CMS Incentive Program for Meaningful Use of HIT and Reporting Quality of Care Measures

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Richard E. Wild, MD,JD,MBA, FACEP

Chief Medical Officer

CMS Region 4, Atlanta

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Presentation Overview

- Problems with US Healthcare Today, Quality and Cost
- HIT and Congressional Initiatives to address Quality and Cost
- CMS' E.HR Incentive Program for Meaningful Use of HIT

CMS' Quality Improvement Roadmap

- Vision: The right care for every person every time Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century, March, 2001.
  - Make care:
    - Safe
    - Effective
    - Efficient: **absence of waste, overuse, misuse, and errors**
    - Patient-centered
    - Timely
    - Equitable

What's Wrong with US Healthcare Today?

Too Costly?

Inefficient?

Disparities in Access and Quality?

Evidence Base foundation often lacking?

Lack of Prevention focus?

Fragmentation of care, between providers and sites of care? (Silos, care transitions)

Poor information and data sharing and transfer?

Patient safety and quality ? (Compare to aviation industry?)

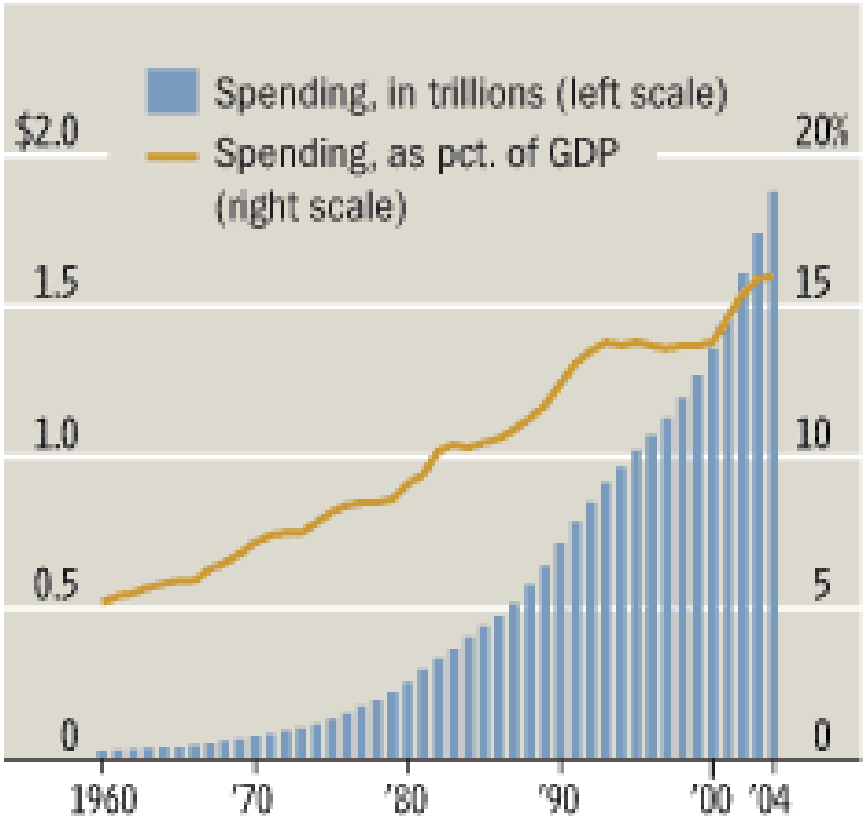
A payment system that rewards providing services rather than outcomes?

Coordinated, accountable or Uncoordinated, Unaccountable care?

Aviation or Health Care ?

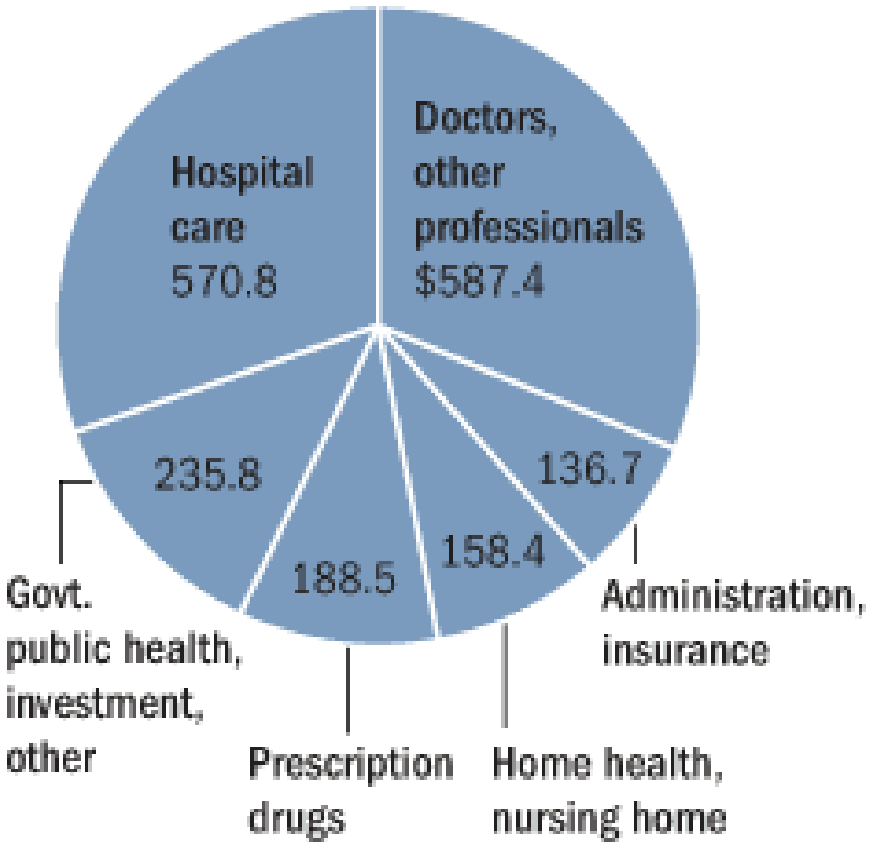
Health-Care Spending, American-Style

Up, up and still up



Source: Centers for Medicare & Medicaid Services

Where the money goes, in billions



Increasing Expenditures

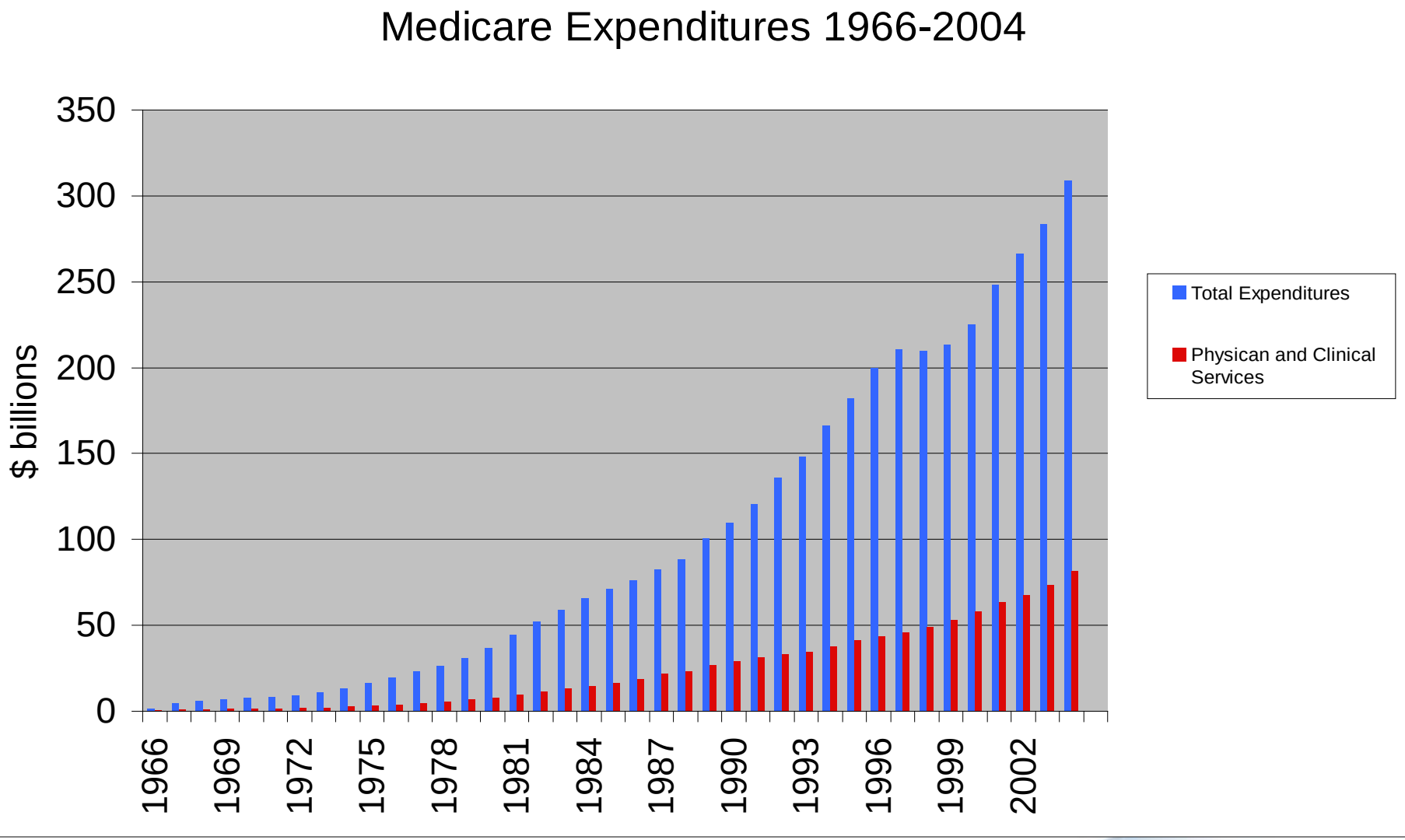
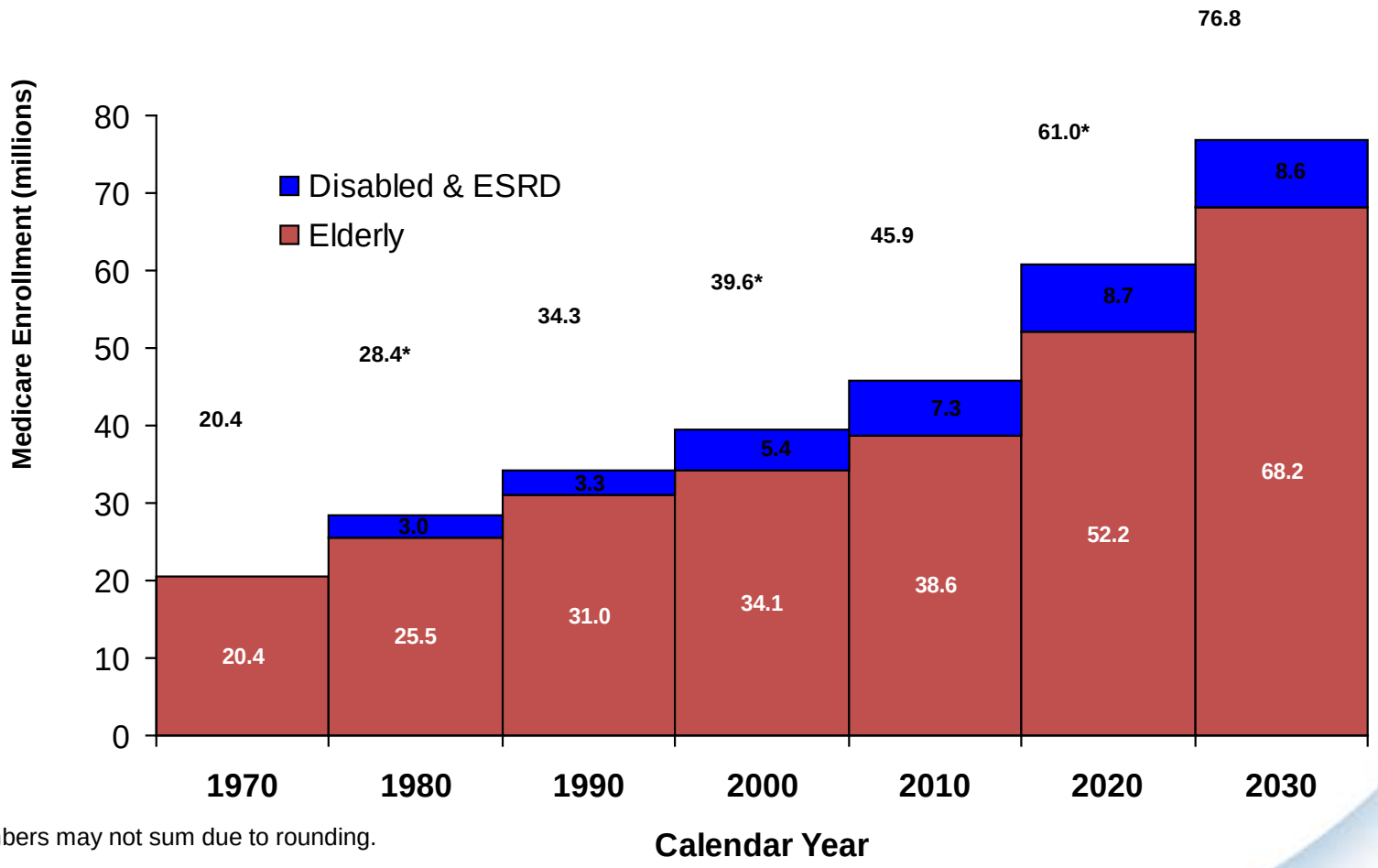


