National Health IT Week
September 17, 2013

Medicare and Medicaid EHR Incentive Programs: Overview and a Look Ahead

Presentation Objectives

Assist Eligible Professionals with:

1. Eligibility requirements for EPs
2. Basic participation requirements
3. Key program deadlines
4. Payment amounts
5. Payment Adjustments & Hardship Exceptions

What are the EHR Incentive Programs?

- The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals (EPs) who demonstrate meaningful use of electronic health records (EHRs)

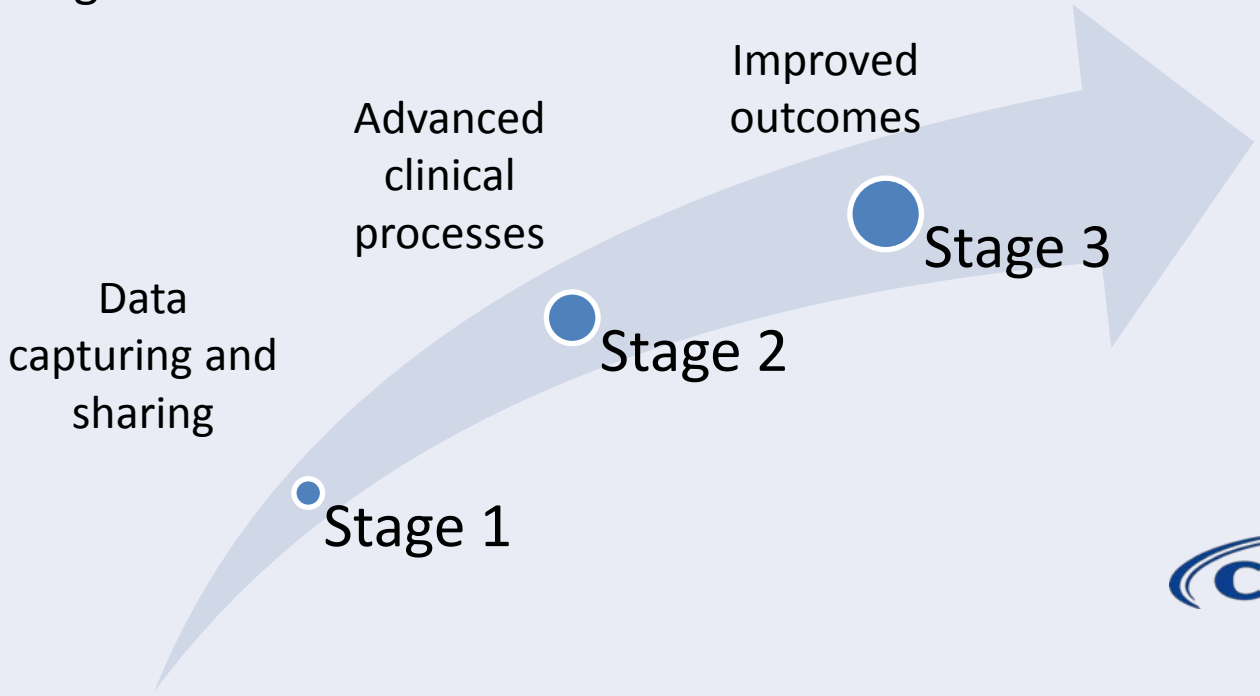
- EPs must demonstrate meaningful use and submit measures for Stage 1, Stage 2, and Stage 3

What is 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 by law to receive incentives

How does the program work?

- The EHR Incentive Programs consist of 3 stages of meaningful use
- Each stage has its own set of requirements to meet in order to demonstrate meaningful use



HIT can also turn data into information

Eligibility

Who is eligible to participate?

- Eligibility determined by law
- Hospital-based EPs are NOT eligible for incentives
  - DEFINITION: 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
  - Definition of hospital-based determined in law
- Incentives are based on the individual, not the practice

Who is eligible to participate?

- Medicare EPs include:
  - Doctors of medicine or osteopathy
  - Doctors of dental surgery or dental medicine
  - Doctors of podiatric medicine
  - Doctors of optometry
  - Chiropractors
- EPs may not be hospital-based
- CAH II physicians can begin participation in calendar year (CY) 2013

Who is eligible to participate?

