Meaningful Use and Pay for Performance Programs:

Where are we headed?

David Lansky, PhD, *President and CEO*

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My perspective…

Health IT Policy Committee *(purchaser representative)*

- **Chair, Quality Measures Workgroup**
- **Co-chair, Information Exchange Workgroup**
- **Member, Meaningful Use Workgroup**
- **Member, Privacy-Security Tiger Team**

HIT Standards Committee

- **Clinical Quality Workgroup**

Cal eConnect *(state designated entity for health information exchange)*

- **Co-chair, Board of Directors**

Pacific Business Group on Health – President & CEO

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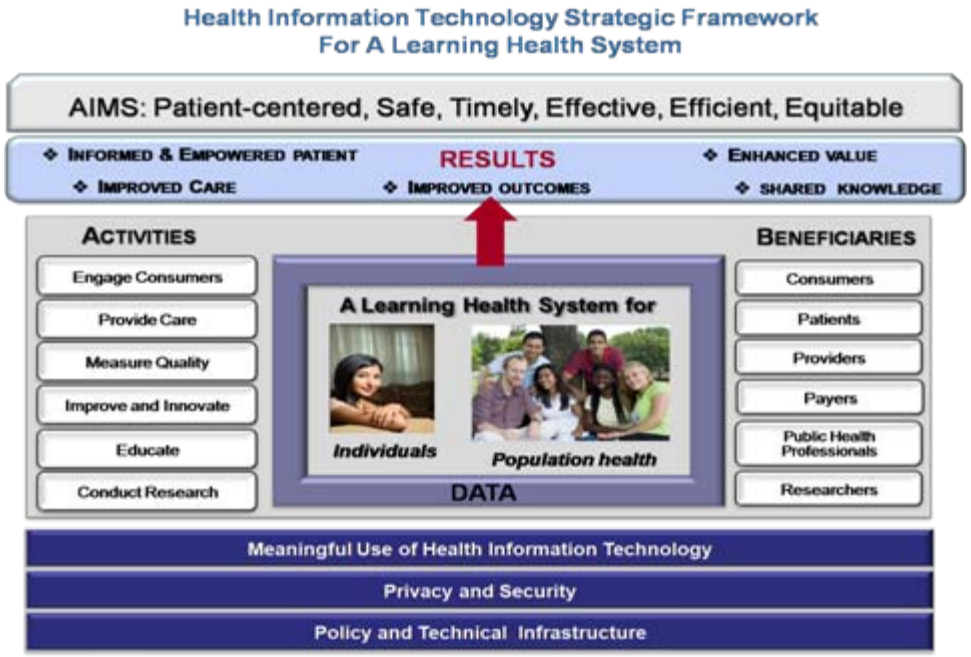
ONC's Vision

A system that is designed to generate and apply the best evidence for the collaborative health care choices of each patient and provider; to drive the process of new discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care.

(Charter of the Institute of Medicine Roundtable on Value & Science-Driven Health Care)



