

Medicare & Medicaid EHR Incentives Program

Implementing the American
Recovery & Reinvestment Act of
2009



Overview

- American Recovery & Reinvestment Act – February 2009
- EHR Incentive Notice of Proposed Rulemaking on Display – December 30, 2009; published January 13, 2010
- NPRM Comment Period Closed – March 15, 2010

What Was in the CMS EHR Incentive Program NPRM?

- Definition of Meaningful Use
- Definition of Hospital-Based Eligible Professional
- Medicare FFS EHR Incentive Program
- Medicare Advantage EHR Incentive Program
- Medicaid EHR Incentive Program
- Collection of Information Analysis (Paperwork Reduction Act)
- Regulatory Impact Analysis

What Was Not in the CMS NPRM?

- Information about applying for grants
- Changes to HIPAA
- Office of the National Coordinator (ONC) Interim Final Rule – HIT: Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology
- EHR certification requirements
- ONC NPRM - Establishment of Certification Programs for Health Information Technology
- Procedures to become a certifying body

What the NPRM Did

- Harmonized MU criteria across CMS programs as much as possible
- Closely linked with the ONC certification and standards regulation
- Built on the recommendations of the HIT Policy Committee
- Coordinated with the existing CMS quality initiatives
- Provided a platform that allows for a staged implementation over time

Eligibility Overview

- Medicare FFS
 - Eligible professionals (EPs)
 - Eligible hospitals and critical access hospitals (CAHs)
- Medicare Advantage (MA)
 - MA EPs
 - MA-affiliated eligible hospital
- Medicaid
 - EPs
 - Eligible hospitals

Who is a Medicare Eligible Provider?

Eligible Providers in Medicare

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 DC (including Maryland hospitals)

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

Qualifying 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 (Pediatricians have special eligibility & payment rules)

Nurse Practitioners (NPs)

Certified Nurse-Midwives (CNMs)

Dentists

Physician Assistants (PAs) who lead a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is directed by a PA

Eligible Hospitals

Acute Care Hospitals

Children's Hospitals

Incentive Payments for Medicare EPs

First Calendar Year in which the EP receives an Incentive Payment

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

Additional Incentives for Medicare EPs Practicing in HPSAs

First Calendar Year in which the EP receives an Incentive Payment					
Calendar Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
2011	\$1,800				
2012	1,200	\$1,800			
2013	800	1,200	1,500		
2014	400	800	1,200	\$1,200	
2015	200	400	800	800	0
2016		200	400	400	0
TOTAL	\$4,400	\$4,400	\$3,900	\$2,400	\$0

