# Joint Public Health Forum & CDC
## Nationwide Webinar

September 21, 2017

## Question and Answer Session
### How to submit or ask questions for the panel members?
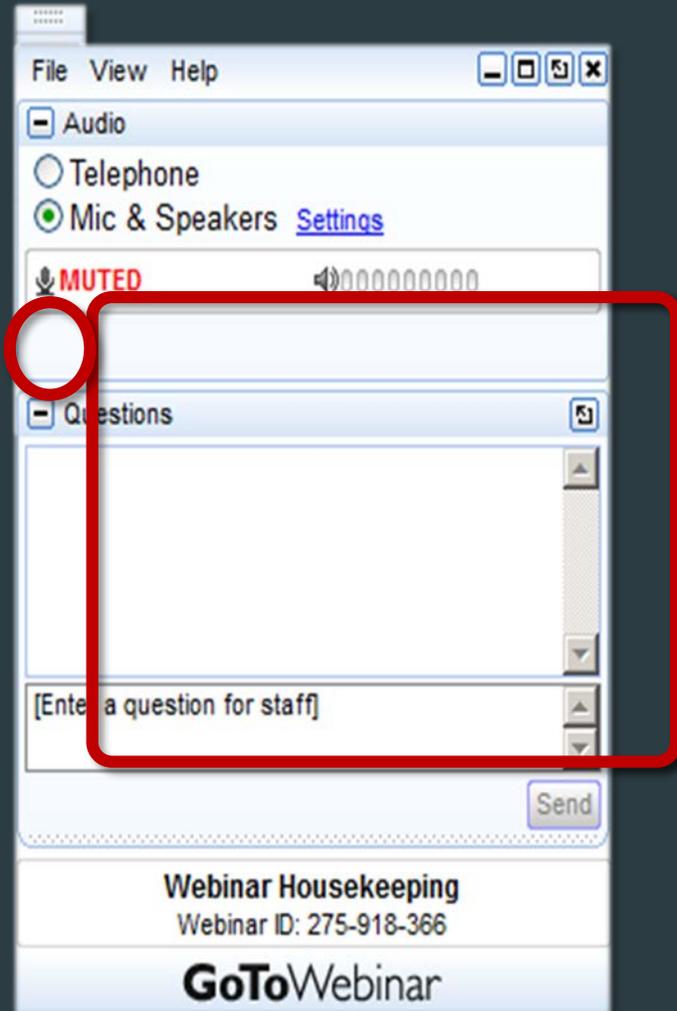


## Submit or Ask Questions

▶ Submit your text question and comments using the Question Panel

▶ Please raise your hand to be unmuted for verbal questions.

Special thanks to the members of the Stage 3 MU Public Health Reporting Requirements Task Force for your continued hard work and your commitment to Public Health.

# An update by the Public Health Stage 3 Task Force on Declaration of Readiness by Public Health Authorities- Meaningful Use Stage 3/MIPS

Meaningful Use Public Health Task Force

# Electronic Health Records Meaningful Use: Terms

MU- Meaningful Use

EHR- Electronic Health Record

EMR- Electronic Medical Record

CMS- Centers for Medicare & Medicaid Services

ONC- Office of the National Coordinator for Health Information Technology

EP- Eligible Professional

EH- Eligible Hospital

CAH- Critical Access Hospital

PHA- Public Health Agency

MACRA-Medicare Access & CHIP(Children Health Insurance Plan) Reauthorization Act of 2015

MIPS-Merit-Based Incentive Payment System (MIPS)

APM-Alternative Payment Models (APMs).

