Meaningful Use Stage 2: What Ambulatory Practices Need to Know

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General Electric Company, by and through its GE Healthcare division.

Overview

HITECH Act and Meaningful Use

HITECH Act

Part of American Recovery & Reinvestment Act of 2009 (ARRA)

$30B+ for HIT infrastructure and EHR adoption/use

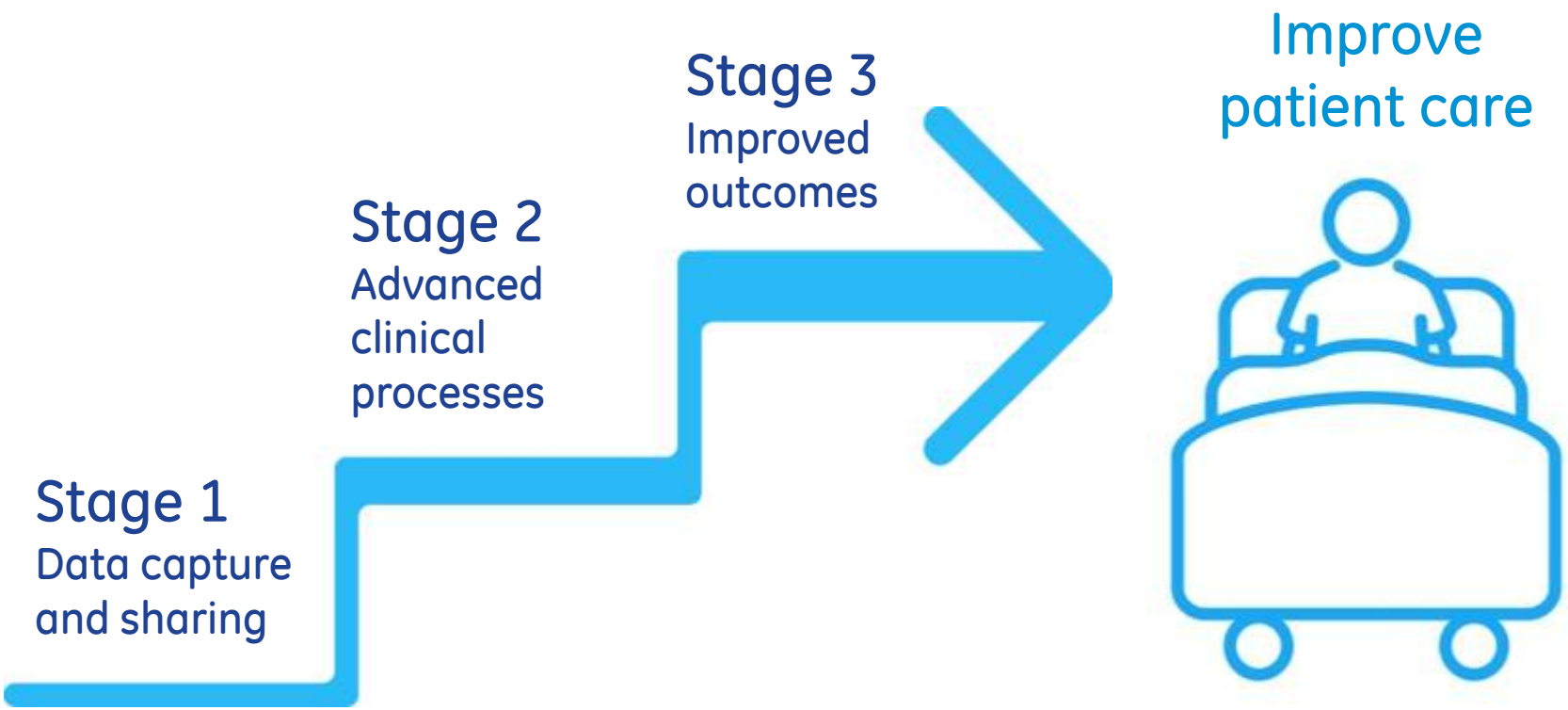
Meaningful Use

Eligible Professionals (EP) and Hospitals demonstrate “Meaningful Use” of Certified EHR to receive Medicare or Medicaid EHR incentives

EHR solution achieves **Certification**

EP/Hospital demonstrates **Meaningful Use**

Evolution of Meaningful Use



Stages of Meaningful Use

Applies if incentive or adjustment year

First Payment Year	Stage of Meaningful Use Criteria by First Payment Year										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2*	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2*	2	3	3	TBD	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

*3-month quarter EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at state option) for Medicaid EPs. All providers in first year in 2014 use any continuous 90-day EHR reporting period. (note mix of 3-month and 90-day)

Medicare EP incentive payments

Calendar year	First calendar year in which the Eligible Professional receives an incentive payment				
	2011	2012	2013	2014	2015 +
2011	$18,000				
2012	$12,000	$18,000			
2013	$8,000	$12,000	$15,000		
2014	$4,000	$8,000	$12,000	$12,000	
2015	$2,000	$4,000	$8,000	$8,000	$0
2016		$2,000	$4,000	$4,000	$0
TOTAL	**$44,000**	**$44,000**	**$39,000**	**$24,000**	**$0**

Medicaid EP incentive payments

Adoption year	First calendar year in which the qualifying Eligible Professional receives an incentive payment					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
TOTAL	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule, January 13, 2010, Federal Register, pp. 1844-2011

Stage 1 status

2013 is third year of Stage 1

Total payouts nearly $13B (through 2/2013)

2013 transitions in some Stage 2/2014 changes

Learnings driving preparation for Stages 2 & 3

Stage 1 Meaningful Use performance

On average all thresholds greatly exceeded; each had borderline providers

Drug formulary, immunization registries and patient list most popular EP menu objectives

- Advance Directives, Clinical Lab Results, Drug Formulary for hospitals

Transition of care summary and patient reminders least popular EP menu objectives

- Transition of Care and Reportable Lab Results for hospitals

Little difference between EP and hospitals

Little difference among specialties in performance, but differences in exclusions and deferrals

