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## The Meaningful Use Incentives: Small Steps for Great Reward

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# The Statements

Become Meaningful Use Certified  
Fulfill 15 Core and 5 Menu Requirements  
Receive \$63,750 Per Provider  
Start Receiving Incentives in 2011

- 1) Results may vary
- 2) Not available in all states
- 3) See CMS for Details

# Background

- Health IT has tremendous potential to transform how health care is delivered
- Health Information Technology for Economic & Clinical Health Act (HITECH) attempts to realize that potential
- \$34 billion in financial incentives to Medicare & Medicaid providers for the adoption and meaningful use of Health IT

# Critical Goals

- Increase care coordination and foster better doctor-patient communication
- Reduce medical errors and improve patient safety
- Support delivery of evidence-based care
- Provide patients with their own portable health information
- Improve quality of care, while fostering more cost effective delivery

# Meaningful Use

Multi-year, multi-stage incentive program to help expand Health IT infrastructure, spur the adoption of Certified EHR Technology and utilize it to reach a series of specified objectives

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Medicaid Incentives

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# Incentives for the State

- Almost all costs incurred by State will be reimbursed by CMS
  - 100% of incentive payments
  - 90% of acceptable administrative costs
- States can request 4 additional measures as requirements to support state specific initiatives
- States can opt out of participation

# Who is eligible

- Hospitals
  - Acute care hospitals with at least 10% Medicaid patient volume
  - Children's hospitals (no Medicaid patient threshold)
- Eligible Professionals (EP)
  - Non hospital-based Physicians, NP, Certified Nurse-Midwife, Dentist, Physician Assistants in a FQHC
  - Must see 50% of patients at a facility that has certified EHR technology

# Provider Incentives & Rules

- Must have a minimum of 30% Medicaid patient volume for each EP during period
- Incentives capped at \$63,750 per EP over 6 years
- Only need to Adopt, Implement or Upgrade for first year incentive payment
- Providers can only participate in a single state's Medicaid incentive program
- An EP can only assign his/her incentive to a single taxpayer ID number

# Adopt/Implement/Upgrade

- Adopted – Acquired
  - Eg: Evidence of acquisition prior to incentive
- Implemented – Commenced Utilization
  - Eg: Training or begin data entry
- Upgraded – Expanded
  - Upgrade to certified EHR Technology or add new functionality to meet MU criteria
- No EHR reporting period



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Medicare Incentives

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# Who is eligible

- Hospitals
  - “Subsection (d) hospitals” that are paid under the Inpatient Prospective Payment System (IPPS)
  - Medicare Advantage (MA-Affiliated) Hospitals
  - Critical Access Hospitals (CAHs)
- Eligible Professionals (EP)
  - Non hospital-based MD, DO, DDS, DDM, Podiatrists, Optometrists, Chiropractors
  - Must see 50% of patients at a facility that has certified EHR technology

# Provider Incentives

- Calculated by multiplying your allowable charges to Medicare by 75% (up to cap)
  - Part B claims for FFS program
  - Items in Medicare Physicians Fee schedule
  - Only the “professional” components
- No minimum patient volume required
- 10% bonus available for those practicing predominantly in a Health Professional Shortage Area
- Can’t “double dip” if you are already receiving ePrescribing Medicare MIPPA incentive

# Penalties

- If not a meaningful user by 2015 reimbursement reduced by 1% each year for 4 years\*
- HITECH act also authorizes CMS to further reduce reimbursement rate beginning in 2018 if proportion of meaningful users is less than 75%

\*Unless due to a significant hardship

# Reimbursement Schedule

Incentive Paid In	Meaningful Use of a Certified EHR				Failure to Demonstrate by			
	2011	2012	2013	2014	2015	2016	2017	2018
2011	\$18k	-	-	-				
2012	\$12k	\$18k	-	-				
2013	\$8k	\$12k	\$15k	-				
2014	\$4k	\$8k	\$12k	\$12k				
2015	\$2k	\$4k	\$8k	\$8k				
2016		\$2k	\$4k	\$4k				
2017								
<b>Total</b>	<b>\$44k</b>	<b>\$44k</b>	<b>\$39k</b>	<b>\$24k</b>	-1% Penalty	-2% Penalty	-3% Penalty	-4% Penalty
HPSA	\$48.4k (+10%)	\$48.4k (+10%)	\$42.9k (+10%)	\$26.4k (+10%)				

