Meaningful Use – Then, Now and Beyond

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Health IT Advisor

Healthcare Intelligence
Objectives

- Long Term Program Alignment
  - Meaningful Use in 2015 - 2018
- Meaningful Use Program for Eligible Professionals (EP) and Eligible Hospitals (EH) for 2015
  - Modified Stage 2
  - Removal of Core and Menu Objectives
  - Consolidation of Public Health Measures
- Medicaid EHR Program Attestation Updates
- Payment Adjustments
- IHIN
Long Term Program Alignment

MEANINGFUL USE IN 2015 - 2018
Stages of Meaningful Use

Stage 2: Advanced Clinical Processes

- Stage 1: Data Capturing and Sharing
- Stage 2: Advanced Clinical Processes
- Stage 3: Improved Outcomes
Participation Timeline

2015
• Attest to modified version of Stage 2 with accommodations for Stage 1 Providers

2016
• Attest to modified version of Stage 2, at stage 2 thresholds

2017
• Attest to either modified version of Stage 2 or full version of Stage 3, depending on availability of 2015 CEHRT

2018
• Attest to full version of Stage 3 with 2015 CEHRT
Long Term Program Alignment

Meaningful Use in 2015

- Includes alternative exclusions and specifications for objectives for providers who were scheduled to demonstrate Stage 1 of Meaningful Use in 2015

  - EPs and EHs will be able to take an exclusion for any Stage 2 measure that does not have an equivalent objective in Stage 1

  - Exclusion to menu objectives which would now be otherwise required
Meaningful Use in 2016

- Starting in 2016 all providers will need to attest to the modified Stage 2
  - Must meet Stage 2 thresholds
  - 2015 exclusions will not apply in 2016
  - Reporting period will be for one full calendar year
Long Term Program Alignment

Meaningful Use in 2017 and 2018

2017
- Transitional year
- Providers can attest to either modified Stage 2 objectives or Stage 3 objectives, depending on 2015 Certified EHR Technology availability
- Reporting period will be for one full calendar year

2018
- All providers MUST attest to Stage 3
- All providers need to be on 2015 Certified EHR Technology
- Reporting period will be for one full calendar year
Proposed Stage 3 MU Objective Groups

- Protect Patient Health Information
- Computerized Provider Order Entry
- Health Information Exchange
- Electronic Prescribing
- Patient Electronic Access to Health Information
- Coordination of Care Through Patient Engagement
- Clinical Decision Support
- Public Health & Clinical Data Registry Reporting

8 Objective Groups
Meaningful Use Program for EPs and EHs for 2015

MODIFIED STAGE 2
**Modified Stage 2 Goals**

**Proposed Provisions**

- Align with Stage 3 proposed rule to achieve overall goals of programs
- Synchronize reporting period objectives and measures to reduce burden
- Continue to support advanced use of health IT to improve outcomes for patients
Modifications to MU in 2015 - 2017

Proposed rule for Medicare and Medicaid EHR Incentive Programs:

- Streamlines program by removing redundant, duplicative and topped out measures
- Modifies patient action measures in Stage 2 objectives related to patient engagement
- Aligned reporting period with full calendar year
- Changes EHR reporting period in 2015 to 90-day period to accommodate modifications (not tied to a calendar quarter)
## Updated Meaningful Use Timeline

<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>Stage of Meaningful Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>2*</td>
</tr>
<tr>
<td>2016</td>
<td>2</td>
</tr>
<tr>
<td>2017</td>
<td>2 or 3</td>
</tr>
</tbody>
</table>
Meaningful Use in 2015

- Starting in 2015 all participants will attest to a modified version of Stage 2 of Meaningful Use
  - Regardless of which year of Meaningful Use you are in, all participants will attest to a modified version of Stage 2 of Meaningful Use
  - Those providers who were scheduled to meet Stage 1 of Meaningful Use in 2015 will have alternate exclusions and specifications for certain objectives in 2015 only
  - All Meaningful Use Participants will be required to report on Stage 3 starting in 2018 for one full calendar year
Meaningful Use in 2015

- All Eligible Professionals and Eligible Hospitals will move to any continuous 90 day reporting period for 2015
  - Eligible Hospitals will move to the calendar year for reporting period in 2015
  - Eligible Hospitals past their first year will have until February 2016 to attest to Meaningful Use
    - Eligible Hospitals in their first year will have until November 30, 2015 to attest to Meaningful Use
  - The CMS attestation system will not be ready until 2016 for the 2015 reporting period
Meaningful Use in 2015

Modified Stage 2

- Any provider scheduled to attest to Stage 1 of Meaningful Use in 2015 will:
  - Attest to Stage 1 thresholds
  - Will take an exclusion for the Stage 2 measure if there is no equivalent Stage 1 measure
  - Menu objectives move to core objective
Proposed Stage 2 Structure

Eligible Professionals

Current Stage 2
- 17 core objectives
- 3 of 6 menu objectives
- 9 CQMs from 3 domains

Proposed Stage 2
- 9 objectives
- 2 public health measures
- 9 CQMs from 3 domains
**Proposed Stage 2 Structure**

