2016 Meaningful Use Requirements Webinar - Transcript
Tuesday, February 9, 2016

Laurie Fink: Good afternoon, everyone. Thanks so much for joining us today. The Quality Insights Innovation Network team welcomes you to today's webinar, 2016 Meaningful Use Requirements for Eligible Professionals. My name is Laurie Fink, and I am the Communications Specialist for the Improving Outcomes by Optimizing your EHR Initiative.

Before we get things started, I would like to take a moment to review a few housekeeping items. First, all participants have been muted and will remain in a listen-only mode during the presentation. There will be a question and answer session following the presentation, so if a question comes to mind at any time during the session, please feel free to type in the chat or Q&A box, which can be found on the right of your screen. We will address all questions during the Q&A session.

Please know this webinar is being recorded and as soon as available, which should be later this afternoon, the recording along with a copy of the slide deck will be posted on the Quality Insights website at www.qualityinsights-qin.org and it's found under the events tab as an archived event. It will also be posted on the My Quality Insights platform online learning platform.

At this time, I would like to hand the presentation over to today's presenter, Mr. Joe Pinto. Joe is a Health IT Practice Transformation Specialist with the Quality Insights Improving Outcomes by Optimizing your EHR Initiative. Joe?

Joe Pinto: Thank you and good afternoon everyone. I want to take the moment to thank all of you for joining us for this afternoon's presentation focusing on the rules, modifications for the 2016 Meaningful Use requirements for eligible professionals. This presentation will offer you valuable information and guidance as you prepare your practices to meet the requirements for Meaningful Use in 2016.

The focus of this webinar is to provide you with an overview of the Meaningful Use requirements, the main objectives and also find some resources for the 2015 and 2016 Meaningful Use reporting periods. [inaudible 00:02:23] attestations will also be discussed as well as view the hardship exception application. [inaudible 00:02:33] that are provided today are also available on the My Quality Insights web portal for [inaudible 00:02:41] network [inaudible 00:02:42]. Already registered and set up your account. Just make sure you do so at your earliest convenience in order to access the materials.

This presentation was prepared to assist EHR Incentive Program Eligible Providers and their office staff to gain knowledge about the 2016 Meaningful Use requirements that were published by Centers for Medicare & Medicaid Services October the 16th of 2015. The information that's provided today is based on the interpretation of the CMS final rule by the Quality Insights staff and is not intended to take the place of either the written law or regulations.

If you've not yet attested for program year 2015, just remember that there are only 20 days left until the deadline. February 29th of 2016 is the last possible day to attest with Medicare. Please do not wait until the last day. Providers that attested with Medicaid in 2014 who don't have a 30% Medicaid patient volume in 2015, should attest with Medicare in 2015 to avoid the penalty. Providers that can attest with Medicaid in 2015 need to check with their local state Medicaid agency for attestation deadlines.

Attestation resources, as I discussed [inaudible 00:04:18] are available on the My Quality Insights web portal. You login by accessing the Optimizing Your EHR community then click on the resources icon. Your 12 mini-webinar recordings are listed 2 to 20 minutes each, in total about 45 minutes [inaudible 00:04:37] for each Meaningful Use objective plus how to attest to the clinical quality measures. There are slides provided, also attestation instruction manual is available and the CMS attestation worksheet for the 10 objectives that are currently in place. Clinical Quality Measures worksheet is available as well. Always, the Quality Insights staff is available for any individual assistance that you may need.

The Attestation Clarification for 2015 and 2016 is for 10 objectives to a provider in their first or second year of EHR program eligibility in 2015, may claim an alternate exclusion for Measure 1, that would be the immunization registry. Measure 2, is the syndromic surveillance or Measure 3, a specialized registry. Eligible providers who are in their 3rd, 4th or maybe even in their 5th year of EHR program eligibility in 2015 may claim an alternative exclusion for Measure 2, which is syndromic surveillance or for Measure 3, which is specialized registry or it maybe claimed for both.

What if you can't attest for Meaningful Use in 2015? CMS will impose a 3% penalty in 2017 to Medicare eligible providers who did not meet Meaningful Use in 2015. Eligible providers can avoid this penalty by submitting a hardship exception. The deadline for submitting the hardship exception is March 15th of 2016 for physicians and April 1st of 2016 for hospitals and Critical Access Hospitals.

