

# Understanding the EHR Incentive Final Rule



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# Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the Minnesota – North Dakota Regional HIT Extension Center, REACH. He will be mentioning HIT Extension Centers in this talk.
- No other conflict of interest

# Objectives

- Understand how the incentive program fits into the broader range of programs intended to facilitate adoption
- Be able to identify the difference between the proposed and final rule
- Understand the definition of an eligible provider and eligible hospital and the calculation of incentives for both Medicare and Medicaid
- Be able to identify the national health care goals underlying CMS incentives for meaningful use of health information technology
- Examine the elements of the meaningful use that make up the criteria and quality measures
- Understand the workflow implications of the meaningful use criteria and quality measures
- Know what you can do to prepare regardless of your stage of EHR implementation

# Outline

- The Final Rule
- Financial Incentives for Hospitals and Providers
  - Medicare
  - Medicaid
- Elements of Meaningful Use
- Quality Measures
- What You Can Do Now

# Meaningful Use Overview: Statutory Framework

- In HITECH, Congress established three fundamental criteria of 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 and coordination of care
  - In using certified EHR technology, the provider submits clinical quality measures and other measures as determined by the secretary

Source: Brian Wagner, Senior Director of Policy and Public Affairs, eHealth Initiative (eHI) presentation to the MN Exchange and Meaningful Use Workgroup January 15, 2010

# HITECH Funding Initiatives

Funding Initiative	Focus
<b>CMS Incentives</b> (Section 4201) For “meaningful use”	<b>Incentive payments to eligible professionals and hospitals</b> participating in Medicare and Medicaid programs that adopt and meaningfully use certified EHRs
<b>Regional Extension Centers</b> (Section 3012)	Establish up to 70 Regional Extension Centers to <b>support providers in adopting and becoming meaningful users of health information technology (HIT)</b>
<b>Health Information Exchange</b> (Section 3013)	Support state programs to <b>ensure the development of health information exchange</b>
<b>HIT Workforce Development</b> (Section 3016) University-based Training; Community College Consortia; Curriculum Development; Competency development	Create several distinct programs that aim to <b>support the education of HIT professionals</b> . Train up to 45,000 new HIT workers to assist providers in becoming meaningful users of EHRs
<b>Beacon Community Program</b> (Section 3011)	Create up to 15 demonstration communities to <b>show how the meaningful use of EHRs can achieve measurable improvement in the quality and outcomes</b>
<b>Strategic Health Information Technology Advanced Research Projects (SHARP)</b> - (Section 3011)	<b>Achieving breakthroughs to address well-documented problems</b> that have impeded adoption of HIT, including the security, cognitive support, health care application and network architectures, and secondary use of EHR data



# Rules to Implement the Goals of HITEC:

## **CMS Final Rule on EHR Incentive Program**

Defines the provisions for incentive payments to eligible professionals and hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use certified EHRs.

Final Rule released

## **ONC Final Rule for EHR Certification Criteria, Standards and Implementation Specifications**

Defines an initial set of standards, implementation specifications, and certification criteria to “enhance the interoperability, functionality, utility, and security of health IT and to support its meaningful use.”

Final Rule released

## **ONC Final Rule for EHR Certification**

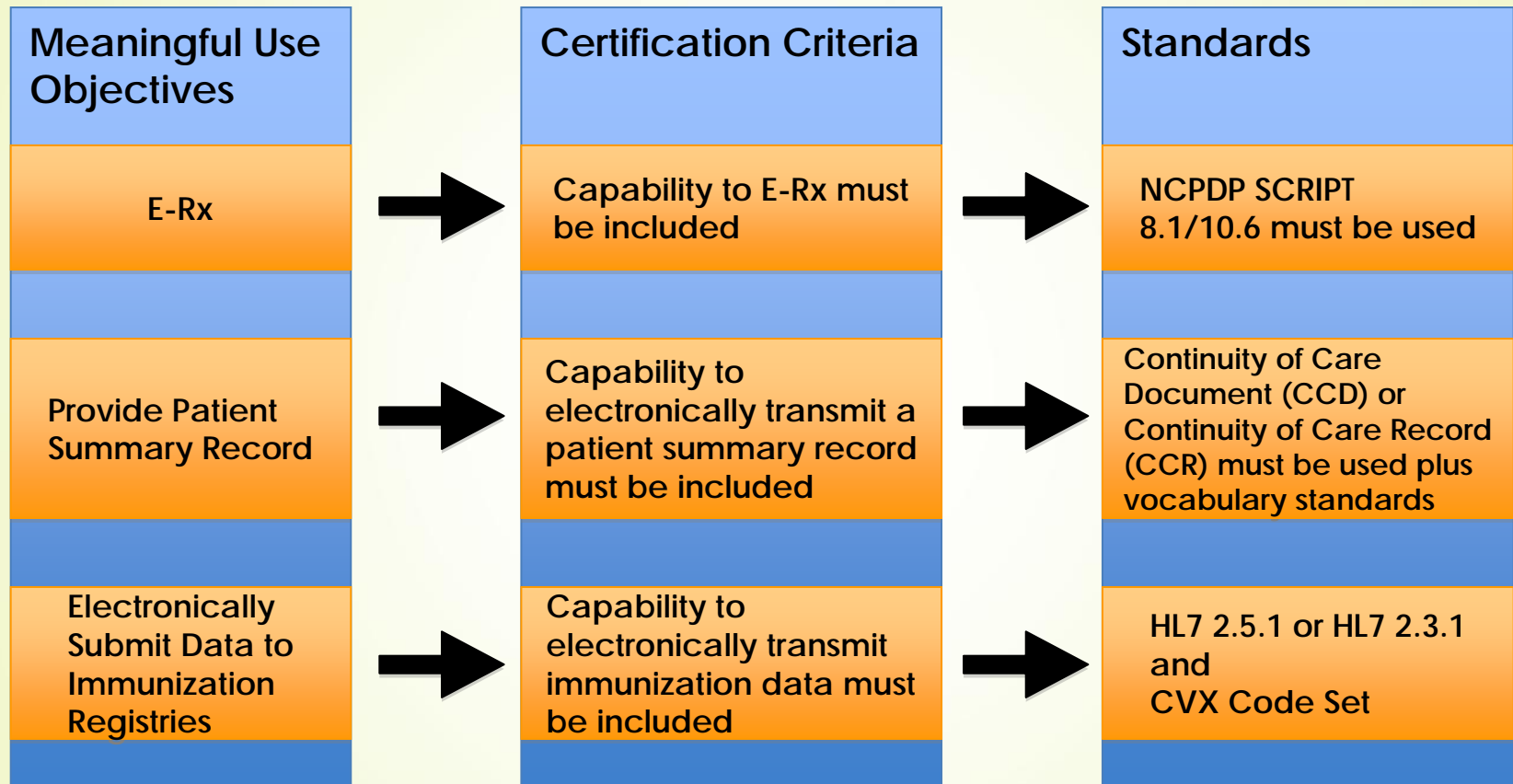
Addresses the process by which EHR systems will be certified and by which accreditation / certification entities can become recognized by CMS in order to certify EHR systems.

