Meaningful Use and Health IT

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National Director of Government Affairs

November 17th, 2010
ARRA, HITECH and MU

- Historical Perspective and State of EHR in the U.S.
- ARRA/HITECH
- Review of 3 Final Rules
- Key Definitions
- Overview Final Rule for MU – Stage 1
- Medicare
- Medicaid
- SF Regional Extension Center
- Vendors and MU
Clinic Automation - Historic

- 1985 Electronic Claims and Remits
- HIPAA – 1996 (Kennedy Kassebaum Act)
  - Standardization of Electronic Administrative and Financial Data
  - Unique Health Identifiers
  - Security and Privacy
- Today BCBS, Care/Caid, Commercial Near 100% Elec.
- Has Impacted Technical and Operational Aspects of Every Facet of Healthcare
Enter Electronic Health Records (EHR)

- Late 1990’s/Early 2000 EHR Here
- Over 2,000 flavors of EHR
- Executive Order 13335 Signed in 2004
  - Provide leadership for implementation of interoperable HIT infrastructure
  - Established the position of National Coordinator for HIT (ONC) to develop strategy for both the Public and Private sectors
- ONC to Coordinate with other departments and establish federal activities necessary to implement the plan between 2008-2014
- June 3, 2008 – ONC Releases Strategic Plan
- January 20, 2009 – Obama Inauguration
- February 17, 2009 – ARRA Signed
U.S. Healthcare Spending – 17% of GDP

Source: CMS, Office of the Actuary, National Health Statistics Group
State of EHR in the U.S.

Practices with Advanced Electronic Health Information Capacity

Percent reporting at least 9 of 14 clinical IT functions*

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ</td>
<td>92</td>
</tr>
<tr>
<td>AUS</td>
<td>91</td>
</tr>
<tr>
<td>UK</td>
<td>89</td>
</tr>
<tr>
<td>ITA</td>
<td>66</td>
</tr>
<tr>
<td>NET</td>
<td>54</td>
</tr>
<tr>
<td>SWE</td>
<td>49</td>
</tr>
<tr>
<td>GER</td>
<td>36</td>
</tr>
<tr>
<td>US</td>
<td>26</td>
</tr>
<tr>
<td>NOR</td>
<td>19</td>
</tr>
<tr>
<td>FR</td>
<td>15</td>
</tr>
<tr>
<td>CAN</td>
<td>14</td>
</tr>
</tbody>
</table>

* Count of 14 functions includes: electronic medical record; electronic prescribing and ordering of tests; electronic access test results, Rx alerts, clinical notes; computerized system for tracking lab tests, guidelines, alerts to provide patients with test results, preventive/follow-up care reminders; and computerized list of patients by diagnosis, medications, due for tests or preventive care.

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
U.S. EHR Adoption Trend


- Any EMR/EHR system:
  - 2001: 18.2%
  - 2002: 17.3%
  - 2003: 17.3%
  - 2004: 20.8%
  - 2005: 23.9%
  - 2006: 29.2%
  - 2007: 34.8%
  - 2008: 41.5%
  - 2009: 43.0%

- Basic system:
  - 2001: 10.5%
  - 2002: 11.8%
  - 2003: 3.1%
  - 2004: 3.8%
  - 2005: 4.4%
  - 2006: 6.3%

- Fully functional system:
  - 2001: 3.1%
  - 2002: 3.8%
  - 2003: 4.4%
  - 2004: 6.3%

**NOTES:** Any EMR/EHR is a medical or health record system that is either all or partially electronic (excluding systems solely for billing). The 2009 data are preliminary estimates (as shown on dashed lines), based only on the mail survey. Estimates of basic and fully functional systems prior to 2006 could not be computed because some items were not collected in the survey. Fully functional systems are a subset of basic systems. Starting in 2007, the skip pattern after the all or partial EMR/EHR systems question was removed. Includes nonfederal, office-based physicians. Excludes radiologists, anesthesiologists, and pathologists.

**SOURCE:** CDC/NCHS, National Ambulatory Medical Care Survey.
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ARRA/HITECH (Generally)

• Signed 2/17/09 in Denver, CO
• **Purpose:** Stimulate the economy through investments in infrastructure, unemployment benefits, transportation, education, and **healthcare**.

