

2024 Qualified Clinical Data Registry (QCDR) Fact Sheet

What is a QCDR?

A QCDR is defined as an entity that demonstrates clinical expertise in medicine and quality measurement development that collects medical or clinical data on behalf of a Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) eligible clinician for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.¹ A QCDR may include:

- An entity with clinical expertise in medicine. Clinicians are on staff with the organization and lend their clinical expertise in the work carried out by the organization as a QCDR.
- An entity with stand-alone quality measurement development expertise.
- An entity that uses an external organization for purposes of data collection, calculation, or transmission may meet the definition of a QCDR as long as the entity has a signed, written agreement that specifically details the responsibilities of the entity and the external organization. The written agreement must be effective as of September 1 of the year preceding the applicable performance period.²

Entities without clinical expertise in medicine and quality measure development that want to become a QCDR may collaborate with entities with such expertise.

As described in calendar year (CY) 2018 Medicare Physician Fee Schedule (PFS) Final Rule,³ changes to the QCDR's organizational structure (for example, if a specialty society wishes to partner with a different data submission platform vendor) are considered substantive and would need to be included as an update at the time of self-nomination. The roles and responsibilities of each organization should be specifically detailed within the Self-Nomination form.

As an alternative to becoming a QCDR, entities may seek to qualify as another type of third party intermediary, such as a Qualified Registry. A Qualified Registry doesn't require quality measurement development experience.

A QCDR may self-nominate up to 30 quality measures not in the annual list of MIPS quality measures.⁴ QCDRs will need to provide full QCDR measure specifications to CMS at the time of self-nomination.⁵ CMS will review the quality measures and determine if they're appropriate for

¹ [§ 414.1305](#)

² [§ 414.1400\(b\)\(3\)\(ii\)](#)

³ [82 FR 53809](#)

⁴ [§ 414.1400\(b\)\(4\)\(iv\)\(P\)](#)

⁵ [§ 414.1400\(b\)\(4\)\(i\)\(B\)](#)



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QCDR reporting.⁶ You may refer to the [QCDR Measure Development Handbook](#) for more information.

Measures submitted by a QCDR may be from one or more of the following categories:

- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS), which must be reported via a CAHPS-certified vendor. Although the CAHPS for MIPS Survey is included in the MIPS measure set, the changes needed for reporting by individual clinicians are significant enough to treat it as a QCDR measure for the purposes of reporting via a QCDR. Submitting a subset of CAHPS survey measures as a QCDR measure won't count for credit toward completing the CAHPS for MIPS Survey.
- Consensus-Based Entity (CBE) endorsed measures.
- MIPS quality measures approved for the 2024 MIPS performance period.
- QCDR measures developed by the QCDR.
- QCDR measures developed by other entities, such as boards, specialty societies or regional quality collaboratives, with the appropriate documented permission to use the QCDR measure.

What are the requirements to become a QCDR?

1. **Participants:** You must have at least 25 participants by January 1 of the year prior to the applicable performance period (January 1, 2023 for consideration for the 2024 MIPS performance period).⁷ These participants aren't required to use the QCDR to report MIPS data to CMS, but they must submit data to the QCDR for quality improvement.⁸ **QCDRs must be able to accept and retain data by January 1 of the applicable performance period.**⁹ A system that isn't "live", beginning with the start of the MIPS performance period, is considered non-compliant with this requirement.
2. **Certification Statement:** You must certify that all data submissions to CMS on behalf of MIPS eligible clinicians, groups, virtual groups, subgroups, and/or Alternative Payment Model (APM) Entities, inclusive of voluntary and opt-in participants are true, accurate, and complete to the best of your knowledge.¹⁰ This certification applies to data submissions based on the acceptance of data exports directly from an electronic health record (EHR) or other data sources and for traditional MIPS, MIPS Value Pathways (MVPs), and the APM Performance Pathway (APP). If you become aware that any submitted information isn't true, accurate, and complete, corrected information may be submitted until the end of the data submission period. If false, inaccurate, or incomplete data are identified after the data submission period, you should immediately notify CMS.

⁶ [§ 414.1400\(b\)\(4\)\(iv\)\(P\)](#)

⁷ [§ 414.1400\(b\)\(3\)\(i\)](#)

⁸ [81 FR 77365](#)

⁹ [§ 414.1400\(b\)\(3\)\(xvii\)](#)

¹⁰ [§ 414.1400\(a\)\(3\)](#)



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3. **Data Submission:** You should submit data via a CMS-specified secure method for data submission, such as a defined Quality Payment Program (QPP) data format.¹¹ Additional information regarding data submission methodologies can be found in the Developer Tools section of the [QPP website](#). (Data submission is discussed in more detail below).

Except as provided in the CY2023 Medicare Physician Fee Schedule (PFS) Final Rule,¹² QCDRs, qualified registries, and health information technology (IT) vendors must be able to submit data for all of the following MIPS performance categories:

- Quality, except:
 - The CAHPS for MIPS Survey; and
 - For qualified registries and health IT vendors, QCDR measures.
- Improvement activities; and
- Promoting Interoperability, if the eligible clinician, group, virtual group, subgroup, or APM Entity is using Certified Electronic Health Record Technology (CEHRT); however, a third party intermediary may be excepted from this requirement if its MIPS eligible clinicians, groups, virtual groups, subgroups, MVPs, or APM Entities fall under the reweighting policies.^{13,14}

Beginning with the CY 2023 MIPS performance period/2025 MIPS payment year, QCDRs must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data. QCDRs may also support the APP).¹⁵ A QCDR must support all measures and improvement activities available in the MVP with two exceptions:

- If an MVP includes several specialties, then a QCDR is only expected to support the measures that are pertinent to the specialty of their clinicians.¹⁶
- QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR doesn't own the QCDR measures in the MVP, the QCDR may only support the QCDR measures if they have the appropriate permissions.¹⁷

4. **Data Validation and Targeted Audits:** You must submit a data validation annually, at the time of self-nomination for CMS' approval and may not change the data validation once approved without prior CMS approval. You must conduct annual data validation audits. You must conduct data validation for the 2024 MIPS performance year prior to any data

