Meaningful Use Update: Stage 1 and Stage 2

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CMIO Stratis Health

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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
Objectives

• Understand the new EHR Incentive program rules for Stage 1 and Stage 2
• Be able to describe what is being considered for Stage 3
• 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
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
• Looking ahead to Stage 3
• What you need to do now
• Resources
• In closing
Per Capita Health Expenditure vs. Life Expectancy

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

  - 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

  - 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

  - Greater than 25% improvement in the rates of corollary orders with implementation of computerized reminders.

  - 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%

  - Assessing the impact of CPOE with CDSSs in a before-after comparison study demonstrated a 55% decrease in non-intercepted serious medication errors.
  - 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)
Health Information Technology and Quality, Efficiency and Cost (2006)


- 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.
EHRs: Problems with Commercial Installations (2005 – 2007)

  – 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.

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

  – 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%.

  – 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.
EHRs and Quality (2012)

  - Study compared physicians using EHRs to physicians using paper on performance for each of the nine quality measures
  - EHRs were associated with significantly higher quality of care for hemoglobin A1c testing in diabetes, breast cancer screening, chlamydia screening and colorectal cancer screening
  - When all nine measures were combined into a composite, EHR use was associated with statistically significant higher quality of care

  - Statistically significant improvements in treatment intensification after HbA1c ≥ 9% or LDL-C values of 100 to 129 mg/dL
  - Increases in 1-year retesting for HbA1c and LDL-C levels among all patients
  - Decreased 90-day retesting among controlled patients with HbA1c levels <7% and LDL-C levels <100 mg/dL
  - **Statistically significant reductions in HbA1c and LDL-C levels**, with the largest reductions among patients with the worst control
Meaningful Use Outline

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Bending the Curve Towards Transformed Health

Advanced clinical processes

Data capture and sharing

Improved outcomes

2011
2014
2016

“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
## Stages of Meaningful Under Medicare

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<thead>
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</tbody>
</table>

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

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
Maximum Medicare Incentives for EPs

<table>
<thead>
<tr>
<th>First Attestation Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<td>Stage 1 $8k</td>
<td>Stage 2 $4k</td>
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<td>Stage 2</td>
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<td>Stage 1²</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

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 to avoid the penalty in the next year.
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.
Maximum Medicaid Incentives for EPs with ≥30% volume

<table>
<thead>
<tr>
<th>First Year of Adopt, implement, Upgrade or MU Demonstration</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015¹</th>
<th>2016¹</th>
<th>2017¹</th>
<th>2018¹</th>
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<th>2020¹</th>
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<td>2013</td>
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<tr>
<td>2014</td>
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<td>$63,750</td>
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1. Note: Medicare penalties will apply for any of the professional’s billing to Medicare part B if not a meaningful user.
## Medicare Incentives for Prospective Payment System (PPS) Hospitals

<table>
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<th>First Attestation Year</th>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<th>% Max Payment</th>
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<td>Stage 1 100%</td>
<td>Stage 1 75%</td>
<td>Stage 1 50%</td>
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<tr>
<td>2012</td>
<td>Stage 1 100%</td>
<td>Stage 1 75%</td>
<td>Stage 2 50%</td>
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<td>100%</td>
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<tr>
<td>2013</td>
<td>Stage 1 100%</td>
<td>Stage 1 75%</td>
<td>Stage 2 50%</td>
<td>Stage 2 25%</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>Stage 3</td>
<td>100%</td>
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<tr>
<td>2014</td>
<td>Stage 1^{2} 75%</td>
<td>Stage 1 50%</td>
<td>Stage 2 25%</td>
<td>Stage 2</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>60%</td>
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</tr>
<tr>
<td>2015</td>
<td>Stage 1^{2} 50%</td>
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<td>Stage 2</td>
<td>30%</td>
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<tr>
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</table>

**Penalties:** Market basket update would be reduced: -25% -50% -75%

1. Percentages in the cells indicate the transition factor for the Medicare Share incentive
2. Must demonstrate and attest to MU by July 1, to avoid the penalty in the next year.
## Medicare Incentives for Critical Access Hospitals

<table>
<thead>
<tr>
<th>First Attestation Year</th>
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<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<td>Stage 1</td>
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**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**
Maximum Medicaid Incentives for Eligible / Critical Access Hospitals

