

Connecting America
for Better Health



Medicaid EHR Incentive Program & Family Planning

*Implementing the American
Recovery & Reinvestment Act of 2009*

-Jessica Pollak Kahn, MPH

9/29/2010



Overview

- American Recovery & Reinvestment Act (Recovery Act) – February 2009
- Final Rule Published – July 28, 2010
- Medicare EHR Incentive Program (FFS and Managed Care) –CMS
- Medicaid EHR Incentive Program – implemented by State Medicaid Agencies

Who is a Medicaid Eligible Provider?

Eligible Providers in Medicaid
<u>Eligible Professionals (EPs)</u>
Physicians
Nurse Practitioners (NPs)
Certified Nurse-Midwives (CNMs)
Dentists
Physician Assistants (PAs) working in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is so led by a PA
<u>Eligible Hospitals</u>
Acute Care Hospitals (now including CAHs)
Children's Hospitals

Eligibility: Patient Volume

Entity	Minimum Medicaid patient volume threshold	Or the Medicaid EP practices predominantly in an FQHC or RHC—30% <i>needy individual</i> patient volume threshold
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC—30% <i>needy individual</i> patient volume threshold
- Pediatricians	20%	
Dentists	30%	
CNMs	30%	
PAs when practicing at an FQHC/RHC that is so led by a PA	30%	
NPs	30%	
Acute care hospitals	10%	Not an option for hospitals
Children’s hospitals	No requirement	

What About Clinics?

- Clinics are not directly eligible for the Medicaid EHR Incentive Program payments.
 - However if the practitioners at your clinic meet the eligibility criteria and successfully adopt, implement, upgrade or meaningfully use certified EHR technology, they may choose to reassign their incentive payments to your clinic.
 - Your clinic would need to have a taxpayer identification number (TIN) that is already established with the State Medicaid agency.

Eligibility: Patient Volume

- Defined “encounter”
- 2 main options for calculating patient volume
 - Encounters
 - Patient panel
- State picks from these or proposes new method for review and approval
- If CMS approves a method for one state, it may be considered an option for all states

Eligibility: Patient Volume

Defines encounter differently in 3 scenarios:

1. Fee-for-service
2. Managed care and medical homes
3. Hospitals

Eligibility: Practices Predominantly & Needy Individuals



- EP is also eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals*
- *Practicing predominantly* is when FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year
- *Needy individuals* (specified in statute) include:
 - Medicaid or CHIP enrollees;
 - Patients furnished uncompensated care by the provider; or
 - furnished services at either no cost or on a sliding scale.
- Note- Providers in Family Planning Clinics, unless the FP clinic is an FQHC as defined by law, do not fall into this category

