Meaningful Use: What Are the 2015 Requirements for Eligible Professionals? Tuesday, October 20, 2015

Laurie Fink: The Quality Insights Quality Innovation Network team welcomes you to today's webinar, "Meaningful Use: What Are the 2015 Requirements for Eligible Professionals?" My name is Laurie Fink, and I'm the Communications Specialist for the Improving Outcomes by Optimizing Your EHR Initiative.

Before we get things started, I would like to take a moment to review a few housekeeping items. First, all participant lines have been muted and will remain in a listen-only mode during the presentation. There will be a question-and-answer session following the formal presentation, so if you have any questions that come to mind at any time during the session, please feel free to type them into the chat or the Q&A box which can be found on the right of your screen. We will address all questions during the Q&A session. If your chat feature isn't opened, just go to the top right of your screen and click on the chat icon, and that will open up that box for you.

Please note that this webinar is being recorded, and the recording, along with a copy of the presentation slides, will be posted within the next few days on the Quality Insights website at www.qualityinsights-qin.org. Those resources could be found under the Events tab as an archived event.

At this time, I will hand the presentation to today's presenter, Kathy Wild, Quality Insights Improving Outcomes by Optimizing Your EHR Network Task Lead. Kathy?

Kathy Wild: Thank you, Laurie, and welcome, everyone, for joining the Quality Insights webinar. We have over 157 people that registered for it, and it looks about 90 people have joined us so far. We have representatives from all 5 of our network states in Delaware, Louisiana, New Jersey, Pennsylvania, West Virginia. Welcome, everybody.

My goal is for you to learn what eligible professionals have to in order to meet Meaningful Use this year in 2015. Although hospitals and critical access hospitals have almost identical requirements, I am going to focus today's presentation on eligible professionals that work in physician offices, rural health clinics, and federally qualified health centers.

For the agenda, what I'd like to do is go over the following topics. First, I'll give a brief review of the EHR Incentive Program and discuss the future of the program. Although the incentive part of the program and next year for Medicare providers and 2021 for Medicaid providers, Meaningful Use is here to stay. It's not going away. It's just going to be incorporated into a new CMS program.

We'll also go over the CMS rulemaking process. Every year, Congress makes new rules. First they have to propose them. Then they allow a 60-day comment period. CMS collects those comments, reads them and addresses each one, and then they release the final rule. What happened this year is in April, CMS released the proposed rule. They

received comments, and then as you know, on October 6, they went and released the final rule.

Originally, the plan was to have 3 stages of Meaningful Use with the provider progressing to stage 2 after participating in stage 1 for 2 years, but in 2014, CMS passed a new law that allowed providers to meet stage 1 again. It was taking vendors a long time to roll out their upgrades. Now, in 2015, the plan is altered again, and we have new rules to meet this year. That's why it's important to go over this since it's already October 20th.

I'm also going to talk about the reporting period for 2015. The original rule in 2009 was for an EP in its first year of participation would have a reporting period of just 90 consecutive days. Then all subsequent years would require full calendar year reporting. Last year, CMS had to change that because it took a long time for vendors to upgrade everyone's EHR to the 2014 version. Now, you'll soon see that this year, the rule has changed, and we'll be able to do 90 days again.

I wanted to simply the Meaningful Use process and this final rule as much as possible. Today, I'm only going to go over the requirements for 2015. The final rule did include reporting requirements for 2016, 2017, as well as stage 3. I'll host another webinar in January to go over the 2016 requirements, which will be a little bit different. I think it's important now to just focus on what we need to do in the next 3 months.

I am further breaking down the presentation into 2 different sections. First, I'm going to focus on the requirements for providers who have been participating in the EHR Incentive Program for at least 3 years. That means that they first met Meaningful Use in 2011, when the program first started, 2012, or 2013. These sets of providers have certain criteria they have to meet. The other providers that just started participating last year or are going to start this year, they have the same overall requirements, but they're giving additional exclusions. They have a little bit of more lenience to do.

I did post a disclaimer here. I feel that there are 752 pages in this final rule. I can be the first one to tell you I have not read all of them. I focused on what the requirements are for 2015 to 2017, but still the language that CMS writes in there can still be confusing and hard to follow. We have asked for some clarification for some of the writings in there, and I'll talk about that later.

Briefly, I just want to start with the history of the EHR Incentive Program. It all began in 2009, when President Obama said, "I want all Americans to have access to their EHR by 2014." Have we met President Obama's goals? The answer is no, but we're well on our way. I do believe three-quarters of EPs, eligible hospitals, and critical access hospital do have EHRs right now. They're not all labeled to meet all the Meaningful Use measures and [inaudible 00:06:39] in the program, but at least they're implementing that.

Back in 2009, Congress passed a law and allotted money to allow the Office of National Coordinator for Health Information Technology, which you may have heard referred to by the acronym, ONC. They put them in charge of the program with CMS, and they

developed regional extension centers, sometimes called RECs, that were around in almost every state to help providers find the right EHR, implement it, and then eventually get them to Meaningful Use. The most current data shows that over half a million of EPs and EHs use an EHR.

Okay, getting on to incentives and penalties. In addition to the funding that the HITECH act gave to the regional extension centers to set them up, CMS allotted incentive money to reward the providers that were able to meet Meaningful Use. Over 5 years, if they participated in a Medicare program, they could get $44,000. If they had a large Medicaid population, they could get $63,750 over 6 years from the Medicaid program in their state.

