Pennsylvania Promoting Interoperability Program

Eligible Professionals

MAPIR Screenshots

Program Years

2019, 2020 and 2021

Table of Contents

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Purpose of Document

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- The purpose of this document is to provide users with information regarding changes and new features within MAPIR for Program Years 2019, 2020 and 2021. Screenshots offer visual references to the MAPIR screens that have been updated since last program year. There are also navigation tips included to aid users as they advance through the application with the new screens.
- Please note that this document gives users information for ***new*** items in MAPIR for Program Years 2019, 2020 and 2021 only. It does **not** include screenshots for MAPIR sections in which there are no changes from Program Year 2018. To see a complete collection of MAPIR screenshots from application start to finish, you can click on the 2018 EP Stage 3 Screenshots document on our website.

Requirements for Program Years 2019 through 2021

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2015 Edition CEHRT is required for Program Years 2019 through 2021

NOTE: if you have upgraded from a 2014 edition to a 2015 edition CEHRT since your last program participation, you will need to submit a new signed vendor letter

All eligible providers (EPs) are required to complete Stage 3 Meaningful Use

- Program Year 2019 specification sheets can be accessed by clicking here
- Program Year 2020 & 2021 specification sheets can be access by clicking here

Meaningful Use Reporting Periods for all EPs

- Meaningful Use reporting period for all EPs is any continuous 90-day period in the applicable Program Year (2019, 2020 or 2021)
- CQM reporting period for Program Year 2019 is a full calendar year 2019 for EPs who have attested to MU in previous program years
- CQM reporting period for Program Year 2019 is any continuous 90-day period in 2019 for EPs that are attesting to MU for the first time
- CQM reporting period for all EPs in Program Years 2020 and 2021 is any continuous 90-day period in the applicable program year (2020 or 2021)

New Features in MAPIR

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- A **Provider On-Demand Resource** allows provider groups to track current program status for all their current providers
- An **Instructional Patient Volume Click here link** provides clarification between the two patient volume reporting options
- The **Meaningful Use Navigation Panel** allows users to complete their MU Objectives in any order and shows them their progress within the section
- **Public Health Drop Down Boxes** have been added for each public health option so EPs can select the appropriate registry instead of manually typing in the name
- The **CQM Selection Screen** is now split into three sections: Outcome CQMs, High Priority CQMs and All Other CQMs
- The **Required Prepayment Documentation Screen** includes information on the documentation the Department requires in order to process the MAPIR application

New Features in MAPIR (continued)

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- In 2021, MAPIR will allow for a provider to have Two Applications Open at the Same Time
- Providers will be able to submit a Program Year 2021 application even if their Security Risk Analysis hasn't been completed by the date of attestation.

Provider On-Demand Resource

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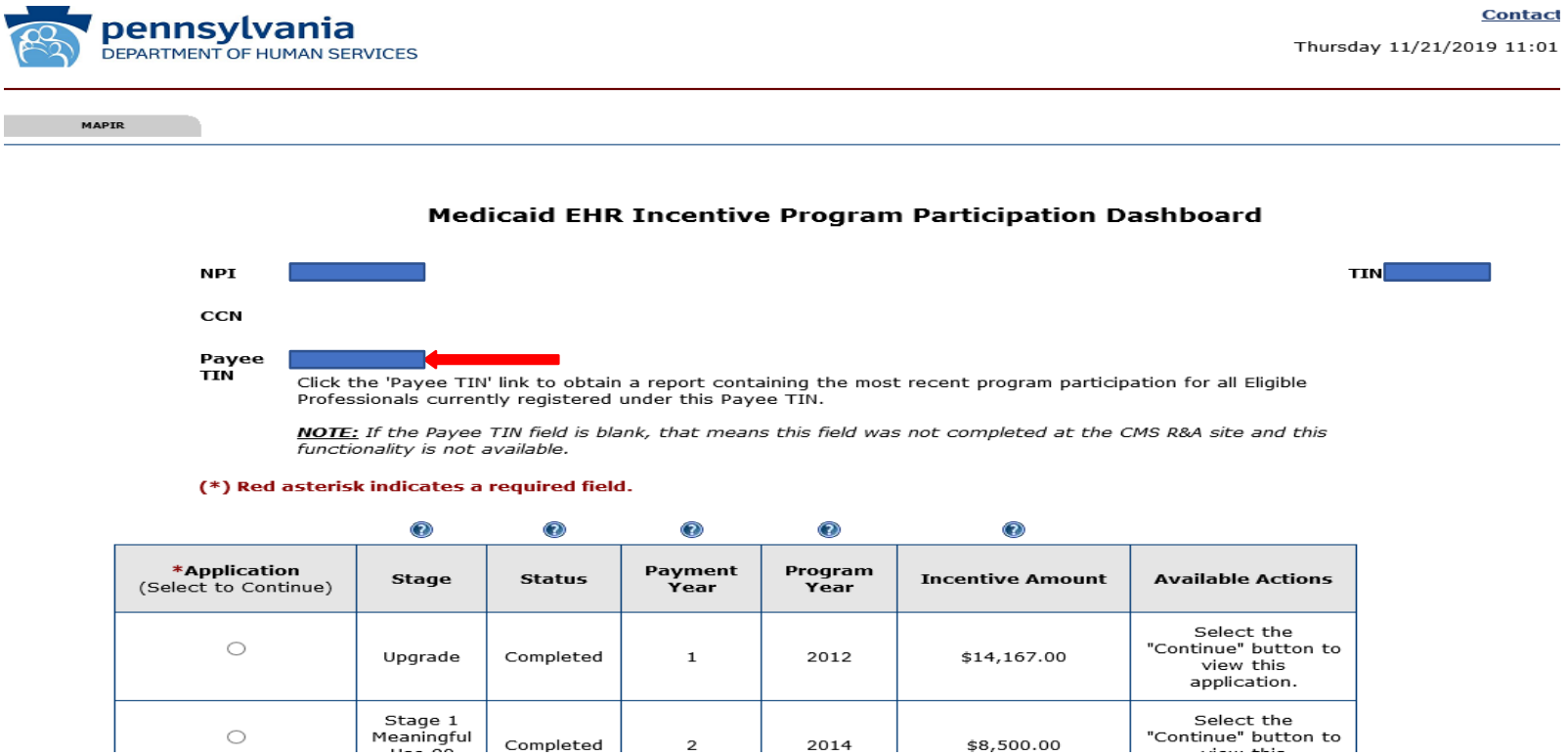
Once at the dashboard page, click on the hyperlink for the Payee TIN. The Payee TIN report will appear on your screen that includes the list of EPs currently registered under your Payee TIN at the CMS R&A.



Provider On-Demand Resource

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The report includes each provider's name, NPI and most recent Medicaid Promoting Interoperability Program (PIP) participation information. This information can be helpful in determining each provider's eligibility for the current Program Year.

Payee TIN Application Report

Applicant Last Name	Applicant First Name	Applicant NPI	Most Recent Program Year	Most Recent Payment Year	Most Recent MU Stage	Most Recent Application Status
[redacted]	[redacted]	[redacted]	2019	4	3	Incomplete
[redacted]	[redacted]	[redacted]	2018	2	2	Incomplete
[redacted]	[redacted]	[redacted]	2014	1	1	Completed
[redacted]	[redacted]	[redacted]	2016	3	1	Submitted
[redacted]	[redacted]	[redacted]	2016	3	1	Submitted
[redacted]	[redacted]	[redacted]	2015	3	1	Completed
[redacted]	[redacted]	[redacted]	2016	3	1	Submitted
[redacted]	[redacted]	[redacted]	2016	3	1	Submitted

Provider On-Demand Resource

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For ease of data manipulation and re-sorting, you can export the report to a CSV file by scrolling down to the very bottom of the report and clicking on the ‘Extract To CSV File’ button.

[redacted]	[redacted]	[redacted]	2014	2	1	Completed
[redacted]	[redacted]	[redacted]	2015	4	2	Completed
[redacted]	[redacted]	[redacted]	2015	3	1	Completed
[redacted]	[redacted]	[redacted]	2012	1	1	Completed
[redacted]	[redacted]	[redacted]	2015	3	1	Completed
[redacted]	[redacted]	[redacted]	2012	1	1	Completed
[redacted]	[redacted]	[redacted]	2016	3	1	Submitted
[redacted]	[redacted]	[redacted]	2015	3	1	Completed
[redacted]	[redacted]	[redacted]	2015	4	2	Completed

Return to Dashboard Extract To CSV file

Provider On-Demand Resource

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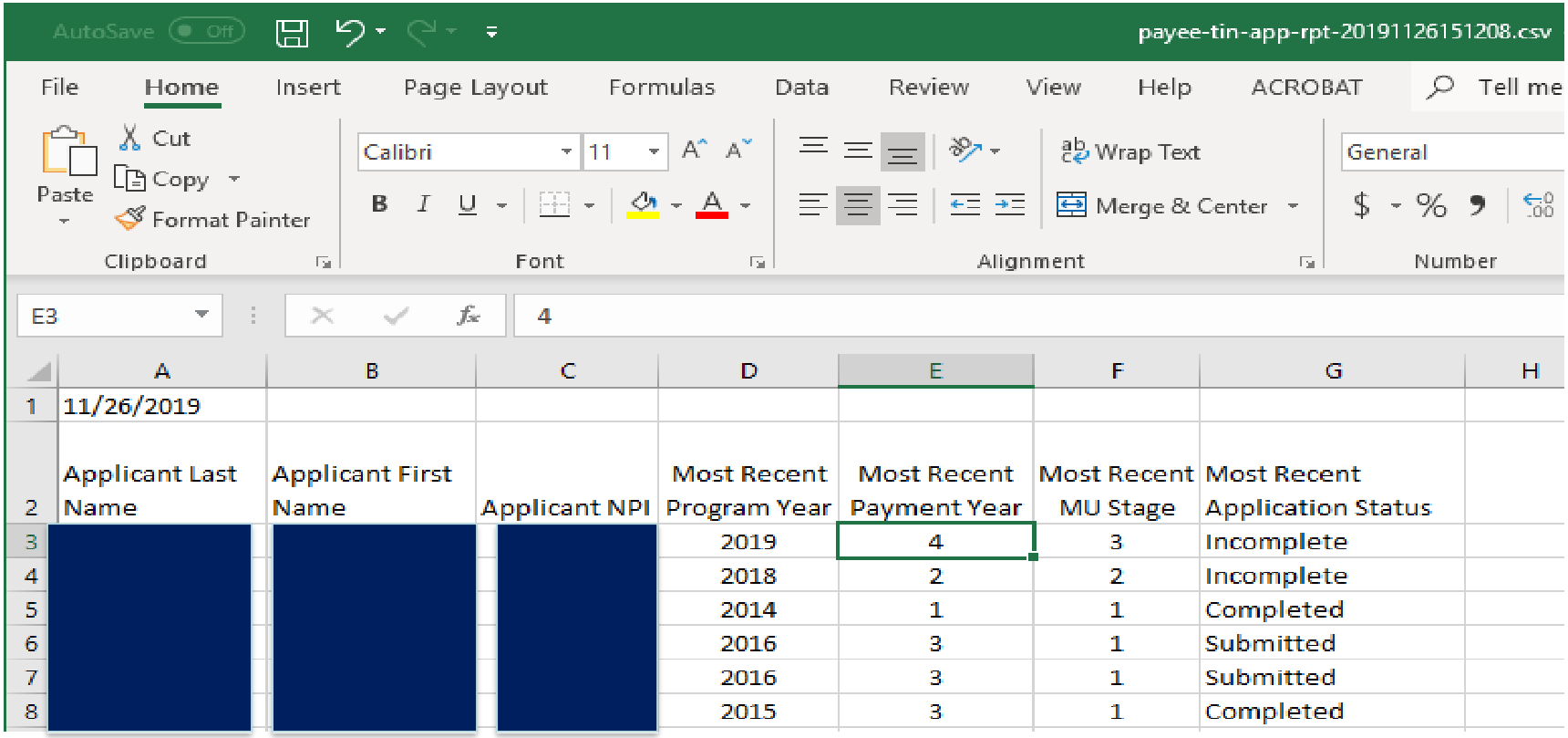
Once the report is downloaded into the CSV file, you can format and re-sort the data as desired. The date of the data export is noted at the top of the left side (Cell A1).



