**Centers for Medicare & Medicaid Services Measures under Consideration 2019 Data Template for Candidate Measures**

| **Row** | **Field Label** | **Req'd** | **Screen Guidance** | **Data Form** | **Possible Values** | **Add Your Content Here** |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | Auto Date (no user input required) |  |  |  |  |  |
| 2 | Issue Type | Yes | Select Measure Submission to nominate a measure for the 2019 MUC list. Select Question to ask a question on the MUC process. Select Modify Candidate Measure to change a measure already submitted for 2019. Select Feedback to leave feedback about the 2019 MUC process. | Select one | Measure Submission  Question  Modify Candidate Measure  Feedback | Measure Submission |
| 3 | Component/s | Yes | Start typing to get a list of possible matches or press down to select. Enter CMS program(s) for which the measure is being submitted.  If you are submitting for MIPS, there are two choices of program. Choose MIPS-Quality for measures that pertain to quality and/or efficiency. Choose MIPS-Cost only for measures that pertain to cost. Do not select both MIPS-Quality and MIPS-Cost for the same measure.  If you select MIPS (either Quality or Cost), please navigate to the Additional Resources list at this web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html, download the “MIPS Peer Review Template and a Completed Sample,” and attach the completed form to your JIRA submission using the “Attachments” field at the bottom of this web page. | Multi-select | Ambulatory Surgical Center Quality Reporting Program  End-Stage Renal Disease Quality Incentive Program  Home Health Quality Reporting Program  Hospice Quality Reporting Program  Hospital-Acquired Condition Reduction Program  Hospital Inpatient Quality Reporting Program  Hospital Outpatient Quality Reporting Program  Hospital Readmissions Reduction Program  Hospital Value-Based Purchasing Program  Inpatient Psychiatric Facility Quality Reporting Program  Inpatient Rehabilitation Facility Quality Reporting Program  Long-Term Care Hospital Quality Reporting Program  Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs)  Medicare Shared Savings Program  Merit-based Incentive Payment System-Cost  Merit-based Incentive Payment System-Quality  Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program  Skilled Nursing Facility Quality Reporting Program  Skilled Nursing Facility Value-Based Purchasing Program | Medicare Shared Savings Program  Merit-based Incentive Payment System-Quality |
| 4 | What is the history or background for including this measure on the 2019 MUC list? | Yes | Select only one reason | Select one | None  New measure never reviewed by MAP Workgroup or used in a CMS program  Measure previously submitted to MAP, refined and resubmitted per MAP recommendation  Measure currently used in a CMS program being submitted as-is for a new or different program  Measure currently used in a CMS program, but the measure is undergoing substantial change | Measure currently used in a CMS program, but the measure is undergoing substantial change |
| 5 | If currently used: |  |  |  |  |  |
| 6 | Range of year(s) this measure has been used by CMS Program(s). | No | For example: Hospice Quality Reporting (2012-2018) | Free text |  | Not applicable; this is a new measure. However, another version of this measure specified for Accountable Care Organizations (ACOs), “Risk-standardized Acute Admission Rates for Patients with Multiple Chronic Conditions” (ACO-38) has been used in the CMS Medicare Shared Savings Program since 2015. The primary difference of the currently reported ACO-level measure and the new measure for MIPS are that the new measure adds diabetes to the list of conditions that qualify patients for the cohort (in combinations of two or more) and narrows the types of admissions counted in the outcome to those most influenced by ambulatory care providers. |
| 7 | What other federal programs are currently using this measure? | No | Select as many as apply. These should be current use programs only, not programs for the 2019 submittal. | Multi-select | Ambulatory Surgical Center Quality Reporting Program  End-Stage Renal Disease Quality Incentive Program  Comprehensive Primary Care Plus (CPC+)  Health Homes Core Set  Home Health Quality Reporting Program  Hospice Quality Reporting Program  Hospital-Acquired Condition Reduction Program  Hospital Inpatient Quality Reporting Program  Hospital Outpatient Quality Reporting Program  Hospital Readmissions Reduction Program  Hospital Value-Based Purchasing Program  Inpatient Psychiatric Facility Quality Reporting Program  Inpatient Rehabilitation Facility Quality Reporting Program  Long-Term Care Hospital Quality Reporting Program  Medicaid Adult Core Set  Medicaid and CHIP Child Core Set  Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals  Medicare and Medicaid Promoting Interoperability Program for Eligible Professionals  Medicare Part C  Medicare Part D  Medicare Shared Savings Program  Merit-based Incentive Payment System | Medicare Shared Savings Program |
| 7 | What other federal programs are currently using this measure? (continued) |  |  |  | Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program  Quality Health Plan Quality Rating System  Skilled Nursing Facility Quality Reporting Program  Skilled Nursing Facility Value-Based Purchasing Program |  |
| 8 | Summary | Yes | Provide the measure title only (255 characters or less). Put program-specific ID number in the next field, not in the title. Note: Do not enter the NQF ID, former JIRA MUC ID number, or any other ID numbers here (see below). | Free text 255 characters max |  | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions; in the Medicare Shared Savings Program, the score would be at the ACO level. |
| 9 | Measure ID | No | Alphanumeric identifier (if applicable), such as a recognized program ID number for this measure (20 characters or less). Examples: 199 GPRO HF-5; ACO 28; CTM-3; PQI #08.  Fields for the NQF ID number and previous year(s) JIRA MUC ID number are provided in other data fields within this form. | Free text 20 characters max |  | This is a new measure, which has not yet been assigned an alphanumeric identifier. |
| 10 | Measure description | Yes | Provide a brief description of the measure (700 characters or less). When you paste text, any content over the limit will be truncated. | Free text 700 characters or less) |  | Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs). |
| 11 | Numerator | Yes | The upper portion of a fraction used to calculate a rate, proportion, or ratio. A clinical action to be counted as meeting a measure's requirements. For all fields, especially Numerator and Denominator, use plain text whenever possible. If needed, convert any special symbols, math expressions, or equations to plain text (keyboard alphanumeric, such as + - \* /). This will help reduce errors and speed up data conversion, team evaluation, and MUC report formatting. | Free text |  | The outcome for this measure is the number of acute, unplanned hospital admissions per 100 person-years at risk for admission during the measurement period.  Time Period  The outcome includes inpatient admissions to an acute care hospital during the measurement year.  Excluded Admissions  This measure does not include the following types of admissions in the outcome because they do not reflect the quality of care provided by ambulatory care clinicians who are managing the care of MCC patients:  1. Planned hospital admissions.  2. Admissions that occur directly from a skilled nursing facility (SNF) or acute rehabilitation facility.  