



Medicare & Medicaid EHR Incentive Program

Specifics of the Program for Hospitals

August 11, 2010





Today's Session

This training will cover the following topics:

- EHR Incentive Programs – a Background
- Who Is Eligible to Participate
- How Much Are the Incentives
- What Are the Requirements/Meaningful Use
- What You Need to Participate
- Timeline of the Programs
- Resources to Get Help and Learn More
 - <http://www.cms.gov/EHRIncentiveprograms>



Overview

- American Recovery & Reinvestment Act (Recovery Act) – February 2009
- Medicare & Medicaid Electronic Health Record (EHR) Incentive Program Notice of Proposed Rulemaking (NPRM)
 - Publication – January 13, 2010
 - NPRM Comment Period Closed – March 15, 2010
 - CMS received 2,000+ comments
- Final Rule on Display – July 13, 2010
- Final Rule Published – July 28, 2010



What is the EHR Incentive Program?

EHR Incentive Programs were established by law

- American Recovery & Reinvestment Act of 2009
- Incentive programs for Medicare and Medicaid
- Programs for hospitals and eligible professionals
- Must use certified EHR technology AND demonstrate adoption, implementation, upgrading (Year 1 Medicaid Only) or meaningful use
- Programs differ between Medicare and Medicaid
- Medicare incentive program is federally run by CMS
- Medicaid incentive program is run by States and is voluntary



Who is Eligible to Participate?

- Eligibility determined in law
- Medicare Hospitals include:
 - Acute Care Hospitals
 - Subsection (d) hospitals that are paid under the PPS and are located in the 50 States or Washington, DC (including Maryland)
 - Critical Access Hospitals (CAHs)



Who is Eligible to Participate?

- Medicare Advantage Affiliated Eligible Hospitals:
 - Will be paid under the Medicare Fee-for-service EHR incentive program
- Medicaid Hospitals include:
 - Acute Care Hospitals (now including CAHs)
 - Medicaid included critical access hospitals in its definition of “acute care hospital” (but incentive is like other acute care hospitals, not following the Medicare CAH formula)
 - Children’s Hospitals



How Much Are the Incentives?

- Federal Fiscal Year
- \$2M base + per discharge amount (based on Medicare/Medicaid share)
- Medicare's calculation derives a payment amount, while Medicaid's calculation derives a total amount that States may pay eligible hospitals.
- Hospitals meeting Medicare Meaningful Use requirements may be deemed eligible for Medicaid payments



How Much Are the Incentives?

- Payment adjustments for Medicare begin in 2015
 - No Federal Medicaid payment adjustments
- Medicare hospitals: No payments after 2016



How Much Are the Incentives?

- Medicaid Hospital specifics:
 - Similar to Medicare hospital methodology
 - Payment is calculated, then disbursed over 3-6 years
 - No annual payment may exceed 50% of the total calculation; no 2-year payment may exceed 90%
 - Hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016
 - States must use auditable data sources in calculating the hospital incentive (e.g., cost report)
 - Payments through 2021



How Much Are the Incentives? Medicare Hospital Calculation

(Base Amount + Discharge Related Amount
Applicable for Each Year)*

$$\left[\frac{\text{Medicare inpatient-bed-days} + \text{Medicare Advantage inpatient-bed-days}}{\text{total inpatient-bed days}} * (\text{estimated total charges} - \text{charity care charges}) / (\text{estimated total charges}) \right]$$

* Transition Factor Applicable for Each Year



How Much Are the Incentives? Medicaid Hospital Calculation

(Overall EHR Amount) * (Medicaid Share)

or

{Sum over 4 year of [(Base Amount)+ Discharge
Related Amount Applicable for Each Year) *
Transition Factor Applicable for Each Year]} *

[(Medicaid inpatient-bed-days + Medicaid
managed care inpatient-bed-days) / {(total
inpatient-bed days) * (estimated total charges –
charity care charges)/(estimated total charges)}]



What are the Requirements/ Adopt/Implement/Upgrade?

- Adopted: Acquired and installed
 - - e.g., evidence of installation prior to incentive
- Implemented: Commenced utilization of
 - - e.g., staff training, data entry of patient demographic information into EHR
- Upgraded: Expanded
 - - e.g., upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology



What are the Requirements/ Adopt/Implement/Upgrade?

