Meaningful Use: Today and in the Future

VMGMA Spring Conference
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Agenda-Three Timeframes

• 2015 Meaningful Use: hardship exception process
• 2016-2017 Challenging Requirements Made Easier with Flexibility Final Rule
• 2017+: A look Ahead at Stage 3, MACRA, and the “wildcard” issue
• MU Tips
• Resources
• Q/A
Meaningful Use 2015: Avoiding the 2017 Penalty
2015 Round-Up:  
Attestation and Hardship Exception Applications

- **Attested** for 2015 meaningful use by **March 11**.
- Submit a 2015 hardship exception **application** by **July 1**.

**What’s special about 2015?** Due to delay of the modifications rule, Congress/CMS created a blanket, streamlined exception process.

- Applies to **every** provider, even those who never applied to program or don’t have an EHR system.
- Forms require less information & no supporting documentation.
- One form may be submitted for **all** of the providers in the group.
- Applications will receive an expedited, automatic review.
Hardship Application Process

• Review the hardship exception instructions and access the exception application form.

• Note below: no CEHRT # required
Avoiding the 2017 Penalty: 2.2.d

☐ 2.2.b Practice or Hospital Closure
I, ______________________, on behalf of the provider(s) listed in Section 3 and/or 4, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form of a practice or hospital closure. I further attest that this extreme and uncontrollable circumstance in the form of a closure constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(iii).

☐ 2.2.c Severe Financial Distress (Bankruptcy or Debt Restructuring)
I, ______________________, on behalf of the provider(s) listed in Section 3 and/or 4, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form of severe financial distress resulting in bankruptcy or restructuring of debt. I further attest that this extreme and uncontrollable circumstance in the form of severe financial distress constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(ii).

☐ 2.2.d EHR Certification/Vendor Issues (CEHRT Issues)
I, ______________________, on behalf of the provider(s) listed in Section 3 and/or 4, am requesting this Medicare EHR Incentive Program Hardship Exception and attest that the provider(s) faced extreme and uncontrollable circumstances in the form of issues with the certification of the EHR product or products such as delays or decertification, issues with the implementation of the CEHRT such as switching products, or issues related to insufficient time to make changes to the CEHRT to meet CMS regulatory requirements for reporting in 2015. I further attest that this extreme and uncontrollable circumstance in the form of EHR certification/vendor issues constitutes a significant hardship in demonstrating meaningful use as defined under: 42 CFR 495.102 (d)(4)(iii).

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FAQ on 2.2.d

• CMS also released an FAQ to provide additional guidance specific to sub-category 2.2.d:
  – “This category can be used for issues related to the 2015 rulemaking timeline and is included under the existing category for extreme and uncontrollable circumstances related to the implementation and use of certified EHR technology. Providers who experienced an issue with their CEHRT related to the rule timing – and any other provider for whom the timing of the rule caused a significant hardship – should select sub-category 2.2.d on the 2017 hardship exception application.

  No additional documentation is required for this selection.”
• Question: If I submit a hardship exception application by the March 15, 2016 deadline, does that mean that I cannot attest for the 2015 EHR reporting period and possibly receive an incentive pay?

• Answer: No. Submission of a hardship exception application does not prevent a provider from attesting and receiving an incentive payment if meaningful use requirements are met.
New Hardship Exception

• CMS recent FAQ:
  – The FAQ addresses the question of whether or not providers that have switched EHR vendors can apply for a hardship exception to avoid the Medicare payment adjustment.

Answer: yes, EP may apply for an Extreme and/or Uncontrollable Circumstances hardship exception and if approved may be exempt from the payment adjustment.
## The Penalty Phase

<table>
<thead>
<tr>
<th>Year/Program</th>
<th>eRx</th>
<th>PQRS</th>
<th>Meaningful Use</th>
<th>Value Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>-1.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>-1.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>-2.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>-1.5%</td>
<td>-1.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2017 - 2019</td>
<td></td>
<td>-2.0%</td>
<td>-3.0 – 5%* (each year)</td>
<td>Amount TBD</td>
</tr>
</tbody>
</table>

* Penalty amount could increase up to 5% depending on meaningful use success rates and discretion of HHS
2015-2017 MU Flexibility Final Rule and 2016 Reporting
Pathway to Flexibility

• EP Stage 2 success minimal
• Significant pressure on CMS from MGMA and many others in a broad coalition
• Coalition helped introduce bipartisan Flex-IT Act requiring 90-day reporting
• Dr. Conway Jan 29, 2015 blog signal
• CMS Releases Proposed Rule April 10, 2015
• Final rule “no later than Aug” comes out Oct.6, 2015 (after start of last 90-day reporting period)
Final Rule Key Provisions