Table 3.6
Number of Medicare *serves* Beneficiaries, 1970-2030

The number of people Medicare serves will nearly double by 2030.

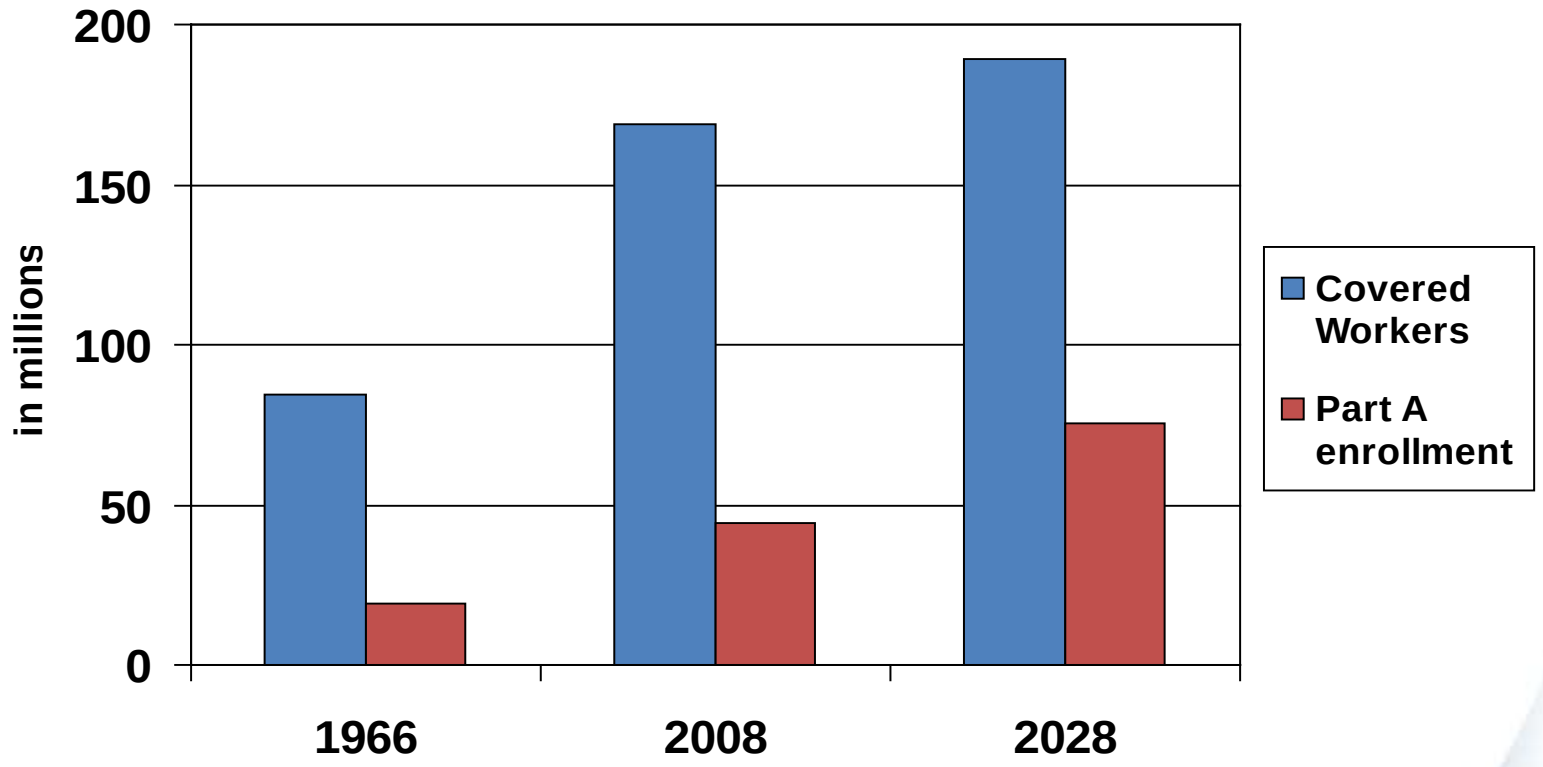


* Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary.

