eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

eHealth Vendor Workgroup

July 17, 2014

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Agenda

Agenda Item	Speaker
Measure-Applicability Validation FAQs	Sophia Autrey
ICD-10 Update	Denesecia Green
New Resources	
• Transitions of Care and View, Download, Transmit Quick Guide	Brett Andriesen
• Clinical Decision Support: More Than Just 'Alerts' Tipsheet	Elise Anthony and Michael Wittie
• Patient Electronic Access Tipsheet	Beth Myers

PQRS

New FAQs on Measure Applicability Validation (MAV):

- **FAQ 10058: What is MAV?**
  - MAV is a validation process that will determine whether individual eligible professionals or group practices should have reported additional measures OR additional domains.
  - MAV determines 2014 PQRS incentive eligibility and 2016 PQRS payment adjustment status for individual EPs and group practices.
- **FAQ 10060: When does MAV apply?**
  - MAV applies if less than nine measures OR less than three domains are reported for claims-based and registry-based reporters.
  - MAV does not apply to Measures Groups, EHR, Group Practice Reporting Option (GPRO) Web Interface, Certified Survey Vendor - Clinician & Group Surveys Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS; CAHPS for PQRS), or Qualified Clinical Data Registry (QCDR) Reporting Mechanisms.

PQRS

- **FAQ 10062: What happens if we report less than nine measures across three domains?**
  - MAV is automatically triggered in scenarios where less than nine measures OR less than three domains are satisfactorily reported by claims-based and registry-based reporters.
  - If MAV analytically determines that the individual eligible professional or group practice could have reported additional measures or domains within the clinical cluster, then the 2014 PQRS incentive would not be earned and the 2016 PQRS payment adjustment may apply.

PQRS

- **FAQ 10064: How does CMS apply the MAV Clinical Retention/Domain Test for PQRS?**
  - The MAV Clinical Relation/Domain Test is based on:
    1) If an individual eligible professional or group practice reports data for a measure, then that measure applies to their practice, and
    2) The concept that if one measure in a cluster of measures related to a particular clinical topic, OR individual EP, or group practice service is applicable to an individual EP's or group's practice, then other closely-related measures (measures in that same cluster) would also be applicable.

ICD-10 Planning Discussions with Clearinghouses, Vendors, Payers and CMS

- Biweekly on Tuesdays at 1 – 1:30 pm EST
- Next meeting: July 22
- To register for this meeting please email CMSeHealthTeam@Ketchum.com

Quick Guide: Transitions of Care and View, Download, Transmit Resources

Brett Andriesen
HHS/ONC
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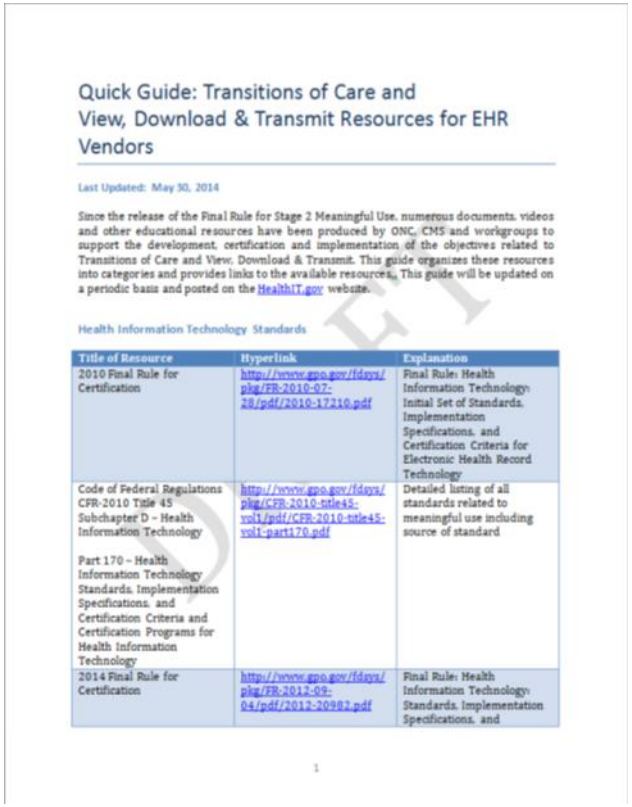
Quick Guide: TOC/VDT Resources

- Compilation of Resources for vendors and others to quickly find key resources related to TOC & VDT on topics of:
  - Health IT Standards (final certification rules, etc)
  - Certification and Testing (glossary, test methods, test procedures, etc)
  - Implementation & Real World Tools (education modules, trainings, videos, links to resources and CMS FAQs, etc)
  - Health Information Exchange Resources (key considerations for HIOs/HIEs, etc)

Quick Guide: TOC/VDT Resources

- Currently finalizing to create enhanced resource repository on HealthIT.gov
- Draft available for review and additional feedback
- Please email Brett.Andriesen@hhs.gov to receive a copy in advance of availability on HealthIT.gov



Quick Guide: Transitions of Care and View, Download & Transmit Resources for EHR Vendors

Last Updated: May 30, 2014

Since the release of the Final Rule for Stage 2 Meaningful Use, numerous documents, videos and other educational resources have been produced by ONC, CMS and workgroups to support the development, certification and implementation of the objectives related to Transitions of Care and View, Download & Transmit. This guide organizes these resources into categories and provides links to the available resources. This guide will be updated on a periodic basis and posted on the HealthIT.gov website.

