Proposed CMS and ONC EHR Incentive Rules for Stage 2

Paul Kleeberg, MD, FAAFP, FHIMSS
CMIO, Stratis Health

Minnesota Rural Health Conference
June 26, 2012
Conflict of Interest

• Dr. Kleeberg is the Clinical Director for the Minnesota - North Dakota Regional Extension Assistance Center for HIT (REACH) – a federally subsidized non-profit entity designed to assist Hospitals and Professionals in becoming meaningful users of EHRs.

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

• No other conflict of interest
Objectives

• Become familiar with the meaningful use and penalty timeline as proposed in the CMS Proposed rule
• Identify the Meaningful Use criteria that will be required for Stage 2
• Understand the changes to the Stage 1 Criteria
• Understand the proposed changes to the EHR incentive quality reporting
• Be able to describe the proposed differences between 2011 and 2014 Certified EHRs
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – Changes to Stage 1
  – Clinical Quality Measures
  – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
## Stages of Meaningful Use

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
### Maximum Medicare Incentives for EPs in a non shortage area

<table>
<thead>
<tr>
<th>Year</th>
<th>Stage 1</th>
<th>Stage 1</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 2</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$18k</td>
<td>$12k</td>
<td>$8k</td>
<td>$4k</td>
<td>$2k</td>
<td></td>
<td>$3k</td>
<td>$3k</td>
<td>$44k</td>
</tr>
<tr>
<td>2011</td>
<td>$18k</td>
<td>$12k</td>
<td>$8k</td>
<td>$4k</td>
<td>$2k</td>
<td></td>
<td>$3k</td>
<td>$3k</td>
<td>$44k</td>
</tr>
<tr>
<td>2012</td>
<td>$18k</td>
<td>$12k</td>
<td>$8k</td>
<td>$4k</td>
<td>$2k</td>
<td></td>
<td>$3k</td>
<td>$3k</td>
<td>$44k</td>
</tr>
<tr>
<td>2013</td>
<td>$15k</td>
<td>$12k</td>
<td>$8k</td>
<td>$4k</td>
<td>$2k</td>
<td></td>
<td>$3k</td>
<td>$3k</td>
<td>$39k</td>
</tr>
<tr>
<td>2014</td>
<td>$12k</td>
<td>$8k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2k</td>
<td></td>
<td>$24k</td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Penalty (deduction from Medicare charges) if not at stage 3 by January 1 of that year:

1. 1%
2. 2%
3. 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.
## Maximum Medicaid Incentives for EPs with ≥ 30% volume

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>First Year of Adopt, implement, Upgrade or MU Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
</tr>
<tr>
<td>2012</td>
<td>$8,500</td>
</tr>
<tr>
<td>2013</td>
<td>$8,500</td>
</tr>
<tr>
<td>2014</td>
<td>$8,500</td>
</tr>
<tr>
<td>2015¹</td>
<td>$8,500</td>
</tr>
<tr>
<td>2016¹</td>
<td>$8,500</td>
</tr>
<tr>
<td>2017¹</td>
<td>$8,500</td>
</tr>
<tr>
<td>2018¹</td>
<td>$8,500</td>
</tr>
<tr>
<td>2019¹</td>
<td>$8,500</td>
</tr>
<tr>
<td>2020¹</td>
<td>$8,500</td>
</tr>
<tr>
<td>2021¹</td>
<td>$8,500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$63,750</strong></td>
</tr>
</tbody>
</table>

1. Note: Medicare penalties will apply for any of the professional’s billing to Medicare part B if not a meaningful user
Professional EHR Reporting Period

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

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Reporting Period</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 day EHR Reporting Period</td>
<td>2014*</td>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Year EHR Reporting Period</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* In order to avoid the 2015 payment adjustment the professional must attest no later than October 1, 2014
# EP Medicare Payment Adjustments

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EP is not subject to the payment adjustment for e-Rx in 2014</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>EP is subject to the payment adjustment for e-Rx in 2014</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EP is not subject to the payment adjustment for e-Rx in 2014</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>EP is subject to the payment adjustment for e-Rx in 2014</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>
EP Hardship Exception

- Proposed Exception on an application basis submitted by July 1 before the payment year
  - Insufficient internet access for the two years prior
  - Newly practicing EPs for two years
  - Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

