Health Information Technology and Meaningful Use For Providers

September 2010

The MARYLAND
HEALTH CARE COMMISSION

EHR Incentive Program

- EHR Incentive Programs were established by law
  - American Recovery & Reinvestment Act of 2009 (ARRA)
  - Incentive programs for Medicare and Medicaid
  - Programs for hospitals and eligible professionals
  - Must use certified EHR technology AND demonstrate adoption, implementation, upgrading or meaningful use
  - Programs differ between Medicare and Medicaid
  - Medicare incentive program is federally run by CMS
  - Medicaid incentive program is run by States and is voluntary

Information obtained from CMS *Medicare & Medicaid EHR Incentive Program – Specifics of the Program for Eligible Professionals* August 10, 2010

Eligibility

- Eligibility determined in law
- Hospital-based Eligible Professionals (EP) are NOT eligible for incentives
  - Definition: 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
  - Definition of hospital-based determined in law
- Incentives are based on the individual, not the practice

Eligibility (Continued)

- Medicare EPs include:
  - Doctors of medicine or osteopathy
  - Doctors of dental surgery or dental medicine
  - Doctors of podiatric medicine
  - Doctors of optometry
  - Chiropractors
- Specialties are eligible if one of above criteria are met
- EPs may not be hospital-based

Eligibility (Continued)

- EPs in Medicare Advantage (MA) must:
  - Furnish, on average, at least 20 hours/week of patient care services and be employed by the qualifying MA organization, OR
  - Furnish, on average, at least 20 hours/week of patient care services and be employed by, or be a partner of, an entity that through contract with the qualifying MA organization ,furnishes at least 80% of the entity's Medicare patient care services to enrollees of the qualifying MA organization AND
  - 80% of professional services are provided to enrollees of the MA organization

Eligibility (Continued)

- Medicaid EPs include:
  - Physicians
  - Nurse practitioners
  - Certified nurse-midwives
  - Dentists
  - Physicians assistants working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is so led by a physicians assistant
- EPs may not be hospital-based

Eligibility (Continued)

- Medicaid EPs must also meet one of the three patient volume thresholds:
  - Have a minimum of 30% Medicaid patient volume
  - Pediatricians ONLY: Have a minimum of 20% Medicaid patient volume
  - Working in FQHC or RHC ONLY: Have a minimum of 30% patient volume attributed to needy individuals
- CHIP, sliding scale, free care only count towards thresholds if working in RHC or FQHC

Eligibility (Continued)

- Participation in EHR incentive program and other Medicare incentive programs

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.

Incentives

- Medicare Incentive Payments Overview
  - Incentive amounts based on Fee-for-Service allowable charges
  - Incentives decrease if starting after 2012
  - Must begin by 2014 to receive incentive payments.
  - Last payment year is 2016
  - Extra bonus amount available for practicing predominantly in a Health Professional Shortage Area
  - Only 1 incentive payment per year
  - Maximum incentives are $44,000 over 5 years

Incentives (Continued)

- Medicare Incentive Payments Detail
  - Columns = first calendar year EP receives a payment
  - Rows = payment amount yearly if meeting requirements

	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY2011	$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

Incentives (Continued)

- Health Professional Shortage Area Bonuses for Medicare Incentive Program
  - Columns = first calendar year EP receives a payment
  - Rows = payment amount yearly if meeting requirements

	CY 2011	CY 2012	CY 2013	CY2014	CY 2015 and later
CY2011	$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

Incentives (Continued)

- Medicaid Incentive Payments Overview
  - Maximum incentives are $63,750 over 6 years
  - Incentives are same regardless of start year
  - The first year payment is $21,250
  - Must begin by 2016 to receive incentive payments
  - No extra bonus for health professional shortage areas available
  - Incentives available through 2021
  - Only 1 incentive payment per year

Incentives (Continued)

- Medicaid Incentive Payments Detail
  - Columns = first calendar year EP receives a payment
  - Rows = payment amount yearly if meeting requirements

	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

Adopt/Implement/Upgrade Requirements

- Medicaid – only for first participation year
  - Adopted – Acquired and Installed (A)
    - Evidence of installation prior to incentive
  - Implemented – Commenced Utilization (I)
    - Staff training, data entry of patient demographic information into EHR
  - Upgraded – Expanded (U)
    - Upgraded to certified EHR technology or added new functionality for certified EHR technology definition
- Must be certified EHR technology capable of meeting Meaningful Use
- No EHR reporting period