	A	B	C	D	E	F	G	H
1	11/26/2019							
2	Applicant Last Name	Applicant First Name	Applicant NPI	Most Recent Program Year	Most Recent Payment Year	Most Recent MU Stage	Most Recent Application Status	
3	[redacted]	[redacted]	[redacted]	2019	4	3	Incomplete	
4				2018	2	2	Incomplete	
5				2014	1	1	Completed	
6				2016	3	1	Submitted	
7				2016	3	1	Submitted	
8				2015	3	1	Completed	

Instructional Patient Volume Link

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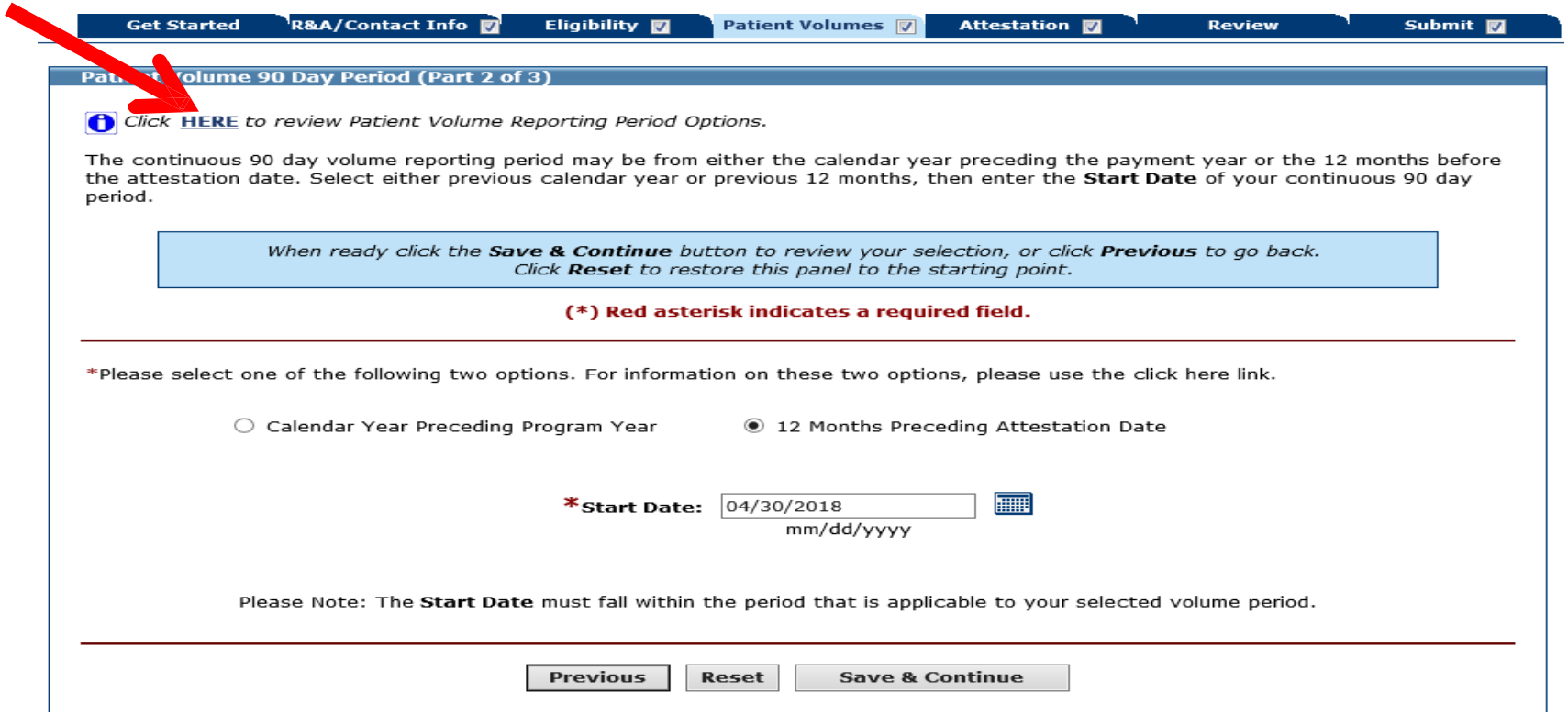
The new *Click* HERE link is located at the top of the Patient Volume 90 Day Period (Part 2 of 3) screen. Just click on the hyperlink to access the information. The instructional patient volume link provides additional clarification between the two different patient volume reporting period options.



Instructional Patient Volume Link

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The Patient Volume Reporting Period Options document will open to provide the user with more detailed explanations between the options Calendar Year Preceding Program Year and 12 Months Preceding Attestation Date.

Medicaid Promoting Interoperability Program
Patient Volume Reporting Period Options

Patient Volume Reporting Period Options

The PIP Team receives many questions around selecting the right 90-day Patient Volume time period for the two options available, as shown in the MAPIR attestation screens:

Calendar Year Preceding Program Year

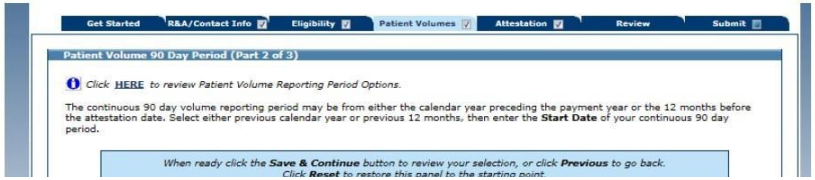
or

12 Months Preceding Attestation Date

IMPORTANT: The Patient Volume 90-Day period for an individual practitioner or any member of a Group Patient Volume Definition cannot overlap a previous Program Year 90-Day Patient Volume Period. CMS Rules do not allow recycling eligibility criteria in subsequent Program Years, e.g., re-using all or part of a patient volume period from a previous Program Year attestation.

1. Calendar Year Preceding Program Year

Using **Program Year 2019** as an example, when selecting the option "Calendar Year Preceding Program Year," you will be able to put in a Start Date from any date in **Calendar Year 2018**, as long as the end date of the 90-day period is also contained within Calendar Year 2018. In the example below, the start date of 10/01/2018 was entered:



Meaningful Use Navigation Panel

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- The Meaningful Use Navigation Panel is identical in nature to the CQM Navigation Panel that has been available since 2017. The navigation panel identifies objectives that are complete.
- **NOTE:** The white checkmark indicates the objective is completed but does not mean you passed or failed the objective.
- The Meaningful Use Navigation Panel allows users to complete their MU Objectives in any order and shows them their progress within the section.
- Please see next slide for a screenshot.

Meaningful Use Navigation Panel

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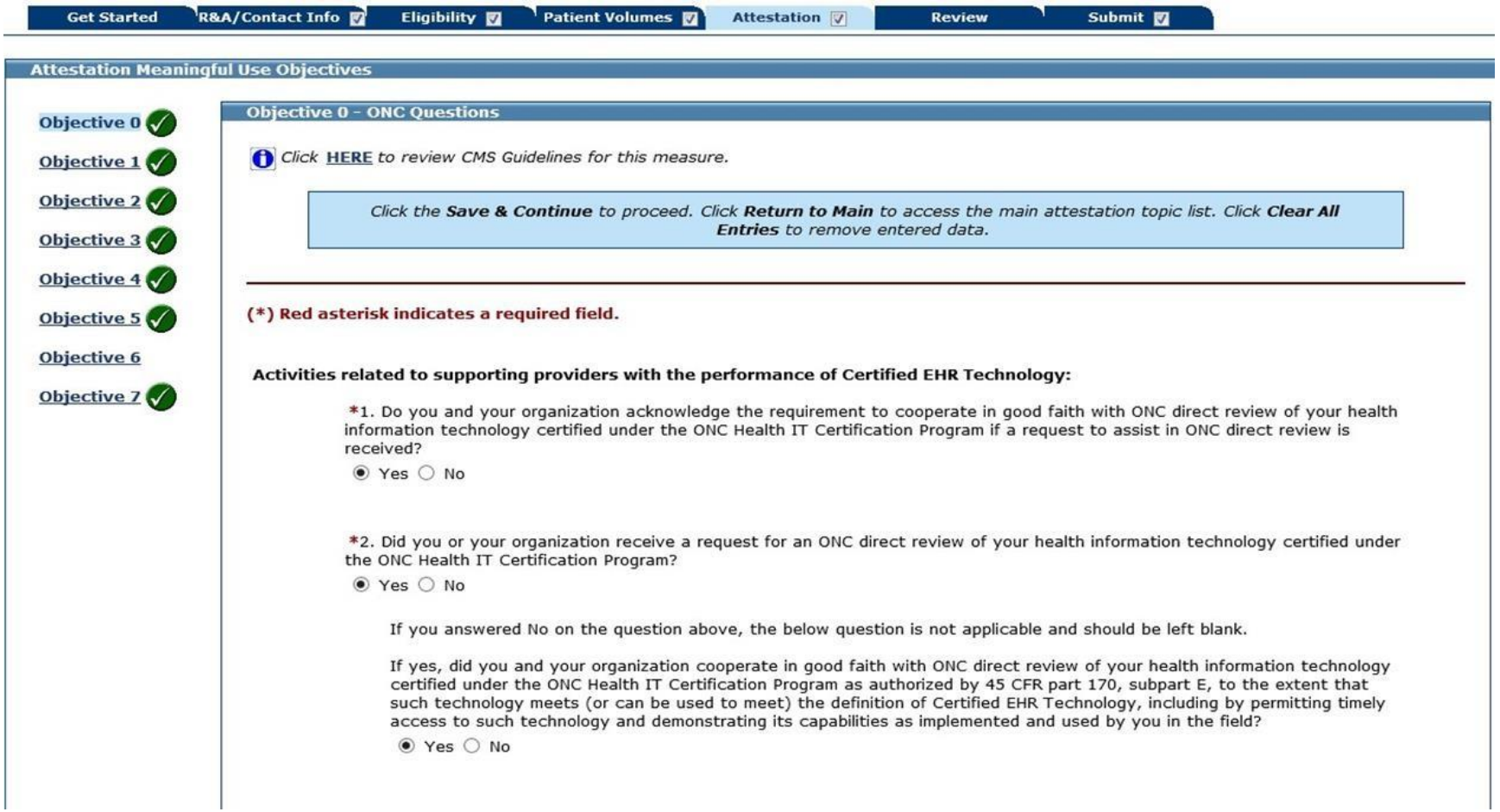

Public Health Drop Down Boxes

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- MAPIR now incorporates the most common public health registries in a drop-down box for each public health option.
- The pre-populated drop-down box will provide a consistent approach for reporting active engagement to the various public health options.
- In addition to the most common registries, EPs also have the option to report to other registries that are not included in the list.
- If your registry is not included in the drop-down list, you can still select **'Other'** and type in the name of the registry in the text field.
- The Public Health Drop Down boxes provide standardized registry names for the most common registries for each public health option. It is a more user-friendly feature, so EPs do not have to manually type in the registry name.
- Please see slides 16-20 for screenshots of each public health option.

