Centricity™ Clinical Quality Reporting

Version 1.6.12 Release Notes

October 2019

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Who should read this document....

This document is intended for system administrators and clinic managers. It identifies documentation for product features and technical requirements for configuring and using Centricity Clinical Quality Reporting services for this release.

What's new in this release?

Centricity Clinical Quality Reporting is our cloud-based Quality reporting solution for all users of Centricity Practice Solution 12.3 or higher, and Centricity EMR 9.12 or higher.

Note: Please clear the cache in your browser so that you can view the new features in every release.

Getting help with Clinical Quality Reporting website

For questions about implementation and setup on the site, contact Centricity Practice Services at 888.436.8491 (option 2, option 3) or your Value Added Reseller (VAR).

Enhancements and issues resolved in this release

This section describes an enhancement and fixes in this release.

Obsolete Quality Measures for PY 2019

Under the MIPS program, the following CQMs are obsolete for 2019:

- CMS65 Hypertension: Improvement in blood pressure
- CMS123 Diabetes: Foot Exam
- CMS158 Pregnant Women that had HBsAG testing
- CMS164 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- CMS169 Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

Obsolete measures do not display in the MIPS tab, but may display in the Dashboard tab if they are configured in Measurement Settings. Measures are labeled as obsolete in Measurement Settings and each one must be manually selected for configuration in the Dashboard tab.
(KM87125)

Fixes

CMS156 Use of High-Risk Medications in the Elderly
Previously, the displayed score for CMS156 was an average of Population 1 and Population 2 for the measure.
Now, the displayed score for CMS156 matches the Population 1 score.
(KM87095)

Bookmark Messages Updated
Bookmark messages were updated to provide improved guidance when creating or editing a bookmark.

New MIPS & Dashboard Tab Messaging
Bookmark names are restricted to 30 characters. New messaging provides this guidance in the 'Create' and 'Edit' bookmark workflows.
Bookmark names must be unique. When a duplicate bookmark name is being created, new messaging indicates the bookmark name is a duplicate of an existing bookmark name.

New Dashboard Tab Messaging
Bookmarks with the same results as a previously created bookmark cannot be saved. New messaging indicates a duplicate bookmark is being created and identifies the name of the previously created bookmark that has the same results.
The MIPS tab allows users to create bookmarks with the same results. This will be restricted in a future release.
(KM87092)

CQR: 90-Day Calculations Not Returning Results
Previously, some users reported that new 90-day calculation results were not returning properly when calculations were requested after selecting a reporting period using the Previous Calculations drop-down.
Now, this has been corrected, and 90-day results should display within 24 hours of calculation.
(KM80648)

Corrected Numerator Count for Send a Summary of Care measures
Previously, some users reported receiving Numerator credit for the MIPS and Medicaid Send a Summary of Care measures (“PI_HIE_1” and “FNC_PI3_Objective_7_Measure_1,” respectively) when the Numerator event occurred outside of the reporting period.
Now, these out-of-range Numerator overcounts have been corrected. Note that this may result in a reduced Numerator total for these two measures once recalculated.
(KM86325)

Known Issue

CMS156 Use of High-Risk Medications in the Elderly
CQR is unable to limit prescriptions counted in the numerator to only the current provider. High-risk prescriptions by other providers who have seen the patient will impact this measure.
(KM72491)

Appendix: Previous Releases

The Appendix contains documentation from previous CQR release notes as far back as v1.6.

Version 1.6.11 Release Notes

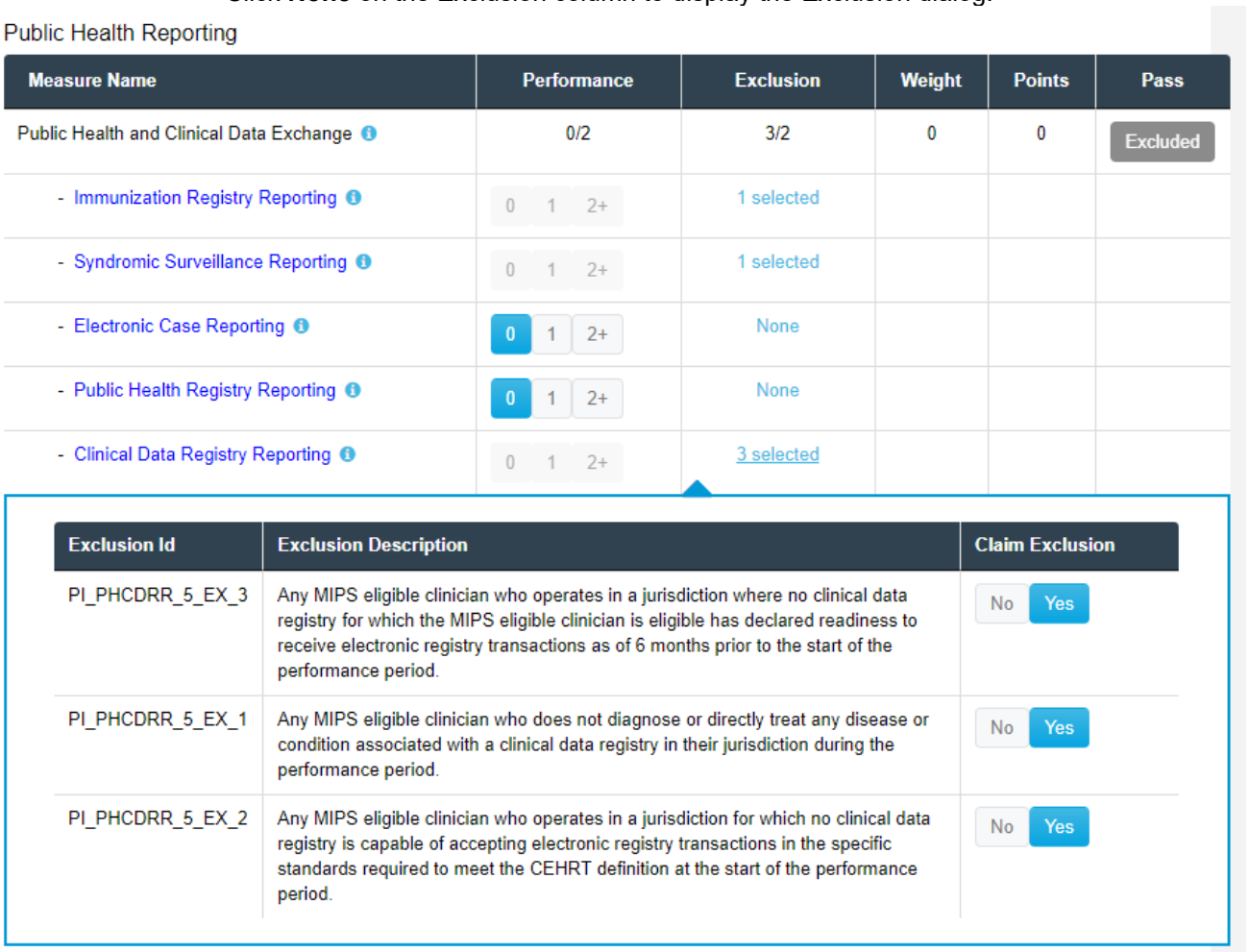
Enhancements and issues resolved in this release

Year 2019 Public Health Reporting measures now indicate exclusion

For the Public Health Reporting measures, you can now indicate exclusion on the Exclusion column of the **MIPS > PI** tab:

- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

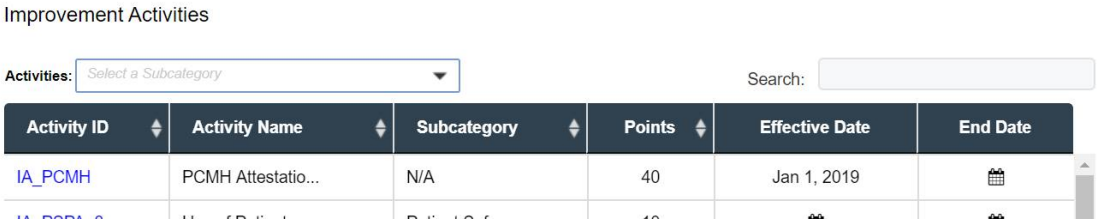
Click **None** on the Exclusion column to display the Exclusion dialog.



Click **Yes** to claim a measure Exclusion. There are three exclusions available for each measure.

Note: For more information, please refer to the *CQR User Manual - August 2019 revision.*

Improvement Activities (IA) table on IA tab now displays the PCMH tracking



PCMH tracking has moved from the Additional Program Details window (Accessible via the gear button at the top right of the MIPS dashboard) to the Improvement Activities tab. Instead of checking a box, users will now select an Effective Date when they became eligible PCMH participants. In the above example, the user was eligible for all of 2019, so an Effective Date of January 1st was selected.

Fixes

Multiple Blood Pressures During an Encounter
Previously, when multiple blood pressures were recorded with the same date and time during an encounter for CMS165, CMS65 and CMS22, it was indeterminate which blood pressure value would be used to calculate the measure results. Now, the lowest blood pressure will be used to calculate measure results.
(KM46116/KM28037)

Topped Out Measures
CMS68v8, Documentation of Current Medications in the Medical Record, and CMS156v7, Use of High Risk Medications in the Elderly, are topped out for PY 2019 and subject to the 'Seven Point Cap'. A maximum of 7 points may be earned for each topped out measure as compared to a non-topped out measure which can earn up to 10 points. With this release, a maximum of 7 points may be earned for CMS68 and CMS156 and the Decile column will indicate 'Topped out'.
(KM85833)

Duplicate Provider Entries in Group Summary Excel Spreadsheet
Previously, some Functional Measure tabs in the downloaded Group Summary Excel spreadsheet contained duplicate provider entries. Now, provider entries are no longer duplicated.
(KM46586/KM62404)

CMS69 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up Plan
Previously, CMS69 was not providing credit for "Referrals where weight assessment may occur", resulting in the patient not being included in the numerator. This has been corrected.
(KM85834)

Bookmark Error Messages
Previously, a bookmark error message related to the use of special characters did not provide enough information so that users understood the problem in order to correct it. Now, the bookmark message provides additional details and states, "The bookmark name contains an invalid special character and cannot be saved. Special characters that may be used include a hyphen, period, underscore, plus sign and a comma. Please choose a different bookmark name."
(KM85835)

Bookmark View in the MIPS tab
Previously the bookmark view in the MIPS tab defaulted to the Quality tab. Now it will default to the PI tab. Additional enhancements are planned for a future release.
(KM85836)

CMS147 Preventative Care and Screening: Influenza Immunization
Previously, CMS147 was listing patients in the denominator without a proper encounter during the Influenza Season resulting in the patient being unmet for the measure. This has been corrected.
(KM46841/KM62573)

Patient Electronic Access
Previously, patients were being listed in the Numerator for Patient Electronic Access measures when an office visit occurred after denying API access (by unchecking the Patient Data Access Authorized checkbox).
Now, patients will only show in the Numerator if timely access was granted for each encounter in the reporting period.
(KM46843/KM62549)

CMS154 Appropriate Treatment for Children with Respiratory Infection (URI)
Previously CMS154, displayed duplicate patients in the IPP, Denominator, Denominator Exclusions, Denominator Exceptions and Numerator Met/Unmet. Now, duplicate patients no longer display in CMS154.
(KM47016/KM81075)

CMS 347 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Patients with a Statin allergy should be included in Denominator Exceptions for CMS347. Instead, these patients were included in the Numerator Unmet or Met in CQR. Now, patients with a Statin allergy are included in the Denominator Exceptions per the measure logic.
(KM47020/KM44584)

CPC+ Practice Configuration
Previously, when clinicians in a CPC+ practice were manually included or excluded from the group practice, the selections did not persist. This has been corrected.
(KM47069/KM44585)

Exclusion Information Listed Under MIPS Tab
Previously, it was possible for MIPS PI exclusions to become locked in a “Yes” state. Now, this issue has been resolved.
(KM44568)

Known Issue

CMS155 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS153 Chlamydia Screening for Women
CMS137 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

CMS155, CMS153, CMS137 are all multi-stratum measures that are not using the overall population to average the performance score correctly. This issue will be corrected in a future release.
(KM85831)

Version 1.6.10 Release Notes

Enhancements and issues resolved in this release

Upgraded Clinical Quality Measures for reporting year 2019

These 12 Clinical Quality Measures were upgraded to the measure versions applicable to reporting year 2019, while retaining measure versions applicable to reporting year 2018. The changes for 2019 will take effect when you calculate any performance period in 2019.

Note: The *Quality Reporting Guide – June 2019 revision* has been updated to reflect the changes for the Performance Year 2019 reporting for the following Quality measures.

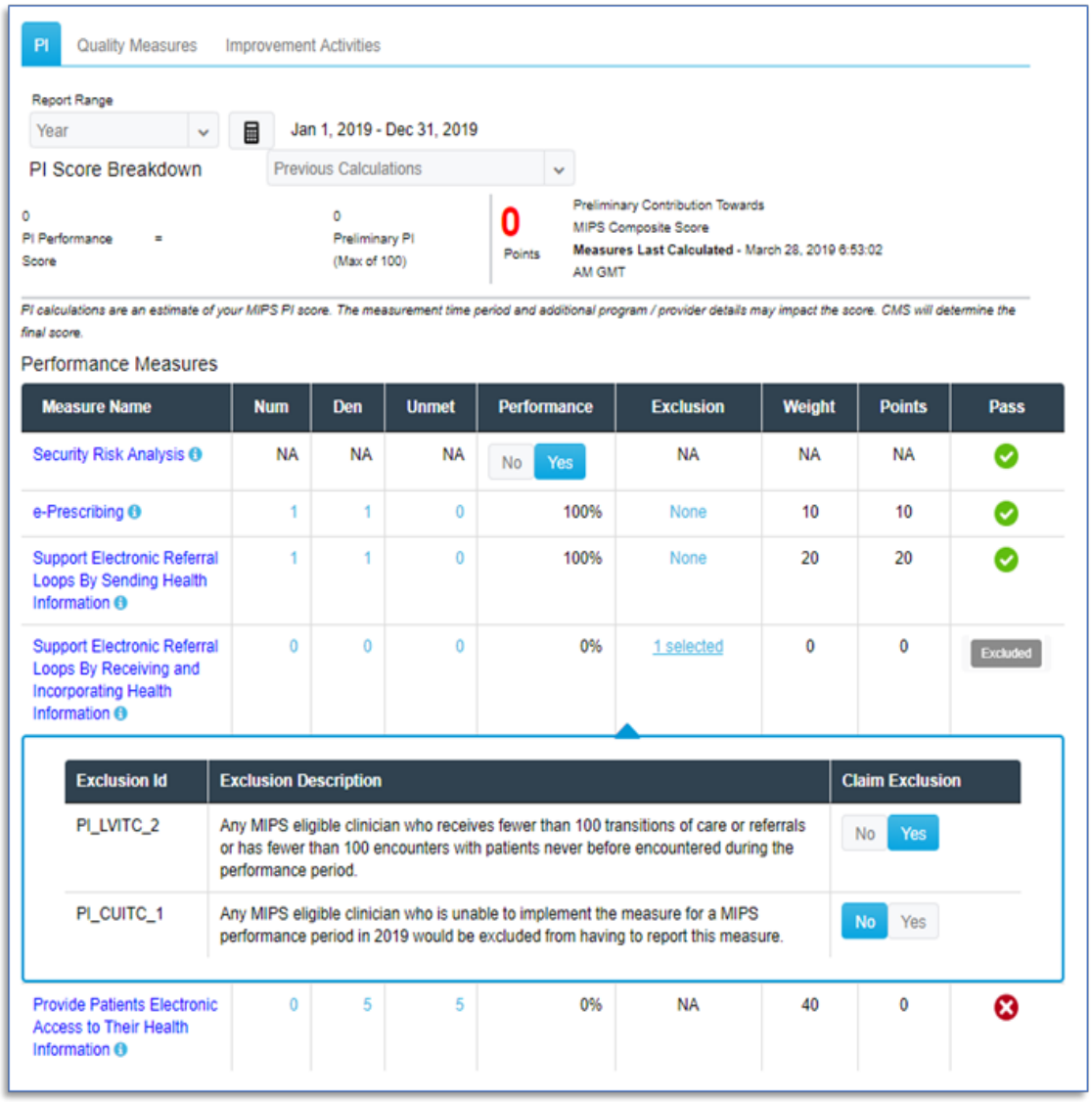
- CMS22 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – version 7.1
- CMS52 HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis – version 7.2
- CMS66 Functional Status Assessment for Total Knee Replacement – version 7.5
- CMS68 Documentation of Current Medications in the Medical Record – version 8.1
- CMS117 Childhood Immunization Status – version 7.2
- CMS139 Falls: Screening for Future Fall Risk – version 7.2
- CMS144 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) – version 7.1
- CMS145 Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) – version 7.2
- CMS146 Appropriate Testing for Children with Pharyngitis – version 7.2
- CMS154 Appropriate Treatment for Children with Upper Respiratory Infection (URI) – version 7.2
- CMS156 Use of High-Risk Medications in the Elderly – version 7.3
- CMS177 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment – version 7.2

Year 2019 Performance measures now indicate exclusion

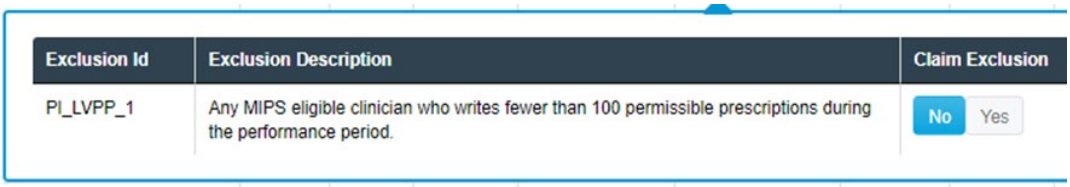
For these three PI measures, you can now indicate exclusion on the Exclusion column of the **MIPS > PI** tab:

- Electronic Prescribing
- Support Electronic Referral Loops by Sending Health Information
- Support Electronic Referral Loops by Receiving and Incorporating Health Information

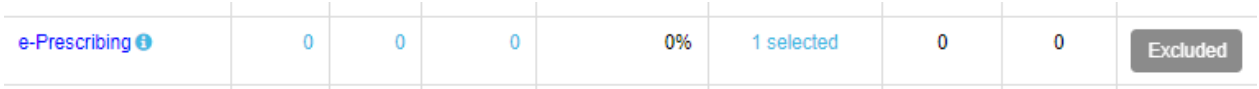
Click **None** on the Exclusion column to display the Exclusion dialog.



Click **Yes** to indicate that there is a measure Exclusion.



For example, claiming an exclusion for e-Prescribing displays “1 selected” on the Exclusion column and “Excluded” on the Pass column.



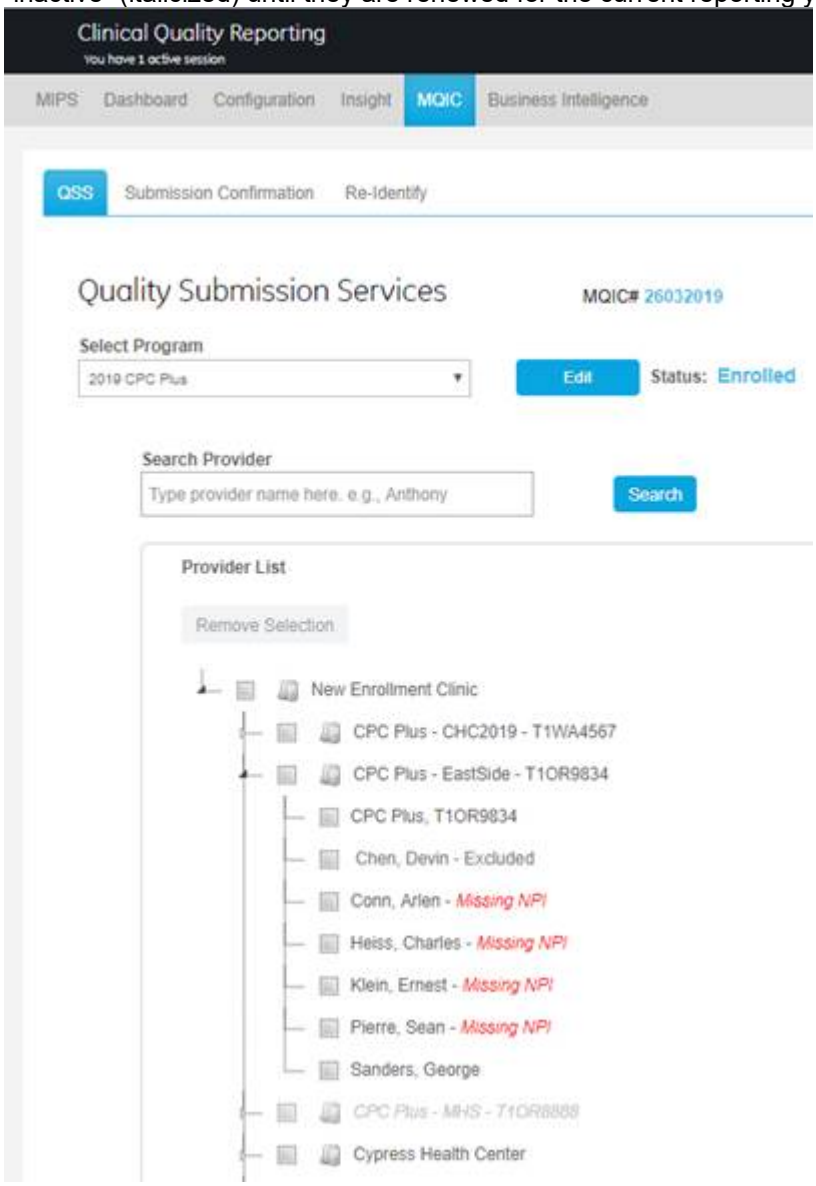
Note: For more information, please refer to the *CQR User Manual - June 2019 revision.*

Important Scoring Update
Due to incomplete 2019 exclusion guidelines from CMS, CQR will reduce all excluded / reweighted PI Performance measures to a zero Weight, but the dashboard will not be able to reflect Weight increases to companion measures. Because of this, **if one or more exclusions are claimed there will likely be a difference between the PI category / MIPS dashboard scores and the score determined by CMS at submission.** CMS will determine the final score.