Workers per Medicare Beneficiary

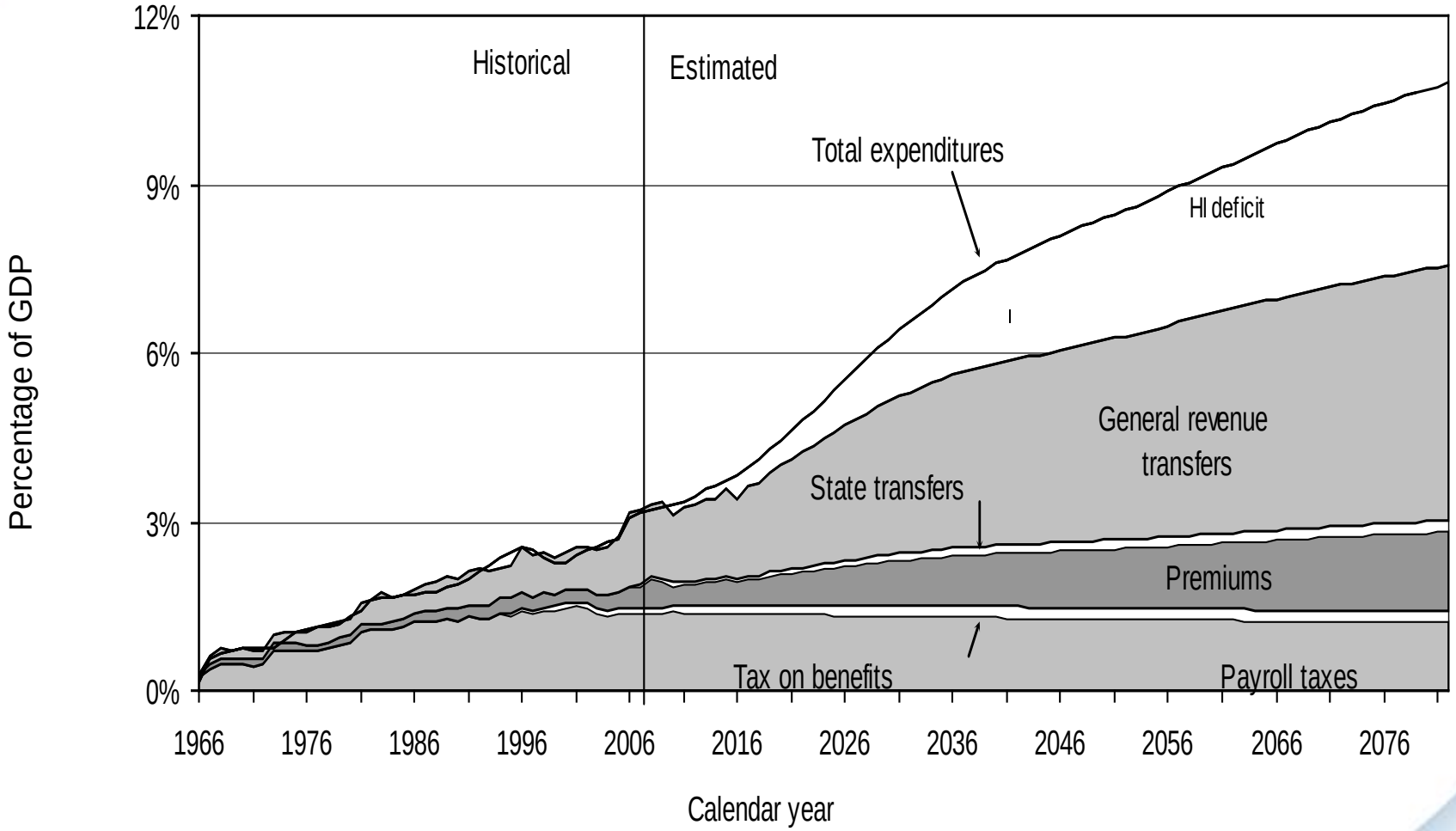
Selected Years



Worker to Beneficiary Ratio	**4.46**	**3.39**	**2.49**

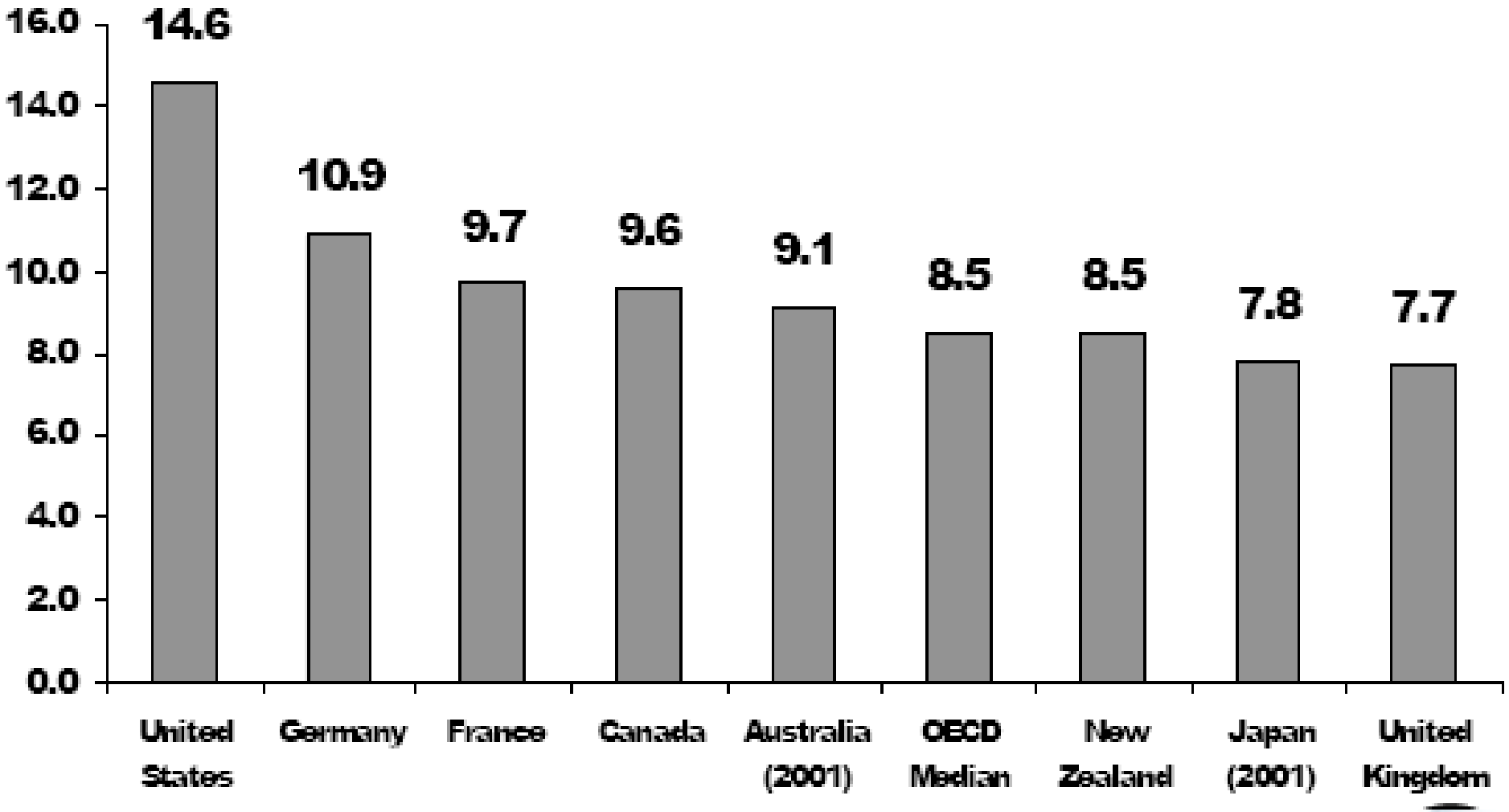
Source: OACT CMS and SSA

Medicare Will Place An Unprecedented Strain on the Federal Budget in the Future if Spending increases not slowed



Source: 2008 Trustees Report

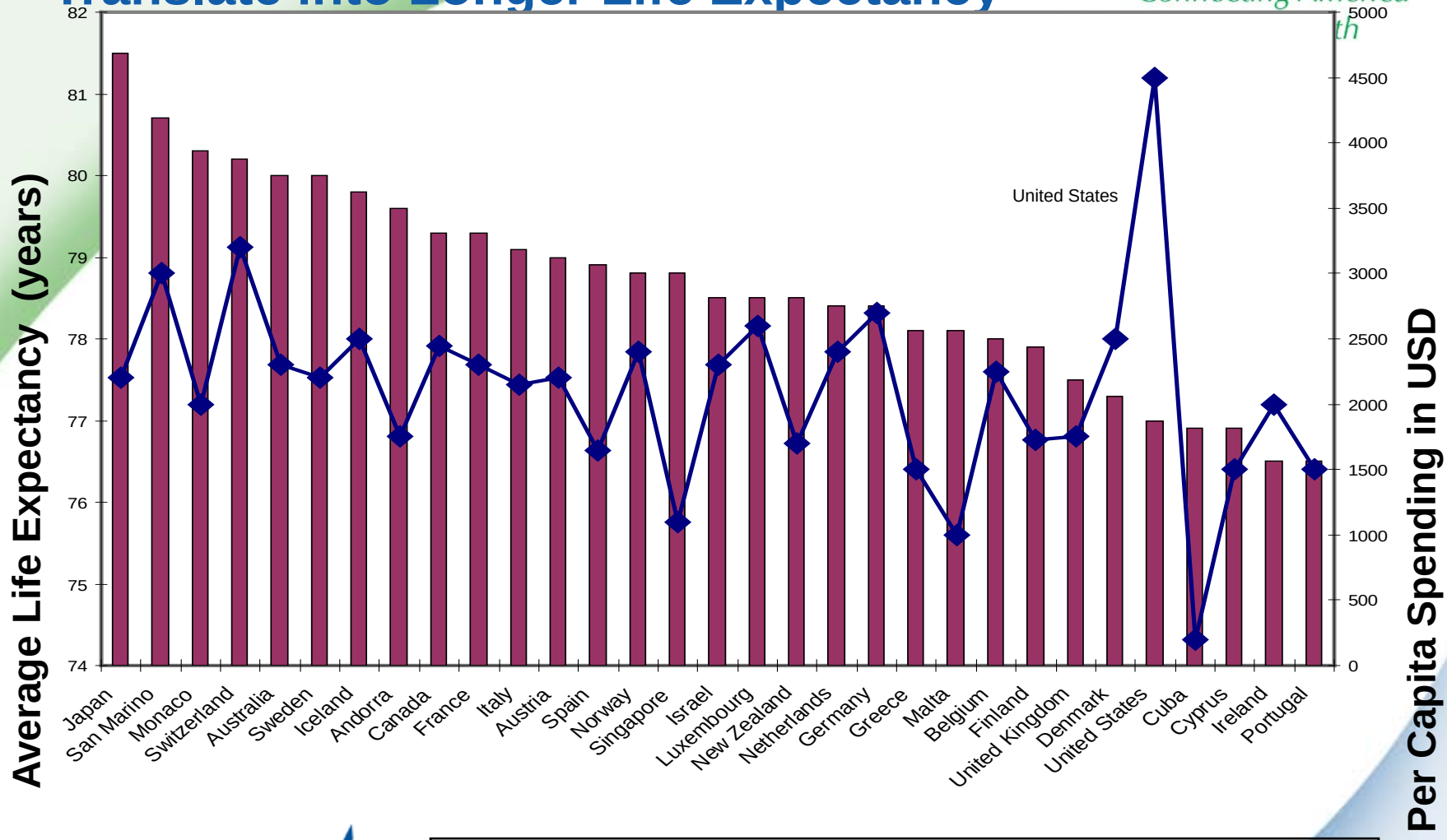
Percent of gross domestic product (GDP) spent on health care, 2002



Source: G. F. Anderson and P. S. Hussey, *Multinational Comparisons of Health Systems Data 2004*, The Commonwealth Fund, October 2004. OECD data.

Higher Per Capita Spending in the U.S. does not Translate into Longer Life Expectancy

Connecting America

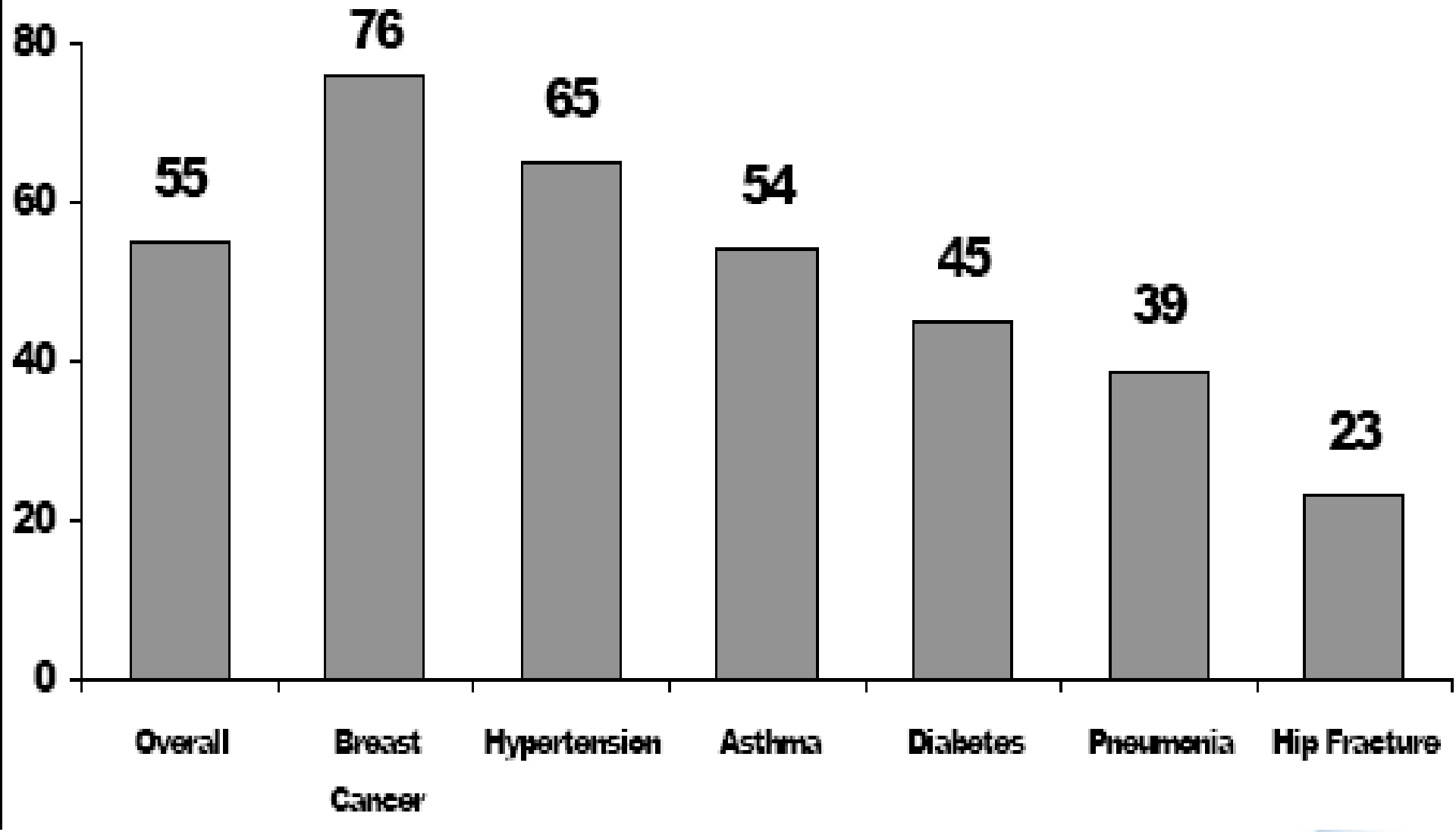


CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Life Expectancy – Per Capita Spending

