Meaningful Use Update: Stage 1 and Stage 2

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Minnesota e-Health Pre-Summit
June 12, 2013

Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the Minnesota - North Dakota Regional Extension Assistance Center for HIT (REACH) – An ONC REC

- Dr Kleeberg also serves on the Physician Advisory Board for Elsevier

- No other conflict of interest

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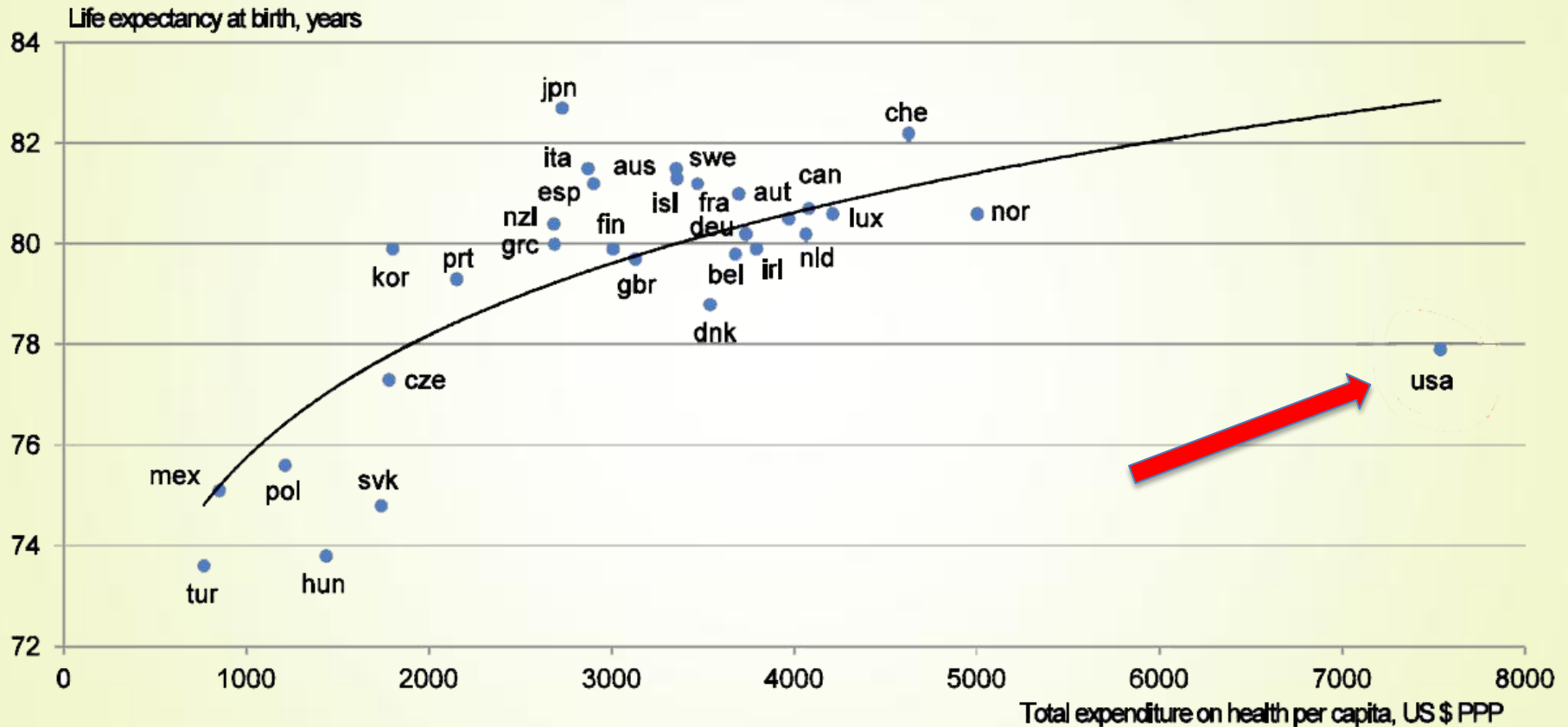Regional Extension
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Objectives

- Understand the new EHR Incentive program rules for Stage 1 and Stage 2

- Know what to do to prepare to meet the new requirements

- Understand the impact this will have on your EHR technology, your staff and your workflow

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Meaningful Use Outline

- **A reminder of why we are doing this**
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Per Capita Health Expenditure vs. Life Expectancy

Life expectancy at birth, years

Total expenditure on health per capita, US $ PPP

1. Or latest year available.
Source: OECD Health Data 2010.

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From the Health and Human Services Web Site:

- "Health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information.

Health Information Technology (HIT) Improves Care (1993 – 1994)

- Tierney, William M., et al. "Physician inpatient order writing on microcomputer workstations." *JAMA: the journal of the American Medical Association* 269.3 (1993): 379-383. ↗
    - A randomized controlled clinical trial of order writing on computers resulted in
        - **Charges that were 12.7%** lower per admission
        - Significant reductions for bed charges, diagnostic test charges and drug charges.
        - A mean length of stay was 0.89 day shorter
- Evans, R. Scott, et al. "Improving empiric antibiotic selection using computer decision support." *Archives of Internal Medicine* 154.8 (1994): 878. ↗
    - Random-selection study to compare antibiotics suggested by the antibiotic consultant with those ordered by physicians demonstrated a **17% greater pathogen susceptibility** to an antibiotic drug regimen suggested by a computer consultant vs. a physician

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CPOE Decreases Errors (1997 – 1998)

- Overhage, J. Marc, et al. "A randomized trial of "corollary orders" to prevent errors of omission." *Journal of the American Medical Informatics Association* 4.5 (1997): 364-375. ↗
  - Greater than **25% improvement in the rates of corollary orders** with implementation of computerized reminders.
- Evans, R. Scott, et al. "A computer-assisted management program for antibiotics and other anti-infective agents." *New England Journal of Medicine* 338.4 (1998): 232-238. ↗
  - Pre and post intervention study alerting for drug allergies, excessive dosages, antibiotic-susceptibility, lack of appropriateness and patients' renal function
  - Faster retrieval of relevant patient-specific information 14 minutes vs. 3.5 seconds
  - **Reductions in erroneous orders** for drugs where the patients had
    - Adverse Drug Event 70%
    - Reported allergies: 76%
    - Excess drug dosages 79%
    - Antibiotic-susceptibility mismatches 94%

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CPOE Decreases Medication Errors (1998 – 1999)

- Bates, David W., et al. "Effect of computerized physician order entry and a team intervention on prevention of serious medication errors." *JAMA: the journal of the American Medical Association* 280.15 (1998): 1311-1316. ↗
    - Assessing the impact of CPOE with CDSSs in a before-after comparison study demonstrated a **55% decrease in non intercepted serious medication errors**

- Bates, David W., et al. "The impact of computerized physician order entry on medication error prevention." *Journal of the American Medical Informatics Association* 6.4 (1999): 313-321. ↗
    - Evaluated medication error rates before CPOE and in the 3 years subsequent to its implementation. It demonstrated an 81% decrease in medication errors and an **86% decrease in non intercepted serious medication errors** (*P*<.001 for both)

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Health Information Technology and Quality, Efficiency and Cost (2006)

- Wu, Shinyi, et al. "Systematic review: impact of health information technology on quality, efficiency, and costs of medical care." *Annals of internal medicine* 144.10 (2006): 742-752. ↗
- 257 studies met the inclusion criteria of which 25% were from 4 academic institutions with internally developed systems
  - Brigham and Women's Hospital in Boston
  - LDS Hospital in Salt Lake City
  - Vanderbilt University Medical Center in Nashville
  - The Regenstrief Institute in Indianapolis
- Those 4 institutions (and only those 4) demonstrated
  - Benefits on quality:
    - Increased adherence to guideline-based care
    - Enhanced surveillance and monitoring
    - Decreased medication errors.
  - Benefit of improvement
    - Preventive health (DVT, pressure ulcers and post-op infections)
  - Efficiency benefit
    - Decreased utilization of care.

