Centers for Medicare & Medicaid Services

CMS Implementation Guide for Quality Reporting Document Architecture Category III

Eligible Clinicians and Eligible Professionals Programs

Implementation Guide for 2021

Version 1.1
12/14/2020

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QRDA III STU R2.1 CMS Implementation Guide for Eligible Clinicians and Eligible Professionals Programs

1 Introduction

1.1 Overview

The Health Level Seven International (HL7) Quality Reporting Document Architecture (QRDA) defines constraints on the HL7 Clinical Document Architecture Release 2 (CDA R2). QRDA is a standard document format for the exchange of electronic clinical quality measure (eCQM) data. QRDA reports contain data extracted from electronic health records (EHRs) and other information technology systems. The reports are used for the exchange of eCQM data between systems for quality measurement and reporting programs.

This QRDA guide contains the Centers for Medicare & Medicaid Services (CMS) supplemental implementation guide to the *HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture, Category III, STU Release 2.1*[1] *(June, 2017)* for the 2021 performance period. This HL7 base standard is referred to as the HL7 QRDA III STU R2.1.

1.2 Organization of the Guide

This implementation guide contains the following chapters:

- Chapter 1: Introduction
- Chapter 2: Conformance Conventions Used in This Guide — describes the formal representation of templates and additional information necessary to understand and correctly implement the content found in this guide
- Chapter 3: Overview
- Chapter 4: QRDA Category III Submission Rules — includes guidelines for submissions under the Comprehensive Primary Care Plus (CPC+) and the Primary Care First (PCF) models, and the Merit-Based Incentive Payment System (MIPS) Program
- Chapter 5: QRDA Category III Validation — contains the formal definitions for the QRDA Category III report for the CMS Eligible Clinicians and Eligible Professionals Programs:
    - Document-level template that defines the document type and header constraints specific to CMS reporting
    - Section-level templates that define measure reporting and reporting parameters
    - Entry-level templates that define entry templates
- Chapter 6: 2021 Performance Period eCQM Specifications for Eligible Professionals and Eligible Clinicians UUID List
- Chapter 7: Measure Identifiers

[1] HL7 QRDA III STU R2.1. http://www.hl7.org/documentcenter/public/standards/dstu/CDAR2_IG_QRDAIII_R1_STU_R2.1_2017JUL.zip

APPENDIX

- Chapters 8-15 provide references, resources, and several change logs including a list of all changes made to the HL7 QRDA III STU R2.1 to produce this CMS Implementation Guide

2 Conformance Conventions Used in This Guide

2.1 Conformance Verbs (Keywords)

The keywords **SHALL**, **SHOULD**, **MAY**, **NEED NOT**, **SHOULD NOT**, and **SHALL NOT** in this guide are to be interpreted as follows:

- **SHALL**: an absolute requirement for the particular element. Where a **SHALL** constraint is applied to an Extensible Markup Language (XML) element, that element must be present in an instance, but may have an exceptional value (i.e., may have a `nullFlavor`), unless explicitly precluded. Where a **SHALL** constraint is applied to an XML attribute, that attribute must be present, and must contain a conformant value.
- **SHALL NOT**: an absolute prohibition against inclusion.
- **SHOULD/SHOULD NOT**: best practice or recommendation. There may be valid reasons to ignore an item, but the full implications must be understood and carefully weighed before choosing a different course.
- **MAY/NEED NOT**: truly optional; can be included or omitted as the author decides with no implications.

2.2 Cardinality

The cardinality indicator (0..1, 1..1, 1..*, etc.) specifies the allowable occurrences within a document instance. The cardinality indicators are interpreted with the following format "[m…n]" where m represents the least and n the most:

- 0..1 zero or one
- 1..1 exactly one
- 1..* at least one
- 0..* zero or more
- 1..n at least one and not more than n

When a constraint has subordinate clauses, the scope of the cardinality of the parent constraint must be clear. In Figure 1, the constraint says exactly one participant is to be present. The subordinate constraint specifies some additional characteristics of that participant.

Figure 1: Constraints Format – only one allowed

1. **SHALL** contain exactly one [1..1] **`participant`** (CONF:2777).
   a. This participant **SHALL** contain exactly one [1..1] **`@typeCode`**="LOC" (CodeSystem: 2.16.840.1.113883.5.90 HL7ParticipationType) (CONF:2230).

In Figure 2, the constraint says only one participant “like this” is to be present. Other participant elements are not precluded by this constraint.

Figure 2: Constraints Format – only one like this allowed

1. **SHALL** contain exactly one [1..1] **`participant`** (CONF:2777) such that it
   a. **SHALL** contain exactly one [1..1] **`@typeCode`**="LOC" (CodeSystem: 2.16.840.1.113883.5.90 HL7ParticipationType) (CONF:2230).

2.3 Null Flavor

Information technology solutions store and manage data, but sometimes data are not available; an item may be unknown, not relevant, or not computable or measureable. In HL7, a flavor of null, or `nullFlavor`, describes the reason for missing data.

Figure 3: nullFlavor Example

```
<raceCode nullFlavor="ASKU"/>
<!—coding a raceCode when the patient declined to specify his/her
race-->

<raceCode nullFlavor="UNK"/>
<!--coding a raceCode when the patient's race is unknown-->
```

Use null flavors for unknown, required, or optional attributes:

- **NI** No information. This is the most general and default null flavor.
- **NA** Not applicable. Known to have no proper value (e.g., last menstrual period for a male).
- **UNK** Unknown. A proper value is applicable, but is not known.
- **ASKU** Asked, but not known. Information was sought, but not found (e.g., the patient was asked but did not know).
- **NAV** Temporarily unavailable. The information is not available, but is expected to be available later.
- **NASK** Not asked. The patient was not asked.
- **MSK** There is information on this item available but it has not been provided by the sender due to security, privacy, or other reasons. There may be an alternate mechanism for gaining access to this information.
- **OTH** The actual value is not and will not be assigned a standard coded value. An example is the name or identifier of a clinical trial.

This list contains those null flavors that are commonly used in clinical documents. For the full list and descriptions, see the `nullFlavor` vocabulary domain in the HL7 standard, *Clinical Document Architecture, Release 2.0*.

Any **SHALL** conformance statement may use `nullFlavor`, unless the attribute is required or the `nullFlavor` is explicitly disallowed. **SHOULD** and **MAY** conformance statements may also use `nullFlavor`.

3 Overview

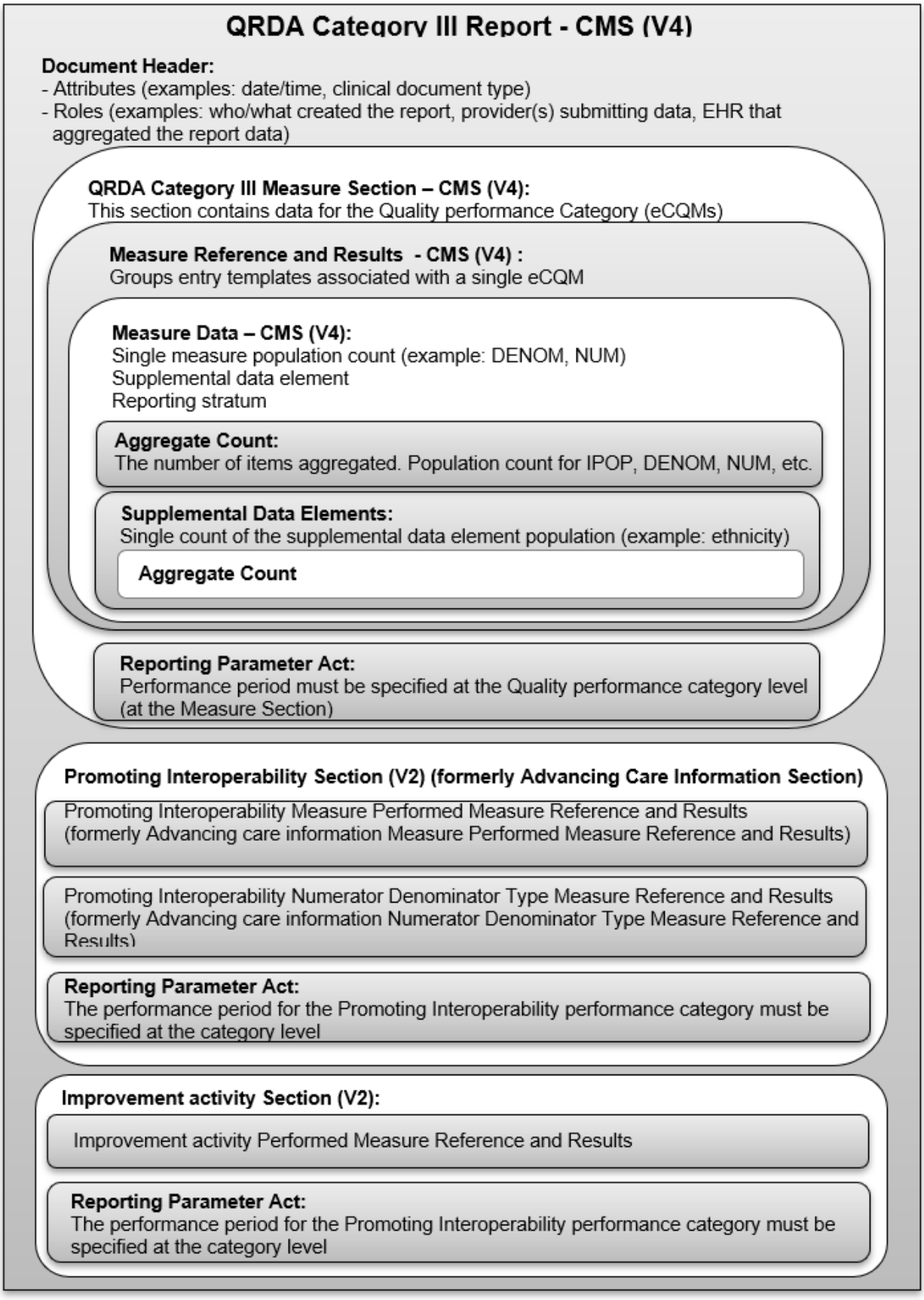
3.1 Background

This guide is a CMS Quality Reporting Document Architecture Category III (QRDA III) implementation guide to the HL7 QRDA III STU R2.1. Templates defined in this implementation guide are conformant with HL7 QRDA III STU R2.1. The CMS Eligible Clinicians and Eligible Professionals Programs QRDA III templates address aggregate reporting requirements for:

- Comprehensive Primary Care Plus (CPC+)
- Primary Care First (PCF)
- Merit-Based Incentive Payment System (MIPS)

A QRDA III report is an aggregate quality report. Each QRDA III report contains calculated summary data for one or more measures for a specified population of patients within a particular health system over a specific period of time. Summary data in the QRDA III report are defined based on the specified measures in HL7 Health Quality Measures Format (HQMF), which standardizes the representation of a health quality measure as an electronic document. Other summary data provided in the QRDA III report include Promoting Interoperability measures, formerly Advancing Care Information measures, and Improvement Activities. The structure of a QRDA III report is depicted in Figure 4: QRDA III Report Structure Example.

Figure 4: QRDA III Report Structure Example



3.2 How to Read This QRDA III Guide

This guide includes the formal template definitions and submission criteria for submitting QRDA III documents to the CPC+ and PCF models and MIPS program. Some of the conformance statements in the HL7 QRDA III STU R2.1 have been further constrained to meet the specific requirements from these CMS Eligible Clinicians and Eligible Professionals programs. The "CMS_" prefix (e.g., CMS_1) indicates the new conformance statements. The "_C01" postfix indicates that the conformance statement from the base HL7 QRDA III STU R2.1 standard is further constrained in this guide.

This guide only lists the templates specifying CMS-specific reporting requirements from the base HL7 QRDA III STU R2.1 standard. For example, Payer Supplemental Data Element – CMS (V3) (`identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.18:2018-05-01`) conforms to Payer Supplemental Data Element (V2) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.9:2016-02-01)`. The Payer Supplemental Data Element – CMS (V3) template specifies the CMS-specific requirements that further constrain the parent Payer Supplemental Data Element (V2) template. The conformance statements from the parent Payer Supplemental Data Element (V2) template from HL7 QRDA III STU R2.1 are not repeated in this guide. Therefore, the base HL7 QRDA III STU R2.1 must be referenced in conjunction with this guide.

4 QRDA Category III Submission Rules

CMS will process eCQM QRDA III documents originating from CEHRT EHR systems. Submitted QRDA III documents must meet the conformance statements specified in the QRDA Category III Validation section of this implementation guide.

4.1 Comprehensive Primary Care Plus (CPC+) Submissions

CPC+ practice sites need to adopt health IT (HIT) meeting requirements published by the CPC+ model. These requirements will be posted on https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus.

For the 2021 performance period, the CPC+ QRDA III file must contain the CMS EHR Certification ID. Nulls will not be allowed. Only one CMS EHR Certification ID should be submitted for CPC+ quality reporting. Full instructions on how to generate a CMS EHR Certification ID are in the CHPL Public User Guide, https://www.healthit.gov/sites/default/files/policy/chpl_public_user_guide.pdf.

CPC+ quality measure data must be submitted at the CPC+ practice site level. CPC+ practice site level reporting includes all patients (including all payers and the uninsured) who were seen one or more times at the practice site location during the performance period by one or more clinicians (TIN(s)/NPI(s)) who were active on the CPC+ Practitioner Roster at any point during the measurement period and who meet the inclusion criteria for the initial population as specified in each measure.

A CPC+ clinician (i.e., TIN/NPI combination) should only be active on one CPC+ Practitioner Roster at a time. Please note that if a CPC+ clinician provides care under multiple TINs, that clinician's NPI may be active on more than one CPC+ Practitioner Roster during the measurement period.

If the CPC+ practice site includes multiple clinicians (CPC+ and non-CPC+), the eCQM population includes all patients who had at least one visit at the CPC+ practice site location and were seen by a CPC+ clinician(s) (TIN(s)/NPI(s)) during the performance period who meet the initial population criteria of the eCQM.

Each CPC+ practice site submitting QRDA III files for the 2021 performance period must provide at least the minimum number of eCQMs required by the CPC+ program.

Promoting Interoperability or Improvement Activity data **should not be submitted** in a CPC+ quality measure QRDA III submission file. Since Promoting Interoperability and Improvement Activity data are not required to be reported for CPC+, if these data are submitted they will be ignored. If you are submitting Promoting Interoperability or Improvement Activity data for MIPS, see 4.3 Merit-Based Incentive Payment System (MIPS) QRDA III Submissions for more information.

QRDA III submissions for CPC+ will use the 2021 Performance Period eCQM Specifications for Eligible Professionals and Eligible Clinicians[2] provided in the eCQI Resource Center.

[2] eCQI Resource Center, Eligible Professional/Eligible Clinician eCQMs web page. https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms. Select 2021 Performance Period.

The performance period for the CPC+ program begins on January 1, 2021 and ends on December 31, 2021.

4.2 Primary Care First (PCF) Submissions

PCF practice sites need to adopt health IT (HIT) meeting the requirements published by the PCF model. This guide only provides information for QRDA III reporting of eCQMs for the PCF program. Please note that only PCF participants in Practice Risk Groups 1 and 2 are required to report eCQMs. More information about the health IT requirements and reporting additional measures will be posted on https://innovation.cms.gov/initiatives/primary-care-first-model-options.

For the 2021 performance period, the PCF QRDA III file must contain the CMS EHR Certification ID. Nulls will not be allowed. Only one CMS EHR Certification ID shall be submitted for PCF quality reporting. Full instructions on how to generate a CMS EHR Certification ID are in the CHPL Public User Guide, https://www.healthit.gov/sites/default/files/policy/chpl_public_user_guide.pdf.

Practices must report all measures at the PCF practice site level, which is identified by the PCF Practice ID. PCF practice site-level reporting includes all patients (including all payers and the uninsured) who were seen one or more times at the practice site location during the performance year by one or more clinicians who were active on the PCF Practitioner Roster at any point during the performance year and who meet the criteria as specified in each measure.

Each PCF practice site submitting QRDA III files for the 2021 performance period must provide at least the minimum number of eCQMs required by the PCF program.

Promoting Interoperability or Improvement Activity data **should not be submitted** in a PCF quality measure QRDA III submission file. Since Promoting Interoperability and Improvement Activity data are not required to be reported for PCF, if these data are submitted they will be ignored. If you are submitting Promoting Interoperability or Improvement Activity data for MIPS, see 4.3 Merit-Based Incentive Payment System (MIPS) QRDA III Submissions for more information.

QRDA III submissions for PCF will use the 2021 Performance Period eCQM Specifications for Eligible Professionals and Eligible Clinicians[3] provided in the eCQI Resource Center.

The performance period for the PCF program begins on January 1, 2021 and ends on December 31, 2021.

4.3 Merit-Based Incentive Payment System (MIPS) QRDA III Submissions

MIPS QRDA III submissions must contain data for at least one of the following three MIPS performance categories: Quality, Promoting Interoperability, or Improvement Activities. The QRDA III XML format can be used for submissions made via file upload on qpp.cms.gov. Please refer to the Quality Payment Program website for Quality, Promoting Interoperability, and Improvement Activity scoring rules.

[3] eCQI Resource Center, Eligible Professional/Eligible Clinician eCQMs web page. https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms. Select 2021 Performance Period.

Under MIPS, a group is defined as a single Taxpayer Identification Number (TIN) with 2 or more clinicians (including at least one MIPS eligible clinician), as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN. If a MIPS eligible clinician bills Medicare Part B under multiple TINs, such MIPS eligible clinician is required to submit data for each TIN association that he/she exceeds the low-volume threshold as an individual (TIN associations participating in MIPS at the individual level). For TIN associations that are participating in MIPS as a group and exceed the low-volume threshold at the group level, such MIPS eligible clinician will have his/her data included as part of the TIN's aggregated data and group submission.

Under MIPS, a virtual group is defined as a combination of two or more TINs assigned to one or more solo practitioners or to one or more groups consisting of 10 or fewer clinicians (including at least one MIPS eligible clinician), or both, that elect to form a virtual group for a performance period.

