Meaningful Use Stage 2: What’s Next?

Introduction and Welcome:
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Center for Health Policy
MO HIT Assistance Center

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Susan Shumate
Implementation Specialist
Primaris
Before we begin...

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  - Center for Health Policy
  - Department of Family and Community Medicine
  - Missouri School of Journalism

- Partners:
  - EHR Pathway
  - Hospital Industry Data Institute (Critical Access Hospitals)
  - Missouri Primary Care Association
  - Missouri Telehealth Network
  - Primaris
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The Office of Continuing Education, School of Medicine, University of Missouri is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Office of Continuing Education, School of Medicine, University of Missouri designates this live Internet educational activity for a maximum of one AMA PRA Category 1 Credit™. Physicians should only claim the credit commensurate with the extent of their participation in the activity.

The learning objectives of this live Internet educational activity are:

- Choose an appropriate electronic health record for the practice, create a change team, redesign practice workflow and successfully implement transition to electronic records.
- Appropriately track quality measures in electronic health records and to create accurate reports of quality indicators; physicians will understand how to use indicators to improve patient outcomes.
- Identify potential privacy and security issues in individual practices that are utilizing electronic health records and provide tools for practices to use to assess their security measures to see if they are appropriate.
- Measure and track the way individual practices are reporting on the meaningful use requirements in the federal HI Tech Act; understand additional clinical reporting requirements contained in meaningful use phases two and three.
- Appropriately design and implement patient portals for patients to access their health care information and learn how to better take care of their health conditions.

The planning members and presenter for this activity have no commercial relationships to disclose.
Disclosures

This regional extension center is funded through an award from the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services Award Number 90RC0039/01

Cerner and the University of Missouri Health System have an independent strategic alliance to provide unique support for the Tiger Institute for Health Innovation, a collaborative venture to promote innovative health care solutions to drive down cost and dramatically increase quality of care for the state of Missouri. The Missouri Health Information Technology Assistance Center at the University of Missouri, however, is vendor neutral in its support of the adoption and implementation of EMRs by health care providers in Missouri as they move toward meaningful use.
Meaningful Use Stage 2: What’s Next?

Stage 2 Proposed Rule

Sue Shumate, Implementation Specialist
Slides adapted from

Robert Anthony, CMS

Steve Posnack
Director of Federal Policy Division
Proposed Rule

Everything discussed in this presentation is part of a notice of proposed rulemaking (NPRM).

Full notices for the 2014 EHR-technology certification are online:


Comments period: through May 7. Visit www.regulations.gov and search for “CMS 0044”.

Content on this page is subject to the Notice on the title page of this presentation.
What is in the Proposed Rule

- Minor changes to Stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Appeals
- Details on the Medicare payment adjustments
- Minor Medicare Advantage program changes
- Minor Medicaid program changes
Stage 2 Timeline

- June 2011: HITPC Recommendations on Stage 2
- February 2012: Stage 2 Proposed Rule
- Summer 2012: Stage 2 Final Rule
## Stages of Meaningful Use

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<td>2016</td>
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</table>
Stage 1 to Stage 2 Meaningful Use

Eligible Professionals
- 15 core objectives
- 5 of 10 menu objectives
- 20 total objectives

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

Eligible Professionals
- 17 core objectives
- 3 of 5 menu objectives
- 20 total objectives

Eligible Hospitals & CAHs
- 16 core objectives
- 2 of 4 menu objectives
- 18 total objectives
Meaningful Use Concepts

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

No Changes

- No change in 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology

- Measure compliance = objective compliance
Changes to Stage 1

CPOE

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+

Vital Signs

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

Vital Signs

Exclusion: All three elements not relevant to scope of practice

Exclusion: Allows BP to be separated from height/weight

*Optional in 2013 Required in 2014+

Test of Health Information Exchange

One test of electronic transmission of key clinical information

Requirement removed effective 2013

*Effective 2013

http://www.cms.gov/EHRIncentivePrograms/
Changes to Stage 1 E-Copy and Online Access