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EHRs: Problems with Commercial Installations (2005 – 2007)

- Han YY, Carcillo JA, Venkataraman ST, et al. Unexpected increased mortality after implementation of a commercially sold computerized physician order entry system. *Pediatrics*. 2005;116(6):1506–1512 ↗
  - The rapid implementation of a minimally modified, commercially available CPOE system in a pediatric critical care unit was associated with an **increase in mortality rate** for children admitted via interfacility transport over a 5-month period.
- Linder, Jeffrey A., et al. "Electronic health record use and the quality of ambulatory care in the United States." *Archives of Internal Medicine* 167.13 (2007): 1400-1405. ↗
  - Evaluated 50,000 patient records from over 1500 physician practices in 2003 and 2004 and found: "As implemented, EHRs were **not associated with better quality** ambulatory care."
  - Acknowledged the positive information came from 4 "benchmark" institutions

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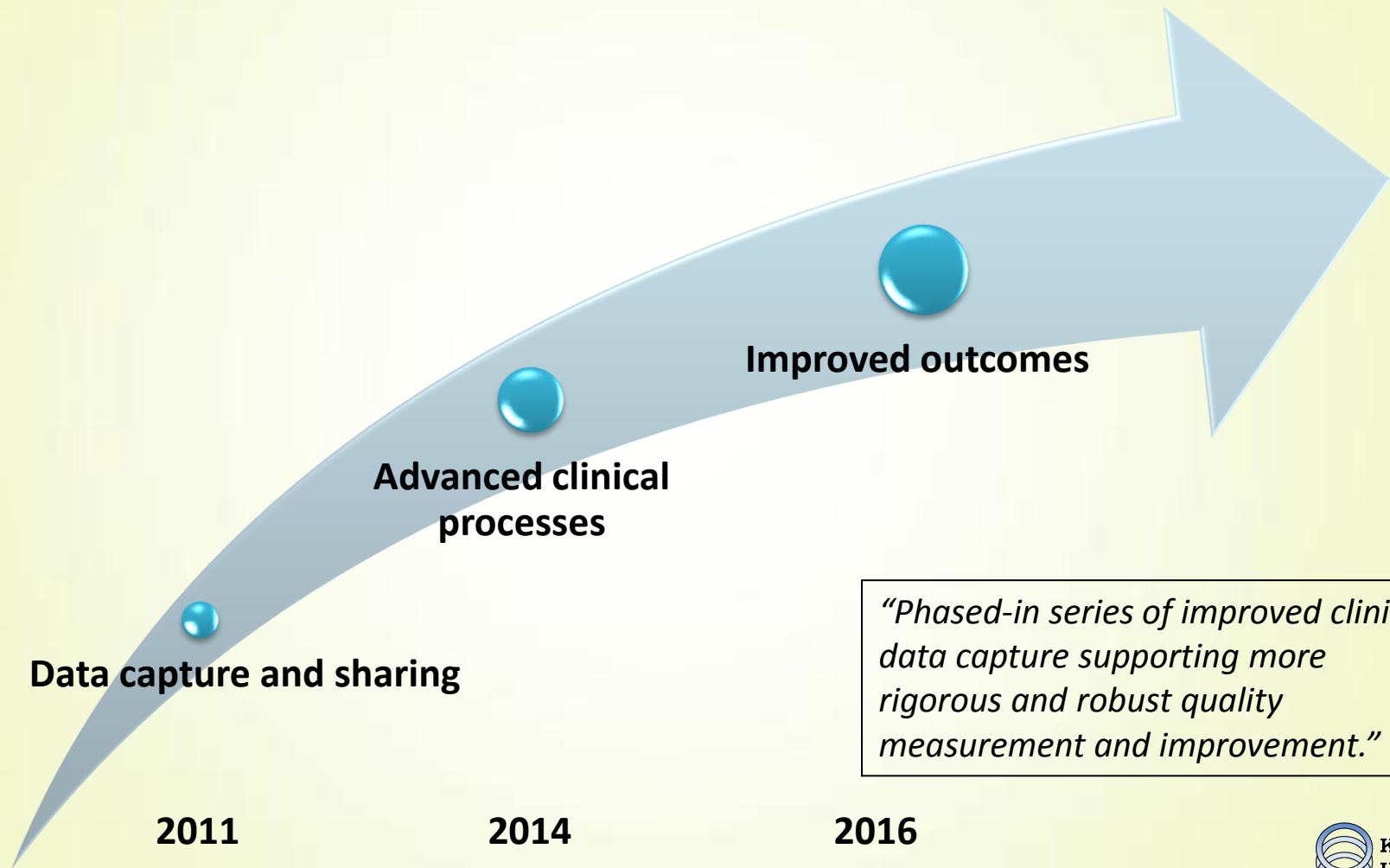Regional Extension
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Local Customization of CPOE Improves Quality (2010 – 2012)

- Longhurst, Christopher A., et al. "Decrease in hospital-wide mortality rate after implementation of a commercially sold computerized physician order entry system." *Pediatrics* 126.1 (2010): 14-21. ↗
  - Pre and Post implementation of a locally modified CPOE and electronic nursing documentation system at quaternary care academic children's hospital demonstrated a monthly adjusted **mortality rate decreased by 20%**
- Bright, Tiffani J., et al. "Effect of clinical decision-support systems: a systematic review." *Annals of internal medicine* 157.1 (2012): 29-43. ↗
  - A review of 148 randomized, controlled trials of electronic CDSSs implemented in clinical settings, used at the point of care and reported either clinical, health care process, workload, relationship-centered, economic, or provider use outcomes.
  - Both **commercially and locally developed clinical decision-support systems (CDSSs) showed statistical significance in improved health care process measures** related to performing preventive services, ordering clinical studies and prescribing therapies across diverse settings.

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Bending the Curve Towards Transformed Health

Improved outcomes

Advanced clinical processes

Data capture and sharing

"Phased-in series of improved clinical data capture supporting more rigorous and robust quality measurement and improvement."

2011   **2014**   **2016**

Source: Connecting for Health, Markle Foundation "Achieving the Health IT Objectives of the American Recovery and Reinvestment Act" April 2009

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Stages of Meaningful Under Medicare

		Stage of Meaningful Use										
		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
First Attestation Year	2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
	2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
	2013			1	1	2	2	3	3	TBD	TBD	TBD
	2014				1	1	2	2	3	3	TBD	TBD
	2015					1	1	2	2	3	3	TBD
	2016						1	1	2	2	3	3
	2017							1	1	2	2	3

1. Note: Under Medicaid, if a Medicaid only provider does not receive a payment for that year, the stage of MU does not progress.

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Incentives

- Some broadening of Medicaid eligibility

- Some broadening of professional and Medicare eligibility

- Medicare and Medicaid Incentive amounts remain unchanged from the Stage 1 Rule

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Eligibility Change: Hospital Based EP

- If a professional funds, implements and maintains a CEHRT including hardware and interfaces without reimbursement from a Hospital or CAH may apply to be considered an EP and receive an incentive payment.

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Eligibility Change: EPs Billing Through CAHs

- Physicians who assign their reimbursement and billing to a Critical Access Hospital (CAH) under Method II (CAH IIs)

- CAH II physicians can begin participation in calendar year (CY) 2013. They will able to submit attestations starting in January 2014

- CAH II physicians will be subject to payment adjustments if they are not MUsers beginning in 2015

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CAH_Method_II_Participation_FactSheet.pdf

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Medicaid Changes

- Service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability

- CHIP encounters for patients in Title 19 and Title 21 Medicaid expansion programs (not stand-alone CHIP)

- States may allow providers to calculate Medicaid (or needy individual) patient volume across 90-day period in last 12 months preceding attestation

Impact of the Sequester:

- Medicare MU Incentive payments are subject to the mandatory reductions in federal spending known as sequestration

- Incentive payments made to eligible professionals and hospitals will be reduced by 2%.