For 2021, MIPS eligible clinicians and groups are required to submit a full year of data for the Quality performance category, 90-days of data for Improvement Activities—unless otherwise specified within the activity, and 90-days of data for the Promoting Interoperability performance categories. For the MIPS eligible clinician participating as an individual, your eCQM populations include all patients (all-payer data) seen by the MIPS eligible clinician during the performance period. For group participation, eCQM populations include all patients (all-payer data). Data submission for both individual MIPS eligible clinicians and groups will occur prior to January 2, 2022, if technically feasible, through March 31, 2022 for the 2021 performance period.

For the 2021 performance period, a CMS EHR Certification ID is required for the Promoting Interoperability performance category. See 5.1.3 Participant (CMS EHR Certification ID) for details. CMS EHR Certification ID is optional for the MIPS Quality performance category.

4.4 Identifiers

For all CMS eligible clinicians and eligible professionals program reporting, certain identifiers are **mandatory**, meaning that they must be present in the QRDA III report and no nulls are allowed. Exceptions and considerations are noted where applicable. Mandatory identifiers for CMS eligible clinicians and eligible professionals program reporting include:

- Alternative Payment Model (APM) Entity Identifier
  - For CPC+, this is the CPC+ Practice Site Identifier assigned by CPC+
  - For PCF, this is the PCF Practice Site Identifier assigned by PCF

- National Provider Identifier (NPI)
  - Required for MIPS individual reporting
  - Not allowed for MIPS group reporting and MIPS virtual group reporting
  - Required for CPC+ reporting
  - Required for PCF reporting

- Tax Identification Number (TIN)
  - Required for MIPS group reporting and MIPS individual reporting
  - Required for CPC+ reporting
  - Required for PCF reporting

- Virtual Group Identifier
  - Required for MIPS virtual group reporting

4.5 Succession Management

This section describes the management of successive replacement documents for QRDA III reports. For example, a submitter notices an error in an earlier submission and wants to replace it with a corrected version. For the MIPS receiving system, managing replacement documents is sometimes referred to as Final Action Processing (FAP). For MIPS QRDA III reporting, replacement documents will be handled at the category level for final processing.

4.5.1 Final Action Processing used in Succession Management

The MIPS receiving system at CMS uses Final Action Processing to reliably determine the current version per category of a QRDA III document. There are different sets of Final Action Processing rules that apply to the MIPS program and the CPC+ program respectively.

Please note that the CMS receiving system will not be able to analyze specific elements outside of any given category within the file of earlier QRDA III submissions. Therefore submitters should ensure all QRDA III reports are complete data re-submissions per category being resubmitted.

4.5.2 Final Action Processing Rules for MIPS

For group reporting (except for the CPC+ and PCF models), the Final Action Processing rules include the combination of the CMS program name, the TIN, and the submission timestamp. For individual reporting, the Final Action Processing rules include the combination of the CMS program name, the TIN, the NPI number, and the submission timestamp.

When submitting a replacement QRDA III report for the MIPS program use the same TIN, or the same TIN/NPI, or the same virtual group identifier. For example, suppose a QRDA III report containing Quality data for eCQMs 1, 2, and 3 was submitted on Monday and a replacement QRDA III report for the same TIN/NPI was resubmitted the next day for eCQMs 1, 2, and 4. eCQMs 1, 2, and 4 contained in the latest submission will be used for final processing. Data submitted for eCQM 3 on Monday would not be marked for final processing and not be used for MIPS analysis.

At the category level, if a QRDA III report containing data for Quality, Promoting Interoperability, and Improvement Activities was submitted on Monday and a replacement QRDA III report for the same TIN was resubmitted the next day with data for Promoting Interoperability, only the Quality and Improvement Activities data from the first submission and then Promoting Interoperability from the subsequent submission would be marked for final processing for MIPS analysis.

4.5.3 Final Action Processing Rules for CPC+

The last file successfully submitted for a CPC+ practice site is used to determine if that CPC+ practice site satisfactorily meets reporting requirements for the program year.

For QRDA III files that are submitted to the CPC+ program, the Final Action Processing rules include the combination of the CMS program name, the CPCPLUS APM Entity Identifier (aka CPC+ Practice Site Identifier), and the submission timestamp.

4.5.4 Final Action Processing Rules for PCF

The last file successfully submitted for a PCF practice site is used to determine if that PCF practice site satisfactorily meets reporting requirements for the program year.

For QRDA III files that are submitted to the PCF program, the Final Action Processing rules include the combination of the CMS program name, the PCF APM Entity Identifier (aka PCF Practice Site Identifier), and the submission timestamp.

4.5.5 Program Identifiers Used in Succession Management

The CMS program name requirement for QRDA III submission is specified in 5.1.1 informationRecipient. Each QRDA III report **must** contain only one CMS program name, which shall be selected from the QRDA III CMS Program Name value set (2.16.840.1.113883.3.249.14.101) for the 2021 performance period. The CMS program name specified in a QRDA III report ensures the report is routed to the correct CMS program once it is received by the CMS QRDA III receiving system. Therefore, when submitting a QRDA III report to CMS, it is critical to specify the correct CMS program. The CMS program name is also used for managing successive replacement QRDA III reports. When submitting a replacement QRDA III report, the replacement QRDA III report **must** contain the same CMS program name as specified in the report that it is intended to replace. The timestamp of the latest file submitted will be used to determine which file is to be analyzed for the specified CMS program, therefore an error in the CMS program name will produce the wrong analysis. For example, if you are submitting a file initially for CPC+, find an error, and resubmit the file with another CMS program name (such as MIPS_GROUP), the resubmitted file will only be analyzed for MIPS.

4.6 Time Zone

Time comparisons or elapsed time calculations are frequently involved as part of determining measure population outcomes.

Table 1: Time Zone Validation Rule

CONF.#	Rules
CMS_0122	A Coordinated Universal Time (UTC time) offset should not be used anywhere in a QRDA Category III file or, if a UTC time offset is needed anywhere, then it ***must*** be specified ***everywhere*** a time field is provided.

This time zone validation rule is performed on the following elements:

- `effectiveTime/@value`
- `effectiveTime/low/@value`
- `effectiveTime/high/@value`
- `time/@value`
- `time/low/@value`
- `time/high/@value`

There is one exception to this validation rule. The `effectiveTime` element of the Reporting Parameters Act template (CONF: 23-3274 and CONF: 23-3275) will not be validated using this time zone validation rule:

- act[@templateId="`2.16.840.1.113883.10.20.17.3.8`"]/effectiveTime/low
- act[@templateId="`2.16.840.1.113883.10.20.17.3.8`"]/effectiveTime/high

4.7 Performance Period and Performance Rate

The performance period for the CPC+ and PCF models begins on January 1, 2021 and ends on December 31, 2021. If the CMS program name code is "CPCPLUS" or "PCF", the Reporting

Parameters Act `effectiveTime/low` and `effectiveTime/high` value must be set as the following:

- act[@templateId="2.16.840.1.113883.10.20.17.3.8"]/effectiveTime/low/@value="20210101"
- act[@templateId="2.16.840.1.113883.10.20.17.3.8"]/effectiveTime/high/@value="20211231"

For the MIPS performance period requirement, please see 4.3 Merit-Based Incentive Payment System (MIPS) QRDA III Submissions and 5.1.5 component.

For the CPC+ and PCF models, performance rate(s) must be reported for eCQMs that are proportion measure-based. This is specified in the following conformance statements:

> If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then Performance Rate for Proportion Measure – CMS (V3) **SHALL** be present (CONF:CMS_14).
>
> If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Performance Rate for Proportion Measure – CMS (V3) **SHALL** be present (CONF:CMS_97).

For MIPS reporting (CMS program name code is either “MIPS_INDIV”, “MIPS_GROUP”, or “MIPS_VIRTUALGROUP”), performance rates for eCQMs and Promoting Interoperability measures are not required for submissions. If performance rates are provided, they will be ignored by the receiving system.

4.8 Templates Versioning and Validations

Both the base HL7 QRDA III STU R2.1 and the CMS QRDA III Implementation Guide have versioned the templates if changes were made to the previous version of the template. Details about CDA templates versioning in general are described in 1.8.2 Template Versioning of the HL7 QRDA III STU R2.1. For example, in the HL7 QRDA III STU R2.1, the previous Measure Reference and Results template is now Measure Reference and Results (V3), its template identifier is “`2.16.840.1.113883.10.20.27.3.1:2016-09-01`”. Both the `@root` and `@extension` are required as specified in the IG.

SHALL contain exactly one [1..1] **`templateId`** (CONF:3259-17908) such that it

a. **SHALL** contain exactly one [1..1] **`@root`**="`2.16.840.1.113883.10.20.27.3.1`" (CONF:3259-17909).

b. **SHALL** contain exactly one [1..1] **`@extension`**="`2016-09-01`" (CONF:3259-21170).

Correct template versions that are specified by both the base HL7 QRDA III STU R2.1 and the 2021 CMS IG must be used for 2021 CMS QRDA III submissions.

5 QRDA Category III Validation

5.1 Document-Level Template: QRDA Category III Report - CMS (V5)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.27.1.2:2020-05-01 (open)]`

Table 2: QRDA Category III Report - CMS (V5) Contexts

Contained By	Contains
N/A	QRDA Category III Measure Section - CMS (V4) (optional)

This template describes constraints that apply to the QRDA Document Category III Report for CMS Eligible Clinicians and Eligible Professionals Programs including the CPC+and PCF models and MIPS.

Document-level templates describe the rules for constructing a conforming CDA document. They include constraints on the CDA header and identify contained section-level templates. The document-level template contains the following information:

Description and explanatory narrative
Template metadata (e.g., templateId, etc.)
Header constraints
Required section-level templates

1. Conforms to **`QRDA Category III Report (V4)`** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.1.1:2017-06-01)`.
2. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:CMS_1) such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**`="2.16.840.1.113883.10.20.27.1.2"` (CONF:CMS_2).
    b. **SHALL** contain exactly one [1..1] **`@extension`**`="2020-05-01"` (CONF:CMS_3).
3. **SHALL** contain exactly one [1..1] **`confidentialityCode`** (CONF:4427-17238_C01).
    a. This confidentialityCode **SHALL** contain exactly one [1..1] **`@code`**`="N"` Normal (CodeSystem: `HL7Confidentiality urn:oid:2.16.840.1.113883.5.25`) (CONF:CMS_4).
4. **SHALL** contain exactly one [1..1] **`languageCode`** (CONF:3338-17239).
    a. This languageCode **SHALL** contain exactly one [1..1] **`@code`**`="en"` English (CodeSystem: `Language urn:oid:2.16.840.1.113883.6.121`) (CONF:4427-19669_C01).

5.1.1 informationRecipient

The informationRecipient represents the CMS eligible clinicians and eligible professionals program the report is being submitted to.

5. **SHALL** contain exactly one [1..1] **`informationRecipient`** (CONF:CMS_7).
    a. This informationRecipient **SHALL** contain exactly one [1..1] **`intendedRecipient`** (CONF:CMS_8).

i. This intendedRecipient **SHALL** contain exactly one [1..1] **`id`** (CONF:CMS_9).
    1. This id **SHALL** contain exactly one [1..1] **`@root="`**`2.16.840.1.113883.3.249.7`**`"`** CMS Program (CONF:CMS_10).
    2. This id **SHALL** contain exactly one [1..1] **`@extension`**, which **SHALL** be selected from ValueSet `QRDA III CMS Program Name urn:oid:2.16.840.1.113883.3.249.14.101` **STATIC** 2020-05-01 (CONF:CMS_11).
       Note: The extension value is the CMS program name code, which indicates the CMS program the report is being submitted to.
        a. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then ClinicalDocument/participant/@typeCode="LOC" **SHALL** be present (CONF:CMS_12).
           Note: For CPC+ reporting, CPC+ APM Entity Identifier must be submitted.
        b. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then QRDA Category III Measure Section – CMS (V4) **SHALL** be present (CONF:CMS_13).
           Note: For CPC+ reporting, the QRDA III document must contain a quality (eCQMs) section.
        c. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then Performance Rate for Proportion Measure – CMS (V3) **SHALL** be present (CONF:CMS_14).
           Note: For CPC+ reporting, performance rate for a proportion eCQM must be specified.
        d. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then CMS EHR Certification ID **SHALL** be present (CONF:CMS_92).
        e. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then ClinicalDocument/participant/@typeCode="LOC" **SHALL** be present (CONF:CMS_99).
           Note: For PCF reporting, PCF APM Entity Identifier must be submitted.
        f. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then QRDA Category III Measure Section – CMS (V4) **SHALL** be present (CONF:CMS_100).
           Note: For PCF reporting, the QRDA III document must contain a quality (eCQMs) section.

g. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Performance Rate for Proportion Measure – CMS (V3) **SHALL** be present (CONF:CMS_97).
Note: For PCF reporting, performance rate for a proportion eCQM must be specified.

h. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then CMS EHR Certification ID **SHALL** be present (CONF:CMS_98).

Table 3: QRDA III CMS Program Name

Value Set: QRDA III CMS Program Name 2.16.840.1.113883.3.249.14.101 Specifies the CMS Program for QRDA III report submissions.			
Code	**Code System**	**Code System OID**	**Print Name**
CPCPLUS	CMS Program	2.16.840.1.113883.3.249.7	CPC+
PCF	CMS Program	2.16.840.1.113883.3.249.7	PCF
MIPS_INDIV	CMS Program	2.16.840.1.113883.3.249.7	MIPS Individual
MIPS_GROUP	CMS Program	2.16.840.1.113883.3.249.7	MIPS Group
MIPS_VIRTUALGROUP	CMS Program	2.16.840.1.113883.3.249.7	MIPS Virtual Group

Figure 5: informationRecipient Example, QRDA Category III Report - CMS (V4)

```
<informationRecipient>
  <intendedRecipient>
    <id root="2.16.840.1.113883.3.249.7" extension="CPCPLUS"/>
  </intendedRecipient>
</informationRecipient>
```

5.1.2 participant is Location (CPC+ or PCF Practice Site)

For CPC+ and PCF reporting, the generic participant with a participationType of 'LOC' (location) and an associatedEntity classCode of 'SDLOC' (service delivery location) representing the CPC+ or PCF Practice Site respectively is required.

If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS" or "PCF", then this location participant must be present.

6. **MAY** contain zero or one [0..1] **`participant`** (CONF:CMS_15) such that it
   a. **SHALL** contain exactly one [1..1] **`@typeCode="LOC"`** Location (CodeSystem: `HL7ParticipationType urn:oid:2.16.840.1.113883.5.90`) (CONF:CMS_16).
   b. **SHALL** contain exactly one [1..1] **`associatedEntity`** (CONF:CMS_17).
      i. This associatedEntity **SHALL** contain exactly one [1..1] **`@classCode="SDLOC"`** Service Delivery Location (CONF:CMS_18).
      ii. This associatedEntity **SHALL** contain exactly one [1..1] **`id`** (CONF:CMS_19) such that it

1. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.3.249.5.1**"** CPC+ Practice Site (CONF:CMS_20).
   Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.1) designates that the @extension must hold a CPCPLUS APM Entity Identifier.
2. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_21).
   Note: This is the CPCPLUS APM Entity Identifier assigned to the CPC+ practice site.

iii. This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_101) such that it

1. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.3.249.5.3**"** PCF Practice Site (CONF:CMS_102).
   Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.3) designates that the @extension must hold a PCF APM Entity Identifier.
2. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_103).
   Note: This is the PCF APM Entity Identifier assigned to the PCF practice site.

iv. This associatedEntity **SHALL** contain exactly one [1..1] **code** (CONF:CMS_22).

1. This code **SHALL** contain exactly one [1..1] **@code="**394730007**"** Healthcare Related Organization (CONF:CMS_23).
2. This code **SHALL** contain exactly one [1..1] **@codeSystem** (CodeSystem: SNOMED CT urn:oid:2.16.840.1.113883.6.96) (CONF:CMS_24).

v. This associatedEntity **SHALL** contain exactly one [1..1] **addr** (CONF:CMS_25).

vi. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then this participant/associatedEntity **SHALL** contain the id for CPC+ Practice Site (CONF:CMS_104).

vii. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then this participant/associatedEntity **SHALL** contain the id for PCF Practice Site (CONF:CMS_105).

Figure 6: Location Participant Example – CPC+ Practice Site

```
<participant typeCode="LOC">
  <associatedEntity classCode="SDLOC">
    <id root="2.16.840.1.113883.3.249.5.1" extension="T2OR1234"
        assigningAuthorityName="CMS-CMMI"/>
    <code code="394730007"
        displayName="healthcare related organization"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED-CT"/>
    <addr>
      <streetAddressLine>123 Healthcare St</streetAddressLine>
      <city>Norman</city>
      <state>OK</state>
      <postalCode>73019</postalCode>
    </addr>
  </associatedEntity>
</participant>
```

5.1.3 Participant (CMS EHR Certification ID)

For the 2021 performance period, participants will submit a single set of Promoting Interoperability Objectives and Measures to align with 2015 Edition certified EHR technology (CEHRT). As part of their submission, participants shall include a CMS EHR Certification ID that represents the CEHRT used by the individual or group during the performance period. Groups should ensure that their CMS EHR Certification ID reflects all products used by clinicians within the group before generating the ID. Only one CMS EHR Certification ID should be submitted for group reporting. To obtain a CMS EHR Certification ID, participants should enter their product information in the ONC Certified Health IT Product List (CHPL) website search tool and select all certified products or certified health IT modules used during the performance period. Full instructions on how to create a CMS EHR Certification ID are in the CHPL Public User Guide, https://www.healthit.gov/sites/default/files/policy/chpl_public_user_guide.pdf.

For MIPS submissions, a CMS EHR Certification ID is only required if the Promoting Interoperability performance category (**`Promoting Interoperability Section (V2)`** `identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.5:2017-06-01`) is present in a QRDA III document. If a CMS EHR Certification ID is not supplied, the score for the PI performance category will be 0.