Meaningful Use Requirements

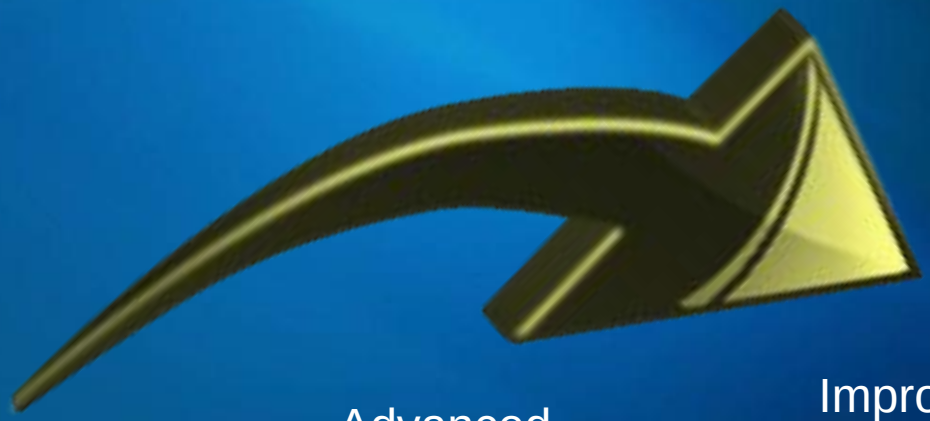
- Meaningful Use is using certified EHR technology to
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and families in their health care
  - Improve care coordination
  - Improve population and public health
  - All the while maintaining privacy and security
- Meaningful Use mandated in law to receive incentives

Meaningful Use Requirements (continued)

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

Meaningful Use Requirements (continued)

- Rule making was open to public comment
- Listened to many comments received
- Established 3 stages of Meaningful Use: 2011, 2013 and 2015



Meaningful Use Requirements (continued)

- Basic Overview of Stage 1 Meaningful Use:
  - Reporting period is 90 days for first year and 1 year subsequently
  - Reporting objectives and Clinical Quality Measures
  - Reporting may be yes/no or numerator/denominator attestation for first year and CQM submitted electronically in years 2 forward
  - To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology

Meaningful Use Requirements (continued)

- Stage 1 Objectives and Measures Reporting
- Must complete:
  - 15 core objectives
  - 5 objectives out of 10 from menu set
  - 6 total Clinical Quality Measures (3 core or alternate core, and 3 out of 38 from menu set)

Meaningful Use Requirements (continued)

- Some Meaningful Use objectives 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 would be excluded from having to meet that measure
  - e.g., dentists who do not perform immunizations; chiropractors do not e-prescribe

Meaningful Use Requirements (continued)

- 2 types of percentage-based measures for denominator:
  - All patients seen during EHR reporting period
  - Patients and actions taken for patients whose records are kept in the certified EHR technology

Meaningful Use Requirements (continued)

- EPs –15 Core Objectives
  - Computerized physician order entry (CPOE)
  - E-Prescribing (eRx)
  - Report ambulatory clinical quality measures to CMS/States
  - Implement one clinical decision support rule
  - Provide patients with an electronic copy of their health information, upon request
  - Provide clinical summaries for patients for each office visit
  - Drug-drug and drug-allergy interaction checks
  - Record demographics

Meaningful Use Requirements (continued)

- EPs –15 Core Objectives (continued)
  - Maintain an up-to-date problem list of current and active diagnoses
  - Maintain active medication list
  - Maintain active medication allergy list
  - Record and chart changes in vital signs
  - Record smoking status for patients 13 years or older
  - Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
  - Protect electronic health information

Meaningful Use Requirements (continued)

- Menu objectives - must complete 5 of 10
- At least 1 public health objective must be selected (noted by an asterisk *)
- EPs –10 Menu Objectives
  - 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

Meaningful Use Requirements (continued)

- EPs –10 Menu Objectives (continued)
  - 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*

Meaningful Use Requirements (continued)

- 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 Requirements (continued)

- States can seek CMS prior approval to require 4 Meaningful Use 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 Requirements (continued)

- A Medicare EP who does NOT demonstrate meaningful use by 2015 will be subject to payment reductions in their Medicare reimbursement schedule
- Medicaid – only EPs are not subject to payment reductions
- Payment reductions may apply for any EP who accepts Medicare and does not meet meaningful use, even if the EP only participates in the Medicaid EHR incentive program

Meaningful Use Requirements (continued)

- HHS intends 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
- Administrative transactions will be added
- CPOE measurement will go to 60%
- Will reevaluate other measures – possibly higher thresholds

Clinical Quality Measures Requirements

- Details of Clinical Quality Measures
  - 2011 – EPs 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 seeking to demonstrate Meaningful Use can continue attestation for most of the meaningful use objectives but will initiate electronic submission of the CQM numerator, denominator, and exclusion data to CMS or the States

Clinical Quality Measures Requirements (Continued)