<table>
<thead>
<tr>
<th>First Year of Adopt, implement, Upgrade or MU Demonstration</th>
<th>Calendar Year</th>
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<tr>
<td></td>
<td>2011</td>
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<tr>
<td>2011</td>
<td>50%</td>
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<td>2016¹</td>
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<tr>
<td>2017¹</td>
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</tbody>
</table>

Percentage is total of calculated 3 year EHR costs

1. Note: Medicare penalties will apply for any of the hospital’s charges if not a meaningful user
2. Any payment year skipped after 2016 will end the payment program for that facility
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• 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
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Medicare Payment Adjustments

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

<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>
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<tr>
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<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>

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

<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>
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<td>90 day EHR Reporting Period</td>
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<td>2016</td>
<td>2017</td>
<td>2018</td>
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</tr>
</tbody>
</table>

* 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
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)

• 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
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](http://www.cms.gov/EHRIncentivePrograms)
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
• Looking ahead to Stage 3
• What you need to do now
• Resources
• In closing
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
**2014 Edition CEHRT**

**Base EHR**
- Capabilities certified to meet the definition of Base EHR.

**MU 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.

**MU 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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**REACH - Achieving meaningful use of your EHR**
“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
# 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)  
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)                                      |
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
Opportunities with 2014 Certified Software Standards

• Buy only what you need
• Mix and match
• “Base” standards can provide a platform for other electronic clinical records
• Greater ability to exchange
• More granular data defined
• Beginning of the end of vendor lock-in
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
• Looking ahead to Stage 3
• What you need to do now
• Resources
• In closing
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
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 removed starting in 2013

• The yes/no measure “Reporting CQMs” removed starting in 2014

• 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
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
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...
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 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
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*
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
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.
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
Meaningful Use Specification Sheet

• The authoritative source on MU Criteria
• Downloadable PDF index that links to the Stage 2 Criteria:
  – Updated by CMS to account for any corrections or changes
• Includes relevant certification criteria
### Eligible Professional Core Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>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.</td>
</tr>
<tr>
<td>(2)</td>
<td>Generate and transmit permissible prescriptions electronically (eRx).</td>
</tr>
<tr>
<td>(3)</td>
<td>Record the following demographics: preferred language, sex, race, ethnicity, date of birth.</td>
</tr>
<tr>
<td>(4)</td>
<td>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.</td>
</tr>
<tr>
<td>(5)</td>
<td>Record smoking status for patients 13 years old or older.</td>
</tr>
<tr>
<td>(6)</td>
<td>Use clinical decision support to improve performance on high-priority health conditions.</td>
</tr>
<tr>
<td>(7)</td>
<td>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.</td>
</tr>
<tr>
<td>(8)</td>
<td>Provide clinical summaries for patients for each office visit.</td>
</tr>
<tr>
<td>(9)</td>
<td>Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.</td>
</tr>
<tr>
<td>(10)</td>
<td>Incorporate clinical lab-test results into Certified EHR Technology as structured data.</td>
</tr>
</tbody>
</table>
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 50 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[i][14][i][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)(1).
  - 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
- 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.

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 fluid, 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.
Example of Transfer of Care Measure

**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 transfers of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHR 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 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 §495.60(c)(14)(iii)(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.

**If the provider to whom the referral is made or to whom the patient is transitioned 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 CEHR 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 CEHR’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 CEHR’s “SOAP-based” capability (natively or combined with an intermediary) would be able to count all of those transmissions in their numerator.
- **Use of CEHR 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 CEHR 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.]
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

(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)(2), § 170.205(a)(3), 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(d)(2).
      - 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)(1) Transitions of care receive, display, and incorporate transition of care/referral summaries

§ 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(a)(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:

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

| § 170.202(a) | OCN Applicability Statement for Secure Health Transport (incorporated by reference in § 170.299). |
| § 170.202(b) | OCN XDR and XDMS for Direct Messaging Specification (incorporated by reference in § 170.299). |
| § 170.202(c) | OCN Transport and Security Specification (incorporated by reference in § 170.299). |
| § 170.205(a)(1) | Patient summary records |
| § 170.205(a)(2) | Problem list |
| § 170.205(a)(3) | Medicaions |
| § 170.205(a)(4) | Medicaions |
| § 170.207(1) | Encounter diagnoses |
| § 170.207(2) | Immunizations |

REACH - Achieving meaningful use of your EHR
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)
The Classic: Clinical (After Visit) Summaries

• Technical:
  – Does the summary have what is needed?
  – Can it be produced before the note is signed?

• Workflow
  – Is the EP left to complete most of what is required?

