health.

Response: We agree that obesity-related care is important; however, we believe that this issue will continue to be addressed under several of the measures that remain in the CMS Web Interface and SSP measure set, for example the 30 day all-cause readmission measure, and the hypertension, statin, diabetes measures.

Comment: A few commenters expressed concern that the measures we proposed to remove from the CMS Web Interface would continue to be used in other programs or that they would remain available to report to MIPS via other reporting mechanisms, creating inconsistency in the available measure set by reporting mechanism.

Response: We acknowledge that measures proposed for removal from the CMS Web Interface may continue to be required by other programs and available by other collection types. However, removing them from the CMS Web Interface would reduce burden on MIPS groups and ACO participants by removing the requirement that they actively submit the measure performance data through the CMS Web Interface. Specific to ACO participants, ACOs can track these additional metrics in order to participate in the Shared Savings Program and potentially earn shared savings. We note, however, that one of the advantages of clinician participation in a Shared Savings Program ACO is that the ACO reports quality on the clinicians' behalf, reducing clinician burden. We believe that this streamlined approach benefits ACOs in reducing program complexity and enables CMS to make meaningful comparisons on a consistent measure set, across ACOs who are eligible to share in any earned savings or may be responsible for any owed losses, based on that performance. For MIPS groups, we are removing this measure to reduce burden of reporting the required measure set. However, we are retaining this measure through the Medicare Part B Claims Measure Specifications and MIPS CQMs Specifications collection types to allow clinicians an opportunity to report this measure as one of the six measures to meet the quality performance category requirements.

FINAL ACTION: We are finalizing the changes to measure Q128 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure: The CMS eCQM ID changed from "CMS69v6" to "CMS69v7." These changes were also applied to specialty measure sets in Table Group B where this measure is included.

D.5. Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain

Category	Description
NQF #:	0383
Quality #:	144
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having moderate to severe pain with a plan of care to address pain documented on or before the date of the second visit with a clinician
Substantive Change:	**The new numerator is revised to read**: Patients for whom a plan of care to address moderate to severe pain is documented on or before the date of the second visit with a clinician. Updated the denominator to clearly state that population for this measure would be limited to patients who had moderate to severe pain. **The new denominator is revised to read**: All patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy who report having moderate to severe pain or All patients, regardless of age, with a diagnosis of cancer currently receiving radiation therapy.
Steward:	American Society of Clinical Oncology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We modified the numerator to state that the plan of care for pain management should be documented in the first 2 visits (not at any point during the performance period). The current measure requires the plan of care to be documented at any time during the performance period. We modified the denominator to clearly state that the population for this measure would be limited to patients who had moderate to severe pain. Pain severity continues to remain largely unaddressed, especially in those patients who have moderate/severe pain. The edits to this measures numerator would ensure that the oncologist documents a plan of care early, so as to ensure that patients who have moderate to severe pain know what pain management options are available to them earlier on when receiving chemotherapy and radiation, and can become engaged early on in their healthcare decisions. The update to the numerator is based on American Society of Clinical Oncology feedback on the measure by Quality Oncology Practice Initiative registry users who realize that the measure should focus on this to ensure quality of life via pain management is improved in cancer patients.

Comment: One commenter supported the changes to this measure.

Response: We thank the commenter for their support.

FINAL ACTION: We are not finalizing the changes to measure Q144 as proposed for the 2019 Performance Period and future years because, upon reviewing the steward's test results for the proposed numerator and denominator changes, NQF determined that the measure steward's testing data was insufficient. As a result, the NQF has requested that the measure steward retest these changes with sufficient data. Therefore, we will retain the current 2018 numerator and denominator specifications for this measure, as follows:

Numerator: Patient visits that included a documented plan of care to address pain
Denominator: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain.

Please note that, although the proposed substantive changes are not finalized, the following technical changes were made to this measure for further accuracy based on feedback from the measure steward: The Measure Title was changed from "Medical and Radiation – Plan of Care for Pain" to "Medical and Radiation – Plan of Care for Moderate to Severe Pain." This change was applied to specialty measure sets in Table Group B where this measure is included.

