Stage 2 Meaningful Use: What You Need to Know

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What is in the Rule

- Changes to Stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Payment adjustments and hardships
- Medicare Advantage program changes
- Medicaid program changes

Active Registrations

	July 2012	Program-to-Date
Medicare Eligible Professionals	**8,327**	**180,513**
Doctors of Medicine or Osteopathy	7,407	161,586
Dentists	9	242
Optometrists	444	8,119
Podiatrists	221	6,122
Chiropractors	246	4,444

Medicare Incentive Payments

	July 2012 Providers Paid	July 2012 Payment Amount	Program-to-Date Providers Paid	Program-to-Date Payment Amount
Eligible Professionals				
Doctors of Medicine or Osteopathy	3,005	$ 54,018,000	59,461	$ 1,015,567,550
Dentists	2	$ 36,000	59	$ 892,856
Optometrists	39	$ 702,000	2,683	$ 41,054,975
Podiatrists	116	$ 2,088,000	3,257	$ 57,944,773
Chiropractors	5	$ 90,000	1,423	$ 18,263,696
Total Eligible Professionals	**3,167**	**$ 56,934,000**	**66,883**	**$ 1,133,723,850**

Medicare Incentive Payments

Doctors of Medicine or Osteopathy

Doctors of Medicine or Osteopathy	Program-to-Date Providers Paid	Program-to-Date Payment Amount
FAMILY PRACTICE	12,881	$217,195,568
INTERNAL MEDICINE	12,209	$212,937,293
CARDIOVASCULAR DISEASE (CARDIOLOGY)	4,609	$82,574,832
OBSTETRICS/GYNECOLOGY	2,786	$30,407,587
GASTROENTEROLOGY	2,637	$46,925,535
ORTHOPEDIC SURGERY	2,500	$44,459,815
GENERAL SURGERY	2,137	$37,919,774
NEUROLOGY	1,760	$30,702,021
UROLOGY	1,750	$31,374,031
PULMONARY DISEASE	1,509	$26,858,608
OTOLARYNGOLOGY	1,466	$25,995,566
OPHTHALMOLOGY	1,398	$24,715,275
NEPHROLOGY	1,357	$24,282,462
DERMATOLOGY	1,024	$18,082,415
ENDOCRINOLOGY	887	$14,950,573
OTHER	8,551	$146,186,197
TOTAL	**59,461**	**$1,015,567,550**

Podiatrists	3,257	$ 57,944,773

What Stage 2 Means to You

- **New Criteria** – Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use Stage 2 criteria.

- **Improving Patient Care** – Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient engagement.

- **Saving Money, Time, Lives** – With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives.