Public Health Drop Down Boxes

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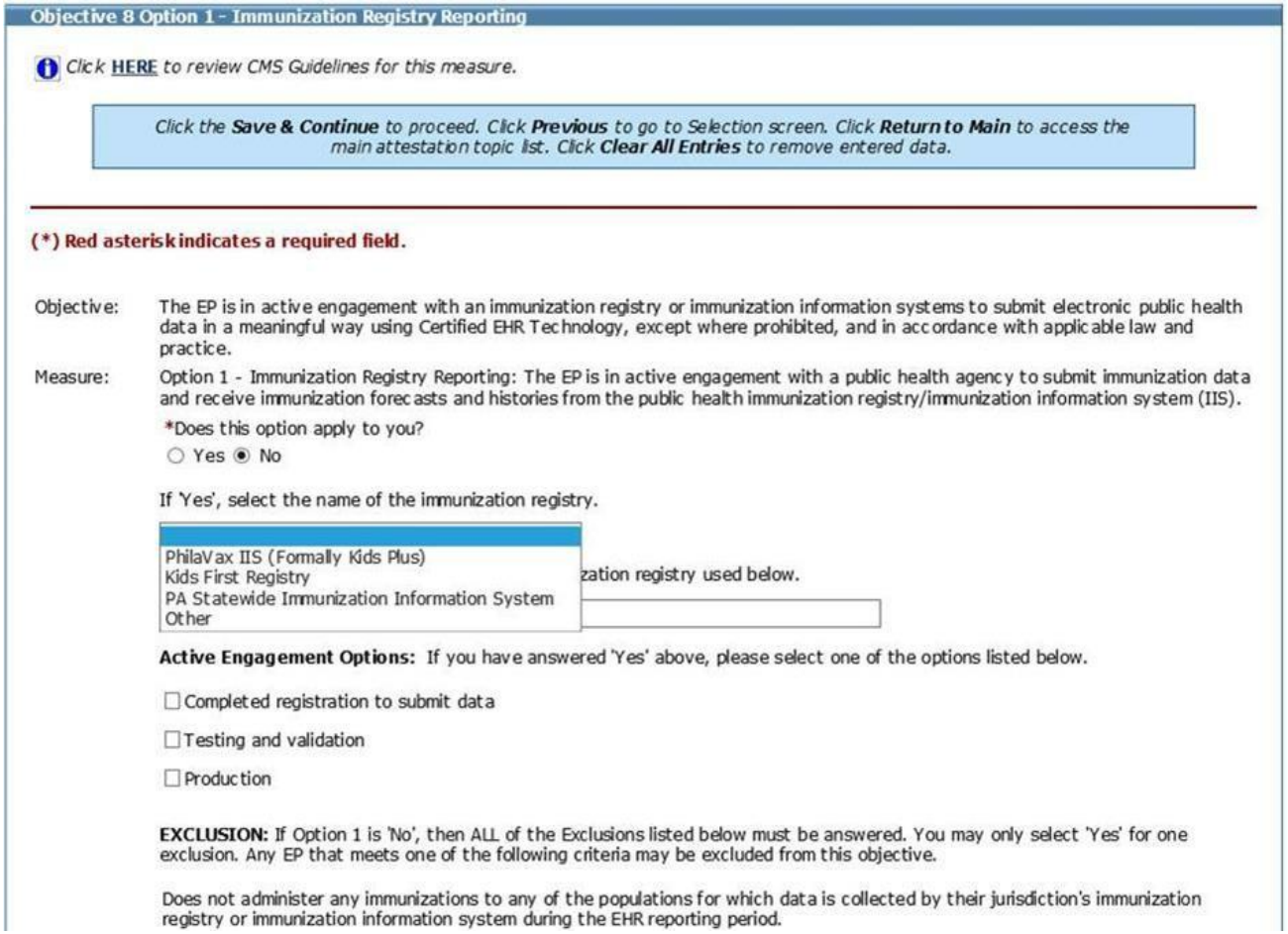
Immunization Registry



Objective 8 Option 1 - Immunization Registry Reporting

Click HERE to review CMS Guidelines for this measure.

*Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.*

(*) Red asterisk indicates a required field.

Objective: The EP is in active engagement with an immunization registry or immunization information systems to submit electronic public health data in a meaningful way using Certified EHR Technology, except where prohibited, and in accordance with applicable law and practice.

Measure: Option 1 - Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

*Does this option apply to you?

○ Yes ◉ No

If 'Yes', select the name of the immunization registry.

PhilaVax IIS (Formally Kids Plus)
Kids First Registry
PA Statewide Immunization Information System
Other

zation registry used below.

Active Engagement Options: If you have answered 'Yes' above, please select one of the options listed below.

☐ Completed registration to submit data

☐ Testing and validation

☐ Production

EXCLUSION: If Option 1 is 'No', then ALL of the Exclusions listed below must be answered. You may only select 'Yes' for one exclusion. Any EP that meets one of the following criteria may be excluded from this objective.

Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.

Public Health Drop Down Boxes

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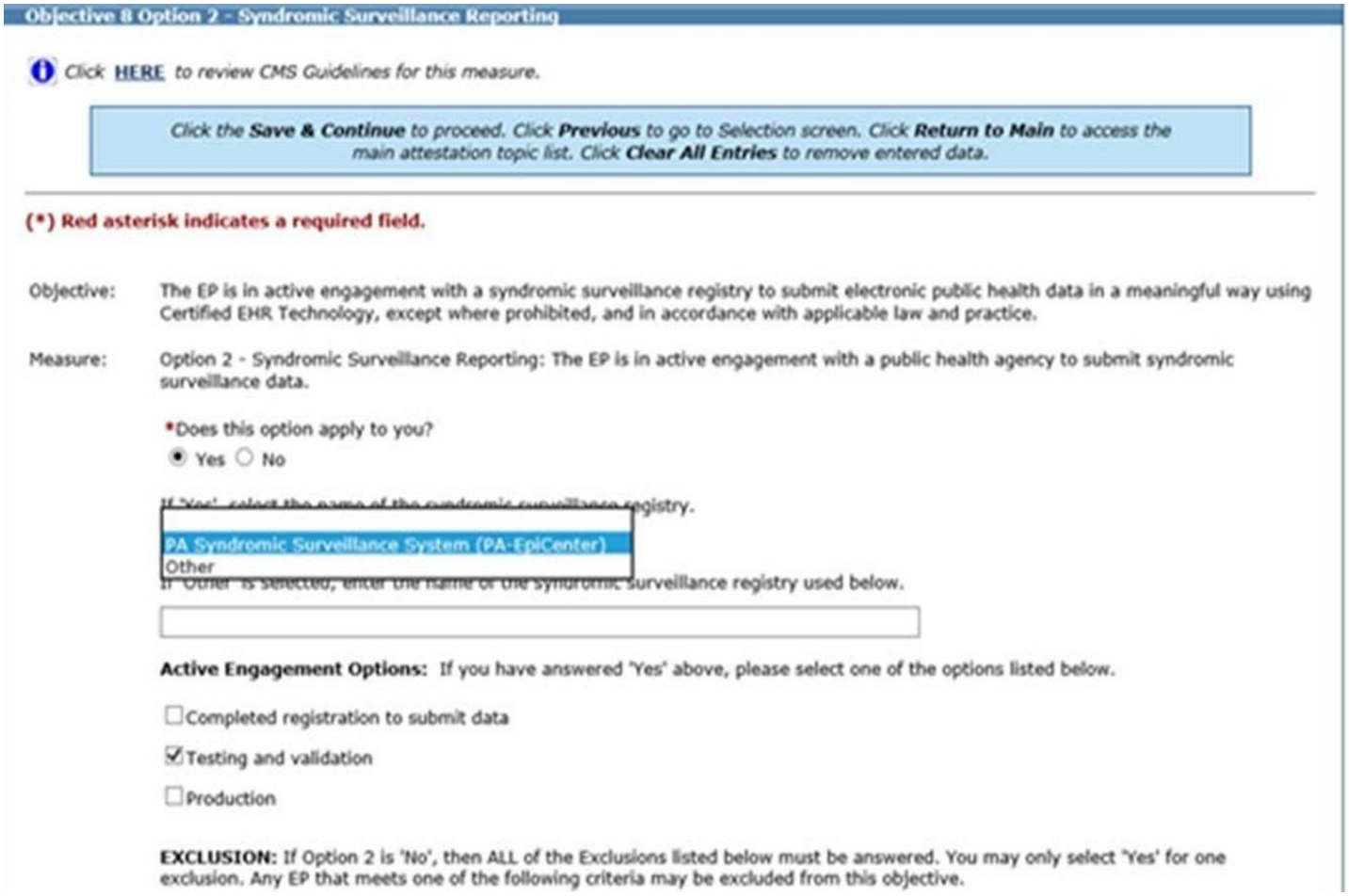
Syndromic Surveillance



Public Health Drop Down Boxes

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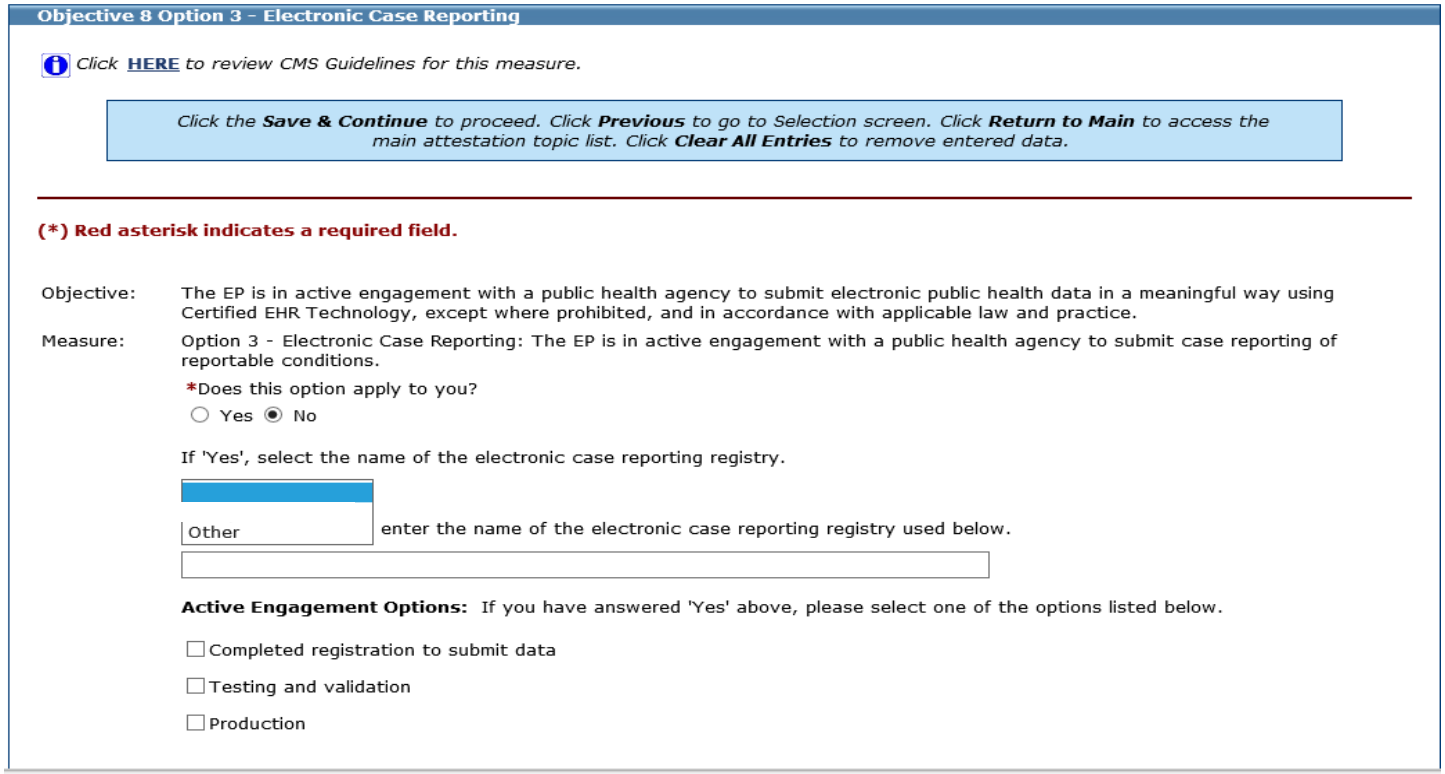
As of the publication of this document, Pennsylvania does not currently have a registry capable of receiving electronic case reporting data for in-state providers. If an EP submits data to an electronic case reporting registry, the EP will need to select 'Other' in the drop-down list and enter the name of the registry to which data is being submitted.



