Washington Update:
A Pulse on QPP, Meaningful Use, and Health IT Policies

Mari Savickis

Vice President, Federal Affairs, CHIME

2017 CHIME Policy Priorities

- Patient Identification
- Regulatory Oversight of Health IT
- Telemedicine/Telehealth
- Interoperability
- Clinical Quality Measurement
- Meaningful Use & MACRA
- Patient Safety
- Alternative Payment Models
- Cybersecurity
- EHR Incentive Program

CHiME

Sometimes working in Washington feels like….

CHiME

Topics for Discussion

I. Year 1 of new administration
II. Congressional Update
III. Meaningful Use & Quality Payment Program Update
    A. IPPS
    B. MIPS
    C. Other policies
IV. Impact of Twenty First Century Cures Act

I. Year 1 – New Administration

High-level Overview – Impact on Health IT

- Seen a flurry of Executive Orders
- Efforts to reduce the budget
- Big-ticket issues dominating airtime stalled health IT issues
- Congressional impact on Administration priorities
- Lots of attention on “regulatory relief”
- Continued focus on opioids – some health IT implications
- VA Telehealth – check out VA Video Connect
- Slow down in pace of rules
- Some political spots slow to fill

Executive Orders

- 45 EO's published to WH website
- Presidential Executive Order Expanding Apprenticeships in America – signed June 15th
- Presidential Executive Order on Strengthening the Cybersecurity of Federal Networks and Critical Infrastructure – signed May 11th
- Presidential Executive Order Establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis – signed March 29th
- Reorganizing Executive Branch – signed March 13th
- Enforcing Regulatory Reform Agenda – signed February 24th
- Reducing Regulation and Controlling Regulatory Costs – Signed January 30th
- Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal – signed January 20th

CHiME

Administration’s FY18 Budget Proposal Submitted to Congress

- The President outlines what he calls "eight pillars of reform":
  1) health reform;
  2) tax reform and simplification;
  3) immigration reform;
  4) reductions in federal spending;
  5) regulatory rollback;
  6) American energy development;
  7) welfare reform; and
  8) education reform.

The budget calls for $69 billion in discretionary funding and another $1,046 billion in mandatory funding.

FY18 HHS Budget Line Items of Note

The HHS budget, which is chronicled in its Budget in Brief, estimates it reduces spending by cutting $665 billion over 10 years by reducing Medicaid spending. Below is a recap of some of the healthcare items:

- **Office of the National Coordinator (ONC):** Would see drop in funding from $60 million at the current level to $38 million (page 97 of budget in brief)
- **Office for Civil Rights (OCR):** Would see a drop in funding from $39 million to $33 million
- **Centers for Medicare and Medicaid Services (CMS):** Would see an increase of $13 billion to its current $1 trillion spending
- **Food and Drug Administration (FDA):** Would see an increase of $456 million added to its current level of $5.1 billion
- **Agency for Healthcare Research & Quality (AHRQ):** Would be folded into the National Institutes of Health and will no longer be a stand-alone agency, keeping $272 million in funding for this under NIH

CHiME

So we are we with the Budget?

- Trump and Democrats broker deal to fund Harvey, keep government open, and increase debt limit. Keeps government funded at current FY17 levels through Dec. 8th. More time to work through budget disagreements.
- House and Senate Disagree on ONC Funding Levels for FY18
- The president's budget and the House proposal would cut ONC's budget in FY18 by nearly 40 percent over FY17 levels , to about $38 million. The Senate proposal would maintain the FY17 funding level into FY18, $60 million.
- Patient ID Update! The Senate directs the secretary under ONC's funding explanation "… to study approaches to improve person-centered healthcare through patient access to health information. This work should examine accurately and timely record matching so that EHR systems are collecting the information necessary for a fully interoperable system that protects patients from identity mismatch errors, but also considers patient privacy and security." Further, the Senate appropriators maintains "a provision prohibiting the use of funds to promulgate regulations regarding the individual health identifier."
- CMS budget static during CR.

CHiME

“Regulatory Relief” – CHIME Top Requests

- CHIME sent two letters to Secretary Price in February:
  - Stakeholder letter requesting indefinite delay of MU Stage 3 / Version 2015 CEHRT. Signed by 15 other organizations.
  - Letter detailing CHIME’s “regulatory relief” requests.

