Understanding the EHR Incentive Final Rule

Key Health Alliance

Regional Extension Assistance Center for HIT

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REACH Webinar
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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
- Describe elements of the meaningful use framework that make up the objectives and measures

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Outline

- The Recovery Act
- The Final Rule
- Financial Incentives for Hospitals and Providers
  - Medicare
  - Medicaid
- Elements of Meaningful Use
- Quality Measures

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Placing our Bet on HIT: The "Stimulus Package"

- The stimulus package (Feb 2009)
  - American Recovery and Reinvestment Act (ARRA) - $787 B
  - Health Information Technology for Economic and Clinical Health (HITECH) Act
    - $29.2 B ($17.2 B net) starting in 2011 to incent Medicare- and Medicaid-participating physicians and hospitals to use certified EHR systems in a "meaningful" way

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Meaningful Use Overview: Statutory Framework

In HITECH, Congress established three fundamental criteria of requirements for meaningful use:

1. Use of certified EHR technology in a meaningful manner
2. 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
3. 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

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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."

Interim 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

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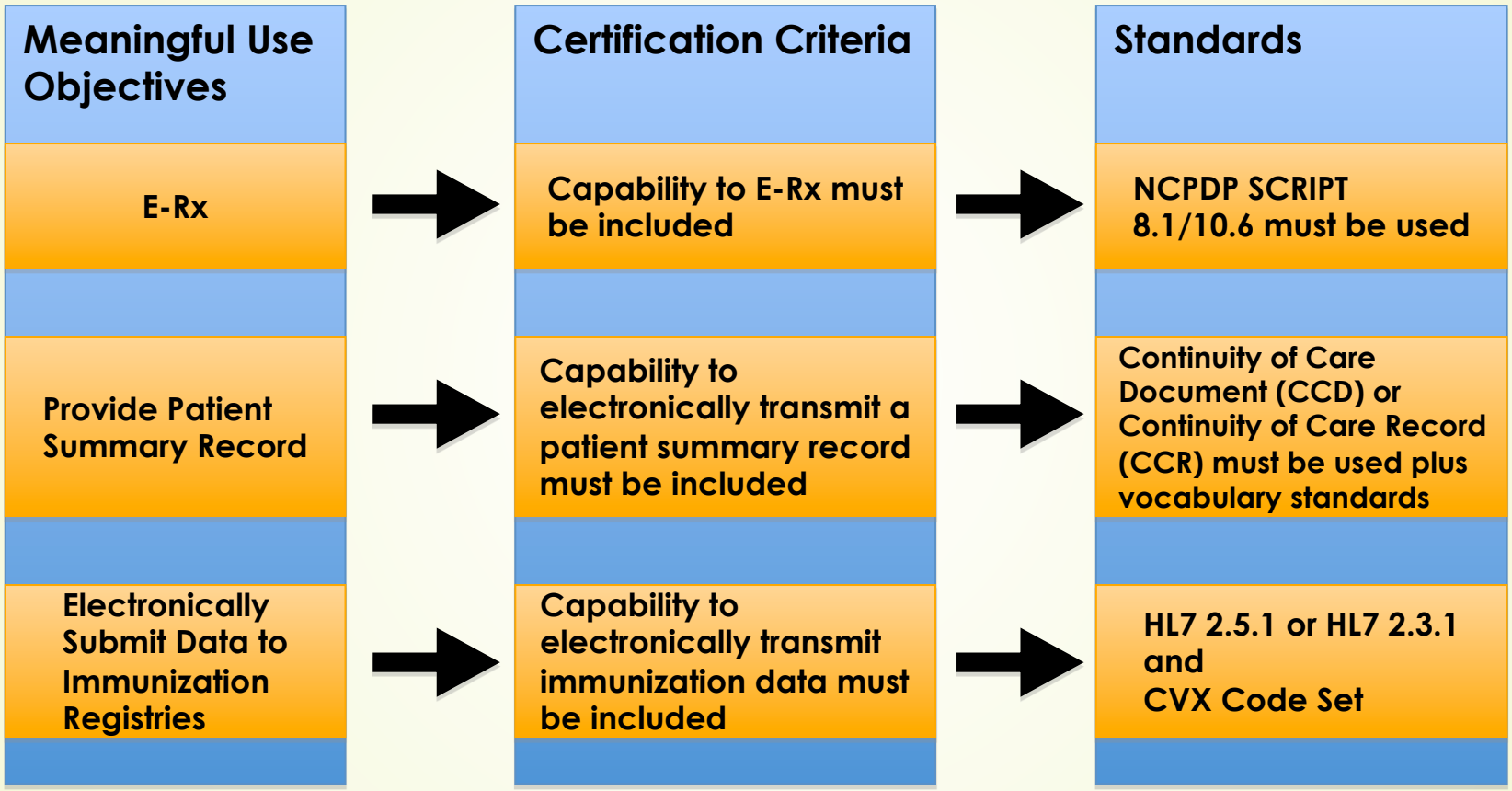
Aligning Certification and Standards



