The Advisory Board Company

Health Care IT Advisor

Meaningful Use Reboot and Refresh

Directions and Opportunities to Enhance Your Journey

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Road Map

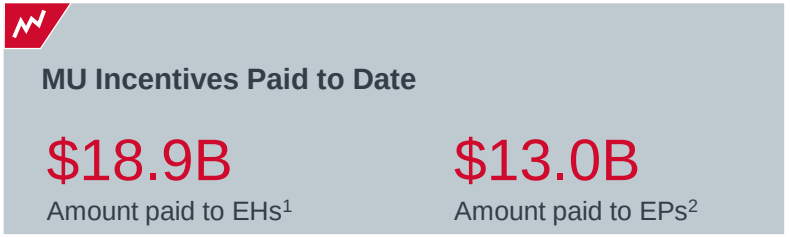
1 Modified Stage 2, Stage 3, and MACRA

2 Successful Practices to Prepare for Stage 3

3 Summary and Resources

The Progression of Meaningful Use

Stages Increase in Complexity and Participation Accumulates



Stage 1	Stage 2/Modified Stage 2	Stage 3
	Care coordination	Patient-centered care coordination
	Patient engagement	Patient engagement/patient self management
Basic EHR functionality, structured data	Structured data utilized for quality improvement	Registries for disease and population health management
Connect to public health	Connect to public health	Connect to public health
Privacy and security protections	Privacy and security protections	Privacy and security protections
		Enhanced access and care continuity
		Evidence-based medicine, team-based care/case management
		Data utilized to improve delivery and outcomes
Stage 1 Adoption & Data Capture *2011–2014*	**Stage 2/Modified Stage 2** Advanced Clinical Processes *2014–2017*	**Stage 3** Improve Outcomes *2018–Onward*[3]

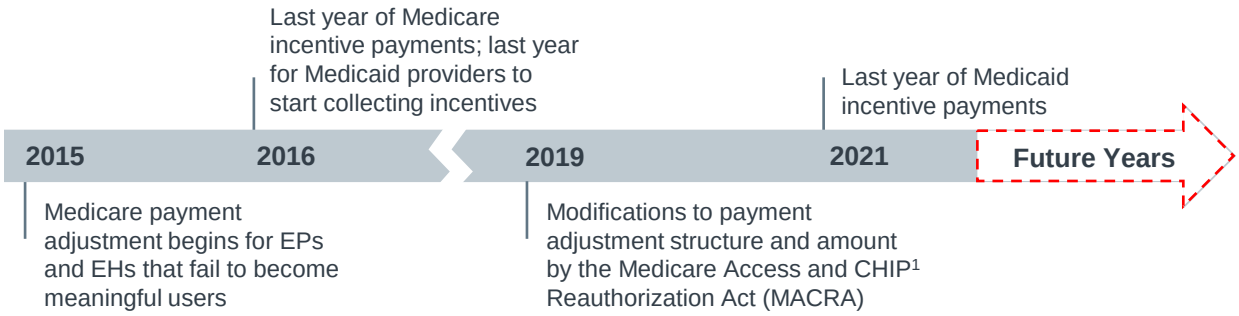
1) EH = eligible hospital; 2) EP = eligible professional; 3) Providers may optionally attest to Stage 3 in 2017. However, all providers must meet Stage 3 requirements beginning in 2018.

Sources: Centers for Medicare & Medicaid Services (CMS), EHR Incentive Program Summary Report; Health Care IT Advisor research and analysis.

Moving from “Carrots” to “Sticks”

Medicare Penalty Starts in 2015, But Incentives Stop in 2016

Timeline for Payment Adjustment and Remaining Incentive



209,000
Estimated number of EPs subject to payment adjustment in 2016

200
Estimated number of EHs subject to payment adjustment in 2015

Sustainable Growth Rate Repeal Impacts EP Adjustment Calculation

Separate payment adjustment for EPs that don’t meet MU is replaced effective 2019. Providers must choose between two models in which MU becomes a part of the calculation that will result in a payment bonus or penalty.

1) CHIP = Children’s Health Insurance Program.

Sources: CMS, Medicare & Medicaid EHR Incentive Programs, HIT Policy Committee, February 10, 2015; CMS, 2016 EP Payment Adjustment Fact Sheet; HIMSS, “CMS Announces Number of EPs Expected to Incur Payment Adjustments in 2015,” December 19, 2014; Health Care IT Advisor research and analysis.