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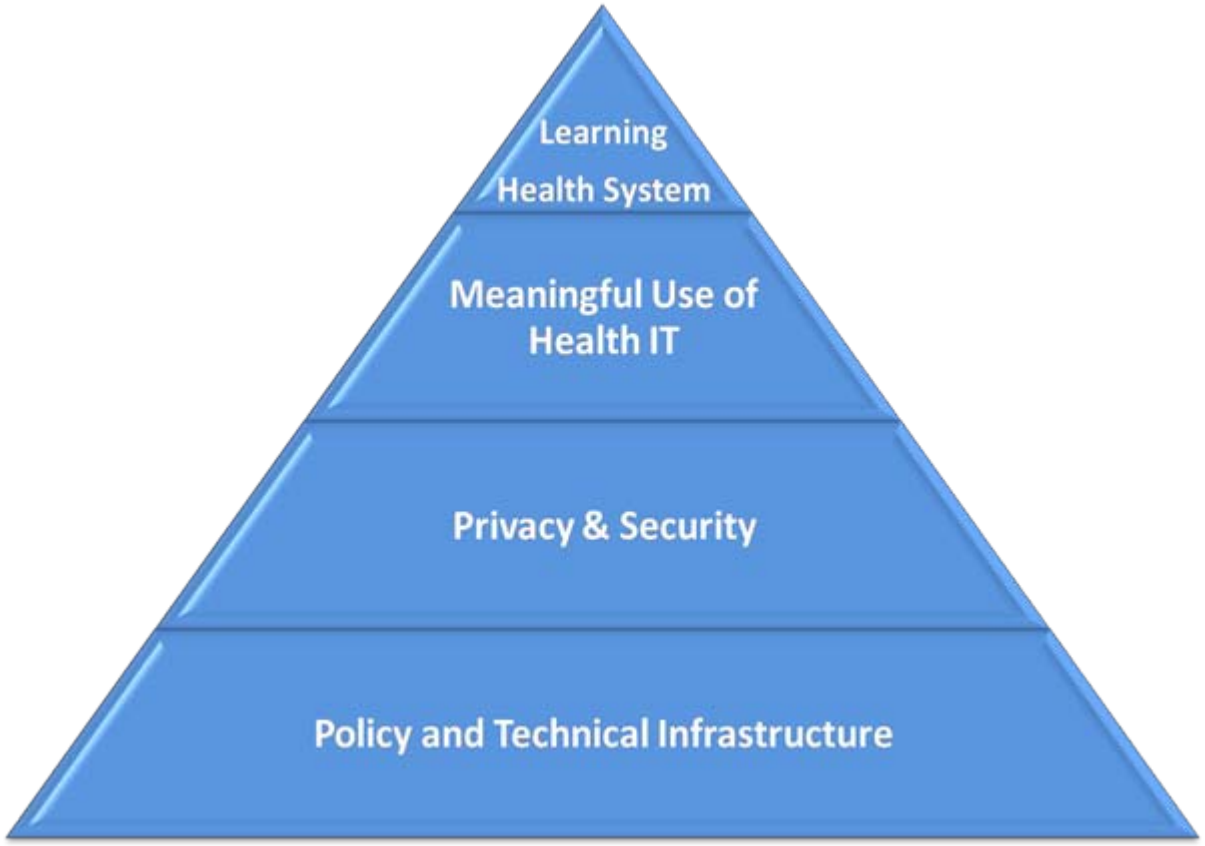
Strategic Framework Goals



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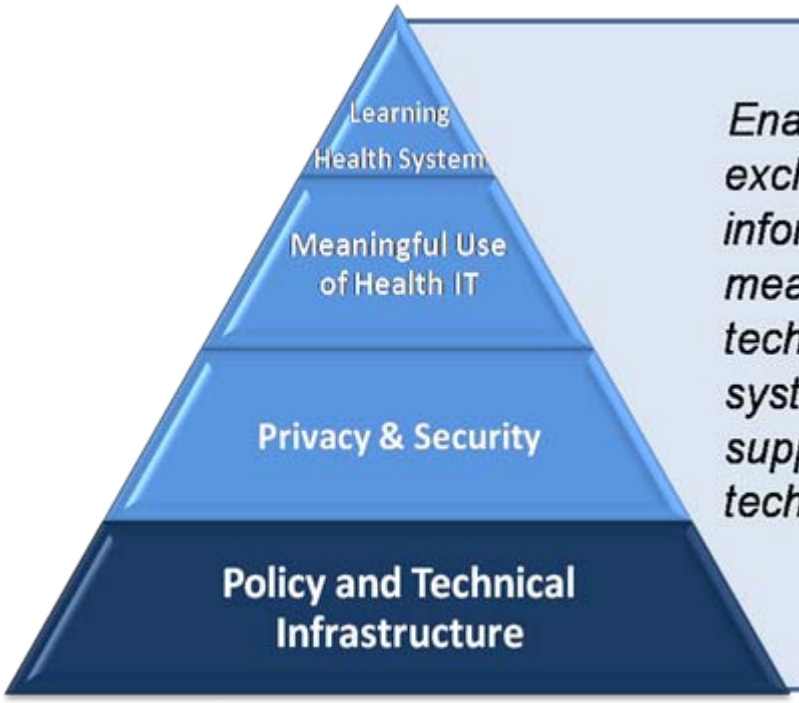
Policy and Technical Infrastructure Goal



Enable management and secure exchange of electronic health information to meet goals for meaningful use of health information technology and a learning health system through the development and support of appropriate policies and technical specifications.