Next year is the last year that Medicare will be able to give incentives for the Medicare professionals, however, Medicaid, the incentive program goes on until 2021. The provider can only get payments for 6 years. To date, CMS and Medicaid have paid eligible professionals and hospitals over $31 billion.

Okay. The program was designed like other Medicare programs. I'm sure most of you have heard about PQRS. When that started, it was like a carrot and stick approach, meaning that the carrot or the incentive money was used initially to get people to participate in the program. They slowly decreased the amount of the incentive, and then they implement the stick, or the penalty towards the end of the program, meaning everybody should be on board by now. If you're not on board, you're just going to have those penalties.

With the EHR Incentive Program in 2013 was the first year that if a provider did not meet Meaningful Use in 2015, meaning this past January, their pocketbook was affected, and they had a penalty applied, a 1% penalty for not meeting Meaningful Use. If providers did not meet Meaningful Use last year in 2014, then on January, you are going to see a 2% penalty in your Medicare Part B payment for not meeting Meaningful Use.

This is in addition to the other Medicare programs that you're working on, PQRS reporting. That is an automatic 2% penalty if you don't participate in that. Then CMS came up with the Value Based Modifier, which is adding another 2% to 4% penalty based on your PQRS outcome.

Potentially, these 3 programs could really affect your pocketbook. Part of the QIM program that we're working on with practices is to get you to participate in all these programs, not only because they all affect patient care and improvement, but also because they do affect the business aspect in that you are penalized.

In this past April, CMS passed this new law, the Merit-Based Incentive Payment System, MIPS. It's going to go into effect. The law is called the Medicare Access and CHIP Reauthorization Act of 2015, called MACRA. I just wanted to tell you about that because what that basically is going to be doing is CMS is going to combine the 3 current reporting programs of Meaningful Use, PQRS, and the Value Based Modifier, into this

program. In addition, they're adding a new category to look at providers called clinical practice improvement.

What they're going to do is take these 4 categories, come up with a 100-point score. Every eligible professional, remember this is at the individual level, not at the practice level, they're going to come up with a 100-point score. Meaningful Use will make up 25% of the score. What we want to do is make sure that you guys can meet Meaningful Use because then you will automatically lose 25 of the 100 points and be down to 75% at that time. I don't have all the details. That hasn't been finalized yet, but just know that it will impact your finances in the years to come.

Let's get talking about how to meet Meaningful Use this year because remember, if you don't meet Meaningful Use this year in 2015, you will automatically have a 3% penalty if you don't meet it. The final rule, I think I already said, was released on October 9. It takes a couple days to get that published. It was published in the Federal Register on October 16.

It does include two parts. One part is totally final, and that is what we're going to go over today, the requirements for eligible professionals and hospitals to meet Meaningful Use in 2015 to 2017. CMS also wrote a huge section of that 752 pages to talk about stage 3. However, the part dealing with stage 3 is not finalized yet. That section, if anyone wants to read that, you are more than welcome to submit comments, and comments are open for 60 days, which has a deadline somewhere in mid-December.

Then CMS of course will read those comments, and then I would think in January, February, maybe even in March, they will pass another final rule, which will have all the stage 3 requirements. This next screen, the final rule, what I did is break down the 10 requirements that everybody has to meet, just as a little tip sheet to help you go to the pages if you want to look up one of the Meaningful Use measures in detail. That might be handy.

Okay, next slide, 2015 reporting period and stages. As I mentioned, everybody is going to have a 90-day period for this year. Nobody has to worry about a full reporting year. The last possible dates to use for 2015 are October 3 to December 31. If you want to keep that in mind, you can go ahead when you set up your dashboard reports, you could start your reports with the starting date of October 3 through 12/31. Then if you want to run your reports weekly to see how you're doing, that would be the best bet.

If doesn't mean you can't use the reporting period prior to this, but the only way you'd be able to meet Meaningful Use is if you can meet all the requirements that just got passed, you can meet all of those. Almost everyone that's been participating for the EHR program for 2 or more years, will probably have to use these October 3 to December 31 dates, unless they've been reporting to two registries, which is required for 2015.

If an EP just met Meaningful Use for the first time last year or the starting this year, the requirement is they're only going to have to report to one public health register. They

can probably use a different reporting periods. As I said, it doesn't matter, just 90 consecutive days.

The final rule completely eliminated stage 1 and stage 2 measures. If you a new dashboard report right now, you're going to have, especially for those in stage 2, it's going to list 17 measures or core, and then they'll list 6 menu measures. All of that terminology has gone away. Several of those measures have been eliminated. CMS felt they were [top top 00:15:06] meaning that they had really high compliance rates. They didn't feel it was worthwhile to continue monitoring them. Then some of the measures went away because they were redundant or they built them into one of these other measures.

Even though you can create that dashboard report now, what we'll be looking at are just these 10 objectives. You can ignore the other ones that this time. CMS is calling the new criteria modified stage 2 criteria. Basically, what it is, is the 10 objectives, and everybody has to meet them.

You're vendors are working like crazy right now to change the dashboard reports to coincide with the new requirements. I'm sure each of you will receive notification from them when the new dashboard reports are ready. In the meantime, I'll show you. We have some tools at the QIN. Report cards, where we can go ahead and plug in what the current dashboard report says, and plug it into our report card to show where you do stand.