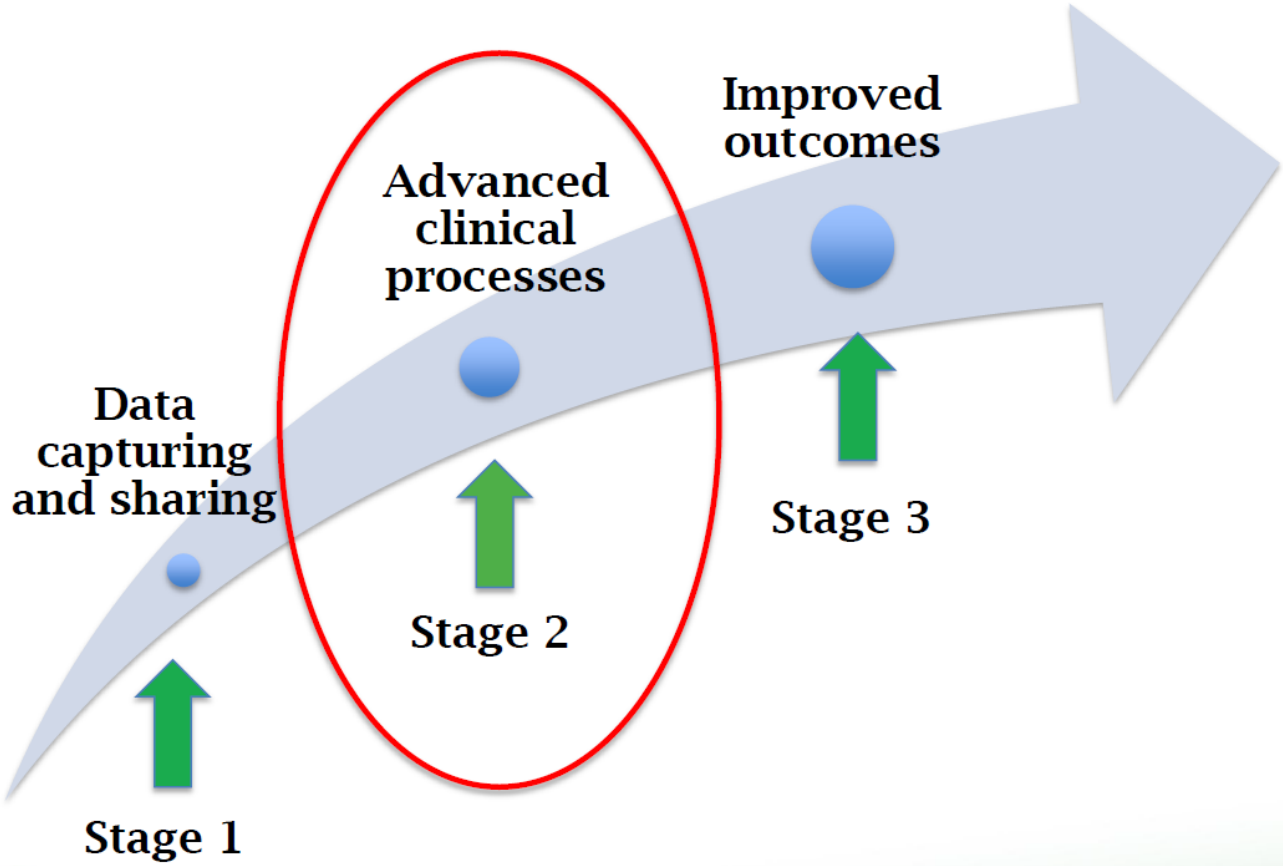
Stage 2 Change: Hospital-Based EP Definition

EPs can demonstrate that they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH — *in lieu of using the hospital's CEHRT* — can be determined non-hospital-based and potentially receive an incentive payment.

Determination will be made through an application process.

Stage 2 Meaningful Use

Stages of Meaningful Use



What is Your Meaningful Use Path?

For Medicare EPs:

Maximum Payment by Start Year	Annual Incentive Payment by Stage of Meaningful Use					
	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$44,000	$18,000	$12,000	$8,000	$4,000	$2,000	
2012		1	1	2	2	3
$44,000		$18,000	$12,000	$8,000	$4,000	$2,000
2013			1	1	2	2
$39,000			$15,000	$12,000	$8,000	$4,000
2014				1	1	2
$24,000				$12,000	$8,000	$4,000

Meaningful Use: Changes from Stage 1 to Stage 2

Stage 1	Stage 2
Eligible Professionals 15 core objectives 5 of 10 menu objectives 20 total objectives	**Eligible Professionals** **17** core objectives **3 of 6** menu objectives 20 total objectives
Eligible Hospitals & CAHs 14 core objectives 5 of 10 menu objectives 19 total objectives	**Eligible Hospitals & CAHs** **16** core objectives **3 of 6** menu objectives 19 total objectives

Changes to Meaningful Use

Changes

- **Menu Objective Exclusion**– While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed.

No Changes

- **Half of Outpatient Encounters**– at least 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology.
- **Measure compliance = objective compliance**
- **Denominators based on outpatient locations equipped with CEHRT** and include all such encounters or only those for patients whose records are in CEHRT depending on the measure.

2014 Changes

1. **EHRs Meeting ONC 2014 Standards** – starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC's Standards & Certification Criteria 2014 Final Rule

2. **Reporting Period Reduced to Three Months** – to allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2, all participants will have a three-month reporting period in 2014.

