The "Final" Say on Meaningful Use:

Rural Issues

AHA Member Call

August 6, 2010

American Hospital Association

Agenda

- **Overview of rule**
- **Certification**
- **Medicaid eligibility and payment formulas**
- **Medicare eligibility and payment formulas**
- **Payment Timeline and CMS operations**
- **Additional resources**

American Hospital Association

Overview of Key Rural Issues

Overview of Key Rural Issues

- **Definition of "meaningful use"**

- **Definition of hospital-based docs** → **Fixed in Jobs Bill**

- **Critical Access Hospitals' access to Medicaid Incentives**

American Hospital Association

Incentive Program Basics

- **Must use an EHR certified through the new federal process (none currently available)**
- **Must have 80 percent of patients in the EHR (inpatient and ED)**
- **Hospitals (including CAHs) report on 19 of 24 objectives**
- **Physicians and other eligible professionals (EPs) report on 20 of 25 objectives**
- **Reporting period is 90 days in the first payment year; one year after that**

American Hospital Association

Meaningful Use Definition

24 Objectives of Meaningful Use

1. CPOE for Medications
2. Drug-drug/drug-allergy checks
3. Record demographics
4. Structured problem list
5. Structured medication list
6. Structured medication allergy list
7. Record and chart changes in vital signs
8. Record smoking status
9. 1 clinical decision support rule
10. Report clinical quality measures
11. Electronic health info to patients
12. Electronic copy of discharge instructions
13. Exchange key clinical information (capability)
14. Protect electronic health information
15. Drug-formulary checks
16. Record advanced directives
17. Incorporate structured clinical-lab data
18. Generate patient lists by condition
19. Identify patient-specific education resources
20. Medication reconciliation
21. Summary care record transitioned or referred patients
22. Submit data to immunization registries
23. Submit lab results to public health
24. Submit syndromic surveillance data

14 Core Objectives Required of All Hospitals

Choose 5 from Menu Set

Choose at least 1 Public Health Option

19 Objectives Required in Stage 1

1. CPOE for Medications
2. Drug-drug/drug-allergy checks
3. Record demographics
4. Structured problem list
5. Structured medication list
6. Structured medication allergy list
7. Record and chart changes in vital signs
8. Record smoking status
9. 1 clinical decision support rule
10. Report clinical quality measures
11. Electronic health info to patients
12. Electronic copy of discharge instructions
13. Exchange key clinical information (capability)
14. Protect electronic health information
15. Option 1
16. Option 2
17. Option 3
18. Option 4
19. Public Health reporting option

CPOE Required for Medications

- **Objective:** Use CPOE for medication orders directly entered by **any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines**

- **Measure:** More than **30%** of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's **inpatient or emergency department** (POS 21 or 23) have **at least one medication order entered using CPOE**

American Hospital Association

Possible Exclusions

- **Can exclude certain objectives if they are not applicable to you**
  - **Hospitals can exclude up to 7 objectives**
  - **Must meet specific exclusion criteria detailed in final rule**
- **Exclusion *reduces* total number of objectives to be met**

Examples of Hospital Objectives that can be excluded as not applicable:

- *Provide electronic copy of discharge instructions, if NO patients request it*
- *Submit data to immunization registries, if NO immunizations given or NO registry can receive data*
- *Submit reportable lab results, if NO public health agencies can accept data*

American Hospital Association

Quality Reporting: "Get Started"

- **Hospitals (INCLUDING CAHs) must report 15 measures (3 sets)**
  - **Endorsed by National Quality Forum**
  - **Not in current quality reporting program (RHQDAPU)**
  - **"e-specified" but not field tested**
- **Calculation through the EHR, but submission is through attestation in 2011**
  - **Numerators**
  - **Denominators**
  - **Patient exclusions**
- **Anticipate electronic submission in 2012**

