Understanding the Changes for the EHR Incentive Program for Professionals

Key Health Alliance

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IHN – Integrity Health Network

EHR User Group Call

September 17, 2012

Meaningful Use Outline

- **A reminder of why we are doing this**
- Changes to the timeline
- Clarification of the penalties
- New requirements and options for stage 1
- Stage 2 requirements
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- New EHR software certification standards for all in 2014
- What you need to do now

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Institute of Medicine Report 2012: Best Care at Lower Cost

- If banking were like health care:
  - Automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
- If shopping were like health care:
  - Product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.
- If automobile manufacturing were like health care:
  - Warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
- If airline travel were like health care:
  - Each pilot would be free to design his or her own preflight safety check, or not to perform one at all.

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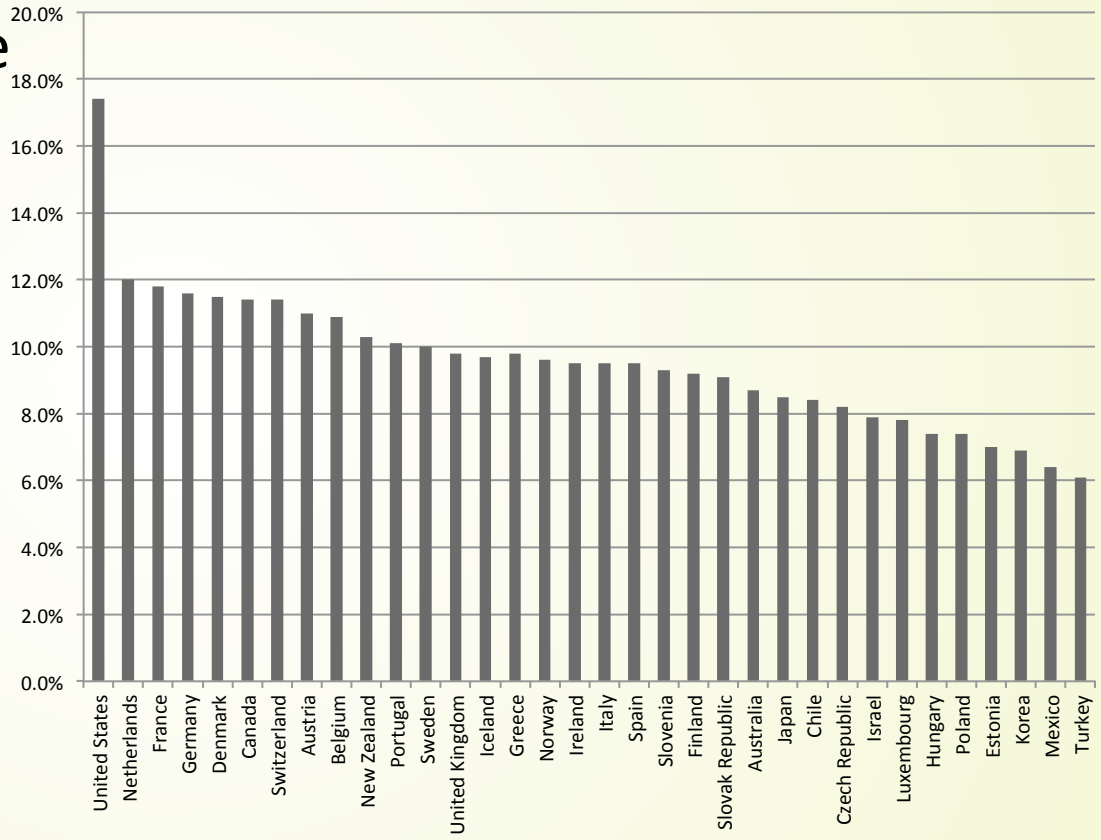
Are we getting value for our dollar? Cost vs. Quality

- Per capita health care spending[1]
  - $2.6T (2010)
  - 17.9% GDP
  - $8,402 per person
- 2009 Life expectancy as a surrogate for quality: 25th of 33 countries[2]

Spending as a % of GDP[3]



[1] CMS Health Expenditures 1960-2010 (http://www.cms.gov/NationalHealthExpendData/downloads/nhegdp10.zip)
[2] Organization for Economic and Co-operation and Development (http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT)
[3] OECD Health Data 2011: http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html

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Stages of Meaningful Use Once you Attest

1st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
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