• Health Care is in the Spotlight
  – Affordable Care Act - Health Care Reform ($828B)
  – Fueling push for HIT ($54B per year savings)
  – Rapid market movement and positioning

• Up to $45B for direct EHR adoption:
  – $20B in Medicare Incentives
  – $14B in Medicaid Incentives
Summing-up HITECH Goals

1. Push Provider adoption/use of approved (certified) EHR Technology
2. Capture DATA
3. Move DATA – Interoperability
4. Report DATA

- $27B in “Carrots” - incentives:
  - Up to $48,400 through Medicare
  - Up to $63,750 through Medicaid
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Rulemaking - Three Notables

- CMS Final Rule – *Medicare and Medicaid EHR Incentive Program*
  - Known as the “Meaningful Use” Rules
  - Rule Scope: What eligible providers (EPs) “need to do”
  - NPRM Published 1.13.2010
  - Final Rule Released 7.13.2010 (864 pages)

- ONC Final Rule – *Initial Standards, Implementation Specs, and Certification Criteria for EHRs Rules*
  - Rule Scope: What EHR Vendors “need to do”
  - IFR Published 1.13.2010
  - Final Rule Released 7.13.2010 (228 pages)

- ONC Final Rule – *Establishment of the Temporary Certification Program for Health Information Technology*
  - Rule Scope: What Authorized Certification Bodies (ACBs) “need to do”
  - Final Rule for temporary ACBs (ONC-ATCB) published 6.24.2010
  - CCHIT, Drummond Group, and InfoGard
  - Final Rule for permanent ACBs expected early Fall
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Meaningful Use Definitions

- **Payment Year** - § 495.4:
  - **Medicare**: Starting **January 1, 2011** (calendar year)
  - **Medicaid**: **January 1, 2011** for adoption, implementation, or upgrading of a certified EHR. MU begins for the EP in second payment year
  - Hospitals follow Federal Fiscal Year (Oct-Sept)

- **EHR Reporting Periods** - § 495.4:
  - **Medicare**:
    - First payment year, any **continuous 90-day period** in a calendar year;
    - Second, third, fourth, fifth payment year, the **entire calendar year**
  - **Medicaid**:
    - **Adopt, implement, upgrade** during the 1st year;
    - First time MU in second payment year is **any continuous 90-day period** within a calendar year
    - **Full calendar year** for third, fourth, fifth or sixth payment year.
Meaningful Use Definitions

- **Types of Providers** - § 495.100:
  - **Medicare**: MD, DO, DDS, DMD, DPM, Optometrist, DC
  - **Medicaid**: Physicians, Dentists, Certified Nurse Midwives, Nurse Practitioners, Physician Assistants (in FQHC/RHC led by a PA)

- **Adopt, Implement, Upgrade** - § 495.302:
  - Acquire, purchase, or secure access to certified EHR technology;
  - Install/use certified EHR technology capable of MU; or
  - Expand functionality of certified EHR technology at the practice, including:
    - Staffing,
    - Maintenance,
    - Training, or
    - Upgrading from existing EHR to certified EHR technology.
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**Overview Final Rule – Stage 1**

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Meaningful Use Stages

- Stages will be used for Phasing EHR adoption
- Initial meaningful use criteria is Stage 1
- 2 Additional Updates – Stage 2 and Stage 3
- Stage 1 Menu Measures = Stage 2 Core (↑ Thresholds) + HIE

<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>Stage 1</td>
</tr>
<tr>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
</tr>
<tr>
<td>2015 + *</td>
<td></td>
</tr>
</tbody>
</table>

* Avoids payment adjustments only for EPs in the Medicare EHR Incentive Program
** Stage 3 criteria of meaningful use or subsequent update to the criteria if established through rulemaking
Stage 1 – Ways to Qualify

- Medicare
  - MD, DO, DDS/DMD, DPM, Doctor of Optometry, Chiropractor
  - PECOS # Required
  - Fee-for-Service (FFS)
  - Medicare Advantage (MA) – (HMO’s)
    - EP’s with 20 hours/week patient-care for MA and employed by qualifying MA Organization; or,
    - EP’s that are employee/partner of contracting MA entity that furnishes 80%+ services to enrollees