American Hospital Association

Stage 1: Hospital Quality Reporting Measures

Condition	Measure Name
Emergency Department Throughput	Median time from ED arrival to ED departure for admitted patients
	Admission decision time to ED departure time for admitted patients
Stroke	Discharge on anti-thrombotics
	Anticoagulation for A-fib/flutter
	Thrombolytic therapy for patients arriving within 2 hours of symptom onset
	Anti-thrombotic therapy by day 2
	Discharge on statins
	Stroke education
	Rehabilitation assessment
Venous Thrombo-embolism (VTE)	VTE prophylaxis within 24 hours of arrival
	Intensive care unit VTE prophylaxis
	Anticoagulation overlap therapy
	Platelet monitoring on unfractionated heparin
	VTE discharge instructions
	Incidence of potentially preventable VTE

Certification Requirements

Hospitals Must Use Certified EHRs

- Vendors may certified either a “Complete EHR” or an “EHR Module” that meets one or more of the certification criteria linked to each meaningful use objective
- Hospitals must “attest” that they have certified EHR technology for ALL of the objectives
  - Complete EHR or
  - Combination of EHR Modules
  - Either vendor product or “self-developed”
- NO certified products available on the market today
- Prior CCHIT certification does NOT count

American Hospital Association

Timeline for Certification

- **ONC will approve one or more "testing and certification bodies" (ONC-ACTBs) under a temporary certification program**
  - **Currently receiving and evaluating applications**
  - **Hope to have first ONC-ACTB approved in "late summer"**
- **ONC-ATCBs will conduct certifications**
  - **Testing requirements set by ONC with guidance from NIST**
  - **ONC anticipates first certifications by end of year**
- **Certification will be for 2011 and 2012**
  - **NEW certification will be required in 2013**

American Hospital Association

Medicare EHR Incentive Program

Medicare EHR Incentive Program Basics

- Must be a meaningful user
- PPS and Critical Access Hospitals
- Hospitals receive up to 4 years of sequential incentive payments
- Payment penalties begin in 2015

American Hospital Association

Medicare Incentives Timeline

First Fiscal Year in Which the Hospital Receives Incentive Payment	Fiscal Year						
	2011	2012	2013	2014	2015	2016	2017
2011	100%	75%	50%	25%			
2012		100%	75%	50%	25%		
2013			100%	75%	50%	25%	
2014				75%	50%	25%	
2015					50%	25%	
Penalties if not adopting by FY 2015. Three-quarters of the applicable market basket update is reduced by:					33.33%	66.66%	100%

Medicare Hospital Payment Formulas Unchanged

Hospital Medicare Incentives in ARRA	
Calculate base dollar amount	***($2 million + (your discharges from 1150 through and including 23,000)*200))*** **Example assuming 3,149 discharges (2,000 within eligible range):** **$2 million + $400,000 = $2,400,000**
Calculate "Medicare Share"	***Medicare inpatient days / (total inpatient days*((gross revenue – charity) / gross revenue))***
Multiply by Medicare Share	**Using an example Medicare Share of .50: $2,400,000 X .50 = $1,200,000**
Calculate four payments	**Payment Year 1: $1,200,000 (100%)** **Payment Year 2: $900,000 (75%)** **Payment Year 3: $600,000 (50%)** **Payment Year 4: $300,000 (25%)**

Critical Access Hospitals: Accelerated Depreciation Under Medicare

CAH Medicare Incentives in ARRA	
Hypothetical Cost of HIT	**FY 2011: $5 million** **FY 2012: $5 million** **FY 2013: $5 million** **FY 2014: $5 million**
Calculate "Medicare Share"	***(Medicare inpatient days / (total inpatient days*((gross revenue – charity) / gross revenue))) + 20%***
Multiply by Medicare Share	**Using an example Medicare Share of 50%, plus 20% bonus = 70% $20,000,000 X .70 = $14,000,000**
Calculate 100 percent of Medicare Share of Costs	**Total Payment: 100% * $14,000,000 = $14,140,000**
Penalty phase	**If not a meaningful user of EHR by 2015**