10 core reporting obj (incl. new public health obj.)
- Previously 17 core and 3 menu objectives
- Redundant and “topped out” objectives were eliminated

Reduced “patient action” measure thresholds
- Patient electronic access (view, download, transfer) objective
  5% of patients 1 patient (at least 50% provided access)
- Secure messaging objective
  5% patients 1 patient (up from demonstrating capability in 2015)

• Hospitals move to calendar year reporting
# Reporting Periods

<table>
<thead>
<tr>
<th>Year</th>
<th>Reporting Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>All providers attest to EHR reporting period of any continuous 90-day period within calendar year</td>
</tr>
<tr>
<td>2016</td>
<td>First-time participants may use EHR reporting period of any continuous 90-day period between January 1 and December 31, 2016. All returning participants must use EHR reporting period of full calendar year (January-December 31, 2016)</td>
</tr>
<tr>
<td>2017</td>
<td>First-time participants may use EHR reporting period of any continuous 90-day period; providers attesting to Stage 3 may also use 90-day reporting period. All returning participants must use EHR reporting period of full calendar year (January-December 31, 2017)</td>
</tr>
<tr>
<td>2018</td>
<td>First-time Medicaid participants may use 90-day EHR reporting period. All other providers must use EHR reporting period of full calendar year (January 1- December 31, 2018)</td>
</tr>
</tbody>
</table>
The following objectives are no longer required to be reported:

- Record Demographics
- Record Vital Signs
- Record Smoking Status
- Clinical Summaries
- Structured Lab Results
- Patient List

- Patient Reminders
- Summary of Care
  - Measure 1 – Any Method
  - Measure 3 – Test
- Electronic Notes
- Imaging Results
- Family Health History
New List of MU Requirements

1. Protect Patient Health Information
2. Clinical Decision Support
3. CPOE
4. Electronic Prescribing (eRx)
5. Health Information Exchange
6. Patient Specific Education
7. Medication Reconciliation
8. Patient Electronic Access (VDT)
9. Secure Messaging
10. Public Health and Clinical Data Registry Reporting
1. Protect PHI
   • Conduct or review a security risk analysis, address security and encryption of ePHI, implement security updates as necessary, and correct identified security deficiencies

2. Clinical Decision Support (CDS)
   • 5 rules relative to 4 or more CQMs
   • Enable drug-drug and drug-allergy interaction

3. Computerized Provider Order Entry (CPOE)
   • More than 60% Medication order
   • More than 30% Radiology orders
   • More than 30% Laboratory orders
4. Electronic Prescribing (eRx)
   • More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary AND transmitted electronically

5. Health Information Exchange (HIE)
   • Any EP who refers a patient to another provider or transitions a patient to another setting must: Use CEHRT to create a Summary of Care record, and
   • Electronically transmit the Summary of Care record to a receiving provider for more than 10 percent of referrals and transitions of care
   • CMS is aware that many EPs do not have DIRECT e-mail addresses but did not lower threshold
6. Patient Education

• More than 10 percent of all unique patients seen by the EP during the EHR reporting period are given patient specific education resources that were identified by CEHRT

7. Medication Reconciliation

• The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP
8. Patient Electronic Access

• Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information

• Measure 2: At least 1 patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads, or transmits his/her health information to a third party during the EHR reporting period
9. Secure Messaging

• The capability for an EP and patient to send and receive a secure electronic message must be fully enabled during the EHR reporting period.

• At least 1 patient uses SM.
Stage 2: Public Health

10. The EP is in “active engagement” (registered, testing, or production) with a public health agency to submit electronic public health data from CEHRT. EP must meet 2 of the following:

- Measure 1: the EP is in active engagement with a public health agency to submit **immunization data**
- Measure 2: the EP is in active engagement with a public health agency to submit **syndromic surveillance data** (menu previously)
- Measure 3: the EP is in active engagement to submit data to a **specialized registry** (menu previously)

- **Exclusions are available for each measure. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all measures.**