MACRA: The Law That Repealed The SGR

Jan 1, 2019

MACRA implementation date

A Refresher: MACRA-in-Brief

- Legislation passed in April 2015 that repealed the Sustainable Growth Rate (SGR)
- Locks provider rates at near zero growth
  - 2015 – 2019: 0.5% increase
  - 2020 – 2025: 0.0% increase
  - 2026 and on: 0.25% increase
- Stipulates development of two new Medicare payment tracks: Merit-Based Incentive Payment System (MIPS), Alternative Payment Models (APMs)

Goals in Reshaping Provider Payment

1. Offer multiple pathways with varying levels of risk, reward for providers to better tie payment to value
2. Expand the options so that a broad range of providers can participate in alternative payment models
3. Minimize additional reporting burdens for APM participants
4. Support multi-payer initiatives, the development of risk-based or alternative payment models in Medicaid, Medicare Advantage, and other payer arrangements

Source: H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board Company interviews and analysis.

Two New Payment Tracks For Provider Groups

The Merit-Based Incentive Payment System (MIPS)

- Consolidates existing P4P[1] programs including Meaningful Use, Physician Quality Reporting System, and Value-Based Payment Modifier
- Gives providers performance score based on four categories: quality, resource use, clinical practice improvement, and EHR[2] use
- Adjustments reach -9% / +27% by 2022
- From 2019 through 2024, potential to share in $500M annual bonus pool

Alternative Payment Models (APMs)

- Provides financial incentives (5% annual bonus in 2019-2024, 0.75% annual payment increase from 2026 on) and exemption from MIPS
- Requires that physicians meet increasing targets for revenue at risk
- Qualifying APMs must involve downside risk and quality measurement that is comparable to the MIPS

Related Tool

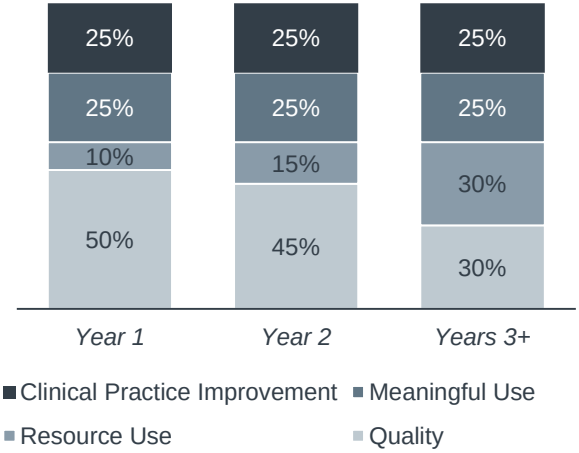
Access Health Care IT Advisor Policy Monitor, a summary of health-IT related federal legislative acts and regulations, on advisory.com.

1) Pay-for-Performance.
2) Electronic Health Record.

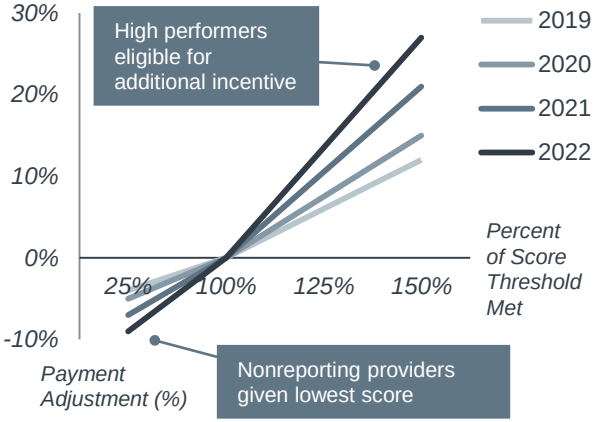
Source: H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board Company interviews and analysis.

Multiple Medicare Incentives Aggregated Into MIPS[1]

MIPS Score Comprised of Four Categories



Score Will Determine Medicare Payment Adjustment



Important Details to be Specified by HHS[2] Secretary

- *By what metrics will categories be measured?*
- *Where will the threshold MIPS score be set?*

1) Merit-based Incentive Payment System.
2) U.S. Department of Health and Human Services.

Source: H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board Company interviews and analysis.

