

**AMGA Council of Attorneys
2011 Meeting**

**Meaningful Use Stage 2
Update**

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Stage 2 Regulations Anticipated

- CMS is expected to publish a NPRM on Stage 2 requirements in late 2011, with the final rule to follow in or about June 2012.
- CMS receives recommendations from two Federal Advisory Committees established by the American Recovery and Reinvestment Act of 2009 (ARRA).

Advisory Committees:

- The HIT Policy Committee (HITPC) makes recommendations on policy issues such as the schedule and timing of new requirements, criteria associated with new objectives and measures, and changes to existing measures.
- The HIT Standards Committee (HITSC) makes recommendations on standards, implementation specifications and certification criteria based on the policies developed by HITPC.

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Stage 2 Timing Issue

Current Schedule for MU Stage 2 Objectives

TABLE 1—STAGE OF MEANINGFUL USE CRITERIA BY PAYMENT YEAR

First Payment Year	Payment Year			
	2011	2012	2013	2014
2011	Stage 1	Stage 1	Stage 2	Stage 2.
2012 .....	.....	Stage 1	Stage 1	Stage 2.
2013 .....	.....	.....	Stage 1	Stage 1.
2014 .....	.....	.....	.....	Stage 1.
	Complete EHRs and EHR Modules certified by ONC-ATCBs or ONC-ACBs ² to all of the applicable certification criteria adopted for the 2011 & 2012 payment years meet the definition of Certified EHR Technology.		Complete EHRs and EHR Modules certified by ONC-ACBs to all of the applicable certification criteria adopted for the 2013 & 2014 payment years meet the definition of Certified EHR Technology.	

Current Schedule

- Eligible Professionals (EPs) and Eligible Hospitals (EHs) who attest to meeting 90 days of Stage 1 during 2011 are responsible for a full year of Stage 1 in 2012, followed by a full year of Stage 2 in 2013.

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Current Schedule

- For EPs, the 2013 payment year begins in January of 2013.
- For EHs, the 2013 payment year is the federal fiscal year, starting in October of 2012.

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Public Comments

- The HITPC heard from vendors and providers that the current schedule would pose an enormous timing challenge for those who attest to meaningful use in 2011.

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Public Comments, cont'd

- The anticipated release of the stage 2 final rule in June 2012 would require EHR vendors to develop and release new functionality, and would require EHs to implement and begin using the new functionality by the beginning of the reporting year in October of 2012.

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HITPC Recommendation:

- Delay transition from stage 1 to stage 2 by one year for providers who qualify for Meaningful Use in 2011.

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Result:

- Gives an extra year to phase in the stage 2 expectations.
- Removes disincentive to attest in 2011.
- Allows 2011 attesters two years of payments for stage 1—2012 and 2013.

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Affects only 2011 Attesters

- The proposed delay in Stage 2 would affect only those EPs and EHs who attest to Stage 1 MU in 2011.
- Those who attest to Stage 1 for the first time in 2012 would continue to have the same expectation for meeting the Stage 2 criteria in 2014.

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Current Schedule for MU Stage Objectives

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Medicare and Medicaid EHR Incentive Programs

- Registration and Payment Status
 - Current through August 2011

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Active Registrations – August 2011

		August -11	YTD
Medicare Meaningful Use (MU)	Eligible Professional	9,268	71,378
	Hospital	0	121
	Total	9,268	71,499
Medicaid Adopt, Implement or Upgrade (AIU)	Eligible Professional	3,569	17,181
	Hospital	3	37
	Total	3,572	17,218
Medicare/Medicaid	Hospital (registered for both Medicare & Medicaid)	259	1,933
Total		13,099	90,650

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States Open for Registration – August 2011

23 States are currently open for Medicaid EHR Incentive Program registration:

- Alabama
- Alaska
- Arizona
- Connecticut
- Indiana
- Iowa
- Kentucky
- Louisiana
- Michigan
- Mississippi
- Missouri
- North Carolina
- Ohio
- Oklahoma
- New Mexico
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Washington
- West Virginia
- Wisconsin

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Medicare and Medicaid EHR Incentive Programs - Total Summary – August 2011

REGISTRATIONS	August 2011	YTD
Medicare EPs	9,268	71,499
Medicaid EPs	3,572	17,218
Medicaid/Medicare Hospitals	259	1,933
Total	13,099	90,650

PAYMENTS	August – 11	YTD
Medicare EPs	\$18,918,000	\$42,419,516
Medicaid EPs	\$38,255,688	\$126,844,564
Medicaid/Medicare Hospitals (Medicare Payment)	\$95,942,938	\$220,822,305
Medicaid/Medicare Hospitals (Medicaid Payment)	\$111,458,105	\$262,156,108
Total	\$264,601,731	\$652,242,493

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Stage 2 Measures

- In the final rule, CMS said:
 - We will consider every objective that is optional for Stage 1 to be required in Stage 2, as well as re-evaluate the thresholds and exclusions of all the measures both percentage based and those currently a yes/no attestation. Additionally, we may consider applying the criteria more broadly to all outpatient hospital settings (not just the emergency department).

