The Advisory Board Company

Health Care IT Advisor

Meaningful Use

Adjusting to a New Normal

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Maryland HIMSS Spring Education Event

Transforming Healthcare IT Delivery Systems

April 24, 2014

Road Map

1 The Journey Winds On and On

2 The New Normal: Adaption

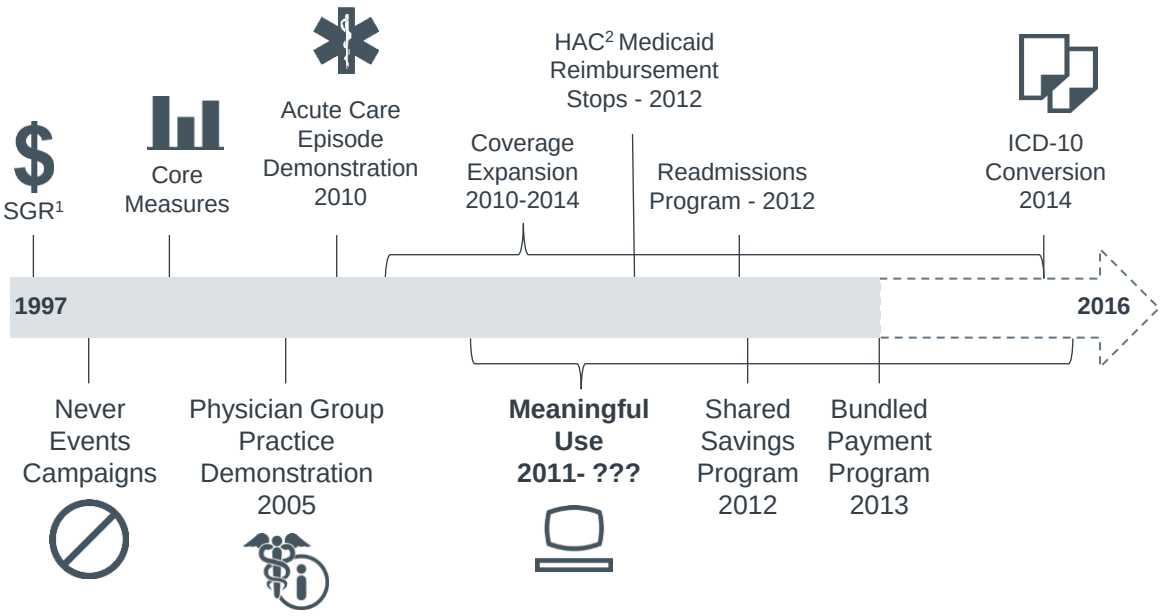
3 The New Normal: Audits

4 The New Normal: Alignment

Many Moving Parts in Health Care Reform

Not a Destination, But a Journey

Delivery System Reform Timeline



1) Sustainable growth rate.
2) Hospital-acquired condition.

Source: Health Care IT Advisor research and analysis.

Second of Three Increasingly Complex Stages

Data Capture and Sharing

Stage 1

- Increase implementation and adoption of EHR systems
- Capture structured data

Advanced Clinical Processes

Stage 2

- Increase exchange of health information
- Demonstrate care coordination across sites of care
- Empower patients with health information

Improved Outcomes

Stage 3

- Drive use of real-time data at the point of care
- Use outcomes-focused clinical quality measures
- Utilize CDS[1] for prevention, disease management, and safety

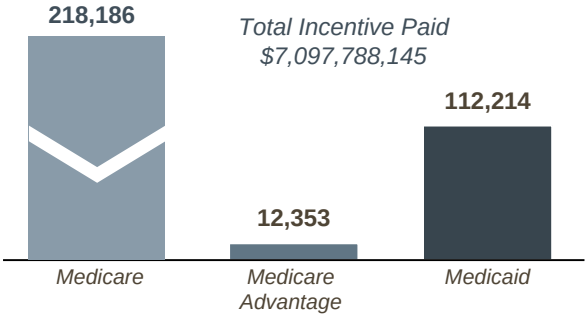
1) Clinical decision support.