- Clinical Quality Measures – Core Set

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

Clinical Quality Measures Requirements (Continued)

- Clinical Quality Measures – Core Set

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF0041 PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
NQF 0038	Childhood Immunization Status

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Diabetes: Hemoglobin A1c Poor Control
  - Diabetes: Low Density Lipoprotein (LDL) Management and Control
  - Diabetes: Blood Pressure Management
  - Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
  - Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
  - Pneumonia Vaccination Status for Older Adults
  - Breast Cancer Screening

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Colorectal Cancer Screening
  - Coronary Artery Disease (CAD): Oral Anti-platelet Therapy Prescribed for Patients with CAD
  - Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
  - Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
  - Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
  - Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
  - Asthma Pharmacologic Therapy
  - Asthma Assessment
  - Appropriate Testing for Children with Pharyngitis
  - Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
  - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
  - 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
  - Diabetes: Eye Exam
  - Diabetes: Urine Screening

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Diabetes: Foot Exam
  - Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
  - Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
  - Ischemic Vascular Disease (IVD): Blood Pressure Management
  - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
  - Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
  - Prenatal Care: Anti-D Immune Globulin
  - Controlling High Blood Pressure
  - Cervical Cancer Screening
  - Chlamydia Screening for Women

Clinical Quality Measures Requirements (Continued)

- Additional set CQM – must complete 3 of 38
  - Use of Appropriate Medications for Asthma
  - Low Back Pain: Use of Imaging Studies
  - Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
  - Diabetes: Hemoglobin A1c Control (<8.0%)
- Clinical Quality Measures align with Physicians Clinical Quality reporting (PQRI)
- Alignment between 4 HITECH CQM and the CHIPRA initial core set that providers report to States

What You Need to Participate

- 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
    - *Medicaid providers may adopt, implement, or upgrade in their first year*
- All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS
  http://www.cms.gov/EHRIncentivePrograms

What You Need to Participate (Continued)

- Registration: Medicaid Specific Details
- States will interface to the EHR Incentive Program registration website
- States will ask providers to provide and/or attest to additional information in order to make accurate and timely payments, such as:
  - Patient Volume
  - Licensure
  - A/I/U or Meaningful Use
  - Certified EHR Technology

What You Need to Participate (Continued)

- Registration requirements include:
  - Name of the EP
  - NPI
  - Business address and business phone
  - Taxpayer Identification Number (TIN) to which the provider would like their incentive payment made
  - Medicare or Medicaid program selection (may only switch once after receiving an incentive payment before 2015) for EPs
  - State selection for Medicaid providers

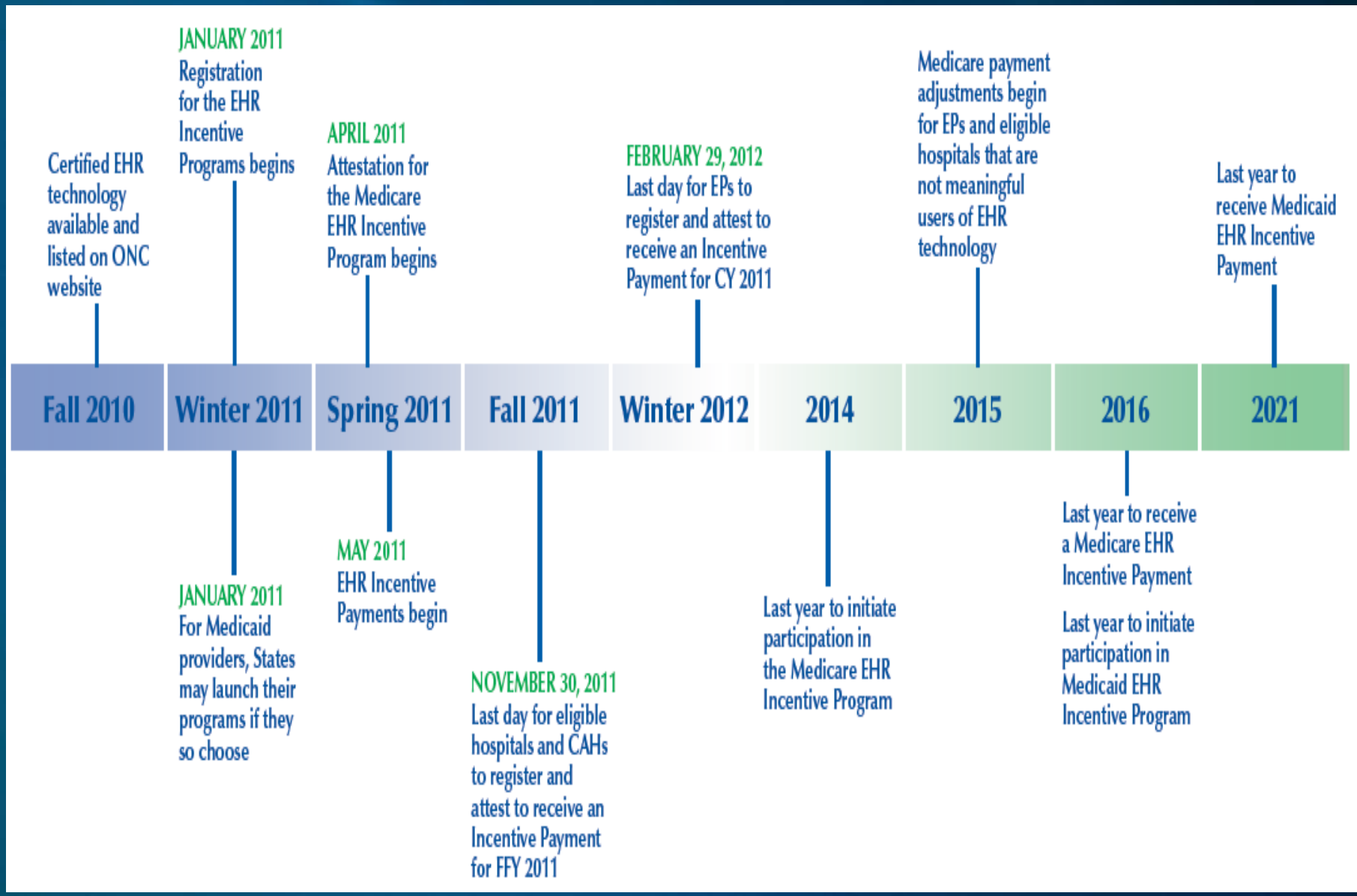
What You Need to Participate (Continued)