Incentive Payments for Medicare EPs

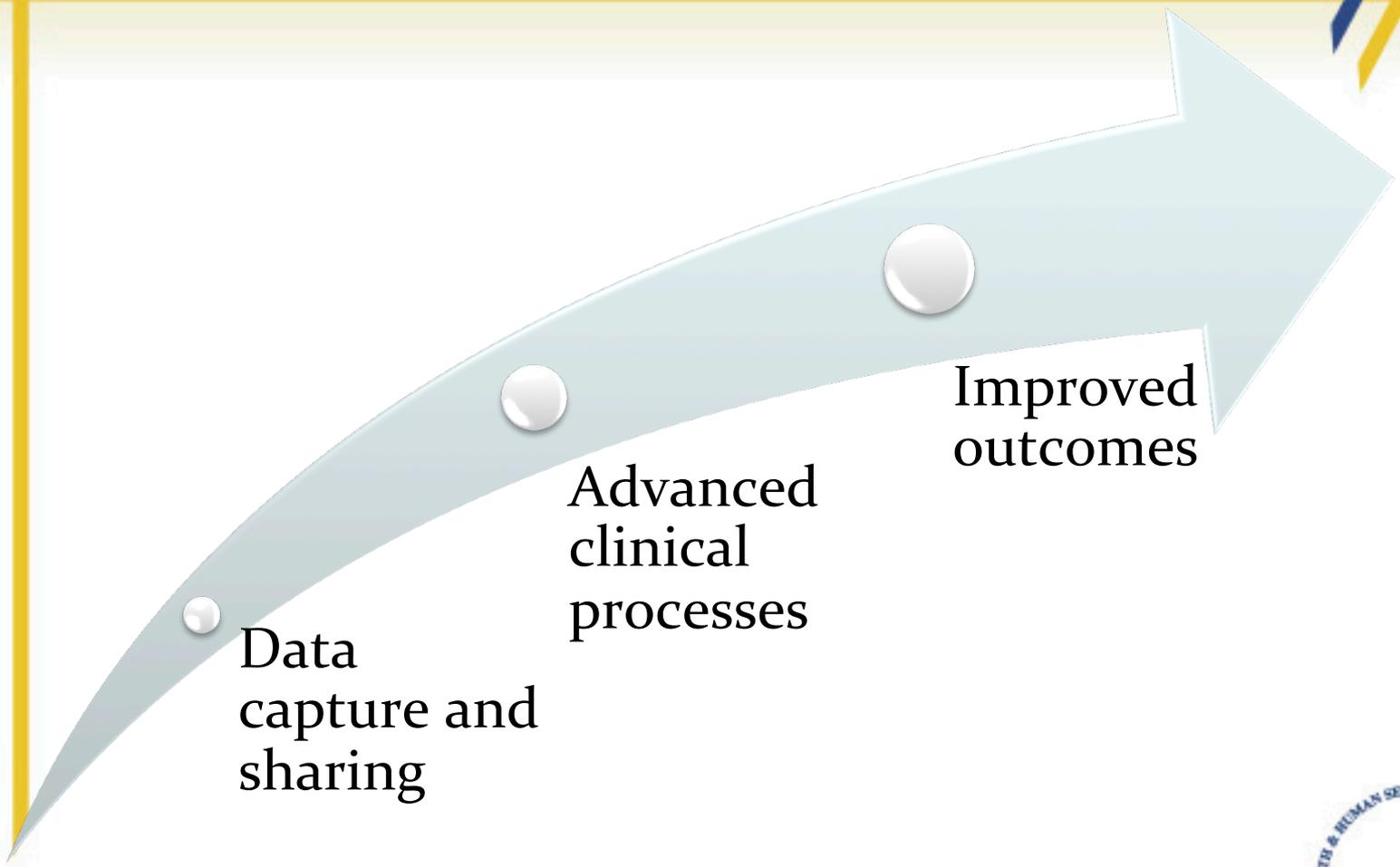
First Calendar Year in which the EP receives an Incentive Payment

Calendar Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
2011	\$21,250					
2012	8,500	\$21,250				
2013	8,500	8,500	\$21,250			
2014	8,500	8,500	8,500	\$21,250		
2015	8,500	8,500	8,500	8,500	21,250	
2016	8,500	8,500	8,500	8,500	8,500	\$21,250
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
2020					8,500	8,500
2021						8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Defining Meaningful Use

- Definition
 - To be determined by Secretary
 - Must include quality reporting, electronic prescribing, information exchange
- Process of defining
 - NCVHS Hearings
 - HIT Policy Committee recommendations
 - Listening Sessions with providers/organizations
 - Public Comments on the HIT Policy Committee recommendations
 - NPRM internal clearance comments received from the Department and OMB
 - Public comments on the NPRM

Conceptual Approach to Meaningful Use



Data capture and sharing

Advanced clinical processes

Improved outcomes

Meaningful Use Stages

- Meaningful Use will be defined in 3 stages through rulemaking
 - Stage 1 – 2011
 - Stage 2 – 2013*
 - Stage 3 – 2015*

*Stages 2 and 3 will be defined in future CMS rulemaking.