**Eligible Hospitals**

**Current Stage 2**
- 16 core objectives
- 3 of 6 menu objectives
- 16 CQMs from 3 domains

**Proposed Stage 2**
- 8 objectives
- 3 public health measures
- 16 CQMs from 3 domains
Meaningful Use in 2015

- There will be no changes to the CQM reporting or attesting
  - All EPs and EHs will still need to report CQMs for the Meaningful Use program
  - CQMs will need to span at least 3 of the 6 domains
  - CQMs can be electronically reported using established methods
  - CQMs will be reported for a 90 day period
Stage 2 Clinical Quality Measures

Report on 9 CQMs

Quality Measures must cover at least 3 of 6 NQS domains:

– Patient and Family Engagement
– Patient Safety
– Care Coordination
– Population and Public Health
– Efficient Use of Health Care Resources
– Clinical Processes/Effectiveness
Vendor Requirements

- 2015 – No changes to the 2014 CEHRT currently in use
- 2018 – Required to update CEHRT to 2015 standards

<table>
<thead>
<tr>
<th>Reporting Year</th>
<th>Certified EHR Technology Edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>2014 CEHRT</td>
</tr>
<tr>
<td>2016 -2017</td>
<td>2014 or 2015 CEHRT</td>
</tr>
<tr>
<td>2018</td>
<td>2015 CEHRT</td>
</tr>
</tbody>
</table>
Proposed Changes

Qualifications for Hospital-Based EPs

- Include place of service 22 (outpatient) for those EPs considered hospital-based*
- EP is ineligible for incentive payment and payment adjustments if >90% covered professional services in sites of service identified as:
  - POS 21 (inpatient)
  - POS 22 (outpatient)*
  - POS 23 (emergency room)
Proposed EP and EH Stage 2 Objective Changes

“Current” Patient Electronic Access

Measure 1: More than 50% unique patients have timely online access with ability to VDT

Measure 2: More than 5% unique patients VDT their information to a third party

“Proposed” Patient Electronic Access

Measure 1: More than 50% unique patients have timely online access with ability to VDT

Measure 2: At least one patient during the reporting period VDT their information to a third party
Modifications to MU 2015-2017

Proposed EP Stage 2 Objective Changes

"Current" Secure Messaging
A secure message was sent using the electronic messaging function of the CEHRT by more than 5% of unique patients during the reporting period.

"Proposed" Secure Messaging
During the reporting period the capability to send and receive a secure electronic message with the provider is **fully enabled**.
## MU Objectives 2015 -2017

<table>
<thead>
<tr>
<th>Objective</th>
<th>EP Measure</th>
<th>EH Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE</td>
<td>&gt;60% med, &gt;30% lab, &gt;30% radiology</td>
<td>Same</td>
</tr>
<tr>
<td>eRx</td>
<td>&gt;50%; drug formulary query</td>
<td>&gt;10%; drug form query</td>
</tr>
<tr>
<td>Clinical Decision Support</td>
<td>5 rules related to 4+ CQM; drug/drug and drug/allergy interaction ck</td>
<td>Same</td>
</tr>
<tr>
<td>Patient Elec Access (VDT)</td>
<td>&gt;50% timely access; 1 patient VDT</td>
<td>Same</td>
</tr>
<tr>
<td>Protect Elec Health Info</td>
<td>Conduct SRA/correct deficiencies</td>
<td>Same</td>
</tr>
<tr>
<td>Patient Specific Education</td>
<td>&gt;10% unique patients</td>
<td>Same</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>&gt;50% transitions of care</td>
<td>Same</td>
</tr>
<tr>
<td>Summary of Care</td>
<td>Use CEHRT to create summary; &gt;10% electronically transmit</td>
<td>Same</td>
</tr>
<tr>
<td>Secure Messaging</td>
<td>Fully enabled</td>
<td>n/a</td>
</tr>
<tr>
<td>Public Health</td>
<td>5 measure options</td>
<td>6 measure options</td>
</tr>
</tbody>
</table>

*MU Objectives 2015 - 2017*
Meaningful Use Program for EPs and EHs for 2015

REMOVAL OF CORE AND MENU

OBJECTIVES
### MU Objectives Removed for EPs

#### Removal for Modified Stage 2

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Demographics</td>
</tr>
<tr>
<td>Record Vital Signs</td>
</tr>
<tr>
<td>Record Smoking Status</td>
</tr>
<tr>
<td>Clinical Summaries</td>
</tr>
<tr>
<td>Structured Lab Results</td>
</tr>
<tr>
<td>Patient List</td>
</tr>
<tr>
<td>Patient Reminders</td>
</tr>
<tr>
<td>Summary of Care</td>
</tr>
<tr>
<td>Measures 1 and 3</td>
</tr>
<tr>
<td>Electronic Notes</td>
</tr>
<tr>
<td>Imaging Results</td>
</tr>
<tr>
<td>Family Health History</td>
</tr>
</tbody>
</table>
## MU Objectives Removed for EHs