¹¹ [81 FR 77367 through 77369](#)

¹² [§ 414.1400\(b\)\(1\)\(i\)](#)

¹³ [§ 414.1400\(b\)\(1\)\(i\)\(C\)](#)

¹⁴ [§ 414.1380\(c\)\(2\)\(i\)\(A\)\(4\)](#) or [414.1380\(c\)\(2\)\(i\)\(A\)\(5\)](#) or [§ 414.1380\(c\)\(2\)\(i\)\(C\)\(1\)](#) through [414.1380\(c\)\(2\)\(i\)\(C\)\(7\)](#) or [§414.1380\(c\)\(2\)\(i\)\(C\)\(9\)](#)

¹⁵ [§ 414.1400\(b\)\(1\)\(ii\)](#)

¹⁶ [§ 414.1400\(b\)\(1\)\(ii\)\(A\)](#)

¹⁷ [§ 414.1400\(b\)\(1\)\(ii\)\(B\)](#)



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submission via traditional MIPS, MVPs, and/or the APP **for the 2024 MIPS performance period.**¹⁸

Your data validation must include all:

- Collection types (QCDR measures, MIPS CQMs, electronic clinician quality measures (eCQMs), and Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs for ACOs)).
- Performance categories (quality, improvement activities, Promoting Interoperability);
- Reporting options (traditional MIPS, MVPs, the APP); and
- Participation options (MIPS eligible clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs, inclusive of voluntary, opt-in, and/or MVP participants).

You must use clinical documentation (provided by the clinicians for whom you're submitting data for) to validate that the action or outcome measured actually occurred or was performed.¹⁹ In addition, each data validation audit must include the following:

- ☐ Verification of the eligibility status of each eligible clinician, group, virtual group, subgroup, voluntary, and opt in participants.
- ☐ Verification of the accuracy of tax identification numbers (TINs) and National Provider Identifier (NPIs).
- ☐ Calculation of reporting and performance rates.
- ☐ Verification that only the MIPS quality measures, improvement activities, Promoting Interoperability measures and objectives, and QCDR measures that are relevant for the performance periods will be used for MIPS submission, including traditional MIPS, MVPs, and the APP. For the 2024 MIPS performance period, this means:
 - 2024 MIPS CQMs, eCQMs, Medicare CQMs for ACOs, and/or QCDR measures for the quality performance category.
 - 2024 Promoting Interoperability measures and objectives for the Promoting Interoperability performance category.
 - 2024 improvement activities for the improvement activities performance category.²⁰
- **Data Validation Audits.** Each data validation audit (formerly known as “randomized audit”) must use a sampling methodology that meets the following requirements for all performance categories for which you'll submit data (traditional MIPS, MVP reporting, the APP):
 - Sample size of at least 3% of a combination of individual clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs submitted to CMS, except that the sample size must have a minimum of 10 individual

¹⁸ [§ 414.1400\(b\)\(3\)\(v\)\(A\)](#)

¹⁹ [§ 414.1400\(b\)\(3\)\(v\)\(D\)](#)

²⁰ [§ 414.1400\(b\)\(3\)\(v\)\(F\)\(1\)](#) through [414.1400\(b\)\(3\)\(v\) \(F\)\(4\)](#)



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clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs, and that the sample size must have a minimum of 10 individual clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs and the sample size doesn't need to include more than 50 individual clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs.²¹

- Sample that includes at least 25% of the patients of each individual clinician, group, virtual group, subgroup, and APM Entity including Shared Savings Program ACOs in the sample, except that the sample size for each individual clinician, group, virtual group, subgroup, and APM Entity including Shared Savings Program ACOs must have a minimum of 5 patients and doesn't need to include more than 50 patients.²²

If your organization is supporting Medicare CQMs, the intermediary will need to evaluate the ACO's list of beneficiaries eligible for Medicare CQMs against each Medicare CQM specification prior to submission, including confirming the beneficiaries meet the numerator and denominator criteria for the measure. The ACO list of beneficiaries eligible for Medicare CQMs is provided to the ACO each quarter throughout the performance year as part of its Quarterly Informational Reports Packages

- **Targeted Audits.** If a data validation audit identifies one or more deficiencies or data errors, you must also conduct a targeted audit (formerly known as "detailed audit") into the impact and root cause of each such deficiency or data error for that MIPS payment year.²³ Any required targeted audits for the 2024 MIPS performance year and correction of any deficiencies or data errors identified through such audit must be completed prior to the submission of data for the 2024 MIPS performance period.²⁴ The sample used for auditing in the targeted audit must be based on a sampling methodology that meets the requirements for data validation audits and must not include data from the sample used for the data validation audit in which the deficiency or data error was identified.²⁵ (*The targeted audit is required if any errors or deficiencies are found through the data validation audit of traditional MIPS, MVP reporting, and/or the APP*).
5. **Data Validation Execution Report (DVER) and Targeted Audits:** You must execute your 2024 data validation and any required targeted audits **prior** to the submission of data for traditional MIPS, MVPs, and the APP for the 2024 MIPS performance period.

²¹ [§ 414.1400\(b\)\(3\)\(v\)\(E\)\(1\)](#)

²² [§ 414.1400\(b\)\(3\)\(v\)\(E\)\(2\)](#)

²³ [§ 414.1400\(b\)\(3\)\(vi\)\(A\)](#)

²⁴ [§ 414.1400\(b\)\(3\)\(vi\)\(B\)](#)

²⁵ [§ 414.1400\(b\)\(3\)\(vi\)\(C\)](#)