D.6. Rheumatoid Arthritis (RA): Tuberculosis Screening

Category	Description
NQF #:	N/A
Quality #:	176
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)
Substantive Change:	**The new description is revised to read:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD). **The new numerator is revised to read**: Patients for whom a TB screening was performed and results interpreted within 12 months prior to receiving a first course of therapy using a biologic DMARD.
Steward:	American College of Rheumatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We updated to the numerator to require the TB screening 12 months prior to the first biologic treatment rather than 6 months as currently stated. The measure steward believes this measure should be more in line with the specifications found in a similar measure developed by the American College of Rheumatology (ACR) and endorsed by the National Quality Forum (NQF). In creating its version of this measure, the ACR conducted an extensive development and review process. The measure was built by a panel of rheumatology experts, in conjunction with the ACR, based on quality of care guidelines and broad reviews of relevant research. Upon completion, the measure was shared with thousands of rheumatology clinicians across the U.S. for public comment. Following the comment period, the measure was updated appropriately based on the feedback received, then rigorously tested to ensure reliability and validity. The measure, along with the results of the testing, was submitted to the NQF for review and obtained trial endorsement. We typically prefer the use of NQF endorsed measures over measures that lack endorsement. However, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus. We believe this measure revision from tuberculosis screening from 6 months to 12 months can be supported by evidence and is an important measure to ensure proper tuberculosis screening for rheumatoid arthritis patients.
We did not receive specific comments regarding these measure changes. **FINAL ACTION:** We are finalizing the changes to measure Q176 as proposed for the 2019 Performance Period and future years.	

D.7. Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity

Category	Description
NQF #:	N/A
Quality #:	177
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease activity within 12 months.
Substantive Change:	**The new numerator is revised to read**: Patients with disease activity assessed by an ACR-endorsed rheumatoid arthritis disease activity measurement tool classified into one of the following categories: remission, low, moderate or high, at least >=50 percent of total number of outpatient RA encounters in the measurement year. **The new definition is revised to read**: Assessment and Classification of Disease Activity – Assesses if physicians are utilizing a standardized, systematic approach for evaluating the level of disease activity for each patient at least for >=50 percent of total number of outpatient RA encounters. The scales/instruments listed are the ACR-endorsed tools that should be used to define activity level and cut-off points: -Clinical Disease Activity Index (CDAI) -Disease Activity Score with 28-joint counts (erythrocyte sedimentation rate or C-reactive protein) (DAS-28) -Patient Activity Scale (PAS) -Patient Activity Score-II (PAS-II) -Routine Assessment of Patient Index Data with 3 measures (RAPID 3) -Simplified Disease Activity Index (SDAI) A result of any kind qualifies for meeting numerator performance.
Steward:	American College of Rheumatology
High Priority Measure:	No
Measure Type:	Process
Rationale:	We updated the numerator to change the requirement to assess disease activity from once a year to "≥ 50 percent of encounters in the measurement year" and to change the use of any standardized tool to only use ACR-endorsed tools. Currently, the measure is only required to be submitted once per performance period. The current measure identifies tools that are available, but allows eligible clinicians to utilize tools not listed within the specification. The changes add a considerable degree of specificity to quality measure 177 by (1) limiting options for disease activity measures to those that have been found to be valid through a rigorous ACR process, and (2) changing the frequency of assessment to include a majority of clinical encounters for RA, since this approach would be consistent with current guidelines regarding treating to a pre-specified target. The ACR developed recommendations for the use of RA disease activity measures in clinical practice. And after thorough evaluation of around 63 available measures, ACR recommends the following 6 measures: CDAI, DAS28 (ESR or CRP), PAS, PAS-II, RAPID-3, and SDAI as ACR-endorsed RA disease activity measures to be used in clinical practice. Many of these tools are available free of charge. The tools were selected to ensure a comprehensive and standardized approach to assess disease activity for rheumatoid arthritis. Given this evidence, the measure steward believes this measure should be updated to be more in line with the specifications found in similar measures developed by ACR and endorsed by NQF. We agree with the revision to promote utilization of the most current guidelines that have been developed by the panel of rheumatology experts. We typically prefer the use of NQF endorsed measures over measures that lack endorsement. Disease activity assessment is imperative to development of an appropriate treatment plan. Revising the numerator to require a more frequent assessment supports development of a more effective treatment plan. We support the use of standardized tools to assess disease activity so the score can be standardized and comparable among eligible clinicians.

Comment: One commenter supported the revisions to measure Q177: Rheumatoid Arthritis (RA) Periodic Assessment of Disease Activity as the changes would limit the measurement tools available to clinicians for assessing disease activity levels only to those that have been found to be valid through the American College of Rheumatology process. The change to increase the frequency of disease activity assessment from only once per year to "at least 50 percent or more of clinical encounters for RA" would be consistent with clinical guidelines for RA disease activity assessment and supported those changes. A narrower list of ACR-endorsed measurement tools will create measurement uniformity for clinicians, can help establish clinical consensus in how disease activity levels should be defined, and promotes consistent outcomes measurement across RA patients.