- **Challenge**: vendor fees to connect with registries
PH Reporting Exclusions

- In 2016, everyone must attest to two measures.
- An EP can be excluded from reporting to an Immunization registry if he/she:
  - Does not administer any immunizations; or
  - Operates in a jurisdiction for which no immunization registry is able to accept data; or
  - Operates in a jurisdiction where no immunization registry has declared readiness to receive data.
- An EP can be excluded from Syndromic Surveillance reporting if he/she:
  - Operates in a jurisdiction that does not collect data from their category of providers; or
  - Operates in a jurisdiction for which agency is not able to accept data; or
  - Operates in a jurisdiction where agency has not declared readiness to receive data.
- An EP can be excluded from Specialized Registry reporting if he/she:
  - Does not diagnose or treat any disease associated with or collect relevant data that is required by a specialized registry; or
  - Operates in a jurisdiction for which no registry is able to accept data; or
  - Operates in a jurisdiction where no registry has declared readiness to receive data.
  - CMS: “The EP is not required to make an exhaustive search”
Stage 2 Requirements

Clinical quality measures (no change)

– 9 measures out of 64, covering at least three domains
– None are “required” but some are recommended
– Zero in the denominator is a positive response
– Can report through the PQRS Portal
– Note that the CQM reporting period can be different than the rest of MU
Leading Cause of Failing an MU Audit
Security RA Requirement

• “Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process.”
RA Challenges

• Although conducting a risk analysis has been required since 2005 (HIPAA Security final rule), not all practices have conducted one
• RA delves into areas of the practice that staff typically do not have expertise (i.e., network security, encryption)
• Many practices have focused on privacy, not RA
• One of the few MU requirements that the EHR vendor cannot completely address without significant practice input
• Hiring a consultant to conduct a RA is costly
Risk Analysis Tips

• Don’t assume your RA will be conducted by your EHR vendor (without additional cost)
• Talk to colleagues—how did they conduct their RA?
• Do assume that you will be audited
• Document everything RA-related (hard-copy or e-binder)
• Review the available resources (i.e., MGMA, HHS)
• Consider outside help (especially for a narrow set of issues (i.e., mobile tech, security for remote access to EHR)
Resources at mgma.org

- HIPAA Security Risk Analysis Toolkit  Adobe PDF
- Link to RA tool developed by ONC and OCR
- MGMA and OCR Sample Notices of Privacy Practices
- Sample Business Associate Agreement
- MGMA Webinars
  - ‘Laptops, Tablets, Smartphones and HIPAA: An Action Plan to Protect your Practice”
  - “HIPAA Omnibus Rule: A practical approach for physician practices”
The Future: Stage 3 and MACRA
The Death of Meaningful Use?

“We are now in the process of ending Meaningful Use and moving to a new regime culminating with the MACRA implementation….The Meaningful Use program as it has existed, will now be effectively over and replaced with something better.”

- Acting Administrator Andy Slavitt,
  J.P. Morgan Annual Health Care Conference
  (Jan. 11, 2016)
The Inevitable Clarification…

“The current law requires that we continue to measure [MU] under the existing set of standards….While MACRA provides an opportunity to adjust payment incentives…it does not eliminate it, nor will it instantly eliminate all the tensions of the current system….

[O]ur existing regulations – including meaningful use Stage 3 – are still in effect.”

- Acting Administrator Andy Slavitt &
  Acting Assistant Secretary for Health Karen DeSalvo
  (Jan.19, 2016)
## The Future of Meaningful Use

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting period</td>
<td>Full-year; 90 consecutive days for new EPs</td>
<td>Full-year; 90 consecutive days for new EPs and those electing to move to Stage 3</td>
<td>Full-year</td>
</tr>
<tr>
<td>MU stage</td>
<td>All EPs in Stages 1 or 2</td>
<td>EPs can elect to move to Stage 3</td>
<td>All EPs must move to Stage 3</td>
</tr>
<tr>
<td>Penalty</td>
<td>3-4%</td>
<td>3-5%</td>
<td>3-5%</td>
</tr>
</tbody>
</table>
Stage 3 - the Big Picture

- Voluntary in 2017 for EPs
- 90-day reporting in 2017
- Mandatory in 2018 for all EPs and all year reporting for most
- Significant push back from MGMA, other associations, Congress
- All calling for stage 3 to be delayed
- CMS opened up Oct. 2015 rule for an additional comment period
- CMS suggested S3 changes incl in MIPS NPRM
Stage 3 looks a different than 2016 Stage 2

- No core and menu measures, just options for many of the 8 reporting areas (“flexible” measures)
- Reporting will be 1 year (except for 1st year Medicaid)
- CQMs will be reported electronically; no chart abstraction or paper based measures
- Increased thresholds for many measures (i.e., back to 5% for VDT or API and SM)
- Patient-generated data from a nonclinical setting must be incorporated into the EHR for more than 5% of patients seen by the EP
Removal of Measures

- Original measures that are removed are either “topped out” (i.e., standards have been widely adopted as best practices) or appear elsewhere in MU reporting and are considered redundant for reporting purposes.