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- ☐ The 2024 DVER with the results of your data validation audit must be submitted to CMS by June 2, 2025.²⁶
- ☐ The 2024 DVER must include:
 - The name of the QCDR.
 - Whether the data submitted was for any of the performance categories for the 2024 MIPS performance period.
 - Overall Data Deficiency or Data Error Rate – (number of clinicians with a data issue / total number of clinicians supported).
 - For each type of deficiency or data error discovered, you must provide (1) a description and examples of the deficiency/error; (2) the percentage of clinicians impacted by the deficiency/error and (3) when and how each deficiency/error was corrected. Types of deficiencies or data errors include, but aren't limited to, the following:
 - Errors or deficiencies related to verifying MIPS eligibility of clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs.
 - Errors or deficiencies related to verifying the accuracy of TINs and NPIs.
 - Errors or deficiencies related to the use of 2024 MIPS measures and activities that were used for submission, namely:
 - the 2024 MIPS CQMs, eCQMs, Medicare CQMs for ACOs, and/or QCDR measures for the quality performance category.
 - the 2024 Promoting Interoperability measures and objectives for the Promoting Interoperability performance category.
 - the 2024 improvement activities for the improvement activities performance category.
 - Errors or deficiencies in calculating data completeness and performance rates (i.e., were any issues identified with how the MIPS quality measure specifications and/or QCDR measure specifications (as applicable) were implemented in the system?)
 - Errors or deficiencies identified during the data validation audit. If one or more errors or deficiencies are identified during the data validation audit, a targeted audit is required.
 - If you're required to conduct any targeted audits for 2024 MIPS performance period, the corresponding 2024 targeted audit results should also be submitted to CMS by June 2, 2025.
 - Your report with the results of each targeted audit must include:
 - the overall deficiency or data error rate;
 - the types of deficiencies or data errors discovered;
 - how and when each error or deficiency was corrected; and
 - the percentage of your total clinicians impacted by each deficiency or data error.

²⁶ [§ 414.1400\(b\)\(3\)\(v\)\(G\)\(1\)](#)



Late, incomplete, and/or absent submission of your DVER or the results for a required targeted audit constitutes non-compliance with program requirements and may result in remedial action or termination of the QCDR for the current and possibly future program years of the MIPS program.

CMS will provide a DVER template for data validation and targeted audit results, which will be posted on the [CMS QPP Resource Library](#).

6. **Performance Category Feedback Reports:** QCDRs are required to provide performance category feedback at least 4 times a year, and provide specific feedback to all clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs on how they compare to other clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs who have submitted data on a given measure for traditional MIPS, MVPs, and the APP.
- CMS doesn't provide a template for the performance feedback reports.
 - If a real-time feedback dashboard is available to clinicians, CMS asks that the QCDR e-mail clinicians, groups, virtual groups, subgroups, MVPs, and APM Entities including Shared Savings Program ACOs at least 4 times a year, to remind them the feedback is available.
 - Exceptions to this requirement may occur if the QCDR doesn't receive the data from their clinician until the end of the performance period, as mentioned in the CY2023 Medicare Physician Fee Schedule (PFS) Final Rule.²⁷
7. **Attestation:** Attest that you understand the QCDR qualification criteria and program requirements and will meet all program requirements.

What are the organization approval criteria?

To be approved as a third party intermediary, an intermediary must agree to meet these requirements including, but not limited to, the following:

1. A third party intermediary's principal place of business and retention of any data must be based in the U.S.²⁸
2. If the data is derived from a CEHRT, then a QCDR, qualified registry, and/or health IT vendor must be able to indicate its data source.²⁹
3. All data must be submitted in the form and manner specified by CMS.³⁰
4. If the clinician chooses to opt-in in accordance with [§ 414.1310](#), the third party intermediary must be able to transmit that decision to CMS.³¹

²⁷ [§ 414.1400\(b\)\(3\)\(iii\)](#)

²⁸ [§ 414.1400\(a\)\(2\)\(i\)\(A\)](#)

²⁹ [§ 414.1400\(a\)\(2\)\(i\)\(B\)](#)

³⁰ [§ 414.1400\(a\)\(2\)\(i\)\(C\)](#)

³¹ [§ 414.1400\(a\)\(2\)\(i\)\(D\)](#)



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5. The third party intermediary must provide services throughout the entire performance period and applicable data submission period.³²
6. Prior to discontinuing services to any MIPS eligible clinician, group, virtual group, subgroup, or APM Entity including any Shared Savings Program ACO during a performance period, the third party intermediary must support the transition of each MIPS eligible clinician, group, virtual group, subgroup, MVP, or APM Entity including any Shared Savings Program ACO to an alternate third party intermediary, submitter type, or, for any measure on which data has been collected, collection type according to a CMS approved a transition plan.³³
7. The determination of whether to approve an organization as a third party intermediary for a MIPS payment year may take into account:
 - a. Whether the organization failed to comply with the requirements of this section for any prior MIPS payment year for which it was approved as third party intermediary; and
 - b. Whether the organization provided inaccurate information regarding the requirements of this subpart to any eligible clinician.³⁴
8. Beginning with the 2023 MIPS payment year, third party intermediaries must attend and complete training and support sessions in the form and manner, and at the times, specified by CMS.
9. All data submitted to CMS by a third party intermediary on behalf of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity including Shared Savings Program ACOs must be certified by the third party intermediary as true, accurate, and complete to the best of its knowledge. Such certification must be made in a form and manner and at such time as specified by CMS.³⁵ This applies to data submitted for traditional MIPS, MVPs, and the APP.

What data submission functions must an approved QCDR perform?

Following the self-nomination and QCDR measure process, an approved QCDR should be able to perform the following data submission functions:

1. Indicate:

- ☐ Whether the QCDR is using a CEHRT data source
- ☐ Performance period start and end dates.
- ☐ Report data on quality measures, Promoting Interoperability measures and objectives or improvement activities, as applicable, to the standards and requirements of the respective performance categories.