- Eligible hospitals, unlike EPs, may receive incentives from Medicare and Medicaid
 - Subsection(d) hospitals, acute care (including CAHs)



What are the Requirements/ Meaningful Use?

- Meaningful Use is using certified EHR technology to
 - Improve quality, safety, efficiency, and reduce health disparities
 - Engage patients and families in their health care
 - Improve care coordination
 - Improve population and public health
 - All the while maintaining privacy and security
- Meaningful Use mandated in law to receive incentives



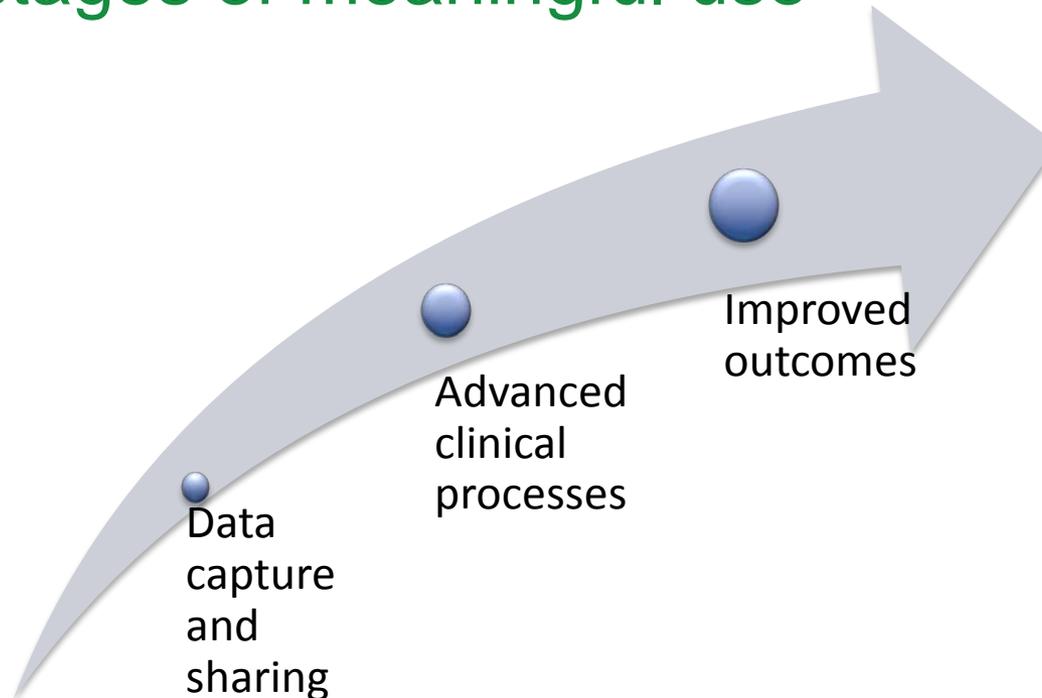
What are the Requirements/ Meaningful Use?

- The Recovery Act specifies the following 3 components of Meaningful Use:
 1. Use of certified EHR in a meaningful manner (e.g., e-prescribing)
 2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care
 3. Use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary



What are the Requirements/ Meaningful Use?

- Rule making was open to public comment
- Listened to many comments received
- Three stages of meaningful use





What are the Requirements/ Meaningful Use?

- Basic Overview of Stage 1 Meaningful Use:
 - Payments based on Federal Fiscal Year
 - Reporting period is 90 days for first year and 1 year subsequently
 - Reporting through attestation
 - Meaningful Use Objectives and Clinical Quality Measures
 - Reporting may be yes/no or numerator/denominator attestation
 - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology



What are the Requirements/ Meaningful Use?

- Stage 1 Objectives and Measures Reporting
- Eligible Hospitals must complete:
 - 14 core objectives
 - 5 objectives out of 10 from menu set
 - 15 total Clinical Quality Measures



What are the Requirements/ Meaningful Use?

- Meaningful Use Core Objectives Selected:
 - Overarching considerations
 - Statutory requirements-e.g.- e-prescribing, CQM, health information exchange
 - Foundational objectives-e.g. privacy and security and those that provide foundational data needed for other measures, like demographics, medication lists, etc.