- Same as 2015 Flex final rule list
Stage 3 Objectives

1. Protect Patient Health Information
2. Clinical Decision Support
3. Patient Access to Health Information (5%)
4. Health Information Exchange
5. Electronic Prescribing
6. CPOE
7. Coordination of Care Through Patient Engagement
8. Public Health & Clinical Data Registry Reporting
MACRA
MACRA Basics

• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (April 16, 2015)
  – Repealed Medicare sustainable growth rate (SRG) formula
  – Sunsets EP payment adjustments at the end of 2018

• Establishes two payment tracks:
  – Merit-Based Incentive Payment System (MIPS)
  – Alternative Payment Model (APM)

• MIPS consolidates PQRS, MU and Value-Based Payment Modifier (VBPM) into single program
**MACRA: The Basics**

**2016-2018**
- Last performance year 2016??
- PQRS
- Value-Based Payment Modifier
- Meaningful Use

**2019 onward**
- First performance year 2017??
- MIPS (Merit-Based Incentive Payment System)
  - Score comprised of four performance categories:
    - Quality
    - Resource use
    - Clinical practice improvement
    - Meaningful use of EHR
- APMs* (Alternative Payment Models)
  - TBD, examples include:
    - PCMHs
    - Bundled payment models
    - CMMI models
    - ACOs

* “Non-qualifying” APMs will receive “favorable scoring” in MIPS
MIPS Composite Score

Four Components of MIPS Composite Score

- Quality Measure: 15%
- Resource Use: 30%
- Meaningful Use: 30%
- Clinical Practice Improvement Activities (CPIAs): 25%
MIPS Adjustment/Bonuses

- Based on composite performance score EPs may receive an upward, downward or no payment adjustment

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty Cap</th>
<th>Value-based Bonus (Up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-4.0%</td>
<td>+12%</td>
</tr>
<tr>
<td>2020</td>
<td>-5.0%</td>
<td>+15%</td>
</tr>
<tr>
<td>2021</td>
<td>-7.0%</td>
<td>+21%</td>
</tr>
<tr>
<td>2022</td>
<td>-9.0%</td>
<td>+27%</td>
</tr>
</tbody>
</table>

- Exceptional Performers see significant opportunities for additional bonuses/adjustments on top of traditional MIPS incentives
  - Available in 2019 through 2024
The 2017 “WildCard”
2016 election
MU TIPS
Audit Tips

• Three government agencies can audit a practice for RA’s
  – CMS (Figliozzi), OCR, and OIG (new)

• TIPS
  – Review documentation for each measure and for every year an incentive payment was received
  – Save dated screen shots that establish that the EPs successful met a particular measure
  – Retain documentation to support the attestation for six years
  – Consider conducting a mock audit
MU Tips

✓ Remove deleted measures from your dashboard
✓ Select the portal technology that best meets the needs of your practice/your patients
✓ Offer what the patients want (registration, scheduling, bill payment, lab results, refills, questions answered)
✓ Remember that for Patient Engagement Objectives #3 (CPOE), #6 (Patient Educ), and #9 (SM), patient actions may count towards the numerator of any provider in the practice who saw that patient during the reporting period.
✓ Develop a reasonable long-term IT and IT security strategy
✓ Look at patient engagement as a marketing tool
MU Tips

✓ Pick the right software for your practice, not necessarily the cheapest
✓ Carefully review ROI (cost/penalties vs incentives)
✓ Remember that MIPS/APM intersect with MU
✓ Leverage your professional networks and learn from your colleagues
✓ MU will change over the next few months and years—keep up or fall behind!
✓ Keep up on all MU changes through MGMA
Thank you!

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MGMA Resources: mgma.org/meaningfuluse

- How to avoid the 2017 penalty
- Overview of the 2015 MU modifications final rule
- Overview of the Stage 3 final rule
- Meaningful Use FAQs: What MGMA Members are Asking
- Meaningful Use Incentive Program Checklist
- Member-benefit webinar: Meaningful Use Stage 2
- Webinar-CMS presents EHR Incentive Programs: Getting to Meaningful Use
- Webinar CMS walks participants through the Medicare and Medicaid EHR Incentive programs
CMS Resources

- EHR Incentive Stage 3 and Modification Rule 2015-2017

- 2015 EHR Incentive Program Requirements

- Hardship Exception

- EHR Incentive Program Website
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/valuebasedpaymentmodifier.html

- National Institutes of Health
  http://www.nih.gov/health/clinicaltrials/registries.htm

- National Quality Registry Network (NQRN)