# Meaningful Use Stages



**Stage 1**

Data capture and sharing

**Stage 2**

Advanced clinical processes

**Modified Stage 2** (2014/2015 CEHRT)

Advanced clinical processes

**Stage 3** (2015 CEHRT or 2014/2015)

Improved outcomes

Source : Centers for Medicare & Medicaid Services (CMS)
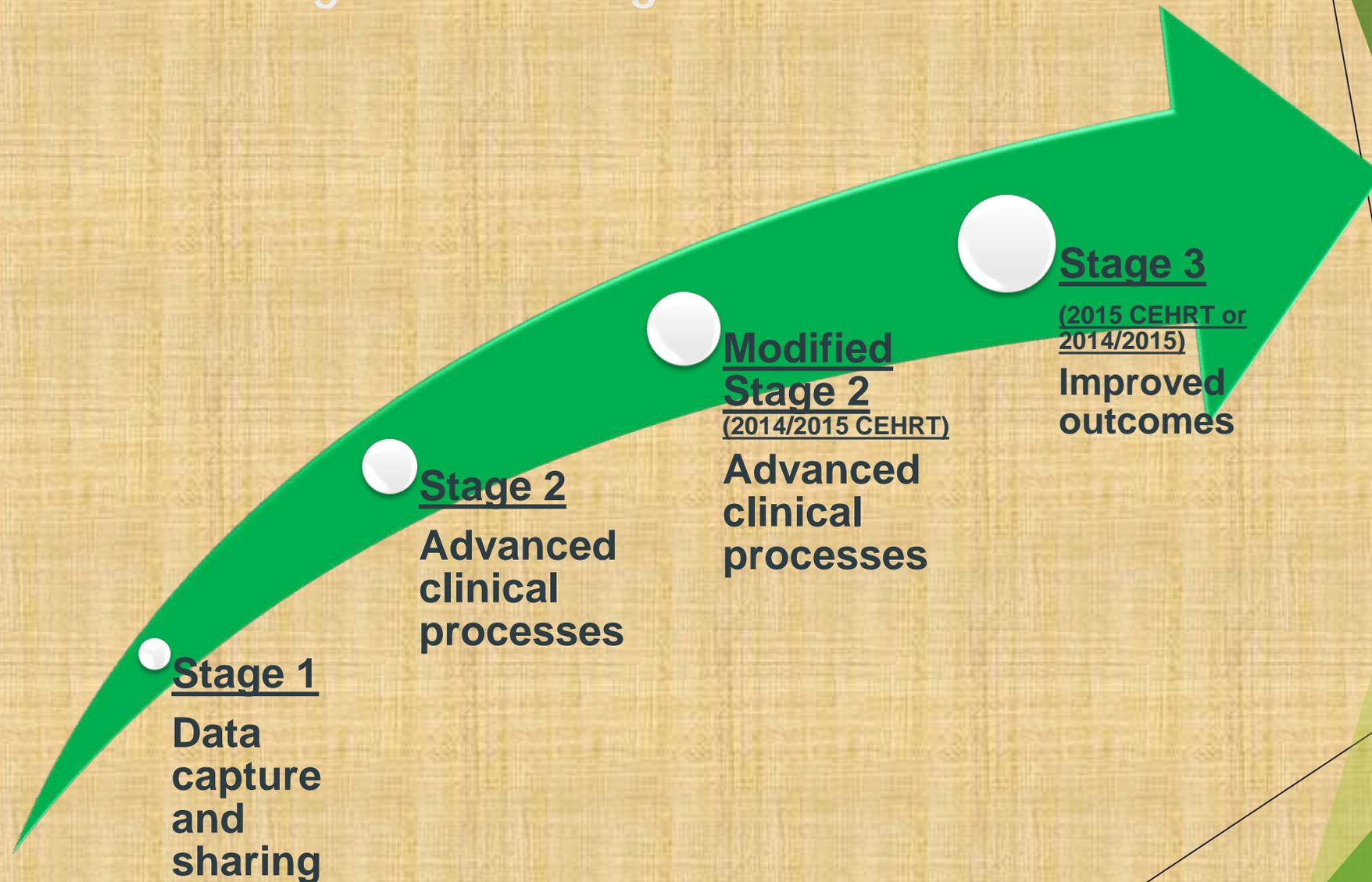
# Federal Rules & Public Health Reporting Requirements : At-a-glance*