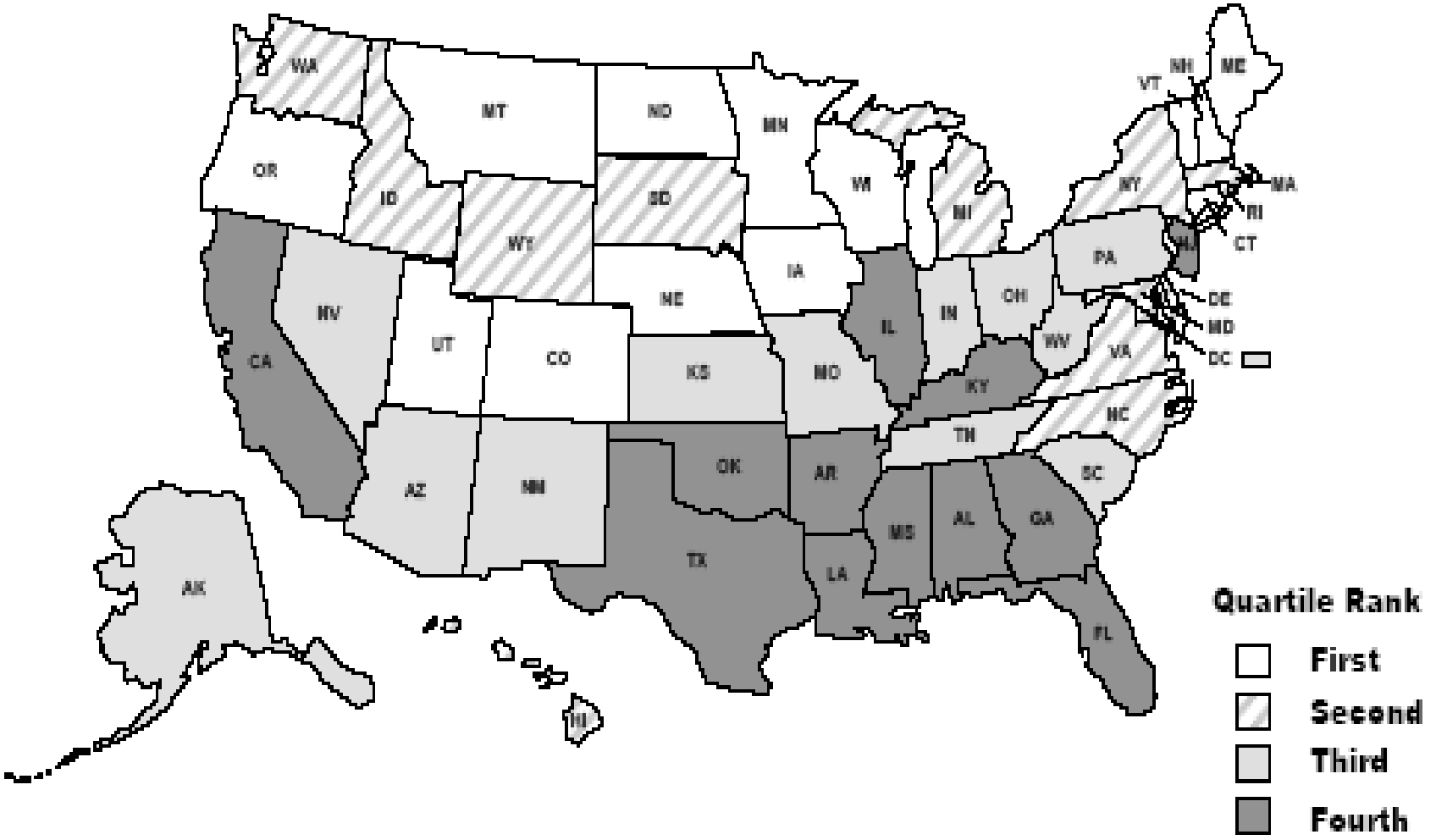
Source: 2006 CIA FACT BOOK

Percent of recommended care received



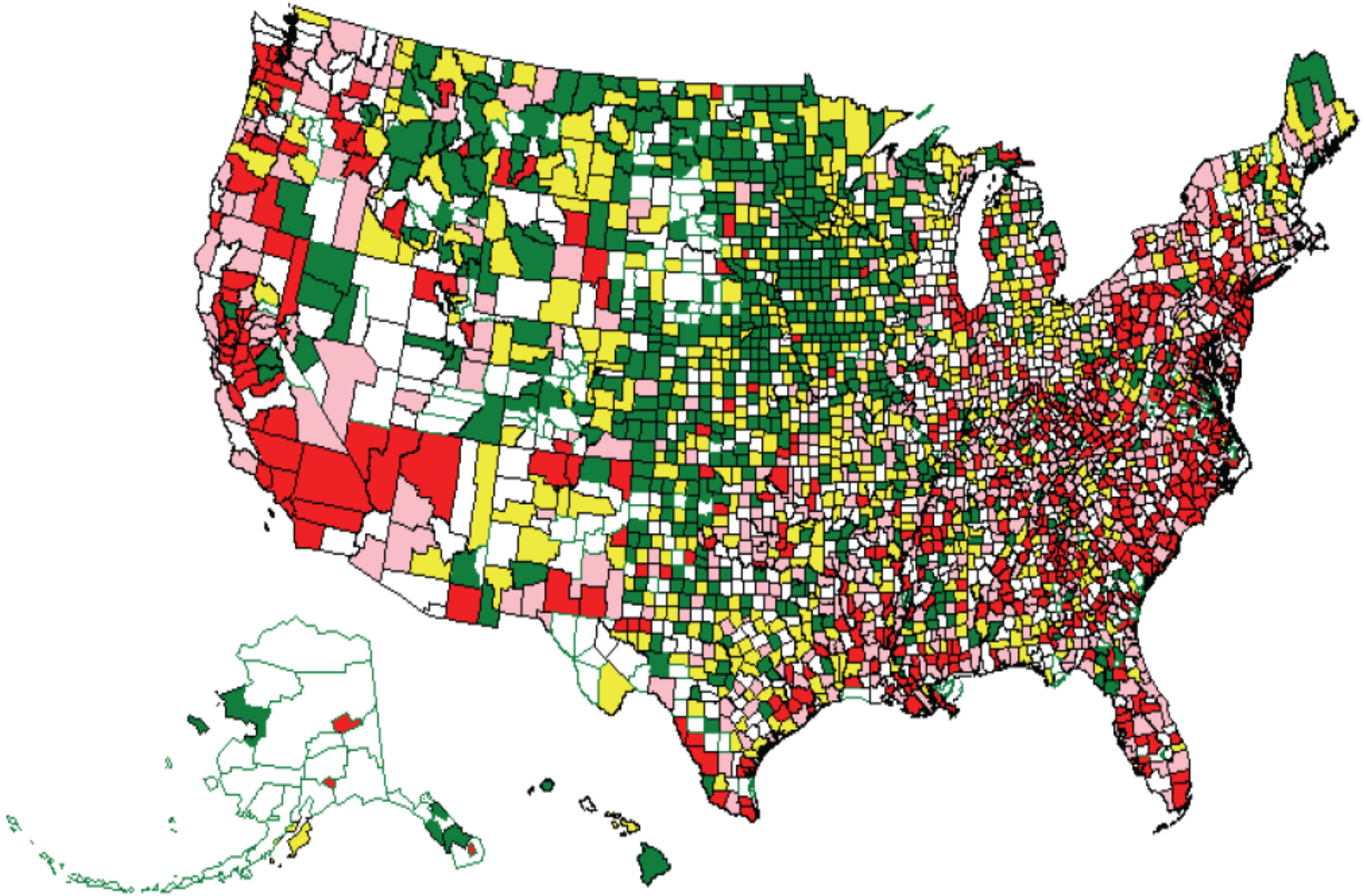
Source: E. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.

Performance on Medicare Quality Indicators, 2000–2001



Source: S. F. Jencks, E. D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289 (Jan. 15, 2003): 305–312.