- Proposed combination of 3 barriers would constitute a significant hardship
  - Lack of direct interaction with patients
  - Lack of need for follow-up care for patients
  - Lack of control over the availability of Certified EHR Technology
# Medicare Incentives for Prospective Payment System (PPS) Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>% Max Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Percentages in the cells indicate the transition factor for the Medicare Share incentive.
2. Must demonstrate and attest to MU by July 1, 2014 to avoid the 2015 penalty.
Subsection (d) (PPS) Hospital EHR Reporting Period

- Hospital which has demonstrated meaningful use in 2011 through 2013 (fiscal years)

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful User Year</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>

- Hospital which demonstrates meaningful use in 2014 for the first time

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 day EHR Reporting Period</td>
<td>2014*</td>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Year EHR Reporting Period</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* In order to avoid the 2015 payment adjustment the hospital must attest no later than July 1, 2014
Subsection (d) (PPS) Hospital Payment Adjustments

% Decrease in the Percentage Increase to the IPPS Payment Rate that the hospital would otherwise receive for that year

<table>
<thead>
<tr>
<th>% Decrease</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020+</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Decrease</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

• For example if the increase to IPPS for 2015 was 2% than a hospital subject to the payment adjustment would only receive a 1.5% increase
Subsection (d) (PPS) Hospital Hardship Exception

- Proposed Exception on an application basis
  - Insufficient internet access two years prior to the payment adjustment year
  - New hospitals for at least 1 full year cost reporting period
  - Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

- Applications need to be submitted no later than April 1 of year before the payment adjustment year
## Medicare Incentives for Eligible Critical Access Hospitals (CAHs)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 2 Payment</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 2 Payment</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 2 Payment</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 2 Payment</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 2 Payment</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 1 Payment</td>
<td>Stage 2 Payment</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>0</td>
</tr>
</tbody>
</table>

**Penalties:** Reasonable cost reimbursement of 101% would be reduced to:

- 100.66%
- 100.33%
- 100%

Incentive payments calculation based on the Medicare Share of the EHR cost
CAH EHR Reporting Period

- CAH which has demonstrated meaningful use prior to the 2015 fiscal year

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Year EHR Reporting Period</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
</tr>
</tbody>
</table>

- CAH which demonstrates meaningful use in 2015 for the first time

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 day EHR Reporting Period</td>
<td>2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Year EHR Reporting Period</td>
<td></td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
</tr>
</tbody>
</table>
## Critical Access Hospital Payment Adjustments

Applicable % of reasonable costs reimbursement which without payment adjustments is 101%

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of reasonable costs</td>
<td>100.66%</td>
<td>100.33%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
CAH Hardship Exception

• Proposed Exemptions on an application basis
  – Insufficient internet access for the payment adjustment year
  – New CAHs for one year after they accept their first patient
  – Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.
Outline

- CMS EHR Incentive Proposed Rule
  - Rewards, Penalties and Timeline
  - Stage 2
  - Changes to Stage 1
  - Clinical Quality Measures
  - Changes to Medicaid

- ONC Standards & Certification Proposed Rule
  - Redefining Certified EHR Technology
  - EHR Standards
  - EHR Certification Program
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

• Changes
  – Exclusions no longer count to meeting one of the menu objectives
  – All denominators include all patient encounters at outpatient locations equipped with certified EHR technology
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

Eligible Hospitals & CAHs
- 14 core objectives
- 5 of 10 menu objectives
- 19 total objectives

Eligible Hospitals & CAHs
- 16 core objectives
- 2 of 4 menu objectives
- 18 total objectives
Stage 2 EP Core Objectives

1. Use CPOE > 60% of all medication, laboratory and radiology orders
2. E-Rx > 65%
3. Record demographics > 80%
4. Record vital signs > 80%
5. Record smoking status > 80%
6. Implement 5 clinical decision support interventions + drug/drug and drug/allergy
7. Provide office visit summaries in 24 hours
8. Conduct or review security analysis and incorporate in risk management process
Stage 2 EP Core Objectives – No Longer Menu:

9. Incorporate lab results > 40% 55%
10. Generate patient list by specific condition
11. Use EHR to identify and provide > 10% with reminders for preventive/follow-up
12. Provide **online access** to health information > 50% with > **10% actually accessing**
13. Use EHR to identify and provide education resources > 10%
Stage 2 EP Core Objectives – No Longer Menu:

14. Medication reconciliation > 50 65% of transitions of care

15. Provide summary of care document > 50 65% of transitions of care and referrals with > 10% sent electronically

16. Successful ongoing transmission of immunization data

New Stage 2 EP Core Objective:

17. > 10% of patients send secure messages to their EP
Stage 2 EP Menu Objectives
(Select 3 of 5)

