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MIPS and Medicaid Clinical Quality Measures

Measure	Description
CMS002	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS022	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
CMS050	Closing the referral loop: receipt of specialist report
CMS052a	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis - <=3 Mon. of CD4 <200 cells/mm3
CMS052b	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis - At Diagnosis of HIV
CMS052c	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis - <=3 Mon. of CD4 <500 cells/mm3 or CD4 <15%
CMS056	Functional Status Assessment for Hip Replacement
CMS066	Functional Status Assessment for Knee Replacement
CMS068	Documentation of Current Medications in the Medical Record
CMS069	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - 18-64
CMS074	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - 0-20
CMS075	Children Who Have Dental Decay or Cavities
CMS082	Maternal Depression Screening
CMS090	Functional Status Assessment for Congestive Heart Failure
CMS117	Childhood Immunization Status
CMS122	Diabetes: Hemoglobin A1c Poor Control
CMS124	Cervical Cancer Screening
CMS125	Breast Cancer Screening
CMS127	Pneumonia Vaccination Status for Older Adults
CMS128	Anti-depressant Medication Management
CMS129	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
CMS130	Colorectal Cancer Screening
CMS131	Diabetes: Eye Exam
CMS132	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
CMS133	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS134	Diabetes: Urine Protein Screening
CMS135a	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS135b	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS136a	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Visit within 30 days
CMS136b	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Visit with 2+ followups
CMS137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
CMS138a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention - 18 years and older who were screened one or more times within 24 months
CMS138b	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention - 18 years and older who were screened and identified as a tobacco user who received tobacco cessation intervention

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CMS138c	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention - 18 years and older who were screened one or more times within 24 months and identified as a tobacco user who received tobacco cessation intervention
CMS139	Falls: Screening for Future Fall Risk
CMS142	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS143	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS144a	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS144b	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS145a	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - LVSD
CMS145b	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - prior MI
CMS146	Appropriate Testing for Children with Pharyngitis
CMS147	Preventive Care and Screening: Influenza Immunization
CMS149	DementiaCognitive - Dementia: Cognitive Assessment
CMS153	Chlamydia Screening for Women - 16-24
CMS154	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS156	Use of High-Risk Medications in the Elderly
CMS157a	Oncology: Medical and Radiation – Face to Face Encounter with Ongoing Chemotherapy
CMS157b	Oncology: Medical and Radiation – Radiation Treatment with Cancer Diagnosis
CMS159	Depression Remission at Twelve Months
CMS160a	Depression Utilization of the PHQ-9 Tool - Sep-Dec
CMS160b	Depression Utilization of the PHQ-9 Tool - May-Aug
CMS160c	Depression Utilization of the PHQ-9 Tool - Jan-Apr
CMS161	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS165	Controlling High Blood Pressure
CMS177	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS347a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease - Patients aged >= 21 years with clinical ASCVD diagnosis
CMS347b	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease - Patients aged >= 21 years laboratory result of LDL-C >=190 mg/dL
CMS347c	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
CMS645	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy

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MIPS Promoting Interoperability Measures		
Measure		**Description**
PI_EP_1	e-Prescribing	Generate and transmit permissible prescriptions electronically
PI_EP_2	Query of Prescription Drug Monitoring Program (PDMP)	For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.
PI_HIE_1	Support Electronic Referral Loops by Sending Health Information	Creates or electronically exchanges a SOC record for transitions of care and referrals or new patients
PI_HIE_4	Support Electronic Referral Loops by Receiving and Incorporating Health Information	Perform a clinical information reconciliation (medications, allergies, problem lists) where at least one SOC was received for transitions of care, referrals, or new patients
PI_PEA_1	Provide Patients Electronic Access to Their Health Information	Provide patients the ability to view online, download, and transmit their health information
PI_PHCDRR_1	Immunization Registry	Actively engaged to submit Immunization data and receive forecasts from the registry or IIS
PI_PHCDRR_2	Syndromic Surveillance	Actively engaged to submit syndromic surveillance data from an urgent care setting
PI_PHCDRR_3	Electronic Case	Actively engaged to submit case reporting of reportable conditions
PI_PHCDRR_4	Public Health Registry	Actively engaged to submit data to a Public Health Registry
PI_PHCDRR_5	Clinical Data Registry	Actively engaged to submit data to a Clinical Data Registry
PI_PPHI_1	Security Risk Analysis	Protect ePHI by implementing appropriate technical, administrative and physical safeguards

