Meaningful Use - Is it Useful?

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Regional Extension Assistance Center for HIT

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North Central Medical Conference

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Outline

- **Background to the Drive to Adopt EHRs**
- Benefits of having an EHR
- Financial Incentives from the HITECH Act
- Elements of Meaningful Use
- Proposed Stage II and other Changes
- Closure

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The History:
National Academies Reports

1999 "… at least 44,000 and perhaps as many as 98,000 hospitalized Americans die every year from medical errors." *To Err is Human: Building a Safer Health System*

2001 "A concerted national commitment to building information infrastructure is needed to support health care delivery" *Crossing the Quality Chasm*

2007 "Medication errors injure 1.5M people and cost $3.5B per year in the U.S." *Preventing Medication Errors*

2009 "Even in organizations with advanced HIT, it is rarely used to provide clinicians with evidence-based decision support or for data-driven process improvement." *Crossing the Health Care IT Chasm*

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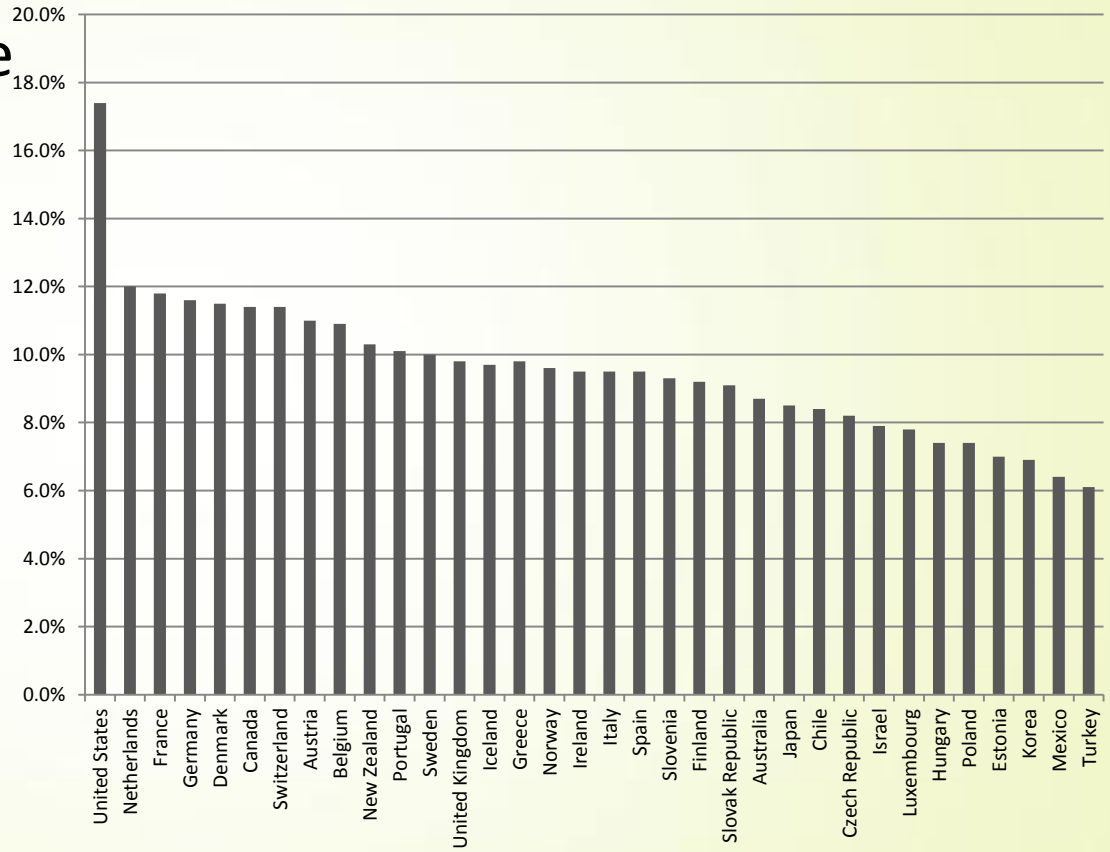
Are we getting value for our dollar? Cost vs. Quality

- Per capita health care spending
  - $2.6T (2010)[1]
  - 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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Underinvestment in HIT

Per Capita Spending on Health Information Technology

Source: Anderson, G. F., Frogner, B. K., Johns, R. A., & Reinhardt, U. E. (2006). Health Care Spending And Use Of Information Technology In OECD Countries. Health Affairs, 25(3), 819-831.

