

Incentives Offered for ‘Meaningful Use’ of EHR Technology



Session 1: Overview of Medicare & Medicaid Incentive Programs for Electronic Health Records

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Sustainable Healthcare Solutions

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Three Part Series Overview

- **Session 1: Overview of Medicare & Medicaid Incentive Programs for Electronic Health Record**
 - Date: Tuesday, February 23, 2009
 - Presenter: Rob Schile, CPA
- **Session 2: EHR Planning, Implementation and “Meaningful Use”**
 - Date: Tuesday, March 2, 2010
 - Presenter: Jeremy Pierotti, Validus Consulting
- **Session 3: Security and EHR**
 - Date: Tuesday, March 9, 2010
 - Presenter: Jeremy Pierotti, Validus Consulting and Randy Romes, LarsonAllen



Today's Agenda

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



Proposed EHR Incentive

- Issued by The Centers for Medicare & Medicaid Services (CMS) on December 30, 2009.
 - Outlines provisions related to the EHR incentive program, including:
 - Public comment period ends March 15, 2010
 - CMS expects to issue final rule sometime after March 2010, with the final rule becoming effective 60 days later.
- Released in tandem with an Interim-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” in CMS proposed rule.
 - Interim final rule, that becomes effective February 12, 2010



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 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.



Incentive Eligibility Overview *(cont'd)*

- In order to receive incentives, EPs and eligible hospitals will have to meet the “meaningful use” criteria, as outlined in the proposed 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.



Incentive Eligibility Overview *(cont'd)*

- Proposed 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.
 - Proposed rule will utilize “Place of Service” (POS) codes to identify if hospital based or not.
 - POS 21 for IP, 22 for OP, 23 for ED.
 - If 90% or more of services fall into one or more of the above POS, EP will be deemed “Hospital Based”.



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.



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%.



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.

Calendar Year	1st CY in Which EP Receives Medicaid Incentive Pymnt					
	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.



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



Incentive Eligibility Overview *(cont'd)*

- Eligible hospitals will receive incentive payments from Medicare 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 Medicare share
 - Multiplied by the transition factor
- FIs/MACs will calculate the incentive payments using:
 - Prior year cost reports
 - Provider Statistical & Reimbursement (PS&R) System Data
 - Other estimates
- The “Medicare share” for eligible hospitals is defined as:
 - # of IP Part A days + # of IP Part C Days, divided by the following
 - Sum of the ratio: $[(\text{total charges} - \text{charity charges}) / \text{total charges}] \times \text{total inpatient days}$



Incentive Calculation Formula for PPS Hospitals

- The table below outlines for formula that will be used to arrive at the eligible incentive amount for PPS hospitals.
- Incentive payments will be made to PPS hospitals on an interim basis, with final settlement based on filed cost report information for each respective payment year.
- The payment formula is designed to incent implementation of EHR for inpatient services, and ignores outpatient/ambulatory services.

PPS HOSPITAL EHR INCENTIVE PAYMENT FORMULA

$$\text{Base \$ Amount} + \text{Discharge \$ Amount} \times \text{Medicare Portion} \times \text{Transition Factor} = \text{Incentive}$$

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



Incentive Eligibility Overview *(cont'd)*

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

Fiscal Year	Fiscal Year First Incentive Payment Received				
	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

- The maximum number of years a hospital will be eligible to receive an incentive payment from Medicare will be 4 years.
 - However, reductions to the annual PPS update factors will begin in FY 2015, for those hospitals who are deemed to not be meaningful users.
- Once a hospital has demonstrated meaningful use for a payment year, the FI/MAC will calculate the hospitals incentive amounts and disburse on an interim basis.
- Data from the prior year filed cost report will be used to calculate interim payments, and final settlement will be made based on the current payment year cost report.



Incentive Eligibility Overview *(cont'd)*

- Beginning in FY 2015, Hospitals that are not deemed “meaningful users” will receive reduced updates to the IPPS standardized amount.
- The adjustment will be applied to three-quarters of the percentage increase in the IPPS standardized amount, as follows:
 - 2015: 33 1/3rd percent reduction
 - 2016: 66 2/3rd percent reduction
 - 2017 and subsequent years: 100% reduction
- Reduction Example: Assume 2% market basket increase for 2015.
 - $2\% \times 75\% = 1.50\%$
 - $1.50\% \times 33\frac{1}{3}\% = .50\%$ reduction for 2015
- These reductions would be in addition to the reduction of .25% for not reporting quality data.
- Once “meaningful use” is achieved, hospital will receive the same market basket increase as other hospitals.



Incentive Eligibility Overview *(cont'd)*

- Medicaid incentive for hospitals is calculated using essentially the same formula as Medicare, described earlier.
 - The primary difference is under the Medicaid incentive program, the sum over 4 years is calculated, 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.
 - Have at least 10% of their patient volume be Medicaid



Incentive Eligibility Overview *(cont'd)*

- The table below outlines for formula that will be used to arrive at the 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

$$\text{Cost of EHR} \times \left(\frac{\text{Medicare Portion}}{\text{(Part A IP Days + Part C IP Days)}} \times \frac{\text{(Total Charges - Charity)}}{\text{Total Charges}} \right) + 20\% * = \text{Incentive}$$

* *Not to exceed 100%.*



Incentive Eligibility Overview *(cont'd)*

- FIs/MACs will calculate the incentive payments using same methodology as for PPS Hospitals.
 - 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.
- 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.



Incentive Eligibility Overview *(cont'd)*

- If a CAH has not demonstrated meaningful use by FY 2015, then they will receive adjustments to its reasonable costs.
- Instead of receiving reimbursement at 101% of its 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
- Because CAHs do not meet the eligibility requirements for the Medicaid incentive program, they would not be eligible to receive Medicaid incentives.