Source: CMS presentation to HIT Policy Committee, 2/6/2013

Meaningful Use payments

	Amount Paid 2011 Program Year	Amount Paid 2012 Program Year	Amount Paid 2013 Program Year	Amount Paid Program - To - Date
Medicare Eligible Professionals	**$ 980,457,027**	**$ 1,592,952,000**	**$ -**	**$ 2,573,409,027**
Doctors of Medicine or Osteopathy	$ 870,354,833	$ 1,452,036,000		$ 2,322,390,833
Dentists	$ 829,707	$ 1,380,000		$ 2,209,707
Optometrists	$ 38,965,329	$ 57,360,000		$ 96,325,329
Podiatrists	$ 51,783,023	$ 60,654,000		$ 112,437,023
Chiropractors	$ 18,524,135	$ 21,522,000		$ 40,046,135
Medicaid Eligible Professionals	**$ 1,052,693,358**	**$ 677,155,396**	**$ 9,068,798**	**$ 1,738,917,552**
Physicians	$ 786,791,852	$ 470,514,728	$ 5,770,798	$ 1,263,077,378
Certified Nurse-Midwives	$ 23,268,750	$ 13,336,500	$ 106,250	$ 36,711,500
Dentists	$ 56,503,750	$ 66,504,000	$ 454,750	$ 123,462,500
Nurse Practitioners	$ 172,677,756	$ 120,726,918	$ 2,609,500	$ 296,014,174
Physicians Assistants	$ 13,451,250	$ 6,073,250	$ 127,500	$ 19,652,000
Eligible Hospitals	**$ 3,150,538,362**	**$ 4,886,459,014**	**$ 119,586,610**	**$ 8,156,583,985**
Medicare Only	$ 117,701,046	$ 220,449,668	$ 8,888,200	$ 347,038,914
Medicaid Only	$ 127,010,563	$ 89,246,383	$ 4,075,125	$ 220,332,071
Medicare/Medicaid	$ 2,905,826,753	$ 4,576,762,963	$ 106,623,284	$ 7,589,213,000
Medicare Advantage Organizations For Eligible Professionals	**$ 189,436,486**	**$ -**	**$ -**	**$ 189,436,486**
Total	**$ 5,373,125,233**	**$ 7,156,566,410**	**$ 128,655,408**	**$ 12,658,347,050**

Source: CMS EHR Incentive Program data, 4/2013

Meaningful Use achievement

	Unique Providers Paid 2011 Program Year	Unique Providers Paid 2012 Program Year	Unique Providers Paid 2013 Program Year	Unique Providers Paid Program To - Date
Medicare Eligible Professionals	58,452	92,138	-	139,910
Doctors of Medicine or Osteopathy	51,456	83,618		126,456
Dentists	56	79		130
Optometrists	2,571	3,436		5,264
Podiatrists	2,916	3,671		5,688
Chiropractors	1,453	1,334		2,372
Medicaid Eligible Professionals	50,113	37,026	490	79,257
Physicians	37,582	26,218	324	57,577
Certified Nurse-Midwives	1,095	759	5	1,640
Dentists	2,664	3,183	22	5,779
Nurse Practitioners	8,135	6,531	133	13,365
Physicians Assistants	637	335	6	896
Eligible Hospitals	2,310	2,990	80	3,781
Medicare Only	86	146		187
Medicaid Only	57	61	4	104
Medicare/Medicaid	2,167	2,783	76	3,490
Medicare Advantage Organizations For Eligible Professionals	11,117	-	-	11,117
Total	121,992	132,154	570	234,065

Source: CMS EHR Incentive Program data, 4/2013

Meaningful Use progress: context

75+% eligible hospitals received MU or AIU incentive

- 73% are meaningful users
- Demonstrates financial commitment to implement EHR

About 36% of Medicare EPs meaningful users

- 58% of Medicare EPs receiving incentives are specialists

About 44% of Medicare and Medicaid EPs made financial commitment to implement EHR

Source: CMS presentation to HIT Policy Committee, 4/2013

EHR adoption continues to grow

71.85% of physicians have adopted EHRs as of 2012 according to the NCHS, up from 57% in 2011*

69% of primary care physicians used EHRs in 2012, up by 50% from 46% in 2009: recent Commonwealth Foundation report**

HIMSS Analytics reports large increases in % of hospitals in EMRAM^{SM} Stages 5 (97%), 6 (83%), 7 (64%)***

Meaningful Use has accelerated this growth, likely focused on EHRs with robust, certified functionality, including interoperability foundations

**Hsiao CJ, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001–2012. NCHS data brief, no 111. Hyattsville, MD: National Center for Health Statistics. 2012.*
***S. Thomson, R. Osborn, D. Squires, and M. Jun, International Profiles of Health Care Systems, 2012, The Commonwealth Fund, November 2012*
**** HIMSS Analytics press release, January 14, 2013*

Stage 2

Stage 2 Meaningful Use Final Rules

Final Rules released August 2012

CMS: revised objectives and measures for eligible professionals (EPs) and hospitals

ONC: revised certification and standards

CMS/ONC Interim Final Rule: December 2012

Final Rules only *start* of needed guidance

Final Rule highlights

- ✓ Stage 2 start delayed to FY/CY 2014
- ✓ 3-month quarter reporting period for all in 2014 – new (CQMs can't be submitted till end of full year)
- New objectives and measures for Stage 2
  - Nearly all proposed are finalized
  - Menu: clinical notes
- Revisions to some Stage 1 criteria
  - Some start in 2013 and others 2014
- Some thresholds lowered and new exclusions

Final Rule changes (selected)