- This will apply to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. Those ending before will not be subject to the reduction.

- Does not apply to Medicaid EHR incentive payments

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Medicare Payment Adjustments

- EPs and EHs (not CAHs) who demonstrate meaningful use in 2011 through 2013 calendar years will not be penalized 2 years

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
EHR Reporting Period	2013	2014	2015	2016	2017	2018

- For EPs or EHs (not CAHs) who demonstrates meaningful use in 2014 or later for the first time (using 2014 as an example):

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

* If the EP attests no later than the October 1 or the EH attests no later than July 1 before the penalty year

EP Medicare Payment Adjustments Unchanged From Stage 1 Rule

- For the EP starting in 2015:
  - If > 75% of EPs are meaningful users, allowable charges will be reduced 1%/year to a max of 3%
  - If < 75% of EPs are meaningful users, again 1%/year with a maximum reduction of 5%

- For EHs:
  - Market basket update would be reduced by 25%/year to a max of 75%

Critical Access Hospital Payment Adjustments Unchanged from Stage 1

- CAHs use an EHR reporting period aligned with the payment adjustment year.

  - If a CAH is not a meaningful EHR user in FY 2015, then its Medicare reimbursement will be reduced for its cost reporting period that begins in FY 2015.

- Reasonable costs reimbursement (normally 101%) would be reduced by .33% starting in 2015 to 100% by 2017 and thereafter

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EP and EH/CAH Hardship Exceptions

Providers can apply for hardship exceptions in the following categories:

- Infrastructure
  - Insufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband)
  - http://www.broadbandmap.gov/
- Unforeseen Circumstances
  - Natural disaster or other unforeseeable barrier.

Additional EP Hardship Exceptions

- New EPs
  - Newly practicing EPs can apply for a 2-year limited exception to payment adjustments.
- EPs who demonstrate that they meet the following criteria:
  - Lack of face-to-face or telemedicine interaction with patients
  - Lack of follow-up need with patients
- EPs who practice at multiple locations demonstrate that they:
 - Lack of control over availability of CEHRT for more than 50% of patient encounters

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Additional EH and CAH Hardship Exceptions

- New Eligible Hospitals or CAHs can apply for a limited exception to payment adjustments.

  – For CAHs one full year after it accepts its first Medicare patient.

  – For eligible hospitals one full-year cost reporting period after it accepts its first Medicare patient.

Applying for Hardship Exceptions

- EPs, EHs, and CAHs must apply each year to avoid the payment adjustments.

- Applications need to be submitted by April 1 for hospitals, and July 1 for EPs of the year before the payment adjustment year

- Granted if providers demonstrate that those circumstances pose a significant barrier to their achieving meaningful use.

- Details will be posted on the CMS EHR Incentive Programs website in the future:
 - www.cms.gov/EHRIncentivePrograms
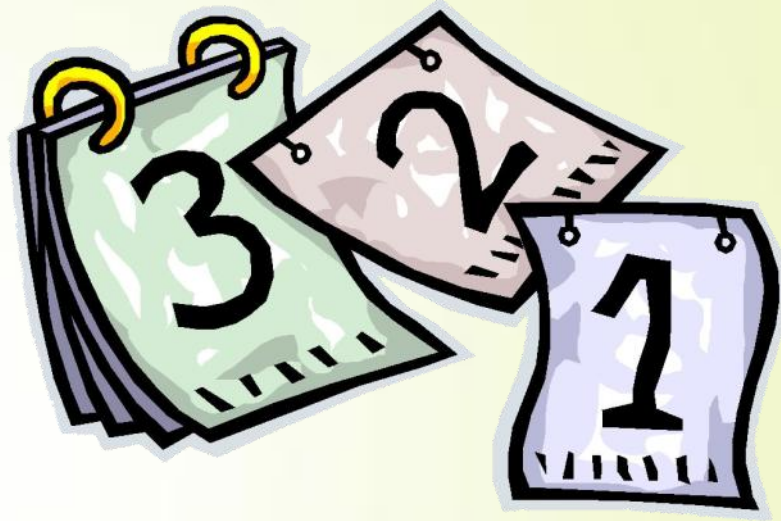
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Essential Changes in EHR Certification

- EHR Certification:
  - From "Stage 1 Certified" ➔ 2011 Certification
  - New Certification criteria ➔ 2014 Certification
- All will need to have 2014 Certified EHR Technology (CERT) in payment year 2014
- ONC/CMS will not require an EP/EH CAH to purchase components they do not need
  - If an EHR is certified as a complete EHR, all of its components are certified modules
- Vendors will not need to recertify on criteria that have not changed since 2011
- New Criteria: Safety-enhanced design

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2014 Edition CEHRT

MU Menu
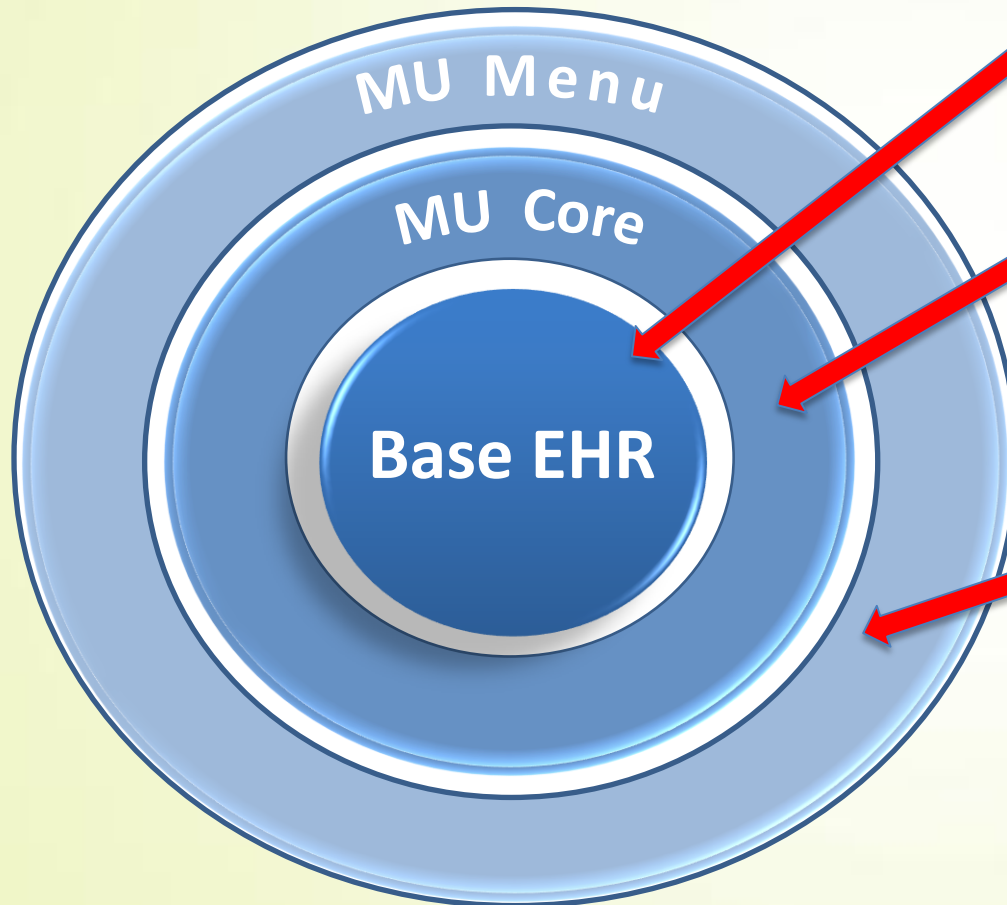
MU Core

Base EHR

Base: Capabilities certified to meet the definition of Base EHR.

Core: Capabilities certified for the MU core objectives & measures for the stage of MU they seek to achieve unless the EP/EH/CAH meets an exclusion.

