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MEANINGFUL USE FOR FINANCIAL PROFESSIONALS: WHAT YOU NEED TO KNOW TO MAXIMIZE INCENTIVES

OUTLINE

- Overview of EHR Incentive Programs
- Program Differences
- Strategies for Maximum Incentives
- A/I/U and Demonstration of Meaningful Use
- Registration, Attestation, & Payment
- Auditing Guidance
- Q&A Session

DISCLAIMER

- All information is based on the 7/28/10 CMS Final Rule
  - http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
- All information pertains to Meaningful Use Stage 1 requirements only
- Focus is on hospitals vs. providers

OVERVIEW OF EHR INCENTIVE PROGRAMS

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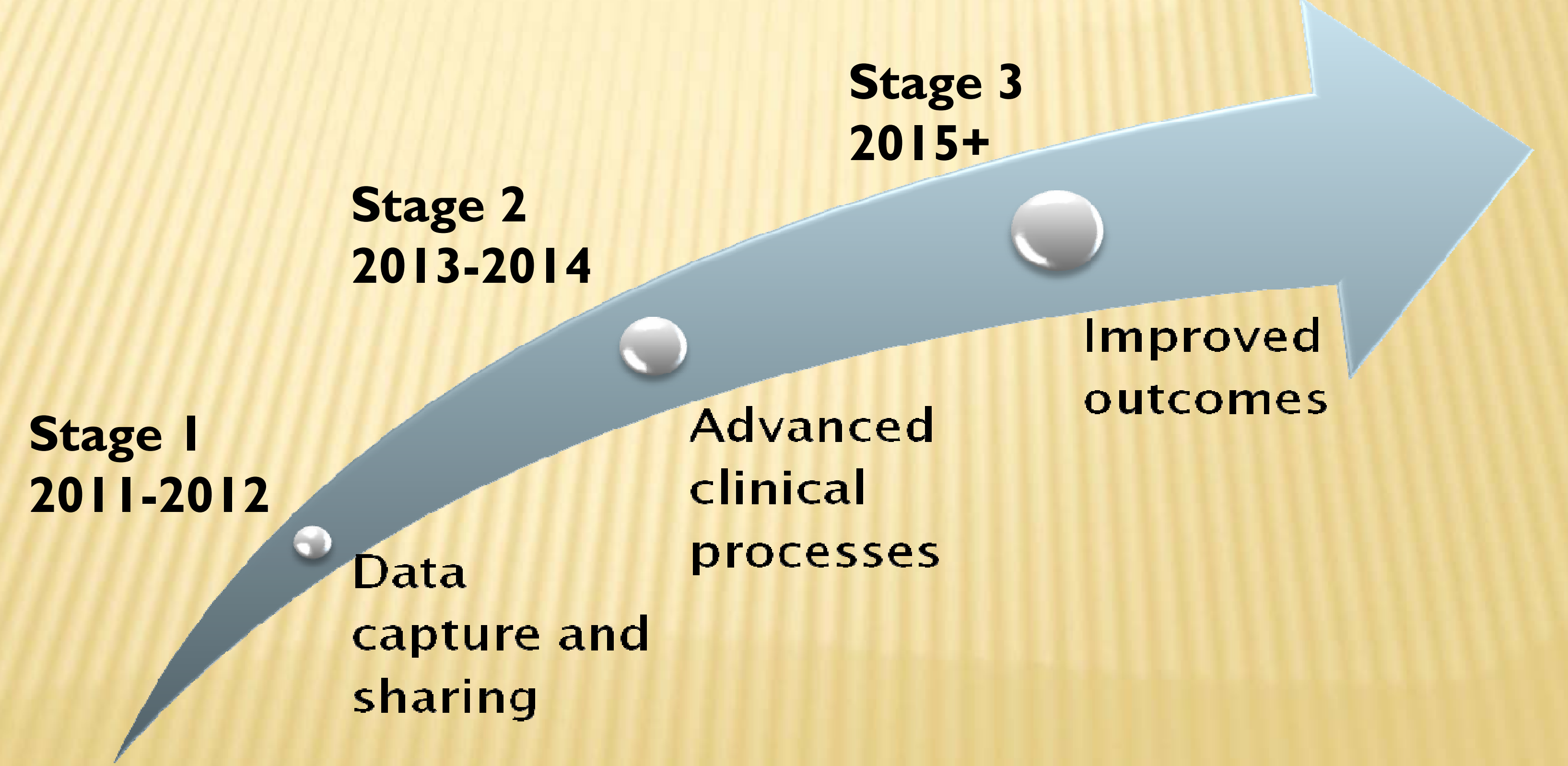
- Voluntary programs established by American Recovery and Reinvestment Act (ARRA)
- Authorizes CMS to provide incentive payments to promote adoption and meaningful use of a certified EHR
- To receive payments, participants must demonstrate "Meaningful Use" of a certified EHR
- Meaningful Use is using certified EHR technology to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and families in their health care
  - Improve care coordination
  - Improve population and public health
  - All the while maintaining privacy and security