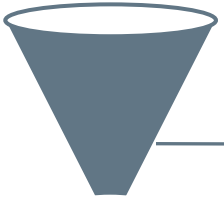
Qualifying for APM Track No Easy Feat

Providers Must Meet Two Conditions

1 Participate in an *Eligible* Alternative Payment Model

Alternative Payment Models

New approaches for paying for care that incentivize quality, value



***Eligible* Alternative Payment Models**

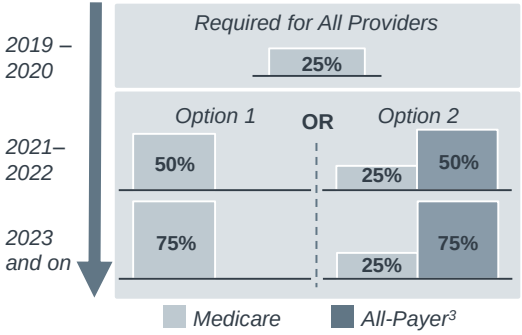
Eligibility Criteria

- Incentivize providers to meet quality measures comparable to those in MIPS
- Require use of certified EHR[1] technology
- Bear *more than nominal financial risk for monetary losses* OR are medical home model expanded under CMMI[2] authority

Thought to mean two-sided risk, but CMS is not yet definitive on whether that model will include one-sided risk models like MSSP Track One as well

2 Meet Revenue at Risk Requirement

Revenue at Risk Requirements

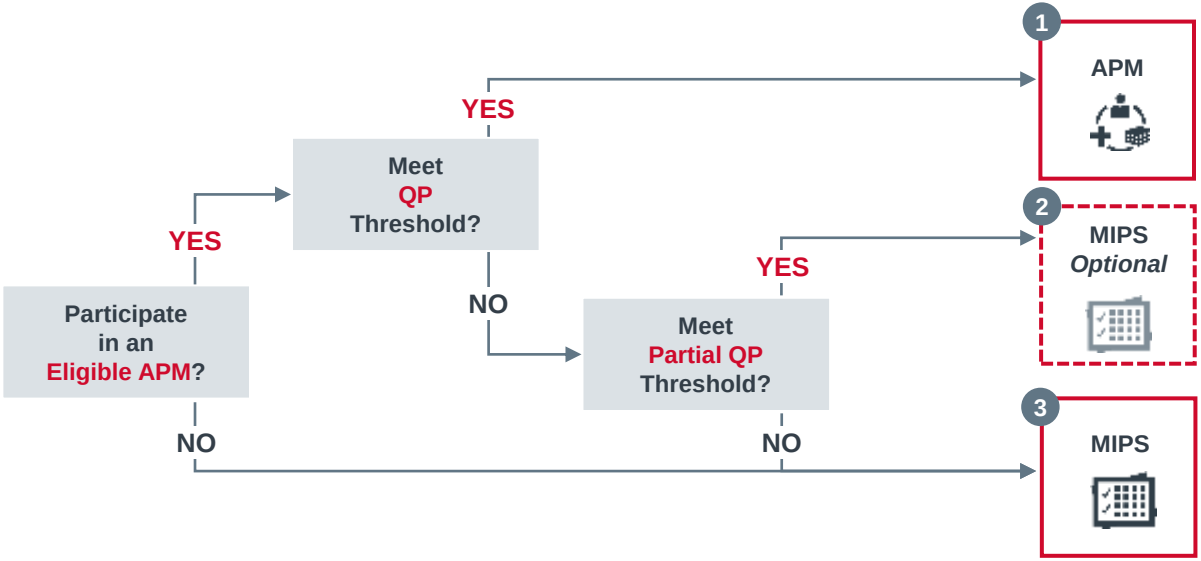


1) Electronic Health Record.
2) Center for Medicare and Medicaid Innovation.
3) Includes risk-based contracts with Medicare Advantage plans.

Source: CMS, "The Medicare Access and Chip Re-Authorization Act of 2015 Path to Value", available at www.cms.gov; H.R. 2: Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board Company interviews and analysis.

Which Track Do I Qualify For?

Must Know First Whether Payment Model is an Eligible APM



Additional Circumstances

If a provider has low total patient volume and/or is a new practitioner, they may be excluded from both tracks for a period of time.

Archived Webconference

A Primer on Provider Payment Under MACRA presents detailed look at how these new changes will impact providers.

Source: Advisory Board research and analysis.