• Culture
  – Do EPs believe it is a valuable component of patient care?
New Challenge: Patients accessing their records and your office via the Web

• Requirements:
  – More than 5% of unique patients (or their representatives) seen by the EP during the reporting period send the EP a secure message.
  – >50% are provided timely online access to their health information within 4 business days
  – >5% view, download, or transmit their health information
New Challenge: Patients accessing their records and your office via the Web

• Challenges:
  – Patient Engagement
  – Problem List Clean-up
    • Incomplete, sensitive diagnoses
      – V65.2 Person feigning illness
    • Warnings to colleagues
      – Drug seeker
  – Physician spelling and grammar
  – As an independent specialist, getting patients to come to your portal and communicate with you
New Challenge: Patients accessing their records and your office via the Web

• Opportunities:
  – Accurate problem, medication and allergy lists
  – Patient entered data
  – Asynchronous communication
  – Easier for patients to reach a provider, less disruptive to workflow
  – Collaboration on a patient portal
New Challenge: Real Electronic Exchange with other providers

• 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
New Challenge: Real Electronic Exchange with other providers

• Challenges
  – Finding exchange partners

• Opportunities
  – More complete records
  – More up-to-date problems, medications, allergies and lab results
  – Shared care plans
  – Knowing the care team
  – Care coordination across locations of care
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
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
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 totalling 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
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

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Clinical Quality Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0013</td>
<td>Blood pressure measurement</td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Tobacco use assessment and intervention</td>
</tr>
<tr>
<td>NQF 0421</td>
<td>Adult Weight Screening and Follow-up</td>
</tr>
<tr>
<td>PQRI 128</td>
<td></td>
</tr>
</tbody>
</table>

**Alternate Core Measures**

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Clinical Quality Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
</tr>
<tr>
<td>NQF 0041</td>
<td>Influenza Immunization for Patients ≥ 50 Years Old</td>
</tr>
<tr>
<td>PQRI 110</td>
<td></td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status</td>
</tr>
</tbody>
</table>
38 Additional Quality Measures

- Diabetes
- Cardiovascular Disease
- Preventative care and Screening
- Appropriate use
- Asthma
- Tobacco, alcohol, drug abuse
- Depression
- Oncology
- Ophthalmology
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
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Family Engagement.</td>
<td>Functional status assessment for complex chronic conditions</td>
</tr>
<tr>
<td>Patient Safety.</td>
<td>Use of High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td></td>
<td>Documentation of Current Medications in the Medical Record Description</td>
</tr>
<tr>
<td>Care Coordination.</td>
<td>Closing the referral loop: receipt of specialist report</td>
</tr>
<tr>
<td>Population/Public Health.</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>Efficient Use of Healthcare Resources.</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td>Clinical Process/Effectiveness.</td>
<td>Controlling High Blood Pressure</td>
</tr>
</tbody>
</table>
# 2014 CQMs Recommended for Children

<table>
<thead>
<tr>
<th>Population/Public Health.</th>
<th>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlamydia Screening for Women</td>
</tr>
<tr>
<td></td>
<td>Childhood Immunization Status</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>Efficient Use of Healthcare Resources.</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td></td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
</tr>
<tr>
<td>Clinical Process/Effectiveness.</td>
<td>Use of Appropriate Medications for Asthma</td>
</tr>
<tr>
<td></td>
<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
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
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
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
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.
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.
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
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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Optional Reporting Period in 2014</th>
<th>Reporting Period for Subsequent Years of Meaningful Use</th>
<th>Submission Period for Subsequent Years of Meaningful Use</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Level</th>
<th>Payer Level</th>
<th>Submission Type</th>
<th>Reporting Schema</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year of Demonstrating MU*</td>
<td>Aggregate</td>
<td>All payer</td>
<td>Attestation</td>
<td>Submit 9 CQMs from EP measures table covering at least 3 domains</td>
</tr>
</tbody>
</table>

EPs Beyond the 1st Year of Demonstrating Meaningful Use

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Aggregate</th>
<th>All payer</th>
<th>Electronic</th>
<th>Submit 9 CQMs from EP measures table covering at least 3 domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2</td>
<td>Patient</td>
<td>Medicare</td>
<td>Electronic</td>
<td>Satisfy requirements of PQRS EHR Reporting Option using CEHRT</td>
</tr>
</tbody>
</table>