3 STAGES OF MEANINGFUL USE

- Requirements will increase over time…more work lies ahead
- Stage 2 may be delayed by 1 year for those who start in 2011… waiting for CMS Stage 2 final rule (est. release: summer 2012)



Slide content adapted from CMS (EHR_Incentive_Program_EP_Training_Final ONC changes 8 10 10.pptx)

MEANINGFUL USE PROGRAMS

- Separate programs for Eligible Hospitals (EHs) and Eligible Professionals (EPs)
  - Federally-run Medicare and Medicaid Advantage programs
  - State-run Medicaid program
    - Requires minimum patient volumes that are based on encounters/ discharges, premiums, co-pays or cost shares paid by New Mexico Medicaid, excluding SCI and CHIP encounters
      - Certified EHRs are not required to calculate patient volume
      - Hospitals need to calculate and attest to it each year
      - Don't underestimate the amount of time it takes to create a report to calculate patient volume
    - EHs must have ALOS <= 25 days

MEANINGFUL USE PROGRAMS (CONT'D)

- EPs must not be hospital-based
  - Hospital-based: 90% or more of services billed with Place of Service code 21-Inpatient or 23-Emergency Room
- EPs practicing in hospital-owned outpatient clinics (Place of Service code 22) <u>are</u> eligible to participate
- EPs must choose one program
- Dual-eligible hospital criteria
  - Subsection (d) hospitals in the 50 states/DC or critical access hospital; and
  - CMS Certification Number ending in 0001-0879 or 1300-1399; and
  - Have 10% Medicaid patient volume

MEDICARE PENALTIES IN 2015+

- Beginning in 2015, Medicare will assess penalties for providers and hospitals that are not meaningful EHR users
  - Providers will have their Medicare physician fee schedule amount for covered professional services adjusted
    - Includes providers eligible for both programs (i.e. physicians) but participating in Medicaid incentives
    - 1% reduction-2015, 2% in 2016, 3% in 2017+
  - Subsection D hospitals will have their market basket updates to the IPPS payment rate adjusted downward
    - Varies depending if the hospital does not 1) demonstrate MU and 2) submit quality data for the Hospital Inpatient Quality Reporting Program
  - Critical Access hospitals will have their reimbursements adjusted
    - .34% reduction-2015, .67% in 2016, and 1.0% in 2017+

PROGRAM DIFFERENCES

ELIGIBILITY CRITERIA FOR HOSPITALS

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<tr><th>MEDICARE</th><th>MEDICAID</th></tr>
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- **Subsection (d) hospitals** that either receive reimbursement for services under Medicare Fee-for-Service (FFS) program **or** are affiliated with a qualifying Medicare Advantage (MA) organization
  - Includes inpatient, acute care hospitals in the State of Maryland
  - Excludes psychiatric, rehabilitation, long term care, children's, and cancer hospitals
  - An MA-affiliated eligible hospital operates under common corporate governance with a qualifying MA organization and serves primarily individuals enrolled under MA plans offered by such organizations
- **Critical access hospitals (CAHs)**
  - A facility that has been certified as a critical access hospital under section 1820(c) of the Social Security Act