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+

Public Health Objectives

Immunizations
Reportable Labs
Syndromic Surveillance

Addition of “except where prohibited” to all three

*Effective 2013

http://www.cms.gov/EHRIncentivePrograms/

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Stage 2 EP Core MU Objectives

1. Use CPOE for more than 60% of medication, laboratory and radiology orders

2. eRx for more than 50%

3. Record demographics for more than 80%

4. Record vital signs for more than 80%

5. Record smoking status for more than 80%

6. Implement 5 clinical decision support rules + drug-drug and drug-allergy
Stage 2 EP Core MU Objectives

7. Incorporate lab results for more than 55%

8. Generate patient list by specific condition

9. Use EHR to identify and provide more than 10% with reminders for preventive/follow-up

10. Provide **online access** to health information for more than 50% with more than 10% actually accessing

11. Provide office visit summaries in **24 hours**

12. Use EHR to identify and provide education resources more than 10%
Stage 2 EP Core MU Objectives

13. More than 10% of patients send secure messages to their EP
14. Medication reconciliation at more than 65% of transitions of care
15. Provide summary of care document for more than 65% of transitions of care and referrals with 10% sent electronically
16. Successful ongoing transmission of immunization data
17. Conduct or review security analysis and incorporate into risk management process

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Stage 2 EP Menu Objectives (3 of 5)

1. More than 40% of imaging results are accessible through Certified EHR Technology
2. Record family health history for more than 20%
3. Successful ongoing transmission of syndromic surveillance data
4. Successful ongoing transmission of cancer case information
5. Successful ongoing transmission of data to a specialized registry

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Stage 2 Hospital Core Objectives

1. Use CPOE for more than 60% of medication, laboratory and radiology orders
2. Record demographics for more than 80%
3. Record vital signs for more than 80%
4. Record smoking status for more than 80%
5. Implement 5 clinical decision support rules + drug-drug and drug-allergy
6. Incorporate lab results for more than 55%
Stage 2 Hospital Core Objectives

7. Generate patient list by specific condition

8. EMAR is implemented and used for more than 10% of medication orders

9. Provide online access to health information for more than 50% with more than 10% actually accessing

10. Use EHR to identify and provide education resources more than 10%

11. Med. Rec. at more than 65% of transitions of care
Stage 2 Hospital Core Objectives

12. Provide summary of care document for more than 65% of transitions of care and referrals with 10% sent electronically

13. Successful ongoing transmission of immunization data

14. Successful ongoing submission of reportable laboratory results

15. Successful ongoing submission of electronic syndromic surveillance data

16. Conduct or review security analysis and incorporate in risk management process
Stage 2 Hospital Menu Objectives (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. eRx for more than 10% of discharge prescriptions
Clinical Quality Measures

Change from Stage 1 to Stage 2:

CQMs are no longer a meaningful use core objective, but reporting CQMs is still a requirement for meaningful use.

http://www.cms.gov/EHRIncentivePrograms/
# CQM - Timing

Time periods for reporting CQMs - NO CHANGE from Stage 1 to Stage 2

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Reporting Period for 1st year of MU (Stage 1)</th>
<th>Submission Period for 1st year of MU (Stage 1)</th>
<th>Reporting Period for Subsequent years of MU (2nd year and beyond)</th>
<th>Submission Period for Subsequent years of MU (2nd year and beyond)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP</td>
<td>90 consecutive days within the calendar year</td>
<td>Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year</td>
<td>1 calendar year (January 1 - December 31)</td>
<td>2 months following the end of the EHR reporting period (January 1 - February 28)</td>
</tr>
<tr>
<td>Eligible Hospital/ CAH</td>
<td>90 consecutive days within the fiscal year</td>
<td>Anytime immediately following the end of the 90-day reporting period, but no later than November 30 of the following fiscal year</td>
<td>1 fiscal year (October 1 - September 30)</td>
<td>2 months following the end of the EHR reporting period (October 1 - November 30)</td>
</tr>
</tbody>
</table>