All right. Time to get started. We're going to go through these 10 measure in detail. Hopefully, we'll have a better understanding after this. Objective 1, protect PHI. The requirements for this are pretty much the same as last year. Every practice has to have a manual privacy and security risk assessment done on an annual basis. To meet this measure for 2015, the privacy and security assessment must be done between January 1, 2015, and the date of attestation. Notice that it does not have to be completed by December 31, but I do recommend that you try to get it done before the end of the year.

The way CMS wrote it is as long as it's done before you attest, the currently attestation deadline for 2015 is February 29 of 2016. That gives you an additional two months at the beginning of the year to get that done if haven't. Like I said, it's recommended to get it done earlier.

There's really specific criteria involved in this privacy and security assessment. If your vendor tells you that the EHR has privacy and security features built into that meet Meaningful Use, that is incorrect. You have to have the full assessment done. It's a huge involved process. The HealthIT website has some suggestions of what needs to be done.

I also want to just tell you, put in a plug here, that the regional extension centers in all 5 of our states, they offer this service of performing a privacy and security risk assessment for all the practices in our states. There is a fee involved. You do not have to be a regional extension center client, and we would do that for you.

I also wanted to let you know that in August, we hosted a webinar by the privacy and security assessment specialists in the states of Delaware and Pennsylvania. They talked about the requirements. You can access the recording for that webinar, the transcript, and the slides on our Quality Insights website. Next slide will show you the email addresses for all 5 of our states and who you can contact if you want to have a privacy and security assessment done. Note that there are no exclusions for this measure. Everybody has to do it.

Next slide. We are at objective 2, which is clinical decision support. In order to meet this objective, you have to do 2 things. One is implement 5 clinical decision support interventions related to 4 or more of the clinical quality measures that the individual EP is reporting. Remember that in addition to meeting these 10 objectives that we're going over right now, providers also have to meet the clinical quality reporting requirement for the EHR incentive program. That didn't change, and we're going to go over it at the end of this webinar.

Basically, everyone is required to attest to 9 clinical quality measures. CMS approved a list of 64 of them, which we'll go over. This clinical decision support objective number 2 requires you to implement work flow based on at least 4 of these clinical quality measures. The purpose of this is to of course help your providers improve their compliance rates by having those clinical decisions support interventions in place. It will not only improve patient care, but if you think about, this is going to help improve the clinical quality measure score, which is the probably the same clinical quality measure that the providers are using for PQRS. Therefore, you can avoid the Value Based Measure penalties.

The higher your percentages are, the chances are that you will be penalized. CMS is doing the pay for quality now instead of pay for performance, so we want to improve our care all around. Most vendors have built-in clinical decision support intervention, but you may have to enable them to be counted for this measure. If your vendor does not have dashboard report for clinical decision support, be sure to take screen shots of the tools that you are using at the beginning of your reporting period, as well as at the ending of the reporting period.

I'm suggesting this so that you save the documentation, and you have it in case you are audited down the road. CMS has 6 years to ask you to be audited for Meaningful Use. As a matter of fact, they are currently auditing some providers in some of our states for what they did in 2011. Expect to be prepared and have this done when you're actually working in the reporting period.

In case you don't know what a clinical decision support is, it's basically like a pop-up or an alert. If a patient has a diagnosis of diabetes, the EHR can have an alert to remind the provider to order a hemoglobin A1-c or recommend an eye exam. Another example could be that if it's flu season, there could be a pop-up to remind to offer a flu shot in that time.

The second part of this measure, remember, you have to meet both of them, is really easy to meet. All it's stating is that drug-drug and drug allergy interaction checks must be enabled. This is built into the functionality in order for the EHR to be certified. You just have to make sure that never gets turned off, and you can definitely meet that part of the measure. There is an exclusion for the second part of the measure, however. If a provider does not write at least 100 prescriptions in the reporting period, they can actually claim an exclusion for that part.

All right. Next screen. We are going on to objective number 3 which is CPOE. There's 3 parts to this measure, and once again, you have to either meet all of them, or be excluded from each or any of them. If we are looking at computerized provider order entry for medications, labs, and radiology, the measure rates for medication orders you have to have more than 60% using CPOE. For labs and radiology, it's greater than 30% using CPOE. Both of these can have exclusions. If your EP does not write at least 100 med or lab or radiology orders during the reporting period.

All right. Next screen. Now we can move on to e-prescribing. This is objective number 4. This also has 2 parts to it. One part is that at least 50% of permissible prescriptions written by the provider are, number 1, queried for a drug formulary, and number 2, they have to be transmitted electronically. The exclusion for this is if a provider does not write 100 prescriptions during the reporting period. He can be excluded. CMS also added an exclusion for rural practice that doesn't have a pharmacy within 10 miles that can accept electronic prescriptions.

I think this has been around, even e-prescribe was around, as a Medicare program before the Meaningful Use program came into effect. Most providers are in good shape with meeting that measure.

All right. Objective 5. This was formally called in summary a care objective for providers that previously attested. They now have renamed it and called it the Health Information Exchange objective. Basically, it involves transitions of care out of your providers' office. Remember that this is going out of. Basically, it involves when your provider transfers the patient to a different level of care, such as sending them to the hospital or the emergency room, or when the provider refers patient to another provider, such as a specialist. It can be the setting or the provider, and transferring out of the practice.

It has 2 parts that have to be met. One is the certified EHR must create a summary of care record, and all certified EHRs can do this. That part should be met. The second part of this measure is the one that is giving people a lot of problems, and this is that summary of care records, which might be the referral form, whatever you used to call it, has to be transferred electronically to greater than 10% of the transitions of care during that reporting period.