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- **Acute care hospitals**
  - A health care facility where the average length of patient stay is 25 days or fewer AND has a CMS Certification Number (CCN) in the range of 0001-0879 or 1300-1399
    - Includes short-term general hospitals, cancer hospitals, and critical access hospitals (CAHS) that meet the Medicaid patient volume criteria
- **Children's hospitals**
  - Must have a CCN in the range of 3300-3399
  - Predominantly treats individuals under 21 years of age

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- **Patient volume requirements:** None

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- **Patient volume requirements**
  - **Acute care hospitals:** >=10%
  - **Children's hospitals:** None

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HOSPITAL INCENTIVE PROGRAMS COMPARISON

HOSPITAL INCENTIVE PROGRAMS COMPARISON		
	MEDICARE	**MEDICAID**
Incentives Start	CY 2011	CY 2011
Incentives End	CY 2016 (max. 4 years, Subsection D start by 2013 & CAH must start by 2012 for max. incentives)	2021 (max. 6 years, must start by 2016)
Incentive Amount	Varies, depending on % Medicare inpatient bed days. CAHs paid based on EHR costs and % Medicare inpatient bed days.	Varies, depending on % Medicaid inpatient bed days.
Reimbursement Reduced	CY 2015	No penalties

HOSPITAL INCENTIVE CALCULATIONS

- Medicare Subsection D/Acute Care and MA-Affiliated Eligible Hospitals
  - Initial Amount x Medicare Share x Transition Factor
    - Initial Amount: Base Amount of $2,000,000 plus bonus
      - Bonus: $200 each discharge between 1,150-23,000 Example: Hospital w/5,000 discharges is $770,200 bonus
    - Medicare Share: Proportion of Medicare inpatient bed days (Parts A and C) to total inpatient bed days
      - Higher Medicare Share = Larger Incentive
      - Reporting Charity Care = Larger Incentive
    - Transition Factor: Decreases after year 1

HOSPITAL INCENTIVE CALCULATIONS (CONT'D)

- Transition factor decreases over time
  - E.G. $1,000,000 payment in 2011 would be $750,000 in 2012

TRANSITION FACTOR					
Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	-----	-----	-----	-----
2012	0.75	1.00	-----	-----	-----
2013	0.50	0.75	1.00	-----	-----
2014	0.25	0.50	0.75	0.75	-----
2015	------	0.25	0.50	0.50	0.50
2016	------	-----	0.25	0.25	0.25

HOSPITAL INCENTIVE CALCULATIONS (CONT'D)

- Medicaid Acute Care & Critical Access Hospitals
  - Similar to Medicare Subsection D/Acute Care calculation
  - Calculates aggregate incentive amount to be paid out by State in 3 – 6 years
    - NM will pay out in 3 years: 50/40/10
  - Initial Amount is adjusted for years 2-4 based on hospital's 3-year average annual growth/reduction rate
  - Medicaid Share is proportion of Medicaid FFS plus Medicaid Managed Care inpatient bed days to total inpatient bed days

HOSPITAL INCENTIVE CALCULATIONS (CONT'D)

- Medicare - Critical Access Hospital (CAH)
  - [Reasonable EHR Costs] x [Adjusted Medicare Share]
    - Adjusted Medicare Share: Adds 20% to Medicare Share, not to exceed 100%
      - E.G. Medicare Share is 40%; Adjusted Medicare Share = 40% + 20%, or 60%
    - Reasonable EHR Costs: Costs in current cost reporting period plus costs from prior reporting periods that have not been fully depreciated
      - Excludes depreciation and interest expenses
      - Purchase of depreciable assets, such as computers and associated hardware and software necessary to administer certified EHR technology.
  - Last payment must be made by 2015!