Final Rule for Transitional Criteria for Stage 1 Certifications released

Final Rule for Permanent Criteria for Stage 2 Certification and beyond to be released early fall 2010



# Aligning Certification and Standards



Source: Farzad Mostashari, ONC Presentation to HIT Policy Committee January 13, 2010

# Evolution of the Final Rule

- Recommendations from the ONC Policy Committee -July 16, 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 Available –July 13, 2010
- Final Rule Published –July 28, 2010

# Meaningful Use: Changes from the Proposed Rule to the Final Rule

Proposed Rule	Final Rule
Meet all MU reporting objectives (“all or nothing”)	Must meet “core set”/can defer 5 from optional “menu set” (flexibility)
Measure thresholds range from 10% to 80% of patients or orders (most at higher range)	Measure thresholds range from 10% to 80% of patients or orders (most at lower to middle range)
90 CQM total for EPs with specialty specific measures	44 CQM total for EPs –must report total of 6 with no specialty specific measures
35 CQM total for eligible hospitals and 8 alternate Medicaid CQM	15 CQM total for eligible hospitals
Denominators –To calculate the threshold, some measures required manual chart review	Denominators –No measures require manual chart review to calculate threshold
Measures for Patient-Specific Education Resources and Advanced Directives discussed but not proposed	Measures for Patient-Specific Education Resources and Advanced Directives (for hospitals) included

Adapted from: CMS presentation July 20, 2010

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# Incentive Program Key Provisions

## Eligibility

- Eligible Hospitals and Critical Access Hospitals can receive both Medicare and Medicaid incentives
- Eligible professionals must choose between Medicare & Medicaid Incentives, but may switch once

## Timeframe for Demonstrating Meaningful Use (MU):

- In the 1st year of demonstrating meaningful use, hospitals and each provider must demonstrate MU over any continuous 90 period.
  - Note: This could be the second payment year if money was received from Medicaid for adopt, implement, upgrade
- For subsequent years hospitals and individual providers must demonstrate MU over the entire reporting year.

# Definition of a Medicare Eligible Provider

- A physician, defined by the Social Security Act Sec 1861(r):
  - A doctor of medicine or osteopathy
  - A doctor of dental surgery or dental medicine
  - A doctor of podiatric medicine
  - A doctor of optometry
  - A chiropractor
- Does not provide more than 90% of services with a place of service (POS) code of 21 or 23 (considered hospital inpatient or ED based)
- If at multiple sites, must have certified EHR technology available for  $\geq 50\%$  of their patient encounters
- Incentive amount is 75% of the physician's Medicare allowable charges up to the payment year limit

# Maximum Medicare Incentives for EPs in a non shortage area<sup>1</sup>

2010	2011	2012	2013	2014	2015	2016	2017	
	Stage 1 \$18k	Stage 1 \$12k	Stage 2 \$8k	Stage 2 \$4k	TBD \$2k	TBD	TBD	\$44k
		Stage 1 \$18k	Stage 1 \$12k	Stage 2 \$8k	TBD \$4k	TBD \$2k	TBD	\$44k
			Stage 1 \$15k	Stage 1 \$12k	TBD \$8k	TBD \$4k	TBD	\$39k
				Stage 1 \$12k	TBD \$8k	TBD \$4k	TBD	\$24k
					TBD	TBD	TBD	0
Penalty (deduction from Medicare charges) if not at stage 3 by January 1 of that year:					1%	2%	3%	

