EHR Meaningful Use Updates

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EHR Incentive Programs Overview

• The American Recovery and Reinvestment Act of 2009 authorizes CMS to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade or demonstrate meaningful use of certified electronic health record (EHR) technology.

• Providers have to meet specific requirements in order to receive incentive payments: Meaningful Use Objectives
Goal

Adoption

Meaningful Use

Exchange

Improved Individual and Population Health Outcomes

Increased Transparency and efficiency

Improved ability to study and improve care delivery

- Regional Extension Centers
- Medicaid EHR Program 1st year incentive
- Workforce Training

- Medicare and Medicaid EHR Incentive Programs

- State Grants for Health Information Exchange
- Medicaid Administrative Funding for HIE
- Standards and Certification Framework
- Privacy and Security Framework

Health IT Practice Research
AIU & MU

- **Adopt, implement, upgrade (AIU)**
  - First participation year only
  - No EHR reporting period

- **Meaningful use (MU)**
  - Successive participation year; and
  - Some dually-eligible hospitals in year 1

- Medicaid Providers’ AIU/MU does not have to be over six consecutive years
Adopt/Implement/Upgrade for Incentives

- MEDICAID – Only for first participation year
- Adopt and have purchase agreement
- Implement — Acquire and Install, Commence Utilization of EHR
  - Eg: Staff training, data entry of patient demographic information into EHR
- Upgrade – Expand
  - Upgrade to certified EHR technology or added new functionality to meet the definition of certified EHR technology
- Must be certified EHR technology capable of meeting meaningful use
- No EHR reporting period
Certified EHR Technology

• To meet meaningful use, providers must attest to the use of EHR technology that is certified by the Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB)

• A list of the latest certified technology can be found on the ONC website
  ▪ http://onc-chpl.force.com/ehrcert
Meaningful Use

- Meaningful Use is using certified EHR technology to meet 15 specific measures that will:
  - 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
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
## Eligibility: Patient Volume

<table>
<thead>
<tr>
<th>Type</th>
<th>Medicaid PV</th>
<th>Medicaid EP practices predominately in FQHC / RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>30%</td>
<td>30% “needy individual” PV</td>
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<tr>
<td>- Pediatrician</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Certified nurse-midwife (CNM)</td>
<td>30%</td>
<td></td>
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<tr>
<td>Nurse practitioner (NP)</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Physician assistant (PA) when practicing in FQHC/RHC <em>led by a PA</em></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospital (CAH)</td>
<td>10%</td>
<td>Not an option for hospitals</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>No Requirement</td>
<td></td>
</tr>
</tbody>
</table>
Eligibility: Practices Predominantly & Needy Individuals

- EP is also eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals*

- *Practicing predominantly* is when FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year

- *Needy individuals* (specified in statute) include:
  - Medicaid or CHIP enrollees;
  - Patients furnished uncompensated care by the provider; or
  - Furnished services at either no cost or on a sliding scale
Eligibility: Hospital-based EPs

- EPs must not be *hospital-based* for participation
  - Does not apply to EPs practicing predominantly in FQHC/RHC

- *Hospital-based* is an EP who “furnishes *substantially all* of the individual’s professional services in a hospital setting…”

- If 90% or more of the EP’s services are conducted in an inpatient hospital or ER: = *hospital-based* (i.e., ineligible)
Meaningful Use for EPs Working in Multiple Settings

- An Eligible Professional 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
## Payments: EP Adoption Timeline

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<tr>
<td>2011</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2012</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
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<tr>
<td>2013</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
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<tr>
<td>2014</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
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<tr>
<td>2015</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
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<tr>
<td>2016</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
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<td>$21,250</td>
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<td>2017</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
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<tr>
<td>2018</td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
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<tr>
<td>2019</td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
</tr>
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</table>
# Notable Differences Between Medicare and Medicaid Programs

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government will implement (will be an option nationally)</td>
<td>Voluntary for States to implement (may not be an option in every State)</td>
</tr>
<tr>
<td>Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use</td>
<td>No Medicaid payment reductions</td>
</tr>
<tr>
<td>Must demonstrate MU in Year 1</td>
<td>A/I/U option for 1\textsuperscript{st} participation year</td>
</tr>
<tr>
<td>Maximum incentive is $44,000 for EPs (bonus for EPs in HPSAs)</td>
<td>Maximum incentive is $63,750 for EPs</td>
</tr>
<tr>
<td>MU definition is common for Medicare</td>
<td>States can adopt certain additional requirements for MU</td>
</tr>
<tr>
<td>Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015</td>
<td>Last year a provider may initiate program is 2016; Last year to register is 2016</td>
</tr>
<tr>
<td>Only physicians, subsection(d) hospitals and CAHs</td>
<td>5 types of EPs, acute care hospitals (including CAHs) and children’s hospitals</td>
</tr>
</tbody>
</table>
Requirements for MU Reporting