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Patients Want More Accessible, Coordinated, Well-Informed Care

Percent reporting it is very important/important that:	Total very important or important
You have easy access to your own medical records	94%
All your doctors have easy access to your medical records	96%
You have information about the quality of care provided by different doctors/hospitals	95%

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

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The Bi-Partisan Support:

2004 "…an Electronic Health Record for every American by the year 2014. By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care." George W Bush - State of the Union address, Jan. 20, 2004

2009 "Computerize all health records within five years." Barack Obama - George Mason University, January 12, 2009

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The "Stimulus Package"

- 2009 American Recovery and Reinvestment Act (ARRA) - $787 B
- Health Information Technology for Economic and Clinical Health (HITECH) Act
  - $29.2 B starting in 2011 to incent Medicare and Medicaid participating physicians and hospitals to use certified EHR systems in a "meaningful" way

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Meaningful Use Overview: Statutory Framework

In HITECH, Congress established three fundamental criteria of requirements for meaningful use:

1. Use of certified EHR technology in a meaningful manner
2. Certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality and coordination of care
3. In using certified EHR technology, the provider submits clinical quality measures and other measures as determined by the secretary

Source: Brian Wagner, Senior Director of Policy and Public Affairs, eHealth Initiative (eHI) presentation to the MN Exchange and Meaningful Use Workgroup January 15, 2010

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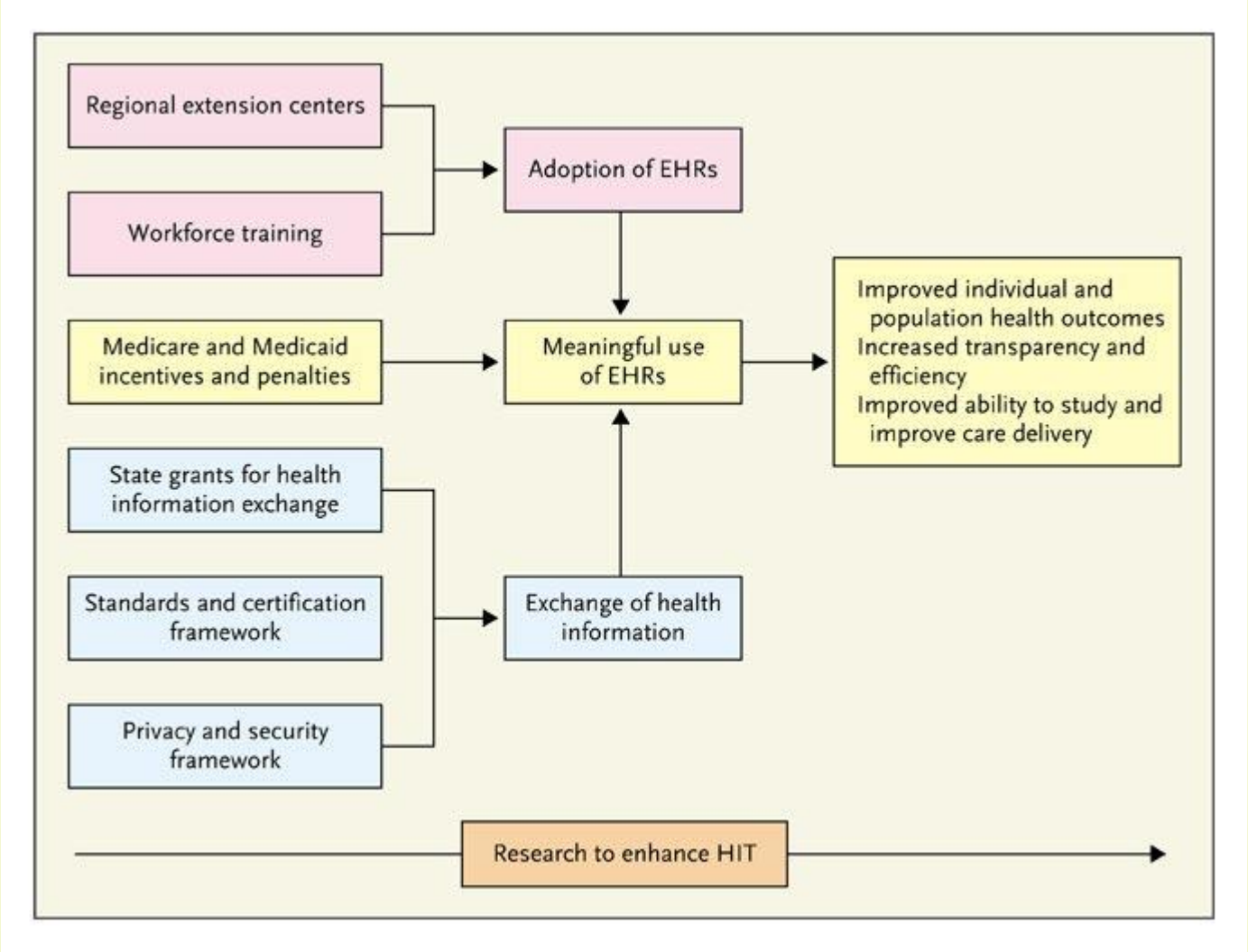
The HITECH Act's Framework