For MIPS submission, CMS EHR Certification ID is optional for the Quality performance category.

For CPC+, all QRDA III files must include a CMS EHR Certification ID. Nulls will not be allowed. Please refer to section 4.1 for additional information.

For PCF, all QRDA III files must include a CMS EHR Certification ID. Nulls will not be allowed. Please refer to section 4.2 for additional information.

7. **MAY** contain zero or one [0..1] **`participant`** (CONF:CMS_85) such that it
    a. **SHALL** contain exactly one [1..1] **`@typeCode`**`="DEV"` device (CodeSystem: `HL7ParticipationType urn:oid:2.16.840.1.113883.5.90`) (CONF:CMS_86).
    b. **SHALL** contain exactly one [1..1] **`associatedEntity`** (CONF:CMS_87).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **`@classCode`**`="RGPR"` regulated product (CodeSystem:

HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:CMS_88).

ii. This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_89).

1. This id **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.3.2074.1**"** CMS EHR Certification ID (CONF:CMS_90).
2. This id **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_91).
   Note: The value of @extension is the CMS EHR Certification ID, which must be 15 alpha numeric characters in length.

5.1.4 documentationOf

The aggregated data contained in a QRDA Category III report was provided by one or more providers. The documentationOf service event can contain identifiers for all of the (one or more) providers involved, using the serviceEvent/performer elements.

8. **SHALL** contain exactly one [1..1] **documentationOf** (CONF:4427-18170_C01).

For MIPS group reporting: it must contain exactly one performer, which contains one TIN. No NPI is allowed.

For MIPS virtual group reporting: it must contain exactly one performer, which contains one Virtual Group Identifier. No NPI is allowed.

For MIPS individual reporting: it must contain exactly one performer, which contains one TIN and one NPI.

For CPC+ and PCF: it must contain at least one performer, each performer contains one TIN and one NPI. Only CPC+ or PCF Practice Site providers are listed as performers.

a. This documentationOf **SHALL** contain exactly one [1..1] **serviceEvent** (CONF:4427-18171_C01).

i. This serviceEvent **SHALL** contain at least one [1..*] **performer** (CONF:3338-18173).

The assignedEntity id/@root =' 2.16.840.1.113883.4.6' coupled with the id/@extension represents the individual provider's National Provider Identification number (NPI).
NPI is required except for group reporting. For group reporting, id/@root=' 2.16.840.1.113883.4.6' is coupled with @nullFlavor="NA", and @extension shall be omitted.

1. Such performers **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:3338-18176).

   a. This assignedEntity **SHALL** contain exactly one [1..1] **id** (CONF:4427-18177_C01) such that it

      i. **MAY** contain zero or one [0..1] **@nullFlavor** (CONF:CMS_29).
      Note: @nullFlavor is only present for MIPS group reporting and MIPS virtual group reporting.

      ii. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.4.6**"** National Provider ID (CONF:4427-18178_C01).
      Note: This OID contained in the @root

(2.16.840.1.113883.4.6) designates that the @extension must hold a National Provider ID.

iii. **MAY** contain zero or one [0..1] **`@extension`** (CONF:3338-18247).
Note: This is the provider's NPI. It is only present when this is not MIPS group reporting or MIPS virtual group reporting. For CPC+, only those NPIs that are participating in the CPC+ program should be provided. For PCF, only those NPIs that are participating in the PCF program should be provided.

b. This assignedEntity **SHALL** contain exactly one [1..1] **`representedOrganization`** (CONF:3338-18180).

i. This representedOrganization **MAY** contain zero or one [0..1] **`id`** (CONF:4427-18181_C01) such that it

1. **SHALL** contain exactly one [1..1] **`@root="`**`2.16.840.1.113883.4.2`**`"`** Tax ID Number (CONF:3338-18182).
Note: This OID contained in the @root (2.16.840.1.113883.4.2) designates that the @extension must hold a Tax Identification Number (TIN).
2. **SHALL** contain exactly one [1..1] **`@extension`** (CONF:3338-18190).
Note: This is the organization's TIN.

ii. This representedOrganization **MAY** contain zero or one [0..1] **`id`** (CONF:CMS_79) such that it

1. **SHALL** contain exactly one [1..1] **`@root="`**`2.16.840.1.113883.3.249.5.2`**`"`** MIPS Virtual Group (CONF:CMS_80).
Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.2) designates that the @extension must hold a Virtual Group Identifier.
2. **SHALL** contain exactly one [1..1] **`@extension`** (CONF:CMS_81).
Note: This is the Virtual Group Identifier.

iii. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_GROUP", then this representedOrganization **SHALL** contain one [1..1] id such that it, **SHALL** be the group's TIN (CONF:CMS_82).

iv. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_VIRTUALGROUP", then this representedOrganization **SHALL** contain one [1..1] id such that it, **SHALL**

be the virtual group's Virtual Group Identifier (CONF:CMS_83).

Figure 7: documentationOf Example – TIN and NPI

```
<documentationOf>
  <serviceEvent classCode="PCPR">
    <!-- Multiple performers can be included for CPC+ or PCF,
         each with an NPI and TIN -->
    <performer typeCode="PRF">
      <time>
        <low value="20210101"/>
        <high value="20211231"/>
      </time>
      <assignedEntity>
        <!-- Provider NPI -->
        <id root="2.16.840.1.113883.4.6" extension="2589654740"/>
        <representedOrganization>
          <!-- Organization TIN -->
          <id root="2.16.840.1.113883.4.2" extension="990000999"/>
          <name>Good Health Clinic</name>
        </representedOrganization>
      </assignedEntity>
    </performer>
  </serviceEvent>
</documentationOf>
```

5.1.5 component

A CMS QRDA Category III document for the 2021 performance period must contain at least a QRDA Category III Measure Section, an Improvement Activity Section, or a Promoting Interoperability (formerly known as Advancing Care Information) Section.

For the 2021 performance period, performance period reporting for Improvement Activities, Promoting Interoperability, and Quality performance categories all must be specified at the performance category level using the Reporting Parameters Act template in each of the sections.

The QRDA Category III Reporting Parameters Section shall not be used for specifying performance period.

9. **SHALL** contain exactly one [1..1] **`component`** (CONF:3338-17217).
    a. This component **SHALL** contain exactly one [1..1] **`structuredBody`** (CONF:3338-17235).
        i. This structuredBody **SHALL NOT** contain [0..0] **`component`** (CONF:4427-17281_C01) such that it
        Note: Reporting Parameter Section shall not be used for specifying performance period.
            1. **SHALL** contain exactly one [1..1] QRDA Category III Reporting Parameters Section `(identifier: urn:oid:2.16.840.1.113883.10.20.27.2.2)` (CONF:3338-17282).
        ii. This structuredBody **MAY** contain zero or one [0..1] **`component`** (CONF:3338-17283) such that it
            1. **SHALL** contain exactly one [1..1] **QRDA Category III Measure Section - CMS (V4)** (identifier:

urn:hl7ii:2.16.840.1.113883.10.20.27.2.3:2019-05-01) (CONF:4427-17301_C01).

iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:3338-21173) such that it
    1. **SHALL** contain exactly one [1..1] Improvement Activity Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.4:2017-06-01) (CONF:3338-21174).

iv. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:3338-21317) such that it
    1. **SHALL** contain exactly one [1..1] Promoting Interoperability Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.5:2017-06-01) (CONF:3338-21318).
    Note: Formerly known as Advancing Care Information Section

ii. This structuredBody **SHALL** contain at least a QRDA Category III Measure Section - CMS (V4), or an Improvement Activity Section (V2), or a Promoting Interoperability Section (V2) (CONF:4427-21394_C01).
Note: Promoting Interoperability Section (V2) is formerly the Advancing Care Information Section (V2)

Figure 8: structuredBody Example

```
<component>
  <structuredBody>
    <component>
      <!-- QRDA Category III Measure Section - CMS (V4)-->
      <section>
        ...
        <title>Measure Section</title>
        ...
      </section>
    </component>
    <component>
      <!-- Improvement Activity Section -->
      <section>
        ...
        <title>Measure Section</title>
        ...
      </section>
    </component>
    <component>
      <!—- Promoting Interoperability Section (V2) -->
      <section>
        ...
        <title>Measure Section</title>
        ...
      </section>
    </component>
  </structuredBody>
</component>
```

5.2 Section-Level Templates

5.2.1 CMS QRDA Category III Measure Section - CMS (V4)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.27.2.3:2019-05-01 (open)]`

Table 4: QRDA Category III Measure Section – CMS (V4) Contexts

Contained By	Contains
QRDA Category III Report - CMS (V4) (optional)	Measure Reference and Results - CMS (V4) (required)

This section references the eCQM(s) being reported. For each reported eCQM, this section includes entries for reporting various aggregate counts (e.g. number of patients in the measure's denominator). For continuous variable measures, this section includes entries for reporting the continuous variables. This section can also include entries not only for aggregate counts, but also for stratified aggregate counts (e.g. not just total number of patients in the denominator, but also the number of males in the denominator). Note that the QRDA III standard allows for more than one measure within this section, but does not allow multiple occurrences of the same measure in a single QRDA III instance.

For CPC+ or PCF reporting, this section must contain a Measure Reference and Results template for each eCQM that is being reported on by the CPC+ or PCF practice site respectively.

1. Conforms to QRDA Category III Measure Section (V4) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.1:2017-06-01)`.
2. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:CMS_64) such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**`="2.16.840.1.113883.10.20.27.2.3"` (CONF:CMS_65).
    b. **SHALL** contain exactly one [1..1] **`@extension`**`="2019-05-01"` (CONF:CMS_66).
3. **SHALL** contain at least one [1..*] **`entry`** (CONF:4427-17906_C01) such that it
    a. **SHALL** contain exactly one [1..1] **`Measure Reference and Results - CMS (V4)`** `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.17:2019-05-01)` (CONF:4427-17907_C01).

Figure 9: QRDA III Measure Section – CMS (V4) Example

```
<section>
    <!-- Measure Section template ID -->
    <templateId root="2.16.840.1.113883.10.20.24.2.2" />
    <!-- QRDA Category III Measure Section (V4) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.2.1"
extension="2017-06-01"/>
    <!-- QRDA Category III Measure Section - CMS (V4) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.2.3"
extension="2019-05-01"/>
    <code code="55186-1" codeSystem="2.16.840.1.113883.6.1"/>
    <title>Measure Section</title>
    <text>
        <table border="1" width="100%">
            <thead>
                <tr>
                    <th>eCQM Title</th>
                    <th>Version specific identifier</th>
                </tr>
            </thead>
            <tbody>
                <tr>
                    <td>Controlling High Blood Pressure</td>
                    <td>2c928085-7198-38ee-0171-9da6456007ab</td>
                </tr>
            </tbody>
            <list>
            ...
            </list>
        </table>
     </text>
    <entry>
        <!-- Measure Reference and Results - CMS (V4) -->
        <organizer classCode="CLUSTER" moodCode="EVN">
        ...
        </organizer>
    </entry>
</section>
```

5.3 Entry-Level Templates

5.3.1 Measure Data - CMS (V4)

```
[observation: identifier
urn:hl7ii:2.16.840.1.113883.10.20.27.3.16:2019-05-01 (open)]
```

Table 5: Measure Data – CMS (V4) Contexts

Contained By	Contains
Measure Reference and Results - CMS (V4) (required)	Aggregate Count (required) Continuous Variable Measure Value (optional) Reporting Stratum (optional) Sex Supplemental Data Element (V3) (required) Ethnicity Supplemental Data Element (V2) (required) Race Supplemental Data Element (V2) (required) Payer Supplemental Data Element - CMS (V3) (required)

This observation asserts a population into which a subject falls and provides the number of patients in the population. It may also contain reporting stratum, supplemental data element counts, and continuous variables that are relevant to the population. The measure data entry must reference a unique measure population ID as listed in Section 6, below.

Populations that are used in eCQMs can be complicated. The simple case has one each of initial population (IPOP), numerator, and denominator, along with denominator exclusions and denominator exceptions. It is also possible to have eCQMs with multiple population groups (a population group is a set of IPOP, numerator, denominator, etc.), and eCQMs with multiple denominators and numerators (e.g., an eCQM with 3 denominators and 2 numerators will require a QRDA Category III report with 6 sets of data). QRDA Category III reports were designed to allow the representation of data sets that map to all of these types of multiple populations.

A measure may not be submitted more than once in the same file. The same population may not be submitted more than once in the same measure. Uniqueness of a measure is determined based on the UUID provided for it in the associated `reference/externalDocument/id`. This `id` **SHALL** equal the version specific identifier that comes from the applicable HQMF file. Uniqueness of a population is determined based on the UUID provided for it in the `associated reference/externalObservation/id`. This id **SHALL** equal the respective population identifier that comes from the applicable HQMF file.

Table 6: Measure Data - CMS (V4) Constraints Overview

observation[templateId/@root = '2.16.840.1.113883.10.20.27.3.16']
[templateId/@extension="2019-05-01"]

XPath	Card	Verb	Data Type	CONF#	Value
templateId	1..1	SHALL		CMS_41	
@root	1..1	SHALL		CMS_42	2.16.840.1.113883.10.20.27.3.16
@extension	1..1	SHALL		CMS_43	2019-05-01

XPath	Card	Verb	Data Type	CONF#	Value
entryRelationship	1..*	SHALL		4427-18141_C01	
@typeCode	1..1	SHALL		3259-18146	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
Observation	1..1	SHALL		4427-18151_C01	Payer Supplemental Data Element - CMS (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.18:2018-05-01)
entryRelationship	1..*	SHALL		4427-18136_C01	
@typeCode	1..1	SHALL		3259-18137	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
Observation	1..1	SHALL		3259-18138	Sex Supplemental Data Element (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.6:2016-09-01)
entryRelationship	1..*	SHALL		4427-18140_C01	
@typeCode	1..1	SHALL		3259-18145	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
Observation	1..1	SHALL		3259-18150	Race Supplemental Data Element (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.8:2016-09-01)
entryRelationship	1..*	SHALL		4427-18139_C01	
@typeCode	1..1	SHALL		3259-18144	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = COMP
Observation	1..1	SHALL		3259-18149	Ethnicity Supplemental Data Element (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.7:2016-09-01)

1. Conforms to Measure Data (V3) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.5:2016-09-01)`.
2. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:CMS_41) such that it
    a. **SHALL** contain exactly one [1..1] **`@root="`**`2.16.840.1.113883.10.20.27.3.16`**`"`** (CONF:CMS_42).
    b. **SHALL** contain exactly one [1..1] **`@extension="`**`2019-05-01`**`"`** (CONF:CMS_43).
3. **SHALL** contain at least one [1..*] **`entryRelationship`** (CONF:4427-18141_C01) such that it

a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) (CONF:3259-18146).
b. **SHALL** contain exactly one [1..1] **Payer Supplemental Data Element - CMS (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.18:2018-05-01) (CONF:4427-18151_C01).

4. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:4427-18136_C01) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:3259-18137).
   b. **SHALL** contain exactly one [1..1] Sex Supplemental Data Element (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.6:2016-09-01) (CONF:3259-18138).
5. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:4427-18140_C01) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:3259-18145).
   b. **SHALL** contain exactly one [1..1] Race Supplemental Data Element (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.8:2016-09-01) (CONF:3259-18150).
6. **SHALL** contain at least one [1..*] **entryRelationship** (CONF:4427-18139_C01) such that it
   a. **SHALL** contain exactly one [1..1] **@typeCode**="COMP" (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:3259-18144).
   b. **SHALL** contain exactly one [1..1] Ethnicity Supplemental Data Element (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.7:2016-09-01) (CONF:3259-18149).

Figure 10: Measure Data - CMS (V4) Example

```
<observation classCode="OBS" moodCode="EVN">
    <!-- Measure Data (V3) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.5" extension="2016-
09-01"/>
    <!-- Measure Data - CMS (V4) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.16"
extension="2019-05-01"/>
    <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"
        displayName="Assertion" codeSystemName="ActCode"/>
    <statusCode code="completed"/>
    <value xsi:type="CD" code="IPOP"
         codeSystem="2.16.840.1.113883.5.4"
         displayName="initial population"
         codeSystemName="ActCode"/>
    <!-- Aggregate Count -->
    <entryRelationship typeCode="SUBJ" inversionInd="true">
        <observation classCode="OBS" moodCode="EVN">
         ...
        </observation>
    </entryRelationship>
    <!-- Sex Supplemental Data Element (V3)-->
    <entryRelationship typeCode="COMP">
        <observation classCode="OBS" moodCode="EVN">
         ...
        </observation>
    </entryRelationship>
    <!-- Ethnicity Supplemental Data Element (V2) -->
    <entryRelationship typeCode="COMP">
        <observation classCode="OBS" moodCode="EVN">
         ...
        </observation>
    </entryRelationship>
    <!-- Race Supplemental Data Element (V2) -->
    <entryRelationship typeCode="COMP">
        <observation classCode="OBS" moodCode="EVN">
         ...
        </observation>
    </entryRelationship>
    <!-- Payer Supplemental Data Element - CMS (V3) -->
    <entryRelationship typeCode="COMP">
        <observation classCode="OBS" moodCode="EVN">
        ...
        </observation>
    </entryRelationship>
    <!-- reference to the relevant population in the eCQM -->
    <reference typeCode="REFR">
        <externalObservation classCode="OBS" moodCode="EVN">
            <id root="87338BA5-170B-4264-9E59-6A4A3A57C785"/>
            <!-- This is the population ID in the eCQM.
                 In this case, the IPOP -->
        </externalObservation>
    </reference>
</observation>
```

5.3.2 Measure Reference and Results - CMS (V4)

```
[organizer: identifier
urn:hl7ii:2.16.840.1.113883.10.20.27.3.17:2019-05-01 (open)]
```

Table 7: Measure Reference and Results - CMS (V3) Contexts

Contained By	Contains
QRDA Category III Measure Section - CMS (V4) (required)	Performance Rate for Proportion Measure - CMS (V3) (optional) Measure Data - CMS (V4) (required)

This template defines the way that a measure should be referenced. Measures are referenced through `externalAct` reference to an `externalDocument`. The `externalDocument/ids` and version numbers are used to reference the measure. Component entries can be used to report various rates, aggregate counts (e.g., number of patients in the measure's denominator); stratified aggregate counts (e.g., number of male patients in the measure's denominator); or continuous variables from continuous variable measures.