### Removal for Modified Stage 2

- Record Demographics
- Record Vital Signs
- Record Smoking Status
- Structured Lab Results
- Patient List
- Summary of Care
- Measures 1 and 3
- eMAR
- Advanced Directives
- Electronic Notes
- Imaging Results
- Family Health History
- Structure Labs to Ambulatory Providers
CONSORTIATION OF PUBLIC HEALTH MEASURES

Meaningful Use Program for EPs and EHs for 2015
## Meaningful Use in 2015

### Public Health Measure

- Consolidation of all public health reporting objectives into one objective with different measure options

<table>
<thead>
<tr>
<th><strong>EHs</strong></th>
<th><strong>EPs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Immunization Registry Reporting</td>
<td>• Immunization Registry Reporting</td>
</tr>
<tr>
<td>• Syndromic Surveillance Reporting</td>
<td>• Syndromic Surveillance Reporting</td>
</tr>
<tr>
<td>• Case Reporting</td>
<td>• Case Reporting</td>
</tr>
<tr>
<td>• Public Health Registry Reporting*</td>
<td>• Public Health Registry Reporting*</td>
</tr>
<tr>
<td>• Clinical Data Registry Reporting*</td>
<td>• Clinical Data Registry Reporting*</td>
</tr>
<tr>
<td>• Electronic Reportable Laboratory Reporting</td>
<td></td>
</tr>
</tbody>
</table>

* May choose to report to more than one registry to meet the number of measures required to meet the objective
Medicaid EHR Participants

Additional attestation option

- Providers who have Medicaid patient volume fall below program thresholds will be able to avoid a Medicare payment adjustment by:
  - Will be able to attest using the CMS Medicare EHR portal
  - Medicaid participants will not earn an incentive for that program year
  - This does not affect their Medicaid program eligibility for subsequent years
  - Would not constitute a switch in programs
PAYMENT ADJUSTMENTS AND HARDSHIP EXCEPTIONS
EP Payment Adjustments

- Payment adjustments began 1/1/15 for providers who did not attest by 10/1/14
- 2016 EP hardship applications are available on the CMS website
- Providers must attest EACH year to avoid Medicare payment adjustment
- Payment adjustments will stop after the calendar year it was applied if the provider meets MU
- Providers only eligible to participate in the Medicaid Program (i.e. PA, ARNP, CMW) are not subject to payment adjustment
EP Payment Adjustments

- Adjustment applied to the Medicare physician fee schedule amount for covered professional services furnished by EP during the year

- 1% payment adjustment per year
  - 1% - 2015
  - 2% - 2016
  - 3% - 2017
  - Government decision year 2018
    - >75% of nation’s EPs meet MU, payment adjustment caps at 3%
    - <75% of nation’s EPs meet MU, payment adjustments increase to 5%
### Hardship Exception Application Categories

EPs can apply for hardship exceptions by July 1, 2015 in the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of Infrastructure</td>
<td>EPs must demonstrate they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure.</td>
</tr>
</tbody>
</table>
| 2. Unforeseen and/or Uncontrollable Circumstances  | Natural disaster, practice closure, bankruptcy or debt re-structuring, EHR Certification/Vendor Issues:  
  • Loss of EHR Certification  
  • Closure of EHR Vendor  
  • 2014 EHR Vendor Certification Issues and Delays |
| 3. Lack of Control over the Availability of Certified EHR Technology | Lack of control of availability of CEHRT at one practice location or a combination of practice locations and where the location(s) constitute > 50% of patient encounters. |
| 4. Lack of Face-to-Face Interaction                 | Lack of face-to-face patient interaction AND lack of need for follow up with patients OR extremely rare cases of face-to-face patient interaction and follow-up.                                                 |
IHIN

Healthcare Intelligence
Benefits of Statewide HIE/IHIN

**Without** the IHIN
Each healthcare provider must build point-to-point connections.

**With** the IHIN
Each healthcare provider is connected.
Core IHIN Services

- Direct Messaging
- Patient Query/Look-Up
- State Public Health Reporting
Direct Messaging

- Send/receive patient information in a secure method with providers outside your organization
  - Direct works like conventional email but encrypts the message, enabling electronic transfer of protected health information (PHI) to an authenticated user

- Push messaging

- Used for treatment, payment and healthcare operations

- Approved for use among all provider organization types
How to Connect...Direct Messaging

- **System to System Connection**
  - EHR interface
  - Technical protocols, testing required

- **Clinical Portal**
  - Interface is via the Internet
  - Accessible, even without an EHR

Note: Direct Messaging with IHIN requires a DirectTrust accredited HISP.

\[HISP = Health\ Information\ Service\ Provider\]
Direct Messaging

Direct Messaging Exchange Use Cases

Referral
- When referring a patient, a primary care provider can use Direct to send the necessary patient information to a specialist

Transition of Care
- When admitting a patient to a long term care facility, the provider can use Direct to send a treatment summary to the facility

Hospital Discharge
- When discharging a patient, the hospital can use Direct to send the discharge instructions to the primary care provider

Communication
- Direct is an efficient communication tool where documents can be attached to a secure email, resulting in a reduction of the number of faxes & phone calls sent
THANK YOU
CMS Resources


Questions?

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