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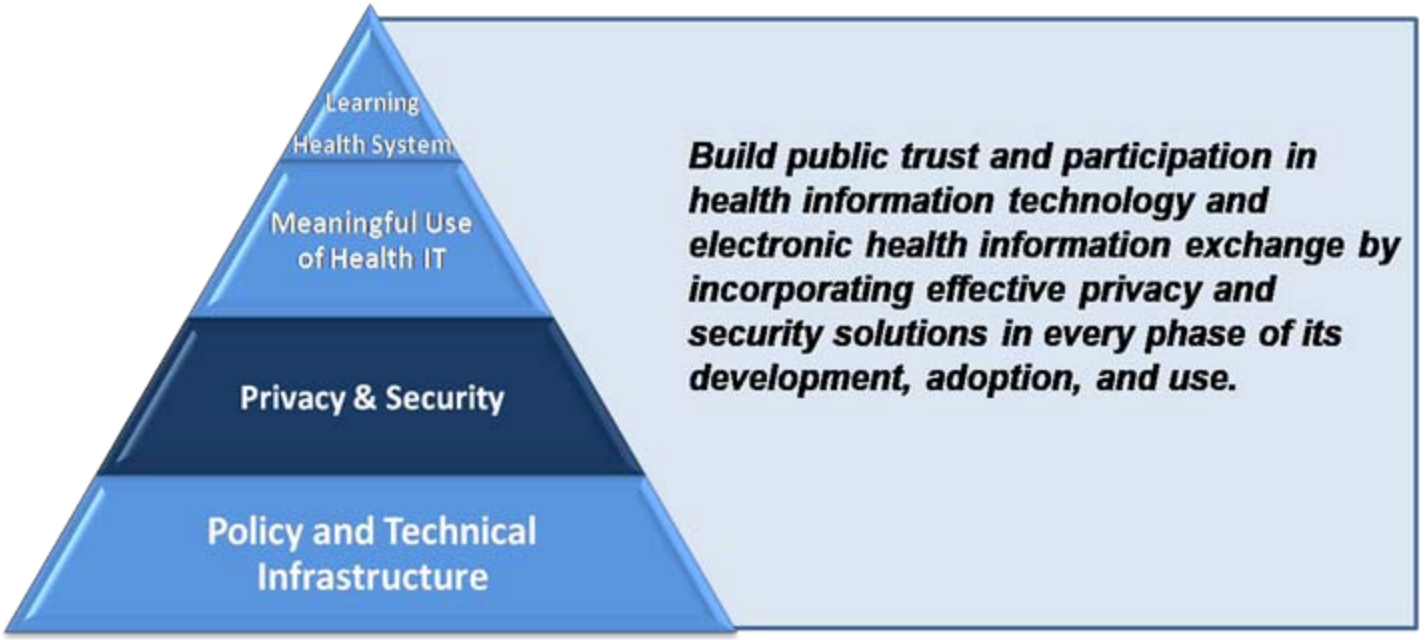
Privacy and Security Goal