# Medicare vs Medicaid

Medicare	Medicaid
Federal implementation in January of 2011	Voluntary for states to implement
Penalties begin in 2015	No Penalties
No patient volume threshold	30% Medicaid volume threshold
Must demonstrate MU in Year 1	A/I/U option for 1 <sup>st</sup> participation year
\$18k 1 <sup>st</sup> year max incentive	\$21,250 1 <sup>st</sup> year max incentive
Max of \$44k over 5 years (\$48.4k in HPSA)	Max of \$63,750 over 6 years
Start date of 2012 will still receive max incentive	Start date of 2016 will still receive max incentive
MU definition common	States can adopt additional requirements
If you skip a year, you return to later payment year	If you skip a year, you return to where you left off

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Becoming a Meaningful User

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# How to Become a Meaningful User

- Use of Certified EHR Technology
- Meet Staged IT Functionality Measures
- Meet Staged Clinical Quality Measures

# Certified EHR Technology

- “Complete” option
  - Acquire a system from a single vendor
  - “Complete” or “Bundled”
- “Assembled” option
  - Acquire modules from one or more vendors
  - Provider must attest that assembled system is complete
- <http://onc-chpl.force.com/ehrcert>

# It's a Big Decision, Choose Meaningfully™



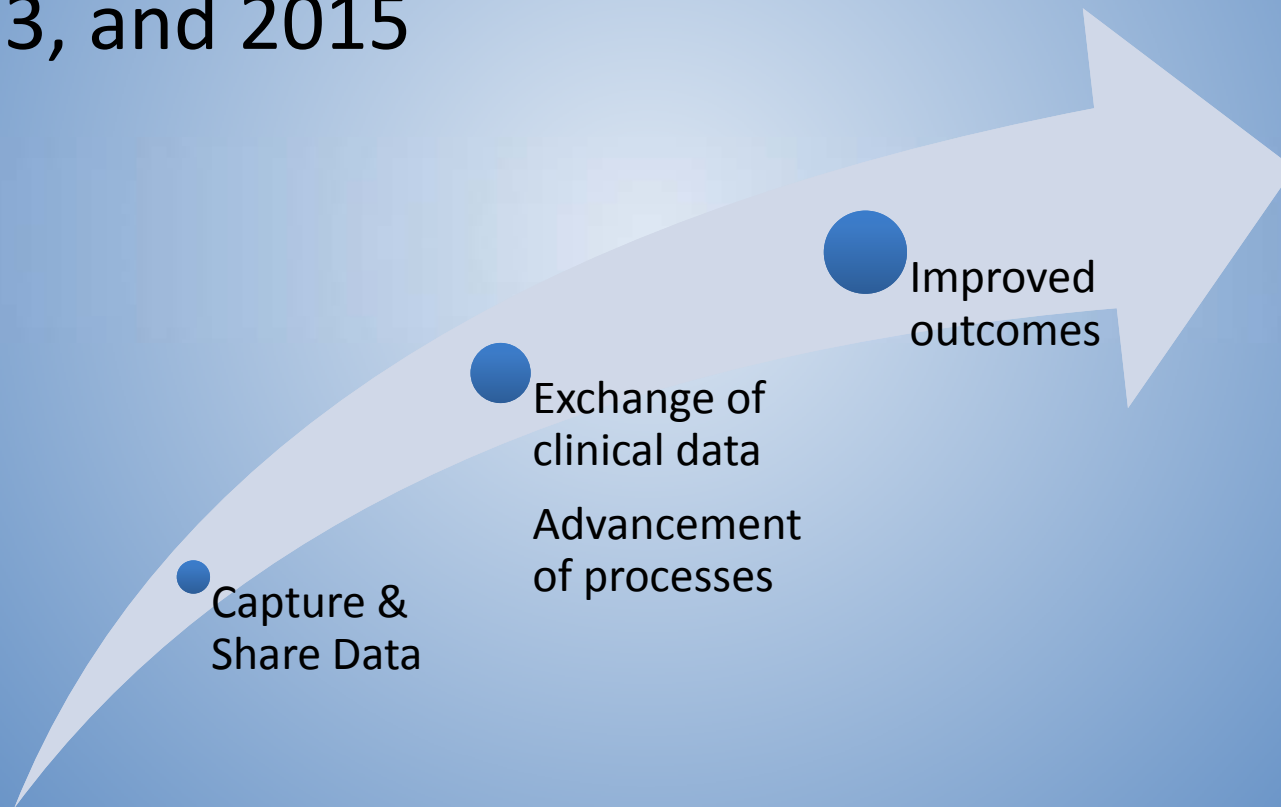
- ✓ Achieved “Complete” certification on March 22, 2011
- ✓ Largest and fastest growing Software as a Service Enterprise EHR focused exclusively on the behavioral health community
- ✓ Our platform allows us to achieve ONC-ATCB certification without charging our customers an additional dime more
- ✓ No versions, no upgrades, just a single platform with a single certification