Sources: HITPC Meaningful Use Workgroup, Stage 3 Subgroups; Medicare and Medicaid Programs; Electronic Health Record Incentive Program-- Stage 2 Proposed Rule. Available at: http://www.ofr.gov/OFRUpload/OFRData/2012-04443_PI.pdf; Health Care IT Advisor research and analysis.

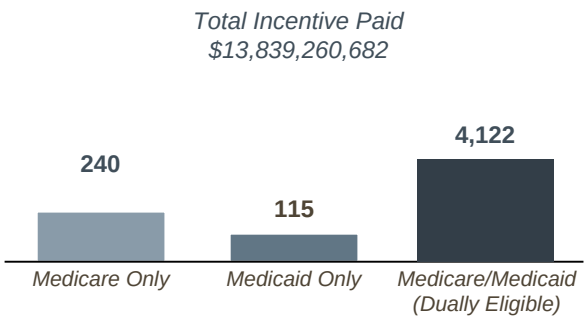
Nearly $21 Billion Paid in Incentives to Date

Meaningful Use Payment Status as of January 2014

Number of Eligible Professionals That Have Received Incentive Payments



Number of Eligible Hospitals That Have Received Incentive Payments



Average Incentives Received So Far

$23,402	$19,047	$25,557	$3.09M
Per Medicaid Eligible Professional	Per Medicare Eligible Professional	Per Medicare Advantage Eligible Professional	Per Eligible Hospital

Source: CMS, Data and Program Reports, available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html

Late Starters Lose Out on Medicare Incentives

Medicare Incentive Payment Schedule for Eligible Professionals

Calendar Year	First Payment Year				
	2011	2012	2013	2014	2015 and Later
2011	$18,000[1]				
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

1) Medicare incentive payment capped at $18,000, calculated as 75% of $24,000 in Medicare allowable charges.

Source: Medicare and Medicaid EHR Incentive Program Basics, at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html

Longer Payment Schedule for Medicaid Incentives

2016 Last Year to Earn Maximum Incentives

Medicaid Incentive Payments Schedule for Eligible Professionals

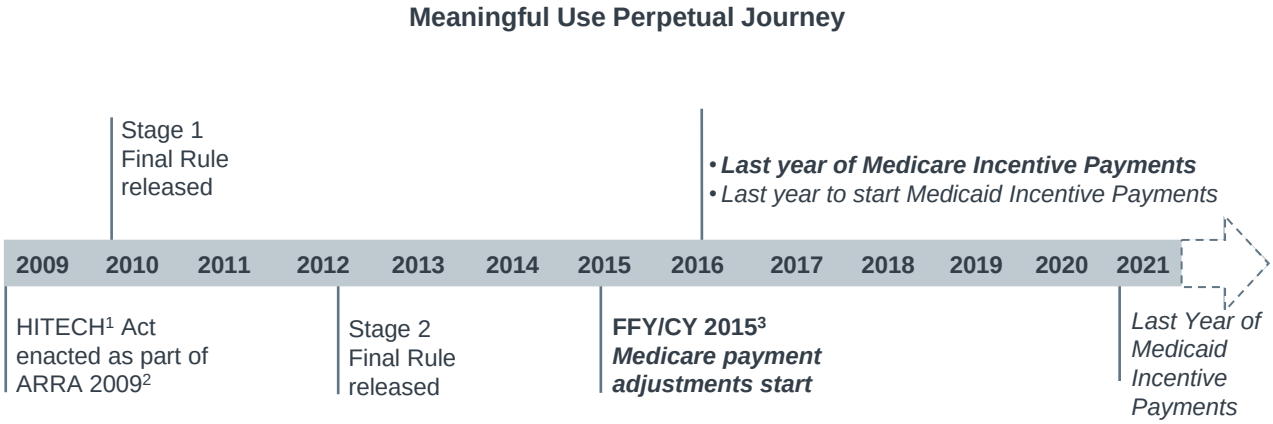
Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$ 21,250					
2012	$8,500	$ 21,250				
2013	$8,500	$8,500	$ 21,250			
2014	$8,500	$8,500	$8,500	$ 21,250		
2015	$8,500	$8,500	$8,500	$8,500	$ 21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$ 21,250
2017		$8,500	$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