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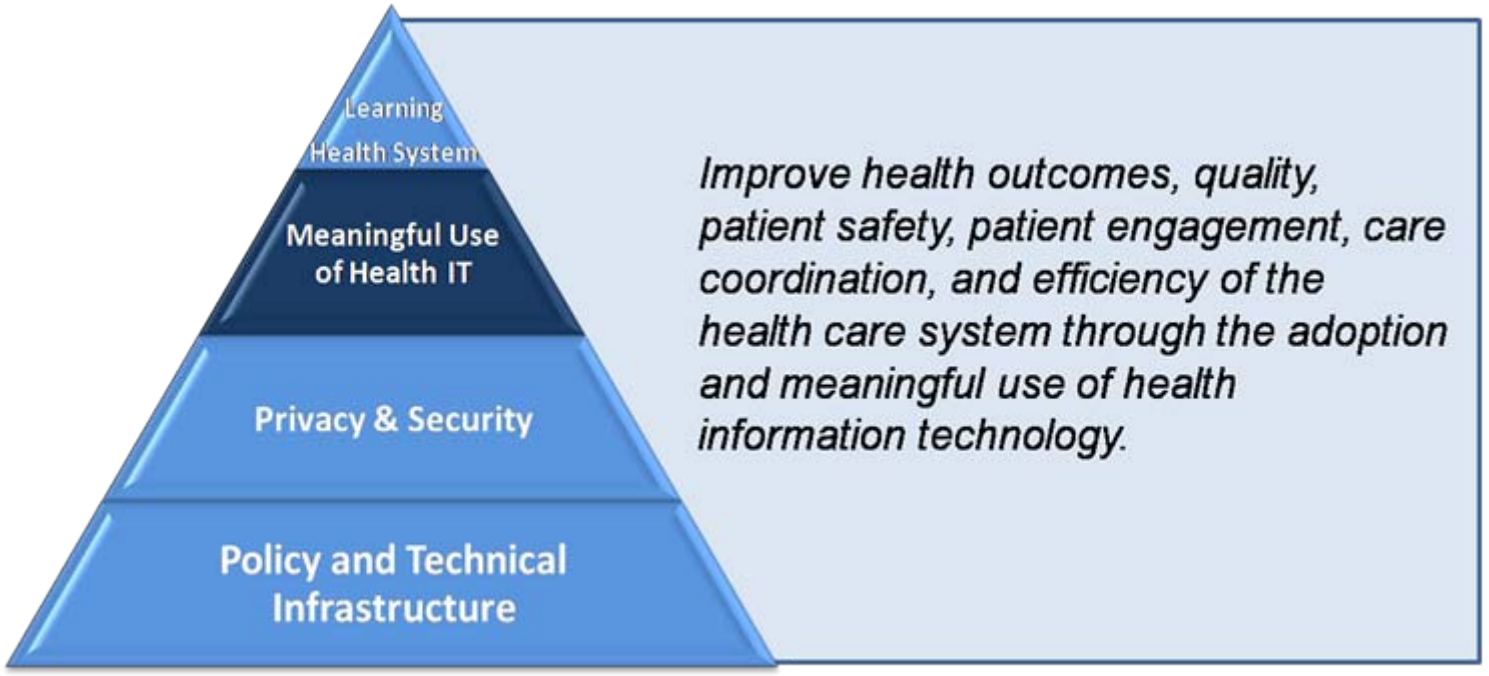
Meaningful Use of Health IT Goal



