Centers for Medicare & Medicaid Services

CMS Implementation Guide for Quality Reporting Document Architecture Category III

Eligible Clinicians Programs

Implementation Guide for 2024

Version 1.1

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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 CDA R2 Implementation Guide: Quality Reporting Document Architecture(QRDA III), Release 1 – US Realm*[1] *(September, 2021)* for the 2024 performance period. This is a normative release approved by American National Standards Institute (ANSI) and HL7. This HL7 base standard is referred to as the HL7 QRDA III R1.

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 Primary Care First (PCF) model, traditional Merit-Based Incentive Payment System (MIPS), APM Performance Pathway (APP), and MIPS Value Pathways (MVPs)
- Chapter 5: QRDA Category III Validation—contains the formal definitions for the QRDA Category III report for the CMS Eligible Clinicians 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: 2024 Performance Period eCQM Specifications for Eligible Clinicians UUID List
- Chapter 7: Measure Identifiers

APPENDIX

- Chapters 8 -15 provide references, resources, and several change logs including a list of all changes made to the HL7 QRDA III R1 to produce this CMS Implementation Guide

[1] HL7 QRDA III R1. https://www.hl7.org/implement/standards/product_brief.cfm?product_id=286

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

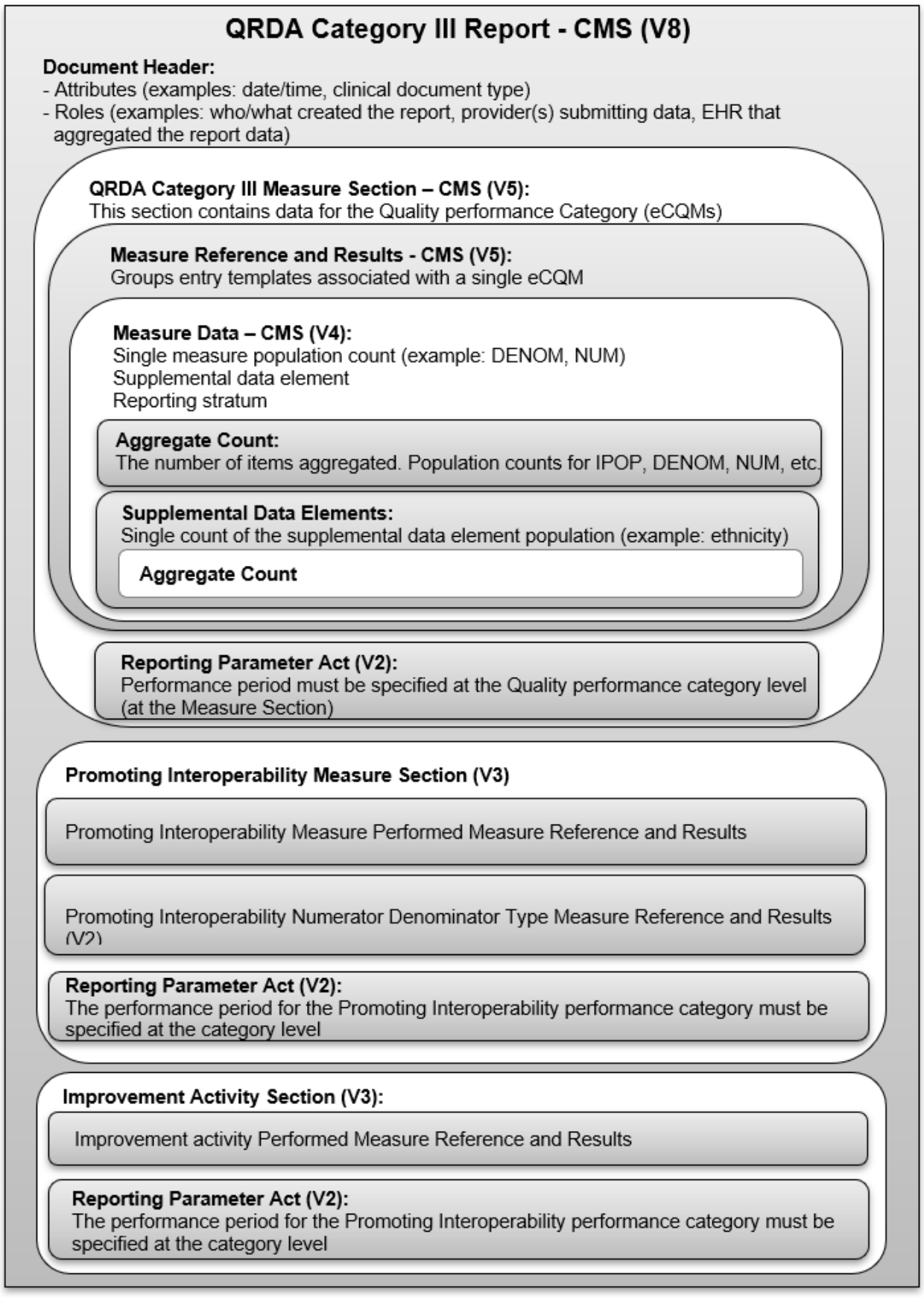
3.1 Background

This guide is a CMS Quality Reporting Document Architecture Category III (QRDA III) implementation guide to the HL7 QRDA III R1. Templates defined in this implementation guide are conformant with HL7 QRDA III R1. The CMS Eligible Clinicians Programs QRDA III templates address aggregate reporting requirements for:

- Primary Care First (PCF)
- Traditional Merit-Based Incentive Payment System (MIPS)
- APM Performance Pathway (APP)
- MIPS Value Pathway (MVP)

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) and Clinical Quality Language (CQL) specification, which standardizes the representation of a health quality measure as an electronic document. Other summary data provided in a QRDA III report include Promoting Interoperability 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 PCF model and MIPS program. Some of the conformance statements in the HL7 QRDA III R1 have been further constrained to meet the specific requirements from these CMS Eligible Clinicians 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 R1 standard is further constrained in this guide.

This guide only lists the templates specifying CMS-specific reporting requirements from the base HL7 QRDA III R1 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 R1 are not repeated in this guide. Therefore, the base HL7 QRDA III R1 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 Primary Care First (PCF) Submissions

PCF practices must adopt health IT meeting the requirements published by the PCF model. This guide only provides information for QRDA III reporting of eCQMs for the PCF model. More information about health IT and other reporting requirements will be made available to PCF participants prior to the start of the performance year; please contact PCF Support with questions.

The PCF QRDA III file must contain the CMS EHR Certification ID. Nulls will not be allowed and 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. Clinicians who are active on the roster may include, but are not limited to, physicians (MD or DO), nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists (CNS).

Each PCF practice submitting QRDA III files for the 2024 performance period must provide the eCQMs required by the PCF model. If additional eCQMs are reported, they will be ignored.

Improvement Activity data **should not be submitted** in a PCF quality measure QRDA III submission file. Improvement Activity data are not required to be reported for PCF. If Improvement Activity data are submitted for PCF, they will be ignored. Promoting Interoperability data **shall not be submitted** in a PCF quality measure QRDA III submission file. If Promoting Interoperability data are submitted for PCF, PCF will reject the file. If you are submitting Promoting Interoperability or Improvement Activity data for MIPS, see 4.2 Traditional Merit-Based Incentive Payment System (MIPS) QRDA III Submissions, 4.3 APM Performance Pathway (APP), 4.4 MIPS Value Pathways (MVPs), or 4.5 Subgroup Reporting through MVP for more information.

QRDA III submissions for PCF will use the 2024 Performance Period eCQM Specifications for Eligible Clinicians[2] provided in the eCQI Resource Center.

The performance period for the PCF model begins on January 1, 2024 and ends on December 31, 2024.

[2] eCQI Resource Center, Eligible Clinician eCQMs web page. https://ecqi.healthit.gov/ep-ec. Select 2024 Performance Period.

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

This section describes submission requirements for traditional MIPS individual reporting, group reporting, virtual group reporting, and APM Entity reporting.

4.2.1 Traditional MIPS Individual, Group, and Virtual Group Reporting

QRDA III submissions for traditional MIPS individual, group, and virtual group reporting 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.

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 2024, 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, 2025, if technically feasible, through March 31, 2025 for the 2024 performance period.

For the 2024 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.

4.2.2 Traditional MIPS APM Entity Reporting

MIPS QRDA III submissions for APM Entity reporting must contain data for at least one of the following three MIPS performance categories: Quality,Improvement Activities and Promoting Interoperability. 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, Improvement Activity and Promoting Interoperability scoring rules.

Under MIPS, an APM Entity group is defined as a group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, TIN, and NPI for each participating eligible clinician.

For 2024, MIPS APM Entity groups are required to submit a full year of data for the Quality performance category and 90-days of data for Promoting Interoperability and Improvement Activities—unless otherwise specified within the activity. eCQM populations include all patients (all-payer data). Data submission for APM Entity groups will occur prior to January 2, 2025, if technically feasible, through March 31, 2025 for the 2024 performance period.

For the 2024 performance period, CMS EHR Certification ID is optional for the MIPS Quality performance category.

4.3 APM Performance Pathway (APP)

The APM Performance Pathway (APP) is a MIPS reporting and scoring pathway for MIPS eligible clinicians who are also participants in MIPS Alternative Payment Models (APMs). The APP is a single, pre-determined measure set that MIPS APM participants may report on at the individual, group, and/or APM Entity levels. It's designed to provide reliable and consistent MIPS reporting requirements to reduce reporting burden and encourage continued APM participation. The APP is optional for all MIPS APM participants; however, it is required for all Medicare Shared Savings Program (Shared Savings Program) ACOs.

QRDA III submissions for individuals, groups, or APM Entities reporting through the APP must contain data for the Quality performance category for the specific measures required by the APP. In addition, a submission for PI containing the APP Program name is required for APP scoring. Improvement activities can be reported, but all MIPS APM participants who report through the APP will receive a full score for the Improvement Activities performance category.

4.4 MIPS Value Pathways (MVPs)

MIPS Value Pathways (MVPs) are a new optional way to meet MIPS reporting requirements beginning with the 2024 performance period. MVPs are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2024 performance period. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties, clinical conditions, or episodes of care. MVPs incorporate a foundational layer that include Promoting Interoperability measures and population health administrative claims-based quality measures. MVPs offer reduced reporting requirements, allowing MVP participants to report on a smaller, more cohesive subset of measures and activities (within the measures and activities available for traditional MIPS) that are relevant to a specialty, clinical condition, or episode of care.

MVPs can be reported by MIPS individual, group, subgroup, or APM entity. Virtual groups are not able to report an MVP.

4.5 Subgroup Reporting through MVP

A subgroup is a subset of clinicians within a MIPS group which contains at least one MIPS eligible clinician. A unique subgroup identifier will be assigned upon successful subgroup registration. Subgroups do not apply to virtual groups.