The exception process is laid out ... In the past, CMS reviewed each application on a case by case basis to determine if the penalty will be waived. However, recent legislation passed on December 28th of 2015, Patient Access and Medicare Protection Act, allows CMS to consider hardship exceptions for categories of providers so that all applications will automatically be approved. Practices can submit one application for multiple providers in their group.

CMS released on February the 1st of 2015 stating that hardship applications do not require submission of documentation. Also on February 1st 2015 released information, additional guidance specific to the hardship category. Providers who experienced an issue with their Certified EHR Technology related to the 2015 rule timing and any other provider for whom the timing of the rule caused a significant hardship, should select a sub-category listed on the 2017 hardship exception application.

Hardship Exception Categories. First being for insufficient internet activity that applied to those who do not have high speed broadband connectivity. Secondly, for disaster that would include [inaudible 00:08:10] a flood, et cetera. The third is practice or hospital closure. Fourth is severe financial distress such as if the practice had filed for bankruptcy. Then EHR certification or vendor issues and that would be if your EHR vendor has not [inaudible 00:08:32] their 2014 certification or if there is a connectivity problem. The sixth is lack of control over availability of Certified EHR Technology and the seventh would be a lack of face-to-face patient interaction or follow up. The hardship exception application and instructions are available at the link provided on that slide.

[inaudible 00:09:00] the Meaningful Use requirements were recently updated and CMS has them on their web site and now have a page dedicated to 2016 program requirements. The link you can find here on this slide.

The Certified EHR Technology, eligible providers can use EHRs that have been certified to the 2014 edition or 2015 edition. Everyone will need to upgrade their EHR to the 2015 certified edition prior to January 1st of 2018.

Full calendar year for the reporting period, which would be 365 days of reporting data except eligible providers that have never participated in the EHR program. The 2016 eligible providers that are new participants in the EHR program have a reporting period of any continuous 90-day period.

Eligible providers who attest prior to February 28th of 2017 will avoid the 2018 adjustment penalty. Eligible providers who are new participants in 2016 can also avoid the 2017 penalty if they attest prior to October 1st of 2016.

Now the objectives. Objective number 1 is protecting your PHI. There are no changes from the reporting rules from 2015 in place for 2016. To measure, you must conduct or review a security risk analysis, address security and encryption of electronic PHI, implement security updates as necessary, and correct identified security deficiencies. There are no exclusions to the objective. The Regional Extension Centers in each state is available to perform privacy and security assessment however there are some fees that may be involved. You will have to check with each of your own individual states for information on this.

To request privacy and security assessments are listed here for the individual states that are on the call today. For New Jersey we have it, Louisiana, also Delaware, Pennsylvania and West Virginia.

Two, is the clinical decision support. There is no change for 2016 from the 2015 rules. Eligible providers in the first year of program must implement 5 clinical decision support interventions instead of 1 in 2016. To meet this objective, an eligible provider must satisfy both Measure 1 and Measure 2. Measure 1 is implementing clinical decision support interventions related to 4 or more clinical quality measures, that's your CQMs for the entire EHR reporting period. They must be turned on prior to the start of the reporting period. There are no exclusions to Measure 1.

For 2, the eligible provider has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire reporting period. Once again, they must be active before you start your reporting period. The exclusion Measure for 2 would apply to any eligible professional, any eligible provider who write fewer than 100 medication orders during the EHR reporting period.

Objective 3 focuses on CPOE that's Computerized Provider Order Entry. The change in 2015 reporting period would be that eligible providers in first year of program must meet 60% of the threshold for medication order instead of 30%. It's an alternate exclusion and it's only available for the eligible providers in their first year of program. That was the laboratory and radiology orders but not for medication orders.

In order to meet this objective, the eligible providers must satisfy all 3 measures. Measure 1 would be more than 60% of your medication orders created by the eligible provider during the EHR reporting period and are recorded using CPOE. Exclusion for Measure 1 would be, any EP who writes less than 100 medication orders during the EHR reporting period.

For radiology, Measure 2, more than 30% of laboratory orders created by the eligible provider during the EHR reporting period are recorded using CPOE. Exclusion for Measure 2 would apply to any eligible provider who writes fewer than 100 lab orders during the EHR reporting period. There is an exclusion for Measure 2 and that would apply to any EP in first year of program may claim an alternate exclusion for lab orders. Measure 3, more than 30% of radiology orders created by the eligible provider during the EHR reporting period are recorded using CPOE.