What are the Requirements/ Meaningful Use?

- Meaningful Use Core Objectives Selected:
(continued)
 - Patient-centered
 - Patient access- e.g. clinical summaries
 - Patient safety-e.g.-drug-drug and drug-allergy features)
 - Part of providers' "standard" of practice
 - Looked at how the objectives aligned with other CMS programs
 - Feedback received from HIT Policy Committee and commenters



What are the Requirements/ Meaningful Use?

- Some MU objectives not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator. Exclusions do not count against the 5 deferred measures
- In these cases, the eligible professional, eligible hospital or CAH would be excluded from having to meet that measure



What are the Requirements/ Meaningful Use?

- Two types of percentage based measures are included to address the burden of demonstrating Meaningful Use
 1. Denominator is all patients seen or admitted during the EHR reporting period
 - The denominator is all patients regardless of whether their records are kept using certified EHR technology
 2. Denominator is actions or subsets of patients seen or admitted during the EHR reporting period
 - The denominator only includes patients, or actions taken on behalf of those patients, whose records are kept using certified EHR technology



What are the Requirements/ Meaningful Use?

- Thresholds determined:
 - 80%-Objective part of standard practice-e.g.-maintain active medication list
 - Others-defined on a case-by-case basis based on commenter or clearance feedback
 - Example-e-prescribing set at 40% lowered from 75% to address concerns by commenters regarding non-participation by pharmacies and patient preference.



What are the Requirements/ Meaningful Use?

- **Eligible Hospitals – 14 Core Objectives**
 1. CPOE
 2. Drug-drug and drug-allergy interaction checks
 3. Record demographics
 4. Implement one clinical decision support rule
 5. Maintain up-to-date problem list of current and active diagnoses
 6. Maintain active medication list
 7. Maintain active medication allergy list



What are the Requirements/ Meaningful Use?

- **Eligible Hospitals – 14 Core Objectives**
 8. Record and chart changes in vital signs
 9. Record smoking status for patients 13 years or older
 10. Report hospital clinical quality measures to CMS or States
 11. Provide patients with an electronic copy of their health information, upon request



What are the Requirements/ Meaningful Use?

- **Eligible Hospitals – 14 Core Objectives**
 12. Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request
 13. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
 14. Protect electronic health information



What are the Requirements/ Meaningful Use?

- **Eligible Hospitals – 10 menu items**
- At least 1 public health objective must be selected (designated with asterisk)
 1. Drug-formulary checks
 2. Record advanced directives for patients 65 years or older
 3. Incorporate clinical lab test results as structured data
 4. Generate lists of patients by specific conditions
 5. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate



What are the Requirements/ Meaningful Use?

- **Eligible Hospitals – 10 menu items**
 6. Medication reconciliation
 7. Summary of care record for each transition of care/referrals
 8. Capability to submit electronic data to immunization registries/systems*
 9. Capability to provide electronic submission of reportable lab results to public health agencies*
 10. Capability to provide electronic syndromic surveillance data to public health agencies*



What are the Requirements/ Meaningful Use?

- States can seek CMS prior approval to require 4 MU objectives be core for their Medicaid providers:
 - Generate lists of patients by specific conditions for quality improvement, reduction of disparities, research, or outreach (can specify particular conditions)
 - Reporting to immunization registries, reportable lab results, and syndromic surveillance (can specify for their providers how to test the data submission and to which specific destination)



What are the Requirements/ Meaningful Use?

- Meaningful Use for Hospitals that Qualify for Both Medicare & Medicaid Payments:
 - Applicable for subsection (d) hospitals that are also Medicaid acute care hospitals (including CAHs)
 - Attest/Report on Meaningful Use to CMS for the Medicare EHR Incentive Program
 - Will be deemed meaningful users for Medicaid (even if the State has CMS approval for the MU flexibility around public health objectives)



What are the Requirements/ Meaningful Use?

- A Medicare hospital or eligible professional who does NOT demonstrate meaningful use by 2015 will be subject to payment adjustments in their Medicare reimbursement schedule
- Medicaid-only hospitals are not subject to payment adjustments



What are the Requirements/ Meaningful Use?