CAH Timeline

	2011	2012	2013	2014	2015	2016	2017
Incentive for meeting meaningful use	**Full depreciation Medicare share bonus (four years only)**	→	→	→	→		
Penalties begin if CAH has not met meaningful use by FY 2015					**100.66%**	**100.33%**	**100%**

American Hospital Association

Medicaid EHR Incentive Program

Medicaid EHR Incentive Program Basics

- Optional and administered by states
- Eligible hospitals
  - Acute care hospitals, ***INCLUDING CAHS***, with 10 percent or more Medicaid patient volume (inpatient and ED)
  - Children's hospitals
- Hospitals can get both Medicaid and Medicare
- Up to 5 years of payment
- No penalties

American Hospital Association

Hospital “Deeming” Provision

- **States can seek CMS approval to modify the meaningful use requirements for public health objectives and data registries.**
- **However, hospitals that meet the Meaningful Use requirements for Medicare will be DEEMED to meet Medicaid requirements without having to meet additional criteria imposed by the states.**

American Hospital Association

Medicaid Hospital Payment Formula

- **Based on Medicare payment formula**
  - **Scaled to Medicaid share in base year**
- **States decide payment structure**
  - **3 to 6 years of payments**
  - **Cannot start after 2016**
  - **Cannot pay more than 50 percent in 1 year, or 90 percent in 2 years**
- **CAHs use the same formula**

American Hospital Association

Adopt, Implement, or Upgrade

- **First year of Medicaid Program only requires Adoption, Implementation, or Upgrade of certified EHR technology – NOT Meaningful Use**
- **Adopt = Acquired and installed**
- **Implement = Commenced utilization**
- **Upgrade = Expanded EHR to meet meaningful use (including certification)**
- **Payments can begin January 2011**

State to develop specific requirements, subject to CMS approval

American Hospital Association

Payment Timeline/CMS Operations

Payment Timeline: PPS

- **CMS estimates that it will take 15 to 46 days from attesting to meaningful use to receive initial lump-sum incentive payment.**
- **Hospital's most recently filed cost report will be used to estimate incentive payment**
- **Hospital's cost report beginning in the payment year will be used to settle incentive payments.**

American Hospital Association

Payment Timeline: CAHs

- **Incentive payment made to CAHs through prompt interim payment.**
  - **CAHs must attest to being a meaningful user and submit documentation FIs/MACs to support the costs incurred for HIT.**
  - **FIs/MACs review documentation and determine allowable amount. Payment contractor will make the initial incentive payment, subject to reconciliation.**
- **CMS anticipates that initial payments will be made within two months of determination of the allowable amount.**

American Hospital Association

CMS Operations

- **Start delayed until January 2011**
- **Registration begins January 2011 through CMS website: http://www.cms.gov/EHRIncentivePrograms**
- **Pre-Requisites:**
  - **Have an NPI**
  - **Be registered through PECOS**
  - **Have an active user account in the National Plan and Provider Enumeration System (NPPES)**
- **Attest through the website**
- **Fiscal Intermediaries and Contractors with calculate payments, but a single contractor will make payments**