* 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.
### EP Group CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Level</th>
<th>Payer Level</th>
<th>Submission Type</th>
<th>Reporting Schema</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)</td>
<td>Patient</td>
<td>Medicare</td>
<td>Electronic</td>
<td>Satisfy requirements of Medicare Shared Savings Program or Pioneer ACOs using CEHRT</td>
</tr>
<tr>
<td>EPs satisfactorily reporting via PQRS group reporting options</td>
<td>Patient</td>
<td>Medicare</td>
<td>Electronic</td>
<td>Satisfy requirements of PQRS group reporting options using CEHRT</td>
</tr>
</tbody>
</table>

*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.*
# Hospital CQM Reporting Beginning in 2014

Eligible Hospitals reporting for the Medicare EHR Incentive Program

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

*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.*
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
• Looking ahead to Stage 3
• What you need to do now
• Resources
• In closing
One in 20 Will Face Audits

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

### Example Audit Questions:

<table>
<thead>
<tr>
<th>Meaningful Use Objective</th>
<th>Audit Validation</th>
<th>Suggested Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support</td>
<td>Functionality is available, enabled, and active in the system for the duration of the EHR reporting period.</td>
<td>One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation.</td>
</tr>
<tr>
<td>Protect Electronic Health Information</td>
<td>Security risk analysis of the certified EHR technology was performed prior to the end of the reporting period.</td>
<td>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.).</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Documentation to support each exclusion to a measure claimed by the provider</td>
<td>Report from the certified EHR system that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion.</td>
</tr>
</tbody>
</table>

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 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

• Email

• 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.
Meaningful Use Outline

- A reminder of why we are doing this
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- New EHR certification standards for 2014
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- New quality measure requirements for 2014
- Audits
- **Looking ahead to Stage 3**
- What you need to do now
- Resources
- In closing
Looking Ahead to Stage 3

- Policy Committee’s RFC for Stage 3 caused them to rethink
  - Had proposed many increases in # or %
  - Had proposed many new EHR standards
- Decided to await experience with Stage 2 before releasing a proposed rule for Stage 3
- Very likely to contain:
  - Patients ability to communicate corrections to errors in their medical history
  - Patient generated data
  - “Deeming”
    - Performance and/or improvement thresholds deems satisfaction of a subset of MU functionality as an optional pathway to MU
Deemed MU Objectives

Deemed in Satisfaction of:
- CDS
- Reminders
- Electronic notes
- Test tracking
- Clinical summary
- Patient education
- Reconcile problems, meds, allergies

- *View, download, transmit (VDT), consider adding if stage 2 reports good uptake
- *Secure patient messaging, consider adding if stage 2 reports good uptake

Remaining Items:
- Advance directive
- eMAR
- Imaging results
- EH: provide lab results
- Patient generated data
- *VDT
- *Secure patient messaging
- Care summary
- Care plan
- Referral loop
- Notification of health event
- Immunization registry
- ELR
- Case reports to PHA
- Syndromic surveillance
- Reporting to 2 registries
- Adverse event reporting
Example Criteria for Deeming for EPs

- **Demonstrate**
  - high (top 30%ile) or
  - improved performance (20% reduction of gap between last year's performance and top quartile).

- **An example of one of the 6 NQS domains**
  - Prevention of high priority diseases
    - Breast cancer (mammography screening)
    - Colon cancer (colonoscopy screening)
    - Influenza (flu vax)
    - Pneumonia (pneumococcal vaccine)
    - Obesity (BMI screening and follow up)
    - Cardiovascular disease (LDL screen)
    - HTN (BP screen and follow up)

- **Under consideration is to select 2 from each of the 6 NQS domains**
Meaningful Use Outline

- A reminder of why we are doing this
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- 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
- Looking ahead to Stage 3
- **What you need to do now**
- Resources
- In closing
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
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
• Looking ahead to Stage 3
• What you need to do now
• **Resources**
• In closing
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** – 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** – 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** – 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** – 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/](https://www.cms.gov/EHRIncentivePrograms/)

- **Registration instructions:**

- **Meaningful Use Stage 1 Criteria Specifications**

- **CMS Stage 2 web page (with information on revised Stage 1 as well as Stage 2):**

- **Stage 2 Toolkit (Updated February 2013):**

- **Attestation Worksheets**
  - [http://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf](http://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf)
Other Resources:

- Quality Measure Specifications on the CMS web site:
- 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:
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
• Looking ahead to Stage 3
• What you need to do now
• Resources
• In closing
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.
REACH - Achieving meaningful use of your EHR

Paul Kleeberg, MD, FAAFP, FHIMSS
pkleeberg@stratishealth.org

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

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