EPs in Medicare Advantage must:

- Furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MA organization

OR

- Furnish, on average, at least 20 hours/week of patient care services and be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80% of the entity's Medicare patient care services to enrollees of the qualifying MA organization

AND

- 80% of professional services are provided to enrollees of the MAO

Who is eligible to participate?

- Medicaid EPs include:
  - Physicians
  - Nurse practitioners
  - Certified nurse-midwives
  - Dentists
  - Physicians assistants working in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is so led by a physicians assistant
- EPs may not be hospital-based

Who is eligible to participate?

Medicaid EPs must also meet one of the three patient volume thresholds:

1. Have a minimum of 30% Medicaid patient volume
2. Pediatricians ONLY: Have a minimum of 20% Medicaid patient volume
3. Working in FQHC or RHC ONLY: Have a minimum of 30% patient volume attributed to needy individuals

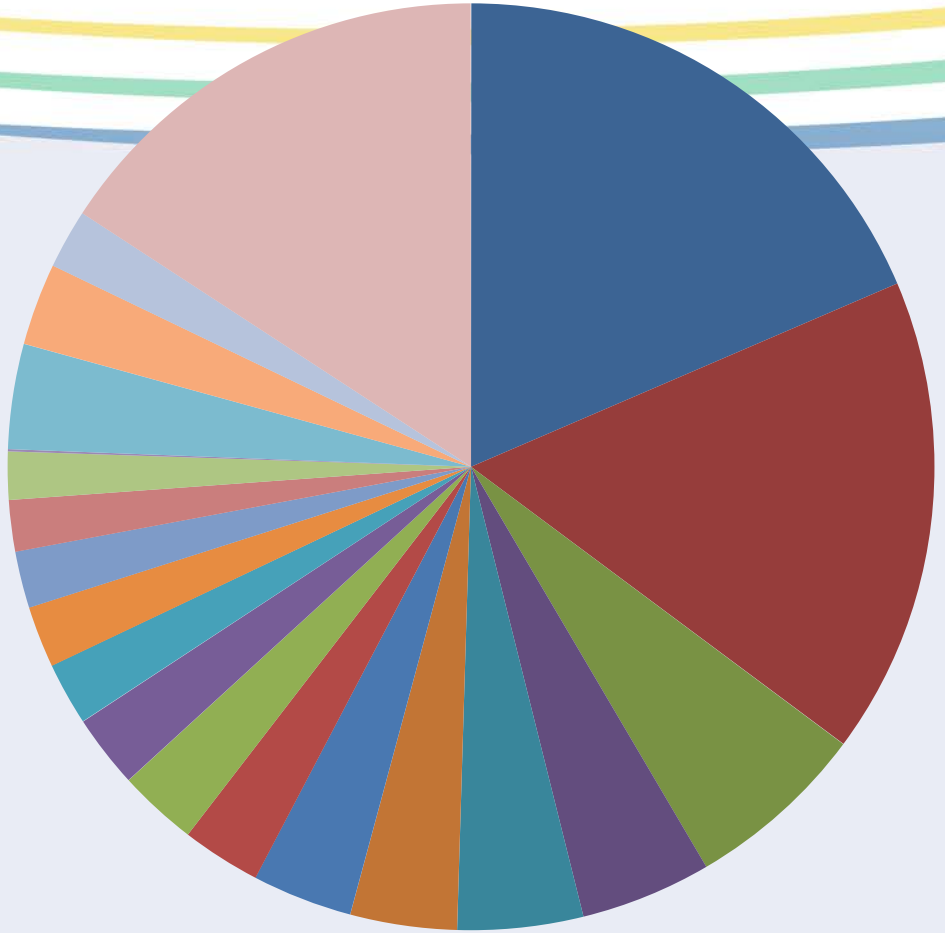
CHIP, sliding scale, free care only count toward thresholds if working in RHC or FQHC

Are you eligible?