- Medicaid
  - Physicians, NP’s, Certified Nurse-Midwives, Dentists, PA’s (working in FQHC/RHC led by a PA)
  - Volume Threshold Requirement

- Programs are mutually exclusive
Stage 1 – What Providers Must Do …

(Objectives and Measures)

- Objectives are broad spanning goals/activities
- Measures are specific task(s) requirements
- Meeting the measures = meeting the Objectives for that Stage
- Stage 1 MU
  - 15 Core Measures required by all EP’s
  - 10 “Menu” Measures from which EP’s choose 5
  - States can opt to add up to 4 Menu Measures to Core Medicaid Requirements
- Exclusions Clause – must meet all the following:
  - Ensure that Objective is not applicable (e.g. Dentists do not immunize)
  - Meet criterion in the other applicable objectives permitting attestation, and
  - Provide attestation
- Exclusions will reduce the number of Objectives required by EP
# Stage 1 MU – Core Measures

## 15 Core Objectives – Required for All EPs

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Measure</th>
<th>Exclusions</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Record Patient Demographics</td>
<td>Gender, race, ethnicity, DOB, and preferred language as structured data</td>
<td>None</td>
<td>50%</td>
</tr>
<tr>
<td>2</td>
<td>Record Vital Signs and Chart Changes</td>
<td>Height, weight, blood pressure, BMI, and growth charts for children as structured data</td>
<td>EP does not see pts. age 2 or older; or, EP believes all 3 vitals have no relevance to his/her scope of practice</td>
<td>50%</td>
</tr>
<tr>
<td>3</td>
<td>Maintain Up-to-date Problem List</td>
<td>One entry recorded as structured data</td>
<td>None</td>
<td>80%</td>
</tr>
<tr>
<td>4</td>
<td>Maintain Active Medication List</td>
<td>One entry recorded as structured data</td>
<td>None</td>
<td>80%</td>
</tr>
<tr>
<td>5</td>
<td>Maintain Active Medication Allergy List</td>
<td>One entry recorded as structured data</td>
<td>None</td>
<td>80%</td>
</tr>
<tr>
<td>6</td>
<td>Record Smoking Status</td>
<td>Patients age 13 and older as structured data</td>
<td>EP see no patients age 13 or older</td>
<td>50%</td>
</tr>
<tr>
<td>7</td>
<td>Provide Patients with Clinical Summaries</td>
<td>For each office visit to patients within 3 business days</td>
<td>EP has no office visits during the EHR Reporting Period</td>
<td>50%</td>
</tr>
<tr>
<td>8</td>
<td>Electronic Copy of Health Information, upon request</td>
<td>Upon request, including diagnostic test results, problem list, medication list, and medication allergies</td>
<td>EP has no requests during the EHR Reporting Period</td>
<td>50% within 3 business days of request</td>
</tr>
</tbody>
</table>
## Stage 1 MU – Core Measures

### 15 Core Objectives – Required for All EPs

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<thead>
<tr>
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<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Generate and Transmit Permissible Prescriptions Electronically</td>
<td>Using a certified EHR technology (Controlled Substance Permissible 6.1.2010)</td>
<td>EP writes fewer than 100 scripts during EHR Reporting Period</td>
<td>40%</td>
</tr>
<tr>
<td>10</td>
<td>Computerized Provider Order Entry (CPOE)</td>
<td>Patients with at least one medication in their medication list must have at least one medication ordered through CPOE</td>
<td>EP writes fewer than 100 scripts during EHR Reporting Period</td>
<td>30% of Medication Orders Only</td>
</tr>
<tr>
<td>11</td>
<td>Implement Drug-Drug and Drug-Allergy Interaction Checks</td>
<td>Enable functionality</td>
<td>None</td>
<td>Entire Reporting Period</td>
</tr>
<tr>
<td>12</td>
<td>Implement Ability to Exchange Key Clinical Information</td>
<td>Electronically among providers and patient-authorized entities</td>
<td>None</td>
<td>1 Test</td>
</tr>
<tr>
<td>13</td>
<td>Implement Clinical Decision Support and Track Compliance</td>
<td>One Rule implemented and tracked compliance</td>
<td>None</td>
<td>1 Rule</td>
</tr>
<tr>
<td>14</td>
<td>Implement Systems to Protect Privacy and Security of Patient Data</td>
<td>Conduct/review a security risk analysis; implement security updates as necessary and correct security deficiencies</td>
<td>None</td>
<td>During Reporting Period</td>
</tr>
<tr>
<td>15</td>
<td>Report Clinical Quality Measures (CQM)</td>
<td>To CMS or states; number of measures reduced from 99 to 44; all quality measures are NQF and have electronic specifications to map code for electronic transmission; 3 Core (and 3 alternative core) and 38 menu</td>
<td>None</td>
<td>CY2011 provide aggregate numerator / denominator through attestation; CY2012 electronic submission of measures</td>
</tr>
</tbody>
</table>
## Stage 1 MU – Menu Measures