# How to Become a Meaningful User

- ✓ Use of Certified EHR Technology
  - Meet Staged IT Functionality Measures
  - Meet Staged Clinical Quality Measures

# Stages of Meaningful Use

- Established 3 stages of meaningful use: 2011, 2013, and 2015



# Stage 1: Overview

- Capture health information in a coded and structured format
- Track key clinical conditions and communicate for coordination purposes
- Implement Clinical Decision Support tools
- Report clinical quality measures & public health information

# Stage 1: Reporting & Payment

- Reporting period is a 90 day consecutive period
  - Subsequent years will be full payment year
- Reporting through attestation
- Payment received once CMS has been shown attainment and reached either yearly maximum or end of calendar year

# IT Functionality Measures

- Purpose: Show how well the provider/hospital is using their Certified EHR Technology
- Core Measures
  - Must attain or qualify for exception on all measures
- Menu Items
  - Must attain or qualify for exception on 5 measures
  - Must choose one public health measure

# How to Become a Meaningful User

- ✓ Use of Certified EHR Technology
- ✓ Meet Staged IT Functionality Measures
- Meet Staged Clinical Quality Measures

# Clinical Quality Measures

- Purpose: Show how meaningful use has improved the care patients receive
- Providers required to report on 6 Quality Measures
  - 3 mandatory “Core” or “Alternate” measures
  - Select 3 more from list of 38 Quality Measures according to provider’s specialty
- Hospital measures
  - Required to report on 35 Medicare measures
  - For Medicaid, hospitals have the option to report on 8 alternative measures if the 35 do not apply to patient population

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Next Steps for Eligible Professionals

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# What You Need to Participate

- Register via the EHR Incentives Program Website
  - <https://ehrincentives.cms.gov>
- Be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care)
- Have a National Provider Identifier (NPI) and National Plan and Provider Enumeration System (NPPES) web user account
- Have the Taxpayer ID number of the agency for which you are assigning the benefits
- Use Certified EHR Technology
  - Medicaid providers may adopt, implement or upgrade in their first year
  - Collect 15-digit certification number from ONC website

# Medicaid Next Steps



- *For States that have opened registration (AK, IA, KY, LA, OK, MI, MS, NC, SC, TN, TX)*
  1. Register now
    - No need to wait. You can register at National level today
    - Expect a couple of weeks to receive acceptance email from State agency that administers Medicaid
  2. Provider attestations through State attestation process
    - Identify 90-day continuous period for 2010 and gather data to measure Medicaid patient volume
    - Documentation showing you have adopted, implemented, or upgraded your certified EHR technology
  3. Receive 2011 incentive payment – some of these States already distributing payments

# Medicaid Next Steps



- *For States that have not opened registration*
  1. Identify 90-day continuous reporting period for 2010 and gather data to measure Medicaid patient volume
  2. Gather documentation showing you have adopted, implemented, or upgraded to certified EHR technology
  3. Visit State CMS website often to determine when your State will be ready (<https://www.cms.gov/apps/files/medicaid-HIT-sites>)
  4. Follow steps from previous slide once State registration is open

# Medicare Next Steps



- *For those of you opting to pursue the Medicare incentive*
  1. Register now
    - No need to wait. You can register at National level today
  2. Provider attestations through National attestation process
    - Must demonstrate meaningful use of your Certified EHR for a 90-day period in 2011
      - Qualify for 20 of the 25 MU Objectives (15 required core objectives and 5 additional objectives from the menu set)
      - Report on 6 Clinical Quality Measures (3 required core measures and 3 additional measures from the menu set)
    - Attestation portal opens in April
  3. Receive 2011 incentive payment – Medicare starts cutting checks in May