| | Prior Final Rules for All Providers | | | | Proposed Rules for All Providers (retroactive to 2017 and 2018) |
|---|---|---|---|---|---|
| **Federal rule** | EHR Incentive Program/Stage 3 Meaningful Use | MACRA, Quality Payment Program (MIPS) | OPPS Rule, Medicare Hospitals (and dual- eligible hospitals) | IPPS Final Rule for 2018 (Medicaid and Medicare Eligible Hospitals and Medicaid EPs)<br><br>Comment period closed: Final Rule must be effective prior to October 1 | QPP Proposed Rule for 2018 (Medicare Eligible Clinicians)<br><br>Comment period Closed August 21st |
| **Eligible provider types** | Medicaid clinicians and hospitals who bill either Medicare or Medicaid | Medicare part B clinicians | Hospitals that attest to Medicare EHR incentive program or both Medicaid and Medicare (dual-eligible) | Medicare and Medicaid EH and Medicaid EP | Medicare eligible clinicians |
| **How rule impacts meaningful use public health reporting** | No more required vs. optional public health reporting options but eligible providers must choose a set number (2 for EPs and 4 for EHs and CAHs) of measures from all that are available (from public health agency) *see OPPS rule column for note on number of measures for Medicare and dual-eligible hospitals | Reduces the overall meaningful use reporting requirements including making all public health reporting optional. The options are the same as in meaningful use.<br><br>All of the public health measures are yes/no vs. numerator/denominator | Revises some MU requirements for hospitals only. Resets number of required public health options to report on at 3 for EH and CAH. | No more required vs. optional public health reporting options but eligible providers must choose a set number (2 for EPs and 3 for EHs and CAHs) of measures from all that are available (from public health agency) *see OPPS rule column for note on number of measures for Medicare and dual-eligible hospitals | Revise requirements for Eligible Clinicians (previously referred to as Eligible Clinicians) |

*Created by the Meaningful Use Public Health Reporting Requirements Task Force

# Public Health Agencies' Declaring Readiness

- Public health agencies (PHAs) should declare readiness six months prior to being able to receive data.
  - Example 1: By July 1, 2017 for service availability January 1, 2018
  - Example 2: By September 15, 2017 for service availability March 15, 2018.
- Declarations hosted on public health authorities' publicly available web pages
  - Example: http://www.dshs.texas.gov/mu/.
- CMS Repository- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CentralizedRepository.zip

# PHA Declaration Contents

- Declaration should include:
  - Which measures will be supported
  - Which specific implementation guides and requirements from the ONC rule(s)
  - Any EH/CAH/EP restrictions or targets based on factors such as provider type
  - Date PHA will begin/began accepting data consistent with the criteria
  - Providers may retain copies of these pages as documentation of public health's status

# Examples of Public Health Registries

- For Antibiotic Resistance/Antibiotic Use, a provider would need to own 2015 edition CEHRT for that module. Beginning January 1st, 2017 the CDC/National Healthcare Safety Network (NHSN) has started accepting registration of intent from healthcare providers to submit data for Antimicrobial Use (AU) and Antimicrobial Resistance (AR) (AUR) reporting, as a new option for public health registry reporting under Meaningful Use Stage 3 (MU3).

- For Hospital Surveys, a provider could report either using a module certified to the 2015 Edition or using 2014 Edition technology which has no specific criteria for this measure.

- For other public health registries such as Prescription Drug Monitoring Program, providers can continue to report using 2014 edition technology without a specific criteria for that measure.

# Centers for Medicare and Medicaid Services Final Rule, August 14, 2017

- ▶ CMS Final Rule published in the Federal Register August 14, 2017
  82 FR 38517

- ▶ Effective Date: October 1, 2017

- ▶ Changes reporting period to 90 days

- ▶ **Extends use of modified Stage 2 through 2018**

- ▶ **Use of Stage 3 criteria is *optional* through 2018**

- ▶ **Requires Stage 3 for EPs, EHs, and CAHs in 2019**

# Reporting Period for CY 2018

▶ The Centers for Medicare and Medicaid Services has modified the 2018 EHR reporting period from the full calendar year to a minimum of any continuous 90-day period for new and returning participants in the Medicare and Medicaid EHR Incentive Programs for 2018.

▶ MIPS already had a 90 day reporting period for 2018.

▶ Goal is focused on full-year reporting.

▶ An EP, eligible hospital, or CAH may begin the EHR reporting period and implement EHR technology before it is certified.

   ▶ Certification must be in place prior to the <u>end</u> of the EHR reporting period.

   ▶ If the reporting period is completed without certification in place, participant may not be a meaningful EHR user for that EHR reporting period.