Exclusion for Measure 3 does apply to any eligible provider who writes fewer than 100 radiology orders during the EHR reporting period. There is also an alternate exclusion for Measure 3 and that is applying to any EP in the first year of program eligibility claiming an alternate exclusion for radiology orders.

e-Prescribing is listed as objective number 4 for Meaningful Use. The change from 2015 would be that eligible providers in the first year of the program must meet 50% of the threshold instead of the 40% prior for 2015. The Measure applies to more than 50% of permissible prescriptions written by an eligible provider are queried for a drug formulary as well as transmitted electronically.

There are exclusions in play. Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period may claim the exclusion or the eligible provider who does not have a pharmacy in their organization or within 10 miles of the practice that accepts electronic prescriptions at the start of the EHR reporting period. Those practices especially those that are in an urban setting that would not apply.

Objective 5 is the Health Information Exchange. The change from 2015 is that eligible providers in their first year of the program must meet the objective instead of claiming an exclusion. In order to meet the measure for the Health Information Exchange, an eligible provider who refers a patient to another provider or transitions a patient to another setting must use Certified EHR Technology to create a Summary of Care Record, and electronically transmit it to a receiving provider for more than 10% of referrals and transitions of care. Exclusion available to any EP who has fewer than 100 referrals or transitions of care during the EHR reporting period.

Is listed as Objective 6. The change is from 2015 and that would be for eligible providers in the first year of the program, they must meet this objective instead of claiming an exclusion that was available prior. To measure, more than 10% of all unique patients seen by the eligible provider during the EHR reporting period are given patient specific education resources that were identified by Certified EHR Technology. Exclusion that is available and that would apply to any eligible provider who has no office visits during the EHF reporting period. If that would be the case they can be excluded from measure.

Medication Reconciliation is objective 7. The change from the 2015 reporting period applies that eligible providers in the first year of the program must now meet this objective instead of being able to claim an exclusion. In order to measure, eligible providers must perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into care of the eligible provider. The exclusion that can be used only for eligible provider who was not the recipient of a transition of care at any time during the EHR reporting period.

Objective 8 is Patient Electronic Access. The change from the 2015 reporting period applies that eligible providers in the first year of the program must meet both measures instead of claiming an exclusion for Measure 2. To meet this objective, the eligible provider must satisfy both Measure 1 and Measure 2. If you Measure 1, it states that more than 50% of all unique patients seen by the eligible provider during the EHR reporting period are provided timely access to

view online, download and transmit to a third party their health information subject to the EPs discretion to withhold certain information.

Exclusions that may be taken for this measure include an eligible provider who neither orders nor creates any of the information listed for the inclusion as part of the measures. They may be excluded. Also, an eligible provider with restricted broadband capability on the very first day that the reporting period begins may take an exclusion from this measure.

Measure 2 of Patient Electronic Access states that at least 1 patient seen by the eligible provider during the EHR reporting period views, downloads or transmits his/her health information to a third party during the EHR reporting period. An exclusion can be taken if an eligible provider who neither orders nor creates any of the information listed for inclusion as part of the measures, they may take the exclusion then.

Also, eligible providers who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4 megabytes of broadband availability according to the latest information available from the FCC on the very first day that the reporting period begins, if that be the case, they may be excluded from the measure.

Objective 9 pertains to Secure Messaging. There is a change from the 2015 reporting period measures and it applies for 2016 stating that the eligible provider must send a message to at least 1 patient using the patient portal. Also, eligible providers in the first year of the program must meet this objective now instead of claiming an exclusion. To measure, the eligible provider must send a secure electronic message using electronic messaging function of the Certified EHR Tehcnology to at least 1 patient or representative during the EHR reporting period.

A reply to the patient's message also counts for this measure. The measure is focused on the eligible provider's action rather than the patient-initiated action. Exclusions can be taken for this measure however and any eligible provider who has no office visits during the EHR reporting period may take the exclusion. An eligible provider with restricted broadband capability on the first day of the reporting period can be excluded from meeting this measure.

We move to Objective 10, which is the Public Health Reporting measure. There is a change made from the 2015 reporting period for 2016 and they state the the alternate exclusions are not available for anyone and eligible providers in the first year of program. They must all now meet 2 measures instead of 1. In 2016, all eligible providers must meet 2 measures and eligible hospitals and critical access hospitals must meet 3 measures. The health measures as we discussed earlier would be for Measure 1 Immunization Registry Reporting, Measure 2 would be Syndromic Surveillance Reporting, and 3 would be the Specialized Registry Reporting.