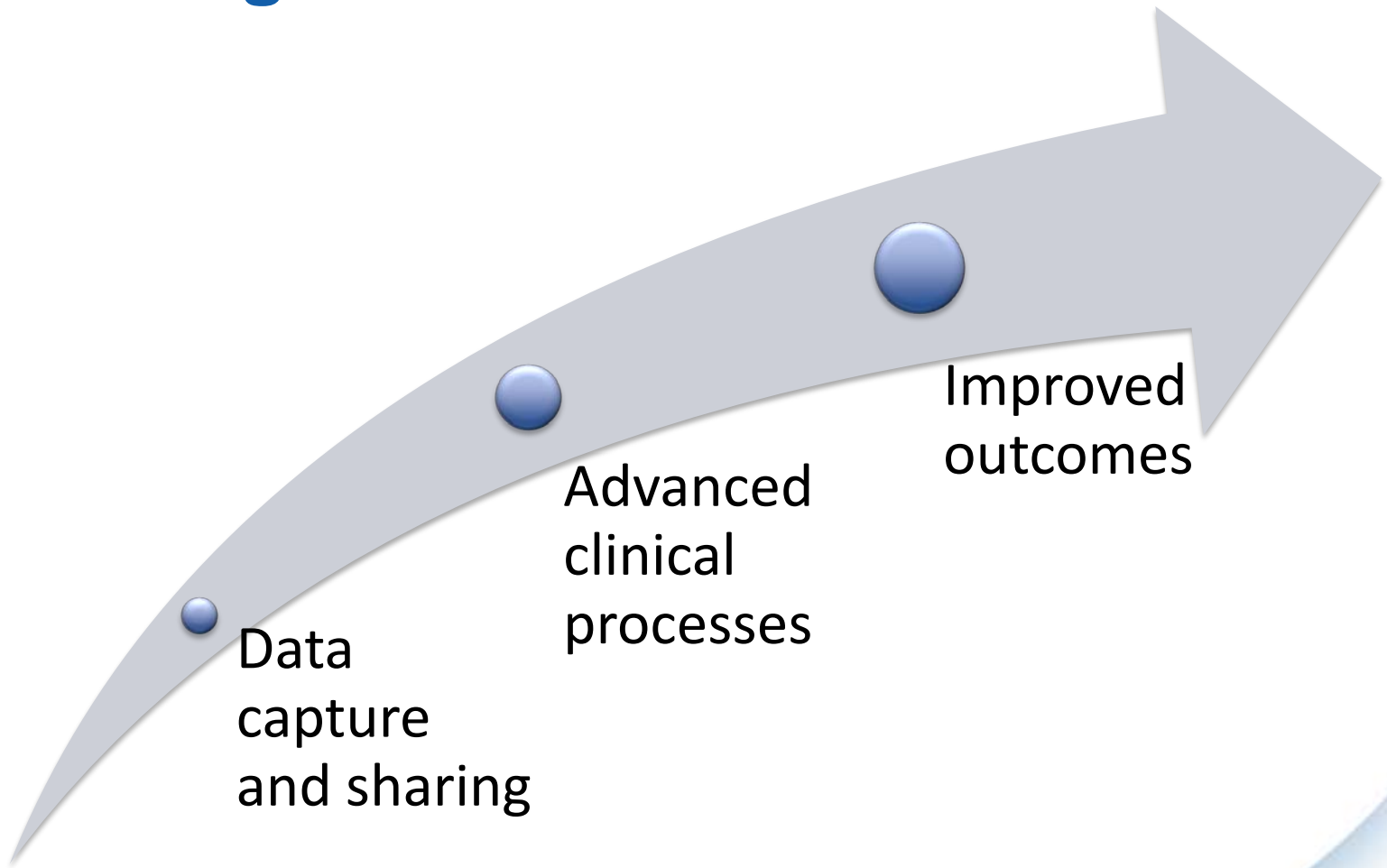
Medicaid Only: Adopt/Implement/ Upgrade (A/I/U)

- First participation year only for Medicaid providers
- Adopted – Acquired and Installed
 - Ex: Evidence of installation prior to incentive
- Implemented – Commenced Utilization of
 - Ex: Staff training, data entry of patient demographic information into EHR
- Upgraded – Expanded
 - Upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology
- Must use certified EHR technology
- No EHR reporting period

Meaningful Use: HITECH Act Description

- The Recovery Act specifies the following 3 components of Meaningful Use:
 1. Use of certified EHR in a meaningful manner (e.g., e-prescribing)
 2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care
 3. Use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary

Conceptual Approach to Meaningful Use



Meaningful Use Stage 1 – Health Outcome Priorities*

- Improve quality, safety, efficiency, and reduce 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.



Meaningful Use: Basic Overview of Final Rule

- Stage 1 (2011 and 2012)
 - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
 - EPs have to report on 20 of 25 MU objectives
 - Eligible hospitals have to report on 19 of 24 MU objectives
 - Reporting Period – 90 days for first year; one year subsequently

Meaningful Use: Core Set Objectives

- **EPs – 15 Core Objectives**

1. Computerized physician order entry (CPOE)
2. E-Prescribing (eRx)
3. Report ambulatory clinical quality measures to CMS/States
4. Implement one clinical decision support rule
5. Provide patients with an electronic copy of their health information, upon request
6. Provide clinical summaries for patients for each office visit
7. Drug-drug and drug-allergy interaction checks
8. Record demographics
9. Maintain an up-to-date problem list of current and active diagnoses
10. Maintain active medication list
11. Maintain active medication allergy list
12. Record and chart changes in vital signs
13. Record smoking status for patients 13 years or older
14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
15. Protect electronic health information

