Meaningful Use Stage 2: Where We Are Now, Where We’re Going, and What it Means for Your Practice

Russell B. Leftwich, MD, FAAAI
Chief Medical Informatics Officer
Office of eHealth Initiatives, State of Tennessee

Stephen McCallister, CPEHR, CPHIT
Independent Consultant, Healthcare Consulting Group
Medical Group Management Association

Disclosures:

Russell Leftwich:
Nothing to Disclose

Stephen McCallister:
Nothing to Disclose
Learning Objectives

- Understand the background of meaningful use and its overall goals
- Describe Stage 1 criteria and what needs to be done to meet the criteria
- Understand the differences between Stage 1 and Stage 2 meaningful use
- Understand where we are headed after Stage 2

Background & Goals of MU

- A Physician’s Perspective
- Meaningful Use Quiz
- Definition & Goals
- Medicare & Medicaid Incentive Programs
- Current Status of Programs
- MU Audits
- Is It Too Late?
A Physician’s Perspective

Melinda Rathkopf, MD,
FAAAAI, FAAP, FACAAI

Meaningful Quiz
Meaningful Quiz: Question 1

If your first year of Meaningful Use is 2014, what is the maximum incentive amount you can receive?

A. Nothing, 2014 is too late for both the Medicaid and Medicare Incentive programs
B. You can receive the full $63,750 in the Medicaid program, but your maximum in the Medicare program will be reduced to $24,000
C. You can receive the full $44,000 in the Medicare program, but your maximum in the Medicaid program will be reduced to $37,375
D. You can receive the full amount from either program – but don’t wait until 2015!

Meaningful Quiz: Question 2

Which program provides eligibility for mid-level providers, such as advanced registered nurse practitioners?

A. Neither Medicare nor Medicaid
B. Mid-level providers are eligible under the Medicare program, but not the Medicaid program
C. Mid-level providers are eligible under the Medicaid program, but not the Medicare program
D. Mid-level providers are eligible under both the Medicare and the Medicaid programs
Meaningful Quiz: Question 3

Do the Incentive programs allow you to “skip” a year, to not meet MU requirements in each consecutive year of participation?

A. Yes, both Medicare and Medicaid programs allow you to skip a year, but only one year
B. The Medicare program allows you to skip a year, the Medicaid program does not
C. The Medicaid program allows you to skip a year, the Medicare program does not
D. Neither program allows you to skip a year, you can only permanently drop out

Meaningful Quiz: Question 4

Which is not a focus of Stage 1 Meaningful Use?

A. Patient access to self-management tools
B. Electronically capturing health information in a standardized format
C. Initiating report of clinical quality measures and public health information
D. None of the above; all are included in Stage 1
Meaningful Quiz: Question 5

Which IS a focus of Stage 2 Meaningful Use?

- More patient-controlled data
- Electronic transmission of patient care summaries across multiple settings
- Increased requirements for e-prescribing and incorporating lab results
- More rigorous health information exchange (HIE)
- All of the above

Meaningful Quiz: Question 6

Which of the following statements about DIRECT is true?

A. Unlike email, DIRECT permits secure electronic messaging between providers and patients
B. DIRECT permits exchange of information such as lab orders, test results, and closed loop referrals
C. DIRECT stands for Digital Integrated Records for Electronic Clinical Transmission
D. A & B, but not C
Meaningful Quiz: Question 7

If you start Meaningful Use Stage 2 in 2014, the reporting periods for 2014 and 2015 are:

A. 90 days in 2014, 90 days in 2015
B. 90 days in 2014, 180 days in 2015
C. 90 days in 2014, full year in 2015
D. Different for the Medicare and Medicaid programs

Meaningful Quiz: Question 8

Which of the following have changed between Stage 1 and Stage 2 Meaningful Use?

A. Stage 2 adds lab and radiology orders to CPOE
B. Generation of patient lists by specific condition are a core Stage 2 Requirement
C. EHR software must meet new 2014 certification requirements
D. Patients ability to view, download and transmit information is a core requirement
E. All of the above
Meaningful Quiz: Question 9

If you choose NOT to participate in the Medicare or Medicaid EHR Incentive programs:

A. You may be subject to Medicare payment reductions beginning in 2015
B. You will be exempt from the ICD-10 transition deadline
C. You will miss out on learning a bunch of sweet, sweet technical acronyms
D. You will not be allowed to sit at the Cool Docs’ table at conference gala events beginning in 2014

MU: What Does It Mean?

Meaningful use is using certified electronic health record (EHR) technology to:

• Improve quality, safety, efficiency, & reduce health disparities
• Engage patients & family
• Improve care coordination, & population & public health
• Maintain privacy & security of patient health information

Source: http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives
What Will MU Achieve?