This year, in 2015, because we have a 90-day reporting period, maybe some of the providers will be able to take an exclusion to this measure. If you have less than 100 referrals or transitions of care, you can claim an exclusion. However, if you're a busy primary care practice, you might be referring a lot of people to cardiologists,

endocrinologists, whoever, and you won't be able to claim that exclusion. In that case, you do have to send summary care documents electronically.

You can do that one of two ways. One is to use something like direct messaging. Some EHR vendors have a certain program built in their EHR to send secure encrypted email messages. For anyone who has clinical work, I think their program is called the Peer-to-Peer program. That's where you can send PHI from one provider to another, but it's totally secure.

The other method to meet this measure is to utilize what is called a health information service provider, a HISP. They can assist you in sending PHI from one provider to another. There are two ways. I think direct messaging is the most common. It probably has the least amount of cost involved, but the huge challenge here is that many EPs are having difficulty meeting it because of a lot of EPs in all of our states don't have direct messages. It could be because they are not participating in the program, so they need no need to have to do this. Why should they have to go through all this trouble? They might not even have an EHR.

CMS read a lot of comments where providers are having difficulty, but they did not lower the threshold. They kept it at 10%. One of the hints we can give you is that you can try to identify referrals in the EHR in a different way. In other words, you may indicate a referral as sending a patient to a specialist for the first time, but if your provider recommends that at patient follow-up with a specialist that they've already been seeing multiple times, just say a cardiologist, that the patient needs to see every 6 months or whatever, check your work flow and see if the provider is identifying this as a referral.

It really isn't a referral at that time because the patient has seen the specialist before. This may cut down on the number of referrals for this measure and may help. The other hint is to even though providers might have, what I want to say, their favorite specialist that they refer their patients to, just say in your area, almost all of your cardiology patients go to one or two different practices. You may have to expand that horizon and give your patient the option to see a different cardiologist from a different practice that has a direct messaging if you run into a problem.

Like I said, CMS is aware of the barriers. What they have done is they have put some federal funding to multiple states and organizations earlier this year that are looking at improving health information exchange across the country. Even though we're struggling with this now, hopefully, in the next year or so, there won't be a problem, or as much of a problem.

Moving on to objective 6, patient education. This is the same objective that was in stage 1 and stage 2. Basically, more than 10% of all unique patients seen during the reporting period are given specific patient education resources, and they have to be identified by the EHR. It can't be a handout you have in the office that you've been using. You will not be getting credit for that. It doesn't mean you can't give it. It's just that you will not get credit for that measure for that.

CMS has an exclusion here that really doesn't make sense. It states if EP has no office visits during the reporting period is excluded, but if you didn't have any office visits, you wouldn't be able to do Meaningful Use. I'm not sure about that one.

All right, moving on, we are now at objective 7. We're getting through them quickly. This is medication reconciliation. This is also the same objective that CMS had for stage 1 and stage 2. They just moved it around a little bit. This involves patients that are transitioned into the care of your provider. Remember, it is the opposite of the summary of care objective. That one, you have to use the summary of care and send it electronically is for people leaving the doctor's office. This is for people coming into your office.

The requirement is that a provider performs medication reconciliation for greater than 50% of transitions of care. If a patient comes in and was recently seen by a specialist, or if they were at their urgent care center over the weekend, or just discharged from a hospital, your provider should be comparing a list of the meds that the patient was on prior to this office visit, and compare it to a list of the meds the patient is on now and reconcile the list to make sure that the EHR is updated to reflect the most current meds the patient is on. This can change quite often.

It's actually pretty good protocol to follow this plan of med reconciliation for every office visit. If you do it every time, you're sure to have an accurate medication list. Not only that, you'll have 100% compliance rate with this measure, even though you only need 50%.

All right. We're up to objective number 8, patient electronic access. This is one of the measures that requires that every provider has to have and utilize a patient portal. If you recall, if you were in Meaningful Use last year, you had to have a patient portal starting then. There's two parts to this measure, and both have to be met. One is that over 50% the patient seen during the reporting period, so remember it's not your entire population. It's just during that reporting period. They have to have access to view, download, and transmit their information. In other words, they have to have access to a patient portal.

The second part is that the EP must make this information available within 4 days of an office visit or when the EP receives [inaudible 00:33:02] radiology results. The vendor behind the scene has that done seamlessly, so that that information automatically goes to the portal. As far as meeting this measure of more than 50% have access, you really need to check with your vendor to see if you could credit by just sending out an invitation, asking the patient to register, or if you only get credit if the patient actually registers. Once again, that's something that it varies vendor by vendor how you get credit for that.

The second part of the requirement is to have at least one patient utilize the portal during the reporting period. If you recall looking at the stage 2 criteria before this was published, a lot of providers were very anxious because it was difficult to get 5% of them to actually use the portal. CMS realized that this was going to be difficult to do, so they

did lower the threshold, and you only have to have one patient to utilize the portal during the reporting period.

Once again, if you're using October 3 to December 31, just make sure one patient uses that. You can do it during an office visit, or however you please, but just get that one done. There are a couple of exclusions, if the doctor doesn't write any orders, or med lists during reporting period. Another one is if there's limited broadband access.

Okay. We are onto objective number 9, secure electronic messaging. This objective is easily met in 2015 because all certified EHRs and patient portals have the functionality so that a provider and a patient can email each other. That's part of the program of having a patient portal. For 2015, no one even has to even send a message. All CMS said was that you have to have that functionality completely enabled.

