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Meaningful Use

Legal Issues in Medicare/Medicaid Incentive Programs

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Overview of Legislation

- American Recovery & Reinvestment Act (ARRA) – February 2009
- CMS Electronic Health Record (EHR) Incentive Program
  - Notice of Proposed Rulemaking – Published January 13, 2010
  - Final Rule – Published July 28, 2010
- ONC Standards, Implementation Specifications and Certification Criteria for EHR Technology
  - Interim Final Rule – Published January 13, 2010
  - Final Rule – Published July 28, 2010
- ONC Certification Program
  - Certification Programs for HIT Notice of Proposed Rulemaking – Published March 10, 2010
  - Temporary Certification Program for Health Information Technology Final Rule – Published June 24, 2010

Key Concepts

- Program Distinctions
  - Medicare v. Medicaid
  - Eligible Professionals, Eligible Hospitals and Critical Access Hospitals
- Eligibility
  - Definition of Eligible Professional (EP) and Eligible Hospital/Critical Access Hospital (CAH)
  - Definition of Hospital-based EP
- Certified EHR Technology
  - Complete EHR and EHR Modules
- Meaningful Use (MU) Requirements
  - Staged Progression
  - Stage 1 Criteria – Core and Menu Requirements
  - Clinical Quality Measure Reporting
- Financial Incentives
  - Medicare and Medicaid Programs
- Timing

Program Distinctions

- Requires analysis by Medicare or Medicaid program and provider type
- Medicare and Medicaid have distinct incentive programs
  - Common definition of “meaningful use” for both Medicare and Medicaid
  - But States may adopt additional criteria, subject to certain requirements
- Key Distinctions
  - Eligible Professionals and eligible hospitals differ
  - Payment structures, timing and amounts are not identical
    - Medicare has downward payment adjustment
  - Medicaid program allows first year participation for adoption, implementation or upgrade of certified EHR technology
  - Medicaid programs will depend on State activity

Eligible Professionals

- **Medicare**
  - Medical doctors, doctors of osteopathy, dentists, podiatrists, optometrists, chiropractors
- **Medicaid**
  - Physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants in federally qualified health center (FQHC) or rural health clinic (RHC) led by a physician assistant
- An EP is identified by his/her unique National Provider Identifier (NPI)

Hospital-Based Eligible Professionals

- Hospital-Based Eligible Professionals are excluded from participation in both programs
- The Continuing Extension Act of 2010 revised the definition
  - EP providing substantially all of its covered services in an inpatient or emergency department hospital setting
    Eligible Professionals providing services in hospital based outpatient setting may now participate in the incentive programs
- Rule excludes EPs who furnish 90% or more of their covered professional services in an inpatient hospital or emergency room of a hospital.
  - Site of service codes (21 and 23) used for determination
- Medicaid providers practicing predominantly in an FQHC or RHC are not subject to the hospital-based exclusion

Eligible Hospitals and CAHs

- **Medicare:**
  - "Subsection (d) hospitals" that are paid under the hospital inpatient prospective payment system (IPPS)
    - Includes Medicare FFS and MA participants and Critical Access Hospitals
    - Psychiatric, rehabilitation, long term care, children's, and cancer hospitals are excluded
  - Hospitals located in the 50 States or District of Columbia, but not the territories
- **Medicaid:**
  - Acute care hospitals (now including Critical Access Hospitals)
  - Children's hospitals
- A hospital is determined by its unique CMS certification number (CCN)

Program Participation

- Eligible Professionals may participate in only one program: Medicare or Medicaid
  - A one-time only switch between programs is permitted prior to 2015
- Qualifying hospitals may participate in both programs simultaneously.
- If a provider serves a multistate population and participates in the Medicaid incentive program, the provider can participate only in the Medicaid incentive program through a single State in any year
- Medicaid program has additional requirements based on the provider's Medicaid patient volume

Medicaid Only: Adopt, Implement or Upgrade

- Medicaid providers may receive incentive payment in first participation year for adoption, implementation or upgrade to certified EHR technology
- Adopted – Acquired and installed
  - Examples include evidence of installation prior to incentive or a purchase commitment
- Implemented – Install and use begun
  - Includes staff training, data entry of patient demographic information into EHR
- Upgraded – Expanded functionality
  - 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

EHR Requirements for Meaningful Use

- "Certified EHR Technology" means
  - Qualified EHR
    - Patient demographics and clinical health information
    - Clinical decision support
    - Supports CPOE
    - Captures and query health care quality data
    - Electronic information exchange
  - Certified through ONC certification program
- Must use Certified EHR Technology for MU
  - Not sufficient if the EHR meets ONC criteria, but has not been certified
  - Must achieve MU objectives using certified EHR
- Certification criteria for EHR technology tracks meaningful use criteria set out in CMS rulemaking
  - Supports achievement of MU measure by including the necessary functionality