Enhanced HIE provisions per proposal/comments

Revised hospital-based definition

Revised CPOE denominator

Medicare non-MU “payment adjustments” start 2015

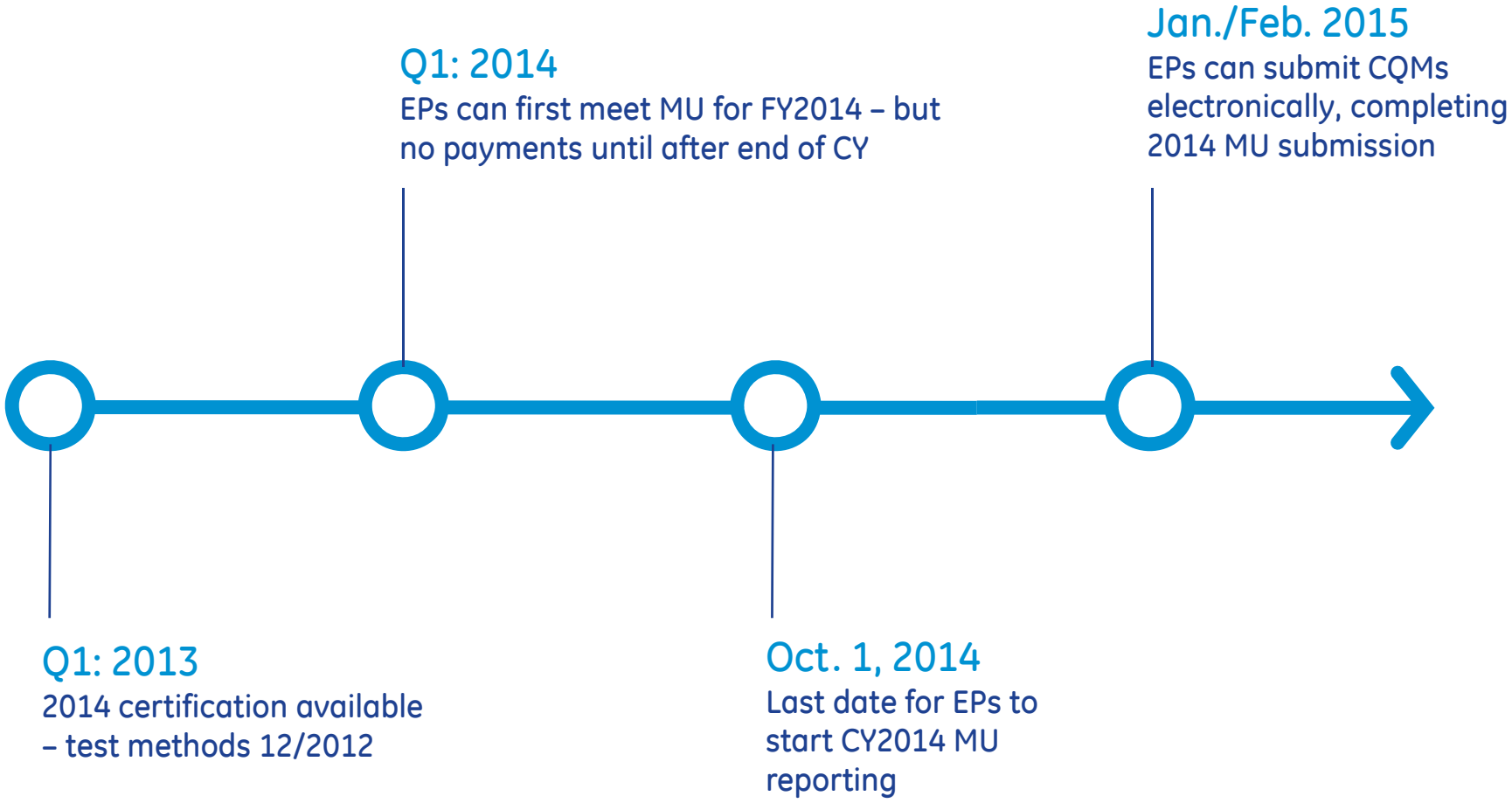
Medicaid revisions

Revised certification criteria and process

Key GE Healthcare CMS comments

- ✓ Overall: comments carefully reviewed and responded to
- ✓ Stage 2 timing and implementation: majority of comments received
- ✓ Measurement and reporting: e.g., transit. defn., exchange, CPOE
- ✓ CDS and Clinical Quality Measures: more flexible CDS, fewer CQMs but no e-specifications when regulations published
- ✓ HIE and interoperability: loosened requirement to send to other vendor system and allows NwHIN query models
- ✓ Patient engagement: lower thresholds and exclusions
- ✓ Access to imaging results: kept for providers, clarified and lower thresholds
- ✓ Specialist provisions

EPs: Meaningful Use Stage 2



2013 Changes for Stage 1

Computerized Physician Order Entry (CPOE)

Add alternative measure based on # of med orders created in reporting period
Timing: 2013 and onward

Revised description of who can enter orders into EHR and have count as CPOE
Timing: 2013 and onward (regardless of stage)

Electronic Prescribing

Additional exclusion for providers not within 10 miles of pharmacy accepting eRx
Timing: 2013 and onward

Electronic Exchange of Key Clinical Information

No longer required for Stage 1
Timing: No longer required 2013 and onward

Record and Chart Changes in Vital Signs

Age limit increased for recording BP in patients from ages 2 to 3; no age limit for height and weight
Timing: Optional in 2013; required 2014+

Exclusion if EP sees no patients 3 years or older, if all three vital signs not relevant to scope of practice, if height and weight not relevant to scope of practice, or if BP not relevant to scope of practice
Timing: Optional in 2013; required in 2014+

Public Health Reporting Objectives

Require that providers perform at least one test of CEHRT capability to send data to PH agencies, except where prohibited
Timing: Required in 2013 and onward (for all Stage 1 public health objectives)

Final Rules are just the beginning

FAQs: Ongoing

Meaningful Use measure specifications: 11/2012

"Final" certification test methods: 12/2012

- Revisions to methods, data, tools: Q1 2013

"Final" eCQM specifications: 12/2012

- Continuing issues/adjustments

Stage 3

Stage 3

CMS outlines expected themes in Final Rule

- Improve quality, safety and efficiency ➔ better outcomes
- Decision support for high priority conditions
- Patient access to self-management tools
- Access to comprehensive patient data via robust, patient-centered HIE
- Improving population health

HIT Policy Committee Request for Comments late November 2012 – comments January 14, 2013

CMS: menu to core and no "delay" for Stage 3 start in 2016 – NPRM in early 2014

Stage 3 expected timeline

- August 2012 – HITPC draft preliminary stage 3 proposal
- November 2012 – RFC distributed
- January 2012 – RFC comments submitted
- Q2 2013 – HITPC draft stage 3 recommendations
- Q3 2013 – HITPC final stage 3 recommendations to HHS
- Q1/Q2 2014 – Stage 3 proposed rules
- Q3 2014 – Stage 3 final rules
- October 1, 2015 – Stage 3 starts for hospitals
- January 1, 2016 – Stage 3 starts for eligible professionals

