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Incentives Offered for ‘Meaningful Use" of EHR Technology

Overview of Medicare and Medicaid Incentive Programs for Electronic Health Records for Critical Access Hospitals

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Today's Agenda

- EHR Incentive Eligibility
- Meaningful Use Overview
- Reporting on Quality Measures
- Demonstrating "Meaningful Use"

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Proposed and Final Rule EHR Incentive

- Proposed Rule published by The Centers for Medicare & Medicaid Services (CMS) on January 13, 2010.
- Final Rule published by The Centers for Medicare & Medicaid Services (CMS) on July 28, 2010.
  - Outlines provisions related to the EHR incentive program.
  - Final Rule became effective September 27, 2010.
- Released in tandem with an Interim-Final Rule and a Final Rule from the Office of National Coordinator for Health Information Technology (ONC)
  - Represents a first step in an evolving process to adopting standards, implementation specifications, & certified criteria.
  - Goal is to enhance interoperability, functionality, utility & security of health information technology.
  - Intended to support the achievement of Stage 1 “meaningful use”.
  - Interim final rule became effective February 12, 2010
  - Final Rule becomes effective January 1, 2012.

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Incentive Eligibility Overview

- Congress has specified three requirements for meaningful use:
  - Use of certified EHR technology in a meaningful manner
  - Certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care
  - Providers submit to the Secretary of Health & Human Services information on clinical quality measures and such other measures selected by the Secretary.

- Incentives are available through both Medicare and Medicaid
  - "Meaningful use" requirements are the same

- Hospitals and CAHs will be entitled to participate in ***both*** Medicare and Medicaid incentive programs.

- Eligible Providers (EPs) are required to pick either the Medicare or the Medicaid program, and are not entitled to participate in both.
  - EPs do have the option to elect a one time switch between programs.

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Incentive Eligibility Overview *(cont'd)*

- In order to receive incentives, EPs and eligible hospitals and CAH's will have to meet the "meaningful use" criteria, as outlined in the final rule, within a specified payment period.
  - For the first "payment year" must demonstrate "meaningful use" for 90 consecutive days in order to be eligible for Medicare incentive.
  - For first payment year for Medicaid need only demonstrate engagement in efforts to adopt, implement, or upgrade certified EHR technology.

- The first payment year begins in 2011
  - For EPs the first year payment year is January 1, 2011 through December 31, 2011.
  - For eligible hospitals, the first year payment year is October 1, 2010 through September 30, 2011

- For remaining years, must demonstrate "meaningful use" throughout the entire payment period.

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Incentive Eligibility Overview *(cont'd)*

- Final rule defines "Eligible Physicians" as:
  - Doctor of medicine or osteopathy
  - Doctor of dental surgery or dental medicine
  - Doctor of podiatric medicine
  - Doctor of optometry
  - Chiropractor

- "Hospital based" physicians are currently not eligible to receive the incentive.
  - Final rule will utilize "Place of Service" (POS) codes to identify if hospital based or not.
  - POS 21 for IP and POS 23 for ED.
  - If 90% or more of services fall into one or more of the above POS, EP will be deemed "Hospital Based".

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Incentive Eligibility Overview *(cont'd)*

- Method and Timing of Payments to EPs
  - Payments cannot be comingled with other funds.
  - Payments made through a single payment contractor.
  - Integrated Data Repository (IDR) will accumulated the allowed charges.
  - Payment will be made to the EP, unless the EP reassigns their billing rights to employer or facility.
  - Payments made on rolling basis once EP has successfully demonstrated meaningful use for the applicable period and the EP's allowed charges has reached the required threshold.
  - Single, annual payment to be made and is expected to be paid within 15 to 46 days from when EP Attests to be a meaningful user.

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Incentive Eligibility Overview *(cont'd)*

- The table below depicts the maximum incentive amount from Medicare by year for qualifying EPs.
- Once a qualifying EP's charges reaches the required threshold in any year, full disbursement of the incentive will be made.