Note: Assumes EPs will collect Medicaid incentive for six consecutive years; EPs are allowed to skip years until 2016 and EPs must start in the Medicaid program no later than 2016.

Source: Medicare and Medicaid EHR Incentive Program Basics, at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html

Carrots Followed by Sticks

Avoiding Medicare Payment Adjustments: FY 2015 and Beyond



1) Healthcare Information Technology for Economic and Clinical Health Act.
2) American Recovery and Reinvestment Act of 2009.
3) Federal fiscal year/calendar year.
4) Notice of Proposed Rulemaking.

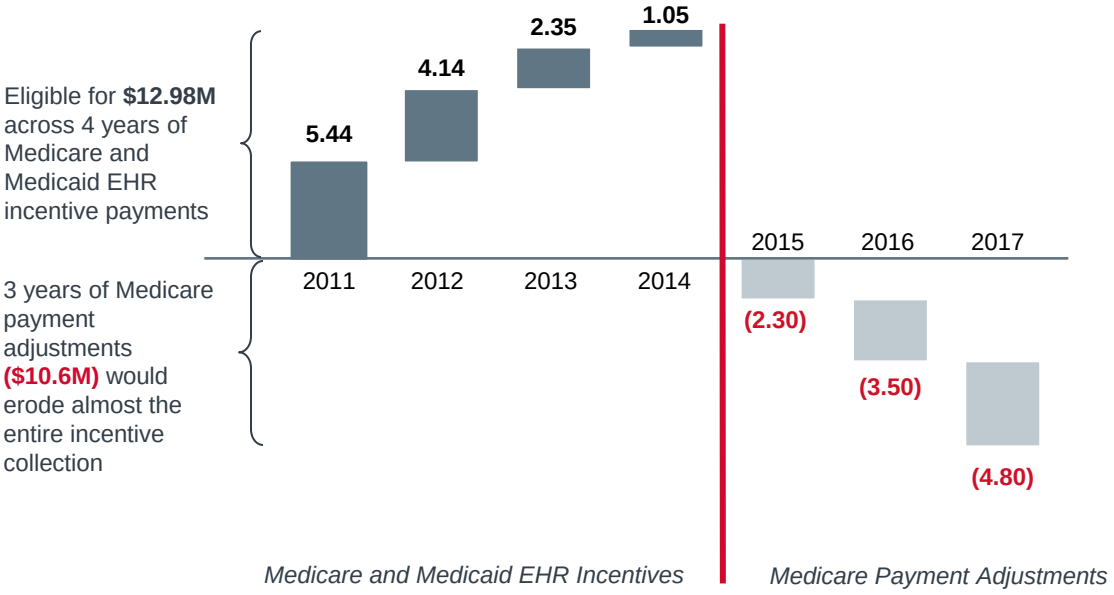
Source: Health Care IT Advisor research and analysis.

Once Medicare Incentives Start, They Cannot Stop

Payment Adjustments Could Erode Incentives

Annual Incentive and Payment Adjustment Estimate, Typical Hospital[1]

2011 First Year of MU Demonstration, in Millions of Dollars



1) Assumes ~34,000 discharges, 66% Medicare share, 15% Medicaid, and 3% annual market basket update.

Sources: American Recovery and Reinvestment Act, 2009; Health Care IT Advisor research and analysis.