- Future Stages of Meaningful Use:
 - Intend to propose 2 additional Stages through future rulemaking. Future Stages will expand upon Stage 1 criteria.
 - Stage 1 menu set will be transitioned into core set for Stage 2
 - Administrative transactions will be added
 - CPOE measurement will go to 60%
 - Will reevaluate other measures – possibly higher thresholds
 - Stage 3 will be further defined in next rulemaking



What are the Requirements/ Meaningful Use?

- Why Didn't CMS Change the Definition of a Hospital in the Final Rule?
 - CMS considered the issue very carefully and heard from a number of hospital groups as well as members of Congress.
 - Final regulation does not change the NPRM definition of treating a hospital with a single provider number (CCN) as a single entity.
 - We felt that we could not change our existing policy of treating without clear statutory intent. Our concern is that CMS would be vulnerable to a legal challenge for having inconsistent policies. Examples of where this could become an issue would be conditions of participation, DSH payments, and graduate medical education payments.



What are the Requirements/ Clinical Quality Measures

- Details of Clinical Quality Measures
 - 2011 – Hospitals seeking to demonstrate Meaningful Use are required to submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States by ATTESTATION.
 - 2012 – Hospitals seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.



What are the Requirements/ Clinical Quality Measures

- **CQM– Eligible hospitals and CAHs**
- **Must complete all CQMs**
 1. Emergency Department Throughput – admitted patients – Median time from ED arrival to ED departure for admitted patients
 2. Emergency Department Throughput – admitted patients – Admission decision time to ED departure time for admitted patients
 3. Ischemic stroke – Discharge on anti-thrombotics
 4. Ischemic stroke – Anticoagulation for A-fib/flutter
 5. Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset



What are the Requirements/ Clinical Quality Measures

- **CQM– Eligible hospitals and CAHs**
 6. Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
 7. Ischemic stroke – Discharge on statins
 8. Ischemic or hemorrhagic stroke – Rehabilitation assessment
 9. VTE prophylaxis within 24 hours of arrival
 10. Intensive Care Unit VTE prophylaxis
 11. Anticoagulation overlap therapy
 12. Platelet monitoring on unfractionated heparin
 13. VTE discharge instructions
 14. VTE discharge instructions
 15. Incidence of potentially preventable VTE



What are the Requirements/ Clinical Quality Measures

- CMS' goals:
 - Coordinate CQM development and reporting with implementation of the Patient Protection and Affordable Care Act (ACA) (e.g., pilot programs and State-based programs and infrastructure)
 - Align with PQRI and RHQDAPU reporting



What You Need to Participate

- All providers must:
 - Register via the EHR Incentive Program website
 - Be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care)
 - Have a National Provider Identifier (NPI)
 - Use certified EHR technology
 - Medicaid providers may adopt, implement, or upgrade in their first year
- All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS
 - www.cms.gov/EHRIncentivePrograms



What You Need to Participate

- Registration: Medicaid Specific Details
- States will interface with to the EHR Incentive Program registration website
- States will ask providers to provide and/or attest to additional information in order to make accurate and timely payments, such as:
 - Patient Volume
 - Licensure
 - A/I/U or Meaningful Use
 - Certified EHR Technology



What You Need to Participate

- Hospital registration requirements include:
 - Name of the hospital or CAH
 - National Provider Identifier (NPI)
 - Business address and business phone
 - Taxpayer Identification Number (TIN) to which the provider would like their incentive payment made
 - CMS Certification Number (CCN)
 - State selection for Medicaid providers



What You Need to Participate

- **Certified EHR Technology:**
 - Required in order to achieve meaningful use
 - Standards and certification criteria announced on July 13, 2010. See <http://healthit.hhs.gov/standardsandcertification> for more information
 - ONC in process of authorizing “testing and certification bodies” for temporary certification program
 - Certified products are expected to be available in the Fall
 - List of certified EHRs and EHR modules will be posted on ONC web site
 - Educational sessions will be held August 18, 2010
 - Visit <http://healthit.hhs.gov/certification> for more information
 - Email ONC.Certification@hhs.gov with questions