Table 8: Measure Reference and Results - CMS (V4) Constraints Overview

organizer[templateId/@root = '2.16.840.1.113883.10.20.27.3.17']
[templateId/@extension="2019-05-01"]

XPath	Card	Verb	Data Type	CONF#	Value
templateId	1..1	SHALL		CMS_54	
@root	1..1	SHALL		CMS_55	2.16.840.1.113883.10.20.27.3.17
@extension	1..1	SHALL		CMS_56	2019-05-01
component	0..*	MAY		3259-17903	
observation	1..1	SHALL		4427-17904_C01	Performance Rate for Proportion Measure - CMS (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2018-05-01)
component	1..*	SHALL		4427-18425_C01	
observation	1..1	SHALL		4427-18426_C01	Measure Data - CMS (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.16:2019-05-01

1. Conforms to Measure Reference and Results (V3) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.1:2016-09-01)`.
2. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:CMS_54) such that it
   a. **SHALL** contain exactly one [1..1] **`@root`**`="2.16.840.1.113883.10.20.27.3.17"` (CONF:CMS_55).
   b. **SHALL** contain exactly one [1..1] **`@extension`**`="2019-05-01"` (CONF:CMS_56).
3. **MAY** contain zero or more [0..*] **`component`** (CONF:3259-17903) such that it

a. **SHALL** contain exactly one [1..1] **Performance Rate for Proportion Measure - CMS (V3)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2018-05-01) (CONF:4427-17904_C01).

4. **SHALL** contain at least one [1..*] **component** (CONF:4427-18425_C01) such that it
   a. **SHALL** contain exactly one [1..1] **Measure Data - CMS (V4)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.16:2019-05-01) (CONF:4427-18426_C01).

Figure 11: Measure Reference and Results - CMS (V4) Example

```
<organizer classCode="CLUSTER" moodCode="EVN">
    <!-- Measure Reference template ID -->
    <templateId root="2.16.840.1.113883.10.20.24.3.98" />
    <!-- Measure Reference and Results (V3) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.1"
extension="2016-09-01"/>
    <!-- Measure Reference and Results - CMS (V4) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.17"
extension="2019-05-01"/>
    <statusCode code="completed" />
    <reference typeCode="REFR">
        <externalDocument classCode="DOC" moodCode="EVN">
            <!-- This is the version-specific identifier for eCQM -->
            <id root="2.16.840.1.113883.4.738"
                extension="40280382-6963-bf5e-0169-da4fbfb93891"/>
            <code code="57024-2"
                displayName="Health Quality Measure Document"
                codeSystemName="LOINC"
                codeSystem="2.16.840.1.113883.6.1" />
            <!--  This is the title of the eCQM -->
            <text>Breast Cancer Screening</text>
        </externalDocument>
    </reference>
    <component>
        <!-- Measure Data - CMS (V4) -->
        <observation classCode="OBS" moodCode="EVN">
          ...
        </observation>
    </component>
</organizer>
```

5.3.3 Payer Supplemental Data Element - CMS (V3)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.27.3.18:2018-05-01 (open)]

Table 9: Payer Supplemental Data Element – CMS (V3) Contexts

Contained By	Contains
Measure Data - CMS (V4) (required)	Aggregate Count (required)

This observation represents the policy or program providing the coverage for the patients being reported on and provides the number of patients in the population that are covered by that policy or program. When a patient has multiple payers, only count the primary payer (usually this is the first payer listed). For CMS eligible clinicians and eligible professionals programs, all

codes present in the value set must be reported, even if the count is zero. If an eCQM is episode-based, the count will reflect the patient count rather than the episode count.

Individual payer codes from the Public Health Data Standards Consortium Source of Payment Typology (2.16.840.1.113883.3.221.5) have been grouped for QRDA III aggregate reports.

Table 10: Payer Supplemental Data Element - CMS (V3) Constraints Overview

observation[templateId/@root='2.16.840.1.113883.10.20.27.3.18']
[templateId/@extension="2018-05-01"]

XPath	Card	Verb	Data Type	CONF#	Value
templateId	1..1	SHALL		CMS_47	
@root	1..1	SHALL		CMS_48	2.16.840.1.113883.10.20.27.3.18
@extension	1..1	SHALL		CMS_49	2018-05-01
value	1..1	SHALL	CD	CMS_50	
@nullFlavor	1..1	SHALL		CMS_51	OTH
translation	1..1	SHALL		CMS_52	
@code	1..1	SHALL		CMS_53	urn:oid:2.16.840.1.113883.3.249.14.102 (CMS Payer Groupings)

1. Conforms to **`Payer Supplemental Data Element (V2)`** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.9:2016-02-01)`.
2. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:CMS_47) such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**`="2.16.840.1.113883.10.20.27.3.18"` (CONF:CMS_48).
    b. **SHALL** contain exactly one [1..1] **`@extension`**`="2018-05-01"` (CONF:CMS_49).
3. **SHALL** contain exactly one [1..1] **`value`** with @xsi:type="CD" (CONF:CMS_50).
    a. This value **SHALL** contain exactly one [1..1] **`@nullFlavor`**`="OTH"` (CONF:CMS_51).
    b. This value **SHALL** contain exactly one [1..1] **`translation`** (CONF:CMS_52).
        i. This translation **SHALL** contain exactly one [1..1] **`@code`**, which **SHALL** be selected from ValueSet `CMS Payer Groupings urn:oid:2.16.840.1.113883.3.249.14.102` (CONF:CMS_53).

Table 11: CMS Payer Groupings

Value Set: CMS Payer Groupings 2.16.840.1.113883.3.249.14.102

Values specifying the primary payer for CMS QRDA III report submissions that groups codes from the Public Health Data Standards Consortium Source of Payment Typology (2.16.840.1.113883.3.221.5). Codes are grouped as follows:

Payer Grouping A: Medicare (1)

Payer Grouping B: Medicaid (2)

Payer Grouping C: Private Health Insurance (5), Blue Cross/Blue Shield (6)

Payer Grouping D: Other Government (3), Department of Corrections (4), Managed Care Unspecified (7), No Payment Listed (8), Miscellaneous/Other (9)

Code	Code System	Code System OID	Print Name
A	CMS Clinical Codes	2.16.840.1.113883.3.249.12	Medicare
B	CMS Clinical Codes	2.16.840.1.113883.3.249.12	Medicaid
C	CMS Clinical Codes	2.16.840.1.113883.3.249.12	Private Health Insurance
D	CMS Clinical Codes	2.16.840.1.113883.3.249.12	Other

Figure 12: Payer Supplemental Data Element - CMS (V3) Example

```
<observation classCode="OBS" moodCode="EVN">
    <!-- Payer Supplemental Data Element (V2) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.9"
extension="2016-02-01"/>
    <!-- Payer Supplemental Data Element - CMS (V3) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.18"
extension="2018-05-01"/>
    <code code="48768-6" displayName="Payment source"
        codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC"/>
    <statusCode code="completed"/>
    <!-- Parent template requires "SHALL be drawn from
       Value Set: PHDSC Source of Payment Typology
       2.16.840.1.114222.4.11.3591 DYNAMIC"-->
    <!-- CMS Prefers to group the insurances more broadly than the
       Source of Payment Typology allows. Therefore,
       nullFlavor of OTH will be used and CMS local codes used to
       identify groupings-->
    <value xsi:type="CD" nullFlavor="OTH">
        <translation code="A" displayName="Medicare"
         codeSystem="2.16.840.1.113883.3.249.12"
                codeSystemName="CMS Clinical Codes"/>
    </value>
    <entryRelationship typeCode="SUBJ" inversionInd="true">
        <!-- Aggregate Count -->
        <observation classCode="OBS" moodCode="EVN">
        ...
        </observation>
    </entryRelationship>
</observation>
```

5.3.4 Performance Rate for Proportion Measure – CMS (V3)

```
[observation: identifier
urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2018-05-01 (open)]
```

Table 12: Performance Rate for Proportion Measure – CMS (V3) Contexts

Contained By	Contains
Measure Reference and Results - CMS (V4) (optional)	

This template is only used with proportion measures. The performance rate is a ratio of patients that meet the numerator criteria divided by patients in the denominator (after accounting for exclusions and exceptions). Performance Rate is calculated using this formula: Performance Rate = (NUMER – NUMER EXCL) / (DENOM – DENOM EXCL – DENOM EXCEP).

Based on the Performance Rate calculation, a Performance Rate must not exceed 1 (e.g., 100, 1.5), since a value of 1 indicates 100%. The Performance Rate value that is provided in a QRDA Category III file should not be the Performance Rate times 100, but instead should be the value obtained from the calculation of (NUMER – NUMER EXCL)/(DENOM– DENOM EXCL – DENOM EXCEP), rounded to the nearest millionth; refer to the rounding rules listed in this section. In addition, if the expression (DENOM – DENOM EXCL– DENOM EXCEP) results in a null or a value of 0, then a nullFlavor of "NA" should be provided for the Performance Rate. Finally, if the expression (DENOM – DENOM EXCL – DENOM EXCEP) results in a value greater than or equal to 1 and a Numerator count equal to 0 is provided, then a Performance Rate of "0" should be submitted.

The following rounding rules must be used when submitting performance rates:

- For a calculated performance rate that has >= 7 digits after the decimal point, round the decimal number to the millionth.
- For a calculated performance rate that has <= 6 digits after the decimal point, rounding is not permitted for the performance rate.

Table 13: Performance Rate for Proportion Measure - CMS (V3) Constraints Overview

observation[templateId/@root = '2.16.840.1.113883.10.20.27.3.25']
[templateId/@extension="2018-05-01"]

XPath	Card	Verb	Data Type	CONF#	Value
templateId	1..1	SHALL		CMS_59	
@root	1..1	SHALL		CMS_60	2.16.840.1.113883.10.20.27.3.25
@extension	1..1	SHALL		CMS_61	2018-05-01
Value	1..1	SHALL	REAL	3259-21307_C01	
Reference	1..1	SHALL		3259-19651_C01	
@typeCode	1..1	SHALL		3259-19652_C01	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR

XPath	Card	Verb	Data Type	CONF#	Value
externalObservation	1..1	SHALL		3259-19653_C01	
@classCode	1..1	SHALL		3259-19654	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass)
Id	1..1	SHALL		3259-19655	
@root	1..1	SHALL		3259-19656	
Code	1..1	SHALL		3259-19657	
@code	1..1	SHALL		3259-19658	NUMER
@codeSystem	1..1	SHALL		3259-21180	urn:oid:2.16.840.1.113883.5.4 (HL7ActCode) = 2.16.840.1.113883.5.4

1. Conforms to **`Performance Rate for Proportion Measure (V2)`** template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.14:2016-09-01)`.
2. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:CMS_59) such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**`="2.16.840.1.113883.10.20.27.3.25"` (CONF:CMS_60).
    b. **SHALL** contain exactly one [1..1] **`@extension`**`="2018-05-01"` (CONF:CMS_61).
3. **SHALL** contain exactly one [1..1] **`value`** with @xsi:type="REAL" (CONF:3259-21307_C01).
    a. The value, if present, **SHALL** be greater than or equal to 0 and less than or equal to 1 (CONF:CMS_62).
    b. The value, if present, **SHALL** contain no more than 6 digits to the right of the decimal (CONF:CMS_63).

    This is a reference to the specific Numerator included in the calculation.
4. **SHALL** contain exactly one [1..1] **`reference`** (CONF:3259-19651_C01).
    a. This reference **SHALL** contain exactly one [1..1] **`@typeCode`**`="REFR"` refers to (CodeSystem: `HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002`) (CONF:3259-19652_C01).
    b. This reference **SHALL** contain exactly one [1..1] **`externalObservation`** (CONF:3259-19653_C01).
        i. This externalObservation **SHALL** contain exactly one [1..1] **`@classCode`** (CodeSystem: `HL7ActClass urn:oid:2.16.840.1.113883.5.6`) (CONF:3259-19654).
        ii. This externalObservation **SHALL** contain exactly one [1..1] **`id`** (CONF:3259-19655).
            1. This id **SHALL** contain exactly one [1..1] **`@root`** (CONF:3259-19656). Note: This is the ID of the numerator in the referenced eCQM.
        iii. This externalObservation **SHALL** contain exactly one [1..1] **`code`** (CONF:3259-19657).
            1. This code **SHALL** contain exactly one [1..1] **`@code`**`="NUMER"` Numerator (CONF:3259-19658).

2. This code **SHALL** contain exactly one [1..1] **`@codeSystem=`**`"2.16.840.1.113883.5.4"` (CodeSystem: `HL7ActCode urn:oid:2.16.840.1.113883.5.4`) (CONF:3259-21180).

Figure 13: Performance Rate for Proportion Measure - CMS (V3) Example

```
<observation classCode="OBS" moodCode="EVN">
  <!-- Performance Rate -->
  <templateId root="2.16.840.1.113883.10.20.27.3.30" extension="2016-
09-01"/>
  <!-- Performance Rate for Proportion Measure (V2) template ID -->
  <templateId root="2.16.840.1.113883.10.20.27.3.14" extension="2016-
09-01"/>
  <!-- Performance Rate for Proportion Measure – CMS (V3)
       template ID -->
  <templateId root="2.16.840.1.113883.10.20.27.3.25" extension="2018-
05-01"/>
  <code code="72510-1" codeSystem="2.16.840.1.113883.6.1"
        displayName="Performance Rate"
        codeSystemName="2.16.840.1.113883.6.1"/>
  <statusCode code="completed"/>
  <value xsi:type="REAL" value="0.833000"/>
  <!-- This is the reference to the Numerator in the eCQM -->
  <reference typeCode="REFR">
     <externalObservation classCode="OBS" moodCode="EVN">
       <!-- The externalObservationID contains the ID of the
            numerator in the referenced eCQM. -->
       <id root="63DAFD4E-CBD5-4BEE-BE19-E64337356748"/>
       <code code="NUMER" displayName="Numerator"
             codeSystem="2.16.840.1.113883.5.4"
             codeSystemName="ActCode"/>
     </externalObservation>
  </reference>
</observation>
```

6 2021 Performance Period eCQM Specifications for Eligible Professionals and Eligible Clinicians UUID List

The following tables list the Version Specific Measure Identifier for each eCQM included in the 2021 Performance Period eCQM Specifications for Eligible Professionals and Eligible Clinicians, and the population identifiers for all population criteria within each eCQM. If an eCQM specifies Reporting Stratification, identifiers of reporting strata are also listed for that eCQM. **All UUIDs are case insensitive**.

Populations in Table 14 are labeled using the population codes listed below:

- Initial Population: IPOP
- Denominator: DENOM
- Denominator Exclusion: DENEX
- Numerator: NUMER
- Denominator Exception: DENEXCEP
- Stratum: STRAT

(Note: all eCQM specifications contained in the 2021 Performance Period eCQM Specifications for Eligible Professionals and Eligible Clinicians are proportion measures.)

Table 14: UUID List for MIPS CY 2021 Performance Period eCQM Specifications Eligible Professionals and Eligible Clinicians

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
0418e/ 134	CMS2v10	2c928085-7198-38ee-0171-9989a2cf03d2	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	D5104BF0-8328-47AC-862A-379E5A8323FA B172437E-0F4D-40C4-B707-996315432E53 671BD08B-E02D-44F4-85B0-CB776CB0D029 BB36DD9F-8AEC-40B3-B377-192F7CEE77C8 D64A72F7-224F-486A-805C-CBA9BD06354F
N/A/ 317	CMS22v9	2c928085-7198-38ee-0171-996316c403a1	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	1CD3E749-5317-4DCB-AF01-42A208A63873 2F333EF9-774E-4748-B277-2F43957DBE18 E6F8A291-F63A-4567-BBAE-A828761C3474 8A271814-D327-4D9D-A239-CDB5A9A4F423 5E0F3AD0-A2AF-4231-9EB2-D39DF6B6C34E
N/A/ 374	CMS50v9	2c928085-7198-38ee-0171-9983f7b003c1	IPOP: DENOM: NUMER:	84909538-B21D-4FEF-A39A-5B6CD8E5ABF6 E2423A7C-4CDC-4AC3-9A62-C5A42AA6EC90 D88B2BC2-B510-448B-AD39-EC0424E0A5B2
N/A/ 376	CMS56v9	2c928085-7198-38ee-0171-9d3ba3b30572	IPOP: DENOM: DENEX: NUMER:	688AFBFB-1F6B-4C19-8DF5-DEE620488A63 F03E5B4A-29F5-4126-B6D2-149F2301F99B 0D631113-333A-4177-8228-895337056ACD CE0EDD99-1953-4E2D-BD17-53B3125A7220
N/A/ 375	CMS66v9	2c928085-7198-38ee-0171-9d4b226a05d0	IPOP: DENOM: DENEX: NUMER:	07F00615-05B2-4CB4-AD59-EC4800002403 6C43F178-73B0-4492-8F87-05CDE817D19A 0EF25614-4C56-4E77-A2FC-120D57E92D78 BF424716-C760-4911-B3EA-3D359C2B8634
0419e/ 130	CMS68v10	2c928085-7198-38ee-0171-999107e803fd	IPOP: DENOM: NUMER: DENEXCEP:	11F99084-383C-4CDC-8519-56858014D884 07F5DB6C-B8EB-4614-AE90-84B76494A721 EF429DD9-F8C1-48B7-8DFB-BF4B48A17E03 1AD53991-E199-4729-95D7-D2668D25616D