Blumenthal D. Launching HITECH. N Engl J Med posted online Dec 30 2009.
http://healthcarereform.nejm.org/?p=2669

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Benefits: Potential Productivity and Financial Improvement

- Fewer chart pulls
- Improved efficiency of handling telephone messages and medication refills
- Improved charge capture
- Reduced transcription costs
- Increased formulary compliance and clearer prescriptions leading to fewer pharmacy call backs
- Improved coding of visits
- ARRA incentives and avoiding penalties from CMS and health plans
- Proactive patient reminders increasing traffic and revenue

Adapted from Potential Benefits of an EHR, AAFP Center for HealthIT

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MGMA report shows groups with EHRs report better financial performance

- Medical Practices that were not hospital/IDS- owned and that had an EHR reported $49,916 greater total medical revenue after operating cost per FTE physician than practices on paper.
- For multispecialty practices that were hospital-/IDS-owned and had an EHR reported an operating margin that was $42,042 more.
- After five years of EHR use, these practices reported an operating margin 10.1 percent greater than practices in their first year.
- IT staffing per FTE physician increased slightly after five years (0.13 to 0.15), and FTE medical records staff per physician decreased by 44.12% (0.34 to 0.19).

Electronic Health Records Impacts on Revenue, Costs, and Staffing: 2010 Report Based on 2009 Data

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Benefits: Quality of Care Improvement

- Easier preventive care leading to increased preventive care services
- Point-of-care decision support
- Reduced transcription errors
- Rapid and remote access to patient information
- Easier chronic disease management
- Integration of evidence-based clinical guidelines
- Population management
- Proactive patient reminders

Adapted from Potential Benefits of an EHR, AAFP Center for HealthIT

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Benefits: Job Satisfaction Improvement

- Fewer repetitive, tedious tasks
- Fewer repetitive dictations
- Less "chart chasing"
- Improved intra-office communication
- Access to patient information while on-call or at the hospital
- Easier compliance with regulations
- Demonstrable high-quality care
- Access records from multiple locations in an office

Adapted from Potential Benefits of an EHR, AAFP Center for HealthIT

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Benefits: Customer Satisfaction Improvement

- Quick and easier access to their records and medical information
- Reduced turn-around time for telephone messages and medication refills
- A more efficient office leads to improved care access for patients
- Improved continuity of care (fewer visits without the chart)
- Improved delivery of patient education materials
- Easier access to their information by patients

Adapted from Potential Benefits of an EHR, AAFP Center for HealthIT

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Benefits: Increased Security

- Chart access controlled by passwords
- Possible to limit medical record access by job function
- Log file creates a very detailed audit trail of who looked at what in the chart – helps keep honest people honest
- “Break the glass” functionality allows for wider access in an emergency

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Incentive Payments to Eligible Professionals

- Made either directly to the professional or the professional may reassign it to another entity
- Eligible professionals must choose between Medicare & Medicaid Incentives, but may switch once
- In the 1st year of demonstrating meaningful use, each provider must demonstrate MU over any continuous 90 period.