# Which CEHRT Will Apply in 2018?

CMS is adopting final policies to allow healthcare providers to use either 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 Edition and 2015 Edition CEHRT, for an EHR reporting period in 2018.

This policy is based on the ongoing monitoring of progress on the deployment and implementation status of EHR technology certified to the 2015 Edition, as well as feedback by stakeholders expressing the need for more time and resources are needed for the transition process.

# Policies included in the IPPS Rule for EHR Incentive Program and Meaningful Use - CEHRT

- In CY 2018, health care providers will have the option to attest to the Modified Stage 2 objectives and measures using 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 and 2015 Edition CEHRT, as long as the EHR technology they possess can support the objectives and measures to which they plan to attest.

- Similarly, health care providers will have the option to attest to the Stage 3 objectives and measures using 2015 Edition CEHRT or a combination of 2014 and 2015 Edition CEHRT, as long as their EHR technology can support the functionalities, objectives and measures for Stage 3.

# MU Stage, CEHRT Version, Balloted Standards and Specialized Registries

- Balloted standards/Implementation guides are currently available for cancer registries, immunization registries, electronic lab reporting, syndromic surveillance, NHSN antimicrobial reporting, and national healthcare surveys.

- To be compliant with Stage 3, public health registries/specialized registries must use message standards/implementation guides recognized by federal rule to be used to meet meaningful use requirements.

- Other registries:  Providers who participate in Stage 2 and begin sending to production systems maintained by public health agencies, regardless of a balloted standard being available, prior to January 1, 2019 may be grandfathered and continue to utilize reporting to the system to meet the appropriate measure in Stage 3.

# Immunization Registry- Stage 3 and 2015 CEHRT Criteria

- Readiness for Stage 3 includes:
  - Compliance with the Implementation Guide, v.1.5
  - The ability to receive and respond to queries (QBP/RSP).
  - The capacity to receive NDC codes (Note: an IIS may also opt to require CVX codes in parallel with NDC codes until full adoption of NDC codes has been completed).
- Registries may choose to support non-vaccinating providers by offering query-only access.

# Cancer Registry (under Public Health Registries) - 2015 CEHRT Criteria

- Implementation Guide for ambulatory provider cancer reporting to state cancer registries is updated to *HL7 CDA ® Release 2 Implementation Guide: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1, DSTU Release 1.1 – US Realm.*

  - Addition of "Modification to the cancer patient's EHR" as a second criterion (trigger) for identifying cancer cases.

# Electronic Reportable Lab Results
# Stage 3 and 2015 CEHRT Criteria

▶ There are no changes to the HL7 implementation guide used for Electronic Laboratory Reporting.

▶ Despite no change, there may be a need to revalidate submissions if a hospital updates or purchases new certified software.

# Syndromic Surveillance – Stage 3 and 2015 CEHRT Criteria

▶ In Stage 3, syndromic surveillance for EPs is limited to professionals in **urgent care settings.**

▶ The messaging guide for hospital surveillance is updated to version 2.0 (formerly the PHIN guide). The rule does not specify a guide for surveillance in ambulatory settings, however the PHIN 2.0 guide is appropriate for use in urgent care ambulatory settings.

▶ The revised guide supports emergency department, urgent care and inpatient settings. While EHs without emergency departments can claim an exclusion for syndromic surveillance, the new guide allows for the transmission of inpatient data.

▶ The PHA may determine if inpatient visits will be accepted in addition to emergency department or urgent care visits.

# Public Health Registries at the Centers for Disease Control and Prevention

▶ **National Center for Health Statistics** – National health care surveys is currently accepting registrations from eligible hospitals, critical access hospitals and eligible professionals.

▶ **National Healthcare Safety Network** – Antimicrobial use and resistance reporting (EH and CAH only) plans to start accepting data in 2018.

▶ A PHA may post information regarding this option on their MU webpage.

# Electronic Case Reporting

- Electronic case reporting is a new option starting in 2018.

- The options for Active Engagement allow for flexibility by the PHA.

  - A PHA may choose to enable registration of intent, register providers, and place them in a "hold" queue if they plan to have case reporting ready in 2018.

# Thank You. Time for Discussion!!

https://www.cdc.gov/ehrmeaningfuluse/Meaningful-Use-MU-Public-Health-PH-Reporting-Requirements-Task-Force.html

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