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 128	CMS69v9	2c928085-7198-38ee-0171-9995e1f90412	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	3E32D9BB-3E5D-4D04-A8FE-C3304B782E92 D6590CC1-1156-48B4-8455-5540F23FDDB5 4CA78179-B2BF-41DC-A84F-47CE165F5002 462979D4-8A62-4DAC-9887-3085ED46BD2F 5CFA9CF5-F847-4C43-B828-3EEA31E1B8E8
N/A/ 379	CMS74v10	2c928085-7198-38ee-0171-9d602fc3061a	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2: STRAT 3:	98E4F56E-2A4A-43CF-B89B-E5DC8E9A1348 D630F0DC-A7DD-4DE5-8F8A-43C6C9F0BD6D 2F2944A9-C372-4347-B19C-BD4C3BBC81BB 3920E2F1-A3D1-4C0B-829A-AA5EB1BDD46A F06F7349-B75E-450A-854E-B93A3119A545 BC21022F-7A08-4AA4-A53C-689BA51D1378 51E2DEC7-217A-436E-B27F-BC2DA9384534
N/A/ 378	CMS75v9	2c928085-7198-38ee-0171-9d56875005f8	IPOP: DENOM: DENEX: NUMER:	78E06F92-E035-4AFC-9290-33CD6F0F6E1F 8DFABFF0-A1E4-432F-960B-E3AAB8738F76 4C15ACA6-8FCE-4328-8441-4B1AA7521949 BDEF3B51-CBFD-4425-8772-35B4F5927E4F
N/A/ 377	CMS90v10	2c928085-7198-38ee-0171-9e6fc13d08f2	IPOP: DENOM: DENEX: NUMER:	4BB978B2-C988-444B-A11B-82FF49D2DA33 FB611C04-1B03-44CF-9520-BFD5DDC546E7 0F338C02-C66E-4F3C-AB8B-2C44B9C2392C 5AF174D3-3FCC-4081-8102-01ADDEE7C0AA
N/A/ 240	CMS117v9	2c928085-7198-38ee-0171-9d6e75580676	IPOP: DENOM: DENEX: NUMER:	C250C33A-DB0C-4BCA-B960-1C4233F43F4B 6CC68F62-3E17-4A10-8612-5496F0D42E85 4556ED56-B7FF-47F5-A84E-B3916BA13EB2 74914562-4904-47EB-84D4-72C25964B5B0
N/A/ 001	CMS122v9	2c928085-7198-38ee-0171-9d78a0d406b3	IPOP: DENOM: DENEX: NUMER:	C7396995-408E-4254-BF40-D2CD2A97E858 02793E57-2555-4145-BECF-1BE0F6CAED62 3FAC8D80-C279-47FC-B001-5E41407757AF 44E72F3A-B3EC-42E6-85DB-928A9515255C
N/A/ 309	CMS124v9	2c928085-7198-38ee-0171-9d8c44fe0746	IPOP: DENOM: DENEX: NUMER:	ECFD977D-D1A2-487B-8033-CC9E61B5B5F7 C373C463-77DF-4C19-80E0-2A344BD3FEA2 1F694042-1951-404A-B0CB-92527C9505CB 7502090C-3073-419F-8A76-63CEF417107B
N/A/ 112	CMS125v9	2c928085-7198-38ee-0171-9d6793ec0657	IPOP: DENOM: DENEX: NUMER:	186D78A2-9734-4860-B0CE-D804A3652EA6 292B7874-95B8-4576-8E85-CEFB1AFD27ED 9BBBA758-2D9F-41A6-9C11-1088B674BD2E A5F303A3-11CF-4BB2-8D2E-6AE0C857D9B5
N/A/ 111	CMS127v9	2c928085-7198-38ee-0171-9d81c756070c	IPOP: DENOM: DENEX: NUMER:	D6BF1254-F95E-4017-A040-36C784B48A67 8B7E7DFF-9391-45E8-A9A9-FCFEFEFFE317 C77A1344-549C-47AD-B3AF-8F622B074681 A62E019A-F0FA-4799-9BC8-EA0C4889EA19
N/A/ 009	CMS128v9	2c928085-7198-38ee-0171-9d7f304f06ee	IPOP 1: DENOM 1: DENEX 1: NUMER 1: IPOP 2: DENOM 2: DENEX 2: NUMER 2:	57D85599-15C7-41DB-AA2B-A822DFA3D590 F8DA7718-407C-4506-A0AC-EAA244583AA3 11AB50E5-468A-47EA-87F6-7365A68A2695 73BEC504-0B7D-4EA1-BD42-F1F29BFBBE36 867C82CD-4C9C-4366-87C6-2295EF09B1AB 77F157BE-AF09-478E-ADEB-9F66CE228BC5 56391018-F5C8-4D4C-886C-71C36085610C F3B54143-CDFC-4563-B4CA-19169A12252D
0389e/ 102	CMS129v10	2c928085-7198-38ee-0171-988ab12a00b7	IPOP: DENOM: NUMER: DENEXCEP:	6F2742B3-89C2-44DB-B884-870352B6F2D9 7601AA43-5078-49B6-85DD-843B9178AD5E FB1A1EE4-76C0-4272-8DD5-CCC275559E92 BF332E8F-BD5F-464E-A9BF-0C92A058D19E

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 113	CMS130v9	2c928085-7198-38ee-0171-9d6e026b066b	IPOP: DENOM: DENEX: NUMER:	0C34F7DA-92D7-4B44-9A24-E4950853A642 7D6E33BB-31BA-42A9-9447-73A6B47F07D5 81F6DC72-FA7A-433E-9DFA-A889343F6008 97995C43-D36C-417F-A1A6-7C379A7F46FF
N/A/ 117	CMS131v9	2c928085-7198-38ee-0171-9d72a6ec0692	IPOP: DENOM: DENEX: NUMER:	C7C7715D-9DB2-4DF9-8952-3B072EF2C206 6A4825B1-B1B7-45E4-A2BC-DF633F7C9715 B39B756C-553A-479B-9808-3032D99E439B E06A8B68-12F2-4936-A08F-44F4B01833CD
0565e/ 191	CMS133v9	2c928085-7198-38ee-0171-999d514f043e	IPOP: DENOM: DENEX: NUMER:	9D0D39BC-532D-4190-8280-038AC505A33F 0B734BD9-2577-4DB7-9906-282DB6344FA9 187261B4-967A-4BD5-BA4D-8276EACDD384 DA0E1ADA-4EF4-42E7-B8C3-5AD1DF7A6942
N/A/ 119	CMS134v9	2c928085-7198-38ee-0171-9d7c32a106d4	IPOP: DENOM: DENEX: NUMER:	403CB3B1-EDC5-42E7-8F49-DE5482F96927 3258CBA9-311E-4B3A-8B3D-52A117228645 15A00AAE-9BC4-4E30-BBA2-946DFB15CD53 DB24F137-A9DC-4F40-BD7A-913FB0331EAC
0081e/ 005	CMS135v9	2c928085-7198-38ee-0171-9895226d00fe	IPOP 1: DENOM 1: NUMER 1: DENEXCEP 1: IPOP 2: DENOM 2: NUMER 2: DENEXCEP 2:	590BCACE-13CA-4CF8-BDDE-007A35D05A2B A56A5A7F-B981-48CC-BFBD-2EB27A294DAD D2BE9791-4C01-4403-99EE-6D2B3B1C27F9 BFED94C0-70A0-4ECC-8E7E-89996A29AAE7 97DD6D6F-CE23-4C4A-8AC4-D1479BAE2565 D0466F55-B262-4060-94FF-14ED1E8D7267 F1DE987F-3149-4920-B146-E318F7069715 AF7AF77C-15CB-496A-BC4E-7F41AF50CC5D
N/A/ 366	CMS136v10	2c928085-7198-38ee-0171-9dab7a4b07c4	IPOP 1: DENOM 1: DENEX 1: NUMER 1: IPOP 2: DENOM 2: DENEX 2: NUMER 2:	258C7C5D-33A9-4344-8D26-D35CE7FD11FF 2D031600-3FF7-43FB-8D07-56D05DFB1092 EF583993-6453-4B51-97B3-84FAF366B3F6 91F1B47D-8357-4D1F-982C-F1CA45EA80B2 6FFE774B-CFA8-481E-B201-1CFC738E4685 0F80BF70-B407-4E09-9803-3AAB15CA9E14 7705EDA2-8A0B-4E3F-A83B-483B5F9BD87A A823E7C1-8B1E-4A75-AFF2-BF4946F8980D
N/A/ 305	CMS137v9	2c928085-7198-38ee-0171-9d81b6570705	IPOP 1: DENOM 1: DENEX 1: NUMER 1: STRAT 1-1: STRAT 2-1: IPOP 2: DENOM 2: DENEX 2: NUMER 2: STRAT 2-1: STRAT 2-2:	0D7EB2C8-A8C7-406E-9F6F-961C85CB5791 3A93FF10-3E3A-47E4-9D97-EFB6B6241BE1 00DAA49B-10E5-4E02-A9B9-20911A88C14A F2EC55BA-4652-4705-84DC-6AC184A5C4C1 C447FBC7-B826-4CE1-A23C-4932EAE2A587 B9348806-52DD-415D-9496-EA21566DFD21 13982B0A-1AE1-48AD-A1C7-6A7CA3A8ECD6 9092B765-3F9C-4067-9695-673B7A0AA818 36BE31B3-B355-42DA-ACC9-75EFF0A0F553 6B89D395-0750-4DB2-BAAF-6ADBBE802592 598BEF83-C10C-4A99-95F1-85B66842C4BC 06E5DF8B-6BAD-4F9C-9F6D-A653F4B0208A

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0028e/ 226	CMS138v9	2c928085-7198-38ee-0171-99aa63300462	IPOP 1: DENOM 1: NUMER 1: DENEXCEP 1: IPOP 2: DENOM 2: NUMER 2: DENEXCEP 2: IPOP 3: DENOM 3: NUMER 3: DENEXCEP 3:	FF12FAC1-3D9A-4174-9C05-B313984408DB 69248984-A61F-4E87-B75B-73EA2EFCE11F 370D70D8-5872-4742-BE13-F17720FD33B1 7D72D403-963E-44DF-8F18-F95A90418C66 AFFE52DA-9272-4F23-9761-45E35ACE8FD0 D61839FF-8407-4EAD-8D2B-B6C68FDB5D60 38833BA5-0B98-45C5-9FA3-B01481B5BC53 ECC8E00F-60E8-4D0A-81B5-B4AFF39026F9 B986CD1C-A155-48EC-BE5A-3F5508491265 87010EBD-E324-477C-BDF1-D8690B282D6A 0ED2B666-DBBE-4BF3-A886-A4FF54774382 F5AD9DAC-1160-4DFF-BD03-DCE12AB12696
N/A/ 318	CMS139v9	2c928085-7198-38ee-0171-9d9aa4f50774	IPOP: DENOM: DENEX: NUMER:	C47726CD-2A7B-4B6C-802E-7E8301E36027 72599758-6E09-4680-AB93-F433DB231544 14F60175-B484-460C-86EE-7B14CC87F0C7 5729CEBB-00AD-4D45-9529-435743474321
N/A/ 019	CMS142v9	2c928085-7198-38ee-0171-99a391370450	IPOP: DENOM: NUMER: DENEXCEP:	D005FECC-3926-49E8-9D49-50DF068523C7 43257C96-8E3F-4B4B-9267-7548AC7A0739 35E27C5F-1848-43A0-966B-3CED3639B936 6BCF0B1A-9558-45DF-A5A7-90279E6A9B49
0086e/ 012	CMS143v9	2c928085-7198-38ee-0171-9999e27a042b	IPOP: DENOM: NUMER: DENEXCEP:	A985907B-E233-49E6-B3B3-9DAECFA00563 0FBAF9DC-C698-42B6-B03C-5AAAF94F2C44 41AE9BE4-61C3-4548-8FDE-9FDEB00B3808 358A7208-4389-4B7C-AE2A-0AFDE1AB8F25
0083e/ 008	CMS144v9	2c928085-7198-38ee-0171-98972d42011e	IPOP 1: DENOM 1: NUMER 1: DENEXCEP 1: IPOP 2: DENOM 2: NUMER 2: DENEXCEP 2:	065E56F2-BC96-4306-9CB3-8D5E727A8EC9 04025C9A-D1F0-44D0-8214-D8E9E592BD89 AAB85AF3-3582-4C34-9C36-4339A2DE059C 092B3C50-14DA-48DC-985C-A73DA2693793 78DA301F-CCF0-452B-BE03-497F9DAC5E7E 307ACFDF-3ED9-4164-A9DD-2CCC3B84A7A3 59CA6C03-0C8B-45B7-8E4F-E3BBFD89296F 6CED6D74-B23A-4DA1-8677-8C00DD9EE901
0070e/ 007	CMS145v9	2c928085-7198-38ee-0171-98988f540135	IPOP 1: DENOM 1: NUMER 1: DENEXCEP 1: IPOP 2: DENOM 2: NUMER 2: DENEXCEP 2:	C8AFA985-2388-41DF-8AE2-05C4BE4E77C9 13FB25BF-DD03-48D3-8088-03E203EFA540 D457813A-E76D-4BF8-B653-84B73B355847 85E384BB-2C9E-4BEF-B14F-72F3A0C97997 32D51C08-635E-4CA7-A4C7-960B023BB9AD 27B59C9C-3B15-4D7C-AFBB-D5CCAA642C19 60310BDB-A417-49A0-A055-7E5C1C273C01 ED454452-BE62-4C4E-A45A-1BF4F79E3933
N/A/ 066	CMS146v9	2c928085-7198-38ee-0171-9e37b26f089a	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2: STRAT 3:	048A9A82-63D7-45F5-848F-947BFDCA37F1 F271D59F-B538-4868-965A-AC9F3D8CC212 38C9F894-9D3A-4122-B159-B5BE7E88CDBC 0AAE606F-A1AD-4B8E-B999-4F55C5BB313F 0111CBFC-16DF-44A9-B960-837518049C2B B95BDC0E-19BB-4661-8857-F48AE5CC045F F809D8EC-A125-45A7-A336-1D7A46C4FA17
0041e/ 110	CMS147v10	2c928085-7198-38ee-0171-98a8ea4d0169	IPOP: DENOM: NUMER: DENEXCEP:	EC467309-99B3-4EF7-936E-F8BBBA8A2D84 1129DA7B-0B9E-4E5F-86CB-43598130E3BE 2B655B5D-1751-4F2C-88B6-7546F5F3FEE1 615E9A89-AAF3-4302-8602-FFB7CDEB05BA

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2872e/ 281	CMS149v9	2c928085-7198-38ee-0171-98a9d3bf017a	IPOP: DENOM: NUMER: DENEXCEP:	FA642DFE-1C0D-4724-9538-B0F199C9CEFD 115AD8E4-8FC1-484C-8F7A-426DEEFD989F 6621BE4E-4E50-46A6-8952-E9AE5B45540B C4504094-168D-437D-B8AB-7C28DC3D1FB7
N/A/ 310	CMS153v9	2c928085-7198-38ee-0171-9d4e202e05e3	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2:	3ECA314C-7C3B-4A78-8B1C-736D90B1066F E1043B38-DB72-4D88-931E-F80450F8AA58 5FE92D37-26D2-4F15-AD37-B0A084FC4DF4 DAC328D0-B833-435E-ACA7-9A57FE8F62B7 A4B4EAB9-C09A-4D3C-ACD1-7C1B778F3C54 3C09C16C-1CEF-4E9A-8311-BA78FE66734E
N/A/ 065	CMS154v9	2c928085-7198-38ee-0171-9d9305330758	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2: STRAT 3:	D4AD84B2-546B-46FB-A588-9216E6CAC5B6 71DACCC3-6D55-454C-93D7-C8C4B9781CBE 1B14341C-12AE-4B05-93D3-BB7882951128 6BC0B7BE-8692-477C-B423-3858B7ECF706 EA32A714-3087-469C-B034-64883750692D 35CE0304-E632-4165-B2B5-E6DAF916F155 3F38BFB5-D0D3-4132-B7E4-51E4DC3B7143
N/A/ 239	CMS155v9	2c928085-7198-38ee-0171-9da0c2cd078a	IPOP 1: DENOM 1: DENEX 1: NUMER 1: STRAT 1-1: STRAT 1-2: IPOP 2: DENOM 2: DENEX 2: NUMER 2: STRAT 2-1: STRAT 2-2: IPOP 3: DENOM 3: DENEX 3: NUMER 3: STRAT 3-1: STRAT 3-2:	9E3EA1A3-A9F6-4201-AB27-730159AE3933 3B78FA52-5E6A-4303-B0C8-814C0193AC2B 3C70608B-18FE-4B72-A6D7-91D943E911D6 D1C92A35-8591-4EC4-8E9B-2EBD1EA18351 448FCA10-812D-4903-B543-E6E8E7FBEF76 8B3991A7-E8D9-4AC2-826A-85509403162B 6C91B9DD-6F96-4BC0-84CB-846DD842C622 7C12DAFF-C8D9-4F30-BBE7-189DB25E2E23 C42B42A0-17E2-4A37-993B-C917C9175FC5 B421B619-B8DE-4C8E-A1ED-325ECBF84958 27547B31-B1C5-44A7-B29E-90076761C77A 7146FA26-F771-48ED-A079-99B5E7F868F2 FE1D7F2D-742F-473E-A27B-F032E73B8CC4 7991ABCD-4420-43BB-924F-EE83042CB3B9 6783A696-C02C-40FE-BFDB-94E9EBB03B3D 4C2B1545-7C5F-4D4A-B95E-A79BBA28BAC7 CE10198E-5303-4EE8-A924-0078CB258C1E 8FD1AEF2-5112-47CC-A854-5194000091EB
N/A/ 238	CMS156v9	2c928085-7198-38ee-0171-9d752d1a069e	IPOP: DENOM: DENEX: NUMER:	3E177A28-30DE-4381-8C7A-B42CD914DA33 E7E1C3BB-730F-4020-9BF3-3AA508B914FC 827502FD-FF19-45FB-974B-B7F32B281873 14F9E2DB-C09F-4E06-AFBD-C1E5E178D920
0384e/ 143	CMS157v9	2c928085-7198-38ee-0171-988d211d00d6	IPOP: DENOM: NUMER: IPOP 2: DENOM 2: NUMER 2:	9EC8C903-6703-4894-A50C-B527280BF031 B9762119-E99D-4CA7-AFD2-E04E5C6DA5EC 2989C5F0-2301-4E9E-A6CB-258076E08E8D 00CD5E45-80B5-466B-B966-DB544C983968 9E0BE4F2-1A3E-4AC2-8FDD-964499040B3A 500BBB7E-6FA3-4CAB-BBC3-A95F3BCF98AE
0710e/ 370	CMS159v9	2c928085-7198-38ee-0171-9e951ae1097e	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2:	BBB0D5FB-58B3-4F52-B34B-FE1FA70FA37A ABA073DB-F22A-40DF-85BA-D4C817E9DA42 51BDFCA5-362F-429A-A776-5FC9A2E0EFC1 779282B6-7FFE-4261-A979-833C6D7E9BD5 0D2DD3A1-9851-4557-8509-73C67315A7FF 8CA59F72-62BE-4478-83FB-C304A6E5B65A
0104e/ 107	CMS161v9	2c928085-7198-38ee-0171-98ab3dc7018b	IPOP: DENOM: NUMER:	6AE028E4-F2AB-4021-AE51-8307D0A223D7 A197002D-CC8C-4BC2-8ACF-EEE54FD356BF 84D60531-27E4-4ED4-A68E-27C5BD90F210