- Certified EHR Technology:
  - Required in order to achieve meaningful use
  - Standards and certification criteria published in final rule on July 13, 2010.
  - ONC in process of authorizing “temporary certification bodies”
  - Certified products are expected to be available in the Fall
  - List of certified EHRs and EHR modules will be posted on ONC web site upon receipt from authorized certification bodies to support providers in identifying certified products

Differences Between Medicare and Medicaid Incentive Programs

Medicare	Medicaid
Federal Government will implement starting in January 2011	Voluntary for States to implement-Most are expected to start by late summer 2011
Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use	No Medicaid payment reductions
Must demonstrate Meaningful Use 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
Meaningful Use definition is common for Medicare	States can adopt certain additional requirements for Meaningful Use
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 register for and initiate program is 2016; last payment year is 2021
Only physicians, subsection(d) hospitals and CAHs	5 types of EPs, acute care hospitals (including CAHs) and children's hospitals

Program Timeline



Leading Resources to Learn More

- Get information, tip sheets and more at CMS' official website for the EHR incentive programs:

  http://www.cms.gov/EHRIncentivePrograms

- Learn about certification and certified EHRs, as well as other ONC programs designed to support providers as they make the transition:

  http://healthit.hhs.gov

Maryland Health Care Commission

Leading Initiatives in Maryland

- Establish a comprehensive multi-stakeholder consumer-centric statewide health information exchange (HIE) for the secure exchange of electronic health information among appropriately authorized health care providers in Maryland
- Develop robust policies for the exchange of electronic health information
- Substantially increase in the adoption and meaningful use of EHRs across Maryland.
- Maximize all available federal funding opportunities

Current Federal Health IT Funding

- $9.3M – State HIE Cooperative Agreement Grant Program *(Maryland Health Care Commission)*
  - Build capacity for exchanging electronic health information
- $5.5M – HIT Extension Program: Regional Centers Cooperative Agreement Program *(Chesapeake Regional Information System for our Patients (CRISP))*
  - Provide outreach, education, and technical support for EHR adoption
- $1.3M – Maryland Medicaid
  - Planning costs – State Medicaid HIT Plan and EHR adoption incentives
- $5.5M – Johns Hopkins University
  - Graduate level HIT program development
- $325K – Community College Consortia Program *(Baltimore County Community College)*
  - Develop non-degree HIT training programs

Health Information Exchange

HIE – The Rationale

- A statewide HIE will ensure that providers have greater access to secure and accurate health information when and where it is needed
- A Maryland HIE will enhance public health initiatives such as biosurveillance, disease management, and emergency preparedness efforts
- Maryland's approach balances the need for information sharing with the need for strong privacy and security policies

HIE – The Approach

- A decentralized standards-based hybrid model that supports both distributed data, personal health records, and health record banks
  - The model ensures that data is held where it is created and not in a large centralized HIE repository
- Allows statewide availability for the secure transfer of a defined set of clinical information between appropriate participating entities
- Enables the consumer to control the flow of electronic health information
- Includes opt-out as the baseline consumer consent process