Issue	Status
Patient identification: Support private sector-led efforts to locate a solution to patient identification and provide technical support.	Outstanding
Meaningful Use: Indefinitely delay Stage 3 and required use of V15 CEHRT while retaining a 90-day reporting period after 2017.	Achieved
MIPS: Treat 2018 (like 2017) as a transition year removing MU3-like measures under the Advancing Care Information (ACI) part of MIPS.	Achieved
Interoperability: Prioritize adoption of a single set of standards to facilitate interoperability.	Outstanding
Quality: Institute 90-day reporting period for 2017+ & postpone eCQM reporting requirements until adequate technical infrastructure is in place.	Partially Achieved
Telemedicine: Expand coverage of telemedicine services and policies to support payment and delivery reform efforts.	Partially Achieved
Cybersecurity: Encourage investment in good cyber hygiene through positive incentives for providers.	Outstanding

CHiME

CMS RFI's on Regulatory Relief

- Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping, Rural areas, X-rays.
- Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.
- Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.
- Administrative practice and procedures, Biologics, Drugs, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.
- Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.
- Grant programs-health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-ray.
- Administrative practice and procedure, Health facilities, Medicare, Reporting and recordkeeping requirements.
- Health facilities, Medicare, Reporting and recordkeeping requirements.
- Administrative practice and procedure, Electronic health records, Health facilities, Health professions, Health maintenance organizations (HMO), Medicaid, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.
- CMS is particularly interested in ways to incent organizations and clinicians treating patients with opioid addictions.

CHiME

II. Congressional Affairs Update

Key Congressional Actions in Play

Big Ticket Items

What's been done	What's left to do
Government Funding	Children's Health Insurance Plan
Debt Ceiling Increase	Affordable Care Act Repeal/Replace/Reform Action may done via reconciliation
Disaster Funds/Harvey Relief	Insfrastructure?
Food and Drug Administration User Fees	Tax reform?
	Medicare Extenders – expire at end of 2017 – may carry other policies

NOTE: Congress recesses Dec. 15th

Meaningful Use Grabs Congressional Attention

- Markup Update
- H.R. 3120 - To amend title XVIII of the Social Security Act to reduce the volume of future electronic health record-related significant hardship requests
  - Original HITECH language: *The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.*
  - H.R. 3120 proposal: *The Secretary shall seek to improve the use of electronic health records and health care quality over time.* ~~by requiring more stringent measures of meaningful use selected under this paragraph.~~
- July Hearing: "**Examining Bipartisan Legislation to Improve the Medicare Program**"
- Cletis Earle, CIO of Kaleida Health and Chair-Elect of the CHIME Board of Trustees testified

CHiME

Other Health IT Bills to Note

- Every Prescription Conveyed Securely (EPCS) Act (H.R. 3528) - Mandatory e-Prescribing of Controlled Substances in Medicare Part D by 2020
- Improving Access to Behavioral Health Information Technology Act (S.1732) / (H.R. 3331) – CMMI Project to Expand Incentive for EHRs into behavioral health space
- Internet of Things (IoT) Cybersecurity Improvement Act of 2017 (S.1691) – Addresses standards for govt procured IoT devices
- Jessie's Law (S.581) – Best practices for capture and sharing of highlight painkiller sensitivities to make doctors more aware of patients with opioid addiction by highlighting that information in their medical records

CHiME

III. Meaningful Use & Quality Payment Program Update

Tracking the Rules in Play

Rules published in 2017 affected 2018 reporting and policies			
CMS Rules	Proposed	Comments due on Proposed	Final / expected
Hospital Inpatient Prospective Payment System (IPPS)	April 14	June 13th	August 2nd
Quality Payment Program (QPP)	June 20	August 21st	Fall
Physician Fee Schedule (PFS)	July 13	September 11th	End of November

CHiME

The Rules in Play

Rule	Affected Providers	Link
Stage 3 & Modified Stage 2 Meaningful Use Final Rule	Hospitals, CAHs, Medicaid, Medicare clinicians (QPP has supplanted their requirements)	Rule
OPPS Final Rule for 2017	Hospitals, CAHs, Medicaid	Rule
QPP Year 1 Final Rule	Medicare clinicians mostly. But has info blocking requirements for all.	Rule
QPP Year 2 rule (proposed)	Medicare clinicians	Rule CMS fact sheet here.
CERHT 2015 Final Rule	Vendors	Rule
IPPS final rule for 2018	Hospitals, CAHs, Medicaid, Medicare clinicians	Rule CMS fact sheet here