Maximum Medicare Incentives for EPs in a non shortage area[1]

1st Attest	2011	2012	2013	2014	2015	2016	2017	Total
2011	Stage 1 $18k	Stage 1 $12k	Stage 1 $8k	Stage 2 $4k	Stage 2 $2k	Stage 3	Stage 3	$44k
2012		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3 $2k	Stage 3	$44k
2013			Stage 1 $15k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3	$39k
2014				Stage 1 $12k[2]	Stage 1 $8k	Stage 2 $4k	Stage 2	$24k
2015					Stage 1	Stage 1	Stage 2	0
Penalty (deduction from Medicare charges) if not at stage 3 by January 1 of that year:					1%	2%	3%	

1. Professionals with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment
2. Must demonstrate and attest to MU by October 1 2014 to avoid the 2015 penalty

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Maximum Medicaid Incentives for EPs with ≥ 30% volume

First Year of Adopt, implement, Upgrade or MU Demonstration	Calendar Year											
	2011	2012	2013	2014	2015[1]	2016[1]	2017[1]	2018[1]	2019[1]	2020[1]	2011[1]	Total
2011	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500						$63,750
2011	$21,250		$8,500	$8,500	$8,500	$8,500	$8,500					$63,750
2011	$21,250		$8,500		$8,500		$8,500	$8,500		$8,500		$63,750
2012			$8,500	$8,500	$8,500	$8,500	$8,500					$63,750
2013			$21,250	$8,500	$8,500	$8,500	$8,500	$8,500				$63,750
2014				$21,250	$8,500	$8,500	$8,500	$8,500	$8,500			$63,750
2015[1]					$21,250	$8,500	$8,500	$8,500	$8,500	$8,500		$63,750
2016[1]						$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$63,750
2017[1]						$0						$0

1. Note: Medicare penalties will apply for any of the professional's billing to Medicare part B if not a meaningful user

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Professional EHR Reporting Period

- Professionals who have demonstrated meaningful use in 2011 through 2013 (fiscal years)

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

- Professional who demonstrates meaningful use in 2014 for the first time

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

* In order to avoid the 2015 payment adjustment the professional must attest no later than October 1, 2014

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EP Medicare Payment Adjustments

% adjustment assuming less than 75 percent of EPs are meaningful EHR users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% adjustment assuming more than 75 percent of EPs are meaningful EHR users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%

EP Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

- Infrastructure
  - EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- New EPs
  - Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments.
- Unforeseen Circumstances
  - Examples may include a natural disaster or other unforeseeable barrier.
- EPs must 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 must demonstrate that they:
  - Lack of control over availability of CEHRT for more than 50% of patient encounters

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Changes to Meaningful Use

Changes

- Menu Objective Exclusion– While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed.

No Changes

- Half of Outpatient Encounters– at least 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology.
- Measure compliance = objective compliance
- Denominators based on outpatient locations equipped with CEHRT and include all such encounters or only those for patients whose records are in CEHRT depending on the measure.

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Changes to Stage 1: CPOE

Current Stage 1 Measure

Denominator=

Unique patient with at least one medication in their medication list

New Stage 1 Option

Denominator=

Number of orders during the EHR Reporting Period

This optional CPOE denominator is available in 2013 and beyond for Stage 1

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Changes to Stage 1: Vital Signs

Current Stage 1 Measure		New Stage 1 Measure	
Age Limits=	Age **2** for Blood Pressure & Height/ Weight	Age Limits=	Age **3** for Blood Pressure, No age limit for Height/ Weight
Exclusion=	All three elements not relevant to scope of practice	Exclusion=	Blood pressure to be separated from height /weight

The vital signs changes are optional in 2013, <u>but required starting in 2014</u>

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Changes to Stage 1: Testing of HIE

Current Stage 1 Measure	Stage 1 Measure Removed
One test of electronic transmission of key clinical information	**Requirement removed effective 2013**

The removal of this measure is effective starting in 2013

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Changes to Stage 1: E-Copy & Online Access

Current Stage 1 Objective

Objective=

Provide patients with e-copy of health information upon request

Provide electronic access to health information

New Stage 1 Objective

Objective=

Provide patients the ability to view online, download and transmit their health information

- The measure of the new objective is 50% of patients have access to their information; there is no requirement that 5% of patients actually access their information for Stage 1.
- **The change in objective takes effect in 2014 to coincide with the 2014 certification and standards criteria**

