WHITE PAPER

Six Steps to Achieving Meaningful Use Qualification, Stage 1

Shefali Mookencherry
Principal Healthcare Strategy Consultant
Hayes Management Consulting
Background

Providers can qualify for Stage 1 of Meaningful Use and begin receiving incentive payments starting in 2011. They can also wait until 2015 to comply with all three stages of Meaningful Use criteria. However, the longer providers wait, the more criteria there are and the less time there is for implementation.

The Recovery Act specifies the following three components of Meaningful Use:

1. Use of certified EHR in a meaningful manner (e.g., e-prescribing)
2. Use of certified EHR technology for electronic exchange of health information to improve healthcare
3. Use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary

Is it too late to start now? What should you do to qualify for the Meaningful Use Stage 1 incentives?

It would be prudent and wise to start to comply with the stages of Meaningful Use criteria as they are finalized and released over the five-year period. If you have not started yet, there is still time to qualify. This paper provides a high-level overview that outlines the six steps that could allow providers to achieve Meaningful Use Stage 1 qualification.

Steps to Qualify for Meaningful Use, Stage 1

To qualify for Meaningful Use Stage 1 incentives, an organization should take the following six steps:

1. Create an MU governance structure with resources that understand the regulations.
2. Conduct a systematic review. Map current workflows and data flows to coincide with objectives.
3. Identify gaps and risks. Conduct an operations SWOT analysis.
4. Determine remediation approach and understand risks. Track progress toward ability to qualify for Stage 1. Anticipate Stage 2 gaps.
5. Design, develop, test and implement data collection and reporting capabilities.
6. Understand attestation requirements and post payment audits.

1. Governance

In a well-planned EHR implementation, success can be ensured by the development of clear guiding principles, structured planning, effective subcommittee oversight (monitoring and reporting project progress) and effective communication relating to the MU project. A governance structure can translate the vision into reality. This structure is needed to deliver transformation in clinical workflows and quality outcomes through standards-driven technology capabilities aligned with health reform requirements. It is critical that a MU governance structure be created that includes a project manager, an executive steering committee comprised of clinical/business process leaders and specific subcommittees (which should also include clinical/business process owners).

Governance structure:

- Project manager
- Executive steering committee
- Subcommittees:
  - Quality Improvement
  - Process Improvement
Hayes White Paper: Six Steps to Achieving Meaningful Use Qualifications, Stage 1

- Billing and Charge Capture
- Information Management and Technology
- Programming and Reporting
- Communication and Training

The executive steering committee should include executives from medical staff leadership, nursing, performance improvement, technology, operations, strategic planning, privacy and security, and physician practice relations. The subcommittees should help direct the process and system design in process standardization, implementation, best practices, patient safety, and quality of care. To implement foundational changes, Meaningful Use must be integrated into all levels and functions within an organization.

The executive committee will also need to address critical issues throughout the organization. This is another reason its members should be leaders in the organization and be able to make or influence cross-functional decisions. Some issues could include:

- Ensuring the use of certified EHR technology to collect, store, calculate, and report on Meaningful Use criteria.
- Determining the optimal timeline and application sequencing for achieving Meaningful Use.
- Aligning reporting across systems and practice areas.
- Supporting cultural changes in practice patterns.
- Developing new policies and procedures due to EHR usage and modifications.
- Assuring a proactive privacy and security program within the context of HITECH Act regulations.
- Standardizing and aggregating clinical information across products, practice areas, and locations to calculate measure thresholds for reporting.
- Planning to qualify for Stages 2 and 3 Meaningful Use criteria, which hold providers responsible for patient portal participation and inter-organizational health information exchanges.

2. Systematic Review

A readiness assessment should be performed including a comprehensive and systematic review of your organization’s current state of EHR technology, information management systems, interfaces, integration, and interoperability. The assessment should also include the following key areas:

- EHR technologies, data collection, coding, reporting, and decision support
- Patient and family engagement
- Care coordination and interoperability
- Personal health information privacy and protection
- Clinical quality measures
- Public health
- EHR roadmap, strategic and implementation plans
- Current processes
- Change capacity

If a vendor performs the readiness assessment, recommendations to the findings would need to be considered.
3. Identify Gaps and Risks

What are the gaps and risks you should consider? A comprehensive technology inventory assessment by facility and by Meaningful Use measure can help to identify where measurement criteria are technology-enabled and where gaps exist.

Sample gap analysis

Stage 1 objective: Use Computerized Provider Order Entry (CPOE)
Criteria: Enable a user to, at a minimum, electronically record, store, retrieve, and manage the following order types:

1. Medications
2. Laboratory
3. Radiology/imaging
4. Referrals

Requirement(s): Support the electronic ordering for 80% of medications, laboratory, radiology/imaging, and referrals (direct entry by an authorizing provider).

Current process review:

1. Medication – CMIS medical supports electronic ordering of sample medications only. Prescriptions are paper.
2. Laboratory – Already electronically ordered
3. Radiology – Order is electronic and/or paper
4. Referrals – “Mostly” electronic. Other referrals will be completely electronic via the HIE as well.