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 236	CMS165v9	2c928085-7198-38ee-0171-9da6456007ab	IPOP: DENOM: DENEX: NUMER:	87338BA5-170B-4264-9E59-6A4A3A57C785 B2E2AA67-26CD-48CB-9536-094F1D047149 9B6EDB4C-A390-4833-A135-2A2AC6334126 63DAFD4E-CBD5-4BEE-BE19-E64337356748
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N/A/ 438	CMS347v4	2c928085-7198-38ee-0171-989a534a0146	IPOP 1: DENOM 1: DENEX 1: NUMER 1: DENEXCEP 1: IPOP 2: DENOM 2: DENEX 2: NUMER 2: DENEXCEP 2: IPOP 3: DENOM 3: DENEX 3: NUMER 3: DENEXCEP 3:	C32CF047-AD16-4D19-A86B-C598FAFA5D2F C0FE1159-81F5-449B-83EB-3395FC3A3210 17D080CB-6211-4E3E-AD9A-DFA623DD6F42 15EFD92A-56D4-45C6-B39F-89570858B544 95596CBC-9665-4BA2-BB88-4768D9576F7C 164ECE60-97E5-4F72-8FE1-D1C62E04D174 DA3E9773-E6F9-415E-B6DF-9DFDAB829D91 01B500BB-4556-4CF4-9676-28FA2392147C BABDCD3E-75C1-40A5-8527-C9EBDDBB5E55 84CD03D9-6BAA-4C56-9205-2F5A22CBDEE6 44D2CD88-3F1C-4908-AFA7-5EB3D2B46F79 1A916B14-DA81-4CBD-AA50-78CBFDEC7BD4 0EAEA873-BD9C-4CF8-9989-BB138F2BDFE5 EA99DDF7-D7D0-4B83-BA2C-9DA99548055C 120861DA-61F1-48CC-BA99-27EE9073D896
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7 Measure Identifiers

For all CMS eligible clinicians and eligible professionals programs reporting, certain identifiers are **mandatory**, meaning that they must be present in the QRDA III report and no nulls are allowed. Exceptions and considerations are noted where applicable. Each improvement activity included in the QRDA III report must reference its Activity ID. Each Promoting Interoperability Objective and Measure included in the QRDA III report must reference its Measure Identifier.

Table 15: Improvement Activities Identifiers for the MIPS CY 2021 Performance Period

Activity Name	Activity Description	Activity ID
Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	IA_EPA_1
Use of telehealth services that expand practice access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	IA_EPA_2
Collection and use of patient experience and satisfaction data on access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	IA_EPA_3
Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).	IA_EPA_4
Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.	IA_EPA_5

Activity Name	Activity Description	Activity ID
Anticoagulant Management Improvements	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program.	IA_PM_2
RHC, IHS or FQHC quality improvement activities	Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.	IA_PM_3
Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	IA_PM_4

Activity Name	Activity Description	Activity ID
Engagement of community for health status improvement	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	IA_PM_5
Use of toolsets or other resources to close healthcare disparities across communities	Take steps to improve healthcare disparities, such as Population Health Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	IA_PM_6
Use of QCDR for feedback reports that incorporate population health	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	IA_PM_7
Regular Review Practices in Place on Targeted Patient Population Needs	Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews, which includes access to reports that show unique characteristics of eligible clinician's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.	IA_PM_11
Population empanelment	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the “active population” of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define “active patients” operationally, but generally, the definition of “active patients” includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.	IA_PM_12

Activity Name	Activity Description	Activity ID
Chronic Care and Preventative Care Management for Empaneled Patients	In order to receive credit for this activity, a MIPS eligible clinician must manage chronic and preventive care for empaneled patients (that is, patients assigned to care teams for the purpose of population health management), which could include one or more of the following actions: • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; and plan of care for chronic conditions; • Use evidence based, condition-specific pathways for care of chronic conditions (for example, hypertension, diabetes, depression, asthma, and heart failure). These might include, but are not limited to, the NCQA Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP); • Use pre-visit planning, that is, preparations for conversations or actions to propose with patient before an in-office visit to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools, (that is, registry functionality) or other technology that can use clinical data to identify trends or data points in patient records to identify services due; • Use predictive analytical models to predict risk, onset and progression of chronic diseases; and/or • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals, and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.	IA_PM_13
Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	IA_PM_14
Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or • Managing care intensively through new diagnoses, injuries and exacerbations of illness.	IA_PM_15
Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews.	IA_PM_16
Participation in Population Health Research	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	IA_PM_17

Activity Name	Activity Description	Activity ID
Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.	IA_PM_18
Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.	IA_PM_19
Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	IA_PM_20
Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.	IA_PM_21
Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.	IA_CC_1
Implementation of improvements that contribute to more timely communication of test results	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	IA_CC_2
Regular training in care coordination	Implementation of regular care coordination training.	IA_CC_7
Implementation of documentation improvements for practice/process improvements	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	IA_CC_8
Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	IA_CC_9

Activity Name	Activity Description	Activity ID
Care transition documentation practice improvements	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.	IA_CC_10
Care transition standard operational improvements	Establish standard operations to manage transitions of care that could include one or more of the following: • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or • Partner with community or hospital-based transitional care services.	IA_CC_11
Care coordination agreements that promote improvements in patient tracking across settings	Establish effective care coordination and active referral management that could include one or more of the following: • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.	IA_CC_12
Practice Improvements for Bilateral Exchange of Patient Information	Ensure that there is bilateral exchange of necessary patient information to guide patient care, such as Open Notes, that could include one or more of the following: • Participate in a Health Information Exchange if available; and/or • Use structured referral notes.	IA_CC_13
Practice Improvements that Engage Community Resources to Support Patient Health Goals	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and provide a guide to available community resources. • Including through the use of tools that facilitate electronic communication between settings; • Screen patients for health-harming legal needs; • Screen and assess patients for social needs using tools that are preferably health IT enabled and that include to any extent standards-based, coded question/field for the capture of data as is feasible and available as part of such tool; and/or • Provide a guide to available community resources.	IA_CC_14
PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities:	IA_CC_15

Activity Name	Activity Description	Activity ID
	• Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.	
Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	IA_CC_16
Patient Navigator Program	Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.	IA_CC_17
Relationship-Centered Communication	In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans, monitor progress, and promote stability around improved clinician communication.	IA_CC_18
Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.	IA_CC_19
Use of certified EHR to capture patient reported outcomes	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of certified EHR technology, containing this data in a separate queue for clinician recognition and review.	IA_BE_1
Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	IA_BE_3
Engagement of patients through implementation of improvements in patient portal	To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative. Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with	IA_BE_4

Activity Name	Activity Description	Activity ID
	hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.	
Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities	Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTechGenInfo/07_Section508.asp that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.	IA_BE_5
Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	IA_BE_6
Participation in a QCDR, that promotes use of patient engagement tools.	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	IA_BE_7
Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	IA_BE_8
Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	IA_BE_12
Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	IA_BE_13

Activity Name	Activity Description	Activity ID
Engage Patients and Families to Guide Improvement in the System of Care	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.	IA_BE_14
Engagement of Patients, Family, and Caregivers in Developing a Plan of Care	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.	IA_BE_15
Evidenced-based techniques to promote self-management into usual care	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or motivational interviewing.	IA_BE_16
Use of tools to assist patient self-management	Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).	IA_BE_17
Provide peer-led support for self-management.	Provide peer-led support for self-management.	IA_BE_18
Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	IA_BE_19
Implementation of condition-specific chronic disease self-management support programs	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	IA_BE_20
Improved Practices that Disseminate Appropriate Self-Management Materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.	IA_BE_21
Improved Practices that Engage Patients Pre-Visit	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.	IA_BE_22

Activity Name	Activity Description	Activity ID
Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	IA_BE_23
Financial Navigation Program	In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient- centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.	IA_BE_24
Drug Cost Transparency	To receive credit for this improvement activity, MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary. (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).)	IA_BE_25
Participation in an AHRQ-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	IA_PSPA_1
Participation in MOC Part IV	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.	IA_PSPA_2
Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or Other Similar Activity	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.	IA_PSPA_3

Activity Name	Activity Description	Activity ID
Administration of the AHRQ Survey of Patient Safety Culture	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html). Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	IA_PSPA_4
Consultation of the Prescription Drug Monitoring Program	Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the transition year, clinicians would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.	IA_PSPA_6
Use of QCDR data for ongoing practice assessment and improvements	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.	IA_PSPA_7
Use of Patient Safety Tools	In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice. Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.	IA_PSPA_8
Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	IA_PSPA_9
Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments	Completion of training and obtaining an approved waiver for provision of medication -assisted treatment of opioid use disorders using buprenorphine.	IA_PSPA_10
Participation in CAHPS or other supplemental questionnaire	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	IA_PSPA_11

Activity Name	Activity Description	Activity ID
Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	IA_PSPA_12
Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative.	IA_PSPA_13
Implementation of an ASP	Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with facility or clinic compliance policies and hospital medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions. • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections. • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance.	IA_PSPA_15
Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	IA_PSPA_16
Implementation of analytic capabilities to manage total cost of care for practice population	In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include: 1.) Train appropriate staff on interpretation of cost and utilization information; 2.) Use available data regularly to analyze opportunities to reduce cost through improved care. An example of a platform with the necessary analytic capability to do this is the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform.	IA_PSPA_17

Activity Name	Activity Description	Activity ID
Measurement and Improvement at the Practice and Panel Level	Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	IA_PSPA_18
Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • Participation in multisource feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data; • Participation in Bridges to Excellence; • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	IA_PSPA_19
Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes	Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: • Make responsibility for guidance of practice change a component of clinical and administrative leadership roles; • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or • Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	IA_PSPA_20
Implementation of fall screening and assessment programs	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	IA_PSPA_21
CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	IA_PSPA_22
Completion of CDC Training on Antibiotic Stewardship	Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	IA_PSPA_23

Activity Name	Activity Description	Activity ID
Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	IA_PSPA_25
Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.	IA_PSPA_26
Invasive Procedure or Surgery Anticoagulation Medication Management	For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.	IA_PSPA_27
Completion of an Accredited Safety or Quality Improvement Program	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. • An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).	IA_PSPA_28
Consulting AUC Using Clinical Decision Support when Ordering Advanced	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.	IA_PSPA_29

Activity Name	Activity Description	Activity ID
PCI Bleeding Campaign	Participation in the PCI Bleeding Campaign which is a national quality improvement program that provides infrastructure for a learning network and offers evidence-based resources and tools to reduce avoidable bleeding associated with patients who receive a percutaneous coronary intervention (PCI). The program uses a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for PCI patients by implementing quality improvement strategies: • Radial-artery access, • Bivalirudin, and • Use of vascular closure devices.	IA_PSPA_30
Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75% of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co- prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	IA_PSPA_31
Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.	IA_PSPA_32
Engagement of New Medicaid Patients and Follow-up	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.	IA_AHE_1
Promote Use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PHQ-2 or PHQ-9, PROMIS instruments, patient reported Wound-Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	IA_AHE_3
MIPS Eligible Clinician Leadership in Clinical Trials or CBPR	MIPS eligible clinician leadership in clinical trials, research alliances or community-based participatory research (CBPR) that identify tools, research or processes that can focuses on minimizing disparities in healthcare access, care quality, affordability, or outcomes.	IA_AHE_5
Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.	IA_AHE_6

Activity Name	Activity Description	Activity ID
Comprehensive Eye Exams	To receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following: • providing literature, • facilitating a conversation about this topic using resources such as the "Think About Your Eyes" campaign, • referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology's EyeCare America and the American Optometric Association's VISION USA, or • promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment. This activity is intended for: • Non-ophthalmologists / optometrists who refer patients to an ophthalmologist/optometrist; • Ophthalmologists/optometrists caring for underserved patients at no cost; or • Any clinician providing literature and/or resources on this topic. This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.	IA_AHE_7
Participation on Disaster Medical Assistance Team, registered for 6 months.	Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response.	IA_ERP_1
Participation in a 60-day or greater effort to support domestic or international humanitarian needs.	Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	IA_ERP_2

Activity Name	Activity Description	Activity ID
COVID-19 Clinical Data Reporting with or without Clinical Trial	To receive credit for this improvement activity, a MIPS eligible clinician or group must: (1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or (2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Data would be submitted to the extent permitted by applicable privacy and security laws. Examples of COVID-19 clinical trials may be found on the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19. In addition, examples of COVID-19 clinical data registries may be found on the National Institute of Health website at https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=COVID19+registries&commit=Search. For purposes of this improvement activity, clinical data registries must meet the following requirements: (1) the receiving entity must declare that they are ready to accept data as a clinical registry; and (2) be using the data to improve population health outcomes. Most public health agencies and clinical data registries declare readiness to accept data from clinicians via a public online posting. Clinical data registries should make publically available specific information on what data the registry gathers, technical requirements or specifications for how the registry can receive the data, and how the registry may use, re-use, or disclose individually identifiable data it receives. For purposes of credit toward this improvement activity, any data should be sent to the clinical data registry in a structured format, which the registry is capable of receiving. A MIPS-eligible clinician may submit the data using any standard or format that is supported by the clinician's health IT systems, including but not limited to, certified functions within those systems. Such methods may include, but are not limited to, a secure upload function on a web portal, or submission via an intermediary, such as a health information exchange. To ensure interoperability and versatility of the data submitted, any electronic data should be submitted to the clinical data registry using appropriate vocabulary standards for the specific data elements, such as those identified in the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR 170.213.	IA_ERP_3
Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	IA_BMH_1
Tobacco use	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	IA_BMH_2
Depression screening	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions.	IA_BMH_4
MDD prevention and treatment interventions	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	IA_BMH_5
Implementation of co-location PCP and MH services	Integration facilitation and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	IA_BMH_6

Activity Name	Activity Description	Activity ID
Implementation of Integrated Patient Centered Behavioral Health Model	Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions such as dementia or other poorly controlled chronic illnesses. The services could include one or more of the following: • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between MIPS eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; • Use of a registry or health information technology functionality to support active care management and outreach to patients in treatment; • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible; and/or • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised surveyor guidance.	IA_BMH_7
Electronic Health Record Enhancements for BH data capture	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	IA_BMH_8
Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.	IA_BMH_9
Completion of Collaborative Care Management Training Program	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative care management training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public, in order to implement a collaborative care management approach that provides comprehensive training in the integration of behavioral health into the primary care practice.	IA_BMH_10
Electronic submission of Patient Centered Medical Home accreditation	N/A	IA_PCMH

Table 16: Promoting Interoperability Objectives and Measures Identifiers for the MIPS CY 2021 Performance Period

Objective	Measure Identifier	Measure	Reporting Metric
e-Prescribing	PI_EP_1	e-Prescribing	proportion
	PI_LVPP_1	*e-Prescribing Exclusion	boolean
	PI_EP_2	Query of the Prescription Drug Monitoring Program (PDMP)	boolean
Health Information Exchange	PI_HIE_1	Support Electronic Referral Loops By Sending Health Information	proportion

Objective	Measure Identifier	Measure	Reporting Metric
	PI_LVOTC_1	*Support Electronic Referral Loops By Sending Health Information Exclusion	boolean
	PI_HIE_4	Support Electronic Referral Loops By Receiving and Reconciling Health Information	proportion
	PI_LVITC_2	*Support Electronic Referral Loops By Receiving and Incorporating Health Information Exclusion	boolean
	PI_HIE_5	Health Information Exchange (HIE) Bi-Directional Exchange	boolean
Provider to Patient Exchange	PI_PEA_1	Provide Patients Electronic Access to Their Health Information	proportion
Public Health and Clinical Data Exchange	PI_PHCDRR_1	Immunization Registry Reporting	boolean
	PI_PHCDRR_1_MULTI	Immunization Registry Reporting for Multiple Registry Engagement	boolean
	PI_PHCDRR_1_EX_1	*Immunization Registry Reporting Exclusion	boolean
	PI_PHCDRR_1_EX_2	*Immunization Registry Reporting Exclusion	boolean
	PI_PHCDRR_1_EX_3	*Immunization Registry Reporting Exclusion	boolean
	PI_PHCDRR_2	Syndromic Surveillance Reporting	boolean
	PI_PHCDRR_2_MULTI	Syndromic Surveillance Reporting for Multiple Registry Engagement	boolean
	PI_PHCDRR_2_EX_1	*Syndromic Surveillance Reporting Exclusion	boolean
	PI_PHCDRR_2_EX_2	*Syndromic Surveillance Reporting Exclusion	boolean
	PI_PHCDRR_2_EX_3	*Syndromic Surveillance Reporting Exclusion	boolean
	PI_PHCDRR_3	Electronic Case Reporting	boolean
	PI_PHCDRR_3_MULTI	Electronic Case Reporting for Multiple Registry Engagement	boolean
	PI_PHCDRR_3_EX_1	*Electronic Case Reporting Exclusion	boolean
	PI_PHCDRR_3_EX_2	*Electronic Case Reporting Exclusion	boolean
	PI_PHCDRR_3_EX_3	*Electronic Case Reporting Exclusion	boolean
	PI_PHCDRR_4	Public Health Registry Reporting	boolean
	PI_PHCDRR_4_MULTI	Public Health Registry Reporting for Multiple Registry Engagement	boolean
	PI_PHCDRR_4_EX_1	*Public Health Registry Reporting Exclusion	boolean
	PI_PHCDRR_4_EX_2	*Public Health Registry Reporting Exclusion	boolean

Objective	Measure Identifier	Measure	Reporting Metric
Public Health and Clinical Data Exchange	PI_PHCDRR_4_EX_3	*Public Health Registry Reporting Exclusion	boolean
	PI_PHCDRR_5	Clinical Data Registry Reporting	boolean
	PI_PHCDRR_5_MULTI	Clinical Data Registry Reporting for Multiple Registry Engagement	boolean
	PI_PHCDRR_5_EX_1	*Clinical Data Registry Reporting Exclusion	boolean
	PI_PHCDRR_5_EX_2	*Clinical Data Registry Reporting Exclusion	boolean
	PI_PHCDRR_5_EX_3	*Clinical Data Registry Reporting Exclusion	boolean

* Indicates a Measure Exclusion.