1. Providers with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment

# Incentive Payments to Eligible Providers

- Made either directly to the provider or the provider may reassign it to another entity
- Providers who work in multiple sites and achieve MU by combining the work they did at multiple sites, still may only assign their payment to one entity
- In the first year of demonstrating MU, a payment will be made when the provider reaches his/her Medicare allowable charges limit or the end of the year, whichever comes first

# Definition of an Medicare Eligible Hospital

- A subsection (d) hospital defined in the Social Security Act, essentially an acute care facility:
  - Located in the 50 states
  - Not a psychiatric, rehabilitative, predominately pediatric or cancer facility.
  - Where average length of stay is 25 days or less
- A critical access hospital
- Individual or groups of hospitals that have the same CMS Certification Number (CCN) for cost reporting (OSCAR number) are seen as one hospital

# PPS\* EH Medicare Incentives

$(\$2M + \text{Discharge Amount}) \times \text{Medicare Share} \times \text{Transition \%}$ :

Discharge amount:

$$\$200 \times (\# \text{ of discharges } \geq 1,150 \text{ and } \leq 23,000)$$

The Medicare share (MS):

$$\frac{\text{Medicare Inpatient Days}}{\text{Total Inpatient Days} \left( \frac{\text{Gross Revenue} - \text{Charity}}{\text{Gross Revenue}} \right)}$$

Transition Percentage:

*Based on the payment year and the fiscal year*

\* PPS = Prospective Payment System

# Medicare Incentives for Eligible PPS Hospitals

2010	2011	2012	2013	2014	2015	2016	2017	%
	Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	TBD	TBD	TBD	100%
		Stage 1 100%	Stage 1 75%	Stage 2 50%	TBD 25%	TBD	TBD	100%
			Stage 1 100%	Stage 1 75%	TBD 50%	TBD 25%	TBD	100%
				Stage 1 75%	TBD 50%	TBD 25%	TBD	60%
					TBD 50%	TBD 25%	TBD	30%
						TBD	TBD	0%
Penalties: Market basket update would be reduced by:					-25%	-50%	-75%	

Percentages in the cells indicate the transition factor for the Medicare Share incentive



# Eligible CAH Medicare Incentives

Reasonable EHR costs × Medicare Share plus

Reasonable EHR costs:

- *Software / hardware costs during the first payment year plus the undepreciated costs less interest from previous periods*
- *Software / hardware costs for other payment years*

Medicare Share Plus

Medicare Share (MS%):

$$\frac{\text{Medicare Inpatient Days}}{\text{Total Inpatient Days} \left( \frac{\text{Gross Revenue} - \text{Charity}}{\text{Gross Revenue}} \right)}$$

Plus:

*MS% + 20% or 100% whichever is less*

Paid on an interim basis for a up to 4 years or through 2015

# Medicare Incentives for Eligible Critical Access Hospitals

2010	2011	2012	2013	2014	2015	2016	Payments
	Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2 Payment	TBD	TBD	4
		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	TBD Payment	TBD	4
			Stage 1 Payment	Stage 1 Payment	TBD Payment	TBD	3
				Stage 1 Payment	TBD Payment	TBD	2
					TBD Payment	TBD	1
						TBD	0
Penalties: Reasonable cost reimbursement of 101% would be reduced to:					100.66%	100.33%	100%

Incentive payments calculation based on the Medicare Share of the EHR cost



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# Medicaid Eligible Provider

- An Eligible Provider for Medicaid is defined in statute as a
  - Physician (MD, DO and in some states, optometrists)
  - Dentist
  - Certified nurse mid-wife
  - Nurse practitioner
  - Physician assistant if the assistant is practicing in either a rural health clinic (RHC) or a federally qualified health center (FQHC) that is led by a physician assistant
- PA would be leading an FQHC or RHC if:
  - A PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider)
  - A PA is a clinical or medical director at a clinical site of practice
  - A PA is an owner of an RHC.

# Medicaid Eligible Provider, cont.

- In order to be eligible for the Medicaid incentives, one must have
  - Greater than 30% Medicaid patient volume
  - Greater than 20% if a pediatrician
  - Greater than 30% “needy individuals” if > 50% encounters at an FQHC or rural health clinic.
    - The Social Security Act defines a needy individual<sup>1</sup> as one who
      - Is receiving assistance under Medicaid
      - Is receiving assistance under title XXI the State Child Health Insurance Program (SCHIP)
      - Is furnished uncompensated care by the provider;
      - Has charges reduced by the provider based on ability to pay.
  - Volume can be calculated by clinic in most instances
  - No minimum patient volume required
  - Volume is defined as services rendered on any one day to an individual

1. [http://www.socialsecurity.gov/OP\\_Home/ssact/title19/1903.htm#act-1903-t-3-f](http://www.socialsecurity.gov/OP_Home/ssact/title19/1903.htm#act-1903-t-3-f)

# Eligible Provider Medicaid Incentives

- For providers with >30% Medicaid, incentive amount is 85% of the physician's allowable costs for the purchase, implementation and use of EHR technology up to the payment years' allowable cost limit
  - Allowable cost limit is \$25K year one and \$10K for the next 5 years
  - The first year payment can be as high as \$21,250 and \$8500 for each of the following 5 years
- For pediatricians with between 20 and 30% Medicaid, incentive amount and limit is reduced by 1/3
  - The first year payment can be as high as \$14,167 and \$5,667 for each of the following 5 years
- The first payment year can be as late as 2016

