Medicare & Medicaid EHR Incentive Program Final Rule

Implementing the American Recovery & Reinvestment Act of 2009

Purpose of this Presentation

- To give an overview of the CMS final rule on the EHR Incentive Programs
  - What changed since the NPRM
  - What generated the most comments
  - Final policies
- What is not covered in this presentation:
  - Related CMS policy topics not covered by the regulation, such as systems interfaces, outreach and communication, guidance for States about implementation, CMS auditing strategies, etc

Overview

- American Recovery & Reinvestment Act (Recovery Act) – February 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 on Display – July 13, 2010
- Final Rule Published – July 28, 2010

What is in the Medicare & Medicaid EHR Incentive Program Final Rule?

- Definition of Meaningful Use (MU)
- Clinical Quality Measures (CQM)
- Definition of Eligible Professional (EP) and Eligible Hospital/Critical Access Hospital (CAH)
- Definition of Hospital-based EP
- Medicare Fee-For-Service (FFS) EHR Incentive Program
- Medicare Advantage (MA) EHR Incentive Program
- Medicaid EHR Incentive Program
- Collection of Information Analysis (Paperwork Reduction Act)
- Regulatory Impact Analysis

What is not in this Final Rule?

- Information about applying for grants (including State Cooperative Agreements, Regional Extension Centers, and broadband expansion)
- Changes to HIPAA
- Office of the National Coordinator (ONC) Final Rule – Health Information Technology (HIT): Initial Set of Standards and Certification Criteria for EHR Technology (Also on display July 13, 2010)
- Establishment of Certification Programs for HIT
  - EHR certification requirements
  - Procedures for becoming a certifying body

What Changed from the NPRM to the Final Rule?

- Meaningful Use Objectives
  - Clinical Quality Measures
- Hospital-based EPs
- Medicaid acute care hospitals
- Medicaid patient volume
- Medicaid programs can start in 2011
- More clarification throughout

Major Comment Themes

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

Major Comment Themes

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

What the Final Rule Does

- Harmonizes MU criteria across CMS programs as much as possible
- Closely links with the ONC Certification and Standards final rules
- Builds on the recommendations of the HIT Policy Committee and Public Commenters
- Coordinates with existing CMS quality initiatives
- Provides a platform that allows for a staged implementation of EHRs over time

Eligibility Overview

- Medicare Fee-For-Service (FFS)
  - Eligible Professionals (EPs)
  - Eligible hospitals and critical access hospitals (CAHs)
- Medicare Advantage (MA)
  - MA EPs
  - MA-affiliated eligible hospitals
- Medicaid
  - EPs
  - Eligible hospitals

Who is a Medicare Eligible Provider?

Eligible Providers in Medicare FFS
Eligible Professionals (EPs)
Doctor of Medicine or Osteopathy
Doctor of Dental Surgery or Dental Medicine
Doctor of Podiatric Medicine
Doctor of Optometry
Chiropractor
Eligible Hospitals
Acute Care Hospitals*
Critical Access Hospitals (CAHs)

*Subsection (d) hospitals that are paid under the PPS and are located in the 50 States or Washington, DC (including Maryland)

Who is a Medicare Advantage Eligible Provider?

Eligible Providers in Medicare Advantage (MA)
MA Eligible Professionals (EPs)
Must furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MA organization
-or-
Must be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying MA organization
MA-Affiliated Eligible Hospitals
Will be paid under the Medicare Fee-for-service EHR incentive program

Who is a Medicaid Eligible Provider?

Eligible Providers in Medicaid
Eligible Professionals (EPs)
Physicians
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
Eligible Hospitals
Acute Care Hospitals (now including CAHs)
Children's Hospitals

Hospital-based EPs

- Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.
- The Continuing Extension Act of 2010 modified the definition of a hospital-based EP as performing substantially all of their services in an inpatient hospital setting or emergency room. The rule has been updated to reflect this change.
- A hospital-based EP furnishes 90% or more of their services in either the inpatient or emergency department of a hospital.