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Definition of a Medicare Eligible Professional

- A physician, defined by the Social Security Act Sec 1861(r):
  - A doctor of medicine or osteopathy
  - A doctor of dental surgery or dental medicine
  - A doctor of podiatric medicine
  - A doctor of optometry
  - A chiropractor
- Does not provide more than 90% of services with a place of service (POS) code of 21 or 23 (considered hospital inpatient or ED based)
- Incentive amount is 75% of the physician's Medicare part B allowable RBRVS charges up to the payment year limit
  - Medicare Advantage plan charges are excluded from the calculation

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Maximal Medicare Incentives for EPs[1]

2010	2011	2012	2013	2014	2015	2016	2017	Total
	Stage 1 $18k	Stage 1 $12k	Stage 1 $8k	Stage 2 $4k	Stage 2 $2k	Stage 3	Stage 3	$44k
		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3 $2k	Stage 3	$44k
			Stage 1 $15k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3	$39k
				Stage 1 $12k[2]	Stage 1 $8k	Stage 2 $4k	Stage 2	$24k
					Stage 1	Stage 1	Stage 2	0
Penalty (deduction from Medicare charges) if not a meaningful user:					**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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Medicaid Eligible Professional

- An Eligible Professional for Medicaid is defined in statute as a
  - Physician (MD, DO and in some states, optometrists)
  - Dentist
  - Certified nurse mid-wife
  - Nurse practitioner
  - Some physician assistants
- In order to be eligible for the Medicaid incentives, one must have
  - Greater than 30% Medicaid patient volume
  - Greater than 20% if a pediatrician (physician)
  - Greater than 30% “needy individuals” if at an FQHC or RHC.
- First payment year can be for Adopt, Implement or Upgrade only

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Calculating Eligible Professional Medicaid Incentives

- Any provider who has the patient mix is eligible for the incentive.
- For professionals with >30% Medicaid patient mix:
  - $21,250 for the first payment year
  - $8500 for each of the following 5 years
- For pediatric physicians with between 20% and 30%:
  - $14,167 in the first payment year
  - $5,667 for each of the following 5 years
- The first payment year can be as late as 2016

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Maximum Medicaid Incentives for EPs with ≥ 30% volume

		First Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	2011
Calendar Year	2011	$21,250						$21,250
	2012	$8,500	$21,250					
	2013	$8,500	$8,500	$21,250				$8,500
	2014	$8,500	$8,500	$8,500	$21,250			
	2015	$8,500	$8,500	$8,500	$8,500	$21,250		$8,500
	2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250	$8,500
	2017		$8,500	$8,500	$8,500	$8,500	$8,500	
	2018			$8,500	$8,500	$8,500	$8,500	
	2019				$8,500	$8,500	$8,500	$8,500
	2020					$8,500	$8,500	
	2021						$8,500	$8,500
	Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

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Statistics as of February 1

- $3.1 billion paid to hospitals and professionals
- 1169 ambulatory and 571 inpatient products have become certified
- 189,000 eligible professionals have registered
- 3,247 Hospitals have registered
  - And the number of hospitals and professionals attesting has been increasing steadily