“Single Definition” of Meaningful Use

Program Simplicity Not Truly Realized Until 2018

First Year as a Meaningful EHR User	Stage of MU by Program Year										
					Modified Stage 2 (M2)			Stage 3 - One Definition of MU			
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021 and future years
2011	1	1	1	2	M2	M2	M2 or 3	3			
2012		1	1	2	M2	M2	M2 or 3				
2013			1	1	M2	M2	M2 or 3				
2014				1	M2	M2	M2 or 3				
2015					M2	M2	M2 or 3				
2016						M2	M2 or 3				
2017							M2 or 3				

Legend

- Exclusion options and alternate thresholds for providers scheduled to report Stage 1, and eRx[1] for all EHs
- eRx exclusion option for all EHs
- Providers can report Modified Stage 2 or Stage 3 in 2017

Note: Providers that were originally slated to report on Stage 2 in 2014 but used alternate reporting options that year due to delays in the availability of Certified EHR Technology (CEHRT) are expected to report Stage 2 in 2015 as their “second year” in the program.

1) eRx = electronic prescribing.

Source: Health Care IT Advisor research and analysis.

Three MU Tenets Remain

But Major Changes to MU Measures in Modified Stage 2

1) **Possess CEHRT**

- No change in Modified Stage 2
- 2014 CEHRT in 2015
- 2014 and/or 2015 CEHRT in 2016 and 2017
- 2015 CEHRT only in 2018

!

Modified Stage 2 Considered Final

The final rule with comment period only applied to policies in Stage 3. CMS will not accept further comment on Modified Stage 2.

2) **Meet MU Measures**

- 90-day reporting period for all in 2015; EHs move to calendar year
- Removed measures
- Lower thresholds
- Align objectives and measures with Stage 3
- "Single" definition with alternate thresholds and exclusions for some providers

3) **Report CQMs**[1]

- No significant changes in Modified Stage 2, except that the reporting period is 90-days in 2015
- 2015 CQM reporting period may differ from the MU objectives and measures reporting period selected
- May report electronically or via attestation
- EHs report 16; EPs report 9 CQMs in 2015

1) CQMs = Clinical Quality Measures.

Sources: CMS, Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 FR 62761, https://federalregister.gov/a/2015-25595; and Health Care IT Advisor research and analysis.

Modified Stage 2 Pocket Guide for 2016

Protect Electronic Health Information	Clinical Decision Support	Computerized Provider Order Entry	Electronic Prescribing	Health Information Exchange (formerly Transitions of Care)
Conduct or review a **security risk analysis**[1]	**Five** Clinical decision support interventions **-AND-** Drug-drug and drug-allergy interaction checking enabled	**>60%** Medication orders; **>30%** Laboratory orders; **>30%** Radiology orders	Query for a drug formulary **+** Electronically transmit prescriptions (EPs) and discharge medications (EHs)	Electronic exchange of summary of care record for **>10%** of referrals and transitions
			>50% EP; **10%** EH	

Patient Education Resources	Medication Reconciliation	Patient Electronic Access	Secure Messaging	Public Health Reporting
Provide patient education resources for **>10%** of unique patients	Perform medication reconciliation for **>50%** of unique patients	**>50%** of patients provided online access to health information; **One patient** View, download, and transmit	EP only **One patient**	1. Immunization registry; 2. Syndromic surveillance; 3. Specialized registry[2]; 4. Reportable lab results (EH only)
				EP Report 2 of 3[3]; EH Report 3 of 4[3]

1) Providers scheduled to report Stage 1 must also address encryption of data at rest, previously required for Stage 2 providers only.
2) Specialized Registry can count more than once toward the Public Health Reporting objective.
3) CMS clarifies that providers can claim certain alternate exclusion(s) for public health measure(s) they did not previously intend to meet in 2016.
Red boxes denote change from original Stage 2.
Shading denotes measures with exclusion options for providers scheduled to report Stage 1 in 2016. EHs in Stage 2 may also claim an exclusion for Electronic Prescribing.

Sources: CMS, Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 FR 62761, https://federalregister.gov/a/2015-25595; Health Care IT Advisor research and analysis.

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Patient Education Resources	Medication Reconciliation	Patient Electronic Access	Secure Messaging	Public Health Reporting
Provide patient education resources for **>10%** of unique patients	Perform medication reconciliation for **>50%** of unique patients	**>50%** of patients provided online access to health information **>5%** View, download, and transmit	EP only **>5%**	1. Immunization registry 2. Syndromic surveillance 3. Specialized registry[2] 4. Reportable lab results (EH only) EP Report 2 of 3 EH Report 3 of 4

1) Providers scheduled to report Stage 1 must also address encryption of data at rest, previously required for Stage 2 providers only.
2) Specialized Registry can count more than once toward the Public Health Reporting objective.