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Questions

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Appendix

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Core Functionality Measures

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Objective	Measure	Reporting Requirements	Exclusions
Computerized Physician Order Entry for medication orders	>30% of patients Transmission of the order to the pharmacy is not required	<u>N</u> : # of patients in the denominator that have at least one medication order entered using CPOE <u>D</u> : Number of patients with at least one medication in their medication list	Any EP who writes < 100 prescriptions
Implement Drug-Drug and Drug Allergy Interaction	Functionality must be enabled for entire EHR reporting period	Yes/No Attestation	Any EP who writes < 100 prescriptions
Generate and transmit permissible prescriptions electronically	>40% of all permissible prescriptions	<u>N</u> : # of prescriptions in the denominator generated and transmitted electronically <u>D</u> : # of prescriptions written for permissible drugs requiring a prescription	Any EP who writes < 100 prescriptions
Record the following demographics: preferred language, gender, race & ethnicity, DOB	>50% of patients have demographics	<u>N</u> : # of patients in denominator who have all elements or specific exclusion <u>D</u> : # of patients seen during reporting period	None

All references to patients should be interpreted as unique patients

Objective	Measure	Reporting Requirements	Exclusions
Maintain up-to-date problem list of current and active diagnoses	>80% of patients	N: # of patients in denominator who have at least one active diagnosis entry D: # of patients seen during reporting period	None
	If no active diagnosis then an entry must exist that states this fact		
Maintain active medication list	>80% of patients	N: # of patients in denominator who have at least one active medication entry D: # of patients seen during reporting period	None
	If no active medications then an entry must exist that states this fact		
Maintain active medication allergy list	>80% of patients	N: # of patients in denominator who have a least one active medication allergy entry D: # of patients seen during reporting period	None
	If no known medical allergies then an entry must exist that states that fact		
Record and chart vital signs (Height, Weight ,BP ,BMI, Growth Chart)	>50% of patients $\geq$ 2 years old	N: # of patients in denominator who have one entry for each D: # of patients $\geq$ 2 years old during the period	No patients 2 or older  Vital signs not relevant

All references to patients should be interpreted as unique patients

Objective	Measure	Reporting Requirements	Exclusions
Implement one clinical decision support rule with ability to track	Implement one rule	Yes/No Attestation	None
Provide patients with an electronic copy of their health information	>50% of patients who request are given a copy within 3 business days	N: # of patients in denominator who received copy within 3 business days D: # of patients who requested within 4 days of reporting period ending	No requests during reporting period
Clinical summaries provided to patients for all office visits	>50% of all office visits within 3 days  Can be provided through PHR, Secure email, electronic media such as CD or USB or printed	N: # of patients in denominator who are provided summary within 3 business days D: # of patients seen during reporting period	EP Only  No office visits during reporting period

All references to patients should be interpreted as unique patients

Objective	Measure	Reporting Requirements	Exclusions
Capability to exchange key clinical information among providers of care and patient authorized entities electronically	Performed at least one test of capability from EHR technology	Yes/No Attestation	None
Protect Health Information	Conduct or review a security risk analysis and implement updates and correct identified security deficiencies as part of risk management process	Yes/No Attestation	None
Provide patients with an electronic copy of their discharge instructions when leaving facility	>50% of patients who request are given a copy prior to leaving facility	N: # of patients in denominator who receive an electronic copy of discharge instructions D: # of patients who request a copy of discharge instructions during reporting period	Hosp Only  No discharges or requests during reporting period

All references to patients should be interpreted as unique patients

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Menu Functionality Measures

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Objective	Measure	Reporting Requirements	Exclusions
Implement drug-formulary checks	Functionality has been enabled and has access to at least one internal or external formulary for entire reporting period	Yes/No Attestation	None
Lab results	>40% of all clinical lab tests results ordered by the provider or an authorized provider whose results are expressed as +/-/#	N: # of lab test results whose results are expressed in +/-/#number and are stored as structured data D: # of lab tests ordered during reporting period whose results are expressed as +/-/#	No lab orders with results expressed as +/-/#
Generate lists of patients based on specific conditions to use for quality improvement, reduction in disparities, research or outreach	Generate at least one report listing patients with a specific condition	Yes/No Attestation	None