Medicare Payment Adjustments

Payment Adjustments Apply to EP's Entire Medicare population

Potential Payment Adjustments for Eligible Professionals by Specialty

Specialty	Median Compensation	Payment Adjustment Year		
		2015	2016	2017
		Payment adjustment to Medicare physician fee schedule		
		1%	2%	3%
Internal medicine	$219,500	$2,195	$4,390	$6,585
Pediatrician and adolescent	$213,379	$2,134	$4,268	$6,401
Orthopedics (surgery)	$501,808	$5,018	$10,036	$15,054
Cardiology	$422,921	$4,229	$8,458	$12,688
Oncology (surgical)	$313,046	$3,130	$6,261	$9,391
Orthopedics (medical)	$293,873	$2,939	$5,877	$8,816

Source: Health Care IT Advisor research and analysis

Hardships vs. "Just Hard"

Hardship Exceptions Not for Everyone

Potential Scenarios

Qualify for Exception

- http: Insufficient Internet connection
- No face-to-face interactions or no follow up care with patients
- A new physician or hospital
- No control over CERHT decisions at multiple locations
- Unforeseen circumstances/ Natural disasters
- Anesthesiology, Pathology, and Radiology in the PECOS system

Do Not Qualify

- 2014 Software upgrade to 2014 Edition (exceptions to this rule)
- A B Changing EHR vendors
- Merger or acquisition

! Notes

- Hardship exceptions are considered on a case-by-case basis; EHR vendor hardships considered
- Eligible professionals must apply for the hardship exception by July 1st (EPs) of the year prior to the payment adjustment year (i.e., July 1, 2014 to avoid payment adjustments in CY 2015)

Source: Medicare and Medicaid Programs; Electronic Health Record Incentive Program-- Stage 2, Final Rule at http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf; Health Care IT Advisor research and analysis.

The New Normal of MU

Three Key Principles Underpin Ongoing Success of Meaningful Use

Adaptation

Organizations must devote resources to react to the ever-changing nature of meaningful use requirements.

- Monitor newly released CMS[1] and ONC[2] meaningful use content for any clarifications and/or modifications (e.g., Stage 3 delay to 2017[3])
- Assess the impact of the changes and revise meaningful use work plan

Audit Preparation

Organizations must prepare for meaningful use audits from the "when" not "if" perspective.

- Build a robust book of evidence
- Conduct a mock audit and address business continuity gaps in documentation and response processes

Alignment

Forward thinking organizations view meaningful use as an enabling agent to health care transformation.

- Seize an opportunity to align meaningful use with population health management and other quality reporting programs (e.g., IQR[4] and PQRS[5])
- Align tactical approach to meaningful use with the national health priority goals listed below

Stage 3 will Put Greater Emphasis on Six Health Priority Goals

1 Improving quality of care and safety

2 Engage patients and families in their health care

3 Improve care coordination

4 Improve population and public health

5 Affordable Care

6 Reduce Health Disparities

1) The Centers for Medicare and Medicaid Services
2) The Office of National Coordinator for Health Information Technology
3) Hospitals – Federal Fiscal Year 2017 (October 1, 2016 – September 30, 2017) and Ambulatory Providers – Calendar Year 2017
4) The Hospital Inpatient Quality Reporting Program
5) The Physician Quality Reporting System

Source: Health Care IT Advisor research and analysis

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Early Adopters Benefit from Stage 3 Delay