Connecting America for Better Health

EHR INCENTIVE PROGRAM

American Hospital Association

Additional Resources

AHA HIT Education Efforts

AHA Member Call Series

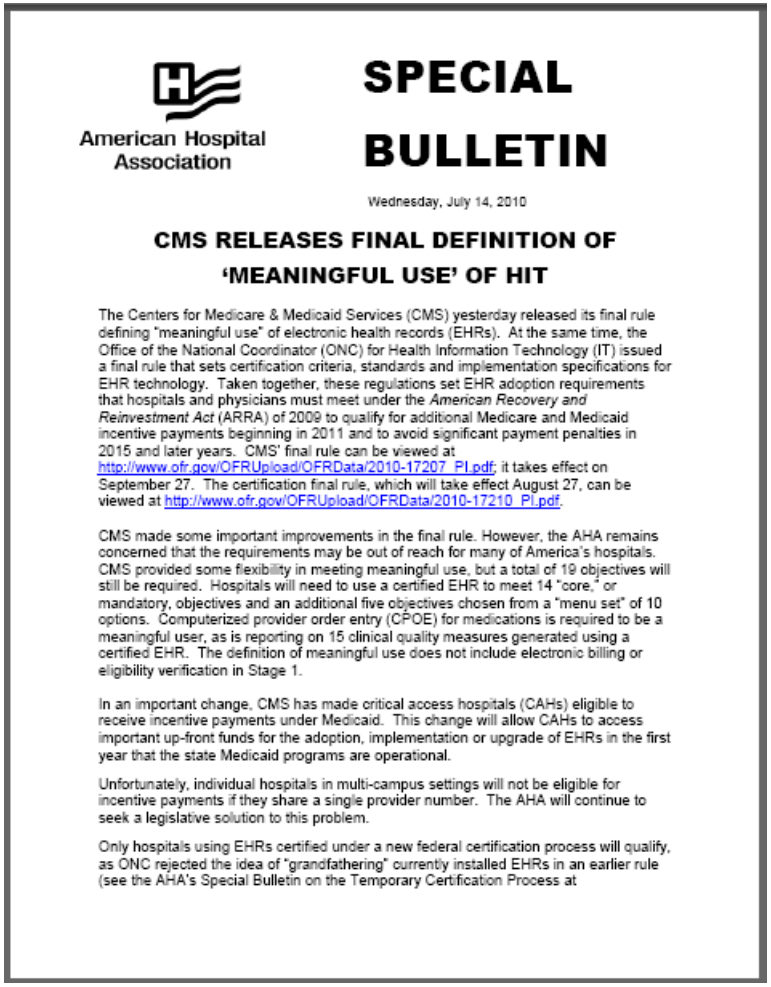
July 28	–	Health IT Rules Overview
July 29	–	Privacy and Security Requirements
August 2	–	Definition of "Meaningful Use"
August 4	–	Reporting Clinical Quality Measures & Functionality Measures
August 5	–	ONC Standards & Certification Regulation
August 6	–	Rural Considerations
August 9	–	Physician Considerations

Calls recorded and available for re-play through AHA website

American Hospital Association

AHA HIT Education Efforts

Policy Analysis



American Hospital Association

SPECIAL BULLETIN

Wednesday, July 14, 2010

CMS RELEASES FINAL DEFINITION OF 'MEANINGFUL USE' OF HIT

The Centers for Medicare & Medicaid Services (CMS) yesterday released its final rule defining "meaningful use" of electronic health records (EHRs). At the same time, the Office of the National Coordinator (ONC) for Health Information Technology (IT) issued a final rule that sets certification criteria, standards and implementation specifications for EHR technology. Taken together, these regulations set EHR adoption requirements that hospitals and physicians must meet under the *American Recovery and Reinvestment Act* (ARRA) of 2009 to qualify for additional Medicare and Medicaid incentive payments beginning in 2011 and to avoid significant payment penalties in 2015 and later years. CMS' final rule can be viewed at http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf; it takes effect on September 27. The certification final rule, which will take effect August 27, can be viewed at http://www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf.