3. Admissions that occur within a 10-day “buffer period” of time after discharge from a hospital, SNF, or acute rehabilitation facility.  4. Admissions that occur after the patient has entered hospice.  5. Admissions related to complications from procedures or surgeries.  6. Admissions related to accidents or injuries.  7. Admissions that occur prior to the first visit with the assigned clinician.  To identify planned admissions, the measure adopted an algorithm CORE previously developed for CMS’s hospital readmission measures, CMS’s Planned Readmission Algorithm Version 4.0. [1,2] In brief, the algorithm uses the procedure codes and principal discharge diagnosis code on each hospital claim to identify planned admissions. A few specific, limited types of care are always considered planned (for example, major organ transplant, rehabilitation, and maintenance chemotherapy). Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure (for example, total hip replacement or cholecystectomy). Admissions for an acute illness are never considered planned.  To identify complications of procedures or surgeries, we use the Agency for Healthcare Research and Quality’s (AHRQ’s) Clinical Classifications Software (CCS), which clusters diagnoses into clinically meaningful categories using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or International Classification of Diseases, Tenth Revision, and Clinical Modification (ICD-10-CM) codes. We exclude the following 23 CCS categories.  1. 145: Intestinal obstruction without hernia  2. 237: Complication of device; implant or graft  3. 238: Complications of surgical procedures or medical care  4. 257: Other aftercare  b) Accidents or injuries  5. 2601 E Codes: Cut/pierce  6. 2602 E Codes: Drowning/submersion  7. 2604 E Codes: Fire/burn  8. 2605 E Codes: Firearm  9. 2606 E Codes: Machinery  10. 2607 E Codes: Motor vehicle traffic (MVT)  11. 2608 E Codes: Pedal cyclist; not MVT  12. 2609 E Codes: Pedestrian; not MVT  13. 2610 E Codes: Transport; not MVT  14. 2611 E Codes: Natural/environment  15. 2612 E Codes: Overexertion  16. 2613 E Codes: Poisoning  17. 2614 E Codes: Struck by; against  18. 2615 E Codes: Suffocation  19. 2616 E Codes: Adverse effects of medical care  20. 2618 E Codes: Other specified and classifiable  21. 2619 E Codes: Other specified; NEC  22. 2620 E Codes: Unspecified  23. 2621 E Codes: Place of occurrence  Person-time at risk  Persons are considered at risk for hospital admission if they are alive, enrolled in Medicare FFS, and not in the hospital during the measurement period. In addition to time spent in the hospital, we also exclude from at-risk time: 1) time spent in a SNF or acute rehabilitation facility; 2) the time within 10 days following discharge from a hospital, SNF, or acute rehabilitation facility; and 3) time after entering hospice care.  Citations  1. Yale New Haven Health Services Corporation – Center for Outcomes Research & Evaluation (YNHHSC/CORE). 2018 All-Cause Hospital Wide Measure Updates and Specifications Report - Hospital-Level 30-Day Risk-Standardized Readmission Measure – Version 7.0. Centers for Medicare & Medicaid Services; March 2018.  2. Horwitz L, Grady J, Cohen D, et al. Development and validation of an algorithm to identify planned readmissions from claims data. Journal of Hospital Medicine. October 2015;10(10):670-677. |
| 12 | Denominator | Yes | The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure’s inclusion requirements. | Free text |  | Patients included in the measure (target patient population)  The cohort is comprised of patients whose combinations of chronic conditions put them at high risk of admission and whose admission rates could be lowered through better care. This definition reflects NQF’s “Multiple Chronic Conditions Measurement Framework,” which defines patients with MCCs as people “having two or more concurrent chronic conditions that. . .act together to significantly increase the complexity of management, and affect functional roles and health outcomes, compromise life expectancy, or hinder self-management.” [1]  The specific inclusion criteria are as follows.   * Patient is alive at the start of the measurement period and has two or more of nine chronic disease groups in the year prior to the measurement period. Chronic conditions, except for diabetes, are defined using CMS’s Chronic Conditions Data Warehouse (CCW). For diabetes, we used the diabetes cohort definition from the Accountable Care Organization (ACO) diabetes admission measure developed by CORE (v2018a ACO-36) as opposed to the definition used in CCW; CCW includes diagnoses for secondary and drug-induced diabetic conditions that are not the focus of the MIPS MCC admission measure.   1. Acute myocardial infarction (AMI),  2. Alzheimer’s disease and related disorders or senile dementia,  3. Atrial fibrillation,  4. Chronic kidney disease (CKD),  5. Chronic obstructive pulmonary disease (COPD) or asthma,  6. Depression,  7. Diabetes,  8. Heart failure, and  9. Stroke or transient ischemic attack (TIA).   * Patient is aged ≥65 years at the start of the year prior to the measurement period. * Patient is a Medicare FFS beneficiary with continuous enrollment in Medicare Parts A and B during the year prior to the measurement period. * Patients attributed to hematologists and oncologists.   Provider types included for attribution   * Primary care providers (PCPs): CMS designates PCPs as physicians who practice internal medicine, family medicine, general medicine, or geriatric medicine, and non-physician providers, including nurse practitioners, certified clinical nurse specialists, and physician assistants. * Relevant specialists: Specialists covered by the measure are limited to those who provide overall coordination of care for patients with MCCs and who manage the chronic diseases that put the MCC patients in the measure at risk of admission. These specialists were chosen with input from our Technical Expert Panel (TEP) and include cardiologists, pulmonologists, nephrologists, neurologists, endocrinologists, and hematologists/oncologists. (Note: Hematologists/oncologists are included for attribution but not for measure scoring.)   Outcome attribution  We begin by assigning each patient to the clinician most responsible for the patient’s care, based on the pattern of outpatient visits with PCPs and relevant specialists. The patient can be assigned to a PCP, a relevant specialist, or can be left unassigned.   * A patient who is eligible for attribution can be assigned to a relevant specialist only if the specialist has been identified as “dominant”. A specialist is considered “dominant” if they have two or more visits with the patient, as well as at least two more visits than any primary care provider or other relevant specialist. * There are two scenarios where a patient can be assigned to a PCP. First, the patient must have seen at least one PCP. The patient will then be assigned to the PCP with the highest number of visits if there are no relevant specialists who are considered “dominant”. Second, if the patient has had more than one visit with a relevant specialist, no “dominant” specialist has been identified, and has two or more visits with a PCP, they will be assigned to that PCP. * Finally, the patient will be unassigned if they only saw non-relevant specialists, if the patient has not seen a PCP and no “dominant” specialist can be identified, or if the patient has not had more than one visit with any individual PCP.   Patients are then assigned at the Taxpayer Identification Number (TIN) level, which includes solo clinicians and groups of clinicians who have chosen to report their quality under a common TIN.   * Patients “follow” their clinician to the TIN designated by the clinician (i.e. they are assigned to their clinician’s TIN). Patients unassigned at the individual clinician-level, therefore, continue to be unassigned at the TIN level.   Citations  1. National Quality Forum. Multiple Chronic Conditions Measurement Framework. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71227. Accessed February 20, 2019. |