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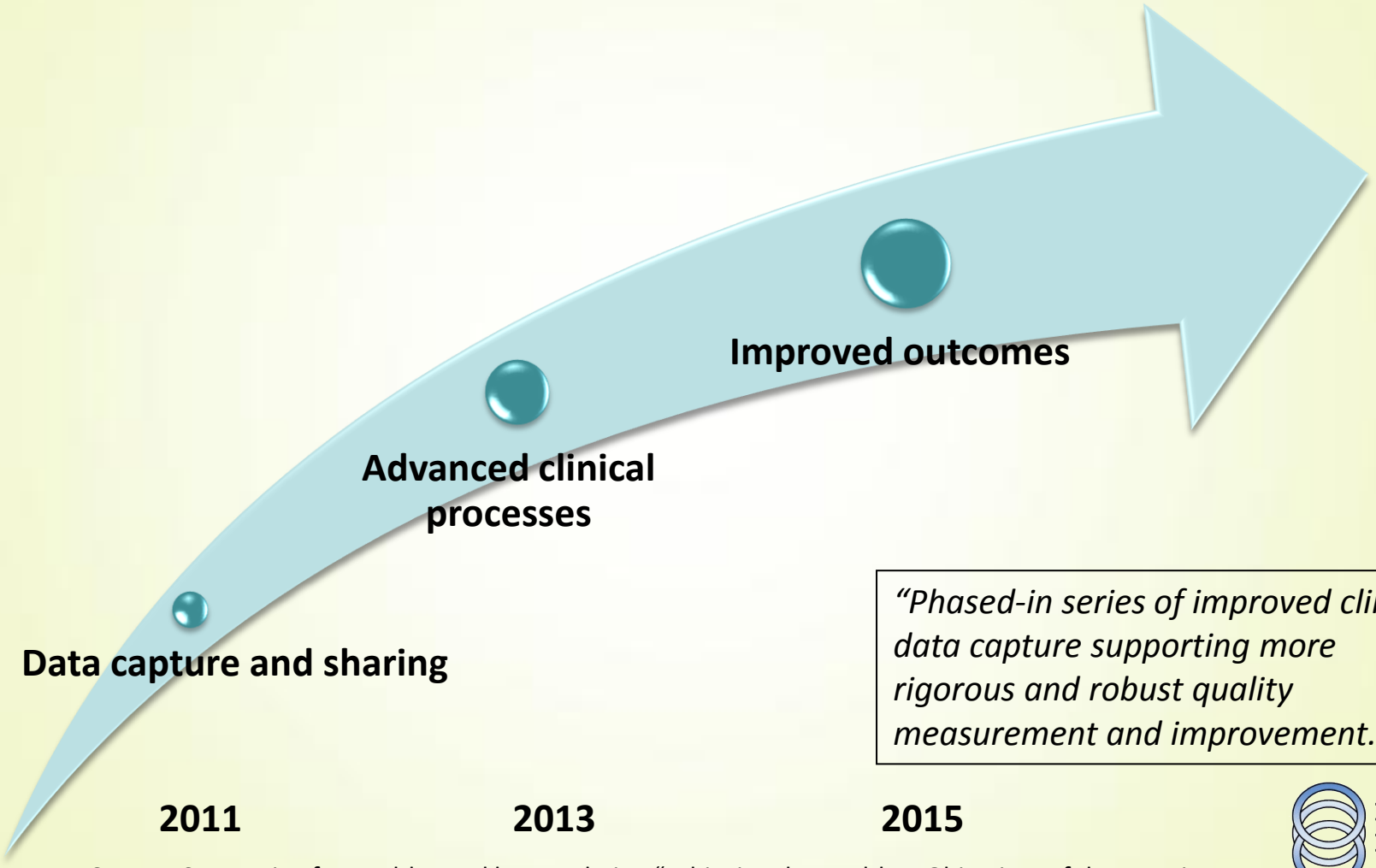
Meaningful Use Criteria

- Adapted from National Priorities and Goals of the National Priorities Partnership:[1]
  - Improving quality, safety, efficiency, and reducing health disparities
  - Engage patients and families in their health care
  - Improve care coordination
  - Improve population and public health
  - Ensure adequate privacy and security protections for personal health information
- Are divided into Core Criteria and Menu Criteria

1. National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008.

Bending the Curve Towards Transformed Health



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

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

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“Stage 1” Meaningful Use Criteria

- 25 objectives and measures for eligible professionals (EP)
  - 15 are required (“core”), up to 5 of the remaining 10 may be deferred to Stage 2 (“menu”)
- Professionals must complete each of the core criteria unless they qualify for an exclusion:
  - Chiropractor and e-prescribing

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1. Improve quality, safety, efficiency and reduce health disparities

Core (Required unless exempt)

- Collect demographics
- Complete a problem list
- Maintain a med list
- Record med allergies
- Vital signs
- Record smoking status
- Order meds (CPOE)
  - ePrescribe
  - Drug (D-A, D-D) Interactions
  - Decision Support
- Report Quality Measures

Menu

- Use a formulary
- Incorporate lab results so they can populate a flow sheet
- Be able to create a list of patients based on a criteria
- Reminder patients of needed follow-up

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2. Engage Patients and Families in Their Health Care

Core

- Give a patient an electronic copy of their health information if requested
- Clinical (after visit) summaries available for patients

Menu

- Electronic access to their health information (10%)
- Patient specific education materials identified with the EHR (10%)

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3. Improve Care Coordination

Core

- Attempt electronic exchange with another provider

Menu

- Medication reconciliation for each transition of care
- Summary care record (can be paper) for referrals.