### 10 Menu Objectives – EPs Must Choose 5

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Measure</th>
<th>Exclusions</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Implement Drug Formulary Checks</td>
<td>Must be implemented and must access at least one internal or external drug formulary</td>
<td>None</td>
<td>During Reporting Period</td>
</tr>
<tr>
<td>2</td>
<td>Incorporate Clinical Lab Test Results into EHR</td>
<td>Incorporated as structured data – positive/negative or numerical format – within the EHR</td>
<td>EP orders no labs with +/- or numeric format during EHR Reporting Period</td>
<td>40%</td>
</tr>
<tr>
<td>3</td>
<td>Generate Lists of Patients by Condition</td>
<td>For use in quality improvement, reduction of disparities, research or outreach.</td>
<td>None</td>
<td>1 List with a Specific Condition</td>
</tr>
<tr>
<td>4</td>
<td>Use EHR for Patient-Specific Education Resources</td>
<td>Provide patient-specific education resources to patients, as appropriate</td>
<td>None</td>
<td>10%</td>
</tr>
<tr>
<td>5</td>
<td>Perform Medication Reconciliation</td>
<td>During transitions of care</td>
<td>EP did not receive any transitions of care during EHR Reporting Period</td>
<td>50% during transitions of care</td>
</tr>
</tbody>
</table>

*Note: At least 1 public health objective must be selected*
### Stage 1 MU – Menu Measures

#### 10 Menu Objectives – EPs Must Choose 5

<table>
<thead>
<tr>
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<th>Measure</th>
<th>Exclusions</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Provide Summary of Care Record</td>
<td>Patients referred or transitioned to another provider or setting</td>
<td>EP neither transfers or refers a pt. during EHR Reporting Period</td>
<td>50%</td>
</tr>
<tr>
<td>7</td>
<td>Submission of Electronic Immunization Data to Registry/Information Systems*</td>
<td>Submission and follow-up submission (where registries can accept electronic submissions)</td>
<td>EP administers no immunizations during EHR reporting period; or, no registry available</td>
<td>One Test</td>
</tr>
<tr>
<td>8</td>
<td>Submission of Electronic Syndromic Surveillance Data*</td>
<td>Data submission and follow-up submission to Public Health agencies (where agencies can accept electronic data)</td>
<td>EP does not collect any reportable data during EHR reporting period; or, electronic info cannot be received by public health agency</td>
<td>One Test</td>
</tr>
<tr>
<td>9</td>
<td>Send Reminders to Patients</td>
<td>Preventative and follow-up care for patients aged 65+ or age 5 or less</td>
<td>EP has no pts. age 65+ or age 5 and younger</td>
<td>20%</td>
</tr>
<tr>
<td>10</td>
<td>Timely Electronic Access to Health Information</td>
<td>Including lab results, problem list, medication list, medication allergies – within 4 days of being updated in the EHR</td>
<td>EP neither orders nor creates labs, problem list, Rx list, and Rx allergy list during the EHR Reporting Period.</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Note: At least 1 public health objective must be selected*
MU - Clinical Quality Measures (CQM’s)

- **Proposed Rule:** 3 Core + 96 Menu - Must submit on 8
- **Final Rule:** 3 Core/3 Alternative Core + 38 Menu - Must submit on 6

**Core Measures**
- HTN: BP Measurement (NQF 0013)
- Tobacco Prevention/Screening: 1-Tobacco Use Assessment; 2-Cessation Intervention (NQF 0028)
- Adult Weight Screening & Follow-up (NQF 0421; PQRI 128)