HOSPITAL INCENTIVE CALCULATIONS (CONT'D)

- Medicare - Critical Access Hospital (cont'd)
  - CAH must submit supporting documentation for incurred costs to its Medicare contractor (FI/MAC).
    - The Medicare contractor will review the CAH's current year and each subsequent year's cost report to ensure
      - Assets associated with the acquisition are expensed in a single period
      - Depreciation and interest expenses associated with the acquisition are not reported

STRATEGIES FOR MAXIMUM INCENTIVES

MAXIMUM INCENTIVE STRATEGIES

- All hospitals: Report charity care OR uncompensated care less bad debt
- Subsection D/Acute Care
  - Medicare: Start by 2013 (maximum 4 payments); report Medicare Parts A and C on hospital cost report
  - Medicaid: Start by 2016 (NM pays maximum 3 payments); report both Medicaid FFS and Managed Care on hospital cost report

MAXIMUM INCENTIVES (CONT'D)

- Critical Access Hospital (CAH)
  - Start by 2012 (maximum 4 payments, provided there are reasonable EHR costs to report)
  - Keep records on reasonable EHR costs
  - Ensure assets associated with the acquisition are expensed in a single period
  - Multi-hospital organizations need to apportion EHR costs to all hospitals, including any CAHs

A/I/U & DEMONSTRATION OF MU

A/I/U & DEMONSTRATION OF MU

- Medicaid
  - Year 1: Proof of A/I/U; no demonstration of MU
  - Year 2: Demonstration of MU for any 90 days during EHR Reporting Period
  - Year 3+: Demonstration of MU during entire EHR Reporting Period
- Medicare
  - Year 1: Demonstration of MU for any 90 days during EHR Reporting Period
  - Year 2+: Demonstration of MU during entire EHR Reporting Period
- EHR Reporting Period for Hospitals
  - Based on federal fiscal year (Oct 1 – Sep 30)

ADOPT/IMPLEMENT/UPGRADE (A/I/U)

- Adopt: Acquire a certified EHR
  - For NM, EHR does not have to be installed
  - NM requires copy of contract or invoice for purchase of certified EHR
  - If contract or invoice does not include the certified EHR number, a vendor letter including the information will suffice
- Implement: Start using the EHR
  - Includes staff training, data entry of patient data, or establishing data exchange agreements with other providers, such as labs, pharmacies, and health information exchanges
- Upgrade: Expand EHR for Certification
  - Expand the functionality and start using a certified EHR that meets meaningful use requirements

STAGE 1 HOSPITAL DEMONSTRATION OF MU

- Demonstration of MU is an all-or-nothing approach and must occur during the EHR Reporting Period
- Requirements include reporting on:
  - 14 core objectives, 9 of which have minimum performance targets that must be met
  - 5 of 10 menu set objectives, some have performance targets
  - 15 clinical quality measures

STAGE 1 DEMONSTRATION OF MU (CONT'D)

- More about clinical quality measures
  - Must report all 15 measures, even if denominator is 0
  - MU measures are not the same as the core measures for the Hospital Inpatient Quality Reporting Program or Joint Commission accreditation
  - Measures must be calculated by certified EHR technology according to CMS' electronic measure specifications
    - https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

DEMONSTRATION OF MU-CORE OBJECTIVES

CORE SET OBJECTIVES (14)
>30%: Patients w/at least one medication on medication list have at least one medication ordered w/CPOE
>50%: Patients are provided with an electronic copy of their health information, upon request
>50%: Patients are provided an electronic copy of their discharge instructions at time of discharge, upon request
>50%: Patients have demographics recorded (DOB, gender, race, ethnicity, & preferred language)
>80%: Patients have active problem or indication of no active problems recorded
>80%: Patients have active medication or indication of no active medications recorded
>80%: Patients have active medication allergy or indication of no active medication allergies recorded
>50%: Patients have vital signs recorded (BP, height, & weight)
>50%: Patients 13 years or older have smoking status recorded
Yes/No: Report hospital clinical quality measures to CMS or States (see slides 26-27 for a measure list)
Yes/No: Implement one clinical decision support rule
Yes/No: Implement drug-drug and drug-allergy interaction checks during the entire EHR reporting period
Yes/No: Perform test of exchanging key clinical information among providers of care and patient-authorized entities electronically
Yes/No: Conduct or review a security risk analysis per CFR 164.308(a)(1) and implement security updates as necessary & correct deficiencies as part of risk management process