Fixes

MIPS and CPC+ Group Practices in the Provider List

- Previously, MIPS and CPC+ group practices displayed in the clinician list regardless of program selection. Now, group practices display based on program selection.
- Previously, MIPS & CPC+ group practices from the prior year displayed as active in the Provider List before being renewed. Now, group practices display as “inactive” (italicized) until they are renewed for the current reporting year.



PI Bonus column removed from the Improvement Activities tab

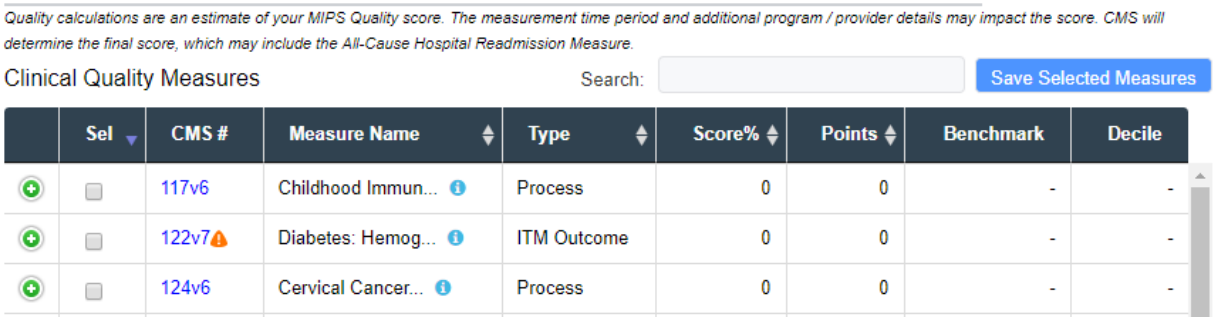
- The PI Bonus column has been removed from the Improvement Activities tab to reflect the discontinuation of the 2018 "Report Improvement Activities Using CEHRT" bonus.

Quality Measure Decile Score Calculation

- Previously, the ‘Update Quality Score’ button had to be selected to view the correct quality score if CMS 138 or CMS 156 (multi strata measures) were included in the six measures selected.
  Now, when the quality measures are calculated, the appropriate aggregation method is applied to the multi strata measures and the current quality score displays without having to select ‘Save Selected Measures’ button, previously labeled ‘Update Quality Score’.

Update Quality Score Button

The 'Update Quality Score' button label has been updated to 'Save Selected Measures'. There are no changes to the button's functionality.



Known Issues

Topped Out Quality Measure Scoring

- *CMS 68 Documentation of Current Medications in the Medical Record*, and *CMS156 Use of High Risk Medications in the Elderly*, are topped out measures for PY2019 and scoring is capped at 7 points. Currently, these two measures allow providers to earn the full 10 points for each measure and will be capped at 7 points in a future release.

MIPS & CPC+ Group Practice Providers

- Currently, for providers to be included in a MIPS or CPC+ group practice, they must be included in the standard practice in Organizational Structure that is associated with the group practice. This requirement will be removed in a future release so that providers with an encounter at a location of care associated with the group practice will be dynamically included in a group practice regardless of whether they are included in the standard practice in Organizational Structure.

  In the short term, providers may be copied into the standard practice in order to be included in the group practice.
  (KM46581)

Group Summary Excel Spreadsheet Download Contains Duplicate Providers.

- Currently the Group Summary Excel Spreadsheet download in CQR contains duplicate providers on tabs for various measures. This will be corrected in a future release.
  (KM46586)

Multiple Blood Pressures During an Encounter

- When multiple blood pressures are recorded with the same date and time during an encounter, it is indeterminate which blood pressure value will be used for the measure. By default, observations are recorded with the date/ time of the document, not the actual clock time. CMS165, CMS65 and CMS22 are impacted.

  In a future release, this will be changed to use the lowest blood pressure value. For serial blood pressures, record the time the blood pressure is taken in the flow sheet so that the most recent blood pressure will be used for the measure.
  (KM46116)

CMS155v7 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

The Observation Term DIET COUNSEL was mapped to SNOMED Code 42475300. CMS removed this code from the value set in 2019 for this measure.

Solution: New mapping will be included in the June KB.

- SNOMEDCT 441041000124100, Counseling about nutrition (procedure), will be mapped to DIET COUNSEL.

- New mapping in the June KB will resend all mapping for DIET COUNSEL that occurred in 2019.

In the short term: Add custom mapping.

Version 1.6.9 Release Notes

Enhancements and issues resolved in this release

This section describes enhancements and fixes in this release.
Note: The *Quality Reporting Guide – April 2019 revision* has been updated to reflect the changes for the Performance Year 2019 reporting for the following PI and Quality measures.

Performance Year 2019 MIPS PI Objectives and Measures

To use the 2019 PI Objectives and Measures, you must have version CPS 12.3 or CEMR 9.12 or higher installed. **Customers who use earlier versions of CPS or CEMR will see a zero PI score.**

On the **CQR > MIPS tab**, to view the updated 2019 MIPS PI scoring interface, you must select a report range within the calendar year of 2019. (Note that the 2019 view no longer has a toggle for the now-obsolete Transition measures)

Configuration note: You will not need to configure MIPS or Medicaid PI measures again if you participated in the 2018 version of that program. If you previously configured one or more MIPS PI or PI (non-transition) measures in 2018, all 2019 PI measures will be configured - this includes the new measure *Support Electronic Referral Loops By Receiving and Incorporating Health Information*. Similarly, if one or more Medicaid PI – Modified Stage 2 or Medicaid PI - Stage 3 measures were configured in 2018, all Medicaid PI – Stage 3 measures will be configured for 2019.

For customers who do not upgrade to either version CPS 12.3 or CEMR 9.12, these two measures will receive a zero score, which will result in a zero PI score.
- Support Electronic Referral Loops by Receiving and Incorporating Health Information (new measure for 2019)
- Provide Patients Electronic Access to Their Health Information

Please see the 2019 Software Requirements on our Customer Portal and the *CQR User Manual.*
Note: There are substantial updates to how the Objectives and Measures are scored for Performance Year 2019. Please refer to the *CQR User Manual - April 2019 revision.*

Performance measures
- Security Risk Analysis
- Electronic Prescribing
- Support Electronic Referral Loops by Sending Health Information (**previously** named Send a Summary of Care)
- Support Electronic Referral Loops by Receiving and Incorporating Health Information (**new** measure for 2019) – This new measure is the combination of two measures from 2018: *Request/Accept Summary of Care* and *Clinical Information Reconciliation*, but with updated denominator and stricter reconciliation requirements. Please see the *Quality Reporting Guide* for complete measure description.
- Provide Patients Electronic Access to Their Health Information (**previously** named Provide Patient Access)

Public Health Reporting
- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

Obsolete measures for Performance Year 2019:
- Request/Accept Summary of Care

- Clinical Information Reconciliation
- Patient-Specific Education
- View, Download or Transmit (VDT)
- Secure Messaging
- Patient-Generated Health Data

Upgraded Clinical Quality Measures for reporting year 2019

These 9 Clinical Quality Measures were upgraded to the measure versions applicable to reporting year 2019, while retaining measure versions applicable to reporting year 2018. The changes for 2019 will take effect when you calculate any performance period in 2019.

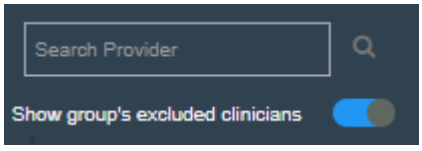
- CMS56 Functional Status Assessment for Total Hip Replacement – version 7.4
- CMS69 Body Mass Index (BMI) Screening and Follow-Up – version 7.1
- CMS124 Cervical Cancer Screening – version 7.2
- CMS125 Breast Cancer Screening – version 7.2
- CMS135 Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) – version 7.1
- CMS142 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care – version 7.1
- CMS153 Chlamydia Screening for Women – version 7.4
- CMS155 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents – version 7.2
- CMS159 Depression Remission at Twelve Months – version 7.2

Updated Improvement Activities for reporting year 2019

The list of Improvement Activities has been updated for reporting year 2019. Click the **MIPS > Improvement Activities** tab to view the complete list.
Note: CMS has discontinued the Improvement Activities “PI Bonus” for 2019.

Show or Hide a Group’s Excluded Clinicians

Previously, clinicians excluded from a MIPS or CPC+ group practice displayed in the MIPS and Dashboard tabs, Organizational Structure, and Measurement Settings in a lighter colored font to differentiate the included clinicians versus the excluded clinicians. Now, users can opt to ‘Show’ or ‘Hide’ the excluded clinicians in a group practice using the **Show group’s excluded clinicians** toggle located on the MIPS tab, below the Search Provider field. Click to show the excluded clinicians, as indicated with a blue toggle. (The toggle defaults to ‘Hide’.) Selections made on the MIPS tab reflects consistently across all provider views of a MIPS or CPC+ group in CQR, except for the QSS Provider List on the MQIC tab.
Note: Excluded providers in Measurement Settings do not appear with a lighter colored font and will be corrected in a future release.



Fixes

Managing the Removal of the Face to Face Interaction Value Set and SCT-308335008 for 2019

- The 'Face-To-Face Interaction' value set, which included SCT-308335008, was removed **for the following measures in the 1.6.9 upgrade: CMS56, CMS124, CMS125, CMS135, CMS142, CMS153, CMS155, and CMS159.** It cannot be used for year 2019 encounters and should be replaced with the following codes:
  - New Patients: SCT-37894004
  - Established Patients: SCT-30346009

  CQR mapping has been added to accommodate the use of SCT-308335008 until you transition to the New and Established Patient codes in your workflows. (KM46117)

Submission Confirmation for QSS Participants in MIPS and CPC+

- Previously, MIPS and CPC+ submission confirmations in the MQIC tab displayed duplicate rows and excluded and duplicate providers. The accuracy of the submission was not affected and this has been corrected so that a single submission confirmation will display for each individual or group submission for program year 2017.
  (KM45944)

Update Quality Score Button

- Previously in the MIPS Quality tab, if multi-population measures were selected, the Quality MIPS Composite Score did not update unless the 'Update Quality Score' button was selected. This has been corrected.
  (KM44365)

Known Issues

CMS155v7 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

- The observation term 'DIET COUNSEL' is currently mapped to SNOMED code 424753004 and this code was removed from the value set (Counseling for Nutrition) for PY2019. To meet Numerator 2 (Patients who had counseling for nutrition during the measurement period), you will need to perform a custom mapping from DIET COUNSEL to a SNOMED code within the 'Counseling for Nutrition' value set.

CMS159 Depression Remission at Twelve Months

- The numerator requires a PHQ-9 score less than five; however, the PHQ-2 form requires a minimum score of 3 in order to prompt the display of the PHQ-9 form. If a patient has a PHQ-2 score less than 3, then a total PHQ-9 score cannot be calculated, which is required to meet the numerator. In the case of a patient with a PHQ-2 score less than 3, manually enter the PHQ-9 score in the flowsheet.

Version 1.6.8.5 Release Notes

This section describes a fix in this release.

Fix

Quality Submission Services (QSS) Participants Only: MIPS & CPC+ Submission Confirmation

- Previously, submission confirmations in the MQIC tab displayed duplicate, inactive, or excluded providers for MIPS individuals and groups, and CPC+ practice submissions. The accuracy of the submission was not affected and this has been corrected so that a single submission confirmation will display for each individual or group submission for program years 2017 and 2018. (KM45185)

Version 1.6.8.4 Release Notes

This section describes a fix in this release.

Fix

- Previously, the QRDA-III included one PI measure ID for the selected registry type. If 2+ was selected (as shown below), _MULTI was appended to the measure ID. QPP did not reflect any points for that registry. Now, the QRDA-III includes two measure IDs for multi-registries, which is counted correctly in QPP. If you selected PI registry measures with 2+, download a new QRDA-III and resubmit to QPP.
  Note: No action is required for customers participating in QSS. Virence will resubmit for them.
  (KM45871)

Public Health Reporting

Measure Name	Performance	Points
Public Health and Clinical Data Registry Reporting	Multiple	10
- Specialized Registry Reporting	0 1 **2+**	
- Syndromic Surveillance Reporting	**0** 1 2+	
- Immunization Registry Reporting	0 **1** 2+	

Version 1.6.8.3 Release Notes

This section describes fixes in this release.

Fixes

Description of issues:

- QRDA-III files downloaded from the CQR legacy dashboard prior to our March 6th 1.6.8.2 release, may contain an exclusion for a Promoting Interoperability measure (either transition or non-transition) that has a denominator too large to qualify for the exclusion.
(KM45483)

- QRDA-III files downloaded from the CQR legacy dashboard after our March 6th 1.6.8.2 release, may record attestation statements values as 'No' when the value is a 'Yes' on the MIPS tab in CQR. CMS requires a 'Yes' value for these statements to receive any Promoting Interoperability points. This issue is now fixed.
(KM45713)

Recommended actions:

- Quality Submission Services (QSS) customers: No action required.
- Non-QSS customers:
    - Login to the CMS Quality Payment Program (QPP) website, https://qpp.cms.gov/login, and verify your submitted results. CMS offers this video if you want additional information on how to view your Promoting Interoperability results. https://www.youtube.com/watch?v=X8vHB2gfonU&feature=youtu.be.
    - If the QPP site shows the expected results, including yes values for your attestation statements and only identifying Promoting Interoperability measures as excluded if they have a denominator less than 100, no further action is required.
    - If the QPP site shows Promoting Interoperability measures with an exclusion that does not qualify for one, download a new QRDA III file for the impacted provider and resubmit prior to the CMS MIPS submission deadline of April 2nd. Confirm the newly submitted results display accurately on the QPP site.
    - If you have previously downloaded a QRDA and have not yet submitted, we recommend downloading a new QRDA.

Version 1.6.8.2 Release Notes

This section describes fixes in this release.

Fixes

For those enrolled in Quality Submission Service (QSS):

- Removed incorrect warning during MIPS authorization that Yes / No measures would be submitted with a denominator of 0.
  (KM45357)

- Previously, providers who were part of a group in 2017 and changed to individual providers in 2018 were unable to select performance categories submitted by the group. Now, individual providers for the 2018 performance year can select from all QSS categories.
  (KM45248)

- Previously, providers who were part of a deleted group and are reporting as individual providers in 2018 were unable to select performance categories submitted by the group. Now, individual providers for the 2018 performance year can select from all QSS categories.
  (KM45416)

- Previously, when viewing a bookmark with a PI period of 90 days, the date range displayed for PI in the MIPS final score showed the full year. Now, the date displays the bookmarked PI date range. The data authorized for submission is accurate. There is no need to recalculate. Previous bookmarks will be updated with no further action from customers.
  (KM45457)

- MIPS authorization displays total points for categories authorized for submission. The total shown in MIPS authorization has been updated to include small practice bonus points.
  Note: Small practice bonus points are not part of the MIPS submission file. Verify bonus eligibility on the QPP web site.
  (KM45545)

- Previously, authorization warning messages displayed when there were inactive providers associated with a MIPS group. This has been corrected so that inactive providers will not display in the warning messages at authorization. Inactive providers are not included in group calculations or QRDA-III. There is no need to recalculate.
  Known Issue: Excluded providers will continue to display in the authorization warning messages. However, they are not included in the group calculations or QRDA-III. This will be corrected in a future release.
  (KM45521)

For all customers:

- From the Update Provider Details window, the URL address link for the Refresh button has been updated so that the provider's specialty information can be retrieved from the NPPES database.
  (KM44269)

- QRDA-III files downloaded from the CQR dashboard may contain an exclusion for a PI measure that has a denominator too large to qualify for the exclusion. If you downloaded a QRDA-III file with this problem, we will notify you by email after the patch is released. If you already uploaded your QRDA-III file to QPP, please verify your results on the QPP site.
  Measures impacted:
  - PI Transition: E-Prescribing, HIE Send Summary of Care
  - PI (CEHRT 2015): E-Prescribing, HIE Send Summary of Care, HIE

Request/Accept Summary of Care
(KM45483)

- PI Preliminary scores have been updated to include the PI bonus score in the total. All bookmarks will be updated.
(KM45500)

Tip

When reviewing your Quality score, when you change a date range or measure selection, click **Update Quality Score** to reflect the change.
(KM44365)

Version 1.6.8.1 Release Notes

This section describes fixes in this release.

Fixes

- **Two Medicaid PI - Stage 3 Measures Displayed Incorrect Goals**
Previously, two Medicaid-Stage 3 PI measures, displayed measure goals incorrectly:
    - View, Download and Transmit (VDT) incorrectly displayed a goal of 10%
    - Secure Messaging incorrectly displayed a goal of 25%

  Now, both measures display correctly with a goal of 5%.
(KM45082)
- **MIPS Quality: Benchmark Changes 2019**
Previously, 2018 Quality benchmarks displayed for a 2019 report range.
Now, 2019 benchmarks display when a 2019 report range is calculated.
(KM45358)
- **Encounters Performed On December 31, 2018 Caused Patients To Be Listed Incorrectly For Quality Measures**
Previously, patients with an encounter order start date of December 31, 2018 were not included in the denominator for Quality measures. This has been corrected so that patients are included in the measure's denominator. Use **Chart > Reports > Inquiries** to find patients who had a visit on this date to resend impacted patients to CQR.
(KM45306)
- **QSS PI Warning Message Revised**
Previously, QSS participants authorizing for MIPS PI received a warning message about PI measures with a denominator of 0. This warning has been revised to provide greater clarity. The updated warning identifies all PI measures with a denominator of 0 and indicates the measures will not be submitted to CMS. It instructs the user to ensure the measures are selected in measurement settings and recalculate if a denominator greater than 0 is expected.

  Note: An extraneous warning about denominator of 0 remains for yes/no measures. It can be ignored. This will be removed in a future release.
(KM45357)

Version 1.6.8 Release Notes

This section describes enhancements and fixes in this release.

Upgraded Clinical Quality Measures for reporting year 2019

These 8 Clinical Quality Measures were upgraded to the measure versions applicable to reporting year 2019, while retaining measure versions applicable to reporting year 2018. The changes for 2019 will take effect when you calculate any performance period in 2019.

CMS90 Functional Status Assessment for Complex Chronic Conditions – version 8.3
CMS127 Pneumonia Vaccination Status for Older Adults – version 7.2
CMS130 Colorectal Cancer Screening – version 7.2
CMS138 Tobacco Use: Screening and Cessation Intervention – version 7.1
CMS147 Preventive Care and Screening: Influenza Immunization – version 8.1
CMS149 Dementia: Cognitive Assessment – version 7.3
CMS160 Depression Utilization of the PHQ-9 Tool – version 7.3
CMS161 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment– version 7.2

- Our *Quality Reporting Guide – February 2019 revision* has been updated to reflect the changes for 2019 reporting.