# Maximum Medicaid Incentives for EPs with $\geq 30\%$ volume

		Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	2011
Calendar Year	2011	\$21,250						\$21,250
	2012	\$8,500	\$21,250					
	2013	\$8,500	\$8,500	\$21,250				\$8,500
	2014	\$8,500	\$8,500	\$8,500	\$21,250			
	2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250		\$8,500
	2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	\$8,500
	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	\$8,500
	2020					\$8,500	\$8,500	
	2021						\$8,500	\$8,500
	Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

# Medicaid Eligible Hospital Definition

- Acute Care Hospital or Critical Access Hospital
  - Same definition as Medicare
- A Freestanding Children's Hospital
  - Has a Medicare CCN with the last four digits in the series 3300 through 3399
- It continues to exclude psychiatric, rehabilitation, and long-term care hospitals.
- Non pediatric hospitals must have a Medicaid patient volume >10%

# Eligible Hospital Medicaid Incentives

- Maximum aggregate payment is the calculated Medicaid share cost of EHR defined as sum of payment years 1 to 4 of:

$$(\$2M + \text{Discharge Amount}) \times \text{Medicaid Share} \times \text{Transition \%}$$

Discharge amount:

$$\$200 \times (\# \text{ of discharges } \geq 1,150 \text{ and } \leq 23,000)$$

The Medicaid share (MS):

$$\frac{\text{Total Medicaid} + \text{Medicaid Managed Care Inpatient Days}}{\text{Total Inpatient Days} \left( \frac{\text{Gross Revenue} - \text{Charity}}{\text{Gross Revenue}} \right)}$$

Transition Percentage:

$$100\% \text{ Yr1, } 75\% \text{ Yr2, } 50\% \text{ Yr3, } 25\% \text{ Yr4}$$

- This total amount can be made by states over a 3 to 6 year period starting as late as 2016

# Maximum Medicaid Incentives for Eligible Hospitals

		Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	Alt
Calendar Year	2011	Y1						Y1
	2012	Y2	Y1					
	2013	Y3	Y2	Y1				Y2
	2014	Y4	Y3	Y2	Y1			
	2015	Y5	Y4	Y3	Y2	Y1		
	2016	Y6	Y5	Y4	Y3	Y2	Y1	Y3
	2017		Y6	Y5	Y4	Y3	Y2	Y4
	2018			Y6	Y5	Y4	Y3	Y5
	2019				Y6	Y5	Y4	Y6
	2020					Y6	Y5	
	2021						Y6	
Total:		Calculated Medicaid share or EHR Cost						



# Medicaid Adopt, Implement or Upgrade

- Hospitals and eligible professionals can receive incentives for adoption, implementation and upgrade of certified EHR technology in their first year of participation
- “Adopt, implement, or upgrade” means:
  - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
  - Expand the functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.

# Notable Differences Between the Medicare & Medicaid EHR Programs

Medicare	Medicaid
Federal Government will implement (available nationally)	Voluntary for States to implement (may not be an option in every State)
Fee schedule reductions begin in 2015 for providers that do not demonstrate Meaningful Use	No Medicaid fee schedule reductions (but Medicare penalties still apply)
Must demonstrate meaningful use in Year 1	Adopt/Implement/Upgrade option for 1 <sup>st</sup> participation year
Maximum incentive is \$44,000 for EPs (bonus for EPs in HPSAs)	Maximum incentive is \$63,750 for EPs
MU definition will be common for Medicare	States can adopt a more rigorous definition (based on common definition) though hospitals only have to meet the Medicare definition if they participate in both
Last year an EP may initiate program is 2014; Last payment in program is 2016. Payment adjustments begin in 2015	Last year an EP may initiate program is 2016; Last payment in program is 2021
Payment years must be consecutive	Payment years needn't be consecutive for EPs but must be for EHs after 2016
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, acute care hospitals (including CAHs) and children's hospitals