CHiME

The Various Flavors of Meaningful Use: Keeping it all Straight

	Meaningful Use Measures				QPP Rule Finalized in 2017		QPP PROPOSED Changes for 2018 in QPP reg for Year 2	
	Modified Stage 2 2017 and 2018	Stage 3 2017 & 2018: optional 2019: mandatory	Modified Stage 2 2017 & 2018	Stage 3 2019: mandatory 2017 & 2018: voluntary	MIPS ACI Transition Measures 2017 ONLY	MIPS ACI Stage 3-like measures 2018: mandatory 2017: optional	MIPS ACI in 2018 2nd year at transition measures permitted	MIPS ACI Stage 3-like measures in 2018 and 2019 2018: optional 2019: required
Applies to: ➡	*Medicaid EPs and EHs and CAHs attesting under state Medicaid MU*	*Medicaid EPs and EHs and CAHs attesting under state Medicaid MU*	*Medicare EHs and CAHs*	*Medicare EHs and CAHs*	*MIPS eligible clinicians*	*MIPS eligible clinicians*	*MIPS eligible clinicians*	*MIPS eligible clinicians*
Reporting Period: ➡ Objectives: ⬇	2017: 90 days 2018: 90 days	2017: 90 days 2018: 90 days 2019: Full year	2017: 90 days 2018: 90 days	2017: 90 days 2018: 90 days 2019: Full year	2017: 90 days	2017: 90 days 2018: 90 days	2018: 90 days	2018: 90 days 2019: 90 days
Protect Patient Information	Security risk analysis: Required	Security risk analysis: Required	Security risk analysis: Required	Security risk analysis: Required	Security risk analysis: Required Base score only	Security risk analysis: Required Base score only	UNCHANGED Security risk analysis: Required Base score only	UNCHANGED Security risk analysis: Required Base score only
eRx	EP: >50% EH: >10%	EP: >60% EH: >25%	>10%	>25%	Required Base score only	Required Base score only	CHANGED	CHANGED

Updated CHIME Resource: Comparison Chart. Go here.

A. IPPS Rule: Hospitals & Medicaid Providers

What's New for Hospitals, CAHs and Medicaid Providers

- Meaningful Use:
  - Reporting period scaled from back from year to 90 days for 2018; full year after
  - Allowed to continue using 2015 CEHRT / meeting Modified Stage 2 in 2018
- New changes stemming from Cures
  - Exception for those who have had CEHRT decertified
  - EPs that furnish ≥ 75% care in Ambulatory Surgical Center (ASC) carved out
- Fewer eCQMs
  - Measures: Down from 8 to 4 for 2017 and 2018
  - Reporting period: One self-selected quarter 2017 and 2018
  - 2014 CEHRT allowed for 2018
  - If EHR technology is not certified to all 15 available eCQMs available to report, provider will be required to have its EHR technology certified to all 15 eCQMs that are available to report in the Hospital IQR Program.
  - 8 cases / quarter
- Medicaid:
  - Gets 90 days reporting too for MU
  - No change to measures
  - CQMs get 90 days reporting if attesting; doesn't apply to eCQMs

CHiME

B. QPP Year 2 Proposed Rule: Medicare physicians & clinicians

What's new in QPP – the Big Stuff

- Reporting periods and weighting
- Changes to low volume thresholds
- Virtual Group proposal
- Flexibilities for small practices
- New bonus points
- Submission flexibilities
- Incorporating improvement performance scoring under quality
- Option to use facility-based scoring for facility-based clinicians.
- Reweighting ACI category to 0% for ASCs