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4. Improve Population and Public Health

Core

- [one menu item must be done]

Menu

Attempt sending

- Immunization records to a registry
- Syndromic Surveillance to public health

5. Privacy/security protections for PHI

Core

- Protect Patient Personal Health Information

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Core Quality Measures for EPs

- **Clinical Quality Measures**
  - Blood pressure measurement
  - Tobacco use assessment and intervention
  - Adult Weight Screening and Follow-up
- **Alternate Core Measures**
  - Weight Assessment and Counseling for Children and Adolescents
  - Influenza Immunization for Patients ≥ 50 Years Old
  - Childhood Immunization Status

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Additional Quality Measures

(Choose 3 of 38)

- Diabetes (9)
- Cardiovascular
  - Coronary artery disease (3)
  - Heart failure (3)
  - Ischemic vascular disease (3)
- Prevention (7)
- Appropriate use (3)
- Asthma (3)
- Oncology (2), Tobacco (1), Alcohol (1), Depression (1), Glaucoma (1), Hypertension (1)

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What's in store? Stage 2 (2014)

- Minor changes to Stage 1 of meaningful use for 2013 and then 2014 and beyond
- New proposed criteria
- New proposed clinical quality measures
- New clinical quality measure reporting mechanisms
- Details on the Medicare payment adjustments
- Requirements to use 2014 certified EHR technology (CEHRT)

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Stages of Meaningful Use

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

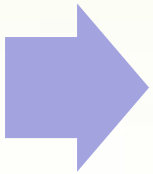
Stage 1 to Stage 2 Meaningful Use

Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives



Eligible Professionals

17 core objectives

3 of 5 menu objectives

20 total objectives

- Stage 1 items:
  - Higher percentages for core items
  - Most menu items become core
  - Success required for immunization data
- New Certified EHR Standards
  - Greater flexibility in constructing a Certified EHR
  - Encryption of data at rest

- New Items
  - Patients are able to access their health information online and actually do it
  - Patients send secure messages
  - Electronic transmission of referral / transfer of care documents
  - Imaging results accessible through EHR technology (menu)
  - Family Health History (menu)
  - Submission to registries (menu)

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Clinical Quality Measure (CQM) - 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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CQM – Changes from July 28, 2010 Final Rule

2010 Final Rule

Eligible Professionals

3 core OR 3 alt. core CQMs

+

3 menu CQMs

6 total CQMs

2012 Proposed Rule

Eligible Professionals

1a) 12 CQMs (≥1 per domain)

1b) 11 core + 1 menu CQMs

2) PQRS

Group Reporting

12 total CQMs

Align with ONC's 2011 Edition Certification

Align with ONC's 2014 Edition Certification

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CQM Reporting for EPs Beginning in CY2014

- EHR Incentive Program Only
  - Option 1a: 12 CQMs, ≥1 from each domain
  - Option 1b: 11 “core” CQMs + 1 “menu” CQM
  - Medicaid – State based e-submission
  - Aggregate XML-based format specified by CMS
- EHR Incentive Program + PQRS
  - Option 2: Submit and satisfactorily report CQMs under PQRS EHR Reporting option using CEHRT

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EP Payment Adjustments

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

Proposed Exception on an application basis

- Insufficient internet access two years prior to the payment adjustment year
- Newly practicing EPs for two years
- Extreme circumstances

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EP EHR Reporting Period

- EP who has demonstrated meaningful use in 2011 or 2012

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

- EP who demonstrates meaningful use in 2013 for the first time

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

EP EHR Reporting Period

- EP 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[1]	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