Fixes

- **2019 Quality Measure Results**
  Previously, 2019 quality measure results did not display.
  Now, results will display with 2019 benchmarks. (KM45210)

- **MIPS&CPC+ Authorization: Inactive & Excluded Providers included in QSS Warnings and Restriction Messages**
  Previously, inactive and excluded providers were included in Warning and Restriction messaging at authorization for MIPS and CPC+ participants. This did not impact the provider's authorization outcome.
  Now, this has been corrected so that only *active* providers and providers *included* in a group practice are considered for authorization warning and restriction messages. (KM45208)

- **Providers within Organizational Structure**
  Previously, some users on PROD2 (https://dashboard.cqr.gehealthcare.com/) were unable to move or copy providers to a different practice in Configuration> Organizational Structure.
  Now, users with the Member or Practice Administrator role are able to move or copy providers. (KM42496)

- **PI Yes/No Measures or Statements**
  Previously, when a PI category was included in a new bookmark or QRDA-III and any of the Yes/No measures or statements were displayed as 'Yes' on the MIPS tab, the bookmark and/or QRDA-III file recorded the value as 'No'.
  Now, the bookmark and QRDA-III file will accurately save the value as 'Yes'.
  Note: If PI measures were submitted prior to the 1.6.8 release, download a new QRDA-III file and resubmit and/or check the CMS QPP site to verify whether your Yes/No attestation measures were populated correctly. (KM45209)

Known Issue

- Two Medicaid-Stage 3 PI measures displayed measure goals incorrectly:
  - View, Download and Transmit (VDT) (FNC_P13_Objective_6_Measure_1) incorrectly displayed a goal of 10% when it should be 5%.
  - Secure Messaging (FNC_P13_Objective_6_Measure_2) incorrectly displayed a goal of 25% when it should be 5%.

Measure results and QRDA files reflect accurately and this measure maybe submitted for PY2018. The goal's display will be corrected in a future release. (KM45082)

Version 1.6.7.2 Release Notes

This section describes a fix in this release.

Fix

- **E-Prescribing and HIE Measure Exclusions in the QRDA-III**
  Previously, the QRDA-III file downloaded from the dashboard contained an error that prevented submission to CMS. The file included an exclusion for E-prescribing and HIE measures in addition to the numeric result even if the denominator was greater than 99. This occurred only when a prior calculation in 2018 had a denominator less than 100. This impacted both PI and PI Transition measures.

  Now, the QRDA-III file will only contain an exclusion for these measures when the calculation has a numerator of 0 and a denominator less than 100 and will not include the numeric result. If the numerator is greater than 0 or the denominator is greater than 99, only the numeric results will be included which will count toward the base measure results, and for HIE will also count for performance measure points. You must recalculate or wait for automatic calculations to complete before generating the QRDA or authorizing submission.
  (KM45006)

Version 1.6.7.1 Release Notes

This section describes fixes in this release.

Fixes

- **MIPS Group Calculations: Medication Reconciliation**
  Previously, for clinicians in a MIPS group where two clinicians in the group signed the same document for a new patient, the patient was included in the denominator twice. This has been corrected. Once the MIPS group is calculated in CQR, the group practice will show one denominator result for the patient.
  (KM44732)

- **Public Health Measures**
  Previously, the 10 points earned for reporting on Public Health measures were not displayed or counted in the PI Score Breakdown. This has been corrected.
  (KM44999)

- **Improvement Activities Display**
  Previously, some Improvement Activities (IA) with an "Effective Date" were duplicated and not displaying at the top of the IA table. This has been corrected so that the duplicates are removed, and selected Improvement Activities display at the top of the IA table.
  (KM44859)

- ***CMS136v8 Follow-Up Care for Children Prescribed ADHD Medication (ADD)***
  Previously for CMS136 Population 1, when a medication was prescribed on the same day as the office visit, patients displayed as Excluded when they should be displayed as Met. This occurred because the "Medication Active" start date / time was 12:00 AM on the day the medication was prescribed, but the "Medication Dispensed" start date / time was equivalent to the date / time of the office visit. Since the "Medication Active" date/ time occurred before the "Medication Dispensed" date/ time in the system, the patient was included in the Denominator

Exclusion because they met the measure criteria, “actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date”. This has been corrected and a patient in Population 1 with a medication prescribed on the same day as the office visit will be included in the numerator for CMS136, given all other numerator criteria are met.
(KM44844)

- **Quality Measure Benchmarks**
  Previously if a quality measure’s score fell into the gap between two decile ranges, it displayed a benchmark of N/A and potentially impacted the measure’s points earned.
  Now, the benchmark displays, and the measure’s points will be computed.
  Note: For customers who have already self-submitted a QRDAIII to CMS for MIPS PY2018, review the submitted measure results.
  (KM44846)

- **Group Measure Summary Excel file**
  Previously, the Excel file downloaded from **Dashboard > Download Reports > Group Measure Summary** did not contain performance tabs for individual PI measures. Now, the Group Measure Summary Excel file downloaded contains individual performance tabs for each calculated PI measure.
  (KM44877)

Version 1.6.7 Release Notes

This section describes enhancements and fixes in this release.

Upgraded Clinical Quality Measures for reporting year 2019

These 7 Clinical Quality Measures were upgraded to the measure versions applicable to reporting year 2019, while retaining measure versions applicable to reporting year 2018. The changes for 2019 will take effect when you calculate any performance period in 2019.

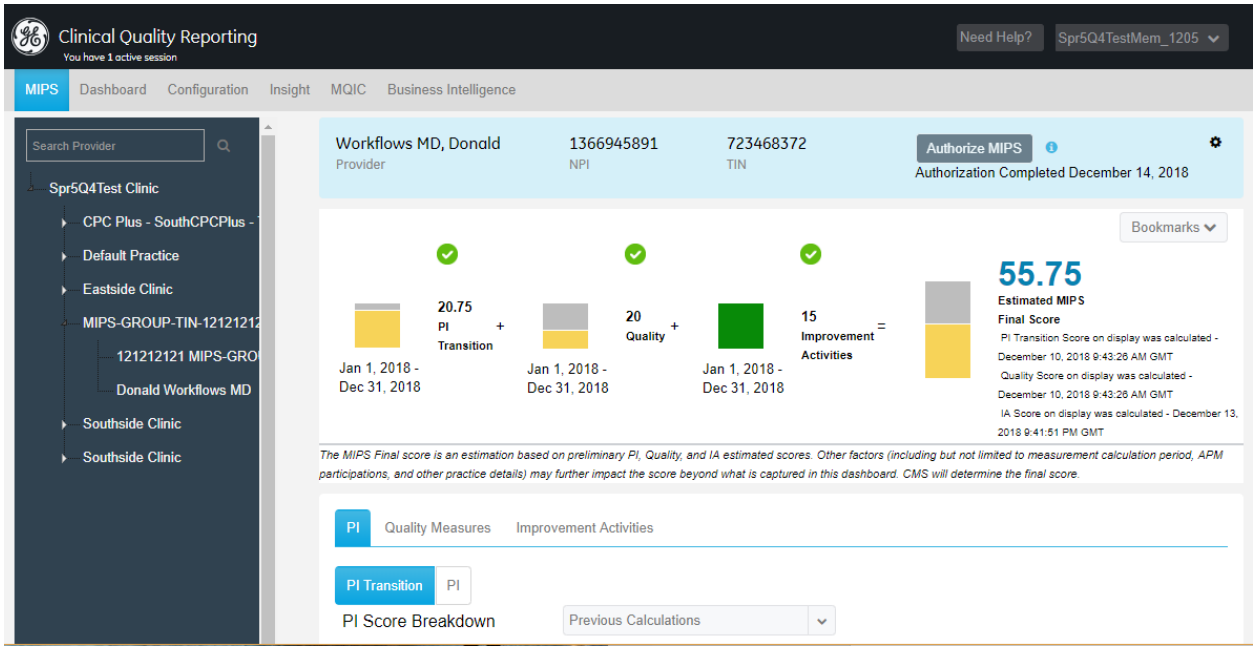
CMS2 Screening for Clinical Depression and Follow-Up Plan – version 8.1
CMS50 Closing the Referral Loop: Receipt of Specialist Report – version 7.1
CMS131 Diabetes: Eye Exam – version 7.2
CMS134 Diabetes: Medical Attention for Nephropathy – version 7.2
CMS136 Follow-Up Care for Children Prescribed ADHD Medication (ADD) – version 8.3
CMS137 Initiation & Engagement of Alcohol & Other Drug Dependence Treatment – version 7.2
CMS347 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease – version 2.1

- Find out more about the changes in logic and value sets in the Clinical Quality Measures for the 2019 performance period by referring to the *CMS Electronic Clinical Quality Improvement Resource Center*: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2019-performance-period-epec-ecqms.
- Our *Quality Reporting Guide – January 2019 revision* has been updated to reflect the changes for 2019 reporting.

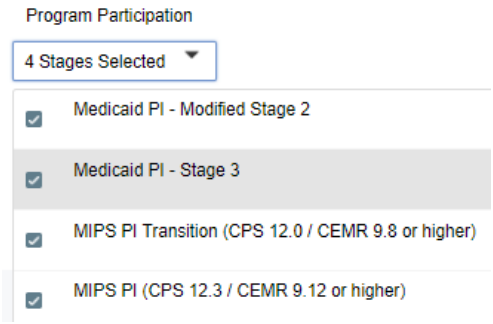
Enhancements

Renamed ACI/MU to PI on CQR
Advancing Care Information (ACI) and **Advancing Care Information Transition (ACI Trans)** are now called **Promoting Interoperability (PI)** and **Promoting Interoperability Transition (PI Trans)**, respectively.
Meaningful Use - Modified Stage 2 (MU2) and **Meaningful Use - Stage 3 (MU3)** are now called **Medicaid Promoting Interoperability Program Modified Stage 2** and **Medicaid Promoting Interoperability Program Stage 3**, respectively.
The measure names and measure IDs have been renamed on the CQR MIPS tab and legacy Dashboard tab, as well as on Configuration>Measurement Settings.
Please refer to the *CQR User Manual– January 2019* revision for more information.

MIPS tab

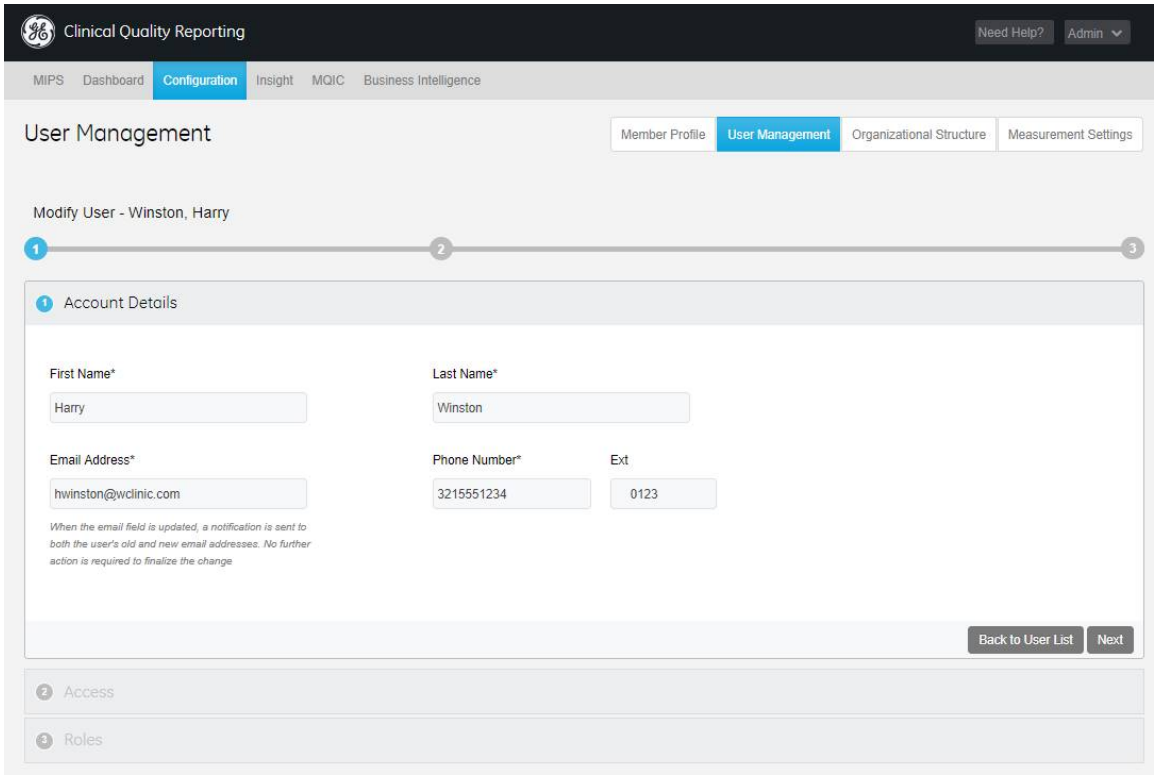


Configuration>Measurement Settings



CQR Member Admin can now modify user details
Member Admins can now edit a user's name, email address, and phone number.
Note: Member Admins are unable to edit other Member Admins.

From **Configuration > User Management > Current User**, select a user from the table and click **Edit**. The new Account Details dialog displays the name, email address, and phone number of the user. You can edit the user details as needed.
Note: When the email field is updated, a notification is sent to both the user's old and new email addresses.



Public Health Reporting measures and scoring bonus

The Public Health Reporting measures and their scoring behavior have been updated. The updates were applied to both the PI Transition and PI Non-Transition measures. Click on 0, 1, or 2+ in the Performance column to update your status for scoring.

- Select "0" under the Performance column for a Public Health Reporting measure to attest No to participating in any registries of that type. The Performance column indicates “No” and the Points column indicates “0”.
- Select "1" under the Performance column for a Public Health Reporting measure to attest Yes to participating in one registry of that type. The Performance column indicates “One” and the Points column indicates “10”.
- Select "2+" under the Performance column for a Public Health Reporting measure to attest Yes to participating in two or more registries of that type. The Performance column indicates “Multiple” and the Points column indicates “10”.

Public Health Reporting

Measure Name	Performance	Points
Public Health and Clinical Data Registry Reporting	Multiple	10
- Specialized Registry Reporting	0 **1** 2+	
- Syndromic Surveillance Reporting	0 1 **2+**	
- Immunization Registry Reporting	**0** 1 2+	

Bonus Measures

Measure Name	Performance	Points
Additional Public Health Reporting	Yes	5
Report improvement activities using CEHRT	No	0

For the Additional Public Health Reporting – Selecting “1” on two or more of the Reporting measures, or selecting “2+” on at least one of the Reporting measures, earns a 5 point bonus towards the preliminary PI score.

General updates made to MIPS and CPC+ authorization warnings and restrictions for PY2018.

New authorization warnings were added:

- Clinicians that configured Improvement Activities may have received 10 PI bonus points for the PI category measure, ‘Report improvement activities using CEHRT’. If the clinician authorizes PI but not IA, the new warning will alert clinicians they are authorizing PI only and in order to secure any expected PI bonus points derived from ‘Reporting Improvement Activities Using CEHRT’, the clinician should submit Improvement Activities through the method of their choice.
- To alert users about clinicians that have the same NPI / TIN combination.
- To alert users that if an Improvement Activities ‘Effective’ and ‘End’ dates are not within the date range calculated, the clinician would not be credited for the Improvement Activity and the IA score would change.

QSS participants can validate their submission data on the MQIC > Submission Confirmation tab

Previously, QSS participants whose data was submitted to CMS by Virence Health, received an email to confirm their submission data.

Now, QSS participants will be able to validate their MIPS or CPC+ submission data directly in the MQIC > Submission Confirmation tab.

Note: Members are strongly urged to review this information prior to the submission deadline and contact Support or their VAR if there are concerns.

Fixes

- Previously, the selection of Improvement Activities (IA) was limited to a maximum of 40 points.
  Now, there is no limitation on the number of Improvement Activities that may be selected. The IA potential score will display after selecting a date range and calculating.

- Previously, Improvement Activities were saved by selecting the corresponding checkbox and the 'Save Selections' button.
  Now, the check boxes and 'Save Selections' button have been removed and IA selection is identified when the minimum of a start date (end date is optional) is added for each Improvement Activity.

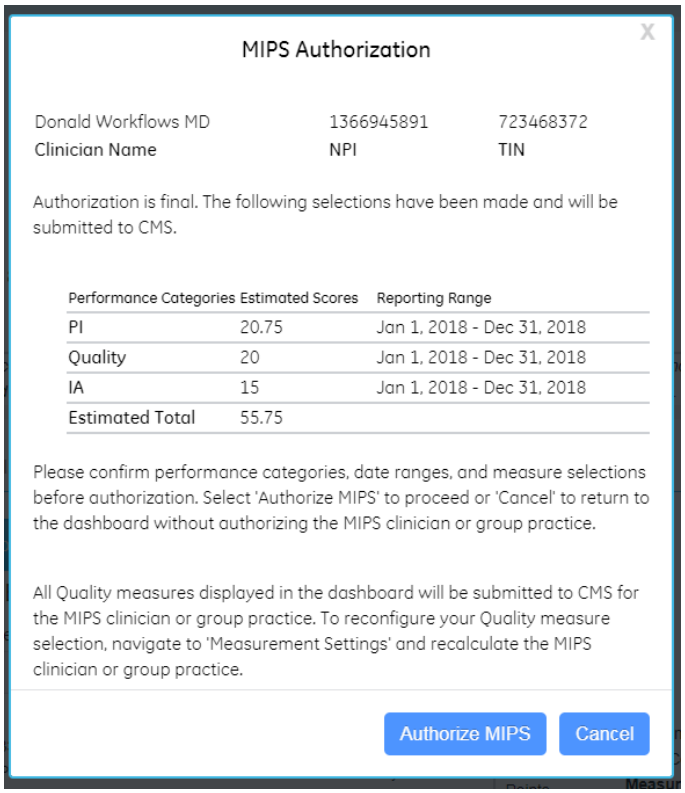
- Previously, 2017 CPC+ measures, CMS159 and CMS166, were available for configuration in 'Measurement Settings' and consequently available for calculation on the MIPS and legacy dashboards for PY2018.
  Now, the 2017 CPC+ measures are removed from 'Measurement Settings' and after calculating a 2018 CPC+ practice, the 2017 CPC+ measures will no longer display in the dashboard.

  CPC+ practices that self-submit a QRDA III to CMS for PY2018: Remember to remove the 2017 CPC+ measures (CMS159 & CMS166) from the dashboard and recalculate before generating a QRDA III.

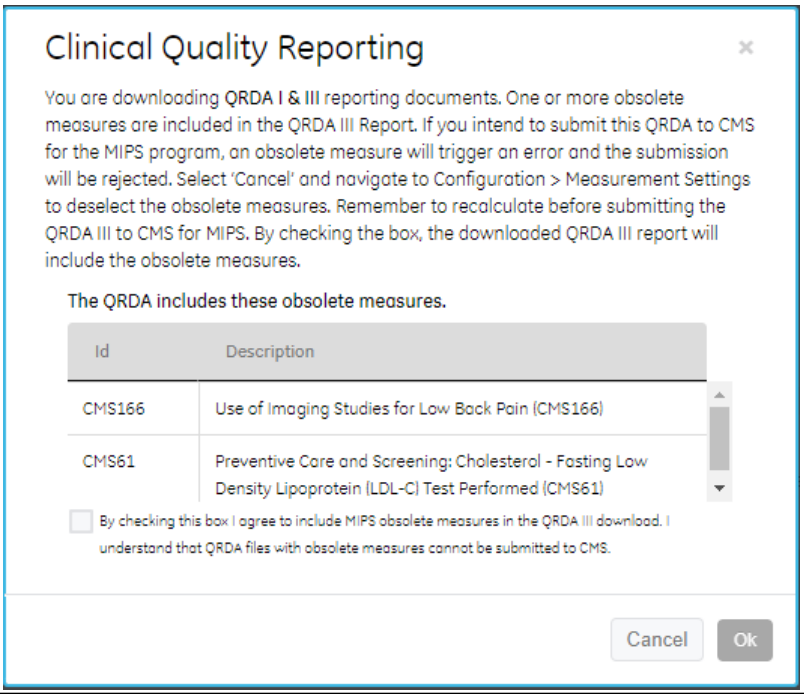
  Note: If a member recalculates a 2018 CPC+ practice for PY2017, CMS159 and CMS166 will not display in the calculation results.

- Previously, the text 'QSS' could be used to name a manually created bookmark.
  Now, 'QSS' can no longer be used to name a manually created bookmark and is reserved for system created bookmarks only. All 'QSS' text in the names of manually created bookmarks will be replaced with 'QSX'.

- Once the PI bonus is applied for PI bonus-eligible IA activities, the PI score will continue to display 10 bonus points even if the IA activities configured no longer include a bonus-eligible IA activity. The PI bonus does not dynamically update based on the calculation displaying in the IA tab. To alert users to potential changes in clinician scores at authorization, the estimated score for each performance category will be included in the 'MIPS Authorization' popup window.