Stage 3 Request for Comments

Comments submitted on HITPC RFC January 2014

Industry alignment on comments

GE Healthcare advocated more focused approach to Stage 3

- Focus on encouraging and assisting providers to take advantage of substantial capabilities from Stages 1 and 2, rather than adding extensive new meaningful use requirements and certification criteria
- Meaningful use and functionality changes should emphasize driving interoperability, accelerating momentum and deepening Stage 2 use
- CMS & ONC should continue to invest in aligned quality measurement
- Given timing issues from Stages 1 and 2, ONC and CMS should not start Stage 3 until at least three years after Stage 2 start

Stage 3 RFC comment themes (660)

Greater focus on clinical outcomes

- Empower flexibility to foster innovation, limit scope

Timing concerns

- Experience needed from Stage 2 before increasing thresholds, accelerating measures, moving from menu to core
- Concerns about standards readiness to support Stage 3 goals

Address interoperability limitations

Meaningful Use only one component of provider responsibilities

Continue to invest in CQM alignment, infrastructure, standards

Ensure patient safety remains high priority and related requirements synchronized with Meaningful Use

Source: ONC presentation to HIT Policy Committee, 2/6/2012

Stage 2
Requirements

Overall requirements: EPs

Meet (or exclusion) 17 core objectives (Stage 1 = 15)

Meet (or exclusion) 3/6 menu objectives (Stage 1 = 5/10)

New and continuing exclusions

EPs report 9/64 CQMs (Stage 1: 6; NPRM 12/125)

Almost all Stage 1 menu to core

Some new Stage 2 menu

CQMs aligned with other quality initiatives

Meaningful Use concepts

Change

Exclusions no longer count to meet menu objectives

- Do not reduce needed menu items
- But, if 3+ exclusions, can attest to one
- Starts in 2014 for all stages

No Change

50% of EP outpatient encounters must occur at locations equipped with certified EHR technology

- Starting in 2013, EP cannot create record of an encounter without CEHRT at practice/location and then later input information into CEHRT

Measure compliance = objective compliance

Numerators can include events before, during, *after* reporting period for patients in denominator

- Had been unclear in Stage 1

Greater (some) relevance to specialists

Imaging results & information “accessible through” CEHRT

State cancer registry and specialized registry

Continued use of core/menu concept

No changes to statutory eligibility but specialty-relevant “hardship exceptions” for “payment adjustments”

- Calls out radiologists, anesthesiologists, and pathologists

CMS modified hospital-based definition

ONC changes to definition to CEHRT – more flexibility

Split exclusion for vitals – height/weight from BP

Hospital-based EP definition relaxed

EPs who demonstrate they:

- Fund acquisitions, implementation, and maintenance of CEHRT, including hardware and interfaces needed for MU
- Without reimbursement from hospital
- And use at hospital in lieu of hospital's CEHR
- Can be "non-hospital based" and receive incentive

Application process

Payment adjustments (penalties)

Start in 2015 per HITECH if not meaningful user

- 2015 (1%), 2016 (2%), 2017+ (3%)
- But, if HHS finds EP meaningful users less than 75%, beginning in 2018, penalty grows 1 point annually up to 5%
- Hospital: annual update cut: 2015 (25%), 2016 (50%), 2017+ (75%)

Medicaid attestations for AIU will not prevent penalty

To avoid 2015 penalty: meaningful use in 2013 – or first attest by 7/1/2014 (hospital) or 10/1/2014 (EP)

- Same timing offsets in out years

Penalties: “Hardship exceptions”

Lack of internet access

New EPs

“Extreme” circumstances such as natural disasters

Scope of practice/specialties: anesthesiology, radiology, pathology

Lack of control of CEHRT availability if practice in multiple locations

Payment adjustments (penalties)*

If demonstrated meaningful use in **2011** or **2012**

Payment Adjustment Year	2015	2016	2017	2018	2019
Based on Full Year EHR Reporting Period	2013	2014	2015	2016	2017

If demonstrates meaningful use in **2013** for the first time (and so on)

Payment Adjustment Year	2015	2016	2017	2018	2019
Based on 90 day EHR Reporting Period	2013				
Based on Full Year EHR Reporting Period		2014	2015	2016	2017

To Avoid Payment Adjustments: Providers must continue to demonstrate meaningful use every year to avoid adjustments in later years

**Sequence applies to EPs and subsection(d) hospitals. If first attest in 2013, hospitals must attest by July 1, 2014 and EPs by October 1, 2014 - to avoid 2015 penalty - same sequence in out years.*

Transitions of care/referrals and HIE

Cut test "Exchange of key clinical information" starting in 2013

Transitions/referrals to core but stay at 50% (NPRM was 65%)

More HIE: 10% TOC summaries sent *electronically* via CEHRT

- NPRM: all *electronic exchange* w/ different organization, EHR, vendor
- Final Rule: one successful test exchange with provider using EHR technology designed by different vendor *or* CMS-designated test EHR

CMS to monitor/respond for Stage 3 and via other policy tools if not enough cross-vendor exchange: eliminate "walled gardens"

CMS looks to more robust exchange in Stage 3 – including query

Transitions of care/referrals and HIE

Sender must use CEHRT

Recipient need not use CEHRT

Summary must be received/measurement must address receipt

Transport standards: Direct and two options

- "HISP" part of certification for Direct and option 1

MU Final Rule counts in numerator when referring/transitioning provider uses CEHRT to generate summary and provides via NwHIN Exchange participant or per NwHIN governance

- Need not use certified transport capabilities/standards, but
- Summary must actually be accessed for transition/referral

Updated care summary content

Care plan field, including goals and instructions

Care team members beyond referring, transitioning, receiving provider

Up-to-date problem list of “pertinent” current and ~~active~~ historical diagnoses, active medication list, active medication allergy list (replaces 3 objectives)

Meaningful Use reporting must confirm presence of problems, med, med allergies

Other fields can be blank

Public Health and HIE

Ongoing submission requires provider and public health agencies to identify electronic process for data to move from EHR to public health: efficient, automated, secure

- If ongoing from pre-2014, may use 2011 standards
- Must identify PHA capability within first 60 days of reporting period
- Registration with PHA within first 60 days is key, then depends on onboarding

States/PHAs may specify transport methods

- CMS clarifies: limits on state Medicaid flexibility re: transmission apply *only* to certified capabilities, which do not include PH transmission

State PH Agencies can use HIEs to collect EHR data from providers on their behalf in addition to accepting direct provider to PH data submission