Red boxes denotes change from original Stage 2 or a significant change from the previous year.

Source: CMS, Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 FR 62761, https://federalregister.gov/a/2015-25595; Health Care IT Advisor research and analysis.

Stage 3 Pocket Guide

Protect Electronic Health Information

Conduct or review a **security risk analysis**

Electronic Prescribing

Query for a drug formulary

+

Electronically transmit prescriptions (EPs) and discharge medications (EH)

>60% EP | **>25% EH**

Clinical Decision Support

Five

Clinical decision support interventions

-AND-

Drug-drug and drug-allergy interaction checking

Computerized Provider Order Entry

>60% Medication orders

>60% Laboratory orders

>60% Diagnostic imaging orders

Patient Electronic Access

>80%
Patient electronic access[1] through VDT[2] and Application Program Interface (API)

>35%
Provided electronic access to **patient education resources**

Patient Engagement

Attest to 3, Meet 2

>10%[3]
Actively engaged through any combination of **VDT and/or API** actions

>25%[3]
Secure electronic messages[4]

>5%
Incorporate **non-clinical setting data** (including patient-generated data)

Health Information Exchange

Attest to 3, Meet 2

>50%
Provide **outbound electronic summary of care**

>40%
Incorporate **inbound electronic summary of care**

>80%
Perform **clinical information reconciliation** of patient data

Public Health Reporting

EPs Report 2 of 5[6]

EHs Report 4 of 6

1. Immunizations
2. Syndromic surveillance
3. Case reporting
4. Public health registry[5]
5. Clinical data registry[5]
6. Reportable laboratory results (EH only)

1) All three functionalities (view, download, and transmit) and an API must be present and accessible to meet the measure.
2) VDT = View, download, and transmit
3) In 2017, providers may optionally meet Stage 3 and attest to different thresholds for these measures (e.g., >5%).
4) Messages include provider-initiated, provider-to-provider communication if the patient is included, and patient-initiated messages if the provider responds.
5) Public Health Registry and Clinical Data Registry can count more than once toward the Public Health Reporting objective.
6) There are four public health measures available to all EPs, and a fifth is available only to EPs who practice in urgent care settings (i.e., Syndromic surveillance).

Source: CMS, Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017, 80 FR 62761, https://federalregister.gov/a/2015-25595; Health Care IT Advisor research and analysis.

Road Map

1 Modified Stage 2, Stage 3, and MACRA

2 Successful Practices to Prepare for Stage 3

3 Summary and Resources

Creative Solutions for MU Challenges Catalog

1 Electronic CQM Reporting

Present: Attest or report CQMs electronically (with opportunity to align with other CMS program requirements)
Stage 3: Electronic only (with opportunity to align with other CMS programs)

2 HIE/Transitions of Care

Present: >10% of summary of care records transmitted electronically
Stage 3: >50% of outbound summary of care records transmitted electronically (+40% increase)

3 View, Download, and Transmit

Present: 1 patient views, downloads, or transmits his/her health information
Stage 3: >10% of patient views, downloads, or transmits their health information and/or API (+10% increase)

4 Secure Messaging

Present: Secure messaging capability enabled for EPs
Stage 3: >25% of patients receives a secure message from the EH or EP (+25% increase)

5 Inpatient eRx[1]

Present: >10% of prescriptions electronically transmitted for EHs; >50% for EPs
Stage 3: >25% of prescriptions electronically transmitted for EHs; >60% for EPs (+10% to +15% increase)

6 Program Management

Present: Audit risk high; difficult to manage physician affiliation changes
Stage 3: Audit risk remains high; still difficult to manage physician affiliation changes

1) eRx = electronic prescribing. EHs may claim exclusion in 2015 and 2016.

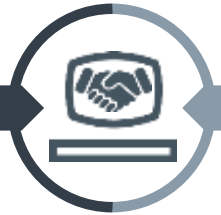
Source: Health Care IT Suite research and analysis.

