CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1746	**Date: November 4, 2016**
	Change Request 9836

SUBJECT: Medicare Electronic Health Record (EHR) Incentive Program – Analysis of Meaningful Use Hospital Transition into Hospital Quality Reporting System

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to detail analyses and draft business requirements necessary for the changes in systems or processes affected by the National Level Repository system decommissioning and the transition of the hospitals into the Hospital Quality Reporting System.

EFFECTIVE DATE: January 2, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under the PFS. This proposed rule would establish the MIPS, a new program for certain Medicare-enrolled practitioners. MIPS would consolidate components of three existing programs, the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), and would continue the focus on quality, resource use, and use of certified EHR technology (CEHRT) in a cohesive program that avoids redundancies.

With the Eligible professional transition into MIPS and Hospitals transition into Hospital Quality Reporting (HQR) System, the Medicare functions within National Level Repository system become redundant thus being decommissioned. This CR will allow FISS to analyze the system changes required for transition into HQR.

B. Policy: Section 1848(o)(2)(A) of the Act requires that the Secretary seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use. In implementing MIPS and the advancing care information performance category, we seek to improve and encourage the use of certified EHR technology over time by adopting a new, more flexible scoring methodology, as discussed in section II.E.5.g.6. of this proposed rule, that would more effectively allow MIPS eligible clinicians to reach the goals of the HITECH Act, and would allow MIPS eligible clinicians to use EHR technology in a manner more relevant to their practice. This new, more flexible scoring methodology puts a greater focus on Patient Electronic Access, Coordination of Care Through Patient Engagement, and Health Information Exchange—objectives we believe are essential to leveraging certified EHR technology to improve care by engaging patients and furthering interoperability. This methodology would also de-emphasize objectives in which clinicians have historically achieved high performance with median performance rates of over 90 percent for the last 2 years. We believe shifting focus away from these objectives would reduce burden, encourage greater participation, and direct attention to other objectives and measures which require more attention. Through this flexibility, MIPS eligible clinicians would be incentivized to focus on those aspects of certified EHR technology that are most relevant to their practice, which we believe would lead to improvements in health care quality.

We also seek to increase the adoption and use of certified EHR technology by incorporating such technology into the other MIPS performance categories. For example, in section II.6.a.2.f. of this proposed rule, we are proposing to incentivize electronic reporting by awarding a bonus point for submitting quality measure data using certified EHR technology. Additionally, in section II.E.5.f. of this proposed rule, we have aligned some of the activities under the CPIA performance category such as Care Coordination, Beneficiary Engagement and Achieving Health Equity with a focus on enhancing the use of certified EHR technology. We believe this approach would strengthen the adoption and use of EHR systems and program participation consistent with the provisions of section 1848(o)(2)(A) of the Act.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9836.1	The contractors shall have discussions with CMS staff on developing business requirements relating to the transition of hospitals into Hospital Quality Reporting Program beginning 2018. CMS shall schedule up to 5 one hour calls, once a week, beginning the week of Nov. 01, 2016. The due date for delivering the final draft business requirements is 30 days after the last call.					X				EHR, HIGLAS, NLR, STC, VDC
9836.1.1	The business requirements developed shall be incorporated into an implementation CR.									CCSQ, NLR
9836.2	The business requirements shall address, but not be limited to, the following points: • Connectivity with a new system/contract • Maintain current connectivity during the transition period as a back up • File names • Testing and preparing test files • Banking • Payments • Accepting files from both sources (NLR and HQR) during transition phase • Contact information • Response file and error resolution					X				EHR, HIGLAS, NLR, Other CMS Contractor, VDC
9836.3	FISS shall document meeting minutes for each call and post in eCHIMP within 3 business days after the call. The minutes will include action items, outstanding issues and draft business requirements.					X				
9836.4	CMS shall issue the updated draft implementation CR for discussion prior to the next meeting.									CCSQ

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Steven Johnson, 410-786-3332 or Steven.Johnson@cms.hhs.gov , Swapna Gubbala, 443-286-0439 or swapna.gubbala@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0