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

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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

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Meaningful Use: Changes from the NPRM to the Final Rule

NPRM	Final Rule
Meet all MU reporting objectives ("all or nothing")	Must meet "core set"/can defer 5 from optional "menu set" (flexibility)
25 measures for EPs/23 measures for eligible hospitals	25 measures for EPs/24 for eligible hospitals
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)
Denominators –To calculate the threshold, some measures required manual chart review	Denominators –No measures require manual chart review to calculate threshold
Administrative transactions (claims and eligibility) included	Administrative transactions removed
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

Meaningful Use: Changes from the NPRM to the Final Rule, cont.

NPRM	Final Rule
States could propose requirements above/ beyond MU floor, but not with additional EHR functionality	States' flexibility with Stage 1 MU is limited to seeking CMS approval to require 4 public health-related objectives to be core instead of menu
Core clinical qualitymeasures (CQM) and specialty measure groups for EPs	Modified Core CQM and removed specialty measure groups for EPs
90 CQM total for EPs	44 CQM total for EPs –must report total of 6
CQM not all electronically specified at time of NPRM	All final CQM have electronic specifications at time of final rule publication
35 CQM total for eligible hospitals and 8 alternate Medicaid CQM	15 CQM total for eligible hospitals
5 CQM overlap with CHIPRA initial core set	4 CQM overlap with CHIPRA initial core set

Adapted from: CMS presentation July 20, 2010

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Incentive Program Overview

- The CMS Incentive program defines:
  - Eligibility requirements for professionals and hospitals
  - Criteria for Stage 1 Meaningful Use
  - Reporting methodology and timeframes
  - Payment periods
  - Payment calculations/procedures for Medicare & Medicaid
  - Medicare penalties for failing to meaningfully use certified EHRs
  - Medicaid Agencies' implementation of incentives

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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

"Stage 1" Meaningful Use Criteria

- 25 objectives and measures for eligible professionals (EP)
  - 15 are required, up to 5 of the remaining 10 may be differed to Stage 2
  - 8 require attestation; 17 require data submission
- 24 objectives and measures for eligible hospitals (EH)
  - 14 are required, up to 5 of the remaining 10 may be differed to Stage 2
  - 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

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Incentive Program Key Provisions (cont.)

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.

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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 ≥ 50% of their patient encounters
- Incentive amount is 75% of the physician's Medicare allowable charges up to the payment year limit

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Maximum Medicare Incentives for EPs in a non shortage area[1]

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

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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

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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

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PPS* EH Medicare Incentives

($2M + Discharge Amount) × Medicare Share × Transition %:

Discharge amount:

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

The Medicare share (MS):

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

Transition Percentage:

Based on the payment year and the fiscal year

* PPS = Prospective Payment System

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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

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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%):

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

Plus:

MS% + 20% or 100% whichever is less

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

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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.

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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 as one who
      - Is receiving social security assistance
      - 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

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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

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Maximum Medicaid Incentives for EPs with ≥ 30% volume

Calendar Year	Year of Adopt, implement, Upgrade or MU Demonstration						
	2011	2012	2013	2014	2015	2016	2011
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

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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%

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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:

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

  Discharge amount:

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

  The Medicaid share (MS):

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

  Transition Percentage:

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

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

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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						

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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.

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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 1st 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

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Meaningful Use Criteria

- Organized according to the Health Outcomes Policy Priorities:[1]
  - 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. Adapted from National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008.