| 13 | Exclusions/Exceptions | Yes | If applicable, specify Numerator Exclusion, Denominator Exclusion, or Denominator Exception. | Free text |  | The cohort excludes the following patients:  1) Patients without continuous enrollment in Medicare Part A or B during the measurement period.  2) Patients who were in hospice at any time during the year prior to the measurement year or at the start of the measurement year.  3) Patients who had no Evaluation & Management (E&M) visits to a MIPS-eligible clinician. |
| 14 | Measure Type | Yes | Select only one type of measure. For definitions, visit this web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html> and link to the user guide under The JIRA System. | Select one | None  Composite  Cost/Resource Use  Efficiency  Intermediate Outcome  Outcome  Patient Reported Outcome  Process  Structure  Other (enter in Comments at far bottom of this form) | Outcome |
| 15 | Which clinical guideline(s)? | No | The measure should improve compliance with standard clinical guidelines. Provide a detailed description of which guideline supports the measure and how the measure will enhance compliance with the clinical guidelines. Indicate whether the guideline is evidence-based or consensus-based. | Free text |  |  |
| 16 | Is this measure similar to and/or competing with measure(s) already in a program? | Yes | Consider other measures with similar purposes. | Select one | Yes  No | Yes |
| 17 | If Yes: |  |  |  |  |  |
| 18 | Which measure(s) already in a program is your measure similar to and/or competing with? | No | Identify the other measure(s) including title and any other unique identifier | Free text |  | There is one related measure to the measure being submitted for initial endorsement: ACO-38/NQF #2888 “Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions.” The measure being submitted is adapted from NQF #2888 to assess the quality of ambulatory care provided by individual clinicians and clinician groups caring for patients with MCCs.  CMS intends to harmonize the ACO-38/NQF #2888 measure with this MIPS MCC measure in the future (i.e. replace the currently reported measure with the new measure); hence, CMS is submitting this new measure to the MUC for consideration in both programs. |
| 19 | How will this measure add value to the CMS program? | No | Describe benefits of this measure, in comparison to measure(s) already in a program. | Free text |  | N/A |
| 20 | How will this measure be distinguished from other similar and/or competing measures? | No | Describe key differences that set this measure apart from others. | Free text |  | The MIPS MCC admission measure is adapted from the ACO MCC admission measure, which was implemented in the Medicare Shared Savings Program in 2015. There are three main ways that the newly developed measure differs from its predecessor.  •Cohort: CMS added diabetes as a cohort-qualifying condition.  •Outcome: CMS narrowed the outcome to focus on admissions where risk can be reduced by providing high-quality ambulatory care, so that the measure can be used to assess ambulatory (rather than ACO-wide) care quality.  •Risk-adjustment: We added social risk factors to the risk-adjustment model. |
| 21 | What is the target population of the measure? | Yes | What populations are included in this measure? e.g., Medicare Fee for Service, Medicare Advantage, Medicaid, CHIP, All Payer, etc. | Free text |  | The target patient population for the outcome includes Medicare FFS patients aged 65 years and older with MCCs. |
| 22 | What one area of specialty is the measure aimed to, or which specialty is most likely to report this measure? | Yes | Select the most applicable area of specialty. Use the scroll bar to view all available specialties. | Select one | **See Appendix A.22 for list choices.** | Primary care |
| 23 | What one primary healthcare priority applies to this measure? | Yes | Healthcare priorities (also known as domains); select the best one. | Select one | Make care safer by reducing harm caused in the delivery of care  Strengthen person and family engagement as partners in their care  Promote effective communication and coordination of care  Promote effective prevention and treatment of chronic disease  Work with communities to promote best practices of healthy living  Make care affordable | Promote effective prevention and treatment of chronic disease |
| 24 | What one primary meaningful measure area applies to this measure? | Yes | Select the best one. The meaningful measure area choices depend on your selection of primary healthcare priority above. | Select one | If #23 is Make care safer…, then choices are:  Healthcare-associated infections  Preventable healthcare harm  If #23 is Strengthen person…, then choices are:  Care is personalized and aligned with patient’s goals  End of life care according to preferences  Patient’s experience of care  Functional outcomes  If #23 is Promote effective communication…, then choices are:  Medication management  Admissions and readmissions to hospitals  Transfer of health information and interoperability  If #23 is Promote effective prevention…, then choices are:  Preventive care  Management of chronic conditions  Prevention, treatment, and management of mental health  Prevention and treatment of opioid and substance use disorders  Risk adjusted mortality  If #23 is Work with communities…, then choices are:  Equity of care  Community engagement  If #23 is Make care affordable, then choices are:  Appropriate use of healthcare  Patient-focused episode of care  Risk adjusted total cost of care | Management of chronic conditions |
| 25 | What secondary healthcare priority applies to this measure? | No | Healthcare priorities (also known as domains); select one alternate or secondary priority only if applicable. | Select one | Make care safer by reducing harm caused in the delivery of care  Strengthen person and family engagement as partners in their care  Promote effective communication and coordination of care  Promote effective prevention and treatment of chronic disease  Work with communities to promote best practices of healthy living  Make care affordable | Promote effective communication and coordination of care |
| 26 | What secondary meaningful measure area applies to this measure? | No | Select an alternate or secondary area only if applicable. The meaningful measure area choices depend on your selection of secondary healthcare priority above. | Select one | If #24 is Make care safer…, then choices are:  Healthcare-associated infections  Preventable healthcare harm  If #24 is Strengthen person…, then choices are:  Care is personalized and aligned with patient’s goals  End of life care according to preferences  Patient’s experience of care  Functional outcomes  If #24 is Promote effective communication…, then choices are:  Medication management  Admissions and readmissions to hospitals  Transfer of health information and interoperability  If #24 is Promote effective prevention…, then choices are:  Preventive care  Management of chronic conditions  Prevention, treatment, and management of mental health  Prevention and treatment of opioid and substance use disorders  Risk adjusted mortality  If #24 is Work with communities…, then choices are:  Equity of care  Community engagement  If #24 is Make care affordable, then choices are:  Appropriate use of healthcare  Patient-focused episode of care  Risk adjusted total cost of care | Admissions and readmissions to hospitals |