Meaningful Use: Core Set Objectives

- **Eligible Hospitals – 14 Core Objectives**

1. CPOE
2. Drug-drug and drug-allergy interaction checks
3. Record demographics
4. Implement one clinical decision support rule
5. Maintain up-to-date problem list of current and active diagnoses
6. Maintain active medication list
7. Maintain active medication allergy list
8. Record and chart changes in vital signs
9. Record smoking status for patients 13 years or older
10. Report hospital clinical quality measures to CMS or States
11. Provide patients with an electronic copy of their health information, upon request
12. Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request
13. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
14. Protect electronic health information

Meaningful Use: Menu Set Objectives*

- Eligible Professionals
 - Drug-formulary checks
 - Incorporate clinical lab test results as structured data
 - Generate lists of patients by specific conditions
 - Send reminders to patients per patient preference for preventive/follow up care
 - Provide patients with timely electronic access to their health information
 - Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
 - Medication reconciliation
 - Summary of care record for each transition of care/referrals
 - Capability to submit electronic data to immunization registries/systems*
 - Capability to provide electronic syndromic surveillance data to public health agencies*

*At least 1 public health objective must be selected

Meaningful Use: Menu Set Objectives*

- Eligible Hospitals
 - Drug-formulary checks
 - Record advanced directives for patients 65 years or older
 - Incorporate clinical lab test results as structured data
 - Generate lists of patients by specific conditions
 - Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
 - Medication reconciliation
 - Summary of care record for each transition of care/referrals
 - Capability to submit electronic data to immunization registries/systems*
 - Capability to provide electronic submission of reportable lab results to public health agencies*
 - Capability to provide electronic syndromic surveillance data to public health agencies*

*At least 1 public health objective must be selected

Meaningful Use: Applicability of Objectives and Measures

- Some MU objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator. Exclusions do not count against the 5 deferred measures
- In these cases, the EP, eligible hospital, or CAH would be excluded from having to meet that measure
 - E.g., Dentists who do not perform immunizations; Chiropractors do not e-prescribe

States' Flexibility to Revise Meaningful Use

- States can seek CMS prior approval to require 4 MU objectives 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)

Meaningful Use for EPs who Work at Multiple Sites

- An EP who works at multiple locations, but does not have certified EHR technology available at all of them would:
 - Have to have 50% of their total patient encounters at locations where certified EHR technology is available
 - Would base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available

Meaningful Use: Stage 2

- Intend to propose 2 additional Stages through future rulemaking. Future Stages will expand upon Stage 1 criteria.
- Stage 1 menu set will be transitioned into core set for Stage 2
- Will reevaluate measures – possibly higher thresholds
- Will include greater emphasis on health information exchange across institutional boundaries
- Additions to the list of eligible professionals (and to allow clinics to be directly eligible) and to the patient volume thresholds would require a legislative change

Registration Overview

- All providers must:
 - Register via the EHR Incentive Program website
 - Be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care)
 - Have a National Provider Identifier (NPI)
 - Use certified EHR technology to demonstrate Meaningful Use
 - Medicaid providers may adopt, implement, or upgrade in their first year
- All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS

Registration: Medicaid

- States will connect to the EHR Incentive Program website to verify provider eligibility and prevent duplicate payments
- States will ask providers for additional information in order to make accurate and timely payments
 - Patient Volume
 - Licensure
 - A/I/U or Meaningful Use
 - Certified EHR Technology

Registration: Requirements

1. Name of the EP, eligible hospital, or qualifying CAH
2. National Provider Identifier (NPI)
3. Business address and business phone
4. Taxpayer Identification Number (TIN) to which the provider would like their incentive payment made
5. CMS Certification Number (CCN) for eligible hospitals
6. Medicare or Medicaid program selection (may only switch once after receiving an incentive payment before 2015) for EPs
7. State selection for Medicaid providers



Incentive Payments for Medicaid EPs

- First Calendar Year (CY) for which the EP Receives an Incentive Payment

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Incentive Payments for Eligible Hospitals