Public Health Drop Down Boxes

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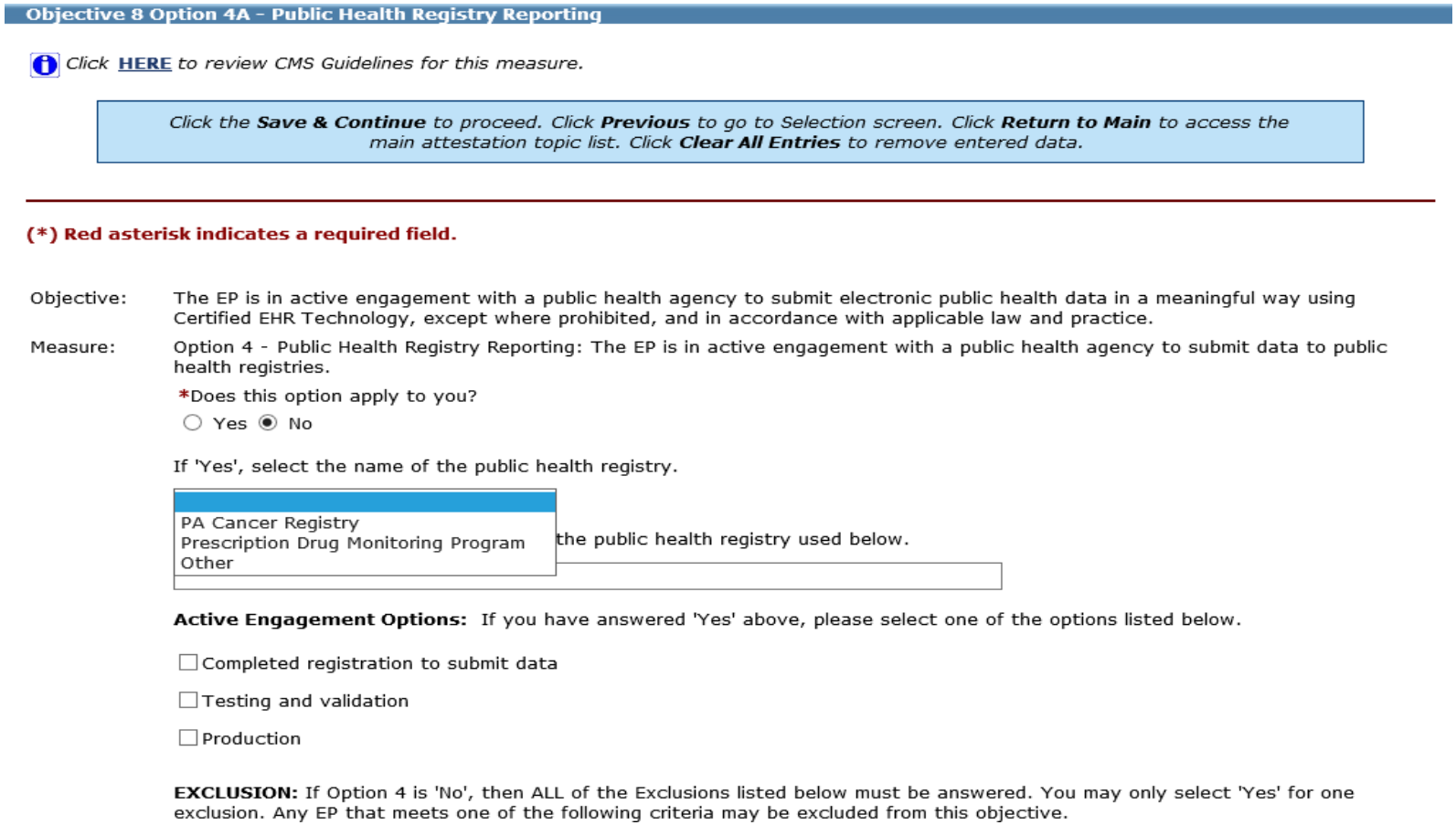
Public Health Registry



Objective 8 Option 4A - Public Health Registry Reporting

Click **HERE** *to review CMS Guidelines for this measure.*

Click the ***Save & Continue*** *to proceed. Click* ***Previous*** *to go to Selection screen. Click* ***Return to Main*** *to access the main attestation topic list. Click* ***Clear All Entries*** *to remove entered data.*

(*) Red asterisk indicates a required field.

Objective: The EP is in active engagement with a public health agency to submit electronic public health data in a meaningful way using Certified EHR Technology, except where prohibited, and in accordance with applicable law and practice.

Measure: Option 4 - Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries.

*Does this option apply to you?

○ Yes ◉ No

If 'Yes', select the name of the public health registry.

PA Cancer Registry
Prescription Drug Monitoring Program
Other

the public health registry used below.

Active Engagement Options: If you have answered 'Yes' above, please select one of the options listed below.

☐ Completed registration to submit data

☐ Testing and validation

☐ Production

EXCLUSION: If Option 4 is 'No', then ALL of the Exclusions listed below must be answered. You may only select 'Yes' for one exclusion. Any EP that meets one of the following criteria may be excluded from this objective.

Public Health Drop Down Boxes

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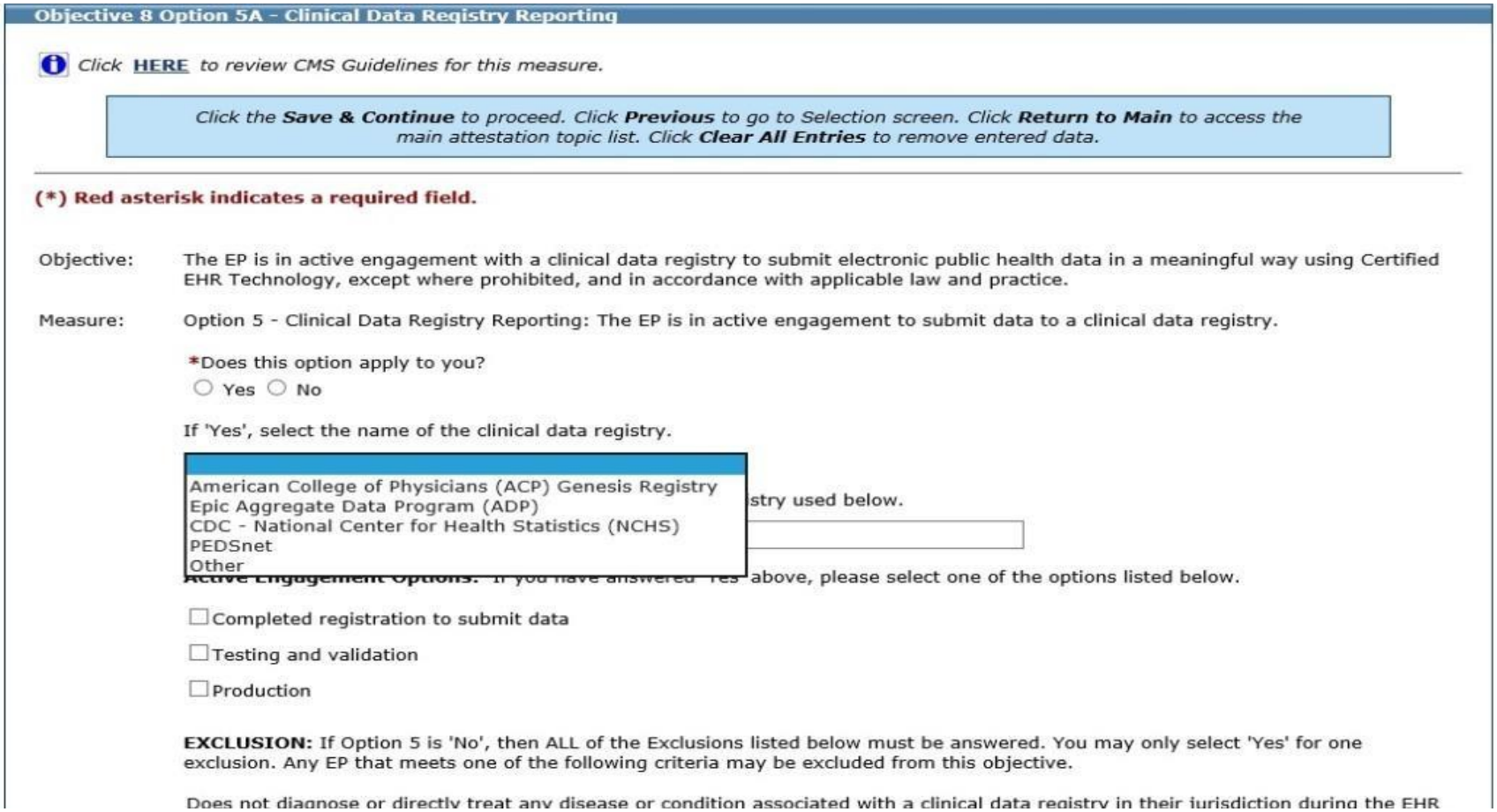
Clinical Data Registry



Objective 8 Option 5A - Clinical Data Registry Reporting

Click **HERE** *to review CMS Guidelines for this measure.*

Click the ***Save & Continue*** *to proceed. Click* ***Previous*** *to go to Selection screen. Click* ***Return to Main*** *to access the main attestation topic list. Click* ***Clear All Entries*** *to remove entered data.*

(*) Red asterisk indicates a required field.

Objective: The EP is in active engagement with a clinical data registry to submit electronic public health data in a meaningful way using Certified EHR Technology, except where prohibited, and in accordance with applicable law and practice.

Measure: Option 5 - Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.

*Does this option apply to you?

○ Yes ○ No

If 'Yes', select the name of the clinical data registry.

American College of Physicians (ACP) Genesis Registry
Epic Aggregate Data Program (ADP)
CDC - National Center for Health Statistics (NCHS)
PEDSnet
Other

stry used below.

above, please select one of the options listed below.

☐ Completed registration to submit data

☐ Testing and validation

☐ Production

EXCLUSION: If Option 5 is 'No', then ALL of the Exclusions listed below must be answered. You may only select 'Yes' for one exclusion. Any EP that meets one of the following criteria may be excluded from this objective.

Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR

CQM Selection Screen

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- To comply with CMS' requirement, the CQM selection screen has been modified to classify the CQMs into three distinct categories: **Outcome, High Priority and All Other**. EPs are still required to select a minimum of six CQMs, but EPs must select at least one Outcome measure.
- If no Outcome CQM is applicable to the provider's scope of practice, then the EP must select at least one High Priority CQM. If no Outcome or High Priority CQM pertains to the scope of practice, then the EP must attest to at least six CQMs for the list of Other CQMs.
- Please see slides 22-24 for screenshots.

CQM Selection Screen

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Meaningful Use Clinical Quality Measure Worklist

You must select a minimum of six (6) CQMs in order to proceed. CMS now requires that you must select at least one (1) Outcome measure or if no Outcome measures are applicable, at least one (1) High Priority measure. If no Outcome or High Priority CQMs are relevant to your scope of practice, then please choose a minimum of six (6) CQMs from the list of Other available CQMs.

If none of the Outcome or High Priority CQMs are relevant to your scope of practice, you must check the acknowledgement box within each section in order to proceed to the next screen.

CQMs below are listed by NQF number within each section. You have the ability to sort and view the CQMs by NQF or CMS number by clicking on the sort arrows below.

*Please note you are not limited to only selecting one Outcome or High Priority CQM, you may select multiple CQMs from any category with a minimum total of six (6). When all CQMs have been edited and you are satisfied with the entries, select **"Return to Main"** button to access the main attestation topic list.*

Outcome Clinical Quality Measures

NQF#	Measure#	Title	Selection
0018	CMS165 v7.3.000	Controlling High Blood Pressure	☐
0059	CMS122 v7.4.000	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	☐
0564	CMS132 v7.2.000	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	☐
0565	CMS133 v7.2.000	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	☐
0710	CMS159 v7.2.000	Depression Remission at Twelve Months	☐
Not Applicable	CMS75 v7.2.000	Children Who Have Dental Decay or Cavities	☐

☐ None of the Outcome Clinical Quality Measures listed above pertain to my scope of practice.

Check this box if no Outcome CQMs apply to your scope of practice

CQM Selection Screen

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High Priority Clinical Quality Measures

NQF#	Measure#	Title	Selection
0004	CMS137 v7.2.000	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	☐
0022	CMS156 v7.3.000	Use of High-Risk Medications in the Elderly	☐
0024	CMS155 v7.2.000	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	☐
0033	CMS153 v7.4.000	Chlamydia Screening for Women	☐
0069	CMS154 v7.2.000	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	☐
0089	CMS142 v7.1.000	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	☐
0101	CMS139 v7.2.000	Falls: Screening for Future Fall Risk	☐
0105	CMS128 v7.2.000	Antidepressant Medication Management	☐
0108	CMS136 v8.3.000	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	☐
0384	CMS157 v7.4.000	Oncology: Medical and Radiation - Pain Intensity Quantified	☐
0389	CMS129 v8.2.000	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	☐
0418	CMS2 v8.1.000	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	☐
0419	CMS68 v8.1.000	Documentation of Current Medications in the Medical Record	☐
1365	CMS177 v7.2.000	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	☐
2372	CMS125 v7.2.000	Breast Cancer Screening	☐
Not Applicable	CMS50 v7.1.000	Closing the Referral Loop: Receipt of Specialist Report	☐
Not Applicable	CMS56 v7.4.000	Functional Status Assessment for Total Hip Replacement	☐
Not Applicable	CMS66 v7.5.000	Functional Status Assessment for Total Knee Replacement	☐
Not Applicable	CMS90 v8.3.000	Functional Status Assessments for Congestive Heart Failure	☐
Not Applicable	CMS146 v7.2.000	Appropriate Testing for Children with Pharyngitis	☐
Not Applicable	CMS249 v1.4.000	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	☐

☐ None of the High Priority Clinical Quality Measures listed above pertain to my scope of practice.