Median Pressure Sore Prevalence in U.S. Nursing Homes, 2006

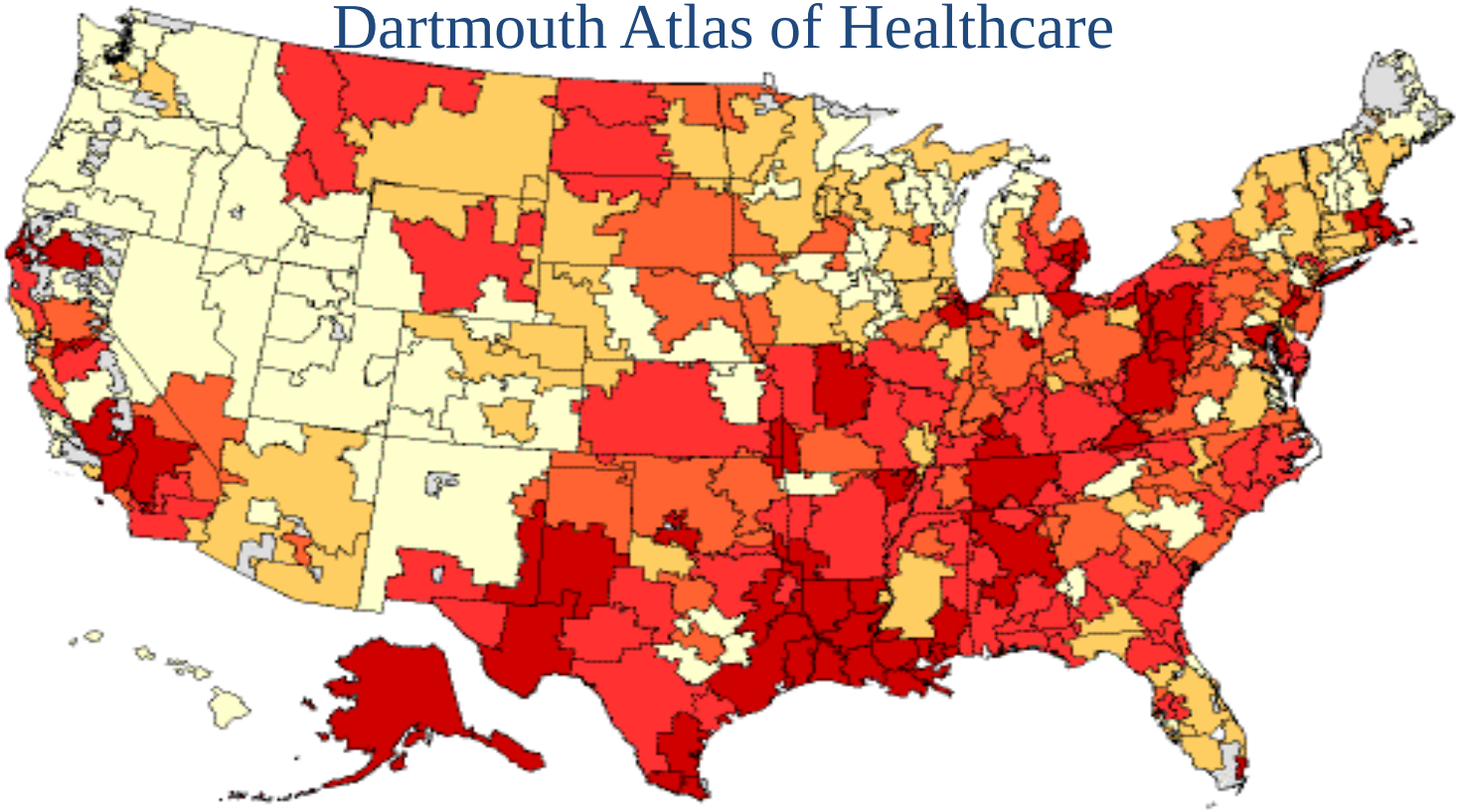


Source: MDS Data, June 2007

CMS

A Variation Problem

Dartmouth Atlas of Healthcare



Map 2.5. Inpatient Hospital Services per Medicare Enrollee
by Hospital Referral Region (1995)

- $2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated

HIT Overview

- HIT and Congressional Initiatives
  - ARRA of 2009, HITECH ACT, established CMS E.HR incentive program for Meaningful Use of HIT
- Recent Studies: Archives of Internal Medicine, Jan. 26 2009, Amarasingham, et.al,“Clinical Information Technologies and Inpatient Outcomes, a Multiple Hospital Study”

  -Hospitals with automated notes and records, order entry and clinical decision support had fewer complications, lower mortality rates, and lower costs.

Connecting America for Better Health

EHR INCENTIVE PROGRAM

Post The Affordable Care Act

Strategic Value of Meaningful Use

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The Triple Aim Goals of CMS

Better Care

- Patient Safety
- Quality
- Patient Experience

Reduce Per Capita Cost

- Reduce unnecessary and unjustified medical cost
- Reduce administrative cost thru process simplification

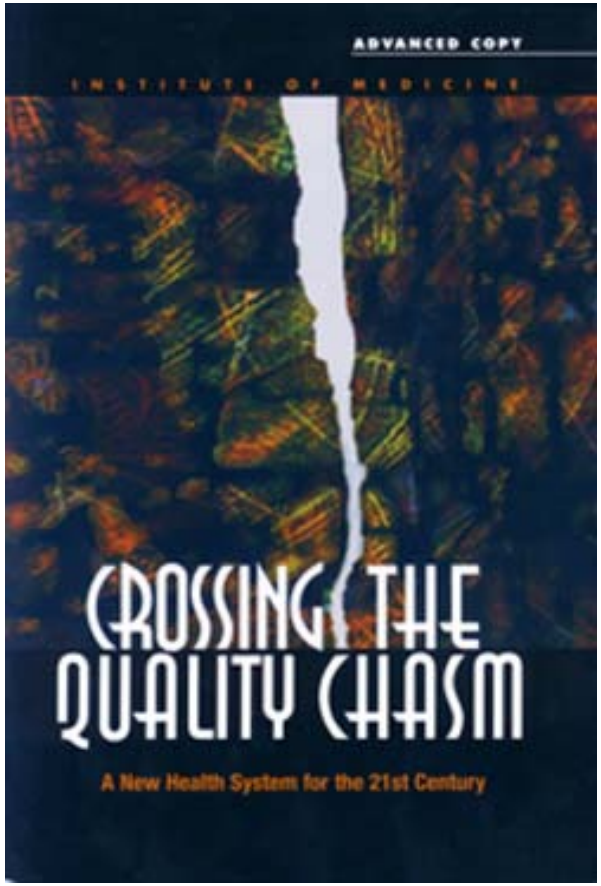
Improve Population Health

- Decrease health disparities
- Improve chronic care management and outcome
- Improve community health status