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Medicaid Promoting Interoperability Measures	
Measure	**Description**
View, Download or Transmit (VDT)	Actively engage with the electronic health record made accessible by the provider
Secure Messaging	Send a secure electronic message using CEHRT to the patient, or respond to a secure message sent by the patient
Patient Generated Health Data	Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for unique patients discharged during the reporting period
CDS Interventions	Use clinical decision support (5 interventions) to improve performance on high-priority health conditions
Drug Interaction	Implement drug-drug and drug-allergy interaction checks
CPOE Medications	Use computerized provider order entry (CPOE) for medication orders
CPOE Laboratory	Use computerized provider order entry (CPOE) for laboratory orders
CPOE Diagnostic Imaging	Use computerized provider order entry (CPOE) for radiology orders
e-Prescribing	Generate and transmit permissible prescriptions electronically
Send a Summary of Care	Creates or electronically exchanges a SOC record for transitions of care and referrals or new patients
Request/Accept Summary of Care	Requests or accepts an electronic SOC record for transitions of care and referrals or new patients
Clinical Information Reconciliation	Perform a clinical information reconciliation (medications, allergies, problem lists) for transitions of care and referrals
Provide Patient Access	Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge
Patient-Specific Education	Provide patient-specified educational resources
Immunization Registry	Actively engaged to submit Immunization data and receive forecasts from the registry or IIS
Syndromic Surveillance	Actively engaged to submit syndromic surveillance data from an urgent care setting
Electronic Case	Actively engaged to submit case reporting of reportable conditions
Public Health Registry	Actively engaged to submit data to a Public Health Registry
Clinical Data Registry	Actively engaged to submit data to a Clinical Data Registry
Security Risk Analysis	Protect ePHI by implementing appropriate technical, administrative and physical safeguards

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Improvement Activities Measures	
Activity	**Description**
IA_AHE_1	Engagement of New Medicaid Patients and Follow-up
IA_AHE_2	Leveraging a QCDR to standardize processes for screening
IA_AHE_3	Promote Use of Patient-Reported Outcome Tools
IA_AHE_4	Leveraging a QCDR for use of standard questionnaires
IA_AHE_5	MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
IA_AHE_6	Provide Education Opportunities for New Clinicians
IA_AHE_7	Comprehensive Eye Exams
IA_BE_1	Use of certified EHR to capture patient reported outcomes
IA_BE_10	Participation in a QCDR, that promotes implementation of patient self-action plans.
IA_BE_11	Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan.
IA_BE_12	Use evidence-based decision aids to support shared decision-making.
IA_BE_13	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
IA_BE_14	Engage patients and families to guide improvement in the system of care.
IA_BE_15	Engagement of patients, family and caregivers in developing a plan of care
IA_BE_16	Evidenced-based techniques to promote self-management into usual care
IA_BE_17	Use of tools to assist patient self-management
IA_BE_18	Provide peer-led support for self-management.
IA_BE_19	Use group visits for common chronic conditions (e.g., diabetes).
IA_BE_2	Use of QCDR to support clinical decision making
IA_BE_20	Implementation of condition-specific chronic disease self-management support programs
IA_BE_21	Improved practices that disseminate appropriate self-management materials
IA_BE_22	Improved practices that engage patients pre-visit
IA_BE_23	Integration of patient coaching practices between visits
IA_BE_24	Financial Navigation Program
IA_BE_3	Engagement with QIN-QIO to implement self-management training programs
IA_BE_4	Engagement of patients through implementation of improvements in patient portal
IA_BE_5	Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities
IA_BE_6	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
IA_BE_7	Participation in a QCDR, that promotes use of patient engagement tools.
IA_BE_8	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.
IA_BE_9	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.
IA_BMH_1	Diabetes screening
IA_BMH_10	Completion of Collaborative Care Management Training Program
IA_BMH_2	Tobacco use
IA_BMH_3	Unhealthy alcohol use
IA_BMH_4	Depression screening
IA_BMH_5	MDD prevention and treatment interventions
IA_BMH_6	Implementation of co-location PCP and MH services
IA_BMH_7	Implementation of Integrated Patient Centered Behavioral Health Model
IA_BMH_8	Electronic Health Record Enhancements for BH data capture