	1st CY in Which EP Receives Medicare Incentive Pymnt				
Calendar Year	**2011**	**2012**	**2013**	**2014**	**2015+**
2011	$ 18,000	---------------	---------------	---------------	---------------
2012	12,000	$ 18,000	---------------	---------------	---------------
2013	8,000	12,000	$ 15,000	---------------	---------------
2014	4,000	8,000	12,000	$ 12,000	---------------
2015	2,000	4,000	8,000	8,000	$ -
2016	---------------	2,000	4,000	4,000	-
Total *	**$ 44,000**	**$ 44,000**	**$ 39,000**	**$ 24,000**	**$ -**

***** Based on 75% of the EPs Medicare physician fee schedule allowed charges.***

Eligible for additional maximum of $4,400 over 5 year period if in HPSA.

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Incentive Eligibility Overview *(cont'd)*

- Physicians are eligible to receive Medicare incentive payments for a maximum of 5 consecutive years.
  - No incentive payments will be made beginning in 2015 and later years.

- Starting in 2015, reductions to the physician fee schedule will begin for those physicians who are not "meaningful users". These reductions are proposed to be as follows:
  - 2015 99% of fee schedule
    - ◊ If not a successful electronic prescriber for 2014, then reduction would be 2% to 98%
  - 2016 98% of fee schedule
  - 2017 and each subsequent year 97% of fee schedule.
  - 2018 and beyond, risk of receiving 95% of fee schedule.
    - ◊ If proportion of "meaningful users" is less than 75%.

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Incentive Eligibility Overview *(cont'd)*

- The table below depicts the maximum incentive amount from Medicaid by year for qualifying EPs.
- The Medicaid incentive is based on the "net allowable cost" of EHR technology.

	1st CY in Which EP Receives Medicaid Incentive Pymnt					
Calendar Year	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
2011	$ 21,250	---------------	---------------	---------------	---------------	---------------
2012	8,500	$ 21,250	---------------	---------------	---------------	---------------
2013	8,500	8,500	$ 21,250	---------------	---------------	---------------
2014	8,500	8,500	8,500	$ 21,250	---------------	---------------
2015	8,500	8,500	8,500	8,500	$ 21,250	---------------
2016	8,500	8,500	8,500	8,500	8,500	$ 21,250
2017	---------------	8,500	8,500	8,500	8,500	8,500
2018	---------------	---------------	8,500	8,500	8,500	8,500
2019	---------------	---------------	---------------	8,500	8,500	8,500
2020	---------------	---------------	---------------	---------------	8,500	8,500
2021	---------------	---------------	---------------	---------------	---------------	8,500
Total *	**$ 63,750**	**$ 63,750**	**$ 63,750**	**$ 63,750**	**$ 63,750**	**$ 63,750**

**** Based on 85% of net allowable costs in first year of $25,000 & $10,000 thereafter.***

EP must meet 30% Medicaid patient volume threshold (with some exceptions) to qualify.

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Incentive Eligibility Overview *(cont'd)*

- To qualify for Medicaid incentives, provider must be:
  - Physician
  - Dentist
  - Certified Nurse-Midwives
  - Nurse Practitioner
  - Physician Assistants practicing in an FQHC or RHC.

- Providers can not be provider based
  - Utilizing the same proposed definition as the Medicare incentive program.
  - Medicaid EPs practicing predominantly in an FQHC or RHC are not subject to the hospital-based exclusion.

- Must also meet the patient volume thresholds or practice predominantly in an FQHC or RHC to qualify.
  - Patient volume thresholds are as follows:
    - ◊ Physicians, Dentists, Certified Nurse-Midwives, Physician Assistants, Nurse Practitioner 30% Medicaid
    - ◊ Pediatricians 20% Medicaid
    - ◊ Patient volume thresholds will be based on patient encounters and not charges

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Incentive Eligibility Overview *(cont'd)*

- The table below outlines for formula that will be used to arrive at the Medicare eligible incentive amount for CAH hospitals.

- The CAH formula is primarily driven by the cost to acquire and implement EHR technology and does not encompass a base dollar, plus a per discharge amount.