- Obsolete measures for the current MIPS program year may be selected in Measurement Settings and display in the legacy dashboard. Obsolete measures do not display in the MIPS dashboard.
  Users that choose to download the 'QRDA-I and III Reports' from the legacy dashboard, will receive an alert to indicate that obsolete measures are included in the QRDAIII, and the measures would be rejected if submitted to CMS.
  If one or more obsolete measures are included in the QRDAIII, the user can either:
  - Check the box and agree to include the obsolete measures in the QRDAIII.
  - Select 'Cancel' and return to Measurement Settings to deselect the obsolete measures and recalculate.



If no obsolete measures are included in the QRDAIII file, the existing message displays.

For QSS participants who authorize with obsolete quality measures configured in measurement settings, the obsolete measures will be removed from the QRDA III being submitted to CMS and the system-generated bookmark.

- Previously, CPC+ practices that enrolled in QSS could view the enrollment workflow before signing the QSS agreement.
  Now, the QSS agreement must be signed in order to view the next steps in the enrollment process.

- Previously, the CPC+ enrollment workflow was missing an enrollment status of 'QSS Agreement Signed' and a button, 'Complete Enrollment'. This has been corrected.

- Previously, a low volume error would appear for e-Prescription and Health Information Exchange (HIE) measures even though an exclusion was available. This did not affect the submission, but it caused some confusion.
  Now, the error messages have been updated so that they do not display when an exclusion is available.

- Previously, some users were experiencing an issue where some selections in the Additional Program Details window were not saving for a subset of their providers. Now, this issue has been resolved. If you have experienced this issue, please return to the Additional Program Details window for the affected providers and confirm their selections. (KM43339)

- Previously, if you had a PI base measure with a denominator of zero, the measure was not included in the QRDA and resulted in a PI score of zero. This issue has been resolved. In addition, measure identifiers within the QRDA were updated to reflect the change from ACI to PI measure IDs. (KM4414)

- Previously, Numerator and Denominator results for objective measures could contain patients whose relevant documents were Filed in Error, causing inaccuracies in the calculated results.
  Now, patient encounters where the patient's documents were Filed in Error are no longer being included in the Numerator or Denominator. Users who have previously created bookmarks for affected providers will need to recalculate and save new bookmarks. (KM43092)

- Previously, the CVX 186 code was not included in the Influenza Vaccine value set for CMS147v7 for 2018. It is now included. (KM44648)

Known Issue

- For the Medication Reconciliation measure calculation, a patient seen by multiple providers is counted as Met in the numerator for each provider linked to a TOC encounter where medication reconciliation was performed, but under the group calculation – the patient is listed as both Met and Unmet.
  Customers that want to report 2018 Group results to CMS should hold off until this issue is addressed in an upcoming patch.
  (KM44732)

Version 1.6.6.1 Release Notes

This section describes two fixes in this release.

Fixes

- In 2018, CQMs changed to require RxNorm ingredient codes, rather than dispensable drug codes. Previously, only single ingredient drugs selected from the medication reference could be linked to an ingredient code.
  Now, when you add a medication allergy from the custom allergy list for a drug class such as 'Ace Inhibitor' or a multi-ingredient drug such as 'Caduet' (atorvastatin + amlodipine), the medication allergy is linked to an RxNorm ingredient code if it is used by at least 1 CQM.

  Measures impacted:
  ACE Inhibitor or ARB Ingredient - CMS135
  Beta Blocker Therapy Ingredient - CMS144, CMS145
  Statin Allergen - CMS347

  Known Issue: When a medication allergy is mapped from a Medispan GPI code to an RxNorm ingredient code, it is displayed in the Insight - Patient data - Patient Quality Data Model with the original 'GPI' code type. This does not affect the calculation.(KM44461)

- Previously, when editing provider details in CQR Configuration > Organizational Structure - Update Provider Details, if the NPI value was changed, the NPI field would show an error. Upon clicking Refresh, you would see "unable to connect to NPPES for Speciality verification at this time". Now, CQR can connect to the NPPES NPI registry to validate NPI entries. (KM44269)

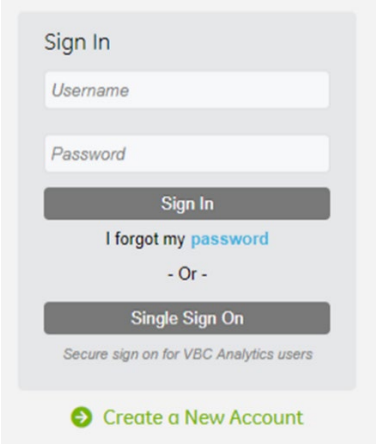
Version 1.6.6 Release Notes

Enhancements and issues resolved in this release

This section describes enhancements and fixes in this release.

Enhancement for VBC Analytics customers only

If you are a VBC Analytics customer, the CQR Sign In window has been redesigned so that you can logon to CQR using your Active Directory credential. The **Single Sign On** button was added to the Sign In window.
Note: Existing CQR customers can still sign in as usual with the Username and Password fields.



Note: Please see the *CQR User Manual– November 2018* revision for information on the Single Sign On feature.

Upgraded Clinical Quality Measures for reporting year 2019

Two Clinical Quality Measures were upgraded to the measure versions applicable to reporting year 2019, while retaining measure versions applicable to reporting year 2018. The changes for 2019 will take effect when you calculate any performance period in 2019.

CMS122 Diabetes: Hemoglobin A1c Poor Control – version 7.4
CMS165 Controlling High Blood Pressure – version 7.3

- Find out more about the changes in logic and value sets in the Clinical Quality Measures for the 2019 performance period by referring to the *CMS Electronic Clinical Quality Improvement Resource Center*: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2019-performance-period-epec-ecqms.
- Our *Quality Reporting Guide – November 2018 revision* has been updated to reflect the changes for 2019 reporting.

Added Clinical Quality Measure for reporting year 2018

Note: This measure is for use in the Medicaid EHR Incentive Program for Eligible Professionals only.
CMS166 Use of Imaging Studies for Low Back Pain – version 7.1

Fixes

- Previously, the **MIPS>ACI** tab inconsistently showed either green 'check' or red 'x' for ACI measures that should get an exclusion for less than 100 patients. This issue has been fixed so that the green check consistently displays for the exclusion. (KM43075)
- Previously, for a patient with an active medication of "Aspirin" imported to CQR, if the default RxNorm code was not found in the "Aspirin and Other Antiplatelets" value set, we automatically added the code for a low dose formulation - Aspirin 75 MG Chewable Tablet. This formulation was removed in 2018, causing CMS164 performance to be lower than expected. Now, "Aspirin" is automatically coded as Aspirin 81 MG Oral Tablet, which is counted in CMS164. After the upgrade, we will reprocess all patient data received since the beginning of 2018 to apply the new Aspirin code. We will post a notification on the login page when this step is complete and subsequent calculations will reflect this update. (KM43039)
- *CMS159 Depression Remission at Twelve Months* – Previously, if a patient had a visit in the prior year but not during the performance year, the patient was not included in the Initial Patient Population. Now, CQR counts patients with a prior year visit Initial Patient Population. (KM44358)
- *Health Information Exchange - Request/Accept Summary of Care* (ACI_HIE_2)– Previously, if both a Reconciliation and a Request are in the same encounter document for a patient, then the patient is considered UNMET in CQR. Now, if the same encounter document has the same date for both a Reconciliation and a Request, then the patient is considered MET. (KM 43194)
- Previously, on the MIPS tab, if a user requests calculation for a measurement period, then the user cannot request a second calculation using a different measurement period. This issue has been fixed so that multiple requests for different measurement periods are processed. (KM43863)
- Previously, submission confirmation data did not display for QSS participants whose data was submitted by Virence on behalf of providers and groups for MIPS and CPC+ in 2017. This issue has been fixed. (KM44359)
- When providers were excluded from a CPC+ practice in the 'Add or Edit CPC+ Practice' window, the provider's name was grayed out and 'Yes' displayed in the 'Excluded' column. However, when a user saved this change and returned to this window, the provider's status of 'Excluded' was not retained. This issue has been fixed. (KM44360)
- Previously, the CPC+ 'Add or Edit CPC+ Practice' popup window had delays in the screen refresh when selecting locations of care and displaying associated clinicians. A Loading Spinner was added to improve the user experience, avoid data inconsistency and prevent user intervention until all data is loaded and displayed. (KM44366)
- Previously, 2017 CPC+ practices that were renewed for 2018 were carrying forward manually associated providers from 2017 even if the provider did not have valid encounters in 2018. This issue has been fixed so that the CPC+ provider list is based on the provider having an encounter at a location of care associated with the CPC+ practice in the program year instead of the manual provider association workflow from the previous year. (KM43178)
- Previously, the decile score was not accurately displayed for CMS145, CMS138, CMS136, CMS155, CMS156 and CMS160 and would sometimes change when you click on 'Update Quality Score'. Now, these quality measures reflect the accurate decile score and the overall quality score when the Quality tab is selected. They all have multiple denominator or Initial Patient Population (IPP) values that use different methods for calculating the decile score. CMS136, CMS155, CMS156 and CMS160 use a simple average. CMS145 uses performance rate 1. CMS138 uses performance rate 2. (KM44365)
- Previously, for providers who had only quality measures, but no PI (formerly ACI) measure results, downloading QRDA files from the legacy dashboard would not generate files. Now, downloading QRDA files with only quality measures will generate QRDA I and III files and send email with a link to download. (KM44165)

Known Issues

- CPC Plus (2018) has an obsolete 2017 Measure (CMS 159) automatically checked in Measurement Settings. As a workaround, customers need to manually uncheck this obsolete measure before attestation. (KM43706)
- If you have a PI base measure with a denominator of zero, the measure is not included in the QRDA and will result in a PI score of zero. This will be resolved in the January release. In addition, measure identifiers within the QRDA do not reflect the change from ACI to PI measure IDs. If you are submitting QRDA to CMS directly, including ACI measures, wait until the January release is posted.
- In 2018, medication allergy value sets were changed to use RX Norm ingredient codes. Currently, medication allergies are shown in CQR with the clinical drug code and do not qualify the patient for exclusion in CMS135, CMS144, CMS145, and CMS347. This will be resolved before the end of 2018 and data will not have to be resent. We'll post a notification on the login page when this issue is resolved.

Version 1.6.5.2 Release Notes

Enhancements and issues resolved in this release

This section describes a fix in this release.

Fix

- Previously, every calculation from the MIPS Dashboard was taking full-year measurement period as opposed to the specific measurement period selected by the user. This issue has been fixed.

Version 1.6.5 Release Notes

Enhancements and issues resolved in this release

This section describes an enhancement and fixes in this release.

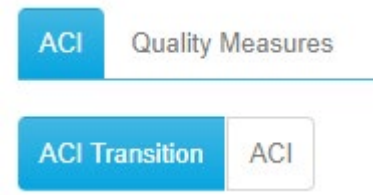
Enhancement for VBC Analytics customers only

If you are a VBC Analytics customer, a new **Insight > Data Sync** tab has been added so that you can view recent Sync jobs.

Note: Please see the *CQR User Manual– September 2018* revision for information on the Data Sync tab.

Fixes

- Previously, documents filed in error for the ACI Measure Patient-Generated Health Data were incorrectly included in the counts for numerator and denominator. This issue has been corrected. (KM43092)
- Previously, for MIPS Groups, patients seen by a provider within an organization are shown in the denominator for ACI measures regardless of location of care. Now, locations of care are correctly filtered for those on CPS 12.3 or CEMR 9.12 or higher. (KM43067)
- The **MIPS>ACI** tab now displays the ACI Transition measures as the default view.



Known Issue

- The **MIPS>ACI** tab is inconsistently showing either green 'check' or red 'x' for ACI measures that should get an exclusion for less than 100 patients. (KM43075)

Version 1.6.4.2 Release Notes

Enhancements and issues resolved in this release

This section describes a fix in this release.

Fix

Quality Submission Services (QSS) QSS Agreement and Provider Consent Forms

Participants in GE's QSS program for MIPS and CPC+ can send an electronic form from CQR and the recipient receives the form from DocuSign within approximately 15 minutes. An issue in this process resulted in users being able to send a document from CQR but the recipient would not receive it. Now QSS participants can send a QSS agreement or provider consent form and recipients will receive the document within approximately 15 minutes. QSS participants that sent but did not receive a QSS agreement should cancel enrollment and resend the QSS agreement.

Version 1.6.4.1 Release Notes

Enhancements and issues resolved in this release

This section describes a fix in this release.

Fix

The following issues for CPC+ practices and MIPS Groups are resolved. (ALM 2351)

Creating or Renewing multiple CPC+ practices with the same Tax ID

With the 1.6.4 release of 2018 CPC+ enrollment, organizations with multiple CPC+ practices reporting with the same Tax ID were not able to:

- Create multiple CPC+ practices using the same Tax ID.
- Renew 2017 CPC+ practices if more than one CPC+ practice had the same Tax ID.

Now, organizations can create or renew multiple CPC+ practices using the same Tax ID.

Renewing a MIPS Group: Provider exclusions

Previously, when a MIPS group was renewed, a provider excluded from the practice in a prior program year did not maintain its 'excluded' status after the MIPS group was renewed.
Now, when a MIPS group is renewed, a provider excluded from the practice in a prior program year displays as excluded for the current program year.

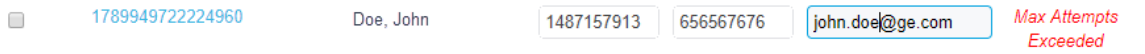
Version 1.6.4 Release Notes

Enhancements and issues resolved in this release

This section describes enhancements and fixes in this release.

MIPS Provider Consent Forms

- A clinician that signed a consent form for a MIPS QSS program in a previous year does not need to resign a consent form to participate in subsequent years. The originally signed MIPS clinician consent form is perpetual unless program requirements necessitate modification of the consent form.
- A consent form that is sent to an incorrect but valid email address can be updated and resent to the clinician by the Program Administrator. Update the email address and click Save, and then select the Send link. A maximum of three attempts are allowed before you are restricted from sending additional consent forms to that clinician. On the fourth 'Send' attempt, you will receive 'Max Attempts Exceeded' message and a 4th consent form will not be sent. You will need to contact support, if a fourth consent form needs to be sent to the clinician.



MIPS & CPC+ 2018 Group Enrollment

- Existing group practices have a one-month grace period to enroll in the current year's QSS program year for MIPS or CPC+. For example, if enrollment opens on May 25th, group calculations would be restricted on June 26th.
- Once the grace period has expired, MIPS and CPC+ group practices will receive a popup message when the calculation button is selected, which indicates that the existing group practice must enroll in the QSS program for the current program year to continue group calculations.

Note: If a MIPS or CPC+ customer cancels QSS enrollment, the MQIC>QSS tab displays the status "Enrollment Cancelled".

Renewing MIPS & CPC+ 2017 Groups Enrollment

The new QSS 'Renew' feature will allow organizations that created a MIPS or CPC+ group practice in a prior year to renew their group practice for the current program year. This will facilitate enrollment and eliminate the need to recreate an existing group practice although some configuration may be required based on any group changes.

There are two sections in MIPS & CPC+ Enrollment:

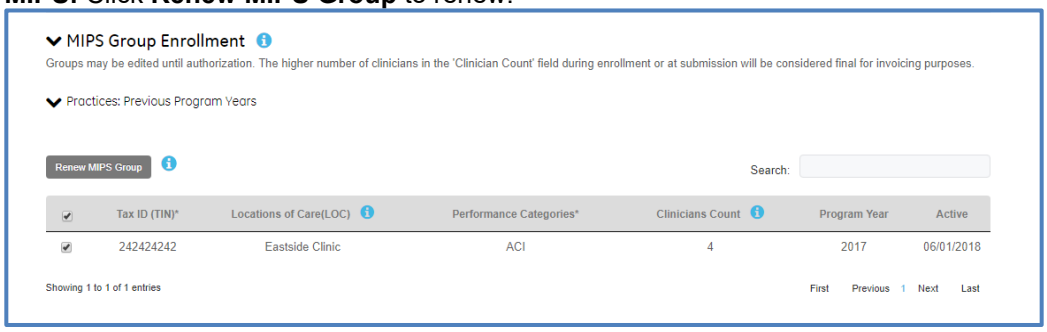
- Practices: Previous Program Years
- Practices: Current Program Year 2018

'Practices: Previous Program Years' includes all previously created group practices, which may be selected for renewal. Once a practice is renewed:

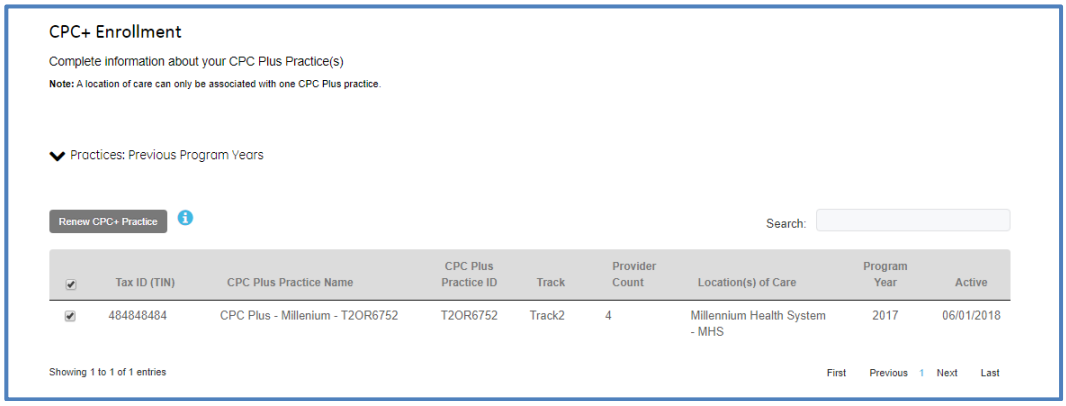
- The practice will display as inactive in "Practices: Previous Program Years"
- The practice will display as active in "Practices: Current Program Year 2018" and may be edited as needed.

If an organization does not have a group practice from the previous year, the 'Practices: Previous Program Years' option would not display.

MIPS: Click **Renew MIPS Group** to renew.



CPC+: Click **Renew CPC+ Practice** to renew.



Updating the clinicians listed in a CPC+ or MIPS group practice

CPC Plus or MIPS group practices are dynamically updated based on changes made to the providers in the group practice or to the group practice's configuration. These changes are reflected in the group's provider list and may be immediate or updated nightly. The list below identifies the potential changes that may be made to a group practice and whether the change is immediate or updated nightly.

CPC+

The provider list for CPC+ group practices is updated based on the following actions:

- Provider status changes from active to inactive and vice versa (Immediate)
- Provider is included or excluded from the group (Immediate)
- Locations of care (LOC) associated with the group practice are edited:
  - In the 'Add/Edit CPC Plus Group Practice' workflow (Immediate)
  - When the TIN of a LOC associated with the CPC Plus practice is edited from the Organizational Structure, it results in a change to the CPC Plus practice's configuration. In order for the changes made in the Organizational Structure to be reflected in the group practice, the user must navigate to the 'Add/Edit CPC Plus Group Practice' and manually select the newly added LOC or manually deselect the LOC that was removed through Organizational Structure (Immediate).

MIPS

The provider list for MIPS group practices is updated based on the following actions:

- Provider status changes from active to inactive and vice versa (Immediate)
- Provider is included or excluded from the group (Immediate)
- Locations of care (LOC) associated with the group practice are edited (Nightly)
- A provider has an encounter at a location of care associated with the group practice (Nightly)

MIPS Tab view

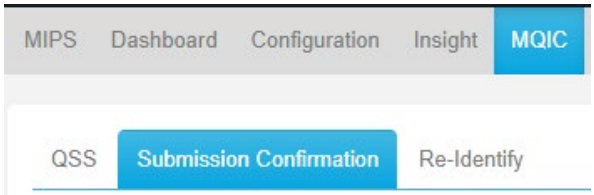
The MIPS tab view has been reconfigured to display only the MIPS performance categories that were selected during QSS enrollment.

- If you are a MIPS Group practice participant, the MIPS tab view displays the tabs for the categories that were selected during enrollment.
  For example, if Quality Measures and Improvement Activities were selected at enrollment, but not Advancing Care Information, then only the Quality Measures and IA tabs displays.
- If you are a CPC+ practice participant, only the Quality Measures tab displays on the MIPS tab view.