Providers That First Attested in 2011 or 2012 Remain in Stage 2 Longer

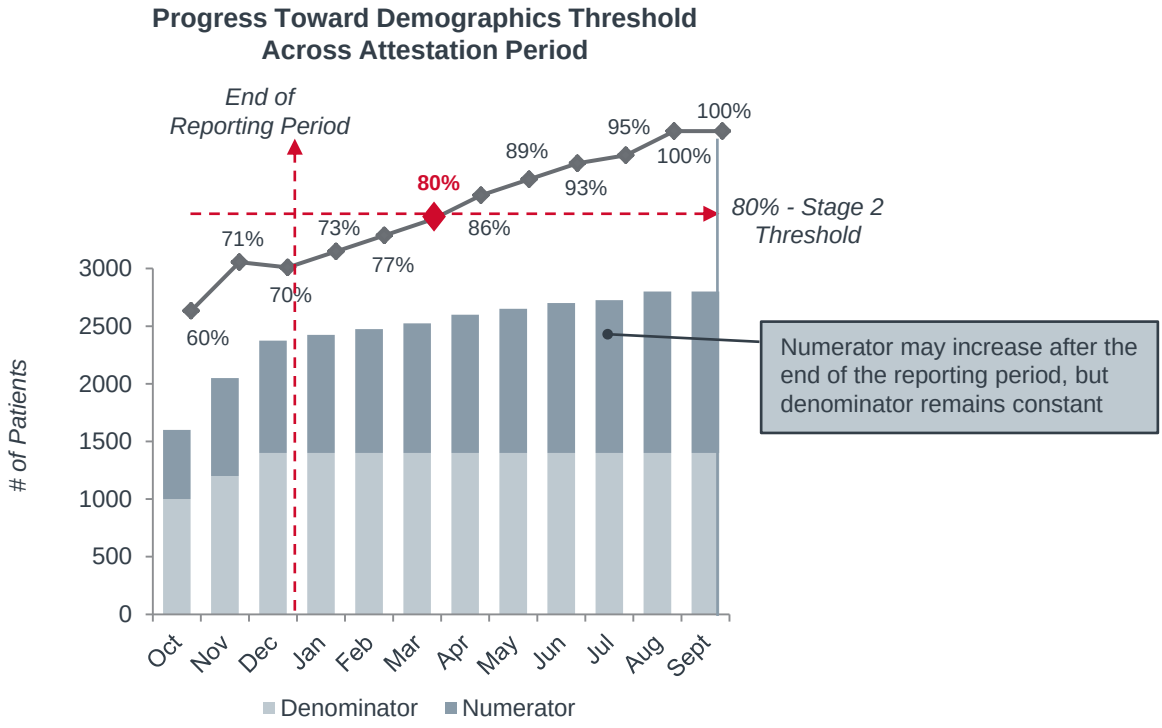
Advisory Board's Anticipated Update to First Payment Year and Corresponding MU Stage

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

Source: Progress on Adoption of Electronic Health Records, CMS Blog post. Health Care IT Advisor research and analysis.

Numerator Not Bound by a Reporting Period

Several Measures Provide Extra Time to Increase Numerators



Source: CMS Frequently Asked Questions (FAQ). Available at:: https://questions.cms.gov/faq.php?faqId=8231.

Stage 1 Is a Moving Target

Some Stage 1 Objectives Change Starting in 2014

Assigned Priority Level	Requirement	Change
High	View, Download, and Transmit – Measure 1	Replaces e-Copy of Health Information and e-Copy of Discharge Instructions Objectives
High	Report CQMs	Increases the number of required CQMs
Medium	Vital signs	Changes the age for blood pressure measurement and expands the options for EPs to claim an exclusion
Medium	CPOE[1]	Adds an alternative measure
None	Public health objectives	Includes “except where prohibited” to regulatory text
None	Test of information exchange	Removes the test of exchange requirement

1) Computerized provider order entry.

Source: Health Care IT Advisor research and analysis.

Electronic Quality Reporting in 2014

Opportunity to Reduce Manual Costs and Streamline Data Capture

Inpatient Quality Reporting (IQR) Program

- 57 measures
- Chart abstraction
- 1 full calendar year

Quality Reporting Alignment

- 16 specified measures (7 STKs, 6 VTEs, 3 EDs, and 1 PC)
- Electronic submission via QualityNet
- 1 fiscal quarter (FFY14 Q2, FFY 14 Q3, or FFY 14 Q4)

Note: need to submit the other 41 measures to fully satisfy the IQR requirements

Meaningful Use

- 16 measures from 29 available measures
- Electronic submission of patient level data OR attestation of aggregate patient data
- 1 fiscal quarter

Source: CMS Final Rule for the 2014 Hospital Inpatient Prospective Payment System (IPPS). See pages 50903-50906 of the FY 2014 IPPS Final Rule.