Adapted from: CMS presentation July 20, 2010

# Outline

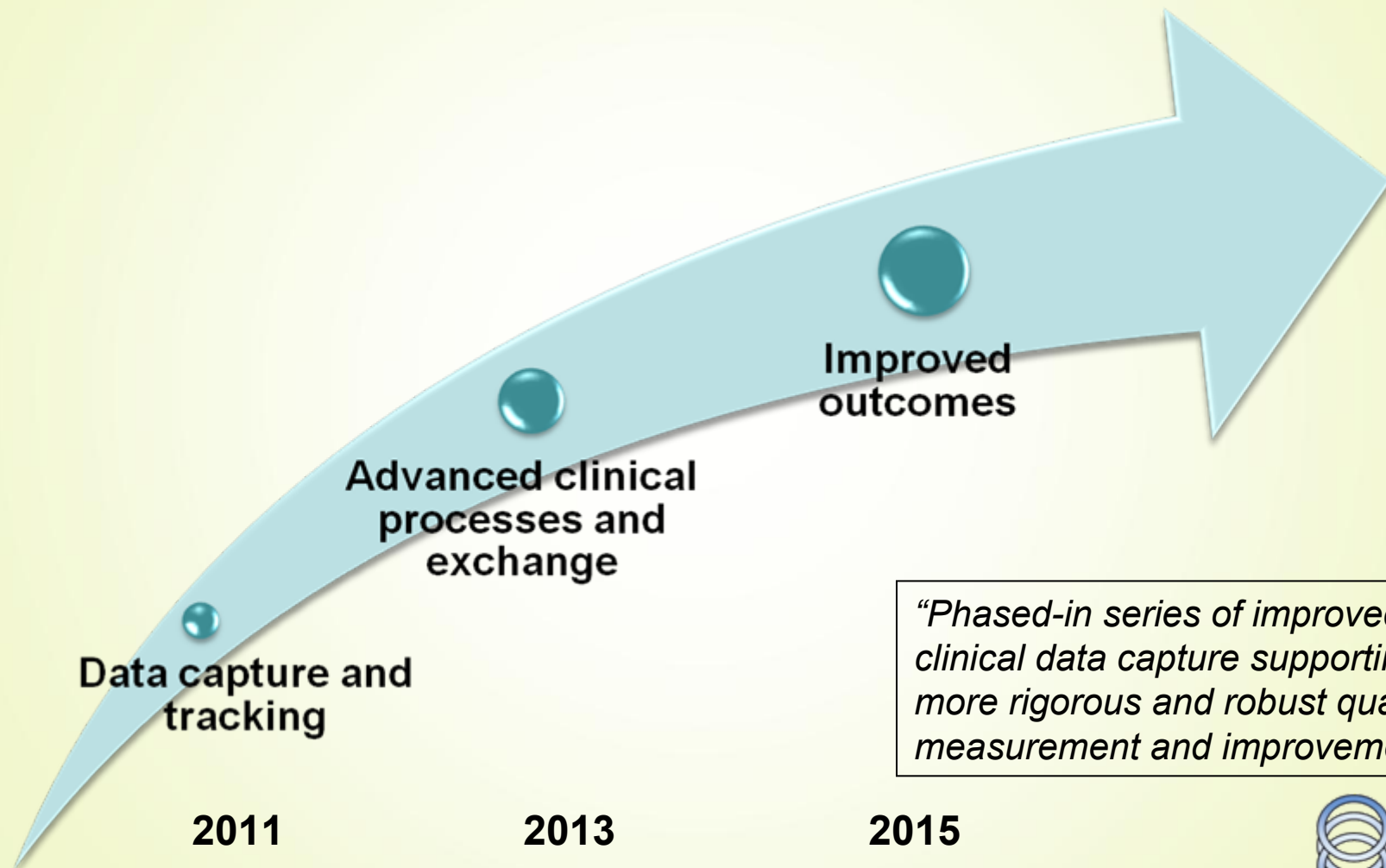
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# Meaningful Use Criteria

- Adapted from National Priorities and Goals of the National Priorities Partnership:<sup>1</sup>
  - Improving quality, safety, efficiency, and reducing 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
- Are divided into Core Criteria and Menu Criteria

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

# Bending the Curve Towards Transformed Health



Source: Connecting for Health, Markle Foundation “Achieving the Health IT Objectives of the American Recovery and Reinvestment Act” April 2009

# Progression of the Stages:

- The Stage 1 meaningful use criteria focus on
  - Electronically capturing health information in a structured format
  - Using that information to track key clinical conditions and communicating that information for care coordination purposes
  - Implementing clinical decision support tools to facilitate disease and medication management
  - Using EHRs to engage patients and families and reporting clinical quality measures and public health information.

# Progression of the Stages:

- The Stage 2 meaningful use criteria will focus on
  - More rigorous expectations for health information exchange
  - More demanding requirements for e-prescribing and incorporating structured laboratory results
  - The expectation that providers will electronically transmit patient care summaries to support transitions in care across unaffiliated providers, settings and EHR systems
  - Increasingly robust expectations for health information exchange to support and make real the goal that information follows the patient.

# Progression of the Stages:

- The Stage 3 meaningful use criteria will focus on
  - Promoting improvements in quality, safety and efficiency leading to improved health outcomes
  - Focusing on decision support for national high priority conditions
  - Patient access to self management tools
  - Access to comprehensive patient data through robust, patient-centered health information exchange
  - Improving population health.

# “Stage 1” Meaningful Use Criteria

- 25 objectives and measures for eligible professionals (EP)
  - 15 are required (“core”), up to 5 of the remaining 10 may be deferred to Stage 2 (“menu”)
  - 8 require attestation; 17 require data submission
- 24 objectives and measures for eligible hospitals (EH)
  - 14 are required (“core”), up to 5 of the remaining 10 may be deferred to Stage 2 (“menu”)
  - 9 require attestation; 15 require data submission
- In 2012, clinical quality metrics will be reported electronically
- To meet certain objectives/measures, 80% of patients seen during the reporting period must have records in the certified EHR technology

# Core Criteria

- Providers must complete each of the core criteria unless unable to due to scope of practice, population served or number in the denominator. For example:
  - Chiropractor and ePrescribing
  - Dentists and immunizations

# Core: Improve quality, safety, efficiency and reduce health disparities

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
CPOE <sup>3</sup> (Lic HC Prof)	>30% of patients with $\geq$ one CPOE med order (n/d EHR) <sup>1</sup>	>30% of patients with $\geq$ one CPOE med order (n/d EHR) <sup>1</sup>
Drug (D-A, D-D) Interactions	Turned on (y/n)	Turned on (y/n)
ePrescribe <sup>3</sup>	>40% of permissible scripts (n/d EHR) <sup>1</sup>	-
Demographics	>50% of patients seen: language, gender, race, ethnicity, DOB (n/d all) <sup>2</sup>	>50% of patients seen: language, gender, race, ethnicity, DOB, date and cause of death (n/d all) <sup>2</sup>
Problem List	>80% of patients seen at least one or “none” as <i>structured data</i> (n/d all) <sup>2</sup>	>80% of patients seen at least one or “none” as <i>structured data</i> (n/d all) <sup>2</sup>