DEMONSTRATION OF MU – MENU OBJECTIVES

MENU SET OBJECTIVES (CHOOSE 5 OF 10)
>40%: Incorporate clinical lab test results as structured data
>10%: Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
>50%: Medication reconciliation at transitions of care
>50%: Summary of care record for each transition of care/referrals
>50%: Record advanced directives for patients 65 years or older
Yes/No: Implement drug-formulary checks for entire EHR reporting period
Yes/No: Generate lists of patients by specific conditions
Yes/No: Capability to submit electronic data to immunization registries/systems*
Yes/No: Capability to provide electronic syndromic surveillance data to public health agencies*
Yes/No: Capability to provide electronic submission of reportable lab results to public health agencies*

**At least one public health measure must be selected.*

NOTE: *States have the option to require one or more of the items shown in italic font as core measures. NM has not exercised this option.*

DEMONSTRATION OF MU - CQMS

CLINICAL QUALITY MEASURES (15, REPORT ON ALL)
Emergency Department Throughput – admitted patients – Median time from ED arrival to ED departure for admitted patients
Emergency Department Throughput – admitted patients – Admission decision time to ED departure time for admitted patients
Ischemic stroke – Discharge on anti-thrombotics
Ischemic stroke – Anticoagulation for A-fib/flutter
Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
Ischemic stroke – Discharge on statins
Ischemic or Hemorrhagic stroke – Stroke Education
Ischemic or hemorrhagic stroke – Rehabilitation assessment
VTE prophylaxis within 24 hours of arrival
Anticoagulation overlap therapy
Intensive Care Unit VTE prophylaxis
Platelet monitoring on unfractionated heparin
VTE discharge instructions
Incidence of potentially preventable VTE

REGISTRATION, ATTESTATION, & PAYMENT

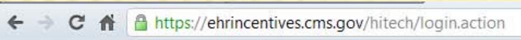
REGISTRATION PROCESS

- Separate registrations for Medicare and Medicaid
- Must register with Medicare even if only participating in Medicaid incentives
- CMS website has registration guides & webinars
  - https://www.cms.gov/ehrincentiveprograms/20_RegistrationandAttestation.asp
- Medicare registration website
  - https://ehrincentives.cms.gov/hitech/login.action
- NM Medicaid registration website
  - https://nm.arraincentive.com/

MEDICARE REGISTRATION

- Information Needed
  - Users working on behalf of a hospital must have a CMS Identity and Access Management (I&A) account (user ID and password)
  - CMS Certification Number (CCN)
  - National Provider Identifier (NPI)
  - Hospital Tax Identification Number
  - Type of hospital (Medicaid: Acute Care [including Critical Access Hospital] or Children's; Medicaid-Subsection D or Critical Access Hospital)
  - MA-Affiliated Only: Whether or not to register as MA-Affiliated or non MA-Affiliated
  - Certified EHR number (optional but required for attestation)
  - Complete business address, phone, and e-mail address
- If also eligible for Medicaid, wait 24 hours before registering to allow for processing

MEDICARE REGISTRATION (CONT'D)



Medicare & Medicaid EHR Incentive Program Registration and Attestation System

Welcome to the Medicare & Medicaid EHR Incentive Program Registration & Attestation System

About This Site

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

This web system is for the Medicare and Medicaid EHR Incentive Programs. Those wanting to take part in the program will use this system to register and participate in the program.

Additional Resources: For User Guides to Registration and Attestation that will show you how to complete these modules, a list of EHR technology that is certified for this program, specification sheets with additional information on each Meaningful Use objective, and other general resources that will help you complete registration and attestation, please visit CMS website

Eligible to Participate - There are two types of groups who can participate in the programs. For detailed information, visit CMS website.

