28th Annual PHYSICIAN-COMPUTER CONNECTION Symposium
AMDIS Annual Meeting

CMS Update:
Data Transparency, Interoperability, and Protecting Patient Health Information

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Centers for Medicare & Medicaid Services
Region IX

June 19, 2019

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Objectives for today

- CMS Strategic Goals

- Key Initiatives Update
  - My HealthEData Initiative and Blue Button 2.0
  - Telemedicine, Behavioral Health and the Opioid Epidemic
  - QPP and Promoting Interoperability

- Interoperability of Electronic Health Record Technology
  - Reducing Administrative Burden
  - Documentation Simplification and Interoperability
  - Interoperability Proposed Rule

- Questions

CMS Strategic Goals

1. Empower patients and clinicians to make decisions about their health care.

2. Usher in a new era of state flexibility and local leadership.

3. Support innovative approaches to improve quality, accessibility, and affordability.

4. Improve the CMS customer experience.

Advancing Value over Volume

CMS NEWS

FOR IMMEDIATE RELEASE
April 24, 2018

Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

CMS Proposes Changes to Empower Patients and Reduce Administrative Burden
Changes in Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System would advance price transparency and interoperability

Today, the Centers for Medicare & Medicaid Services (CMS) proposed changes to empower patients through better access to hospital price information, improve patients' access to their electronic health records, and make it easier for providers to spend time with their patients. The proposed rule issued today proposes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

"Patients must be at the center of cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families."
– May 7, 2018 Remarks by Administrator Seema Verma at the American Hospital Association Annual Membership Meeting

MyHealthEData Initiative

https://bluebutton.cms.gov/

Giving patients control of their health records

➢ It is NOT acceptable to limit patient records or to prevent them and their doctors from seeing their complete history

➢ Launch "Digital Seniors" initiative: recognize the increasing role of technology in seniors' lives; update Medicare resources accordingly

CMS Blue Button 2.0

Developer Conference · Documentation · Support · Blog · Login · Sign up

API

Blue Button 2.0

A developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to the applications, services and research programs they trust.

View the documentation → · Sign up for the Developer Sandbox →

https://bluebutton.cms.gov

Reduce patient burden: A research organization can pre-populate a medication lists for a patient during clinical trial enrollment.

Streamline information about different kinds of care over time: A primary care physician can access information on other patient care (e.g. related to behavioral health) to better inform treatment.

Uncover new insights that can improve health outcomes: A pharmacy can determine if a beneficiary gets healthier over time due to medication adherence.

Access and monitor health information in one place: A health application can aggregate data into a health dashboard for beneficiaries.

Menu (sidebar)

- Login to MyMedicare.gov
- Advance directives & long-term care
- Electronic prescribing
- Electronic Health Records (EHRs)
- **Medicare's Blue Button & Blue Button 2.0**
  - Find apps to use with Medicare's Blue Button
- Coordinating your care

Medicare's Blue Button & Blue Button 2.0

What's the Medicare Blue Button?

MyMedicare.gov's Blue Button makes it easy for you to download your personal health information to a file. The Blue Button is safe, secure, reliable, and easy to use. You can use the Blue Button to:

- Download and save a file of your personal health information on your computer or other device
- Print or email the information to share with others after you've saved the file
- Import your saved file into other computer-based personal health management tools

What's Blue Button 2.0?

Medicare's Blue Button 2.0 lets you connect your Medicare health information to other services you trust, like:

- Applications (apps)
- Computer-based programs
- Research programs

Blue Button 2.0 gives you a wide range of options to manage and improve your health. Options might include things like:

- Using an app to keep track of the regular tests and services you need based on your personal health information. The app can send you reminders when it's time to schedule your next appointment.
- Using an app or other computer program to track your health over long periods of time. This can help you and your doctor make better decisions about your health.
- Using an app to organize your health information in an easy-to-read format, like charts and graphs. This can help you keep track of important information, like your medicines, allergies, or results of lab tests.

Find someone to talk to

Select your state... ▼

Go

Is my test, item, or service covered?

type your test, item, or service

Go

Medicare.gov

The Official U.S. Government Site for Medicare

| type search term here | **Search** |

| Sign Up / Change Plans | Your Medicare Costs | What Medicare Covers | Drug Coverage (Part D) | Supplements & Other Insurance | Claims & Appeals | Manage Your Health | Forms, Help, & Resources |

Open enrollment is almost here. Are you ready?

🔍 **Find health & drug plans**   ▤ **Compare coverage options** $ **Estimate Medicare costs**

New Medicare cards mailing now   **Learn more**

Address change/Medicare card issue?
| Select your card issue... | **Go** |

Information for my situation
| Select your situation... | **Go** |

Find someone to talk to
| Select your state... | **Go** |

Find doctors, providers, hospitals, plans & suppliers

Find doctors & other health professionals

Find nursing homes

Find hospitals

Find home health services

Find dialysis facilities

| **Blogs** | News | Videos |

Know your body, know the signs for ovarian cancer

Preventing pneumonia is easy

Protect yourself from hepatitis

Take charge, get tested for HIV

✉ **Sign up for email updates from Medicare**

$ **Get help with costs**

☌ **Find out how Medicare works with other insurance**

✉ **Mail you get about Medicare**

✉ **Go paperless: get MSNs or Medicare & You electronically**

Medicare.gov | Medicare Plan Finder

The Official U.S. Government Site for Medicare

| type search term here | Search |

| Medicare Plan Finder Home | Learn More About Plans | Help | Glossary | FAQ |

Home

Find a plan that works for you

Start here to view Medicare Advantage plans (like an HMO or PPO), or Medicare Prescription Drug Plans (Part D).