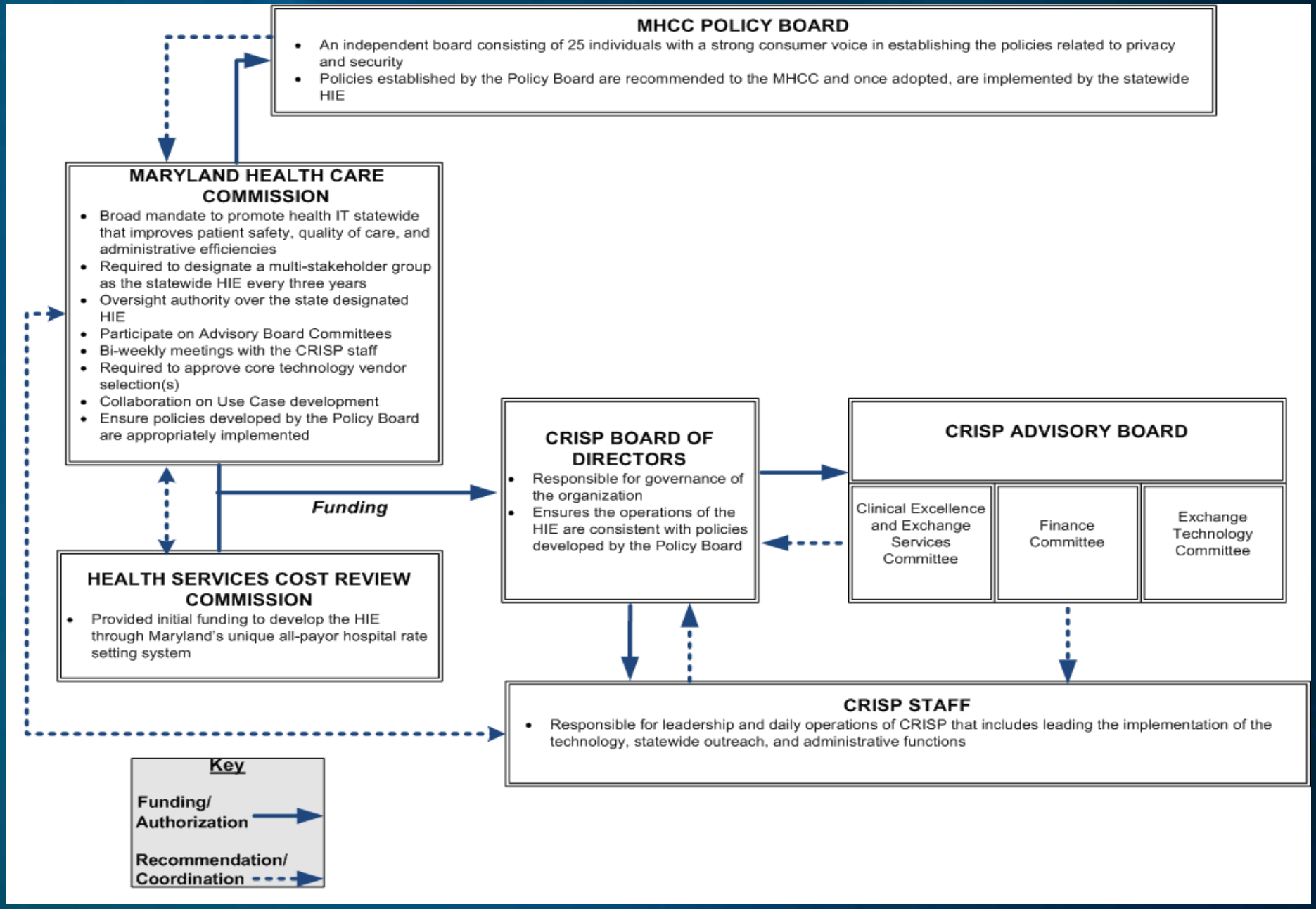
Connectivity Goals

- Establish a secure exchange for clinical data based on sound policy
- Connect 46 Maryland acute care hospitals to the HIE
  - Hospital deployment will occur by region in phases
- Enable roughly 7,900 physician practices with certified EHRs to connect to the HIE
  - Focus initially will be to connect the nearly 2,300 primary care practices
- Eventually connect the 234 nursing homes in the state to the HIE