Subgroup reporting can offer more meaningful data collection and feedback, particularly for clinicians in a large or multispecialty group. A subgroup may not include clinicians from a different TIN. Subgroup reporting is voluntary for the 2024 performance period. Reporting through a subgroup may be an option for clinicians in a practice with multiple specialties to get better insight into clinical areas and performance for clinicians within a practice. A large practice may participate as multiple subgroups and therefore report to more than one MVP based on clinical relevance.

Subgroup reporting within MIPS is limited to MVP for the 2024 performance period. Subgroup reporting of Promoting Interoperability is based on the group data; however, it is still required to be reported at the subgroup level with the correlating MVP identifier.

4.6 Identifiers

For all CMS eligible clinicians 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 program reporting include:

- Alternative Payment Model (APM) Entity Identifier
  - Required for MIPS APM Entity reporting
  - Required for APP APM Entity reporting
  - For PCF, this is the PCF Practice Identifier assigned by PCF

- National Provider Identifier (NPI)
  - Required for MIPS individual reporting
  - Required for APP individual reporting
  - Not allowed for MIPS group reporting, MIPS virtual group reporting, MIPS APM Entity reporting, APP group reporting, or APP APM Entity reporting
  - Required for PCF reporting

- Tax Identification Number (TIN)
  - Required for MIPS group reporting and MIPS individual reporting
  - Required for APP group reporting and APP individual reporting
  - Not allowed for MIPS APM Entity reporting or APP APM Entity reporting
  - Required for PCF reporting

- Virtual Group Identifier
  - Required for MIPS virtual group reporting
  - Not allowed for MIPS individual reporting, MIPS group reporting, MIPS APM Entity reporting, APP individual reporting, APP group reporting, or APP APM Entity reporting

- Subgroup Identifier
  - Required for subgroup reporting

4.7 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.

4.7.1 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 PCF model.

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.

4.7.2 Final Action Processing Rules for MIPS

For group reporting (except for the PCF model), the Final Action Processing rules include the combination of the CMS program name, the TIN, and the submission timestamp. For virtual group reporting, the Final Action Processing rules include the combination of the CMS program name, the Virtual Group Identifier, 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. For APM Entity reporting, the Final Action Processing rules include the combination of the CMS program name, the APM Entity ID, and the submission timestamp.

When submitting a replacement QRDA III report for the MIPS program use the same TIN, or the same TIN/NPI, the same virtual group identifier, or the same APM Entity 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.

4.7.3 Final Action Processing Rules for PCF

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

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

4.7.4 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 2024 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 PCF, 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.

4.8 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

4.9 Performance Period and Performance Rate

The performance period for the PCF model begins on January 1, 2024 and ends on December 31, 2024. If the CMS program name code is "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="`20240101`"
- act[@templateId="`2.16.840.1.113883.10.20.17.3.8`"]/effectiveTime/high/@value="`20241231`"

For the MIPS performance period requirement, please see 4.2 Traditional Merit-Based Incentive Payment System (MIPS) QRDA III Submissions and 5.1.6 component.

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

> If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Performance Rate for Proportion Measure – CMS (V4) **SHALL** be present (CONF:CMS_97).

For MIPS reporting, performance rates for either eCQMs or Promoting Interoperability measures are not required for submissions. If performance rates are provided, they will be ignored by the receiving system.

4.10 Templates Versioning and Validations

Both the base HL7 QRDA III R1 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 R1 (Volume 1). For example, in the HL7 QRDA III R1, the previous Measure Reference and Results (V3) template is now Measure Reference and Results (V4), its template identifier is "`2.16.840.1.113883.10.20.27.3.1:2020-12-01`". Both the `@root` and `@extension` are required as specified in the IG.

SHALL contain exactly one [1..1] **`templateId`** (CONF:4484-17908) such that it

a. **SHALL** contain exactly one [1..1] **`@root=`**"`2.16.840.1.113883.10.20.27.3.1`" (CONF:4484-17909).

b. **SHALL** contain exactly one [1..1] **`@extension=`**"`2020-12-01`" (CONF:4484-21170).

Correct template versions that are specified by both the base HL7 QRDA III R1 and the 2024 CMS IG must be used for 2024 CMS QRDA III submissions.

5 QRDA Category III Validation

5.1 Document-Level Template: QRDA Category III Report - CMS (V8)

`[ClinicalDocument: identifier urn:hl7ii:2.16.840.1.113883.10.20.27.1.2:2022-12-01 (open)]`

Table 2: QRDA Category III Report - CMS (V8) Contexts

Contained By	Contains
N/A	QRDA Category III Measure Section - CMS (V5) (optional)

This template describes constraints that apply to the QRDA Document Category III Report for CMS Eligible Clinicians Programs including PCF model 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 (V5) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.1.1:2020-12-01)`.
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`**`="2022-12-01"` (CONF:CMS_3).
3. **SHALL** contain exactly one [1..1] **`confidentialityCode`** (CONF:4526-17238_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:4526-17239).
    a. This languageCode **SHALL** contain exactly one [1..1] **`@code`**`="en"` English (CodeSystem: `Language urn:oid:2.16.840.1.113883.6.121`) (CONF:4526-19669_C01).

5.1.1 informationRecipient

The informationRecipient represents the CMS eligible clinicians 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** 2022-12-01 (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="PCF", then ClinicalDocument/participant/@typeCode="LOC" **SHALL** be present (CONF:CMS_99).
      Note: For PCF reporting, PCF APM Entity Identifier must be submitted.
   b. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then QRDA Category III Measure Section – CMS (V5) **SHALL** be present (CONF:CMS_100).
      Note: For PCF reporting, the QRDA III document must contain a quality (eCQMs) section.
   c. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Performance Rate for Proportion Measure – CMS (V4) **SHALL** be present (CONF:CMS_97).
      Note: For PCF reporting, performance rate for a proportion eCQM must be specified.
   d. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then CMS EHR Certification ID **SHALL** be present (CONF:CMS_98).
   e. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Promoting Interoperability Measure Section (V3) **SHALL NOT** be present (CONF:CMS_113).

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**
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
MIPS_APMENTITY	CMS Program	2.16.840.1.113883.3.249.7	MIPS APM Entity
MIPS_APP1_INDIV	CMS Program	2.16.840.1.113883.3.249.7	MIPS APP Individual Reporting
MIPS_APP1_GROUP	CMS Program	2.16.840.1.113883.3.249.7	MIPS APP Group Reporting
MIPS_APP1_APMENTITY	CMS Program	2.16.840.1.113883.3.249.7	MIPS APP APM Entity Reporting
MIPS_SUBGROUP	CMS Program	2.16.840.1.113883.3.249.7	MIPS Subgroup Reporting

Figure 5: informationRecipient Example

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

5.1.2 participant is Location (PCF Practice Site)

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

If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension= "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_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.

iii. 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).

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

v. 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 – PCF Practice Site

```
<participant typeCode="LOC">
  <associatedEntity classCode="SDLOC">
    <id root="2.16.840.1.113883.3.249.5.3" extension="OR1234"
        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 2024 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 Measure Section (V3) `identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.5:2020-12-01)` 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 PCF, all QRDA III files must include a CMS EHR Certification ID. Nulls will not be allowed. Please refer to section 4.1 Primary Care First (PCF) Submissions 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 (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 participant is MVP

Each MIPS individual, group, subgroup, or APM Entity can select one MVP to report. The available MVPs for the 2024 performance period and their identifiers are listed in Table 4.

8. **MAY** contain zero or one [0..1] **`participant`** (CONF:CMS_118) such that it
    a. **SHALL** contain exactly one [1..1] **`@typeCode="`**`TRC`**`"`** tracker (CodeSystem: `HL7ParticipationType urn:oid:2.16.840.1.113883.5.90`) (CONF:CMS_119).
    b. **SHALL** contain exactly one [1..1] **`associatedEntity`** (CONF:CMS_120).
        i. This associatedEntity **SHALL** contain exactly one [1..1] **`@classCode="`**`PROG`**`"`** program eligible (CodeSystem: `HL7RoleClass urn:oid:2.16.840.1.113883.5.110`) (CONF:CMS_121).
        ii. This associatedEntity **SHALL** contain exactly one [1..1] **`id`** (CONF:CMS_122).
            1. This id **SHALL** contain exactly one [1..1] **`@root="`**`2.16.840.1.113883.3.249.5.6`**`"`** MIPS Value Pathway (CONF:CMS_123).
            2. This id **SHALL** contain exactly one [1..1] **`@extension`** (CONF:CMS_124).
            Note: The value of @extension is the MVP identifier.

Table 4: MVP Identifiers for the 2024 Performance Period

Identifier	MIPS Value Pathway (MVP)
M0001	Advancing Cancer Care
M0002	Optimal Care for Kidney Health
M0003	Optimal Care for Patients with Episodic Neurological Conditions
M0004	Supportive Care for Neurodegenerative Conditions
M0005	Value in Primary Care
G0053	Advancing Rheumatology Patient Care
G0054	Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
G0055	Advancing Care for Heart Disease
G0057	Advancing Best Practicies and Promoting Patient Safety with Emergency Medicine
G0058	Improving Care for Lower Extremity Joint Repair
G0059	Patient Safety and Support for Positive Experiences with Anesthesia
M1366	Focusing on Women's Health
M1367	Quality Care for the Treatment of Ear, Nose, and Throat Disorders
M1368	Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
M1369	Quality Care in Mental Health and Substance Use Disorders
M1370	Rehabilitative Support for Musculoskeletal Care

5.1.5 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.

9. **SHALL** contain exactly one [1..1] **`documentationOf`** (CONF:4526-18170_C01).

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

For MIPS subgroup reporting: it must contain exactly one performer, which contains one Subgroup Identifier. 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 APM Entity reporting: it must contain one performer, which contains one APM Entity Identifier. NPI and TIN are not allowed..

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

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

For APP APM Entity reporting: it must contain one performer, which contains one APM Entity Identifier. No NPI is allowed.

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

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

a. This documentationOf **SHALL** contain exactly one [1..1] **`serviceEvent`** (CONF:4526-18171_C01).
    i. This serviceEvent **SHALL** contain at least one [1..*] **`performer`** (CONF:4526-18173).

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 for MIPS individual reporting, APP individual reporting and PCF reporting.

NPI is not allowed for for group reporting, MIPS virtual group reporting, MIPS APM Entity reporting, APP group reporting, and APP APM Entity reporting. This is represented by id/@root='2.16.840.1.113883.4.6' coupled with @nullFlavor="NA", and @extension shall be omitted.

1. Such performers **SHALL** contain exactly one [1..1] **`assignedEntity`** (CONF:4526-18176).
    a. This assignedEntity **SHALL** contain exactly one [1..1] **`id`** (CONF:4526-18177_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, MIPS virtual group reporting, MIPS APM Entity reporting, APP group reporting, and APP APM Entity reporting.
        ii. **SHALL** contain exactly one [1..1] **`@root="`**`2.16.840.1.113883.4.6`**`"`** National Provider ID (CONF:4526-18178_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:4526-18247).
        Note: This is the provider's NPI. It is only present when this is a MIPS individual reporting, APP individual reporting, or PCF reporting. For PCF, only those NPIs that participated in the PCF model during the performance year should be provided.
    b. This assignedEntity **SHALL** contain exactly one [1..1] **`representedOrganization`** (CONF:4526-18180).
        i. This representedOrganization **MAY** contain zero or one [0..1] **`id`** (CONF:4526-18181_C01) such that it

1. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.4.2**"** Tax ID Number (CONF:4526-18182).
   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:4526-18190).
   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. This representedOrganization **MAY** contain zero or one [0..1] **id** (CONF:CMS_106) such that it
1. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.3.249.5.4**"** APM Entity Identifier (CONF:CMS_107).
   Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.4) designates that the @extension must hold an APM Entity identifier.
2. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_108).
   Note: This is the APM Entity identifier.

iv. This representedOrganization **MAY** contain zero or one [0..1] **id** (CONF:CMS_115) such that it
1. **SHALL** contain exactly one [1..1] **@root="**2.16.840.1.113883.3.249.5.5**"** Subgroup (CONF:CMS_116).
   Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.5) designates that the @extension must hold a Subgroup Identifier.
2. **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_117).
   Note: This is the Subgroup identifier.

v. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_GROUP" or

"MIPS_APP1_GROUP", then this representedOrganization **SHALL** contain one [1..1] id such that it, **SHALL** be the group's TIN (CONF:CMS_82).

vi. 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).

vii. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_APMENTITY" or "MIPS_APP1_APMENTITY", then this representedOrganization **SHALL** contain one [1..1] id such that it, **SHALL** be the APM Entity's APM Entity identifier (CONF:CMS_109).

viii. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_INDIV" or "MIPS_APP1_INDIV" or "PCF", then this representedOrganization **SHALL** contain one [1..1] id such that it, **SHALL** be the practitioner's TIN (CONF:CMS_112).

ix. If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_SUBGROUP", then this representedOrganization **SHALL** contain one [1..1] id such that it, **SHALL** be the subgroup's Subgroup Identifier (CONF:CMS_114).

Figure 7: documentationOf Example – TIN and NPI