Certified EHR Technology Options

- Complete EHR: All-in-one EHR solution
  - Qualified EHR
  - Certified to meet all criteria
- EHR Modules
  - Any service, component or combination thereof that meets at least one criterion
    - May include, e.g., software as service, interface allowing participation in health information exchange, quality measure reporting service
- It is the responsibility of the ***eligible professional or hospital*** for a proper combination of EHR Modules
  - Must meet Qualified EHR requirements
  - Each constituent EHR Module of the combination must be certified
  - All criteria must be certified within the various EHR Modules

Meaningful Use Not Static

- Definition of Meaningful Use takes a staged approach
  - Criteria will become increasingly rigorous through three stages
- Stage 1: Data capture and sharing
- Stage 2: Advanced clinical processes
- Stage 3: Improved outcomes
- This rulemaking designed to cover Stage 1
  - Criteria applies for all payment years until updated by future rulemaking.
  - CPOE objective for Stage 2 finalized; all other comments on Stage 2 are expected criteria or considerations

Required Progression through Stages

First Payment Year	Payment Year				
	2011	**2012**	**2013**	**2014**	**2015**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015					Stage 3

- May receive incentives for meeting the Stage 1 criteria for meaningful use over a span of several years (as late as 2014)
- Expected to move through the stages at a defined pace
- The later that a EP or eligible hospital first meets the Stage 1 criteria, the shorter the timeframe to advance through stages

Key Changes from NPRM

NPRM	Final Rule
Meet all MU reporting requirements (“all or nothing”	Must meet “core set”/ can select 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 ranges from 10% to 80% of patients or orders (most at higher range)	Measure thresholds ranges 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

Key Changes from NPRM

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 up to 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 Criteria

- "Core set" of requirements
  - EPs, eligible hospitals and CAHs must meet the measure for each objective
    - 14 for EPs
    - 15 for eligible hospitals and CAHs
  - Certain objectives have defined exceptions
    - Must meet requirements of exception to claim the objective/measure is inapplicable
- "Menu set" of requirements
  - EPs, eligible hospitals and CAHs must meet five of 10 requirements
    - Can select which five
  - Must include one population and public health measure

Core Meaningful Use Objectives

- Use CPOE
- Implement drug to drug and drug allergy interaction checks
- E-Prescribing (EP only)
- Record demographics
- Maintain an up-to-date problem list
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status
- Implement one clinical decision support rule
- Report CQM as specified by the Secretary
- Electronically exchange key clinical information
- Provide patients with an electronic copy of their health information
- Provide patients with an electronic copy of their discharge instructions (Eligible Hospital/CAH only)
- Provide clinical summaries for patients for each office visit (EP only)
- Protect electronic health information created or maintained by certified EHR

“Menu” Meaningful Use Objectives

- Implement drug-formulary checks
- Record advance directives (Eligible Hospitals/CAHs only)
- Incorporate clinical lab-test results into EHR
- Generate lists of patients by specific conditions
- Send reminders to patients per patient preference (EPs only)
- Provide patients with timely electronic access to their health information (EPs only)
- Identify and provide patient-specific education resources
- Perform medication reconciliation when receiving patients
- Provide summary of care for transferring patients
- Submit electronic data to immunization registries and Immunization Information Systems
- Submit electronic data on reportable lab results to public health agencies (Eligible Hospitals/CAHs only)
- Submit electronic syndromic surveillance data to public health agencies

Data for MU Measures

- Will not require manual chart review
- Some measures will be based on the percentage of unique patients cared for during EHR reporting period
  - Regardless of whether patient record is entered into EHR
- Other criteria measured as percentage of patient whose records are maintained in EHR

Clinical Quality Measures

- Summary information (i.e., not personally identifiable) for all patients to whom clinical quality measure applies, whether or not Medicare or Medicaid beneficiary
- Finalized CQM have clearly defined electronic specifications by date of final rule
  - All National Quality Forum (NQF) endorsed
- EPs – Medicare and Medicaid
  - Must report on all three core clinical quality measures (CQM)
    - Three alternate core measures available
  - Must report on three additional CQM required
    - Can choose from 38 options
- Eligible Hospitals/CAHs
  - 15 clinical quality measures required
- Submission
  - 2011 – Providers required to submit summary quality measure data to CMS by attestation
  - 2012 – If Secretary has capacity to accept information electronically, providers will be required to electronically submit summary quality measure data to CMS
    - If not, continue to use attestation

Additional State Requirements for Medicaid

- States limited to changes for public health objectives and data repositories
- CMS plans to review and adjudicate State requests to add to Meaningful Use requirements for Medicaid Programs
- A hospital that meets MU criteria for Medicare program is deemed to meet MU requirements for Medicaid
  - Do not need to meet additional State requirements

Medicare Payments to EPs

- Up to $44,000 over 5 consecutive years
- 75% of charges for Medicare-covered services for the year, capped at annual maximum. Cap depends on:
  - Year in which provider first qualified for the incentive payment (first payment year)
  - Number of years the provider has earned the incentive
- Providers who furnish services in a geographic Health Professional Shortage Area (HPSA) are eligible for a 10% increase to their incentive payments.