2. Submit:

³² [§ 414.1400\(a\)\(2\)\(i\)\(E\)](#)

³³ [§ 414.1400\(a\)\(2\)\(i\)\(F\)](#)

³⁴ [§ 414.1400\(a\)\(2\)\(ii\)](#) through [414.1400\(a\)\(2\)\(ii\)\(B\)](#)

³⁵ [§ 414.1400\(a\)\(2\)\(i\)](#) through [414.1400\(a\)\(3\)](#)



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- ☐ The data and results for all supported MIPS performance categories.
 - ✓ The data must include **all-payer data**, and not just Medicare Part B claims patients.
 - ✓ If reporting Medicare CQMs on behalf of an ACO participating in the Medicare Shared Savings Program, the data should include beneficiaries eligible for Medicare CQMs that meet the measure specification.³⁶
- ☐ If submitting MIPS CQMs, eCQMs, and/or QCDR measures, results for at least 6 quality measures including one outcome measure, as applicable.
 - ✓ If an outcome measure isn't available, use at least one other high priority measure.³⁷ Give entire distribution of measure results by decile, if available.
- ☐ If submitting Medicare CQMs for ACOs, all 3 measures must be submitted.
- ☐ Appropriate measure and activity identifiers (IDs) for quality measures, Promoting Interoperability measures and objectives, and improvement activities, and titles for MVPs.³⁸
- ☐ Measure-level data completeness rates by TIN/NPI, TIN and/or aggregated TINs.
- ☐ Measure-level performance rates by TIN/NPI and/or TIN.³⁹
- ☐ The sampling methodology used for data validation.
- ☐ Risk-adjusted results for any risk-adjusted measures.
- ☐ Additional details for QCDR Measures:
 - ✓ Data elements and QCDR measure specifications.
 - ✓ Risk-adjusted results for QCDR quality data, if applicable.
 - ✓ Comparison of quality of care by measure, by clinician or group.

3. Report on the number of:

- ☐ Eligible instances (reporting denominator).
- ☐ Instances a quality action is performed (performance numerator).
- ☐ Instances the applicable quality action wasn't met (performance not met).
- ☐ Instances a performance exception/exclusion occurred (denominator exceptions/numerator exclusions).

4. Verify and maintain clinician information:

- ☐ Signed verification of clinician names, contact information, services provided, costs charged to clinicians, quality measures (MIPS quality measures and/or QCDR measures), and specialty-specific measure sets (if applicable).
- ☐ Business associate agreements must comply with Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. Records of the authorization must be maintained for 6 years after the performance period ends.⁴⁰

³⁶ [§ 425.20](#)

³⁷ [§ 414.1400\(b\)\(3\)\(x\)](#)

³⁸ [§ 414.1400\(b\)\(3\)\(ix\)](#)

³⁹ [§ 414.1400\(b\)\(3\)\(v\)\(F\)\(3\)](#)

⁴⁰ [§ 414.1400\(b\)\(3\)\(xii\)](#) and [414.1400\(b\)\(3\)\(xiii\)](#)



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- ☐ Business agreement(s) with clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs who provide patient-specific data.
- ☐ Obtain and keep on file signed documentation from each holder of an NPI has authorized the QCDR to submit quality measure results, improvement activities measure and activity results, Promoting Interoperability objective results and numerator and denominator data or patient-specific data on Medicare and non-Medicare beneficiaries to CMS for the purpose of MIPS participation. This documentation should be obtained annually at the time the clinician or group enters into an agreement with the QCDR to submit MIPS data to the QCDR⁴¹ and must meet the requirements of any applicable laws, regulations, and contractual business associate agreements. Groups participating in MIPS via a QCDR may have their group's duly authorized representative grant permission to the QCDR to submit their data to us. If submitting as a group, each individual clinician doesn't need to grant their individual permission to the QCDR to submit their data to us.
- ☐ A practice administrator may give consent on behalf of a group, virtual group, subgroup, or APM Entity including any Shared Savings Program ACO, reporting as a group, but **not** for an individual clinician reporting as an individual. If you're submitting the individual clinician data as an individual, you must have a business associate agreement and consent in place for each individual clinician.
- ☐ Include disclosure of MIPS quality measure results and data on Medicare and non-Medicare beneficiaries. If your organization is submitting Medicare CQMs for ACOs, the disclosure would be specific to an identified Medicare population rather than all-payer data.
- ☐ Clinician consent with signed authorization to submit results and data to CMS for MIPS.
- ☐ Certification statement that all data and results are true, accurate, and complete to the best of your knowledge.⁴²

5. Comply with:

- ☐ Any CMS request to review your submitted data. For the purposes of auditing, CMS may request any records or data retained for the purposes of MIPS for up to 6 years from the end of the MIPS performance period.⁴³
- ☐ Requirement to attend and complete training and support sessions.⁴⁴
- ☐ Participation requirements (for example, and not limited to conducting data validation and submitting required reports, performance feedback to clinicians, QCDR would be up and running by January 1 of the given performance period, etc.).
- ☐ All data must be submitted in the form and manner specified by CMS.⁴⁵

⁴¹ [§ 414.1400\(b\)\(3\)\(xii\)](#) and [414.1400\(b\)\(3\)\(xiii\)](#)

⁴² [§ 414.1400\(a\)\(3\)](#)

⁴³ [§ 414.1400\(b\)\(3\)\(xv\)](#)

⁴⁴ [§ 414.1400\(a\)\(2\)\(iii\)](#)

⁴⁵ [§ 414.1400\(a\)\(2\)\(i\)\(C\)](#)

What are considered data inaccuracies?

Data inaccuracies may result in:

- Remedial action, up to and including termination for future program year(s) based on data inaccuracies affecting the third party intermediary's clinicians based on CMS discretion.⁴⁶
- The QCDR posting updated for the MIPS performance period will indicate the QCDR's data error rate on the CMS website until the data error rate falls below 3% and to indicate that remedial action or termination has been taken against the QCDR.

CMS will further evaluate the QCDR to determine if any additional inaccurate, unusable, or otherwise compromised data has been submitted. Data inaccuracies may lead to remedial action/termination of the QCDR for future program year(s), based on CMS discretion.

CMS will evaluate data submitted for quality measures for data completeness and accuracy. The QCDR will also certify that all data submitted (including quality measures, improvement activities, and Promoting Interoperability objectives and measures) are true, accurate, and complete to the best of their knowledge.

CMS will determine error rates calculated on data submitted to CMS for clinicians, groups, virtual groups, subgroups, and APM Entities including Shared Savings Program ACOs.

CMS will evaluate data inaccuracies including, but not limited to:

- TIN/NPI Issues – Incorrect TINs, incorrect NPIs, submission of group NPIs.
- Formatting Issues – Submitting files with incorrect file formats, submitting files with incorrect element formats, failure to update and resubmit rejected files.
- Calculation Issues – Incorrect qualities for measure elements, performance rates, and/or data completeness rates; numerators larger than denominators.
- Data Audit Discrepancies – Since data audits are required to occur prior to data submission, QCDRs should correct all identified errors prior to submitting the data to CMS. QCDR acknowledgement of data discrepancies found post submission from clinician feedback reports will be taken into consideration by CMS.