Response: We agree this would align would the current guideline and provide standardized approach to assess rheumatoid arthritis.

FINAL ACTION: We are finalizing the changes to measure Q177 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to "Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment of disease activity at ≥50 percent of encounters for RA for each patient during the measurement year." These changes were also applied to specialty measure sets in Table Group B where this measure is included.

D.8. Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines

Category	Description
NQF #:	N/A
Quality #:	364
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of final reports for computed tomography (CT) imaging studies of the thorax for patients aged 18 years and older with documented follow-up recommendations for incidentally detected pulmonary nodules (for example, follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors.
Substantive Change:	**Updated the denominator**: To patients 35 years and older. **Updated denominator exclusions**: Added heavy tobacco smokers **Updated denominator exceptions**: To include medical reasons. **Updated numerator**: Includes a recommended interval and modality for follow-up. **The new description is revised to read:** Percentage of final reports for CT imaging studies with a finding of an incidental pulmonary nodule for patients aged 35 years and older that contain an impression or conclusion that includes a recommended interval and modality for follow-up [(for example, type of imaging or biopsy) or for no follow-up, and source of recommendations (for example, guidelines such as Fleischner Society, American Lung Association, American College of Chest Physicians).
Steward:	American College of Radiology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We updated the measure description and denominator from 18 years and older to 35 years and older. We also updated the numerator to include a recommended interval and modality for follow-up. The revised measure assesses final reports for CT imaging studies with a finding of an incidental pulmonary nodule for patients aged 35 years and older that contain an impression or conclusion that includes a recommended interval and modality for follow-up [(for example, type of imaging or biopsy) or for no follow-up, and source of recommendations (for example, guidelines such as Fleischner Society, American Lung Association, American College of Chest Physicians)]. The current measure specification does not allow a denominator exclusion for heavy smokers. A new denominator exclusion is included for heavy tobacco smokers who qualify for lung cancer screening. Furthermore, the current denominator exception does not account for the indication of a modality. A new denominator exception for medical reasons for not including a recommended interval and modality for follow-up. The changes add specificity to this measure and ensure the appropriate patient population is being targeted for this measure by: (1) updating the numerator quality action to specify a recommended interval and modality for follow-up; (2) specifying additional denominator exclusions and exceptions; and (3) changing the intended patient population (to 35 years and older) as supported by an update to clinical guidelines. We agree with the revision to promote utilization of the most current guidelines. It creates a more robust measure that defines the required clinical action to the narrowed patient population. We also agree with the addition specific denominator exceptions and denominator exclusions to promote consistent data among eligible clinicians.

We did not receive specific comments regarding these measure changes.

FINAL ACTION: We are finalizing the changes to measure Q364 as proposed for the 2019 Performance Period and future years.

D.9. Depression Remission at Twelve Months

Category	Description
NQF #:	0710
Quality #:	370
CMS eCQM ID:	CMS159v7
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications, CMS Web Interface Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	The percentage of patients 18 years of age and or older with major depression or dysthymia who reached remission 12 months (+/- 30 days) after an index visit
Substantive Change:	**The new description is revised to read**: The percentage of adolescent patients 12 to 17 years of age and adult patients18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date. **The new denominator is revised to read:** Adolescent patients 12 to 17 years of age with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event. The new numerator is revised to read: Adolescent patients aged 12 to 17 years of age who achieved remission at 12 months as demonstrated by a 12-month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five.
Steward:	Minnesota Community Measurement (MNCM)
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We added adolescents to the denominator via stratification and references to the PHQ-9M, which is specific for adolescents. The patient population has been revised to include patients 12 years of age and older, when previously only included patients over the age of 18. The score to determine denominator eligibility was based on the PHQ-9 assessment, this was expanded to include the PHQ-9M to accommodate the expanded age with age appropriate assessment tools. The measure steward worked in collaboration with NCQA, who requested a consideration of incorporating adolescents into the existing depression measures. We agreed with the expansion of the denominator to include the adolescent patient population. Depression assessment is a clinically relevant and important topic to address among adolescents. We appreciated the collaboration among the stakeholders to broaden the measure.