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

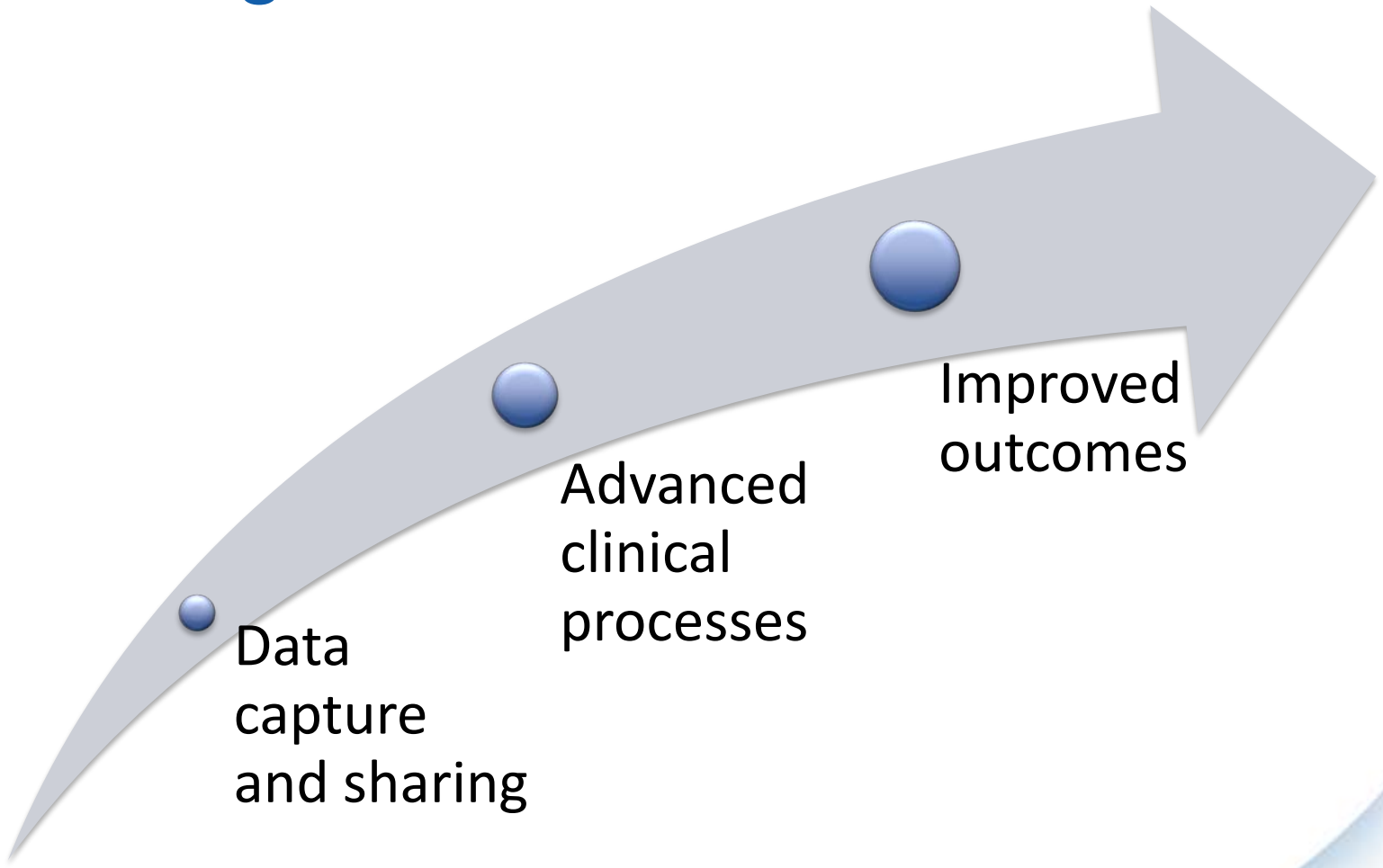
Meaningful Use: HITECH Act Description

- 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

Meaningful Use: Process of Defining

- National Committee on Vital and Health Statistics (NCVHS) hearings
- HIT Policy Committee (HITPC) recommendations
- Listening Sessions with providers/organizations
- Public comments on HITPC recommendations
- Comments received from the Department and the Office of Management and Budget (OMB)
- Revised based on public comments on the NPRM