Stage 2: Batch Reporting

Stage 2 rule allows for batch reporting.

What does that mean?

Starting in 2014, **groups** will be allowed to submit attestation information for **all of their individual EPs** in one file for upload to the Attestation System, rather than having each EP individually enter data.

Stage 2 EP Core Objectives

EPs must meet all 17 core objectives:

Core Objective	Measure
1. CPOE	Use CPOE for more than 60% of medication, 30% of laboratory, and 30% of radiology (30% in Stage 1)
2. E-Rx	E-Rx for more than 50% (40% in Stage 1)
3. Demographics	Record demographics for **more than 80%** (50%)
4. Vital Signs	Record vital signs for **more than 80%** (50%)
5. Smoking Status	Record smoking status for **more than 80%** (50%)
6. Interventions	Implement 5 clinical decision support interventions + drug/drug and drug/allergy (1 in Stage 1)
7. Labs	Incorporate lab results for **more than** 55% (40% and Menu set In Stage 1)
8. Patient List	Generate patient list **by specific condition** (Menu set Stage 1)
9. Preventive Reminders	Use EHR to identify and provide reminders for preventive/follow-up care for **more than 10%** of patients with two or more office visits in the last 2 years (Menu set Stage 1 and 20%)

Stage 2 EP Core Objectives

EPs must meet all 17 core objectives:

Core Objective	Measure
10. Patient Access	Provide online access to health information for **more than 50%** with **more than** 5% actually accessing (Menu set Stage 1 with 10% and no access requirement)
11. Visit Summaries	Provide office visit summaries for **more than** 50% of office visits (50% in 3 Days in Stage 1)
12. Education Resources	Use EHR to identify and provide education resources **more than 10%** (Menu set in Stage 1)
13. Secure Messages	**More than** 5% of patients send secure messages to their EP (not in Stage 1)
14. Rx Reconciliation	Medication reconciliation at **more than** 50% of transitions of care (Menu Set in Stage 1)
15. Summary of Care	Provide summary of care document for **more than** 50% of transitions of care and referrals **with 10% sent electronically** and **at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR** (50% and Menu Set in Stage 1)
16. Immunizations	Successful ongoing transmission of immunization data (Modification of Menu set item from Stage 1)
17. Security Analysis	Conduct or review security analysis and incorporate in risk management process (continued from Stage 1)

Stage 2 EP Menu Objectives

EPs must select 3 out of the 6:

Menu Objective	Measure
1. Imaging Results	More than **10%** of imaging results are accessible through Certified EHR Technology
2. Family History	Record family health history for more than **20%**
3. Syndromic Surveillance	Successful ongoing transmission of syndromic surveillance data
4. Cancer	Successful ongoing transmission of cancer case information
5. Specialized Registry	Successful ongoing transmission of data to a specialized registry
6. Progress Notes	Enter an electronic progress note for **more than** 30% of unique patients

Closer Look at Stage 2: Patient Engagement

- **Patient engagement** – engagement is an important focus of Stage 2.

Requirements for Patient Action:

- **More than 5% of patients must send secure messages to their EP**
- **More than 5% of patients must access their health information online**

- **EXCULSIONS** – CMS is introducing exclusions based on broadband availability in the provider's county.