Gap(s) identified:

1. ePrescribing – DEA does not allow controlled substances to be e-prescribed
2. Laboratory – None
4. Referrals – Dependent on partner capability

Risk assessment

Under the rules for both Stage 1 and Stage 2 of the electronic health record incentive program, Meaningful Users must conduct a security risk assessment in accordance with HIPAA’s security rule. In addition, any identified deficiencies must be corrected. To conduct an appropriate risk analysis, it is recommended that providers dive in and take a good look at their EHR and health IT security processes, with particular focus on:

- Physical safeguards, such as facility access and data storage
- Administrative safeguards, including implementing policies and procedures to prevent, detect and correct security violations
- Technical safeguards, such as automatic log-off policies and use of encryption

A vendor assessment should be performed to review the costs/benefits of certifying an in-house-developed solution versus adopting a comparable, certified commercial offering. Determine which Eligible Providers (EPs) are most prepared for Meaningful Use. Compare Meaningful Use criteria against each EP’s roles,
responsibilities and area of operations. This may suggest prioritization when applying for incentives. To bridge various gaps, dozens of simultaneous and independent projects (ranging in size and complexity) will need to be identified, coordinated, funded, and executed in a short timeframe. Conduct an operations SWOT analysis. The source data used for reporting and tracking compliance with Meaningful Use criteria should be evaluated. Furthermore, analyze data to determine need for remediation.

4. Identify Remediation Needs

After a gap analysis is completed, the remediation process could reveal further findings and identify organizational champions and industry experts. Organizational champions could then identify and implement solutions based on the findings. Your organization should estimate resources for remediation by performing a cost/benefit analysis. Implementing IT solutions could ensure that accurate and timely data capture at the point-of-care is in place. Healthcare organizations can redesign the workflows/data flows to maximize efficiency, create policies and procedures for uniform clinical data capture and documentation, build standardized templates and diagnostic-specific order sets and reconfigure standardized existing order sets for all visit types. Your organization should review system remediation vs. process flow remediation as these apply to the core set of MU requirements for Stage 1.

Examples of remediation could include:

- Core 5: Maintain up-to-date problem list of current and active diagnoses
  - Review system/process flow changes
- Core 13: Provide clinical summaries after office visit
  - Review system changes

In addition, anticipate Stage 2 criteria to reduce duplication.

5. Data Collection and Reporting

The data required for reporting criteria thresholds and clinical quality measures should be mapped from point-of-origination, retrieval, storage and through reporting. Use business intelligence to develop reports for CMS certification that meet the standards for EHR Meaningful Use. In 2011 and 2012, eligible professionals and eligible hospitals seeking to demonstrate Meaningful Use are required to submit aggregate Clinical Quality Measures (CQMs) numerator, denominator, and exclusion data to CMS—by reporting and attestation in 2011 and electronically in 2012. In addition, the governance staff should identify core, alternative core, and additional CQMs.

A provider’s certified EHR technology must be able to calculate each measure’s numerators, denominators, and exclusions for each CQM. To report Clinical Quality Measures (CQMs) from an Electronic Health Record (EHR), electronic specifications were developed by CMS that included data elements, logic and definitions for each measure. The specifications for each measure were in a format that could be captured or stored in the EHR for sending or sharing electronically with other entities in a structured, standardized format while remaining and unaltered. Each electronic specification contains four main components:

1. Measure overview/description: This contains the measure title, description, number, measurement period, measure steward and other relevant information to the measure.
2. Measure logic: This contains the population criteria and measure logic for the numerator, denominator and exclusion categories. The measure logic contains the algorithm used to calculate performance.

3. Measure code lists: This contains all codes pertaining to the measure.

4. QDS elements: This lists and describes each Quality Data Set (QDS) data element associated with the measure. The QDS is an information model that contains the standard element, the quality data element and the data flow attributes. It is a way to describe clinical concepts in a standardized format so individuals (i.e., providers, researchers, measure developers) monitoring clinical performance and outcomes can clearly and concisely communicate necessary information. The QDS model also describes information in a manner that allows EHR and other clinical electronic system vendors to unambiguously interpret the data and clearly locate the data required.

The reporting period for the EHR Incentive Program using a certified EHR is any continuous 90-day period during the first payment year. Please note that although the measure specifications assume a full calendar year, you should only calculate the denominator and numerator from the first day of the 90-day reporting period to the last day.

6. Understand Attestation Requirements and Auditing

To receive incentive payments, make sure the EHR technology that you are using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology (ONCHIT). EPs will need to register first with CMS to attest to Meaningful Use. Make sure EPs have the following:

- A National Provider Identifier (NPI)
  - All eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must have a National Provider Identifier (NPI) to participate in the Medicare and Medicaid EHR Incentive Programs.
- An enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)
  - All eligible hospitals and Medicare eligible professionals must have an enrollment record in PECOS to participate in the EHR Incentive Programs. (Note: Eligible professionals who are only participating in the Medicaid EHR Incentive Program are not required to be enrolled in PECOS.)
  - If you do not have an enrollment record in PECOS, you should still register for the Medicare and Medicaid EHR Incentive Programs.