What is the overall process to become a CMS approved QCDR?

To become a QCDR for the MIPS program under QPP, you must self-nominate and successfully complete a qualification process.

The overall process includes these steps:

- The QCDR completes and submits the Self-Nomination form and supported quality measures (MIPS quality measures and/or QCDR Measures), improvement activities,

⁴⁶ [§ 414.1400\(e\)\(3\)](#)

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Promoting Interoperability objectives and measures, the APP, and MVPs through the QPP website for CMS consideration.⁴⁷

- If the Self-Nomination form is approved, all submitted QCDR measures are reviewed (if applicable). CMS may approve, provisionally approve, or reject the QCDR measures. The QCDR measure statuses are defined as:
 - Approved – The QCDR measure is approved for the given performance period.
 - Rejected – The QCDR measure isn't approved for the given performance period. CMS will provide a rationale for the rejection.
- A qualified posting is developed for the approved QCDR and should include the following:
 - Organization type;
 - Specialty;
 - Previous participation in MIPS (if applicable);
 - Program status [remedial action taken against the QCDR or terminated as a third party intermediary (if applicable)];
 - Contact information;
 - Last date to accept new clients.
 - Virtual groups specialty parameters (if applicable);
 - The approved quality measures;
 - Reporting option(s) supported;
 - Participation options supported;
 - MVPs supported;
 - Performance categories supported;
 - Services offered;
 - Costs incurred by clients.

CMS requires that QCDRs attest that the information listed on the qualified posting is accurate.⁴⁸

- Approved QCDRs review and acknowledge the measure specifications for their approved QCDR measures.
- Approved QCDRs are required to support the performance categories, reporting options, measures and activities listed on their qualified posting and meet all applicable approval criteria for the applicable performance period as a condition of participation in MIPS. Failure to do so may lead to remedial action or possible termination of the QCDR from future MIPS program years. Prior to discontinuing services to any clinician, group, virtual group, subgroup, or APM Entity including any Shared Savings Program ACO during a performance period, the third party intermediary must support the transition of such clinician, group, virtual group, subgroup, or APM Entity including Shared Savings Program ACOs to an alternate third party intermediary, submitter type, or, for any measure on

⁴⁷ [82 FR 53810](#)

⁴⁸ [§ 414.1400\(b\)\(3\)\(xiv\)](#)

which data has been collected, collection type according to a CMS approved transition plan.⁴⁹

The list of CMS-approved QCDRs that have been approved to submit data to CMS as a QCDR for the 2024 MIPS performance period will be posted in the 2024 QCDR Qualified Posting on the [QPP Resource Library](#).

When is the self-nomination period?

You can self-nominate from:

July 1 – September 1 of the year prior to the applicable performance period. For the 2024 MIPS performance period, the self-nomination period will open at **10 a.m. ET** on July 1 and close at **8 p.m. ET** on September 1, 2023. Self-nominations submitted after the deadline won't be considered.⁵⁰

Tips for successful self-nomination:

1. You must provide all required information at the time of self-nomination, and before the close of the self-nomination period via the [QPP website](#) for CMS consideration.
2. Self-nomination is an annual process. If you want to qualify as a QCDR for a given MIPS performance period, you'll need to self-nominate for that MIPS performance period. Qualification and participation in a prior program year doesn't automatically qualify an intermediary for subsequent MIPS performance periods.

A simplified self-nomination form is available to reduce the burden of self-nomination for those existing QCDRs that have previously participated in MIPS and are in good standing (i.e., CMS didn't take remedial action against or terminate the QCDR as a third party intermediary).

QCDRs that are in good standing are still required to submit their self-nomination form even if they utilize the simplified self-nomination process as there may be new sections to fill out and they need to respond to attestations within the course of the application.⁵¹

A simplified Self-Nomination form is available **only** to existing QCDRs who are in good standing. Existing QCDRs in good standing should contact the MIPS QCDR/Registry Support Team (Practice Improvement and Measure Management Support (PIMMS Team)) at QCDRVendorSupport@gdit.com if they can't find or access the simplified Self-Nomination form instead of submitting a new Self-Nomination form.

⁴⁹ [§ 414.1400\(a\)\(2\)\(i\)\(F\)](#) through [414.140\(a\)\(3\)\(iv\)](#)

⁵⁰ [§ 414.1400\(b\)\(2\)](#)

⁵¹ [§ 414.1400\(b\)\(2\)](#)

What information is needed to self-nominate?

You should provide the following when you self-nominate:

- ☐ Your QCDR's intermediary name.
- ☐ Specify any partnerships or collaborations.
- ☐ For the 2024 MIPS performance period, a QCDR that was approved but didn't submit any MIPS data for either of the 2 years preceding the applicable self-nomination period must submit a participation plan for CMS' approval. This participation plan must include the QCDR's detailed plans about how the QCDR intends to encourage clinicians to submit MIPS data to CMS through the QCDR.⁵² Beginning with the 2024 MIPS performance period/2026 MIPS payment year, an organization that submits a participation plan, but doesn't submit MIPS data for the applicable MIPS performance period for which they self-nominated, will be terminated.⁵³
- ☐ Whether you're a new applicant or previously approved QCDR (approved in a previous year of MIPS and/or the Physician Quality Reporting System (PQRS)).
- ☐ MIPS performance categories you'll support. QCDRs are required to support the quality, Promoting Interoperability, and improvement activity performance categories. Third party intermediaries could be excepted from this requirement if ALL of its supported clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs fall under the reweighting policies.
- ☐ Whether you can support the APP including Medicare CQMs for ACOs.
- ☐ The list of MVPs you're supporting.
- ☐ Which QCDR Measure Specifications you're submitting (if submitting QCDR Measures).
- ☐ The list of MIPS CQMs you're supporting. The reporting of MIPS CQMs must use the current measure specification for the performance period in which they'll be used and must be used as specified. Third party intermediaries aren't permitted to alter or modify measure specifications.
- ☐ The list of eCQMs you're supporting. The reporting of eCQMs must use the current measure specification for the performance period in which they'll be used and must be used as specified. Third party intermediaries aren't permitted to alter or modify measure specifications.
- ☐ The list of 2024 improvement activities you're supporting.
- ☐ The list of 2024 Promoting Interoperability objectives and measures you're supporting.
- ☐ An intermediary seeking to become a QCDR must submit specifications for each measure, activity, and objective that the intermediary intends to submit for MIPS (including the information described in paragraphs [§ 414.1400\(b\)\(4\)\(i\)](#)) at the time of self-nomination.
- ☐ Please identify your intermediary type (i.e., Collaborative, Health Information Exchange/Regional Health Information Organization, Health IT vendor, Regional Health Collaborative, Specialty Society, Other).
- ☐ The list of data collection method(s) you use (i.e., claims, EHR, practice management system, web-based tool, etc.).