Active engagement as defined by CMS is [inaudible 00:22:59] as registry or syndromic surveillance reporting. There are three phases of active engagement. Phase number 1 would be completing registrations to submit the data. Phase 2 would be the testing and validation portion also known as onboard and 3 would be the actual production.

Phase 1 of active engagement, you must complete the registration and submit the data. Eligible providers must contact the Public Health Agency or Clinical Data Registry prior to or within the first 60 days of the EHR reporting period and notify them that they intend to report. Deadline to register for 2016 is February 29th so please if you haven't already done so, that time frame is coming up shortly so make sure that you select the registry that you intend to report to. This phase of active engagement also continues until the testing begins.

Phase 2 of active engagement, the testing and validation portion, an eligible provider receives an invitation from the PHA or the CDR to begin testing electronic submission of the data. An eligible provider must respond to the request from the PHA or CDR within 30 days of the initial request. If an EP fails to respond to the PHA or CDRs second request within 30 days, the objective cannot be met and Meaningful Use therefore would not be achieved.

Phase 3 of the active engagement is the production phase. Testing and validation is completed and the eligible provider is electronically then submitting data to the PHA or the CDR.

[inaudible 00:24:56] Immunization Registry Reporting. To meet the measure, eligible providers must actively engage with a public health agency to submit immunization data. As far as exclusions that are available however, eligible provider that does not administer immunizations during the EHR reporting period is excluded from meeting the measure. Eligible providers who operate in a jurisdiction for which no immunization registry [inaudible 00:25:27] ability to or capability to accept specific standards required to meet the Certified EHR Technology definition at the start of the EHR reporting period are all still excluded.

Eligible providers who operate in a jurisdiction where no immunization registry has declared readiness to receive immunization data at the start of the EHR reporting period may also take an exclusion for meeting this measure.

Measure 2, Syndromic Surveillance Reporting, eligible provider must be in an active engagement with a public health agency to submit syndromic surveillance data. Exclusions are applicable for some measures and they include that an eligible provider is not in a category or providers from which ambulatory syndromic surveillance is collected by their jurisdiction's syndromic surveilance system. You must check with your home states and locales for the availability.

Eligible provider, who is also operating in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance from eligible providers and the specific standards required to meet the Certified EHR Technology definition at the start of the EHR reporting period are also excluded. Eligible providers operating in a jurisdication where no PHA has declared readiness to receive syndromic surveillance from the eligible provider at start of EHR reporting period can also take an exclusion from meeting this measure.

Only 17 states have a PHA set up accepting registrations for syndromic surveillance reporting from physician's offices. If we look at the list, only Pennsylvania applies of the 5 states that are on the call today in which syndromic surveillance is currently available. Once again, you need to check with your state locale for the availability of if and when syndromic surveillance does become available.

Measure 3, you have Specialized Registry Reporting. This measure is for an eligible provider to be actively engaged in submitting data to a specialized registry. There are exclusions that can be applied for that however such as eligible providers do not diagnose or treat any disease or condition associated with, or collect any relevant data that is collected by a specialized registry in their jurisdiction during the EHR reporting period.

Also, an exclusion can be taken for eligible providers who operate in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in specific standards required to meet the Certified EHR Technology definition at the start of the EHR reporting period. Also, eligible providers who operate in a jurisdiction for which no specialized registry has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

Specialized Registry Reporting Options such as the cancer registry, participation is usually limited to eligible providers that diagnose and treat cancer but please once again, check with your state registry to see if you can submit the data based on your specialty. If your EHR system is not capable of submitting data to the cancer registry, this does not allow you to take a standard exclusion.

Specialized Registries Reporting Options. Making sure that you check your state health department for registries that are available. Check for a clinical data registry that is run by a National or a Specialty Society that you are engaged with as a member of and ask if they have a qualified clinical data registry. Just because your vendor has the capability to submit to the national specialized registries, it is not required that you report to one. If EP for example, does not diagnose or treat cancer patients, and does not belong to a specialized society that accepts the data, the eligible provider can claim an exclusion from this measure.

If an eligible provider cannot pass two of the measures, then the eligible provider must be able to qualify for the standard exclusion for all 3 measures or pass 1 and take the standard exclusions for the other 2 measures.

They are related to Objective 10 that we find to be frequently asked. Question 1 would be an example of a provider who is excluded from immunizations because I do not administer them. I registered intent for syndromic surveillance. My Electronic Health Record vendor is able to report to 10 specialized registries, but will charge me. Am I required to pay the vendor to report to a specialized registry in order to pass this objective?