Challenges and Benefits of eCQM Reporting

Recognize Uphill Climb, Realize Downstream Efficiencies

Challenges

- Vendor readiness
- Regulatory complexities
- Competing priorities, limited resources
- Lack of ownership, accountability, cooperation
- Customization needed for each reporting method



Benefits

- Centralize reporting efforts
- Avoid hefty penalties for reporting
- Meet regulatory imperatives
- Satisfy requirements for multiple reporting programs simultaneously: MU (EP/EH), PQRS (EP), VBPM (EP), IQR (EH)

Estimated Financial Penalties in 2017 per Provider Type

$2K[1]	$6K[1]	$1.2M[2]
EP: Penalty for not reporting PQRS data	EP: PQRS penalty plus VBPM penalty	EH: IQR penalty for not reporting CQM data

1) Assumes $100K in Medicare Part B claims.
2) Assumes $145M in annual Medicare fee for service (FFS) inpatient revenue and a 3% annual market basket update.

Sources: Health Care IT Advisor research and analysis.

Proven eCQM Alignment Strategies

A Four-Pronged Approach

Action Items	Successful Practices
Assess Technical Readiness	• **Your vendor is the gatekeeper**: You cannot achieve eCQM reporting success unless your vendor is ready to provide the capability • Plan to validate reports at a detailed level to ensure accurate performance
Assemble the Right Team	• Identify stakeholders with clinical quality experience • Enlist the help of early adopters to act as initiative champions
Estimate Operational and Strategic Gains	• Assess operational efficiencies gained by reduction in manual abstraction costs; one group saw 30%-40% improvement • Align high-quality goals with acquisition of value-based contracts
Map Out Measures and Evaluate Success	• Survey providers and practices to determine their preferred measures; alignment may be easier than you think • Choose a high-performance measure over an easy measure to report as it will have a huge impact on the VBPM

Related Research

"The Hospital 2016 Electronic CQM Reporting Mandate" (August 2015), "2016 EP Quality Reporting: CMS Offers More Flexible Reporting Options, But It's Time to Align" (March 2016), and on-demand webconference "How to Align Quality Reporting Across PQRS, MU, and VBPM" on advisory.com

Source: Health Care IT Advisor research and analysis.

Stepwise Approach for HIE (aka Transitions of Care)

Most EPs Have Yet to Report These Measures

86%

Percentage of EPs excluded from all Transitions of Care Stage 2 measures in 2014

Identify Outbound Transition Settings

- Track where patients are transferred or referred to
- Target top settings

Define the Denominator

- Choose whether to include or exclude internal transitions, if applicable
- Assess pros and cons of including "selfies" or not

Assess Available Technical Solutions

- Contract with third party to deliver summary of care records, if appropriate

Build Sustainability

- Formalize policies and procedures to ensure new providers receive Direct addresses

Additional Research

See Health Care IT Advisor Research Tool, Reporting Options for the Meaningful Use Health Information Exchange Objective: Decision trees for eligible hospitals and eligible professionals (August 2014)

Sources: CMS, Data and Program Reports, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HITPC_August-2015_Fulldeck.pdf; Health Care IT Advisor research and analysis.

Three Keys to Optimize HIE/Transitions of Care

Geisinger Solidifies External Partnerships, Automates Internal Process

1 Communicate value to transition partners

- Increase availability of Direct addresses among community providers
- Educate providers that electronic transmission addresses may be more cost effective than printing and fax
- Provide additional value to transition partners (e.g., send Skilled Nursing Facilities Minimum Data Set required for quality reporting)

2 Automate the TOC process

- Collect patient's PCP[1] upon registration
- Capture next provider of care (e.g., within referral order)
- Automate electronic SOCR[2] transmission

3 Increase your strategic gain

- Use utilization alerts to track transition and referral patterns
- Prepare for future MU requirements (e.g. receipt of incoming SOCR in Stage 3)

Case in Brief: Geisinger Health System

- Large integrated health services organization in central, south-central, and northeast Pennsylvania
- Serves more than 3 million residents in 48 counties

1) PCP = primary care physician.
2) SOCR = summary of care record.

Source: Health Care IT Advisor research and analysis.