Check this box if no Outcome or High Priority CQMs apply to your scope of practice

CQM Selection Screen

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Other Clinical Quality Measures

NQF#	Measure#	Title	Selection
0028	CMS138 v7.1.000	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	☐
0032	CMS124 v7.2.000	Cervical Cancer Screening	☐
0034	CMS130 v7.2.000	Colorectal Cancer Screening	☐
0038	CMS117 v7.2.000	Childhood Immunization Status	☐
0041	CMS147 v8.1.000	Preventive Care and Screening: Influenza Immunization	☐
0055	CMS131 v7.2.000	Diabetes: Eye Exam	☐
0062	CMS134 v7.2.000	Diabetes: Medical Attention for Nephropathy	☐
0070	CMS145 v7.2.000	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	☐
0081	CMS135 v7.1.000	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	☐
0083	CMS144 v7.1.000	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	☐
0086	CMS143 v7.1.000	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	☐
0104	CMS161 v7.2.000	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	☐
0405	CMS52 v7.2.000	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	☐
0421	CMS69 v7.1.000	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	☐
0712	CMS160 v7.3.000	Depression Utilization of the PHQ-9 Tool	☐
2872	CMS149 v7.3.000	Dementia: Cognitive Assessment	☐
Not Applicable	CMS22 v7.1.000	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	☐
Not Applicable	CMS74 v8.2.000	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	☐
Not Applicable	CMS82 v6.3.000	Maternal Depression Screening	☐
Not Applicable	CMS127 v7.2.000	Pneumococcal Vaccination Status for Older Adults	☐
Not Applicable	CMS347 v2.1.000	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	☐
Not Applicable	CMS 645 v2.1.000	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy	☐

Required Prepayment Documentation Screen

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- The Required Prepayment Documentation screen replaces the Application Submission screen from previous program years. Providers can still upload their supporting documentation, but this new screen provides more details about documentation requirements.
- The Required Prepayment Documentation screen includes details regarding supporting documentation requirements. In addition to uploading documents here, providers can also identify the type of supporting document. At the bottom of the screen, providers will check the acknowledgement statement to indicate they are aware of application processing delays that will occur in the absence of all required documentation.
- Please see next slide for a screenshot.

Required Prepayment Documentation Screen

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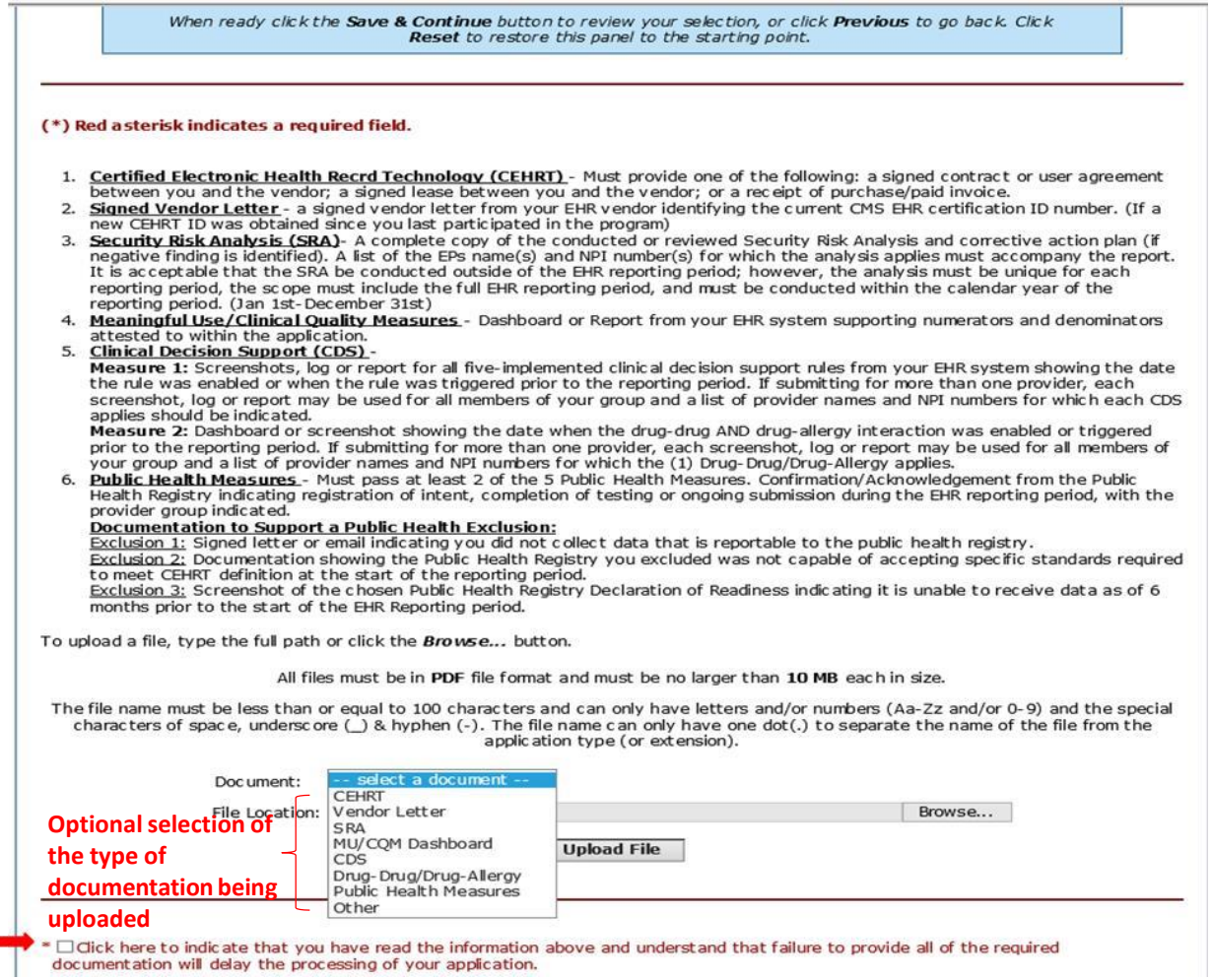

*When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.*

(*) Red asterisk indicates a required field.

1. **Certified Electronic Health Recrd Technology (CEHRT)** - Must provide one of the following: a signed contract or user agreement between you and the vendor; a signed lease between you and the vendor; or a receipt of purchase/paid invoice.
2. **Signed Vendor Letter** - a signed vendor letter from your EHR vendor identifying the current CMS EHR certification ID number. (If a new CEHRT ID was obtained since you last participated in the program)
3. **Security Risk Analysis (SRA)**- A complete copy of the conducted or reviewed Security Risk Analysis and corrective action plan (if negative finding is identified). A list of the EPs name(s) and NPI number(s) for which the analysis applies must accompany the report. It is acceptable that the SRA be conducted outside of the EHR reporting period; however, the analysis must be unique for each reporting period, the scope must include the full EHR reporting period, and must be conducted within the calendar year of the reporting period. (Jan 1st-December 31st)
4. **Meaningful Use/Clinical Quality Measures** - Dashboard or Report from your EHR system supporting numerators and denominators attested to within the application.
5. **Clinical Decision Support (CDS)** -
   Measure 1: Screenshots, log or report for all five-implemented clinical decision support rules from your EHR system showing the date the rule was enabled or when the rule was triggered prior to the reporting period. If submitting for more than one provider, each screenshot, log or report may be used for all members of your group and a list of provider names and NPI numbers for which each CDS applies should be indicated.
   Measure 2: Dashboard or screenshot showing the date when the drug-drug AND drug-allergy interaction was enabled or triggered prior to the reporting period. If submitting for more than one provider, each screenshot, log or report may be used for all members of your group and a list of provider names and NPI numbers for which the (1) Drug-Drug/Drug-Allergy applies.
6. **Public Health Measures** - Must pass at least 2 of the 5 Public Health Measures. Confirmation/Acknowledgement from the Public Health Registry indicating registration of intent, completion of testing or ongoing submission during the EHR reporting period, with the provider group indicated.
   Documentation to Support a Public Health Exclusion:
   Exclusion 1: Signed letter or email indicating you did not collect data that is reportable to the public health registry.
   Exclusion 2: Documentation showing the Public Health Registry you excluded was not capable of accepting specific standards required to meet CEHRT definition at the start of the reporting period.
   Exclusion 3: Screenshot of the chosen Public Health Registry Declaration of Readiness indicating it is unable to receive data as of 6 months prior to the start of the EHR Reporting period.

To upload a file, type the full path or click the ***Browse...*** button.

All files must be in **PDF** file format and must be no larger than **10 MB** each in size.

The file name must be less than or equal to 100 characters and can only have letters and/or numbers (Aa-Zz and/or 0-9) and the special characters of space, underscore (_) & hyphen (-). The file name can only have one dot(.) to separate the name of the file from the application type (or extension).

Document: -- select a document --
File Location: Browse...
Upload File

-- select a document --
CEHRT
Vendor Letter
SRA
MU/CQM Dashboard
CDS
Drug-Drug/Drug-Allergy
Public Health Measures
Other

* ☐ Click here to indicate that you have read the information above and understand that failure to provide all of the required documentation will delay the processing of your application.

Optional selection of the type of documentation being uploaded

Must check here to acknowledge you have read and understand the information regarding supporting documentation requirements

Two Applications Open Simultaneously

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- Due to the tight turnaround time in the final year of the PI Program, MAPIR will allow providers to submit their Program Year 2021 application even if the Program Year 2020 application has not yet been finalized.
- MAPIR will be accepting Program Year 2021 applications from June 1, 2021, through October 31, 2021.

Security Risk Analysis in 2021

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- Since MAPIR will be closed to new incentive applications after October 31, 2021, providers will be able to submit their Program Year 2021 applications even if they have not completed their Security Risk Analysis (SRA) prior to attestation. The new screen for Objective 1 will prompt the provider to indicate if the SRA has been completed prior to attestation.
- If the provider's SRA has not been completed prior to attestation, the provider must then attest to having it completed by December 31, 2021, with the understanding that the incentive payment will be subject to an audit.
- See next slide for a screenshot.

Security Risk Analysis 2021 Screenshot

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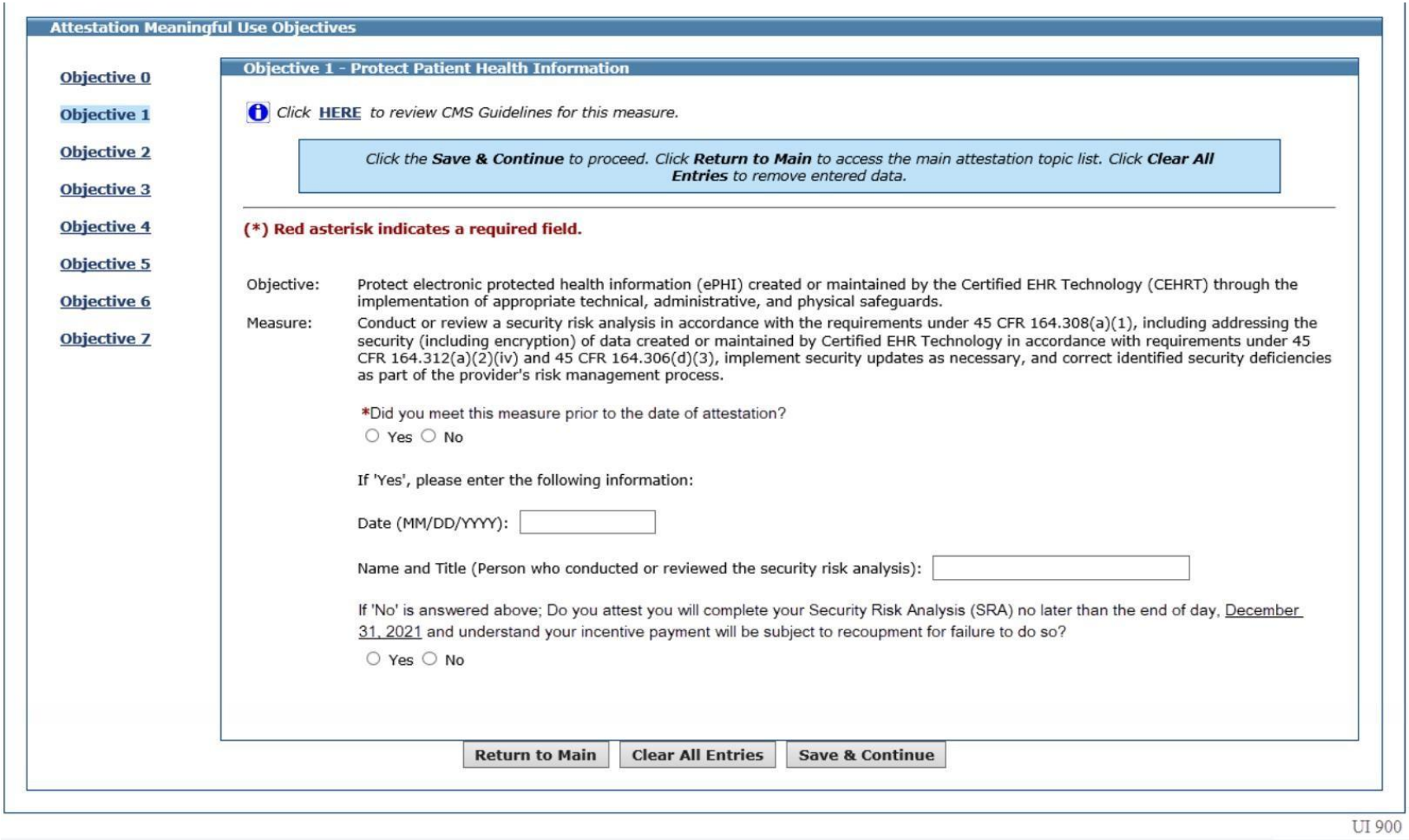