⁵² [§ 414.1400\(b\)\(3\)\(vii\)](#)

⁵³ [§ 414.1400\(e\)\(5\)](#)



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- ☐ Confirm you'll conduct your 2024 data validation audits and any required targeted audits and correct any deficiencies or data errors identified through such audits prior to the submission of data for the MIPS payment year.
- ☐ Confirm you'll submit reports with the results of each 2024 MIPS performance period data validation audit and targeted audit by the deadline of June 2, 2025.
- ☐ The list of available performance data.
- ☐ The Risk Adjustment Method for QCDR Measures (if applicable).
- ☐ The list of participation options you intend to support (i.e., clinician, group, virtual group, subgroup, APM Entities including any Shared Savings Program ACOs).
- ☐ Specify the cost [frequency (monthly, annual, per submission)] and if the cost is per provider/practice, services included in cost, and if there's a different cost for supporting traditional MIPS compared to MVPs.
- ☐ Detailed information on quality measure development experience and clinical expertise.

What is a QCDR measure?

QCDR Measures may be comprised of:

- A measure that isn't contained in the annual list of MIPS quality measures for the applicable performance period.
- A measure that may be in the annual list of MIPS quality measures but has substantive differences in the manner it's submitted by the QCDR.
- The CAHPS for MIPS Survey, which can only be submitted using a CMS-approved survey vendor. Although the CAHPS for MIPS Survey is included in the MIPS measure set, the changes needed for reporting by individual clinicians are significant enough to treat it as a QCDR measure for the purpose of reporting via a QCDR. CMS won't approve patient survey measures that only measure whether the survey was distributed and/or completed. In addition, QCDRs won't receive CAHPS for MIPS Survey credit for CAHPS for MIPS Survey measures submitted as QCDR measures.

CMS recommends that QCDRs use the following when developing and self-nominating QCDR measures:

- [Measure Development Plan](#)
- [QCDR Measure Development Handbook](#)
- [Blueprint Measure Lifecycle content on the CMS Measures Management System \(MMS\) Hub](#)

What is required for nominating a QCDR measure?

QCDR measures must have the following:

- Be beyond the measure concept phase of development.
- Address significant variation in performance.
- Meet face validity for the initial MIPS payment year for which it is approved.



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- Meet the definition of fully developed and tested for subsequent years following their first year of being approved. All QCDR measures must be fully developed and tested, with complete testing results at the clinician level, prior to submitting the QCDR measure. At the time of self-nomination, QCDR measures must be fully tested prior to inclusion in an MVP.
- QCDRs are required to collect data appropriate to the measure type, prior to the submission of the QCDR measure for CMS consideration during the self-nomination period.
- Address areas of duplication.

You must provide QCDR measure specifications for each QCDR measure that you would like to nominate for CMS consideration:

- Provide QCDR measure specifications for each QCDR measure. This should be submitted in your Self-Nomination form in the Self-Nomination website QCDR Measure tab no later than the last day of the applicable self-nomination period. In addition, no later than 15 calendar days following CMS posting of all approved specifications for a QCDR measure, entities must publicly post the CMS-approved measure specifications for the QCDR measure (including the CMS-assigned QCDR measure ID) and provide CMS with a link to where this information is posted. The approved QCDR measure specifications must remain published through the performance period and data submission period.⁵⁴ QCDRs must also confirm that the measure specifications they post align with the measure specifications posted by CMS.⁵⁵

Beginning with the 2022 MIPS performance period, QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

For a complete listing of all QCDR measure self-nomination requirements and QCDR measure specifications, please see the Self-Nomination User Guide which is included in the 2024 Self-Nomination Toolkit. Table 1 lists the basic QCDR measure specifications.

Table 1: Measure Specifications

QCDR Measures	MIPS Quality Measures
QCDR measure specifications must include: • Measure Title • Description • CMS assigned QCDR measure ID. • Denominator and numerator statements • Descriptions of the denominator exceptions, denominator exclusions, and numerator exclusions	For MIPS CQMs/eCQMs, or Medicare CQMs for ACOs, only the MIPS CQM IDs for individual measures and/or the specialty-measure set measures must be submitted.

⁵⁴ [§ 414.1400\(b\)\(4\)\(i\)\(B\)](#)

⁵⁵ [§ 414.1400\(b\)\(4\)\(i\)\(B\)](#)



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QCDR Measures	MIPS Quality Measures
- Care setting - Telehealth, if applicable - Measure type - High priority measure and high priority type, if applicable - Primary data source used for abstraction and any additional data source information - Consensus-based Entity (CBE) ID number, if applicable - Number of performance rates required - Description of performance rates, if more than one required - Designation of overall performance rate - Traditional vs Inverse measure analytic - Proportional, continuous variable, ratio measure indicator - If risk-adjusted and which score is risk-adjusted - Risk adjustment variables and risk adjustment algorithms, when applicable	

What are other QCDR measure approval considerations?

QCDRs should be able to collect ALL that's required for the QCDR measure and feasibly implement the QCDR measure by January 1 of the performance period.

