Meaningful Use
2013 Changes
Overview

JoAnne Hawkins
Meaningful Use Sr. Healthcare Policy Analyst
DNC (Contractor) for
U.S. Indian Health Service
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- Review and understand CMS EHR Incentive Program Stage 1, 2013 changes.

- Review Patient Volume Calculation changes.
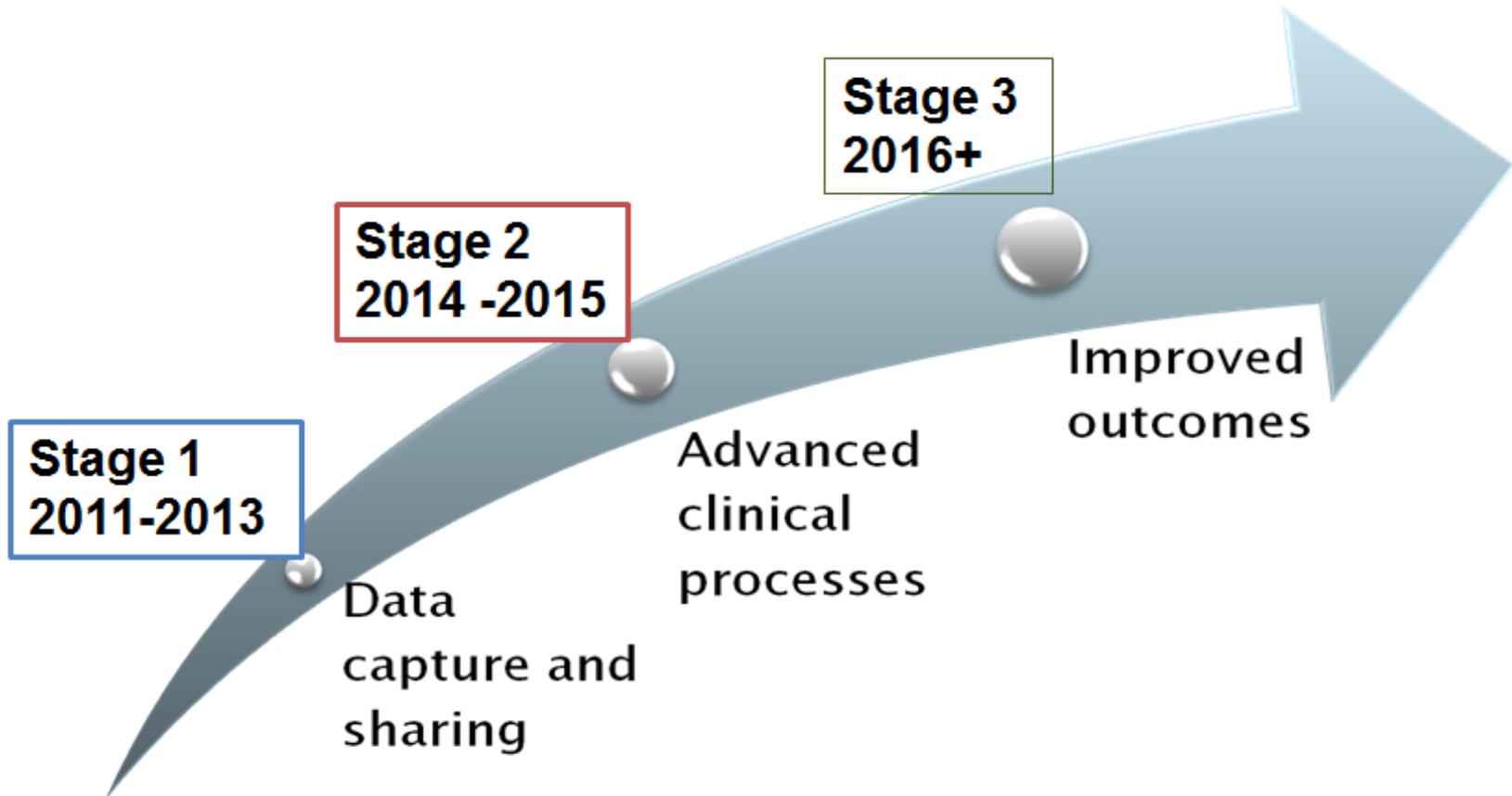
- Review Performance Measure changes.

- All changes made for 2013 are **not retroactive** to CY/FY 2011 or 2012.

MEANINGFUL USE

What is Meaningful Use?

- Meaningful Use is using certified EHR technology to:
  - Improve quality, safety, efficiency, and reduce health disparities.
  - Engage patients and families in their health care.
  - Improve care coordination.
  - Improve population and public health.
  - All the while maintaining privacy and security.