CAH HOSPITAL EHR INCENTIVE PAYMENT FORMULA

Cost of EHR x (Medicare Portion + 20% *) = Incentive

Medicare Portion:

$$\frac{\text{(Part A IP Days + Part C IP Days)}}{\text{(Total IP Days) x ((Total Charges - Charity)/Total Charges))}}$$

**** Not to exceed 100%.***

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Incentive Eligibility Overview *(cont'd)*

- FIs/MACs will calculate the incentive payments using:
  - Prior year cost reports
  - Provider Statistical & Reimbursement (PS&R) System Data
  - Other Estimates
  - This includes interim payment and with year-end settlement.

- Days for the Medicare share will exclude swing bed days.
  - Medicare Days will come from Worksheet S-3, Part I lines 1, 6 through 9, 10 and 14, in column 4
  - Total days will come from Worksheet S-3, Part I lines 1, 6 through 9, 10 and 14 in column 6.

- "Cost of EHR" is equal to the undepreciated cost of EHR implementation.
  - If costs of EHR previously depreciated, they would not be eligible to consider in the "cost of EHR" for incentive purposes.

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Incentive Eligibility Overview *(cont'd)*

- Incentive based on reasonable cost of depreciable costs expensed in a single year. Non-depreciable costs are expensed and reimbursed through the Medicare cost report at 101%.
- Medicare share of reasonable cost cannot exceed 100%.
- Incentive payments to be made by a single payment contractor in prompt interim payments, one payment per year.
  - Payments expected to be made within 2 months of determination of the allowable amount
- Final payment to be calculated on the Medicare cost report.
- FI/MAC to review current and subsequent year's Medicare cost reports to ensure assets associated with the acquisition of certified EHR technology are expensed in a single year and that depreciation and interest expense associated with the acquisition are not allowed.

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Incentive Eligibility Overview *(cont'd)*

- CAHs are eligible to receive incentive payments for 4 consecutive years, with 2015 being the last year of eligibility.
  - If 2013 is first year of "meaningful use", then 2016 would be the 4th year, and no incentive would be received for 2016.
- If a CAH has not demonstrated meaningful use by FY 2015, then they will receive adjustments to it's reasonable costs.
- Instead of receiving reimbursement at 101% of it's costs, the CAH will receive the following:
  - FY 2015 100.66% of costs
  - FY 2016 100.33% of costs
  - FY 2017 and subsequent years 100% of reasonable costs

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Incentive Eligibility Overview *(cont'd)*

- Eligible CAH's will receive incentive payments from Medicaid based on the following methodology:
  - Base amount of $2,000,000
  - Plus $200 per discharge for discharges from 1,150th to 23,000th
  - Multiplied by the hospitals specific Medicaid share
  - Multiplied by the transition factor

- The "Medicaid share" for eligible hospitals is defined as:
  - Number of IP Medicaid days + Number of IP Medicaid Managed Care Days, divided by the following
  - Sum of the ratio: [(total charges – charity charges)/total charges) x total inpatient days]

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Incentive Calculation Formula for Hospitals

- The table below outlines for formula that will be used to arrive at the Medicaid eligible incentive amount for CAH's.
- The payment formula is designed to incent implementation of EHR for inpatient services, and ignores outpatient/ambulatory services.

CAH MEDICAID EHR INCENTIVE PAYMENT FORMULA

Base $ Amount + Discharge $ Amount x Medicaid Portion x Transition Factor = Incentive

Medicaid Portion:

$$\frac{\text{(Medicaid IP Days + Medicaid Managed Care IP Days}}{\text{(Total IP Days) x ((Total Charges - Charity) / Total Charges))}}$$

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Incentive Eligibility Overview *(cont'd)*

- The transition factor applied to the formula for eligible hospitals is as follows:

	Fiscal Year First Incentive Payment Received				
Fiscal Year	**2011**	**2012**	**2013**	**2014**	**2015+**
2011	1.00	---------------	---------------	---------------	---------------
2012	0.75	1.00	---------------	---------------	---------------
2013	0.50	0.75	1.00	---------------	---------------
2014	0.25	0.50	0.75	0.75	---------------
2015	---------------	0.25	0.50	0.50	0.50
2016	---------------	---------------	0.25	0.25	0.25

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Incentive Eligibility Overview *(cont'd)*

- Medicaid incentive for hospitals is equal to:
  - The sum over 4 years, utilizing an average annual growth rate for years 2-4.
  - The average annual growth rate is based on the provider's average annual rate of growth for the most recent 3 years for which data is available.
  - The payments are then distributed over a minimum of 3 years, and maximum of 6 years.
  - The last year a hospital may begin receiving incentive payments under the Medicaid program is 2016.

- Unlike Medicaid EPs who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

- In order to qualify for the Medicaid incentive, a hospital must:
  - Have an average length of stay of 25 days or less
  - Have the last 4 digits of their CMS Certification Number (CCN) in the series range of 0001 to 0879 or 1300 to 1399.
  - Have at least 10% of their patient volume be Medicaid

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Meaningful Use Summary

"Certified EHR technology used in a meaningful way by providers is one piece of a broader HIT infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety. Our goal is for this ultimate vision to drive the definition of meaningful use……"

CMS Quote from Proposed Rule For EHR Incentive Program

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Meaningful Use Overview

- Stage 1
  - Electronically capturing health information in a coded format.
  - Using electronic health information to track key clinical conditions and communicating that information for care coordination purposes.
  - Implementing clinical decision support tool to facilitate disease and medication management.
  - Report on clinical quality measures and public health information

- Stage 2
  - Expand upon Stage 1 criteria to encourage use of health IT for continuous quality improvement
    - ◊ Electronic transmission of orders using Computer Physician Order Entry (CPOE)
    - ◊ Electronic transmission of diagnostic test results.
      - Blood test, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests and other such data needed to diagnosis and treat disease.
    - ◊ Consideration being given to broaden criteria to both inpatient and outpatient services

- Stage 3
  - Primary focus is on promoting improvements in quality, safety and efficiency.
  - Key focus areas will be:
    - ◊ Decision support for national high priority conditions
    - ◊ Patient access to self management tools
    - ◊ Access to comprehensive patient data and improving population health

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Meaningful Use Overview *(cont'd)*

- CMS is proposing a phase-in approach to meaningful use.
  - Phases are based on available technology and provider practice experience and builds to more "robust" criteria through each phase.
  - Updates to meaningful use will be through future rule making.

- CMS has outlined criteria for three stages, and the timing of each stage is reflected in the table below.
  - Updates for each stage will be provided on a bi-annual basis
  - Stage 2 will be available by the end of 2011
  - Stage 3 will be available by the end of 2013

- Stage 1 will be the criteria until Stage 2 criteria are published

	Payment Year				
First Payment Year	**2011**	**2012**	**2013**	**2014**	**2015+**
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012	----------------	Stage 1	Stage 1	Stage 2	TBD
2013	----------------	----------------	Stage 1	Stage 1	TBD
2014	----------------	----------------	----------------	Stage 1	TBD

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Meaningful Use Overview *(cont'd)*

- Stage 1 meaningful use criteria structure is derived from recommendations of the HIT Policy Committee.
  - Group objectives under "care goals"
  - "Care goals" are in turn grouped under health outcomes priorities.

- The corresponding health outcomes priorities and care goals are as follows:
  - Improving Quality, Safety, Efficiency and Reducing Health Disparities.
    - ◊ Provide access to comprehensive patient health data
    - ◊ Use evidence base orders and CPOE
    - ◊ Apply clinical decision support
    - ◊ Generate lists of patients who need care
    - ◊ Report information for quality improvements

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Meaningful Use Overview *(cont'd)*

- Engage Patients & Families in Their Health Care
  - ◊ Provide patients and families with timely access to data, knowledge, and tool to make informed decisions to manage their health.
- Improve Care Coordination
  - ◊ Exchange meaningful clinical information among professional health care team.
- Ensure Adequate Privacy and Security Protections for Personal Health Information
  - ◊ Ensure privacy and security protections for confidential information through operating policies and procedures, and technologies and compliance with applicable law.
  - ◊ Provide transparency of data sharing to patient.