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CQM Changes for Program Year 2019 Part 1

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- Here are the CQMs that were removed from the list of available CQMs for Program Year 2019:
  - **CMS 65** - Hypertension: Improvement in Blood Pressure
  - **CMS 123** - Diabetes: Foot Exam
  - **CMS 158** - Pregnant women that had HBsAg testing
  - **CMS 164** - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
  - **CMS 166** - Use of Imaging Studies for Low Back Pain
  - **CMS 167** - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
  - **CMS 169** - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

CQM Changes for Program Year 2019 Part 2

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- New CQMs for Program Year 2019:
  - **CMS 249** - Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
  - **CMS 347** - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
  - **CMS 349** - HIV Screening
  - **CMS 645** - Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy
- CQMs with added Stratums:
  - **CMS 159** - Depression Remission at Twelve Months
  - **CMS 160** - Depression Utilization of the PHQ-9 Tool

CQM Changes for Program Year 2019

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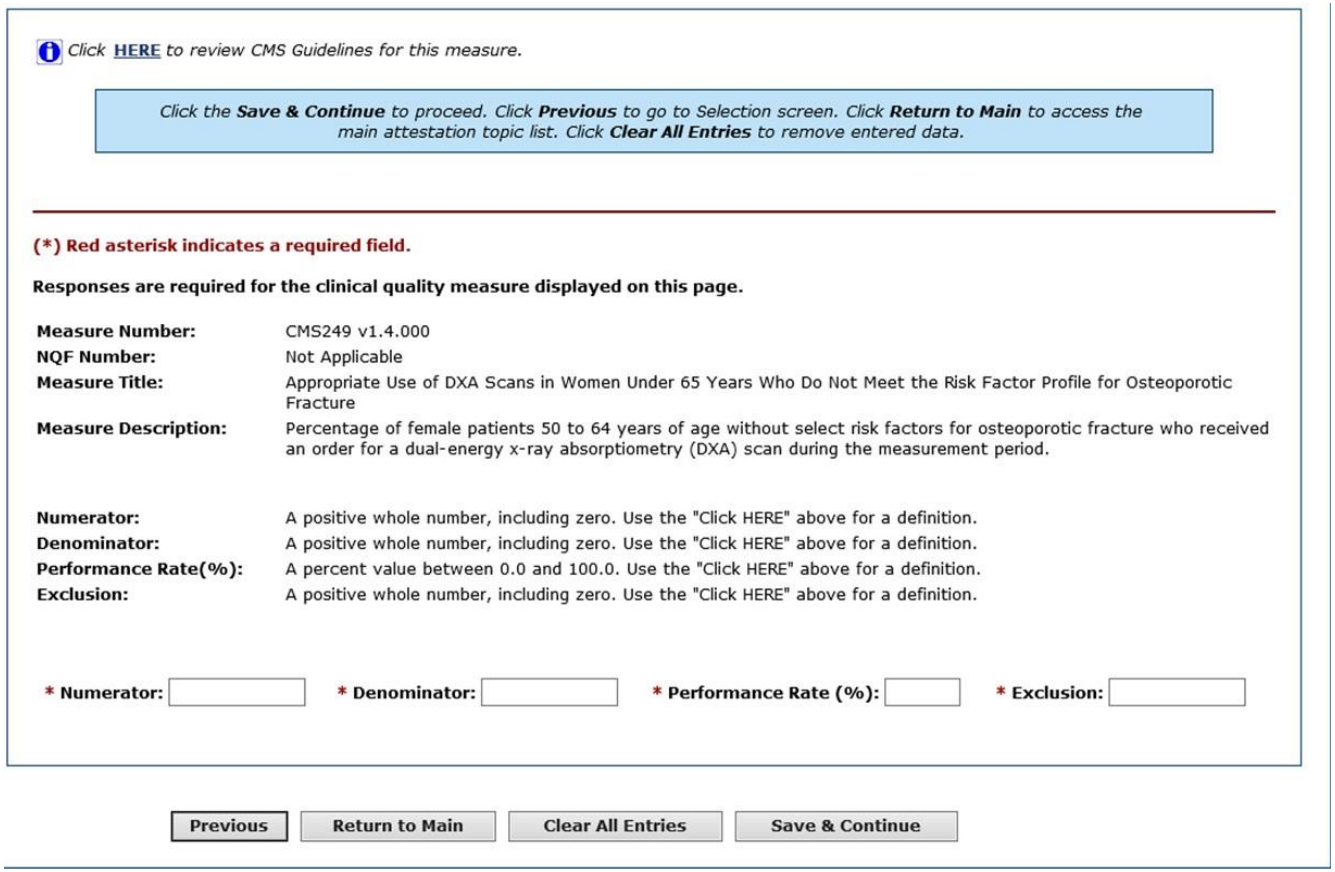
CMS 249 - Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture



Click HERE to review CMS Guidelines for this measure.

Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS249 v1.4.000
NQF Number:	Not Applicable
Measure Title:	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
Measure Description:	Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

* Numerator: * Denominator: * Performance Rate (%): * Exclusion:

Previous | Return to Main | Clear All Entries | Save & Continue

CQM Screenshot for 2019

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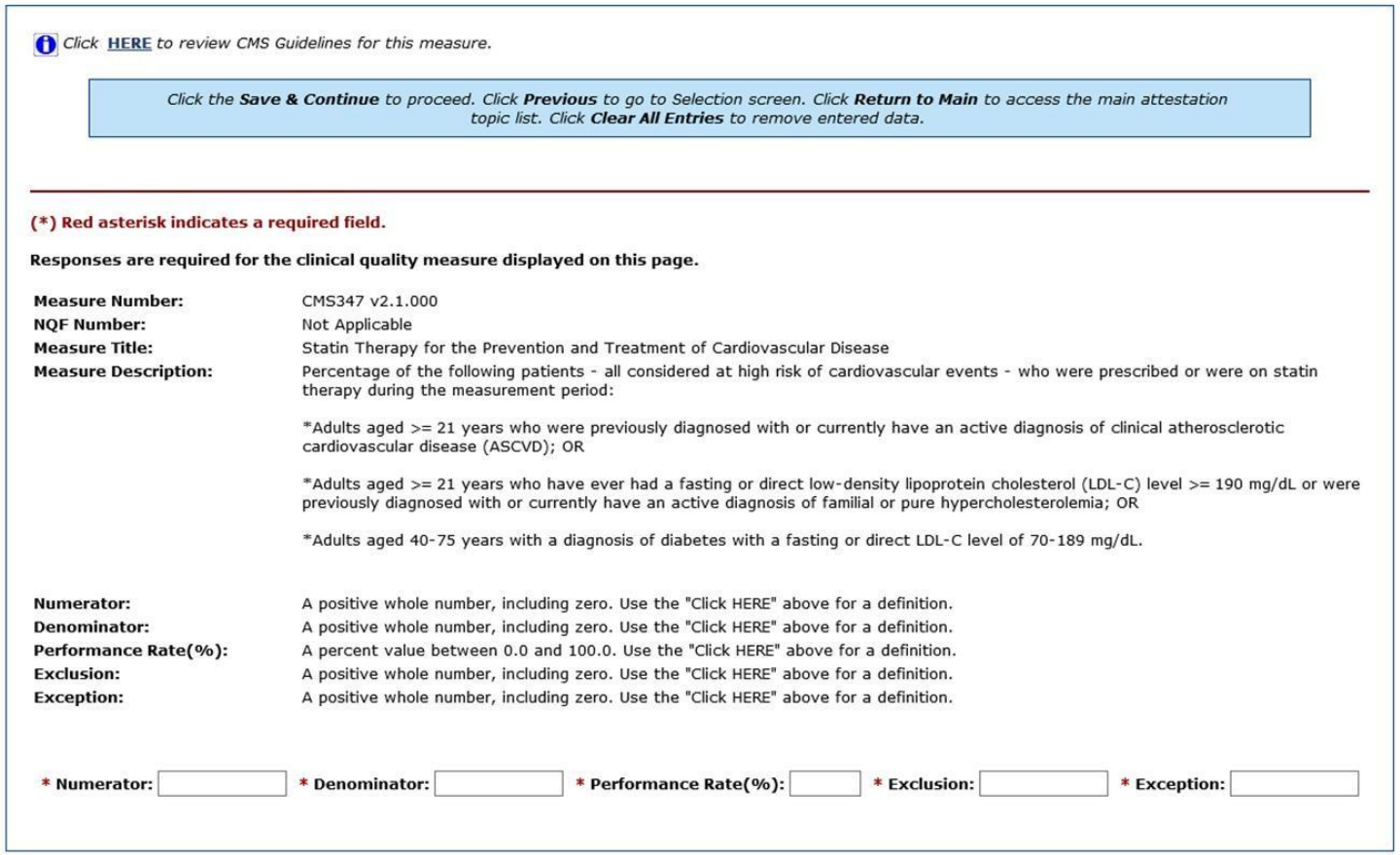
CMS 347 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease



Click **HERE** *to review CMS Guidelines for this measure.*

Click the ***Save & Continue*** *to proceed. Click* ***Previous*** *to go to Selection screen. Click* ***Return to Main*** *to access the main attestation topic list. Click* ***Clear All Entries*** *to remove entered data.*

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS347 v2.1.000
NQF Number:	Not Applicable
Measure Title:	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
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 >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR *Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR *Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Exception:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