- HIE intermediaries can just capture the data for PH; or
- HIE intermediaries can accept data from EHRs and transform it into correct version of HL7 (must be certified as a module)
- If PHA uses HIE, can eliminate some exclusions based on PHA capabilities

Medicaid

Patient volume

- Encounters expanded to more Medicaid services – zero pay visits
- Could increase pediatricians' eligibility

CQMs

- New measures include several targeted to Medicaid patients

States' flexibility with PH measures for Stage 2 (same as Stage 1 + new cancer registry measure)

- Would meet at least 1 PH from menu if state moves 1+ to core

Attestation for MU measures

Generally unchanged from Stage 1

Group report option allowing individual EP data to be uploaded in a batch file

Definitions

Reporting period

- Clarifies 90 days for first year of MU, regardless of payment year
- For 2014, reporting period is 3 month quarter for all Medicare and option of state Medicaid to use 90-days or 3-month quarter

CQMs part of "Meaningful Use" vs. an Objective in 2013+

Office visit

- In *Proposed Rule*, CMS defined as "any billable visit that includes: (1) concurrent care or transfer of care visits; (2) consultant visits; or (3) prolonged physician service without direct, face-to- face patient contact (for example, telehealth). In *Final Rule*, CMS states that "in some cases removing sutures or giving allergy shots do not represent an office visit if that is the only service provided."
- Relevant to reporting for patient summary and other objectives

Denominators: EPs

CMS standardizes on four denominators

1. Unique patients "seen by" EP during reporting period (stratified by age or previous office visit)
   - "Seen by" clarifications including if no physical or telemedicine contact (latter must define some visits as "seen by")
   - Flexibility for EPs practicing in multiple locations using different CEHRT or switching CEHRT during reporting period
2. Number of orders (medication, labs, radiology)
3. Office visits: definition adopted as proposed
   - Need not be billable
4. Transitions of care/referrals: definitions refined

CQMs for EPs

EPs to report 9/64 clinical quality measures, covering at least 3/6 domains*

CMS recommends core set of 9 adult BP-focused measures & alternate pediatrics core of 9

Medicare EPs participating in both PQRS & EHR Incentive Program can use PQRS Reporting Option

CMS issued eSpecifications in October 2012 that were “finalized” December 2012 with revisions in Q1: 2013

**Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, Clinical Process/Effectiveness*

CQM reporting: EPs

Attestation (Stage 1, Year 1)*

Report individually or as group

Options

- PQRS EHR reporting option – patient level (after year 1, PQRS and MU)
- CMS portal – aggregate data using QRDA III format

For 2014 *quarter* reporting, CQM reporting in 2 months after end of *full* CY

Two group reporting options for EPs

- ACO or PQRS-group: if report using CEHRT

Medicaid reporting may vary by state

**Providers can only use CQMs for which CEHRT is certified and CEHRT must be certified for "incorporate", "calculate" and "reporting"*

Care Summaries

Clinical Summary Content: Stage 2

Patient Name

Provider's name & office contact information

Date and location of the visit

Reason for the office visit

Current problem list & *any updates*

Current medication list & *any updates*

Current medication allergy list & *any updates*

Procedures performed during the visit

Immunizations or medications administered during visit

Vital signs taken during the visit (or other recent vital signs).

Laboratory test results

List of diagnostic tests pending

Clinical instructions

Future appointments

Referrals to other providers

Future scheduled tests

Demographic information maintained within CEHRT (sex, race, ethnicity, date of birth, preferred language).

Smoking status *(New for Stage 2)*

Care plan field, including ~~problems~~, goals and instructions. *(New for stage 2)*

Recommended patient decision aids (if applicable to the visit) (*New for Stage 2)*

For EP Visit

Summary of Care Content: Stage 2

Patient Name

Referring or transitioning provider's name and office contact information (EP only)*

Provider's name & office contact info

Procedures

Encounter diagnosis

Immunizations

Laboratory test results

Vital signs

Smoking status*

*Functional status, including activities of daily living, cognitive and disability**

Demographics (preferred language), *sex*, race, ethnicity, date of birth*

**New for Stage 2*

Care plan field, including problems, 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 (EP only)*

Discharge instructions (Hospital only)

Current problem list (historical at discretion)

Current medication list

Current medication allergy list

All can be blank if no EHR info except problems, meds, med allergies.

EP Online Access Content: Stage 2

Patient name

Provider's name and office contact information

Current and past problem list

Procedures

Laboratory test results

Current medication list and medication history

Current medication allergy list and medication allergy history

Vital signs (height, weight, blood pressure, BMI, *growth charts*)

Smoking status*

Demographic information (preferred language, sex, race, ethnicity, date of birth)

Care plan field(s), including goals and instructions*

Any known care team members including the primary care provider (PCP) of record*

**New for Stage 2*

Revised in Final Rule for view, download, transmit
All can be blank if no EHR info except problems, meds, med allergies.

Objectives & Measures

Stage 2 EP MU objectives

Core Set

Computerized provider order entry for Med, **Labs**, and **Rad** orders (3 measures)

eRx (50%)

Record demographics (80%)

Vital signs (80%)

Smoking status (80%)

Clinical decision support

- 5 CDS "Interventions"
- Drug-drug; drug-allergy checks

Incorporate lab test results

Generate patient lists

Patient Reminders

View online, download, transmit info about an office visit

Clinical Summaries for each office visit

Patient education resources

Secure electronic messaging

Medication reconciliation

Summary of care record for each transition of care

Submission to immunization registries

Protect electronic health information

Menu Set (Pick three)

Imaging results (10%)

Family health history (20% of unique patients)

Syndromic surveillance

Cancer registry

Specialized registry

Progress notes

Legend

Stage 1 but modified for Stage 2

Unchanged requirement

New requirement

Comparison Stage 1 to 2 for EP

Menu to Core

- Incorporate lab data
- Generate patient lists
- Patient Reminders
- Timely Access
- Patient education Resources
- Med Reconciliation
- Transition of Care Summary
- Immunization Registry

Still Menu:

- Syndromic Surveillance

Raising the Bar

- CDS to 5 “Interventions” plus DD/DA
- Clinical Summary to patient from 3 days to 24 hours

