The Other “Stage 2” of Meaningful Use

HIMSS Heart of America Chapter

January 17, 2012

Meaningful Use Presentations: The New "Cat Story"

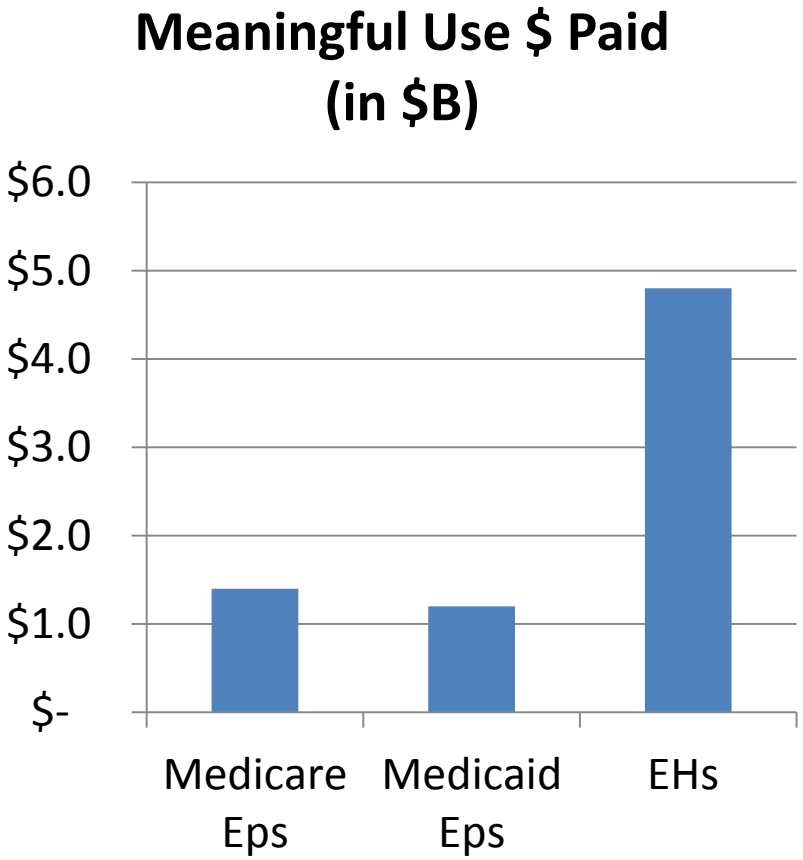
"What makes you think we found your cat story boring?"

Agenda

- Brief Stage 2 review
- New Normal of MU . . .
  - Compliance
  - Platform for Regulation
  - As a Standard In New Care Model Development

MU Statistics as of Sept. 2012

- Registrations:
  - 80 % of EHs (4,057 hospitals)
  - 55 % of Medicare EPs (208,331 eligible professionals)
  - 94,741 Medicaid EPs in 44 states.
- Dollars:
  - $7.7 billion paid
  - ~$1.4 billion for Medicare EPs; ~$1.2 billion to Medicaid EPs; ~4.8 billion to eligible hospitals.
- EPs menu objectives chosen for attestation:
  - Most popular: Immunization registry, drug formulary and patient lists
  - Least popular: transitions of care and patient reminders
- EHs menu objectives chosen for attestation:
  - Most popular: Advance directives, drug formulary and clinical lab results
  - Least popular: transitions of care and syndromic surveillance



Stage 2 Final Rule in 1 Slide . . .

- More time for Stage 2
  - Attested Stage 1 in 2011 → attest Stage 2 2014 (instead of 2013).
- Basic Structure Retained
  - Objectives and Core and Menu Measures Refined and consolidated
    - "Capability to exchange" eliminated from Stage 1 and 2
    - "Copy of Record" eliminated in favor of "view, download, transmit"
  - Data capture promoted over data exchange
  - Stage 2 measures same in number as Stage 1, but not complexity
- CQM Changes
  - Electronic reporting mandates starting in 2014
  - Incorporated into definition of MU (rather than separate measure)

. . . OK I Lied:
A Couple More Stage 2 Slides

Medicare Incentives for PPS Hospitals[1]