Reporting Period & Weights

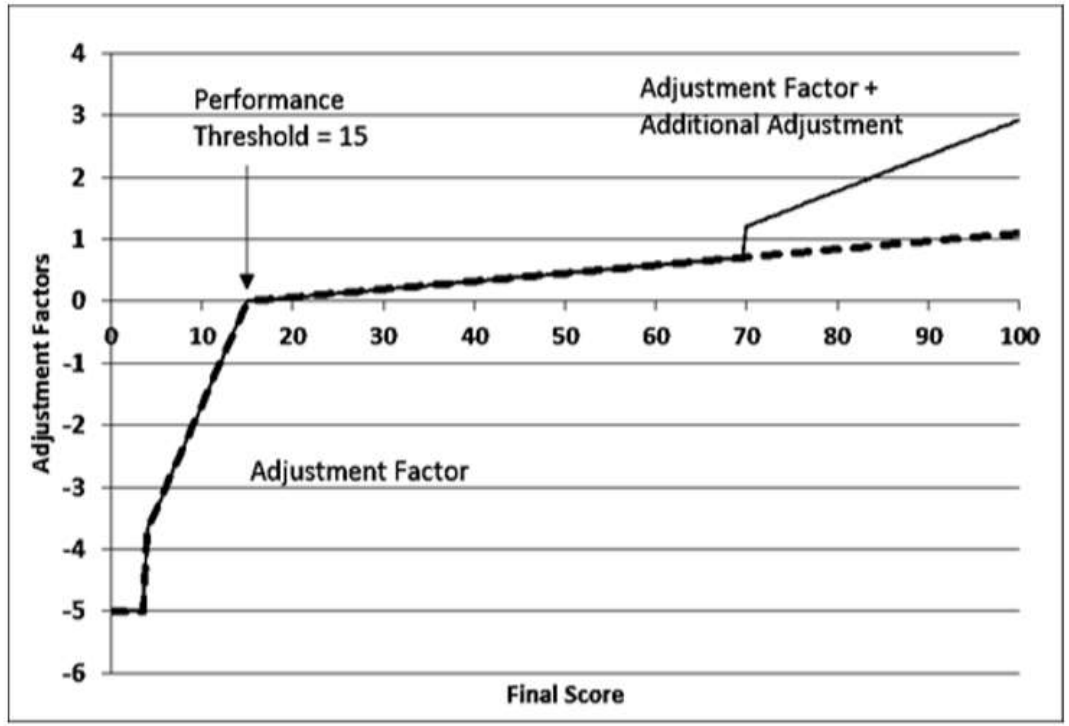
	2017	2018 (as proposed in Year 2 reg)	2019 (as proposed in Year 2 reg)
Cost	**Weight:** 0% **Reporting:** 12 months	**Weight:** 0% (down from 10% as finalized last year) **Reporting:** 12 months	**Weight:** 30% Reporting:
Quality	**Weight:** 60% **Reporting:** 90 days	**Weight:** 60% (up from 50% as finalized last year) **Reporting:** 12 months	**Weight:** 30% **Reporting:** 12 months
IAs	**Weight:** 15% **Reporting:** 90 days	**Weight:** 15% **Reporting:** 90 days	**Weight:** 15% **Reporting:** 90 days
ACI	**Weight:** 25% **Reporting:** 90 days	**Weight:** 25% **Reporting:** 90 days	**Weight:** 25% **Reporting:** 90 days

CHiME

Points, Rewards, Penalties

Issue	2017	Proposed for 2018
Total Penalty / Reward	+/- 4%	+/- 5%
Performance Threshold	3 composite points	15 composite points
Exceptional performance	70 composite points	same

FIGURE A: Illustrative Example of MIPS Payment Adjustment Factors Based on Final Scores and Proposed Performance Threshold and Additional Performance Threshold for the 2020 MIPS Payment Year



Flexibilities for Small Practices

- Change to low-volume threshold

2017	2018	2019
≤$30,000 in Part B allowed charges OR	≤$90,000 in Part B allowed charges OR	-
≤100 Part B beneficiaries	≤200 Part B beneficiaries	-
-	-	Opt-in: Let exempt clinicians in

- New bonus points
  - Up to 5 for small practice bonus.
  - Up to 3 to the final score for caring for complex patients
- New ACI hardships for small practices
  - For those with ≤ 15 clinicians – new hardship category to reweight ACI to 0%
- Virtual Groups
  - Comprised ≤10 clinicians who organize virtually with another such group to participate in MIPS for 1 year
  - Would be under single V group TIN

CHiME

Other Notable Changes

- Improvement: Proposed to reward performance improvement by offering up to 10 percentage points under Quality
- Facility-based Measurement: Would be optional for 2018 offering a voluntary facility-based scoring mechanism based on hospital value-based purchasing program
- ASC policy: Proposes to reweight ASCs automatically to zero for ACI category if deliver 75%+ of your services in ASC (POS code 24). PSC legend here.
- More data submission flexibilities: Multiple mechanism across and with performance categories would be permitted.
- Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists: CMS will assign weight of 0% for ACI if they submit no measures

CHiME

Cost Performance Category

- CMS adopted 2 measures that had been used in the VM:
  - The total per capita costs for all attributed beneficiaries measure; and
  - The Medicare Spending Per Beneficiary (MSPB) Measure
- What CMS did for 2017 in final rule last year:
  - Weighted cost category at 0%
  - Finalized 10% for 2018.
- What CMS is proposing to change for 2018:
  - Keep at 0% another year.
  - Catch is it will jump to 30% in year 3.