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Meaningful Use Overview *(cont'd)*

- For each "Care Goal", CMS has outlined a series of objectives that must be met in order to achieve "meaningful use".
- These objectives have been designed for both EP's and eligible hospitals.
- Stage 1 Objectives in two categories:
  - Core Objectives – must meet all
  - Menu Objectives – must meet all but 5

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Overview of Stage 1 Objectives & Measures

CORE SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Improving quality, safety, efficiency, and reducing health disparities.	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered
	Implement drug-drug, drug-allergy interaction tests	Implement drug-drug, drug-allergy interaction tests	The EP/eligible hospital has enabled this functionality for the entire EHR reporting period.
	Generate and transmit permissible prescriptions electronically (eRX).		More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
	Record demographics: - Preferred language - Gender - Race - Ethnicity - Date of birth	Record demographics: - Preferred language - Gender - Race - Ethnicity - Date of birth - Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

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Overview of Stage 1 Objectives & Measures *(cont'd)*

CORE SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Improving quality, safety, efficiency, and reducing health disparities.	Maintain an up-to-date problem list of current and active diagnoses.	Maintain an up-to-date problem list of current and active diagnoses.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no
	Maintain active medication list.	Maintain active medication list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.
	Maintain active medication allergy list.	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known allergies) recorded as structured data.
	Record and chart changes in vital signs: - Height - Weight - Blood pressure - Calculate and display BMI - Plot and display growth charts children 2-20 years, including BMI	Record and chart changes in vital signs: - Height - Weight - Blood pressure - Calculate and display BMI - Plot and display growth charts children 2-20 years, including BMI	More than 50% of all unique patients age 2 and over seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) height, weight and blood pressure are recorded as structured data.

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Overview of Stage 1 Objectives & Measures *(cont'd)*

CORE SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Improving quality, safety, efficiency, and reducing health disparities.	Record smoking status for patients 13 years and older.	Record smoking status for patients 13 years and older.	More than 50% of all unique patients 13 years old and older seen by EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have "smoking status" recorded as structured data.
	Implement 1 clinical decision support rule relevant to specialty or high clinical priority, including diagnostic test ordering along with the ability to track compliance with that rule.	Implement 1 clinical decision support rule relevant to a high priority hospital condition along with the ability to track compliance with that rule.	Implement 1 clinical decision support rule.
	Report ambulatory clinical quality measures to CMS or the States.	Report hospital clinical quality measures to CMS or the States.	For 2011 provide aggregate numerator, denominator and exclusions through attestation as discussed in Section II (A)(3) of the final rule. For 2012 electronically submit the clinical quality measures as discussed in Section II (A)(3) of the final rule.

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Overview of Stage 1 Objectives & Measures *(cont'd)*

CORE SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Engage Patients & Families in Their Health Care.	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.	More than 50% of all patients of the EP or the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.
		Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge
	Provide clinical summaries for patients for each office visit.		Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.

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Overview of Stage 1 Objectives & Measures *(cont'd)*

CORE SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Improve Care Coordination	Capability to exchange key clinical information (for example problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically.	Capability to exchange key clinical information (for example discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Ensure adequate privacy and security protections for personal health information.	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correctly identify security deficiencies as part of its risk management process.