Comment: One commenter noted the benefits and challenges associated with reporting the Depression Remission at 12 Months measure. While its inclusion in MIPS provides a more comprehensive measure set from which clinicians can choose to report, the commenter noted it carries a significant data collection burden. A second commenter stated that measure Q370 has been a challenge for academic medical centers is the depression remission measure. The depression remission measure (MH-1) measures the number of patients with major depression as defined as an initial PHQ-9 score> 9 who demonstrate remission at 12 months as defined as a PHQ-9 score <5. The requirement for PHQ-9 use for evaluating patients combined with a follow-up evaluation is problematic for many large group practices. The measure must be recorded for 248 patients, a very difficult bar for large multi-specialty group practices which refer patients for treatment and follow-up to psychiatrists if they have a PHQ-9. The measure seems to be designed for group practices that do not have this type of referral pattern. This is just one example of practice pattern differences between large academic medical groups and small and or/ rural practices. The commenter requested that the measure be removed, and that CMS determine if there may be other measures related to depression that would be more appropriate to use in the MIPS program.

Response: We believe this measure aligns with our policy to maintain meaningful measures within the program. Mental health issues have become prevalent in the nation and we believe it is critical to maintain measures that support improvement in mental health especially since our proposal is to expand this measure to adolescents. For this reason, we believe the benefit of measuring outcomes, as well as providing a more comprehensive measure set for the eligible clinician to report outweighs the data collection burden. In response to the commenter concern regarding the workflow of a large academic medical centers, the PHQ-9 derived from the psychiatrist could be used to determine remission as long as it is documented within the medical record. This would require communication and care coordination between the referring clinician and psychiatrist.

FINAL ACTION: We are finalizing the changes to measure Q370 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure: The CMS eCQM ID changed from "CMS159v6" to "CMS159v7." These changes were also applied to specialty measure sets in Table Group B where this measure is included.

D.10. Depression Utilization of the PHQ-9 Tool

Category	Description
NQF #:	0712
Quality #:	371
CMS eCQM ID:	CMS160v7
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	eCQM Specifications
Current Measure Description:	The percentage of patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4-month period in which there was a qualifying visit.
Substantive Change:	**The new description is revised to read**: The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have a completed PHQ-9 or PHQ-9M tool during the measurement period. **The new denominator is revised to read**: Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia. **The new numerator is revised to read**: Adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) included in the denominator who have at least one PHQ-9 or PHQ-9M tool administered and completed during a 4-month measurement period.
Steward:	Minnesota Community Measurement (MNCM)
High Priority Measure:	No
Measure Type:	Process
Rationale:	We added adolescents to the denominator via stratification and references to the PHQ-9M for both denominator and numerator, which is specific for adolescents. The patient population has been revised to include patients 12 years of age and older, when previously only included patients over the age of 18. The measure steward worked in collaboration with NCQA, who requested a consideration of incorporating adolescents into the existing depression measures. We agreed with the expansion of the denominator to include the adolescent patient population. Depression assessment is a clinically relevant and important topic to address among adolescents. We appreciated the collaboration among the stakeholders to broaden the measure.
We did not receive specific comments regarding these measure changes. **FINAL ACTION:** We are finalizing the changes to measure Q371 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure: The CMS eCQM ID changed from "CMS160v6" to "CMS160v7." These changes were also applied to specialty measure sets in Table Group B where this measure is included.	

D.11. Melanoma Reporting

Category	Description
NQF #:	N/A
Quality #:	397
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate.
Substantive Change:	**The new numerator is revised to read**: Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness, ulceration and mitotic rate.
Steward:	College of American Pathologists
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We updated the numerator to include mitotic rate for all pT categories. The current measure specification only requires a statement the mitotic rate for pT1. The American Joint Committee on Cancer's Melanoma Expert Panel strongly recommends that mitotic rate be assessed and recorded for all primary melanomas, although it is not used for T1 staging in the eighth edition. The mitotic rate will likely be an important parameter for inclusion in the future development of prognostic models applicable to individual patients. Although it is not included in the T1 subcategory criteria, mitotic activity in T1 melanomas also has been associated with an increased risk of sentinel lymph node metastasis. We agreed with the addition of mitotic rate assessment for all primary melanomas. This creates valuable clinical information to the eligible clinician in order to create an effective treatment plan specific to the melanoma.
We did not receive specific comments regarding these measure changes. **FINAL ACTI**ON: We are finalizing the changes to measure Q397 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to **"**Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness, ulceration and mitotic rate." These changes were also applied to specialty measure sets in Table Group B where this measure is included. .	