Menu: Capabilities certified for the MU menu set objectives & measures for the stage of MU they seek to achieve as well as the selected quality measures

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"Base EHR"

- EHR technology that includes fundamental capabilities all providers would need to have.
- Defined by statute:
  - Demographics
  - Computerized Provider Order Entry (CPOE)
  - Clinical Decision Support (CDS)
  - Quality Reporting
  - Information exchange
- Security requirements, though not required by statute, were added to the base EHR

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Base EHR

Certification Criteria Required to Satisfy the Definition of a Base EHR	
Base EHR Capabilities	**Certification Criteria**
Includes patient demographic and clinical health information, such as medical history and problem lists	Demographics § 170.314(a)(3) Problem List § 170.314(a)(5) Medication List § 170.314(a)(6) Medication Allergy List § 170.314(a)(7)
Capacity to provide clinical decision support	Clinical Decision Support § 170.314(a)(8)
Capacity to support physician order entry	Computerized Provider Order Entry § 170.314(a)(1)
Capacity to capture and query information relevant to health care quality	Clinical Quality Measures § 170.314(c)(1) and (2)
Capacity to exchange electronic health information with, and integrate such information from other sources	Transitions of Care § 170.314(b)(1) and (2)
	Data Portability § 170.314(b)(7)
Capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged	Privacy and Security § 170.314(d)(1) through (8)

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Certified EHR Technology

For the 2013 EHR reporting period, eligible providers (EPs, EHs & CAHs) will be able to meet the CEHRT definition in one of three ways:

1. Adopt EHR technology certified to the **2011 Edition** EHR certification criteria that meets **all applicable criteria**;

2. Upgrade parts of their 2011 Edition EHR technology to the equivalent **2014 Edition** EHR technology

3. Adopt EHR technology that meets the CEHRT definition for CY / FY 2014

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Important Changes to Meaningful Use

- Starting in 2014
  - Menu objective exclusions will now count as a deferred item

- For all in the 2014 reporting year not in their first year of attestation:
  - Reporting period reduced to a fiscal or calendar quarter
    - To allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2
    - To allow quality measures to correspond with reporting requirements of other quality reporting programs

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Changes to Stage 1

- CPOE:
  - Starting in 2013 option of 30% of all medication orders
- Vital Signs:
  - Optional in 2013 and required in 2014:
    - ≥ 3 for BP; all ages for height/length & weight; growth charts ≤ 20
    - May claim exclusion for H/L&W or BP or both
- Test of exchange and the yes/no measure "Reporting CQMs":
  - Removed starting in 2013
- Electronic copies and access:
  - 2 EP and 2 EH measures replaced in 2014 with online view, download and transmit
- Public Health Measures:
  - "…except where prohibited…" added to the requirements

Concepts for the Updated Meaningful Use Rules Starting in 2014

- For both stages:
  - More exchange
  - More patient online access and involvement
- For Stage 2:
  - Stage 1 menu items have become core
  - Percentages have increased
  - Turnaround time is shorter
  - Some measures incorporated into others
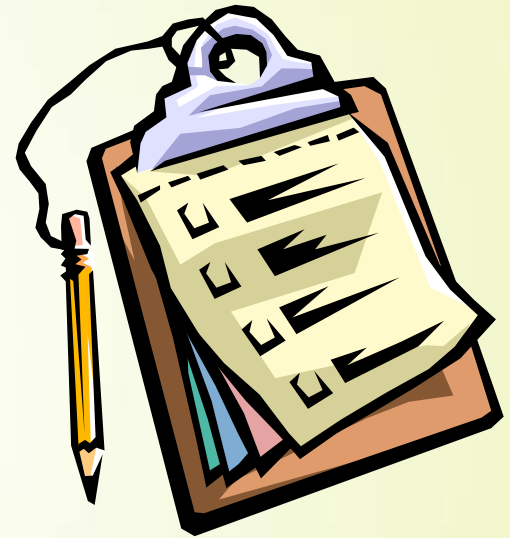
Stage 1 and Stage 2 Meaningful Use for 2014

Eligible Professionals

13 core objectives

5 of 9 menu objectives

18 total objectives

Eligible Professionals

17 core objectives

3 of 6 menu objectives

20 total objectives

Eligible Hospitals & CAHs

11 core objectives

5 of 10 menu objectives

16 total objectives

Eligible Hospitals & CAHs

16 core objectives

3 of 6 menu objectives

19 total objectives

Stage ~~1 and~~ 2 Core Objectives for All

- Use CPOE > ~~30~~ **60%** of *all* medication ***orders, and >30% of all laboratory and radiology*** orders

- Record demographics > ~~50~~ ***80%***

- ~~Record Problems > 80% *~~

- ~~Record Medications > 80% *~~

- ~~Record Allergies > 80% *~~

  * Problems, Meds and Allergies incorporated into the transfer of care document

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Stage ~~1 and~~ 2 Core Objectives for All

- Record vital signs > ~~50~~ **80%**

- Record smoking status > ~~50~~ **80%**

- Implement ~~1~~ **5** clinical decision support interventions + drug/drug and drug/allergy

- Conduct or review security analysis and incorporate in risk management process

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Stage ~~1 Menu and~~ 2 Core Objectives for All

- Incorporate lab results > ~~40~~ **55%**

- Generate at least one patient list by a specific condition

- Use EHR to identify and provide education resources > 10% of unique patients

- Medication reconciliation > 50% of transitions of care (or all relevant encounters if there is a policy for this)

- ***Successful ongoing*** transmission of immunization data

- Provide summary of care document > 50% of transitions of care and referrals...

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New Stage 2 Core Objectives for All

- Provide summary of care document > 50% of transitions of care and referrals ***with > 10% sent electronically and 1 to another organization with a different vendor's EHR***

- ***Provide online access to health information > 50% with > 5% actually accessing it***

Stage ~~1 and~~ 2 EP Core Objectives

- Formerly Stage 1 Core
    - E-Rx > ~~40~~ **65%**
    - Provide visit summaries for >50% of office visits within in ~~72 hours~~ **1 business day**

- Formerly Stage 1 Menu:
    - Use EHR to identify and provide > 10% with reminders for preventive/follow-up

- New
    - ***More than 5% of patients send a secure messages to their EP***

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Stage ~~1 and~~ 2 EH/CAH Core Objectives:

- Formerly Stage 1 Menu:
    - ~~Attempted~~ ***Successful ongoing*** submission of reportable laboratory results
    - ~~Attempted~~ ***Successful ongoing*** submission of electronic syndromic surveillance data

- New
    - ***EMAR with barcode scanning is implemented and used for more than 10% of medication orders***

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Stage 1 Core Measures Incorporated Into Others

- In order to meet the Transition of Care / Referral measure, must contain an up-to-date problem list, medication list and allergy list whether or not they are electronically transferred

Transition of Care / Referral Summary

Problem list

Medication List

Medication Allergies
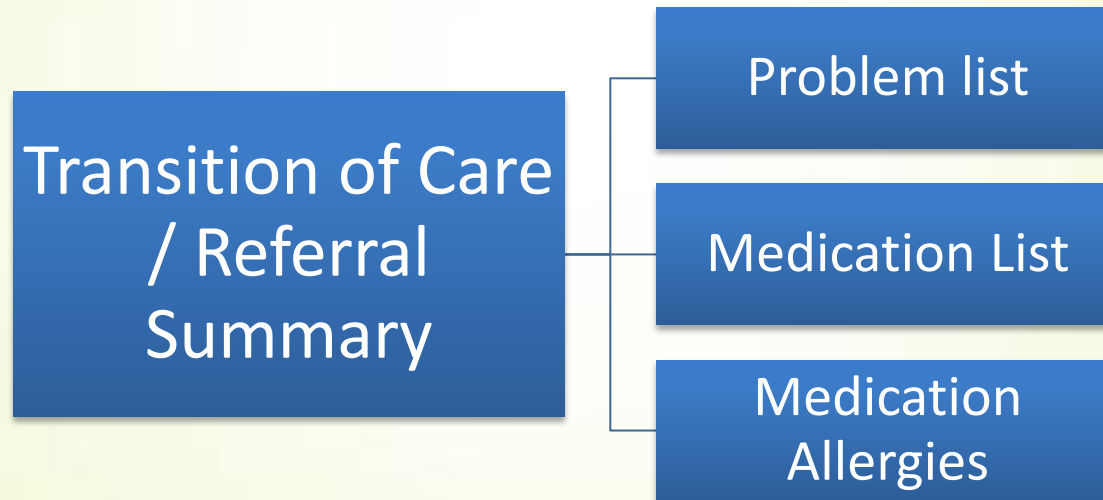
Elements of the Transfer of Care / Referral Summary Document