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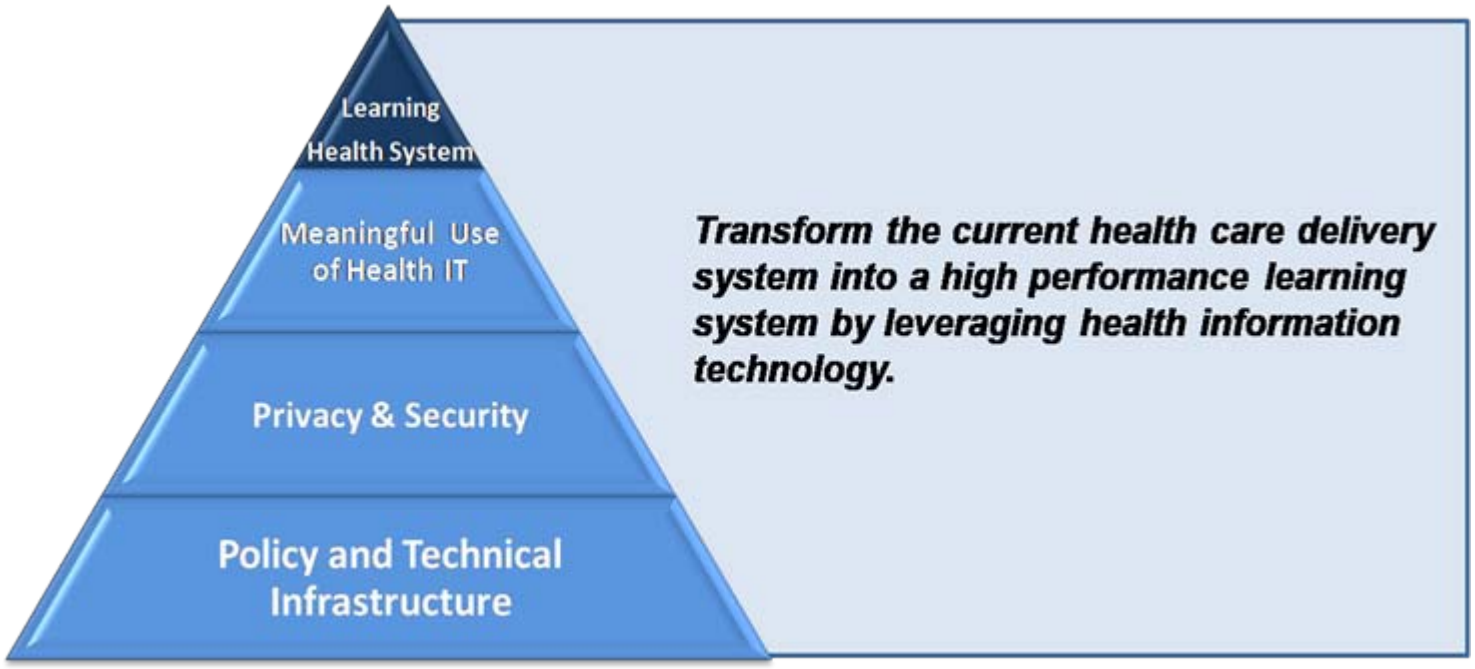
Learning Health System Goal



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What the HITECH law said …

In HITECH, Congress specified three types of requirements for meaningful use:

1. use of certified EHR technology in a meaningful manner (e.g. Electronic Prescribing);

2. that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and

3. that, in using certified EHR technology, the provider submits to the Secretary information on clinical quality measures and such other measures selected by the Secretary.

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Meaningful Use Overview

Vision:

Enable significant and measurable improvements in population health through a transformed health care delivery system.

Goals:

- Improve quality safety and efficiency
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Ensure privacy and security protections

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Meaningful Use *IS* a P4P Program!

(first, ONC must ensure that certified EHR technology can support the required functions and produce the required quality measures)

- Demonstrate that your installed EHR can perform desired functions.
- Generate and report on clinical quality measures.