D.12. Psoriasis: Clinical Response to Systemic Medications

Category	Description
NQF #:	N/A
Quality #:	410
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	Percentage of psoriasis vulgaris patients receiving oral systemic or biologic therapy who meet minimal physician-or patient-reported disease activity levels. It is implied that establishment and maintenance of an established minimum level of disease control as measured by physician-and/or patient-reported outcomes will increase patient satisfaction with and adherence to treatment.
Substantive Change:	**The new description is revised to read**: Percentage of psoriasis vulgaris patients receiving systemic medication who meet minimal physician-or patient- reported disease activity levels. It is implied that establishment and maintenance of an established minimum level of disease control as measured by physician-and/or patient-reported outcomes will increase patient satisfaction with and adherence to treatment **The new denominator is revised to read**: All patients with a diagnosis of psoriasis vulgaris and treated with a systemic medication. **The new numerator is revised to read**: Patients who have a documented physician global assessment (PGA; 5-point OR 6-point scale), body surface area (BSA), psoriasis area and severity index (PASI) and/or dermatology life quality index (DLQI) that meet any one of the below specified benchmarks.
Steward:	American Academy of Dermatology
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We updated the measure title, description and denominator to expand the measure to include systemic medications that are administered both orally and subcutaneously. The measure still includes biologics rather than only oral and biologic medications. The patient population includes those diagnosed with psoriasis vulgaris receiving systemic medications that are administered both orally and subcutaneously or biologic therapy who meet minimal physician-or patient- reported disease activity levels. In addition, the numerator is being expanded to include the 5-point PGA scale as an additional benchmark. The current numerator allow the use of PGA; 6-point scale), body surface area (BSA), psoriasis area and severity index (PASI) and/or dermatology life quality index (DLQI) to assess clinical response. The measure steward believes the update to allow all systemic medications is relevant as they have deemed them to all apply to the measure. Based on recent literature, there is a strong correlation in how the 5-point scale is used like the 6-point PGA scale, resulting in comparative results. This scale is requested to be added to allow clinicians a shorter scale to choose from which would be more user-friendly in a clinical setting. We agreed with the expansion of the denominator to include all systemic medications, not limited to oral systemic or biologic therapy. Including systemic medications administered subcutaneously provides an additional opportunity to assess effective outcomes this treatment option. We agreed with the 5-point PGA scale to allow an additional tools to assess psoriasis outcomes.

Comment: Several commenters supported the measure expansion for Q410: Psoriasis: Clinical Response to Systemic Medications to systemic drugs that are administered both orally and subcutaneously. Psoriasis had been an underrepresented clinical category within the MIPS measure set in recent years, and the expansion of this measure creates additional opportunities to demonstrate the effectiveness of new treatment options.

Response: We thank the commenters for their support of measure Q410: Psoriasis: Clinical Response to Systemic Medications.

FINAL ACTION: We are finalizing the changes to measure Q410 as proposed for the 2019 Performance Period and future years. We are finalizing this measure as a MIPS CQMs Specification only. This measure will not be available as a Medicare Part B Claims Measure Specification as it is not analytically feasible for this collection type. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Title was changed from "Psoriasis: Clinical Response to Oral Systemic or Biologic Medications" to "Psoriasis: Clinical Response to Systemic Medications." These changes were applied to specialty measure sets in Table Group B where this measure is included.

D.13. Depression Remission at Six Months

Category	Description
NQF #:	0711
Quality #:	411
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	The percentage of patients 18 years of age or older with major depression or dysthymia who reached remission 6 months (+/- 30 days) after an index visit.
Substantive Change:	**The new description is revised to read**: The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 6 months (+/- 60 days) after an index event date. **The new denominator is revised to read:** Submission Criteria 1: Adolescent patients 12 to 17 years of age with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event. Submission Criteria 2: Adult patients 18 years of age or older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event.
Steward:	Minnesota Community Measurement
High Priority Measure:	Yes
Measure Type:	Outcome
Rationale:	We added adolescents to denominator via stratification and references to the PHQ-9M which is specific for adolescents. The patient population has been revised to include patients 12 years of age and older, when previously only included patients over the age of 18. The score to determine denominator eligibility was based on the PHQ-9 assessment, this was expanded to include the PHQ-9M to accommodate the expanded age with age appropriate assessment tools. The measure steward worked in collaboration with NCQA, who requested a consideration of incorporating adolescents into the existing depression measures. We agreed with the expansion of the denominator to include the adolescent patient population. Depression assessment is a clinically relevant and important topic to address among adolescents. We appreciated the collaboration among the stakeholders to broaden the measure.
We did not receive specific comments regarding these measure changes. **FINAL ACTION:** We are finalizing the changes to measure Q411 as proposed for the 2019 Performance Period and future years.	