Basic Search

Enter your ZIP code to see a list of all available plans in your area.

Enter your ZIP code

| Example: 90210 | **Find Plans** |

See a list of plans tailored to you

Log in to MyMedicare

Don't want to log in to your account? Answer the questions below to personalize your search.

Answer these questions to see a list of plans tailored to you

Complete the fields below to see a personalized list of plans without logging in. Your Medicare card includes all necessary information.

Enter your ZIP code

Example: 90210

Medicare Number: ❶

Where can I find my Medicare Number?

Additional Tools

- ◆ Help with your Medicare choices
- ◆ Estimate Medicare Costs
- ◆ Find and compare Medigap policies
- ◆ Find PACE Plan(s)
- ◆ Search by plan name and/or ID
- ◆ Enroll now

Supporting Telemedicine

Mental and Behavioral Health

Figure showing Treating (Billing) Practitioner, Beneficiary, BH Care Manager, Registry, Psychiatric Consultant, Validated Rating Scales, with legend: solid line = Frequent communication, dashed line = Infrequent communication.

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Medicare Telehealth Codes
Updated Jan 1 of each Calendar Year

CPT Code	Short Descriptor
90785	Psychiatric treatment (complex, interactive)
90791	Psychiatric diagnostic evaluation
90845	Psychoanalysis
G0444	Depression screening
90951 - 90964	ESRD Services
96150 - 96154	Behavioral health
97802	Medical nutrition risk assessment
99201 - 99205	Office visit (new patient)
99211 - 99215	Office visit (established patient)
99231	Subsequent Hospital care
99307	Nursing facility care
99354	Prolonged service (office)
99497, 99498	Advanced care planning
G0425	Inpatient/ed teleconsult
G0459	Telehealth inpatient pharmacy mgmt
G0506	Comprehensive assessment care plan (CCM)
G0508, G0509	Critical Care telehealth consult

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

Virtual Care: Physician Payment for Communication Technology-Based Services

2019 Physician Fee Schedule Final Rule

CMS is finalizing our proposals to pay separately for two newly defined physicians' services furnished using communication technology:

- ✓ Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012) and

- ✓ Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)

- ✓ Practitioners could be separately paid for the brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries.

https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

CMS Roadmap
TO ADDRESS THE **OPIOID EPIDEMIC**

Opioids killed more than 42,000 in 2016, or 116 people a day.[2]
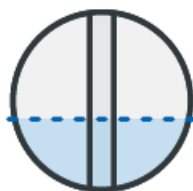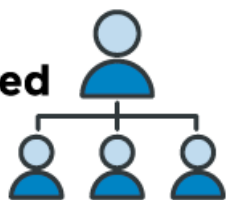
40% of all opioid overdose deaths involve a prescription opioid.[1]

PREVENTION

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

TREATMENT

Expand access to treatment for opioid use disorder

DATA

Use data to target prevention and treatment efforts and to identify fraud and abuse

PRESCRIPTION OPIOID MISUSE

When used correctly, prescription opioids are **helpful** for treating pain.

The CDC outlined **guidelines** for safe prescribing of opioids.

An estimated **11.5 million** people misused prescription opioids[2]—putting them at risk for dependence and addiction.

3 out of 4 people who used heroin misused prescription opioids first.[3]

OPIOID USE DISORDER

Over **two million** people suffer from opioid use disorder.

Treatment **options** exist, including medication-assisted treatment (MAT).

Only 20% of people with opioid use disorder receive treatment.[3]

Learn more about prescription opioid misuse

Learn more about opioid use disorder and treatment

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Medicare Part D Opioid Prescribing Mapping Tool

The Medicare Part D opioid prescribing mapping tool is an interactive tool that shows geographic comparisons, at the state, county, and ZIP code levels, of de-identified Medicare Part D opioid prescription claims – prescriptions written and then submitted to be filled – within the United States. The mapping tool presents Medicare Part D opioid prescribing rates for 2016 as well as the change in opioid prescribing rates from 2013 to 2016.

The mapping tool allows the user to see both the number and percentage of opioid claims at the local level in order to better understand how this critical issue impacts communities nationwide. By openly sharing data in a secure, broad, and interactive way, CMS and the U.S. Department of Health and Human Services (HHS) believe that this level of transparency will inform community awareness among providers and local public health officials.

The data reflect Medicare Part D prescription drug claims prescribed by health care providers. Approximately 70% of Medicare beneficiaries have Medicare prescription drug coverage either from a Part D plan or a Medicare Advantage Plan offering Medicare prescription drug coverage. In 2016, Medicare Part D spending was $146 billion; U.S. retail prescription drug spending was about $329 billion. The mapping tool does not contain beneficiary information nor does the information presented in this tool indicate the quality or appropriateness of care provided by individual physicians or in a given geographic region.

Note: the map will automatically adjust between state, county, and zip code levels as users zoom in or out. Zooming is available by clicking on the zoom buttons in the top left corner of the map, or by using the mouse wheel or keyboard "+" or "-" keys. Users can navigate the map by dragging with the mouse or by using the keyboard arrow keys. To ensure full functionality of the tool, using a browser other than Internet Explorer may be required.

Opioid Mapping Tool

View Prescriber Level Opioid Rates

Download Opioid Map Data

Part D Prescriber Look-up Tool

https://go.cms.gov/opioidheatmap

Medicare Part D Opioid Heat Map

https://go.cms.gov/opioidheatmap

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Opioid Prescribing Rate

This map displays the Medicare Part D opioid prescribing rate for 2016. The Part D opioid prescribing rate reflects the percentage of a prescriber's total Part D claims that are opioid prescriptions.