% Increase

- CPOE* – 30% to 60% for meds
- Demographics – 50 to 80%
- Vitals – 50% to 80%
- Smoking status – 50% to 80%
- Incorporate Lab – 40 to 55%
- eRx – 40% to 50%

New

- Imaging Results (40% to 10% of tests ordered from NPRM)
- CPOE for lab and imaging*
- Family Health History
- View, Download, Transmit (10% to 5%)
- Cancer Registry
- Specialized Registry
- Secure Electronic Messaging (10% to 5%)
- Progress Notes

**CPOE changes: include denominator to all orders*

More

Eliminated as Separate Objective

- Problem List
- Active Med List
- Medication Allergy List
- Clinical Quality Measures
- Drug-drug, Drug-Allergy
- eCopy of Health Info
- Drug Formulary

Certification

ONC HIT Certification Program

Temporary program sunset on effective date with 6 months to finish existing work in progress – **no new requests**

ONC-ACBs cannot "update" 2011 modular certifications to 2014 but, for unchanged criteria, "gap certification" allows use of applicable 2011 test results for modules, but still must address QMS, automated measure calculation, safety-enhanced design

Revisions to EHR module certification requirements

- Privacy and security certification
  - Base EHR definition includes all P&S certification criteria
- Other changes to make certification "more efficient"
  - Revised definition of CEHRT: Base, Core, Menu
  - Revised process to provide industry with flexibility to quickly use newer versions of "minimum standard" code sets on voluntary basis
- Application of specific new criteria
  - § 170.314(g)(1): Automated numerator recording
  - § 170.314(g)(3): Safety-enhanced design
  - § 170.314(g)(4). Quality management system

Certification test methods/scripts

Sept–Dec 2012: Test Procedures out for comment

Test procedures finalized in December - revisions to methods, data, tools through February

2014 certifications started early 2013

- 2014 Edition Test Method
  - 2014 Edition Test Scenarios Overview
- ONC HIT Certification Program Technical Workshops

Criterion #	Certification Criterion Name	Document Type	Last Revised
§170.314(a)(1)	Computerized provider order entry	Test Procedure [PDF - 110 KB]	12/14/12
		Test Data [PDF - 124 KB]	01/16/13
§170.314(a)(2)	Drug-drug, drug-allergy interactions checks	Test Procedure [PDF - 393 KB]	12/14/12
§170.314(a)(3)	Demographics	Test Procedure [PDF - 395 KB]	12/14/12
		Test Data [PDF - 71 KB]	01/16/13

Certified EHR Technology redefined

Certified EHR Technology (CEHRT)

Revision starts with 2014 reporting period but providers can use 2014 in 2012/13

“Possession” for 2012/13 unless use 2014 edition

New definition regardless of provider’s stage

Meeting CEHRT definitions: options

Complete EHR

Module(s) sufficient for provider MU

- Combination of modules
- Single module

52% of hospitals used modular elements**

Modular/Complete*

- Can combine vendor and self-developed
- Can use alternate certified modules to those in Complete EHR - need CHPL #
- Can use alternate solutions by Department
- All software used to meet meaningful use criterion must be certified

Ancillaries/data sources*

- Certification needed only if capability used to meet meaningful use

* http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163 - 8/13/2012

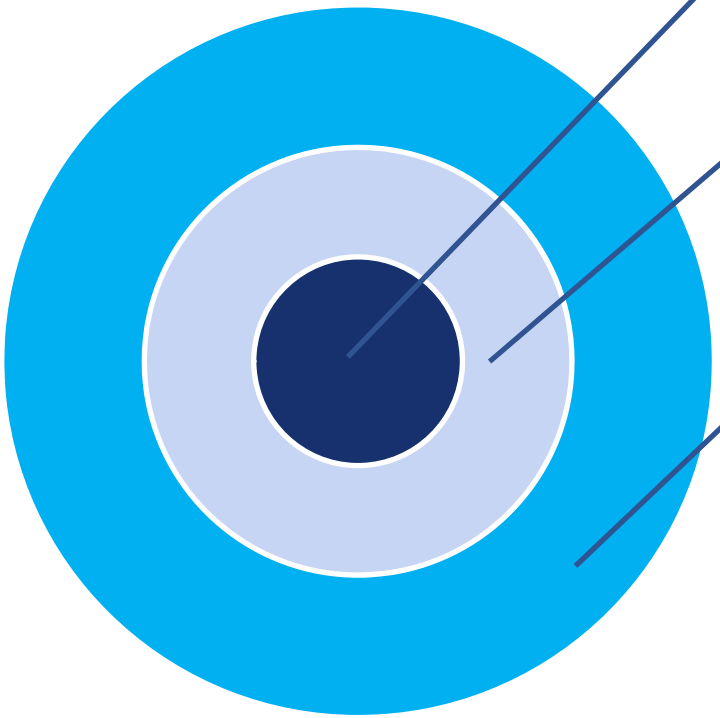
** http://www.govhealthit.com/news/why-ehr-market-brink-mass-consolidation - 8/13/2012

CEHRT compliance

Meaningful Use Reporting Period	
FY/CY 2011-2013: Stage 1	FY/CY 2014: Stage 1 or 2
All EPs, EHs, and CAHs must have: 1) EHR technology that has been certified to all applicable 2011 Edition EHR certification criteria or equivalent 2014 Edition EHR certification criteria adopted by Secretary; or *2) EHR technology certified to 2014 Edition EHR certification criteria that meets Base EHR definition and would support objectives, measures, and ability to successfully report CQMs, for MU Stage 1*	All EPs, EHs, and CAHs must have EHR technology certified to 2014 Edition EHR certification criteria that meets Base EHR definition and would support objectives, measures, and ability to successfully report CQMs, for MU stage that they seek to achieve

CEHRT: Base, Core, Menu

What varies is quantity of EHR technology certified to 2014 Edition EHR certification criteria that will be needed



Base: EP/EH/CAH must have EHR technology with capabilities certified to meet definition of Base EHR (even if exclusions apply)

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

MU Menu: EP/EH/CAH only needs to have EHR technology with capabilities certified for MU menu set objectives & measures for stage of MU they seek to achieve