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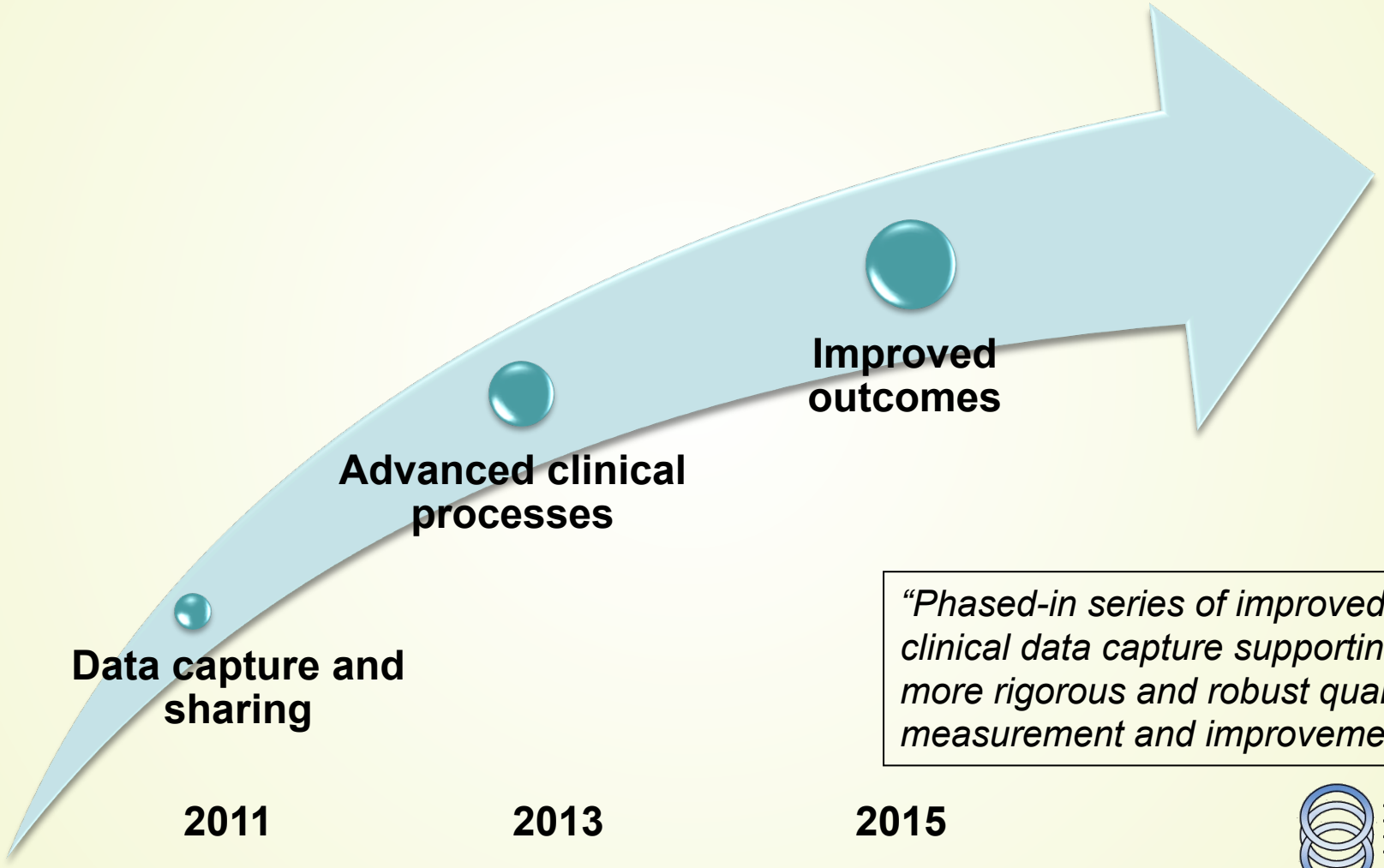
Bending the Curve Towards Transformed Health



"Phased-in series of improved clinical data capture supporting more rigorous and robust quality measurement and improvement."

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

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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.

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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.

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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.