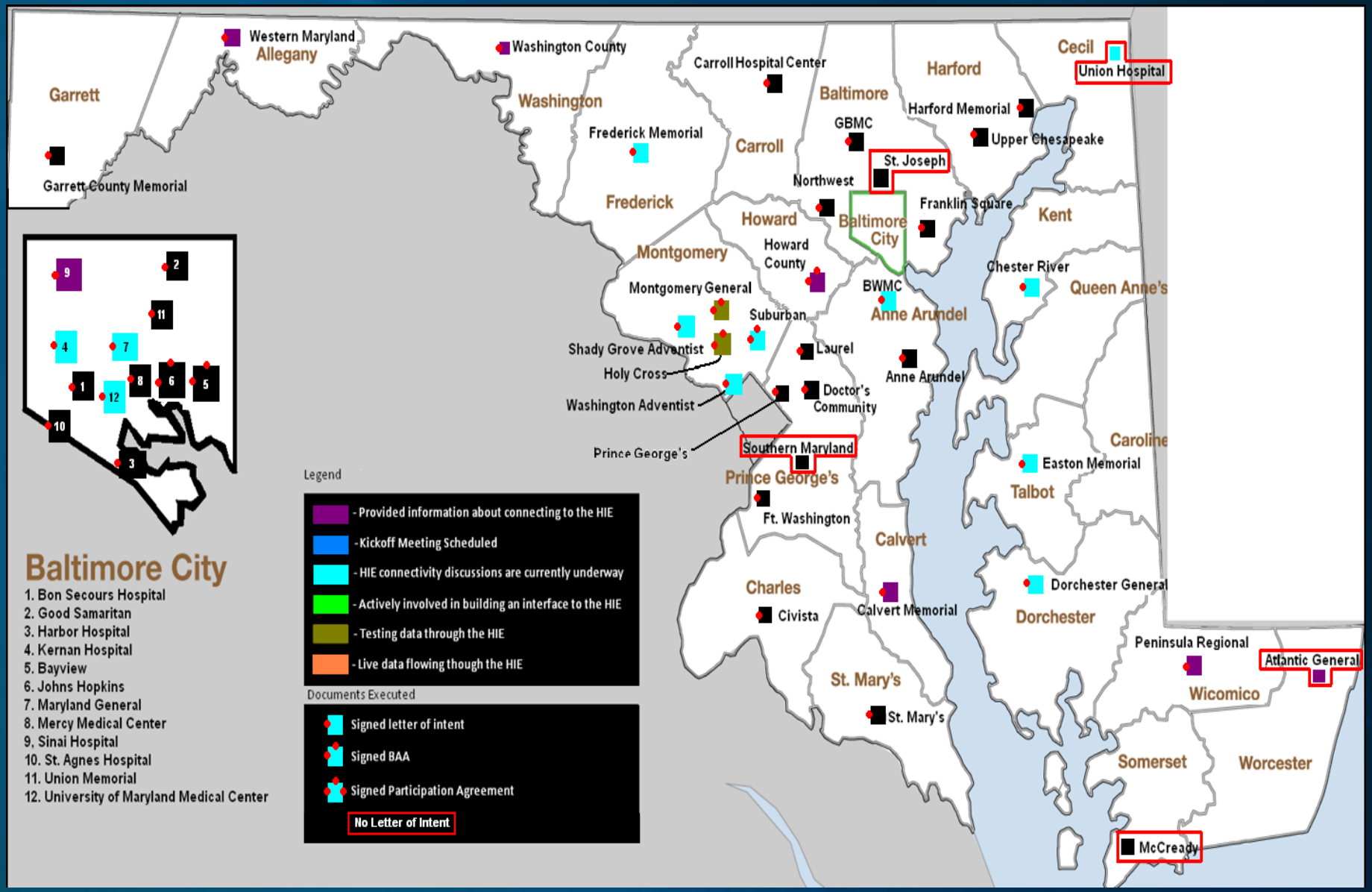
HIE Implementation

- A *Request for Application* to build a statewide HIE was released in April 2009
  - A technical panel recommended that CRISP receive funding through Maryland's unique all-payor hospital rate setting system
- CRISP formally designated by the MHCC in July 2009 and by the HSCRC in August
  - CRISP is a particularly strong not-for-profit collaborative effort between the Johns Hopkins Health System, MedStar Health, University of Maryland Medical System, and the Erickson Foundation with support from multiple stakeholder groups
  - Representatives appointed to the Board of Directors by the founding members