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HITPC Recommendations

- 4 categories:
 - *Measures unchanged from Stage 1*
 - *Measures unchanged from Stage 1, except in Stage 2 they are no longer optional*
 - *Measures with higher thresholds or wider scopes in Stage 2 than in Stage 1*
 - *New measures unique to Stage 2*

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HIT Policy Committee Stage 2 Recommendations

Presentation to HIT Standards Committee

June 22, 2011

Reminder of Stage 2 Timing Issue *Timing of EHR Certification and MU Stage Objectives*

Considered:

1. Maintain current timeline and one-year EHR reporting period; or
2. Maintain current timeline and permit 90-day EHR reporting period; or
3. Delay transition from stage 1 to stage 2 by one year only for providers who qualify for MU in 2011

Recommends #3

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Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities

Stage 1 Final Rule	HITPC Proposed Stage 2
Improving Quality, Safety, Efficiency & Reducing Health Disparities	
>30% of unique patients with at least one med order have at least one med order entered using CPOE	Raise threshold to >60% for medication orders and include at least one lab order using CPOE for >60% of unique patients who have at least one lab test result; at least one radiology test is ordered using CPOE (unless no radiology orders)
Implement drug-drug and drug-allergy interaction checks (enabled functionality)	Employ drug interaction (drug-drug, drug-allergy) checking; Providers have the ability to refine DDI rules. [In stage 3, goal is to have nationally endorsed lists of DDI with higher positive predictive value and ability to record reason for overriding alert]
EP: Generate and transmit permissible prescriptions electronically for >40% of prescriptions	50% of outpatient medication orders and 10% of hospital discharge medication orders transmitted as eRx
>50% of all unique patients have demographics recorded as structured data. (preferred language, gender race ethnicity, DOB, date and preliminary COD- EH ONLY).	80% of patients have demographics recorded and can use them to produce stratified quality reports; for stage 3, use more granular demographic categories per IOM report (HITSC needs to work on standards for granular demographics)
Report CQM as per CMS attestation	Report CQM electronically as per CMS
Maintain an up-to-date problem list for >80% of all unique patients	Maintain problem list <u>(80%)</u>

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Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities, II

Stage 1 Final Rule	HITPC Proposed Stage 2
Maintain active med list for >80% of all unique patients	Maintain active med list <u>(80%)</u>
Maintain active med allergy list for >80% of all unique patients	Maintain active med-allergy list <u>(80%)</u>
Record and chart vital signs for >50% of all unique patients age 2 and over	80% of patients have vital signs recorded during the reporting year; change age for peds BP from 2 yrs to 3 yrs
Record smoking status for >50% of all unique patients 13 years or older	80% of patients have smoking status recorded [stage 3 add new field in certification for secondhand smoke]
Implement 1 clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance	Use CDS; HITSC: Suggest changing certification criteria definition as indicated on comment summary
Menu: Implement drug-formulary checks with access to at least one drug formulary	Move to Core: Implement drug formulary checks according to local needs (e.g., may use internal or external formularies, which may include generic substitution as a "formulary check")
Menu: Record AD for 50% of all unique patients 65 years and older	Move to Core: For hospitals (inpatient), 50% of patients 65 years and older have recorded whether an advance directive exists (with date and timestamp of recording) and access to a copy of the directive itself if it exists; for EPs, >25 unique patients have recorded whether an advance directive exists (with date and timestamp of recording) and access to a copy of the directive itself if it; (signal ability to store and retrieve AD for Stage 3)

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Draft Stage 2 MU Objectives <i>Improving Quality, Safety, Efficiency & Reducing Disparities</i>	
Stage 1 Final Rule	HITPC Proposed Stage 2
Menu: Incorporate clinical lab-tests results as structured data for more than 40% of all lab tests results ordered	Move to Core: Incorporate lab results as structured data (40%); HITSC: Use LOINC where available
New	EHS: Hospital labs <i>send</i> (directly or indirectly) structured electronic clinical lab results to outpatient providers for ≥ 40% of electronic orders received; HITSC: Use LOINC where available; (note challenge to small hospitals; may require exclusions)
Menu: Generate at least one report listing patients by specific conditions	Move to Core: Generate patient lists for multiple patient-specific parameters
Menu: Send an appropriate reminder for preventive/follow up care to more than 20% of all unique patients 65 years or older or 5 years or younger	Move to Core: EPs:10% of all active patients are sent a clinical reminder (reminder for existing appointment does not count)
New	30% of EP visits have at least one electronic EP note and 30% of EH patient days have at least one electronic note by a physician, NP, or PA; non-searchable, scanned notes do not qualify [use broad definition of qualifying note types]
New	EH medication orders automatically tracked via electronic medication administration record; (in-use in at least one hospital ward/unit) ("automatically" implies "5 rights" recorded without manual transcription)
New	Consider adding recording of family health history in stage 3 (due to absence of standards for FH)