The answer to that question would be that CMS does not allow cost to [inaudible 00:31:10] for a provider to take an exclusion. In order to attest to the specialty registry, the registry needs to be a specialty society, that the provider is affiliated with or a member of and the provider is able to submit data to that registry.

Just because the vendor has this option available, if the eligible provider is not a member of the society, the vendor can submit the data to, the EP is then not required to consider any of these registries. Keep in mind that the provider is not required to go through the EHR system to submit the data to the specialized registry. The data does need to be submitted electronically but does not have to be done through the EHR system.

Question that we see is, for example, if I get audited, what documentation is acceptable to show that I have registered to report to a specialized registry? The answer would be that CMS is still finalizing this guideline. However, ONC, which is the Office of the National Coordinator stated that you need a confirmation from the registry that you registered your intent. Here [inaudible 00:32:30] for example, if you registered your intent, you normally receive an email confirmation stating so. We recommend that the providers hold on to that email as clarification that this process has been completed.

On Objective 10, these happen quite often is, what is the definition of submit electronically for specialized registries? Can it be manual entry of data into a web portal of some sort? Well, the answer to that is, that the data needs to come from the EHR system and be submitted electronically but it does not actually need to be submitted through your EHR system. Manual entry would not be considered an electronic submission but it is my understanding that if you pulled a report from EHR and transmitted that electronically, then that would be sufficient to meet measure.

Clinical Quality Measure Reporting. There is no change from the 2015 CQM reporting requirement for 2016. [inaudible 00:33:42] must report on 9 measures from 3 of the 6 listed National Quality Strategy domains. They report measures that do not have a zero denominator unless any of the remaining measures also contain a zero denominator and implemented at least 5 clinical

decision support rules based on at least 4 of the CQMs that you are reporting on.

Quality Insights is still accepting practices to join our Improving Outcomes by Optimizing Your EHR project should you still need assistance. Practices must see Medicare patients however in order to participate. We have a new 2016 Meaningful Use Pocketcard that is available on the My Quality Insights web site and the report cards to track your Meaningful Use status so you can identify those barriers that might prevent you from achieving Meaningful Use in 2016. They are very helpful guides for the practices to use and we strongly encourage that.

Quality Insights Health Information Technology team and we have the state contacts listed for each of the 5 states on the call today. You'll see I am listed here for Pennsylvania so those of you from Pennsylvania, if you need some insight or some additional information, please feel free to contact me at the information ... My email address or my phone number and extension that are listed there. [inaudible 00:35:18] states your contact. From Quality Insights, the HIT teams are listed as well. The questions and answers on the information that was provided. I'll [inaudible 00:35:34] over to Laurie.

Laurie Fink: Thank you, Joe. Yeah, we are going to now go into the question and answer portion of the webinar. If you have any questions, please feel free to type them in either the chat or the Q&A feature on the right of your screen. If you have already submitted a question that you have not received an answer to, it will be addressed during this session. We had a couple of questions submitted and Kathy Wild, who is our Health IT [inaudible 00:36:03] lead has been answering some of them but I'll go ahead and read a couple of them so that everyone is on the same page. If they have a similar question, that information will be useful to them as well.

First question asked, and I think this a common problem that practices experienced is that, almost 75% of our patients are elderly [inaudible 00:36:27] using the internet or having access to it, and it's very challenging to meet the 50% requirement. What choices do we have? Do you want to answer that?

Kathy Wild: I had typed something in but I'll go ahead. Basically, we realize that that is a barrier to a lot of physicians. CMS, they kept the threshold at 50% even though I know a lot of comments were sent and they had asked them to lower that but they did not. The best suggestion is to ask your elderly patients if they have a family member, maybe a son or daughter, grandchild, anything. Anyone that has an email address that you can go ahead and get them enrolled to use the patient portal.

Be sure to tell them about all the advantages of that, getting your lab work earlier, getting a copy of their visit summary that goes over what was discussed that day, all those kind of things. If they have someone that's younger than ... Is computer savvy, they might want to share that information with them to go

over it and get a better understanding of it. That's the best idea at this time for those people that don't have computers or an email address.

Joe Pinto: Good, Kathy on that. We run into that quite frequently in the practice settings and especially with the internal medicine providers, who do see a large portion of med care population of patients over the age of 65. Once again, as Kathy reiterated is getting the family involved in this more so because if patients are elderly and they do not have internet access or they just are not computer savvy, getting the family involved in this to actively engage on their behalf is really the only way you can focus on getting those numbers up.