Better Care

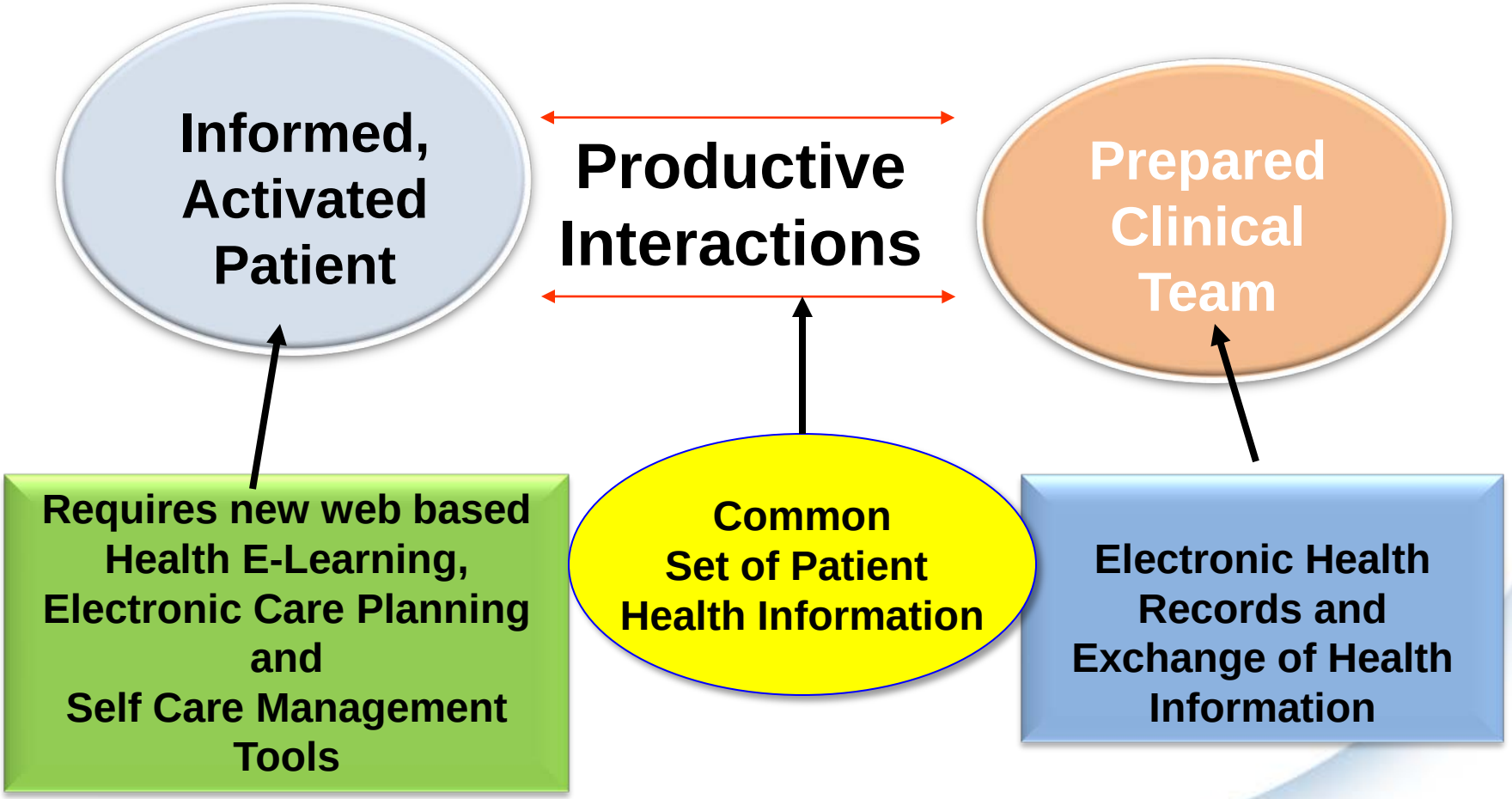
Closing the Quality Chasm

CMS Specific Aims for Health System Improvement

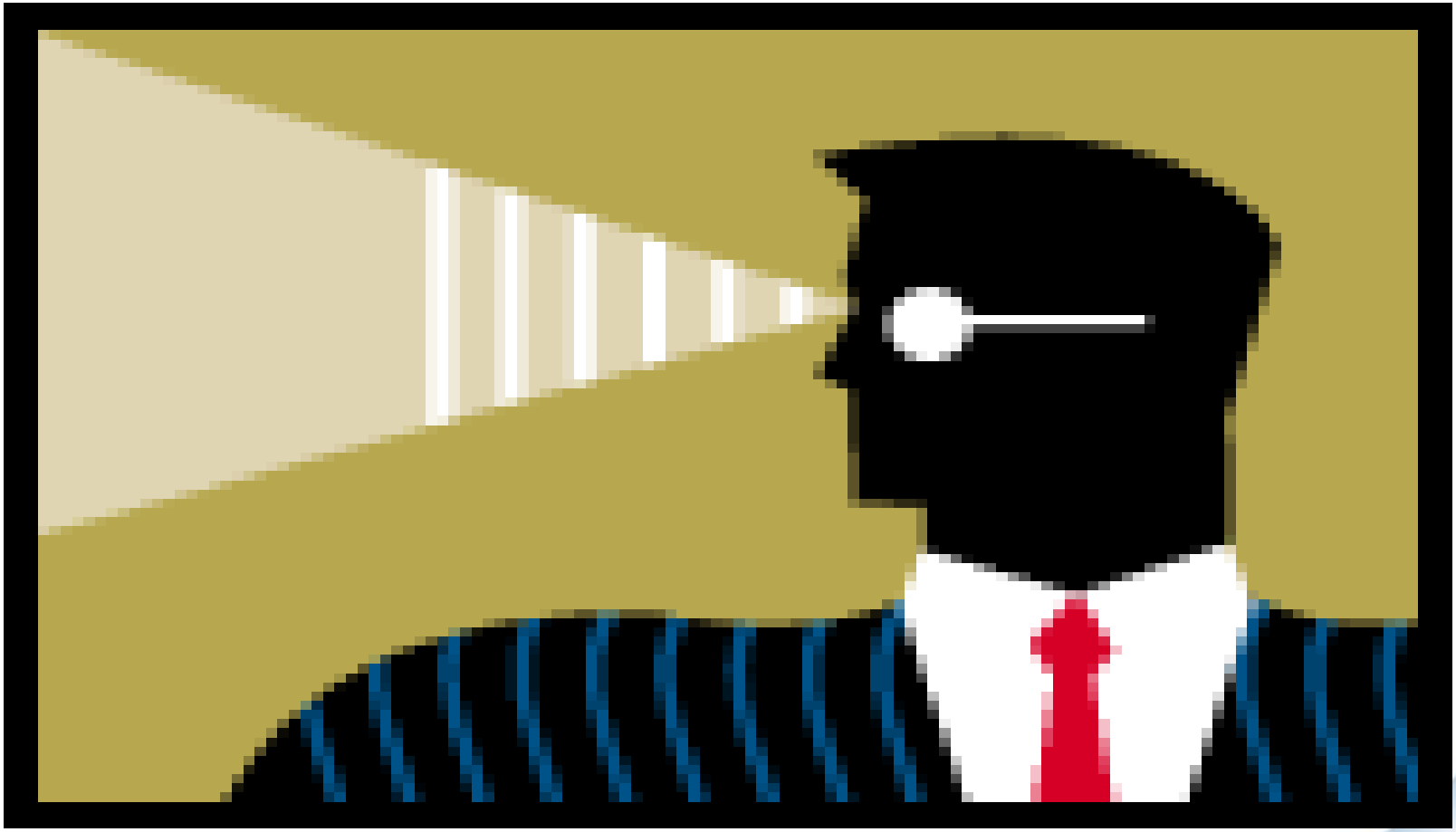


- Safety
- Effectiveness
- Patient-centeredness
- Timeliness
- Efficiency
- Equity

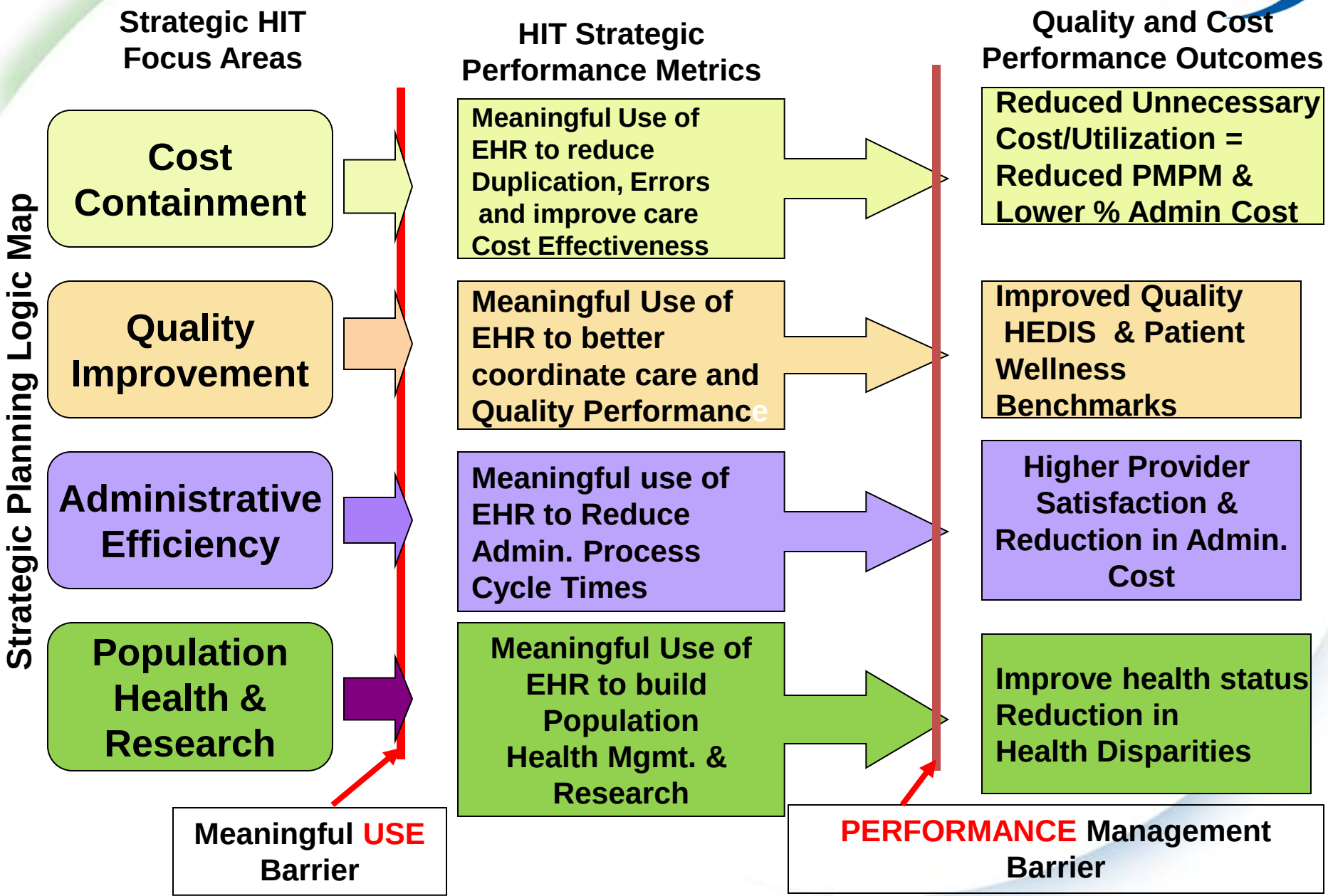
Essential Elements of The Patient Experience Transformed Healthcare System



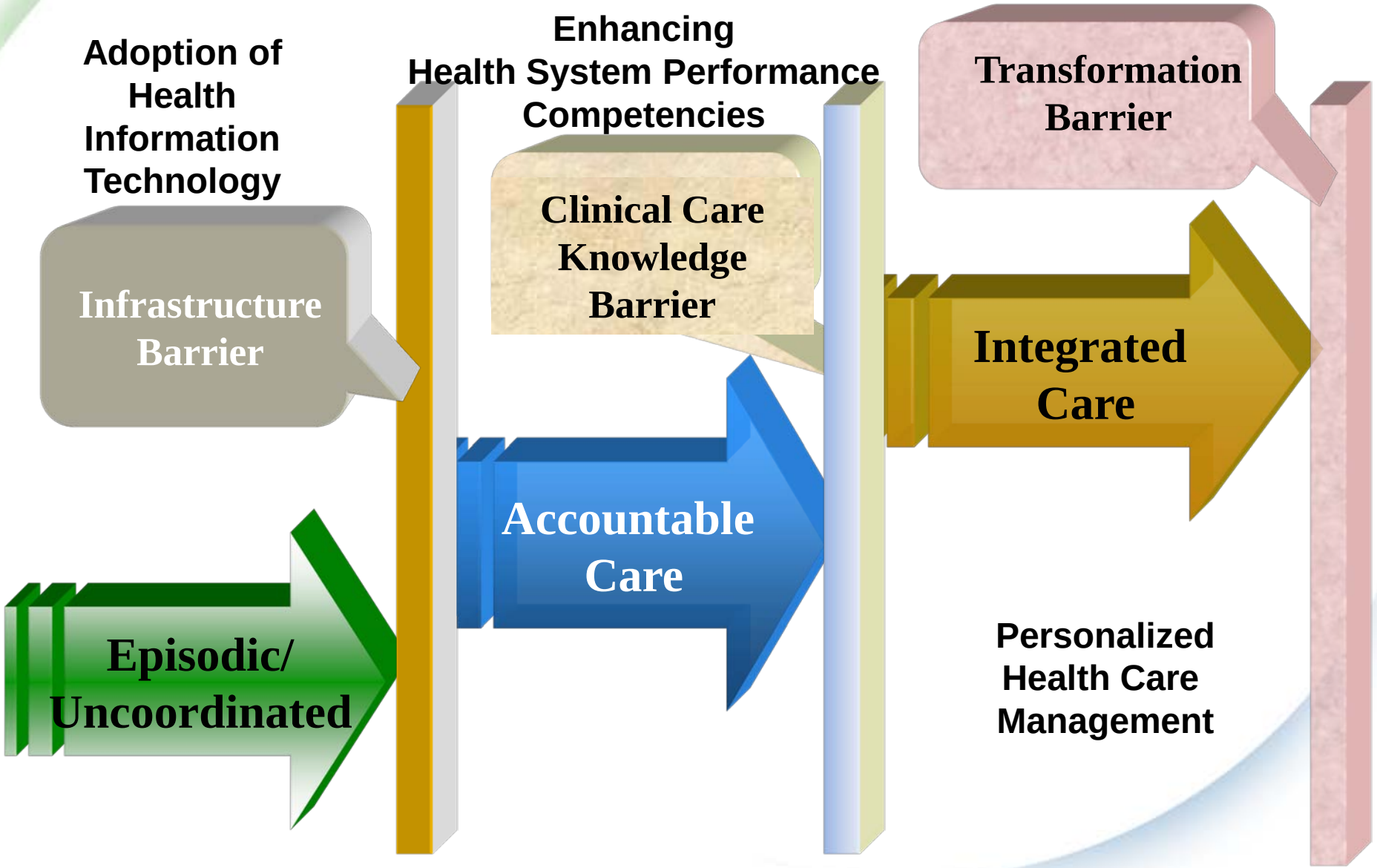
The CMS Vision of Leveraging Meaningful Use of HIT