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Overview of Stage 1 Objectives & Measures *(cont'd)*

MENU SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Improving quality, safety, efficiency, and reducing health disparities.	Implement drug-formulary checks	Implement drug-formulary checks	The ER/eligible hospital/eligible CAH has enabled this functionality and has access to at least one internal for external drug formulary for the entire EHR reporting period
		Record advance directives for patients 65 years old and older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded
	Incorporate clinical lab tests into certified EHR technology as structured data.	Incorporate clinical lab tests into certified EHR technology as structured data.	More than 40% of all clinical lab tests ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to the inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are in the positive/negative or numerical format are incorporated in certified EHR as structured data.
	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of EP or eligible hospital or CAH with a specific condition.
	Send reminder to patients per patient preference for preventive/follow-up care.		More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR

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Overview of Stage 1 Objectives & Measures

(cont'd)

MENU SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Engage Patients & Families in Their Health Care.	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP.		More than 10% of all unique patients seen by the EP are provided timely (within four business days of being updated of the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources
Improve Care Coordination	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH performs medication reconciliations for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals

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Overview of Stage 1 Objectives & Measures *(cont'd)*

MENU SET			
	STAGE 1 OBJECTIVES		
Health Outcomes Policy Priority	**Eligible Professionals**	**Hospitals**	**Stage 1 Measures**
Improve Population and Public Health (2)	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits information have the capacity to receive the information electronically)
		Capability to submit electronic data on reportable lab results (as required by State or local law) to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).
	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	Performed at least one test of certified HER technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP or eligible hospital or CAH submits such information have the capacity to receive the information electronically).

(2) Unless the EP, eligible hospital or CAH has an exception for all of these objectives and measures they must complete at least one as part of the menu set in order to be a meaningful EHR user.

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Reporting on Quality Measures

- For 2011, CMS proposes that EPs and eligible hospitals use an attestation methodology to submit summary information to CMS on clinical quality measures as a condition of demonstrating meaningful use.
  - For Medicaid incentive, reporting on quality measures is deferred until 2012.
- Submission by attestation is primarily due to the anticipation that HHS will not complete necessary steps to enable CMS to electronically accept data on clinical measures in time for 2011.
  - It is anticipated, however, that these steps will be completed by 2012 payment year.
  - Assuming necessary steps are completed by 2012 EPs and eligible hospital will be required to submit quality data electronically, regardless if this is their first or second year.
- In an effort to reduce duplication, CMS is proposing reporting on the same quality measures for both Medicare and Medicaid.
  - They have provided some alternative quality indicators for hospitals to report on in the proposed rule.

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Reporting on Quality Measures *(cont'd)*

- Even though electronic reporting on quality measures will not be required until 2012, CMS is proposing to avoid delaying the use of certified EHR technology to measure and improve clinical quality.
- It is CMS's belief that the functionalities that support measurement of clinical quality is highly important to an overall goal of the HITECH Act, to improve health care quality.
- Because of this belief, CMS is proposing the following related to quality reporting in 2011:
  - Certified EHR technology must be used to capture data elements and calculate results for applicable quality indicators.
  - EPs & eligible hospitals must demonstrate meeting this requirement by attestation for 2011.
  - EPs & eligible hospitals must attest to the accuracy & completeness of the numerators & denominators used for each applicable measure.
  - Must report results to CMS for ***all*** applicable patients.
- States may accept attestations in the same manner for Medicaid incentive.

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Reporting on Quality Measures *(cont'd)*

- The final rule outlined 90 different quality measures to be reported on by EPs. The final rule specifies 44 of the measures to be applicable for Stage 1 requirements and the remaining 46 to be applicable for Stage 2.
  - Measures are consistent with Physician Quality Reporting Initiative (PQRI)
- Measures encompass the following measures groups:
  - Core Measures Group
  - Cardiology
  - Pulmonology
  - Endocrinology
  - Oncology
  - Proceduralist/Surgery
  - Primary Care
  - Pediatrics
  - OB &Gyn
  - Neurology
  - Psychiatry
  - Ophthalmology
  - Podiatry
  - Radiology
  - Gastroenterology
  - Nephrology
- CMS is requiring that all EPs report on six total measures;
  - Three measures under the "Core Measures Group",
  - Plus three other additional measures, other than those in the core and alternative core group.