Closer Look at Stage 2: Electronic Exchange

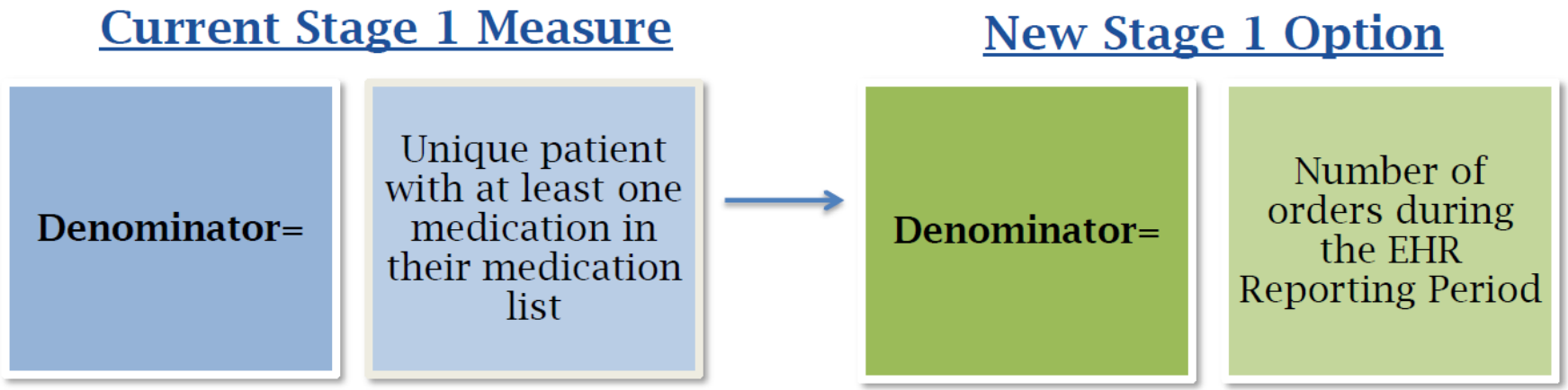
Stage 2 focuses on actual use cases of electronic information exchange:

- Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.
- The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.
- At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.

Changes to Stage 1

	Current	Proposed	Timeframe
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+
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 Info Exchange	One test of electronic transmission of key clinical information	Requirement removed effective 2013	Effective 2013
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

Changes to Stage 1: CPOE



This optional CPOE denominator is available in 2013 and beyond for Stage 1

Changes to Stage 1: Vital Signs

Current Stage 1 Measure			New Stage 1 Measure	
Age Limits=	Age **2** for Blood Pressure & Height/ Weight	→	**Age Limits=**	Age **3** for Blood Pressure, No age limit for Height/ Weight
Exclusion=	All three elements not relevant to scope of practice	→	**Exclusion=**	Blood pressure to be separated from height /weight

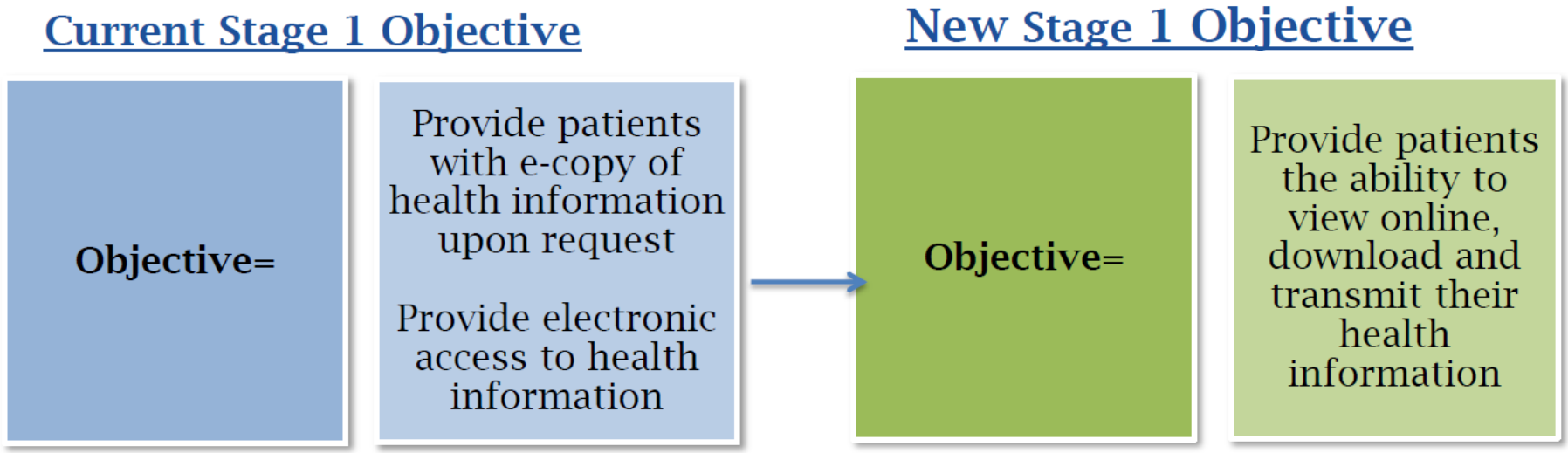
The vital signs changes are optional in 2013, but required starting in 2014