CMS has created an eligibility tool to help EPs determine their eligibility:

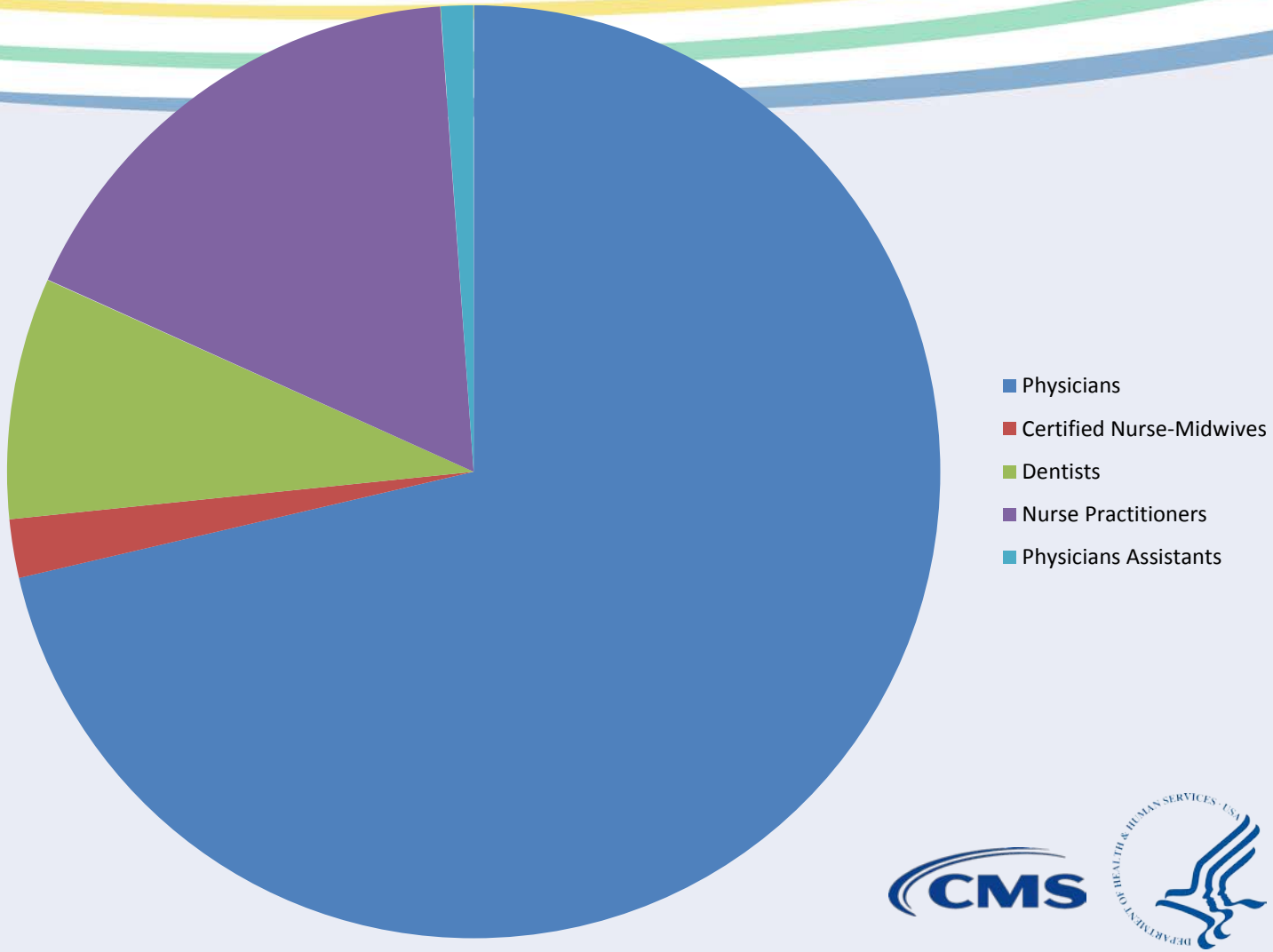
Who has participated?

201,927 Medicare EPs



Who has participated?

101,544 Medicaid EPs



Who has participated?

4,098 Hospitals

Requirements

What are the requirements for 1st year Medicaid EPs?