1. **Successful ongoing** transmission of syndromic surveillance data
2. > 40% of imaging results are accessible through Certified EHR Technology
3. *Record family health history* > 20%
4. **Successful ongoing transmission of cancer case information**
5. **Successful ongoing transmission of data to a specialized registry**
Stage 2 Hospital Core Objectives

1. Use CPOE > **30 60%** of all medication, 
   laboratory and radiology orders
2. Record demographics > **50 80%**
3. Record vital signs > **50 80%**
4. Record smoking status > **50 80%**
5. Implement ± **5** clinical decision support interventions + drug/drug and drug/allergy
6. Conduct or review security analysis and incorporate in risk management process
Stage 2 Hospital Core Objectives – No Longer Menu:

7. Incorporate lab results > 40\textsuperscript{55\%}
8. Generate patient list by specific condition
9. Provide \textit{online access} to health information > 50\% with > 10\% \textit{actually accessing}
10. Use EHR to identify and provide education resources > 10\%
11. Medication reconciliation > 65\% of transitions of care
Stage 2 Hospital Core Objectives – No Longer Menu:

12. Provide summary of care document > 50% 65% of transitions of care and referrals with 10% sent electronically

13. Successful ongoing transmission of immunization data

14. EH: Successful ongoing submission of reportable laboratory results

15. EH: Successful ongoing submission of electronic syndromic surveillance data

New Stage 2 EP Core Objective:

16. EMAR with barcode scanning is implemented and used for more than 10% of medication orders
Stage 2 Hospital Menu Objectives (Select 2 of 4)

1. Record indication of advanced directive for more than 50%

2. More than 40% of imaging results are accessible through Certified EHR Technology

3. Record family health history for more than 20%

4. E-Rx for more than 10% of discharge prescriptions
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – **Changes to Stage 1**
    – Clinical Quality Measures
    – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
Changes to Stage 1:

Denominator: Unique Patient with at least one medication in their med list → Denominator: Number of Orders during the EHR Reporting Period

Optional in 2013 Required in 2014+

Age Limits: Age 2 for Blood Pressure & Height/Weight → Age Limits: Age 3 for Blood Pressure, No age limit for Height/Weight

Optional in 2013 Required in 2014+
Changes to Stage 1:

Exclusion: All three elements not relevant to scope of practice

Optional in 2013 Required in 2014+

Exclusion: Allows BP to be separated from height/weight

Effective 2013

One test of electronic transmission of key clinical information

Requirement removed effective 2013
Changes to Stage 1:

Objective: Provide patients with e-copy of health information upon request
Objective: Provide electronic access to health information

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

Required in 2014+

Immunizations
Reportable Labs
Syndromic Surveillance

Addition of “except where prohibited” to all three

Effective 2013
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – Changes to Stage 1
  – Clinical Quality Measures
  – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
Alignment Among Programs

• CMS is committed to aligning quality measurement and reporting among programs

• Alignment efforts on several fronts:
  – Choosing the same measures for different programs
  – Coordinating quality measurement stakeholder involvement
  – Identifying ways to minimize multiple submission requirements
CQM - Domains

• Patient and Family Engagement
• Patient Safety
• Care Coordination
• Population and Public Health
• Efficient Use of Healthcare Resources
• Clinical Processes/Effectiveness
CQM – Changes from Stage 1 Final Rule

2010 Final Rule

Eligible Professionals
3 core OR 3 alt. core CQMs
+ 3 menu CQMs
6 total CQMs

Eligible Hospitals & CAHs
15 total CQMs

Align with ONC’s
2011 EHR Certification

2012 Proposed Rule

Eligible Professionals
1) 12 CQMs (≥1 per domain)
   2) PQRS
Group Reporting
12 total CQMs

Eligible Hospitals & CAHs
24 CQMs (≥1 per domain)
24 total CQMs

Align with ONC’s
2014 EHR Certification
CQM Reporting in 2013 EPs & Hospitals

- CQMs will remain the same through 2013
  - As published in the July 28, 2010 Final Rule
- Electronic specifications for the CQMs will be updated
- Reporting Methods:
  - Attestation
  - 2012 Electronic Reporting Pilots (PQRS for EPs and IQR for EHs) extended to 2013
  - Medicaid – State-based e-submission
CQM Reporting for EPs
Beginning in CY2014

• Option 1: EHR Incentive Program Only
  – 12 CQMs, ≥1 from each domain
  – Medicaid – State based e-submission
  – Aggregate XML-based format specified by CMS