Usual Suspects

- Patient name.
- Referring or transitioning provider's name and office contact information (EP only).
- Procedures.
- Immunizations.
- Laboratory test results.
- Vital signs
- Smoking status.
- Demographic information
- Discharge instructions (Hospital Only).
- Reason for Referral (EP)

New Elements:

- Encounter diagnosis.
- Functional status, including activities of daily living, cognitive and disability status.
- Care plan field, including goals and instructions.
- Care team including the primary care provider of record and any additional care team members beyond the referring or transitioning provider and the receiving provider.

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Stage 2 Menu Objectives
(Select 3 of 6)

1. *More than 10% of imaging results are accessible through Certified EHR Technology*
2. *Record electronic notes in patient records for >30% of unique patients*
3. *Record family health history > 20%*

EP Only:

4. *Successful ongoing* transmission of syndromic surveillance data
5. *Successful ongoing transmission of cancer case information*
6. *Successful ongoing transmission of data to a specialized registry*

EH Only:

4. *More than 10% electronic prescribing (eRx) of discharge medication orders*
5. Record advanced directives for more than 50% of patients 65 years or older
6. *Provide structured electronic lab results to EPs for more than 20% of labs ordered electronically*

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Meaningful Use Specification Sheet

- The authoritative source on MU Criteria
- Downloadable PDF index that links to the Stage 2 Criteria:
  - EP: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf
  - EH/CAH: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EligibleHospitals_CAHs.pdf
  - Updated by CMS to account for any corrections or changes
- Includes relevant certification criteria

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Professional Criteria Specification Sheet

Stage 2
Eligible Professional (EP)
Meaningful Use Core and Menu Measures
Table of Contents
Date issued: October, 2012

Eligible Professional Core Objectives

(1)	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
(2)	Generate and transmit permissible prescriptions electronically (eRx).
(3)	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.
(4)	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.
(5)	Record smoking status for patients 13 years old or older.
(6)	Use clinical decision support to improve performance on high-priority health conditions.
(7)	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.
(8)	Provide clinical summaries for patients for each office visit.
(9)	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.
(10)	Incorporate clinical lab-test results into Certified EHR Technology as structured data.

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Example of Transfer of Care Measure

Stage 2
Eligible Professional
Meaningful Use Core Measures
Measure 15 of 17
Date issued: November, 2012

Summary of Care

Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measures	EPs must satisfy both of the following measures in order to meet the objective: **Measure 1:** • The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. **Measure 2:** • The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. **Measure 3:** An EP must satisfy one of the following criteria: • Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). • Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Certification and Standards Criteria

Definition of Terms
Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

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Summary of Care Record – A summary of care record must include the following elements:
- Patient name.
- Referring or transitioning provider's name and office contact information (EP only).
- Procedures.
- Encounter diagnosis
- Immunizations.
- Laboratory test results.
- Vital signs (height, weight, blood pressure, BMI).
- Smoking status.
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth).
- Care plan field, including goals and instructions.
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider.
- Reason for referral
- Current problem list (EPs may also include historical problems at their discretion).
- Current medication list, and
- Current medication allergy list.

Problem List – At a minimum a list of current, active and historical diagnoses. We do not limit the EP to just including diagnoses on the problem list.

Active/current medication list – A list of medications that a given patient is currently taking.

Active/current medication allergy list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan – The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Attestation Requirements

DENOMINATOR/NUMERATOR/ THRESHOLD/EXCLUSION

MEASURE 1:
- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was provided.
- THRESHOLD: The percentage must be more than 50 percent in order for an EP to meet this measure.

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Example of Transfer of Care Measure

- EXLCUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

MEASURE 2:
- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.
- THRESHOLD: The percentage must be more than 10 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

MEASURE 3:

YES/NO

The EP attests YES to one of the two criteria:
1. Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).

   or

2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

Additional Information
- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- The EP that transfers or refers the patient to another setting of care or provider should provide the summary of care document. It is for this provider that has the most recent information on the patient that may be crucial to the provider to whom the patient is transferred or referred.
- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so and meet Measure 1.

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- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient must not be included in the denominator for transitions of care.
- To count in the numerator of any measure, the EP must verify these three fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP or hospital as of the time of generating the summary of care document.
- To count in the numerator of measure 2, the summary of care record must be received by the provider to whom the sending provider is referring or transferring the patient.
- To count in the numerator of measure 2, one of the following three transmission approaches must be used:
  - Use of the transport standard capability required for certification. As required by ONC to meet the CEHRT definition, every EP, eligible hospital, and CAH, must have EHR technology that is capable of electronically transmitting a summary care record for transitions of care and referrals according to the primary Direct Project specification (the Applicability Statement for Secure Health Transport). Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "Direct" capability (natively or combined with an intermediary) would be able to count all such electronic transmissions in their numerator.
  - Use of the SOAP-based optional transport standard capability permitted for certification. As part of certification, ONC permits EHR technology developers to voluntarily seek certification for their EHR technology's capability to perform SOAP-based electronic transmissions. EHR technology developers who take this approach would enable their customers to also use this approach to meet the measure. Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "SOAP-based" capability (natively or combined with an intermediary) would be able to count all of those transmissions in their numerator.
  - Use of CEHRT to create a summary care record in accordance with the required standard (i.e., Consolidated CDA as specified in 45 CFR 170.314(b)(2)), and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator. See related FAQ.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (g)(1), and (g)(2).

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Example of Transfer of Care Measure

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria

Certification Criteria	
§ 170.314 (b) (1) Transitions of care receive, display, and incorporate transition of care/referral summaries	(i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: A. The standard specified in § 170.202(a). B. Optional. The standards specified in § 170.202(a) and (b). C. Optional. The standards specified in § 170.202(b) and (c). (ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: § 170.205(a)(1), § 170.205(a)(2), and § 170.205(a)(3). (iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3), EHR technology must be able to: A. Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. B. Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): ▪ Medications. At a minimum, the version of the standard specified in § 170.207(d)(2); ▪ Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); ▪ Medication allergies. At a minimum, the version of the standard specified in § 170.207(d)(2). ▪ Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at § 170.205(a)(3).
§ 170.314(b)(2) Transitions of care create and transmit transition of care/referral summaries	(i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): A. Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard specified § 170.207(a)(3); B. Immunizations. The standard specified in § 170.207(e)(2); C. Cognitive status; D. Functional status; and E. The reason for referral; and referring or transitioning provider's name and office contact information. (ii) Transmit. Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with:

(second panel)

A. The standard specified in § 170.202(a).
B. Optional. The standards specified in § 170.202(a) and (b).
C. Optional. The standards specified in § 170.202(b) and (c).

Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.