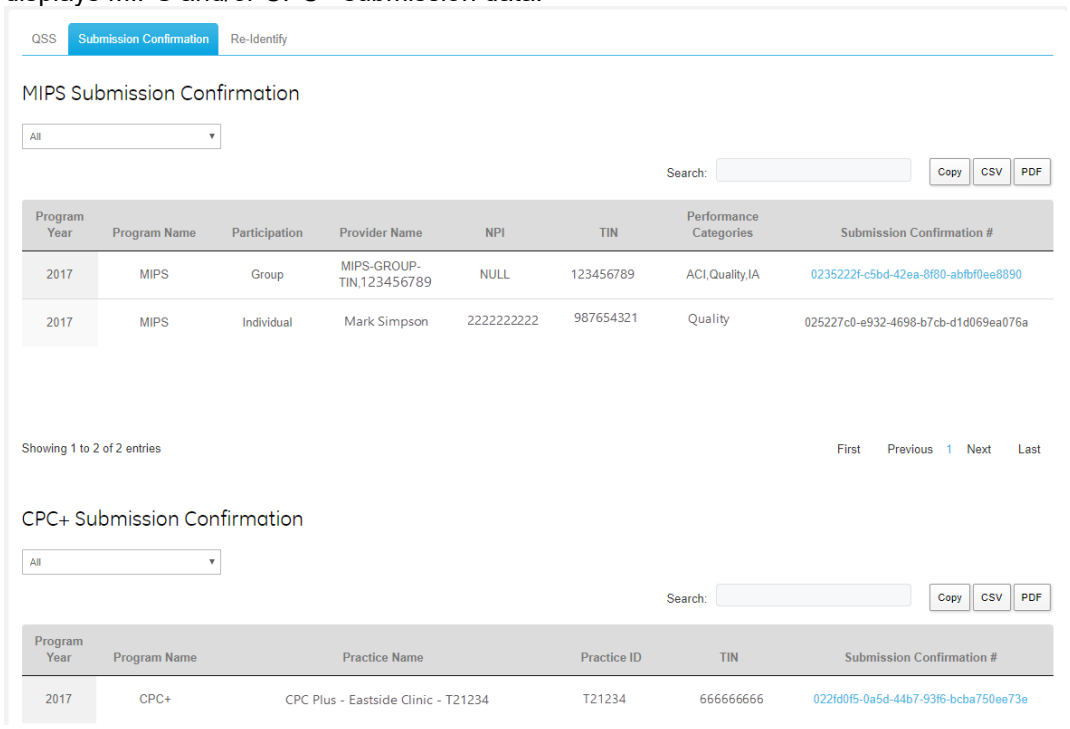
New MQIC > Submission Confirmation tab

The MIPS and CPC+ Submission Confirmation feature provides key submission information in a single convenient location in the MQIC tab for those QSS participants whose data was submitted in 2017 or later, to CMS by GE Healthcare. Click **MQIC > Submission Confirmation** tab to view.

This feature replaces the submission confirmation email beginning in PY2018. GE submission of MIPS and CPC+ data simplifies your work with the automated submission confirmation and bookmark features, making it easy to access historical program data for record-keeping and auditing purposes.



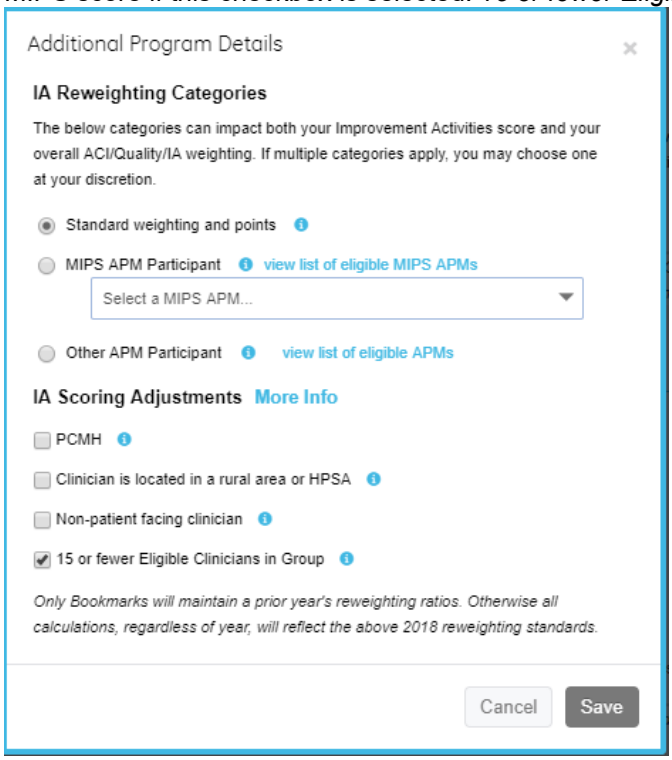
Depending on the programs in which you are enrolled, the Submission Confirmation tab displays MIPS and/or CPC+ submission data.



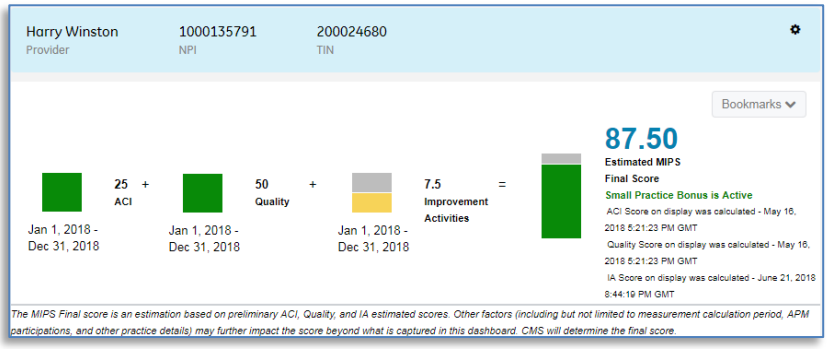
Please refer to the *CQR User Manual– July 2018* revision for more information.

MIPS Small Practice Bonus for Improvement Activities category

Participants with 15 or fewer Eligible Clinicians in their group will receive 20 points for each medium-weight activity and 40 points for each high-weight activity selected. Now, these participants are eligible for a small practice bonus of 5 points towards their final MIPS score if this checkbox is selected: *15 or fewer Eligible Clinicians in Group*.

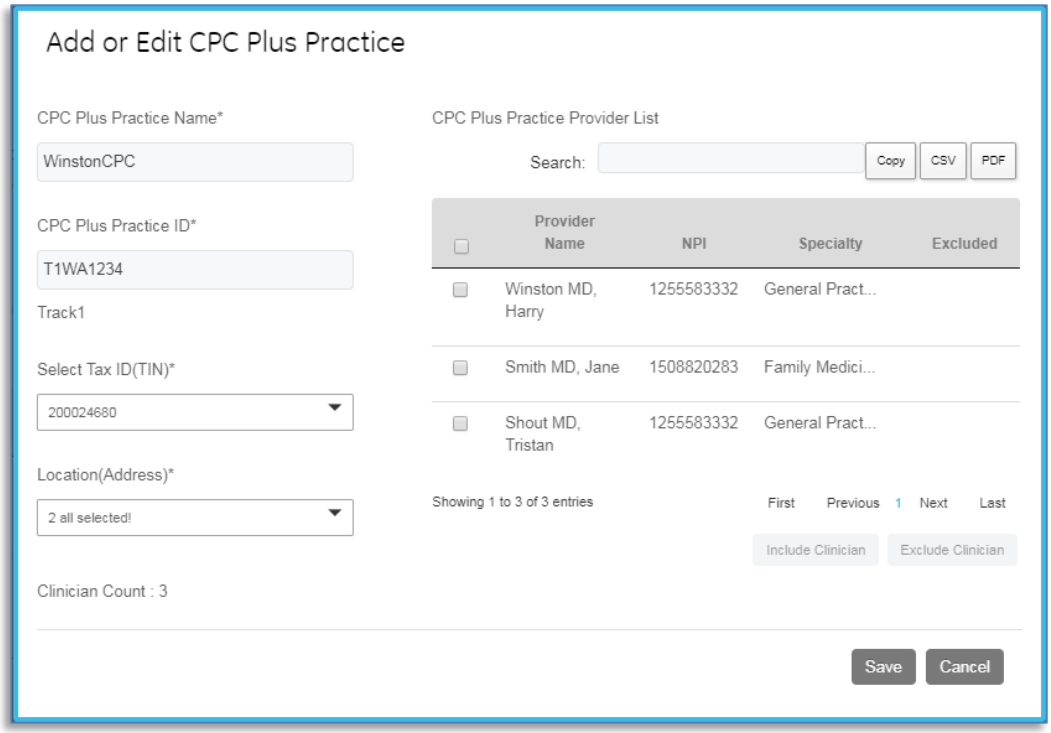


If you select this option, the Estimated MIPS Final Score will indicate “Small Practice Bonus is Active” in green.



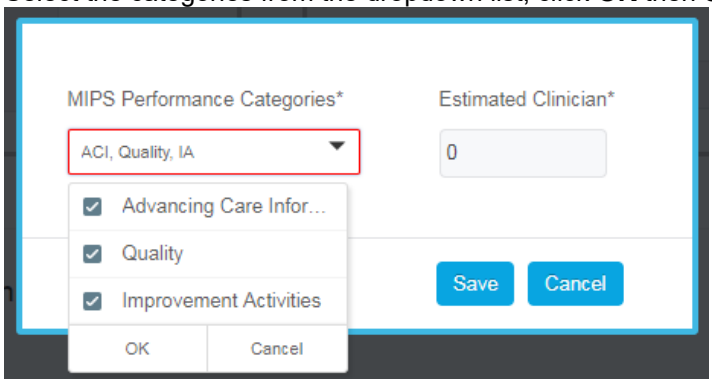
CPC+ Group Practice Creation

When you add or edit a CPC+ group, enhancements have been added to give you more control.
A new CPC Plus Practice table displays the clinician or group name, NPI, and specialty, and indicates “Yes” if excluded from the group. The table has a search feature and the list may be copied or exported as a CSV or PDF. You can also sort the list by clicking the column header. A clinician can be included or excluded by selecting the provider name and clicking the corresponding **Include Clinician** or **Exclude Clinician** button.



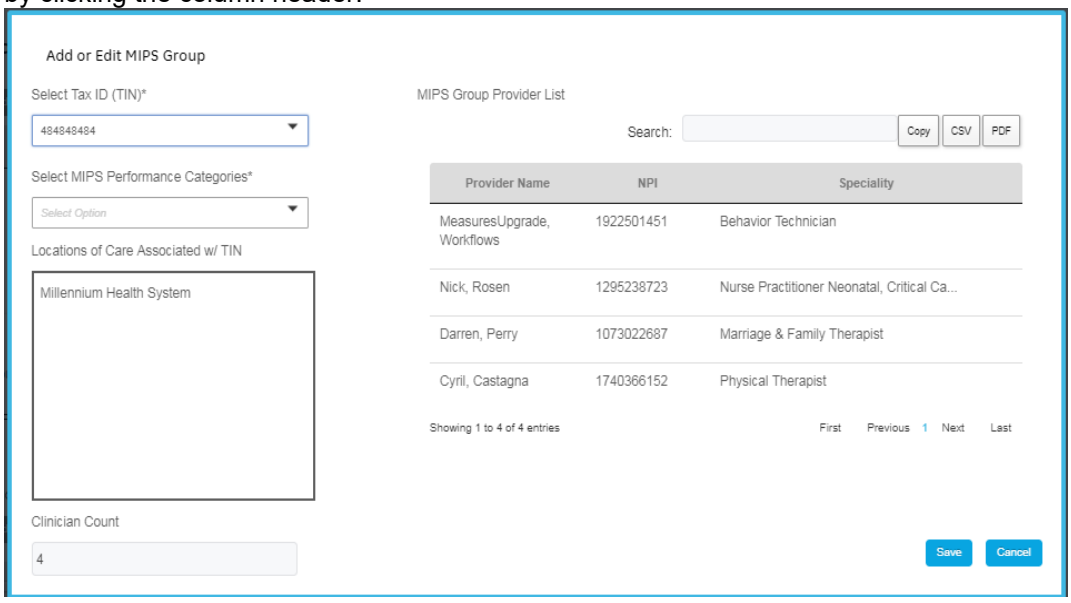
MIPS Individual Eligible Clinician Enrollment

For an individual eligible clinician (EC) who participates in multiple performance categories, you can accommodate that EC by adding or editing the categories.
From the Individual Eligible Clinician Enrollment pane, click **Add Row** or select **Edit**.
Select the categories from the dropdown list, click **OK** then **Save**.



MIPS Group Creation

When you add or edit a MIPS group, enhancements have been added to give you more control.
A new MIPS Group table displays the providers who belong to this group. The table columns display the clinician or group name, NPI, and specialty. The table has a search feature and the list may be copied or exported as a CSV or PDF. You can also sort the list by clicking the column header.



Group Practices & Clinician Counts for QSS Orders

MIPS and CPC+ group practices have a two-week window of time once the group practice is created or renewed to configure the clinicians in the group before a clinician count is calculated for billing purposes. As an example, if a group practice is created on July 12th, the first billing count of the clinicians in the group practice would be calculated on July 27th.
Clinician counts will continue to display automatically when a group practice is created or reconfigured. However, group configurations should be completed within the first two weeks to ensure an accurate clinician count.

Fix

- Previously, the reporting period label indicated on bookmarks from the MIPS>ACI tab displayed incorrectly for the ACI results previously saved. This issue has been fixed. (ALM 2328 and SPR 71658)
- *CMS 146v6.1 Appropriate Testing for Children with Pharyngitis* – Previously, patients with qualifying events were not properly included in the Initial Population. This issue has been fixed. (ALM 2332 and SPR 71692)

Known Issues

- The two issues explained below impact the following measures: CMS131v6, CMS138v6, CMS153v6, and CMS2v7. If you report on any of these measures, it is likely that your results are lower to an extent that is difficult to determine.

    1. **CPS and CEMR:** If an Observation Term is imported through LinkLogic, it will not be associated with a result code, regardless of whether you have mapped that term in the Data Mapping tool. (ALM 2330 and SPR 71662)
    2. **CEMR only:** If you enter an Observation Term in a form or flowsheet that is mapped to more than one code and one of those mappings does not have a result code associated with it, the result code may not be included in the CCDA transmitted to CQR. This is fixed in CEMR 9.12 Service Pack 2 and a script is planned for early Q3 for CEMR 9.12.1, 9.8.13 and 9.10.3. (SPR 71471)

- *CMS 166 Use of Imaging Studies for Low Back Pain version 7* is eligible for Medicaid reporting in 2018. We will update CQR to version 7 later in the year. Version 6 is available today. Refer to https://ecqi.healthit.gov/ecqm/measures/cms166v7 for detailed information about the changes coming in version 7. Once CQR is updated to version 7, results will accurately reflect 2018 activity. (ALM 2327 and SPR 71632)

Version 1.6.3.1.1 Release Notes

Enhancements and issues resolved in this release

Fix

- Previously, calculations and scores were not displaying in MIPS dashboard, ACI Score, Quality Measures and Improvement Activities tab. The issue had an unintended time sensitivity, which started July 1. Now, the calculations and scores are displayed as expected. (ALM 2338)

Version 1.6.3.1 Release Notes

Enhancements and issues resolved in this release

Fix

- After the CQR 1.6.3 update was applied, customer or QSS generated bookmarks created within CQR are either missing and/or there is missing information in the bookmarks. This issue has been fixed so that previously saved bookmarks now display with all data. (ALM 2320 and SPR 71609)

Version 1.6.3 Release Notes

Enhancements and issues resolved in this release

Note: The *Quality Reporting Guide – May 2018 revision* has been updated to reflect the changes for the Performance Year 2018 reporting for the following measures.

Performance Year 2018 MIPS ACI (Non-Transition) Objectives and Measures

To use the 2018 ACI Objectives and Measures, you must have version CPS 12.3 or CEMR 9.12 or higher installed.

Protect Patient Health Information
- Security Risk Analysis

Electronic Prescribing (eRx)
- Electronic Prescribing (eRx)

Patient Electronic Access
- Provide Patient Access
- Patient-Specific Education (*Updated measure*)

Coordination of Care Through Patient Engagement
- View, Download, or Transmit (VDT)
- Secure Messaging
- Patient-Generated Health Data (*New measure*)

Health Information Exchange
- Send a Summary of Care (*Formerly "Health Information Exchange"*)
- Request/Accept Summary of Care (*New measure*)
- Clinical Information Reconciliation (*Updated measure*)

Public Health and Clinical Data Registry Reporting
- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Electronic Case Reporting (*New measure*)
- Public Health Registry Reporting (*New measure*)
- Clinical Data Registry Reporting (*New measure*)

ACI Bonus Measures

- **Additional Public Health Reporting** – Report one or more additional public health agencies or clinical data registries beyond the one identified for the performance score. Earn a 5 point bonus towards the preliminary ACI score by attesting to two or more public health and registry reporting measures.

- **Report Improvement activities using CEHRT** - Attest to having completed at least one Improvement Activity that requires CEHRT. Earn a 10 point bonus towards the preliminary ACI score by attesting to one or more Improvement Activities that require CEHRT.

- **Report using only 2015 Edition CEHRT** – Click "**Yes**" in the Performance column if your ACI performance period begins after you have installed the 2015 certified edition.

Performance Year 2018 MU Stage 3 Objectives and Measures

To use the 2018 MU Stage3 Objectives and Measures, you must have version CPS 12.3 or CEMR 9.12 or higher installed.

01 Protect Patient Health Information
02 Electronic Prescribing (eRx)
03 Clinical Decision Support
04 Computerized Provider Order Entry (CPOE)
- CPOE for Medication Orders
- CPOE for Laboratory Orders
- CPOE for Diagnostic Imaging Orders

05 Patient Electronic Access
- Provide Patient Access
- Patient-Specific Educational Resources

06 Coordination of Care through Patient Engagement
- View, Download, or Transmit (VDT)
- Secure Messaging
- Patient-Generated Health Data (*New measure*)

07 Health Information Exchange (TOC)
- Send a Summary of Care (*New measure*)
- Request/Accept Summary of Care (*New measure*)
- Clinical Information Reconciliation (*New measure*)

08 Public Health Reporting
- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Electronic Case Reporting (*New measure*)
- Public Health Registry Reporting (*New measure*)
- Clinical Data Registry Reporting (*New measure*)

Performance Year 2018 New and Upgraded Clinical Quality Measures

New Measures

Two new CQMs have been added for the performance year 2018. See the *Quality Reporting Guide – May 2018 revision* for the complete measure descriptions.

CMS161 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
Description: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

CMS177 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Description: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.

Note: A suicide risk assessment must be completed to meet the numerator requirements for the two measures. The Columbia - Suicide Severity Rating Scale (C-SSRS) with Release Notes are available for download on the community as a standalone package. They can be downloaded from the Customer Portal: https://digital.gehealthcare.com/

- Centricity Practice Solution > All Resources & Products > Centricity Clinical Content.
- Centricity EMR > All Resources & Products > Centricity Clinical Content.

Upgraded Measures

There are 9 more CQMs that have been upgraded to CMS specifications for the performance year 2018, which completes our 2018 CQM upgrades. The following measure upgrades include changes in value sets, guidance and clinical recommendations.

Timing operators are being updated across these measures to address situations where time stamps are not attached to procedures, diagnosis, and immunizations.

- Previously: ‘ends before start of’ Now: ‘ends before or concurrent with start of’
- Previously: 'ends before end of’ Now: 'ends before or concurrent with end of’
- Previously: 'starts before start of’ Now: 'starts before end of’ with ‘starts before or concurrent with start of’ or ‘starts before or concurrent with end of’

Key changes to the measure logic are noted here.

CMS56 Functional Status Assessment for Total Hip Replacement
Description: Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.

Initial Population:

- Simplified the timing restrictions for the primary surgical procedure to ensure it takes place in the year prior to the measurement period.
- The timing for the outpatient encounter is no longer tied to the primary surgical procedure; the encounter only needs to take place during the measurement year.

Numerator:

- Removed VR-36 and PROMIS-29 tools from list of approved functional status assessments (FSAs).
- Updated the timing for the initial and follow-up FSAs to 90 days prior to surgical procedure and 270-365 days after surgical procedure, respectively.

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS65 Hypertension: Improvement in blood pressure
Description: Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.

Numerator: Updated to reflect that the delta systolic blood pressure should be greater than or equal to 10 mm Hg to meet the measure intent.

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS66 Functional Status Assessment for Total Knee Replacement
Description: Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery.

Initial Population:
- Simplified the timing restrictions for the primary surgical procedure to ensure it takes place in the year prior to the measurement period.
- The timing for the outpatient encounter is no longer tied to the primary surgical procedure; the encounter only needs to take place during the measurement year.

Numerator:
- Removed VR-36 and PROMIS-29 tools from list of approved functional status assessments (FSAs).
- Updated the timing for the initial and follow-up FSAs to 90 days prior to surgical procedure and 270-365 days after surgical procedure, respectively.

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS69 Body Mass Index (BMI) Screening and Follow-Up
Description: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.