**Alternative Core Measures**
- Weight Assessment/Counseling for Children/Adolescents (NQF 0024)
- Prevention/Screening: Flu Shots patients age 50+ (NQF 0041, PQRI 110)
- Childhood Immunization Status (NQF 0038)

CQM’s align with Afford Care Act, PQRI, CHIPRA reporting
Stage 2 – What is Coming

- Stage 1 “Menu” Measures become core in Stage 2
- Administrative transactions will return
- CPOE measurement will go to 60%
- Will reevaluate other measures – possibly higher thresholds
- Stronger focus on health information exchange
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The Bottom-line: Medicare – Stage 1

- EP is an individual provider, not a clinic / practice
- Must have PECOS Number with CMS
- Must be type of provider
- Must register with CMS
  - Registration Website: cms.gov/EHRIncentivePrograms/
- Must meet 15 Core + 5 Menu Objectives/Measures for continuous 90-days
- CY2011 - Must gather data, run calculations, attest and send to CMS
- CY2012 and Beyond – Electronic Submission
- Qualification is reviewed annually
Medicare EHR Incentive Program

- Provider Enrollment, Chain & Ownership System (PECOS) – used to verify ‘Care enrollment
  - Medicare enrolled pre-November, 2003, and no update
    - Provider is NOT enrolled in PECOS
    - Must enroll to receive Medicare incentives
    - To enroll, go to www.cms.hhs.gov/MedicareProviderSupEnroll
    - post-November, 2003 → No further action required
  - Unsure – Contact Medicare enrollment contractor
    - Go to www.cms.hhs.gov/MedicareProviderSupEnroll
    - Click on “Medicare Fee-for-Service Contact” under “Downloads”
Qualifying as a Medicare Advantage EP – (Medicare HMO)

- Qualifying MA Organization is a HMO that:
  - ID’s their intent to seek Medicare incentives in its bid for plan year 2012
- EP must meet all following requirements:
  - Must be a MD or DO, and
    - Employed by a qualifying MA Organization, or
    - Employed/Partnered with entity contracted to MA furnishing 80% of its Medicare services to a qualifying MA Organization’s enrollees
  - Averages 20 hours/week of services to MA enrollees, and
  - Meets MU requirements, and
  - Is not a “hospital-based” EP
- Within 60 days after CY, MA will submit attestation on MA-EP’s behalf
- MA will submit compensation info or EP can submit directly to CMS
- Payment sent to MA for MA-related incentives, if EP has not hit max on Medicare FFS incentives
Medicare Fee-For Service  (§ 495.102)

- Paid out over 5-year period
- Equivalent to 75% of Allowables for EP Payment Year
- Capped at HITECH statutory EHR Payment Year amounts
- Reduced for late initiation
- Increased 10% if practicing in a “shortage” area
### Potential Medicare Incentives

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>First Calendar Year in which the EP Receives an Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>$18,000</td>
</tr>
<tr>
<td>2012</td>
<td>$12,000</td>
</tr>
<tr>
<td>2013</td>
<td>$8,000</td>
</tr>
<tr>
<td>2014</td>
<td>$4,000</td>
</tr>
<tr>
<td>2015</td>
<td>$2,000</td>
</tr>
<tr>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$44,000</td>
</tr>
<tr>
<td>Shortage Area Totals*</td>
<td>$48,400</td>
</tr>
</tbody>
</table>

*Providers practicing in a federally identified shortage area are eligible for a 10% increase.*
Medicare Penalties

- Providers not meeting MU by 2015:
  - 99% of fee schedule
  - Also not ePrescribing = 98% of fee schedule

- Providers not meeting MU by 2016:
  - 98% of fee schedule

- Providers not meeting MU by 2017:
  - 97% of fee schedule
  - Caps at 5% reduction
  - Significant hardship exception
  - No exceptions for more than 5 years
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The Bottom-line: Medicaid – Stage 1

- EP is correct provider type (Physician, Dentist, NP, Midwife, or PA)
- EP meets State Medicaid Volume Threshold
- Must register with CMS – with pass to State
  - Registration Website: [cms.gov/EHRIncentivePrograms/](http://cms.gov/EHRIncentivePrograms/)
  - National Level Registration testing underway
- State must have system in place to administer or No Program
- Year 1 – Adopt, Implement, or Upgrade (No Reporting)
- Year 2 – Must meet 15 Core + 5 Menu Objectives/Measures for continuous 90-days
- Year 3 and Beyond – Must meet MU for full calendar year
- Year 2+ gather data, run calculations, attest and send to State
- Qualification reviewed annually
Stage 1 - Medicaid Incentive Program

- PA lead FQHC/RHC means:
  - PA is primary provider in a clinic (e.g. Part-time MD, Full-time PA)
  - PA is a clinical / medical director at a clinical practice site; or
  - PA is the owners of a RHC.