The map can be used to explore geographic comparisons of the Part D opioid prescribing rate at the state, county, and ZIP code-levels. At each geographic level, the opioid prescribing rate is displayed in quintiles, with darker areas representing higher opioid prescribing rates and lighter areas representing lower prescribing rates.

Users can select specific geographic areas and additional information is displayed, including the national opioid prescribing rate, the number of claims, and the number of prescribers.

Please click here for more information on the methodology.

Long-Acting Opioid Prescribing Rate

Change in Opioid Prescribing Rate

Change in Long-Acting Opioid Prescribing Rate
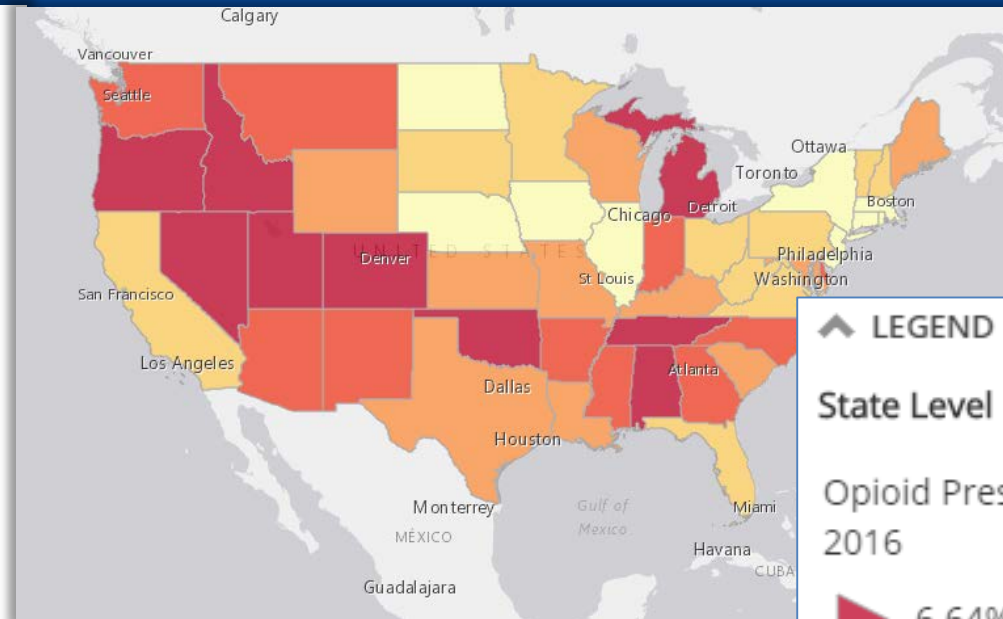
LEGEND

State Level

Opioid Prescribing Rate 2016

- 6.64% to 7.46%
- 5.91% to 6.64%
- 5.40% to 5.91%
- 4.66% to 5.40%
- 2.90% to 4.66%
- No Data
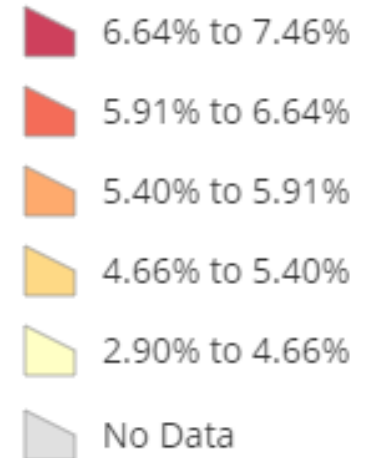
- Download Opioid Map Data
- View Prescriber-level Opioid rates
- Part D Prescriber Look-up tool

- Technical expert panel on quality measures
- Adult behavioral health quality measures reporting
- Revise measures used under HCAHPS survey relating to pain management
- Commit to opioid medical prescriber accountability and improved safety for older adults
- Grants for technical assistance to educate outlier prescribers

- Cover services provided in Opioid Treatment Programs (OTPs)
- Expand Medicaid Institutes for Mental Disease coverage for mothers and beneficiaries with SUDs
- Creates demonstration program to test bundled payment for MAT
- Program integrity actions Permits a Prescription Drug Plan sponsor to suspend payments if there is a credible allegation of fraud
- Expands "sunshine" efforts to additional health professionals such as physician assistants

SUPPORT for Patients and Communities Act

https://www.congress.gov/bill/115th-congress/house-bill/6

- **Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders**

- Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that **removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder** or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

- Additionally, the SUPPORT for Patients and Communities Act **establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B**, beginning on or after January 1, 2020. We note that **there is a 60-day period to comment on the provisions of the interim final rule**, during which we are requesting information regarding services furnished by OTPs, payments for these services, and additional conditions for Medicare participation for OTPs that stakeholders believe may be useful for CMS to consider for future rulemaking to implement this new Medicare benefit category.