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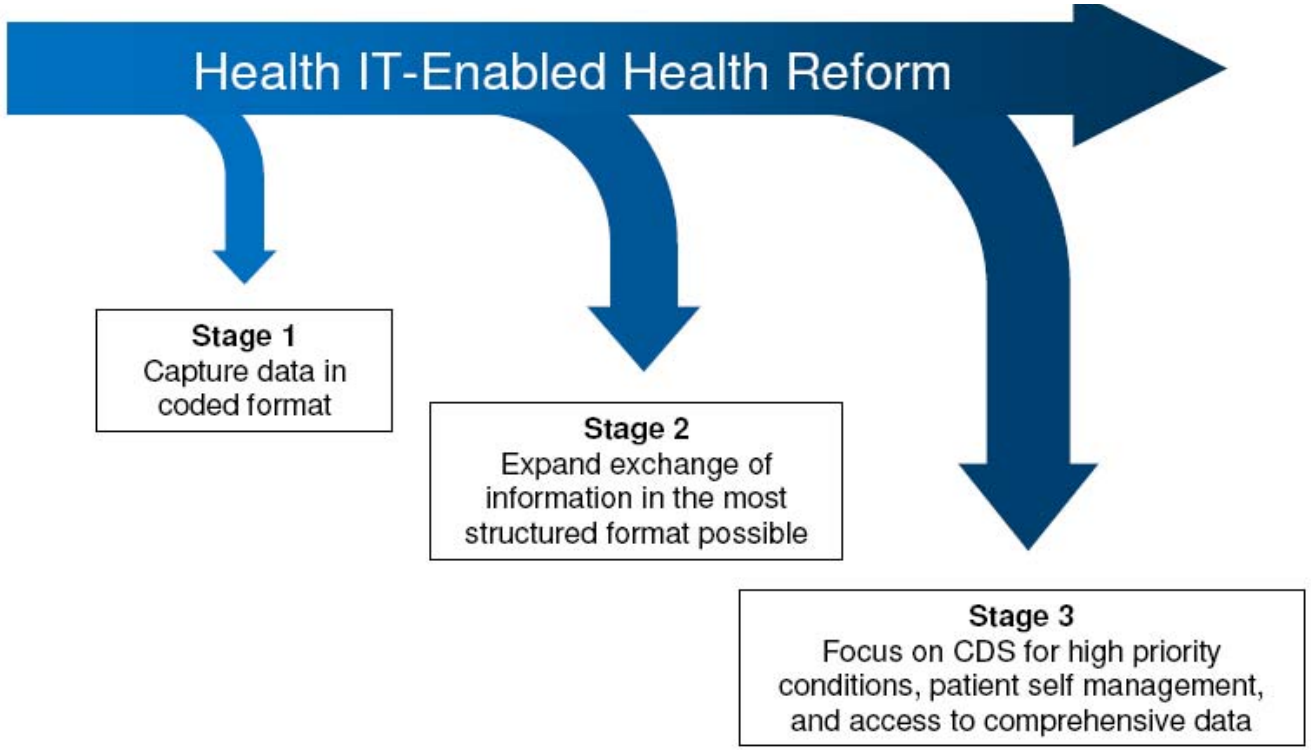
The Stages of Meaningful Use



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CMS Vision for Stages
Requirements Scaling Up Over Time

Stage 1	Stage 2	Stage 3
1. Capturing health information in a coded format 2. Using the information to track key clinical conditions 3. Communicating captured information for care coordination purposes 4. Reporting of clinical quality measures and public health information	1. Disease management, clinical decision support 2. Medication management 3. Support for patient access to their health information 4. Transitions in care 5. Quality measurement 6. Research 7. Bi-directional communication with public health agencies	1. Achieving improvements in quality, safety and efficiency 2. Focusing on decision support for national high priority conditions 3. Patient access to self-management tools 4. Access to comprehensive patient data 5. Improving population health outcomes

For Stage 2, CMS may also consider applying the criteria more broadly to both the inpatient and outpatient hospital settings. CMS expects to propose Stage 2 criteria by the end of 2011.

CMS expects to propose Stage 3 criteria by the end of 2013.

Source: Manatt Health Solutions

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Stages of Meaningful Use

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015+
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015+					Stage 3

Medicare Incentive Payment Schedule

Adoption Year	Maximum Payment							PFS Penalty
	2011	2012	2013	2014	2015	2016	Total	
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$44,000	
2012		$18,000	$12,000	$8,000	$4,000	$2,000	$44,000	
2013			$15,000	$12,000	$8,000	$4,000	$39,000	
2014				$12,000	$8,000	$4,000	$24,000	
2015							$0	1%
2016							$0	2%
2017+							$0	3%

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Stage 1 Meaningful Use Criteria

- Use of existing features of an EHR
- Incorporating EHR functions into daily work flow
- Engaging in information exchange
- Producing and reporting quality measures
- Increasing privacy and security of personal health data

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Principles Guiding Development of Stage 2 Criteria

- Position stage 2 as steppingstone to stage 3
- Move towards outcomes, where possible
- Parsimony
- Ensure functionality “floor”
- Promote innovation
- At this stage, draft recommendations to form basis for Request for Comment only
  - At least 2 more opportunities for full committee comment/feedback