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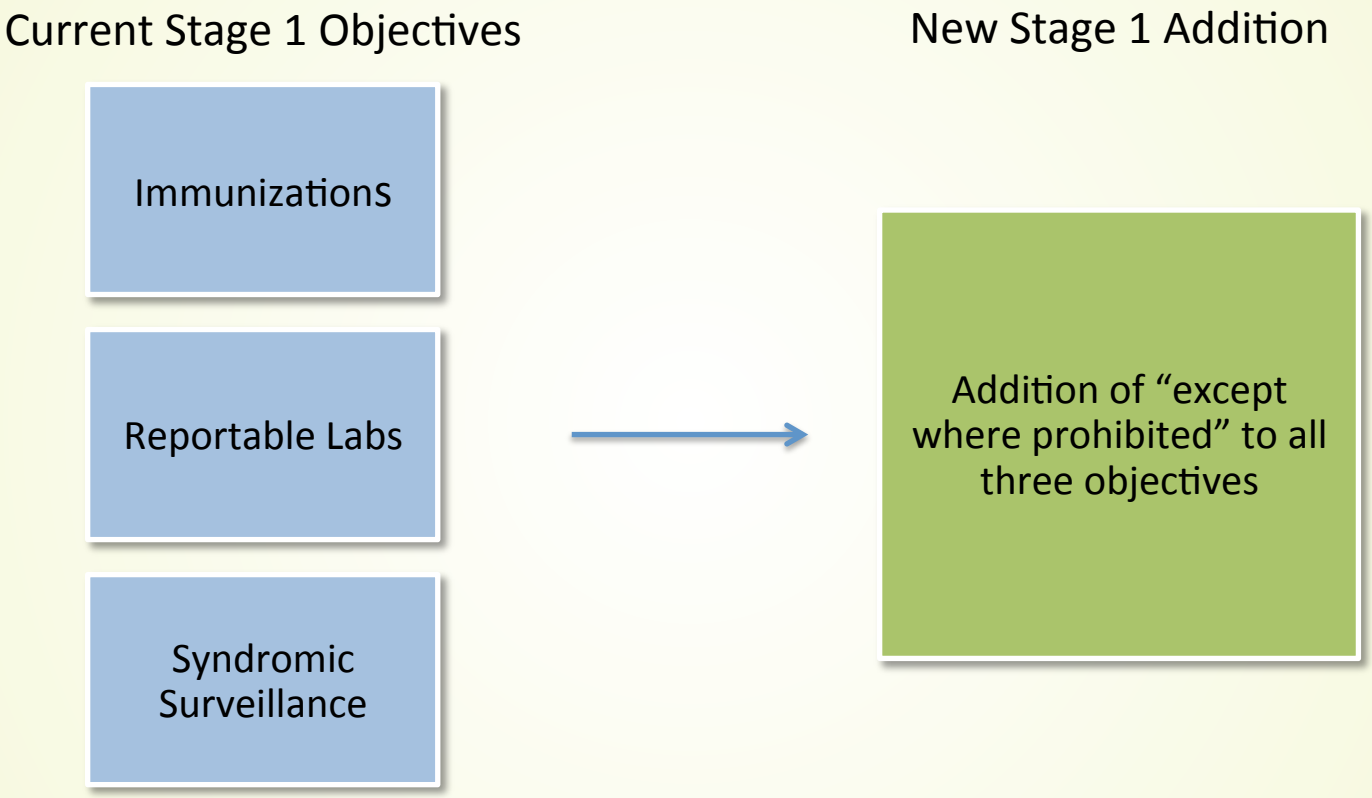
Changes to Stage 1: Public Health Objectives



This addition is for clarity purposes and does not change the Stage 1 measure for these objectives.

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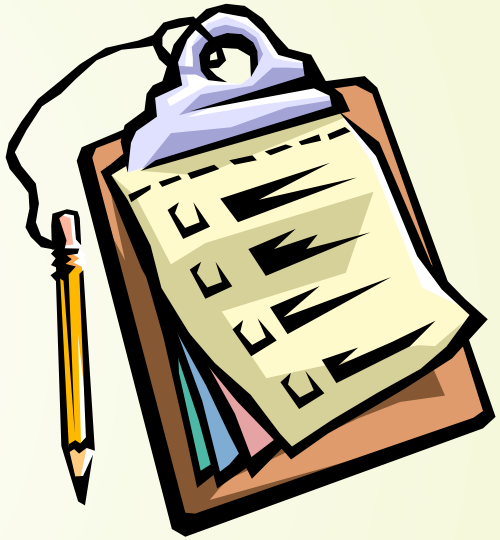
Meaningful Use Concepts

