Medicare & Medicaid EHR Incentive Program Final Rule

Implementing the American Recovery & Reinvestment Act of 2009

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

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 <u>do not</u> 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.

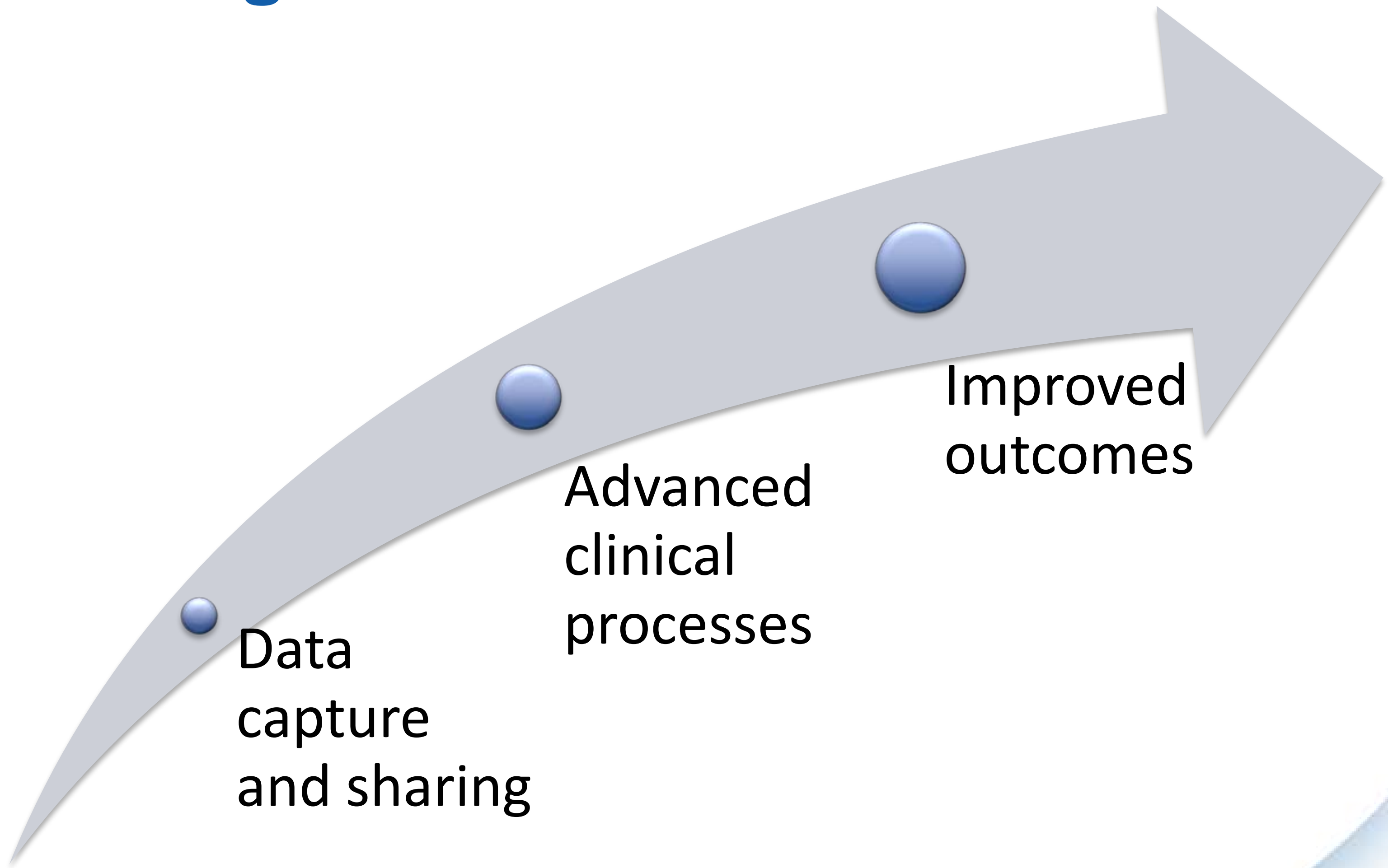
Meaningful Use: HITECH Act Description

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

Meaningful Use: Process of Defining

- National Committee on Vital and Health Statistics (NCVHS) hearings
- HIT Policy Committee (HITPC) recommendations
- Listening Sessions with providers/organizations
- Public comments on HITPC recommendations
- Comments received from the Department and the Office of Management and Budget (OMB)
- Revised based on public comments on the NPRM

Conceptual Approach to Meaningful Use



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: Core Set Objectives

- **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
  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
  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

EHR INCENTIVE PROGRAM

Meaningful Use: Menu Set Objectives*

- Eligible Hospitals
  - Drug-formulary checks
  - Record advanced directives for patients 65 years or older
  - Incorporate clinical lab test results as structured data
  - Generate lists of patients by specific conditions
  - Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
  - Medication reconciliation
  - Summary of care record for each transition of care/referrals
  - Capability to submit electronic data to immunization registries/systems*
  - Capability to provide electronic submission of reportable lab results to public health agencies*
  - Capability to provide electronic syndromic surveillance data to public health agencies*

*At least 1 public health objective must be selected

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
- Will include greater emphasis on health information exchange across institutional boundaries

Meaningful Use: Denominators

- Two types of percentage-based measures are included to address the burden of demonstrating MU
  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

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 do not count against the 5 deferred measures
- In these cases, the EP, eligible hospital, or CAH would be excluded from having to meet that measure
  - E.g., Dentists who do not perform immunizations; Chiropractors do not e-prescribe

MU 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)

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 Hospitals and CAHs

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

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: Requirements

1. Name of the EP, eligible hospital, or qualifying CAH
2. National Provider Identifier (NPI)
3. Business address and business phone
4. Taxpayer Identification Number (TIN) to which the provider would like their incentive payment made
5. CMS Certification Number (CCN) for eligible hospitals
6. Medicare or Medicaid program selection (may only switch once after receiving an incentive payment before 2015) for EPs
7. State selection for Medicaid providers

EHR INCENTIVE PROGRAM

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 Eligible Hospitals

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

EHR Incentive Program Timeline

- 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 – EHR incentive payments begin
- 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

Next Steps

- Summer/Fall 2010 – Outreach and education campaign
- CMS to issue State Medicaid Directors Letter with policy guidance on the implementation of the Medicaid EHR Incentive Program
- Early 2011 – EPs and eligible hospitals can register for the Medicare and Medicaid EHR Incentive Programs
- More Information: http://www.cms.gov/EHRIncentivePrograms