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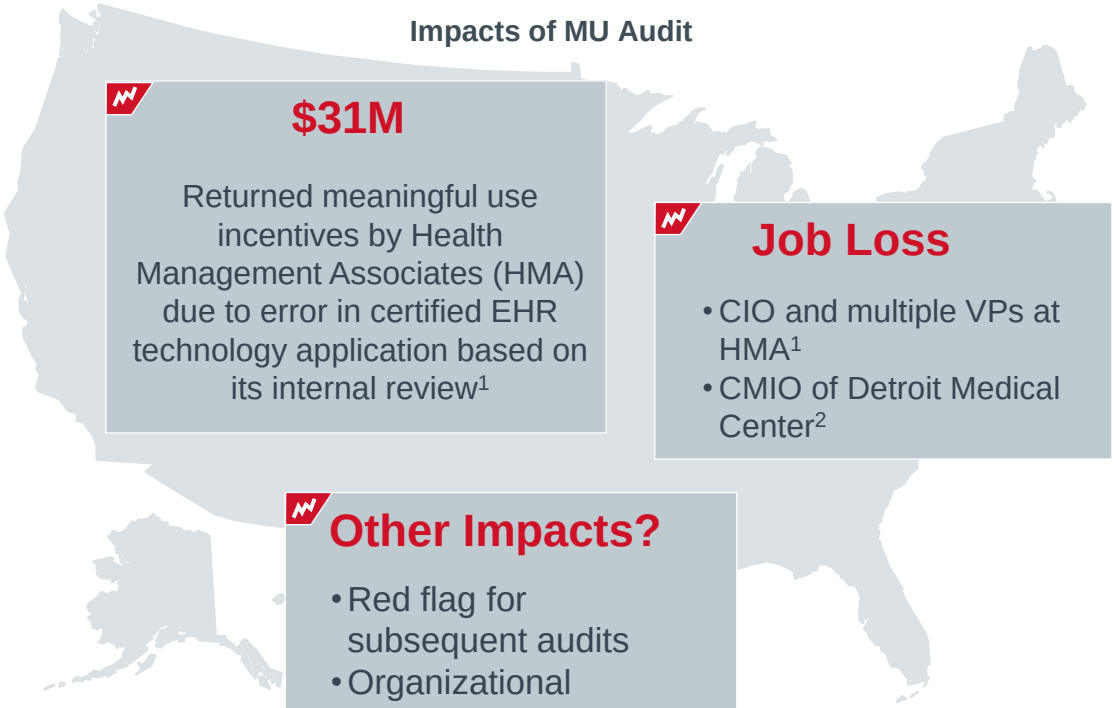
Potential Price Tags of MU Audit Failure



Impacts of MU Audit

$31M

Returned meaningful use incentives by Health Management Associates (HMA) due to error in certified EHR technology application based on its internal review[1]

Job Loss

- CIO and multiple VPs at HMA[1]
- CMIO of Detroit Medical Center[2]

Other Impacts?