Three Stages of Meaningful Use

Stage 3
2016+

Stage 2
2014 -2015

Stage 1
2011-2013

Data
capture and
sharing

Advanced
clinical
processes

Improved
outcomes

TIMELINE

Eligible Professionals: Incentive Program Timeline

CY 2013	Key Events
01/01/13	First day of calendar and EHR reporting year
10/03/13	**Last day to begin 90-day reporting period** for the Medicare Incentive Program
12/31/13	Last day of calendar and EHR reporting year
02/28/14	**Last day to register and attest**

FY 2013	Key Events
10/03/12	First day of calendar and EHR reporting year
07/01/13	**LAST day to begin 90-day reporting period** for the Medicare Incentive Program
09/30/13	Last day of fiscal year and EHR reporting year
11/30/13	**Last day to register and attest**

Medicaid EP/EH MU Timeline

2011	2012	2013	2014*	2015	2016	2017
A/I/U	Stage1 90 Days	Stage 1 365 Days	Stage 2 90 Days	Stage 2 365 Days	Stage 3 365 Days	Stage 3 365 Days
	A/I/U	Stage1 90 Days	Stage 1 90 Days	Stage 2 365 Days	Stage 2 365 Days	Stage 3 365 Days
		A/I/U	Stage1 90 Days	Stage 1 365 Days	Stage 2 365 Days	Stage 2 365 Days
			A/I/U	Stage 1 90 Days	Stage 1 365 Days	Stage 2 365 Days
				A/I/U	Stage 1 90 Days	Stage 1 365 Days
					A/I/U	Stage 1 90 Days

Medicare EP/EH MU Timeline

2011	2012	2013	2014*	2015	2016
Stage1 90 Days	Stage 1 365 Days	Stage 1 365 Days	Stage 2 90 Days	Stage 2 365 Days	Stage 3 365 Days
	Stage1 90 Days	Stage 1 365 Days	Stage 2 90 Days	Stage 2 365 Days	Stage 3 365 Days
		Stage1 90 Days	Stage 1 90 Days	Stage 2 365 Days	Stage 2 365 Days
			Stage1 90 Days	Stage 1 365 Days	Stage 2 365 Days

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Eligible Professionals: Medicare Incentive Payment Example

Amount of Payment Each Year of Participation	First Payment is in CY 2011	First Payment is in CY 2012	First Payment is in CY 2013	First Payment is in CY 2014	First Payment is in CY 2015 or later
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0
CY 2016		$2,000	$4,000	$4,000	$0
TOTAL	**$44,000**	**$44,000**	**$39,000**	**$24,000**	**$0**

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Amount of payment each year if EP continues meeting requirements	First Payment is in CY 2011	First Payment is in CY 2012	First Payment is in CY 2013	First Payment is in CY 2014	First Payment is in CY 2015	First Payment is in CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

EP PATIENT VOLUME
AND
MEDICAID HOSPITAL INCENTIVE CALCULATION

Eligible Professional	If EP *does not* practice predominantly at FQHC/RHC: Minimum *Medicaid* patient volume thresholds	If EP *does* practice predominantly at FQHC/RHC*: Minimum *needy individual* patient volume thresholds
Physicians	30%	30%
- Pediatricians	20%	30%
Dentists	30%	30%
Certified Nurse-Midwives	30%	30%
NPs	30%	30%
PAs practicing at an FQHC/RHC led by a PA	N/A	30%

* All Tribal/Urban clinics are deemed FQHC/RHC for the CMS incentive program

- Current Patient Volume Calculation is based on Medicaid Paid Claims.
- Beginning in 2013, the patient volume calculation will include:
  - Medicaid paid claims
  - Zero paid claims
  - Individuals enrolled in Medicaid at the time of service
  - CHIP encounters for patients in Title 19 *and* Title 21 Medicaid expansion programs (still cannot include CHIP stand-alone Title XXI encounters)
- Release date for New Patient Volume Report will be April 30, 2013.