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Improving Quality, Safety, Efficiency & Reducing Health Disparities

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
CPOE for Rx orders **(30%)**	CPOE for 60% of Rx, lab, and radiology orders entered by licensed professionals (not specify transmission mode)	CPOE for 80% of Rx, lab, radiology, and referral orders entered by licensed professional (not specify transmission mode)	Stages 2 and 3, order can be transmitted electronically or on paper, except as noted in other objectives (allows market forces to push electronic transmission)
E-prescribing (EP) **(40%)**	60% of orders (outpatient and hospital discharge) transmitted as eRx if fits patient preference	90% of orders (outpatient and hospital discharge) transmitted as eRx if fits patient preference	

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Engage Patients and Families in Their Care

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Provide clinical summaries each office visit (EP)* **(50%)**	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in a uniformly human-readable form by 2013 (HITSC to define; eg, use of PDF or text).	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in a uniformly structured form by 2015 (HITSC to define; eg, use of CCD or CCR).	"Uniformly" implies HITSC should pick a single standard for human readable and a single standard for structured. The following data elements about the encounter are included (where relevant): encounter date and location; reasons for encounter; provider; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic test results; clinical instructions; orders: future appointment requests, referrals, scheduled tests; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status.

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Improve Care Coordination

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Perform test of HIE	Connect to at least one external provider in “primary referral network” or establish an ongoing bidirectional connection to at least one health information exchange	Connect to at least 30% of external providers in “primary referral network” or establish an ongoing bidirectional connection to at least one health information exchange	Successful HIE will require development and use of infrastructure like ELPD
Perform medication reconciliation **(50%)**	Medication reconciliation conducted at 80% of transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	Medication reconciliation conducted at 90% of transitions by receiving provider	
(NEW)	Record a longitudinal care plan for 20% of patients with high priority health conditions	Longitudinal care plan available for electronic exchange for 50% of patients with high priority health conditions	Such as: care team members, diagnoses, meds, allergies, goals

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Improve Population and Public Health

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments
Submit reportable lab data	For EH make Stage 1 core. For EP make lab reporting menu.	Mandatory test. For EHs, submit if accepted and as required by law. For EPs, ensure that reportable lab results are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law). Include complete contact information (e.g., patient address, phone and municipality) in 30% (EH) of reports.	

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Meaningful Use Stage 2 Timeline

- December 2010: refine draft MU criteria, prepare for RFC
- January 2011: release Request for Comment
- March 2011: analyze RFC submissions and revise MU draft criteria
- April 2011: present revised draft MU criteria to HITPC
- Q2 2011: CMS report on initial MU submissions
- Q3 2011: Final HITPC recommendations on stage 2
- Late Q4 2011: CMS MU Notice of Proposed Rulemaking