```
<documentationOf>
  <serviceEvent classCode="PCPR">
    <!-- Multiple performers can be included for PCF,
         each with an NPI and TIN -->
    <performer typeCode="PRF">
      <time>
        <low value="20240101"/>
        <high value="20241231"/>
      </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>
```

5.1.6 component

A CMS QRDA Category III document for the 2024 performance period must contain at least a QRDA Category III Measure Section, an Improvement Activity Section, or a Promoting Interoperability Measure Section.

For the 2024 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.

10. **SHALL** contain exactly one [1..1] **component** (CONF:4526-17217).
    a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:4526-17235).
        i. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:4526-17283) such that it
            1. **SHALL** contain exactly one [1..1] **QRDA Category III Measure Section - CMS (V5)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.3:2022-05-01) (CONF:4526-17301_C01).
        ii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:4526-21173) such that it
            1. **SHALL** contain exactly one [1..1] Improvement Activity Section (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.4:2020-12-01) (CONF:4526-21174).
        iii. This structuredBody **MAY** contain zero or one [0..1] **component** (CONF:4526-21317) such that it

1. **SHALL** contain exactly one [1..1] Promoting Interoperability Measure Section (V3) `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.5: 2022-12-01)` (CONF:4526-21318).

ii. This structuredBody **SHALL** contain at least a QRDA Category III Measure Section - CMS (V5), or an Improvement Activity Section (V3), or a Promoting Interoperability Measure Section (V3) (CONF:4526-21394_C01).

Figure 8: structuredBody Example

```
<component>
  <structuredBody>
    <component>
      <!-- QRDA Category III Measure Section - CMS (V5)-->
      <section>
        ...
        <title>Measure Section</title>
        ...
      </section>
    </component>
    <component>
      <!-- Improvement Activity Section -->
      <section>
        ...
        <title>Measure Section</title>
        ...
      </section>
    </component>
    <component>
      <!-- Promoting Interoperability Measure Section (V3) -->
      <section>
        ...
        <title>Measure Section</title>
        ...
      </section>
    </component>
  </structuredBody>
</component>
```

5.2 Section-Level Templates

5.2.1 QRDA Category III Measure Section - CMS (V5)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.27.2.3:2022-05-01 (open)]`

Table 5: QRDA Category III Measure Section – CMS (V5) Contexts

Contained By	Contains
QRDA Category III Report - CMS (V8) (optional)	Measure Reference and Results - CMS (V5) (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 PCF reporting, this section must contain a Measure Reference and Results template for each eCQM that is being reported on by the PCF practice.

1. Conforms to QRDA Category III Measure Section (V5) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.1:2020-12-01).`
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`**`="2022-05-01"` (CONF:CMS_66).
3. **SHALL** contain at least one [1..*] **`entry`** (CONF:4526-17906_C01) such that it
    a. **SHALL** contain exactly one [1..1] **`Measure Reference and Results - CMS (V5)`** `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.17:2022-05-01)` (CONF:4526-17907_C01).

Figure 9: QRDA III Measure Section – CMS (V5) Example

```
<section>
    <!-- Measure Section template ID -->
    <templateId root="2.16.840.1.113883.10.20.24.2.2" />
    <!-- QRDA Category III Measure Section (V5) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.2.1"
extension="2020-12-01"/>
    <!-- QRDA Category III Measure Section - CMS (V5) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.2.3"
extension="2022-05-01"/>
    <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>2c928085-806c-39a2-0180-7092fa9b0145</td>
                </tr>
            </tbody>
            <list>
            ...
            </list>
        </table>
     </text>
    <entry>
        <!-- Measure Reference and Results - CMS (V5) -->
        <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 6: Measure Data – CMS (V4) Contexts

Contained By	Contains
Measure Reference and Results - CMS (V5) (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 7: 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="F348D767-1BDE-41AB-884D-5F0E19093980">
            <!-- This is the population ID in the eCQM.
                 In this case, the IPOP -->
        </externalObservation>
    </reference>
</observation>
```

5.3.2 Measure Reference and Results - CMS (V5)

```
[organizer: identifier
urn:hl7ii:2.16.840.1.113883.10.20.27.3.17:2022-05-01 (open)]
```

Table 8: Measure Reference and Results - CMS (V5) Contexts

Contained By	Contains
QRDA Category III Measure Section - CMS (V5) (required)	Performance Rate for Proportion Measure - CMS (V4) (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 9: Measure Reference and Results - CMS (V5) Constraints Overview

organizer[templateId/@root = '2.16.840.1.113883.10.20.27.3.17']
[templateId/@extension="2022-05-01"]

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	2022-05-01
component	0..*	MAY		4526-17903_C01	
observation	1..1	SHALL		4526-17904_C01	Performance Rate for Proportion Measure - CMS (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2022-05-01)
component	1..*	SHALL		4526-18425_C01	
observation	1..1	SHALL		4526-18426_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 (V4) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.1:2020-12-01)`.
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`**`="2022-05-01"` (CONF:CMS_56).
3. **MAY** contain zero or more [0..*] **`component`** (CONF:4526-17903_C01) such that it

a. **SHALL** contain exactly one [1..1] **Performance Rate for Proportion Measure - CMS (V4)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2022-05-01) (CONF:4526-17904_C01).

4. **SHALL** contain at least one [1..*] **component** (CONF:4526-18425_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:4526-18426_C01).

Figure 11: Measure Reference and Results - CMS (V5) 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 (V4) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.1"
extension="2020-12-01"/>
    <!-- Measure Reference and Results - CMS (V5) template ID -->
    <templateId root="2.16.840.1.113883.10.20.27.3.17"
extension="2022-05-01"/>
    <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="2c928084-8211-3ece-0182-c771f89f2ff3"/>
            <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 10: 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 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 11: 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 12: 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 (V4)

```
[observation: identifier
urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2022-05-01 (open)]
```

Table 13: Performance Rate for Proportion Measure – CMS (V4) Contexts

Contained By	Contains
Measure Reference and Results – CMS (V5) (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 14: Performance Rate for Proportion Measure - CMS (V4) Constraints Overview

observation[templateId/@root = '2.16.840.1.113883.10.20.27.3.25']
[templateId/@extension="2022-05-01"]

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	2022-05-01
Value	1..1	SHALL	REAL	4526-21307_C01 CMS_62 CMS_63	
Reference	1..1	SHALL		4526-19651_C01	

XPath	Card	Verb	Data Type	CONF#	Value
@typeCode	1..1	SHALL		4526-19652_C01	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalObservation	1..1	SHALL		4526-19653_C01	
@classCode	1..1	SHALL		4526-19654	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass)
Id	1..1	SHALL		4526-19655	
@root	1..1	SHALL		4526-19656	
Code	1..1	SHALL		4526-19657	
@code	1..1	SHALL		4526-19658	NUMER
@codeSystem	1..1	SHALL		4526-21180	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 (V3) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.14:2020-12-01)`.
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`**`="2022-05-01"` (CONF:CMS_61).
3. **SHALL** contain exactly one [1..1] **`value`** with @xsi:type="REAL" (CONF:4526-21307_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:4526-19651_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:4526-19652_C01).
    b. This reference **SHALL** contain exactly one [1..1] **`externalObservation`** (CONF:4526-19653_C01).
        i. This externalObservation **SHALL** contain exactly one [1..1] **`@classCode`** (CodeSystem: `HL7ActClass urn:oid:2.16.840.1.113883.5.6`) (CONF:4526-19654).
        ii. This externalObservation **SHALL** contain exactly one [1..1] **`id`** (CONF:4526-19655).
            1. This id **SHALL** contain exactly one [1..1] **`@root`** (CONF:4526-19656). Note: This is the ID of the numerator in the referenced eCQM.
        iii. This externalObservation **SHALL** contain exactly one [1..1] **`code`** (CONF:4526-19657).

1. This code **SHALL** contain exactly one [1..1] **`@code`**="NUMER" Numerator (CONF:4526-19658).
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:4526-21180).

Figure 13: Performance Rate for Proportion Measure - CMS (V4) 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 (V3) template ID -->
  <templateId root="2.16.840.1.113883.10.20.27.3.14" extension="2020-
12-01"/>
  <!-- Performance Rate for Proportion Measure – CMS (V4)
       template ID -->
  <templateId root="2.16.840.1.113883.10.20.27.3.25" extension="2022-
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="45BBBED1-06A2-4381-837F-95755D2C0D72"/>
       <code code="NUMER" displayName="Numerator"
             codeSystem="2.16.840.1.113883.5.4"
             codeSystemName="ActCode"/>
     </externalObservation>
  </reference>
</observation>
```

6 2024 Performance Period eCQM Specifications for Eligible Clinicians UUID List

The following tables list the Version Specific Measure Identifier for each eCQM included in the 2024 Performance Period eCQM Specifications for 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 15 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 2024 Performance Period eCQM Specifications for Eligible Clinicians are proportion measures.)