Standards Criteria

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport (incorporated by reference in § 170.299).
§ 170.202(b) Transport standards	ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in § 170.299).
§ 170.202(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in § 170.299).
§ 170.205(a)(1) Patient summary records	(i) Standard. Health Level Seven Clinical Document Architecture (CDA) Release 2, Level 2 Continuity of Care Document (CCD) (incorporated by reference in §170.299). (ii) Alternative standard. ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369 (incorporated by reference in §170.299).
§ 170.205(a)(2) Problem list	(i) Standard. The code set specified for the conditions specified at 45 CFR 162.1002(a)(1). (ii) Alternative standard. International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) July 2009 version (incorporated by reference in §170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in § 170.299). The use of the "unstructured document" document level template is prohibited.
§ 170.207(d)(2) Medications	RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, August 6, 2012 Release (incorporated by reference in § 170.299).
§ 170.207(a)(3)	IHTSDO SNOMED CT® International Release July 2012 (incorporated by reference in § 170.299) and US Extension to SNOMED CT® March 2012 Release (incorporated by reference in § 170.299).
§ 170.207(i) Encounter diagnoses	The code set specified at 45 CFR 162.1002(c)(2) for the indicated conditions.
§ 170.207(e)(2) Immunizations	HL7 Standard Code Set CVX -- Vaccines Administered, updates through July 11, 2012 (incorporated by reference in § 170.299).

CMS — EHR INCENTIVE PROGRAM

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Stage 1 Criteria for 2014:

Core:

Numerator/Denominator:

- Demographics
- Problem list
- Medication list
- Medication allergy list
- CPOE
- E-Prescribing (EP only)
- Vital signs
- Smoking status
- Clinical summaries (EP Only)
- Provide patients with eAccess

On (Yes or No):

- Drug (D-A, D-D) Interactions
- One clinical decision support rule
- Protect electronic health information

Menu:

Numerator/Denominator:

- Provide patient-specific education resources
- Advanced directives (EH only)
- Labs as structured data
- Patient reminders (EP only)
- Medication reconciliation
- Referral/Transfer of care summary

On (Yes or No):

- Drug - formulary checks
- Patient list by specific condition
- Test of submission of electronic data to immunization registries. *
- Test of submission of reportable labs to public health. (EH only) *
- Test of providing electronic syndromic surveillance data to public health agencies. *

* At least 1 public health objective must be selected

Stage 2 Criteria for 2014:

Core:

Numerator/Denominator:
- Demographics
- Medication reconciliation
- CPOE
- E-Prescribing (EP only)
- Electronic medication administration (EH Only)
- Vital signs
- Smoking status
- Clinical summaries (EP Only)
- Labs as structured data
- Provide patient-specific education resources
- Provide patients with eAccess with some using it
- Referral/Transfer of care summary
- Patient reminders (EP only)
- Secure messages from patients (EP Only)

Yes or No:
- Patient list by specific condition
- 5 clinical decision support rules (with D-D, D-A)
- Submission of electronic data to immunization registries.
- Submission of reportable labs to public health. (EH only)
- Protect electronic health information
- Provide electronic syndromic surveillance data to public health agencies. (EH Only)

Menu:

Numerator/Denominator:
- Advanced directives (EH only)
- Electronic notes
- Imaging results
- Family health history
- Report to cancer registries (EP Only)
- Report to specialized registries (EP Only)
- E-Prescribing (EH only)
- Return lab results electronically (EH only)

Yes or No:
- Provide electronic syndromic surveillance data to public health agencies. (EP Only)

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Meaningful Use Outline

- A reminder of why we are doing this
- Changes to the timeline
- Reminder of the incentives
- Clarification of the Medicare penalties
- New EHR certification standards for 2014
- New and revised functional criteria requirements for Stages 1 & 2
- **New quality measure requirements for 2014**
- Audits
- What you need to do now
- Resources
- In closing

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Changes to CQMs Reporting

Prior to 2014

| EPs | Report 6 out of 44 CQMs

• 3 core or alt. core
• 3 menu |

| Eligible Hospitals and CAHs | Report 15 out of 15 CQMs |

Beginning in 2014

| EPs | Report 9 out of 64 CQMs

Selected CQMs must cover at least 3 of the 6 NQS domains

Recommended core CQMs:

• 9 for adult populations
• 9 for pediatric Populations |

| Eligible Hospitals and CAHs | Report 16 out of 29 CQMs

Selected CQMs must cover at least 3 of the 6 NQS domains |

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CQM Specifications

- No change in specifications for the CQMs in 2013
- For EPs starting in 2014
  - 32 of the 44 CQMs finalized in the Stage 1 final rule will remain
  - 32 new CQMs will be added totaling 64
- For EHs / CAHs
  - All 15 of the CQMs finalized in the Stage 1 final rule plus 14 new CQMs totaling 29
- Case Thresholds for EHs/CAHs

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Case Thresholds for Hospital CQM Exemptions, 2014 and later

- For EHs/CAHs in their first year of Meaningful use
  - No change regardless of year – attest to the numbers
- For EHs/CAHs in 2014 *only*:
  - If 5 or fewer discharges per quarter, measure may be exempted
  - Must still submit aggregate and sample size counts for the quarter CQM reporting period
- For EHs/CAHs in 2015 and after:
  - If 20 or fewer discharges per full fiscal year reporting period, measure may be exempted
  - Must still submit aggregate and sample size counts for the fiscal year CQM reporting period

2013 Core Quality Measures for EPs

Measure Number	Clinical Quality Measure Title
NQF 0013	Blood pressure measurement
NQF 0028	Tobacco use assessment and intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up
Alternate Core Measures	
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Influenza Immunization for Patients ≥ 50 Years Old
NQF 0038	Childhood Immunization Status

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38 Additional Quality Measures

- Diabetes

- Cardiovascular Disease

- Preventative care and Screening

- Appropriate use

- Asthma

- Tobacco, alcohol, drug abuse

- Depression

- Oncology

- Ophthalmology

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CQM Selection for 2014

- All EPs must select 9 and EHs/CAHs 16 CQMs from at least 3 of the 6 HHS National Quality Strategy domains:
  - Patient and Family Engagement
  - Patient Safety
  - Care Coordination
  - Population and Public Health
  - Efficient Use of Healthcare Resources
  - Clinical Processes/Effectiveness

2014 CQMs Recommended for Adults

Patient and Family Engagement.	Functional status assessment for complex chronic conditions
Patient Safety.	Use of High-Risk Medications in the Elderly
	Documentation of Current Medications in the Medical Record Description
Care Coordination.	Closing the referral loop: receipt of specialist report
Population/Public Health.	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
	Preventive Care and Screening: Screening for Clinical Depressionand Follow-Up Plan
Efficient Use of Healthcare Resources.	Use of Imaging Studies for Low Back Pain
Clinical Process/Effectiveness.	Controlling High Blood Pressure

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2014 CQMs Recommended for Children

Population/Public Health.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
	Chlamydia Screening for Women
	Childhood Immunization Status
	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
Efficient Use of Healthcare Resources.	Appropriate Testing for Children with Pharyngitis
	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Clinical Process/Effectiveness.	Use of Appropriate Medications for Asthma
	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
	Children who have dental decay or cavities Description: Percentage of children ages 0-20, who have had tooth decay or cavities during the measurement period.