| 27 | Briefly describe the peer reviewed evidence justifying this measure | Yes | Add description of evidence. | Free text |  | Hospital admission rates are an effective marker of ambulatory care quality. Hospital admissions from the outpatient setting reflect a deterioration in patients’ clinical status and as such reflect an outcome that is meaningful to both patients and providers. Patients receiving optimal, coordinated high-quality care should use fewer inpatient services than patients receiving fragmented, low-quality care. Thus, high population rates of hospitalization may, at least to some extent, signal poor quality of care or inefficiency in health system performance.  Patients with MCCs are at high risk for hospital admission, often for potentially preventable causes, such as exacerbation of pulmonary disease. [1] Evidence from several Medicare demonstration projects suggests that care coordination results in decreased hospital admission rates among high-risk patients. [2] In addition, studies have shown that the types of ambulatory care clinicians this measure targets (for example, primary care providers and specialists caring for patients with MCCs) can influence admission rates through primary care clinician supply, continuity of care, and patient-centered medical home interventions such as team-based and patient-oriented care. [3-5]  Given evidence that ambulatory care clinicians can influence hospital admission rates through optimal care and coordination, this measure will incentivize quality improvement efforts leading to improved patient outcomes.  Citations:  1. Abernathy K, Zhang J, Mauldin P, et al. Acute Care Utilization in Patients With Concurrent Mental Health and Complex Chronic Medical Conditions. Journal of primary care & community health. 2016;7(4):226-233.  2. Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. Health Aff (Millwood). 2012;31(6):1156-1166.  3. van Loenen T, van den Berg MJ, Westert GP, Faber MJ. Organizational aspects of primary care related to avoidable hospitalization: a systematic review. Fam Pract. 2014;31(5):502-516.  4. Dale SB, Ghosh A, Peikes DN, et al. Two-Year Costs and Quality in the Comprehensive Primary Care Initiative. N Engl J Med. 2016;374(24):2345-2356.  5. Casalino LP, Pesko MF, Ryan AM, et al. Small primary care physician practices have low rates of preventable hospital admissions. Health Aff (Millwood). 2014;33(9):1680-1688. |
| 28 | What is the NQF status of the measure? | Yes | Select only one. Refer to <http://www.qualityforum.org/QPS/> for information on NQF endorsement, measure ID, and other information. | Select one | None  Endorsed  Endorsement Removed  Submitted  Failed endorsement  Never submitted | Never submitted |
| 29 | NQF ID | Yes | Four- or five-digit identifier with leading zeros and following letter if needed. If no NQF ID number is known, enter numerals 0000. | Can be four- or five-character alphanumeric ID value |  | 0000 |
| 30 | Evidence that the measure can be operationalized | No | Provide evidence that the data source used by the measure is readily available to CMS. Summarize how CMS would operationalize the measure. For example, if the measure is based on registry data, the submitter must provide evidence that the majority of the hospitals in the program in which the measure will be used participate in the registry; if the measure is registry-based, the submitter must provide a plan for CMS to gain access to the registry data. For eCQMs, attach feasibility scorecard or other quantitative evidence indicating measure can be reported by the intended reporting entities. | Free text |  | The data source for this measure is Medicare administrative claims and enrollment data and is readily available to CMS. Calculating the measure score imposes no data collection burden for CMS or entities measured. |
| 31 | If endorsed: |  |  |  |  |  |
| 32 | Is the measure being submitted **exactly** as endorsed by NQF? | No | Select only one | Radio button | Yes  No | N/A |
| 33 | If not exactly as endorsed, specify the locations of the differences | No | Which specification fields are different? Select as many as apply. | Multi-select | Measure title  Description  Numerator  Denominator  Exclusions  Target Population  Setting (for testing)  Level of analysis  Data source  eCQM status  Other (see next field) | N/A |
| 34 | If not exactly as endorsed, describe the nature of the differences | No | Briefly describe the differences | Free text |  | N/A |
| 35 | Year of most recent NQF Consensus Development Process (CDP) endorsement | No | Select one | Select one | None  1999  2000  2001  2002  2003  2004  2005  2006  2007  2008  2009  2010  2011  2012  2013  2014  2015 2016  2017  2018  2019 | None |
| 36 | Year of next anticipated NQF CDP endorsement review | No | Select one | Select one | None  2019  2020  2021  2022 2023 | 2020 |
| 37 | In what state of development is the measure? | Yes | Select as many as apply. Hold down the Ctrl button while choosing to make multiple selections. | Multi-select | Early Development  Field Testing  Fully Developed | Fully developed |
| 38 | State of Development Details | No | Details are helpful to CMS in understanding where the measure is in the developmental cycle and will weigh heavily in determining whether or not the measure will be published on the MUC List.  If you selected early development above, meaning testing is not currently underway, please describe when testing is planned (i.e., specific dates), what type of testing is planned (e.g., alpha, beta, etc.) as well as the types of facilities in which the measure will be tested.  If you selected field testing or fully developed above, please describe what testing (e.g., alpha, beta, etc.) has taken place in addition to the results of that testing.  Related to testing, summarize results from validity testing including number of reporting entities and patients measured, and how validity was assessed. Summarize results from reliability testing including number of reporting entities and patients measured, and how reliability was assessed. | Free text |  | We tested the measure using 2015 as the measurement year in a MIPS-based Medicare FFS population (derived based on individual clinicians and clinician groups participating in the Value-Based Payment Modifier [VM] program, the predecessor program to MIPS). 6,148,751 patients met the inclusion/exclusion criteria.  The initial individual-level attribution algorithm assigned 79.5% of patients to PCPs and 7.6% to specialists; it left unassigned 10.7% of patients who did not visit a PCP or relevant specialist at least twice in the measurement year or whose pattern of visits did not allow us to identify the clinician most responsible for the patients’ care. 2.2% of patients who were assigned to hematologists/oncologists not scored on the measure. Thus, the final MCC cohort used for model building and testing included 4,937,865 patients. We calculated measure scores for all TINs; of note, the TIN-level analysis includes all clinicians – those who report as individuals and those reporting through MIPS groups.  As expected, the results showed wide variation in the number of patients per TIN, ranging from 1 to 10,328 patients, with a median of 22 and an interquartile range (IQR) of 7 to 59.  The measures scores also showed wide variation at the TIN level. When calculated for TINs (n=64,025), risk-standardized acute admission rates (RSAAR) measure scores ranged from 16.9 to 112.8 per 100 person-years, with a median of 41.5 and an IQR of 39.1 to 44.7 per 100 person-years.  