

Meaningful Use of Certified Electronic Health Record Technology (CEHRT) in 2016- Module 6

Module six of the 2016 Medicare quality programs presentation focuses on this year's requirements for the EHR Incentive Programs.

The final rule that included the EHR Incentive Programs in 2015 through 2017 made many significant changes to the program in order to help providers meet program requirements. Chief among these changes was the alignment of objectives and measures from both stage 1 and stage 2 into one set of objectives. In doing so, CMS eliminated several measures that were duplicative or "topped out" (which are measures that have achieved widespread adoption at a high rate of performance and no longer represent a basis upon which provider performance may be differentiated).. Some of these individual measures that have been removed include recording vital signs, demographics, smoking status, sending patient reminders and imaging results. Starting in 2016, eligible hospitals and critical access hospitals report on the calendar year just as eligible professionals (EPs) do, as opposed to the fiscal year by which hospitals and CAHs previously reported. The final rule also made important modifications to the two objectives that require patient activity: patient electronic access and secure messaging. We will detail those changes in a minute. The reporting requirements for the clinical quality measures were not affected by the modification rule.

For 2016, the reporting period for all participants who are returning to the program is one full calendar year, from January 1 through December 31, 2016. EPs, eligible hospitals and CAHs that are new participants in the program have an EHR reporting period of any continuous 90day period between January 1, 2016 and December 31, 2016. The final rule allows for specific alternate exclusions for measures 2 and 3 of Objective 3 CPOE for all providers who were scheduled to be in stage 1 in 2016. Eligible hospitals and CAHs also have an alternate exclusion for Objective 4 Electronic Prescribing if they were either scheduled to demonstrate Stage 1 in 2016 or are scheduled to demonstrate Stage 2 but did not intend to select the Stage 2 Electronic Prescribing objective for an EHR reporting period in 2016.

As mentioned earlier, two critical changes to the meaningful use objectives for 2016 deal with the measures that require patient engagement: Objective 8 Patient Electronic Access and Objective 9 Secure Messaging. Patient electronic access is a requirement for all EPs, hospitals, and critical access hospitals, while secure messaging is a requirement for EPs only.

Measure 2 of the patient electronic access objective previously stated "More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) or who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their health information" In the modified Stage 2, the requirement is that at least one patient seen by the EP during the EHR reporting period (or patient authorized representative) or is discharged from the inpatient or emergency department of an eligible hospital or CAH (or patient authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period in 2016. In 2017, the measure threshold reverts to the more than 5 percent threshold.

For the secure messaging objective, the previous stage 2 measure stated, "A secure message was sent

using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period." In the final rule, the measure threshold was lowered in 2016 to require that "For at least one patient seen by the EP during the calendar year, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient (or the patient authorized representative) during the EHR reporting period.". Note that in 2017, as with the patient electronic access objective, the measure for secure messaging also reverts to a threshold of more than 5 percent.

The tables on the following slides give detailed information for the objectives and measures for the 2016 EHR Incentive programs for all providers. For 2016, EPs are required to meet 10 objectives, and eligible hospitals and CAHs must meet 9. Objective 1 Protect Patient Health Information, requires providers to conduct or review a security risk analysis of CEHRT including addressing encryption and security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.

Objective 2, clinical decision support, includes two measures that must be met by all providers. The first is for providers to implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. The second requires providers to enable and implement the functionality for drug and drug allergy interaction checks for the entire EHR reporting period. EPs who write fewer than 100 medication orders during the reporting period can claim an exclusion from the second measure. If there are limited clinical quality measures applicable to a provider's scope of practice, they should implement clinical decision support interventions that they believe will drive improvements in the delivery of care for the high priority health conditions relevant to their specialty and patient population.

Objective 3 Computerized Provider Order Entry, or CPOE, has three measures. The first measure requires that more than 60 percent of medication orders created by the EP or authorized providers in the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. The second and third measures each have a more than 30 percent threshold, and address laboratory orders and radiology orders respectively. For all three measures eligible professionals who write fewer than 100 medication, laboratory and/or radiology orders during the reporting period, can claim an exclusion for the associated measure. As mentioned earlier, all providers scheduled to be in stage 1 in 2016 may claim an alternate exclusion for the laboratory and/or radiology measures. Providers would still be required to report on measure 1 for medication orders, however; EPs may claim an exclusion if they write few than 100 medication orders during the EHR reporting period.