*** Numerator:** *** Denominator:** *** Performance Rate(%):** *** Exclusion:** *** Exception:**

CQM Screenshot for 2019

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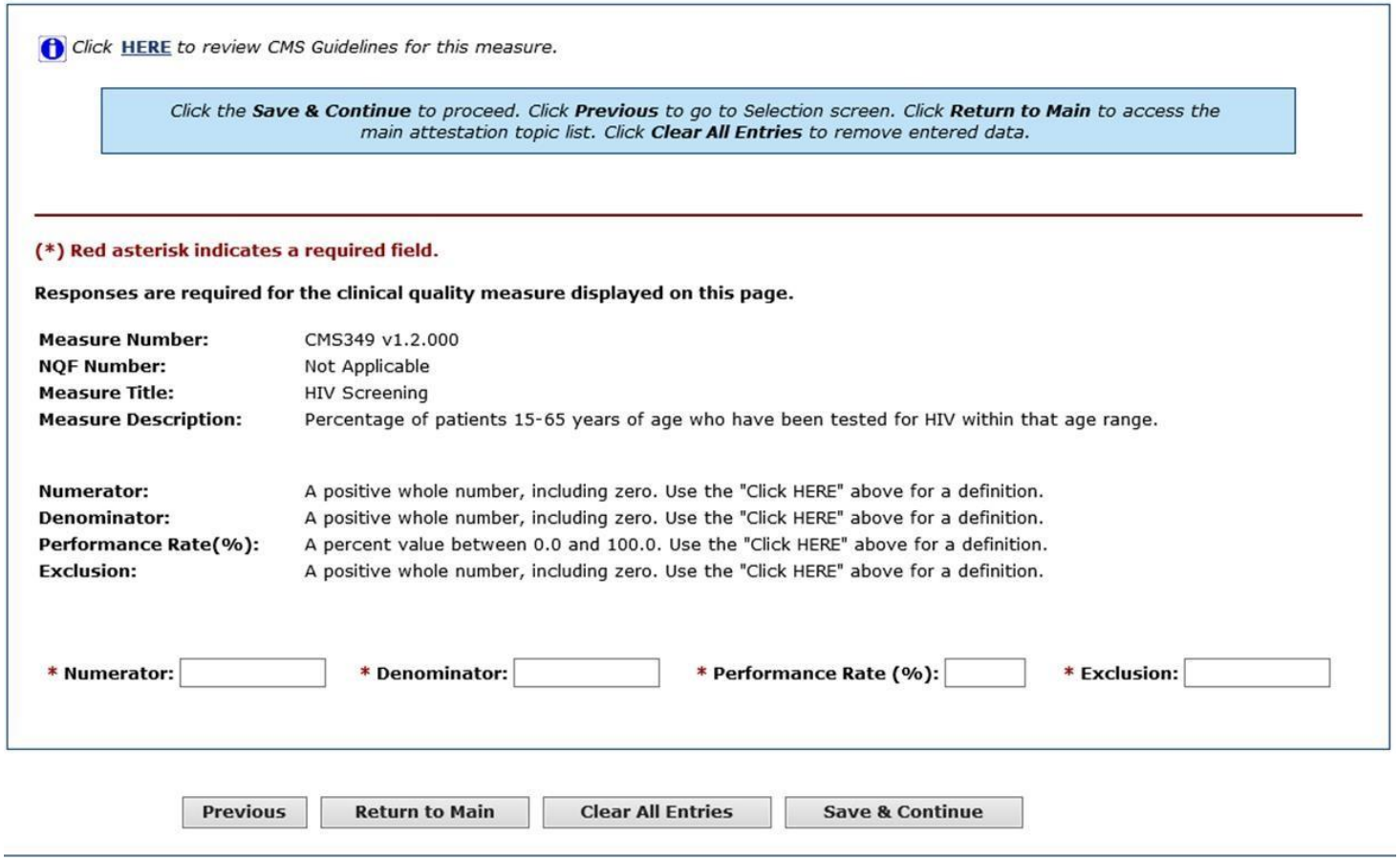
DEPARTMENT OF HUMAN SERVICES

CMS 349 - HIV Screening



Click HERE to review CMS Guidelines for this measure.

Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS349 v1.2.000
NQF Number:	Not Applicable
Measure Title:	HIV Screening
Measure Description:	Percentage of patients 15-65 years of age who have been tested for HIV within that age range.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

* Numerator: * Denominator: * Performance Rate (%): * Exclusion:

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CQM Screenshot for 2019

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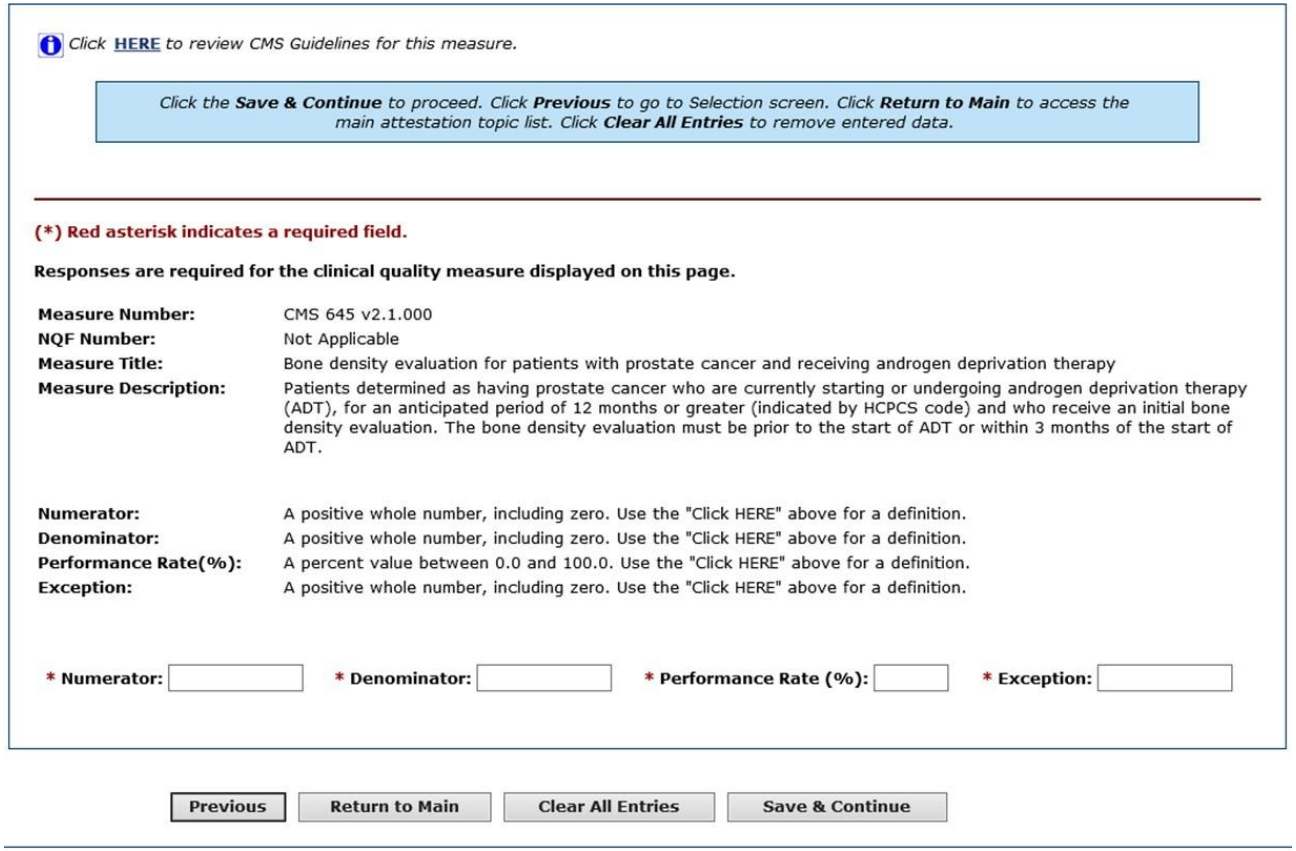
CMS 645 - Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy



Click HERE to review CMS Guidelines for this measure.

Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS 645 v2.1.000
NQF Number:	Not Applicable
Measure Title:	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy
Measure Description:	Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater (indicated by HCPCS code) and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exception:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

* Numerator: * Denominator: * Performance Rate (%): * Exception:

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CQM Screenshot for 2019

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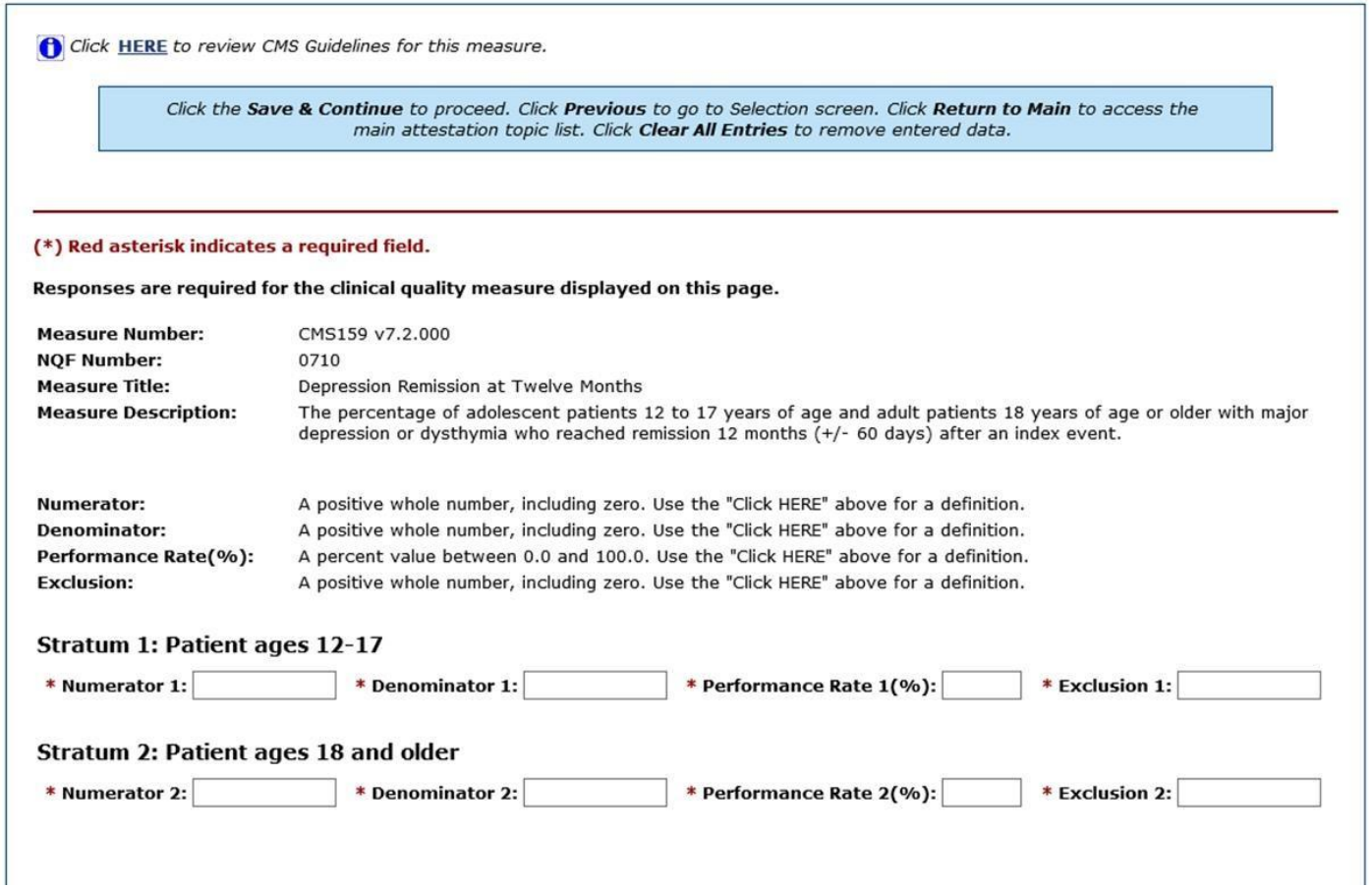
CMS 159 - Depression Remission at Twelve Months



Click HERE to review CMS Guidelines for this measure.

Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS159 v7.2.000
NQF Number:	0710
Measure Title:	Depression Remission at Twelve Months
Measure Description:	The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

Stratum 1: Patient ages 12-17

* **Numerator 1:** * **Denominator 1:** * **Performance Rate 1(%):** * **Exclusion 1:**

Stratum 2: Patient ages 18 and older

* **Numerator 2:** * **Denominator 2:** * **Performance Rate 2(%):** * **Exclusion 2:**

CQM Screenshot for 2019

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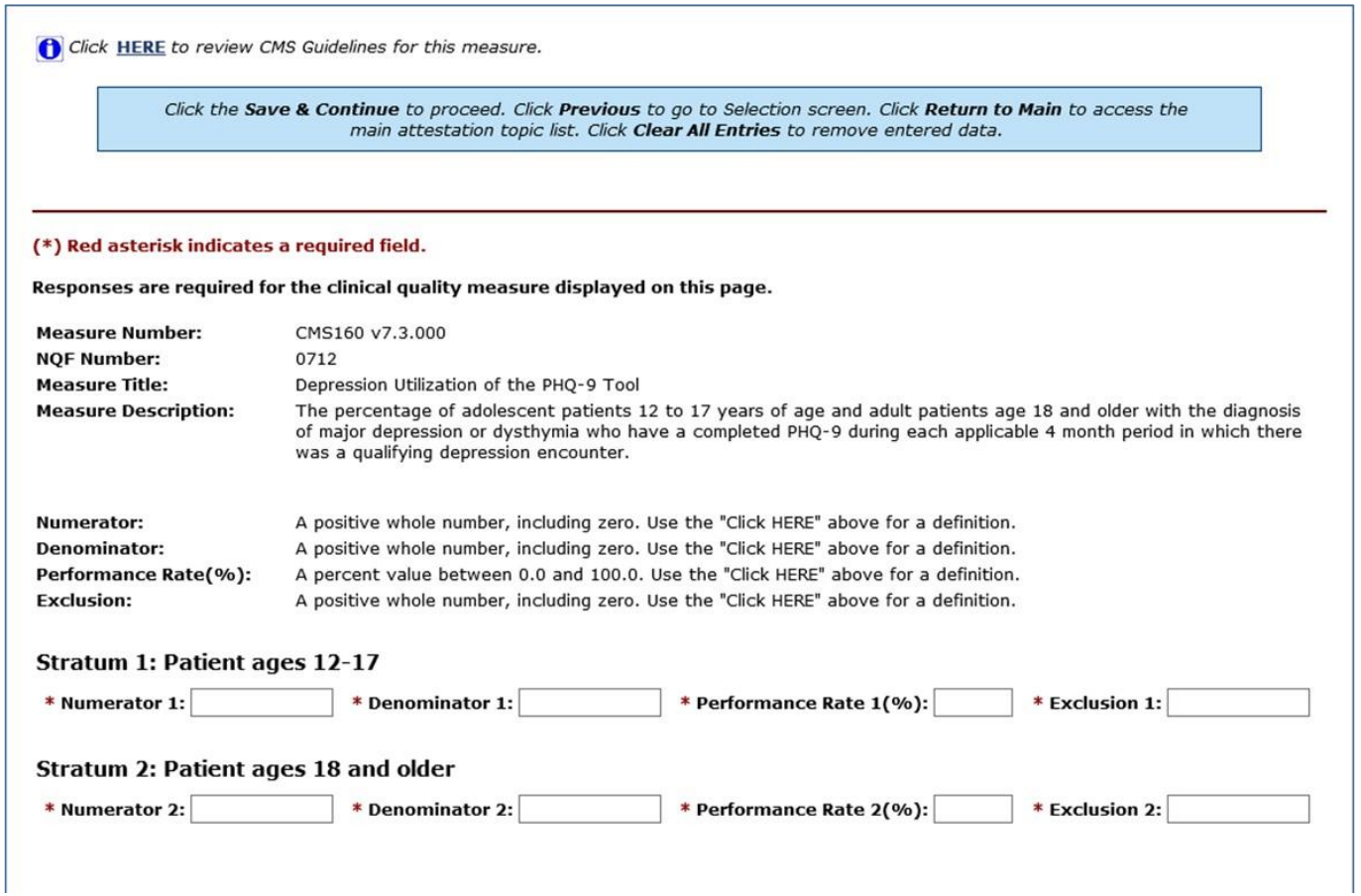
CMS 160 - Depression Utilization of the PHQ-9 Tool



Click HERE to review CMS Guidelines for this measure.

*Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.*

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS160 v7.3.000
NQF Number:	0712
Measure Title:	Depression Utilization of the PHQ-9 Tool
Measure Description:	The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

Stratum 1: Patient ages 12-17

*** Numerator 1:** *** Denominator 1:** *** Performance Rate 1(%):** *** Exclusion 1:**

Stratum 2: Patient ages 18 and older

*** Numerator 2:** *** Denominator 2:** *** Performance Rate 2(%):** *** Exclusion 2:**

CQM Changes for Program Year 2020

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- For providers who manually enter their CQM information into MAPIR, a new CQM Reporting Period screen will prompt you to enter your CQM reporting period start and end dates. At a minimum the reporting period must span 90 days, but it can be longer to accommodate providers who choose full quarter CQM reporting periods or full year CQM reporting periods.
- If for some reason, the provider's data reflects a time span that is less than the reporting period indicated, then you will input the start and end dates that reflect the actual period for which the CQM data represents.
- Please see next slide for a screenshot.

CQM Screenshot for 2020

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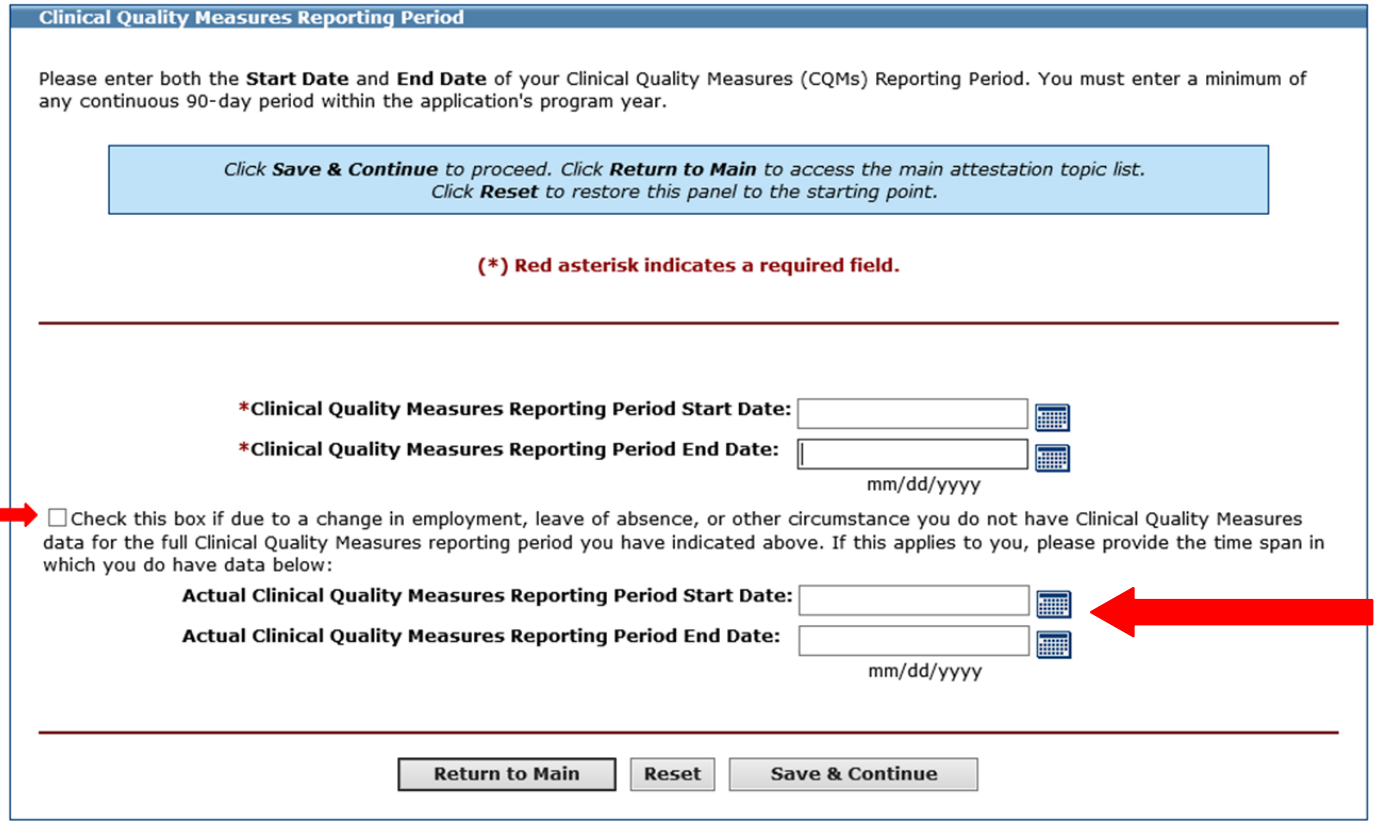

Check this box if the actual CQM reporting period is shorter than the ime span reflected above

Only enter dates here if you checked the box above because the provider had a leave of absence or change in employment during the CQM reporting period above

CQM Changes for Program Year 2020

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- Additionally, CMS removed four CQMs from the list of available CQMs.
  - **CMS 52** - HIV/AIDS Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
  - **CMS 82** - Maternal Depression Screening
  - **CMS 132** - Cataracts, Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
  - **CMS 160** - Depression Utilization of the PHQ-9 Tool
- New CQM for Program Year 2020:
  - **CMS 771 -** International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
- Please see next slide for a screenshot of CMS 771.

CQM Screenshot for 2020

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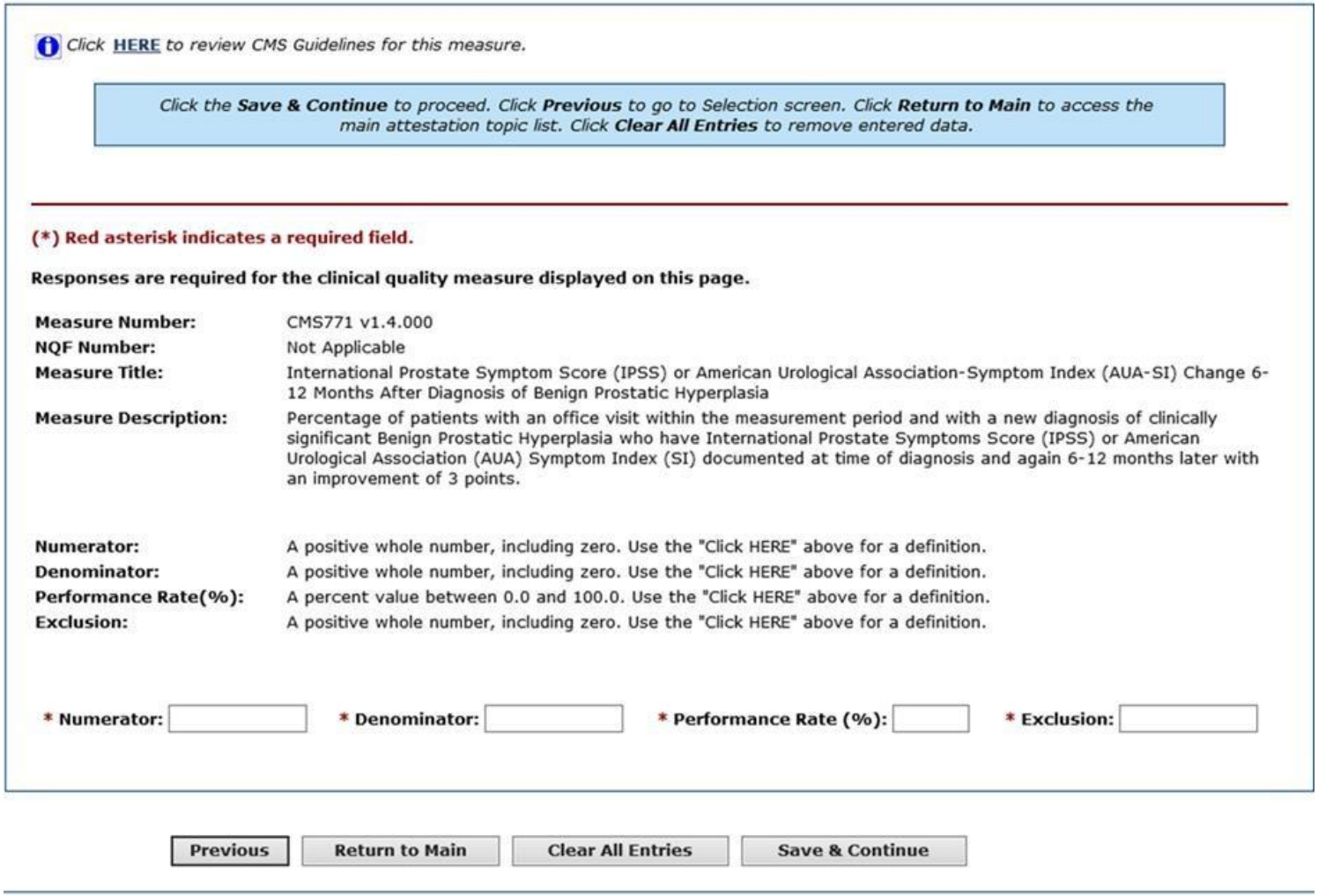

Click HERE to review CMS Guidelines for this measure.

Click the **Save & Continue** to proceed. Click **Previous** to go to Selection screen. Click **Return to Main** to access the main attestation topic list. Click **Clear All Entries** to remove entered data.

(*) Red asterisk indicates a required field.

Responses are required for the clinical quality measure displayed on this page.

Measure Number:	CMS771 v1.4.000
NQF Number:	Not Applicable
Measure Title:	International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
Measure Description:	Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.
Numerator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:	A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):	A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:	A positive whole number, including zero. Use the "Click HERE" above for a definition.

* **Numerator:** * **Denominator:** * **Performance Rate (%):** * **Exclusion:**

Previous | Return to Main | Clear All Entries | Save & Continue