Source: ONC MU2 presentation, August 23, 2012

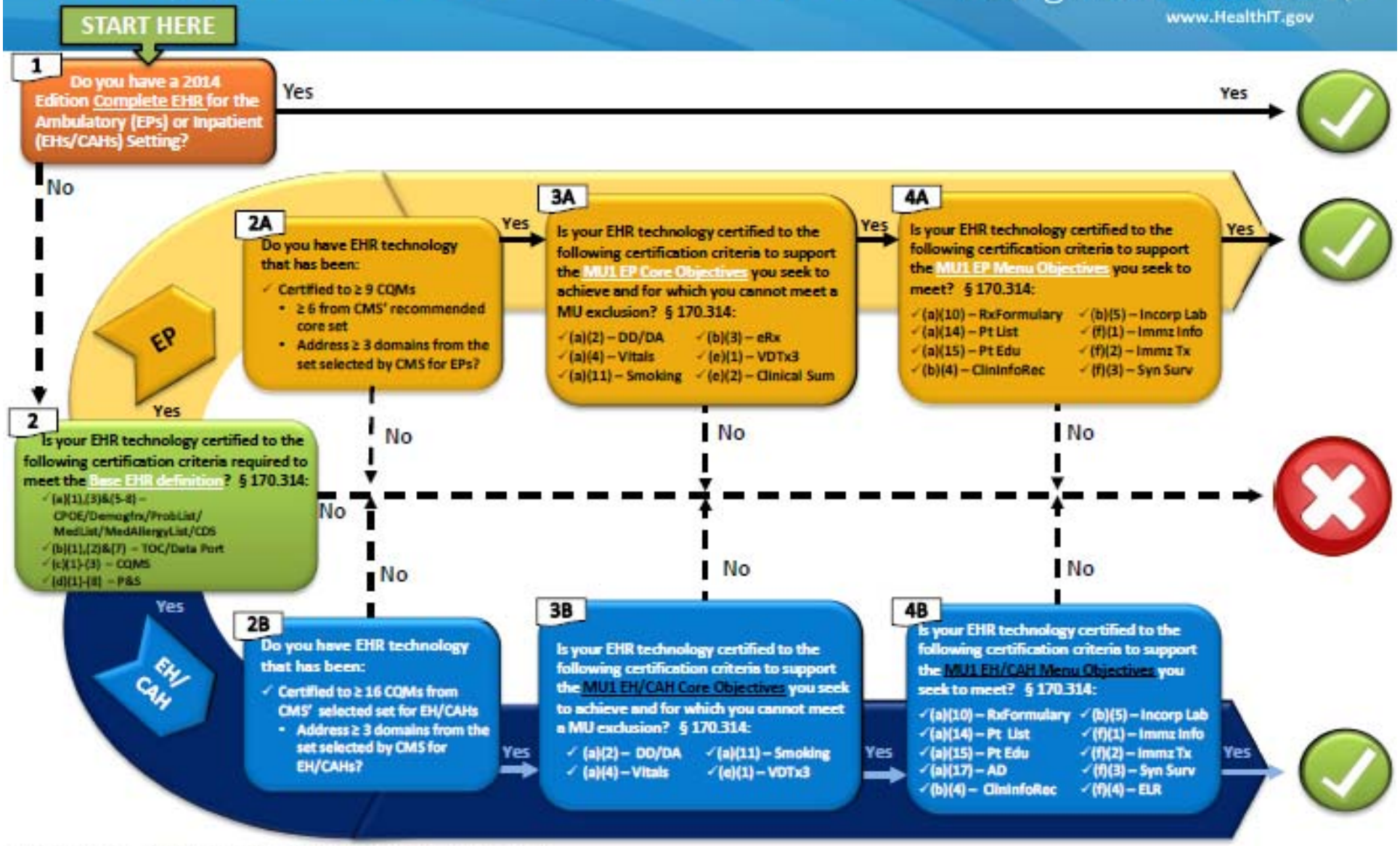
Base* EHR criteria

Certification Criteria Required to Satisfy the Definition of a Base EHR	
Capabilities	**Certification Criteria**
Includes patient demographic and clinical health information, such as medical history and problem lists	Demographics § 170.314(a)(3) ~~Vital Signs § 170.314(a)(4)~~ Problem List § 170.314(a)(5) Medication List § 170.314(a)(6) Medication Allergy List § 170.314(a)(7)
Capacity to provide clinical decision support	~~Drug-Drug and Drug-Allergy Interaction Checks § 170.314(a)(2)~~ Clinical Decision Support § 170.314(a)(8)
Capacity to support physician order entry	Computerized Provider Order Entry § 170.314(a)(1)
Capacity to capture and query information relevant to health care quality	Clinical Quality Measures § 170.314(c)(1) & (2) (capture & export, import and calculate) and specific CQMs
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)* ~~View, Download, and Transmit to 3rd Party § 170.314(e)(1)~~
Capacity to protect the confidentiality, integrity, and availability of health information stored & exchanged	Privacy and Security § 170.314(d)(1)-(8)

**"Base" definition to be used as a checklist by providers to ensure they meet CEHRT definition; it is not a type of EHR.*
Base includes CQMs not in this table.

Do you have EHR Technology that meets the new Certified EHR Technology definition for Meaningful Use Stage 1?