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CQM - Stage 1 to Stage 2

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

Eligible Hospitals & CAHs
15 total CQMs

Eligible Professionals
1a) 12 CQMs (≥1 per domain)
1b) 11 core + 1 menu CQMs
2) PQRS
   Group Reporting
12 total CQMs

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

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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 extended to 2013
  • Medicaid - State-based e-submission

http://www.cms.gov/EHRIncentivePrograms/
CQM Reporting for EPs beginning in CY2014

EHR Incentive Program Only
- Option 1a: 12 CQMs, ≥1 from each domain
- Option 1b: 11 “core” CQMs + 1 “menu” CQM
- Medicaid - State based e-submission
- Aggregate XML-based format specified by CMS

EHR Incentive Program + PQRS
- Option 2: Submit and satisfactorily report CQMs under PQRS EHR Reporting option using CEHRT
- Requirements for PQRS are in CY 2012 Medicare Physician Fee Schedule final rule (76 FR 73314)

http://www.cms.gov/EHRIncentivePrograms/

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CQM Reporting for EPs Beginning in CY2014

• Group Reporting (3 options):

(1) ≥ 2 EPs, each with a unique NPI under one TIN
Submit 12 CQMs from EP measures table, ≥1 from each domain

(2) EPs in an ACO (Medicare Shared Savings Program)
Satisfy requirements of Medicare Shared Savings Program using Certified EHR Technology

(3) EPs satisfactorily reporting via PQRS GPRO option
Satisfy requirements of PQRS GPRO option using Certified EHR Technology

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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

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### EP Payment Adjustments

#### % ADJUSTMENT ASSUMING LESS THAN 75 PERCENT OF EPs ARE MEANINGFUL EHR USERS FOR CY 2018 AND SUBSEQUENT YEARS

<table>
<thead>
<tr>
<th>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>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>
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<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>
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</table>

#### % ADJUSTMENT ASSUMING MORE THAN 75 PERCENT OF EPs ARE MEANINGFUL EHR USERS FOR CY 2018 AND SUBSEQUENT YEARS

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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EP EHR Reporting Period

EP who has demonstrated meaningful use in 2011 or 2012

<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>
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<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2019</td>
</tr>
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</table>

EP who demonstrates meaningful use in 2013 for the first time

<table>
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<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<td>90 day EHR Reporting Period</td>
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<td>Full Year EHR Reporting Period</td>
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# EP EHR Reporting Period

**EP who demonstrates meaningful use in 2014 for the first time**

<table>
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<th>Payment Adjustment Year</th>
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<tr>
<td>Full Year EHR Reporting Period</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2019</td>
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*In order to avoid the 2015 payment adjustment the EP must attest no later than Oct 1, 2014 which means they must begin their 90 day EHR reporting period no later than July 2, 2014*
EP Hardship Exemption

Proposed Exemptions on an application basis

- Insufficient internet access two years prior to the payment adjustment year
- Newly practicing EPs for two years
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

Applications need to be submitted no later than July 1 of year before the payment adjustment year; however, earlier submission is encouraged

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EP Hardship Exemption

Other Possible Exemption Discussed in NPRM

• Concerned that the 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

• They do not believe any one of these barriers taken independently constitutes a significant hardship

• In their discussions, it was considered whether any specialty may nearly uniformly face all 3 barriers

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CAH Hardship Exemption

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.

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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

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Redefining Certified EHR Technology

Why they think it is important...

1. Provides greater flexibility
2. Clearer definition of CEHRT and its requirements
3. Promotes continued progress towards increased interoperability requirements
4. Reduces regulatory burden (EO 13563)
Certified EHR Technology

Here’s what it looks like today...
2011-2013

Here’s what we are proposing...
2014
MU Menu

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.

MU Core

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.

Base EHR

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

- CMS Rule:
  http://www.ofr.gov/OFRUpload/OFRData/2012-04443_Pl.pdf

- ONC Rule:
  http://www.ofr.gov/OFRUpload/OFRData/2012-04430_Pl.pdf

- Comments period: through May 7 at www.regulations.gov. Search for “CMS 0044”
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  - 1-877-882-9933