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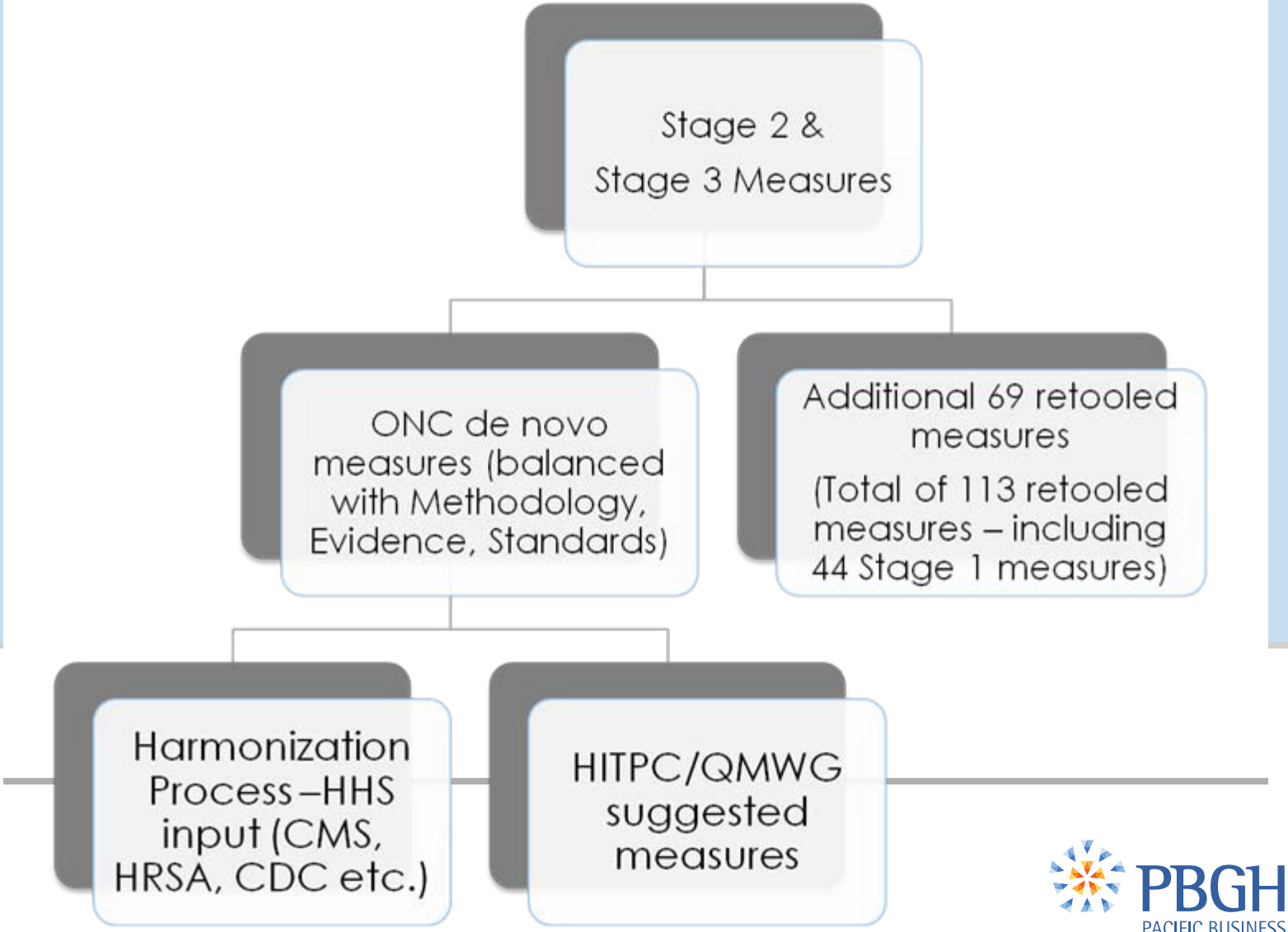
Quality Measure Selection – Stages 2 and 3



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Quality Measures Domains for Stage 2

- Clinical Appropriateness/Efficiency
- Population & Public Health
- Patient & Family Engagement
- Care Coordination
- Patient Safety

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Projected Timeline (draft)

March 2011: HITPC endorses QMWG recommendations

March - June 2011: ONC to initiate measure development activities

June - December 2011: Stage 2 measure concepts & specifications to be defined and put out for public comment

January – April 2012: Development of *de novo* Stage 2 measures based on QMWG guidance to be completed

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Issues Going Forward

- Implementation realities: vendors, bandwidth, clinical adoption
- Staying on the fast-moving train… anticipating stages 2 and 3
- Getting beyond the silos… shifting to information exchange focus
- Aligning measurement and payment programs: P4P, PQRS, CMS value-based payment, ACOs, qualified health plans …

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For more information:

- Learn more about the Pacific Business Group on Health and our effort to improve the quality of health care while moderating costs at www.pbgh.org
- Learn more about our work to bring employers, consumers and labor organizations together to improve access to publicly reported health care performance information at www.healthcaredisclosure.org
- Learn more about our efforts to reform payment at www.catalyzepaymentreform.org