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period
3. CPOE and ePrescribe excluded if < 100 scripts written

# Core: Improve quality, safety, efficiency and reduce health disparities cont.

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
Med List	>80% of patients seen at least one or “none” as <i>structured data</i> (n/d all) <sup>2</sup>	>80% of patients seen at least one or “none” as <i>structured data</i> (n/d all) <sup>2</sup>
Med Allergies	>80% of patients seen at least one or “none” as <i>structured data</i> (n/d all) <sup>2</sup>	>80% of patients seen at least one or “none” as <i>structured data</i> (n/d all) <sup>2</sup>
Vitals	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI (n/d EHR) <sup>1</sup>	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI (n/d EHR) <sup>1</sup>

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period

# Core: Improve quality, safety, efficiency and reduce health disparities cont.

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
Smoking	>50% of patients $\geq$ 13yo seen, record status <i>as structured data</i> (n/d EHR) <sup>1</sup>	>50% of patients $\geq$ 13yo seen, record status <i>as structured data</i> (n/d EHR) <sup>1</sup>
Decision Support	1 CDS rule relevant to the specialty specific quality metric <i>with the ability to track compliance</i> (y/n)	1 CDS rule relevant to a high priority hospital condition <i>with the ability to track compliance</i> (y/n)
Quality Reporting	Report ambulatory quality measures to CMS or states 2011: Attest numerator/denominator 2012: Electronic submission	Report hospital clinical quality measures to CMS or states 2011: Attest numerator/denominator 2012: Electronic submission

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR

# Core: Engage Patients and Families in Their Health Care

- Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
eHealth summary	>50% of patients who request it (incl: test results, prob list, med list, med allergies) w/i 3 business days (n/d EHR) <sup>1</sup>	>50% of patients who request it (incl: test results, prob list, med list, med allergies, d/c summary, procedures) w/i 3 business days (n/d EHR) <sup>1</sup>
eDischarge Instructions	-	>50% of patients who request it at discharge (n/d EHR) <sup>1</sup>
Visit summaries	>50% of patients seen get visit summary within 3 business days (n/d EHR) <sup>1</sup>	-

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR

# Core: Improve Care Coordination

- Exchange meaningful clinical information among professional health care teams

Objective	Ambulatory Measure	Hospital Measure (ED & IP)
Exchange with providers <sup>1</sup>	Capability of electronic exchange of key information (Ex: prob list, med list, allergies, test results <sup>2</sup> ). One test per measurement period (y/n)	Capability of electronic exchange of key information (Ex: d/c summary, procedures prob list, med list, allergies, test results). One test per measurement period (y/n)

1. Clinical information must be sent between different legal entities with distinct certified EHR technology or other system that can accept the information and not between organizations that share certified EHR technology
2. “Diagnostic test results “ are all data needed to diagnose and treat disease, such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.



# Core: Privacy and security protections for personal health information

- Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.
- Provide transparency of data sharing to patient.

Objective	Ambulatory Measure	Hospital Measure
Protect Patient Personal Health Information	Conduct or review a security risk analysis per <a href="#">45 CFR 164.308 (a)(1)</a> and correct deficiencies (y/n)	Conduct or review a security risk analysis per <a href="#">45 CFR 164.308 (a)(1)</a> and correct deficiencies (y/n)

# Menu Criteria

- Providers and hospitals may defer up to 5 of the menu criteria until stage 2
- At least one of the criteria from population and public health must be included in order to qualify as a meaningful user
- States can seek CMS prior approval to require 4 MU criteria 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)

# Menu: Improve quality, safety, efficiency and reduce health disparities

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
<i>Formularies</i>	<i>Implement drug formulary checks with at least one internal or external formulary (y/n)</i>	<i>Implement drug formulary checks with at least one internal or external formulary (y/n)</i>
<i>Advanced Directives</i>	-	<i>&gt;50% of <math>\geq 65</math>yo admitted indicate advanced directive recorded (n/d EHR non ED)</i>
Lab Results	>40% of labs with numeric or +/- result in chart as structured data (n/d EHR)	>40% of labs with numeric or +/- result in chart as structured data (n/d EHR)
Patient Lists <sup>3</sup>	Generate at least one pt list based on a specific condition (y/n)	Generate at least one pt list based on a specific condition (y/n)
Reminders	>20% of pts $\geq 65$ or $\leq 5$ yo sent reminders for follow up care (n/d EHR)	-

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period
3. States may seek approval from CMS to require a specific condition be tracked for Medicare

# Menu: Engage Patients and Families in Their Health Care

- Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
eResults	>10% patients seen with electronic access to lab results, prob lists, med list, med allergies w/i 4 business days of it being updated in the EHR (n/d all)	-
<i>Patient Ed</i>	<i>&gt;10% patients seen provided with ed resources identified with the EHR (n/d all)</i>	<i>&gt;10% patients seen provided with ed resources identified with the EHR (n/d all)</i>