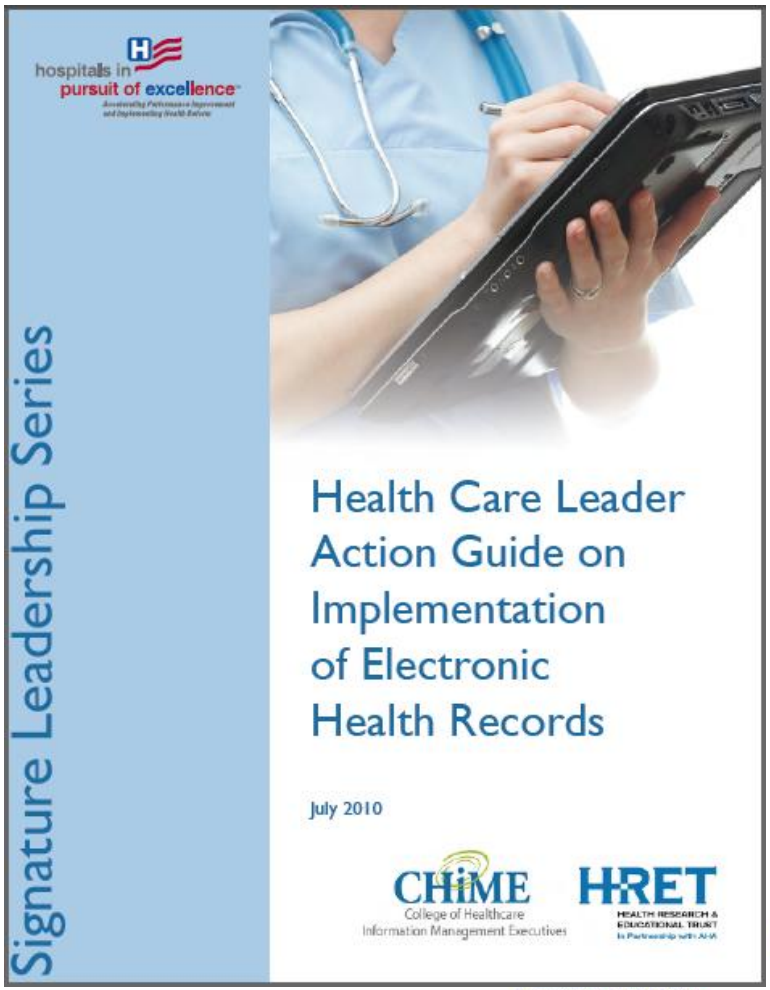
CMS made some important improvements in the final rule. However, the AHA remains concerned that the requirements may be out of reach for many of America's hospitals. CMS provided some flexibility in meeting meaningful use, but a total of 19 objectives will still be required. Hospitals will need to use a certified EHR to meet 14 "core," or mandatory, objectives and an additional five objectives chosen from a "menu set" of 10 options. Computerized provider order entry (CPOE) for medications is required to be a meaningful user, as is reporting on 15 clinical quality measures generated using a certified EHR. The definition of meaningful use does not include electronic billing or eligibility verification in Stage 1.

In an important change, CMS has made critical access hospitals (CAHs) eligible to receive incentive payments under Medicaid. This change will allow CAHs to access important up-front funds for the adoption, implementation or upgrade of EHRs in the first year that the state Medicaid programs are operational.

Unfortunately, individual hospitals in multi-campus settings will not be eligible for incentive payments if they share a single provider number. The AHA will continue to seek a legislative solution to this problem.

Only hospitals using EHRs certified under a new federal certification process will qualify, as ONC rejected the idea of "grandfathering" currently installed EHRs in an earlier rule (see the AHA's Special Bulletin on the Temporary Certification Process at

HPOE Best Practices



Resources

- AHA Member Materials on Meaningful Use
  http://www.aha.org/hit
  http://www.aha.org/hitcalls
- Office of Civil Rights – HIPAA resources
  http://www.hhs.gov/ocr/privacy
- Office of the National Coordinator for HIT - Certification program
  http://healthit.hhs.gov/portal/server.pt?open=512&objID=1153&mode=2
- Centers for Medicare and Medicaid Services – Medicare and Medicaid EHR Incentive Programs
  http://www.cms.gov/EHRIncentivePrograms

American Hospital Association


American Hospital
Association