- Red flag for subsequent audits
- Organizational reputation

Sources: 1. http://www.marketwatch.com/story/health-management-associates-announces-restatement-of-financial-statements-2013-11-05?reflink=MW_news_stmp and 2. http://www.healthcareitnews.com/news/physicians-symposium-offers-cautionary-tale-incentive-payment-audits

Consequences and Rates of Audit

Serious Consequences for Fraud

Types of Penalties[2]

- Significant fines
- Imprisonment
- Both fines and imprisonment
- Loss of licenses
- Exclusion from Medicare participation for a specified period of time
- Civil liability

5%[1] of ALL Attesters Will Be Audited

Type of Providers	Program Type	
	Medicare	Medicaid
 EPs	YES	YES
 EHs and CAHs	YES	YES

Sources: 1. http://www.advisory.com/Daily-Briefing/2013/04/24/CMS-One-in-20-meaningful-use-attesters-will-face-audits
2. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

MU Audit Mechanisms

Auditors

Type of Providers	Program Type	
	Medicare	Medicaid
EPs	Figliozzi and Company OR the EHR Meaningful Use Audit Team	State or its contractor
EHs and CAHs		

Audit Methodology

Random

&

Risk Profile

Audit Timing

6 Years

Attestation

Pre-Payment Audit

Incentive Payments

Post-Payment Audit

Off the Audit Hook

Source: Centers for Medicare and Medicaid Services. (February, 2013). EHR Incentive Programs Audit Overview. Accessed 11/6/13 http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Audit_Overview_FactSheet.pdf and The Advisory Board Company – Health Care IT Advisor research and analysis.

Robust Book of Evidence

Per Payment Year

Electronic vs. Paper

Centralized, Secured Location

Effective Naming Convention and Organization

Detailed Support Documentation (CEHRT, Core and Menu Objectives, Clinical Quality Measures)

Source: The Advisory Board Company – Health Care IT Advisor research and analysis.

Highlights from The Field

Reports with Vendor Logo

Date of Security Risk Analysis Completion and Inclusion of Remediation Plan

Screenshots of CEHRT Functionalities

Rationale for Selecting the CEHRT

Consistency of Denominators

Volume-Based Review
EH: Cost Reports - Medicaid
EP: Low Patient Volume

Source: The Advisory Board Company – Health Care IT Advisor research and analysis.

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Incorporate Health Priority Goals into Your Plans

Stage 3 Puts Greater Emphasis on the Health Priority Goals

1
Improve quality, safety, and efficiency, and reduce health disparities

2
Engage patients and families in their health care

3
Improve care coordination

4
Improve population and public health

5
Affordable care

6
Ensure adequate privacy and security protections for patient health information

Source: ONC Request for Comment located at http://www.healthit.gov/sites/default/files/hitpc_stage3_rfc_final.pdf

Aligning MU with Population Health Management

Population Health Management		Meaningful Use
	**Identify Populations**	Clinical data (e.g., ***Problem List, Medication List, Medication Allergy List, Demographics, Vital Signs***) collected and normalized in CEHRT for subsequent use to identify high utilizers, high-risks patients, and patients with chronic diseases
	**Map and Track Care**	***Patient List, Public Health objectives, and Clinical Quality Measures*** contribute to map and track care of patient population, as well as the health of the community and public
	**Deliver Care**	***CDS, CPOE, e-prescribing*** are gearing towards evidence-based care delivery at the point of care and beyond; ensure the right care is delivered correctly
	**Coordinate Cross Continuum Care**	***Transitions of Care*** with care plans and future requirements to ***Follow Through the Orders and Referral*** focus on care coordination across different settings
	**Engage Patients**	***View, Download, and Transmit, Patient-Specific Education Resources, Patient-Generated Health Data*** engage patients into their own care; allow patients to be proactive in their own health.

Source: Kilbridge, P. A Framework for IT-Enabled Population Health Management, Health Care IT Advisor, February 2013. Available at: http://www.advisory.com/Research/IT-Strategy-Council/Research-Notes/2013/A-Framework-for-IT-Enabled-Population-Management.