Changes to Stage 1: Testing of HIE

Current Stage 1 Measure		Stage 1 Measure Removed
One test of electronic transmission of key clinical information	→	Requirement removed effective 2013

The removal of this measure is effective starting in 2013

Changes to Stage 1: E-Copy & Online Access



- The measure of the new objective is 50% of patients have accessed their information; there is no requirement that 5% of patients do access their information for Stage 1.
- **The change in objective takes effect in 2014 to coincide with the 2014 certification and standards criteria**

26

Changes to Stage 1: Public Health Objectives

Current Stage 1 Objectives

- Immunizations
- Reportable Labs
- Syndromic Surveillance

New Stage 1 Addition

Addition of "except where prohibited" to all three objectives

This addition is for clarity purposes and does not change the Stage 1 measure for these objectives.

Clinical Quality Measures

CQM Reporting in 2013

- CQMs will **remain the same** through 2013.
- Electronic specifications for the CQMs for reporting in 2013 **will not be updated**.
- In 2012 and continued 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**.

How are CQMs selected?

CQMs are selected in **alignment with the HHS National Quality Strategy (NQS),** which aims to guide health care delivery by the needs of patients and families.

NQS incorporates the evidence-based results of the latest research in clinical medicine, public health, and health care delivery.

CQM Alignment with HHS Priorities

All providers must select 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

How do CQMs relate to the CMS Incentive Programs?

- Although reporting CQMs is **no longer a core objective of the EHR Incentive Programs**, all providers are required to report on CQMs in order to demonstrate meaningful use.

- In 2014 and beyond, reporting programs (e.g., PQRS) will be **streamlined** in order to reduce provider burden.

CQMs in 2014 and Beyond

- A complete list of 2014 CQMs and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website (www.cms.gov/EHRIncentivePrograms) in the future.

- CMS will include a recommended core set of CQMs for EPs that focus on high-priority health conditions and best-practices for care delivery.

Core CQMs for EPs

CMS selected the CQMs for the proposed core set based on analysis of several factors:

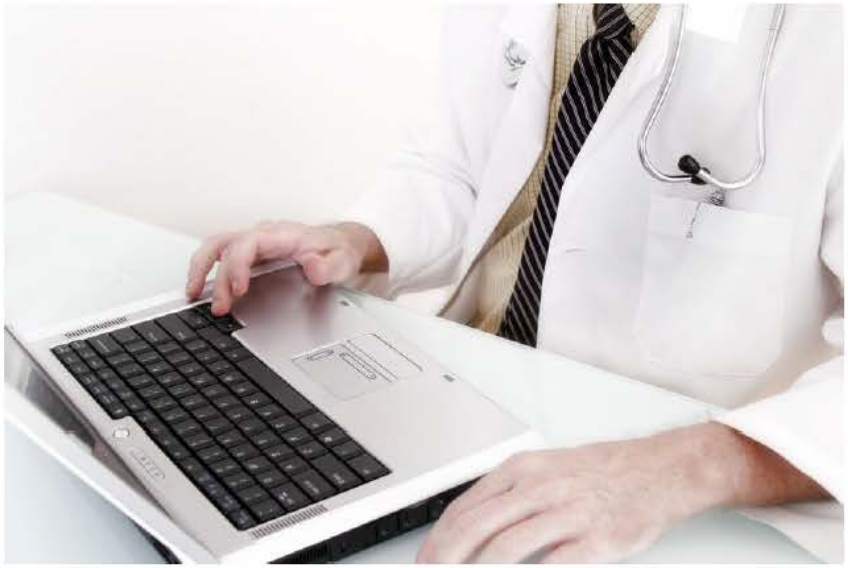
- Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries
- Conditions that represent national public/ population health priorities
- Conditions that are common to health disparities

Core CQMs for EPs (cont'd)

- Conditions that disproportionately drive healthcare costs and could improve with better quality measurement
- Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement
- Measures that include patient and/or caregiver engagement

Reporting CQMs in 2014 and Beyond

- Beginning in 2014, all Medicare-eligible providers in their second year and beyond of demonstrating meaningful use **must electronically report** their CQM data to CMS.
- Medicaid providers will electronically report their CQM data to their state.