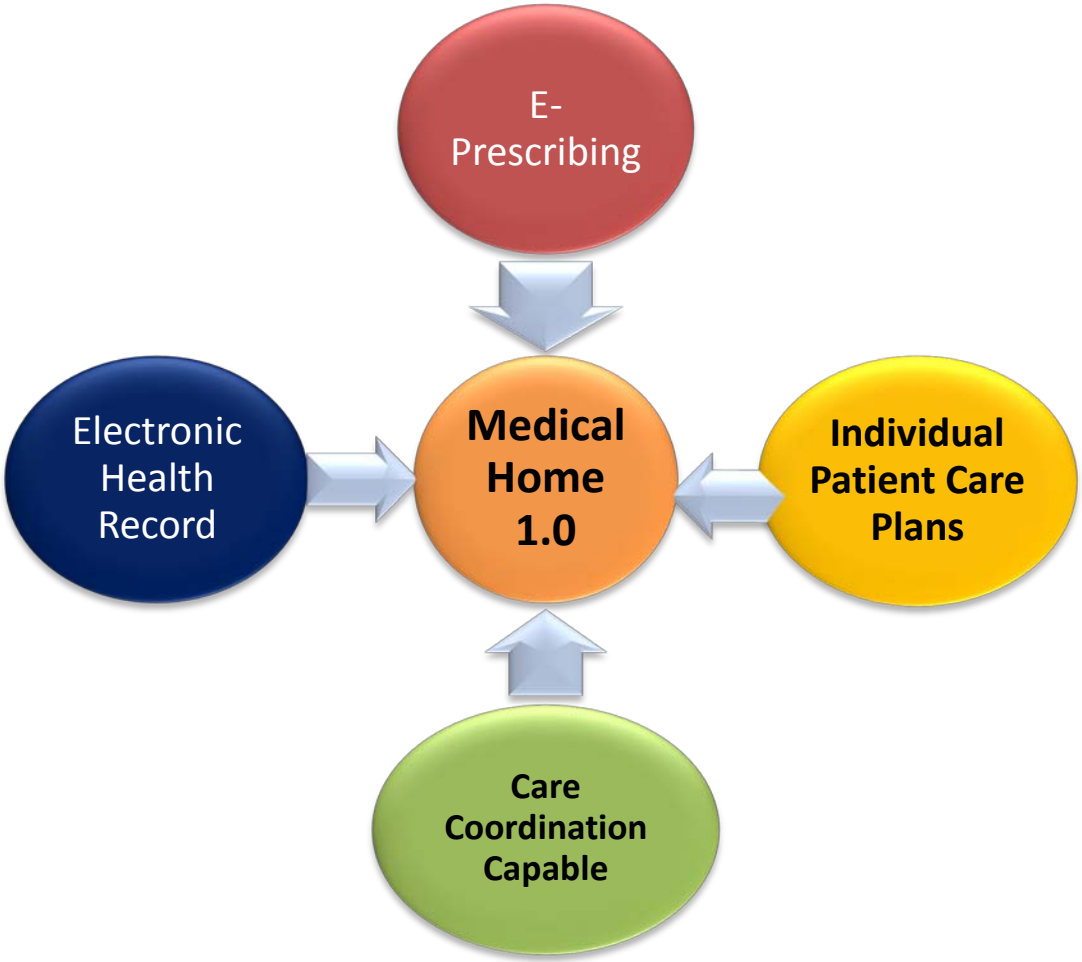
A Strategic System Approach to Healthcare Delivery Transformation



Health Care Delivery System Transformation

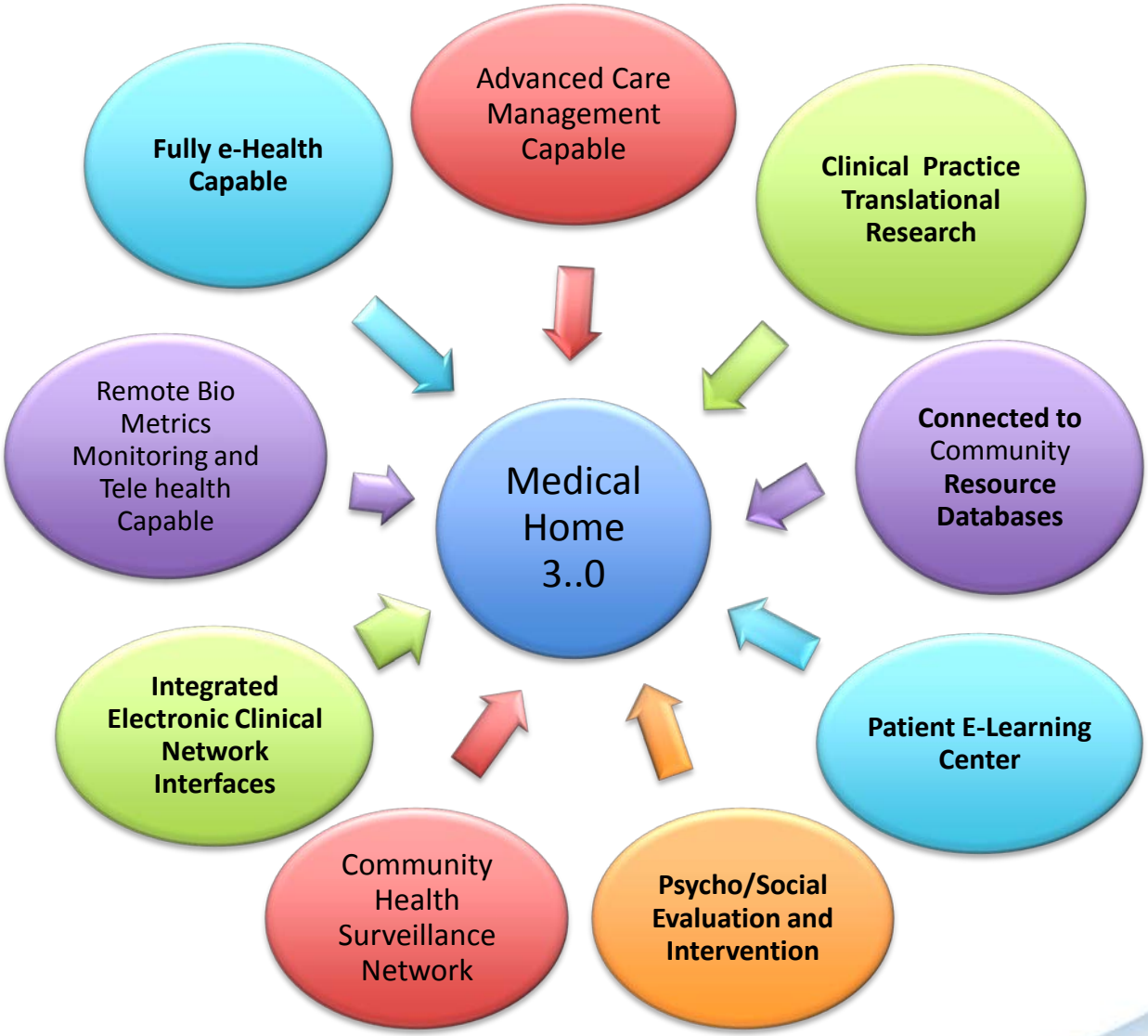


Medical Home 1.0



Medical Home 2.0

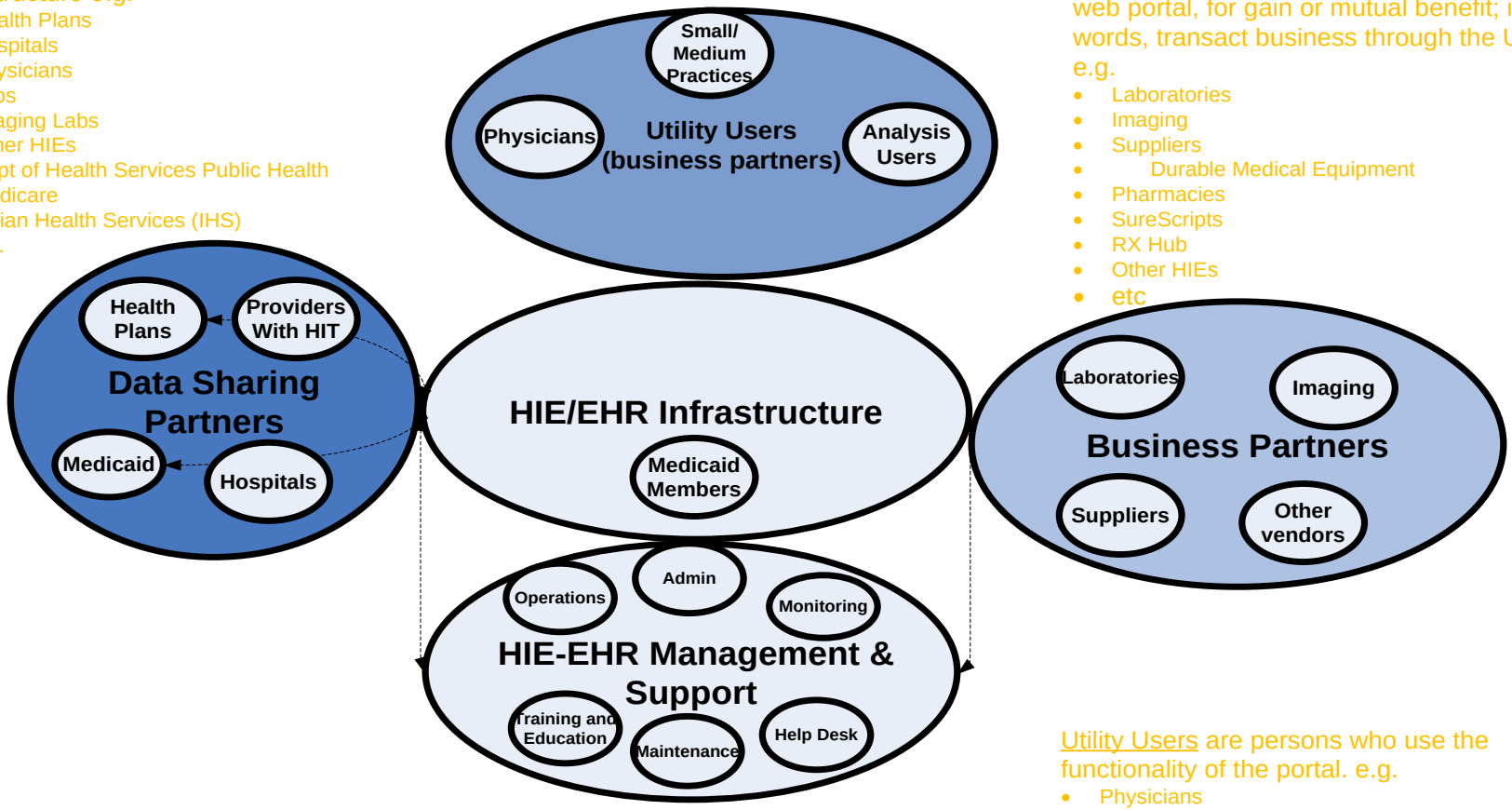
Medical Home 3.0



The Relationships Development for Meaningful Use of Health Information Exchange and EHR

Data Partners are organizations that share or exchange data through the HIE-EHR Infrastructure e.g.

- Health Plans
- Hospitals
- Physicians
- Labs
- Imaging Labs
- Other HIEs
- Dept of Health Services Public Health
- Medicare
- Indian Health Services (IHS)
- etc.



Business Partners are organizations that expose web content and applications through the Utility web portal, for gain or mutual benefit; in other words, transact business through the Utility. e.g.

- Laboratories
- Imaging
- Suppliers
- Durable Medical Equipment
- Pharmacies
- SureScripts
- RX Hub
- Other HIEs
- etc

Utility Users are persons who use the functionality of the portal. e.g.

- Physicians
- Small/medium Practices
- Analysis users (TBD)
- Emergency Depts
- Dept of Public Safety
- Department of Health Services
- etc

Administrative and management users use the portal to access administrative and management applications supported by the portal.