Attest Year	2011	2012	2013	2014	2015	2016	2017	% Max Payment
2011	Stage 1 100%	Stage 1 75%	Stage 1 50%	Stage 2 25%	Stage 2	Stage 3	Stage 3	100%
2012		Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	Stage 3	100%
2013			Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	100%
2014				Stage 1[2] 75%	Stage 1 50%	Stage 2 25%	Stage 2	60%
2015					Stage 1[2] 50%	Stage 1 25%	Stage 2	30%
2016						Stage 1[2]	Stage 1	0%
Penalties: Market basket update reduced by:					-25%	-50%	-75%	

1. Percentages in the cells indicate the transition factor for the Medicare Share incentive
2. Must demonstrate and attest to MU by July 1, to avoid the penalty in the next year.

. . . OK I Lied:
A Couple More Stage 2 Slides

Maximum Medicare Incentive for EPs[1]

1st Attest	2011	2012	2013	2014	2015	2016	2017	Total
2011	Stage 1 $18k	Stage 1 $12k	Stage 1 $8k	Stage 2 $4k	Stage 2 $2k	Stage 3	Stage 3	$44k
2012		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3 $2k	Stage 3	$44k
2013			Stage 1 $15k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3	$39k
2014				Stage 1[2] $12k	Stage 1 $8k	Stage 2 $4k	Stage 2	$24k
2015					Stage 1[2]	Stage 1	Stage 2	0
Medicare charge reduced if not a meaningful user:					1%	2%	3%	

1. Professionals with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment
2. Must demonstrate and attest to MU by October 1 to avoid the penalty in the next year

Penalty Scenarios

First Year of MU	Requirement to Avoid Penalty		
	2015	2016	2017
2011	Achieve MU in 2013 (365 days)	Achieve MU in 2014 (One 3-month quarter)	Achieve MU in 2015 (365 days)
2012	Achieve MU in 2013 (365 days)	Achieve MU in 2014 (One 3-month quarter)	Achieve MU in 2015 (365 days)
2013	Achieve MU in 2013 (Any 90-consecutive-day period)	Achieve MU in 2014 (One 3-month quarter)	Achieve MU in 2015 (365 days)
2014	Achieve MU in 2014 (Any 90-consecutive-day period ending no later than 3 months before the end of the reporting period)	N/A	Achieve MU in 2015 (365 days)

CQM Quick Reference

CQM - 2013

- EHs and CAHs
  - Report on same 15 CQMs as Stage 1
- EPs
  - Report from same 44 Stage 1 measures (3 core/alternate core, 3 additional measures)
- Two reporting methods
  - Attestation (https://ehrincentives.cms.gov/)
  - eReporting Pilots:
    - Physician Quality Reporting System (PQRS) EHR Incentive Program Pilot for EPs
    - eReporting Pilot for EHs and CAHs

CQM - 2014 and beyond

- All Medicare-eligible providers regardless of their stage of meaningful use will electronically report on CQMs
  - EHs and CAHs
    - Report on 16 out of 29 total CQMs
    - QRDA I similar to EHR Reporting Pilot for Inpatient Quality Reporting or QRDA III (vie CEHRT)
  - EPs
    - Report on 9 out of 64 total CQMs.
    - Recommended core CQMs – encouraged but not required
    - PQRS QRDA I or CMS-designated QRDA III
    - Selected CQMs must cover at least 3 of the National Quality Strategy domains

EP CQM 2014 and Beyond

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in First Year of Demonstrating Meaningful Use*	Aggregate	All payer	Attestation	Submit 9 CQMs (includes adult and pediatric recommended core CQMs), covering at least 3 NQS domains
EPs Beyond the First Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs (includes adult and pediatric recommended core CQMs), covering at least 3 NQS domains
Option 2	Patient	Medicare Only	Electronic	Satisfy requirements of PQRS reporting options using CEHRT
Group Reporting (only EPs Beyond the First 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

EH & CAH CQM 2014 and Beyond

Category	Data Level	Payer Level	Submission Type	Reporting Schema
Eligible Hospitals in First Year of Demonstrating Meaningful Use*	Aggregate	All payer	Attestation	Submit 16 CQMs, covering at least 3 NQS domains
Eligible Hospitals/CAHs Beyond the First Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 16 CQMs, covering at least 3 NQS domains
Option 2	Patient	Sample - all payer	Electronic	Submit 16 CQMs, covering at least 3 NQS domains ➢ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

The New Normal of . . .