They are changing the focus. They recognize that before, the way it was written last year, is that providers had to get patients to send them a message first. CMS realizes that really wasn't fair to the provider to be at the mercy of their patients. They are turning this around, putting the responsibility back on the provider, so when the time comes where there is a threshold for this measure, it will be the provider contacting the patient initially. For this year, all you have to do is have that functionality.

Get a screen shot of this at the beginning of your reporting period, and at the end, to show that you have that functionality enabled. There's exclusions again, restricted broadband and someone that didn't have any office visits, which again, doesn't really make sense.

All right. Now we are at the objective that is giving most people headaches because it really isn't clear the way it's written in the final rule. This is objective number 10, the public health reporting objective. We really need further clarification from CMS. Several questions have been submitted from all kinds of organizations, mainly regional extension centers, QINs, vendors. Public health departments. I know Medicaid has written then, and even some of the registries have sent in questions about this measure to CMS. Of course, we don't have any answers yet.

What I'm going to do is review what I think is correct. Know that I could be wrong, but we really need to wait for clarification from CMS. This objective includes the fact the EP has to be in active engagement with the public health agency or a clinical data registry to submit electronic data from certified EHR technology. I think what we need to do is looking to what CMS defines as active engagement.

There's really 3 different choices here. As long as you meet one of them, then you're going to be okay for being able to meet part of this measure. Active engagement can include completed registration to submit data. You're in the testing and validation phase, or you're in the production phase. Option number 1 state that the EP must complete the registration process to submit data. Note that I say that they have to complete it.

The way to accomplish this is you have to within the first 60 days of the reporting periods send a request to a registry or a public health agency, telling them that you are interested in reporting to that agency or registry for 2015. If you're reporting period is going to be October 3 to December 31, the registration process must be completely by December 2. That gives you plenty of time. What you'll need to do that we go over in the next couple of screens is look at those registry lists and figure out who you want to report to.

If any of you are already reporting to a registry, which means that you've completed this process prior to the reporting period, of course, that's perfectly fine too. If you submitted your intent to register and submit data to a registry prior to your reporting period, that's perfectly fine too.

What you want to do is save a confirmation by the public health agency or registry that they received your request. You will need to go to their website or contact them. They probably all of different registration processes, whether it's just filling out a form, or you're just going to deal with emails back and forth to each other. Just keep that document aside so that if you attest, and that's the phase you're in, you have that documentation if you're audited.

Okay, option number 2. This is where you progress, and the agency has actually sent you, the provider, an invitation to begin testing. If you've got that email from the registry or the agency, this is the option you should pick when you attest. Check your spam mail. Make sure that you get this communication from the public health agency or registry. You are responsible for responding to that request within 30 days to begin testing.

CMS is allowing the public health agency or registry to send a second invitation to the practice, but if the provider does not respond to the second invitation in the next 30 days, then you cannot meet this measure, which means you cannot meet Meaningful Use. Once again, overall CMS is allowing you 60 days to respond to the public health agency or registry to begin testing once you get that initial notification. You need to look for that once you send out your letter of intent.

The public health department and the registry have been instructed that they're only going to send those two messages. They're not going to keep contacting you to say, "Do you want to start testing now? Do you want to start testing now?" Once again, check your email. Make sure you get that done.

Option number 3 is production, and that's the last phase. That is after testing and validation are completed. You're actually submitting data. As long as you're in any of those phases, then you're okay to meet these measures. Now we need to get into the nitty-gritty of what these different registry reportings are.

There are three options. If you're a provider that has been participating in Meaningful Use for at least 2 years, then you have to meet 2 of these 3 measures. One of them is

reporting to an immunization registry. The second one is reporting to syndromic surveillance, and third is a, quote, unquote, specialized registry.

Option 1 is the immunization registry reporting. That means the EP is any type of active engagement, whether they're just registering, or they're actually submitting it, that part doesn't matter. They have selected to report immunization data to a public health agency. There are some exclusions to this measure. There's a lot of specialists out there that don't administer immunizations, or what if someone just doesn't administer any immunizations during that 90-day reporting period? That would be an exclusion.

Number 2 is if you operate in a state or a jurisdiction for which the immunization registry can't accept data from your EHR yet, and I'll give an example. In Delaware, there's currently, I think, between 10 and 12 vendors that can send immunization data to the Delaware Division of Public Health. None of the other vendors can. If I had one of those EHRs that wasn't already submitting, then I would be able to claim that exclusion.

The third exclusion is basically saying that state public health immunization registry can't accept immunizations yet from anybody, from no vendors. I'm not even sure if that's even still applicable in any states or not. When we first started the program, there were plenty of states that only took them a while to get them up and running.

Option number 2 is syndromic surveillance reporting. Syndromic surveillance has been done by emergency rooms and hospitals in the past, but CMS has included this for providers and division offices now. The problem is that not many states are ready syndromic surveillance yet from practices. Once again, we have a lot of exclusions for this. Basically, they're the same 3.

Number 1 would be maybe your specialty doesn't even include capturing syndromic surveillance data. Number 2 is your EHR can't report it yet to the state agency, but maybe others can. Third is your state can't even accept it. If we go to the slide, slide 28, you'll see as of October 15, there really are only 17 states that are accepting registrations for syndromic surveillance reporting. If you look at the list, out of our 5 states in our network, Pennsylvania is the only one on that, that is accepting that.