MU Demands Data Normalization

Improve Ability to Identify Patient Segments

- **HIE/Integration Broker**
- **EMR(s)**
- **Lab Systems**
- **E-prescribing Systems**
- **Patient Portal/PHR**[1]

Required Clinical Data in MU

- Problem List
- Medication List
- Medication Allergy List
- Demographics
- Vital Signs
- Smoking Status
- Lab Results into EHR
- Imaging Results

Structured, Coded Data

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Completeness

1 Today's High Utilizers

2 Tomorrow's High-Risk Patients

3 Patients with Chronic Diseases

Source: Kilbridge, P. A Framework for IT-Enabled Population Health Management, Health Care IT Advisor, February 2013. Available at: http://www.advisory.com/Research/IT-Strategy-Council/Research-Notes/2013/A-Framework-for-IT-Enabled-Population-Management.

1) Personal health record

Map and Track Care to Optimize Health Outcomes

Meet Organizational and National Health Management Needs

MU Requirement	Population Health Management	Community and Public Health	CMS[1] Triple Aim	ARRA Health Outcome Policy Priority
Patient List Objective	✓		Improve Patient Experience of Care	Improve Quality, Safety, Efficiency, and Reduce Health Disparities
Public Health Objectives		✓	Improve Health of Population	Improve Population and Public Health
Clinical Quality Measures	✓	✓	Improve Health of Population	Improve Quality, Safety, Efficiency, and Reduce Health Disparities

Source: Kilbridge, P. A Framework for IT-Enabled Population Health Management, Health Care IT Advisor, February 2013. Available at: http://www.advisory.com/Research/IT-Strategy-Council/Research-Notes/2013/A-Framework-for-IT-Enabled-Population-Management.

1) Centers for Medicare & Medicaid Services.

Using EHR to Deliver Evidence-Based Care

Enhanced Data Validity

- Use data from multiple sources in decision making
- Drive use of real-time data at the point of care

Care Delivery Guidance

- Perform CPOE
- Utilize CDS
- Ensure E-prescribing

Beyond Point of Care

- Report to immunization registries
- Submit cancer case data
- Collect data for specialized registries

Source: Kilbridge, P. A Framework for IT-Enabled Population Health Management, Health Care IT Advisor, February 2013. Available at: http://www.advisory.com/Research/IT-Strategy-Council/Research-Notes/2013/A-Framework-for-IT-Enabled-Population-Management.

Incremental Steps to Optimal Care Coordination

Care Coordination Inputs

- Transmission and migration of data across EHRs
- Medication Reconciliation
- Summary of Care at Transition

Stage 1

- Low participation of menu set Summary of Care objective

Stage 2

- Mandatory transmission of Summary of Care document
- Requirement to provide patient Care Plan goals and instructions

Stage 3

- Order and Referral follow-through
- Patient medication and follow-up compliance

Future Stages?

- Standardized care plan
- Electronically send adverse event reports
- E-consults

Data Capture and Sharing → **Advanced Clinical Processes** → **Improve Outcomes** → **Data Transparency**

Source: Kilbridge, P. A Framework for IT-Enabled Population Health Management, Health Care IT Advisor, February 2013. Available at: http://www.advisory.com/Research/IT-Strategy-Council/Research-Notes/2013/A-Framework-for-IT-Enabled-Population-Management.

Prioritize Patient Engagement for Better Outcomes

Engage, Measure, Improve

Patient's View, Download, or Transmit Health Data

- Develop a patient engagement campaign
- Tailor engagement techniques to patients' needs and communication preferences*
- Support telemedicine*

Patient Generated Data*

- Permit patients to add and amend their own health information
- Incorporate patient amendments to online data

Patient-Specific Education

- Provide education resources specific to each individual patient
- Encourage participation in care management programs

Patient List

- Generate lists of patients based on normalized clinical data
- Customize care plans for different patient populations with specific conditions

Governance & Oversight

* Not a current MU requirement, but included as recommended objectives in Stage 3

Source: Kilbridge, P. A Framework for IT-Enabled Population Health Management, Health Care IT Advisor, February 2013. Available at: http://www.advisory.com/Research/IT-Strategy-Council/Research-Notes/2013/A-Framework-for-IT-Enabled-Population-Management.

Thank You!

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