Meaningful Use Compliance

The New Normal of Compliance

- Increased Compliance Burden From…
  - Increased Transparency
  - Increased Data Capture
  - Increased Consumerism
  - Increased Data Security

Demonstrating MU from the Provider Perspective

- Online self-reporting in the National Level Repository (NLR).
  - The NLR is a CMS database that stores professionals' and hospitals' information relevant to the EHR incentive program.
  - For yes/no measures → checking a box.
  - For percentage-based measures → provide totals for the numerator and denominator of each measure.
- Report certified EHR technology to the NLR using an EHR certification code.
  - Obtain EHR certification code that corresponds to their certified EHR technology from the Certified Health Information Technology Product List database.

Demonstrating MU from CMS's Perspective

- NLR runs prepayment system edits to validate that self-reported information meets measure criteria.
  - Ex. For percentage-based measures, the NLR divides the self-reported numerator by the self-reported denominator and determines whether the result meets the relevant percentage threshold.
- The NLR also automatically checks professionals' and hospitals' self-reported EHR certification codes against ONC's CHPL database to confirm that they are valid.
- CMS does not approve incentive payments for professionals and hospitals whose self-reported information fails prepayment validation
- And THAT'S IT!

Post-Payment Audits

- CMS has authority for post-payment audits.
  - "Desk" off-site audit followed by onsite audit if cannot verify information
  - Professionals and hospitals must retain documentation supporting their self-reported meaningful use information for 6 years
- CMS plans to audit selected professionals and hospitals after payment.
  - Plans to conduct a risk assessment using data analyses to select audit targets (e.g., check that self-reported denominators are consistent across certain meaningful use measures).
- CMS has ***not*** yet completed any post-payment audits

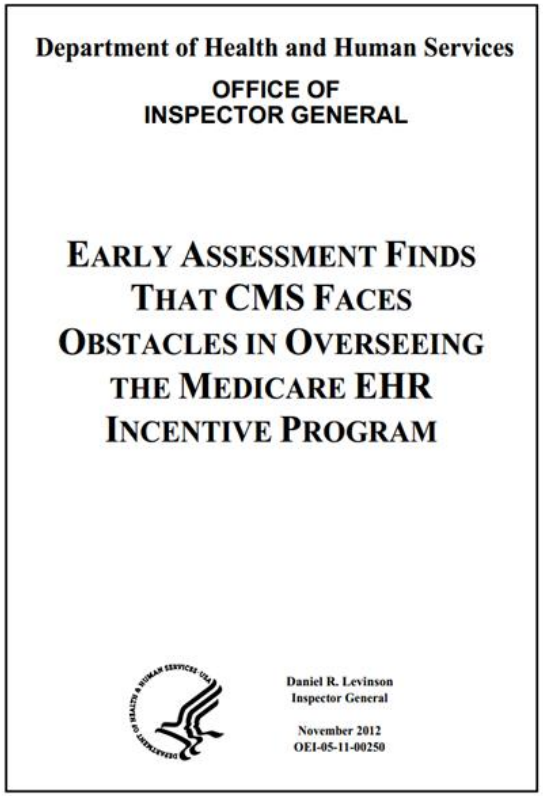
MU $ is All or Nothing

- Federal regulations state that professionals and hospitals must meet all relevant meaningful use requirements to receive incentive payments.
- Partially meeting meaningful use requirements does not qualify professionals and hospitals to receive incentive payments.