- In general:
  - Stage 1 menu items have become core
  - Percentages have increased
  - Turnaround time is shorter
  - More exchange and patient involvement
  - Some core measures incorporated into other activities



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Stage 1 to Stage 2 Meaningful Use

Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives

Eligible Professionals

17 core objectives

3 of 6 menu objectives

20 total objectives

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Stage 2 EP Core Objectives

1. Use CPOE > ~~30~~ ***60%*** of ***all*** medication ***orders, and >30% of all laboratory and radiology*** orders
2. E-Rx > ~~40~~ ***65%***
3. Record demographics > ~~50~~ ***80%***
4. Record vital signs > ~~50~~ ***80%***
5. Record smoking status > ~~50~~ ***80%***
6. Implement ~~1~~ ***5*** clinical decision support interventions + drug/drug and drug/allergy
7. Provide visit summaries for >50% of office visits within in ~~72 hours~~ ***1 business day***
8. Conduct or review security analysis and incorporate in risk management process

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Stage 2 EP Core Objectives – No Longer Menu:

9. Incorporate lab results > ~~40~~ ***55%***
10. Generate at least one patient list by a specific condition
11. Use EHR to identify and provide > 10% with reminders for preventive/follow-up
12. Use EHR to identify and provide education resources > 10% of unique patients
13. Medication reconciliation > 50% of transitions of care (or all relevant encounters if there is a policy for this)

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Stage 2 EP Core Objectives – No Longer Menu:

14. 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***
15. ***Successful ongoing*** transmission of immunization data

New Stage 2 EP Core Objective:

16. ***Provide online access to health information > 50% with > 5% actually accessing it***
17. ***More than 5% of patients send a secure messages to their EP***

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Stage 2 EP 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. ***Successful ongoing*** transmission of syndromic surveillance data
4. ***Record family health history > 20%***
5. ***Successful ongoing transmission of cancer case information***
6. ***Successful ongoing transmission of data to a specialized registry***

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CQM Reporting in 2013

- CQM reporting will remain the same through 2013.
  - 44 EP CQMs
    - 3 core or alternate core (if reporting zeroes in the core) plus 3 additional CQMs
    - Report minimum of 6 CQMs (up to 9 CQMs if any core CQMs were zeroes)
- In 2012 and continued 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
  - Medicaid providers submit CQMs according to their state-based submission requirements.

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CQM Specifications

- No change in specifications for the CQMs for in 2013
- For 2014
  - 41 of the 44 CQMs finalized in the Stage 1 final rule will remain. Excluded will be:
    - NQF 0013: Controlling High Blood Pressure
    - NQF 0027: Smoking and Tobacco Use Cessation, Medical Assistance
    - NQF 0084: Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation
  - 23 new CQMs will be added totalling 64

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CQM Selection and HHS Priorities

- All providers must select 9 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

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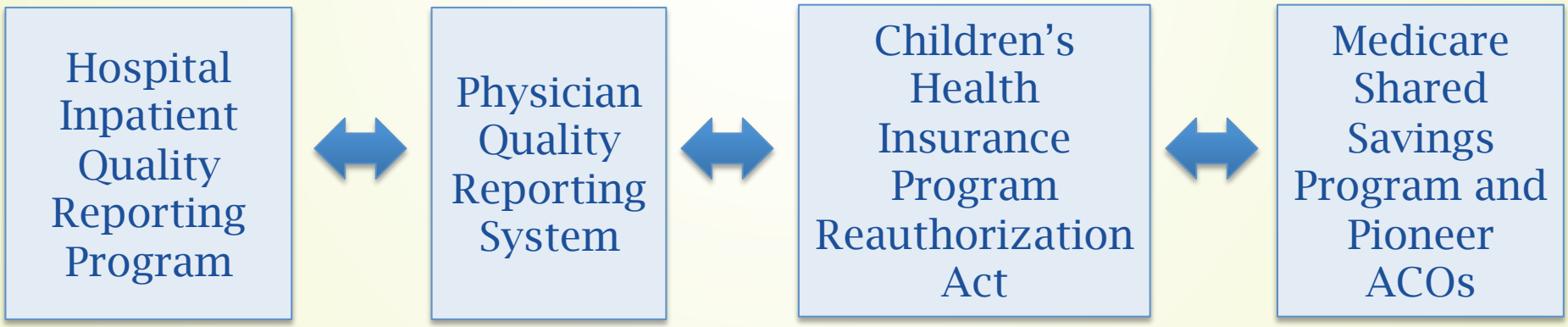
Aligning CQMs Across Programs