EPs eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register. Before 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

Medicare eligible professionals, eligible hospitals, and critical access hospitals will have to demonstrate Meaningful Use through CMS’ web-based Registration and Attestation System. In the Medicare & Medicaid EHR Incentive Program Registration and Attestation System, providers will need to fill in numerators and denominators for the Meaningful Use objectives and clinical quality measures, indicate if they qualify for exclusions to specific objectives and legally attest that they have successfully demonstrated Meaningful Use.
To attest for the Medicare EHR Incentive Program in your first year of participation, you will need to have met Meaningful Use for a consecutive 90-day reporting period. If your initial attestation fails, you can select a different 90-day reporting period that may partially overlap with a previously reported period. To attest for the Medicare EHR Incentive Program in subsequent years, you will need to have met Meaningful Use for a full year.

Please note that the reporting period for eligible professionals must fall within the calendar year, while the reporting period for eligible hospitals and critical access hospitals must fall during the Federal fiscal year. Providers will qualify for a Medicare EHR incentive payment upon completing a successful online submission through CMS’ Attestation System. Immediately after you submit your results, you should see an attestation summary and whether it was successful.

Incentive payments for the Medicare EHR Incentive Program are made approximately four-to-eight weeks after an eligible professional, eligible hospital or critical access hospital meets the program requirements and successfully attests that they have demonstrated Meaningful Use of certified EHR technology.

**Audits after attestation**

After payments are made, CMS may conduct audits for maintaining Meaningful Use compliance. Any provider attesting to receive an EHR incentive payment may be subject to an audit. Here's what you need to know to make sure you are prepared:

CMS EHR Incentive Programs audits:

- All providers attesting to receive an EHR incentive payment for either Medicare or Medicaid EHR Incentive Programs should retain ALL relevant supporting documentation (in either paper or electronic format used in the completion of the Attestation Module responses). Documentation to support the attestation should be retained for six years post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.
- CMS and its contractors will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers.
- States and their contractors will perform audits on Medicaid providers.
- CMS and states will also manage appeals processes.

Preparing for an audit:

- To ensure that you are prepared for a potential audit, save the supporting electronic or paper documentation that support your attestation. Also, save the documentation to support your Clinical Quality Measures (CQMs). Hospitals should also maintain documentation to support their payment calculations.
- Upon audit, the documentation will be used to validate that the provider accurately attested and submitted CQMs, as well as to verify that the incentive payment was accurate.

Audit details:

- There are numerous pre-payment edit checks built into the EHR Incentive Programs’ systems to detect inaccuracies in eligibility, reporting and payment.
- Post-payment audits will also be completed during the course of the EHR Incentive Programs.
If, based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped.

CMS will be implementing an appeals process for eligible professionals, eligible hospitals and critical access hospitals that participate in the Medicare EHR Incentive Program. More information about this process should be posted to the CMS website.

States will implement appeals processes for the Medicaid EHR Incentive Program. For more information about these appeals, contact your State Medicaid Agency.

Summary

Many providers have taken advantage of the incentives this year. Millions of dollars have been paid out by Medicare and Medicaid. Some of Hayes’ clients needed assistance with system and process gap analyses while others required help setting up an MU governance structure, MU requirements education and/or MU readiness assessments. Each organization will need to assess where they are in the CMS timeline.

It is imperative that providers begin immediate actions to become MU-compliant to maintain financial viability. The question to ask is “what does the organization need to establish, adopt, develop, upgrade, and implement to qualify for the MU incentives?”

Through governance, planning/project monitoring, reporting dashboards and metrics, your organization should be in a strong position to meet Meaningful Use requirements. In addition, internal/external communication, training, and staff/patient education will be critical to the initial acceptance and success of the Meaningful Use initiatives.

At this point, the revenue clock is ticking. Avoiding MU penalties should be a priority for your organization. By following these six steps, your organization could get started on mapping out and planning your MU project. To meet the MU deadlines, providers will need to implement new health IT initiatives quickly and effectively. The bottom line: get MU compliant - it’s the law!

About Hayes

Hayes works with healthcare organizations to increase net revenue and improve patient experience. Hayes is ranked Top Professional Services Firm by KLAS (2007 – 2010)* and has received multiple Best in KLAS awards since 2005. Hayes is listed in Modern Healthcare’s Best Places to Work, Healthcare Informatics’ Top 100 and Inc. 5000’s list of fastest growing companies.

Hayes consultants are subject-matter experts in MU, IT strategic planning, revenue cycle improvement, system implementation, interoperability and business and clinical operational efficiency. Hayes also offers software solutions to improve efficiency and productivity. To learn more about Hayes’ services, visit www.HayesManagement.com or call us at 617-559-0404.

*Source: 2010 Top 20 Best in KLAS Awards: Software & Professional Services, December 2010. © 2010 KLAS Enterprises, LLC. All rights reserved. www.KLASresearch.com