**Stage 1**
- Eligible Professionals
  - 15 core objectives
  - 5 of 10 menu objectives
  - 20 total objectives
- Eligible Hospitals & CAHs
  - 14 core objectives
  - 5 of 10 menu objectives
  - 19 total objectives

**Stage 2**
- Eligible Professionals
  - 17 core objectives
  - 3 of 6 menu objectives
  - 20 total objectives
- Eligible Hospitals & CAHs
  - 16 core objectives
  - 3 of 6 menu objectives
  - 19 total objectives
## Requirements of CQM Reporting

<table>
<thead>
<tr>
<th>Provider</th>
<th>Before 2014</th>
<th>2014 and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPs</td>
<td>Complete 6 out of 44 CQMs</td>
<td>Complete 9 out of 64 CQMs</td>
</tr>
<tr>
<td></td>
<td>• 3 core or</td>
<td>Choose at least 1 measure in 3 NQS domains</td>
</tr>
<tr>
<td></td>
<td>3 alternate core</td>
<td>Recommended core CQMs include:</td>
</tr>
<tr>
<td></td>
<td>• 3 menu</td>
<td>• 9 CQMs for the adult population</td>
</tr>
<tr>
<td></td>
<td>Selected CQMs must cover at least 3 of the National Quality Strategy (NQS)</td>
<td>• 9 CQMs for the pediatric population</td>
</tr>
<tr>
<td></td>
<td>domains</td>
<td>• Prioritize NQS domains</td>
</tr>
<tr>
<td>Eligible Hospitals and CAHs</td>
<td>Complete 15 out of 15</td>
<td>Complete 16 out of 29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Choose at least 1 measure in 3 NQS domains</td>
</tr>
</tbody>
</table>

- Reporting period is 90 days for first year and 1 year subsequently
- All providers must report on CQMs to demonstrate meaningful use, even though CQM reporting was removed as a core objective
Stage 2 CQM: Oral Health

Measure 1: Children who have dental decay or cavities

Description: Percentage of children ages 0-20, who have had tooth decay or cavities during the measurement period.

Measure 2: Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Description: Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.
Role of the Dental Quality Alliance

…to advance the field of performance measurement to improve oral health, patient care, and safety through a consensus building process.

- Is a comprehensive multi-stakeholder entity
- Formed at the request of CMS
- Developing CQM’s
- Administrative Data and EHR
- Actively engaged with federal agencies to ensure useful and appropriate measures are developed for dentistry
Role of the American Dental Association

- EHR Functional Requirement Standards
- Diagnostic and Procedure Code standards
  - CDT Code
  - SNODENT is now an internationally recognized subset of SNOMED-CT. SNOMED-CT is a required terminology for use in certified Electronic Health Records Systems for Medicaid and Medicare meaningful use incentive program
More to Come

• Stage II released August 23, 2012
• NNOHA and DQA at ADA are working together with CMS, NQF, AHRC and HRSA on oral health measures.
• Will update as we receive information
Stage I Payments

- More than 287,000 eligible health care professionals and more than 3,900 hospitals have registered for the program.
- Over 66,000 EPs have received Medicare payments and over 57,000 have received Medicaid payments since it began in January 2011. That exceeds the 100,000 goal set earlier this year.
- This means 1 out 5 EP’s have gotten the payment.
- In August, 2012, 89 hospitals registered for the Medicare and Medicaid electronic health record incentive program bringing the program total to 3,663 eligible and critical access hospitals.
- In August 2012, eligible hospitals and critical access hospitals received $195 million in Medicare incentive payments and $101 in Medicaid incentive payments.
Stage I Payments (Cont’d)

• Since January 2011, when the EHR incentive program began, eligible and critical access hospitals received $2.3 billion in Medicare incentive payments and $2.1 billion in Medicaid incentive payments.
Stage I Payments (Cont’d)

The following states have had the highest Medicare and Medicaid provider payments since the program began:

1. Texas
2. Florida
3. California
4. Pennsylvania
5. New York
How’s it Going?

- Registrants for Medicare AND Medicaid
  - 287,119 Total
  - 6,923 Dentists

- Medicaid Payments
  - 57,584 Total for $3,327,450,494
  - 3,378 Dentists for $71,523,250
How’s it Going?