The fourth objective is electronic prescribing, and the measures for EPs and eligible hospitals and CAHs vary. For EPs, the measure states, "More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. An exclusion can be claimed by any EP who writes fewer than 100 prescriptions during the reporting period, or does not

have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

For eligible hospitals and CAHs, more than 10 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT. Hospitals and CAHs can claim an exclusion if they do not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period. Additionally, hospitals and CAHs can claim an alternate exclusion to the eprescribing measure in 2016 if they were previously scheduled to demonstrate stage 1 in 2016 or if they are scheduled to demonstrate Stage 2 but did not intend to select the Stage 2 eRx objective for an EHR reporting period in 2016. Objective 5 is health information exchange. All providers that transition or refer their patient to another setting of care or provider of care must (1) use CERHT to create a summary of care record; and (2) electronically transmit that summary to a receiving provider for more than 10 percent of transitions of care and referrals.. A provider must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the provider as of the time of generating the summary of care document. EPs can claim an exclusion if they transfer a patient to another setting or refer patients to another provider less than 100 times during the reporting period.

Objective 6 is patient specific education which is required for all providers. The measure(s) state, "Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period." EPs may claim an exclusion if they have no office visits during the EHR reporting period. The provider must use certified EHR technology (CEHRT) to identify patient specific educational resources although these resources or materials do not have to be maintained within or generated by the CEHRT. Certified EHR technology is certified to use the patient's problem list, medication list, or laboratory test results to identify the patient specific educational resources. The provider may use these elements or may use additional elements within CEHRT to identify educational resources specific to patients' needs. The provider can then provide these educational resources to patients in a useful format for the patient (such as, electronic copy, printed copy, electronic link to source materials, or through a patient portal).

Objective 7 requires all providers perform medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23). If an EP is not the recipient of any transitions of care during the reporting period, they can claim an exclusion.

We discussed the patient electronic access objective earlier, but it is important to note that this objective actually includes two measures, the second of which is the one that requires action on the part of the patient. The first measure of objective 8 requires that all providers provide timely access for more than 50 percent of all unique patients to view, download or transmit health information to a third party. Timely is understood to mean within four business days for EP's and within 36 hours after the information is available to the eligible hospital and CAH for eligible hospitals and CAHs. The information

that must be included in the health information differs between EPs and hospitals and CAHs and can be found on the measures specification sheets.

The exclusions listed in the table show the measure 1 and 2 exclusion criteria.

The objective dealing with secure electronic messaging applies only to eligible professionals. We reviewed the requirements for the secure messaging objective on an earlier slide, for both 2016 and 2017. EPs can claim an exclusion from this objective if they have no office visits during the reporting period, or if they meet the criterion regarding broadband access listed in the table.

The final objective is the public health reporting objective, which for eligible professionals includes three measures: reporting to an immunization registry, syndrome surveillance reporting, and specialized registry reporting. Eligible hospitals and CAHs also have these three measures, along with a fourth specific to hospitals and CAHs: electronic reportable laboratory result reporting. In 2016, the requirement for EPs is to meet two of the three measures that pertain to EPs, while hospitals and CAHs must meet three of the four measures. The exclusions that pertain to EPs and also to hospitals and CAHs are detailed on the four tables shown on these slides, and more information can be found on the specification sheets for this Objective, which can be found on the 2016 Program Requirements page on the CMS website. You will note that the four measures for the public health objective all require "active engagement" on the part of the provider with the registry in question. CMS defines "active engagement" as meaning that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry. There are three options to meeting this definition: a completed registration to submit data, testing and validation, and production.

As mentioned earlier, the requirements for reporting the clinical quality measures for meaningful use in 2016 remain unchanged. For EPs, the requirement is to report at least 9 measures that cover at least 3 of the 6 National Quality Strategy domains of: Patient and Family Engagement, Patient Safety, Care Coordination, Population/Public Health, Efficient Use of Healthcare Resources, and Clinical Process/Effectiveness. For hospitals and CAHs, the requirement is to report 16 clinical quality measures, also covering three of the 6 domains. CMS is continuing its effort to align reporting requirements for meaningful use with other quality reporting programs, such as PQRS. All providers are required to use the 2014 electronic specifications for CQMs when reporting.

If providers have questions about the PQRS, they should call the Quality Net Help Desk at 8662888912. For questions to be addressed by your Medicare Administrative Contractor, you can find the phone number for your MAC's call center at the link on this slide, which can also be found in the Descriptions section below this video.

A list of online resources available on the CMS website for each of the programs is found on this slide. You can find links to these sites in the Description section below this video.

That concludes Module six of the Medicare Quality Reporting Programs presentation for 2016. Thank

you for watching. To view the remaining modules of this presentation, please see the links in the "Descriptions" section of this video.