Eligible Hospitals

Eligible Professionals (EPs)

CONTINUE

Web Policies & Important Links | Department of Health & Human Services | CMS.gov | Accessibility | File formats and Plugins

CENTERS FOR MEDICARE & MEDICAID SERVICES, 7500 SECURITY BOULEVARD, BALTIMORE, MD 21244

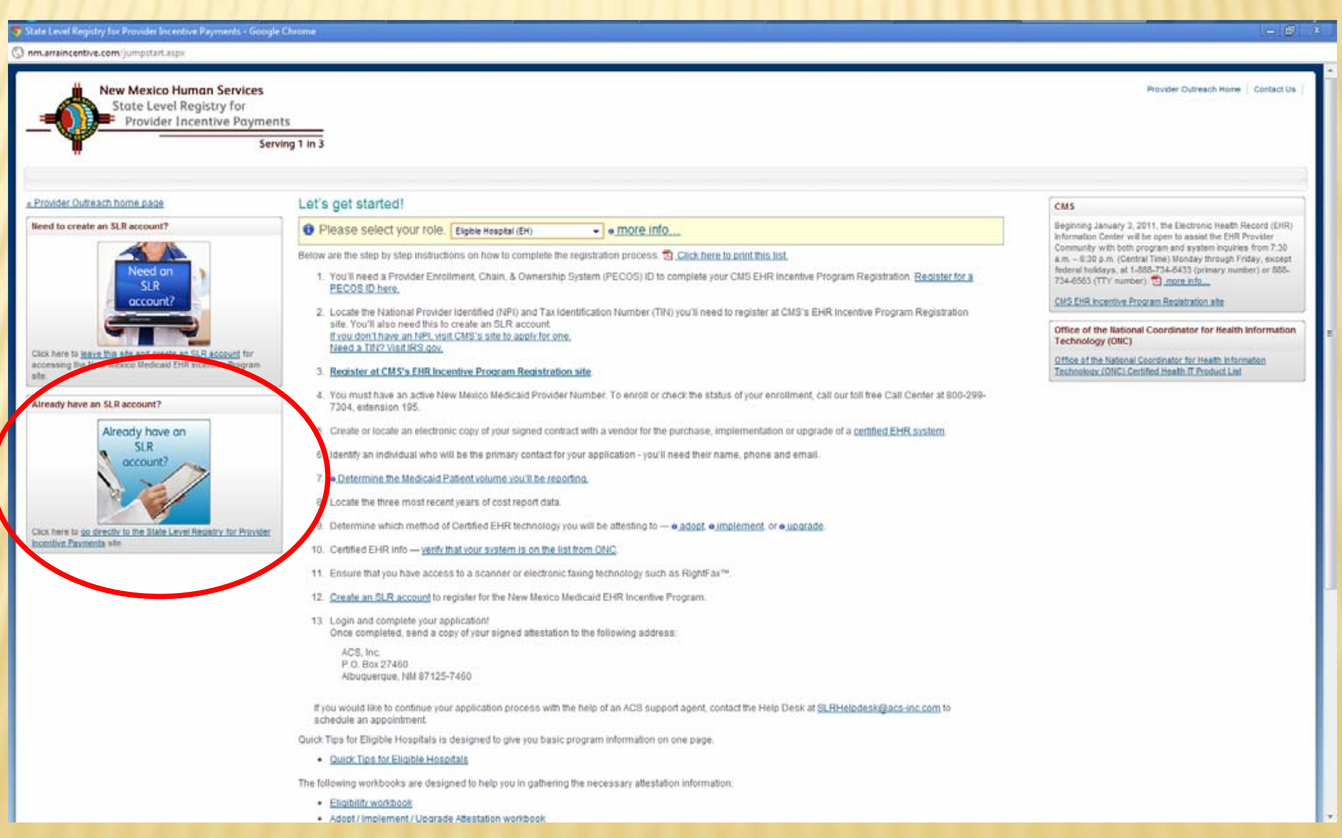
CMS

MEDICARE ATTESTATION

- Information needed
  - EHR certification number (if not provided during registration)
  - ED admission method (i.e. observation service or all ED visits method)
  - EHR reporting period (start and end dates; must be at least 90 days in same FFY)
  - Objectives and Clinical Quality Measures Data
    - Numerator, Denominator, Exclusions for calculated objectives/measures
    - Yes/No answer for attestation objectives (e.g. test of submitting immunization data)
    - Answer to question for objectives reporting patients (i.e. reported on all patients OR only patients whose records are maintained by certified EHR)
    - Identification of which 5 of 10 menu set objectives were reported, including which public health objective(s) was reported