• Option 2: EHR Incentive Program + PQRS
  – Submit and satisfactorily report CQMs under PQRS EHR Reporting option using CEHRT to satisfy MU
CQM Reporting for EPs
Beginning in CY2014

• Group Reporting (3 options):

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) ≥ 2 EPs, each with a unique NPI under one TIN</td>
<td>Submit 12 CQMs from EP measures table, ≥1 from each domain</td>
</tr>
<tr>
<td>(2) EPs in an ACO (Medicare Shared Savings Program)</td>
<td>Satisfy requirements of Medicare Shared Savings Program using Certified EHR Technology</td>
</tr>
<tr>
<td>(3) EPs satisfactorily reporting via PQRS GPRO option</td>
<td>Satisfy requirements of PQRS GPRO option using Certified EHR Technology</td>
</tr>
</tbody>
</table>
CQM Reporting for Hospitals Beginning in FY2014

• 24 CQMs, ≥1 from each domain
  – Includes 15 CQMs from July 28, 2010 Final Rule
  – Considering instituting a case number threshold exemption for some hospitals

• Reporting Methods
  – Aggregate XML-based format specified by CMS
  – Manner similar to 2012 Medicare EHR Incentive Program Electronic Reporting Pilot
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – Changes to Stage 1
  – Clinical Quality Measures
  – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
Medicaid- Specific Changes

- Proposed an expanded definition of a Medicaid encounter:
  - To include any encounter with an individual receiving medical assistance under 1905(b), including Medicaid expansion populations
  - To permit inclusion of patients on panels seen within 24 months instead of just 12
  - To permit patient volume to be calculated from the most recent 12 months, instead of on the CY
  - To include zero-pay Medicaid claims
Medicaid-Specific Changes Continued

• Proposed the inclusion of additional children’s hospitals that do not have a CMS Certification Number (CCN)
• Proposed to extend States’ flexibility with the definition of meaningful use to Stage 2
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – Changes to Stage 1
  – Clinical Quality Measures
  – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
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
## “New” Certification Criteria

<table>
<thead>
<tr>
<th>Ambulatory &amp; Inpatient</th>
<th>Inpatient Only</th>
<th>Ambulatory Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Notes</td>
<td>Electronic medication administration record</td>
<td>Secure messaging</td>
</tr>
<tr>
<td>Imaging (access to)</td>
<td>eRx (for discharge)</td>
<td>Cancer case information</td>
</tr>
<tr>
<td>Family Health History</td>
<td>Transmission of electronic lab tests and values/results to ambulatory providers</td>
<td>Transmission to cancer registries</td>
</tr>
<tr>
<td>Amendments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View, Download, &amp; Transmit to 3rd party</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auto numerator recording</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-%-based measure use report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety-enhanced design</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## “Revised” Certification Criteria

<table>
<thead>
<tr>
<th>Ambulatory &amp; Inpatient</th>
<th>Ambulatory Only</th>
<th>Inpatient Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-drug, drug-allergy interaction checks</td>
<td>Incorporate lab tests and values/results</td>
<td>eRx</td>
</tr>
<tr>
<td>Demographics</td>
<td>CQMs</td>
<td>Clinical summaries</td>
</tr>
<tr>
<td>Problem list</td>
<td>Auditable events and tamper-resistance</td>
<td></td>
</tr>
<tr>
<td>Clinical decision support</td>
<td>Audit report(s)</td>
<td></td>
</tr>
<tr>
<td>Patient-specific education resources</td>
<td>Encryption of data at rest</td>
<td>Transmission of reportable lab tests and values/results</td>
</tr>
<tr>
<td>TOC – Incorporate summary care record</td>
<td>Immunization Information</td>
<td></td>
</tr>
<tr>
<td>TOC – Create transmit summary care record</td>
<td>Transmission to Immunization Registries</td>
<td></td>
</tr>
<tr>
<td>Clinical information reconciliation</td>
<td>Automated measure calculation</td>
<td></td>
</tr>
</tbody>
</table>
“Unchanged” Certification Criteria

<table>
<thead>
<tr>
<th>Ambulatory &amp; Inpatient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE</td>
<td>Drug-formulary checks</td>
</tr>
<tr>
<td>Vital signs, BMI, &amp; growth charts</td>
<td>Medication list</td>
</tr>
<tr>
<td>Smoking status</td>
<td>Medication allergy list</td>
</tr>
<tr>
<td>Patient reminders</td>
<td>Patient lists</td>
</tr>
<tr>
<td>Authentication, access control, &amp; authorization</td>
<td>Accounting of disclosures</td>
</tr>
<tr>
<td>Automatic log-off</td>
<td>Advance directives</td>
</tr>
<tr>
<td>Emergency access</td>
<td>Public health surveillance</td>
</tr>
<tr>
<td>Integrity</td>
<td>Immunization information</td>
</tr>
<tr>
<td>Reportable lab tests and values/results</td>
<td>Incorporate lab test results (inpatient only)</td>
</tr>
</tbody>
</table>

• Roughly 40% of 2014 Edition Certification Criteria Eligible for “Gap Certification”
Certified EHR Technology

Here’s what it looks like today...