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Improvement Activities Measures	
IA_BMH_9	Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients
IA_CC_1	Implementation of use of specialist reports back to referring clinician or group to close referral loop
IA_CC_10	Care transition documentation practice improvements
IA_CC_11	Care transition standard operational improvements
IA_CC_12	Care coordination agreements that promote improvements in patient tracking across settings
IA_CC_13	Practice improvements for bilateral exchange of patient information
IA_CC_14	Practice improvements that engage community resources to support patient health goals
IA_CC_15	PSH Care Coordination
IA_CC_16	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients
IA_CC_17	Patient Navigator Program
IA_CC_18	Patient Navigator Program
IA_CC_2	Implementation of improvements that contribute to more timely communication of test results
IA_CC_3	Implementation of additional activity as a result of TA for improving care coordination
IA_CC_4	TCPI participation
IA_CC_5	CMS partner in Patients Hospital Improvement Innovation Networks
IA_CC_6	Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination
IA_CC_7	Regular training in care coordination
IA_CC_8	Implementation of documentation improvements for practice/process improvements
IA_CC_9	Implementation of practices/processes for developing regular individual care plans
IA_EPA_1	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record
IA_EPA_2	Use of telehealth services that expand practice access
IA_EPA_3	Collection and use of patient experience and satisfaction data on access
IA_EPA_4	Additional improvements in access as a result of QIN/QIO TA
IA_EPA_5	Participation in User Testing of the Quality Payment Program Website
IA_ERP_1	Participation on Disaster Medical Assistance Team, registered for 6 months.
IA_ERP_2	Participation in a 60-day or greater effort to support domestic or international humanitarian needs.
IA_PCMH	Patient Centered Medical Home Option
IA_PM_1	Participation in systematic anticoagulation program
IA_PM_10	Use of QCDR data for quality improvement such as comparative analysis reports across patient populations
IA_PM_11	Regular review practices in place on targeted patient population needs
IA_PM_12	Population empanelment
IA_PM_13	Chronic care and preventative care management for empanelled patients
IA_PM_14	Implementation of methodologies for improvements in longitudinal care management for high risk patients
IA_PM_15	Implementation of episodic care management practice improvements
IA_PM_16	Implementation of medication management practice improvements
Improvement Activities Measures	

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IA_PM_17	Participation in Population Health Research
IA_PM_18	Provide Clinical-Community Linkages
IA_PM_19	Glycemic Screening Services
IA_PM_2	Anticoagulant management improvements
IA_PM_20	Glycemic Referring Services
IA_PM_21	Advance Care Planning
IA_PM_3	RHC, IHS or FQHC quality improvement activities
IA_PM_4	Glycemic management services
IA_PM_5	Engagement of community for health status improvement
IA_PM_6	Use of toolsets or other resources to close healthcare disparities across communities
IA_PM_7	Use of QCDR for feedback reports that incorporate population health
IA_PM_9	Participation in population health research
IA_PSPA_1	Participation in an AHRQ-listed patient safety organization.
IA_PSPA_10	Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments
IA_PSPA_11	Participation in CAHPS or other supplemental questionnaire
IA_PSPA_12	Participation in private payer CPIA
IA_PSPA_13	Participation in Joint Commission Evaluation Initiative
IA_PSPA_14	Participation in Bridges to Excellence or other similar program
IA_PSPA_15	Implementation of antibiotic stewardship program
IA_PSPA_16	Use of decision support and standardized treatment protocols
IA_PSPA_17	Implementation of analytic capabilities to manage total cost of care for practice population
IA_PSPA_18	Measurement and improvement at the practice and panel level
IA_PSPA_19	Implementation of formal quality improvement methods, practice changes or other practice improvement processes
IA_PSPA_2	Participation in MOC Part IV
IA_PSPA_20	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
IA_PSPA_21	Implementation of fall screening and assessment programs
IA_PSPA_22	CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain
IA_PSPA_23	Completion of CDC Training on Antibiotic Stewardship
IA_PSPA_24	Initiate CDC Training on Antibiotic Stewardship
IA_PSPA_25	Cost Display for Laboratory and Radiographic Orders
IA_PSPA_26	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event
IA_PSPA_27	Invasive Procedure or Surgery Anticoagulation Medication Management
IA_PSPA_28	Completion of an Accredited Safety or Quality Improvement Program
IA_PSPA_29	Consulting AUC Using Clinical Decision Support when Ordering Advanced
IA_PSPA_3	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS(R) or other similar activity.
IA_PSPA_30	PCI Bleeding Campaign
IA_PSPA_31	Patient Medication Risk Education
IA_PSPA_32	Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support
IA_PSPA_4	Administration of the AHRQ Survey of Patient Safety Culture
IA_PSPA_5	Annual registration in the Prescription Drug Monitoring Program
IA_PSPA_6	Consultation of the Prescription Drug Monitoring program
IA_PSPA_7	Use of QCDR data for ongoing practice assessment and improvements
Improvement Activities Measures	

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IA_PSPA_8	Use of patient safety tools
IA_PSPA_9	Completion of the AMA STEPS Forward program