Table 15: UUID List for MIPS CY 2024 Performance Period eCQM Specifications Eligible Clinicians

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 134	CMS2v13	2c928083-8651-08a3-0186-c82995a91d28	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	AD83208C-1313-401E-BB62-ABCCE0982B49 696066C7-C558-4849-A325-A3CDDB58CF8F E52F7FAE-96D9-417A-8538-6E3DB4A31D7A E2557B71-1B97-413F-BE26-2B037E4D590B FBA7B9D9-8588-4CB2-AB72-642CBD980334
N/A/ 317	CMS22v12	2c928082-86db-6718-0187-09773acf09d0	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	F071FE72-E624-401F-BEA1-93B16E883386 8A30830D-9606-4AF2-836C-40EC4CF3A4D4 DEBE98FB-5956-4BFD-8EA4-D14B15E53BE1 B9122899-0E15-4BB1-A049-B5038D708AD2 5AC75B0E-E6A1-419E-8F46-1F49755BCC09
N/A/ 374	CMS50v12	2c928084-82ea-d7c5-0183-41af6b41186d	IPOP: DENOM: NUMER:	76338B6C-C26C-4190-BAF1-0AAC5873C7B9 E846226B-FB7D-4B3C-8C3E-EC0FC4509C5F 256DDBEE-BDFA-4BEC-A777-448CFC17938E
N/A/ 376	CMS56v12	2c928084-82ea-d7c5-0183-6bd4e33420bd	IPOP: DENOM: DENEX: NUMER:	AF4C1C0E-79D7-4693-ACB8-6FACDCEEF0D4 60759161-5DB6-4E1B-8D07-32A5561AE0C4 A640731E-3B26-4662-A243-C1BED87544AF AA9FBD3C-49EC-4A9E-BDD5-65F454BC7416
N/A/ 130	CMS68v13	2c928082-86db-6718-0187-0b4977140ad5	IPOP: DENOM: NUMER: DENEXCEP:	018818BA-BAEE-4F63-B345-0ECF647B7580 F0F5F489-3AE0-4128-A3D3-7427B5F333A4 A65C0BE1-19D2-40E5-910D-9B95960C4B6C 294E02A5-FBA5-4863-B215-D25B396C3E79
N/A/ 128	CMS69v12	2c928082-82cb-a3f5-0182-cc6968e30090	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	AA4FB3BF-5710-420F-9A5C-DE12B49C6976 06FBEA08-FCFF-4A81-AD0F-944E3905A8D2 D28BB99A-13F9-4789-9890-0EE2A303E46A 5C891031-333A-4BF2-9EE6-98657DB3D7B0 9D67E64C-4F4E-4A49-B7F9-E4CC25465AE4

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 379	CMS74v13	2c928084-82ea-d7c5-0183-6ba7b54220a8	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2: STRAT 3:	6AEE2ABF-4E94-4EDC-ABF8-E93B14CEFC0B C82B7932-A51A-4282-AD2F-60124341C172 0A8E4FD6-44FF-4442-A51A-9AF66C1EF353 E50E2341-598D-412C-912B-3C837E59D64E A2618003-B48E-4A29-9969-0D928852DF50 15D408C1-92D9-4CB0-AF67-08D1F7B0CDA6 95814C15-5559-4CC6-B358-2F81245AF571
N/A/ 378	CMS75v12	2c928084-82ea-d7c5-0183-6d3507282122	IPOP: DENOM: DENEX: NUMER:	4BA69C4A-51FB-4A29-A0D6-D450DFECD3B6 035785B3-DB35-4CEB-81F3-888AEE341510 9E3A0D44-7413-468D-8AA8-F95836EB45A0 7132A615-8EB6-48E5-9747-2C617C29E2D1
N/A/ 377	CMS90v13	2c928084-8389-524e-0183-c80f9e480dff	IPOP: DENOM: DENEX: NUMER:	FA9EF028-5532-437D-9125-4187BF72E952 3BDFDBDD-CEBF-4C34-8AA7-8D65A324F4B1 CC8028CF-86F0-4930-AB9F-475DA2370A5B 91550F78-0296-4B2A-996C-0B9F51B9FAF3
N/A/ 240	CMS117v12	2c928084-82ea-d7c5-0183-138ff3280ad1	IPOP: DENOM: DENEX: NUMER:	1BF7CD8D-B257-401E-ABF7-252DABA0D209 74892E72-0D00-4391-8577-5C387410C89D 403C825E-43CA-410D-A105-62A9E7058BD0 511390B8-515A-4CA0-B52D-68DBD9ABE83C
N/A/ 001	CMS122v12	2c928084-83d3-1b44-0183-eb75dc8a03db	IPOP: DENOM: DENEX: NUMER:	F09F8D18-F787-46EA-8791-3D3EF50A4C72 66505C6C-AAB0-4232-B0CA-15FB438090F4 6AD9B271-BBB4-4BB6-95B1-D1A7E50D812F 95BCB9D4-86A8-43C1-BE29-7440A2ECE294
N/A/ 309	CMS124v12	2c928084-82ea-d7c5-0183-6bf198d120d0	IPOP: DENOM: DENEX: NUMER:	3AF3235F-EDCA-4EB9-827E-71987F79CDD4 E4C30FAC-4E01-4B7A-9765-427708423275 1C74FAE8-2761-49B9-803B-226477179DB1 98980303-5719-4B0A-89C8-A284E41FD6E7
N/A/ 112	CMS125v12	2c928084-8211-3ece-0182-c771f89f2ff3	IPOP: DENOM: DENEX: NUMER:	43AA0269-D0DC-41E1-AF57-DEC8865CEFB2 AE17C979-C086-4FD0-AD65-6F91B1BA6DB7 7E0603B0-134D-45E7-97AE-C3E1E35EBA05 45BBBED1-06A2-4381-837F-95755D2C0D72
N/A/ 009	CMS128v12	2c928084-83d3-1b44-0183-ec9f5639051f	IPOP 1: DENOM 1: DENEX 1: NUMER 1: IPOP 2: DENOM 2: DENEX 2: NUMER 2:	5C0C2E55-560F-42C1-85E0-2CE36D7F48B4 23702C38-4048-438D-BCFC-5B507AB0E058 3810F33A-CC55-4949-9DE6-0CD5CCF31723 D1230E54-3ED7-4E37-9BD9-14BD987A89CD 7FE1D093-EFE8-4A37-BB62-F54FE320ABD1 2C0FDE5F-C7A5-43A4-9AB2-EF1ED5AF9017 C25C172D-A823-4ADD-AABD-4BF11ABA3928 2707A6AA-72DE-4D68-B619-775D8715A7BE
0389e/ 102	CMS129v13	2c928082-82cb-a3f5-0182-cc6b3d5600b0	IPOP: DENOM: NUMER: DENEXCEP:	8EB5DA27-ADE5-4E8E-8C4F-934F0F8B8C63 36E7BB9E-4573-441A-B684-F680D2AF5022 F57519D7-4AAE-4020-8239-A8C9DE7E59EA C8885C12-E38D-4B28-A2B5-86867AB94660
N/A/ 113	CMS130v12	2c928084-82ea-d7c5-0183-6bf2944520dc	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2:	CE7E7820-62A0-430C-93D4-36F096BC66F1 01CFAAD2-55BE-4F1F-AF0D-58C11583FEFC 6B6E3E45-86AA-4AEC-917D-6A7D5D452513 D01C8F72-6AA1-4DF9-8458-29DE8F10D4FE 0C8CCBC3-BC5D-45AE-9ADD-4AA70859516C 4874EA9D-3E03-4E4D-8605-264136B3A0B7
N/A/ 117	CMS131v12	2c928084-83d3-1b44-0183-eb5b615a038d	IPOP: DENOM: DENEX: NUMER:	122474BF-173C-4993-A45D-E8ACA5FC3D46 3B8410A4-573B-43A5-A739-505204CBF25B 09957F27-2BD4-47FA-AAF4-201FD6F76E90 0BE93516-A3B7-44E5-AAB3-0B2EA25EAE08

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
0565e/ 191	CMS133v12	2c928083-8651-08a3-0186-be2f15911815	IPOP: DENOM: DENEX: NUMER:	160359D2-7F76-4E14-A48F-6A3C26362ADC 33277593-C9A1-4604-AC41-9E924C3ACB88 6A29982C-BF52-4BC1-9DCF-C120B35ED292 8692F7ED-0E83-4A5E-A9A4-F60FF5DA2176
0081e/ 005	CMS135v12	2c928082-86db-6718-0186-ec6666280586	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	3BBD33AA-ACDC-4D08-A22D-2B640B3BAC55 D5EC2146-2734-4AEA-941E-73954FBC0CAC F269B9AD-04EE-4129-9B20-81DD1B1A0FAA 91C32273-EEF9-4557-992A-3C5DA994B1A5 EED321A6-8960-4A3E-84C8-0E9F06919DC2
N/A/ 366	CMS136v13	2c928084-8211-3ece-0182-1de98c500310	IPOP 1: DENOM 1: DENEX 1: NUMER 1: IPOP 2: DENOM 2: DENEX 2: NUMER 2:	9B70E808-0E6B-44FB-AC46-0548A1E409DE 886B4ABD-BEB6-43DC-90AE-C529F5E07B47 00B7D640-5DD7-41D1-BF47-B95A2C19B6D7 FD0D1365-F405-4A66-9B7A-2ABE64033E8A 72606B57-2F1C-40B4-9655-F691A594A611 F6EA0497-C79C-4722-838F-528A8635F1BE CD78A07D-8D5B-4E22-B05E-9A569B2FC375 0DFDC593-66E3-4532-9F27-6C5C6C947EE5
N/A/ 305	CMS137v12	2c928084-82ea-d7c5-0182-ec98d1c20129	IPOP 1: DENOM 1: DENEX 1: NUMER 1: STRAT 1-1: STRAT 1-2: STRAT 1-3: IPOP 2: DENOM 2: DENEX 2: NUMER 2: STRAT 2-1: STRAT 2-2: STRAT 2-3:	703CE63C-957D-4214-AAEF-6DE14AE91E80 CBB623A8-C906-4712-983B-A532F984C2E9 A6BAB6F7-FEB7-465E-8669-B48C2A05A003 D2C1C13B-097B-4210-922F-7AAE70F50F46 404DA201-FD78-41DF-89F8-57E135602098 C8C9D5C1-4D6D-4F11-BA18-09645919EE7E BB3F8E59-845E-4D0A-BEE2-30D270EAC5CD 6492A3E6-D8C8-40A1-B280-909DB3436D1E 1F384AE6-DC33-4464-A743-D883C75BDCE9 353DB0FA-5117-40DD-A989-8FA220D184BC 3C89FB2F-3335-4384-8F25-FB58A1B00AE3 E96FDC2B-1E60-41FE-A93D-ED20407BFDB5 54B42C7D-4F4D-4F6B-BCB8-920B974DFC9C 6834216F-BB45-4BFE-B326-5D710D33E041
0028e/ 226	CMS138v12	2c928084-82ea-d7c5-0183-14b6afcb0cc9	IPOP1: DENOM1: DENEX1: NUMER1: IPOP2: DENOM2: DENEX2: NUMER2: IPOP3: DENOM3: DENEX3: NUMER3:	8B63E323-F12A-4174-9EB2-FB64A7285C99 1AF6FBFC-F6BA-4042-BA31-66127FE4CA0A 07496BE4-AE52-47FA-8076-337EB1FB8307 718DDAB1-A99D-40B2-9F33-DB0AA5D464A7 F65684D1-43BD-440C-AF43-93F592672854 26CCD818-574C-4325-9BA8-3992BAB67070 076BA627-E3B6-40C8-ABA8-9FDE6FF11070 EB24BBAB-E314-4A42-8329-E559D0AADAA6 9434749C-2953-46FF-9C2F-393DDAA96365 7461BAC8-F77B-44BF-ADE6-ED9F599CF3FB 5BC836CA-2EC0-417B-8D55-182CEF941994 FAAEB19D-EE61-4F58-970C-933F47B38E34
N/A/ 318	CMS139v12	2c928084-83d3-1b44-0183-eca0b20c052a	IPOP: DENOM: DENEX: NUMER:	37671229-ED87-4DA8-A6AC-6F582490677B 34FE0E39-10FD-4FDE-8153-AA2BA305B932 88313CAE-FC20-4EA6-9375-0F5CB0106E63 BA0D192C-510B-4426-AA90-0835DF0F5F91
N/A/ 019	CMS142v12	2c928084-83d3-1b44-0183-e7a92aa602f4	IPOP: DENOM: NUMER: DENEXCEP:	638B2963-BA05-46A1-8B77-3048996550D5 4F2B95F6-6C7C-4F94-B179-F287728137B5 C4A0619A-6D14-4730-9962-709A3A1C5115 8EF9060A-EA84-4161-A32F-24A93D72D49C