Quality Performance Category

	Final for 2017	Proposed for 2018
Weight	For 2017: 60% For 2018: 50% For 2019: 30%	For 2018: 50% For 2019: 30%
Measures	6 measures including at least 1 outcomes measure.	Same
Data Completeness	2017: 50% (Automatically receive 3 points for submitting 1 measure) 2018: 60%	2018: 50% (1 point with small practice exception (15 or fewer clinicians; get 3 points) 2019: 60%
Topped Out Measures	No policy was discussed.	Proposes removing topped out measures 3 years after they have been identified as such removing the measure in the 4th year.
Cross-cutting measure	Had considered for future years.	CMS had planned on requiring a cross-cutting measure but has not done so yet.
Episode Groupers		CMS is sunsetting their older episode-based measures and replacing them with newer ones. The old episode measures will no longer be in use after 2017.

CHiME

Improvement Activities Performance Category

For 2017 need refresher on IA?

See CMS Fact Sheet

For 2018 see:

- Table 6 (page 30060): Proposed new IA's for ACI bonus credit for Year 2
- Table F (page 30479): Proposed new IA's for Year 2+
- Table G (page 30486): Proposed changes to existing IA's for Year 2+

Issue	2017	Propose for 2018
Weight	15%	Same
Points	40 (4 medium or 2 high)	Same
Subcategories	9 including: 1. Expanded Practice Access 2. Population Management 3. Care Coordination 4. Beneficiary Engagement 5. Patient Safety and Practice Assessment 6. Participation in an APM 7. Achieving Health Equity 8. Integrating Behavioral and Mental Health 9. Emergency Preparedness and Response	Same but considering adding a new subcategory specific to health IT
# of IAs	Almost 100	See Tables 6, F & G in rule
Bonus points under ACI	Up to 10% bonus points for performing at least 1 IA (certain ones) using CEHRT under ACI category	• CMS proposing to expand list of activities that afford credit (Table 6) • 10% would still be max credit for 1+ activities.
Patient Medical Home	Clinician working on a certified patient-centered medical home get full IA credit	CMS is changing the term from "certified" to "recognized"

CHiME

Improvement Activities Performance Category: Annual Call for Activities

- For Year 2+ CMS plans would apply 1 or more of below criteria when submitting improvement activities for call for activities:
  - Relevance to an existing improvement activities subcategory (or a proposed new subcategory);
  - Importance of an activity toward achieving improved beneficiary health outcome;
  - Importance of an activity that could lead to improvement in practice to reduce health care disparities;
  - Aligned with patient-centered medical homes;
  - Activities that may be considered for an advancing care information bonus;
  - Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care);
  - Feasible to implement, recognizing importance in minimizing burden, especially for small practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA;
  - Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes; or
  - CMS is able to validate the activity.

CHiME

Advancing Care Information Performance Category

Issue	2017	Propose for 2018
Weight	25% (up to 155 points)	25% (up to 165 points)
Point structure	Base, Performance, Bonus structure Base: 50 points Performance: Up to 90 Bonus: Up to 15 points Total points: 155 points	Maintained but modified Base: Same Performance: Same points but changes to public health scoring Bonus: Up to 25 points Total points 165 point
CEHRT	2017: 2014 or 2015 2018: 2015 mandatory	2017: 2014 or 2015 2018: 2014 or 2015 2019: 2015 mandatory
Immunization measure	Up to 10%; miss and get 0 points for immunization but get try for another 5% bonus with another registry	Up to 10% but if miss can qualify for additional 10% bonus if report on 2 other registries
Transition Measures (aka Modified Stage-2 like measures)	2017: Available to use 2018: Must move to higher measures (aka “Stage 3-like measures”)	2017: Available to use 2018: Available to use 2019: Must move to higher measures (aka “Stage 3-like measures”)
Bonus Points (details)	Up to 10% for meeting certain IAs using CEHRT	CMS calls for expanding list of activities where this extra credit is available NOTE: Extra 10% points ONLY available for those using 2015 CEHRT (not available if using combo)

CHiME

Changes to other Measures Beyond Public Health

- Minor technical corrections that slightly change wording of measures / objectives; other more substantive changes
- eRx: NEW: Proposed Exclusion: Any clinician who writes fewer than 100 permissible prescriptions during the performance period.
- Patient access: NEW: CMS proposes to define “timely” as within 4 business days.
- HIE: NEW: Proposed exclusions:
  - Transition year: For any clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.
  - (Non-transition):
    - Send SoC: Any clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.
    - Request/Accept SoC: For any clinician who receives a ToC or referrals or has patient encounters in which clinician has never before encountered the patient fewer than 100 times during the performance period.