- Improve care coordination
- Engage patients and families in their health care
- Improve quality, safety, efficiency, and reduce health disparities
- Maintain privacy and security
- Improve population and public health

Stages of Meaningful Use

- Stage 1: Capture Structured Data
- Stage 2: Health Information Exchange
- Stage 3: Improving Care
Focus of MU Criteria

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronically capturing health information in a standardized format</td>
<td>More rigorous health information exchange (HIE)</td>
<td>Improving quality, safety, and efficiency, leading to improved health outcomes</td>
</tr>
<tr>
<td>Using that information to track key clinical conditions</td>
<td>Increased requirements for e-prescribing and incorporating lab results</td>
<td>Decision support for national high-priority conditions</td>
</tr>
<tr>
<td>Communicating that information for care coordination processes</td>
<td>Electronic transmission of patient care summaries across multiple settings</td>
<td>Patient access to self-management tools</td>
</tr>
<tr>
<td>Initiating the reporting of clinical quality measures and public health information</td>
<td>More patient-controlled data</td>
<td>Access to comprehensive patient data through patient-centered HIE</td>
</tr>
<tr>
<td>Using information to engage patients and their families in their care</td>
<td></td>
<td>Improving population health</td>
</tr>
</tbody>
</table>

Medicare & Medicaid Programs

- Allergists more likely to participate in Medicare program
- Presenting information on both to highlight differences which can be confusing
- Medicare incentive amounts are capped at 75% of an EP’s Medicare allowed charges for the reporting year
Medicare EHR Incentive Program

- Incentive amount varies based on Fee-for-Service allowable charges
- Maximum of $44,000 over 5 years
- Requires 5 consecutive years: may not skip a year
- Administered by CMS
- Payment reductions starting 2015 if eligible provider not participating (1% in 2015, increasing 1% / year to 5%)

Medicaid EHR Incentive Program

- Requires at least 30% Medicaid patient visit volume (20% for pediatricians) to be eligible to participate
- Program allows for mid-level providers (e.g. nurse practitioners) as well as physicians to participate
- Maximum of $63,750 over 6 years of participation
- May “skip” years
- Administered by state Medicaid agencies
- No Medicaid payment reductions if not participating
- First year: Adopt / Implement / Upgrade:
  - Adopt: purchase access to certified EHR
  - Implement: begin using certified EHR
  - Upgrade: upgrade existing EHR to certified version
**Program Timelines**

**CMS Medicare and Medicaid EHR Incentive Programs**

**Milestone Timeline**

- **Fall 2010**: Registration for the CMS EHR Incentive Programs begins.
- **Winter 2011**: Certified EHR technologies available and eligible providers learn more.
- **Spring 2011**: More than 50% (295K) of eligible professionals and 80% of eligible hospitals have received incentive payments.
- **Winter 2011**: $14.6 billion paid through Medicare and Medicaid EHR Incentive programs as of April 2013.
- **April 2011**: EHR Incentive Reimbursed Begin.
- **Fall 2011**: Medicare and Medicaid EHR Incentive Program.
- **Winter 2012**: Last day for eligible hospitals and CAHs to register and attest on meaningful use.
- **2014**: Last year for eligible providers who report for FY 2011.
- **2015**: Last year for eligible providers who report for FY 2013.
- **2016**: Last year for eligible providers who report for FY 2014.
- **2021**: Last year for eligible providers who report for FY 2020.

Source: CMS

**MU Current Status**

- More than 50% (295K) of eligible professionals and 80% of eligible hospitals have received incentive payments.
- $14.6 billion paid through Medicare and Medicaid EHR Incentive programs as of April 2013.

MU: Where Are They Now?

Eligible professional progress to MU, April 2013

Eligible Professionals (n = 527,200)

- 43% Attested MU
- 20% MU only
- 14% Entered EHR Incentive Program
- 23% Not Participating

Note: Categories are hierarchical and mutually exclusive. For example, a professional that has received Medicaid payment for both innovation and AR is counted only in the Innovation category.

Source: Presentation: "Data Analytics Update", Jennifer King, ONC HITPC, 6/5/2013

MU by Specialty

Physician specialty by MU status, April 2013

- 33% Radiology/Pathology/Anesthesiology
- 43% Medical/Surgical Specialty
- 42% Pediatrics
- 42% Other Primary Care

* Includes all professionals who are registered with ONC EHR Incentive Program or enrolled with an EHRIncentive Program.