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
0086e/ 012	CMS143v12	2c928082-853a-caf8-0185-f403c54b1a15	IPOP: DENOM: NUMER: DENEXCEP:	42ED6272-F01E-4EED-A790-390F3EEE3062 8BACF708-E10D-4614-8614-C2A5E97884D6 50A864CE-3A7A-41CE-93D5-DA29517AF2F5 804B8FB4-9462-4A13-91B5-9B9FFED6EF99
0083e/ 008	CMS144v12	2c928084-82ea-d7c5-0183-65e9c0061ec1	IPOP: DENOM: DENEX: NUMER: DENEXCEP:	BC5D30AA-8AA4-4BA6-9FBE-B52D47CAF292 F2435FA0-0AF1-4A64-BB27-4E7ED13F387B C7CFF7D2-0A86-4FB1-BBA7-2A91E65262C8 D997534A-AF2A-4AEE-9EFC-358EB0273EDB A3ED0DA1-60C2-4D42-BF86-EDEF350CD369
0070e/ 007	CMS145v12	2c928084-82ea-d7c5-0183-622192411e05	IPOP 1: DENOM 1: NUMER 1: DENEXCEP 1: IPOP 2: DENOM 2: NUMER 2: DENEXCEP 2:	2E452C4A-C782-4373-AB54-646521DCDDEE 901D3C9A-DB42-4A92-9E78-2693F6EEDA99 DBA0383C-B6EE-4ACC-A44F-9A11E0C4C33F 223FC84C-A50A-4460-92B5-3808D89FF2C9 F0F58CC7-7DC0-4BC2-AD55-4B92696A4501 C0A53EC4-5324-4C8B-B7E1-BA52F9D3D10C A3DAC3E6-BAAF-4A42-89E6-8AC8FAA71E68 4315CAB0-73F3-4756-A9F2-DDADD376D77E
N/A/ 066	CMS146v12	2c928084-8389-524e-0183-cd90c213122b	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2: STRAT 3:	3CB297BD-CF52-44ED-85C1-F2D22C338BF3 B9860D63-1954-4AAD-A6BC-7A3996B1914B AA5B2690-F5A3-440F-84B6-F7306C9C7467 3A230D4E-2D2A-44C4-8693-140BD8752334 1CAE8E7A-0C61-4722-B5B5-687DF40EFC03 2994AE5B-A5A1-406A-ACF6-D5311EB83C78 4AF11413-C7B5-4206-A521-32CB21DB3350
2872e/ 281	CMS149v12	2c928082-86db-6718-0186-ec153eff0520	IPOP: DENOM: NUMER: DENEXCEP:	673EA403-B47A-4D1B-AC0E-21433ECB2F6F 0560F410-479D-4AAC-8637-C60A33BD9EBA A0400F83-1D8C-4EAE-8477-970F25C28916 ECB48742-57C1-44DA-9EAF-14FC0BC55F9B
N/A/ 310	CMS153v12	2c928084-82ea-d7c5-0183-6bf2f90320e6	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2:	34EA6AAA-3940-444F-AF54-40F61808E3A7 C74AE380-0593-4D95-BFD6-D71D3AF4AC8D C5EEC624-E6B5-4197-BF65-A932BC9D7CEA 8113EBC1-FE78-4EEF-BD38-5A7EF93EF90F E85ECBA1-7955-4EB8-B520-70A2F3B78986 47C21B1E-D2B7-4348-847E-9B055959943E
N/A/ 065	CMS154v12	2c928084-8389-524e-0183-c8d7a6700f02	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2: STRAT 3:	83DB196F-463B-4E77-ABC4-7B38F0C60D36 766AC88F-A02D-42E1-B34C-7BFB2874A824 8DABD0C9-3DE6-4221-9F84-0E2EB872075F EE960FF9-ED6B-49E8-A1CC-D0C93513355B 79520F15-07EF-4D9C-BA96-080F356FF328 B5624EA1-BB69-4366-B65F-2192D2BB7BA7 C4096D01-6428-4021-8E72-AE255C8874BE

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
N/A/ 239	CMS155v12	2c928084-83d3-1b44-0184-62ae126a1f0f	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:	9167639A-D698-40C4-9C15-2EB0EFD3A78C 6B3A0F3B-7918-4C92-9554-4CE8BD22D85A A212CB41-A5DE-4B48-BF10-9D8A5998C777 4044128B-08AC-4F62-9B34-DC2D8C5BCF75 B4B0199B-F81B-4229-B889-A8C00C5CF228 E3789DE5-4844-4EC0-BD57-312F5BA20396 989F58BC-AA7D-4B84-A65D-733B2BC91988 D75CAE28-A482-4365-8710-D18E03F20009 17E77543-B68D-48E2-98DE-CA35F6984CB4 5405AB82-FB25-4751-A79B-6B9118D38721 10030198-C714-417E-9177-534F9D1AD8C6 DF3D6375-C0BC-47A6-8E15-D8074AD8542C 18A31343-FDAD-46BF-8E7B-F3EC2A3A5A24 2D2DD45E-43A8-494D-AFBA-EB888DC127D1 5D515304-DA28-4F12-8F36-DF1ED7C640FA 4A2A1F08-2CB8-494B-BC02-1773CBB9D820 A8B7DA4C-2284-4964-B263-7B2442DE8821 CD8CA782-C9E1-475E-B3BB-CA2E1604684C
N/A/ 238	CMS156v12	2c928084-82ea-d7c5-0183-6293dcff1e19	IPOP 1: DENOM 1: DENEX 1: NUMER 1: IPOP 2: DENOM 2: DENEX 2: NUMER 2: IPOP 3: DENOM 3: DENEX 3: NUMER 3:	1D3F49A0-F7A0-4E55-B953-DB944A082814 4960C71F-4317-4A3A-85FF-A0144EEFCBE5 DA1FD97B-4CD9-4BFD-9DEA-60146DCACF2D 6CC7B742-D134-49C1-95B9-35CA2E96D754 07BFBC59-A849-4BA4-8998-9C7876573D4E D17677FA-08EB-4729-B22D-33874A21216F 8EF5897B-E8CD-46AB-B5E3-5E543E3A47FC 3ED7845E-19B0-476B-9650-D439EB4E5900 3233FCCF-FA30-41B3-8A3D-13B0E3F2FC97 4323442F-0C78-4BE2-B2D8-982A5BD89A4F BAB26534-B8DA-415B-8AC6-7C87CC4BCDA9 6300B4BC-C38E-41D4-A904-1D9D76964F98
0384e/ 143	CMS157v12	2c928084-8389-524e-0183-d1b67f3a1388	IPOP1: DENOM1: NUMER1: IPOP2: DENOM2: NUMER2:	0271EF2B-26A3-4672-A697-F227D294C5E8 E0C4BF62-6A49-4CFF-A215-49C1E1D966F1 DF2CFD3B-1B2E-45C0-A2C3-F048317ECCE6 05739862-79A6-4DEC-BD34-0ADE00ED65A8 5E21A436-94F8-47BD-BD09-C1F94F1C347D 81010375-6D7E-42D3-89F7-9FD33A231FD8
0710e/ 370	CMS159v12	2c928082-86db-6718-0187-0ad80afa0a7e	IPOP: DENOM: DENEX: NUMER: STRAT 1: STRAT 2:	E4E92400-0CE1-403C-818D-EF5C25A952AA 4B7B1714-FE42-40EB-A652-7C077636A8BF 4539BAD0-93C8-4606-B167-91086446F8D8 8A5DE292-E5E6-45CE-99C6-22E6F8E688E4 16B03548-4E23-4D9B-B1C6-F7D3DC6F1727 B44C46D8-64D6-405B-8283-981CDC1D6E5E
N/A/ 236	CMS165v12	2c928085-806c-39a2-0180-7092fa9b0145	IPOP: DENOM: DENEX: NUMER:	F348D767-1BDE-41AB-884D-5F0E19093980 3E0D40B3-64FC-4998-B371-34978D033116 95E1480E-8B61-4777-865D-B2A1D6525E1A 24803F44-C643-45C7-A2A5-4C58BD540579
1365e/ 382	CMS177v12	2c928084-82ea-d7c5-0182-ff64c38d094f	IPOP: DENOM: NUMER:	2A6F66CE-9C98-471E-93C7-5C8A67261CDD 913060C1-BAAB-456E-99C5-A6B9662CC06E 9C5E92E5-D8B5-4DC9-9021-195E264FB2E0

NQF/ Quality #	eCQM CMS #	Version Specific Measure ID	Population ID	
3475e/ 472	CMS249v6	2c928084-82ea-d7c5-0183-204c9a0c1112	IPOP: DENOM: DENEX: NUMER: NUMEX:	CBBBA0E8-63BC-4E0F-BFA4-A28A95C1527D EEEAFBC3-AAFB-417C-81BD-9034CFE7F5E1 F5F72298-D99A-4669-A1C1-F6851CCE3303 769B6087-B19F-4FE1-88C8-C4519D1A6674 06BE45AA-51B5-4E8E-BDBF-4C0E68E7B5CC
N/A/	CMS314v1	2c928082-86db-6718-0187-03d1acee0811	IPOP: DENOM: NUMER:	F8EEABA6-5F4A-435A-B0A5-25BB3D24205D 1633252F-B022-4E7D-8DDB-3D439A18AEE2 3723189C-3247-428F-AF1E-D2E510D0A9DB
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7 Measure Identifiers

