TABLE E: Measures with Substantive Changes Finalized for MIPS Reporting for the 2018 Performance Period and Future Years

E.1. CAHPS for MIPS Clinician/Group Survey

Category	Description
NQF#:	0005 & 0006
Quality#:	321
CMS E-Measure ID:	N/A
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	CMS Approved Survey Vendor
Current Measure Description:	The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Clinician/Group Survey is comprised of 12 Summary Survey Measures (SSMs) and measures patient experience of care within a group practice.
Substantive Change:	The survey change would eliminate 2 SSMs (Helping You to Take Medication as Directed and Between Visit Communication)
Steward:	Agency for Healthcare Research & Quality (AHRQ)
High Priority Measure:	Yes (Patient Experience)
Rationale:	For the Quality Payment Program Year 2 and beyond, CMS proposed to remove two SSMs, "Helping You to Take Medication as Directed" due to low reliability and "Between Visit Communication" as this SSM currently contains only one question. This question could also be considered related to other SSMs entitled: "Care Coordination" or "Courteous and Helpful Office Staff," but does not directly overlap with any of the questions under that SSM. However, we proposed to remove this SSM in order to maintain consistency with the Medicare Shared Savings Program which utilizes the CAHPS for Accountable Care Organizations (ACOs) Survey. The SSM entitled "Between Visit Communication" has never been a scored measure in the CAHPS for ACOs Survey used in the Medicare Shared Savings Program. Please refer to section II.C.6.b.(3)(a)(iii) of this final rule for additional details on the removal of the two SSMs.
We did not receive specific comments regarding these measure changes. **FINAL ACTION:** We are finalizing the changes to Q321 as proposed for the 2018 Performance Period and future years.	

E.2. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Category	**Description**
NQF#:	0028
Quality#:	226
CMS E-Measure ID:	138v6
National Quality Strategy Domain:	Community/Population Health
Current Data Submission Method:	EHR, Claims, Web Interface, Qualified Registry
Current Measure Description:	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Substantive Change:	We proposed to restructure the measure more similarly to its original construct to make it more apparent where potential gaps in care exist and how performance can be improved. Instead of being comprised of just 1 performance rate (Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user), it is now comprised of the 3 components below: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
Steward:	Physician Consortium for Performance Improvement (PCPI)
High Priority Measure:	No
Rationale:	This measure was originally developed as a two-part measure: the first part assessed whether a patient had been screened for tobacco use within the past 24 months; the second part assessed whether those who had been screened and identified as tobacco users in the first part of the measure also received tobacco cessation intervention (either counseling and/or pharmacotherapy). The two parts were eventually combined into one performance rate. That performance rate is collective and does not show the difference in performance with respect to how well clinicians adhere to performing tobacco use screenings and how well clinicians follow the guidelines to provide tobacco cessation interventions. As written, the measure has had a continuously high performance rate. The performance rate currently does not differentiate between smokers and non-smokers with regards to counseling, thereby demonstrating a potential inaccurately high performance rate. To address this, based on discussions with CMS' Million Hearts program as well as the technical expert panel (TEP) recently convened by our measure development contractor, the measure has been updated to more accurately reflect the intended quality action. Accordingly, the measure will look to assess tobacco use, the percentage of patients who use tobacco and were counseled to quit and the overall percentage of patients who received counseling.

Comment: Three commenters expressed concerns about the changes to this measure. One commenter expressed concern that this change did not follow the NQF process. Two commenters expressed that it is unclear how the three rates will combine into a composite measure and how it will be scored in Medicare Shared Savings Program (MSSP).

Response: This substantive change was recommended by the measure steward to demonstrate the original intent of the measure. We will continue to work with the measure steward to ensure it cycles back through the NQF review process. Currently, specific measure information related to scoring is provided via sub-regulation guidance; therefore, additional scoring information for this multiple performance rate measure will be provided in sub-regulation guidance including how it will be scored in MSSP.

Comment: A commenter supported the revisions to measure Q226.

Response: We thank the commenter for their support.

Comment: One commenter objected that the substantive change makes year to year benchmarking and trending inconsistent, potentially lowering scores for the same performance.

Response: We thank the commenter for their feedback and intend to evaluate this change further to assess impact on scoring and new benchmarks for future rulemaking. If we receive performance data that meets the reliability minimum threshold, a new benchmark will be established based on the revised measure specification.

FINAL ACTION: We are finalizing the changes to Q226 as recommended for the 2018 Performance Period and future years.