Laurie Fink: This question asks, do you have a list of specialized registry specific to orthopedics, sports medicine and podiatry?

Kathy Wild: Oh, I could answer that. Yes, in My Quality Insights, we do have [inaudible 00:39:08] resource posted there that the AMA put together. It's a list of registries divided by different specialties. One thing I wanted you to know is that what CMS has said is that, the physicians should see what kind of societies they currently belong to and check with the society they belong to ... I don't know if there's an orthopedic association, I would assume so. They have a registry that they can report to and then that's the registry that they should use to go ahead and report.

Once again we do have that posted on My Quality Insights. For everyone that belongs to this project, you would want to have access to that and if you're not already registered, just reach out to your contact person from the state and we will go ahead and make sure tht you can go ahead and get that easily.

Joe Pinto: I'd like to just add as well in addition to that. You can also check with the Department of Health in the state. I know here in Pennsylvania, they do have a listing of the registries that are available with all different types of specialties on the Department of Health's web site. That's also a good resource to access and find out exactly which registries are available in the state that you practice in.

Kathy Wild: I didn't know Pennsylvania had that. Do specialists besides the cancer registry and [inaudible 00:40:41]?

Joe Pinto: [inaudible 00:40:44].

Kathy Wild: Oh, great. That's a great resource.

Laurie Fink: Next question asks, what is the best resource for a pediatrician to find a syndromic or specialized registry?

Kathy Wild: Depending on where the pediatrician practices. Pennsylvania is the only of our 5 states that actually is expecting syndromic surveillance. The other states do not have any intention at this time to ever accept that from a physician practice.

You would be excluded from that measure. For specialists, it would be advisable to contact if you belong to a pediatric society to see if they have a registry available.

We have a listing on our My Quality Insights and the resources [inaudible 00:41:36]. Then you might want to check the Pennsylvania Department of Health because they might be national society listings also.

Joe Pinto: Also, I just wanted to add too that as Kathy was talking about the syndromic surveillance, just one note for those providers here in the State of Pennsylvania, we do have syndromic surveillance however it is only available for ambulatory data submission from hospitals and urgent care centers. For pediatricians or other specialties, you can register your intent to submit the data but you then have to take option 1 with the exclusion for that because you [inaudible 00:42:22] cannot report on the data at this time. Only hospitals and urgent care centers are able to report on ambulatory data to the syndromic surveillance registry.

Laurie Fink: This question is in regards to Objective 8, Patient Electronic Access. It asks, is there a specific number of days that meets the "timely access?"

Kathy Wild: That would be 4 days.

Joe Pinto: Yes, 4 days.

Laurie Fink: Is syndromic surveillance application for Pennsylvania available from the VA Department of Health and where would I get this?

Joe Pinto: [crosstalk 00:43:19] I think I might have the web site. It's actually ... [inaudible 00:43:25], could you post the web site link to this later on the session because there is a web ... Actually, web server [inaudible 00:43:32] state.va and it's a whole web link that I have that you can actually click on and that will take you to the registration for syndromic surveillance. You can register your intent and then will receive an email verification from the Department of Health stating that you successfully registered your intent. However, they are unable to begin the onboarding process at this time. If we were able to link that later, we absolutely can put that ... Or on the My Quality Insights web site.

Laurie Fink: We'll probably just post that on the My Quality Insights web site and everyone can access the link there.

Joe Pinto: Okay.

Laurie Fink: One of our attendees is looking for a little bit more confirmation on an answer. It asks, are the surgical specialists who does not immunizations, does diagnose cancer, [inaudible 00:44:33] Objective number 10 by being registered for a PA

cancer registry and being registered for intent with my surgical specialty registry?

Joe Pinto: Did it say which state they are in?

Laurie Fink: In Pennsylvania.

Joe Pinto: Okay, Pennsylvania. For the registry, the requirements first and foremost is your EHR vendor must be certified to report cancer registry. That's something that the provider needs to contact their vendor to find whether or not their particular Certified EHR Technology has been certified to report cancer registry.

There are also the additional fees to purchase a module from the individual EHR vendor depending on which system that they're using as well as there may be some additional fees from the registry themselves. This is something that they can get more clarification from the vendor. In order to submit to the cancer registry in Pennsylvania, the EHR vendor must be certified in order to do so.