For all CMS eligible clinicians 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 16: Improvement Activities Identifiers for the MIPS CY 2024 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 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 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	Create and implement a standardized process for providing telehealth services to expand access to care.	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
Create and Implement a Language Access Plan	Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).	IA_EPA_6

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 Health and Health Care Inequities Across Communities	Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety.	IA_PM_6
Regular Review Practices in Place on Targeted Patient Population Needs	Implement regular reviews of targeted patient population needs, such as structured clinical case reviews, which include access to reports that show unique characteristics of MIPS eligible clinician's patient population, identification of underserved 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. The review should consider how structural inequities, such as racism, are influencing patterns of care and consider changes to acknowledge and address them. Reviews should stratify patient data by demographic characteristics and health related social needs to appropriately identify differences among unique populations and assess the drivers of gaps and disparities and identify interventions appropriate for the needs of the sub-populations.	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

Activity Name	Activity Description	Activity ID
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
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
Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services	Establish policies and procedures to improve practice capacity to increase HIV prevention screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake. Use one or more of the following activities: • Implement electronic health record (EHR) prompts or clinical decision support tools to increase appropriate HIV prevention screening; • Require that providers and designated clinical staff take part in at least one educational opportunity that includes components on the importance and application of HIV prevention screening and PrEP initiation in clinical practice; and/or • Assess and refine current policies for HIV prevention screening, including integrated sexually transmitted infection (STI)/HIV testing processes, universal HIV screening, and PrEP initiation.	IA_PM_22
Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines	Incorporate the Cervical Cancer Screening and Management (CCSM) Clinical Decision Support (CDS) tool within the electronic health record (EHR) system to provide clinicians with ready access to and assisted interpretation of the most up-to-date clinical practice guidelines in CCSM to ensure adequate screening, timely follow-up, and optimal patient care. The CCSM CDS helps ensure that patient populations receive adequate screening and management, according to evidence-based recommendations in the United States Preventive Services Task Force (USPSTF) screening and American Society for Colposcopy and Cervical Pathology (ASCCP) management guidelines for cervical cancer. The CCSM CDS integrates into the clinical workflow a clinician-facing	IA_PM_23

Activity Name	Activity Description	Activity ID
	dashboard to support the clinician's awareness and adoption of and preventive care for cervical cancer, including screening and any necessary follow-up treatment. The CCSM CDS is fully conformant with the HL7 Fast Healthcare Interoperability Resources (FHIR) standard, so it can be used with any Office of the National Coordinator for Health Information Technology (ONC) certified EHR platform. The CDS Hooks and SMART-on-FHIR interoperability interface standards provide two ways to integrate with the clinical workflow in a way that complements existing displays and information pre-visit, during visit, and for post-visit follow-up. CCSM CDS helps the clinician evaluate the patient's clinical data against existing guidance and displays patient-specific recommendations.	
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
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

Activity Name	Activity Description	Activity ID
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 to Align with OpenNotes Principles	Adherence to the principles described in the OpenNotes initiative (https://www.opennotes.org) to ensure that patients have full access to their patient information to guide patient care.	IA_CC_13
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: • 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.	IA_CC_15
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

Activity Name	Activity Description	Activity ID
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	To improve patient access, perform activities beyond routine care that enable capture of patient reported outcomes (for example, related to functional status, symptoms and symptom burden, health behaviors, or patient experience) or patient activation measures (that is, measures of patient involvement in their care) through use of certified electronic health record technology, and record these outcomes data for clinician 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 hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.	IA_BE_4
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
Regularly Assess Patient Experience of Care and Follow Up on Findings	Collect and follow up on patient experience and satisfaction data. This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans. To fulfill the requirements of this activity, MIPS eligible clinicians can use surveys (e.g., Consumer Assessment of Healthcare Providers and Systems Survey), advisory councils, or other mechanisms. MIPS eligible clinicians may consider implementing patient surveys in multiple languages, based on the needs of their patient population.	IA_BE_6
Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	IA_BE_12
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	IA_BE_14

Activity Name	Activity Description	Activity ID
	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.	
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
Promote Self-management in Usual Care	To help patients self-manage their care, incorporate culturally and linguistically tailored evidence-based techniques for promoting self-management into usual care, and provide patients with tools and resources for self-management. Examples of evidence-based techniques to use in usual care include: goal setting with structured follow-up, Teach-back methods, action planning, assessment of need for self-management (for example, the Patient Activation Measure), and motivational interviewing. Examples of tools and resources to provide patients directly or through community organizations include: peer-led support for self-management, condition-specific chronic disease or substance use disorder self-management programs, and self-management materials.	IA_BE_16
Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	IA_BE_19
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
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

Activity Name	Activity Description	Activity ID
Drug Cost Transparency	Provide counseling to patients and/or their caregivers regarding: costs of medications using 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.	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
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
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 health efforts, like 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 drivers of health, such as food security, housing stability, and transportation accessibility; • Generation and use of regular feedback reports that summarize local practice patterns and treatment outcomes, including for populations that are disadvantaged and/or underserved by the healthcare system;	IA_PSPA_7

Activity Name	Activity Description	Activity ID
	• Use of processes and tools that engage patients to improve adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision-making capabilities; • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement; • Promotion of collaborative learning network opportunities that are interactive; • 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 of adverse outcomes after an outpatient surgical procedure and corrective steps to address these outcomes.	
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
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

Activity Name	Activity Description	Activity ID
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 decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools —and standardized treatment protocols to manage workflow on the care team to meet patient needs.	Use decision support—ideally platform-agnostic, interoperable clinical decision support (CDS) tools—and standardized treatment protocols to manage workflow on the care team to meet patient needs. Clinicians should focus on utilizing open-source, freely available, interoperable CDS in completing the requirements of this activity.	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; and/or • Use relevant data sources to create benchmarks and goals for performance at the practice or panel levels. • MIPS eligible clinicians can apply the measurement and quality improvement to address inequities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities.	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, including leadership,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
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
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

Activity Name	Activity Description	Activity ID
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
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

Activity Name	Activity Description	Activity ID
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
Application of CDC's Training for Healthcare Providers on Lyme Disease	Apply the Centers for Disease Control and Prevention's (CDC) Training for Healthcare Providers on Lyme Disease using clinical decision support (CDS). CDS for Lyme disease should be built directly into the clinician workflow and support decision making for 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_33
Enhance Engagement of Medicaid and Other Underserved Populations	To improve responsiveness of care for Medicaid and other underserved patients: use time-to-treat data (i.e., data measuring the time between clinician identifying a need for an appointment and the patient having a scheduled appointment) to identify patterns by which care or engagement with Medicaid patients or other groups of underserved patients has not achieved standard practice guidelines; and with this information, create, implement, and monitor an approach for improvement. This approach may include screening for patient barriers to treatment, especially transportation barriers, and providing resources to improve engagement (e.g., state Medicaid non-emergency medical transportation benefit).	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 Community-Based Participatory Research (CBPR)	Lead clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research, or processes that focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Research could include addressing health-related social needs like food insecurity, housing insecurity, transportation barriers, utility needs, and interpersonal safety.	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
Create and Implement an Anti-Racism Plan	Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one. The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization's plan to prevent and address racism and/or improve language access and accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.	IA_AHE_8
Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols	Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.) Actions to implement this improvement activity may include, but are not limited to, the following: • Use Malnutrition Quality Improvement Initiative (MQii) or other quality improvement resources and standardized screening tools to assess and improve current food insecurity and nutritional screening and care practices. • Update and use clinical decision support tools within the MIPS eligible clinician's electronic medical record to align with the new food insecurity and nutrition risk protocols. • Update and apply requirements for staff training on food security and nutrition.	IA_AHE_9

Activity Name	Activity Description	Activity ID
	• Update and provide resources and referral lists, and/or engage with community partners to facilitate referrals for patients who are identified as at risk for food insecurity or poor nutritional status during screening. Activities must be focused on patients at greatest risk for food insecurity and/or malnutrition—for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility.	
Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data	Use security labeling services available in certified Health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation. Certification criteria for security tags may be found in the ONC Health IT Certification Program at 45 CFR 170.315(b)(7) and (b)(8).	IA_AHE_10
Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients	Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories.	IA_AHE_11
Practice Improvements that Engage Community Resources to Address Drivers of Health	Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following: • Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or • Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers of health; or • Record findings of screening and follow up within the electronic health record (EHR); identify screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources. Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.	IA_AHE_12
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
Implementation of a Personal Protective Equipment (PPE) Plan	Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients. In accordance with guidance from the Centers for Disease Control and Prevention (CDC) the PPE plan should address: • Conventional capacity: PPE controls that should be implemented in general infection prevention and control plans in healthcare settings, including training in proper PPE use. • Contingency capacity: actions that may be used temporarily during periods of expected PPE shortages. • Crisis capacity: strategies that may need to be considered during periods of known PPE shortages. The PPE plan should address all of the following types of PPE: • Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment) • Eye protection • Gowns (including coveralls or aprons) • Gloves • Facemasks • Respirators (including N95 respirators)	IA_ERP_4

Activity Name	Activity Description	Activity ID
Implementation of a Laboratory Preparedness Plan	Develop, implement, update, and maintain a preparedness plan for a laboratory intended to support continued or expanded patient care during COVID-19 or another public health emergency. The plan should address how the laboratory would maintain or expand patient access to health care services to improve beneficiary health outcomes and reduce healthcare disparities. For laboratories without a preparedness plan, MIPS eligible clinicians would meet with stakeholders, record minutes, and document a preparedness plan, as needed. The laboratory must then implement the steps identified in the plan and maintain them. For laboratories with existing preparedness plans, MIPS eligible clinicians should review, revise, or update the plan as necessary to meet the needs of the current PHE, implement new procedures, and maintain the plan. Maintenance of the plan in this activity could include additional hazard assessments, drills, training, and/or developing checklists to facilitate execution of the plan. Participation in debriefings to evaluate the effectiveness of plans are additional examples of engagement in this activity.	IA_ERP_5
COVID-19 Vaccine Achievement for Practice Staff	Demonstrate that the MIPS eligible clinician's practice has maintained or achieved a rate of 100% of office staff staying up to date with COVID vaccines according to the Center for Disease Control and Prevention (https://web.archive.org/web/20220630004435/https:/www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html). Please note that those who are determined to have a medical contraindication specified by CDC recommendations are excluded from this activity.	IA_ERP_6
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 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;	IA_BMH_7