Coming Soon?
MU Audits

OIG Report November 2012

- "Currently, CMS has not implemented strong prepayment safeguards, and its ability to safeguard incentive payments post-payment is also limited"
- OIG Recommended CMS:
  - Pre-payment attestation audits of self-reported information (CMS did not concur)
  - Issue guidance with specific examples of documentation to support compliance. (CMS concurred)
- OIG Recommended ONC:
  - require that certified EHR technology be capable of producing reports for yes/no meaningful use measures where possible (ONC concurred)
  - improve the certification process for EHR technology to ensure accurate EHR reports (ONC concurred)


Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

EARLY ASSESSMENT FINDS THAT CMS FACES OBSTACLES IN OVERSEEING THE MEDICARE EHR INCENTIVE PROGRAM

Daniel R. Levinson
Inspector General

November 2012
OEI-05-11-00250

OIG Report Highlights

- HHS push to move away from “pay and chase”
- OIG analysis
  - If CMS applied one of ***its own*** proposed post-payment risk analyses prior to payment it would have identified the following for pre-payment review:
    - 14 % of EPs (3,825 professionals) and
    - 17 % of EHs (111 hospitals).
  - These EPs and EHs reported different denominator values across measures that should have the same denominator.
- ***NOTE***: OIG (NOT CMS or ONC) subtlety notes it is also conducting a series of audits of Medicare and Medicaid EHR incentive payments. These audits will verify the accuracy of professionals’ and hospitals’ self-reported meaningful use information, as well as eligibility and payment amounts.

Documenting MU

- According to CMS, EPs and EHs should keep detailed supporting documentation to substantiate their self-reported MU info
  - CMS auditors will use supporting documentation to verify self-reported information for the 19 yes/no measures and denominator values for percentage-based measures with all-patient denominators.
- CMS staff expect professionals and hospitals to maintain the following:
  - screen shots showing that required EHR technology functions were enabled on the first day of or at some point during the 90-day reporting period (yes/no measures),
  - documents showing that a security risk assessment was conducted (yes/no measures), and
  - evidence of the number of patients with paper records for percentage-based measures with all-patient denominators (percentage-based measures).

CDS Identified as Area of Focus by OIG

- Screen shots or demonstrations only verify functions at a specific time—not for the entire 90-day reporting period.
- Even if professionals and hospitals retain the types of supporting documentation that CMS staff expect, it will not be sufficient to verify self-reported meaningful use information for
  - drug-drug and drug-allergy interaction checks,
  - one clinical decision support rule, and
  - drug formulary checks.
- Because physicians often view CDS as onerous or unnecessary and develop "alert fatigue" EPs and EHs may disable clinical decision support tools for their reporting period.

CMS Data Sources: Unverified Verification

- CMS did not identify any data sources it could use to verify any of the 49 meaningful use measures.
- According to CMS staff, existing internal and external data sources are not comprehensive enough for verification and, in some cases, are not easily accessible.
- No data sources exist for many of the meaningful use measures.

Assessment	# of MU Measures
Internal CMS data sources are accessible but not comprehensive enough for verification (e.g., Medicare claims data).	25
External data sources are not accessible for verification (e.g., privately held e-prescribing data, public health data).	6
No data source exists (i.e., data for measure are not currently collected by any entity).	19
Internal CMS data sources and external data sources exist but are not comprehensive or accessible for verification	(1)
Total	49

Audits? Sound Familiar?

"It's funny how two intelligent people can have such opposite interpretations of the tax code!"

Favorite Government Audits Techniques

Audit Method	IRS	MU Example
Discriminant Function System (DIF) Scoring	Analyze population groupings, standards and trends for potential abnormal circumstances based on past experience. E.g., zip code = Bel Air; DMV tags = Lamborghini; pay interest on a $1 million mortgage; BUT declare less than $100,000 of income.	Hospital with certain higher level of IP days or discharges but low volume on percentage based measures
Hot-Spot Market Segments	Every year the IRS selects a particular industry for compliance examinations. E.g., foreign trusts, s-corps, restaurant servers	Certain EP specialties, hospitals of a certain size or location
Information Matching	Employers, banks, brokerage firms, independent contractors all file documents with the IRS and send the same documents to tax payers e.g., Forms 1099, W2.	Unusual variations in volume of percentage based measures among EPs within the same TIN; or between MU and PQRS