### Medicaid Incentive Payments

<table>
<thead>
<tr>
<th></th>
<th>Eligible Professionals</th>
<th>Eligible Professional Payments</th>
<th>Eligible Hospitals</th>
<th>Eligible Hospital Payments</th>
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<tbody>
<tr>
<td>January-11</td>
<td>36</td>
<td>$765,000</td>
<td>10</td>
<td>$20,982,290</td>
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<tr>
<td>February-11</td>
<td>130</td>
<td>$2,691,670</td>
<td>17</td>
<td>$13,166,786</td>
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<tr>
<td>March-11</td>
<td>453</td>
<td>$9,626,250</td>
<td>28</td>
<td>$16,861,205</td>
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<tr>
<td>April-11</td>
<td>338</td>
<td>$7,182,500</td>
<td>27</td>
<td>$23,542,516</td>
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<tr>
<td>May-11</td>
<td>570</td>
<td>$12,034,587</td>
<td>21</td>
<td>$20,698,510</td>
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<tr>
<td>June-11</td>
<td>807</td>
<td>$16,978,758</td>
<td>43</td>
<td>$30,873,891</td>
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<tr>
<td>July-11</td>
<td>1,038</td>
<td>$21,682,100</td>
<td>50</td>
<td>$50,453,781</td>
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<tr>
<td>August-11</td>
<td>1,563</td>
<td>$32,852,517</td>
<td>125</td>
<td>$125,351,280</td>
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<tr>
<td>September-11</td>
<td>1,890</td>
<td>$39,595,860</td>
<td>117</td>
<td>$106,879,114</td>
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<tr>
<td>October-11</td>
<td>2,219</td>
<td>$46,757,102</td>
<td>228</td>
<td>$170,778,905</td>
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<tr>
<td>November-11</td>
<td>2,668</td>
<td>$55,919,370</td>
<td>191</td>
<td>$157,565,682</td>
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<tr>
<td>December-11</td>
<td>3,778</td>
<td>$79,318,958</td>
<td>349</td>
<td>$291,023,238</td>
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<tr>
<td>January-12</td>
<td>4,039</td>
<td>$84,702,553</td>
<td>198</td>
<td>$151,824,184</td>
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<tr>
<td>February-12</td>
<td>5,380</td>
<td>$113,014,643</td>
<td>182</td>
<td>$148,083,094</td>
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<tr>
<td>March-12</td>
<td>6,479</td>
<td>$136,085,056</td>
<td>202</td>
<td>$182,840,218</td>
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<tr>
<td>April-12</td>
<td>5,091</td>
<td>$106,439,890</td>
<td>205</td>
<td>$212,124,376</td>
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<tr>
<td>May-12</td>
<td>4,603</td>
<td>$93,630,413</td>
<td>133</td>
<td>$132,371,617</td>
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<tr>
<td>June-12</td>
<td>5,544</td>
<td>$113,579,879</td>
<td>140</td>
<td>$115,640,469</td>
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<tr>
<td>July-12</td>
<td>4,507</td>
<td>$90,498,114</td>
<td>155</td>
<td>$114,750,768</td>
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<tr>
<td>August-12</td>
<td>3,879</td>
<td>$76,803,202</td>
<td>151</td>
<td>$101,480,151</td>
</tr>
<tr>
<td>TOTAL</td>
<td>55,012</td>
<td>$1,140,158,421</td>
<td>2,572</td>
<td>$2,187,292,073</td>
</tr>
</tbody>
</table>
Recap: Three Stages

- **Stage 1**: The basic functionalities electronic health records must include such as capturing data electronically and providing patients with electronic copies of health information.
- **Stage 2**: (Will begin in 2014) Increases health information exchange between providers and promotes patient engagement by giving patients secure online access to their health information.
- **Stage 3**: (Rule will be released in 2014) Will continue to expand meaningful use objectives to improve health care outcomes.
Recap: (Cont’d)

• Stage two of the program will begin in 2014. No providers will be required to follow the Stage 2 requirements outlined today before 2014.

• Outline the certification criteria for the certification of EHR technology, so eligible professionals and hospitals may be assured that the systems they use will work, help them meaningfully use health information technology, and qualify for incentive payments.

• Modify the certification program to cut red tape and make the certification process more efficient.
Recap: (Cont’d)

• Allow current “2011 Edition Certified EHR Technology” to be used through 2013. Providers have the option of using 2014 certification in 2013 but they MUST use the 2014 certification starting in 2014.

• The CMS final rule also provides a flexible reporting period for 2014 to give providers sufficient time to adopt or upgrade to the latest EHR technology certified for 2014.
Stay Up-to-Date

• NNOHA’s HIT Resources: http://www.nnoha.org/practicemanagement/hit.html

• Upcoming Resources:
  ▪ Use of Diagnostic Codes in Health Centers
  ▪ Newsletter article on Meaningful Use updates (Planned for November 2012)
ACKNOWLEDGEMENT:
Dr. Krishna Aravamudhan, ADA

Questions?