Meaningful Use
New 2014 Requirements
October 2014
CMS 2014 CEHRT Flexibility Rule Overview

» CMS published final rule on August 29

» Effective Mid-October

» Rule provisions:

  – Allows providers to meet meaningful use with EHRs certified to the 2011 or the 2014 Edition criteria, or a combination of both Editions for an EHR Reporting Period in 2014


  – Extends Stage 2 through 2016
New CMS rule allows flexibility in certified EHR technology for 2014

<table>
<thead>
<tr>
<th>If you were scheduled to demonstrate:</th>
<th>Using 2011 Edition CEHRT to do:</th>
<th>Using a combination of 2011 &amp; 2014 Edition CEHRT to do:</th>
<th>Using 2014 Edition CEHRT to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 in 2014</strong></td>
<td>2013 Stage 1 objectives and measures*</td>
<td>2013 Stage 1 objectives and measures* -or- 2014 Stage 1 objectives and measures*</td>
<td>2014 Stage 1 objectives and measures</td>
</tr>
<tr>
<td><strong>Stage 2 in 2014</strong></td>
<td>2013 Stage 1 objectives and measures* -or- 2014 Stage 1 objectives and measures* -or- Stage 2 objectives and measures *</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Only providers who could not fully implement 2014 Edition CEHRT for the reporting period in 2014 due to delays in 2014 Edition CEHRT availability*
New Regulations

What **IS** sufficient rationale?

CMS stresses that the delay in 2014 Edition CEHRT availability must be attributable to the issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor.

- Software development
- Certification delay
- Implementation issues
- Unable to adequately test the updated system
- Delay in product release
- Delayed or missing software updates
- Software itself renders a provider unable to reliably use it

- Software does not yet contain all required components
- Not enough time to put new workflows in place or adequately train staff

The basis for using one of the flexible options must stem from a problem with first getting the software installed because of vendor delays, and then fully implementing 2014 CEHRT in time for a full EHR reporting period in 2014.
"delays in 2014 Edition CEHRT availability"

- "refers specifically to one or more delays related to the development, certification, testing and release of an EHR product (including updates, software patches and other modifications required by the provider after rollout of the EHR product) by the EHR vendor or developer that resulted in an inability of the provider to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014."
What **IS NOT** sufficient rationale?

The main distinction to draw here is WHO caused the delay? If the issue is/was caused by the EP, EH or CAH, then the flexible options cannot be used. If the EP can demonstrate that the issue resided with the vendor, then one of the flexible options can be used in 2014.

▲ Financial issues, such as costs associated with implementing, upgrading, installing, testing, or other similar financial issues.

▲ Inability to meet one or more MU measure* (*exception – SoC, see slide 14)

▲ Staff changes

▲ Turnover

▲ Provider’s inaction or delay
  – EP waited too long to engage vendor
  – EP’s inability or refusal to purchase the requisite software update(s)
  – Provider had 2014 CEHRT installed earlier in 2014 but simply delayed training, testing or implementation till later in the year.
“not able to fully implement”

- “The agencies therefore do not establish a specific definition for “not able to fully implement,” but instead offer four non-exclusive scenarios, as examples, that would not constitute inability to fully implement 2014 Edition CEHRT: (i) financial issues, such as costs associated with implementing, upgrading, installing, testing or similar financial issues; (ii) with a limited exception related to technical requirements of the summary of care document measure, issues related to the meaningful use objectives and measures; (iii) personnel matters, including staff changes and turnover; and (iv) provider inaction or delay.”
Summary of Care Measure

Referring providers may not be able to meet the Stage 2 Summary of Care (SoC) measure in 2014 if receiving providers they frequently use have not upgraded to 2014 Edition CEHRT. Therefore, a limited exception is warranted for providers who could not meet the 10% threshold for Stage 2 SoC (measure 2) because the recipients were impacted by issues related to 2014 Edition CEHRT availability delays and therefore could not implement the functionality required to receive the electronic SoC document. Therefore, the “inability to fully implement” is extended to those providers. A referring provider under this circumstance may instead attest to 2014 Stage 1.