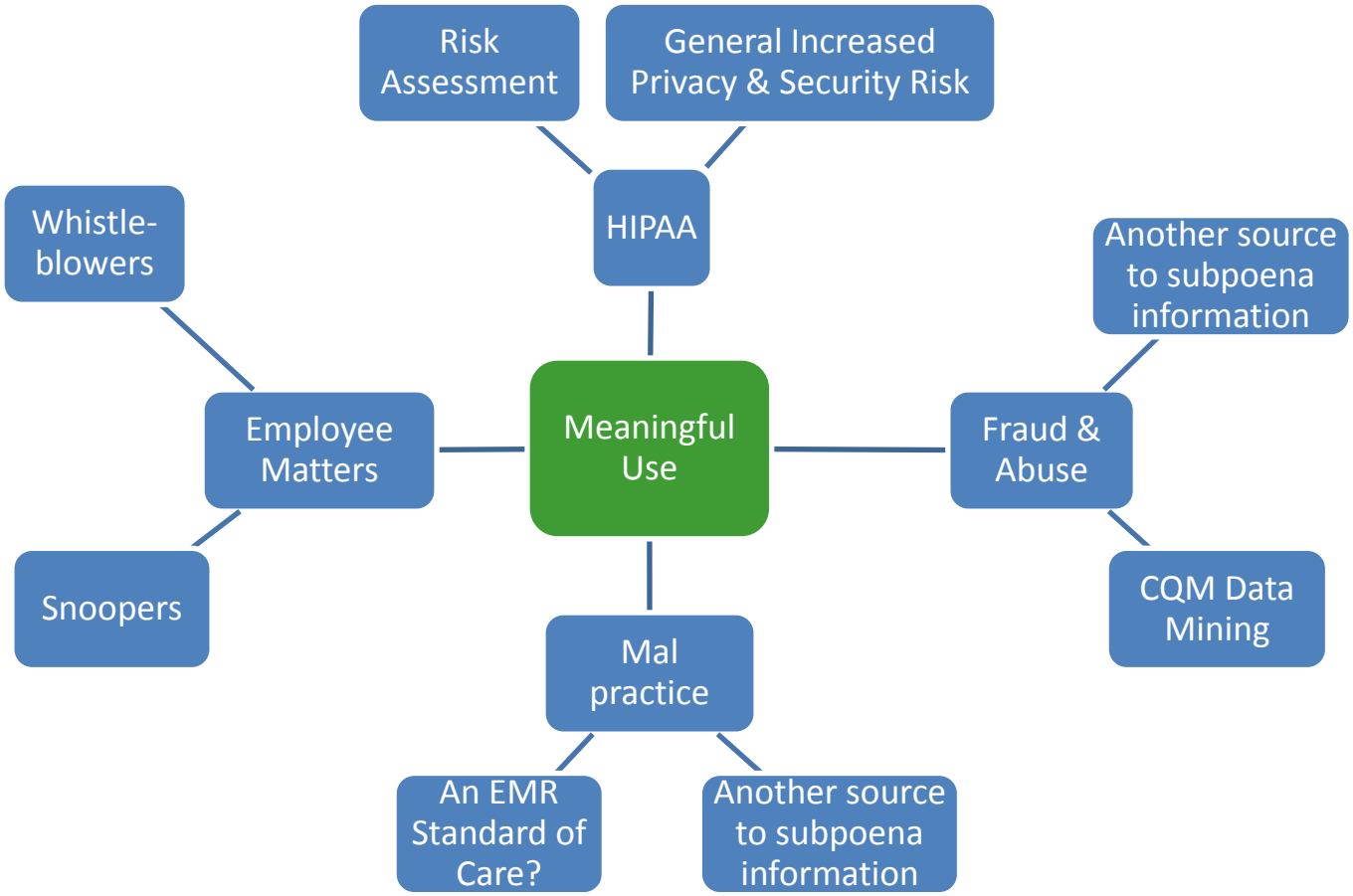
Recommendations

- Incorporate MU into Compliance Program
  - Compliance Officer involvement in attestation and annual review
- Ensure Attestation documentation is consistent with CMS's recommendations
- Prepare for more oversight – not just from CMS

The New Normal of . . .