EP Patient Volume Calculation

EP Patient Volume Calculation 2013 **(Non-Medicaid Expansion State)** – Federal Sites	
Numerator =	Medicaid Paid + Zero Paid Claims + Medicaid Enrolled
Denominator =	All encounters for that EP

EP Patient Volume Calculation 2013 **Medicaid Expansion State** – Federal Sites	
Numerator =	Medicaid Paid + Zero Paid Claims+ CHIP+ Medicaid Enrolled
Denominator =	All encounters for that EP

EP Needy Patient Volume

EP Patient Volume Calculation – Needy Individual (Tribal and Urban sites)	
Numerator =	Medicaid Paid + Zero Paid Claims + Medicaid Enrolled + CHIP (Title 19 & Title 21) + Uncompensated Care
Denominator =	All encounters for that EP

- Prior to 2013, patient volume was calculated on a 90-day period on the previous calendar year (qualification year).
- Beginning in 2013, states have the option to allow EPs to generate a patient volume report based on a different look-back period, for either of the following:
  - A 90-day period in the last 12 months preceding the provider's attestation
  - A 90-day period in the previous calendar year

MEDICAID HOSPITAL INCENTIVE CALCULATION

- Prior to 2013, Medicaid Hospital Incentive Calculation was based on the most recent cost report data (previous year).
- Participation beginning in 2013 can utilize data from the most recent continuous 12-month period prior to attestation:
  - The FEIR report will be updated to reflect the data elements needed for Medicaid Hospital Incentive Calculation.

STAGE 1 2013 MU PERFORMANCE AND CLINICAL QUALITY MEASURES

Stage 1: 2013 Objectives and Measures

- Eligible Professionals must complete:

  - 13 core objectives

  - 5 out of 10 objectives from menu set

  - 6 total Clinical Quality Measures (3 core or alternate core, and 3 out of 38 from additional set)

  Eligible Hospitals must complete:

  - 12 core objectives

  - 5 out of 10 objectives from menu set

  - 15 Clinical Quality Measures

Note: A new performance measure report will be released in March 2013.

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EP	EH	Target	Core Measure
X	X	>30%	CPOE for Medication Orders *Denominator Calculation change*
X	X	Yes/No	Drug Interaction Checks
X	X	>80%	Maintain Problem List
X		>40%	E-Prescribing *New Exclusion added*
X	X	>80%	Active Medication List
X	X	>80%	Medication Allergy List
X	X	>50%:	Record Demographics
X	X	>50%	Record Vital Signs
X	X	>50%	Record Smoking Status
			Clinical Quality Measures Removed in 2013
X	X	Yes/No	Clinical Decision Support Rule
X	X	>50%	Electronic Copy of Health Information
X		>50%	Clinical Summaries
	X	>50%	Electronic Copy of Discharge Instructions
			Electronic Exchange of Clinical Information Removed in 2013
X	X	Yes/No	Protect Electronic Health Information

EP	EH	Target	Menu Set Measure
X	X	Yes/No	Drug Formulary Checks
	X	>50%	Advance Directives
X	X	>40%	Clinical Lab Test Results
X	X	Yes/No	Patient Lists
X		>20%	Patient Reminders
X		10%	Patient Electronic Access
X	X	>10%	Patient Specific Education Resources
X	X	>50%	Medication Reconciliation
X	X	>50%	Transition of Care Summary
X	X	Yes/No	*Immunization Registries Data Submission
X	X	Yes/No	*Syndromic Surveillance Data Submission
	X	Yes/No	*Reportable Lab Results to Public Health Agencies

Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines.

- **DENOMINATOR**: The number of medication orders created by the EP during the EHR reporting period

- **NUMERATOR**: The number of medication orders in the denominator recorded using CPOE

- **THRESHOLD**: The resulting percentage (must be greater than 30 percent for an EP to meet this measure)

- **EXCLUSION**: Any EP who writes fewer than 100 medication orders during the EHR reporting period

e-Prescribing

Objective: Generate and transmit permissible prescriptions electronically (eRx)

- **DENOMINATOR**: The number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period or the number of prescriptions written for drugs requiring a prescription to be dispensed during the EHR reporting period
- **NUMERATOR**: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT
- **THRESHOLD**: The resulting percentage (must be more than 50 percent for an EP to meet this measure)
- **EXCLUSIONS**: Any EP who meets either of the following conditions:
  - Writes fewer than 100 permissible prescriptions during the EHR reporting period
  - Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period

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- Core Set: If the denominator = 0, EPs must report on the Alternate Core measures.

NQF Measure Number and PQRI Implementation Number	Clinical Quality Measure Title
NQF 0013	Hypertension: Blood Pressure Measurement
NQF 0028	Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up

- Alternate Core Set

NQF Measure Number and PQRI Implementation Number	Clinical Quality Measure Title
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
NQF 0038	Childhood Immunization Status

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- Diabetes: *Nine measures*
- Heart Failure (HF): *Three measures*
- Coronary Artery Disease (CAD): *Three measures*
- Pneumonia Vaccination Status for Older Adults
- Anti-depressant medication management: *Two Measures*
- Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- Asthma: *Three measures*
- Appropriate Testing for Children with Pharyngitis
- Cancer Prevention and/ or Oncology: *Six measures*
- Smoking and Tobacco Use Cessation: *Three measures*
- Ischemic Vascular Disease (IVD): *Three measures*
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: *Two Measures*
- Prenatal Care: *Two Measures*
- Controlling High Blood Pressure
- Chlamydia Screening for Women
- Low Back Pain: Use of Imaging Studies