- The referring provider must retain documentation clearly demonstrating that they were unable to meet the 10% threshold for this specific reason.
Add’l Points to Consider

Public Health Measures

▲ Regarding the Stage 1 public health menu measures, if a provider sent a test message to a public health agency in a previous EHR reporting period and chooses to report to 2013 Stage 1 objectives and measures or 2014 Stage 1 objectives and measures for the 2014 reporting period with one of the flexible options, the provider is NOT required to send another test message to meet the public health measure for the 2014 reporting period.
Add’l Points to Consider

Practicing in Multiple Locations

▲ EPs who practice in multiple locations which have been unable to fully implement 2014 Edition CEHRT may attest using the flexible options. If an EP uses different editions of CEHRT at multiple locations, s/he may choose to use the option that is best applied for his or her patient encounters across all locations during the EHR reporting period.

- Just as in any other MU year, these EPs must then use the data from all patient encounters which occur at any location equipped with an edition of certified EHR technology (2011, 2014 and/or combination).

▲ However, if over 50% of the EPs patient encounters during the EHR reporting period occur at locations equipped with 2014 Edition CEHRT which HAS been fully implemented, the EP would not be eligible to use the flexible options and should therefore limit their denominators to only those patient encounters in locations equipped with fully implemented 2014 Edition CEHRT.
<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1 OR 2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1 OR 2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New Regulations - Timing
Details and Consequences

**If a Medicaid eligible professional is in the first year (A/I/U) of the program in 2014 they must use 2014 CEHRT.**

**Eligible hospitals or professionals will not have the option to use 2011 Edition software in the 2015 MU year. That begins in October 1, 2014 for EHs and January 1, 2015 for EPs.**

**Catch 22:** If an EP uses 2011 Edition CEHRT to achieve MU they must attest no later than October 1st to avoid 2015 penalties. However, the CMS attestation site will not be available until “mid-October”.
Proposed Regulations

Legislation Would Continue 90-Day Reporting Period for Meaningful Use in 2015

**Key Takeaway:** Bipartisan legislation was introduced into the House of Representatives last Tuesday that would maintain a 90-day reporting period for the Meaningful Use Program in 2015. Introduced during National Health IT Week, the Flex-IT Act received widespread attention throughout the industry’s primary advocacy week.

**Next Steps:** CHIME has issued an open "Call to Action" to all members who believe a shortened reporting period for Meaningful Use in 2015 would positively impact their efforts to improve care and patient safety through health IT. Interested CHIME members should click here to learn more.

**Why it Matters:** The Flex-IT Act would negate the latest final rule from CMS and adjust the program reporting timeline, giving providers the option to choose any three-month quarter for EHR reporting in 2015. CHIME and many other healthcare organizations believe this legislation will reinforce investments made to date and will ensure continued momentum toward the goals of the Meaningful Use Program, including enhanced care coordination and interoperability. To date, only 143 hospitals have met Stage 2 requirements using updated technology. This represents a very small percentage of the 3,800 hospitals required to be Stage 2-ready within the next 10 days.

Last week, Representatives Renee Ellmers (R-NC) and Jim Matheson (D-UT) introduced HR 5481, the Flexibility in Health IT Reporting Act of 2014. The bill received swift and widespread support from CHIME. "The Flex-IT Act would negate the latest final rule by CMS and adjust the program reporting timeline; giving providers the option to choose any three-month quarter for EHR reporting in 2015," said CHIME President and CEO Russell Branzell. "CHIME commends Congresswoman Ellmers and Congressman Matheson for their immense leadership on this critically important issue following the healthcare industry's joint call to action..."

During the course of National Health IT Week, several groups, including the AHA, AMA and HIMSS, offered support for the bill's language. At a press conference, Rep. Phil Gingrey (R-GA) pointed to the Flex-IT Act and a shortened reporting period as way to provide relief for physicians, a key to ensuring the success of the Meaningful Use Program. Rep. Gingrey, the Vice Chair of the GOP Doctors Caucus, is one of four cosponsors of the legislation.

Rumor has it...
Long Road Traveled
Questions