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Reporting on Quality Measures *(cont'd)*

- Eligible hospitals will have 15 different quality measures to report on in 2011 and 2012.
  - Measures are consistent with Reporting Hospital Quality Data for Annual Payment Update (RHPQDAPU).
- CMS is requiring hospitals to report on all EHR incentive clinical quality measures for which they have applicable cases.
- Eligible hospitals who report on all 15 quality measures will qualify for both the Medicare and Medicaid submission requirements.
- For 2013, CMS is proposing to add measures for the following:
  - Additional pediatrics measures
  - Long-term care measures
  - Additional obstetrics measures
  - Dental care/oral health measures
  - Additional mental health and substance abuse measures

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Demonstrating Meaningful Use

- In order to be eligible to receive incentive payments, EP's and eligible hospitals will have to complete an initial registration.

- The initial registration will be made in the first payment year, and will require the following:
  - Name of EP or hospital
  - National Provider Identification (NPI) number
  - Business address and telephone number
  - Taxpayer Identification Number (TIN) for EPs
  - CMS Certification Number (CCN) & TIN for hospitals and CAHs
  - Prior to first payment year, EPs must notify if they plan to participate in the Medicare or Medicaid incentive program.

- In order to demonstrate "meaningful use" EPs and hospitals will have to attest to the following:
  - During the EHR reporting period, certified EHR technology was used, and will have to specify the EHR technology.
  - Each of the applicable objectives and associated measures were satisfied.

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Demonstrating Meaningful Use *(cont'd)*

- To accomplish the attestations for 2011, CMS has broken down the objectives into three categories:
  - Set A - Attestation
    - ◊ Those objectives which certified EHR technology will generate automated numerator and denominator information, where required, or automated summary reports.
  - Set B - Attestation
    - ◊ Those objectives which will still require the manual gathering of information in order to report numerators and denominators, or to take any other additional steps before attesting that the objective has been met.
  - Attestation for Quality Measures

- Set A Attestation Example:
  - Stage 1 Objective
    - ◊ Maintain active medication list
  - Measure Requirement
    - ◊ At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least 1 entry recorded as structured data.
  - Reporting Requirement:
    - ◊ Numerator and denominator data
  - In this case, CMS is assuming the functionality to arrive at the numerator and denominator data will be built into the certified EHR technology.

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Demonstrating Meaningful Use *(cont'd)*

- Set B Attestation Example
  - Stage 1 Objective
    - ◊ Generate and transmit permissible prescriptions electronically
  - Measure Requirement
    - ◊ For EPs, at least 75% of all permissable prescriptions are transmitted using certified EHR technology.
  - Reporting Requirement
    - ◊ Numerator and denominator data

- For this objective, CMS anticipates some EHR technology may not have the functionality to generate numerator and denominator information automatically, so EPs and hospitals will be required to gather it manually to complete the attestation.

- For 2012 and after, the attestations will be as follows:
  - Set A - Attestation
  - Set B - Attestation
  - ***Electronic Submission*** of Quality Measures

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Demonstrating Meaningful Use *(cont'd)*

- For Quality Reporting, CMS has proposed that EP's & hospitals attest to following 8 requirements:
  - Certified EHR technology was used to ***capture*** the data elements & ***calculate*** the results.
  - Attest to the accuracy and completeness of data submitted.
  - Information submitted was generated as output of an identified certified health record.
  - Information submitted includes information on ***all patients*** to whom the measure applies (regardless of payer).
  - The identifying information for the EP or hospital is accurate.
  - For EPs who are exempt from reporting on core measures or specialty measurement group, that they do not apply to practice of the EP.
  - For hospitals that do not report on one or more of the measures, an attestation that the measure not reported did not apply to any patients treated by the hospital during the reporting period.
  - Accuracy of the beginning and ending dates for which the numerators & denominators and exclusions apply.
  - The numerators, denominators and exclusions for each clinical quality measure result reported, providing separate information for all patients irrespective of third party payer.

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Conclusion

- Incentive dollars are significant and represent a real opportunity for providers
- Stage 1 represents only the beginning……….
- For some, achieving “meaningful use” represents a significant amount of work

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Thank You

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Additional questions can be submitted by email to:

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