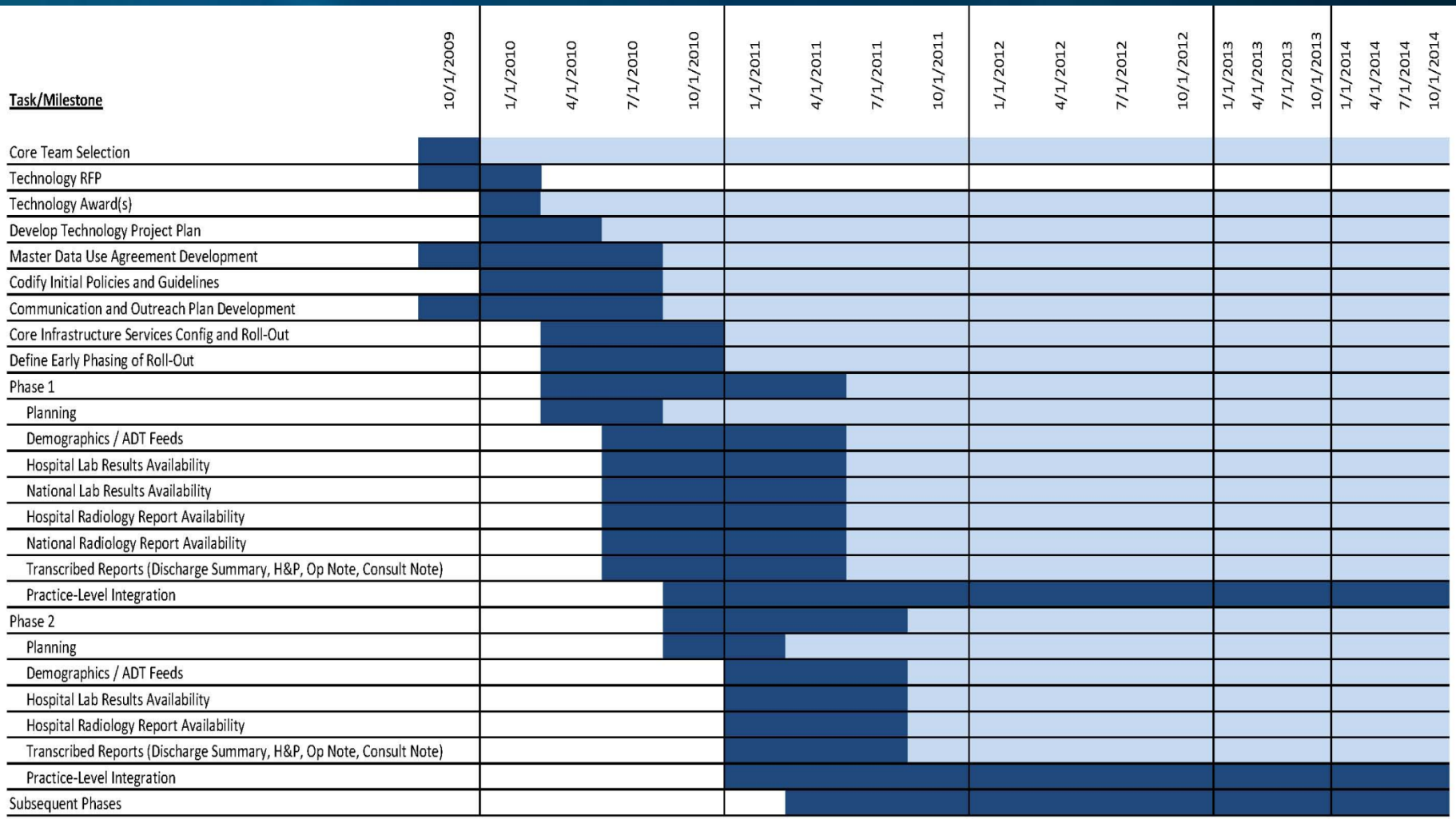
HIE Structure



Hospital Connectivity



HIE Connectivity Timeline



ASSUMPTIONS

1) Hospitals are willing and technically able to participate in the HIE
2) Hospitals are willing to commit the people resources necessary to complete the HIE integration work
3) National labs and radiology providers are willing to participate in the HIE

Setting Policies Governing HIE

- The MHCC has established a Policy Board that sets broad policies governing the operation of the HIE
  - Privacy and security: authorization, authentication, access, and audit
  - Participation rules: opt-out of queries, opt-in to additional functions (such as a personal health data bank), no option for results delivery, and public health requirements set in law
  - Use of identifiable or de-identified data for research, and quality assessment
- Policies established in consultation with the HIE
  - If necessary, implementation of the policies could be enforced through MHCC/HSCRC control of the funding stream (all-payor funds and federal grant)