Medicare Incentive Payments to EPs

- EPs can still achieve the maximum incentive payments if first reaching Stage 1 meaningful use in 2012
- Incentive payments available to later adopters are reduced

Calendar Year	**First Calendar Year in which EP Receives an Incentive Payment**				
	2011	2012	2013	2014	2015 and on
2011	$18,000	-	-	-	-
2012	$12,000	$18,000	-	-	-
2013	$8,000	$12,000	$15,000	-	-
2014	$4,000	$8,000	$12,000	$12,000	-
2015	$2,000	$4,000	$8,000	$8,000	$0
2016	-	$2,000	$4,000	$4,000	$0
Total Potential Incentive Payment	**$44,000**	**$44,000**	**$39,000**	**$24,000**	**$0**

Medicaid Payments to EPs

- 85% of "net average allowable costs" costs for EHR
  - "Average allowable costs" is set by Secretary of HHS at $54,000 in the first year and $20,610 for subsequent years
  - "Net average allowable costs" requires subtracting cash payment directly attributable to Certified EHR Technology
- "Net average allowable costs" capped at $25,000 for first year and $10,000 in each of five for subsequent years
- Maximum incentive of $63,750 (85% of $75,000) over a 6-year period
- Pediatricians with under 30% Medicaid patient volume may receive only 2/3 of these amounts
- Medicaid EPs must begin receiving incentive payments no later than CY 2016

Medicaid Incentives for EPs

- Additional eligibility requirements based on threshold Medicaid patient volume
  - For EPs generally, at least 30% of patient encounters must be attributable to Medicaid over 90 continuous days in CY prior to reporting
  - Pediatricians must have at least 20% Medicaid patient volume over 90 continuous days in CY prior to reporting
  - EPs practicing predominantly in an FQHC or RHC must have at least 30% of patient volume considered “needy individuals”

Medicare Incentives for Eligible Hospitals

- Eligible hospitals can receive:
  - Baseline min amount (before adjusting for Medicare share and charity work) in year 1 is $2M and max amount is over $6M
  - Payable for four consecutive years
  - Over four year period (before adjusting for Medicare share and charity), an EH could receive between $5M and almost $16M
- Calculated using a complex formula
  - Based primarily on hospital discharges
  - Also factors in the hospital's Medicare share, which considers the amount of charity care, and percentage of Medicare-covered inpatient days related to the hospital's total number of inpatient days
  - Discharge portion of the formula will vary based on numbers of discharges in the year, between a floor of less than 1,150 discharges and a ceiling of 23,000 discharges

Medicare Incentives for Eligible Hospitals

- Hospitals may qualify for financial incentive payments for four consecutive years
- Incentive payment will be reduced each year
  - The first year, 100% of calculated incentive payment
  - In the second year, only 75%
  - 50% in the third year, and
  - 25% in the fourth year
- Hospitals that become meaningful users later (after FY 2013) will either receive reduced payments or be ineligible for any incentives
  - Policies for 2015 reduction in Medicare payments are subject of future rulemaking

Medicaid Incentives for Eligible Hospitals

- Medicaid patient volume threshold requirement applies to CAHs
  - Must have 10% Medicaid patient volume
- Parameters for incentive payments are designed, with some adjustments, to replicate to the calculation for Medicare hospital incentive payments
  - Uses same base amount as Medicare formula (Incentive amount multiplied by Medicaid share
  - EHR amount largely based on discharge volume
- Payable for three to six consecutive years
  - States may pay up to 100% of the aggregate EHR hospital incentive amount over a minimum of a 3-year period and a maximum of a 6-year period

Timing of Payment

- Payment Years
  - For EPs, a payment year is a calendar year beginning on January 1, 2011.
  - For Eligible Hospitals and critical access hospitals, a payment year is the federal fiscal year. FY 2011 begins on October 1, 2010.
- For purposes of incentive payments, the first payment year is the year for which the first incentive payment is received
  - Subsequent years are second, third, fourth, fifth and sixth payment years

Timing of Payment

- Medicare EPs
  - Five payment years are consecutive
  - Once a payment is received, each year is considered a “payment year”, even if you don’t meet meaningful use
  - You would only be able to receive incentive payments for the remaining years
- Medicaid EPs
  - Payment may generally be non-consecutive

Demonstrating Meaningful Use

- No reporting period for Medicaid first year Adopt/Implement/Upgrade (AIU)
- First year of meaningful use
  - Initial accomplishment of meaningful use
  - Meet the criteria for any continuous 90-day period and report for that year
  - May be second payment year for Medicaid participants
- For all subsequent payment years, meaningful use is measured over the entire year.
- Providers will demonstrate through attestation
  - Medicare program participants will report to CMS
  - Medicaid participants will report to the applicable state
- Further guidance is expected through established outreach venues

Questions?

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