- MEDICAID – Only for first participation year:
  - **Adopted** – Acquired access to certified EHR technology in a legally and/or financially committed manner
  - **Implemented** – Began using certified EHR technology
  - **Upgraded** – Demonstrated having upgraded access to EHR technology newly certified in a legally and/or financially committed manner
- Must be certified EHR technology capable of meeting meaningful use
- No EHR reporting period in 1st year, but in 2nd year Medicaid EPs must meet the meaningful use requirements for 90 days

What are the requirements for 1st year Medicare EPs?

- For the first year they participate, Medicare EPs have to:
  - Meet the requirements for and report data on a continuous 90-day period during the calendar year (any 90 days from January 1st to December 31st)
- For the remaining years they participate, EPs have to meet the requirements for the entire calendar year
- Both of these are called the reporting periods

What do Medicare EPs need for registration?

Before registering:

- Make sure to have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)*
- Verify that the Medicare Administrative Contractor (MAC) has the correct banking information and payee information including:
  - Bank account number
  - Bank routing number
  - Payee Address
  - Payee National Provider Identifier (NPI) and Payee Tax Identification Number (TIN) Combinations

When registering, have on-hand:

- An NPI
- A National Plan and Provider Enumeration System (NPPES) Identity and Access Management (I&A) ID and password for the individual provider;
- A Payee TIN
- A Payee NPI
- EHR Certification Number

What do Medicaid EPs need for registration?

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

When registering, have on-hand:

- An NPI
- An NPPES I&A ID and Password
- A Payee TIN
- A Payee NPI**
- EHR Certification Number