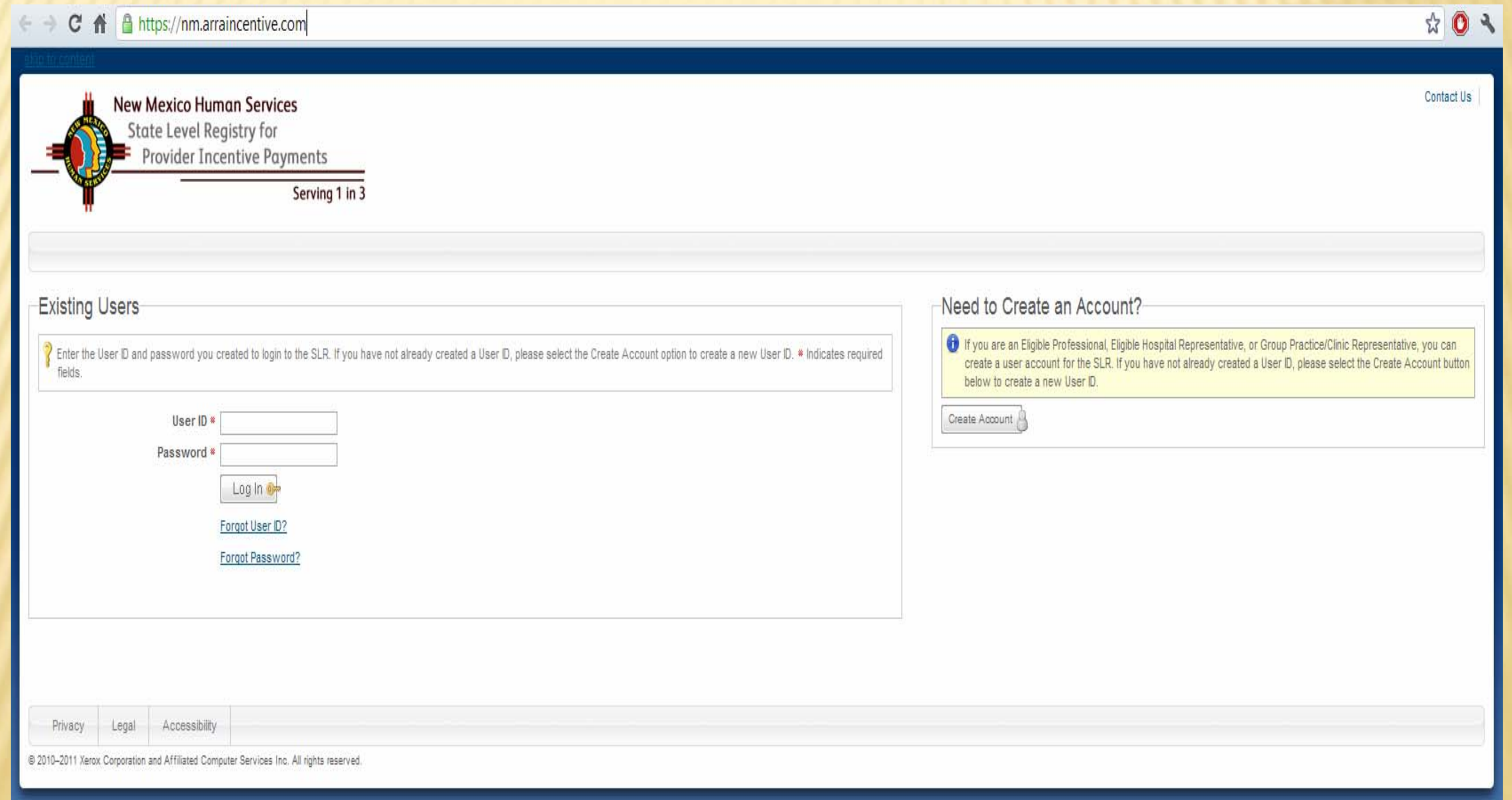
MEDICAID REGISTRATION & ATTESTATION

- Information Needed
  - NM's Jump Start page lists all of the information needed to register
  - When you're ready to register, click link in bottom left to login with your SLR account
  - Some of the information will be provided during attestation, e.g. patient volume



MEDICAID REGISTRATION & ATTESTATION (CONT'D)

- NM Medicaid Registration & Attestation Site



REGISTRATION & ATTESTATION (CONT'D)

- Additional Information - Medicaid
  - Will need to determine if Medicaid incentives will be calculated from most recently filed or settled cost report
    - If most recently filed report, incentives will not be adjusted after the report is settled
  - NM has indicated it will prompt user to enter all cost report data needed to calculate the incentive payment
    - Have a spreadsheet of the data available when attesting
    - NM has provided a sample
  - NM requires a "wet" signature of the attestation form
  - Some requirements for calculating patient volume and incentive payments are not mentioned on the website (e.g. excluding SCI encounters and usage of reduction factors)

REGISTRATION & ATTESTATION (CONT'D)

- Additional Information – General
  - Attestation is a time-consuming process – allow plenty of time!
  - Websites have been slow – expect delays!

TIMING OF INCENTIVE PAYMENTS

- Medicare
  - Initial payment will be made within 4-8 weeks of attestation
  - Final payment will be determined at the time of settling the hospital Medicare cost report
- Medicaid
  - Payment will be made within 45-60 days from day it receives hardcopy of signed attestation form

AUDITING GUIDANCE

AUDITING GUIDANCE

- CMS does not give any guidance on what specific information must be kept; only says to keep all relevant supporting documentation
- Documents must be kept for 6 years after attestation