Different types of TINs based on provider composition scored similarly on the measure, suggesting the measure fairly evaluates care for a range of MIPS providers caring for patients with MCCs. Similar distributions in measure scores were found across TINs with different combinations of PCPs and/or specialists within the TIN (for example, TINs limited to one type of specialist such as cardiologists, TINs with a mix of PCPs and specialists, and TINs with just PCPs). Solo clinician and multi-provider TINs had similar score distributions.  We determined the minimum sample size needed to achieve provider-level measure score reliability of >0.5 (an acceptable cutoff for outcome measures) among TINs likely to participate in MIPS. We calculated that ≥28 patients per TIN are needed to achieve measure score reliability estimates of 0.5 or greater. If CMS established this volume cutoff for public reporting, about half the TINs (55.7%) would be excluded; however, the measure would include 93.3% of patients and 78.9% of clinicians if reported with this reliability at the TIN level.  Following presentation and review of the final measure specifications and testing results, we systematically assessed the face validity of the measure score as an indicator of quality by confidentially soliciting the TEP members’ agreement with the following statements (via an online survey):   * The risk-standardized acute admission rates obtained from the MCC measure as specified:   + Can be used to distinguish good from poor quality of care provided to MCC patients by TINs reporting under MIPS?   + Will provide TINs reporting under MIPS with information that can be used to improve their quality of care for MCC patients?   Of 17 TEP members who were active through the end of the project, 12 responded. the majority of the respondents – 10/12 or 83% –  strongly, moderately, or somewhat agreed that the MIPS MCC admission measure can be used to distinguish good from poor quality of care. The majority of the respondents – 9/12 or 75% – strongly, moderately, or somewhat agreed that the MIPS MCC admission measure scores (RSAARs) will provide MIPS TINs with information that could be used to improve the quality of care for MCC patients.  We developed the measure with input from a national TEP, public comment, and CMS. CMS decided to not adjust the measure for Medicare-Medicaid dual-eligibility status in June 2019; this form therefore was updated in July 2019 to reflect this decision and results of face validity testing. |
| 39 | In which setting was this measure tested? | Yes | Select as many as apply. Hold down the Ctrl button while choosing to make multiple selections. | Multi-select | None  Ambulatory surgery center  Ambulatory/office-based care  Behavioral health clinic and treatment facility  Community hospitals  Dialysis facility  Emergency department  Federally qualified health center (FQHC)  Hospital outpatient department (HOD)  Home health  Hospital inpatient  Hospital/acute care facility  Inpatient psychiatric facility  Inpatient rehabilitation facility  IP units within acute care hospitals  Long-term care hospital  Nursing home  Post-acute care facility(s)  PPS-exempt cancer hospital  Psychiatric outpatient  Veterans Health Administration facilities  Other (enter in Comments at far bottom of this screen) | Ambulatory/office-based care |
| 40 | At what level of analysis was the measure tested? | Yes | Select as many as apply. Hold down the Ctrl button while choosing to make multiple selections. | Multi-select | None  Clinician  Group  Facility  Health plan  Medicaid program (e.g., Health Home or 1115)  State  Not yet tested  Other (enter in Comments at far bottom of this screen) | Group |
| 41 | What data sources are used for the measure? | Yes | Select as many as apply. Hold down the Ctrl button while choosing to make multiple selections.  If Claims, then enter relevant parts in the field below.  If EHR, then enter relevant parts in the field below.  If Registry, then enter which registry in the field below.  Use the “Comments” field to specify or elaborate on the type of data source, if needed to define your measure. | Multi-select | Administrative clinical data  Facility discharge data  Chronic condition data warehouse (CCW)  Claims  CROWNWeb  EHR  Hybrid  IRF-PAI  LTCH CARE data set  National Healthcare Safety Network  OASIS-C1  Paper medical record  Prescription Drug Event Data Elements  PROMIS  Record review  Registry  Survey  State Vital Records  Other (enter in Comments at far bottom of this screen)  None | Claims  Other:   * Medicare Enrollment Database * Agency for Healthcare Research Quality (AHRQ) Socioeconomic Status (SES) Index derived from American Community Survey data * Area Health Resources File |
| 42 | If Registry: |  |  |  |  |  |
| 43 | Specify the registry(ies) | No | Identify the registry using the submitted measure. Select as many as apply. Use the scroll bar to view all available registries. | Multi-select | **See Appendix A.43 for list choices.** | N/A |
| 44 | If EHR or Claims or Chart-Abstracted Data, description of parts related to these sources | No | Provide a brief, specific description of which parts of the measure are taken from EHR, claims-based, or chart-abstracted (i.e., paper medical records) data sources. | Free text |  | N/A |
| 45 | How is the measure expected to be reported to the program? | Yes | This differs from the data sources above. This is the anticipated data submission method. Select as many as apply. Hold down the Ctrl button while choosing to make multiple selections. Use the “Comments” field to specify or elaborate on the type of reporting data, if needed to define your measure. | Multi-select | eCQM  CQM (Registry)  Claims  Web interface  Other (enter in Comments at far bottom of this screen) | Medicare Part B administrative claims |
| 46 | Is this measure an eCQM? | Yes | Is this an electronic clinical quality measure (eCQM)? Select only one. If your answer is yes, the Measure Authoring Tool (MAT) ID number must be provided below. | Select one | Yes  No | No |
| 47 | If eCQM = Yes |  |  |  |  |  |
| 48 | If eCQM, enter Measure Authoring Tool (MAT) number | Yes | In the Attachments field below, you must attach Bonnie test cases for this measure, with 100% logic coverage (test cases should be appended), attestation that value sets are published in Value Set Authority Center, and NQF feasibility scorecard. If not an eCQM, or if MAT number is not available, enter 0. | Free text |  | N/A |
| 49 | If eCQM, does the measure have a Health Quality Measures Format (HQMF) specification in alignment with the latest HQMF standards? | Yes | If not eCQM, select No | Select one | Yes  No | N/A |
| 50 | Evidence of performance gap | Yes | Evidence of a performance gap among the units of analysis in which the measure will be implemented. Provide analytic evidence that the units of analysis have room for improvement and, therefore, that the implementation of the measure would be meaningful. The distribution of performance should be wide. Measures must not address “topped-out” opportunities. Please provide current rate of performance and standard deviation from that rate to demonstrate variability. If available, please provide information on the testing data set. If available, include percent average performance rate, minimum, and maximum. Include validity and reliability values in a standard format, and the population size used in determining these values. | Free text |  | Across the 64,025 TINs who had at least one MCC patient, RSAAR measure scores, including adjustment for the social risk factors of AHRQ SES Index and specialist density, ranged widely from 16.9 to 112.9 per 100 person-years, with a median of 41.5 and an IQR of 39.1 to 44.7. This indicates that after adjustment half of Medicare patients with multiple chronic conditions had between 39 and 45 acute care visits in a year.  Overall, measure results suggest that there is substantial need to reduce the number of admissions for this patient population, decrease the variation in admissions across providers, and that improvement goals are achievable. |