- 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



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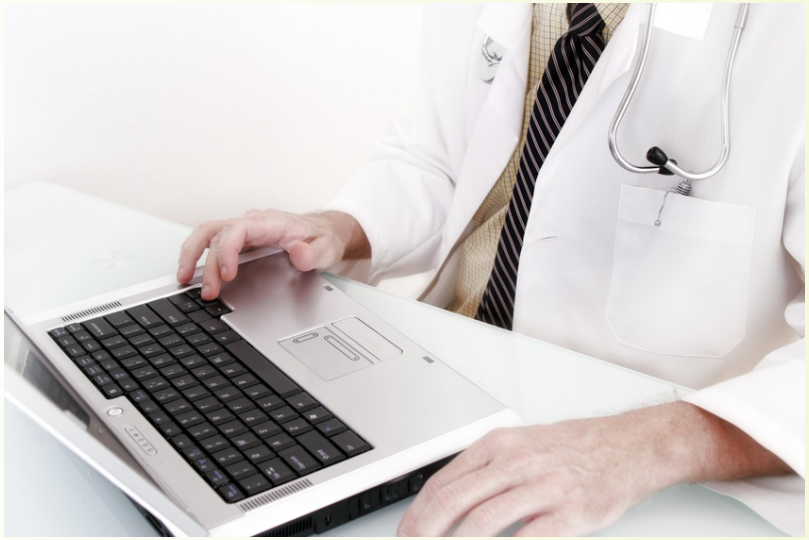
Electronic Submission of CQMs Beginning in 2014

- 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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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.	Title: 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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Changes to CQMs Reporting

Prior to 2014

EPs

Report 6 out of 44 CQMs

- 3 core or alt. core
- 3 menu

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

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EP CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), 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 (includes adult and pediatric recommended core CQMs), covering at least 3 domains
Option 2	Patient	Medicare	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT
Group Reporting (only EPs Beyond the 1st Year of Demonstrating Meaningful Use)**				
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

**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.*

***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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CQM – Timing

- No change in CQM Reporting period except for 2014. For all other years:

Provider Type	Reporting Period for 1st year of MU	Submission Period for 1st year of MU	Reporting Period for Subsequent years of MU	Submission Period for Subsequent years of MU
EP	90 consecutive days within the calendar year	Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year*	1 calendar year (January 1 – December 31)	2 months following the end of the EHR reporting period (January 1 – February 28)

**In order to avoid payment adjustments, EPs must submit CQMs no later than October 1 starting in the 2014 payment year.*

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2014 CQM Quarterly Reporting

For Medicare providers, the 2014 3-month reporting period is fixed to the quarter of the calendar year for Eps in order to align with existing CMS quality reporting programs.

In subsequent years, the reporting period for CQMs would be the entire calendar year for Eps beyond the 1st year of MU.

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)

**In order to avoid payment adjustments, EPs must submit CQMs no later than October 1 starting in the 2014 payment year.*

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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
- Vendors will not need to recertify on criteria that have not changed since 2011
- New Criteria: Safety-enhanced design

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Certified EHR Technology

What it is today

2011 - 13

What is proposed

2014

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"Base EHR"

- EHR technology that includes fundamental capabilities all providers would need to have.
- All are defined by statute as the ability to support:
  - Demographics
  - CPOE
  - CDS
  - Quality Reporting
  - Information exchange
- Security requirements, though not required by statute, were added to the base EHR