Activity Name	Activity Description	Activity ID
	• 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.	
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
Implementation of a Trauma-Informed Care (TIC) Approach to Clinical Practice	Create and implement a plan for trauma-informed care (TIC) that recognizes the potential impact of trauma experiences on patients and takes steps to mitigate the effects of adverse events in order to avoid re-traumatizing or triggering past trauma. Actions in this plan may include, but are not limited to, the following: • Incorporate trauma-informed training into new employee orientation • Offer annual refreshers and/or trainings for all staff • Recommend and supply TIC materials to third party partners, including care management companies and billing services • Identify patients using a screening methodology • Flag charts for patients with one or more adverse events that might have caused trauma • Use ICD-10 diagnosis codes for adverse events when appropriate TIC is a strengths-based healthcare delivery approach that emphasizes physical, psychological, and emotional safety for both trauma survivors and their providers. Core components of a TIC approach are: awareness of the prevalence of trauma; understanding of the impact of past trauma on services utilization and engagement; and a commitment and plan to incorporate that understanding into training, policy, procedure, and practice.	IA_BMH_11
Promoting Clinician Well-Being	Develop and implement programs to support clinician well-being and resilience—for example, through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being—using one of the following approaches: • Completion of clinician survey on clinician well-being with subsequent implementation of an improvement plan based on the results of the survey. • Completion of training regarding clinician well-being with subsequent implementation of a plan for improvement.	IA_BMH_12
Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant	Screen for perinatal mood and anxiety disorders (PMADs) and substance use disorder (SUD) in pregnant and postpartum women, and screen and refer to treatment and/or refer to appropriate social services, and document this in patient care plans.	IA_BMH_14

Activity Name	Activity Description	Activity ID
and Postpartum Women		
Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults	Complete age-appropriate screening for mental health and substance use in older adults, as well as screening and referral to treatment and/or referral to appropriate social services, and document this in patient care plans.	IA_BMH_15
Practice-Wide Quality Improvement in MIPS Value Pathways	Create a quality improvement initiative within your practice and create a culture in which all staff actively participates. Clinicians must be participating in MIPS Value Pathways (MVPs) to attest to this activity. Create a quality improvement plan that involves a minimum of three of the measures within a specific MVP and that is characterized by the following: • Train all staff in quality improvement methods, particularly as related to other quality initiatives currently underway in the practice; • Promote transparency and accelerate improvement by sharing practice-level and panel-level quality of care and patient experience and utilization data with staff; • Integrate practice change/quality improvement into all staff duties, including communication and education regarding all current quality initiatives; • Designate regular team meetings to review data and plan improvement cycles with defined, iterative goals as appropriate; or • Promote transparency and engage patients and families by sharing practice-level quality of care and patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data. Optional activities related to this activity (but do not count towards completion of this IA) include the following: • Creation of specific plans for recognition of individual or groups of clinicians and staff when they meet certain practice-defined quality goals. Examples include recognition for achieving success in measure reporting and/or a high level of effort directed to quality improvement and practice standardization; and • Participation in the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	IA_MVP
Electronic submission of Patient Centered Medical Home accreditation	N/A	IA_PCMH

Table 17: Promoting Interoperability Objectives and Measures Identifiers for the MIPS CY 2024 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

Objective	Measure Identifier	Measure	Reporting Metric
	PI_EP_2_EX_1	*PDMP Exclusion	boolean
	PI_EP_2_EX_2	*PDMP Exclusion	boolean
	PI_EP_2_EX_3	*PDMP Exclusion	boolean
Health Information Exchange	PI_HIE_1	Support Electronic Referral Loops By Sending Health Information	proportion
	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 Reconciling Health Information	boolean
	PI_HIE_5	Health Information Exchange (HIE) Bi-Directional Exchange	boolean
	PI_HIE_6	Enabling Exchange under TEFCA	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_PRE	Pre-production and Validation	boolean
	PI_PHCDRR_1_PROD	Validated Data Production	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_PRE	Pre-production and Validation	boolean
	PI_PHCDRR_2_PROD	Validated Data Production	boolean
	PI_PHCDRR_3	Electronic Case Reporting	boolean
	PI_PHCDRR_3_PRE	Pre-production and Validation	boolean
	PI_PHCDRR_3_PROD	Validated Data Production	boolean
	PI_PHCDRR_3_EX_1	*Electronic Case Reporting Exclusion	boolean
	PI_PHCDRR_3_EX_2	*Electronic Case Reporting Exclusion	boolean

Objective	Measure Identifier	Measure	Reporting Metric
	PI_PHCDRR_3_EX_3	*Electronic Case Reporting Exclusion	boolean
	PI_PHCDRR_4	Public Health Registry Reporting	boolean
	PI_PHCDRR_4_PRE	Pre-production and Validation	boolean
	PI_PHCDRR_4_PROD	Validated Data Production	boolean
	PI_PHCDRR_5	Clinical Data Registry Reporting	boolean
	PI_PHCDRR_5_PRE	Pre-production and Validation	boolean
	PI_PHCDRR_5_PROD	Validated Data Production	boolean

* Indicates a Measure Exclusion.

Note that for the Public Health and Clinical Data Exchange objective, PI_PHCDRR_1 and PI_PHCDRR_3 are both required. Public Health and Clinical Data Exchange measures also must submit level of active engagement by indicating them as either “Pre-production and Validation” or “Validated Data Production”.

Table 18: Promoting Interoperability Attestation Statements Identifiers

Identifier	Attestation Statement	Reporting Metric
PI_INFBLO_1	Actions to limit or restrict the compatibility or interoperability of CEHRT attestation (Required)	boolean
PI_PPHI_1	Security Risk Analysis (Required)	boolean
PI_PPHI_2	Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) (required)	boolean
PI_ONCDIR_1	ONC Direct Review Attestation (required)	boolean

APPENDIX

8 Troubleshooting and Support

8.1 Resources

The following provide additional information:

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 19: Support Contact Information

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

8.3 Errata or Enhancement Requests

Table 20: Errata or Enhancement Request Location

Contact	Organization	URL	Purpose
HL7 Jira Tracker	HL7	https://jira.hl7.org	Document errors or enhancement request to the HL7 standard. Create a Jira tracker by selecting project "CDA Specification Feedback" and specification "Quality Reporting Document Architecture Category III)".

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 21: 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 22: NPI Validation Rules and Table 23: TIN Validation Rules list the validation rules performed on the NPI and TIN.

Table 22: 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 23: 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 – 2024 CMS QRDA III Implementation Guide Changes to QRDA III Release 1 Base Standard

This table lists all changes made to this 2024 guide from the "Base Standard", the *HL7 CDA R2 Implementation Guide: Quality Reporting Document Architecture(QRDA III), Release 1 – US Realm.*

Table 24: 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="2022-12-01" (CONF:CMS_3).
4526-17238_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:4484-17238).	SHALL contain exactly one [1..1] confidentialityCode (CONF:4526-17238_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).
4526-19669_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:4484-19669).	This languageCode SHALL contain exactly one [1..1] @code="en" English (CodeSystem: Language urn:oid:2.16.840.1.113883.6.121) (CONF:4526-19669_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 2022-12-01 (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_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 (V5) 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 (V4) 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).

CONF. #	Section	Base Standard	Changed To
CMS_113	5.1.1	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="PCF", then Promoting Interoperability Measure Section (V3) SHALL NOT be present (CONF:CMS_113).
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).
CMS_101 CMS_102 CMS_103	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.
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).

CONF. #	Section	Base Standard	Changed To
CMS_25	5.1.2	n/a	This associatedEntity SHALL contain exactly one [1..1] addr (CONF:CMS_25).
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.

CONF. #	Section	Base Standard	Changed To
CMS_118 CMS_119 CMS_120 CMS_121 CMS_122 CMS_123 CMS_124	5.1.4	n/a	Each MIPS individual, group, subgroup, or APM Entity can select one MVP to report. The available MVPs for the 2024 performance period and their identifiers are listed in Table 4. MAY contain zero or one [0..1] participant (CONF:CMS_118) such that it SHALL contain exactly one [1..1] @typeCode="TRC" tracker (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90) (CONF:CMS_119). SHALL contain exactly one [1..1] associatedEntity (CONF:CMS_120). This associatedEntity SHALL contain exactly one [1..1] @classCode="PROG" program eligible (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.110) (CONF:CMS_121). This associatedEntity SHALL contain exactly one [1..1] id (CONF:CMS_122). This id SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.249.5.6" MIPS Value Pathway (CONF:CMS_123). This id SHALL contain exactly one [1..1] @extension (CONF:CMS_124). Note: The value of @extension is the MVP identifier.
4526-18170_C01	5.1.5	MAY contain zero or one [0..1] documentationOf (CONF: 4484-18170).	SHALL contain exactly one [1..1] documentationOf (CONF:4526-18170_C01).

CONF. #	Section	Base Standard	Changed To
4526-18171_C01	5.1.5	The documentationOf, if present, SHALL contain exactly one [1..1] serviceEvent (CONF:4484-18171).	For MIPS group reporting: it must contain exactly one performer, which contains one TIN. No NPI is allowed. For MIPS subgroup reporting: it must contain exactly one performer, which contains one Subgroup Identifier. 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 APM Entity reporting: it must contain one performer, which contains one APM Entity Identifier. NPI and TIN are not allowed. For MIPS individual reporting: it must contain exactly one performer, which contains one TIN and one NPI. For PCF: it must contain at least one performer, each performer contains one TIN and one NPI. Only PCF Practice Site providers are listed as performers. This documentationOf SHALL contain exactly one [1..1] serviceEvent (CONF:4526-18171_C01). This serviceEvent SHALL contain at least one [1..*] performer (CONF:4526-18173).
4526-18177_C01	5.1.5	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:4484-18177) 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 for MIPS individual reporting, APP individual reporting, and PCF reporting. NPI is not allowed for for group reporting, MIPS virtual group reporting, MIPS APM Entity reporting, APP group reporting, and APP APM Entity reporting. This is represented by id/@root='2.16.840.1.113883.4.6' coupled with @nullFlavor="NA", and @extension shall be omitted. This assignedEntity SHALL contain exactly one [1..1] id (CONF:4526-18177_C01) such that it

CONF. #	Section	Base Standard	Changed To
CMS_29	5.1.5	n/a	MAY contain zero or one [0..1] @nullFlavor="NA" (CONF:CMS_29). Note: @nullFlavor is only present for MIPS group reporting, MIPS virtual group reporting, MIPS APM Entity reporting, APP group reporting, and APP APM Entity reporting.
4526-18178_C01	5.1.5	MAY contain zero or one [0..1] @root="2.16.840.1.113883.4.6" National Provider ID (CONF:4484-18178).	SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.6" National Provider ID (CONF:4526-18178_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:4526-18247). Note: This is the provider's NPI. It is only present when this is a MIPS individual reporting, APP individual reporting, or PCF reporting. For PCF, only those NPIs that are participating in the PCF model should be provided.
4526-18181_C01	5.1.5	This representedOrganization MAY contain zero or one [0..1] id (CONF:4484-18181) such that it	This representedOrganization SHOULD contain zero or one [0..1] id (CONF:4526-18181_C01) such that it
CMS_79 CMS_80 CMS_81	5.1.5	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	5.1.5	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_GROUP" or "MIPS_APP1_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	5.1.5	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).
CMS_106 CMS_107 CMS_108	5.1.5	n/a	This representedOrganization MAY contain zero or one [0..1] id (CONF:CMS_106) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.249.5.4" APM Entity Identifier (CONF:CMS_107). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.4) designates that the @extension must hold an APM Entity identifier. SHALL contain exactly one [1..1] @extension (CONF:CMS_108). Note: This is the APM Entity identifier.
CMS_115 CMS_116 CMS_117	5.1.5	n/a	This representedOrganization MAY contain zero or one [0..1] id (CONF:CMS_115) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.249.5.5" Subgroup (CONF:CMS_116). Note: This OID contained in the @root (2.16.840.1.113883.3.249.5.5) designates that the @extension must hold a Subgroup Identifier. SHALL contain exactly one [1..1] @extension (CONF:CMS_117). Note: This is the Subgroup identifier.
CMS_109	5.1.5	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_APMENTITY" or "MIPS_APP1_APMENTITY", then this representedOrganization SHALL contain one [1..1] id such that it, SHALL be the APM Entity's APM Entity identifier (CONF:CMS_109).

