Connecting America for Better Health

EHR INCENTIVE PROGRAM

Medicare & Medicaid EHR Incentive Program Final Rule

Implementing the American Recovery & Reinvestment Act of 2009

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CMS
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Overview

- American Recovery & Reinvestment Act (Recovery Act) – February 2009
- Medicare & Medicaid Electronic Health Record (EHR) Incentive Program Notice of Proposed Rulemaking (NPRM)
  - Display – December 30, 2009
  - 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 in the Medicare & Medicaid EHR Incentive Program Final Rule?

- Definition of Meaningful Use (MU)
- Clinical Quality Measures (CQM)
- Definition of Eligible Professional (EP) and Eligible Hospital/Critical Access Hospital (CAH)
- Definition of Hospital-based EP
- Medicare Fee-For-Service (FFS) EHR Incentive Program
- Medicare Advantage (MA) EHR Incentive Program
- Medicaid EHR Incentive Program
- Collection of Information Analysis (Paperwork Reduction Act)
- Regulatory Impact Analysis

What the Final Rule Does

- Harmonizes MU criteria across CMS programs as much as possible
- Closely links with the ONC Certification and Standards final rules
- Builds on the recommendations of the HIT Policy Committee and Public Commenters
- Coordinates with existing CMS quality initiatives
- Provides a platform that allows for a staged implementation of EHRs over time

Eligibility Overview

- Medicare Fee-For-Service (FFS)
  - Eligible Professionals (EPs)
  - Eligible hospitals and critical access hospitals (CAHs)
- Medicare Advantage (MA)
  - MA EPs
  - MA-affiliated eligible hospitals
- Medicaid
  - EPs
  - Eligible hospitals

Who is a Medicare Eligible Provider?

Eligible Providers in Medicare FFS
Eligible Professionals (EPs)
Doctor of Medicine or Osteopathy
Doctor of Dental Surgery or Dental Medicine
Doctor of Podiatric Medicine
Doctor of Optometry
Chiropractor
Eligible Hospitals
Acute Care Hospitals*
Critical Access Hospitals (CAHs)

*Subsection (d) hospitals that are paid under the PPS and are located in the 50 States or Washington, DC (including Maryland)

Who is a Medicare Advantage Eligible Provider?

Eligible Providers in Medicare Advantage (MA)
MA Eligible Professionals (EPs)
Must furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MA organization
-or-
Must be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying MA organization
MA-Affiliated Eligible Hospitals
Will be paid under the Medicare Fee-for-service EHR incentive program

Who is a Medicaid Eligible Provider?

Eligible Providers in Medicaid
Eligible Professionals (EPs)
Physicians
Nurse Practitioners (NPs)
Certified Nurse Midwives (CNMs)
Dentists
Physician Assistants (PAs) working in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is so led by a PA
Eligible Hospitals
Acute Care Hospitals (now including CAHs)
Children's Hospitals

Hospital-based EPs

- Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.
- The Continuing Extension Act of 2010 modified the definition of a hospital-based EP as performing substantially all of their services in an inpatient hospital setting or emergency room. The rule has been updated to reflect this change.
- A hospital-based EP furnishes 90% or more of their services in either the inpatient or emergency department of a hospital.

Adopt/Implement/Upgrade (A/I/U)

- Adopted – Acquired and Installed
  - Ex: Evidence of installation prior to incentive
- Implemented – Commenced Utilization of
  - Ex: Staff training, data entry of patient demographic information into EHR
- Upgraded – Expanded
  - Upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology

Meaningful Use: HITECH Act Description

- The Recovery Act specifies the following 3 components of Meaningful Use:
  1. Use of certified EHR in a meaningful manner (ex: 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

Meaningful Use Stage 1 – Health Outcome Priorities*

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

*Adapted from National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008.

Meaningful Use: Basic Overview of Final Rule

- Stage 1 (2011 and 2012)
  - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
  - EPs have to report on 20 of 25 MU objectives
  - Eligible hospitals have to report on 19 of 24 MU objectives
  - Reporting Period – 90 days for first year; one year subsequently

Meaningful Use for EPs who Work at Multiple Sites

- An EP who works at multiple locations, but does not have certified EHR technology available at all of them would:
  - Have to have 50% of their patient encounters at locations where certified EHR technology is available
  - Would base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available

Meaningful Use: Applicability of Objectives and Measures

- Some MU objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator. Exclusions count against the 5 deferred measures
- In these cases, the EP, eligible hospital or CAH would be excluded from having to meet that measure
  - Ex: Dentists who do not perform immunizations; Chiropractors do not e-prescribe

Meaningful Use: Stage 2

- 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
- Will reevaluate measures – possibly higher thresholds

States' Flexibility to Revise 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)

Clinical Quality Measures (CQM) Overview

- 2011 – EPs, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States by attestation.
- 2012 – EPs, eligible hospitals and CAHs seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.