- For additional information, please see the 2019 PFS Final Rule:
https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

Promoting Interoperability

Quality Payment Program

Considerations

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

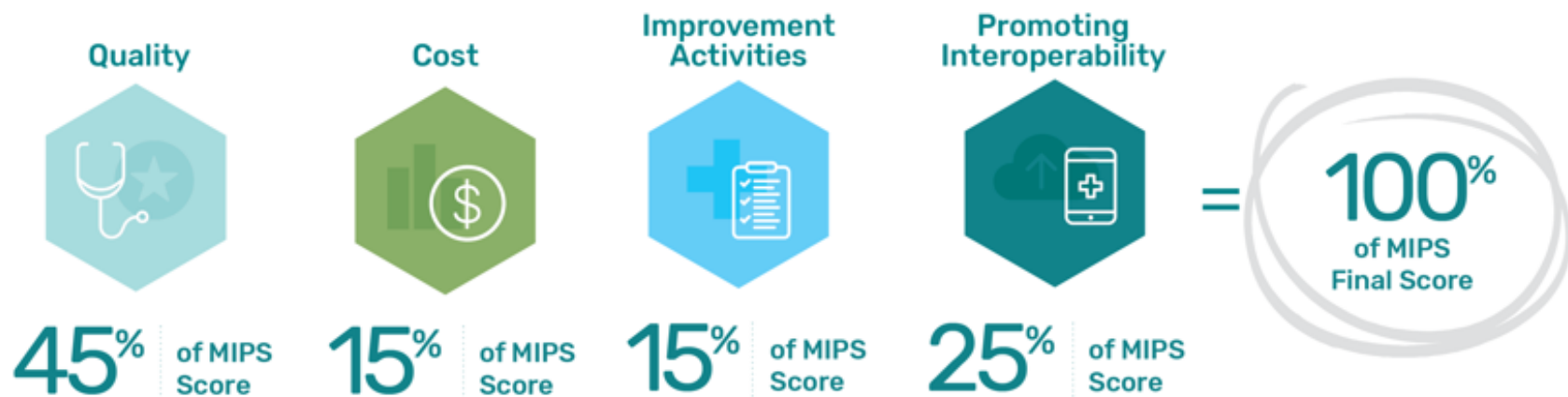Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories

Quality	Cost	Improvement Activities	Promoting Interoperability	=	100% of MIPS Final Score
45% of MIPS Score	15% of MIPS Score	15% of MIPS Score	25% of MIPS Score		

- Comprised of **four** performance categories

- So What? *The points from each performance category are added together to give you a MIPS Final Score*

- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**

Merit-based Incentive Payment System (MIPS)

What is a Performance Period under MIPS?

- A performance period is the length of time that you or your group are required to report data for a specific MIPS performance category

- In order to receive the highest possible MIPS final score, you should report data for the minimum performance period under each performance category

Performance Category	Performance Periods for 2019
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

Basics for 2019

- 25% of your MIPS Final Score

- Must use 2015 Edition Certified EHR Technology (CEHRT)

- Performance-based scoring at the individual measure level

- Four Objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

Objectives	Measures	Maximum Points
e-Prescribing	• e-Prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

- Reweighting of the Promoting Interoperability performance category is available

- Clinicians who qualify for reweighting will have the 25% weight reallocated to the Quality performance category (i.e. Quality would be worth 70%; Promoting Interoperability 0%)

Automatic Reweighting	Application-based Reweighting
Non-patient Facing clinicians	Insufficient internet connectivity
Hospital-based clinicians	Extreme and uncontrollable circumstances
Ambulatory Surgical Center-based clinicians	Lack of control over the availability of CEHRT
PAs, NPs, Clinical Nurse Specialists, CRNAs, Physical Therapists, Occupational Therapists, Clinical Psychologists, Speech-Language Pathologists, Audiologists, Registered Dieticians, and Nutrition Professionals	Clinicians in small practices
	Clinicians using decertified EHR technology