Putting the I in Health IT
www.HealthIT.gov

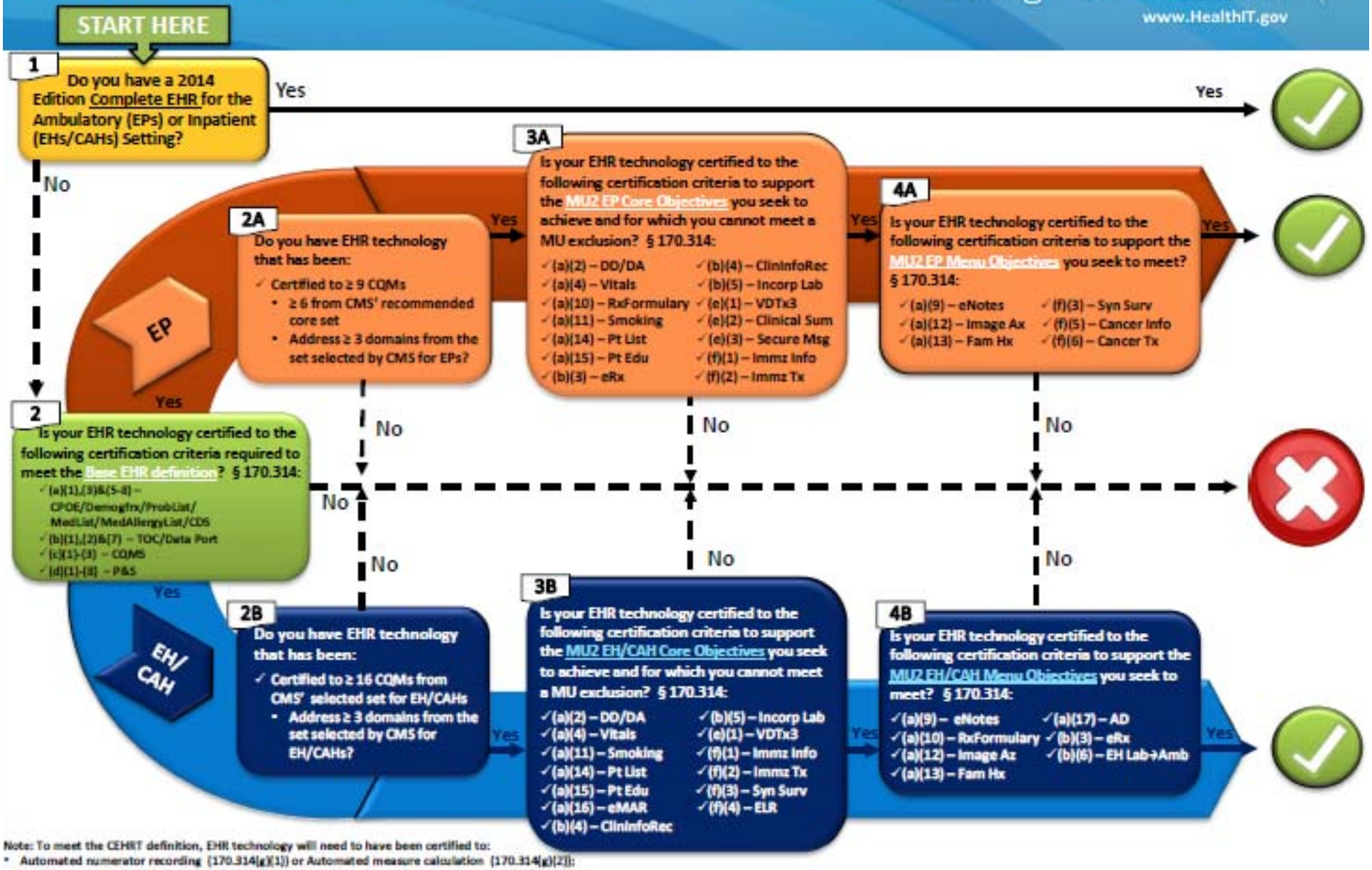


Note: To meet the CEHRT definition, EHR technology will need to have been certified to:

- Automated numerator recording (170.314(g)(1)) or Automated measure calculation (170.314(g)(2));
- Safety-enhanced design (170.314(g)(3)); and
- Quality management system (170.314(g)(4))

Do you have EHR Technology that meets the new Certified EHR Technology definition for Meaningful Use Stage 2?

Putting the I in HealthIT
www.HealthIT.gov



Note: To meet the CEHRT definition, EHR technology will need to have been certified to:

- Automated numerator recording (170.314(g)(1)) or Automated measure calculation (170.314(g)(2));
- Safety-enhanced design (170.314(g)(3)); and
- Quality management system (170.314(g)(4))

Pre-2014 roll-out of 2014 Edition EHR

Providers can implement 2014 Edition in 2013, allowing more flexible deployment schedule

Providers can use mix of 2011 and 2014 CEHRT

- ONC cross-walk between 2011/2014 Stage 1 criteria
- Complete EHR must be either 2011 or 2014, not mix

Essential to work through MU reporting and other issues for those using 2014 EHR before FY/CY 2014

Incentives for 2014 don't come faster if attest in earlier quarter unless in first year of Stage 1

Standards

Diagnosis, problem, and procedure

SNOMED CT for *problems* but need not display SNOMED CT so long as user interface maps to SNOMED CT

ICD-10 *or* SNOMED-CT for *encounter (billing) diagnoses*, ONC cited available ICD-10:SNOMED-CT maps

SNOMED CT or CPT/HCPCS for *procedures*, with ICD-10-PCS and CDT as eligible for optional certification

ONC removes “encounter diagnosis” from view, download, transmit but retains for TOC and portability

Next Steps

Key implications and action steps for GE Healthcare partners and GE Healthcare

- Review the rules and engage in/monitor discussions
- Assess your gaps in workflows, both MU and CQM
- Understand shifts from menu to core
- Plan for increased thresholds: eRx, CPOE, etc.
- Prepare for HIE and/or e-referral relationships
- Lay groundwork for patient engagement that requires *patients* to act: portal & secure message use

Audits

Retain ALL relevant supporting documentation (paper or electronic) used in attestation for MU and CQMs

Documentation should be retained for six years post-attestation

Documentation to support payment calculations should follow current documentation retention processes.

On audit, documentation will be used to validate that provider accurately attested and submitted CQMs and that incentive payment was accurate.

If provider found to be ineligible for incentive, payment will be recouped

CMS and states have appeals processes

Audit may review any documentation needed to support attestation.

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Audits

Primary documentation is source document(s) used for attestation.

Should be summary of data that supports information entered during attestation, ideally from certified EHR, but other documentation may be used if report unavailable or information entered differs from report

Include, at minimum:

- Numerators and denominators for measures
- Time period report covers
- Evidence to support that it was generated for that provider

Could be other, more detailed reviews, including medical/patient records

Provider should be able to provide documentation to support each attested measure and any exclusions

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Stage 2 Resources

Code of Federal Regulations –http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl

ONC Stage 2 webpage –http://www.healthit.gov/policy-researchers-implementers/meaningful-use-stage-2-0

CMS Stage 2 webpage –http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Links to the Federal Register

Tip sheets:

- Stage 2 Overview
- Specifications
- 2014 Clinical Quality Measures
- Payment Adjustments & Hardship Exceptions (EPs & Hospitals)
- Stage 1 Changes
- Stage 1 vs. Stage 2 Tables (EPs & Hospitals)

Thank you for joining us.

Questions

imagination at work