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Draft Stage 2 MU Objectives <i>Engaging Patients and Families</i>	
Stage 1 Final Rule	HITPC Proposed Stage 2
Provide >50% patients with an electronic copy of health information	(combined with other objectives)
EH: Provide >50% of all discharged patients with an electronic copy of their discharge instructions	(discharge instructions combined with other objectives)
New	Hospitals: 10% of patients/families view and have ability to download [took out "relevant"] information about a hospital admission; information available for all patients within 36 hours of the encounter
Menu: Provide >10% of all unique patients with timely electronic access to health information (EP)	Move to Core: EPs: >10% of patients/families view & have ability to download their longitudinal health information; information available to all patients within 24 hours of an encounter (or within 4 days after available to EPs) [P&S TT to consider whether a P&S warning should be put in S&C criteria]
Provide Clinical Summaries to patients for >50% of all office visits within 3 business days	EPs: patients are provided a clinical summary after 50% of all visits, within 24 hours (pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs; (electronically accessible for viewing counts)
Menu: Use certified EHR technology to identify patient-specific educational resources and provide to patient if appropriate for >10% of all unique pts.	Move to Core: Both EPs and hospitals: 10% of patients are provided with EHR-enabled patient-specific educational resources; make core; take out "if appropriate" instead of raising threshold
New	EPs: patients are offered secure messaging online and at least 25 patients have sent secure messages online
New	EPs: Patient preferences for communication medium recorded for 20% of patients
New	Stage 3: Provide mechanism for patient-entered data (supply list); consider "information reconciliation" for stage 2 to correct errors

Draft Stage 2 MU Objectives <i>Improve Care Coordination</i>	
Stage 1 Final Rule	HITPC Proposed Stage 2
Improve Care Coordination	
Capability to exchange key clinical information – Perform at least one test	(HIE test eliminated in favor of use case objectives)
Menu: Perform medication reconciliation for >50% of transitions for receiving provider	Move to Core: Medication reconciliation conducted at >50% of transitions by receiving provider
Menu: Provide summary of care record for >50% transitions of care for the referring EP or EH	EH and EP: Record and provide (by paper or electronically) a summary of care record for >50% transitions of care for the referring EP or EH EH and EP: Record care plan fields (goals and instructions in Stage 2) for 10% of patients [majority voted in favor, minority wanted 50% threshold] EH and EP: Record team member (including PCP, if available; unstructured in Stage 2) for 10% of patients EH: 10% of all discharges have care summary (including care plan and care team if available) sent electronically to EP or post-acute care facility. EP: at least 25 transactions sent electronically.
New	(care team merged with summary of care)
New	(care plan objective merged with summary of care)

Draft Stage 2 MU Objectives <i>Improving Population and Public Health</i>	
Stage 1 Final Rule	HITPC Proposed Stage 2
Improve Population and Public Health*	
Capability to submit electronic data to immunization registries or immunization IS – Perform a test	EH and EP: Submit immunization data (attest to at least one) in accordance with applicable law and practice; move to core for both EH and EP [In Stage 3, view cumulative immunization record and recommendations]
EH: Capability to submit electronic lab data on reportable lab results to public health agencies – Perform a test	EH: Submit reportable lab results (attest to submitting to at least one organization) in accordance with applicable law and practice; move to core
Capability to submit electronic syndromic surveillance data to public health agencies - Perform a test	EH: Submit syndromic surveillance data (attest to at least one) in accordance with applicable law and practice; move to core
New for Stage 3	For Stage 3: Patient-generated data submitted to public health agencies
*Signal to HITSC to include a single standard to be used for submitting PH data for each PH objective.	

Draft Stage 2 MU Objectives <i>Ensure Privacy and Security Protections</i>	
Stage 1 Final Rule	HITPC Proposed Stage 2
Ensure adequate privacy and security protections for personal health information	
Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process	Perform, or update, security risk assessment and address deficiencies
	Address encryption of data at rest
	Signal that Stage 3 may require meeting conditions of participation in NWHIN