Source: Presentation: "Data Analytics Update", Jennifer King, ONC HITPC, 6/5/2013
MU Audits

- CMS Target: 5-10% for pre- and post-audits
- CMS does Medicare audits, states do Medicaid audits
- Selection is a mix of random & targeted (e.g., questions re: attestation data)
- May delay payments & adverse findings may require return of incentive funds
- Retain all documentation for attestation
- Early findings: HIPAA Security Risk Analysis often lacking

Security Risk Analysis

Elements:
1. Identify scope & data collection
2. Identify potential threats & vulnerabilities
3. Assess current security
4. Determine threat likelihood
5. Determine threat impact
6. Assign risk level
7. Finalize documentation

<table>
<thead>
<tr>
<th>Risk Analysis Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat Impact</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>Low</td>
</tr>
</tbody>
</table>

Must be specific to your practice & updated to reflect EHR

Adapted from: http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/rafinalguidancepdf.pdf
Is It Too Late?

- The last year to enroll for Medicare incentives is 2014
- Medicare “Late Starters” receive less than the full potential $44,000* in total payments (see next slide for details)
- The last year to enroll for Medicaid incentives is 2016
- Medicaid “Late Starters” receive no reduction in payments, $63,750 in total potential payments

*This does not include an additional 10%, for Medicare incentives only, which may be added if you are working in a Health Professional Shortage Area (HPSA). For those attesting for a reporting period ending after 4/1/2013, a 2% reduction will be applied due to federal budget sequestration, again for Medicare incentives only.

Medicare Incentive Payments by Year First Qualifying

Note: These figures do not include adjustments for HPSA or Medicare Sequestration (see prior slide)

MU Stage 1

- MU Stage 1 Requirements
- MU Stage 1: Core & Menu Objectives
- REC’s & Other Resources
- Attesting for Stage 1
- Challenges
- Health Information Exchange (HIE)

MU Stage 1 Requirements

For eligible professionals, there are a total of 24 meaningful use objectives. To qualify for an incentive payment, 19 of these 24 objectives must be met:
- 14 required core objectives
- 5 objectives chosen from a list of 10 menu set objectives
MU Stage 1 Core Set Objectives

1. Computerized physician order entry (CPOE)
2. E-Prescribing (eRx)
3. Report ambulatory clinical quality measures to CMS/States
4. Implement one clinical decision support rule
5. Provide patients with an electronic copy of their health information, upon request
6. Provide clinical summaries for patients for each office visit
7. Drug-drug and drug-allergy interaction checks
8. Record demographics
9. Maintain an up-to-date problem list of current and active diagnoses
10. Maintain active medication list
11. Maintain active medication allergy list
12. Record and chart changes in vital signs
13. Record smoking status for patients 13 years or older
14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
15. Protect electronic health information

MU Stage 1 Menu Set Objectives

1. Drug-formulary checks
2. Incorporate clinical lab test results as structured data
3. Generate lists of patients by specific conditions
4. Send reminders to patients per patient preference for preventive/follow up care
5. Provide patients with timely electronic access to their health information
6. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
7. Medication reconciliation
8. Summary of care record for each transition of care/referrals
9. Capability to submit electronic data to immunization registries/systems*
10. Capability to provide electronic syndromic surveillance data to public health agencies*

* Must select at least one public health objective.
REC’s & Other Resources

- REC’s main focus is on primary care
- May be helpful in:
  - Navigating attestation process
  - Vetting required data/reports
  - Assisting with security risk analysis
  - Getting established with HIE
- REC’s funding is declining, so their future is uncertain

Challenges: Workflow

- Optimist: EHR’s *enable* work flow changes
- Realist: EHR’s *require* work flow changes
- Examples:
  - CPOE / ePrescribing
  - Patient portal / Messaging
  - Referrals
  - Enables mobile use
MU Stage 2

• Beyond Stage 1
• MU Stage 2: What’s New
• Goals of MU Stage 2
• MU Stage 2: Health Information Exchange
• MU Stage 2 Indicators
• Pitfalls for MU Stage 2?

Beyond Stage 1: Challenges & Contradictions

• Pushback: Stage 2 Criteria
• Uncertainty: more delays?
• Stage 2 demands increase as incentive amounts decrease
• REC funding begins winding down, as technical requirements increase
• Medicare: MU costs vs. payment penalty sting
Meaningful Use Stage 2: What’s New?