https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

Provider Feedback

What We Heard from Providers

CMS requirements are excessive

Documentation requirements are too hard to find

Providers are afraid of audits

ReducingProviderBurden@cms.hhs.gov

What CMS is Doing to Minimize Burden

1. Simplifying Paperwork

2. Making Required Paperwork Easier to Find
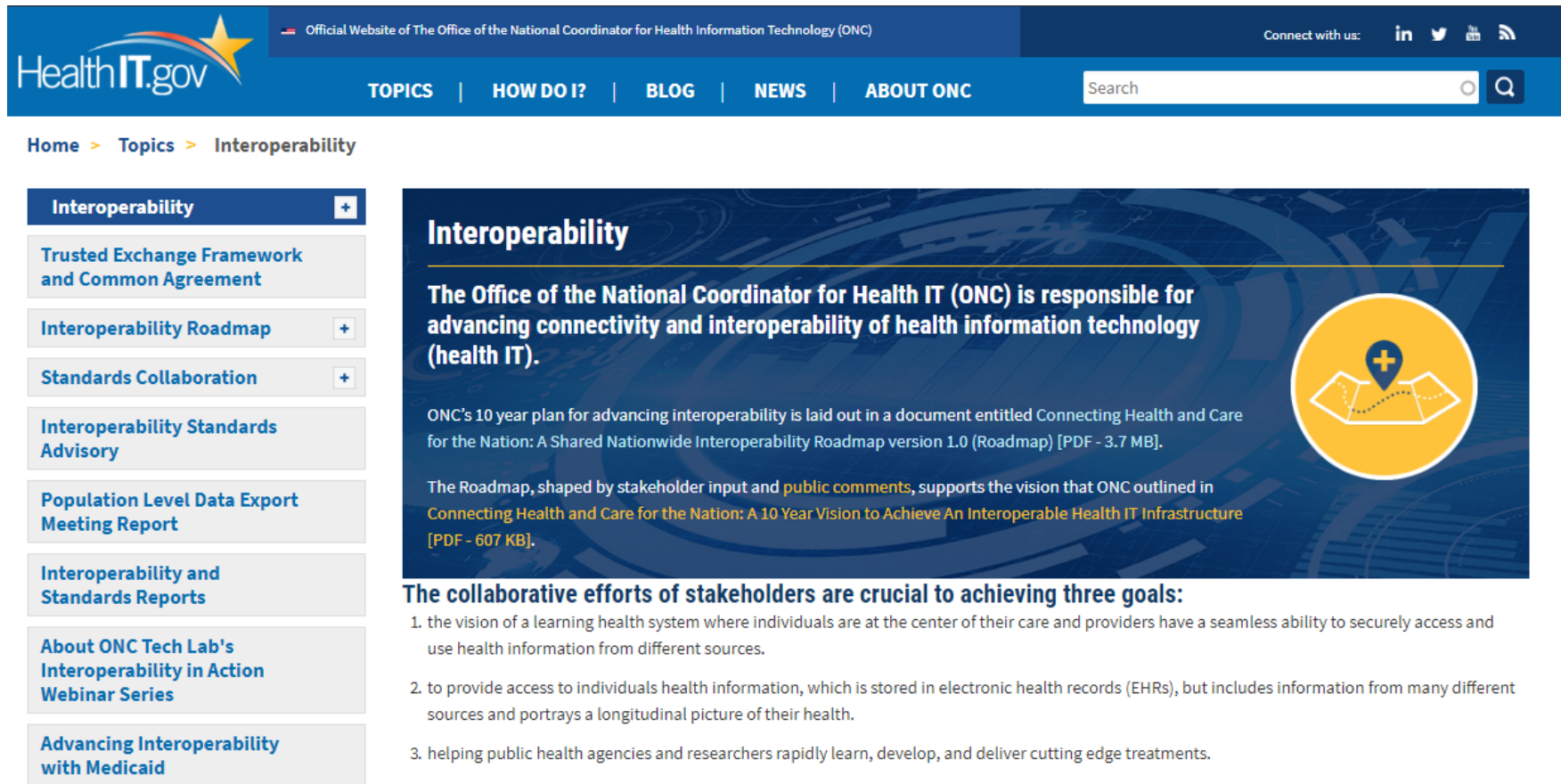
3. Improving the Audit Process

4. Making EHRs Interoperable

5. Improving Communications

EHR Interoperability: Opportunities and Resources

https://www.healthit.gov/topic/interoperability

https://www.healthit.gov/news/events/oncs-2nd-interoperability-forum

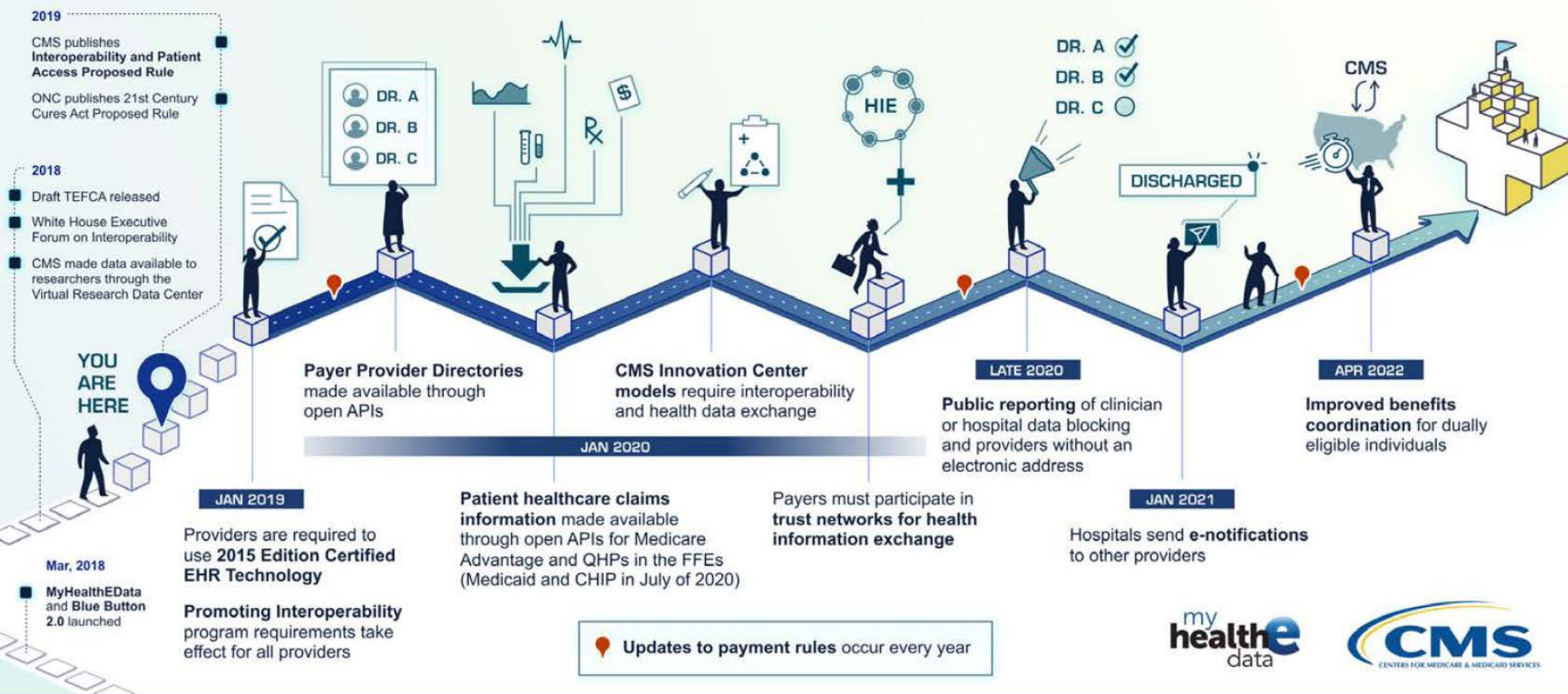A lack of seamless data exchange in healthcare…

leads to disconnected care, worse health outcomes, and higher costs.