Numerator:
- Updated the look back period for abnormal BMI to be recorded from <=6 month to <=12 months to align with guidelines.
- Deleted attribute 'reason: Overweight' from 'Intervention, Order: Above Normal Follow-up' and 'Medication, Order: Above Normal Medications'.
- Deleted attribute 'reason: Underweight' from 'Intervention, Order: Below Normal Follow up' and 'Medication, Order: Below Normal Medications'.

Denominator Exceptions:
- Updated the look back period for abnormal BMI to be recorded from <=6 month to <=12 months to align with guidelines.

Denominator Exclusion:
- Added 'Encounter, Performed: Palliative care encounter' starts before end of 'Occurrence A of Encounter, Performed: BMI Encounter Code Set' to incorporate new value set with ICD-10 Palliative care encounter.

CMS90 Functional Status Assessment for Complex Chronic Conditions
Description: Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.

Initial Population: Expanded patient age range from 65 years and older to 18 years and older to be as inclusive as possible for this measure per clinical experts' recommendations.

Numerator:
- Updated to include patients who have results documented in the EHR for the follow-up FSA that is at least 30 days but no more than 180 days after the initial FSA (previously the timing was in relation to the encounter).

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS135 Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

Denominator Exceptions: Replaced value set 'ACE Inhibitor or ARB Ingredient' with 'ACE Inhibitor or ARB' in the 'Medication, Order not done' logic. The CQM map was updated and no user action is required.

CMS145 Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.

No changes to the measure logic.

CMS146 Appropriate Testing for Children with Pharyngitis
Description: Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

Denominator Exclusion:
- Added a new line of logic to the Denominator Exclusions that requires the medication to be active at least one day prior to diagnosis of pharyngitis or tonsillitis to better meet the intent of the measure.
- Added an exclusion for patients in hospice care.

CMS155 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Description: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.
- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation
- Percentage of patients with counseling for nutrition
- Percentage of patients with counseling for physical activity

Denominator Exclusion: Added an exclusion for patients in hospice care.

Performance Year 2018 Supporting Documentation

These supporting documents include descriptions of the objectives and measures.

- MIPS ACI (Non-Transition) - Program Specification:

  https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Advancing-Care-Information-Measure-Specifications.zip

- MU Stage 3 Program Specification:

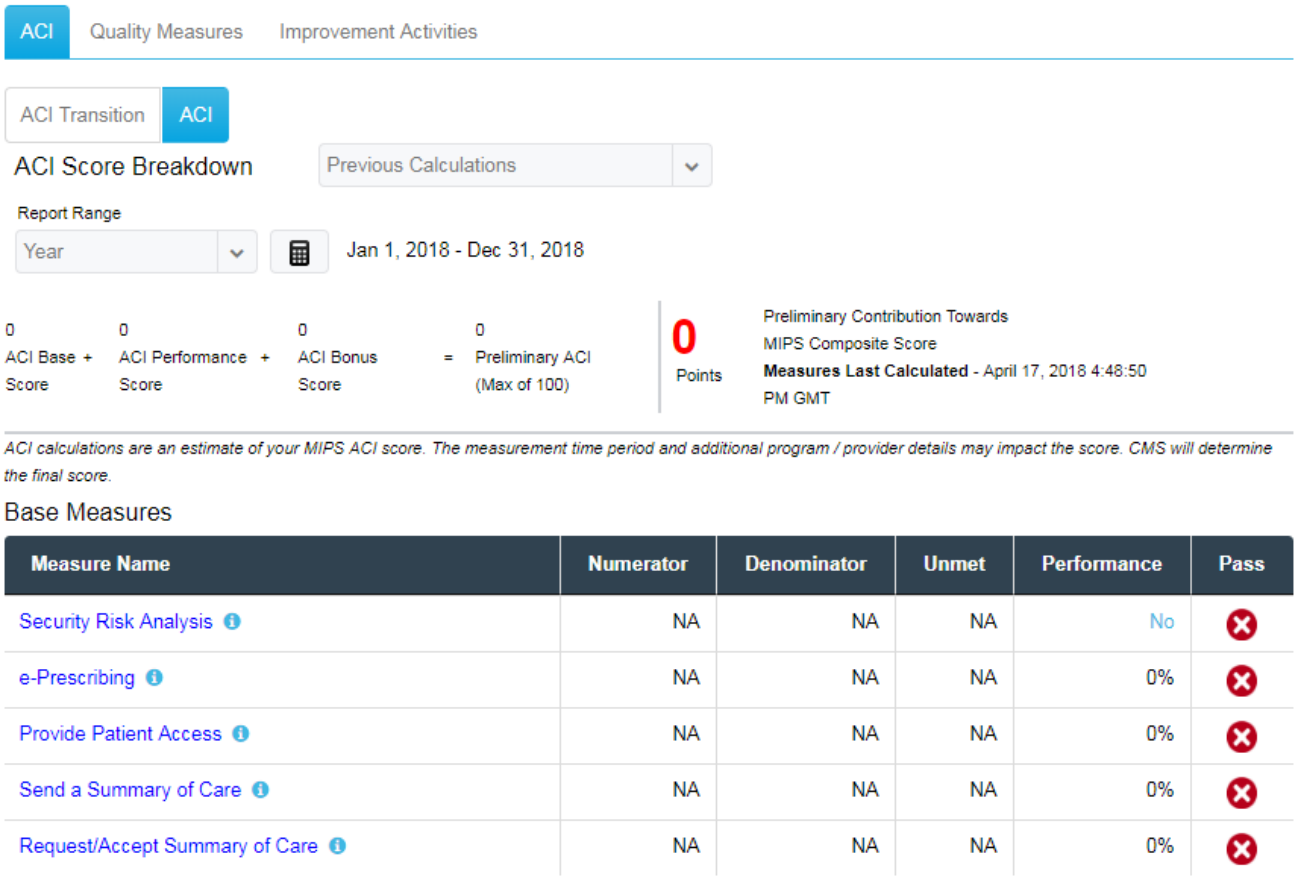
  https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3.pdf

- Find out more about the changes in logic and value sets in the Clinical Quality Measures for the 2018 performance period by referring to the *CMS Electronic Clinical Quality Improvement Resource Center*: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2018-performance-period-epec-ecqms.
- Our *Quality Reporting Guide – May 2018 revision* and C*QR User Manual– May 2018 revision* have been updated to reflect the changes for 2018 reporting. They can be downloaded from the Customer Portal: https://digital.gehealthcare.com/. Choose Community, then Quality Reporting resource button.

MIPS ACI Tab - Year 2018 MIPS ACI (Non-Transition) Objectives and Measures

Click the **MIPS - ACI > ACI** tab to display the Year 2018 MIPS ACI (Non-Transition) measures.

Note: The **ACI Transition** tab displays the existing ACI Transition measures.

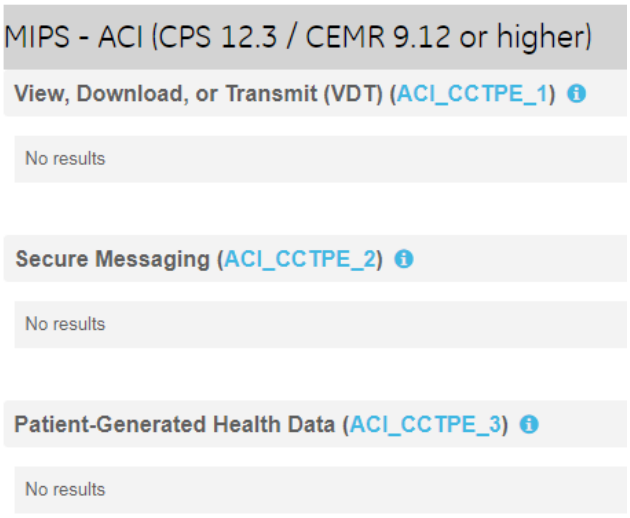


Note: The C*QR User Manual– May 2018 revision* has been updated to reflect the changes for the Performance Year 2018 reporting for ACI measures.

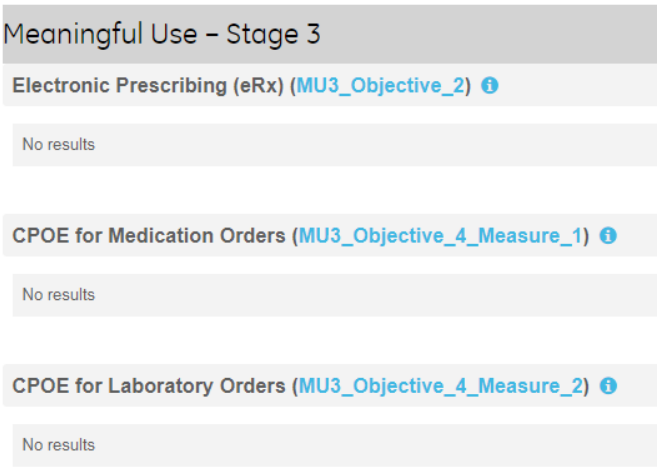
MIPS ACI and MU Stage 3– Dashboard Changes

The MIPS ACI and MU Stage 3 measure results display on the Dashboard.

MIPS ACI



MU Stage 3



Auto-configuration of ACI Transition and ACI (non-Transition) measures

CMS has extended ACI Transition measure eligibility from 2017 only to 2017 and 2018. For 2018, CQR will allow users to view and compare their ACI Transition and ACI (non-Transition) measure results in order to better determine which program they wish to submit for the calendar year.
Starting with the 1.6.3 release, all providers have their ACI Transition / ACI (non-Transition) measure configurations updated and viewable on the Dashboard tab as follows. Please review the below scenarios to better understand how this change will affect you.

I have some or all ACI Transition measures configured, but no ACI (non-Transition) measures configured:

- After the update, CQR will keep the existing ACI Transition configuration as-is and will add all ACI (non-transition) measures.

I have some or all ACI Transition measures and some or all ACI (non-Transition) measures configured:

- After the update, CQR will keep the existing ACI Transition and ACI (non-Transition) configurations as they are.

I have no ACI Transition and no ACI measures configured:

- ACI Transition and ACI (non-Transition) measure settings are not changed.

I am a CPC+ Provider:

- ACI Transition and ACI (non-Transition) measure settings are not changed.

Improvement Activities

For the 1.6.3 release, 2017 Improvement Activities will continue to be viewable when a 2017 calculation period is selected in the Improvement Activities tab. Selecting a 2018 calculation period, however, will result in a blank Improvement Activities grid and no score until the 2018 activities are enabled in an upcoming release.

Quality Measures 2018 – Dashboard Changes

Quality Scoring

The MIPS Quality score is updated from the 2017 weight of 60% to the 2018 weight of 50% including:

- MIPS Quality Score Breakdown: Now calculated at the 2018 weight of 50%.
- Estimated MIPS Final Score.
  - Quality component now calculated at the 2018 weight of 50%.
  - When hovering over the Quality graph and text, messaging will indicate '[the number of quality points] out of 60 Quality Points' and the 'Quality category weight is 50%' respectively.

Calculating Benchmarks for Multi-strata Measures

Multi-strata measures use different logic to determine a single performance percentage for calculating the measure's benchmark and decile. Below are the multi-strata measures and the logic used for each.

	Measures	**Definition**
Simple	CMS136, 137, 155	Determined by adding the percentages for each submeasure and divide by the total number of component submeasures.
Weighted	CMS 52, 145, 160	Determined by summing the numerator counts of each submeasure and dividing by the sum of the denominator counts of each submeasure.
1st Performance Rate	CMS156	First performance rate used for the overall performance rate.

CMS138 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention was newly updated in Performance Year (PY) 2018 to include 3 strata. CMS has not provided guidance for multi strata measures for PY2018 so this measure will be calculated using a weighted logic to determine the single performance percentage for calculating this measure's benchmark.

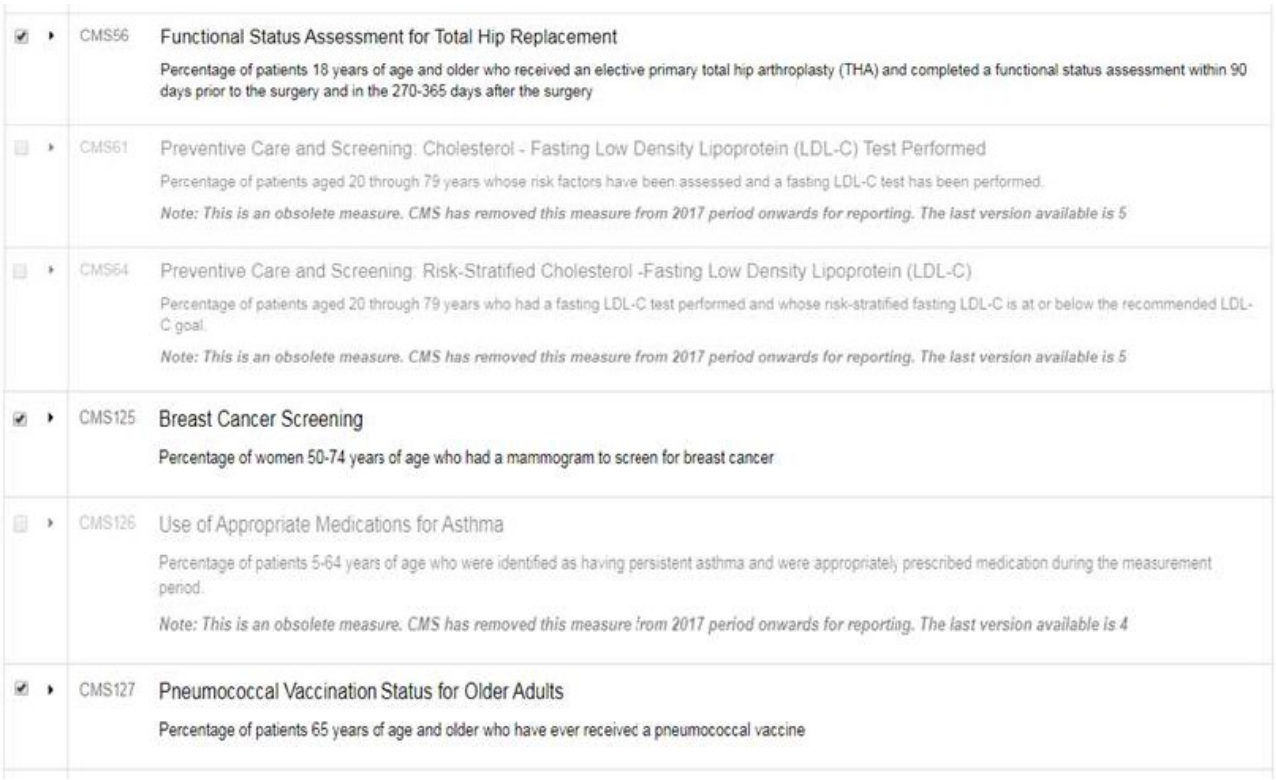
Obsolete Clinical Quality Measures for Performance Year 2018

The following Clinical Quality Measures are obsolete for PY2018:

- CMS61 - Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed
- CMS64 - Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
- CMS126 - Use of Appropriate Medications for Asthma
- CMS148 - Hemoglobin A1c Test for Pediatric Patients
- CMS163 - Diabetes: Low Density Lipoprotein (LDL) Management
- CMS166 - Use of Imaging Studies for Low Back Pain
- CMS182 - Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

From the **Configuration > Measurement Settings** tab:

- The obsolete measures display a Note below their measure titles that indicates “This is an obsolete measure.”
- When a user checks the "Select All" checkbox in the “Select Clinical Quality Measures” section, all the measures will get selected except for these 7 obsolete measures (CMS# 61, 64, 126, 148, 163, 182, and 166). If the user wants to configure any of these obsolete measures, then the user will have to manually select the checkbox next to each of these measures and can calculate for the versions last available for these measures as indicated in the note text with the each of the measure titles.
- Obsolete measures can be manually selected and deselected. They will not be part of the ‘Select All’ functionality. For example, if you check ‘Select All’ checkbox, then all the measures except the obsolete measures (grayed out measures) will be selected. And if you uncheck the ‘Select All’ checkbox, then all the measures except the obsolete measures (grayed out measures) will be deselected.”



Known Issue

In 2018, CMS138v6 (*Tobacco Use Screening and Cessation Intervention*) changed the way tobacco use status is recorded. Now, tobacco use status is reported as a result of tobacco use screening. Data mapping for observation terms used in CCC content are correctly mapped in the April KnowledgeBase (KB). However custom mappings do not show the related result codes for this measure. This will be corrected in a future KB. (ALM 2306 and SPR 71538)

Version 1.6.2 Release Notes

Enhancements and issues resolved in this release

New and Upgraded Clinical Quality Measures

New Measure
CMS52 HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis is a new measure added to the library of CQR-supported measures. This measure uses the CMS specification for the 2018 reporting year.
Note: This measure requires that the 2018 value sets be uploaded into CPS or CEMR, which were available in the November Knowledgebase and every Knowledgebase thereafter.

Description: Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.

Initial Population / Denominator:

1. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit.
2. All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit.
3. All patients aged 6 weeks to 12 months with a diagnosis of HIV who had at least two visits during the measurement year, with at least 90 days in between each visit.

Numerator:
Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis:

1. Within 3 months of CD4 count below 200 cells/mm3.
2. Within 3 months of CD4 count below 500 cells/mm3 or a CD4 percentage below 15%.
3. At the time of diagnosis of HIV.

Upgraded Measures
Twelve more Clinical Quality Measures that GE currently supports for reporting year 2017 were upgraded to the measure versions applicable to reporting year 2018, while retaining measure versions applicable to reporting year 2017.

We are highlighting changes below that impact CQR but you should review the full CMS list for all changes that may impact care.

CMS22 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – version 6
Description: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.

There are no changes to the measure logic.

CMS68 Documentation of Current Medications in the Medical Record – version 7.1
Description: Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

There are no changes to the measure logic.

CMS117 Childhood Immunization Status – version 6.2
Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

Denominator Exclusion: Added an exclusion for patients in hospice care.

Numerator:
- Replaced the 'starts before start of' and 'starts before end of' logical operator to address situations where time stamps are not attached to procedures, diagnosis, and immunizations.
- Added 'HIV' and 'Disorders of the Immune System' as diagnosis options to satisfy the Numerator criteria for Influenza vaccination.
- Added 'Intussusception' and 'Severe Combined Immunodeficiency' as diagnosis options to satisfy the Numerator criteria for Rotavirus vaccination (dose 2 and dose 3 schedules).

CMS123 Diabetes: Foot Exam – version 6.2
Description: Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS136 ADHD: Follow-Up Care for Children Prescribed ADHD Medication (ADD) - version 7.1
Description: Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.
a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional

follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Measure Title Change:

- Previously 'Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication'
- Now 'Follow-Up Care for Children Prescribed ADHD Medication (ADD)'

Denominator Exclusion: Added an exclusion for patients in hospice care.

Numerator: Updated the timing operators for ADHD medications from 'ends after end of' to 'starts after end of' to better reflect the measure intent.

CMS142 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care – version 6
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

There are no changes to the measure logic.

CMS144 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) – version 6
Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

Denominator Exception: Replaced value set Beta Blocker Therapy Ingredient with value set Beta Blocker Therapy for LVSD in the 'Medication, Order not done' logic. As a result, the Data Criteria 'Medication, Order: Beta Blocker Therapy Ingredient' has been removed.

CMS153 Chlamydia Screening for Women – version 6.2
Description: Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

Initial Population: Updated to include women who respond yes to a question about sexual activity as an additional way to identify a sexually active woman.

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS154 Appropriate Treatment for Children with Upper Respiratory Infection (URI) – version 6.1
Description: Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

Initial Population: Changed timing operator for URI diagnosis in Initial Population from 'ends after or concurrent with end of' to 'overlaps' to ensure inclusion of patients without an end date for their diagnosis.

Denominator Exclusion:

- Added an exclusion for patients in hospice care.
- Requires that the medication be active at least one day prior to diagnosis of pharyngitis or tonsillitis to better meet the intent of the measure.

CMS158 Pregnant Women that had HBsAG testing – version 6
Description: Percentage of pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.

There are no changes to the measure logic.

CMS159 Depression Remission at Twelve Months – version 6.2
Description: Percentage of patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 30 days) after an index visit.

Initial Population: Updated the encounter numeric month timings from < *12 month(s)* ends before end of Measurement Period' to < *13 month(s)* ends before end of Measurement Period' to more accurately reflect the measure intent.

CMS169 Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use – version 6
Description: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

Initial Population & Numerator:

- Updated to avoid omitting from the measure those qualifying patients who had only BH Outpatient Psychotherapy encounters and specify that the treatment may occur after the BH Outpatient encounter or the BH Outpatient Psychotherapy encounter.