CONF. #	Section	Base Standard	Changed To
CMS_112	5.1.5	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_INDIV" or "MIPS_APP1_INDIV or "PCF", then this representedOrganization SHALL contain one [1..1] id such that it, SHALL be the practitioner's TIN (CONF:CMS_112).
CMS_114	5.1.5	n/a	If ClinicalDocument/informationRecipient/intendedRecipient/id/@extension="MIPS_SUBGROUP", then this representedOrganization SHALL contain one [1..1] id such that it, SHALL be the subgroup's Subgroup Identifier (CONF:CMS_114).
4526-17301_C01	5.1.6	SHALL contain exactly one [1..1] QRDA Category III Measure Section (V5) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.1:2020-12-01) (CONF:4484-17301).	SHALL contain exactly one [1..1] QRDA Category III Measure Section - CMS (V5) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.2.3:2022-05-01) (CONF:4526-17301_C01).
4526-21394_C01	5.1.6	This structuredBody SHALL contain at least a QRDA Category III Measure Section (V5), or an Improvement Activity Section (V3), or a Promoting Interoperability Measure Section (V3) (CONF:4484-21394).	This structuredBody SHALL contain at least a QRDA Category III Measure Section - CMS (V5), or an Improvement Activity Section (V3), or a Promoting Interoperability Measure Section (V3) (CONF:4526-21394_C01).
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="2022-05-01" (CONF:CMS_66).
4526-17906_C01 4526-17907_C01	5.2.1	SHALL contain at least one [1..*] entry (CONF:4484-17906) such that it SHALL contain exactly one [1..1] Measure Reference and Results (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.1:2020-12-01) (CONF:4484-17907).	SHALL contain at least one [1..*] entry (CONF:4526-17906_C01) such that it SHALL contain exactly one [1..1] Measure Reference and Results - CMS (V5) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.17:2022-05-01) (CONF:4526-17907_C01).

CONF. #	Section	Base Standard	Changed To
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).
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).

CONF. #	Section	Base Standard	Changed To
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="2022-05-01" (CONF:CMS_56).
4526-17903_C01 4526-17904_C01	5.3.2	MAY contain zero or more [0..*] component (CONF:4484-17903) 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:4484-17904).	MAY contain zero or more [0..*] component (CONF:4526-17903_C01) such that it SHALL contain exactly one [1..1] Performance Rate for Proportion Measure - CMS (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.27.3.25:2022-05-01) (CONF:4526-17904_C01).
4526-18425_C01 4526-18426_C01	5.3.2	SHALL contain at least one [1..*] component (CONF:4484-18425) such that it SHALL contain exactly one [1..1] Measure Data (V3) (identifier:urn:hl7ii:2.16.840.1.113883.10.20.27.3.5:2016-09-01) (CONF:3259-18426).	SHALL contain at least one [1..*] component (CONF:4526-18425_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:4526-18426_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="2022-05-01" (CONF:CMS_61).
4526-21307_C01 CMS_62 CMS_63	5.3.4	n/a	SHALL contain exactly one [1..1] `value` with @xsi:type="REAL" (CONF:4526-21307_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).
4526-19651_C01 4526-19652_C01 4526-19653_C01	5.3.4	MAY contain zero or one [0..1] reference (CONF:4484-19651). 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:4484-19652). The reference, if present, SHALL contain exactly one [1..1] externalObservation (CONF:4484-19653).	SHALL contain exactly one [1..1] reference (CONF: 4526-19651_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:4526-19652_C01). This reference SHALL contain exactly one [1..1] externalObservation (CONF:4526-19653_C01).

12 Change Log – Changes from the 2023 CMS QRDA Implementation Guide

The Table 25 lists the changes made in each section of this 2024 CMS QRDA Eligible Clinicians Implementation Guide, as compared with the 2023 CMS QRDA III Implementation Guide.

Table 25: Changes Made to the 2024 CMS Eligible Clinicians QRDA IG from 2023 CMS QRDA IG

Section Heading	2024 CMS QRDA III Eligible Clinicians IG (Version 1.1)	2023 CMS QRDA III Eligible Clinicians
Base Standard	HL7 Clinical Document Architecture (CDA) R2 Implementation Guide: Quality Reporting Document Architecture (QRDA III), Release 1 – US Realm	HL7 Clinical Document Architecture (CDA) R2 Implementation Guide: Quality Reporting Document Architecture (QRDA III), Release 1 – US Realm
n/a	Updated to 2024 performance period througout	2023 performance period.
4.1 Primary Care First (PCF) Submissions	Language is updated for the 2024 performance period.	Language for the 2023 performance period.
4.9 Performance Period and Performance Rate	4.9 Performance Period and Performance Rate The performance period for the PCF model begins on January 1, 2024 and ends on December 31, 2024	4.6 Performance Period and Performance Rate The performance period for the PCF model begins on January 1, 2023 and ends on December 31, 2023
5.1.4 participant is MVP	Updated Table 4 MVP Identifiers for the 2024 Performance Period	Table 4 MVP Identifiers for the 2023 Performance Period
5.1.5 documentationOf	MAY contain zero or one [0..1] @extension (CONF:4526-18247). Note: This is the provider's NPI. It is only present when this is a MIPS individual reporting, APP individual reporting, or PCF reporting. For PCF, only those NPIs that participated in the PCF model during the performance year should be provided.	MAY contain zero or one [0..1] @extension (CONF:4526-18247). Note: This is the provider's NPI. It is only present when this is a MIPS individual reporting, APP individual reporting, or PCF reporting. For PCF, only those NPIs that are participating in the PCF model should be provided.
5.1.6 component	Updated to “the 2024 performance period” where “the 2023 performance” was mentioned. Removed the sentence, “The QRDA Category III Reporting Parameters Section shall not be used for specifying performance period.”, because this template was deprecated from the base standard.	The QRDA Category III Reporting Parameters Section shall not be used for specifying performance period.

Section Heading	2024 CMS QRDA III Eligible Clinicians IG (Version 1.1)	2023 CMS QRDA III Eligible Clinicians
5.1.6 Payer Supplemental Data Element – CMS (V3)	Corrected a typo: In Table 10, updated Contained By to Measure Data – CMS (V4)	Table 10. Payer Supplemental Data Element – CMS (V3) Contexts
5.3.4 Performance Rate for Proportion Measure – CMS (V4)	Corrected a typo: In Table 13, updated Contained By to Measure Data – CMS (V5)	Table 13. Performance Rate for Proportion Measure – CMS (V4) Contexts
6. 2024 eCQM Specifications for Eligible Clinicians UUID List	Updated the UUID list based on the eCQM specifications for Eligible Clincians for the 2024 performance period.	UUID list based on the eCQM specifications for Eligible Clincians and Eligbile Professionals for the 2023 performance period.

7. Measure Identifiers	Updated Table 16: Improvement Activities Identifiers for the MIPS CY 2024 Performance Period
	• IA_PSPA_16 updated with a new name and description
	• New IAs added:
	  ○ IA_MVP, IA_PM_22, IA_PM_23, IA_BMH_14, and IA_BMH_15
	• Removed:
	  ○ IA_BMH_6, IA_BMH_13, and IA_PSPA_29
	
	Updated Table 17: Promoting Interoperability Objectivies and Measures Identifiers for the MIPS CY 2024 Performance Period
	• No changes from the 2023 performance period
	
	Updated Table 18: Promoting Interoperability Attestation Statements Identifiers
	• No changes from the 2023 performance period
		Identifiers for the 2023 performance period.

13. Acronyms	Added NP, PA, and CNS	n/a
16. Glossary	Updated the definition for eCQM: An electronic clinical quality measure (eCQM) is a measure specified in a standard electronic format that uses data electronically extracted from electronic health records (EHR) and/or health information technology (IT) systems to measure the quality of health care provided.	eCQM

12.1Version 1.1 Change Log

The 2024 CMS QRDA III IG Version 1.1 high level changes include:

- Updated Table 4: MVP Identifiers for the 2024 Performance Period
  - Updated M0005 description
  - Removed G0056
  - Added M1366, M1367, M1368, M1369, and M1370
- Updated Table 15: UUID List for MIPS CY 2024 Performance Period eCQM Specifications Eligible Clinicians
  - Removed CMS161v12, CMS147v13, and CMS127v12 based on the CY 2024 Physician Fee Schedule Final Rule released in November, 2023
  - Corrected UUIDs for CMS142v12 and CMS177v12
- The following tables are updated based on the CY 2024 Physician Fee Schedule Final Rule
  - Table 16: Improvement Activities Identifiers for the MIPS CY 2024 Performance Period
  - Table 17: Promoting Interoperability Objectives and Measures Identifiers for the MIPS CY 2024 Performance Period
  - Table 18: Promoting Interoperability Attestation Statements Identifiers

13 Acronyms

The table below contains acronyms used in this guide.

Table 26: Acronyms

Acronym	Literal Translation
APM	Alternate Payment Model
APP	APM Performance Pathway
ANSI	American National Standards Institute
ASKU	Asked, but not known
CDA	Clinical Document Architecture
CEHRT	Certified EHR Technology
CMS	Centers for Medicare & Medicaid Services
CNS	clinical nurse specialist
CONF	conformance
CQL	Clinical Quality Language
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
MVP	MIPS Value Pathway
n/a	not applicable
NA	Not applicable

Acronym	Literal Translation
NLM	National Library of Medicine
NP	nurse practitioner
NPI	National Provider Identification Number
OID	Object Identifier
ONC	Office of the National Coordinator for Health Information Technology
PA	physician assistant
PCF	Primary Care First
PHDSC	Public Health Data Standards Consortium
QDM	Quality Data Model
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
QRDA III	Quality Reporting Document 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 measure specified in a standard electronic format that uses data electronically extracted from electronic health records (EHR) and/or health information technology (IT) systems to measure the quality of health care provided.
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/

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

HL7 Clinical Document Architecture (CDA) R2 Implementation Guide: Quality Reporting Document Architecture (QRDA III) Release 1 – US Realm http://www.hl7.org/implement/standards/product_brief.cfm?product_id=286

MIPS Value Pathways: https://qpp.cms.gov/mips/mips-value-pathways

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