Multiple Successful Approaches to Portal Enrollment

Increase Enrollments and Prove Value with Every Patient Interaction

Case in Brief: *Creativity and Competition* at MedStar Health

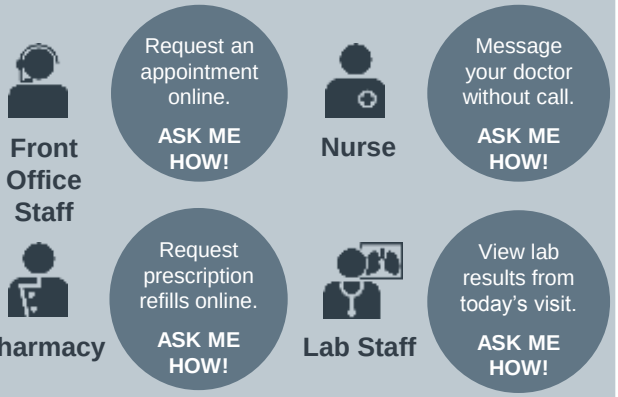
- Not-for-profit, 10-hospital system in MD, DC areas
- Allow each site to take ownership in patient engagement strategies
- Create competition across sites
- Recognize success and share best practices in a learning environment

Case in Brief: *Patient Population Needs* at Adventist Health

- Faith-based, not-for-profit, 19-hospital system headquartered in Roseville, CA
- Analyze patient's preferred language data
- Recruit additional multi-lingual staff to support patient log-in
- Adapt marketing materials to meet different patient population needs

Case in Brief: *Uninterrupted, Context-Driven Engagement* at St. Joseph Heritage Medical Group

- 45-physician primary care medical group based in Orange County, CA
- Train staff to engage in portal in ways relevant to job
- Create custom buttons worn by staff to increase opportunities to promote portal



Source: Health Care IT Advisor research and analysis.

Evolving Future Patient Engagement Strategies

Adventist Health's Next Moves to Engage Patients in Portal Use

Enhance Portal Functionality

- Manage consent for data proxy access
- Offer a mobile app
- Upload health and fitness data; sync with monitoring devices
- Provide context-driven health risk assessment and condition-specific questionnaires

Customize Value Message for Different Patient Groups

- Enhance support for different groups (e.g., new mothers)
- Create a one-stop-shop portal, including capability to combine data from various sources or providers, links to trusted health education sites, and customized reports

Address Privacy Issues Among Specific Patient Population

- Improve security and privacy understanding among non-English speaking, undocumented, indigent, and homeless patients
- Seek to develop multi-lingual documents
- Involve providers in building trust

Source: Health Care IT Advisor research and analysis.

Build Sustainable, Scalable Messaging Strategy

Providers Must Go Beyond Just Enabling the Functionality

Leverage Existing Workflows

- Expand communications infrastructure to incorporate secure messaging
- Educate staff on how to triage and monitor messages

Set Strategic Expectations

- Aim above MU measure performance threshold
- Ensure patient satisfaction (e.g., reply within two business days)[1]

Address Common Concerns

- Communicate proactively to build clinician buy-in
- Provide examples of efficiencies (e.g., no more “playing phone tag”)

Offer Providers Flexibility

- Accommodate individual workflow preferences
- Encourage advanced usage (e.g., follow-up after a patient’s visit)

Case in Brief: Susquehanna Health

- Four-hospital integrated health system in north-central Pennsylvania
- Used existing call center to rapidly implement secure messaging in September 2014

Source: Health Care IT Advisor research and analysis.

Prioritize Inpatient eRx Implementation

Realize Immediate Benefits (and More) from MU eRx Mandate

Reduced Risks and Improved Efficiency with Inpatient eRx

RISK REDUCTION

Complete view of inpatient, discharge, and outpatient medications and medication history

Payer collaboration with drug formularies

Compliant controlled substance prescribing

OPERATIONAL EFFICIENCY

Enables greater visibility into eRx practices on a per-prescriber basis

Closed-loop process with CPOE, medication reconciliation, patient education, and eRx

Internal pharmacy utilization to deliver medications via concierge service prior to discharge

Source: Health Care IT Advisor research and analysis.

Successful Inpatient eRx Implementation Practices

Inpatient eRx Implementation Phases and Member's Successful Practices





Readiness	Configuration	Training	Implementation	Optimization
• Leverage experience from previous CPOE adoption • Establish strategic imperatives • Identify champions	• Validate number and details of every intended user (e.g., collect NPIs[1]) • Confirm capabilities of external entities to receive electronic prescriptions	• Pilot functionality with specific groups (i.e., ED[2] or hospitalists) • Train SMEs,[3] nurses, and other front-line staff to support prescribers	• Provide 24x7 support for first several months • Know when to require eRx, set defaults • Confirm who is responsible for errors	• Configure ability to eRx controlled substances • Query external sources for prescription history

1) NPIs = National Provider Identifier.
2) ED = emergency department.
3) SME = subject matter expert.