Laurie Fink: Another question asks, if we are unable to get the labs and radiology to work on our EHR but met everything else, does that mean we don't qualify?

Kathy Wild: We need some labs. In other words, [inaudible 00:46:23] the numerator ... Is the report showing zero? I guess we would need more information. What [inaudible 00:46:31] is because the EHR report should show a denominator for those. They're coming up both a zero for this one and zero or less than a hundred they can claim the exclusion for the radiology and labs. I'd send more information for that question to answer it.

Joe Pinto: Yeah, I think we need a little more clarification on whether this was a reporting issue with their EHR technology or an interfacing problem.

Laurie Fink: Regarding clinical decision support, we don't have rules set up but I am having difficulty with the specialists in our practice meeting 5 CDS. Able to modify the CDS rules now for 2016 and still meet Meaningful Use. It seems to not add new CDS rules.

Kathy Wild: The CDS rules and interventions must be in place for the entire reporting period, which unless you're a new provider, the reporting period would have started January 1st. You would not be able to create a new rule because it's already February 9th. You would not be able to show that those rules were used the whole 365 days. [inaudible 00:48:08] meeting them ... The threshold for those so all I have to do is make sure that at least 5 alerts or pop ups or whatever you want to call them, have been implemented and then at least 4 of them have to do with the clinical quality measures that you're picking.

Smoking could be one. You could be doing something with obesity. Let me see. I don't know what kind of specialty you are but those are ... Hypertension is

another one so if you're checking blood pressure then you can report that but it all depends ... Every [inaudible 00:48:48] has different alerts that are ... You kind of have to check with your vendor to see what ones they have available and you have to make sure that they are, first and foremost, enable that whole reporting period. Joe, do you have anything to add to that?

Joe Pinto: You stated exactly how I was going to state it. The only other point I'd like to make is, if the practice is going to their very first year of Meaningful Use in 2016, you will have to have 5 CDS rules in place like everyone else starting for 2016 instead of one the first year. They had a little bit of leeway because their reporting period is only going to be 90 days. If they haven't turned on their CDS rules yet, they do have time to do so because they would just push their reporting period to a later date but as Kathy indicated, if this is their second, third, fourth or fifth year of Meaningful Use, those CDS rules must be in place and active prior to the start of the reporting period.

Laurie Fink: The next question, [inaudible 00:50:14] public health reporting. [inaudible 00:50:17] report to specialized registries. I don't do immunizations or have syndromic surveillance available. Must we be a member of the society to submit data?

Kathy Wild: I am going to say no, you do not need to be. What CMS did in one of their clarification is kind of give the providers I think a little bit of leeway. That would be like the first place to look is if ... You want this reporting to a registry. You don't want to just do it to meet Meaningful Use. You want it to be meaningful for you, your practice and for improving the quality of care to your patients.

The thing you would do is, if you are a surgeon or an orthopedic or whatever, look to that society you belong to, to see if there's some type of registry reporting. Often, you would go ahead and you would pick some that are most applicable and they're going to be able to give some data, meaningful data that are applicable to your practice because otherwise it would be worthless. Joe?

Joe Pinto: You had just stated exactly what I was going to state on that. The only thing that we do recommend is, when it comes to the specialized registry, to check ... Even if you are not a member of the medical society, your area, you also check with which ever organization ... The organizations of your specialty. If you're orthopedics, if you're pediatrics, you can check with the individual organizations that are pertinent to your specialty for some clarifications on ... Also some advice on who they think ... Which registries do they think are available in your state or in your locale in which you have the option of registering for. It also comes down to the availability of your EHR vendor and whether or not they have the ability to submit to those registers.

Kathy Wild: [inaudible 00:52:33] Joe, just say we find our registry, a surgical registry but the EHR vendor they have ... Cannot go and submit. I know I've read where it doesn't necessarily have to be electronically from the EHR. There might be another method. Have you heard that?

Joe Pinto: I haven't run into that yet here in the region that I'm in in Pennsylvania however. I really don't feel comfortable answering that because I haven't actually dealt with that myself to provide basically accurate information on how to go about answering that question.

Kathy Wild: I read one sentence that CMS put out about that. The other thing I want to state is that I've heard CMS say that it belongs to an ACO that if an ACO is willing to document that they are accepting data and they go through the different phases where you would submit it and do the testing and validation. CMS would accept you using data to your ACO as a registry but one thing the ACO would have to confirm and document that they are acting as a registry. Have you heard that Joe also?