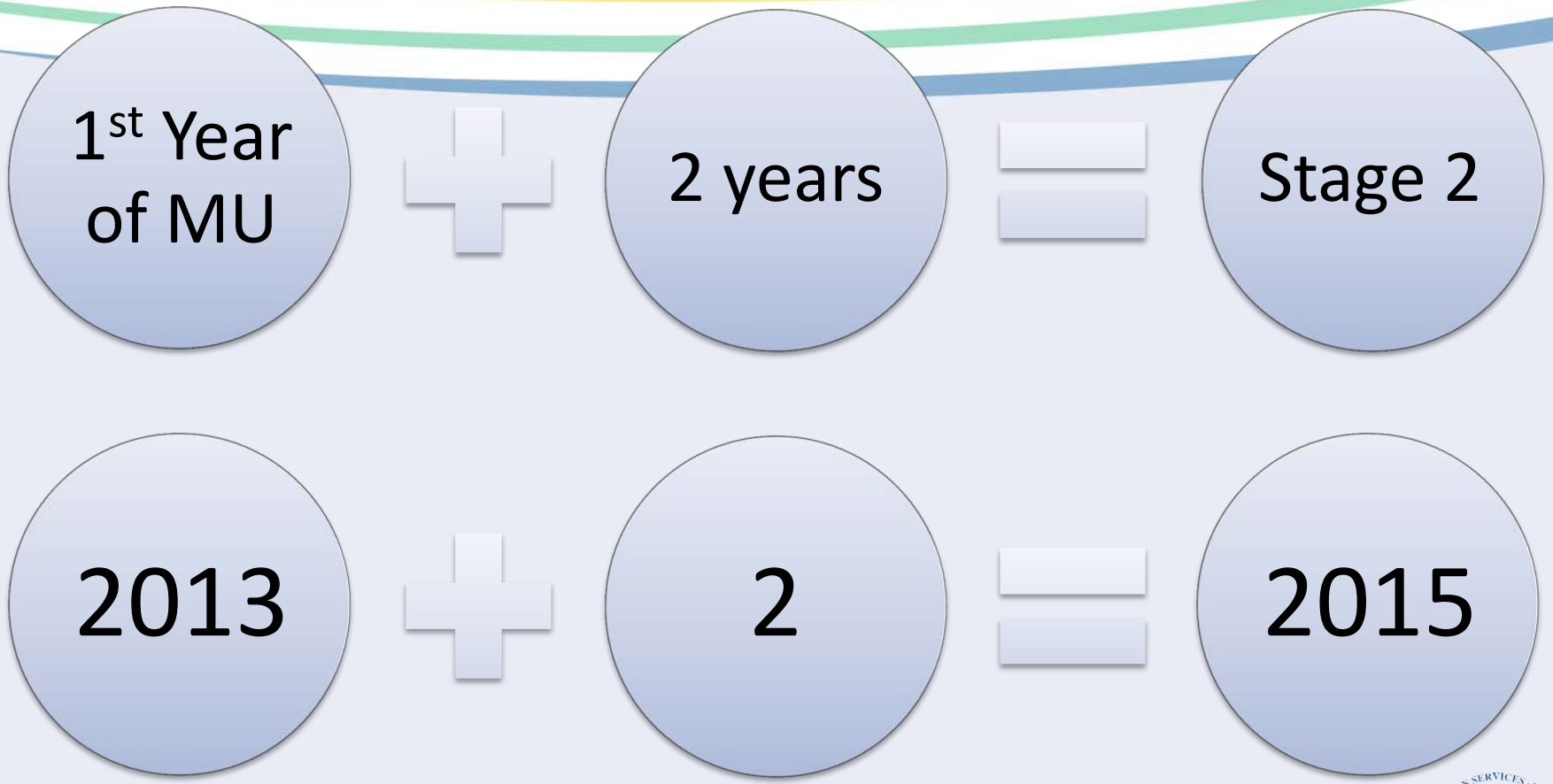
CMS
DEPARTMENT OF HEALTH & HUMAN SERVICES - USA

What Stage am I in?

Everyone starts in Stage 1

No one starts Stage 2 before 2014

When do I start Stage 2?



When Do I Start Stage 2?

http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html

What are the requirements for Stage 1 of meaningful use?

- EPs participating must meet the following for Stage 1:
  - 14 required core objectives
  - 5 objectives chosen from a list of 10 menu set objectives

- In addition to meeting the thresholds for the 14 core and 5 menu objectives, all EPs have to report on clinical quality measures (CQMs)

Meaningful Use			
13 Core Measures	**+ 5** Menu Measures	**+ 6** CQMs	**= MU** **Meaningful Use**

Beginning in 2014, reporting CQMs will no longer be part of the 14 core measures, but will be still be required. The total of core measures will become 13.

What are the core objectives for Stage 1?

EPs must meet all core objectives:

Core Objective	Measure
1. CPOE	Use CPOE for at least 30% of medication orders
2. Drug-drug and Drug-allergy Checks	Enable drug-drug and drug-allergy checks on EHR
3. Problem List	Record patient diagnoses for more than 80%
4. E-Rx	E-Rx for more than 40%
5. Medication List	Record patient medications for more than 80%
6. Medication Allergy List	Record patient medications for more than 80%
7. Demographics	Record demographics for more than 50%
8. Vital Signs	Record vital signs for more than 50%

What are the core objectives for Stage 1?

EPs must meet all core objectives:

Core Objective	Measure
9. Smoking Status	Record smoking status for more than 50%
10. Clinical Decision	Implement one clinical decision support rule
11. Electronic Copy	Provide electronic copy of health information for more than 50% of patients
12. Clinical Summaries	Provide clinical summaries to more than 50% of patients
13. Protect health information	Conduct security risk analysis and implement security updates

What are the menu objectives for Stage 1?

EPs must select 5 menu objectives:

Menu Objective	Measure
1. Drug Formulary Checks	Enable the formulary check for the entire reporting period
2. Lab Results	Incorporate lab results for more than 40%
3. Patient List	Generate patient list by specific condition
4. Preventive Reminders	Use EHR to identify and provide reminders for preventive/follow-up care for more than 20% of patients 65 years or older or 5 years old or younger
5. Patient Access	Provide online access to health information for at least 10%
6. Education Resources	Use EHR to identify and provide education resources more than 10%
7. Rx Reconciliation	Medication reconciliation at more than 50% of transitions of care
8. Summary of Care	Provide summary of care document for more than 50% of transitions of care and referrals
9. Immunization Registries	Submit at least one immunization registry electronically
10. Syndromic Surveillance	Perform at least one transmission of syndromic surveillance data

What do EPs need for attestation?