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Additional Quality Measures

- Diabetes
- Cardiovascular disease
- Preventative care and Screening
- Pediatrics
- Geriatrics
- Appropriate use
- Asthma
- Oncology

- Alcohol and drug dependence
- Depression
- Ophthalmology
- HIV/AIDS
- Functional assessment
- Medication management
- Pregnancy
- Referral reports

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2013 Hospital Quality Measures

- **ED Throughput**
  - Admitted patients: Median time from ED arrival to ED departure for admitted patients
  - Admitted patients: Admission decision time to ED departure time for admitted patients

- **Ischemic Stroke**
  - Discharge on antithrombotics
  - Anticoagulation for A-fib/flutter
  - Thrombolytic therapy for patients arriving within 2 hours of symptom onset
  - Discharge on statins

- **Ischemic or Hemorrhagic Stroke:**
  - Antithrombotic therapy by day 2
  - Stroke education
  - Rehabilitation assessment

- **Venous Thromboembolism:**
  - Prophylaxis within 24 hours of arrival
  - Intensive Care Unit prophylaxis
  - Anticoagulation overlap therapy
  - Platelet monitoring on unfractionated heparin
  - VTE discharge instructions
  - Incidence of potentially preventable VTE

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2014 Hospital Quality Measures
14 Additional Measures

- **ED Throughput**
  - Median time from ED arrival to ED departure for discharged ED patients

- **AMI measures**
  - Aspirin Prescribed at Discharge for AMI
  - Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival
  - Primary PCI Received Within 90 Minutes of Hospital Arrival
  - Statin Prescribed at Discharge

- **Pediatric**
  - Elective Delivery Prior to 39 Completed Weeks Gestation
  - Healthy Term Newborn
  - Hearing screening prior to hospital discharge
  - Exclusive Breast Milk Feeding

- **Surgical Care**
  - Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision
  - Prophylactic Antibiotic Selection for Surgical Patients
  - Urinary catheter removed on Postoperative Day 1 or 2

- **Home Management Plan of Care**
  - Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

- **Pneumonia**
  - Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients

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CQM Reporting in 2013

- CQM reporting will remain the same through 2013.
- In 2013, there are two reporting methods available for reporting the Stage 1 measures:
  - Attestation
  - eReporting pilots
    - Physician Quality Reporting System EHR Incentive Program Pilot for EPs
    - eReporting Pilot for eligible hospitals and CAHs
  - Medicaid providers submit CQMs according to their state-based submission requirements.

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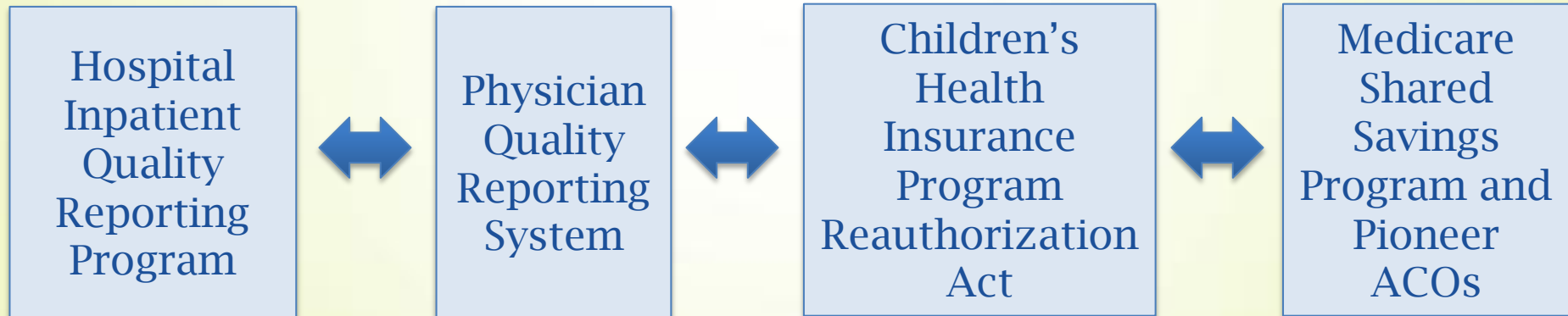Regional Extension
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Electronic Submission of CQMs Beginning in 2014

- Beginning in 2014, all Medicare-eligible providers in their second year and beyond of meaningful use must electronically report their CQM data to CMS.

- Medicaid providers will report their CQM data to their state, which may include electronic reporting.

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Aligning CQMs Across Programs

- The same CQMs will be used in multiple quality reporting programs beginning in 2014
  - Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs

| Hospital Inpatient Quality Reporting Program | ⟷ | Physician Quality Reporting System | ⟷ | Children's Health Insurance Program Reauthorization Act | ⟷ | Medicare Shared Savings Program and Pioneer ACOs |

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2014 CQM Quarterly Reporting

- For Medicare providers, beyond their first attestation year
  - The 2014 3-month reporting period is fixed to the quarter of either the fiscal or calendar year
  - In subsequent years, the reporting period for CQMs would be the entire calendar or fiscal year

Provider Type	Optional Reporting Period in 2014	Reporting Period for Subsequent Years of Meaningful Use	Submission Period for Subsequent Years of Meaningful Use
EP	Calendar year quarter: January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31	1 calendar year (January 1 - December 31)	2 months following the end of the reporting period (January 1 - February 28)
Eligible Hospital/CAH	Fiscal year quarter: October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	1 fiscal year (October 1 - September 30)	2 months following the end of the reporting period (October 1 - November 30)

EP Individual CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
First Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table covering at least 3 domains
EPs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs from EP measures table covering at least 3 domains
Option 2	Patient	Medicare	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT

*   *Attestation is required for EPs in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

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EP Group CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

EPs Beyond the 1st Year of Demonstrating Meaningful Use*				
Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare	Electronic	Satisfy requirements of Medicare Shared Savings Program or Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

* Groups with EPs in their 1st year of demonstrating MU can report as a group, however the individual EP(s) who are in their 1st year must attest to their CQM results by October 1 to avoid a payment adjustment.

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Hospital CQM Reporting Beginning in 2014

Eligible Hospitals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
First Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Eligible Hospitals/CAHs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Option 2	Patient	All payer (sample)	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains ➢ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

Attestation is required for Eligible Hospitals in their first year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of July 1 to avoid a payment adjustment.

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Meaningful Use Outline

- A reminder of why we are doing this
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- New and revised functional criteria requirements for Stages 1 & 2
- New quality measure requirements for 2014
- **Audits**
- What you need to do now
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Why Audits?

- [PUBLIC LAW 111–5—FEB. 17, 2009 123 STAT. 227](#)
  - **SEC. 13411. AUDITS.**

  "The Secretary shall provide for periodic audits to ensure that covered entities and business associates that are subject to the requirements of [the EHR Incentive] Act, comply with such requirements."

One in 20 Will Face Audits

- CMS aims to audit about 5% of all meaningful use attesters by conducting *prepayment* and *post-paymen*t audits

- Still in early stages of auditing efforts

- Health care providers with adverse audit notices are starting the appeals process and some providers are facing investigation for possible fraud

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How are the audits Operationalized?

- Your authorizing official for an EH or an EP will receive an email letter from Figliozzi & Co.

- Letter contains an "Information Request List"

- You have 2 weeks from the date on the letter to supply the information to the auditing firm.

- Submission options:
  - Figliozzi portal
  - Secure email
  - Snail mail

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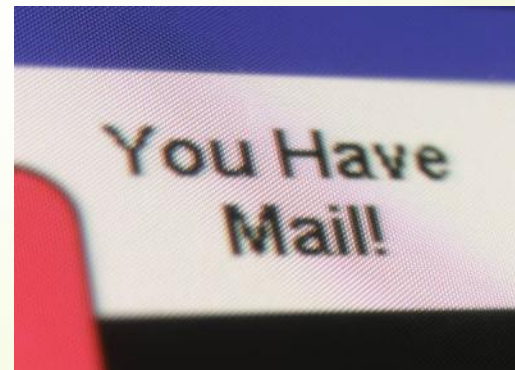
The Letter…

Dear Dr. Smith,

The Centers for Medicare and Medicaid Services (CMS) has contracted with Figliozzi & Company, CPAs P.C.1 to conduct meaningful use audits of certified Electronic Health Record (EHR) technology...