- No EHR reporting period for participation year 1
- Year 2 and beyond – MU Objectives/Measures Apply
- States can move 1-4 “Menu” measures to “Core” measures *(up to 4 Menu can be moved for hospitals)*
  - Generate Lists of patients – *can specify condition*
  - Reporting to Immunization Registry – *can specify testing requirements*
  - Reporting Lab Results – *can specify testing requirements*
  - Syndromic Surveillance – *can specify testing requirements*
Stage 1 - Medicaid Volume Thresholds

(Generally)

- Encounter is either
  - One day when services are rendered and paid by Medicaid, or,
  - One day when services are rendered and Medicaid paid premiums, copayment and/or cost-sharing

- Required Threshold:
  - Pediatricians: 20%
  - FQHC/RHC: 30%
  - All Other: 30%

- Documentation for A/I/U
  - IRS model
  - State upload/online
  - States must be very clear on requirements
Stage 1 - Medicaid Volume Thresholds

(\textit{Calculation Option 1 - Basic})

- **General EP Example**
  - March 1 – May 29
  - Total ‘Caid Encounters = 537 (Numerator)
  - Total Patient Encounters = 1,625 (Denominator)
  - Thus, \(\frac{537}{1,625} = 0.33 \times 100 = 33\%\)

- **FQHC/RHC Example**
  - March 1 – May 29
  - Total ‘Caid & Needy Encounters = 787 (Numerator)
  - Total Patient Encounters = 1,625 (Denominator)
  - Thus, \(\frac{787}{1,625} = 0.48 \times 100 = 48\%\)
Stage 1 - Medicaid Volume Thresholds

(Calculation Option 2 - Panel)

- Panel Patients = Total ‘Caid Patients assigned through managed care panel, medical home, or similar capitation / case assignment structure

- General EP Example
  - March 1 – May 29
  - Panel Patients assigned same time previous year seen in current calendar year + Unduplicated ‘Caid encounters = 537 (Numerator)
  - Panel Patients assigned same time previous year seen in current calendar year + All unduplicated Patient Encounters = 1,625 (Denominator)
  - Thus, \( \frac{537}{1,625} = .33 \times 100 = 33\% \)

- FQHC/RHC Example
  - March 1 – May 29
  - Needy Patients assigned same time previous year seen in current calendar year + Unduplicated ‘Caid encounters = 787 (Numerator)
  - Needy Patients assigned same time previous year seen in current calendar year + All unduplicated Patient Encounters = 1,625 (Denominator)
  - Thus, \( \frac{787}{1,625} = .48 \times 100 = 48\% \)
Stage 1 - Medicaid Volume Thresholds

(Calculation Option 3 - Group)

- Calculation of patient volume by group practice/clinic is allowed if:
  - Group/clinic patient volume is appropriate methodology for the EP,
  - Auditable data source exists to support calculation,
  - ALL EP’s in group/clinic use the same methodology for the payment year,
  - Group/clinic uses the ENTIRE practice or clinic’s patient volume and does not limit patient volume in any way, and
  - If EP works inside and outside of the clinic/group, then
    - The patient volume calculation includes only those encounters associated with the clinic/group, and
    - Does not include the EP’s outside encounters
Medicaid Incentives (Continued)

