2016 Meaningful Use Requirements Webinar Unanswered Questions Submitted During the Q&A

The Q&A session that followed the 2016 Meaningful Use Requirements webinar, hosted by the Quality Insights Quality Innovation Network on Tuesday, February 9, 2016, was quite robust. Due to time constrains, we were not able to address all of the questions that were submitted by the session attendees. Please find the answers to all of those questions below.

1. **What if your EHR only has capability to track a limited number of CQMs and you have a zero?**
   Although CMS approved 64 CQMs for meaningful use, many EHR vendors still only have a limited number of CQMs available for physicians to choose from. Physicians must report 9 CQMs from 3 different national quality strategy domains to meet MU. When vendors were certified in 2014, they had to meet the minimum requirement to offer at least 9 CQMs from 3 domains. Since no thresholds are required for CQM reporting, it is acceptable to report a zero in the numerator. A zero in the denominator can also be reported, but only if all of the remaining CQMs available also have a zero in the denominator. In other words, if CMS audited you and asked why you reported one or two CQMs with zeros in the denominator, you would need to provide documentation to show the numerator and denominator for all available measures.

2. **Can Summary of Care be faxed electronically thru your EHR to count for MU?**
   No. Faxing, even electronically through the EHR, does not count towards electronically submitting the summary of care document to another provider.

3. **For clarification, if we submit data for immunizations and take exclusion for syndromic surveillance, must we still report to a registry or can we take an exclusion?**
   The requirement for this objective is to report to two registries. Reporting to an immunization registry does count as one registry. Since you are excluded from syndromic surveillance (SS), you must try to submit to a specialized registry to meet the two registry reporting requirement. Please read the following FAQs from CMS for further clarification: **FAQ 13657**, **FAQ 13653**, **FAQ 11988**.

4. **I am under resources on your website, and I can't find information about specialized registry for Delaware.**
   The information about specialized registry reporting for each state is posted on the My Quality Insights portal, which is only available to practices that have a signed agreement with Quality Insights to work on the HIT project called “Optimizing Your EHR”. At least one person from each practice must be registered for our learning platform to access the resources. From the Quality Insights website, you login and then access My QI from the MEMBERS section in the header. If you

need assistance logging in to our learning platform or want to join the project, please contact your state representative as noted below. Please note that Quality Insights can only work with providers that have Medicare patients or dual eligible patients. Below is a list of the Health IT Leads for each state within our Network.

- **Delaware:** Kathy Wild - krivard@wvmi.org, 877.987.4687, Ext 108
- **Louisiana:** Chris Gatlin - christine.gatlin@hcqis.org, 225.248.7035
- **New Jersey:** Maureen Kelsey - maureen.kelsey@hcqis.org, 732.238.5570, Ext. 2030
- **Pennsylvania:** Joe Pinto - jpinto@wvmi.org, 877.346.6180, Ext. 7817
- **West Virginia:** Paula Clark - pclark@wvmi.org, 304.346.9864, Ext. 3483

5. **Is there a time limit for the syndromic surveillance registry intent-- the same as the immunization registry February 29?**
   Providers must contact syndromic surveillance reporting agencies and complete registration with them by 2/29/16 in order to meet MU in 2016. This is the same deadline as the immunization registry and specialized registry.

6. **So are you saying that if you have not set the 5 Clinical Decisions now, it is too late and you have already failed this measure?**
   The MU objective requirement is that five clinical decision support (CDS) interventions must be implemented at a relevant point in care **for the entire reporting period**. Since almost all providers have a full calendar year reporting period in 2016 the CDS alerts must have been turned on and functional since January 1, the first day of the 2016 reporting period. The only exception is for providers that are participating in the EHR program for the first time in 2016. They have a 90-day reporting period, so they still have an opportunity to meet this measure.

7. **If our vendor does not have two specialized registries that pertain to our practice/specialty and we cannot submit to any registries other than those on their list, what are we to do?**
   Please read the response from CMS for **FAQ 13657.** You did not state whether you are able to report to an immunization registry or syndromic surveillance, but since your question asks about reporting to two specialized registries, I will assume that you are a specialist and cannot report immunizations or SS. Therefore, you should try to find one specialized registry and claim an exclusion for either immunizations or SS. If you are unable to find a specialized registry, then you are excluded from all 3 measures for this objective.

8. **When you say specialized registry, do you mean specific society such as Parkinson's disease, Diabetic Association, etc.?**
   Please read the responses from CMS for the following FAQs about specialized societies - **FAQ 13653, FAQ 11988, FAQ 13413, FAQ 3605.** CMS wants providers to report to registries that are applicable to their practice and patient population. If your practice treats patients with diabetes or Parkinson's disease and there are registries available, then they would count towards meeting this measure.

9. **Are we able to use the Opt Out form in 2016 for patients that do not want to sign up for the portal?**

One of the measures for Objective 8 requires more than 50 percent of all unique patients seen during the reporting period to have timely access to their information via a patient portal or PHR.

Per the Federal Rule published in October, 2015 "*we note that in the EHR Incentive programs, the specifications for measure 1 (to ensure that more than 50 percent of patients are provided access to their health information) allow the provision of access to take many forms and do not require a provider to obtain an email address from the patient. We understand that many CEHRT products may be designed in that fashion, but it is not by the program. If a provider's CEHRT does require a patient e-mail address, but the patient does not have or refuses to provide an e-mail address or elects to "opt out" of participation, it is not prohibited by the EHR Incentive Program requirements nor does it allow the provider to exclude that patient from the denominator. Instead, the provider may still meet the measure by providing that patient all of the necessary information required for the patient to subsequently access their information, obtain access through a patient authorized representative, or otherwise opt-back-in without further action required by the provider.*

The confusion on this issue may relate to the ways in which different EHRs are set up to initiate access for a patient for the first time. The measure does not address the enrollment process or how the initiation process to 'turn on' access for a patient within an EHR system should function. The measure is addressing the health information itself. To count in the numerator, the health information needs to be made available to each patient for view/download/and transmit within 4 days of its availability to the provider every time information is generated.

10. **Under the CQM measure reporting slide, the last point states that the clinical decision support rules should be based on four of the CQMs being reported. What/where is the reference for this relationship?**

This requirement is stated in Objective #2: Clinical Decision Support. Specifically, measure 1 is to "implement 5 CDS interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EP's scope of practice or patient population, the CDS interventions must be related to high priority health conditions. If you get audited, CMS will want to compare the CQMs you reported with the CDS alerts you implemented.

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-B4-021216B