All references to patients should be interpreted as unique patients

Objective	Measure	Reporting Requirements	Exclusions
Provide access to patient-specific education resources upon request	>10% of patients are provided patient-specific education resources	N: # of patients in the denominator who are provided resources D: # of patients seen during reporting period	None
Send reminders to patients based on patient preferences and selected by specific criteria	Reminders sent to at least 20% of all patients seen that are $\geq 65$ years of age or $\leq 5$ years of age	N: # of patients in the denominators who are sent appropriate reminders D: # of patients $\geq 65$ years old or $\leq 5$ years old	No patients $\geq 65$ years old or $\leq 5$ years old
Provide patients with timely access to their health information within 4 days of information being available	>10% of all patients are provided timely electronic access to their health information  Provider has discretion to withhold certain info	N: # of patients in the denominator who were provided timely electronic access to their health information D: # of unique patients seen during reporting period	EP Only  No required information created (Labs, problem list, medications, medication allergies)

All references to patients should be interpreted as unique patients

Objective	Measure	Reporting Requirements	Exclusions
Capability to submit electronic data to immunization registries	Perform at least one test from EHR technology and verify success	Yes/No Attestation	No immunizations provided during reporting period
Perform medication reconciliation when a patient is received from another setting or provider	>50% of transitions of care where patient is transferred into providers care	N: # of transitions of care in the denominator where medication reconciliation was performed D: The number of transitions of care during the reporting period where the provider was the receiving party of the transition	No transitions of care where the provider was the receiving part of the transition
Provide summary of care record for each transition of care	>50% of transitions of care where patient is transferred out of providers care or referred to another provider	N: # of transitions of care and referrals in the denominator where a summary of care record was provided D: # of transitions of care and referrals during reporting period where provider was transferring or referring	No patients transferred to another setting or referred to another providers

All references to patients should be interpreted as unique patients

Objective	Measure	Reporting Requirements	Exclusions
Capability to submit electronic syndromic surveillance data to public health agencies	Perform at least one test from EHR technology and verify success	Yes/No Attestation	No reportable syndromic information collected during reporting period
Capability to submit electronic lab test results to public health agencies	Perform at least one test from EHR technology and verify success	Yes/No Attestation	Hosp Only  No lab results collected during reporting period
Collect advanced directives	>50% of patients ≥ 65 years old	N: # of patients in the denominator who have advanced directives recorded D: # of patients ≥ 65 years old seen during reporting period	Hosp Only

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Core Clinical Quality Measures

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NQF & PQRI Number	Measure	Description
NQF 0013	Hypertension: Blood Pressure Measurement	% of patient visits for patients $\geq 18$ years old with a diagnosis of hypertension who have been seen for at least 2 office visits, with BP recorded
NQF 0028	Preventative Care and Screening Measurement Pair: a) Tobacco use Assessment, b) Tobacco Cessation Intervention	a) % of patients $\geq 18$ years old seen multiple times within 24 months & asked about tobacco use at least one time b) % of patients $\geq 18$ years old seen multiple times within 24 months and have received cessation intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up	% of patients $\geq 18$ years old with a calculated BMI in the past six months or during the current visit documented AND if outside parameter follow-up plan is documented

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Alternate Clinical Quality Measures

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NQF & PQRI Number	Measure	Description
NQF 0024	Weight Assessment and Counseling for Children and Adolescents	% of patients 2-17 years of age who have had an outpatient visit with PCP and have evidence of BMI documentation, counseling for nutrition and counseling for physical activity
NQF 0041 PQRI 110	Preventative Care and Screening: Influenza Immunization for Patients 50 Years Old or Older	% of patients aged 50 years and older who received an influenza immunization during the flue season (September through February)
NQF 0038	Childhood Immunization Status	% of children $\geq$ 2 years old who had four diphtheria, tetanus and acellular pertussis; three polio, one measles, mumps, and rubella; two H influenza type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; two hepatitis A; two or three rotavirus ; and two influenza vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

# Additional Quality Measures

NQF 0059	NQF 0064	NQF 0061	NQF 0081	NQF 0070	NQF 0043
NQF 0031	NQF 0034	NQF 0067	NQF 0083	NQF 0105	NQF 0086
NQF 0088	NQF 0089	NQF 0047	NQF 0001	NQF 0002	NQF 0387
NQF 0385	NQF 0389	NQF 0027	NQF 0055	NQF 0062	NQF 0056
NQF 0074	NQF 0084	NQF 0073	NQF 0068	NQF 0004	NQF 0012
NQF 0014	NQF 0018	NQF 0032	NQF 0033	NQF 0036	NQF 0075
NQF 0575	NQF 0052				