| 51 | Unintended consequences | No | Summary of potential unintended consequences if the measure is implemented. Information can be taken from NQF CDP manuscripts or documents. If referencing NQF documents, you must submit the document or a link to the document, and the page being referenced. | Free text |  | None |
| 52 | Was this measure published on a previous year's Measures under Consideration list? | Yes | If **yes,** you are submitting an existing measure for expansion into additional CMS programs or the measure has substantially changed since originally published, then proceed to the following subset of data fields including: In what prior year(s) was this measure published?, What were the MUC IDs for the measure in each year?, Why was the measure not recommended by the MAP workgroups in those year(s)?, What were the programs that NQF MAP reviewed the measure for in each year?, List the NQF MAP workgroup(s) in each year, What was the NQF MAP recommendation each year?, and NQF MAP report page number being referenced for each year. If **no,** then skip these subset questions. | Select one | Yes  No | No |
| 53 | In what prior year(s) was this measure published? | No | Select as many as apply. Hold down the Ctrl button while choosing to make multiple selections. | Multi-select | None  2011  2012  2013  2014  2015  2016  2017  2018  Other (enter in Comments at far bottom of this screen) | N/A |
| 54 | What were the MUC IDs for the measure in each year? | No | List both the year and the associated MUC ID number in each year. If unknown, enter N/A. | Free text |  | N/A |
| 55 | List the NQF MAP workgroup(s) in each year | No | List both the year and the associated workgroup name in each year. Workgroup options: Clinician; Hospital; Post-Acute Care/Long-Term Care; Coordinating Committee. Example: "Clinician, 2014" | Free text |  | N/A |
| 56 | What were the programs that NQF MAP reviewed the measure for in each year? | No | List both the year and the associated program name in each year. | Free text |  | N/A |
| 57 | What was the NQF MAP recommendation in each year? | No | List the year(s), the program(s), and the associated recommendation(s) in each year. Options: Support; Do Not Support; Conditionally Support; Refine and Resubmit | Free text |  | N/A |
| 58 | Why was the measure not recommended by the MAP workgroups in those year(s)? | No | Briefly describe the reason(s) if known. | Free text |  | N/A |
| 59 | NQF MAP report link for each year | For your reference in completing this section, click on the links below or copy/paste the links into your browser to view each year's MAP pre-rulemaking report (2012 to 2019).  2019: Link currently unavailable  2016-18: <http://www.qualityforum.org/map/>  2015: <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=78711>  2014: <http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx>  2013: <http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx>  2012: <http://www.qualityforum.org/Publications/2012/02/MAP_Pre-Rulemaking_Report__Input_on_Measures_Under_Consideration_by_HHS_for_2012_Rulemaking.aspx>  All major NQF reports going back to 2008 should be locatable here: <http://www.qualityforum.org/Publications.aspx> | | | | |
| 60 | NQF MAP report page number being referenced for each year | No | List both the year and the associated MAP report page number for each year. | Free text |  | N/A |
| 61 | If this measure is being submitted to meet a statutory requirement, please list the corresponding statute | No | List title and other identifying citation information. | Free text |  | Medicare Access and Children’s  Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA). Note, MACRA specifically calls for outcome measures. |
| 62 | Measure steward | Yes | Select the current Measure Steward. Select as many as apply. Use the scroll bar to view all available stewards. Hold down the Ctrl button while choosing to make multiple selections. | Multi-select | **See Appendix A.62-64 for list choices.** |  |
| 63 | Measure Steward Contact Information | Yes | Last name, First name; Affiliation (if different); Telephone number; Email address | Free text |  | Meyyur, Vinitha; Centers for Medicare & Medicaid Services; (410) 786-8819; vinitha.meyyur@hhs.cms.gov |
| 64 | Long-Term Measure Steward (if different) | No | Entity or entities that will be the permanent measure steward(s), responsible for maintaining the measure and conducting NQF maintenance review. Use the scroll bar to view all available stewards. Hold down the Ctrl button while choosing to make multiple selections. | Multi-select | **See Appendix A.62-64 for list choices.** |  |
| 65 | Long-Term Measure Steward Contact Information | No | If different from Steward above: Last name, First name; Affiliation; Telephone number; Email address | Free text |  |  |
| 66 | Primary Submitter Contact Information | Yes | If different from Steward above: Last name, First name; Affiliation; Telephone number; Email address | Free text |  | Purvis, Danielle; Center for Outcomes Research and Evaluation; 770-653-1330; Danielle.purvis@yale.edu |
| 67 | Secondary Submitter Contact Information | No | If different from name(s) above: Last name, First name; Affiliation; Telephone number; Email address | Free text |  |  |
| 68 | Comments | No | Any notes, qualifiers, external references, or other information not specified above. For OTHER entries: please indicate the type of additional data you are providing, such as Measure Type, Setting, Level of Analysis, or Measure Steward. | Free text |  | The measure is currently posted for measure development public comment on the CMS Public Comment page: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Public-Comments.html>  Additional data sources for the measure include the following:   * Medicare Enrollment Database * Agency for Healthcare Research Quality (AHRQ) Socioeconomic Status (SES) Index derived from American Community Survey data * Area Health Resources File |
| 69 | Attachment(s) | No | The maximum file upload size is 10.00 MB. You are encouraged to attach measure information form (MIF) if available. This is a detailed description of the measure used by NQF during endorsement proceedings. If a MIF is not available, comprehensive measure methodology documents are encouraged.  If you select MIPS, please navigate to the Additional Resources list at this web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html, download the “MIPS Peer Review Template and a Completed Sample,” and attach the completed form to your JIRA submission using the “Attachments” field at the bottom of this web page.  If eCQM, you must attach Bonnie test cases for this measure, with 100% logic coverage (test cases should be appended), attestation that value sets are published in Value Set Authority Center, and NQF feasibility scorecard. | Browse for files |  | MIPS Peer Review Template |
| 70 | MIPS Journal Article Requirement | No | For those submitting measures to MIPS program, click “Yes” after you have attached your completed Peer Reviewed Journal Article Requirement form. | Radio button | Yes  No | Yes |