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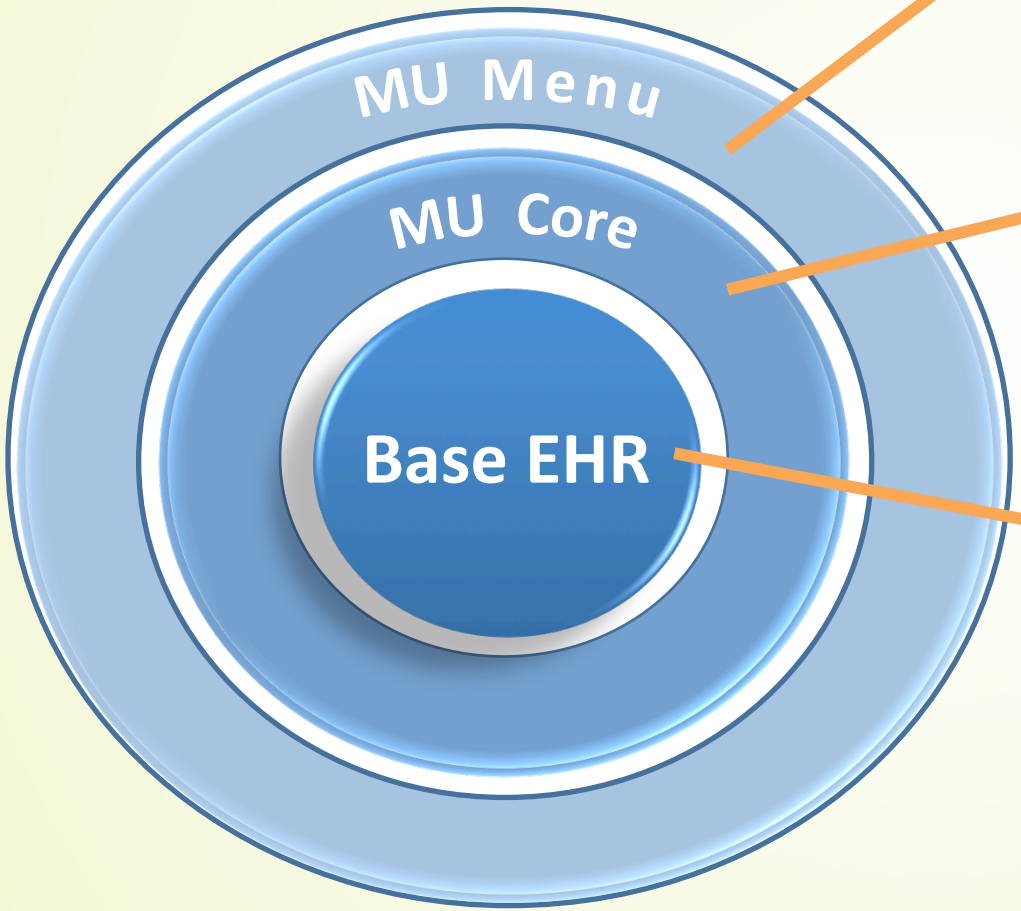
Base EHR

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)

2014 Edition CEHRT



Capabilities certified for the MU menu set objectives & measures for the stage of MU they seek to achieve.

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.

Capabilities certified to meet the definition of Base EHR.