- Before attesting Medicare EPs should have:

✓ Met all of the necessary measures to successfully demonstrate meaningful use and qualify for an EHR incentive payment
✓ Completed the appropriate reporting period and timeframe
✓ A successful and active Registration status in the Registration and Attestation system
✓ An EHR Certification Number

- State requirements may vary for Medicaid EPs
  - EPs should refer to their State for details about attestation

Changes for Stage 2

- Secure Messaging
- Family Health History
- Imaging Results
- Registry Reporting
- Progress Notes

EP

- Online Patient Information
- Family Health History
- Imaging Results
- Registry Reporting
- Progress Notes
- E-Prescribing
- eMAR
- Electronic lab results

Hospital

Changes for Stage 2

- Lab Results
- Patient Lists
- Patient Education
- Summary of Care Records
- Medication Reconciliation
- Immunizations
- Patient Reminders
- Online Patient Information

EP

- Lab Results
- Patient Lists
- Patient Education
- Summary of Care Records
- Medication Reconciliation
- Immunizations
- Public health lab results
- Syndromic surveillance

Hospital

What is required for Stage 2?

- In the Stage 1 meaningful use regulations, CMS had established a timeline that required providers to progress to Stage 2 criteria after two program years under the Stage 1 criteria

- CMS delayed the onset of Stage 2 criteria, therefore the earliest that the Stage 2 criteria will be effective is in calendar year 2014 for EPs

- EPs must meet the following for Stage 2:
  - 17 core objectives
  - 3 menu objectives that they select from a total list of 6

Deadlines

What are the important 2013 deadlines?

Date	Deadline
October 3, 2013	Last day for EPs to begin 90-day reporting period for CY 2013
December 31, 2013	Reporting year ends for EPs
February 28, 2014	Last day for Medicare EPs to register and attest to receive an incentive payment for CY 2013 *(deadline varies for Medicaid EPs)*

January 1, 2014- Reporting period begins for EPs for CY 2014 (90 days for Medicaid and 3 months on the quarter for Medicare)

What is happening in 2014?

For 2014 only, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 3-month EHR reporting period:

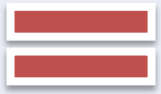
- **For Medicare EPs-** 3-month reporting period is fixed to the quarter of the year in order to align with existing CMS quality measurement programs
- **For Medicaid EPs-** 3-month reporting period is not fixed for Medicaid EPs that are only eligible to receive Medicaid EHR incentives, where providers do not have the same alignment needs

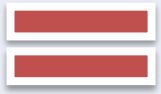
This one-time 3-month reporting period in 2014 will help all providers who must upgrade to 2014 Certified EHR Technology to have adequate time to implement their new Certified EHR systems

Clinical Quality Measures

Clinical Quality Measures

CQM Requirements  **Stage of Meaningful Use**

CQM Requirements  **Year**

CQM Requirements  **Output of Certified EHR**

Changes to CQMs Reporting

Prior to 2014		Beginning in 2014	
EPs	Report 6 out of 44 CQMs • 3 core or alt. core • 3 menu	**EPs**	Report 9 out of 64 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains Recommended core CQMs: 9 for adult populations 9 for pediatric populations
Eligible Hospitals and CAHs	Report 15 out of 15 CQMs	**Eligible Hospitals and CAHs**	Report 16 out of 29 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains

EP CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
EPs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
Option 2	Patient	Medicare	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT
Group Reporting (only EPs Beyond the 1st Year of Demonstrating Meaningful Use)**				
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare	Electronic	Satisfy requirements of Medicare Shared Savings Program of Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

**Attestation is required for EPs in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

***Groups with EPs in their 1st year of demonstrating MU can report as a group, however the individual EP(s) who are in their 1st year must attest to their CQM results by October 1 to avoid a payment adjustment.*

Payment Amounts

Medicare incentive payment schedule

Maximum Payment by Start Year	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$44,000	18,000	12,000	8,000	4,000	2,000	
2012		1	1	2	2	3
$44,000		18,000	12,000	8,000	4,000	2,000
2013			1	1	2	2
$39,000			15,000	12,000	8,000	4,000
2014				1	1	2
$24,000				12,000	8,000	4,000