These supporting documentation for the measures includes descriptions of the measures and changes.

- Find out more about the changes in logic and value sets in the Clinical Quality Measures for the 2018 performance period by referring to the *CMS Electronic Clinical Quality Improvement Resource Center*: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2018-performance-period-epec-ecqms.
- Our *Quality Reporting Guide – April 2018 revision* has been updated to reflect the changes for 2018 reporting.

New Quality Reporting Customer Portal for User Documentation

There is a new Quality Reporting Customer Portal Home Page for our central location for all CQR documentation.

Login to Customer Portal: http://digital.gehealthcare.com. Choose Quality Reporting resource button, followed by CQR icon. Choose *document name.*

Version 1.6.1.2 Release Notes

Enhancements and issues resolved in this release

Fix

- Health Information Exchange (HIE) is a Base and Performance measure in the ACI Category. If a provider's HIE denominator count is less than 100, CQR automatically applies the HIE exclusion flag. When the exclusion criteria is met, CQR still displays the HIE performance measure and includes it in the ACI Score Breakdown, assuming it was selected in Configuration > Measurement Settings. Currently, a downloaded QRDA III file would not include the HIE performance measure score when the provider meets the exclusion criteria. Now, based on guidance from CMS, the QRDA downloaded from CQR will also include the HIE performance measure even when the exclusion criteria is met. For Quality Submission Services (QSS) customers, GE will automatically re-submit impacted provider QRDA files prior to the submission deadline. For impacted non-QSS providers that submitted to CMS with a CQR QRDA file, if they would like to add HIE performance measure points to their submission, they should download a new QRDA III from the CQR dashboard and resubmit before the March 31st 2018 deadline. It is not necessary to recalculate. The CPC+ program is not impacted by this. (ALM 2298 and SPR 71456)

Version 1.6.1.1 Release Notes

Enhancements and issues resolved in this release

Enhancements

- All quality measures are available for 2018 calculations in the MIPS dashboard. Measures currently upgraded to the 2018 version include:
  CMS2, CMS50, CMS122, CMS124, CMS125, CMS127, CMS130, CMS131, CMS134, CMS137, CMS138, CMS139, CMS147, CMS149, CMS156, CMS160, CMS164, CMS165, and CMS347.

  Measures that are in the process of being upgraded will display the 2017 measure version. The Quality Reporting Guide also includes the status of the quality measure versions.

- CMS166 is an obsolete measure for PY2018. It can still be configured in measurement settings for 2018 calculations but it will not be upgraded from its 2017 version.

Version 1.6.1 Release Notes

Enhancements and issues resolved in this release

Upgraded Clinical Quality Measures

Six more Clinical Quality Measures that GE currently supports for reporting year 2017 were upgraded to the measure versions applicable to reporting year 2018, while retaining measure versions applicable to reporting year 2017.

The supporting documentation for the measures includes descriptions of the changes.

- Find out more about the changes in logic and value sets in the Clinical Quality Measures for the 2018 performance period by referring to the *CMS Electronic Clinical Quality Improvement Resource Center*: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2018-performance-period-epec-ecqms.
- Our *Quality Reporting Guide – March 2018 revision* has been updated to reflect the changes for 2018 reporting.

We are highlighting changes below that impact CQR but you should review the full CMS list for all changes that may impact care.

CMS137 Initiation & Engagement of Alcohol & Other Drug Dependence Treatment – version 6.2

Description: Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following.

Two rates are reported.

a. Percentage of patients who initiated treatment within 14 days of the diagnosis.
b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Initial Population:

- Updated requirements for the diagnosis so that it occurs between January 1 and November 15 to ensure all services occur before the end of the measurement period.
- Updated the logic for the $FirstAlcoholDrugDependenceDx variable in reference to the first diagnosis.

Denominator Exclusion: Added an exclusion for patients in hospice care.

CMS138 Tobacco Use Screening and Cessation Intervention – version 6.1

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Three rates are reported:

a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months.
b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention.
c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Initial Populations: 'Encounter, Performed: Face-to-Face Interaction' and 'Encounter, Performed: Speech and Hearing Evaluation' now require a Count >= 2. In previous versions they required a Count >= 1.

Denominator: Updated to reflect the population criteria for the three performance rates per the measure description. Previously there was one population.

Denominator Exception: Revised to reflect that the medical reason exception is

applicable to both not screening a patient for tobacco use and not providing tobacco cessation intervention for patients identified as tobacco users.

CMS139 Falls: Screening for Future Fall Risk – version 6.1
Description: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

Denominator Exclusion: Added exclusion for patients in hospice care.

Replaced Denominator Exceptions with Denominator Exclusions.

CMS156 Use of High-Risk Medications in the Elderly – version 6.4
Description: Percentage of patients 65 years of age and older who were ordered high-risk medications.

Two rates are reported.

a. Percentage of patients who were ordered at least one high-risk medication.
b. Percentage of patients who were ordered at least two of the same high-risk medications.

Initial Population: Updated the patient age from 66 years to 65 years.

Numerator 1: Removed the SUM function and replaced it with a 'cumulative medication duration >= 90 day(s). Previously the logic added multiple medication orders for a sum total of 90 cumulative days. Now it looks at one medication order for a cumulative duration greater than 90 days.

Numerator 2: Updated to identify multiple dispensing events for the same high-risk medication (as opposed to different medications in the previous versions of the measure).

Denominator Exclusion: Added exclusion for patients in hospice care.

CMS160 Depression Utilization of the PHQ-9 Tool – version 6.1
Description: The percentage of 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 visit.
No remarkable changes

CMS165 Controlling High Blood Pressure – version 6.2
Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Initial Population: Updated to include a diagnosis that has a start date that is concurrent w/ start of the measurement period.

Denominator: Updated to exclude patients in hospice care.

Numerator: Updated the logic to ensure the BP reading takes place after the diagnosis of essential hypertension to meet the measure intent.

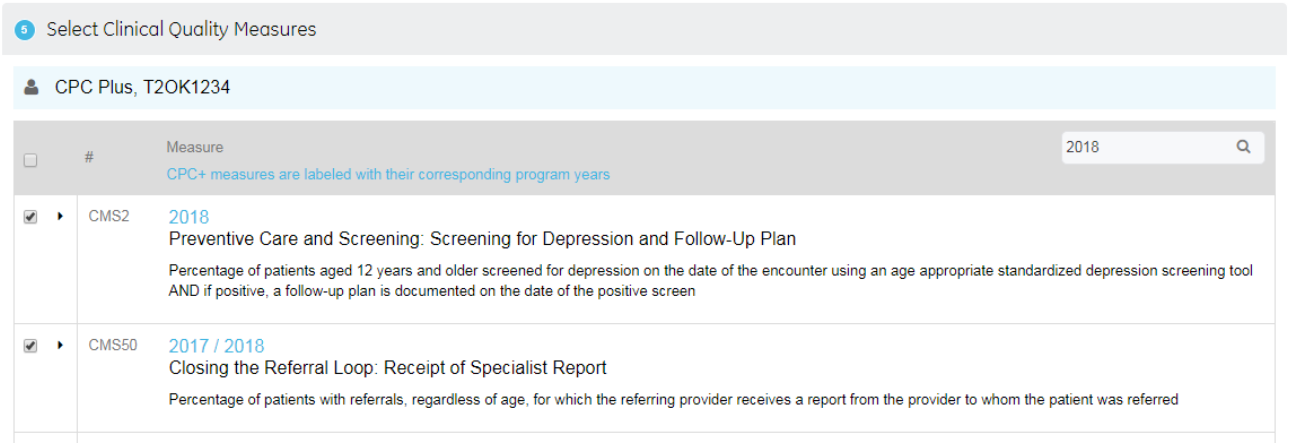
Denominator Exclusions: Removed ‘Other Services Related to Dialysis' and 'Dialysis Education' interventions’.

CPC+ 2018

The CPC+ dashboard was updated for 2018, including:

- 19 CPC+ measures for program year 2018.
- Automatic update to the 2018 measure set for existing CPC+ practices in CQR.
- All CPC+ measures are updated to the 2018 version requirement.
- CPC+ measure groups updated to Group 1 or Group 2 for PY2018.

Measurement settings for CPC+ practices reflect the new 2018 measurement set with a '2018' label. Both 2017 and 2018 measure sets display in measurement settings.



MIPS Quality benchmarks and deciles

Temporary messaging will display in the MIPS Estimated Final Score and the Quality Score Breakdown as notification about the measure upgrades and measure availability and quality scoring.

Estimated MIPS Final Score
When calculating for the 2018 reporting period, the MIPS Quality score will reflect the 2017 weight of 60% in the Estimated MIPS Final Score instead of the 2018 weight of 50%.
Quality Score Breakdown
Measure Upgrades and Availability: Nineteen quality measures are upgraded to the 2018 version and available for 2018 calculations in the MIPS dashboard. Quality measures will continue to be added. All quality measures are available for 2018 calculations in the legacy dashboard.
Quality Scoring: When calculating for the 2018 reporting period, the MIPS 2018 benchmarks & deciles will display with corresponding measure 'Points' and 'Scores'. However, the MIPS Quality score will reflect the 2017 weight of 60% in the Quality Score Breakdown instead of the 2018 weight of 50%.

Fixes

- Previously, after MIPS authorization was done, authorization features did not display. Now, MIPS authorization features display through March 31, 2018, including the following: (ALM 2294)
    - Green checkmarks display over the performance categories selected for authorization.
    - Authorize Button displays but inactive.
    - Text: Authorization Completed with date stamp displays below the 'Authorization Button'.
    - Clinician List: Processed with date stamp displays.
- Previously users could only authorize for reporting periods greater than or equal to 90 days. Now, the issue has been fixed so that users are able to authorize for reporting periods less than 90 days. (ALM 2295 and SPR 71439)

Version 1.6.0.5 Release Notes

Fix

- Previously, some MIPS group calculations for very large provider/patient combinations did not complete. Now, MIPS group calculations complete. (ALM 2257 and SPR 71201; ALM 2262 and SPR 71231)

Version 1.6.0.4 Release Notes

Enhancements and issues resolved in this release

Fixes

- On February 13th, the Centers for Medicare & Medicaid Services (CMS) has identified an additional advancing care information (ACI) identifier to be incorporated in QRDA III files. The identifier 'ACI_IACEHRT_1' for Advancing Care Information Improvement Activities Bonus, should be used when submitting for an advancing care information bonus for the use of certified electronic health record technology (CEHRT) for an improvement activity (IA). The identifier ACI_IACEHRT_1 is 'Yes' in QRDA III only when submitting an Improvement Activity that is eligible for the ACI bonus and the Improvement Activity was completed using CEHRT. This requires both ACI and IA categories to be included in the QRDA III file. (ALM 2284)

  For clinicians participating in QSS for MIPS, the QRDA III submitted by GE will include this new identifier, ACI_IACEHRT_1 = 'Yes', if both ACI and IA measures are authorized and an applicable improvement activity is included.

  For clinicians downloading a QRDA III from the dashboard tab, that QRDA III does not include improvement activities, so this identifier value will be 'No'. For clinicians wanting to request the improvement activity CEHRT ACI bonus, we would recommend attesting manually for ACI.

  For clinicians participating in CPC+, you are not impacted by this change.

- Previously, QRDA-III settings for ACI measures were not configured to force an Insurance Stratification (CQR Filter By) equal to **All**, as it was for Quality measures. This resulted in incorrect counts for Numerator/Denominator in QRDA-III files for the MIPS-ACI measures. Now, QRDA-III files are configured to support an insurance stratification (filter by) of **All** and the results stored in the QRDA should match those displayed in CQR. GE will automatically resubmit data for QSS customers. This has no impact on the CPC+ Program. For non-QSS customers, if any of your providers downloaded a QRDA-III file for submission purposes that included ACI measures, they should download and submit a new file. (ALM 2285 and SPR 71378)

Known Issue

- The MIPS Quality tab does not currently display 2018 measure results or a *Quality Breakdown Score* for groups or individual clinicians. CMS recently published the 2018 quality measure benchmarks, which are required to calculate and display the Quality scores. Quality measure results (denominator, numerator, percentage, etc.) for the 2018 reporting period may be calculated and viewed in the legacy dashboard until the 2018 benchmarks are incorporated into the MIPS Quality tab. (ALM 2286 and SPR 71389)

Version 1.6.0.3 Release Notes

Enhancements and issues resolved in this release

Fixes

- Previously, for a few Quality measures, when the unit of measure for certain Observation terms was NULL, the results were not considered for measure calculation and impacted the measure counts. This was fixed in v1.6.0.1. In this release, the QRDA-I download file is enhanced to reflect that fix. (ALM 2256 and SPR 70981; ALM 2282)
- Previously, a warning message was displayed during authorization even though the report range selected was a valid 90 days period for the ACI, IA and Quality categories. This issue has been fixed (ALM 2278 and SPR 71293)
- Quality benchmark and decile changes have been updated for Quality measures per the latest specifications published by CMS/QPP on 12/19/2017 for the 2017 performance year. CMS reference: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Quality-Benchmarks.zip. Download the Quality Benchmarks zip file and open the spreadsheet labeled: *MIPS_Benchmark_Update 2017 12 19.xlsx*. Please note that this spreadsheet uses a Quality Number vs. CMS# so searching by number does not translate to our CQR measure numbers. Therefore, we recommend that you filter by submission method of EHR and/or by measure name, using the measure names as listed in the table below. We also recommend new calculations be performed as a result of these CMS changes. (ALM 2272)

  Measure type changed from Intermediate Outcome to Outcome Measure:
  - CMS 65v6 Hypertension: Improvement in Blood Pressure
  - CMS 122v5 Diabetes: Hemoglobin A1c Poor Control
  - CMS 165v5 Controlling High Blood Pressure

  Benchmarks & Deciles Changes:
  The Benchmark and decile ranges of the following measures have been changed and the scores will be calculated based on the new ranges published.
  - CMS 69v5 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
  - CMS 137v5 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (0% or more of performance rate can earn 10 decile points {maximum})
  - CMS 145v5 Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
  - CMS 155v5 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
  - CMS 156v5 Use of High-Risk Medications in the Elderly
  - CMS 160v5 Depression Utilization of the PHQ-9 Tool (0% or more of performance rate can earn = or > 8 decile points)

  Changes for reference: The blue rows are the latest changes.

Measure_Name	CMS#	nission_Me	easure_Tyr	nchma	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	69v5	EHR	Process	Y	28.73 - 31.80	31.81 - 34.45	34.46 - 37.23	37.24 - 40.19	40.20 - 43.64	43.65 - 48.75	48.76 - 68.18	>= 68.19	No
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan		EHR	Process	Y	26.03 - 30.00	30.01 - 33.32	33.33 - 36.46	36.47 - 39.99	40.00 - 44.37	44.38 - 49.99	50.00 - 68.89	>= 68.90	No
Use of High-Risk Medications in the Elderly (Inverse)	156v5	EHR	Process	Y	26.32 - 21.23	21.22 - 15.75	15.74 - 9.40	9.39 - 3.86	3.85 - 0.91	0.90 - 0.01	--	0	No
Use of High-Risk Medications in the Elderly		EHR	Process	Y	29.53 - 24.11	24.10 - 18.67	18.66 - 12.51	12.50 - 5.50	5.49 - 0.85	0.84 - 0.01	--	0.00	No
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	155v5	EHR	Process	Y	25.72 - 28.72	28.73 - 30.38	30.39 - 31.52	31.53 - 32.30	32.31 - 32.80	32.81 - 33.32	33.33 - 34.94	>= 34.95	No
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents		EHR	Process	Y	27.27 - 30.76	30.77 - 32.51	32.52 - 33.32	--	--	--	33.33 - 39.04	>= 39.05	No
Initiation and Engagement of Alcohol and Other Drug	137v5	EHR	Process	Y	0.71 - 0.94	0.95 - 1.20	1.21 - 2.10	2.11 - 2.49	2.50 - 5.12	5.13 - 6.98	6.99 - 12.05	>= 12.06	No
Initiation and Engagement of Alcohol and Other Drug		EHR	Process	Y	--	--	--	--	--	--	--	>= 0.00	No
Depression Utilization of the PHQ-9 Tool	160v5	EHR	Process	Y	1.38 - 1.95	1.96 - 2.91	2.92 - 4.29	4.30 - 6.81	6.82 - 12.23	12.24 - 21.20	21.21 - 52.62	>= 52.63	No
Depression Utilization of the PHQ-9 Tool		EHR	Process	Y	--	--	--	--	--	0.00 - 1.07	1.08 - 11.53	>= 11.54	No
Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction	145v5	EHR	Process	Y	61.21 - 71.99	72.00 - 76.62	76.63 - 80.76	80.77 - 84.00	84.01 - 88.88	88.89 - 92.65	92.66 - 98.14	>= 98.15	No
Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction		EHR	Process	Y	62.50 - 77.41	77.42 - 90.90	90.91 - 99.99	--	--	--	--	100.00	No

Update

- Prior to December 21st, when an Encounter patch was released, when patient data was imported, CQR performed additional code mapping for things such as 'Aspirin' formulations and CVX-88 used to record historical influenza immunizations. (ALM 2280 and SPR 71299)

  After the patch, all patient data sent since January 1st, 2017 was reprocessed, but the table of additional code mappings in CQR was not applied. This likely caused lower scores for the measures listed below. With the release of 1.6.0.3, all CQR data will have completed being reparsed again, this time applying the CQR code mapping table. We recommend that all customers using any of the measures below recalculate their 2017 reporting period.

  List of impacted measures:

CMS117	CMS123	CMS126	CMS127	CMS134	CMS135
CMS136	CMS137	CMS138	CMS144	CMS145	CMS146
CMS147	CMS153	CMS154	CMS156	CMS164	CMS169
CMS22	CMS2	CMS61	CMS64	CMS69	

Known Issue

- The ACI bonus displays 10 points if you saved at least one bonus eligible Improvement Activity for any 90-day period. The ACI bonus is shown on the ACI tab and included in the estimated MIPS final score regardless of which reporting period (2017 or 2018) is selected on the IA tab. If the reporting period of IA category selected for authorization is different than that of the reporting period which contains the IA measure qualifying for ACI bonus, then this message is displayed: "Warning: If you authorize an Improvement Activities performance period which does not include the selected IA measure(s) that qualify for the ACI bonus, then your ACI score will be reduced by 10 bonus points upon submission. Please note that your submission to CMS includes just the measure results and not the estimated MIPS final score". (ALM 2267 and SPR 71255; ALM 2276)
- On February 13, CMS distributed a communication designated for vendors, notifying us of a new field that should be filed for providers requesting the Improvement Activity ACI Bonus. GE will resubmit data for QSS participants with the new measure ID. For customers who do not use QSS, the QRDA-III available for download on the Dashboard does not include improvement activities, and therefore cannot infer the ACI Bonus. (ALM 2284)

Version 1.6.0.2 Release Notes

Enhancements and issues resolved in this release

Fix

Previously, inactive clinicians associated with a group in CQR were being included in the calculations for MIPS and CPC+ groups, which may have resulted in inaccurate calculations, and overcounting the Initial Patient Population (IPP). If a group was created and a clinician associated with the group was later made inactive, the inactive clinician would still be included in the calculations and the QRDA if the group was not refreshed. In addition, inactive clinicians did not display in the MIPS tab, Dashboard tab, or the MQIC tab for group practices, but they could trigger a restriction at authorization if the required data was missing.
Now, inactive clinicians are not included in the calculations for MIPS and CPC+ groups, and will not restrict authorization or impact calculations. (ALM2264)

Known Issue: Configuration changes to a group practice are not automatically reflected in a MIPS or a CPC+ group's clinician list. Configuration changes to a group practice include:

- The addition of new clinicians and clinician encounters
- Changes to locations of care associated with the group practice
- Changing the clinician status from active to inactive or vice versa

To update the clinicians listed in a group practice, follow these steps:

Note: A one-time refresh will be performed before the patching is complete so that every practice has an accurate physician count with the right providers. After that, any configuration change to the MIPS group will require you to 'refresh' the group.

MIPS

1. From the **MQIC>QSS** tab, navigate to the Clinician List and confirm the clinicians included in the MIPS group.
2. Use the **Exclude Clinician** feature to manage the clinician list.
3. Refresh the MIPS group by navigating to:
    a. Select Program: **2017 MIPS**, then click **Edit**.
    b. Expand **MIPS Group Enrollment**.
    c. Navigate to the MIPS group and click the pencil icon  in the Edit column.
    d. In **Clinician Count**, click the Refresh button  .
    e. Navigate to the MIPS dashboard and recalculate the MIPS group.

CPC+

1. From the **MQIC>QSS** tab, navigate to the Clinician List and confirm the clinicians included in the CPC+ practice.
2. Use the **Update Selected Providers** feature to manage the clinician list.
3. Navigate to the MIPS dashboard and recalculate the CPC+ practice.