2011 - 13

Here’s what ONC is proposing...

2014+
“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
**Certification Criteria Required to Satisfy the Definition of a Base EHR**

<table>
<thead>
<tr>
<th>Base EHR Capabilities</th>
<th>Certification Criteria</th>
</tr>
</thead>
</table>
| Includes patient demographic and clinical health information, such as medical history and problem lists | Demographics § 170.314(a)(3)  
Vital Signs § 170.314(a)(4)  
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                                            | Drug-Drug and Drug-Allergy Interaction Checks § 170.314(a)(2)  
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)  
View, Download, and Transmit to 3rd Party § 170.314(e)(1) |
| Capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged | Privacy and Security § 170.314(d)(1)-(8) |
CEHRT – as defined in NPRM

EP/EH/CAH would only need to have EHR technology with capabilities certified for the MU menu set objectives & measures for the stage of MU they seek to achieve.

EP/EH/CAH would need to have EHR technology with capabilities certified for the MU core set objectives & measures for the stage of MU they seek to achieve unless the EP/EH/CAH can meet an exclusion.

EP/EH/CAH must have EHR technology with capabilities certified to meet the definition of Base EHR.

Base EHR

MU Core - 2

MU Menu - 3
3 proposed ways to meet CEHRT Definition

• Complete EHR

• EHR Module(s):
  – Combination of EHR Modules
  – Single EHR Module

• The new proposal would allow an eligible professional or hospital to have only the 2014 certified EHR modules they needed to meet the definition of CEHRT
## Proposed Revised Definition of CEHRT Compliance

<table>
<thead>
<tr>
<th>EHR Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>MU Stage 1</td>
</tr>
</tbody>
</table>

All EPs, EHs, and CAHs must have EHR technology certified to all applicable 2011 Edition EHR certification criteria or equivalent 2014 Edition EHR certification criteria.

All EPs, EHs, and CAHs must have EHR technology (including a Base EHR) that has been certified to the 2014 Edition EHR certification criteria that would support the objectives and measures, and their ability to successfully report the CQMs, for the MU stage that they seek to achieve.
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – Changes to Stage 1
  – Clinical Quality Measures
  – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
# Vocabulary/Code Sets

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures</td>
<td>ICD-9-CM/ CPT-4</td>
<td>ICD-10-PCS/HCPCS &amp; CPT-4</td>
</tr>
<tr>
<td>Lab Tests</td>
<td>LOINC 2.27</td>
<td>LOINC 2.38</td>
</tr>
<tr>
<td>Medications</td>
<td>Any source vocabulary in RxNorm</td>
<td>RxNorm – Feb 6, 2012</td>
</tr>
<tr>
<td>Race &amp; Ethnicity</td>
<td>OMB standards</td>
<td>OMB standards</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>N/A</td>
<td>ISO 639-1:2002</td>
</tr>
<tr>
<td>Preliminary Determination of Cause of Death and Encounter Diagnoses</td>
<td>N/A</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>N/A</td>
<td>Current every day; current some day; former; never; smoker, current status unknown; and unknown if ever smoked</td>
</tr>
</tbody>
</table>
## Content Exchange

|---------|--------------|-------------------------|
| **Summary Record** | HL7 CDA R2, CCD  
*HITSP Summary Doc using HL7 CCD Component HITSP/C32*  
ASTM E2369 Standard Spec for CCR and Adjunct to ASTM E2369 | Consolidated CDA |
| **eRx** | NCPDP SCRIPT 8.1 / 10.6 | NCPDP SCRIPT 10.6 |
| **Electronic submission of lab results to PH agencies** | HL7 2.5.1  
HL7 2.5.1 IG electronic lab reporting to PH, R1 (US Realm) | HL7 2.5.1  
HL7 2.5.1 IG: electronic lab reporting to PH, R1 (US Realm) |
| **Electronic submission to PH agencies for surveillance or reporting** | HL7 2.3.1 / 2.5.1 | HL7 2.5.1  
## Content Exchange (cont.)