Appendix: Lengthy Drop-Down List Choices

A.22 Choices for **What area of specialty best fits the measure?**

None  
Addiction medicine   
Allergy/immunology   
Anesthesiology   
Cardiac electrophysiology   
Cardiac surgery   
Cardiovascular disease (cardiology)  
Chiropractic medicine   
Colorectal surgery (proctology)   
Critical care medicine (intensivists)   
Dermatology  
Diagnostic radiology   
Electrophysiology  
Emergency medicine  
Endocrinology   
Family practice  
Gastroenterology  
General practice   
General surgery   
Geriatric medicine  
Gynecological oncology  
Hand surgery   
Hematology/oncology   
Hospice and palliative care  
Infectious disease   
Internal medicine  
Interventional pain management   
Interventional radiology  
Maxillofacial surgery   
Medical oncology   
Mental health professionals  
Nephrology   
Neurology  
Neuropsychiatry   
Neurosurgery  
Nuclear medicine  
Obstetrics/gynecology  
Ophthalmology  
Optometry  
Oral surgery (dentists only)  
Orthopedic surgery  
Osteopathic manipulative medicine   
Otolaryngology  
Pain management   
Palliative care   
Pathology   
Pediatric medicine  
Peripheral vascular disease   
Physical medicine and rehabilitation   
Plastic and reconstructive surgery   
Podiatry   
Preventive medicine   
Primary care  
Psychiatry   
Pulmonary disease   
Pulmonology  
Radiation oncology   
Rheumatology   
Sleep medicine   
Sports medicine  
Surgical oncology   
Thoracic surgery   
Urology   
Vascular surgery   
Other (enter in Comments at far bottom of this screen)

A.43 Choices for **Specify the registry(ies)**

None

CDC, NHSN (National Healthcare Safety Network)

American Nursing Association’s National Database for Nursing Quality Indicators® (NDNQI®)

American College of Surgeons National Surgical Quality Improvement Program ASC NSQIP)

American College of Surgeons National Cancer Data Base (ASC NCDB)

American Heart Association’s Get With the Guidelines Database

Alere Analytics Registry

American Board of Family Medicine Registry

American College of Surgeons (ACS) Surgeon Specific Registry (SSR)

American Health IT

American Osteopathic Association Clinical Assessment Program

American Society of Clinical Oncology’s Quality Oncology Practice Initiative (QOPI)

Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry (NACOR)

Bayview Physician Services Registry

BMC Clinical Data Warehouse Registry

Care Coordination Institute Registry

CECity Registry (“PQRSwizard”)

Cedaron Medical

Central Utah Informatics

CINA

Clinical Support Services

Clinicient

Clinigence

Conifer Value-Based Care

Corrona, LLC

Covisint Corporation Registry (formerly Docsite)

Crimson Care Registry

DC2 Healthcare (NOC2 Spine Registry and C3 Total Joint Registry)

Digital Medical Solutions Registry

DrexelMed Registry

E\*HealthLine.com Inc

eClinicalWeb (eClinicalWorks) Registry

EVMS Academic Physicians and Surgeons Health Services Foundation

Falcon Registry

FORCE-TJR Registry QITM

FOTO PQRS Registry

Fresenium Medical Care CKD Data Registry

Geriatric Practice Management LTC Registry

Greenway Health PrimeDATACLOUD PQRS Registry

HCA Physician Services PQRS Registry

HCFS Health Care Financial Services LLC (HCFS)

Health Focus Registry

ICLOPS

Ingenious Med, Inc.