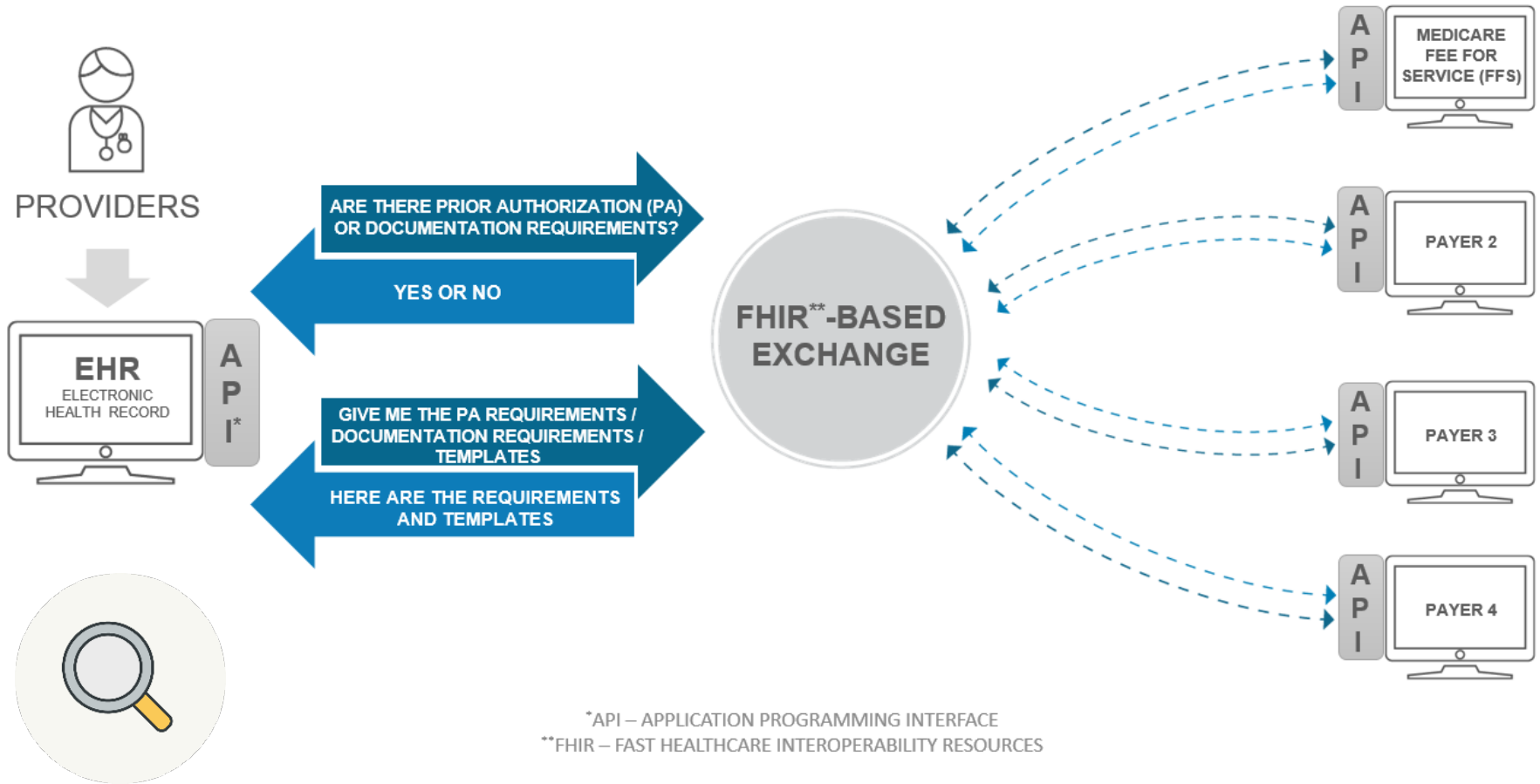Interoperable healthcare data exchange…

enables coordinated care, improved health outcomes, and reduced cost.

30

How might we get there?

The proposed rule would lay the foundation for healthcare interoperability.

Schematic

https://go.cms.gov/MedicareRequirementsLookup

CMS and ONC Interoperability Proposed Rules
Released February 11, 2019

- On February 11, 2019, the Centers for Medicare & Medicaid Services (CMS) proposed policy changes supporting its *MyHealthEData* initiative to improve patient access and advance electronic data exchange and care coordination throughout the healthcare system.

- The **Interoperability and Patient Access Proposed Rule** outlines opportunities to make patient data more useful and transferable through open, secure, standardized, and machine-readable formats while reducing restrictive burdens on healthcare providers.
  - *Health Information Exchange and Care Coordination Across Payers*
  - *API Access to Published Provider Directory Data*
  - *Care Coordination Through Trusted Exchange Networks*
  - *Improving the Dual Eligible Experience by Increasing Frequency of Federal-State Data Exchanges*
  - *Public Reporting and Prevention of Information Blocking*
  - *Provider Digital Contact Information*
  - *Revisions to the Conditions of Participation (CoPs) for Hospitals and Critical Access Hospitals*
  - *Advancing Interoperability in Innovative Models*

- *Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/cms-advances-interoperability-patient-access-health-data-through-new-proposals*

- *ONC proposed rule (released in conjunction with CMS):*
  https://www.hhs.gov/about/news/2019/02/11/hhs-proposes-new-rules-improve-interoperability-electronic-health-information.html

CMS and ONC Interoperability Proposed Rules
Released February 11, 2019
## Clinician and Provider specific proposals

- **Public Reporting and Prevention of Information Blocking**
  - We believe it would benefit patients and caregivers to know if individual clinicians, hospitals, and critical access hospitals (CAHs) have submitted a "no" response to any of the three attestation statements regarding the prevention of information blocking in the Promoting Interoperability Programs.