Known Issue

CMS159 (Depression Remission at Twelve Months)
This measure requires a visit from January 1 through December 31 of the prior year, 2016, but not during the current measurement year; it does not require a visit in 2017. CQR, however, is only counting patients that had a visit (at least one encounter, intervention, or procedure) during the measurement period, which may result in undercounting the IPP. (ALM 2269)

Version 1.6.0.1 Release Notes

Enhancements and issues resolved in this release

This section describes fixes in this release.

Individual and Group Calculations:
Previously, Observation terms with units of measure that do not exactly match the units indicated in the CMS eCQM specifications were not counted. (ALM 2170 and SPR 70981)

The rule logic will now count the following Observation units by assuming the specified unit types below:

- BP units as mm[Hg]. This impacts CMS22, CMS65, and CMS165.
- Heart rate units as BPM (beats per minute). This impacts CMS144 and CMS145.
- BMI units as kg/m2. This impacts CMS69.

The rule logic still requires mg/dL for LDL and HDL but is no longer case sensitive and ignores white space.

- This impacts CMS61, CMS65, CMS163, CMS182, and CMS347.

Known issue: QRDA-I continues to export units as imported from CPS/CEMR. If you import the QRDA-I into another system, your results may be different than CQRs. We plan on addressing in an upcoming CQR release. (ALM 2256 and SPR 70981)

Group Calculations Only:

1. Previously, patients were counted in a group practice calculation without having a qualifying encounter at a Location of Care (LOC) configured in a group. (ALM 2238 and SPR 71152)

   Group calculations are a two-phase process.
   a) Patients who had any type of encounter or procedure performed at a group's location are queued to calculate for all measures selected for the group.
   b) Each measure then calculates based on the value sets associated with the rule.

   Previously, the second phase considered all patient encounters, not just those encounters based on group locations. As a result, the Initial Patient Population (IPP) for some measures could have been overcounted. For example, consider a patient with an office visit (CPT-99214) at the Southside clinic and a psych visit (CPT-90792) at the Eastside clinic. If the group calculation includes the Eastside clinic, but not the Southside, the patient may have been included in all measures that use the Office Visit value set, even though they did not have an office visit at the Eastside clinic. Now the rule logic excludes encounters not at a group's location.

2. Previously, procedure orders authorized by a provider were counted at the provider's home location. This includes all order codes other than E&M encounter codes, e.g. CPT-99xxx. Now, all patients seen on or after 01-Jan-2017 reflect the procedure order's Location of Care. (ALM 2263)

3. Known issues impacting group calculations:
   - MIPS group calculations require use of encounter orders to associate a provider with a Location a Care. MIPS ACI calculations count "seen by" encounters using document types; however, in order to associate a provider to a group's location, the provider must have at least one encounter order at that location. If you use only document types, you can work around this issue by adding at least one order with an appropriate code (such as SCT-308335008) at a Location of Care configured in the group. Set the authorizing provider of the order to the clinician that should be displayed in the MIPS group. Refer to the "Seen By" section of the Quality Reporting Guide (CPS PDF / .CHM, CEMR PDF / .CHM) for more information about using orders to record "Seen By" events. (ALM 2239 and SPR 71153)

- CQR does not automatically create a practice for each Location of Care where an encounter occurred. Practices are only created when a new provider is detected in a CCDA. This can cause an incomplete practice list and lead to incomplete group configurations. Refer to 'Importing Practices from CPS/CEMR to CQR' in the CQR User Manual (CPS / CEMR) for instructions to create and update practices with Location of Care identifiers. (ALM 2248 and SPR 71179)

- Group authorization may be blocked if there are any inactive providers associated with the group with no NPI. (ALM 2264)

Timeline and Next Steps:

1) January 26: GE will deploy CQR 1.6.0.1 starting at 9AM PST.
2) From January 26 for roughly five days, GE will re-parse CCDA data. This prevents customers from having to resend data to CQR. The calculation button will be disabled until reparsing is complete. Auto-calculations will also be turned off the weekend of January 27 for re-parsing and restarted the following weekend.
3) Once reparsing is complete and the calculation button is available again, clinicians impacted by this issue should recalculate their 2017 reporting period they want to use for submission.
4) Submit results to CMS.

Version 1.6 Release Notes

Enhancements and issues resolved in this release

This section describes enhancements and fixes in this release.

Upgraded Clinical Quality Measures

Twelve of the existing 40 Clinical Quality Measures that GE currently supports for reporting year 2017 were upgraded to the measure versions applicable to reporting year 2018, while retaining measure versions applicable to reporting year 2017.

Note: Under the MIPS reporting year 2018, the following CQM is obsolete:

- CMS166 Use of Imaging Studies for Low Back Pain

The measures upgraded for the 2018 program year require that the 2018 value sets be uploaded into CPS/ CEMR. The 2018 value sets that correspond with the 2018 measure versions being released will be available in an upcoming release of the Knowledgebase. Confirm completion of all quality reporting for 2017 including MIPS, CPC+, MU, and any other quality reporting programs before loading the 2018 value sets in order to avoid a negative impact on your 2017 measure results.

The supporting documentation for the measures includes descriptions of the changes.

- Find out more about the changes in logic and value sets in the Clinical Quality Measures for the 2018 performance period by referring to the *CMS Electronic Clinical Quality Improvement Resource Center*: https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms/2018-performance-period-epec-ecqms.
- Our *Quality Reporting Guide – January 2018 revision* has been updated to reflect the changes for 2018 reporting.

We are highlighting changes below that impact CQR but you should review the full CMS list for all changes that may impact care.

CMS2 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan – version 7.1

- Revised the example list of screening tools in the definition to include additional example tools, including perinatal screening tools.

CMS50 Closing the Referral Loop: Receipt of Specialist Report – version 6

- No change

CMS122 Diabetes: Hemoglobin A1c Poor Control – version 6.1

- Hospice Exclusion: Updated the denominator exclusion to exclude patients in hospice care from the Denominator. Measures that focus on screenings and procedures may not be appropriate or a priority for those who are at end of life (i.e., on hospice).

CMS124 Cervical Cancer Screening – version 6.1

- Hospice Exclusion
- Guidance states that a 'reflex' test does not meet the Numerator criteria. Language was added to the guidance that the measure specification data model does not support. Although measure authors can specify additional guidance in the text, Centricity cannot distinguish whether an HPV test result was ordered as a reflex test because the patient had an abnormal Pap. If a patient has an HPV result, it will be counted as if it was 'ordered', resulting in the numerator being inconsistent with guidance. This measure is certified based on the QDM specification logic.

CMS125 Breast Cancer Screening – version 6.2

- Hospice Exclusion

CMS127 Pneumonia Vaccination Status for Older Adults – version 6.1

- Hospice Exclusion

CMS130 Colorectal Cancer Screening – version 6.1

- Hospice Exclusion
- Added additional screenings to the Numerator:
  - FIT-DNA during the measurement period or the two years prior to the measurement period.
  - CT Colonography during the measurement period or the four years prior to the measurement period.

CMS131 Diabetes: Eye Exam – version 6.2

- Hospice Exclusion
- Updated the timing logic to align with the description of the numerator: a retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period.

CMS134 Diabetes: Medical Attention for Nephropathy – version 6.1

- Hospice Exclusion

CMS147 Preventive Care and Screening: Influenza Immunization – version 7.2

- Denominator: Removed the requirement for two or more visits for certain types of encounters to align with clinical experts' recommendations
- Allergy to Eggs
  - Previously, clinicians had to record the problem of 'Allergy to Egg'.
  - Now, clinicians can record an egg allergy on the patient's allergy list. The February KB will update all patients with 'eggs' on the allergy list to have the required SNOMED-CT code.

CMS149 Dementia: Cognitive Assessment – version 6

- No change

CMS164 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet – version 6.2

- Hospice Exclusion

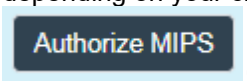
Authorizing MIPS or CPC+ Submission

For customers enrolled in the QSS program for MIPS or CPC+, measure data submission can now be authorized on the MIPS tab. The authorization feature is the final and most important step in the QSS process.

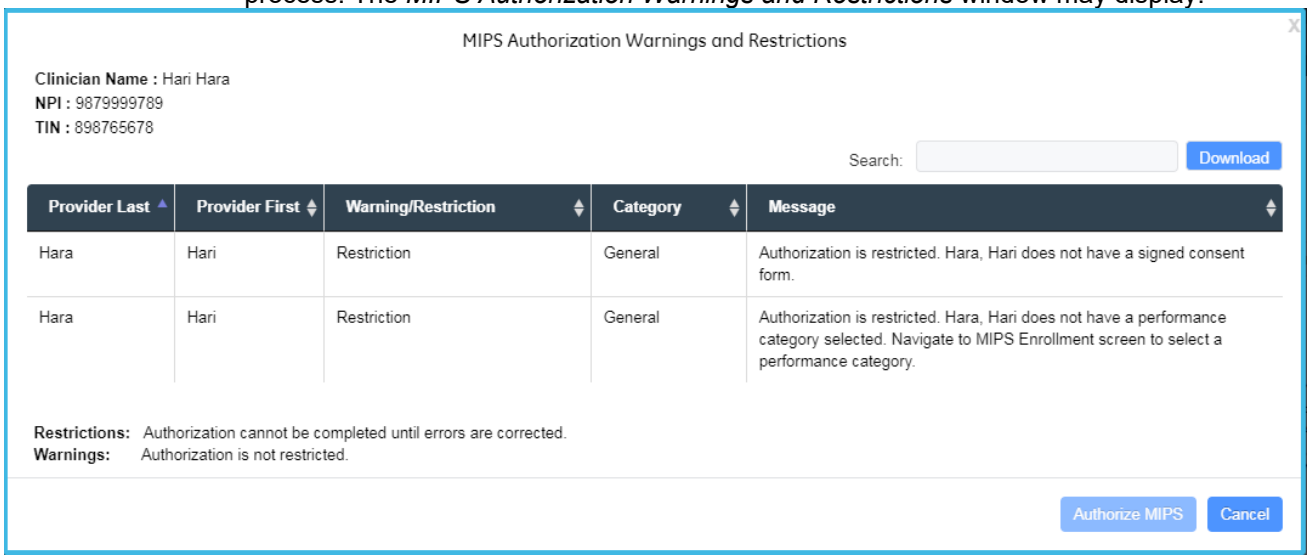
- For MIPS participants, it designates the clinicians and groups, performance categories, measures, and date ranges that will be submitted to CMS by GE Healthcare. If a clinician or MIPS group is not authorized, the data will not be submitted to CMS. Verify the ACI, Quality Measures, and Improvement Activities performance categories. All performance categories selected will be authorized simultaneously. Before authorization, confirm that each performance category has the correct report range and measures selected.
  All measures displayed on the Quality tab will be submitted at authorization. The MIPS Selected field only controls the estimated score and not which measures are submitted. To reconfigure your Quality Measure selection, navigate to **Configuration > Measurement Settings**, and select only the measures you want submitted. After reconfiguration, recalculate the MIPS clinician or group practice.
- For CPC+ participants, it designates the practices, measures, and date ranges that will be submitted to CMS by GE Healthcare. If a CPC+ practice is not authorized, the data will not be submitted to CMS. Before authorization, confirm that the Quality category has the correct report range and measures selected. Before authorization, confirm that the Quality category has the correct report range and measures selected.
  All measures displayed on the Quality tab will be submitted at authorization. The

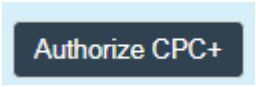
CPC+ Selected field only controls the estimated score and not which measures are submitted. To reconfigure your Quality Measure selection, navigate to **Configuration > Measurement Settings**, and select only the measures you want submitted. After reconfiguration, recalculate the CPC+ practice.

Either the **Authorize MIPS** or **Authorize CPC+** button displays on the MIPS tab, depending on your clinician participation.

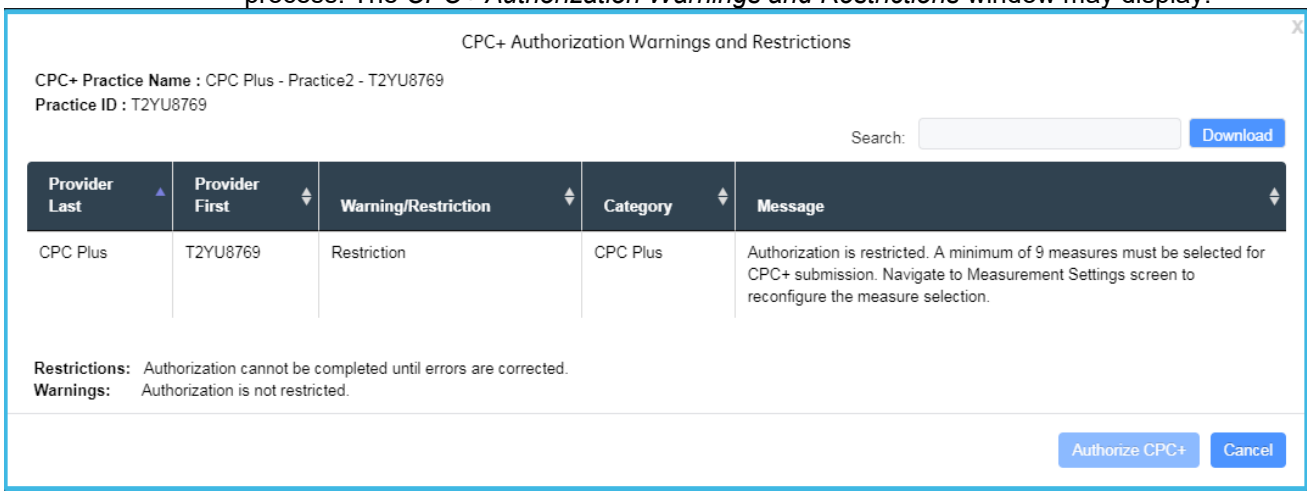


Click **Authorize MIPS** on the MIPS tab to start the authorization process. The *MIPS Authorization Warnings and Restrictions* window may display.





Click **Authorize CPC+** on the MIPS tab to start the authorization process. The *CPC+ Authorization Warnings and Restrictions* window may display.



Clicking the Authorize button may display the corresponding *Authorization Warnings and Restrictions* window. The Authorization Warnings and Restrictions window identifies potential issues with measure selection that may impact MIPS scoring (Warnings) and severe problems that will interrupt authorization until corrected (Restrictions). Provider names, warnings vs restrictions, categories and messaging are identified for each. The list may be downloaded to Microsoft Excel by clicking the Download button. It also includes a search feature and the ability to sort columns.

If there is no restriction, then the user can continue with the authorization process.

Please refer to the *Clinical Quality Reporting User Manual – January 2018 revision* on

how to authorize measures for a clinician or MIPS group, or for a CPC+ practice.

Attestation Statements for the ACI Performance Category

Attestation Statements for the ACI Performance Category

Attestation Statement	Response	Status
Prevention of Information Blocking Attestation	Yes	
ONC Direct Review Attestation	Yes	
ONC-ACB Surveillance Attestation (Optional)	Yes	

MIPS eligible clinicians are required to show that they have not knowingly or willfully limited or restricted the compatibility or interoperability of their certified electronic health record technology (CEHRT) by attesting to three statements about how they implement and use CEHRT. These statements are collectively called “Prevention of Information Blocking Attestation”.
The statements apply to individual clinicians and groups. By default, the Response column indicates “No” for each statement. The first and second statements require a “Yes” response to earn an ACI score. The third statement is optional. Authorization is restricted unless responses are provided.

The Attestation Statements pane displays three attestations:

- **Prevention of Information Blocking Attestation**
  I have not knowingly and willfully taken action to limit or restrict the interoperability of certified EHR technology. I have responded to requests to retrieve or exchange information-including requests from patients and other health care providers regardless of the requestor's affiliation or technology. I have implemented appropriate standards and processes to ensure that certified EHR technology was connected in accordance with applicable law and standards, allowed patients timely access to their electronic health information; and supported exchange of electronic health information with other health care providers.
- **ONC Direct Review Attestation**
  I have (1) acknowledged the requirement to cooperate in good faith with ONC direct review of health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; AND (2) if requested, cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program, as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.
- **ONC-ACB Surveillance Attestation (Optional)**
  I have (1) Acknowledged the option to cooperate in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and (2) if requested, cooperated in good faith with ONC_ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the MIPS eligible clinician in the field.

To attest for each statement:

1. Put the cursor over the blue info icon to display and read the popup attestation description.

2. On the Response column, toggle to **Yes**. The Status column displays a green check mark for confirmation.

   Note: The first and second statements are required to indicate “Yes” for attestation. The third statement is optional.

For more information about “Prevention of Information Blocking Attestation”, click this link for the fact sheet on CMS.gov:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/ACI-Information-Blocking-fact-sheet.pdf

QRDA III Updates for Program Year 2017

The QRDA-III file has been upgraded to incorporate the 2017 CMS Implementation Guide version 1.0. This upgrade addresses the aggregate reporting requirements for the following programs:

- Comprehensive Primary Care Plus (CPC+)
- Merit-based Incentive Payment System (MIPS)

Comprehensive Primary Care Plus (CPC+):
For CPC+ program year 2017, the QRDA-III includes the clinical quality measures that must be reported at the CPC+ practice site level.
Practice site level reporting includes all patients who were seen at least once at the practice site location during the Performance Period (i.e., calendar year) by CPC+ clinicians (TIN/NPI) and who met the inclusion criteria for the Initial Population (IP)/Denominator
Merit-Based Incentive Payment System (MIPS):
For MIPS program year 2017, the QRDA-III includes measures for all three MIPS performance categories: Advancing Care Information, Quality, or Improvement Activity. At least one measure in one category should be submitted to avoid a penalty.
The QRDA-III file downloaded from dashboard will have only ACI (trans) & Quality only.

The QRDA-III file available post authorization through MIPS dashboard (QSS) will have ACI (trans) measures; Quality measures & Improvement Activities support.

Fixes

- *CMS138 Tobacco Use Screening and Cessation Intervention* – Additional mapping was added in CQR to count Tobacco Non-User or Tobacco User as Tobacco Use Screening. This should increase your performance rate. You will have to recalculate this measure. (ALM 2035)
- GPRO calculations from previous PQRS programs will no longer allow new calculations. (ALM 2128)
- After auto-calculation, the ACI or Quality measures configured for a provider sometimes did not show complete measure list on the MIPS and Dashboard tabs. This issue has been fixed so that the configured ACI and Quality measures both display on the tabs. (ALM 2135 and SPR 70715)
- Previously: CPC Plus Details link would disappear when the legacy dashboard page was refreshed or user navigated away from the legacy Dashboard. Now: If a CPC+ practice displays on the legacy Dashboard, the CPC+ Details link will no longer disappear when the user refreshes or navigates away from the page. (ALM 2137)
- Previously, if a Quality measure's performance score falls between two benchmark limits, it displayed as NA in the Benchmark column on the **MIPS>Quality Measures** tab. Now, when the performance score is calculated, it is rounded to 2 decimal places so that it falls into a specific benchmark. (ALM 2187 and SPR 71026)
- Previously, some measure calculations that were submitted did not return measure results. This issue was resolved with the fixes for the defects listed here: (ALM 2017 and SPR 69472), (ALM 2180 and SPR 71015), and (ALM 2193 and SPR 71060).
- In Q4 of 2017, GE introduced performance enhancements in Clinical Quality Reporting (CQR) to support group calculations and improve the timely return of calculations. This change resulted in patients being attributed to only one provider they had seen in 2018. As a result, the IPP for some measures may be undercounted, and thus the results may not be accurate.
  A CQR fix was applied and all CCDAs were processed **There is no need to resend data.** Full-year auto-calculations were completed on December 26. If you selected (and bookmarked) a calculation for attestation or QSS submission that was calculated before December 26, recalculate and update your bookmarks.
  (ALM 2196 and SPR 71072)
- Previously, the ACI Bonus for Improvement Activities did not display properly after the first of the year. Although the reporting range of YTD 2017 was selected, configured (and saved) to include Improvement Activities listed with ACI Bonus, the ACI tab did not reflect ACI Bonus points. This issue has been fixed. (ALM 2234 and SPR 71134)

Known issues

ALM 2238 - Patients with encounters or procedures at multiple locations of care that are not part of the same MIPS or CPC+ group may be overcounted in the IP for eCQMs. We will address this issue in the next update.

ALM 2239 - Eligible Clinicians who do not use orders to record encounters are not included in MIPS groups. To work around this issue, create an encounter order authorized by the EC with a test patient with at least one location of care associated with the MIPS group. The test patient should be excluded from calculations in **CQR > Insights**.