Intellicure, Inc

Intelligent Healthcare

iPatientCare Registry

IPC The Hospitalist Company Registry

IRISTM Registry

Johns Hopkins Disease Registry

Lumeris Registry

M2S Registry

Mankato Clinic Registry

Massachusetts General Physicians Organization Registry

McKesson Population Manager

MDinteractive

MDSync LLC

MedAmerica/CEP America Registry

Meditab Software, Inc

MedXpress Registry

MEGAS, LLC Alpha II Registry

Michigan Spine Surgery Improvement Collaborative

myCatalyst

Net Health Specialty Care Registry

Net.Orange cOS Registry

NeuroPoint Alliance (NPA)’s National Neurosurgery Quality & Outcomes Database (N2QOD)

NextGen Healthcare Solutions

NJ-HITEC Clinical Reporting Registry

OmniMD

Patient360

PMI Registry

PQRS Solutions

PQRSPRO NetHealth LLC

Pulse PQRS Registry

Quintiles PQRS Registry

ReportingMD Registry

RexRegistry by Prometheus Research

Solutions for Quality Improvement (SQI) Registry

Specialty Benchmarks Registry

SunCoast RHIO

SupportMed Data Analytics & Registry

Surgical Care and Outcomes Assessment Program (SCOAP)

SwedishAmerican Medical Group

TeamPraxis-Allscripts CQS

The Pain Center USA PLLC

Unlimited Systems Specialty Healthcare Registry

Venous Patient Outcome Registry

Vericle, Inc.

Webconsort LLC

WebOutcomes LLC

WebPT, Inc

Wellcentive, Inc

Wisconsin Collaborative for Health Care Quality Registry

AAAAI Allergy, Asthma & Immunology Quality Clinical Data Registry in collaboration with CECity

American College of Cardiology Foundation FOCUS Registry

American College of Cardiology Foundation PINNACLE Registry

American College of Physicians Genesis RegistryTM in collaboration with CECity

American College of Radiology National Radiology Data Registry

American College of Rheumatology Informatics System for Effectiveness

American Gastroenterological Association Colorectal Cancer Screening and Surveillance Registry in collaboration with CECity

American Gastroenterological Association Digestive Recognition Program Registry in collaboration with CECity

American Joint Replacement Registry

American Society of Breast Surgeons Mastery of Breast Surgery Program

American Society of Clinical Oncology Quality Oncology Practice Initiative (QOPI)R

Anesthesia Quality Institute National Anesthesia Clinical Outcomes Registry

Chronic Disease Registry, Inc

CUHSM.ORG

Faculty Practice Foundation, Inc. supported by BMC Clinical Data Warehouse Registry

Geriatric Practice Management LTC Qualified Clinical Data Registry

GI Quality Improvement Consortium’s GIQuIC Registry

Louisiana State University Health Care Quality Improvement Collaborative [Louisiana State University, Quality in Health Care Advisory Group, LLC (QHC Advisory Group), CECity]

Massachusetts eHealth Collaborative Quality Data Center QCDR

Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) QCDR

Michigan Bariatric Surgery Collaborative QCDR

Michigan Urological Surgery Improvement Collaborative QCDR

National Osteoporosis Foundation and National Bone Health Alliance Quality Improvement Registry in collaboration with CECity

OBERD QCDR

Oncology Nursing Quality Improvement Registry in collaboration with CECity

Oncology Quality Improvement Collaborative (The US Oncology Network, McKesson Specialty Health, Quality in Health Care Advisory Group, LLC (QHC Advisory Group), CECity)

Physician Health Partners QCDR

Premier Healthcare Alliance Physician RegistryTM

Renal Physicians Association Quality Improvement Registry in collaboration with CECity

Society of Thoracic Surgeons National Database

The Guideline AdvantageTM (American Cancer Society, American Diabetes Association, American Heart Association) supported by Forward Health Group's PopulationManagerR

Vancouver Clinic

Wisconsin Collaborative for Healthcare Quality

Wound Care Quality Improvement Collaborative (Paradigm Medical Management, Patient Safety Education Network (PSEN), Net Health Systems, Inc., CECity)

A.62-64 Choices for **Measure steward (62)** and **Long-Term Measure Steward (if different) (64)**

None

Agency for Healthcare Research & Quality

Alliance of Dedicated Cancer Centers

Ambulatory Surgical Center (ASC) Quality Collaboration

American Academy of Allergy, Asthma & Immunology (AAAAI)

American Academy of Dermatology

American Academy of Neurology

American Academy of Ophthalmology

American Academy of Otolaryngology – Head and Neck Surgery (AAOHN)

American College of Cardiology

American College of Emergency Physicians

American College of Emergency Physicians (previous steward Partners-Brigham & Women's)

American College of Obstetricians and Gynecologists (ACOG)

American College of Radiology

American College of Rheumatology

American College of Surgeons

American Gastroenterological Association

American Health Care Association

American Medical Association

American Medical Association - Physician Consortium for Performance Improvement

American Medical Association - Physician Consortium for Performance Improvement/American College of Cardiology/American Heart Association

American Nurses Association

American Psychological Association

American Society for Gastrointestinal Endoscopy

American Society for Radiation Oncology

American Society of Addiction Medicine

American Society of Anesthesiologists

American Society of Clinical Oncology

American Society of Clinical Oncology

American Urogynecologic Society

American Urological Association (AUA)

AQC/ASHA

ASC Quality Collaboration

Audiology Quality Consortium/American Speech Language Hearing Association

Bridges to Excellence

Centers for Disease Control and Prevention

Centers for Medicare & Medicaid Services

Eugene Gastroenterology Consultants, PC Oregon Endoscopy Center, LLC

Health Resources and Services Administration (HRSA) - HIV/AIDS Bureau

Heart Rhythm Society (HRS)

IAC

Indian Health Service

Infectious Diseases Society of America (IDSA)

KCQA- Kidney Care Quality Alliance

MN Community Measurement

National Committee for Quality Assurance

National Minority Quality Forum

Office of the National Coordinator for Health Information Technology

Office of the National Coordinator for Health Information Technology/Centers for Medicare & Medicaid Services

Oregon Urology Institute

Oregon Urology Institute in collaboration with Large Urology Group Practice Association

Other (enter in Comments at far bottom of this screen)

Pharmacy Quality Alliance

Philip R. Lee Institute for Health Policy Studies

PPRNet

RAND Corporation

Renal Physicians Association; joint copyright with American Medical Association - Physician Consortium for Performance Improvement

Seattle Cancer Care Alliance

Society of Gynecologic Oncology

Society of Interventional Radiology

The Academy of Nutrition and Dietetics

The Joint Commission

The Society for Vascular Surgery

The University of Texas MD Anderson Cancer Center

University of Minnesota Rural Health Research Center

University of North Carolina- Chapel Hill

Wisconsin Collaborative for Healthcare Quality (WCHQ