That takes us back to the specialized registry reporting. This is the part of the rule that needs a lot clarification from CMS. Basically, the provider has to be in active engagement to submit data to a specialized registry. CMS doesn't want to give us a black-and-white list and say it has to be one of these. They want to give you providers flexibility to report to a registry that is most relevant to your practice. It can be to a public health agency. It could be a national specialty society, a patient safety organization, a quality improvement organization. There are numerous entities where it says that if your EHR is certified and can submit that way, then they'll accept that.

Some examples are cancer registry, birth defect registry, diabetes, all different other kinds of chronic care. Health care associated and infection registry. One of the things to note though is that the individual EHR vendor has to be certified to be able to do that registry. It's not as if you can go ahead and enter data into the registry site. That defeats

the purpose of what Meaningful Use is. We're trying to get that information to flow electronically from the EHR to the registry, and there's a process and certification criteria that will have to be followed.

I know several vendors can't report to the cancer registry yet, but there in the process of trying to let their clients do that. As soon as they can get that cancer registry certified, that will be an easy option to meet the s specialized registry. I have a link down here at the bottom. The American Medical Association actually created a listing for the national quality registry network. There's a lot of registries on there.

We have heard that some vendors are contracting with a third party, and they're going to offer registry options to their clients for a reduced rate, so that it won't cost you as much as if you deal with that registry individually. I really recommend you talk with your vendor to find out what the plans are to meet this measure. If you go out on your own and just contact the registry and set that all up, it might cost you thousands of more dollars than it needs to be.

We've also learned recently that New Jersey HITECH, which is the regional extension center in New Jersey, they plan on launching a registry to meet this specialized registry objective, and they will open it up to all states. You don't have to be in New Jersey to report to them. As we get more information on all of that, we will share that.

Next slide. The exclusions for this objective are basically … I'm going to go over 2 and 3 first. This is stating that there isn't a registry capable of accepting electronic registry transactions, from that certified EHR at the start of the reporting period. Another one is that there aren't any registries ready to accept from anybody. Okay, so that doesn't exist, or has moved.

The first one is that a specialized registry does not collect data relative to or associated with any disease or condition that EP diagnoses or treats during their EHR reporting period. Since there are registries available for primary care providers and most specialists, this may not be an easy exclusion to claim. I'll repeat that again. Chances are, there is going to a registry out there that you can use, even if it costs you some money, but it's out there.

Registries and vendors are going to charge you fees, setup fees, monthly fees. CMS will not accept cost as a reason not to participate. That's what they said over and over again. If it really is a hardship, we can talk about submitting hardship exemptions, but that's where they stand right now

Slide 31, what I did was I stated that eligible providers participating in years 2 or more, they have to report to two registries to meet this objective. I think I've listed all the possible scenarios below. Someone could possibly be reporting to both immunization and syndromic surveillance, or immunization and one specialized registry, or syndromic and specialized.

When we get down to number 5, you'll see that they were only reporting to one, immunization, but they could be excluded from the other two. That's okay. They can claim one as an exclusion. Number 6 is the same thing, and 7. If you can do one, but you can definitely exclude yourself from the others.

The other thing to remember is with specialized registries, you can report to more than one specialized registry to meet this measure, meaning you can report to two separate registries and not report to the immunization, and not report to syndromic surveillance, and you'll meet the measure. You can only claim an exclusion to meet this objective, if you could be excluded from two of the other three. The only way to claim exclusions, two exclusions to meet this measure, is if you can be excluded from all three. As I said, since there are a lot of registries out there that are important to a lot of practices, it will be difficult to claim two exclusions.

All right. I'm getting short on time. I'm going start buzzing through these now. Slide 32, this is just a snapshot of a tool that Quality Insights developed to help us measure providers' progress to meeting Meaningful Use in 2016. What I've done is on slide 32 this is a report card for providers that have begun participation in 2011, 2012, or 2013.

If you look at slide 33, that's a tool for providers that just began last year or are starting this year. The difference is although those same 10 measures are listed, you see a lot of shaded areas with the word exclusion above them. That's because CMS is allowing a lot more exclusions to the providers that are new to the program. This coincides with what they did when they progress from stage 1 to stage 2 criteria. These providers are just getting their feet wet, so let's only make them do a little bit, and then we'll fit them into the pool farther next year.

Okay, starting on screen 34, what I've done now is taken those same 10 objectives, and I have the measures down for providers that just started last year or this year. It may or may not applicable. You have to remember when you started reporting, what year. I'm just going to go through these really quickly.

This measure for PHI, there is absolutely no change. Everybody has to do the same thing. For objective 2, clinical decision support, the guys that are new to the program, they only have to do one clinical decision support rule. Objective number 3, CPOE. All they have to do is have more than 30% of their medications using CPOE. They don't have to deal with labs or radiology because those didn't exist then.

Slide 37 is e-prescribe. It's the same measure, but just with a lower threshold. Instead of 50%, it's 40%. Objective 5, you'll see you can be automatically excluded from this measure because it didn't exist in state with the other providers started. You can have an automatic exclusion. I do want to note that it doesn't mean you can't attest if you meet this, but you can claim the exclusion and CMS would not question it.

The same goes with the next slide, objective 6, patient education. This shoots to be one of the menu measures, which was an optional measure. CMS said if you're in your first or second year this year, you can claim an exclusion because you may not have picked

that on. The same thing with objective 7, medication reconciliation, you could be automatically excluded because this used to be an optional measure.