Health Care System Transformation Maturity

Initial Level of Health System Transformation Maturity

Episodic Non Integrated Care

- **Episodic Health Care**
  - Sick care focus
  - Uncoordinated care
  - High Use of Emergency Care
  - Multiple clinical records
  - Fragmentation of care
- **Lack integrated care networks**
- **Lack quality & cost performance transparency**
- **Poorly Coordinate Chronic Care Management**

Managed Performance Level of Health System Transformation Maturity

Accountable Care

- **Transparent Cost**
- **Quality Performance**
  - Results oriented
  - Access and coverage
- **Accountable Provider Networks Designed Around the patient**
- **Focus on care management and preventive care**
  - Primary Care Medical Home
  - Utilization management
  - Medical Management

Optimize Care Level of Health System Transformation Maturity

Integrated Health

Patient Care Centered

- Patient centered Health Care
- Productive and informed interactions between Family and Provider
- Cost and Quality Transparency
- Accessible Health Care Choices

Aligned Incentives for wellness

Integrated networks with community resources wrap around

Aligned reimbursement/cost Rapid deployment of best practices

Patient and provider interaction

- Aligned care management
- E-health capable
- E-Learning resources

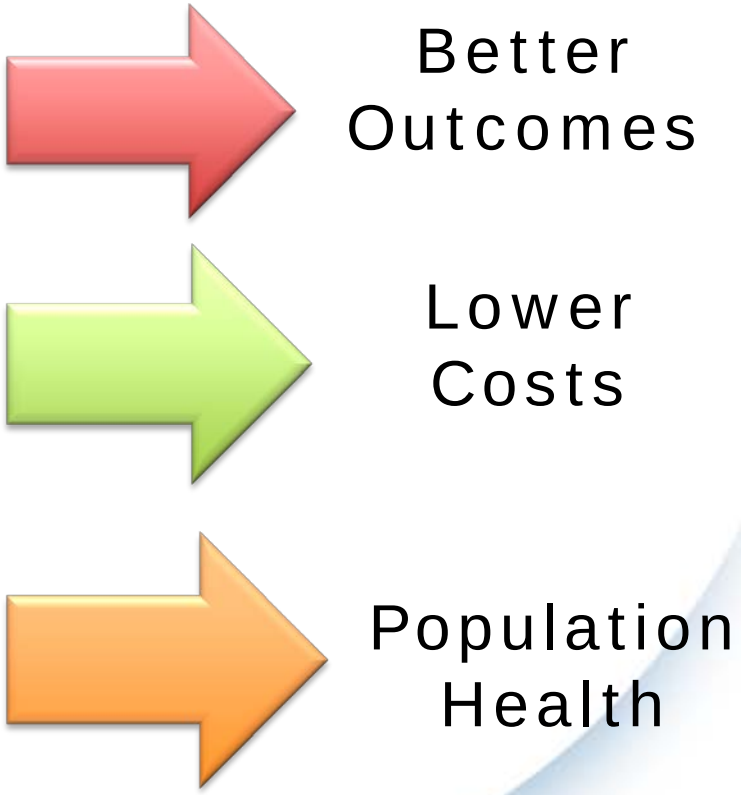
Return on Investment from HIT

Wide Spread Adoption of Electronic Health Information (EHI) Technologies for Better Outcomes , Lower Cost , Improve Population Health

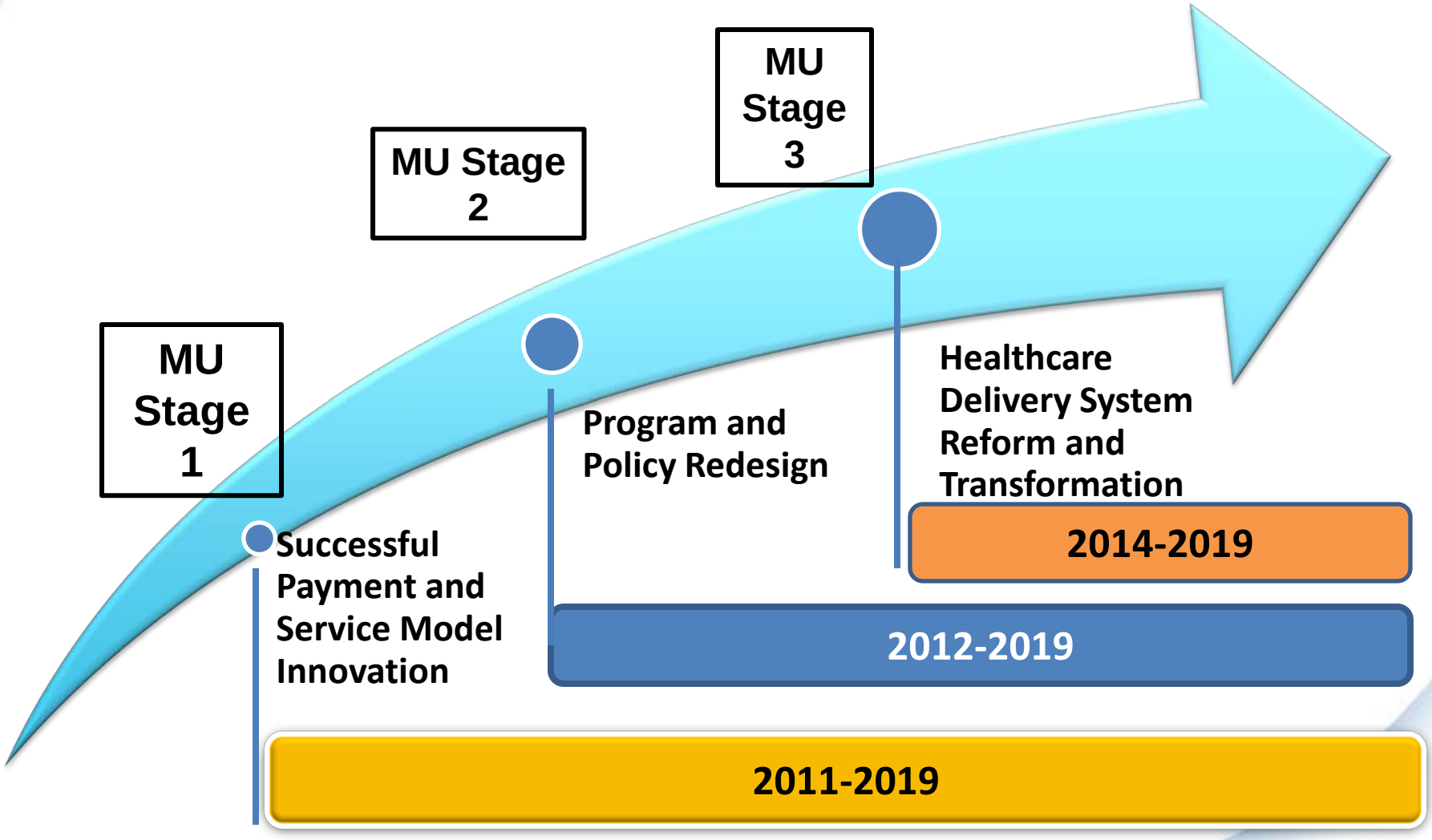
Improving Health Care Quality, Cost Performance, Population Health

ROI of EHI at Point of Care:

- Improved Patient Safety
- Reduced Complications Rates
- Reduced Cost per Patient Episode of Care
- Enhanced cost & quality performance accountability
- Improved Quality Performance
- Improve Community Health Surveillance



Timeline for Delivery System Reform and Transformation 2011-2019

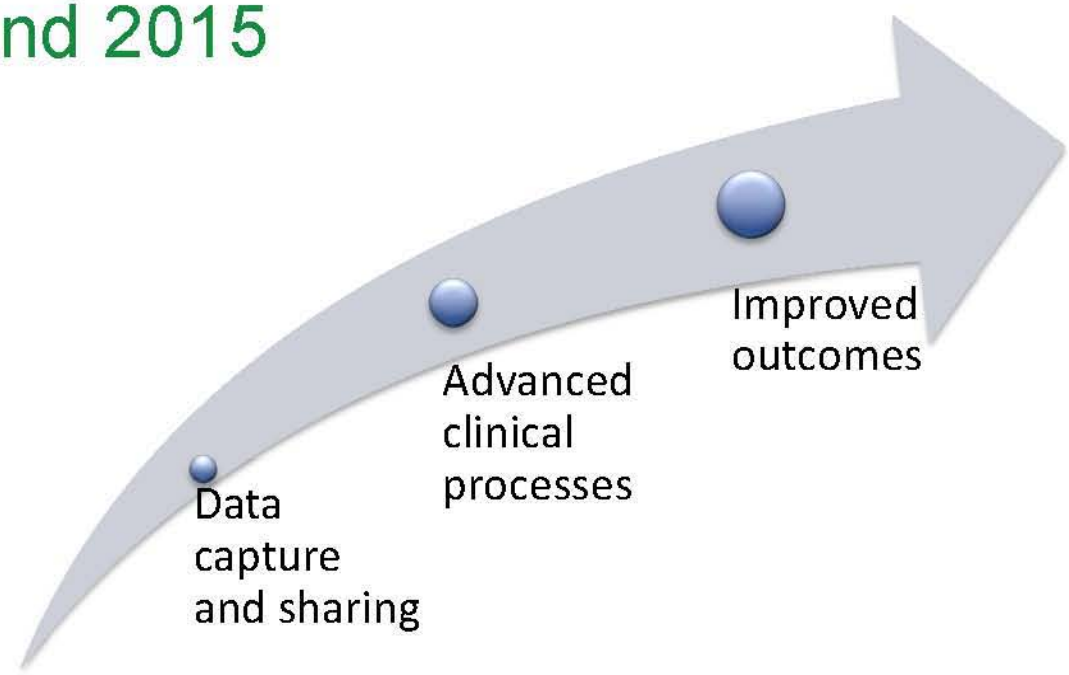


Medicare & Medicaid EHR Incentive Program Final Rule

Implementing the American Recovery & Reinvestment Act of 2009

What are the Requirements / Meaningful Use?

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



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 for the E.HR Incentive Program

- 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 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

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 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: 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 (15 Core and choose 5 of 10 from menu set.)
  - Eligible hospitals have to report on 19 of 24 MU (14 Core and 5 of 10 menu) 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 (CQMs)
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: 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

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 Programs / 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 Physician Quality Reporting (PQRI/PQRS) and Hospital Inpatient Quality Reporting System (formerly known as RHQDAPU)

States' Flexibility to Revise Meaningful Use for Medicaid Providers

- States can seek CMS prior approval to require 4 MU public health 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)

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

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

What Providers 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
  - www.cms.gov/EHRIncentivePrograms

What Providers Need to Participate

- Certified EHR Technology:
  - Required in order to achieve meaningful use
  - Standards and certification criteria announced on July 13, 2010. See http://healthit.hhs.gov/standardsandcertification for more information
  - ONC in process of authorizing “testing and certification bodies” for temporary certification program
  - Certified products are expected to be available in the Fall
  - List of certified EHRs and EHR modules will be posted on ONC web site (CHPL)
  - Visit http://healthit.hhs.gov/certification for more information
  - Email ONC.Certification@hhs.gov with questions

Resources to Get Help and Learn More

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

  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

More information:

- http://www.cms.gov/EHRIncentivePrograms

Questions?

THANK YOU