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**



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 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



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	Stage 3
2012	-----	Stage 1	Stage 1	Stage 2	Stage 3
2013	-----	-----	Stage 1	Stage 2	Stage 3
2014	-----	-----	-----	Stage 1	Stage 3
2015+	-----	-----	-----	-----	Stage 3



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



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.
 - Improve Population and Public Health
 - ◇ Communicate with public health agencies
 - 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.
-
- 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.



Overview of Stage 1 Objectives & Measures

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities.	Provide access to comprehensive patient health data for patient's health care team.	Use CPOE	Use CPOE for orders (any type) directly entered by authorizing provider (for example MD, DO, RN, PA, NP).	For EP's CPOE is used for at least 80% of all orders. For eligible hospitals, CPOE is used for 10% of all orders.
	Use evidence based order tests and CPOE	Implement drug-drug, drug-allergy, drug formulary checks.	Implement drug-drug, drug-allergy, drug formulary checks.	The EP/eligible hospital has enabled this functionality.
	Apply clinical decision support at point of care.	Maintain an active up to date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT.	Maintain an active up to date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT.	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data.
	Generate lists of patients who need care and use them reach out to patients.			
	Report information for quality improvement and public reporting.	Generate and transmit permissible prescriptions electronically (eRX).	-----	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
		Maintain active medication list.	Maintain active medication list.	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital 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.	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.



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

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities.		Record demographics: - Preferred language - Insurance type - Gender - Race - Ethnicity - Date of birth	Record demographics: - Preferred language - Insurance type - Gender - Race - Ethnicity - Date of birth - Date and cause of death in the event of mortality.	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics 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	For at least 80% of all unique patients seen by the EP or admitted to the eligible hospital, record blood pressure, and BMI; additionally plot growth chart for children age 2-20.
		Record smoking status for patients 13 years and older.	Record smoking status for patients 13 years and older.	At least 80% of all unique patients 13 and older seen by EP or admitted to the eligible hospital have "smoking status" recorded.
		Incorporate clinical lab tests into EHR as structured data.	Incorporate clinical lab tests into EHR as structured data.	At least 50% of all clinical lab tests ordered 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 and outreach.	Generate lists of patients by specific conditions to use for quality improvement reduction of disparities and outreach.	Generate at least one report listing patients of EP or eligible hospital with a specific condition.



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

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities.		Report ambulatory quality measures to CMS or the States.	Report hospital quality measures to CMS or the States.	For 2011 provide aggregate numerator and denominator through attestation as discussed in Section II (A)(3) of proposed rule. For 2012 provide aggregate numerator and denominator through attestation as discussed in Section II (A)(3) of proposed rule.
		Send reminder to patients per patient preference for preventive/follow-up care.	-----	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over.
		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering along with the ability to track compliance with those rules.	Implement 5 clinical decision support rules relevant to a high priority hospital condition, including diagnostic test ordering along with the ability to track compliance with those rules.	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).
		Check insurance eligibility electronically from public and private payers.	Check insurance eligibility electronically from public and private payers.	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital.
		Submit claims electronically to public and private payers.	Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital.

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

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
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.	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request.	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request.	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.
			Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it.
		Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP.	-----	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information.
		Provide clinical summaries for patients for each office visit.	-----	Clinical summaries are provided for at least 80% of all office visits.



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

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
Improve Care Coordination	Exchange meaningful clinical information among professional health care team.	Capability to exchange key clinical information (for example problem list, medication list 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 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.
		Perform medication reconciliation at relevant encounters and each transition of care.	Perform medication reconciliation at relevant encounters and each transition of care.	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care.
		Provide summary care record for each transition of care and referral.	Provide summary care record for each transition of care and referral.	Provide summary of care record for at least 80% of transitions of care and referrals.



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

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
Improve Population and Public Health	Communicate with public health agencies.	Capability to submit electronic data to immunization registries and actual submission where required and accepted.	Capability to submit electronic data to immunization registries and actual submission where required and accepted.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.
			Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received.	Performed at least one test of the HER system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital 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 (unless none of the public health agencies to which an EP or eligible hospital submit such information have the capacity to receive the information electronically).



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

STAGE 1 OBJECTIVES

Health Outcomes Policy Priority	Care Goals	Eligible Professionals	Hospitals	Stage 1 Measures
<p>Ensure adequate privacy and security protections for personal health information.</p>	<p>Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.</p> <p>Provide transparency of data sharing to patient.</p>	<p>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.</p>	<p>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.</p>	<p>Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary.</p>



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.



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.



Reporting on Quality Measures *(cont'd)*

- The proposed rule outlines 90 different quality measures to be reported on by EPs.
 - 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 proposing that all EPs report on the measures under the “Core Measures Group”, plus one other measures group that most closely resembles the EPs practice focus.
- CMS also expects to narrow the standardized sets of measures in each group to 3 to 5 measures.
 - These will be based on availability of electronic measure specifications and comments received.



Reporting on Quality Measures *(cont'd)*

- Eligible hospitals will have approximately 34 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 proposing to requires hospitals to report on all EHR incentive clinical quality measures for which they have applicable cases.
- Eligible hospitals who are also participating in the Medicaid EHR incentive program, will also be required to report on all Medicaid clinical quality measures.
- CMS is soliciting comments as to if it would be more feasible to defer some or all clinical quality reporting until 2012.
- 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



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.



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.



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 permissible 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



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.



Conclusion

- Regulations are still in proposed format
- 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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