Okay, for objective 8, patient electronic access, this basically is the same that you have to have 50% of the people sign up to use your portal. People have to be seen during the reporting period. You don't have to have anybody actually log in and use that. You're excluded from that part. Objective number 9, secure messaging, you're excluded from that. You don't have to worry. Since you have the portal, you do have functionality, which is all that anybody needs. You can have an automatic exclusion.

Then for objective 10, the public health reporting measure, the providers that just started, we still have those 3 measures, but these providers only have to do 1 out of 3. You can do immunization or syndromic surveillance or specialty. Then you can claim an exclusion if you can be exclude from all 3. Like I said, it's a little bit easier on those guys because they're new to the program and getting used to it.

Slide 44. I just want to touch quickly. I did refer to this earlier that clinical quality measure reporting is still a part of the requirement for Meaningful use. There is absolutely no changes to that. Providers have to select 9 measures from 3 of the 6 different domains. They encourage you to not pick measures that have zero in denominators, meaning that you didn't see any patients in that population. You should really take a look at whatever your new dashboard report is, and pick the measures to report that have the highest percentage rate. Remember you have to pick clinical decision support rules based on these.

The reason why you want to go ahead and pick the ones with the highest percentage is it not only improves patient care, but it's going to help you get a higher Value Based Modifier when they look at that. You have the least likelihood to have a penalty for that.

Slide 45 is just another Quality Insight tool. It's a snapshot of the 64 clinical quality measures that CMS approved. All right. Slide 46. This is showing you the report card section that has to do with the clinical quality measures. We can put in the national quality form number and the percentage rate so you have that handy.

Slide 47, attestation. CMS, because they have just finalized these rules, they have to change their whole attestation program in the registration attestation system. That part is down right now. You cannot access that. They have stated that they will not reopen it until January 4, 2016. As of right now, if you want to meet Meaningful Use and attest, you will need to do that between January 4 and February 29. However, CMS has issued extensions in several of the previous years when it gets closer to the deadline. Chances are, it will be extended. At this time, however, in law, it's February 29.

This slide is showing you. This is part of the Meaningful Use webinar that CMS hosted last week. Basically, they just wanted to tell you that we realize we were really late in giving these requirements. If you really can't meet Meaningful Use in 2015 because CMS' implemented this publication so late in the year, can you apply for hardship exemption and the answer that CMS gives here on their website is absolutely yes. If you

find that you're trying to, and you just can't meet it, you can go ahead and submit a hardship exception. There's a category called extreme and uncontrollable circumstances. You'll be able to write a narrative and explain, "I tried this, that, and the other, but I wasn't able to meet it."

CMS reviews each hardship application on an individual basis, and they do have a rate of approving 85% of the applications. What that means is that if you can't meet Meaningful Use, and you submit a hardship application, and they accept it, you will not be penalized the 3% for not meeting Meaningful Use. You save yourself that in 2017. However, if you have been participating and were due for an incentive this year from meeting Meaningful Use, you would forego that. You wouldn't be able to get that, but you still saved money from the penalty.

All right. Real quick, Meaningful Use reporting in 2016, my plans are to go ahead and have that in January or early February because some of these 2015 exclusions are no longer offered, but I think we need to concentrate on what we have to get done in the next two months first. The same thing with 2017 and beyond, that part of the rule hasn't been published yet. We will definitely let you know once it's finalized

Slide 51 is just asking some questions about where you are right now. What you need to think about. Hopefully, you've selected your 9 clinical quality measures. Make sure that they represent 3 different domains, and make sure that they have non-zero denominators, probably with the highest rates. That's what you want to look at. Make sure that you've implemented 5 clinical decision support interventions based on those clinical quality measures. The rule in regulation is that those tools, those clinical decision support rules have to be in place the entire reporting period. Hopefully, whatever you pick and implemented, you've had since October 3, which was what, 17 days ago.

Okay, another thing, ask yourself have you had your privacy and security assessment done? It's not pick up the phone or email someone to get that scheduled. Another thing, do you have a direct email address? Contact your provider to get the ball rolling so you can start sending that summary of care document if you have a lot of referrals. The other thing is, do you have direct email addresses for the providers that you refer your patients to? That's a good thing to start collecting.

The other thing to think about right now is what two registries are you going to report to? Can you do immunization? Can you do syndromic surveillance? If not, start looking at what registries are out there, and get your letter to intent settled.

On slide 52, I just want to say that Quality Insights, what we're doing is we're offering assistance to help providers. We're still accepting practices to join our projects. This week, we're actually opening a new members-only portal. What we'll be doing is we'll be posting a lot of these tools and resources, things like that, as well as easy access to the CMS tools. We have newsletters. We'll have a discussion forum and an EHR vendor-user group, blog. We'd love for you to join us.

On slide 53, you can find the contacts for someone in each of our 5 states that we hope you can reach out to them if you want any type of assistance. We'd love to have you join this project. I apologize profusely. It is 3:01. We have not had time for questions. Laurie, can we extend this, or what should we do?

Laurie Fink: We can, if people would like to stay on the line. We have had a bunch of questions submitted in the Q&A, so I can go ahead and start reading some of those to you.

Kathy Wild: Sure.

Laurie Fink: How many we can get through.