- **Provider Digital Contact Information**
  - As of June 2018, the National Plan and Provider Enumeration System (NPPES) has been updated to include one or more pieces of digital contact information that can be used to facilitate secure sharing of health information.
  - To ensure that the NPPES is updated, CMS is proposing to publicly report the names and National Provider Identifiers (NPIs) of those providers who have not added digital contact information to their entries in the NPPES system beginning in the second half of 2020.

- **Advancing Interoperability in Innovative Models**
  - The Innovation Center is seeking public comment on promoting interoperability among model participants and other healthcare providers as part of the design and testing of innovative payment and service delivery models.

CMS and ONC Interoperability Proposed Rules
Released February 11, 2019

- Two Requests for Information (RFI) included in the CMS Proposed Rule:
  - Requesting input on how CMS can promote wide adoption of interoperable health IT systems for use across healthcare settings such as long-term and post acute care, behavioral health, and settings serving individuals who are dually eligible for Medicare and Medicaid and/or receiving home and community-based services. Key topics include:
    - Promote interoperability
    - Reduce burden for clinicians, providers, and patients, while encouraging care coordination, and
    - Lead change to a value-based healthcare system
  - *To view proposal: https://www.cms.gov/Center/Special-Topic/Interoperability-Center.html*

- **The public comment period is now closed (ended June 3rd, 2019)**

- **To receive more information about CMS's interoperability efforts**, sign-up for the listserv here:
 https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12443
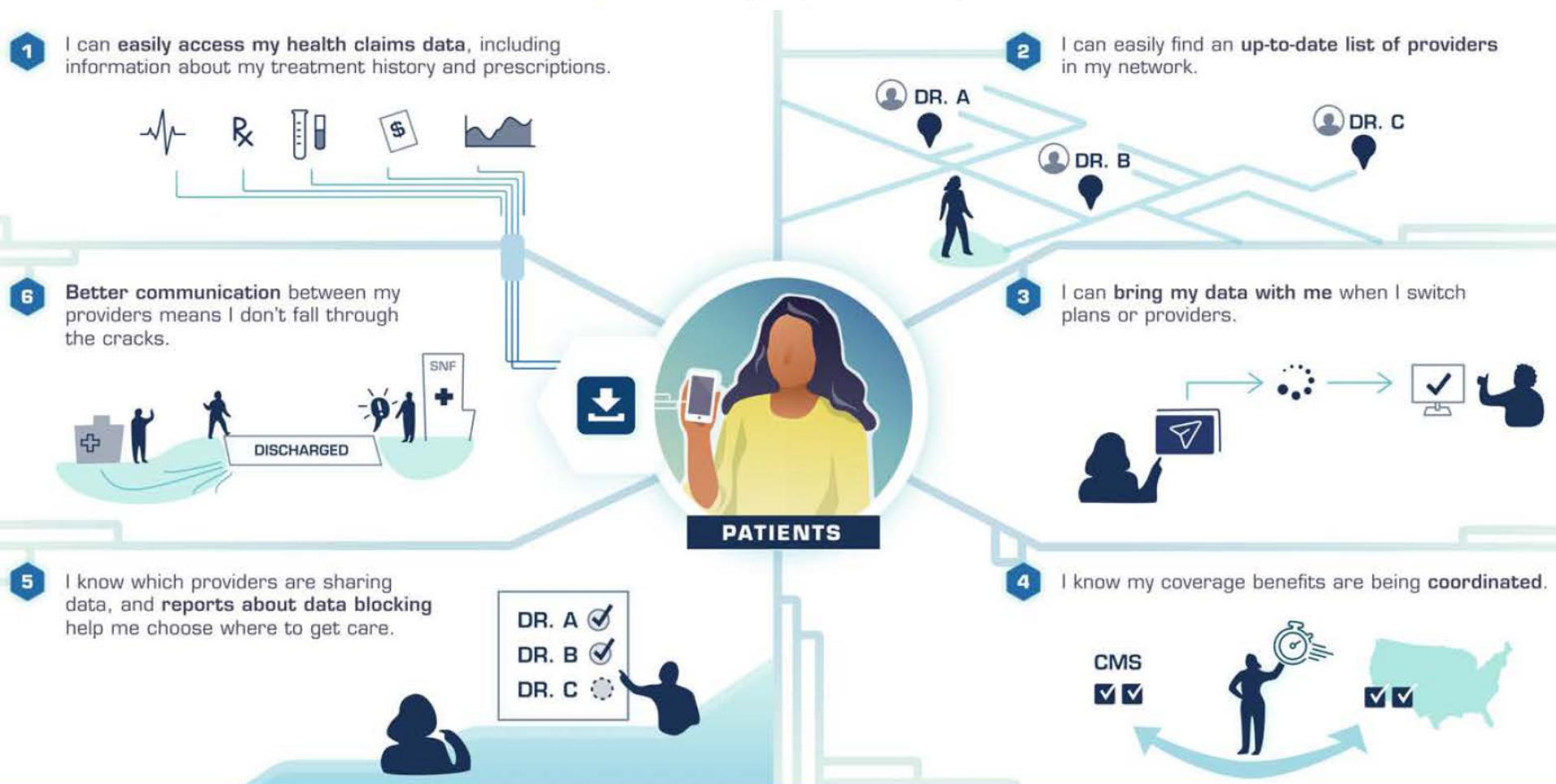
The proposals would help empower me to take ownership over my health data.