Table 17: Promoting Interoperability Attestation Statements Identifiers

Identifier	Attestation Statement	Reporting Metric
PI_INFBLO_1	Prevention of Information Blocking Attestation (Required)	boolean
PI_ONCDIR_1	ONC Direct Review Attestation (Required)	boolean
PI_ONCACB_1	ONC-ACB Surveillance Attestation (Optional)	boolean
PI_PPHI_1	Security Risk Analysis (Required)	boolean

APPENDIX

8 Troubleshooting and Support

8.1 Resources

The following provide additional information:

Comprehensive Primary Care Plus (CPC+):
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
eCQI Resource Center is the one-stop shop for the most current resources to support electronic clinical quality improvement: https://ecqi.healthit.gov/
eCQM Library contains resources for eCQMs including Measure Logic Guidance: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html
Electronic Clinical Quality Measure specification feedback system is a tool offered by CMS and the Office of the National Coordinator (ONC) for Health Information Technology for implementers to submit issues and request guidance on eCQM logic, specifications, and certification: https://oncprojectracking.healthit.gov/
National Library of Medicine (NLM) Value Set Authority Center (VSAC) contains the official versions of the value sets used for eCQMs: https://vsac.nlm.nih.gov/
Primary Care First (PCF): https://innovation.cms.gov/innovation-models/primary-care-first-model-options
Quality Payment Program: https://qpp.cms.gov

8.2 Support

Table 18: Support Contact Information

Contact	Organization	Phone	Email
QPP Service Center	CMS	1-866-288-8292 TTY: 1-877-715-6222	QPP@cms.hhs.gov
CPC+	CMS	1-888-372-3280	CPCPlus@telligen.com
PCF	CMS	1-888-517-7753	PCF@telligen.com

8.3 Errata or Enhancement Requests

Table 19: Errata or Enhancement Request Location

Contact	Organization	URL	Purpose
HL7 QRDA III, STU Release 2.1 Comments page	HL7	http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=197	Document errors or enhancement request to the HL7 standard.

9 Null Flavor Validation Rules for Data Types

CDA, Release 2 uses the HL7 V3 Data Types, Release 1 abstract and XML-specific specification. Every data element either has a proper value or it is considered NULL. If and only if it is NULL, a "null flavor" provides more detail on why or in what way no proper value is supplied. The table below provides clarifications to proper nullFlavor use for a list of common data types used by this guide.

Table 20: Null Flavor Validation Rules for Data Types

Data Type	CONF.#	Rules
Boolean (BL)	CMS_0105	Data types of BL SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor (CONF:CMS_0105).
Coded Simple (CS)	CMS_0106	Data types of CS SHALL have either @code or @nullFlavor but SHALL NOT have both @code and @nullFlavor (CONF:CMS_0106).
Coded Descriptor (CD)	CMS_0107	Data types of CD or CE SHALL have either @code or @nullFlavor but SHALL NOT have both @code and @nullFlavor (CONF:CMS_0107).
Coded With Equivalents (CE)		
Instance Identifier (II)	CMS_0108	Data types of II SHALL have either @root or @nullFlavor or (@root and @nullFlavor) or (@root and @extension) but SHALL NOT have all three of (@root and @extension and @nullFlavor) (CONF:CMS_0108).
Integer Number (INT)	CMS_0109	Data types of INT SHALL NOT have both @value and @nullFlavor (CONF:CMS_0109).
Physical Quantity (PQ)	CMS_0110	Data types of PQ SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor. If @value is present then @unit SHALL be present but @unit SHALL NOT be present if @value is not present (CONF:CMS_0110).
Real Number (REAL)	CMS_0111	Data types of REAL SHALL NOT have both @value and @nullFlavor (CONF:CMS_0111).
String (ST)	CMS_0112	Data types of ST SHALL either not be empty or have @nullFlavor (CONF:CMS_0112).
Point in Time (TS)	CMS_0113	Data types of TS SHALL have either @value or @nullFlavor but SHALL NOT have @value and @nullFlavor (CONF:CMS_0113).
Universal Resource Locator (URL)	CMS_0114	Data types of URL SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor (CONF:CMS_0114).

10 NPI and TIN Validation Rules

Table 21: NPI Validation Rules and Table 22: TIN Validation Rules list the validation rules performed on the NPI and TIN.

Table 21: NPI Validation Rules

CONF.#	Rules
CMS_0115	The NPI should have 10 digits.
CMS_0116	The NPI should be composed of all digits.
CMS_0117	The NPI should have a correct checksum using the Luhn algorithm.
CMS_0118	The NPI should have @extension or @nullFlavor, but not both.

Table 22: TIN Validation Rules

CONF.#	Rules
CMS_0119	When a Tax Identification Number is used, the provided TIN must be in valid format (9 decimal digits).
CMS_0120	The TIN SHALL have either @extension or @nullFlavor, but not both.

11 Change Log – 2021 CMS QRDA III Implementation Guide Changes to QRDA III STU R2.1 Base Standard

This table lists all changes made to this 2021 guide from the "Base Standard", the *HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture, Category III, STU Release 2.1*.

Table 23: Changes Made to the QRDA III Base Standard

CONF. #	Section	Base Standard	Changed To
CMS_1 CMS_2 CMS_3	5.1	n/a	SHALL contain exactly one [1..1] templateId (CONF:CMS_1) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.27.1.2" (CONF:CMS_2). SHALL contain exactly one [1..1] @extension="2020-05-01" (CONF:CMS_3).
4427-17238_C01 CMS_4	5.1	SHALL contain exactly one [1..1] confidentialityCode, which SHOULD be selected from ValueSet HL7 BasicConfidentialityKind urn:oid:2.16.840.1.113883.1.11.16926 STATIC (CONF:3338-17238).	SHALL contain exactly one [1..1] confidentialityCode (CONF: 4427-17238_C01). This confidentialityCode SHALL contain exactly one [1..1] @code="N" Normal (CodeSystem: ConfidentialityCode urn:oid:2.16.840.1.113883.5.25) (CONF:CMS_4).
4427-19669_C01	5.1	This languageCode SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet Language urn:oid:2.16.840.1.113883.1.11.11526 DYNAMIC (CONF:3338-19669).	This languageCode SHALL contain exactly one [1..1] @code="en" English (CodeSystem: Language urn:oid:2.16.840.1.113883.6.121) (CONF:4427-19669_C01).
CMS_7	5.1.1	n/a	SHALL contain exactly one [1..1] informationRecipient (CONF: CMS_7).
CMS_8	5.1.1	n/a	This informationRecipient SHALL contain exactly one [1..1] intendedRecipient (CONF:CMS_8).
CMS_9	5.1.1	n/a	This intendedRecipient SHALL contain exactly one [1..1] id (CONF:CMS_9).

CONF. #	Section	Base Standard	Changed To
CMS_10	5.1.1	n/a	This id SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.249.7" CMS Program (CONF:CMS_10).
CMS_11	5.1.1	n/a	This id SHALL contain exactly one [1..1] @extension, which SHALL be selected from ValueSet CMS Program Name 2.16.840.1.113883.3.249.14.101 STATIC 2020-05-01 (CONF:CMS_11). Note: The extension value is the CMS program name code, which indicates the CMS program the report is being submitted to.
CMS_12	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then ClinicalDocument/participant/@typeCode="LOC" SHALL be present (CONF: CMS_12). Note: For CPC+ reporting, CPC+ APM Entity Identifier must be submitted.
CMS_13	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then QRDA Category III Measure Section – CMS (V4) SHALL be present (CONF: CMS_13). Note: For CPC+ reporting, the QRDA III document must contain a Quality (eCQMs) section.
CMS_14	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then Performance Rate for Proportion Measure – CMS (V3) SHALL be present (CONF: CMS_14). Note: For CPC+ reporting, performance period for the Quality (eCQMs) section must be specified.
CMS_92	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then CMS EHR Certification ID SHALL be present (CONF:CMS_92)

CONF. #	Section	Base Standard	Changed To
CMS_99	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then ClinicalDocument/participant/@typeCode="LOC" **SHALL** be present (CONF:CMS_99). Note: For PCF reporting, PCF APM Entity Identifier must be submitted.
CMS_100	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then QRDA Category III Measure Section – CMS (V4) **SHALL** be present (CONF:CMS_100). Note: For PCF reporting, the QRDA III document must contain a quality (eCQMs) section.
CMS_97	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Performance Rate for Proportion Measure – CMS (V3) **SHALL** be present (CONF:CMS_97). Note: For PCF reporting, performance rate for a proportion eCQM must be specified.
CMS_98	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then CMS EHR Certification ID **SHALL** be present (CONF:CMS_98).
CMS_15	5.1.2	n/a	MAY contain zero or one [0..1] participant (CONF:CMS_15) such that it
CMS_16	5.1.2	n/a	SHALL contain exactly one [1..1] @typeCode="LOC" Location (CodeSystem: HL7ParticipationType 2.16.840.1.113883.5.90) (CONF:CMS_16).
CMS_17	5.1.2	n/a	SHALL contain exactly one [1..1] associatedEntity (CONF: CMS_17).
CMS_18	5.1.2	n/a	This associatedEntity SHALL contain exactly one [1..1] @classCode="SDLOC" Service Delivery Location (CodeSystem: RoleClass 2.16.840.1.113883.5.110) (CONF: CMS_18).

CONF. #	Section	Base Standard	Changed To
CMS_19 CMS_20 CMS_21	5.1.2	n/a	This associatedEntity SHALL contain exactly one [1..1] id (CONF: CMS_19) such that it **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.3.249.5.1**"** CPC+ Practice Site (CONF:CMS_20). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.1) designates that the @extension must hold a CPCPLUS APM Entity Identifier. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_21). Note: This is the CPCPLUS APM Entity Identifier assigned to the CPC+ practice site.
CMS_101	5.1.2	n/a	This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_101) such that it **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.3.249.5.3" PCF Practice Site (CONF:CMS_102). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.3) designates that the @extension must hold a PCF APM Entity Identifier. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_103). Note: This is the PCF APM Entity Identifier assigned to the PCF practice site.
CMS_22	5.1.2	n/a	This associatedEntity SHALL contain exactly one [1..1] code (CONF:CMS_22).
CMS_23	5.1.2	n/a	This code SHALL contain exactly one [1..1] @code="394730007" Healthcare Related Organization (CodeSystem: SNOMED CT 2.16.840.1.113883.6.96) (CONF: CMS_23).
CMS_24	5.1.2	n/a	This code SHALL contain exactly one [1..1] @codeSystem (CodeSystem: SNOMED CT urn:oid:2.16.840.1.113883.6.96) (CONF:CMS_24).
CMS_25	5.1.2	n/a	This associatedEntity SHALL contain exactly one [1..1] addr (CONF: CMS_25).

CONF. #	Section	Base Standard	Changed To
CMS_104	5.1.2	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then this participant/associatedEntity **SHALL** contain the id for CPC+ Practice Site (CONF:CMS_104).
CMS_105	5.1.2	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then this participant/associatedEntity **SHALL** contain the id for PCF Practice Site (CONF:CMS_105).
CMS_85 CMS_86 CMS_87	5.1.3	n/a	MAY contain zero or one [0..1] participant (CONF:CMS_85) such that it SHALL contain exactly one [1..1] @typeCode="DEV" device (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90) (CONF:CMS_86). SHALL contain exactly one [1..1] associatedEntity (CONF:CMS_87).
CMS_88 CMS_89 CMS_90 CMS_91	5.1.3	n/a	This associatedEntity SHALL contain exactly one [1..1] @classCode="RGPR" regulated product (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:CMS_88). This associatedEntity SHALL contain exactly one [1..1] id (CONF:CMS_89). This id SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.2074.1" CMS EHR Certification ID (CONF:CMS_90). This id SHALL contain exactly one [1..1] @extension (CONF:CMS_91). Note: The value of @extension is the CMS EHR Certification ID, which must be 15 alpha numeric characters in length.
4427-18170_C01	5.1.4	MAY contain zero or one [0..1] documentationOf (CONF: 3338-18170).	SHALL contain exactly one [1..1] documentationOf (CONF:4427-18170_C01).

CONF. #	Section	Base Standard	Changed To
4427-18171_C01	5.1.4	The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:3338-18171).	For MIPS group reporting: it must contain exactly one performer, which contains one TIN. No NPI is allowed. For MIPS virtual group reporting: it must contain exactly one performer, which contains on Virtual Group Identifier. No NPI is allowed. For MIPS individual reporting: it must contain exactly one performer, which contains one TIN and one NPI. For CPC+ and PCF: it must contain at least one performer, each performer contains one TIN and one NPI. Only CPC+ or PCF Practice Site providers are listed as performers. This documentationOf SHALL contain exactly one [1..1] serviceEvent (CONF:4427-18171_C01). This serviceEvent SHALL contain at least one [1..*] performer (CONF:3338-18173).
4427-18177_C01	5.1.4	This assignedEntity id/@root coupled with the id/@extension can be used to represent the individual provider's National Provider Identification number (NPI). Other assignedEntity ids may be present. This assignedEntity SHALL contain exactly one [1..1] **id** (CONF:3338-18177) such that it	The assignedEntity id/@root =' 2.16.840.1.113883.4.6' coupled with the id/@extension represents the individual provider's National Provider Identification number (NPI). NPI is required except for group reporting. For group reporting, id/@root=' 2.16.840.1.113883.4.6' is coupled with @nullFlavor="NA", and @extension shall be omitted. This assignedEntity SHALL contain exactly one [1..1] id (CONF:4427-18177_C01) such that it
CMS_29	5.1.4	n/a	MAY contain zero or one [0..1] @nullFlavor="NA" (CONF:CMS_29). Note: @nullFlavor is only present for MIPS group reporting and MIPS virtual group reporting.

CONF. #	Section	Base Standard	Changed To
4427-18178_C01	5.1.4	MAY contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider ID (CONF:3338-18178).	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider ID (CONF: 4427-18178_C01). Note: This OID contained in the @root (2.16.840.1.113883.4.6) designates that the @extension must hold a National Provider ID. **MAY** contain zero or one [0..1] **@extension** (CONF:3338-18247). Note: This is the provider's NPI. It is only present when this is not MIPS group reporting or MIPS virtual group reporting. For CPC+, only those NPIs that are participating in the CPC+ program should be provided. For PCF, only those NPIs that are participating in the PCF program should be provided.
4427-18181_C01	5.1.4	This representedOrganization MAY contain zero or one [0..1] id (CONF:3338-18181) such that it	This representedOrganization SHOULD contain zero or one [0..1] id (CONF:4427-18181_C01) such that it
CMS_79 CMS_80 CMS_81	5.1.4	n/a	This representedOrganization SHOULD contain zero or one [0..1] id (CONF:CMS_79) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.249.5.2" MIPS Virtual Group (CONF:CMS_80). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.2) designates that the @extension must hold a Virtual Group Identifier. SHALL contain exactly one [1..1] @extension (CONF:CMS_81). Note: This is the Virtual Group Identifier.
CMS_82	5.1.4	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_GROUP", then this representedOrganization SHALL contain exactly one [1..1] id, which is the group's TIN (CONF:CMS_82).

CONF. #	Section	Base Standard	Changed To
CMS_83	5.1.4	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_VIRTUALGROUP", then this representedOrganization SHALL contain exactly one [1..1] id, which is the virtual group's Virtual Group Identifier (CONF:CMS_83).
4427-17281_C01	5.1.5	This structuredBody MAY contain zero or one [0..1] component (CONF:3338-17281) such that it SHALL contain exactly one [1..1] QRDA Category III Reporting Parameters Section (identifier: urn:oid:2.16.840.1.113883.10.20.27.2.2) (CONF:3338-17282).	This structuredBody SHALL NOT contain [0..0] component (CONF:4427-17281_C01) such that it Note: Reporting Parameter Section shall not be used for specifying performance period. SHALL contain exactly one [1..1] QRDA Category III Reporting Parameters Section (identifier: urn:oid:2.16.840.1.113883.10.20.27.2.2) (CONF:3338-17282).
4427-17301_C01	5.1.5	SHALL contain exactly one [1..1] QRDA Category III Measure Section (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.1:2017-06-01) (CONF:3338-17301).	SHALL contain exactly one [1..1] QRDA Category III Measure Section - CMS (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.3:2019-05-01) (CONF:4427-17301_C01).
4427-21394_C01	5.1.5	This structuredBody SHALL contain at least a QRDA Category III Measure Section (V4), or an Improvement Activity Section (V2), or an Advancing Care Information Section (V2) (CONF:3338-21394).	This structuredBody SHALL contain at least a QRDA Category III Measure Section - CMS (V4), or an Improvement Activity Section (V2), or a Promoting Interoperability Section (V2) (CONF:4427-21394_C01). Note: Promoting Interoperability Section (V2) is formerly the Advancing Care Information Section (V2)
CMS_64 CMS_65 CMS_66	5.2.1	n/a	SHALL contain exactly one [1..1] templateId (CONF:CMS_64) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.27.2.3" (CONF:CMS_65). SHALL contain exactly one [1..1] @extension="2019-05-01" (CONF:CMS_66).