ACI Significant Hardships

- Small provider hardships:
  - For practices ≤ 15 clinicians
  - Reweights points to quality
  - No limitation on years to file
  - Applications due 12/31 of performance year or later.
  - Examples of significant hardship include: lack sufficient internet connectivity, face extreme and uncontrollable circumstances, lack control over the availability of CEHRT, or do not have face-to-face interactions with patients.
- Exceptions de-certified CEHRT:
  - Eligible if product decertified either during the performance period for payment year or during the calendar year preceding the performance period for payment year
  - Will result in 0% weight for ACI
  - Cannot exceed 5 years

CHiME

Extreme & Uncontrollable Circumstances

- Calls for extending policy to the quality & cost performance categories.
- Reweights performance categories if hardship is granted.
- Example include natural disasters in which an EHR or practice location is destroyed.
- NOT included: Inability to renew a lease – even a long or extended lease – nor a facility being found not compliant with federal, state, or local building codes or other requirements would be considered “extreme and uncontrollable circumstances.” Also does not include issues that third party intermediaries, such as EHRs, Qualified Registries, or QCDRs, might have submitting information to MIPS on behalf of a MIPS eligible clinician.
- Filing deadline is 12/31/18 for 2018 performance.

CHiME

Hospital-based Clinician Carve Out

- Largely unchanged
- CMS assigned 0% weight for ACI if meet criteria
- But, if clinician reports on ACI measures they will be scored
- CMS proposing to include covered professional services provided in an off-campus hospital (POS 19)
- POS legend: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

CHiME

Complex Patient and Small Practice Bonus

- CMS proposes to add a complex patient scoring bonus and add a small practice bonus to the final score.
- Considers this approach to be a short-term strategy for 2018 performance year
- Involves accounting for Risk Factors; law requires CMS consider this.
  - CMS is thinking thru policies involving:
    - Social determinants of health (“social risk”)
    - Complex patient bonus:
      - CMS proposes that the complex patient bonus cannot exceed 3 points.
      - To receive the complex patient bonus, CMS proposes that MIPS clinician / APM Entity must submit data on at least 1 measure or activity in a performance category during the performance period

CHiME

Other Bonuses

- Incentives to report high priority measures:
  - CMS awards 2 bonus points per outcome or patient experience measure, and 1 bonus point per additional high priority measure reported provided that the measure has a performance rate greater than zero, and the measure meets the case minimum and data completeness requirements.
  - Bonus points for the CMS Web Interface for the QPP based on the finalized set of measures reportable through that submission mechanism.
  - Cap on bonus points is 10% of quality performance category denominator for the first 2 years of MIPS.
  - No changes for 2018.
- Incentives to Use CEHRT to Support Quality Performance Category Submissions:
  - 1 bonus point available for each quality measure submitted with end-to-end electronic reporting, under certain criteria.
  - Cap on bonus points is 10% of denominator of the quality category score, for the first 2 years of the program.
  - Bonus available to all submission mechanisms except claims submissions.
  - No changes for 2018.

CHiME

Performance feedback

- CMS proposes to provide performance feedback to clinicians / groups on the quality and cost performance categories beginning July 1, 2018 (for the 2017 performance period), and, if feasible also for the IA's and ACI categories if technically feasible.
- Feedback would be provided annually, and more frequently and more often if possible.
- CMS also proposes that the measures and activities specified for the 2017 performance period for all four performance categories along with the final score would be included in performance feedback provided on or about July 1, 2018.