E.3. Dementia: Cognitive Assessment

Category	Description
NQF #:	N/A
Quality #:	281
CMS E-Measure ID:	149v6
National Quality Strategy Domain:	Effective Clinical Care
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period
Substantive Change:	The measure currently allows for medical exceptions, including diagnosis of severe dementia, palliative care, or other medical reasons, from numerator compliance. Moving forward, the measure will not include a denominator exception for medical reasons (e.g., very advanced stage receiving palliative care, other medical reason).
Steward:	Physician Consortium for Performance Improvement (PCPI)
High Priority Measure:	No
Rationale:	The technical expert panel convened by our measure development contractor recommended removing these exceptions as cognitive assessment is especially important for planning the care of patients who are very sick or have advanced-stage dementia. The denominator identifies patients with dementia. Prior to this change, patients with severe dementia, palliative care, and medical reasons were removed from the denominator. While the denominator seeks patients with dementia, the number of patients with severe dementia is likely non-trivial and could impact performance rates. It is recognized that patients with perceived severe dementia still need an objective assessment of their cognition to appropriately care for them.

Comment: Four commenters expressed support for removing the denominator exception from the measure as cognitive assessment is essential throughout palliative care and the dementia trajectory.

Response: We thank the commenters for their support.

FINAL ACTION: We are finalizing the changes to Q281 as proposed for the 2018 Performance Period and future years.

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

Category	Description
NQF #:	0421
Quality #:	128
CMS E-Measure ID:	69v6
National Quality Strategy Domain:	Community/Population Health
Current Data Submission Method:	Claims, Web Interface, Registry, EHR
Current Measure Description:	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2
Substantive Change:	Change the frequency of documenting BMI from 6 to 12 months.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	No
Rationale:	Based on current evidence, the expert work group for the measure recommended revising the time frame for frequency of documenting BMI from 6 to 12 months. This change doubles the time frame for numerator compliance, providing additional opportunities for meeting measure criteria. Extending the timeframe for numerator compliance will decrease the burden on the clinician, and can also potentially impact the performance rates.

Comment: Four commenters expressed support for this substantive change. Two commenters supported changing the denominator for this measure; however, the commenters would like to understand how CMS will account for the measure change in scoring and requested that CMS seek comment on adjusting benchmarks. Another commenter objected that the substantive change makes year to year benchmarking and trending inconsistent, potentially lowering scores for the same performance.

Response: We thank the commenters for their support and intend to evaluate this change further to assess impact on scoring and new benchmarks which will be provided in program guidance. If we receive performance data that meets the reliability minimum threshold, a new benchmark will be established based on the revised measure specification.

FINAL ACTION: We are finalizing the changes to Q128 as proposed for the 2018 Performance Period and future years.

E.5. Preventive Care and Screening: Influenza Immunization

Category	Description
NQF #:	0041
Quality #:	110
CMS E-Measure ID:	147v7
National Quality Strategy Domain:	Community/Population Health
Current Data Submission Method:	Claims, Web Interface, Registry, EHR
Current Measure Description:	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
Substantive Change:	Remove encounter count requirement from initial population. This change applies to the Registry and EHR data submission methods only.
Steward:	Physician Consortium for Performance Improvement (PCPI)
High Priority Measure:	No
Rationale:	The technical expert panel (TEP) convened by our measure development contractor recommended removing the 2-visit requirement from CMS147. The TEP suggests the measure should encourage clinicians to take advantage of every opportunity to administer the flu vaccination. We agree with the TEP's recommendation and believe that each patient contact during the flu season is an opportunity to ensure that the patient received proper vaccination. This will reduce the number of missed opportunities for vaccination. We believe this change allows clinicians to take advantage of every opportunity to administer the flu vaccination. In light of this change, the Initial Population language and the Initial Population logic need to be modified.

Comment: One commenter objected that the substantive change makes year to year benchmarking and trending inconsistent, potentially lowering scores for the same performance.

Response: We thank the commenter for their feedback and intend to evaluate this change further to assess impact on scoring and new benchmarks which will be provided in program guidance. If we receive performance data that meets the reliability minimum threshold, a new benchmark will be established based on the revised measure specification.

FINAL ACTION: We are finalizing the changes to Q110 as proposed for the 2018 Performance Period and future years.

E.6. Use of High-Risk Medications in the Elderly

Category	Description
NQF #:	0022
Quality #:	238
CMS E-Measure ID:	156v6
National Quality Strategy Domain:	Patient Safety
Current Data Submission Method:	Registry, EHR
Current Measure Description:	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.
Substantive Change:	The change is in rate b, which will be going from two different medications to two instances of the same medication. This new change aligns with Beers criteria.
Steward:	National Committee for Quality Assurance (NCQA)
High Priority Measure:	Yes (Patient Safety)
Rationale:	The American Geriatrics Society has established the Beers criteria, inclusive of a list of medications considered to be inappropriate for elderly patients. The Beers criteria is important because it involves closer monitoring of drug use, application of real-time interventions, and better patient outcomes. The parent measure requires that the patients have two or more dispensing events (any days supply) on different dates of services during the measurement year. The dispensing events should be for the same drug (as identified by the drug ID in the HEDIS NDC code list).