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period

# Menu: Improve Care Coordination

- Exchange meaningful clinical information among professional health care teams

Objective	Ambulatory Measure	Hospital Measure (ED & IP)
Medication reconciliation	>50% of transitions of care <sup>1</sup> or a relevant encounter <sup>2</sup> (n/d EHR) <sup>3</sup>	>50% of transitions of care <sup>1</sup> or a relevant encounter <sup>2</sup> (n/d EHR) <sup>3</sup>
Summary care record	>50% of referrals and transitions of care <sup>1</sup> (n/d EHR) <sup>3</sup>	>50% of referrals and transitions of care <sup>1</sup> (n/d EHR) <sup>3</sup>

1. “transition of care” is the transfer of a patient from one clinical setting (inpatient, outpatient, ambulatory’ primary care practice, specialty care practice, home health, rehab, long term care facility, etc) to another or from one EP, eligible hospital, or CAH (as defined by CCN) to another.
2. “relevant encounter” is an encounter during which the EP, eligible hospital or CAH performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP, eligible hospital or CAH.
3. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR



# Menu: Improve Population and Public Health<sup>1</sup>

- Communicate with public health agencies

Objective	Ambulatory Measure	Hospital Measure (ED & IP)
Immunization Records <sup>2</sup>	≥ 1 test of submission to state immunization registry (unless no registries are capable) with continued submission if successful (y/n)	≥ 1 test of submission to state immunization registry (unless no registries are capable) with continued submission if successful (y/n)
Reportable Labs <sup>2</sup>	-	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)
Syndromic Surveillance <sup>2</sup>	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)

1. Unless an EP, eligible hospital or CAH has an exception for all of these objectives and measures they must complete at least one in this group as part of their demonstration of a meaningful EHR use to be eligible for incentives.
2. States may specify how to test the data submission and to which specific destination

# Eliminated from the final rule<sup>1</sup>

Objective	Ambulatory Measure	Hospital Measure
Insurance Eligibility	80% of patients seen	80% of patients seen
Electronic claim submission	80% of patients seen	80% of patients seen

1. Some form of these are predicted to be part of Stage 2

# Outline

- The Final Rule
- Financial Incentives for Hospitals and Providers
  - Medicare
  - Medicaid
- Elements of Meaningful Use
- **Quality Measures**
- What You Can Do Now

# Reporting of Clinical Quality Measures

- EPs would be required to submit clinical data on 2 measure groups:
  - A core set of 3 measures
  - An alternate core measure of the denominator of a core measure is zero
  - 3 additional measures selected from among 38 others
- EHs would be required to submit data on all 15 measures
- All measures have specifications for electronic reporting
  - Electronic specifications can be found at:  
[https://www.cms.gov/QualityMeasures/03\\_ElectronicSpecifications.asp](https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp)
- Patient information must be submitted regardless of payer

# Core Quality Measures for EPs

Measure Number	Clinical Quality Measure Title
<p>NQF 0013 Blood pressure measurement</p>	<p>Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.</p>
<p>NQF 0028 Tobacco use assessment and intervention</p>	<ol style="list-style-type: none"> <li>1. Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months</li> <li>2. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.</li> </ol>
<p>NQF 0421 PQRI 128 Adult Weight Screening and Follow-up</p>	<ol style="list-style-type: none"> <li>1. Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND</li> <li>2. if the most recent BMI is outside parameters, a follow-up plan is documented.</li> </ol>



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# Alternate Core Quality Measures for EPs

Measure Number	Clinical Quality Measure Title
<p>NQF 0024 Weight Assessment and Counseling for Children and Adolescents</p>	<p>Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.</p>
<p>NQF 0041, PQRI 110 Influenza Immunization for Patients ≥ 50 Years Old</p>	<p>Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).</p>
<p>NQF 0038 Childhood Immunization Status</p>	<p>Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio(IPV), one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.</p>



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# Optional Quality Measures EPs

- Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- Diabetes: Low Density Lipoprotein (LDL) Management and Control
- Diabetes: Blood Pressure Management
- Heart Failure: ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
- Pneumonia Vaccination Status for Older Adults
- Breast Cancer Screening
- Colorectal Cancer Screening
- Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
- Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Asthma Pharmacologic Therapy
- Asthma Assessment
- Appropriate Testing for Children with Pharyngitis
- Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer

# Optional Quality Measures EPs cont

- Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
- Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- Smoking and Tobacco Use Cessation, Medical assistance: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications and Strategies
- Diabetes: Eye Exam
- Diabetes: Urine Screening
- Diabetes: Foot Exam
- Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
- Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
- Ischemic Vascular Disease (IVD): Blood Pressure Management
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
- Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
- Prenatal Care: Anti-D Immune Globulin
- Controlling High Blood Pressure
- Cervical Cancer Screening
- Chlamydia Screening for Women
- Use of Appropriate Medications for Asthma
- Low Back Pain: Use of Imaging Studies
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
- Diabetes: Hemoglobin A1c Control (<8.0%)

# Clinical Quality Measures for Hospitals

- 15 quality Measures
- Hospitals must report values on all the measures
- Some hospitals, such as children's hospitals, will have zero in the denominator of some measures