Meaningful Use as a Regulatory Platform

The Interconnectedness of MU



An example

- Hospital A Receives MU $$ in 2011 and 2012.
- Mid-2012 Laptop Stolen → Qualifies as HIPAA Breach less than 500 patients
  - Report at year end
- CMS Investigation reveals no risk assessment performed
  - [MU Core Stage 1 & 2 Measure = Conduct HIPAA Security risk analysis and address deficiencies as appropriate]
- CMS or OIG sees HIPAA press release and checks 2011 and 2012 MU Attestation
- Hospital A attested to performing Risk Assessment
- Hospital A's entire MU $$ placed at risk
  - REMEMBER: MU is all or nothing

MU CQMs & PQRS

- EPs may satisfy the meaningful use objective to report CQMs to CMS by reporting them through:
  - Medicare and Medicaid EHR Incentive Programs' web-based Registration and Attestation System; or
  - participation in the Physician Quality Reporting System-Medicare EHR Incentive Pilot which utilizes the
- Physician Quality Reporting System Incentives & Penalties for reporting
    - 2013 & 2014 Incentive Payments for Reporting (.5%)
    - 2015 & 2016 Payment Adjustments for Non-Reporting (-1.5%, -2%)
    - 2015 Value-Based Payment Modifier (-1% to 1%)
- Reporting Methods
  - Claims; Registry; Group-practice; **EHR-Based CQM**

PQRS EHR-Based Reporting

- A way to leverage MU Investment
  - Beginning in 2014, ONC's certification process would test the submission of data on CQMs for MU and PQRS (2013 Medicare Physician Fee Schedule Final Rule)
- 2013 PQRS = Stage 1 MU CQM
  - As required by the MU Stage 1 final rule, eligible professionals must report on 3 Medicare EHR Incentive Program core or alternate core measures, plus 3 additional measures of remaining 38 measures.

2013 PQRS

- If you have EPs that meet MU, don't leave money on the table
  - 2013: 0.5% incentive
  - 2015: 1.5% penalty
- How?
  - Direct
  - Through Vendor

ONC Patient Safety Plan

- Released December 21, 2012
- "Target Resources and *Corrective Action* to Improve *Health IT Safety* and Patient Safety"
  - Goal 1: Use Meaningful Use of EHR technology to improve patient safety
  - Goal 2: Incorporate safety into certification criteria for health IT products.
  - Goal 5: Investigate and take corrective action, when necessary, to address serious adverse events or unsafe conditions involving EHR technology

How the Federal Government Incentivizes Certain Practices

- Traditionally: Power of the Purse
  - E.g., War funding; drinking age, certain medical practices
- Under MU: $ + Required Data Capture
  - Just as EMRs can increase the quality and efficiency of care delivery, they increase the regulatory risk
  - Claims Data vs Clinical Data
  - “Sunlight is said to be the best of disinfectants” – Justice Brandeis

The New Normal of . . .

Meaningful Use in New Care Model Development

MU Role in New Care Model Development

- Consolidation/M&A
- ACOs
- Clinically Integrated Networks
- Private Payor Network Development/Contracting
- Others
  - Transitional Care Management/Re-Admissions/Value-based Purchasing

MU & Consolidation

- Weathering the Storm with a Bigger Ship:
  - From 2000 to 2010, hospital physician employment rose 32%.
  - Hospitals directly employ about a quarter of all U.S. physicians.
  - By 2013, 2/3^{rds} of physicians will work for hospitals or large groups
  - By 2006, over 75% of U.S. MSAs had experienced enough hospital merger activity to be considered “highly consolidated.”
- Strategic Consideration:
  - Affiliate or Merge with an organization without an MU plan or at risk of a penalty?
    - Cost-benefit analysis for implementations
    - Example: the “Anti-Obama” Hospital