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: 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

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

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 quality measures (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

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: 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

Meaningful Use: Denominators

- Two types of percentage-based measures are included to address the burden of demonstrating MU
  1. Denominator is all patients seen or admitted during the EHR reporting period
     - The denominator is all patients regardless of whether their records are kept using certified EHR technology
  2. Denominator is actions or subsets of patients seen or admitted during the EHR reporting period
     - The denominator only includes patients, or actions taken on behalf of those patients, whose records are kept using certified EHR technology

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

MU for Hospitals that Qualify for Both Medicare & Medicaid Payments

- Applicable for subsection (d) hospitals that are also Medicaid acute care hospitals (including CAHs)
- Attest/Report on Meaningful Use to CMS for the Medicare EHR Incentive Program
- Will be deemed meaningful users for Medicaid (even if the State has CMS approval for the MU flexibility around public health objectives)

Clinical Quality Measures (CQM) Overview

- 2011 – EPs, eligible hospitals, and CAHs seeking to demonstrate Meaningful Use are required to submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States by attestation.
- 2012 – EPs, eligible hospitals, and CAHs seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States.

CQM: Eligible Professionals

- Core, Alternate Core, and Additional CQM sets for EPs
  - EPs must report on 3 required core CQM, and if the denominator of 1 or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures
  - EPs also must select 3 additional CQM from a set of 38 CQM (other than the core/alternate core measures)
  - In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures

CQM: Core Set for EPs

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0013	Hypertension: Blood Pressure Measurement
NQF 0028	Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up

CQM: Alternate Core Set for EPs

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
NQF 0038	Childhood Immunization Status

CQM: Additional Set for EPs

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b)Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
19. Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

CQM: Additional Set for EPs, cont'd

20. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
21. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
22. Diabetes: Eye Exam
23. Diabetes: Urine Screening
24. Diabetes: Foot Exam
25. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
26. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
27. Ischemic Vascular Disease (IVD): Blood Pressure Management
28. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
29. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
30. Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
31. Prenatal Care: Anti-D Immune Globulin
32. Controlling High Blood Pressure
33. Cervical Cancer Screening
34. Chlamydia Screening for Women
35. Use of Appropriate Medications for Asthma
36. Low Back Pain: Use of Imaging Studies
37. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
38. Diabetes: Hemoglobin A1c Control (<8.0%)

CQM: Eligible Hospitals and CAHs

1. Emergency Department Throughput – admitted patients – Median time from ED arrival to ED departure for admitted patients
2. Emergency Department Throughput – admitted patients – Admission decision time to ED departure time for admitted patients
3. Ischemic stroke – Discharge on anti-thrombotics
4. Ischemic stroke – Anticoagulation for A-fib/flutter
5. Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
6. Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
7. Ischemic stroke – Discharge on statins
8. Ischemic or hemorrhagic stroke – Stroke education
9. Ischemic or hemorrhagic stroke – Rehabilitation assessment
10. VTE prophylaxis within 24 hours of arrival
11. Intensive Care Unit VTE prophylaxis
12. Anticoagulation overlap therapy
13. Platelet monitoring on unfractionated heparin
14. VTE discharge instructions
15. Incidence of potentially preventable VTE

Alignment with Other Quality Program/Initiatives

- CMS' goals:
  - Coordinate CQM development and reporting with implementation of the Patient Protection and Affordable Care Act (ACA) (e.g., pilot programs and State-based programs and infrastructure)
  - Align PQRI and RHQDAPU reporting

CQM Overlap with CHIPRA

- The 2009 CHIPRA required HHS to develop an initial core set of CQM for providers to report to States. It is an agency priority to align CHIPRA and HITECH CQM where possible. The following 4 measures overlap between the 2 programs for Stage 1 of MU:
  - Childhood Immunization Status
  - Weight Assessment Counseling for Children and Adolescents
  - Chlamydia Screening for Women
  - Appropriate Testing for Children with Pharyngitis

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 Overview

- Eligible Professionals
  - Medicare FFS
  - Medicare Advantage
  - Medicaid
- Eligible Hospitals and CAHs
  - Medicare FFS
  - Medicare Advantage (paid under Medicare FFS)
  - Medicaid