- Stage 2 begins January 2014
- Stage 1 extends through 2013
- 90 day reporting if 2014 is 1st year Stage 2
- EHRs have new functions
- Secure messaging from EHR
- Electronic summary exchange
- Patients can view, download, transmit info

MU Stage 2 Objectives

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Professionals</strong></td>
<td><strong>Eligible Professionals</strong></td>
</tr>
<tr>
<td>15 core objectives</td>
<td>17 core objectives</td>
</tr>
<tr>
<td>5 of 10 menu objectives</td>
<td>3 of 6 menu objectives</td>
</tr>
<tr>
<td>20 total objectives</td>
<td>20 total objectives</td>
</tr>
</tbody>
</table>
Remember the Game of Telephone?

Goals of MU Stage 2

Care Coordination
- Summary exchanged electronically >10% of transitions and referrals
- Maintaining problem list, active medication list, and medication allergy list are combined with providing a summary of care record for each transition of care
Goals of MU Stage 2

**Care Management:**
- Adds labs and radiology orders to CPOE
- Clinical decision support to 4 adds drug-drug and drug-allergy
- Exchange of lab results between hospitals and ambulatory providers
- Structured lab results were made core and increased from 40% - 55%
- Generation of patient lists by specific condition also now core requirement

**Patient Engagement:**
- View patient history online, download, transmit
- Visit summaries after each visit
- Exchange secure messages with patients
The Big Picture: Beyond MU Stage 2

- The Importance of Standards
- Standards & Meaningful Use
- Quality Standards
- Quality Standards & ICD-10
- Using Direct Messaging
- MU Stage 3

The Importance of Standards

- Electronic standards for connecting two systems together
- Document standards for the display of information & to make machine readable
- Vocabulary standards for the meaning of data transmitted
Meaningful Use & Standards

• Transport standards
  – Direct secure messaging

• Document standards
  – Clinical Document Architecture (CDA)
    • Continuity of Care Record (CCD) – summary of care for discharges, referrals, consult reports
Meaningful Use & Standards

- Transport standards
  - Direct secure messaging
- Document standards
  - Clinical Document Architecture (CDA)
    - Continuity of Care Record (CCD)
- Vocabulary Standards
  - ICD-10 (Oct 1, 2014)
  - SNOMED CT
  - LOINC

Meaningful Use: Quality Measures

- Most CQM have been on clipboards
- Electronic has meant claims based
- Stage 1 requires 3 core measures, 3 menu
- 2013 will require same 6 of 44 measures
- 2014 will require 9 of 64 measures for any MU Stage
Reporting on Clinical Quality Measures

- e-Measures are new, still developing
- Most measures have been converted
- NQF published Quality Data Model
  - leverage data in EHR
  - facilitate e-measure development
  - enable e-reporting
- 2013 report by attestation and e-report pilots
- 2014 e-reporting under Medicare

ICD-10 & Clinical Quality Measures

- ICD-10 has more clinical information
- Captures disease state and severity
- Combined with e-prescribing can evaluate treatment
- Based on ICD-10 can suggest treatment
MU Stage 2: Health Information Exchange (HIE)

- Stage 2 Final Rule published August 2012
- Requirements apply January 2014
- Only required if you want incentive $$
- HIE for transitions of care
- HIE for quality reporting (CQM)
- HIE for exchange with patients

Health Information Exchange Networks

- Regional Health Information Exchanges
- Statewide Health Information Exchanges
- Healthcare Organizations Private HIEs
- Anatomy of an HIE
  - Data sharing agreement
  - Consent from patients
  - Data repositories
  - Patient identification: Master Patient Index
  - Document Locator
  - Transport interface ($$$) to EHR
Exchange Using “Direct” Messages

Examples of Meaningful Use Content

- Other Providers/Authorized Entities:
  - Closed loop referrals
  - Labs – orders & test results
  - Summary of hospital stay

- Patients:
  - Visit summaries
  - Discharge instructions
  - Clinical summaries
  - Reminders

- Public and Population Health:
  - Immunization registries
  - Clinical Quality Measures

1. Get a Direct Address (e-mail-like) and a security certificate
2. Find the Direct Address of another individual
3. Select the information or document in your system you wish to send

Russ.Leftwich@direct.Myclinic.org

Patient Centered Care & Care Team
MU Stage 3

- Scheduled for 2016
- Standards not yet final; HIT Policy Committee has made proposals
- Pressure for both further delays & proceeding as scheduled
Virtual Patient Record

MU: Why Bother?

- It’s tempting to think MU is not relevant to allergy practices
- But MU is important to your primary care partners
- As MU & HIE make electronic messaging & referrals easier, you may be “out of the loop”
- Thus, MU may be strategic to your practice’s future economic viability
The CMS website includes a wide variety of resources, such as a comprehensive MU Stage 2 Toolkit.

This CMS document summarizes the differences between MU Stage 1 & MU Stage 2 requirements

MU Audit program fact sheet.

Fact sheet on documentation required for MU Audits