Medicare incentive payment sequestration schedule*

**This 2% reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction.*

Maximum Payment by Start Year	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$43,720	18,000	12,000	**7,840** Reduction ($160)	**3,920** Reduction ($80)	**1,960** Reduction ($40)	
2012		1	1	2	2	3
$43,480		18,000	**11,760** Reduction ($240)	**7,840** Reduction ($160)	**3,920** Reduction ($80)	**1,960** Reduction ($40)
2013			1	1	2	2
$38,220			**14,700** Reduction ($300)	**11,760** Reduction ($240)	**7,840** Reduction ($160)	**3,920** Reduction ($80)
2014				1	1	2
$23,520				**11,760** Reduction ($240)	**7,840** Reduction ($160)	**3,920** Reduction ($80)

Medicaid incentive payments amounts

Annual Incentive Payment by Stage of Meaningful Use					
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
(AIU)	1	1	2	2	3
$21,250	$8,500	$8,500	$8,500	$8,500	$8,500

Maximum incentive payment amount is $63,750. Payments are made over 6 years and do not have to be consecutive.

*2016 is the last year that Medicaid EPs can begin participation in the program.

Payment Adjustments & Hardship Exceptions

Avoiding 2015 Payment Adjustments

Meaningful EHR User in 2011 or 2012	Never been a Meaningful EHR User
End EHR reporting period by Dec 31, 2013	End EHR reporting period by Sep 30, 2014
Attest by Feb 28, 2014	Attest by Oct 1, 2014

Hospitals Subtract 3 Months

Apply to CMS for a hardship exemption by:

July 1, 2014

Avoiding the 2015 payment adjustments

- Demonstrate meaningful use to CMS by:

Meaningful EHR User in 2011 or 2012	Never been a Meaningful EHR User
End EHR reporting period by December 13, 2013	End EHR reporting period by September 30, 2014
Attest by February 28, 2014	Attest by October 1, 2014

- Apply to CMS for a hardship exemption by **July 1, 2014**

- Medicaid EPs are not subject to payment adjustments

Payment adjustments for EPs eligible for both programs

Eligible for both programs?

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use according to the timelines in the previous slides to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

Note: *Congress mandated that an EP must be a meaningful user in order to avoid the payment adjustment; therefore receiving a Medicaid EHR incentive payment for adopting, implementing, or upgrading your certified EHR Technology would not exempt you from the payment adjustments.*

What are the hardship exceptions for EPs?

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).

2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments.

3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.

4. **EPs must demonstrate that they meet the following criteria:**

- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients

5. **EPs who practice at multiple locations must demonstrate that they:**

Lack of control over availability of CEHRT for more than 50% of patient encounters

What are the hardship exceptions for EPs?

EPs whose primary specialties are anesthesiology, radiology or pathology:

As of July 1st of the year preceding the payment adjustment year, EPs in these specialties will receive a hardship exception based on the 4th criteria for EPs

EPs must demonstrate that they meet the following criteria:

- **Lack of face-to-face or telemedicine interaction with patients**
- **Lack of follow-up need with patients**

How do EPs apply for a hardship exceptions?

- **Applying:** EPs, eligible hospitals, and CAHs must apply for hardship exceptions to avoid the payment adjustments.
- **Granting Exceptions:** Hardship exceptions will be granted only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use.
- **Deadlines:** Applications need to be submitted **no later than April 1 for hospitals**, and **July 1 for EPs** of the year before the payment adjustment year; however, CMS encourages earlier submission

For More Info: Details on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website in the future: **www.cms.gov/EHRIncentivePrograms**

Resources

Resources from CMS and ONC

- Get information, tip sheets and more at CMS' official website for the EHR incentive programs: www.cms.gov/EHRIncentivePrograms
  - Introduction to EHR Incentive Programs
  - Frequently Asked Questions (FAQs)
  - Meaningful Use Attestation Calculator
  - Registration & Attestation User Guides
  - Listserv

- Learn about certification and certified EHRs, as well as other ONC programs designed to support providers as they make the transition: www.healthit.gov/

Questions?

The **Electronic Health Record (EHR) Information Center** is open to assist you with all of your registration and attestation system inquiries.

- 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday (except federal holidays)
- 1-888-734-6433 (primary number) or 888-734-6563 (TTY number)