- Federal Fiscal Year
- \$2M base + per discharge amount (based on Medicare/Medicaid share)
- There is no maximum incentive amount
- Hospitals meeting Medicare MU requirements may be deemed eligible for Medicaid payments
- Payment adjustments for Medicare begin in 2015
 - No Federal Medicaid payment adjustments
- Medicare hospitals: No payments after 2016
- Medicaid hospitals: Cannot initiate payments after 2016



Conditions for State Participation

- Prior approval for reasonable administrative expenses (P-APD, I-APD)
- Establish a State Medicaid HIT Plan (SMHP)
 - Has Family Planning been at the table?
- State may receive 90% FFP to implement the program and 100% FFP for the incentives

State Medicaid HIT Plans

- Key elements:
 - As-Is landscape (results of the environmental scan)
 - Plans for implementing the program
 - Incremental approach allowed
 - Timeline and key benchmarks
 - To-Be Vision and HIT Roadmap
 - Incremental approach allowed with future updates
- Meant to be an iterative document
- Accompanied by IAPDs to request CMS funding

Medicaid and Family Planning

- Between 2008 and 2009, saw an increase of 1 million women of reproductive age enrolled in Medicaid (currently approx. 8 million women)
- 14.8% of all American women of reproductive age covered by Medicaid in 2009
- 27 States have 1115 FP waivers
- Medicaid/CHIP pay for 4 out of 10 births in the U.S.

Health IT & Family Planning

- Is it just “infrastructure?”
- Essential tool for healthcare service delivery
 - Practice management- for billing, eligibility determination, pre-authorization, administrative streamlining, etc
 - E-Prescribing (refills)
 - Clinical decision support (risks, contraindications, missed screenings)
 - Health information exchange (continuity of care)
- Linkages to health care reform lend urgency



Possible Barriers to EHR Adoption for Family Planning Providers

- Cost of EHR Adoption (cost of Meaningful Use)
 - Solutions:
 - Adopt, implement and upgrade in 1st participation year
 - Consider renegotiated employment contracts with EPs for reassigned incentive payments
 - Public providers can be EPs(state, local, county clinics)
 - Participation with RECs, FQHC networks or other clinic consortium for leveraged purchasing



Possible Barriers to EHR Incentive Payments for Family Planning Providers

- 30% Medicaid patient volume requirement
 - Solutions: use the patient volume for the whole clinic as a proxy for each EP; query Medicaid eligibility even if not billing and keep record; part-time providers can calculate their patient volume across all their clinical settings; 1115 waiver patients count for patient volume