CHiME

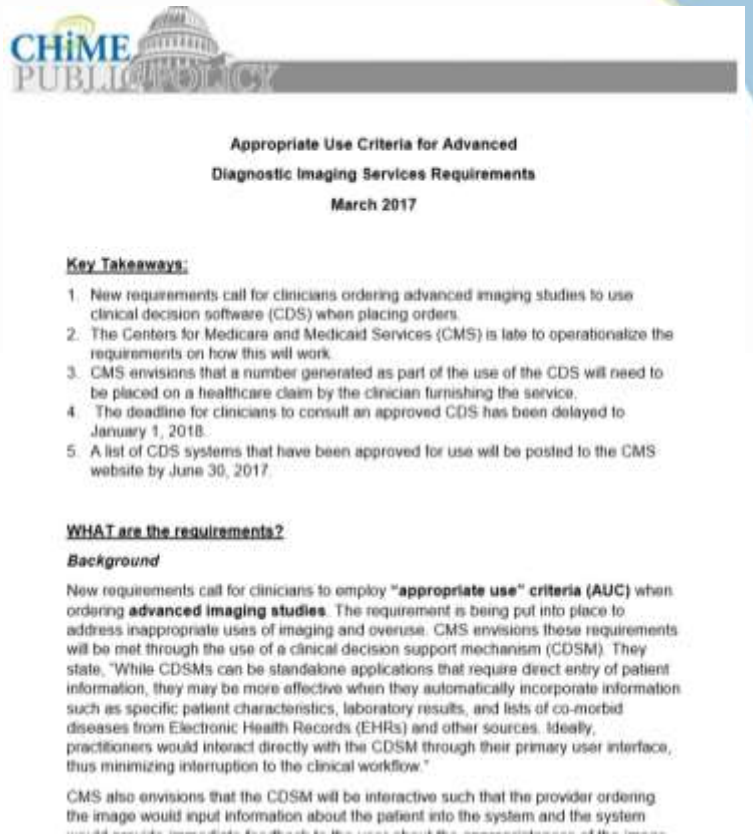
Data Submission to CMS

- US Digital Service is working with CMS
- Seeking feedback on third party data submissions to the agency
- Interested in ensuring data feeds are done successfully and APIs work well

C. Appropriate Use

Appropriate Use: What is it & What's New?

- Congressionally mandated
- Four pieces to the program
- Delayed several times
- Proposed physician fee schedule rule calls for delaying until January 1, 2019
- Under Year 2 QPP proposed Rule CMS calls for adding a new IA that a clinician could choose if they attest they're using AUC through a qualified clinical decision support mechanism for all advanced diagnostic imaging services ordered.
- CHIME Cheat Sheet (will be updated for final rule) here.



CHIME PUBLIC POLICY

Appropriate Use Criteria for Advanced

Diagnostic Imaging Services Requirements

March 2017

Key Takeaways:

1. New requirements call for clinicians ordering advanced imaging studies to use clinical decision software (CDS) when placing orders.
2. The Centers for Medicare and Medicaid Services (CMS) is late to operationalize the requirements on how this will work.
3. CMS envisions that a number generated as part of the use of the CDS will need to be placed on a healthcare claim by the clinician furnishing the service.
4. The deadline for clinicians to consult an approved CDS has been delayed to January 1, 2018.
5. A list of CDS systems that have been approved for use will be posted to the CMS website by June 30, 2017.

WHAT are the requirements?

Background

New requirements call for clinicians to employ **"appropriate use" criteria (AUC)** when ordering **advanced imaging studies**. The requirement is being put into place to address inappropriate uses of imaging and overuse. CMS envisions these requirements will be met through the use of a clinical decision support mechanism (CDSM). They state, "While CDSMs can be standalone applications that require direct entry of patient information, they may be more effective when they automatically incorporate information such as specific patient characteristics, laboratory results, and lists of co-morbid diseases from Electronic Health Records (EHRs) and other sources. Ideally, practitioners would interact directly with the CDSM through their primary user interface, thus minimizing interruption to the clinical workflow."

CMS also envisions that the CDSM will be interactive such that the provider ordering the image would input information about the patient into the system and the system

CHIME

IV. Impact of 21st Century Cures Act

What is 21st Century Cures? Why Should I care?

- The 21st Century Cures Act was signed into law by President Obama on December 13, 2016, finishing nearly 2 years of work by the House Energy & Commerce Committee and Senate HELP Committee
- Key Health IT Provisions:
  - GAO Patient Matching Report within 2 years
  - New Health IT Advisory Committee, focused on standards
  - Information Blocking Attestation Mandated for Technology Vendors
  - Transparency in CERT capabilities, real-world testing mandate
  - Trusted exchange framework to be developed
- A summary of the health IT provisions can found here.

CHiME

New Health IT Advisory Committee

Hill Appointments Thus Far

- **Patrick Soon-Shiong**, biotech billionaire (Speaker Paul Ryan appointed)
- **Steve Ready,** VP & CIO, Norton Healthcare (appointed by Senate Majority Leader Mitch McConnell)
- **Steven Lane**, Sutter Health informatics executive (appointed by House Minority Leader Nancy Pelosi)