Health Information Technology Standards

Title of Resource	Hyperlink	Explanation
2010 Final Rule for Certification	http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17210.pdf	Final Rule: Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology
Code of Federal Regulations CFR-2010 Title 45 Subchapter D – Health Information Technology Part 170 – Health Information Technology Standards, Implementation Specifications, and Certification Criteria and Certification Programs for Health Information Technology	http://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/pdf/CFR-2010-title45-vol1-part170.pdf	Detailed listing of all standards related to meaningful use including source of standard
2014 Final Rule for Certification	http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-20982.pdf	Final Rule: Health Information Technology: Standards, Implementation Specifications, and

The Office of the National Coordinator for Health Information Technology

Clinical Decision Support: More than Just 'Alerts'

Elise Anthony, Esq.
ONC Office of Policy

Michael Wittie, MPH
ONC Office of Clinical Quality and Safety

CDS in MU

- In Stage 2, EPs must implement 5 CDS interventions and have drug-drug and drug-allergy interaction checks enabled.

- The final rule states:
  - "**CDS is not simply an alert, notification, or explicit care suggestion**"

  - It replaces the term "clinical decision support *rule*" with "clinical decision support *intervention*" to "clearly allow for the variety of decision support mechanisms available to help improve clinical performance and outcomes."

What is CDS?

- There is **no definitive or comprehensive list** of what can constitute CDS.
- CDS can be a variety of tools including, but not limited to:
    - clinical guidelines;
    - condition-specific order sets;
    - alerts or reminders for providers and patients;
    - focused patient data reports and summaries;
    - documentation templates;
    - contextually relevant reference information

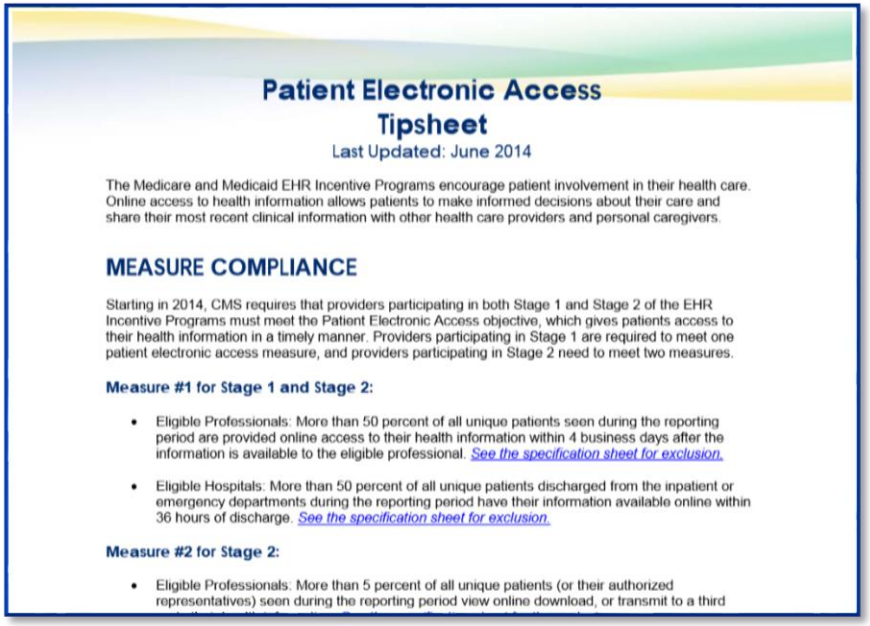
Tip Sheet

- ONC and CMS jointly created a Tip Sheet, published July 2014, to provide examples of CDS in the context of the EHR Incentive Programs.
- It includes more details on:
  - What is CDS?
  - Evaluating Eligible Providers' Use of CDS for Meaningful Use
  - Questions and Answers
- http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/ClinicalDecisionSupport_Tipsheet-.pdf

EHR Incentive Programs

Patient Electronic Access Tipsheet

- Explains the requirements for the patient electronic access objective, or View, Download, Transmit, for:
  - 2014 Definition Stage 1 of Meaningful Use
  - Stage 2
- Includes a list of related frequently asked questions
- Available on Educational Resources, Stage 2, and 2014 Stage 1 of Meaningful Use pages



Patient Electronic Access Tipsheet

Last Updated: June 2014

The Medicare and Medicaid EHR Incentive Programs encourage patient involvement in their health care. Online access to health information allows patients to make informed decisions about their care and share their most recent clinical information with other health care providers and personal caregivers.

MEASURE COMPLIANCE

Starting in 2014, CMS requires that providers participating in both Stage 1 and Stage 2 of the EHR Incentive Programs must meet the Patient Electronic Access objective, which gives patients access to their health information in a timely manner. Providers participating in Stage 1 are required to meet one patient electronic access measure, and providers participating in Stage 2 need to meet two measures.

Measure #1 for Stage 1 and Stage 2:

- Eligible Professionals: More than 50 percent of all unique patients seen during the reporting period are provided online access to their health information within 4 business days after the information is available to the eligible professional. *See the specification sheet for exclusion.*
- Eligible Hospitals: More than 50 percent of all unique patients discharged from the inpatient or emergency departments during the reporting period have their information available online within 36 hours of discharge. *See the specification sheet for exclusion.*

Measure #2 for Stage 2:

- Eligible Professionals: More than 5 percent of all unique patients (or their authorized representatives) seen during the reporting period view online download, or transmit to a third

QUESTIONS?