Kathy Wild: Okay. Let's do this. We will answer questions for another few minutes, and then I will make sure that every question that is submitted in the Q&A or in the chat box gets answered. What I will do is collect all them, write answers, and then I will post a little attachment to the webinar recording or the PowerPoint presentation with all the questions and answers so you can use that.

Once again, I apologize. I didn't realize that I was going to be talking so much, but I just wanted to go over everything thoroughly. All right, Laurie, you can start with the first question.

Laurie Fink: Okay, sure. First question was must you maintain screen shots for each individual provider in your organization for audit purposes? Or do you just have to show your system capability by using one provider as an example?

Kathy Wild: Okay. The EHR incentive program is based on individual, meaning Meaningful Use. It is highly recommended individual screen shots. Now, with some of them, with the functionality, you can do it for your practice really either way would work. Create a file for each provider so that you have a copy. It really could be either way, but just remember what happens when a provider's notified that they're being audited. Sometimes you might have a practice with 6 doctors and only 1 is audited. You would have to know where that documentation is for Doctor X if you put it in another area. If you have it labeled correctly, then it should work.

Laurie Fink: Okay. Another question asks, do you have to direct message to another direct message address?

Kathy Wild: No. As long as it's using a secure, encrypted email, then that's okay. Different vendors utilize. It might not have direct after it. Like I said, each vendor might have a different program to do it. It just can't be regular email to a regular email.

Laurie Fink: Okay. This question is in reference to objective 10 about public health reporting. It asks, do we need 1 or 2 registries?

Kathy Wild: Two. It depends on where you are in the EHR Incentive Program. For providers that just started last year, or this year, with their very first year, they only have to meet 1 out of

the 3 public health registry, which means either immunization, either syndromic surveillance, or 1 specialized registry. If they've been in the program for more than 2 years, you have to pick 2 things. You have to tell CMS you're doing 2 things. I suggest that you look at that scenario, so it could be immunization plus a registry. If you don't give immunizations, and you can't do syndromic surveillance, then yes, it will have to be 2 different registries.

Laurie Fink: Okay. This is question asks, we are a multispecialty practice. Do we have to register to a registry that will be applicable for every specialty we support?

Kathy Wild: Once again, you have to look at this from the aspect that it is an individual program. If you can find one registry that can collect data from all of the providers in your practice, even though maybe one refers to diabetes, the EHR will be pulling data from that. Another one might be looking at heart failure or something. That would probably be more bang for your buck that way. Each individual provider has to be doing this.

You're going to have to be doing some research, and I think there are some out there. There are some registries out there that can accept for multiple different specialties. If you look at that inventory, I gave the link. The AMA created that inventory of registries out there. There's a couple on there that apply to almost all specialists. I would suggest working with them, and then that would meet the requirement for all those providers in that practice.

Laurie Fink: Okay. Next question. Can we register to the cancer registry and complete the intent to submit even though our EMR does not have an approved interface connection with them? Our practice believes that this registry provides useful information.

Kathy Wild: Okay. As far as I know, no, you can't put a letter of intent in until the EHR vendor … Actually, let me … I'm not going to answer that one because I'm not positive. That's a good question. Okay. That's one I'll do research on, and get back to. I'm really not sure.

Laurie Fink: Right. If we were a specialist and have never administered immunizations, even if our EHR can transmit immunizations to our registry, then can we be excluded?

Kathy Wild: No. You can't claim an exclusion. You have to meet two of the measures. The only way you can be excluded is if you can't find 2 specialized registries to report to. You can't pick one of the specialized registries. Just say if it was an oncology office. You found an oncology registry. You don't do syndromic surveillance, or your state doesn't let you, but you don't give immunizations. You can't pick the exclusion unless you can definitely tell CMS that there is not a second registry out there.

Once again, this is where we really need CMS to clarify about these public health measures, if you see most of the questions are involving that. I really don't want to steer you wrong, but what I've heard so far is that they're not going to accept an exclusion to meet one of those two measures very easily. Maybe when they respond to all these questions, they'll change their mind, but as of right now, I would say I don't believe so.

Laurie Fink: Okay, and I'll ask you one more question, Kathy, and then we'll probably have to wrap things up. As Kathy mentioned earlier, if we didn't get to your question, we will definitely put together some sort of a fact sheet that addresses all the questions that were asked. Our last question here is if your vendor provides the proper report, can you retroactively report on an earlier reporting period in 2015?

Kathy Wild: Yeah, absolutely. If you can run a report right now and look at your measures from January to March, and now take what is required right now, but pull the data from then, and you meet all the measures, absolutely. Like I said, I can think that providers in their first or second year are going to easily be able to do that, but providers in their second or more year, unless they're already reporting the two registries, then they might not be able to.

If you were on top of things, and in January, you were reporting immunizations into a registry, then you very well could too. Once again, I think the hang-up on that is going to be where you stand with your public health measure, and where you stand with your summary of care. I think those are the two measures.

Laurie Fink: All right. Thank you so much, Kathy. Thanks, everyone for joining us today. We hope you found this information helpful, and if you have any questions, please reach to your state Quality Insights Health IT lead. I'll go ahead and go back to that slide so you can get their contact information if you do not have it already.

Please not that we will post the presentation slides and the recording of today's session on our website. You'll be able to access them at www.QualityInsights-QUN.org, and they'll be under the events tab as an archived event. There will be a very brief evaluation at the close of this session. Please take a minute to complete it. Your input helps us plan future programs.

With that, I'd like to thank you again for taking time out of your day to join us for this session. Have a great rest of your day.