GAO Appointments

- **Michael Adcock,** Executive Director of the Center for Telehealth, University of Mississippi Medical Center
- **Christina Caraballo,** Director of Healthcare Transformation at Get Real Health (vendor)
- **Tina Esposito,** VP, Information and Technology Innovation at Advocate Health Care
- **Brad Gescheider,** Senior Director of Provider and Payer Solutions at PatientsLikeMe (software platform where patients can share health info)
- **John Kansky,** President and CEO, Indiana Health Information Exchange,
- **Kensaku Kawamoto, MD,** Associate CMIO, University of Utah Health, and Assistant Professor, University of Utah Department of Biomedical Informatics.
- **Denni McColm,** CIO, Citizens Memorial Healthcare
- **Brett Oliver, MD,** CMIO, Baptist Health & practicing part-time family physician with Baptist Family Physicians
- **Terrence O'Malley, MD,** Geriatrician at Massachusetts General Hospital and Spaulding Nursing and Therapy Center North End
- **Carolyn Petersen,** Patient Advocate and Senior Editor for Mayo Clinic's health information website.
- **Raj Ratwani,** Acting Center Director and Scientific Director of the National Center for Human Factors in Healthcare within MedStar Health, and Assistant Professor at the Georgetown University School of Medicine.
- **Sasha TerMaat**, Director at Epic,
- **Andrew Truscott**, Managing Director for Health and Public Service at Accentur.
- **Sheryl Turney,** Senior Director, All-Payer Claims Database Analytics and Data Policy and Administration at Anthem Blue Cross Blue Shield
- **Denise Webb, MA,** is CIO, Marshfield Clinic Health System and CEO, Marshfield Clinic Information Services, Inc.

CHiME

ONC Update: Measuring Interop

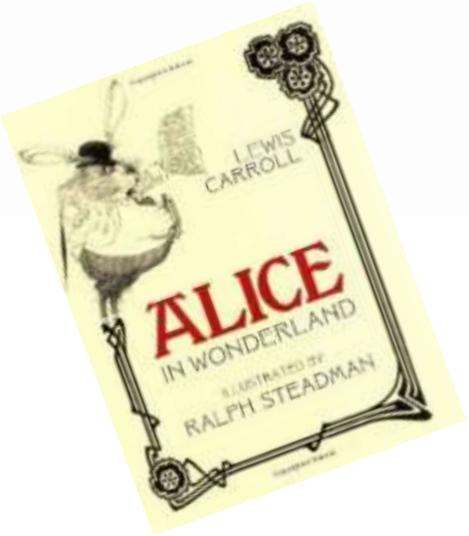
- CHIME submitted comments on ONC's **Proposed Interoperability Standards Measurement Framework**
- Our perspective is it's premature to measure standards – still too much variability.
- Advocated for ONC to consider several key principles:
  - Open standards
  - Universality
  - Context
  - Trust
  - Seamless communication
  - Usability
  - Affordability

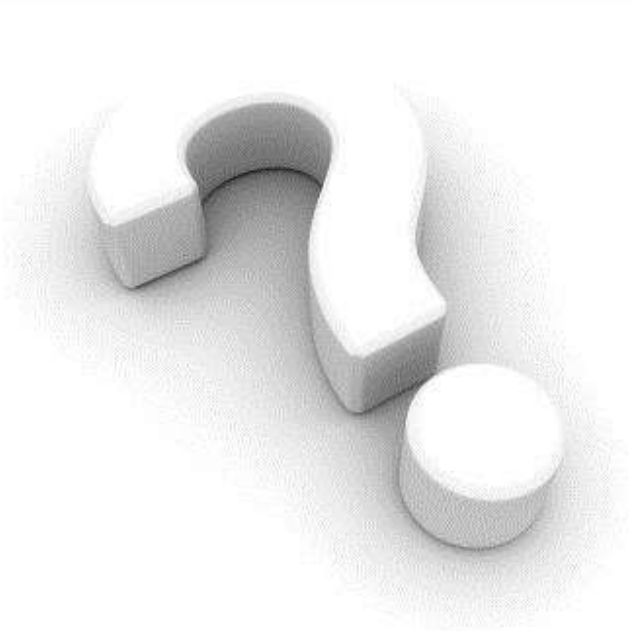
Get Involved in Public Policy

- What's of interest to you?
  - CHIME Ad-hoc Comment Workgroups
  - Issue Area Workgroups
- Questions about regulations or legislation? Are you having difficulty attesting to MU?
  - Public Policy Office Hours
  - Washington Debrief (every Monday morning)
  - CHIME Website

Trivia

1. Total # of pages of rules finalized by end of 2016 providers had to navigate to comply with MACRA, Meaningful Use, and CEHRT in 2017?
2. Month Congress was in session the longest thus far in 2017?
3. What year was Alice in Wonderland written?





Mari Savickis
Vice President, Federal Affairs
(202)294-3828
msavickis@chimecentral.org