Joe Pinto: I've heard that but I do know that they have been discussing that. That they have to look at that a little bit more.

Kathy Wild: It's unfortunate but CMS comes out with a couple of things here and there and doesn't go into a lot of detail. I know you're looking to us for answers but this is all new. All we can do is kind of give you the guidance we've heard and I know it's really unfortunate because it's February 9th and they have set a deadline of February 29th for you to go ahead and register with these registries in order to meet Meaningful Use. You definitely have to do that if you need to report to specialized registry. I would go ahead and explore some of those areas and see what you can find out.

Laurie Fink: Another attendee has a question about the onboarding with a specialized registry reporting to the CDCs National Center of Health Statistic to report electronically. They also submit to the GIQuIC, spelled G-I-Q-U-I-C specialized registry. Is the combination okay to meet Objective number 10?

Kathy Wild: I think the GIQuIC is because that's a registry. Submitting to the CDC, I don't know. We'd have to look into that. Is data going directly from the EHR to the CDC or is it a manual? I do a manual entry into the CDC web site. I don't think that will qualify as a registry per se but the GIQuIC is because I know another practice that's doing that. We need more details on that.

Laurie Fink: We're able to use a opt out form and it counted. Is that not still an option for 2016?

Joe Pinto: Opt out form or are they referring to the hardship exception?

Kathy Wild: Thinking about the portal in this, I think what they're saying is some vendors are giving the provider credit when a patient opts out of using the portal and other vendors are not allowing that. I know some are and some aren't. I would say you'd have to check with your vendor and see how they are going to give you credit. The true measure is that 50% of the people are enrolled. If you ask a

patient, would you like to enroll in the portal, and they say, "No, thank you." In reality, you should not be getting credit for that patient as they didn't enroll.

There are some vendors that were saying, "Well, at least we made the attempt." That is a vendor issue. The true meaning of that objective, you should only be receiving credit for how many people are actually enrolled to use the portals.

Laurie Fink: A question is asked for Objective number 5. Does summary of care have to be sent via direct messaging?

Kathy Wild: That answer would be no. There is eClinicalWorks, I don't know the name of it but they have an internal system where you can send it that way and then there's the Health Information Exchange if you want to go that route and use a [inaudible 00:58:07] and [inaudible 00:58:08]. [inaudible 00:58:10] when all the vendors were certified to be upgraded to 2014 technology, they all had to have the functionality to be able to send and receive direct emails because they're secure and encrypted.

We know for a fact that all EHR vendors can do that because it's the only method now. That's probably the easiest one. The best advice we could give you as far as that is to contact the providers that you normally refer your patients to and ask those providers to give you their direct email address if you don't have it. If they tell you they don't have an EHR or they're not participating in Meaningful Use, don't know what you're talking about, then you might want to explain to them, well, I am participating in Meaningful Use so I'm required to send a [inaudible 00:59:07] care document for all of my referrals electronically.

Unfortunately, if I can't send these to you, I could lose and be penalized by Medicare by not doing this therefore we have to stop referring my patients to see you until you're capable of receiving them. Hopefully, that might entice them because that would hurt their practice also if they see the referrals coming down. Maybe then that would get them involved to at least be able to accept direct email [inaudible 00:59:41].

Laurie Fink: Have time for just one more question and if we do not get to your question, we will make sure we get back to you with answers to all your questions after the webinar presentation. For the last question, it asks, can you explain standard and alternate level exclusions?

Kathy Wild: For 2016, all we need to tell you is, the only measure that's going to have alternate exclusions is CPOE. In 2015, because CMS released that final rule so late [inaudible 01:00:23], they allowed providers to be able to attest to Meaningful Use and claim a lot of alternate exclusions. All of them went away for 2106 except for CPOE. Only ones that went away for that are the radiology and the laboratory reporting and that's only for new doctors. That's only going to be available for a small percentage. Otherwise, all you have available are the regular exclusions.

Laurie Fink: That puts us to the 3 o'clock hour. I want to thank you, Joe and Kathy so much and also, thanks to everyone for joining us today. Hope you found this information helpful and if you have any additional questions, please [inaudible 01:01:17] to state Quality Insights Health IT lead. We have a very brief evaluation at the close of the session. Please take a minute to complete it. It helps us to plan future programs. With that, I'd like to thank you again for taking time out of your day to join us for this session. Have a great day.

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This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization for West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QI-B4-021216A