Notable Differences Between Medicare and Medicaid Incentive Programs

Medicare	Medicaid
Federal Government will implement (will be an option nationally)	Voluntary for States to implement (may not be an option in every State)
Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use	No Medicaid payment reductions
Must demonstrate MU in Year 1	A/I/U option for 1 st participation year
Maximum incentive is \$44,000 for EPs (bonus for EPs in HPSAs)	Maximum incentive is \$63,750 for EPs
MU definition is common for Medicare	States can adopt certain additional requirements for MU
Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015	Last year a provider may initiate program is 2016; Last year to register is 2016
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, acute care hospitals (including CAHs) and children's hospitals



Timeline of the Program

- Fall 2010 – Certified EHR technology will be available and listed on website
- January 2011 – Registration for the EHR Incentive Programs begins
- January 2011 – For Medicaid providers, States may launch their programs if they so choose
- April 2011 – Attestation for the Medicare EHR Incentive Program begins
- May 2011 – Medicare EHR incentive payments begin



Timeline of the Program

- November 30, 2011– Last day for hospitals to register and attest to receive an incentive payment for FY 2011
- 2015 – Medicare payment adjustments begin for EPs and eligible hospitals that are not meaningful users of EHR technology
- 2016 – Last year to receive a Medicare EHR incentive payment; Last year to initiate participation in Medicaid EHR Incentive Program
- 2021 – Last year to receive Medicaid EHR incentive payment



Resources to Get Help and Learn More

- Get information, tip sheets and more at CMS' official website for the EHR incentive programs:
www.cms.gov/EHRIncentivePrograms
- Learn about certification and certified EHRs, as well as other ONC programs designed to support providers as they make the transition:
<http://healthit.hhs.gov>



ONC Programs Designed to Support Achievement of Meaningful Use

Area of Support	ONC Program
Technical Assistance	Regional Extension Center Program: ONC has provided funding for 70 regional extension centers that will help providers with EHR vendor selection and support and workflow redesign. Go to http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_re_c_program/1495
Health Information Exchange	State Health Information Exchange Program: Funding and technical assistance to states to support providers in achieving health information exchange requirements Nationwide Health Information Network Activities: Expanded definitions, specifications and sample implementations to support exchange to achieve meaningful use
Breakthrough Examples	Beacon Communities Program Demonstration communities involving clinicians, hospitals and consumers who are showing how EHRs can achieve breakthrough improvements in care
Human Resources	Workforce Training Programs Several distinct programs that are supporting the education of up to 45,000 new health IT workers to support implementation



Resources to Get Help and Learn More - Acronyms

- ACA – Patient Protection and Affordable Care Act
- A/I/U – Adopt, implement, or upgrade
- CAH – Critical Access Hospital
- CCN – CMS Certification Number
- CHIPRA – Children's Health Insurance Program Reauthorization Act of 2009
- CMS – Centers for Medicare & Medicaid Services
- CNM – Certified Nurse Midwife
- CPOE – Computerized Physician Order Entry
- CQM – Clinical Quality Measures
- CY – Calendar Year
- EHR – Electronic Health Record
- EP – Eligible Professional
- eRx – E-Prescribing
- FFS – Fee-for-service
- FQHC – Federally Qualified Health Center
- FFY – Federal Fiscal Year
- HHS – U.S. Department of Health and Human Services
- HIT – Health Information Technology
- HITECH Act – Health Information Technology for Economic and Clinical Health Act
- HITPC – Health Information Technology Policy Committee
- HIPAA – Health Insurance Portability and Accountability Act of 1996
- HPSA – Health Professional Shortage Area
- MA – Medicare Advantage
- MCMP – Medicare Care Management Performance Demonstration
- MU – Meaningful Use
- NCVHS – National Committee on Vital and Health Statistics
- NP – Nurse Practitioner
- NPI – National Provider Identifier
- NPRM – Notice of Proposed Rulemaking
- OMB – Office of Management and Budget
- ONC – Office of the National Coordinator of Health Information Technology
- PA – Physician Assistant
- PECOS – Provider Enrollment, Chain, and Ownership System
- PPS – Prospective Payment System (Part A)
- PQRI – Medicare Physician Quality Reporting Initiative
- Recovery Act – American Reinvestment & Recovery Act of 2009
- RHC – Rural Health Clinic
- RHQDAPU – Reporting Hospital Quality Data for Annual Payment Update
- TIN – Taxpayer Identification Number