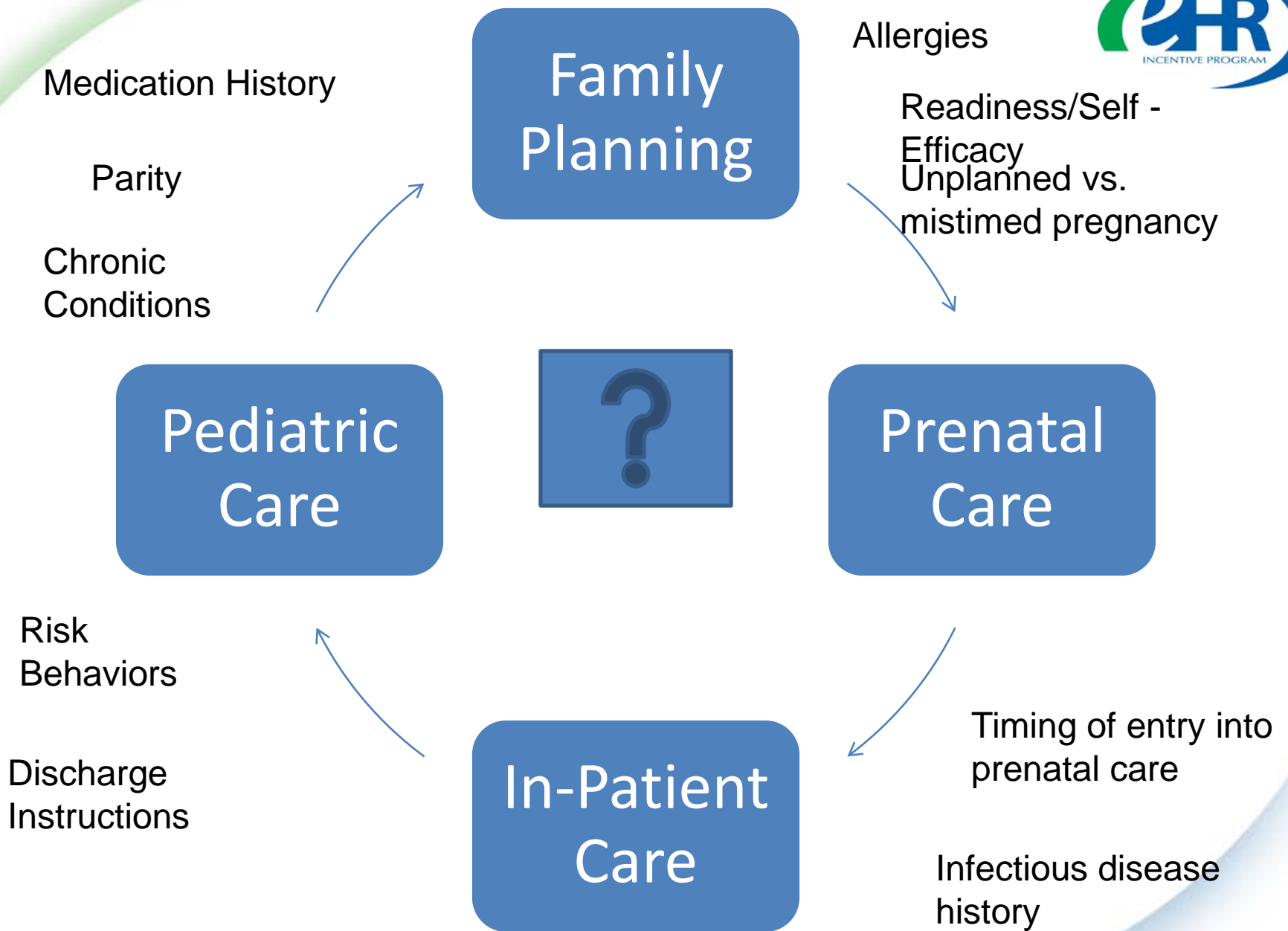


Possible Barriers to EHR Adoption for Family Planning Clinics

- Privacy Concerns
 - Solutions: Patient consent + provider authentication + master patient index + automated audit logs + smart/localized business analytics = enhanced privacy of patient data as compared to paper charts

And Yet So Critical

- Family Planning providers are many women's only contact with the healthcare system
 - Essentially “primary care plus”
 - Population/public health (cancer screenings, immunizations, STD, HIV)
 - Almost always involves a prescription
 - Patient reminders, missed visits, loss to follow-up challenges
- Ripe to reap the benefits of meaningful use of EHRs and Health Information Exchange





EHR Incentive Program Timeline

- January 2011 – Registration for the EHR Incentive Programs begins
- January 2011 – For Medicaid providers, States may launch their programs if they so choose and could start making payments within 45 days of successful registration and attestation
- April 2011 – Attestation for the Medicare EHR Incentive Program begins
- May 2011 – Medicare EHR incentive payments begin
- November 30, 2011 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FFY 2011
- February 29, 2012 – Last day for EPs to register and attest to receive an incentive payment for CY 2011
- 2015 – Medicare payment adjustments begin for EPs and eligible hospitals that are not meaningful users of EHR technology
- 2016 – Last year to receive a Medicare EHR incentive payment; Last year to initiate participation in Medicaid EHR Incentive Program
- 2021 – Last year to receive Medicaid EHR incentive payment

Next Steps & Resources

- Fall 2010 – Outreach and education campaign
- State Medicaid Agencies are drafting and submitting their SMHPs for CMS Review
- More Information:
<http://www.cms.gov/EHRIncentivePrograms>
- Questions on the Medicaid EHR Incentive Program?
 - State Medicaid Agency
 - CMS Regional Office
 - Jessica.kahn@cms.hhs.gov or michelle.mills@cms.hhs.gov