This letter is to inform you that you have been selected by CMS for an audit of your meaningful use of certified EHR technology for the attestation period. Attached to this letter is an information request list. Be aware that this list may not be all-inclusive and that we may request additional information necessary to complete the audit.
Please supply all requested items by March 11, 2013, by utilizing one of the following methods:

1. Electronically uploading the information to our secure web portal (*see step by step instructions attached*)

2. Mailing the information to:
    Figliozzi & Company, CPAs P.C.
    585 Stewart Avenue
    Suite 416
    Garden City, NY 11530

... If you have any questions, please contact me by email at pfigliozzi@figliozzi.com or by telephone at (516) 745-6400 extension 302.
Sincerely,
Peter Figliozzi CPA, CFF, FCPA

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SampleAuditLetter.pdf

Example Audit Questions:

Meaningful Use Objective	Audit Validation	Suggested Documentation
Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support	Functionality is available, enabled, and active in the system for the duration of the EHR reporting period.	One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation.
Protect Electronic Health Information	Security risk analysis of the certified EHR technology was performed prior to the end of the reporting period.	Report that documents the procedures performed during the analysis and the results. Report should be dated prior to the end of the reporting period and should include evidence to support that it was generated for that provider's system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.).
Exclusions	Documentation to support each exclusion to a measure claimed by the provider	Report from the certified EHR system that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

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Common Problems Identified in Audits

- Noncompliance with the requirement that health care providers conduct a data security risk assessment (also is a requirement under HIPAA)

- Lack of adequate documentation to support responses to some of the "yes or no" meaningful use requirements

  - For example, whether an EHR system has been tested for the ability to exchange clinical data

Audit Status Reported to CMS

"Upon the completion of the audit, the contractor is required to communicate non compliances identified to the organizations or personnel. CMS Management will evaluate the evidence in order to make a final determination of each 'meaningful EHR users' eligibility."

-*Recovery HiTech*

Audit Questions or Appeals

- Contact the auditing firm with questions:
  Peter Figliozzi at (516) 745-6400 x302 or
  pfigliozzi@figliozzi.com

- Use the CMS appeals website

  – http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Appeals.html

- Email

  – https://questions.cms.gov/newrequest.php for general appeal questions and updates on the status of any pending appeals.

- Toll-free hotline

  – 888-734-6433, between 9 a.m. and 5 p.m. EST, Monday through Friday, for general questions on how to file appeals and the status of any pending appeals.

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Meaningful Use Outline

- A reminder of why we are doing this
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- New quality measure requirements for 2014
- Audits
- **What you need to do now**
- Resources
- In closing

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What you can do to prepare

- Prepare for sharing information with patients:
  - Complete patients' problem, medication and allergy lists. Make sure they are up to date and current
  - Decide what types of information you will share with patients
    - Patient portals will require a lot of decision making on the part of providers
  - Begin to encourage patients to get involved in their care
    - Talk up the fact that you will be adding technology to allow them to make appointments on line, message their provider and get their lab results
    - Help patients identify where they might access a computer (library, waiting room) and how to manage privacy in such a setting
  - Explore whether you will use your vendor's portal solution or some other option
- Prepare for exchanging information with others:
  - Establish relationships with other organizations to which you refer in order to begin planning exchange (be sure to include nursing homes and home care)
  - Think about a connecting with your cancer registry or some other national registry to submit data

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What you can do to prepare

- Make sure your technology will be ready
  - Plan to undergo an EHR upgrade in late 2013 early 2014
  - Talk with your vendor about upgrade timelines
  - Look at the quality measures and let your vendor know which ones are important to you
  - For hospitals, prepare for bar-coded medication administration

- Plan for more decision support
  - Understand how your vendor will support having 5 "interventions" tied to relevant quality measures
  - Begin to think about the types of interventions you will incorporate into your EHR

- Evaluate your workflows
  - Look for efficiencies and make sure everyone is working at the top of their license

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CMS Stage 2 Toolkit

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Toolkit_EHR_0313.pdf

EHR Incentive Programs
Stage 2 Toolkit

The Basics

- Stage 2 Overview Tipsheet – provides an overview of the major provisions included in the Stage 2 rule

- Stage 1 Changes Tipsheet – focuses on the changes that were made to Stage 1 of meaningful use in the Stage 2 rule

- 2014 Clinical Quality Measures Tipsheet – provides information on the next phase of Clinical Quality Measures (CQMs) and how to report them to meet meaningful use in 2014 and beyond
- Stage 2 FAQs – provides answers to questions about the Stage 2 rule and how it affects hospitals and EPs
- 2014 eCQM Resources – lists all of the 2014 CQM webpages and resources

Resources for Eligible Professionals (EPs)

Stage 2 Details
- Stage 2 Meaningful Use Specification Sheet Table of Contents for Eligible Professionals – lists all the core and menu objectives for EPs, with direct links to each individual measure specification sheet (requires internet access to view spec sheets)

- Stage 1 vs. Stage 2 Comparison Table for Eligible Professionals – compares core and menu measures from Stage 1 with measures for Stage 2 of meaningful use for EPs

- Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals – provides an overview of the payment adjustment and hardship exceptions included in the Stage 2 rule for EPs

2014 CQMs
- 2014 CQMs for Eligible Professionals [PDF, 348KB] – contains the description and definition statements for the 64 CQMs for use by EPs in the EHR Incentive Programs beginning in 2014

- Technical release notes for 2014 eCQMs for Eligible Professionals [PDF, 131KB] – contains information about changes made to 2011 CQMs for the measures that were kept as part of the 2014 CQMs for EPs

- Full Table of Recommended Adult Measures – lists the 9 CQMs in the recommended core set for the adult population

- Full Table of Recommended Pediatric Measures – lists the 9 CQMs in the recommended core set for the pediatric population

Resources for Eligible Hospitals & Critical Access Hospitals (CAHs)

Stage 2 Details
- Stage 2 Meaningful Use Specification Sheet Table of Contents for Eligible Hospitals and CAHs – lists all the core and menu objectives for eligible hospitals and CAHs, with direct links to each individual measure specification sheet (requires internet access to view spec sheets)

- Stage 1 vs. Stage 2 Comparison Table for Eligible Hospitals and CAHs – compares core and menu measures from Stage 1 with measures for Stage 2 of meaningful use for eligible hospitals and CAHs

- Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Hospitals and CAHs – provides an overview of the payment adjustment and hardship exceptions included in the Stage 2 rule for eligible hospitals and CAHs

2014 CQMs
- 2014 CQMs for Eligible Hospitals [PDF, 377KB] – provides the description and definition statements for the 64 CQMs for use by eligible hospitals in the EHR Incentive Programs beginning in 2014

- Technical Release Note 2014 eCQMs for Eligible Hospitals [PDF, 362KB] – contains information about changes made to 2011 CQMs for the measures that were kept as part of the 2014 CQMs for eligible hospitals

CMS Resources:

- Meaningful Use:
  - https://www.cms.gov/EHRIncentivePrograms/

- Registration instructions:
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html

- Meaningful Use Stage 1 Criteria Specifications
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf

- CMS Stage 2 web page (with information on revised Stage 1 as well as Stage 2):
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

- Stage 2 Toolkit (Updated February 2013)
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Toolkit_EHR_0313.pdf

- Attestation Worksheet
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_Worksheet.pdf
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf

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Other Resources:

- Quality Measure Specifications on the CMS web site:
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html
- ONC-ATCB Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl
- Office of the National Coordinator Health IT site:
  - http://HealthIT.gov
- Regional Extension Assistance Center for Health Information Technology (REACH)
  - http://www.khaREACH.org
- Stratis Health HIT Toolkits for hospitals, clinics, home health, nursing homes and chiropractic
  - http://www.stratishealth.org/expertise/healthit/
- North Dakota Department of Health Information Technology
  - http://www.healthit.nd.gov
- Minnesota Department of Health Info Sheet on Public Reporting Measures:
  - http://www.health.state.mn.us/e-health/phreportmu.pdf

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In Closing

- The EHR Incentive program is intended to encourage the health care industry to improve the quality, safety and efficiency of care through health information technology

- Requirements are becoming more demanding over time with demonstrated improvement of quality to be considered for incentives or payment increases in the future

- Effective use will require close attention to workflow

- Use your reports to track progress in your use of your EHR and to improved quality

- Remember that we are doing this to achieve the "Triple Aim" of health care:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care

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Key Health Alliance—Stratis Health, Rural Health Resource Center, and The College of St. Scholastica.

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