Electronic Health Records

EHR Product Portfolio – A Purchasing Guide

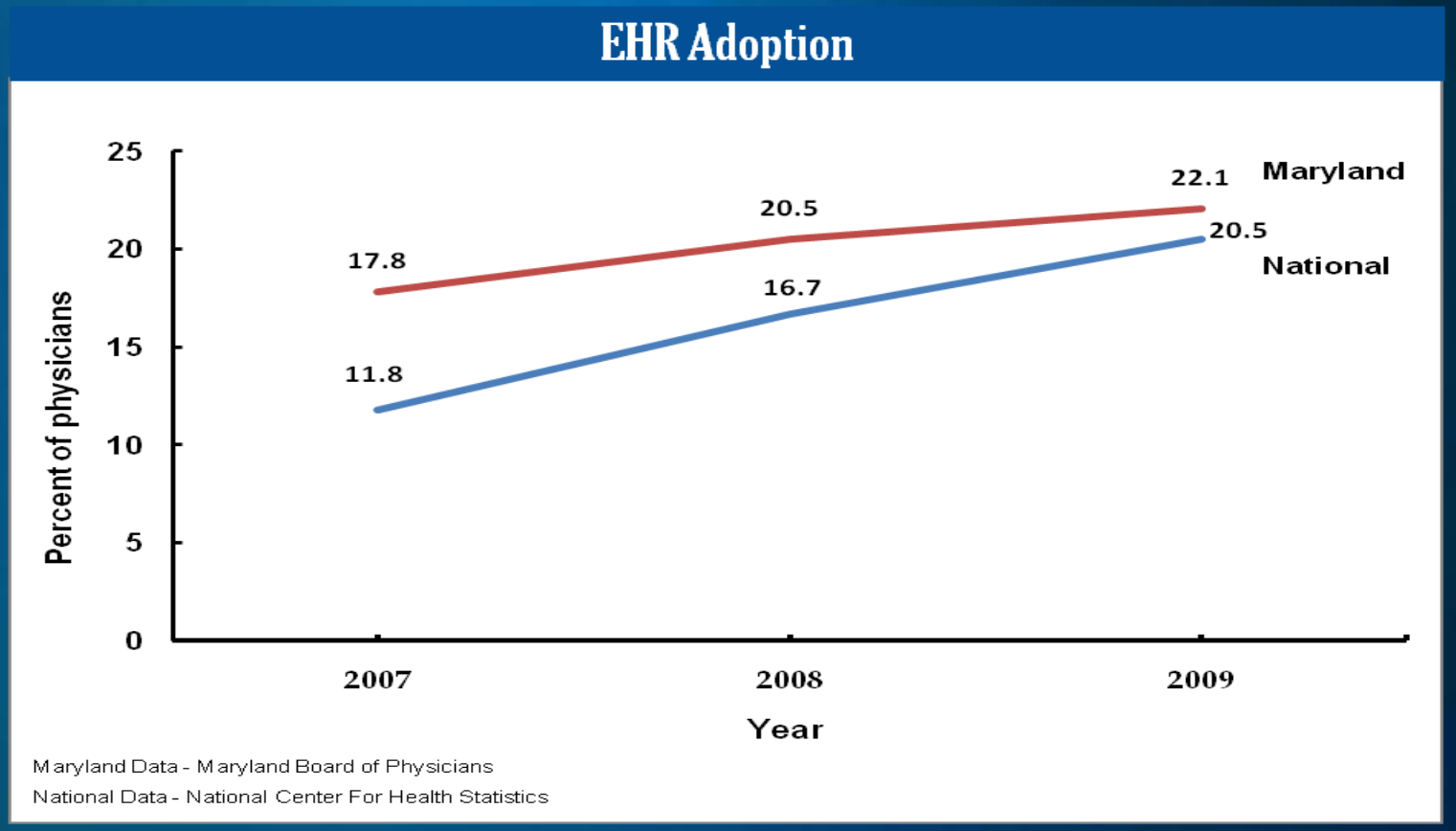
- The EHR product portfolio includes 32 vendors
- The web-based document includes a vendor contact list, privacy and security policies, product overview, pricing, and a user reference report.
- ONC has recognized authorizing testing and certification bodies (ONC-ATCBs), which will test and certify both complete EHRs and EHR Modules for conformance with adopted standards, implementation specifications, and other certification criteria.
  - The MHCC will update its Product Portfolio to include only those EHRs certified by the ONC-recognized ATCBs as EHR products become available.

Hosted EHRs

- Existing law (HB 706) requires the MHCC to designate one or more management service organizations (MSOs) to offer services in the state by October 1, 2012 which:
  - Use an application service provider model to host one or more EHR systems through the Internet
  - Well positioned to leverage buying power and manage the technical aspects of EHRs
  - Will likely compete for market share based on their EHR solutions and other administrative practice support services
- An Advisory Board has been convened to identify criteria for MSOs that seek state designation
- The MHCC began designating MSO(s) in May, with 17 responding

EHR Adoption

- Physician adoption reported nationally and locally
  - Maryland hospital adoption ~81 percent *(MHCC Hospital Survey April 2010)*



Questions

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