D.14. Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

Category	Description
NQF #:	N/A
Quality #:	415
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of emergency department visits for patients aged 18 years and older who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT
Substantive Change:	Updated the measure description and denominator to remove the requirement of a patient presenting to the emergency department within 24 hours of a minor blunt head trauma, as well as remove the requirement to document a GCS of 15. **The new description is revised to read:** Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care clinician who have an indication for a head CT. **The new denominator is revised to read**: All emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider **Updated the numerator**: To indicate the GCS score less than 15 is an appropriate indication for a head CT. The new definition within the numerator is revised to include a GSC score less than 15.
Steward:	American College of Emergency Physicians (ACEP)
High Priority Measure:	Yes
Measure Type:	Efficiency
Rationale:	We updated to the measure description and denominator to remove the requirement of a patient presenting to the emergency department within 24 hours of a minor blunt head trauma, as well as remove the requirement to document a GCS of 15. We updated the numerator to indicate the GCS score less than 15 is an appropriate indication for a head CT. The new description is revised to read: Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT. Based on feedback from the measure steward, this measure is appropriate for all minor blunt head traumas, regardless of when they occurred in relation to presentation to the ED. Additionally, in order to better align the measure with the evidence base and guidelines supporting the measure, the measure steward determined that the GCS of <15 data element would be more accurately included as an appropriate indication for ordering a head CT, so this has been relocated to the numerator definition. We agreed with the recommendation and accept the revision as this promotes utilization of the most current guidelines to determine imaging requirements based on the documented GCS.
We did not receive specific comments regarding these measure changes. **FINAL ACTION:** We are finalizing the changes to measure Q415 as proposed for the 2019 Performance Period and future years.	

D.15. Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 through 17 Years

Category	Description
NQF #:	N/A
Quality #:	416
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of emergency department visits for patients aged 2 through 17 years who presented within 24 hours of a minor blunt head trauma with a Glasgow Coma Scale (GCS) score of 15 and who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury
Substantive Change:	**Updated denominator**: To remove the requirement of a patient presenting to the emergency department within 24 hours of a minor blunt head trauma, as well as remove the requirement to document a GCS of 15. **The measure description is revised to read**: Percentage of emergency department visits for patients aged 2 through 17 years who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network (PECARN) prediction rules for traumatic brain injury. **Updated the numerator**: To indicate the GCS score less than 15 is an appropriate indication for a head CT.
Steward:	American College of Emergency Physicians
High Priority Measure:	Yes
Measure Type:	Efficiency
Rationale:	We updated the measure description and denominator to remove the requirement of a patient presenting to the emergency department within 24 hours of a minor blunt head trauma, as well as remove the requirement to document a GCS of 15. We updated the numerator to indicate the GCS score less than 15 is an appropriate indication for a head CT. Based on feedback from the measure steward, this measure is appropriate for all minor blunt head traumas, regardless of when they occurred in relation to presentation to the ED. Additionally, in order to better align the measure with the evidence base and guidelines supporting the measure, ACEP physician leaders determined that the GCS of <15 data element would be more accurately included as an appropriate indication for ordering a head CT, so this has been relocated to the numerator definition. We agreed with the revision as this promotes utilization of the most current guidelines to determine imaging requirement based on the documented GCS.
We did not receive specific comments regarding these measure changes. **FINAL ACTION:** We are finalizing the changes to measure Q416 as proposed for the 2019 Performance Period and future years.	

D.16. Functional Status Change for Patients with Knee Impairments

Category	Description
NQF #:	0422
Quality #:	217
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report measure of change in functional status for patients 14 year+ with knee impairments. The change in functional status (FS) assessed using FOTO's (knee) PROM (patient-reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality
Substantive Change:	Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agreed with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for measure Q217: Functional Status Change for Patients with Knee Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted, not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing changes to measure Q217 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status for patients aged 14 years+ with knee impairments. The change in functional status (FS) is assessed using the Knee FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was changed from "Outcome" to "Patient Reported Outcome." These changes were applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.17. Functional Status Change for Patients with Hip Impairments