1. In order to avoid the 2015 payment adjustment the EP must attest no later than Oct 1, 2014

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In Closing

- The Meaningful Use Incentive is intended to encourage the health care industry to improve the quality, safety and efficiency of care through health information technology
- Incentives are available for those who adopt certified EHR technology now and use it effectively
- Penalties will begin to kick in for those who do not adopt a certified EHR and use it meaningfully
- Over time, a demonstrated level of quality will be necessary for any incentives or payment increases
- Careful preparation will enable a more rapid recovery from an implementation which always are challenging

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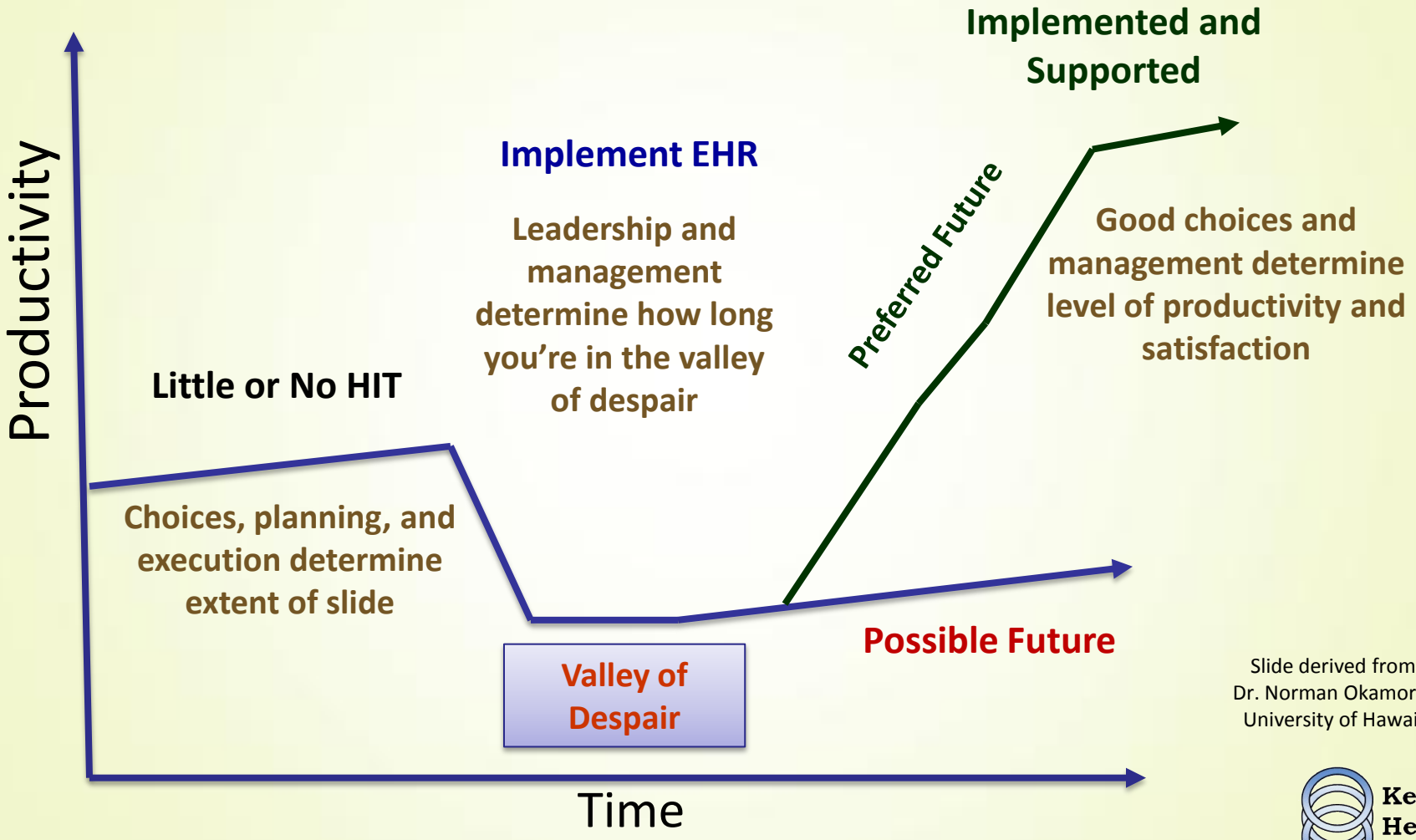
Minimizing the Challenges depends on Preparation



Slide derived from
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Questions?

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

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