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How might these proposals impact me?

1 With **better access to patient data**, I can provide more informed treatment recommendations and help my patients make better care decisions.

2 I know how to **contact other providers** my patient is seeing so we can share information and provide coordinated care.

DR. B

DR. C

DR. A

PROVIDERS

4 As a participant in **alternative payment models**, I can showcase my commitment to health care interoperability and standards-based data exchange.
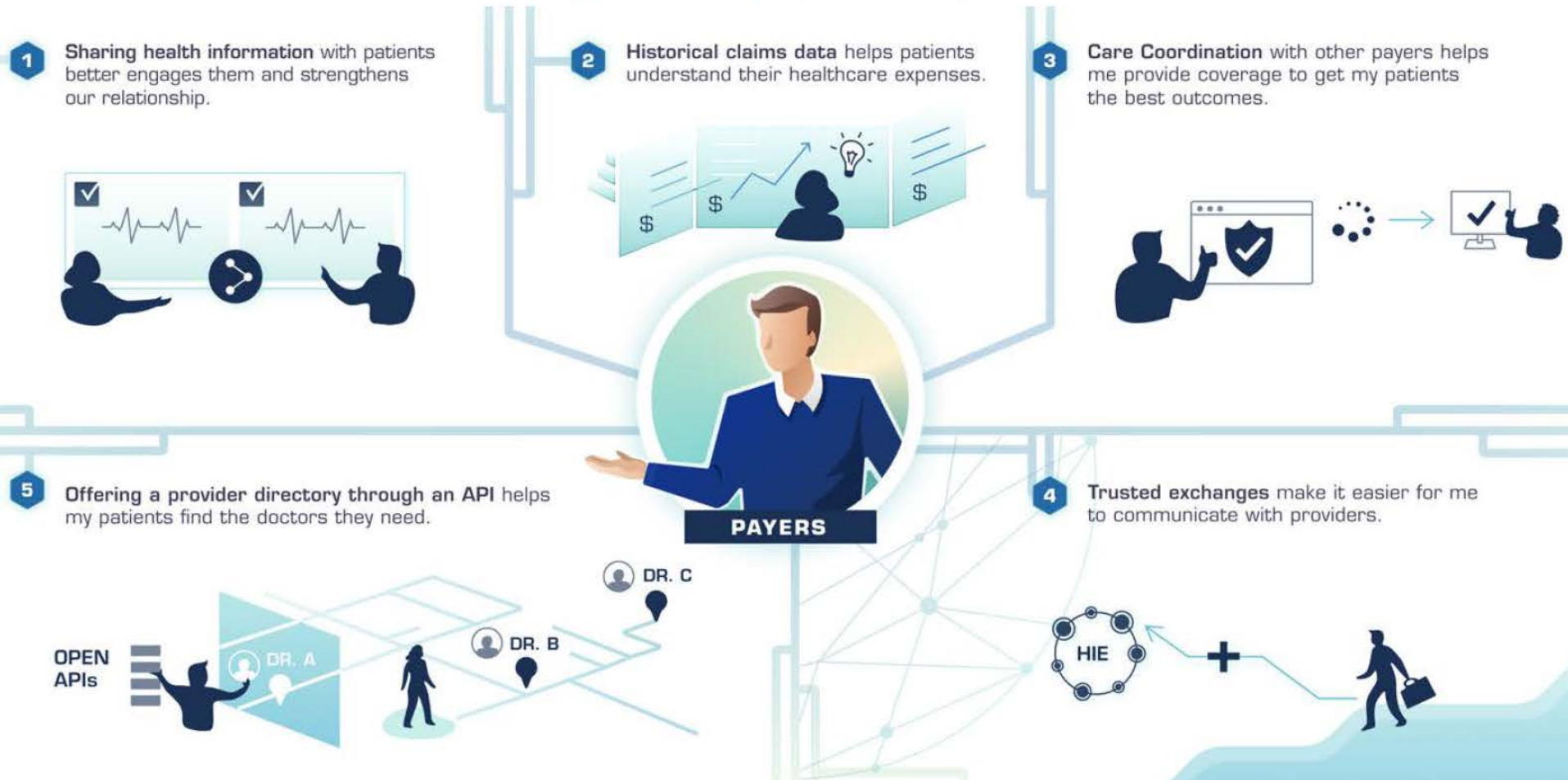
3 **E-notifications** that my patients are admitted or discharged keep me in the loop.

SNF

PT. DISCHARGED

The proposals would help me to confidently provide better care to patients.

How might these proposals impact me?

1 **Sharing health information** with patients better engages them and strengthens our relationship.

2 **Historical claims data** helps patients understand their healthcare expenses.

3 **Care Coordination** with other payers helps me provide coverage to get my patients the best outcomes.

PAYERS

5 **Offering a provider directory through an API** helps my patients find the doctors they need.

4 **Trusted exchanges** make it easier for me to communicate with providers.

DR. C

DR. B

OPEN APIs

DR. A

HIE

The proposals would increase my ability to provide more efficient and coordinated coverage.

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