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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
  - CAH and no patients have requested electronic access

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

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
CPOE[3]	>30% of patients with ≥ one CPOE med order (n/d EHR)[1]	>30% of patients with ≥ one CPOE med order (n/d EHR) [1]
Drug (D-A, D-D) Interactions	Turned on (y/n)	Turned on (y/n)
ePrescribe[3]	>40% of permissible scripts (n/d EHR)[1]	-
Demographics	>80% of patients seen: language, gender, race, ethnicity, DOB (n/d all)[2]	>80% of patients seen: language, gender, race, ethnicity, DOB, date and cause of death (n/d all)[2]
Problem List	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]

1. (n/d EHR): Numerator divided by denominator of all 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

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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 structured data* (n/d all)[2]	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]
Med Allergies	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]
Vitals	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI (n/d EHR)[1]	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/ BMI (n/d EHR)[1]

1. (n/d EHR): Numerator divided by denominator of all 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 ≥ 13yo seen, record status *as structured data* (n/d EHR)[1]	>50% of patients ≥ 13yo seen, record status *as structured data* (n/d EHR)[1]
Decision Support	1 CDS rule relevant to the specialty specific quality metric *with the ability to track compliance* (y/n)	1 CDS rule relevant to a high priority hospital condition *with the ability to track compliance* (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 patients seen during the measurement period whose records are maintained in a certified EHR

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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)[1]	>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)[1]
eDischarge Instructions	-	>50% of patients who request it at discharge (n/d EHR)[1]
Visit summaries	>50% of patients seen get visit summary within 3 business days (n/d EHR)[1]	-

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

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Core: Improve Care Coordination

- Exchange meaningful clinical information among professional health care teams

Objective	Ambulatory Measure	Hospital Measure (ED & IP)
Exchange with providers[1]	Capability of electronic exchange of key information (Ex: prob list, med list, allergies, test results[2]). One test per payment 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 payment 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.

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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 45 CFR 164.308 (a)(1) and correct deficiencies (y/n)	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and correct deficiencies (y/n)

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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)

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

Objective	Ambulatory Measure	Hospital Measure (ED or IP)
Formularies	*Implement drug formulary checks with at least one internal or external formulary (y/n)*	*Implement drug formulary checks with at least one internal or external formulary (y/n)*
Advanced Directives	-	*>50% of ≥ 65yo admitted indicate advanced directive recorded* (n/d EHR non ED)
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[3]	Generate at least one pt lists based on a specific condition (y/n)	Generate at least one pt lists based on a specific condition (y/n)
Reminders	>20% of pts ≥ 65 or ≤ 5yo sent reminders for follow up care (n/d EHR)	-

1. (n/d EHR): Numerator divided by denominator of all 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

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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)	-
Patient Ed	*>10% patients seen provided with ed resources identified with the EHR* (n/d all)	*>10% patients seen provided with ed resources identified with the EHR* (n/d all)

1. (n/d EHR): Numerator divided by denominator of all 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

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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[1] or a relevant encounter[2] (n/d EHR)[3]	>50% of transitions of care[1] or a relevant encounter[2] (n/d EHR)[3]
Summary care record	>50% of referrals and transitions of care[1] (n/d EHR)[3]	>50% of referrals and transitions of care[1] (n/d EHR)[3]

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 patients seen during the measurement period whose records are maintained in a certified EHR

Menu: Improve Population and Public Health[1]

- Communicate with public health agencies

Objective	Ambulatory Measure	Hospital Measure (ED & IP)
Immunization Records[2]	≥ 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[2]	-	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)
Syndromic Surveillance[2]	≥ 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[1]

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

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Outline

- The Recovery Act
- The Final Rule
- Financial Incentives for Hospitals and Providers
  - Medicare
  - Medicaid
- Elements of Meaningful Use
- Quality Measures

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Reporting of Clinical Quality Measures

- EPs would be required to submit clinical data on 2 measure groups:
  - A core set of 3 measures (or alternates)
  - 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
- Patient information must be submitted regardless of payer

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Core Quality Measures for EPs

Measure Number	Clinical Quality Measure Title
NQF 0013	Blood pressure measurement
NQF 0028	Tobacco use assessment and intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up
Alternate Core Measures	
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Influenza Immunization for Patients ≥ 50 Years Old
NQF 0038	Childhood Immunization Status

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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
- 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

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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 proposed measures in the NPRM 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

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In Review

- Incentives are available for both eligible hospitals and providers who meaningfully use an EHR
- The final rules are more readily achievable than were the rules in the NPRM
- Eligibility for incentives use 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
- Begin identifying the criteria and measures you will report on now
- Begin evaluating your workflow now

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Resources:

- Regional Extension Assistance Center for Health Information Technology (REACH)
  - http://www.khaREACH.org
- 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/35_Meaningful_Use.asp

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Understanding the EHR Incentive Final Rule

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