Comment: One commenter objected that the substantive change makes year to year benchmarking and trending inconsistent, potentially lowering scores for the same performance.

Response: We thank the commenter for their feedback and intend to evaluate this change further to assess impact on scoring and new benchmarks which will be provided in program guidance. If we receive performance data that meets the reliability minimum threshold, a new benchmark will be established based on the revised measure specification.

FINAL ACTION: We are finalizing the changes to Q238 as proposed for the 2018 Performance Period and future years.

E.7. Functional Status Assessment for Total Knee Replacement

Category	Description
NQF #:	N/A
Quality #:	375
CMS E-Measure ID:	66v6
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients 18 years of age and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported functional status assessments
Substantive Change:	Aligning the initial population more closely with the measurement period. The overall duration of period remains the same. Changes to the measure description: Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Patient Experience)
Rationale:	The American Association of Hip and Knee Surgeons have recommended that the general/mental health survey be completed prior to surgery (during the preoperative visit) and after surgery (during the post-operative visit). The guidance calls for revised alignment with the measurement period.

Comment: One commenter supported the substantive change to align initial population with the measurement period.

Response: We thank the commenter for their support.

FINAL ACTION: We are finalizing the changes to Q375 as proposed for the 2018 Performance Period and future years.

E.8. Functional Status Assessment for Total Hip Replacement

Category	Description
NQF #:	N/A
Quality #:	376
CMS E-Measure ID:	56v6
National Quality Strategy Domain:	Person and Caregiver-Centered Experience and Outcomes
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients 18 years of age and older with primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported functional status assessments
Substantive Change:	Revise timing to identify initial population, to align more closely with the measurement period. The overall duration of period remains the same. Changes to the measure descriptions: Percentage of patients 18 years of age and older with who received an elective primary total hip arthroplasty (THA) who completed baseline and follow-up patient-reported and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Patient Experience)
Rationale:	The American Association of Hip and Knee Surgeons have recommended that the general/mental health survey be completed prior to surgery (during the preoperative visit) and after surgery (during the post-operative visit). The guidance calls for revised alignment with the measurement period.
Comment: One commenter supported the substantive change to align initial population with the measurement period. **Response:** We thank the commenter for their support. **FINAL ACTION:** We are finalizing the changes to Q376 as proposed for the 2018 Performance Period and future years.	

E.9. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Category	Description
NQF #:	N/A
Quality #:	438
CMS E-Measure ID:	347v1
National Quality Strategy Domain:	Effective Clinical Care
Current Data Submission Method:	Web Interface, Registry
Current Measure Description:	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: • Adults aged $\geq$ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged $\geq$21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level $\geq$ 190 mg/dL; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.
Substantive Change:	We propose to offer this measure as an eCQM for the 2018 performance period and future years.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	No
Rationale:	To provide eligible clinicians with an additional reporting option that can be used to report for the measure.

Comment: One commenter encouraged CMS to work with measure stewards to develop measures where the denominator addresses patients with the both Type 2 Diabetes and CVD.

Response: We will take this request into consideration and assess measure gap analysis for future Measure Development Plan revisions.

Comment: One commenter requested clarification on the inclusion of this measure because they noted that it is new in 2018 according the eCQI Resource Center 2018 list of EP/EC eCQMs.

Response: We would like to clarify that this measures was included in the finalized MIPS measures in 2017. We are proposing to offer this as an eCQM in 2018, which would be a submission method that was not available in 2017.

FINAL ACTION: We are finalizing the changes to Q438 as proposed for the 2018 Performance Period and future years.

E.10. Closing the Referral Loop: Receipt of Specialist Report

Category	Description
NQF #:	N/A
Quality #:	374
CMS E-Measure ID:	50v6
National Quality Strategy Domain:	Communication and Care Coordination
Current Data Submission Method:	EHR
Current Measure Description:	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
Substantive Change:	We propose to offer this measure as a registry measure for the 2018 performance period and future years.
Steward:	Centers for Medicare and Medicaid Services (CMS)
High Priority Measure:	Yes (Care Coordination)
Rationale:	To provide eligible clinicians with an additional reporting option that can be used to report for the measure.

Comment: Two commenters expressed support for this change. Another commenter did not support this change based on concerns with inconsistencies of reporting the denominator and numerator. The commenter indicated the denominator does define which eligible clinician is being held responsible for submitting the measure. Additionally, the commenter stated the measure does not take into consideration for delinquent specialist reports and inadequate time to complete the referral loop late in the performance period.