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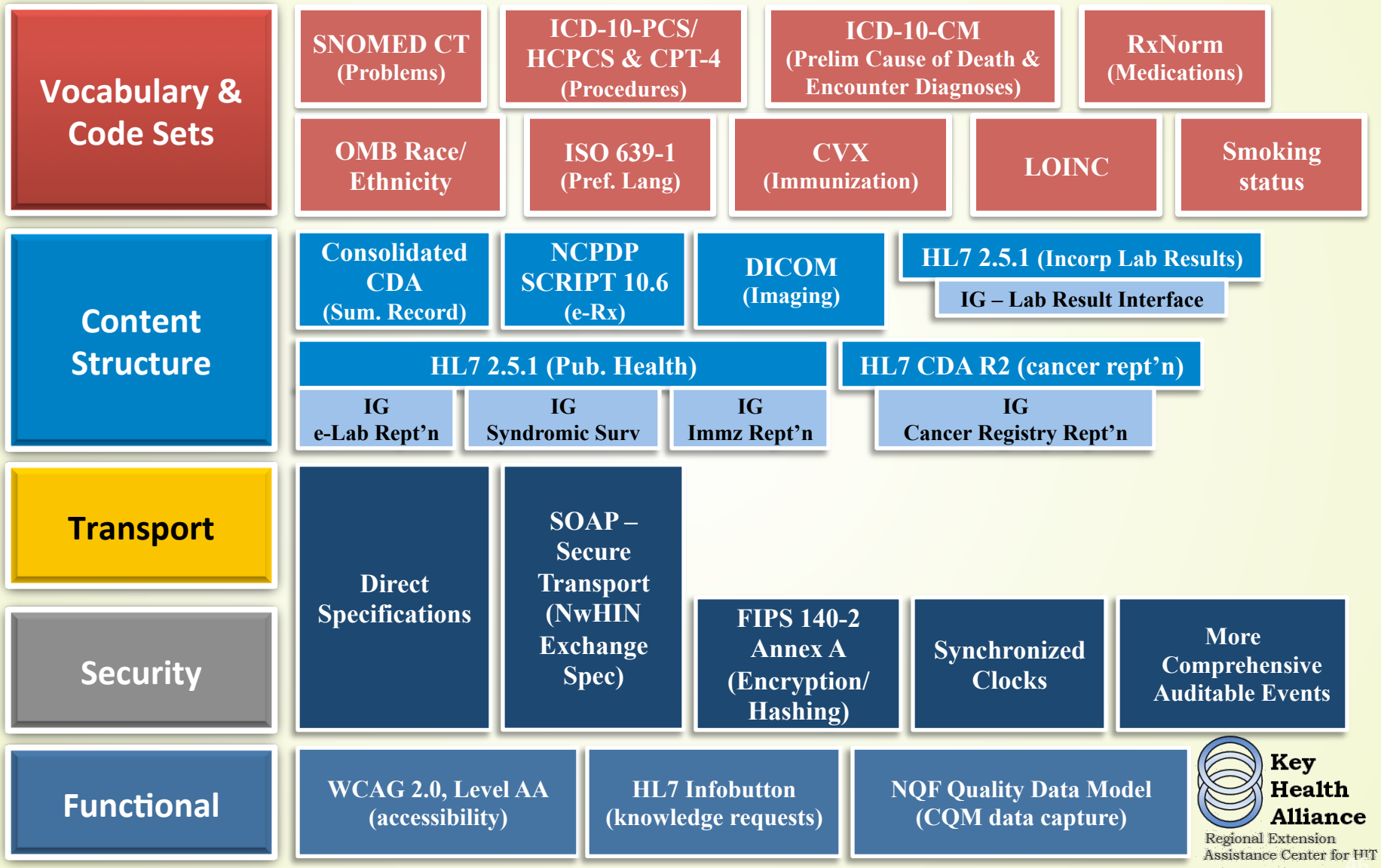
Proposed Revised Definition of CEHRT Compliance

EHR Reporting Period			
FY/CY 2011	**FY/CY 2012**	**FY/CY 2013**	**FY/CY2014**
MU Stage 1	MU Stage 1	MU Stage 1	MU Stage 1 or MU Stage 2
All EPs, EHs, and CAHs must have: 1. EHR technology that has been certified to all applicable 2011 Edition EHR certification criteria or equivalent 2014 Edition EHR certification criteria adopted by the Secretary; or 2. EHR technology that has been certified to the 2014 Edition EHR certification criteria that meets the Base EHR definition and would support the objectives, measures, and their ability to successfully report CQMs, for MU Stage 1.			All EPs, EHs, and CAHs must have EHR technology certified to the 2014 Edition EHR certification criteria that meets the Base EHR definition and would support the objectives, measures, and their ability to successfully report the CQMs, for the MU stage that they seek to achieve.

2014 Edition Standards



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What do you need to do now

- Complete patients' problem, medication and allergy lists. Make sure they are up to date and current
- Establish relationships with other organizations to which you refer to begin to plan for exchange
- Talk with your vendor about upgrade timelines
- 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
- Look at the quality measures and decide which ones are important to you. Let your vendor know
- Plan to have a major EHR upgrade in late 2013 early 2014
  - Patient portals will require a lot of decision making on the part of providers
- Explore whether you plan to use your vendor's patient portal or another option

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Resources:

- 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/
- CMS Meaningful Use Site:
  - http://www.cms.gov/EHRIncentivePrograms/
- Office of the National Coordinator Health IT site:
  - http://HealthIT.gov
- Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl

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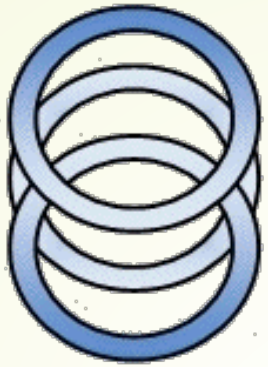

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Key Health Alliance—Stratis Health, Rural Health Resource Center, and The College of St. Scholastica.

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