- EPs limited to 1 State
- Payments/Program administered by States
  - State Medicaid HIT Plan (SMHP) – (OK, LA, WI, SC approved)
  - State Implementation Advanced Planning Document (IAPD) – (WI approved)
  - Incentives will be 100% funded by Feds
  - 90% Fed funding for State administration
- Does the State have the 10% match for incentive administration?
- State variance anticipated
  - Menu rules made “core”
  - Volume Calculations
  - A/I/U Documentation
- Patient Volume, ‘Caid Provider, A/I/U or MU, and Certified EHR
- Incentive = 85% of Net Average Allowable Costs
  - HSS “Average Allowable” Year 1 = $54,000 for EHR Technology/EP
  - HHS “Average Allowable” Annual Maintenance/EP = $20,610

<table>
<thead>
<tr>
<th>Cap on Net Average Allowable Costs</th>
<th>85% Allowed for EP</th>
<th>Max Cumulative Incentive over 6-year Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000 in Year 1 for most professionals</td>
<td>$21,250</td>
<td>$63,750</td>
</tr>
<tr>
<td>$10,000 in Years 2-6 for most professionals</td>
<td>$8,500</td>
<td></td>
</tr>
<tr>
<td>$16,667 in Year 1 for pediatricians with 20% volume, but less than 30% volume, Medicaid patients</td>
<td>$14,167</td>
<td>$42,500</td>
</tr>
<tr>
<td>$6,667 in Years 2-6 for pediatricians with 20% patient volume, but less than 30% volume, Medicaid patients</td>
<td>$5,667</td>
<td></td>
</tr>
</tbody>
</table>
### Potential Medicaid Incentives

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>First Calendar Year in which the EP Receives an Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
</tr>
<tr>
<td>2012</td>
<td>$8,500</td>
</tr>
<tr>
<td>2013</td>
<td>$8,500</td>
</tr>
<tr>
<td>2014</td>
<td>$8,500</td>
</tr>
<tr>
<td>2015</td>
<td>$8,500</td>
</tr>
<tr>
<td>2016</td>
<td>$8,500</td>
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<tr>
<td>2017</td>
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<tr>
<td>2018</td>
<td>$0</td>
</tr>
<tr>
<td>2019</td>
<td>$0</td>
</tr>
<tr>
<td>2020</td>
<td>$0</td>
</tr>
<tr>
<td>2021</td>
<td>$0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$63,750</td>
</tr>
</tbody>
</table>
9.10.2010 - Rulemaking process reinitiated for Stage 2

Fall - Certified EHR Technology to the market

1.1.2011 - CMS EHR Incentive Program Registration
  - Medicare: cms.gov/EHRIncentivePrograms/
  - Medicaid (start depends on State):
    - Information will be passed to state cms.gov/EHRIncentivePrograms/

1.1.2011 – States can launch Medicaid EHR Programs
  - Most states will have launched programs by Summer 2011

3.15.2011 – Medicaid Incentives could be paid

1.1.2011 – Medicare EHR Program launch

4.1.2011 – Attestation begins for Medicare

5.1.2011 – Medicare Incentives Pay begins
ARRA, HITECH and MU

- Historical Perspective and State of EHR in the U.S.
- ARRA/HITECH
- Review of 3 Final Rules
- Key Definitions
- Overview Final Rule – Stage 1
- Medicare
- Medicaid
- SF Regional Extension Center
- Vendors and MU
South Florida REC

- Collaboration – South Florida Health Information Exchange (SFHIE) and Health Choice Network (HCN)
- Serving Broward, Dade, Indian River, Monroe, Martin, St. Lucie, Palm Beach and Okeechobee
- Assistance with:
  - Vendor Selection
  - Purchasing Discounts
  - Readiness Assessment
  - Operational Assessment / Redesign
  - MU guidance and execution
  - Implementation support & training
  - HIE positioning
ARRA, HITECH and MU

- Historical Perspective and State of EHR in the U.S.
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- Vendors and MU

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Vendors and Meaningful Use Positioning

- Ability and Statement regarding Meaningful Use *(All Stage 1 and future stages)*
- Ability and Statement regarding Certification
- Using HITSP Standards and ability to general C32 Messaging / CCD / CCR for HIE
- Reporting
  - Ability to extract data ad hoc
  - Dashboard for monitoring MU progress and ability to provide MU metrics
  - Vetting for CMS EHR-based reporting for PQRI
- EHR implementation timelines/queues and success rates
- Process post-implementation to validate / optimize
- Commitment to support and EHR growth path
- If using EHR today, how will vendor conduct gap analysis *(Above still applies)*
Questions?

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