Stage 1 – Health Outcome Priorities*

- 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

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

Proposed Stages of Meaningful Use Timeline

First Payment Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015 and later*					Stage 3

*Avoids payment adjustments only for EPs in Medicare EHR Incentive Program

**Stage 3 criteria of meaningful use or a subsequent update to criteria if one is established

Meaningful Use Summary

- EPs
 - 25 Objectives and Measures
 - 8 Measures require ‘Yes’ or ‘No’ as structured data
 - 17 Measures require numerator and denominator
- Eligible Hospitals and CAHs
 - 23 Objectives and Measures
 - 10 Measures require ‘Yes’ or ‘No’ as structured data
 - 13 Measures require numerator and denominator
- Reporting Period – 90 days for first year; one year subsequently

Clinical Quality Measures Overview

- 2011 – Providers required submit summary quality measure data to CMS by attestation
- 2012 – Providers required to electronically submit summary quality measure data to CMS
- EPs are required to submit clinical data on the two measure groups: core measures and a subset of clinical measures most appropriate to the EP's specialty
- Eligible hospitals are required to report summary quality measures for applicable cases

Core Quality Measures for EPs

- Preventive care and screening: Inquiry regarding tobacco use
- Blood pressure management
- Drugs to be avoided by the elderly:
 - Patients who receive at least one drug to be avoided
 - Patients who receive at least two different drugs to be avoided

Specialty Quality Measures for EPs

EPs will need to select one of the following specialties

Cardiology	Obstetrics and Gynecology
Pulmonology	Neurology
Endocrinology	Psychiatry
Oncology	Ophthalmology
Proceduralist/Surgery	Podiatry
Primary Care	Radiology
Pediatrics	Gastroenterology
Nephrology	

Clinical Quality Measures for Eligible Hospitals

- Hospitals are required to report summary data on 35 clinical quality measures to CMS
- Hospitals only eligible for Medicaid will report directly to the States
- For hospitals in which the measures don't apply, they will have the option of selecting an alternative set of Medicaid clinical quality measures

Notable Differences Between the Medicare & Medicaid EHR Programs

Medicare	Medicaid
Feds will implement (will be an option nationally)	Voluntary for States to implement (may not be an option in every State)
Fee schedule reductions begin in 2015 for providers that are not Meaningful Users	No Medicaid fee schedule reductions
Must be a meaningful user in Year 1	Adopt/Implement/Upgrade option for 1 st participation year
Maximum incentive is \$44,000 for EPs	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)
Medicare Advantage EPs have special eligibility accommodations	Medicaid managed care providers must meet regular eligibility requirements
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
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, 3 types of hospitals

Public Comment Period

- Ended March 15, 2010
- Over 2,000 comments received
- Comment review period
 - All comments must be addressed
 - Comments reviewed in terms of rationale and statutory, policy, and operational feasibility
 - Key policy decisions are teed up early for senior HHS and other leadership

Major Comment Themes

- Most liked the context but...
 - The criteria for meaningful use is set too high
 - There needs to be more flexibility with meeting the objectives and measures
 - Don't give states latitude in setting additional requirements
 - Concerns about the attestation process and providing a measure denominator where it is not available through an EHR
 - Don't include administrative measures (eligibility verification and claims submission)

Major Comment Themes

- Quality measures
 - Delay reporting even by attestation
 - Avoid redundancy with other CMS programs
 - Limit measures to EHR-ready
 - More clarification is needed
- Hospitals
 - Need more specificity on later stages
 - Definition of a hospital-based eligible professional is too broad
 - Definition of a hospital is too narrow
 - Concerns about meeting CPOE measure

Incentive Payment Timeline

- Registration start date for all programs - January 2011
- First attestations - April 2011
- First payments - May 2011

Current Status

- Review of comments completed
- Draft final regulation-completed
- CMS/HHS/OMB clearance-May/June
- Final rule publication-Late June 2010