CQMs in 2014 and Beyond

CQMs change in 2014:

Provider	Prior to 2014	2014 and Beyond*
EPs	Complete 6 out of 44 • 3 core or 3 alt. core • 3 menu	Complete 9 out of 64 • Selected CQMs must cover at least 3 of the 6 NQS domains Recommended core CQMs include: • 9 CQMs for the adult population • 9 CQMs for the pediatric population • Prioritize NQS domains
Eligible Hospitals and CAHs	Complete 15 out of 15	Complete 16 out of 29 • Selected CQMs must cover at least 3 of the 6 NQS domains

*Regardless of the stage of meaningful use, all providers must follow these reporting requirements for CQMs beginning in 2014.

Reporting CQMs in 2014 and Beyond

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
EPs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
Option 2	Patient	Medicare Only	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT
Group Reporting (only EPs Beyond the 1st Year of Demonstrating Meaningful Use)**				
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare Only	Electronic	Satisfy requirements of Medicare Shared Savings Program of Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare Only	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

**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.*

***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.*

CQM – Timing

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

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

2014 CQM Quarterly Reporting

For Medicare providers, the 2014 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs.

In subsequent years, the reporting period for CQMs would be the entire calendar year (for EPs) or fiscal year (for eligible hospitals and CAHs).

Provider Type	Optional Reporting Period in 2014*	Reporting Period for Subsequent Years of Meaningful Use (Stage 1 and Subsequent Stages)	Submission Period for Subsequent Years of Meaningful Use (Stage 1 and Subsequent Stages)
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)

Payment Adjustments & Hardship Exceptions

Medicare Only

EPs, Subsection (d) Hospitals and CAHs

EP Payment Adjustments

% Adjustment shown below assumes **less than 75%** of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% Adjustment shown below assumes **more than 75%** of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%

EP EHR Reporting Period

Payment adjustments are based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For an EP who has demonstrated meaningful use in **2011** or **2012**:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2013	2014	2015	2016	2017	2019

To Avoid Payment Adjustments:
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

EP EHR Reporting Period

For an EP who demonstrates meaningful use in **2013** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2013					
Based on Full Year EHR Reporting Period		2014	2015	2016	2017	2019

To Avoid Payment Adjustments:
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

EP EHR Reporting Period

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

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2014*	2014				
Based on Full Year EHR Reporting Period			2015	2016	2017	2019

In order to avoid the 2015 payment adjustment the EP must attest no later than October 1, 2014, which means they must begin their 90 day EHR reporting period no later than July 1, 2014.

EP Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments.
3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.
4. **EPs must demonstrate that they meet the following criteria:**
   - Lack of face-to-face or telemedicine interaction with patients
   - Lack of follow-up need with patients
5. **EPs who practice at multiple locations must demonstrate that they:**
   - Lack of control over availability of CEHRT for more than 50% of patient encounters

Applying for Hardship Exceptions

- **Applying:** EPs, eligible hospitals, and CAHs must apply for hardship exceptions to avoid the payment adjustments.

- **Granting Exceptions:** Hardship exceptions will be granted only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use.

- **Deadlines:** Applications need to be submitted **no later than April 1 for hospitals**, and **July 1 for EPs** of the year before the payment adjustment year; however, CMS encourages earlier submission

For More Info: Details on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website in the future:

www.cms.gov/EHRIncentivePrograms

RESOURCES

WEBSITE:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

TIP SHEET:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2Overview_Tipsheet.pdf

QUESTIONS

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