- CMS will audit Medicare and dual-eligible hospitals
- States will audit Medicaid hospitals

AUDITING GUIDANCE (CONT'D)

- Pre-payment checks will detect inaccuracies in eligibility, reporting, and payment
- Post-payments audits will occur during the life of the MU programs
- If hospitals found not to be eligible, the payment will be recouped
- CMS and States will be implementing appeals processes

AUDITING GUIDANCE (CONT'D)

- Suggested Documents to Retain
  - Copies of all reports submitted for attestation for both objectives and clinical quality measures (CQMs)
  - Raw data for the reports (e.g. patient lists for numerator, denominator, and exclusions)
  - EHR logic used to calculate objectives and CQMs
  - Medicaid patient volume report and raw data
  - Hospital cost reports used to calculate incentive payment

AUDITING GUIDANCE (CONT'D)

- CMS Final Rule for each MU Stage
- Copies of any e-mails, FAQs, etc. that clarify and/or revise the final rule requirements
- Think of the MU reports as your IRS 1040 form used for federal tax returns
  - Will need to provide all supporting documentation to prove what is reported on your attestation reports

AUDITING GUIDANCE (CONT'D)

- Other Recommendations
  - Track all MU information in a single location, such as a spreadsheet or database
    - Used to provide all information for each hospital, including CMS registration ID, date attestation form signed & mailed to State, incentive payments received by payment year, etc
    - Include filenames of electronic copies of attestation and patient volume reports for quick identification in case of audit
  - Store all attestation reports & supporting data in a single location that is backed up & stored off-site
    - Create a special backup at the end of MU that is retained for 6 years

Q&A SESSION

THANK YOU!

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