CQM: Eligible Professionals and Hospitals

- EPs must report on 3 required core CQM, and if the denominator of 1or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures
- EPs also must select 3 additional CQM from a set of 38 CQM (other than the core/alternate core measures)
- In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures
- Eligible hospitals must report on 15 clinical quality measures

Registration Overview

- 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 to demonstrate Meaningful Use
    - Medicaid providers may adopt, implement, or upgrade in their first year
- All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS

Registration: Medicaid

- States will connect to the EHR Incentive Program website to verify provider eligibility and prevent duplicate payments
- States will ask providers for additional information in order to make accurate and timely payments
  - Patient Volume
  - Licensure
  - A/I/U or Meaningful Use
  - Certified EHR Technology

Incentive Payments Overview

- Eligible Professionals
  - Medicare FFS
  - Medicare Advantage
  - Medicaid
- Eligible Hospitals and CAHs
  - Medicare FFS
  - Medicare Advantage (paid under Medicare FFS)
  - Medicaid

Incentive Payments for Medicare EPs

- First Calendar Year (CY) for which the EP Receives an Incentive Payment

	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0
CY 2016		$2,000	$4,000	$4,000	$0
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

•Incentive payment is 75 percent of total allowed Medicare charges
•Amounts listed above are the maximum incentive payment amounts

Additional Incentive Payments for Medicare EPs Practicing in HPSAs

- First Calendar Year (CY) for which the EP Receives an Incentive Payment

	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY 2011	$1,800				
CY 2012	$1,200	$1,800			
CY 2013	$800	$1,200	$1,500		
CY 2014	$400	$800	$1,200	$1,200	
CY 2015	$200	$400	$800	$800	$0
CY 2016		$200	$400	$400	$0
TOTAL	$4,400	$4,400	$3,900	$2,400	$0

Payment Adjustments

- A Medicare Eligible Professional who does NOT demonstrate meaningful use by 2015 will be subject to payment reductions in their Medicare reimbursement schedule
- Medicaid-only EPs are not subject to payment reductions
- Payment reductions may apply for any EP who accepts Medicare, even if you only participate in the Medicaid EHR incentive program

Incentive Payments for Medicaid EPs

- First Calendar Year (CY) for which the EP Receives an Incentive Payment

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Incentive Payments for Eligible Hospitals

- Federal Fiscal Year
- $2M base + per discharge amount (based on Medicare/Medicaid share)
- Hospitals meeting Medicare MU requirements may be deemed eligible for Medicaid payments
- Payment adjustments for Medicare after 2015
  - No Federal Medicaid payment adjustments
- Medicare hospitals: No payments after 2016
- Medicaid hospitals: Cannot <u>initiate payments</u> after 2016

Eligible Hospitals That Qualify for Both Medicare and 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)

Participation in HITECH and other Medicare Incentive Programs for EPs

Other Medicare Incentive Program	Eligible for HITECH EHR Incentive Program?
Medicare Physician Quality Reporting Initiative (PQRI)	Yes, if the EP is eligible.
Medicare Electronic Health Record Demonstration (EHR Demo)	Yes, if the EP is eligible.
Medicare Care Management Performance Demonstration (MCMP)	Yes, if the practice is eligible. The MCMP demo will end before EHR incentive payments are available.
Electronic Prescribing (eRx) Incentive Program	If the EP chooses to practice in the Medicare EHR Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously in the same program year. If the EP chooses to participate in the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously.

Notable Differences Between the Medicare & Medicaid EHR 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 1st 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

EHR Incentive Program Timeline

- Registration for the EHR Incentive Programs will begin 6 months after the rule is published*
- Attestation for the EHR Incentive Programs will begin 9 months after the rule is published*
- EHR incentive payments will be made 11 months after the rule is published*
- States may launch their programs in January 2011 and thereafter
- November 30, 2011 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FFY 2011
- February 29, 2012 – Last day for EPs to register and attest to receive an incentive payment for CY 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**

*Projected **Statutory

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

- Follow the latest information about the EHR Incentive Programs on Twitter at
  www.Twitter.com/CMSGov

- 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	**RegionalExtension 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__rec_program/1495
Health Information Exchange	**State HealthInformation 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 TrainingPrograms** Several distinct programs that are supporting the education of up to 45,000 new health IT workers to support implementation

Acronyms

- 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 Electronic 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
- TIN – Taxpayer Identification Number

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