# Hospital Measures

Measure Number	Clinical Quality Measure Title & Description
ED-1 NQF 0495	ED Throughput – admitted patients: Median time from ED arrival to ED departure for admitted patients
ED-2 NQF 0497	ED Throughput – admitted patients: Admission decision time to ED departure time for admitted patients
Stroke-2 NQF 0435	Ischemic stroke – Discharge on anti-thrombotics
Stroke-3 NQF 0436	Ischemic stroke – Anticoagulation for A-fib/flutter
Stroke-4 NQF 0437	Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
Stroke-5 NQF 0438	Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
Stroke-6 NQF 0439	Ischemic stroke – Discharge on statins

Measure Number	Clinical Quality Measure Title & Description
Stroke-8 NQF 0440	Ischemic or hemorrhagic stroke – Stroke education
Stroke-10 NQF 0441	Ischemic or hemorrhagic stroke – Rehabilitation assessment
VTE-1 NQF 0371	VTE prophylaxis within 24 hours of arrival
VTE-2 NQF 0372	Intensive Care Unit VTE prophylaxis
VTE-3 NQF 0373	Anticoagulation overlap therapy
VTE-4 NQF 0374	Platelet monitoring on unfractionated heparin
VTE-5 NQF 0375	VTE discharge instructions
VTE-6 NQF 0376	Incidence of potentially preventable VTE

# Projected Stage 2 Measures

- Inclusion of the measures in the proposed rule that have electronic specifications specified
- Additional pediatrics measures
  - such as completed growth charts, electronic prescriptions with weight-based dosing support and documentation of newborn screening
- Long-term care measures.
- Additional obstetrics measures.
- Dental care/oral health measures.
- Additional behavioral/mental health and substance abuse measures

# Outline

- The Final Rule
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# What Providers Can Do...

- Begin planning now
- Seek out the experience of others
- Urge your clinical staff to accurately record allergies, medications, medical and surgical histories and diagnoses in the chart
- Create a process to verify that this is being done accurately and completely
- Involve your staff throughout the facility in EHR selection, implementation and workflow analysis.
- Begin to make those changes you have been putting off so it is not blamed on the EHR
- Consider working with your HIT Regional Extension Center to assist in the process

# What Vendors Can Do...

- Certify according to the new ONC authorized testing and certification bodies
- Build so that they are able to certify for any of the quality measures their clients may choose from the menu list
- Facilitate the sharing of best practices among their clients for leveraging their product
- Encourage their clients to use their regional extension center (REC) services for optimal EHR use *beyond* meaningful use Stage 1 if the client is eligible for REC subsidies
- Consider using the help of extension centers to augment their implementation and upgrade teams for practices or hospitals eligible for subsidies



# Extension Center Services

- Readiness assessments
- Practice and workflow redesign
- Assist in selecting a certified EHR product that offers the best value for our client's needs
- Vendor contracting
- Process for EHR project management
- EHR optimization and meaningful use
- Technical reporting
- Privacy and security best practices
- Functional interoperability and HIE
- Meaningful use assessments

# Regional Extension Assistance Center for HIT (REACH)

- An HIT Extension Center serving small hospitals and clinics in Minnesota and North Dakota
- Project of the Key Health Alliance: Stratis Health, National Rural Health Resource Center, and The College of St. Scholastica
- Working in close cooperation with:
  - North Dakota Health Care Review, Inc.
  - University of ND, Center for Rural Health
- Building our clients' internal capacity for self support



# For a Short time Extension Center Services are Federally Subsidized

- For 2010 and 2011, the subsidies are very generous for clinics who have priority primary care providers and are committed to be meaningful users by October 2011
  - Up to 90% discounted off the cost of services
- The HITECH Act defines priority primary care providers as those individuals who meet all of the following criteria:
  - Physicians, physician assistants, nurse practitioners, nurse midwives with prescription writing privileges
  - Family medicine, internal medicine, Ob/Gyn, and pediatrics
  - In FQHCs, CAHs, RHCs, or small practices with < 10 providers or practices that serve underserved or needy populations
- Clinics need to sign with their RECs now to be eligible for subsidized services in 2011

# In Review

- Incentives are available for both eligible hospitals and providers who meaningfully use an EHR
- The final rules are more readily achievable than the rules in the proposed rule
- Eligibility for incentives will require demonstration of meaningful use of certified technology
- Criteria for meaningful use will become more demanding over time
- First measures of quality and then demonstration of quality will be required to be considered for incentives or payment increases
- Depending on your organization, your regional extension center may be subsidized to assist you in selecting an EHR, in getting the most out of your investment if you have one or assist you in implementing an EHR for your customers or affiliates
- There are significant subsidies available for hospitals and providers now so there will never be a better time to adopt an EHR and learn to use it effectively

# Resources:

- REACH
  - <http://khaREACH.org>
- Regional Extension Centers:
  - <http://healthit.hhs.gov/programs/REC>
- Stratis Health HIT Toolkits
  - <http://www.stratishealth.org/expertise/healthit/>
- “Meaningful Use” information on the Health and Human Services web site:
  - <http://healthit.hhs.gov/meaningfuluse>
- “Meaningful Use” on the CMS web site:
  - <https://www.cms.gov/EHRIncentivePrograms/>

# Understanding the EHR Incentive Final Rule



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To register or find our more information about REACH  
<http://khaREACH.org>  
877-331-8783, ext. 222



Key Health Alliance—Stratis Health, Rural Health Resource Center, and The College of St. Scholastica.

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