Source: Health Care IT Advisor research and analysis.

MU Audits from All Directions

EPs Fail at Higher Rates, New Types More Challenging for All

Four Separate Auditors and Their Audit Scope

CMS EHR MU Audit Team

- Limited audit of CEHRT

Medicaid State Agencies and Designees

- Eligibility volume validation

Figliozzi & Company

- Full pre- and post-payment audit
- Specific stage and year

Office of Inspector General (OIG)

- Security risk analysis audit
- Full audit for multiple years
- Volume validation for multiple years
- State audit for program integrity

Medicare Audits

10,605	~22%
Number of EP audits	EP Failure Rate
651	~5%
Number of EH audits	EH Failure Rate

Related Research and Tool

- Meaningful Use Audits: Lessons Learned from the Front Line
- Thrive on Meaningful Use Audit – Webinar
- Meaningful Use Audit Checklist

Sources: Health Care IT Advisor research and analysis; http://www.healthsecuritysolutions.com/2014/11/05/meaningful-use-audits-infographic/#.VO9xtFEmZ8F.

Hidden Risks of Physician Affiliation Changes

Prepare Upfront to Prevent Costly Consequences

Challenges

Financial

- Collection of remaining incentive payments: who is the payee?
- Consequences of an EP's failure to demonstrate MU: who pays for the penalty?

Legal

- Agreement on payment and penalty ownership and potential audits
- An unexpected liability: non-cooperation data sharing between organizations

Operational

- MU status tracking and continuity of a provider's eligibility
- Technology adoption and workflow compliance
- Audit preparation and response

Six Steps to Mitigate the Risks

1. Partner with finance, legal, compliance, and HR to develop policy and contractual agreement
2. Gather information about an incoming EP's MU status and support documentation for an audit
3. Confirm continuity of an EP's eligibility in either Medicare or Medicaid program
4. Ensure consistency of an EP's information across multiple CMS systems, especially in the Registration and Attestation system
5. Collaborate with the training/coaching team to drive CEHRT adoption and compliance to organization-specific workflows and policies
6. Coordinate with an EP's previous and next employment entity

Related Research and Tool

- The Meaningful Use Risks Posed by Provider Affiliation Changes (July, 2015)
- Meaningful Use Participation Checklists for Eligible Professionals

Source: Health Care IT Advisor research and analysis.

Road Map

1 Modified Stage 2, Stage 3, and MACRA

2 Successful Practices to Prepare for Stage 3

3 Summary and Resources

Key Takeaways: Creative Solutions

1

Keep in lock-step with your vendor(s)

- Understand current capabilities and how to use them to your full advantage for MU
- Identify barriers to proactive MU performance that may relate to current vendor capabilities

2

Garner **strong, enterprise-wide buy-in**

- Build sustainability into your approach, and lend the effort to realize gains beyond MU alone
- Solicit support from across stakeholders to ensure successful, proactive strategies

3

Anticipate the **need to adapt**

- Assign staff to monitor for regulatory changes that may impact the approach
- Mitigate roadblocks with creative thinking and tenacity

Source: Health Care IT Advisor research and analysis.

MU Resources to Support Your Initiative

Our Most Recent Research

Research Notes

- 2016 EP Quality Reporting: CMS Offers More Flexible Reporting Options, But It's Time to Align
- Your Latest Meaningful Use Forecast
- Meaningful Use Crash Course: A Primer for Staff New to MU
- The Hospital 2016 Electronic CQM Reporting Mandate

Expert Insights

- Looking For a Specialized Registry? We Can Help
- A Deeper Dive: The 'Need to Know' and the 'Nice to Know' About the New MU Rules
- A Hospital Electronic CQM Reporting Mandate May Arrive Sooner Than You Think: Are You Ready?

Webconferences

- The Meaningful Use Field Guide for Health IT Developers
- The Latest Meaningful Use Forecast
- The Meaningful Use Hidden Risks Posed by Provider Affiliation Changes
- Meaningful Use Audits: Lessons Learned from the Front Line

Tools

- Meaningful Use Registry List (MURL)
- Meaningful Use Participation Checklists for Eligible Professionals
- Meaningful Use Audit Checklist

Questions?
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Source: Health Care IT Advisor research and analysis.