1. Emergency Department (ED) Throughput – admitted patients
   - Median time from ED arrival to ED departure for admitted patients
2. Emergency Department Throughput – admitted patients
   - Admission decision time to ED departure time for admitted patients
3. Ischemic stroke – discharge on anti-thrombotics
4. Ischemic stroke – anticoagulation for A-fib/flutter
5. Ischemic stroke – thrombolytic therapy for patients arriving within two hours of symptom onset
6. Ischemic or hemorrhagic stroke – antithrombotic therapy by Day Two
7. Ischemic stroke – discharge on statins

8. Ischemic or hemorrhagic stroke – rehabilitation assessment

9. VTE prophylaxis within 24 hours of arrival

10. Anticoagulation overlap therapy

11. Ischemic or Hemorrhagic stroke – stroke education

12. Intensive Care Unit VTE prophylaxis

13. Platelet monitoring on unfractionated heparin

14. VTE discharge instructions

15. Incidence of potentially preventable VTE

RESOURCES

Resources

- Stage 1 Changes Tip Sheet: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1ChangesTipsheet.pdf
- Stage 1 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

Area MU Contacts

Area	Area MU Contact	Email	Phone Number
Aberdeen	CAPT Scott Anderson	Scott.Anderson@ihs.gov	(605) 335-2504
Alaska	Richard Hall Kimi Gosney Karen Sidell	rhall@anthc.org kgosney@anthc.org ksidell@anthc.org	(907) 729-2622 (907) 729-2642 (907) 729-2624
Albuquerque	Jacque Candelaria	Jacque.Candelaria@ihs.gov	(505) 946-9311
Bemidji	Jason Douglas	Jason.Douglas@ihs.gov	(218) 444-0550
Billings	CAPT James Sabatinos	James.Sabatinos@ihs.gov	(406) 247-7125
California	Marilyn Freeman Steve Viramontes	Marilyn.Freeman@ihs.gov Steve.Viramontes@ihs.gov	(916) 930-3981, x362 (916) 930-3981, x359
Nashville	Robin Bartlett	Robin.Bartlett@ihs.gov	(615) 467-1577
Navajo	CDR Michael Belgarde Donna Nicholls	Michael.Belgarde@ihs.gov Donna.Nicholls@ihs.gov	(928) 871-1416 (505) 205-9177
Oklahoma	Amy Rubin	Amy.Rubin@ihs.gov	(405) 951-3732
Phoenix	CAPT Lee Stern Keith Longie, CIO	Lee.Stern@ihs.gov Keith.Longie@ihs.gov	(602) 364-5287 (602) 364-5080
Portland	Woody Crow	Sherwood.Crow@ihs.gov	(503) 414-5594
Tucson	Scott Hamstra, MD	Scott.Hamstra@ihs.gov	(520) 295-2532

Regional Extension Center

REC	REC Contact	Email	Areas
NIHB	Tom Kauley	Tkauley@nihb.org; (505) 977-6053	All
ANTHC	Richard Hall Kimi Gosney Karen Sidell	RHall@anthc.org; (907) 729-2622 KGosney@anthc.org; (907) 729-2642 KSidell@anthc.org; (907) 729-2624	Alaska
CRIHB	Tim Campbell Rosario Arreola Pro Amerita Hamlet	Tim.campbell@ihs.gov; (707) 889-3009 Rosario.arreolapro@crihb.net; (916) 929-9761, x1300 Amerita.hamlet@crihb.net; (916) 929-9761, x1323	California
NPAIHB	Katie Johnson	Kjohnson@npaihb.org; (503) 416-3272	Portland
USET	Vicki French	Vicki.French@ihs.gov (615) 467-1578	Aberdeen Albuquerque Bemidji Billings Nashville Navajo Oklahoma Phoenix Tucson

IHS Meaningful Use: Contacts

Contact	Title	E-mail	Phone
Chris Lamer	Meaningful Use Project Lead, IHS	Chris.Lamer@ihs.gov	(615) 669-2747
Luther Alexander	MU Project Manager, DNC	Luther.Alexander@ihs.gov	(301) 443-8114
JoAnne Hawkins	MU Healthcare Policy Analyst, DNC	JoAnne.Hawkins@ihs.gov	(505) 767-6600, x1525
Cecelia Rosales	MU Requirements Manager, DNC	Cecelia.Rosales@ihs.gov	(505) 767-6600, x1230

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Questions?

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