For additional information, please reference the CY2024 Medicare Physician Fee Schedule (PFS) Final Rule. In reviewing potential QCDR measures, we take into consideration the following points:⁵⁶

- Develop measures using the measure development processes as defined in the most recent [Blueprint Measure Lifecycle content on the CMS MMS Hub](#).
- Conduct an environmental scan for duplicity with other QCDR measures; current or proposed MIPS quality measures; or quality measures retired from MIPS or the legacy PQRS program.
- Be clinically relevant and evidence based (align with current clinical guidelines).
- Preference for measures that are outcome-based rather than clinical process measures.
 - Focus on an actionable performance rather than a documentation process.
 - Focus on a clinical outcome rather than a process, if able.
- Represents a sufficient denominator population and measure adoption for the QCDR measure to have a more significant impact on quality improvement.
- Clearly define the quality action and population in the description for clinician ease of understanding.
- If a QCDR measure is being used by a QCDR that doesn't own the measure, it is expected that the ability to abstract the data according to the QCDR measure owner's specifications is a condition of self-nominating the QCDR measure.
- Indicates accurate measure analytics (inverse, risk-adjusted, ratio, proportional, or continuous variable).

⁵⁶ [§ 414.1400\(b\)\(4\)\(iii\)](#)



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- Be thoroughly vetted by the QCDR to ensure proper spelling and grammar throughout the QCDR measure specification.
- Provide CMS, if available, QCDR measure data from years prior to the start of the performance period.⁵⁷

QCDR measure rejection criteria considerations include, but aren't limited to, the following factors:

- Duplicative, or identical, to other QCDR measures or MIPS quality measures that are currently in the program or that have been removed or retired from MIPS or the legacy PQRS program.
- Meet the topped out definition. As defined at [§ 414.1305](#),⁵⁸ a topped out non-process measure means a measure where the Truncated Coefficient of Variation is less than 0.10 and the 75th and 90th percentiles are within 2 standard errors. A topped out process measure means a measure with a median performance rate of 95% or higher. This definition aligns with other CMS Value Based Payment programs.
- Process-based, with consideration to whether the removal of the process measure impacts the number of measures available for a specific specialty.
- Whether the QCDR measure has potential unintended consequences to a patient's care.
- Considerations and evaluation of the measure's performance data, to determine whether performance variance exists.
- Whether the previously identified areas of duplication have been addressed as requested.
- Split a single clinical practice or action into several QCDR measures.
- "Check-box" with no actionable quality action.
- Doesn't meet the case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive years.
- No longer considered clinically and/or analytically robust. In instances where new QCDR measures are considered to have a more vigorous quality action, CMS preference is to include the new QCDR measure rather than requesting QCDR measure reconciliation of areas of duplication.
- Clinician attribution issues, where the quality action isn't under the direct control of the reporting clinician.
- Focus on rare events or "never events" in the measurement period.⁵⁹
- QCDR measures submitted after self-nomination period has closed.⁶⁰
- If the QCDR submits more than 30 quality measures not in the annual list of MIPS quality measures for CMS consideration.⁶¹

⁵⁷ [§ 414.1400\(b\)\(4\)\(i\)\(C\)](#)

⁵⁸ [§ 414.1305](#)

⁵⁹ [§ 414.1400\(b\)\(4\)\(iv\)](#)

⁶⁰ [§ 414.1400\(b\)\(4\)\(iv\)\(O\)](#)

⁶¹ [§ 414.1400\(b\)\(4\)\(iv\)\(P\)](#)



QCDR Measure Approval

QCDR measures are generally approved annually for one performance period. QCDR measures may be approved for 2 years, at CMS discretion. Upon annual review, CMS may revoke a QCDR measure's second year approval, if the QCDR measure is found to be: topped out; duplicative of a more robust measure; reflects an outdated clinical guideline; or if the QCDR that is nominating the QCDR measure is no longer in good standing.⁶²

We place greater preference on [QCDR](#) measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive performance periods. Those that don't meet reporting volumes required to establish benchmarks may not continue to be approved.⁶³

In instances where a [QCDR](#) believes the low-reported [QCDR](#) measure that didn't meet benchmarking thresholds is still important and relevant to a specialist's practice, the [QCDR](#) may develop and submit a [QCDR](#) measure participation plan for our consideration. This [QCDR](#) measure participation plan must include the [QCDR's](#) detailed plans and changes to [encourage](#) clinicians, groups and virtual [groups](#) to submit data on the low-reported [QCDR](#) measure for purposes of the [MIPS](#) program.⁶⁴

As examples, a QCDR measure participation plan could include one or more of the following:

- Development of an education and communication plan.
- Update the QCDR measure's specification with changes to encourage broader participation.
- Require reporting on the QCDR measure as a condition of reporting through the QCDR.

What may cause remedial action to be taken or termination of third party intermediaries from the program?

CMS has the authority to impose remedial action or termination based on its determination that a third party intermediary is non-compliant with one or more applicable criteria for approval, has submitted a false certification or has submitted data that is inaccurate, unusable, or otherwise compromised,⁶⁵ not maintained current contact information for correspondence,⁶⁶ or are on remedial action for 2 consecutive years.⁶⁷

⁶² [§ 414.1400\(b\)\(4\)\(iii\)\(C\)](#)

⁶³ [§ 414.1400\(b\)\(4\)\(iii\)\(B\)\(10\)](#)

⁶⁴ [§ 414.1400\(b\)\(4\)\(iii\)\(B\)\(10\)\(i\)](#)

⁶⁵ [§ 414.1400\(e\)](#)

⁶⁶ [§ 414.1400\(e\)\(2\)\(iv\)](#)

⁶⁷ [§ 414.1400\(e\)\(2\)\(v\)](#)



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QCDRs that have remedial action taken against them will be required to submit a corrective action plan (CAP) to address any deficiencies and detail any steps taken to prevent the deficiencies from reoccurring within a specified time period. The third party intermediary is required to submit a CAP by a date specified by CMS. The CAP must address the following issues unless different or additional information is specified by CMS:

- The issues that contributed to the non-compliance.
- The impact to individual clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs regardless of whether they're participating in the program because they're MIPS eligible, voluntarily participating, or opting in to participating in the MIPS program, and any QCDRs that were granted licenses to the measures of a QCDR upon which a CAP has been imposed.
- The corrective actions to be implemented by the third party intermediary to ensure that the non-compliance has been resolved and won't recur in the future.
- The detailed timeline for achieving compliance with the applicable requirements.
- Develop a communication plan for communicating the impact to the parties identified in finalized [§ 414.1400\(e\)\(1\)\(i\)\(B\)](#).⁶⁸ This would include individual clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs, regardless of whether they're participating in the program because they're MIPS eligible, voluntarily participating, opting in to participate, and/or MVP participating in the MIPS program, and any QCDRs that were granted licenses to the measures of a QCDR upon which a CAP has been imposed.
- Communicate the final resolution to CMS once the resolution is complete, and to provide an update, if any, to the monitoring plan provided.⁶⁹

Failure to comply with the remedial action process may lead to termination of third party intermediaries for the current and/or subsequent performance year. If a third party intermediary is terminated, a transition plan must be submitted by a date specified by CMS. The transition plan must address the following unless different or additional information is specified by CMS:⁷⁰

- State the issues that contributed to the withdrawal mid-performance period or discontinuation of services mid-performance period.
- State the number of clinicians, groups, virtual groups, subgroups or APM Entities including Shared Savings Program ACOs inclusive of MIPS eligible, opt-in and voluntary participants that would need to find another way to report and as applicable, and identify any QCDRs that were granted licenses to QCDR measures which would no longer be available for reporting due to the transition.
- State the steps the third party intermediary will take to ensure that the clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs identified in [§ 414.1400\(a\)\(3\)\(iv\)\(B\)\(1\)](#) are notified of the transition in a timely manner

⁶⁸ [§ 414.1400\(e\)\(1\)\(i\)\(B\)](#)

⁶⁹ [§ 414.1400\(e\)\(1\)\(i\)\(F\)](#)

⁷⁰ [§ 414.1400\(a\)\(3\)\(iv\)](#)



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and successfully transitioned to an alternate third party intermediary, submitter type, or, for any measure or activity on which data has been collected, collection type, as applicable.

- Require that the transition plan include a detailed timeline of when the third party intermediary will take the steps identified in paragraph (a)(3)(iv)(C), including notification of affected clinicians, groups, virtual groups, subgroups, or APM Entities including Shared Savings Program ACOs, the start of the transition, and the completion of the transition.
- The third party intermediary must communicate to CMS that the transition was completed by the date included in the detailed timeline.⁷¹

The 2024 QCDR Qualified Posting will be updated to reflect when remedial action has been taken and/or termination of third party intermediaries participating as a qualified QCDR.

Resources

- **CY2024 Payment Policies under the Physician Fee Schedule (PFS)** - CMS provides an overview of the major policies finalized for the 2024 MIPS performance period in the [CY2024 QPP Policies Final Rule Resources \(ZIP, 1,794 KB\) file](#), which includes a table comparing the previous policy to the newly finalized policy.
- **QCDR Support Calls** - CMS will hold mandatory joint support calls for QCDRs and Qualified Registries that are approved to participate in the 2024 MIPS performance period. These support calls will be held approximately once a month, with the kick-off meeting (in-person or virtually) being the first of the monthly calls. The support calls address reporting requirements, steps for successful submission, and allow for a question-and-answer session. The monthly support calls are limited to only include approved 2024 MIPS performance period QCDRs. Each QCDR must attend both the webinar and audio portion via computer or phone to receive credit for attending the support call. One representative from an intermediary supporting multiple QCDRs, **WON'T** be counted as attendance for multiple QCDRs.
- **Virtual Office Hours (VOHs)** - CMS will host joint VOHs to offer QCDRs and Qualified Registries an opportunity to ask CMS subject matter experts questions related to the assigned topics for those calls. Only topic specific questions will be addressed during each call. All other questions will be referred to as the QPP Service Center. Participation in the VOHs **isn't required** but is strongly encouraged.
- **QPP Listserv** - The QPP Listserv will provide news and updates on new resources, website updates, upcoming milestones, deadlines, CMS trainings, and webinars. To subscribe, visit the [QPP website](#) and select 'Subscribe to Updates' at the bottom of the page or in the footer.
- **QPP Website** - Educational documents for QCDR participation will be available on the website to help support you in your submission process. In addition, lists with the criteria

⁷¹ [§ 414.1400\(a\)\(3\)\(iv\)\(A\)](#) through [414.1400\(a\)\(3\)\(iv\)\(E\)](#)



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used to audit and validate data submitted in each of the MIPS performance categories will be available on the website.

- **QPP** - For assistance contact the Quality Payment Program Service Center by e-mail at: QPP@cms.hhs.gov, by phone at 1-866-288-8292 (Monday-Friday 8 a.m.- 8 p.m. ET), or by creating a [QPP Service Center ticket](#). Customers who are deaf or hard of hearing- can dial 711 to be connected to a TRS Communications Assistant.
- [2024 Self-Nomination Toolkit for QCDRs and Registries \(ZIP, 1MB\)](#) - The Self-Nomination User Guide within the zip files provides step-by-step instructions for entities looking to become an approved QCDR for the 2024 MIPS performance period.
- [Blueprint Measure Lifecycle content on the CMS MMS Hub](#) - Provides a standardized system for developing and maintaining the quality measures used in CMS's various quality initiatives and programs. The primary goal is to provide guidance to measure developers to help them produce high-caliber healthcare quality measures and document the core set of business processes and decision criteria used when developing, implementing, and maintaining measures.
- [Measure Development Plan](#) - Is a focused framework to help CMS build and improve quality measures that clinicians could report under MIPS and as participants in Advanced APMs (collectively known as the QPP).
- [QCDR Measure Development Handbook](#) - Provides guidance and suggestions to QCDR measure developers on QCDR measure structure, analytics and types as well as a QCDR measure development check list, resources for QCDR measure development and definitions used by CMS to communicate QCDR measure review decisions.

Version History Table

Date	Change Description
06/01/2023	Original Version
01/12/2024	Updates based on CY 2024 Medicare PFS Final Rule
02/07/2024	Updated 2024 DVER deadline