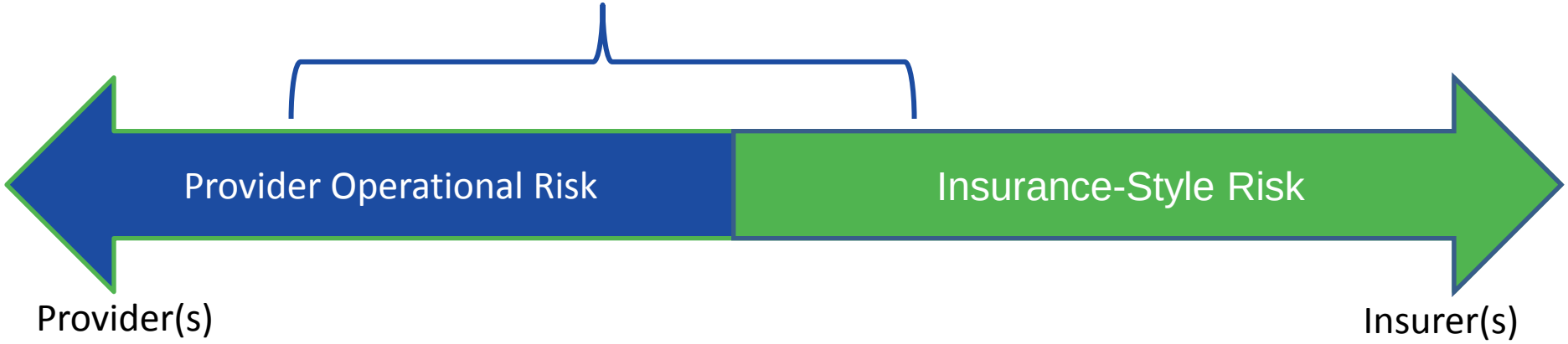
MU & Consolidation

- Transaction Due Diligence Consideration:
  - MU due diligence happens in almost all health care transactions now.
  - Is your organization ready to review or be reviewed on MU?
    - Gets back to MU as part of your compliance program

MU & Accountable Care Organizations

ACOs are health care providers that:

- Take responsibility for a defined patient population
- Coordinate care across settings
- Are jointly accountable for the quality and cost



Types of ACOs

- **Public Payor**
  - Medicare
  - Medicaid
- **Private Payor**
  - Private Payors (Blue Cross, United, Cigna, Aetna)
    - ACOs with private insurers in effect or development at **4X Medicare ACOs**
  - Large Employers
  - Self-Insured Hospitals and Health Systems

MU & ACOs

- ACO 33 Quality Measures include:
  - Percent of PCPs who Successfully Qualify for MU Payment
  - CQMs overlap with ACO measures

CQM Overlap with ACO and Other Programs

Stage 2 2014 CQM Measure	Other CMS Program
Controlling High Blood Pressure Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	**ACO**; EHR PQRS; Group Reporting PQRS
Use of High-Risk Medications in the Elderly	PQRS
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	**ACO**; EHR PQRS Group Reporting PQRS
Use of Imaging Studies for Low Back Pain	
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	EHR PQRS; **ACO**; Group Reporting PQRS
Documentation of Current Medications in the Medical Record	PQRS; EHR PQRS
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	EHR PQRS; **ACO**; Group Reporting PQRS
Closing the referral loop: receipt of specialist report	

MU & Clinically Integrated Networks

- "Clinical Integration" originally an antitrust legal concept
  - Applies to joint action by providers
- General "Rules"
  - Must produce efficiencies
  - Monitor and Control Utilization
  - **Significant investment in human and financial capital (e.g., information systems)**
  - Limit network membership

MU & Clinically Integrated Networks

Potential MU Role	MU Stage 2 Measures to Leverage
• Backbone of coordinated care among network members • Efficiently centralize IT and/or operational MU requirements • Pre-requisite to inclusion in network • Third party standard to support legal challenges	• Summary of care document • Clinical Decision Support Rule • Reminders for follow-up care (EPs)

MU & Private Payor Contracting

- A growing number of private payers have added the MU requirements to their P4P programs
  - Aetna, United and WellPoint
  - Highmark modified its "Quality Blue" programs to include MU:
    - Require copy of attestation
    - Incorporate CQM for physician practice best practice indicator program
- Payors not setting up proprietary mini-MU programs
  - Rather use developed MU system
  - Similar to using DRGs as a reference price for rates

MU & Other Programs

- Transitional Care Management
  - Coordinated Care
- Re-Admission Penalty
  - Coordinated Care
- Value-Based Purchasing
  - Patient Experience / Online Access

What will MU Become in Your Organization?

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