Response: We thank the commenter for their support and we will discuss concerns about the methodology to assess potential changes in future rulemaking. We have added clarification to the denominator to identify the eligible clinician who referred the patient should be submitting the measure. The intent of this measure is to promote communication to specialists prior to visit as well as providing reports to the referring provider. We do not end the performance period early as this may exclude potential denominator eligible encounters. We understand the other commenter's concern regarding inadequate time to complete the referral loop; however, all eligible clinicians submitting measure CMS50 will include eligible encounters occurring late in the performance period. Therefore, comparable results will be reported when calculating the performance of the measure.

FINAL ACTION: We are finalizing the changes to Q374 as proposed for the 2018 Performance Period and future years.

E.11. Dementia: Counseling Regarding Safety Concerns

Category	Description
NQF #:	N/A
Quality #:	286
CMS E-Measure ID:	N/A
National Quality Strategy Domain:	Patient Safety
Current Data Submission Method:	Qualified Registry
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period
Substantive Change:	We proposed to update the title, description and numerator of this measure to further specify the safety screening required and documentation of mitigation recommendations, consistent with updates from the measure steward.
Steward:	American Academy of Neurology
High Priority Measure:	Yes (Patient Safety)
Rationale:	CMS proposed to update this measure consistent with updates from the measure steward, as it will provide a more comprehensive assessment from which the results may provide additional insight about the patient's condition and alterations needed in the treatment plan therefore making this a more robust measure.

We did not receive specific comments regarding these measure changes.

FINAL ACTION: We are finalizing the changes to Q286 as proposed for the 2018 Performance Period and future years.

E.12. Dementia: Neuro-Psychiatric Symptom Assessment

Category	Description
NQF #:	N/A
Quality #:	283
CMS E-Measure ID:	N/A
National Quality Strategy Domain:	Effective Clinical Care
Current Data Submission Method:	Qualified Registry
Current Measure Description:	Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12-month period
Substantive Change:	The measure was updated to change 'Functional Status Assessment and Results Reviewed' to 'Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management' Symptoms screening is for three domains 'activity disturbances', 'mood disturbances' and 'thought and perceptual disturbances' including depression. To meet the measure, a documented behavioral and psychiatric symptoms screen inclusive of at least one or more symptom from each of three defined domains AND documented symptom management recommendations if safety concerns screening is positive within the last 12 months.
Steward:	American Academy of Neurology
High Priority Measure:	No
Rationale:	The measure steward updated the measure to combine it with Q284: *Dementia: Management of Neuropsychiatric Symptoms,* to make the measure more robust to include assessment of neuropsychiatric symptoms modified to include depression screening and the management of those symptoms.
Comment: Two commenters supported the substantive change to update the measure title to align with the updated specifications requiring behavioral and psychiatric symptom screening and management. **Response:** We thank the commenters for their support. **<u>FINAL ACTION:</u>** We are finalizing the changes to Q283 as proposed for the 2018 Performance Period and future years.	

General Comments: This table contains a compilation of comments and responses that do not pertain to any specific measure or measure set.

General Comments	Responses
Several commenters expressed support for: the adoption of new individual measures; the addition of new specialty measure sets, substantive changes to individual measures; substantive changes to specialty measure sets; and for removing the requirement to report cross-cutting quality measures.	We thank the commenters for their support.
Several commenters recommended additional measures for consideration in future rulemaking, including: applicable measures within the Core Measures Quality Collaborative; core sets of high-value measures by specialty/subspecialty; measures that address primary prevention for stroke patients; measures that assess quality of care for patients with rare and multiple chronic diseases; a new specialty measure set for physical therapy; new efficiency measures reportable under MIPS and AAPM with regard to diagnostic imaging; and new measures that would benefit from remote electronic collection related to tobacco use cessation/prevention, BMI screening/follow-up, unhealthy alcohol use, and diabetes testing/reporting.	We will take this into consideration for future rulemaking. In addition, we encourage the commenters to work with measures' developers to submit new measures through the Call for Measures process to fill any perceived gaps in measures.
A commenter expressed concerns that CMS's interpretation of three PRO measures for depression fundamentally change the meaning of the measures. CMS requires an encounter during the performance period for QPP #370, QPP #411, and CMS WI MH-1 whereas (1) a qualifying event may occur before the start of the performance period, (2) patient reported outcomes can be captured not only during face-to-face encounters but also via telephone, mail, patient portal, and the internet, and (3) providers have the flexibility to deliver care through a variety of modalities that are patient-centered.	We are planning to allow for the encounter to occur prior to the performance period for all applicable data submission methods except the Web Interface. The Web Interface has unique implementation challenges of this measure that will not currently allow this to occur but will be taken into consideration in the future.