Category	Description
NQF #:	0423
Quality #:	218
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report measure of change in functional status (FS) for patients 14 years+ with hip impairments. The change in functional status (FS) assessed using FOTO's (hip) PROM (patient- reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality
Substantive Change:	Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agreed with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for measure Q218: Functional Status Change for Patients with Hip Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing the changes to measure Q218 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with hip impairments. The change in functional status (FS) is assessed using the Hip FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was changed from "Outcome" to "Patient Reported Outcome." These changes were applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.18. Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments

Category	Description
NQF #:	0424
Quality #:	219
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report measure of change in functional status (FS) for patients 14 years+ with foot and ankle impairments. The change in functional status (FS) assessed using FOTO's (foot and ankle) PROM (patient reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality
Substantive Change:	Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agree with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for the Q219: Functional Status Change for Patients with Foot or Ankle Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing the changes to measure Q219 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Title was changed from "Functional Status Change for Patients with Foot or Ankle Impairments" to "Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments". The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with foot, ankle and lower leg impairments. The change in functional status (FS) assessed using the Foot/Ankle FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was changed from "Outcome" to "Patient Reported Outcome." These changes were also applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.19. Functional Status Change for Patients with Low Back Impairments

Category	Description
NQF #:	0425
Quality #:	220
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report outcome measure of change in functional status for patients 14 years+ with lumbar impairments. The change in functional status (FS) assessed using FOTO (lumbar) PROM (patient reported outcome measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level by to assess quality
Substantive Change:	Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agreed with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for the Q220: Functional Status Change for Patients with Lumbar Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing the changes to measure Q220 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Title was changed from "Functional Status Change for Patients with Lumbar Impairments" to "Functional Status Change for Patients with Low Back Impairments". The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with low back impairments. The change in functional status (FS) is assessed using the Low Back FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level by to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was changed from "Outcome" to "Patient Reported Outcome." These changes were also applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.20. Functional Status Change for Patients with Shoulder Impairments

Category	Description
NQF #:	0426
Quality #:	221
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report outcome measure of change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in functional status (FS) assessed using FOTO's (shoulder) PROM (patient reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality
Substantive Change:	**The new description is revised to read:** A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with shoulder impairments. The change in functional status (FS) is assessed using the Shoulder FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.).The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey). Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agreed with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for measure Q221: Functional Status Change for Patients with Shoulder Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing the changes to measure Q221 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status for patients 14 years+ with shoulder impairments. The change in functional status (FS) is assessed using the Shoulder FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.).The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was updated from "Outcome" to "Patient Reported Outcome". These changes were also applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.21. Functional Status Change for Patients with Elbow, Wrist or Hand Impairments

Category	Description
NQF #:	0427
Quality #:	222
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report outcome measure of functional status (FS) for patients 14 years+ with elbow, wrist or hand impairments. The change in FS assessed using FOTO (elbow, wrist and hand) PROM (patient reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality
Substantive Change:	Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agreed with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for measure Q222: Functional Status Change for Patients with Elbow, Wrist or Hand Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing the changes to measure Q222 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist or hand impairments. The change in FS is assessed using the Elbow/Wrist/Hand FS patient-reported outcome measure (PROM) (©Focus on Therapeutic Outcomes, Inc.) The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was updated from "Outcome" to "Patient Reported Outcome". These changes were also applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.22. Functional Status Change for Patients with General Orthopedic Impairments

Category	Description
NQF #:	0428
Quality #:	223
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Communication and Care Coordination
Current Collection Type:	MIPS CQMs Specifications
Current Measure Description:	A self-report outcome measure of functional status (FS) for patients 14 years+ with general orthopedic impairments (neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment). The change in FS assessed using FOTO (general orthopedic) PROM (patient reported outcomes measure) is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level by to assess quality
Substantive Change:	Updated the denominator to allow coding for chiropractors and outpatient eligible clinicians. **The new denominator is revised to expand to**: Physician Denominator Criteria and Chiropractic Care Denominator Criteria.
Steward:	Focus on Therapeutic Outcomes, Inc.
High Priority Measure:	Yes
Measure Type:	Patient Reported Outcome
Rationale:	We expanded the denominator to allow coding for chiropractors and outpatient eligible clinicians. The current measure only includes coding to support physical and occupational therapists. The measure steward has recommended expanding the denominator to include other types of eligible clinicians providing outpatient and chiropractic services. Physical functional status is relevant to a broad spectrum of specialties in order to assess the effectiveness of a treatment plan. We agreed with the recommendation and are proposing the expansion as it allows a broader spectrum of eligible clinicians the opportunity to submit outcome measures.