|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Electronic submission to immunization registries | HL7 2.3.1 / 2.5.1  
*IG for immunization Data Transactions using Version 2.3.1 of HL7 Standard Protocol Implementation Guide Version 2.2  
HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0* | HL7 2.5.1  
*HL7 2.5.1 IG for Immunization Messaging Release 1.3*                                                          |
| Quality Reporting                            | CMS PQRI Registry XML Spec  
PQRI Measure Specs Manual for Claims and Registry                                                                                                                                                                 | TBD XML Spec                                                                                               |
| Cancer information                           | N/A                                                                                                                                                                                                                                          | HL7 CDA, R2  
*IG for Healthcare Provider Reporting to Central Cancer Registries, Draft, Feb 2012*                    |
| Imaging                                      | N/A                                                                                                                                                                                                                                          | DICOM PS3 – 2011                                                                                           |
| Electronic incorporation and transmission of lab results | N/A                                                                                                                                                                                                                                          | HL7 2.5.1  
*HL7 2.5.1 IG: S&I Framework Lab Results Interface, Release 1 (US Realm)*                                  |
## Transport

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Specifications</td>
<td>N/A</td>
<td>Applicability Statement for Secure Health Transport</td>
</tr>
<tr>
<td>SOAP-Secure Transport</td>
<td>N/A</td>
<td>External Data Representation and Cross-Enterprise Document Media Interchange for Direct Messaging</td>
</tr>
<tr>
<td>NwHIN Exchange Modular Specification</td>
<td>N/A</td>
<td>Simple Object Access Protocol (SOAP)-Based Secure Transport Requirements Traceability Matrix (RTM) version 1.0</td>
</tr>
</tbody>
</table>
# Security

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditable events</td>
<td>The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which action(s) occurred and by whom must also be recorded.</td>
<td>The 2011 specs plus: 1. The electronic health information affected by the action(s) 2. When audit log is enabled and disabled 3. When encryption of electronic health information managed by EHR technology on end-user devices is enabled and disabled</td>
</tr>
<tr>
<td>Encryption and hashing</td>
<td>N/A</td>
<td>FIPS 140-2 Annex A</td>
</tr>
<tr>
<td>Synchronized clocks</td>
<td>N/A</td>
<td>NTPv3 or NTPv4</td>
</tr>
</tbody>
</table>
# Functional

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>N/A</td>
<td>WCAG 2.0, Level AA Conformance</td>
</tr>
<tr>
<td>Reference Source</td>
<td>N/A</td>
<td>Infobutton, International Normative Ed 2010</td>
</tr>
<tr>
<td>CQM - data capture and export</td>
<td>N/A</td>
<td>NQF Quality Data Model, 2011</td>
</tr>
</tbody>
</table>
Clinical Quality Measure (CQMs) Standards

• Focuses on the CQM lifecycle
  – Data capture (+ export)
  – Calculation (+ incorporation of external sources)
  – Reporting

• Identified Challenges from Stage 1
  – “EHR-Ready” CQMs
  – Exclusions
  – Workflow
Outline

• CMS EHR Incentive Proposed Rule
  – Rewards, Penalties and Timeline
  – Stage 2
  – Changes to Stage 1
  – Clinical Quality Measures
  – Changes to Medicaid

• ONC Standards & Certification Proposed Rule
  – Redefining Certified EHR Technology
  – EHR Standards
  – EHR Certification Program
Permanent Certification Program
Proposed Changes

• Vendors may use newer versions of certain identified minimum code sets standards that have been identified without adversely affecting certification status *unless*:
  – The Secretary *expressly prohibits* the use of a newer version of a “minimum standard” code set

• Two methods to identify newer versions of adopted minimum standards:
  – Anyone can notify the National Coordinator, or
  – The Secretary of HHS identifies a new version
In Closing:

• Summary of Stage 2:
  – Increased provider use of Certified EHRs
  – Increased involvement of patients
  – Increased electronic exchange of information
  – Continued pay-for-reporting of Clinical Quality Measures; pay-for-performance is coming
  – Penalties for non-use are slated to come sooner than we thought

• The direction is clear – we will need to wait until later this summer to know the specifics.
Paul Kleeberg, MD, FAAFP, FHIMSS
pkleeberg@stratishealth.org

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

REACH is a project federally funded through the Office of the National Coordinator, Department of Health and Human Services.