Incentive Payments for Medicare EPs

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

	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0
CY 2016		$2,000	$4,000	$4,000	$0
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

Additional Incentive Payments for Medicare EPs Practicing in HPSAs

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

	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY 2011	$1,800				
CY 2012	$1,200	$1,800			
CY 2013	$800	$1,200	$1,500		
CY 2014	$400	$800	$1,200	$1,200	
CY 2015	$200	$400	$800	$800	$0
CY 2016		$200	$400	$400	$0
TOTAL	$4,400	$4,400	$3,900	$2,400	$0

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

Participation in HITECH and other Medicare Incentive Programs for EPs

Other Medicare Incentive Program	Eligible for HITECH EHR Incentive Program?
Medicare Physician Quality Reporting Initiative (PQRI)	Yes, if the EP is eligible.
Medicare Electronic Health Record Demonstration (EHR Demo)	Yes, if the EP is eligible.
Medicare Care Management Performance Demonstration (MCMP)	Yes, if the practice is eligible. The MCMP demo will end before EHR incentive payments are available.
Electronic Prescribing (eRx) Incentive Program	If the EP chooses to participate in the Medicare EHR Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously in the same program year. If the EP chooses to participate in the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously.

Notable Differences Between the Medicare & Medicaid EHR Programs

Medicare	Medicaid
Federal Government will implement (will be an option nationally)	Voluntary for States to implement (may not be an option in every State)
Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use	No Medicaid payment reductions
Must demonstrate MU in Year 1	A/I/U 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 is common for Medicare	States can adopt certain additional requirements for MU
Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015	Last year a provider may initiate program is 2016; Last year to register is 2016
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, acute care hospitals (including CAHs) and children's hospitals

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
- April 2011 – Attestation for the Medicare EHR Incentive Program begins
- May 2011 – 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

- Summer/Fall 2010 – Outreach and education campaign
- CMS to issue State Medicaid Directors Letter with policy guidance on the implementation of the Medicaid EHR Incentive Program
- Early 2011 – EPs and eligible hospitals can register for the Medicare and Medicaid EHR Incentive Programs
- More Information: http://www.cms.gov/EHRIncentivePrograms

Acronyms

- ACA – Patient Protection and Affordable Care Act
- A/I/U – Adopt, implement, or upgrade
- CAH – Critical Access Hospital
- CCN – CMS Certification Number
- CHIPRA – Children's Health Insurance Program Reauthorization Act of 2009
- CMS – Centers for Medicare & Medicaid Services
- CNM – Certified Nurse Midwife
- CPOE – Computerized Physician Order Entry
- CQM – Clinical Quality Measures
- CY – Calendar Year
- EHR – Electronic Health Record
- EP – Eligible Professional
- eRx – E-Prescribing
- FFS – Fee-for-service
- FQHC – Federally Qualified Health Center
- FFY – Federal Fiscal Year
- HHS – U.S. Department of Health and Human Services
- HIT – Health Information Technology
- HITECH Act – Health Information Technology for Economic and Clinical Health Act
- HITPC – Health Information Technology Policy Committee
- HIPAA – Health Insurance Portability and Accountability Act of 1996
- HPSA – Health Professional Shortage Area
- MA – Medicare Advantage
- MCMP – Medicare Care Management Performance Demonstration
- MU – Meaningful Use
- NCVHS – National Committee on Vital and Health Statistics
- NP – Nurse Practitioner
- NPI – National Provider Identifier
- NPRM – Notice of Proposed Rulemaking
- OMB – Office of Management and Budget
- ONC – Office of the National Coordinator of Health Information Technology
- PA – Physician Assistant
- PECOS – Provider Enrollment, Chain, and Ownership System
- PPS – Prospective Payment System (Part A)
- PQRI – Medicare Physician Quality Reporting Initiative
- Recovery Act – American Reinvestment & Recovery Act of 2009
- RHC – Rural Health Clinic
- RHQDAPU – Reporting Hospital Quality Data for Annual Payment Update
- TIN – Taxpayer Identification Number