Comment: Two commenters supported the substantive change proposed for measure Q223: Functional Status Change for Patients with Other General Orthopedic Impairments measure by allowing coding for chiropractic clinicians but emphasized that unless chiropractors are reimbursed for CPT code 98943 which covers extraspinal, one or more regions (currently NOT covered by Medicare), the current three codes will not apply to this measure.

Response: This measure can only be submitted utilizing the MIPS CQMs Specifications, which allows all payer data to be submitted not just Medicare. Therefore, chiropractors utilizing CPT code 98943 can include those patients in the denominator for this measure. Specific Medicare reimbursement for this code would not preclude the eligible clinician from submitting this measure.

FINAL ACTION: We are finalizing the changes to measure Q223 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: The Measure Description was updated to "A patient-reported outcome measure of risk-adjusted change in functional status (FS) for patients aged 14 years+ with general orthopedic impairments (neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment). The change in FS is assessed using the General Orthopedic FS PROM (patient reported outcome measure) (©Focus on Therapeutic Outcomes, Inc.). The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient level, at the individual clinician, and at the clinic level to assess quality. The measure is available as a computer adaptive test, for reduced patient burden, or a short form (static survey)." The Measure Type was updated from "Outcome" to "Patient Reported Outcome". These changes were also applied to specialty measure sets in Table Group B where this measure is included. (Please note that these technical changes were erroneously characterized as substantive changes in the proposed rule.)

D.23. Overuse of Imaging for the Evaluation of Primary Headache

Category	Description
NQF #:	N/A
Quality #:	419
CMS eCQM ID:	N/A
National Quality Strategy Domain:	Efficiency and Cost Reduction
Current Collection Type:	Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications
Current Measure Description:	Percentage of patients with a diagnosis of primary headache disorder whom advanced brain imaging was not ordered
Substantive Change:	Updated the measure analytics to be an inverse measure and remove the assessment of the appropriate use for Computed Tomography Angiography (CTA) and Magnetic Resonance Angiography (MRA). **The new description is revised to read**: Percentage of patients for whom imaging of the head (CT or MRI) is obtained for the evaluation of primary headache when clinical indications are not present **The new numerator is revised to:** Patients for whom imaging of the head (Computed Tomography (CT) or Magnetic Resonance Imaging (MRI)) is obtained for the evaluation of primary headache when clinical indications are not present.
Steward:	American Academy of Neurology
High Priority Measure:	Yes
Measure Type:	Process
Rationale:	We adjusted the measure analytics to produce inverse performance data and update the numerator to reflect new clinical evidence regarding the diagnostic imaging modalities (removing CTA and MRA). Updating inverse measure analytics for this measure will appropriately represent the data produced by an overuse measure. The measure development workgroup, procured by AAN, reviewed available evidence and found that there are different indications for imaging with CTA and MRA compared to CT and MRI. The indications for clinical management of primary headache, (which are listed in the measure) are only appropriate for CT and MRI. The updated clinical guidelines included in the measure support this as well.

Comment: One commenter supported changes to measure Q419: Overuse Of Imaging For Patients With Primary Headache so that it would focus only on CT and MRI scans ordered (omitting CTA and MRA imaging to create consistency with the indication for clinical management of primary headache), and will also capture inverse performance data. However, the commenter underscored that unmet needs continue to exist related to quality measures for migraine and primary headache disorder, and that CMS is missing an opportunity to consider the costly impact of medication overuse that can result from inadequate response to existing treatments for migraine and primary headache disorder. The commenter requested that CMS, along with the MAP, NQF, and other stakeholders consider new and/existing measures that addresses the rate of acute medication overuse among patients suffering from migraine. The Institute for Clinical Systems Improvement (ICSI) has developed the measure, "Percentage of patients with migraine headache with a prescription for opiates or barbiturates for the treatment of migraine" to address overuse of opioids and narcotics for the treatment of migraine headache.

Response: We encourage the commenter to collaborate with measure developers to submit measures to the Call for Measures process that have been fully tested and address migraine and headache disorder.

FINAL ACTION: We are finalizing the changes to measure Q419 as proposed for the 2019 Performance Period and future years. Please note that the following technical changes were also made to this measure for further accuracy based on feedback from the measure steward: Measure Title was updated from "Overuse of Imaging For Patients With Primary Headache" to "Overuse of Imaging for the Evaluation of Primary Headache". Measure Type was updated from "Efficiency" to "Process". These changes were also applied to specialty measure sets in Table Group B where this measure is included.