CONF. #	Section	Base Standard	Changed To
4427-17906_C01 4427-17907_C01	5.2.1	SHALL contain at least one [1..*] entry (CONF:3338-17906) such that it SHALL contain exactly one [1..1] Measure Reference and Results (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.1:2016-09-01) (CONF:3338-17907).	SHALL contain at least one [1..*] entry (CONF:4427-17906_C01) such that it SHALL contain exactly one [1..1] Measure Reference and Results - CMS (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.17:2019-05-01) (CONF: 4427-17907_C01).
CMS_41 CMS_42 CMS_43	5.3.1	n/a	SHALL contain exactly one [1..1] templateId (CONF:CMS_41) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.27.3.16" (CONF:CMS_42). SHALL contain exactly one [1..1] @extension="2019-05-01 (CONF:CMS_43).
4427-18136_C01	5.3.1	MAY contain zero or more [0..*] entryRelationship (CONF:3259-18136) such that it	SHALL contain at least one [1..*] entryRelationship (CONF:4427-18136_C01) such that it SHALL contain exactly one [1..1] Sex Supplemental Data Element (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.6:2016-09-01) (CONF:3259-18138).
4427-18139_C01	5.3.1	MAY contain zero or more [0..*] entryRelationship (CONF:3259_18139) such that it	SHALL contain at least one [1..*] entryRelationship (CONF:4427-18139_C01) such that it SHALL contain exactly one [1..1] Ethnicity Supplemental Data Element (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.7:2016-09-01) (CONF:3259-18149).
4427-18140_C01	5.3.1	MAY contain zero or more [0..*] entryRelationship (CONF:3259-18140) such that it	SHALL contain at least one [1..*] entryRelationship (CONF:4427-18140_C01) such that it SHALL contain exactly one [1..1] Race Supplemental Data Element (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.8:2016-09-01) (CONF:3259-18150).

CONF. #	Section	Base Standard	Changed To
4427-18141_C01 4427-18151_C01	5.3.1	MAY contain zero or more [0..*] entryRelationship (CONF:3259-18141) such that it	SHALL contain at least one [1..*] entryRelationship (CONF:4427-18141_C01) such that it SHALL contain exactly one [1..1] Payer Supplemental Data Element - CMS (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.18:2018-05-01) (CONF:4427-18151_C01).
CMS_54 CMS_55 CMS_56	5.3.2	n/a	SHALL contain exactly one [1..1] templateId (CONF:CMS_54) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.27.3.17" (CONF:CMS_55). SHALL contain exactly one [1..1] @extension="2019-05-01" (CONF:CMS_56).
4427-17904_C01	5.3.2	MAY contain zero or more [0..*] component (CONF:3259-17903) such that it SHALL contain exactly one [1..1] Performance Rate for Proportion Measure (identifier: urn:oid:2.16.840.1.113883.10.20.27.3.14) (CONF:3259-17904).	MAY contain zero or more [0..*] component (CONF:3259-17903) such that it SHALL contain exactly one [1..1] Performance Rate for Proportion Measure - CMS (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2018-05-01) (CONF:4427-17904_C01).
4427-18425_C01 4427-18426_C01	5.3.2	SHALL contain at least one [1..*] component (CONF:3259-18425) such that it SHALL contain exactly one [1..1] Measure Data (V2) (identifier:urn:hl7ii:2.16.840.1.113883.10.20.27.3.5:2016-02-01) (CONF:3259-18426).	SHALL contain at least one [1..*] component (CONF:4427-18425_C01) such that it SHALL contain exactly one [1..1] Measure Data - CMS (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.16:2019-05-01) (CONF:4427-18426_C01).
CMS_47 CMS_48 CMS_49	5.3.3	n/a	SHALL contain exactly one [1..1] templateId (CONF:CMS_47) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.27.3.18" (CONF:CMS_48). SHALL contain exactly one [1..1] @extension="2018-05-01" (CONF:CMS_49).

CONF. #	Section	Base Standard	Changed To
CMS_50 CMS_51 CMS_52 CMS_53	5.3.3	SHALL contain exactly one [1..1] value with @xsi:type="CD", where the code SHOULD be selected from ValueSet Payer urn:oid:2.16.840.1.114222.4.11.3591 DYNAMIC (CONF:2226-18250).	SHALL contain exactly one [1..1] value with @xsi:type="CD" (CONF:CMS_50). This value SHALL contain exactly one [1..1] @nullFlavor="OTH" (CONF:CMS_51). This value SHALL contain exactly one [1..1] translation (CONF:CMS_52). This translation SHALL contain exactly one [1..1] @code, which SHALL be selected from ValueSet CMS Payer Groupings urn:oid:2.16.840.1.113883.3.249.14.102 (CONF:CMS_53).
CMS_59 CMS_60 CMS_61	5.3.4	n/a	SHALL contain exactly one [1..1] templateId (CONF:CMS_59) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.27.3.25" (CONF:CMS_60). SHALL contain exactly one [1..1] @extension="2018-05-01" (CONF:CMS_61).
3259-21307_C01 CMS_62 CMS_63	5.3.4	n/a	SHALL contain exactly one [1..1] `value` with @xsi:type="REAL" (CONF:3259-21307_C01). The value, if present, SHALL be greater than or equal to 0 and less than or equal to 1 (CONF:CMS_62). The value, if present, SHALL contain no more than 6 digits to the right of the decimal (CONF:CMS_63).
3259-19651_C01 3259-19652_C01 3259-19653_C01	5.3.4	MAY contain zero or one [0..1] reference (CONF:3259-19651). The reference, if present, SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:3259-19652). The reference, if present, SHALL contain exactly one [1..1] externalObservation (CONF:3259-19653).	SHALL contain exactly one [1..1] reference (CONF: 3259-19651_C01). This reference SHALL contain exactly one [1..1] @typeCode="REFR" refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002) (CONF:3259-19652_C01). This reference SHALL contain exactly one [1..1] externalObservation (CONF:3259-19653_C01).

12 Change Log – Changes from the 2020 CMS QRDA Implementation Guide

The 2021 CMS QRDA III IG contains the following high-level changes as compared with the 2020 CMS QRDA III IG:

- Updated eCQM UUIDs for the 2021 performance period eCQMs.
- Included preliminary QRDA III requirements for Primary Care First.

The Table 24 lists the changes made in each section of this 2021 CMS QRDA Eligible Clinicians and EPs Implementation Guide since the release of 2020 CMS QRDA Implementation Guide.

Table 24: Changes Made to the 2021 CMS Eligible Clinicians and EPs QRDA IG from 2020 CMS QRDA IG

Section Heading	2020 CMS QRDA III Eligible Clinicians and EPs IG, V2 (07/28/18)	2021 CMS QRDA III Eligible Clinicians and EPs IG
4 QRDA Category III Submission Rules	Submission rules for the 2020 performance period.	Language is updated to reflect the requirement updates for the 2021 performance period.
5.1 Document-Level Template: QRDA Category III Report – CMS (V5)	QRDA Category III Report – CMS (V4) (identifier urn:hl7ii:2.16.840.1.113883.10.20.27.1.2:2019-05-01)	QRDA Category III Report – CMS (V5) (identifier urn:hl7ii:2.16.840.1.113883.10.20.27.1.2:2020-05-01)
5.1 Document-Level Template: QRDA Category III Report – CMS (V5)	This template describes constraints that apply to the QRDA Document Category III Report for CMS Eligible Clinicians and Eligible Professionals Programs including the CPC+ program and MIPS.	This template describes constraints that apply to the QRDA Document Category III Report for CMS Eligible Clinicians and Eligible Professionals Programs including the CPC+and PCF models and MIPS.
5.1.1 informationRecipient	This id **SHALL** contain exactly one [1..1] **`@extension`**, which **SHALL** be selected from ValueSet `QRDA III CMS Program Name urn:oid:2.16.840.1.113883.3.249.14.101` **STATIC** 2019-05-01 (CONF:CMS_11).	This id **SHALL** contain exactly one [1..1] **`@extension`**, which **SHALL** be selected from ValueSet `QRDA III CMS Program Name urn:oid:2.16.840.1.113883.3.249.14.101` **STATIC** 2020-05-01 (CONF:CMS_11).
5.1.1 informationRecipient	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then ClinicalDocument/participant/@typeCode="LOC" **SHALL** be present (CONF:CMS_99). Note: For PCF reporting, PCF APM Entity Identifier must be submitted.

Section Heading	2020 CMS QRDA III Eligible Clinicians and EPs IG, V2 (07/28/18)	2021 CMS QRDA III Eligible Clinicians and EPs IG
5.1.1 informationRecipient	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then QRDA Category III Measure Section – CMS (V2) **SHALL** be present (CONF:CMS_100). Note: For PCF reporting, the QRDA III document must contain a quality (eCQMs) section.
5.1.1 informationRecipient	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Performance Rate for Proportion Measure – CMS (V3) **SHALL** be present (CONF:CMS_97). Note: For PCF reporting, performance rate for a proportion eCQM must be specified.
5.1.1 informationRecipient	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then CMS EHR Certification ID **SHALL** be present (CONF:CMS_98).
5.1.1 informationRecipient Table 3 QRDA III CMS Program Name	CPCPLUS MIPS_INDIV MIPS_GROUP MIPS_VIRTUALGROUP	CPCPLUS PCF MIPS_INDIV MIPS_GROUP MIPS_VIRTUALGROUP
5.1.2 participant is Location (CPC+ or Practice Site)	5.1.2 participant is Location (CPC+ Practicie Site)	5.1.2 participant is Location (CPC+ or Practice Site)
5.1.2 participant is Location (CPC+ or Practice Site)	For CPC+ reporting, the generic participant with a participationType of 'LOC' (location) and an associatedEntity classCode of 'SDLOC' (service delivery location) representing the CPC+ Practice Site respectively is required. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then this location participant must be present.	For CPC+ and PCF reporting, the generic participant with a participationType of 'LOC' (location) and an associatedEntity classCode of 'SDLOC' (service delivery location) representing the CPC+ or PCF Practice Site respectively is required. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS" or “PCF”, then this location participant must be present.

Section Heading	2020 CMS QRDA III Eligible Clinicians and EPs IG, V2 (07/28/18)	2021 CMS QRDA III Eligible Clinicians and EPs IG
5.1.2 participant is Location (CPC+ or Practice Site)	This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_19). This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_19). This id **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.3.249.5.1" CPC Practice Site (CONF:CMS_20). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.1) designates that the @extension must hold a CPCPLUS APM Entity Identifier. This id **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_21). Note: This is the CPCPLUS APM Entity Identifier assigned to the CPC+ practice site.	This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_19) such that it **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.3.249.5.1" CPC+ Practice Site (CONF:CMS_20). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.1) designates that the @extension must hold a CPCPLUS APM Entity Identifier. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_21). Note: This is the CPCPLUS APM Entity Identifier assigned to the CPC+ practice site.
5.1.2 participant is Location (CPC+ or Practice Site)	n/a	This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_101) such that it **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.3.249.5.3" PCF Practice Site (CONF:CMS_102). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.3) designates that the @extension must hold a PCF APM Entity Identifier. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_103). Note: This is the PCF APM Entity Identifier assigned to the PCF practice site.
5.1.2 participant is Location (CPC+ or Practice Site)	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="CPCPLUS", then this participant/associatedEntity **SHALL** contain the id for CPC+ Practice Site (CONF:CMS_104).
5.1.2 participant is Location (CPC+ or Practice Site)	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then this participant/associatedEntity **SHALL** contain the id for PCF Practice Site (CONF:CMS_105).

Section Heading	2020 CMS QRDA III Eligible Clinicians and EPs IG, V2 (07/28/18)	2021 CMS QRDA III Eligible Clinicians and EPs IG
5.1.3 Participant is Device (CMS EHR Certification ID)	n/a	Added the following about PCF: For PCF, all QRDA III files must include a CMS EHR Certification ID. Nulls will not be allowed. Please refer to section 4.2 for additional information.
5.1.4 documentationOf	For CPC+: it must contain at least one performer, each performer contains one TIN and one NPI. Only CPC+ Practice Site providers are listed as performers.	For CPC+ and PCF: it must contain at least one performer, each performer contains one TIN and one NPI. Only CPC+ or PCF Practice Site providers are listed as performers.
5.1.4 documentationOf	**MAY** contain zero or one [0..1] **@extension** (CONF:3338-18247). Note: This is the provider's NPI. It is only present when this is not MIPS group reporting or MIPS virtual group reporting. For CPC+, only those NPIs that are participating in the CPC+ program should be provided.	**MAY** contain zero or one [0..1] **@extension** (CONF:3338-18247). Note: This is the provider's NPI. It is only present when this is not MIPS group reporting or MIPS virtual group reporting. For CPC+, only those NPIs that are participating in the CPC+ program should be provided. For PCF, only those NPIs that are participating in the PCF program should be provided.
6 eCQM Specifications for Eligible Clinicians and Eligible Professionals UUID List	UUID list based on the eCQM specifications for Eligible Clincians and Eligbile Professionals for the 2020 performance period	Updated the UUID list based on the eCQM specifications for Eligible Clincians and Eligbile Professionals for the 2021 performance period
7. Measure Identifiers	Identifiers for the 2020 performance period.	Identifiers for the 2021 performance period based on the CY 2021 Physician Fee Schedule Rule. See the 2021 CMS QRDA III IG Version 1.1 Changes listed below.
8.1 Resources	n/a	Added resource for PCF
8.2 Support	n/a	Added PCF support contact information

The 2021 CMS QRDA III IG Version 1.1 Changes (12/14/2020):

The following tables are updated based on the CY 2021 Physician Fee Schedule Final Rule released in December, 2020.

- Updated Table 14: UUID List for MIPS CY 2021 Performance Period eCQM Specifications Eligible Professionals and Eligible Clinicians
    - Updated the NQF # of CMS142v9 from 0089e to N/A
    - Updated the NQF # of CMS69v9 from 0421e to N/A
    - Updated the NQF # of CMS68v10 from N/A to 0419e
- Updated the NQF # of CMS249v3 from N/A to 3475e

- Updated Table 15: Improvement Activities Identifiers for the MIPS CY 2021 Performance Period
- Updated Table 16: Promoting Interoperability Objectives and Measures Identifiers for the MIPS CY 2021 Performance Period
- Updated Table 17: Promoting Interoperability Attestation Statements Identifiers

13 Acronyms

This section describes acronyms used in this guide.

Acronym	Literal Translation
ASKU	Asked, but not known
CDA	Clinical Document Architecture
CEHRT	Certified EHR Technology
CMS	Centers for Medicare & Medicaid Services
CONF	conformance
CPC+	Comprehensive Primary Care Plus
EP	Eligible Professional
eCQI	electronic clinical quality improvement
eCQM	electronic Clinical Quality Measure
EHR	electronic health record
HL7	Health Level Seven
HL7 V3	Health Level 7 Version 3
HQMF	Health Quality Measures Format
ID	identifier
IHTSDO	International Health Terminology Standard Development Organization
IP	initial population
LOINC	Logical Observation Identifiers Names and Codes
MIPS	Merit-Based Incentive Payment System
n/a	not applicable
NA	Not applicable
NLM	National Library of Medicine
NPI	National Provider Identification Number
OID	Object Identifier
ONC	Office of the National Coordinator for Health Information Technology
PCF	Primary Care First
PHDSC	Public Health Data Standards Consortium

Acronym	Literal Translation
QDM	Quality Data Model
QPP	Quality Payment Program
QRDA	Quality Reporting Data Architecture
QRDA III	Quality Reporting Data Architecture Category III
SNOMED CT	Systematized Nomenclature of Medicine, Clinical Terms
STU	Standard for Trial Use
TIN	Taxpayer Identification Number
UNK	Unknown
UTC	Coordinated Universal Time
UUID	Universally Unique Identifier
VSAC	Value Set Authority Center
XML	Extensible Markup Language

14 Glossary

Term	Definition
Electronic health record (EHR)	Electronic Health Record (EHR) is also known as the electronic patient record, electronic medical record, or computerized patient record. As defined by Healthcare Information Management and Systems Society, “the electronic health record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and imaging reports.”
Electronic Clinical Quality Measure (eCQM)	An electronic clinical quality measure (eCQM) is a clinical quality measure that is expressed and formatted to use data from electronic health records (EHR) and/or health information technology systems to measure healthcare quality, specifically data captured in structured form during the process of patient care. So they can be reported from an EHR, the Health Quality Measure Format (HQMF) is used to format the eCQM content using the Quality Data Model (QDM) to define the data elements and Clinical Quality Language (CQL) to express the logic needed to evaluate a provider or organization’s performance.
Merit-Based Incentive Payment System (MIPS)	A quality reporting system that includes an incentive payment for eligible clinicians who satisfactorily report data on quality measures for covered clinician services provided during the specified program year.
XML Path Language (XPath)	This notation provides a mechanism that will be familiar to developers for identifying parts of an XML document. XPath syntax selects nodes from an XML document using a path containing the context of the node(s). The path is constructed from node names and attribute names (prefixed by an '@') and concatenated with a '/' symbol.

15 References

Certified Health IT Product List. https://chpl.healthit.gov/

Comprehensive Primary Care Plus (CPC+). https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

eCQI Resource Center. https://ecqi.healthit.gov/

HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture, Category III, Release 1, Draft Standard for Trial Use, Release 2.1, 2017 http://www.hl7.org/implement/standards/product_brief.cfm?product_id=286

ONC, Electronic Clinical Quality Measure issue reporting system. https://oncprojectracking.healthit.gov/

Primary Care First (PCF) Model. https://innovation.cms.gov/innovation-models/primary-care-first-model-options

Quality Payment Program: https://qpp.cms.gov

U.S. National Library of Medicine, Value Set Authority Center. https://vsac.nlm.nih.gov